aetna™

60.6 Technical Proposal Content

Kentucky | Transforming Health Care | **Aetna**

PROPOSAL SUBMISSION CHECKLIST

The vendor **MUST** include the following with the proposal submission.

If the items highlighted below are not submitted with the proposal submission, the Commonwealth **MUST** deem the proposal non-responsive and SHALL NOT consider for award.

All other items **MUST** be submitted prior to award.

- [X] FACE OF SOLICITATION - SIGNED [see Section 60.4]
- [X] *PROPOSED TECHNICAL SOLUTION UNDER SEALED COVER AND BY CLOSING DATE AND TIME [see Sections 60.5 – 60.7]
- [X] TRANSMITTAL LETTER [see Section 60.6(A)]
- [X] REVENUE FORM 10A100 KENTUCKY TAX REGISTRATION APPLICATION (see Section 60.6 (C)]
- [X] CERTIFICATE OF AUTHORITY- REGISTRATION WITH SECRETARY OF STATE BY A FOREIGN ENTITY [see Section 60.6 (D)]
- [X] REQUIRED ANNUAL AFFIDAVIT AND OTHER AFFIDAVIT(S) [see Attachment A]
- [X] EEO FORMS IF APPLICABLE [see Section 40.21]

**The Commonwealth defines SEALED as "a closure that must be broken to be opened and that thus reveals tampering". (Merriam-Webster Dictionary, http://www.merriam-webster.com/dictionary/seal)*

60.6.A Transmittal Letter

Kentucky | Transforming Health Care | **Aetna**

David J. McNichols,
Chief Executive Officer,
Aetna Medicaid
3600 Mansell Road, 4th Floor
Alpharetta, GA 30022

Commonwealth of Kentucky
Finance and Administration Cabinet
Office of Procurement Services
Amy Monroe
Bid Clerk
702 Capitol Ave, Capitol Annex Room 095
Frankfort KY 40601

February 7, 2020

RE: RFP 758 2000000202 - Medicaid Managed Care Organization (MCO) - All Regions

Dear Ms. Monroe,

Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health® of Kentucky Inc. (Aetna) is pleased to submit this response to the Commonwealth of Kentucky's Request for Proposal (RFP) for Medicaid Managed Care Organization (MCO) – All Regions, RFP 758 2000000202.

Aetna serves over 211,000 Kentucky Medicaid enrollees statewide, and our enrollees are at the forefront of all we do. Aetna is a quality leader with a Commendable rating from the National Committee for Quality Assurance and currently has a top score in the state for Medicaid managed care organizations. At the same time, we recognize our responsibilities as a steward of the Commonwealth's managed care resources. We take seriously our obligation to use financial resources efficiently while providing high-quality services that improve the health of Kentucky Medicaid managed care enrollees.

Aetna's Medicaid organization is proud of its deep roots and history of serving Medicaid managed care enrollees in Kentucky since the program's beginning in 2011. For over 30 years, Aetna's Medicaid organization has honed its approach to serving high-acuity, medically frail, and low-income populations with diverse benefits, and we leverage that experience in serving the full range of Kentucky Medicaid beneficiaries.

In accordance with RFP Section 60.6.A.i-ix, we provide the following statements and information:

i. Aetna understands that deviations are not allowed.

ii. Aetna swears that, if awarded a contract as a result of this solicitation, it will comply in full with all requirements of the Kentucky Civil Rights Act, and shall submit all data required by KRS 45.560 to 45.640;

iii. Pursuant to KRS 11A.040, Aetna swears that it has not knowingly violated any provisions of the Executive Branch Code of Ethics;

iv. Aetna swears that, to the best of its knowledge and belief, it is in compliance with RFP Section 40.27, Prohibitions of Certain Conflicts of Interest as set forth in KRS 45A.340. Aetna further swears that in the

performance of the contract, no person, including any subcontractor, having any conflict of interest as described in KRS 45A.340 shall be employed. Furthermore, in accordance with KRS 45A.340 and KRS 11A.040(4), Aetna swears that it shall not knowingly allow any official or employee of the Commonwealth who exercises any function or responsibility in the review or approval of the undertaking or carrying out of this contract to voluntarily acquire any ownership interest, direct or indirect, in the contract prior to the completion of the contract.

v. Aetna certifies that in accordance with Federal Acquisition Regulation 52.209-5, Certification Regarding Debarment, Suspension, and Proposed Debarment, that to the best of its knowledge and belief, Aetna and/or its principals is (are) not presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any State or Federal agency.

vi. The name, address, telephone number, fax number, and email address of the contract person for this RFP is as follows:

Jonathan E. Copley, Esq.
CEO, Aetna Better Health® of Kentucky
Aetna Medicaid
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223
Office: (502) 719-8767
Mobile: (859) 285-5251
Fax: (855) 454-5584
CopleyJ@aetna.com

vii. The name, address, telephone number, fax number, and email address of the contact person to serve as a point of contact for day-to-day operations:

Jonathan E. Copley, Esq.
CEO, Aetna Better Health® of Kentucky
Aetna Medicaid
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223
Office: (502) 719-8767
Mobile: (859) 285-5251
Fax: (855) 454-5584
CopleyJ@aetna.com

viii. Aetna certifies that the thumb/flash drives submitted have been properly scanned for infected viruses, using the following virus software and version: Crowdstrike Falcon Enterprise version 4.26.8904 with NextGenAV component enabled.

ix. Subcontractor information, including name of company, address, telephone number, and contact name, is listed within the table located at the end of this letter.

We declare that our proposal includes proprietary information.

Thank you for this opportunity to submit a proposal to the Commonwealth. Aetna and our Kentucky-based staff are proud of our successful service to members and providers, as well as our relationship with the Commonwealth. We look forward to future collaboration and the opportunity to further improve the health care delivery system on behalf of all Kentuckians.

aetna

January 27, 2020
Date

David J. McNichols
Chief Executive Officer, Aetna Medicaid
3600 Mansell Road, 4th Floor
Alpharetta, GA 30022

I am authorized to bind Aetna and hereby affirm the accuracy of the information contained herein.

Subscribed and sworn to before by CEO David J. McNichols
(Title) (Affiant)

Of Aetna Medicaid this 27th day of January, 2020

Cynthia Montano
Notary

CYNTHIA MONTANO
Notary Public, State of Connecticut
My Commission Expires March 31, 2021

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Aetna Better Health® of Kentucky Subcontractor Contact Information

Entity Name	Name and Contact Information
Accipio Language Services	Doug Reed Accipio Language Services 838 East High St, Ste 160 Lexington KY 40502 (859) 533-4313 doug@accipioservices.com
ActiveHealth Management, Inc. (subsidiary of CVS Health)	Gary Bucello 233 Spring Street—East New York, NY 10013 (703) 995-6395 GBucello@activehealth.com
Advanced Medical Reviews, LLC (subsidiary of ExamWorks Group, Inc.)	Jeffrey Schulze VP Enterprise Accounts 600 Corporate Pointe, Suite 300 Culver City, CA 90230 (310) 907-9380 jschulze@admere.com
Aetna Health Management LLC	Sheryl Burke Adkins 151 Farmington Avenue, Hartford, CT 06156 (860)273-9243 BurkeSA@aetna.com
Aetna Medicaid Administrators LLC	David J. McNichols CEO 4500 E. Cotton Center Blvd., Building 1 Phoenix, Arizona 85040 (770) 346-1045 McNicholsD@aetna.com
Akorbi Consulting	Azam Mirza President of Akorbi Group of Companies 6504 International Parkway, Suite 1500 Plano, TX 75093 (214) 256-9222 amirza@akorbi.com

Entity Name	Name and Contact Information
The Guardian Life Insurance Company of America, parent company of Avēsis, Inc.	Dale Miracle Strategic Client Partner, Avesis, Inc. 10324 S. Dolfield Road Owings Mills, MD 21117 (410) 413-9314 dmiracle@avesis.com
Bluegrass Care Navigators	Susan Swinford VP of Administration 2312 Alexandria Dr Lexington, KY 40504 (859) 276-5344 susans@bgcarenav.org
Care Innovations, LLC	Mike Bradshaw Key Account Manager 950 Iron Point Road, Suite 160 Folsom, CA 95630 (530)309-5307 mike.bradshaw@careinnovations.com
CaremarkPCS Health (subsidiary of CVS Health)	Ryan Steadman Strategic Account Director One CVS Drive Woonsocket, Rhode Island 02895 (513) 309-3610 Ryan.Steadman@CVSHealth.com
Conduent Credit Balance Solutions, LLC (parent Conduent Inc)	Walter Schmidt307 International Circle, Suite 300 Hunt Valley, MD 21030 (443) 386-9725 walter.schmidt@conduent.com
Center for the Study of Services	Eban Lewis Senior Research Associate 1625 K Street, NW, 8th Floor Washington, DC 20006 (202) 454-3046 elewis@cssresearch.org

Entity Name	Name and Contact Information
Central Kentucky Interpreter	Jennifer Paycheck Director of Operations PO Box 104 Danville, KY 40423 (859) 236-9888 Jennifer@ckira.org
Change Healthcare LLC	Ann Armstrong Senior Client Executive 3055 Lebanon Pike, Suite 1000 Nashville, TN 37214 (414) 405.8651 aarmstrong@changehealthcare.com
Cotiviti Holdings, Inc.	Lori Walsh One Glenlake Parkway, Suite 1400 Atlanta, GA (770) 379-2800 lori.walsh@cotiviti.com
CQ fluency	Alan Vernon VP of Healthcare 2 University Plaza Drive Suite 406 Hackensack, NJ 07601 (201) 487-8007 alan.vernon@cqfluency.com
Donnelley Financial Solutions	Glen Donaldson Executive Director 55 Water Street NY, NY 10041 (917) 402-4344 glen.donaldson@dfinsolutions.com
Edifecs	John Wright Regional Vice President - Sales 137 Park Street, Unit 5 Portland, ME 04101 (617) 824-0813 johnw@edifecs.com

Entity Name	Name and Contact Information
Equian, LLC	Stephanie Elliott VP, Sales & Client Managing 600 12th Street, Suite 300 Golden, CO 80401 (720) 259.4367 selliott@equian.com
eviCore healthcare MSI, LLC d/b/a eviCore healthcare (parent company is Cigna)	Scott Bowman Client Experience Director 400 Buckwalter Place Blvd. Bluffton, SC 29910 (800) 918-8924 Scott.Bowman@evicore.com
HMS Holdings Corp. (Eliza Holdings Corp. and Health Management Sytems, Inc.)	Robert Dickerson Senior Director, Health Plan Solutions 1450 Broadway New York, NY 10018 (212) 857-5270 rdickerson@hms.com
Inovalon Holdings, Inc.	Bill Carden, Senior Director and General Manager Quality Spectrum® 4321 Collington Road Bowie, MD 20716 (301) 809-4000 ext. 6162 bcarden@inovalon.com
John Michael Associates Inc.	John J. Papa President 94 Holmes Road Newington CT 06111 (860)666-1414 john@jmalogos.com
Kentucky Hospital Association (KHA)	Brian Brezosky General Counsel 2501 Nelson Miller Parkway Louisville, KY 40223 (502) 426-6220, ext. 4333 BBrezosky@kyha.com

Entity Name	Name and Contact Information
Language Line Services, Inc.	J Wolfrum One Lower Ragsdale Drive Monterey, CA 93940 (831) 200-6846 jwolfrum@languageline.com
MCG Health, LLC	Cheryl Earls, RN, BSN, PAHM Senior Account Executive 901 Fifth Ave, Suite 2000 Seattle, WA 98164 (206) 348-1175 cheryl.earls@mcg.com
NantHealth (Eviti)	Anne Donovan 9920 Jefferson Boulevard Culver City, CA 90232 (201) 618-7439 Anne.Donovan@nanthealth.com
Office Ally, Inc.	Daniel Wojta PO Box 872020 Vancouver, WA 98687 (360) 975-7000 daniel.wojta@officeally.com
Pursuant Health Inc.	Kathryn Laughlin 780 Johnson Ferry Road, Suite 625 Atlanta, GA 30342 (706) 339-3214 Kathryn.Laughlin@pursuanthealth.com
Red-Card Systems, LLC / Red Card Holdings, LLC	Brian Lager Technical Account Manager 744 Office Parkway St. Louis, MO 63141 (314) 938-5870 BLager@redcard.com
Symphony Performance Health, Inc. d/b/a SPH Analytics	John DiCesare Vice President, Sales 11605 Haynes Bridge, Suite 400 Alpharetta, GA 30009 (866) 460-5681 John.DiCesare@SPHAnalytics.com

Entity Name	Name and Contact Information
Unite USA, Inc. dba Unite Us	Taylor Justice President & Co-Founder 217 Broadway floor 8 New York, NY 10007 (844) 786-4838 taylor@uniteus.com
Welltok	Beth Capucci 1515 Arapahoe Street, Tower 3, Suite 700 Denver, CO 80202 (617) 285-5623 Beth.Capucci@welltok.com

60.6.B Disclosure of Violation of Statutes

Kentucky | Transforming Health Care | **Aetna**

60.6 B. Disclosure of Violation of Statutes

Vendor, Aetna Better Health® of Kentucky, has incurred no final determinations of violations of the tax and employment laws set forth in KRS Chapters 136, 139, 141, 337, 338, 341, and 342 in the last five years. Any such violations that have been incurred by our proposed subcontractors in the last five years are set forth on the Reports of Prior Violations of Tax and Employment Laws provided on the following pages.

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Report of Prior Violations of Tax and Employment Laws for Affiliated Subcontractors Aetna Medicaid Administrators LLC, Aetna Health Management, LLC, and Active Health Management, Inc.

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STANDARD ATTACHMENTS MENU CHOICE 11

REPORT OF PRIOR VIOLATIONS OF TAX AND EMPLOYMENT LAWS

1. KRS 45A.485 requires Vendor to Report Prior Violations:

KRS 45A.485 requires the bidder to report prior violations and reveal to the Commonwealth, prior to the award of a contract, any final determination of a violation by the contractor within the previous five (5) year period of the provisions of KRS Chapters 136, 139, 141, 337, 338, 341, and 342. These statutes relate to the State Sales and Use Tax, Corporate and Utility Tax, Income Tax, wages and hours laws, Occupational Safety and Health laws, Unemployment Insurance laws, and Workers Compensation insurance laws, respectively.

To comply with the provisions of KRS 45A.485, each Bidder shall report any, if any, such final determination(s) of violation(s) by listing below the KRS violated, the date of the final determination, and the State Agency which issued the final determination. This form shall be submitted with the Bid if any final determinations were issued during the applicable 5-year period.

KRS violated	Date of Final Determination	State Agency
141	4/26/2019	Department of Revenue

KRS 45A.485 also requires that, for the duration of any contract, the contractor shall be in continuous compliance with the provisions of the above statutes that apply to the contractor's operations. The contractor's failure to reveal a final determination as described above or failure to comply with the above cited statutes for the duration of the contract shall be grounds for the Commonwealth's cancellation of the contract and the contractor's disqualification from eligibility to bid or submit proposals to the Commonwealth for a period of two (2) years.

60.6.C Kentucky Tax Registration Application

Kentucky | Transforming Health Care | **Aetna**

Commonwealth of Kentucky
Department of Revenue
Frankfort , KY-40620
revenue.ky.gov

AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY COMPANY
151 FARMINGTON AVE
HARTFORD CONNECTICUT -06156

DATE: 6/13/2019

RE : SALES AND USE TAX ACCOUNT NUMBER : KRS 61.878(1)(a)

FILING FREQUENCY : **QUARTERLY**

THE SALES AND USE TAX ACCOUNT NUMBER REFERENCED ABOVE HAS BEEN ASSIGNED TO YOUR BUSINESS. DEPARTMENT OF REVENUE (DOR) RECORDS INDICATE THE LIABILITY DATE IS **02/01/2016** , IF THIS IS INCORRECT , PLEASE CONTACT THE DIVISION OF REGISTRATION. PLEASE USE THIS ACCOUNT NUMBER ON ALL TAX RETURNS AND CORRESPONDENCE REGARDING SALES AND USE TAX.

ELECTRONIC FILING AND PAYMENT OF SALES AND USE TAX IS AVAILABLE AT HTTP://REVENUE.KY.GOV/COLLECTIONS/PAGES/E-FILE-PAYMENT-OPTIONS.ASPX. IF YOU HAVE NOT REGISTERED FOR E-FILING AND PAYMENT YET, A PREPRINTED RETURN WILL BE MAILED TO YOU APPROXIMATELY FIFTEEN (15) DAYS PRIOR TO THE DUE DATE OF EACH RETURN. RETURNS MUST BE FILED, EVEN IF NO TAX IS DUE, BY THE 20TH OF THE FOLLOWING MONTH ACCORDING TO THE FILING PERIOD.

YOUR KENTUCKY SALES AND USE TAX PERMIT IS ACCESSIBLE ONLINE IF REGISTERED FOR E-FILING AND INCLUDED ON THE NEXT PAGE OF THIS CORRESPONDENCE. THIS PERMIT MUST BE POSTED IN A CONSPICUOUS PLACE AT THE BUSINESS LOCATION LISTED ON THE PERMIT PURSUANT TO KRS 139.250.

IF IT IS NECESSARY THAT YOU FILE BACK PERIOD RETURNS , THE PROPER FORMS WILL BE MAILED TO YOU SEPARATELY. PLEASE INCLUDE A COPY OF THIS LETTER WITH ANY RETURNS FILED FOR PRIOR PERIODS . PENALTIES FOR LATE FILING AND LATE PAYMENT APPLY AT THE RATE OF 2% FOR EACH MONTH UP TO A MAXIMUM OF 20% OF THE TAX DUE . THE MINIMUM PENALTY FOR A NO TAX DUE RETURN IS $10.00 . THE MINIMUM PENALTY FOR ANY PERIOD THAT IS NOT FILED TIMELY AND A JEOPARDY ASSESSMENT HAS BEEN ISSUED PURSUANT TO KRS 131.150 IS $100.00.

FOR ASSISTANCE WITH UPDATING YOUR BUSINESS INFORMATION, CONTACT THE DIVISION OF REGISTRATION AT 502-564-3306. FOR FURTHER INFORMATION ABOUT YOUR RESPONSIBILITIES AS A RETAILER, PLEASE ACCESS A “RETAIL PACKET” AND “FAQS” AT HTTPS://REVENUE.KY.GOV/BUSINESS/SALES-USE-TAX/PAGES/DEFAULT.ASPX. YOU MAY ALSO ACCESS SELECTED SALES AND USE TAX FORMS AND PUBLICATIONS AT THE SAME WEB SITE. IF YOU HAVE QUESTIONS, PLEASE CONTACT THIS OFFICE AT (502) 564-5170 OPTION #1, OR DIRECT ANY CORRESPONDENCE TO THE E-MAIL ADDRESS OR MAILING ADDRESS BELOW.

DIVISION OF SALES AND USE TAX
DEPARTMENT OF REVENUE
P.O. BOX 181, Station 67.
FRANKFORT KY-40602-0181
PHONE : (502) 564-5170
FAX : (502) 564-2041
EMAIL : DOR.WebResponseSalesTax@ky.gov

FORM 51A101(e)
(4-2015)

Commonwealth of Kentucky
Department of Revenue
Sales and Use Tax Permit

Account Number	KRS 61.878(1)(a)
Issue Date	02/01/2016
Address	AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY 9900 CORPORATE CAMPUS DR STE 100 LOUISVILLE KENTUCKY-40223

THIS SELLER'S PERMIT IS ISSUED PURSUANT TO KRS 139.250.

POST IN A CONSPICUOUS PLACE

THIS PERMIT IS ISSUED PURSUANT TO AUTHORITY OF CHAPTER 139 OF THE KENTUCKY REVISED STATUTES AND IS VALID UNTIL CANCELLED OR REVOKED.

THIS PERMIT IS NOT TRANSFERABLE

60.6.D Registration with the Secretary of State by a Foreign Entity

Kentucky | Transforming Health Care | **Aetna**

60.6 D. Registration with the Secretary of State by a Foreign Entity

This section is not applicable to Aetna Better Health of Kentucky because we are not a foreign entity as defined in KRS 14A.1-070.

Definition of "Foreign Entity" KRS14A.1-070

(10) "Foreign entity" means a corporation, not-for-profit corporation, cooperative, limited cooperative association, association, business or statutory trust, partnership, limited partnership, limited liability company, or unincorporated nonprofit association not:

(a) Organized pursuant to the laws of the Commonwealth of Kentucky; or

(b) As to its internal affairs, governed by the laws of the Commonwealth of Kentucky.

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60.6.E Required Annual Affidavit and Other Affidavit(s)

Kentucky | Transforming Health Care | **Aetna**

Attachment A
60.6 E. Required Affidavit for Bidders, Offerors and Contractors

With respect to Subpart (b) of the attached Required Affidavit for Bidders, Offerors and Contractors, any information required to be disclosed by KRS 45A.485 can be found under the tab titled "60.6.B Disclosure of Violation of Statutes".

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ANNUAL AFFIDAVIT FOR BIDDERS, OFFERORS AND CONTRACTORS

Affidavit Effective Date: _____
Affidavit Expiration Date: _____
Maximum Length One-Year

REQUIRED AFFIDAVIT FOR BIDDERS, OFFERORS AND CONTRACTORS

FOR BIDS AND CONTRACTS IN GENERAL:

I. Each bidder or offeror swears and affirms under penalty of perjury, that to the best of their knowledge:

a. In accordance with KRS 45A.110 and KRS 45A.115, neither the bidder or offeror as defined in KRS 45A.070(6), nor the entity which he/she represents, has knowingly violated any provisions of the campaign finance laws of the Commonwealth of Kentucky; and the award of a contract to the bidder or offeror or the entity which he/she represents will not violate any provisions of the campaign finance laws of the Commonwealth.

b. The bidder or offeror swears and affirms under penalty of perjury that, to the extent required by Kentucky law, the entity bidding, and all subcontractors therein, are aware of the requirements and penalties outlined in KRS 45A.485; have properly disclosed all information required by this statute; and will continue to comply with such requirements for the duration of any contract awarded.

c. The bidder or offeror swears and affirms under penalty of perjury that, to the extent required by Kentucky law, the entity bidding, and its affiliates, are duly registered with the Kentucky Department of Revenue to collect and remit the sales and use tax imposed by KRS Chapter 139, and will remain registered for the duration of any contract awarded.

d. The bidder or offeror swears and affirms under penalty of perjury that the entity bidding is not delinquent on any state taxes or fees owed to the Commonwealth of Kentucky and will remain in good standing for the duration of any contract awarded.

e. The bidder or offeror swears and affirms under penalty of perjury that the entity bidding, is not currently engaged in, and will not for the duration of the contract engage in, the boycott of a person or an entity based in or doing business with a jurisdiction with which Kentucky can enjoy open trade, as defined in Executive Order No. 2018-905.

f. The bidder or offeror swears and affirms that the entity bidding, and all subcontractors therein, have not violated any of the prohibitions set forth in KRS 11A.236 during the previous ten (10) years, and further pledge to abide by the restrictions set forth in such statute for the duration of the contract awarded.

FOR "NON-BID" CONTRACTS (I.E. SOLE-SOURCE; NOT-PRACTICAL OR FEASIBLE TO BID; OR EMERGENCY CONTRACTS, ETC):

II. Each contractor further swears and affirms under penalty of perjury, that to the best of their knowledge:

a. In accordance with KRS 121.056, and if this is a non-bid contract, neither the contractor, nor any member of his/her immediate family having an interest of 10% or more in any business entity involved in the performance of any contract awarded, have contributed more than the amount specified in KRS 121.150 to the campaign of the gubernatorial slate elected in the election last preceding the date of contract award.

b. In accordance with KRS 121.330(1) and (2), and if this is a non-bid contract, neither the contractor, nor officers or employees of the contractor or any entity affiliated with the contractor, nor the spouses of officers or employees of the contractor or any entity affiliated with the contractor, have knowingly contributed more than $5,000 in aggregate to the campaign of a candidate elected in the election last preceding the date of contract award that has jurisdiction over this contract award.

c. In accordance with KRS 121.330(3) and (4), and if this is a non-bid contract, to the best of his/her knowledge, neither the contractor, nor any member of his/her immediate family, his/her employer, or his/her employees, or any entity affiliated with any of these entities or individuals, have directly solicited contributions in excess of $30,000 in the aggregate for the campaign of a candidate elected in the election last preceding the date of contract award that has jurisdiction over this contract.

As a duly authorized representative for the bidder, offeror, or contractor, I have fully informed myself regarding the accuracy of all statements made in this affidavit, and acknowledge that the Commonwealth is reasonably relying upon these statements, in making a decision for contract award and any failure to accurately disclose such information may result in contract termination, repayment of funds and other available remedies under law. If the bidder, offeror, or contractor becomes non-compliant with any statements during the affidavit effective period, I will notify the Finance and Administration Cabinet, Office of Procurement Services immediately. I understand that the Commonwealth retains the right to request an updated affidavit at any time.

Signature

David J. McNichols
Printed Name

Chief Executive Officer, Aetna Medicaid
Title

January 27, 2020
Date

Company Name Aetna Medicaid

Address 4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Commonwealth of Kentucky Vendor Code (if known) KY0029237

Subscribed and sworn to before me by David J. McNichols (Affiant) Chief Executive Officer (Title)

of Aetna Medicaid (Company Name) this 27th day of January, 2020.

Cynthia Montano
Notary Public

[seal of notary]

My commission expires: 3-31-21

CYNTHIA MONTANO
Notary Public, State of Connecticut
My Commission Expires March 31, 2021

60.6 E. Required Affidavit for Bidders, Offerors and Contractors Claiming Resident Bidder Status

Footnote to Subpart 2(a): Kentucky Income Taxes:

As an insurance company, Aetna Better Health® of Kentucky files a Kentucky insurance premiums tax return and is not required to file a Kentucky income tax return. Aetna Better Health of Kentucky has filed an insurance premium tax return for calendar year 2018 and will file a return for calendar year 2019 in early 2020. Since Aetna Better Health of Kentucky writes only Medicaid and CHIP business, and those premiums are exempt from Kentucky insurance premiums tax, no tax has been owed or paid for one year prior to and through the date of advertisement.

Footnote to Subpart 2(b) and (c): Payments to the Kentucky Unemployment Insurance Fund; Kentucky Workers' Compensation Policy

The staff that supports Aetna Better Health of Kentucky is employed by one or more affiliated entities (Employer Company). Any Employer Company that employs Aetna Better Health of Kentucky staff has made payments to the Kentucky unemployment insurance fund and has maintained a Kentucky workers' compensation policy for such staff for one year prior to and through the date of advertisement.

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Solicitation/Contract #: RFP 758 2000000202

REQUIRED AFFIDAVIT FOR BIDDERS, OFFERORS AND CONTRACTORS CLAIMING RESIDENT BIDDER STATUS

FOR BIDS AND CONTRACTS IN GENERAL:
The bidder or offeror hereby swears and affirms under penalty of perjury that, in accordance with KRS 45A.494(2), the entity bidding is an individual, partnership, association, corporation, or other business entity that, on the date the contract is first advertised or announced as available for bidding:

1. Is authorized to transact business in the Commonwealth;
2. Has for one year prior to and through the date of advertisement
   a. Filed Kentucky income taxes;
   b. Made payments to the Kentucky unemployment insurance fund established in KRS 341.49; and
   c. Maintained a Kentucky workers' compensation policy in effect.

The BIDDING AGENCY reserves the right to request documentation supporting a bidder's claim of resident bidder status. Failure to provide such documentation upon request shall result in disqualification of the bidder or contract termination.

Signature

David J. McNichols
Printed Name

Chief Executive Officer, Aetna Medicaid
Title

January 27, 2020
Date

Company Name: Aetna Medicaid

Address: 4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Subscribed and sworn to before me by David J. McNichols Chief Executive Officer
(Affiant) (Title)

of Aetna Medicaid (Company Name) this 27th day of January, 2020.

Cynthia Montano
Notary Public
[seal of notary]

My commission expires: 3-31-21

CYNTHIA MONTANO
Notary Public, State of Connecticut
My Commission Expires March 31, 2021

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60.6 E. Required Affidavit for Bidders, Offerors and Contractors Claiming Qualified Bidder Status

Aetna Better Health® of Kentucky does not meet the requirements to be considered a "qualified bidder" and therefore has not identified a qualified bidder status on the attached Required Affidavit for Bidders, Offerors, and Contractors Claiming Qualified Bidder Status (Affidavit). We are returning a signed Affidavit without making a qualified bidder claim because we understand RFP Section 60.6(E) to require the submission of all affidavits in Attachment A with our proposal regardless of their applicability.

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Solicitation/Contract #: RFP 758 2000000202

REQUIRED AFFIDAVIT FOR BIDDERS, OFFERORS AND CONTRACTORS CLAIMING QUALIFIED BIDDER STATUS

FOR BIDS AND CONTRACTS IN GENERAL:

I. The bidder or offeror swears and affirms under penalty of perjury that the entity bidding, and all subcontractors therein, meets the requirements to be considered a "qualified bidder" in accordance with 200 KAR 5:410(3); and will continue to comply with such requirements for the duration of any contract awarded. Please identify below the particular "qualified bidder" status claimed by the bidding entity.

_____ A nonprofit corporation that furthers the purposes of KRS Chapter 163

_____ Per KRS 45A.465(3), a "Qualified nonprofit agency for individuals with severe disabilities" means an organization that:
(a) Is organized and operated in the interest of individuals with severe disabilities; and
(b) Complies with any applicable occupational health and safety law of the United States and the Commonwealth; and
(c) In the manufacture or provision of products or services listed or purchased under KRS 45A.470, during the fiscal year employs individuals with severe disabilities for not less than seventy-five percent (75%) of the man hours of direct labor required for the manufacture or provision of the products or services; and
(d) Is registered and in good standing as a nonprofit organization with the Secretary of State.

The BIDDING AGENCY reserves the right to request documentation supporting a bidder's claim of qualified bidder status. Failure to provide such documentation upon request may result in disqualification of the bidder or contract termination.

Signature: [signature] Printed Name: David J. McNichols

Title: Chief Executive Officer, Aetna Medicaid Date: January 27, 2020

Company Name: Aetna Medicaid

Address: 4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

Subscribed and sworn to before me by David J. McNichols (Affiant) Chief Executive Officer (Title)

of Aetna Medicaid (Company Name) this 27th day of January, 2020.

Cynthia Montano
Notary Public

[seal of notary] CYNTHIA MONTANO Notary Public, State of Connecticut My Commission Expires March 31, 2021 My commission expires: 3-31-21

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60.6.F Completed and Signed Face of Solicitation

Kentucky | Transforming Health Care | **Aetna**

Commonwealth of Kentucky
SOLICITATION

Addenda: No **Addenda #:**

TITLE: Medicaid Managed Care Organization (MCO) - All Regions

Date Issued: 1/10/20 **Record Date:** 2020-01-10	**Solicitation Closes Date:** 2/7/20 **Time:** 15:30	**Solicitation No:** RFP 758 2000000202

Online Bidding Prohibited: Yes

For Information Call: Amy Monroe 502-564-4510	**Bid Receiving Location:** Finance - Office of Procurement Services Bid Clerk 702 Capitol Ave, Capitol Annex Room 095 Frankfort KY 40601

Vendor Customer Number: KY0029237

Vendor Name: Aetna Better Health® of Kentucky, Assignee for Coventry

Phone Number: (502) 719-8767

Fax Number: (855) 454-5583

Email Address: CopleyJ@aetna.com

Ordering	**Payment**
Address: 9900 Corporate Campus Drive, Suite 1000	**Address:** 9900 Corporate Campus Drive, Suite 1000
City, State, Zip: Louisville, KY 40223	**City, State, Zip:** Louisville, KY 40223
Contact Name: Mr. Jonathan Copley, ESQ	**Contact Name:** Ms. Lisa Chandler
Contact Email: CopleyJ@aetna.com	**Contact Email:** LMChandler@aetna.com
Contact Phone Number: (502) 719-8767	**Contact Phone Number:** (502) 719-8767

Ownership Type

__ Sole Proprietorship __ Partnership X Corporation __ Other_____

SIGNATURE OF AUTHORIZED AGENT IS REQUIRED UNLESS RESPONSE IS SUBMITTED ELECTRONICALLY. FAILURE TO SIGN SHALL RENDER THE BID INVALID.

Signature X _____ **FEIN#** KRS 61.878(1)(a) _____ **Date** Jan 27 2020

David J. McNichols, CEO, Aetna Medicaid

All offers subject to all terms and conditions contained in this solicitation.

Commonwealth of Kentucky
SOLICITATION

Addenda: No **Addenda #:**

Line Items

Commodity Group: Default

Line	CL Description	Quantity	UOM	Unit Cost	Line Total or Contract Amnt
1	Managed Care Services	0.00000	EA		

Comm Code	Comm Description	Manufacturer	Model #	Manuf Part #
95856	Health Care Management Services (Including Managed Care Serv			

Extended Description

Provided managed care services for Kentucky Medicaid recipients.

Capitated Rates contained in the contract are set by the Department within the actuarially sound range developed by the Department's Actuarial Contractor. These rates are subject to final approval by CMS. Therefore, cost will not be a factor in the evaluation and award of any resulting contracts.

Sample rates and rate books are included as Attachment E, Exhibits 1-3 of this RFP. These rates are provided as an example of the process. Actual rates will be developed and made available to successful Contractors during the review and acceptance of the contract.

Shipping Information			Billing Information		
CHFS DMS Division of Fiscal Management			CHFS DMS Division of Fiscal Management dms.invoice@ky.gov		
275 E Main Street 6W-C			275 E Main Street 6W-C		
Frankfort	KY	40621	Frankfort	KY	40621

60.6.G Signed Face of Latest Addendum of the Solicitation

Kentucky | Transforming Health Care | **Aetna**

Commonwealth of Kentucky
SOLICITATION MODIFICATION

Addenda: Yes **Addenda #:** 2

TITLE: Medicaid Managed Care Organization (MCO) - All Regions

Date Issued: 1/27/20 **Record Date:** 2020-01-27	**Solicitation Closes Date:** 2/7/20 **Time:** 15:30	**Solicitation No:** RFP 758 2000000202

Online Bidding Prohibited: Yes

For Information Call: Amy Monroe 502-564-4510	**Bid Receiving Location:** Finance - Office of Procurement Services Bid Clerk 702 Capitol Ave, Capitol Annex Room 095 Frankfort KY 40601

Vendor Customer Number: KY0029237

Vendor Name: Aetna Better Health® of Kentucky, Assignee for Coventry

Phone Number: (502) 719-8767

Fax Number: (855) 454-5583

Email Address: CopleyJ@aetna.com

Ordering	**Payment**
Address: 9900 Corporate Campus Drive, Suite 1000	**Address:** 9900 Corporate Campus Drive, Suite 1000
City, State, Zip: Louisville, KY 40223	**City, State, Zip:** Louisville, KY 40223
Contact Name: Mr. Jonathan Copley, ESQ	**Contact Name:** Ms. Lisa Chandler
Contact Email: CopleyJ@aetna.com	**Contact Email:** LMChandler@aetna.com
Contact Phone Number: (502) 719-8767	**Contact Phone Number:** (502) 719-8767

Ownership Type

__ Sole Proprietorship __ Partnership X Corporation __ Other_____

SIGNATURE OF AUTHORIZED AGENT IS REQUIRED UNLESS RESPONSE IS SUBMITTED ELECTRONICALLY. FAILURE TO SIGN SHALL RENDER THE BID INVALID.

Signature X _____ **FEIN#** KRS 61.878(1)(a) **Date** 1/27/2020

David J. McNichols, CEO, Aetna Medicaid

All offers subject to all terms and conditions contained in this solicitation.

Commonwealth of Kentucky
SOLICITATION MODIFICATION

Addenda: Yes **Addenda #:** 2

Line Items

Commodity Group: Default

Line	CL Description	Quantity	UOM	Unit Cost	Line Total or Contract Amnt
1	Managed Care Services	0.00000	EA		

Comm Code	Comm Description	Manufacturer	Model #	Manuf Part #
95856	Health Care Management Services (Including Managed Care Serv			

Extended Description

Provided managed care services for Kentucky Medicaid recipients.

Capitated Rates contained in the contract are set by the Department within the actuarially sound range developed by the Department's Actuarial Contractor. These rates are subject to final approval by CMS. Therefore, cost will not be a factor in the evaluation and award of any resulting contracts.

Sample rates and rate books are included as Attachment E, Exhibits 1-3 of this RFP. These rates are provided as an example of the process. Actual rates will be developed and made available to successful Contractors during the review and acceptance of the contract.

Shipping Information	Billing Information
CHFS DMS Division of Fiscal Management	CHFS DMS Division of Fiscal Management
	dms.invoice@ky.gov
275 E Main Street 6W-C	275 E Main Street 6W-C
Frankfort KY 40621	Frankfort KY 40621

60.6.H EEO Forms

Kentucky | Transforming Health Care | **Aetna**

60.6 H. EEO Certification

In connection with the Commonwealth's 2019 Medicaid Managed Care Organization Solicitation, Vendors were permitted to submit proof of their one-year EEO certification (Annual Certification) to demonstrate compliance with the EEO requirements in RFP Section 40.21, in lieu of submitting new EEO-1 Employer Information Reports with their proposals. See the Commonwealth's response to the applicable Vendor question on page 111 of 123 of the Commonwealth of Kentucky's Solicitation Modification, Addendum #2, issued June 14, 2019. Aetna Better Health of Kentucky submitted its annual Certification Renewal Form to the Office of EEO and Contract Compliance (EEO Office) on January 12, 2020, for renewal effective February 1, 2020. On January 27, 2020, we received verbal confirmation from the EEO Office that it has received our EEO Certification Renewal Form and that we are still certified, but that our renewal has not yet been processed. Therefore, to demonstrate compliance with the EEO requirements in RFP Section 40.21, we are submitting the attached Certification Renewal Form instead of submitting written proof of our Annual Certification or new EEO-1 Employer Information Reports. We will submit proof of our Annual Certification for the forthcoming certification period, or any other EEO information the Commonwealth seeks, upon request.

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FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)
E-MAIL: Finance.ContractCompliance@ky.gov

CERTIFICATION RENEWAL FORM

Important Notice: To reduce/eliminate processing delays, complete all questions. Incomplete forms will not be processed. **A substitute or alternate version of this form will not be accepted or processed.**

SECTION I: EMPLOYER/FIRM IDENTIFICATION

1) Name of Parent Company (owns or controls the branch/ office/other location or subsidiary or affiliate listed in Section I, #2) CVS

Street Address: 151 Farmington Avenue
City, State and Zip Code: Hartford, CT 06156

2) Name of Subsidiary or Affiliate for which this form is filed: Aetna

Street Address: 151 Farmington Avenue
City, State and Zip Code: Hartford, CT 06156

3) Does the company have any Kentucky locations (check one) ☒ Yes ☐ No If the response is "Yes," complete the information in 3a and 3b. **Note: a location does not include an employee's home address, a construction worksite or any other temporary project site.**

a) Number of Kentucky locations 1

b) Name of Kentucky Headquarters/ Main office for which this form is filed: Aetna Better Health of Kentucky Insurance Company

Street Address: 9900 Corporate Campus Drive, Suite 100
City, State and Zip Code: Louisville, KY 40223

SECTION II: ESTABLISHMENT INFORMATION

Describe the major activity of this establishment. Be specific, e.g. wholesale computer supplies, vehicle insurance carrier, electrical contractor, contractor, bus transportation, hot mix/cold mix supplier, landscape architectural services, custom computer programming, etc. Direct health and medical insurance carrier

SECTION III: GENERAL INFORMATION

1) Does the company hire primarily from (check one): ☐ County? ☐ City? ☐ Metropolitan Statistical Area? ☐ State? OR ☒ Nationwide?

2) Identify the primary geographical area(s) from which the company draws its employees by listing the counties, cities, Metropolitan Statistical Areas (MSAs) or states that apply (attach a separate sheet if necessary): Nationwide

3) Does the company have a current Affirmative Action Plan? ☒ Yes ☐ No If "Yes" indicate plan year: 2020

4) Within the past five (5) years has the company been subject to administrative or other legal fines or other penalties arising from employment practices relating to any local, state or federal contract (check one)? ☐ Yes ☒ No
If "Yes," attach a separate sheet fully explaining the situation.

5) Within the past five (5) years has the company been declared ineligible for any local, state or federal contract (check one)? ☐ Yes ☒ No If "Yes," attach a separate sheet fully explaining the situation.

SECTION IV: 'COMPANY-WIDE' WORKFORCE DATA/NUMBER OF EMPLOYEES (ALL LOCATIONS)

1) Indicate the total number of employees: 49,333

2) Indicate the total number of ethnic minority employees (including ethnic females): 18,146

3) Indicate the total number of female employees (including ethnic females): 37,491

SECTION V: KENTUCKY WORKFORCE DATA/NUMBER OF EMPLOYEES (KENTUCKY LOCATIONS ONLY)

1) Indicate the total number of employees: 388

2) Indicate the total number of ethnic minority employees (including ethnic females): 91

3) Indicate the total number of female employees (including ethnic females): 326

SECTION VI: DATA COLLECTION METHOD

1) How was employment data obtained (check one)? ☐ Visual Survey ☐ Payroll ☒ Other (specify): Voluntary Self Identification

(Note: Data must not be more than 90 days old. Data more than 90 days old will not be accepted or processed.)

2) Indicate date or timeframe used for data collection method: 01/08/2020 to 01/08/2020

SECTION VII: CERTIFICATION

Name of Person to Contact Regarding this Form			Title	
Catherine Easley			Director, Service Operation	
Mailing Address 9900 Corporate Campus Dr., Suite 1000				
City Louisville	State KY	Zip Code 40223	Telephone Number (502) 622-7577	Fax Number _____
Email Address EasleyC@aetna.com				

I certify that the information contained in this Certification Renewal Form, and any attachments, is true and accurate to the best of my knowledge and belief. The employer agrees to comply with the requirements found in the Kentucky EEO Act, KRS 45.550 – KRS 45.640 and Finance and Administration Cabinet rules and regulations. Further, I am authorized to sign this form on behalf of the employer.

Jonathan Copley,
CEO Aetna Better Health of Kentucky
Print Name and Title of Certifying Official

January 10, 2020
Date

Signature of Certifying Official (must be an official or manager)

For Official Use Only (Minority/Female Employment Utilization):	Initials: _____	Review Date: _____

60.6 H. Subcontractor Report Form Footnotes

Footnote 1: Calculation of "valued at $500,000": The instructions at the top of the Subcontractor Report Form require Vendors/Contractors to report subcontracts "valued at $500,000 or more." To calculate which contracts are valued at $500,000 or more and the "Subcontract Amount" we utilized our spend for each subcontractor for the 2019 calendar year.

Footnote 2: "Contracts below the second tier": The instructions to the Subcontractor Report Form state that "information is not required for contracts below the second tier." We understand first tier contracts to be subcontracts entered into directly between the Vendor and a subcontractor (Party 1). We understand second tier contracts to be subcontracts between Party 1 and another party (Party 2). We understand any contracts between Party 2 and any other party (Party 3), or further downstream than that, to be below the second tier and therefore excluded from the Subcontractor Report Form reporting requirement, notwithstanding that such "below the second tier" subcontractors may be listed as proposed subcontractors in other parts of our proposal. Proposed subcontractors with current subcontracts below the second tier that are valued at $500,000 or more are [redacted] If the Commonwealth would like the information in Section 5) of the Subcontractor Report Form for these proposed subcontractors, we will provide it upon request.

Footnote 3: "Has entered into agreements with subcontractors valued at $500,000 or more": The proposed subcontractors listed on the Subcontractor Report Form currently hold first or second tier contracts, as these terms are described in Footnote 2 above, for the provision of services to Aetna Better Health of Kentucky. We anticipate that these subcontractors will continue to provide services for any contract awarded as a result of this RFP, subject to their agreement to any new terms, conditions, or requirements set forth in the RFP, Draft Medicaid Managed Care Contract (Draft Contract), and any other attachments, exhibits or appendices to the RFP and/or the Draft Contract.

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Form—EEO Part III

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

Effective: 26-Jun-07

SUBCONTRACTOR REPORT FORM

Notice: Vendors/Contractors are required to report all subcontracts valued at $500,000 or more (Note: information is not required for contracts below the second tier). The subcontracts reported on this form must be for a specific line item(s) of work on a contract/project your firm has with the Commonwealth of Kentucky, i.e., you should not report contracts your firm has with a company to clean your office building, to provide security for your office, to routinely service your vehicles or equipment, to upgrade your warehouse, etc. Type or print legibly. Do not use pencil; use black or dark blue ink. A substitute or alternate version of this form will not be accepted or processed. Incomplete forms will not be processed.

1) Business Name (REQUIRED): Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health® of Kentucky

2) Solicitation or Contract Number (REQUIRED): 758 2000000202

3) Project Name or Contract Description: Commonwealth of Kentucky, Request for Proposal for Medicaid Managed Care Organization (MCO) - All Regions

4) Indicate if your company has entered into agreements with subcontractors valued at $500,000 or more (check one):

☐ Our company **has not** entered into agreements with subcontractors valued at $500,000 or more (skip section 5 and complete section 6).

☒ Our company **has** entered into agreements with subcontractors valued at $500,000 or more (complete section 5 and section 6).

5) Provide subcontract information as follows (attach Additional Reporting Sheets if necessary):

Name of Subcontractor	Contact Person	Telephone Number (including area code)	Street Address, City, State and Zip Code	Subcontract Amount
[redacted]				

6) Certification: I certify that the information contained in this report and any Additional Reporting Sheets or other attachments, is true and accurate to the best of my knowledge and belief. Further, I am authorized to sign this form on behalf of the company. If necessary, the company will update this report should it enter into additional subcontracts valued at $500,000 or more.

David J. McNichols, Chief Executive Officer, Aetna Medicaid

Printed Name and Title of Certifying Official

Signature of Certifying Official (**must be an official or manager**)

January 27, 2020

Date

PROPRIETARY

Form—EEO Part III

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY/CONTRACT COMPLIANCE

Effective: 26-Jun-07

SUBCONTRACTOR REPORT FORM
Additional Reporting Sheet

A substitute or alternate version of this form will not be accepted or processed.

Business Name (REQUIRED): N/A

Solicitation or Contract Number (REQUIRED): N/A

Name of Subcontractor	Contact Person	Telephone Number (including area code)	Street Address, City, State and Zip Code	Subcontract Amount

Page _____ of _____

Form—EEO Part II

Effective: 05-Jan-10

FINANCE AND ADMINISTRATION CABINET
OFFICE OF EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE
CAPITOL ANNEX, ROOM 395, FRANKFORT, KY 40601
TELEPHONE: 502-564-2874 (FAX: 502-564-1055)

AFFIDAVIT OF INTENT TO COMPLY

A substitute or alternate version of this form will not be accepted or processed.

The undersigned, after first being duly sworn, states as follows: I, David J. McNichols
Type or Print Name

have authority to sign this affidavit on behalf of Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health® of Kentucky
Type or Print Company Name

Check one:

☒ I acknowledge and agree that the aforementioned company will "comply in full with all requirements of the Kentucky Civil Rights Act," and "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

☐ The aforementioned company is exempt from compliance with the Kentucky Civil Rights Act because the company is not an "employer" as defined by KRS 344.030(2). I acknowledge and agree that the aforementioned company will "submit data required by 45.560 to 45.640 upon being designated the successful bidder." I also acknowledge and agree that the Finance and Administration Cabinet, Office of EEO and Contract Compliance may request additional information and/or documentation, in accordance with KRS 45.550 et seq at any point during the life of any contract awarded. I further acknowledge and agree that a failure to provide information requested in a timely manner may result in the Commonwealth of Kentucky pursuing any and all legal remedies available, including but not limited to, termination of contract and a prohibition against doing business with the Commonwealth in the future.

AFFIANT:

Affix Notary Seal Below

Signature of Certifying Official
(must be an official or manager)

David J. McNichols, Chief Executive Officer, Aetna Medicaid
Type or Print Name and Title of Certifying Official

January 27, 2020
Date

Commonwealth or State Connecticut

County of Hartford

Subscribed and sworn to before me by David J. McNichols, Chief Executive Officer
(Affiant)/ (Title)

of Aetna Medicaid (Company Name) this 27th day of January, 20 20.

MY COMMISSION EXPIRES ON: (Date) 3-31-21

NOTARY PUBLIC Cynthia Montano

CYNTHIA MONTANO
Notary Public, State of Connecticut
My Commission Expires March 31, 2021

60.6.I Proposed Solution

Kentucky | Transforming Health Care | **Aetna**

aetna™

60.7.A Executive Summary

Kentucky | Transforming Health Care | **Aetna**

60.7.A. Executive Summary

As a longstanding and committed partner to the people of the Commonwealth and the Department of Medicaid Managed Services (Department), Aetna Better Health of Kentucky[1] (Aetna) has the structure and resources, a proven and flexible technical approach, and the innovative and collaborative drive to deliver high-quality, cost-effective health care services to Kentucky Medicaid enrollees. Under the leadership of Chief Executive Officer (CEO) Jonathan Copley, a proud fifth-generation Kentuckian from Taylor County, Aetna's experienced team has a deep understanding of the critical health issues and enrollees' needs in the Commonwealth. Since 2011, we[2] have provided access to care through the delivery of comprehensive services supporting the program's full scope of work. The Aetna Medicaid organization's established presence in the Commonwealth as an original Medicaid managed care organization (MCO) informs our organizational framework to provide coordinated services; our approach for administering services; the development and management of a provider network that exceeds Department requirements; and the implementation of innovations and initiatives to achieve improved health outcomes and support population health management.

> "KentuckyOne Health and CHI Saint Joseph Health would like to extend full support for Aetna Better Health of Kentucky's bid to remain in the Kentucky Medicaid Managed Care program. Aetna Better Health works collaboratively with our providers to ensure our patients, their enrollees, have access to and receive quality health care services. Our value-based arrangement aligns our organizations around improving the health of the communities we both serve. We are excited to continue this partnership and recommend that the State keep Aetna Better Health as one of their managed care organizations."
>
> **—Lynn Tanner**
> **Vice President of Payer Strategy, KentuckyOne Health**

The Aetna organization combines strong leadership, expert local knowledge, and a 130-year service history in the Commonwealth with the vision and strength of our corporate parent, CVS Health—a Fortune 10 company whose mission is helping people on their path to better health.

Every day, we are working to create a healthier Kentucky.

1. Our Understanding of the Health Care Environment in the Commonwealth, the Kentucky Medicaid Program and Vision, and Needs of Medicaid Enrollees

Aetna has approximately 250 staff members in Kentucky, including many multigenerational Kentuckians who are committed to the present and future of the Commonwealth. As a health plan, we know the population we serve and have solutions to address their local, regionally specific needs.

1 For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its parents, Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Kentucky to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of Kentucky's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Kentucky. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

2 Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

Understanding of the Health Care Environment

With our experience serving Kentuckians since 2011, Aetna understands the diverse needs of the local population; we are deeply invested in Kentucky's local communities. We are aligned with the Kentucky State Health Improvement Plan, focused on the following key populations: substance use disorders, smoking cessation, obesity, adverse childhood experiences (ACEs), and integration to health access. **Table C.24-1** demonstrates Kentucky's current national rank for several factors related to these Commonwealth priorities[3]. Aetna develops solutions through our Population Health Management (PHM) program to impact these rankings and improve the health of our enrollees and the population of the Commonwealth as a whole.

Table C.24-1: Kentucky Health Rankings—2019

Measure	Kentucky Ranking
Preventable Hospitalizations	50th
Smoking	49th
Premature Deaths	47th
Drug Deaths	46th
Obesity	46th
Children in Poverty	44th

Aetna understands that our populations face social inequities that impact accessing health care, achieving optimal health outcomes, and meeting personal goals for health and wellness. Understanding trends throughout the Commonwealth and within our own enrollees informs our population health strategy and priorities and allows us to provide the best support to the enrollees when and where they need it. Approximately 21 percent of Kentuckians are covered by Medicaid with enrollment varying by region.

Understanding of the Kentucky Medicaid Program and Vision

Highly experienced leadership with extensive local, program-specific knowledge is the cornerstone of our health plan. Mr. Copley has more than 16 years of Medicaid experience, joining Aetna Better Health of Kentucky as CEO in 2017. **He is the only Kentucky Medicaid CEO with executive-level experience with the Commonwealth.** His time as undersecretary for the Cabinet for Health and Family Services (Cabinet) gives him a unique understanding of the Cabinet and Department's priorities for the Medicaid program. Mr. Copley's stature as a health care leader in the Commonwealth is reflected in his selection as chair of two organizations making an impact in the Commonwealth: the Opioid Response Program for Business, an initiative of the Kentucky Chamber of Commerce's Workforce Center, and the Kentucky Association of Health Plans, a trade association that monitors issues related to managed care organizations and commercial insurers, health care policy, and tax reform.

Our local Aetna leadership team will manage the delivery and operations of our Kentucky Medicaid health plan, leveraging our longstanding, positive relationships with the Department, providers, community resources, advocacy groups, regulatory agencies, and other Medicaid-focused organizations throughout the Commonwealth. Our current health plan leadership—who are proposed key staff for the new Medicaid contract—together bring a wealth of experience in working toward better health outcomes, better patient experiences with health care, and lower total cost of care. Our health plan CEO, chief medical officer, and chief financial officer (CFO) in Kentucky have approximately 65 years of collective health care experience, bringing both longevity and continuity to the Kentucky Medicaid program. In addition to Mr. Copley, our team includes the following key leaders:

- **Lisa Chandler, chief financial officer:** Ms. Chandler has been CFO of the Kentucky health plan since 2011. She has 9 years of Medicaid experience and 28 years of health care industry experience.
- **David Hiestand, medical director:** Dr. Hiestand has had a 20-year career in health care, including 6 years with Aetna, where he most recently served as the regional medical director for the Midwest Region. He has a PhD in Medicinal Chemistry and Pharmaceutics from the University of Kentucky.

[3] County Health Rankings and Roadmaps, "Kentucky Rankings Data": https://www.countyhealthrankings.org/rankings/data/ky; Accessed June 1, 2019

He completed medical school, residency, and fellowship at the University of Kentucky and is board-certified in Internal Medicine, Pulmonary, Critical Care, Sleep Medicine, and Pediatrics.

Understanding the Needs of Medicaid Enrollees

Living and working in Kentucky leads us to understand some of the key health care-related issues affecting Kentucky today, including the devastating effects of the looming opioid crisis, the role of social determinants of health in an enrollees' health outcomes, and the importance of good provider relations.

Addressing the Opioid Crisis

Aetna is committed to reversing the rising trend of opioid abuse. According to the National Institute on Drug Abuse, in 2017 there were 1,160 reported opioid-involved deaths in Kentucky—a rate of 27.9 deaths per 100,000 persons, compared to the average national rate of 14.6 deaths per 100,000 persons.[4] As discussed in Kentucky's State Health Improvement Plan, more than half (57 percent) of the Commonwealth's opioid overdose emergency department visits were billed to Medicaid.

We are executing strategic solutions that focus on the needs of our enrollees and will make sure initiatives and programs integrate pharmacy, behavioral health, and physical health.

Aetna has developed a multifaceted, national strategy for combating the complex issue of inappropriate use of opioids, focused on prevention, intervention, and support. We are implementing this strategy in Kentucky and 15 other states where we operate Medicaid plans. We bring our national expertise to our partnerships with local, Commonwealth, and federal governments, as well as local stakeholder groups, such as first responders and public health agencies. Our approach includes the following:

- Emphasizing care coordination and continuity of care by reducing barriers that restrict access to medication-assisted treatment, support programs, and non-pharmaceutical alternatives through our extensive provider network, use of telemedicine, remote patient monitoring, and our comprehensive Medicaid and value-added benefits package.
- Creating an innovative opioid dashboard which uses pharmacy and medical claims data to trend key metrics to help us combat inappropriate use of opioids.
  - Data from our opioid dashboard demonstrate our success in Kentucky. For example, data from our opioid dashboard demonstrate that between June 2016 and August 2019 we have achieved the following:
    - Increased the rate of non-opioid treatment for chronic pain by 52.9 percent
    - Decreased the rate of opioid prescriptions for enrollees with opioid use disorder by 44.4 percent
    - Decreased the rate of opioid prescriptions for enrollees with a previous overdose by 62.7 percent
    - Decreased the rate of 7-day opioid prescription after an acute procedure by 88.6 percent

Aetna Initiative Equips, Prepares First Responders to Administer Narcan

In 2017, representatives from Aetna joined Commonwealth and local officials to announce a partnership providing 720 doses of the overdose-reversal drug Narcan® to first responders in the northern Kentucky and Appalachia regions. The kits are Aetna donations. By sponsoring the Narcan event, Aetna increased the number of first responders prepared to administer Narcan. Prior to the event, 11 of 33 law enforcement agencies in northern Kentucky were carrying naloxone. After the event, 8 additional law enforcement agencies were interested in carrying naloxone—**nearly doubling the number of agencies carrying or wanting to carry naloxone.**

[4] 1 National Institute on Drug Abuse, "Kentucky Opioid Summary" (2017): https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary; accessed June 2019

- Initiating the Keeping Kids Safe program as a part of Aetna's national campaign to fight the opiate crisis. This harm reduction intervention is used to support safety by providing enrollees with a lockbox to secure their medications. The primary goal is to reduce the number of accidental opioid exposures that could result in poisoning, injury, or even accidental death.
- Offering coverage for acupuncture, massage therapy, dry-needling, and yoga. Adult enrollees can receive up to $150 to use towards these services. This value-added service is provided to reduce opioid utilization and promote healthy and sustainable pain management.

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Figure A-3: Our Support for Volunteers of America Mid-States

Aetna CEO Jonathan Copley presents a check for Volunteers of America Mid-States to Volunteers of America Mid-States CEO Jennifer Hancock at a ceremony in Frankfort in May 2019.

We incorporate trending for opioid use as part of our population health management tracking to ensure we are providing the most resources to the areas of greatest need. Prioritizing support for our enrollees who are struggling with opioid use is of top concern and informs everything from our clinical assessments to our sponsorships within the community. We cannot overcome these obstacles on our own and so **we collaborate with over 1,500 community-based organizations (CBOs) to fulfill our mission.**

As a demonstration of our commitment to community partnerships, Aetna contributed $150,000 to Volunteers of America Mid-States in support of its new Freedom House program in southeastern Kentucky. Freedom House provides state-of-the-art and nationally recognized addiction recovery treatment and care to pregnant and parenting mothers working to overcome substance use disorder. On February 11, Volunteers of America is scheduled to open a new 16-bed facility located in Clay County, marking the first program of its kind in the region. **Figure A-3** is a photo of the check presentation to the Volunteers of America Mid-States.

Addressing Social Determinants of Health Needs

Aetna is partnering with Unite Us in a unique collaboration to address the full spectrum of social determinants of health (SDOH). The partnership, currently in Louisville, establishes new and innovative models that improve the engagement between enrollees, traditional health care providers (e.g., primary care providers), and social services providers. Aetna's intent is to expand this partnership statewide. This SDOH services integrated model connects enrollees to community-based organizations who participate in the closed-loop referral network, including all types of social service agencies. Enrollee referrals for integrated service needs—physical health, behavioral health, and SDOH—are triggered through multiple sources; there are not any limitations on how enrollee referrals are triggered.

Unite Us currently powers the United Community Network, a network of health care providers, payers, government service, and CBOs that serves the Louisville metropolitan area and is sponsored by Metro United Way. Network users who generate and receive referrals in this integrated community network include government, leading health systems, clinical providers, and CBOs across Jefferson County. The network continues to grow, with plans underway to integrate the network with the Jefferson County public schools and additional CBOs and stakeholders.

The Unite Us platform provides the unifying infrastructure between health care entities and community-based organizations. This robust, collaborative approach equips health care and community service providers with a shared platform that they can use to identify

available resources for enrollees, while simultaneously tracking outcomes within a single integrated network of care and social services. The Unite Us platform combines medical and social care through integrations with existing electronic health records designed to enhance—not impede—workflows. It integrates with the most commonly used medical, social, and community tools to streamline methods and increase efficiency. Aetna enrollees residing outside Louisville have access to referral services for identified SDOH needs through current processes such as Aunt Bertha, a comprehensive online directory of social service organizations, and care management processes to facilitate connecting enrollees with appropriate community-based resources to address identified enrollee needs. Our Care Management teams, Enrollee Support teams, and community health workers (CHWs) continue to work closely with our enrollees to assure their social resource needs are met.

Addressing and Strengthening Provider Relations

An example of our knowledge of the local health care market includes our work to identify provider areas of concern, striving to resolve them as expediently as possible. To best serve enrollees, our commitment to excellent provider relations aligns with a Commonwealth goal of "improving delivery of health and family services through quality customer service." **We have seen a steady decline in outstanding issues on the Kentucky Hospital Association's MCO issues log, culminating in the resolution of all outstanding issues for 10 consecutive months.** The Kentucky Hospital Association presented the referenced data to the Hospital Care Technical Advisory Committee in December 2019. We achieved this clean record by developing an internal process for escalation that begins with our network managers who are aware of any pain points experienced by our providers. The network managers escalate these areas of concern to a health plan work group that meets regularly to triage and solution for provider concerns. **Figure A-4** illustrates Aetna's transformational performance with the Kentucky Hospital Association since 2018 in comparison to the other Medicaid MCOs in the Commonwealth.

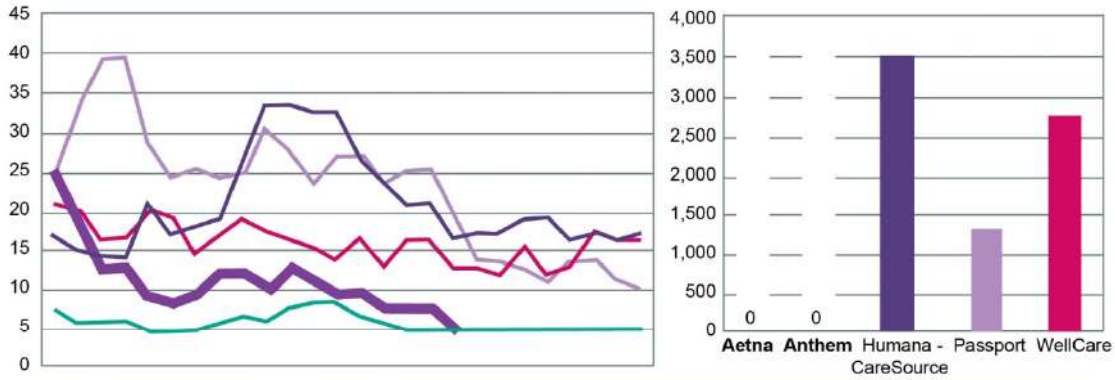

	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	Mar '19	Apr '19	May '19	Jun '19	Jul '19	Aug '19	Sept '19	Oct '19	Nov '19	Dec '19
Aetna	23	16	9	9	5	4	5	8	8	6	9	7	5	5	3	3	3	–	–	–	–	–	–	–	–	–
Anthem	3	1	1	1	–	–	–	1	2	1	3	4	4	2	1	–	–	–	–	–	–	–	–	–	–	–
Humana – CareSource	14	12	11	11	18	14	15	16	23	32	32	31	31	25	21	18	18	13	14	14	16	16	13	14	13	14
Passport	23	33	39	39	27	22	23	22	23	29	26	21	25	25	21	23	23	17	10	10	9	7	10	10	7	6
WellCare	18	17	13	13	17	16	11	13	16	14	13	12	10	13	9	13	13	9	9	8	12	8	9	14	13	13

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Figure A-4: Kentucky Hospital Association Issues Log

This graphic depicts data from the Kentucky Hospital Association issues log published in December 2019. Aetna's improvement is represented by the thick purple line starting at line 25.

2. Proposed Organization to Provide Coordinated Services

We designed our organizational structure to provide the framework for our Kentucky staff to efficiently coordinate services and implement innovative solutions that empower our enrollees on their health journeys. To drive a culture of innovation and collaboration, our staff members participate in cross-functional teams aimed at improving performance across every area of the organization. Examples of ways that our organizational structure supports innovative solutions and stakeholder groups include our cross-functional Service Improvement Committee, integrated care coordination, our System of Care model, our robust Quality Management and Population Health staff, and our focus on SDOH. **Figure A-5** is an overview of our organizational structure.

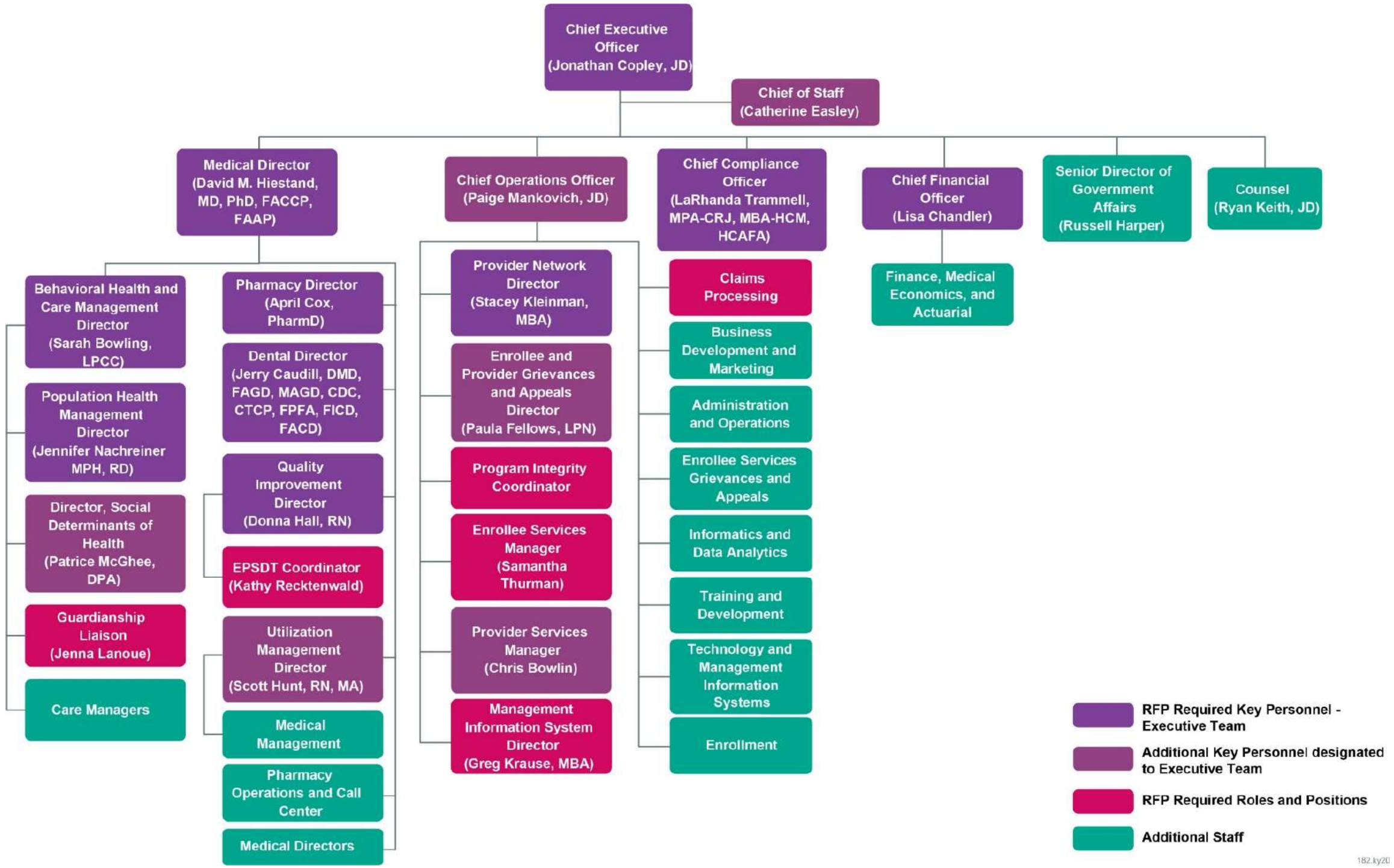

Figure A-5: Aetna's Organizational Structure

Our organizational structure supports an integrated model of care and service delivery for an enhanced enrollee and provider experience.

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Aetna has a clearly defined staffing model designed to serve our enrollees in a manner that integrates their physical health, behavioral health, functional, and social determinant needs. **Aetna currently manages behavioral health services through our provider network and does not intend to outsource or delegate any behavioral health services to an external entity.**

Aetna's Integrated Health team is a multidisciplinary group of interdepartmental staff from Care Management, Utilization Management, Community Outreach, Population Health Management, Pharmacy, etc., that specializes in supporting enrollees to receive integrated, holistic health care. The Integrated Health team consists of staff with a variety of backgrounds and credentials, including expertise in physical health (e.g., physicians and registered nurses), behavioral health (e.g., licensed counselors and social workers), and social needs (e.g., community health workers). As an enrollee enters any level of care at any point, the members of the Integrated Health team know how to coordinate with the right person at the health plan to help address the enrollee's holistic needs. While the Integrated Health team operates as a unit, specialty subgroups also convene to address the needs of enrollees in priority populations for which Aetna operates programs, such as high-risk pregnant women.

In addition, our staffing model emphasizes local, boots-on-the-ground care managers, Aetna CHWs and Community Outreach staff, field-based population health specialists, and community-based CHWs and peer support workers. **Many of our experienced personnel have tenure dating back to 2011 and have developed deep knowledge of the local community and challenges faced by Kentuckians.**

Our plan structure continuously evolves as we incorporate best practices and lessons learned to serve our fellow Kentuckians. Key components of our structure include our high-performing teams from Quality Management, Enrollee Services, and Provider Services.

Quality Management

Aetna brings the full complement of our local and national quality improvement infrastructure and resources in alignment with the Department's goals to transform the Kentucky Medicaid program. We empower enrollees to achieve their optimal health care outcomes and quality of life by addressing their SDOH and giving them the skills and tools to navigate their health care to help them be responsible for their health. We maintain a demographic profile of the community and develop collaborative partnerships with community agencies and organizations to reduce or eliminate health disparities in underserved communities, including The Homeless Coalition, Kentucky Family Resource and Youth Services Centers, Alcohol and Drug Abuse Prevention Team (ADAPT), and the Kentucky Oral Health Coalition.

As a **National Committee for Quality Assurance (NCQA) Commendable-**accredited organization, we have proven our commitment to continuous quality improvement as shown by our substantial improvement trajectory in the following measures aligning with the Commonwealth's health priorities:

- **Obesity/nutrition:** Body mass index assessment is currently in the 95th percentile and has improved by over 20 percentage points since HEDIS 2016
- **Diabetes:**
  - HbA1c poor control (>9.0 percent), 90th percentile; trends show improvement
- **Substance abuse/opioid:**
  - Opioid abuse or dependence: engagement of AOD (alcohol or other drug) treatment: total is in the 90th percentile
  - Engagement of AOD treatment over 18 years and total: 75th percentile

Aetna uses an **integrated and collaborative approach** to quality, involving each department within Aetna, input from primary care providers, specialists, enrollees, and partnerships with the Department, subcontractors including Avēsis, Bluegrass Care Navigators[SM], Eviti, Pursuant Health, Welltok, and Eliza, as well as local community providers and resources including the Kentucky Primary Care Association. Quality is truly a comprehensive, interdepartmental collaboration within Aetna; all areas have responsibility and accountability to meet performance goals. As led by our chief medical officer (CMO) and our quality director, our Quality Management program staff members are dedicated to maximizing health outcomes with support and guidance from the Aetna national team. Under the direction of the CMO, the Quality Management department coordinates Aetna's Quality Assessment and Performance Improvement program and provides administrative support for the health plan committees.

Enrollee Services

Our Enrollee Services call center staff and supervisors live and work in local Kentucky communities—they know Kentucky. Aetna's call center serves as the gateway for our enrollees to access information concerning their covered services and as a resource to improve their health. We strive on every call to advocate for our enrollees' best health by helping them get the most from their benefits, building trust, and always providing a clear path to care. Our staff is well-trained and has deep knowledge of the Kentucky Medicaid program, as indicated by our consistent Net Promoter score of 79 percent.

All Enrollee Services staff instruct callers about what to do in case of an emergency and connect enrollees to our 24/7/365 Health Information line (nurse line). Additionally, Enrollee Services representatives are trained in Mental Health First Aid and will conduct warm transfers of enrollees to our Behavioral Health Services Hotline for clinical support. Aetna consistently exceeds performance requirements for our current Behavioral Health Services Hotline. **Since 2015, we have answered 100 percent of calls by the fourth ring and 0 calls receive a busy signal with an average call abandonment rate of 2.3 percent, much lower than the standard of 7 percent or less.**

Our Enrollee Services call center meets the current American Accreditation Health Care Commission/ Utilization Review Accreditation Commission-designed Health Call Center Standard for call center abandonment rate, blockage rate, and average speed to answer. Responding to all our enrollees'[5] needs quickly, we average over 10,700 calls per month answered with **service levels greater than 87 percent in our most recent four quarters, exceeding the Commonwealth's benchmark of 80 percent.**[6] Our Enrollee Services representatives **achieve a first-call resolution rate of 95.6 percent.**

Aetna values enrollees' choice in how they engage with us. Increasingly, this engagement in addressing the whole person is enhanced by technology. Our goal is to provide and connect enrollees to programs and applications that improve wellness and our population health programs, increasing access to health information with priorities including reducing obesity, prevalence of diabetes, and substance abuse in alignment with Kentucky's health priorities. Aetna uses our website, mobile application, social media, and opt-in text messaging programs for chronic conditions, pregnancy, or other health-related needs to engage enrollees. The Aetna Health Mobile Platform enables enrollees to schedule appointments within the application, find providers, view their current prescriptions and dosages, and access their care plans.

[5] When we use the term enrollee or enrollees in this section, we are collectively referring to enrollees, their guardians, and their legally authorized representatives.
[6] Service level is a measure of customer service quality and defined as the percent of calls answered in a specified amount of time.

Provider Services

We actively recruit Provider Services representatives (PSRs) and Network Operations staff who have worked for providers, know Kentucky Medicaid, and live and work in the communities where they live. Our PSRs are based in the communities they serve, fostering a higher level of responsiveness and personalized relationships. The PSRs engage with providers through a variety of mechanisms that are designed to provide and promote prompt and collaborative communications, as depicted in **Figure A-6**. Our PSR engagement activities include new provider orientation, training webinars, provider forums, operational meetings, regular site visits, and other face-to-face meetings. We have also established or participate in a variety of provider and association meetings, in which we actively collaborate with our provider partners to identify improvement opportunities, reduce administrative burden, and provide education and training.

Reducing Department Provider Complaints

Through our formalized internal meeting structure, we were successful in reducing provider Department complaints by nearly 80% from January 2018 to January 2019. During 2019, we saw an additional reduction in provider complaints of 35%.

We have learned the importance of having dedicated Behavioral Health Network Management and Operations staff that understand the nature of behavioral health services and can respond to the unique experience of behavioral health providers. Our behavioral health manager has 15 years of experience working for and with Kentucky's behavioral health providers.

Figure A-6: Aetna Provider Communication Strategies

Aetna uses multiple strategies to communicate with our providers.

Aetna understands that our commitment to collaboration and developing innovative solutions to address Kentucky's unique needs requires sincere and transparent communications with our providers. We have established a comprehensive and coordinated process for gathering, analyzing, and responding to provider feedback at both the individual and network levels. Provider feedback is solicited through multiple channels, including through our Aetna Provider Partnership Program, local PSRs, internal departments, data tracking and trending, and provider committees. Information from all these touchpoints is tracked and analyzed, so we can assess and identify the most effective mechanism for improvement, such as individual provider education, inclusion in provider trainings, and our Tips Tuesday Campaign, which gives providers brief routine updates and information.

3. Strategy and Approach for Administering Services for Enrollees

Improving health outcomes for our fellow Kentuckians inspires everything Aetna does as an MCO in the Commonwealth. Our deep commitment and devotion encompass every enrollee and provider interaction, every partnership, every innovation, every community event, and every collaborative effort with the Commonwealth, enrollees, providers, and other MCOs. As an original Medicaid MCO in the Commonwealth, the Aetna Medicaid organization has been committed to serving the people of Kentucky, improving their health, and helping them be responsible for their health for nearly a decade.

In 2018 and 2019, our community outreach initiatives resulted in **direct engagement with more than 132,000 people throughout the Commonwealth.**

Integrated Care Management

Aetna's enrollees are our Kentucky family, neighbors, friends, and acquaintances. Aetna values an enrollee's choice in how they engage with care management services. **Figure A.7** illustrates the framework of our enrollee-focused approach.

We specifically designed our care management model—an enhanced, locally based multidisciplinary team model—to better engage enrollees and families in care management services and sustain health outcomes. Since 2011, our use of person-centered approaches formulates our understanding of the needs of our enrollees and their families and informs the condition- and population-specific tactics and activities that we use to establish and promote high-level participation and deliver evidence-based care and treatment. We organize Care Management teams close to the enrollees they support, reducing travel time and costs for staff and promoting improved specialty knowledge of services and providers in the area.

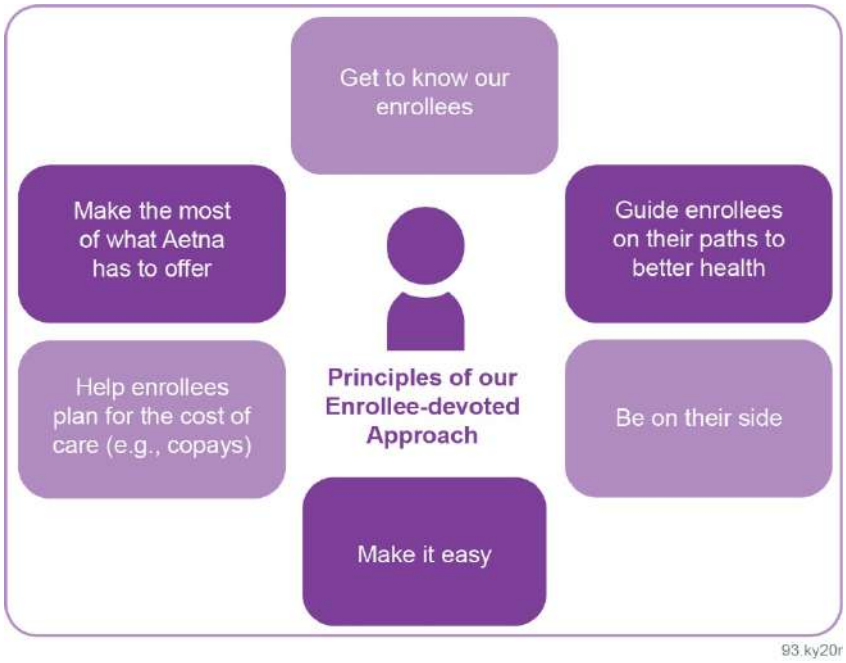

Figure A-7: Principles of our Enrollee-devoted Approach
Aetna follows six tenets in the support and services we provide for enrollees.

Care managers are cross-trained in physical and behavioral health, act as a single point of contact for the enrollee, and work with other members of the multidisciplinary team (e.g., PCP, licensed behavioral health clinicians, nurses, pharmacists, and peer support specialists) to engage the enrollee in services. Engaging enrollees and their supports is a key tenet of motivational interviewing and a cornerstone skill for all staff interfacing with enrollees. Aetna's integrated care management approach identifies our most complex and vulnerable enrollees with whom we have an opportunity to make a significant difference. We engage these enrollees in care management programs to remove or mitigate barriers that limit their ability to manage their own health and well-being. We educate them about population health initiatives, enhance their engagement, and help them remain in the least restrictive and most integrated environment. We coordinate services based on their preferences, needs, safety, burden of illness, and availability of family or other supports in a manner consistent with each person's personal and cultural values, beliefs, and preferences. We help individuals develop resiliency, move toward recovery, and reach their self-defined level of optimal functioning.

We use multiple modalities to reach and engage our enrollees, including face-to-face visits, provider coordination, community health workers and community-based peer support workers, text messaging, social media offerings, and the Lifeline smartphone.

System of Care Model

Our innovative, integrated system of care approach is based on a whole-person view of our enrollees' physical health, behavioral health, oral health, health literacy, functional needs, and SDOH. The system of care positions in Kentucky that serve to support the PHM program include the following: adult system of care administrator, children's system of care administrator, recovery and resiliency administrator, emergency department/crisis administrator, justice system liaison, and trauma system of care administrator.

Figure A-8: Aetna's Integrated System of Care

Aetna's integrated system of care includes all health care and related services and supports necessary for enrollees to achieve improved health outcomes.

Figure A-8 depicts our integrated system of care demonstrating our comprehensive focus on meeting enrollees' needs and goals by wrapping around them.

Population Health Management

Aetna's person-centered population health management program facilitates enhanced quality of care and effective management of the health of defined populations by empowering enrollees to engage and drive their health care and to improve their health outcomes. **The elements of our program are in alignment with NCQA's population health management model and standards and Kentucky's target populations and conditions.** Aetna has completely integrated the NCQA PHM standards into the fabric of our PHM plan.

The PHM program, supported by our system of care, is integrated with our value-based purchasing (VBP) programs and supported by our use of powerful analytics to deliver actionable data to support enrollee identification and risk stratification.

Our VBP program is aligned with our PHM strategy to advance improvements in the delivery of quality, access, and evidence-based services with the goal of improving the health of our enrollee population as a whole, and for specific subpopulations as well. Our VBP arrangements are designed to align with Commonwealth-specific quality and performance goals to optimize outcomes and results. In addition, as part of our VBP program, Aetna's Population Health team uses predictive modeling reports, gaps in care information, claims data, and provider input to target enrollee-level intervention related to emergency room utilization, inpatient admissions, risk for readmission, and enrollees who are lost to follow-up.

Our VBP programs are successful for key Kentucky priority populations, such as achieving a **25 percent improvement in Adolescent Well Care Visits** over a four-year period for enrollees served by providers in VBP arrangements.

Success Story of Collaboration and Coordination: Welcoming 68,000 New Enrollees Overnight

We demonstrated our commitment and devotion to fellow Kentuckians and the power of collaboration with the Department and other Commonwealth agencies at a critical time in July 2013. On July 6—Saturday of the Fourth of July holiday weekend—our health plan (operating then as Coventry Health and Life Insurance Company) welcomed 68,000 new enrollees when one of three Medicaid managed care organizations in the Commonwealth, Kentucky Spirit (Centene), ceased operations. Through diligent planning, expert execution, and unmatched passion by our experienced staff, we provided a smooth transition for our new enrollees and providers, while continuing to provide the best service for our existing membership.

Our staff addressed the needs of our new membership, including processing enrollment and identification cards, conducting enrollee and provider calls, managing prior authorization, and more. To this day, our health plan takes great pride in how we stepped up for our new enrollees and providers and collaborated with the Department to manage this rapid development and provide an opportunity for everyone involved. The outcomes of this transition proved that we will stop at nothing to serve and support our fellow Kentuckians.

4. Strategy and Approach for Establishing a Comprehensive Provider Network

Our Kentucky Medicaid **provider network is 100 percent compliant with the Department's adequacy standards.** We have **29,355 contracts representing 33,794 providers at 118,977 locations.**

Having served the Commonwealth's Medicaid managed care program since its inception in 2011, Aetna's Medicaid organization has learned that the most effective provider network strategy is to continually monitor and assess our network so we can anticipate and respond to network changes. In support of our commitment to quality, ready access, and innovation to maximize enrollee health, advance health equity, and address SDOH within a flexible VBP approach, we have developed a robust Commonwealth-wide provider network capable of meeting the health care needs of Kentucky Medicaid enrollees in an accessible, timely, and convenient manner.

> "Aetna's leadership and staff have been exceptional to work with and they have worked diligently to develop a contract that will move the health care of its members forward. It seems measuring outcomes and working to improve medical care has been implemented in Kentucky for many years; however, most of those value-based contracts have been centered around physical health. Because behavioral health is often more complex, regarding measuring outcomes, the MCOs have been hesitant to engage with the CA-IPA (Children's Alliance Independent Provider Association), apart from Aetna. Aetna leaders expressed their concern and commitment to specifically helping the most vulnerable children and families in Kentucky, which are those cared for by CA-IPA members."
>
> **—Michelle M. Sanborn**
> **President, Children's Alliance**

Our strong community relationships with providers, integrated network analysis and recruitment processes, and high-touch model of network management assist us in ensuring a network sufficient to meet the needs of Kentucky Medicaid enrollees.

Our strategy is to maintain a comprehensive region-specific, experienced, and high-quality network that offers provider selection, preserves existing community referral patterns, and ensures access to care for the underserved. When possible, Aetna is committed to using local providers; however, when local providers are not available, we draw on our national expertise to deploy innovative alternative models as we have with telehealth services. We use our comprehensive contracting methodology, VBP arrangements, technology/telehealth services, and an ongoing level of engagement and diligence to continuously recruit providers and scale our provider network to meet the needs of our Kentucky enrollees.

As part of our recruitment and retention strategy, Aetna offers providers a variety of alternative payment arrangements through our Aetna Better Value program. **Since 2012, we have grown from 41 provider**

groups contracted through a VBP arrangement to 581 groups today. Currently, 38 percent of Aetna enrollees are served by a value-based provider with 43 percent of Aetna-contracted PCPs participating in a physician incentive plan.

Aetna recognizes the important role system collaboration can have in addressing workforce shortages and certain network gaps. As an example, there is a workforce shortage for behavioral health providers, particularly in rural areas, which may be mitigated through improved utilization of mental health associates. We are currently collaborating with community mental health centers to make sure they understand the full scope of services that may be provided by appropriately supervised mental health associates. Another initiative where we have partnered with the Department and the other MCOs was in regard to a workforce shortage specific to psychologists. As a result of this collaboration, the Department now allows psychologists to provide services to enrollees and receive reimbursement while working under their temporary license. Another example of a strategy that we use to address workforce shortages and network gaps is the utilization of telehealth to provide real-time interactive communication between the enrollee, provider, and care team, as well as live video consultation between practitioners to address the enrollee's care plan.

5. Innovations and Initiatives Aetna Proposes to Implement to Achieve Improved Health Outcomes for Enrollees in a Cost-effective Manner

Aetna recognizes the Department's focus on developing "collaborative efforts and initiatives" with the contracted MCOs and State agency partners to enhance the Medicaid program and improve the health of enrollees in a cost-efficient manner. We take great pride in our ongoing collaboration with the Department and stakeholders serving the Medicaid population across the Commonwealth, providing greater access for enrollees with a goal of improved outcomes. Aetna is a proven collaborative and innovative partner working with the Commonwealth to achieve the statewide mission of creating a healthier Kentucky.

Improving Medical and Pharmacy Utilization in Partnership with Community Pharmacy Enhanced Services Network

Leading Medicaid members on their journey to better health starts by addressing the basics and increasing member touchpoints. Aetna, in partnership with pharmacies in the Community Pharmacy Enhanced Services Network (CPESN), initiated a new program in 2019 to provide a higher level of care for shared members, addressing factors like medication reconciliation and care coordination.

> "Aetna enrollees reported a very high rate of satisfaction with the program, and both CPESN pharmacies and Aetna care managers have multiple stories of problems resolved and progress to better health outcomes because of the program. CPESN Kentucky looks forward to more opportunities to collaborate with Aetna in the new managed care contract term that begins in 2020."
>
> **—David Figg**
> **Lead Network Facilitator, CPESN Kentucky**

The CPESN program utilizes local community pharmacists to engage enrollees and create individual enrollee pharmacy care plans that define interventions based on a comprehensive assessment of enrollee medication use and health needs. Enrollees are identified for outreach based on presence of polypharmacy concerns (greater than 4 prescriptions in 60 days) commonly seen with medical conditions such as hypertension, diabetes, asthma/chronic obstructive pulmonary disorder, behavioral health conditions, and chronic pain.

In 2019, the Aetna-CPESN care team conducted over 65 case conferences discussing 181 enrollees with potential health concerns. The integrated team collaborated on and assisted over 98 enrollees, created 151 pharmacy care plans for 90 enrollees, and took over 314 actions to resolve care issues. Pharmacist actions

that focused on coordinating care with medical providers and changing drug therapy had a 59.5 percent (50 of 84 recommendations) acceptance and success rate.

Participating CPESN pharmacists attested the program removed enrollee barriers to care and improved health outcomes. Completed program assessments demonstrated the positive impact of collaboration between Aetna and the community pharmacists. As the participating pharmacies saw success with this program, they began to refer new pharmacies to join the program. This level of support has been critical to engaging our members and expanding services. The program began expanding to multiple communities across the Commonwealth in July 2019, and will continue to grow in 2020. Additional program assessments will be conducted six months post-implementation focusing on measuring the program's impact on enrollee medication adherence, closure of care gaps, decreased use of emergency department and hospitalizations, and resolution of SDOH concerns.

CPESN Q1 2019 Outcomes

- **Emergency department utilization:** decreased cost by $28,070 and decrease in claims by 32
- **Outpatient utilization:** decreased cost by $141,299 and decrease in claims by 93
- **Inpatient utilization:** decreased cost by $45,147 and decrease in claims by 6
- **Pharmacy utilization:** increased cost by approximately $500 and decrease in claims by 232

Challenge: Adoption by providers who would be transitioning into a non-traditional role. The vision and purpose of the program is to improve communication between enrollees and Aetna by utilizing community retail pharmacists. We are expanding pharmacists' traditional role, educating them on new focus areas such as SDOH so they can help monitor enrollees' needs. This information enables Aetna to support the delivery of services for enrollees. As the program expands, we will leverage pharmacies that participated in the initial program to support new pharmacies in the program. Additionally, we are reviewing reporting components and collaborating with software vendors to ensure we are receiving comprehensive enrollee data in an efficient manner.

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Figure A-9: Supplying Emergency Kits
Aetna employees deliver supply bags for enrollees in need of daily essentials to a participating CPESN pharmacy. "The pharmacies are most appreciative of these supplies and the ability to help our neighbors," said David Figg, CEO of Rice's Pharmacy in Beaver Dam. "Partnerships within our community allow us to address the needs of our members when and where they need it most."

As the pharmacists grew into this expanded role, they saw a need for addressing real-time SDOH, as well as ways to make it easier for members to focus on their health priorities. Identifying SDOH needs can be challenging for the health plan because daily face-to-face meetings with every single member is impractical. SDOH needs can change quickly, leading to drastic impacts on health access and outcomes. However, local pharmacists and their delivery drivers are on the front lines—they know their community and understand when their neighbors need a little extra help. Aetna collaborated to address this need by purchasing and assembling kits with emergency food, toiletries, and warm weather gear to provide to the local partner pharmacies (please refer to **Figure A-9**). Now pharmacy home delivery drivers are able to supply these kits to community members that they find have an acute

need, based on their observations in the home. As a result, the health plan estimates that this ongoing SDOH component of the partnership has the potential to touch upwards of 750 community members over the course of the next year. The CPESN program represents Aetna's commitment to innovation and improving enrollees' access to care for improved health outcomes.

CPESN Program Identifies and Resolves Food Insecurity Issue for Enrollee

An enrollee was referred to the CPESN program to resolve polypharmacy concerns. His medical history was positive for diabetes, peripheral neuropathy, hypertension, and heart disease. Even though the enrollee was working with his pharmacist and was compliant with his medications for diabetes, the enrollee still struggled with uncontrolled blood sugar levels. Because of the enrollee/pharmacist relationship, the enrollee felt comfortable confiding in his community pharmacist, and shared that he had limited access to healthy food and no food in his home at that time.

The pharmacist sent an urgent referral to the Aetna Care Management team for assistance with locating resources for the enrollee. The team contacted the enrollee and assessed his needs. A care manager recognized that the enrollee was disabled, lived on a fixed income in a low-income housing apartment, had lost his Supplemental Nutrition Assistance Program benefits, had no transportation, suffered from impaired mobility, and had very limited social supports. The enrollee also disclosed that he utilized his local convenience store for his grocery needs.

The care manager located a community resource that could supply the enrollee with a food basket delivered directly to the enrollee's residence to resolve his acute need for nutritional food. Additionally, Aetna established a plan to prevent future situations through a community resource that services the enrollee's low-income housing unit: a mobile grocery store that is available every week at a set time. This community resource eliminated the transportation barrier, was more cost-effective for the enrollee, and provided healthier nutritional food options.

Aetna's Transformation into a Trauma-informed Organization

The Aetna Medicaid organization is undertaking a system-wide transformation initiative to enhance our system of care into a system that includes trauma-informed practices and providers. **We are the first managed care organization to collaborate with the National Council for Behavioral Health to implement an enterprise-wide trauma-informed care initiative.**

Multiple research studies, including the Adverse Childhood Experiences Study, have confirmed exposure to severe stress and trauma such as abuse, neglect, discrimination, and violence can increase an individual's risk for serious and lifelong physical and behavioral health issues, poor health outcomes, reduced quality of life, and increased cost of care. Individuals exposed to violence are not only more likely to have diabetes, obesity, heart disease, mental illness, substance use disorders, and asthma, but their symptoms are also more severe.[7] Aetna's goal is to stop the cycle of intergenerational trauma for enrollees.

Aetna's transformation initiative is occurring at all levels of the organization—from the CEO to care managers as well as Enrollee Services staff, human relations, and all aspects of the health care company. In Kentucky, our entire staff has begun the trauma transformation training and we will be initiating a year-long collaborative with local providers of both health and social services to expand the availability of trauma-informed resources for Kentucky populations.

As part of our trauma transformation, Aetna is looking at prevention and early intervention for the foster population, a group with a high prevalence of a history of ACEs. **Aetna is in development of a**

[7] Dolezal, Theresa, McCollum, David, and Callahan, Michael, "Hidden Costs in Health Care: The Economic Impact of Violence and Abuse," (2009): accessed June 1, 2019; http://www.ccasa.org/wp-content/uploads/2014/01/Economic-Cost-of-VAW.pdf

proprietary predictive modeling tool to look at rising risk for foster placement as well as risk of entering into the social service system. Understanding that the root cause of many challenging population outcomes is a history of trauma, having trauma-informed communities, providers, and staff and making resources available is key to an effective population health strategy.

Challenge in provider adoption: We will partner with providers to deliver education and training on evidence-based practices established by the Substance Abuse and Mental Health Services National Center for Trauma-Informed Care. We are exploring value-based payment options to incent providers along the path of becoming trauma-informed practitioners.

Social Determinants of Health Integration Model

Aetna is partnering with Unite Us to address the SDOH needs of our enrollees, as described previously in the "Understanding the Needs of Medicaid Enrollees" section. This network serves Louisville and will be expanded to cover the rest of the Commonwealth. The Unite Us model results in cost-efficiency by improving enrollees' access to community resources for their social needs (**Figure A-10**). In addition to episodic support, Unite Us also provides sustainable solutions such as community health workers offering enrollees assistance with enrollment in federal and Commonwealth benefit programs such as Women, Infants, and Children, the Kentucky Transitional Assistance Program, the Kentucky Low Income Home Energy Assistance Program, and the Continuum of Care Homeless Assistance Program.

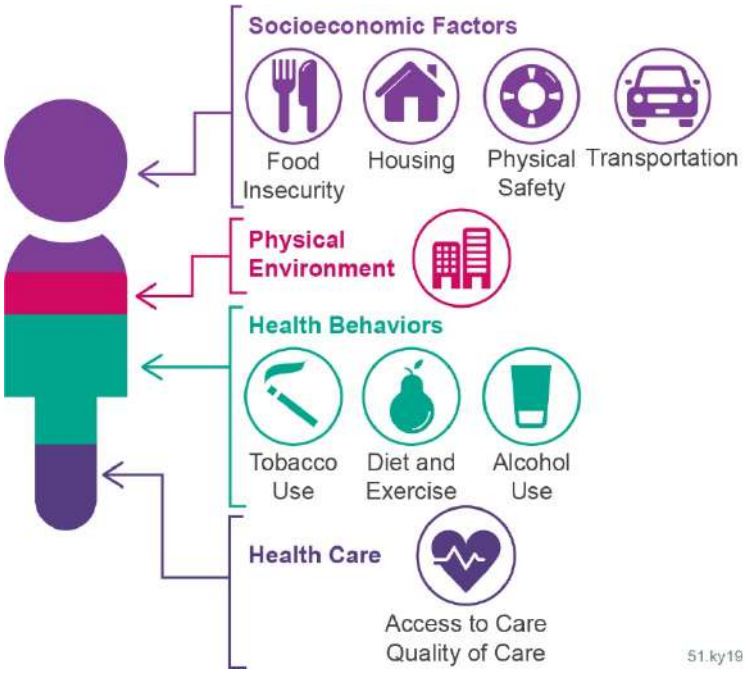

Figure A-10: Social Determinants of Health
Aetna's partnership with Unite Us will provide enrollees access to a network of comprehensive resources.

Aetna's Health Care Equity Dashboard includes enrollees' self-reported data on their demographics, conditions, and needs. **We are developing capability to track use of non-Medicaid services (e.g., enrollee use of services for unmet social resource needs like housing, food, and transportation) through the Unite Us network of providers. We aim to incorporate this data into our risk stratification methodology in the near future.**

Challenge: Unite Us will require time to develop a comprehensive statewide network because of a lack of electronic integration points in parts of the Commonwealth. Unite Us faced similar challenges in North Carolina, and the length of time needed to provide access to comprehensive services for North Carolinians across all counties has taken longer than originally scheduled.

In Kentucky, we will use the Aunt Bertha services resources database for additional support during the Unite Us expansion efforts.

Summary

The Medicaid Managed Care Organization Request for Proposal provides a critical opportunity to address key health issues and enrollees' needs and to determine the course for health care in the Commonwealth. Since 2011, we have been a strong and willing partner to the Commonwealth's leadership, people, providers, and community organizations. Aetna has a proven record of performance, capitalizing on our experienced and expert health plan leadership and deep Aetna enterprise resources, sound strategies and technical approach, ability to implement and deliver programs and services, and vision for innovation.

Our approach to the Kentucky Medicaid managed care program is one of passion and compassion. Being collaborative defines who we are as an organization. We take on the challenges that others will not because we know we can make an impact on people's lives and the Commonwealth's total population health. The bluegrass of the Commonwealth is who we are, not just where we live. We are excited about the opportunity to continue supporting the Medicaid population because we know we can build on excellent results and strong relationships across the Commonwealth.

We are totally committed to creating a healthier Kentucky—now and in the future.

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60.7.B Company Background

Kentucky | Transforming Health Care | **Aetna**

60.7.B.1 Corporate Experience

Kentucky | Transforming Health Care | **Aetna**

60.7.B.1 Corporate Experience

Improving the lives of Kentuckians through our focus on health outcomes inspires everything we do at Aetna Better Health of Kentucky. For over 30 years, Aetna's Medicaid organization has honed its approach to serving high-acuity, medically frail, and low-income populations with diverse, enrollee-focused benefits. The Aetna Medicaid organization currently serves approximately 2 million people in 16 states. In our extensive Medicaid managed care experience, we have served families and children, Supplemental Security Income (SSI), children in foster care, dually eligible individuals, Affordable Care Act (ACA) Modified Adjusted Gross Income (MAGI) adults, and ACA former foster care children. Aetna Better Health of Kentucky understands that each population is unique, with unique service needs, and our local, enrollee-devoted approach focuses on our individual enrollees' holistic health needs. We are fully aligned with the Department for Medicaid Services' (Department) mission "to ensure access to and improve delivery of high-quality, cost-effective health care services." We are committed to collaborating with the Department and other Kentucky agencies, enrollees, providers, and community-based organizations, and we are excited to leverage our local and national experience to provide individualized, quality care and exceptional customer service for enrollees, caregivers, and providers.

Aetna[1] is proud of our deep roots and history of service in Kentucky dating to 1889. Over 130 years ago, our affiliate, Aetna Life Insurance Company, was granted a license from the Commonwealth of Kentucky Bureau of Insurance, as depicted in **Figure B.1-1.** Aetna Better Health of Kentucky is a loyal partner of the Commonwealth, as we are an original Medicaid managed care organization (MCO) in Kentucky. We have served Kentucky's Medicaid managed care enrollees since the program's beginning in 2011.[2]

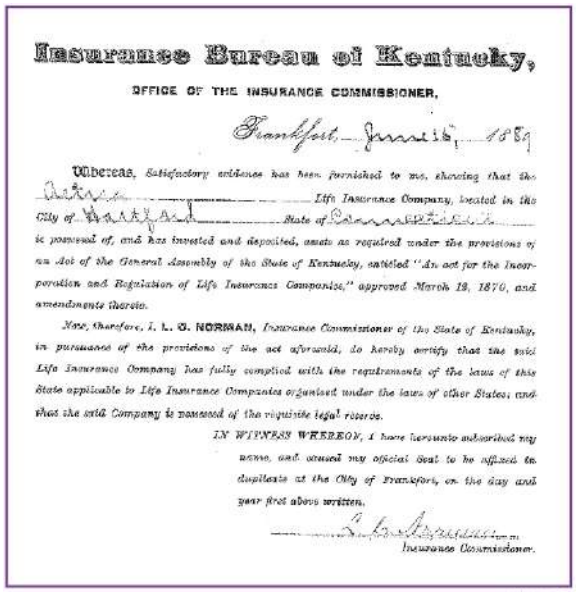

Insurance Bureau of Kentucky,

OFFICE OF THE INSURANCE COMMISSIONER,

Frankfort, June 15, 1889

Whereas, Satisfactory evidence has been furnished to me, showing that the Aetna Life Insurance Company, located in the City of Hartford State of Connecticut is possessed of, and has invested and deposited, assets as required under the provisions of an Act of the General Assembly of the State of Kentucky, entitled "An act for the Incorporation and Regulation of Life Insurance Companies," approved March 19, 1870, and amendments thereto.

Now, therefore, I, L. G. NORMAN, Insurance Commissioner of the State of Kentucky, in pursuance of the provisions of the act aforesaid, do hereby certify that the said Life Insurance Company has fully complied with the requirements of the laws of this State applicable to Life Insurance Companies organized under the laws of other States; and that the said Company is possessed of the requisite legal reserve.

IN WITNESS WHEREOF, I have hereunto subscribed my name, and caused my official Seal to be affixed in duplicate at the City of Frankfort, on the day and year first above written.

Insurance Commissioner.

81.ky19

Figure B.1-1: Affiliate Aetna Life Insurance Company's License

Aetna Life Insurance Company began proudly serving Kentuckians over 130 years ago.

Aetna Better Health of Kentucky is led by Kentuckians who understand the Commonwealth and its people. **Our Chief Executive Officer, Jonathan Copley, is a fifth-generation Kentuckian** hailing from Taylor County. Mr. Copley has 16 years of Medicaid experience, having served as Undersecretary for the Cabinet for

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its parents, Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Kentucky to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of Kentucky's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Kentucky. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

[2] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

Health and Family Services and in an executive leadership role for a local behavioral health provider.

Mr. Copley has led Medicaid managed care organizations in Kentucky for more than five years and has been the driving force behind Aetna Better Health of Kentucky's recent transformation that resulted in the resolution of Kentucky providers' most significant issues. This included the reduction of open items on the Kentucky Hospital Association issue log, as Aetna went from having 36 issues in November 2017 to 0 by April 2019, and we have maintained that 0 status for the past 10 months.

Under Mr. Copley's leadership, Aetna Better Health of Kentucky has realigned itself with the priorities and initiatives of the Cabinet and the Department and has reinvented its approach to partnering with providers through innovative agreements to positively impact the health of our enrollees. Aetna is honored and privileged to provide integrated, managed care capitated services for over 211,000 Kentuckians. **We are here. We are local.**

Aetna's qualifications and experience, including an innovative, integrated service coordination model, quality-driven provider networks, value-added benefits, and high rates of enrollee satisfaction, provide the framework necessary to achieve the Department's mission to ensure access to and improve delivery of high quality, cost-effective health care services. Aetna Better Health of Kentucky is a quality leader with a **Commendable** rating from the National Committee for Quality Assurance (NCQA). Additionally, we tied for the top NCQA score overall amongst the five managed care plans in Kentucky.

Table B.1-1 summarizes our current experience serving the full spectrum of Medicaid populations, including those that we serve in Kentucky.

Table B.1-1: Aetna's Medicaid Managed Care Experience Nationwide[3]

State/ Approx. 2019 Year End Enrollment	Years	ABD[4]/SSI	ACA Exp.	BH[5] Carve-In	CHIP[6]	Duals	LTSS[7]	TANF[8]	Children in Foster Care
Arizona[9]** 383,600	17	●	●	●	●	●	●	●	●
California 19,550	1	●	●		●	●	●	●	
Florida 146,000	26	●			●		●	●	
Illinois[10]* 348,600	7	●	●	●		●	●	●	

3 Table depicts eligibility classes that may be covered within a contractual obligation.
4 Aged, Blind, and Disabled
5 Behavioral Health
6 Children's Health Insurance Program
7 Long-term Services and Supports
8 Temporary Assistance for Needy Families
9 Aetna's Medicaid managed care experience in Arizona is through Mercy Care, which is not a subsidiary of Aetna Inc. but is managed by Aetna's Medicaid organization
10 On January 23, 2020 CVS Health acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare)located in Illinois. Membership numbers for Illinois include IlliniCare membership for Medicaid populations.

State/ Approx. 2019 Year End Enrollment	Years	ABD[4]/SSI	ACA Exp.	BH[5] Carve-In	CHIP[6]	Duals	LTSS[7]	TANF[8]	Children in Foster Care
Kansas 103,250	1	●		●	●	●	●	●	●
Kentucky 211,000	8	●	●	●	●			●	●
Louisiana 120,030	3	●	●	●	●	●		●	●
Maryland 27,975	2	●	●		●			●	●
Michigan[11]* 47,670	14	●	●	●	●	●		●	●
New Jersey 65,800	4	●	●	●	●	●	●	●	●
New York 8,200	6					●	●		
Ohio*/** 25,500	4			●		●	●		
Pennsylvania 222,200	25	●	●	●	●			●	●
Texas[12]** 282,200	20	●		●	●	●	●[13]	●	
Virginia** 164,100	22	●	●	●	●	●	●	●	●
West Virginia 138,100	23	●	●	●				●	●[14]

*Indicates Dual Demonstration Medicare Medicaid Plan
**Indicates Dual-Special Needs Plan

Our experience delivering Medicaid services across the country demonstrates our continued commitment to advancing a delivery system that moves away from isolated and fragmented care to integrated physical and behavioral health services for our enrollees. Additionally, we continue to invest in support services that address key areas of urgency of these enrollees, such as the opioid epidemic and improving maternal

[11] 7,600 of the Medicaid members are Dual MMP
[12] Aetna's Medicaid managed care experience in Texas is both through an Aetna affiliated health plan and an unaffiliated health plan administered by Aetna.
[13] Aetna Better Health® of Texas Inc., our affiliate plan, was recently awarded the STAR+PLUS, LTSS contract scheduled to go live third quarter 2020.
[14] Aetna Better Health of West Virginia was recently awarded the Mountain Health Promise contract, which is scheduled to go live first quarter 2020.

and child health. We also continue to expand the use of innovative payment models to create an empowered environment in which providers become more accountable for quality and value.

a.i. Experience with Population Health Management

Aetna has been providing population health management services in Kentucky since 2011. We currently serve approximately 211,000 enrollees with a provider network of more than 33,700 providers. Aetna possesses the expertise and business acumen necessary to provide a quality-driven, integrated health care delivery model that directly aligns with the Department's objectives. Adapting to the changing landscape of health care, Aetna has responded to the needs of our enrollees by expanding our focus to include population health management, unmet health-related resource needs, and primary prevention to promote health and well-being among our enrollees. Aetna's integrated System of Care model approaches the enrollee's physical, behavioral, and social needs in an individualized, person-centered, holistic manner. We recognize all aspects of these needs are intricately woven together, often in unpredictable ways, and that an enrollee's complexity is exponentially driven by their unique physical and behavioral health conditions and social determinants of health (SDOH) factors.

The goal of our population health management approach is to improve health outcomes and reduce health disparities while serving as a responsible steward of Commonwealth resources. Aetna emphasizes education and self-management, integrating care management and utilization management to close gaps in care. Enrollees' Care Management teams link them to community-based resources and social and behavioral health providers (e.g., peer support).

We draw upon our local experience and our familiarity with Kentucky's geography, provider communities, area resources, and community organizations to tailor support for each of our enrollees' unique needs in order to address known and emerging risks with a focus on prevention. By engaging the support and expertise of numerous stakeholders, we promote enrollee empowerment in making the daily decisions that influence an individual's personal health and well-being. Our history as a Kentucky Medicaid health plan has enabled us to influence population health issues in positive and meaningful ways, as we invest in communities through grants and volunteerism to lower-income populations in the regions we serve.

Addressing Social Determinants of Health

Recognizing that enrollees that have the greatest medical challenges are very often the same individuals who are dealing with food insecurity, housing stability, and a wide variety of other challenges, Aetna proposes to address social, economic and behavioral needs for Medicaid enrollees in Kentucky using an outcome-focused, social care coordination platform, powered by Unite Us. This robust, collaborative approach equips health care and community service providers with a shared platform that they can use to identify available resources for patients, while simultaneously tracking outcomes within a single integrated network of care and social services.

Unite Us Referral Network

Aetna embraces a 'no wrong door' approach to population health management. Any way an enrollee chooses to access care, their level of need is assessed. Individuals with multiple social determinants of health or multiple health conditions will receive care management, while those with lower needs are referred to a wellness center and/or community health worker. The community health worker will connect the enrollee to Unite Us and its network of social determinants of health resources. Unite Us will make referrals and follow up and manage the electronic health record and data reporting to enable Aetna Better Health of Kentucky to monitor and confirm that the enrollee's social determinants of health needs are met. If Unite Us determines that an enrollee's risk level is higher than originally assessed, they will refer the enrollee back to an Aetna care manager. In addition, Aetna care managers can access the Unite Us network as they assist enrollees with more complex needs. By collaborating with Unite Us, Aetna offers

an innovative network that addresses enrollees' physical, behavioral, and social determinants of health needs.

> "I was delivering an order to a couple where the husband had significant disabilities due to back injury and his wife is a bilateral lower extremity amputee. They are essentially housebound with limited access to community resources. I provided them with Community Pharmacy Enhanced Services Network (CPESN) emergency kits created and provided by Aetna Better Health and it was like watching a child open up a present on Christmas day. It's not only a blessing for the members, but it is a blessing for us to be a part of this moment with them."
>
> **—Valkye Addington**
> **CPESN driver for Rice's Pharmacy in Beaver Dam**

Community Pharmacy Enhanced Services Network

As part of our strategy, Aetna is collaborating with the CPESN to increase enrollee touchpoints and provide a higher level of care for shared members, addressing medication reconciliation and care coordination. The pharmacists also saw a need for addressing real-time SDOH, as well as ways to make it easier for enrollees to focus on their health priorities.

In 2019, the Aetna-CPESN care team conducted over 65 case conferences discussing 181 enrollees with potential health concerns. The integrated team collaborated on and assisted over 98 enrollees, created 151 pharmacy care plans for 90 enrollees, and took over 314 actions to resolve care issues. Pharmacist actions that focused on coordinating care with medical providers and changing drug therapy had a 59.5 percent (50 of 84 recommendations) acceptance and success rate.

Participating CPESN pharmacists attested the program removed enrollee barriers to care and improved health outcomes. Completed program assessments demonstrated the positive impact of the Aetna and community pharmacist collaboration. As the participating pharmacies saw success with this program, they began to refer new pharmacies to join the program. This level of support has been critical to engaging our enrollees and expanding services.

Early Identification

Aetna's population health management strategy focuses on early identification. Our evidence-based, enrollee-centered health risk assessments provide us with a deep understanding of our enrollees and their needs from a holistic perspective. We assess enrollees' goals and aspirations to improve their opportunities for independence, self-determination, and self-management.

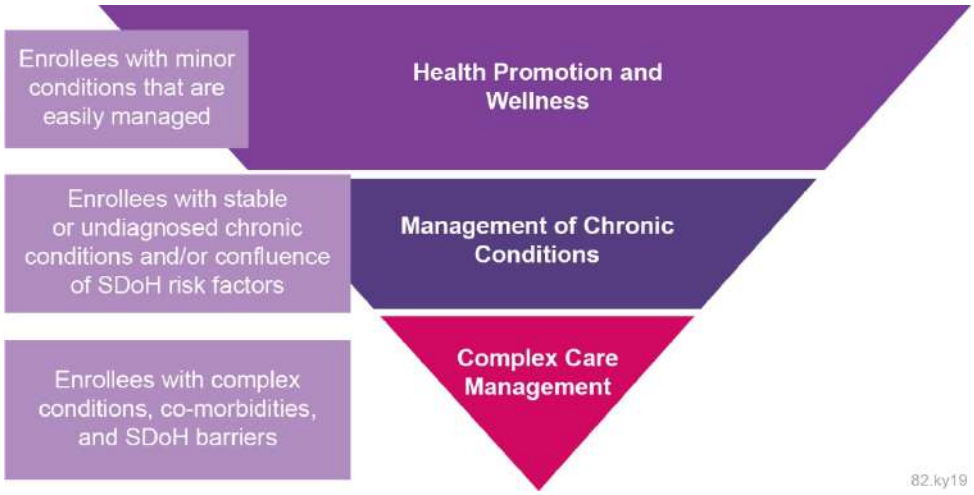

Figure B.1-2: Stratification Levels
Aetna's stratification levels for population health management align with NCQA standards and make sure we can provide care management based on enrollees' needs and level of risk.

Aetna completes over 90,000 initial comprehensive assessments annually across all Medicaid health plans. Additionally, provider gaps-in-care reports identify enrollees on their panel in need of a health screening or preventive exam. Information can be filtered by the provider to examine their performance by provider, by location, and for each enrollee. This helps us target outreach for enrollees who need more targeted outreach and care. Aetna's Care Management team will assist enrollees with access to care and resources as needed.

Enrollees are stratified into three levels as indicated by the needs identified in assessment and screening processes, as shown in **Figure B.1-2.** We align population health management programs to each group in the population and the identified risk level of each enrollee. As enrollees are stratified into population health management levels, their conditions, diagnoses, risk for future emergency room (ER) visits or inpatient admissions, and gaps in care are identified. Identifying enrollees' SDOH needs is integral to addressing risk factors, because we know that we cannot accomplish whole-person care without addressing the circumstances that have the greatest impact on health such as housing, transportation, and food insecurity. Aetna's dedicated care managers coordinate with our Community Outreach team and community-based organizations to link enrollees with the resources they need based on their identified risk.

Aetna is not a transactional insurance company; rather, **we are a personal health care company** that cares for every enrollee we serve. We have expanded our service model to serve all populations, focusing not on disease but rather on helping enrollees achieve their health and wellness ambitions. We seek to engage individuals who otherwise are not engaged in their health care, including those on the continuum of care with few risk factors and rising risk, in an effort to change Kentucky's health care culture and to align with the Kentucky Health Improvement Plan.

Microclinics Focus on Prevention

Microclinics are interactive health programs that teach participants how to adopt practical, healthy behaviors and make positive changes while receiving periodic health screenings to monitor their progress. Practical applications include, but are not limited to, deciphering nutrition labels, group fitness activities, cooking healthy foods, making sustainable lifestyle changes to manage or prevent chronic disease, and sharing the applications with others (which is what we call 'contagious health'). The University of Louisville Trager Center provides the training for Microclinic facilitators, and they informed us that there is no other organization as involved in Microclinics as Aetna.

Aetna has moved beyond the traditional model and made population health management an integral function of not only the Care Management team but of every department, including Utilization Management, Community Outreach, and Quality Management. Our care managers perform health risk assessments as part of their role, and all of our employees look for opportunities to better serve enrollees.

We have hired Population Health Management staff, operationalized population health management, and made it systemic in order to align all functional areas in addressing population health in a collaborative, interdepartmental way. By doing so, we break down silos and create efficiencies while improving health outcomes for enrollees.

Health Promotion and Wellness: Keeping Enrollees Healthy

Aetna works to improve enrollee health status through prevention and wellness activities. Prevention and wellness initiatives are based on Aetna's population health management strategic plan, population assessments, prior year activity results, identified gaps in care, care management goals, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and other special programs. Activities integrate outreach and educational programs for all enrollees. For low-risk populations, population health management initiatives are focused on keeping enrollees healthy with an emphasis on preventive health screenings, using health benefits effectively, and engaging with their primary care providers/medical home. Our

Community Outreach team engages enrollees in fun and informative nutrition and health literacy programs.

We meet enrollees where they are—in their communities, at food pantries, and in community gardens. For example, Aetna is proud to donate healthy, nutritious items to food pantries statewide every month. We used county health rank data to identify food deserts and areas with limited access to healthy foods, and then collaborated with local food pantries and community partners offering free food distribution. Our goal is to supplement regular community donations with healthier options. Through this initiative, we provide fresh produce and healthy shelf-stable items. From the pantry support endeavor, we expanded our efforts to include community gardening initiative called Garden-to-Pantry, in which produce grown in community gardens will be donated to local pantries. We are also working to expand our healthy slow cooking demonstrations into food pantries. Some of our population health management initiatives aimed at keeping enrollees healthy are presented in **Table B.1-2.**

Table B.1-2 Initiatives Aimed at Keeping Enrollees Healthy

Focus Area	Targeted Initiatives
Healthy Kids	• EPSDT immunization education • Value-based payment (VBP) well-child visit measures • Flu vaccination program • KIDS Health online education • Truck FARM • Metamorphosis program
Healthy Pregnancies	• Postpartum visit incentive • Flu vaccination program • Community baby showers • Quit Incentives for Pregnant Smokers smoking cessation program • Maternity Matters program
Healthy Adults	• Microclinics • Snack pantry • Flu vaccination program • Community gardens • Slow cooking and nutrition classes • VBP screening measures

Management of Chronic Conditions: Engaging Enrollees with Emerging Risk

Individuals living with chronic conditions often need effective education and sometimes are not actively involved in their health. These risk factors can put enrollees on a trajectory toward greater health problems in the future. For enrollees with emerging risks, activities and programs are targeted to align with medium risk/rising risk population with emphasis on health maintenance, self-management, and preventing conditions from worsening. We identify and address factors that are predictors of rising risk, including SDOH needs, and encourage enrollees to access community resources.

For example, HealthRunsDEEP is an intervention that identifies individuals with prediabetes and incorporates face-to-face educational sessions held in community-based sites, remote patient monitoring for early evaluation with providers in the community, weekly touchpoints with a health coach, and incentives such as meal delivery service and vouchers for fresh fruits and vegetables. The key to this program is activating communities to focus on early intervention and provide local organizations with resources to help our enrollees. Some of our population health management initiatives aimed at engaging enrollees with emerging risk are presented in **Table B.1-3.**

Table B.1-3: Initiatives Aimed at Engaging Enrollees with Emerging Risk

Focus Area	Targeted Initiatives
Diabetes and Prediabetes	• HealthRunsDEEP program • Health risk assessment screening • Diabetes prevention program • Diabetes nutrition classes • Statewide coalition participation • Enrollee newsletter education
Obesity	• Slow cooking/nutrition classes • Microclinics • HealthRunsDEEP program • Active Health nutrition videos • Text messaging campaigns
Opioid Use Disorder	• Provider education (e.g., letters sent to dental providers who were outliers in opioid prescribing patterns) • Harm reduction, such as dispensing Narcan® to community partners • Start Strong program • Neonatal abstinence syndrome (NAS) program • Text messaging campaigns • CPESN medication optimization program

Complex Care Management: Engaging Enrollees with Multiple Chronic Conditions

For high-risk populations managing multiple chronic conditions, Aetna's population health strategy emphasizes seeing the enrollee as a whole person rather than a set of conditions. Our Care Management and Community Outreach teams help enrollees identify the priorities that will support enrollees on their path to better health. Population health specialists in our affiliate Michigan health plan in 2018 used their health information exchange connection with our population health management platform to manage high-risk enrollees who had frequent ER and inpatient (IP) admissions. Through close monitoring and collaboration with providers, Aetna's population health staff significantly reduced ER visits and IP admissions nine months post-intervention by 24.7 percent and 16.1 percent, respectively.

Chronic Disease Self-Management Program

In Kentucky, Aetna has three facilitators trained to lead the Chronic Disease Self-Management Program. This evidence-based program developed by Stanford University teaches older adults how to better manage their chronic disease. Course objectives include chronic condition management, how to advocate for themselves and speak with providers, handling stress, and creating and implementing action plans.

Aetna makes population health management a focus of our value-based arrangements with providers such as Children's Alliance. In addition, we work with enrollees, providers, facilities, and social supports to ensure both medical and non-medical issues, such as those leading ER usage, are addressed. Some of our population health initiatives focused on enrollees managing multiple chronic conditions are presented in **Table B.1-4.**

Table B.1-4: Initiatives Aimed at Engaging Enrollees with Multiple Chronic Conditions

Focus Area	Targeted Initiatives

Priorities	• ER utilization work group
	• Discharge planning focus
	  – Behavioral health and behavioral health foster care
	  – Physical health extended inpatient

Focus Area	Targeted Initiatives
Programs	• Start Strong • NAS program • Disease management
Partnerships	• Bluegrass Care Navigators • Children's Alliance • Kentucky Primary Care Association (KPCA) • CPESN • Detention Center

a.ii. Outcome Improvement Initiatives

Design and implementation of outcome improvement initiatives begins with examination of relevant clinical, survey, demographic, and/or encounter data that relate to quality of care, utilization of services, or other factors that impact enrollees, providers, or the larger community. We consider the prevalence of conditions among enrollees, the need for specific services, identified barriers to service, demographic characteristics, identified racial disparities, and health risks among enrollees and the communities served by Aetna. Some of our outcome improvement initiatives in Kentucky include opioid use disorder, diabetes, and readmission reduction initiatives.

Example 1: Opioid Use Disorder Initiatives

We know that a multifaceted and complex problem such as the opioid epidemic requires a multipronged, collaborative approach involving numerous stakeholders. Aetna has developed meaningful relationships with local stakeholder groups, such as first responders, public health agencies, and business leaders to help combat the opioid epidemic. Chief Executive Officer Jonathan Copley was named Chair of the Kentucky Chamber of Commerce's new Opioid Response Program for Business. Economic research has found a strong link between rising opioid prescriptions and declining workforce participation rates, estimating that nearly half of men age 25 to 54 who are not in the workforce take pain medication daily and that there is a higher rate of absenteeism among opioid abusers who work. Kentucky's high level of substance abuse was a contributing factor in the Commonwealth's low workforce participation rate (one of the lowest in the country) in a 2017 Kentucky Chamber of Commerce report. The Opioid Response Program for Business, led by a task force of business and industry representatives, will work directly with employers to help audit their policies and recommend best practices to maintain a drug-free workplace while supporting a recovery-friendly culture. It will focus on destigmatizing the addiction epidemic and supporting employers' role in opioid prevention, treatment, and recovery in the workplace.

> Ruth (not her real name) was hospitalized after she attempted suicide by overdosing on medications, including oxycodone. In addition to substance use disorder, Ruth experienced post-traumatic stress syndrome, bipolar disorder, anxiety, binge eating disorder, diabetes, and pain from a degenerative disc disorder. When Ruth began participating in intensive outpatient substance use therapy, she agreed to care management. Her care manager used motivational interviewing techniques to help Ruth express her desire to reduce her interactions with hospitals and doctors and find new options for pain management. A year later, Ruth is no longer using oxycodone and no longer feels suicidal. In fact, she leads peer group therapy sessions at her community behavioral health office.

Aetna has developed a multifaceted strategy for combating the complex issue of opioid use disorder (OUD). Aetna emphasizes care coordination and continuity of care by reducing barriers that restrict access to medication-assisted treatment (MAT), support programs, and non-pharmaceutical alternatives. We created an innovative opioid dashboard which uses pharmacy and medical claims data to trend key metrics to help us combat inappropriate use of opioids. Data from our opioid dashboard demonstrate our

success in Kentucky. For example, data from our opioid dashboard demonstrate that between June 2016 and August 2019 we have achieved the following:

- Increased the rate of non-opioid treatment for chronic pain by 52.9 percent
- Decreased the rate of opioid prescriptions for enrollees with OUD by 44.4 percent
- Decreased the rate of opioid prescriptions for enrollees with a previous overdose by 62.7 percent
- Decreased the rate of 7-day opioid prescription after an acute procedure by 88.6 percent

In Kentucky, Aetna has improved health outcomes for individuals with OUD using a three-pronged approach that includes prevention, early intervention, and full-risk initiatives.

Guardian Angel Program

Aetna Better Health of Kentucky's Guardian Angel Program identifies enrollees with emergency room claims due to non-fatal opioid related overdose. A designated care manager outreaches the enrollee to offer evidence-based substance use disorder services and education about community resources and supports. We connect them with resources for care and support, so they can reduce the risk of another overdose.

Keeping Enrollees Healthy: Opioid-related Prevention Initiatives

Aetna's OUD prevention initiatives focus on preventing illness and injury, promoting health and productivity, increasing health awareness, and reducing risk through enrollee, provider, and stakeholder initiatives. For enrollees who have been placed in our Supportive Managed Care Program (formerly known as the lock-in program), we have engaged pharmacists to notify the enrollee's care manager the first time the enrollee fills a MAT prescription. This way, the care manager can proactively engage and support the enrollee to identify potential barriers to success, such as social determinants of health needs, so that the enrollee feels empowered in their efforts to avoid relapse.

In addition, the Aetna enterprise is taking a proactive approach to working with providers to reduce opioid prescribing, misuse, and abuse. We are using our considerable data resources to encourage prescribers to reduce misuse and prevent the diversion of unused pills. Starting in 2016, Aetna's enterprise-wide chief medical officer began sending letters to the top 1 percent of opioid prescribers within their respective specialties to alert them of their prescribing pattern. Aetna provided 1,000 opioid 'super-prescribers' with educational materials for prescribing opioids for chronic pain. This program continues with separate outreach to 'super-prescribing' dentists and oral surgeons. Aetna continues to work closely with prescribers, including recently setting up a dedicated email address for prescribers to respond to these letters and request more information on their prescribing patterns.

By sponsoring the Narcan event in northern Kentucky, Aetna increased the number of first responders prepared to administer Narcan. Prior to the event, 11 of 33 law enforcement agencies in northern Kentucky were carrying naloxone. After the event, 8 additional law enforcement agencies were interested in carrying naloxone—nearly doubling the number of agencies carrying or wanting to carry naloxone.

We are providing Narcan and educational training to local fire and rescue teams in Boone County and Hazard County, two regions particularly hard hit by the opioid epidemic. In 2017, Aetna provided 720 doses of Narcan to first responders in the northern Kentucky and Appalachia regions to help prevent opioid overdose-related deaths in the area. **The Aetna enterprise, through the Aetna Foundation, will donate additional Narcan kits via a state-by-state distribution initiative.**

Engaging Enrollees with Emerging Risk: Opioid Early Intervention Initiatives

Aetna is providing our enrollees with integrated pharmacy, behavioral health, and medical programs to prevent and treat opioid abuse. We look at trends and identify outliers; we work with our providers and

enrollees to address prescribing practices and barriers to accessing alternative pain management therapies and MAT and provide the resources to help enrollees towards recovery. Our system of care is designed to look beyond the acute to identify the other factors that may contribute to an individual's substance use disorder. Aetna works to help enrollees, providers, and communities understand that there are options and opportunities for pain management that are not opioids. Through our Controlled Substance Use program, Aetna monitors if an enrollee receives multiple prescriptions from different prescribers or is filling them at numerous pharmacies. Depending on the situation, Aetna may send a letter to the prescriber and enrollee, while also referring them to a specialist.

Aetna is also taking a leadership role at the local community level by partnering with governments and local law enforcement to combat the epidemic. We go beyond mandated requirements to conduct clinical reviews on all long-acting opioids prior to coverage to ensure appropriate use and the safety of our enrollees. This includes collaborating with prescribers to complete an addiction risk assessment and agreement by the enrollee to use one pharmacy for all prescriptions.

Figure B.1-3: Gov. Beshear, Aetna Support Volunteers of America

"The women who will come to Freedom House in southeastern Kentucky need and deserve comprehensive and proven treatment, and this gift from Aetna will help to make our work possible."

—Jennifer Hancock, President and CEO, Volunteers of America, pictured here with Gov Andy Beshear and Aetna Chief Executive Officer Jonathan Copley

We screen and identify pregnant women who are at risk for giving birth to opioid-dependent babies, and through an assigned care manager, provide access to specialized care. At the University of Kentucky neonatal intensive care unit (NICU), Aetna has a care manager co-located to support at-risk mothers. In addition, Aetna supported Volunteers of America Mid-States in its efforts to address NAS with a $150,000 contribution in support of its new Freedom House program in southeastern Kentucky (refer to **Figure B.1-3**). Thanks in part to this grant, on February 11, Volunteers of America is scheduled to open a new 16-bed facility located in Clay County—the first program of its kind in the region. Volunteers of America's addiction recovery programs provide a two-generation, family-centered solution. More than 200 healthy babies have been born at Freedom House. Healthy babies and reunited families represent cost savings to Kentucky taxpayers, as babies born with neonatal abstinence syndrome costs Kentucky taxpayers an average of more than $100,000 each. A total of 200 healthy babies means an estimated cost-savings of at least $20 million. Out-of-home placements for children is also expensive and Freedom House is focused on family reunification.

In addition, Aetna is proud of our relationship with Start Strong, a coalition of community partners in the northern Kentucky region working to support justice-involved enrollees as they transition back to their communities. The coalition includes the Northern Kentucky Re-entry Council, Warren Country Jail Re-entry Program, Judges of Kenton County, Drug Courts of Campbell and Kenton counties, Oxford House of Kentucky, Healthpoint, and many others. Some of the interventions designed to reduce recidivism include the following:

- Having Aetna staff onsite at Kenton County Detention Center (KCDC) to perform care management and encourage enrollees to enter the Start Strong Re-entry Program
- Involving the Jail Substance Abuse Program, COR-12, which is out of the Hazeldon/Betty Ford Center inside KCDC to connect its enrollees to MAT for substance use disorder. Each enrollee, before leaving the jail, will receive up to two injections of Sublocade in order to help stabilize them on their road to recovery.
- Providing bus passes to help enrollees seek employment, attend recover support group meetings, and comply with probation and parole requirements
- Assisting enrollees to receive a state identification card, which is required to participate in job training programs and obtain employment

Aetna is the only Medicaid managed care organization in the Commonwealth with a re-entry coach (care manager) embedded in a justice system facility. The Start Strong Re-entry Program, a 90-day jail substance abuse program with 6 months of follow-up support, helps people move beyond addiction and establish healthy, productive lives.

Aetna also has identified three UK HealthCare providers in the area who will provide MAT for our enrollees. These providers have Aetna Gold Card status, which removes the administrative burden when prescribing these medications. By collaborating with providers in this way, we help enrollees avoid treatment disruption and possible relapse. Since January 2019, 37 Aetna enrollees have been released from KCDC and have participated in the Start Strong Re-entry Program. We have a 91 percent success rate of participants returning to the community and being productive citizens.

Engaging Enrollees with Multiple Chronic Conditions: Opioid Full-risk Initiatives

Aetna is committed to enhancing access to evidence-based treatment options for our enrollees. One important treatment option available to those with opioid use disorder is MAT. In the past, insurers generally required doctors to request preauthorization before prescribing opioid agonists like buprenorphine and Suboxone® (a drug containing both buprenorphine and naloxone). Recently, we removed this requirement, making it easier for prescribers to get this critical medication to their patients quickly. Now we classify these drugs as chronic medications and put them in the same category as drugs like blood pressure medication—offering enrollees a reduced cost to help ensure compliance and reduce stigma. In addition, Aetna Behavioral Health is partnering with providers to increase adoption of MAT by providing education, technical support, and promoting adoption through value-based contracting. Furthermore, we recognize the importance of promoting alternatives to opioids. Aetna's Resources for Living program prompts enrollees to consider these alternatives for pain relief, including physical therapy, chiropractic treatment, and mindfulness.

As part of our commitment to collaborating with community stakeholders to support enrollees battling opioid addiction, our affiliate in West Virginia engages the services of Lily's Place. Lily's Place opened in October 2014 as the first NAS center in the nation. Lily's Place provides observational, therapeutic, and pharmacological care to infants suffering from prenatal drug exposure. The facility is designed to make weaning as comfortable as possible in a quiet, low-stimulation environment. Importantly, it offers non-judgmental support, education, and counseling services to families and caregivers. Aetna collaborated with Lily's Place to support the goal of allowing infants to remain in custody of their birth parents rather than entering the foster care system. Lily's Place works closely with Aetna Better Health of West Virginia care managers who follow the mothers through delivery and then into Lily's Place if the child needs additional care. Our care managers meet face-to-face with the mother and father (if present) and develop a plan of care and follow-up. The care manager will follow infants for a year or more, if needed.

Outcomes, Cost-effectiveness, and Sustainability

From our experience in Kentucky and other states served by the Aetna Medicaid organization, we know that efforts to combat the opioid crisis lead to improved outcomes. For example, our affiliate in West Virginia supports pregnant women at risk of delivering babies with NAS by co-locating care managers in three high-risk obstetrics practices that offer MAT. The same way Aetna Better Health of Kentucky collaborates with University of Kentucky NICU, these West Virginia care managers meet with the mothers face-to-face, enroll them in care management, and follow them throughout pregnancy and concurrent treatment for substance use disorder. Following birth, the baby is enrolled in care management and followed through the first year. The program has shown success in keeping the mom engaged in prenatal care as well as engaged in substance use disorder treatment. Most importantly, the majority of babies are remaining with their birth mother. Outcomes include the following:

- In 2018, 59 percent of moms stayed in engaged in opioid treatment and/or counseling during pregnancy and through first year after delivery.
- In 2018, 82 percent of babies have remained with birth mom and were not removed from the home and/or placed in foster care.
- For first quarter 2019, 87 percent of NAS mothers remaining on opioid treatment and/or counseling during pregnancy and through first year after delivery.
- For first quarter 2019, 78 percent of babies have remained with birth mom and were not removed from the home and/or placed in foster care.

Collaboration with Addiction Recovery Care (ARC) Improves Outcomes

Aetna Better Health of Kentucky recently signed a letter of intent to collaborate with ARC to support pregnant women at risk for delivering a child with NAS. Eighty-eight percent of babies born to mothers participating in the ARC program have been discharged after a standard five-day watch period without developing signs and symptoms of NAS or requiring NICU admission. None of the other babies had prolonged NICU stays for treatment of NAS or other complications.

Engaging in OUD initiatives designed to reduce inappropriate prescribing patterns, educating enrollees and providers, and supporting at-risk women is cost-effective because these strategies save lives and reduce costs associated with emergency response, overdose, and incarceration. We know these efforts are cost-effective and sustainable because they have led to outcomes that continue to improve over time, such as in reduced opioid-related claims, as shown in **Table B.1-5.**

Table B.1-5: Year-over-Year Reduction Trend in Opioid Medication Claims

	Year			
Region	2016	2017	2018	2019
Region 1	6,339	5,832	5,661	4,568
Region 2	17,364	17,008	15,819	13,831
Region 3	9,577	9,089	8,555	8,866
Region 4	25,006	24,427	22,323	18,300
Region 5	34,841	31,181	29,985	31,679
Region 6	12,882	11,650	10,183	10,128
Region 7	7,236	7,277	7,036	7,390
Region 8	24,854	22,164	26,002	26,835
Annual Total	138,099	128,628	125,564	121,597

Example 2: Initiatives Aimed at Improving Diabetes Outcomes

Aetna Better Health of Kentucky has several initiatives supporting our goal of improving health outcomes for enrollees living with diabetes and empowering these individuals to improve their health and engage in their health care. Our population health management program is designed to improve health outcomes statewide by making sure enrollees with diabetes get needed services including retinal exams, blood pressure checks, and hemoglobin HgA1c monitoring, including using remote patient monitoring for enrollees who have difficulty leaving their home for services. Our diabetes management program is focused on outcomes improvement for the entire population of Aetna enrollees with diabetes and pre-diabetes. We are supported in our efforts by the Aetna Medicaid organization's Health Care Equity team, which has developed a Diabetes Disparities Resource Workbook to assist Care Management teams in serving populations facing disparities in diabetes-related health outcomes. Additionally, our Population Health team has identified food insecurity as an important social determinant of health for enrollees with diabetes and has integrated a food-insecurity metric to our Diabetes Management Program in 2019.

Aetna also has developed a pharmacy-specific strategy to reduce access disparities. Aetna offers support to enrollees through the CPESN, which is comprised of community-based pharmacies that develop relationships with enrollees and support medication management, social determinant needs identification, and care management. Aetna's Pharmacy team has direct vendor oversight, acts as a liaison between the community pharmacy and Aetna integrated care management teams, and supports identification of enrollees for referral. The program focuses on identifying enrollees at risk for adverse medication and health outcomes due to non-adherence and gaps in care. CPESN pharmacists support enrollees to manage chronic conditions like diabetes by providing enrollee-specific education about their individual risk factors and how to administer medications.

> "Aetna enrollees reported a very high rate of satisfaction with the program, and both CPESN pharmacies and Aetna care managers have multiple stories of problems resolved and progress to better health outcomes because of the program. CPESN Kentucky looks forward to more opportunities to collaborate with Aetna in the new managed care contract term that begins in 2020."
>
> **—David Figg**
> **Lead Network Facilitator,**
> **CPESN Kentucky**

Keeping Enrollees Healthy: Diabetes-Related Prevention Initiatives

As part of our enrollee-centered approach to support prevention and wellness interventions related to obesity and diabetes, we contact enrollees with targeted initiatives. These efforts focus on annual dilated eye exam, low-density lipoprotein, and Hemoglobin A1c (HbA1c) testing; daily self-monitoring of blood glucose; body mass index (BMI) screening; type-2 diabetes screening at prenatal visits; coaching for self-management of condition; nutrition; exercise; weight management; annual flu shot campaign; annual pneumonia shot; and gaps in care. Aetna's Community Outreach team supplements these efforts with enrollee education programs designed to engage enrollees in fun and interesting ways. Some examples of these programs include the following:

- **Living with Diabetes education program:** This is a basic diabetes course provided at no cost to enrollees, offered at various venues throughout the community. Aetna provides the course as a series of 8 to 10 classes, or the course can be customized to meet an organization's needs. Our most popular option is the 1.5-hour cooking class which focuses on basic carbohydrate counting and how to shop using food labels and nutrition information.
- **Slow Cooking and Healthy Nutrition program:** Community Outreach staff provide enrollees with tips about nutrition and healthy cooking techniques using slow cookers. Classes are held once a week or biweekly at different community settings. The classes cover the following topics: nutrition, BMI, diabetes, high blood pressure, heart disease, and dietary guidelines. Facilitators provide cooking

demonstrations of healthy and affordable recipes. At the end of the class, each participant receives a slow cooker.

In collaboration with our community dental and vision vendor, Aetna has developed the Oral and Ocular Care Coordination (O2C2) program. Aetna will implement O2C2 to expand access to preventive services for enrollees at risk of or diagnosed with diabetes. The O2C2 program reaches enrollees who would benefit from regular screening and preventive services to help prevent the development of expensive medical complications. This program goes beyond identifying gaps and providing education. It helps Aetna enrollees find providers and schedule their appointments for dental and vision services based on their preferences and needs. Provider portal and fax blasts for providers with information such as updates to Department guidelines and protocols. A component of the O2C2 program is to reach out to the provider with a list of diabetic enrollees who have visited that provider in the past but have not visited in the last year to make an appointment. Additionally, Aetna sends a mailer informing providers when one of their patients may have diabetes.

Engaging Enrollees with Emerging Risk: Diabetes Early Intervention Initiatives

Aetna's diabetes management program assists enrollees with a diagnosis of diabetes and supports them in understanding the health risks of living with the chronic condition and the benefits of adhering with prescribed treatment regimen; the program seeks to elicit changes in enrollees' behaviors, positively impacting their current and future health and wellness. For example, Aetna's Microclinic program is an initiative designed to empower enrollees to lead healthier lives and manage chronic conditions such as diabetes and cardiovascular disease. This program also engages enrollees who are at risk for diabetes or cardiovascular disease. Participants learn how to decipher nutrient labels, cook healthy meals, take part in group fitness activities, and reach health goals. Meetings are held weekly for 16 weeks by a facilitator who is trained on the curriculum. The meetings are held in community settings where enrollees and their families can participate. The program encourages enrollees with positive reinforcement through small performance rewards and comprehensive teamwork. After the 16-week program is completed, participants can continue in a program called My Health Matters where they check in once a month for 8 months.

All Aetna enrollees with diabetes may choose automated phone call, text messaging, or email reminders when a prescription refills is due to be filled. Reminders are conducted by our pharmacy benefits manager, CVS retail pharmacies, or other pharmacies. These may also include prescription status alerts that will notify an enrollee when their prescription has been filled and is ready for pick up or if there are any issues with the medication

In addition, Aetna is bringing the Diabetes Education and Empowerment Program to our communities. This diabetes management program will be implemented in conjunction with the CPESN pharmacy initiative. The program will serve enrollees and non-enrollees with prediabetes or Type 2 diabetes. We will be leveraging the CPESN pharmacies to refer enrollees for the program. The group education series will focus on improving diet and increasing exercise to prevent, delay, or better manage diabetes.

Engaging Enrollees with Multiple Chronic Conditions: Diabetes Full-risk Initiatives

We support enrollees whose diabetes is not well well-managed or controlled and living with chronic conditions through the following initiatives:

- **Eye SPI (Screen, Prevent, and Improve) for diabetic retinal screening:**
  The Eye SPI project is designed to encourage enrollees who have diabetes but who have not had a dilated retinal eye exam (DRE) exam to get their eyes examined by an optometrist and use a kiosk within a Walmart in the Commonwealth to attest to the completion of their eye exam. Targeted enrollees receive a mailer explaining how diabetes damages the eyes over time and reminds them to

go to a local Walmart to attest to the completion of their DRE exam. Upon completion of the attestation of the DRE exam, the enrollee receives a $10 Walmart gift card.

- **Text message campaign:** A digital campaign designed to help close diabetes gaps in care. Engaging enrollees with diabetes who are non-compliant with their care, this campaign sends reminders of their comprehensive diabetes care screenings, shown to decrease hospitalization for short-term complications.
- **Diabetes mailer program:** A targeted mailing to enrollees 18 and older who are diagnosed with diabetes and are non-adherent for checking HbA1c or low-density lipoprotein cholesterol levels, or for nephropathy or diabetic retinopathy screenings. The mailers include information on gift card incentives.
- **Enrollee incentives:** Aetna supports and encourages its enrollees living with diabetes to seek appropriate screening and tests related to diabetes care through enrollee incentives. This is a value-added benefit which provides for enrollees to receive $10 in gift cards for completion of a diabetic retinopathy eye exam. Gift cards are mailed to eligible enrollees on a monthly basis.
- **Comprehensive diabetes dilated retinal eye exam:** DRE assesses the percentage of enrollees ages 18 to 75 with diabetes who had a dilated retinal eye exam performed by an eye care professional (optometrist or ophthalmologist). Enrollees will get a $10 gift card once per calendar year for completing a diabetic retinopathy eye exam.

Outcomes, Cost-effectiveness, and Sustainability

Diabetes is a health improvement priority for Aetna and the Commonwealth, and we have implemented several strategies to improve health outcomes in a cost-effective and sustainable way. Aetna participated in the collaborative Increasing Diabetes Testing and Screening performance improvement project (PIP) that concluded in 2017 with four out of seven of the Comprehensive Diabetes Care measures were in the 50th NCQA Benchmark percentile. While we had good outcomes during the PIP, we recognized the need for continued efforts and to establish sustainability for this initiative. Aetna decided to continue this PIP as a focused study and through our efforts achieved even greater results. In our most recent final rates for 2018, we have exceeded the 50th percentile in five out of seven measures, two of which exceed the 75th percentile and one reaching the 90th percentile. Aetna has focused our efforts and interventions on the following areas to sustain the positive improvements:

- Training and educating our own staff
- Outreaching and educating our enrollees through increased care manager involvement
- Sponsoring multiple events
- Instituting an enrollee incentive for receiving a compliant DRE
- Instituting and expanding our VBS contracts to 8 provider groups and making diabetes a priority with both DRE and HbA1c testing indicators being part of the 10 incentive measures

Other indications that our initiatives related to diabetes are improving outcomes include the following:

- **Weight Assessment/BMI Assessment and Counseling for Nutrition and Physical Activity for Adults (ABAKY):** BMI assessment is currently in the 95th percentile
- **Weight Assessment/BMI Assessment and Counseling for Nutrition and Physical Activity for Children (WCCKY):** BMI Screening is currently 75th percentile but showing significant improving trends
- **Counseling for Nutrition:** Significant upward trends; 10 percent improvement in 2019 rates
- **Counseling for Physical Activity:** Improved 8 percent in 2019
- **Prenatal and Postpartum Risk Assessment and Education/Counseling (PPRKY):** Improved 7.5 percent in 2019

Aetna's diabetes outcome improvement initiatives are cost-effective because, by helping enrollees to better manage their condition, we are helping to save lives and reduce the costs related to dialysis,

amputations, kidney transplants, and hospital stays. In human terms, we help enrollees stay healthy and active, giving them more opportunities to be involved in the workforce and their communities.

The diabetes-related Healthcare Effectiveness Data and Information Set (HEDIS) results displayed in **Table B.1-6** show sustainable improvements in several comprehensive sub-measures from 2014 to 2018.

Table B.1-6: Comprehensive Diabetes Care HEDIS Results

Comprehensive Diabetes Care Measure	HEDIS 2014 Actual	HEDIS 2015 Actual	HEDIS 2016 Actual	HEDIS 2017 Actual	HEDIS 2018 Actual
HbA1c Testing	83.08%	87.04%	85.23%	83.19%	87.02%
HbA1c Poor Control (>9.0%)*	45.73%	39.78%	37.28%	36.99%	34.91%
HbA1c Control (<8.0%)	45.43%	50.18%	53.65%	50.73%	54.64%
HbA1c Control (<7.0%)	36.38%	36.08%	40.44%	38.17%	41.36%
Eye Exam (Retinal) Performed	38.11%	40.51%	44.30%	46.64%	48.40%
Medical Attention for Nephropathy	79.57%	80.84%	88.60%	90.50%	91.06%
Blood Pressure Control (<140/90 mm Hg)	52.13%	57.85%	63.01%	53.80%	62.56%

*Indicates lower figures are better for this measurement

Example 3: Reducing Readmission Rates

Reducing readmission rates is a priority for Aetna, and we emphasize this goal in our interactions with enrollees and providers, including our VBP partners. Readmission is a quality measure in our VBP contracts, and we support providers with reports on readmission rates. Our Care Management/Utilization Management team has a readmissions workgroup, and they engage Bluegrass Care Navigators to identify inpatient enrollees and follow up at home. After co-locating care managers, we achieved a 9 percent reduction in readmission rates. Aetna also collaborates with hospitals and providers to reduce readmission rates. For example, we noticed a trend in readmissions after inpatient treatment for enrollees with endocarditis. We approached hospitals with a plan to evaluate root causes for this phenomenon and a strategy for looking at enrollees with endocarditis in a more holistic way. We are partnering with our providers on this important issue. Using hospitals' daily discharge list, our providers engage enrollees by calling enrollees directly and asking them to come in for follow-up at their doctor's request. We monitor for members who may have received care in a facility that is not part of their usual network. When we identify these members, we collaborate and coordinate with the provider to ensure that the member receives the follow up care and support needed to improve their health. By working with our partners, we are maximizing the outreach and support for members. This has resulted in an increase in the number of enrollees visiting their providers for post-discharge care.

Aetna's care model integrates physical and behavioral health (BH) to impact readmission rates. We use data from VBP shared savings arrangements that impact care related to utilization measures (ER and readmission) to track high ER utilizers and all-cause readmission, inclusive of physical and behavioral health. Our ER workgroup focuses on physical conditions related to diabetes, heart health, opioid/substance abuse, and behavioral activity demonstrated in depression, severe mental illness, and lack of follow-up care. This data drives activity for provider education, enrollee education, and interventions related to self-care and appropriateness of care. Additionally, we are currently working on the collaborative ambulatory care sensitive conditions (ACSC) PIP, which focuses on ER visits and readmissions. The four conditions of focus in the ACSC PIP include asthma, diabetes, heart disease, and

chronic obstructive pulmonary disease. In addition, our care managers complete a mental health assessment, as we know that chronic physical conditions can impact an enrollee's mental health.

Keeping Enrollees Healthy: Readmission Prevention Initiatives

Aetna's initiatives aimed at preventing readmission focus on enrollee education. The enrollee handbook contains information regarding appropriate use of emergency services and promotes post-discharge follow up with their providers. We also encourage enrollees to establish a relationship with primary care so that they are familiar with their clinician's office and therefore more likely to call with questions before visiting the ER. Aetna also advises enrollees of where the nearest urgent care centers are located and offer the opportunity to utilize telehealth options.

Engaging Enrollees with Emerging Risk: Early Intervention Initiatives to Reduce Readmission Rates

As part of our strategy to reduce readmission rates, Aetna makes evaluating readmission risk a critical component of our care management process. We know that the discharge diagnosis only tells part of the important story for our enrollees. Many of the reasons enrollees are readmitted multiple times stem from circumstances such as lack of attention to discharge medications, enrollee taking discharge medications along with their medications at home, enrollee lacking transportation, and behavioral health issues affecting the enrollee's ability to comply with discharge instructions. To address these issues, Aetna care managers engage enrollees with post-discharge follow-up calls, Bluegrass Care Navigators performs medication reconciliation, and we incentivize follow-up care with our gift card program.

In addition, we continually look for opportunities to partner with hospitals and facilities to involve Aetna care managers to facilitate effective discharge planning. Aetna has collocated clinical care managers with three Kentucky hospitals to facilitate an integrated approach to seamless, coordinated discharge to the community. The clinical care managers participate with utilization management clinicians, hospital staff, and our integrated care teams in discharge planning to address the physical, behavioral, and oral health needs as well as social determinants of health prior to discharge.

Enrollee Success Story

Joe (not his real name) was admitted to an inpatient behavioral health facility several times for major depressive disorder and alcohol dependence. During his last inpatient stay, his Aetna care manager met with Joe to discuss his barriers and social determinants of health needs. Joe shared that he lacked transportation and experienced food insecurity. After Joe's discharge, his care manager connected Joe to transportation resources, provided contact information for churches and Dare to Care sites close to Joe's home, and referred Joe to Change Health to explore Social Security options. Over time, the care manager established a relationship with Joe so that Joe now proactively calls his care manager to discuss his progress and goals.

We identify real-time hospital admissions and ER visits and begin analyzing the cause of the admission and discharge planning needs on the first day of admission. During an acute stay, the integrated care team examines medical, behavioral, social determinants, and health literacy indicators for readmission and begins to address the root cause of the primary admission.

Engaging Enrollees with Multiple Chronic Conditions: Readmission Full-risk Initiatives

Aetna takes an integrated approach to engage enrollees at risk for overutilization of emergency services. We work collaboratively with providers, pharmacists, and behavioral health facilities to improve outcomes. Enrollees face significant challenges when discharged from the hospital. Currently, a lack of coordinated care leaves patients vulnerable to negative health outcomes. Certain groups of enrollees are particularly vulnerable when care transitions are not provided in a coordinated and seamless manner. The Aetna Medicaid Hospital Readmission Reduction program is a clinical program focused on coordinating care between providers, care managers, and clinical pharmacists as enrollees are discharged from the

hospital. A clinical pharmacist will perform a medication reconciliation/review utilizing all available data, including but not limited to paid pharmacy claims data, utilization management documents, and any discharge summaries obtained. The pharmacist calls the enrollee inquire about any medication-related problems the enrollee may have and follows up with the provider as necessary. Following outreach to the provider, the clinical pharmacist will communicate the outcomes of the pharmacist interventions to the enrollee's care manager.

The Aetna Medicaid Pharmacy Supported Comorbid Condition Management program is a clinical program focused on coordinating care between enrollees, care managers, and clinical pharmacists. Enrollees can either be identified directly by the clinical pharmacist or referred to the program by care managers. The primary goal of the program is to improve medication-related outcomes in complex high-risk enrollees through the completion of a thorough clinical medication review. The program is intended to supplement, not replace, established care management programs.

Aetna also is working with behavioral health facilities on an initiative aimed at reducing readmission rates for individuals who overutilize emergency services. An Aetna care manager visits with enrollees face-to-face in an inpatient setting to help enrollees identify their barriers to adhering to their aftercare/discharge plan. Aetna care managers can assist enrollees with making therapy and medication management appointments, as well as arrange transportation to assist enrollees in getting to the appointment. Our care managers also meet with enrollees transitioning from the inpatient setting to intensive outpatient programs. For example, one of our dedicated care managers met Christy (not her real name) during one of her inpatient behavioral health stays at a behavioral health facility in 2018. In her conversation with Christy, the care manager learned that Christy had received a diagnosis of hepatitis C, which led to her contemplating suicide and prompted her most recent admission. Christy also shared that she had high blood pressure, high cholesterol, depression, and bipolar disorder. Using active listening and motivational interviewing techniques, Christy's care manager advised Christy about her benefits and encouraged her to engage in outpatient follow-up and respond to communications from Aetna. Since 2017, Aetna had attempted to reach Christy by telephone 19 times and sent Unable to Reach letters in an effort to follow up with her after each behavioral health discharge. Every attempt was unsuccessful. **After meeting her care manager face-to-face, Christy began engaging and taking an active role in her health care**, responding to care manager telephone calls, and reaching out when she has questions or needs assistance. To date, Christy has not been readmitted.

Outcomes, Cost-effectiveness, and Sustainability

Aetna's initiatives to reduce readmission rates have resulted in improved outcomes and are cost-effective. Not only is it less costly to treat enrollees in the appropriate setting, preventing readmission reduces the risk of hospital-acquired conditions. In our traditional Medicaid block of business, we have seen a decrease in readmissions from 9.8 percent to 8.7 percent from 2015 to 2018, respectively. Based on this reduction in readmissions, Aetna Better Health of Kentucky has decreased costs by over $12 million. In addition, our initiative to include readmissions as a quality measure in our VBP contracts has shown sustainable results, as shown in the plan all-cause readmission (PCR) measure improvements presented in **Table B.1-7.**

Table B.1-7: Year-over-Year Improvement in PCR Measure

	HEDIS PCR Measure		
VBP Providers	HEDIS 2017	HEDIS 2018	HEDIS 2019
KPCA	12.86%	13.75%	12.68%
Big Sandy Health Care, Inc.	11.19%	11.19%	6.82%
St. Elizabeth Physicians	10.72%	15.33%	10.04%

VBP Providers	HEDIS PCR Measure		
	HEDIS 2017	HEDIS 2018	HEDIS 2019
Association of Primary Care Physicians	12.77%	0%*	10.11%
The Physician Network	13.58%	4.76%	18.84%
Norton	12.09%	5.00%	13.13%
KentuckyOne Health	13.11%	15.33%	13.99%

*Indicates HEDIS denominator was 70 for 2017, with zero readmissions.

a.iii.-iv. Lessons Learned Serving Similar Populations

Having a strong organizational structure and robust communications at the national level allows Aetna to identify best practices and apply them locally. In Aetna's experience serving populations similar to those in the Kentucky Medicaid managed care program—families and children, individuals receiving SSI, children in foster care, dually eligible individuals, ACA MAGI adults, and ACA former foster care children—we have learned how essential it is to meet enrollees and providers where they are and address the social determinants factors that impact enrollees' ability to manage their health, well-being, and independence.

Lessons Learned: Improving Health by Addressing Social Determinants of Health

In our experience serving Medicaid enrollees over 30 years, the Aetna Medicaid organization's approach to care has evolved from focusing only on utilization management and care management to include other factors that impact enrollees' wellbeing and ability to achieve their health ambitions. We have learned that social determinants of health are often the root cause of poor health and high utilization. Aetna considers how the conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. Because an individual's ZIP code is often as meaningful as their genetic code, we focus on addressing social determinants of health and resulting health inequities throughout all aspects of our work. Simply stated, health care occurs beyond the boundaries of clinical care settings. With our awareness of the impact of social determinants and our activities to address resulting health disparities, we can advance health equity and assist our enrollees to self-manage their health. With a community-focused population health approach, Aetna is addressing social determinants of health and independence in a meaningful way by providing locally tailored solutions that integrate community initiatives and the health care delivery system.

> "Aetna has made important investments in helping to create a more effective nonprofit sector in Kentucky. Their support has helped Kentucky Nonprofit Network provide valuable professional development for nonprofit executives and strengthened nonprofit efforts to better share their stories of impact and value. Both are important to creating an environment where the work and expertise of nonprofits is valued."
>
> **—Danielle Clore, CEO**
> **Kentucky Nonprofit Network**

For example, Aetna was looking for a partner to address lack of access to healthy foods for enrollees with specific conditions affected by food insecurity, such as chronic heart failure, diabetes, obesity, and heart disease. The Metropolitan Area Neighborhood Nutrition Alliance (MANNA) in southeastern Pennsylvania needed support in its mission to deliver nutritious, medically appropriate meals and nutrition counseling for rising risk and high-risk populations, such as individuals battling life-threatening illnesses such as cancer, renal disease, and HIV/AIDS. Through a combination of financial support and volunteerism, Aetna began working with MANNA to deliver three meals a day, seven days a week, for up

to four months for these populations. MANNA reports that a recent study by the OMG Center for Collaborative Learning[15] demonstrates the health benefits of MANNA's medically modified diets: increased energy, improved weight, better tolerance of medication, and less stress over preparing meals. We are now including MANNA as part of our value-added benefits in Kentucky.

Bringing services locally to communities that may struggle with access to healthy food and health care, Cora is a new mobile health and wellness unit made possible through Aetna Better Health of Pennsylvania and Latino Connection, a multicultural marketing and communications firm. Traveling throughout Pennsylvania to health fairs, festivals, and community centers, Cora has already met more than 13,000 community enrollees and shared healthy tips, fun physical activities, and general wellness education. Everyone who visits Cora can taste samples from a healthy smoothie bar, measure their BMI with state-of-the-art equipment, and move with a Nintendo Wii station equipped with interactive games. In one month, Cora made more than 7,000 healthy smoothies and conducted more than 1,400 BMI screenings. There's also dedicated space for health screenings, assessments, and education with trained health care professionals. They provide a range of guidance from eating healthy on a budget to fitting more healthy activities into busy schedules. In Kentucky, we offer a similar interactive opportunity with our Smoothie Bike. As an enrollee rides the bike, their pedaling action powers a blender that makes a delicious smoothie to enjoy after the ride.

Aetna is more than just an insurance company—we are a holistic health partner. Each enrollee's unique health care needs are intricately woven together by his or her personal life story. We have learned that the best way to serve each individual's needs within a diverse population is to integrate medical and behavioral health services within an integrated system of care.

Application to Kentucky Medicaid Managed Care Program

Recognizing the valuable role that community stakeholders play in addressing enrollees' social determinants of health needs, Aetna Better Health of Kentucky continually seeks opportunities to develop initiatives with community-based organizations to improve accessibility, close health care gaps, promote health literacy, and address the social determinants of health for Kentucky Medicaid enrollees. Our community stakeholders are an extension of our efforts to provide integrated, holistic, person-centered care. We involve community-based services in caring for special needs populations by collaborating with child welfare agencies, agencies serving individuals with intellectual and developmental disabilities, criminal and juvenile justice systems, community service organizations, targeted care management agencies, educational systems, and by collaborating and contracting with community-based provider organizations. Our Community Outreach team will continue to seek out community-based organizations who share our commitment to addressing enrollees' social determinants of health needs in order to engage greater numbers of individuals where they are.

Aetna Better Health of Kentucky care managers have a new pathway to connecting enrollees to much-needed resources: a new collaboration with Unite Us to address the full spectrum of social determinants of health. The Unite Us platform provides the unifying infrastructure between health care entities and community-based organizations. The platform allows for the current ecosystem of health care and social care partners to connect around every member and track the outcomes delivered across each partner in a secure environment. This infrastructure provides the ability to track an individual's journey, regardless if they start their journey post-discharge from medical provider or at a community-based organization's office. The main themes of the platform include the following:

- Configurable screening for needs with immediate decision support

[15] Gurvey, Jill, et al, "Examining Health Care Costs Among MANNA Clients and a Comparison Group," Journal of Primary Care & Community Health, published online 3 June 2013, http://jpc.sagepub.com/content/early/2013/06/02/2150131913490737

- Electronic referrals and tracking with external agencies
- Assessment and care plan management
- Bidirectional communication (between partners and members)
- Alerts and email notifications on referral progress
- Outcome tracking across network partners and each community

Lessons Learned: Meeting Providers Where They Are

During the Aetna Medicaid organization's years of experience helping providers move along the continuum from volume-based to VBP arrangements, Aetna has learned the importance of assessing each provider's readiness and willingness to participate in the development of a comprehensive, integrated system of care and to engage with them accordingly. Aetna's Virginia Medicaid health plan found that attempting to move providers too quickly can create confusion and does not allow the time necessary for providers to adapt and assimilate; therefore, incremental change yields greater success. The Virginia plan implemented the following strategies that we will employ in Kentucky:

- Recognition of the diverse types of provider organizations in the state, such as size, practice composition (single vs. multispecialty), geography, and population types
- Alignment of providers with Aetna Better Value VBP programs based on provider readiness:
  - Development of a 20-question survey to determine where on our VBP continuum a provider's capabilities fall and to gauge the provider's interest in participating in Aetna Better Value
  - Transparent, face-to-face conversations in the provider's environment to yield honest and accurate capabilities and readiness assessments
- Flexibility and simplicity to offer a variety of agreements without the limits of single agreement/single payer that are less than ideal for all lines of business and service types
- Maximum coverage of VBP across our enrollees through engagement with large systems that serve the greatest percentage of enrollees, while motivating small practices to improve quality and create value
- Creation of a no-cost health information platform which affords providers the timely data they require to make highly informed decisions with a 360-degree view of the enrollee

St. Elizabeth Healthcare joined the tiered program for measurement year 2017 and improved in six of seven of the HEDIS measures (one measure was changed from Weight Assessment and Counseling for Physical Activity to CDC HbA1c Testing) from the 2016 measurement year by an average of 5.40 percentage points in those improved measures.

Application to Kentucky Medicaid Managed Care Program

Our former VBP structure in Kentucky required providers to achieve the 75th NCQA percentile before they could receive incentives. Provider buy-in was low, and the feedback we received indicated that the targets were too high. Providers believed that the high target was unachievable and therefore it was not worth the time and money to invest in the VBP program. Applying the lessons learned that health plans should assess providers' readiness and use a more flexible approach to VBP, Aetna Better Health of Kentucky changed the structure of our VBP program to a tiered model. This approach allows us to incentivize providers as they make incremental improvements towards achieving the 75th NCQA percentile goal. Creating this structure allowed for achievable goals, thus creating sustainability in our collaboration with these providers and positively impacting outcomes.

As a result of Aetna Better Health of Kentucky's cross-departmental process for addressing provider concerns, we have seen a steady decline in outstanding issues on the Kentucky Hospital Association's MCO issues log culminating in the resolution of all outstanding issues for 10 consecutive months.

Going forward, we will apply lessons learned to offer VBP arrangements to other provider types, including behavioral health providers. The performance of providers in the behavioral health population is not clearly outlined in HEDIS measures alone, so we look to include more operational and strategic metrics such as utilization measures or trauma assessments in these value-based arrangements. Aetna has been successful in implementing a BH VBP model with a provider partner in Kentucky and is seeking additional opportunities in this area considering the impact on an enrollee's physical and mental health.

In addition, we learned from other Aetna health plans that it is essential to continually review our health plan processes to identify those that create unnecessary burdens on providers. End-to-end provider experience is critical to getting the best care and outcomes for our enrollees. To simplify and streamline the provider experience with our health plan, Aetna Better Health of Kentucky monitors our administrative appeals meetings to identify trends in appeal overturns that suggest there is an administrative burden for providers. For example, we recognized a trend in radiology administrative denials caused by our system configuration conducting a code-to-code match. We changed the logic to conduct a code family match that allowed claims to be adjudicated on the initial submission instead of appeal overturns. In addition, we learned that long provider satisfaction surveys can create a burden and discourage providers from participating. We redesigned the survey to make it more streamlined, and now offer methods other than paper forms for completing it, such as providing an online survey form.

Aetna Better Health of Kentucky proactively works to identify provider areas of concern, striving to resolve them as expediently as possible. We have developed an internal process for escalation that begins with our network managers who are aware of any pain points experienced by our providers. The network managers escalate these areas of concern to a health plan work group that meets regularly to triage and solution for provider concerns. This work group includes representation from health plan executive leadership; health plan operations leadership, including network management and contracting, provider data services, claims processing, system configuration; finance; and compliance. Provider concerns are identified, discussed, addressed, and worked as projects by the teams represented in the work group. The projects are tracked until they are completed and any and all impacted claims are reprocessed and paid to the provider. The network manager then confirms with the provider that their concern has been resolved. By employing this cross-departmental approach, we prevent issues from escalating and improve our responsiveness to provider concerns. Going forward, Aetna Better Health of Kentucky will continue to actively seek ways to improve the provider experience.

Lessons Learned: Executing Plan to Transition 68,000 Enrollees at Critical Time

We demonstrated our commitment and devotion to fellow Kentuckians and the power of collaboration with the Department and other State agencies at a critical time in July 2013. On July 6—Saturday of the July 4 holiday weekend—our health plan (operating then as Coventry Health and Life Insurance Company) welcomed 68,000 new enrollees when one of three Medicaid managed care organizations in the Commonwealth, Kentucky Spirit (Centene), ceased operations. Through diligent planning, expert execution, and unmatched passion by our experienced staff, we provided a smooth transition for our new enrollees and providers, while continuing to provide the best service for our existing membership.

Our staff addressed the needs of our new membership, including processing enrollment and identification cards, conducting enrollee and provider calls, managing prior authorization, and more. We urgently and necessarily achieved the following:

- Monitored and loaded special enrollee files from July 5 through July 8
- Managed an almost 50 percent increase in fax/call volumes for our Prior Authorization and Health Services staffs
- Maintained the highest service levels and the best average speed to answer rates, with an average abandonment rate of less than 1 percent
- Conducted care management outreach

- Contacted new transplant enrollees and conducted medical review for each enrollee
- Identified high-risk obstetrics patients and conducted outreach
- Loaded enrollee eligibility files at the pharmacy benefit manager within 24 hours to allow new enrollees uninterrupted access to needed medications
- Made sure of no interruptions in therapy for medications that required prior authorization for the new enrollees through our transition of care policy
- Managed transition of care for and contacted enrollees with behavioral health needs
- Maintained strong service levels for claims processing

To this day, our health plan takes great pride in how we stepped up for our new enrollees and providers and collaborated with the Department to manage this rapid development and provide an opportunity for everyone involved. The outcomes of this transition proved that we will stop at nothing to serve and support our fellow Kentuckians.

Application to Kentucky Medicaid Managed Care Program

The successful transition of 68,000 Kentucky Spirit members to Aetna still provides valuable lessons to Aetna several years after it occurred. Today, we apply all of those learnings into our everyday operations to serve approximately 211,000 enrollees, nearly 34,000 providers, community stakeholders, and the Commonwealth. Those lessons include the following:

- First and foremost, Aetna is here for the people of the Commonwealth. As an original Medicaid managed care organization in the Commonwealth, we have always been collaborative, innovative, and proactive in providing services.
- The Kentucky Spirit experience demonstrates the value of preparation and anticipation. Aetna completed extensive preparation for the transition and was able to avoid common issues. Our experience and expertise will enable us to welcome new enrollees with any new contract and demonstrate flexibility with program changes.
- The Kentucky Spirit transition demonstrated our deep understanding of the Commonwealth, including the Medicaid program, the provider market, and our communities. Our knowledge proved essential in a time of urgency.

Behind strong leadership and an experienced staff across the Commonwealth, Aetna is well-positioned to address both daily challenges and large-scale implementations.

60.7.B.2 Corporate Information

Kentucky | Transforming Health Care | **Aetna**

60.7.B.2. Corporate Information

Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health® of Kentucky (Aetna)[1] serves over 211,000 Kentucky Medicaid enrollees statewide today. We are proud to be a collaborative and innovative partner to Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier Kentucky. Aetna is a quality leader in Kentucky with a **Commendable rating from the National Committee for Quality Assurance and currently has the top score in the Commonwealth for Medicaid managed care organizations.** We recognize our responsibilities as a steward of the Commonwealth's managed care resources. We take seriously our obligation to use financial resources efficiently while providing high-quality services that improve the health of Kentucky Medicaid managed care enrollees.

a. Required 42 CFR 1.04 disclosures

a.i.1. The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

a.i.2. Date of birth and Social Security Number (in the case of an individual).

a.i.3 Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

In **Table B.2-1**, we provide the name, address, date of birth, social security number or tax identification number (as applicable), of any person (individual or corporation) with an ownership or control interest in Aetna Better Health of Kentucky, other than institutional investors with a beneficial ownership of 5 percent or more of CVS Health Corporation's common stock.

Please note that Aetna Better Health of Kentucky's ultimate parent, CVS Health Corporation, is a publicly traded company listed on the New York Stock Exchange and registered with the Securities Exchange Commission (SEC). As a publicly traded company, CVS Health Corporation does not track the identity of individual shareholders but relies on disclosures of beneficial ownership of CVS Health Corporation stock, which the SEC requires investors to file on Schedules 13D and 13G and related amendments. From time to time, certain institutional investors have filed Schedules 13D and 13G with the SEC, indicating beneficial ownership of 5 percent or more of CVS Health Corporation's common stock. In such filings, the beneficial owner certifies that their shares were acquired in the ordinary course of business and were not acquired for the purpose of changing or influencing the control of CVS Health Corporation.

There are no subcontractors in which Aetna Better Health of Kentucky has a 5 percent or more ownership or control interest.

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor and Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Kentucky to refer to the vendor and Aetna Inc. to refer to one of Aetna Better Health of Kentucky's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Kentucky. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

Please see **Attachment A** for additional office locations and P.O. Box addresses.

Table B.2-1: Ownership or Control Interest in Aetna Better Health of Kentucky

Name	Address	Date of Birth	Social Security Number	Tax Identification Number
CVS Health Corporation	One CVS Drive Woonsocket, RI 02895	N/A	N/A	05-0494040
CVS Pharmacy, Inc.	One CVS Drive Woonsocket, RI 02895	N/A	N/A	05-0340626
Aetna Inc.	151 Farmington Ave. Hartford, CT 06156	N/A	N/A	23-2229683
Aetna Health Holdings, LLC	151 Farmington Ave. Hartford, CT 06156	N/A	N/A	30-0123754
Coventry Health and Life Insurance Company	151 Farmington Ave. Hartford, CT 06156	N/A	N/A	75-1296086
David J. McNichols	3600 Mansell Road, 4th Floor Alpharetta, GA 30022	[redacted]	[redacted]	N/A
David P. Delaney	4500 E Cotton Center Blvd. Phoenix, AZ 85040	[redacted]	[redacted]	N/A
Debra J. Bacon	4500 E Cotton Center Blvd. Phoenix, AZ 85040	[redacted]	[redacted]	N/A
Jonathan E. Copley	9900 Corporate Campus Drive Suite 1000 Louisville, KY 40223	[redacted]	[redacted]	N/A
Tracy L. Smith	200 Highland Corporate Drive Cumberland, RI 02864	[redacted]	[redacted]	N/A
Robert M. Kessler	4500 E Cotton Center Blvd. Phoenix, AZ 85040	[redacted]	[redacted]	N/A
Peter Keller	151 Farmington Ave. Hartford, CT 06156	[redacted]	[redacted]	N/A

Name	Address	Date of Birth	Social Security Number	Tax Identification Number
Bryan J. Lane	151 Farmington Ave. Hartford, CT 06156	[redacted]	[redacted]	N/A
William S. Maynes	151 Farmington Ave. Hartford, CT 06156	[redacted]	[redacted]	N/A
Scott D. Miller	3721 Tecport Drive Harrisburg, PA 17111	[redacted]	[redacted]	N/A
Kevin J. Casey	151 Farmington Ave. Hartford, CT 06156	[redacted]	[redacted]	N/A
Robert J. Parslow	151 Farmington Ave. Hartford, CT 06156	[redacted]	[redacted]	N/A

a.ii. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

No person (individual nor corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in Aetna Better Health of Kentucky as a spouse, parent, child, or sibling. Aetna Better Health of Kentucky does not have a 5 percent or more interest in any subcontractor; and therefore, the second portion of this question is not applicable.

a.iii. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

CVS Health Corporation
CVS Pharmacy, Inc.

CVS Pharmacy, Inc.

- Alabama CVS Pharmacy, L.L.C.
- Pharmacy, L.L.C.
- American Drug Stores Delaware, L.L.C.
- Arizona CVS Stores, L.L.C.
- Caremark Rx, L.L.C.
- Connecticut CVS Pharmacy, L.L.C.
- CVS 2948 Henderson, L.L.C.
- Alaska CVS
- Arkansas CVS Pharmacy, L.L.C.
- Busse CVS, L.L.C.
- CareCenter Pharmacy, L.L.C.
- CVS 3268 Gilbert, L.L.C.
- CVS 3745 Peoria, L.L.C.
- CVS Albany, L.L.C.

- CVS Bellmore Avenue, L.L.C.
- CVS Gilbert 3272, L.L.C.
- CVS Manchester NH, L.L.C.
- CVS NV Holding Company, L.L.C.
- CVS PR Center, Inc
- CVS PR Holding Company, L.L.C.
- CVS RS Arizona, L.L.C.
- CVS Rx Services, Inc.
- CVS State Capital, L.L.C.
- D.A.W., L.L.C.
- Delaware CVS Pharmacy, L.L.C.
- District of Columbia CVS Pharmacy, L.L.C.
- Garfield Beach CVS, L.L.C.
- Georgia CVS Pharmacy, L.L.C.
- German Dobson CVS, L.L.C.
- Goodyear CVS, L.L.C.
- Grand St. Paul CVS, L.L.C.
- Highland Park CVS, L.L.C.
- Holiday CVS, L.L.C.
- Hook-SupeRX, L.L.C.
- Idaho CVS Pharmacy, L.L.C.
- Iowa CVS Pharmacy, L.L.C.
- Kansas CVS Pharmacy, L.L.C.
- Kentucky CVS Pharmacy, L.L.C.
- Longs Drug Stores California, L.L.C.
- Longs Drug Stores, L.L.C.
- Louisiana CVS Pharmacy, L.L.C.
- Maryland CVS Pharmacy, L.L.C.
- Melville Realty Company, Inc.
- MinuteClinic, L.L.C.
- Mississippi CVS Pharmacy, L.L.C.
- Missouri CVS Pharmacy, L.L.C.
- Montana CVS Pharmacy, L.L.C.
- Nebraska CVS Pharmacy, L.L.C.
- Nevada CVS Pharmacy, L.L.C.
- New Jersey CVS Pharmacy, L.L.C.
- North Carolina CVS Pharmacy, L.L.C.
- Ohio CVS Stores, L.L.C.
- Oklahoma CVS Pharmacy, L.L.C.
- Omnicare, Inc.
- Oregon CVS Pharmacy, L.L.C.
- Pennsylvania CVS Pharmacy, L.L.C.
- ProCare Pharmacy, L.L.C.
- Puerto Rico CVS Pharmacy, L.L.C.
- Rhode Island CVS Pharmacy, L.L.C.
- Sheffield Avenue CVS, L.L.C.
- South Carolina CVS Pharmacy, L.L.C.
- South Wabash CVS, L.L.C.
- Tennessee CVS Pharmacy, L.L.C.
- Thomas Phoenix CVS, L.L.C.
- Utah CVS Pharmacy, L.L.C.
- Vermont CVS Pharmacy, L.L.C.
- Virginia CVS Pharmacy, L.L.C.
- Warm Springs Road CVS, L.L.C.
- Washington CVS Pharmacy, L.L.C.
- Washington Lamb CVS, L.L.C.
- West Virginia CVS Pharmacy, L.L.C.
- Wisconsin CVS Pharmacy, L.L.C.
- Woodward Detroit CVS, L.L.C.

The disclosing entities listed and their subsidiaries operate over 10,000 retail pharmacy, LTC pharmacy, mail service pharmacy, specialty pharmacy, prescription drug plan, infusion provider, and clinical provider locations. Detailed information is available upon request.

Aetna Inc. and Aetna Health Holdings, LLC

- Aetna Better Health of North Carolina Inc.
- Aetna Better Health of California Inc.
- Aetna Better Health of Florida Inc.
- Aetna Better Health Inc., an Illinois Corporation dba Aetna Better Health of Illinois
- IlliniCare Health Plan, Inc.
- Aetna Better Health of Kansas Inc.
- Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky
- Aetna Better Health, Inc., a Louisiana Corporation dba Aetna Better Health of Louisiana
- Aetna Better Health of Michigan Inc.
- Aetna Better Health Inc., a New Jersey Corporation dba Aetna Better Health of New Jersey
- Aetna Better Health Inc., a New York Corporation dba Aetna Better Health of New York
- Aetna Better Health Inc., an Ohio Corporation dba Aetna Better Health of Ohio
- Aetna Better Health Inc., a Pennsylvania Corporation dba Aetna Better Health of Pennsylvania
- Aetna Health Inc., a Pennsylvania Corporation dba Aetna Better Health Kids
- Aetna Better Health of Texas Inc.
- Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia
- Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia
- Aetna Health of California Inc.
- Aetna Health Inc., a Georgia Corporation
- Coventry Health and Life Insurance Company
- Aetna Health of Iowa Inc. d/b/a Coventry Health Care of Iowa, Inc.
- Coventry Health Care of Missouri, Inc. dba Care Management Resources (fictitious name: Coventry Health Care)
- Aetna Health Inc., a New Jersey Corporation
- Allina Health and Aetna Insurance Company
- Aetna Health Inc., a New York Corporation
- Aetna Health Inc., a Maine Corporation
- Aetna Health Inc., a Louisiana Corporation d/b/a Coventry Health Care of Louisiana, Inc.
- Aetna Health Inc., a Pennsylvania Corporation
- Aetna Health Inc., a Pennsylvania Corporation d/b/a HealthAmerica Pennsylvania
- Aetna Health Inc., a Texas Corporation
- Aetna Health Inc., a Georgia Corporation d/b/a Coventry Health Care of Georgia, Inc.
- Coventry Health Care of Kansas, Inc.
- Aetna Life Insurance Company
- HealthAssurance Pennsylvania, Inc.
- Aetna Health Inc., a Connecticut Corporation
- Coventry Health Care of Nebraska, Inc. d/b/a Aetna Health Better Health of Nebraska
- Coventry Health Care of Illinois, Inc.
- Aetna Health of Utah Inc. d/b/a Altius Health Plans Inc.
- First Health Life & Health Insurance Company
- Innovation Health Insurance Company
- Innovation Health Plan, Inc.
- Aetna Dental Inc., a New Jersey Corporation
- Aetna Dental Inc., a Texas Corporation

- Aetna Dental of California Inc.
- Aetna Health and Life Insurance Company
- Aetna Health Inc., a Florida Corporation
- Aetna Health Inc., a Louisiana Corporation
- Aetna Health Inc., a Michigan Corporation
- Aetna Health Insurance Company
- Aetna Health Insurance Company of New York
- Aetna Health of Iowa Inc.
- Aetna Health of Utah Inc.
- Aetna HealthAssurance Pennsylvania, Inc.
- American Continental Insurance Company
- Banner Health and Aetna Health Insurance Company
- Banner Health and Aetna Health Plan Inc.
- Continental Life Insurance Company of Brentwood, Tennessee
- Coventry Health Care of Florida, Inc.
- Coventry Health Care of Missouri, Inc.
- Coventry Health Care of Virginia, Inc.
- Coventry Health Care of West Virginia, Inc.
- Coventry Health Plan of Florida, Inc.
- Health and Human Resource Center, Inc.
- MHNet Life and Health Insurance Company
- Texas Health + Aetna Health Insurance Company
- Texas Health + Aetna Health Plan Inc.
- Aetna Health Inc., a Pennsylvania Corporation d/b/a Aetna Better Health of Maryland

a.iv. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

Table B.2-2 lists the managing employees of the disclosing entity.

Table B.2-2: Managing Employees

Name	Address	Date of Birth	Social Security Number
David J. McNichols	3600 Mansell Road, 4th Floor Alpharetta, GA 30022	[redacted]	
David P. Delaney	4500 E Cotton Center Blvd. Phoenix, AZ 85040		
Debra J. Bacon	4500 E Cotton Center Blvd. Phoenix, AZ 85040		
Jonathan E. Copley	9900 Corporate Campus Drive Suite 1000 Louisville, KY 40223		
Tracy L. Smith	200 Highland Corporate Drive Cumberland, RI 02864		
Robert M. Kessler	4500 E Cotton Center Blvd. Phoenix, AZ 85040		
Peter Keller	151 Farmington Ave. Hartford, CT 06156		
Bryan J. Lane	151 Farmington Ave. Hartford, CT 06156		

Name	Address	Date of Birth	Social Security Number
William S. Maynes	151 Farmington Ave. Hartford, CT 06156	[redacted]	
Scott D. Miller	3721 Tecport Drive Harrisburg, PA 17111		
Kevin J. Casey	151 Farmington Ave. Hartford, CT 06156		
Robert J. Parslow	151 Farmington Ave. Hartford, CT 06156		
Paige E. Mankovich	9900 Corporate Campus Drive Suite 1000 Louisville, KY 40223		
Lisa Chandler	9900 Corporate Campus Drive Suite 1000 Louisville, KY 40223		
David M. Hiestand, M.D.	9900 Corporate Campus Drive Suite 1000 Louisville, KY 40223		

b. Form of Business

Aetna Better Health of Kentucky is a Kentucky corporation (for-profit). Aetna Better Health of Kentucky's federal tax identification number is 47-3279217. Our Kentucky tax identification number is 895250.

b.i. Officers, Directors, and Partners

In **Table B.2-3,** Aetna provides the names and contact information for all principal officers and directors. Aetna Better Health of Kentucky does not have partners.

Table B.2-3: Aetna Better Health of Kentucky Principal Officers and Directors

Name	Title	Title Role	Contact Information
Debra J. Bacon	Director	Director	4500 E. Cotton Center Blvd., Phoenix, AZ 85040 602-659-1120
Jonathan E. Copley	Director	Director	9900 Corporate Campus Drive, Suite 1000, Louisville, KY 40223 502-719-8767
David P. Delaney	Director, Chief Financial Officer	Principal Officer	4500 E. Cotton Center Blvd., Phoenix, AZ 85040 602-659-1214
David J. McNichols	Director, President , and Chief Executive Officer	Director and Principal Officer	3600 Mansell Road, 4th Floor, Alpharetta, GA 30022 770-346-1045
Tracy L. Smith	Vice President and Treasurer	Principal Officer	200 Highland Corporate Drive, Cumberland, RI 02864 401-770-5097
Robert M. Kessler	Vice President and Secretary	Principal Officer	4500 E. Cotton Center Blvd., Phoenix, AZ 85040 602-659-1141
Peter Keller	Assistant Controller	Principal Officer	151 Farmington Ave., Hartford, CT 06156 860-273-6594

Name	Title	Title Role	Contact Information
Bryan J. Lane	Assistant Controller	Principal Officer	151 Farmington Ave., Hartford, CT 06156 860-273-6594
William S. Maynes	Assistant Controller	Principal Officer	151 Farmington Ave., Hartford, CT 06156 860-273-6594
Scott D. Miller	Assistant Controller	Principal Officer	3721 Tecport Drive, Harrisburg, PA 17111 717-671-2474
Kevin J. Casey	Senior Investment Officer	Principal Officer	151 Farmington Ave., Hartford, CT 06156 860-273-3708
Robert J. Parslow	Principal Financial Officer and Controller	Principal Officer	151 Farmington Ave., Hartford, CT 06156 860-273-3708

b.ii. Relationship to Parent, Affiliated, and/or Related Business Entities

Figure B.2-1 depicts the relationship between Aetna Better Health of Kentucky and its parent entities. In **Attachment A,** Aetna Better Health of Kentucky provides a detailed organizational chart depicting our relationship to our parent companies and the affiliated and/or related business entities that are subsidiaries of Aetna Inc. and/or CVS Health Corporation (CVS Health), that provide pharmacy benefit management services (CaremarkPCS Health, L.L.C.,) and that are parents of CaremarkPCS Health, L.L.C. Aetna Better Health of Kentucky has no management agreements with parent organizations. We have an Administrative Services Agreement with our affiliate Aetna Medicaid Administrators LLC, which is provided in **Attachment B**. In addition, through downstream intercompany agreements, our affiliate, Aetna Health Management, LLC contracts with Aetna Medicaid Administrators LLC and separately contracts with Aetna Life Insurance Company. Those agreements are also provided in **Attachment B.**

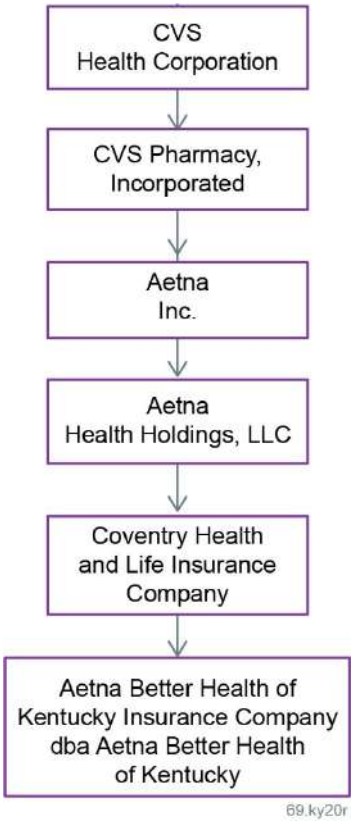

Figure B.2-1: Aetna Better Health of Kentucky's Relationship to its Parent Entities

The chart illustrates Aetna Better Health of Kentucky's relationship to its parent companies.

b.iii. Business Entity Documents

In **Attachment C**, Aetna Better Health of Kentucky provides copies of articles of incorporation, bylaws and similar business entity documents for itself and any legal entity having a direct or indirect ownership interest of 5 percent or more in Aetna Better Health of Kentucky. Aetna Better Health of Kentucky has no partnership agreements.

b.iv. Uniform Certificate of Authority

Aetna Better Health of Kentucky presents our Uniform Certificate of Authority, as well as copies of reports filed with the Kentucky Department of Insurance during the prior 12 months, in **Attachment D**.

60.7.B.2.c Financial Viability

Aetna has a proven record of improving outcomes for our Kentucky enrollees by providing appropriate, coordinated care and services in a financially responsible manner. According to our 2018 Risk-Based Capital report, Aetna Better Health of Kentucky far exceeds the required [redacted] internal company action level for capital and surplus requirements. Aetna Better Health of Kentucky's adjusted capital and surplus is [redacted], demonstrating our financial strength. We have not had any areas of significant financial risk and demonstrate our financial viability and that of our subcontractors in **Table B.2-4**. Some of our subcontractors do not show sustained bottom line profitability for each of the last three years and/or have identified current areas of significant financial risk. In our view, none of these subcontractors' financial viability will have a material impact on the ability of Aetna Better Health of Kentucky to serve its enrollees or meet all contractual requirements. There are viable alternatives should any subcontractor become unable to fulfill its contract with Aetna Better Health of Kentucky for financial or any other reasons.

Aetna provides copies of our financial statements from the most recently completed and audited year, as well as those of our subcontractors, if applicable, in **Attachment E**.

Table B.2-4: Aetna Better Health of Kentucky and Subcontractors' Financial Viability

	2016		2017		2018		2019[2]	
Entity Name	Revenue	Net Income (Loss)	Revenue	Net Income (Loss)	Revenue	Net Income (Loss)	Revenue	Net Income (Loss)
Aetna Better Health of Kentucky	$1.1B	$122.2M	$1.1B	$55.7M	$1.1B	$59.1M	—	—
Accipio Language Services	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
ActiveHealth Management, Inc.[7] (subsidiary of CVS Health)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Advanced Medical Reviews, LLC (subsidiary of ExamWorks Group, Inc.)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—
Aetna Health Management, LLC	$2.6B	$59.3M	$2.2B	$85.0M	$2.1B	$325.1M	—	—
Aetna Medicaid Administrators LLC	$971.1M	$89.1M	$997.9M	$55.8M	$961.7M	$58.1M	—	—
Akorbi Consulting	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
The Guardian Life Insurance Company of America, parent company of Avēsis, Inc.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—
Bluegrass Care Navigators	$53.4M	$3.5M	$57.0M	$5.8M	$67.5M	$0.3M	—	—
Care Innovations, LLC[8]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—
CaremarkPCS Health (subsidiary of CVS Health)[9]	$177.5B	$5.3B	$184.8B	$6.6B	$194.6B	($0.6M)	—	—
Center for the Study of Services	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—

[2] 2019 audited financial statements for many of Aetna's subcontractors were not available to publish in this response. Please refer to the listed financial information for 2016-2018 in the table.
[3]Earnings before interest, taxes, depreciation, and amortization (EBITDA)
[4]EBITDA
[5]EBITDA
[6] EBITDA
[7]Active Health is a wholly owned subsidiary of CVS Health and therefore does not produce audited financial statements.
[8]Please refer to **Attachment E** for an alternative form of viability. Care Innovations does not issue an annual report and their financial statements are not public. Care Innovations, LLC is a wholly owned subsidiary of Care Innovations, Inc., a privately held corporation, with investments from recognized and profitable publicly traded companies.
[9] Financial data for CVS Health; CaremarkPCS Health is a wholly owned subsidiary of CVS Health and therefore does not produce audited financial statements.
[10]Operating income

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	2016		2017		2018		2019[2]	
Entity Name	Revenue	Net Income (Loss)	Revenue	Net Income (Loss)	Revenue	Net Income (Loss)	Revenue	Net Income (Loss)
Central Kentucky Interpreter[12]	Nonprofit	Nonprofit	Non-profit	Non-profit	Non-profit	Non-profit	—	—
Change Healthcare LLC	N/A[13]	N/A	$309.5M	($83.6M)	$3.3B	$193.0M	—	—
Conduent Credit Balance Solutions, LLC (parent Conduent Inc)	$6.4M	$(1.0M)[14]	$6.0M	$0.2M[15]	$5.4M	($0.4M)[16]	—	—
Cotiviti Holdings, Inc.	$625.2M	$48.9M	$678.6M	$138.2M	N/A[17]	N/A	—	—
CQ fluency	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—
Donnelley Financial Solutions	$983.5M	$59.1M	$1.0B	$9.7M	$963.0M	$73.6M	—	—
Edifecs	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—
Equian, LLC	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—
eviCore healthcare MSI, LLC d/b/a eviCore healthcare (parent company is Cigna)[18]	$39.8B	$1.8B	$41.8B	$2.2B	$48.7B	$2.6B	—	—
HMS Holdings Corp. (Eliza Holdings Corp. and Health Management Systems, Inc.)	$489.7M	$37.6M	$521.2M	$40.1M	$598.3M	$55.0M	—	—
Inovalon Inc.	$427.6M	$27.1M	$449.4M	$34.8M	$572.7M	($39.2M)	—	—
John Michael Associates Inc.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—
Kentucky Hospital Association (KHA)	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[11]Operating income
[12]Central Kentucky Interpreter is a nonprofit local small business. Please refer to **Attachment E** for an alternative form of viability; audited financial statements are not available.
[13]Change Healthcare began reporting financials in 2017.
[14] Net income (loss) attributable to Conduent
[15] Net income (loss) attributable to Conduent
[16] Net income (loss) attributable to Conduent
[17]Financials are not publicly available for 2018.
[18]Financial data is for Cigna.
[19]Operating income
[20]Operating income
[21]Operating income
[22]Operating income

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	2016		2017		2018		2019[2]	
Entity Name	Revenue	Net Income (Loss)	Revenue	Net Income (Loss)	Revenue	Net Income (Loss)	Revenue	Net Income (Loss)
Language Line Services, Inc. (subsidiary of Teleperformance)[25]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MCG Health[26]	N/A	N/A	N/A	N/A	N/A	N/A	—	—
Nanthealth (Eviti)	$80.4M	$36.3M[27]	$86.7M	$45.2M[28]	$89.5M	$45.2M[29]	—	—
Office Ally, Inc.	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
Pursuant Health Inc.[30]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—
Red-Card Systems, LLC / Red Card Holdings, LLC	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
Symphony Performance Health, Inc. d/b/a SPH Analytics	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—
Unite USA, Inc. dba Unite Us	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
Welltok	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	—	—

[23]Operating income
[24]Operating income
[25] Please refer to **Attachment E** for the financial statements of Teleperformance, the parent of Language Line Service, Inc.
[26]Please refer to **Attachment E** for an alternative form of viability. MCG Health is a private company and does not provide this information to third parties.
[27]Gross Profit
[28]Gross Profit
[29]Gross Profit
[30]Pursuant Health is a growth company in the health IT industry that is backed by private and strategic investors. While the company was not profitable in 2018 from a net income perspective, the company grew revenue 60% and generated $1M of EBITDA, both of which are expected to grow by 20% and 60%, respectively, in 2019. When the company has required additional capital in the past, it has been successful in raising funds from current and new investors.
[31]Operating income
[32]Operating income
[33]Operating income
[34]Operating income
[35]Operating income
[36]Operating income

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60.7.B.2.d Litigation and Sanctions [37]

Aetna Better Health of Kentucky's vision for our relationship with the Department is to serve as a dependable, transparent, and trusted partner in creating solutions to key public health issues. This includes collaborating with stakeholders to design effective policy and achieve the Kentucky Medicaid program goals, especially the requirements of the contract. From time to time, an Aetna Medicaid organization health plan may receive a notice of action, an important indicator of an opportunity for improvement. Our multidisciplinary approach to identifying, remediating, and monitoring compliance issues is companywide. We perform root-cause analysis and employ the Plan-Do-Study-Act method to address the underlying issues that lead to a notice of action. Results and recommendations are reported to Aetna organization leadership and translated into improved policies and procedures. Aetna is committed to a culture of continuous quality improvement. **We listen. We learn. We take action. We improve.**

d.i. Litigation[38]

We understand the request for "litigation involving Vendor's failure to provide timely, adequate, or quality Covered Services" to be seeking litigation against Aetna Better Health of Kentucky, and/or any Parent Company, affiliate or subsidiary, involving the alleged failure to provide timely, adequate, or quality coverage for Covered Services. **Based upon a reasonably diligent search and inquiry, to the best of our knowledge Attachment F Tables A, B, C, D, and E list any past or pending litigation within the past 10 years involving the alleged failure to provide timely, adequate or quality coverage for Covered Services against the following:**

- Aetna Better Health of Kentucky, including any such litigation against Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company, which held a Medicaid contract in Kentucky until it assigned the contract to Aetna Better Health of Kentucky in February 2016 **(Table A)**
- Any Aetna Better Health of Kentucky Parent Company, affiliate, or subsidiary operating as a Medicaid managed care organization and to the extent we are aware of it, such litigation against health plans that are not affiliates of Aetna Better Health of Kentucky, but which are administered by Aetna's Medicaid organization (Unaffiliated Health Plans). **(Table B)**

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[37] In the Solicitation Modification dated January 27, 2020 the Commonwealth indicated that responses to Section 60.7.B.2.d, which is the RFP question asking about litigation, sanctions, and SEC filings, should include information for the Vendor, Parent Company, subsidiaries and all Subcontractors. See Solicitation Modification, page 91.The original RFP question as written, however, does not list Subcontractors as one of the entity types from which such information is requested, nor does the redlined RFP released as part of the Solicitation Modification include any redlined changes adding Subcontractors to this subpart. As a result, we respectfully assume that the Commonwealth's response to the applicable bidder question was in error and we did not provide litigation, sanctions, and SEC filings for our subcontractors, except where a subcontractor is an affiliate, as required by the wording of the question. If the Commonwealth seeks litigation, sanctions, and SEC filing disclosures for our unaffiliated subcontractors, we will provide it upon request.

[38] On January 23, 2020, CVS Health Corporation (CVS Health) acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare), which is now Aetna Better Health of Kentucky's affiliate and a subsidiary of our ultimate parent, CVS Health. The following narrative, tables, and/or attachments provided in response to this question include information for Aetna Better Health of Kentucky, its legacy affiliates, its parent companies, and their legacy subsidiaries, , as they existed before CVS Health's acquisition of IlliniCare. IlliniCare's disclosures in response to this question are located in Attachment CC.

- Any Aetna Better Health of Kentucky Parent Company, or affiliate or subsidiary in the Medicare line of business, that was part of the legacy Aetna organization as it existed before Aetna Inc. was acquired by CVS Health in November 2018 **(Table C)**
- Any Aetna Better Health of Kentucky Parent Company, or affiliate or subsidiary in any other line of business, that was part of the legacy Aetna organization as it existed before Aetna Inc. was acquired by CVS Health in November 2018 **(Table D)**
- Any Aetna Better Health of Kentucky Parent Company, or affiliate or subsidiary, that was part of the legacy CVS organization as it existed before CVS Health acquired Aetna Inc. in November 2018 **(Table E)**

Aetna Better Health of Kentucky and its affiliates for which litigation is reported in **Attachment F** record reserves for outstanding legal matters when they believe it is probable that a loss will be incurred, and the amount can be reasonably estimated. Such entities evaluate, on a quarterly basis, developments in legal matters that could affect the amount of any reserve and developments that would make a loss contingency both probable and reasonably estimable. These entities are covered by insurance policies that are believed to be customary and adequate for their size and industry. In the opinion of Aetna Better Health of Kentucky and its counsel, the litigation matters pending against Aetna Better Health of Kentucky and its affiliates listed in **Attachment F** do not present a risk that Aetna Better Health of Kentucky's performance in a Kentucky Medicaid Managed Care Contract will be impaired.

d.ii. Sanctions[39]

Attachment G, Tables F, G, and H list sanctions imposed upon the entities set forth below within the past 10 years for deficiencies in their performance of contractual requirements related to an agreement with any federal or State regulatory entity:

- Aetna Better Health of Kentucky, including sanctions imposed upon Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company, which held a Medicaid contract in Kentucky until it assigned the contract to Aetna Better Health of Kentucky in February 2016 **(Table F)**
- Any Aetna Better Health of Kentucky Parent Company, affiliate, or subsidiary operating as a Medicaid managed care organization, and to the extent we are aware of them, such sanctions imposed upon Unaffiliated Health Plans **(Table G)**
- Any Aetna Better Health of Kentucky Parent Company, or affiliate or subsidiary in the Medicare line of business. **(Table H)**

d.iii. Securities and Exchange Commission Filings[40]

CVS Health acquired Aetna Inc. on November 28, 2018. As a participant in the health care industry, our combined business operations are subject to complex federal and State laws and regulations and oversight by federal and State governmental agencies. As such, we are subject from time to time to various claims,

[39] On January 23, 2020, CVS Health Corporation (CVS Health) acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare), which is now Aetna Better Health of Kentucky's affiliate and a subsidiary of our ultimate parent, CVS Health. The following narrative, tables, and/or attachments provided in response to this question include information for Aetna Better Health of Kentucky, its legacy affiliates, its parent companies, and their legacy subsidiaries as they existed before CVS Health's acquisition of IlliniCare. IlliniCare's disclosures in response to this question are located in **Attachment CC.**

[40] On January 23, 2020, CVS Health Corporation (CVS Health) acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare), which is now Aetna Better Health of Kentucky's affiliate and a subsidiary of our ultimate parent, CVS Health. The following narrative and attachments provided in response to this question include SEC filings for CVS Health and Aetna Inc. IlliniCare's disclosures in response to this question are located in **Attachment CC.**

lawsuits and/or governmental investigations. **Attachment H** provides the section of Aetna Inc.'s 10-Ks and 10-Qs that describes certain legal proceedings affecting Aetna Inc. for the portion of the applicable 10-year lookback period before CVS Health acquired Aetna Inc., which includes10-Ks for the 2010-17 calendar years and 10-Qs for the first three quarters of 2018. **Attachment H** also provides the section of CVS Health's 10-Ks and 10-Qs, which describe certain legal proceedings affecting CVS Health for the applicable 10-year lookback period, which includes 10-Ks for the 2010-2018 calendar years and 10-Qs for the first three quarters of 2019.

60.7.B.2.e PHI Breaches[41]

Aetna's privacy practices regarding protected health information (PHI) follow all federal and Commonwealth laws and regulations. Our corporate privacy office, established when the Healthcare Insurance Portability and Accountability Act (HIPAA) was implemented, has overall responsibility for developing policies and procedures to safeguard PHI against uses and disclosures that are inconsistent with applicable law. Aetna's chief privacy officer has been with Aetna for over 20 years and has led the privacy office for over three years, after serving as Aetna's lead Privacy and Security counsel for several years. Aetna's privacy program has matured to include technology-based privacy impact assessments, enhanced data use and governance processes, and an established and mature incident response process. In addition to compliance with state, federal, and international privacy and security laws, the privacy office has an ongoing privacy program strategy to address cutting edge privacy issues as well as the appropriate resource model to address ongoing privacy legislation and initiatives. Our Kentucky-based compliance officer, supported by our corporate privacy office, manages a compliance program that includes education and ongoing policy and procedure review for maintaining our enrollees' privacy and confidentiality.

Aetna maintains comprehensive policies and procedures that address the proper handling, use, and disclosure of enrollee PHI while administering their health care benefits and providing high-quality customer service. We update policies and procedures annually, and more frequently as needed, to stay up to date with changes in legislation and to verify they are current and complete. We implement numerous administrative, physical, and technical safeguards to help comply with HIPAA requirements. Some of our policies and procedures to safeguard the use of PHI include the following:

- Implementing, enforcing, and providing training and education for our staff on policies and procedures regarding the appropriate uses and disclosures of PHI
- Establishing the proper handling, use, and disclosure of enrollee PHI while administering their health care benefits and providing an appropriate level of customer service
- Sharing health information with others when necessary for aiding delivery of health care services, administering health care benefits or health care payments, or as otherwise required by law
- Requiring all staff to complete compliance and ethics privacy training upon hire and annually thereafter

Even with these safeguards in place, in rare instances an enrollee's health information may be disclosed impermissibly. In the last five years, with approximately 2.3 million Medicaid enrollees currently, the combined CVS Health-Aetna enterprise has had only 22 privacy breaches that have touched a Medicaid enrollee served by a health plan managed by Aetna's Medicaid organization. Our combined CVS Health-Aetna organization has a comprehensive incident response plan to handle potential breaches. We follow a rigorous process to halt any ongoing issue and to mitigate the impact of the event to our customers as quickly as possible. This includes notifying enrollees and the State agency as required under applicable State and federal laws and taking other steps such as offering free credit monitoring when an enrollee's financial information is exposed. We also address the root cause of the breach to strengthen controls, where necessary, to prevent a reoccurrence.

[41] On January 23, 2020, CVS Health Corporation (CVS Health) acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare), which is now Aetna Better Health of Kentucky's affiliate and a subsidiary of our ultimate parent, CVS Health. The following narrative and tables provided in response to this question include information for Aetna Better Health of Kentucky, its parent companies, and their legacy subsidiaries as they existed before CVS Health's acquisition of IlliniCare. IlliniCare's disclosures in response to this question are located in **Attachment CC.**

In **Table B.2-5,** we list and describe PHI breaches involving Aetna's Kentucky Medicaid enrollees during the last five years and the response.

Table B.2-5: PHI Breaches Involving Kentucky Medicaid Enrollees

Discovery Date	Description	Response	Plan(s) of Impacted Enrollee(s)
04/18/2018	AMR, a contracted Independent Review Organization, unknowingly employed a person fraudulently pretending to be a physician. This individual had access to PHI for enrollees whose claims he was asked to review.	Enrollees whose claims were reviewed by this individual were re-reviewed. The individual was charged in April 2018 with wire fraud, health care fraud, and aggravated identity theft.	Aetna Better Health of Missouri; Coventry Health and Life Insurance Company and Aetna Better Health of Kentucky, for itself and as assignee of and successor-in-interest to Coventry Health and Life Insurance Company
03/29/2019	Avēsis, a third-party vendor that handles dental and eye care benefits for our Kentucky Medicaid enrollees, mailed five letters to enrollees using addresses that were not current.	The vendor confirmed that the enrollee addresses had been updated.	Aetna Better Health of Kentucky
09/25/2019	On July 5, 2019 the Security team at National Imaging Associates, a Magellan company, discovered that the Office 365 mailboxes belonging to four of their employees had been leveraged to send out high volumes of unauthorized spam emails dating back to May 28, 2019.	Magellan has taken steps to further secure all employee email accounts by disabling certain email protocols on all mailbox accounts, establishing relevant geofencing, and implementing Microsoft Password Hash sync as well as other similar measures.	Aetna Better Health of Kentucky, Pennsylvania, West Virginia, Florida, and Virginia; Medicare and Commercial

Table B.2-6 lists PHI breaches during the past five years and the response for any Parent Company of Aetna Better Health of Kentucky or any Parent Company's subsidiaries, which impacted Medicaid enrollees served by health plans managed by Aetna's Medicaid organization. The table includes any such incidents involving our affiliated subcontractors.

Table B.2-6: PHI Breaches Involving Medicaid Enrollees Served by Aetna's Medicaid Organization

Discovery Date	Description	Response	Plan(s) of Impacted Enrollee(s)
05/1/2015	CaremarkPCS Health, L.L.C. sent faxes containing PHI for five enrollees to the wrong number.	CaremarkPCS Health, L.L.C. information technology added a system update, retrained the employee and supervisor, and issued disciplinary actions for both.	Mercy Care, Aetna Better Health of Ohio
10/29/2015	A Mercy Maricopa Integrated Care (MMIC) staff member admitted to using her system access for purposes unrelated to her job. She viewed personal information about two health plan enrollees who are also MMIC staff. She also admitted to verbally sharing some information with other staff members.	The staff member who viewed the personal information was terminated. The staff who heard the personal information were instructed not to further disclose it.	Mercy Maricopa Integrated Care[42]
01/31/2017	An Aetna social worker's briefcase was stolen from her car while conducting a scheduled wellness check at an enrollee's residence. The briefcase contained an Aetna-issued laptop, Aetna-issued cellphone, and paper documents. The laptop and cell phone were password protected and encrypted. The paper documents contained PHI for seven enrollees.	The social worker notified the local police department, her manager, and Aetna Security. Wireless services and inventory management were also notified. The police department issued a report. All staff in the business unit were reminded that laptops and confidential paperwork should be stored in the trunk of their vehicles if they are unable to keep these items with them when they leave the vehicle.	Aetna Better Health of Florida
02/22/2017	Two boxes of treatment records for 23 Aetna Better Health of Louisiana enrollees were mailed by a staff member to the Aetna imaging facility. The boxes were received at the facility with a letter from the USPS indicating the boxes had been damaged.	An inventory of the documents was completed to determine which pages were missing, if any. It was determined that pages were missing, and the impacted enrollees were notified.	Aetna Better Health of Louisiana
03/23/2017	A staff member's briefcase containing a company-issued laptop and paper documents for two enrollees was stolen from her car. The laptop was password protected and encrypted. The paper documents contained PHI for two enrollees.	The staff member informed her manager and Aetna Security. Retraining was conducted by the individual's department.	Mercy Care
04/6/2017	A case manager was performing enrollee assessments. Upon entering the facility, she had four service plans in her laptop bag. When she left, she discovered she only had one.	The case manager made the facility staff aware that the paperwork was missing and asked that they contact her immediately if they found it. In addition, she went back to the facility twice to look for the missing documents. They were not found.	Mercy Care

[42] As of July 1, 2018, Mercy Maricopa Integrated Care merged into Mercy Care Plan. The resulting entity is now known as Mercy Care.

Discovery Date	Description	Response	Plan(s) of Impacted Enrollee(s)
07/11/2017	Instead of being faxed to the pharmacy area, pharmacy prior authorizations were being sent to a managed care organization which was not serving the enrollees identified in the prior authorizations. While 10 faxes were sent, the managed care organization was only able to confirm receipt of 6.	The fax number was immediately disabled so it could not be used. The fax contact list used by the Pennsylvania plan staff was updated to reflect the correct pharmacy authorization fax number.	Aetna Better Health of Pennsylvania
10/20/2017	A staff member's laptop, Aetna ID and enrollee case folders were stolen from their car. The laptop was encrypted. The paper documents contained PHI for 21 enrollees.	The staff member notified the local police department, her manager and Aetna Security. Wireless services and inventory management were also notified. The police department issued a report. All staff in the business unit were reminded that laptops and confidential paperwork should be stored in the trunk of their vehicles if they are unable to keep these items with them when they leave the vehicle.	Aetna Better Health of Illinois
01/2/2018	Incorrect mapping of digital account records as part of processing carrier to carrier enrollee changes allowed some enrollees using caremark.com to see PHI belonging to another enrollee.	CaremarkPCS Health L.L.C. implemented several corrective actions in its carrier to carrier program and quality assurance processes.	Aetna Better Health of Ohio, Aetna Better Health of Maryland, Aetna Better Health of Virginia
02/5/2018	When mailing a care plan document to an enrollee, a care manager coordinator inadvertently included records for another enrollee.	Feedback was provided to the care manager about the importance of printing and mailing one file at a time.	Aetna Better Health of Ohio
02/27/2018	Aetna Better Health of Florida mailed records that contained PHI for two enrollees to a vendor. In transit, something occurred that caused the records to be lost. The envelope was returned to Aetna Better Health of Florida with the contents missing.	After investigating the incident, we were able to determine who the two enrollees were and what the contents of the mailing included. The impacted enrollees were notified.	Aetna Better Health of Florida
05/18/2018	Approval for services for five enrollees were faxed to an incorrect number. The provider's number was not clear, and the staff member did not call the provider to confirm the fax number before sending.	The fax number was immediately disabled so it could not be used. Feedback was provided to the staff member and manager, and the privacy manager was asked to provide retraining.	Aetna Better Health of Virginia
07/26/2018	A third-party subcontractor for Aetna Better Health of Pennsylvania disclosed PHI to an Aetna Medicaid enrollee's granddaughter without authorization.	Reminder provided to receive authorization prior to talking to family members.	Aetna Better Health of Pennsylvania
09/20/2018	During an outreach call for a high-risk pregnancy, an Aetna nurse disclosed an enrollee's pregnancy to her father without authorization.	Reminder provided to receive authorization prior to talking to family members.	Aetna Better Health of West Virginia

Discovery Date	Description	Response	Plan(s) of Impacted Enrollee(s)
11/20/2018	A staff member mailed a package via UPS to a vendor for review. The package contained a disk drive from a provider that was unencrypted and not password protected. The drive contained 10,000+ pages of medical records for one enrollee—and was being mailed because the file was too big to send electronically. The package and disk drive were lost.	Retraining on sending PHI securely for both the individual who mailed the package and the provider who sent us the data in an unencrypted manner.	Aetna Better Health of Pennsylvania
04/12/2019	A case management coordinator emailed PHI to the incorrect recipient. The email was sent from a company issued cellphone but was not sent securely.	The recipient of the PHI was cooperative, and a verbal attestation of destruction was obtained. However, due to the sensitive nature of the PHI this was determined to be a breach. Employee was retrained on the proper process to send emails securely.	Mercy Care
06/3/2019	An Aetna employee's briefcase was stolen from her car. The briefcase contained an Aetna-issued laptop and paper documents that contain PHI for five enrollees. The laptop was encrypted.	The employee notified the local police department, her manager and Aetna Security. The police department issued a report. The impacted enrollees were notified.	Aetna Better Health of Ohio
06/27/2019	An authorization letter for approved services was inadvertently mailed to the wrong enrollee.	The enrollee contacted Aetna to report the mistake. She signed an attestation confirming she returned the letter to Aetna and will not use the information she received in any way. The impacted enrollee was notified.	Aetna Better Health of California
09/20/2019	An Aetna employee's briefcase was stolen from her car. The briefcase contained an Aetna-issued laptop and paper documents that contain PHI for seven enrollees. The laptop was encrypted.	The employee notified the local police department, her manager and Aetna Security. The police department issued a report. The impacted enrollees were notified.	Aetna Better Health of New Jersey

Table B.2-7 lists, for any CVS Health subsidiary, PHI breaches not covered in **Tables B.2-5** and **B.2-6** and that impacted 500 people or more. None of the incidents reported involved Medicaid enrollees. These breaches were filed with the Office of Civil Rights and information is publicly available on the Office of Civil Rights breach portal. We cannot provide any additional detail on these incidents or information about incidents impacting fewer than 500 people and which are therefore not publicly available on Office of Civil Rights breach portal due to the confidentiality provisions of our customer and vendor contracts. The standard practice of the Privacy Office is to disclose incident information, regardless of incident size, only to those impacted, as we want to be mindful that these individuals' privacy has already been compromised.

Table B.2-7: PHI Breaches Involving CVS Health Subsidiaries but which do not Involve Medicaid Enrollees

Discovery Date	Description	Response
06/26/2015	CVS Health Store 3976, the covered entity (CE), was looted and burned during rioting activity that occurred in the city of Baltimore, Maryland, and some computers containing electronic ePHI were stolen. 12,914 individuals were affected by the incident. The specific type of ePHI on the stolen computers included patients' first and last names, partial dates of birth, addresses, medication names, medication dosage, and prescription number.	CVS Health provided the Office of Civil Rights (OCR) with assurances that individuals affected by this breach and the media were notified in accordance with the Breach Notification Rule. All individuals affected by the breach were given one year of free credit monitoring by the CE.
09/18/2015	A former employee of CVS Health (in the role as business associate (BA) for this incident) impermissibly accessed enrollee information in the CVS Health systems and saved the PHI onto his personal computer. The PHI involved in the breach included full names, enrollee identification numbers, health card numbers, plan codes and states, and start and end dates. The breach affected approximately 54,203 individuals.	The CE provided breach notification to OCR, affected individuals, and the media, and also provided substitute notification. The CE also offered individuals one year of free identity theft protection membership. As a result of this incident, the CE required CVS Health to improve safeguards by enhancing security for its fraud management tool and databases containing PHI and updating its security procedures. OCR reviewed the CE's policies, procedures, and/or documentation related to impermissible disclosures, safeguards, BAs, and breach notification and obtained assurances that CVS Health, as the BA, implemented the corrective actions listed.
04/19/2016	Quarles & Brady is a BA of CVS Health. On March 16, 2016, a briefcase containing a Quarles & Brady workforce member's laptop computer was stolen from the workforce member's vehicle in Indianapolis. The laptop was password protected, but not encrypted, and contained the PHI of 7,261 individuals, in violation of the BA's policy. The PHI included names, addresses, and medications. CVS Health provided breach notification to affected individuals and the media.	To resolve the issues raised in this matter, the BA disciplined the workforce member involved by issuing a formal reprimand, retrained the workforce member, and subjected the workforce member to a period of monitoring. The BA also encrypted all workforce laptops, sent emails to all workforce members reminding them that storing PHI on a computer hard drive violates its policy, and gave instructions on how to delete PHI from the hard drive. Additionally, the BA required all health law attorneys to attest to reviewing all information saved to their hard drives and removing any PHI and retrained all health law attorneys and staff on the importance of HIPAA compliance for the use of laptops. OCR obtained documented assurances from the BA that it implemented the corrective action steps described here.
11/28/2016	Aetna's rental network area had one employee mail an encrypted/password protected CD to another employee—however, the password was written on a Post-it® note and sent with the disk. In this instance the envelope was delivered to the recipient but arrived empty. The CD and Post-it note were not recovered.	The root cause of this breach was human error. Aetna employs a number of safeguards to prevent breaches from occurring, including mandatory HIPAA training and administrative, physical and technical safeguards. Aetna has also limited the ability to burn CDs to only a small population of employees.

Discovery Date	Description	Response
12/05/2016	An individual broke into a CVS Pharmacy in Whiteville, North Carolina, during Hurricane Matthew. The thief stole 626 individuals' completed prescriptions. The types of PHI on the prescriptions included names, partial birthdates, addresses, medication names and doses, providers' names, and prescription numbers. CVS provided breach notification to OCR, affected individuals, and the media.	Following the breach, CVS assessed the damage and secured the store to prevent any other unauthorized access. OCR reviewed CVS policies and procedures on uses and disclosure of PHI and safeguarding PHI and determined that they were in compliance with the Privacy Rule. OCR obtained assurances that the CE implemented the corrective actions noted.
03/03/2017	On January 11, 2017, a box containing hard copy, controlled substance prescriptions written between January 2, 2017 and January 11, 2017, was stolen by an unknown individual from a CVS pharmacy, the covered entity (CE), in Michigan City, Indiana. The breach affected 724 individuals and the types of PHI involved included patients' names, dates of birth, addresses, medication names, medication dosages, prescription numbers, and prescriber information. The CE provided breach notification to affected individuals, the media, and HHS.	Following the breach, the CE retrained its staff at the Michigan City location. Additionally, the CE's management conducted an internal audit to ensure that patient records were not easily visible to waiting customers or accessible by anyone standing outside of the pharmacy. OCR reviewed the CE's policies and procedures on uses and disclosure of PHI and safeguarding PHI and obtained assurances that the CE implemented the corrective actions noted above.
06/20/2017	It was identified that in some instances related to two Aetna web services used to display plan-related documents to enrollees and other intended recipients, login credentials were not required to access the URL. As a result, automated processes used by certain Internet search engines (e.g., Google) were able to catalog the unique URLs, making them searchable on the Internet. While the cataloged information varied by document, the information generally included enrollee name, Aetna enrollee identification number, provider information, claim payment amount, and in some cases procedure/service code and dates of service. There are no instances of Social Security numbers, bank account or credit card information being involved. Aetna is not aware of any evidence that indicates misuse of the information available through the URLs.	After identifying the root cause of this issue, Aetna immediately took action to restrict external access to documents rendered through the impacted web services. On April 27, 2017, less than two hours after first being made aware of this issue, Aetna blocked external access to the two impacted web services by shutting down each respective web service on Aetna's external web servers. In addition, on April 28, 2017, Aetna installed an updated robots.txt file on all servers running the impacted services, which prevented search engines from cataloguing documents rendered using those services. With those immediate tactical fixes in place, Aetna identified a strategic set of changes to provide enhanced security over the long term. On April 29, 2017, Aetna implemented a blocking rule (iRule) via the load balancers that handle inbound Aetna web traffic (F5 LTM) to restrict external access to all documents rendered by the two impacted services that contained PHI and other types of confidential or restricted data.
08/29/2017	On July 31, 2017, Aetna became aware that a letter sent to enrollees regarding a litigation settlement had been mailed in an envelope with a large window, in some cases causing sensitive information to be revealed.	Aetna has undertaken remedial steps and is in the process of modifying its standard operating procedures to address unintended disclosures of PHI in our print and mail operations.
10/13/2017	An individual broke into a CVS Pharmacy in Riverview, Florida, during Hurricane Irma and stole completed prescriptions intended for 836 individuals. The type of PHI stolen included patients' first and last names, dates of birth, addresses, medication names, and provider names.	CVS assessed the damage and secured the store to prevent any other unauthorized access. OCR reviewed CVS policies and procedures on uses and disclosure of PHI and safeguarding PHI and obtained assurances that CVS provided breach notification to affected individuals and the media in accordance with the Breach Notification Rule.

Discovery Date	Description	Response
10/23/2017	On August 30, 2017, Aetna became aware that a cybersecurity professional had discovered that Real Time Health Quotes LLC (RTHQ), an insurance producer appointed by Aetna in Florida, was utilizing an unsecured Amazon S3 'bucket' which potentially contained Aetna information. Based upon Aetna's investigation, it appears that RTHQ utilized the bucket to maintain various insurance applications and other related documentation, a small portion of which related to Aetna enrollees and applicants. Aetna also learned that the bucket was configured with improper permissions, which may have allowed the documents to be accessible online.	Aetna understands that RTHQ promptly secured the bucket upon outreach from Aetna and has since removed all information from the bucket. On its breach notification report, in response to "Safeguards in Place Prior to Breach," Aetna responded with respect to its own safeguards. Unfortunately, RTHQ did not provided Aetna with information about its own safeguards sufficient for Aetna to answer this question with respect to RTHQ.
11/08/2017	On Monday, September 25, 2017, Aetna mailed a letter to enrollees selected to participate in an FDA Sentinel research study, which is intended to improve anti-coagulant medication usage among individuals who have a diagnosis of atrial fibrillation (AFib). As part of the study, enrollees were sent educational materials intended to improve their medication adherence. The logo/name of the study ("IMPACT-AFib") was printed on the outside of the envelope used for the mailing. No information about the enrollee other than his or her name and address was included on the envelope.	The root cause of this breach was human error. This incident was caused when an Aetna employee responsible for overseeing the study, acting in good faith, believed the logo would show a collaborative effort between the Sentinel research study and Aetna. Aetna employs several safeguards to prevent breaches from occurring, including mandatory HIPAA training and administrative, physical and technical safeguards. In addition, Aetna has undertaken remedial steps and is in the process of modifying its standard operating procedures to address unintended disclosures of PHI in our print and mail operations.
01/30/2019	On December 11, 2018, Centerstone Insurance and Financial Services, Inc. d/b/a BenefitMall (BenefitMall), a general agent who also acts as a third-party vendor that Aetna utilizes to provide administrative services related to employee benefits, notified Aetna that phishing attacks, which occurred between approximately June 2018 and October 2018, had compromised certain BenefitMall employee email accounts containing Aetna enrollee information.	BenefitMall informed Aetna that it retained a cybersecurity forensics firm to assist in a thorough investigation of the incident and that it has implemented additional security measures designed to protect employee email accounts, including two-factor authentication for access to its email system. Additionally, BenefitMall informed Aetna that it reported the incident to law enforcement.
1/30/2019	A third-party vendor who provides storage to the CVS Pharmacy located at 5701 Kipling Street in Wheat Ridge, Colorado had a storage container vandalized. Unknown person(s) broke in a locked storage container and stole records, including paper copies of the prescriptions dispensed by this pharmacy location between 2016 and 2018.	CVS provided OCR with assurances that individuals affected by this breach were notified in accordance with the Breach Notification Rule. With each case, CVS Health applies consistent privacy and security policies and procedures, and investigates the incidents immediately, following the federal and state notification requirements. We then take the necessary steps to mitigate any harm and implement corrective action, including sanctioning employees or subcontractors. An Incident Response Procedure is in place with documented roles, responsibilities and contact information. We notify clients within the agreed upon response time in the established business associate agreement.

PHI breaches during the last five years and the responses to those breaches reported by our unaffiliated subcontractors are provided in **Table B.2-8**.

Table B.2-8: PHI Breaches Reported by Unaffiliated Subcontractors

Entity Name	Breach Description	Response
Avēsis	Avēsis' information security infrastructure is overseen by their parent company, Guardian. Over the last five years, Avēsis has had one privacy breach affecting 500 or more enrollees. In January 2019, Avēsis became aware of a privacy breach related to eligibility file errors which resulted in utilization review decision letters being sent to the wrong enrollee. This breach affected 650 Medicaid enrollees in the Commonwealth of Kentucky, eight of whom were Aetna Better Health enrollees.	Avēsis used their standard breach protocol to conduct a root cause analysis that identified a code change associated with the 834-file created waterfall logic resulting in enrollee mailing addresses being cascaded to other enrollee records. To mitigate the issue: • The bad code was replaced with the correct code and logic. • Eligibility filed were reloaded and tested to ensure records were loaded correctly. Avēsis collaborated with their health plan clients, the Business Associate under HIPAA definitions, to notify enrollees of the breach and its potential impact on the privacy of their PHI and PII. To further rectify the problem, Avēsis made systemic changes to the eligibility/EDI file change process.
Cotiviti	Unauthorized Access/Disclosure affecting 138 individuals in April 2017. This event involved a UPS package that was lost in transit.	Cotiviti conducted extensive efforts to locate the package and included both working with UPS' Privacy Office and with the initially identified signatory recipient of the package (subsequently confirmed the recipient had not accepted delivery), as well as working with Anthem's Privacy Office. In order to mitigate the risk of similar incidents, Cotiviti discontinued using UPS for sending packages to this address and resumed using USPS for sending packages.
Equian, LLC	An Equian Business Associate Subcontractor, Wolverine Solutions Group (WSG), did have an incident in late 2018 involving PHI.	Equian concluded through its internal assessment of this incident that it was not a breach, but the information is provided for transparency. Equian terminated its relationship with WSG and revised its policies and procedures for vendor oversight.
Inovalon	Inovalon has experienced one privacy breach involving enrollee information. In this instance, one of Inovalon's third-party vendors breached PHI comprising less than 500 records. This incident was caused by human error and fully remediated.	The subject vendor was audited to verify compliance with regulatory and contractual requirements, refresher training occurred, and the responsible employee was appropriately disciplined. Additionally, the Company is no longer using this vendor for services.
Office Ally	ERAs delivered to incorrect provider	Training was provided to senior representatives that when working with ERA Transfer letters, they are to open a new ERA Management Tool (in a new tab) to ensure there is no older provider/username information left over to prevent any other accidental linkage.
Office Ally	Incorrect parsing claim information caused incorrect information to appear on incorrect patient's claims	Added additional requirements during testing and code reviews; increased volume of testing processes to better mimic production environment.
Office Ally	ERAs were delivered to incorrect providers	The ERA linking process was updated to eliminated using previous IDs for another linking request. The unintended ERAs were deleted from the provider's account.

60.7.B.2.f Accreditation Status[43]

Aetna Better Health of Kentucky achieved National Committee for Quality Assurance (NCQA) accreditation in 2014. The health plan earned **Commendable** status in 2018 and has maintained that level. A Commendable ranking is awarded to organizations with well-established programs that meet rigorous requirements for consumer protection and quality improvement. **Aetna Better Health of Kentucky is a top scorer for Medicaid managed care organizations in the Commonwealth.**

Nationally, the Aetna Medicaid organization is NCQA Health Plan-accredited in 13 states, achieving Commendable accreditation status in 4 states, including Kentucky.

Aetna Better Health of Kentucky has never had its accreditation status adjusted down, suspended, or revoked. No Aetna Better Health of Kentucky Parent Company or subsidiary of any Aetna Better Health of Kentucky Parent Company has had its NCQA Health Plan Accreditation, for any product line, suspended or revoked in the last five years.

Some subsidiaries of Aetna Inc., one of Aetna Better Health of Kentucky's parent companies, have had their accreditation statuses adjusted in the past five years, and this information is presented in **Table B.2-9.** No legacy subsidiary of CVS Health, as it existed before it acquired Aetna Inc. in November 2018, has had its accreditation adjusted down, suspended, or revoked.

Table B.2-9: NCQA Accreditation Adjustments by Product Line and State

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
Medicaid					
Texas	Aetna Better Health of Texas	Commendable	05/30/2020	Adjusted up from Accredited to Commendable (2019)	Submission of Healthcare Effectiveness and Data Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results
Louisiana	Aetna Better Health, Inc. dba Aetna Better Health of Louisiana	Accredited	07/25/2021	Adjusted down from Commendable to Accredited (2018)	Change in HEDIS and CAHPS results

[43] On January 23, 2020, CVS Health Corporation (CVS Health) acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare), which is now Aetna Better Health of Kentucky's affiliate and a subsidiary of our ultimate parent, CVS Health. The following narrative and tables provided in response to this question include information for Aetna Better Health of Kentucky, its parent companies, and their legacy subsidiaries as they existed before CVS Health's acquisition of IlliniCare. IlliniCare's disclosures in response to this question are located in **Attachment CC.**

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
Michigan	Aetna Better Health of Michigan Inc.	Accredited	09/11/2021	Adjusted down from Commendable to Accredited (2015)	Change in HEDIS and CAHPS results
Pennsylvania	Aetna Better Health Inc. dba Aetna Better Health of Pennsylvania	Accredited	12/27/2020	Adjusted down from Commendable to Accredited (2018)	Change in HEDIS and CAHPS results
Virginia	Coventry Health Care of Virginia, Inc. dba Aetna Better Health of Virginia	Accredited	04/20/2021	Adjusted down from Commendable to Accredited (2015)	Change in HEDIS and CAHPS results
Medicare					
Arizona/ Nevada	Aetna Health, Inc. (Pennsylvania)	Commendable	03/16/2020	Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2016)	Change in HEDIS results
California	Aetna Health of California, Inc.	Accredited	03/16/2020	Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2017) Adjusted down from Commendable to Accredited (2019)	Change in HEDIS results
Carolinas	Aetna Health, Inc. (Pennsylvania)	Commendable	08/10/2021	Adjusted down from Excellent to Commendable (2015)	Change in HEDIS results
Colorado	Aetna Health, Inc. (Pennsylvania)	Commendable	03/16/2020	Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2016)	Change in HEDIS results
Connecticut	Aetna Health, Inc. (Connecticut)	Commendable	08/10/2021	Adjusted down from Excellent to Commendable (2014)	Change in HEDIS results

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
Delaware	Aetna Health, Inc. (Pennsylvania)	Commendable	08/10/2021	Adjusted down from Excellent to Commendable (2013) Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2016)	Change in HEDIS results
Florida	Aetna Health, Inc. (Florida)	Accredited	08/10/2021	Adjusted down from Excellent to Commendable (2013) Adjusted up from Commendable to Excellent (2014) Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2017) Adjusted down from Commendable to Accredited (2018)	Change in HEDIS results
Georgia Medicare PPO	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted down from Excellent to Commendable (2015)	Change in HEDIS results
Georgia Medicare HMO	Aetna Health, Inc. (Georgia)	Accredited	08/10/2021	Adjusted down from Commendable to Accredited (2019)	Change in HEDIS results
Illinois/Indiana	Aetna Health, Inc. (Pennsylvania)	Commendable	03/16/2020	Adjusted up from Accredited to Commendable (2016)	Change in HEDIS results
Iowa	Aetna Health, Inc. (Florida)	Commendable	04/28/2020	Adjusted down from Commendable to Accredited (2018) Adjusted up from Accredited to Commendable (2019)	Change in HEDIS results

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
Maine	Aetna Health, Inc. (Maine)	Excellent	08/10/2021	Adjusted down from Excellent to Commendable (2015) Adjusted up from Commendable to Excellent (2016) Adjusted down from Excellent to Commendable (2017) Adjusted up from Commendable to Excellent (2018)	Change in HEDIS results
Massachusetts	Aetna Health, Inc. (Pennsylvania)	Commendable	08/10/2021	Adjusted down from Excellent to Commendable (2015)	Change in HEDIS results
Missouri/ Kansas	Aetna Health, Inc. (Pennsylvania)	Commendable	03/16/2020	Adjusted down from Excellent to Commendable (2015)	Change in HEDIS results
New York	Aetna Health, Inc. (New York)	Accredited	08/10/2021	Adjusted down from Commendable to Accredited (2019)	Change in HEDIS results
Ohio/ Kentucky	Aetna Health, Inc. (Pennsylvania)	Commendable	03/16/2020	Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2016)	Change in HEDIS results
Oklahoma	Aetna Health, Inc. (Pennsylvania)	Commendable	03/16/2020	Adjusted up from Accredited to Commendable (2016)	Change in HEDIS results
Pennsylvania	Aetna Health, Inc. (Pennsylvania)	Commendable	08/10/2021	Adjusted down from Excellent to Commendable (2015)	Change in HEDIS results
Tennessee	Aetna Health, Inc. (Pennsylvania)	Commendable	08/10/2021	Adjusted up from Accredited to Commendable (2015)	Change in HEDIS results
Texas Medicare HMO	Aetna Health, Inc. (Texas)	Commendable	03/16/2020	Adjusted up from Accredited to Commendable (2019)	Change in HEDIS results
Texas Medicare PPO	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted down from Excellent to Commendable (2013)	Change in HEDIS results
Commercial					
California	Aetna Life Insurance Company	Accredited	12/13/2022	Adjusted down from Commendable to Accredited (2018)	Change in HEDIS results

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
Colorado	Aetna Life Insurance Company	Accredited	12/13/2022	Adjusted down from Commendable to Accredited (2015)	Change in HEDIS results
Connecticut	Aetna Health, Inc. (Connecticut)	Accredited	08/10/2021	Adjusted down from Commendable to Accredited (2017)	Change in HEDIS results
Delaware	Aetna Health, Inc. (Pennsylvania)	Accredited	08/10/2021	Adjusted up from Accredited to Commendable (2018) Adjusted down from Commendable to Accredited (2019)	Change in HEDIS results
Florida Commercial HMO/POS	Aetna Health, Inc. (Florida)	Accredited	08/10/2021	Adjusted down from Commendable to Accredited (2014)	Change in HEDIS results
Florida Commercial PPO	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted down from Commendable to Accredited (2016) Adjusted up from Accredited to Commendable (2018)	Change in HEDIS results
Georgia Commercial HMO/POS	Aetna Health, Inc. (Georgia)	Commendable	08/10/2021	Adjusted down from Commendable to Accredited (2016) Adjusted up from Accredited to Commendable (2017)	Change in HEDIS results
Georgia Commercial PPO	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted down from Commendable to Accredited (2016) Adjusted up from Accredited to Commendable (2017)	Change in HEDIS results
Kansas	Coventry Health Care of Kansas, Inc.	Accredited	05/31/2019	Adjusted down from Commendable to Accredited (2015)	Change in HEDIS results
Illinois	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted up from Accredited to Commendable (2017)	Change in HEDIS results
Iowa	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted up from Accredited to Commendable (2019)	Change in HEDIS results
Maine	Aetna Health, Inc. (Maine)	Accredited	08/10/2021	Adjusted down from Commendable to Accredited (2016)	Change in HEDIS results

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
Massachusetts Commercial HMO/POS	Aetna Health, Inc. (Pennsylvania)	Accredited	08/10/2021	Adjusted down from Excellent to Commendable (2013) Adjusted down from Commendable to Accredited (2015)	Change in HEDIS results
Massachusetts Commercial PPO	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted up from Accredited to Commendable (2017)	Change in HEDIS results
Maryland/ Washington D.C./ Virginia	Aetna Health, Inc. (Pennsylvania)	Commendable	08/10/2021	Adjusted down from Commendable to Accredited (2014) Adjusted up from Accredited to Commendable (2015) Adjusted down from Commendable to Accredited (2016) Adjusted up from Accredited to Commendable (2017)	Change in HEDIS results
Minnesota	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted up from Accredited to Commendable (2019)	Change in HEDIS results
Missouri/ Kansas	Aetna Health, Inc. (Pennsylvania)	Commendable	03/16/2020	Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2017) Adjusted down from Commendable to Accredited (2018) Adjusted up from Accredited to Commendable (2019)	Change in HEDIS results
Nebraska	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted up from Accredited to Commendable (2018)	Change in HEDIS results
New Jersey Commercial HMO/POS	Aetna Health, Inc. (New Jersey)	Commendable	08/10/2021	Adjusted down from Excellent to Commendable (2013) Adjusted down from Commendable to Accredited (2014) Adjusted up from Accredited to Commendable (2015)	Change in HEDIS results

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
New Jersey Commercial PPO	Aetna Life Insurance Company	Accredited	12/13/2022	Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2017) Adjusted down from Commendable to Accredited (2018)	Change in HEDIS results
New York Commercial HMO/POS	Aetna Health, Inc. (New York)	Accredited	12/13/2022	Adjusted down from Commendable to Accredited (2016)	Change in HEDIS results
New York Commercial PPO	Aetna Life Insurance Company	Commendable	12/13/2019	Adjusted down from Commendable to Accredited (2014) Adjusted up from Accredited to Commendable (2015) Adjusted down from Commendable to Accredited (2016) Adjusted up from Accredited to Commendable (2017) Adjusted down from Commendable to Accredited (2018) Adjusted up from Accredited to Commendable (2019)	Change in HEDIS results
North Carolina	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted up from Accredited to Commendable (2018)	Change in HEDIS results
Ohio Commercial PPO	Aetna Life Insurance Company	Accredited	12/13/2022	Adjusted down from Commendable to Accredited (2014) Adjusted up from Accredited to Commendable (2017) Adjusted down from Commendable to Accredited (2018)	Change in HEDIS results
Oklahoma Commercial HMO/POS	Aetna Health, Inc. (Pennsylvania)	Accredited	03/16/2020	Adjusted down from Commendable to Accredited (2014)	Change in HEDIS results
Pennsylvania Commercial HMO	Aetna Health, Inc. (Pennsylvania)	Commendable	08/10/2021	Adjusted up from Accredited to Commendable (2017)	Change in HEDIS results

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
Pennsylvania Commercial PPO/EPO	Aetna Life Insurance Company	Commendable	12/13/2022	Adjusted down from Commendable to Accredited (2016) Adjusted up from Accredited to Commendable (2017)	Change in HEDIS results
Pennsylvania Commercial PPO	Aetna HealthAssurance of Pennsylvania, Inc.	Commendable	08/14/2020	Adjusted up from Accredited to Commendable (2019)	Change in HEDIS results
Tennessee Commercial HMO/POS	Aetna Health, Inc. (Pennsylvania)	Accredited	08/10/2021	Adjusted down from Commendable to Accredited (2016)	Change in HEDIS results
Tennessee Commercial PPO	Aetna Life Insurance Company	Accredited	12/13/2022	Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2018) Adjusted down from Commendable to Accredited (2019)	Change in HEDIS results
Texas Commercial HMO/POS	Aetna Health, Inc. (Texas)	Commendable	03/16/2020	Adjusted down from Commendable to Accredited (2014) Adjusted up from Accredited to Commendable (2015) Adjusted down from Commendable to Accredited (2016) Adjusted up from Accredited to Commendable (2017) Adjusted down from Commendable to Accredited (2018) Adjusted up from Accredited to Commendable (2019)	Change in HEDIS results
Texas Commercial PPO	Aetna Life Insurance Company	Accredited	12/13/2022	Adjusted down from Commendable to Accredited (2016) Adjusted up from Accredited to Commendable (2017) Adjusted down from Commendable to Accredited (2018)	Change in HEDIS results

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
Utah	Aetna Health of Utah, Inc.	Commendable	08/16/2020	Adjusted up from Accredited to Commendable (2018)	Change in HEDIS results
Virginia	Aetna Life Insurance Company	Accredited	12/13/2022	Adjusted down from Commendable to Accredited (2015) Adjusted up from Accredited to Commendable (2017) Adjusted down from Commendable to Accredited (2018)	Change in HEDIS results

60.7.B.2.g Contract Terminations[44]

Aetna Better Health of Kentucky is proud that we have no contract terminations to report pertaining to our health plan. Aetna Better Health of Kentucky has never voluntarily terminated all or part of a Medicaid managed care contract under which it provided health care services as the licensed entity; had such a contract partially or fully terminated before the contract end date (with or without cause); had such a contract not renewed; or withdrawn from a contracted service area or had a reduction of enrollment levels imposed in connection with such a contract.

In the past 10 years, the following outcomes apply for affiliates of Aetna Better Health of Kentucky, under which they provided health care services as the licensed entity:

- Have not had a Medicaid managed care contract partially or fully terminated before the contract end date for cause
- Have not had any such contracts not renewed for cause
- Have not had a reduction of enrollment levels imposed in connection with any such contract

While we make every attempt to maintain contracts and service levels, in limited circumstances, it becomes necessary to make changes to these contracts. **Table B.2-10** discloses instances where, in the past 10 years, affiliates of Aetna Better Health of Kentucky have voluntarily terminated all or part of a Medicaid managed care contract under which they provided health care services as the licensed entity, have had such a contract partially or fully terminated before the contract end date or not renewed for reasons unrelated to poor or non-performance, or have withdrawn from a contracted service area in connection with such a contract.

[44] On January 23, 2020, CVS Health Corporation (CVS Health) acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare), which is now Aetna Better Health of Kentucky's affiliate and a subsidiary of our ultimate parent, CVS Health. The following narrative and tables provided in response to this question include the requested information for Aetna Better Health of Kentucky, its parent companies, and their legacy subsidiaries as they existed before CVS Health's acquisition of IlliniCare. IlliniCare's disclosures in response to this question are located in **Attachment CC.**

Table B.2-10: Medicaid Managed Care Contract Terminations and Non-renewals Without Cause and Withdrawals Relating to Affiliates of Aetna Better Health of Kentucky:

Health Plan Name	Date of Action	Reason
Coventry Health Care of Delaware, Inc.	10/2013	Coventry Health Care of Delaware, Inc. had a Medicaid contract with the Maryland Medicaid agency to participate in the state's managed Medicaid program. This contract was terminated by Aetna after Aetna Inc. acquired Coventry Health Care, Inc., to avoid any conflict of interest that would result from Aetna operating the Maryland managed Medicaid business of the newly acquired (Coventry Health Care of Delaware, Inc.) plan, while also continuing to provide administrative services to a nonaffiliated plan administered by Aetna in Maryland.
Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois	12/2017	After the 2017 re-procurement of the State of Illinois' Medicaid program, the Illinois Department of Healthcare and Family Services partially terminated (other than runout) this contract known as the Family Health Plan/Affordable Care Act (FHP-ACA) contract, with all incumbent managed care organizations (MCOs) before the scheduled end date to accommodate the start date of the newly awarded contracts to successful bidders. The contract was in runout through 12/31/19.
Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois	12/2017	After the 2017 re-procurement of the State of Illinois' Medicaid program, the Illinois Department of Healthcare and Family Services partially terminated (other than runout) this contract, known as the Integrated Care Program (ICP) contract, with all incumbent MCOs before the scheduled end date to accommodate the start date of the newly awarded contracts to successful bidders. The contract was in runout through 12/31/19.
Aetna Better Health Inc. d/b/a Aetna Better Health of Illinois	12/2017	After the 2017 re-procurement of the State of Illinois' Medicaid program, the Illinois Department of Healthcare and Family Services partially terminated (other than runout) this contract known as the Managed Long Term Supports and Services (MLTSS) contract, with all incumbent MCOs before the scheduled end date to accommodate the start date of the newly awarded contracts to successful bidders. The contract was in runout through 12/31/19.
Aetna Health of Iowa Inc. dba Coventry Health Care of Iowa, Inc.	12/2015	Coventry Health Care of Iowa, Inc. had a memorandum of understanding (MOU) with the Iowa Department of Human Services, Iowa Medicaid Enterprise (IME) for participation in the Iowa Marketplace Choice Plan. The MOU did not have an end date. The IME terminated the MOU effective January 1, 2016 because the population rolled into the State's new managed care program.
Aetna Better Health of Missouri LLC	04/2017	The contract, as amended, had an additional one-year renewal period that the State could have exercised but did not because, instead, it rebid its Medicaid program and entered into new contracts with successful bidders.
Aetna Better Health of Nevada Inc. dba Aetna Better Health of Nevada	08/2017	Due to the extremely low redistribution of less than 2,000 enrollees, far less than the critical number of enrollees needed to ensure a viable Medicaid plan capable of delivering quality care and competitive programs, Aetna Better Health of Nevada Inc. gave notice to terminate the contract in accordance with the contract terms. To minimize enrollee disruption that would result from continuing to enroll new enrollees and then transitioning them to new health plans after the notice period ended, the State opted to waive the full, contractually required 180-day notice period. Aetna agreed to the State's timeline and assisted the State in transitioning enrollees to new health plans.
Aetna Better Health Inc. dba Aetna Better Health of New York	12/2017	The Fully Integrated Duals Advantage program faced enrollment challenges since its inception because it is not mandatory and most eligible people who were initially enrolled automatically in the program chose to opt out. Because our enrollment never exceeded 70 enrollees, the plan made the business decision to exit the program. In accordance with the notice requirements of the contract, we gave notice of our intent to terminate the contract in June 2017 but continued to serve enrollees under the contract until December 31, 2017.

Health Plan Name	Date of Action	Reason
Southern Health Services, Inc. (CareNet)	09/2010	Before Aetna Inc.'s acquisition of Coventry Health Care, Inc. in 2013, Southern Health Services, Inc. (CareNet), which was a subsidiary of Coventry Health Care, Inc., contracted with the Virginia Department of Medical Assistance Services for services in connection with the Virginia Medical Assistance Program. Effective September 1, 2010, CareNet withdrew from 11 out of 45 localities because rates were not sustainable given the experience of the population in those regions.
Coventry Health Care of West Virginia, Inc. dba Aetna Better Health of West Virginia	06/2016	The State of West Virginia re-procured its managed Medicaid contracts in 2016 and, pursuant to that procurement process, entered into a new contract with Aetna for state fiscal year 2017 (i.e., July 1, 2016 through June 30, 2017), even though the prior fiscal year's contract still had unused renewal options. There was no gap in Aetna's coverage/service as a Medicaid MCO in West Virginia.

60.7.B.3 Staffing

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60.7.B.3 Staffing

Building and fostering relationships—the kind necessary to make a lasting difference—requires talent, time, and commitment, as exemplified by Aetna's[1] approximately 250 Medicaid health plan staff members living and working in Kentucky communities. **We[2] have proudly served the Kentucky Medicaid Program and Kentucky Children's Health Insurance Program since the inception of the managed care program in 2011.** For nine years, we have provided whole-person integrated care in support of improved health outcomes to Medicaid enrollees. Hailing from every corner of the Commonwealth, our dedicated staff of Kentuckians is looking forward to continuing to serve enrollees under the Kentucky Medicaid program.

In keeping with our core values of integrity, caring, excellence, and inspiration, Aetna staff care for, empathize with, listen to, plan for, and educate enrollees, knowing that together we reach common understanding and shared goals. We place every enrollee at the center of all we do, anticipating their needs while valuing regional differences and understanding the dynamics of cultural variations. We join our enrollees on their health journeys, working together to achieve their individual health ambitions based on their unique needs and desires.

A Loyal Partner Providing Support During Critical Times

We demonstrated our commitment and devotion to fellow Kentuckians and the power of collaboration with the Department and other Commonwealth agencies at a critical time in July 2013. On July 6—Saturday of the Fourth of July holiday weekend—our health plan (operating then as Coventry Health and Life Insurance Company) welcomed 68,000 new enrollees when one of three Medicaid managed care organizations in the Commonwealth, Kentucky Spirit (Centene), abruptly ceased operations. Through diligent planning, expert execution, and unmatched passion by our experienced staff, we provided a smooth transition for our new enrollees and providers, while continuing to provide the best service for our existing enrollees.

Our staff spent long hours addressing the needs of our new enrollees, including processing enrollment and identification cards, conducting enrollee and provider calls, honoring existing prior authorization, managing new requests, and more. To this day, our health plan takes great pride in how we stepped up for our new enrollees and providers and collaborated with the Department to manage this rapid development and seize an opportunity for everyone involved. The outcomes of this transition proved that we will stop at nothing to serve and support our fellow Kentuckians.

a. Approach to Staffing

Our staffing plan is a continuous, integrated, and scalable model. It is built on the principle of **Kentuckians serving Kentuckians**, managed by local health plan leaders to ensure quality staffing for a growing enrollment or any new contract requirements. Our experienced personnel—many of whom have a personal investment in the program long-term—support the statewide **mission of achieving a healthier Kentucky** by providing support services for traditional benefits and services to address social determinants of health (SDOH). We have a clearly defined staffing model designed to fulfill all contract requirements and adjust to the Department's changing needs.

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its parents, Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Kentucky to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of Kentucky's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Kentucky. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

[2] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

The cornerstone of our staffing plan is highly experienced leadership with extensive local, program-specific knowledge. With more than 16 years of health care and public policy experience, the last three of which were spent leading Aetna Better Health of Kentucky, Chief Executive Officer (CEO) Jonathan Copley (a proud fifth-generation Kentuckian) plays a key role in identifying, hiring, and retaining key staff. He is supported by Aetna's highly experienced, qualified, talented leadership team and our Implementation Talent Acquisition team. To support any growth resulting from this contract, we are committed to attracting additional professional staff with significant managed care experience with Medicaid populations. When a new position is created or a position becomes open for hire, Mr. Copley and his leadership team seek local candidates who are experienced and familiar with the local Medicaid health care delivery system and culture in the Commonwealth and have all the Kentucky licensures and certifications required by law and the Draft Medicaid Managed Care Contract and Appendices.

Our current staffing plan assumes providing services for approximately 211,000 enrollees. Under this scenario, we expect to augment our present staffing levels with the hiring of community health workers and System of Care (SOC) staff as detailed in the following section. We anticipate having more than 250 staff members in Kentucky supporting the Medicaid program, with additional hiring for the Kentucky SKY program as detailed in **Section 60.7.G.2.c** of our proposal. As part of the Aetna Medicaid organization, we are able to draw upon national resources on the rare occasion where a critical need abruptly emerges.

> Aetna Better Health of Kentucky is a loyal and invested Kentucky company and recognizes the impact we have in the daily lives of both our staff, enrollees, and other Kentucky citizens. This is a primary reason why we have implemented a minimum wage of $16 per hour, compared with the standard Kentucky minimum wage of $7.25 per hour.

Based on our years of experience across 16 states, Aetna's Medicaid organization continuously reevaluates and revises staffing levels to ensure consistent delivery of services. We have the flexibility to hire and train additional staff, refine processes, provide backup resources, and institute other changes to meet the Commonwealth's requirements. We base our staffing analysis on our proprietary Aetna Medicaid organization standard operating model, which projects staff needed by proven ratios or other metrics appropriate to each position type. Our model captures level of care, category of covered services, category of aid, unique contractual requirements, enrollment levels, use of subcontractors, and other components. While our more than 30 years of experience operating Medicaid plans across the nation drives our staffing model, we also use evidence-based guidelines built on time studies and complexity of care. We will augment staffing in our Louisville office and in each region as necessary so that we can meet all needs of enrollees, providers, and the Commonwealth.

Appropriate staffing ratios are essential to a balanced and successful care management program. The staffing ratio tool we use to develop caseloads is based on workload studies that consider time elements, such as how long it takes to schedule and complete an assessment, call an enrollee, or drive to an enrollee's home, as well as time for case rounds with the medical director, community-based service collaboration, interdisciplinary care team meetings, personal development enrichment, training, supervision, and documentation. When we approach the caseload maximum thresholds, our leadership team conducts a staffing review. Based on the results of this review, we submit a requisition to hire additional care managers or reallocate resources, without exceeding the maximum ratios, in a manner that enables us to provide enrollees the services they need.

a.i. Organizational Structure: Supporting Innovative Solutions and Stakeholder Groups

Aetna recognizes that technology alone does not create innovation; the innovation we seek is a broad behavior change in providers, enrollees, and the delivery system at large. This is driven by people on the ground dedicated to achieving the Commonwealth's goal of **improving participants' health and helping them to be responsible for their health. In 2020, we plan to utilize community health**

workers for deeper reach into communities across the Commonwealth, providing enhanced support services and increased access to care for our enrollees.

We designed our organizational structure to provide the framework for our Kentucky staff to implement innovative solutions to empower our enrollees on their health journeys, as demonstrated in **Table B.3-1.**

Table B.3-1: Examples of Innovative Solutions Resulting in Strong Outcomes

Programmatic Goal	Solution	Key Actions	Outcome
Engage Vulnerable Populations	Established Aetna's Start Strong Program, which is a partnership with the Kenton County Detention Center (KCDC) aimed at improving recidivism rates and health outcomes for our members who are released from the jail.	Aetna's care management coordinator is embedded onsite, allowing for the following: • Face-to-face visits with enrollees to build rapport • Completion of a health risk assessment • Development of individualized release plans • Collaboration with KCDC staff regarding resources and enrollee medical and social determinants of health needs • Day-of-release meeting with enrollee to ensure they are supported as they start their aftercare plan	We ensure enrollees are able to access their health care and are provided with support in following their release plan. The program has achieved the following outcomes: • 500-plus individuals have received a presentation on Start Strong while at KCDC • CMC has worked with 77 enrollees • 91% success rate of Start Strong enrollees
Improve the Transition from Physical Health Inpatient Admission to Home and Reduce the Potential of Readmissions	Engage Bluegrass Care Navigators, utilizing its Transition Program	• Identify members • Enroll members in the program • Bluegrass Care Navigators to conduct weekly at-home visits up to six weeks post-discharge	• Experienced a reduction of readmissions within the facilities where Bluegrass Care Navigators are embedded • Reduced readmission rates in those facilities from 12.8% initial to 10.7% (based on Aetna claims data and Bluegrass Care Navigators data)

Programmatic Goal	Solution	Key Actions	Outcome
Ensure Providers Feel Valued by Aetna	• Creation of the Aetna Provider Partnership Advisory Council, which enables practice managers to provide feedback about our processes to aid in identifying opportunities to reduce administrative burdens on our providers • Created a dashboard, visualization tools, and better education resources • Engagement with Provider Engagement team	• Engage with providers in the field or their offices so provider has platform to gain insight and knowledge of Aetna and to work directly with us for any outstanding concerns • Yearly roundtables conducted in each region • Quarterly claims workshops conducted in each region	• Council provides opportunity for a shared focus on collaboration by identifying shared challenges and shared opportunities • Dashboard enables providers to better see trends and allow for more timely processing of claims • Team is able to share better information with providers during operations meetings

To drive a culture of innovation and collaboration, our staff members participate in cross-functional teams aimed at improving performance across every area of the organization. We communicate initiatives through CEO all-staff town hall meetings, email notifications, staff website articles, web-based learning modules, and demonstrations. Examples of ways that our organizational structure supports innovative solutions and stakeholder groups include our community-based provider services representatives (PSRs), cross-functional Service Improvement Committee, integrated care coordination, our system of care model, our robust Quality Management and Population Health staff, and inclusion of SDOH staff.

Provider Engagement

Our PSRs are based in the communities they serve, fostering a higher level of responsiveness and personalized relationships. These locally based PSRs engage with providers through a variety of mechanisms designed to provide proactive, prompt, and collaborative communications. Our PSR engagement activities include new provider orientation, training webinars, provider forums, operational meetings, regular site visits, and other face-to-face meetings. We have also established several provider meetings, participate in provider association meetings, and actively collaborate with our provider partners to identify improvement opportunities, reduce administrative burden, and provide education and training.

An example of our knowledge of the local health care market includes our work to identify provider areas of concern, striving to resolve them as expediently as possible. **We have seen a steady decline in outstanding issues on the Kentucky Hospital Association's MCO issues log, culminating in the resolution of all outstanding issues for 10 consecutive months.** We achieved this clean record by developing an internal process for escalation that begins with our network managers who are aware of any pain points experienced by our providers. The network managers escalate these areas of concern to a health plan work group that meets regularly to triage and find solutions for provider concerns.

Cross-functional Service Improvement Committee

In Kentucky, Aetna drives innovation through the Service Improvement Committee, which is a cross-functional team represented by each department in the plan. The committee was developed as a repository to review all service impacts related to satisfaction for both providers and enrollees. Items reviewed in this committee by plan expertise include satisfaction survey results, appeals and grievance trends, and activity related to reducing administrative burden. Our Chief Operations Officer (COO) Paige Mankovich chairs the committee, which has representation from both the Operations and Clinical departments. Members of this committee include plan leadership as well as provider and enrollee front-line staff.

Through the committee's work, action plans are created and then carried out by appropriate departments. Consistent follow-up has been the key to this committee's success and impact on our provider and enrollee satisfaction improvements. An example of an issue brought to the committee in late 2017 involved enrollees voicing concerns over not having adult eyewear as a covered benefit. Our committee discussed the concern and recommended outreach to our vision subcontractor to discuss a proposal for providing this benefit. In January 2019, we updated our benefits to provide this service.

Quality Management Staff

Aetna is a quality leader with a **Commendable rating** from the National Committee for Quality Assurance and an overall rating of 3.5 for 2018-19, representing a **top score** in the Commonwealth for Medicaid managed care organizations. **The Quality Management team is comprised 100 percent of local Kentucky staff,** led by Quality Improvement Director Donna Hall, who has been with the plan since March 2012. The chief medical officer and plan Quality Management team are supported by the Aetna Medicaid organization's national Quality Management team. Their collection of accurate, timely, and complete quality management data and results of clinical performance measures is pivotal to developing successful interventions to improve health outcomes and quality of care.

Field-based Quality Management staff: Aetna's Quality staff participates in activities embedded within the community, advocacy groups, and provider partner Joint Operating Committees to further influence collaboration. Our team includes a Healthcare Effectiveness Data and Information Set (HEDIS®) department and a Quality Improvement department. Two members of the HEDIS team are field-based and live in the communities of our enrollees and provider partners. Our Quality Improvement team focuses not only on the quality of care for enrollees, but the delivery of care with efforts central around National Committee for Quality Assurance (NCQA), Commonwealth health priorities, and evidence-based practices. This team is inclusive of Population Health Management and Prevention and Wellness team members who are active participants within our community and provider partners, with a strategy focusing on health equity and SDOH. All team members contribute their expertise and passion in a collaborative effort to achieve healthier outcomes for enrollees.

System of Care Model Staffing

Our SOC model is an innovative approach to improving delivery system capability. More than simply a collection of various resources, our SOC staff works together to help each enrollee achieve important clinical and functional outcomes: at home, in school, at work, in the community, and throughout life. This model includes a full spectrum of effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support that are organized into a coordinated network-within-a-network functioning as a virtual team (**Figure B.3-1**). Working together, this team achieves the following:

- Drives collaboration across agencies and community-based organizations
- Builds meaningful partnerships with enrollees and their families/circle of support
- Addresses peoples' cultural and linguistic needs such as language and cultural differences, which can create barriers for individuals with limited English proficiency
- Includes consideration of enrollees with visual and hearing impairments/disabilities; need for American Sign Language, braille, etc.

Aetna uses all these tools in combination to encourage innovative care management (CM) solutions and fosters the development of workflows that are uniquely adaptive and targeted at the same time so that populations can be identified and interventions designed with agility and personalization.

Fragmentation of health care and human services resources is pervasive. When required resources are not available and/or not working well together, people will not obtain the care they need, compromising their health and well-being. Delivery system capability is a result of how available resources are organized and managed. Service gaps are common, including both the absence of specific services and practitioners, and inadequate capacity of services that are present. This may be challenging in rural regions as well as impoverished urban locations.

Figure B.3-1: System of Care Model

Our System of Care model is an innovative approach to improving delivery system capability.

To address these vital needs, Aetna will hire highly qualified individuals who apply the elements of the system of care model. Our staff infuses recovery and resiliency, cultural sensitivity, and trauma-informed services and support to address social determinants, health and wellness, and health care services (as shown in **Figure B.3-1**) in a person-centric approach in the following roles:

- **Adult SOC administrator:**
  - Builds key stakeholder relationships and processes based on market needs and populations needing a system of care approach
  - Builds community-based services and supports
  - Leverages full partnership with social supports and caregivers in all aspects of the planning and delivery of their own services
- **Child SOC administrator:**
  - Builds key stakeholder relationships and processes based on market needs and children's populations needing a system of care approach
  - Bridges with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes
  - Builds community-based services and supports
- **Recovery and resiliency administrator:**
  - Builds supportive programs to mental health and substance use delivery
  - Participates in integrated rounds
  - Collaborates with local, Commonwealth, and national partners and stakeholders
  - Collaborates with enrollees and family to identify and remove barriers to services
  - Promotes the hope for recovery within the health plan
- **Juvenile system liaison:**
  - Collaborates with the Department of Juvenile Justice, Department of Corrections, county jails, Sheriff's Office, Correctional Health Services, Office of the Courts, probation departments, and

  Department of Behavioral Health and Developmental Disability to identify systemic changes and promote community integration
  - Trauma-informed expert
  - Understands reclaiming futures framework; works closely with other systems that serve youth; works with the community
  - Bridges communication with the health plan staff, court, and the justice systems
- **Emergency room/crisis administrator:**
  - Builds collaborative relationships with fire, police, emergency medical services, and hospital emergency rooms
  - Duties related to complex patient populations and coordination of services with community programs
  - Collaborates with Medical Management on transition of care for enrollees discharging from inpatient settings and mitigates system gaps
  - Builds collaborative protocols with first responders
  - Builds systems for transitioning individuals in crisis to and from hospital emergency rooms
  - Develops the crisis response teams, the crisis plan development process, and identifies gaps, i.e., placement for domestic violence victims, unaccompanied minors, etc.
- **Trauma liaison:**
  - Leads and establishes structure and mechanisms to drive the trauma transformation and principles in the health plan, provider network, and Commonwealth regulators and stakeholders
  - Collaborates with the director of training to coordinate quarterly training for law enforcement officials, judges, and district and county attorneys, including the Kentucky Administrative Office of the Courts, the Kentucky County Attorneys Association, and the Kentucky Department of Public Advocacy
  - Participates in separate or joint monthly meetings or as requested by the Department, the Department for Community Based Services, and Department of Juvenile Justice to collaborate on issues, ideas, and innovations for the efficient and economical delivery of trauma-informed services to Kentucky SKY enrollees
  - Supports the development of trauma-informed social/emotional programs within the Commonwealth
  - Provides expert consultation regarding complex situations and addresses challenging cases in a collaborative setting. These staff members are 'trauma champions' who can provide needed expertise in a trauma-informed organization to promote trauma-informed policies, staff development, and trauma-based services consistent with the mission of the organization.

Innovative Care Coordination Model

Aetna's strong history of innovation, most notably with pioneering our integrated care coordination model, delivers quality, efficient care. Aetna's Medicaid organization has 30 years of experience overall and 9 years of experience in Kentucky delivering successful solutions to complex Medicaid populations. Through these programs, we have developed a system of care model for coordinated care tailored to serving enrollees with complex medical, behavioral, and/or social needs, as well as improving care for the entire population. Our approach focuses not only on clinical risk factors, but also the enrollee's functional status, social support structures, environmental conditions, and behavioral health risks.

Our integrated Care Management teams are individuals with mixed credentials and expertise. This allows for a holistic care approach that leverages interdepartmental collaboration for the care coordination of our enrollees. There is staff dedicated to specialty areas for those that are more medically complex, which will help promote positive health outcomes. The team is supported by a point person to facilitate collaboration within the team to include coaching/mentoring, problem-solving, and staff coverage at all times to meet

enrollees' needs. The care team model is designed to improve quality outcomes by focusing on gaps in care and positively impacting avoidable utilization and corresponding expenses.

Collaborative Social Determinants of Health Integrated Model

Aetna is partnering with Unite Us in a unique collaboration to address the full spectrum of SDOH. The partnership, currently in Louisville, establishes new and innovative models that improve the engagement between enrollees, traditional health care providers (e.g., primary care providers), and social services providers. Aetna's intent is to expand this partnership statewide. This SDOH services integrated model connects enrollees to community-based organizations that participate in the closed-loop referral network, including all types of social service agencies. Enrollee referrals for integrated service needs (physical health, behavioral health, and SDOH) are triggered through multiple sources; there are no limitations on how enrollee referrals are triggered. One example is a health risk assessment (HRA), which is attempted to be completed for 100 percent of enrollees within 30 calendar days of eligibility with the health plans; 3 outreach attempts are made to complete the HRA.

Additional tools, such as the Health Care Equity Contact Assessment, are completed in combination with the HRA, which includes SDOH and biopsychosocial questions. Enrollees determined to have socially or medically complex needs (multiple chronic conditions, SDOH barriers, gaps in care, health disparities) will be warm transferred to a care manager for evaluation based upon defined criteria for potential enrollment into our integrated care management program. Enrollees that are identified to have SDOH needs not requiring care management intervention are warm transferred to a community health worker (CHW) located at the Wellness Center in the community where the enrollee resides. The Wellness Center will serve as a point of contact for our enrollees to access services including Women, Infants, and Children, federal food stamps, and housing information, as well as a direct link to the CM staff. The CHW will engage with the enrollee with Unite Us via telephonic outreach to complete referral for SDOH needs identified. Unite Us has engaged a full network of social service providers including food banks, transportation vendors, and education organizations.

a.ii. Organizational Structure: Supporting Whole-person Integrated Care, Population Health, and Improved Health Outcomes

With a keen understanding that the provision of person-centered care encompasses the complexity of co-occurring physical and behavioral health conditions, Aetna brings our **local, enrollee-centered approach** to the delivery of cost-effective health care services that support whole-person integrated care, population health, and improved health outcomes.

Whole-person Integrated Care

At the local level, Aetna's organizational structure and culture support whole-person integrated care, including building relationships with other managed care organizations, behavioral health organizations such as Children's Alliance, providers, advocates, community-based organizations, and enrollees. Aetna has invested in Mental Health First Aid, trauma-informed care, and other staff training opportunities to build a culture focused on seeing the whole person and recognizing that enrollees are the experts in defining their health ambitions. Aetna's capacity for full integration of physical and behavioral health is matched only by our respect for and commitment to a system of care that engages the individuals receiving covered services at every level. Our entire organization—from leadership to clinicians to enrollee service representatives and other staff members—is composed of individuals whose responsibilities and past experience includes working on integrated teams and gaining an understanding of physical health as well as behavioral health, long-term care, and other health-related social needs so they can ensure enrollees are

> Aetna is fully committed to integrated physical and behavioral health care. We do not outsource or subcontract our behavioral health care management responsibilities.

connected to appropriate resources and services. We are Kentuckians serving Kentuckians, meeting them where they are with a culturally focused orientation to meet each enrollee's unique needs and building on the unique relationships and circle of support existing in their lives. The supportive structure encourages coordination at every level, assuring a team approach centered on the individual and their unique needs and leveraging needed resources to achieve quality health outcomes.

The health of some of our most vulnerable enrollees is compromised by the biopsychosocial complexity of their lives. If their health is to improve, they need to address root causes, which frequently are related to unmet health-related resource needs or health opportunities, illness, disability, health care inequities, and/or patterns of behavior that compromise their health over time. Aetna employs a system of care approach to solve for fragmentation, with the goal of helping enrollees experience a seamless process while obtaining specialized services available from different funding streams, programs, and plans. By linking the full complement of Medicaid and non-Medicaid supports needed by the enrollee, our integrated system of care virtually creates the foundation and provides the collaborative structure necessary to meet the needs of all the populations we serve.

Population Health Management

Aetna's Population Health Management (PHM) program recognizes that health is more than the optimal delivery of clinical care, and is about the health of the population, including the distribution of health outcomes, disparities, genetics, and environment in the population. Aetna achieves population health management excellence by understanding drivers of health inequities and the impact of prevention and early intervention. We also understand that population health management aims to drive health care to prevention and early intervention, and away from emergency rooms and inpatient care. Together with our provider partners, Aetna has created a nimble system that is able to both identify the population disparities and enrollees' needs and engage enrollees to proactively address the uniqueness of their individual circumstance.

Led by Population Health Management Director Jennifer Nachreiner, our Population Health team acts as a liaison between our internal Care Coordination teams and external stakeholders to meet the needs of our unique enrollees and the Commonwealth. Ms. Nachreiner's responsibilities include the following:

- Providing training support and adoption of Aetna's proprietary web-based population health management platform
- Performing regular data analysis on total cost of care, utilization trends, and quality outcomes
- Reviewing and identifying enrollees of various risk levels and aligns care and services for their needs
- Coordinating regular care team rounds, especially for complex enrollees, around clinical events such as a hospital discharge and confirming follow-up appointments are completed
- Engaging the provider, enrollee, and their circle of support with community service agencies where appropriate
- Aligning and driving additional resources and care coordination with hospital systems or behavioral health providers to increase integration of the care delivery system
- Utilizing the Kentucky Health Information Exchange in connection with our electronic population health management system to address gaps in care, manage admission discharge and transfers, monitor risk levels, and population trends

Through the listed team functions, the Population Health team under Ms. Nachreiner assists individuals develop resiliency, move toward recovery, and reach their self-defined level of optimal functioning. In alignment with the Commonwealth's objective to transform from a traditional system to a population health management model, Aetna staff recognizes that health is more than the optimal delivery of clinical care; it encompasses the "health of the population, including the distribution of health outcomes and

disparities in the population" as defined by the National Quality Forum[3]. It is made up of the factors that influence the health of a population at the socio-cultural, economic, and individual levels. Following from this understanding of population health, Ms. Nachreiner works collaboratively with team members to develop programs guided by the following principles:

- **Person-centered:** Our strategy is a personalized approach that emphasizes empowering enrollees to achieve health goals by recognizing and elevating the individual's expertise and central role in their own health. Our PHM programs meet enrollees with the right level of services for each person and enable enrollees to use those services to achieve their individual health goals.
- **Accessible:** Our programs ensure convenience and easy-to-access resources that are targeted to meet the needs of our populations. Our programs are coordinated so all benefits and resources can be accessed regardless of point of access, cultural orientation, health literacy, preferred language, or SDOH factors that impact accessibility.
- **Integrated:** We aim to increase integration of enrollees' care across internal and external partners and providers, including care managers, patient-centered medical homes, specialist care, and community resources. An effective strategy is one that coordinates to minimize silos in our system.
- **Holistic:** Our PHM strategy is holistic. We seek to recognize the unique biological, cognitive, social, and cultural factors that culminate in enrollee and community health outcomes. We deploy personalized care planning and programs that incorporate an enrollee's assets and attend to their needs stemming from each of these intersecting factors.
- **Health care equity:** Health care equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions. Enrollees in particular groups experience major obstacles to health due to socio-economic disadvantages and injustices. These enrollees may face social inequities based on race, gender, class, sexual orientation, or immigration status. They may face economic inequities when government or community institutions use their authority to limit educational or job opportunities. The environment or area in which the enrollee lives may also contribute to inequity particularly for rural areas where access to health care may be limited. To assist enrollees to achieve health equity, it is important to identify the root causes of health. Our PHM strategy strives to reduce the disparities and lack of resources and opportunities for our low-income enrollees and their inability to access needed services.
- **Data- and evidence-driven:** Programs follow from a locally rooted understanding of population health priorities, needs, and assets while having the underpinnings of a national structure driven by population data analytics and evidence-based practices that focus our PHM activities for distinct enrollee populations throughout the continuum of care.

> Aetna is partnering with the University of Kentucky's Center for Health Equities Transformations to create synergies, using our resources to reduce disparities and improve health outcomes across the Commonwealth , particularly in rural areas.

Improved Health Outcomes

Our System of Care model and integrated care teams essential to our staffing model brings the full complement of our local and national quality improvement infrastructure and resources in alignment with the Department's goals in transforming the Kentucky Medicaid program. Our integrated care teams and Quality Improvement staff work together to empower enrollees in achieving their optimal health care outcomes and quality of life, while honoring their culture, goals, and need for access to timely resources.

[3] "Improving Population Health by Working with Communities," National Quality Form, p.9, August 2016.

By integrating physical and behavioral health coupled with training of trauma-informed care to our entire staff, we infuse a quality, person-centered focus throughout or organization. We fully engage our providers and enrollees through our quality initiatives, targeting Kentucky communities experiencing health disparities, such as women living in Regions 7 and 8 who are pregnant tobacco users. Through our Quit Incentives & Tailored Support (QUITS) program we partnered with the University of Pennsylvania to develop a best-in-country strategy to reduce smoking during pregnancy. Our Prenatal and Postpartum Risk Assessment for tobacco use Healthcare Effectiveness Data and Information Set (HEDIS) measure increased by 59 percent since 2016 due to increased member touchpoints.

As an **NCQA Commendable** accredited organization, we have demonstrated our commitment to continuous quality improvement and improved health outcomes, as evidenced by our substantial improvement trajectory in quality measures and health outcomes. We have seen increasing trends in outcomes related to measures in diabetes, well-child visits, access to care, dental, and weight/body mass index assessment, to name a few. Many of these measures are in the 75th percentile or greater or have achieved significant improvements.

Through our population health data collection process, we identified the need to help our members better understand healthy eating and nutrition. As a result, we created the prevention and wellness component of our population health program including a dedicated prevention and wellness coordinator. We have seen substantial increasing trends in HEDIS scores related to Body Mass Index assessment moving from the 25th to 95th percentile since 2016 concurrent with an 84 percent improvement in education and counseling for nutrition.

A major tenet of our population health efforts includes increasing member touchpoints in part through collaboration with providers that enhance the Aetna staff's ability to reach members during their time of need. Successful and timely outreach attempts will always be one of the most challenging components of providing managed care to Medicaid enrollees. As a result, we partner with local pharmacies through the Community Pharmacy Enhanced Services Network (CPESN) to deliver resources to enrollees and providers in a coordinated and easy-to-understand, actionable manner while leveraging local community pharmacist-provider relationships to impact change and improve access to services. Results from the first three months of this program include a reduction in the following:

Figure B.3-2: Social Determinants of Health Kits
Aetna staff package emergency kits to distribute to community members in need through CPESN pharmacies.

- ED utilization resulting in a decrease in cost of $28,000
- Outpatient utilization resulting in a decrease in cost of $14,000
- Inpatient utilization resulting in a decrease in cost by $45,000

Through our CPESN relationships, we identified significant SDOH needs within the community and created emergency kits comprised of shelf stable food items, toiletries, and seasonal winter items (hats, gloves, and blankets) to distribute to community members in need (please refer to **Figure B.3-2**). As a result, we began delivering emergency SDOH kits to local partner pharmacies allowing delivery drivers to supply emergency kits to community members that they find are in need, based on their observations in

the home. **As a result, the health plan estimates that this ongoing SDOH component of the partnership has the potential to touch upwards of 750 community members over the course of the next year.**

a.iii. Governing Body

Aetna Better Health of Kentucky's governing body is a four-person board of directors selected for these roles based on their health care and Medicaid managed care experience in serving vulnerable populations and leading innovative practices. These directors serve on the board because of their connection to Aetna Better Health of Kentucky's Medicaid business and/or the broader Medicaid organization.

Figure B.3-3 provides a listing of our board members and brief description of their roles.

This board is responsible for governance, policymaking, and compliance with federal and Commonwealth laws, rules, and regulations. Responsibility for compliance includes rules or regulations related to significant business transactions and adequacy of financial resources. The board reviews and votes on the following significant aspects of the health plan's functions:

- Board bylaws, resolutions, and executive summary of major functional areas
- Annual review of quality programs and work plans, including HEDIS and quality improvement activities

David J. McNichols, CEO, Aetna Medicaid Organization

As Aetna's CEO for Medicaid, Mr. McNichols oversees all Medicaid markets to ensure we meet our enrollees' and stakeholders' needs.

Debra Bacon, Regional Vice President, Aetna Medicaid Organization

Ms. Bacon ensures efficient distribution of operational and financial resources to best support Aetna Better Health of Kentucky.

David Delaney, Chief Financial Officer, Aetna Medicaid Organization

Mr. Delaney ensures efficient distribution of financial resources to best support Aetna Better Health of Kentucky.

Jonathan Copley, CEO, Aetna Better Health of Kentucky

Fifth-generation Kentuckian responsible for driving the Aetna Better Health of Kentucky strategy to deliver enrollee-focused, high-value health care to over 211,000 Kentuckians.

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Figure B.3-3: Aetna Better Health of Kentucky's Governing Board
Our governing body is selected for these roles based on their health care and Medicaid managed care experience in serving vulnerable populations and leading innovative practices.

In support of the Kentucky Medicaid managed care program, our board members leverage their breadth of Medicaid experience and resources nationally to bring best practices and lessons learned to our Kentucky plan. Each individual board member brings a passion dedicated to serving Kentucky enrollees to create enrollee's best outcomes both through our innovative system of care approach and in leading our transformation to a trauma-informed care organization. This ensures that its business practices and performance are optimized for the benefit of the Commonwealth Medicaid enrollees we serve.

a.iv. Key Personnel

An **onsite, local Aetna leadership team** will manage the delivery and operations of our Kentucky Medicaid health plan, leveraging our longstanding, positive relationships with the Department, providers,

community resources, advocacy groups, regulatory agencies, and other Medicaid focused organizations throughout the Commonwealth. Our current health plan leadership—who are proposed key staff for the new Medicaid contract—together bring a wealth of experience in working toward better health outcomes, better patient experiences with health care, and lower total cost of care. As detailed in **Table B.3-2**, our health plan leadership in Kentucky provides both **longevity and continuity** to the Kentucky Medicaid Program.

Table B.3-2: Aetna Better Health of Kentucky Key Personnel

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff or Subcontractor
Jonathan Copley, JD	Chief Executive Officer	This position is the full-time administrator with clear authority over the general administration and implementation of the requirements detailed in the contract. The CEO has direct oversight of Operations, Behavioral Health, Care Management, Compliance, Program Integrity, and the medical director.	Fifth-generation Kentuckian; CEO of Aetna Better Health of Kentucky since 2017; previously CEO of Aetna Medicaid organization health plans in Missouri and Nebraska; former executive positions with CareSource Kentucky, Centene/Kentucky Spirit Health Plan, and Bluegrass Regional Mental Health Board; acting undersecretary and chief administrative officer, Kentucky Cabinet for Health and Family Services; Juris Doctor (JD), University of Kentucky College of Law; Bachelor of Science, Business Marketing and Marketing Management, Campbellsville University; recently named chairman, Kentucky Chamber of Commerce Opioid Response Program for Business	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators
Paige Mankovich, JD	Chief Operations Officer	This position is the full-time chief operations officer in charge of day-to-day health plan operations. The COO position has direct oversight of Provider Network, Management Information System, and Enrollee and Provider Grievances and Appeals.	Native Kentuckian; tenure with Aetna Better Health of Kentucky since 2017; previous positions include chief of staff, plan compliance officer; corporate counsel for compliance and government affairs at Kentucky Employers' Mutual Insurance; associate attorney in litigation practice; Juris Doctor, University of Kentucky College of Law; Bachelor of Science in Accounting, University of Kentucky	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators
Lisa Chandler	Chief Financial Officer (CFO)	This position is the full-time chief financial officer overseeing the health plan's budget and accounting systems.	CFO of Aetna Better Health of Kentucky since 2011; 9 years of Medicaid experience and 28 years of health care industry experience; Bachelor of Science, Accountancy with a minor in Psychology, University of Missouri-Columbia; member of board of directors of nonprofit Our Little Haven (2002 to 2011), which specialized in programs for children in foster care	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff or Subcontractor
LaRhanda Trammell, MPA-CRJ, MBA-HCM, HCAFA	Chief Compliance Officer	This position is the full-time chief compliance officer maintaining current knowledge of federal and state legislation, legislative initiatives, and regulations relating to the Medicaid health plan; oversees the health plan's compliance with the laws and requirements of the Department; also serves as the primary contact for and facilitates communications between health plan leadership and the Department relating to contract compliance issues; oversees implementation of and evaluation of any actions required to correct a deficiency or address noncompliance with contract requirements as identified by the Department.	Native Kentuckian; chief compliance officer of Aetna Better Health of Kentucky since August 2018; extensive experience in private and public health care operations specifically through the field of auditing, investigations, and compliance; previously associate director for program integrity at Passport Health Plan/Evolent Health Medicaid Center of Excellence; 5 years of managed Medicaid experience and 16 years of health care industry experience; Master of Public Affairs with a specialization in Criminal Justice (MPA-CRJ), Indiana Wesleyan University; Master of Business Administration with specialization in Health Care Management (MBA-HCM), Indiana Wesleyan University; Bachelor of Science in Business Administration, Indiana Wesleyan University; Health Care Anti-Fraud Associate (HCAFA)	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff or Subcontractor
David M. Hiestand, MD, PhD, FACCP, FAAP	Medical Director	This position is the full-time medical director physician licensed to practice in Kentucky; oversees the health plan's clinical functions and the Medically Frail portion of Kentucky HEALTH; actively involved in all major health programs of the health plan; all clinical directors, including those employed by subcontractors, report to the medical director for all responsibilities of the contract; also responsible for treatment policies, protocols, quality improvement activities, population health management activities, and utilization management decisions; must devote sufficient time to ensuring timely medical decisions; shall also be available for after-hours consultation, if needed.	Chief medical officer for Aetna Better Health of Kentucky. Dr. Hiestand has had a 20-year career in health care, including six years with Aetna, where he most recently served as the regional medical director for the Midwest Region. He also served as the chief medical officer for Aetna Better Health of Kentucky. He previously worked in both academic and private practice Pulmonary, Critical Care, and Sleep Medicine. He obtained a BA in philosophy from Centre College in Danville, Kentucky, and a PhD in Medicinal Chemistry and Pharmaceutics from the University of Kentucky. He completed medical school, residency, and fellowship at the University of Kentucky and is board-certified in Internal Medicine, Pulmonary, Critical Care, Sleep Medicine, and Pediatrics. He also has training in Hyperbaric Medicine. His academic interests included quality assurance and improvement and health information technology. Prior to joining Coventry/Aetna, he served as a medical director for Express Scripts.	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators
April Cox, PharmD	Pharmacy Director	This position is the full-time pharmacy director/licensed pharmacist in Kentucky; coordinates, manages, and oversees the provision of pharmacy services to enrollees; responsible for pharmacy utilization review.	Native Kentuckian; pharmacy director of Aetna Better Health of Kentucky since 2017; 7 years of experience in managed Medicaid and 12 years of health care industry experience; previous positions include clinical pharmacist at Humana, consultant outreach pharmacist at Passport Health Plan, Special Investigations Unit clinical pharmacist at Coventry Health Care; Doctor of Pharmacy (PharmD), University of Kentucky; Bachelor of Science in Chemistry, Western Kentucky University; licensed pharmacist in Kentucky	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff or Subcontractor
Jerry Caudill, DMD, FAGD, MAGD, CDC, CTCP, FPFA, FICD, FACD	Dental Director	This position is the full-time dental director licensed to practice dentistry in Kentucky; actively involved in all oral health programs of the health plan and devotes sufficient time to ensuring timely oral health decisions; shall be available for after-hours consultation, if needed.	Kentucky State Dental Director at Avēsis, a Guardian Company, since 2013; previous positions include dental claims consultant at Avēsis and the Premier Dental Group, private general dentistry practice; national dental director at Castle Dental Centers; licensed to practice dentistry in Kentucky; Doctor of Dental Medicine (DMD), University of Kentucky College of Dentistry; past president, North Carolina Academy of Dentistry; Tele-dentistry Committee member of the Kentucky Board of Dentistry; Certified Dental Consultant (CDC)	1	Campbellsburg, Kentucky	Subcontractor: Avēsis
Sarah Bowling, LPCC	Behavioral Health (BH) and Care Management Director	This position is the full-time BH practitioner licensed in Kentucky and actively involved in all programs or initiatives relating to behavioral health; coordinates efforts to provide BH services by the health plan. The role also helps in ensuring physical health and BH integration of care through our System of Care approach.	Ms. Bowling is a Licensed Professional Clinical Counselor with more than 10 years of experience providing exceptional treatment and care management support to individuals in the Commonwealth. Ms. Bowling has successfully implemented and currently manages initiatives related to improving health outcomes, ensuring integration of care, and meeting social determinant of health needs. Master of Rehabilitation Counseling (MRC)	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators
Stacey Kleinman, MBA	Provider Network Director	This position is the full-time provider network director responsible for oversight of Provider Services and Provider Network Development; provides oversight of required coordination with the Department's contracted credentialing verification organization(s); coordinates workforce development initiatives conducted by the health plan and collaboratively with the Department and other contracted MCOs.	Fourth-generation Kentuckian; tenure with Aetna Better Health of Kentucky since 2017; previous Aetna positions include director of network operations, lead business consultant, and manager of informatics; actuarial, data analytics, and financial analysis positions at Humana; 3 years of experience in managed Medicaid and 12 years of health care industry experience; Master of Business Administration (MBA), Bellarmine University; Bachelor of Science in Business Administration, Sullivan University	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff or Subcontractor
Donna Hall, RN	Quality Improvement Director	This position is the full-time quality improvement director responsible for the operation of the health plan's quality improvement program activities. This position is responsible for infusing advances in quality measures and innovative practices that result in improved enrollee quality outcomes.	Native Kentuckian; quality improvement director at Aetna Better Health of Kentucky since 2013; tenure with the health plan since 2012; 12 years of managed Medicaid experience and 21 years of health care industry experience; previous positions include utilization management clinical reviewer at Texas Medicaid and Healthcare Partnership; quality and training specialist at SHPS/Carewise; nursing positions in long-term care, medical-surgical, allergy and asthma, and wound care; registered nurse (RN) in Kentucky; Bachelor of Arts, Health Care Management (in progress), Southern New Hampshire University; Associate of Science in Nursing, Excelsior College, New York; Diploma of Practical Nursing, Spencerian College, Louisville, Kentucky; Associate of Science, Business Administration, Sullivan College, Louisville, Kentucky	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators
Jennifer Nachreiner, MPH, RD	Population Health Management Director	This position is the full-time population health management director responsible for coordination and oversight of the Population Health Management program and services. The position directs and provides population health training support, data analysis, and directing additional resources to our care coordination efforts, and more. These efforts drive improvements related to health disparities and health outcomes across all Medicaid enrollees.	Population health management director at Aetna Better Health of Kentucky since January 2019; previous positions with Aetna include account manager, wellness account consultant, and registered dietician/health coach; 2 years of managed Medicaid experience and 11 years of health care industry experience; guest speaker for American Academy of Pediatrics EPIC Program; Master of Public Health (MPH), University of North Carolina at Chapel Hill; Bachelor of Science in Dietetics, University of Cincinnati; Registered Dietician (RD), Academy of Nutrition and Dietetics; certified worksite wellness program manager; licensed dietician/nutritionist, PA Board of Nursing	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff or Subcontractor
Christina Bowlin	Provider Services Manager	This position is responsible for management of the resolution of provider access and availability issues. This position must have knowledge of Kentucky providers, including BH providers, and patterns of care/referral in Kentucky managing the Provider Services team's interaction with Kentucky providers across the Commonwealth.	Ms. Bowlin is an experienced network development executive with 15 years of health care industry experience and 6 years of managed Medicaid experience. Her expertise includes provider relations, credentialing, provider billing, and process improvement. In her role as the manager of provider services for Aetna Better Health of Kentucky, Christina is responsible for overseeing the day-to-day operations of staff members, education, service, reimbursement, and management of existing provider networks, supporting the recruitment of providers, the delivery of provider data, and ensuring all contractual metrics are met and/or exceeded.	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators
Scott Hunt, RN, MA	Utilization Management (UM) Director	This position is the full-time UM director responsible for the operation of the health plan's UM program and any subcontractors performing services relevant to UM.	UM director at Aetna Better Health of Kentucky since 2012; 8 years of managed Medicaid experience and 21 years of health care experience; previous positions include assistant nurse manager in the emergency department at Norton Audubon Hospital; emergency room nurse at Baptist Hospital East and Jewish Hospital; firefighter, paramedic, and emergency medical services director for the Town of Clarksville; Master of Arts (MA) in Leadership and Health System Administration, Excelsior College	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators
Paula Fellows, LPN	Enrollee and Provider Grievances and Appeals Coordinator	This full-time position is responsible for the operation of the health plan's Grievances and Appeals unit.	Enrollee and provider complaint, grievance, and appeal coordinator at Aetna Better Health of Kentucky since 2014; tenure with the health plan since 2012; 10 years of experience in managed Medicaid and 33 years of health care industry experience; previous positions include concurrent review/retroactive review nurse; nurse reviewer at SHPS; allergy technician/licensed practice nurse at advanced ENT and allergy practice; government inquiry representative and disabilities coordinator at Humana; associate's degree in licensed practical nursing, Galen Health Institute for Nursing, Louisville, Kentucky; licensed practical nurse (LPN) in Kentucky; two-time winner of the Aetna Way Silver Excellence Award	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff or Subcontractor
Patrice McGhee, DPA	Director, Social Determinants of Health	This full-time position drives SDOH (including but not limited to food insecurity, housing, physical safety, and transportation), health equity, and outreach innovation and education activities at the health plan.	Native Kentuckian; tenure with Aetna Better Health of Kentucky since 2017; previous positions include manager of community development; director of community partnerships and programs at Freestore Foodbank in Cincinnati, Ohio; KIPDA region executive advisor/director, Commission for Children and Special Health Care Needs; senior program manager at Kentuckiana Regional Planning and Development Agency; 3 years of managed Medicaid experience and 11 years of health care industry experience; Doctor of Public Administration (DPA), Capella University; Master of Science, Justice Administration, University of Louisville; Bachelor of Arts, Criminal Justice, Kentucky State University	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators
Catherine Easley	Chief of Staff	This full-time position provides strategic counsel to the CEO regarding health plan operations, working across all internal departments both at the health plan and national level to develop and implement best practices in health services and plan operations.	Ms. Easley is a native Kentuckian with over 10 years of strategic communications and project management experience, 3 focused specifically on Kentucky Medicaid. Her expertise includes working with diverse constituencies to develop and implement innovative and creative campaigns that engage stakeholders. In her role as chief of staff for Aetna Better Health of Kentucky, Ms. Easley provides strategic counsel to the CEO regarding health plan operations, working across all internal departments both at the health plan and national level to develop and implement best practices in health services and plan operations. Prior to joining Aetna, Ms. Easley worked in various positions in state and federal government where she managed communication efforts among multiple internal and external stakeholders, beneficiaries, legislators, media, and the general public. Her educational background includes a Bachelor of Arts in Political Science and Communications from Wake Forest University.	1	Louisville, Kentucky	Staff of Aetna Medicaid Administrators

Please refer to **Attachment I** for key personnel resumes.

a.v. Recruitment Timelines and Activities

All Kentucky key personnel, as identified in **Table B.3-2**, are presently in place and serving the Kentucky Medicaid Program. Should a position become vacant, we are able to draw upon the resources and staff of the national Aetna Medicaid organization to ensure seamless continuity of service to our enrollees, providers, and the Department. Further, our locally based leadership can draw on their knowledge and networks to recruit talented and experienced staff located in Kentucky.

a.vi. Staff Training

Aetna's structured training and development program ensures that our staff have consistent experience and background knowledge to fulfill all requirements and responsibilities of the **Draft Medicaid Managed Care Contract and Appendices,** for all operational areas. We have the capabilities to train large groups (for example, Prior Authorization and Enrollee Services staff, which we brought to Kentucky) with dedicated space and technology. This ensures our staff are trained to be culturally, linguistically, and disability competent. Importantly, our training program allows our staff members to witness the impact their roles have on the lives of enrollees. For example, we provide in-depth training on issues that affect enrollees, such as housing, transportation, education, nutrition, behavioral health, and trauma-informed care. We train our staff to find community resources and make referrals to applicable agencies and programs. Training emphasizes a holistic, person-centered approach to enrollee issues. Staff members learn to help enrollees achieve improved health outcomes, integrate care, improve quality of care and services, emphasize person-centered planning, and enhance preventive and disease condition management to reduce the rate of costly avoidable care.

> In 2019, Aetna again received the distinction of being named one of *Training Magazine's* Top 125 Organizations for Excellence in Staff Training and Development.

Our comprehensive training and development program includes initial and ongoing training offered through a variety of mediums. Every staff member goes through training that includes, at a minimum, a review of company policies, Medicaid program requirements, and Commonwealth-specific information. Additional tailored training is provided for specific positions such as our cultural competency training and trauma-informed training efforts that cross departments to ensure integration of our training efforts across the organization. Completion of all training requirements is closely monitored. We routinely review and update our training program in accordance with federal and local policy changes to ensure our staff are up to date with requirements and best practices.

We provide our subcontractors with initial training and, when necessary, retrain in aspects of contract requirements that are included in their scope of work. We require our subcontractors to comply with all Commonwealth requirements.

Initial Orientation and Ongoing Training

Our initial onboarding and ongoing training program prepares our staff to hit the ground running in their respective roles. Within 90 days of initial new-hire orientation, all health plan staff participate, as appropriate, in a three-tiered training process that includes onboarding, position-specific, and Kentucky Medicaid program-specific training. Our Learning and Performance team provides a mix of face-to-face learning sessions, extensive subject matter expert job shadowing, and technology-based training as a part of our onboarding process to help ensure consistency in service delivery to our enrollees. Technology-based training allows new staff to acquire standardized information at their own pace, while in-person meetings with subject matter experts, managers, and other leaders connect the training to the hands-on work of the plan. The following are key components of our onboarding plan:

- **Onboarding-in-a-Box**, our structured five-day new staff orientation where staff complete a step-by-step list of daily activities as they learn the basics of their job and how it connects to Aetna's mission to build a healthier world
- **Comprehensive overview of our culture** with specific training to reinforce our mission, values, and commitment to person-centered, high-quality, efficient health care
- **Specific leadership curriculum/training courses** for managers and supervisors
- **Cultural competency and health literacy** initiatives and training for enrollee-specific cultural, social, and language needs, as well as SDOH and independence
- **Mandatory Medicaid compliance and ethics training**, including Health Insurance Portability and Accountability Act and other Commonwealth and federal rules and regulations including enrollee rights and advance directives; Ethical Code of Conduct; fraud, waste, and abuse prevention; and diversity training
- **Achieving Business eXcellence (ABX) training** and rapid-cycle process improvement to simplify processes and create a culture of continuous quality improvement; all staff are required initially to earn the ABX White Belt level of certification; managers are required to obtain at least the next level of Yellow Belt certification
- **Concepts in community integration and independent living** including functional limitations and/or chronic illnesses that impact on individuals living or working in the community
- **Trauma-informed care training** for all enrollee-facing staff
- **Mental Health First Aid** for all enrollee-facing staff
- **Housing First training** for all enrollee-facing staff
- Extensive training on all business and clinical systems used by our staff
- Any additional training topics as determined by the Commonwealth

All Kentucky health plan and subcontractor staff members, as appropriate, participate in mandatory, ongoing training supporting ethics and continued compliance, promoting cultural competency and health literacy, and aiding business continuity planning. Quality-of-care issues, service concerns, enrollee and provider complaints, and program changes resulting in regulatory updates all inform our training curriculum. Aetna employs a system of electronic tracking and monitoring with a series of increasingly escalated reminders to the staff and their direct managers to complete the training.

Kentucky Medicaid Program Training

Following completion of position-specific training, we require all health plan and subcontractor staff, as appropriate, to attend and participate in Kentucky Medicaid program training, which includes a Kentucky-specific portal that connects staff to the following job-specific contract requirements:

- Program training
- The diversity needs of our enrollees
- The roles and responsibilities of staff
- The Department policies and procedures
- The identification and reporting of adverse incidents and enrollee grievances
- The types of covered services provided
- Pharmacy benefit
- Waivers
- Commonwealth-specific objectives and program-specific goals
- The challenges facing our enrollees and providers in Kentucky

During this phase, personnel will need to demonstrate knowledge, retention, and understanding of the material covered in the initial and position-specific trainings. Staff members who will work with enrollees and providers are mentored and evaluated through on-the-job training at the outset of their service, receiving additional training as necessary.

Aetna staff and contracted practitioners/providers are required to participate in mandatory critical incident reporting training and to report, respond to, and document critical incidents to Aetna in accordance with all requirements set forth in the contract and those applicable to Adult and Child Protective Services. All Aetna staff members are trained on critical incident reporting upon hire and complete annual refresher training.

Position-specific Training

Upon successful completion of initial training but before there is contact with enrollees, providers, or the Department, staff attend training specific to performance of their respective roles. During this phase, new staff must demonstrate knowledge, retention, and understanding of the material covered in the initial training.

Training specific to staff positions in Prior Authorization, Enrollee Services, Claims, Provider Services, Enrollment/Coordination of Benefits, and Contracting is conducted through instructor-led classroom instruction and on-the-job training. Courses range from one to six weeks. These staff complete online assessments while in the classroom and are evaluated throughout training using a checklist of criteria constructed to demonstrate knowledge transfer. Leaders receive daily reports on how staff are progressing and how they can reinforce learning. The checklist is sent to the hiring manager detailing the new staff's performance at the completion of class. The trainer consults with the manager of the department and provides suggested additional training based upon the staff's performance.

All personnel having contact with enrollees or providers receive initial and ongoing training regarding the appropriate identification and handling of quality of care/service concerns. For instance, prior authorization representatives, Enrollee Services representatives, and any staff working on potential transportation issues are trained in the geography of Kentucky. These personnel have access to Quest Analytics reports and mapping search engines for the purposes of authorizing services, recommending providers, or arranging transport for enrollees in the most geographically appropriate location. This training phase provides staff with tools, supports, and instructions that can be applied to successful performance in their specific positions.

Functional job training (the length of which varies by position) includes education and mentoring on the job from experienced staff members, access to job-specific policies, procedures and helpful resources, and job-specific training through an online job shadowing resource library. We require in-depth behavioral health training, including training on trauma-informed care, Mental Health First Aid, chronic conditions, co-occurring disorders, and our Patient Activation Measure® program. New staff members in key positions are linked with more experienced health plan staff for mentorship and support.

Training for Care Coordination Staff

Our Care Coordination team members receive the didactic and classroom training necessary to address enrollees' medical, behavioral, social support, and functional needs holistically. The following are examples:

- Motivational interviewing, patient activation, and trauma-informed principles
- Mental Health First Aid
- Chronic conditions
- Use of assessment tools and utilization management criteria
- Targeted population care coordination, collaborative service planning and facilitation, and use of Aetna's systems and tools
- Robust case scenarios and activities
- SDOH trainings

- Relias monthly training includes the following topics: economic stability, education, neighborhood and built environment, social and community context, practice scenarios, substance abuse, and violence against women
- Dynamo system health care equity documentation training
- Integrated care management training includes SDOH/health care equity training
- NCQA annual training on population health standards

Training on Specific Issues Affecting Access to Care

Aetna's Kentucky staff receives training on specific issues affecting access to care and enrollee health at the regional level, along with Aetna's corresponding solutions and strategies. They also learn about enrollee, provider, stakeholder, and staff participation in interdisciplinary care team meetings, and receive education on documenting information in our fully integrated plan of service and on our electronic population health management platform. Staff also receives training on the following topics: utilization management; disease management; chronic condition coaching and education; condition-specific service coordination for high-risk pregnancy; hepatitis-C; transplants; neonatal abstinence syndrome throughout the episode of care; and care coordination services including conducting outreach, engagement, performing assessments, and providing a plan of service.

Comprehensive Training on Benefits

All Aetna care coordinators receive comprehensive training on benefits available to the enrollee. Care coordinators are required to pass a post-training test with a minimum score of 90 percent for passing, depending on the capstone, practicum, and/or assessment administered, prior to starting work on their assigned teams. New care coordinators are required to complete a two-month-long specialized training program prior to receiving a caseload. This training program begins with two weeks of field observation visits followed by three weeks of classroom training that includes 68 hours of instruction time, 30 hours of which are spent studying our Kentucky health plan's policies and procedures (P&Ps). Our Behavioral Health integrated team coordinates job shadowing provided by Mercy Care, a health plan managed by Aetna, as part of the onboarding process. Care coordinators are assigned a senior care coordination mentor who is available to answer questions and provide guidance. One hundred percent of new care coordinators' work is monitored by their supervisors for the first three months. In addition, care coordinators are required to participate in mandatory quarterly training courses and receive weekly electronic training reminders and updates regarding our P&Ps. Our care coordinators must attend at least six critical community resource training events per year.

Specialized and Ongoing Training

Aetna provides specialized and ongoing training for all Medical Management staff working in care coordination and utilization management to better equip them to provide our enrollees the skilled and compassionate care they deserve. Medical Management staff complete 20 hours of long-term services and supports training and monthly mandatory Relias Learning Management System training, which focuses heavily on topics related to behavioral health, ethics, cultural diversity, care planning, abuse and neglect, recovery, transition of care processes, and SDOH. Licensed behavioral health clinicians teach these sessions. All Medical Management staff members receive an eight-hour course to become certified in Mental Health First Aid conducted by MHFA trainers on staff. We also provide state-specific enrollee population training and care management practices and processes training on developmental and intellectual disabilities, foster children, and SDOH to help ensure staff understand the specific needs of and resources available for the enrollees they serve.

Additionally, our integrated Care Coordination teams hold monthly/quarterly meetings to receive additional support through updates regarding plan directions, barriers, and identifying next steps and solutions to address enrollee needs.

Expanded Cultural Competency Training

Aetna uses an expanded cultural competency training program across the organization that goes beyond annual e-learning. This training program engages individual departments across the Kentucky health plan to instill a sense of ownership and responsibility for a culturally competent workforce at every level. In this 2.5-hour, instructor-led session, participants engage in dialogue that increases their awareness of their own views on culture, while heightening their sensitivity toward different cultural groups. The course broadens the definition of culture by facilitating rich discussion on cultural implications of poverty, behavioral health, and disability. It also explores the link between culture and health through conversation on health literacy, SDOH, health disparities, and health equity. Participants are challenged to identify and stamp out stigma. Each person leaves with a specific action item to help increase cultural awareness and appreciation in our organization as well as sensitivity toward those we serve. They will recognize cultural competence as a journey and gain resources to aid in their commitment to embrace it. In addition to this enhanced training program, we provide a poverty simulation experience in Kentucky to help make sure all staff remain connected to the enrollee experience.

Evaluation of Effectiveness and Outcomes

Aetna's Kentucky staff training coordinator maintains responsibility for developing, overseeing, and evaluating the staff training and education plan. The plan compliance officer documents compliance with all contractual training requirements. All Aetna staff are registered into new and ongoing continuing education courses through our learning management system. Training course attendance is monitored by the Learning and Performance department; a staff supervisor is notified if a staff member has not attended. Attendance reports for all courses are available on demand. We monitor and test new staff 45 to 60 days after formal training to ensure they meet our standards and to measure the transfer of knowledge and training outcomes. This gives us the opportunity to implement appropriate training interventions (as needed), such as compliance with Department rules, regulations, and reporting.

Aetna uses the Kirkpatrick Model, a four-level approach recognized as one of the most successful models to measure the effectiveness of each training program. Post-training quizzes, staff performance audits, one-to-one discussions, staff surveys, participant case studies, and exams are ways Aetna evaluates training effectiveness. Staff data is collected on measurable outcomes, quality trends, and supervisor observations. A quarterly assessment and review process are in place to adjust training to ensure the best outcomes.

Throughout their time with Aetna, Kentucky staff can provide feedback about how well our training prepares them for their jobs and about strategies to improve training. We continuously use enrollee feedback to improve staff training to provide better service to our enrollees.

a.vii. Monitoring Subcontractor Progress

Aetna performs ongoing monitoring of subcontractor performance, including staffing and training activities. Our subcontractors are required to complete CVS Health and Aetna trainings related to privacy, security, and conduct prior to working with our enrollees, providers, and staff. Our Quality Assurance and Performance Improvement program has a comprehensive set of policies and procedures to manage the delegation of responsibility for any delegated program function. We understand all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight, selecting subcontractors, and ongoing monitoring of subcontractor performance. By leveraging this experience, we ensure the successful completion of all delegated functions under the Kentucky Medicaid program, including the recruiting and training of subcontractor staff.

We meet with subcontractors on a weekly, monthly, or quarterly basis, depending on the subcontractor, and perform a comprehensive review annually in which we measure performance efforts that address past

concerns identified by the Department. If any deficiencies or areas for improvement are identified, we require the subcontractor to take corrective action. Aetna provides the Department with a copy of the annual review and any corrective action plans developed as a result.

We use well-qualified, experienced subcontractors to provide services in support of the Kentucky Medicaid program—subcontractors with unique expertise and proven records of accomplishment relative to improving outcomes for our enrollees by providing appropriate, coordinated care and services in a financially responsible manner. All our proposed material subcontractors have an established relationship with Aetna and currently demonstrate sustained quality performance serving Kentucky Medicaid enrollees.

Although we may delegate the authority to perform functions in support of the Kentucky Medicaid managed care program, we do not delegate accountability for the quality of care or services the subcontractor provides. We provide our subcontractors with initial training and, when necessary, retrain in aspects of contract requirements that are included in their scope of work. We require our subcontractors to comply with all Commonwealth requirements.

Prior to contracting with a subcontractor, Aetna evaluates the prospective subcontractor's ability to perform the activities to be subcontracted. We perform a pre-delegation review audit to determine staff qualifications, clinical and administrative capabilities, integration capabilities, data transfer capabilities, operational readiness, and alignment with the Kentucky Medicaid program scope of work. Our quality management program includes formal, multilayered processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract. All aspects of the contract are evaluated through our Compliance Committee to ensure compliance with contractual requirements.

Subcontractor Monitoring and Oversight Activities

Monitoring is performed as follows:

- ✓ Monitoring and evaluating delegated functions through at least semiannual reports
- ✓ Conducting pre-assessments prior to delegation, with annual desk audits or web conference reviews conducted with a random sampling of files thereafter
- ✓ Confirming (no less than annually) that delegated functions/services are carried out consistently and in compliance with both Aetna's and other applicable accredited standards (i.e., NCQA and others as indicated) and the mutually agreed upon delegation agreement
- ✓ Performing, at minimum, an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards
- ✓ Monitoring ongoing corrective actions to address identified deficiencies, promote progress, and take necessary action, if improvements do not occur
- ✓ Reviewing the delegated organization's program that oversees the delegated functions and its quality program to verify it is in alignment with Aetna's quality improvement processes
- ✓ Monitoring the subcontractor downstream provider agreements to ensure they comply with the regulatory requirements of the Commonwealth contract

National Oversight

At the national level, we have a centralized team of delegation oversight experts that manages the oversight process across Aetna Medicaid lines of business to make certain that all of our multi-state delegated agreements are represented and that all requirements, such as Commonwealth- and contract-required elements for each plan and delegate, are accounted for. This team includes members from our national Delegation Management, Quality Management, and Finance departments. The appropriate national Medical Management, Credentialing, Grievance and Appeals, and other teams conduct audits as directed by the Medicaid-specific Quality Management department. The audit team reports audit findings to Aetna's National Vendor Delegation Oversight Committee (DOC), National Medicaid DOC, and the local

health plan DOC in order to identify opportunities for improvement and solutions that are disseminated across our health plans.

Local Oversight

The chief executive officer, chief medical officer (CMO), compliance officer, chief operating officer, director of clinical health services, director of quality management, and selected leadership staff from our Enrollee Services, Provider Services, Network Management, and Grievance and Appeals departments comprise the local-level DOC. These local, executive-level plan leaders and key leaders from functional areas meet with subcontractors on a monthly or quarterly basis, depending upon the type of subcontractor, to monitor service delivery, troubleshoot problems, review and resolve enrollee complaints, and most importantly, identify opportunities to collaborate on new or enhanced services for enrollees. The DOC approves all delegates and delegation reports, and monitors subcontractor performance at the plan level. Executive-level leaders monitor the success of corrective action plans and handle escalated issues when the corrective actions are not producing satisfactory results.

Aetna Collaborates with Subcontractor to Achieve Prior Authorization Compliance

On May 4, 2018, Aetna placed eviCore on a corrective action plan (CAP) for consistently and chronically demonstrating noncompliance with Commonwealth and federal Requirements with regard to prior authorization requests within Commonwealth-established timeframes that may not exceed two business days following receipt of the request for service, with a possible extension of up to 14 additional days. The issue was identified during an off cycle file review.

As such, by May 11, 2018 Aetna required that eviCore provide us with a response plan of action for organization to immediately come into compliance with our contractual turnaround times. EviCore response included a root cause analysis of the issue and a plan to correct the deficiencies, as well as evidence of their monitoring and oversight of adhering to timeframes.

Aetna required eviCore to provide daily summaries of all requests and their respective turnaround times, including approvals, denials, and extension requests. Within two weeks of providing notification to eviCore, Aetna required 95% compliance with required turnaround times on a daily basis. Within four weeks, Aetna required 99% compliance with required turnaround times on a daily basis.

EviCore identified server capacity issues, workflow routing issues, and delay in notification activities as the cause. EviCore resolved the server capacity issue May 11, 2018. Workflow adjustments and increased oversight/monitoring was completed by May 14, 2018.

The health plan audit for May 2018 revealed 95.3% compliance, which met the 95% compliance goal within two weeks. In June 2018, eviCore remained at 96% compliance and by July it was at 98.8% compliance.

The CAP closed on March 12, 2019. EviCore continues to provide monthly reports for turnaround time metrics.

a.viii. Retention Approach for Key Personnel

Aetna is committed to attracting and retaining professional key personnel with experience managing care for the Medicaid population. We achieve this through a strong workplace culture (please refer to **Figure B.3-4, Figure B.3-5, and Figure B.3-6** on the following pages) and personal and professional development opportunities. Our salaries and benefits are market-competitive, with bonuses for high achievers. We recognize the importance of family and provide eligible colleagues with up to 4 weeks of

leave time with 100 percent of pay to bond with a new baby, adoption or foster care child. Further, our benefits come with many choices aimed at helping our staff achieve health and financial well-being. We increased our U.S. minimum base wage to $16 per hour for both hourly and salaried staff. Eligible Aetna employees can qualify for an enhanced medical benefits program that could save some families thousands of dollars.

Aetna's Best Practices for Employee Retention

- Incentives and comprehensive benefits package
- Aetna nationwide mentoring program to provide additional support
- Thorough recruitment practices for candidates that are a good fit minimizes early turnover and enhances retention
- Conduct interviews with newly hired staff to obtain feedback about the hiring process and training curriculum to gain feedback for continuous improvement
- Values in Action program is an interactive tool used to implement timely appreciation and acknowledgement of employees performance. Colleagues as well as managers utilize this system to award employees points in areas such as Caring, Collaboration, and Innovation.
- Sponsor wellness programs, self-care promotion, and programs to help deal with stress
- Offer flexibility, realistic workloads, and promote healthy work life balance
- Opportunities for promotion as well as additional learning opportunities
- Routine staff satisfaction surveys
- Identify turnover trends, workforce supply and demand, workforce gaps and create action steps to strategically address these gaps and how to enhance and support the current workforce for future growth

As part of our commitment to retaining our key personnel, Aetna is always looking for ways to enhance our culture of the plan. Our Kentucky Medicaid Appreciation Committee (KMAC) is a dedicated group of volunteers focused on showing Aetna's appreciation of our staff and all the work they do to support our enrollees, providers, and other stakeholders. This committee meets monthly to plan activities and share info about various opportunities to get involved within the community. A staff survey is completed annually to get feedback on the KMAC's activities, to determine a workplan, and to determine the priority of future topics and activities.

167.ky20

Figure B.3-4: Award for Accomplishments in Wellness
Aetna Better Health of Kentucky was awarded Silver Wellness status by the Aetna enterprise, honoring the staff for its participation and accomplishments in the area of wellness.

From an engagement perspective, Aetna Better Health of Kentucky is a leader across all Medicaid plans thanks to our very successful employee engagement survey results year-over-year. We were often looked to for ideas because of our successes.

Our employee referral program rewards employees at every level when they help us achieve our goal of attracting and retaining top talent. Our

colleagues who refer an external candidate that is hired are eligible to receive a monetary award. History has shown us that referrals from our staff and former colleagues usually result in strong candidates.

Aetna also provides telework opportunities for qualified individuals, enabling us to recruit the most qualified individuals from a larger pool across the Commonwealth. Additionally, Aetna shows personnel that they care about the health of the staff and their families. The focus on wellness provides a great morale booster and focuses on several areas of mental and physical health, as well as areas of life that affect our overall well-being and whole person health. Our intranet and wellness benefits provide a location to store health and wellness information and tips, as well as a place for staff to get health or work-related questions answered. This platform also provides personal ways to improve health.

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Figure B.3-5: Heart Walk
The Aetna Heart Walk Team raised over $2,000 for the 2019 American Heart Association Heart Walk.

Aetna focuses on empowering staff and incentivizes several opportunities to get involved in our own health and increase engagement. A few of the activities include, but are not limited to the following: events with massages offered to staff to promote relaxation, walking and weight loss challenges to promote health eating/ activities, and healthy eating cooking classes.

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Figure B.3-6: Demonstrating Teamwork at Community Event
Aetna staff members participated in the Louisville Corporate Games, which is a community-wide event that brings together employees from Louisville-area businesses for a day of friendly competition and employee camaraderie.

Aetna also has a platform, Values in Action, that allows management and staff to acknowledge each other for their hard work to promote our values (collaboration, accountability, innovation, integrity, and caring). This platform allows others to see and appreciate the work of their co-workers. This platform is also tied to incentives, with different actions accumulating points that can then be spent on various items related to health and well-being.

Aetna promotes a culture that understands the importance of a 'happy' workplace focused on helping staff to be their best self professionally and personally. We have a Learning Center, Wellness Classes and Resource for Living catalog that enables staff to develop. These resources allow staff to gain knowledge and skills that will aid in their current role (as an employee/ community member) and advancement in life. This promotes an environment of learning and sharing.

Figure B.3-7: Canned Food Drive
Pictured is the first-place winner for the 2019 'Canstruction' office canned food drive benefiting Dare to Care. The Aetna staff collected over 400 cans to help families in need.

Finally, we understand that there is more to life than the workday and Aetna provides opportunities for staff to volunteer in numerous activities year round. These volunteer activities typically focus on supporting our community-based organization network, such as the "Everyone Reads" program with Jefferson County Public Schools, the Homeless Street Count with the Coalition for the Homeless, and the Heart Walk with American Cancer Society. The following list of activities and volunteer opportunities we have participated in demonstrates our commitment to our staff and the communities we serve:

- Blood drives
- Flu clinic: onsite flu shots offered to staff
- Mindfulness sessions: guided meditations and massages for staff
- 'Canstruction' Event: canned food drive where staff used canned food to create different displays, which were then judged by staff (please refer to **Figure B.3-7**)
- Corporate games: Family fun outside of work that promotes teamwork
- American Heart Association Heart Walk
- National Alliance on Mental Illness walk
- Kidney walk
- Breast cancer walk
- Cold turkey event: wellness event that promoted the Great American Smoke Out and celebrated staff who quit smoking and provided motivation for those who were thinking about quitting smoking.
- Holiday trainings and celebrations: events are hosted around holidays that helps staff with wellness both physical and mental during holidays
- Resource for Living: resource that provides webinars that cover topics from parenting skills to managing finances.
- Financial wellness event: webinar on planning for the future

Our reputation as an employer of choice enables us to attract and retain the best-qualified candidates, as evidenced by the recognition we have received from a variety of organizations. For example, the United States Business Leadership Network recently recognized the Aetna organization as a best place to work and the American Association of People with Disabilities honored Aetna for our disability-inclusive business practices. Additionally, in 2018, **we were included for the 11th time since 2001 on *DiversityInc*'s list of the Top 50 Companies for Diversity[4].**

[4] "The 2018 *DiversityInc* Top 50 Companies for Diversity," National Black MBA Association website: accessed June 19, 2019; https://nbmbaa.org/the-2018-diversityinc-top-50-companies-for-diversity/.

Our core values of integrity, excellence, caring, and inspiration shape our culture. Aetna conducts business using a clear, strongly held set of core beliefs and values that reflect who we are and how we approach the hiring, development, and retention of our staff. Our culture is positive, transparent, and inclusive. Routine management planning and strategy meetings, all-staff town hall meetings in which all levels of management present updates and new projects, and the implementation of various engagement and recognition programs have all served us well to improve satisfaction and retention year over year.

Aetna is a Recognized Employer of Choice

- Human Rights Campaign Foundation Corporate Equality Index: 100% rating
- United States Business Leadership Network Best Place to Work
- American Association of People with Disabilities Disability Equality Index: 100% Rating
- *DiversityInc's* Top 50 Companies for Diversity
- National Association of Female Executives Top 60 Companies for Executive Women
- Military Friendly® Silver Status
- *Black EOE Journal* named Aetna to its 2018 Best of the Best lists: Top Employer and Top LGBTQ-Friendly Employer
- Latina Style 50 list for 2018 (recognizes the best companies for Latinas to work in the U.S.)

b. Organizational Structure

Aetna's organizational structure provides sufficient personnel to fulfill the requirements of the Kentucky Medicaid managed care program. The leadership team is responsible for maintaining a level of staffing necessary to perform and carry out all the functions, requirements, roles, and duties described, regardless of the level of staffing included in our proposal. Aetna's hiring approach assesses the size and demographic makeup of our enrollees and the Commonwealth to ensure we have qualified team members in all roles to contribute to the successful operation of our Medicaid managed care program in Kentucky.

b.i. Management Structure, Lines of Responsibility, and Authority for all Operational Areas of the Contract

Aetna Better Health of Kentucky's organizational structure provides clear lines of authority and accountability, including direct functional connections between departments and positions (please refer to **Figure B.3-8**). This fosters open communication and coordination of effort among executive leadership, management, and staff serving the Kentucky Medicaid Program.

Our **onsite, local Aetna leadership team** in Kentucky manages the delivery and operations of the Medicaid managed care program, leveraging our longstanding, positive relationships with providers, community resources, advocacy groups, regulatory agencies, and other organizations throughout the Commonwealth.

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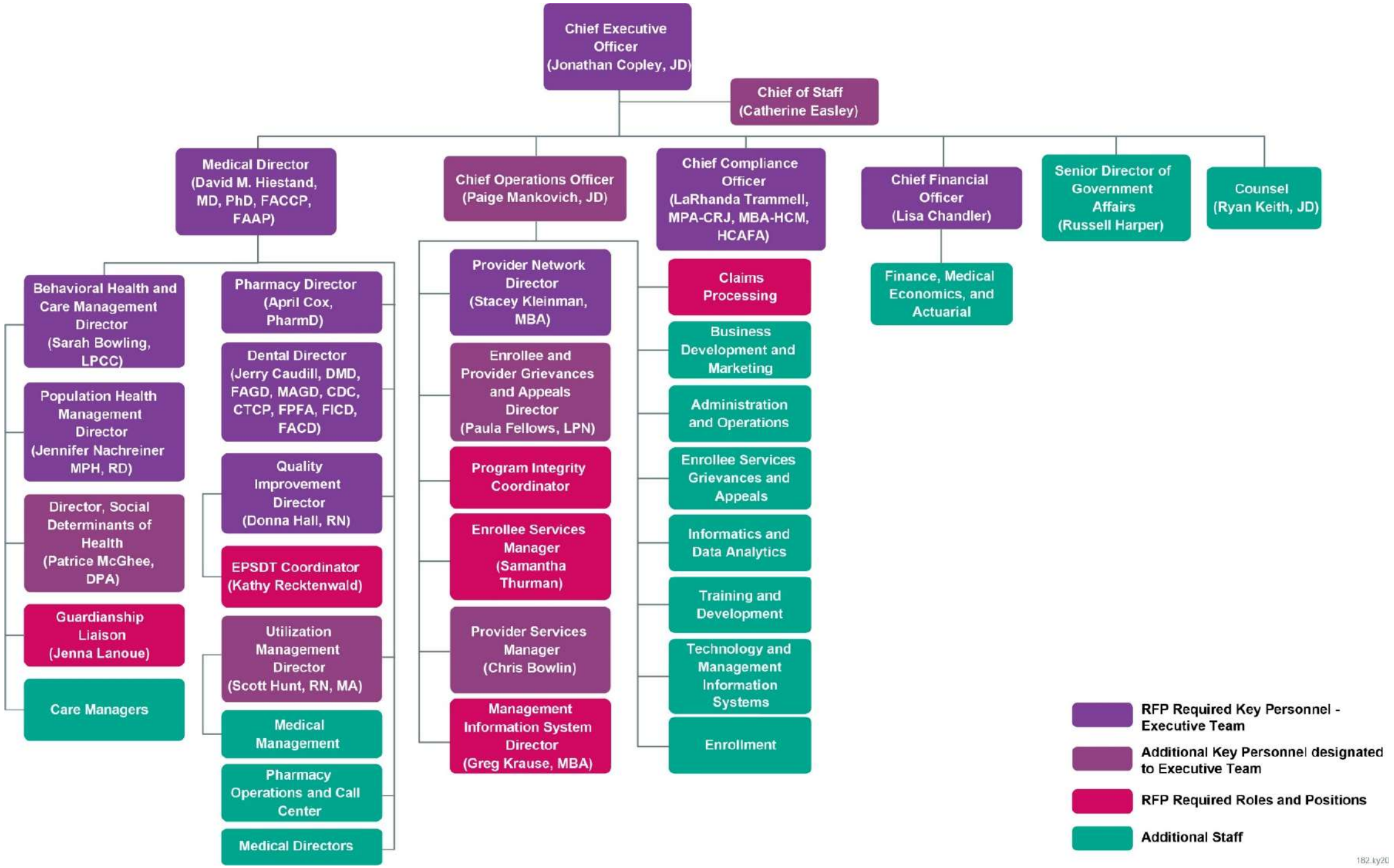

Figure B.3-8: Aetna Better Health of Kentucky Organizational Design

Our organizational structure supports an integrated model of care and service delivery for an enhanced enrollee and provider experience.

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Attachment A provides organizational charts that illustrate the integration of our organizational structure within Aetna Inc. Plan leadership is empowered to make rapid-cycle decisions, ensuring timely and responsive action while delivering high-quality care and services. Regular meetings, clear responsibilities, and a positive rapport enable the team to function as a cohesive, productive unit to meet all contract requirements. Please refer to **Attachment C** for copies of Aetna's articles of incorporation, bylaws, partnership agreements, or similar business entity documents

b.ii. Parent Company Organizational Structure

Please refer to **Figure B.3-9**, Aetna Better Health of Kentucky's Relationship to its Parent Entities, for an organizational chart depicting Aetna Better Health of Kentucky's relationship to its parent entities. For a more extensive organizational chart that includes Aetna Better Health of Kentucky's parent entities and its affiliated entities that (1) are subsidiaries of Aetna Inc., (2) provide PBM services for Aetna Better Health of Kentucky (CaremarkPCS Health, L.L.C.), and (3) are parents of CaremarkPCS Health, L.L.C., please refer to **Attachment A**.

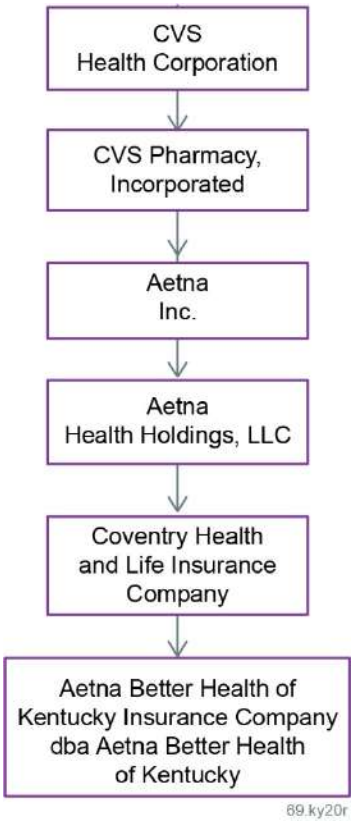

Figure B.3-9: Aetna Better Health of Kentucky's Relationship to its Parent Entities

Aetna Better Health of Kentucky enjoys tremendous support from our parent entities in providing health care services to our Kentucky enrollees

b.iii.-b.iv. Subcontractors

Aetna undertakes subcontracts only when it adds value for our enrollees. We use well-qualified, experienced subcontractors to provide services in support of the Kentucky Medicaid program—subcontractors with unique expertise and proven records of accomplishment relative to improving outcomes for our enrollees by providing appropriate, coordinated care and services in a financially responsible manner. All our proposed subcontractors have an established relationship with

Aetna and currently demonstrate sustained quality performance serving Kentucky Medicaid enrollees in a seamless manner.

Subcontractor oversight is integrated into the health plan organizational structure with clear lines of responsibility and oversight to ensure a streamlined experience for enrollees, providers, and the Department. Please refer to **Figure B.3-10** for an illustration of how each subcontractor will be integrated into Aetna's services.

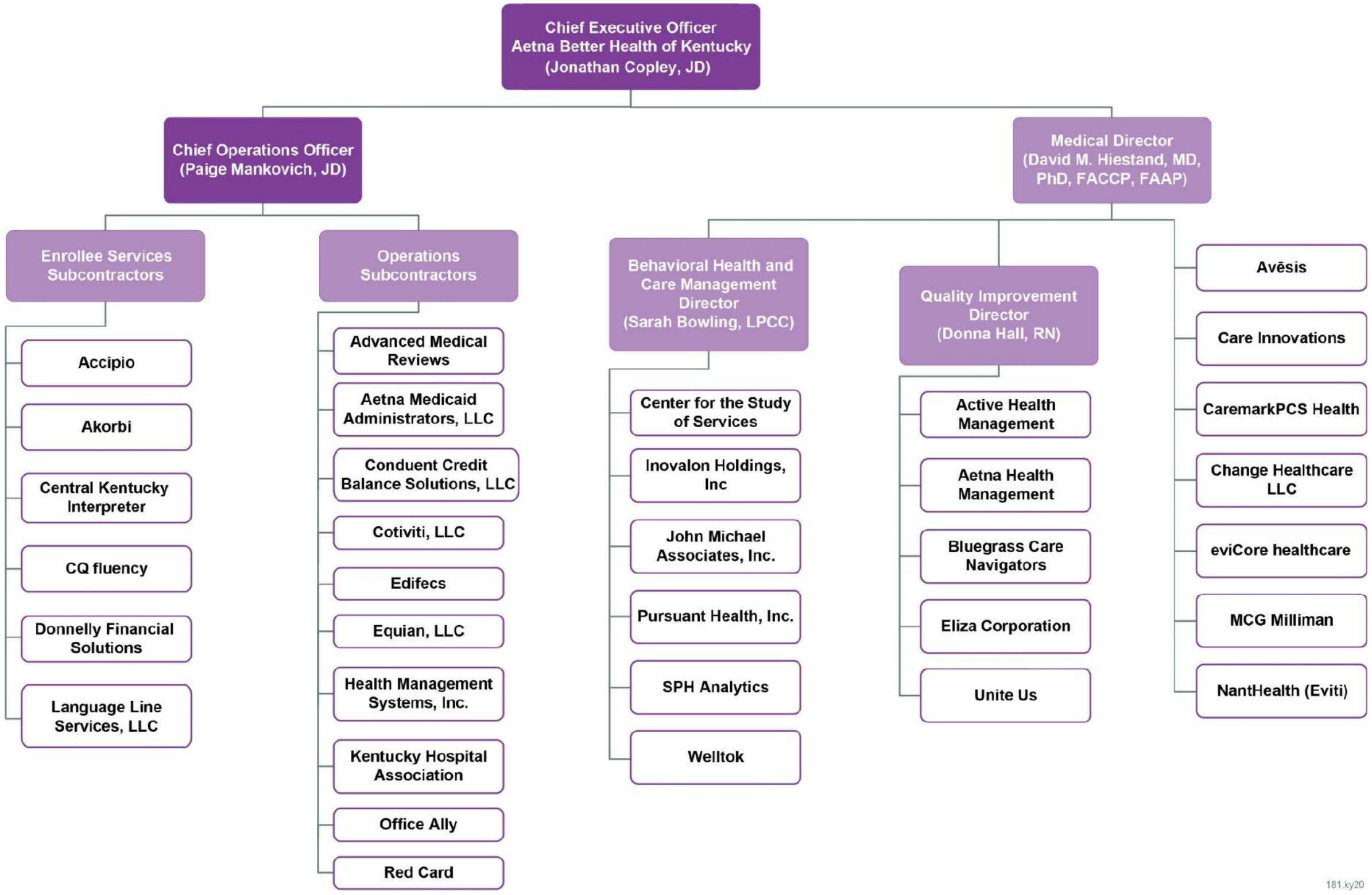

Figure B.3-10: Integration of Subcontractors into Program Services

Subcontractor oversight is integrated into the health plan organizational structure with clear lines of responsibility and oversight.

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Table B.3-3 describes the role of each Aetna subcontractor.

Table B.3-3: Subcontractors Supporting Aetna Better Health of Kentucky

Subcontractor's Name	Role
Accipio Language Services	Provides translation services for enrollees
ActiveHealth Management, Inc. (subsidiary of CVS Health)	ActiveHealth will provide an online member website to Aetna that includes the following products: Personal Health Record, Health Assessment for adults, and online Disease Management and Health Coaching
Advanced Medical Reviews, LLC (subsidiary of ExamWorks Group, Inc.)	Provides advisory medical reviews and recommendations for medical necessity or medical appropriateness of treatment
Aetna Health Management, LLC	After-hours call center; credentialing for certain types of network providers; pharmacy benefit management administrative services (when not performed by CVS Health or the Health Information line [Nurse line])
Aetna Medicaid Administrators LLC	Enrollment processing, claims payment administration, and actuarial and reporting functions
Akorbi Consulting	Provides qualified and professional interpreters for onsite, sign language, video, and telephone interpretation
Avēsis	Dental and eye care benefits administration
Bluegrass Care Navigators	Transitional care for enrollees, including post-hospital discharge intervention, planning, and assessment, development of a care plan for post-discharge, and home follow-up visits; coordinates with Aetna case managers to ensure safe transition from acute care to the enrollee's home
Care Innovations	Provides remote patient monitoring for enrollees including programs and devices for disease conditions
CaremarkPCS Health	Pharmacy benefit manager
Center for the Study of Services	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey administrator, including mailing survey to enrollees, telephonic follow-ups
Central Kentucky Interpreter	Provides services to enrollees who are deaf or require other special communication techniques
Change Healthcare LLC	SSI Advocate, Medical Network EDI Claims/Real-time, Payments, CPS/Print and InterQual Medical Necessity Criteria
Conduent Credit Balance Solutions, LLC (parent Conduent Inc)	Hospital credit balance identification and recovery at hospitals in Kentucky
Cotiviti, LLC	Performs data mining and recovery audit services, as well as software for claims edits
CQ fluency	Enrollee material translation services
Donnelley Financial Solutions	Printing, inventory, and mailing of enrollee enrollment materials
Edifecs	Encounter validation and submission vendor
Eliza Holdings Corp. (Eliza)—part of HMS Holdings Corp.	Provides automated communications including telephone and email/text messaging for new enrollee onboarding, health risk assessment, appointment and service reminders, and post-discharge assessments
Equian, LLC	Reviews claims for possible overpayments and subsequent resolution and recovery; also pursues subrogation claims in cases of third-party liability

Subcontractor's Name	Role
eviCore healthcare MSI, LLC d/b/a eviCore healthcare (f/k/a MedSolutions, Inc.)	Medical necessity review for radiology and musculoskeletal pain management services
Health Management Systems, Inc. (HMS)—part of HMS Holdings Corp.	Performs coordination of benefits and third-party liability identification and recovery services
Inovalon Inc.	Healthcare Effectiveness and Data Information Set data management system
John Michael Associates Inc.	Mail vendor for enrollee incentive gift cards
Kentucky Hospital Association	Delegated credentialing of network providers
Language Line Services,Inc.	On-demand language access provider with remote interpretation and translation solutions
MCG/Milliman	Medical necessity criteria
Nanthealth (Eviti)	Provides utilization management review for oncology treatment as well as access to and use of web-based decision platform for Aetna providers to obtain evidence-based treatment plans and prior authorizations
Office Ally	Claim intake vendor: identify, validate, and recover or resolve claim payment variances
Pursuant Health Inc.	Provides multichannel access points and communication to educate and engage enrollees about incentivized activities, covered services, and wellness topics
Red-Card Systems, LLC/Red Card Holdings, LLC	Provides print production and mailing of enrollee identification cards
Symphony Performance Health, Inc. d/b/a SPH Analytics	SPH Analytics partners with Aetna Better Health of Kentucky to administer an annual provider satisfaction survey and an annual behavioral health enrollee satisfaction survey. The provider satisfaction survey targets health care providers in the Aetna Better Health of Kentucky network to measure their satisfaction with the health plan.
Unite USA, Inc., dba Unite Us	Provides a network and coordination of services to enrollees including housing assistance, nutrition counseling, and transportation
Welltok	Provides multichannel communication to educate and engage enrollees about incentivized activities, covered services, and wellness topics

Aetna performs ongoing monitoring of subcontractor performance. We meet with subcontractors on a weekly, monthly, or quarterly basis, depending on the subcontractor, and perform a comprehensive review annually in which we measure performance efforts that address past concerns identified by the Department. If any deficiencies or areas for improvement are identified, we require the subcontractor to take corrective action. Aetna provides the Department with a copy of the annual review and any corrective action plans developed as a result. Aetna performs ongoing monitoring of subcontractor performance, as depicted in **Figure B.3-11.** We meet with subcontractors on a weekly, monthly, or quarterly basis, depending on the subcontractor, and perform a comprehensive review at least annually in which we review ongoing performance as well as measure performance efforts that address past concerns identified by the Department. If any deficiencies or areas for improvement are identified, we require the subcontractor to take corrective action. If requested, Aetna provides the Department with a copy of the annual review and any corrective action plans developed as a result.

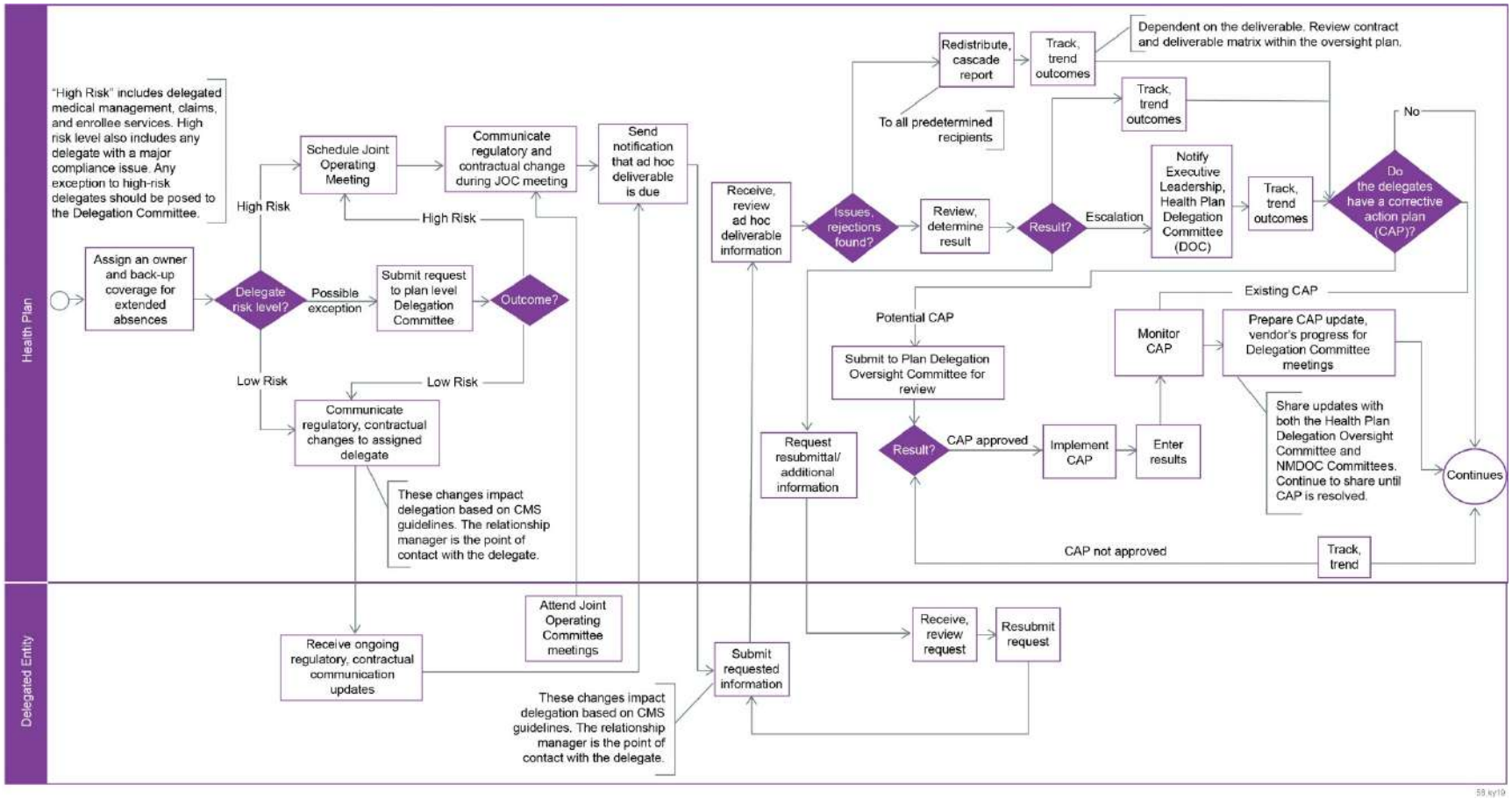

Figure B.3-11: Delegation Oversight End-to-End Workflow

Aetna understands all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business.

Example: Seamless Subcontractor Integration

Avēsis has seamlessly delivered eye care benefits management for Aetna's Kentucky Medicaid program since 2014. They have delivered integrated dental benefits management services since 2011. Avēsis' dedicated, in-state dental director, Jerry Caudill, DMD, is designated as key personnel within the Aetna Better Health of Kentucky organizational structure.

Avēsis provides the following staffing support:

- Relationship Management team made up of a strategic client partner and account executive (two staff members)
- Clinical Management team anchored by Jerry Caudill, DMD (two staff members)
- Dental Provider Recruitment and Relations team (five staff members, four of whom live in the Commonwealth)
- Eye Care Provider Recruitment and Relations (one staff member)
- In addition, Avēsis' chief optometric officer collaborates with the clinical director of eye care utilization management to deliver peer support for eye care providers who serve Aetna's Kentucky Medicaid enrollees

Over the course of our eight-year relationship with Avēsis in the Commonwealth, we have developed a streamlined experience for enrollees, providers, and the Department by doing the following:

- Ensuring enrollees and providers who contact the dental or eye care call center understand they are reaching Aetna Better Health of Kentucky as their Kentucky Medicaid managed care plan
- Requiring Avēsis to provide Aetna with comprehensive files to access and resolve formal complaints and appeals within the contractual timeframes
- Co-branding formal enrollee and provider correspondences
- Integrating Avēsis dental and eye care provider search links in the Aetna Better Health of Kentucky enrollee portal
- Consistently meeting and exceeding performance metric standards and delivering timely reporting to Aetna to help ensure Aetna is providing timely, accurate, and comprehensive reporting to the Department
- Avēsis representing Aetna at the quarterly Dental Technical Advisory Committee (TAC) meetings, the quarterly Optometric TAC meetings, and the quarterly Advisory Council for Medical Assistance meetings
- Avēsis representing Aetna at professional meetings across the Commonwealth (e.g., Tele-dentistry Committee and the Kentucky Optometric Association)

b.v. Full-time Equivalents Dedicated to the Contract

We have approximately 250 FTEs dedicated to the **Draft Medicaid Managed Care Contract and Appendices**, including the following listed in **Table B.3-4**:

Table B.3-4: FTE Dedicated to the Kentucky Medicaid Program

Operational Area	Position Type and Number of FTE
Leadership (18 FTE)	• Executive Director (1) • Chief of Staff (1) • Chief Financial Officer (1) • Chief Compliance Officer (1) • Compliance Coordinator (1) • Finance, Medical Economics and Actuarial (13)

Operational Area	Position Type and Number of FTE
Medical (124 FTE)	• Chief Medical Director (1) • Behavioral Health and Care Management Director (1) • Population Health Management Director (1) • Director, Social Determinants of Health (1) • Pharmacy Director (1) • Dental Director (1) • Utilization Management Director (1) • Guardianship Liaison (1) • Care Managers (39) • Medical Management (71) • Medical Directors (6)
Enrollee Services (34 FTE)	• Enrollee and Provider Grievance and Appeals Director (1) • Enrollee Services Manager (1) • Enrollee Services Staff (20) • Grievance and Appeals Staff (12)
Operations (52 FTE)	• Chief Operations Officer (1) • Provider Network Director (1) • Program Integrity Coordinator (2) • Provider Services Manager (1) • Management Information System Director (1) • Network Operations/Credentialing Team (14) • Provider Services Team (13) • Community Outreach Coordinators (8) • Project Managers (2) • Network Contractors (2) • Informatics Analysts (4) • Administrative Assistants (3)
Quality Improvement (26 FTE)	• Quality Improvement Director (1) • EPSDT Coordinator (1) • Quality Improvement Staff (20) • Community Health Workers (3) • System of Care Worker (1)

Method for Determining the Appropriateness of Staffing Ratios

We base our staffing analysis on our **proprietary Aetna Medicaid organization standard operating model**, which projects staff needed by proven ratios or other metrics appropriate to each position type. Our model captures level of care, category of covered services, category of aid, unique contractual requirements, enrollment levels, use of subcontractors, and other components. While our more than 30 years of experience operating Medicaid plans across the nation drives our staffing model, we also use evidence-based guidelines built on time studies and complexity of care. We will augment staffing in our Louisville office and in each region as necessary so that we can meet all needs of enrollees, providers, and the Commonwealth. Appropriate staffing ratios are essential to a balanced and successful care management program. The staffing ratio tool we use to develop caseloads is based on workload studies that consider time elements, such as how long it takes to schedule and complete an assessment, call an enrollee, or drive to an enrollee's home, as well as time for case rounds with the medical director, community-based service collaboration, interdisciplinary care team meetings, personal development enrichment, training, supervision, and documentation. When we approach the caseload maximum thresholds, our leadership team conducts a staffing review. Based on the results of this review, we submit a requisition to hire additional care managers or reallocate resources, without exceeding the maximum ratios, in a manner that enables us to provide enrollees the services they need.

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60.7.C Technical Approach

Kentucky | Transforming Health Care | **Aetna**

60.7.C.1 Subcontracts

Kentucky | Transforming Health Care | **Aetna**

60.7.C.1 Subcontracts (Sections 4.3 Delegations of Authority and 6.0 Subcontracts)

Aetna Better Health of Kentucky[1] has a proven record of improving outcomes for our enrollees by providing appropriate, coordinated care and services in a financially responsible manner. Our commitment to providing the best and most comprehensive integrated care for enrollees sometimes involves delegating certain services or functions to other organizations that are expert specialists in their disciplines. In this event, we enlist the services of subcontractors to perform specialized functions or services on Aetna's behalf.

a. Approach to Subcontracting Services

Our approach to subcontracting services for this contract includes a comprehensive assessment of potential subcontractors to ensure they are qualified and aligned with the goals of the contract, ongoing collaboration between Aetna and the subcontractor for the best program results, and streamlined communications to ensure the subcontractors are being responsive to the Department and Aetna for the sharing of data, reporting and information.

Assessment of Value to Program and Subcontractors' Credentials

To improve overall access to services and complement our clinical model, we utilize the services of subcontractors that contribute additional capacity, specific experience, or expertise. As part of Aetna's quality management program, we use a comprehensive set of policies and procedures to evaluate and manage the subcontracting of responsibility for any program function. Before deciding to use the services of a subcontractor, Aetna assesses the following:

- The business need for subcontracting
- The cost-to-benefit ratio and the subcontractor's readiness to assume the obligations under a subcontract, including financial integrity, management expertise, and information technology capabilities
- The potential impact on clinical care and service to enrollees

Aetna uses a subcontractor pre-assessment questionnaire in the decision-making process. When the subcontractor is a provider that also renders administrative services, Aetna's process includes a review of the prospective subcontractor's program for adherence to health plan and National Committee for Quality Assurance (NCQA) standards, as well as compliance with applicable federal and Commonwealth laws and regulations. Our staff reviews relevant documentation before conducting an onsite assessment. They use standardized audit tools for evaluation and documentation during assessment of the prospective subcontractor's program. The completed assessment report provides documentation of the prospective subcontractor's strengths and opportunities for improvement and is used by the Quality Management/Utilization Management (QM/UM) Committee to review and approve subcontracted relationships.

Per contract requirements, Aetna policies require a written, signed agreement for all subcontracting arrangements. The agreement outlines the responsibilities of the parties; defines their relationship, rights, and obligations; specifies how we will monitor their performance; and includes required Commonwealth

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its parents, Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Kentucky to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of Kentucky's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Kentucky. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

contract provisions and other terms, including Aetna's remedies if the subcontractor does not meet contractual obligations.

The integration of subcontractors into our program model is an integral part of implementation activities. We conduct implementation meetings with subcontractors to ensure alignment. For example, we hosted Unite Us at our office in Louisville to discuss ways to optimize our collaboration and deliver new and innovative models that improve the engagement between enrollees, traditional health care providers, and social services providers.

Additionally, our subcontractors are required to complete CVS Health and Aetna trainings related to privacy, security, and conduct prior to working with our enrollees, providers, and staff.

Ongoing Collaboration to Serve Enrollees and Providers

We have ongoing collaboration with subcontractors in multiple ways, including conducting monthly Joint Operating Committee meetings to ensure effective, ongoing communication. Avēsis, our dental and vision vendor, attends the Department's Technical Advisory Committee meetings with our team members. We meet weekly with our pharmacy benefit manager, CaremarkPCS Health, to discuss operations.

We monitor our subcontractors for areas of risk such as claims processing and encounters. Our Finance and Quality teams work with the subcontractors to ensure they are meeting their service level agreements. We regularly communicate and work continuously with our subcontractors to promote compliance with reporting requirements. To correct behaviors, reporting and deliverables are discussed as part of the Joint Operating Committee meetings we conduct with our subcontractors. If subcontractors fail to submit complete, timely, and accurate reports, we use training, oversight, corrective action, as well as contractually appropriate sanctions, to address the deficiency.

As an example, we receive dental dashboard reports from Avēsis on a monthly basis. The reports are submitted to our Informatics team via their shared mailbox. The Informatics team prepares the reports for internal review. Aetna's Compliance and Finance departments, as well as our chief medical officer, are copied on the reports.

b. Subcontractor Responsiveness and Accountability

Aetna takes a collaborative approach to ensuring subcontractor responsiveness and accountability for the Kentucky Medicaid program. The chief executive officer, chief medical officer, compliance officer, chief operating officer, director of clinical health services, director of quality management, and selected leadership staff from our Enrollee Services, Provider Services, Network Management, and Grievance and Appeals departments comprise the local-level Delegation Oversight Committee (DOC). These local, executive-level plan leaders and key leaders from functional areas meet with subcontractors on a periodic basis, depending upon the type of subcontractor, to monitor service delivery, troubleshoot problems, review and resolve enrollee complaints, and most importantly, identify opportunities to collaborate on new or enhanced services for enrollees. Additionally, if any delegates are common with other Aetna Medicaid organization or national plans, the National Delegation Vendor Oversight teams perform oversight and audits in conjunction with the local committee.

Conducting Pre-delegation Audits

Aetna utilizes a pre-delegation audit to evaluate the prospective subcontractor's ability to perform the activities to be subcontracted, including their responsiveness to Department requests for reporting, data, and information specific to operation of the Medicaid managed care program. The pre-delegation reviews are conducted by individuals with expertise in the applicable area using standardized audit tools for evaluation. Aetna's process includes a review of the prospective subcontractor's program for adherence to

health plan and National Committee for Quality Assurance (NCQA) standards, as well as compliance with applicable federal and Commonwealth laws and regulations. The pre-delegation review allows Aetna to determine staff qualifications, clinical and administrative capabilities, integration capabilities, data transfer capabilities, operational readiness, and alignment with the Kentucky Medicaid scope of work. Our quality management program includes formal, multilayered processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract, as shown in the Delegation Management Process Flow depicted in **Figure C.1-1.** All aspects of the contract are evaluated through our Compliance Committee to ensure compliance with contractual requirements.

Maintaining Open Lines of Communication

We ensure ongoing collaboration with subcontractors for a streamlined and coordinated approach to serving enrollees and providers by maintaining open lines of communication with subcontractor leaders. For example, Aetna holds regular touchpoints with subcontractors providing covered services to enrollees, such as Avēsis and CaremarkPCS Health. We require our subcontractors to have dedicated account managers who are familiar with Aetna and our Kentucky Medicaid enrollment. We also conduct quarterly Joint Operating Committee (JOC) meetings with subcontractors to whom we delegate covered services. These meetings provide opportunities to discuss topics such as operations, program integrity, and contract compliance issues

Monitoring and Evaluating Service Level Agreements

Aetna performs monitoring and evaluation of service level agreements (SLA) agreed upon between Aetna and subcontractor on a monthly and/or quarterly basis. SLA reporting is reviewed with the DOC to identify areas that are substandard. The routine monitoring allows collaboration between Aetna and the subcontractor in order to address identified deficiencies and implement corrective action. SLA ongoing monitoring includes adherence with claims processing, claims timeliness, call center management and account administration.

Ongoing delegation oversight and monitoring activities include, but are not limited to, the following:

- Monitoring and evaluating delegated functions through at least semiannual reports
- Conducting pre-assessments prior to delegation, with annual desk audits or web conference reviews conducted with a random sampling of files thereafter
- Confirming (no less than annually) that delegated functions/services are carried out consistently and in compliance with both Aetna's and other applicable accredited standards (i.e., NCQA and others as indicated) and the mutually agreed upon delegation agreement
- Performing, at minimum, an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards
- Monitoring ongoing corrective actions to address identified deficiencies, promote progress, and take necessary action, if improvements do not occur
- Monitoring and evaluating service level agreements outlined in contract
- Reviewing the delegated organization's program that oversees the delegated functions and its quality program to verify it is in alignment with Aetna's quality improvement processes
- Monitoring the subcontractor downstream provider agreements to ensure they comply with the regulatory requirements of the Commonwealth contract

The DOC approves all delegates and delegation reports and monitors subcontractor performance at the plan level. All our subcontracts contain language requiring responsiveness to Department requests, and Aetna makes our ongoing expectations clear through continual communication and clearly defined deadlines. We require subcontractors to submit their responses for approval before sending the information to the Department. In this way, we can hold subcontractors accountable and escalate any

issues in a timely manner. **If a subcontractor response to a Department request is delayed, or the subcontractor fails to respond or fails to respond appropriately or in a timely fashion, we place the subcontractor on a corrective action plan (CAP).** Executive-level leaders monitor and report to Compliance the success of CAPs and handle escalated issues if the corrective actions do not produce satisfactory results. Continued failure to comply will lead to penalties as outlined in the subcontract, including monetary penalties and termination of the contract, if necessary.

Aetna Collaborates with Subcontractor to Achieve Prior Authorization Compliance

On May 4, 2018, Aetna placed eviCore on a corrective action plan (CAP) for consistently and chronically demonstrating noncompliance with Commonwealth and federal Requirements with regard to prior authorization requests within Commonwealth-established timeframes that may not exceed two business days following receipt of the request for service, with a possible extension of up to 14 additional days. The issue was identified during an off cycle file review.

As such, by May 11, 2018 Aetna required that eviCore provide us with a response plan of action for organization to immediately come into compliance with our contractual turnaround times. EviCore response included a root cause analysis of the issue and a plan to correct the deficiencies, as well as evidence of their monitoring and oversight of adhering to timeframes.

Aetna required eviCore to provide daily summaries of all requests and their respective turnaround times, including approvals, denials, and extension requests. Within two weeks of providing notification to eviCore, Aetna required 95% compliance with required turnaround times on a daily basis. Within four weeks, Aetna required 99% compliance with required turnaround times on a daily basis.

EviCore identified server capacity issues, workflow routing issues, and delay in notification activities as the cause. EviCore resolved the server capacity issue May 11, 2018. Workflow adjustments and increased oversight/monitoring was completed by May 14, 2018.

The health plan audit for May 2018 revealed 95.3% compliance, which met the 95% compliance goal within two weeks. In June 2018, eviCore remained at 96% compliance and by July it was at 98.8% compliance.

The CAP closed on March 12, 2019. EviCore continues to provide monthly reports for turnaround time metrics.

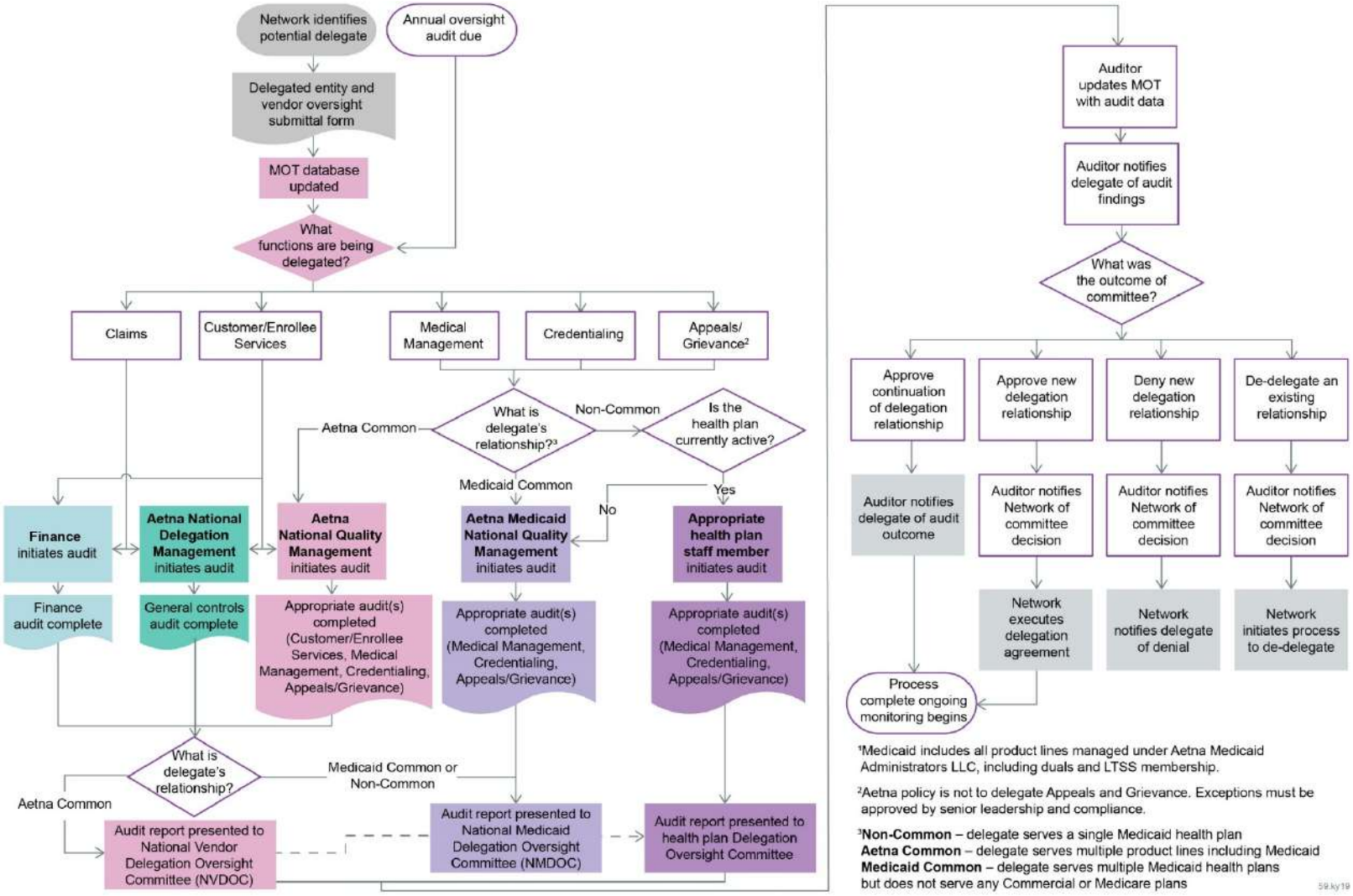

Figure C.1-1: Delegation Management Process Flow

Aetna's quality management program includes formal, multilayered processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract.

c. Subcontractors Supporting the Contract

Aetna utilizes subcontractors only when their service add value for our enrollees. We use well-qualified, experienced subcontractors to provide services in support of the Kentucky Medicaid program—subcontractors with unique expertise and proven records of accomplishment relative to improving outcomes for our enrollees by providing appropriate, coordinated care and services in a financially responsible manner. All our subcontractors have an established relationship with Aetna and currently demonstrate sustained quality performance serving Kentucky Medicaid enrollees. In **Table C.1-1,** we provide the names, roles, and locations of subcontractors that will support any contract awarded as a result of this Request for Proposal.

Table C.1-1: Subcontractors Supporting Aetna Better Health of Kentucky

Subcontractor's Name	Role	Location(s)
Accipio Language Services	Provides translation services for enrollees	Throughout Kentucky
ActiveHealth Management, Inc. (subsidiary of CVS Health)	ActiveHealth will provide an online member website to Aetna that includes the following products: Personal Health Record, Health Assessment for adults, and online Disease Management and Health Coaching	New York, NY (corporate headquarters)
Advanced Medical Reviews, LLC (subsidiary of ExamWorks Group, Inc.)	Provides advisory medical reviews and recommendations for medical necessity or medical appropriateness of treatment	Los Angeles, CA
Aetna Health Management, LLC	After-hours call center; credentialing for certain types of network providers; pharmacy benefit management administrative services (when not performed by CVS Health or the Health Information line [Nurse line])	Hartford, CT
Aetna Medicaid Administrators LLC	Enrollment processing, claims payment administration, and actuarial and reporting functions	Phoenix, AZ
Akorbi Consulting	Provides qualified and professional interpreters for onsite, sign language, video, and telephone interpretation	Headquarters: Plano, TX; Other locations: Oak Brook, IL; Sacramento, CA; Gilbert, AZ; Tucson, AZ
Avēsis	Dental and eye care benefits administration	Corporate headquarters: Phoenix, AZ; Executive offices; Owings Mills, MD
Bluegrass Care Navigators	Transitional care for enrollees, including post-hospital discharge intervention, planning, and assessment, development of a care plan for post-discharge, and home follow-up visits; coordinates with Aetna case managers to ensure safe transition from acute care to the enrollee's home	Lexington, KY
Care Innovations	Provides remote patient monitoring for enrollees including programs and devices for disease conditions	Folsom, CA
CaremarkPCS Health	Pharmacy benefit manager	Phoenix, AZ
Center for the Study of Services	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey administrator, including mailing survey to enrollees, telephonic follow-ups	Washington, DC

Subcontractor's Name	Role	Location(s)
Central Kentucky Interpreter	Provides services to enrollees who are deaf or require other special communication techniques	Central Kentucky
Change Healthcare LLC	SSI Advocate, Medical Network EDI Claims/Real-time, Payments, CPS/Print and InterQual Medical Necessity Criteria	Nashville, TN; San Francisco, CA; Atlanta, GA; Boston MA; Chicago, IL; Philadelphia, PA; Minneapolis, MN
Conduent Credit Balance Solutions, LLC (parent Conduent Inc)	Hospital credit balance identification and recovery at hospitals in Kentucky	Hunt Valley, MD
Cotiviti, LLC	Performs data mining and recovery audit services, as well as software for claims edits	Atlanta, GA
CQ fluency	Enrollee material translation services	Hackensack, NJ
Donnelley Financial Solutions	Printing, inventory, and mailing of enrollee enrollment materials	Lancaster, PA
Edifecs	Encounter validation and submission vendor	Headquarters: Bellevue, WA; Other Location: Atlanta, GA
Eliza Holdings Corp. (Eliza)—part of HMS Holdings Corp.	Provides automated communications including telephone and email/text messaging for new enrollee onboarding, health risk assessment, appointment and service reminders, and post-discharge assessments	Beverly, MA
Equian, LLC	Reviews claims for possible overpayments and subsequent resolution and recovery; also pursues subrogation claims in cases of third-party liability	Headquarters: Indianapolis, IN; Other locations: Montgomery, AL; Scottsdale, AZ; Golden, CO; Norwalk, CT; West Des Moines, IA; Naperville, IL; Louisville, KY ; Bethesda, MD; Woburn, MA; Southfield, MI; Portsmouth, NH; Tulsa, OK; Pittsburgh, PA; Radnor, PA; Franklin, TN; Milwaukee, WI
eviCore healthcare MSI, LLC d/b/a eviCore healthcare (f/k/a MedSolutions, Inc.)	Medical necessity review for radiology and musculoskeletal pain management services	Headquarters: Bluffton, SC; Other locations: Boston, MA; Colorado Springs, CO; Franklin, TN; Melbourne, FL; Plainville, CT; St. Louis, MO; West Seneca, NY
Health Management Systems, Inc. (HMS)—part of HMS Holdings Corp.	Performs coordination of benefits and third-party liability identification and recovery services	New York, NY
Inovalon Inc.	Healthcare Effectiveness and Data Information Set data management system	Corporate headquarters: Bowie, MD; Other locations: Boston, MA; Herndon, VA; Minneapolis, MN; Nashville, TN; Phoenix, AZ; Pittsburgh, PA; Snellville, GA; Tampa, FL; Washington, DC
John Michael Associates Inc.	Mail vendor for enrollee incentive gift cards	Newington, CT
Kentucky Hospital Association	Delegated credentialing of network providers	Louisville, KY
Language Line Services,Inc.	On-demand language access provider with remote interpretation and translation solutions	El Paso, TX; Portland, OR

Subcontractor's Name	Role	Location(s)
MCG/Milliman	Medical necessity criteria	Seattle, WA; Albany, NY; Atlanta, GA; Boise, ID; Boston, MA; Burlington, VT; Chicago, IL; Dallas, TX; Denver, CO; Hartford, CT; Houston, TX; Indianapolis, IN; Little Falls, NJ; Los Angeles, CA; Milwaukee, WI; Minneapolis, MN; New York, NY; Omaha, NE; Orange County, CA; Philadelphia, PA; Phoenix, AZ; Portland, ME; Portland, OR; Salt Lake City, UT; San Diego, CA; San Francisco, CA; St. Louis, MO; Tampa, FL; Walnut Creek, CA; Washington, DC
Nanthealth (Eviti)	Provides utilization management review for oncology treatment as well as access to and use of web-based decision platform for Aetna providers to obtain evidence-based treatment plans and prior authorizations	Culver City, CA; Philadelphia, PA
Office Ally	Claim intake vendor: identify, validate, and recover or resolve claim payment variances	Vancouver, WA; Irvine, CA; San Antonio, TX
Pursuant Health Inc.	Provides multichannel access points and communication to educate and engage enrollees about incentivized activities, covered services, and wellness topics	Atlanta, GA
Red-Card Systems, LLC/Red Card Holdings, LLC	Provides print production and mailing of enrollee identification cards	St. Louis, MO
Symphony Performance Health, Inc. d/b/a SPH Analytics	SPH Analytics partners with Aetna Better Health of Kentucky to administer an annual provider satisfaction survey and an annual behavioral health enrollee satisfaction survey. The provider satisfaction survey targets health care providers in the Aetna Better Health of Kentucky network to measure their satisfaction with the health plan.	Fort Worth, TX; Farmington Hills, MI; Duluth, GA
Unite USA, Inc., dba Unite Us	Provides a network and coordination of services to enrollees including housing assistance, nutrition counseling, and transportation	New York, NY
Welltok	Provides multichannel communication to educate and engage enrollees about incentivized activities, covered services, and wellness topics	Denver, CO

d. Subcontractor Experience

In **Table C.1-2,** we describe the relevant experience of each subcontractor and indicate whether, and for how long, they have provided services for Aetna's Medicaid organization and/or Aetna Better Health of Kentucky for prior contracts of similar size and scope.

Table C.1-2: Relevant Experience of Subcontractors

Subcontractor's Name	Relevant Experience	Contracts with Aetna
Accipio Language Services	Has been incorporated since 2005 and has provided translation services to Aetna's Kentucky Medicaid enrollees since 2012.	Accipio Language Services has been providing services to Aetna's Kentucky Medicaid enrollees since 2012.
Active Health Management, Inc. (a subsidiary of CVS Health)	Active Health Management, Inc., an affiliate of Aetna Better Health of Kentucky, is a clinically based, technology-driven health management services company covering over 20 million enrollees. ActiveHealth has established capabilities, stability, and credibility with nearly 20 years of market leadership and innovation.	ActiveHealth has been providing services to Aetna's Medicaid organization since approximately 2007. ActiveHealth has been providing services to Aetna's Kentucky Medicaid enrollees 2016.
Advanced Medical Reviews, LLC (subsidiary of ExamWorks Group, Inc.)	Founded in 2004, Advanced Medical Reviews, LLC (AMR) provides independent medical case review and utilization management services that are timely and customizable, covering all specialties and subspecialties nationwide.	Advanced Medical Reviews, LLC has been providing services to Aetna's Kentucky Medicaid enrollees since 2014
Aetna Health Management, LLC	Aetna Health Management began operations in May 1993 and has performed services for Aetna's Medicaid health plans nationally since 2004. It has been providing services to Aetna's Kentucky Medicaid enrollees since 2011.	Aetna Health Management has performed services for Aetna's Medicaid health plans nationally since 2004. Aetna Health Management has been providing services to Aetna's Kentucky Medicaid enrollees since 2011.
Aetna Medicaid Administrators LLC	Aetna Medicaid Administrators is a leader in Medicaid managed care with 30 years of experience managing the care of the most medically vulnerable. Aetna Medicaid Administrators manages health plans that serve approximately 2.3 million people in 16 states, including Kentucky, Arizona, California, Florida, Illinois, Kansas, Louisiana, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, Virginia, West Virginia, and Texas.	Aetna Medicaid Administrators LLC has been providing services to Aetna's Medicaid organization since 2008. It has been providing services to Aetna's Kentucky Medicaid enrollees since 2011.
Akorbi Consulting	Akorbi is a trusted language service provider offering staffing, enterprise translation, interpretation, localization, and technology solutions to health care plans and the health care industry. The world's largest companies use Akorbi's enterprise language services to translate content, reduce translation costs, increase speed-to-market, and minimize project management costs. Akorbi's professional document translation services are available in more than 170 languages. Certified as a woman-owned company, Akorbi was founded on providing the highest quality possible, and on devotion to customer satisfaction. Akorbi services and administers onsite, over the phone, and video interpretation in 170 languages. The Akorbi Enterprise Management Model oversees fraud, waste, and abuse prevention, cost savings, and cost avoidance; and its control metrics meet Centers for Medicare and Medicaid Services (CMS) compliance and reporting requirements.	Aetna's Medicaid organization has utilized the services of Akorbi since 2015. Akorbi has been providing services to Aetna's Kentucky Medicaid enrollees since 2016.

Subcontractor's Name	Relevant Experience	Contracts with Aetna
Avēsis	Avēsis manages the administration of dental and eye care benefits for the Kentucky Medicaid enrollees whose care is entrusted to Aetna. Avēsis has developed a streamlined experience for Kentucky enrollees, providers, and the Department by providing the following delegated dental and vision services: claims adjudication, prior authorization, enrollee call center, network recruitment, including credentialing, network and provider management including provider call center, and quality assurance and performance improvement.	Avēsis has provided dental benefits to Aetna's Kentucky enrollees since plan inception in 2011 and eye care benefits since 2014.
Bluegrass Care Navigators	Bluegrass Care Navigators provides transition services for Aetna's Kentucky enrollees who are discharged from inpatient care, including medication reconciliation, medication education, ensuring physician follow-up, assessment, resource referral, and coaching regarding medical conditions.	Bluegrass Care Navigators has been providing services to Aetna's Kentucky Medicaid enrollees since 2016.
Care Innovations	Care Innovations supplies remote patient monitoring to monitor patients with various chronic conditions from their home after discharge from hospital or emergency department. Care Innovations' clinical specialists are nurses by background and have over 20 years of experience in the telehealth and remote patient monitoring industry and provide services to 5 Aetna Medicaid affiliates.	Aetna's Medicaid organization has utilized the services of Care Innovations since 2015. Care Innovations has been providing services to Aetna's Kentucky Medicaid enrollees since 2019.
CaremarkPCS Health	CaremarkPCS Health is the pharmacy benefit management and mail service pharmacy segment of CVS Health, providing a full range of PBM services. Pharmaceutical Card System (PCS), a predecessor of Caremark, was founded in 1969 in Scottsdale, Arizona, effectively launching the pharmacy benefit management industry.	Aetna's Medicaid organization has utilized the services of CaremarkPCS Health since 2010. CaremarkPCS Health has been providing services to Aetna's Kentucky Medicaid enrollees since 2016.
Center for the Study of Services	CSS provides enrollees surveys to Aetna health plans, including HealthCare Effectiveness and Data Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys for commercial and Medicaid plans, and CAHPS and health outcomes surveys for Medicare plans.	Aetna's Medicaid organization has utilized the services of Center for the Study of Services since 2008. Center for the Study of Services has been providing services to Aetna's Kentucky Medicaid enrollees since 2015.
Central Kentucky Interpreter	Central Kentucky Interpreter is a not-for-profit agency, providing professional, qualified, and licensed interpreters for many different settings. Various settings include, educational, industrial, legal, medical, mental health, religious, social services, and many more. Central Kentucky Interpreter is a member of RID, (The Registry of Interpreters for the Deaf). Central Kentucky Interpreter is a member of NAJIT (National Association of Judicial Interpreters and Translators).	Central Kentucky Interpreter has been providing services to Aetna's Kentucky Medicaid enrollees since 2012.

Subcontractor's Name	Relevant Experience	Contracts with Aetna
Change Healthcare LLC	Change Healthcare has been a solutions partner with Aetna Medicaid and its affiliates for six years, providing a variety of health care technology solutions across the continuum of care. CHC is in a constant state of developing and deploying new technologies and tool sets to increase efficiency, decrease cost, and enhance the user experience for our clients. This business is currently covered under an enterprise-wide agreement with Aetna.	Aetna's Medicaid organization has utilized the services of Change Healthcare LLC since 2012. Change Healthcare LLC has been providing services to Aetna's Kentucky Medicaid enrollees since 2016.
Conduent Credit Balance Solutions, LLC (parent Conduent Inc)	Conduent has partnered with the Aetna Medicaid organization since 2014, identifying overpayments and returning them to Aetna. Conduent has or is in the process of finalizing agreements with 12 additional Aetna plans.	Aetna's Medicaid organization has utilized the services of Conduent since 2014. Conduent has been providing services to Aetna's Kentucky Medicaid enrollees since 2018.
Cotiviti, LLC (Cotiviti)	Cotiviti is a leading solutions and analytics company that is reshaping the economics of health care, helping its clients uncover new opportunities to unlock value. Cotiviti's solutions are a critical foundation for healthcare payers in their mission to lower healthcare costs and improve quality through higher performing payment accuracy, quality improvement, risk adjustment, and network performance management programs. We currently serve more than 180 health plans, including 24 of the top 25 payers and more than 90 percent of Blues plans.	Aetna's Medicaid organization has utilized the services of Cotiviti since 2016. Cotiviti has been providing services to Aetna's Kentucky Medicaid enrollees since 2016.
CQ fluency	CQ provides document translation, 508 compliance, website hosting, document creation and graphic design. CQ fluency has been hosting and translating the Aetna Better Health of Kentucky website since February of 2016. CQ fluency also provides website hosting and translation for the websites of 13 other Aetna Medicaid plans.	Aetna's Medicaid organization has utilized the services of CQ fluency since 2016. CQ fluency has been providing services to Aetna's Kentucky Medicaid enrollees since 2016.
Donnelley Financial Solutions	Donnelley Financial Solutions has been servicing Aetna Medicaid for eight years and has been printing and fulfilling Kentucky Medicaid kits for over three years. Donnelly Financial Solutions also provide similar services to 12 additional Aetna Medicaid plans.	Aetna's Medicaid organization has utilized the services of Donnelley Financial Solutions since 2011. Donnelley Financial Solutions has been providing services to Aetna's Kentucky Medicaid enrollees since 2011.
Edifecs	Edifecs provides an integrated platform that manages the end-to-end lifecycle submission and reconciliation. Edifecs has been working with Aetna implementing the encounter management system over the last two years to support all Aetna Medicaid state submissions and reconciliation. Specifically for Aetna Better Health of Kentucky, Encounter Management has been live for over a year with submitting and reconciling encounters for Kentucky Medicaid.	Aetna's Medicaid organization has utilized the services of Edifecs since 2017. Edifecs has been providing services to Aetna's Kentucky Medicaid enrollees since 2018.

Subcontractor's Name	Relevant Experience	Contracts with Aetna
Eliza Holdings Corp. (Eliza) - part of HMS Holdings Corp.	Eliza, a pioneer in health care communication technology, has been providing multichannel communication programs for commercial, Medicare, and Medicaid health plans for over 15 years.	Aetna's Medicaid organization has utilized the services of Eliza Corporation since 2014. Eliza Corporation has been providing services to Aetna's Kentucky Medicaid enrollees since 2016.
Equian, LLC	Equian was established in 2004 as Health Systems International, focusing on network solutions and ancillary payment integrity solutions. Today, Equian provides end-to-end payment integrity solutions and operates worldwide. Equian works on behalf of clients to identify claims with accident-related diagnoses for investigating potential third-party liability.	Equian has been providing services to Aetna's Kentucky Medicaid enrollees since 2011, and to other health plans in the Aetna Medicaid organization since 2014.
eviCore healthcare MSI, LLC d/b/a eviCore healthcare (f/k/a MedSolutions, Inc.)	eviCore is a leading provider of medical benefits management (MBM) solutions that assist health plans in reducing costs and help enrollees receive the most appropriate and necessary care based on their clinical presentation. eviCore's gained MBM expertise from more than 25 years of experience bringing its clients practical, innovative, and effective strategies that reduce costs while guiding providers and their patients to higher quality, evidence-based care. eviCore offers ten major solutions: medical oncology; radiation therapy; specialty drug management; laboratory management; musculoskeletal; cardiology; radiology; sleep; gastroenterology; and post-acute care.	Aetna's Medicaid organization has utilized the services of EviCore: MedSolution since 2014. EviCore: MedSolution has been providing services to Aetna's Kentucky Medicaid enrollees since 2015.
Health Management Systems, Inc. (HMS)- part of HMS Holdings Corp.	HMS is the nation's leading provider of comprehensive third-party liability (TPL) identification and recovery services for government health care programs. Since its founding more than 40 years ago, HMS has focused exclusively on serving the needs of health care programs. In 1985, HMS began providing TPL to state Medicaid agency clients. HMS provides Medicaid services for more than 40 states—a unique national footprint. It also provides these services to hundreds of health care plans and the federal government.	Aetna's Medicaid organization has utilized the services of Health Management Systems Inc. since 2010. Health Management Systems Inc. has been providing services to Aetna's Kentucky Medicaid enrollees since 2011.
Inovalon Holdings, Inc.	Inovalon, Inc. provides complete administrative and hybrid rate reporting services in support of Aetna's NCQA HEDIS submission process. As an NCQA-certified vendor for the past 18 years, Inovalon's experienced teams will support the Aetna Medicaid team as they complete the key milestones and tasks associated with the HEDIS reporting requirements using Inovalon's quality measurement and reporting software.	Aetna's Medicaid organization has utilized the services of Inovalon since 2012. Inovalon has been providing services to Aetna's Kentucky Medicaid enrollees since 2012.

Subcontractor's Name	Relevant Experience	Contracts with Aetna
John Michael Associates Inc.	JMA is a provider of promotional products management services and web-based procurement applications to Aetna and to Aetna Better Health of Kentucky. Their services include branded promotional merchandise including custom products, and kitting and fulfillment services.	Aetna's Medicaid organization has utilized the services of John Michael Associates Inc. since 2007. John Michael Associates Inc. has been providing services to Aetna's Kentucky Medicaid enrollees since 2014.
Kentucky Hospital Association	The Kentucky Hospital Association has partnered with Center Care to supply delegated credentialing services to Aetna Better Health of Kentucky. Center Care has provided provider network solutions for health plans since 1989.	Kentucky Hospital Association has been providing services to Aetna's Kentucky Medicaid enrollees since 2019.
Language Line Services,Inc.	Language Line provides a full suite of language solutions in over 240 languages. Language Line has 37 years of experience with 28,000 clients.	Language Line has been providing services to Aetna's Kentucky Medicaid enrollees since 2020.
MCG/Milliman	MCG licenses evidence-based guidelines and support software to healthcare entities. Additional support including clinical educators, project managers, and technical and clinical support staff will be brought to bear on the contract as needed, the majority of which are based out of MCG's headquarters in Seattle, WA	Aetna's Medicaid organization has utilized the services of MCG/Milliman since 2007. MCG/Milliman has been providing services to Aetna's Kentucky Medicaid enrollees since 2015.
Nanthealth (Eviti)	Eviti Connect provides expertise and integration with an external base of oncology guidelines allowing Aetna Better Health of Kentucky to make informed decisions when authorizing or denying enrollee care. Eviti Connect serves as a conduit between the oncology providers and Aetna Better Health of Kentucky, performing an automated analysis of the care plan. If any deviation from evidence-based care is flagged, the Eviti Medical Office team reviews and issues a recommendation for approval or denial. Aetna Better Health of Kentucky will be able to review the treatment plan reviews in real-time and enter the information into Aetna Better Health of Kentucky systems to generate letter to the provider.	Aetna's Medicaid organization has utilized the services of Nanthealth (Eviti) since 2017. Nanthealth (Eviti) has been providing services to Aetna's Kentucky Medicaid enrollees since 2017.
Office Ally	Office Ally takes in provider claims data and transmits to Kentucky Medicaid. Office Ally also retrieves 835 data and returns it back to the providers.	Aetna's Medicaid organization has utilized the services of Office Ally since 2013. Office Ally has been providing services to Aetna's Kentucky Medicaid enrollees since 2018.

Subcontractor's Name	Relevant Experience	Contracts with Aetna
Pursuant Health Inc.	Aetna Better Health of Kentucky contracts with Pursuant Health to reach and reward our enrollees. We use their platform, which includes web, mobile, and kiosk channels, to collect important health data and manage the rewards for our quality programs. Their kiosk channel is comprised of self-service health kiosks that are conveniently located in all Kentucky Walmart pharmacies. We plan to use their platform to increase completions of health risk assessments and diabetic eye exams. In fact, we were the first to pilot an on-demand, kiosk-based diabetic eye screening in 2018. Additionally, we use their various engagement channels, like texting and print mail, to engage our members.	Pursuant Health Inc. has been providing services to Aetna's Kentucky Medicaid enrollees since 2018.
Red-Card Systems, LLC / Red Card Holdings, LLC	Aetna Better Health contracts with Red Card for streamlined design and production of enrollee communications upon enrollment, including welcome kits and identification cards.	Red Card has been providing services to Aetna's Kentucky Medicaid enrollees since 2013, and to other health plans in the Aetna Medicaid organization since 2016.
Symphony Performance Health, Inc. d/b/a SPH Analytics	SPH Analytics has partnered with Aetna on Member and Provider Satisfaction Survey programs since its acquisition of Schaller Anderson in the early 2000's. As of 2016, SPH Analytics has been a preferred survey vendor for Aetna administering member and provider satisfaction surveys for all Aetna Medicaid Plans on an annual basis. SPH Analytics has also worked with numerous Aetna Medicaid Plans for other custom market research programs. For similar types of services and many others around measuring member and provider experience and satisfaction with health plan services, SPH Analytics partners with over 500 health plans throughout the country, including current partnerships with 4 Kentucky Medicaid Managed Care Organizations. SPH Analytics is an NCQA certified and CMS approved survey vendor.	Aetna's Medicaid organization has utilized the services of SPH Analytics since 2006. SPH Analytics has been providing services to Aetna's Kentucky Medicaid enrollees since 2015.
Unite USA, Inc. dba Unite Us	Unite Us is a platform and support for Aetna Better Health of Kentucky, its provider network, and community-based organization to address the social, economic, and behavioral needs for enrollees	Aetna's Medicaid organization has utilized the services of Unite Us since 2019. Unite Us has provided Services to Aetna's Kentucky Medicaid enrollees since 2019.
Welltok	Welltok is currently providing health messaging services through text and secure messaging. Welltok's comprehensive messaging approach is offered through clinically validated population health programs, targeted campaigns, and individualized person to person outreach.	Welltok has partnered with each Aetna Medicaid state plan to engage members for over 6 years with our SMS capabilities, with the exception of California. Welltok supported over 1.2 million Medicaid members in 2019 and engaged those members by sending over 18.5 million messages.

60.7.C.2 Collaboration

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60.7.C.2 Collaboration (Section 9.0 Organization and Collaboration)

Aetna proposes monthly onsite meetings with the Department, other agencies, and other contracted managed care organizations (MCOs) to discuss issues, ideas, and innovations; set up action items; establish topical ad hoc work committees; and determine issue resolution guidelines. The Department's innovative approach was successful in the past with large-scale programs, creating a valuable platform for collaboration.

In addition to our strong partnership with the Commonwealth, Aetna is a leader in collaboration across industries, communities, and initiatives. Chief Executive Officer (CEO) Jonathan Copley has been chosen by his peers to serve as the chairman of the Kentucky Association of Health Plans, a trade association that monitors issues related to MCOs and commercial insurers, health care policy, and tax reform. Further, Mr. Copley chairs the Opioid Response Program for Business, an initiative of the Kentucky Chamber of Commerce's Workforce Center, which works directly with employers to help audit their policies and recommend best practices to maintain a drug-free workplace while supporting a recovery-friendly culture. The initiative focuses on destigmatizing the addiction epidemic and supporting employers' role in opioid prevention, treatment, and recovery in the workplace.

Both of these roles give Aetna a unique opportunity to unite people who may otherwise have never worked together. By breaking down traditional silos, we have identified opportunities to improve not only our enrollees' health and well-being, but the greater well-being of Kentuckians across the Commonwealth.

Aetna's dedication to being a collaborative and innovative partner to Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier Kentucky. We are a loyal partner to the Commonwealth as one of the original MCOs. Providing services since 2011, we partner for solutions during critical times (e.g., transition of Kentucky Spirit enrollees in 2013) and by solely taking on new opportunities (e.g., Quit Incentives & Tailored Support program for pregnant smokers) in the current contract.

We are proud to be local and supported by the resources of the Aetna Medicaid organization, which has a long history of collaborating with Commonwealth agencies, MCOs, providers, and other stakeholders to support successful Medicaid managed care programs. With the Department's guidance and whenever possible, we will work with other MCOs and providers to identify opportunities to continually improve the Medicaid managed care program and advance the health of Kentuckians.

a. Approach for Conducting Monthly Meetings

Aetna shares the Department's vision and is committed to serving as a key partner to the Department and other MCOs to collaborate on issues, ideas, and innovations for the efficient and economical delivery of quality services to enrollees. Aetna proposes adopting the Department's innovative approach used when planning and preparing for previous implementations to promote collaboration among contracted MCOs.

> Aetna is currently taking a leadership role in collaborating with the Commonwealth's MCOs, the Kentucky Hospital Association, providers, and key stakeholders on the new Upper Payment Limit reimbursement program for Medicaid providers. The goal is to reduce administrative burden on hospitals.

In our view, monthly meetings provide an opportunity to collaborate with a wide array of stakeholders to identify and address the core issues that affect Kentucky's health care delivery system. By working together, we can develop solutions to key public health issues, help design effective policy, and achieve the Department's overarching objectives.

As Aetna looks holistically at enrollees' health care, taking the whole person into perspective, our approach for conducting monthly meetings also is holistic. We propose monthly meetings like the forums held during previous implementations to be conducted in collaboration with the Department, the Department of Community Based Services, the Department of Public Health, the Department of Behavioral Health, as well as other MCOs and stakeholders. Each meeting, a sample agenda could focus on a few timely issues and include a brief presentation, an open comment period, and a review of action items. This approach provides opportunities to identify and understand enrollee, provider, and other stakeholder needs; address gaps in care; and align strategies for overcoming barriers to accessing care, simplifying the enrollee and provider experience, addressing the social determinants of health, and promoting enrollee independence and self-management.

We welcome the opportunity to expand our partnership with the Department and its sister agencies through the facilitation and coordination of meetings and committees that serve to identify common objectives and to develop solutions that improve processes and bring one voice to enrollees. Aetna proposes the use of a 'Top Indicators' dashboard, depicted in **Figure C.2-1**, which would allow stakeholders to identify areas for improvement that are conducive to a collaborative, multi-MCO approach, such as chronic disease management strategies. MCOs would share innovations and best practices, collaboratively identify priorities and goals, and design future performance improvement plans. Additionally, Aetna supports developing and participating in future work groups and committees with the Department to further its goals. For example, **we anticipate population health management, provider administrative simplification, and strategy committees may be needed to advance the Department's program goals in the future.**

	Metric	Frequency	Benchmark	2018					2019			
				Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Enrollee Services	Call Quality	Monthly	95%	96.0%	96.7%	96.6%	95.5%	96.9%	95.5%	95.6%	95.7%	96.4%
	Average Speed of Answer (sec)	Monthly	30	17.7	18.3	17.2	13.9	12.3	18.1	12.2	6.4	8.0
	Telephone Service Factor %	Monthly	80%	83.3%	82.2%	85.5%	86.5%	88.4%	84.6%	89.7%	95.6%	96.1%
	Abandonment Rate %	Monthly	5%	1.5%	1.5%	1.4%	1.4%	1.3%	1.6%	1.1%	0.8%	0.9%
	Blocked Call - No Answer %	Monthly	<1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
Appeals and Grievances	Enrollee	Monthly	95%	96.0%	96.7%	96.6%	95.5%	96.9%	95.5%	95.6%	95.7%	96.4%
	Resolved Appeals Timeliness %	Quarterly	100%	N/A	100.0%	N/A	N/A	97.8%	N/A	N/A	100.0%	N/A
	Resolved Appeals Overturn Rate %	Quarterly	n/a	53.4%	36.8%	51.3%	48.3%	54.8%	40.7%	56.4%	56.4%	56.4%
	Resolved Grievances Timeliness %	Quarterly	100%	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	-
	Provider											
	Resolved Appeals Timeliness %	Quarterly	100%	N/A	100.0%	N/A	N/A	99.9%	N/A	N/A	100.0%	N/A
	Resolved Appeals Overturn Rate %	Quarterly	n/a	52.3%	55.9%	50.6%	48.6%	59.7%	48.3%	52.5%	52.5%	52.5%
	Resolved Grievances Timeliness %	Quarterly	100%	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A
Medical Management	Readmission Rates	Monthly	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Outpatient Average Length of Stay	Monthly	-	-	-	-	-	-	0.0	0.0	0.0	0.0
				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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Figure C.2-1: Top Indicators Dashboard

The Top Indicators dashboard allows stakeholders to identify areas for improvement that are conducive to a collaborative, multi-MCO approach.

a.i. Meeting Formats

Aetna proposes an open, collaborative meeting format in which stakeholders enjoy multiple avenues of participation, including accessing meetings via webinar, becoming involved in special committees or workgroups, and having the opportunity to share successes and best practices. Semiannually, the meetings should take the form of 'lunch and learn' opportunities where a subcommittee, work group, or stakeholder may share in-depth information about a specific population health issue and their proposed solution. In addition, because we realize that collaboration with providers is integral to improving health outcomes,

Aetna proposes that stakeholder organizations such as the Kentucky Association of Health Plans, chaired by Aetna CEO Jonathan Copley, Kentucky Hospital Association, the Kentucky Health Information Exchange, Technical Advisory Committees, and community resource organizations be invited to participate periodically.

This is an opportunity for MCOs to come together to discuss opportunities to improve health outcomes of enrollees, addressing social determinants of health and efforts for population health management. Aetna recommends that the monthly meetings be held over one or two days to allow time for a variety of topics to be addressed. For example, blocks of time could be set aside to work on quality, finance, provider experience, utilization and care management, health information exchange, and encounter issues. Each MCO should bring a project manager along with subject matter experts to the meetings to assist in taking notes and following up on action items.

a.ii. Issues, Ideas, and Innovations

At Aetna, collaboration with community-based organizations and stakeholders is a part of our company culture. Aetna regularly engages with stakeholders to find new ways to support enrollees through joint efforts. For example, Aetna participates in a maternal wellness program with the Louisville Metro health department to address low birthweight babies. We currently work with other stakeholders to meet enrollee needs related to health literacy, nutrition, oral health, children's screenings, and behavioral health screenings. We are excited to participate in collaborative monthly meetings with the Department, other agencies, and other MCOs, and appreciate the opportunity to suggest issues, ideas, and innovations that could be addressed during the initial three to six meetings.

Proposed Meeting Topic #1: Development of a Health Improvement Priorities Taskforce

Aetna proposes that one of the first monthly meeting topics should be developing a Health Improvement Priorities taskforce to identify collaborative ways in which MCOs can work together to address Kentucky Health Improvement Plan (KHIP) focus areas of substance abuse, smoking, obesity, adverse childhood experiences, and integration to health access. For example, Aetna supports the development of a comprehensive joint strategy for the prevention of diabetes and the reduction of diabetes disparities such as those associated with socioeconomic status, gender, and race. The Health Improvement Priorities taskforce should use the Centers for Disease Control's National Diabetes Prevention Program Coverage Toolkit as a starting point to develop a program for MCOs to jointly engage in reducing health disparities in the prevention of diabetes. In addition, the taskforce should discuss how Kentucky MCOs can take a coordinated approach, along with Commonwealth agencies, community-based organizations, and other key stakeholders, to help enrollees with pre-diabetes engage in self-management and take an active role in their health.

Getting on T.R.A.C.K.

Aetna collaborates with several organizations to support the Transition Ready Assistance & Core Knowledge (T.R.A.C.K.) health literacy program. Designed specifically for young adults transitioning out of foster care system, the course is the culmination of a joint effort between the Aetna Community Development team and community stakeholders across Kentucky that offer services to children in the foster system. These organizations are partnering with the Community Development team to offer the courses in their facilities. The curriculum is robust and can be customized to fit the needs of the audience. For example, Woodforest National Bank will teach budgeting to the transitioning fosters.

The Health Improvement Priorities taskforce should identify priorities that lend themselves to a joint approach to finding solutions. For example, the prevalence of diabetes in Kentucky continues to climb despite targeted efforts within our community to address this complex disease. Kentucky ranks fifth in the

nation for diabetes mortality[1], and Kentucky's prevalence of diabetes increased significantly by 22 percent from 2014 to 2018 while the rate of adults who are now overweight or obese has reached 67.8 percent.[2] Currently, 1 in 8 adults in Kentucky has a diagnosis of diabetes, and even more alarming, 1 in 3 Kentucky adults has prediabetes with only a fraction of these being officially diagnosed.[3]

Diabetes is the most expensive chronic disease in America.[4] Medical expenditures for people with a diagnosis of diabetes are about 2.3 times higher than those without a diagnosis of diabetes.[5] Aetna Inc. paid approximately $123 million in the 2018 plan year for enrollees with a diagnosis of diabetes.[6] Despite the complex nature of this disease process, it is possible to cut the risk of developing type 2 diabetes in half through lifestyle changes and modest weight loss.[7] Successful prevention or delay of diabetes onset, as well as improved adherence for those already diagnosed, poses significant opportunity for cost savings and enrollee quality of life improvement.

Like any of the KHIP focus areas, preventing diabetes, reducing health disparities related to diabetes, and appropriately addressing the needs of enrollees living with pre-diabetes will involve short- and long-term solutions. In the short term, MCOs should develop a provider education campaign to encourage providers to include a pre-diabetes diagnosis on claims so that MCOs can identify these individuals at the population level and evaluate outcomes. A long-term solution is to develop a strategy for diabetes prevention when only medically necessary services are currently covered. The Health Improvement Priorities taskforce can identify and research solutions such as alternative payment models or bundled payment for preventive services for enrollees that meet criteria (e.g., medical nutrition therapy, behavioral health).

The Health Improvement Priorities taskforce should also research a long-term solution to improving community health worker outreach efforts to address KHIP focus areas like diabetes. Because hiring community health workers to visit only their enrollees is not efficient, MCOs should build a coalition and take a coordinated approach to using community resources that already exist to complete community health worker activities and address social determinants of health.

Proposed Meeting Topic #2: Joint Strategy for Addressing the Opioid Crisis

We suggest developing a joint strategy for addressing the opioid crisis as another monthly meeting topic. MCOs could share best practices and prioritize possible joint solutions and initiatives. For example, since its launch in 2017, Aetna's Enterprise Wide Opioid Taskforce has supported the advancement of Aetna's clinical strategy to combat the opioid overdose crisis. The taskforce has developed an innovative Opioid Management Dashboard for all Aetna lines of business designed to manage appropriate use of opioids and support enrollees with opioid use disorder. This tool allows for heatmapping opioid use down to the county level, enabling targeted intervention efforts aimed at improving enrollee health outcomes.

Another example of an innovative practice that Aetna proposes to be discussed among Kentucky MCOs is the way that Aetna offers support to enrollees through the Community Pharmacy Enhanced Services

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[1] CDC WONDER, Underlying Cause of Death, 2017
[2] CDC, Behavioral Risk Factor Surveillance System, 2017
[3] Kentucky Department for Public Health and CDC. 2019 Kentucky Diabetes Report https://chfs.ky.gov/agencies/dph/dpqi/cdpb/dpcp/diabetesedscorecard.pdf; accessed April 24, 2019.
[4] Economic Costs of Diabetes in the U.S. in 2017, Diabetes Care 2018 May; 41(5): 917-928; https://doi.org/10.2337/dci18-0007 accessed April 24, 2019.
[5] Centers for Disease Control and Prevention Chronic Kidney Disease (CKD) Surveillance Project
[6] Data source: Aetna Consolidated CORE report 1/1/18-12/31/18
[7] Knowler WC, Barrett-Connor E, Fowler SE, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin, *The New England Journal of Medicine* (2002) 346(6):393–403.

Network (CPESN). CPESN is comprised of community-based pharmacies that develop relationships with enrollees and support medication management, social determinant needs identification, and care management. Aetna's Pharmacy team has direct vendor oversight; the team acts as a liaison between the community pharmacy and Aetna Care Management teams and supports identification of enrollees for referral. The program focuses on identifying enrollees at risk for adverse medication and health outcomes due to non-adherence and gaps in care, and actions are implemented to create a care plan that is shared with the enrollee's care team. CPESN pharmacists support enrollees to manage chronic conditions. Pharmacies in the CPESN network identify enrollees at high risk of opioid misuse and provide enrollee-specific education about their individual risk factors; they dispense naloxone and provide education to the enrollee or caregiver(s) about how to administer medications.

Aetna spearheaded an initiative to adopt Screening, Brief Intervention, and Referral to Treatment for substance abuse for dentists. This evidence-based public health practice uses motivational interviewing techniques to help dentists perform pre-screenings and full screenings for substance use and determine a patient's level of risk. The goal is to empower dental health providers to effectively screen and refer patients to addiction treatment and recovery supports when appropriate. With opioid addiction on the rise, providers are seeking effective alternative pain management options for their patients.

Fueled by cross-functional collaborations and insights, the Aetna enterprise's opioid initiatives have yielded meaningful results. In the first year since announcing our five-year enterprise goals, we have seen a more than 47% increase in the rate of medication-assisted treatment or other evidence-based treatments used by enrollees with opioid use disorder, among other significant improvements.

We believe that by sharing information about the ways in which health plans are combatting the opioid crisis on their own, Kentucky MCOs can develop joint strategies for addressing aspects of the crisis that would be benefit from a collaborative approach.

Proposed Meeting Topic #3: Provider Administrative Simplification

We recognize that we cannot help to improve health outcomes for enrollees without the buy-in and support of our providers, and therefore we propose provider administrative simplification as a recurring monthly meeting topic. MCOs can collaborate with providers, each other, and the Department to standardize forms, streamline processes, and improve the provider experience. For example, Aetna works to streamline the service authorization process to reduce administrative burden. We are reducing prior authorization requirements for high-performing practices on value-based payment arrangements. Aetna's Gold Card-tiered preferred provider performance incentive program eliminates prior authorization requirements, reduces administrative burden on providers, and leads to cost savings and high provider satisfaction. Our Gold Card providers must show low denial rates and must exceed quality standards.

Aetna also creates efficient and effective processes for providers who request services. We support providers not accustomed to managed care practices, and employ multiple strategies designed to minimize their administrative burden and enhance their experience, including the following:

- Assuring providers can access crucial data on rising-risk enrollees and gaps in care
- Using the common prior authorization form
- Reviewing appeals related to denials
- Streamlining processes using trends identified by Utilization Management, Quality, and Provider Services
- Promoting the use of evidence-based clinical guidelines and care paths
- Conducting annual evaluation of practitioner performance and health care professional education that targets appropriate and cost-effective use of health care resources
- Conducting quarterly site visits to facilities to collaborate on reduction of denials

In the monthly meetings, MCOs can work with providers and the Department to identify additional opportunities in which MCOs can align processes to reduce providers' administrative burden. By coming together to discuss these issues, MCOs can hear from peers, providers, and the Department about how we can collaboratively develop solutions to meet stakeholder needs.

b. Lessons Learned from Similar Collaborations

Aetna Better Health of Kentucky will apply lessons learned from the Aetna Medicaid organization's plans in Ohio, Texas, and Arizona in moving forward with monthly meetings.

Ohio Initiative

The Aetna Medicaid organization's affiliate in Ohio was an active partner with the Ohio Office of Health Transformation (OHT), which worked to ensure Medicaid enrollees were getting the most out of their benefits. The OHT was an initiative of Governor John Kasich involving all Ohio agencies that touched health care, including public health, Medicaid, mental health and addiction services, jobs and family services, veterans affairs, and administrative services, as well as representatives of the private and commercial insurance market. The OHT developed an integrated eligibility system so beneficiaries could determine whether they also qualified for food assistance, childcare, child welfare, and cash assistance.

Aetna was an active partner with OHT by providing data and thought leadership and served on the OHT advisory council. The local plan also provided input in the primary focus areas for improvement in health care that OHT focused on during its eight years of existence. Aetna provided support in OHT initiatives including applying for federal programs like the Centers for Medicare & Medicaid Services Duals Demonstration project, Primary Care Physicians Plus, Medicaid expansion, and State Innovation Model grants. OHT pushed health plans toward value-based contracts with providers, which Aetna embraced. By all accounts, the OHT was a successful program that maximized Medicaid benefits for enrollees in Ohio. Through this collaboration, we learned that with a defined goal and mission, such collaborations between Medicaid stakeholders can impact the Medicaid program in a positive way and improve the health and livelihood of the enrollees we serve. We will leverage this understanding in our approach to conducting monthly meetings in Kentucky.

Texas Initiative

Much like Aetna's proposal to develop a Health Improvement Priorities taskforce in Kentucky, our Medicaid affiliate in Texas regularly participates in collaborative performance improvement projects with other MCOs. Together with the State agency, Medicaid MCOs prioritize goals for improvement. Using the vehicle of quality forums sponsored by the State agency, we continue to collaborate with the other MCOs to make sure guidelines are consistent throughout Texas. As requested by the Texas Medicaid agency, we also met with the other plans regarding our successful score of 92.7 percent on our Collaborative Performance Improvement Project to share our best practice methodology. Through this collaboration, we learned that taking a joint approach to tackling population health goals can lead to improved outcomes. For example, from 2014 to 2017, our Texas Aetna affiliate collaborated formally with other MCOs to improve adherence to clinical practice guidelines on asthma. In Kentucky, Aetna will help identify strategies to address health improvement plan priorities that will benefit from a joint-MCO approach.

Arizona Initiative

Mercy Care, an Aetna-administered Medicaid health plan in Arizona that serves 20,000 enrollees designated as seriously mentally ill, has a collaborative protocol with the State's Rehabilitation Services Administration (RSA) vocational rehabilitation (VR) program. The protocol was developed to help ensure enrollees have direct access to the VR program. The organizations share a commitment to support our mutual enrollees with recovery-oriented services. The partnership between Mercy Care and RSA

embraces the evidence-based practice of supported employment, maximizes vocational services, and provides a quality service delivery to the mutual enrollees. Our combined mission supports enrollees on their path to recovery. Through this collaboration, we learned that it is important to define roles and responsibilities and functions as a foundational framework for implementing joint initiatives. In Kentucky, Aetna will apply this lesson in collaborating with the Department, its sister agencies, and other MCOs going forward.

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60.7.C.3 Capitation Payments

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60.7.C.3 Capitation Payments (Section 10.0 Capitation Payment Information, Section 11.0 Rate Component

Aetna is a leader in implementing physician incentive plans with ingenuity and a collaborative spirit with our provider partners to provide better health, better care, and lower costs among all Medicaid plans in the Commonwealth. We adhere to physician incentive plan contract requirements within **Section 11.5 of the Draft Medicaid Managed Care Contract and Appendices**, as well as 42 C.F.R 422.208 and 422.210. In calendar year 2018 for Aetna Better Health of Kentucky in shared savings arrangements, 30.6 percent of total medical spend was in provider physician incentive plans, accounting for over $284 million in provider payments. We are committed to providers by being true partners in taking care of our enrollees. Currently, 38 percent of Aetna enrollees are served by a value-based provider with 43 percent of Aetna-contracted primary care providers (PCPs) participating in a physician incentive plan.

a. Aetna's Approach to Successful Physician Incentive Plans

Aetna[1] has instituted a physician incentive plan contracting initiative within our value-based purchasing program, **Aetna Better Value.** Among the tools we use to achieve appropriate delivery of care and manage utilization of services, Aetna Better Value offers providers an array of Health Care Payment Learning & Action Network alternative payment models (HCP-LAN APM) designed to facilitate participation of providers—large and small, traditional and non-traditional. From physician incentive plans with patient-centered medical homes (PCMHs)/advanced medical homes to shared risk and then to full-risk capitation, we work toward having the majority of our network providers successfully moving across the value-based continuum within the HCP-LAN framework. We place emphasis on advancing providers through the APM continuum to Categories 3 and 4, which include upside gainsharing, downside risk, and condition-specific population-based payments and other incentives. As shown in **Figure C.3-1**, Aetna achieved significant enrollee growth to more than 83,000 current enrollees from our starting point of 4,741 enrollees in April 2012 in shared savings arrangements. As providers evolve along the APM value continuum, we link incentives to improved quality, reduced costs, and increased enrollee satisfaction and engagement. For example, we added a new shared savings agreement with Baptist Health Network Partners and its 344 participating PCPs effective January 2019.

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its parents, Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Kentucky to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of Kentucky's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Kentucky. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

Figure C.3-1: Shared Savings Membership 2012-2019

Aetna has achieved steady advancement of enrollees engaged in shared savings physician incentive plans since April 2012.

National Value-based Payment Expertise Informs Kentucky Efforts and Success

The Aetna enterprise has developed over 2,600 value-based payment (VBP) arrangements of all types within the HCP-LAN APM continuum and approximately 7.5 million enrollees in various VBP arrangements across all lines of business. Through Aetna Better Value, our Medicaid suite of VBP solutions, our physician incentive strategy supports delivery system reform and practice transformation. Aetna has been highly successful building on a national record of success in payment reform. As providers evolve along the HCP-LAN APM continuum, we link more provider payments and incentives to value and realize improved quality, reduced costs, and increased enrollee satisfaction and engagement. We also leverage our national and Kentucky commercial and Medicare enrollment to encourage providers delivering care to all product lines to accept physician incentive plans.

Our physician incentive plans are data-driven, based upon improvement opportunities identified via an analysis of claims, quality outcomes, social determinants of health, public health, and disparities for each provider and model type. These physician incentive plans align with the HCP-LAN APM framework of 2A, 2B, 2C, 3, and 4 with direct linkage to the provider-specific and applicable quality performance measures. Aetna's physician incentive plan approach includes primary care and specialty care (including behavioral health and hospital-based care) and expands into other treatment venues, such as community mental health centers, federally qualified health centers (FQHCs), rural health clinics (RHCs), and non-traditional providers. Our unique approach with these providers increases improvement in the health of Kentuckians through innovative, whole-person care and well-coordinated systems of care addressing medical and non-medical drivers of health. We have collaborated with the provider community to advance the Kentucky health priority of implementing delivery system reforms to improve quality and

outcomes and the reduction or elimination of health disparities through our innovative physician incentive plans.

Innovative Approaches to Incent Provider Participation

Aetna developed an array of innovative and collaborative approaches that resulted from our existing value-based partnerships. These approaches evolved and were jointly developed to include physician incentive plans in such areas as medication adherence, delegated case management, tiered quality incentives, and rural provider electronic health record (EHR) adoption. We are also developing incentives for participation in the Kentucky Health Information Exchange (KHIE). We collaborated with providers in the development of these approaches to provide incentives for physician incentive plan participation, with an 'outside the box' approach such as tiering quality incentives to recognize improvement, rather than overall performance. We included delegated case management to allow our VBP partners the opportunity to case manage their patients' needs.

The Healthcare Effectiveness Data and Information Set (HEDIS) measures we select to include in our physician incentive plans are prioritized according to both enrollees' needs and Commonwealth health improvement priorities. With greater than 50 percent of our enrollees being children, we have captured measures to impact the care they receive. Those measures include immunizations, well child, and adolescent well care. Additionally, Aetna recognizes the prevalence of diabetes in the Commonwealth and among our enrollees and we address this by capturing that activity in diabetic HEDIS measure results. Other measures including preventive screenings, emergency department (ED) visits, and hospital readmission are of interest as we encourage movement toward screening and detection of health issues such as cancer or diabetes.

Addiction Recovery Care (ARC) Maternity Program—supporting pregnant females in addiction: Through Karen's Place Maternity Center, ARC has been admitting pregnant females who suffer from substance use disorder for more than two years. This pilot program has been operated by ARC as a proof-of-concept investment to demonstrate the value of ARC's unique maternity care program. ARC admits pregnant females with substance use disorder at any time during pregnancy and maintains residential levels of care throughout pregnancy until three months after delivery (despite no reimbursement for this level of care after the first 30 days). ARC has achieved overwhelmingly positive results. Eighty-eight percent of babies have been discharged after a standard five-day watch period without developing signs and symptoms of neonatal abstinence syndrome (NAS) or requiring neonatal intensive care unit (NICU) admission. None of the other newborns had prolonged NICU stays for treatment of NAS or other complications. Aetna has a signed letter of intent with ARC to collaborate on this program with similarly successful and effective results expected.

Medication adherence improvement incentive: An example of innovative provider incentive plan collaboration is with Community Pharmacy Enhanced Services Network USA (CPESN). The agreement with CPESN involves incentives for medication adherence related to select medical conditions including diabetes, depression, schizophrenia, and asthma. Incentives also entail reviewing enrollee records for indications of polypharmacy usage. The agreement also ties incentives to HEDIS performance measures for enrollees with asthma and diabetes.

CPESN Q1 2019 Outcomes

- **ED utilization:** decreased cost by $28,070 and decrease in claims by 32
- **Outpatient utilization:** decreased cost by $141,299 and decrease in claims by 93
- **Inpatient utilization:** decreased cost by $45,147 and decrease in claims by 6
- **Pharmacy utilization:** increased cost by approximately $500 and decrease in claims by 32

Kentucky Primary Care Association (KPCA) delegated case management: Our relationship with KPCA continues to bring innovative solutions

through their collaboration and quality strategy. With our Joint Operating Committees and continuous improvement meetings, we have been able to bring solutions to our enrollee community through this relationship. An example of this innovation is our delegated case management arrangement we are currently implementing. The intent is for the enrollees to benefit from more direct, face-to-face case management locally in the provider offices. The enrollee needs are met in almost real time and the care plan and activity is communicated to the Aetna Care Management team for tracking and outreach on our end as well. We have selected five practices to develop a proof of concept, all impacting various regions throughout the Commonwealth. Aetna will collaborate in support of KPCA obtaining this accreditation.

Quality incentives: We have entered into a quality incentive agreement with Children's Alliance and its 14 provider groups that began July 1, 2019 with incentives targeting the following measures:

- Follow-Up Care for Children Prescribed an Attention-deficit/Hyperactivity Disorder Medication
- Follow-Up After Hospitalization for Mental Illness
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

> "Aetna's leadership and staff have been exceptional to work with and they have worked diligently to develop a contract that will move the health care of its enrollees forward. It seems measuring outcomes and working to improve medical care has been implemented in Kentucky for many years. However, most of those value-based contracts have been centered around physical health. Because behavioral health is often more complex, regarding measuring outcomes, the managed care organizations have been hesitant to engage with the CA-IPA (Children's Alliance Independent Provider Association), apart from Aetna. Aetna leaders expressed their concern and commitment to specifically helping the most vulnerable children and families in Kentucky, which are those cared for by CA-IPA enrollees."
>
> **—Michelle M. Sanborn**
> **President, Children's Alliance**

Rural provider EHR adoption: We recognize that EHR adoption by rural providers may present more of a challenge due to their geographic location and practice structure (many are independent practices and may not have larger systems support). Therefore, our incentive programming allows flexibility in that rural providers may be eligible for additional incentives to encourage adoption of EHR. Some of the incentives are related to both HEDIS and non-HEDIS metric performance that may be enhanced through use of an EHR.

It is important to engage rural non-traditional providers in provider incentive plan arrangements—those providers beyond primary care, such as nursing facilities, home- and community-based providers, and transportation and housing providers. These provider discussions help us understand their unique capabilities and challenges to shape physician incentive plan arrangements creating flexible, customized solutions.

KHIE participation incentive: Currently, we have physician incentive plans in place with eight provider groups that are engaged in improving outcomes for our enrollees. As part of our contractual arrangement, we will include provisions related to connection with KHIE. Incentives may include offering a credit and/or pay-for-performance to reduce some of the cost associated with joining the KHIE and using EHR. Connection to KHIE can lead to improved HEDIS metrics and the ability for our shared savings providers to meet medical loss ratio targets, thus increasing the likelihood of receiving maximum payouts. Better management of admit, discharge, and transfers and more robust data reporting will improve our efforts to find enrollees that have gaps in care or are in urgent need of supportive services. To incentivize and create greater provider participation in the KHIE, Aetna will provide physician's incentives through payouts to those providers who engage in the KHIE and exchange data.

Demonstrated Success in Kentucky Physician Incentive Plan Enrollee Outcomes

Our physician incentive plans have the primary goal of ensuring enrollees have better health and receive better care at a lower cost. Aetna has proven success in creating physician incentive plans that make a real difference in enrollees' lives.

Aetna has achieved year-over-year success in HEDIS measure quality outcomes through our physician incentive plans. **Figure C.3-2** illustrates the improving trends in HEDIS improvements across eight important health outcome measures over the period of 2016-2018, including cervical cancer screening and chlamydia screening in women. HEDIS improvements noted within **Figure C.3-2** identify measures where Aetna has either reached the 75th percentile or have shown improvement. Aetna has continued to show great progress in our HEDIS measurements, as evidenced by our performance in the Commonwealth quality incentive program. In 2016, we were able to capture 93 percent of the State quality incentive pool payout. In 2017, we saw significant improvements for both Commonwealth quality incentive pools, but most significantly in the improvement shares and attained 127 percent of the pool payout. In 2018, our Commonwealth quality incentive payout was 91 percent of the payout, which included successful gains in our performance shares. We reinvest these earnings in both our provider relationships through physician incentive plans as well as our enrollees through innovative solutions to become more empowered with their health. As shown, these improvements also tie specifically to improved outcomes in Commonwealth health priority areas such as adolescent well-care visits, comprehensive diabetes care, and well-child visits in the first 15 months of life, respectively.

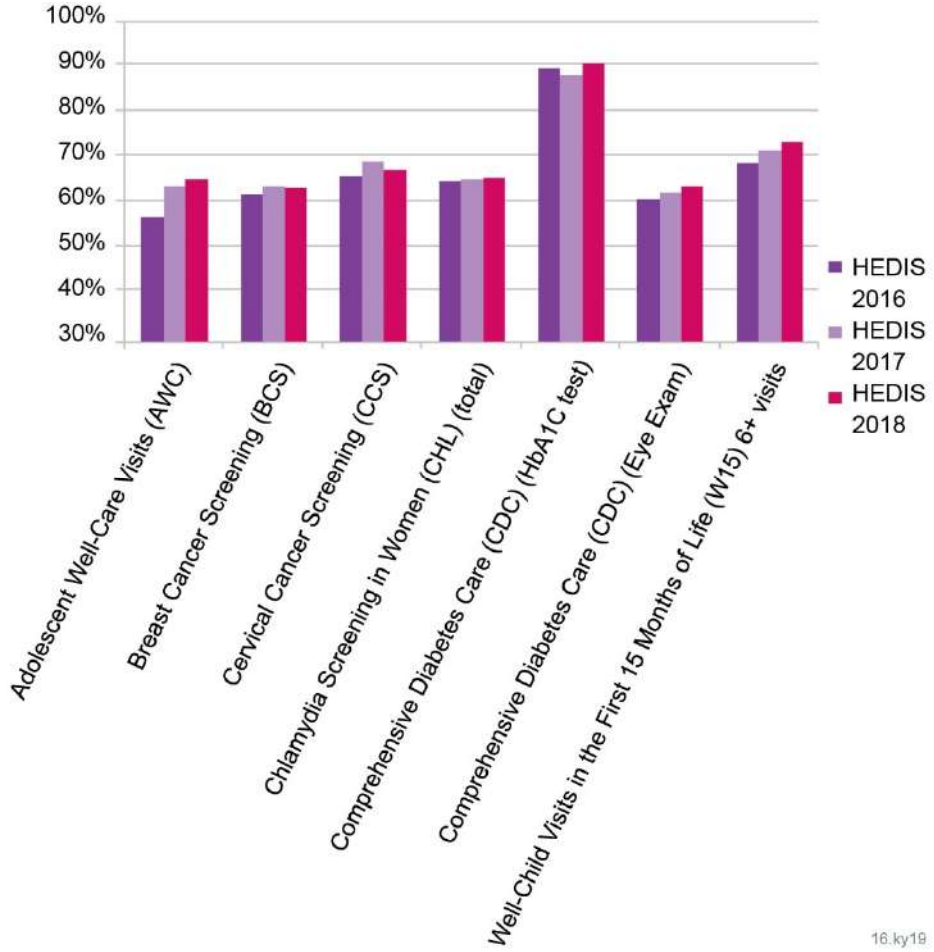

Figure C.3-2: HEDIS Trend Improvements 2016-2018

Aetna is improving HEDIS outcomes through our Kentucky physician incentive plans (2016-2018).

Successes have been aided by collaboration through Joint Operating Committees, which have focused on quality measures and the health of our enrollees. These arrangements are shared saving APM Level 3A on the HCP-LAN APM continuum. Through monthly reporting, providers gain an understanding of where

they stand with individual enrollee outcomes and the overall picture of population health within their practice. The reports help identify on a risk analysis basis where to focus their effort to achieve the greatest outcomes and improve enrollee health. By engaging physicians in pay-for-quality (P4Q) incentive plans as they begin engagement in values-based contracting, we introduce them to physician incentives.

In the second year of the contract, providers move to more complex arrangements including PCMHs or shared savings arrangements. Particularly with primary care physicians, we believe the P4Q model is a useful inauguration to physician incentive plans and sets them on a forward path to value.

b. Examples of Successful Physician Incentive Plan Implementation

We have implemented physician incentive plans with KPCA, St. Elizabeth Healthcare, and Kentucky Health Partners (KHP) to identify and collaborate on a quality strategy, discuss trends and performance, and work through gaps in care. We seek innovative solutions with each of them. For example, we have been collaborating with KHP on the electronic population health management platform to create efficient communication between our Care Management teams (Aetna and KHP) as well as providing gaps in care reporting through the platform. This close collaboration has a shared savings incentive and has achieved success with our provider partner in showing improvement to quality outcomes. Also, we are currently collaborating with St. Elizabeth Healthcare to review ED trends and physician prescribing practices that have led to corresponding pharmacy trends.

Successful Physician Incentive Plans

Our physician incentive plans in Kentucky are a proven success with providers earning incentives contingent upon achieving targets in quality HEDIS metrics. **Since the Aetna Medicaid organization began serving the Commonwealth's Medicaid program in 2011, Aetna has paid $16.6 million in physician incentives[2].** As our physician incentive plan program has evolved in Kentucky, Aetna has increased the number of groups involved as well as incentive options for our partners. The original contract goals were tied to the 75th National Committee for Quality Assurance (NCQA) quality compass percentile for the measures included in our physician incentive reports, except for the Plan All Cause Readmission (PCR) rate, which was a two-percentage point reduction from the previous year. The following eight successful entities engaged with Aetna in physician incentive plans:

- Association of Primary Care Physicians
- Baptist Health Network Partners
- Big Sandy Health Care
- Community Medical Associates and Norton Louisville Primary Care Centers
- KHP
- KPCA
- St. Elizabeth Healthcare
- The Physician Network

The following are Aetna's three most successful arrangements. They are with Kentucky Health Partners, Kentucky Primary Care Association, and St. Elizabeth Healthcare:

[2] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program until February 1, 2016, when CHLIC assigned its Medicaid contract to Aetna Better Health of Kentucky.

1. Kentucky Health Partners

Our physician incentive plan collaboration with KHP began in January 2018 and includes 212 PCPs. The program is focused on achieving results for our enrollees in several HEDIS measures, including breast cancer screening and adolescent well-child visits:

- **Structure:** The physician incentive plan arrangement is (HCP-LAN APM 3A), a primary care PCMH with shared savings in which the provider must attain a certain quality performance level to receive incentive payouts. This physician incentive plan covers services not furnished by KHP. The shared savings agreement includes bonus payments with upside only and includes various bonus percentages. The panel size consisted of 7,306 average enrollees for 2018 and is not pooled. The physician group is not at substantial financial risk as defined by 42 C.F.R 422.208 and 422.210.
- **Measurable outcomes:** For measurement year 2018, KHP achieved four HEDIS goals related to adolescent well-child visits, breast cancer screening, comprehensive diabetes care, and ambulatory ED visits. Working on a collaborative strategy to address behavioral health and physical health initiatives holistically led to successful outcomes.
- **Hospital readmission reduction incentive:** As an example, we have achieved success in reduced readmission rates for Our Lady of Peace (OLOP), a provider group within our KHP arrangement. OLOP hospital readmissions have decreased by 6.2 percent over the period of May 2015 to December 2018.
- **Challenge:** At the outset, KHP wanted to address physical and behavioral health separately. Through our collaboration with KHP, we were able to educate them on the importance of behavioral health and physical health occurring concurrently in order to provide the best enrollee experience and outcome. Secondly, we worked with KHP to resolve enrollee attribution issues. This might be alignment to the provider the enrollee was seeing or assignment to a new PCP with the mileage requirements as the enrollee had changed residence.
- **Lessons learned:** At inception of implementing physician incentive plans, provider incentives were based on a 'one-size-fits-all' approach for achieving the 75th percentile of HEDIS measures. However, few providers were able to achieve this level of success at the outset. As a result, Aetna's leadership prepared a three-tier option in 2017 to improve incentives for physician incentive plans for our provider partners to attain year-over-year improvements. Incentive opportunities were based on tier levels which included: 10 percent improvements, 25 percent improvements, or 50 percent improvements over the previous year for a HEDIS measure. If the 75th NCQA percentile was achieved, 100 percent of the pool for that HEDIS measure was earned. Our physician incentive plan provider partners were much more receptive to this tiered proposal than the previous non-tier, one-size-fits-all approach. Since implementation, they have shown increased motivation for additional reporting and collaboration with our plan. Specifically, providers have played more of a key role in promoting PCP involvement in our enrollees' lives by helping to close their care gaps and improve the health of Kentucky's population. As a result of this tiered approach, our physician incentive plan partners' rates have exceeded our plans overall administrative rates in all five of the HEDIS measures included in the program. We were able to implement this structure with KHP from inception of the VBP arrangement and recognized immediate engagement and rate improvements.

> "KentuckyOne Health and CHI St. Joseph Health would like to extend full support for Aetna Better Health of Kentucky's bid to remain in the Kentucky Medicaid Managed Care program. Aetna works collaboratively with our providers to ensure our patients, their enrollees, have access to and receive quality health care services. Our value-based arrangement aligns our organizations around improving the health of the communities we both serve. We are excited to continue this partnership and recommend that the State keep Aetna as one of their managed care organizations."
>
> **—Lynn Tanner**
> **Vice President of Payer Strategy, KentuckyOne Health**

2. Kentucky Primary Care Association

Our physician incentive plan agreement with the KPCA began in November 2012. In our continual effort to advance providers in provider incentives, we are now implementing a delegated care management arrangement to have a more direct impact on enrollee care. KPCA is predominately made up of FQHCs/RHCs in rural areas and includes more than 1,250 PCPs practicing under this physician incentive plan. KPCA also works with us on NCQA measures and strategies to impact the provider network data accuracy:

- **Structure:** The physician incentive plan arrangement is a (HCP-LAN APM 3A) primary care PCMH with shared savings, in which the provider must attain a certain quality performance level to receive incentive payouts. The shared savings agreement includes bonus payments with upside only and includes various bonus percentages. The panel size consisted of an average of 43,028 enrollees for 2018 and is not pooled. The physician group is not at substantial financial risk as defined by 42 C.F.R 422.208 and 422.210.
- **Measurable outcomes:** Since the baseline year 2015, KPCA has improved upon 9 of 10 of the measures used for physician incentive plan reporting for the three-year period of 2016-2018 as shown in **Table C.3-1.**

Table C.3-1: Improving HEDIS Measures 2016-2018

HEDIS Measure	HEDIS 2016	HEDIS 2017	HEDIS 2018
AWC—Adolescent Well-Child Visits	32.15%	39.61%	40.72%
BCS—Breast Cancer Screening	43.42%	56.43%	52.98%
CCS—Cervical Cancer Screening	48.62%	57.96%	58.60%
CDC—Comprehensive Diabetes Care Eye Exam	35.15%	47.27%	46.53%
CHL—Chlamydia Screening Total	52.08%	55.08%	54.21%
CIS Combo 10	5.20%	21.78%	28.43%
W15—Well-Child Visits in the First 15 Months	51.52%	58.86%	57.09%
CDC—Comprehensive Diabetes Care Testing	85.00%	87.73%	87.73%
AMBED—Emergency Department Utilization	77.03%	117.10%	117.91%
PCR—Plan All-Cause Readmission Rate	15.00%	12.86%	13.75%

- **Challenges:** Enrollee attribution and PCPs working at multiple practices/locations are challenges we have been working closely on within our KPCA partnership. As an enrollee may be assigned to one PCP but could go to any PCP in the network, this can create challenges for the assigned PCP to manage the enrollee's care.
- **Lessons learned:** As a result of these challenges, we are working collaboratively with our VBP provider partners to develop an attribution model that utilizes claims data to provide insight into which physicians the enrollee has seen.

3. St. Elizabeth Healthcare

Aetna has collaborated with St. Elizabeth Healthcare and its 355 contracted PCPs since July 2015 to create a physician incentive plan that has achieved success in improving HEDIS measures:

- **Structure:** The physician incentive plan arrangement is a (HCP-LAN APM 3A) primary care PCMH with shared savings, in which the provider must attain a certain quality performance level to receive incentive payouts. The shared savings agreement includes bonus payments with upside only and includes various bonus percentages. The panel size consisted of 13,513 average number of enrollees

for 2018 and is not pooled. The physician group is not at substantial financial risk as defined by 42 C.F.R 422.208 and 422.210.

- **Measurable outcomes:** For measurement year 2018, St. Elizabeth Healthcare improved on four of their HEDIS measures year-over-year and achieving the 75th percentile on a fifth HEDIS measure. St. Elizabeth Healthcare has achieved success related to adolescent well-care visits, diabetic eye exams, and immunizations.
- **Challenges:** In our collaboration with St. Elizabeth Healthcare, we had to include enhanced trainings on current physician incentive plan reports and review requests for additional reporting to meet our goals in improving health outcomes. The Aetna team worked alongside our corporate physician incentive plan teams to align current incentives and additional reporting analytics requested by St. Elizabeth Healthcare.
- **Lessons learned:** Most provider groups expressed that the original contract goals were out of reach and it would not be in their best interest to waste resources on unattainable goals with little impact on their business initiatives and Aetna's outcomes. In response to this feedback, Aetna's leadership prepared a tiered option in 2017, which incentivized our physician incentive plan partners in attaining year-over-year improvements. Improvement shares were based on tier levels, which included seeing 10 percent improvements over the previous year for a measure, 25 percent improvements, and 50 percent improvements with the full goal staying at attaining the 75th NCQA percentile. Our physician incentive plan partners were much more receptive to this tiered proposal. Since implementation, they have shown increased motivation for additional reporting and collaboration with our plan. Specifically, they have played more of a key role in promoting PCP involvement in our enrollees' lives by helping to close their care gaps and improve the health of Kentucky's population. As a result of this tiered approach, our physician incentive plan partners' rates have exceeded our plans overall administrative rates in all eight of the HEDIS measures included in the program.

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60.7.C.4 Financial Security Obligations

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60.7.C.4 Financial Security Obligations (Section 13.0 Contractor's Financial Security Obligations)

Aetna Better Health of Kentucky ensures compliance with all financial security obligations by maintaining a high net worth, exceeding solvency requirements, and providing transparency into lines of credit and provider risk arrangements. Aetna[1] is proud of our history as a Kentucky Medicaid health plan working to improve health outcomes and reduce health disparities while serving as a responsible steward of Commonwealth resources. Our excellent quality scores and strong financials demonstrate our commitment to providing exceptional enrollee service while ensuring fiscal sustainability. Aetna's dedication to being a collaborative and innovative partner to the Department and its sister agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier Kentucky.

a. Compliance with Net Worth, Solvency, Reinsurance, and Surplus Requirements

Aetna is currently in and will maintain compliance with the requirements contained in the **Draft Medicaid Managed Care Contract and Appendices Section 13.0**, KRS Chapter 304, and related administrative regulations regarding protection against insolvency and risk-based capital requirements. As shown in Aetna Better Health of Kentucky's 2018 Risk-Based Capital report, included as **Attachment J**, Aetna Better Health of Kentucky far exceeds the $70.6 million internal company action level for capital and surplus requirements. Should there be a concern at any time regarding net worth, solvency, or surplus requirements, Aetna Better Health of Kentucky will receive financial support in the form of capital contributions from its parent company, Coventry Health and Life Insurance Company, whose ultimate parent is CVS Health, a Fortune 10 company.

Aetna Better Health of Kentucky's adjusted capital and surplus is [redacted] as of September 30, 2019. That is five times the required level.

The CVS Health Capital Management team routinely assesses the financial position of each subsidiary. This team completes an estimated net worth calculation one month prior to the close of quarterly financials. If capital contributions are required, the team initiates the transfer of funds prior to the close of each quarter. If the net worth of the subsidiary is deficient after the quarterly closing, the deficiency is noted on the Notes to the Financial Statements and a capital contribution is requested from the Capital Management team for immediate transfer of funds prior to the release of the financial statement.

One example of Aetna's commitment to partnering with Kentucky and making enrollees our core focus occurred in 2013 when another health plan, Kentucky Spirit (Centene), abruptly exited the market. Despite rate issues and profitability concerns, Aetna collaborated with the Department and other stakeholders in order to ensure rates were suitable from the beginning of the program and that enrollees experienced a seamless transition from one organization to another.

Coventry Health and Life Insurance Company, the immediate parent of Aetna Better Health of Kentucky, will provide unconditional financial support to Aetna Better

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its indirect parents, Aetna Inc., and/or any Aetna Inc. subsidiary that conducts Medicaid/CHIP business or participates in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Kentucky to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of Kentucky's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Kentucky. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

Health of Kentucky in the form of capital contributions to meet Commonwealth solvency requirements. There is no maximum limit to the financial support that Coventry Health and Life Insurance Company will provide. We have included the current Capital Support Letter in **Attachment J**, which details the capital support from Aetna Better Health of Kentucky's parent.

Due to the strength of Aetna's financial performance and the number of our enrollees, Aetna currently does not utilize a reinsurer. Aetna periodically reviews the decision to have reinsurance coverage to ensure we remain fiscally sound. Our analysis has not warranted the need for reinsurance for the eight years that we have been supporting the Commonwealth of Kentucky. Additionally, the Commonwealth has identified that there is no reinsurance requirement for this contract.

b. Lines of Credit Available to Aetna Better Health of Kentucky

The Aetna Better Health of Kentucky entity does not hold lines of credit. CVS Health, the ultimate parent of Aetna Better Health of Kentucky, holds lines of credit for all its subsidiaries. The current, publicly available documentation of lines of credit for CVS Health and its subsidiaries, including maximum credit amounts and available credit amount, are attached as **Attachment J**. CVS Health Corporation renewed and refinanced its unsecured revolving credit facilities during the second quarter of 2019. The aggregate amount of its credit facilities is [redacted]

c. Provider Risk Arrangements

Aetna has instituted a physician incentive plan contracting initiative within our value-based purchasing program, Aetna Better Value. Among the tools we use to achieve appropriate delivery of care and manage utilization of services, Aetna Better Value offers providers an array of Health Care Payment Learning & Action Network alternative payment models (HCP-LAN APM) designed to facilitate participation of providers—large and small, traditional and non-traditional. From physician incentive plans with patient-centered medical homes/advanced medical homes to shared risk and then to full-risk capitation, we work toward having the majority of our network providers successfully moving across the value-based continuum within the HCP-LAN framework.

This continuum is illustrated in **Figure C.4-1.** We place emphasis on advancing providers through the APM continuum to Categories 3 and 4, which include upside gainsharing, downside risk, and condition-specific population-based payments and other incentives.

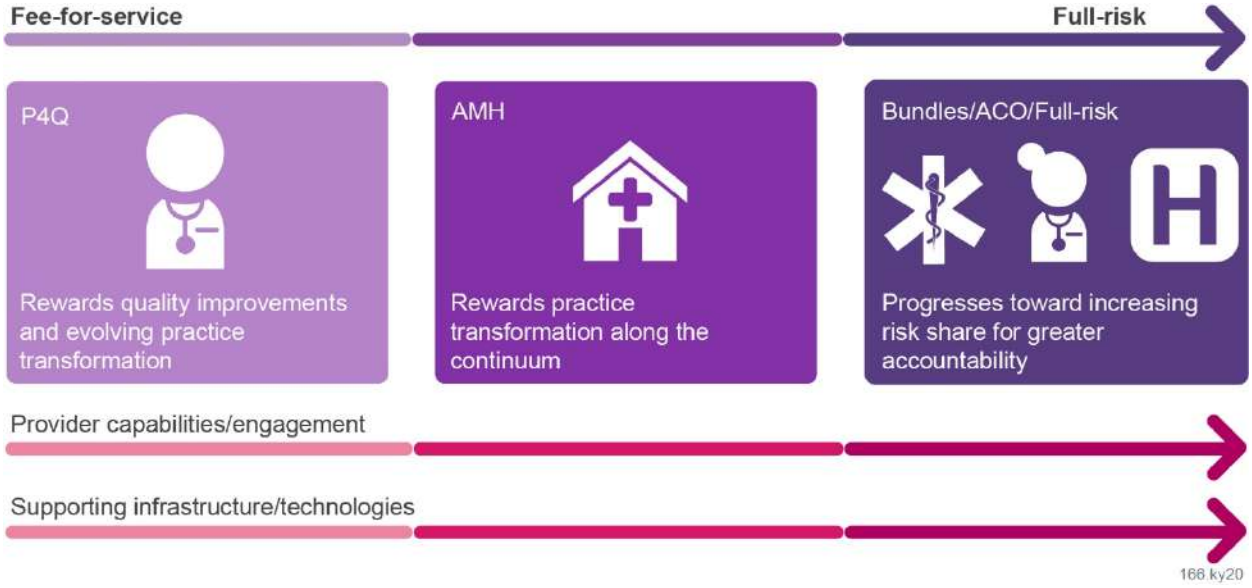

Figure C.4-1 Volume-to-Value Continuum

Our volume-to-value graphic expresses the steps a provider can take to earn more rewards from a progressive payment model that incrementally moves providers from a fee-for-service to full-risk arrangement.

If Aetna enters into a value-based payment arrangement in which a provider assumes substantial financial risk for contracted services in the future, Aetna will ensure that the provider has adequate stop-loss protection, as required. Aetna will provide the Department proof the provider has adequate stop-loss coverage, including an amount and type of stop-loss.

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60.7.C.5 Third Party Resources

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60.7.C.5 Third Party Resources (Section 14.0 Third Party Resources)

Aetna is committed to being a collaborative partner with the Department in supporting fiscal sustainability while keeping the enrollee experience as seamless as possible, whether payment is from Medicaid or another insurance source. Aetna is an industry leader in coordinating care and controlling costs with proven strategies to help ensure Medicaid is the payer of last resort. Aetna's internal policies and procedures are augmented by working with industry-leading vendors HMS and Equian to maximize recovery. We begin third-party liability (TPL) and coordination of benefit (COB) efforts at the earliest point possible, educating providers of their responsibility to identify other existing coverage to maximize TPL/COB recovery opportunities. **Aetna's standards exceed contractual requirements for responding to enrollee and provider requests for COB or TPL.** We respond in the following timeframes:

- **Urgent requests:** 24 hours within receiving the request—vs. 48-hour contract requirement
- **Routine requests:** Two business days within receiving the request—vs. 3 business days contract requirement

Aetna directs third-party information to our TPL and COB departments. Our TPL/COB analysts are guided by written policies and procedures (developed in accordance with federal and Commonwealth regulations) that maximize use of other available sources of payment and recovery. Our COB and TPL staff is trained with a focus on accuracy and compliance. Training is conducted across all departments whenever new or modified Commonwealth or federal regulations are implemented.

Aetna Better Health of Kentucky's TPL/COB savings for 2016 through 2019 was over $399 million.

Aetna has extensive experience in matching enrollee data with vendors for other insurance leads to promote proactive cost avoidance. When evidence suggests an enrollee has other insurance coverage, these leads are validated against an online verification tool and against files like the reports we receive from our COB/TPL identification and recovery vendor and the Council for Affordable Quality Healthcare's (CAQH) COB Smart™ registry, and by calling the other insurance company. We share enrollee enrollment data via secured File Transfer Protocol with vendors that specialize in matching enrollment data from other insurance companies. Aetna has experience with COB and the exchange of information via the crossover claim process. In addition to electronic transfers, our TPL/COB staff is trained to research all TPL/COB leads using all available resources within federal and Kentucky guidelines.

Coordination of Benefits

Aetna identifies evidence of other insurance coverage through a variety of internal and external information resources. Our COB savings from 2016 through 2019 are shown in **Table C.5-1**. We participate in a collaborative industry-wide solution: the CAQH COB Smart™ registry. On a weekly basis, we send our enrollee coverage data to CAQH, which identifies individuals with benefits that should be coordinated. We also send our enrollee coverage data on a monthly basis to HMS to identify proactively individuals with primary insurance coverage. Standard rules are then applied to determine the correct order of benefits.

Table C.5-1: Aetna Better Health of Kentucky COB Savings by Year

	2016	2017	2018	2019
Total paid claim dollars	$632,541,685	$732,747,301	$657,241,737	$656,370,211
Claim dollars saved	$98,291,258	$104,180,191	$100,937,961	$94,461,453

Aetna's COB department is notified of known third-party resource information provided by the Department through the enrollment process based on the information obtained through the enrollee's eligibility determination or redetermination. Our COB department also receives third-party information from our other departments (i.e., Provider Services, Claims Inquiry/Claims Research, and Enrollee Services); we validate the information directly with the other payers via phone and web systems, as shown in **Figure C.5-1.** Following validation, we process the information in our operations management system to coordinate benefits and adjust affected claims, ensuring that enrollees are covered for services and verifying that Medicaid is the payer of last resort. In addition, we send COB/TPL information to our subcontractors so that they are adjudicating claims with up-to-date information. In turn, we also receive quarterly COB/TPL reports from Avēsis for dental and vision claims.

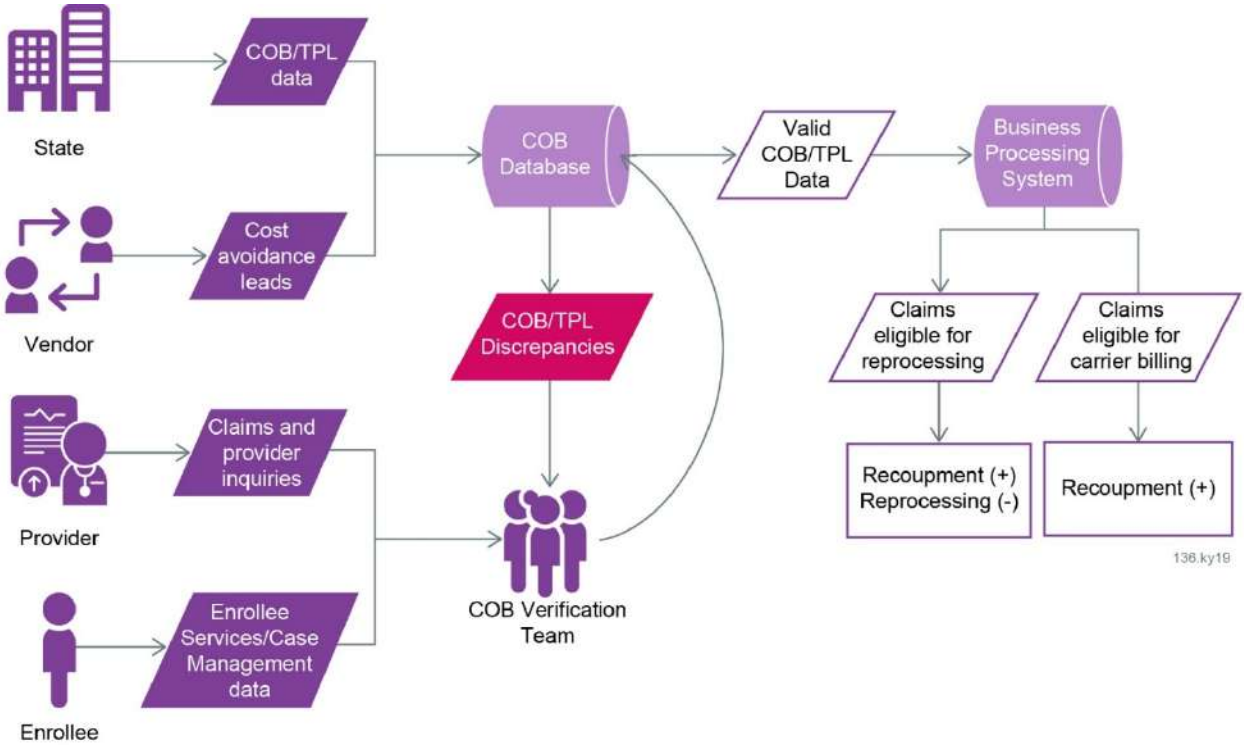

Figure C.5-1: COB/TPL Identification and Recovery Process Flow

Aetna's COB/TPL identification and recovery process is designed to find evidence of other insurance coverage through a variety of internal and external information resources.

COB Collection Records and Reporting Requirements

Aetna actively pursues, collects, and retains all monies available from all available resources for services to enrollees except where the amount of reimbursement we can reasonably expect to receive is less than estimated cost of recovery. The chief financial officer and chief operating officer review all claim

recoupment projects to determine whether to seek reimbursement from a liable third party or if seeking reimbursement would not be cost-effective.

Aetna only recoups payments to providers if the third-party payer is Medicare. Aetna will ensure that services are delivered without charge to all our enrollees. We will coordinate with Medicare payers, Medicare Advantage plans, and Medicare providers (as appropriate) to coordinate enrollee care and benefits for those eligible for Medicare and receive and process crossover claims managed by Medicare through our claims system. We do not restrict enrollees' access to covered services due to COB collection. As required, Aetna maintains records of all COB collections. We comply with all Department COB/TPL guidelines and will demonstrate, upon request, that reasonable and appropriate collection efforts and recovery actions were pursued. To comply with Centers for Medicare & Medicaid Services (CMS) reporting requirements, Aetna submits a monthly COB report for all enrollee activity, which will be audited by the Department or its agent no less than every six months. Additionally, Aetna submits a report that includes subrogation collections from auto, homeowners, or malpractice insurance, etc. In addition, Aetna complies with the requirements of 42 CFR 433.138 through 433.139 and maintains a management information system that includes a third-party resource file, third-party liability billing file, and questionnaire file.

Monitoring Method Saves over $1 Million

Aetna Compliance Officer LaRhanda Trammell monitors the development of algorithms from our Special Investigations team and our subcontractors. Factors on how algorithms are created include reviewing trends that could potentially pay out high-dollar amounts.

Additionally, provider payment activities that are closely monitored by our prepayment policy allow us to review the claims and determine if they meet the criteria for payment.

Aetna has saved over $1 million using this method.

Coordination of Third-party Information

We utilize and validate TPL files provided by the Department, information available in claims data, and data from our TPL vendors, and enter the information into our integrated claims management system. All coverage information is then available for non-clinical and clinical staff to both coordinate payment to providers and care for enrollees. We authorize and pay for services and coordinate with primary insurance later for prenatal and preventive pediatric care and related to Kentucky child support enforcement action as required. To preserve continuity of care, our care managers and our Enrollee Services team assist enrollees in coordinating primary and secondary insurance to obtain medically necessary services. The care manager also aids in identifying primary and secondary covered services, including pharmacy.

Division of Child Support Enforcement

Upon request, Aetna will provide county attorneys and the Division of Child Support Enforcement with amounts paid to seek restitution for the payment of past medical bills and to obtain insurance coverage to cost avoid payment of future medical bills.

Casualty Recoveries

Aetna provides the necessary information regarding paid claims to seek recovery from liable parties in legal actions involving enrollees. In cases where an attorney has been retained, a lawsuit filed, or a lump sum settlement offer is made, Aetna notifies Medicaid within five days so that recovery efforts can be coordinated when the Department has a claim for the same accident.

Aetna contracts with an external vendor to pursue TPL and subrogation investigation, perform file maintenance, and provide recovery services. The vendor performs the following primary TPL functions:

- Reviews all ICD-9 and ICD-10 diagnosis codes and other CMS-mandated code ranges for potential subrogation cases

- Performs data mining and utilizes outside sources such as the Kentucky motor vehicle accident report to identify potential recovery opportunities
- Communicates with attorneys, insurance representatives, and other parties as necessary to communicate Aetna subrogation rights and interest
- Generates, tracks, and processes enrollee questionnaires to assist in identifying other third-party resource opportunities when amounts exceed $250
- Assists with communicating with the Department on compromise/settlement requests less than the full amount of the lien, and case closure requests without recovery, including consulting with the Department's designated legal counsel in the event of recovery disputes
- On a monthly basis, Aetna will provide case management reports, including recoveries, new case, and closed case updates, and provide any Department-mandated monthly activity reports

Third-party Liability

Aetna understands and will comply with the requirements outlined in the **Draft Medicaid Managed Care Contract and Appendices Section 14.2,** 907 KAR 1:604, 42 CFR 433.138, and 42 CFR 433.139.

Aetna recovered more than $15 million through subrogation processes from 2016 to 2019.

Aetna has policies and procedures in place to help ensure that Medicaid is the payer of last resort, and as a result, shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. Aetna maintains a current TPL Resource File that contains enrollees' current TPL information, including coverage that has ended for the enrollee. We share this information with subcontractors that are responsible for the payment of covered services for enrollees. Aetna understands that enrollee copayments, co-insurance, and deductible amounts cannot exceed amounts specified in 907 KAR 1:604.

The most effective approach to TPL is cost avoidance, under which claims covered by other available resources are prevented from being processed. Our sophisticated information technology infrastructure uses proprietary software to expedite identification of enrollees with other forms of insurance and isolates any claims that must be submitted to other payers. This process confirms our ability to inform the Department quickly via confidential electronic transmission of any discrepancies, further enabling the regulator to investigate the third-party coverage status of a Medicaid enrollee.

Care managers have access to information about third-party resources available as a benefit to cover enrollees' care in our claims processing system. Care managers use this information to identify potential responsible payers for benefit coordination, such as Medicare for dual-eligible enrollees. During the assessment and benefit analysis processes, care managers request information on available third-party resources and identify the primary responsible party for services. We engage in coordination of benefits practices so that Medicaid is the payer of last resort.

Once third-party coverage is identified and verified directly with the other payer, we coordinate activities to make sure costs for services are either avoided or recovered from the liable party. If we are unable to establish third-party insurance coverage timely, the claim is adjudicated and post-payment recovery is pursued, as appropriate.

In accordance with the Bipartisan Budget Act of 2018 (BBA), we take all reasonable measures to identify sources of TPL before making payment for a claim for Medicaid prenatal care services. Aetna will make payment for preventive pediatric services within 30 days without regard to TPL but may wait up to 90 days after the provider bills the third party if it will not adversely affect access to care. Additionally, pursuant to the BBA, Aetna may make payment for services provided to a child on whose behalf child support enforcement is being carried out by the State without regard to TPL if (a) the liable third party is a

parent whose obligation to pay is being enforced, and (b) the parent has not made the payment within 90 days after the provider submitted the claim. A 2019 amendment to the BBA requires the State to make payments without regard to third-party liability for pediatric preventive services unless the State has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.

Claims Processing

We collaborate across multiple departments within Aetna (e.g., Provider Services, Claims Inquiry/Claims Research, and Enrollee Services) to identify other available sources of payment and capture them in our claims processing system to position Kentucky Medicaid as the payer of last resort. Our policies and procedures validate this through a thorough investigation of claims for potential third-party payers. When we receive a claim for an enrollee with other documented insurance with no remittance advice attached, we cost avoid or deny and return the claim to the provider with instructions to submit it to the other insurance company.

Our Provider Services staff trains our network providers about their important role in the TPL process and their responsibility to identify, capture, and report TPL information. TPL collection and recovery begins as soon as third-party resources are identified. The goal for collection activities is to collect 100 percent of what we paid that is the responsibility of a third-party insurance company

Third-party Liability Subsystem

Aetna maintains a management information system that provides support for all aspects of our health plan, including a third-party liability subsystem. Claims received for enrollees with documented other insurance—where no other insurance payment data is included, whether paper or electronic—are denied and returned to the provider with instructions to submit to the other insurance company for primary payment. Payment is coordinated for claims received with other insurance payment data. For specific enrollee coverage types such as foster and Medicare members, exemptions are built into both our processes and written procedures to exclude specific claim scenarios from denial.

Claims Billed with Provider as Department of Health

Claims billed with the provider as the Kentucky Department of Health—those with no payment made from another TPL carrier—are all identified in written procedures as exemptions to bypass explanation of benefits (EOB) requirements. Written procedures include the following: toolkits to include bill types, provider specialties, diagnosis codes and procedure codes, and modifiers considered exempt from EOB requirements to support accurate payment processing. In the case of new births, Early and Periodic Screening, Diagnostic and Treatment, prenatal, and pregnancy services, Aetna will pay the claims and seek TPL liability recovery through our vendor.

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60.7.C.6 Management Information System

Kentucky | Transforming Health Care | **Aetna**

60.7.C.6 Management Information System (Section 15 Management Information System)

Aetna understands, acknowledges, and will comply with all the **Draft Medicaid Managed Care Contract and Appendices** requirements to support **Section 15 Management Information System,** and **Appendix G Management Information System Requirements.**

a. Supporting Aetna's Medicaid Program through our Management Information System

Aetna's robust, integrated management information system (MIS) is designed to support the Cabinet for Health and Family Services' goal to support the enrollee/provider journey and increase service efficiency and effectiveness. We support this goal through both the Aetna Medicaid organization's MIS approach and our local Kentucky health plan's application and use of this system. The Aetna Medicaid organization[1] has been serving the Commonwealth's Medicaid population since 2011 and offers the Commonwealth information systems that are flexible, scalable, and integrative. This enables our platforms to provide rules-based eligibility, enrollment, customer service, claims processing systems, and web-based case management applications that serve individuals and providers.

Locally, Aetna currently offers benefits and services to approximately 211,000 enrollees. Aetna augments by bringing national robust expertise, resources, and innovative data solutions. This helps solidify an enrollee care experience that is effective, seamless, and personalized to their individual needs while supporting provider partners to help them achieve success in meeting their quality and cost outcomes.

In the following narrative, we describe our MIS system and our eight subsystems including enrollee, third-party liability (TPL), provider, reference, encounter/claims processing (to include encounter data), financial, utilization data/quality improvement, and surveillance utilization review and their accompanying flowcharts and/or graphics. We also highlight the following:

- Potential risks and mitigation strategies for implementing new information systems
- Current and planned use and support of new and existing technology in health information exchange (HIE), electronic health records (EHR), and personal health records (PHR)
- Our approach to assessing integrity, accuracy, and completeness of data submitted
- Our data security approach and how the we comply with Health Insurance Portability and Accountability Act (HIPAA) standards
- Our upcoming changes and enhancements

Management Information System

Our system is designed and well-positioned to scale and evolve to benefit the health care and service provider needs for all enrollees across Kentucky's eight Medicaid regions. Leveraging our deep, local experience and national resources and expertise, Aetna delivers to the Department an inclusive suite of innovative technologies and tools to drive advanced care coordination and delivery transformation. Our proprietary system delivers best-in-class capabilities and performance using the highest industry standards, controls, business continuity, security, and redundancy features to assure the highest level of data protection. We have a national Information Technology (IT) team that supports our local health plan team to ensure our technology platform continues to deliver performance, innovation, and value in collaboration with our Commonwealth and local partners. For example, in previous implementations,

[1] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

Greg Krause, our MIS director, and his national team worked closely with the Department, DXC Technology, and other parties from policy interpretation to implementation. The process of developing and operationalizing complex policy and system changes allowed for the creation of a strong partnership.

This collaboration between our national and local teams is also evident in our Multi-Year Technology Innovation Roadmap, which will bring significant new investments and capabilities for our providers and enrollees in in areas of digital and clinical engagement, automation, administrative simplification, and personalized health solutions. Some examples of these capabilities we are working together to deliver include the new Aetna Health enrollee mobile application, prior authorization process automation and simplification, and our 'Next Best Action' personalized health analytics engine. Examples of our vision for these future capabilities are depicted in the following two Journey Maps—**Figure C.6-1** and **Figure C.6-2.** These illustrations show how our investments in these integrated capabilities will drive end-to-end engagement and value to our enrollees and providers throughout their health care journey with Aetna.

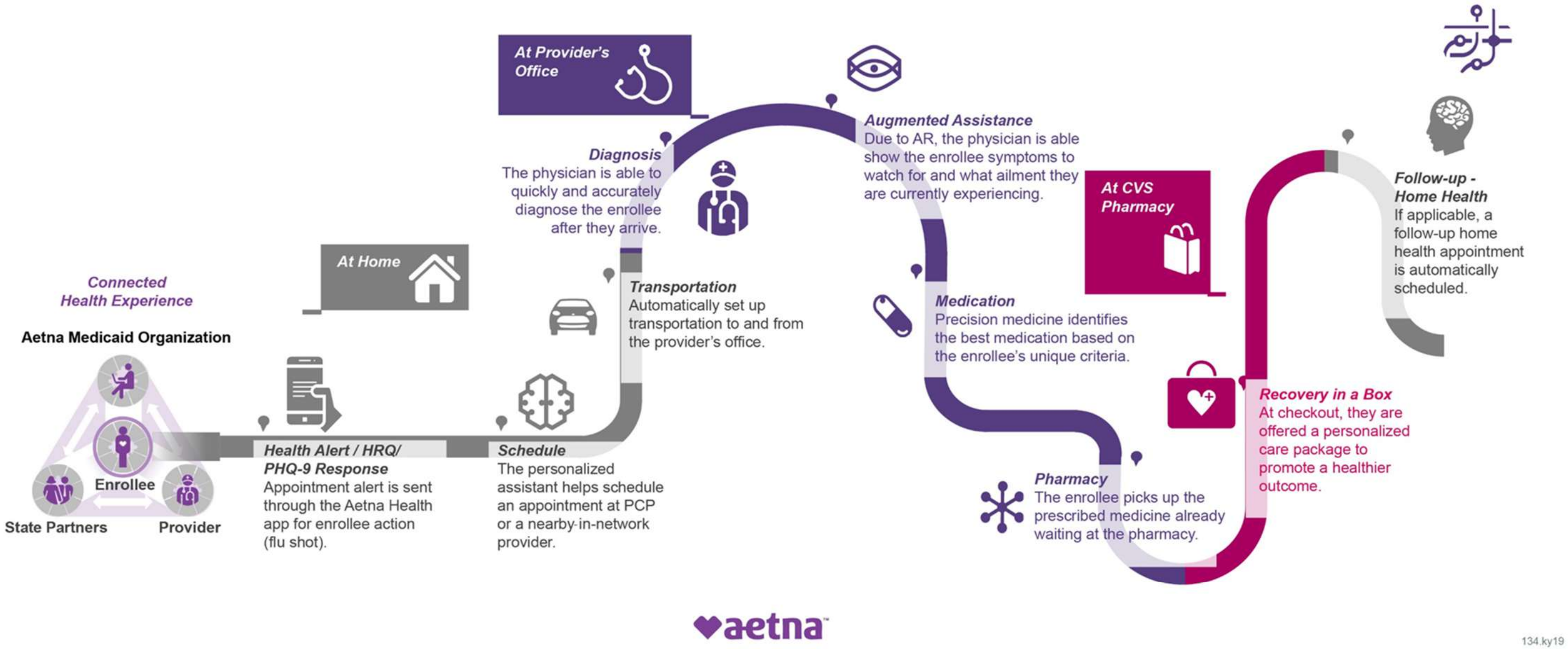

Figure C.6-1: Our Vision for Enrollees

This 'journey' shows all the touchpoints and opportunities for collaboration we create for our enrollees.

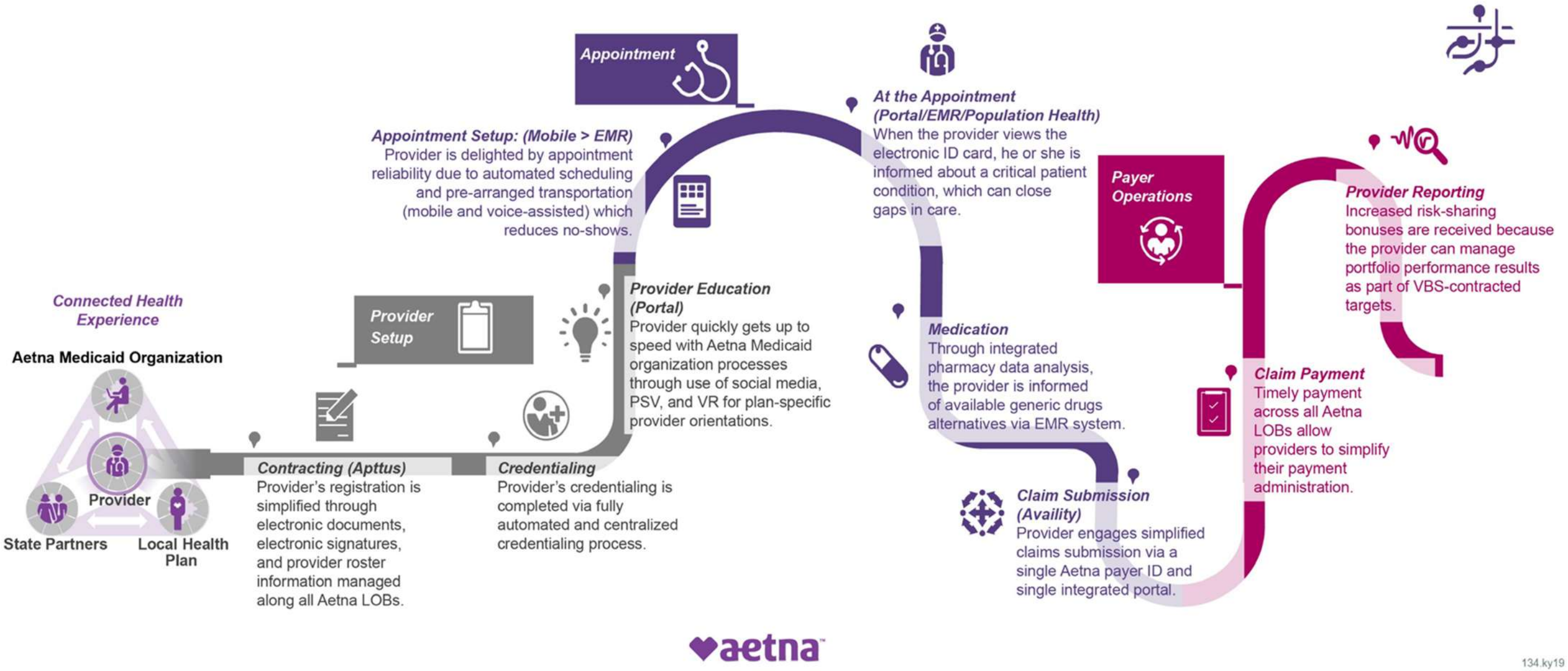

Figure C.6-2: Our Vision for Providers

This 'journey' shows all the touchpoints and opportunities for collaboration we create for our providers.

All stakeholders benefit from ready access to **local, dedicated, and comprehensive MIS staff expertise in our Kentucky Medicaid program.** Our Aetna-designated MIS personnel participate regularly in the Department's MIS calls and other MIS-related work groups (i.e., encounters and technology calls), and adhere to the Commonwealth's policies and procedures regarding advance notification of major systems changes and implementations, communication of changes within the MIS organization structure, and prompt updates to point-of-contact information.

We are fully capable of adapting our systems to changes in business practices/policies within required timelines, and our history and experience show we stand ready to assist with any required desk or onsite readiness review. The following narrative addresses the eight subsystems including enrollee, TPL, provider, reference, claims processing (to include encounter data), financial, utilization/quality improvement, and surveillance utilization review. **Figure C.6-3** provides an overview of our entire information platform.

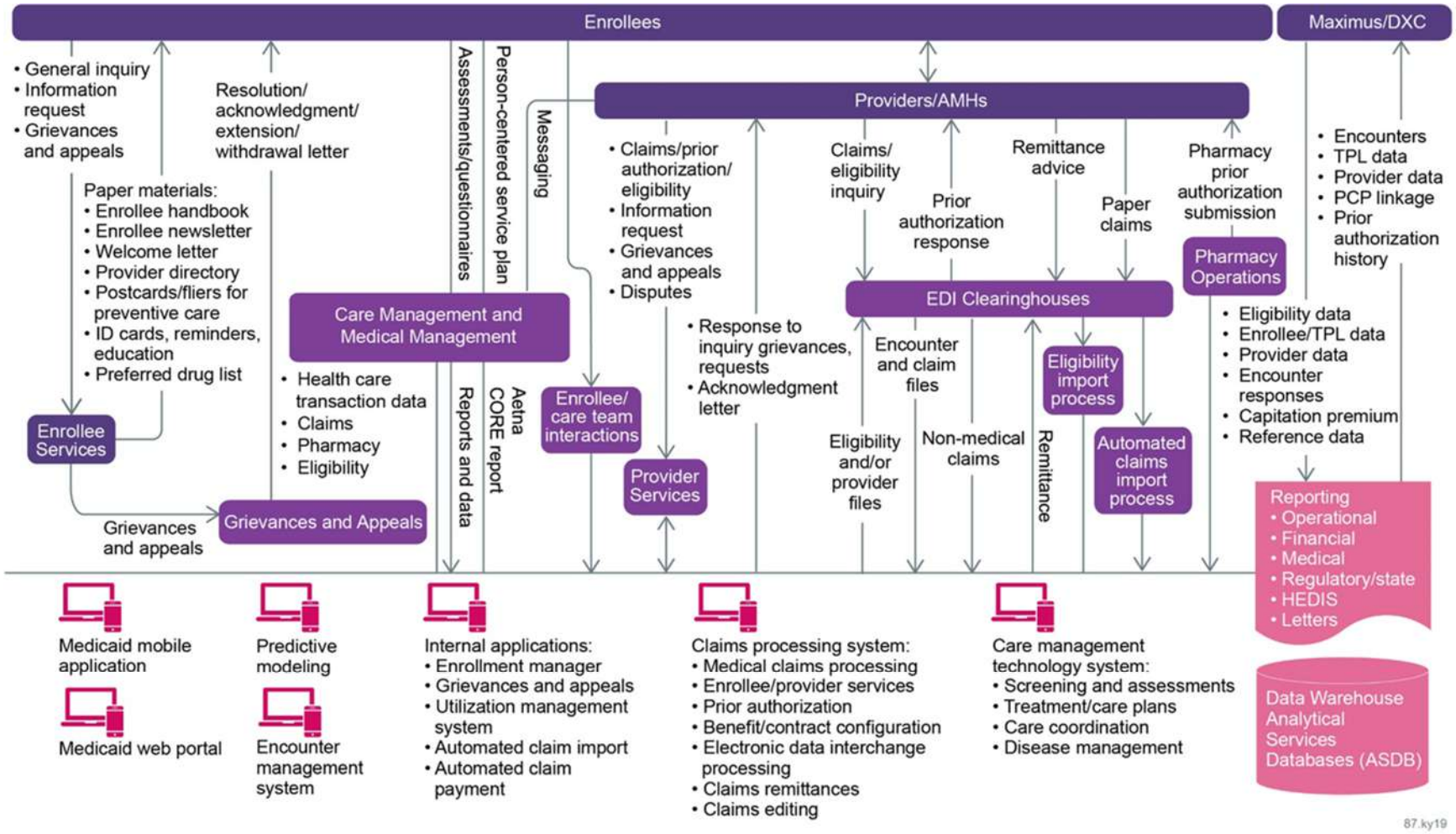

Figure C.6-3: Management Information System Architecture

This flow chart illustrates the MIS component components and how they interface between the support systems.

Table C.6-1 describes the systems within the previous flowchart and highlights the functions of each subsystem of the flowchart.

Table C.6-1: Aetna Management Information Systems

MIS Subsystems	Description
Enrollment/Enrollee	Highly customizable, rules-based system to process and load 834, coordination of benefits (COB), TPL, primary care provider (PCP) assignment, and supplemental enrollee files to our core claims processing system.
TPL	Customizable staging platform to ingest, validate, and prepare TPL data for internal and external use.
Provider	Contracting, credentialing, and staging systems which prepare and load provider data to our claim processing system.
Reference	File intake, analysis, preparation, and loading tools to ensure accurate and up to date reference data in our core claim processing system.
Claims processing system	Suite of modules which include the books of record for claims processing, enrollment, customer services, utilization management/service authorization, provider and contract information, and reference files such as files such as National Drug Codes, American Medical Association Current Procedural Terminal 4, Centers for Medicare and Medicaid Services (CMS)-Healthcare Common Procedure Coding System, International Statistical Classification of Diseases and Related Health Problems (ICD)-10, Diagnostic and Statistical Manuel of Mental Disorders IV, diagnosis-related group, revenue codes, and American Dental Association codes.
Financial	Financial reporting system for administrative revenue and expense management as well as integrated provider claim and capitation payment module within our core claim processing system.
Utilization/Quality Improvement	Integrated module within our core claims processing system to support utilization management (UM) intake and determination through claim payment and back end clinical and quality reporting.
Surveillance	Integrated component of our data warehouse to support proactive analytics and reporting in support of fraud, waste, and abuse detection, including our use of the Healthcare Fraud Shield (HCFS) application.
Additional subsystems:	
Care management system	Clinical tools such as screenings, assessments, and care plan documents used in our care management activities, stored and available to permitted enrollees and providers.
Population health system	A unified view of enrollee data for providers that shares data digitally and aggregates actionable data across enrollee roster.
Enrollee and provider portals	Offers both enrollees and providers secure data access and extensive, interactive functionality through a web browser capability.
Mobile application	App store-accessible platform that enrollees access to most widely sought functionality (e.g., find a provider, view identification (ID) card, check an authorization).
Grievance and appeals	Tracks and monitors grievance and appeals records, provides workflows for service teams, and provider auto-letter generation using customized reporting templates for Kentucky.

a.i. Enrollee Subsystem

Aetna has a successful eight-year history working with the Department to use HIPAA-compliant benefit enrollment and maintenance (834) transactions to process and reconcile enrollment data.

The Aetna Medicaid organization has successfully processed over 50 million daily and monthly 834 records over the last 13 months.

We follow standard, documented, and approved processes and procedures for receiving and processing enrollment data. Aetna accepts and processes the standard X12 Benefit Enrollment and Maintenance (834), Version 5010 enrollment file provided by the Department as the mechanism to update enrollee enrollment and disenrollment information. We use enrollee data contained in these data files to manage eligibility, authorize services, and process claim transactions.

The Enrollment Services team resolves daily 834 change files in one business day and reconciliation files within five business days. We reconcile enrollee eligibility information between the 834 file and the enrollee files in the core system. We meet the criteria for the timely loading of enrollee data. **Table C.6-2** provides a summary of our Kentucky and national enrollment processing volume over the preceding 13-month period (December 2018 and December 2019 are both listed to complete the year-to-year view).

Table C.6-2: 834 File Processing

Plan	File Type	Total 834 Files Processed	Total 834 File Records Processed
Kentucky	Daily	284	4,247,881
Kentucky	Monthly	14	2,956,331
All	Daily	11,515	13,851,976
All	Monthly/Reconciliation	684	35,691,185

As illustrated in the following **Figure C.6-4,** the Enrollment Services team identifies, researches, and validates exceptions, making the appropriate updates in the core system and notifying the Department as required. Aetna's enrollment manager is configured to extract all data elements in the 834 file including waiver type of assistance and tiers type of assistance codes along with their effective and termination dates. These changes trigger additional benefit changes, and they cascade to all other systems to help ensure change in enrollee eligibility type also changes the benefits coverage. This allows consistency across systems and connects enrollees with their appropriate program benefits, which avoids disruption in enrollee services.

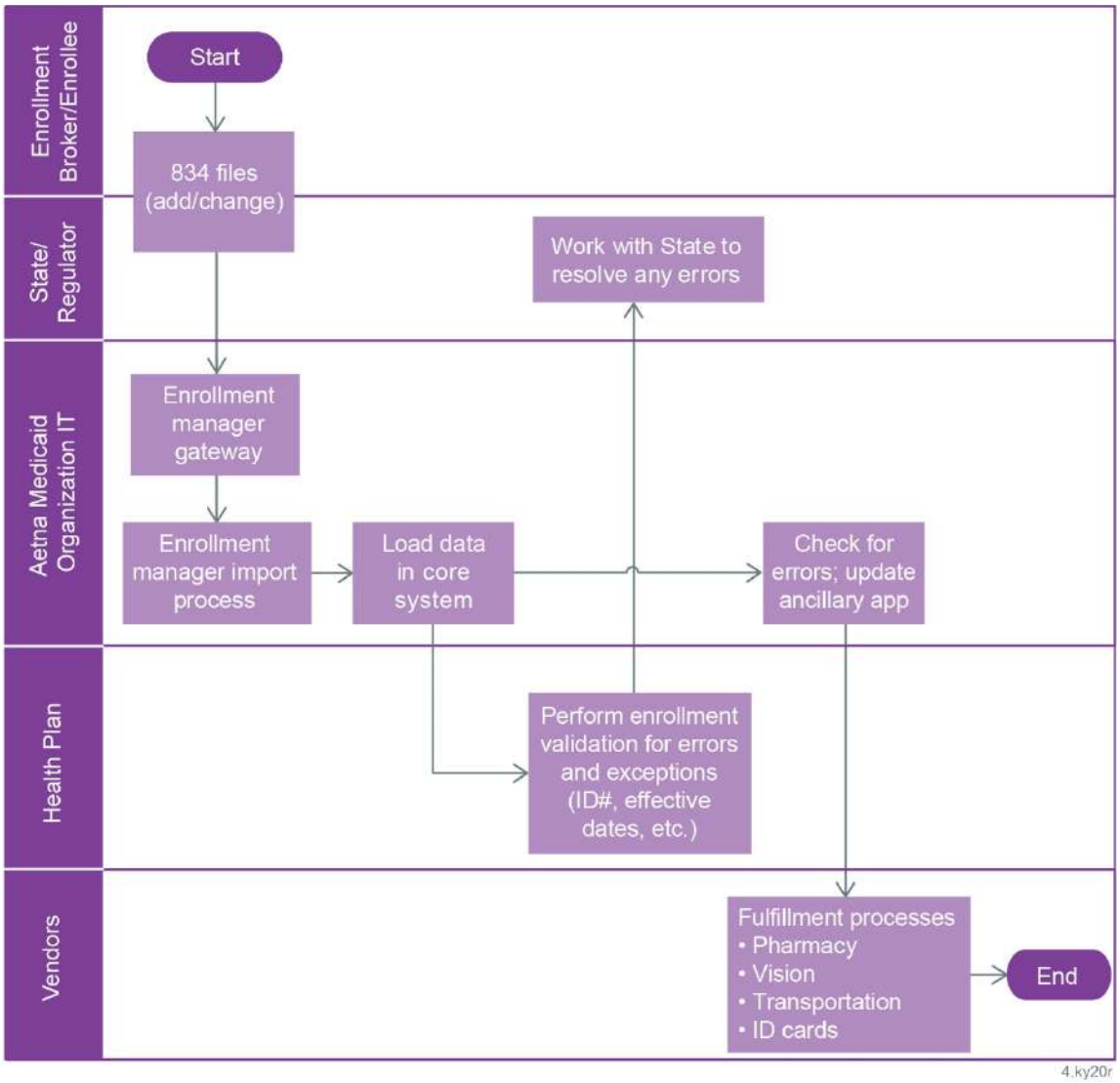

Figure C.6-4: Enrollment Process

This illustration shows the flow enrollment information from the enrollee through to our vendors.

To provide greater efficiency and accuracy of enrollment record handling, we will be deploying artificial intelligence (AI) capability for the Kentucky plan to improve eligibility file processing quality, preserve data integrity, and reduce manual intervention to fix and analyze the data issues. This AI-based solution will use anomaly detection, a technique used to identify unusual patterns that do not conform to normal, expected behavior to identify anomalies in enrollee enrollment data. Enrollment product capabilities that will benefit from this AI solution are as follows:

- New enrollee with insufficient enrollment information
- Identify eligible benefit
- Enrollment termination
- Term/void by absence
- Enrollment benefit change: term/void and reinstate

Anomaly detection and resolution will be refined with detailed configurable parameters specific to the plan, ensuring enrollee enrollment and status changes are updated automatically and appropriately.

We have also implemented bulk enrollment handling improvements within our enrollment manager application, which has decreased our average processing time by 90 percent.

Table C.6-3 illustrates the efficiency of our new enrollment application before and after performance improvement.

Table C.6-3: Processed Files in Minutes

Enrollment Manager	Processing Step	Total Minutes	Records Processed	Records per Hour
Old version	Enrollee enrollment update	22	154,014	**413,460**
Enhanced version	Enrollee enrollment update	8	592,946	**4,338,629**

Changes in Enrollee Eligibility Type

Aetna understands that changes in an enrollee's eligibility can impact continuity of care. Our Enrollment Services team uses consistent processes for tracking changes in enrollee eligibility, including review of monthly HIPAA-compliant benefit enrollment and maintenance (834) transactions to process and reconcile enrollment data as well as employing standard, documented, and approved processes and procedures for receiving and processing enrollment data.

Our Enrollment Services team meets the Department's technical specifications criteria for timely processing of enrollee data and reflecting enrollee enrollment changes electronically on a daily and/or monthly basis by taking the following actions:

- Resolving 834-change files in a standard 24-hour business day
- Reconciling enrollee eligibility information between the 834 file and the enrollee files in our electronic claims management system, including notifying the Department within five business days when there are changes to the enrollee's circumstances that may affect the enrollee's eligibility (including changes in the enrollee's residence, such as out-of-state claims, or the death of the enrollee)
- Identifying, researching, reconciling, and validating exceptions, making appropriate updates in our electronic claims management system, and notifying the Department, as required

Newborn Enrollment Process

Our system is flexible, allowing newborns to receive services immediately. We identify newborns through our Medical Management staff and processes; therefore, we can enroll them into our system while waiting for the newborn to be included on the 834 file. Unmatched enrollees are reported to the Commonwealth monthly. When the newborn records are sent on the 834, our enrollment manager application is configured to match them to their mothers using their shared case number. The application will store matching case numbers for family members so that they are linked in our system, but each enrollee will keep their own unique identification number.

Our enrollment manager application utilizes proprietary enrollee matching rules to ensure file records (including newborns) are accurately matched to existing records in our system when processing 834 files. Our rules include 24 unique combinations of demographic data in order to determine if the enrollee already exists in our system. The application also has logic in place that will place a record for manual review by our Enrollment Services team if there is a potential discrepancy when matching to our existing system records. This process prevents duplication and allows us to maintain a single system record per enrollee.

Tracking Enrollee Eligibility Dates

When we receive daily or monthly eligibility files from the Department, Aetna's enrollment manager application extracts all the key dates from the 834 files including eligibility start and end dates. We also

make certain that any retro-enrollments or retro-termination dates are processed in the system correctly. If an enrollee's benefit changes, we create a new enrollment span with correct effective and end dates. Enrollment data cascades to other systems and to our subcontractors as well.

a.ii. Third Party Liability Subsystem

Aetna is an industry leader in managing care and controlling costs with proven strategies to help ensure Medicaid is the payer of last resort. To ensure that federal TPL requirements are met and to maximize savings from available third-party resources, identification and recovery of those resources is a joint effort between the Department and Aetna. We begin COB and TPL efforts upon receipt of files from multiple sources including the Department at the earliest point possible, educating providers of their responsibility to identify other existing coverage to maximize COB/TPL identification and recovery opportunities. **Figure C.6-5** illustrates our COB/TPL data and process flow. **Over the past three years, we have recognized in excess of $365 million in TPL savings.**

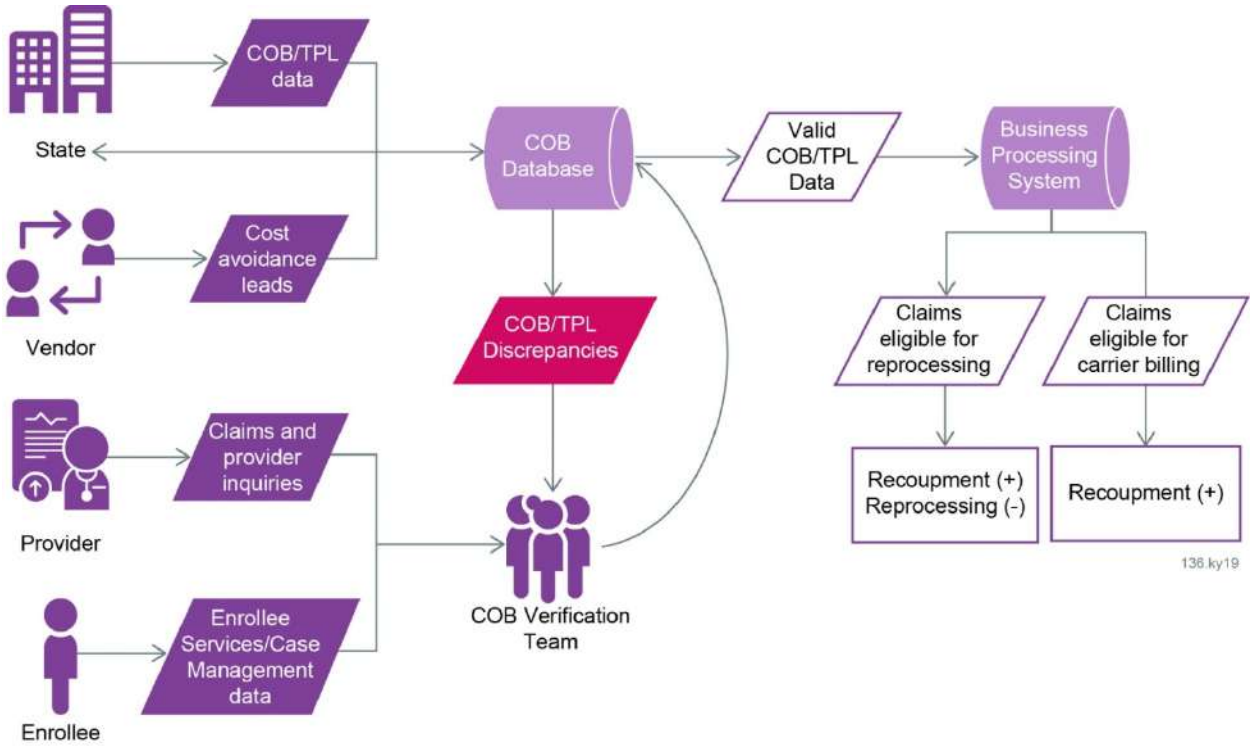

Figure C.6-5: COB/TPL Data and Process Flow

This flow chart depicts receipt of files from multiple sources and how we educate providers and identify other existing coverage to maximize COB/TPL recovery opportunities.

Aetna directs third-party information to our COB and TPL departments. Our COB/TPL analysts adhere strictly to written policies and procedures (developed in accordance with federal and Commonwealth regulations) that include use of other available sources of payment and recovery. Our provider agreements specify provider responsibilities for TPL, including identifying Medicare and other insurance when applicable and seeking payment through that source before filing a claim with Medicaid.

Our extensive experience matching enrollee data with vendors for other insurance leads promotes proactive cost avoidance. We share enrollee enrollment data via secured file transfer protocol with vendors that specialize in matching enrollment data from other insurance companies. Aetna has experience with COB and the exchange of information via the crossover claim process. In addition to

electronic transfers, our TPL/COB staff is trained to research all TPL/COB leads using all available resources within federal and Kentucky guidelines. Aetna's COB department is notified of known third-party resource information provided by the Department through the enrollment process based on the information obtained through the enrollee's eligibility determination or redetermination.

Our COB department also receives third-party information from our other departments (i.e., Provider Services, Claims Inquiry/Claims Research, and Enrollee Services); we validate the information directly with the other payers via phone and web systems. Following validation, we process the information in our claims management system to coordinate benefits on new day claims as well as and adjust any prior affected claims, ensuring that enrollees are covered for services and verifying that Medicaid is the payer of last resort. We comply with all Department COB/TPL guidelines and will demonstrate, upon request, that reasonable collection efforts and appropriate recovery actions were pursued. In addition, we send TPL information to our subcontractors so that they are adjudicating claims with up-to-date information and to the Department to allow updates to their system.

a.ii.i. Provider Subsystem

The narrative below outlines our provider subsystems including data inputs, data processing, inquiry/on-line directory, and data interfaces.

Provider Data Inputs

Aetna has a robust and extensive provider network throughout the Commonwealth. Our Kentucky Medicaid provider network exceeds the Department's adequacy standards. Provider data is housed in our claims management system, which serves as the book of record for Medicaid provider data. Our provider data, which encompasses all required data elements to support claims/encounter processing, PCP assignment/selection and provider searches, is collected through various mechanisms including the following:

- **Contracting:** New provider data is initially captured during our network contracting efforts through the completion of a standard application and currently uploaded to our provider data staging tool. Finalized contracts are then used to configure rates and uploaded to claims management system. We are in the process of enhancing our contracting capabilities by deploying an automated contract management solution, Apttus, to manage all stages of the contract lifecycle from new contract generation through negotiations, final signature, obligation management, and storage/search. Our automated contracting tool will eliminate errors through tight version control, reduce the time required to execute a network agreement with Aetna, and ensure greater compliance with enhanced tracking capabilities. We are implementing this tool in early 2020.
- **Credentialing:** Aetna will be using robotic process automation to improve the efficiency with which we collect and enter accreditation data into our provider data staging tool. This will ensure greater accuracy and ensure that credentialing information is updated in a timely fashion.
- **Monthly roster updates:** Aetna's Provider Services staff reconciles and validates all roster data prior to updating in the claims management system. Aetna will be piloting automated roster comparisons using various sources such as Commonwealth data files, National Committee for Quality Assurance (NCQA) data and other internal Aetna databases to improve the timeliness of roster updates in our systems. **Figure C.6-6** show our provider inputs, processing, and requirements flows.

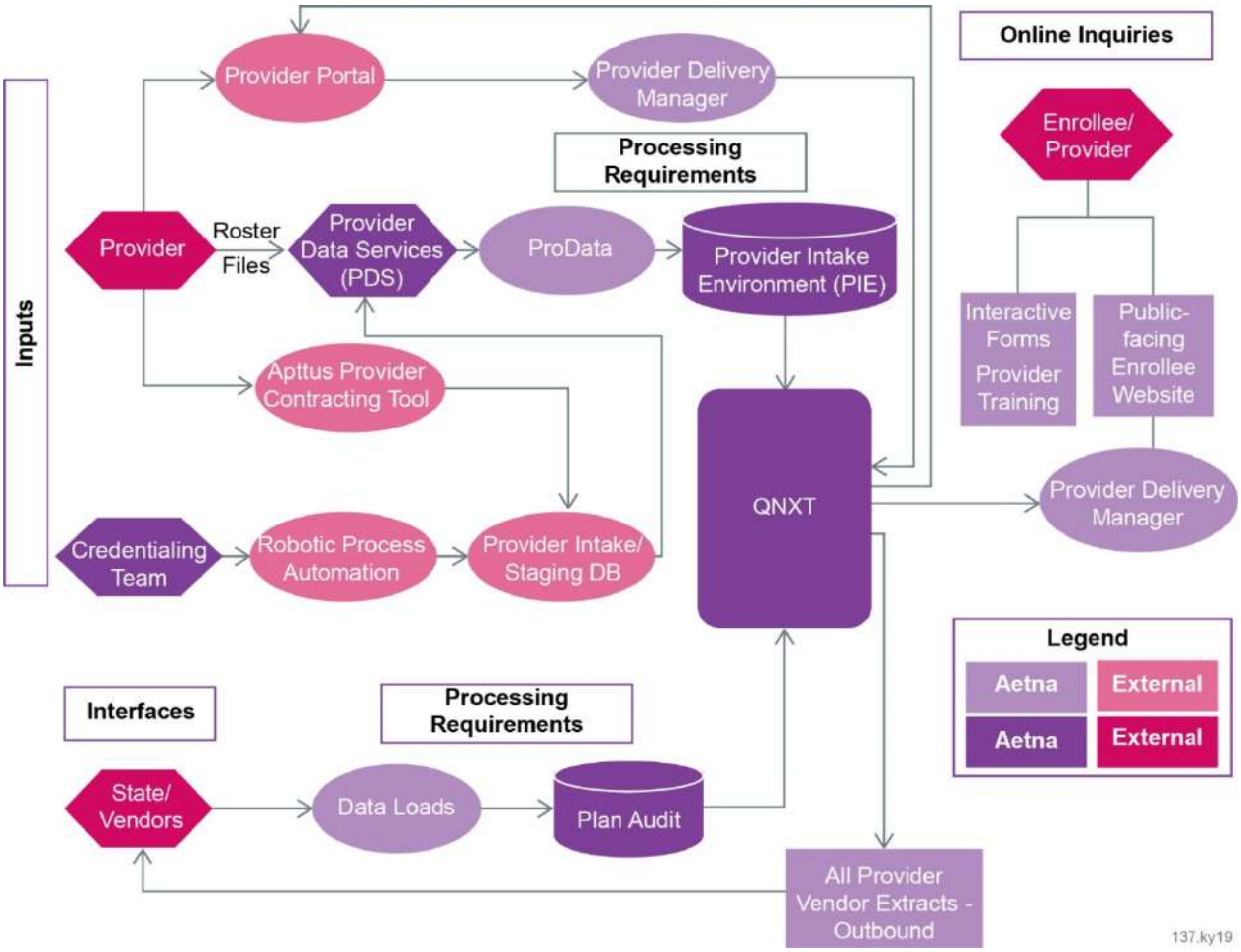

Figure C.6-6: Provider Domain Process

The provider inputs flowchart depicts the relationship between our internal and external provider data platforms.

- **Provider data processing:** Managing the provider book of record begins first in our provider data staging tool where our data standards are established. During data entry, records are required to go through extensive validations to ensure they meet the correct formats established by the Commonwealth of Kentucky and the Aetna claims management system platform. Once network contracts have been executed, our Provider Experience team initiates the data load through our ProData/provider intake environment (PIE) platform. Our ProData/PIE platform allows for bulk loading; supports further data validations, such as address conformity with United States Postal Service standards; and maintains a history of data updates for traceability and permits a final quality check on the data load into the book of record. Upon completion of the data load, automated notifications are generated to confirm successful transmission or any fallout records, as appropriate.

  The claims management system serves as the Aetna provider book of record; there are external feeds to our vendors and the self-service provider portal. Today, the Aetna provider portal offers a wide range of capabilities from provider reports to claims status information. As we continually review and identify opportunities to improve the functionality and ease of use on our provider portal, Aetna is currently in the process of reviewing and planning enhancements to our current portal functionality including integrating with the Availity web portal, a provider web portal that supports multiple MCOs' data. These future enhancements will offer providers a more robust set of provider self-

service tools and information, including but not limited to one-stop shopping for providers to access their data across multiple MCOs if they have an account with Availity; improvements to the submission of attachments to support administrative and clinical processes, such as appeals; ease in contacting Aetna directly through the portal; and improved access to provider demographic updates.

- **Provider inquiry—online directory:** Our web-based directory offers visitors a convenient, searchable tool to locate health care professionals or group practices including doctor, dentists, vision care providers, pharmacies and other types of health care service providers within our network. Using a variety of search criteria, such as location, provider name or provider specialty, visitors can quickly find a practitioner that meets their health care needs. Our online directory makes available the most current information about these health care professionals from our claims management system provider book of record including whether the provider is accepting new patients, board certifications, hospital/group certifications, service location with Google Maps information, etc. We also regularly review our onsite accessibility compliance to ensure we meet Web Content Accessibility Guidelines 2.0 at level AA standards.

  As we continue to review and identify opportunities to improve the usability of the online directory, Aetna will implement additional search criteria to more readily locate the following specialized services:
  - Telehealth
  - Medication-assisted treatment
  - Opioid-related services
  - Urgent care

  Visitors may select one, many, or all the attribute values within that provider specialty to further refine their search and locate a practitioner that best suits their needs.
- **Provider data interfaces:** Aetna supports a variety of different data sharing approaches and data formats. Aetna has a successful track record generating provider data files to the Department as well as receives and processes provider files received from the Department. In addition, Aetna supports downstream provider data feeds to our vendors to share key Aetna provider data to support their administrative processes. We use a Splunk-branded security and incident management tool to monitor our external file transmissions.

a.ii.ii. Reference Subsystem

Our integrated claims management system is our book of record for all reference data and includes powerful, highly configurable capability to store and leverage these data in the full range of system and operational administration processes including claims, encounters, TPL/COB, utilization management, care management, quality reporting, provider contract configuration, enrollee/provider service, grievance and appeals, etc. Our system can fully store and maintain both current and historical base records, as well as configure those records to ensure accurate, timely system processing. Reference files that are processed and loaded to our core system are then integrated into our downstream systems and data warehouse to ensure reliability and consistency throughout our technology platform.

We follow a standard, rigorous process to ensure complete and accurate updates to all our reference files on a scheduled basis. We use Optum for our standard reference files and the standard reference file list including the following:

- Service code–quarterly
- Current Dental Terminology code–annually (typically first quarter)
- Modifier–quarterly
- Service code modifier–quarterly
- Service category group and service category group header–quarterly
- Revenue code–annually (typically third quarter)

- Revenue code Healthcare Common Procedure Coding System (HCPCS) rule and revenue code HCPCS group–quarterly
- Diagnosis code and procedure code–annually (Q4)
- Relative value code and geographical practice cost index–quarterly
- UB04 (UB condition, UB occurrence, UB value)–quarterly
- ZIP code (region, region ZIP, Medicare locality)–annually (first quarter)

Our national Configuration Standards Reimbursement Administration (CSRA) team works closely with our information technology and local health plan operations teams to analyze, process, test, and load each file to our system. The following is an overview of the step-by-step process we use to load each reference file:

- Collect all current health plan reference file data onto our configuration management server
- Receive notification of updated reference file availability from our source vendor (primarily Optum)
- Download the updated reference files from the source vendor
- Reformat the vendor reference files into a standard spreadsheet content
- Upload the standard reference file spreadsheets to the configuration management server
- Create internal work management tickets for tracking of claim processing system table updates
- Execute standard reference file analysis scripts, which do the following:
  - Compare the quarterly/annual updates against the data currently in our system
  - Determine the number of record updates which are required
  - Generate the reference table update impact for the health plan
- Perform independent validation of the service code, Current Procedural Terminology (CPT)/modifier, and service group updates
- Execute standard reference file quality check (QC) validation scripts against pre-load reference table updates
- Execute Powershell batch script to load the reference table updates to the pre-production environment
- Execute standard reference file QC validation scripts against completed reference table updates to the pre-production environment and ensure all changes completed successfully
- Submit requests to IT team to promote the table updates to the production environment
- Perform reference table promotes from the pre-production to production environment
- Execute standard reference file QC validation script against reference table updates completed in the production environment to ensure all changes completed successfully
- Notify the management and project lead of the successful completion of the reference file updates
- Execute standard reference file post-production query scripts in our production environment:
  - Determine if any previously adjudicated provider claims have been impacted
  - If so, initiate a work management ticket for claims to complete any claim reprocessing
- Distribute a closure notice email communication to the appropriate CSRA distribution list confirming completion of the process.

Figure C.6-7 shows the end-to-end workflow process for our quarterly reference file updates:

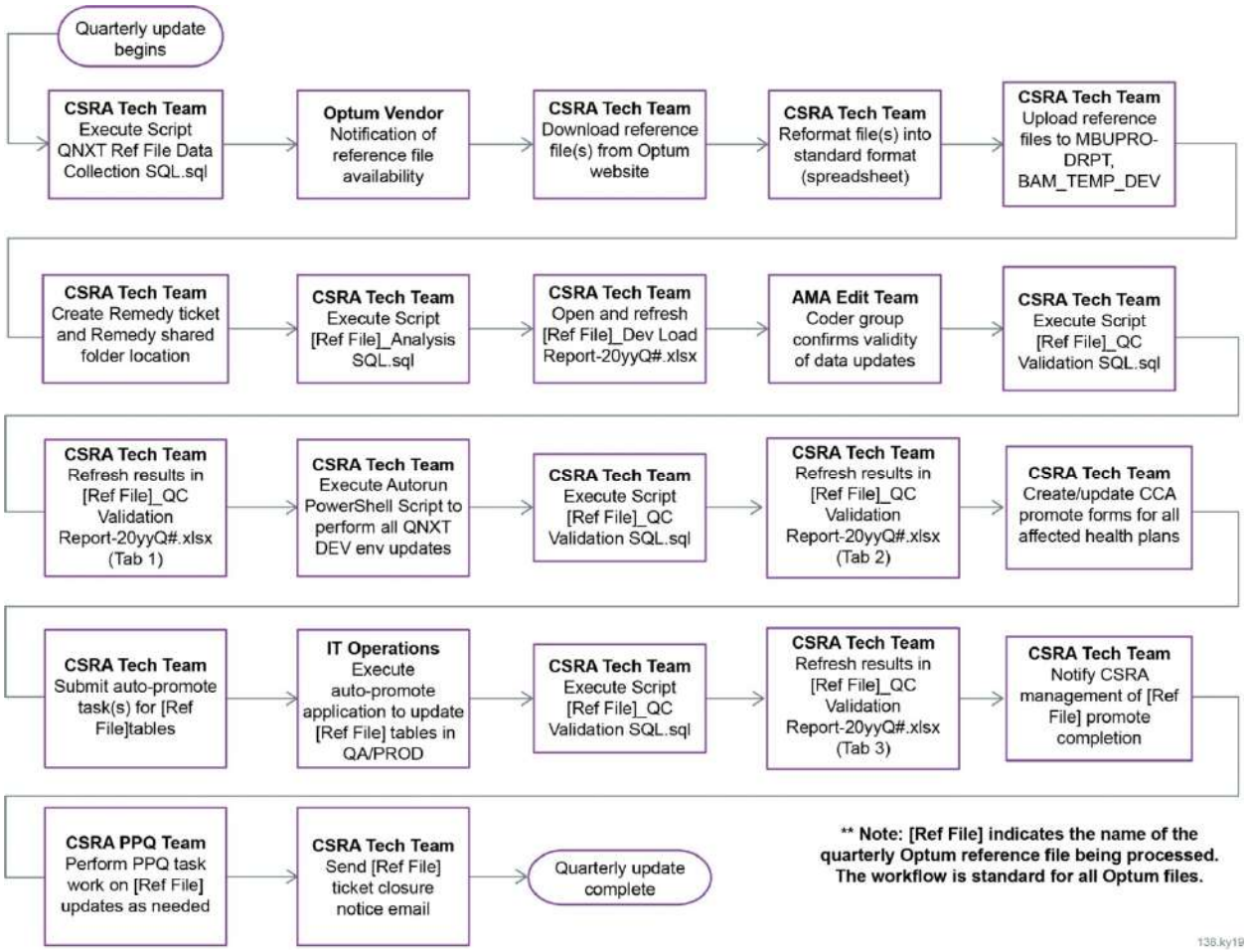

Figure C.6-7: Quarterly Updates Flow Chart

Depicting our different teams, this flow chart shows the collaboration between each of them and how they are interrelated.

In addition to the standard reference files outlined previously, the Commonwealth-defined Medicaid fee schedules are currently loaded in our claims management system. A quarterly reconciliation occurs to identify updates that are applied to the system. We also load the physician administered drug list file from the Department and the CMS Active Server Page files. These code sets and pricing are used to adjudicate physician-administered drugs in our claims management system.

a.iii. Claims Processing Subsystem including Encounter Data

Our claims adjudication system is a HIPAA-compliant, rules-based information processing system. It includes 28 integrated modules that maintain and process health care administration data, allowing us to increase administrative efficiency and improve the quality of care. The system contains every data element required for claims data adjudication. It is a claims hierarchical rules engine that was built with a feature-flagging design (rules for claims processing with a minimum disruption of services) that allows us to rapidly adjust the configuration to provide flexibility while minimizing down time and providing greater platform responsiveness. Kentucky claims import rules have been programmed and the application is built to ease turning rules and configuration characteristics on and off as needed without affecting the entire system, further ensuring service continuity. Additionally, claim adjudication edits are configured within the claims processing system to validate the accuracy and completeness of data

allowing for the seamless submission of encounters. The system has over 400 business rules in addition to standard configuration payment rules that our CSRA department configures to enforce policies and procedures, as illustrated in **Figure C.6-8.**

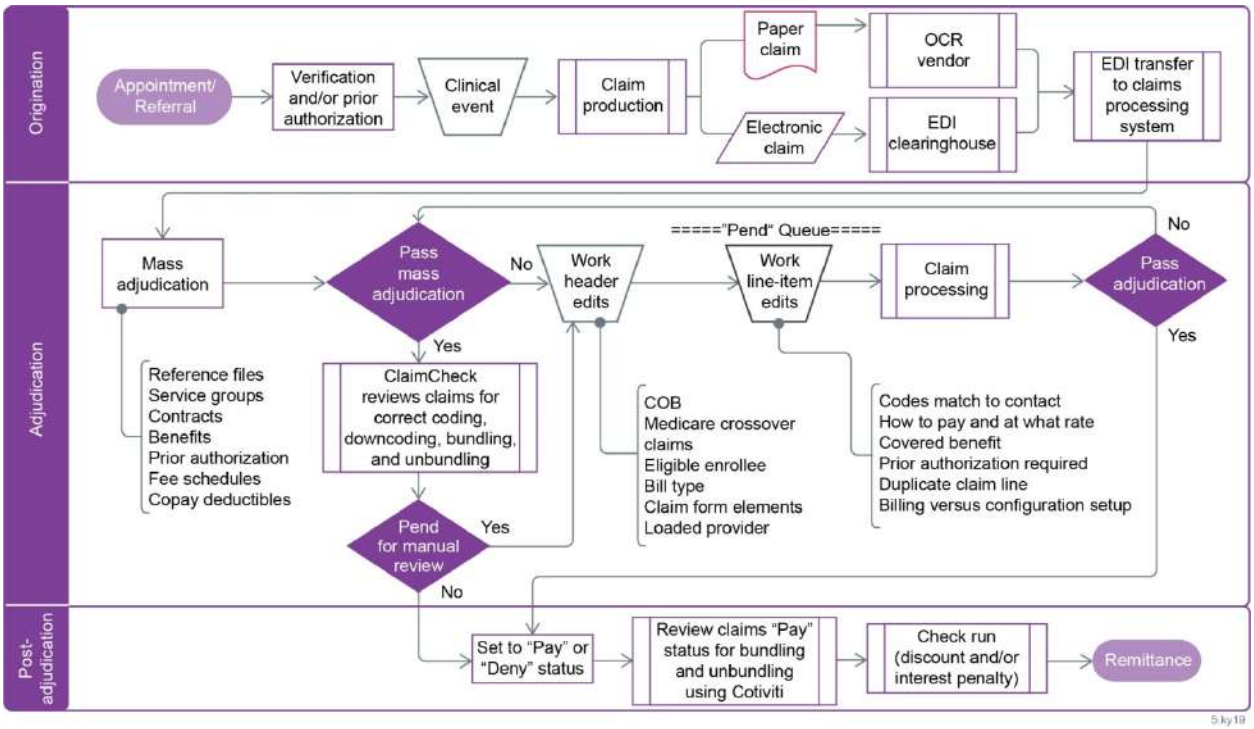

Figure C.6-8: Life of a Claim

Our end-to-end claims processing workflow ensures timely and accurate claims payment.

Edifecs, our encounter management system, is a centralized repository for our encounter data. It performs comprehensive encounter validation through a coordinated set of edits and validation rules. This allows us to proactively identify potential data issues and correct them at the earliest stage of the reporting process to help ensure accurate data, consistent tracking and trending, process improvement, monitoring, validation, reporting, and correction of encounter data. Edifecs validates all encounter files received from subcontracted vendors such as vision, dental, and pharmacy for compliance to standard HIPAA 5010 guidelines (SNIP Level 1 to 5) and performs multiple levels of validations including duplicate checks on the encounter information. To further ensure our files are fully comprehensive, correct, and complete based on Commonwealth requirements, Edifecs applies Kentucky-specific encounter editing to encounter records.

Our encounter data submission system is an integrated, HIPAA X12-compliant, single system for encounter management that consolidates submission and reconciliation processes. It performs comprehensive encounter validation through a coordinated set of edits and validation rules that comply with Commonwealth-specific business rules, allowing us to proactively identify potential data issues and correct them at the earliest stage of the reporting process. A dedicated team monitors regulatory changes in the market and performs any needed product updates to meet Commonwealth requirements and timelines. This helps to ensure accurate, consistent tracking, trending, process improvement, data collection, monitoring, validation, reporting, and error correction. The encounter management system validates

For Kentucky in calendar year 2019, **99.3% of the encounters submitted by Aetna were accepted on the first submission**, attesting to the strict internal quality controls on the encounters process.

encounter files received from all subcontracted vendors (such as vision, dental, and pharmacy) for compliance using standard HIPAA guidelines, SNIP levels one to five. It performs multiple levels of validations, including duplicate checks on the encounter information, and provides comprehensive validation steps that ensure files are accurate and complete prior to submission.

We conduct a coordinated set of edits and data checks, allowing us to identify proactively potential data issues and correct them at the earliest possible stage of the reporting process, correcting as necessary to help secure the integrity of the encounter. In addition to our internal checks, we also replicate all Department-defined encounter-editing logic as add-ons to our list of data checks. This added due diligence helps us to identify encounter errors proactively. To monitor and maintain timeliness of encounter submission, we track timeliness for both initial encounter submission and error correction to make sure all medical encounters are submitted no later than the 30th day after the last day of the month in which claim(s) are adjudicated, and within 25 days from adjudication date for pharmacy encounters.

Additionally, weekly dollar and volume reconciliation by adjudication date with claims data helps us monitor completeness of encounter submission. Please refer **Figure C.6-9** for a workflow demonstrating the quality of our encounter data submission process.

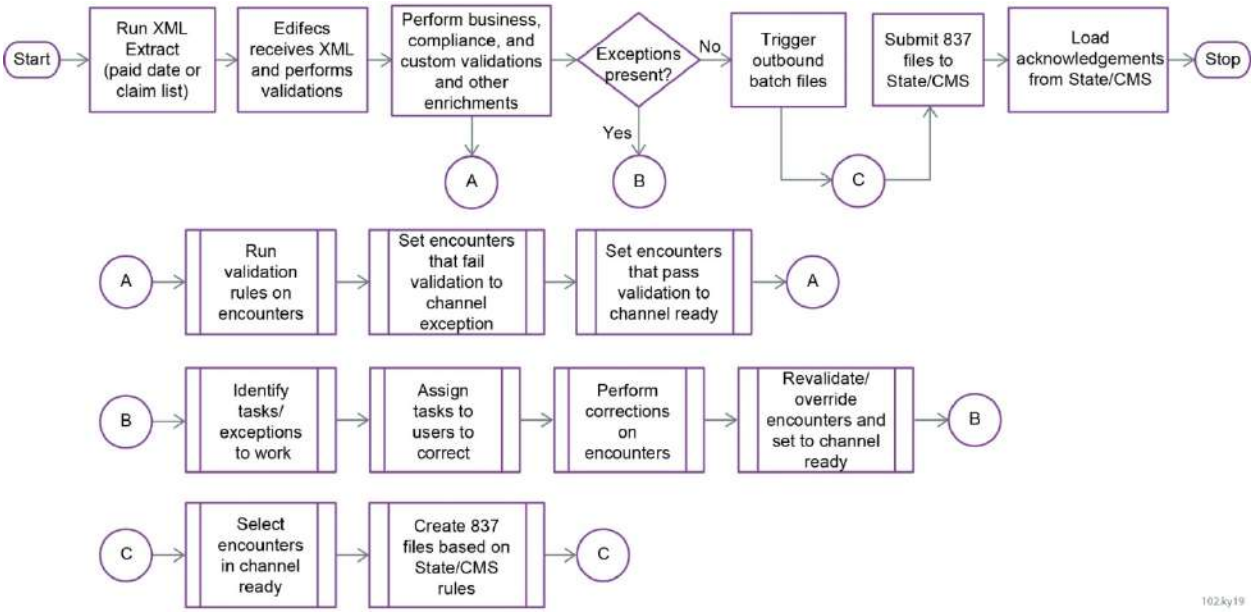

Figure C.6-9: Life of an Encounter

This graphic depicts the multiple levels of validations for our encounter data.

Once data is extracted into Edifecs, the system first validates that the data complies with standard 5010 HIPAA SNIP levels one to five. It then checks data against built-in business rules that emulate the specific Commonwealth edit requirements and uses integrated Commonwealth reference files for validation. As part of this process for Kentucky, we have integrated the daily master provider file from the Commonwealth as part of our validation which has afforded improved accuracy and reporting of encounter data elements, thereby increasing initial acceptance. Overall, these initial steps help us ensure files are as error-free and complete as possible prior to submission. To provide greater efficiency and accuracy in our claims and encounter process, we have deployed robotic processing automation (RPA) extensively within Aetna. RPA allows Aetna to remove manual processing and assists our team in providing additional data checks and revisions. In one case, claims pended for manual provider selection are instead processed through RPA, resulting in a significant reduction in turnaround time from over a week to less than one day without impacting the resulting quality of the claim. In another scenario,

previous manual handling of national drug code (NDC) pricing was replaced by RPA, resulting in a turnaround on average situational claim volumes from 8 hours to less than 10 minutes. RPA is also assisting in generating encounter file for submission; validating 837 files using Commonwealth and internal validators, tracking all file movements, reconciling return responses, and accurately reporting for improved encounter business team handling.

a.iv. Financial Subsystem

Adjudicated claims are disbursed from the claims management system operating systems. Once the Claims department completes the adjudication process, the ready-to-pay claims are processed in the weekly check runs performed by our IT department. Prior to and during the check run process, the payment automation tool will run a query on all claims being processed for the week in our claims management system to ensure no duplicate payments have occurred. It will also be used before and during the check run to identify those providers and checks that will be issued as electronic funds transfer. Once the check run occurs, IT will initiate the process to generate the official check register through the auxiliary check process system and internal reports of the remittance detail. The Check Run Finance team will match the total dollars on the check register to the total dollars on the remittance report to ensure the two items agree. **Figure C.6-10** shows our payment process.

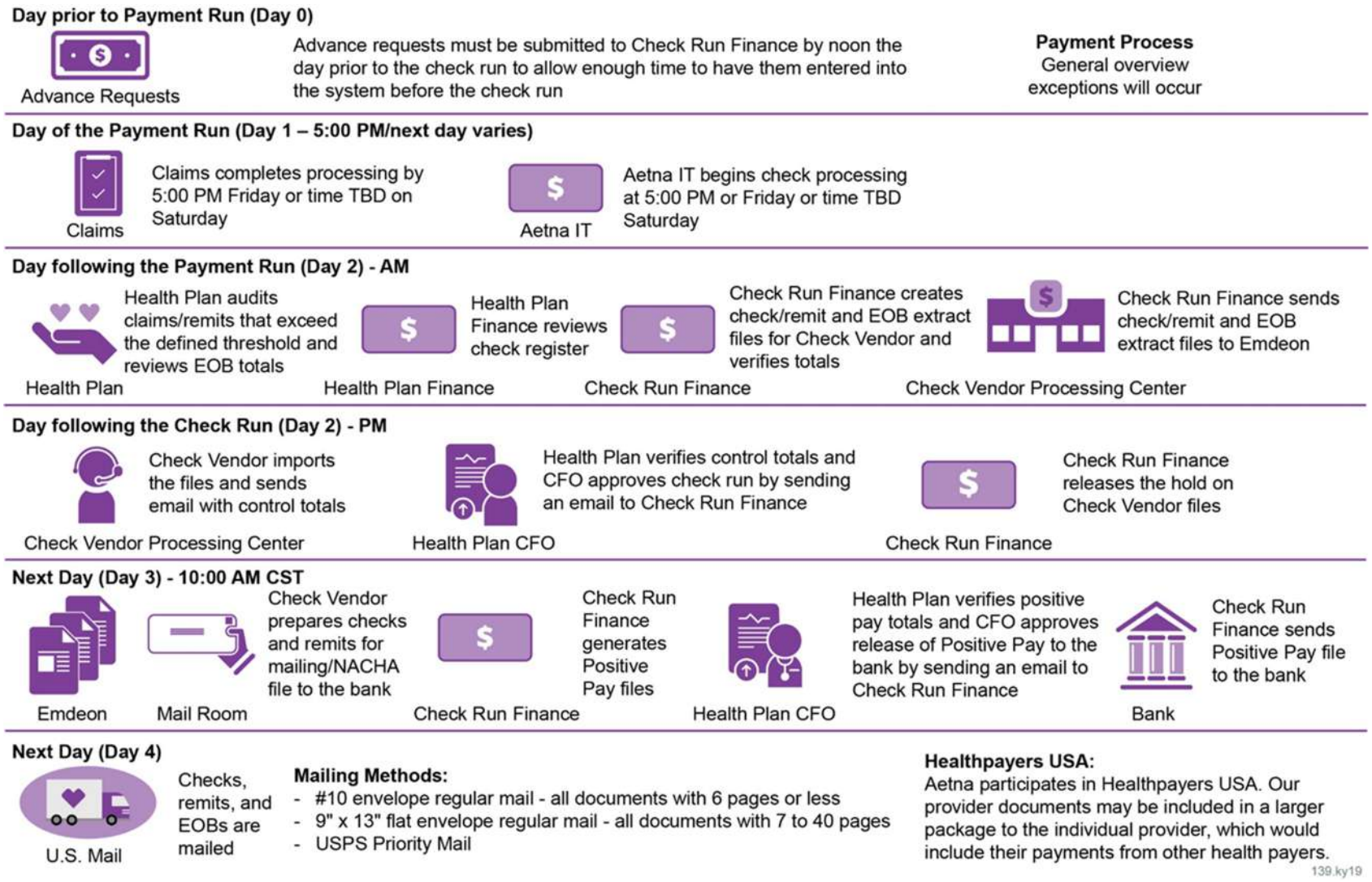

Figure C.6-10: Financial Data and Process Flow

Aetna's financial processes show the efficient turnaround of our four-day payment steps.

Aetna uses a financial reporting and planning system that stores financial information including revenue and expenses for Aetna by line of business. The financial system is used for external and management reporting and for internal financial planning purposes and ensures that all funds are appropriately disbursed. **Figure C.6-11** depicts our databases and warehousing capabilities.

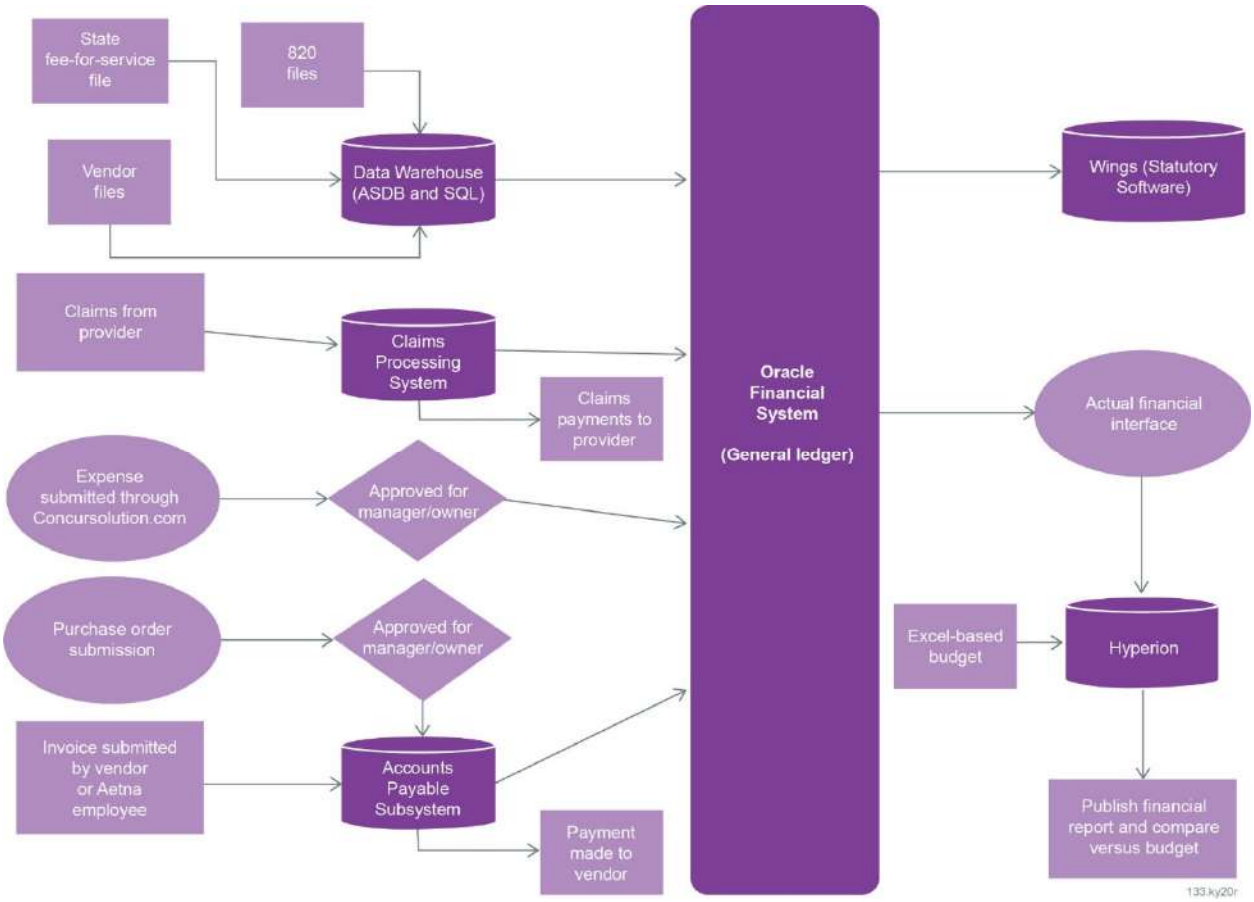

Figure C.6-11: Financial System

This graphic shows the internal and external flow of our financial database and the systematic way it flows into our general ledger storage function.

Components of our financial system include the following:

- **Databases:**
  - General ledger (Oracle Financials): Captures all the financial data that interface from various sources such as AP, claim processing system, Concur, etc. as noted in the diagram and the following descriptions
  - Accounts payable subsystem captures all the payments made through AP to vendors, subcontractors, and delegates
  - Hyperion: Reporting tool that captures actual financial and budget data for comparison analysis
  - Data warehouse (ASDB and SQL): The Medicaid data warehouse is sourced from the claims processing system, 820 files, and vendor files, and is used to provide reporting for financial statements
  - Claims processing system: Maintains our book of record for enrollee, claims, and capitation data (includes voids, claims adjustments, and claims recoveries)

- **Files:**
  - 820 file captures monthly premium from the Commonwealth
  - Vendor files include pharmacy, vision, and dental claims at detail level
  - Commonwealth fee-for-service files: The Commonwealth sends fee-for-service claims information for our enrollees that is loaded into our Medicaid Data Warehouse and is used in analytic and care management processes

All financial systems noted above align into our Oracle, Hyperion, and Wings reporting systems to allow for the appropriate financial reporting to all internal and regulatory bodies. Each of the resulting financial reports are reviewed for alignment to Generally Accepted Accounting Principles, statutory, and Sarbanes-Oxley 404 auditing requirements.

a.v. Utilization/Quality Improvement Subsystem

We use technology infrastructure and databases as tools described in **Table C.6-4.** These tools allow us to gather accurate utilization data to identify, track, analyze, and improve quality and performance metrics as well as the quality of services provided by network providers at the regional and statewide levels.

Table C.6-4: Internal Tools and Technology Infrastructure

Technology Tool	Description
Claims management system	Collection of medical claims for inpatient, outpatient, and professional services
HEDIS™ NCQA-certified data platform	For generation of annual Healthcare Effectiveness Data and Information Set (HEDIS) and non-standard HEDIS rates, creation of monthly trend reports, and provider gap in care lists
Hotspot analytics	Identification of enrollee presence by gender, race, ethnicity, culture, HEDIS, and non-standard performance indicators by regional and statewide levels
Population health management	Identifies enrollee health risk factors and social determinant of health indicators, and alerts care manager of gaps in services, emergency department disparity dashboard, and health equity dashboard at the regional and statewide levels
Medical record audits	Provider adherence to medical record, HEDIS standards, and clinical practice guidelines
Grievances and appeals data platform	Collection and tracking of enrollee and provider satisfaction with the plan and services rendered
Quality data platform	Tracking of provider preventable conditions, health care-acquired conditions, and potential quality of care concerns

Our utilization/quality improvement subsystem integrates data from many sources, both internal and external, to provide a comprehensive repository which staff use for monitoring and developing action items that can be enrollee- and provider-specific.

The Quality Management team coordinates with multiple departments at the local and national levels to ensure HEDIS reporting needs are met. This process includes, but is not limited to, the following:

- Create outbound eligibility file information to support receipt of vendor data
- Receive and store all inbound supplemental data utilized in HEDIS
- Compiles/maintains all needed data to support HEDIS reporting within the HEDIS data mart
- Prepares all data files utilized to operate the HEDIS software
- Receives data files from the data warehouse and runs monthly/annual HEDIS rates
- HEDIS intervention evaluation support
- HEDIS reporting support
- Pay-for-performance support

Data sources include claims/encounters, including behavioral health from our claims processing system. Standard supplemental data includes lab results, vision, dental, pharmacy, immunization registries, and

Commonwealth historical claim data. Non-standard supplemental data includes year-round medical record review results.

Please refer to the following flow chart **Figure C.6-12.**

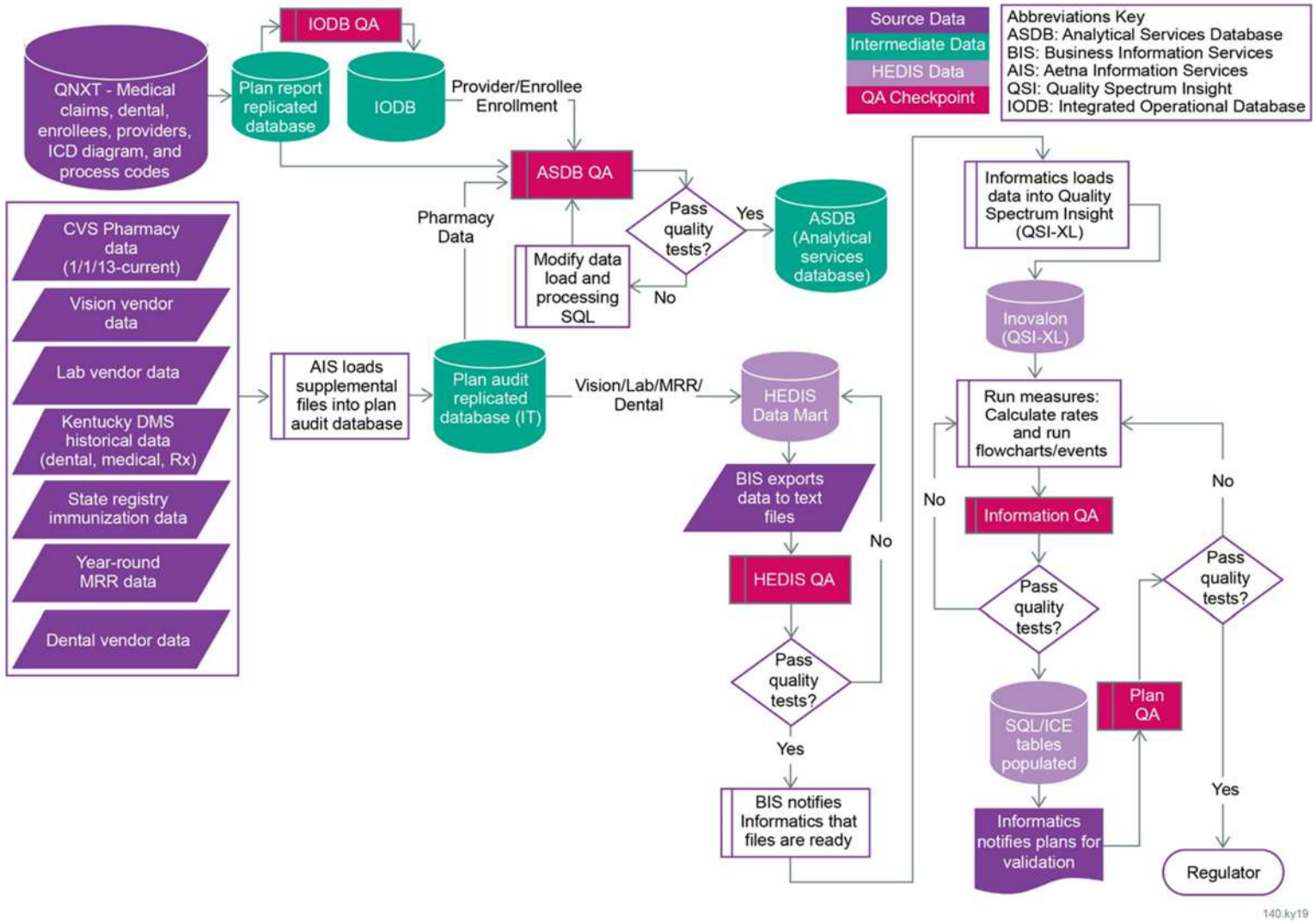

Figure C.6-12: HEDIS and Quality Data Integration Process Flow

The quality data integration process depicts the relationship between our claims management system, QNXT, our vendor information, our different data flows, and our quality assurance checkpoints.

Figure C.6-13 depicts the broader reach of our data sources.

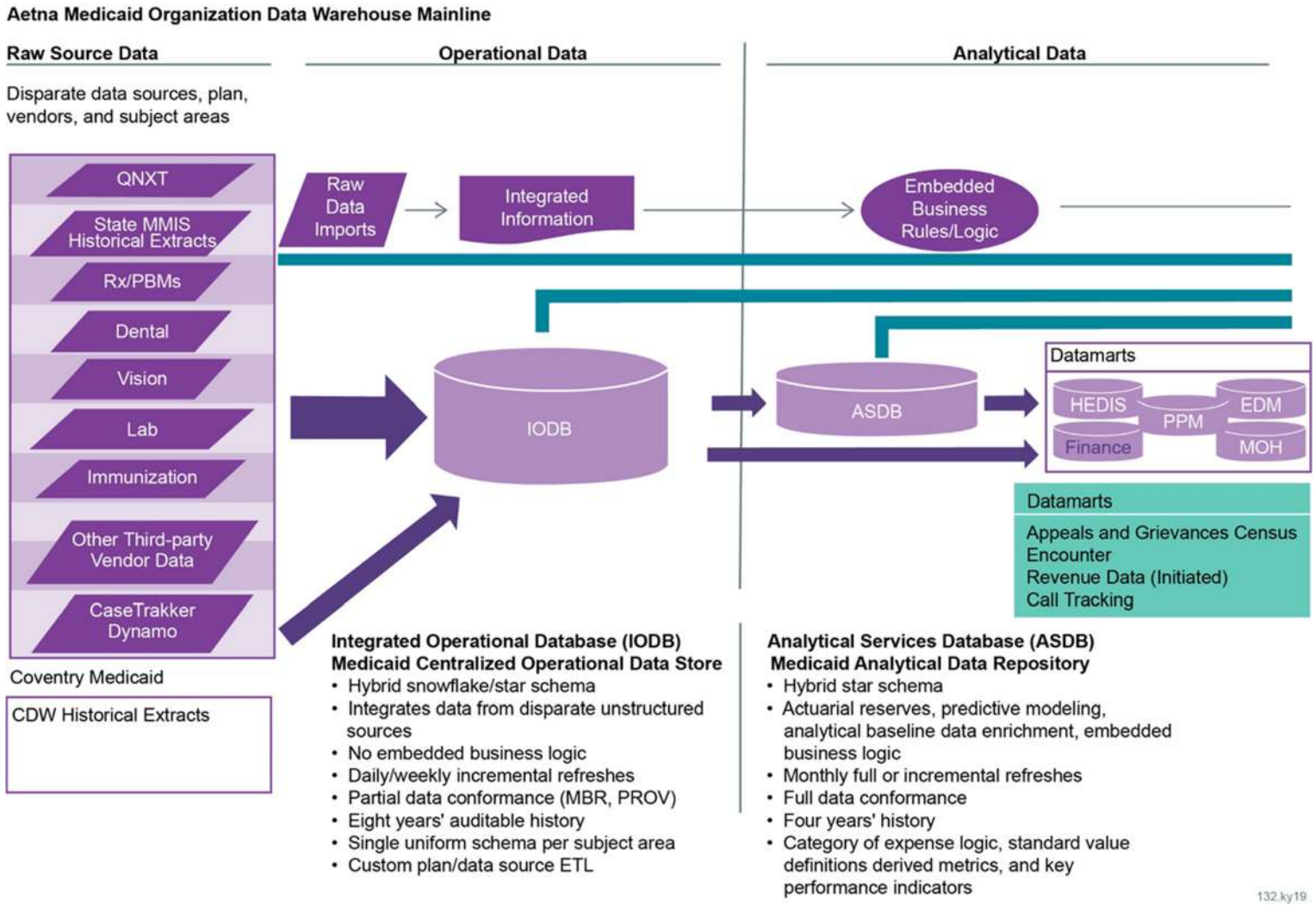

Figure C.6-13: Aetna Medicaid Data Warehouse Mainline Flow Chart

This graphic illustrates how our raw data sources are integrated into a centralized repository and then used to support our analytics.

a.vi. Surveillance Utilization Review Subsystem

Our compliance program contains robust program integrity processes designed to identify potential fraud and/or abuse of providers or enrollees and reduce or neutralize the deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification of services; prior authorization of services; or claiming payment for a service that was never delivered or received. Our major fraud, waste, and abuse (FWA) activities include the following: **prevention**—prepayment claim review and routing to avoid fraudulent payments; **detection**—using proactive data analysis to identify providers of interest based on behaviors within their peer groups; **investigation**—thoroughly exploring historical/current provider billing/practice behavior; **recovery**—working with providers to understand, educate, and pursue recovery; and **reporting and compliance**—operational and financial results reporting and mandated Commonwealth and federal fraud reporting. We focus on practices that are inconsistent with sound fiscal business or medical practices that result in unnecessary cost to the Commonwealth's Medicaid program. Our program will support profiling, random sampling, groupers, and ad hoc and targeted queries. The following narrative describes how our data mining efforts are enhanced by our Healthcare Fraud Shield application. **Figure C.6-14** shows the overall flow of our fraud, waste, and abuse process.

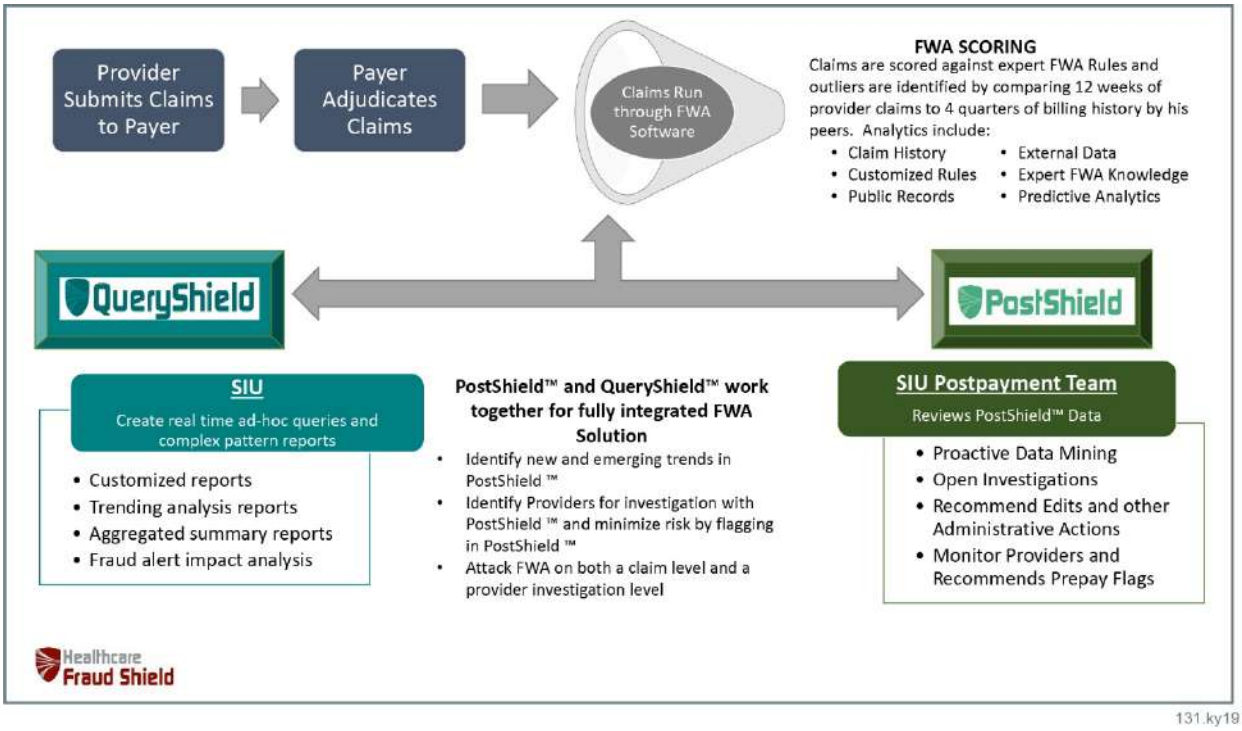

Figure C.6-14: Healthcare Fraud Shield Overview

This overview depicts the flow between our claims, Special Investigations Unit (SIU), and post-SIU payment processes of our fraud, waste, and abuse application, which allows our staff to monitor for potential fraud or abuse.

HCFS is a platform that comes equipped with approximately 600 business rules and algorithms that are maintained and updated quarterly. They are customizable at the health plan level to account for benefit variations and can be applied pre- and post-payment. This platform identifies providers with potential FWA behaviors and assigns them a risk score. We use the HCFS application screens to visualize all leads and billing activity as well as download the past 24 months' worth of claims for each lead. This helps us

further avoid inappropriate billing, identifies and mitigates provider confusion, and deters criminal activities, among others.

Aetna's Quality Management, Provider Services, and SIU teams work with the UM team to identify, track, and address over-and under-utilization, and to identify solutions with the provider community. Aetna maintains processes to monitor for appropriate utilization. For example, actuaries review categories of expenses through monthly operating reports and monthly expense reports. At the health plan level, we review the previously described UM reports and dashboards weekly and monthly through our QM/UM Committee to identify trends and implement interventions. SIU reviews reports and dashboards to identify provider patterns for potential fraud, waste, and abuse and acts as indicated. **Figure C.6-15** outlines the process we use to monitor claims.

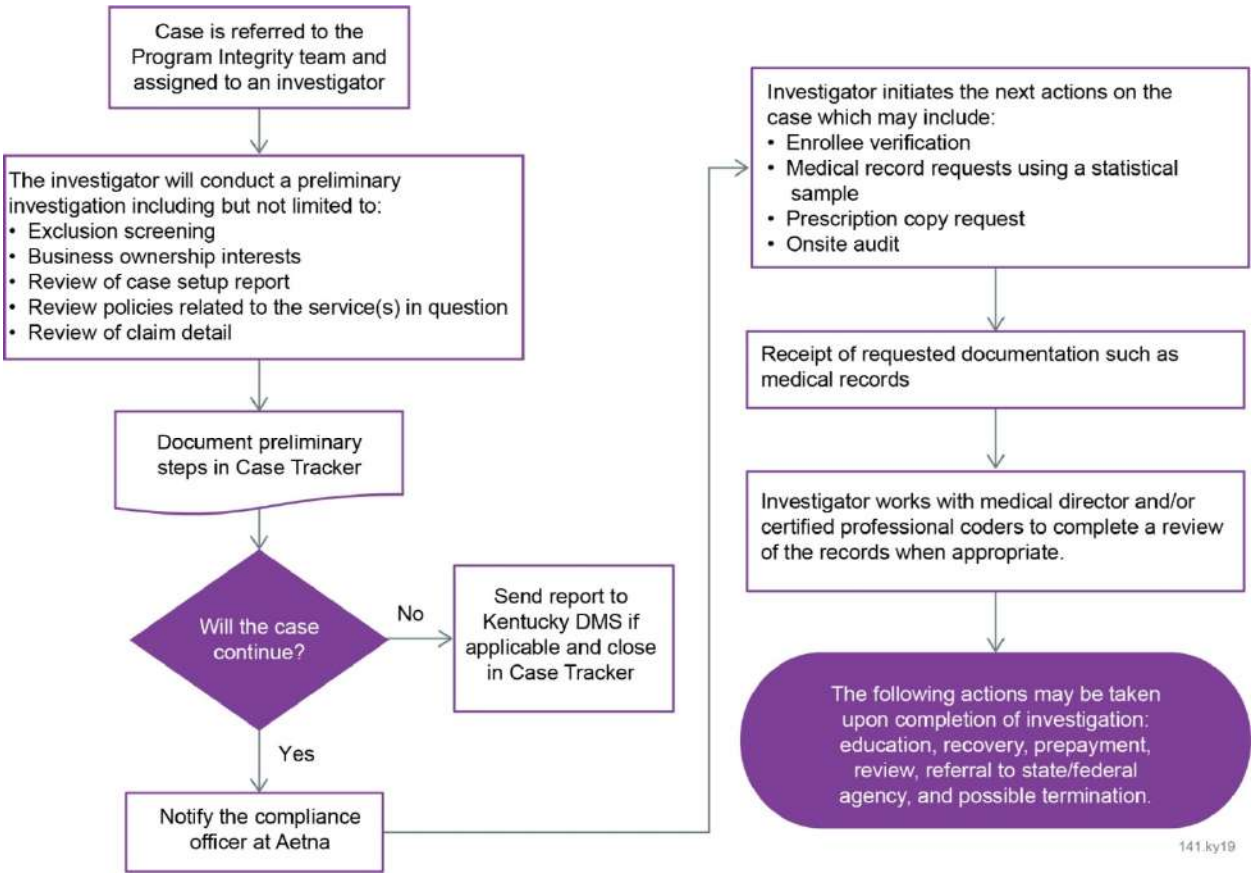

Figure C.6-15: Claims Monitoring

This process illustrates the steps we take in monitoring claims, including how a case is assigned to and tracked by an investigator.

i. Required Interfaces; Sharing/Receiving Information with the Department; Aetna's System to use Department Files; and Subcontractors, Providers, and Other Supporting Entities

As an existing MCO for the Kentucky Medicaid program, we have an established history of creating and maintaining EDI interfaces with all key regulatory entities and other stakeholders as necessary. The following narrative describes our interfaces and information sharing with the Department, subcontractors, providers, and others.

Establishing and Maintaining Electronic Data Interfaces

The Aetna Medicaid organization has implemented required HIPAA transactions with every Commonwealth agency with which they are contracted since HIPAA's inception in 1996. **Table C.6-5** lists our key interfaces. We follow a secure process for all file exchange interfaces and use a Secure File Transfer Protocol server to handle inbound/outbound file exchanges.

File Sharing/Exchanging Information with the Department

We verify successful inbound/outbound file transmission, employing a rigorous combination of automated/manual processes to validate successful exchange of files and notify the Department as applicable. A dashboard provides an end-to-end view of a file's status through each intake step. File monitoring software alerts automatically in the event of a failure and if a failure occurs, production support is immediately engaged to research and resolve the issue. An audit trail for all inbound and outbound files and data processed is generated and retained in a separate audit database that is retrievable for audit and compliance purposes. We confirm that our enrollee data maintenance function will continue to accommodate an external electronic interface (HIPAA ASC X12 834, ver.50102) with the Department and our provider data maintenance function accommodates defined data elements, formats, and file layouts including input and output job schedule with backend reporting and data reconciliation and an external interface to receive licensure information with both the Department and other governmental agencies. **Table C.6-5, Summary of Kentucky Interface Categories,** offers an overview of our types of data exchanges. **Figure C.6-16, End-to-end Managed File Transfer Process,** shows the interaction between our files, the types of exchanges, and their functions.

Table C.6-5: Summary of Kentucky Interface Categories

Type of Exchange	Entities	Function	Frequency
Enrollment, TPL, capitation, cost share	DXC	Enrollee and eligibility, other insurance, capitation revenue, and enrollee cost share accumulation	Daily, weekly, monthly
Encounters, cross-over claims, historical claims	DXC	Inpatient/professional/dental/vision, encounters, Medicare, COB claims, and enrollee claim history	Daily, weekly
Master provider file and provider network files	DXC	Master provider file and MCO network file	Weekly, monthly
Level of care, lock-in, and prior authorization files	DXC	Clinical operational files	Daily
EDI clearinghouses	Change Healthcare Office Ally	Facility and professional claim files	Daily
Pharmacy Benefit Manager	CVS Health	Eligibility, encounters, formulary, prior authorizations, reports, and Kentucky National Drug Code-to-Healthcare Common Procedure Coding System crosswalk	Daily, weekly, monthly
Subcontracted Vendors	Multiple, including Avēsis for dental and vision benefits	Eligibility, encounters, reports, prior authorization, and claims	Daily

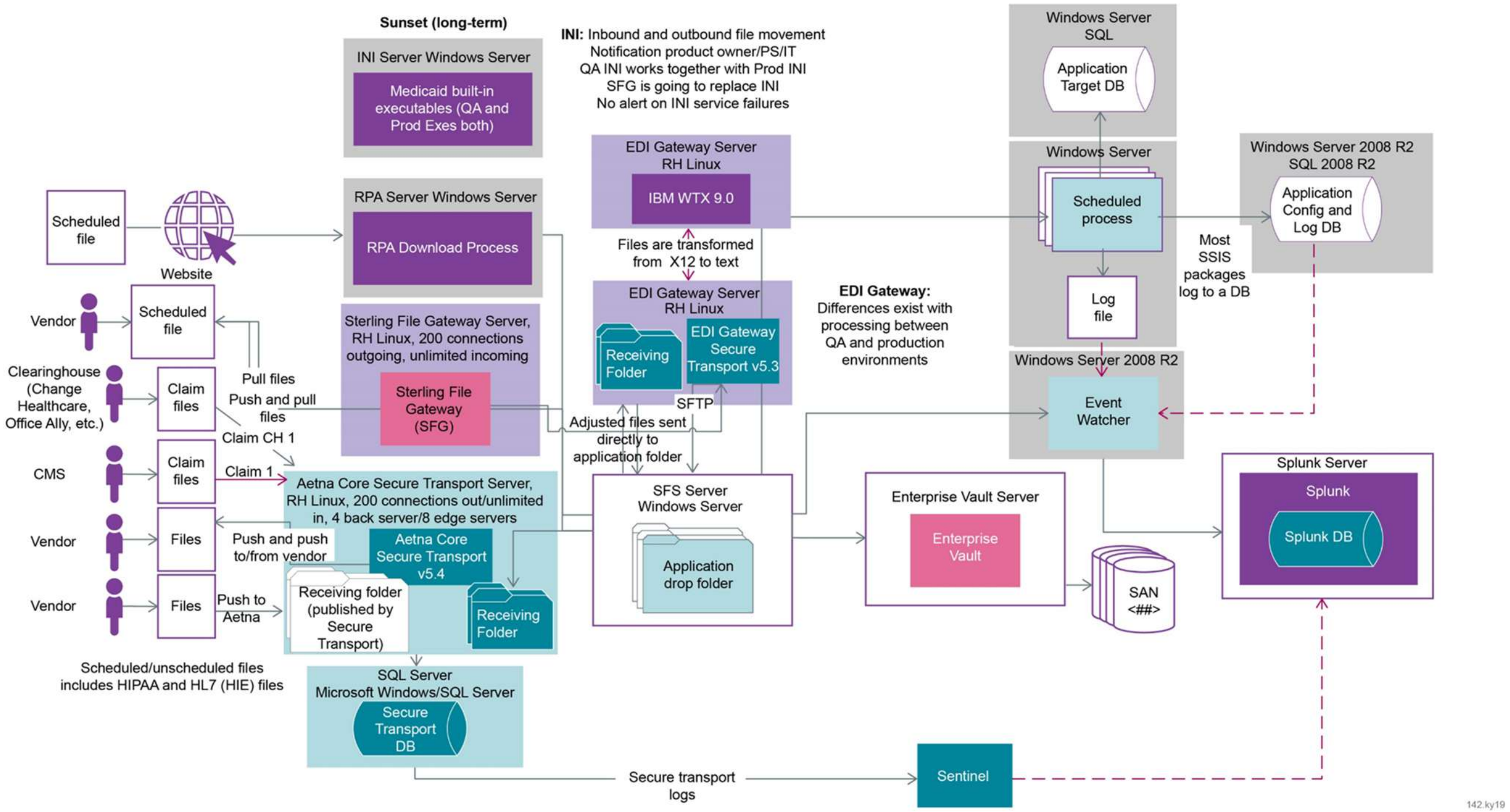

Figure C.6-16: End-to-end Managed File Transfer Process

This process ensures that our file management process safeguards our department data files and that of our subcontractors and provider partners are properly implemented and verified.

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Using Department Files and Sharing with Subcontractors, Providers, and Supporting Entities

Aetna has extensive experience communicating with Commonwealth agencies and all external partners including stakeholders, vendors, and subcontractors. As described in the previous **Figure C.6-16, End-to-end Managed File Transfer Process**, our robust file management process ensures all department files are fully implemented and verified in our systems as well as with our subcontractor and provider partners.

Interfaces: To validate compliance with HIPAA and seamless connectivity/minimal interruption of services provided by all vendors/subcontractors, Aetna is currently in compliance with the recently released Statement on Standards for Attestation Engagements No. 18 (SSAE 18), which has enhanced requirements for adequate control environments for vendors/subcontractors.

ii. Capability to Store and Use Large Amounts of Data, Support Data Analyses, and Create Standard and Ad Hoc Reports

Capability to store and use large amounts of data—support data analysis: Our Informatics team creates a primary comprehensive data source in our Medicaid data warehouse comprised of data from our operational systems. We also maintain external vendor data through data files, data system transfers, and XML files. Our multilayered data collection, analytics and reporting/interface structure is robust and designed to handle and protect large amounts of data. Aetna maintains (and requires each subcontractor to maintain) records, books, documents, and information adequate to verify that services are provided and payments made in accordance with contract, federal, and Commonwealth requirements. We retain such records for a period of 10 years after the applicable contract expiration date or until the resolution of any associated litigation, claim, financial management review, or audit, whichever is longer.

We use SQL reporting tables or data building blocks that serve as a foundation for all our reporting needs. Our Informatics team combines key data elements into a reporting dimension creating standardized queries to best use these data building blocks from which as entire suite of reports, dashboards, and applications can be built. Analysts across the enterprise are then able to develop reports from one server, one database, and only a few tables, rather than joining multiple objects. The data consolidated from multiple data sources, inclusive of all our health plans, and includes the following:

- Operational, analytical, and transactional databases
- Other data marts, like HEDIS, finance, encounters, and appeal and grievances
- New sources being developed for clinical events and social determinants

The Aetna Medicaid organization encourages collaboration between our affiliate health plans and national Shared Services departments. One example of our shared engagement is the Reporting Collaboration Group. Our Reporting Collaboration Group serves as a forum for groups to share information and experiences with a broad group of individuals. The function of the reporting collaboration group is a cross-functional group of Aetna plan level reporting managers and subject area experts, led by Medicaid Informatics, to execute collaborative reporting governance by doing the following:

- Maintaining an intranet site and Microsoft Teams site for communication and collaboration
- Maintaining reporting catalog for managing content, discontinuing obsolete reports and identifying best practices across the Aetna Medicaid organization
- Provide central repository that plans can access to find report examples
- Identifying opportunities to create and utilize standard logic and reports across plans
- Cultivating a Center of Excellence around reporting for better education and training for standard and Commonwealth reports
- Serving as an escalation forum to identify gaps, reconcile conflicting needs, address questions, and set priorities

- Acting as primary contact and expert for designated reports and help identify contacts and business area owners for reports
- Optimizing resources across the Medicaid segment to meet reporting needs

Our approach to reporting provides timely, consolidated, relevant, and accessible information. This is essential to informed decision-making and critical ongoing program monitoring. Aetna acknowledges the Commonwealth's requirement to compile and submit accurate reports Aetna produces a robust suite of reports, including ad hoc reports. Through a combination of comprehensive data sources, we generate data analysis reports, and in turn, encourage deep thought analysis and data-driven decision-making. Aetna complies with all current Commonwealth and federal laws and regulations that govern reporting, disclosure, and certification requirements. We catalog every statutory, regulatory, and compliance-based report across the organization. These reports are centralized and standardized with associated metrics to improve data integrity and consistency. The report catalog can identify existing reports that meet (or meet with minor modification) the requirements of any new requests, minimizing the need to develop any reports from scratch. Centralizing reporting in this manner improves data integrity while providing complete, accurate, and timely submission of reports. Moreover, we have used the results and feedback from the states to develop more enhanced, informational, and actionable models and reporting. The lessons learned have also led us to develop additional coordinated population health capabilities to help providers support the care and management of enrollees.

We provide timely, accurate, and compliant reports to help the Department make informed decisions and promote our mutual goals of providing high-quality, cost-effective, and integrated care to enrollees. Our Informatics team will work with the plan to generate all required operational reports, adhere to required report formats (including using prescribed templates), and meet the reporting schedule required. Our Informatics team builds the reports and the plan assumes responsibility for reviewing, cross-checking, and certifying the data, information, and documents (e.g., web content accessibility guidelines-compliant for outward-facing reports). Required reports are submitted to the Department on or before the date required in an agreed-upon format and in accordance with its submission procedures; we acknowledge the Department may alter the reporting formats, content, and reporting frequencies at any time.

Our Medicaid Compliance team uses Archer, a tracking system, that ensures that all required reports and contractual deliverables are tracked and submitted to regulators accurately and timely. Archer operates in the following two phases:

- **Informatics:** Our Informatics team builds reports for each contract deliverable
- **Compliance:** Our Compliance team tracks and documents contract deliverables, as well as reports on the timeliness and accuracy of our reporting; plan compliance officers retain copies of signed attestations and final reports in Archer for archival and auditing

Aetna uses the following platforms to bring information from multiple components to provide the Commonwealth with an accessible combined view of project and performance information:

- SQL Server Management Studio
- SQL Server Reporting Services
- Crystal Reports
- Tableau
- SAS
- Cognos
- Microsoft SharePoint
- Microsoft Excel

These standardized tools and repeatable processes give us a clearly defined roadmap for consistent and predictable high-quality reporting and work products. In addition to these conventional reporting tools,

we also leverage the advanced data visualization capability of Tableau to provide a more interactive, user-driven, self-serve experience in accessing and analyzing data. The following two figures in this narrative show the specifics of our Medicaid data warehouse (the 'micro' view, if you will) and the much broader 'macro' view of how our Medicaid data warehouse interacts with all of our systems as well as our external entities' systems. **Figure C.6-17, Aetna's Warehousing Capabilities: Micro View,** and **Figure C.6-18: Aetna's Warehousing Capabilities: Macro View,** depict our warehousing capabilities.

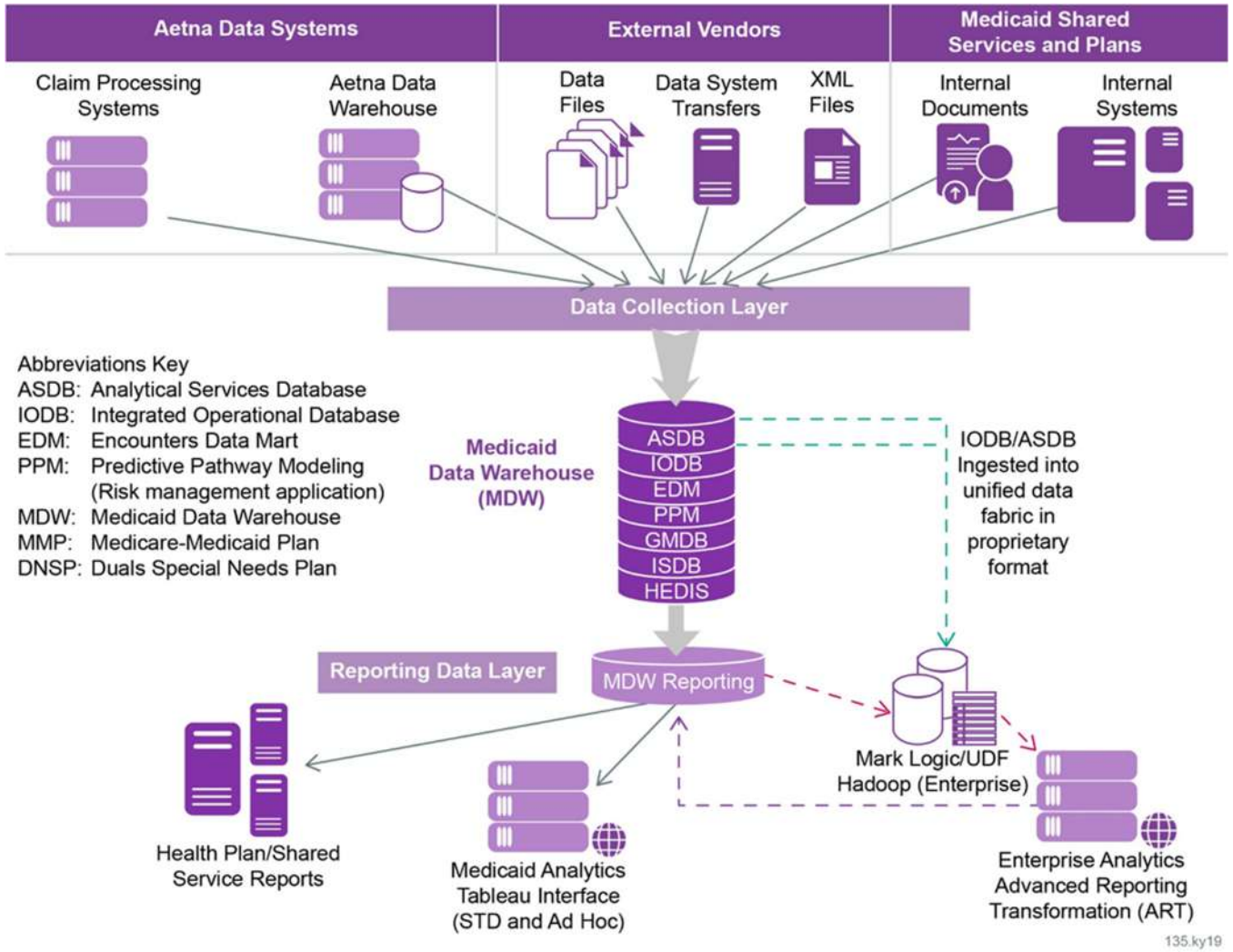

Figure C.6-17: Aetna's Warehousing Capabilities: Micro View

This graphic displays our warehousing capabilities and the interaction between our data system, external vendors, and our shared services platforms.

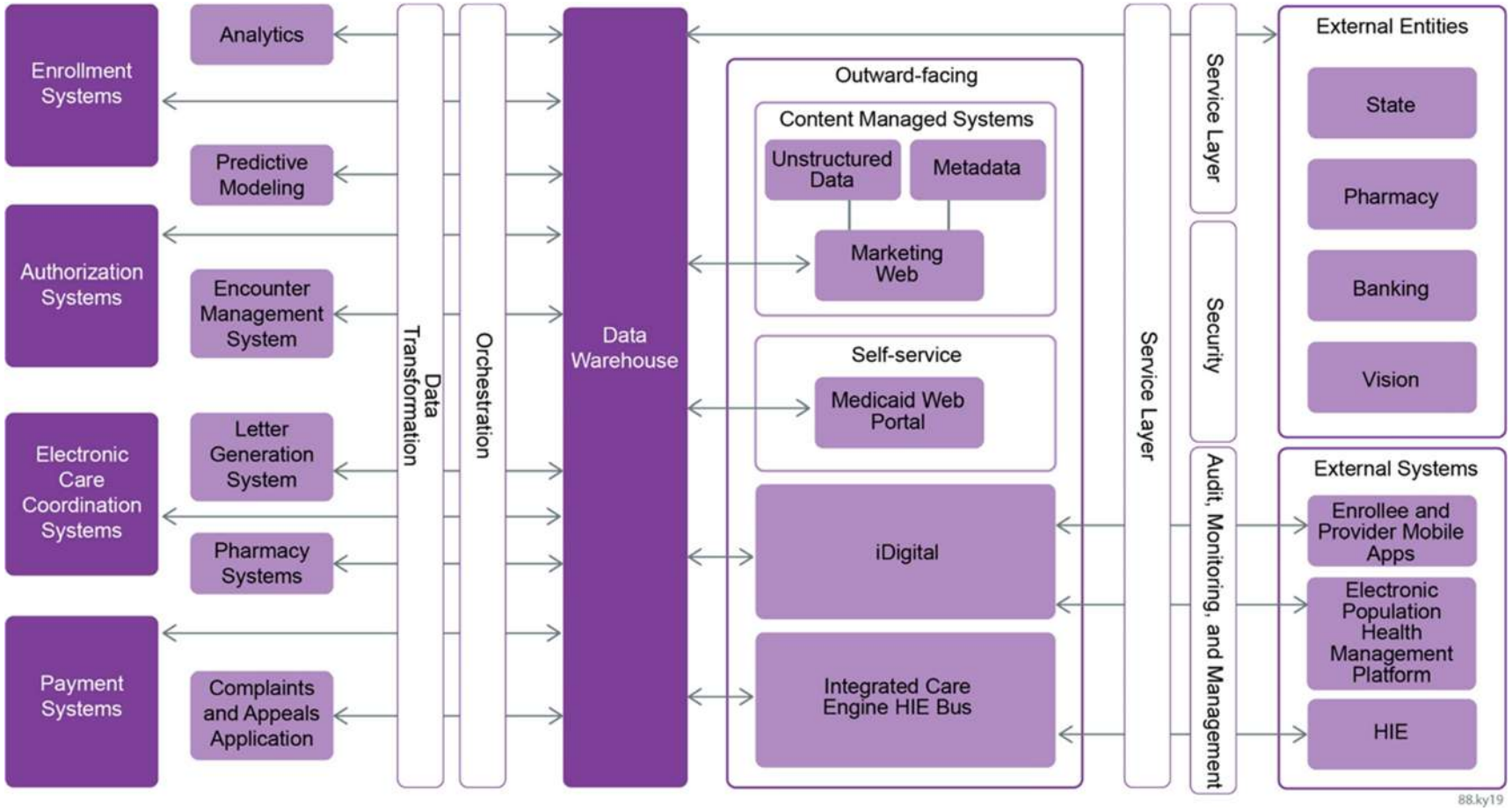

Figure C.6-18: Aetna's Warehousing Capabilities: Macro View

This graphic displays our warehousing capabilities and the interaction between our enrollment, authorization, electronic care coordination, and payment systems, and our data warehouse and security and monitoring platforms.

Supporting Data Analysis

Through our capability, collection, and storage of such vast amounts of data, our Informatics team supports data analysis needs for departments and teams companywide. This ultimately supports our decision-making and ability to recommend improvements/enhancements to programs in support of the Department's goal of creating a healthier Kentucky. In 2019, we created 30 dashboards and 20 demonstrations and training videos for more than 800 active users and have received approximately 107,000 server hits to enhance staff knowledge of our data goals. A breakdown of the dashboards we offer access to by department includes the following:

- **Trend and utilization management:** Utilization management, readmissions, observations vs. one/two-day inpatient stays, emergency department, neonatal intensive care unit, outpatient urine drug testing, medical claims trends, authorization trends, and inpatient performance-to-target
- **Population health:** Eligibility trends, demographics, enrollee conditions, CORE™ (Consolidated Outreach and Risk Evaluation) predictive analytics for risk stratification, risk adjustment, month-over-month risk adjustment
- **Operations:** Utilization management, claims key indicators, case management executive, care management, HEDIS trends in case management, and call tracking
- **Pharmacy:** Prescription claims, pharmacy summary, weekly prescription lite, pharmacy high-utilizer, and pharmacy market share
- **Quality and value-based services:** Gaps in care and value-base services quality
- **Opioid:** Performance summary and improved trends related to decreased utilization of opioids

iii. Systems Currently Implemented/Integrated with Other Systems, Internal and External, and Assuring Systems are Operational within Required Timeframes

Our systems have been integrated with the Department since 2011 and are currently fully operational. Any additions included in the new contract will follow our change management process, which provides a structured, fully recoverable framework in which to implement and manage system change releases on schedule and per federal, Commonwealth, and contract-specific requirements. This change management process includes the following steps in the application development process:

- Analysis
- Development
- Peer review and testing
- Approval prior to implementation into production
- Post-implementation validation to ensure all impacted production systems are functioned as designed by the change requirements

System Integration and Assuring Integration for Systems not fully Integrated

For any system not fully integrated, Aetna will notify Commonwealth personnel of major changes, upgrades, modifications, or updates to core production systems or associated operating software within our span of control 90 calendar days or more prior to the projected effective date of the change. Changes are typically communicated through multiple vehicles to maximize impacted user acknowledgement and feedback. Some of these methods include mail notifications, email, fax, WebEx, and web alerts. In addition, system changes with impact to providers, enrollees, or the agency are documented on the Aetna website. The use of this notice and centralized location assists in ensuring all stakeholders can access the information in addition to the traditional notification methods mentioned above.

Testing

The Aetna Medicaid organization's testing methodology and MIS provides an objective, independent view of our software implementation to allow the business to validate that our systems are functioning as

mandated by contract requirements. Testing is a critical component of all implementation projects and is performed throughout all the phases of the project lifecycle by our subject matter experts and end users. We have adopted DevSecOps principles, which includes fully automated continuous integration and continuous delivery for our implementations; this includes a detailed test plan that ensures all requirements are successfully built, tested, and deployed per the deployment schedule. Our testing protocol utilizes waterfall and agile methodologies to plan, assign, execute, and report on the status of all testing across functional areas. Functional areas and vendors involved include claims, eligibility, enrollee services, medical management, encounters, and compliance.

The following types of testing are used during the project lifecycle (note that each type of testing is accompanied by robust testing artifacts, including but not limited to strategies, scripts/test cases, and test results summary that can be traced back to Commonwealth requirements):

- **Unit testing:** Tests functionality and is executed by developer who builds the code or code module
- **System testing (positive and negative):** Performed to assess the proper behavior of an application based on business requirements and application design
- **Commonwealth testing:** We exchange data file(s) with the Commonwealth to validate that system changes and logic are compatible with requirements and is certified by the Commonwealth if needed. In addition, we have a dedicated team to facilitate testing between the Commonwealth, vendors, and Aetna utilizing any Commonwealth-specific testing tools required.

  Aetna has experience with real-time payment interface testing and batch interface support. Our team worked to resolve any issues to align with the testing timeline, which led to a highly collaborative relationship with the Commonwealth throughout the testing process. The following types of testing in different phases of the software development lifecycle workflows allow for all components of implementation to be tested thoroughly and exhaustively, including subcontractor changes. Each type of testing was accompanied by robust deliverables, including but not limited to test strategy, test scripts, and test results summary:
  - **Specialty/performance testing:** Performed to assess the proper behavior of an application based on documented requirements, this testing occurs to validate how the application behaves under various conditions (i.e., browser testing performed on web applications to assess compatibility on different browsers such as Internet Explorer and Google Chrome, performance testing on proper screen response time or file processing time).
  - **Regression testing:** Examines the application to see whether it is operating in a business-as-usual mode and that it has not been affected negatively by changes; automated test scripts are executed where possible to validate that there are no additional impacts on upstream and downstream applications.
  - **End-to-end testing:** Performed to see if data flows from one application to the other and works as expected (e.g., claims end-to-end testing includes file load/import, adjudication, payment check run, and encounter process).
  - **User acceptance testing:** Validates the business requirements using defined user acceptance test strategies, plans, and script/test cases and verifies that the application/file(s) functions as expected and no defects are encountered.
  - **Production checkout testing:** Confirms that all application changes have been migrated successfully to the production environment and all functionality is working properly.

  Our testing team leverages industry standards tools and best practices in accordance with our testing methodology.

The different phases of all our testing components are shown in **Figure C.6-19**.

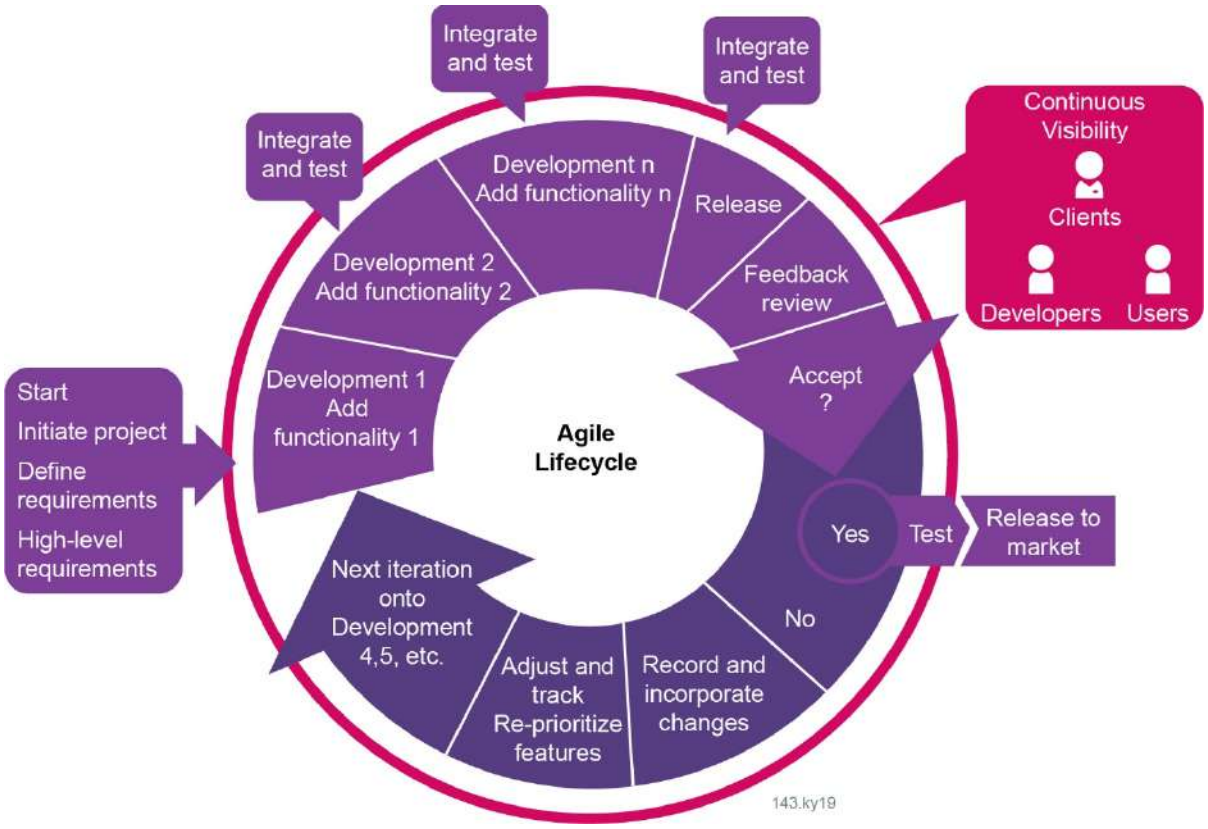

Figure C.6-19: Aetna's Agile Lifecycle Flow

This graphic depicts the continual flow of data, which allows for all components of implementation to be tested thoroughly and exhaustively, including subcontractor changes.

b. Potential Risks/Mitigation Strategies to Implement New Information Systems and Changes to Support the Program

We have significant experience navigating and managing risk throughout the deployment of new technologies. As an example, during the deployment preparation for a recent implementation, we prepared a detailed roll-back plan across our technology and business teams to mitigate any potential impacts to the go-live date. As a result, we were well-prepared to execute that plan prior to suspension of the deployment. Within 24 hours, our technology team rolled back the changes to eligibility, digital, and configuration assets, coordinated integration rollbacks with our vendors, worked with our health plan partners to develop member and provider communications outlining this change, and collaborated in an integrated business command center to ensure all aspects of the mitigation plan were executed in lockstep across the organization.

One detailed example of our risk management capability is our adoption of our DevSecOps methodology for system implementations. This methodology transforms change management into a fully automated continuous integration and delivery process tailored to focus on speed and quality. The emphasis is on the collaboration and communication of software developers, code/configuration management, and testing teams, while automating the process of software delivery and infrastructure changes. It establishes a culture and environment where building, testing, and releasing software can happen rapidly, frequently, and of higher quality. Components of this transformation include the following:

- **Continuous integration:** Merging code into a common source code repository and executing automated build, quality check, and unit testing

- **Continuous delivery:** Rapidly deploying the development version of the software into higher environments, including production
- **Continuous testing:** Testing of code at every stage of project lifecycle in an automated manner and providing feedback on quality. Repetitive automated testing leaves the business stakeholder with the only manual handling for end-user validation.
- **Continuous monitoring:** Process and tools to intelligently monitor, analyze, and manage solutions and IT infrastructure in the production environment of the application

Figure C.6-20 depicts the continual feed of information between our components to reduce risk.

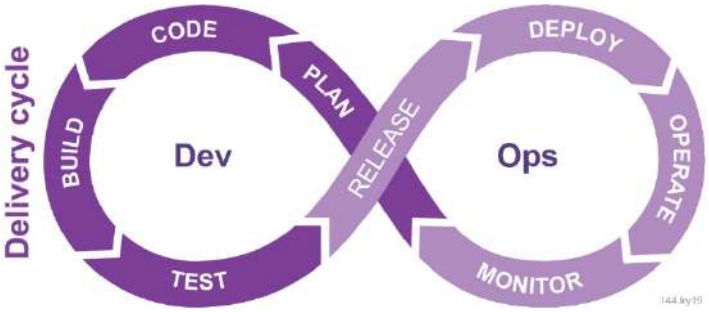

Figure C.6-20: IT Delivery Cycle

This graphic shows the seamless, continual flow between our integration, delivery, testing, and monitoring components to reduce risks using our mitigation strategies.

c. Aetna's Current/Planned Use and Support of Technology in Health Information Exchange, Electronic Health Records, and Personal Health Records

Our system is designed and well positioned to scale and evolve to meet the health care and service provider needs for all eight regions across Kentucky. We leverage our deep experience and national resources, and work with the Department to deliver an inclusive suite of innovative technologies and tools to drive advanced care coordination and delivery transformation. Our proprietary system is composed of proven best practices and performance standards optimized for the delivery of health information technology (HIT) and HIE using the highest industry standards, controls, continuity, security, and redundancy features to ensure the highest level of data protection. Our system is fully compliant with HIPAA; Health Information Technology for Economic and Clinical Health (HITECH) in 42 USC 17931, Section 6504(a) of the Affordable Care Act; and other applicable Commonwealth and federal laws and regulations. As part of our comprehensive HIE efforts, we will focus on the following key areas:

- Supporting broad data sharing capabilities to accept and use data from certified EHR systems
- Promoting EHR incentive payments and models tied to the American Recovery and Reinvestment Act of 2009 (ARRA), HITECH, Merit-Based Incentive Payment Systems regulations, and meaningful use requirements
- Creating data reporting synergies with existing certified EHR and HIE systems

Current Use

The Aetna Medicaid organization has significant national HIE and market-leading electronic medical record (EMR) data integration experience. We have dedicated personnel responsible for vendor management, including contracting and vendor engagement, connectivity, procurement, infrastructure and transmission security, business, and technical requirements. We connect with over a dozen different HIEs in as many markets. We support proprietary, XML, and HL7 formats and have plans to deliver Fast Healthcare Interoperability Resources upon receipt of the final decisions and deadline imposed by CMS. In partnership with Equality Health, a leading clinical and population health platform company, we have an admission, discharge, and transfer (ADT) data engine which, using sophisticated proprietary

algorithms, parses, organizes, and summarizes ADT records into clear, easily consumed event records and reports. Details of these functions include the following:

- 20 unique HIE connections
- HIE file exchanges are active in 14 states
- Processing 25 incoming CCD, ADT, ORU, MDM, and GIC daily files
- 2018 file volume: 6,444,599 files
- Two national EMR vendors

Table C.6-6 shows our broad national experience.:

Table C.6-6: EMR/HIE Data Exchanges

Market	Organization	Source	Data Exchanged	Frequency
AZ	Health Current	HIE	ADT, CCD	Real Time
FL	AI	HIE	ADT	Real Time
LA	GNOHIE	HIE	ADT	Real Time
LA	LaEDIE	HIE	ADT	Real Time
MI	MiHIN	HIE	ADT	Real Time
NJ	Trenton	HIE	ADT	Real Time
OH	HealthBridge	HIE	ADT	Real Time
OH	CliniSync/OHIP	HIE	ADT, MDM, ORU	Real Time
OH	Mercy Health	HIE	GIC	Monthly
PA	HSX	HIE	ADT	Real Time
TX	HASA	HIE	ADT	Real Time
VA	CMT/ConnectVA	HIE	ADT	Real Time
WV	CMT/PreManage	HIE	ADT	Real Time
IL	CCHHS	Hospital	ADT	Daily
LA	OLOL	Hospital	ADT	Daily
All	Athena	EMR	CCD	Real Time

This data is then shared in real time with our clinical and care management platforms; our population health platform that supports providers closing enrollees' gaps in care, HEDIS measures, and other value-based contract metrics; the Quality teams for clinical metrics; and finally our extensive informatics and big data repository whose analytics functions provide trends, clinical and financial risks, and other insights.

In addition to the HIEs, we also are contracted with several national EMR systems for the integration of CCD/C-CDA/ORU data. Two national systems, Athena and eClinicalWorks (eCW), are contracted with Aetna to provide this data. This information is again widely distributed to several of our clinical systems, including population health.

Currently, select value-based provider organizations such as KentuckyOne Health, St. Joseph Health System, and Catholic Health use this application to improve team connectivity and strengthen care management and care coordination for our enrollees. The tool provides an organized look at populations of enrollees and each individual enrollee while illuminating previously unknown enrollee data and information not available in the provider's EHR. Accordingly, it supports practice and enrollee goal achievement such as for HEDIS metric performance, value-based contracts, transition of care management, and medication management.

Planned Use and Support

Our digital platform has evolved to include a PHR electronic application through which Aetna Medicaid organization members, providers, and authorized care group participants can maintain and manage health information in a private, secure, and confidential environment. We will deploy the PHR application in support of the new contract. Sharing integrated EHR, HIE, social determinants of health (SDOH), care plan, and claim data with the users supports the expansion of interoperability, providing additional care management and care coordination for our enrollees. As part of our Kentucky HIE, EHR, and PHR plan, we will continue to engage in a full statewide stakeholder assessment and listening tour to understand the opportunities to expand data obtainment and sharing. Upon successful negotiations with KHIE, much of their data capabilities will be immediately integrated into our systems as described above. Additionally, as our digital platforms continue to evolve, we will look to use these systems as integration points for HIE data, including services like push notifications to enrollee and provider digital devices, alerts and secure messaging for our web-based portals and mobile applications, and greater EMR interoperability to provide critical, actionable data where providers need it most.

While continuing to contractually direct providers to KHIE, we will also look for opportunities to build relationships with facilities and providers, laboratories, and Commonwealth data registries for obtainment of ADT, CCD, lab, and immunization data that can be shared through our systems and tools, including our population health platform. We will also focus on gathering and sharing enrollee-specific and aggregate population SDOH information across the network to optimize enrollee care and will obtain and integrate data from telemedicine interactions to enable a more complete enrollee record and knowledge of the population served. Moreover, as current and new HIE and EHR technology evolves around standards and usage that allows improved interoperability and as applications and enrollee wearables are developed that incorporate health, social, economic, behavioral, and environmental data that sheds increased light on the realities and complexity of those we serves, we will define ways of using the information to enhance learning and foster more precise care delivery.

We will also sponsor regular in-person community meetings, events, and webinars, collaborating with the KHIE to create an advisory council to provide guidance around our technology and innovation. We also see other opportunities as we have in states like Florida to leverage data with the state's Division of Emergency Management to create virtual safety nets in event of natural or manmade disasters. Our approach will be to complement and build upon the existing platform and work closely with the Department, the State, and our health care and community service provider network as true stakeholder partners.

d. Aetna's Approach to Data Integrity, Accuracy, and Completeness Submitted by Providers and Subcontractors

We ensure integrity using front-end HIPPA format validator, Optum code set reference files, Commonwealth-supplied provider reference files, and Commonwealth-supplied 834 enrollment files. And these files are used to validate the data before being loaded to our core processing systems. Invalid data results in rejection of the file or records back to the submitter.

We know the critical role that timely, accurate, and complete encounter data plays in the Department's ability to continuously review the health care utilization of its Medicaid enrollees, to analyze expenditures associated with that utilization, and to monitor service delivery performance with its partners. The following narrative addresses our strategy for complete, accurate, and timely encounters starting with provider contracting; then applying our comprehensive claims edits; and finally, our use of a robust encounter management system by our experienced staff.

To achieve accurate, complete, and timely submissions, Aetna transmits all encounter data using HIPAA-compliant 837 (I and P) and National Council for Prescription Drug Programs electronic formats. Validation begins with the delivery of services by requiring all participating providers submit encounter services with the required information. All providers, including sub-capitated and atypical, are educated upon contract agreement and at orientation on the submission of claims and what is required to submit a clean claim to receive payment. Our claims adjudication system requires that key data fields be provided at the claim level to adjudicate and includes data fields such as recipient Medicaid ID number, provider Medicaid ID, National Provider Identifier (NPI), claim type, place of service/bill type, revenue codes, procedure codes (Current Procedural Terminology 4), diagnosis code (international classification of 10), Healthcare Common Procedure Coding System I and II, modifiers, dates, and charges.

Claim Edits

Claim adjudication edits are configured within the claims processing system to validate the accuracy and completeness of data allowing for the seamless submission of encounters. The system has over 400 business rules in addition to standard configuration payment rules that our CSRA department configures to enforce policies and procedures. Examples include the following:

- **Benefits package variations:** The system automatically analyzes CPT, revenue, and HCPCS codes to determine whether specific services are covered under the contract or under benefit rules. If services are not covered, the system automatically denies the respective claim line with the appropriate HIPAA remittance remark on the recipient explanation of medical benefits
- **Data accuracy:** The system is continually updated based on the most current code sets available (HCPCS, revenue, CPT, NDC, ICD codes) by year. As new codes are added, terminated, or changed, we update the codes so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, the system denies the claim line and advises the provider the code is invalid via remittance advice.
- **Adherence to prior authorization requirements:** The system is configured to enforce the supporting documentation requirements of certain services. In addition, it can configure prior authorization by code, provider type, and place of service. Claim edit rules are set to validate the claim against the network provider, enrollee, dates of service, services rendered, and units authorized.
- **Provider qualifications:** Provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, the system will not permit the processing of a claim for in-office heart surgery by a podiatrist. Cotiviti Healthcare (Cotiviti), an industry leader for front-end automation of correct-coding and medical-policy decisions, lends additional support, reviewing any claim line set to 'Pay' for billing appropriateness by specialty. The system checks other provider specific items, verifying, for example, that each provider has obtained the requisite NPI or its equivalent, has included the identifier on all claims submissions, and is registered with the state with a valid Medicaid ID.
- **Enrollment eligibility and enrollment:** The system validates the date of service against the enrollee's enrollment segment to determine if they were eligible on that date. If not, the system denies the claim using the appropriate HIPAA-approved remittance comment.
- **Duplicate billing logic:** The system uses a robust set of edits to determine duplication of services (e.g., same enrollee, same date, same network provider, same service, or any combination of these criteria). In addition, claim lines set to 'Pay' are subjected to Cotiviti's duplicate logic. This logic protects against payment for services rendered by the same physician or other physicians within the same provider group.

Other claims processing edits and tools used to maximize accuracy throughout the adjudication process include ClaimCheck® edits. ClaimCheck is a comprehensive code auditing solution that supports the claims processing system by applying expert industry edits from a provider recognized knowledge base to

analyze claims for accuracy and consistency with relevant policies and procedures. ClaimCheck clinical editing software identifies coding errors in the categories, including procedure unbundling, mutually exclusive procedures, incidental procedures, medical visits/same date of service, bilateral and duplicate procedures, pre- and post-operative care, assistant surgeon, modifier auditing, and medically unlikely services. Aetna also uses integrated claims management services, powered by Cotiviti, to enhance the claim processing system's edit functionality for professional claims that reach an adjudicated status of 'Pay.' The system uses algorithms to detect potential claims up-coding with follow-up procedures for chart audits as appropriate. Cotiviti clinically edits claims to assist Aetna to assist the Department in promoting proper and fair payment of claims. Examples include the following:

Coding Accuracy

If services are up-coded or unbundled, Cotiviti alerts the Claims department to deny the claim line along with the specific clinical editing policy justification. The claim line denies with the appropriate HIPAA remittance remark on the recipient of medical benefit.

Durable Medical Equipment Editing

Cotiviti performs edits related to select durable medical equipment (DME) payment policies that align with Medicaid covered service policies. These edits include DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps, and anatomic/functional modifiers required for DME services.

Procedure Code Guidelines

Aetna follows the American Medical Association (AMA) CPT-4 Book and CMS HCPCS Book for instructions on code usage. Cotiviti has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, we deny the code as inappropriate based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s). Cotiviti supports correct coding based on the definition or nature of a procedure code/combination of procedure codes.

The ability to code in this manner supports prior authorization requirements during claim adjudication. Furthermore, these editing policies either bundle or recode procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, Cotiviti applies editing logic that bundles all the procedures billed into the most appropriate code. If a provider bills an office visit and bills separately for heart monitoring with a stethoscope at the same visit, Cotiviti rebundles the service into the appropriate evaluation and management or office code. Using the edits and tools described in this section, we deny, completely or in part, claims with missing or invalid information. Providers and subcontractors are required to resubmit the claim with valid information to receive payment. We configure our claim system to align with the Department's coverage and payment policies. When we deny claims at submission, configuration is added to align with Department's guidelines. In such instances, we require providers or subcontractors to resubmit the claim with valid information to receive payment.

Timely and accurate data is essential in obtaining meaningful information on enrollees and promoting better health outcomes. From the financial prospective, the monthly incurred but not reported process, the Actuary and Finance team reconcile the claims detail in the data warehouse back to the invoice payments made throughout the month for medical, dental, and pharmacy claims. This ensures that any data used for reporting purposes is accurately loaded into our data warehouse.

From the training perspective, initial provider training and orientation begins as soon as a provider joins our network, which includes encounter and contract requirement information. After orientation, providers receive ongoing training based on encounter denial trends and best billing practices. They may also receive additional training and information at any time by requesting it from the health plan, or

referencing their manual, provider forums, webinars, and face-to-face visits. All our subcontractors are trained immediately upon initiation of contract on Commonwealth billing and submission requirements. At a minimum, they meet weekly with the Encounter Management Unit (EMU) and the health plan through the development and implementation phase. Full testing is conducted prior to production submissions in order to make sure all encounter requirements are being met. Post-implementation, the EMU meets regularly with the subcontractor to review denial trends, accuracy results, and provide feedback and assistance in resolution of errors.

We communicate regularly and work continuously with our providers and subcontractors to promote compliance. To correct behaviors, encounters and claims denials are discussed regularly as part of the Joint Operating Committee meetings we conduct with large provider groups, providers, and subcontractors. We also meet with providers on an add-needed basis, depending on agenda topics. If providers or subcontractors fail to submit complete, timely, and accurate encounter data, we use training, oversight, corrective action, as well as contractually appropriate sanctions, to address the deficiency.

Subcontractors and network providers must attest to the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna, including required medical records data, and must ensure that they submit the information on the applicable claim form or electronic format type. We train our providers during the orientation process and our local Kentucky provider service representatives provide support with the claims submission process. Additionally, all our subcontractors are trained on proper encounter data submission, including submission frequency, acceptable data formats, accuracy and completeness. We provide support on proper coding and present an overview of how the encounter management system enforces accuracy. We meet regularly with our vendors to ensure we address any questions and issues and to discuss error resolution. Aetna uses contractual requirements and service performance agreements to monitor provider and subcontractor compliance with all contractual responsibilities. We hold subcontractors to the same requirements as our internal Encounters department, which includes meeting the State's encounter data submissions requirements.

e. Aetna's Data Security Approach

At Aetna, protecting enrollee data—keeping all information safe and secure—is of utmost importance. Each enrollee is treated as an individual, thoughtful consumer; they are not just statistics or data figures to us. As such, we push our global cybersecurity program beyond what is standard for our industry. We improve security while making it more convenient for each individual and we continue to invest in practices, processes, and controls to stay a step ahead of an ever-evolving issue. We commit to continue providing access to best practice health care for Kentucky Medicaid program enrollees while diligently protecting their privacy. We comply with both the HIPAA and the HITECH Act and comply with all Department requirements, as demonstrated by formal results from external audits.

Our electronic system security protocols include the following data and physical security controls:

- Layered encryption strategy, including encryption of data in motion internal to our wide area network and across the Internet, and encryption of production data at rest as well as backup media encryption
- Secure hardware disposal and destruction of all physical media types removed from all user equipment and datacenters
- Data loss prevention controls, including Symantec's data loss prevention solutions for perimeter web, email, and network traffic, as well as internal data at rest scanning
- Secure access management practices, including preregistration, identity, authorization, business need validation for access, and legally binding agreements (employee, contractor)
- Physical security monitoring, including the use of a centralized, monitored access management
- system for monitoring and tracking access, anomalous access activity monitoring and reporting of privileged access, and integrated video surveillance systems
- Physical access controls (e.g., card access readers, anti-pass-back entrance/exit, tailgate detection)

Complying with Health Insurance Portability and Accountability Act Standards

Our core system is fully compliant with HIPAA, Health Information Technology for Economic and Clinical Health in 42 USC 17931, Section 6504(a) of the Affordable Care Act, and other applicable Commonwealth and federal laws and regulations. Our information security program involves creating, administering, and overseeing policies to help ensure the prevention, detection, containment, and correction of security breaches. A comprehensive solution is in place for handling incidents 24/7/365. We discuss incidents that come in from a variety of methods during our daily threat calls. There are response time requirements based on the levels of potential risk for each incident. Splunk is the security information and event management solution in place to provide monitoring of incidents. Aetna has documented procedures in place for response to or reporting of security incidents.

Our privacy practices regarding individually identifiable health information follow federal and Commonwealth laws and regulations. We have established a corporate Privacy Office, which has overall responsibility for developing policies and procedures to safeguard protected health information (PHI) against uses and disclosures that are inconsistent with applicable law. Our Kentucky-based compliance officer, supported by the Aetna organization's Privacy Office, manages a compliance program that includes education and ongoing policy and procedure review for maintaining our enrollees' privacy and confidentiality. The compliance officer is responsible for conducting mandatory privacy policies and procedures training and education for our staff, and for overseeing the implementation and enforcement of these policies and procedures.

Before sharing any enrollee-related information, we obtain written permission from enrollees and their families/guardians (when applicable) that specifies the type of information we can share and with whom. We store completed release forms in our database for easy access by care managers. Call center staff verify telephone callers' identity by asking for an enrollee's date of birth, identification number, and/or address, and review our database to ensure there is a documented release of information before providing enrollee PHI. We do not share third-party information and redirect practitioners to contact other providers directly to obtain the records. When we receive an authorized request for information, we electronically send it in PDF format via secure email or establish a secure data exchange.

We have developed policies and procedures that address the proper handling, use, and disclosure of enrollees' PHI while administering their health care benefits and providing high-quality customer service, and we maintain them. We update policies and procedures annually and as needed to stay current with changes in legislation and to verify that they are current and complete. Any time we update our policies and procedures, we also update training materials or other related communications and notify our staff. Our policies and procedures to safeguard the use of PHI include the following:

- Implementing, enforcing, and providing training and education for our staff on policies and procedures regarding the appropriate uses and disclosures of PHI, including monthly distribution of compliance fact sheets
- Establishing the proper handling, use, and disclosure of enrollees' PHI while administering their health care benefits and providing an appropriate level of customer service
- Recognizing each enrollee's right to privacy and treating all their health information with the strictest confidentiality and obtaining their permission to release it

Sharing health information with others only when it is appropriate for aiding delivery of health care services, administering health care benefits or health care payments, or as otherwise required by law as previously described.

Protecting Data in Motion and At-Rest

To protect data in motion and at rest, Aetna has implemented NextGen server architecture for all Medicaid production environments. Databases reside in an environment with full disk encryption,

ensuring encryption of data at-rest. Additionally, data in motion is encrypted internally to encompass our wide network area as well as across the Internet. Our database servers are protected by physical and logical access controls within a highly secured data center. Backup media is encrypted, and we destroy retired hardware following strict disposal protocols further protecting data. Database activity is monitored by Guardium software to capture all activity including reading and accessing the database. Additionally, we have a 100 percent compliance training rate concerning data protection and protecting enrollee health information.

Security Awareness and Education

A key component of Aetna's security program is employee education and awareness of the critical role each of us plays in protecting enrollee health information, the Department's data, and our interfaces and platforms. Front-line personnel stay well informed about current threats via communication channels and receive training on how to validate inquiries to personal data. To ensure all staff and contingent workers are aware and understand the importance of their role in protecting Aetna's information and resources, all workers are required to complete, upon commencement of employment, an online Information Security Awareness course.

Security Audits

As part of our ongoing commitment toward protecting the confidentiality, integrity, and availability of our enrollees' PHI, Aetna contracts with IBM Security Services to perform an annual HIPAA Security Health Check audit of existing controls as one of the key assessments performed along with other continuous audit activities throughout the year. The most recent completed assessment, conducted between April 10 and May 10, 2019, was facilitated through a series of onsite interviews; a review of all documented policies, processes, procedures, and guidelines; and a comparison of Aetna's security practices against HIPAA security standards as it relates to the Omnibus Final Rule.

Commendation from IBM for Maintaining Strong Security Controls for PHI

We received the following commendation regarding the finalized assessment: "The daily risk and threat monitoring of Aetna information assets is leading edge and ensures a high awareness of threat vectors into the environment. In addition, a very robust security awareness campaign is also in place with multiple methods of distribution to ensure that employees fully understand and take part of securing sensitive information. There are continuous audits and assessments (both regulatory and non-regulatory) occurring throughout the year and Aetna has shown proactive due diligence in its approach to security and providing all the necessary documentation/evidence to the various assessors in a timely and organized manner."

IBM Security Services concluded: "Aetna takes information security seriously within the organization and strives to focus on various technical operational and management controls for the protection of ePHI. Aetna has numerous audits performed throughout the year and as such, remains in good standing with the various compliance requirement…Aetna is performing well in all areas, thus meeting all the HIPAA Security Rule requirements."

Internally, we audit a series of technical controls designed to either eliminate security defects altogether or to facilitate the identification of potential vulnerabilities as early within the lifecycle as possible. These controls can be classified into the following categories:

- Application obfuscation technologies, which help provide Aetna's applications with protection against reverse engineering and other forms of compromise
- Implementation of static code review technologies on the developer's workstation in a manner that not only supports the identification and remediation of defects, but also provides developers with feedback that helps avoid creating such defects in the future

A sampling of controls we audit include the following:

- Detective application security controls designed to facilitate the identification and remediation of defects identified after development activity has ceased
- Policies pertaining to the implementation of open source code components, defined by a cross-functional team and enforced through a series of technical controls integrated at several layers
- Threat-modeling practices, which allows us to outline threats to an application and design appropriate countermeasures
- Next-generation authentication platform based on a comprehensive analytical model that leverages a variety of behavioral and biometric attributes which, when analyzed in correlation with one another, allows for instantaneous authentication decisions to be made at assurance levels that far exceed traditional binary forms of authentication.

f. Aetna's Proposed System Changes/Enhancements for the Program during the Contract Term and Ensuring Operations are not Disrupted

Aetna has developed and refined its implementation approach and brought best practices based on three decades of Medicaid managed care experience. Our process enables us to serve the needs of enrollees as we work to achieve full compliance and a seamless transition to new regulatory and contractual requirements. Using our proven approach, the Implementation team manages and monitors a timely process. Our team of experts conducts kickoff meetings, establishes project management governance, and prepares and guide operational readiness. We use 30 years of best practices to create plans for every contingency; Aetna has passed 16 consecutive state readiness reviews and achieved go-live within required timeframes and without any disruptions.

Successful Migration of Encounter Management System

On July 25, 2018, our Encounter Management Unit successfully migrated the existing encounter management system known as EDM to our new system, Edifecs. Migration activities were extensive, including a historical data load of over 20 million 837 and response records and robust quality assurance, user acceptance testing, and Commonwealth testing. System cutover was completed during the weekend, making the migration completely seamless with no disruption to our processes, the Department, our enrollees, or subcontractors. Our first submission from the new system achieved a 99.94% acceptance rate on over 60,000 medical encounters, and 100% acceptance on our pharmacy submission of over 90,000 encounters. As a result of this migration, we experienced an increase of our overall accuracy results—accuracy improved 1.37% and timeliness improved over 1.79%. This was achieved through the expansion of compliance and Commonwealth-specific editing and the integration of the historical daily master provider file.

We do not subcontract any of our MIS applications and therefore continually update to safeguard our robust investment. Recent system upgrades have allowed us to further safeguard all our MIS systems and data. Currently, disruptions are virtually undetectable and should remain so throughout the course of this new contract.

Proposed Enhancements

We have many exciting initiatives in our pipeline that will be going live within the next two years. As articulated in our previously mentioned enrollee and provider journeys in the section's introduction, these initiatives will serve both our enrollees and providers and will bring meaningful benefits to the Department. An overview of upcoming applications and enhancements includes the following:

- **Prior authorizations simplification:** Implement 'gold card' programs, reduce prior authorization gridlock, and improve administration review/approval automation. We will offer artificial intelligence clinical approval algorithms.
- **Availity provider portal:** A multi-payer provider platform, it will offer a single system to drive a unified provider experience across all Aetna lines of business
- **Social determinants of health strategy:** Through strategic vendor partnership, platform integration with Unite Us will close the loop on social determinant interventions.

- **Aetna Health:** Will migrate our current enrollee mobile application to our Next Generation Aetna Health digital platform, which will bring significant personalized health, benefit navigation, and interactive capabilities in a simplified interface.
- **Provider load efficiencies:** Will include deployment of an automated contract process to manage all stages of the contract lifecycle to ensure tight version control of all retained data, and robotic process automation to improve the efficiency in how we collect and enter accreditation data into systems.

60.7.C.7 Encounter Data

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60.7.C.7 Encounter Data (Section 16.0 Encounter Data Submissions)

Aetna understands, acknowledges, and will comply with all the requirements to support **Section 16.0, Encounters Data Submissions, of the Draft Medicaid Managed Care Contract and Appendices.**

a. Aetna's Processes to Ensure Complete, Accurate, and Timely Encounter Data and Correcting Errors with Providers and Subcontractors

Aetna understands the critical role that timely, accurate, and complete encounter data plays in Kentucky Medicaid's ability to continuously review the health care utilization of its Medicaid enrollees, to analyze expenditures associated with that utilization, and to monitor service delivery performance with its partners. Aetna has been submitting encounters in Kentucky for 8 years and our larger Medicaid organization has over 30 years of experience transmitting encounter data to Medicaid agencies focusing on accuracy, completeness, and timeliness. We are dedicated to our collaborative and innovative relationship with the Department, Commonwealth agencies, enrollees, providers, and community-based organizations, to continue driving the statewide mission to create a healthier Kentucky. We support this goal through our expertise in providing accurate and timely encounter data through technology that increases service efficiency and effectiveness, which allows us to offer our enrollees additional benefit programs and/or services to create a healthier Kentucky.

Our Kentucky 2019 Encounter Data Statistics:

- Accuracy: 99.30%
- Timeliness: 99.57%

Processes to Ensure Complete, Accurate, and Timely Data

Our extensive expertise with Kentucky encounters, paired with our superior rate of accuracy and timeliness, has helped mitigate provider administrative burden, support our enrollees, and serve the Department as a dedicated and loyal managed care organization. We are compliant with the Health Insurance Portability and Accountability Act (HIPAA) and all other federal and Commonwealth regulatory requirements. The following narrative addresses our strategy for ensuring complete, accurate, and timely encounter submissions, starting with provider contracting; then applying our comprehensive claims edits; and finally, our robust encounter management system and experienced staff.

To achieve accurate, complete, and timely submissions, Aetna transmits all encounter data using HIPAA-compliant 837 (I and P) and National Council for Prescription Drug Programs (NCPDP) electronic formats. Validation begins with the delivery of services by requiring all participating providers to submit encounter services with the required information. All providers, including sub-capitated and atypical, are educated upon contract agreement and at orientation on the submission of claims and what is required to submit a clean claim to receive payment. Our claims adjudication system requires that key data fields be provided at the claim level to adjudicate and include data fields such as the following:

- Recipient Medicaid identification (ID) number, provider Medicaid ID, and national provider identifier (NPI)
- Claim type
- Place of service/bill type
- Revenue codes
- Procedure codes (Current Procedural Terminology [CPT]-4)
- Diagnosis code (International Classification of Diseases [ICD]-10)
- Healthcare Common Procedure Coding System (HCPCS)-I, II
- Modifiers
- Dates
- Charges

Claim adjudication edits are configured within the claims processing system to validate the accuracy and completeness of data allowing for the seamless submission of encounters. The system has over 400 business

rules in addition to standard configuration payment rules that our Configuration Standards Reimbursement Administration department configures to enforce policies and procedures. Examples include the following:

- **Benefits package variations:** The system automatically analyzes CPT, revenue, and HCPCS codes to determine whether specific services are covered under the contract or under benefit rules. If services are not covered, the system automatically denies the respective claim line with the appropriate HIPAA remittance remark on the recipient explanation of medical benefits.
- **Data accuracy:** The system is continually updated based on the most current code sets available (HCPCS, revenue, CPT, national drug code [NDC], ICD codes) by year. As new codes are added, terminated, or changed, we update the codes so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, the system denies the claim line and advises the provider the code is invalid via remittance advice.
- **Adherence to prior authorization requirements:** The system is configured to enforce the supporting documentation requirements of certain services. In addition, it can configure prior authorization by code, provider type, and place of service. Claim edit rules are set to validate the claim against the network provider, enrollee, dates of service, services rendered, and units authorized.
- **Adherence to Commonwealth-specific requirements:** The system is configured to enforce the rules and requirements set forth by the Commonwealth, such as timely filing and procedure code validity.
- **Provider qualifications:** Provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, the system will not permit the processing of a claim for in-office heart surgery by a podiatrist. Cotiviti Healthcare (Cotiviti), an industry leader for front-end automation of correct-coding and medical-policy decisions, lends additional support, reviewing any claim line set to 'Pay' for billing appropriateness by specialty. The system checks other providers' specific items, verifying, for example, that each provider has obtained the requisite NPI or its equivalent, has included the identifier on all claims submissions, is registered with the Commonwealth with a valid Medicaid ID, and is an active provider for the date of service.
- **Eligibility and enrollment:** The system validates the date of service against the enrollee's enrollment segment to determine if they were eligible on that date. If not, the system denies the claim using the appropriate HIPAA-approved remittance comment.
- **Duplicate billing logic:** The system uses a robust set of edits to determine duplication of services (e.g., same enrollee, same date, same network provider, same service, or any combination of these criteria). This logic protects against payment for services rendered by the same physician or other physicians within the same provider group.

Other claims processing edits and tools used to maximize accuracy throughout the adjudication process include ClaimCheck® and Cotiviti edits. ClaimCheck is a comprehensive code-auditing solution that supports the claims processing system by applying expert industry edits from a provider-recognized knowledgebase to analyze claims for accuracy and consistency with relevant policies and procedures. ClaimCheck clinical editing software identifies coding errors in the categories, including procedure unbundling, mutually exclusive procedures, incidental procedures, medical visits/same date of service, bilateral and duplicate procedures, pre- and post-operative care, assistant surgeon, modifier auditing, and medically unlikely services. Aetna also uses integrated claims management services, powered by Cotiviti, to enhance the claim processing system's edit functionality for professional claims that reach an adjudicated status of 'Pay.' The system uses algorithms to detect potential claims up-coding with follow-up procedures for chart audits as appropriate, including the following steps:

- **Coding accuracy:** If services are up-coded or unbundled, Cotiviti alerts the Claims department to deny the claim line along with the specific clinical editing policy justification. The claim line denies with the appropriate HIPAA remittance remark on the recipient of medical benefit.
- **Durable medical equipment (DME) editing:** Cotiviti performs edits related to select DME payment policies that align with Medicaid covered service policies. These edits include DME rentals, oxygen and

oxygen systems, hospital beds and accessories, external infusion pumps, and anatomic/functional modifiers required for DME services.

- **Procedure code guidelines:** Aetna follows the American Medical Association (AMA) CPT-4 Book and Centers for Medicare & Medicaid Services (CMS) HCPCS Book for instructions on code usage. Cotiviti has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, we deny the code as inappropriate based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s). Cotiviti supports correct coding based on the definition or nature of a procedure code/combination of procedure codes. The ability to code in this manner supports prior authorization requirements during claim adjudication. Furthermore, these editing policies either bundle or recode procedures based on the appropriateness of the code selection.

For example, if a provider attempts to unbundle procedures, Cotiviti applies editing logic that bundles all the procedures billed into the most appropriate code. If a provider bills an office visit and bills separately for heart monitoring with a stethoscope at the same visit, Cotiviti rebundles the service into the appropriate evaluation and management or office code. Using the edits and tools described in this section, we deny, completely or in part, claims with missing or invalid information. Providers and subcontractors are required to resubmit the claim with valid information to receive payment. We configure our claim system to align with the Department's coverage and payment policies. When we deny claims at submission, configuration is added to align with the Department's guidelines. In such instances, we require providers to resubmit the claim with valid information to receive payment.

Encounter Management System Accuracy

Our encounter management system, Edifecs, is an integrated, HIPAA X12-compliant, single system for encounter management that consolidates submission and reconciliation processes. It performs comprehensive encounter validation through a coordinated set of edits and validation rules that comply with Commonwealth-specific business rules, allowing us to proactively identify potential data issues and correct them at the earliest stage of the reporting process. A dedicated team monitors regulatory changes in the market and performs any needed product updates to meet Commonwealth requirements and timelines. This helps to ensure accurate, consistent tracking, trending, process improvement, data collection, monitoring, validation, reporting, and error correction. The encounter management system validates encounter files received from all subcontracted vendors (such as vision and pharmacy) for compliance using standard HIPAA guidelines, Strategic National Implementation Process (SNIP) levels 1-5. It performs multiple levels of validations including duplicate checks on the encounter information and provides comprehensive validation steps that ensure files are accurate and complete prior to submission. **Figure C.7-1** illustrates the process.

With the migration to Edifecs, we experienced immediate improvement in our overall results. Accuracy improved 1.37%, timeliness improved over 1.79%, and duplicate rejects reduced by 91% to date. This, combined with our risk adjustment process, resulted in a claim to encounter gap reduction of 1.03% over three years. These practices allow us to continue to experience sustainable results. We will continue to employ Six Sigma-based methodology to further improve and reduce remaining internal and external rejects.

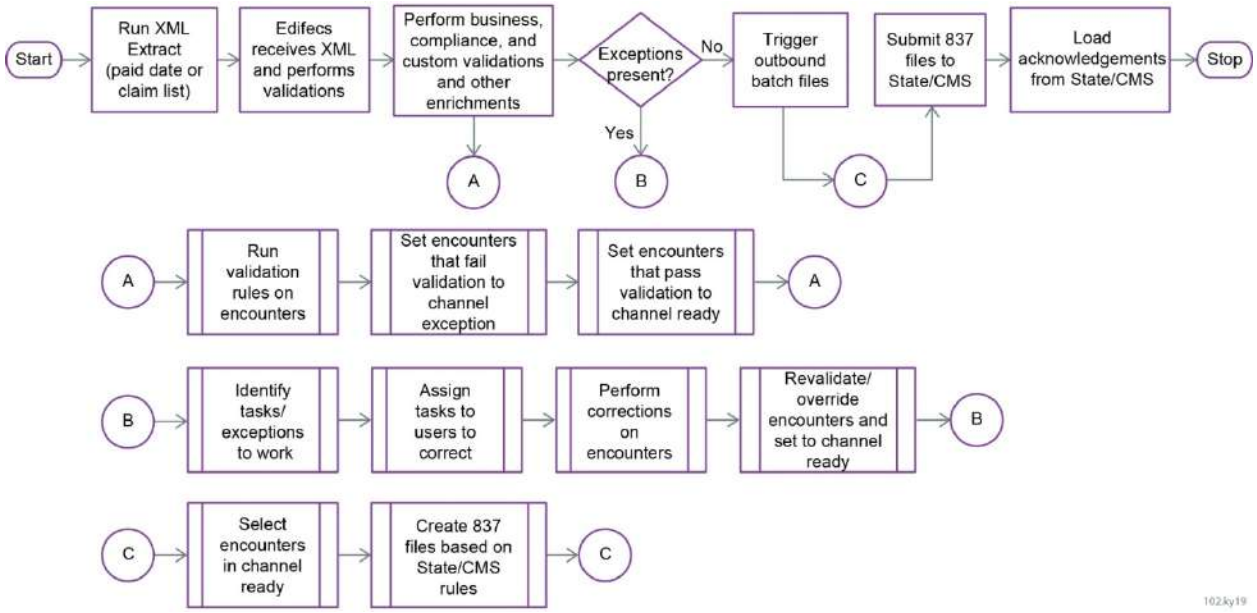

Figure C.7-1: Life of an Encounter

This illustration depicts the multiple levels of validations for our encounter data.

Once data is extracted into Edifecs, the system first validates that the data complies with standard 5010 HIPAA SNIP Levels 1 to 5. It then checks data against built-in business rules that emulate the specific Commonwealth edit requirements and uses integrated Commonwealth reference files for validation. As part of this process for Kentucky, we have integrated the daily Master Provider File from the Commonwealth as part of our validation, which has afforded improved accuracy and reporting of encounter data elements, thereby increasing initial acceptance. Overall, these initial steps help us ensure files are as error-free and complete as possible prior to submission.

To further ensure our files are fully comprehensive, correct, and complete based on Commonwealth requirements, Edifecs applies Kentucky-specific encounter editing to encounter records. We have a dedicated team that monitors regulatory changes in the market and performs any needed product updates to meet Commonwealth requirements and timelines. Edits are built based on Commonwealth requirements; however, the Encounter Management Unit (EMU) can customize edits (internal exceptions) when needed to ensure only complete and accurate encounters are being sent. For example, internal exceptions have been put in place to prevent encounter rejections for provider-related edits 562/201 and 562/1750-1788, which include edits such as provider identification number missing, referring or ordering provider NPI, and provider NPI not on file, among others. Encounters that meet the internal edit criteria are held as internal exceptions until the Encounter team validates that they are populated with all the required appropriate values or the necessary recoupment is completed in order to obtain the corrected or needed data.

Encounters that have passed internal editing are then batched and submitted to the Commonwealth via Secure File Transfer Protocol in the required format at least weekly, on our required submission date. The EMU monitors all our submissions and the data correction process closely to ensure encounters are submitted and resubmitted to the Commonwealth in the required timeframes. Once the files are submitted, Commonwealth 999 and 277 response files are retrieved, reviewed, loaded, and tracked to ensure records were processed successfully. In the event of a file failure, they are worked and resubmitted immediately with the appropriate attestation. Accepted and rejected encounters on 277 files are tracked, reviewed, and corrected on a first-in/first-out basis within 60 days. With the new contract, we will make certain that

resubmissions are completed within the new 30-day requirement. We will continue to experience sustainable results by employing the Six

Sigma-based methodology to further improve and reduce rejects, which ultimately supports timeliness. Edifecs allows management and error tracking across denial reasons, claim type, recipients, providers, claim adjudication date, and the 277 file received date. Weekly, the encounter certification is completed and authorized by the approved health plan chief financial officer and submitted within the Commonwealth's submission requirements.

To date, all of our Kentucky encounter certifications have been submitted timely to the Commonwealth.

Procedures to Correct Errors

The following narrative describes how we correct errors for claims, providers, enrollment, and subcontractors.

Claims

How we correct the claims errors depends on the errors received from the Department. The EMU prepares weekly reports of the denied inventory and assigns the work to the responsible department for review and correction. Our EMU uses two processes to manage correction activities, depending upon whether re-adjudication is necessary. If claim re-adjudication is not necessary, the EMU executes corrections to allow the resubmission of encounter errors per the Department's encounter correction protocol. If re-adjudication is necessary, the EMU reprocesses the encounters in the appropriate claim system following the encounter correction protocol and provider recovery process if needed. They are then imported back into Edifecs for resubmission if necessary. Edifecs generates, as required, the appropriate void, replacement, and/or adjustment records. To help ensure accuracy, our data correction procedures enable the team to identify and correct encounters that failed the acceptance process. We apply lessons learned to improve the accuracy of encounter submissions and to minimize rejections as part of our continuous process improvement protocol.

Providers

Denials related to provider information and billing issues are sent weekly to the Network Relations team. The team researches and corrects provider setup issues and educates providers via fax blasts, email, or face-to-face communication on proper billing practices when needed. The EMU attends the daily Collaboration and Teamwork Summit, which includes representatives from all departments as well as the Network Relations team. During this open forum meeting, various issues and potential issues are brought forward from all departments for resolution. These issues are tracked daily until they are resolved. Specifically, for encounter-related issues, resolution can include identifying specific provider education needs where the network manager will then work with the provider or provider groups directly until it is resolved.

Enrollment

Errors related to enrollment are assigned to the Enrollment Services team, where they validate and correct enrollee issues such as eligibility and enrollee demographics within the claims processing system. The EMU coordinates with these teams to track and resubmit the corrected claim/encounters within the 30-day requirement.

Subcontractors

The EMU meets with all subcontracted vendors regularly to review denial trends, accuracy results, and provide feedback and assistance in resolution of errors. For additional information, please refer to **Section d., Aetna's Educational Approaches to Support Providers and Subcontractors with Ongoing Challenges Submitting Complete, Accurate, Timely Data**.

Operating Model and Staff to Support the Encounter Process

Our centralized operational EMU is responsible for data collecting, submission, and correction processing. They are subject matter experts on claims/encounter processing systems and have detailed knowledge of HIPAA files including X12 (837P, 837I, 837D, NCPDP, 2.2); Medicaid compliance requirements; business intelligence tools; and knowledge of analytic programming tools and methods (SAS, SQL, Business Objects, Crystal, Visual Studio, Microsoft Office, etc.). In addition, Kentucky's dedicated EMU has over 35 years of Kentucky-specific experience combined. The existing team, listed in **Table C.7-1**, includes one manager and dedicated staff in the following roles:

Table C.7-1: EMU Team

Position	Function
Project manager	Acts as the health plan/Commonwealth encounter liaison; manages metrics/compliance and end-to-end processing from core claim system through submission to Commonwealth/federal regulator, and monitors system updates, conversions, and migrations
Encounter technical analyst (ETA)	Controls data management and reconciliation of large data sets, technical business requirements, mapping documents, and Commonwealth and system testing; displays intimate knowledge of electronic data interchange transaction sets; and interacts with the Commonwealth's technical intermediaries and Commonwealth Information Technology (IT) departments on an ongoing basis
Encounter validation analyst (EVA)	Manages data exports for submission to Commonwealth/federal regulator, regulator response file imports, reconciliation of submissions, testing of support systems and workflows, and analysis for submissions accuracy and timeliness
Encounter correction analyst	Manages claims and encounter error corrections and claim/encounter data issue identification and resolution
Encounter report analyst	Supports, develops, and maintains standard reports; creates on-demand ad hoc reports; and works with EVA/ETA to monitor data, inventories, and anomalies

Our Kentucky-dedicated team meets daily to review encounter exceptions, rejections, denials, file tracking, and trend reports with the health plan. During the review process, if the Encounters team identifies any system-related issues, we work directly with our IT and business teams to identify the root cause for quick resolution. This joint team analysis determines if adjustments need to be made to the claim adjudication system, encounter editing, or encounter processing. Feedback from the Commonwealth also prompts review of system rules. Our dedicated plan-centric team allows us to streamline decision-making, increase accountability, reduce risk of compliance issues, and has improved how we work with our business and Commonwealth partners.

Importance of Accurate, Timely Data

Aetna understands the importance of submitting accurate, timely encounter data to the Department for Kentucky Medicaid programs, which we have demonstrated through our consistent improvement year-over-year for superior accuracy and timeliness. Accuracy and timeliness results in **Table C.7-2** include medical, pharmacy, vision, and dental.

Table C.7-2: Encounters Accuracy and Timeliness Results

Year	Acceptance Rate	Timeliness Rate
2017	98.00%	98.01%
2018	99.02%	98.56%
2019	99.30%	99.57%
Total	98.75%	98.68%

Incenting Providers to Submit Timely, Accurate Claims

We have several programs that encourage providers to submit timely, accurate claims. They include value-based payment (VBP) contracts that support the increase in shared savings to our VBP providers for enrollees who are at a higher risk level. We collaborate with our VBP providers to help them educate their

staff on the importance of accurate diagnosis specificity to provide ease in identifying these important enrollees.

b. Aetna's Encounter Data Processing Policies and Procedures

The following narrative includes our encounter data processing policies and procedures (P&Ps). Specific policies are as follows (please refer to **Attachment K for Encounter Data Policies and Procedures** to view the P&P):

- **2400.05 Encounter Data submission:** Defines the process for the submission of encounter data and supplemental data to the designated agency, in accordance with HIPAA standards and regulatory requirements, for the purpose of rate setting, quality management, risk adjustment, and other mandated requirements. The Medicaid Encounters team will cooperate with the regulator or designated entities in conducting encounter data quality assessments.
- **2400.07 Encounter and Health Plan Roles and Responsibilities:** Clearly defines roles and responsibilities for the end-to-end encounter process.
- **2400.10 Data Transfer to Encounter Management System:** Defines the process of centralizing finalized claims data for Medicaid and Medicare health plans; confirming timely, complete, and accurate representation of the health plan enrollees' utilization is reported, including third-party vendors.
- **2400.14 Encounter Inventory Management:** Confirms proper inventory control for complete, timely, and accurate encounter submissions.
- **2400.15 Correction of Encounter Data in the Encounter Management Systems:** Highlights the correction activities that occur within or outside of the encounter management system(s).
- **2400.17 Encounter Financial Completeness:** Defines the reconciliation and evaluation of the overall financial completeness of encounter data submitted to the regulator.
- **2400.20 Processing of Encounter Response File Info from Regulatory Agencies:** Defines the processing of encounter response file information received from regulatory agencies that are imported into the encounter management systems.

All Aetna Medicaid Administrators LLC policies are reviewed at least annually (within 12 calendar months of last reviewed/revised date). Policies may be updated more frequently if there are changes to the contract, federal/Commonwealth/other regulatory requirements, or Aetna business processes. All policy updates are reviewed by the Aetna Medicaid Policy Committee and require approval from the Aetna Medicaid Administrators chief operations officer (COO) and chief medical officer prior to being published. Common Challenges in Encounter Data Development; Submission and Mitigation Strategies/Best Practices to Ensure Required Encounter Data

To address challenges in encounter development and submission, we work collaboratively with our internal teams such as Claims, Information Technology, Enrollment, and Provider Services as well as with the Commonwealth to develop mitigation strategies and best practices. This collaboration has created continuous improvement ensuring that our encounter data is accurate and complete. We have made several system enhancements and modifications to both our front-end claims system as well as processing and to our encounter system in order to reduce rejects and increase throughput. On July 25, 2018, the EMU successfully migrated the existing encounter management system (known as EDM) to our new system, Edifecs. As a result, we have reduced our overall reject volume by 95 percent from 2017 through June 2019 and currently remain at steady state. Most of the challenges we have faced were tied to upstream front-end claim processes and our previous encounter system, which had a significant impact on our reject volume and timeliness.

Strategies

The following are steps we took to correct these issues and their impact:

- **Front-end claim updates:** We made several enhancements to our claim intake, processing, and editing logic in order to avoid paying claims that we could not encounter such as the following:
- **Form type validation and type of bill (TOB) editing:** By enhancing our front-end form type validation and TOB editing, we experienced an 84 percent reduction in related errors.
- **Updated provider NPI/operating, referring, and prescribing (ORP) edits:** Although we have ongoing efforts to enhance our NPI and ORP editing, the updates which we have made thus far have resulted in a 98 percent decrease in related encounter rejects.
- **Updated taxonomy edits:** By incorporating the historical daily master provider file during the adjudication process, we reduced encounter rejects by 95 percent.
- **Enhanced NDC editing:** We automated NDC average wholesale pricing to reduce manual pends and risk through front-end system configuration; with this enhancement we reduced errors by 98 percent.
- **Reference files:** Implemented an overarching policy for annual updates to fee schedule/codes and reference files. Our department-specific process was streamlined in the first quarter of 2017; this includes fee schedule exception and procedure code alignment, which allowed claims to deny due to improper provider billing.
- **Enhanced duplicate claim editing:** These enhancements resulted in a 66 percent reduction from 2016 to 2018, and 70 percent from 2017 to 2018.
- **Edit 402/threshold edit 4419:** Amount paid must be less than $0 cleanup; uncapped penalty reduced from $3.1 million in March to less than $1,000 in September; a 99.9 percent reduction in new rejects in 2017.

Best Practices

Encounter system modifications to reduce rejects: On July 25, 2018, the EMU successfully migrated the existing encounter management system (known as EDM) to our new system, Edifecs. This decision was made to develop a gold standard in encounter submissions by using a system that is 'out-of-box' compliant to Commonwealth/CMS regulations as well as HIPAA standards, resulting in reduced implementation effort, faster speed to market, and product-driven updates triggered by Commonwealth/CMS regulation changes. The decision was also largely driven by the fact that this system also aligns to what the Department uses to support encounter processing.

This new encounter management system is an integrated, HIPAA X12-compliant, single system for encounter management that consolidates submission and reconciliation processes. It performs comprehensive encounter validation through a coordinated set of edits and validation rules that comply with Commonwealth-specific business rules, allowing us to proactively identify potential data issues and correct them at the earliest stage of the reporting process. A dedicated team monitors regulatory changes in the market and performs any needed product updates to meet Commonwealth requirements and timelines. This helps to ensure accurate, consistent tracking, trending, process improvement, data collection, monitoring, validation, reporting, and error correction.

Risk adjustment: We engage a multidisciplinary team that proactively addresses enrollee gaps in care and promotes complete, accurate, and factual documentation that reflects the enrollee's health status. Components of the multidisciplinary teams are the following:

- **Care Management:** Ensure enrollee is receiving appropriate care and gaps in care are identified and resolved
- **Provider Services:** Ensure enrollee is receiving appropriate care and work collaboratively with providers to ensure complete, accurate, and factual documentation
- **Enrollee Services:** Partner with our enrollees to coordinate the right services and benefits depending on their unique health status

- **Community Outreach:** Leverage community relationships to engage the enrollee where they live and have access to appropriate services
- **Quality Management:** Coordinate efforts to address Commonwealth-related initiatives around quality while addressing enrollee gaps in care
- **Value-based Services:** Work with our providers to ensure enrollees are receiving appropriate care and we have alignment as we work together to achieve quality outcomes
- **Information Technology and Informatics:** Develop and maintain data analytics to identify enrollee gaps in care and track timely resolution

Proactively addressing gaps has reduced the gap closure from claims payment to encounter acceptance for high-risk enrollees—consistently decreased over the last three years from 2.02 to 0.99 percent with a positive net revenue impact of $295,037.

Reporting and analytics include a standard suite of reports and dashboards that provide the following:
- Monitor risk scores by population, provider, and enrollee; trending to manage fluctuations
- Identify gaps in care and disseminate across multidisciplinary teams to resolve
- Track-and-trend enrollee risk scores and chronic conditions to ensure continuity of care

c. Aetna's Educational Approaches to Support Providers and Subcontractors with Ongoing Challenges Submitting Complete, Accurate, Timely Data

Timely and accurate encounter data is essential in obtaining meaningful information on enrollees and promoting better health outcomes. Aetna actively works and supports both providers and subcontractors to address any challenges they may have to submitting complete, accurate, and timely data. The following are our training and orientation, behavior correction, and monitoring approaches:

We hold subcontractors to the same requirements as our internal Encounters department, which includes meeting the Commonwealth's encounter data submissions requirements.

- **Training and orientation:** Initial provider training and orientation begins as soon as a provider joins our network, which includes encounter and contract requirement information. After orientation, providers receive ongoing training based on encounter denial trends and best billing practices. They may also receive additional training and information at any time by requesting it from the health plan, or referencing their manual, provider forums, webinars, and face-to-face visits. All our subcontractors are trained immediately upon initiation of contract on Commonwealth billing and submission requirements. At a minimum, they meet weekly with the EMU and the health plan through the development and implementation phase. Full testing is conducted prior to production submissions to make sure all encounter requirements are being met. Post-implementation, the EMU meets regularly with the subcontractor to review denial trends, accuracy results, and provide feedback and assistance in resolution of errors.
- **Correcting provider and subcontractor behaviors:** We communicate regularly and work continuously with our providers and subcontractors to promote compliance. To correct behaviors, encounters and claims denials are discussed regularly as part of the Joint Operating Committee meetings we conduct with large provider groups, providers, and subcontractors. We also meet with providers as needed, depending on agenda topics. If providers or subcontractors fail to submit complete, timely, and accurate encounter data, we use training, oversight, corrective action, as well as contractually appropriate sanctions, to address the deficiency.

  Subcontractors and network providers must attest to the completeness, truthfulness, and accuracy of all claims and encounter data submitted to Aetna, including required medical records data, and must ensure that they submit the information on the applicable claim form or electronic format type. We train our providers during the orientation process and our local Kentucky provider service representatives

provide support with the claims submission process. Additionally, all our subcontractors are trained on proper encounter data submission, including submission frequency, acceptable data formats, accuracy, and completeness. We provide support on proper coding and present an overview of how the encounter management system enforces accuracy. We meet regularly with our vendors to ensure we address any questions and issues and to discuss error resolution. Aetna uses contractual requirements and service performance agreements to monitor provider and subcontractor compliance with all contractual responsibilities.

- **Monitoring providers and subcontractors:** Aetna created a delegation oversight policy that outlines how we actively monitor subcontractor performance, including non-submission of encounter data. Specifically, Aetna monitors subcontractors and providers by approving subcontractors' or providers' program operations as outlined in our quality and utilization management programs and plans. The medical management director monitors the reports from subcontractors or providers (delegated-use organizations) according to the delegation agreement (or contract). The medical management director shares findings with the chief medical officer.

  We proactively report subcontractor or provider non-submission of encounter data to our quality management director, who promptly reviews the report with the vendor relations and provider services manager. Additionally, our quality management director prepares and delivers quarterly summaries to our COO. The vendor relations and service operations director assess the situation. This includes meeting with the subcontractor or provider to determine whether the performance issue can be resolved or if escalation to the COO is necessary. If issues persist, the COO refers the matter to the appropriate committees to create a corrective action plan that includes all actions necessary to correct deficiencies. If the provider or subcontractor does not correct the problem, Aetna may impose a financial penalty or even terminate the relationship in accordance with the contract. The quality management director submits audit reports of delegated activities and corrective action plans to the appropriate Aetna Oversight Committee (e.g., the Quality Assurance Plan Committee [Quality Management/Utilization Management Committee] or Subcontractor Oversight Committee [Delegation Subcommittee]). The committee reviews and gives approval. From this point, the Quality Management/Utilization Management Committee reviews the item and may recommend one of the following actions:
  - Assessment of performance credits against subcontractors if they fail to meet designated standards for claims processing and encounters
  - Pursuit of indemnification from any subcontractor for any financial penalty, fine, or interest assessed against Aetna as a result of the subcontractor's failure to meet required standards, or offsetting the amount of any such penalty, fine, or interest against payments Aetna owes to the subcontractor
  - Termination if other remedies fail to help the provider or subcontractor meet encounter data and submission requirements

Corrective Action Plan Improves Compliance Rate for Subcontractor

In 2016, our dental and vision benefits administrator, Avēsis, was in substantial noncompliance with its obligation to supply accurate, timely, and complete vision and/or dental encounter data as well as provider files. This was due to 21% of their encounter files that were submitted between February 1, 2016 and May 1, 2016 had an acceptance rate of less than 95%, continued submission of provider file errors, and untimely submission of encounters, which put Aetna out of compliance and at risk for potential penalties. On May 5, 2016, Avēsis was placed on a corrective action plan, which required them to delineate the issues and provide a timeline in which the deficiencies would be corrected. As a result, Avēsis identified the root cause of each issue and took the appropriate actions in order to mitigate the issues. We continue to work closely with Avēsis to ensure there is constant improvement.

Aetna also has developed a comprehensive system to provide multiple feedback opportunities and use the data to identify education opportunities and reduce administrative burden. These mechanisms track provider feedback from across the organization and identify the most effective mechanism for responding, such as our Tip Tuesday campaign that provides weekly ongoing provider tips and education.

d. Working with the Encounter Technical Workgroup to Enhance Data Submission Requirements and Improve Accuracy, Quality, and Completeness

As an incumbent with the Commonwealth, we regularly attend and actively participate in the Encounter Technical Workgroup in order to improve accuracy, quality, and completeness of encounter submissions. In addition to our Encounters team, our chief executive officer and other senior leaders attend the Encounter Technical Workgroup to ensure the highest level of commitment and collaboration. Over the last eight years, Kentucky's Medicaid operations have brought several questions and process flows to the Encounter Technical Workgroup for discussion to improve our results and outcomes. During the initial workgroup meetings, when the Department included all the managed care organizations to when we broke off into individual meetings, various topics were discussed including but not limited to duplicate resolution, edit roll-off, and pharmacy and provider concerns related to encounter rejections.

As we continue to participate in these meetings, the following are some of the initiatives we would like to bring to the Encounter Technical Workgroup to continue our collaboration with the Commonwealth on improving accuracy, timeliness, and completeness of encounter data:

- We would like to partner with the Department on the technical process to clear rejected encounters. When a recovery is needed on a rejected encounter, the Medicaid Management Information System does not accept void transactions on the rejected encounter.
- Partner with the Department to discuss a process to assess encounters rejections as a result of other insurance, enrollee retro-enrollment updates/termination.
- Ongoing collaboration with the Commonwealth and providers to reconcile wrap payments.
- Proactively monitor and discuss variances in data that prevent acceptance of encounters.
- Discuss new encounter edits with the Department and Aetna Claims and Encounters teams to assure that any claim processing logic is consistent with the encounter edit logic. This will help to reduce the number of claims that are paid yet the encounter is rejected.
- Partner with the Department on provider communications explaining new claim processing and encounter edits.

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60.7.C.8 KHIE and Electronic Health Records

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60.7.C.8 Kentucky Health Information Exchange (KHIE) and Electronic Health Records (Section 17 Kentucky Health Information Exchange, Section 18 Electronic Health Records)

Aetna understands, acknowledges, and will comply with all the requirements to support **Section 17, Kentucky Health Information Exchange (KHIE), and Section 18, Electronic Health Records, of the Draft Medicaid Managed Care Contract and Appendices.**

a. Aetna Strategies and Incentives to Encourage Provider Adoption and Use of Electronic Health Records

Aetna values the importance of interoperability of data within the Commonwealth to improve quality and reduce cost for our enrollees. In Kentucky, we will promote flexible solutions that support our health care providers and community service partners where they are in their health information technology journey. As part of our electronic health record (EHR) strategy, we will work with the Commonwealth where necessary to align any incentive program or technical support to coincide with and build on existing Commonwealth initiatives to prevent additional provider administrative burdens and encourage participation and movement along their chosen EHR transformation pathway.

> Aetna was proud to co-sponsor the Kentucky eHealth Renovate to Innovate summit in August 2019. The conference brought together managed care organizations, hospitals, providers, and clinics that work with KHIE. This summit offered attendees information on enhanced features available through the new KHIE platform.

Our role is to assist with incorporating health information technology into our providers' current care delivery workflows to improve point-of-care delivery and larger population health management activities. We realize a well-designed solution should not disrupt current provider workflows or increase administrative burden and should be easy and convenient to use. **Our Kentucky EHR and health information exchange (HIE) strategy will support an innovative and collaborative approach designed to be secure, scalable, and in line with the State Medicaid Health Information Technology Plan** to move toward a 'to-be' landscape of true interoperability, transformation, and outcome improvement. We are dedicated to being a collaborative and innovative partner to the Commonwealth and its agencies. We leverage our deep experience with HIEs in 13 affiliate health plans and national resources to collaborate with the Department to deliver a solid approach to incent and support providers in adopting and using the EHR platform.

To fully support the Commonwealth's goal of providers adopting EHRs and KHIE use, Aetna will lead an effort that will include other Kentucky managed care organizations (MCOs) and a needs-based financial support system. **We will work with other Kentucky MCOs and commit to a significant monetary donation to be made to an appropriate entity that will aid providers who need funding for EHR adoptions or KHIE connectivity.** We feel this funding, managed by a Kentucky provider association, will allow needed dollars to be given to providers and remove any potential MCO competitiveness from the equation.

In this section, we outline our process that will continue to foster a culture of EHR expansion and build upon the Commonwealth's current successes of having close to 11,000 eligible providers in Kentucky who have a signed participation agreement with the EHR incentive payment program. Central to our outreach and EHR adoption and use plan are the following components:

- Complete an annual gaps analysis, assessment, and utilization review for all appropriate participating network providers

- Support a broad provider outreach and education strategy through our Provider Services and Population Health Specialist teams to complement Commonwealth outreach efforts already in place
- Promote EHR incentive payments and models tied to the Kentucky Medicaid EHR Incentive Payment Program, meaningful use requirements, and attestation support
- Connect to the Kentucky Regional Extension Center and the Kentucky Rural Health Information Organization for access to the Commonwealth's most current resources

Our Strategies for Supporting EHR Adoption

In this section, we discuss our strategies for EHR adoption: gap analysis, outreach and education, and our innovative fund for providers.

Gap analysis: The Commonwealth uses several assessments to determine provider EHR readiness and capabilities. We will look to leverage these assessments or other assessments approved by the Commonwealth to support measuring ongoing competencies and movement within meaningful use requirement. As part of this effort, we will work with the Commonwealth to support additional and targeted reassessments to create a complete picture of current EHR assets and any existing gaps within our provider network. Our assessment process will leverage our health plan network, Provider Services, and Population Health Specialist teams to examine existing provider capabilities, including whether they are meeting meaningful use and certification requirements. We will be engaged in a thorough assessment upon contract award. We will complete the EHR assessment annually, and on an individual basis, each time we add a new eligible provider to our network.

Outreach and education: Aetna will also implement a comprehensive education and outreach program that will align with the Commonwealth's existing EHR incentive and reporting requirements. Our Network, Provider Services, and Population Health Specialist teams will provide individual provider outreach, and they will educate and engage providers on Commonwealth and federal programs available to them to support their EHR adoption and use. Our team will be educated on all Commonwealth and/or federal incentive programs and prepared to discuss in detail with each of our network providers specific difficulties in meeting meaningful use other reporting requirements as defined by the Commonwealth. We will also work with the Commonwealth and their existing partners, such as Kentucky Regional Extension Centers and Kentucky Rural Health Information Organization, to offer access to the Commonwealth's most current resources, and we will defer questions where appropriate back to the Commonwealth for monitoring and full compliance with the incentive program.

We will use several methods to communicate with our provider partners, including our health plan website with a link to frequently asked questions, information and links to various programs' educational content, and technical assistance linked to the Commonwealth. We will also include information in our provider manual, electronic and paper brochures, provider newsletters, or presentations. We will work with the Commonwealth to ensure all content is approved and consistent with the existing programs, with content continually updated to match meaningful use requirements and any other programmatic changes. We will send regular updates via fax and email reminding providers of our resources and other Commonwealth and federal information available to them to ensure they have the resources they need to stay abreast of the latest changes or updates. Where possible, we would welcome sponsoring and holding webinars and in-person outreach events with the Commonwealth, including the Coordinating Council or other appropriate partners, to discuss EHR adoption opportunities and ongoing certification requirements.

Aetna's innovative fund for providers: We commit to leading an initiative among Kentucky MCOs that coordinates incentive payments from MCOs to augment the Commonwealth's current incentive program with a targeted focus on specific areas of financial need and low EHR adoption as determined by an environmental scan. Aligning financial incentives across MCOs will simplify the administrative

process for providers by limiting duplication, reducing confusion, and removing financial barriers to EHR adoption. Through all these efforts, we look to reinforce the existing incentive programs and seek out other opportunities, working closely with the Commonwealth and our provider partners to optimize their EHR capabilities. If adoption of an EHR is not feasible or EHR is not compatible with KHIE, Aetna will recommend that these providers sign up for direct secure messaging services so that clinical information can be shared securely with other providers in their community of care.

We also include language in our provider contracts and manuals to encourage EHR participation and to provide next steps for adopting the technology, including the appropriate contact information for support from dedicated Provider Services and Population Health Specialist staff, as well as regionally based support provided by the Commonwealth.

HIE and Population Health Platform Success

Population health specialists in our affiliate Michigan health plan in 2018 used their HIE connection to our population health management platform to manage high-risk enrollees who had frequent emergency department (ED) and inpatient (IP) admissions. Through close monitoring and collaboration with providers, our Population Health Specialist staff significantly reduced ED visits and IP admissions 9 months post-intervention by 24.7% and 16.1%, respectively.

EHRs Facilitate Quality Care and Improved Outcomes

EHR synergies within our provider community will increase efficiency, improve health care quality, reduce errors, duplicate tests and procedures, and improve population health. The following narrative illustrates the types of improvements we anticipate with greater provider participation and how we expect that it will lower costs.

Improvements in Quality

As our providers continue to adopt and participate in the EHR, we expect to see an upward trend in improved enrollee outcomes. We expect the following results:

- **Preventing adverse events** through decision-making tools within the EHR will help providers prevent adverse events associated with drug allergies and negative drug interactions; real-time access to enrollee history will enable providers to make better-informed decisions at the point of care and quickly share with other caregivers.
- **Viewing enrollee health holistically** means complex medical histories and multiple chronic conditions will be accessed digitally and will allow primary care providers/specialists/care team to review comprehensive files that clearly identify all aspects of an enrollee's health.
- **Improving enrollee compliance/engagement** by creating better-informed enrollees who have their health information will support providers' goals of greater enrollee compliance; higher level of enrollee engagement will result in better Healthcare Effectiveness Data and Information Set (HEDIS) scores and a deeper enrollee-provider relationship.
- **Enhancing enrollee-provider interaction** through a reduction in the amount of time enrollees spend filling out paperwork and discussing their medical history, allowing more time for discussions about health concerns and treatments.

Improvements in Lowering Costs

Data from the EHR helps every provider improve outcomes by giving them access to meaningful clinical data on enrollees in near real-time without the added administrative burden of increased paperwork and phone calls. Sharing information between providers creates a more robust and comprehensive enrollee record, which can lead to a reduction in duplicative services, tests, and imaging and expedited access to test results. A more comprehensive record and communication between providers can help avoid costly mistakes since everyone has the same record of information. Once connected to KHIE, providers will have access to admission, discharge, and transfer (ADT)

information, which will enhance case management and chronic disease efforts as well as afford the opportunity to provide support to enrollees at opportune times during the discharge phase to prevent costly readmissions. When combined with our data analytics engine and our electronic population health management platform, it can have a profound impact on reducing hospital readmissions, ED use, and inpatient utilizations as well as improving quality measures and overall health care costs. It will also have a positive effect between primary and specialist providers, helping to reduce unnecessary laboratory, radiology, and other similar tests/requests.

Aetna's Use of EHR Information when Connected to KHIE

We will leverage EHR data through KHIE when connected to our **highly innovative electronic population health management platform,** a dynamic, web-based software application that creates a single place to view enrollee care information and connect the entire care community around an individual enrollee or group of assigned enrollees. Our electronic population health management platform is both an internal tool for our population health management program and care managers as well as a provider-facing solution that will interface with our primary care, hospital, and community service partners. The system aggregates actionable data in one place across systems and organizations with the purpose to promote effective and efficient care coordination, virtually bringing together all individuals on an enrollee's care team. The strength of this system rests in the ability to timely expose a variety of actionable clinical data and other critical pieces of the care record, including **electronic service plans, care plans, visit notes, clinical/life event notifications, behavioral health, quality reports, HEDIS gaps in care, pharmacy, total cost of care, and social determinants.**

Our electronic population health management platform provides an enriched data source that will empower providers to be more proactive with access to a complete profile of enrollees with greater visibility into the entire complexity of each enrollee. This information will provide valuable insights and increase opportunities to tailor care individually while also promoting well-coordinated handoffs that reduce duplication of services and improve the care experience. **Figure C.8-1** illustrates the general features of how we will use the electronic population health management platform to create a connected network that integrates data from the larger community.

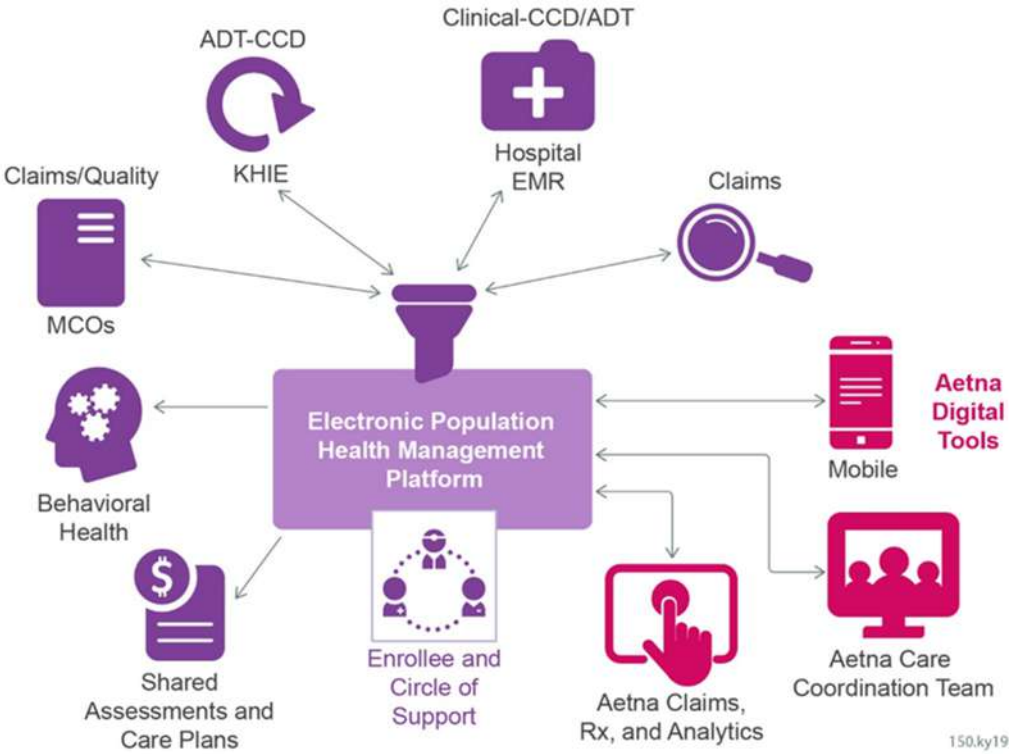

Figure C.8-1: Aetna's KHIE Information Flow Model

This graphic illustrates the capabilities of Aetna's electronic population health management platform in connection with KHIE.

b. Strategies for Requiring Participants to Establish Connectivity to the Kentucky Health Information Exchange

As part of our strategy, we welcome working with the Commonwealth and their newly designed KHIE platform to develop a transformative solution to optimize care coordination and service delivery and to achieve quality outcomes. Our efforts will help to expand upon the nearly 3,000 provider locations currently submitting live data and actively exchanging information with KHIE. Our strategies include contractual agreements and targeted provider training on connection to KHIE are outlined in this section.

Contract will require connection to KHIE: Providers who contract with us moving forward will sign a participation agreement with KHIE within one month of signing our contract to fulfill new contract requirements and to stay current with the forward-thinking Kentucky initiative. This will further our efforts and our network providers' efforts to more fully engage with KHIE and share clinical information between the provider community. This will also help providers fulfill meaningful use requirements in order to qualify for Medicaid's EHR Incentive Payment Program since providers must have a signed participation agreement and signed addendums on file with KHIE for each public health objective selected for attestation.

Provider training for connection to KHIE: We will conduct targeted outreach for providers who are not currently connected to the KHIE platform. Outreach is through both in-person and virtual training models and includes the following information as listed in **Table C.8-1**.

Table C.8-1: Provider KHIE Training

Focus Areas	Description
Education	• Promote the benefits to enrollees that can result with near real-time access to data across settings and facilities, including education on how to take action on admission, discharge, and transfer data • Provider efficiencies that result from access to data, including expedited testing results, decrease in duplicative services, and more comprehensive enrollee records
Best Practices	• Best practices from our experience facilitating KHIE utilization with high-volume/high-performing providers
Setup	• User access setup and training provided by our Population Health Specialist team on use of Aetna's electronic population health management system for managing enrollee care and accessing enrollee records through our system • Education on importance of KHIE connectivity for public health surveillance initiatives and improving health outcomes in Kentucky • Connect providers to a regional KHIE outreach coordinator to help act as an advisor for support on technology innovations, performance improvement possibilities, and health care transformation • New providers will have training as part of their provider onboarding; evaluation and verification of connectivity will occur during initial onsite visit
Data Sharing	• Orientation to data-sharing solutions, including our suite of remote patient monitoring tools • Value of full connectivity with KHIE beyond minimum standards of public health reporting for providers and ADT and public health reporting for hospitals

In addition, we will encourage KHIE participation in our advisory council to include updates to our provider website and provider newsletter concerning specific health care events, KASPER data integration in KHIE, access to other KHIE initiatives, and associated registries such as the Kentucky Cancer Registry.

b.i. Providers and Applicable Public Health Reporting

At a minimum, we will require our providers to submit public health data but would prefer to see our providers realize the benefits of full connectivity to KHIE. Submission of public health reporting information will fulfill certain Commonwealth requirements; however, we will educate our providers on the use and the value of full connection to reinforce the benefits of interoperability within the Commonwealth.

Submission of public health data is an important aspect for understanding the health needs across the Commonwealth, including identifying inequities and disparities. Adoption of EHR and connection to KHIE ensures seamless transfer of diagnosis information that is tracked for public health reporting purposes. KHIE serves as a data intermediary for all electronic public health reporting in Kentucky. KHIE interfaces with the Kentucky Immunization Registry, National Electronic Disease Surveillance System, and the National Syndromic Surveillance Program's BioSense Platform, syndromic surveillance, electronic laboratory reporting, and the KHIE Advance Directive Registry. KHIE also shares data with the Kentucky Cancer Registry, which will help us target efforts related to prevention and early detection, as Kentucky ranks last in the country for cancer deaths.

The Commonwealth requires timely submission of data for public health surveillance related to certain conditions. It now requires health care providers to report all animal bites within 12 hours; measles, meningococcal infections, rabies, and rubella, among others within 24 hours; and another 24 diseases and conditions, including foodborne disease outbreaks, mumps, pertussis, streptococcus pneumoniae, and tetanus within 1 business day. Connection to KHIE makes this process seamless and efficient, as these notifications are automatically transmitted from provider to KHIE and the respective registry.

b.ii. Hospitals and Applicable Public Health Reporting and Admit Discharge Transfer

Currently, 95 percent of Kentucky's hospitals are connected to KHIE. In working with the Department and the Kentucky Regional Extension Center, our strategies for engaging the remaining 5 percent center around identifying those hospital systems and developing an action plan to work with them to address their barriers to EHR and KHIE connectivity. Based on feedback received from these facilities, we will create an action plan with timeframe completion dates and needed results. It is essential that we have 100 percent of hospitals in Kentucky transmitting ADT and clinical information to enhance wellness and prevention efforts as well as improve timeliness of care management outreach.

c. Initiatives and Incentives to Encourage Adoption of EHRs and Information Exchange

We recognize the transformation process is a journey that will take time and commitment to working collaboratively with the State and providers to find solutions that deliver results. Our model aligns with the Commonwealth by embracing a truly collaborative approach with the entire provider continuum—where we are community-focused with a local presence and aligned with payment models incentivizing the delivery of quality care.

Incentives for value-based payment (VBP) providers: Currently, we have contracts with nine VBP providers who are highly engaged in efforts to improve outcomes for our enrollees. As part of our contractual arrangement, we will include provisions related to connection with KHIE. Incentives may include offering an additional credit and/or pay-for-performance dollars that could be applied toward their cost associated with connecting to KHIE. Connection to KHIE can lead to improved HEDIS metrics and the ability for our shared savings providers to meet medical loss ratio targets, thus increasing the likelihood of receiving maximum payouts. Better management of ADTs and more robust data reporting will improve our efforts to find enrollees who have gaps in care or are in urgent need of supportive services. Our VBP providers are highly engaged in managing enrollee care, and we are confident that data shared through KHIE will improve our care coordination efforts and translate into meaningful outcomes for our enrollees (see **Table C.8-2**).

Table C.8-2: Value-based Payment Measures

Measure	VBP Rate	Non-VBP Rate	Percent Difference (VBP over Non-VBP)
AWC—Adolescent Well Care	47.25%	40.03%	18.04%
BCS—Breast Cancer Screening	50.40%	46.49%	8.41%
CCS—Cervical Cancer	57.16%	47.73%	19.76%
CDC Eye Exam—Diabetes Eye Exam	46.42%	39.36%	17.94%
CHL Chlamydia Total—Chlamydia Screening	54.39%	51.47%	5.67%
CIS Combo 10—Combo 10 Immunizations	24.63%	15.83%	55.59%
W15—Well Child 15 Months	59.26%	55.99%	5.84%
CDC Testing—HbA1c Testing	87.11%	82.87%	5.11%

Collaboration across all MCOs for incentive payments: In an effort to improve efficiency for smaller providers and to aid in administration of the program, we propose a cross-functional workgroup to include the Department, MCOs, and other private and public sector stakeholders to devise an incentive model whose costs would be divided equitably across all payers. This will include engaging in a full statewide stakeholder assessment and listening tour to understand the opportunities to expand

data-sharing. This will give our providers an opportunity to express their concerns and questions related to KHIE and how to best incorporate the platform. We will address barriers to connecting with KHIE and pull solutions that have worked for other network providers. The investment in interoperability will far outweigh the costs, as removing barriers to KHIE connection is important for engaging smaller rural or independent providers for whom KHIE connection is cost prohibitive. This effort could be incorporated into the State Health Information Technology Coordinator's Kentucky Collaborative Workgroup.

Advisory council: As our Kentucky plan grows in its use of KHIE, we have a time-tested experience from 13 other affiliate health plans from which to pull best practices and make our own unique exchange. First steps toward a robust KHIE program will include sponsoring regular in-person community meetings, events, and webinars, collaborating with organizations like the Kentucky Hospital Association to create an advisory council to provide guidance around our technology and innovation with respect to KHIE adoption strategies and techniques. We will invite KHIE representatives to join us in our provider education efforts and our advisory council to leverage their deep experience of best practices and efficiencies.

Building upon other successful initiatives such as the KHIE opioid overdose project, Aetna is ready and willing to partner with the Department, our provider community, the Department of Public Health, and other MCOs to leverage the full functionality of the enhanced KHIE system to address the serious health concerns that our enrollees face in Kentucky.

60.7.C.9 Quality Management and Health Outcomes

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60.7.C.9 Quality Management and Health Outcomes (Section 19.0 Quality Management and Health Outcomes)

Aetna achieves quality management excellence by empowering enrollees across the care continuum to engage in their physical and psychosocial well-being and improve their health outcomes with enhanced quality of care and the reduction or elimination of health disparities.

a. Aetna's Commitment to Quality Improvement

Aetna brings the full complement of our local and national quality improvement infrastructure and resources in alignment with the Department's goals to transform the Kentucky Medicaid program. We empower enrollees to achieve their optimal health care outcomes and quality of life by addressing their social determinants of health (SDOH) and giving them the skills and tools to navigate their health care to help them be responsible for their health. We maintain a demographic profile of the community and develop collaborative partnerships with community agencies and organizations to reduce or eliminate health disparities in underserved communities, including the Homeless Coalition, Kentucky Family Resource and Youth Services Centers, Alcohol and Drug Abuse Prevention Team, and the Kentucky Oral Health Coalition.

As a **National Committee for Quality Assurance (NCQA) Commendable-**accredited organization, we have proven our commitment to continuous quality improvement (CQI) as shown by our substantial improvement trajectory in measures aligning with the Commonwealth health priorities as described in **Table C.9-1.**

Table C.9-1: Aetna Health Care Outcomes in Alignment with Commonwealth Health Priorities

Measure	Description of Trending 2019 Performance
Obesity/nutrition	
Weight assessment/body mass index (BMI) assessment and counseling for nutrition and physical activity for adults (ABAKY)	BMI assessment is currently in the 95th percentile and has improved by over 20 percentage points since Healthcare Effectiveness and Data Information Set (HEDIS) 2016, which represented the 10th percentile
Counseling for nutrition	Significant upward trends (19.38 percentage point improvement seen since HEDIS 2017)
Counseling for physical activity	Improved 6.05% in 2018, and an additional 8.27% improvement in 2019
Prenatal and postpartum risk assessment and education/counseling (PPRKY)	Improved 8.65% in 2018, and an additional 7.50% improvement in 2019
Respiratory	
Pharmacotherapy management of chronic obstructive pulmonary disorder (COPD) exacerbation (PCE)	Meeting 90th percentile for the systemic corticosteroid sub-measure; 50th percentile for the bronchodilator sub-measure in 2019
Medication management for people with asthma (MMA)	Medication compliance: • 5 to 11 years old is 50th percentile • 12 to 18 years old is 50th percentile • 19 to 50 years is 75th percentile • For 51 to 64 years is 90th percentile

Measure	Description of Trending 2019 Performance
Asthma medication ratio (AMR)	• 5 to 11 years is in the 90th percentile • 12 to 18 years is in the 90th percentile • Total age (5 to 64) is in the 75th percentile
Diabetes	
HbA1C poor control (>9.0%)	90th percentile; trends show improvement
HbA1c Control (<7.0%)	50th percentile
Substance abuse/opioid	
Initiation and engagement of alcohol and other drug (AOD) dependence treatment (IET)	• Total: engagement of AOD treatment: over 18 years is in the 75th percentile • Total: engagement of AOD treatment: total is in the 75th percentile • Opioid abuse or dependence: initiation of AOD treatment: total is in the 75th percentile • Opioid abuse or dependence: engagement of AOD treatment: total is in the 90th percentile

a.i. Organizational Structure

Aetna uses **an integrated and collaborative approach** to quality, involving each department within Aetna, input from primary care providers (PCPs), specialists, enrollees, and partnerships with the Department, subcontractors including Avēsis, Bluegrass Care Navigators℠, Eviti, Pursuant Health, Welltok, Eliza, as well as local community providers and resources including Kentucky Primary Care Association (KPCA). Quality is truly comprehensive, interdepartmental collaboration within Aetna; all areas have responsibility and accountability to meet performance goals. As led by our chief medical officer (CMO) and our quality director, our Quality Management (QM) program staff members are dedicated to maximizing health outcomes with support and guidance from the Aetna national team. Under the direction of the CMO, the Quality Management department coordinates Aetna's Quality Assessment and Performance Improvement (QAPI) program and provides administrative support for the health plan committees. The QM department responsibilities include, but are not limited to, the following:

- Review and investigation of information received related to potential quality of care issues (enrollee safety)
- Coordination with Care Management, Utilization Management (UM), and other departments to carry out quality management and performance improvement activities
- Monitoring rates for performance measures, gaps in care, and emerging risk
- Documentation of quality management and performance improvement activities and reports to the appropriate committees
- Maintaining databases for tracking quality of care/service issues, trends, and issue resolutions
- Annual review and revision, if applicable, of the QAPI program
- Development and maintenance of the annual QAPI work plan, revising as necessary
- Coordination of activities involved in the preparation of the annual QAPI evaluation
- Support and coordination of quality management processes and monitoring activities
- Performance improvement projects, focus studies, and coordination of enrollee satisfaction surveys
- External quality review organization (EQRO) coordination
- NCQA accreditation
- NCQA HEDIS
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program management for children from birth up to age 21

Our quality staffing model as depicted in **Figure C.9-1** aligns to quality initiatives, including staff dedicated to HEDIS outreach and education, prevention and wellness, delegation and subcontract oversight, and provider liaisons who close gaps in care.

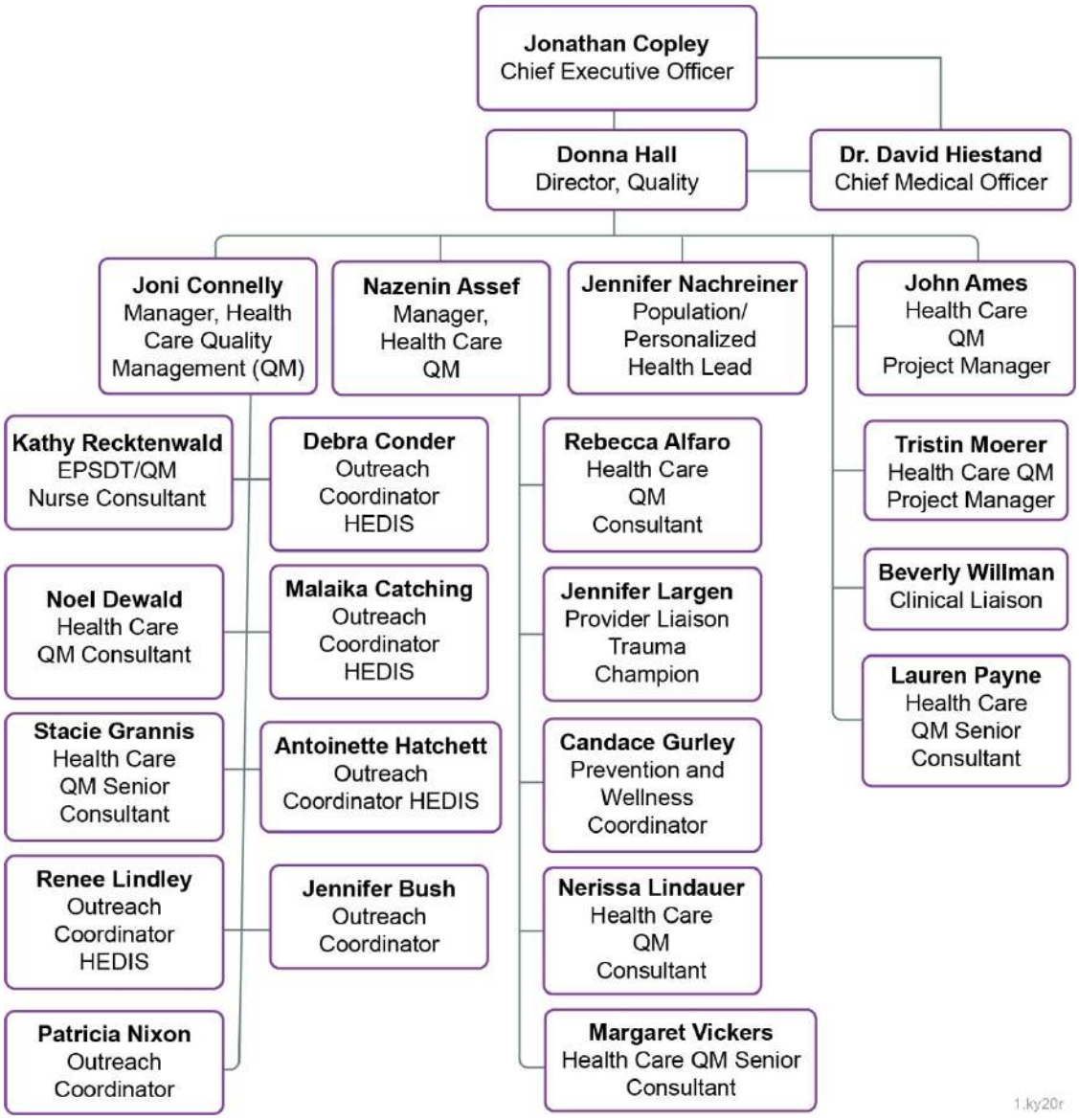

Figure C.9-1: Quality Management Organizational Structure

Aetna's organizational structure supports a comprehensive and holistic approach to meet goals.

The QM department's role in initiating and coordinating communications about the program is critical in linking the parties involved (enrollees, family members and caregivers, practitioners and providers, applicable Commonwealth and regulatory agencies, and other staff members) and in keeping information about quality management requirements and the status of activities current. **Table C.9-2** provides detail on how our staffing resources meet QAPI goals. **The Quality Management team is comprised 100 percent of local Kentucky staff**. These are office-based positions in our Louisville location that are guiding the quality initiatives to achieve targets and outcomes. The team is led by the quality director, who has been with the plan since March 2012. The local staff takes part in activities that are embedded within the community, advocacy groups, and provider partner Joint Operating Committees (JOCs) to further influence collaboration for the positive impact on our enrollees. Our team is made up of a HEDIS department and a Quality Improvement department. Our Quality Improvement team focuses not only on the quality of care for the enrollees, but on the delivery of care with efforts centered around NCQA,

Commonwealth health priorities, and evidence-based practices. This team is inclusive of Population Health Management and Prevention and Wellness team members with strategy focusing on the enrollee experience, health equity, and SDOH.

Table C.9-2: Aetna Staffing Resources to Meet Quality Goals

Staffing Resources	Qualifications, Roles, and How We Meet QAPI Goals
Medical Director (one full-time equivalent [FTE]) (Doctor of Medicine)	This position is the full-time medical director physician licensed to practice in Kentucky; oversees the health plan's quality and clinical functions; directs quality management and is actively involved in all major health programs of the health plan; all clinical directors, including those employed by subcontractors, report to the CMO for all responsibilities of the contract; also responsible for treatment policies, protocols, quality improvement activities, population health management activities, and utilization management decisions.
Director of Quality (one FTE) (registered nurse)	The director of quality is responsible for driving quality results which ultimately improve health outcomes. This position encourages interdepartmental collaboration and fosters provider partnerships in advancing our efforts in quality improvement.
Quality Improvement Manager (one FTE) (Master of Science, Nutrition)	The quality improvement manager role is critical in studying our enrollee behavior, population demographics, and seeking community partnerships. These partnerships work to create resources for our enrollees and drive efforts in research for health outcomes. The quality improvement manager is instrumental in assisting with NCQA accreditation, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, behavioral health member survey, prevention and wellness initiatives, and population health programs.
HEDIS Manager (one FTE) (registered nurse)	The health care quality management HEDIS manager is responsible for driving outcomes related to NCQA measures, Healthy Kentucky measures, and EPSDT initiatives, and leading the HEDIS and QM programs and projects. The manager coordinates campaigns to address enrollee behavior and gaps in care and oversees the HEDIS project to ensure compliance with NCQA standards and manages the EPSDT program.
NCQA Project Manager (two FTEs)	The project managers work to accomplish NCQA accreditation and all activities related to the NCQA accreditation survey. The focus of this role is to successfully define and demonstrate behaviors of our health plan that improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
Population Health Specialist (one FTE) (Master of Public Health, registered dietician)	The population health specialist is a unique position that studies the behavior and needs of our enrollees and communicates findings to our providers. Strategies of positive impact are implemented based on these findings.
Provider Liaison/Trauma Champion (one FTE) (registered nurse)	The provider liaison/trauma champion leads and establishes structure and mechanisms to drive the trauma transformation and principles in the health plan, provider network, and Commonwealth regulators and stakeholders. This position is Certified Professional in Healthcare Quality-certified and supports the development of trauma-informed, social-emotional programs within Kentucky and provides expert consultation regarding complex situations and addresses challenging cases.
QM Nurse Consultants (two FTEs) (registered nurses)	The QM nurse consultants support all quality activities and include quality of care outcomes, trends in utilization, oversight of subcontractors and providers, provider education, HEDIS record review, and enrollee engagement and education.
Prevention and Wellness Coordinator (one FTE) (Master of Public Health)	This position focuses on educating enrollees on preventive care. The areas of focus for preventive care include cancer screenings, well childcare, diabetes prevention, smoking cessation, and nutrition/healthy weight. Nurturing and developing community partnerships is an important task as enrollees utilize the resources and services. This allows access to our enrollees and the community as well as the ability to identify the needs and gaps in care. Participating in local coalitions that focus on areas of health that affect our population is another way to increase knowledge of the community so that the plan can adapt and meet the needs.

Staffing Resources	Qualifications, Roles, and How We Meet QAPI Goals
Health Care Quality Management Sr. Consultant (two FTEs)	The health care quality management senior consultant serves as a project lead and is responsible for driving outcomes for HEDIS, Healthy Kentuckians, and NCQA. This position supports the team by conducting trainings and implementing outreach campaigns to positively impact enrollees' health. The health care quality management senior consultant is engaged in the provider incentives, member incentives, NCQA accreditation, EQRO audits, and HEDIS/Healthy Kentuckians medical record retrieval and review and other activities to ensure compliance.
Health Care Quality Management Consultant (three FTEs)	The health care quality management consultant serves as support for the team via all aspects for HEDIS, EPSDT, member outreach, provider incentives, and education.
Outreach Coordinators/ Consultants (six FTEs)	The outreach coordinators support HEDIS outreach to enrollees for identified gaps in care to provide education and to inform members of the incentive gift card programs available. Additionally, they support and work on campaigns that align with our health priorities and provider initiatives.

Coordination with Subcontractors and Providers

We coordinate formally with subcontractors and providers through contracting, our QAPI program subcommittees, JOCs, and Provider Services. We set the expectations for performance through our contracting language; we contractually require all providers to take part in our QAPI activities, including submission of complete encounter records and documentation for hybrid measures and focus studies and providing regular ongoing feedback for performance improvement, including correction action plans as needed.

Joint Operating Committees

We hold monthly JOCs with our partners and major subcontractors to ensure effective, ongoing communication, including the following:

- Avēsis: Provides dental and vision services, as well as the innovative program Oral and Ocular Care Coordination (O2C2), to screen pre-diabetics and connect them with a PCP
- Bluegrass Care Navigator: Provides physical health and behavioral health (BH) discharge planning
- Eviti: Provides cancer care planning and UM best practices
- Pursuant Health: Provides enrollee communications and innovations, including kiosks, text messaging, gift cards, and targeted location-based messaging (geo-fencing)
- Eliza: Health risk assessment (HRA) process
- KPCA: Delegated care management for 2020 implementation
- CaremarkPCS Health: Provides pharmacy benefit management services
- eviCore: Performs radiology medical necessity reviews and musculoskeletal pain management medical necessity reviews

We have strategy meetings with our value-based payment (VBP) partners, including KPCA, St. Elizabeth Healthcare, and KentuckyOne Health (KHP) to identify and collaborate on a quality strategy, discuss trends and performance, and work through gaps in care (GIC) reports to identify enrollee behavior and closing gaps.

Collaborative Innovations with our Partners and Subcontractors

Aetna continually seeks innovative solutions with our partners. **We are the first managed care organization (MCO) in Kentucky** to pursue a delegated care management (CM) arrangement with KPCA to address biopsychosocial needs at the enrollee level to have a direct impact on care. Using our predictive modeling, we use analytic methods to rank all plan enrollees from highest to lowest risk in our general risk model (GRM). The model identifies people at risk of high cost and/or high utilization in the future by using medical, behavioral, laboratory, and pharmacy diagnoses and claims data, and the

likelihood of integrated care management making an impact. Additional predictive modeling techniques are used to identify enrollees at risk for emergency room or inpatient utilization in the next 12 months. The predictive modeling shows that our highest risk enrollees have multiple physical health conditions, and 70 percent to 90 percent had co-morbid behavioral health conditions.

The top one percent of enrollees in the GRM is combined with enrollees at high or moderate risk for inpatient utilization and high risk for emergency room utilization in a consolidated outreach and risk evaluation (CORE™) report that is produced monthly. The risk rankings feed directly into our care management software to allow Aetna to identify and prioritize enrollees for outreach into intensive or supportive care management as well as those who would benefit from chronic condition management. Through our CORE algorithm report, we have identified 475 enrollees who could benefit from this delegated CM arrangement and will continue to add enrollees as they are found through regular reporting and collaboration. We are partnering directly with five of KPCA's clinics to train their staff and provide policies and procedures and audit tools for them to achieve NCQA accreditation. KPCA also works with us on NCQA and strategies to impact the provider network data accuracy. We are collaborating with KentuckyOne on our electronic population health management platform to create efficient communication between our Care Management teams (Aetna and KHP) as well as providing GIC reporting. Through our close collaboration, all our VBP provider partners have shown improvement on their VBP rates.

Provider Services

Our Provider Services department facilitates interactions between providers and Aetna and coordinates the ongoing education including the following:

- Coordinating the provider satisfaction survey
- Conducting provider training and education on QAPI-related activities
- Supporting implementation of provider interventions
- Monitoring network compliance with access and availability standards
- Providing and educating providers on profiling reports and overall performance

Additional QAPI Resources

All Aetna departments and personnel are integral components of the QAPI program as described in **Table C.9-3.** Each department is responsible for reporting performance and monitoring metrics to the quality committees. Based upon the results and trends identified, the committees collaborate to develop and implement processes and programs that meet regulatory and contractual requirements and to facilitate the continuous growth in the quality program. An example of a new program is our Prevention and Wellness program. Our Service Improvement Committee (SIC) was able to capture emerging enrollee needs on topics such as diabetes and nutrition, which resulted in our implementing the Prevention and Wellness program in 2016. Aetna's QAPI program and committee structure are designed to foster an environment of continuous quality improvement with the stated goal of improving the continuity, quality, safety, accessibility, availability, and cost-effectiveness of health care provided to enrollees.

Table C.9-3: Additional Resources Supporting Quality Goals

Resource	Description
Informatics Population Health Analytics and Outcome Evaluation departments	The Aetna QAPI program is supported by the Aetna Medicaid organization's Informatics Population Health Analytics and Outcome Evaluation departments. The Informatics Population Health Analytics team analyzes health and financial information to develop insights that support business decision-making about health care costs and trends, quality, and outcomes. The Informatics Population Health Analytics team uses the results to address business questions regarding population health management, health and economic outcomes, quality of health care, and health care program and product design. The Outcomes Evaluation team, a subset of the Informatics Population Health Analytics team, provides technical support and analyses for monitoring and evaluation of QAPI performance improvement activities. Such support includes data management and statistical analyses to support the effective measurement of performance and execution of improvement projects.
Enrollee Services	Monitors call center performance metrics (such as call volume, percent of calls answered within targeted number of seconds, average speed to answer, average call time, abandonment rate), administers the enrollee satisfaction survey, and accepts and resolves enrollee complaints.
Enrollee Outreach	Leads the Member Advisory Committee (MAC) and education and outreach activities.
Utilization Management	Monitors UM performance metrics trends in authorizations decisions (approvals and denials); trends in utilization metrics by category of expense, including bed-days, readmission rates, changes in prior authorization grid, and results of inter-rater reliability assessments.
Care Management	Monitors the volume of enrollees outreached, enrolled, engaged, and closed; new enrollee assessments and new enrollee care plans; health outcomes; changes to intervention strategies; and program evaluation; recommends changes to improve outcomes.
Grievance and Appeals	Monitors the trends in volume and types of grievances and appeals; volumes by grievance and appeal levels; volumes of appeals over-turned and analysis for overturned appeals.
Business Operations	Maintains and supports system applications to provide support to the QAPI program, including Commonwealth reporting, reports for NCQA health plan accreditation, and the EQRO process, as well as the generation of key indicator reports across all operational areas.

Each department is responsible and accountable for their contributions to quality that is rolled up into an integrated effort through our QAPI program and committee structure.

a.ii. Strategic Solutions in Quality Management, Measurement, and Improvement

As an NCQA-accredited organization at the **Commendable** level, we have an innovative CQI approach that encompasses an extensive array of strategic solutions to improve the experience of our enrollees and the care delivered by our providers. Understanding and acting on data is foundational to improving enrollee health outcomes, ensuring gaps in care closure, and decreasing health care costs. Aetna formally assesses information through our established QAPI structure and processes, including review of historic and current performance data. We produce monthly reports showing aggregate performance rates, predictive rates, and encounter data to identify enrollees needing care or outreach. See **Attachment L** for an example of a report we use with providers (KentuckyOne) to show gaps in care and HEDIS trends. Hotspot drilled-down reports show enrollee characteristics, race, ethnicity, specific gaps by county, SDOH, and other variables to identify need for intervention based on region.

a.iii. Innovative Strategies and Enhanced Services

Our innovative strategies and enhanced services strive to drastically improve outcomes for a variety of health care conditions and to empower individuals to improve their health and engage in their health care. Innovative strategies and enhanced services that support enrollees across the care continuum, promote healthy behaviors and self-management and provide care coordination for complex health conditions include the following: tobacco cessation (e-cigarette), Aetna Cares Program, Be Healthy Program, Unite

Us and community health workers, trauma-informed practice, diabetic retinal screening, and communication through Pursuant Health, Microclinic, Diabetes Education and Empowerment Program, our Kentucky Flu Campaign, and Dental Office Anesthesia Service.

Tobacco Cessation (E-Cigarette)

The 2018 National Youth Tobacco Survey[1] indicates there are 3.6 million middle and high school students who are current e-cigarette users, a dramatic increase from the more than 1.5 million students the previous year. This represents a 78 percent increase among high school students, and a 48 percent increase among middle school students. According to a study cited by the Foundation for a Healthy Kentucky, the number of youth vaping in Kentucky doubled from 2016 to 2018 among 6th-, 8th-, 10th- and 12th-graders who were surveyed.

Given the significant increase in the number of teens using e-cigarettes, CVS Health and its charitable foundations will award a total of more than $10 million in 2019 to support youth smoking and e-cigarette prevention strategies and education delivered in classrooms, by clinicians, and in communities across the United States. The new commitment, funded through the company and the CVS Health and Aetna Foundations, is part of Be The First, CVS Health's five-year $50 million initiative to help deliver the nation's first tobacco-free generation.

The CVS Health Foundation is investing in a multiyear, multimillion dollar collaboration with Discovery Education to create and distribute standards-aligned digital curriculum resources and engaging content to help middle and high school students learn about the risks of e-cigarette use. Leveraging Discovery Education's instructional expertise, production capabilities, and strong distribution channels, these resources will be available to every school district in the United States with plans to integrate best in-class curriculum partners including the CATCH Global Foundation's CATCH My Breath™, a prevention program specific to middle and high schoolers' use of e-cigarettes. As part of the program, instructional and programmatic resources will be provided to students, educators, and parents at no cost.

QUITS

Aetna partnered with the University of Pennsylvania (UPenn) to pilot a sustainable incentives-based tobacco cessation program (QUITS – Quit Incentives & Tailored Support) for pregnant members of Medicaid in 2019. Maternal smoking during pregnancy leads to significant high-cost complications such as 30 percent low birthweight babies, 10 percent of premature deliveries, 5 percent of infant deaths, and 23 to 34 percent of sudden infant death syndrome cases. The goal of this pilot program is to develop a best-in-country strategy to reduce smoking during pregnancy. Financial incentives have been proven to aid in smoking cessation among pregnant women but determining the best method to engage participants and support them during this process has limited results. This pilot program will engage in rapid cycle pilot tests of program elements and assumptions to learn quickly and create a program that can be shared. UPenn estimates that the potential savings based on average smoking attributable expenses of $2,437 and a proposed cessation rate of 20 percent to be $3.91 million annually.

The following is a brief description of each of the program phases and the lessons learned:

- **Phase 1:** Vapor test for program demand. Utilized flyers to gauge interest based on different messages (financial gain, health benefits, and available resources to aid in quitting). Financial incentive received the most interest.

[1] Food and Drug Administration, "2018 National Youth Tobacco Survey Finds Cause for Concern," National Tobacco Youth Survey (2018):accessed June 23, 2019; https://www.fda.gov/tobacco-products/youth-and-tobacco/youth-tobacco-use-results-national-youth-tobacco-survey.

- **Phase 2:** Survey of enrollees to determine program elements, (i.e., level of financial incentive required and what program features were important to them). Amounts ranged from $10-$500 but all respondents stated they would quit for $250. Access to support services is most important program element.
- **Phase 3:** Test best method to monitor smoking cessation; carbon monoxide monitor proved easiest to use and enrollees experienced no adverse effects versus the cotinine swab
- **Phase 4:** Potential to earn a $45 gift card incentive if negative at each of next two appointments. We experienced a 25 percent success rate (1 success out of 4 women enrolled) for this targeted intervention geared towards gestation of 28 weeks or greater.
- **Phase 5:** Warm handoff to QuitNowKY, the Commonwealth's quitline program, which recently increased incentive amounts. Eleven enrollees participated; however, outreach from the state program was unsuccessful. A potential barrier was identified in unknown caller ID that prevented women from answering the phone.
- **Phase 6:** Ongoing: Testing the Phase 4 intervention with the addition giving the enrollee the choice of support services (e.g., enrollment in the quitline or using the SmokeFreeMom app)

Be Healthy

Aetna's Be Healthy program encompasses multiple services and activities that are offered to plan enrollees across the Commonwealth of Kentucky. While continuing to develop services and activities that target enrollees with emerging risk at the pre-diabetes stage, upon diagnosis and on an annual basis, Aetna's Be Healthy program currently targets enrollees who are experiencing short-term complications and who have reached a transition of care event. Be Healthy activities aim to support enrollees through a short-term complication episode and reduce emergency department (ED) usage by interacting with the enrollees, providers, facilities, and social supports, to ensure both medical and non-medical issues that lead to ED usage are addressed.

The goal of the Be Healthy ED Outreach service is to assist enrollees with identifying factors and removing barriers that prevent them from having a medical home in which they can seek care for diabetes complications. The ED Outreach team accesses informatics reports that identify enrollees who have utilized ED services and have diabetes. The team then interacts with enrollees by phone to provide education on ED use and to identify and reduce barriers that prevent the enrollee from receiving care in their medical home or outpatient specialist office. Interventions include education, community resource and SDOH referrals, and problem-solving for barriers and deterrents to the enrollee's health maintenance plan. The ED Outreach team is staffed by nurses from both the Care Management and Quality Management teams. If an enrollee agrees, a referral is also made to the appropriate Care Management team for ongoing support and assistance with chronic condition(s). Enrollees who opt in to the ED Outreach program who are not engaged in care management receive ongoing telephonic support on a monthly basis from the ED Outreach team to reinforce utilization of their medical home rather than the ED, and to continue to identify and overcome barriers that prevent them from having a medical home to manage their diabetes. Additional Be Healthy activities and services include the following:

- Assignment to a community health worker employed by Aetna who works to link members with community-based organizations and using the Unite Us platform to address SDOH
- Low-risk chronic condition management or intensive care management, depending on acuity, for members with diabetes

Aetna Cares

The Aetna Cares program seeks to improve overall health outcomes, reduce hospital readmissions, and increase primary care and behavioral health follow-up for enrollees who have asthma, congestive heart failure (CHF), COPD, and depression. During the re-admission reduction service, the enrollee may receive interventions such as assistance with appointment, medication reminder system, and

transportation setup, and referrals to community resources provided by the Re-Admission Reduction Team. If a review of the post-discharge questionnaire (PDQ) indicates it as a potential need, the enrollee will be offered CM services. If a review of the PDQ indicates no need for CM services, the enrollee will be supported by the Readmission Reduction team with ongoing follow-up. The Readmission Reduction team is comprised of Care Management and Population Health Management staff.

Additional Aetna Cares activities and services for enrollees across continuum of care:

- Intensive care management for enrollees with asthma, CHF, COPD, and depression
- Low-risk chronic disease management for enrollees with asthma, CHF, COPD, and depression
- Hospital Readmission Reduction program for medication reconciliation and pharmacy support

Unite Us/Community Health Workers:

Aetna is partnering with Unite Us in a unique collaboration to address the full spectrum of SDOH. The partnership, currently operational in the Louisville metropolitan area, establishes new and innovative models that improve engagement between members, traditional health care providers (e.g., PCPs), and social services providers. Aetna's intent is to expand this partnership statewide. This SDOH services integrated model connects enrollees to community-based organizations that participate in the closed-loop referral network, including all types of social service agencies. Community health workers (CHWs), co-located in community-based organizations, serve as a liaison between enrollees in the community and Aetna, helping link enrollees to the health care and social services that address their unique needs. Their role is to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs facilitate as a bi-directional flow of information between members and the health system by doing the following:

- Engaging Aetna Medicaid organization members experiencing or at risk of health disparities to improve their health care engagement and access to care and reduce unnecessary hospitalizations and ED visits
- Educating health care professionals about opportunities for improving and understanding the SDOH that may be impacting the members' engagement, health, and treatment plan
- Serving as a member of the multidisciplinary team treating Aetna members. This level of involvement will allow the CHW to bridge information back to the care team regarding any identified cultural and other psychosocial elements.

Trauma-Informed Care

Aetna has undertaken an enterprise-wide initiative to bring trauma-informed care (TIC) practices to all levels of the organization from the chief executive officer (CEO) to care managers as well as Member Services staff, human relations, and all aspects of the health care company. Aetna subscribes to the following tenets, as established by the National Institute for Trauma-Informed Care: "We realize that trauma is common; we recognize how trauma affects individuals seeking care; we are committed to implementing TIC best practices; and at all costs avoiding re-traumatization." As a trauma-informed organization, our Care Management, Enrollee Services, and Community Outreach staff receive comprehensive and ongoing training established in partnership with the National Council for Behavioral Health. Some of the comprehensive training includes motivational interviewing and Mental Health First Aid for our member-facing staff. In the spring of 2020, Aetna will begin inviting providers to attend a one-day TIC training provided by the National Council. This will first be available to providers in Eastern Kentucky in February 2020, followed by training in Louisville scheduled for April 2020.

Eye SPI (Screen, Prevent, and Improve) for Diabetic Retinal Screening

The goal of the diabetic retinal screening program is to promote enrollees with diabetes who are not getting their eyes examined to go to a Walmart kiosk for retinal screening attestation to close gaps in care. The Eye SPI (screen, prevent, improve) project is designed to encourage enrollees who have diabetes but who have not had a dilated retinal eye exam (DRE) exam to get their eyes examined by an optometrist

and use a kiosk within a Walmart in the Commonwealth to attest to the completion of their eye exam. Enrollees receive a mailer explaining how diabetes damages the eyes over time and reminds them to go to a local Walmart to attest to the completion of their DRE exam. Upon completion of the attestation of the DRE exam, the enrollee receives a $10 Walmart gift card.

Pursuant Health

Pursuant Health utilizes multichannel communication to educate and engage enrollees about incentivized activities, covered services, and relevant wellness topics. With Pursuant Health, enrollees receive instructions that are concise and easy to understand. Pursuant Health utilizes several different engagement mechanisms in an effort to meet enrollees where they are for maximum reach. These outreach methods include 4,400 direct mailers to date as well as the following:

- Text and interactive voice response (IVR)
- Email
- Digital campaigns

In addition, Pursuant Health has kiosks in every Walmart in Kentucky to provide enrollees educational information, assistance, and access to the HRA.

Microclinic

In Kentucky, 95 percent of Microclinic participants improved in at least one indicator for chronic disease (BMI, waist circumference, blood pressure, cholesterol, and/or HbA1c measurements of blood glucose[2]). Microclinic is an initiative designed to empower enrollees to lead healthier lives and manage chronic conditions such as diabetes and cardiovascular disease (CVD) with the goal of improving quality indicators of HbA1c testing, HbA1c poor control (above 9.0 percent), BMI, statin therapies, and persistent medications. This program also reaches out to enrollees who are at risk for diabetes or CVD. Enrollees learn how to decipher nutrient labels, cook healthy meals, take part in group fitness activities, and reach health goals. Meetings are held weekly for 16 weeks by a facilitator who is trained with the curriculum. Aetna internal staff attended the trainings and became certified facilitators and assist in teaching the classes for our members. The meetings are held in the community settings where enrollees and their families can join these classes. The program encourages enrollees with positive reinforcement through small performance rewards and comprehensive teamwork. After the 16-week program is completed, enrollees can continue in a program called My Health Matters where they check in once a month for 8 months.

Aetna and CPESN Collaboration

In Kentucky, pharmacies can make direct referrals to Aetna care management for identified enrollee SDOH needs. Aetna created 750 care packages with pharmacy delivery drivers to include food or personal care items. CPESN shares pharmacy care plans with Aetna care managers for coordination of care and support.

Centerstone Chronic Disease Self-Management Program (CDSMP) Training

The purpose of the CDSMP is to assist enrollees and their caregivers with self-management of chronic conditions such as heart disease, arthritis, diabetes, depression, asthma, bronchitis, emphysema, and other physical and mental health conditions. Aetna staff are certified to conduct classes for enrollees on the principles and techniques of self-management, and how to identify their role and the provider's role when dealing with chronic illness. Aetna certified staff conducts the 16-week classes for enrollees and their caregivers in community settings. Some topics include physical activity, decision-making, medications, action planning, breathing

[2] Microclinic International, "Microclinic Program Statistics" (2017): accessed June 23, 2019; https://microclinics.org.

techniques, understanding emotions, problem solving, healthy eating, sleep, weight management, communication, and working with health care professionals.

HealthRunsDEEP (Diabetes Education and Empowerment Program)

This program was born through collaboration across departments within Aetna to empower our members to prevent diabetes. In conjunction with independent community retail pharmacies in the Community Pharmacy Enhanced Services Network (CPESN) and the local housing authorities, the program serves enrollees and non-enrollees throughout Kentucky. We leverage our relationships with CPESN pharmacies to refer enrollees and maximize engagement using our remote patient monitoring capabilities. The program includes an in-person group education series focusing on improving diet and increasing exercise to prevent, delay, or better manage diabetes.

Kentucky Flu Campaign

Kentucky often experiences widespread flu activity and many seasons result in flu outbreaks leading to an epidemic. Aetna works proactively to provide solutions to our enrollees through aggressive and innovative outreach interventions. In 2018, we launched a targeted flu campaign working with our Enrollee Analytics team to take an almost scientific approach to marketing by tracking responses to marketing campaigns based on the call to action. We worked with this team to create a flu campaign to email our enrollees and developed six different emails. Three of the emails have an emotional call to action, while the other three have a rational call to action. The Enrollee Analytics team tracks to see which emails generate the best responses/most interaction. These campaigns differ from previous efforts in that the focus is on behavioral economic concepts and testing and learning which ones work with different audiences or for different topics. Behavioral economics is the science of decision-making. It recognizes that people do not always make decisions based on logic or rational information. Instead, our decisions are often shaped by various biases and other factors. In this campaign we are testing emotional and rational messaging, comparing 'flu facts' with more emotionally focused reasons for why an enrollee should get their flu shot. This information has shaped our marketing strategies; for example, in 2019 we continued the rational call to action approach through an email and text message-based flu shot campaign.

Enrollee Incentives

To promote health and wellness, internal staff contact enrollees identified as qualifying for enrollee incentives to ensure accurate enrollee demographics so that the gift cards are distributed to the appropriate address. Enrollee incentives include the following:

- A $10 gift card for enrollees completing their postpartum visit 21-56 days after delivery
- A portable crib for enrollees attending prenatal visits during their pregnancy
- A $10 gift card for completing a lead screening test for children prior to their second birthday
- A $10 gift card for completing an eye exam for adults 18-75 years old
- A $10 gift card for completing spirometry testing for members 42 years or older with COPD
- A $20 gift card for completing a follow-up visit with a mental health practitioner within seven days of discharge after a hospitalization for mental illness (six years of age or older)
- A $25 gift card for completion of the HRA

Dental Office Anesthesia Service

In partnership with our dental vendor, we are embarking on an initiative that provides full service in-office dental anesthesia services. A dental office will be converted into a high-quality, safe environment for surgery by allowing dental surgical procedures typically performed in a hospital setting to be performed in the office. This will provide an improved experience for providers and enrollees. By replicating the hospital environment, an anesthesia care team (consisting of a post-anesthesia care unit registered nurse, anesthesia coordinator, and an anesthesiologist) will provide all necessary equipment to the site of the operating dentist. This will result in a more compelling environment for both the enrollee

and the provider. A similar program in another market has shown average time spent in the office to be about two hours, compared to greater than four hours in a hospital setting. Typical wait times for surgery are two to three weeks as opposed to up to four to eight months while awaiting a hospital-based service. By reducing wait times, there will be slower progression of disease, which will result in fewer trips to urgent care or EDs; costs will be lower and health outcomes will be improved.

Innovative Strategies and Enhanced Services Successes with Similar Medicaid Populations

As part of our commitment to improving enrollee health and helping them be responsible for their health, Aetna has developed advanced methods to identify reasons for variations of enrollee engagement in their preventive care, and developed enhanced abilities to rapidly deploy, evaluate, and modify our programs to increase enrollee involvement in their own care. This begins with identifying the opportunities where shifting enrollee behavior will lead to improved health, and then identifying the barriers that are preventing a change in behavior. This includes applying advanced analytics to identify different groups of enrollees (e.g., enrollees who are unaware of need for care, opposed to getting care, or unincentivized to change behavior). We then design and deploy engagement strategies to address the different identified enrollee groups.

Aetna uses machine learning processes to identify different groups of enrollees that may require different types of outreach intensity to become engaged. As depicted in **Figure C.9-2**, these models can use a variety of available data to categorize enrollees based on their characteristics and probability of completing necessary preventive care services.

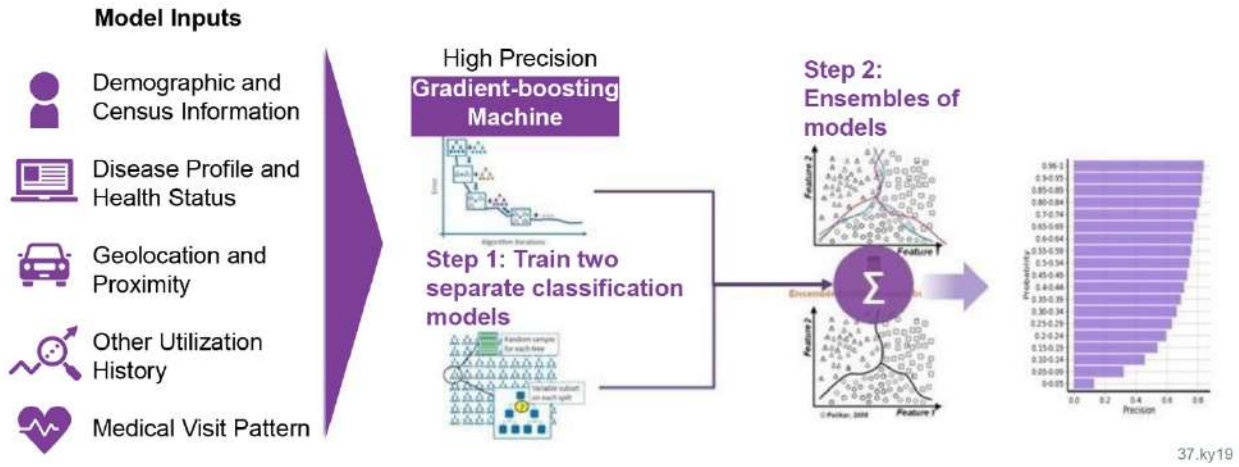

Figure C.9-2: Machine Learning Process

Aetna uses machine learning to identify and target subpopulations.

In early 2019, Aetna formed a new team focused on using these techniques to improving outcomes in our Medicaid enrollees. As depicted in **Figure C.9-3,** one of the initial projects was to identify different groups that would be more likely to obtain a flu vaccine based on specific outreach approaches. This model required data from across Medicaid enrollees, including all eligible Medicaid enrollees in Kentucky, and it was able to predict enrollees most likely or least likely to obtain a flu vaccination. Our intent is to use this model in Kentucky in 2020 to test different interventions for the different groups of enrollees, and then assess the effectiveness of each type of outreach.

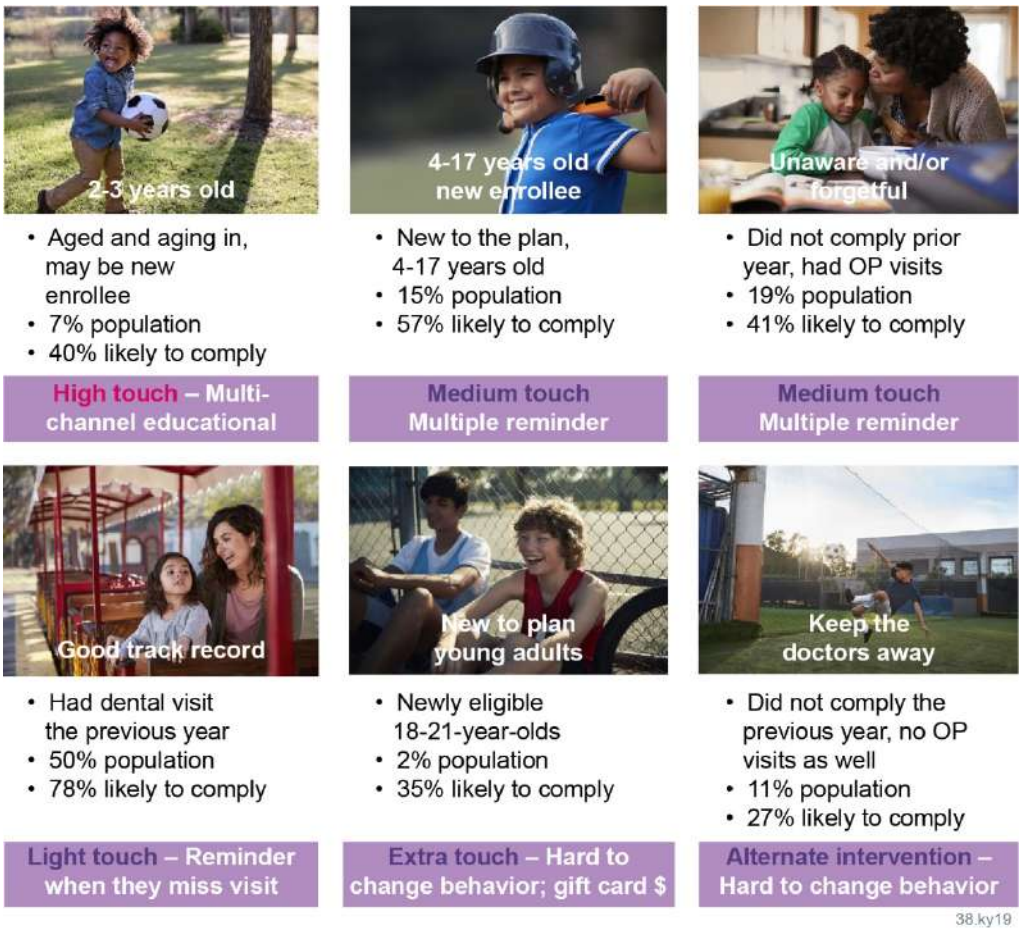

Figure C.9-3: Machine Learning Algorithms

Aetna targets outreach to groups based on findings from machine learning.

An example of this type of approach that has been fully deployed comes from Aetna's Medicare program, which was the first Aetna team to test these advanced analytic techniques to improve breast-screening rates across markets. This project used available information about enrollees and an artificial intelligence/machine learning model to predict correctly 93 percent of the time which enrollees would receive or not receive a mammogram. Enrollees highly resistant or very likely to complete a mammogram continued to receive standard automated messages and email when address was available. However, enrollees with an intermediate probability of going to get a mammogram (probability of completing a mammogram between 0.3 and 0.7) received an additional live phone call to educate and assist in scheduling an appointment. This efficient targeting of enrollees showed that recipients of the enhanced live outreach showed a 28 percent higher mammogram compliance rate than the control group. As part of our continuous testing and learning program, Aetna has compared the effectiveness of different types of messages as well (e.g., "do it for your family" versus "do it for yourself") as depicted in **Figure C.9-4.**

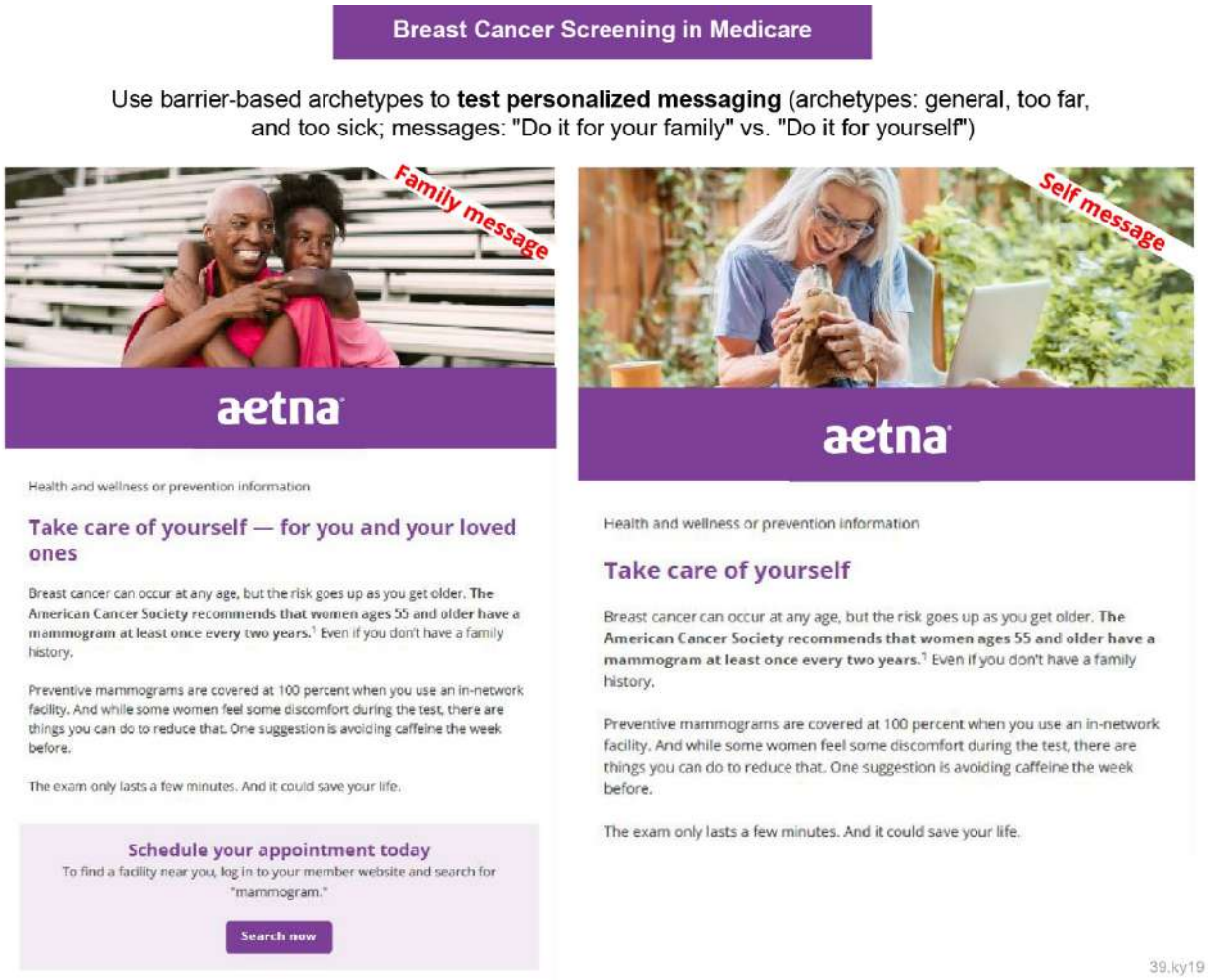

Figure C.9-4: Aetna Breast Cancer Messaging

Aetna customizes messaging based on machine learning findings.

a.iv. Internal Tools and Technology Infrastructure

Aetna utilizes sophisticated internal tools, technology infrastructure, and databases as described in **Table C.9-4** to identify, analyze, track, and improve quality and performance metrics, as well as the quality of services provided by network providers at the regional and statewide levels.

Table C.9-4: Internal Tools and Technology Infrastructure

Data Source Type	Description	Plan for Utilization
Claims Management System	Collection of medical claims for inpatient, outpatient, and professional services	Identify gaps in care and social needs of enrollees; develop population health management strategy based on regional trends; inform predictive modeling and risk stratification
HEDIS NCQA-certified Data Platform	For generation of annual HEDIS and non-standard HEDIS rates, creation of monthly trend reports and provider gap in care lists	Track and trend areas for improvement in quality performance including value-based purchasing arrangements; establish baseline measures on performance indicators for performance improvement projects

Data Source Type	Description	Plan for Utilization
Hotspot analytics	Identification of enrollee presence by gender, race, ethnicity, culture, HEDIS, and non-standard performance indicators by regional and statewide levels	Develop population health management strategy based on observed hotspots; collaborate with Community Development to identify opportunities for enrollee engagement and education activities
Population Health Management (PHM)	Identifies enrollee health risk factors and social determinant of health indicators, and alerts care manager of gaps in services, ED disparity dashboard, and health equity dashboard at the regional and statewide levels	Identify target populations; stratify enrollees by risk level; deliver PHM programs and services; evaluate and refine PHM programs
Surveys/Assessments	Annual and post-call enrollee and provider surveys to measure their satisfaction and experience with our programs and services, social determinants, and care needs	Develop action plans addressing the needs of enrollees and providers to enhance their experience and satisfaction with our services
Medical Record Audits	Provider adherence to medical record, HEDIS standards, and clinical practice guidelines	Identify deficiencies in the quality of medical records and clinical documentation; provide education to provider offices based on results regarding areas for improvement; follow up with providers who did not meet performance standards to evaluate the outcome of our education efforts
Grievances and Appeals Data Platform	Collection and tracking of enrollee and provider satisfaction with the plan and services rendered	Identify patterns in grievances and appeals, including turnover decisions, to inform internal policies and procedures and identify opportunities for provider education and gaps in network adequacy
Quality Data Platform	Tracking of provider preventable conditions, health care-acquired conditions, and potential quality of care concerns	Evaluate and address emerging negative quality of care trends

a.v. Ensuring Data-Driven, Outcomes-based CQI Process

Our QAPI structure and processes were established to standardize the methodology to ensure a data-driven, outcomes-based CQI process with our providers. We contractually require all providers to participate in our QAPI activities, including submission of complete encounter records and providing regular and ongoing feedback for performance improvement, including correction action plans as needed. We seek input from providers through our Quality Management/Utilization Management (QM/UM) Committee, regular JOCs, quality strategy team meetings, provider satisfaction surveys, and onsite technical assistance and trainings.

Overview of Data Shared with Providers to Support Their Understanding of Progress

To close the feedback loop for CQI, we share findings, outcomes, and trends with our providers to support their understanding of progress in achieving improved outcomes as outlined in **Table C.9-5**. We have HEDIS and Population Health staff members in the field working face-to-face with providers to support them with education, training, technical assistance, and issue resolution.

Table C.9-5: Data Shared with Providers for CQI

Information Shared	Description
CAHPS Survey Results	Aetna assesses enrollee satisfaction by evaluating data from the CAHPS® survey for adults and children with results provided to providers through the SIC. The following are the most important items driving the health plans ratings: • Overall ratings (health care, personal doctor, specialist) • Getting needed care (get needed care, tests, and treatment, easy to see specialist) • How well doctors communicate (shows respect, spends time, clearly explains, listens carefully, explanation easy for child to understand) • Getting care quickly (urgent care, routine care) • Customer service (give information needed, treated with courtesy/respect, written materials/internet provided needed information, ease of filling out forms)
Provider Medical Record Audit Results	The QM department administers a medical records documentation review on an annual basis for practitioners that participate in the health plan network. This review aims to facilitate communication, coordination, and continuity of care for our enrollees. Results are communicated to the health plan's QM/UM Committee with recommendations for follow-up. Contractually, participating practitioners agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Additionally, practitioners must maintain their records according to the medical record management standards listed in the provider manual. This review measures the effectiveness of practitioners' documentation against the current recommended standards with the goal of each practitioner receiving an overall score of equal to or above 85%.
VBP Provider Reports/HEDIS Dashboards	This monthly report provides an overview of core metrics, practice core metrics, and care gaps with enrollee information for follow-up.
Provider Care Gap Report	Provider care gap reports are distributed to providers identifying enrollees on their panel in need of a health screen/test. These reports can be filtered by the provider to examine their performance by provider, by location, and for each enrollee.
Provider Webinars	Aetna regularly hosts provider webinars to include health plan goals and initiatives, as well as provider orientation and education on claims, integrated care management, quality initiatives and HEDIS.
Provider Newsletters	Provider and enrollee newsletters include articles on promoting the health of Kentucky Medicaid children (EPSDT services), oral health, smoking cessation, healthy BMI, and other pertinent health topics. Targeted articles for both audiences provide more information on how to access care, shared decision making on care, and compliance with medications and understanding medications prescribed.
Performance Improvement Projects (PIPs)	Aetna has many ongoing PIPs that not only work to promote the health of our enrollees, but also encourage collaboration among the health plan, the providers, and the enrollees for several conditions. We work closely with the providers to increase awareness of PIPs, why they are important, and how to impact scores and positive outcomes for enrollees.
Annual Provider Accessibility Telephonic Survey (PATS) Results	Annually, PATS (formerly secret shopper) is administered to a random selection of providers. Providers not meeting the standards for accessibility receive education. Additional follow-up is provided after education to ensure required processes have been implemented. If the provider is still not meeting standards, our Contracting team will reach out to the provider for a response. This survey is delivered in the fourth quarter each year. Results are reported to the SIC.

Information Shared	Description
Adherence to Evidence-based Clinical Guidelines	Evidence-based clinical guidelines are the basis for all our programs and support our quality improvement activities such as our performance improvement projects and our medical record review. Guidelines selected are developed by professional organizations and are reviewed annually for relevance and accuracy. National guideline clearinghouses are searched annually to ensure the most relevant and current guidelines are used for our programs. In addition, off-cycle reviews are conducted as indicated for any urgent new recommendations. Providers can access the evidence based clinical guidelines via the provider portal of our website.
Feedback on HEDIS and Healthy Kentuckians Measures	The seventh year for reporting of HEDIS and Healthy Kentuckians' measures was completed in 2019 through the NCQA's HEDIS for measurement year 2018.
Provider Communications/HEDIS Trainings and Tip Sheets	Our HEDIS nurse and internal staff create positive relationships with providers and offer ongoing communication and technical assistance on HEDIS. Our provider communications are focused on education of HEDIS, as well as background and overview of the process, glossary of terms related to HEDIS, and measure specific technical specifications. HEDIS staff created HEDIS provider tip sheets and trained internal departmental staff and providers on HEDIS. We update and maintain a comprehensive HEDIS toolkit to educate providers and distribute to each office for provider reference regarding HEDIS measures.
Monthly HEDIS Provider Trainings	Ongoing, we conduct free quarterly provider HEDIS training webinar series with over 3,300 participants trained in the past 15 months, including the following: • Education about HEDIS measure specifics • Exploring ways to reduce the burden of medical record review and maximize administrative data capture • Discussing HEDIS measures applicable to certain populations • Encouraging open discussion to learn how other providers are addressing HEDIS and barriers to care • Developing strategies for improvement • Connecting providers with a single point of contact at the health plan for HEDIS/Quality questions

b. NCQA Accreditation

Aetna has been NCQA Health Plan-accredited in Kentucky since 2014 and currently maintains a **Commendable** level of accreditation for meeting NCQA's rigorous requirements—obtaining one of the highest ratings among MCOs as shown in **Table C.9-6**. Nationally, the Aetna Medicaid organization is NCQA Health Plan-accredited in 13 states, achieving **Commendable** accreditation status in 4 states, including Kentucky.

Table C.9-6: Kentucky MCO Accreditation Rankings

Plan Name	Ranking
Aetna	3.5
Anthem Kentucky Managed Care Plan, Inc.	3.5
WellCare Health Insurance of Illinois, Inc. dba WellCare of Kentucky, Inc.	3.5
Humana Health Plan, Inc. (Kentucky)	3.0
University Health Care dba Passport Health Plan	3.0

c. Quality Improvement Committee

Our QM/UM Committee (i.e., our Quality Improvement Committee), led by our local Kentucky-based CMO, plays an integral role in assuring the quality of care we provide to our enrollees and in improving the Kentucky Medicaid managed care program. The QM/UM Committee advises and make recommendations to Aetna leadership, our vendors, providers, and community partners on matters pertaining to the quality of care and service provided to enrollees, including the oversight and maintenance of the QAPI and utilization management programs. The QM/UM Committee provides summary reports to the Quality Management Oversight Committee (QMOC) for review and approval and submits reports semi-annually to the board of directors.

QM/UM Committee Major Responsibilities

The QM/UM Committee directs quality management activities and policy and operations changes by reviewing and evaluating data sets and other information, such as enrollee demographics, costs, and performance indicator results of QM/quality improvement (QI) activities along with recommended actions. The responsibilities of the QM/UM Committee include the following:

- Continually engage and re-engage providers in the QM/QI program
- Ensures follow-up on all findings and required actions
- Review and approve studies, standards, and clinical guidelines
- Review trends in quality and utilization management measures, outcomes, and review results of provider medical record reviews
- Review and recommend approval, revision, or denial of medical review criteria
- Review and evaluate the results of QAPI activities (such as HEDIS results, reports, data sets, study results, enrollee and provider satisfaction survey findings, and general information related to programs, systems, and processes)
- Find opportunities to improve the care and services provided to enrollees and recommend solutions to the CMO
- Aid in developing action plans, review and approve action plans submitted to the committee from other sources, and review action plan progress reports
- Review and approve the QAPI and medical management program description, work plan, and annual evaluations
- Conduct peer review and investigate quality of care or service and enrollee safety issues, make recommendations to the CMO, and request follow-up by the Aetna Credentialing and Performance Committee (CPC), if appropriate
- Review utilization issues (cases) requested by the CMO
- Review quarterly utilization reports from delegated entities and make recommendations for improvement, if necessary
- Review, evaluate, and recommend practitioner, provider, and enrollee educational activities and interventions

QM/UM Committee Membership

The QM/UM Committee engages a multidisciplinary team comprised of **internal and external community-based membership** with expertise in the best practices of service delivery for our enrollees, including physical health, behavioral health, special health care needs, and population health:

- CMO – chairperson (one voting member)
- Medical director (one voting member)
- Behavioral health practitioner (one voting member)
- A **cross-representation of network providers**, including PCPs/medical homes, specialists, pediatricians, OBG/GYNs, dentists, behavioral health providers (one voting member for each participating practitioner)

- Director of quality management (one voting member)
- Director of medical management (one voting member)
- Support staff as requested

QM/UM Committee Meeting Interval and Documentation

The QM/UM Committee meets no less than 10 times per year and as often as necessary to demonstrate follow-up on all findings and required actions. We provide the schedule, agenda, and related material to the Department's CMO with 10 days advance notice. An assigned staff member records minutes, findings, recommendations, actions, and results, and forwards to the QMOC for review. Aetna maintains a process to ensure rules of confidentiality are followed in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members. Aetna's board of directors reviews approved minutes. Aetna keeps minutes and documents safe, confidential, and protected and available for review by the Department, EQRO, and/or NCQA accreditation review.

d. Quality and Member Access Committee

The Quality and Member Access Committee (QMAC) provides feedback to Aetna regarding strategies for improving enrollee care and services including health education and other enrollee materials. Major responsibilities include the following:

- Reviewing and recommending strategies to improve clinical performance measures, cultural competency, enrollee outreach plans), prevention programs, satisfaction survey tools, and other initiatives requested by QMOC
- Providing input on enrollee educational materials (e.g., readability, content), the enrollee handbook, and applicable Aetna and Department policies
- Soliciting enrollee feedback and opinion about issues related to access and the quality of care and services provided to enrollees as well as potential programs, and activities
- Offering input on grievance and appeals processes and policies based on review of summary data

d.i. QMAC Stakeholder Representation

The committee is composed of enrollees and members of their families, representatives from advocacy groups, and community-based organizations, including the following:

- Manager of community development (chairperson)
- Aetna staff, including the trauma champion, prevention and wellness coordinator, grievance and appeals manager, and population health specialist, etc.
- Quality management representative
- Aetna enrollee and advocacy group representatives (maximum of 15 representatives)

Advocacy groups that are invited and take part in the QMAC include, but are not limited to, the following:

- Charities Human Trafficking
- Family Resource Center
- Home of the Innocents
- Kentucky Voices of Health
- National Alliance on Mental Illness
- Pathways, Inc.

The QMAC meets quarterly. Minutes along with summary reports are recorded for all meetings and are provided to the QMOC and/or SIC for review and consideration. We provide the Department 10 days advance notice of all meetings with the agenda and supporting information and provide the meeting minutes to the Department within 10 days after each meeting. Aetna keeps minutes and documents safe, confidential, and protected, with an annual summary provided to the Department that includes the membership, recommendations from the committee, and actions taken to address the recommendations.

d.ii. Innovative Strategies to Encourage Enrollee Participation

Since the start of the QMAC, we have continuously employed innovative strategies for encouraging enrollee participation in the QMAC. We use multiple engagement tactics, including the enrollee survey and outreaching to different plans in other states to learn and deploy their best practices. In choosing our target QMAC membership, we analyze and match the composition of the enrollee population, including race, ethnicity, gender, and geographic distribution. We include adults receiving services, as well as parents of children in the system.

Aetna is committed to removing barriers to participation in the QMAC for our representatives through the following:

- Reimbursing participants for their travel expenses
- Providing a meal during the meeting
- Reimbursing childcare expenses
- Providing teleconference access
- Hosting ad hoc QMAC meetings at community-based organizations

The QMAC has reviewed and offered critical feedback on our website, enrollee handbook, our QM program description, QM annual evaluation, QM work plan, QM summary, survey results, enrollee policies, grievance and appeals, outreach activities, and the prevention and wellness workplan. They provide us input and strategies on resolving on barriers to care. We incorporate all their input and collaborate to resolve issues. An example of this was when one of our enrollee participants reported the community was not aware of our programs and benefits, including care management; our Care Management team visited providers and attended staff meetings to present our available benefits and how to access them. We have also discussed strategies about ED use and treatment availability for lice and bed bugs.

We offer virtual attendance via teleconferencing capabilities to the QMAC to eliminate transportation barriers, holding the meetings locally in two of our largest service areas, Lexington and Louisville, to encourage participation and better understand regional differences and challenges. To promote participation, we have completed 'lunch and learns' with community partners. We offer time for our enrollees to tell their story at the beginning of each meeting through our 'Enrollee Minute' at the top of the agenda so each participant knows their voice will be heard.

d.iii. Examples of Successful Strategies to Obtain Active Participation in Similar Committees

In Kansas, Aetna has successfully obtained active participation on our Member Advisory Committee through the following:

- Providing a $15 voucher per meeting (not to exceed $75 per year)
- Formation of subcommittees based on population groups and geography to incorporate input that reflects the full diversity of Aetna enrollees in the state (e.g., Spanish-speaking members, parents of children with serious emotional disturbance, members living in rural/frontier areas, etc.)
- Onsite interpretation services, including sign language
- Reporting back to the committee on actions taken and outcomes achieved related to opportunities identified

In Pennsylvania, we conducted statewide enrollee focus groups to better understand what is of interest and relevant to our enrollees. We use the feedback from those focus groups to launch conversations to deepen our understanding by bringing those subjects to our Health Education Member Advisory Committee meetings throughout the year to drive discussion and input. Oftentimes reviewing materials or events does not generate discussion but talking about real health and community barriers that are addressed through those materials has had good success both in the meeting and in follow-ups. We have enrollees that will call us with feedback in between meetings or who now provide us with new ideas and community connections because of the enrollee-informed approach to developing subject matter.

In Michigan, we have attained consistent enrollee participation through the following:

- Completely focusing the agenda on enrollees sharing information or providing feedback on our programs
- Asking enrollees prior to the meeting for agenda items and giving enrollees the floor for most of the meeting time
- Sharing in detail every change made because of enrollee feedback, so that enrollees clearly understand their importance to and impact on the plan
- Having regular attendance from our CEO so the meetings are an opportunity for enrollees to interact with her
- Offering incentives for attendance

e. Quality Assessment and Performance Improvement

Aetna has a well-established QAPI program as described in **Table C.9-7** to direct organization-wide initiatives for continuously improving the health status of covered populations in compliance with the Department's **Quality Strategy, Draft Medicaid Managed Care Contract and Appendices Section 19.3**, 42 C.F.R. 438.330, and NCQA accreditation standards. Aetna integrates quality management and performance improvement processes into all departments, with each department responsible for selected processes, functions, and monitoring activities. Staff perform monitoring activities as a part of routine operations and report results to the appropriate internal departments, committees, or external agencies as required. Every Aetna functional area is accountable for quality outcomes.

Table C.9-7: QAPI Program Components

QAPI Components	Description
QAPI program description	Outlines the strategic plan and goals to meet or exceed the Commonwealth's quality strategy, quality plan, and other requirements. Core elements of the Program Description include goals and objectives, program elements, scope of activities, innovative approaches to achieve, and detailed staffing plan. We modify our QAPI program description and provide it to the Department annually based on our findings, changes to contract, NCQA accreditation standards, and Commonwealth and federal guidelines.
QAPI work plan	A Kentucky-specific activity-tracking tool reviewed quarterly at the QMOC and QM/UM meetings to facilitate achievement of goals identified internally, by the Department, enrollees and providers. It is a dynamic document with specific interventions and activities to drive the implementation of clinical and service quality improvement outcomes related to contractual performance measures, HEDIS measures, performance improvement projects, medical and treatment record audits, enrollee, and provider surveys, and NCQA standards. The work plan names staff members responsible for each activity and the periods for completion. Continuous progress is reflected, and activities, barriers, and outcomes are measured, trended, and compared to defined targets or the industry benchmarks, with the most stringent measure being used.
QAPI program evaluation	An annual evaluation of the QAPI program to assess the overall effectiveness of our QI program and reflects an assessment of completed and ongoing activities in the QAPI work plan. It addresses barriers from the previous year and provides recommended interventions for overcoming issues and barriers identified. Opportunities for improvement identified in the evaluation or articulated by Commonwealth regulators, or from provider or enrollee feedback, drive the development of our goals and objectives. New goals and objectives are created as needed based on findings and information.

We integrate a governance model with responsibilities and accountabilities of top-level management and the board of directors. Our CMO and quality management director are accountable for the management of the QAPI program, in collaboration with enrollees, providers, and key stakeholders, locally and nationally. Aetna takes part in all quality meetings as requested by the Department to support the statewide quality goals, collaborate on initiatives, provide progress updates, and resolve barriers. We fully cooperate with the Department and external review organization requests for documentation. We meet all contract requirements as described in **Table C.9-8.**

Table C.9-8: Aetna's Compliance with QAPI Program Contract Requirements

Contract Requirements	Description of Aetna Compliance
Conducting and Assessing Performance Improvement Projects	Aetna conducts PIPs in accordance with Commonwealth requirements. The goal is to design projects to improve performance in the quality or appropriateness of service provision. PIP topics are identified either from areas of importance or weakness identified by regulators or by the health plan. Examination of relevant clinical, survey, financial, demographic, and/or encounter data that relate to quality of care, utilization of services, or other factors that impact membership, providers, or the larger community precede design and implementation of PIP activities. When not specified by a regulator, selection of PIP activities should consider the prevalence of conditions among enrollees, the need for specific services, identified barriers to service, demographic characteristics, identified racial disparities, and health risks among enrollees or the community served by Aetna. The CMO, QM/UM Committee, and QMOC review and approve PIP proposals.
Collecting and Submitting Performance Measurement Data	The HEDIS medical record review project is completed annually from January through May. We comply with NCQA auditing standards for submission of HEDIS data for validation of all rates. Additionally, the health plan submits annual reports to the Department for HEDIS rates, CAHPS results, Healthy Kentuckian measures, and PIPs.
Detecting under-utilization and over-utilization of Services	Utilization management monitors performance metrics, trends in authorizations decisions (approvals and denials), trends in utilization metrics by category of expense, bed-days, readmission rates, changes in prior authorization grid, and results of inter-rater reliability assessments. Aetna also uses individual provider profiles to evaluate over- and underutilization of services and determine the need for enrollee and/or provider education to improve practice patterns.
Assessing the Quality and Appropriateness of Care Furnished to Enrollees with Special Health Care Needs	Enrollees with special health care needs are captured in our EPDST and foster care populations. Our program structure supports activities that require frequent assessment of this population. Additionally, gaps in care are monitored and specific outreach methods are attempted to reach this population. Outreach initiatives are designed to reach enrollees using various methods including texting, digital campaigns, IVR, mailing, and community education. Our enrollees are encouraged to participate in our MAC to provide feedback to the plan on our quality program structure. Creating a structure that meets evidence-based practice as well as the unique needs of this population drive appropriate, quality care.
A QIC to Provide Oversight of QAPI Functions	Our QM/UM Committee fulfills all requirements of the QIC.
Methods for Seeking Input from and Working with Stakeholders	We seek stakeholder input through our quality committee structure, provider collaboration on JOC, and quality strategy meetings to allow for stakeholder engagement and activity.
Methods for Addressing Department-mandated Performance Measures	Department-mandated performance measures are captured in our HEDIS project. We also build a Healthy Kentuckian project within our HEDIS project, which allows us to capture and analyze data on enrollee compliance. Additionally, we align our PIPs with Department priorities and Commonwealth health priorities.
Integration of Behavioral Health Indicators into the QAPI Program and a Systematic, Ongoing Process for Monitoring, Evaluating, and Improving the Quality and Appropriateness of Behavioral Health Services Provided to Enrollees	Integration of quality management behavioral health activities into the QAPI program occurs through regular reporting of behavioral health metrics and through regularly scheduled workgroup meetings that provide ongoing monitoring of behavioral health care services. Implementation of corrective action plans is on an as-needed basis. The QMOC reviews and approves quality management behavioral health reports integrated with health plan reports annually. A behavioral health practitioner serves as a member of the QMOC and QM/UM committees. Collaboration occurs among all the health plan departments to facilitate continuity of care between medical and behavioral health practitioners. Examples of this collaboration include working closely with network hospitals and practitioners to confirm that enrollees hospitalized with a behavioral health diagnosis receive a timely follow-up appointment at discharge.

Contract Requirements	Description of Aetna Compliance
Methods to Collect Data, and Monitor and Evaluate for Improvements to Physical Health Outcomes Resulting from Behavioral Health Integration into the Enrollee's Overall Care	We use various methods to collect data from an integrated care model of physical and behavioral health. High-impact methods include VBP shared savings arrangement that impact care related to utilization measures (ED and readmission). We use that data to track high ED utilizers and all-cause readmission, inclusive of physical and behavioral health. Our ED workgroup focuses on physical conditions related to diabetes, heart health, opioid/substance abuse, and behavioral activity demonstrated in depression, severe mental illness, and lack of follow-up care. This data drives activity for provider education, enrollee education, and interventions related to self-care and appropriateness of care. Additionally, we are currently working on the MCO collaborative PIP and ambulatory care-sensitive conditions (ASCS) which focus on ED visits and readmissions. The four conditions of focus in the ACSC PIP include asthma, diabetes, heart disease, and COPD. Care managers complete a mental health assessment as chronic physical condition can affect mental health.
Use of a Health Information System to Support Collection, Integration, Tracking, Analysis, and Reporting of Data Analytics Specific to Health Care Outcomes and Performance Metrics	Our health information systems use data collection methods that allow for reporting of data analytics specific to health outcomes and metrics. The methods include trending of measures and performance to show both positive and negative trends. These trends are monitored via heat maps, regional performance, and population demographics. Our population assessment provides details on data to allow for predictive analytics on enrollee behavior, as well as stratification of enrollee conditions.
Methods to Evaluate Data and Findings Reports to Assess QAPI Program Activities, Progress on Objectives, Identified Areas for Improvements and Processes to Implement Changes, including Methods for Providing Feedback or other Information to Providers and Enrollees	The QAPI annual evaluation is a comprehensive report that evaluates plan performance, enrollee behavior, and provider activity impacting our program activities. The results of our annual evaluation drive updated goals and objectives of our QM program structure to capture the needs of the enrollees and providers. Additionally, we comply with all Commonwealth required reports, which capture plan activities for the QAPI program. Last, our required NCQA analyses drive activities, process improvement, policy changes, and education interventions to positively affect the enrollee quality of care and provider experience.

Quality Committees

A formal committee structure, as presented in **Figure C.9-5**, allows for oversight of the QAPI program and for the flow of information to and from the board of directors and the Department. Formal committees, subcommittees, and ad hoc work groups advise and guide the QAPI process. The committees foster collaborative partnerships and integrate provider and enrollee feedback into development of operational policies and our decision-making. We encourage external stakeholders and community agencies to take part in our committees, presenting their programs and initiatives as topics for discussion. We incorporate information gleaned from our participation in the Department Quality Committee and activities into our committee discussions and goals.

Figure C.9-5: QAPI Committees

Aetna's comprehensive Quality Committee structure directs organization-wide CQI initiatives.

Kentucky Board of Directors

The board of directors has ultimate accountability for the QAPI program and related processes, activities, and systems, including the QAPI Program Description and any subsequent revisions, annual evaluation of the previous year QAPI activities, summary reports, data, outcomes of studies and credentialing activities.

Quality Management Oversight Bodies and Schedule of QM Activities

Our QAPI process is guided by committees, subcommittees, and ad hoc work groups as outlined in **Table C.9-9**. All meetings are recorded and minutes or summaries (based on confidentiality restrictions) are provided to the QMOC and the Department as requested. Meeting frequency is increased as needed.

Table C.9-9: QAPI Committees and Schedule of Activities

QAPI Committees	Description	Meeting Frequency
Kentucky-based Committees		
QMOC	Chaired by the CEO with cross-functional representation, integrates QM and performance improvement activities throughout the plan and provider network; provides executive oversight of the QAPI program and makes recommendations to the board of directors about Aetna's quality management and performance improvement activities, including the annual QAPI program description, QAPI work plan, and QAPI evaluation and work to make sure the QAPI plan is integrated throughout the organization, and among departments, delegated organizations and network providers.	Six times per year
QM/UM Committee/Fulfills Requirements of QIC	Chaired by the CMO with cross-functional representation and network providers, including PCPs/medical homes, specialists, pediatrics, OB/GYN, dental, and BH; advises and makes recommendations regarding the quality of care and service provided to enrollees including the oversight and maintenance of the QAPI and utilization management programs. The QMOC receives summary reports for review and approval and submits reports semi-annually to the board of directors.	10 times per year
Delegation Oversight Committee	Chaired by the CMO with cross-functional representation; advises the QMOC about delegated relationships	Quarterly
SIC	Chaired by the director of operations with cross-functional representation; advises the QMOC and/or management about enrollee and provider issues	Quarterly

QAPI Committees	Description	Meeting Frequency
Grievance Committee	Chaired by the grievance and appeals manager, with cross-functional representation and at least one enrollee advocate; reviews trends, resolves issues, and renders decisions related to an expression of dissatisfaction filed by enrollees or providers.	Monthly
Appeal Committee	Chaired by the grievance and appeals manager with cross-functional representation; reviews appeal trends and may render decisions on appeals filed by enrollees or providers.	Monthly
MAC	Chaired by the manager of enrollee services with cross-functional representation and enrollee representatives; provides feedback regarding strategies for improving enrollee care and services, including health education and other enrollee materials.	Quarterly
Compliance Committee (CC)	Chaired by the compliance officer with cross-functional representation; reviews, monitors, and assesses the effectiveness of the compliance plan.	Quarterly
Policy Committee (PC)	Chaired by the compliance officer with cross-functional representation; development, implementation, approval, and communication of all policies.	Monthly
Aetna National Committees		
Aetna Practitioner Appeals Committee (PAC)—Subcommittee to CPC	Facilitated by an Aetna medical director; conducts professional review hearings of providers who appeal decisions made by the CPC involving professional competence or conduct of the provider; consists of providers appointed on an ad hoc basis by the CPC. The committee reports through CPC and to the QMOC.	As needed
Aetna Quality Oversight Committee	Chaired by the Aetna regional head of health care delivery or designee; conducts the credentialing/re-credentialing of facilities/organizational providers/vendors and the review of facilities/organizational providers/vendors potential quality of care issues and complaints.	10 times per year
National Drug Utilization Review Board	Chaired by the Aetna senior medical director with cross-functional representation; analyzes enrollee and practitioner/provider drug utilization patterns to identify educational and/or intervention opportunities that promote patient safety and appropriate utilization, monitor quality outcomes, and to drive cost-effective drug therapy.	Quarterly
Pharmacy and Therapeutics Committee	Chaired by the Aetna senior medical director with cross-functional representation; responsible for advising and making recommendations to the QMOC and/or Kentucky medical director regarding the pharmacy program.	Quarterly

f. Improving Kentucky's Medicaid Populations

Aetna achieves quality management excellence by empowering enrollees to engage in their health care and improve their health outcomes with enhanced quality of care and the reduction or elimination of health disparities, including diabetes, smoking, and colorectal cancer screening.

f.i. Medication Adherence for Diabetes Medications

According to the American Diabetes Association[3], approximately 567,000 people in Kentucky, or 15.3 percent of the adult population, have diabetes. Lack of adherence to medication can result in higher rates of hospitalization and increased health care costs. We are committed to supporting our enrollees with diabetes in taking their medications; our Kentucky 2018 HEDIS measures were in the 90th percentile for HbA1c poor control (>9.0 percent), and in the 75th percentile for HbA1c Control (<8.0 percent) and

[3] American Diabetes Association, "The Burden of Diabetes in Kentucky," State Fact Sheets: accessed June 3, 2019; http://www.diabetes.org/assets/pdfs/advocacy/state-fact-sheets/kentucky-state-fact-sheet.pdf.

HbA1c Control (<7.0 percent). **Table C.9-10** outlines our Kentucky diabetes initiatives, including medication adherence.

Table C.9-10: Medication Adherence for Diabetes Medication Components and Activities

Quality Measure Component	Aetna Activity
Strategies and Interventions	**Aetna diabetes management program:** Assists enrollees with a diagnosis of diabetes and their supports to understand the health risks of living with the chronic condition; the benefits of adhering with prescribed treatment regimen; and elicit changes in enrollees' behaviors, positively impacting their current and future health and wellness. **Text message campaigns:** A digital campaign designed to help close diabetes gaps in care. Targeting enrollees with diabetes who are non-compliant with their care, this campaign sends reminders of their comprehensive diabetes care screenings, shown to decrease hospitalization for short-term complications. **Diabetes mailer program:** A mailing to enrollees 18 and older who are diagnosed with diabetes and are non-adherent for checking HbA1c or LDL cholesterol levels, or for nephropathy or diabetic retinopathy screenings. The mailers include information on gift card incentives. **Provider education:** Provider portal and fax blasts for providers with information such as changes, updates, and Commonwealth information. A component of Oral and Ocular Care Coordination program is to reach out to the provider with a list of diabetic enrollees who have visited that provider in the past but have not visited in the last year to make an appointment. Additionally, Aetna sends a mailer informing the PCP of a suspected diabetic patient. **Enrollee incentives:** Aetna supports and encourages its enrollees living with diabetes to seek appropriate screening and tests related to diabetes care through enrollee incentives. This is a value-added benefit which provides for enrollees to receive $10 in gift cards for completion of a diabetic retinopathy eye exam. Gift cards are mailed to eligible enrollees on a monthly basis. Comprehensive Diabetes Dilated Retinal Eye Exam: DRE assesses the percentage of enrollees ages 18 to 75 with diabetes who had a dilated retinal eye exam performed by an eye care professional (optometrist or ophthalmologist). Enrollees will get a $10 gift card once per calendar year for completing a diabetic retinopathy eye exam.

Quality Measure Component	Aetna Activity
Collaborative Partnerships	**Oral and Ocular Care Coordination (O2C2) Program:** Aetna in collaboration with the plan's vision and dental vendor has implemented Oral and Ocular Care Coordination (O2C2) pilot program for diabetic enrollees. O2C2 is a program that helps with preventive services and drives medical cost reduction by expanding access to preventive services for enrollees at risk of or diagnosed with diabetes. O2C2 helps prevent the development of expensive medical complications through regular screening and preventive treatment for identified enrollees with diabetes. Data on existing diabetic enrollees is used to identify enrollees in need of a dental exam and/or a retinal exam. O2C2 educates enrollees on the value of getting eye/dental exams through mail materials such as a postcard or brochure. Outreach calls (live or IVR) are performed to assist with scheduling appointments with nearby providers. Provider outreach involves providing a list of diabetic enrollees who have visited that provider in the past but has not visited in the last year. Providers are assisted with making the appointments for the enrollees. The PCP is provided documentation informing them of a suspected diabetic patient. **Community diabetes education program:** Microclinic is an initiative designed to empower enrollees to lead healthier lives and manage chronic conditions such as diabetes and cardiovascular disease (CVD). This program also reaches out to enrollees who are at risk for diabetes or CVD. Enrollees learn how to decipher nutrient labels, cook healthy meals, take part in group fitness activities, and reach health goals. Meetings are held weekly for 16 weeks by a facilitator who is trained with the curriculum. The meetings are held in the community settings where enrollees and their families can join these classes. The program encourages enrollees with positive reinforcement through small performance rewards and comprehensive teamwork. After the 16-week program is completed, the enrollees can continue in a program called My Health Matters where they check in once a month for 8 months. **Diabetes nutrition education class**: A diabetes education/nutrition program that is six to eight-week class. Classes include cooking classes where the focus is on nutrition label reading and carbohydrate counting. Classes are 60-90 minutes long. Each class has a certified diabetes educator from the local health department. The cooking supplies that are used are purchased locally and with Supplemental Nutrition Assistance Program benefits. Food insecurity and access issues are taken into account during the planning stages. Classes can be done as a two-way demo (allowing for more participants) or are hands-on (limited to 12 participants). There is no cost to the enrollees or community members to attend. Every class has a door prize item that is provided to the enrollee at the end as a token of appreciation for their participation. **Prescription reminders and alerts:** All enrollees with diabetes may choose automated phone call, text messaging, or email reminders when a prescription refills is due to be filled. Reminders are conducted by our pharmacy benefits manager, CVS retail pharmacies, or other pharmacies. These may also include prescription status alerts that will notify an enrollee when their prescription has been filled and is ready for pick up or if there are any issues with the medication. **VBP program:** Nine provider groups were contracted through 2019, which included diabetes as part of their measure profiles. Six of the groups included both HbA1C testing and diabetic retinal eye exams and the seventh group included, which has only 5 measures instead of 10, includes only the HBA1C testing. **University of Kentucky Center for Health Equity Transformation (CHET):** In 2019, Aetna started a signature collaborative partnership with the University of Kentucky's Center for Health Equity Transformation team with one of the focus areas being SODH on diabetes health outcomes. Aetna is currently identifying collaborative areas of opportunity in order to implement new diabetes programs in 2020. The CHET-Aetna engagement is a value-added partnership. Working closely on SDOH, community needs assessment, epidemiologic surveillance, and the impact of programming including prevention and treatment, CHET researchers share a core mission with Aetna and the Department. We are ready to fully engage our emerging partnership to change the lives of the state's most vulnerable population through evidence-based research.

Quality Measure Component	Aetna Activity
Data Analytics	Since our plan's first HEDIS season in 2013, we have seen improvements in all Comprehensive Diabetes Care (CDC) HEDIS sub-measures: • CDC HbA1C Poor Control (>9.0% /lower is better) improved by 18.28 percentage points from HEDIS 2013 to HEDIS 2019 and hit the 90th percentile for NCQA Quality Compass for 2019 • HbA1C Control (<8.0%) improved by 12.19 percentage points from HEDIS 2013 to HEDIS 2019 • HbA1C Control (<7.0%) improved by 6.85 percentage points from HEDIS 2013 to HEDIS 2019 and was also in the 50th percentile for NCQA Quality Compass for 2019 • Eye Exam (Retinal) Performed improved by 14.75% from HEDIS 2013 to HEDIS 2019 • Medical Attention for Nephropathy improved by 15.2% from HEDIS 2013 to HEDIS 2019 • Blood Pressure Control (<140/90 mm Hg) improved by 13.63% from HEDIS 2013 to HEDIS 2019 • Hemoglobin A1c (HbA1c) Testing improved by 3.86%
Anticipated Timeframes for Success in Achieving Improvements	Our stated plan goals and timelines for diabetes for the next 24 months are as follows: • Reduce admission and readmission rates for diabetes short term complications by 2% as compared to baseline • Increase the rate of annual HbA1c testing to the 50th NCQA benchmark percentile • Increase annual dental visits for diabetic enrollees from the 25th NCQA benchmark percentile to the 50th percentile
Describe Potential Anticipated Challenges and how those will be Addressed	Engaging the diabetic enrollees in educational efforts and having them follow up with their PCPs. Collaborating with different community partner agencies to have educational classes available in community settings; using text messages to remind of their follow-up appointments can help address these challenges.
Examples of Successes in other State Medicaid programs, and how that Success will be Leveraged in Kentucky	We will leverage our success in Florida, where we conducted live phone outreach calls to enrollees who may be due for annual dilated exams and/or Hba1c testing to encourage them to have exams done as it relates to diabetes. If enrollees do not have an appointment set, they are asked to contact doctor to make an appointment or if they need assistance in making appointment. As a result, we moved our DRE and HbA1c testing percentiles from the 50th in 2016 to the 90th in 2018.

f.ii. Tobacco Use and Help with Quitting Among Adolescents

We continue to learn about best practices in tobacco use and helping adolescents quit smoking. As we obtain new resources, we share it across Aetna and use it in our educational efforts with enrollees and providers. Most of our smoking cessation efforts centers around education, including several tobacco cessation articles in our enrollee newsletter. We continuously participate in the webinars that are offered by the University of California San Francisco Smoking Cessation Leadership Center. This center has provided several trainings on e-cigarettes and the increase of usage by adolescents. We make these trainings available to all Care Management staff. Additionally, we have initiated tobacco and e-cigarette classes at school settings, increasing awareness on the dangers of vaping and e-cigarette use. As a result of our work with the Center for Medicare and Medicaid Services (CMS) Tobacco Cessation Affinity Groups, Aetna was instrumental in developing a provider fact sheet in 2016 that was disseminated to all providers along with a magnet. We also were involved in policy level change when Foundation for Healthy Kentucky was proposing a tax increase on tobacco products and increasing smoke-free zone around businesses. Additional activities are described in **Table C.9-11.**

In Kentucky, Aetna improved the Tobacco Screening and Intervention for Adults measure from 65.07 percent in 2017 to 88.32 percent 2019.

Table C.9-11: Tobacco Use and Help with Quitting Among Adolescents Components and Activities

Quality Measure Component	Aetna Activity
Strategies and Interventions	Smoking cessation efforts centers around education. Text messages and enrollee newsletter articles are educational venues used to promote quitting. Quitline information, education on benefits of quitting smoking, dangers of e-cigarette, providing quit smoking resources, and informing of availability of nicotine replacement patches, gum, and medication with prescription from PCP are all interventions to promote smoking cessation.
Collaborative Partnerships	In 2016, Aetna participated in CMS Tobacco Cessation Affinity Group with other MCOs and the Department and learned about the best practices for tobacco cessation. We are an active participant of the University of California San Francisco Smoking Cessation Leadership Center that provides trainings by experts on cessation topics. We continue to learn about the best practices from this Leadership Center and use the provided resources in our education efforts. In 2019, Aetna started a signature collaborative partnership with the University of Kentucky CHET team with one of the focus areas being tobacco cessation and e-cigarette prevention among the youth population, tobacco control policy, and how policy can contribute to the reduction of racial/ethnic and socioeconomic health disparities.
Data Analytics	The Adolescent Screening/Counseling (ASCKY) HEDIS measure for Tobacco Screening and/or Counseling has seen a major improvement since our first HEDIS project to our most recent finalized rates. In our first year, this measure had a rate of 36.36 percent and for HEDIS 2019 our rates for Tobacco Screening and/or Counseling in the ASCKY measure was 75.00 percent which is an improvement of 38.64 percentage points.
Anticipated Timeframes for Success in Achieving Improvements	Tobacco cessation efforts are ongoing with the goal of decreasing smoking rates among all populations, including adolescents. Final rates are evaluated annually, but measures of success/impact are 36 months to determine efficacy and sustainability.
Describe Potential Anticipated Challenges and how those will be Addressed	The main challenge is for providers to educate patients on the benefits of tobacco cessation and providing cessation counseling. The purpose of the Tobacco Cessation Provider Fact Sheet was to not only inform of the cessation medications provided by each MCO, but also provide billing codes that providers could use when counseling on tobacco cessation. Developing cessation toolkits and using it for provider education is another way of addressing this key challenge.
Examples of Successes in other State Medicaid programs, and how that Success will be Leveraged in Kentucky	We will leverage our initiatives in Louisiana, where we collaborate with the American Lung Association and Louisiana Cancer Control programs. Our enrollees receive ongoing counseling from their care manager, community health worker, and peer support specialists. We promote use of the quitline and tobacco control initiative through flyers, website, and messaging.

f.iii. Colorectal Cancer Screening

In 2015, there were 2,515 new cases of colon and rectum cancer; for every 100,000 people, 48 colon and rectum cancer cases were reported[4]. In 2018, we included colorectal cancer screening in the txt4health campaign, sending a series of messages to 8,509 enrollees, with an included link to a website (https://m.connect4health.net/t4h/exam/colon-exam.html) that provides information regarding what a colon exam is, why is it important, and how often it is needed. We will use data visualization software to map colorectal cancer data to identify areas for education, outreach, and engagement. Our target population will be enrollees 50 to 75 years of age. **Table C.9-12** provides details of our program.

[4] U.S. Cancer Statistics Working Group, "U.S. Cancer Statistics Data Visualizations Tool,", U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute: accessed June 3, 2019; https://gis.cdc.gov/Cancer/USCS/DataViz.html.

Table C.9-12: Colorectal Cancer Screening Components and Activities

Quality Measure Component	Aetna Activity
Strategies and Interventions	We will provide education including flyers on needed screening tests and how to obtain services, including taskforce guidelines addressing flexible sigmoidoscopy every 5 years, colonoscopy every 10 years, double-contrast barium enema every 5 years, guaiac-based fecal occult blood test every year, and fecal immunochemical test (FIT) every year. We will promote FIT-First and Flu-FIT campaigns to providers within the federally qualified centers (FQHC) system to provide an annual, low-cost FIT test to enrollees. We will be participating in health fairs and local community meetings, handing out free FIT kits, and promoting National Colorectal Cancer Awareness Month in March through our newsletter and mailers.
Collaborative Partnerships	We will partner with organizations committed to reducing colon cancer, including the Kentucky Cabinet for Health and Family Services, Colon Cancer Prevention Program, and the Kentucky Cancer Consortium.
Data Analytics	Each year, we will apply to our Medicaid population the NCQA HEDIS hybrid sampling and assessment methodology for the Colorectal Cancer Screening measure typically used with Commercial/Medicare populations. This approach will examine enrollees turning 51 to 75 years of age during the year who were continuously enrolled for that year and the year prior. Statistically significant improvement during each successive intervention year as measured from valid samples created using NCQA methodology will be applied to evaluate our overall evaluation of success. It is a general industry challenges capturing full clinical records for enrollees who may have received a colorectal cancer screen prior to enrollment with a health plan. Because enrollees are typically enrolled for less than the 10-year review period acceptable for a prior colonoscopy or 4-year review period acceptable for a CT colonography or flexible sigmoidoscopy, we will also test the effectiveness of several combinations of multi-channel enrollee outreach programs through examination of improvements in screening rates using our available administrative data. This will include comparing small randomized control samples to the larger membership eligible for the screening measure that are exposed to our different outreach interventions. Based upon prior work in Medicare, we expect that after removing those who already show claims-based evidence of a colorectal cancer screen, enrollees will show a higher proportion of screening during the year the interventions were initiated. Because much of our outreach will focus upon the ease of FIT-DNA tests, we expect to find a higher proportion of enrollees receiving these tests, but also see an increase in other colorectal cancer screening claims.
Anticipated Timeframes for Success in Achieving Improvements	NCQA does not supply colorectal cancer screening rates for Medicaid managed care organizations. However, CMS reports these rates for dual-eligible special needs plan (D-SNP) enrollees, which we believe is a moderately close analog for our Medicaid enrollees. Across 265 D-SNPs, CMS reported a statistically significant increase from 68.8% to 71.9% between HEDIS 2015 and 2016. These values are similar to the Medicare health maintenance organization average of 69.1%. Aetna also has experience in our own Medicaid D-SNP populations, where combined enrollee and provider-based interventions have produced improvements of over 6%. Based upon the general trends in medical practice promoting less awkward screening methods and our own experience promoting FIT-DNA tests, we expect an improvement of 7% to 8% following the first two intervention years for enrollees between 51 and 75 years of age.

Quality Measure Component	Aetna Activity
Describe Potential Anticipated Challenges and how those will be Addressed	Aetna efforts to educate and engage enrollees in their own health care and colorectal cancer screenings have been previously successful. However, persistent perceptions about awkward or unpleasant experiences related to colorectal cancer screening still prevent enrollees from receiving needed care. A key component to remediate this will be Aetna's enrollee outreach to educate enrollees about newer advances in screening and the importance of discussing their prior history and risks with a physician. Our provider intervention efforts typically take longer than one year to fully engage provider groups in prioritizing and tracking our enrollee's key gaps in care. This issue will be increased due to frequently absent administrative data in claims or physician electronic medical record systems that indicates a prior colorectal cancer screen. However, with ongoing education and focus, provider groups are able to address clinical/office procedures to capture and track needed information, leading to better monitoring and tracking of overall provider group performance.
Examples of Successes in other State Medicaid programs, and how that Success will be Leveraged in Kentucky	We will leverage our success In Arizona, where starting in 2011, we mailed FIT order forms to the PCPs of enrollees who are in need of screening, and (if appropriate) ask them to sign the order and return it to us, which we then use to generate a call to the enrollee to inform them that their doctor has ordered the test, provide education if necessary, and if the enrollee agrees to it, we mail the kit and instructions directly to their home. The kits are provided to us through a partnership with our lab vendor. In 2017, we added an enrollee incentive program where enrollees can receive a $50 gift card for completion of the screening. Additionally, we do the following: • We conduct an intense medical record review led by a dedicated an Aetna colon cancer subject matter expert staff member (who also manages the interventions for this measure throughout the year) • Mailings including pertinent HEDIS measures, encouraging the PCP to flag chart and/or reach out to the enrollee • Provider newsletter article on colorectal cancer screening and orders • HEDIS gaps in care report located online containing a comprehensive list of enrollees needing care for HEDIS measures • Enrollee mailing: Colorectal Educational Brochure • Enrollee brochure "Getting the Most Out of Your Annual Visit" encouraging enrollees to discuss colorectal cancer screening • Automatic notification to care manager in the electronic care management system that shows enrollees who are non-compliant for one or more HEDIS measures for discussion during outreach call and/or face to face visit • Supplemental data received from provider for administrative HEDIS measures • PCP Annual Wellness letter with need to counsel enrollee and establish or update screening for colorectal cancer As a result, we improved on the colorectal cancer screening (COL) HEDIS measure from 54.93% in 2014 to 63.26% in 2018.

g. Performance Improvement Projects

Aetna conducts PIPs in collaboration with the Department, other MCOs, and providers in accordance with Commonwealth requirements. We consider this type of collaboration across the Department, MCOs, and providers on the same PIP topic a best practice to support sustainability of progress with a membership that is mobile and can move into and out of different MCOs. Our approach is to design projects to improve performance in the quality or appropriateness of service provision. PIP topics are identified either from areas of importance or weakness identified by regulators or internally. Examination of relevant clinical, survey, financial, demographic, and/or encounter data that relate to quality of care, utilization of services, or other factors that impact membership, providers, or the larger community precede design and implementation of PIP activities. When not specified by a regulator, selection of PIP

activities take into account the prevalence of conditions among enrollees, the need for specific services, identified barriers to service, demographic characteristics, identified racial disparities, and health risks among enrollees or the community served by Aetna. The CMO, QM/UM Committee, and QMOC review and approve PIP proposals. Aetna network practitioners receive results to encourage input for continuous quality improvement strategies.

PIP topics and related monitoring activities reflect the needs or issues of Aetna's population in terms of age, disease categories, and special risk status. Indicators associated with studies and monitoring activities are objective, measurable, and based on national benchmarks or historical data. PIP components include, but are not limited to, the following:

- Title
- Implementation date
- Activity name
- Reason for selecting topic
- Population studied (inclusion and exclusion criteria)
- Clinical focus areas (e.g., prevention of acute or chronic conditions, care of acute or chronic conditions)
- Indicators/criteria to measure and trend performance
- Sample selection and size of identified population
- Description of data collection and methodology (including survey instruments, software programs, data sources, and data analysis)
- Determination of baseline measurements
- Analysis of data
- Opportunities for improvement and/or interventions, if appropriate based on analysis
- Re-measurement methodology
- Analysis of findings from re-measurement, including impact assessment of interventions implemented since baseline study

Aetna's PIPs have grown in number, collaboration, and scope over the last six years addressing issues of both a physical and behavioral health nature within the Commonwealth and our enrollee population. Behavior health has expanded to include programs for adults and children, with the focus of those PIPs including attention-deficit/hyperactivity disorder (ADHD) (children), the use of antipsychotic medications in adolescents, and increasing follow-up visits for mental health hospital visits.

Our PIPs are developed in collaboration with the Department and the Island Peer Review Organization (IPRO). In conjunction with IPRO and the Department, Aetna's QM team evaluates our PIP interventions and activities across all departments. Objectives of these collaborations include continuously monitoring and analyzing the effectiveness of interventions and outreach and researching the latest clinical guidelines and developing new ways to educate and assist our enrollee population. In addition, Aetna has regularly scheduled conference calls with the Department and IPRO to discuss selected health outcome measures, as appropriate.

An update on the progress of each PIP is reported quarterly. Annually, a performance improvement project report for each selected PIP is completed by the health plan and submitted by September 1 to the Department and IPRO for review and further recommendations.

g.i. Lessons Learned, Challenges, and Successes

Our QM team has several long-standing staff that have worked for Aetna in collaboration with the Department and IPRO since the first PIP proposals. Challenges have arisen and Aetna worked closely with IPRO and the Department while trying to improve upon understanding of the PIP sections and template changes, creating more aggressive and active enrollee- and provider-centered interventions while

ensuring the sustainability of these improvements after the PIP has been completed. Although during the first year that PIPs were scored, Aetna was put on a corrective action plan (CAP), the QM team has since taken the CAP as an opportunity for improvement and continued to work closely with IPRO and the Department to correct any issues. Aetna can now proudly say we have not received a CAP on a single PIP in the several years since, and our final scores continue to improve year after year. We gain most of our understanding of lessons learned, challenges, and successes through PIP planning session, from provider and enrollee feedback, as well as from open discussions through collaborative meetings between Care Management and Quality Management staff.

Table C.9-13 describes examples of past PIPs, including follow-up care for children prescribed ADHD medication, antipsychotics for children and adolescents, and diabetes.

Table C.9-13: Examples of Past PIP Topics

PIP Topic	Description	Successes
Follow-up Care for Children Prescribed ADHD Medication (PIP 2015 to 2017 and Continued as Focus Study)	Aetna submitted the final PIP report in 2017 and continued this topic as a focused study. We did the following: • Reviewed/improved health plan HEDIS reporting systems • Provided onsite trainings by HEDIS nurses to provider offices that were found to be high-volume/low-performance in regions that were struggling • Involved care management • Increased the focus on including behavioral health specialists and collaborating with VBP provider group partnerships and providing them gaps in care reports • Created tip sheets and score cards We have improved our processes in quickly identifying enrollees for direct outreach to provide resources and education. Our Prevention and Wellness and Outreach teams continue to be involved in the community and schools to help educate and improve the understanding of ADHD medications. There has been increased collaboration between departments as well as biweekly outreach to enrollees that were newly prescribed ADHD medications. There has been continued work with provider groups as well as onsite education and community involvement.	The changes made throughout the PIP were sustainable and impactful and that these efforts helped us to achieve the 90th HEDIS percentile for the Initiation Phase of the ADD measure and the 75th percentile benchmark for the Continuation and Maintenance Phase in the year after the PIP was completed.
Appropriate Use and Management of Antipsychotics for Children and Adolescents (2015 to 2017 and Continued as Focus Study)	Aetna has focused our efforts and interventions on training and educating our own staff, our membership, and our providers in a variety of different forums and manners including onsite trainings and improving our health plans ability to identify at risk enrollees. The Quality Management team works collaboratively with Pharmacy and Care Management to create reports and identify the most at-risk enrollees, especially those in our foster care population. Aetna believes that we have made much progress on this topic, including instituting sustainable plan wide processes to help our enrollees and providers.	Our HEDIS 2019 rates were in either the 50th or 90th NCQA benchmark percentile for the Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) and in the 50th percentile for at least one of the sub-measures for both the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) and Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS measures.

PIP Topic	Description	Successes
Diabetes: Increasing Diabetes Testing and Screenings (2014 to 2016 and Continued as Focus Study)	Aetna has focused our efforts and interventions on the following areas to sustain the positive improvements: • Training and educating our own staff • Outreaching and educating our membership through increased care manager involvement • Sponsoring multiple events • Instituting an enrollee incentive for receiving a compliant DRE • Instituting and expanding our VBP contracts to 8 provider groups and making diabetes priority with both DRE and HbA1c testing indicators being part of the 10 incentive measures	The Increasing Diabetes Testing and Screening PIP concluded in 2017 noting that 4 of the 7 of the CDC measures were in the 50th NCQA benchmark percentile. This PIP was continued as a focused study and in our most recent final rates for 2019 we have reached the 50th percentile in 5 of the 7 measures.

g.ii. Recommended Focus Areas for the First Two Years of the Contract

Aetna recommends 1) substance use disorders and 2) health equity/pre-diabetes in youth as the recommended focus areas for the first two years of the contract as described in **Table C.9-14**

Table C.9-14: Recommended PIP Topics for First Two Years of Contract

PIP Topic	Rationale
Substance Use disorder	Aetna recognizes that substance use disorder (SUD) is a public health concern with increasing use of opioid medications for pain relief as well as an increase in deaths from overdose of these drugs. In Kentucky, drug deaths rank 46th[5]. Aetna works with enrollees and their providers to explore evidence-based alternatives. Enrollees who are experiencing problems with misuse or abuse of these drugs will be assisted to obtain substance use treatment and treatment for the root cause that led to the initial use of the drug.
Health Equity/ Prediabetes in Youth	The intent of this PIP topic would be to create activities and programs targeted to align with detection and interventions for prediabetes in children. The PIP would also focus on the linkage between obesity and diabetes and will include interventions for both conditions. Obesity has many health risks associated with it for adults, teens, and children. This multiplies due to lack of physical activity and poor dietary habits. For the person that is obese, the risks of developing diabetes, high blood pressure, increased fat in their blood, and inflammation of their arteries, veins, and capillaries increases. Prevalence of diabetes indicate a high need for early detection. In the past five years, diabetes prevalence significantly increased in seven states, with the largest increases in Kentucky, Alabama, and West Virginia[6]. Diabetes is the seventh-leading cause of death in Kentucky. Kentucky is fifth in the nation for the diabetes mortality.

g.iii. Monitoring and Ongoing Evaluation

The goal of each PIP selected by Aetna is to achieve demonstrable improvement and to sustain the improvement over time. Each PIP includes performance objectives that are measurable and outcome oriented. If available, national or community standards of care are used; we use reliable proven statistical methodologies in designing and evaluating performance improvement activities taking significant efforts to provide accurate and reliable data. Evaluation and analysis of the data source ensures it is appropriate to answer the study questions and is the most current available. Once the official PIP timeframe has been completed, we continue the project as a focus study to see if the intervention continues to make an impact.

[5] State Health Improvement Plan Committee, "Kentucky State Health Improvement Plan 2017-2022," Cabinet for Health and Family Services, Kentucky Department of Public Health, 12 (2017): accessed May 30, 2019, https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf.

[6] America's Health Rankings, "Annual Report," (2018): accessed June 23, 2019; https://www.americashealthrankings.org/learn/reports/2018-annual-report.

h. Collaboration with Department of Public Health

Aetna has been successfully collaborating with the Department of Public Health on programs to support improvement in public health outcomes as described in **Table C.9-15.**

Table C.9-15: Aetna Collaborations with the Department of Public Health

Program Name	Description
Women, Infants, and Children (WIC)	WIC is a program designed to influence lifetime nutrition and health behavior in low-income women who are pregnant or have given birth to an infant six-months-old or younger, and infants and children from birth to five years of age who need nutritional support.
B.R.I.G.H.T. (Barren River Initiative to Get Healthy Together) Coalition	The BRIGHT Coalition is a 10-county alliance working together for the health, economic, and education wellbeing of the Barren River Area Development District. Aetna currently participates in workgroups dealing with substance abuse issues in the district and assisting in completing the 2019-2021 Community Health Improvement Plan.
Hepatitis-A Intervention	Aetna provided a foundation grant to Louisville Department of Public Health at height of hepatitis-A outbreak to assist in the purchase of the vaccine which helped mitigate the epidemic.
HANDS Program/Community Baby Showers	In partnership with the Health Access Nurturing Development Services (HANDS) program, Aetna offered enrollee appreciation baby showers during open enrollment. Events were held at family health centers, health departments, cooperative extension offices, and neighborhood locations. HANDS offers education to new mothers on breastfeeding and caring for themselves while caring for their baby. Almost 30 baby showers were held throughout the Commonwealth in 2018 and 2019.
First Steps	Aetna Care Management staff educate members about First Steps and refer them to the appropriate point-of-entry. First Steps provides needed services and supports to families and children with developmental disabilities during their first three years of life. Parents and caregivers are educated on how to help their children with special needs develop to their full potential and may decrease the need for additional help later in life.
Services for Children at School	These services are for children from three to 21 years of age, who are eligible under the Individuals with Disabilities Education Act and have an Individualized Education Program. These services include speech therapy, occupational therapy, physical therapy, and behavioral health services.
Community Health Worker Program	Aetna's QM staff is engaged as members of the Kentucky Department of Public Health Community Health Worker Advisory Workgroup and the Kentucky Association of Community Health Workers (KYACHW). This link plays a key role in improving the health of our communities and, for that reason, KYACHW has been a major influence in the advancement of the profession in Kentucky and has provided input into the development of Kentucky CHW certification process and manual, which went live on October 1, 2019. Aetna's QM staff serve on the CHW Certification Sub-Committee of KYACHW and attend the quarterly meetings.
Diabetes Prevention Program	Aetna is involved with the Kentucky Diabetes Prevention Program (DPP) workgroup and Kentucky DPP Coverage State Engagement Meeting, which is designed to improve access to diabetes prevention education throughout the Commonwealth.

In alignment with the Kentucky State Health Improvement Plan 2017 to 2022, we intend on collaborating to support improvement of the public health outcomes identified as priorities in the plan and described in **Table C.9-16:**

- Substance use disorder
- Smoking (lung cancer)
- Obesity (diabetes and cardiovascular disease)
- Adverse Childhood Experiences (ACEs)
- Integration to health access

Table C.9-16: Priority Areas and Aetna Initiatives and Rationale

Initiative	Rationale	Aetna's Role
Substance use disorder		
Prevention Goal 2: Decrease non-medical use of pain relievers in Kentucky. **Strategy 2.2: Enhance education of health care professionals on appropriate opioid prescribing.** **Treatment Goal 6: Increase the availability of evidence-based treatment for SUD. Strategy 6.1: Encourage the expansion of Medicaid coverage to include methadone therapy as a covered service.**	Kentucky ranked 49th in drug deaths in 2017. That is 25.5 deaths per 100,000 as a result of drug use. It was one of the first states in which the disease reached epidemic proportions. Northern and eastern Kentucky, especially the rural areas have been most plagued. In 2016, Kentucky had over 1,400 overdose deaths8. Addressing this is a top issue across all levels of the Commonwealth's infrastructure. The Substance Use Disorder Workgroup developed a three-pronged approach to assess goals and strategies necessary to ending this crisis: prevention, harm reduction, and treatment. We see opportunities to collaborate to meet goals created in each of these areas.	Aetna has incorporated requirements for the education of health care professionals on appropriate opioid prescribing in provider contracts. It is to be included at onboarding and periodically thereafter. We are reviewing the potential expansion of the number of methadone clinics and treatment visits in our network to increase the number of patients served in methadone clinics. In addition, and in alignment with Strategy 6.2, we encourage the use of paraprofessional providers in the treatment of substance use disorders. Paramedicine technicians, peer support specialists, and community health workers are often included as part of our care teams. Medically assisted treatment (Strategy 6.3) is another area where partnering will be beneficial to increase the percentage of medication-assisted treatment clinics.
Smoking (lung cancer)		
Goal 2: Reduce adult smoking, measure 2.1.4 **Goal 5: Reduce lung cancer mortality among Kentucky residents, strategy 5.1 to increase the number and quality of lung cancer screenings of at-risk Kentucky adults.**	Kentucky ranked 49th overall for the percentage of adults who are current smokers (24.5%) in 2016. In addition, 19.5% of mothers smoked during their pregnancy. Cancer accounted for 233.6 deaths per 100,000 people. Among the top five states in the prevalence of current cigarette smoking among adults, Kentucky ranks very high in the prevalence of smoking-related diseases such as cancer and cardiovascular/lung disease[9.]	Aetna will leverage our network to increase the number of mental health hospitals and substance use recovery centers offering tobacco cessation. We will also provide access to the Quit Now Kentucky quitline service to provide counseling and nicotine replacement therapy to smokers who want to quit smoking. Our provider contracts will require education for health care professionals on the increased health insurance coverage of tobacco cessation benefits through webinars, handouts, and media campaigns. We will promote the National Cancer Institute's Population-Based Research Optimizing Screening through Personalized Regiments) and other evidence-based screening protocols identified in partnership with the Kentucky Department of Public Health.

[7] State Health Improvement Plan Committee, "Kentucky State Health Improvement Plan 2017-2022," Cabinet for Health and Family Services, Kentucky Department of Public Health, 12 (2017): accessed May 30, 2019, https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf.
[8] State Health Improvement Plan Committee, "Kentucky State Health Improvement Plan 2017-2022," Cabinet for Health and Family Services, Kentucky Department of Public Health, 24 (2017): accessed May 30, 2019, https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf.
[9] State Health Improvement Plan Committee, "Kentucky State Health Improvement Plan 2017-2022," Cabinet for Health and Family Services, Kentucky Department of Public Health, 28 (2017): accessed May 30, 2019, https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf.

Initiative	Rationale	Aetna's Role
Obesity (diabetes, cardiovascular disease)		
We are fully committed to implementing the Diabetes Prevention and Control Program health initiative designed to reduce new cases of type 2 diabetes and the sickness, disability and death associated with diabetes and its complications.	In 2017, over 34% of adults were obese ranking Kentucky 44th in the United States. Of children aged 10 to 17, 33.5% were overweight or obese, 13% were diagnosed with diabetes, and 29.8% of adults reported physical inactivity[10].	Aetna will promote educational opportunities for enrollees, ensuring our health professionals are educated, conducting surveillance, reports, and evaluation, in addition to quality improvement efforts. Any participant or family member who is diagnosed with diabetes will be referred to the Diabetes Self-Management Program to help them learn how to manage diabetes as part of daily life.
Adverse childhood experiences		
Aetna will partner with the Department of Public Health to promote healthy environments in which children subjected to toxic stress can find relief, feel safe, experience adult support and learn resiliency skills, including improving Kentucky's awareness of ACEs (Goal 1) and Goal 3 to Increase capacity and collaboration with Commonwealth and local partners to address ACEs in Kentucky.	Kentucky ranks 42nd for ACEs scores over 2, which is 26.9% of children aged 1 to 17[11]. A review of chronic conditions and health risk behaviors in relation to ACEs shows an increase in certain behaviors/chronic conditions for those experiencing four or more ACEs compared to those experiencing no ACEs. Kentuckians experiencing five or more ACEs (compared to those with no ACEs) are as follows: • Almost five times likely to have depression • Over four times as likely to have poor mental health • Almost four times as likely to be a current smoker • Almost two-and-a-half times more likely to have asthma	Aetna will collaborative to develop and execute a promotional plan that includes messaging through multiple platforms, including our own provider networks. We will also ensure the networks receive training and technical assistance necessary to understand and address ACEs, family support, and resiliency. We will participate in the Partnership for a Resilient Kentucky task force dedicated to addressing ACEs and promoting healthy families with strong resilience skills.

[10] State Health Improvement Plan Committee, "Kentucky State Health Improvement Plan 2017-2022," Cabinet for Health and Family Services, Kentucky Department of Public Health, 12 (2017): accessed May 30, 2019, https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf.

[11] State Health Improvement Plan Committee, "Kentucky State Health Improvement Plan 2017-2022," Cabinet for Health and Family Services, Kentucky Department of Public Health, 12 (2017): accessed May 30, 2019, https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf.

Initiative	Rationale	Aetna's Role
Integration to health access		
We are fully committed to doing our part to reach Goal 1: Improve health literacy by simplifying and standardizing health insurance.	The Commonwealth ranks last (50th) in preventable hospitalizations with 76.8 discharges per 1,000 Medicare enrollees. It is 47th in premature deaths with 10,042 years lost per 100,000, and 40th for PCPs with 120.6 per 100,000[12]. There are knowledge gaps in what is covered with insurance, how to find a medical home, and how to navigate within the health care system.	Aetna will coordinate with Commonwealth agencies to reduce health insurance complexity by making health plans simpler and more understandable for individuals to make informed decisions. We will continue to develop clearer language to explain health plans for Medicaid enrollees to further this goal. We will provide outreach and enrollment assistance to support education of Medicaid enrollees about how health coverage works so they can maximize the benefits in their plans. We will increase the number of health agencies within our network that receive training on virtual health services, so that more people can access them. This includes adopting and expanding telemedicine technologies, especially for people living in rural and other underserved communities. We will maximize the Kentucky Health Information Exchange participation among our provider network. Shared information is vital when making quality care decisions.

Impact in Addressing Quality Care and Outcomes for Medicaid Enrollees

In partnering with the Kentucky Department of Public Health, we can make the greatest impact by focusing on achieving the same goals for quality care and outcomes for Medicaid enrollees. The Commonwealth has already done the work of bringing together multiple levels of stakeholders and gleaned data to identify priority health concerns that need to be addressed. The State Health Improvement Plan 2017 to 2022 dictates goals, strategies, and measurements that we are capable and ready to implement. The impact of addressing the defined priorities together is far greater than moving toward individual goals. Accomplishing the outlined activities will result in reduced deaths due to substance use, smoking, and obesity. Children will have fewer ACEs and learn how to cope with them as they move toward healthy adult lifestyles. All Kentuckians will have access to quality health care. We are grateful for the multitude of opportunities to partner with the Kentucky Department of Public Health and look forward to creating the greatest impact possible.

i. Monitoring and Evaluating Progress in Improving Quality of Health Care

Aetna's quality management program is designed to continuously monitor, evaluate, and improve the medical care, enrollee safety, behavioral health services, and the delivery of services to enrollees, including ongoing assessment of program standards to determine the quality, accessibility, and appropriateness of care, care management, coordination, and enrollee health outcomes. When developing an initiative, we always take into consideration long-term sustainability of the project and utilize a Plan, Do, Study, Act (PDSA) approach as demonstrated in **Figure C.9-6**.

[12] State Health Improvement Plan Committee, "Kentucky State Health Improvement Plan 2017-2022," Cabinet for Health and Family Services, Kentucky Department of Public Health, 12 (2017): accessed May 30, 2019, https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf.

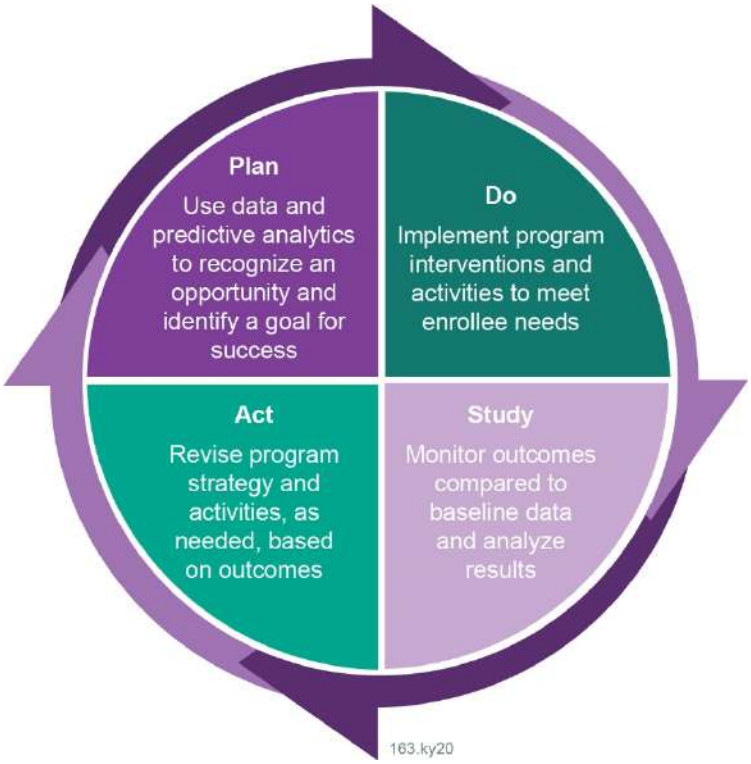

Figure C.9-6: Plan, Do, Study, Act Approach
Aetna uses a PDSA approach to monitor the success of our programs for improving health care quality and enrollee outcomes and adjust them as needed.

i.i. Using Data to Inform and Prioritize Initiatives to Address Enrollee Needs

Aetna uses data and predictive analytics to inform and prioritize initiatives for enrollee needs. We integrate a range of data sources, systems, care sites, and domains to identify enrollee populations and subpopulations, understand their care needs, and operate programs designed to meet those needs. Enrollment data is integrated with medical, pharmacy, utilization reports, provider profiling, and lab claims. Together, these data sources, as well as survey and SDOH information, make up the key data elements necessary to identify enrollee risks and pinpoint subpopulations and opportunities to improve services. We identify areas of low performance and prioritize areas for continuous quality improvement through our QAPI committee structure, using national benchmarks (e.g., NCQA HEDIS percentiles). Through the inter-departmental participation, we can examine the need for initiatives against available resources. Initiatives with high clinical impact take precedence over those for administrative simplification. We maintain the integrity, accuracy, and consistency in all data reported, and we conduct ongoing validation audits. We are a collaborative partner with the Department, providers, and community resources across the Commonwealth to maintain a constant, up-to-date understanding of local health priorities and enrollee needs.

i.ii. Methods for Measuring Provider Performance against Practice Guidelines and Standards

Aetna is committed to supporting providers in the adoption of clinical practice guidelines (CPGs) to measure, evaluate, and start best-practice interventions to provide the best care possible to our enrollees. We use national policies and processes for adopting and updating CPGs and preventive health guidelines from nationally recognized sources and in compliance with 42 CFR 438.236 and NCQA standards. We collaborate with the Department, other Kentucky MCOs, and providers to select physical, behavioral, and preventive CPGs to be used across the system to decrease provider administrative burden. Our quality management director brings all guidelines to our QM/UM Committee for review, input, and adoption. Modifications to the guidelines are made by consensus with each CPG being formally approved by our QMOC.

We support widespread dissemination of CPGs to our **providers** through the website, web portal, provider manual, onsite visits, trainings, newsletter, and fax blasts. Providers receive a customized orientation within 30 days of the provider's effective date with the plan with ongoing training on best

practices and CPGs ongoing. Our CPGs are available to our **enrollees** at any time through our website; we regularly analyze the web traffic data to make certain they are beings accessed. We recognize CPGs are written in academic, scientific language that may not be easily understood. We take the key messages out of the CPG (e.g., screening schedules, symptoms, and treatment options) and push them out through our mobile app, handbook, newsletter, on pharmacy bag tags and through texts. We have staff available to provide explanation to the enrollee in a culturally and linguistically appropriate manner.

We select nationally recognized CPGs based on scientific evidence, national standards, and expert consensus. We encourage provider and enrollee participation in the selection and adoption of the CPGs through our QM/UM and QMOC committees, as well as through our regular regional JOCs. If we do not have a corresponding specialist to the topic within our network, we obtain the opinion of an expert out of network. We make modifications to the guidelines to incorporate input from providers and enrollees as approved through QM/UM and QMOC.

We research annually and ongoing for changes to CPGs to ensure consistency with current medical practice standards. When a revision is needed, we work with the Department, the MCOs, and providers across all regions to review, approve, and adopt the CPG. All CPGs are approved by our QM/UM and QMOC committees no less than every two years or as often as new information is available.

Follow-up with Providers Based on Ongoing Review of Performance Against CPGs:
We check adherence to CPGs through corresponding clinical indicators and performance measures to examine enrollee behavior and provider habits for acute and chronic conditions, and all preventive care measures. Annually our providers are measured against these standards during the medical record review including evidence that preventive screenings and services are offered according to our guidelines. This includes measures such as HbA1c, mammograms, immunizations, and low-density lipoprotein (LDL) among others. For the past two years, our review demonstrates that our providers are following the recommended guidelines and were 99 percent compliant during the 2018 review and 95 percent compliant in 2019. Our QM provider liaison, under the direction of the CMO, follows up directly with poor performing providers with education and technical assistance. We review all measures and trends through our QAPI program committee structure, including appeals and grievances. Through our VBP program, we offer multiple VBP arrangement models for providers to earn financial incentives as well as non-financial incentives for adherence.

i.iii. Approach to Annual Evaluation of Effectiveness of QAPI Program and CQI

Aetna conducts an annual evaluation of the QAPI program to assess the overall effectiveness of our quality improvement program and CQI. The annual program evaluation reflects an assessment of completed and ongoing activities as outlined in the QAPI work plan and described in the QAPI program description. It also addresses barriers from the previous year and identifies barriers encountered during the calendar year evaluated, includes data trends, and provides Aetna with the opportunity to make changes to the quality management program for the upcoming year. The evaluation includes all aspects of the QAPI program to determine the extent and effectiveness of improvements in the quality of care and services.

Using Data to Shape Our QAPI Program

Our Service Improvement Committee was able to capture emerging enrollee needs on topics such as diabetes and nutrition through analysis of data and enrollee and provider feedback, which resulted in the implementation of our Prevention and Wellness program.

Aetna reviews the annual evaluation and uses the findings to establish quality management and performance improvement goals for the upcoming year. Opportunities for improvement identified in the evaluation or articulated by Commonwealth regulators or other key stakeholders drive the development of the goals and objectives. As a result of the annual evaluations, we have made changes and started

initiatives, including establishing our SIC, creating value-based payment arrangements with our providers, creating Microclinics for individuals diagnosed with diabetes, increasing our enrollee-centric philosophies and processes, and focusing on enhancing provider experience and collaboration with behavioral health. The Quality Management department is responsible for preparing the annual evaluation and submitting it for review and approval to the QM/UM Committee, QMOC, and the board of directors.

j. Collaboration with the Department in Developing a Value-based Payment Program

Aetna is committed to working with the Department and other vendors in developing and implementing a VBP program that aligns incentives for enrollees, providers, the MCOs, and the Commonwealth to achieve the goals for improvement in quality and health care outcomes. We have demonstrated success in working with 16 states on VBP Medicaid models since 2012, including Kentucky, Arizona, California, Illinois, Kansas, Louisiana, Maryland, Michigan, Ohio, Pennsylvania, Texas, Virginia, Florida, New Jersey, New York, and West Virginia.

j.i. Lessons Learned and Examples of Effective Models

Aetna has experience with established VBP programs across the nation, including our work within Kentucky with our providers. The overarching lesson we have learned through these experiences is that VBP programs need to set **reasonable and attainable performance targets**, including measures of access, outcomes, quality of care, and savings. VBP arrangements must be data-driven, based upon improvement opportunities via an analysis of claims, quality outcomes, SDOH, public health, and disparities data for each provider and model type. We identify providers for potential VBP arrangements based upon their historical quality and cost performance, provider payment volume, enrollment panel size, region, and their unique value of services they provide to our enrollees. A successful VBP program **engages providers across the care and geographical spectrum**, including those in rural areas, with processes to assure equity in VBP programming.

Our provider VBP experience informs our approach to collaborating with the Commonwealth and other vendors on the VBP program described in the model contract. **Collaboration and partnership with providers are key** for their buy-in and participation. Simple, straightforward contract language allows for setting clear standards and expectations as well as a basis for ongoing, regular communication and education through formats like the quality strategy sessions through our JOCs and the QM/UM Committee. To be successful, providers need to have **meaningful, timely reporting** aligning to the goals of the VBP program.

Specifically, through our VBP work within Kentucky, we have learned that we need to **support behavioral health providers** to adopt VBP arrangements. Since our membership is transient and can move between MCOs, **membership attribution** must also be taken into consideration in development of a model. Finally, we have learned that a successful model requires **local staffing** to be successful including community health workers and population health staff to support both the providers to participate as well as the enrollees in addressing their own health needs.

Examples of Effective VBP Models in Other States

Examples of models that have been most effective at improving performance and outcomes include the arrangements in Arizona, Illinois, and Louisiana as described in this section.

Arizona

The Arizona Health Care Cost Containment System (AHCCCS) incentive plan is based on a 1 percent capitation withhold for all MCOs. The MCOs can earn back more than their individual 1 percent withhold, but the total funds distributed across the MCOs does not exceed the one percent withhold across the MCOs. Performance is based on six quality management performance measures only with no

operational metrics. These measures are a subset of the measures the MCOs report and are chosen by AHCCCS. The measurement period is the state fiscal year (October to September). The measures, as well as the source and weighting for each, are as follows:

- Plan All-cause 30-day Readmissions (CMS adult core): 25 percent
- Ambulatory Care ED Utilization (HEDIS): 25 percent
- Well Child Visits 15 Months (CMS child core): 12.5 percent
- Well Child Visits 3 to 6 Years (CMS child core): 12.5 percent
- Adolescent Well-Child Visits 12 to 21 Years (CMS child core): 12.5 percent
- Children's Dental Visits Ages 2 to 21 (HEDIS): 12.5 percent

In order to be eligible for the incentive, the MCO must meet the minimum percentage of spend in value-based purchasing agreements threshold specified by AHCCCS for each performance year. The current year contract year ending (CYE) 2019 threshold is 50 percent and it will rise to 60 percent in CYE 2020. AHCCCS determines each MCO's incentive opportunity for each measure individually by calculating each MCOs performance results compared to the AHCCCS minimum performance standard for each measure as well as how the MCO performs relative to other MCOs.

Between October 2015 to September 2016, Aetna achieved the following results:

- Received 83.0 percent of the 1 percent quality contribution
- Overperformed on the following measures:
  - Well Child Visits 15 Months (136 percent of possible dollars)
  - Well Child Visits 3-6 Years (115 percent of possible dollars)
  - Adolescent Well Child Visits (132 percent of possible dollars)

Illinois

The State of Illinois deploys a quality withhold program with a percentage of the premium withhold each operational year from the MCOs. The quality withhold program is co-managed by CMS and the state regulator with select performance measures per each regulator for a total number of nine. Historically dating back to measurement year (MY) 2016, the plan continually earned 75 percent of the withhold and the same projections are applicable for HEDIS 2019. The quartile of earn back is based on the rate of P4P measures that met goal. The performance measures included in this program are split up into two groups: CMS core measures and state of Illinois selected measures as described in **Table C.9-17.** The upside to the CMS core measures is that CMS allows for a year-over-year 10 percent improvement gap closure, which means that in the event the plan does not meet the benchmark but demonstrates a 10 percent improvement in performance compared to year prior. CMS considers this an attained goal and counts the measure towards the goals attained rate that drives the earn back. The breakdown of the measures that are considered in the Illinois quality withhold program include various data sources for these measures: CAPHS, HEDIS, potentially preventable events (PPE), and plan reported/submission rates

Table C.9-17: Examples of Illinois VBP Performance

Measure	2016	2017	Benchmark
CMS Core Measures			
Plan All-Cause Readmissions (PCR)	0.93	0.75	<1.0 observed to expected (O/E) ratio
Controlling High Blood Pressure (CBP)	54.0%	61.1%	53%
Medication Adherence for Diabetes	79.3%	79.5%	73%
Encounter Data	97.0%	91.0%	80%

Measure	2016	2017	Benchmark
IL State-specific Measures			
Care for Older Adults-Advance Care Plan (COA-ACP)	15.00%	47.00%	25.00%
COA-Medication Review (MR)	32.00%	70.00%	59.00%
COA-Functional Status Assessment (FSA)	58.00%	70.00%	50.00%
COA-Pain Assessment (PA)	60.00%	74.00%	57.00%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)—Initiation	55.00%	56.00%	52.00%
IET Engagement	9.00%	13.00%	12.00%

Louisiana

In 2018, the Louisiana MCOs were required to provide baseline information on the percentage of provider claim payments tied to value based purchasing programs for the time period of calendar year (CY) 2017. All MCOs were required to improve the percentage of provider claim payments by 10 percent during the period of July 1, 2018 to June 30th of 2019. The MCOs were also required to submit a strategic plan to the state on how we would accomplish that 10 percent increase in which there was a premium withhold that was released once the strategic plan was approved by the state. Aetna is required to submit intermediate reports on the status of meeting our strategic plan goals. Through VBP arrangements, we demonstrated results on improving readmission rate and ED visits per 1,000 enrollees as highlighted in **Table C.9-18**. The providers identified below have achieved year-over-year better care success through participation in our shared savings program in reducing PPEs for utilization measures.

Table C.9-18: Louisiana Admissions, Readmission Rates, and ED Visits for Shared Saving Providers 2015-2018

	Admits/1,000			Readmission Percent			ED Visits/1,000		
Provider	2015	2018	% Change	2015	2018	% Change	2015	2018	% Change
St. Thomas Community Health Center	46.1	16.2	-64.8%	27.3%	20.0%	-26.7%	193.5	79.4	-59.0%
Provider HealthLink	31.6	15.7	-50.3%	50%	12.9%	-74.2%	120.3	92.0	-23.5%
Access Health	23.3	14.0	-39.9%	15.5%	12.2%	-21.1%	100.8	79.0	-21.7%

Improvements in HEDIS measures from 2017 to 2018 show the impact VBP provider incentives, collaboration with our population health specialists, and reporting have had resulting in improved quality performance for better health as illustrated within the Reddy Family Medical practice, as shown in **Table C.9-19.**

Table C.9-19: Reddy Family Medical Clinic Performance

Measure Name	2017 Rate	HEDIS Target	2018 Rate	HEDIS Target
Adult BMI	85.00%	84.54%	100%	86.24%
Adolescent Well Care	0.00%	48.41%	40.00%	50.12%
Cervical Cancer Screening	41.00%	55.94%	64.00%	58.48%
Diabetes Care A1c Testing	87.00%	87.83%	100%	87.10%
Diabetes Care Neuropathy Monitoring	93.00%	90.51%	90.00%	90.27%

Finally, Aetna's value-based providers have had success with lowering the total cost of care for their population. For example, in 2017, our Louisiana provider partners in shared savings VBP arrangements, representing 15 percent of the total plan's enrollment, had an overall 33 percent lower per member per month (PMPM) cost of care than the overall health plan's enrollment. These same provider partners' high-risk enrollees, representing 22 percent of the total plan's high-risk enrollees, had a 12 percent lower PMPM cost of care than the overall health plan's high-risk enrollees.

j.ii. Goals and Focus Areas in the First Two Years of Implementation of the VBP Program

Aetna recommends the Kentucky VBP program contain the following components in the first two years of the VBP program to offer the most participation and success:

- The VBP incentive pool should be funded by a one percent withhold of capitation payments from each participating MCO in the Commonwealth
- In order to earn any of the withhold back, an MCO must be at a minimum of 30 percent of their total medical spend within their provider incentive plans: provider VBP programs must include a combination of physical health, behavioral health, and/or rural health providers
- Participating MCOs may earn less or more than their share of the one percent withhold based upon performance in comparison to the other MCOs
- The timeframe of July 1, 2020 to December 31, 2020 should be the HEDIS measurement baseline to allow for any fluctuations in enrollee assignment that might occur due to RFP award (including foster care membership moving to one MCO), or waiver implementation
- Beginning on January 1, 2021, the withhold could be earned through the achievement of defined HEDIS metrics
- Membership for the plan is currently defined as all membership, including waiver population (assumption is the foster care population will be excluded from this VBP model)
- The 1 percent must be actuarially sound or corresponding adjustments should be made to the capitation rates
- The following should be excluded from the one percent of capitation withhold: kick payments, risk adjustment revenue, pass through payments, and/or health insurer fee
- The MCOs should be allowed a 30-calendar day timeframe to review the VBP results and respond to the Commonwealth
- The Department should execute payment within 60 days after the MCO review period has ended

Aetna recommends not to change the HEDIS metrics more than once every two years to allow for interventions to have their intended impact. The measurement year for the VBP model would include a full calendar year and begins on January 1, 2021 for Year 1. Year 2 would be measurement year January 1, 2021 through December 31, 2021. **Table C.9-20** outlines our recommended goals and focus areas for the first two years of the contract.

Table C.9-20: Recommended Goals and Focus Areas for Kentucky VBP Program

Goals	Focus Areas Year 1	Focus Areas Year 2	Shares Available
Improve HEDIS and CAHPS scores in alignment with plan, NCQA, and Kentucky Health improvement priorities	Year 1 establishes alignment to enrollee needs and Commonwealth health improvement priorities and would measure improvement from the baseline performance period defined above. We recommended HEDIS and CAHPS measures described in **Table C.9-21.**	Year 2 incentives should be based on demonstrated improvement on the proposed measures: • Improvement would be measured at reaching either the 75th percentile or a 3% improvement over year one performance	All 20 measures will be weighted equally. Shares earned would be determined by performance or improvement and an MCO would be eligible to earn more than the withhold by taking the number of shares by MCO, to the total number of shares earned by all MCOs, multiply that percentage by the 1% withhold pool to determine shares earned. Achieving 75th percentile on a measure would earn 1 share. Every 3% improvement on a measure would earn 1 share.

Table C.9-21 outlines the Aetna recommended HEDIS and CAHPS measures to be used for the Kentucky VBP program.

Table C.9-21: Recommended VBP HEDIS and CAHPS Measures

Measure Name	
Effectiveness of Care: Prevention and Screening	
Comprehensive Diabetes Care (CDC)	• HbA1c Control (<8.0%) • Eye Exam (Retinal) Performed • Hemoglobin A1c (HbA1c) Testing
Initiation and Engagement of AOD Dependence Treatment (IET)	Total: Engagement of AOD Treatment: Total
Use of Opioids from Multiple Providers (UOP)	Multiple Prescribers and Multiple Pharmacies
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	BMI Percentile
Follow-Up After Hospitalization for Mental Illness (FUH)	7-Day Follow-Up
Medication Management for People with Asthma (MMA)	Total—Medication Compliance 75%
Pharmacotherapy Management of COPD Exacerbation (PCE)	• Systemic Corticosteroid • Bronchodilator
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Continuation and Maintenance (C&M) Phase
Annual Dental Visit (ADV)	Total
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Received Statin Therapy—Total

Measure Name	
Others: • Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) • Adolescent Well-Care Visits (AWC) • Lead Screening in Children (LSC) • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) • Adult BMI Assessment (ABA)	
CAHPS: Rating of Health Plan	

j.iii. Collaboration with the Department and other MCOs

Aetna commits to providing all necessary staffing for the successful development and implementation of a VBP model in Kentucky, including our executive team members and CMO. Through our experience, we are well-positioned to provide input on design, priorities, and corresponding initiatives to effectively implement the approved model in collaboration with the Department and other MCOs. We will continue our activity with Kentucky Health Collaborative, which includes representation from all MCOs, the Department, key provider groups, and other stakeholders. The focus of this workgroup should be measure alignment for the Medicaid line of business only. Aetna has seen positive outcomes in working on collaborative PIPs which focus on our population's needs and utilize common outcome measures across MCOs. We would encourage a similar approach to the development of a statewide, Medicaid VBP model. Increased collaboration among the MCOs in participating in a quality strategy setting meeting led by the Department would contribute to achieving two goals: 1) focusing on the development of a VBP model; 2) and increased collaborative efforts impacting metrics in that model and outcomes for the enrollees.

j.iv. Potential Challenges and Resolutions

Since beginning our VBP program in Kentucky, Aetna has increased the number of groups involved as well as incentive options for our partners. The original contract goals were tied to the 75th NCQA Quality Compass percentile for the measures included in our VBP reports except for the Plan All Cause Readmission (PCR) rate, which was a two-percentage point reduction from the previous year. Most of the provider groups expressed that the original contract goals were 'out of reach' and it would not be in their best interest to waste resources on unattainable goals that had little impact on their business initiatives and Aetna's outcomes. In response to this feedback, **Aetna's leadership prepared a tiered option in 2017** which incentivized our VBP partners in attaining year over year improvements. Improvement shares were based on tier levels, which included seeing 10 percent improvements over the previous year for a measure, 25 percent improvements, and 50 percent improvements with the full goal staying at attaining the 75th NCQA percentile.

Our VBP partners were much more receptive to this tiered proposal. Since implementation, they have shown increased motivation for additional reporting and collaboration with Aetna. Specifically, they have played more of a key role in promoting PCP involvement in our enrollees' lives by helping to close their care gaps and improve the health of Kentucky's population. **As a result of this tiered approach, our VBP partners' rates have exceeded our plans overall administrative rates in all eight of the HEDIS measures included in the program.**

Any change in membership as a result of the RFP award would have a significant impact on our existing enrollee outcomes. It is important to allow time for a baseline year to establish activities and resources for any new enrollees. Another challenge, in working with the Kentucky Health Collaborative, is that activity focuses on all lines of business rather than just focused on Medicaid. While the health priorities of the Commonwealth are consistent for the total population, the measurement of outcomes is unique to the Medicaid line of business.

Membership attribution is an additional challenge we hear from our provider community. We collaborate to ensure enrollees are assigned to a PCP that is the most convenient and appropriate, but enrollee activity and auto-assignment methodology creates challenges for both the provider and the MCO. The interconnectivity of information technology systems also lends an additional challenge in ensuring consistent and accurate monthly feeds from sources such as Kentucky Health Information Exchange (KHIE) or lab data feeds. Lastly, we have found that behavioral health providers often need additional support to participate in VBP arrangements. The performance of providers in the behavioral health population is not clearly outlined in HEDIS measures alone, so we look to include more operational and strategic metrics such as utilization measures or trauma assessments in these value-based payment arrangements. Aetna has been successful in implementing a behavioral health VBP model with a provider partner and is seeking additional opportunities in this area considering the impact on an enrollee's physical and mental health.

j.v. Approach to Analyzing Performance and Modifying Interventions

In developing VBP arrangements with providers, Aetna fosters a collaborative approach to designing a quality-focused strategy that meets the health care needs of the enrollees served by each provider. Aetna uses multiple data sources to provide real-time information on progress towards our targets on a monthly and quarterly basis. Our systems run VBP and provider profile reporting that is unique to our provider partners on a monthly basis. The designated VBP team within the Quality Management department supports providers to understand and utilize this data by providing tools, resources, and onsite education. The providers are able to trend their data, track gap in care activity, and capture actionable data in improving outcomes. With the roll up of the data from provider reports and HEDIS activity, Aetna proposes semi-annual updates to the Department on VBP activity and outcomes to allow for claims data to process and provide accurate updates on the metrics. Aetna will comply with the format prescribed by the Department to include status, progress, successes, and challenges. We will work with the Department and the other MCOs to use the findings to identify additional opportunities for improvement.

k. Implementation of VBP Arrangements with Providers

Aetna is fully committed to collaboration with the Department and other vendors in developing and implementing a VBP program in Kentucky. The Aetna enterprise has developed over 2,600 VBP arrangements including 350 arrangements with accountable care organizations and over 7.5 million enrollees in various VBP arrangements across all lines of business. Through Aetna Better Value, our Medicaid suite of VBP solutions, our VBP strategy supports delivery system reform and practice transformation. Aetna Better Value currently has over 10,000 individual providers and over 550,000 enrollees across the country participating in multiple Health Care Payment-Learning Action Network (HCP-LAN) alternative payment method (APM) categories. Aetna has been highly successful building on a national record of success in payment reform.

Aetna has an established VBP program in Kentucky, with 38 percent of our provider network, affecting 43 percent of our membership. Our providers with a VBP arrangement include pay-for-quality, patient centered medical homes (PCMHs), and shared savings as described in **Table C.9-22**.

Table C.9-22: Existing Aetna VBP Arrangements in Kentucky

Pay for Quality	PCMH	Shared Savings
• Children's Alliance, Inc.	• Williams, Patricia Mary • Williams, Wayne E. • Carter, Michael W. • Debra R. Bailey MD, FAAP, PSC • Elkton Clinic PSC • Faith Family Practice • Mayfield Pediatric Clinic	• Community Medical Associates • Norton Louisville Primary Care Center • Baptist Health Network Partners, LLC • St. Elizabeth Healthcare • The Physician's Network • Association of Primary Care Physicians • Kentucky Primary Care Association • KentuckyOne Health Partners • Big Sandy Health Care Inc.

k.i. Types of VBP Arrangements

Aetna currently has and will continue to seek out VBP arrangements for both physical health and behavioral health providers. Our current VBP model captures arrangements with FQHCs as well as with PCPs, general practitioners, registered nurses, and pediatricians. Our VBP arrangements are data-driven, based upon improvement opportunities via an analysis of claims, quality outcomes, SDOH, public health, and disparities data for each provider and model type. These VBP arrangements align with the HCP-LAN APM framework with direct linkage to the provider-specific and quality performance measures aligned to Commonwealth goals. Aetna's VBP approach for various provider types includes primary care and specialty care (including behavioral health and hospital-based care) and expands into other treatment venues, such as community mental health centers, FQHCs, rural health clinics, and non-traditional providers. Our unique approach with these providers increases improvement in health outcomes through innovative, whole-person care, and well-coordinated systems of care addressing medical and non-medical drivers of health.

> Aetna was the first MCO to initiate a partnership with the Children's Alliance Independent Provider Association to create and execute a value-based services contract that is designed to incentivize behavioral health care providers to achieve specific outcomes and improve the overall care and well-being of children and families in Kentucky.

To assess a provider's VBP arrangement readiness or move to more advanced APMs, we use the **Aetna Better Value Provider Readiness Survey.** This comprehensive questionnaire helps to determine collaboratively the provider's VBP arrangement path. This proprietary tool leverages extensive research on which capabilities a provider requires to promote VBP success. The tool consists of 20 questions and is the first step in creating a relationship between Aetna and providers to assess their current capabilities. During face-to-face readiness survey completion, this tool promotes dialogue, as opposed to simply completing and returning a survey without interaction. It captures details such as technological capabilities, whether there is a physician champion, care manager involvement, and innovative payment experience. This tool guides providers on their journey to value while prioritizing quality of care.

Types of Planned Arrangements

Aetna plans to use the VBP arrangements described in **Table C.9-23**. These models were selected based on the current and future predicted capabilities of providers in Kentucky. Our goal is not to move providers too quickly, rather, to work with them, give them support, and help them gain confidence to move to the next level of model for success.

Table C.9-23: Types of Arrangements Aetna Plans to Use

Type of Arrangement	Rationale for Selecting Model	HCP-LAN APM Framework maturity level
PCMH Arrangements	Allows practices to get infrastructure funding to support transformation (such as health information technology [and care delivery support) within their practices. NCQA certification is not required.	2A
Incentives for Reporting Z-codes	Allows providers to progress towards payment for reporting, while providing valuable information regarding an enrollee's SDOH status.	2B
PCMH with Quality Incentives	Allows rewarding for performance on specific quality measure targets as well as infrastructure payments to support transformation.	2C
Shared Savings Arrangements	This all upside arrangement allows practices to become familiar with the connection between cost and quality performance and allows for sharing of cost savings after quality targets are met.	3A
Bundled Payments	This is an up and downside arrangement related to bundled payments for services and allows specialists to participate in value-based programming.	3B
Primary Care PCMH with Shared Savings and Losses (Losses will be Capped Initially)	This up and downside arrangement allows PCPs with more capabilities to share in the savings to a greater extent while they are at risk for some losses—after meeting quality targets.	3B
Partial Population Payments for Primary Care	This arrangement begins to introduce population based capitated payments for PCPs for a specific population of enrollees they are treating. This arrangement will be for selected providers who are willing to be partially paid for those specific primary care services.	4A

Example of Aetna VBP Arrangement in Kentucky

Examples of our VBP arrangements in Kentucky is with our provider partner, Addiction Recovery Care (ARC) as described in **Table C.9-24**.

Table C.9-24: ARC Proposed VBP Arrangement

Program Name	Program Description	Proposed Funding Methodology
C.A.R.E.E.R. Path: Care Based Job Skills for Those Pursuing Recovery	ARC's four-phase, self-funded continuum of care has re-framed the dialogue for how the disease of addiction is treated in Kentucky. A truly holistic program, ARC's approach to treatment combines clinical, medical, spiritual, and vocational elements to help create a year-long pathway to stable, long-term recovery, taking people from 'crisis to career.'	• Upon an enrollee' completion of ARC's 60-day soft skills/life skills development program, ARC will be paid a $5,000 payment to support non-care costs associated with the program

Program Name	Program Description	Proposed Funding Methodology
Supporting Pregnant Females in Addiction	Through Karen's Place Maternity Center, ARC has been admitting pregnant females who suffer from substance use disorder for more than two years. This self-funded pilot program has been operated by ARC as a proof of concept investment to demonstrate the value of ARC's unique maternity care program. ARC: • Admits pregnant females with substance use disorder at any time during pregnancy • Maintains residential levels of care throughout pregnancy until 3 months after delivery, despite no reimbursement for this level of care after the first 30 days • Overwhelming success with 88% of babies born with 'normal' delivery and returning home with mother within 5 days • No extended neonatal intensive care unit (NICU) and no complications, resulting in healthier enrollees and healthier babies	• ARC will be paid for residential level of care reimbursement ($230 per day) throughout an enrollee's stay at the ARC maternity center • Currently, ARC receives a declining reimbursement over time via residential, intensive outpatient, traditional outpatient, which results in reimbursement of around $125 per day; this is a net increase of $105 per day for treatment to proactively avoid NICU costs • ARC will be paid a performance incentive for each enrollee completing the maternity center program • These funds will be applied toward non-care related costs for a six-month transitional living home that will be opened especially for maternity care enrollees to further establish the maternal bond, receive family counseling, and support the stability of the mother and child for a strong, healthy future

k.ii. Addressing Improvement in Health Outcomes Through VBP Arrangements

Aetna drives improvements in health outcomes through its VBP arrangements; we collaborate with providers to identify quality metrics that are both meaningful to their enrollee population and Commonwealth goals, and represent benchmarks supported by professionally endorsed entities such as National Quality Forum, NCQA, and CMS. Each strategy within the VBP programming improves quality, with specific quality measures tied to the payment. We recognize the critical importance of aligning incentives for our network providers to what the Department has defined as their overall program goals. We strive to find the right balance between simplicity of collection and meaningfulness of the measures.

Through our robust approach to supporting our VBP providers, led by a designated representative from the Quality Management team, Aetna assists providers in the pursuit of the Triple Aim of achieving better care, better health, and lower costs through shared savings arrangements. Specifically, we assist providers in overall population health management, including providing a minimum of monthly reviews on all performance trends including total cost, quality, and utilization with guidance on actions to achieve targets, and supporting advanced care coordination. Through the provision of standard reports transmitted at least monthly, Aetna supports providers in transforming and improving care delivery with a 360-degree view of the enrollee's health activity. Aetna engages providers with staff from the following departments to further assist the provider in system delivery reform:

- Population Health Management (including Kentucky-based population health specialists and community outreach coordinators)
- Provider Services, Care Management, Quality Management, Network Management, and Claims Management

Quality and outcome measures that Aetna has realized to date and expects to continue from our VBP collaboration with various stakeholders are described in **Table C.9-25**. Overall, our VBP providers have seen improvement from HEDIS 2016 to HEDIS 2019 in all but one measure included in our VBP agreements.

Table C.9-25: HEDIS Measures 2016-2019

Measure Name	HEDIS 2016	HEDIS 2019	Percent Improvement
Adolescent Well-Care Visits (AWC)	38.92%	48.91%	25.67%
Breast Cancer Screening (BCS)	45.92%	47.74%	3.96%
Cervical Cancer Screening (CCS)	51.44%	58.15%	13.04%
Chlamydia Screening in Women (CHL)	50.19%	52.34%	4.28%
Childhood Immunization Status (CIS)—Combo 10	17.69%	28.22%	59.53%
Well-Child Visits in the First 15 Months of Life (W15) 6+ visits	55.66%	60.10%	7.98%
CDC			
Hemoglobin A1c (HbA1c) Testing	85.23%	84.23%	-1.17%
Eye Exam (Retinal) Performed	44.30%	51.89%	17.13%

VBP arrangements will be designed to affect both health plan and the Kentucky Health Improvement Plan priorities. These are sensitive physical and behavioral health conditions affecting the enrollees. Including these in our VBP arrangements will allow for greater impact with activities, interventions, and resources being made available from both the health plan and the provider groups.

k.iii. Methods for Evaluating Effectiveness of VBP, Including Tracking of Costs and Improvement in Health Outcomes

The VBP team works closely with the Finance team to ensure the efficacy of the VBP plan and interventions are not only improving health outcomes but are financially sustainable. We track VBP performance through not only provider profiling, but internal activities such as risk adjustment. This activity is done monthly, and interventions are implemented if there is a negative trend emerging. Specific methods that will be used to determine the effectiveness of the VBP models include the following:

- Review of provider scorecards on quality and cost metrics by the Quality Management and Finance departments
- Trending reports available through our VBP dashboard containing data specific to the provider's identified performance measures (e.g., HEDIS, utilization metrics such as ED visits/1000 and all cause readmission rates). The success of VBP providers is identified via comparison of performance measures to national benchmarks and a tiered milestone approach. Outcome data is reviewed by the quality strategy group within the JOCs as well as the QM/UM Committee to identify best practices and opportunities to further support provider in VBP arrangements.
- Continual feedback between Aetna and VBP providers to guide changes within the VBP program to maximize quality and cost outcomes in the quality strategy meetings within the JOCs

l. Provider Satisfaction Survey

Partnering with providers and enhancing the provider experience is a top priority for Aetna. Aetna conducts an annual Provider Satisfaction Survey through SPH Analytics (SPH), an NCQA-verified survey vendor. Information obtained from these surveys allows Aetna to measure how well we are meeting provider's expectations and needs. The survey allows Aetna to monitor trends, acquire goals, and compare and set benchmarks. We recognize that increasing provider satisfaction has a direct correlation to positively impacting the satisfaction of our enrollees.

Based on the data collected, the report summarizes the results and helps in identifying plan strengths and opportunities. As required, Aetna will submit the survey tool to the Department within 30 days of signing

the contract and annually thereafter prior to any revisions. We provide the Department with all survey results, including the description of the methodology, target population, number and percentage of stakeholders, providers surveyed, response rates, and a sample survey instrument, including the findings and interventions conducted or planned.

Provider Satisfaction Survey Performance over the Last Four Years

SPH followed a two-wave mail and internet with phone follow-up survey methodology to administer the provider satisfaction survey from July to September of 2019. Overall satisfaction improved 9.9 percent over the four years from measurement year 2016 to 2019. For the 2019 survey, 87.5 of those surveyed would recommend Aetna to other providers' offices. **Table C.9-26** shows our results from 2016 to 2019, indicating improvement in six of seven areas. Key indicators measured by the 2019 Provider Satisfaction Survey include the following:

- Overall satisfaction with customer service
- Coordination of care with behavioral health/specialty providers
- Awareness of behavioral health and specialty providers in network
- Comparison to competitors
- Overall experience related to the following:
  - Access to Utilization Management staff
  - Access to case/care managers
  - Timeliness and ease of authorization
  - Claims processing
  - Consistency of reimbursement with contract
  - Formulary

Table C.9-26: Kentucky Provider Satisfaction Survey Trends 2016 to 2019

Area of Survey	2016 Results	2019 Results	Percent Improvement
Overall Satisfaction with Aetna	52.50%	69.90%	33.14%
All Other Plans (Comparative Rating)	23.20%	35.10%	51.29%
Finance Issues	27.00%	27.70%	2.59%
Utilization and Quality Management	26.30%	29.70%	12.93%
Network/Coordination of Care	21.50%	28.10%	30.70%
Health Plan Call Center Service Staff	30.30%	28.10%	-7.26%
Provider Relations	21.90%	23.00%	5.02%

Addressing Dissatisfaction

Provider surveys help us measure and gauge provider satisfaction with our plan and processes and help us discover what is working well and determine where we need to amend our approach. Through this process, we prioritize identified issues, address concerns, implement interventions, and reassess issues to determine change in satisfaction. We review the provider satisfaction survey results and progress in resolving identified issues through our SIC. We create an action plan to develop a strategy for improvement across all the attributes, prioritizing addressing the questions with the lowest scores first. As depicted in **Table C.9-27**, the action plan details the opportunity for improvement, the actions to be taken, the person responsible, dates, and progress. Specific areas of focus to address the 2019 results include interventions related to provider relations, resolution of claims payment problems, and access to knowledgeable UM staff.

Table C.9-27: Action Plan Addressing Dissatisfaction

Opportunity for Improvement	Action Items/Updates	Person(s) Responsible	Start Date	Progress
Finance question: **Resolution of claims payment problems or disputes**	• Plan implemented AP3, a provider partnership program designed to gain feedback from our providers. • Provider scorecard – a dashboard that will trend data and find opportunities for improvement. • Tip Tuesday Campaign – initiated in 2019; provides weekly tips and insight for our providers.	Owner: Chris Bowlin Contributors: Stacey Kleinman Cristy Sheppard	01.01.20 01.01.20 03.01.19	Providers have been identified for this program Tip Tuesday flyer has been created and sent to the providers weekly
Utilization and Quality Management question: **Access to care/case managers from this health plan**	• Tip Tuesday campaign – will highlight the care manager functions within the health plan along with how to reach them.	Owner: Chris Bowlin Contributors: Cristy Sheppard	03.01.19	Ongoing
Network/ Coordination of Care question: **The timeliness of feedback/reports from specialist in this health plan's provider network**	• Educate providers on the need/requirements around coordination of care. • Engaged the CM department to assist with the development of the education. • Integration with KHIE will also increase coordination of care for our providers.	Owner: Chris Bowlin Contributors: Cristy Sheppard	01.01.20 04.01.20 01.01.20	This is part of new provider orientation and onsite provider meetings Fax blast and provider manual updated to promote KHEI
The number of behavioral health clinicians in this health plan's provider network to whom I can refer my patients	• Aetna Better Health of Kentucky has been increasing the network specifically regarding BH clinicians and continually surveys the contracting landscape for new providers. • Network will continue to monitor the provider scorecard to identify areas where new providers are needed. • Telehealth opportunities are also increasing.		Ongoing Ongoing Ongoing	

Opportunity for Improvement	Action Items/Updates	Person(s) Responsible	Start Date	Progress
Health Plan Call Center Service staff question: Ease of reaching health plan call center staff over the phone	• Moved the provider triage line to Claims Information/Claims Research department (CICR), which resulted in more satisfaction by providers. • Continue to monitor the CICR monthly score card to identify top providers calling in to allow for training/education opportunities.	Owner: Chris Bowlin Contributors: Cristy Sheppard CICR Managers	Ongoing Ongoing	Identifying top providers calling in and providing training and education opportunities
Provider Relations question **Quality of provider orientation process**	• Update the provider orientation presentation for 2020. • Quarterly provider newsletters with relevant provider education was initiated in 2019 as well as the Tip Tuesday fax and email campaign. • Offer provider webinars monthly throughout the year. • Implementation of weekly provider satisfaction feedback surveys to allow providers to have immediate feedback. • Develop cross-functional workgroup to improve provider-facing materials.	Owner: Chris Bowlin Contributors: Cristy Sheppard Jennifer Largen	03.01.20 03.01.19 03.01.20 03.01.20 03.01.20	. Receiving positive feedback from providers with the newsletter and Tip Tuesday

Examples of Effective Strategies

As a response to the provider feedback, we moved the provider triage line to the CICR to allow for more staff and monitoring of the line. We monitor the CICR through monthly scorecards to identify top providers calling in to allow for additional training/education opportunities. The metrics from the triage line in **Table C.9-28** show a decrease of 5.7 percent calls over a 10-month period from providers needing to outreach at the higher level. Several webinars have been offered on various training topics (provider portal, changes to copays, and serving medically frail enrollees); the changes in copayments online seminar alone had over 100 providers attend.

Table C.9-28: Aetna Triage Line Calls

Metric	March 2019	June 2019	December 2019
Total Calls Received	8,426	7,172	6,953
Total Calls Answered	8,289	7,088	6,867
Abandoned Rate	1.6%	1.2%	1.2%
Average Speed of Answer	35.6 seconds	24.1 seconds	31.5 seconds
Telephone Service Factor	74.45%	80.17%	74.14%

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60.7.C.10 Utilization Management

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60.7.C.10 Utilization Management (Section 20.0 Utilization Management)

Aetna's utilization management (UM) program coordinates and authorizes whole-person care for our enrollees in the most appropriate setting. We identify, evaluate, manage, and improve clinical care and services. Our unique national experience and local leadership demonstrate our ability to improve enrollees' lives while reducing complexity and administrative burden and serving as responsible stewards of Commonwealth resources. Our UM program goals and objectives improve enrollee health and positively affect unmet health care and social needs. Our local, enrollee-centered approach focuses on individuals' holistic health needs by providing access to and assuring delivery of cost-effective health care services. Aetna acknowledges, understands, and will comply with all the requirements of applicable 42 CFR 456, 431, and 438; KRS 304.17A-600; and **Section 20.0 Utilization Management of the Draft Medicaid Managed Care Contract and Appendices,** as well as the Department's recently revised clinical policies. Aetna's UM activities are coordinated and conducted under the direction of the chief medical officer (CMO). We maintain sufficient staff with clinical expertise and training to apply guidelines effectively. Our UM staffing is compliant with the staffing requirements outlined in **Section 9.2 Administration/Staffing of the Draft Contract** and includes qualified health professionals who live in Kentucky with active Kentucky professional licenses and applicable experience and training. Our integrated UM care teams address the physical and behavioral health needs of enrollees. By creating a multidisciplinary team approach, we can address enrollees' evolving needs seamlessly through these integrated care teams.

As directed by the CMO, physical health (PH) and behavioral health (BH) medical directors provide oversight of Aetna's clinical functions including quality management (QM), UM, care management (CM), and credentialing. The medical directors provide clinical leadership for the Quality Management/Utilization Management (QM/UM) Committee, conduct medical necessity reviews, conduct peer-to-peer reviews, and provide mentoring and clinical leadership for the integrated care management program. The medical directors provide clinical oversight in the development and implementation of ongoing quality improvement initiatives.

a. Identifying and Reducing Inappropriate Utilization of Services

Aetna's UM program helps enrollees get the appropriate care and, whenever possible, avoid the risks associated with overuse, underuse, and misuse of health care interventions. Aetna uses UM processes to advise providers and enrollees of coverage determinations and to provide information on evidence-based care options.

The strategies Aetna implements to identify and reduce inappropriate utilization of services include the following:

- Using a comprehensive suite of authorization and claims-based UM dashboards and reports
- Using the QM/UM Committee to guide identification of trends and direct follow through initiatives
- Employing clinicians to conduct UM activities and engage in clinical rounds
- Engaging providers, enrollees, and community-based organizations to drive appropriate utilization of health care services

Aetna's UM staff identifies both over- and-under-utilization of inpatient and outpatient services, undertakes corrective action, and conducts appropriate follow-up. Aetna's review considers the expected utilization of services regarding the characteristics and health care needs of the enrollee population.

Our QM/UM Committee, which includes network providers, meets quarterly to discuss trends, key performance indicators (KPIs), network gaps, and new clinical guidelines. This committee reviews and approves studies, standards, clinical guidelines, trends in quality and UM measures, outcomes, and results of provider medical record reviews, and satisfaction surveys. The QM/UM Committee receives reports

from each of our health service areas to help us monitor outcomes based on service delivery indicators. In addition to reviewing complaints to determine any unusual quality outcomes or trends that require improvement, we also review KPIs (e.g., Healthcare Effectiveness Data and Information Set [HEDIS]), as well as utilization data (e.g., beds per 1,000, average length of stay, admissions per 1,000, readmissions, and emergency department [ED] visits per 1,000) to determine outcomes that require improvement. This committee makes recommendations related to performance improvement activities using data gleaned from QM monitoring and evaluation that show trends in quality of care issues and updates as appropriate. As previously noted, Aetna's QM/UM Committee tracks and trends UM data and analyzes variances to determine causes. **Figure C.10-1** depicts our UM staffing organization chart.

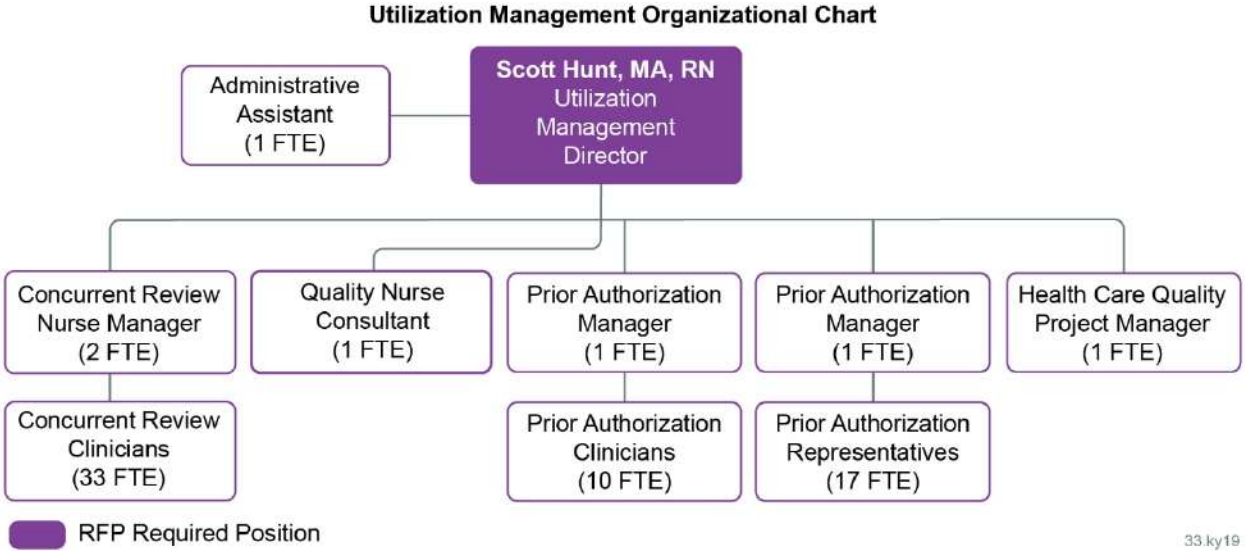

Figure C.10-1: UM Organizational Chart

Our UM program is staffed with qualified health professionals who live in Kentucky with active Kentucky professional licenses and applicable experience and training.

Aetna proactively addresses avoidable inpatient utilization. We evaluate every acute admission for medical necessity in daily concurrent review rounds. We examine the causes of hospitalization, collaborate with our facility-based providers, and identify opportunities for interventions to prevent future readmissions. Discharge planning begins on the first day of admission, and we work aggressively with our providers to help facilitate that all needed services are in place for enrollees before leaving the hospital. These services frequently include durable medical equipment, home care, medications, and scheduled follow-up care with their providers. Aetna conducts weekly interdisciplinary clinical rounds that include our UM team, discharge planners, care managers, and medical directors. In rounds, we do the following:

- Discuss management of complex enrollees, appropriate standards of care, and available resources with the goal of ensuring that enrollees' physical and behavioral health needs are met.
- Seek opportunities for our medical directors to collaborate with providers to identify gaps in care and opportunities to address them proactively. When needed, our team (CMO, medical director(s), health services director/manager, network account manager, and clinical pharmacy advisor) meets onsite with providers to discuss ways to keep our enrollees compliant with their care and to explore alternatives to inpatient admissions.
- Evaluate the medical necessity of each admission using appropriate clinical guidelines.
- Contact the provider to discuss care alternatives (e.g., outpatient/ambulatory care) whenever we identify a potentially avoidable admission.

Aetna uses clinicians (primarily registered nurses and licensed behavioral health clinicians) for UM to support enrollees; daily clinical rounds address both the physical and behavioral needs of enrollees. Clinical inpatient rounds are attended by medical directors, concurrent review nurses, and care management. Interdisciplinary collaboration is imperative to effective discharge planning; this not only results in improved clinical and functional outcomes but also reduces the risk of readmission. Additionally, for inpatient admissions, our discharge planners complete a medication reconciliation to identify potential drug interactions that may occur between medications they receive at discharge and what they were taking before admission. Discharge planners also confirm whether the prescribed drugs are on the formulary/preferred drug list and whether prior authorization (PA) is required. If necessary, we provide a 5-day supply for formulary/non-formulary prescriptions and up to 30-day supply for antibiotics to avoid interruption of the enrollee's treatment at the time of discharge. Aetna continually tracks admissions and readmissions. This data is reported and reviewed by our QM/UM Committee, enabling the UM team to target their activities at facilities and on diagnoses that are outliers.

Emergency Department Use

Medicaid enrollees visit the ED more often than non-Medicaid enrollees do because they often have higher rates of chronic disease and more co-occurring physical and behavioral health disorders. In addition, these enrollees have barriers stemming from social determinants of health. We must help enrollees access the primary and preventive care they need to avoid medical or behavioral health crises that result in avoidable ED usage.

Enrollees who seek non-emergent care in an ED are not receiving the benefit of a medical home and the continuity and familiarity that a primary care provider (PCP) or the appropriate specialist provider can offer. Our goal is to assist enrollees with identifying and removing barriers that prevent them from having a medical home. We use our Integrated Care Management program to address inappropriate ED utilization with enrollees through the following process:

- Care managers access informatics reports that identify enrollees who have utilized ED services.
- Care managers outreach enrollees to educate them on ED use and when it is appropriate to use ED vs. urgent care vs. PCP/specialty provider and give information on the 24-hour Health Information line.
- Care managers identify barriers that prevent enrollees from receiving care in their medical home or outpatient specialist office, such as transportation, work schedules, or social support. Care managers work with enrollees to reduce and/or remove the barriers. If an enrollee agrees, we refer them to the appropriate CM team for ongoing support and assistance with removing barriers if not already enrolled in care management.
- Care managers discuss the enrollee benefits and potential consequences for non-emergency services provided in the ED.
- Care managers identify practice trends that affect enrollees' ability to receive care in a medical home setting.
- For enrollees not reached, the ED care manager sends each enrollee the appropriate letter with information on our 24-hour Health Information line and information on appropriate use of emergency services. The care manager also attempts to outreach the enrollee's medical home to notify them of excessive ED use, and if they received narcotics or other drugs with a potential for overuse in the ED, to notify the provider of the enrollee's health issues and treatments.

a.i. Comprehensive Data Use

Aetna uses multiple data sources to monitor appropriate health care utilization. We use UM reports and dashboards to monitor utilization data to identify trends that fall outside defined parameters and take action to address the trend. When we see these trends, we collaborate with the provider to identify the root cause and develop an intervention to address the trend and then monitor to assess the effect. Specifically, we use UM outcomes data to identify opportunities for CM support as well as readmission reduction and

ED diversion. We make decisions to require PA for certain services based on utilization data that identifies services that are likely to be over-utilized or to trigger the need for collaboration and communication as appropriate for the coordination of the enrollee's care. Our pharmacy director and Prior Authorization team trend volume, types of requests, and determination percentages through daily and monthly reports. We use the data to identify opportunities continually for quality and process improvement and/or to make recommendations related to PA requirements and criteria.

The Aetna Medicaid organization has several initiatives to address readmission. For example, Aetna is working with Our Lady of Peace, a behavioral health facility in Louisville, on an initiative to reduce readmission rates for super-utilizers. An Aetna care manager visits with enrollees face-to-face in an inpatient setting to help enrollees identify their barriers to adhering to their aftercare/discharge plan. For example, the care manager can assist the enrollee with making therapy and medication management appointments, as well as arrange transportation to assist the enrollee in getting to the appointment. Our care manager also meets with enrollees transitioning from the inpatient setting to the Our Lady of Peace intensive outpatient program.

Success Story: Face-to-Face Visit Results in Enrollee's Improved Engagement

In one instance, our dedicated care managers met Anthony (not his real name) during his 11th inpatient behavioral health stay at Our Lady of Peace in 2018. In her conversation with Anthony, the care manager learned Anthony had received a diagnosis of hepatitis-C, which led to him contemplating suicide and prompted his most recent admission. Anthony also shared that he has high blood pressure, high cholesterol, depression, and bipolar disorder. Using active listening and motivational interviewing techniques, his care manager advised him about his benefits and encouraged him to engage in outpatient follow-up and respond to communications from Aetna. Since 2017, Aetna had attempted to reach Anthony by telephone 19 times and sent Unable to Reach letters to follow up with him after each behavioral health discharge. Every attempt was unsuccessful. After meeting his care manager face-to-face, Anthony began engaging and taking an active role in his health care, responding to care manager telephone calls, and reaching out when he has questions or needs assistance. To date, Anthony has not been readmitted.

We maintain close relationships with our providers and assist them to review metrics and develop strategies for improvement Additionally, our provider services representatives meet with providers to address specific data trends in our Joint Operating Committees as well as during onsite provider visits. We provide our value-based payment (VBP) provider partners with regular data, weekly census, and quality metrics. All providers can make data requests as well. We have learned through our experience implementing VBP programs that we need to set reasonable and attainable performance targets including measures of access, outcomes, quality of care, and saving. VBP arrangements must be data-driven, based upon improvement opportunities via an analysis of claims, quality outcomes, social determinants of health (SDOH), public health, and disparities data for each provider and model type.

If an unusual utilization trend is related to enrollee practices, we engage CM to assess if the enrollee has the services and supports in place to meet their PH, BH, and SDOH and help to resolve any barriers. We educate enrollees on appropriate utilizations of ED services and provide tools for effective self-management.

Identifying Potential Fraud and Abuse Referrals

Our data mining is enhanced by Healthcare Fraud Shield (HCFS), a platform that comes equipped with approximately 600 business rules and algorithms maintained and updated quarterly. They are customizable at the health plan level to account for benefit variations and can be applied pre- and post-payment. This platform identifies providers with potential fraud, waste, and abuse behaviors and assigns them a risk score. We use the HCFS application screens to visualize all leads and billing activity as well

as download the past 12 months' worth of claims for each lead. This helps us further avoid inappropriate billing, identifies and mitigates provider confusion, and deters criminal activities, among others. Current HCFS customers report returns from $3 to $10 for every dollar invested. Aetna completed a proof-of-concept analysis of the system in 2018, and based on the results, anticipates even greater increased fraud, waste, and abuse savings, recoveries, and prevented losses.

UM Reports and Dashboards

We have an extensive suite of UM dashboards and reports with near real-time data to monitor appropriate utilization of services and cost-efficiencies. Aetna uses the following data sources:

- **Demographic distribution for ED utilization dashboard:** This dashboard, as depicted in **Figure C.10-2**, allows users to review ED utilization data through a demographic and health equity lens. The dashboard sorts and filters enrollee ED utilization data to identify possible demographic-related disparities related to race, ethnicity, language, geography, or adverse incidents. We map where high ED utilizers reside, which allows us to assess local hospitals, urgent care centers, and providers with after-hours care to divert enrollees to those services when possible. This provides for a region-specific, targeted approach to ED diversion. We use our own care managers and engage **Bluegrass Care Navigators℠** within the community and the facilities with high ED utilization to participate in discharge planning and educate enrollees about these other services available in their local community in lieu of the ED. Additionally, we monitor CM metrics regularly and use data from the ED utilization dashboard to deploy care managers for enrollee outreach during or immediately following an ED visit.

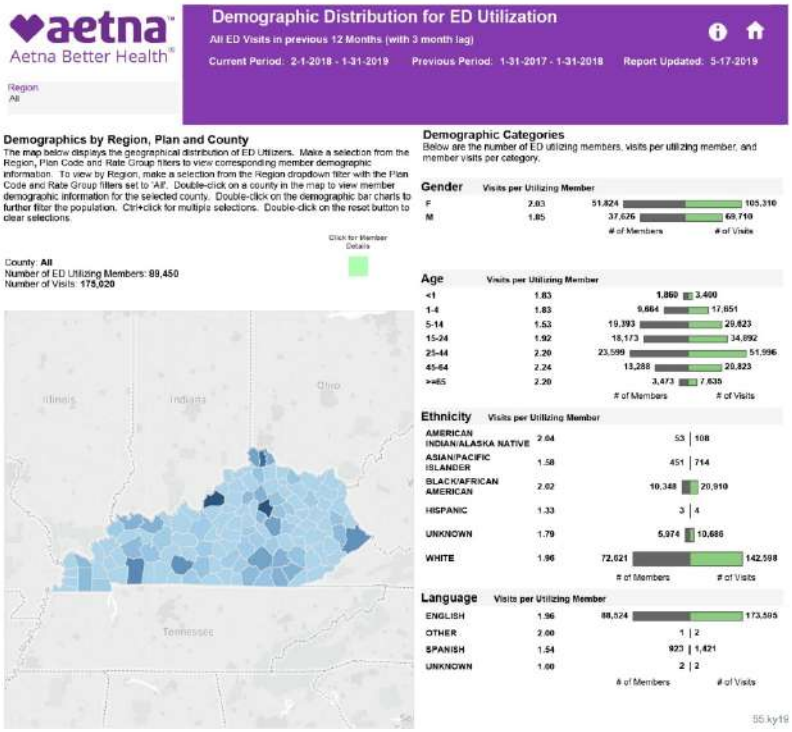

Figure C.10-2: Demographic Distribution for ED Utilization Dashboard

Aetna uses ED utilization data from this dashboard to identify possible demographic-related disparities for a region-specific, targeted approach to ED diversion.

- **UM performance dashboards:** We developed and use a suite of UM dashboards to monitor data reports (please refer to **Figures C.10-2 - C.10-3** for samples of the UM dashboards). We use the UM

performance dashboards to identify high utilizers and engage care managers to outreach the enrollee for immediate intervention, such as dashboards on the following measures:

- Readmissions
- Observations vs. one- to two-day stays
- ED utilization by facility, level billed, and primary system chief complaint
- Neonatal intensive care unit admission patterns
- Medical claims trends
- Outpatient authorization trends
- Inpatient performance to target trends

We work closely with our VBP providers on their areas of focus based on data in the UM dashboards. For example, one of our VBP partners, St. Elizabeth Healthcare, identified utilization concerns. As a result, we are actively collaborating with them around ED and readmission rates. We reviewed their readmission dashboards to determine if admits were for PH or BH conditions. We are working with them to review the data, assess for any root causes, and identify appropriate interventions. We have already seen a trending decrease in both Ambulatory Care: ED visits/1000 (AMBED) and Plan All-Cause Readmissions (PCR) rates. Their AMBED rate was 113.45 in HEDIS 2018 and is 110.65 for HEDIS 2019; their PCR rate was 15.33 percent in HEDIS 2018 and is 10.04 percent for HEDIS 2019.

> "Aetna has been a solid and stable business partner of ours for many years, and we believe will be a good partner for Kentucky. St. Elizabeth has worked closely with Aetna Better Health since the start of the Kentucky managed Medicaid program, and we have come to trust them as a partner in care interested in both the bottom line and the improved health of their members. In the past several years, we have jointly developed new 'pay-for-performance' programs that provide payments that are direct results of the quality care we are providing to our patients. We strongly believe Aetna Better Health's strategy aligns with our mission to improve the health of our patients, and we would encourage you to consider their bid for the Kentucky Medicaid program."
>
> **—William Banks**
> **Vice President, Managed Care**
> **St. Elizabeth Healthcare**

- **Pharmacy data analysis**: We conduct retrospective drug utilization reviews (**RetroDUR**) to detect pharmacy over-utilization. Aetna applies RetroDUR to assess drug over- and under-utilization patterns to drive the development of interventions and/or educational activities. We are developing processes to conduct RetroDUR specifically to address gaps in care for enrollees with diabetes, enrollees with atrial fibrillation on statin drugs, and for enrollees on an antithrombotic agent.

  For example, we utilize our Safety and Monitoring Solutions report generated by our pharmacy benefit manager (PBM) to support identification of enrollees for the **Supportive Managed Care Program (SMCP)**, formerly known as the lock-in program. The program targets high-risk drug classes focusing on controlled substances and inappropriate use and misuse-related indicators such as polypharmacy, provider shopping, and high-total controlled substance claims volume. On a quarterly basis, PBM clinical pharmacists evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention, which can include referral to Aetna for further action. The SMCP Care Coordination team also utilizes the Controlled Substance Polypharmacy/Poly-Prescriber Report, an Aetna-developed tool to identify enrollees who may be over-utilizing pharmacy services. This tool reviews enrollees utilizing 5 to 10 different pharmacies and/or 5 to 10 different prescribers during a quarter.

- **Gaps-in-care reporting** as both an internal and external tool to address under-utilized services. As a health plan, we are evaluating gaps in care daily—every time we interact with an enrollee. This allows us the opportunity to not only encourage needed care such as a screening, well visits, or

follow-up care, but also to assist in getting the enrollee to the visit. Based on the gaps-in-care report and indication of under-utilization, we look at PCP assignment, high ED utilization, and readmission rates to determine if an enrollee needs specific outreach or resources in completing their care. We have been utilizing gaps-in-care reporting since 2015 with our VBP partners and have seen a positive impact on our compliance rates for HEDIS measures such as diabetes, immunization, and screenings as well as decreased ED utilization and readmission rates. We also share gaps-in-care reports with our provider partners and work with them to assess enrollee needs in closing gaps in care. Part of our UM strategy is that our team (CMO, medical director, health services director/manager, network account manager, and clinical pharmacy advisor) meets onsite with providers to discuss ways to encourage enrollees' adherence with their care and to explore alternatives to inpatient admissions.

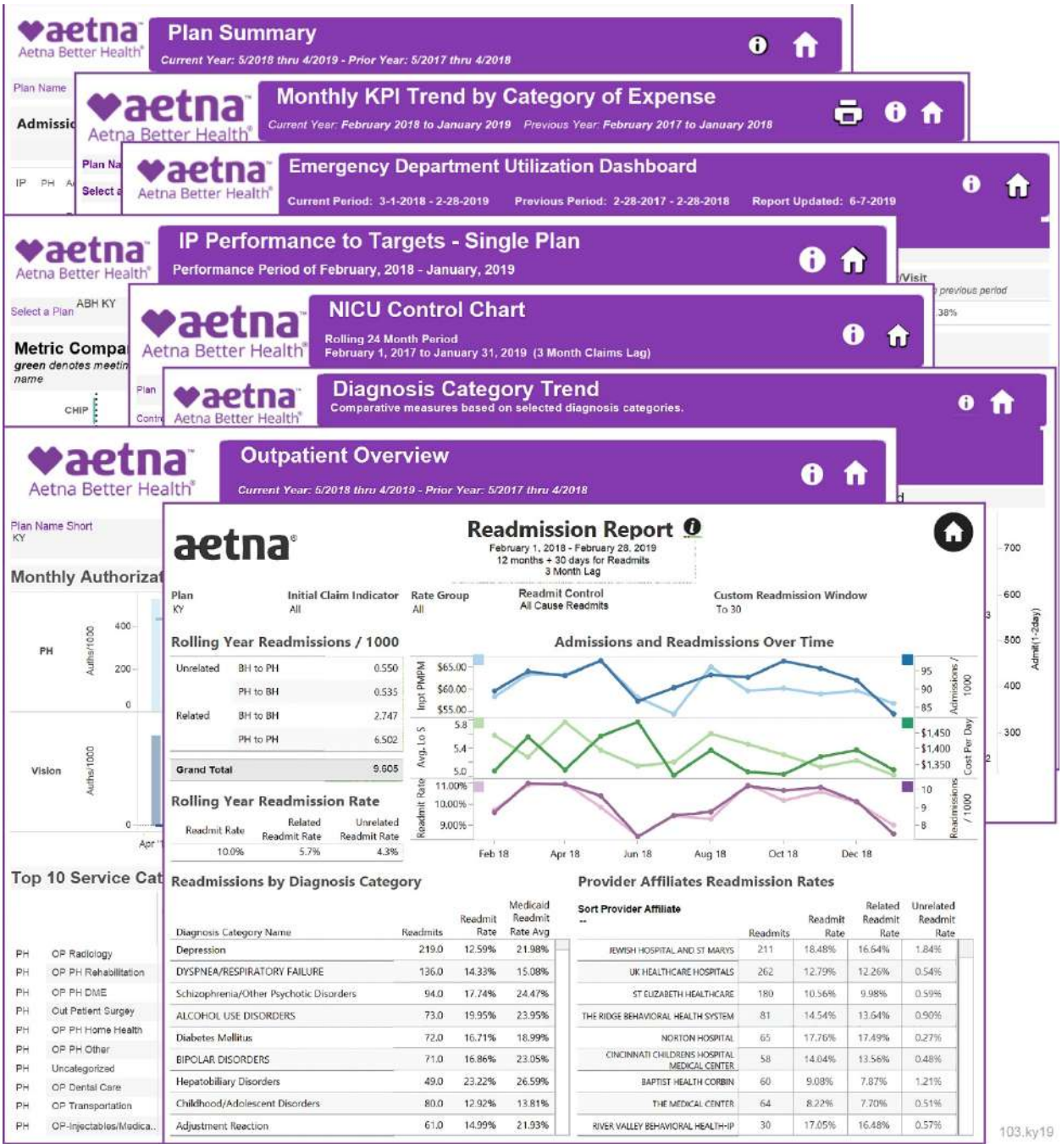

Figure C.10-3: Sample UM Dashboards

Aetna uses near real-time UM dashboards to monitor utilization data to identify opportunities to take timely actions to improve providers' and enrollees' experience.

a.ii. Monitoring Appropriate Health Care Utilization

Aetna's QM, Provider Services, and Special Investigations Unit (SIU) departments work with the UM department to identify, track, and address over-and under-utilization, and to identify solutions within the provider community. The Aetna Medicaid organization maintains processes to monitor for appropriate utilization that transcends down to our local health plan for more intensive evaluation and local initiatives to address concerns of over- and under-utilization. For example, actuaries review categories of expenses

through monthly operating reports and monthly expense reports. At the health plan level, we review the previously described UM reports and dashboards weekly and monthly through our QM/UM Committee to identify trends and implement interventions. SIU specifically reviews the UM reports and dashboards to identify provider patterns for potential fraud, waste, and abuse, and acts as indicated.

Two Examples

Aetna implemented a **Deprescribing Initiative for our proton-pump inhibitors (PPIs)** to minimize the over-utilization, waste, and unintended side effects of long-term usage of PPIs. Short-term prescribing led to long-term use. To achieve a reduction in prescribing practices, we mailed over 5,900 letters to prescribers for educational outreach. Our clinical pharmacist is calling and/or conducting in-person provider (clinician) visits with information and education to assist prescribers and enrollees with clinically appropriate next steps. After a PPI education letter intervention was sent to prescribers of approximately 4900 enrollees, a 7.3 percent decrease in enrollees using PPIs and an additional 26.2 percent decrease in enrollees' days' supply of PPI therapy was observed at six months post-intervention. Additionally, when a clinical pharmacist conducted face-to-face education with the prescribers of 24 enrollees, we saw that 12.5 percent of enrollees discontinued PPIs and another 41.7 percent of enrollees had a decrease in days' supply of PPI therapy within three-to-six months after education by the pharmacist.

Aetna implemented an **Early Elective Deliveries (EED) initiative** to decrease enrollees electing early C-section deliveries over full-term, vaginal deliveries. We implemented UM processes requiring appropriate documentation to support medical necessity for early C-section. Our initiative supports the Department's goals to 1) guide providers and hospitals to sound practice recommendations, 2) reduce morbidity in neonates from birth trauma and fetal immaturity, 3) reduce non-medically necessary deliveries less than 39 weeks gestation, and 4) encourage greater collaborations between hospitals and their physicians in developing quality improvement initiatives aimed at improved birth outcomes in the Commonwealth. Comparison of data from the period of January 2017 – October 2017 to November 2017 – October 2018 demonstrated **a 20 percent reduction in the number of EEDs associated with this intervention**.

a.iii. UM Program Evaluation

The director of clinical health services is responsible for preparing a written annual UM program description and UM annual evaluation of the UM program and submitting it for review and approval to the QM/UM Committee and Quality Management Oversight Committee (QMOC), which includes the CMO and behavioral health medical director. Assessment of completed and ongoing activities and evaluation of data trends over time identify opportunities for changes to the UM program for the coming year. The program description and work plan developed for the subsequent year incorporate recommended changes based on reassessment and goals not achieved.

The annual evaluation process includes reassessment of program structure, scope, processes, and sources used to determine benefit coverage, alignment with Department requirements, covered services, and medical necessity. The Aetna Medicaid organization completes a comprehensive, code-by-code reevaluation of our PA requirements annually, with quarterly and ad hoc reviews based on identified trends. In addition, when new codes are added or retired by the Department, Aetna's local and national UM teams conduct a thorough review to determine potential changes to PA requirements. During our most recent review, we removed more than 500 codes from the PA list. We anticipate removing an additional 400 to 500 codes this year, lessening the administrative burden for our providers.

National Committee for Quality Assurance Annual Analysis of Enrollee and Provider Satisfaction with UM Program

Aetna is a quality leader with a **Commendable** rating from the National Committee for Quality Assurance (NCQA). Additionally, we tied for the top NCQA score overall. As part of our NCQA

accreditation, we engage in an annual survey of enrollee satisfaction with UM processes to examine the effectiveness and administrative ease of our UM processes. Through this process, we prioritize identified issues, address concerns, implement interventions, and reassess issues to determine change in satisfaction.

Enrollee satisfaction survey: **Aetna met and exceeded its goal for the Quality Compass benchmark in all measures for the Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Child CAHPS**. All measures, except for barriers noted which were 'Easy to see a specialist' in the Child CAHPS and 'Easy to get appointment with a specialist' in the adult CAHPS, scored higher when compared to 2017 rates and all measures surpassed the national average. Although the score was in the 50th percentile, our goal is to always strive to exceed our national average.

Provider satisfaction survey: Overall satisfaction improved from 58.8 percent in 2018 to 69.9 percent in 2019, which is an 18.9 percent improvement. We review the provider satisfaction survey results and progress in resolving identified issues in our Service Improvement Committee. We create an action plan to develop a strategy for improvement across all the attributes, prioritizing addressing the questions with the lowest scores and greatest provider and enrollee impact first. Specific areas of focus to address the 2018 results include interventions related to provider relations, resolution of claims payment problems, and access to knowledgeable UM staff.

b. Utilization Management Program Description

Aetna's UM program provides a comprehensive structure designed to identify, evaluate, and improve clinical care and service provided to our enrollees. Our policies and procedures define and guide all work processes and decisions. The program makes sure the care delivered is of the highest quality, appropriate, and medically necessary and that it aligns with clinical best practices. Our UM program links to our Quality Assessment and Performance Improvement (QAPI) program, which promotes continuous monitoring and evaluation of care and services provided to our enrollees. Results and identification of opportunities for improvement contribute to the direction of quality improvement activities.

The scope of our UM activities covers all clinical aspects of preventive, diagnostic, and treatment services in both the inpatient and outpatient settings, which includes PH, BH, and pharmacy management. The UM program incorporates a collaborative approach to our enrollees' care. We recognize that UM and CM programs are interrelated and integrate all physical and behavioral health components, as well as SDOH, to assure enrollees receive consistent access to care and services across the service network, as well as high-quality, cost-effective care promptly.

Aetna will submit the UM program description to the Department for approval within 30 days of signing the contract, annually, and any time when making material revisions.

b.i. UM Program Aligned with the Department's Clinical Coverage Policies

Aetna's approach to aligning with the Department's clinical coverage policies is rooted in our participation in monthly Medicaid operations meetings with the Department to learn of recent changes in covered services and program policies. We incorporate changes to clinical coverage policies in our UM program, in concert with adoption of nationally recognized, evidence-based criteria, which we apply based on the needs of individual enrollees and characteristics of the local delivery system. Our utilization management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. To assure adherence to the Department's clinical coverage policies and compliance to the Commonwealth's definition of medical necessity, as outlined in **Section 1.1 General Definitions of the Draft Medicaid Managed Care Contract and Appendices** and 907 KAR 3:130, we review our existing policies and make updates as appropriate. We review clinical

criteria sets for adoption per award, and then review and update them annually or as applicable when national or community evidence-based clinical criteria guidelines are released or revised. The annual review process involves qualified PH and BH medical directors in developing, adopting, and reviewing criteria. We advise providers that criteria are available upon request, in the notice of adverse benefit determination, provider manual, and provider newsletters. We advise enrollees that criteria are available upon request by contacting Enrollee Services, in the notice of adverse benefit determination, and in the and enrollee handbook.

b.ii. Proposed Evidence-based Decision Support Tool(s)

Clinical UM staff use nationally recognized, evidence-based guidelines to drive consistency in decision-making. Guidelines represent best practices, reflect national standards, support medical necessity determinations, and are applied based on the needs of individual enrollees.

Aetna engaged **Change Healthcare, the organization that develops InterQual criteria**, to provide our UM staff with education regarding InterQual decision support criteria. Through an established collaboration, we continue to meet quarterly to address questions and issues and provide recommendations related to applying clinical criteria.

Aetna uses the following medical review criteria for PH and BH medical necessity decisions consulted in the following order listed:

- Criteria required by the Department or federal regulatory agency
- InterQual guidelines, when available
- American Society of Addiction Medicine (ASAM) criteria for substance use services
- Aetna Medicaid organization pharmacy guidelines
- Level of Care Utilization System (LOCUS)—BH services for adults if no InterQual criteria exist
- Children and Adolescent Service Intensity Instrument (CASII) BH services for children and adolescents or Child and Adolescent Needs Strengths Scale (CANS) if no criteria exist
- Early Childhood Service Intensity Instrument for young children if no InterQual criteria exist
- eviCore criteria for pain management, specified radiology, and cardiology services
- Nationally recognized standards
- Aetna clinical policy bulletins[1]

If InterQual does not address the requested service, we use the next criteria in the hierarchy.

Aetna utilizes Eviti® Connect (a product of NantHealth) to aid in the reviews of oncology treatment plans. Eviti's physicians act as subject matter experts for both radiation and chemotherapy in the treatment of cancer providing decision support to Aetna's medical directors. Eviti uses the most recent research and evidence-based practices to provide a determination on the appropriateness of an enrollee's treatment plan. Eviti engages in peer-to-peer consultation with treating providers to make recommendations related to the enrollee's treatment, as necessary.

Aetna will submit proposed medical necessity criteria not specifically addressed in the listed criteria for approval by the Department. As a current incumbent, we will submit our medical necessity criteria to the Department for review and approval to ensure compliance with this Contract.

Formal medical committees and ad hoc work groups advise and guide the development and adoption of guidelines. Aetna develops clinical criteria policies using peer-reviewed medical literature, technology

[1] Available at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#

assessments, structured evidence reviews, evidence-based consensus statements, expert opinions of health care providers, and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies. Aetna reviews clinical criteria policies annually or more frequently based on knowledge of relevant new medical literature, guidelines, and regulatory action notices. Aetna's **Clinical Policy Council Committee** and external practicing clinicians with expertise in providing the types of services in the clinical criteria policies conduct a comprehensive review process of both new and revised policies.

Aetna's medical directors access the Hayes Knowledge Center and UpToDate® to support clinical decision-making. The Hayes Knowledge Center is a resource that provides unbiased evidence analysis and research on emerging and disruptive health care technologies, including evidence analyses with a focus on emerging technologies that are in the early stages of dissemination; existing technologies that are being used for new applications; and genetic/molecular test assessments. UpToDate is a web-based resource for professionals in medicine, nursing, allied health, and pharmacy designed to support improved patient care and clinician satisfaction.

For example, we identified a gap in the medical necessity criteria that covers pain management for acute inpatient levels of care. This gap in criteria had a potential of altering review outcomes. The medical directors of Aetna worked diligently with the medical directors that govern this specific national evidence-based criterion to correct the gaps within the criteria. The updates to the criteria assured the proper medical necessity review to address the needs of our enrollees.

An additional opportunity presented itself related to UM for BH services. Our BH reviewers as well as our BH medical director identified a lack of criteria for the Child & Adolescence Residential Crisis Stabilization level of service. Once again, medical directors from both Aetna and the medical directors that govern these specific national evidence-based criteria worked to create new criterion that would cover this specific level of care. This criterion assures our enrollees are receiving the proper services and level of care.

InterQual Connect™ Automation

Aetna uses InterQual Connect—a cloud-based medical review and connectivity solution that automates PAs where medical review is required. This integrated, cloud-based solution integrates into our UM program to streamline the medical review process and enable the automation of the PA process. The tool allows for an integrated medical review and connectivity solution for our providers, reducing administrative burden by automating the PA process and eliminating redundant medical reviews. The tool increases payer/provider collaboration by removing costly barriers, providing quicker authorization approvals, and providing transparency into medical review and authorization criteria.

Clinical Criteria

Our UM staff and providers can access the most current clinical guidance through a cloud-based content platform on InterQual Connect. This cloud-based solution provides affordable access to InterQual criteria through the web. The criteria are delivered in a reference-only format and in a simple, easy-to-use interface via our provider portal. Physicians can simply log into the portal and click the link for InterQual criteria. The criteria subsets appear in an easy-to-navigate screen display. Interactive medical review options also provide access to the criteria while streamlining the medical review process.

InterQual acute level of care criteria provides support for determining the medical appropriateness of hospital admission, continued stay, and discharge. Criteria includes the following:

- Acute adult criteria address the observation, acute, intermediate, and critical levels of care
- Acute pediatric criteria include these levels of care and five additional levels of nursery care (Transitional Care, Newborn Level I, Special Care Level II, Neonatal Intensive Care Level III, and Neonatal Intensive Care Level IV)

Acute level of care criteria includes the following features:

- **Initial review:** Some acute adult subsets include initial review criteria. Initial review criteria are a level of care determination tool intended to be used as real-time decision support in the ED to identify if observation or inpatient hospital level services are warranted. They help our UM reviewers determine whether an enrollee is appropriate for observation or inpatient admission at the time a decision to admit the member is being made. Initial review criteria evaluate only data that is available at the time the decision is being made. This may include previously provided interventions or the results of laboratory, imaging, and other tests.
- **Episode days:** Acute criteria subsets (except the extended stay subsets) comprise multiple episode days. An episode day is a calendar day, which normally begins at 12 a.m. For evening admissions, episode day 1 may represent the admission day and the following hospital day. Within a subset, the number of episode days varies by condition; most address common comorbidities and complicating factors associated with the primary condition. For example, the heart failure subset includes criteria through episode day 8. Each episode day includes only those levels of care that are clinically appropriate; an episode day may not include all levels of care.
- **Responder criteria:** On the appropriate episode days, criteria may include one or more of the following responder-type criteria:
  - **Responder or early responder:** If met, indicate that the enrollee is clinically stable, and that discharge is expected on that day.
  - **Partial responder:** If met, indicate that, for this condition and episode day, the enrollee is clinically appropriate for continued stay at this level of care.
  - **Non-responder:** If met, indicate that the enrollee requires continued stay; however, the episode days or level of care within the current condition-specific subset have been exhausted.
- **Redirection:** In some instances, when an enrollee's condition changes and it is clinically appropriate, the user may be redirected from the current subset to use a more appropriate subset. For example, in the case of heart failure, and if non-responder criteria indicate that the member is not clinically stable for discharge but the episode days or level of care within the current condition-specific subset have been exhausted, then you are directed to conduct a review using the extended stay subset or to refer for secondary review.

b.iii. Innovations and Automation to Reduce Provider Administrative Burden

Aetna recognizes the importance of creating efficient and effective UM processes for providers who request services. Our PA process is fully automated and complies with all federal and Commonwealth requirements.

Aetna uses integrated systems and interdepartmental processes to coordinate services for an enrollee. The UM business application system allows departments to share enrollee and provider information, coordinate procedures such as discharge planning, transition an enrollee from an institutional setting back into the community, authorize post-hospital services, and follow up on complex cases or ED care. Aetna's UM business application system also provides the authorization number and effective dates for authorization to participating providers and as applicable non-participating providers. Aetna's UM business application system stores and reports the time and dates all service authorization requests are received, decisions made regarding the service requests, clinical data to support the decisions, and timeframes for notification of providers and enrollees of decisions.

We understand not all providers are familiar with managed care practices, and employ multiple innovations and automation designed to minimize their administrative burden and enhance provider experience including the following:

- Developing a **Preferred Provider Program** with high-performing providers to reduce PA requirements. We will expect participating providers to meet stringent criteria to participate and

maintain enrollment in the program. Participation in the program will include intensive monitoring to the established criteria.

- Using the Department's standardized PA form to reduce variability and increase consistency, resulting in decreased provider burden
- Supporting authorization submission requests through our standard provider portal
- Conducting a comprehensive annual review of services requiring PA to improve enrollee access to services and reduce provider burden
- Automatically adding the modifier for Early and Periodic Screening, Diagnostic and Treatment claims so the claims do not deny
- Removing the pre-payment, high-dollar claim review
- Supporting an electronic prior authorization (ePA) process for pharmacy authorizations in 2018 in the Commonwealth. ePA allows providers to transmit a PA request electronically and check approval and denial statuses after submission. **Aetna is exceeding the Medicaid Prior Authorization Operations Center goal and providers have expressed satisfaction with the tool**.
- Providing access to an e-prescribing tool through a web link
- Implementing **SMART PA place of service** edits to improve safety of medication use while easing the burden on the prescribing provider using known information and pharmacist actions
- Removing PA requirements for smoking cessation drugs in alignment with the Commonwealth's goal to reduce smoking
- Supporting a dedicated provider services line from 7 a.m. to 7 p.m. on weekdays, except holidays, for assistance
- Providing a toll-free fax line
- Having a provider agreement with an oncology vendor (Eviti) to review requests for appropriate course of care in accordance with evidence-based practices. We make a user friendly-application available to oncology providers to receive immediate feedback regarding chemotherapy and radiation therapy requests for authorization based on National Comprehensive Cancer Network guidelines.

b.iv. Balance Timely Access to Care for Enrollees

Our UM program description and written policies and procedures include processes, guidelines, review criteria, turnaround timeframes, and qualifications of health plan staff involved in UM processes. We complete service authorization requests timely and efficiently in compliance with established NCQA turnaround timeframes and the requirements indicated in 42 CFR and 438.210(d).

For example, Aetna's UM program balances timely access to care for our enrollees through the following:

- Requests for members with a substance use disorder are expedited and determinations are made within 24 hours for any level of care
- Prior authorization requirements for core services such as targeted case management and methadone induction/maintenance have been removed, expediting access to care
- Automatic approval autism testing and neuropsychological testing services
- Utilization of an expedited authorization decision process within 24 hours when an enrollee's ability to attain, maintain, or regain maximum function is in serious jeopardy
- Allowances are given for request submission timeframes for providers of substance use residential, partial hospitalization, and intensive outpatient programs who are unable to submit requests during holidays or weekends
- Having a fully automated system to reduce administrative burden

As part of the service request requirements, requesting providers supply pertinent information such as appropriate medical records. Upon receipt, UM staff reviews the request and then applies the hierarchy of appropriate medical necessity guidelines and evaluates the individual enrollee's circumstances. UM staff

first review respective enrollee information in their electronic platforms and may outreach to the requesting provider or care manager to obtain additional information to support the request for services.

Clinicians review the submitted clinical information and align it to the appropriate medical necessity (e.g., InterQual criteria set) before submitting for medical director review. The medical director then reviews the clinical information and determines whether the clinical criteria to support approval of the request has been met. **A board-certified medical director with appropriate clinical expertise is the only staff within UM that has the authority to deny a service authorization request**. Our CMO or delegate is available 24/7/365 for consultations with staff regarding PA, retrospective review, and concurrent review issues. If necessary, our local medical directors consult with other Aetna enterprise medical directors with the appropriate sub-specialty to make informed authorization decisions based on medical necessity. Aetna renders clinical decisions within the timeframes determined by the Department in **Section 20.6 Service Review and Authorization Timeframes** of the **Medicaid Managed Care Contract.**

We comply with the requirement to treat all services authorizations or pre-authorizations for treatment as expedited authorization requests and complete the decision within 24 hours. We provide notices as expeditiously as the enrollee's health condition requires.

Aetna understands the importance of providing services to newborns with immediate medical needs and have developed processes to make sure vulnerable children receive the services they need. Our UM staff proactively identify newborns with urgent needs through initial clinical review and discharge planning to circumvent barriers associated with delayed enrollment. We provide a temporary identification number for newborns within our authorization system based on the mother's coverage, usually within two hours of identification. We supply the Department with the newborn enrollment report that lists newborns so they can add them to the 834-file for enrollment. Our enrollment manager application utilizes proprietary enrollee matching rules to ensure file records (including newborns) are accurately matched to existing records in our system when processing 834-files.

Telehealth: Our virtual health care delivery approach incorporates evidence-based practices to increase timely access to care and to enhance our enrollees' health and focuses on prevention, wellness, early intervention, and comprehensive care. Our expanded delivery approach ensures our enrollees are offered varied options to receive and access the highest quality care from their care team at a time and in a location that best meets their needs, including access to virtual care experiences via telemedicine. We use telemedicine both as an alternative and a complement to traditional face-to-face physician visits for eligible children and adults. Our telehealth and remote patient monitoring programs enable access via real-time interactive communication between the enrollee, their PCP, care team, or other skilled practitioners located in separate locations. While the specific provision of telemedicine is highly regulated by both state and federal Medicaid laws, diagnosis and treatment of illness or injury and services, such as assessment, monitoring, communications, prevention, and education, can be effectively rendered. In markets where the volume of network telehealth providers needs to be strengthened, we will engage and partner with Commonwealth-licensed vendor practitioners. Telemedicine can improve health outcomes and timely access to care while making health care delivery systems more efficient and cost-effective.

b.v. Integrated UM Program

To support integration of PH and BH, **we align our UM staff consisting of registered nurses and BH clinicians into integrated care teams**. We divide our UM non-clinical and clinical teams into seven care teams. These teams will consist of one team lead care team and six care teams to be comprised of PA, concurrent, and BH reviewers as well as non- clinical team members. By creating a multidisciplinary team, we can address enrollees' evolving needs seamlessly through the care teams. We will assign a medical director to each care team, which will enhance the care received. This will create an integrated health care experience for our enrollees from start to finish, which is a benefit to both the enrollees and

care teams. Enrollees will have all their needs addressed within the same care team with a soft handoff from reviewer to reviewer so everyone in the care team is aware of the enrollee's needs and can address them from a team approach. This approach embraces our whole-person approach to meeting our enrollees' needs. With all care aspects working together for the same enrollee, we can assure the seamless transition through the continuum of health care. **Figure C.10-4** displays the organizational structure of our integrated care teams within UM.

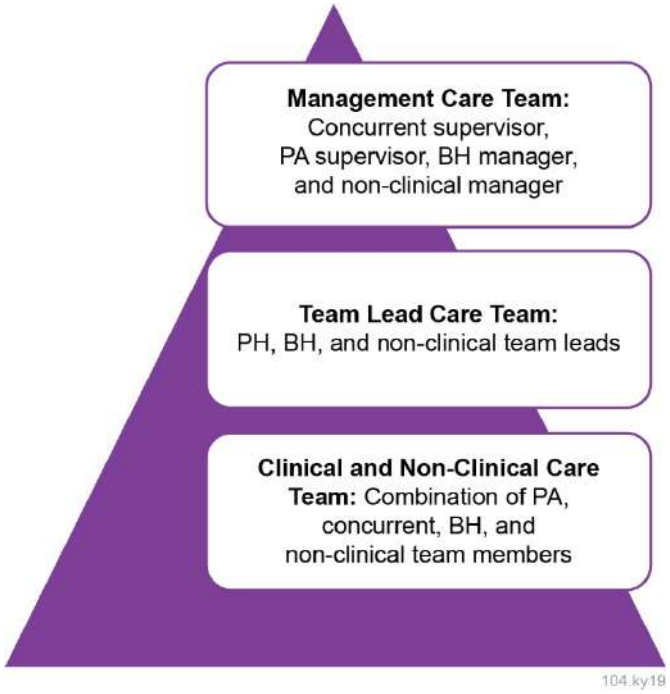

Figure C.10.4: UM Integrated Care Team Organizational Structure

Our restructured integrated UM care teams address whole-person care seamlessly for our enrollees.

Integration of BH in our Quality Assurance and Performance Improvement Program

Integration of BH into our QAPI program occurs through regular reporting of BH metrics and through regularly scheduled workgroup meetings to conduct ongoing monitoring of BH services. Implementation of corrective action plans is on an as-needed basis. The QMOC reviews and approves quality BH reports integrated within health plan reports annually.

A BH practitioner serves as a member of the QMOC and QM/UM Committees. Collaboration occurs among all health plan departments to facilitate continuity of care between medical and BH practitioners. Examples of this collaboration include working closely with network hospitals and practitioners to confirm that enrollees hospitalized with a BH diagnosis **are scheduled for a follow-up appointment prior to discharge to occur within seven days of discharge with an outpatient BH provider**.

Integrated Coordination of Care

Using the PH/BH integrated model, Aetna collaborates with participating BH specialists to monitor and improve coordination between PH and BH care for enrollees with complex care needs. Aetna takes action, as necessary, to improve continuity and coordination of care across the health care network based on routine assessments. **For example, we have achieved improved HEDIS scores across PH and BH through our integration efforts for our enrollees.**

Educating providers regarding integrated care: Our integrated UM care teams communicate with our providers on a regular basis to make sure all the enrollee's needs are being met. Additionally, during UM rounds with the medical directors the UM care teams discuss inpatient enrollees. In the UM rounds, we discuss the root cause of the illness or condition and have encouraged the UM clinician to report back to the provider the need to review these factors and address them. For example, we had an enrollee admitted inpatient to a Kentucky hospital for weight loss and dehydration. We encouraged the hospital to more comprehensively explore her health conditions and provide services while inpatient. She had an eating disorder and received a psychiatric evaluation that determined she did not have competency to make medical decisions. This allowed the hospital to provide nutrition while they were pursing legal outcomes regarding competence and placement opportunities.

> "I am writing to thank Aetna Better Health of Kentucky for gold carding certain UK prescribers for buprenorphine. I am aware of and appreciate your work here at UK. Your efforts have directly helped improve patient care. Going forward, we will continue to work together to improve the health and quality of care for the citizens of the Commonwealth."
>
> **—William H. Mitchell, MD, FACS**
> **Health Plans Medical Director, UK HealthCare**

We understand that in many cases, social determinants such as housing instability, lower levels of education and health literacy, lack of transportation, unemployment or underemployment, food insecurity, social isolation, or a difficult home environment are the root cause of poor health, contributing to health care under- and over-utilization. In addition to our integrated UM care teams that address enrollees' PH and BH needs, our model incorporates SDOH through our utilization of a social needs network by Unite Us. **Aetna is collaborating with Unite Us to address the full spectrum of SDOH**.

b.vi. Ensuring Compliance with Mental Health Parity

Aetna puts the enrollee and their unique PH and BH needs at the center of all we do and works to increase health equity and parity. We integrate Mental Health Parity and Addiction Equity Act (MHPAEA) compliance into our UM program, from how we authorize services to how we evaluate and monitor compliance. In addition to ongoing regular review of policies, Aetna employs the following strategies to assure parity compliance:

- We make sure any quantitative treatment limitations applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits through review of PA requirements.
- We do not impose non-quantitative treatment limitations (NQTL) for BH benefits in any classification unless any factors used in applying the NQTLs to BH benefits in a classification are comparable to and applied no more stringently than factors used in applying the NQTLs for medical/surgical benefits in the classification (e.g., PA, pharmacy, and concurrent review).
- We make BH medical necessity criteria available to any enrollee, potential enrollee, or contracting provider upon request.
- We use the Department's drug formulary.
- We communicate the reason for BH denials to the enrollee.
- We conduct parity analysis for our Aetna covered services.
- We provide out-of-network coverage for BH when needed for medical services.
- Our utilization grids for services requiring PA are mental health parity-compliant.

Our Aetna Medicaid UM Steering Committee evaluates and measures compliance by reviewing our list of services that require authorization at least annually. The CMO oversees this process and reports results to the QMOC. The QMOC annually reviews and approves policies on UM practices, pharmacy, appeals, and peer reviews. Furthermore, Aetna adheres to the requirements outlined in MHPAEA 42 C.F.R. 438.3(e)(1)(ii) and 438.910(b)-(d).

b.vii. Compliance with UM Policies and Consistent Application of Criteria

Aetna's UM program includes processes, guidelines, review criteria, decision-making timeframes, and qualifications of health plan staff involved in UM processes. As an NCQA-accredited health plan with a Commendable rating, we continually monitor our policies and procedures for our UM processes through audits. We conduct an annual review of policies and procedures, which the QM/UM Committee reviews and approves. **Our QM/UM Committee includes network providers who review and approve our policies and procedures**.

Inter-rater Reliability

To promote consistency in decision-making, we employ licensed clinical professionals who receive comprehensive training upon hire and annually. The Inter-Rater Reliability (IRR) test is a valuable process used to determine consistency in the application of medical necessity clinical guidelines as well as for the identification of educational opportunities. The use of InterQual, LOCUS/CASII/CANS, ASAM, and clinical policy bulletin criteria leads to consistency and integrity in the process of making medical determinations. Consistency in the application of the medical necessity criteria is essential for compliance with Commonwealth and regulatory guidelines as well as enrollee satisfaction.

We conduct annual IRR testing with clinical reviewers and medical directors. Our 2019 IRR results indicate that there is a high level of understanding of the UM processes and the application of nationally accepted medical necessity guidelines for both non-behavioral and behavioral health services. Aetna's scores met or exceeded the minimum compliance threshold of 85 percent with an average score of 96 percent. One hundred percent of our clinical reviewers and medical directors passed testing and none required additional follow-up or training.

Physician Review

The Aetna Medicaid organization conducts quarterly audits of physician decision-making. We audit supervising physicians utilizing a tool that provides a score for specific elements of the decision-making process. We audit initial determinations and appeals quarterly. Individuals not meeting the minimum criteria of 90 percent receive reeducation and they must complete a corrective action plan.

b.viii. Utilization Review Criteria

Aetna's Clinical Policy Council Committee and external practicing clinicians with expertise in providing the types of services in the clinical criteria policies conduct a comprehensive review process of both new and revised policies. This committee meets twice monthly and reviews changes to clinical review policies and reviews clinical literature to make sure we are congruent with national evidence-based clinical criteria. A recent example is revision to the utilization review criteria used in decision-making for enrollees with asthma. We revised the criteria to allow for exhaled nitric oxide breathing tests in evaluation of asthma and for monitoring response to long-term control therapy for enrollees aged 5 years and older. This test is a quick and simple way to determine if enrollees are exhibiting signs of ongoing allergic inflammation. **Aetna's change resulted in removal of barriers for better management of asthma and improving health outcomes.**

Aetna makes medical necessity criteria available to practitioners on the Aetna website and in the provider manual. Aetna distributes a provider newsletter or other written forms of communication to notify practitioners and providers of the availability of new guidelines and updates. Practitioners may request a copy of a guideline at any time by contacting their provider services representative or the Aetna office of the CMO.

b.ix. Prior Authorization for Non-participating Providers or Expedited Prior Authorization

Aetna is focused on building and maintaining a robust network to meet enrollees' medical and behavioral health needs. Occasionally, an enrollee is referred to an out-of-network provider because of special circumstances, specific qualifications, or because of a pre-existing relationship. In addition, at any point in the UM processes (e.g., PA, concurrent review), an enrollee or a provider acting on the enrollee's behalf may request an expedited review if a delay in the decision could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. Aetna makes such decisions on a case-by-case basis in consultation with Aetna's medical director.

Non-participating Providers

Prior authorization for out-of-network providers is a two-part process: 1) review of medical necessity for the requested service and 2) verification that the services are not available by network providers. The initial step in reviewing a service request is the same for both in- and out-of-network providers. When we receive a request, the clinician reviews the clinical documentation and applies medical necessity criteria per the clinical guideline hierarchy. Next, the UM clinician reviews network adequacy to provide the requested service. The clinician may approve the request if medical necessity and network deficiency are determined. However, the request is forwarded for medical director review for a determination when the clinician cannot determine medical necessity or network deficiency. If there is an adverse determination based on network adequacy for a service considered medically necessary and rendered after review by the medical director, our CM staff work with the provider and enrollee to access an in-network provider for delivery of care. We invite out-of-network providers to join the network and initiate single-case agreements, if necessary, for an out-of-network provider.

John (not his real name) is a 15-year-old in foster care who was residing in the psychiatric residential treatment facility level of care. It had been difficult to find a residential provider for him, especially with the specialized services he needed to address his diagnosis of autism. To preserve his placement in the residential setting, Aetna worked diligently to find a provider of Applied Behavioral Analysis (ABA) services that would be willing to treat John in the residential setting. As there were no in-network providers in the area of the facility that would provide the services, Aetna entered into a single case agreement with a non-participating provider and John was able benefit from ABA while in the residential setting. With the addition of ABA services, John has been able to maintain his residential placement.

Expedited Authorizations

Prior authorization enables us to monitor utilization of defined services and procedures and non-emergent hospitalizations before the enrollee receives the service. For services that require PA, we confirm that they are the following:

- Requested for eligible enrollees
- Included in the covered benefits
- Provided at an appropriate level of care or place of service to meet the enrollee's needs
- Appropriate, timely, and cost-effective to best meet the enrollee's needs
- Coordinated as necessary with QM or CM, and information is communicated to applicable operations areas (e.g., Finance, Enrollee Services, and Provider Services) or per contractual requirement with external contractors
- Accurately documented to facilitate timely reimbursement and accurate reporting

We make an expedited authorization decision as quickly as clinically needed given the enrollee's health condition and provide notice no later than 24 hours after receipt of the request for service. We proactively address the discharge needs of the enrollee beginning at admission. With the recent

implementation of the integrated UM care teams, addressing the discharge needs of our enrollees from a holistic approach, addressing PH and BH needs as well as SDOH has been greatly enhanced.

Assisting an Enrollee with Life-threatening Injuries to be Cared for in Kentucky after an Accident

A hospital case manager in Texas contacted the CM department at Aetna Better Health of Kentucky to inform us that a young enrollee, Earl (not his real name), was in a severe, head-on motor vehicle accident while traveling with his family. He had been transported via helicopter to the hospital in Texas with life-threatening injuries. The sole survivor of the crash, his closest remaining family, was in in Kentucky. After being stabilized at the hospital, the Aetna CM and UM teams were tasked with transporting Earl home to Kentucky to complete his recovery and be around family. This entailed communicating with the hospitals in Texas and Kentucky, as well as locating a new physician that would accept Earl. The CM and UM teams exercised a great deal of diligent, cross-functional collaboration to identify the appropriate site and level of care, facilitate arrangements, navigate details of the health plans and authorizations, and plan air travel for Earl. All the logistics and elements were successfully accomplished within three hours of the original request for assistance; the following day, Earl was flown to Kentucky to continue his recovery.

Denials

Aetna makes PA decisions and notifies practitioners and/or providers and enrollees as applicable in a timely manner in accordance with Aetna policies and procedures. Where regulatory and accreditation standards differ, Aetna uses the strictest or shortest timeframe to assure compliance with all requirements and in the best interest of the enrollee. Aetna provides the primary practitioner/provider(s) and enrollee with electronic/written notification of any decision to in whole or part deny, reduce, suspend, or terminate a service authorization request, or to limit or authorize a service in an amount, duration, or scope that is less than requested. The notification includes information on how to speak with the reviewing medical director for a peer-to-peer discussion and obtain criteria used to make the decision, as well as enrollee appeal rights and provider appeal rights.

The enrollee's PCP is also provided electronic/written notification of adverse determinations to facilitate care coordination; to assure the PH and BH needs of enrollees are identified; and services are facilitated and coordinated with all service providers, individual enrollees, and their family, if appropriate, and authorized by the enrollee.

Only medical directors with appropriate clinical expertise in the treatment of an enrollee's condition or disease may determine service authorization request denials or authorize a service in an amount, duration, or scope that is less than requested. We notify practitioners/providers in the denial letter (i.e., Notice of Adverse Benefits Determination) that they may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer by calling Aetna. Prior to written notification, Aetna elects to provide verbal notification, at which time we notify the practitioner/provider of the opportunity for the peer-to-peer consultation. If a peer-to-peer conversation or review of additional information does not result in an approval, or if the practitioner/provider elects not to request a peer-to-peer consultation, the denial letter informs the practitioner/provider and enrollee of the right to initiate an appeal and the procedure to do so.

Notice of Adverse Benefit Determination

Our Notice of Adverse Benefit Determination (Notice of Action) process complies with 42 CFR 438.404, including timeframes for notice and notice contents. Following an initial decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, we send written notice to the enrollee and provider. Our notice is on the Commonwealth-required template and is thoroughly completed in easily understandable language, and includes all required information detailed in 42 CFR 431.210.

b.x. Quality Management/Utilization Management Committee

Aetna's QM/UM Committee, consisting of an internal multidisciplinary team (e.g., UM, CM, Pharmacy, Population Health, etc.) and external stakeholders support UM activities through monthly meetings to review a range of UM-related topics, including the following:

- UM policies and procedures
- Utilization trends and outcome data
- Potential quality of care concerns
- Quality performance measures
- Provider and enrollee satisfaction data
- Provider credentialing reviews

Oversight of the UM program activities occur under the direction of the QM/UM Committee. Aetna's Kentucky-licensed CMO directs the QM/UM Committee, which reviews and monitors the UM activities of both Aetna and network practitioners and providers. Formal medical committees, subcommittees, and ad hoc work groups as defined in the QAPI program description and advise and guide UM program activities. The committees integrate Aetna's medical functions, operations departments, the provider network, and enrollees into utilization activities. QMOC members provide executive oversight of utilization activities and integration of activities across the plan through review of reports and minutes from the medical committees.

Major Responsibilities

The QMOC provides executive oversight of the QM and UM programs and provides a semiannual report to the board of directors regarding Aetna's QM and UM activities, including the annual program descriptions, workplans, and evaluations.

The QM/UM Committee's purpose is to advise and make recommendations to the CMO on matters about the quality of care and service provided to enrollees, including the oversight and maintenance of the QAPI and UM programs. The QMOC receives summary reports from the QM/UM Committee for review and approval and submits reports semiannually to the board of directors.

Our QM/UM Committee reviews the UM program policies and procedures to ensure compliance with federal and Commonwealth regulations and evidence-based practices. The review identifies opportunities to modify UM program activities for compliance with changing regulations or evidence-based practices.

Membership

The QM/UM Committee is made up of the following members:

- CMO—chairperson
- Medical directors
- **Behavioral health practitioner**
- **A cross-representation of network providers**, including PCPs/medical homes, specialists, pediatricians, OB/GYNs, dentists, and BH providers
- Director of quality management
- Director of medical management
- Support staff as requested

Meeting Interval and Documentation

The QM/UM Committee meets no less than 10 times per year and as frequently as necessary to demonstrate follow-up on all findings and required actions. An assigned staff member records minutes and forwards to the QMOC for review. Aetna maintains a process to make sure we follow the rules of confidentiality in quality improvement discussions as well as avoidance of conflict of interest on the part

of committee members. Aetna's board of directors review approved minutes. Aetna keeps minutes and documents safe, confidential, and protected.

Our UM program goals and objectives improve enrollee health and positively effect unmet health care and social needs. Our local, enrollee-centered approach focuses on individuals' holistic health needs by providing access to and assuring delivery of cost-effective health care services.

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60.7.C.11 Monitoring and Oversight

Kentucky | Transforming Health Care | **Aetna**

60.7.C.11 Monitoring and Oversight (Section 21.0 Monitoring and Oversight)

Aetna's commitment to serving as a good steward of Kentucky resources is demonstrated by our monitoring and oversight processes, including daily departmental operational meetings, daily cross-function operational oversight meetings at the executive leadership level, provider and network escalation processes, and subcontractor oversight processes. We take seriously our obligation to understand and comply with the unique requirements set forth by the Department and will collaborate with the Department and other key stakeholders to monitor and measure our progress in meeting performance objectives.

a. Internal Monitoring of Operations

Compliance monitoring is a health plan-wide endeavor and Aetna's management team uses an integrated and collaborative approach that involves each operations area to ensure compliance with the contract. Every department monitors performance as part of its daily operational routine. Our compliance program includes oversight committees with representation from team members throughout the plan, our enrollees, and our participating providers. These committees perform day-to-day oversight activities for internal monitoring of operation.

Aetna demonstrates our commitment to contract compliance in our **daily** meeting, called the Kentucky Collaboration and Teamwork Summit (KY CATS), which is designed to identify issues for discussion throughout the health plan's functional areas. The attendees are the leaders of each department as well as executive leadership and our shared services partners. The purpose of the meeting is to set priorities for the week, discuss any outstanding contracting items, review of any Kentucky Hospital Association (KHA) items, review deliverables for the Department, talk through any issues needing escalation, including behavioral health items and ad hoc discussions. Each day, a meeting facilitator captures notes, requests follow-up, and sets timing for next steps. These are followed until each action item has been completed.

Additionally, Aetna proactively works to identify provider areas of concern, striving to resolve them as expediently as possible. We have developed an internal process for escalation that begins with our network managers who are aware of any pain points experienced by our providers. The network managers escalate these areas of concern to a health plan workgroup that meets regularly to triage and solution for provider concerns. This work group includes representation from health plan executive leadership; health plan operations leadership, including network management and contracting, provider data services, pharmacy, claims processing, system configuration; finance; and compliance.

Provider concerns are identified, discussed, addressed, and worked as projects by the teams represented in the workgroup. The projects are tracked until they are completed and any and all impacted claims are reprocessed and paid to the provider. The network manager then confirms with the provider that their concern has been resolved. By employing this cross-departmental approach, we prevent issues from escalating and improve our responsiveness to provider concerns. As a result of this process, we have seen a steady decline in outstanding issues on the KHA's Medicaid managed care organization (MCO) issues log **culminating in the resolution of all outstanding issues as of December 2019**. Please refer to **Figure C.11-1** for an illustration of the Medicaid MCOs' results in the Commonwealth.

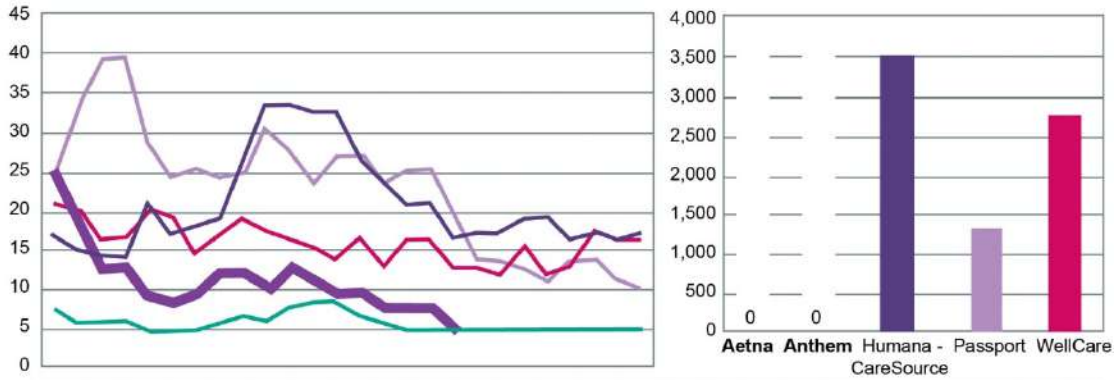

	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	Mar '19	Apr '19	May '19	Jun '19	Jul '19	Aug '19	Sept '19	Oct '19	Nov '19	Dec '19
Aetna	23	16	9	9	5	4	5	8	8	6	9	7	5	5	3	3	3	–	–	–	–	–	–	–	–	–
Anthem	3	1	1	1	–	–	–	1	2	1	3	4	4	2	1	–	–	–	–	–	–	–	–	–	–	–
Humana – CareSource	14	12	11	11	18	14	15	16	23	32	32	31	31	25	21	18	18	13	14	14	16	16	13	14	13	14
Passport	23	33	39	39	27	22	23	22	23	29	26	21	25	25	21	23	23	17	10	10	9	7	10	10	7	6
WellCare	18	17	13	13	17	16	11	13	16	14	13	12	10	13	9	13	13	9	9	8	12	8	9	14	13	13

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Figure C.11-1: Kentucky Hospital Association Issue Trends by MCO

Aetna has resolved all outstanding issues with the Kentucky Health Association as of December 2019.

Role of Plan Leadership and the Compliance Committee

Aetna's executive leadership holds a daily cross-functional meeting focused on ensuring that we are meeting the needs of the Kentucky Medicaid program. We use a QuickBase tool called Kentucky Issue Tracking (KIT) to help prioritize and identify any issues that need to be escalated. All provider data services are tracked through KIT. The Aetna compliance officer holds a meeting every morning with representatives from every department, including Claims, Provider Relations, Credentialing, Enrollment, Pharmacy, and executive leadership. The purpose of the meeting is to discuss any outstanding issues with the Department, such as enrollee and provider complaints the plan has received. The compliance officer tracks all issues using the KIT and reviews and distributes action items to the appropriate department for response and resolution. The Compliance department uses KIT to monitor and track outstanding issues until resolution. The workgroup discusses issues such as the following:

- Enrollee and provider complaints
- Special Investigations Unit inquiries
- Requests for information from providers (claims history, contract info, etc.)
- General questions directed to the health plan
- Pharmacy-related inquires
- Contract questions

Our Compliance Committee is responsible for monitoring contract performance. Aetna's plan compliance officer chairs the committee, which is comprised of representatives from senior leadership and from the Medical Management, Quality, Health Services, Provider Services, Legal, Enrollee Services, and Finance departments. The Compliance Committee meets on a quarterly basis, at a minimum, and its major responsibilities include reviewing and monitoring internal controls and metrics such as compliance issues involving fraud, waste, and abuse; external quality review oversight activities and audits; regulatory and contractual compliance; and corrective action plans. The committee identifies potential compliance gaps and reports any instances of non-compliance to the Quality Management Oversight Committee and the Board of Directors on a monthly basis.

Role Individual Departments Play in Monitoring Performance

Individual departments monitor performance as part of their daily operational routines and report the results to the appropriate internal departments, committees, or external agencies as required.

Compliance team: The Compliance team develops an annual work plan that adheres to the Office of the Inspector General's Seven Elements of an Effective Compliance Program. The work plan is tailored to each plan and is developed in collaboration with the Compliance department and plan leadership from manager-level and above. Areas of risk are identified through discussion and collaboration with key stakeholders and are the focus of subsequent monitoring and auditing efforts. The work plan allows the compliance officer to track contractual metrics, policies and procedures; fraud, waste, and abuse activities; and other areas that pertain to contract adherence. The compliance officer performs a quarterly assessment of each functional area to confirm adherence to contract requirements.

Quality Management/Utilization Management: Because quality assurance is an organization-wide responsibility, we verify that all our staff members have the proper education and training in quality assurance. Every staff member also completes business integrity and compliance training upon hire and annually. In addition, we have systems in place to seek and receive input routinely from enrollees, providers, and other stakeholders in the development of our Quality Assurance and Performance Improvement (QAPI) program and its annual objectives to verify that our work is locally informed and reflects the needs and concerns of the communities we serve.

Claims quality: Aetna has written policies and procedures used for the processing of submitted claims; these policies are used to conduct post-payment audits. Target audits include contract, benefit, provider, diagnosis, procedure, specific service, and place of service. Each audit includes key departmental issues identified in addition to a summary of financial and procedural accuracy. We finalize, publish, and distribute monthly and quarterly audit results to the operational departments. This data enables the Claim Operations department to conduct continuous quality improvement discussions.

Aetna's Claims Audit Procedure

The Claims Audit department reviews approximately 350 to 400 claims by random sampling. For each claim, the following items are reviewed and documented:

- Fee table alignment
- Contract reimbursement methodology
- Electronic data interchange (EDI) enrollee match
- Provider alignment

Our Claims and Operations teams receive and review the results and provide the requested documentation. If we find an opportunity to update our system, we update the system and then adjudicate the claim again.

All results and audit files are shared via email to the respective departments. We then post and retain the results in our internal tracking databases for future reference. Based on audit findings, our management staff coaches, provides, and tracks additional training as needed.

Sources of Feedback for Monitoring Performance

Each department has a role in monitoring the quality of our health care services based on specific, objective performance and outcome measures from nationally validated data sets that encompass the full continuum of care such as the Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), utilization data, complaints and appeals, and telephone customer service. The data is continuously monitored to identify proactively areas in need of improvement, and potentially, the development of a performance improvement project or corrective action plan. Sources of our data include the following.

- **HEDIS:** We contract with a vendor that uses NCQA-certified HEDIS software to produce the measures. We also contract with a certified NCQA HEDIS auditor who reviews the systems and processes for data integration and performs medical record review.

- **CAHPS surveys:** These surveys are conducted by a CMS-approved vendor. We analyze and report the results of the survey to our Service Improvement Committee (SIC). If issues are identified that are clinical in nature, they are referred to the Quality Management/Utilization Management (QM/UM) Committee. The SIC and the QM/UM Committee evaluate the data, identify opportunities for improvement, and formulate action plans. The resulting performance improvement project (PIP) recommendations are reported to the Quality Management Oversight Committee (QMOC).
- **Enrollee utilization data:** We continuously review enrollee utilization data to identify trends and patterns in service utilization, including a review of potential under- and over-utilization.
- **Complaints and appeals:** We review all enrollee complaints for availability or quality of service issues to identify whether there are any trends with any providers or issues related to gaps in the network or access to providers. We monitor and measure timeliness of appeal decisions through the appeals business application system. We monitor trends in the types of complaints and appeals and use this information to formulate action plans to address the root causes of the issues.
- **Telephone customer service:** Our calls are routed using automated call center software. This application provides automatic call routing, distribution, and reporting that enables agents to handle calls effectively while improving overall productivity. We measure metrics such as call abandonment rate, speed in answering, and service quality as part of our commitment to providing the best experience for our enrollees.

Management Information Systems and Electronic Data Interchange

The Compliance team uses the GRC/Archer Compliance system to ensure that all required reports and contractual deliverables are tracked and submitted to regulators in a timely manner. This is a two-phase process, as follows:

- **Informatics:** Our Informatics team builds reports for each contract deliverable. These reports can be automatically generated or entered manually, and their frequency and method are determined in accordance with Kentucky Medicaid program requirements. For example, our Operations team tracks the type and number of enrollee services and provider telephone calls; whether all enrollees timely receive their identification cards and welcome packets; and whether all providers receive training. Medical management reports include the total number of enrollee outreach calls and initial assessments that have been completed. Pharmacy reports can show number of claims paid, and the number of appeals, among other things.
- **Compliance:** Our Compliance department tracks and documents contract deliverables, as well as reports on the timeliness and accuracy of our reporting. Plan compliance officers retain copies of signed attestations and final reports for archive and auditing.

In addition, Aetna has a long history of establishing and maintaining EDI interfaces with all key regulatory entities and other stakeholders as necessary. We have implemented required Health Insurance Portability and Accountability Act (HIPAA) transactions with every Commonwealth agency with which we have contracted since HIPAA's inception in 1996, and we demonstrate that we are fully HIPAA-compliant at system readiness.

Aetna follows a secure and proven process for establishing and maintaining all our EDI interfaces. We utilize a secure File Transfer Protocol server to handle inbound and outbound file exchanges. When establishing a new EDI interface, we collaborate with our partners to exchange key information required to establish the secure connection for exchanging files on both sides. This information includes file paths and naming conventions, secure shell or secure socket layer configurations, internet protocol and domain name system information, acknowledgement responses, and file ownership information. We use this information to create the connection for transferring files.

To verify successful inbound and outbound file transmission, we employ a rigorous combination of automated and manual processes to validate successful exchange of inbound and outbound files and to

respond to the issue promptly, notifying U.S. Department of Health and Human Services as applicable. We use a dashboard that provides an end-to-end view of a file's status through each intake step.

File monitoring software is configured to alert automatically in the event of a failure at any point in the process. If a failure occurs, production support is immediately engaged to research and resolve the issue. An audit trail for all inbound and outbound files and data processed is generated and retained in a separate audit database that is retrievable for audit and compliance purposes.

b. Subcontractor Oversight

Although we may delegate the authority to perform functions in support of the Kentucky Medicaid managed care program, we do not delegate accountability for the quality of care or services the subcontractor provides. Our QAPI program has a comprehensive set of policies and procedures to manage the delegation of responsibility for any delegated program function. We understand all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight, with selecting subcontractors, and with ongoing monitoring of subcontractor performance. By leveraging this experience, we ensure the successful completion of all delegated functions under the Kentucky Medicaid program.

Prior to contracting with a subcontractor, Aetna evaluates the prospective subcontractor's ability to perform the activities to be subcontracted. We perform a pre-delegation review audit to determine staff qualifications, clinical and administrative capabilities, integration capabilities, data transfer capabilities, operational readiness, and alignment with the Kentucky Medicaid program scope of work. Our quality management program includes formal, multilayered processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract. All aspects of the contract are evaluated through our Compliance Committee to ensure compliance with contractual requirements.

Aetna performs ongoing monitoring of subcontractor performance, as depicted in **Figure C.11-2.** We meet with subcontractors on a weekly, monthly, or quarterly basis, depending on the subcontractor, and perform a comprehensive review at least annually in which we review ongoing performance as well as measure performance efforts that address past concerns identified by the Department. If any deficiencies or areas for improvement are identified, we require the subcontractor to take corrective action. If requested, Aetna provides the Department with a copy of the annual review and any corrective action plans developed as a result.

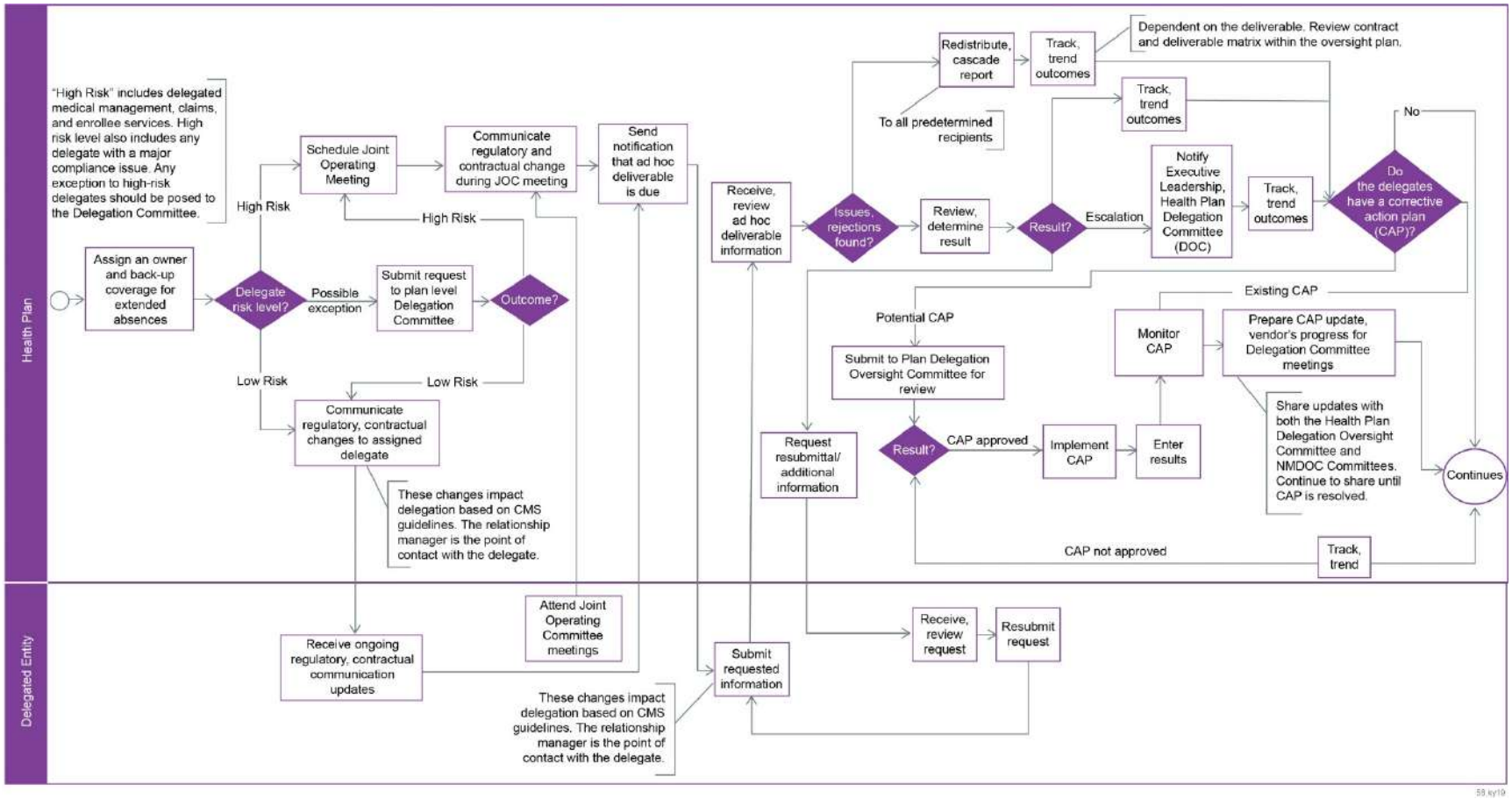

Figure C.11-2: Delegation Oversight End-to-End Workflow

Aetna understands all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business.

National Oversight

At the national level, we have a centralized team of delegation oversight experts that manages the oversight process across Aetna Medicaid lines of business to make certain that all of our multi-state delegated agreements are represented and that all requirements, such as Commonwealth- and contract-required elements for each plan and delegate, are accounted for. This team includes members from our national Delegation Management, Quality Management, and Finance departments. The appropriate national Medical Management, Credentialing, Grievance and Appeals, and other teams conduct audits as directed by the Medicaid-specific Quality Management department. The audit team reports audit findings to Aetna's National Vendor Delegation Oversight Committee (DOC), National Medicaid DOC, and the local health plan DOC in order to identify opportunities for improvement and solutions that are disseminated across our health plans.

Local Oversight

The chief executive officer, chief medical officer (CMO), compliance officer, chief operating officer, director of clinical health services, director of quality management, and selected leadership staff from our Enrollee Services, Provider Services, Network Management, and Grievance and Appeals departments comprise the local-level DOC. These local, executive-level plan leaders and key leaders from functional areas meet with subcontractors on a monthly or quarterly basis, depending upon the type of subcontractor, to monitor service delivery, troubleshoot problems, review and resolve enrollee complaints, and most importantly, identify opportunities to collaborate on new or enhanced services for enrollees. The DOC approves all delegates and delegation reports, and monitors subcontractor performance at the plan level. Executive-level leaders monitor the success of corrective action plans and handle escalated issues when the corrective actions are not producing satisfactory results.

Subcontractor Monitoring and Oversight Activities

Monitoring is performed as follows:

- ✓ Monitoring and evaluating delegated functions through at least semiannual reports
- ✓ Conducting pre-assessments prior to delegation, with annual desk audits or web conference reviews conducted with a random sampling of files thereafter
- ✓ Confirming (no less than annually) that delegated functions/services are carried out consistently and in compliance with both Aetna's and other applicable accredited standards (i.e., NCQA and others as indicated) and the mutually agreed upon delegation agreement
- ✓ Performing, at minimum, an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards
- ✓ Monitoring ongoing corrective actions to address identified deficiencies, promote progress, and take necessary action, if improvements do not occur
- ✓ Reviewing the delegated organization's program that oversees the delegated functions and its quality program to verify it is in alignment with Aetna's quality improvement processes
- ✓ Monitoring the subcontractor downstream provider agreements to ensure they comply with the regulatory requirements of the Commonwealth contract

In accordance with Aetna's culture of compliance, all team members understand they play a role in subcontractor oversight. Team members from Network Management, Provider Services, Operations, and Quality Management are trained to report subcontractor-related concerns to management. For example, our care managers are the front line in identifying potential problems or issues related to vendors and subcontractors. If an interaction with an enrollee related to a subcontractor raises a red flag or suggests there is a problem, the care manager will escalate the issue to management. Issues can often be resolved without further escalation once they are referred to the appropriate department for remediation.

Delegation oversight activities are formally monitored as a component of the QAPI program. Audit reports of delegated activities and corrective action plans (CAPs), if applicable, are submitted to the appropriate oversight committee (e.g., QM/UM Committee, Delegation Subcommittee, National Vendor Delegate Oversight Committee) for review and approval and then to the QMOC.

The Medical Management, Quality Management, Provider Services, and if applicable, Care Management, and Utilization Management departments are responsible for implementing the oversight process and maintaining monitoring activities, including monitoring the delegate's provisions to safeguard enrollees' protected health information, as applicable. Should deficiencies be identified, Aetna works with the delegated organization to set priorities and develop a CAP. We retain the right to revoke the delegation agreement for noncompliance or if CAPs are not sustained.

Examples of Oversight and Corrective Action

When the submission of provider enrollment applications by one of our subcontractors did not meet the standards of the Department or of Aetna, we implemented a corrective action plan for our subcontractor that required heightened review and approval of provider enrollment applications prior to their submission. Further, we used this opportunity to evaluate our own internal process for submission of provider enrollment applications. We found steps in the process that could be streamlined, and we also built in additional check points to ensure accuracy and completeness prior to submission. As a result of this updated process, provider enrollment applications are submitted faster and with less back and forth between provider and health plan. Providers are then credentialed and become part of our network faster, giving our enrollees access to the broadest possible network of providers. As a result, we used the opportunity to increase our oversight of the subcontractor as well as improve our own internal processes.

When eviCore, an Aetna subcontractor, demonstrated noncompliance with Commonwealth-established turnaround times for prior authorization requests, we implemented a CAP that required the subcontractor to provide an action plan to immediately come into compliance with contractual turnaround times. The subcontractor response included a root cause analysis of the issue and a plan to correct the deficiencies, as well as evidence of their monitoring and oversight of adhering to timeframes. Aetna required eviCore to provide daily summaries of all requests and their respective turnaround times. The subcontractor went from 79.3% compliance in December 2017 to 100% compliant in August 2018.

Pharmacy Benefit Manager Oversight

Ongoing pharmacy benefit manager (PBM) oversight and collaboration between Aetna's pharmacy director, Aetna Medicaid Pharmacy Management, CVS Health Corporation, and the Department ensures that PBM services are administered by CaremarkPCS Health, L.L.C. (CaremarkPCS Health) in the best interest of Kentucky Medicaid enrollees; and in the amount, duration, and scope of benefits as defined in the contract and all applicable NCQA, URAC, and other Commonwealth and federal law regulatory requirements and standards. Additionally, Aetna draws on the experiences of affiliate plans regarding oversight of CaremarkPCS Health, and we can adjust our monitoring approach to address any performance problems identified in other states that may be applicable to Kentucky.

Prior to the effective date of new programs, the pharmacy director will confirm that all delegated pharmacy services are prepared for implementation in compliance with contractual and regulatory requirements. The pharmacy director and the CMO, in collaboration with the National Medicaid Pharmacy Management department, will monitor the pharmacy services performed by CaremarkPCS Health through weekly operational meetings to review performance metrics including, but not limited to the following: paid and non-paid claims processing; drug utilization review edits and program activities;

encounter submission acceptance rates; pharmacy network performance and Quest Analytics reports; and pharmacy help desk activities.

As part of Aetna's Quality Management Committee structure, we will continue utilizing the Aetna DOC chaired by the CMO. The DOC will meet on a quarterly basis to assess and evaluate key performance metrics, including, but not limited to the following: cost performance and trends, prospective and retrospective drug utilization review (DUR) programs and impacts; specialty drug utilization and strategies; pharmacy network and pharmacy help desk service levels; and clinical pharmacy programs outcomes. When appropriate, CaremarkPCS Health representatives such as the strategic account executive, strategic account director, clinical advisor, specialty account executive, or analytic consultant will attend DOC meetings to discuss key initiatives that support innovation and a culture of continuous quality improvement in Kentucky.

Other processes Aetna will implement to monitor and evaluate the performance of CaremarkPCS Health to ensure that all contract requirements are met including the following:

- **Third-party audits:** CaremarkPCS Health will undergo an annual third-party audit (the SAS-70) to evaluate controls relevant to the processing of claim and drug rebate transactions and to confirm that these controls are in place and operating effectively. The audit testing includes aspects of the information security, physical security, access to data files and programs, and development of and modification to information systems. Additionally, under the direction of the Aetna Medicaid Pharmacy Management department, a third-party vendor is contracted to complete an annual audit on functions delegated to CaremarkPCS Health that will evaluate the operational effectiveness of controls relevant to benefit and formulary setup, claims processing, and network pricing. The resulting annual reports for these audits will be provided to the Aetna national Medicaid pharmacy director, Aetna pharmacy director, and our medical director/CMO for review and next steps, which may include, but are not limited to, presentation at the DOC.
- **Encounter submissions edits:** Aetna's encounter data management system will use edits and checkpoints to validate CaremarkPCS Health's pharmacy encounters for accuracy, completeness, and enrollee eligibility. Encounters identified with errors will be returned to CaremarkPCS Health for correction. Aetna Medicaid Pharmacy Management, on behalf of Aetna, will submit encounters that pass our edits and controls to the Commonwealth, as required by the contract. **In 2019, the acceptance rate was 99.84 percent.**
- **Reporting:** Aetna will require CaremarkPCS Health to meet all reporting requirements for its functional responsibilities listed in the contract, within the timeframes specified:
  - **Quarterly reports:** A set of important reports used in managing pharmacy services and providing PBM oversight is CaremarkPCS Health's comprehensive quarterly Rx Insights Costs and Trends Detail Report found within the Delegated Oversight quarterly report package. Information and metrics found within the quarterly report package include, but are not limited, to the following: claims statistics; key drug utilization and cost trends; top drugs and therapy classes; pharmacy audit statistics; point-of-service edits; and encounter statistics.
  - **Daily, weekly, and monthly reports:** Reports include CaremarkPCS Health performance reports for claims/encounter timeliness, completeness, and accuracy; reports on Pharmacy Help Desk activities; and other reports pertaining to performance such as complaint statistics, fraud reports, claims dashboard, and encounter aging.

If issues of noncompliance or emerging risks are identified, Aetna will take immediate action to correct the problem. Determined by the nature of the problem, remediation may include training, more frequent monitoring, corrective action plans, sanctions, notices to cure, or subcontractor termination. The pharmacy director will monitor corrective action plans and report progress on them to the DOC and the Quality Management Oversight Committee for tracking to completion.

Dental and Eye Care Benefits Administration Oversight

Our relationship with our dental and eye care benefits administration subcontractor, Avēsis, is guided by their three corporate values, as follow:

- People count
- We do the right thing
- We hold ourselves to very high standards

On a day-to-day basis, Aetna works with Avēsis' designated Relationship Management team, led by a strategic client partner (SCP), to ensure our Kentucky Medicaid enrollees are receiving efficient and effective dental and eye care services. The SCP is a single point of contact and helps to navigate the operational infrastructure, ensures their team understands and accommodates our unique service model, and manages the timely and accurate delivery of projects and reports.

We meet regularly with our Avēsis service team on topics ranging from tactical to strategic. Meetings include the following:

- **Market check-in:** During this meeting, typically hosted via video or audio conference call, Avēsis goes through open issues, identifies action items, and discusses relevant business and market updates. This tactical meeting takes place monthly.
- **Joint Operations Committee:** This quarterly meeting includes a review of service level agreements, market goals and updates, and program initiatives and innovations intended to help us stay ahead of the industry and regulatory curve.
- **Business review:** This semiannual strategy session focuses on presentation and discussion of plan performance and industry updates. During these sessions, we discuss relevant improvements to our Kentucky service model to ensure our ancillary benefits model is meeting our Kentucky Medicaid enrollees' strategic needs.

These meetings are complemented by a biweekly meeting with the Encounter team and monthly meetings with our Fraud, Waste, and Abuse team. In addition, Avēsis has a dedicated audit team who periodically hosts Aetna's Auditing team to test for compliance with our in-house and/or regulatory-mandated audit requirements. In the event Avēsis is found to be noncompliant with a contractual requirement, typically through their internal audit or our external audit process, we launch a formal CAP process. We work collaboratively with Avēsis' External Compliance team and our strategic client partner to develop an efficient solution to their problem. Avēsis takes the lead in assessing the scope of our concern, engaging relevant operational team leads, and drafting responses to our concerns.

60.7.C.12 Enrollee Services

Kentucky | Transforming Health Care | **Aetna**

60.7.C.12 Enrollee Services (Section 22.0 Enrollee Services)

Our Enrollee Services call center staff and supervisors live and work in local Kentucky communities—**they know Kentucky.** Aetna's call center serves as the gateway for our enrollees to access information concerning their covered services and as a resource to improve their health. Our call center staff provides our first opportunity for **exemplary enrollee service. Our staff is well-trained and personable, as indicated by our consistent Net Promoter score of 79 percent**.

a. Aetna's Enrollee Services Call Center

We strive on every call to **advocate for our enrollees' best health by helping them get the most from their benefits, building and maintaining trust, and always providing a clear path to care.** Aetna's Medicaid organization has been serving Medicaid managed care in the Commonwealth since the inception of the Medicaid managed care program in 2011. Our local, enrollee-devoted approach focuses on individuals' holistic health needs by providing access to and delivery of cost-effective health care services. Everything we build and do is focused on their health and quality of life. We make sure the experiences they have are positive and satisfactory so that their entire health and health care experience promotes a strong and communicative relationship with both us and their providers. This better serves our enrollees and Aetna in promoting understanding of what they want and need so we can develop and evolve solutions.

We provide a toll-free number for enrollees to call with questions or concerns. This number gives access to enrollee services representatives during normal business hours, Monday through Friday, 7 a.m. to 7 p.m. Eastern time. All Enrollee Services staff instruct callers what to do in case of an emergency and connect enrollees to our 24/7/365 Health Information line (nurse line). Enrollee Services representatives are trained in Mental Health First Aid (MHFA) and will warm transfer enrollees to our Behavioral Health Crisis Services Hotline for clinical support.

2019 Kentucky Call Center Metrics

- Abandoned call rate: 1.5%
- Average speed to answer: 15 seconds
- Blockage rate: 0%
- First-call resolution rate: 95.6%

Our call center meets the current American Accreditation Health Care Commission/Utilization Review Accreditation Commission-designed Health Call Center Standard for call center abandonment rate, blockage rate, and average speed to answer, and reports these on a monthly basis to the Cabinet for Health and Family Services (Cabinet). Aetna provides an accessible Enrollee Services call center managed by highly trained representatives who are educated in the unique and culturally specific needs of the Kentucky Medicaid population. Our call center is staffed with representatives who can speak prevalent languages associated with Kentucky households with limited English proficiency. We respond to the special communication needs of persons with disabilities, as well as the blind, deaf, and aged, and effectively interpersonally relate with economically and ethnically diverse populations. Responding to all our enrollees'[1] needs quickly, we average over 10,700 calls per month answered with service levels **greater than 87 percent in our most recent four quarters, exceeding the Commonwealth's benchmark of 80 percent.**[2] Our enrollee services representatives achieve a first-call resolution rate of 95.6 percent; if follow-up with an enrollee is needed, we do so within 24-48 hours. Aetna's electronic call documentation system documents and routes calls effectively to assure timely response times.

[1] When we use the term enrollee or enrollees in this section, we are collectively referring to enrollees, their guardians, and their legally authorized representatives.

[2] Service level is a measure of customer service quality and defined as the percent of calls answered in a specified amount of time.

Our Enrollee Services call center routing provides timely, accurate responses to enrollee inquiries. Our interactive voice response (IVR) system offers the opportunity for self-service. If the enrollee wishes to speak to a representative, they can opt out of the IVR. If enrollees want benefit information, a new identification card, or eligibility verification, they can select those options and obtain the information that is pulled from our operating system.

a.i. Call Volume Monitoring to Ensure Full Staffing during Operational Hours

The Kentucky call center has 27 staff members dedicated to serving Kentucky enrollees and includes a Workforce Management (WFM) department that uses real-time tools to monitor the staff and call volume and uses historical call data to forecast daily call volume and staffing requirements. Enrollee Services use technology such as Single User View (SUV) to assist enrollee services representatives with having the most up-to-date information for our Kentucky enrollees. SUV allows representatives to see the 'whole' enrollee when they contact Enrollee Services; this includes eligibility, pharmacy, medical benefits, gaps in care, and recent calls. Our resources create efficiencies in which we can anticipate our enrollee's needs. In addition, we have a dedicated training team with Kentucky-specific subject matter experts that are responsible for creating and maintaining training materials. Our Training department works with Aetna's national Enrollee Services team to update and distribute resources to the staff in a timely and consistent manner.

Our enterprise telephone system includes a suite of tools used by our WFM staff to respond to immediate fluctuations in call volumes. WFM quickly identifies surges in call volumes when they occur and uses real-time tools to redirect calls to fully trained teams to provide prompt, seamless service to Kentucky enrollees. This system is also used to forecast daily, weekly, monthly, and seasonal trends in call volumes for staffing. WFM uses these tools to track, trend, and anticipate future Kentucky call volume and adjust staffing levels accordingly. In state expansions, or the introduction of new Medicaid populations or services, WFM creates staffing models. It studies historical call trends and calculates expected call length and expected call volumes to determine staffing needs. This quality-focused process allows us to meet Kentucky enrollees' needs and consistently exceed the performance standards established by the Commonwealth. For example, **our health plan forecasted and serviced additional call volumes related to recent implementations and mass transition of former Kentucky Spirit (Centene) members, while still meeting required monthly metrics.**

In addition to the day-to-day call volumes, WFM is the first to respond to natural disasters that impact office closings. As part of business continuity planning, WFM can quickly activate telephone coverage by adding the cross-trained enrollee services representatives to the Kentucky call queue. **Aetna has met all Kentucky-required metrics for over two years.**

a.ii. Training and Resources Provided to Call Center Staff

Aetna has dedicated training resources for Medicaid operations. The Learning and Performance team includes skilled trainers, instructional engineers, and state-specific subject matter experts who design Kentucky training materials. Representatives receive quick reference guides (QRGs), benefit summaries, policies, and desktops to help them assist our enrollees. All materials are monitored, reviewed, and updated as changes occur and minimally on an annual basis by the Aetna national Enrollee Services team in collaboration with the Kentucky Medicaid team.

Newly hired enrollee services representatives attend training and onboarding for a four- to six-week period. Training includes, but is not limited to, the following topics:

- Systems overview and practice
- Overview of Kentucky plan operations
- Sensitivity training (telephone etiquette and effective communication techniques such as the use of interpreters and Relay service)

- Review of enrollee materials and website, including QRGs
- Cultural competency
- MHFA training program provided to all Aetna staff, which teaches compassion and skills for supporting those with mental health conditions and substance use disorders
- Covered services
- Prior authorization of services
- Copayments
- Coordination of benefits
- Enrollee bills and reimbursements
- Care management referrals
- Privacy and confidentiality
- Grievances and appeals
- Provider services

Both newly hired and experienced representatives have several resources and tools to serve the enrollee. They are trained extensively on the enrollee handbook and use it as a primary resource tool. Resources have been created to provide easily accessible information and includes a QRG outlining key information for every plan. Examples of currently used QRGs include "Appeals—Second Level Review Requests Process," and "Enrollment—Discrepancy in Eligibility." A benefit summaries worksheet provides one-stop access to benefit information for all plans. Written policies, instructional documents by topic, and job aids are available.

Periodic training to refresh our staff's knowledge is required for existing staff quarterly and annually. We employ various training vehicles such as online courses, instructor-led training sessions, virtual training, small group training, and self-study alternatives.

Aetna routinely audits and monitors call center staff for quality assurance and to assess the need for refresher training. Monitoring also aids in the analysis of the training provided to call center staff and if emerging issues need to be added to our call center training curriculum. Materials provided to call center staff undergo routine review and annual updating to assure resources remain timely and accurate.

a.iii. Approach to using Back-up Staff

Aetna uses integrated telephone solutions to support enrollees' needs quickly and efficiently. Our WFM team monitors telephone performance and call routing in real time. We adapt quickly when enrollee calls increase in volume. They will adjust phone coverage, making sure that every enrollee's call is handled. **When there are peaks in call volume, we collaborate with other Aetna Medicaid organization enrollee services representatives, who are fully cross-trained in Kentucky Medicaid benefits and services.** This occurs quickly and seamlessly, as cross-trained representatives are already skilled in our enterprise telephone system (i.e., identified as trained and able to handle Kentucky calls). When call volume increases, calls automatically transfer to other Kentucky skilled agents. We have 54 backup representatives located in New Jersey and Pennsylvania who assist with business continuity if necessary.

b. Aetna's Approach to Enrollee Outreach and Education Efforts

Aetna values our enrollee's choice in how they engage with us and makes strategic and creative efforts to increase and continually expand how we can better meet their preferences and engage with them. . Through our long-standing relationships with community-based organizations (CBOs), our enrollee engagement efforts take place at the grassroots level. We also make use of innovative technological approaches to reach our members where they are and when they prefer to take advantage of outreach and education efforts.

b.i. Approach to Educating and Engaging Enrollees

Through targeted outreach, we provide and connect enrollees to our population health management programs and applications that improve wellness. This increased access to health information ensures that our enrollees benefit from the Department's and Aetna's population health priorities, including reducing obesity, diabetes prevalence, and substance abuse. We do this through personal interactions and technology-based outreach.

Personal Interaction

Leading Medicaid enrollees on their journey to better health starts by addressing the basics and increasing enrollee touchpoints. Our efforts combine outreach from Aetna care coordinators, outreach representatives, community health workers, and other Aetna representatives who work to establish partnerships with local CBOs, pharmacies, and other stakeholders to increase access for our enrollees. We approach and engage enrollees through numerous mechanisms including the enrollee handbook, enrollee portal, educational programs at local clinics, and health fairs to provide educational materials and resources. We include information on our population health management program, addressing key and critical issues impacting Kentucky, such as obesity and opioid abuse, to improve overall health. Aetna's health literacy program provides benefit resources including value-adds and financial education. Our open enrollment scripting informs enrollees of new benefits and value-adds and provides comparisons of benefits for enrollees in relation to other managed care organizations.

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Figure C.12-1: Community Engagement
The Aetna Community Outreach team participated in the Franklin County Health Department Baby Shower for Health Access Nurturing Development Services program.

One innovative example includes Aetna Better Health of Kentucky's partnership with pharmacies in the Community Pharmacy Enhanced Services Network (CPESN). Through a close collaboration with local pharmacies, we initiated a new program in 2019 to provide a higher level of care for shared enrollees, addressing things like medication reconciliation, synchronization, optimization, and care coordination.

The CPESN program utilizes local community pharmacists to engage enrollees and create individual enrollee pharmacy care plans that define interventions based on a comprehensive assessment of enrollee medication use and health needs. Enrollees are identified for outreach based on the presence of polypharmacy concerns (greater than four prescriptions in 60 days) commonly seen with medical conditions such as hypertension, diabetes, asthma/chronic obstructive pulmonary disorder, behavioral health conditions, and chronic pain.

Participating CPESN pharmacists attested the program removed enrollee barriers to care and improved health outcomes. Completed program assessments demonstrated the positive impact of the Aetna and community pharmacist collaboration.

Aetna's Community Outreach team supplements these efforts with enrollee education programs designed to engage enrollees in fun and interesting ways. Some examples of these programs include the following:

- Living with Diabetes education program: This is a basic diabetes course provided at no cost to enrollees, offered at various venues throughout the community. Aetna provides the course as a series of 8 to 10 classes, or the course can be customized to meet an organization's needs. Our most popular option is the 1.5-hour cooking class which focuses on basic carbohydrate counting and how to shop using food labels and nutrition information.
- Slow Cooking and Healthy Nutrition program: Community Outreach staff provide enrollees with tips about nutrition and healthy cooking techniques using slow cookers. Classes are held once a week or biweekly at different community settings. The classes cover the following topics: nutrition, body mass index, diabetes, high blood pressure, heart disease, and dietary guidelines. Facilitators provide cooking demonstrations of healthy and affordable recipes. At the end of the class, each participant receives a slow cooker.

Technology-based Outreach

Increasingly, this engagement in addressing the whole person is enhanced by technology. Aetna uses our website, mobile application, social media, and opt-in text messaging programs for chronic conditions, pregnancy, or other health-related needs to engage enrollees. Examples include the following:

- **New enrollee welcome calls:** Introduces the enrollee to the health plan and their benefits as well as encourages them to work with care management to complete a health risk assessment. The welcome call also helps in providing enrollees information concerning access services and using the provider directory. Additionally, the welcome call includes information on the opportunity to enroll in our population health management programs.
- **Aetna mobile application:** As part of our digital portfolio, we offer a free Aetna application for both iOS and Android smartphones. The application supports several functions (i.e., electronic identification (ID) card, eligibility verification, authorizations, change of primary care provider (PCP), explanation of benefits display, medication tracking, provider directory lookup, enrollee educational information, identification of care gaps, etc.). Access to this application allows enrollees to self-manage their conditions and be empowered to direct their care, in coordination with their care manager.
- **Enrollee web portal:** This enrollee website is an enrollee's resource for managing their plan. It will help them use their Aetna Better Health benefits and services so they can get and stay healthy. Services offered through this portal include the following:
    - Accessing health plan details
    - Obtaining personalized health information
    - Researching prescription drugs
    - Receiving instant access to authorization approvals
    - Viewing claims details
    - Obtaining other support.
- **Personal smart video:** Aetna launched a series of health and wellness videos in 2018. These are approximately 60-second videos with targeted health and wellness information. We build educational videos customized for specific populations using data that is distributed to enrollees and providers as an outreach to educate, inform, and increase participation. The customization helps engage the target audiences to achieve an enhanced enrollee experience, impact enrollee outcomes, and create market differentiation.
- **Telehealth:** Our virtual health care delivery approach incorporates evidence-based practices to enhance our enrollees' health and focuses on prevention, wellness, early intervention, and comprehensive care. Our expanded delivery approach ensures our enrollees are offered varied options to receive and access the highest quality care from their care team, including access to virtual care experiences via telemedicine. We use telemedicine both as an alternative to and to complement traditional face-to-face physician visits for eligible children and adults. Our telehealth and remote patient monitoring programs enable access via real-time interactive communication between the

enrollee, their PCP, care team, or other skilled practitioner located in separate locations. While the specific provision of telemedicine is highly regulated by both state and federal Medicaid laws, diagnosis and treatment of illness or injury and services such as assessment, monitoring, communications, prevention, and education can be effectively rendered. In markets where the volume of network telehealth providers needs strengthened, we will engage and partner with Commonwealth-licensed vendor practitioners. Telemedicine can improve health outcomes and access to care while making health care delivery systems more efficient and cost-effective.

- **Collaboration with Pursuant Health for enrollee text outreach effort:** We outreach to enrollees through a personalized mobile program that sends text messages to program enrollees on a variety of topics. These include texting campaigns for multiple programs for smoking cessation, prenatal care, preventive screenings, and others, which are free to the enrollee. Aetna utilizes the services of Pursuant Health to reach and reward our enrollees across multiple channels, including mobile, web, and kiosk. We currently mail newsletters to our enrollees and post them to our website, and soon will use texting to distribute our newsletter and notify enrollees about important events like open enrollment. In the future, we plan to use texting to educate our enrollees about important health topics and disease management. We already use social media ads to educate our enrollees on preventive measures like lead screening and the importance of diabetic eye exams.

  In addition to texting and social media posts, we also use Pursuant Health's kiosks located in Kentucky Walmart stores to engage with our enrollees. We have established first-of-its kind kiosks at each Kentucky Walmart location, providing enrollees with health risk assessments, blood pressure checks, and additional communication for enrollees. We are participating in a pilot with Pursuant Health where our enrollees with diabetes can go to a Walmart kiosk when it is convenient for them, get retinal images taken, and earn an instant incentive that they can spend in the store. These retinal images are sent to offsite optometrists who interpret the images and send the results back to the enrollees and their PCPs. We can also use the convenience of Pursuant Health's kiosks and motivation of instant incentives to collect important data on our enrollees.

  Pursuant Health also educates potential Aetna enrollees on open enrollment. **In 2018, we displayed open enrollment information on roughly 100 kiosks in Kentucky Walmart stores, including a sign viewed by all pharmacy shoppers.** Using geo-targeting, we also delivered mobile ads about open enrollment to relevant individuals. In November 2018, we targeted these mobile ads to individuals who had visited a Walmart pharmacy, a Department for Community Based Services office, a federally qualified health center, or a Family Dollar, Dollar General, etc.

  Our enrollee outreach efforts also include text messaging programs that are condition- or need-specific—such as text4baby for pregnant women, asthma campaign, smoking cessation, diabetes, flu messages, breast cancer, diabetes, and well-child visits—and includes targeted reminders. Every time an enrollee calls in, our Enrollee Services staff send enrollees an electronic alert to close any open gaps in care, including the need for a cervical cancer screening.
  - **Social media offerings:** In Kentucky, Aetna engages enrollees through social media platforms. We currently collaborate with Kentucky Medicaid on its social media offerings and with community-based organizations to be active in communicating messages concerning open enrollment through social media. We load ZIP codes of facilities in defined areas so we can direct Aetna information to them, such as information on health programs, health fairs, and cooking classes.
  - **Digital campaign:** In 2019, we launched a targeted digital campaign which highlighted our benefits and services to ensure enrollees and potential enrollees better understand the benefits we offer and how to use them. The six-week campaign drove 5000 percent more traffic to our website than during the same time period in 2018. The campaign consisted of display and Facebook ads and generic and brand searches on Google and Bing.

- **Localized messaging:** Through ZIP code-specific alerts tailored to the enrollee's location, we outreach via text messaging. These include enrollee awareness items such as upcoming events (e.g., cooking classes, open enrollment alerts, and customizable messages such as new providers added to the network.)

Additionally, our enrollee services representatives conduct enrollee outreach calls to schedule enrollee visits with their PCPs for wellness visits and immunizations. At open enrollment, we have also implemented an outbound enrollee retention strategy in which we engage enrollees to assist with their annual Medicaid renewal.

To show appreciation for our enrollees, we provided an Eating Together campaign (enrollees are invited through text messaging) through collaboration with local community health departments. Aetna has collaborations with regional health centers and federally qualified health centers in each of the eight Kentucky service regions and collaborated in 2017 to provide onsite education during open enrollment. We outreach to address potential gaps in social determinants through nutrition-oriented cooking classes, a clothing drive to assist enrollees in attaining interview attire, and resume workshops to assist enrollees in gaining employment. These statewide efforts include education and resources related to enrollee benefits and value-adds.

In 2017, Aetna implemented a national project across all markets to improve breast-screening rates and optimized outreach to enrollees to gain a better understanding of their motivation and barriers to care, including being too far, too sick, or too busy. We also tested the effectiveness of different types of messages ('do it for yourself' versus 'do it for your family'). These education efforts all serve to increase overall access to care, improving population health one enrollee at a time, and meeting enrollees where they are with useful, health-improving resources.

b.ii. Aetna Priority Areas for Enrollee Outreach and Education

In alignment with Kentucky's health priorities, we are focusing our enrollee outreach and education efforts. As examples, enrollees receive disease management education materials and programs, supports to access health services effectively, and supportive care management. Our focus includes keeping enrollees healthy, managing multiple chronic conditions, and improving outcomes on the following key areas to enhance and create a healthy lifestyle. These educational efforts through our health literacy program align with the Kentucky State Health Improvement Plan 2017–2022 priorities and include the following:

- **Integration and health access—telehealth:** Our virtual health care delivery approach incorporates evidence-based practices to enhance our enrollees' health and focuses on prevention, wellness, early intervention, and comprehensive care. Our expanded delivery approach ensures our enrollees are offered varied options to receive and access the highest quality care from their care team including access to virtual care experiences via telemedicine. We use telemedicine both as an alternative to and to complement traditional face-to-face physician visits for eligible children and adults. Our telehealth and remote patient monitoring programs enable access via real-time interactive communication between the enrollee, their PCP, care team, or other skilled practitioner located in separate locations. In markets where the volume of network telehealth providers needs strengthening, we will engage and partner with Commonwealth-licensed practitioners. Telemedicine can improve health outcomes and access to care while making health care delivery systems more efficient and cost-effective.
- **Obesity and nutrition:** Enhances enrollees' health through better eating by helping them learn better cooking techniques and by volunteering in community gardens:
  - Slow Cooking and Healthy Nutrition program: We offer weekly classes to educate enrollees on nutrition and healthy cooking techniques using slow cookers. The classes are held in community settings.

- We outreach to engage enrollees in community gardening volunteer activities to learn how to grow their own vegetables and help sustain healthy eating habits. At the community garden in Ashland, any volunteer who participates at the garden can take produce. Additional produce is donated to a local food pantry, City Harvest, and the community kitchen at The Neighborhood. This program is currently available in Regions 4, 5, 6, 7, and 8. In 2019, we partnered with eight CBOs to cultivate and harvest our community gardens. Plans are underway to expand community garden volunteerism to the remaining regions in 2020.

- **Smoking cessation program:** We offer smoking cessation education to enrollees to eliminate their dependence on nicotine and enhance their overall health.
- **Diabetes gaps in care:** This program closes diabetes gaps for those enrollees with diabetes who are identified as noncompliant in care. The program reminds enrollees of comprehensive diabetes care screenings and behaviors.
- **Maternal and child health:** We conduct educational outreach calls to high-risk pregnant enrollees and text messaging to enrollees identified as pregnant but who have not received prenatal or postpartum services within recommended timeframes.
- **Opioid campaign:** Through our opioid substance abuse campaign, Aetna seeks to prevent opioid addiction and limit long-term opioid usage. We educate enrollees on opioids, promote safe storage and disposal, and promote health plan resources for opioid support.
- **Microclinics:** An interactive health program that teaches participants how to adopt practical health behaviors and changes while receiving periodic health screenings to monitor their progress. Practical applications include, but are not limited to, deciphering nutrition labels, group fitness activities, cooking healthy foods, and making sustainable lifestyle changes to manage or prevent chronic disease. There are two trained facilitators at the local plan.

b.iii. Educational Initiatives Driving Appropriate Utilization and Cost-effectiveness

To promote appropriate utilization and enrollees' efficient use of health care, we create opportunities for the enrollee to receive the most appropriate level of care. We have undertaken two initiatives specifically concerning emergency room (ER) usage and behavioral health, which promotes appropriate utilization. Enrollee services representatives have an essential role in aiding enrollees to use their program benefits. If an enrollee calls while in a behavioral health crisis, our enrollee services representatives warm transfer the call to the Behavioral Health Services Hotline, in addition to enrollees directly calling the hotline. Warm transfers help assure that the enrollee in crisis will not abandon the call while waiting on hold.

HealthRunsDEEP diabetes program: We replicated the core concepts of the diabetes prevention program in our HealthRunsDEEP program, which was adapted for use with Medicaid enrollees. The intervention was administered by a multi-departmental team of Aetna employees from Community Outreach, Wellness and Prevention, and Population Health. The intervention consisted of four in-person sessions held at the Housing Authority over a three-month period from August through October 2019. We targeted Bowling Green, Kentucky as the location of our intervention due to strong community partnerships with two organizations in the area, Hines Pharmacy and the Housing Authority. We leveraged these relationships to recruit enrollees and deploy the intervention. A total of 22 people participated in the program with over half attending at least two or more in-person sessions. Program evaluations revealed positive experiences from all who responded. One responder commented that the impact of the program will "help us live a little longer."

The administrative costs for the program were minimal (around $1,200 for the four sessions including travel time and participant incentives). According to the American Diabetes Association, the average medical expenditures of someone with diabetes are $16,752 per year, of which about $9,601 is attributed

to diabetes[3]. At a cost of only $100 per participant for administering the program, the potential to produce significant return on investment is clear. Preventing the onset of diabetes in just half of our participants could eventually yield a savings of over $55,000 a year in costs associated with diabetes.

ER usage: Enrollee services representatives assist enrollees by appropriately triaging the call by directing them to Care Management or appropriate resources to assist the enrollee with their immediate care needs. We also frequently outreach and engage enrollees on appropriate use of the ER, specifically for those enrollees with chronic diseases such as diabetes and asthma. We encourage greater consistency in use of PCPs and assist them in coordinating follow-up appointments to foster the appropriate level of care and cost-effectiveness.

Supporting behavioral health: Aetna uses referrals from internal resources, including from Enrollee Services and our call center based on interactions over the phone or through historical data, which we assess and trend at the enrollee level. Enrollee services representatives receive behavioral health training to identify when a crisis may be occurring. Enrollees that call during business hours will go to a care manager, and after business hours they will be warm transferred to the Behavioral Health Services Hotline.

Behavioral health is a core function of our health plan and is not subcontracted to a behavioral health organization. This is part of our commitment to integration and holistic care.

b.iv. Collaboration Opportunities with other MCOs, Cabinet Departments, and Community Partners

Aetna shares the Department's vision and is committed to serving as a key partner to the Department and other managed care organization (MCOs) to collaborate on issues, ideas, and innovations for the efficient and economical delivery of quality services to enrollees. Aetna proposes adopting the Department's innovative approach used when planning and preparing for previous implementations to promote collaboration among contracted MCOs.

Aetna is currently taking a leadership role in collaborating with the Commonwealth's MCOs, the Kentucky Hospital Association, providers, and key stakeholders on the new Upper Payment Limit reimbursement program for Medicaid providers. The goal is to reduce administrative burden on hospitals.

In our view, monthly meetings provide an opportunity to collaborate with a wide array of stakeholders to identify and address the core issues that affect Kentucky's health care delivery system. By working together, we can develop solutions to key public health issues, help design effective policy, and achieve the Department's overarching objectives.

As Aetna looks holistically at enrollees' health care, taking the whole person into perspective, our approach for conducting monthly meetings also is holistic. We propose monthly meetings to be conducted in collaboration with the Department, the Department of Community Based Services, the Department of Public Health, the Department of Behavioral Health, as well as other MCOs and stakeholders. Each meeting's agenda could focus on a few timely issues and include a brief presentation, an open comment period, and a review of action items. This approach provides opportunities to identify and understand enrollee, provider, and other stakeholder needs; address gaps in care; and align strategies for overcoming barriers to accessing care, simplifying the enrollee and provider experience, addressing the social determinants of health, and promoting enrollee independence and self-management.

We welcome the opportunity to expand our partnership with the Department and its sister agencies through the facilitation and coordination of meetings and committees that serve to identify common

[3] Economic Costs of Diabetes in the U.S. in 2017, Diabetes Care 2018 May; 41(5): 917-928.https://doi.org/10.2337/dci18-0007 accessed October 15, 2019.

objectives and to develop solutions that improve processes and bring one voice to enrollees. Additionally, Aetna supports developing and participating in future work groups and committees with the Department to further its goals. For example, **we anticipate population health management, provider administrative simplification, and strategy committees may be needed to advance the Department's program goals in the future.**

Aetna collaborates with other MCOs, Cabinet departments, Kentucky Workforce Development, public health departments, and community-based partners such as the Urban League and Community Action Agency, to support services, outreach, and education of our enrollees. We engage with other MCOs, community-based organizations, and Cabinet departments through the oral health coalition (Kentucky Smiles) and other initiatives.

In 2017, Aetna provided 720 doses of Narcan® to first responders in the northern Kentucky and Appalachian regions to help prevent opioid overdose-related deaths in the area.

In 2018, the Aetna Foundation made a donation to the Chrysalis House. Aetna Chief Executive Officer Jonathan Copley presented a $50,000 donation at the 5k event.

In 2019, ABHKY donated $150,000 to Volunteers of America Mid-States for its Manchester, Kentucky Freedom House location.

In collaboration with local non-profits and public health departments, we developed a baby shower program for new mothers, providing them with education on breastfeeding and infant nutrition. Through the program, mothers and newborns received essential infant items such as diapers and baby wipes. Through our moms-to-be program, pregnant enrollees can earn incentives by completing prenatal visits, including a Pack 'n Play and a diaper bag. These collaborations are a key part of our company culture, tapping into community partnerships and allowing enrollees to participate in the community baby showers.

c. Communication Methods with Enrollees

Aetna has developed effective means to interact and communicate with enrollees, ensuring that materials meet enrollee needs but also are effectively distributed and accessible. These communication methods include print materials, call center and outreach calls, text, social media, and our mobile app. Aetna's enrollee-facing materials help to improve health and enrollee health outcomes by including newsletters and illness fact sheets addressing specific illnesses and health conditions, including diabetes and asthma, as well as larger population health concerns such as opioid abuse.

c.i. Creative Efforts to Achieve High Levels of Enrollee Engagement

Aetna engages in numerous creative efforts to increase and continually engage our enrollees in their own health improvement. We engage enrollees across multiple platforms to increase the means by which we interact with enrollees with the goal of engaging enrollees where they are, with what they need, when it is needed. By creating multiple entry points for our enrollees to improve their health, we are creating a trusting relationship and true partnership by being there whenever enrollees need us. These entry points include text, social media, email, apps, and the Aetna Health mobile platform.

The Aetna Health mobile platform is new and upgraded with a user-friendly graphical interface. It allows Medicaid enrollees to schedule provider appointments within the app. The mobile platform provides enrollees help in finding providers, accessing Aunt Bertha to find reduced-cost social services, viewing their list of current prescriptions and dosages, and viewing current care plans developed with a care manager.

Figure C.12-2: Cribs Donation
In October 2019, Aetna donated 20 portable cribs to benefit programs operated by Volunteers of America that help women and children improve their health outcomes. Ten portable cribs were donated to Freedom House, an addiction recovery center for women, and 10 portable cribs were provided to Unity House, which Volunteers of America operates as a shelter for homeless families.

The **value-added enrollee benefit catalog** seeks to significantly improve enrollee participation in all value-added benefit incentive programs by creating easy enrollment paths accessible to enrollees on mobile phones. The value-added benefit information will also be easily accessible to all enrollee services representatives and care managers to assist enrollees in accessing value-adds for their needs, such as pregnant mothers in need of cribs. All value-added benefit information is easily accessible through the enrollee web portal and is visible to care managers. Value-added services available to enrollees include our healthy literacy program, back-to-school assistance program, Start Strong, Keeping Kids Safe lockbox program, and more.

Periodic remote patient monitoring creates access to daily data via easy-to-use software and peripherals. It enables both the enrollee and their care team to know how they are doing on a daily and weekly basis and to implement timely solutions to better manage any untoward situation. Whether individuals are managing chronic conditions such as hypertension and diabetes using glucometers, scales, and blood pressure cuffs, or returning to a pre-hospitalization status, remote patient monitoring is helpful. Through the tool and communication with the care team, enrollees are better monitored, better informed, and more engaged in their health care experience.

Using **advanced data analytics** (biometric data and deep analytics), we are creating the means to determine the appropriate drug regimen and get it right the first time for our enrollees, avoiding adverse drug combinations and limiting trial and error of incorrect prescriptions or negative side effects. Advanced data analytics will also help highlight enrollee needs and help care managers and others create pathways for enrollees to access value-added services.

Health in All Places is our strategy to address the social determinants of health—and is our commitment to making the social, environmental, and behavioral factors that impact the individual's health a part of our comprehensive approach to care in all lines of our business. In 2019, we began targeting 14,000 individuals in Louisville as part of the Unite Us case study to address social determinants of health and link with our Health in All Places program. Aetna proposes to address social, economic, and behavioral needs for Medicaid enrollees in Kentucky using an outcome-focused social care coordination platform powered by Unite Us. This robust, collaborative approach equips health care and community service providers with a shared platform they can use to identify available resources for patients, while simultaneously tracking outcomes within a single integrated network of care and social services.

Seamless Support Reassures Distressed Expectant Mother

At Aetna, we provide resolution the first time an enrollee calls, regardless of the department or staff they are seeking—this is ***service without borders***.

A Spanish-speaking Aetna enrollee called our Enrollee Services call center reporting she was having difficulty communicating with her provider, and she was feeling hopeless during her pregnancy. The enrollee sounded distressed and was talking loudly. The Spanish-speaking enrollee services representative listened compassionately and patiently, using her training and skills in MHFA to validate the enrollee's experience. The representative offered a warm transfer to the enrollee's clinical care manager. She sent an instant message to the enrollee's care manager to verify that she was available and connected the enrollee to the care manager while she stayed on the line. The care manager listened and provided immediate help and resources. After speaking with the care manager, the enrollee said she felt more hopeful and grateful for the support provided. The outcome was that Aetna staff addressed this enrollee's issues immediately and seamlessly, the first time she called.

The Unite Us powered platform that Aetna intends to leverage is verifiably different from other solutions in the marketplace. Unite Us enables providers in a community to work together in real time to coordinate care and track actual care outcomes that result from inter-agency referrals. CBOs, public agencies, health care providers, and behavioral health providers use Unite Us to send and receive referrals to and from each other and to maintain visibility as their clients access care and get help.

Aetna incorporates diverse methods to communicate effectively with our enrollees and encourage engagement in their health benefits and services. Through the **Service Without Borders** initiative, we created a process to engage enrollees fully and effectively resolving issues on their first call.

Enrollee services representatives play a critical role at Aetna as they are often the first point of contact for our enrollees. To answer and resolve enrollees' issues more quickly under the **Service Without Borders** program, implemented across the Aetna enterprise in 2017, representatives now call other parts of the company to gain answers and resolve issues more quickly while the enrollee is on hold, resolving the issue in mere minutes. Our Enrollee services representatives are empowered to assist enrollees and create first-call resolution whenever possible. As a result of Service Without Borders, we have seen enrollee satisfaction scores increase by 10 percent[4]. Through the paradigm shift of Service Without Borders, our representatives actively engage enrollees to determine if they are receiving all their benefits, and if not, how we could make it happen, including value-added services.

Beyond creating ways to address enrollees' needs when they call, we have created text messaging programs and engage enrollees through social media. Aetna's texting campaigns provide enrollees notifications for checkups and screenings recommended by the U.S. Preventive Services Task Force.

[4] "Mission-Driven Leadership: My Journey as a Radical Capitalist," Mark Bertolini, 2019, p. 114.

Reminders are sent for physical, dental, and routine screenings including mammograms and cervical and colon screenings, and are based on enrollee age, gender, and eligibility. These messages will be sent to enrollees for whom a date of their last physical exam is either not received or is more than one year in the past.

c.ii. Identifying, Developing and Distributing Communications to Target the Specific Needs of Enrollees

Aetna's marketing outreach team is rooted in the community; staff live, work, and play in their service regions, which provides a deep understanding of the population we serve. Over time, our outreach team has developed long-standing relationship with organizations that serve our enrollees—working in partnership with CBOs to engage, educate, and empower targeted populations (e.g., homeless, domestic violence, etc.) and the community at large. Through our partnerships, we are able to determine enrollee needs and participate in or develop events and health literacy programs that address the needs of our enrollees. Outreach does not differentiate services for our targeted populations; we focus our efforts to creatively seek out enrollees through customized outreach initiatives. Once we determine the needs of the intended audience, we utilize our community-based partnerships to develop and distribute communications.

Outreach develops all communications for the purpose of marketing an event or promoting a health literacy class/series to enrollees (the types of communications used are outlined in the Marketing section). All events and classes are held in the facilities of our community partners. When developing communication materials, we first identify:

1. The target audience
2. What they need to know
3. When and where the event will take place
4. Point of contact for additional questions

We adhere to all contract requirements when developing communications. We ensure all enrollee-facing communications are at or below a sixth-grade reading level (determined by Flesch-Kincaid), published in at least a 12-point font, available in large print (no more than 18-point), and approved by the Department before any communication is distributed. We maintain a system of control over all content, form, and methods of dissemination of marketing and information materials.

When preparing to distribute State-approved communications to targeted populations, we ensure the appropriate communications are disseminated at the appropriate venues. For example, when exhibiting at a community baby shower, we would provide our "Healthy Mom, Healthy Baby" brochure or if the event is a HealthRunsDEEP health literacy event, we would distribute the "Portion Control Flyer." The outreach team plans and tracks all event specific activities. Staff prepare for all activities the week prior to the event.

Preparation includes the following:

- Pre-event planning with the CBO
- Identifying the audience
- Identifying the type of event and what materials (brochures, pamphlets, etc.) are relevant/needed
- Collecting all identified materials from the central office before the event
- Delivering materials to the CBO ahead of event, when possible

The outreach team uses SalesForce tracking system to capture all event specific activities. Tracking includes the following:

- Pre-event checklist
- To-do list

- Follow-up communication
- Event details/summary

The summary detail is used for the planning and preparation of future events aimed at the same targeted populations.

Our Care Management staff utilizes Krames® on Demand, which is a tool that contains patient education sheets on multiple health, wellness, and social conditions. It contains sheets that can be individualized for each enrollee that provides education on the condition and treatment options. Care managers select items for enrollee education and then mails this targeted communication to members based on the care manager relationship and enrollee care needs.

On our website, we include a page specifically with health information for families[5]. It features thousands of medically reviewed articles, animations, features, and age-appropriate news for parents, kids, and teens.

Aetna writes enrollee materials in plain language at or below a sixth-grade reading level (determined by Flesch-Kincaid), as required by the Commonwealth, using clear and empowering words and active voices to convey messaging, avoiding jargon and technical language whenever possible. With more than 30 years of experience serving Medicaid populations, Aetna's Medicaid organization honors the cultures of our enrollees to better serve them and create a healthier population. This extensive experience has enabled us to gain insights on diverse populations, ensuring we are respectful of our enrollees in relation to a disability or their sexual orientation, gender, and gender identity. Standards for competency, expertise, and cultural sensitivity are communicated through the provider manual, newsletters, during site visits, and in training documents. We ensure enrollee materials are available in braille and large print and are appropriate in discussions of gender, gender identity, and sexual orientation. On an annual basis, our Enrollee Services staff receives updated cultural competency training.

c.iii. Methods of Leveraging Communications to Meet Diverse Needs of Enrollees

Aetna's enrollees are our Kentucky family, neighbors, friends, and acquaintances. Aetna values an enrollee's choice in how they engage with us and how we communicate with them. Since 2011 in Kentucky, our use of person-centered approaches guides our understanding of the needs of our enrollees and their families and informs the condition and population-specific tactics and activities that we use to establish and promote high-level participation. Our local approach allows our staff with specialty skills to more successfully engage with our enrollees.

Aetna's Multicultural Marketing team provides multicultural insights and strategies, including making available translation and interpretation services in over 200 languages, which include Kentucky's top 15 non-English languages and American Sign Language, through our vendor. We engage economically challenged individuals, understanding they may have poor access to the internet or cellphones and other necessities of modern access to health care. To mitigate these challenges, we support the federal program to provide Lifeline mobile phones to enrollees to access Aetna customer service, data texting use, and the Aetna mobile app. Aetna provides telecommunication options for enrollees who are deaf and hard of hearing through the 711 national service.

Based on Commonwealth goals, population-based data, and community and population needs, Aetna has facilitated several programs to engage at-risk enrollees and populations, to address population gaps, disparities, and inequities.

In serving Hispanic enrollees, the largest ethnic minority population in Kentucky[6], we understand that health is a family affair and any health decisions are made as a family. Caregivers and family of enrollees

[5] Available at https://www.aetnabetterhealth.com/kentucky/wellness/focus/kids-health

are strong influencers along the health journey and take part in key decisions. Family responsibilities are a priority over health, and juggling responsibilities can get in the way of enrollees taking care of their own well-being. Health care providers are often viewed as authoritative and respected figures for Hispanic enrollees, who highly respect their provider and expect a formal yet warm and personal relationship with them.

Aetna's enrollee handbook meets all requirements, including written at a sixth-grade reading level (determined by Flesch-Kincaid). The handbook meets all Cabinet requirements, including but not limited to information on availability and selection of network providers and PCPs, making appointments, seeking oral interpretation services, and coordinating emergency and non-emergency transportation.

d. Innovative Outreach Methods to Engage the Homeless Population

Aetna has developed a multipronged approach to outreaching our Kentucky enrollees who are homeless. We have developed a homeless outreach plan because through our experience, we recognize that certain enrollees will be particularly difficult to contact, such as those experiencing homelessness. When a difficult-to-reach enrollee calls in, our call management system alerts the staff member to engage the enrollee and warm transfer them to a care manager to assess their needs and provide any resources needed.

Aetna staff dedicated to outreaching and engaging the homeless population outreach enrollees most successfully by meeting the enrollee where they are. Most often, the Care Management staff meets with enrollees face-to-face at homeless and/or domestic violence shelters, providers' offices, food pantries, or any other agreed-upon location in the community. As part of the outreach process, the Care Management staff attempts to complete the health risk assessment (HRA), health care equity event, and homeless assessment tool. If an Enrollee Services staff receives a call for any reason, they are trained to assess whether an HRA has been completed. If an HRA has not been completed, they will warm transfer the enrollee to a care manager assistant for completion. In addition, any staff can complete an HRA on a mobile device wherever the enrollee is located (i.e., a homeless shelter or park). The HRA can also be completed by the enrollee at a Walmart kiosk. Utilization of the assessments assist the Care Management team in assessing social determinants of health as well as physical and behavioral health risk factors and allows the staff to identify any other needs. The Homeless Services team also visits enrollees face-to-face when they are inpatient in the hospital to address needs and assist them post-discharge. Through this process, we provide resources to the enrollee and attempt to engage them in ongoing care management.

When communicating with homeless enrollees, our care managers conduct health risk assessments, including social determinants of health questions (such as their access to housing, groceries and any impacts of domestic violence). We also have a homeless assessment tool, which explores specific needs related to our homeless enrollees. The tool is used in provider offices and homeless shelters and is used in developing a comprehensive care plan. Depending upon the need, the intensity of our contact efforts may vary based on enrollee information and clinical judgment. Our Homeless Services team can also use a database where we can access enrollee information that tracks interactions with community agencies such as homeless shelters through the Homeless Coalition (specific to a geographic location). If such a check-in is found, our team outreaches to that community agency in hopes of establishing contact with the enrollee. Any time we are unable to contact an enrollee, we may attempt to find them through any of the following means, as appropriate:

- Publicly available sources such as telephone listings and online directories
- Pharmacies where an enrollee may have recently filled a prescription
- Our inpatient census tool and real-time pharmacy claims system

[6] "2017 Kentucky Racial and Ethnic Distribution," Kentucky Public Health: accessed 6/19/2019; https://chfs.ky.gov/agencies/dph/Documents/2017KYEthnic_Distribution.pdf.

- Enrollee's PCP or other providers
- Emergency contacts, family, friends, property owners, or others we know to have previously been in contact with the enrollee
- Other Commonwealth government agencies providing financial or service support to the enrollee
- Community-based organizations such as homeless shelters and food kitchens

Because homeless individuals have difficulty accessing health care and often have numerous unmet health needs, we have a detailed outreach plan to engage them and create multiple potential entry points to care. Aetna's homeless outreach plan is a comprehensive strategy to reach and assist our enrollees who are or are susceptible to becoming homeless. A key component of our outreach efforts includes using the Homeless Management Information System (HMIS), through which we track enrollee interactions, and our homeless enrollees' use of social services. We identify homeless enrollees within the system and document their unique needs and challenges, which include pregnancy, behavioral health services, former foster child status, care management referrals, and utilization management.

Our outreach process uses three distinct means to reach enrollees who are or may be homeless, including calling their known phone number, sending a letter to their current or last known address, and then a follow-up call within 7-10 business days later. For enrollees we cannot reach, we use the HMIS to identify their last social service or CBO interaction and engage that entity to attempt communication. Within our current homeless population outreach strategy and plan we have the following initiatives and currently outreach and collaborate with the following organizations shown in **Table C.12-1**:

Table C.12-1: Aetna Homeless Outreach Plan Key Components

System	Description
Outreach initiatives to communicate with and serve our homeless enrollees	• Snack pantries at St. John Center for Homeless Men and Uniting Partners for Women and Children • Vending machine at Centerstone • Toiletries sent to homeless clinics in Owensboro and Hazard • Participation in Health Care for the Homeless Day • Annual participation and sponsorship of Street Count • Phoenix Health Care Holiday Dinner (for individuals who reached housing during the year)
Organizations Aetna meets with on monthly basis to enhance engagement with homeless community service providers	• Coalition for the Homeless Mainstream Meeting: A monthly meeting with local organizations and services that serve the homeless in our community. Its main purpose is to keep people updated on changes and upcoming events. It also allows organizations to ask other organizations questions that have been hard to find an answer to. It also serves as an opportunity to network and to have a contact person within the organizations. • Workforce Diversity: The Coalition for Workforce Diversity forms trusted partnerships with employers who celebrate diversity in the workplace and are looking to provide work opportunities to those with disabilities. The Coalition represents potential workers with a broad spectrum of physical and mental disabilities, each with unique skills and personalities that contribute to a great workplace. The Coalition helps to place those suffering homelessness as well as the previously incarcerated. • Case Manager Resource Sharing: The purpose for the lunch-and-learns is to increase the understanding of services available in our community. Different community partners present each month on the services provided by their organization. • Greater Louisville Reentry Committee: The Greater Louisville Reentry Coalition is an organization established in Louisville, specializing in offender reentry and related issues. The coalition works hard to maintain open and informative communication related to reentry issues within the Greater Louisville area and includes the counties of Jefferson, Bullitt, Oldham, Spencer, Shelby, Henry, and Trimble.

System	Description
Organizations our Homeless Services team visits routinely to enhance collaboration on services for homeless individuals	• St. John Center for Homeless Men • Uniting Partners for Women and Children • Transition Age Youth Launching Realized Dreams (TAYLRD) through Centerstone • Phoenix Health Center for the Homeless • Kristy Love Foundation • Main Library • Re:Center Ministries (formerly Rescue Mission) • Coffee House

Aetna collaborates with CBOs to provide resources and outreach to homeless enrollees, creating relationships with homeless shelters, food banks, the Salvation Army, and YMCAs. The Homeless Services team has access to the Kentucky HMIs, depicted in **Figure C.12-3**, to update and track key information for enrollees who may be homeless that are difficult to reach.

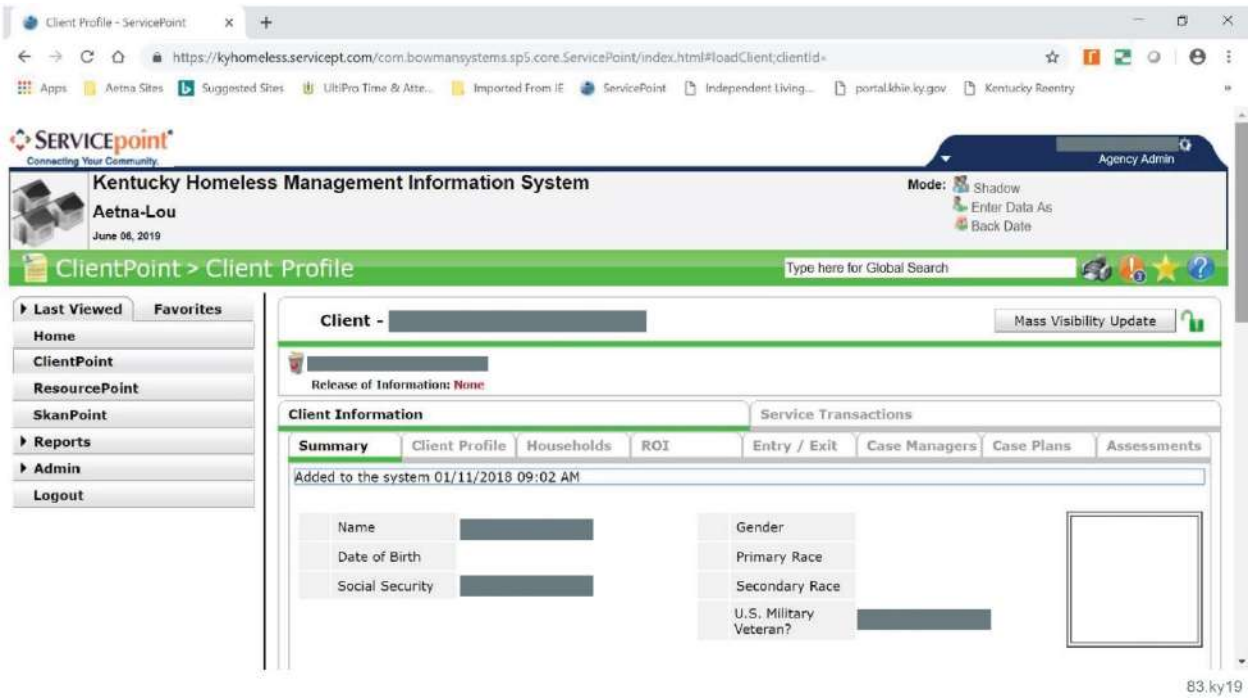

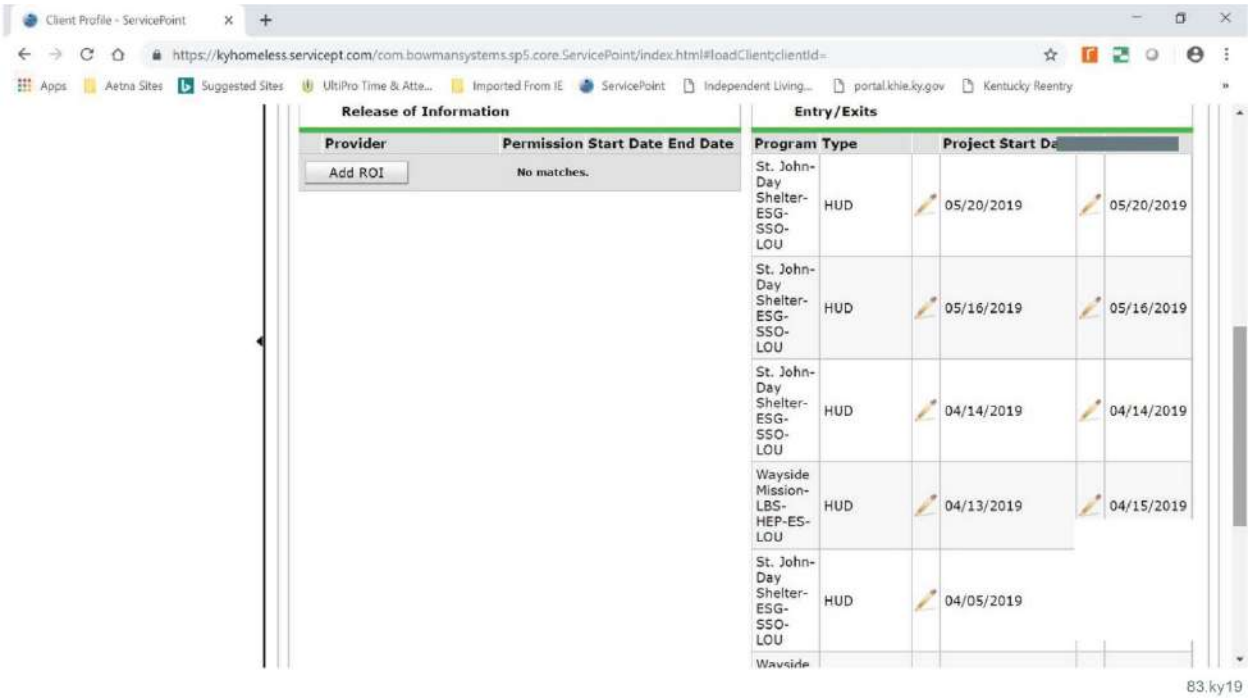

Figure C.12-3: Kentucky Homeless Management Information System

The Kentucky HMIS helps track enrollee interaction and use of community supports.

Additional ways we support the homeless population includes case management activities with the following continuing initiatives:

- Three snack and transportation assistance pantries; one located in Lexington at Catholic Action and two in Louisville at UP for Women ad St. John's Homeless Shelter.

- Two toiletry and cold weather need pantries; one in Hazard Health Clinic and one in Owensboro Health Clinic
- Homeless vending machine at Centerstone
- Support homeless medical clinics in Hazard and Owensboro, onsite at Phoenix Health Center, Homeless Street Count Statewide, and the Stand Down for the Homeless resource fair

In serving homeless individuals across Kentucky, we understand that access to personal hygiene and undergarments is challenging. Our outreach strategy has included the development of a vending machine (example shown in **Figure C.12-4**) to provide these needed items in areas where they are easily accessible to homeless persons. Items available through the vending machine include toiletry items such as soap, deodorant, hats, gloves, socks, toothbrushes, combs, disposable underwear, tampons, and shampoo, among others. Through a collaboration with Welcome House in Region 6, we donated sleeping bags during the Street Medicine Outreach program, providing homeless individuals wound care and other treatments and outreaching to over 400 homeless individuals. In addition, we also passed out public transit vouchers. Additionally, we collaborated with the Phoenix Family Medical Center in Louisville in Region 3.

Figure C.12-4: Kentucky Homeless Services Vending Machine
An Aetna vending machine provides everyday items to fill the human need for dignity and resilience.

e. Approach to Assess Enrollee Satisfaction at each Point of Contact

Paramount to increasing enrollees' satisfaction is providing ongoing opportunities for enrollees to provide feedback. This feedback benefits the service system, can influence enrollee outcomes, and commits to continuous quality improvement. We understand that enrollees who have a positive enrollee experience and are engaged in their health care services are more likely to seek routine and acute care services promptly, which can have a positive effect on their health.

Our approach to assess enrollee satisfaction is to monitor each touchpoint in which we engage our enrollees. Tools used to measure include our annual Consumer Assessment of Healthcare Providers and Systems (CAHPS), behavioral health, and care management satisfaction surveys. Reports from these tools are used to create our enrollee analysis that identifies strengths and opportunities at each enrollee touchpoint. Along with our annual surveys, internal audits are completed on the various enrollee contact points such as phone calls, secured messages, and emails. We use these findings for coaching and to identify knowledge gaps. Improvement plans are put in place to address areas of opportunity.

Aetna has been successful specifically in incorporating CAHPS survey results into actionable items to increase enrollee engagement. To improve our understanding and utility of results, we stratify results by race, ethnicity, and disability related to communication barriers to understand better how approaches to engagement of diverse enrollees are understood by the enrollee for continuous quality improvement. We conduct an annual audit of online responses and submit to the Quality Management department for

National Committee for Quality Assurance reporting. Responses are audited for accuracy and timeliness. Aetna's Care Management team conducts enrollee surveys. Enrollees in care management receive a survey regarding any interactions, whether they were face-to-face, in-person, or by telephone.

Aetna's objective is to measure, monitor, and maintain service excellence for our call center teams. Kentucky enrollee services measures quality and enrollee satisfaction in the following ways.

- Quality assurance analysts audit recorded phone calls daily. Using a phone system audit tool, the auditor can listen to the call and rate the call on soft skills (courtesy, engagement, tone, etc.) as well as accuracy of the information the representative gives to the caller. A passing score must be attained of 95 percent on a monthly basis. We use the quality reports to measure the representative's ongoing performance and identify opportunities for coaching and additional training.
- Post-call surveys are offered to callers at the end of each call. We ask the caller to participate in the survey by remaining on the line for a direct connection to the survey. The survey is brief—less than one minute to complete. It asks the caller to rate their experience from that call. The prompt transfer to the survey allows the caller to rate the call from a fresh and recent perspective. Post-call survey results impact individual and team performance measurements
- Net Promoter Score (NPS) is a rating from the caller. It asks how likely they are to recommend Aetna to family and friends. Aetna uses the NPS to measure team and individual performance. Our goal is to achieve an NPS of 80 percent or higher. We have developed incentives and measurement goals for our teams and representatives based on the NPS.
- First-call resolution: 95 percent. If follow-up with enrollee is needed, we do so within 24-48 hours. Aetna's electronic call documentation system documents and routes calls effectively

f. Sample Enrollee Materials

The following enrollee sample materials are provided in **Attachment M**.

- Draft welcome packet and enrollee ID card aligned with the requirements of the **Draft Medicaid Managed Care Contract and Appendices**
- Sample enrollee handbook meeting the requirements of the **Draft Medicaid Managed Care Contract and Appendices**
- Three sample enrollee materials with taglines and displaying ability to meet translation, accessibility, and cultural competency requirements. The three sample enrollee materials included are the following:
  - **Kentucky Clear the Smoke brochure:** Provides enrollees information on the dangers of secondhand smoke and tips to quit smoking
  - **Kentucky Metabolic Syndrome brochure:** Provides information on how to get screened for possible metabolic syndrome and offers tips to enrollees for lowering their blood pressure, losing weight, and quitting tobacco use as ways to improve their health to avoid metabolic diseases
  - **Kentucky Men's Health brochure**: Provides male enrollees tips for a healthy lifestyle, including receiving regular checkups and information on prostrate health, diabetes, high blood pressure, colorectal cancer, and others

60.7.C.13 Enrollee Selection of Primary Care Provider (PCP)

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60.7.C.13 Enrollee Selection of Primary Care Provider (PCP) (Section 23.0 Enrollee Selection of Primary Care Provider)

The Aetna Medicaid organization has over **30 years of continuous, active participation in Medicaid managed care**. We have been a part of Kentucky's Medicaid landscape since 2011[1], in which we have successfully managed enrollee eligibility, enrollment, and disenrollment. Our seamless approach for helping enrollees select a primary care provider (PCP) is aligned with the Commonwealth's goal of creating a healthier Kentucky. In addition, our local, enrollee-centered approach focuses on individuals' holistic health needs by providing access to and delivery of cost-effective health care services.

a. Helping Enrollees Identify and Make Voluntary Selections of PCPs

For some enrollees, selecting a PCP can be an overwhelming experience, as there are many factors to consider, such as gender, language, and location. In addition, some enrollees may not understand why they must choose a PCP. A PCP understands an enrollee's medical history, family medical history, and personal habits. PCPs can also tailor solutions that are specific to an enrollee's health.

We want to ensure enrollees have the most current information when selecting a PCP. Therefore, Aetna takes a proactive approach to providing the Department with the most comprehensive PCP file update biweekly, which allows our enrollees to have an opportunity to select their PCP medical home prior to joining our health plan. Aetna provides up-to-date information to help enrollees make an informed choice based on their needs by offering a wide variety of PCPs who are located throughout the Commonwealth, including federally qualified health centers (FQHCs), rural health centers, individual practitioners, and large group providers that offer multiple service locations.

For example, an enrollee may want to choose an obstetrician/gynecologist as her PCP. Aetna allows enrollees to choose specialists, as we want to ensure our enrollees are able to select the PCP of their choice. We also contract with FQHCs to serve our enrollees in those areas. We collaborate with other entities whose mission is to reach out to underserved areas, and we look for opportunities to work with additional providers to support those who live in these areas.

If an enrollee who joins our health plan has a desire to continue their relationship with a PCP who is not in our network, we make every effort to contract with that provider. This process supports the enrollee's continuity of care. If we are not able to arrange a contract with the provider, we work with the enrollee to arrange another provider who can meet the enrollee's needs. We provide assistance to help transfer care to the new provider.

To ensure continuity of care, we help enrollees make the most appropriate PCP selection based on the following:

- Previous or current PCP relationship
- Providers of other family members
- Medical history
- Language needs
- Provider location
- Providers who are trauma-informed
- Additional factors that are important to each enrollee

[1] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

Enrollees without Supplemental Security Income (SSI), as well as enrollees who are SSI and non-dual eligible, fall under our auto assignment process. If we auto-assign enrollees, those who change their PCP within 30 days shall have their PCP retroactively added back to the effective date of their managed care organization assignment. This process ensures that enrollees will have a medical home at the beginning of their assignment with Aetna.

Enrollees under the Guardianship program are assigned a PCP if they do not choose one; however, we understand they may have changing needs. The enrollee's Department of Aging and Independent Living worker collaborates with Aetna's Guardianship liaison to coordinate any PCP changes that are needed to support the enrollee's care needs or placement changes.

Our process also supports changing the PCP effective date should an enrollee contact us. Regardless of an enrollee's benefit category, our Enrollee Services department will assist an enrollee at any time with selecting a medical home.

b. PCP Auto-assignment Algorithm for Enrollees who do not Make a Voluntary Selection

If an enrollee does not select a PCP with the Department during the choice selection period or at the time of initial enrollment, **we assign a PCP based on our algorithm**. The goal of our comprehensive PCP assignment solution is to meet our enrollees' needs and to foster continuous care for our enrollees.

Aetna offers a comprehensive rules-based PCP assignment solution that allows for accurate PCP assignments with the flexibility to configure our logic to meet general and Commonwealth-specific requirements. The Aetna ChoiceEngine can accept and assigning PCPs from various sources, such as enrollment files and supplemental files, with customizable logic for each source. For some states, such as California, we receive enrollee PCP information in a supplemental (flat) file from the State or if their vendor is different from an 834 file. In situations where our enrollees do not select their PCP or their selected PCP is not available, we manage a rules-based algorithm that assigns those enrollees to the most preferred PCP based on multiple factors. Rules include, but are not limited to, using the PCP indicated in the enrollment/834 files, claim history algorithms, and value-based provider tiers. This logic is built to move through a hierarchy of steps to find a PCP that best fits the enrollee's history, needs, and location.

We first consider any prior PCP relationships for the enrollee; this is analyzed as a priority to foster continuity of care. If we cannot assign an enrollee to their previous PCP, we review the family's record(s) in our system to find a PCP that can be assigned. If we cannot assign to a PCP from a family member's record, we then locate a PCP within the enrollee's ZIP code or region (with ZIP code taking precedence). Any enrollees who still do not have a PCP assigned after these steps are carefully reviewed daily by our Enrollment Services team for resolution. During all these steps, our logic analyzes a provider's value-based services agreements and Healthcare Effectiveness and Data Information Set (HEDIS®) scores. We also consider the language of both the PCP and the enrollee in an attempt to connect an enrollee with a PCP that meets their language needs and can provide adequate care. **Our enrollees can call us at any time to change their PCP**.

Once Aetna receives the 834 files, the enrollee's records are compared to the existing data within our electronic claims management system. Each enrollee record is fed through our highly configurable rules processor, which identifies matches and consolidates and transforms the enrollee's information to ensure proper updates to demographic, enrollment benefit plan assignments, PCP assignments, enrollee classifications, and other critical information.

All enrollees who are new to the health plan receive a welcome call and a request to complete the Commonwealth health risk assessment. When the enrollee's call is transferred to care management, the

provider selection is reviewed. If the enrollee identifies a PCP other than the provider who has been selected, we assist enrollees with completing the PCP change request. We also assist with any care coordination or support that may be needed.

c. Processing Provider Change Requests

Enrollees may contact Aetna's Enrollee Services department to request a PCP change at any time. They may also submit PCP change requests on our secured enrollee web portal or mobile application. The PCP assignment is confirmed and updated with enrollees during the care management process, and **PCP change requests are made immediately**. Our process supports the logical reasoning behind each change request, and regardless of the reason, we follow the same process to reduce any burden for both providers and enrollees. Overall, **we take the needs of our enrollees into consideration**.

c.i.,ii.,iii. PCP Change after the Initial Assignment, Cause, or Regained Eligibility

When enrollees contact Aetna to change their PCP after the initial assignment for personal reasons, cause, or because they regained eligibility, **the change is made effective immediately**. Enrollees can also log onto our secure web portal or mobile application to change their PCP.

c.iv. Provider Termination

If a provider is terminated, we contact enrollees via mail within 30 days to inform them of the termination. Enrollees are informed they have 10 days to choose a PCP; if not, a new PCP is chosen for them. We coordinate with the enrollee to ensure their care preferences are honored and assist them with scheduling care, transfer of records, etc.

c.v. Provider Request

If the provider requests a PCP change on the behalf of the enrollee, the provider has the enrollee sign a change form which is submitted to Aetna. This form is accessible online via our website or can be requested through our Enrollee Services team. If the enrollee is in the provider's office, we take the change from them verbally after Healthcare Insurance Portability and Accountability Act verification, and the new assignment is effective immediately. We assist enrollees with identifying a new provider and coordinating the transfer of care, and we offer them support and guidance on the change process and education on their care needs.

d. Enrollees who do not Receive Services from their PCP within One Year of Enrollment

Aetna pulls claims data and performs outreach efforts. Enrollees with identified gaps in care are outreached via calls, text messages, and mailers. In addition, they are reminded of the importance of preventive care. Enrollees are encouraged to contact us if assistance is needed with any aspect of scheduling or receiving care. Enrollee incentives are available for receipt of preventive care that may be provided through their PCP.

Our enrollee reporting systems have alerts that notify our team members if there is an identified gap in care. When an enrollee contacts us, even if it is for a reason not related to the gap in care, we utilize the enrollee contact as an opportunity to educate the enrollee on the importance of wellness and preventive care. We also provide comprehensive coordination for this care and assist with removal of any identified barriers.

We collaborate with our provider and community organizations to support our enrollees and facilitate their receipt of annual care from the provider. One way we collaborate is working through enrollee attribution and ensuring enrollees are aware of and are receiving geographically, culturally sensitive, and appropriate options for care. Our provider accessibility telephonic survey is an avenue we use to review

emerging access issues. Aetna works directly with providers to ensure enrollees are aware of services, hours, and locations to facilitate annual care from the provider.

We also have care managers who visit homeless shelters and identify Aetna enrollees to encourage them to visit their PCPs, as they may not want to seek medical care and/or ride public transportation. Aetna care managers, along with homeless shelter staff, educate enrollees on the benefits of care, confirming transportation is available to the enrollee, and providing clothing and hygiene supports. Enrollees are given tokens to facilitate public transportation if needed. We also have supplies that support enrollee hygiene in the event the enrollee wants to wash up before they seek medical care. Care managers are available to provide follow-up and ongoing assistance through individual enrollee outreach or during regularly scheduled CM visits to shelters. **We want to support and help preserve enrollee dignity.**

Care Management Intervention

An Aetna risk adjustment report showed that an enrollee had not received care for diabetes in the past 12 months. Care Management (CM) reviewed the claims and contacted the enrollee, who reported that she was aware she had not sought out care for herself. She had been caring for a terminally ill family member who recently passed away. The enrollee stated that her diabetes had been stable, but she felt like a failure emotionally, as she was not able to prevent the death and she felt like she let her family down. According to the enrollee, she did not have the energy to see a provider.

CM provided support and discussed the enrollee's strengths of providing care and allowing the family member to have a dignified death at home. CM also discussed ongoing care coordination, including counseling support for the enrollee. However, she was unsure if that was something she was interested in. They also talked about her physical health status and benefits of a follow-up visit. The enrollee reported that her PCP managed her diabetes and she would schedule an appointment.

CM completed a follow-up call with the enrollee; she reported she had seen her PCP and was able to discuss her feelings with him. The enrollee also stated her PCP referred her to a counselor through her church and she has her first appointment scheduled. The enrollee declined participation in CM but reported that because of the CM outreach and support, she was able to take action for self-care and is now moving toward a healthy recovery from the death of her family member.

Providers in our value-based payment (VBP) programs are involved with enrollee outreach and coordination of continued care when enrollees do not receive annual care. They receive gaps in care reporting that specifies the enrollees needing some type of annual care. The providers reach out to the enrollee in an attempt to close that gap in care.

Our VBP programs encompass a measure which reviews PCP visits and outreaches to enrollees to address any concerns found in their history. Since starting our VBP program, Aetna has increased the number of groups involved as well as incentive options for our providers. Specifically, they have played more of a key role in promoting PCP involvement in our enrollees' lives by helping to close their care gaps and improve the health of Kentucky's population. To encourage provider engagement and improve impact on enrollee engagement, Aetna introduced a tiered model of payment based on performance improvement. This allowed the provider groups to be incentivized for smaller incremental improvements rather than a higher benchmark that may be further away from their baseline performance.

As a result of this tiered approach, our value-based rate for the provider groups has exceeded our plan's overall administrative rates in all eight of the HEDIS measures included in the program. The HEDIS measures include the following:

- Adolescent Well Care Visits
- Breast Cancer Screenings
- Cervical Cancer Screenings
- CDC Eye Exams—DRE

- CDC HBA1C Testing
- Chlamydia Screenings
- Combo 10 Immunizations
- 6+ Well Child Visits for Infants

Collaborations include Kentucky Primary Care Association (KPCA), St. Elizabeth Healthcare, and KentuckyOne Health (KHP). They are our most active collaborators as far as identifying and working together on a quality strategy. We have strategy meetings to discuss trends and performance, and to work through gaps-in-care reports to drill down on enrollee behavior and closing gaps. We also seek innovative solutions with these entities; with KPCA we are pursuing a delegated care management arrangement to have a direct impact on their care. KPCA also works with us on National Committee for Quality Assurance and strategies to impact the provider network data accuracy. We collaborate with KentuckyOne on our electronic population health management platform to create efficient communication between our care management teams (Aetna and KHP) as well as providing gaps-in-care reporting through the platform. Our approach is to review this data weekly, monthly, and quarterly, and then indicate our outreach plan.

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60.7.C.14 Enrollee Grievances and Appeals

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60.7.C.14 Enrollee Grievances and Appeals (Section 24.0 Enrollee Grievances and Appeals)

Aetna complies with all the requirements and principles of the appeals and grievance system set forth in the **Draft Medicaid Managed Care Contract and Appendices Section 24**, including compliance with all Commonwealth and federal laws and regulations referenced therein including but not limited to 42 C.F.R. §§438 Subpart F, KRS Chapter 13B, and 907 KAR 17:010

a. Compliance with State and Federal Requirements

Our enrollee appeal and grievance processes are simple and user-friendly, affording enrollees the opportunity to voice their issues, concerns, and problems in a non-threatening manner. Our commitment to identify and resolve appeals and grievances timely helps to make sure our enrollees, no matter their background or health condition, receive equitable and effective treatment in a culturally and linguistically appropriate manner. Aetna retains responsibility for all appeal and grievance processing, investigations, and resolutions/decisions, we do not delegate appeal or grievance processing to any subcontractors. Aetna's existing appeal and grievance infrastructure, standardized processes, and staff training optimize compliance and fairness, and support Kentucky's goal of providing high-quality and cost-effective health services.

Aetna Processes in Action

Since 2017, Aetna has maintained 99% or higher compliance with resolution of standard cases within 30-days and expedited cases within 72 hours.

As one of the original Kentucky Medicaid managed care organizations, Aetna Better Health of Kentucky[1] has established appeal and grievance processes that are further supported with Medicaid best practices acquired through the Aetna Medicaid organization's experiences in 16 states. We will leverage our experience and best practices to continue to meet and exceed the requirements in Kentucky. Our enrollee appeal and grievance processes and staff accomplish the following goals:

- Protect and promote enrollee education regarding appeals, grievances, and State Fair Hearings through enhanced enrollee education and training on rights, responsibilities, problem prevention, and easy access to information related to enrollee dissatisfaction, appeals, and grievances
- Provide comprehensive staff training to assist enrollees and to facilitate smooth operation of the appeal and grievance processes to achieve prompt resolution
- Verify that enrollee appeals and grievances are acknowledged and addressed in a manner that supports an equitable outcome
- Facilitate the resolution of issues that potentially affect access to services, quality of care, enrollee choice, and safety
- Support compliance with contractual requirements, National Committee for Quality Assurance standards, and applicable federal and Commonwealth laws and rules
- Maintain accurate and complete records, including all required documentation to enable Aetna and Department to track and review the progress and outcomes of all appeals and grievances throughout the process
- Comply with Commonwealth and federal compliance reporting requirements
- Provide advanced information technology applications that include tracking, document retention, performance evaluation, and sophisticated data analytics to link appeals and grievances to reporting

[1] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

capability for Department, root-cause identification, and operational, clinical quality, and care and service coordination improvement opportunities

- Maintain accountability through the chain of command to make sure there are prompt and thorough responses to findings and lessons learned from data analytics on root causes and quality improvement opportunities to achieve providing high quality cost-effective health care services.

Staff Training and Involvement

We maintain and disseminate internal policy and procedure documents, as well as provide role-specific training for Appeal and Grievance, Member Services, Provider Services, and Clinical Review staff members to help to make sure they are fully educated on the appeal and grievance processes. We thoroughly train all our staff to identify potential appeals and grievances, emphasizing the importance of enrollee confidentiality and privacy throughout the appeal and grievance processes. Our goal is to make the process of filing an appeal or grievance as uncomplicated as possible by removing any undue administrative challenges.

We provide enrollees with thorough and accurate information regarding complaint, appeal and grievance processes and procedures. We communicate with enrollees proactively, addressing the individuality of each enrollee. Enrollees with special needs or disabilities are provided with additional assistance to be able to access the appeal and grievance process; this assistance includes, providing information in English, Spanish and other prevalent languages, as well as in alternative formats (e.g., interpreter services, translation services, audio tapes, sign language, large font, and teletypewriter [TTY] through Relay Kentucky). We also provide reasonable accommodations and have accessible meeting space for enrollees with physical disabilities who wish to file an appeal or grievance, or present information, or otherwise participate in person. Aetna employees are empowered to help enrollees with all aspects of the appeal and grievance processes to minimize frustration, improve resolution timeframes, and verify that the enrollees receive the care they need.

Enrollee-centered Approach

We received an expedited request at the deadline for a peer-to-peer review. Our manager of appeals coordinated with the Utilization Management department, to facilitate a peer-to-peer review with the Aetna medical director, as that process was most beneficial to resolving the enrollee's case. This interdepartmental coordination resulted in resolution of the case within four hours of receipt of the request and allowed the enrollee to have surgery as scheduled.

The Appeal and Grievance department is responsible for the management of enrollee appeal and grievance system. The appeal and grievance manager monitors processing of all cases and conducts daily real-time quality reviews to support timely and accurate processing according to the **Draft Medicaid Managed Care Contract and Appendices Section 24**. The appeal and grievance coordinators are responsible for processing all enrollee appeals, grievances, requests for external review, and State Fair Hearings. This includes documenting the substance of each case including all information submitted as part of the initial review; any new information submitted with the request and the relevant clinical care guidelines as applicable; the resolution of individual cases; coordinating resolutions; and tracking data and reviewing for trends in quality of care or other service-related issues. The Appeal and Grievance Department staff reports to the chief operating officer. Medical directors are responsible for rendering medical necessity decisions; they are physicians who were not involved in any prior decision-making and are not a subordinate of any such individual. Only a provider of the same or similar specialty with the appropriate clinical expertise in treating an enrollee's condition or disease is the decision-maker for any appeal of a denial that is based on medical necessity, grievance regarding the denial of an expedited resolution of an appeal, or a grievance or appeal that involves clinical issues.

Our clinical staff is available to review expedited cases for our enrollees to receive decisions on care or services as quickly as possible. We may employ an outside independent reviewer to assist in the

determination when required to achieve same or similar specialty match if we do not have a medical director who meets the specialty of the provider requesting the item or service being appealed. The results of the independent review are reviewed by our medical directors and considered when making the determination.

Appeal and Grievance Processes

Aetna's appeal and grievance system goes beyond basic requirements to foster a culture of high-quality performance throughout our operations and promote enrollee engagement and individual self-sufficiency. The specific elements of our approach discussed throughout this section describe Aetna's core processes to safeguard enrollee rights and enhanced capabilities, demonstrating that Aetna not only fully meets the requirements of the **Draft Medicaid Managed Care Contract and Appendices Section 24**, but will exceed the Commonwealth's expectations. **Figure C.14-1** and **Figure C.14-2** illustrate our appeal and grievance processes, respectively.

Notice of Adverse Benefit Determination

Our notice of action process provides for a written notice of action to enrollees in accordance with the **Draft Medicaid Managed Care Contract and Appendices Section 20.7**. The notice of action is written in easily understandable language, explains the adverse benefit decision and includes the following:

- Dates, types, and amount of service requested
- Date of the decision and the date of the notice
- Decision made or the decision that will be made
- Medical basis for the decision, the policy, or criteria utilized as part of the decision-making if the decision was based on medical necessity
- Statute, regulation, policy or procedure, if the decision was based on a statute, regulation, policy, or procedure
- Explanation of the enrollee's right and how to request an appeal, and the criteria when the appeal process can be expedited
- Information the enrollee must complete for the appeal process before requesting a State Fair Hearing
- Enrollees' right to represent themselves or designate a representative when requesting an appeal
- Enrollees' right to submit additional information and to obtain copies of the file reviewed as part of the decision-making at no cost to the enrollee
- Enrollees' right, if applicable, to a services continuation and how to request a service continuation.
- Enrollees are informed they may be required to pay for continued services when the make the request for continuation.

We send written notice of action for standard requests to the enrollee as quickly as the enrollee's health condition requires or within 2 business days from receipt, and for expedited requests, within 24 hours from receipt, and retrospective reviews within 14 calendar days. Our notice of action process complies with 42 CFR 438.404, **Draft Medicaid Managed Care Contract and Appendices Section 24**.

Filing an Appeal or Grievance

Enrollees, their representatives, or the legal representatives of an enrollee's estate may file an appeal or grievance in person, by telephone, fax, voicemail, email, through the website, or in writing. We assist enrollees in filing appeals and grievances, if requested or if we identify a need. Enrollee assistance may include auxiliary aids and services, such as interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability. Upon receipt of an enrollee appeal or grievance, our team logs the concern and assigns it for review. An appeal and grievance coordinator reviews all of the facts to determine whether the case should be processed as an appeal or grievance, and whether it should be expedited.

When an enrollee or their designated representative requests the review of an action where we denied, reduced, suspended, or terminated an item or service (typically through a notice of adverse benefit determination), the review is conducted in accordance with our enrollee appeal process. When an enrollee or their designated representative is dissatisfied with service or other concerns unrelated to an appeal, the review is conducted in accordance with our enrollee grievance process.

When the grievance is about the service or care they received from a provider, we always secure enrollee permission to utilize their name to investigate the grievance. Grievances may be filed at any time; appeals must be filed within 60 calendar days of the initial denial. If we identify a potential quality of care issue, we forward the matter to our Quality Department for review and investigation, and simultaneously continue with the grievance process.

Figure C.14-1 provides an illustration of the high-level grievance process.

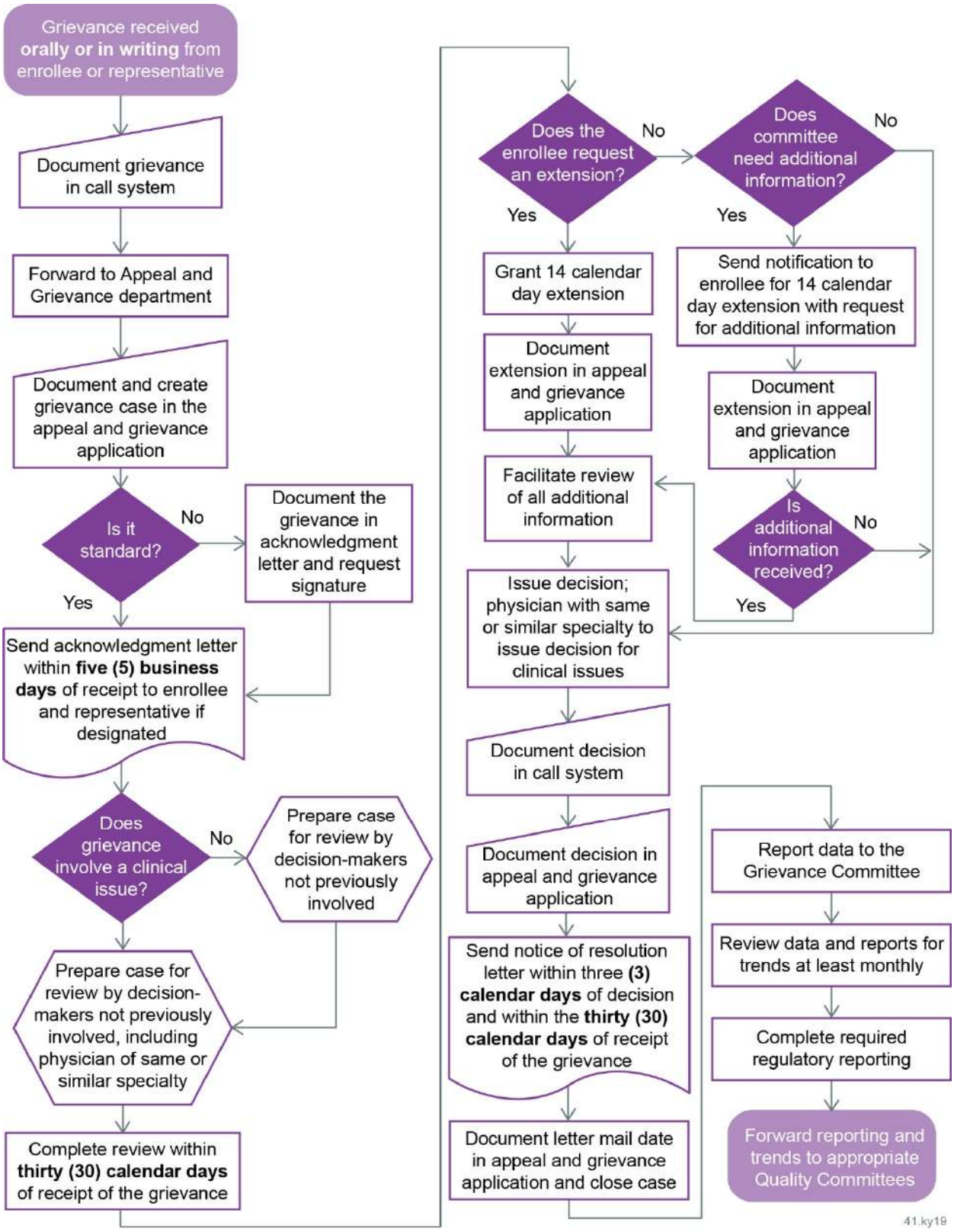

Figure C.14-1: High-level Grievance Process

Aetna's grievance process provides enrollees with easy access to file grievances as issues arise.

Figure C.14-2 provides an illustration of the high-level appeal process.

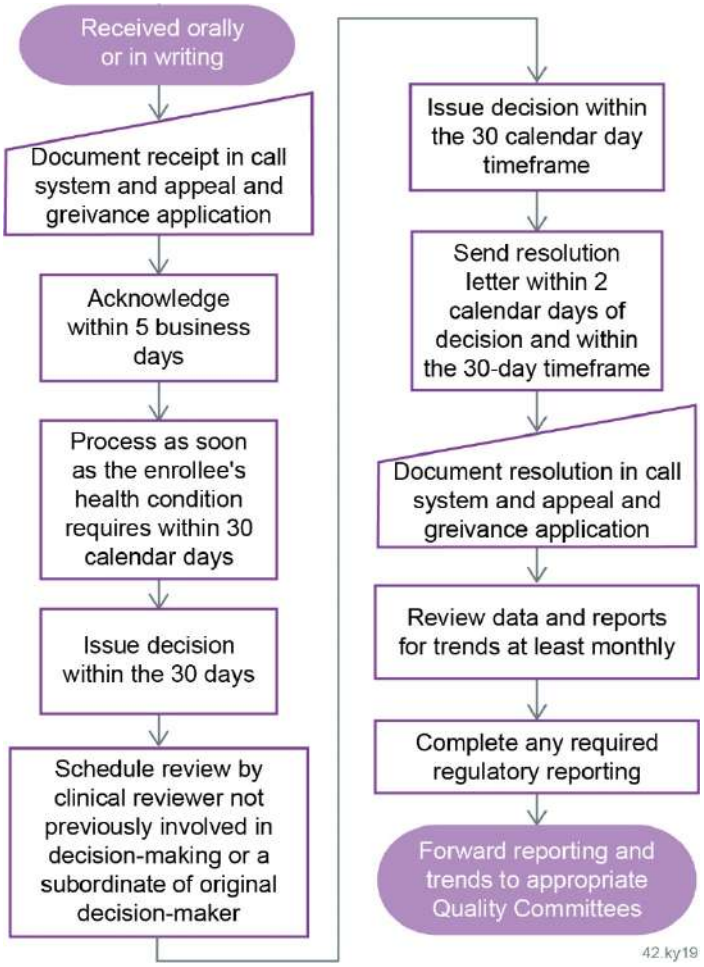

Figure C.14-2 High-level Appeal Process

Aetna's appeal process provides enrollees with easy access to request appeals as issues arise.

Continuation of Benefits

An enrollee may continue to receive services during the appeal or the State Fair Hearing process under the following circumstances:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The enrollee requests an appeal or State Fair Hearing within 10 calendar days from the mailing of the notice of adverse benefit determination or appeal decision letter or the intended effective date of the proposed service termination, suspension, or reduction
- The services were ordered by an authorized provider
- The original authorized period has not expired
- The enrollee requests extension of benefits.

The enrollee is informed that they may be financially liable for the services that were rendered during this process if the appeal or State Fair Hearing decision is adverse to the enrollee. For appeals that meet the criteria for continuation, the appeal and grievance coordinator notifies Utilization Management to continue benefits at the current level. Enrollees continue to receive benefits during a pending appeal or State Fair Hearing until either of the following:

- The enrollee withdraws the appeal or request for a State Fair Hearing,
- The enrollee does not request a State Fair Hearing with continuation of benefits within 10 calendar days from the date the adverse appeal decision letter is mailed, or
- The State Fairing Hearing decision is adverse to the enrollee

If the final resolution of the appeal or State Fair Hearing is in favor of the enrollee the appeal and grievance coordinator notifies Utilization Management of the outcome of the decision to authorize the service. If the final resolution of the appeal or State Fair Hearing is adverse to the enrollee (the decision upholds our action), we may recover the cost of the services furnished to the enrollee while the appeal or State Fair Hearing is pending to the extent that services were furnished solely because of the requirements of this section.

Acknowledgment of Appeals and Grievances

Verbal appeals are acknowledged at the time of receipt and enrollees are asked to submit a written, signed appeal, unless the enrollee is requesting an expedited appeal resolution. To facilitate receipt of the signed appeal, we document the substance of the appeal in the acknowledgement letter and provide a postage paid envelope for the enrollee to send us their signed appeal. We proceed with the case even if the enrollee does not return the appeal statement in an effort to address all enrollee concerns. In order to establish the earliest possible filling date for verbal appeals, our grievance and appeal coordinators document the receipt date as the date of oral inquiry. We acknowledge verbal grievances at the time of receipt. We send a written acknowledgement letter for all standard appeals and written grievances within five business days of date received.

Resolution of Appeals and Grievances

Aetna provides enrollees with the opportunity to present evidence, testimony, and allegations of fact or law, in person and in writing. All information submitted with an appeal or grievance is thoroughly researched, including investigation into the matter, a review of any prior documentation, medical review criteria and communication with the provider, enrollee or enrollee's representative, and vendor or staff member involved as appropriate. If we receive additional clinical information with the appeal or grievance, the case is presented to the original decision-maker for review to determine whether they can overturn their original decision. This is an effort to deliver requested items or services to the enrollee as quickly as possible.

If the original reviewer is unable to overturn their original decision (or if no new clinical information is received), the case is presented to another appropriate reviewer not involved in the initial determination and not a subordinate of any person involved in the initial decision individually or as part of an Appeal Committee for review. For cases involving medical necessity determinations, denial or expedited resolution or clinical issues, the case will be heard by a health care professional who has the appropriate clinical expertise. The reviewer for the appeal considers all comments, documents, records, and other information without regard to whether to such information was submitted or considered in the initial adverse benefit determination.

Improving Enrollee Experience

An out-of-network dialysis center filed an appeal on behalf of our enrollee. The enrollee had been seeing a network physician at a network dialysis center. The enrollee changed to an out-of-network dialysis center and wanted to continue with the same physician, but he was not in-network at the new dialysis center. We approved the request to ensure continuity of care for the enrollee and aided the new dialysis center and physician to join our network.

Extensions

In accordance with 42 CFR 438.408 (c) and the **Draft Medicaid Managed Care Contract and Appendices**, the resolution time period for an appeal or grievance may be extended up to 14 calendar

days if the enrollee requests the extension or at our request when we show there is a need for additional information, and how the delay is in the enrollee's best interest, and that the delay will not seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum functioning. If the resolution timeframe is extended and it was not requested by the enrollee, we attempt to give oral notification of the extension and send written notice of the delay within two calendar days of the decision to extend the timeframe for standard and expedited cases. The written notice of extension informs the enrollee that they may file a grievance if they disagree with the decision for the extension.

Written Notification

Aetna resolves and sends a written notice for all standard appeals and grievances as expeditiously as the enrollee's health condition requires, but in no case exceeds 30 days from receipt, unless there is an extension. When we reach a decision prior to the 30-calendar day timeline, our staff is required to send written notification within three calendar days of the decision, to avoid undue delays in responding to our enrollees. The appeal and grievance application uses the date of receipt to automatically calculate the due date for completion, allowing our staff and managers to track and monitor case timelines.

The written appeal decision or grievance resolution notice includes all required information, including the following:

- Results of the process and the date it was completed
- Right to request a State Fair Hearing and the processes involved to request a hearing for appeals not resolved wholly in favor of the enrollee
- Right to request assistance in the filing process
- Right to request a continuation of benefits while the State Fair Hearing is pending and how to make such requests
- Notification that the enrollee may be held liable for the cost of those continued services if the hearing decision upholds our adverse benefit determination
- Reference to the benefit provision, guideline, protocol, or other criterion on which the appeal decision was based
- Notification that upon request the enrollee can obtain, a copy of the actual benefit provision on which the appeal decision was based and reasonable access to copies of all documents relevant to the appeal or grievance at no cost

When needed, Aetna may also provide oral notice of the resolution to support ease of understanding by the enrollee.

Enrollee State Fair Hearing Process

After exhausting the internal appeal process, the enrollee or their authorized representative may request a State Fair Hearing within 120 calendar days from the appeal decision letter. The request may be made in person, by telephone, voicemail, email, through the website, or in writing. The State Fair Hearing process provides enrollees with an opportunity for a State Fair Hearing before an impartial hearing officer. The parties to the State Fair Hearing include the health plan, the enrollee, and their authorized representative, including a provider, or the representative of a deceased enrollee's estate.

If the request for State Fair Hearing regarding a standard appeal is received by Aetna, we forward the case file to the Kentucky Department for Medicaid Services Division of Program Quality and Outcomes within five calendar days. If the hearing officer reverses our decision to deny, limit, or delay services that were not furnished while the State Fair Hearing was pending, we promptly authorize or provide the disputed services, and as expeditiously as our enrollee's health condition requires, but no later than 72 hours from the date we receive the notice from the State Fair Hearing reversing the decision.

b. Expedited Review Process

Upon receipt of an expedited verbal or written appeal, a clinical reviewer immediately reviews the urgency of the issue being appealed, and assesses the enrollee's current health condition, to determine whether the issue meets the criteria for expedited processing. If the issue fails to meet the expedited appeal criteria, we transfer it to the standard appeal process and maintain the original received date and notify the enrollee within two calendar days of the transfer. The notification informs the enrollee that they may file a grievance if they disagree with our decision to transfer the case to standard review timeframe.

Grievances are processed in an expedited timeframe whenever the grievance is the result of the denial of expedited processing of a prior authorization request or an appeal, or when Aetna takes an extension on the processing of a prior authorization request or an appeal. Appeals are processed in an expedited timeframe whenever the item/service being appealed is pre-service, the provider requests expedited processing or the provider supports the enrollee's request for expedited processing, or anytime it is determined that waiting the standard timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. Neither written confirmation nor the enrollee's written consent is required for the provider to act on the enrollee's behalf to request an expedited appeal.

When processing an expedited appeal or grievance, Aetna complies with all required criteria related to the resolution of the issue, as described in the standard appeal process, including the review of all records and information without regard to whether the information was considered in the initial Adverse Benefit Determination, and that the case is decided by an appropriate decision-maker. Enrollees and their representatives are also advised of their rights, as described in the standard appeal process description, including the limited time to present evidence and information, the right to receive a copy of the case file at no cost.

Aetna resolves expedited appeals and expedited grievances within 72 hours of receipt. We attempt to provide verbal notification followed by written notification within 72 hours. Our written notice includes all required information, including information on how to request an expedited State Fair Hearing, if the decision is adverse to the enrollee. Upon resolution of the expedited appeal, we also make reasonable attempts to contact the enrollee or their representative to inform them of the decision. **Figure C.14-3** and **Figure C.14-4** illustrate our expedited grievance and appeal processes, respectively.

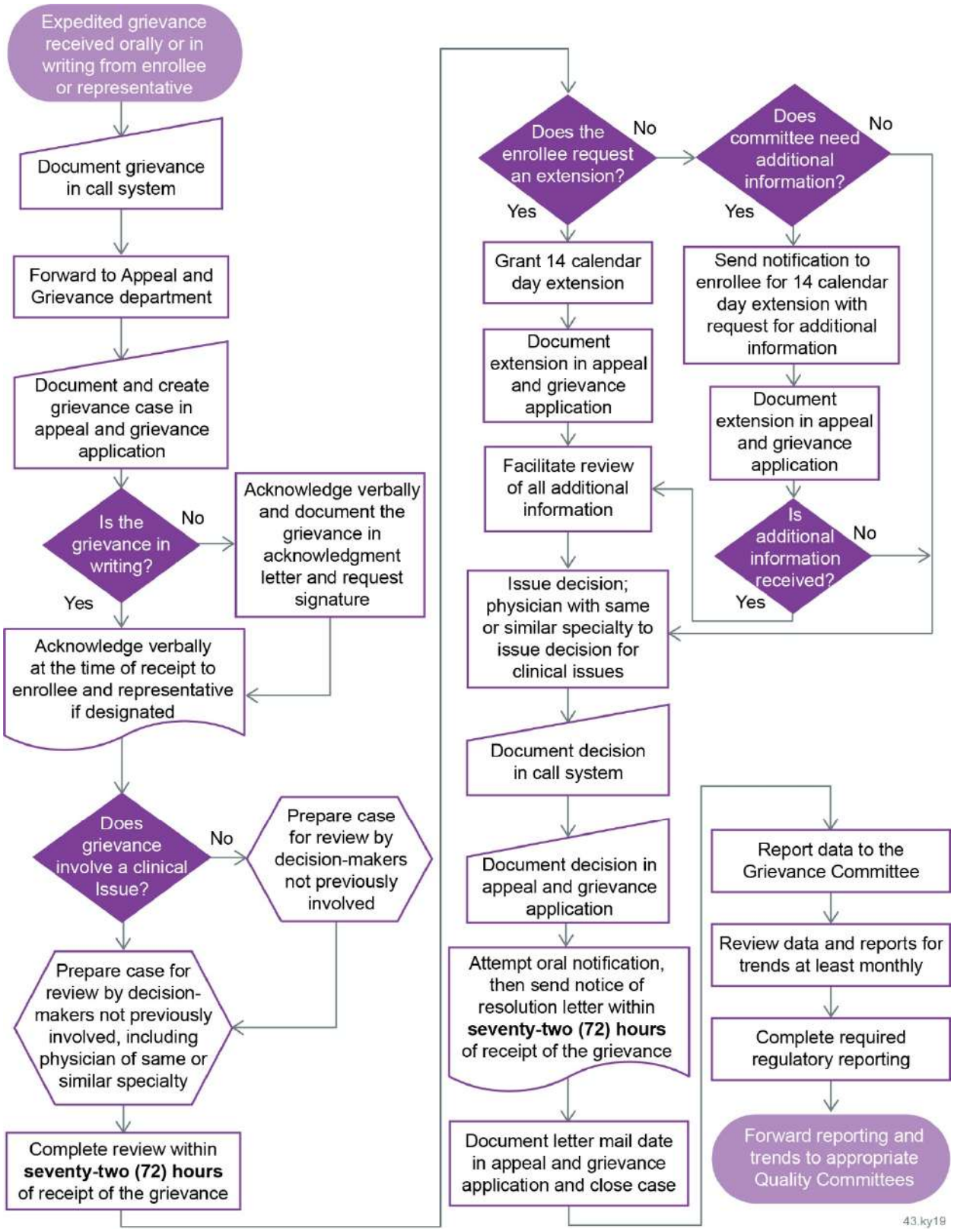

Figure C.14-3: High-level Expedited Grievance Process

Aetna's expedited grievance process is designed to provide rapid resolution of time sensitive issues.

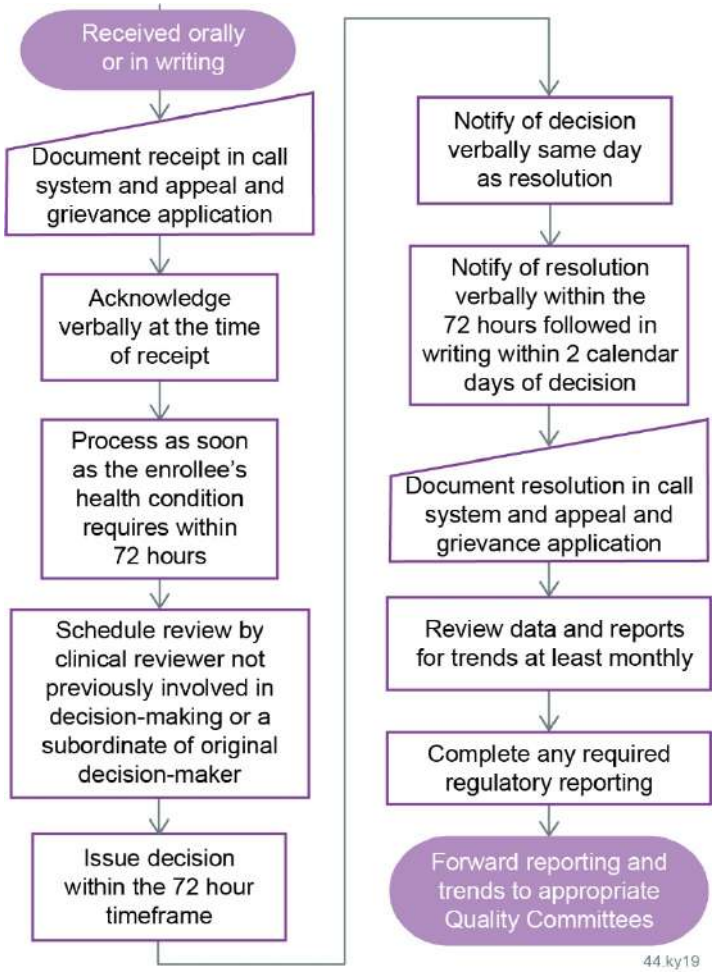

Figure C.14-4: High-level Expedited Appeal Process

Aetna's expedited appeal process is designed to provide rapid resolution service denial and termination issues that could jeopardize the enrollee's health.

c. Enrollee and Enrollee Caregiver Involvement

Aetna places high value on helping make sure enrollees are appropriately educated on their health care and their rights as enrollees through quality customer service. Enrollees are educated about the appeal and grievance system and their right to file an appeal or grievance about any aspect of their care or service including, but not limited to, physical health, behavioral health, prescription drugs, and services. Enrollees are educated about the appeal and grievance system, along with any changes through written materials (e.g., enrollee welcome packet, handbook, website, and letters). Additionally, we provide written materials to all our subcontractors, at the time of contract and whenever changes are made, so they can effectively support and assist our enrollees with filing an appeal or grievance. Enrollee education materials are written at a sixth-grade reading level or less (determined by Flesch-Kincaid) and include the following:

- Availability of assistance in the filing process, including interpreter services, translation services, sign language, and teletypewriter [TTY] through Relay Kentucky, and physically accessible meeting spaces and reasonable physical accommodations.
- Procedure for filing an appeal, grievance, and State Fair Hearing
- Right to representation (e.g., self, family enrollee, attorney, relative, friend or provider)

- Information on how to access the Cabinet's ombudsman's office
- Procedures for exercising the rights to request a State Fair Hearing within a specified timeframe
- Requirement that internal appeals must be exhausted before requesting a State Fair Hearing
- Right to continue benefits at the current level of appeal requested within the specified timeframe
- Communication that the enrollee may be required to pay the cost of services furnished if the final decision is adverse to the enrollee.

Our published enrollee communication materials inform enrollees how to designate a representative, to act on the enrollee's behalf, at any time during the appeal and grievance processes. To verify the authority of designated representatives, Aetna requires authorization to be in writing and signed by the enrollee, unless the person is a legally designated representative (e.g. parent, guardian, conservator). Enrollees or their authorized representative have the right to examine the enrollee's case file, including medical records and any other documents and records considered during the appeal and grievance processes and may request copies of all documents free of charge. They may also present supporting documentation or evidence by phone, in person, or in writing on or before the date of the complaint or appeal meeting date. To present information, the enrollee or their authorized representative should contact the appeal and grievance department. The parties to the appeal or grievance include the health plan, the enrollee, and their representative or the representative of a deceased enrollee's estate.

Our enrollee appeal and grievance processes are simple and user-friendly and as such, afford enrollees the opportunity to voice their issues, concerns, and problems with the assurance that there will be no discrimination based solely on their filing an appeal or grievance. We resolve appeals and grievances in a timely manner and help to make sure that our enrollees, from all racial, ethnic, and cultural backgrounds, receive equitable and effective treatment in a culturally and linguistically appropriate manner. We make sure that no punitive action is taken against enrollees, their authorized representatives, or providers who support them for filing an appeal, grievance, or State Fair Hearing.

When needed, an appeal and grievance coordinator or other staff member assists enrollees with completing forms and navigating procedural steps, from initial filing through requesting a State Fair Hearing. Aetna provides information in English, Spanish and other prevalent languages, as well as in alternative formats (e.g., interpreter services, translation services, audio tapes, sign language, large font, and teletypewriter [TTY] through Relay Kentucky). We also make reasonable accommodations available to enrollees and have accessible meeting spaces for enrollees with physical disabilities who wish to file an appeal or grievance, or present information, or otherwise participate in person, at no cost to the enrollee.

We document all cases in our appeal and grievance application inclusive of those received through the Department. Each case is automatically assigned a tracking number/unique identifier that links together all components of the case. This tracking number is used to identify individual cases for processing and to monitor each case throughout the process. All information pertaining to appeals, grievances and State Fair Hearings are maintained in accordance with the applicable record retention policies, **RFP Section II Obligations and Activities of the Business Associate 2.13,** and Health Insurance Portability and Accountability Act standards to protect enrollee privacy

d. Tracking and Trending for Operational Improvement

Aetna maintains records of all appeals, grievances, and State Fair Hearings within our internal, proprietary application. Our reporting suite enables us to monitor aging of cases in real time to make certain of timely resolution and to identify and report trends for potential opportunities for improvement. Appeals and grievances files are maintained in a secure manner, as required to protect enrollee privacy and confidentiality rights, and are accessible to the Department, its designee, or the Centers for Medicare & Medicaid Services (CMS) upon request. We retain appeal and grievance files for the longer of 10 years

following the final decision, or five years from the date of the expiration or termination of this contract. **Figure C.14-5** illustrates our tracking and trending activities.

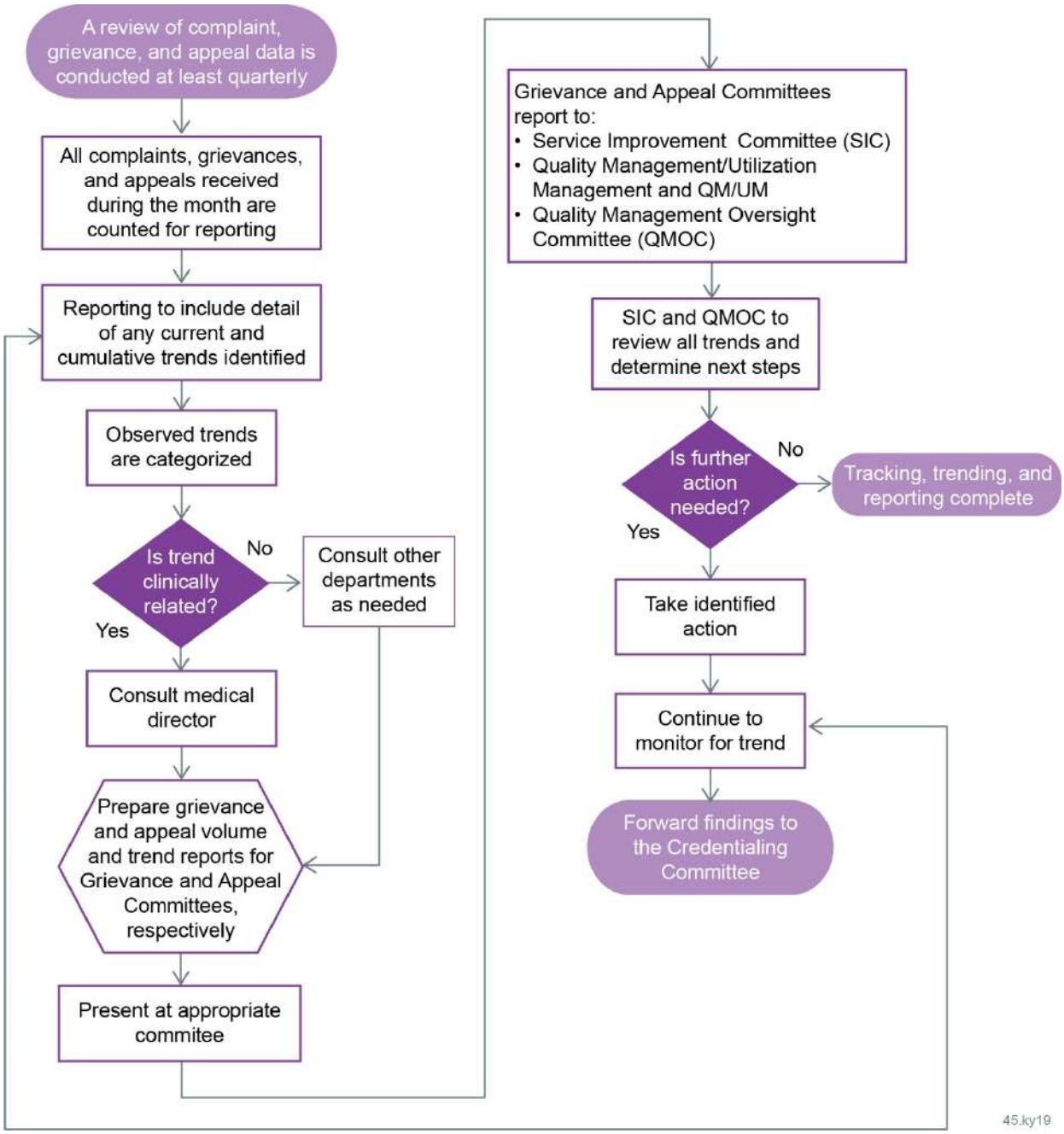

Figure C.14-5: High-level Tracking, Trending, and Reporting Process

Aetna's tracking trending and reporting process is key to identifying improvements.

Data, Reporting, and Trending

Aetna's appeal and grievance records are housed in our inclusive system, which houses all correspondence, letters created, and staff actions taken on the case. This system also allows us to capture and report on all information, as required by the contract and outlined in 42 CFR 438.416, including the following:

- Date of receipt of each case
- Case type
- Staff member assigned to process the case
- Enrollee identification number
- Short, dated summary of each issue
- Consistent with Department-specific categories
- Name of the person filing the case, including the enrollee, their authorized representative, or any representative
- Date of the review or review meeting, and the date of decision
- Resolution for grievances
- Date of decision for appeals and hearings and the criteria used in rendering the decision
- Date of communication of the resolution/decision.

We capture this documentation both to meet the Commonwealth and federal requirements; it allows us to maintain and track all cases from origination through resolution/decision. Our system contains a standard suite of reports and queries by case type of complaint, appeals, grievance, or State Fair Hearing that we utilized to track cases throughout the process. To support the accuracy and integrity our appeal and grievance data and reporting, Aetna has programmed its appeal and grievance application to automatically calculate the due date for completion of the case, to avoid data entry or staff errors in calculating due dates. The application uses this due date when calculating the actual turnaround time on completed cases and, upon resolution, automatically marks the case as timely or untimely.

The appeal and grievance manager uses standard queries and reports within the application to monitor cases in real time to make certain of timely and accurate resolutions, and to manage staff workloads, including reassignment of cases during unscheduled absences such as staff illness. If we see any evidence of an issue requiring escalation, we act on it immediately. For example, the aging report displays all cases in real time and gives their age from received date and time to date and time of report run in calendar days. All follow-up actions such as enrollee phone calls and the overall age of the case are color-coded in each staff person's work queue. Cases that are past due display in red, those due in 48 hours display in blue, and those due in greater than 48 hours display in black. This visual display along with traditional reports allows easy real time identification of cases and work to be completed.

Quality Improvement

The appeal and grievance manager uses standard queries and reports within the application to monitor cases throughout the process, including timeliness and accuracy, and to identify and report trends for potential opportunities for improvement. The appeal and grievance manager also conducts daily and monthly audits to validate consistency and quality standards. Audit results are reported to compliance and plan leaders.

Review of the appeal and grievance data may include, but is not limited to, the following: the number and types of appeals and grievances received, including identification of the top 10 types; the disposition and status of all appeals and grievances; the type of service and dollar amount for all overturned denials; and the average turnaround times for resolution by type of appeals and grievances based on monthly. The data is aggregated to protect enrollee privacy. Consistent evaluation of appeals and grievances trend data allows for the Compliance department and executive staff, with the Quality Management department, to improve on medical, network, operations, and management areas identified through appeals and grievance tracking that requires additional focus.

Aetna Processes in Action

We identified a denial trend related to certain physical, occupational, and speech therapy claims. We conducted an analysis of the claims and identified an opportunity to enhance our prior authorization system to make sure the authorized number of visits were accurately counted against claims as they were submitted. The system enhancement resulted in a reduction in the denial rate of these claims.

All data collected is reported to the Appeal and Grievance Committees, Service Improvement Committee (SIC), Quality Management/Utilization Management (QM/UM) Committee (appeals) and Quality Management Oversight Committee (QMOC) at least quarterly (more frequently if appropriate), summarizing the frequency and resolution of all appeals and grievances. Data from health plan experience, results of oversight activities, and the need for any corrective action plans identified internally or by the Department are presented to our Appeal and Grievance and Quality committees.

The Appeal and Grievance Committees are responsible for reviewing trends and may be responsible for reviewing individual appeal and grievance requests along with all supporting documentation. Appeal and Grievance Committee participants may represent Compliance, Provider Services, Enrollee Services, Claims, Medical Management, Utilization Management, and other departments, depending on the specific case. Participants also include the director of operations, who is authorized to engage other departments (as necessary) and to implement improvement activities and execute corrective action plans as needed.

The quality committees include cross-functional representatives from Enrollee Services, Provider Services, Compliance, Service Coordination, or other departments as needed (please refer to **Table C.14-1**). Participants on the SIC and the QMOC include senior leaders at the health plan.

This makes sure that individuals with the authority to take corrective action participate in the decision-making and can prioritize trends, opportunities for improvement, and corrective actions to address the issues affecting individual enrollee satisfaction, to stabilize trends within the delivery system, and to meet performance standards. These individuals hold relevant departments to deadlines and actions specified in the corrective action plan and supports completion within the timeframes specified.

Table C.14-1: Cross-functional Oversight Representatives

Cross-functional Representative	Format	Frequency	Location(s)
Appeals Committee	Meeting	Weekly	Review and decide appeals. Track and trend data, analyze, identify concerns, and root cause for appeals filed, and collaborative solutions
Grievance Committee	Meeting	Biweekly	Review and decide appeals. Track and trend data, analyze, identify concerns, and root cause for appeals filed, and collaborative solutions
QM/UM Committee	Meeting	Monthly	Report all appeals and grievances from the prior quarter, including the top three providers and top three reasons for both enrollee and provider appeals and grievances.
QMOC	Quality-of-care reporting	Quarterly	Executive oversight of the quality management program; review, recommend, and provide feedback to the QM/UM Committee based on recommended clinical and service quality improvement studies
Service Improvement Committee	Meeting	Quarterly	Track and trend suggested improvement opportunities
Quality Management	Quarterly file review	Quarterly	File review to validate compliance with appeal and grievance system policies, procedures, and contract required standards

e. Review of Overturned Decisions to Identify Needed Changes

Review process: During our weekly Appeals Committee meetings, a cross-functional team of managers and directors (e.g., medical directors, compliance officer, UM director, etc.) review overturned decisions to track patterns and identify trends. The review includes a root cause analysis to identify the specific reasons for the initial denial and justification for the decision to overturn. The Appeals Committee

determines whether particular provider or vendors are experiencing recurring denials and overturns, which may indicate a need for provider education or system changes.

Change process: Through this process we are able to identify opportunities for provider training and education, which is implemented through our Provider Services department. For example, when we identify a trend related to a particular service code, education and training may be provided through our Tip Tuesdays campaign. If a trend is identified with a particular provider, we conduct more targeted training. This process is also utilized to identify and implement changes to internal systems, policies, and procedures, to improve enrollee services and reduce provider administrative burden.

Through our Appeals Committee we identified a trend of increased denials related to MRIs without contrast. Analysis showed the denials were occurring, because the authorization requests were for MRIs with contrast, so the billed code did not match the authorized service.

Our clinical leadership engaged with the provider and in May 2019 we implemented changes to avoid these denials. We had a total of 207 radiology-related administrative appeals that were reviewed from January to September 2019; from October to December 2019 the number was **reduced to 8 appeals** brought to the committee. These 8 cases were related to the provider not obtaining an authorization or asking for one unit when they should have asked for more, so the coding issue has been fixed.

60.7.C.15 Marketing

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60.7.C.15 Marketing (Section 25.0 Marketing).

The specific elements of our approach discussed throughout this section demonstrate that Aetna not only fully meets the requirements of **Section 25** of the **Draft Medicaid Managed Care Contract and Appendices**, including **Section 4.4 Approval of Department,** but will exceed the Department's expectations.

a. Summary of Our Marketing and Distribution Plan

Aetna has demonstrated the breadth and depth of our experience and we have fully understood the needs of Kentucky Medicaid throughout our eight years serving the Commonwealth. Our mission is to continuously deepen our presence in Kentucky's 120 counties, **with a particular focus on the various populations throughout Kentucky**. We achieve this by educating, engaging, and empowering enrollees to act to obtain their best health through locally designed and targeted efforts that maximize investments, form long-term relationships, and leverage the power of Aetna staff giving and volunteerism. Our dedication to being a collaborative and innovative partner to Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier Kentucky.

Aetna participates in **many statewide activities**, including hosting and attending local health and resource fairs, presenting and exhibiting at conferences, and sponsoring numerous community events where we provide enrollee outreach and education.

All marketing materials (e.g., posters, flyers, brochures) are written at or below a sixth-grade reading level, contain a minimum 12-point font, meet all language requirements, and are Commonwealth-approved and distributed throughout Kentucky to enrollees and potential enrollees to prevent selective distribution. Enrollee marketing materials are available at community events and/or given to community partners to hand out to enrollees and the community at large. Community partners include Commonwealth agencies, federally qualified health clinics, faith-based organizations, K-12, homeless organizations, public health departments, family resource centers, community action agencies, public libraries, and other community-based organizations.

A key component of our marketing plan is to ensure all our Medicaid enrollees understand how adopting a healthy lifestyle greatly increases their overall quality of life. Therefore, we continuously search for ways to promote health literacy and address the social determinants of health (SDOH), as well as provide ongoing education to enrollees and their communities.

a.i. System of Control

Aetna's marketing and distribution plan includes the development of an annual outreach process designed to be hyperlocal, **targets each of the Commonwealth's eight regions**, and adheres to our system of control process. The marketing and distribution plan serves as our roadmap for all enrollee communication and engagement. We target our enrollee engagement to grassroots efforts by reaching enrollees on a more individual level in conjunction with our deep relationships with community-based organizations (CBOs). **Figure C.15-1** provides an overview of Aetna's marketing and distribution plan.

Figure C.15-1: Aetna's Marketing and Distribution Plan

The marketing and distribution plan serves as our roadmap for all enrollee communication and engagement.

Our marketing and distribution plan is a comprehensive list of enrollee engagements that encompasses our enrollee handbook, education materials (which includes our suite of health literacy courses), a web-based enrollee portal, enrollee website, community sponsorships, provider and enrollee newsletters, Quarterly Member Advisory Council (QMAC), provider education, and a calendar of community events to which we commit on an annual basis.

Aetna's community outreach manager is responsible for developing our annual outreach plan. After the plan is developed, it is distributed to our executive leadership (chief executive officer, chief operating officer, chief medical officer, and chief financial officer) for approval. After our executive leadership approves the plan, it is sent to our local compliance officer for review of contractual compliance and approval. Once approved, the compliance officer will submit the outreach plan to the Commonwealth for approval**.** Our control and approval process for all marketing materials is in the subsection "Verification and Tracking Process for Marketing Materials and Activities."

Our marketing and distribution plan encompasses the following communication vehicles:

Printed materials: Aetna's outreach coordinator develops printed enrollee materials in coordination with our Marketing department. The content and form is reviewed by Aetna's Marketing department and compliance officer for Aetna brand standards and contract compliance to ensure the content is in a language and format that are easily understood, is at or below a sixth-grade reading level using the Flesch-Kincaid readability score, published in a 12-point font, and is available in an 18-point or larger font. All written materials comply with the Americans with Disabilities Act (ADA), are available through auxiliary aids, services, and alternative formats, are offered in English and Spanish, are provided through oral interpretation services for any language, and include taglines for the top 15 non-English languages. The approval process for our printed materials is the same as our annual outreach plan.

Advertising and social media: Aetna is deliberate in the methods and modalities we employ to reach our enrollees. We research which mediums best reach the enrollees in the areas we serve and target our communications accordingly. Content is developed by each respective department owner (e.g., Community Outreach, Enrollee Services, and Quality Improvement) in conjunction with the Marketing department. The content and form is reviewed by our Marketing department and compliance officer for Aetna brand standards and contract compliance to ensure the content is in a language and format that are easily understood, is at or below a sixth-grade reading level using the Flesch-Kincaid readability score,

and published in a 12-point font and available in an 18-point or larger font. All written materials comply with the ADA, are available through auxiliary aids, services, and alternative formats, are offered in English and Spanish, and are provided through oral interpretation services for any language and include taglines for the top 15 non-English languages. The approval process for our advertising and social materials is the same as our annual outreach plan described previously.

For enrollees who prefer text and email communications: During open enrollment and for specific health campaigns, we engage enrollees through text and email. For example, every flu season we remind enrollees via email to get their flu shot. Content is developed by each respective department owner (e.g., Community Outreach, Enrollee Services, and Quality Improvement) in conjunction with Marketing. The content and form is reviewed by our Marketing department and compliance officer for Aetna brand standards and contract compliance to ensure the content is in a language and format that are easily understood, is at or below a sixth-grade reading level using the Flesch-Kincaid readability score, and is Web Content Accessibility Guidelines ADA website-compliant.

We utilize a vendor to help us reach our enrollees via text and email. As part of this process, before entering any subcontract, the Aetna Digital Governance team reviews the subcontract to confirm compliance with federal accessibility standards. Texts and emails are sent in English and Spanish, are available in the top non-English 15 languages, and can be provided through oral interpretation services. The approval process for our written materials is the same as our annual outreach plan described previously. In addition, our compliance officer is responsible for ensuring enrollee privacy per Healthcare Insurance Portability and Accountability Act (HIPAA) laws and regulations and will obtain all necessary photo release documentation and approvals.

Events and sponsorships: We have eight community outreach professionals who cover all regions of the Commonwealth, and the vast majority were born and raised in the areas in which they live and work. **Figure C.15-2** is a group photo of our outreach professionals. Aetna is an active participant in the communities we serve, and we continuously seek out meaningful community collaboration through engagement in events and sponsorships. Our outreach plan and calendar of committed events and sponsorships illustrate our commitment to Kentucky. We seek out new relationships and opportunities with CBOs that support our enrollees. We go beyond funding to build sustainable relationships that drive increased health outcomes that address SDOH gaps and barriers.

Figure C.15-2: Aetna's Community Outreach Professionals

The vast majority of our Outreach staff were born and raised in the areas in which they live and work.

The community outreach manager works with our community outreach coordinators to identify meaningful community events and sponsorships that are aligned with the Commonwealth's goals, SDOH gaps, and key health disparities. The community outreach manager is responsible for vetting all events and sponsorships and bringing those of highest impact to Aetna's executive leadership for review and approval. Once approval is given, the Community Outreach team will work with the CBOs to finalize logistics. We are deeply dedicated to the events we support and are active participants seeking direct enrollee engagement and interaction. **Through these efforts, we had direct engagement with more than 132,000 people throughout the Commonwealth in 2018 and 2019.** If a formal event or sponsorship agreement is needed, the community outreach manager will engage our internal legal counsel to execute the agreement.

Aetna is honored to have close working relationships with many of our CBOs, as we value our combined impact in the communities we serve. We have received letters of support from various CBOs for Aetna's outreach efforts throughout Kentucky; please refer to **Attachment N**.

In July 2018, Aetna volunteers assisted the **Louisville is Engaging Children Outdoors (Louisville ECHO)** initiative and the Mayor's **SummerWorks** program youth staff to plant trees and lay mulch around the new bicycle pump track in Shawnee Park. The volunteer initiative is a follow-up to the multi-year Aetna Foundations Healthiest Cities & Counties Challenge awarded to the Louisville ECHO program in the amount of $30,000. The volunteers also cleaned up the park by pruning trees and picking up debris to get the site ready for development of the pump track. **Figure C.15-3** shows a group of Aetna volunteers participating in the event.

Getting on T.R.A.C.K.

Aetna developed a SDOH program called Getting on T.R.A.C.K., which stands for Transition Ready Assistance & Core Knowledge. This program is designed specifically for young adults transitioning out of the foster care system. It is an ideation of our Community Development team, which collaborates with and supports the endeavors of various organizations across Kentucky that offers services to children in the foster care system. These organizations work with our Community Development team to offer various courses in their facilities. The curriculum is robust and can be customized to fit the needs of the audience. The courses are taught in collaboration with various entities that deliver different components of the curriculum.

The practice of community outreach and involvement extends beyond our Aetna colleagues. Our parent company, CVS Health Corporation (CVS Health), offers grants and event sponsorships in Kentucky to nonprofit organizations that promote access to health care and chronic disease management. Points of Light, the world's largest organization dedicated to volunteer service, recognized CVS Health as one of the 50 most community-minded companies in the United States. Organizations in Kentucky that have received support include the following:

- Kentucky Hemophilia Foundation
- Children's Hospital Foundation
- Community Health Clinic
- Family Community Clinic

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Figure C.15-3: Aetna Volunteers at Shawnee Park
Our volunteers helped clean up the park and planted trees.

Volunteer Challenge Grants

Each year, CVS Health colleagues volunteer thousands of hours at organizations in their communities. To help our colleagues lend even more support to the causes they care about, the CVS Health Foundation offers grants for volunteer service. Many nonprofits in Kentucky received challenge grants, including the United States Pony Club and Botanica, Inc.

In-kind Product and Gift Cards

CVS Health has provided thousands of dollars in gifts cards and product donations to Kentucky organizations to help provide school supplies, disaster relief products, personal care items, and more to communities across the Commonwealth. Some of the recipients include the following:

- Cumberland River Behavioral Health
- Relay for Life/American Cancer Society

- Preeclampsia Foundation
- Michael Feger Paralysis Foundation
- March of Dimes Central and Eastern Kentucky
- American Cancer Society
- Tim Horton's Children Foundation
- The ALS Association Kentucky Chapter
- Milestones Inc.
- The Walk on Foundation
- Buddy's Sensory Exchange

Enrollee appreciation events in collaboration with local health departments: In 2018 and 2019, Aetna hosted 57 enrollee appreciation events that focused on celebrating our enrollees. We also started the Eating Dinner Together campaign, in which we provide education on slow-cooking nutrition, eating on a budget, and a cooking demonstration where attendees can sit and enjoy a meal with Aetna staff. Attendees also receive a slow cooker.

Aetna's marketing outreach to Kentuckians is active throughout the year. **Table C.15-1** provides an overview of our marketing goals and distribution channels.

Table C.15-1: Aetna's Marketing Goals and Distribution Channels

Time Frame	Marketing Goals	Distribution Channels
Pre-open enrollment	• Touchpoint with all potential enrollees • Build relationships with CBOs, Commonwealth agencies, and other community partners to identify the needs of potential enrollees and build innovative solutions	• Radio • Community events • Unite Us community-based organizational network • Enrollee portal • Direct mail • Press releases • Social media • Plan website • Newsletters (distributed quarterly) • Text messages • Emails • Billboards
Open enrollment	• Enrollee retention • New enrollee growth	
Ongoing throughout the year	• Enrollee education regarding benefits, services, and access to services and supports • Build relationships with CBOs, Commonwealth agencies, and other community partners to identify enrollee needs and to build innovative solutions • Continuous enrollee engagement • Address SDOH needs • Addressing health gaps and key health disparities	

a.ii. Methods and Procedures to Log and Resolve Marketing Grievances

Upon receipt of a marketing grievance from an enrollee, provider, or other stakeholder, our team logs the concern and assigns it for review through our standard enrollee grievance process as shown in **Figur**e C.15-4. Enrollees, providers, health plan staff, or representatives from outside agencies, including the Department, may file a marketing grievance directly with Aetna either verbally or in writing at any time. Verbal grievances may be required to be submitted in writing. A grievance and appeal coordinator reviews all the facts to determine how the case should be resolved.

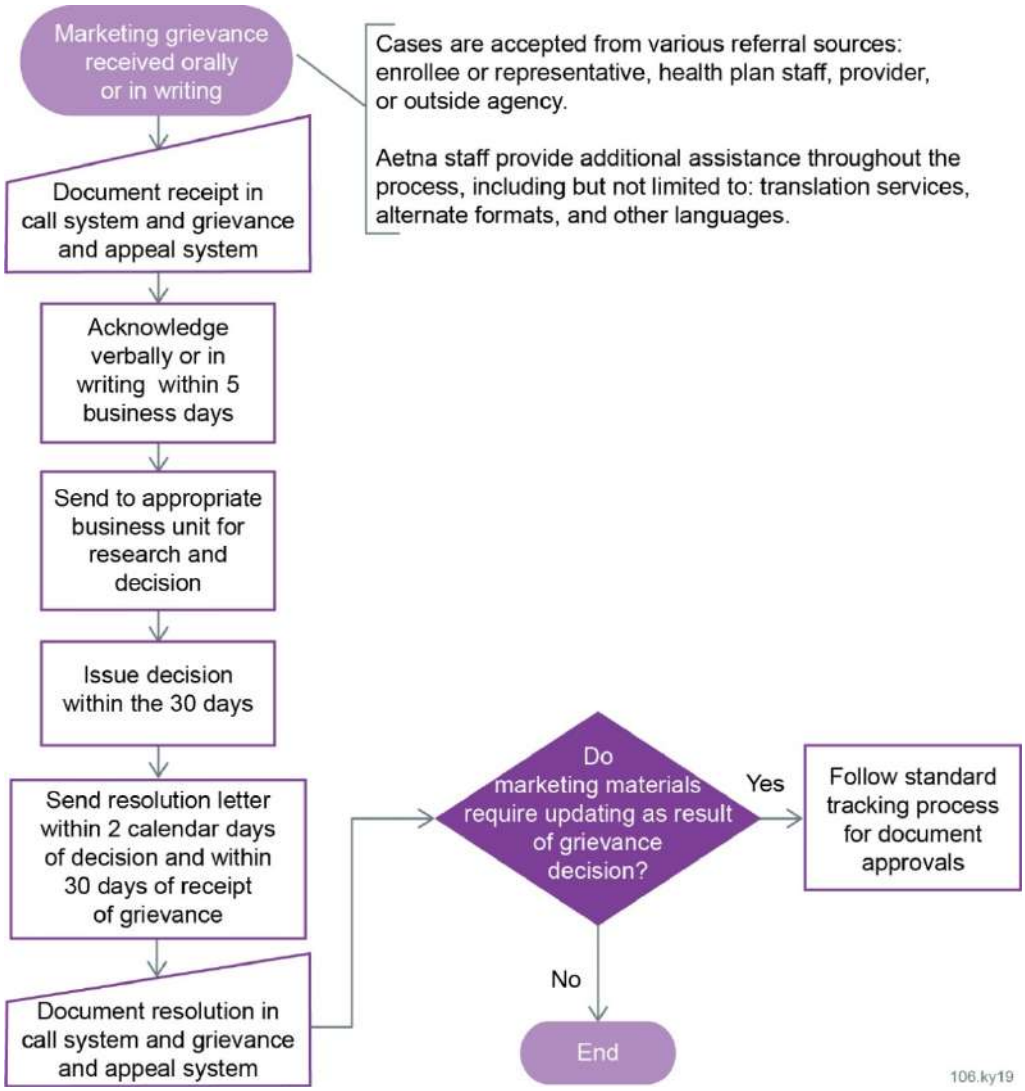

Figure C.15-4: Aetna's Enrollee Grievance Process
Aetna's internal process addresses enrollee grievances.

Since the implementation of the Kentucky Medicaid program, we have not received any marketing grievances.

a.iii. Verification and Tracking Process for Marketing Materials and Activities

Aetna has a standard process that applies to marketing materials and activities which require approval from the Commonwealth. As part of our subcontractor oversight, all our subcontractors must seek Commonwealth approval of enrollee materials through our standard approval process.

Our approval process is tightly controlled; our compliance officer is the only Aetna staff member who is authorized to submit documents for approval. We train and continually remind our staff and subcontractors of the approval process which must be adhered to for all marketing materials.

Our tracking process includes the following steps:

- Once Aetna's internal approval process is complete prior to Commonwealth submission, each document is assigned a tracking number. This number identifies the managed care organization (MCO) (e.g., AE for Aetna), the MCO's department (e.g., Utilization Management, Behavioral Health), and a five-digit identifier in sequential numerical order.
- Our compliance officer logs the tracking number and enters a description in our internal Department approval tracking log, and then submits it to the Commonwealth through its submission process, noting the date of submission and status.
- If we have not received approval by the 31st day after submission, our compliance officer will send an email inquiry to the Commonwealth regarding the submission status. If edits are needed, the document is returned to the department owner who will make the required revisions in track changes and submit it to Aetna's compliance officer for resubmission. The compliance officer will resubmit, noting the resubmission date and status on our Department approval tracking log.
- Once approval is received, our Compliance department is notified by the Commonwealth. Compliance notifies our department owners or subcontractor that approval has been granted, logs the approval date and status on the Department approval tracking log, and retains a copy of the approval notification for our records.
- The Department approval tracking log serves as our verification of the approvals granted and submission status, along with the Commonwealth's formal approval notification email.
- Our compliance officer audits all documents to ensure they have been Commonwealth-approved and have the correct tracking number that correlates to the logged approval.

Figure C.15-5 is the control and approval process for Aetna's marketing materials.

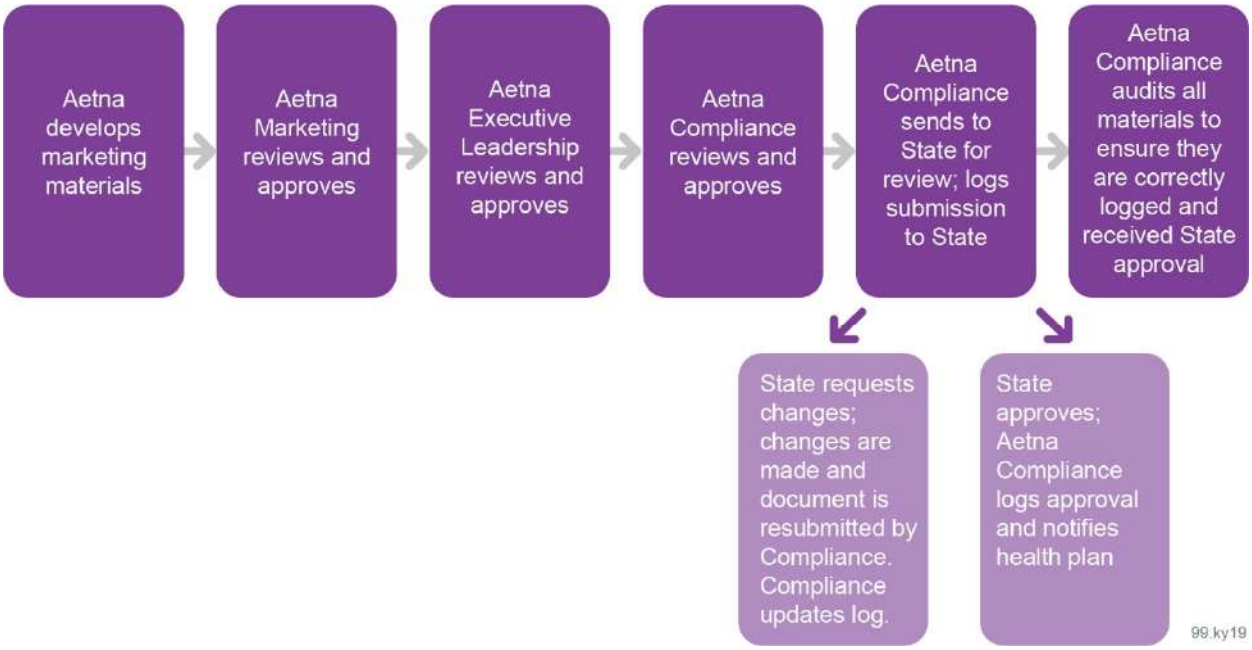

Figure C.15-5: Aetna's Control and Approval Process for Marketing Materials

Our control and approval process ensures all interested entities sign off on all marketing materials.

Marketing materials may also be reviewed by Aetna's QMAC, which gives us feedback regarding their assessment of the use of plain language and readability. In addition, we solicit feedback about our programs and services directly from our enrollees. If changes are made based on their input, we report those changes to QMAC, as we value our enrollees and believe in incorporating their comments as they

relate to their health outcomes. We seek Commonwealth approval through the process noted above if any changes are made.

b. Understanding the Populations in the Commonwealth

Approximately 1.2 million people in Kentucky are eligible for Medicaid. Through an earned understanding and a deep capacity for meeting the needs of Kentucky's local communities, we have joined forces with more than 1,500 CBOs and agencies throughout all eight regions in the Commonwealth. This includes the following:

- Kentucky community action agencies
- Cooperative extension office
- Neighborhood places
- Public health districts
- Rural coalition
- Kentucky YMCAs
- Boys & Girls Clubs of America
- Big Brother, Big Sister
- County agencies
- County-based organizations
- Faith-, school-, and family-based services
- CBOs that deliver services to enrollees and their families

Our mission supports the Department's goals by deepening our market presence in each community we serve. Aetna solicits feedback about our marketing approach and products from community partners and acts on changes as needed. For example, we responded to feedback from the Family Resource and Youth Services Coordinators, who shared that there was a gap in school supplies and backpacks. We revisited our value-added services and incorporated a back-to-school assistance benefit to provide these needed resources. We distributed 10,000 backpacks filled with school supplies in less than a year**.** **Figure C.15-6** shows Aetna volunteers delivering backpacks.

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Figure C.15-6: Backpack Drive
Aetna distributed over 10,000 backpacks filled with school supplies.

Visual Mapping Project

Aetna recently conducted an internal evaluation of our existing marketing materials to determine if we are accurately reflecting the current Kentucky Medicaid population. Our visual mapping project consisted of displaying our enrollee marketing materials and outlining the enrollee journey, starting with enrollment and continuing throughout their enrollment with Aetna. We also conducted the same mapping project for our provider marketing materials. Every department within our Kentucky health plan was invited to participate in the project; staff members provided comments and suggestions on how to improve our marketing materials. We also solicited our QMAC for feedback on our rebrand materials. Everyone's feedback contributed to our recent brand refresh, and **our new Aetna marketing collateral represents the Kentucky Medicaid population**. **Figure C.15-7** provides an example of our rebranded Kentucky marketing collateral.

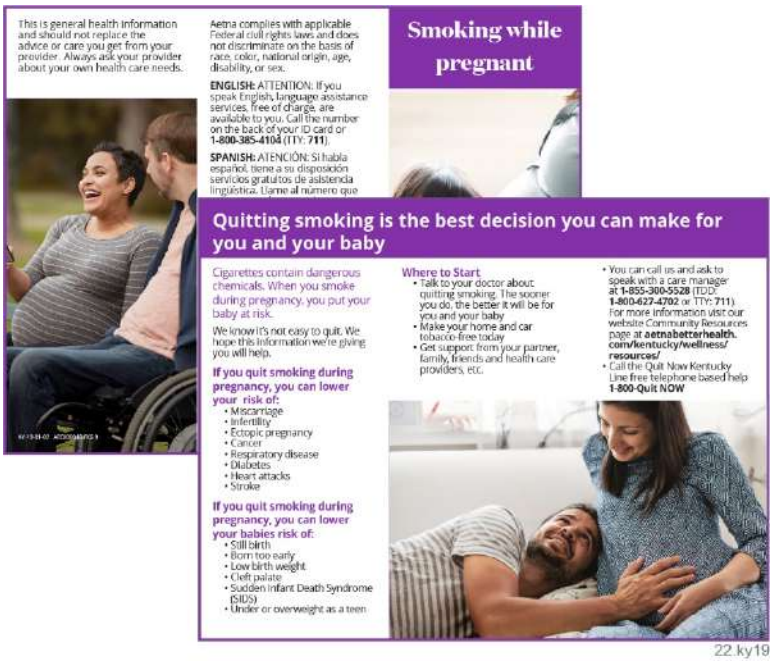

Figure C.15-7: Example of Aetna's Rebranded Marketing Material for Kentucky
Our new collateral reflects the current Kentucky Medicaid population.

Regional Recognition

The Aetna Foundation, in collaboration with the U.S. News & World Report, launched the Healthiest Communities rankings in the United States based on examining more than 3,000 counties across 10 social determinant categories: community vitality, equity, economy, education, environment, food and nutrition, health, housing, public safety, and infrastructure. This effort is part of our overall strategic vision to build healthier communities across the U.S. by informing citizens, community leaders, and elected officials about local practices that drive better health outcomes. This collaboration is designed not only to educate, but also to spark dialogue and drive change.

Aetna recognizes that **each of the eight regions in Kentucky has its own unique population**. Our goal is to address the most common health and social challenges in each region. Some examples of conditions that are prevalent in specific regions of Kentucky are presented in **Table C.15-2:**

Table C.15-2: Regional-specific Health Outcomes

Region	Preventable Hospitalizations per 1000	Children in Poverty	Adult Smoking	Adult Obesity	Drug Overdose Mortality
1	68.65	25%	21%	34%	15%
2	56.85	23%	22%	36%	17%
3	58.18	18%	21%	34%	28%
4	73.01	30%	24%	35%	24%
5	54.46	23%	22%	35%	39%
6	58.00	17%	20%	35%	58%

Region	Preventable Hospitalizations per 1000	Children in Poverty	Adult Smoking	Adult Obesity	Drug Overdose Mortality
7	65.05	31%	24%	37%	38%
8	97.40	41%	26%	39%	34%

Regions 1 and 2[1]

Regions 1 and **2** have among the Commonwealth's lowest ratio of food outlets per capita (2.70 food outlets per 100,000 people vs. a statewide average of 3.65 per 100,000). For example, in McCracken County, 32 percent of the population does not live within one mile of a grocery store (or within 10 miles in rural areas) compared to a statewide average of 18 percent. Recognizing the lack of access to health foods in these regions, Aetna implemented several regional initiatives to specifically address food security issues**.** We sourced county health rankings data to identify food deserts and areas with limited access to healthy foods. To address the SDOH need, we launched a local initiative that has grown across the state. We address all levels of food insecurity by **working with our local food pantries and community stakeholders that offer free food distribution**. Aetna aims to supplement community donations by working with the stakeholders to identify what healthy options are needed. We provide fresh produce and healthy shelf stable items through our outreach initiative. From the pantry support endeavor, we expanded our efforts to include community gardening. The community garden's offerings will be donated to local pantries; we have branded this initiative as the Garden-to-Pantry program.

In addition, we also offer the following:

- **Diabetes nutrition:** Free basic diabetes course that offers a 90-minute cooking class that focuses on basic carbohydrate counting and how to shop using food labels and nutrition information.
- **Eating Dinner Together campaign:** Aetna provides education on slow-cooking nutrition, eating on a budget, and a cooking demonstration where attendees sit and enjoy a meal with Aetna staff. Participants also receive an Aetna-branded slow cooker.

Region 3

This region has the highest incident rate of congestive heart failure among Aetna enrollees (13.1 percent). Therefore, we support the American Heart Association's Go Red for Women and Heart Walk in an effort spread education and awareness of heart health. In addition to financial support, our staff members volunteer at the aforementioned events.

In addition to supporting the American Heart Association, we also work with the Exploited Children's Help Organization (ECHO), a volunteer-based organization dedicated to preventing and reducing the incidences and impact of child abuse by providing education, advocacy, and support services to the children and families of metro Louisville and the surrounding areas. ECHO works closely with law enforcement, educational institutions, community groups, and the courts. In fact, ECHO has a room in the Jefferson County courthouse which is designated to house children during family court proceedings to develop a plan to overhaul the space to meet the needs of all ages. Without this room, many children either have to sit in the courtroom and listen to their parent's court cases or their parents/guardians will miss court because they do not have anywhere to send their children. Aetna sponsored an overhaul of the space and ECHO branded it as the Safe Zone Family Room. The room is now a functional safe space for children to go while their parents/guardians are in family court. **Figure C.15-8** shows what the space looks like.

[1] 2017 County Health Rankings – Kentucky, U.S. Census: accessed June 10, 2019; http://www.countyhealthrankings.org/app/kentucky/2017/overview

Aetna also collaborated with the Park DuValle Community Health Center to place an onsite care manager (CM) in their clinic to assist our enrollees. The CM was onsite at the clinic once a week and the clinic attempted to schedule Aetna enrollees on that day. Signs were posted listing which day our CM would be onsite, and this allowed other enrollees to be seen. Because the Park DuValle Community Health Center is a neighborhood clinic, transportation was not a barrier for enrollees.

Figure C.15-8: ECHO's Safe Zone for Kids
The Jefferson County Courthouse Safe Zone in Region 3 provides a place for children to go to while their parent or guardian is in family court

Region 4[2]

Region 4 has the lowest percentage of births to mothers receiving early and regular prenatal care (57.07 percent). Premature birth and its complications are the largest contributors to infant death in the United States, and a major cause of long-term health problems in children who survive.

We market our Maternity Matters preventive health program to females of childbearing age. We refer these enrollees to Aetna's Care Management team when appropriate. The program is comprised of benefits and incentives to encourage care, such as the following:

- **Family transportation:** Enrollees in the Maternity Matters program receive transportation for their entire family; a car seat for children is included.
- **Initial prenatal visit incentive:** Pregnant enrollees receive a $25 incentive card for completing their initial prenatal visit.
- **Subsequent prenatal visits incentives:** Pregnant enrollees receive a $10 incentive card for each visit with a 10-visit maximum.
- **Postpartum visit incentive:** New mothers receive a $25 incentive card for attending a postpartum visit within 21 to 50 days after their baby is born.

Region 5[3]

An area of concern in **Region 5** surrounds the health behaviors of smoking and excessive drinking. Currently, 19 percent of the population consumes tobacco and 20 percent experiences excessive drinking. To discourage these types of behaviors, Aetna provides education and deterrence programming geared toward youth and adolescents. The Metamorphosis Curriculum began as a collaborative with the Kenton County Alliance. With this program, we have expanded its reach beyond northern Kentucky. Metamorphosis is a 10-session series that focuses on the core strengths of child development to establish

[2] 2018 Premature Birth Report Card: accessed June 10, 2019; https://www.marchofdimes.org/materials/PrematureBirthReportCard-United%20States-2018.pdf

[3] 2017 County Health Rankings – Kentucky, U.S. Census: accessed June 10, 2019; http://www.countyhealthrankings.org/app/kentucky/2017/overview

supports and reinforce healthy choices, which contribute to living a substance-free lifestyle, while paralleling the life cycle of the butterfly to one's own health and role in society. Lesson plans include discussions on self-respect, healthy relationships, self-control, and goal setting.

The program is held at the Kings Center, a community center that offers after-school and summer programs. The Kings Center was selected as our first site in **Region 5** due to its work with inner city, at-risk youth; over half of the adolescents involved in substance abuse treatment are from metropolitan areas such as Frankfort and neighboring Lexington. This early intervention approach corresponds with recommendations from the National Institute on Drug Abuse that highlight the social and environmental factors between birth and age 8 that contribute to teen substance abuse. Youth involved in substance abuse treatment in the Bluegrass region largely self-report behaviors of underage drinking, marijuana use, and abusing prescription painkillers. Such unhealthy behaviors can often be linked to self-medicating for coping with anxiety, social environment, and trauma. Metamorphosis helps target these areas by helping youth identify their personal supports and teaching resilience and ways to better cope with their environments.

Region 6[4]

This region has the highest population experiencing homelessness (1,253 individuals or 0.15 percent of the total population) and the highest average median cost of rent ($727/month). The Housing Choice Voucher Program (commonly known as Section 8) is the primary form of federal housing assistance. The program, which provides vouchers to low-income households to help them pay for housing in the private market, has been found to sharply reduce homelessness. Aetna educates enrollees about the voucher program and makes referrals to the program.

Aetna's marketing efforts include participating in homeless street counts in collaboration with the Coalition for the Homeless. We recruit volunteers to perform an early morning head count of those living on the street, and volunteers also hand out winter clothing and gear provided by Aetna. We also collaborate with Corporative Extension Offices, Goodwill Industries of Kentucky, Lexington Office of Homelessness Prevention and Intervention, and the DV8 (a second-chance employer) organization to address the root causes of housing insecurity and to continue to collaborate on identify enrollees experiencing homelessness to identify community-based resources and supports (including help with rent to move them to housing stability). We work with the Welcome House's Street Med Program, where we handed out 400 sleeping bags to homeless individuals. We also support their education and wound care program.

Regions 7 and 8[5]

These regions encompass a variety of health challenges. Key population characteristics include the following:

- Highest percent of population that is food insecure (19.54 percent)
- Highest percent of population with diabetes (15.00 percent)

The highest incidents of diabetes among our enrollees occur in **Region 8**; therefore, we provide a nutrition class that focuses its efforts in the Appalachian areas of that region. Additionally, our outreach coordinator for these regions is a member of several diabetes coalitions; their mission is to educate and bring awareness to diabetes-related issues and serve as a resource for those seeking prevention and management. **She has been a strong advocate for diabetes since the plan inception in 2011, as she has**

[4] K-Count Homelessness 2017 Report.
[5] 2017 County Health Rankings – Kentucky, U.S. Census: accessed June 10, 2019; http://www.countyhealthrankings.org/app/kentucky/2017/overview

lived with diabetes her entire life. Our outreach coordinator also serves as the Kentucky lead advocate for the American Diabetes Association. She is instrumental in helping her fellow Kentuckians manage their diabetes through lifestyle changes and healthy living by teaching healthy cooking classes, administering our diabetes nutrition health literacy program, and advocating for diabetes issues in Washington, D.C.

Addressing the Opioid Epidemic in Kentucky

Opioid addiction is a prevalent issue across the country. In Kentucky, families are losing loved ones to the opioid crisis as deaths due to drug overdose are on the rise, but it is especially prevalent in **Regions 7** and **8**. **Figure C.15-9** shows the number of drug overdose deaths in each Kentucky county in 2017.[6]

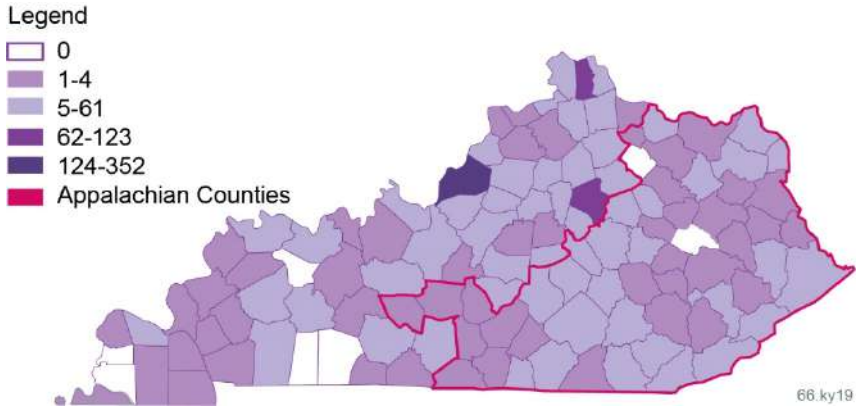

Figure C.15-9: Number of Deaths Due to Drug Overdose by County of Residence in 2017
Most counties in Kentucky were affected by a drug overdose-related death.

Recovery is the first step to becoming independent from drugs. To aid in this effort, **Aetna contributed $150,000 to Volunteers of America Mid-States** in support of its new Freedom House program in southeastern Kentucky. Freedom House provides state-of-the-art and nationally recognized addiction recovery treatment and care to pregnant and parenting mothers working to overcome substance use disorder. On February 11, Volunteers of America is scheduled to open a new 16-bed facility located in Clay County—the first program of its kind in the region.

> "Volunteers of America are incredibly grateful to receive this very important and generous gift. Our addiction recovery program works, and it is successful because we invest heavily in better futures for the women we serve here. The women who will come to Freedom House in Southeastern Kentucky need and deserve comprehensive and proven treatment, and this gift from Aetna will help to make our work possible."
>
> **—Jennifer Hancock, President and CEO, Volunteers of America**

Aetna will help fund the comprehensive services and care that pregnant and parenting mothers receive at Freedom House. The treatment program also includes classes and training on life skills as well as preparation to enter the job market and attend school.

Aetna is also committed to serving those who help fight the battle on the front lines. We provided 720 doses of Narcan® to first responders by partnering with the Northern Kentucky and the Kentucky River

[6] Kentucky Death Certificate Database, Kentucky Office of Vital Statistics, Cabinet for Health and Family Services. June 2018.

public health districts. Aetna's Chief Medical Officer David Hiestand participated in a training for local first responders on how to administer Narcan as shown in **Figure C.15-10**.

Multicultural Marketing

Aetna utilizes demographic data to accurately represent our Medicaid population, which is 82 percent White, 11 percent African American, and 7 percent Other. We utilize this data, with considerations to regional differences, to select the photos for our marketing materials.

Figure C.15-10: Narcan Demonstration
Aetna Chief Medical Officer Dr. David Hiestand participates in a demonstration on how to administer Narcan.

Aetna's Multicultural Marketing team is a center of excellence that provides multicultural insights and strategies, including making translation and interpretation services available in over **200 languages.** This includes Kentucky's top 15 non-English languages (Spanish, Chinese, German, Vietnamese, Arabic, Serbo-Croatian, Japanese, French, Korean, Penn Dutch, Nepali, Oromo [Cushite], Russian, Tagalog, Kirundi [Bantu], and American Sign Language (ASL). We also provide telecommunication options for enrollees who are deaf or hard of hearing through our language line services.

Marketing Material Adaptation

Aetna utilizes the regional differences in Kentucky to not only enhance our multifaceted marketing strategies, but also to enrich our understanding of the diversity and unique challenges of Kentuckians. We strive to create materials, literature, and activities that are diverse and culturally appropriate in its imagery and language, as well as address the unique needs or top priorities for that area or population. The information we provide is targeted to specific populations. For example, our Maternity Matters program is customized to the needs and interests of pregnant women.

Because most of Kentucky is rural, we employ multiple strategic methods for enrollee marketing and communications. We are also launching a social media platform that includes Facebook engagement and other web-based solutions like our enrollee portal. We adapt to new technology as it becomes available. Additionally, we engage enrollees via text and email campaigns.

Alternative Methods of Communication

Aetna's marketing materials are provided in alternative formats, such as large print, audio, or braille, in a manner that takes into consideration the special needs of those who are visually impaired, hearing impaired, or have limited reading proficiency. We inform the public that our materials are available in alternative formats, as well as how to access those formats.

We practice multiple methods of communication, including but not limited to, written, telephonic, face-to-face (when applicable), and ASL interpretative services to any person who requests such services at no cost.

Our Long-term Commitment to Kentucky

Aetna supports the Department's initiative to collaborate with the Kentucky Department of Education to provide school-based mental health services for Kentucky students. We stand ready to provide Mental Health First Aid (MHFA) and Adverse Childhood Experiences (ACEs) training to all educators, staff, parents and students. We have an MHFA trainer on staff that will coordinate and facilitate trainings for

key staff and personnel statewide in collaboration with the school-based Family Resource and Youth Services coordinators. In addition, Aetna has an established relationship to support Stamina, the mental health student-led program created for and by students, and we currently collaborate with the Foundation for a Healthy Kentucky Bounce Coalition, which offers evidence-based, trauma-informed trainings to those who interact with children and families to help them recognize the impact of ACEs. The program ultimately equips them to help youth develop resiliency and the ability to cope with trauma. We are honored to work, and will always stand ready to work, with the Cabinet for Health and Family Services and Commissioner Lisa Lee on their long-term goals.

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60.7.C.16 Enrollee Eligibility, Enrollment and Disenrollment

Kentucky | Transforming Health Care | **Aetna**

60.7.C.16 Enrollee Eligibility, Enrollment and Disenrollment (Section 26 Enrollee Eligibility, Enrollment and Disenrollment)

Aetna has over **30 years of continuous, active participation in Medicaid managed care**. We have been a part of Kentucky's Medicaid landscape since 2011[1], in which we have successfully managed enrollee eligibility, enrollment, and disenrollment. Our seamless approach for enrollees is aligned with the Department's goal of creating a healthier Kentucky.

a. Approach to Meeting the Department's Expectations and Requirements

Aetna's main priority is serving those who are part of our health plan, and that includes managing all aspects of an enrollee's journey. Our local, enrollee-centered approach focuses on individuals' holistic health needs by providing access to and delivery of cost-effective health care services. Aetna understands, acknowledges, and will comply with all the requirements for **Section 26.0 Enrollee Eligibility, Enrollment and Disenrollment** as outlined in the **Draft Medicaid Managed Care Contract and Appendices.**

Eligibility

Aetna uses Healthcare Insurance Portability and Accountability Act (HIPAA)-compliant benefit enrollment and maintenance (834) transactions to process and reconcile enrollment data. We follow standard, documented, and approved processes and procedures for receiving and processing enrollment data.

> The Aetna Medicaid organization has successfully processed over 50 million daily and monthly 834 records over the last 13 months.

Aetna accepts and processes the standard X12 Benefit Enrollment and Maintenance (834), Version 5010 enrollment file provided by the Department as the mechanism to update enrollee enrollment and disenrollment information. Our core system uses the enrollee data contained in these data files to verify eligibility requests, authorize services, and process claim transactions.

We meet the criteria for the timely loading of enrollee data. The Enrollment Services team resolves daily 834 change files in one business day and reconciliation files within five business days. We reconcile enrollee eligibility information between the 834 file and the enrollee in the core system. The Enrollment Services team identifies, researches, and validates exceptions, making the appropriate updates in the core system and notifying the Department as required.

Daily and Monthly Files

The Information Systems department receives and downloads daily 834 transactions each weekday, as well as reconciliation files monthly. The daily files contain enrollee changes, including enrollee additions and terminations, as well as demographic changes for current enrollees. The monthly files contain a full enrollee roster that is used to reconcile enrollment data with the core system. The Information Technology department processes the files sequentially and notifies the Enrollment department when it is complete.

How We Resolve Discrepancies and Processing Errors

After the system imports and accepts the data in the 834 file, it is available for use by the core system for further enrollee eligibility verification, such as claim adjudication.

[1] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

The Department determines managed care enrollee eligibility and health plan assignment. They send Aetna an enrollment file with enrollee assignments, demographics, and other eligibility data via the 834 transactions we load into our core system. We process 834 files and monitor accuracy daily to keep our eligibility data in sync with the Department's data. Current and accurate enrollee data is critical to timely and accurate premium payment processing as well as accurate and appropriate eligibility verification and claims processing.

After we upload the file, the system produces an edit report of errors and exceptions. Errors are 834 file records that do not process into the core system and require manual review and reconciliation; exceptions are 834 file records that process in the core system but require manual validation of the changes made by file processing. Each day, the Enrollment department manually reviews the errors/exceptions report and reconciles the 834 data with system data in the core system. If the 834 file contains insufficient information, the Enrollment department uses the Department's online eligibility verification system to determine the correct eligibility information. If any 834 file records cannot be reconciled in the core system using the file and/or the eligibility verification system, a report of those file records is generated by the Enrollment department and communicated with the Department in a format and at a frequency determined by the Department.

Enrollment

Aetna successfully supports Medicaid enrollments with DXC, the Kentucky-designated enrollment broker. Our goal is to make enrollee enrollment as seamless as possible by leveraging our extensive experience managing the enrollment process in Kentucky. Our system is tailored to accommodate the requests and requirements of Kentucky's Medicaid managed care program administered by the Department, which maintains the sole authority in determining eligibility and enrollment membership, thereby creating a positive experience for our enrollees. As part of the enrollment process, we provide our subcontractors, Avēsis and CaremarkPCS, with updated eligibility files daily and perform oversight of those subcontractors.

The enrollment file import rules engine was built in to support a feature flagging design. This application is designed to easily turn flags on and off as needed to meet the changing needs of the Department without impacting Aetna's enrollment process workflow. Additionally, our extensive experience with other Commonwealth enrollment processes allows us to pre-program the Kentucky enrollment file import rules to manage hundreds of unique data scenarios.

Once we receive the 834 files, the enrollee records are compared to the existing data within our electronic claims management system. Each record is fed through our highly configurable rules processor, which identifies matches and consolidates and transforms the enrollee information to ensure proper updates to demographic, enrollment benefit plan assignments, primary care provider (PCP) assignments, enrollee classifications, and other critical information. Our **proprietary rules engine** automatically evaluates such complicated scenarios like split, overlapping, duplicate, and consecutive enrollment segments and uses intelligent enrollee matching that considers over 20 attributes to match and identify the right enrollee, all of which increases the auto-enrollment percentages to reduce manual interventions. For example, if an enrollee was previously disenrolled due to loss of eligibility but regains eligibility in less than two months, we can seamlessly bring the enrollee back into our plan, assigning the enrollee to their same PCP, and providing continuity of care. Our Enrollment staff manually reviews the records rejected from rules processing to ensure we have the proper enrollment data to enroll an enrollee; our error rate is less than 5 percent of the file processed. If data is missing or inaccurate, we communicate with the Department to retrieve or correct the data. Our 834 process flow, known as Enrollment Manager, is illustrated in **Figure C.16-1.**

Upon receipt of a new enrollee on the 834 file, and according to the requirements of the Medicaid Managed Care contract, Aetna mails a copy of the new enrollee kit, including the enrollee handbook and an ID card, to all new enrollees within five business days of enrollment. In addition, all new enrollees receive a welcome call which introduces the enrollee to the health plan and their benefits, as well as encouraging them to work with case management to do a health risk assessment. This gives them the opportunity to enroll in our population health management programs.

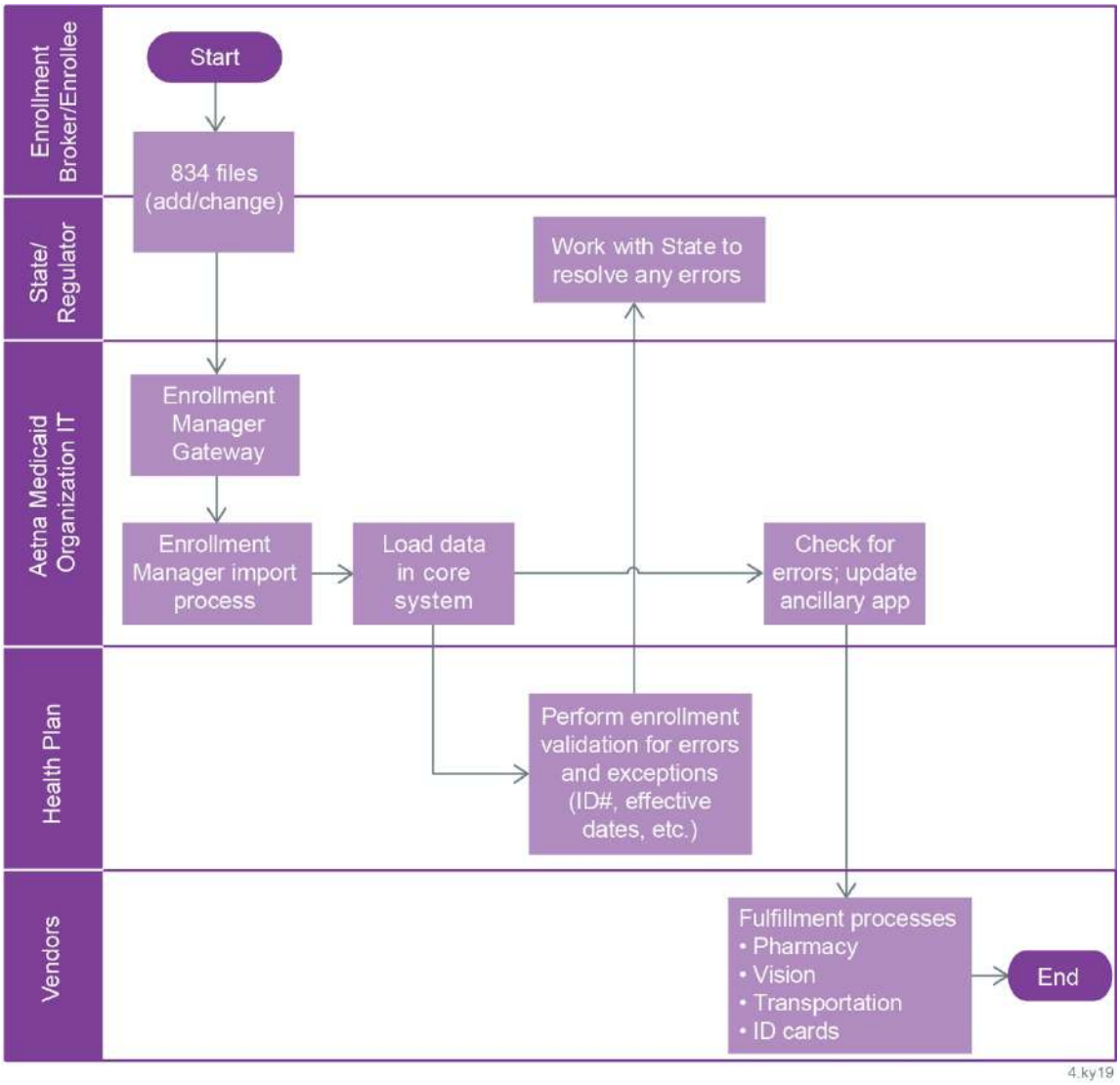

Figure C.16-1: Aetna's Enrollment Manager

Our Enrollment Manager processes and reconciles enrollment data.

In addition to Aetna's extensive experience with standard enrollments, we have created a robust enrollment process for non-standard enrollments. For example, when birth notifications are received and the mother's eligibility and utilization management (UM) documents are reviewed and confirmed, a newborn is enrolled into our core system with a temporary identification (ID) number consisting of the mother's ID number and a prefix of NB (for newborn). This provides seamless processing of UM documents, ID cards, the enrollee handbook, and claim payments. We notify the Department of the newborn birth; once a permanent ID is assigned, the child's temporary record is updated with the

permanent Medicaid ID number. The Enrollment department uses an audit report to ensure all temporary newborn IDs are reconciled and accounted for using the 834 file or by working with the Department to validate eligibility.

Aetna provides freedom of choice for our enrollees. If an enrollee does not select a PCP with the Department during open enrollment or at the time of initial enrollment, we assign a PCP, as illustrated in **Figure C.16-2**, based on the enrollee's location, language needs, and cultural needs, as well as any prior PCP relationship (if known). Enrollees may contact our Enrollee Services department to request a PCP change at any time. Enrollees may also submit PCP change requests via our secured Enrollee Services website or mobile application.

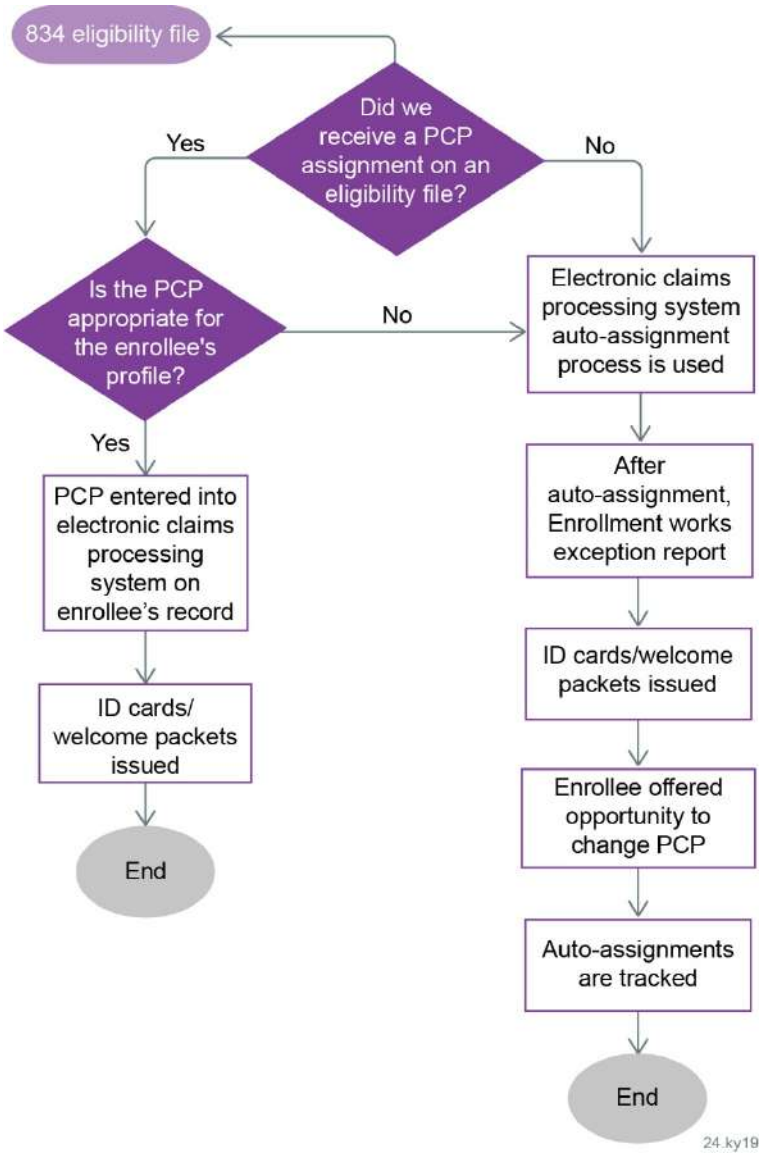

Figure C.16-2: PCP Assignment Workflow
Aetna works closely with enrollees to identify a PCP that matches their individual needs.

Disenrollment

When an enrollee submits a request to the Department for disenrollment, the Department sends the request to Aetna via our compliance mailbox. Our compliance officer receives and reviews the request and determines the appropriate business unit(s) that can address and resolve the enrollee's concern. The request typically involves an enrollee who needs assistance obtaining a medication or an authorization for a covered service. If the request is for medications, it is routed to our pharmacy director for research and resolution. If it involves covered services, treatment, or assistance with finding a provider, it is routed to our director of health services. In all instances, care management is involved and outreaches the enrollee to further discuss their concerns, offer education, and coordinate for resolution. We view each enrollee contact as an opportunity to talk with the enrollee about their needs for ongoing care management support.

For the majority of the disenrollment requests we receive, the concerns are resolved to the enrollee's satisfaction and they are agreeable to remaining our enrollee. Aetna seeks to resolve each request for disenrollment within two business days of its receipt from the Department. Once the concern has been resolved, our compliance officer responds to the Department's request with the details of the resolution and the recommendation that the enrollee remain our enrollee. **In fact, we received 97 requests for disenrollment in 2019, and we were successful in resolving 99 percent of the underlying issues that were the subjects of the disenrollment requests.**

If an enrollee contacts Aetna Enrollee Services or Case Management directly to be disenrolled, we attempt to resolve the reason for disenrollment following the same system described previously. If the issue cannot be resolved, **we quickly facilitate a transfer to the Department for continuity of care**. Our documented process for resolution is focused on ensuring the enrollee receives the care they need in a timely fashion.

Cross-functional Collaboration to Help Aetna Enrollees

St. Claire Bariatric Center is a network provider in **Region 7** that offers bariatric surgery for weight issues. They were directing enrollees to change their managed care organization from Aetna to another provider, citing that Aetna would not allow the procedure to be completed at an inpatient level of care. In conversations with the clinical coordinator for the practice, she cited that the center's Finance department banned the practice from accepting Aetna.

Many of our enrollees submitted letters to the Department requesting disenrollment from Aetna to allow completion of the bariatric surgery. Because every enrollee counts, our Care Management team conducted outreach to convey how important the enrollee was to us. The team explained the processes for prior authorization behind their disenrollment request and that we were working with their provider to get the issue resolved. Prior authorization requests were never submitted by the provider for any of the enrollees. The clinical coordinator for the center was initially contacted to understand the procedure that was to be completed. Once we determined the procedure code, we collaborated with the Prior Authorization team to understand the approval criteria and the clinical criteria requirements. It was determined that Aetna used the clinical criteria in InterQual, which authorized the procedure for an inpatient stay.

Our chief medical officer, chief financial officer, and senior leadership worked together for a solution. In addition, we reached out to a professional association partner to see if they could offer any support. The partner was able to provide some contact information for St. Claire's leadership. Once a leadership representative was contacted, we explained that we currently use InterQual criteria and authorization requests, which are reviewed against the criteria. Based on this information, the decision was made to provide Aetna enrollees with bariatric surgery. Since this resolution, Aetna has approved authorizations for treatment at this facility, and our enrollees continue to successfully obtain care through the St. Claire Bariatric Center.

Aetna advises our enrollees that disenrollment requests must be submitted orally or in writing. Our Enrollee Services staff facilitates a **warm transfer to the Department**. Additionally, we understand that

the Department is solely responsible for disenrolling enrollees, and a disenrollment request will become effective on the first day of the next month following the disenrollment request. Aetna's Enrollment department runs a monthly report of retro-disenrolled enrollees, capturing any claims paid data, and forwards that detail to the Claims department for recoupment.

To further provide validity and accuracy of enrollment, an out-of-area audit report is generated and reviewed daily by Aetna's Enrollment staff. The report identifies anyone with an address in our core system that is outside the service area. We also receive notifications from supporting departments when an enrollee has been identified as deceased or incarcerated.

With each notification or identified enrollee, the Enrollment staff investigates the enrollment scenario to ensure accuracy of the disenrollment information using UM documents, the Commonwealth eligibility website/portal, and previous 834 file data received from the Commonwealth. We also validate that the Department does not already have the disenrollment data on file to prevent duplicate notifications to the Department.

Eligibility Changes

Aetna understands that changes in an enrollee's eligibility can impact continuity of care. Our Enrollment Services team uses consistent processes for tracking changes in enrollee eligibility, including review of monthly HIPAA-compliant benefit enrollment and maintenance (834) transactions to process and reconcile enrollment data as well as employing standard, documented, and approved processes and procedures for receiving and processing enrollment data.

Our Enrollment Services team meets the Department's technical specifications criteria for timely processing of enrollee data and reflecting enrollee enrollment changes electronically on a daily and/or monthly basis by taking the following actions:

- Resolving 834 change files in a standard 24-hour business day
- Reconciling enrollee eligibility information between the 834 file and the enrollee files in our electronic claims management system, including notifying the Department within five business days when there are changes to the enrollee's circumstances that may affect the enrollee's eligibility (including changes in the enrollee's residence, such as out-of-state claims, or the death of the enrollee)
- Identifying, researching, reconciling, and validating exceptions, making appropriate updates in our electronic claims management system, and notifying the Department, as required
- Notifying our Enrollee Retention team to make outreach calls 30, 60, or 90 days prior to the enrollee's recertification date

To help enrollees to maintain eligibility and facilitate continuity of care, Aetna contacts enrollees with pending disenrollment to remind them of their potential disenrollment date and to have them contact the Department. We also work to identify local community-based organizations who can provide services if the enrollee loses eligibility. With the enrollee's permission, we share the exit plan with those involved. We also offer support to assist the enrollee with re-establishing enrollment through the Department. **We are proactive in notifying the Department of enrollees who are pending disenrollment**. If we discover they are ineligible, we have a process in place for notifying the Department. We coordinate and collaborate with the Department to meet the needs of the enrollees to ensure continuity of care.

Outbound Retention Call Center

Aetna created and staffed an outbound retention call center in early 2019. The purpose of the outbound retention call center is to contact enrollees who have a future termination date because they need to recertify with the Commonwealth. Our team contacts the enrollee 30, 60, or 90 days prior to their termination to let them know they may lose their Medicaid coverage if they do not recertify, **and we want**

to assist them to ensure they have continuity of care and uninterrupted services. We explain the process to the enrollee and conduct a warm transfer to their Commonwealth's enrollment broker or department. Three states have been implemented, and we are exploring adding additional states as we analyze the data and success of this program.

b. Meeting the Department's Expectations

Aetna does not have and does not foresee any limitations or issues to meeting the Department's expectations or requirements related to this response. We have the experience and expertise needed to fully comply with all requirements. Most importantly, we are currently performing all requirements set forth by the Department and have not had difficulty meeting any requirements or challenges. We look forward to a continued relationship with the Department.

In the event that any issues arise, we have established and tested communication lines, processes, and resources in place with the Department to quickly address and resolve eligibility, enrollment and disenrollment concerns, as evidenced by the following:

- Aetna receives and processes a weekly enrollee mismatch file received from the Department. Recently, when we noted a discrepancy on this weekly file, we reached out to the Department to express our concern and ask for guidance. The Department responded quickly with the direction we needed to update the file accordingly so it could be processed timely.
- When ChooseWell, the physician services division of Harrison Memorial Hospital, terminated its sole MCO contract and expressed their interest contracting solely with Aetna, we collaborated with the Department and OATS as enrollees expressed their interest to transition their MCO membership to Aetna. We developed a process whereby enrollees were transitioned to Aetna on a monthly basis to ensure continuity of care.
- Recent changes to the cost share requirements necessitated updates to the 834 file, including a significant increase in the amount of data transferred as a result of calculating and conveying the 5% quarterly cost share maximum. We collaborated with the Department to test, update, and validate the file so that our systems were ready to receive and process the file once the implementation process was complete.

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60.7.C.17 Provider Services

Kentucky | Transforming Health Care | **Aetna**

60.7.C.17 Provider Services (Section 27 Provider Services)

A positive and collaborative provider experience is in our DNA. We bring to Kentucky our national expertise and experience in creating new and innovative ways to collaborate with providers, creating a new culture and mindset about delivering high quality, enrollee-centered care. Our dedication to be a collaborative, responsive and innovative partner to Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to provide access to and improve delivery of high-quality, cost-effective health care services.

a. Overall Approach to Provider Services

Aetna's comprehensive provider service functions include all services, tasks, and requirements under the model contract. During our term as a Kentucky managed care organization (MCO), Aetna's Provider Services functions have evolved to better support our providers and exceed minimum expectations.

a.i. Provider Representative Engagement and Local Presence

Our provider services representatives (PSRs) are based in the communities they serve, fostering a higher level of responsiveness and personalized relationships. These locally based PSRs engage with providers through a variety of mechanisms designed to provide proactive, prompt, and collaborative communications, as depicted in **Figure C.17-1**. Our PSR engagement activities include new provider orientation, training webinars, provider forums, operational meetings, regular site visits, and other face-to-face meetings. We have also established several provider meetings, participate in provider association meetings, and actively collaborate with our provider partners to identify improvement opportunities, reduce administrative burden, and provide education and training.

Figure C.17-1: Aetna Provider Communication Strategies
Aetna uses multiple strategies to communicate with our providers.

Locally Based Provider Services Representatives

We have developed an in-depth understanding of Kentucky providers and enrollees at the state, regional, and local levels. We have actively recruited provider representatives and Network Operations staff who have worked for providers, know Kentucky Medicaid, and live and work in the communities where they live. Our highly trained and experienced **Provider Services leadership and staff have a combined 200 years of experience working for Kentucky providers entities, and over 115 combined years of working in Kentucky Medicaid.** We have learned the importance of having dedicated Behavioral Health Network Management and Operations staff who understand behavioral health services and can respond to the unique experience of behavioral health providers. **Our current behavioral health managers have 15 years of experience working for and with Kentucky's behavioral health providers.**

Aetna's PSRs are located throughout the commonwealth, with the majority working in the communities and regions where they live. Our PSRs have established close relationships with providers, allowing them to proactively identify and collaborate with providers to fully and effectively address needs. We continually strive to maintain these strong relationships between PSRs and providers, through PSR recruitment and retention. In addition to their extensive Kentucky provider and Medicaid experience described previously, half of our PSRs have worked for Aetna for nearly six years.

Initial and Ongoing Provider Engagement

Aetna has implemented several activities to engage our providers when they initially contract with us and on an ongoing basis. Our formal initial engagement practices include sending our welcome packet within five days of contracting, which is an effective way to convey important information quickly and in a functional, easy-to-follow format. Our welcome packet includes information about how to attend provider training orientations and information on how to access our provider manual/portal. The welcome packet also includes a welcome letter, orientation schedule, identification of and contact information for their assigned PSR, as well as contact information for all PSRs, their provider contract, and portal enrollment forms. We also include Aetna Better Health of Kentucky At a Glance, a quick reference guide with Aetna key contacts and information on claims and prior authorization processes.

> "I just wanted to tell you that we are very pleased. It's very nice not to have a ton of issues out there needing resolved and, above all, I feel like you are doing a great job responding when I do need answers…that is a breath of fresh air."
>
> **—Carolyn Sallee**
> **Russell County Hospital**

Our PSRs directly contact new providers in-person or by phone to welcome them and to begin establishing a relationship, and to address any questions or concerns the provider may have. Additionally, PSRs will have personalized greeting cards that they will give to any newly assigned providers, as shown in **Figure C.17-2:** Provider Services Representative Greeting Card. These greeting cards include the PSR's picture, contact information, and brief biography, as well as facts about Aetna and key contacts.

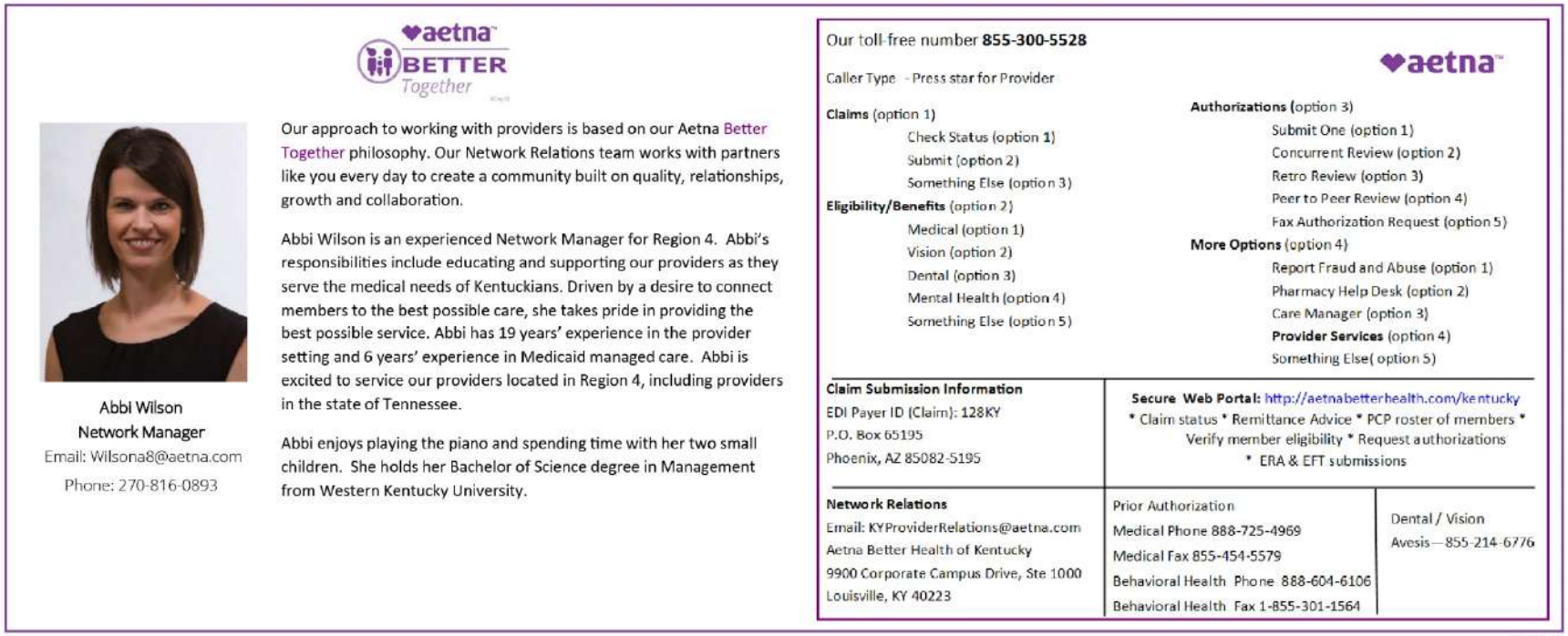

aetna BETTER Together

Abbi Wilson
Network Manager
Email: Wilsona8@aetna.com
Phone: 270-816-0893

Our approach to working with providers is based on our Aetna Better Together philosophy. Our Network Relations team works with partners like you every day to create a community built on quality, relationships, growth and collaboration.

Abbi Wilson is an experienced Network Manager for Region 4. Abbi's responsibilities include educating and supporting our providers as they serve the medical needs of Kentuckians. Driven by a desire to connect members to the best possible care, she takes pride in providing the best possible service. Abbi has 19 years' experience in the provider setting and 6 years' experience in Medicaid managed care. Abbi is excited to service our providers located in Region 4, including providers in the state of Tennessee.

Abbi enjoys playing the piano and spending time with her two small children. She holds her Bachelor of Science degree in Management from Western Kentucky University.

Our toll-free number **855-300-5528**

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Caller Type - Press star for Provider

Claims (option 1)
- Check Status (option 1)
- Submit (option 2)
- Something Else (option 3)

Eligibility/Benefits (option 2)
- Medical (option 1)
- Vision (option 2)
- Dental (option 3)
- Mental Health (option 4)
- Something Else (option 5)

Authorizations (option 3)
- Submit One (option 1)
- Concurrent Review (option 2)
- Retro Review (option 3)
- Peer to Peer Review (option 4)
- Fax Authorization Request (option 5)

More Options (option 4)
- Report Fraud and Abuse (option 1)
- Pharmacy Help Desk (option 2)
- Care Manager (option 3)
- **Provider Services** (option 4)
- Something Else(option 5)

Claim Submission Information
EDI Payer ID (Claim): 128KY
P.O. Box 65195
Phoenix, AZ 85082-5195

Secure Web Portal: http://aetnabetterhealth.com/kentucky
* Claim status * Remittance Advice * PCP roster of members * Verify member eligibility * Request authorizations * ERA & EFT submissions

Network Relations
Email: KYProviderRelations@aetna.com
Aetna Better Health of Kentucky
9900 Corporate Campus Drive, Ste 1000
Louisville, KY 40223

Prior Authorization
Medical Phone 888-725-4969
Medical Fax 855-454-5579
Behavioral Health Phone 888-604-6106
Behavioral Health Fax 1-855-301-1564

Dental / Vision
Avesis—855-214-6776

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Figure C.17-2: Provider Services Representative Greeting Card

Our PSRs foster close, collaborative relationships to better engage, listen, and respond to our providers.

We conduct new provider orientation within 30 days of the provider joining the network. Materials are sent directly to the provider and reviewed during either an onsite or webinar-based meeting. As a part of orientation, providers are given information on a variety of topics including the following:

- Their provider service representatives contact information
- A website overview
- Provider portal overview/enrollment
- Review of access and availability standards
- Cultural sensitivity standards review
- Provider enrollment requirements
- Taxonomy/National Provider Identifier education
- Claims submission guidelines, including the claims resubmission/reconsideration process and remittance advice retrieval
- Information on the provider complaint process and appeals/grievance process
- Fraud, waste, and abuse reporting process
- Healthcare Effectiveness and Data Information Set (HEDIS) overview
- Population health programs and specific information to address the provider's needs

In addition to our orientation program, Aetna continues to engage our providers through the following means:

- **Site visits (face-to-face):** Our PSRs visits each hospital on monthly basis and visits the individual primary care provider and specialist offices at least once a year. We offer ad hoc trainings on topics such as basic billing and provider re-orientations via internal or external request.
- **Provider scorecards:** We are in the process of implementing provider scorecards to allow appropriate trending and provide proactive feedback to address areas of opportunity.
- **Training webinars:** We have a provider education plan that includes a new topic each month. Supplemental trainings are routinely offered and hosted via webinars. Recent topics include co-pay changes, provider portals, and HEDIS. To improve provider access to the orientation information and training, Aetna is in the process of making pre-recorded trainings available to providers, so they and their staff can complete the training at times that are most convenient to the provider.
- **HEDIS toolkits:** Includes tips on how to appropriately close gaps in care inclusive of proper coding and HEDIS guideline interpretation.
- **Email blasts:** We notify providers of policy and program changes through email blasts that are sent as frequently as needed.
- **Newsletters:** Providers receive education and updated information through our quarterly newsletter.
- **Feedback from our call center:** We utilize call center data to track, trend, and identify opportunities for additional provider education topics.

a.ii. Committees, Workgroups, and Forums

Our approach to working with providers is based on our **Aetna Better Together** philosophy. Provider engagement and collaboration is a cornerstone of our processes and critical to achieving improved enrollee experience and health outcomes. We have developed and participate in a variety of formal committees, workgroups, or other forums with providers to offer input about the overall program, initiatives, and challenges. These forums also provide a venue through which providers can receive updates and instructions on various changes and initiatives. Our committees and workgroups include the following:

- **Regular Joint Operating Committee (JOC) meetings:** Aetna has established monthly meetings with hospitals and large physician groups to address emerging issues and identify opportunities to improve their provider experience.

- **Aetna Provider Partnership (AP^3) Advisory Council:** Provider advisory councils that consists of three external provider councils: the Practice Management Advisory Council, Ancillary Management Advisory Council, and Behavioral Health Management Advisory Councils. The AP^3 Advisory Council, for which we are currently recruiting provider members, will offer another mechanism for practice managers to provide feedback about our processes to aid in identifying opportunities to reduce administrative burdens on our providers.
- **Aetna forums/roundtables:** Aetna hosts forums and round tables for providers on a variety of topics to support collaboration and address provider and community concerns.
- **Provider association meetings:** We participate in several monthly provider association meetings, including community mental health centers, Kentucky Hospital Association (KHA), and the Chiropractic Association, to discuss provider needs and concerns, and provide training as requested or needed. We have found participation in these established meetings allows us to reduce provider burden by decreasing their external meetings, while still offering needed information and education.
- **Kentucky Medical Association (KMA):** Our chief medical officer attends KMA meetings and conferences to aid in identifying industry changes and challenges affecting our providers.
- **Technical Advisory Committee (TAC) meetings:** We participate and support the Department in monthly TAC meetings, in collaboration with the other managed care organizations (MCOs) and with the provider community, to address behavioral health, home health, therapy, primary care, and hospitals.
- **Advisory Council for Medical Assistance (MAC):** We engage and collaborate in monthly MAC meetings with the Department, other MCOs, and the provider community
- **Other provider forums (Greater Louisville Medical Society and Kentucky Primary Care Association conference/group):** We attend these meetings in collaboration with the Department, other MCOs, and the provider community.

Provider Collaboration

Through our JOC, the Association of Primary Care Providers (APCP) identified a barrier in using certain pharmacy reports. We worked with the provider to change the report so it meets the needs of APCP and other providers and they can use the information to help improve enrollee outcomes.

a.iii. Methods and Metrics for Collecting Provider Feedback and Satisfaction

Aetna understands that our commitment to collaboration and developing innovative solutions to address Kentucky's unique needs requires a sincere and transparent communications with our providers. We have established a comprehensive and coordinated process for gathering, analyzing, and responding to provider feedback at both the individual and network levels. Provider feedback is solicited through multiple channels, including through our local PSRs, internal departments, data tracking and trending, and provider committees. Information from all these touchpoints is tracked and analyzed, so we can assess and identify the most effective mechanism for improvement, such as individual provider education, inclusion in provider trainings, and our Tip Tuesdays campaign (refer to **Figure C.17-3**), which give providers brief routine updates and information.

Reducing Department Provider Complaints

Through our formalized internal meeting structure, we were successful in reducing provider Department complaints by nearly 80% from January 2018 to January 2019. During 2019, we saw an additional reduction in provider complaints of 35%.

TIP TUESDAY

Aetna Better Health® of Kentucky November 05, 2019

Tip Tuesday Tip # 12

Did you know?

It is that time of year again; Medicaid Managed Care open enrollment begins November 4, 2019 through December 13, 2019.

Aetna Better Health of Kentucky is excited to partner with you to answer any questions. To better serve our members we have added Bonus Benefits for 2020:

- **Free eyeglasses for adults and children**
- **Free hearing aids for adults and children**
- **Free UNITE US Resource access to real time social services**
- **Free CVS Weight Management Program health coach and more**
- **Free opioid lockbox for qualifying members**
- **No limits on Over-the-Counter (OTC) medications with doctor prescription***

* Correction to original email/fax blast distributed on October 29, 2019.

Aetna Better Health of Kentucky offers a secure provider website that directly connects providers with real time information 24 hours a day, 7 days a week at **aetnabetterhealth.com/kentucky/provider/portal** for up-to-date information, forms and other resources.

Our goal for 2020 is to partner with our providers to reduce administrative burdens. Be watching for additional information on upcoming campaigns.

aetna

Member Services - 1-855-300-5528
Behavioral Health Crisis Hotline - 1-888-604-6106
Network Relations - 1-855-454-0061

AEPR00109 Fax 11.05.19

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Figure C.17-3: Sample Aetna Tip Tuesday Flyer

Aetna uses Tip Tuesday notices to inform providers of how they can share important feedback with our Provider Services team.

We encourage our providers to let us know where they are experiencing barriers and challenges, and how we can improve their experiences, decrease administrative burden, and help the providers focus on providing care to our enrollees. We utilize these interaction points, as well as onsite visits, to gather provider feedback. Other mechanism through which we solicit provider feedback include the following:

- **Provider satisfaction survey (annually):** Our annual provider satisfaction survey as part of our quality assurance and performance improvement efforts and is one of the ways that we listen to our providers. Provider surveys help us measure and gauge provider satisfaction with our plan and processes and help us discover what is working well and determine where we need to amend our approach. Through this process we prioritize identify issues, address concerns, implement interventions, and reassess issues to determine change in satisfaction.
- **Ongoing provider survey (weekly):** We have implemented an online provider survey via Survey Monkey, conducted by the PSR, to get immediate provider feedback while evaluating the onsite visit process. These weekly surveys of randomly selected providers allow us to address provider concern in a timelier manner and help mitigate escalation. Responses are tracked and trended, and results are analyzed by our Service Improvement Committee (SIC) to aid in identifying improvement opportunities, including staff education and elevating concerns to the appropriate level of leadership.
- **Internal meetings:** The Provider Services department, executive leadership, and any department subject matter experts who are necessary to identify root causes and implement corrective actions to promptly resolve provider concerns and mitigate provider escalation.
- **Kentucky Issues Tracker Tool (KIT)**: We utilize an internal tracking tool called KIT to track any provider concerns, issues, and request. We use this data to track and trend the provider's needs to reduce turnaround times and improve the overall process and provider experience.

> "KentuckyOne Health and CHI Saint Joseph Health would like to extend full support for Aetna Better Health of Kentucky's bid to remain in the Kentucky Medicaid Managed Care program. Aetna Better Health works collaboratively with our providers to ensure our patients, their members, have access to and receive quality health care services. Our value-based arrangement aligns our organizations around improving the health of the communities we both serve. We are excited to continue this partnership and recommends that the State keep Aetna Better Health as one of their managed care organizations."
>
> **—Lynn Tanner**
> **Vice President of Payer Strategy, KentuckyOne Health**

a.iv Methods to Minimize Provider Complaint and Escalation

Through our experience collaborating with providers to serve Kentuckians, we have identified and successfully implemented several strategies to proactively anticipate and avoid provider complaints. These initiatives include utilizing provider feedback and survey data to identify and implement improvements and tracking and trending of provider appeals and grievances to identify and respond to emerging trends. As described above, we utilize our KIT tool to capture provider concerns and feedback from across departments and processes. This coordinated approach allows us track and trend data at a more comprehensive level and be more proactive in identifying and addressing issues as they emerge, at both at local individual provider level and a systemic level. This data is reviewed in our established SIC, which is comprised of cross-functional leadership team, including the following members: provider experience director, finance director, quality management manager, health and wellness coordinator, care management manager, chief medical officer, utilization management director, enrollee services supervisor and director, appeal and grievance manager, and community development manager. Through our SIC, we are also able to monitor timeliness and quality of responses.

We have also developed strong collaborative relationships with several associations with whom we meet regularly so we can better understand provider challenges and work to develop effective solutions. Another example of Aetna's proactive approach to reducing provider complaints is our work with providers and associations to identify opportunities to reduce the administrative burden on providers, such as our work with KHA to explore a single statewide credential verification organization.

Although these proactive strategies have been effective in reducing provider complaints, Aetna understands that some provider concerns require individual attention. Providers are encouraged to utilize our Provider Services call center, and we fully support our provider's rights to file complaints, appeals, and grievances, and seek to resolve such issues in a timely and thorough manner. In order to improve provider experience, we have established a Provider Services call center triage line, which allows providers to speak directly to Provider Services center staff. The triage line staff have additional Kentucky Medicaid training and access to KIT so they can view historical and current provider information in real time and can transfer the provider to a locally based provider services representative if needed. We have also implemented a single provider services email to improve the response time to concerns submitted via email. Finally, our executive leadership meets daily to review, address, and monitor any high-level complaints, and further avoid complaints from escalating to the Department. An example of the effectiveness of our efforts to reduce provider complaints and concerns is our resolution of open issues with KHA, as depicted in **Figure C.17-4**. The Kentucky Hospital Association publicly released the reference data for December 2019.

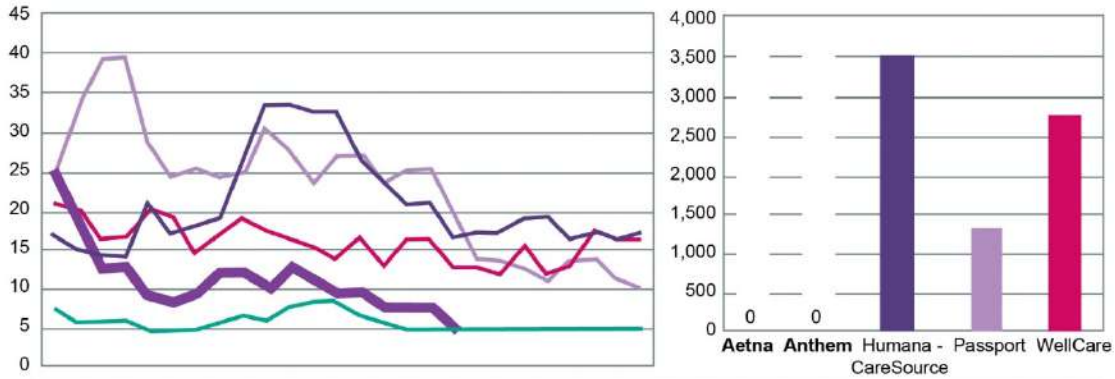

	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	Mar '19	Apr '19	May '19	Jun '19	Jul '19	Aug '19	Sept '19	Oct '19	Nov '19	Dec '19
Aetna	23	16	9	9	5	4	5	8	8	6	9	7	5	5	3	3	3	–	–	–	–	–	–	–	–	–
Anthem	3	1	1	1	–	–	–	1	2	1	3	4	4	2	1	–	–	–	–	–	–	–	–	–	–	–
Humana – CareSource	14	12	11	11	18	14	15	16	23	32	32	31	31	25	21	18	18	13	14	14	16	16	13	14	13	14
Passport	23	33	39	39	27	22	23	22	23	29	26	21	25	25	21	23	23	17	10	10	9	7	10	10	7	6
WellCare	18	17	13	13	17	16	11	13	16	14	13	12	10	13	9	13	13	9	9	8	12	8	9	14	13	13

17.ky20r

Figure C.17-4: Aetna's Successful Resolution of KHA Complaints

We listened when KHA identified issues and have worked collaboratively to resolve identified issues and proactively implement new initiatives to reduce administrative burden for KHA and other providers in our Kentucky Medicaid network.

b. Provider Services Call Center

With the goal of providing reliable service excellence, Aetna's approach to provider call centers extends beyond traditional measures like average speed of answer and abandonment rate. We staff our call center with professional Provider Services staff that are meticulous, supportive, culturally competent, and knowledgeable of the unique needs of our enrollees and providers. We train our call center representatives who operate the Provider Services line, to assist both traditional and non-traditional providers, including those who may be new to Kentucky's Medicaid program. Our staff continually demonstrates sensitivity to provider issues and focus on each interaction with thoughtful and considerate listening skills. We further enhanced our provider call center experience by creating a provider triage line for escalation of complex issues, or calls requiring a higher touch. The provider triage line staff receive additional training to

support call resolution, access to provider data, including complaint information, and the ability to transfer calls to our community-based provider representatives.

Our Provider Services call center operations will continue to meet the requirements outlined in **Attachment C Section 27.2 of the Draft Medicaid Managed Care Contract and Appendices** and as determined by the Department, including maintaining our toll-free line, which is available Monday through Friday, 7 a.m. to 7 p.m. Eastern Time, including federal holidays. Providers also have 24/7/365 access to utilizing self-service tools such as our interactive voice response (IVR) system and a provider portal for eligibility and benefit questions. Aetna maintains an automated system during non-business hours with enough capacity for all callers to leave messages, which are returned on the next business day.

> "Our experiences with Aetna Better Health have been very positive. They are quick to respond to any and all questions regarding claims or any coverage issues with the upmost professionalism. Two years ago, they went to the extra mile for TJ Health Columbia to resolve the timely filing issue due to credentialing delay. Every time we work with Aetna Better Health on different issues, whether for billing, timely filing, payment discrepancy, settlement, or rate review, they handle everything in a very professional and time-efficient manner with diligent follow-up and satisfactory resolutions."
>
> **—Mei Deng, Chief Financial Officer, TJ Regional Health**

We maintain policies and procedures for the operation of the Provider Services call center that address staffing requirements and ratios, orientation and education of call center staff, hours of operation, performance standards, and methods of monitoring calls and complying with standards. Our call center staff receive extensive training related to the Kentucky Medicaid program, responding to issues that are unique to Kentucky, as well as Kentucky's contractually required provider service activities, policies and procedures, and scope of work. We have developed and will maintain scripts for use by call center staff to support providing consistent responses to provider inquiries.

b.i. Approach to Fully Staffed Call Center

Aetna utilizes a variety of mechanisms and data to enable supervisors to anticipate call volume, support enough call center staff scheduling to address providers' needs, and satisfy required performance metrics, including the following:

- **Call center forecasting:** Our staff needs are forecasted on a daily 30-minute interval, on a weekly, monthly, and annual basis.
- **Scheduling:** We use historical patterns to determine the number of Provider Services call center staff every 30 minutes for 12 hours of operation. Staff schedules are based on need derived from the forecasts, which include assumptions for shrinkage, occupancy, and required services levels.
- **National coverage:** Aetna has Provider Services call centers in six locations and three time zones, as well as remote staffing.

b.ii. Location of Proposed Operations

Aetna has ample resources that we leverage for the benefit of our Kentucky providers. Our provider triage line, as described previously, is specially trained and knowledgeable about Kentucky's Medicaid program, and can handle most inquiries received from Kentucky providers. If, however, the provider's inquiry is more complex, a soft transfer to our Kentucky based PSRs is made for resolution. Our Kentucky staff are located in the communities where our providers practice and are best equipped to resolve the more complex questions.

Our primary call center staff are in Jacksonville, Florida, with calls received after 5 p.m. handled in Phoenix, Arizona. We have also trained staff in both Central and Pacific time zones on Kentucky-specific provider needs to make sure we have business continuity with reserve Provider Services call staff to handle volume during peak times. In addition to the call centers in Jacksonville and Phoenix, Aetna has

provider call centers located in Arlington, Texas, Houston, Texas, New Albany, Ohio, and Newark, Delaware.

b.iii. Monitoring Call Center Standards and Adjust Operations

Aetna's call center system tracks and reports call on all required call management metrics. We currently utilize Avaya Workforce Management and Real-Team Technology to monitor intraday performance reporting, including real-time performance based on the interval and day between 7 a.m. and 7 p.m. Eastern Time. Our workforce management team forecasts by the half hour and call center staff schedules are optimized for maximum efficiency. We also track performance and monitor calls using center toolkits that include daily performance reports, as well as weekly, monthly, and quarterly cumulative totals and results. Through these monitoring activities, we can adjust staffing and utilize national resources if needed during volume peaks to respond to changing demands in compliance with the required call metrics. Our provider IVR line received more than 60,000 calls in 2019. **Since January 2018, we have maintained a call abandon rate of 2 percent, a call block rate of less than 1 percent, and first-call resolution rate of over 95 percent.**

> Since January 2019, both our first-call resolution and Provider Services call center satisfaction rates have exceeded 95%.

c. Overview of Provider Website and Functionality

Aetna has an established provider services website[1]. The site includes pages specifically designated for providers, which offers each to use access to current program information, as well as provider-specific information. Information available on the provider services website includes contact information for our call centers and hotlines, including the Provider Services call center; searchable provider manual and provider directory; current and clearly defined prior authorization requirements; pharmacy preferred drug list and pharmacy conditions for coverage and utilization limits; information on enrollee rights and responsibilities; information about Kentucky Health Information Exchange (KHIE); provider updates such as 'What's New' updates; and links to other websites including Cabinet for Health and Family Services, the Department, and the credential verification organization(s) (CVO) once established.

Aetna's secure web-based provider portal offers access to the provider portal through secure single sign-on functionality that improves efficiencies for providers and offers complete accessibility to provider and enrollee data and reports. The portal contains information on the following:

> Nearly 23,000 user accounts have been added to our provider portal since 2016.

- Provider and enrollee records
- Claim or authorization status information
- Electronic explanations of benefits outlining claim services payment or denials, dates of service, procedure codes, amount billed and allowed, and amount paid
- The ability to submit prior authorizations, claims, and appeals and grievances

This web-based platform allows us to communicate enrollee health care information directly with providers in real time, including enrollee identification (ID) cards and panel roster, and to check the status of an enrollee's compliance with HEDIS measures. The system also offers a prior authorization lookup tool designed to perform ID-specific searches for authorizations by enrollee, provider, authorization data, or submission/service dates, and allows for review of prior authorization requirement by specific procedures or service groups and show details on codes and any noted prior authorization exception information. This functionality includes the ability to export Current Procedural Terminology/Healthcare

[1] Available at https://www.aetnabetterhealth.com/kentucky/providers/

Common Procedure Coding System code results and information to Excel. Providers can also obtain information on specific providers claims status and remittance advice by provider user account ID and submit appeals and grievances. Provider training materials and the provider manual are also located on the portal. Providers may also submit inquiries through the provider portal, which will be responded to within one business day.

We continually review and identify opportunities to improve the functionality and ease of use on our provider portal, and currently are in the process of reviewing and planning enhancements to our current portal functionality including integrating with the Availity web portal, a provider web portal that supports multiple MCOs' data. These future enhancements will offer providers a more robust set of provider self-service tools and information, including but not limited to the following: one-stop shopping for providers to access their data across multiple MCOs if they have an account with Availity; improvements to the submission of attachments to support administrative and clinical process, such as appeals; ease in contacting Aetna directly through the portal; and improved access to provider demographic updates.

During new provider orientation, we review the provider services webpage and functionality and assist providers in registering for the portal. Providers may also request ongoing or refresher guidance, as well as assistance with logging into the portal either by contacting their provider services representative or our Provider Services call center. Providers can also register for the portal through our website. Additional information regarding the portal is available through the navigation guide on our website. Please refer to **Attachment O,** which provides screens shots of our provider website and portal functionality.

We review and update the website as needed, but at least monthly, to make sure information available is accurate and up-to-date. Unless otherwise agreed to in writing, we will submit and obtain prior approval from the Department for all materials that will be posted to the website, as well as screen shots of any webpage changes. We will not modify the provider webpage without prior receipt of approval, unless the modifications are upgrades that support the ordinary operation, administration, and maintenance of the website or unless otherwise agreed upon by both parties.

d. Provider Manual Table of Contents and Description

Aetna has, and will maintain, a provider manual that includes applicable specialty manuals for all network providers. We include information on how to access the provider manual online in our welcome packet, to make sure providers have access within five days of inclusion in our network. We also make a hard copy of the provider manual available to providers, upon request. Aetna will continue to submit our provider manual, including any updates provided by a subcontractor for direct services and any updates to the Department for approval.

Our provider manual is designed to serve as a resource for providers to make sure providers have access to a broad range of information and guidance on Aetna's administrative processes. As further detailed in the table of contents, the type of information communicated via the provider manual includes, but is not limited to information on how to directly contact various Aetna departments, an overview of our model of care and a description of administrative process, provider responsibilities and requirements, and claims submission and payment. The proposed table of contents for our updated provider manual is as follows:

- **Section 1.0 Introduction**
  - Provider Welcome
  - Kentucky Medicaid Program
  - About Us
  - Our Values and Model of Care
  - Important Telephone Numbers
  - Claims Information

- **Section 2.0 Administrative:**
  - Medicaid Eligibility
  - Aetna Better Health Plan Assignment
  - Choosing a Primary Care Provider (PCP)
  - Enrollee Identification Cards
  - Overview of Programs for enrollees
  - Provider Specific Information
  - Credentialing/Re-Credentialing Process
  - Provider Terminations
  - Provider Grievances and Appeals
  - Enrollee's Rights and Responsibilities
  - Enrollee Grievances and Appeals
  - Title VI & VII Requirements
  - Americans with Disabilities Act
- **Section 3.0 Provider Roles and Responsibilities**
  - Confidentiality
  - Responsibilities of the Primary Care Provider (PCP)
  - Responsibilities of Specialists and Consulting Practitioners
  - Responsibilities of All Providers (including Fraud and Abuse)
- **Section 4.0 Office Standards**
  - Provider Access Guidelines
  - 24-hour Access to Care
  - Enrollee to Practitioner Ratio
  - Medical Record Documentation Standards
  - Kentucky Health Information Exchange—KHIE
- **Section 5.0 Utilization Management**
  - Utilization Management
  - Review Criteria
  - PA
  - Concurrent
  - Retrospective
  - Medically Necessary
  - Decision & Notification Standards
  - Peer-to-Peer Reviews
  - Authorizations
  - Inpatient Admissions & Observation
  - Specialty Referrals
  - Elective Admissions & Surgeries
  - Urgent Admissions
  - Experimental & Investigational
  - Outpatient & Hospital Services
  - Home Care Services
- **Section 6.0—Referrals**
  - Direct Access Services
- **Section 7.0—Benefits Summary and Exclusions**
  - Enrollee Copayments
  - Benefit Determinations
  - Transportation
  - Enrollee Incentives

- **Section 8.0—Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**
  - EPSDT Overview
  - Covered Services
  - EPSDT Tracking/Enrollee Outreach
  - EPSDT Reporting/Billing (Preventive Health Screens/Immunizations)
  - EPSDT Practitioner Eligibility
  - EPSDT Referrals
  - Components of a Full Medical Exam
- **Section 9.0—Quality Improvement**
  - Quality Improvement Program Description
  - Goals and Objectives
  - Scope of QI Program
  - Continuous Monitoring for Quality of Care Concerns
  - Practitioner Sanctioning Policy
  - Clinical Practice Guidelines
  - Provider Participation
  - Enrollee Safety
  - Trauma Informed Care
  - HEDIS
- **Section 10.0—Emergency Care/Urgent Care Services**
  - Emergency Services
  - Out-of-Service Area Care
  - Urgent Care Services
  - Lock-In Program
- **Section 11.0—Special Programs**
  - Integrated Care Management
  - Health and Disease Management Programs
- **Section 12.0—Outpatient Pharmacy Programs**
  - Prescribing Outpatient Medications for Aetna Enrollees
  - Covered Outpatient Pharmacy Benefits
  - Specialty Medications
  - Non-covered Drugs
  - Copays
- **Section 13.0—Obstetrical**
  - Overview
  - Cribs for Moms Program
  - Obstetrics Observation/Inpatient Admission Authorization
  - Newborns
- **Section 14.0—Family Planning**
  - Family Planning
  - Sterilization Procedures and Policy
  - Network
- **Section 15.0—Provider Billing Manual**
  - Claims Forms
  - Claim Payments and Processing Timeframes
  - Authorizations and Claim Submission
  - Proof of Timely Filing
  - Coordination of Benefits
  - Electronic Funds Transfer (EFT)
  - Remittance Advice

- Claim Specific Requirements
- Submission of Itemized Billing Statements
- Legal Owner of Tax Identification Number (TIN)
- Clinical Claims Editing
- Balance Billing/Hold Harmless
- Completion of Special Reports or Forms for Enrollees

- **Section 16.0—Dental Network**
  - Dental Services
  - Prior Authorization
- **Section 17.0—Vision Network**
  - Vision Services
  - Enrollee Eligibility Verification
  - Vision Services Program Fact Sheet
  - Conditions Covered Under Aetna Better Health Medical Benefit
  - Claim Submission for Vision

We recognize that there are unique challenges and requirements, as well as nuances in the administration of behavioral health services. To improve the convenience and accessibility of information for our behavioral health providers, we are developing a Behavioral Health Provider Manual, as depicted in **Figure C.17-5**. This separate manual has been designed to proactively eliminate ambiguity and confusion about behavioral health services by providing clear guidance on specific requirements including but not limited to covered services, substance use disorder services, prior authorization requirements, utilization management procedures, and continuum of services.

Figure C.17-5: Aetna Behavioral Health Provider Manual

Our Behavioral Health Provider Manual is being designed to clarify requirements and process related to behavioral health services and make information more easily accessible for our providers.

The proposed table of contents for our behavioral health provider manual is as follows:

- **Section 1.0—Introduction**
  - Our guiding principles
  - How to Reach Us
- **Section 2.0—Our programs**
  - Behavioral health condition managements programs
  - Our behavioral health member support program and who can benefit
  - Credentialing/re-credentialing
  - Open the door to electronic communications
  - Site visits and monitoring
  - Notification of status changes
  - Update your office's contact information online
  - Behavioral health care provided access to care standards
  - You'll need to register for our secure website

- **Section 3.0—Clinical delivery**
  - Access to care
  - Authorization/precertification process
  - How we determine coverage
  - Discharge review
  - Continuity/transition of care
  - Collaboration and coordination of care
- **Section 4.0—Quality programs**
  - Quality program overview
  - Quality, accreditation, review, and reporting activities
  - Accreditation
  - Enrollee rights and responsibilities
  - Participating behavioral health practitioner treatment record review criteria and best practices
  - Privacy practices
  - Medical record documentation: standards and criteria
  - Behavioral health screening programs
  - Helpful app screens for abuse
  - Trauma-informed care
  - Adverse incident reporting
  - Telemedicine services
  - Dispute and appeal process
  - Enrollee experience survey
  - Practitioner survey
- **Section 5.0—Working electronically with us**
  - Electronic solutions for health care professionals
  - Register for our secure provider website
- **Appendix A:** Level of care assessment tool
- **Appendix B:** Aetna behavioral health treatment record review criteria and best practices

e. Approach to Provider Orientation and Education

Our approach to provider orientation and education is to give our providers the information they need in the most convenient method available. The goal of our orientation and education program is to support high quality of care and compliance with the contract and applicable requirements, while minimizing the impact to our providers' already demanding schedules. We listen to our providers and continually work to develop new training topics and mechanisms for delivery. We will submit an updated version of our provider orientation and education plan for Department approval within 60 days of the contract execution, and as required thereafter. As required, we maintain and make available upon request attendance rosters that include evidence of training of each provider and their staff.

Provider Orientation: Our provider orientation process begins with our PSRs sending the welcome packet and directly reaching out to begin establishing a relationship with the provider. As described in the provider engagement section, our welcome packet is sent within five days, and includes a welcome letter, an orientation schedule, instructions for accessing our provider manual and portal, the identification of and contact information for the assigned PSR, a copy of the provider contract, and Aetna Better Health of Kentucky At a Glance. The assigned PSR directly contacts the new provider, gives them a personalized greeting card to introduce themselves, responds to any questions, and walks through the welcome packet and orientation materials, including offering assistance with accessing the provider portal. The orientation is provided either at the provider's office or through webinar, within 30 days of a provider joining the network.

Orientations are tailored to the provider's preferences and include all required content, as described in **Attachment C, Section 27.5**, including education initiatives for the Kentucky Medicaid pharmacy provider community. Training materials are online, available upon request, and can be downloaded from either our secure web portal or main website. Materials will also be sent to the Department on request. Our orientation sessions include but are not limited to the following:

- Medicaid coverage requirements, including prior authorization requirements, EPSDT prevention health screening services, and EPSDT special services
- Aetna policies and procedures and administrative clinical practices
- Commonwealth and federal Medicaid policies, procedures, and mandates
- Fraud, waste, and abuse education and reporting
- Medicaid populations and eligibility
- Prevention health service standards
- Telehealth services
- Special needs of enrollees in general that affect access to and delivery of services, including enrollees of the Kentucky SKY program
- Advanced medical directives
- Claims submission and payment
- Special health/care management programs in which enrollees may enroll
- Provider role in Population Health Management program
- Cultural sensitivity
- Responding to needs of enrollees with substance use or behavioral health, developmental, intellectual, and physical disabilities
- Integrated health care, including social determinants of health and population health management initiatives
- Reporting of communicable disease
- Aetna's quality program and the provider's role in impacting quality and heath care outcomes
- Medical records review
- Value-based payment
- How to access information through our website/provider portal
- Other region-specific issues or concerns to help providers meet enrollee needs such as multilingual translation and telecommunications device for the deaf and hard of hearing (TTY/TDD) availability.

Ongoing provider training: Our ongoing provider training is designed to be responsive to provider educational needs, in a manner that is convenient and easily accessible to all providers, including those located in remote or rural areas. For example, our providers let us know they preferred webinar-based trainings, as they were the most convenient and easiest to attend due to their busy schedules. As a result, starting in January 2018, we have used webinars as a primary medium for provider trainings. An example of a webinar is illustrated in **Figure C.17-6.** We continue to also offer training through a variety of other settings, including face-to-face visits and provider forums, to make sure we address the preferences of all our providers. Our locally based PSRs are available to meet with providers and their staff to assist with training and education needs at times that are convenient to the

Figure C.17.6: Sample Webinar Screen Shot
Aetna offers providers webinar-based training to make trainings more convenient for busy providers and improve accessibility and ease for rural providers.

providers.

Aetna has, and will continue to maintain, a provider training program based on what our providers tell us they need. Our program goes beyond the minimum requirements to address these provider needs and support Commonwealth initiatives and system changes. As an example, we have provided and continue to offer trainings on a variety of topics, such as the medically frail, Kentucky substance use disorder, and the Aetna provider portal.

Examples of trainings that may be offered include the following:

- HEDIS training and toolkit resources
- HEDIS training for behavioral health providers
- Risk scores
- Well visits
- Trauma-informed care and toolkit resources
- Family planning
- KHIE
- Behavioral health enrollee accommodation awareness

Since January 2018, Aetna has offered Kentucky providers 69 training opportunities via targeted onsite trainings, webinars, and provider forums.

We are continually working to identify opportunities to expand our training in ways that go beyond simply offering education to provide trainings that will impact provider operations and quality of services. One initiative that we are currently exploring are assessing the ability to offer trainings with Continuing Medical Education and Continuing Education Units for our licensed providers.

Policy and program changes are communicated to providers in a timely manner (e.g., periodic newsletters) along with additional trainings offered around policy changes. Supplemental trainings will also be offered as determined by provider needs, or as requested by the Department. Additional training will be provided if providers request it or if they are identified as needing more direction and guidance through enrollee, provider, or quality improvement committees, or have issues with administrative or clinical documentation. Technical assistance will also be provided via the phone, face-to-face, webinar, forums, and all available channels. Following training, PSRs follow up with providers to address any questions they may have and to make sure they know how to reach us for assistance. Additionally, we have implemented a Tip Tuesdays campaign, which is a brief email blast that includes provider tips, reminders, and other educational materials on a weekly basis.

Aetna supports and will participate in the Medicaid Provider Education Forums designated by the Department and will remit $20,000 at the start of each fiscal year of the contract to support this outreach effort.

f. Supporting Providers in Medicaid Enrollment and Credentialing

Aetna continually looks for opportunities to reduce provider administrative burden related to enrollment in the Kentucky Medicaid program and completion of credentialing activities, while controls to make sure the providers in our network offer high-quality services to our enrollees. To improve the provider experience, we worked in collaboration with KHA to develop a solution to streamline the provider credentialing process. As a result of this collaboration, Aetna has contracted with KHA to perform credentialing activities, which will allow us to improve the credentialing process for providers and leverage additional high-quality providers to participate in the Commonwealth Medicaid program.

f.i. Methods for Assisting Providers with the Medicaid Enrollment Process

To assist providers and support network development, Aetna has established a process to guide and support providers through the Medicaid enrollment process. Through this process, providers can send Aetna their Medicaid enrollment application in a variety of ways, including email or mailing a hard copy.

Once we receive the application, we review to verify that all required fields have completed and that the information is legible. If we identify any deficiencies, we reach out to the provider to obtain the information or corrections needed to complete the application.

Once we have deemed the application to be complete, we submitted it to the Department via the Kentucky Online Gateway by enter the information into the Medicaid Assistance Program (MAP) MAP-811 application form. We notify the provider via email that we have submitted the application to the Department, and the provider receives a welcome letter from the Department once the application is accepted.

f.ii. Process for Conducting Credentialing Prior to the CVO

Our approach to assisting providers is to be there to help at every step in the process and to stay in constant communication so providers know the status of their application and if additional information is needed. As a National Committee for Quality Assurance (NCQA)-accredited health plan, Aetna has written credentialing and re-credentialing policies and procedures that comply with NCQA requirements, KRS 205.560(12), 907 KAR 1, and other applicable federal and Commonwealth requirements. We assure the Commonwealth we will continue to meet all requirements outlined in **Attachment C Section 27 of the Draft Medicaid Managed Care Contract and Appendices** until such activities are transitioned to the Department's contracted CVO. We utilize a single credentialing and re-credentialing process for providers who participate in multiple Aetna networks and do not require providers to complete more than one credentialing or re-credentialing process.

> "Thank you so much with all your help regarding our credentialing issues. We really appreciate you!"
> **—Kentucky Counseling Center**

Aetna maintains credentialing and re-credentialing policies and processes that comply with all the detailed credentialing and re-credentialing process contained in **Appendix J of the Draft Medicaid Managed Care Contract and Appendices**. As a component of our credentialing and re-credentialing process, we have an established Physician Advisory Committee (PAC), which is utilized for review of credentialing status of our plan's providers. The PAC, chaired by Aetna's chief medical officer, includes medical providers who are members of the Aetna's peer review medical board. The committee is a subcommittee of our Aetna National Quality Management and Measurement department. The committee continues to provide an advisory review and approval of each list of Aetna credentialing approved providers and this is accomplished during the monthly Quality Management/Utilization Management (QM/UM) meetings. The Aetna National Quality Management and Measurement department continues responsibility for the following Credentialing functions:

- Committee minutes, policies, and procedures
- Confidentiality and disclosure of credentialing
- Re-credentialing peer review information
- Assessment and credentialing of organizational providers
- Credentialing allied health practitioners
- Practitioner credentialing and re-credentialing
- Credentialing office assessments
- Practitioner applications
- Reporting sanctions
- Practitioner participation and peer review
- Medical director credentialing
- Peer review credentialing and re-credentialing
- Coordination with Medicaid state plans for local approval (PAC)

Aetna does not require providers to complete more than one credentialing or re-credentialing application. We complete credentialing and re-credentialing of providers within 90 days of receipt of all relative information from the provider. If a provider is providing behavioral health services, we complete credentialing within 45 days. All pending requests for credentialing or re-credentialing are submitted as required in **Appendix J of the Draft Medicaid Managed Care Contract and Appendices.** Aetna has a Physician Advisory Subcommittee which meets monthly to review after the Aetna National Quality Management and Measurement department's credentialing process and provide approval of all of Aetna's credentialed providers. We routinely monitor provider performance and compliance, including monthly provider sanction screening and complaints and quality issues, and take appropriate action.

Credentialing Requirements and Procedures

Aetna conducts credentialing or re-credentialing for all providers prior to allowing them to be listed in the provider directory and serve enrollees.

Individual providers: Individual providers who are members of a contracting group, such as an independent association or medical group, are credentialed individually. They must complete the credentialing application, which includes a work history covering at least five years. When Aetna, conducts primary source verification, we gather proof of licensure, education, and training, evidence of graduation and specialty training, and valid Drug Enforcement Administration (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate. The provider's office is contacted, if applicable, to complete the application and acquire additional needed documentation. Prior to admitting a provider into our network and every three years thereafter, selected criteria are verified (state license, medical schools, training, and board certification) with primary sources.

The following are minimum data elements required for applications for primary care providers and specialists:

- Professional license number
- Hospital where applicant has privileges and the type of privileges (initial application only)
- DEA and Commonwealth-controlled drug substance DPS number, when applicable
- Professional education and training (initial application only)
- Board certification and work history
- Malpractice insurance coverage: name of current carrier, policy number and expiration date, and amount of coverage per occurrence and aggregate amount
- Statements from the applicant regarding the following:
  - Reasons for inability to perform the essential functions of the network position for which the practitioner is applying
  - Lack of present illegal drug use
  - History of loss of license and felony convictions
  - History of loss or limitation of privileges or disciplinary activity
  - Attestation by the applicant of the correctness and completeness of the application

Our written policies and procedures prohibit discrimination against any provider or group of providers for participation, reimbursement, or indemnification when they are acting within the scope of their license or certification under applicable Kentucky laws or statutes, solely based on that license or certification. Furthermore, if Aetna declines to include an individual or group of providers in our network, we provide written notice with the reasons for declining.

Facility providers: Aetna follows current NCQA guidelines in credentialing acute care facility providers including behavioral health treatment programs. As a prerequisite for participation or continued participation, organizational providers must be in good standing with Commonwealth and federal regulatory bodies. They must have been reviewed and approved by an Aetna-approved accrediting body,

including but not limited to the Joint Commission and Community Health Accreditation Program, and participate in an onsite assessment if not accredited and a Centers for Medicare and Medicaid Services (CMS) or Commonwealth survey is not obtainable.

Minimum credentialing criteria includes verification of the following:

- Current unrestricted license or certificate of occupancy depending on Commonwealth requirements
- Current accreditation or certification in all locations where services are provided by at least one of Aetna's recognized accrediting agencies or CMS or Commonwealth survey
- Good standing with Medicaid or Medicare and not on the Officer of Inspector General sanctions or Office of Staff Management sanctions
- Professional liability insurance
- Advance directive policy for hospitals and long-term care acute care hospitals
- Internal Revenue Service Form W-9 required during initial credentialing

Re-credentialing Process

Individual and facility acute care providers are re-credentialed using Aetna's standard re-credentialing process every three years. We confirm that these providers are in good standing with applicable accreditation and regulatory agencies; have a signed contract or participation agreement; meet our standards and requirements; and are qualified to provide services to our enrollees. We make sure providers are appropriately licensed by the Commonwealth and have a National Provider Identification Number and appropriate ongoing certification and training, as required, and agreed to in their contract. We make certain all network providers are screened against Commonwealth and federal exclusion registries, and we comply with all contract requirements. In addition to the information obtained during initial credentialing, the re-credentialing process also includes review of the following provided in **Table C.17-1.**

Table C.17-1: Information Reviewed for Re-credentialing Acute Care Providers

Information	Method for Capturing this Information	How the Information is Assessed
Enrollee complaints and appeals	Enrollee complaint and appeals data is collected by our Enrollee Services department.	Enrollee complaints are reviewed, and if any are related to quality and safety, they are investigated. Complaint monitoring reports are used to identify practitioner quality issues between re-credentialing cycles.
Utilization management information	Utilization management data is collected by our Medical Management department.	This data is reviewed and evaluated as part of the re-credentialing process.
Results from quality review and provider quality profiling	Quality information is collected through our quality management structure. This information is obtained through routine data submission requirements and record reviews.	This data is reviewed and evaluated as part of the re-credentialing process.
Information from Commonwealth licensing boards and accreditation agencies	Licensing and accreditation information is collected through review of Commonwealth licensing boards and accrediting agencies.	This information is evaluated through the ongoing monitoring process conducted by the CVO.

f.iii. Proposed CVO Transition and Coordination Process

Aetna will work with the Department to make the transition to the CVO as smooth as possible. We will make sure to have a clear understanding of the timing and steps needed for an implementation and will take steps to reduce provider administrative burden when possible. Recently, Aetna has contracted with KHA for delegated credentialing services. During this process with KHA, we have held regular meetings to discuss the process which will be in place, including smooth transitions from one group to the other

and closed with next steps and expectations for follow-up. In between meetings, Aetna and KHA have kept in regular communication to complete those next steps and make sure all activities are on track for implementation. This collaborative agreement has allowed for a necessary process to have reduced turnaround time for the providers. As providers approach the need for re-credentialing, Aetna will be referring them to KHA to have the process initiated as well as any new providers who have not been credentialed yet.

Our draft process for coordinating with the CVO addresses all requirements contained in **Attachment C Section 27.8 of the Draft Medicaid Managed Care Contract and Appendices.** Activities that are solely Aetna's responsibilities include the following:

- Referring providers to the CVO to complete credentialing prior to contracting
- Providing current providers with information on the CVO re-credentialing process, including CVO contact information
- Providing a mechanism to monitor and verify that we will determine whether we will contract with a provider within 30 days of receipt of the CVO's verified credentialing packet
- Providing a mechanism to monitor timeline updating of internal processing systems to make sure all applicable systems are updated within 10 days of the of contract execution. If additional time is needed, will we notify the provider of the additional time and complete updates within an additional 15 days.
- Processing provider claims based on the date of the provider's credentialing application. Providers will not be required to appeal or resubmit clean claims submitted during the period between provider's credentialing application date and completion of our credentialing process.

Please refer to **Figure C.17-7** for our proposed CVO credentialing and re-credentialing process flow.

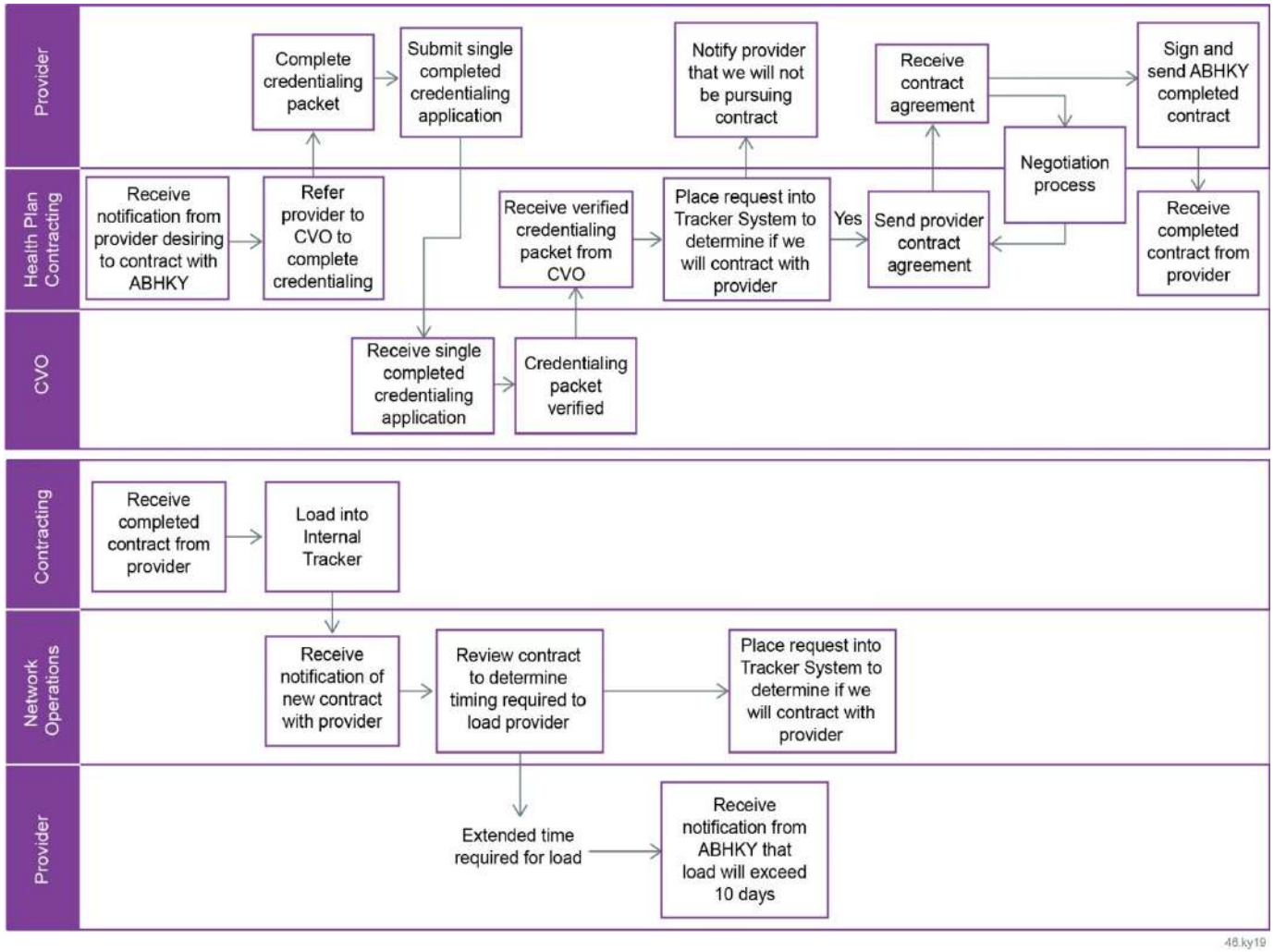

Figure C.17-7: Proposed CVO Credentialing and Re-credentialing Process Flow

Aetna's proposed approach to a coordinated credentialing and re-credentialing process with the CVO.

Aetna understands and agrees to accept provider credentialing and verified information from the Department or its CVO and will not ask providers to submit additional credentialing information, unless we have obtained prior written approval to do so from the Department. Additionally, we understand and acknowledge that we are neither prohibited from collecting additional information to inform our contracting process, nor are we required to contact with providers, if we do not agree on the terms and conditions for participation.

KHA collaboration: As a part of our new collaborative approach with the KHA, we have implemented the use of a standard provider change request (PCR) form. This will reduce provider administrative burden, because they will be able to send a single report of changes to KHA in the format that is the most convenient to the provider. KHA will then convert the information to the standard PCR format. The PCR will be electronically uploaded to a portal via the Aetna Provider Deliverable Manager. This standard PCR form and electronic upload process will reduce the turnaround time of the provider system load process to make sure changes are made in compliance with the Department requirements. This process will also help to make sure KHA and Aetna are developing standards for making sure the data uploads are completed on a regular and timely basis to support daily functions including updating of provider look up information for enrollee, claims payment.

In addition to improving internal functions, this implementation will improve enrollee and provider experiences by providing near real-time publication of provider data updates, making this information available to enrollees using our online provider database and to primary care providers when making referrals.

We continue to collaborate with KHA to discuss opportunities and solutions that will support required processes of both the CVO and Aetna, including but not limited to secure electronic exchanges to support the exchange of credential and re-credentialing packets between the CVO and MCOs, identifying circumstances and a process for re-evaluating provider documentation to maintain participation status, and coordinating monthly implementation meetings and quarterly ongoing meetings with the Department and CVO regarding the credentialing process. Aetna will participate in additional or more frequent meetings, as requested by the Department.

Proactive Approach

Through our KIT tool, we identified a trend of provider concerns related to roster updates. We were able to react, reconfigure, and rework our process to improve roster update times, resulting in a decrease in pending updates from nearly 1,800 in January 2018 to under 400 in August 2018. This level of improvement was maintained throughout 2019.

f.iv. Timely Contracting Review of CVO Credentialing

We will comply with the timelines in the **Draft Medicaid Managed Care Contract and Appendices.** Upon receipt of the information from the CVO that a provider's credentialing is complete, the packet is added to Aetna's KIT tool, which notifies the director of contracting that there is a new item for review. A decision regarding whether we will contract with the provider will be made within 30 days of receipt of the verified credentialing packet from the CVO. Once a determination has been made, the provider will be notified of the results and we will initiate the negotiation process.

As **Figure C.17-8** illustrates, we update our internal processing systems to include the accepted provider as a participating provider within 10 days of executing a contract with a provider. If additional time is needed to update our systems, we notify the provider of the need for additional time and complete the updates within an additional 15 days. Aetna will work with our subcontractors to make sure they also comply with the processes and required timelines.

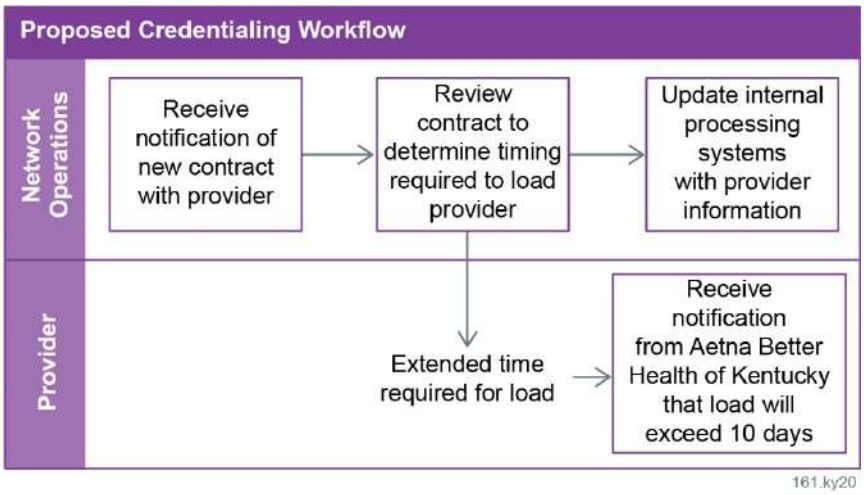

Figure C-17.8: Provider Credentialing Workflow

Aetna's provider credentialing process assures timely contracting for our providers.

g. Appeals and Grievances

Aetna complies with all the requirements and principles of the appeals and grievance system set forth in **Appendix C Section 27 of the Draft Medicaid Managed Care Contract and Appendices**, including compliance with all Commonwealth and federal laws and regulations referenced therein. Aetna's existing appeal and grievance infrastructure, standardized processes, and staff training optimizes compliance, fairness, and promotes the delivery of effective care. Aetna does not delegate any aspect of appeal and grievance processing.

Aetna[2] employs a comprehensive appeal and grievance system based on our experience as one of the original Kentucky Medicaid managed care organizations. We also leverage our Medicaid experience and best practices learned in 16 states to meet the requirements in Kentucky and bring specific capabilities to the appeal and grievance processes that enables us to exceed expectations. Our provider appeal and grievance processes and staff accomplish the following goals:

- Promote provider education regarding appeals and grievances
- Provide comprehensive staff training to assist providers and to facilitate smooth operation of the appeal and grievance processes to achieve prompt resolution
- Verify that provider appeals and grievances are acknowledged and addressed in a manner that supports an equitable outcome
- Facilitate compliance with contractual requirements and NCQA standards, including applicable federal and Commonwealth laws and rules
- Provide accurate maintenance of required documentation to enable Aetna and the Department to track and review the progress and outcomes of all appeals and grievances throughout the process
- Comply with Commonwealth and federal compliance reporting requirements
- Provide advanced information technology applications that include tracking, document retention, performance evaluation, and sophisticated data analytics to link appeals and grievances to reporting capability for the Department, root-cause identification, and operational, clinical quality, and service coordination improvement opportunities

[2] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

- Maintain accountability through the chain of command to validate prompt and thorough responses to lessons learned from data analytics on root causes and quality improvement opportunities to achieve better outcomes in a cost-effective manner, to decrease provider administrative burdens, and to increase provider satisfaction.

g.i. Overall Process for Resolving Appeals and Grievances

Aetna goes beyond basic requirements to validate that our appeals and grievance system fosters high-quality performance throughout our operations and promotes enrollee engagement. The specific elements of our approach discussed throughout this section describe Aetna's core processes to safeguard enrollee rights and the content of these overarching enhanced capabilities, demonstrating that Aetna not only fully meets the requirements of **Appendix C Section 27 of the Draft Medicaid Managed Care Contract and Appendices**, but will exceed the Commonwealth's expectations.

Provider Education

Our provider communication materials inform providers through the provider manual and other methods, including newsletters, training, provider orientation, and the website. We also train provider service representatives about the provider appeal and grievance system process, so they can effectively educate and assist providers. Aetna also makes sure that no punitive action is taken against providers filing an appeal or grievance.

All cases are documented in our appeal and grievance application inclusive of those received through the Department. Each case is automatically assigned a tracking number/unique identifier that links together all components of the case. This tracking number is used to identify individual cases for processing and to monitor each case throughout the process. All information pertaining to appeals and grievances is maintained in accordance with the applicable record retention policies, including **Section II Obligations and Activities of the Business Associate 2.13,** and Health Insurance Portability and Accountability Act standards to protect enrollee privacy.

Staff Training and Involvement

We maintain and disseminate internal policy and procedure documents, as well as provide role-specific training for Appeal and Grievance, Provider Services, and Clinical Review staff members to make sure they are fully educated on the appeal and grievance processes. We thoroughly train all our staff to identify potential appeals and grievances. Our goal is to make the process of filing an appeal or grievance as uncomplicated as possible by removing any undue administrative challenges.

The Appeal and Grievance department is responsible for the management of provider appeal and grievance system. The appeal and grievance manager monitors processing of all cases and conducts daily real-time quality reviews to support timely and accurate processing according to **Attachment C Section 27 of the Draft Medicaid Managed Care Contract and Appendices**. The appeal and grievance coordinators are responsible for processing all provider appeals and grievances. This includes documenting the substance of each case including all information submitted as part of the initial review, any new information submitted with the request and the relevant clinical care guidelines as applicable, the resolution of individual cases, coordinating resolutions, and tracking data and reviewing for trends in quality of care or other service-related issues. The Appeal and Grievance department reports to the chief operating officer.

All data collected is reported to the Appeal and Grievance Committees, SIC, and Quality Management Oversight Committee (QMOC) at least quarterly (more frequently if appropriate), summarizing the frequency and resolution of all appeals.

Provider Education

One of our physical therapists filed an appeal regarding a denial for services provided after the authorization visit limit. We contacted the provider and identified that he did not fully understand the authorization process. We explained the process for requesting authorization for additional services. Although the denial was upheld, the provider felt he had more options for providing needed care and would be able to obtain necessary prior authorizations in the future.

Provider Appeal and Grievance Processes

Aetna has developed and maintains a comprehensive system for responding to provider appeals and grievances, which are distinct from the enrollee appeal and grievance processes as illustrated in **Figure C.17-9** and **Figure C.17-10.** Aetna classifies an expression of dissatisfaction as a grievance and issues related to claim payments or denials as an appeal. Both contracted and non-contracted health care providers may file appeals related to claim payments or denials or grievances related to dissatisfaction with any Aetna policies, procedures, staff, vendors, or enrollees. A dispute between a provider and Aetna does not disrupt or interfere with the provisions of services to the enrollee. We administer an equitable, timely, and balanced review of provider disputes. Aetna will continue to submit any changes to its provider appeal and grievance policies and procedures to the Department for approval prior to implementing such changes.

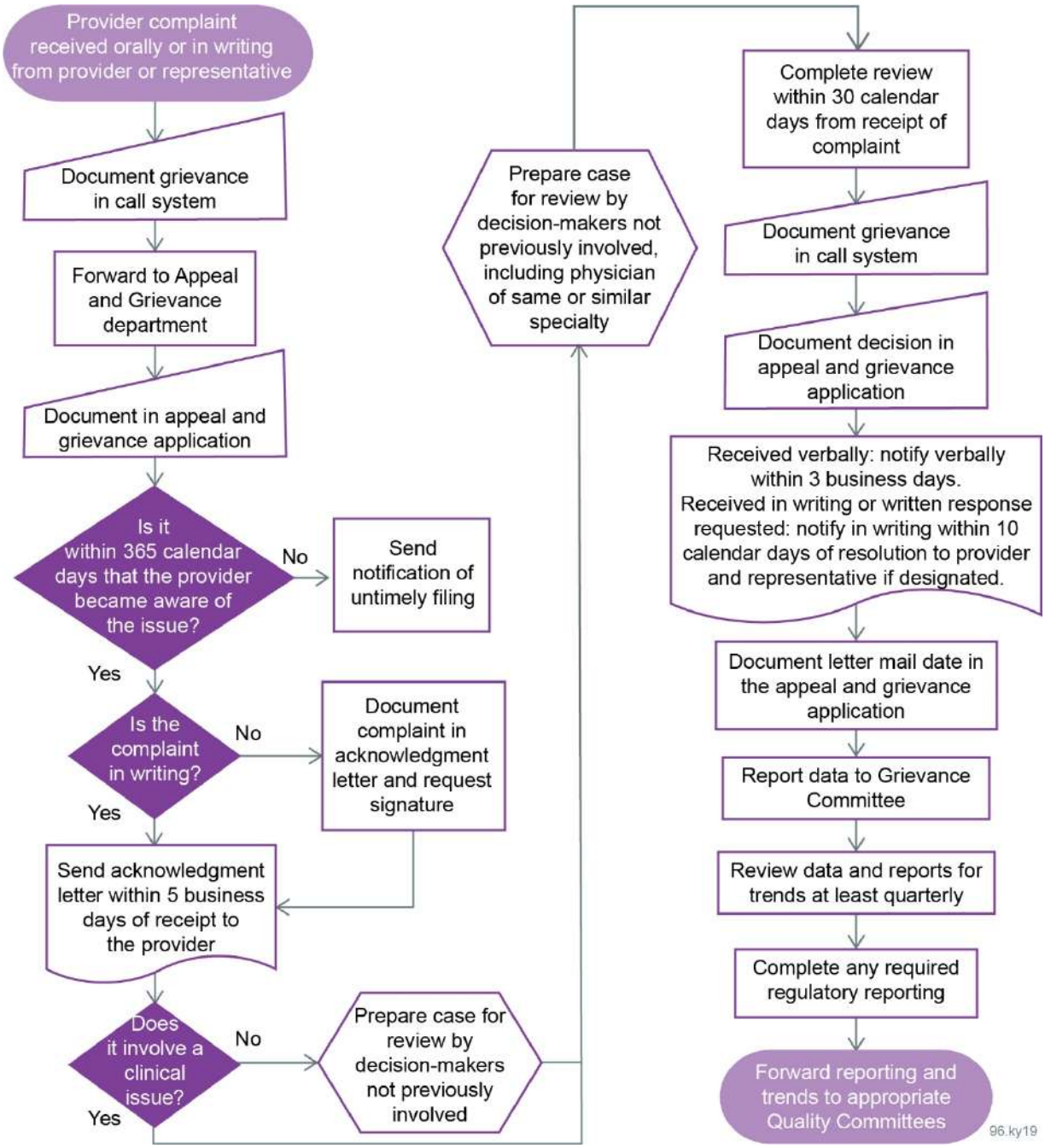

Figure C.17-9: Provider Grievance Process

Aetna's grievance process offers providers easy access to file grievances as issues arise.

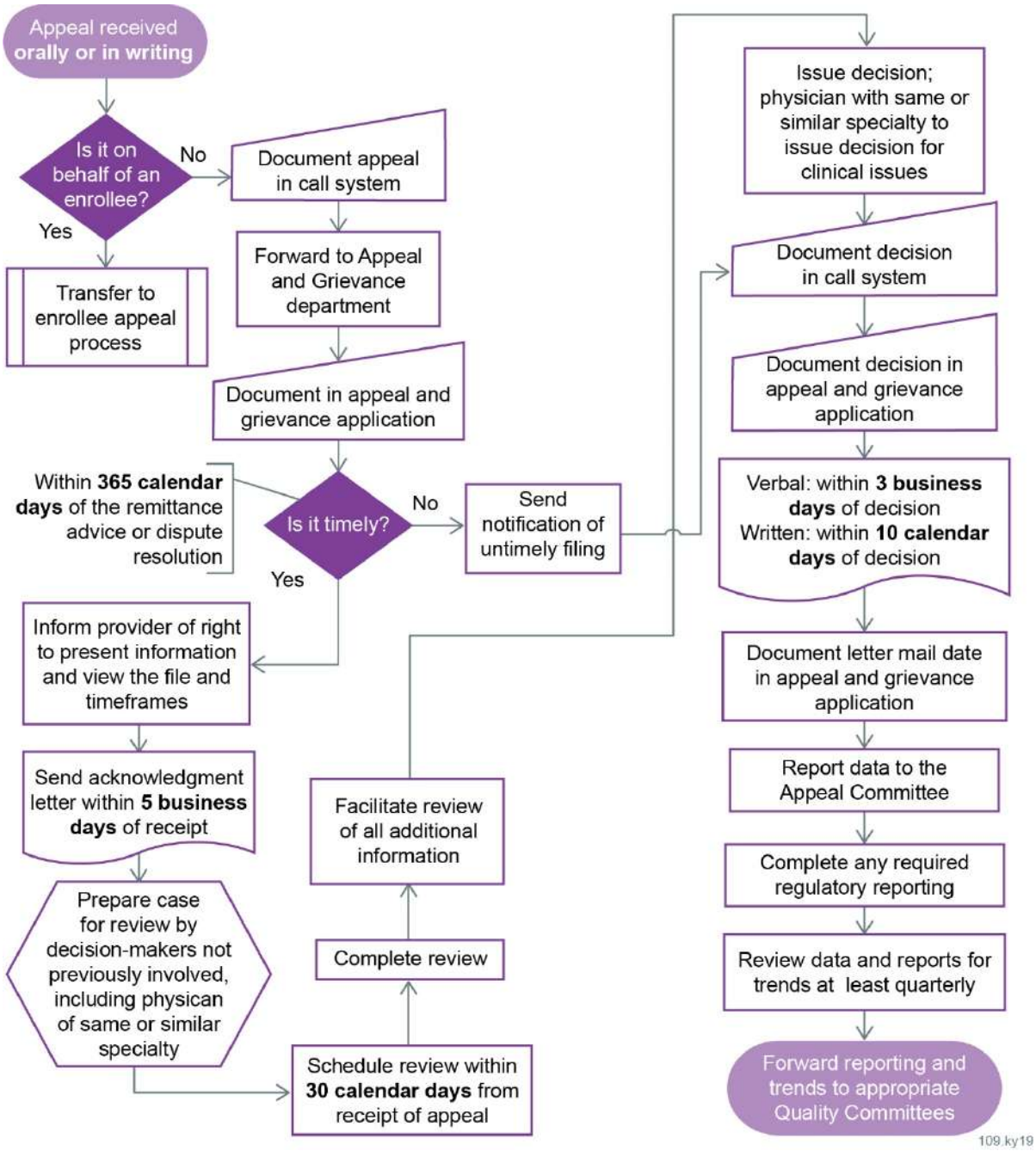

Figure C.17-10: Provider Appeal Process

Aetna's appeal process offers providers easy access to request appeals as issues arise.

Filing a grievance: Providers may file a grievance verbally or in writing at any time directly with us in regard to our policies, procedures, or any aspect of our administrative functions. Verbal grievances may be required to be submitted in writing. Aetna utilizes the standard Department Provider Grievance Form to document provider complaints and disputes that do not request remedial action. Upon receipt of a provider grievance, our team logs the concern and assigns it for review. An appeal and grievance coordinator reviews all the facts to determine how the case should be processed.

Prepayment review: For claims received that are missing required information to process the claim, we will request the missing information from the provider. Providers will have 45 days to submit any missing documents. If the documents supporting the service or code are not received by Day 46, the claim will be denied. Following denial, providers will have the right to appeal following Provision 27.10.

Providers can also call our Claims Inquiry Claims Research team regarding claim-related disputes or send them in writing to our Claims department along with supporting documentation. Providers may also use Aetna's optional Claim Reconsideration Form, which is on our website. The Claims Inquiry Claims Research team responds to these concerns by phone or via the remittance advice if the claim is eligible for reprocessing.

Filing an appeal: Providers have 365 calendar days to file an appeal. If a provider submits a request after that time, we will review for extenuating circumstances and will in good faith process the appeal. If there is no documentation to support the reason for the late filing, we may deny the appeal based on untimely filing.

Upon receipt of a written provider appeal, our team logs the concern and assigns it for review. An appeal and grievance coordinator reviews all the facts to determine how the case should be processed. Providers may appeal a decision to deny a health care service, claim for reimbursement, provider payment or contractual issue. If a provider submits an appeal for a denied service on behalf of an enrollee, the case is processed in accordance with the applicable enrollee appeal and grievance process. When a provider requests the review of an action where we denied, reduced, suspended, or terminated an item or service (typically through a notice of action), the review is conducted in accordance with our provider appeal process.

Acknowledgment: An appeal and grievance coordinator documents the receipt date of the verbal grievance to establish the earliest possible filing date in the appeal and grievance application. All appeals and grievances are acknowledged in writing within five business days of receipt. The appeal and grievance application uses the date of receipt to automatically calculate the due dates for proper handling and completion of the case. All communications related to the case, including the acknowledgement and resolutions letters, are directed to the designee who filed the case.

Resolution of appeals and grievances: Aetna makes all effort to resolve provider appeals and grievances within 30 calendar days of receipt. If Aetna determines additional time is needed to make sure the issue is fully addressed, we will request a 14-calendar day extension from the provider. Providers may also request, and Aetna will approve, a 14-calendar day extension.

Timely Processing

Since 2017, Aetna has maintained 99% or higher compliance with resolution of standard cases within 30 days and expedited cases within 72 hours.

All information submitted with an appeal or grievance is thoroughly researched including investigation into the matter, a review of any prior documentation, medical review criteria, and communication with the provider and vendor or staff member involved as appropriate. Appeals and grievance coordinators will also review complaints with internal staff with applicable expertise, when appropriate.

If the case was submitted with additional clinical information, it is presented to a clinical decision-maker for review to determine whether they can overturn the original decision in an effort to resolve provider issues as quickly as possible. If the original decision cannot be overturned or no new clinical information was submitted, the case will be presented to the Appeal Committee for review by at least three qualified individuals who were not involved in the original decision. None of the reviewers will have been involved in the initial determination nor are they subordinate to any person involved in the initial decision individually or as part of an Appeal Committee for review.

Notification: For verbal requests, we provide notification within three business days of decision; for written requests or where the provider requested written response, we provide a written request within 10 calendar days from the date of the decision unless an extension is obtained.

Providers receive an appeal decision letter or grievance resolution letter that explains the resolution/decision and the reason for the resolution/decision. The written notice includes the following, as applicable:

- Results of the process and the date it was completed
- A summary of or relevant grievance investigation findings
- Reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based
- Right to request external review of appeals where the denial is being upheld through the Cabinet for Health and Family Services Division of Administrative Hearings

Filing a request for external review: Providers must request an external review in writing within 60 calendar days from the appeal decision letter. When a provider requests the review of an appeal decision where we denied, reduced, suspended, or terminated an item or service, the review is conducted in accordance with the Department provider external review process. Upon receipt of notification of a written provider external review, our team logs the request and tracks it through resolution, reprocessing if overturned and reporting. If the external independent third-party decision upholds the denial, in whole or in part, the provider has the right to request an appeal to the Cabinet for Health and Family Services Division of Administrative Hearings. If the provider prevails, in whole or in part, we comply with any final written order within the time frame designated in the order, or if no time is stated within 60 calendar days.

g.ii. Process for Tracking and Trending Appeals and Grievances

Aetna maintains records of all appeals and grievances within our internal proprietary application. Our reporting suite enables us to monitor aging of cases in real time to make certain of timely resolution and to identify and report trends for potential opportunities for improvement. This process is illustrated in **Figure C.17-11.**

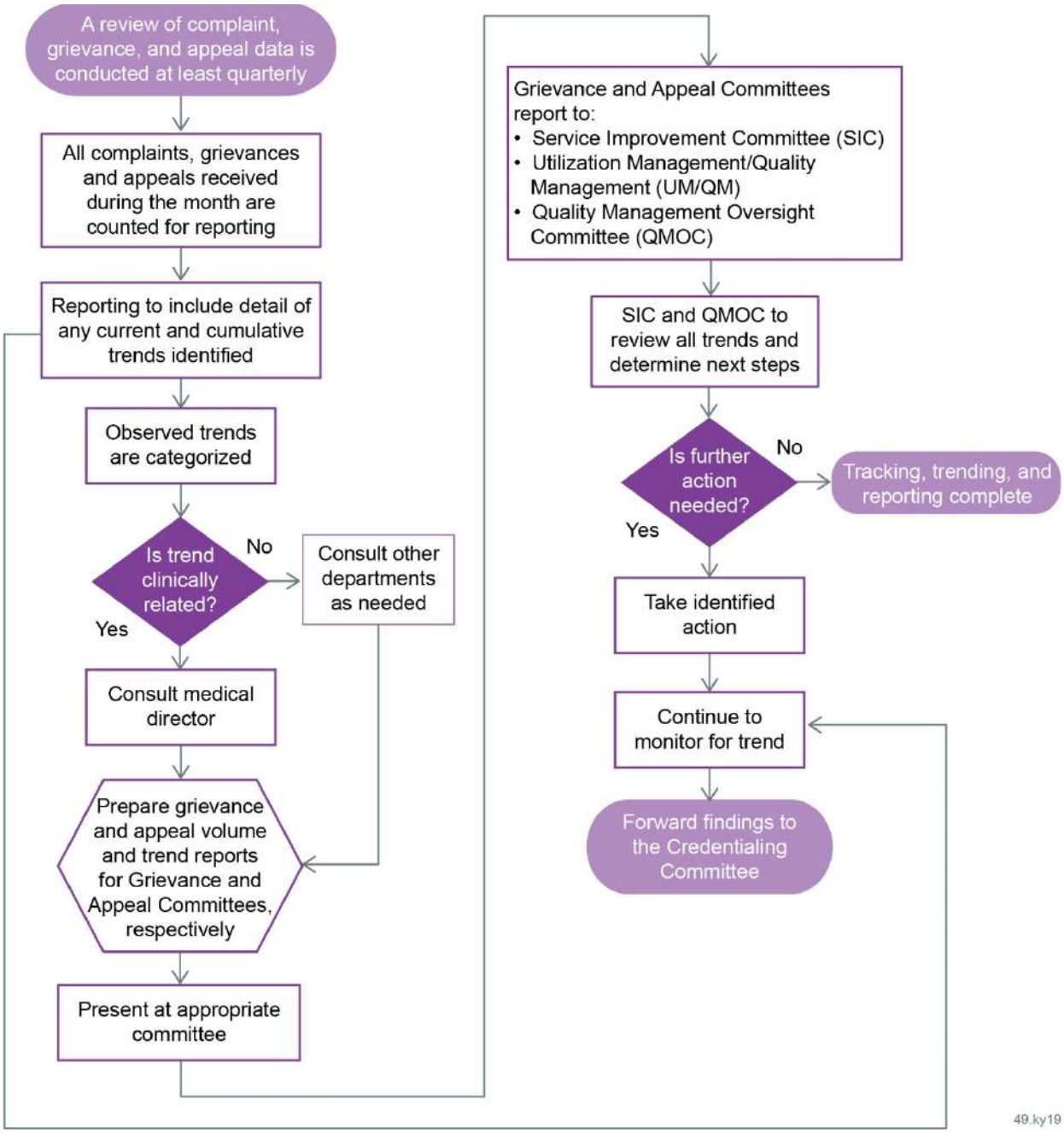

Figure C.17-11: Tracking, Trending, Reporting Process

Aetna's tracking trending and reporting process is key to identifying improvements.

Documentation and Records Maintenance

Aetna maintains records of all appeals and grievances including the provider name and identification number, as well as the following information:

- Name and contact information of the individual filing the grievance
- Date filed
- Type of issue
- Short dated summary of each issue
- Identification of the individual recording the case

- Date of decision
- Disposition of the appeal or grievance
- Criteria, policies, or other criteria used in rendering the decision
- Description of any corrective action required and the date resolved
- Date of communication of the resolution/decision

This documentation allows us to maintain and track all cases from origination through resolution and decision.

Analysis

The application contains a standard suite of reports and queries by case type of appeal or grievance that are utilized to track cases throughout the process. For example, the aging report displays all cases in real time and gives their age from received date and time to date and time of report run in calendar days. The application is inclusive, housing all correspondence, letters created, and staff actions taken on the case. All follow-up actions such as provider phone calls and the overall age of the case are color-coded in each staff person's work queue. Cases that are past due display in red, those due in 48 hours display in blue, and those due in greater than 48 hours display in black. This visual display along with traditional reports allows easy identification of cases and work to be completed. The appeal and grievance manager utilizes standard queries and reports within the application to monitor cases throughout the process, to monitor timeliness and accuracy, and to identify and report upon trends for potential opportunities for improvement.

Aetna has programmed its appeal and grievance application to calculate the due date automatically for completion of the case, and this due date is used to calculate automatically the actual turnaround time on the case. Upon resolution, the application automatically marks the case as timely or untimely. Aetna uses multiple standard reports to monitor aging of cases in real time to make certain of timely resolution. These reports are monitored daily; if we see any evidence of an issue requiring escalation, we act on it immediately.

Quality Improvement

The appeal and grievance manager utilizes standard queries and reports within the application to monitor cases throughout the process, to monitor timeliness and accuracy, and to identify and report trends for potential opportunities for improvement. The appeal and grievance manager also conducts daily and monthly audits to validate consistency and quality standards. Audit results are reported to compliance and plan leaders.

Review of the appeal and grievance data may include but is not limited to the types of cases, volumes of each case type by reason, provider involved, coding issues, and outcomes to identify discernable trends and aggregate data that represent opportunities for improvement. The data is aggregated to protect enrollee privacy. Consistent evaluation of appeal and grievance trend data, through our SIC, allows for the Compliance department and executive staff, in conjunction with the Quality Management department, to improve on medical, network, operations, and management areas identified through appeal and grievance tracking that requires additional focus.

Data from health plan experience, results of oversight activities, and the need for any corrective action plans identified internally or by the Department are presented to our Appeal, Grievance, and Quality Committees.

The Appeal and Grievance Committees review trends, and when appropriate, review individual appeal and grievance along with all supporting documentation. Appeal and Grievance Committee participants may represent Compliance, Provider Services, Enrollee Services, Claims, Medical Management, Utilization Management, and other departments, depending on the specific case. Participants also include the director of operations, who is authorized to engage other departments (as necessary) and to implement improvement activities and execute corrective action plans as needed.

Using Trended Data to Reduce Appeals

Through our Administrative Appeals Committee, we identified providers who were seeking authorizations for Botox through pharmacy instead of medical authorization. We reached out to individual providers to educate them on how to request medical authorization and provided information in our newsletter, which has resulted in a decrease in these appeals.

The quality committees include cross-functional representatives from Enrollee Services, Provider Services, Compliance, Care Management, or other departments, as described in **Table C.17-2.** Participants on the SIC and the QMOC include senior leaders at the health plan. These committees work in a coordinated fashion to track and trend data so we can proactively identify and respond to emerging issues and identify opportunities to reduce provider administrative burden.

The membership of our committee structure also makes sure that individuals with the authority to take corrective action participate in the decision-making and can prioritize trends, opportunities for improvement, and corrective actions to address the issues affecting provider satisfaction, to stabilize trends within the delivery system as a whole and to meet performance standards. The results of improvement activities, which may include changing internal process, providing education to our network, and working with individual providers are monitored to assess effectiveness and identify if additional action is warranted. These individuals hold relevant departments to deadlines and actions specified in the corrective action plan and to monitor completion within the timeframes specified.

Table C.17-2: Cross-functional Representatives

Cross-functional Representative	Format	Frequency	Objective
Appeals Committee	Meeting	Weekly	Review and decide appeals; track and trend data; analyze and identify concerns and root cause for appeals filed and collaborative solutions
Grievance Committee	Meeting	Biweekly	Review and decide appeals; track and trend data; analyze and identify concerns and root cause for grievances filed and collaborative solutions
QMOC	Quality-of-care reporting	Quarterly	Executive oversight of the quality management program; review, recommend, and provide feedback to the Quality Management/Utilization Management Committee based on recommended clinical and service quality improvement studies
QM/UM Committee	Meeting	Quarterly	Report all appeals and grievances from the prior quarter, including the top three reasons for both enrollee and provider appeals and grievances
SIC	Meeting	Quarterly	Track and trend suggested improvement opportunities
Quality Management	Quarterly file review	Quarterly	File review to validate compliance with appeal and grievance system policies, procedures, and contract required standards

g.iii. Process for Ensuring Transparency and Reporting to DMS for Appeals and Grievances

All appeal and grievance data will be reported to the Department in the format and at the frequency required in **Appendix D of the Draft Medicaid Managed Care Contract and Appendices**, including reporting on the type, resolutions, and actions to decrease future grievances. To further support transparency, data will also be available to the Department at any time upon request. Appeals and grievances are a standing agenda item at our monthly Department operations meetings, and we are prepared to respond to the Department's questions and concerns or provide other requested information during these meetings. Appeal and grievance files are maintained in a secure manner and are accessible to the Department, its designee, or CMS upon request. We retain appeal and grievance files for the longer of ten years following the final decision or five years from the date of the expiration or termination of this contract.

During our weekly Appeals Committee meetings, a cross-functional team of managers and directors (e.g., medical directors, compliance officer, UM director, etc.) review overturned decisions to track patterns and identify trends. The review includes a root cause analysis to identify the specific reasons for the

initial denial and justification for the decision to overturn. The Appeals Committee determines whether particular providers or vendors are experiencing recurring denials and overturns, which may indicate a need for provider education or system changes. Through this process, we are able to identify opportunities for provider training and education, which is implemented through our Provider Services department. For example, when we identify a trend related to a particular service code, education and training may be provided through our Tip Tuesdays campaign. If a trend is identified with a particular provider, we conduct more targeted training. This process is also utilized to identify and implement changes to internal systems, policies, and procedures to improve enrollee services and reduce provider administrative burden.

Aetna System Improvement

Through our Appeal Committee, we identified a trend of increased denials related to magnetic resonance imaging (MRI) without contrast. Analysis showed the denials were occurring because the authorization requests were for MRIs with contrast, so the billed code did not match the authorized service. Our clinical leadership engaged with the provider, and in May 2019 we implemented changes to avoid these denials. We had a total of 207 administrative appeals that were reviewed from January to September 2019; this number was reduced to 8 from October to December 2019. The 8 cases were not related to coding.

60.7.C.18 Provider Network

Kentucky | Transforming Health Care | **Aetna**

60.7.C.18 Provider Network (Section 28 Provider Network)

Having served the Commonwealth's Medicaid managed care program since its inception in 2011, Aetna's Medicaid organization has learned that the most effective provider network strategy is to continually monitor and assess our network so we can anticipate and respond to network changes. In support of our commitment to quality, ready access, and innovation to maximize enrollee health, advance health equity, and address social determinants of health within a flexible value-based payment (VBP) approach, we have developed a robust statewide provider network capable of meeting the health care needs of Kentucky Medicaid enrollees in an accessible, timely, and convenient manner.

a. Network Development Strategy for a Comprehensive Statewide Provider Network

At Aetna, a robust and adequate provider network is the cornerstone of our Medicaid program. We have been successful in developing and maintaining a mature and comprehensive statewide provider network by listening to providers, being devoted to our enrollees, communities, and system partners, and working collaboratively to develop and implement solutions that address the unique needs of Kentucky. **Our existing Kentucky Medicaid provider network includes 29,355 contracts representing 33,794 providers at 118,977 locations.**

> Our Kentucky Medicaid provider network **exceeds** the Department's adequacy standards.

Our strong community relationships with providers, integrated network analysis and recruitment processes, and high-touch model of network management assist us in ensuring a network sufficient to meet the needs of Kentucky Medicaid enrollees. We continually monitor our network strategies and implement improvements to and processes to ensure timely access to culturally competent primary and specialty care services necessary to promote the Department's goals. Our provider network exceeds the Department's expectations and requirements. This includes the following provider types:

- Hospitals and ambulatory surgical centers
- Physicians, advanced practice registered nurses, physician assistants, and family planning providers
- Free-standing birthing centers, primary care centers, local health departments, home health agencies, federally qualified health centers (FQHCs), rural health clinics (RHCs), and private duty nursing agencies
- Behavioral health and substance abuse providers
- Opticians, optometrists, audiologists, hearing aid vendors, and speech language pathologists
- Physical therapists, occupational therapists, and chiropractors
- Dentists
- Pharmacies and durable medical equipment suppliers
- Podiatrists
- Renal dialysis clinics
- Transportation providers
- Laboratory and radiology providers
- Individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and EPSDT special services

We acknowledge, understand, and will continue to comply with all the requirements in **the Draft Medicaid Managed Care RFP and Appendices, Section 28**, KRS 304.17A-515, 42 C.F.R. 438.206 and other applicable Commonwealth and federal regulations. As an established Kentucky managed care organization (MCO), we have successfully participated in the Department readiness process and are in full compliance with the network adequacy requirements. Aetna grounds our Medicaid provider network

development and management strategies in grassroots, face-to-face interactions with stakeholders, provider and community groups, focus groups, and enrollees alike.

Aetna's provider network strategy is designed to support the full scope of system goals and initiatives, including the following:

- Providing our enrollees with access to a provider network that is capable of meeting their health care needs in an accessible, timely, and convenient manner
- Anticipating and proactively responding to the changing needs of Kentuckians, including changes in service utilization and Medicaid enrollment
- Achieving the Department's quality and health outcomes goals and requirements, through initiatives such as the use of VBP arrangements
- Collaborating with system partners and community organizations to provide continuity and coordination of services across systems and programs

a.i. Innovative Approaches for Recruitment and Provider Network Maintenance

Our goal and strategy are to build a comprehensive region-specific, experienced, and high-quality network that offers provider selection, preserves existing community referral patterns, and ensures access to care for the underserved. When possible, Aetna is committed to using local providers; however, when local providers are not available, we will draw on our national expertise to deploy innovative alternative models as we have with telehealth services. We will continue to use our comprehensive contracting methodology, VBP arrangements, technology/telehealth services, and an ongoing level of engagement and diligence to continuously recruit providers and scale our provider network to meet the needs of our Kentucky enrollees.

Aetna's Provider Services team is crucial in identifying the need to expand the network to increase timely availability for enrollees across all provider types. Upon notification of a provider need, we immediately initiate recruitment efforts. These notifications can be received from a variety of sources, such as referrals from the integrated care team/medical management or other community agencies. Once notified, the Network team conducts outreach to providers in that area or specialty. Our strategy is to build the most effective, experienced, and highest-quality network that offers provider selection and meets the needs of enrollees, as evidenced by our current provider network.

> "KentuckyOne Health and CHI Saint Joseph Health would like to extend full support for Aetna Better Health of Kentucky's bid to remain in the Kentucky Medicaid Managed Care program. Aetna Better Health works collaboratively with our providers to ensure our patients, their enrollees, have access to and receive quality health care services. Our value-based arrangement aligns our organizations around improving the health of the communities we both serve. We are excited to continue this partnership and recommends that the State keep Aetna Better Health as one of their managed care organizations."
>
> **—Lynn Tanner**
> **Vice President of Payer Strategy, KentuckyOne Health**

Our model of provider engagement is designed in support of the philosophy that developing long-term relationships built on mutual trust improves provider retention. Aetna continually looks for **innovative approaches** to engage, satisfy, incentivize, and retain providers. We use performance improvement projects, educational initiatives, community forums, and projects to help providers improve their practices, create better health outcomes for enrollees, and reduce administrative costs and burdens. Examples of strategies to recruit and retain providers include the following:

- A dedicated Provider Services call center
- Simplified contracting using streamlined agreements that are fully compliant with Commonwealth requirements, and the ability to sign an electronic agreement using Apttus contract management software, making it convenient for a provider to return and sign their document within hours

- Face-to-face engagement activities including one-on-one meetings with our Provider Services staff to help providers understand their managed care contract, Aetna's policies and procedures, how to file claims, and how to receive electronic payments
- No requirement to submit paper or electronic referrals for services
- Technical assistance and training related to Medicaid managed care claims submissions and the technical interfaces providers will have with Aetna
- Online tools through the provider portal that make it easier for providers to interface with Aetna

Value-based Transformation as an Innovative Approach to Provider Recruitment and Maintaining a Provider Network

Aetna remains committed to continuous quality improvement to fulfill the Department's mission of improving the health of enrollees in a cost-efficient and effective manner. Many high-quality providers find value-based payment arrangements an attractive means through which to join a network. Through Aetna's VBP arrangements, we can incentivize cost, utilization, and quality improvement through a reduction in potentially preventable events (primary, specialty, and hospital-based) such as hospital readmissions, avoidable emergency room (ER) visits, avoidable inpatient visits, and preventable complications. Using quality and performance measures in the VBP contracts helps us to determine the provider's success, and together we make continuous progress toward the Department's goals for enrollee access to quality care.

As part of our recruitment and retention strategy, Aetna offers providers a variety of alternative payment arrangements through our **Aetna Better Value** program. To date, Aetna has entered into an alternative payment arrangement with several providers such as Children's Alliance Independent Provider Association, Kentucky Primary Care Association (KPCA), KentuckyOne Health, and Big Sandy Health Care, Inc., to name a few. **Since 2012, we have grown from 41 provider groups contracted through a VBP arrangement to 581 groups to date**. Our programs are customizable, allowing us to combine the most applicable components for a particular provider into a comprehensive and effective, innovative alternative payment model.

> Aetna was the first MCO to initiate a partnership with the Children's Alliance-IPA to create and execute a value-based services contract that is designed to incentivize behavioral health care providers to achieve specific outcomes and improve the overall care and well-being of children and families in Kentucky.

a.i.1. Strategies to Recruit Providers in Traditionally Underserved and Non-urban Areas

Enhancing access to health care for enrollees in rural and other areas with insufficient accessibility is an important part of how Aetna meets enrollees where they are. This essential aspect of our commitment to provide personalized care is founded in our local, enrollee-centered approach that focuses on individual's holistic health needs by providing access to and delivery of cost-effective health care services. The rural nature of Kentucky creates opportunities for improving access to services for our enrollees who may have a geographic obstacle obtaining needed care.

Aetna recognizes a unique approach is needed to improve enrollee access in non-urban and underserved areas. For this reason, we have implemented and continue to fine-tune our effective Kentucky strategy that leverages our experienced Kentucky staff that have grown up in and now work with these communities and are supported with our extensive experience nationwide. We continuously monitor providers leaving and entering rural areas and continually enhance our provider network, especially in hard-to reach areas. Our primary goal is being enrollee-focused to help our diverse enrollees achieve their health ambitions. We have learned that the most effective way to increase access is not through one effort, but a combination of efforts. This includes telemedicine, contracting solutions, and enrollee benefits.

We have a demonstrated ability to respond to network obstacles. Through our relationships with providers, enrollees, and other key stakeholders, we will continue our work to improve choice and access in these communities. For example, in 2012 when we identified a network need in eastern Kentucky, we pursued a contract with Big Sandy Health Care, with whom we were not contracted at the time. We were successful in adding Big Sandy Health Care to the network, which greatly expanded our capacity to serve enrollees in eastern Kentucky. We are also working to improve enrollee access to specialists by co-locating specialists in rural offices. As an example, we have facilitated this by paying for the technology and tools needed for co-location.

> Big Sandy Health Care is our longest standing VBP agreement. The agreement commenced in 2012, less than a year after the inception of Medicaid managed care in Kentucky.

a.i.2. Strategies and Methods to Address Workforce Shortages and Network Gaps

Aetna maintains ongoing review of any potential emerging network gaps, including gaps that may result from workforce shortages, and takes immediate action to make sure our network meets the health care needs of all enrollees. Aetna recognizes the important role system collaboration can have in addressing workforce shortages and certain network gaps. As an example, there is a workforce shortage for behavioral health providers, particularly in rural areas, which may be mitigated through improved utilization of mental health associates. We are currently collaborating with community mental health centers (CMHCs) to make sure they understand the full scope of services that may be provided by appropriately supervised mental health associates. We are working with the CMHCs to gather data on the current use of mental health associates to identify system solutions. Through this collaborative effort, we have also identified opportunities to work with the Department to further explore improving access to behavioral health services by leveraging mental health associates to address this statewide issue. Another initiative where we have partnered with the Department and the other MCOs was in regard to a workforce shortage specific to psychologists. As a result of this collaboration, the Department now allows psychologists to provide services to enrollees and receive reimbursement while working under their temporary license. We plan to initiate a task force with the other MCOs to explore other workforce shortage collaborative opportunities such as telehealth and partnerships with local community colleges and universities.

Another example of a strategy that we use to address workforce shortages and network gaps is the utilization of telehealth to provide real-time interactive communication between the enrollee, provider, and care team, as well as live video consultation between practitioners to address the enrollee's care plan. These strategies not only increase access to services directly, through increasing available providers, they also improve the quality of services through more effective use of providers. For example, the increased use of mental health associates increases the availability of licensed behavioral health professionals for higher needs enrollees. Similarly, providing live video consultation between practitioners improves coordination and integration of care and offers primary care providers (PCPs) the needed support and resources to screen and treat persons with low acuity behavioral health conditions.

Additionally, Avēsis, our dental subcontractor, has invested in expanding the dental workforce in Kentucky by providing financial support to help launch the new Community Dental Health Coordinator training program at Big Sandy Community and Technical College. Avēsis' investment paid for the tuition for the entire first class of students in this workforce training program, which resulted in two new community dental health coordinators being trained and deployed to serve the Commonwealth.

a.i.3. Strategies for Contracting with Providers in Bordering States

As part of our network development strategy, Aetna routinely assesses and identifies border state providers to improve enrollee access and choice. Because of the breadth and reach of our national network, we can leverage our commercial and Medicare provider networks in bordering states to improve

network adequacy when gaps are identified. We have strategically contracted with Kentucky Medicaid-enrolled hospitals in bordering states to ensure enrollees have adequate access to care. For example, we have contracts with Cincinnati Children's Hospital in Ohio, Deaconess Hospital in Indiana, Vanderbilt University Medical Center in Tennessee, and Cabell Huntington Hospital in West Virginia.

When contracting with providers in border states, we require the provider to enter into a signed agreement and we comply with all Kentucky Medicaid enrollment rules. One of the challenges we have encountered when attempting to engage providers in border states is the payment required to become a Kentucky Medicaid provider. When engaging with border state providers, they have frequently given us feedback that they will not pay the required fee to become an enrolled Kentucky Medicaid provider and have advised that they will bill our enrollees. Aetna has applied lessons learned from other markets and has established processes to educate border providers on the importance and benefits of becoming an enrolled Kentucky Medicaid provider. We assisted in removing administrative burdens, including helping with costs of provider enrollment and facilitating the submission of the enrollment form. Additionally, to support our enrollees, we have established an enrollee reimbursement policy that escalates reimbursements should the provider not become a Medicaid provider.

Meeting an Enrollee Need through a Single-case Agreement

Our enrollee, Michelle, is a single, middle-aged female who has been diagnosed with dysthymic disorder, agoraphobia, post-traumatic stress disorder, hypertension, and high cholesterol. Due to symptoms of agoraphobia, Michelle has not left her home since October 2018 and has not been to her PCP's office since July 2018. She becomes anxious and has panic attacks when she begins to think about leaving her home. Michelle's Aetna care manager researched and located the nearest in-home health provider service, located in Jefferson County, Advanced Care House Calls (ACHC). ACHC did not have a contract with Aetna for Medicaid services. The care manager collaborated with ACHC, her manager, and the Aetna Contracting department to initiate a single-case agreement for Michelle to receive in-home services from ACHC. Michelle is now being seen monthly by an ACHA primary care advanced practice nurse. Michelle's comorbid health conditions are now being addressed for the first time since July 2018, when she was last seen by her PCP. She has expressed gratitude to her care manager for assisting with arranging in-home primary care services.

a.ii. Approach to Provider Out of Network Care

Aetna will comply with the requirements to allow adequate, timely, and medically necessary covered services through a non-participating provider if our participating providers are unable to provide these services on a timely basis. If a qualified provider is available outside of the network for a specialized, medically necessary covered service (such as in a bordering state), we will either contract with that provider or allow the enrollee to seek services from that non-participating provider using a single-case agreement (SCA). We coordinate payment to non-participating providers, making certain the cost to the enrollee is not greater than it would be if the service were provided in-network. Our Provider Services team engages and encourages non-participating providers to join by conducting telephonic engagement and in-person visits to the provider's office to discuss becoming a contracted provider.

For our enrollees that have complex medical needs and are under the specialty care of a non-participating provider for the entire episode of care (e.g., transplants, rare forms of cancer), the care manager coordinates care with the non-participating providers and engages the Utilization Management department to review and authorize services according to the enrollee's care plan. An enrollee being treated for a behavioral health disorder with a non-participating provider follows the same transition plan. Enrollees are educated about how to access out-of-network services through the enrollee handbook, our Enrollee Services staff, and Care Management staff. The care manager collaborates with the provider,

ensuring appropriate care, until we can assist our enrollee by transferring care to an in-network provider or the existing provider contracts to our network.

a.iii. Approach to Ensuring Provider Physical Accessibility and Accommodations (Physical or Mental)

Aetna employs several approaches to determine a provider's compliance with American Disabilities Act (ADA) standards for physical accessibility and reasonable accommodations including parking, exam and waiting rooms, and accessible equipment for Medicaid enrollees with physical or mental disabilities. We emphasize identification of providers with key accessibility to care opportunities such as providing oversize exam tables, specialized staff assistance for enrollees with needed care requirements, or materials in braille to serve the varied health care needs of our enrollees. This information is collected through our credentialing process and included in our provider directory. Compliance with ADA standards is assessed during site visits conducted by our Provider Network team. To address the accommodations of enrollees with a behavioral health concern, we will launch an awareness campaign to educate physical health providers on the unique needs of an enrollee with a behavioral health issue.

> Recently, we learned an enrollee who is morbidly obese was having challenges with ambulance service due to her size. She needed an oversized stretcher that could accommodate her weight. The ambulance provider was reluctant to provide the service. Our care manager and Provider Services team intervened with the ambulance provider to make sure the proper equipment was dispatched for enrollee safety.

Aetna assesses a provider's capability during onsite visits, through credentialing and re-credentialing processes, monitoring enrollee complaints, and gathering information used in our provider directory, such as physical accessibility and accommodations. These indicators are available across all provider types, including behavioral health, home health, nursing care, and home- and community-based providers to help make sure the enrollee selects the right provider for the right service and in the right setting. We have a process in place where all potential findings related to enrollee quality of care concern are reported and investigated. When necessary, corrective action plans and enforcements are put in place to address these concerns.

a.iv. Approach to Meeting Enrollee Linguistic and Cultural Needs

Our approach to meet the linguistic and cultural needs of our enrollees includes the development of a comprehensive cultural competency program, the provision of cultural competency training to providers during orientation, continuous assessment of enrollee demographics to best understand language and interpreter needs, and the development of innovative provider collaborations to serve enrollees locally in their home community.

Cultural competency and health literacy are at the core of our service delivery. Aetna's health care equity director prepares a detailed Cultural Competency Plan (CCP) annually to ensure engagement of all health plan leaders and alignment with Culturally and Linguistically Appropriate Services (CLAS) standards and to ensure compliance. The CCP outlines the processes used to develop and maintain a culturally competent staff and provider network. This comprehensive plan includes strategies designed to assist our staff, providers, and subcontractors with integrating cultural and linguistic competence and health literacy into every aspect of our organization. Our CCP focuses on effective and equitable care and services by respecting and honoring each enrollee's cultural health beliefs, practices, preferred language, special needs, and socioeconomic background.

Cultural competency is part of the fabric of our organization, and it should infuse every aspect of enrollee interaction and local, community-based care delivery. To deliver quality health care services, it is necessary to understand the needs of our enrollees, particularly their cultural and linguistic needs. This

understanding enables us to provide, through our provider partners, culturally competent services and to assess where disparities in health care outcomes exist. All our contracted providers, including behavioral health, receive cultural competency training at orientation and on an ongoing basis, including the following:

- Cultural competency and impacts on health care
- Provider obligations for delivering culturally competent care
- Tools and resources such as Aunt Bertha, an online repository of community services
- Social determinants of health and trauma-informed care
- Training staff on the need to understand and respect cultural differences and develop services that better meet the needs of minority populations and remove barriers to care
- Assisting enrollees with limited English proficiency
- Providing access to interpretive and American Sign Language services for Aetna enrollees
- Assessing feedback from enrollees about programs, quality initiatives, enrollee materials, and other education and outreach tools to meet their cultural and linguistic needs

We realize that a critical element to providing quality service involves developing and maintaining culturally appropriate services that address diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the enrollee prevalent language(s) and sign language interpreters. Aetna utilizes the U.S. Department of Health and Human Services (DHHS) Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care and follows DHHS' *A Blueprint for Advancing and Sustaining CLAS Policy and Practice* to inform the annual revision of our policies.

We continually monitor our enrollee demographics to better understand the individuals we serve. The largest ethnic groups of Aetna's current Kentucky enrollees are white (non-Hispanic) and African American, followed by the Hispanic population. The Hispanic populations contribute to the fabric that makes Kentucky unique and brings their own values, beliefs, and perceptions, which must be considered when providing quality care. For example, for **Hispanic enrollees**[1], we understand that health is a family affair and any health decisions tend to be made as a family. Caregivers and family members are strong influencers along the health journey and take part in key decisions. Family responsibilities are a priority over health, and juggling responsibilities can get in the way of enrollees taking care of their own well-being. Health care providers (HCPs) are often viewed as authoritative and respected figures for Hispanics who highly respect their HCP and expect a formal yet warm and personal relationship with them.

Table C.18-1 details the prevalent languages spoken by Aetna's Kentucky enrollees with corresponding contracted provider counts.

Table C.18-1: Prevalent Spoken Languages of Aetna's Enrollees and Contracted Providers

Area	English		Spanish	
	Enrollees	Providers	Enrollees	Providers
North	41,902	35,105	912	506
South	81,267	27,999	1,521	691
East	44,323	12,818	68	90
West	37,050	8,169	364	117

[1] Brethenoux, Caroline, and Furey, Patrick, "Attitudes towards Health & Wellness from the Voice of Hispanics and African Americans in the U.S.," *CulturIntel*, January 2018: accessed February 1, 2018.

Area	English		Spanish	
Total	204,542	84,091	2,865	1,404

Our most frequently utilized interpreter and translation services are for Spanish. Aetna currently has three Spanish-speaking Enrollee Services staff to assist our Spanish-speaking enrollees. We arrange for providers and enrollees to access our translation line services through our arrangement with Language Line. Language Line's certified translators provide over-the-phone interpretation in over 200 languages. Aetna also offers enrollees a choice of providers who can communicate in their preferred language.

Another resource is Unite Us, which is a community resource program that is utilized by care managers and community health workers to identify local resources and supports that may benefit an enrollee. This program allows us to coordinate local resources for enrollees that best met their individual and unique cultural needs.

Delivering a Culturally, Linguistically Responsive Network

Our network will deliver care in a culturally competent manner based on the prevalence of languages (including American Sign Language) and conditions within ethnic groups. Several of our providers offer multilingual or bilingual staff to meet our enrollee needs as evidenced in the previous **Table C.18-1.**

Additionally, **Table C.18-2** details the relationships we have developed with key organizations to provide services and support to our diverse enrollees.

Table C.18-2: Aetna's Collaborative Efforts to Serve Culturally Diverse Enrollees

Area	Relationships
North	In this area, we serve the Hispanic population mainly through our partnerships: • **Education, Empowerment & Respect—**This group is committed to networking and learning more on how to support our Spanish-speaking neighbors living in northern Kentucky. We helped provide funding for a community garden for this group and presented on slow cooking, which was translated into Spanish by the Extension Office, and we supported Spanish Family Nights at Kenton County schools. • **Esperanza Latino Center of Northern Kentucky—**This group aims to make it easier for the Latino community to access outreach and educational services. This center just opened and plans to offer literacy programs, onsite legal assistance, educational services, help navigating housing, banking agencies, and summer camps for kids. Since this is a new organization, Aetna is currently in the beginning stage of partnering.
South	Most of the events in this area serve a large African and Asian population that speaks Swahili, Burmese, Somalian, and Arabic: • **Internal Center of Kentucky—**We provided financial support and participate annually in the World Refugee Day. This is an event that is held for the refugee community to share their culture, food, and talents with the community. • **Immigrant Community Meetings and Conferences—**Aetna participates with groups that meet to discuss community resources for immigrant communities. In addition, we host exhibit tables at refugee conferences and provide health and benefit education. • **Warren County Public Schools Refugee and Immigrant Service Fair—**We participated in this event to disseminate information and provide education about our language services.
East	• We coordinate with local family resource center/youth service center directors regarding the availability of interpreter services and written materials in Spanish and other languages as needed.

Area	Relationships
West	In this area there are a lot of Hispanic, Arabic, and African populations that we engage at our collaborative events: • **We Care Clinic—**This clinic provides services to the Anabaptist community to deal with genetic disorders. Aetna has provided backpacks, teddy bears for the children, and toothbrushes and toothpaste to assist with overnight stays. • **Migrant FRSYC at Webster County High School—**This program assists immigrant communities in a school-based setting. Aetna assisted with coordinating and sponsoring the Latino Health Fair, where attendees were given access to community resources, vaccinations, and access to educational materials. • **Family Health Center and Americana Health Centers Inc.—**Aetna participates in their health fair and provides health literacy education. • **Kentucky Refugee Ministries—**This organization serves many needs of refugee/immigrant families throughout Louisville and surrounding areas. We partner with them for various events and activities including providing financial support and benefits education.

To monitor and evaluate that our network is meeting enrollee cultural and linguistic needs, we obtain stakeholder feedback on network composition, operations, and quality improvement initiatives. We evaluate current population demographics and consider projected population demographic needs, anticipating cultural and health disparities as an integral part of our annual network monitoring plan and Quality Management Oversight Committee meeting process. Standards for competency, expertise, and cultural sensitivity are communicated through the provider manual, newsletters, during site visits, and in training documents. Aetna's provider directories indicate the provider's cultural and linguistic capabilities including languages spoken by provider or skilled medical interpreters at the practitioner's office, such as staff that speak in Spanish or American Sign Language, as well as gender, board certification, and accessibility for persons with disabilities.

a.v. Strategies to Address Network Adequacy and Access to Support Increased Enrollment

We continually assess our network's ability to meet future projections of enrollee needs through various meetings, data and reports, and stakeholder feedback. Aetna Provider Services staff and leadership meet weekly to review our network adequacy and access to care and identify any emerging enrollee and system needs. This analysis involves the following interventions:

- Ongoing active evaluation of network additions and terminations, including identifying trends or particular providers through Provider Experience and Clinical teams
- Appointment access standard reviews; our provider contracts outline requirements to comply with appointment access standard timelines – providers are educated on the standards and compliance is measured through appointment test cases and other random sampling techniques
- Results of our annual provider satisfaction surveys incorporate feedback from network participants on satisfaction of available providers
- Evaluation of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results that evaluate enrollee satisfaction with access to care
- Review of physician panel size and capacity to serve challenging enrollees
- Medical Management staff that identify a unique need during care coordination activities that an inadequacy in the network or inaccessibility of enrollees seeking care exists and thereby define a contracting outreach. Such outreach can be immediate via our SCA process to mitigate enrollee disruption or enlisting our Network staff to initiate contracting with providers by needed specialty that meet the need for additional adequacy and/or accessibility to covered services
- Encourage the use of telemedicine if appropriate and as available, especially in support of access in rural areas

- Transportation: If geographic accessibility issues are present, we provide transportation to the necessary provider type within the closest proximity, as appropriate. We arrange transportation to transport an enrollee to another county or region given the common pattern of care in rural and provider shortage areas
- Identification of non-traditional provider options to address adequacy and accessibility in traditionally rural areas in the State where physician shortages are most acute, which include telehealth, co-location, specialized contracts that bring physician access to the rural area, or leveraging existing providers to expand capacity
- Use of in-person and telehealth interpreters to help bridge language/cultural barriers
- Short-term interventions to address network gaps and resolve barriers

This proactive approach allows us to anticipate and make sure our network is adequate and continues to meet access standards, even in the event of an unexpected and significant increase in enrollment.

Between January 1, 2013 and January 1, 2014, Aetna expanded our coverage into Region 3. **We enrolled 68,000 former Kentucky Spirit (Centene) enrollees overnight on July 4th weekend, and implemented Medicaid expansion in accordance with the Affordable Care Act.** We actively prepared an implementation plan for each of these membership expansions that included an analysis using Quest Analytics to identify any network weaknesses. This analysis guided Aetna's actions in contracting with new providers and entering into single case agreements (when necessary) to ensure service coordination and continuity of care for all new enrollees. Additional activities used to identify future network needs include the following:

- Evaluating current population demographics and consider projected population demographic needs, anticipating cultural and health disparities as an integral part of our annual network monitoring plan and Quality Management/Utilization Management Committee meeting process
- Inviting provider participation and input on future network needs through our Enrollee Advisory Committee, Provider Advisory Committee, and Quality Management Oversight Committee
- Obtaining stakeholder feedback on network composition, operations, and quality improvement initiatives to make sure we meet the cultural needs of the community and assess any areas of concern
- Constantly seeking feedback, suggestions, and innovative ideas from providers to help offer better access and increase enrollee convenience. This includes review of provider satisfaction results.
- Obtaining feedback from our care managers
- Utilizing quarterly and annual monitoring, which triggers recruitment action as we review Quest Analytics reports
- Evaluating projected population needs against the current contracted provider network to identify any opportunities to recruit services and providers. Aetna maintains a recruitment database to help us track recruitment targets, and it shows our progress in obtaining signed agreements and applications.

b. Network Development Coordination and Monitoring of Subcontractors

Our subcontractors that provide covered services have demonstrated sustained quality performance serving Medicaid enrollees and they enhance the value we bring to Kentucky. We meet weekly, monthly, and quarterly with our delegated subcontractors to ensure alignment between Aetna's and each subcontractor's network contracting strategy. Aetna assumes full responsibility for active, ongoing monitoring and continuous evaluation of subcontractor performance and compliance, and we do not delegate grievance or appeal responsibilities or processes.

We ensure ongoing collaboration with subcontractors for a streamlined and coordinated approach to serving enrollees and providers by maintaining open lines of communication with subcontractor leaders. For example, Aetna holds weekly, monthly, and quarterly touchpoints with subcontractors who arrange for the provision of covered services to enrollees, such as Avēsis for dental and vision services and CaremarkPCS Health, L.L.C. (CaremarkPCS Health) for pharmacy services, regarding the adequacy of

their provider networks and contracting strategy. We require our subcontractors to have dedicated account managers who are familiar with Aetna and our Kentucky Medicaid enrollment. We also conduct Joint Operating Committee (JOC) meetings with subcontractors to whom we delegate these responsibilities. These meetings provide opportunities to review network adequacy through Quest Analytics reports, review enrollee complaints and grievances related to provider network accessibility, monitor service delivery, and troubleshoot problems. When necessary, Aetna will provide the Department with detailed reporting of our oversight activities.

Aetna performs monitoring and evaluation of service level agreements (SLA) agreed upon between Aetna and subcontractors on a monthly and/or quarterly basis. SLA reporting is reviewed with the Delegation Oversight Committee to identify areas that are sub-substandard. The routine monitoring allows collaboration between Aetna and the subcontractor in order to address identified deficiencies and implement corrective action. In the event a subcontract fails to meet an SLA or has another contractual failure, Aetna will place the subcontractor on a corrective action plan and may impose penalties or pass along penalties incurred by Aetna as a result of the subcontractor's failure. For example, our dental subcontractor, Avēsis, experienced an issue with submitting correct provider enrollment applications that resulted in a corrective action plan and penalty. As a result of Aetna's oversight, Avesis successfully resolved the issue and has maintained the correction.

Avēsis

There are currently **6,155 dental access points** available to Aetna Kentucky Medicaid enrollees. These access points are made up of **1,084 unique dental providers** delivering care through **1,309 office locations**. Quest Analytics reports run in May 2019 show that 100 percent of the Aetna current Kentucky Medicaid enrollees have access to a dentist within the access standards of 50 miles or 50 minutes of their home. In fact, there are, on average, three dentists within 5.1 miles (5.6 minutes) of an Aetna enrollee's home. The greatest travel distance for enrollees is in Trigg County, which is 20 minutes.

On the vision care side, Avēsis is currently offering Aetna's Kentucky Medicaid enrollees with **6,773 vision care access points** made up of **894 unique providers** delivering care through **959 office locations**. Quest Analytics reports run in May 2019 show that 100 percent of the Aetna's current Kentucky Medicaid enrollees have access to a vision care provider within the access standards of 50 miles or 50 minutes of their home. In fact, there are, on average, three eye care providers within 5.6 miles (6.2 minutes) of an Aetna enrollee's home. The greatest travel distance for enrollees is in Carlisle County, which is 21 minutes.

Avēsis' network retention rate is **99%.**

Given the strength of Avēsis' dental and vision care networks and the different recruitment audiences, our focus of the JOCs has been on monitoring reports to verify their network continues to meet our enrollees' needs and offer high quality providers. These reports include the following:

- Biweekly provider termination report
- Monthly provider additions/termination/changes report
- Monthly provider credentialing report
- Quarterly dental and vision network performance report

We have recently initiated a network of mobile anesthesiologists and sedation centers to provide services for dental enrollees. This effort, being managed by Avēsis' in-state dental director, Dr. Jerry Caudill, will bring anesthesiologists into the dental office so that enrollees can receive their care in a familiar setting with reduced wait times and lower costs compared to a hospital visit. Dr. Caudill is coordinating the recruitment of the Kentucky-based anesthesiologist network with Aetna to achieve economies of scale and help ensure billing paperwork is in order to bill us for services rendered.

CaremarkPCS Health

CaremarkPCS Health has been Aetna's pharmacy subcontractor since 2010 and has been serving Kentucky since 2016. The CaremarkPCS Health pharmacy network consists of **1,276 pharmacies** for our enrollees to access. CaremarkPCS Health is our pharmacy benefit manager (PBM) and mail service pharmacy subcontractor, providing a full range of PBM services. They are Utilization Review Accreditation Commission-accredited in PBM, drug therapy management, mail service pharmacy, specialty pharmacy, and health call center; and National Committee for Quality Assurance-accredited in utilization management, care management, and disease management. Aetna maintains (and requires CaremarkPCS Health to maintain) records, books, documents, and information adequate to verify that services are provided in accordance with our contract, federal, and Commonwealth requirements.

> 100% of Aetna's enrollees have access to at least one pharmacy within 30 minutes and one pharmacy within 30 miles using the CaremarkPCS Health pharmacy network.

Monitoring of Subcontractors and Ensuring Transparency

Although we may delegate the authority to perform functions in support of the Kentucky Medicaid managed care program, we do not delegate accountability for the quality of care or services the subcontractor provides. Our QAPI program has a comprehensive set of policies and procedures to manage the delegation of responsibility for any delegated program function. We understand all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight and with ongoing monitoring of subcontractor performance. By leveraging this experience, we ensure the successful completion of all delegated functions under the Kentucky Medicaid program.

Prior to contracting with a subcontractor, Aetna evaluates the prospective subcontractor's ability to perform the activities to be subcontracted. We perform a pre-delegation review audit to determine staff qualifications, clinical and administrative capabilities, integration capabilities, data transfer capabilities, operational readiness, and alignment with the Kentucky Medicaid program scope of work. Our quality management program includes formal multilayered processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract. All aspects of the contract are evaluated through our Compliance Committee to ensure compliance with contractual requirements.

Aetna performs ongoing monitoring of subcontractor performance. We meet with subcontractors on a weekly, monthly, and quarterly basis. Aetna performs a comprehensive review at least annually in which we review ongoing performance and measure performance efforts that address past concerns identified by the Department. If any deficiencies or areas for improvement are identified, we require the subcontractor to take corrective action. If necessary, Aetna provides the Department with a copy of the annual review and any corrective action plans developed as a result.

For example, we strictly monitor and track CaremarkPCS Health to verify they comply with the Department's contract requirements and are consistent with the Department's criteria. Through our JOC, we review network performance reports and data, including the number of pharmacies within the network, Office of Inspector General (OIG) removals and Quest Analytics report. Aetna collaborates with CaremarkPCS Health weekly to coordinate services and network development strategies.

c. Approach for Using Telehealth

Aetna's telehealth strategy involves comprehensive, multimodal approaches that incorporate the specific needs of enrollees and providers in Kentucky. Our goal is to leverage these technologies to complement

and extend vital health care services to all of our enrollees, focusing on those located in remote, non-urban areas, medically underserved urban areas, and for those most vulnerable.

c.i. Recognized Site Criteria

Aetna will provide telehealth network inclusion to all self-identified or interested providers in Aetna's network who align with the Department's regulatory requirements. We currently contract with 1,993 providers who provide telehealth services. Eligible practitioners interested in delivering care via telehealth service provision for their own enrollees (which can improve care continuity and both provider and enrollee satisfaction) but who do not have access to a technology platform will be offered two options: 1) software leasing via our preferred vendor and 2) ability to apply for vendor provider group inclusion. In addition, the health plan will incorporate the usage of a preferred vendor network to achieve the aim of maximizing provider access.

In alignment with Commonwealth and federal regulations, Aetna has developed minimum practitioner/site criteria designed to support and promote safe, adequate, and efficient high-quality health care services that prevent waste, fraud, and abuse of the Medicaid program; ensure practitioners obtain prior consent; employ confidentiality protocols; and comply with all Commonwealth and federal privacy and security laws. In that regard, all telehealth vendors must complete Aetna's rigorous **Global Information Security** review that validates a vendor meets legal and industry standard protocols to ensure internal and external compliance and that data security requirements are met and followed as a standard part of their business operations.

c.ii. Educating our Providers and Enrollees Regarding Telehealth

Because of the rural nature of a large part of the Commonwealth, Aetna staff take every opportunity to educate our enrollees and providers on the availability and benefits of telehealth. **Since January of 2017, 23,855 telehealth visits have been provided to Aetna Kentucky enrollees statewide.**

Enrollee Education

All enrollees are educated about the availability and benefits of telehealth utilization through Commonwealth-approved enrollee communications (e.g., welcome packets, mobile notifications, newsletters, and website content). In addition, to maximize program effectiveness, care managers educate enrollees on the availability, convenience, and removal of barriers such as transportation when using telehealth services.

> We recently had an enrollee with behavioral health needs that limited her ability to receive care in a community outpatient mental health center. Our care manager educated the enrollee regarding the availability of telehealth services through a behavioral health provider in her area. Once the enrollee was educated, she successfully obtained needed services through the telehealth provider.

Provider Education

Provider Services staff promote telehealth practitioner self-identification and offer support and education regarding telehealth delivery and billing requirements. We educate providers through our welcome packets, face-to-face visits, webinars, **Aetna Provider Partnership Program (AP^3)** Advisory Council, and Tip Tuesdays campaign, and also includes telehealth as one of our monthly targeted training topics. We conducted a provider survey through Survey Monkey to identify providers who offer telehealth services or wish to do so. These results allow Aetna to offer telehealth education to interested providers regarding the delivery and billing of telehealth services. In addition, our telehealth program experts in conjunction with our preferred vendors support, educate, and train providers who choose to provide telehealth independently or who utilize the vendor's platform or join their telehealth provider group. In

summary, the health plan utilizes multiple approaches to promote and educate both providers and enrollees about available telehealth care. An example of our Tip Tuesdays campaign is provided as **Figure C.18-3**, which give providers brief routine updates and helpful information.

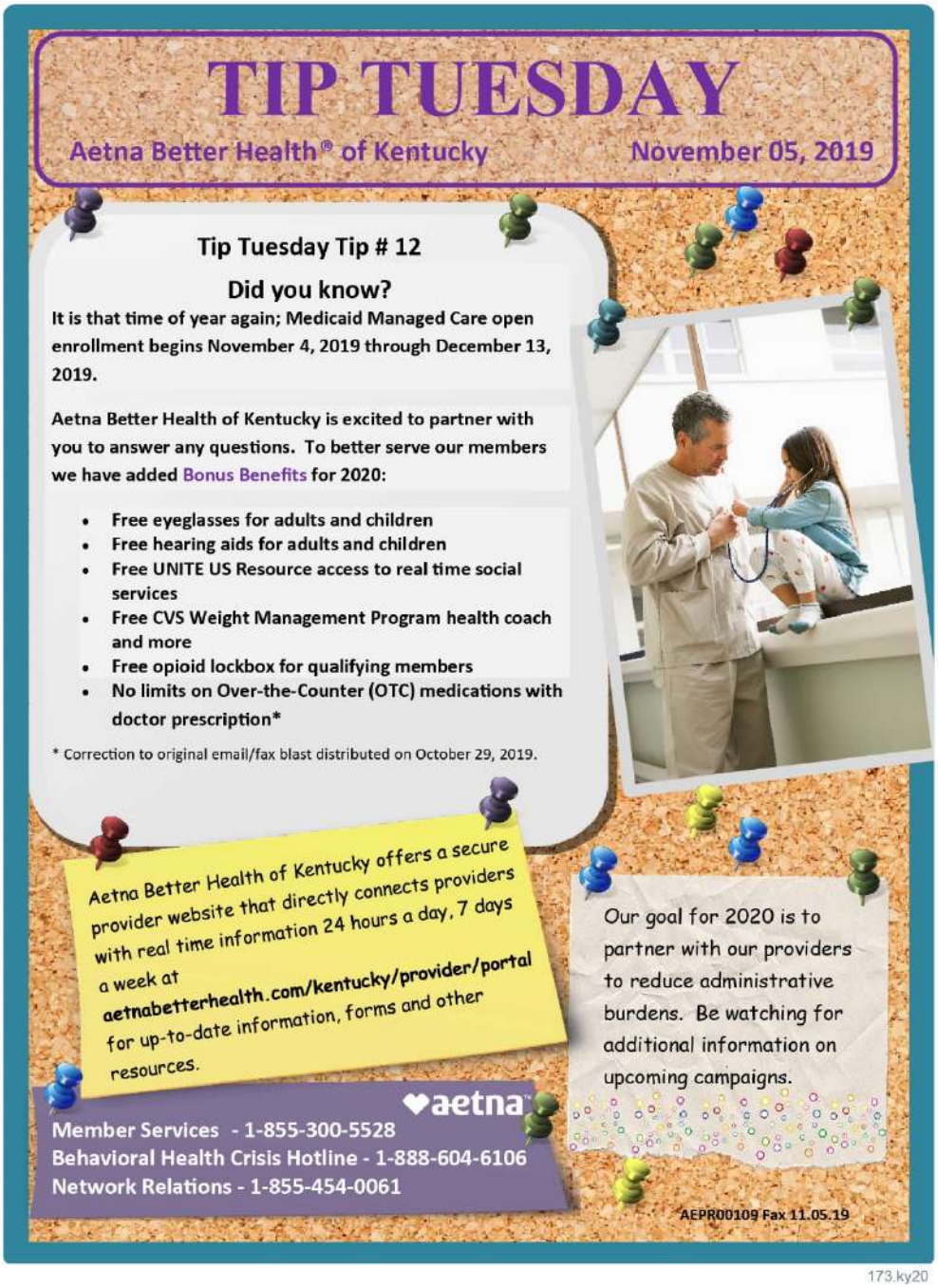

Figure C.18-3: Sample Aetna Tip Tuesday Flyer

Aetna uses Tip Tuesday notices to inform providers of updates and other helpful information.

c.iii. Reimbursement Requirements and Limitations

All providers engaged with our telehealth program must be licensed in Kentucky and contracted to provide telehealth services in accordance will all relevant Kentucky laws. Network practitioners are credentialed by Aetna; our subcontractors Avēsis and CaremarkPCS Health conduct their own credentialing, supported by delegation oversight from Aetna. Providers must be trained in emergency and crisis intervention where appropriate and be able to meet the threshold linguistic and cultural needs of the population. The service must be medically necessary, documented in the enrollee's care plan, and follow generally accepted standards of care. For example, our subcontractors' providers ask enrollees for consent to share details of the telehealth visit with the enrollee's PCP, and upon consent, that information is shared electronically assuring coordination of care. As required by **Attachment C Section 28.2.10** and applicable Kentucky laws and regulations, we do not do the following:

- Require Medicaid providers to be physically present with an enrollee, unless the provider determines it is medically necessary to perform the services in person
- Require the Medicaid provider to be employed by another provider or agency to provide telehealth services that would not be required if the services were provided in person
- Require a provider to be part of a telehealth network

We will offer value-based incentives for providers who offer telehealth services. Further, reimbursement will be available to all practitioners providing telehealth services (i.e., e-visits) at the same rate provided to practitioners conducting face-to-face care, unless a different rate has been mutually agreed upon and captured in their participation agreements. **Reimbursement will also be available to the originating/presenting site provider when an enrollee is utilizing the provider site as the location for initiating of a telehealth visit.** Reimbursement will not occur for a presenting site when the service is a consultation between providers. Provider claims must contain appropriate billing codes, modifiers, and/or place of service identification.

c.iv. Lessons Learned and Successes of Implementing Telehealth

Telehealth has been proven to offer many benefits including improved access and reduction in avoidable ER, inpatient hospitalizations, and overall cost of care. Moreover, both enrollees and providers articulate increased care experiences via telehealth.

Lessons Learned

Our dental subcontractor Avēsis' tele-dentistry pilot in Kentucky will be informed by its participation in First 5, a Virtual Dental Home (VDH) program in Sacramento, California. Through VDH, dental teams consisting of a registered dental hygienist, dental assistant, and care coordinator provide preventive dental care to children at school sites. The onsite team sends X-rays and other information to a designated off-site dentist. If the dentist finds a child needs dental care that cannot be provided at the school site, such as a filling or an extraction, the care coordinator helps the family make a dental appointment with a network provider. Approximately two-thirds of the children are able to have all their dental needs met at the school site while the remaining need to be seen by a dentist for additional, diagnostic, and restorative treatment. The consulting provider is eligible to bill for services.

Launched in Q3 2018, Avēsis' California team has treated 113 children using VDH technology and processes. Lessons learned over the first 12 months of the program include the following:

- Develop a planning team made up of all relevant stakeholders to support tele-dentistry pilot projects and ensure there is sufficient time to implement properly the initiative. Many of the enrollees who visit a virtual dentist may not have a history or culture of preventive oral health treatment and we want to be sure they have a good experience so they can begin developing healthier patterns of seeking care. Stakeholders will vary based on the location where enrollees will be seen virtually.

- Ensure participating partners have access to the necessary technology to make the virtual consultation work. Avēsis' school partners can support the technology equipment, but wireless speed varies significantly from site to site, creating significant delays in the process.
- Ensure there is a professional care coordination team engaged with the work to help ensure enrollees who are treated virtually are receiving necessary follow-up care and develop a facsimile of a dental home.
- Provide clear, concise, and enrollee-focused educational and enrollment materials to make it easy for enrollees to engage with the information. Again, because many of the enrollees who are targeted for a visit to a virtual dentist may not have a history or culture of preventive oral health treatment and we want to be sure they are excited about the opportunity, rather than intimidated, afraid, or confused.

Successes

Aetna enrollees are increasingly using telehealth approaches as an option for care. In 2018, monthly surveys of enrollees in our affiliated Louisiana Medicaid health plan who used telehealth services showed 31 percent of enrollees advised they would have gone to the emergency department if they had not had telehealth as an option for care. In addition, 85 percent of the enrollees rated their experience as outstanding. **The claims cost savings in 2018 was approximately $350,000.**

Our contracted provider, Big Sandy Health Care, developed a behavioral health telehealth program that has been very successful for their enrollees. They received a grant for a two-year initiative. There is a single point of contact with Big Sandy Health Care that schedules all the appointments, which helps manage the flow and makes sure the psychiatrist's office schedule is accurate. This also helps with the no-show rate, which is very low. They have a separate room that is dedicated to telehealth, with a door that is shut during the appointment. The feedback has been very positive because enrollees are happy they do not have to drive very far for an appointment.

Telehealth Services to Improve Network Adequacy and Promote Enrollee Health

To improve access to services in traditionally underserved remote or urban areas, we have also implemented telehealth strategies. Telehealth can be used as an alternative to or to complement traditional service delivery. In alignment with Commonwealth regulations, specific available services include consultation; mental health evaluation and management; individual and group psychotherapy; pharmacologic management; psychiatric/psychological/mental health diagnostic interview examinations; and individual medical nutrition therapy consultation services. In-network providers may use their own approved technology or will be given the opportunity to utilize a plan-sponsored technology platform to enhance access to their enrollees via telehealth. Alternatively, if indicated, preferred Kentucky-licensed subcontractor's telehealth practitioners will be utilized, as per Kentucky regulations, to meet both the physical and behavioral health needs of our enrollees using evidence-based protocols. Unless otherwise agreed upon or directed by the Department, provider reimbursement for telehealth services will be equivalent to that given for the same in-person services.

> Since January of 2017, 23,855 **telehealth visits** have been provided to Aetna Kentucky enrollees statewide.

Telehealth has been proven to improve care treatment compliance, decrease both ER and inpatient hospitalization utilization, reduce disease burden in communities, and promote the concurrent use of advanced specialty capabilities in coordination with an enrollee's local PCP, thereby improving available quality and continuity of care. Moreover, available telehealth services promote the integration of physical and behavioral health care and enable provider-to-provider consultation between PCPs and specialists. We will offer the following telehealth options:

- **Remote patient monitoring (RPM):** Aetna offers an RPM program for enrollees with specific chronic or high-risk diseases such as heart failure, diabetes, high-risk pregnancy, asthma/respiratory disorders, or certain behavioral health conditions. We use remote monitoring to elicit enrollee

empowerment; improve disease management; improve access, adherence, and compliance; decrease ER utilization; and lower total cost of care. Enrollees who participate receive our in-home remote monitoring technology package, which includes a remote monitoring bundle and iPad mini™ kit with up to two peripheral devices, such as a weight scale, pulse oximeter, blood pressure cuff, and glucometer. The unit is designed for simple setup, with the iPad personalized for each enrollee, listing their name on the landing page with easy-to-follow instructions and videos on how to use the devices, how and when to contact their provider and care manager, and how to seek emergency help. In addition, we personalize the iPad mini so the enrollees and their family/circle of support can access educational information targeted to their condition(s). Participating enrollees collect and submit biometric data daily and engage in regular sessions with nurse health coaches. If submitted biometric data is deemed out of range, their practitioner is notified by phone and appropriate interventions implemented. Health plan care managers may be actively involved.

- **Enrollee e-visit and provider-to-provider e-consults:** We provide enrollees face-to-face practitioner encounters via access to real-time interactive audio and video technology. Enrollees will be able to access their PCP or specialty telehealth provider from their home or desired secure location. The service has proven to improve provider ease of access and decrease avoidable ER visits and hospitalizations. Additionally, when PCPs need support and resources to screen and treat persons with low acuity conditions, they can conduct consultations with specialists via telehealth. Consultations may occur face-to-face via technology or via 'store and forward' asynchronous technologies as the standard practice or care or where images are sent to a specialist for evaluation. Consultation services assist with diagnosis and medication management and provide recommendations for ongoing treatment. This improves the integration of behavioral health services in primary care, increases care coordination, and decreases avoidable use of ER services.
- **Tele-dentistry:** Recognizing the power of tele-dentistry as a tool for expanding access to health professional shortage areas and for populations with limited mobility, Avēsis is actively engaged with the Tele-dentistry Committee of the Kentucky Board of Dentistry, as well as the Mid-Atlantic Telehealth Resource Center. The Commonwealth recognizes that the application of telehealth functions in dentistry may be hampered by the following factors:
  - The lack of a tele-dentistry modifier on the ADA claim form, the standard tool for submitting Medicaid dental claims
  - The impact of point-of-service reimbursement versus consulting site reimbursement on FQHCs and RHCs

Avēsis' in-state Dental Director, Dr. Jerry Caudill, has been asked by the Department to help resolve these issues to ensure smooth implementation of the Commonwealth's telehealth regulations when they are finalized. At this time, Avēsis will launch an FQHC/RHC tele-dentistry pilot being planned in collaboration with the Kentucky Primary Care Association.

The overall telehealth program is evaluated no less than annually for impact on the following: enrollee access to and timeliness of care, decrease of non-emergent, ER utilization, cost of care reductions, quality score improvement, enrollee satisfaction, and participating provider experience. As required by the Department, we will seek prior approval through the exceptions process if we plan to include telehealth as a method of meeting network standards. In addition, the telehealth program is reviewed at least quarterly by the chief medical officer and Medical Management and Quality Management teams to examine progress, trends, and course corrections needed during the usage of the program with the support of Aetna's national team. The comprehensive evaluation process will track, measure, and analyze overall program costs, quality/Healthcare Effectiveness Data and Information Set scores, and other key outcomes for each program, culminating in the production of a work plan that will be executed the following year.

d. Provider Contracting Strategies

Our provider contracting goal is to ensure that our enrollees have timely access to the appropriate level of care. To achieve this goal, we continuously assess our provider network through Quest Analytics reporting, enrollee and provider inquiries and feedback, and trends in enrollees' needs. **For example, we monitor medical service trends and costs as a guide for contracting opportunities.** If we identify increasing medical costs in a specific region of the state or enrollee population, we evaluate how we can impact these trends via strategic provider contracting. Then an action plan is initiated to contract with additional providers or restructure existing agreements to bring greater value and care outcomes for our enrollees.
We contract with diverse groups of providers in both large and small systems as we offer time-tested best practice strategies. As described previously, when a non-contracted provider is identified by an enrollee, we contact the provider to provide information regarding enrollment in the Kentucky Medicaid program and determine their willingness to join our network.

Aetna's provider contracts comply with the terms of the contract, Commonwealth, and federal law, and include required standard contracts provisions, as set forth in **Appendix C of the Draft Medicaid Managed Care Contract and Appendices.** Our proposed Kentucky Medicaid contract templates are provided in **Attachment P**. Neither Aetna, nor our subcontractors do the following:

- Require providers to participate exclusively with our networks
- Require practitioners, as a condition of contracting, to participate or accept other products that we offer
- Automatically enroll providers in other products we offer
- Incentivize providers, monetarily or otherwise, to withhold medically necessary services from enrollees

Additionally, we make sure that all network providers have knowingly and willfully agreed to participate in our Aetna Kentucky network. In the event we acquire an established network, we contact with each individual provider to help make sure the provider has knowledge and understanding of, and agrees to, of the contract requirements and terms.

Participating providers require a signed and executed contract or letter of agreement between Aetna and themselves following negotiations. Our Network department provides the Health Plan Reimbursement Administration (HPRA) department with a copy of the signed contract for review and operational analysis. HPRA submits a system change request form to the Configuration team to create a new contract in our claims system. The change request includes the signed executed contract or letter of agreement, the reimbursement schedule, codes, compensation schedules, and other requirements to pay services properly at correct rates as defined in the contract. The new (or modified) contract will be configured in our claims system's applications development testing environment. The Medicaid Provider Services (MPS) team will run through a series of claims to validate accurate configuration of the contract. Once MPS passes the contract, an Internal Quality Control team will also review. The contract is then promoted into the production environment ready for provider assignment/linkage. A provider change request is submitted to the Provider Data Services department to create or modify a new provider record. The provider is aligned to the designated contract on the provider change request, including additional provider information (i.e., language, provider type, specialties). We validate the provider load and complete the process. Claims are adjudicated appropriately based on the data loaded into our claims processing system.

To further support our provider contracting processes, in early 2020 we will implement Apttus, a contract management tool which supports efficient and accurate contract execution including document-tracking to determine a provider meets all contract requirements. A critical factor in implementing this tool was the goal of improving the accuracy of provider set-up and claims payment.

Provider Selection Requirements

Aetna has established policies and procedures that address the selection and retention of our contracted provider network. Our policies and practices are developed to make sure Medicaid providers meet and maintain compliance with all applicable standards, and do not discriminate against providers who service high-risk populations, specialized conditions that require costly treatment, or based on the providers licensure or certification. To join our Aetna network, providers are required to meet credentialing standards as described in **Section 27.7 of the Draft Medicaid Managed Care Contract and Appendices**, be eligible to be enroll in the Kentucky Medicaid program, and meet the Medicaid provider enrollment requirements set for in Kentucky Administrative Regulations and the applicable Medicaid policy and procedure manual. Aetna established process for verifying that all network providers are credentialed and enrolled consistent with applicable requirements.

Providers submit their W-9, OIG disclosure of ownership, provider information form, and application. If a provider is not currently enrolled with Kentucky Medicaid, we facilitate the submission of the provider Medicaid enrollment applications (Medicaid Assistance Program [MAP]) MAP-811 application through our established process. If a provider is enrolled, or once they become enrolled, we utilize the Department's Medicaid provider master to obtain their 10-digit provider number, verify the provider's status with the Medicaid program, Clinical Laboratory Improvement Amendments certification, and other applicable information. While we require providers to be enrolled in the Kentucky Medicaid program, we don't require that they participate in the Kentucky Medicaid fee-for-service program as a condition of participation in our network.

In an effort to reduce provider administrative burden, Aetna has partnered with the Kentucky Hospital association to streamline the credentialing process. The credential process includes, but is not limited to, verifying that the provider does not have active sanctions imposed by Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP) that required licenses and certifications are current, no money is owed to the Medicaid Program, and that the provider is not currently involved in an active Office of the Attorney General Fraud investigation. The credentialing process verifies the provider's eligibility for participation through National Practitioner Database and screens the provider to verify the provider has not been excluded by Medicare, Medicaid, or SCHIP.

If a provider is not accepted into our network, we provide written notice that includes reasons the provider was not accepted, including information on their appeal process if applicable. If a provider is accepted, we send a written network participation welcome letter that includes a contract effective date for which providers are approved to begin providing medical services to enrollees, as well as the required orientation information that meets the requirements of **Attachment C Section 27.5.**

Verifying Provider Compliance with Contracting Requirements

In addition to our formal credentialing, re-credentialing, and contracting processes, we have established a variety of mechanisms to assess provider contract compliance and identify potential noncompliance. These include the following:

- Conducting routine site visits and surveys
- Monitoring enrollee and provider complaints and grievance and appeals, both at a case and trend level
- Reviewing data and reports submitted to our Special Investigations Unit, Compliance department, and compliance hotline
- Reviewing quality management data and reports
- Reviewing notifications received from the Department

If a potential concern is identified through the processes detailed previously, our Provider Services staff coordinates with the appropriate Aetna departments to assess or investigate the matter and determine whether the provider is compliant with the applicable contract requirements. The assessment or

investigation may occur in a variety of ways, based on the circumstances, including but not limited to conducting a record or documentation review, an ad hoc onsite survey, and interviews with the provider.

Corrective Action and Termination Process

Aetna makes every effort to ensure that our relationships are strong enough with our providers to resolve issues as they may arise. We take every step to resolve deficiencies, complaints, grievances, and any other concerns to ensure that our enrollees have a solid and comprehensive network to rely upon. It is our practice to terminate provider contracts for cause when we identify safety or significant quality concerns, or noncompliance with credentialing requirements. It is not our practice to terminate provider contracts arbitrarily for no cause.

Termination Due to Non-compliance

Aetna maintains policies and procedures regarding the termination of providers and provides delegated oversight of all network activities. Our process includes quickly identifying and reporting changes in the provider network to the Department, including voluntary or involuntary provider/practitioner terminations. If the provider materially breaches the terms of their provider contract, and fails to timely and adequately cure such breach, Aetna may, in its discretion, terminate the provider agreement in accordance with the terms of such agreement. We will also terminate providers from the network, or modify their provider agreement, if so directed by the Department, when it determines that such termination or modification is in the best interest of the Commonwealth.

Aetna monitors our network for, and will immediately terminate provider from the network, if we identify any of the following:

- The provider engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare, Medicaid, or KCHIP program
- The provider's license, certification, or accreditation is terminated, revoked, or suspended
- The provider has medical staff privileges at any hospital terminated, revoked, or suspended
- The provider engages in behavior that is a danger to the health, safety, or welfare of enrollees

Aetna's Provider Network

- Number of Current Providers (100% under contract): 33,794
- Number of VBP Providers: 576
- Number of Providers Offering Telehealth: 1,993

e. Network Capabilities

As required by the RFP, the following information has been included as **Attachment P:**

i. A Microsoft Excel workbook by provider type listing every provider that has signed a contract or letter of intent (LOI), including the provider's name, specialty(ies), address and county(ies), Medicaid region(s) served, whether the provider is accepting new patients, accessibility status for individuals with disabilities, language spoken, and the provider's Medicaid Identification Number(s). Please note that we have also included a detailed behavioral health provider list.

ii. A summary Microsoft Excel worksheet with total provider counts by provider type by Medicaid region and county. **We currently are contracted with 33,794 providers, 576 VBP providers, and 1,993 providers who can provide telehealth services.**

iii. A statewide Geographic Access report of all providers with LOIs color-coded by provider type by service region.

f. Proposed Enrollee to Provider Ratios by Provider Type

Aetna's current network **meets** the provider ratios as outlined in **Attachment C, Section 28.4**. We do have capacity to reduce this ratio to approximately 750 enrollees to 1 PCP, and we believe this would

positively impact enrollee care. We are focused on developing a plan to incorporate the provider full-time equivalent (FTE) calculation into our network adequacy monitoring. We will have FTE calculation functionality in place prior to readiness review.

g. Methods for Monitoring Compliance with Network Adequacy and Access to Care Standards

To maintain network adequacy and identify gaps in network access or where gaps are likely to occur, we will leverage our current assessment tools, and will include methods detailed in **Table C.18-3** below:

Table C.18.3: Network Monitoring Data and Reports

Reporting and Monitoring Activity	Data or Report Description
Quest Analytics Reports	We review Quest Analytics reports to measure compliance with the Department's access standard requirement for each ZIP code
PCP-to-Enrollee Ratios	We review ratios by provider type and region to confirm availability of an adequate number of PCPs
Network Adequacy	We review utilization data including prevalent conditions, SCAs, provider referral issues (availability of specialties), providers-gained-and-lost report, and unplanned network exit report to confirm sufficiency of the type and number of providers
Emergency Room Utilization Dashboards	Continuous monitoring is performed using operational dashboards that measure and trend enrollee utilization including ER care. These dashboards allow us to identify opportunities to enhance our network by location, disease state, and enrollee type.
Network Panel Studies	Network panel studies are performed, using the open/closed panel report, to assist in assessing network access and availability needs and identify providers who have reached their capacity
Provider Directory Audits	These audits confirm the accuracy of provider listings and are used to make weekly updates to online directories, including changes in demographics and panel status
Provider Appointment Availability Phone Surveys	To improve monitoring of access for the population served under this contract, we will query providers on appointment availability, open scheduling, and after-hours care
Interdepartmental Reporting	We have implemented a formal interdepartmental process that allows the Provider Experience department to collect, trend, and respond to network needs our staff may identify outside of the other data and reporting mechanisms, such as challenges identified by our care coordinators or informal discussions with community organizations, including access or capacity concerns related to special needs
Call Center Encounters Data	Our call center collects information regarding enrollee calls about network provider availability and access, and shares the call information with the Provider Experience team to assess potential network gaps, barriers, and opportunities for network development
Enrollee and Provider Appeal and Grievance Data	We review analysis and trending of appeal and grievance cases to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, if necessary
Provider Satisfaction Surveys	We review and analyze provider satisfaction survey results and create action plans for opportunities for improvement identified through the survey
CAHPS survey	We review and analyze CAHPS survey results and create action plans for opportunities for improvement identified through the survey

Aetna uses the above tools to determine areas within the Commonwealth, regions, counties, and cities where network adequacy and provider accessibility can be enhanced. These assessments analyze compliance with travel distance standards, appointment availability, after-hours access, open panel status, appropriateness of specialty mix, and cultural competency for key provider types. **If an enrollee cannot access a pharmacy, hospital, PCP, or other specialist, then the network is not adequate (useable) for that enrollee, regardless of whether our network technically meets the Department's definition of adequate.** We monitor our network to make certain that every enrollee has access to services and supports the need to achieve their health ambitions. We already exceed requirements by providing access and choice of providers to 100 percent of enrollees within the required time and distance standards, with the exception of dermatology services, which is still contractually adequate. While the provider counts in this section reflect our current network, we continue to build network capacity to eliminate identified access challenges or deficiencies. Kentucky has known areas of provider shortages.

We review Quest Analytics and provider data to determine the number and type of specialists, including behavioral health providers, in a geographic area to maintain an adequate number of providers to meet health care needs of our enrollees accessing the network. We look to continue to collaborate with associations, community organizations, hospitals, and academic organizations for new providers entering the area, or to develop relationships to meet specific needs, such as providing telehealth or community solutions to maintain and increase network accessibility, especially in rural markets or in geographic areas with limited access to scarce provider specialties.

Ongoing Monitoring Compliance with Provider Network Standards

Aetna actively monitors our provider network, including **all provider types**, for compliance with the provider network standards in **Attachment C, Section 28** to identify and mitigate network accessibility issues or provider noncompliance with policies and procedures that affect an enrollee's reasonable access to care delivery. We continually evaluate reports, including Quest Analytics and network adequacy information, to determine where we need to increase the number and type of new providers to the network as well as appropriately prepare for anticipated network providers across the service area. Quest Analytics reports are generated monthly and reviewed by health plan and network leadership. Network staff will formulate a plan to close any identified gaps based on data or enrollee feedback. We use our provider data warehouse to create a suite of monitoring tools and reports to identify network gaps. In addition to the Quest Analytics reports provided in **Attachment P**, we have provided other sample network analysis tools/reports in **Attachment P.** The results of our monitoring efforts are reviewed by our Service Improvement Committee. The committee develops and monitors action plans to ensure identified gaps are addressed.

- Reporting and monitoring:
  - **Quest Analytics reports:** Monthly reports measure against the Department's access standard requirement for each ZIP code
  - **Network adequacy:** Review utilization data for prevalent conditions, SCAs, provider referral issues (availability of specialties), providers-gained-and-lost report, and unplanned network exits report to confirm sufficiency of the type and number of providers
  - **Operational dashboard that identifies enrollee ER utilization:** Continuous monitoring is performed using operational dashboards that measure and trend enrollee utilization including ER care. These dashboards allow us to identify opportunities to enhance our network by location, disease state, and enrollee type.
  - **Conducting network panel studies using open/closed panel report:** Assessing network access and availability needs
  - **Conducting provider directory audits:** Monthly audits confirm the accuracy of listings and make weekly updates to online directories with changes in demographics and panel status

  - **Conducting provider appointment availability (secret shopper) phone surveys:** Query providers on appointment availability, open scheduling, and after-hours care
  - **SCA data:** Analyze SCA trends to identify potential shortages of services or geographic gaps
  - **Interdepartmental reporting:** We have implemented a formal interdepartmental process that allows provider networks to collect, trend, and respond to identified network needs our staff may identify outside of the data and reporting mechanisms outline above, such as challenges identified by our care managers or informal discussions with community organizations.
- Enrollee feedback:
  - **Call center encounters:** Our call center collects information regarding enrollee calls. Calls received about network provider availability and access are noted and shared weekly with the Operations team to assess potential network gaps or barriers, as well as opportunities for network development efforts.
  - **Grievances:** We review analysis and trending of enrollee grievances to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, if necessary. We receive committee findings and survey results on access, appointment availability and wait times, non-participating prior authorizations, and out-of-network requests.
  - **CAHPS survey:** We create action plans for opportunities presented in the CAHPS results.
- Provider outreach and support:
  - **Interdisciplinary team collaboration:** Identify any access or capacity concerns and addressing special needs
  - **Reviewing PCP-to-enrollee status:** Review ratios by provider type and region to confirm availability of an adequate number of PCPs
  - **Reviewing providers' panel status:** Review open panel status to confirm where new enrollees can be assigned and identify providers who have reached their capacity and/or referral limits

In addition to the formal reports, we also solicit input and feedback from our system partners and community-based organizations. Our strategy for monitoring provider network compliance uses a holistic approach. It is imperative that the network not only achieve adequacy, but also be user-friendly to our enrollees in as close to real time as possible.

Our goal is to maintain a comprehensive network of facilities, clinics, physicians, and related support providers that demonstrate a pattern of practice that understands the varied health care needs of our Medicaid enrollees. We continually work to offer our enrollees the highest quality providers in close proximity to where our enrollees live, work, and play. Our success is based on our demonstrated commitment to engage and collaborate with key stakeholders, community organizations, providers, and enrollees.

Meeting Required Time, Distance, and Appointment Wait Time Standards

Aetna will continue to meet required time, distance, and appointment wait time standards as required by KRS 304.17A-515**, Attachment C Section 28.4 of the Draft Medicaid Managed Care Contract and Appendices**, and other applicable requirements. All participating physicians and other providers in our network are contractually obligated by provider agreements to adhere to timely access and appointment standards and are required to provide services to Medicaid enrollees in the same manner as all non-Medicaid enrollees. Through our financial incentives program, we also offer enhanced payment for those offering after-hours and weekend care Aetna monitors its providers regularly to determine compliance with these requirements. If a contracted provider does not comply with these standards, we meet with the provider face-to-face and we will also take corrective action through our quality management program structure. Standards for wait times and appointments, disability access, competency, expertise, cultural sensitivity, and hours of operation are communicated through the provider manual newsletters, during site visits, and in training documents.

Addressing Network Deficiencies

We use the following global strategies to address identified network deficiencies:

- **Monitoring provider facility changes:** Our local provider services representatives have established open lines of communications with providers in their communities. Through these relationships, we are aware of and able to identify providers who may be considering leaving the network. In these situations, we are able to reach out to the provider before they take formal action, and work with them to resolve barriers or concerns to maintain their network status. Additionally, if we receive notice that a provider is leaving a contracted facility or group, we outreach to the provider and attempt to contract with them as an individual provider, when appropriate.
- **Recruitment of out-of-network providers:** To proactively provide consistent access to services and avoid gaps in care, we recruit out-of-network providers with whom we have authorized care or executed a SCA. We assess use of out-of-network services on a weekly basis to verify that our network contains adequate numbers and types of providers and use this information to evaluate recruitment opportunities.
- **Recruitment of providers through key stakeholder identification:** Enrollees, families, advocates, and system partners, such as Families First, are highly successful in identifying potential providers in the community. Our Network team has successful strategies to recruit those providers into the managed Medicaid network, such as working with providers who have these enrollees in their established panels.
- **E-consult and telephonic consultation services to PCPs:** The primary care setting has become the gateway to behavioral health services, such as mental health and substance use. PCPs need support and resources to screen and treat persons with low acuity conditions. E-consult provides PCPs access to United States-licensed, board-certified specialists from major academic centers across the country via an electronic health record-linked portal, which increases overall capacity.

In addition to the global strategies outlined previously, we will employ the following strategies to address network gaps:

- For enrollees with behavioral health needs, we contract with providers such as Applied Behavior Analysis providers and Maryhurst to address specific population needs.
- Expand the non-emergency medical transportation benefit as a value-added service to facilitate service access for enrollees in neighboring communities when a service is not available in their community.
- Continue to build on our statewide network for FQHCs and RHCs, which currently includes a value-based payment arrangement with KPCA that includes 463 clinic sites, 356 FQHC sites, 197 school-based sites, and 107 RHC sites. KPCA has over 1,500 providers located in 90 counties. Additionally, we have contracted with FQHC and RHC providers in every region.
- Explore a contract with a provider to perform certain assessments of the enrollee in their home; this collaboration is designed to reduce ER utilization by providing in-home care management to frequent utilizers. It also works to reduce non-emergency ambulance transport by having trained emergency medical technicians stationed in the communities. This bridges the gap as it relates to transportation and other enrollee barriers.
- Continue to educate PCPs about the ability to utilize physician assistants and nurse practitioners to serve enrollees. The use of mid-level practitioners allows increased access and capacity to specialty care by having access to other provider types within the specialist's office.
- Continue to collaborate with community-based organizations in rural areas to improve enrollee accessibility to needed services, including general screening or access to specialty providers.
- Increase provider participation in our financial incentives program, which offers enhanced payment for those offering after-hours and weekend care.

Aetna has established a cross-functional team that meets weekly to address contracting opportunities. As a part of this weekly meeting, we review network access, enrollee grievances or appeals regarding network access (if any), single-case agreement requests, and recruitment opportunities and needs. Additionally, the director of provider contracting hosts a quarterly contracting strategy meeting with the executive leadership of the health plan to review the statewide network for any access issues, cost-effectiveness, VBP opportunities, and overall network health.

h. Response to Termination or Loss of Large Provider Group or Health System

Aetna maintains policies and procedures that outline how we would respond to the termination or loss of a large provider group or health system, which address the notification process for the Department and enrollees, identification of transition actives and methods to ensure continuity of care, processes, and tools to analyze the impact to network adequacy and access, and strategies for addressing identified deficiencies.

h.i. Notification to the Department and Enrollees

In the event of a provider termination we will notify the Department via email within three business days of the termination. Our process for notifying the Department of provider contract terminations meets the requirements of **Attachment C Section 28.10**, and will contain the following:

- The reason and a brief description of the provider's actions and/or applicable information leading to termination
- The provider's National Provider Identifier, Medicaid ID, entity name, and provider type (two-digit)
- The provider's complete mailing address
- Assurances of how we will maintain network adequacy and access to care despite the provider termination
- Aetna's plan to make sure enrollees are transitioned in a manner that ensures continuity of care

The written notice to the provider includes the reason for Aetna's decision; the effective date of termination; the provider's right to appeal the decision; and how to request an appeal. The focus of our processes, monitoring, reporting, and communication is to make certain covered and medically imperative services are available to enrollees. As a part of our termination process, we conduct provider surveys, which are used to help inform our provider retention and recruitment strategies. As required, we will obtain prior approval of the survey tool from the Department and will provide survey results upon request.

Notifying Enrollees of Provider Terminations to Minimize Negative Impact

Aetna's processes and policies make certain enrollees are notified in a timely manner and the enrollee has continued access to covered services in the event a provider is terminated. Our Provider Services team coordinates with Enrollee Services staff to start the process of enrollee notifications and maintain continual care for enrollees impacted by the termination of a provider. For terminations involving PCPs, enrollees who have received a service from the terminating provider within the previous six months will have a written notice sent within 15 days from the date a termination notice is sent to the PCP, or from the date Aetna receives notice from the PCP of non-participation in the network. For all other providers, we will send the enroll notices within 30 days of the termination. As applicable, the notice will include the following:

- If the provider was a PCP, information about selecting or being auto-assigned to a new PCP and how we will assist the enrollee to transition care to the newly assigned PCP
- If the provider was a specialist, information about how we will assist the enrollee to transition care to another specialist

In the event that a provider is terminated immediately or without notice from our network, our Enrollee Services and Provider Services teams convene to outreach to affected enrollees within 24 hours of the

event, finding alternative care, and rescheduling appointments as necessary. The Network team assesses the effect of this provider's loss on network adequacy and address any issues that result.

Our enrollee transition process includes a coordinated, cross-departmental response by daily or weekly status reports and updates provided to our leadership through our daily health plan leadership meeting. The transition plan would include the following:

- Identifying affected enrollees through data and reports from Care Management and Utilization Management
- Identifying priority enrollees, such as those in currently in an inpatient setting, scheduled to have surgery, in the middle of care (e.g., pregnant, receiving chemotherapy), or with complex medical needs, to ensure individual care plans are developed or updated as appropriate
- Providing enrollees with notice and assigning care managers to do targeted outreach to enrollees and make sure we understand continuity of care needs
- Reviewing Quest Analytics reports to determine geographic impact and implement targeted strategies to identify and contract with other providers, including the use of single case agreements, and the use of telehealth as necessary to maintain compliance with network adequacy standards
- Initiate a clear communication protocol between Care Management and Provider Services to make information regarding identified network needs through targeted enrollee outreach and individual care plans, and network development activities occur in real time to respond to identified enrollee needs.

h.ii. Transition Activities and Methods for Ensuring Continuity of Care

Aetna allows an enrollee to continue an ongoing course of treatment with the provider/practitioner for up to 90 calendar days from the date of our enrollee Notification Provider Termination letter. Aetna's definition of 'ongoing course' is defined as an enrollee receiving treatment from a practitioner during the previous 12 months for a condition that requires follow-up care or additional treatment, or the services have been prior authorized, such as in the case of an enrollee who is pregnant and in her second or third trimester. Maternity services can continue with the provider/practitioner who is being terminated through the completion of the enrollee's postpartum care. Enrollee choice, including the ability to select a PCP, is our principal goal, especially when transitioning care. When a provider is terminated, enrollees receive information and assistance to make a PCP change. Aetna's Enrollee Services staff and Care Management team are available to assist enrollees in selecting a new PCP.

If an enrollee is receiving an active course of treatment or care at the time, we terminate a provider's participation in the network. We may arrange for the continuity of care through the current active treatment period with the same provider as long as there is not a quality of care or licensure or credentialing issue, regardless of the provider's network status. The extension will continue until care has been fully transferred to a treating provider who has agreed to assume responsibility for the enrollee's care for the remainder of that episode and subsequent follow-up care. We realize the importance of communicating with enrollees quickly and with the appropriate supporting steps to facilitate continual care for those impacted by a provider termination; therefore, our timely and effective communication is critical.

In the event that a provider is terminated immediately or without notice from our network, our Enrollee Services and Provider Services teams convene to outreach to affected enrollees within 24 hours of the event, finding alternative care, and rescheduling appointments as necessary. The Network team assesses the effect of this provider's loss on network adequacy and address any issues that result.

h.iii. Assessing Impacting to Network Adequacy and Identifying Deficiencies

In the event of an unscheduled provider termination, we use the following tools to assess network adequacy, including:

- Enrollee density analysis
- Network Quest Analytics analysis

- Provider satisfaction surveys
- Secret shopper surveys
- Utilization data analytics

Our leadership and local provider services representatives have established strong relationships with our providers. As a result, we know if our providers are encountering barriers or challenges that may impact their continued participation in our network and proactively work with the providers to avoid terminations. We would simultaneously review Quest Analytics reports and other data to assess the impact should a provider be terminated or leave the network and develop a plan to address any identified network gaps.

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60.7.C.19 Provider Payment Provisions

Kentucky | Transforming Health Care | **Aetna**

60.7.C.19 Provider Payment Provisions (Section 29 Provider Payment Provisions)

Aetna understands and will comply with all the requirements in **Section 29 Provider Payment Provisions of the Draft Medicaid Managed Care Contract and Appendices.**

a. Aetna's Claims Adjudication Process and Capabilities to Maintain High Standards in Claims Processing

Aetna has developed state-of-the-art claims processing procedures from serving enrollees for more than 30 years. We process and reimburse providers' claims in accordance with the Department's prompt payment standards. Timely and accurate payments reduce provider abrasion and increases provider satisfaction. Aetna is proficient in handling large numbers of claims through continual monitoring to meet and exceed various Commonwealth requirements. For example, in 2019 our total Medicaid claims processed were 54.1 million. For Kentucky specifically, the total Medicaid claims processed was 5.2 million with a 94.5 percent auto-adjudication rate. **Our average days to payment was 7 in 2019.** **Figure C.19-1** shows the flow of claims from receipt to payment in three phases: origination, adjudication, and post-adjudication.

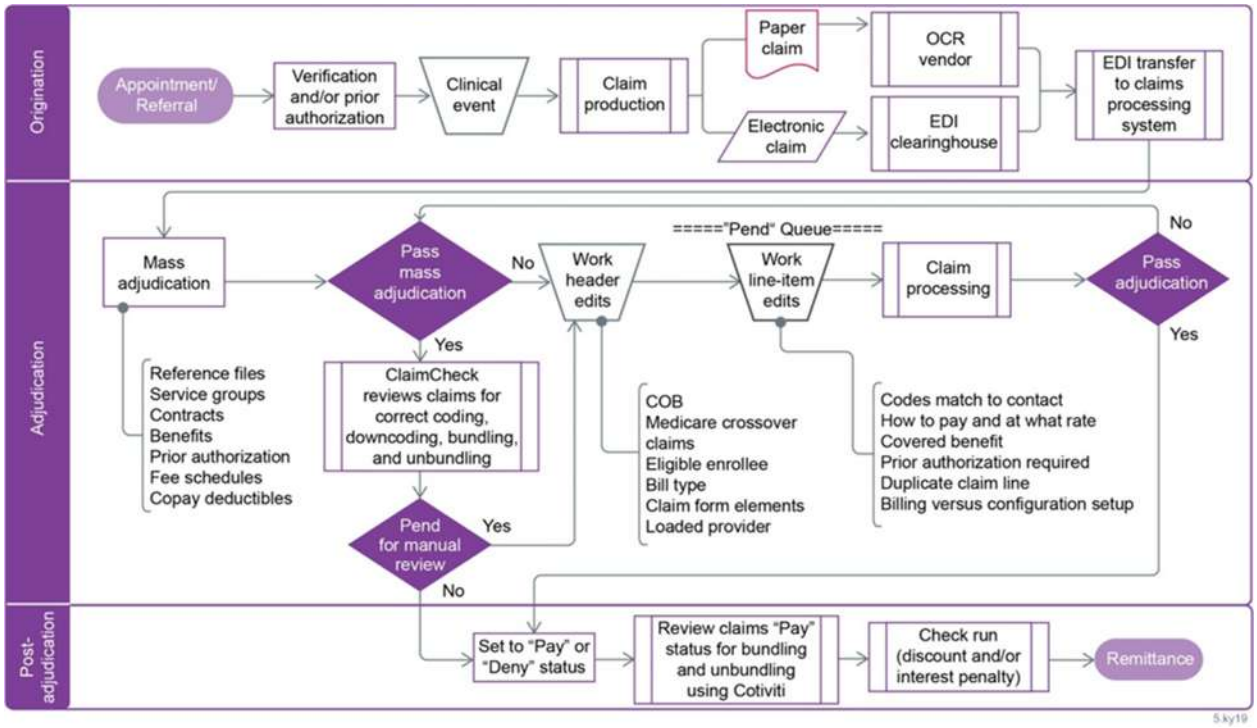

Figure C.19-1: Life of a Claim

Our end-to-end claims processing workflow ensures timely and accurate payment.

Through transparent communication, responsible stewardship, and collaboration with the Department, we have continuously improved our systems to be in alignment with the Department's requirements. Our claims processing system is highly customizable and flexible, which has allowed us to configure our systems in accordance with Kentucky fee schedules, covered services, and provider manual requirements as well as respond quickly to the needs of the Department when off-cycle updates occur in health plan advisories, information bulletins, and ad hoc requests.

We are committed to continuously meeting and exceeding the Department's targets for timeliness of the claims adjudication and payment process. The following narrative outlines our adjudication process and

claims processing capabilities, as well as the methodology we use to help ensure our accuracy and improve our payment standards and performance measures.

Claim Origination and Adjudication

We understand the needs of our providers and that not all provider practices are the same. Therefore, while we strongly encourage our providers to electronically file their claims, we accept claims submitted in both electronic and paper form. We also offer our providers multiple clearinghouses for electronic claim submission, which provides a broad range of submission options. Provider education and training on general claims submission and requirements (e.g., encounter submission requirements, Electronic Data Interface [EDI] claims, Medicaid ID registration, etc.) are easily accessed through the provider portal on our website and through our local Provider Services team. **Currently, our average EDI submission rate for 2019 is 96.3 percent.**

Aetna's 2019 EDI submission rate was 96.3%.

When reimbursing medical and pharmacy provider claims, Aetna follows the requirements stated in 42 C.F.R. 447.46, and the timely claims payment requirements of 42 C.F.R. 447.45 unless the Department issues other specific requirements. When receiving, transmitting, and processing data, we use ASC X12 standards, complying with reporting requirements and capacity standards that expand as needed to accommodate enrollment or program changes.

Aetna's 12-month rolling turnaround time for claims processing was **98.14% within 30 days.**

Our provider and subcontractor payment process is automated so that it adheres to all Commonwealth and federal prompt pay guidelines. If a claim is paid beyond those guidelines, applicable interest is automatically calculated and paid. Additionally, monthly prompt pay reporting is provided by Aetna to the Department to demonstrate compliance with Commonwealth requirements. Through feedback and surveys, we monitor satisfaction with our claims process. To avoid any increase in administration costs and to avoid provider burden through incorrect claim payment or inappropriate claim denial, we bring a best-in-class claims payment and process that minimizes incorrect payments or inappropriate denials. Aetna confirms that our claims processing and management information system meets and will continue to meet the Medicaid managed care requirements, and we will maintain compliance throughout the term of the new contract. This will be accomplished through our compliant, rules-based information processing system.

Our claims adjudication system is a Health Insurance Portability and Accountability Act (HIPAA)-compliant, rules-based information processing system. It includes 28 integrated modules that maintain and process health care administration data, allowing us to increase administrative efficiency and improve the quality of care. The system is a claims hierarchical rules engine that was built with a feature-flagging design (rules for claims processing with a minimum disruption of services) that allows us to rapidly adjust the configuration to provide flexibility while minimizing down time and providing greater platform responsiveness. Kentucky claims import rules have been programmed and the application is built to ease turning rules and configuration characteristics on and off as needed without affecting the entire system, further ensuring service continuity.

The enrollment management system is one of the modules in the larger claims adjudication system. Enrollment files are received, processed, tracked, and stored here. Updates with information received both from the Commonwealth and directly from the enrollee are incorporated in the enrollment files. Once Aetna receives the 834 files, the enrollee records are compared to the existing data within our electronic claims management system. Each enrollee record is fed through our highly configurable rules processor, which identifies, matches, consolidates, and updates the enrollee information to ensure proper updates to demographic, enrollment benefit plan assignments, primary care provider assignments, enrollee

classifications, and other critical information. This system allows Aetna to monitor enrollment and identify enrollees requiring immediate services and/or service coordination and identify opportunities to engage new enrollees and maintain continuity of care.

Aetna has processes to accurately and timely load new provider contracts, provider demographic information, changes in provider contract terms, updated prior authorization requirements, and changes to the provider directory into our claims adjudication system in accordance with all requisite timelines. We load the Kentucky provider files daily. Provider data validation happens immediately upon submission to confirm the provider is enrolled in the Kentucky Medicaid program in support of the Department's program integrity requirements. If the provider is not enrolled, the claim is then denied and returned to the provider advising the reason for the denial. These actions ensure accurate claim payment and encounter submissions.

Claim adjudication edits are configured within the claims processing system to validate the accuracy and completeness of data allowing for the seamless submission of encounters. The system has over 400 business rules in addition to standard configuration payment rules that our Configuration Standards Reimbursement Administration department configures to enforce policies and procedures. Examples include the following:

- **Benefits package variations:** The system automatically analyzes Current Procedural Terminology (CPT), revenue, and Healthcare Common Procedure Coding System (HCPCS) codes to determine whether specific services are covered under the contract or under benefit rules. If services are not covered, the system automatically denies the respective claim line with the appropriate HIPAA remittance remark on the recipient explanation of medical benefits.
- **Data accuracy:** The system is continually updated based on the most current code sets available (HCPCS, revenue, CPT, national drug code, ICD codes) by year. As new codes are added, terminated, or changed, we update the codes so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, the system denies the claim line and advises the provider the code is invalid via remittance advice.
- **Adherence to prior authorization requirements:** The system is configured to enforce the supporting documentation requirements of certain services. In addition, it can configure prior authorization by code, provider type, and place of service. Claim edit rules are set to validate the claim against the network provider, enrollee, dates of service, services rendered, and units authorized.
- **Adherence to Commonwealth-specific requirements:** The system is configured to enforce the rules and requirements set forth by the Commonwealth of Kentucky such as timely filing and procedure code validity.
- **Provider qualifications:** Provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, the system will not permit the processing of a claim for in-office heart surgery by a podiatrist. Cotiviti Healthcare (Cotiviti), an industry leader for front-end automation of correct-coding and medical-policy decisions, lends additional support, reviewing any claim line set to 'Pay' for billing appropriateness by specialty. The system checks other providers' specific items, verifying, for example, that each provider has obtained the requisite national provider identifier or its equivalent, has included the identifier on all claims submissions, is registered with the Commonwealth with a valid Medicaid identification, and is an active provider for the date of service.
- **Eligibility and enrollment:** The system validates the date of service against the enrollee's enrollment segment to determine if they were eligible on that date. If not, the system denies the claim using the appropriate HIPAA-approved remittance comment.

- **Duplicate billing logic:** The system uses a robust set of edits to determine duplication of services (e.g., same enrollee, same date, same network provider, same service, or any combination of these criteria). This logic protects against payment for services rendered by the same physician.

Other claims processing edits and tools used to maximize accuracy throughout the adjudication process include ClaimCheck® edits. ClaimCheck is a comprehensive code auditing solution based on guidelines such as CPT, HCPCS, American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), CMS National Correct Coding Initiative Program (NCCI)/Medically Unlikely Edits (MUE), CMD NCCI/MUE, and ICD-10-CM. These guidelines support the claims processing system by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy and consistency with relevant policies and procedures. Our ClaimCheck clinical editing software identifies coding errors in the categories, including procedure unbundling, mutually exclusive procedures, incidental procedures, medical visits/same date of service, bilateral and duplicate procedures, pre- and post-operative care, assistant surgeon, modifier auditing, and medically unlikely services. Aetna also uses integrated claims management services, powered by Cotiviti, to enhance the claim processing system's edit functionality for professional claims that reach an adjudicated status of 'Pay.' Cotiviti has robust coding rule sets that support Medicare NCCI/MUE, Medicaid NCCI/MUE, ICD-10 CM, NCCI IOM Manuals, AMA, HCPCS, and national and local coverage determinations as well as health plan policies. The system uses algorithms to detect potential claims upcoding with follow-up procedures for chart audits as appropriate. **Table C.19-1** includes examples.

Table C.19-1: Claim Processing System's Edit Functionality

System Capabilities	Description
Coding accuracy	If services are up-coded or unbundled, Cotiviti alerts the Claims department to deny the claim line along with the specific clinical editing policy justification. The claim line denies with the appropriate HIPAA remittance remark on the recipient of medical benefit.
Durable medical equipment (DME) editing	Cotiviti performs edits related to select DME payment policies that align with Medicaid covered service policies. These edits include DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps, and anatomic/functional modifiers required for DME services.
Procedure code guidelines	Aetna follows the AMA CPT-4 book and CMS HCPCS book for instructions on code usage. Cotiviti has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, we deny the code as inappropriate based on industry standards. According to the AMA CPT book, this vaccination must be reported in addition to the vaccine and toxoid code(s).

Cotiviti supports correct coding based on the definition or nature of a procedure code/combination of procedure codes. The ability to code in this manner supports prior authorization requirements during claim adjudication. Furthermore, these editing policies either bundle or recode procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, Cotiviti applies editing logic that bundles all the procedures billed into the most appropriate code. If a provider bills an office visit and bills separately for heart monitoring with a stethoscope at the same visit, Cotiviti re-bundles the service into the appropriate evaluation and management or office code. Using the edits and tools described in this section, we deny, completely or in part, claims with missing or invalid information. Providers and subcontractors are required to resubmit the claim with valid information to receive payment. We configure our claim system to align with the Department for Medicaid Services coverage and payment policies. When we deny claims at submission, configuration is added to align with their guidelines as well. In such instances, we require providers or subcontractors to resubmit the claim with valid information to receive payment.

b. Aetna and Our Partners' Ability and Capability to Support Claims Processing

We currently participate in 16 states providing services comparable in complexity to Kentucky. By leveraging our Medicaid experience, we have created and judiciously amended our time-tested processes, policies, and procedures used to process all claims submitted. These processes illustrate our best practices and allow us to easily meet or exceed our Commonwealth requirements. Our claims' best practices support our collaborative spirit with our providers and Commonwealth partners while helping drive the statewide mission to create a healthier Kentucky and improve the delivery of health and family services through quality customer service.

CaremarkPCS Health has been Aetna's pharmacy material subcontractor since 2010 and has been servicing our Kentucky health plan since 2016. They processed more than 47 million claims for the Aetna Medicaid organization in 2019. CaremarkPCS Health provides prior authorization services, utilization review, and pharmacy benefits management, as well as other key services: arranging for the provision of pharmacy services, pharmacy network, customer service, participant outreach, pharmacy claims processing, quality improvement, medication therapy management, reporting, auditing and investigations for fraud, waste, and abuse, assistance with encounter submissions, and mail-order pharmacy.

Avēsis, our dental and vision provider, has been providing benefits nationally since 1978 and consistently achieves high standards for quality and efficiency. Over the last three years, they have processed an average of 300,000 claims each month with an average turnaround of four days. **In 2019, they paid 100 percent of clean claims within 30 days.** Provider payments are processed weekly in compliance with federal and Commonwealth laws, and regulations. More than 90 percent of all claims processed by Avēsis are submitted electronically, either through automated batch imports sent by providers and clearinghouses or through their secure web portal. Web portal and 837 electronic claims are validated through front-end business and HIPAA validation edits.

Aetna, CaremarkPCS Health, and Avēsis all use highly configurable claims modules to adjudicate claims and process provider payments. Hundreds of system edits, fee tables, benefit plans, codes, policy criteria, and business rules are set to automate claims adjudication to our specifications (i.e., our contracted rates and approved benefits designs) and all county, Commonwealth, and federal requirements. Claims rules are updated every time there is a code update and they review our system settings at least annually to ensure alignment with the Kentucky Medicaid plan design.

b.i. Policies and Procedures to Meet Performance Standards and Prompt Pay Requirements for all Provider Types

Our claims policies and procedures (P&Ps) are crucial to meeting or exceeding our accuracy, timeliness, and completeness to fulfill the Department's requirements and changing needs. These P&Ps include claims submissions, data entry, claims manual adjudication, processing of non-contracted provider claims, and claims inventory management; all are designed to meet prompt payment requirements. Aetna Medicaid Administrators LLC policies are reviewed at least annually (within 12 calendar months of last reviewed/revised date). Policies may be updated more frequently if there are changes to the contract, federal, Commonwealth, or other regulatory requirements, or Aetna business processes. All policy updates are reviewed by the Aetna Medicaid Policy Committee and require approval from Aetna Medicaid Administrators, chief operating officer, and chief medical officer prior to being published. Specific policies are as follows:

- **2000.05 Data Entry:** Documents processes used to facilitate timely and accurate data entry of paper claims and non-standard claim forms
- **2000.10 Claims Adjudication:** Documents claims processes to facilitate claim adjudication in a timely and accurate manner, according to Department and health plan standards and federal requirements

- **2000.20 Claims Submission:** The purpose of the claims submission policy is to make sure paper or electronic claims are submitted and accepted into the claims processing system in a timely and accurate manner, according to Department and health plan standards and federal requirements.
- **2000.30 Non-Contracted Provider Claims:** Defines adjudication process for claims from non-contracted providers, either manually or through mass (auto) adjudication in a timely and accurate manner according to CMS regulations, Department, and health plan standards
- **2100.15 Claims Inventory Management:** The Claim Inventory Management policy confirms proper inventory control for timely claims payment

Monitoring Claims Receipts

We use a suite of automated tools and scheduled and ad hoc reports to monitor claim receipts, including the following:

- **Pended claims tool and reports:** Includes all claims that fail auto-adjudication or are suspended for manual review; the claims manager reviews hourly to balance workload. For example, if a claim is with another department, once the claim is pended back to the Claims team; if it is aging, the manager can assign out as soon as it refreshes on the report to ensure the claim is paid timely.
- **Inventory aging report:** A daily inventory report is created for the health plan to help with prioritization. An example is if a claim for a specific provider needs to be addressed, the health plan can review this report and reach out to the claim manager to have a claim pulled and processed.
- **Non-final claims tool and reports:** Identifies claims in any status other than those finalized. An example is the claim manager or a member of the health plan team can review a claim prior to it being finalized and make changes if necessary.
- **Claims performance reporting:** Monitors turnaround time for clean claims and provides a history of performance; for example, the Claim Management team as well as the health plan will use this report to ensure all Commonwealth requirements are being met.

These reports are used to distribute and manage claims through resolution. In the event that any of the inventory management reports indicate a less than favorable trend, corrective action steps are taken immediately. For example, aged claims remediation steps include the use of overtime hours, temporary labor, and workload balancing of trained operational staff across all Claims Operations, and if necessary, all operations. Additionally, any systematic intervention opportunities by Information Technology to enhance claim processing are investigated and executed.

b.ii. Market-specific Strategies to Address Potential Provider Payment Issues

Our claims payment system is configured to Commonwealth-specific requirements and addresses any potential provider payment issues, including underpayments, overpayments, pre- and post-claims editing policies, and provider billing education. Partnering with providers and enhancing the provider experience is a top priority and none more so than the work we do with the Kentucky Hospital Association (KHA). In the following narrative, we discuss our collaboration with the KHA and any potential provider payment issues and how we resolve them.

Underpayments, Overpayments, Pre-and Post-claims Editing Policies and Activities

Underpayment and overpayment recoveries: Our established policies and procedures help ensure that we and our subcontractors follow established benchmarks that help us proactively manage and analyze prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Commonwealth as required by 42 C.F.R. 447.46 and 42 C.F.R. 447.45. Additionally, all recovery of overpayments and underpayments will be administered in accordance with Kentucky revised statutes 304.17A. We coordinate over- or underpayment reimbursement with the Department to ensure payment recovery is accurately reflected in medical loss ratio calculations and capitation rate setting. Our specific encounter P&Ps help ensure compliance with Kentucky requirements

and include claims submissions, data entry, claims manual adjudication, processing of non-contracted provider claims, and claims inventory management.

Monitoring Trends in Claims Payments

Aetna has several teams and committees that monitor trends in claims payment from different angles to ensure we identify and resolve claims processing issues quickly. For example, we hold a daily operations meeting that involves our Network Operations leadership, Provider Relations representatives, Claims, Configuration, and Encounters team members. This daily meeting focuses on escalated items, configuration and claims projects, and is an opportunity for our team to discuss and solve for observations and provider and state feedback that may indicate an upcoming issue with provider payments. Further, our Finance and Actuary teams meet every other week to review payment patterns and discuss any large claims projects whether over or underpayments. Pended claims are reviewed daily by the Network Operations team to ensure that the providers are set up properly in our system for payment purposes. Claims inventory is reviewed weekly to ensure that claims, whether resubmitted or original, are processed in compliance with our contract. All of these proactive measures ensure providers receive timely and correct payment from Aetna.

Pre-and post-editing policies: Aetna collaborates with industry leaders, Change Healthcare and Cotiviti Healthcare, for front-end automation of correct-coding and medical-policy decisions. This also supports the detection of coding irregularities, conflicts, or errors while making recommendations for correction. Our claims platform and these vendors perform edits on all claims for the following:

- Enrollee data (e.g., age, gender) and provider data
- Current coding protocol, including national correct coding initiative code-to-code pairs, validation of diagnosis (International Classification of Diseases 9/10), CPT-4, health care common procedure coding system I/II, revenue codes, modifiers, procedure code definition and guidelines, multiple-procedure reductions, add-on logic based on CPT guidelines, procedure unbundling, mutually exclusive procedures, assistant surgeon, place of service, type of bill, medical visit logic, medical unlikeliness, durable medical equipment, new-visit frequency, professional, technical, and global services

These edits use historical claims information to detect and correct questionable billing practices and to assist in identifying patterns of fraud, waste, and abuse concerns such as duplicate billing. In the future, Aetna will collaborate with Cotiviti Healthcare to conduct post-pay reviews for all claims using data mining analytics plus validation of diagnosis-related group accuracy. Cotiviti performs a clinical chart review if improper billing or potential fraud, waste, and abuse is identified and contacts the provider for adjustment or recoupment as needed.

Partnering with the Kentucky Hospital Association

While our relationship with all Kentucky providers is a priority, we understand the significance of our hospital systems in both the urban and rural areas. As **Figure C.19-2** shows, we have made great strides over the last two years reducing our outstanding issues. Our whole team has worked hard the last 18 months to be a loyal, dedicated partner to the Commonwealth, our enrollees, and providers. We are mindful that Aetna helps drive the Commonwealth's mission to create a healthier Kentucky. Our deep, ongoing collaboration with the Kentucky Hospital Association has allowed us to reduce our issues on the hospital association's log by 90 percent. We achieved this by listening to all Kentucky providers and changed from Milliman Care Guidelines medical necessity criteria to InterQual; ended our pre-payment $50 emergency fee and Equian audits; supported efforts related to last Session's House Bill 69 (centralized credentialing at the Department); relaxed numerous prior authorization codes to reduce administrative burdens; and entered into several value-based contracting arrangements in true partnership with providers to continue to move the needle in a positive direction related to enrollee outcomes. **We**

recently completed a delegated credentialing agreement with KHA, and they will soon begin collaborating with us as a subcontractor.

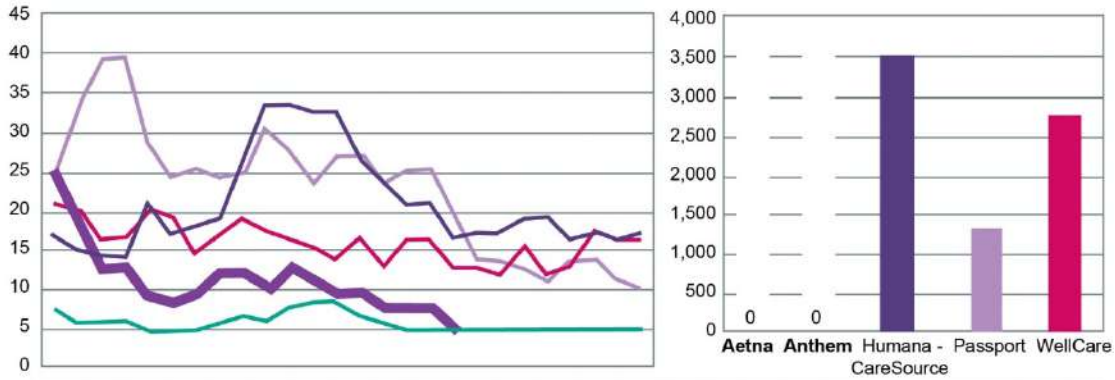

	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	Mar '19	Apr '19	May '19	Jun '19	Jul '19	Aug '19	Sept '19	Oct '19	Nov '19	Dec '19
Aetna	23	16	9	9	5	4	5	8	8	6	9	7	5	5	3	3	3	–	–	–	–	–	–	–	–	–
Anthem	3	1	1	1	–	–	–	1	2	1	3	4	4	2	1	–	–	–	–	–	–	–	–	–	–	–
Humana – CareSource	14	12	11	11	18	14	15	16	23	32	32	31	31	25	21	18	18	13	14	14	16	16	13	14	13	14
Passport	23	33	39	39	27	22	23	22	23	29	26	21	25	25	21	23	23	17	10	10	9	7	10	10	7	6
WellCare	18	17	13	13	17	16	11	13	16	14	13	12	10	13	9	13	13	9	9	8	12	8	9	14	13	13

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Figure C.19-2: Kentucky Hospital Association Issues Log

This graphic depicts our dedication to listening to our provider partners and reducing issues.

Provider Billing Education

The Provider Services team implements innovative approaches using technology and reporting to provide targeted training to our provider community and improve the provider experience. The Provider Services team uses on-demand reporting and analytics to help identify trends specific to claims denials, coding errors, and gaps in care reporting by enrollee panel. Often this analysis results in the identification of opportunities to educate providers and the need for technical assistance to address and remedy claims denials/errors. In some cases, we initiate provider-specific claims projects to remediate claims errors quickly, which facilitate timely claims payment for the provider. Risk adjustment training includes defining risk adjustment; its goals, risk scores, how they are calculated, and their impact on revenue; and how coding and encounter reporting are critical components of risk adjustment. Aetna also reacts to trends in claims denials.

We also use this information as source data for newsletters, news bulletins (provider website/portals), and education opportunities during our quarterly lunch and learn sessions. For example, in Kentucky, we recently distributed an update to our provider community, alerting them of billing attestation trends along with helpful tips on how best to prevent delays and denials. For ongoing provider training and technical assistance, we use webinars for our monthly provider meetings. We also host lunch-and-learn sessions where we invite guest speakers to present on best practices, system initiatives, and other topics relevant to serving Kentucky enrollees. For example, in Kentucky, we issue a provider Quick Tip for clinical claims editing applications that follow the NCCI, AMA, and CMS guidelines. These edits are designed to evaluate the appropriate billing information and CPT coding accuracy on procedures submitted for reimbursement. The major areas reviewed as part of claim editing include the following:

- CPT unbundling
- Incidental procedures
- Mutually exclusive procedures

- Duplicate procedures

Providers are also furnished with toll-free numbers to contact our Provider Services or Claims Inquiry and Research call centers; they have a direct number to reach their designated provider services representative. They may also use email, secured web portal, fax, or mail.

b.iii. Aetna's Average Days to Payment from Claims Submission for Claims Platform

We are committed to continuing to meet and exceed the Department's goals for claims submission and adjudication to payment timeliness. We accomplish this through focused claims inventory and workflow management practices, data monitoring and analysis, and management oversight. **Table C.19-2** shows that in 2019, our average turnaround time from receipt to payment is 7.2 days.

Table C.19-2: Average Days to Payment

Months to Date—2019	Average Days to Payment	Months to Date—2019	Average Days to Payment	Months to Date—2019	Average Days to Payment
January	8	May	7	September	7
February	7	June	7	October	6
March	7	July	11	November	6
April	7	August	7	December	7

Medical Claims

Aetna understands the Department's requirement to process 90 percent of medical clean claims within 30 calendar days and all medical claims within 90 calendar days. In support of these requirements, we generate two payment cycles weekly for medical claim payments. **Table C.19-3** and **Table C.19-4** list our consistently high-performance data from 2019 year-to-date and 2018.

Table C.19-3: Medical Claims Performance

Medical Claims Performance	Aetna Kentucky Performance-2019	Aetna Kentucky Performance-2018
90% in 30 days	2019: 98.14%	2018: 98.12%
100% in 90 days	2019: 99.97%	2018: 99.92%

Pharmacy Claims

Pharmacy claims are processed as a real time point-of-service transaction. The data below lists 2019 year-to-date and 2018 performance:

Table C.19-4: Pharmacy Claims Performance

Pharmacy Claims Performance	Aetna Kentucky Performance-2019	Aetna Kentucky Performance-2018
100% in 14 days	2019: 100%	2018: 100%

Adjustments

When an issue occurs or a provider submits an adjustment to a previously adjudicated claim, we will adjudicate the adjusted claim applying the same timeframe standards as required for the initial clean claim. Our Claims department investigates and corrects the claim payment, either prior to the initial payment or post-payment. Once the claim has been adjudicated, we provide an electronic remittance advice or standard remittance advice to the provider to explain the results and reimbursement of each claim. **Mass adjustment:** Our claim processing system allows for mass adjustments based on provider

types, claims types, dates of services, paid dates, and other data elements. If a mass adjustment is required or a systemic solution beyond the immediate actions of the Claims department is needed, an interim solution permitting claims payment is implemented whenever possible until the systemic issue is resolved.

c. Aetna's Methodology for Ensuring Claims Payment Accuracy Standards is Monitored and Audited

We use our audits to monitor and improve claims payment accuracy standards and ensure accuracy of our claims payments standards through our National Quality Assessment program, which is designed to identify errors and policies and processes that contribute to inappropriate claim payments from a constituent focus. The application of the quality assessment program identifies quality improvement, trending, and training opportunities. This means regardless of the functional area responsible for the root cause of the claim error, errors are charged if the claim is incorrect from an enrollee, plan sponsor, provider, or government entity perspective.

Claim quality analysts report directly to Claim Quality Operations. Claim quality analysts are solely responsible for the administration of the Claim Quality Assessment program. Claim Quality Operations is the official source for all measurement data for internal management and customer reporting. The quality assessment review is based upon the processed date of the claim.

Our Sampling Methodology

We have a process to pull and sample claims on a regular basis to ensure that claims are adjudicated and paid appropriately. The data from the scheduled pull, which is a 2 percent random claim selection volume, is based on the individual analyst's prior day's production with an overall outcome of 2 percent by the end of the audit cycle month and all adjudicated claims below $50,000 bill amount. The high-dollar claims pull is always 100 percent of eligible claims on a pre-pay audit basis, which is $50,000 and greater billed amount and $30,000 paid amounts and greater. The scheduled pull for auto adjudication is 0.15 percent of the random claim volumes based upon the prior day's production with an overall outcome of 0.15 percent of the monthly production by the end of the audit cycle month. The audit cycles run from the first of each month through the last day of that month, and final results are published and distributed to the Medicaid business unit by the fifth day of the next month.

Our administrative guidelines include both high-dollar, auto-adjudicated, and random audit reviews:

- High-dollar audit review:
  - The high-dollar audit review program is a financial-only accuracy review
  - Claims to be audited are those exceeding $50,000; each claim selected for audit will be reviewed for payment dollar accuracy, pay incidence, and overall accuracy
  - Coding and statistical information is reviewed when it directly impacts financial accuracy
- Auto-adjudicated audit review:
  - Validation of claim payment and/or denial accuracy is based on root cause analysis aligned with SOX key controls
  - Validation of benefit and contract build is completed
  - Results are bucketed as procedural or systematic
- Random audit review:
  - Anyone who processes a claim or claims is subject to audit and is included in official office results
  - The reporting cycle runs from the 1st through the end of each month
  - Claim selection criteria can differ from individual to individual with consideration of their total number of claims processed. This is to ensure that one percent of all production is randomly audited.

Our Process for Auditing the Sample

Our process for auditing the sample includes selected claims are pulled randomly from our claims data source and provided to the Claims Quality team. These selected claims are placed into the audit application daily. The samples are auto-populated into the quality analysts queues daily and includes high-dollar prepay, auto-adjudicated claims, and the random two percent manually processed claim samples. All audits include provider, contract, benefit, and claim validations. Our claims audits include the following:

- **Planning:** Conducts routine and ad hoc audits based on timelines and business needs
- **Data gathering:** Extracts claim data from the adjudication system using sampling methodology
- **Verification:** Accesses and verifies data against the required attributes of the Department
- **Completion:** Evaluates audit results and identifies issues
- **Reporting:** Documents results and issues reports to operational departments

Selected claims are pulled randomly from our claims data source and provided to the Claims Quality team. Daily audits include claims with the following statuses: pay, deny, paid, denied.

Documenting Results

Each monthly audit confirms that claims processing met or exceeded outcomes. It includes any key departmental issues identified in addition to a summary of financial and procedural accuracy. We finalize, publish, and distribute both monthly and quarterly audit results to the business units. This includes reports that identify trends by error type, claim ID, and analyst ID to the business units. The reports also identify system configuration accuracy and efficiency. This data enables the Claim Operations department to conduct continuous quality improvement initiatives. All audit documentation, including the audit source information, audit files, and related communications are retained. Results are highlighted in **Table C.19.5.**

Table C.19-5: Kentucky Quality Performance

Kentucky Quality Performance	Payment	Procedure	Financial
Performance—2019 (through November)	98.89%	98.95%	99.20%
Performance—2018	98.61%	98.36%	99.42%

Activities Conducted to Implement Changes or Required Corrective Actions

All results and audit files are shared with the respective business units. Results are posted and retained in an internal tracking database for future reference. Based on audit findings, management staff provides feedback and coaching to individual analysts. If required, training materials and desktop procedures are updated and reviewed with all processing staff. To ensure the areas of concern are resolved, focused audits are conducted, and the results are reviewed with the analyst. One-on-one refresher training is provided if issues are identified through the focused audit.

When provider issues are identified, they are discussed with members of the Appeal and Grievance Committee during weekly meetings. Based on the issues involved, Provider Services staff will provide assistance to the providers to eliminate the issues and reduce administrative burdens.

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60.7.C.20 Covered Services

Kentucky | Transforming Health Care | **Aetna**

60.7.C.20 Covered Services (Section 30 Covered Services)

Aetna has over 30 years of experience caring for the Medicaid population and our organization is currently providing Medicaid services in Kentucky and 15 additional states. We support Kentucky's goals to promote individual self-sufficiency and community sustainability for the betterment of the vulnerable population by building on the existing infrastructure for the delivery of covered Medicaid services as well as non-covered services that meet enrollees' whole-person needs. Our approach is local, devoted to our enrollees, and focuses on individuals' holistic health needs by providing access to and delivery of cost-effective health care services. Aetna is a quality leader with a **Commendable** rating from the National Committee for Quality Assurance (NCQA) Additionally, we tied for a top NCQA score overall.

a. Structure and Practices to Support Integrated Delivery of Services

Aetna offers the comprehensive array of covered services outlined in **Appendix H of the Request for Proposal** in an integrated, whole-person manner to enrollees throughout Kentucky through our staffing structure, contractors, systems, and call center operations.

Staff: Aetna has a clearly defined staffing model designed to serve our enrollees in a manner that integrates their physical health (PH), behavioral health (BH), functional, and social determinant needs, in support of the statewide mission of achieving a healthier Kentucky. Aetna's Integrated Health team is a multidisciplinary group of interdepartmental staff from Care Management, Utilization Management, Community Outreach, Population Health Management, Pharmacy, etc., that specializes in supporting enrollees to receive integrated, holistic health care. The Integrated Health team consists of staff with a variety of backgrounds and credentials, including expertise in physical health (e.g., physicians and registered nurses), behavioral health (e.g., licensed counselors and social workers), and social needs (e.g., community health workers). As an enrollee enters into any level of care at any point, the members of the Integrated Health team know how to coordinate with the right person at the health plan to help address the enrollee's holistic needs. The Integrated Health team actively reviews a broad range of data including claims, utilization reports, outcomes data, and gaps in care reports to name a few, to identify ways in which they can support enrollees' whole-person health. Once a need for supporting an enrollee is identified, the Integrated Health team coordinates with and supports the enrollee's identified interdisciplinary care team (ICT), with the care manager acting as the enrollee's single point of contact. The ICT is comprised of the enrollee, their care manager, primary care provider (PCP), their circle of supports, other health care providers, and representative from other agencies, as chosen to participate by the enrollee. While the Integrated Health team operates as a unit, specialty subgroups also convene to address the needs of enrollees in priority populations for which Aetna operates programs, such high-risk pregnant women. To support each other and the ICTs, the members of the Integrated Health team consult with each

Integrated Care Management Case Rounds

One hundred percent of our integrated care management (ICM) case rounds are multidisciplinary, including review of the integrated behavioral health, physical health, functional, and social determinant needs of enrollees. This step enables us to collaborate effectively with providers, enrollees, and guardians to meet the holistic needs of the enrollee and to make appropriate referrals. Our integrated system of care uses interdisciplinary care teams to meet all levels of care management and care coordination needs of our enrollees. The teams are composed of the enrollee, their circle of support, their PCP and other providers, including specialists and behavioral health providers, and representatives from community-based agencies and non-traditional providers that specialize in addressing their functional and social determinant needs, such as housing, nutrition, and safety.

for subject matter expertise, as need arises. For example, if an enrollee with a primary diagnosis of diabetes is newly diagnosed with hepatitis-C as well, the care management representative on the Integrated Health team would seek assistance from a Pharmacy team member and a medical director on the team with expertise in medications to support the enrollee. As staffing changes or as Aetna's enrollee total grows, our staffing model is flexible to allow for adding staff to Integrated Health team to meet the needs of our population.

In support of our integrated care delivery model, all Aetna staff are cross-trained to recognize physical health, behavioral health, functional, and social determinant needs of our enrollees and receive training on referral pathways to help address enrollee's whole person needs. Aetna staff receive training in trauma-informed care and Mental Health First Aid, as well in cultural and linguistic competency and Culturally Linguistically Appropriate Services standards, so they can meet enrollees where they are and better understand the context of their lived experience.

Our staffing model is built on the principle of Kentuckians serving Kentuckians, managed by local health plan leaders. The cornerstone of our staffing plan is highly experienced leadership with extensive local, program-specific knowledge. With more than 15 years of health care experience, the last two of which leading Aetna Better Health of Kentucky, Chief Executive Officer Jonathan Copley (a proud fifth-generation Kentuckian) plays a key role in identifying, hiring, and retaining key personnel. Aetna's leadership team includes our Chief Medical Officer Dr. David Hiestand, a long-time Kentuckian who has deep knowledge of the Commonwealth's diversity and the needs of our enrollees. In addition, our staffing model emphasizes with local, boots-on-the-ground care managers, Aetna community health workers (CHWs) and Community Outreach staff, field-based population health specialists, and community-based CHWs and peer support workers. Many of our experienced personnel have tenure dating to 2011 and have developed deep knowledge of the local community and challenges faced by Kentuckians.

Together, Aetna staff from across a wide range of departments make sure our enrollees are engaged in evidence-based programs and receive the most appropriate services timely. Aetna's staffing model results is a reduction in complexity for our enrollees and increased access to high-quality, whole-person health care. **Table C.20-1** shows the specific role in contributing to integrated, whole-person care of a wide range of Aetna departments

Table C.20-1: Aetna Departments and Their Role in Providing Integrated Care to our Enrollees

Department	Role in Providing Integrated, Whole-person Care
Care Management	• Evaluate enrollees for physical, behavioral and social risks to their current and future health • Act as a single point of contact to engage each enrollee in a plan that addresses their critical physical, behavioral, and social needs to promote resiliency, recovery, and optimal self-management • Engage enrollees to complete whole-person screeners and assessments that ask about biopsychosocial needs • Team with the enrollee, their circle of support, and care providers to enhance care outcomes: Care Management staff work as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage enrollees' holistic health needs and challenging relationships with enrollees and their families • Care Management works with other departments to advocate for enrollee needs and provide resource and information to support other departments

Department	Role in Providing Integrated, Whole-person Care
Community Outreach	• Collaborate with community-based organizations to facilitate enrollee and community-wide events to increase health plan awareness and provide benefit education • Develop health literacy programs that promote healthy lifestyles, address social resources needs and barriers, and educate enrollees and community on chronic disease self-management • Seek opportunities for sponsorships that support the mission/goals of our community partners that exist to meet the holistic needs of enrollees • Inform care managers of resources to assist meeting enrollees' social needs, upon request • CHWs meet face-to-face with enrollees, caregivers, providers, community organizations, and other stakeholders to link enrollees to covered and social services to meet their social determinant needs • CHWs offer our enrollees a seamless, one-stop system of integrated services and supports • CHWs enable our enrollees to receive the support they need from staff who are knowledgeable and available to assist them with their specific needs • Community Outreach collaborates by identification of enrollees from events that need additional support; they also identify systemic issues or trends in communities
Utilization Management	• Initiate discharge planning discussions on Day 1 with providers, care managers, and System of Care staff, as appropriate, to ensure that a comprehensive aftercare plan that addresses social determinants of health is developed • Verify that providers/facilities are actively engaging parents/families/supports/legal guardians in the treatment process and planning for aftercare services. • Collaborate with provider/facility Utilization Review staff and offers case shaping and recommendations for clinical interventions • Utilization management (UM) clinical reviews focus on whole-person care and treatment options; UM identifies enrollees that could benefit from additional supports and identify barriers to quality care
System of Care	The System of Care team includes the following members: adult system of care administrator, children's system of care administrator, emergency room/crisis administrator, trauma system of care administrator, and juvenile justice manager: • Consult with Care Management about how to obtain specific services and supports: identifying appropriate resources for which the enrollee is eligible, process for applying for services, trouble-shooting the process, etc. • Collaborate with community agencies, providers, Commonwealth officials, as well as internal teams to ensure coordination of efforts • Consult with community providers and care management providers, including state and local community providers, providing information on physical and mental health and substance abuse programs, resources, and care program referrals • Oversee the development and implementation of community support programs and processes that ensure the needs of our enrollees are met • The System of Care team collaborates with other teams based on individual enrollee need and with others on the identification of global trends or needs
Enrollee Services	• Identify how the enrollee can best be served and resolve the enrollee's needs at the time of the call • Address enrollee needs with cultural sensitivity and attention to their spoken and unspoken needs • Connect enrollees to the services and supports the need, including language and translation services, clinical or behavioral health assistance or pharmacy support, or referral to our social determinant integration network • Enrollee Services is often the first enrollee contact and their staff has the first opportunity to identify enrollee unique circumstances and needs, which they communicate to other departments
Population Health Management	• Understand the Aetna Medicaid organization population in Kentucky, including subpopulations with specific needs, and identify health disparities facing our enrollees • Identify and stratify enrollees into a level of care management that is suited to their needs • Develop programs to address physical health, behavioral health, and social determinants needs of the entire enrollee population and specific subpopulations • Population Health works with Care Management to refer individual enrollees identified and with the health plan to implement services and supports that can benefit the lives of Kentuckians

Department	Role in Providing Integrated, Whole-person Care
Pharmacy	• Pharmacy Medication Management Pharmacist (PMMP) participate in care management case rounds • PMMP conducts medication reconciliation with enrollees and gathers information about whether the enrollee can access their prescriptions, identifying social barriers such as transportation needs, which they communicate to care management • PMMP provides education and consultation to enrollees about their PH and BH medications, and address health literacy gaps that might impact medication adherence • Community Pharmacy Enhanced Services Network (CPESN) pharmacists develop relationships with enrollees and support medication management, unmet social needs identification, and opportunities with engagement integrated care management • Collaborate with Care Management on enrollee ability to access and obtain medications and support enrollee understanding of medication therapy
Network Management and Provider Services	• Identifies and contracts with providers to deliver integrated care to enrollees • Develops and implements value-based payment arrangements with providers that incentivize the provision of integrated care • Provides training to providers regarding integrated care including best practices • Collaborate to ensure that the providers are available and meeting the needs of the enrollees
Quality Management	• Shares quality measures, such as Healthcare Effectiveness Data and Information Set (HEDIS), with other departments to identify opportunities for projects to improve all aspects of enrollee health and wellness, including PH, BH and social needs • Reviews grievances and complaints to identify issues related to PH, BH, and social service access that should be addressed • Collaborates to evaluate program delivery and redefine processes and programs that meet needs identified to improve health outcomes for enrollees

Contractors: Aetna supports the delivery of integrated, whole-person care through our value-based payment (VBP) agreements, by developing contracts with providers to support the holistic needs of our enrollees, and through the functions of our Provider Services department:

- **VBP:** Aetna uses VBP to incent providers to provide integrated care by providing additional reimbursement for driving value (e.g., closing gaps in care, encouraging closer relationship between the care team and enrollee, improving integrated health outcomes, and increasing coordination of care). For example, through our patient-centered medical home (PCMH) model, Aetna identifies opportunities to support providers with in-house integrated care teams by offering higher reimbursement rates for the services they provide to our enrollees. For example, Aetna assists PCMH providers to fund staffing and data management costs that are beyond billable services through foundational payments to improve their infrastructure. To date, Aetna has entered into an alternative payment arrangement with several providers such as Children's Alliance Independent Provider Association (CA-IPA), Kentucky Primary Care Association (KPCA), KentuckyOne Health (KHP), and Big Sandy Health Care, Inc. Our VBP arrangement with KPCA currently includes 463 clinic sites, 356 federally qualified health center (FQHC) sites, 198 school-based sites, and 107 RHC sites. KPCA has over 1,500 providers located in 90 counties.

> Aetna was the first managed care organization (MCO) to initiate a partnership with Children's Alliance-IPA to create and execute a value-based services contract in Kentucky. As CA-IPA is a clinically integrated network, our VBP arrangement is designed to achieve specific outcomes and improve the holistic health care, including physical health and unmet social resource needs, of children and families in Kentucky.

- **Contracts: Our network for the Medicaid program also includes all FQHCs, 50 rural health clinics (RHCs), and all community mental health centers (CMHCs) in Kentucky, which increases rural access to integrated health care for our enrollees.** Our provider contracting processes identify the covered services, tasks, and reporting to be performed by all providers and meet all the required standard provisions outlined in **Appendix C of the Draft Medicaid Contract**

and Appendices, along with timely access requirements described in **Section 28.0 of Attachment F of the RFP**.

- **Provider Services:** Aetna's Provider Services team is crucial in identifying the need to expand the network to increase timely availability of integrated care to enrollees. Upon notification of a provider need (including PH, BH, and non-traditional providers), we immediately initiate recruitment efforts. These notifications can be received from a variety of sources, such as referrals from the integrated care team and community-based organizations or social service organizations (SSOs). Once notified, the Network team conducts outreach to providers in that area or specialty. Our strategy is to build the most effective, experienced, and highest-quality network that offers provider selection and meets the integrated, holistic health needs of enrollees.

Systems: Our electronic systems facilitate collaborative, integrated, and coordinated care between providers and facilitate whole-person care for our enrollees. At the heart of our information systems are our rules-based eligibility, enrollment, and claims processing system and our web-based care management application. The system is built on Microsoft's .NET architecture, which benefits the Department by providing a high degree of flexibility, scalability, and integration with other systems. **Table C.20-2** lists our high-level overview of the system critical components, the types of information the systems manage, and how they contribute to the delivery of integrated, whole-person care.

Table C.20-2: Information Technology Systems

System	Description
Electronic care management system	The electronic care management system does the following: creates a 360-degree, unified view of enrollee data for providers at the point of care; enables the enrollee's interdisciplinary care team to manage care in real time, coordinating across care management, behavioral health, and physical health functions; facilitates community-based collaboration among traditional/non-traditional providers on behalf of enrollees; and includes our innovative electronic population health management platform, which digitally shares and aggregates actionable data across multiple systems/organizations.
Claims processing system	Our claims processing system is a suite of modules that handle claims/payment data, eligibility, enrollment, service authorization, provider enrollment, and data management functions. Aetna staff from multiple departments can use information contained in the claims processing system to coordinate with other team members to address the enrollee's unique needs.
Enrollment manager	The enrollment manager is an application that loads/processes/generates enrollment data automatically end-to-end (i.e., enrollee data received via the 834 eligibility file, coordination of benefits/third-party liability records, and enrollment load reports for verification of data load). This data contributes to identification of individuals with special health care needs and can inform care managers about enrollee diagnoses and participation in Commonwealth programs.
Medicaid web portals	Enrollee and provider portals with the following capabilities: • **Enrollee portal**: The enrollee portal contains information in Spanish and English and supports administrative functions available to enrollees such as enrollee history/assessment, referral history, functional assessments, service plans and authorizations, copies of any notices of action sent to the enrollee in the last 12 months, and health summaries. Additional enrollee portal features include the provider directory and enrollee handbook; covered services/benefit; complaints/appeals/fair hearing process; Healthcare Insurance Portability and Accountability Act privacy notice; health plan/enrollee advocate contact information; enrollee community resources; secure messaging with health plan staff; and care management information. Aetna provides the Department with secure access rights to all enrollee access points. • **Provider portal**: The provider portal supports administrative functions such as eligibility verification, online claims submission and status, payment and remittance information, prior authorization submission and status, and submission of credentialing documentation. Additional provider portal features include: provider directory (printable version, online searchable tool with sort capability, PDF format), provider manual, complaints/appeals process, network enrollment information, education tools, cultural competency information, mobile application, online and batch processing, secure exchange of data, downloadable forms, and exchange of clinical documentation in support of integrated care delivery.

System	Description
Pharmacy benefit management (PBM)	Our PBM system Identifies of enrollees with multiple prescribers resulting in potential medication interactions, duplicate therapy, over-utilization, and other safety concerns, so that the interdisciplinary care team can take appropriate action to address potential issues and make sure prescriptions are adjusted as necessary. In addition, PBM data allows care managers to assist enrollees to resolve issues related to acquiring their medications.
Medicaid enrollee mobile application	As part of our digital portfolio, we also offer a free Aetna application for both iOS and Android smartphones. The application supports several functions (i.e., electronic identification (ID) card, eligibility verification, authorizations, change of PCP, explanation of benefits display, medication tracking, provider directory lookup, enrollee educational information, identification of care gaps, etc.). Access to this application allows enrollees to self-manage their conditions and be empowered to direct their care, in coordination with their care manager.
Health Innovation Engine	Our Health Innovation Engine is a new tool that will allow our enrollees, care manager, and enrollee services staff to easily view and engage with the value-added services (VAS) for which they are eligible. This new tool will improve our ability to track and monitor eligibility, engagement, effectiveness, spend, and utilization trends for all VAS. The engine will also enable enrollee engagement with and management of their VAS through the Medicaid Enrollee Application and the enrollee portal.

Call centers: Aetna operates a full suite of call centers that support its integrated delivery of covered services. These call centers are designed to provide direct support to the enrollees, and via warm transfer, put them into direct contact with a member of the team to address their needs regardless of if it is a social need, functional needs, physical health need, or a behavioral health need. Specific call center operations are the following:

- **Outbound welcome call:** During welcome calls, enrollees have the option to press a number on their phone to link directly to Enrollee Services for assistance choosing a PCP.
- **Outbound calls for health risk assessment (HRA) screening:** Aetna's automated outbound HRA screening process is our first attempt to complete the HRA with the enrollee in support of delivering integrated, whole-person care. The HRA identifies PH, BH, and social needs, and serves as an important data source in the enrollee risk stratification process. With multiple entry points and enrollee contacts, we maximize opportunities to engage enrollees to complete screenings, select a PCP, and conduct outreach to those missed through initial outbound screening attempts as described in the next section. Of those who complete the automated outbound screening and we identify for care management, 100 percent complete a comprehensive assessment. Based on the answers of the HRA and enrollee needs assessment (ENA), they are assigned to a single point of contact in care management who has the education and experience to address their unique whole-person care needs. During the outbound HRA screening call, Aetna enrollees can connect to a live Enrollee Services representative from 7 a.m. to 7 p.m. Eastern Time, by pressing the appropriate option on the telephone keypad, assuring assistance with PCP selection and immediate response to any questions the enrollee may have. Once contacted, Enrollee Services representatives can offer quick linkage to behavioral health counselors or nurses in other departments such as care management. Enrollee Services representatives use instant messaging to notify individual care management staff of a caller's need before transferring, allowing a brief description of needs. Representatives use three-way conferencing and complete a warm transfer where the enrollee is introduced and a brief summary of the reason for the call is provided once connected live to the counselor or nurse. Each Enrollee Services representative stays on the line until the caller's issue is adequately resolved and makes certain all questions are answered.
- **Behavioral Health Crisis Services Hotline:** Aetna's internal 24/7/365 toll-free BH Crisis Services Hotline is a key element in our comprehensive, integrated system of care for all enrollees throughout the Commonwealth. Aetna will offer enrollees throughout the Commonwealth a dedicated, toll-free BH Services Hotline 24/7/365. The BH Crisis Services Hotline will include routine assistance with benefits and referrals, as well as BH crisis and emergency services. We will handle crisis, urgent, and

routine requests from enrollees or guardian and remain on every call for as long as necessary to address all needs. Specifically for BH crisis calls, a live BH Services Hotline staff member answers BH crisis calls immediately—we never answer BH crisis calls through an automated call system. The BH Services Hotline staff assess, screen, and triage through telephonic crisis intervention to make sure the enrollee is safe. This staff coordinate the most appropriate level of care needed, including hospital-based emergency room (ER) services, mobile crisis unit services, face-to-face stabilization services, or other care. Our system supports seamless warm transfer of calls to 911 for emergency response, staying on the line with the caller until emergency response arrives, and supports conference calling for consults with the medical director or others regarding complex clinical situations. Our BH Services Hotline staff is trained to warm transfer callers to the local Suicide Hotline or other Crisis Response Systems as needed. After-hours, weekends, and holidays, calls are routed to Aetna's call center. The call center is staffed 24/7/365 with BH clinicians and access to psychiatrists. BH Services Hotline staff work in collaboration with the interdisciplinary care team to coordinate management of the crisis and make sure follow-up occurs after crisis resolution. Care managers see a crisis note and follow up with enrollees following a BH crisis intervention to address their current needs. Our current BH Services Hotlines meet the requirements set forth in **Section 33.6 of the Draft Medicaid Managed Care Contract and Appendices.**

- **Enrollee Services call center:** We provide a single toll-free number for enrollees to call with questions or concerns. This number gives each enrollee access to Enrollee Services representatives during normal business hours, Monday through Friday, 7 a.m. to 7 p.m. Eastern Time. Aetna puts the enrollee first by answering each enrollee's questions thoroughly the first time. The overflow call center staff answers these calls during business hours All Enrollee Services staff, locally and nationally, can instruct callers what to do in case of an emergency, and connect enrollees to our 24/7/365 Health Information line (nurse line) or 24/7/365 Behavioral Health Services Hotline for clinical support. Representatives are thoroughly trained in screening for clinical issues and follow desktop procedures on screening questions and when to transfer to a clinical staff in Care Coordination, BH Services Hotline, or Health Information line. The Enrollee Services call center will meet the requirement established in **Attachment F Section 22.1 of the RFP.** Enrollee Services representatives have access to open gaps in care for each enrollee and educate and support enrollees to address the gap in care. Depending on the barriers the enrollee is facing that contribute to the gap in care, the Enrollee Service representative links the enrollee to their PCP or behavioral health provider, and can also connect the enrollee to care management for assistance with the removal of barriers to addressing the gap in care, such as transportation needs.
- **Provider call center:** Aetna maintains one Provider Services call center that assists all types of providers in our network, including PH, BH, and non-Medicaid providers, such as community-based organizations (CBOs) and SSOs. When providers call Aetna to get information on how to provide care for the enrollees they serve, they are connected to the Care Coordination team for assistance with identifying resources for referrals to meet enrollees' whole person needs, including their unmet social resource needs. Providers also have 24/7/365 access to a provider portal for eligibility and benefit questions. Aetna maintains an automated system during non-business hours with sufficient capacity for all callers to leave messages, which are returned on the next business day. Our Provider Call Center operations will continue to meet the requirements outlined in **Section 27.2 of Attachment F of the RFP** and as determined by the Department, including maintaining our toll-free line, which is available Monday through Friday, 7 a.m. to 7 p.m. Eastern Time, including federal holidays.

a.i. Innovative Approaches to Whole-person Care

Aetna is organizationally committed to whole-person care, which we define as the coordination of health, behavioral health, and social services, as applicable, in an enrollee-centered manner with the goals of improved enrollee health and wellbeing through more efficient and effective use of resources. This commitment is evidenced throughout our innovative approaches, which include becoming trauma

-informed; enrollee engagement strategies; our social determinants of health (SDOH) integration model; approaches to provider onboarding and training; and pharmacy initiatives and CPESN.

Behavioral health is a core function of our health plan, not subcontracted to a behavioral health organization. This is part of our commitment to integration and holistic care.

Aetna trauma transformation: Aetna has learned by listening to enrollees that trauma and adverse childhood experiences are often the root cause of their PH and BH issues and may impact their ability to access social resources to address their unique, whole person needs. Therefore, the Aetna Medicaid organization has undertaken a system-wide transformation initiative to address the impact of physical, emotional, and social trauma amongst enrollees. Underlining this initiative Aetna subscribes to the following tenets as established by the National Institute for Trauma-Informed Care: realizes that trauma is common; recognizes how trauma affects individuals seeking care; responds by implementing trauma-informed care best practices; and resists causing additional trauma. In addition, Aetna supports the holistic, integrated care needs of our enrollees by requiring that all enrollee-facing staff become Mental Health First Aid (MHFA)-certified. We also require youth MHFA certification by all staff members who provide care management and care coordination for children. To monitor providers' adherence to trauma-informed principles, Aetna has developed a proprietary Trauma-Informed Provider Organization Audit Tool that includes domains such as the following:

- Respecting enrollee voice and choice
- Staff beliefs, attitudes and behaviors
- Commitment of leadership to trauma-informed care (TIC)
- Disclosure readiness
- Staff well-being
- Staff knowledge and skills in TIC
- Hospitality to diversity

Enrollee engagement strategies: Using evidence-based, person-centered outreaches and engagement such as trauma-informed principles and motivational interviewing, Aetna outreaches to new enrollees, coordinates referrals for continuation of existing appointments, and facilitates continuity of care:

- **Text messaging:** Aetna care managers use individualized text messages to enrollees to remind them of gaps in care and the services they can access to meet their integrated care needs, including PH, BH, and social resources.
- **Social media:** Aetna's Social Media Response team monitors all our social media accounts for posts by enrollees that may indicate a barrier to whole person care. For example, when an enrollee makes a post that refers to difficulties with access to health care, or that demonstrates an unmet social resource need, the Social Media Response team communicates that identified concern to the appropriate department for outreach to the enrollee and follow-up.
- **Self-service options to improve access to preventive care:** Aetna enrollees will be able to utilize kiosks, through our vendor Pursuant, in Walmart stores across the Commonwealth to complete their HRA (described previously), which may lead to an individualized referral to integrated care management for an integrated, holistic enrollee needs assessment. The HRA may also lead to a referral to a CHW for assistance with linkages to CBOs and SSOs for non-covered services to address unmet social resource needs.
- **Co-location of Community health workers in the community:** Through our Social Determinant of Health Integration Model, enrollees have access to Aetna and community-based CHWs to assist with meeting their unmet social resource needs. CHWs assist with the completion of the HRA, make referrals to care management if necessary, and link enrollees to CBOs and SSOs to address their holistic needs. CHWs serve enrollees in the communities from which they come and can assist with linking enrollees to resources they are aware of and to which they have personal connections. A full description of this model is located in this section.

Integrated Care Management and Case Rounds for an Enrollee with Hepatitis-C

A 44-year-old Aetna enrollee was referred for ICM for education and assessment of his health care and social determinant needs related to his diagnosis of hepatitis-C. While completing the ENA, the enrollee's care manager learned of his history of substance use and high cholesterol, and he also reported increased anxiety and panic attacks and his need for access to healthy food. Through a fully integrated multidisciplinary case round consultation with a specialist provider, the interdisciplinary care team determined that the enrollee would benefit from hepatitis-C medication therapy after first addressing his other physical and behavioral health needs.

The care manager engaged the enrollee in a person-centered care planning process, agreeing on goals and interventions. To meet the enrollee's whole person needs, his care manager coordinated care with his PCP for evaluation and treatment of anxiety and high cholesterol and engaged the enrollee in nutritional counseling to encourage dietary changes (including assisting with an application for food stamps). The care manager also coordinated support and education on understanding his condition and stress management techniques. With the enrollee's input and agreement, the care manager collaborated with the enrollee to establish an abstinence goal related to substance use, as well.

Throughout his enrollment in ICM, the enrollee and his care manager developed a trusting, working relationship. Through regular contact, the enrollee was able to reduce his anxiety and stress levels, he was able to lower cholesterol levels through diet modification and his cholesterol medication was discontinued, and he maintained six months of sobriety. He was approved for hepatitis-C treatment and successfully completed 12 weeks of medication therapy with no evidence of disease at the end of treatment plan. The enrollee ultimately has found employment and no longer receives Medicaid benefits.

Social Determinant of Health Integration Model: Aetna is partnering with Unite Us in a unique collaboration to address the full spectrum of SDOH. This network focuses on Jefferson County, with plans to expand throughout the Commonwealth. It establishes new and innovative models that improve the engagement between enrollees, traditional health care providers (e.g., PCPs), and social services providers. Aetna's intent is to expand this partnership statewide. This SDOH services integrated model connects enrollees to community-based organizations who participate in the closed-loop referral network, including all types of social service agencies. Enrollee referrals for integrated service needs, including PH, BH, and SDOH, are triggered through multiple sources; there are not any limitations on how enrollee referrals are triggered. One example is an HRA, which is attempted to be completed for 100 percent of enrollees within 30 calendar days of eligibility with the health plans; three outreach attempts are made to complete the HRA. Additional tools, such as the ENA and Health Care Equity Contact Event, are completed in combination with the HRA which includes SDOH and questions to identify enrollees' whole-person needs.

Enrollees determined to have socially or medically complex needs (multiple chronic conditions, SDOH barriers, gaps in care, health disparities), will be warm transferred to a care manager for evaluation based upon defined criteria for potential enrollment into our ICM program. Enrollees that are identified to have SDOH needs not requiring care management intervention are warm transferred to a CHW located at the wellness center in the community where the enrollee resides. The CHW will engage with the enrollee with Unite Us via telephonic outreach to complete referral for SDOH needs identified. Unite Us has engaged a full network of social service providers including food banks, transportation vendors, education organizations, etc. Aetna enrollees residing outside of Louisville have access to referral services for identified SDOH needs through current processes such as Aunt Bertha, a comprehensive online directory of social service organizations, and care management processes to facilitate connecting enrollees with appropriate community-based resources to address identified enrollee needs. In addition, CHWs will offer enrollees assistance with enrollment in federal and Commonwealth benefit programs such as Women, Infants, and Children, Kentucky Transitional Assistance Program, Kentucky Low Income Home Energy Assistance Program, and Continuum of Care Homeless Assistance Program. They also offer assistance

with addressing other social determinant needs and with referring enrollees to our fully integrated network when necessary. If the social or medical complexity of an enrollee increases or if there has been a significant care transition to the point where care management intervention is needed, the enrollee will be warm transferred to care management for care manager assessment and intervention.

In addition, the network is connected to our electronic care management system and notes can be made available in near real time. If community organizations providing these services do not have electronic health record equipment, Unite Us has the capability to provide that functionality. Unite Us allows care managers and CHWs to review social resources referrals and utilization, which creates a feedback loop that informs care plan updates and integrated care management case rounds.

The Unite Us platform provides the unifying infrastructure between health care entities and CBOs. This robust, collaborative approach equips health care and community service providers with a shared platform that they can use to identify available resources for enrollees, while simultaneously tracking outcomes within a single integrated network of care and social services. The Unite Us platform combines medical and social care through integrations with existing electronic health records designed to enhance, not impede, workflows. It integrates with the most commonly used medical, social, and community tools to streamline methods and increase efficiency. Unite Us currently powers the United Community Network, a network of health care providers, payers, government service, and CBOs which serves the Louisville metropolitan area and is sponsored by Metro United Way. Network users who generate and receive referrals in this integrated community network include government, leading health systems, clinical providers, and CBOs across Jefferson County. The network continues to grow, with plans underway to integrate the network with the Jefferson County public schools and additional CBOs and stakeholders. The main functions of the platform include the following:

- Configurable screening for needs with immediate decision support
- Electronic referrals and tracking with external agencies
- Assessment and single care plan management
- Bidirectional communication (between partners and enrollees)
- Alerts and email notifications on referral progress
- Outcome tracking across network partners and each community, by resource need (e.g., long-term housing, transitional housing, etc.)

Field-based population health specialists: Our staffing model includes staff that assist providers to increase use of evidence-based service delivery by incorporating data analytics and quality improvement strategies with the goal of helping the provider to offer holistic, medically necessary care and to advance along the continuum of value-based payment initiatives.

Provider onboarding and training: During provider onboarding and ongoing training, Aetna providers receive technology-based and face-to-face training on the importance whole person, integrated care that is delivered in a culturally and linguistically competent manner. Medical providers are educated on flagging behavioral health and social determinants of health in enrollees' medical records for follow-up by the integrated care

Supporting Integration through Training of Dental Providers

Avēsis, our dental benefits administrator, collaborates with Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A), which is dedicated to engaging dentists and dental professionals in identifying child abuse and neglect, elder abuse, domestic violence, and human trafficking. P.A.N.D.A. delivers professional development for network dental providers on the following subjects:

1. Understanding the problem of abuse and neglect of persons of any age.
2. Understanding the clinical signs and symptoms of possible abuse and neglect.
3. Understanding the responsibilities for dental professionals in preventing family violence.

This training covers important topics like precipitating causes and contributing factors to child abuse, the clinical signs of abuse and neglect one might encounter in the dental office, steps to take in the event of suspected abuse or neglect, and professional liability.

management team. They are also educated on the conditions that qualify children to be classified as medically complex and the criteria to identify enrollees as having special health care needs. Aetna collaborates with the KPCA to provide trainings to their PCPs.

Pharmacy safety and monitoring: Our CVS Safety and Monitoring Program targets high-risk drug classes, focusing on controlled substances and inappropriate use and misuse related indicators such as polypharmacy; provider shopping and high-total controlled substance claims volume; and drugs at risk for fraud, waste, and abuse. On a quarterly basis, clinical pharmacists evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. Clinical pharmacists monitor for potential physical and behavioral health impacts of prescribing (e.g., side effects such as potential weight gain, changes to sleeping patterns, effects on mood, etc.). They may make referrals to the Care Management department for enrollees with multiple prescriptions for follow-up and care planning to address all the enrollee's unique needs, including their unmet social determinants of health. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to the Aetna pharmacy director and care manager for further action, which may include engagement in our Supportive Managed Care Program, formerly the lock-in program. Target drugs include opiates, anti-anxiety, and sedative hypnotic agents, muscle relaxants, central nervous system stimulants, and other controlled substances (e.g., testosterone). Prescribers receive actionable alert about concerning findings. Also, our ICM and pharmacy directors are alerted about enrollees of concern.

Community Pharmacy Enhanced Services Network: Aetna supports its enrollees through CPESN to provide high quality and high integrity enrollee-centered enhanced services that are integrated with the enrollee's interdisciplinary care team to promote the improved health of enrollees with chronic conditions. Aetna offers support to enrollees through the CPESN comprised of community-based pharmacies that develop relationships with enrollees and support medication management, unmet social needs identification, and opportunities with engagement through ICM. CPESN uses innovative strategies, such as providing materials resources in a backpack based on the needs of the enrollee (e.g., non-perishable food items, toiletries, etc.) to address enrollees' social determinant needs.

Supporting Social Determinant Needs through Integration with CPESN

An Aetna enrollee struggles with multiple medical, financial, and psychosocial stressors that greatly impact his overall health and quality of life. The enrollee has communicated his struggles with managing and maintaining his physical health, which is compromised further by issues with transportation, access to adequate, sustainable, and healthy food sources, financial instability, impaired mobility, and very limited access to community and natural supports. With the enrollee's individual needs and struggles identified, the CPESN team including the community pharmacist, Aetna care manager, and community-based care navigator coordinated efforts with community agencies to address the enrollee's concerns. The care manager located a community resource to support the enrollee with regular food baskets to resolve the client's issues with food and identified a mobile grocery store to deliver food to the enrollee. The care manager also contacted a community resource to assist with the enrollee's financial struggles and his ability to maintain his housing. Additionally, the care manager coordinated with the enrollee's son who has agreed to assist with the enrollee's transportation to and from a local food pantry. To address the enrollee's issues with obtaining his medications, Aetna staff coordinated with are United Way, Community Action, and several other community agencies to ensure quick turnaround within 24 hours of the enrollee communicating a need.

Aetna's Pharmacy team has direct vendor oversight, acts as a liaison between the community pharmacy and Aetna ICM teams, and supports identification of enrollees for referral. The program focuses on

identifying enrollees at risk for adverse medication and health outcomes due to non-adherence and gaps in care, and actions are implemented to create a care plan that is shared with the enrollee's care team. CPESN pharmacists support enrollees to manage chronic conditions. In addition, pharmacies in the CPESN network identify enrollees at high risk of opioid misuse, provide enrollee-specific education about their individual risk factors, dispense naloxone, provide education to the enrollee or caregiver(s) about how to administer medications, and make referrals to Aetna care management. Currently, Aetna and CPESN are developing an initiative to improve adherence to conditional care guidelines for enrollees with diabetes to include condition-specific educational and nutritional assistance. Enrollee Experience surveys conducted in January 2019 through September 2019 for the program revealed that participants rated their overall experience with the CPESN pharmacy as "Excellent," averaging 4.8 on a 5-point scale, and "Strongly Agreed" that they would recommend the pharmacy to a family member or friend 100 percent of time, with an average score of 5 on a 5-point scale.

a.ii. Coordination with Carved-out Services

Aetna views the coordination of carved-out services as a key aspect of our person-centered whole-person philosophy. Our strategies include the following:

- **Regularly meeting with Commonwealth carve-out vendors:** Aetna participates in regularly slated meetings with the Commonwealth and its carve-out vendors, including the Kentucky Transportation Cabinet's non-emergency medical transportation services available through the Human Service Transportation Delivery program and long-term service and supports (LTSS) vendors for the purpose of problem-sharing. Aetna's behavioral health director meets with the Department and the Department for Behavioral Health, Developmental ad Intellectual Disabilities (DBHDID) no less than quarterly to discuss State Mental Health Authority and Single State Agency protocols, rules, and regulations.
- **Enrollee education:** Our assessment and person-centered care planning processes include identification of enrollees who may benefit from carved-out services, as identified in our care planning process. After being identified enrollees and their interdisciplinary care team receive education concerning applicable carve-out services and alternative levels of care. Enrollees are then assisted by our Care Management team with the completion of any necessary applications and the coordination for waiver applications and other carve-out services is initiated.
- **Provider education:** Our Provider Relations team and ICM staff provide education to providers concerning carve-out services. Our provider manual and website also serve to educate providers.
- **Waiting list support:** For Aetna enrollees on the LTSS waiting list, our care managers complete an assessment to identify the enrollee's needed services and supports, and coordinate with network and community-based providers that can meet the enrollee's needs and ensure enrollee safety until the placement is secured. The care manager assists with the application to the LTSS or waiver services, as needed.

Transportation: Our ICM team facilitates the coordination of transportation for our enrollees with the Kentucky Transportation Cabinet to ensure timely access to appointments and medically necessary care. Our processes include the following:

- Assisting enrollees to obtain financial support for transportation
- Coordinating with the Commonwealth to obtain approvals
- Transmitting approvals to the transportation broker
- Facilitating timely reimbursement

We also communicate and coordinate with the enrollee, family, the guardian, and provider and referral services to affect a positive transportation experience. Aetna recognizes that transportation is a particular challenge for enrollees residing in rural areas, such as Region 8, where they may have to travel long distances to access care. As a proactive step to address this barrier, we include additional transportation benefits (i.e., 10 round-trips of up to 60 miles total per round-trip, per year) for enrollees as a value-added

service to assist them to attend appointments with non-traditional providers, CBOs, and SSOs and to address their whole person needs, including social resource needs such as food insecurity.

LTSS: Due to their local expertise and experience serving Kentuckians, Aetna care managers are familiar with the full range of covered services and non-Medicaid resources that may be implemented to assist enrollees to overcome barriers to health and wellness. In the event that the enrollee's medical care needs cannot be met in a home environment with additional in-home supports, the care manager assists the enrollee and their circle of support with exploring alternative settings of potential care options. These may include adult day care, in-home sitter/homemaker supports, environmental and minor home adaptation, home-delivered meals, or long-term care in a nursing facility. When a transition to LTSS will best support an enrollee's unique needs, Aetna's care managers collaborate with carve-out vendors to coordinate enrollee transitions to LTSS.

Aetna understands that poor transitions, particularly those that lead to gaps in services, can have dire consequences for Kentuckians. Aetna emphasizes the importance of involving community-based organizations familiar with these aspects of service delivery. In addition, Aetna uses multifaceted strategies to help enrollees understand their benefit options using hands-on assistance to help coordinate services, contributing to a person-centered, rather than a program-centered, transition. Enrollees with particularly complex needs, such as individuals with mental illness, developmental disabilities, or multiple chronic conditions, may require special attention to achieve service continuity.

Housing, employment, educational, and non-medical transportation supports are essential to sustaining community integration and making it possible for individuals with LTSS needs to meet their goals and achieve a high quality of life. Individuals of all ages with LTSS needs—including individuals with intellectual and developmental disabilities, children with medical complexity, adults with physical disabilities, older adults who have cognitive needs and face the physical challenges of aging, and individuals with complex behavioral health needs seeking supports in recovery—will need lifelong support to fully engage in their community.

Strategy 1: Minimize disruptions of existing provider relationships: The prospect of change can cause anxiety for our enrollees who may fear that longstanding relationships with providers who assist them in living independently may be at risk. Aetna's transition period policy promotes continuity of care. Care managers coordinate services from various funding streams to provide a coordinated, seamless package of supports.

Strategy 2: Ensure that all enrollees understand the effect of program and benefit changes: Aetna care managers assist enrollees to apply for LTSS programs and with getting on long-term care waiting lists, if necessary. Enrollees face many hurdles in accessing home and community-based waiver services, such as a confusing application process, finding the right waiver, and managing delays in enrollment. Aetna care managers help enrollees utilize benefits through the following:

- Educating and assisting members with the use of State tools, such as Benefind, to assist them in applying for multiple programs
- Assisting with applying for Supports for the Community Living Waiver

Care managers perform a comprehensive assessment to identify the individual's physical health, behavioral health, and functional and social needs. They then use this information to help the individual set priorities and goals for how they want to live their life. They assist the individual or their representative to develop a person-centered care plan that is derived from input provided by the individual during the assessment and which should include representatives chosen by the individual to participate on their team.

Strategy 3: Ensure access to enough community-based services: Based on the enrollee's person-centered plan of care, Aetna care managers make referrals to community-based agencies to assist with their transition to LTSS programs. Aetna's care mangers support enrollees through the following:

- Connecting enrollees to housing services and supports
- Assisting with finding employment supports such as job training
- Accessing available services for educational supports
- Facilitating community access by assisting with resources for non-medical transportation
- Exploring the ongoing availability and funding options for these programs
- Assisting with ongoing coordination and advocacy with any applications and evaluations that are needed

Waivers are available through the Cabinet for Health and Family Services and provide some programming and financial support through traditional Medicaid coverage. When our care manager assesses that the enrollee meets eligibility criteria for these services and the enrollee is willing to receive these services, the care manager uses person-centered approaches to assist the enrollee, guardian, and/or family with the application process. The care manager works with the enrollee or the designee to ensure that all information is submitted. Actions and plans are included in the enrollee's care plan. Aetna's care managers remain engaged with the enrollee and provide support and assistance until the enrollee is transitioned from the MCO roster to the Waiver Support program or is admitted to a long-term care facility.

Supporting Leo While Waiting for Approval of LTSS Waiver Services

Leo (not his real name), 58-years-old, lives alone with some support from his long-term partner. He has reported conditions of Parkinson's, dementia, schizoaffective disorder, chronic pain, and a history of bipolar disorder, depression, and anxiety. Also, he has a history of falls, becomes easily confused, and has a history not making it to his appointments due to a lack of transportation. Leo was outreached and asked to consider enrolling in integrated care management, which he accepted. The assessment by his Aetna care manager identified the need for assistance with locating appropriate providers and coordination of care to treat his medical and behavioral health conditions, and addressing his social needs, such as needed home repairs and food insecurity. The care manager immediately assisted by identifying community resources to attain transportation, housing repairs, and food. The care manager also recommended applying for the home and community-based services (HCBS) waiver program to assist Leo with personal care services. The care manager also worked with Leo's primary care provider to not only to coordinate in-home physical therapy, pain management, cardiac care, and schedule regular dental and vision appointments, but to organize and track all appointments. After eight months, he was approved for HCBS waiver services. Leo reports that he feels less isolated and depressed about his deteriorating health and he has been able to attend his appointments to continue to receive the care he needs.

a.iii. Value-added Services

Our Medicaid experience across the nation indicates that the health and well-being of enrollees are enhanced by their ability to access the services and supports not covered by Medicaid. These services, coupled with covered services, aim to improve quality of life and health outcomes for enrollees. We join the Commonwealth of Kentucky to accomplish the goals of the Request for Proposal. Our value-added services are designed to assist our promotion of individual and family self-sufficiency, recovery, resiliency, and community sustainability for the betterment of the vulnerable population, and to improve participants' health and help them be responsible for their health.

Aetna is committed to offering all value-added services listed below to its enrollees. We believe these are a critical component of the overall program and will provide another path that leads to our enrollees achieving optimal health. The value-added services proposed are based on our 30 years of experience working with vulnerable populations, coupled with lessons we have learned in the Commonwealth since

2011. For example, Aetna's overarching approach to value-added services has moved away from creating incentivizes for enrollees to participate in programs with the end goal of closing gaps in care to increase HEDIS scores and has adopted a strategy of increasing VAS that improve the enrollee experience and address their social determinant needs. We believe this approach to VAS is more person-centered and aligns with our whole-person approach to integrated care, described previously.

Our suite of "Aetna Better" value-added services below are tailored to the Kentucky population's health and social determinant needs, such as transportation, and align with the State Health Improvement Plan (e.g., programs to address risks associated with opioids, obesity, poverty, and more). Aetna commits to providing all the value-added services proposed in this response for the entire 65-month term of the initial contract and for any extensions, if applicable.

Aetna Better Care encourages enrollees to assume responsibility for their health by rewarding healthy choices and offering unique services and resources. **Table C.20-3** describes our value-added services for Aetna Better Care programs to improve care and quality of life of our Kentucky enrollees.

Table C.20-3: Aetna Better Care Benefits

Benefit	Description
Alternatives to Opioids	According to the National Institute on Drug Abuse, in 2017 there were 1,160 reported opioid-involved deaths in Kentucky—a rate of 27.9 deaths per 100,000 persons, compared to the average national rate of 14.6 deaths per 100,000 persons.[1] With opioid addiction on the rise, providers are seeking effective alternative pain management options for their patients. To support these efforts, Aetna will offer coverage for acupuncture, massage therapy, dry-needling, and yoga. Adult enrollees can receive up to $150 to use towards these services. This value-added service is provided to reduce opioid utilization and promote healthy and sustainable pain management.
Asthma Home Care	In Kentucky, 11.9 percent of adults have asthma compared to 8.9 percent in the United States. Asthma is also one of the most common chronic diseases among children, and in Kentucky 10.6 percent of children under age 18 have asthma.[2] Enrollees with an asthma diagnosis can receive one set of hypoallergenic bedding and one carpet cleaning annually. This is an important benefit because dust and pollen, common allergens that induce an asthma attack, can often be found in bedding and around the home. This value-added service will be provided to reduce asthma-related ER utilization other asthma-related complications.
Eyeglasses and Fittings	More than 12 million Americans need prescription eyewear yet don't wear it, often because they cannot afford it.[3] Over 140,000 Kentuckians have reported vision difficulty and many face a similar challenge.[4] This is why we offer eligible adult enrollees one free pair of eyeglasses every two years, including fittings. This value-added service will be provided to reduce vision distortion headaches, increase eye comfort, and improve quality of life.

[1] National Institute on Drug Abuse, "Kentucky Opioid Summary," (2017): https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary; assessed June 2019
[2] Kentucky Public Health, "Kentucky State Plan for Addressing Asthma," (2016-2018): https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Documents/2016KentuckyStatePlanforAddressingAsthmarevised.pdf
[3] MES Vision, "Vision Facts and Statistics," (2006): (https://www.mesvision.com/includes/pdf_Broker/MESVision%20Facts%20and%20Statistics.pdf; accessed, June 1, 2019
[4] American Foundation for the Blind, "Expanding possibilities for people with vision loss," (2018): https://www.afb.org/research-and-initiatives/statistics/state-specific-stats/kentucky#2016; accessed June 1, 2019

Benefit	Description
Hearing Benefits	An estimated 35 million Americans suffer from hearing loss, yet only 28.5% use hearing aids.[5] Current statistics show that 694,301 Kentuckians are deaf/hard of hearing.[6] Additionally, enrollees who have even mild hearing loss have an increased risk of fall; those who wear hearing aids are less likely to go to the hospital or emergency room and those who are hospitalized have shorter stays.[7] Adult enrollees will be eligible for an annual exam and one hearing aid per year with unlimited visits for hearing aid fittings. This value-added service will be provided to reduce falls, hospitalization stays, and to improve quality of life.
Insulin Pumps	Studies have shown the significant value of the ongoing monitoring and support provided through modern insulin pumps, but they are often unaffordable for most individuals.[8] Furthermore, Kentuckians have a higher percentage of people with diabetes than the U.S.[9] For our enrollees with type 1 diabetes, we will offer free Omnipod® insulin pumps to help them with the day-to-day management of their insulin levels, reduce episodes of severe hypoglycemia, and empower self-care.
Maternity Matters	Premature birth and its complications are the largest contributors to infant death in the U.S., and a major cause of long-term health problems in children who survive. March of Dimes Premature Birth Report Cards rate the Commonwealth of Kentucky a "D" at 11.1% of births premature.[10] Maternity Matters will be offered as a preventive health program for pregnant enrollees and new mothers and is filled with benefits and incentives to reduce pre-mature births and mortality and encourage care. Incentives are received via reloadable card. The funds earned can be used for healthy foods, maternity supplies, and diapers at a variety of local and online stores: • **Initial Prenatal Visit Incentive—**Pregnant enrollees can receive $25 for completing their initial prenatal visit. • **Subsequent Prenatal Visits Incentives—**Pregnant enrollees can receive an additional $10 for each visit (10 visit-incentives maximum). • **Cribs for Moms—**Pregnant enrollees can also earn a portable crib at 37 weeks of pregnancy for seeing their doctor regularly during their pregnancy. • **Postpartum Visit—**New mothers can receive $25 for attending a postpartum visit within 21-50 days after the baby is born. • **Family Transportation—**Enrollees in the Maternity Matters program can receive transportation provided for entire family that includes a car seat for children. Limited to 10 roundtrips (up to 60 miles total per round-trip) per year.

[5] Hear-it, "35 Million Americans suffering from hearing loss," (2008): https://www.hear-it.org/35-million-Americans-suffering-from-hearing-loss; accessed June 1, 2019
[6] Kentucky Commission on the Deaf and Hard of Hearing, " Kentucky Def and Hard of Hearing Demographics,: (2015): https://www.kcdhh.ky.gov/ois/demographics.html; accessed June 1, 2019
[7] AARP, "7 Amazing Ways Hearing Aids Can Improve Your Life," (2019): https://www.aarp.org/health/conditions-treatments/info-2019/hearing-aids-benefits.html?CMP=KNC-DSO-Adobe-Bing-Hearing-Aids-Improveands_kwcid=AL!4520!10!73461334267527!73461283940878andef_id=XPGhfwAAFNMq4_vR:20190605144040:s; accessed June 1, 2019
[8] Medical News Today, "Type 2 diabetes and life expectancy," (2019): https://www.medicalnewstoday.com/articles/317477.php; accessed June 1, 2019
[9] Kentucky Public Health, "State Health Assessment," (2017): https://chfs.ky.gov/agencies/dph/Documents/The2017KentuckyStateHealthAssessmentUpdate31517.pdf; accessed June, 2019
[10] March of Dimes, "2018 Premature Birth Report Card," (2018): https://www.marchofdimes.org/peristats/tools/reportcard.aspx?frmodrc=1andreg=21; accessed, June 1, 2019

Benefit	Description
Weight Management Program	Kentucky has the eighth-highest adult obesity rate in the nation, and the 14th-highest obesity rate for youth ages 10 to 17.[11] To help our enrollees achieve a healthy and active lifestyle, we offer a free Nutritional/ Weight Loss counseling program through CVS Health that is provided at local MinuteClinic locations. The initial visit assesses weight loss efforts, enrollee's physical condition, and lifestyle factors. Enrollees are evaluated and offered the opportunity to join the DASH for Health online program where personalized goals and plan are established. Subsequent visits focus on coaching and support of enrollees and the lifestyle and behavioral changes necessary to adopt healthy eating patterns. Individualized plan delivers up to a total of 16 visits over the course of 26 weeks: every week for the first 4 visits; every other week for remaining visits. This value-added service will be provided to reduce obesity rates and the progression of related chronic disease, improve blood pressure, cholesterol and sugar.

Aetna Better Access connects enrollees to services through innovative technology and communication. The program also provides transportation benefits for increased community engagement and social support.

Table C.20-4 depicts our efforts to improve Kentucky access to services with our Aetna Better Access value-added services.

Table C.20-4: Aetna Better Access Benefits

Benefit	Description
Enhanced Transportation	A recent survey found that 27.4% of households do not have a motor vehicle and enrollees who rode a bus to receive health care were twice as likely to miss appointments as enrollees who drove cars. Additionally, 25% of those with low incomes missed an appointment due to transportation.[12] Additionally, this benefit aligns with the Commonwealth priority to Invest in Education and Workforce Development. Aetna provides 10 round-trips (up to 60 miles total per round-trip) per year via a transportation vendor for enrollees to have transportation services to activities such as job interviews, job training, shopping for professional attire, making a trip for food at a grocery store or food bank, and accessing community health services not otherwise covered. Transportation to job interviews is one of the more common uses of this benefit. This value-added service will increase access to non-clinical services for whole-person care and decrease the functional limitations of our enrollees.
Simple Necessities Vending Machines	The United States Interagency Council on Homelessness estimates the point in time homeless population in Kentucky at 3,688. According to the National Health Care for the Homeless Council, homeless persons are three to four times more likely to die prematurely than their housed counterparts, largely because their conditions are exacerbated by life on the streets or in shelters.[13] To begin addressing some of the practical daily needs of these enrollees, Aetna has set up a vending machine for basic needs utilizing a card-based access system that is located in Centerstone. It contains transportation passes and personal hygiene items that include toothpaste and toothbrushes, shampoo and conditioner, body wash for men and women, deodorant, shaving kits, hairbrushes, socks for men and women, underwear, baby wipes, warm hats, Aetna drawstring bags, and Aetna water bottles. We recently have expanded a vending machine to a homeless and foster youth shelter. Additionally, in partnership with the Street Med Program, Aetna will continue to deliver hats and gloves to enrollees in need. These value-added services will increase enrollee access to toiletry items, transportation passes, and other items of necessity.

[11] Kentucky Public Health, "KENTUCKY State Health Improvement Plan," (2017 – 2022): https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf; accessed June 1, 2019
[12] Shawnee Christian Healthcare Center, "Addressing Social Determinants of Health and Improving Quality Through Patient Engagement," (2012): https://chambermaster.blob.core.windows.net/userfiles/UserFiles/chambers/9322/CMS/2018_Fall_Conference_/Monday/Addressing-Social-Determinants-of-Health-and-Improving-Quality%281%29.pdf; accessed June 1, 2019
[13] United States Interagency Council on Homelessness, "Kentucky Homelessness Statistics," (2018): https://www.usich.gov/homelessness-statistics/ky; accessed June 1, 2019

Benefit	Description
Smile Kentucky Program	Children's dental health is important but access to care is often difficult. In fact, according to the 2011-2012 National Survey of Children's Health, 18.6% of children in Kentucky ages 1 to 17 had one or more oral health problems or had unmet needs for dental care during the past 12 months.[14] Additionally, only 40-50% of children in Kentucky are receiving any dental services.[15] Aetna, in partnership with the University of Louisville Dental School, will offer free mobile dental clinics and dental screenings to elementary children in Region 3. This value-added service will be provided to increase preventive oral care, detection of tooth decay, and other oral health issues while also reducing functional limitations to care.

Aetna Better Living aims to assist enrollees with services and community supports to empower them to make the best choices for their health and independence. We continuously work to develop new programs that promote increased enrollee engagement and enable enrollees to overcome personal barriers and lead healthier, happier lives. **Table C.20-5** depicts our efforts to improve the quality of life and living for our Kentucky enrollees with our Aetna Better Living value-added services.

Table C.20-5: Aetna Better Living Benefits

Benefit	Description
Aetna Better Way to Health	Our innovative incentive programs, offered for adults, teens, and children, are designed to encourage enrollees to obtain important preventive services, while emphasizing personal responsibility and ownership of healthy living: • **Follow-up visit with mental health practitioner—**Enrollees 6 years and older will receive a $20 incentive card for a follow-up visit. • **HRA—**Enrollees who are pregnant or newly eligible will receive a $25 incentive card for completing the HRA.
Back to School Program	Overall, 22% of Kentucky children are below the poverty line.[16] Aetna's Community Outreach through school-based family resource coordinators offer backpacks filled with school supplies. This value-added service will increase student access to school supplies and decrease functional limitations.
General Educational Development (GED) certification	As called out in Kentucky's State Health Improvement Plan, 13.5% of adult residents have not graduated from high school.[17] In alignment with Gov. Andy Beshear's initiative to make the GED exam more accessible to Kentuckians, Aetna provides an online prep course. This value-added service will increase GED completion rate and improve overall quality of life and future opportunities of Kentuckians.

[14] Centers for Disease Control and Prevention, "The National Survey for Children's Health," (2011): https://mchb.hrsa.gov/nsch/2011-12/health/pdfs/nsch11child.pdf
[15] Center for Health Workforce Studies, "Oral Health in Kentucky," (2016): http://www.oralhealthworkforce.org/wp-content/uploads/2016/02/Oral_Health_Kentucky_Technical_Report_2016.pdf; accessed June 1, 2019
[16] County Health Rankings & Roadmaps, "Kentucky Rankings Data," (2019) :http://www.countyhealthrankings.org/rankings/data/KY; accessed June 1, 2019
[17] Kentucky Public Health, "KENTUCKY State Health Improvement Plan," (2017 – 2022): https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf; accessed June 1, 2019

Benefit	Description
Health Literacy Program	This program is aligned with the Commonwealth priority of creating a healthier Kentucky by "fostering higher health awareness through education that engages all individuals and communities." Aetna's health literacy courses are delivered in collaboration with our quality and community development partners for course facilitation; occasionally host community partners in Regions 3 and 5: • **Slow-cooking nutrition:** Food insecurity is a concern faced by 15.8% of Kentucky households.[18] Slow-cooking nutrition is a free course taught at various venues throughout the community, consisting of a 1 or 2 class series. The course offers nutrition 101, wellness activities, healthy meals/recipes for a crock pot and Aetna benefits overview. The course focuses on nutritious and affordable meals using a slow cooker. At completion of the course, participants receive an Aetna branded crockpot. This benefit aims to foster awareness and capability of participating enrollees of low-cost nutritious food choices. Additionally, this value-added service will reduce obesity rates; improve lab values; provide better control of daily glucose levels; improved blood pressure levels and a reduction of morbidity. • **Diabetes nutrition:** An estimated 567,000 Kentuckians have diabetes, and the rate is up to three times as high for those with household incomes of less than $25,000 compared to those with household incomes over $50,000.[19] Some estimates have placed the reduction in life expectancy to be 10 years for type 2 diabetes and 20 years for type 1. Aetna offers a free basic diabetes course taught at various venues throughout the communities in Regions 4 and 8, where need is high. It is offered as a 6-8-week series. This value-added service will improve HbA1c levels in diabetic enrollees.
Home-delivered Meals	Meal delivery programs have demonstrated improvements in health outcomes, reducing hospital readmission rates, and lowering overall health care costs[20]. Aetna partners with Metropolitan Area Neighborhood Nutrition Alliance (MANNA), a non-profit organization that cooks and delivers nutritious, medically appropriate meals to enrollees post-discharge who are battling life-threatening illnesses such as cancer, renal disease, and HIV/AIDS. We also provide enrollees with tailored nutritional counseling. Research shows that enrollees who participate in the MANNA program visit the hospital 50% less and when hospitalized, the stay was 37% shorter.[21] This is a 12-week program with opportunity for 2-12-week cycles with the goal of educating enrollees on healthy eating, food preparation and more. This value-added service will improve HEDIS measures, reduce inpatient admissions and ER visits, lower HbA1c levels, improve blood pressure levels, promote a better understanding of healthy diet, and more.
"Keeping Kids Safe" Lockbox Program	Opioid involved deaths are a concern in Kentucky, with deaths per 100,000 persons at 27.9 (nearly two times the national average) and the state also ranks among the top ten in prescription rate.[22] Further, as discussed in Kentucky's State Health Improvement Plan, more than half (57%) of the state's opioid overdose ER visits were billed to Medicaid. The Keeping Kids Safe program is a part of Aetna's national campaign to fight the opiate crisis. This harm reduction intervention is used to support safety by providing enrollees with a lockbox to secure their medications. The primary goal is to reduce the number of accidental opioid exposures that could result in poisoning, injury, or even accidental death.

[18] County Health Rankings and Roadmaps, "Kentucky Rankings Data," (2019): http://www.countyhealthrankings.org/rankings/data/KY; accessed June 1, 2019
[19] Kentucky Public Health, "KENTUCKY State Health Improvement Plan," (2017 – 2022): https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf; accessed June 1, 2019
[20] JAMA Internal Medicine, "Association Between Receipt of a Medically Tailored Meal Program and Health Care Use," (2019): doi:10.1001/jamainternmed.2019.0198; accessed June 1, 2019
[21] Journal of Primary Care and Community Health, "Examining Health Care Costs Among MANNA Clients and a Comparison Group," (2013); http://www.mannapa.org/wp-content/uploads/2014/07/MANNA-Study.pdf; accessed June 1, 2019
[22] National Institute on Drug Abuse, "Kentucky Opioid Summary" (2019): https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary; accessed June 1, 2019

Benefit	Description
Start Strong	Combining in-prison treatment for substance abuse with after care has been shown to reduce recidivism rates by nearly three times.[23] In fact, the Criminal Justice Kentucky Treatment Outcome Study reported that of the substance abuse program graduates 70% were employed during the 12 months following release; 57.2% had not been re-incarcerated and 79.4% considered the treatment program to be successful.[24] Start Strong is a 90-day Jail Substance Abuse Diversion Program with 300 inmates. Each inmate is assigned a care manager assigned and treatment is provided for 90 days with 6 months of continued support; includes treatment, housing, bus passes, and job training. Inmates in Kenton County Detention Center (Region 6) receive wraparound services and additional support to ensure treatment without any gap. The care manager is embedded in the detention facility and works with our enrollees who are preparing for release. This value-added service will reduce gaps in care, increase medication adherence, and improve community re-entry success rates.

Multipurpose value-added service: Medicaid enrollees with chronic conditions often lack the resources, education, and support necessary to truly take charge of their own health and quality of life. After eight years of serving Kentuckians, we have seen and understand these diverse and unique challenges our enrollees face along their health journey. We recognize the need for an innovative, enrollee-driven approach to value added services for these enrollees that supports our fully integrated care model. To that end, we have designed our new **Momentum** program to empower enrollee self-care by providing a curated menu of unique services and supplies tailored to address their medical and social needs. Qualifying enrollees have a pool of funds available to use on these items and benefits through an electronic account accessible through the enrollee web portal, mobile application, or physical card. Examples of available options include funds to cover grocery delivery costs or meal delivery programs, mobile technology to help manage their diabetes, utility payment assistance to keep power on at home, or extra dental services not covered under Medicaid. By providing the tailored resources, education, and support they need, our enrollees will be empowered to proactively pursue their personal health and wellness goals.

Mobile enhancement to value-added services: Aetna is developing innovative enhancements to our enrollee mobile application and web portal to engage and educate enrollees about these value-added services. They will be able to see the value-added services for which they are eligible, as well as view information on their utilization of those benefits, and where applicable, request to receive the benefits or get more information. Enrollees can also receive assistance accessing these services through our Enrollee Services and Care Management staff who receive training about Aetna's VAS, with the goal of increasing enrollee access to and use of VAS.

Additionally, to improve the quality and impact of these benefits, we are developing our new Health Innovation Engine platform that will improve our ability to track and monitor eligibility, engagement, effectiveness, and spend for all enrollee value-added services. This innovative and proprietary web-based tool will be available at contract implementation. It streamlines all oversight functions, including the following:

- Addressing health disparities by proactively monitoring under-utilization trends among key at-risk populations
- Preventing fraud, waste, and abuse through benefit design management
- Identifying opportunities to better promote and improve our value-added services to meet the needs of our enrollees
- Measuring benefit impact through enrollee satisfaction, and where applicable, health outcomes

[23] Kentucky Public Health, "KENTUCKY State Health Improvement Plan," (2017 – 2022): https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf; accessed June 1, 2019
[24] Kentucky Department of Corrections, "Criminal Justice Kentucky Treatment Outcome Study," (2018): http://cdar.uky.edu/cjktos/Downloads/CJKTOS_FY2017_Report_Final.pdf; accessed June 1, 2019

b. Direct Access Services, Second Opinions, and Referrals for Services Not Covered

Aetna's approach to assisting enrollees to access direct access services and second opinions and referrals for services not covered includes informing enrollees through interactions with care managers and CHWs; educating providers so they can properly communicate these options with enrollees; person-to-person discussions with enrollee services call center staff; and through the enrollee handbook.

Aetna initially informs enrollees of our processes for direct access to covered services, second opinions, and referrals for non-covered services via the enrollee handbook. The handbook is in an easy-to-read format, using culturally appropriate language in both English and Spanish. Our enrollee website also includes an easy-to-use provider directory, which includes searchable attributes such as whether a provider is trauma-informed and if they have an accessible office for people with disabilities. Enrollees can also learn about direct access services, second opinions, and referrals for non-covered services by calling our person-centered Enrollee Services call center, which is available from 7 a.m.-7 p.m. Eastern time, Monday through Friday.

Enrollees also continue to receive support to access direct access services, no-cost second opinion, and get referrals for non-covered services through their ongoing interaction with Aetna care managers and CHWs. Care managers engage enrollees to complete an HRA to identify current and potential future physical, behavioral, functional, and social determinant needs. Based on the information provided by the enrollee during the HRA, the enrollee may be referred to care management for a holistic ENA and care planning, during which the enrollee is educated about direct access services, second opinions, and non-covered services that may help meet their whole person needs. All Aetna staff use motivational interviewing, Mental Health First Aid, and trauma-informed principles throughout all enrollee engagement activities.

Our Kentucky provider manual is available upon request via hard copy or via website. The manual also describes our processes for direct access, second opinions, and referrals for services not covered to our providers. Additionally, our provider services representatives make calls to providers, offer regularly scheduled town-hall meetings, and are available to support providers during our scheduled work hours. This comprehensive approach to educating providers facilitates the providers' ability to educate and support our enrollees.

Direct access: Aetna enrollees can directly access covered services from any Aetna provider without authorization from their PCP (as described in **Section 22.2 Enrollee Handbook of the Draft Medicaid Managed Care Model Contract and Appendices**), including the following:

- Primary care vision services, including one pair of eyeglasses for adults each year; also includes getting glasses fitted
- Primary care dental and oral surgery services and evaluations
- Family planning
- Maternity care for enrollees under 18 years of age
- Immunizations for enrollees 19 and over at pharmacy or health department
- Sexually transmitted disease screening, evaluation, and treatment are available from your PCP or public health departments
- Tuberculosis screening, evaluation, and treatment
- Testing for HIV, HIV-related conditions, and other communicable diseases
- Chiropractic services
- Women's health specialists

For individuals with special health care needs, direct access to a specialist is not restricted.

No cost second medical opinions: Aetna facilitates second opinions for an illness, surgery, or treatment that the enrollee's PCP has deemed appropriate. Enrollees are notified of processes for obtaining a second opinion in their enrollee handbook which is provided at the time of enrollment. To decrease administrative burden and promote person-centered care and to access second opinions, enrollees can call Aetna's Enrollee Services department or their PCP for help to access a second opinion. Aetna's enrollee services lines are available from 7 a.m.-7 p.m. Eastern Time, Monday through Friday. There is no cost to enrollees for second opinions administered by our providers or providers not in our network. All second opinions by providers not in our network require prior authorization from Aetna but are provided at no cost to enrollees.

Second Opinions for Eye and Dental Care

Consistent with Kentucky regulations, Avēsis makes available, at no charge to the enrollee, second opinions related surgical procedures and the diagnoses and treatment of complex or chronic conditions. Prior authorization is not required to secure a second opinion for either oral or ocular healthcare services. However, a doctor doing an evaluation for a surgical procedure typically bills for a high-level medical exam. Avēsis's Utilization Review teams conduct post-reviews on these claims to ensure they are not being used inappropriately.

When an enrollee calls to ask about the availability of second opinions, Avēsis's customer service representatives tell them they are welcome to seek a second opinion from an in-network provider at no charge to them. In the event the enrollee needs help finding an in-network provider who can offer a second opinion, we will conduct a search with them on the phone so they can end the call with referrals to providers within the state-mandated access standards.

Referrals for services not covered: We understand that while some enrollees in need of referrals for non-covered services or services not covered by plan (e.g., transportation) may be receiving ICM services, this is not the case for all enrollees needing those services. Through our experience, we recognize that our Enrollee Services and Outreach teams may be the first points of contact by an enrollee in need of non-covered service. Therefore, all enrollee-facing staff receive training in person-centered approaches. By combining person-centeredness with our community resource platforms such as Aunt Bertha and locally developed social resource guides, our ICM, Enrollee Services, and Outreach staff can listen to the enrollee, identify needs, and generate and track referrals. By enabling access to Unite Us, the referral agency can review the referral, follow up with the enrollee, and enter a disposition that enables Aetna to track its status. For unresolved referrals, Aetna's ICM team intercedes within reasonable timeframes.

Helping Tyler Access Non-Covered Services through a Referral to Unite Us

Tyler (not his real name), a 45-year-old enrollee who lives alone, was referred to care management from by the behavioral health (BH) discharge team due to multiple needs, including nutritional and financial difficulties, unemployment, outpatient BH care, and lacking a primary care provider. Tyler's situation was a result of past legal issues, and with the stress of no income, inability to pay bills, and no access to food, he had thoughts of suicide. The Aetna care manager took action and met with Tyler to complete an initial assessment, educate him about available resources, complete a Supplemental Nutrition Assistance Program (SNAP) application, and coordinate outpatient BH and primary care. A referral to Unite Us was also discussed; Tyler agreed, and participating agencies were contacted immediately. In just 10 days, two employment assistance agencies contacted Tyler. Two agencies for emergency financial assistance also reached out to establish continued stable housing, and his SNAP application was submitted. Food pantries and meal centers were also identified, and Tyler went to them to receive food. The care manager's quick, thorough action offered immediate support for Tyler's non-medical needs. Tyler has been very grateful and communicative with Unite Us agencies.

Enrollees may be identified for assessment by our ICM team through the process described previously. However, enrollees may also be identified for ICM services through our predictive modeling processes, provider, enrollee, guardian or community stakeholder referral, through our utilization management activities, or by other means. Aetna's ICM team reviews social determinants impacting health and determination of unmet needs for all the enrollees that they assess. When appropriate, we assist the enrollee to identify a qualified health provider and conduct transition activities, including information and data sharing to coordinate and collaborate effectively. In some cases, an enrollee may require a new PCP; in this situation, our Enrollee Services and ICM teams support enrollee identification of a new PCP and facilitate a seamless transition through direct and virtual coordination services.

c. Interfacing and Coordinating with Commonwealth Departments and Facilities

Aetna strives to be the premier partner to the Department, DBHDID, and Commonwealth-operated or contracted facilities and hospitals, through the engaged participation of our leadership in regular interagency meetings. We proactively engage with stakeholders across the Commonwealth to identify opportunities to extend our collaborative efforts in the delivery of the high-quality health care to Kentuckians. Aetna is committed to continue and enhance our collaboration with the Commonwealth to promote successful Medicaid services for our enrollees. Our operational integrity and person-centered enrollee services and care management functions demonstrate our commitment to ongoing quality improvement and collaboration with the Commonwealth.

c.i. The Department and Department for Behavioral Health, Developmental, and Intellectual Disabilities

Collaborating with the Department: Through our active participation in quarterly quality meetings or more frequent meetings with the Department, we will review progress with the Commonwealth concerning our achievement on identified goals and targeted improvements for the Commonwealth's focal areas. Aetna, through the participation of our senior leadership, contributes to setting meeting agendas through the proactive identification of areas for discussion. By attending ad hoc meetings as requested by the Commonwealth, we will address Commonwealth priority areas and any concerns of noncompliance.

Assisting Eric with Relocation to a Safe Environment through Collaboration with his DAIL Caseworker

After discovering that Eric's (enrollee; not his real name) current person care home had bed bugs, the Department of Aging and Independent Living (DAIL) caseworker requested a new oxygen concentrator and attachments for the new facility in order to avoid spreading the bugs. The worker wanted to ensure that the equipment be delivered and set up to be all ready so Eric could experience a seamless transition. The DAIL case worker partnered with the care manager who reached out to the medical equipment company to coordinate the delivery of the new oxygen equipment, as well as to resolve the billing issues. Together, along with the equipment company, they arranged the delivery of the concentrator at the new home just as Eric arrived. This enabled the enrollee to have his new equipment set up and calibrated as he settled in resulting in a stress-free and painless transition.

Aetna regularly collaborates with IPRO (the Department's External Quality Review Organization) and the Department to monitor performance improvement projects established by the Department or initiated internally. When implementing performance improvement plans, we provide to the Department, no later than 14 business days prior to each quarterly meeting, an electronic report detailing our progress, successful strategies, and challenges in achieving improvements. In our quarterly meetings with the Commonwealth, we share information with the Commonwealth regarding our clinical care improvements such as development of best practices and use of encounter data-driven performance measures. We describe our relationships with existing organizations engaged in provider performance improvement through education and training in best

practices and data collection. We also share information and collaborate with the Commonwealth through our provision timely and accurate required and ad hoc reports. In addition, Aetna will collaborate with the Department on establishing collaborative agreements with Commonwealth-operated or Commonwealth-contracted psychiatric hospitals, as well as with other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use.

Evidence of our past collaboration and support include the following: the transition of 68,000 Kentucky Spirit enrollees when the plan left the Commonwealth; our assistance with the purchase and provision of Naltrexone to support the Commonwealth's efforts to address the opioid epidemic; solely taking on the Quit Incentive for Pregnant Smokers program; piloting a program with the University of Kentucky to remove prior authorization requirements for buprenorphine; and our work with the Department to create a Therapeutic Rehabilitation Program for enrollees with co-occurring disorders.

DBHDID: Aetna coordinates with DBHDID to provide enrollees served through DBHDID high-quality services that meet their unique, whole-person needs. According to the National Alliance on Mental Illness, one in five adults in the United States experiences mental illness, and 43.3 percent of adults with mental illness receive treatment with the average delay between the onset of mental illness symptoms and treatment being 11 years.[25] To demonstrate our commitment to furthering the goals of DBHDID, we have participated in ad hoc meetings to assist in developing better communication and collaboration with CMHCs. To enhance our engagement with behavioral health and developmental/intellectual disability stakeholders, we are including a recovery and resiliency administrator in our system of care in Kentucky whose role will be to forge partnerships with parents, DBHDID, and developmental/intellectual disability and metal health advocacy groups to make sure our organization is well-informed about their specific needs, current resources, and gaps in access and services. We want to make sure that when individuals with serious mental illness, serious emotional disturbance, DID, or other behavioral health or developmental conditions enroll with Aetna, that we are better able to respond quickly and accurately with individualized services designed to stabilize and support their wellness. Aetna stands ready to partner with the Department, the DD Council, and the University Center of Excellence to support these enrollees and to assist in advocacy efforts to eliminate stigma and barriers to much needed funding and services.

Aetna will provide DBHDID with our proposed materials and protocols during implementation within the specified timeframe. During implementation we will also work with the Department, DBHDID and CMHCs to establish written processes and procedures for integrating Behavioral Health Services Hotlines with Aetna's designated Enrollee Services call center processes and systems.

Aetna experience collaborating with the Kentucky justice system: The following programs provide examples of the fruition of our participatory meetings and collaboration with Kentucky agencies:

- **Kenton County Jail:** Aetna is the only Medicaid managed care organization in the state with a re-entry coach (care manager) embedded in a justice system facility. Aetna's partnership with Kenton County Jail and the Hazelden Betty Ford Foundation results in the creation of one of the nation's first prison-based substance use treatment programs, Start Strong. The Start Strong Re-entry Program, a 90-day jail substance abuse program with six months of follow-up support, helps people move beyond addiction and establish healthy, productive lives. This comprehensive opioid response program is integrated with a 12-step approach. Start Strong includes medication and comprehensive therapy. Aetna's full-time onsite licensed clinical social worker works with the inmates to facilitate continued access to medications and treatment upon release. Other organizations working with Aetna on this project include Healthpoint, St. Elizabeth Healthcare's Journey Recovery Center, and Ethan

[25] National Alliance on Mental Illness, "Mental Health by the Numbers," (2019); https://www.nami.org/learn-more/mental-health-by-the-numbers: accessed January 22, 2020

Health to address enrollees' physical and mental health needs, which includes medication-assisted treatment medications.

- **State Project Release Program**: Currently, Aetna is collaborating with the State Project Release Program. The focus of this program is to directly care manage enrollees with co-occurring disorders,
- such as substance use disorder and a mental health diagnosis—for example, bipolar disorder I or II. Working with the Department of Correction re-entry officer, we have been a supportive partner with the Commonwealth and a leader in identifying ways to improve the process and workflow.

Collaboration with Kenton County Detention Center

"New and innovative ways to engage vulnerable populations will always be a primary goal for us at Kenton County Detention Center. Research and experience tell us that individuals are most at-risk during the first few weeks of the re-entry process. Courtney Ham, Aetna's Start Strong targeted care manager, has taken the re-entry process to levels of success we have never seen before. The Start Strong Re-entry Program has reduced recidivism, while increasing the safety and wellness of our communities. We are very proud of our partnership with Aetna Better Health of Kentucky. Making our mutual goals a reality."

—Jason Merrick,
Director of Addiction Services,
Kenton County Detention Center

Meetings during contract implementation: During implementation, Aetna will meet with local health departments, behavioral health agencies, community-based health and social services agencies, and health care delivery systems to discuss the desired priority areas for outcome improvements and outline plans to achieve success. During this time, we will also develop formal collaborative agreements with these organizations. As an example, our collaborative agreements will outline processes for streamlining and promoting enrollee access and information sharing for the services of public health departments, DBHDID, CMHCs, RHCs, FQHCs, the Office for Children with Special Health Care Needs, and charitable care providers such as Shriner's Hospital for Children. We have strategy meetings with KPCA, St. Elizabeth Healthcare, and KHP to identify and collaborate on a quality strategy, discuss trends and performance, and work through gaps in care (GIC) reports to drill down on enrollee behavior and closing gaps. We seek innovative solutions with our partners; specifically, with KPCA we are pursuing a delegated care management arrangement to have a direct enrollee impact on their care. KPCA also works with us on NCQA and strategies to impact the provider network data accuracy. We are collaborating with KentuckyOne on our electronic population health management platform to create efficient communication between our care management teams (Aetna and KHP) as well as providing GIC reporting through our electronic population health management platform. Per section **30.7 of the Draft Medicaid Managed Care Model Contract and Appendices**, Aetna's behavioral health director (or designee) will meet with the Department and DBHDID no less than quarterly to discuss State Mental Health Authority and Single State Agency protocols, rules, and regulations.

c.ii. Collaborative Agreements with State-operated or Contracted Hospitals and Facilities

Since 2011, the Aetna Medicaid organization has collaborated with Commonwealth-operated and contracted hospitals and facilities to improve coordination of care and discharge planning to ensure a safe and smooth transition to most appropriate and least restrictive level of care. For example, currently Aetna assigns designated care managers to Commonwealth hospital admissions for follow-up and outreach with both enrollees and facility administrators. Also, our designated Commonwealth hospital care managers participate in regional transition and Olmstead meetings. During the regional transition meetings, we educate the committee about our array of supports and services available to Aetna's enrollees.

Aetna ensures, by entering into collaborative contractual agreements with state psychiatric hospitals and behavioral health providers, that enrollees have continuity of care upon discharge from the hospital. Our

contractual agreements specify the responsibilities of the behavioral health service providers to ensure successful transition back into community-based supports. In addition, we require providers to participate in quarterly continuity of care meetings hosted by the state psychiatric hospitals. Our contractual agreements require that providers assign a case manager prior to or on the day of discharge. Aetna's care managers also attend these quarterly meetings as well as the regional transition of care meetings to assist with monitoring compliance and improving the provision of continuity of care for our members.

Assisting an Enrollee with Frequent Psychiatric Inpatient Admissions

Nick (enrollee, not his real name) is 58 years of age and has been diagnosed with bipolar disorder with psychotic features, with symptoms first surfacing in 1980. He experiences frequent paranoia and delusional thoughts (including the beliefs that he was taken prisoner to serve in Vietnam and has undergone many unauthorized surgeries). In the past, he has had lithium toxicity which resulted in him being in a coma. To stabilize his mood, he is still taking lithium and Depakote. However, when symptoms and mood improve, he believes he no longer needs his medication, resulting in frequent inpatient treatment at the state psychiatric hospital close to where he lives. Nick and his hospital social worker met with Aetna's embedded care manager at the hospital who agreed that enrolling in Aetna's ICM program could benefit him. Initially reluctant, Nick grew to trust the Aetna care manager through consistent contact, both in person and via telephone that utilized motivational interviewing skills and enrolled in an ICM plan. This resulted in drastic continued improvement in overall mental health; he is experiencing fewer paranoid thoughts, takes his medication, and is engaged in therapy sessions. He is also able to recognize when his mental health may be declining and has had only one inpatient admission in the six months since enrolling. By working with his care manager, Nick has learned to trust and feel comfortable contacting Aetna to make sure his needs are met.

During implementation, we will also meet with designed leadership of the Commonwealth-operated or Commonwealth-contracted psychiatric hospitals, as well as with other Department facilities used by individuals with co-occurring behavioral health and DID. The purpose of these meetings will be to introduce our new contract and to discuss current collaborative processes and effective future-state changes. With the agreement of leadership of the hospital or facility, we will establish written collaborative agreements. Currently, Aetna participates in quarterly/monthly meetings and Olmstead meetings with Commonwealth hospitals to discuss BH discharge follow-up transition processes.

Challenges and solutions: Aetna recognizes the Department's stakeholder community consists of a diverse population of individuals from all backgrounds throughout Kentucky, including individuals with I/DD with co-occurring behavioral health conditions, families, advocacy and protection agencies, DBHDID, the Department of Juvenile Justice, Adult Protective Services, Area Agencies on Aging/Aging & Disability Resource Centers, the Department of Guardianship Services, the Department of Health Services, and the Department of Child Protection Services, among others. Coordinating with such a broad range of stakeholders can lead to challenges in collecting, understanding, and addressing their concerns when developing collaborative agreements with Commonwealth-operated or Commonwealth-contracted psychiatric hospitals or other Department facilities that individuals with co-occurring behavioral health and DID use.

Our Quality Management Committee uses stakeholder feedback to understand areas for improvement that we address through a Plan-Do-Study-Act (PDSA) approach. We maintain a comprehensive Quality Assessment and Performance Improvement (QAPI) program and conduct ongoing self-monitoring to ensure the system is efficient, coordinated, and results in improved health outcomes for enrollees. We review feedback from the PDSA and QAPI data in our multidisciplinary Quality Management/Utilization Management (QM/UM) Committee, and then recommend actions are implemented and traced to ensure strategies effectively improve access to and the quality of enrollee care.

In addition, to best collaborate with Commonwealth-operated or contracted psychiatric hospitals, we have a designated care manager who is assigned to all Commonwealth hospital referrals for follow-up and outreach. Additionally, we have care managers who are assigned to these facilities who participate in Regional Transition Committee (RTC) meetings, as well as Olmstead meetings. Aetna care managers educate the RTC about available supports and services to meet enrollees' unique, whole-person needs as well as answer questions about our authorization processes, including rationales for utilization determinations. Through our QM/UM Committee, Aetna communicates the barrier trends and pattern expressed in RTC meetings to our leadership

Success in Reducing Provider-Preventable Conditions in Kentucky

Monitoring and educating our providers on PPCs has resulted in improved health outcomes for our enrollees. Beginning in 2016, Aetna has successfully reduced PPCs from 36 in 2016, to 32 in 2017, to 30 in 2018, to 28 in 2019. This represents a **22% decline in 4 years**. Breaking down the PPCs by category, Aetna has seen a reduction in complications of surgery where our members had to return to the operating room drop by 57% over the four-year period, while central line infections have declined by 43.5% in the last two years.

c.iii. Complying with the Mental Health Parity and Addiction Equity Act

Aetna is experienced in complying with the Mental Health Parity and Addition Equity Act of 2008 and 42 C.F.R. 438 Subpart K in Kentucky and the additional 15 states where we provide Medicaid managed care services. Through our initiation of activities to comply with these acts in 2008 we have conducted legal reviews and comprehensive actuarial analysis. As a result, our processes and systems are in place to fully comply with the act. The treatment limitations we apply to mental health and substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by Aetna. Additionally, there are no separate treatment limitations applicable to mental health or substance use disorder benefits. Aetna provider agreements require provider compliance with the Mental Health Parity and Addiction Equity Act. Aetna's Kentucky Parity Grid is included as **Attachment Q**.

d. Identifying Trends and Educating Providers on Provider-preventable Conditions

Aetna supports the Commonwealth's goal to improve participants' health and help them be responsible for their health. In support, we identify and trend provider preventable conditions. Aetna monitors all provider preventable conditions (PPCs) on a quarterly basis, or more frequently as needed. PPCs are identified through onsite reviews or review of medical records and claims. Identification of provider preventable conditions also occurs through our UM and QM activities and through the data mining that occurs through use of our predictive modeling tool. These are defined as an event resulting in unintended harm to the enrollee by an act of commission or omission rather than by the underlying disease or condition of the enrollee. PPCs are related to both hospital and non-hospital conditions identified by the Department for nonpayment.

Since 2012, our QAPI has included work streams for trending PPCs. Results are reviewed in our QM/UM Committee and forwarded to the Quality Management Oversight Committee, overseen by the chief medical officer. When identified PPCs require review and support from additional experts outside the Kentucky health plan, they are referred to the National Quality Oversight Committee.

In 2016 the two most common PPCs were infections associated with vascular catheters (12 events) and surgical complications leading to unplanned trips back to the operating room (7 events). These remained the two highest categories in 2017, with 11 and 5 events, respectively. However, by 2018, these PPCs dropped to 4 instances of infection and 3 surgical complications. As PPCs are considered never events, they are always investigated. The trends show the investigations of vascular catheter infections and

surgical complications in 2016 and 2017, ongoing provider education, and outreach to our Provider Relations staff and medical directors after the investigations led to a decrease in PPCs in these categories.

Responding to a PPC with Provider Education

A teenage enrollee was admitted to an inpatient mental health facility for suicidal ideation. While admitted, she told her mother she had been sexually assaulted by a male in the facility. The enrollee's mother informed the Aetna care manager that the Commonwealth facility refused to report incident to police, so she did herself and then picked up her child from the facility. The enrollee had been on suicide checks at the facility every 15 minutes, but she stated a male came into her room and touched her inappropriately. Aetna requested her medical records and verified that the facility had not contacted the Department for Community Based Services about the alleged incident. Based on a review of all available information, Aetna found the facility did not comply with their policy for reporting suspected abuse and did not comply with Commonwealth regulations. A corrective action plan was put in place and the facility modified its policy to conform to Commonwealth regulations. Further incidents of abuse will be reported to local/state police, the Cabinet, and the Commonwealth's attorney as per regulation KRS 620.030. This case was presented at the QM/UM Committee, where the corrective action plan was approved, and was also presented at the National Quality Oversight Committee where it was also approved.

Aetna takes a multipronged approach to reduce the incidence of PPCs, including the following:

- Educating providers on provider-preventable conditions: an Aetna Quality Management nurse seeks information from facilities and providers when a PPC has occurred, identifies educational opportunities to make sure future PPCs do not occur. The facility/provider develops an education plan, which is reviewed both at the local Aetna plan, at the National Quality Oversight Committee, as needed.
- Medical director direct outreach to trended identified outlier providers
- Use of value-based incentives to encourage preventive and evidence-based care
- Direct outreach by our Pharmacy team to enrollees who have medication gaps in care for chronic and complex conditions to prevent adverse medication-related events
- Follow-up reminders for post-discharge physical and behavioral health care within 7 and 30 days of discharge
- Medication reconciliation at discharge by the Care Management team

The role of Avēsis in reducing PPCs: The primary risk for provider preventable conditions in dental is substance use disorder. Research demonstrates that opioids prescribed for young adults following dental procedures are associated with a risk for increased opioid use.[26] The Commonwealth has long understood the relationship between opioid prescriptions and substance use disorder. It was the first in the country to implement a statewide opioid prescription monitoring program and related guidelines, regulations, and laws. Understanding the relationship between substance use disorder and opioid prescriptions, Avēsis and Aetna began working in early 2018 on a joint project to analyze the opioid prescribing patterns of our providers to ascertain if they comply with established guidelines from Kentucky's KASPER program, as well as the recommendations from the American Association of Oral and Maxillofacial surgeons and the American Dental Association. These guidelines generally recommend starting with nonsteroidal anti-inflammatory drugs and Tylenol since double-blind, evidence-based studies show this just as effective as Codeine with Tylenol. The guidelines also recommend prescribing of no more than three days of opioids following dental care.

26 Schroeder, Alan, et al. "Association of opioid prescriptions from dental clinicians for US adolescents and young adults with subsequent opioid use and abuse," JAMA Internal Med 2019; 179(2): 145-152; https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2717503: accessed June 13, 2019

Avēsis analyzed 12 months of data and determined there were 240 unique Kentucky dental providers in their network who prescribed greater than three days of opioids for one treatment in 780 unique enrollee encounters; prescriptions ranged from four days to 30 days of drugs. After all data was analyzed, a co-branded provider notification letter was mailed to these 240 providers in mid-December 2018. Data run in late October 2019, ten months after the letter was mailed, shows a 52.9 percent decrease in dental prescribers prescribing greater than 3 days' supply of opioids among the cohort being monitored. There was a 90 percent decrease in the number of opioid prescriptions being written by providers who had written three or more prescriptions for more than a three-day supply in the initial 12-month analysis period. Dental providers who have not decreased their prescribing patterns will be visited by Avēsis's in-state dental director, Dr. Jerry Caudill, for a peer-to-peer discussion of their prescribing patterns and the impact of opioid prescriptions on substance use disorder, particularly among young people.

This cooperative program between Aetna and our dental benefits subcontractor, Avēsis, is proving to be an effective strategy for reducing Kentucky Medicaid enrollees' exposure to opioid prescriptions, which may potentially contribute to a reduction in the incidence and prevalence of substance use disorder.

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60.7.C.21 Pharmacy Benefits

Kentucky | Transforming Health Care | **Aetna**

60.7.C.21 Pharmacy Benefits (Section 31 Pharmacy Benefits)

Aetna has an extensive experience managing prescription benefits for over 211,000 Kentucky Medicaid enrollees and has a proven track record of providing pharmacy benefits and services. We work collaboratively with our internal and external partners to optimize our enrollees' health outcomes by promoting safe, efficient, and effective medication therapy. Having served Kentucky Medicaid enrollees for over eight years[1], we understand the importance of creating a healthier Kentucky by improving access to health care, creating opportunities for enhanced integration, and working to create and establish enrollee-centric pharmacy programs to help our enrollees and the Commonwealth meet their health and wellness goals.

Our recent initiatives in the Commonwealth include two key innovative, highly collaborative, and integrated enrollee-centered programs that advance our approach: the **Aetna-Community Pharmacy Enhanced Services Network (CPESN) Community Pharmacy Care Management program** and the **Aetna Medicaid Pharmacy Hospital Readmission Reduction Program (HRRP)**. These programs promote appropriate use of medications and health care resources while decreasing fragmentation and increasing integration across providers.

Our local, enrollee-centered approach focuses on individuals' holistic health needs by providing access to and delivery of cost-effective health care services. Aetna understands, acknowledges, and will comply with all the requirements for **Section 31. Pharmacy Benefits** as outlined in the **Draft Medicaid Managed Care Contract and Appendices**.

a. Proposed Approach to Administration of Pharmacy Benefits and Related Pharmacy Services

Aetna's approach to administering pharmacy benefits and supporting positive outcomes involves a comprehensive review of the enrollee's medication history in collaboration with enrollees, providers, and pharmacies before, during, and after dispensing to achieve an appropriate therapeutic regimen. To improve enrollee health and quality of care, we use a systematic, ongoing process to review the prescribing, dispensing, and use of medications that preserve enrollee access to clinically appropriate medications. Our experience has shown there are challenges in the following areas: substance use disorder (SUD), smoking cessation, and hepatitis-C. We are committed to continuing to work collaboratively with the Commonwealth to address these and other ongoing issues that impact enrollee health.

a.i. Approach to Integration of Pharmacy Benefit Manager's Services with Other Plan Services, and Assuring Transparency in Pricing and Reporting

Aetna partners with CaremarkPCS Health, L.L.C. (CaremarkPCS Health) as our pharmacy benefit manager (PBM) to support our provision of the pharmacy benefit. Our PBM delivers a best-in-class pharmacy claims adjudication and payment system to our Medicaid enrollees and providers. Our Utilization Review Accreditation Commission-accredited PBM has been serving the Medicaid population since 1988, and currently supports 33 managed Medicaid health plans and more than 26 million covered

[1] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

enrollees in 35 states. CaremarkPCS Health has provided PBM services in Kentucky since 2013, and they currently support over 1 million enrollees.

Per the supporting documentation requirement, we have included **Attachment R, copy of the Pharmacy Benefit Manager Subcontract**.

Approach to Integration of Pharmacy Information and Services with Our PBM

Aetna integrates pharmacy information and services with our PBM, within our organization, and with the Department as described in this section and throughout the document. Additionally, our use of tools and programs discussed extensively within the drug utilization review (DUR) section of this response further demonstrates the results of our collaboration and integration with all our internal and external stakeholders.

Demonstrating Integration with Our PBM

Aetna works continuously with our PBM to enhance our enrollee and provider experiences. We collaborate to optimize enrollee health outcomes by ensuring access to appropriate medications and providing innovative solutions to enrollees, prescribers, and pharmacies. We work diligently and collaboratively to ensure our pharmacy benefit and clinical programs function consistently with Department requirements and the needs of our enrollees and providers. Systems and services provided by our PBM include, but are not limited to, pharmacy claims processing, encounters creation, call center services, pharmacy network management, and Kentucky-specific clinical medication use programs which are developed and implemented under the direction of the Aetna pharmacy director, chief medical officer (CMO), and Aetna Medicaid organization pharmacy management.

The Aetna Medicaid organization uses pharmacy benefit edits coded within our PBM's pharmacy claims processing system as well as real-time provider education messages to combat the opioid epidemic sweeping across Kentucky and the country. To support our opioid project's overall goal of increasing the health and wellness of enrollees and offering education to our providers, Aetna has developed an opioid strategy that is enterprise-wide and includes all Aetna clinical and operational departments. Our opioid initiative works to impact every aspect of awareness, delivery, and use of opioids. We strive to reduce the supply of opioids and decrease the rates of overdose. Our strategic solutions include prevention, intervention, and support components for enrollees and providers, thus addressing the continuum of needs in an enrollee-centered manner. The Aetna Medicaid organization recently introduced our opioid dashboard that provides national and state-specific progress toward our project goals.

The Kentucky-specific opioid dashboard metrics summarized in **Table C.21-1** demonstrates our progression towards meeting our five-year plan 2022 goals.

Table C.21-1: Opioid Dashboard Metrics for Kentucky

Metric	Goal	Kentucky Metrics as of September 2019
Increasing our rate of treatment with non-opioid procedures for chronic pain	50%	Exceeded at 54.2%
Decreasing our rate of opioid prescriptions in enrollees with opioid use disorder	50%	Close at 45.1%
Decreasing our rate of concomitant opioid and benzodiazepine use	50%	24.4%
Decreasing our rate of opioid prescriptions in enrollee with prior overdose	50%	Exceeded at 65.7%
Decreasing the rate of 7+ day opioid prescriptions after an acute procedure	50%	Exceeded at 83.8%
Increasing the rate of medication assisted treatment (MAT) in enrollees with opioid use disorder	50%	14.6%

Supporting Integration within Aetna

Aetna's Pharmacy staff works closely with our Medical Management, Care Management, Utilization Management, and Provider Services staff to collaborate and exchange ideas on programs used to improve enrollee and provider access and use of medications and services. When we are faced with a challenge, we convene specific interdisciplinary teams to identify and implement solutions. All departments proactively share data and resources to address the challenges and improve health outcomes for our enrollees.

A program that demonstrates the Pharmacy team's integration with our Medical Management and Care Management teams as well as our medical and pharmacy providers is the **CPESN program.** This program focuses on identifying and meeting our enrollees' pharmacy and health needs by bringing resources to enrollees in their community.

CPESN Program Identifies and Resolves Food Insecurity Issue for Enrollee

An enrollee was referred to the CPESN program to resolve polypharmacy concerns. His medical history was positive for diabetes, peripheral neuropathy, hypertension, and heart disease. Even though the enrollee was working with his pharmacist and was compliant with his medications for diabetes, the enrollee still struggled with uncontrolled blood sugar levels. Because of the enrollee-pharmacist relationship, the enrollee felt comfortable confiding in his community pharmacist and shared that he had limited access to healthy food and no food in his home at that time.

The pharmacist sent an urgent referral to the Aetna Care Management team for assistance with locating resources for the enrollee. The team contacted the enrollee and assessed his needs. A care manager recognized that the enrollee was disabled, lived on a fixed income in a low-income housing apartment, had lost his Supplemental Nutrition Assistance Program benefits, had no transportation, suffered from impaired mobility, and had very limited social supports. The enrollee also disclosed that he utilized his local convenience store for his grocery needs.

The care manager located a community resource that could supply the enrollee with a food basket delivered directly to the enrollee's residence to resolve his acute need for nutritional food. Additionally, Aetna established a plan to prevent future situations through a community resource that services the enrollee's low-income housing unit—a mobile grocery store that is available every week at a set time. This community resource eliminated the transportation barrier, was more cost-effective for the enrollee, and provided healthier nutritional food options.

The CPESN program utilizes local community pharmacists to engage enrollees and create individual enrollee pharmacy care plans that define interventions based on a comprehensive assessment of enrollee medication use and health needs. The program goals include the following:

- Encourage collaboration between care managers, community pharmacists, plan pharmacists, and plan medical directors to engage providers and positively impact enrollee outcomes. Engage community pharmacists to identify social determinants, which can be addressed by care managers. Identify care management resources that can be provided through community pharmacists that improves enrollee outcomes.
- Improve health and appropriate medication use: decrease polypharmacy and gaps in care, increase compliance, and improve safety.
- Decrease costs and waste, improve appropriate use of care (emergency room [ER], primary care provider [PCP], etc.).
- Deliver resources to enrollees and providers in a coordinated and simple (easy to understand and act upon) manner.
- Leverage local community pharmacist-provider relationships to impact change and improve access to services.

Enrollees are identified for outreach based on presence of polypharmacy concerns (greater than 4 prescriptions in 60 days) commonly seen with medical conditions such as hypertension, diabetes, asthma/chronic obstructive pulmonary disease (COPD), behavioral health conditions, and chronic pain. For the pilot program, 181 enrollees were supported by the 7 participating CPESN pharmacies for engagement and care planning. The Aetna-CPESN care team limited the number of enrollees for outreach, and the number of CPESN pharmacies allow for us to identify resource requirements and assess value of the program. However, we are expanding the number of participating pharmacies and enrollees in this program based on the positive results described in this section.

Throughout the program, CPESN pharmacists consulted with enrollees, providers, and Aetna team members to resolve medication and health concerns. All activities and resolutions were documented in enrollee pharmacy care plans. CPESN pharmacists contacted Aetna team members via phone to discuss enrollee needs and resolve issues as needed. Additionally, our dedicated care manager and clinical pharmacist had monthly scheduled calls with each pharmacy to discuss submitted care plans, make recommendations for formulary alternatives if appropriate, discuss the social determinants of health (SDOH) issues that were identified, assess care plan goals, and discuss any new cases the CPESN pharmacy wanted to refer to Aetna for outreach.

In 2019, the Aetna-CPESN care team conducted over 65 case conferences discussing 181 enrollees with potential health concerns. The integrated team collaborated on and assisted over 98 enrollees, created 151 pharmacy care plans for 90 enrollees, and took over 314 actions to resolve care issues. Pharmacist actions that focused on coordinating care with medical providers and changing drug therapy had a 59.5 percent (50 of 84 recommendations) acceptance and success rate, resulting in drug therapy changes for members thus improving medication safety, closing gaps, and improving enrollee adherence to required drug therapy. Care plan actions include, but are not limited to, the following:

- Medication reconciliation, synchronization, adherence packaging, and home delivery services
- Coordination of care with PCPs and specialists to change drug therapy by closing therapy gap, decreasing pill burden and medication regimen complexity, or initiating therapy (e.g., vaccines, smoking cessation products)
- Pharmacist-conducted enrollee-specific education on smoking cessation, nutrition and exercise, medication adherence, diabetes care and glucose monitoring, and blood pressure monitoring
- Referrals to Aetna care management for action on identified SDOH issues, need for durable medical equipment or specialty provider consultation, or family planning services

CPESN pharmacist and Aetna care team actions resulted in the following:

- Sixty-one (61) of 90 enrollee care plans were closed due to achievement of care plan goals; care plan closure was agreed upon between the Aetna care management lead, CPESN pharmacist, and enrollee.
- Five SDOH enrollee referrals to Aetna care management were accepted and resolved.
- Three enrollees successfully converted to preferred drug list (PDL) medications (e.g., Admelog®) as needed.
- Six CPESN pharmacies had CPESN USA-quality control assessments conducted and reported to the Aetna team. The quality score cards revealed that five out of six pharmacies overall performance ratings accounting for enrollee experience, care plan completeness, quality of care, and follow-up/timing of care were **above average and exceeded performance of other**

> "Aetna enrollees reported a very high rate of satisfaction with the program, and both CPESN pharmacies and Aetna care managers have multiple stories of problems resolved and progressed to better health outcomes because of the program. CPESN Kentucky looks forward to more opportunities to collaborate with Aetna in the new managed care contract term that begins in 2020."
>
> **—David Figg**
> **Independent Community Pharmacy Owner**
> **CPESN, Kentucky**

CPESN pharmacies in Kentucky. Action plans were created for pharmacies in areas with improvement opportunities.

- Enrollee experience surveys conducted in January 2019 through September 2019 for the program revealed that participants in the survey rated their overall experience with the CPESN pharmacy as "Excellent," **averaging 4.8 on a 5 point scale**, and "Strongly Agreed" that they would recommend the pharmacy to a family member or friend 100 percent of time, with an average score of 5 on a 5 point scale.
- **CPESN pharmacist testimonials** were captured to demonstrate how the program removed enrollee barriers to care and improved health outcomes. Pharmacists shared the following comments about specific enrollee cases:
  - *"My (the CPESN pharmacist) comprehensive medication review and consultation with the enrollee and Aetna team led to a drastic change in medication regimen and medical condition control. Prior to our initial intervention, this enrollee had severe uncontrolled type 2 diabetes, untreated elevated triglycerides, and smoked two packs per day. Since our initial consult this enrollee has met with an endocrinology group, initiated basal and meal-time insulin, completed a diabetes education class, started a fenofibrate to lower triglycerides, and is currently taking Chantix® using a gradual quit approach. The enrollee is now down to smoking a half pack per day of cigarettes. These changes will provide both current and lifelong benefits that may not have been achieved without this program."*
  - *"We (the CPESN pharmacist staff) expeditiously obtained a prior authorization (PA) for a medication via collaboration with the plan pharmacy director. The medication prevented a hospitalization. This incident was a prime example of the pharmacy, the doctor's office, and the insurance provider working together to benefit the enrollee."*
  - *"We (the CPESN pharmacist staff) had an enrollee who was non-adherent due to financial hardship, lack of transportation to office visits, and lack of understanding of the importance of the medications. After consultation with Aetna care manager and pharmacist identifying all resources available for the enrollee, we have educated the enrollee on the importance of all the medications, synced the medications, and put medications in bubble packages; the enrollee is now 95 percent adherent. Additionally, with the help of the Aetna staff, the enrollee was given transportation to office visits. The enrollee is currently working with an Aetna care manager to coordinate all daily living and health care needs."*

Additionally, pharmacists shared the following comments about their interactions with medical providers:

- One pharmacist noted they experienced improved communications and accountability with all involved parties (plan, provider, and enrollee).
- Some pharmacists noted they had positive working relationships with providers and were able to continue to make recommendations that were accepted by the medical provider: "Providers were happy to hear that we are working directly with Aetna enrollees."
- One pharmacist noted that he believes, "Medical providers do not realize how much pharmacists care for their patients and want to do more to improve their health. This program has allowed me to express this desire with medical providers, and so far, they have been very receptive and willing to help me help their patients."

The completed program assessments demonstrate the positive impact of the Aetna and community pharmacist collaboration; therefore, plans to expand the program in multiple communities are scheduled for 2020. Additional program assessments conducted in late 2019 (six months post-implementation) which focused on measuring the program's impact on enrollee medication adherence, closure of care gaps, decreased use of emergency room and hospitalizations, and resolution of SDOH concerns. Some outcomes demonstrated in our program evaluation for 60 members that received care planning services between January and May 2019 are as follows:

- **Emergency department utilization ('all cause'):** decrease by 183 claims (22.2 percent), with a decrease in costs by $29,551 (49.9 percent)

- **Outpatient utilization ('all cause'):** decrease by 749 claims (19.7 percent), with a decrease in costs by $146,319 (46.8 percent)
- **Inpatient utilization:** ('all cause'): decrease by 50 claims (31.7 percent)
- **Pharmacy utilization:** By increasing adherence and closing gaps in care, increased pharmacy utilization by 64 claims (1.5 percent)

Results will be shared by our pharmacy director with the Department. Consistent with our goal to provide options to the Department that align with their goal of exploring health care delivery system reform options that improve the quality and outcomes achieved by covered services (including medications), we believe the CPESN pharmacists' local presence and integrated care plan process is an effective way of bringing enrollee-centric care to our enrollees in their communities.

Another program that demonstrates the Pharmacy team's integration with our Medical and Care Management teams and our providers is the **HRRP.** This program utilizes clinical pharmacists in collaboration with providers and care managers to perform medication reconciliation and review after enrollees are discharged from the inpatient hospital setting. The clinical pharmacist is connected with enrollees in need of transition of care medication reconciliation by Aetna care managers and clinical staff. Additionally, our clinical pharmacist reviews facility discharge reports, care manager notes, and targeted medication profiles to identify enrollees in need of assistance with medications. The clinical pharmacist then outreaches to enrollees to ensure they have access to and understand their medications and how they should be taken. If needed, the clinical pharmacist will engage an enrollee's medical and/or behavioral health providers to determine the appropriate medication regimen and treatment plan for the enrollee. When appropriate and if needed, the clinical pharmacist will engage one of our CPESN pharmacists to assist with an enrollee's transition to home and long-term medication needs, which may include a pharmacy care plan.

Because the HRRP program is new in 2019, outcome results which include pre-post pharmacy and medical claims analysis to assess impact on hospital readmission, ER visits, and other health care costs which are not yet available but are planned to be collected and reported to our Care Management and Medical Management departments as well as the Department in 2020. Based on results achieved by the HRRP program in our Arizona and Virginia Medicaid plans (which are noted in this section), we anticipate that costs savings based on changes in pharmacy and medical resource utilization will be achieved.

In 2019, our clinical pharmacist reviewed and acted on 280 hospital discharged enrollees. The Pharmacy Medication Management Program (PMMP) clinical pharmacist collaborated with an Aetna care manager on the enrollee's care for 106 of 280 of the enrollees. Medication therapy concerns were identified and addressed with enrollees and providers; concerns included adherence and gaps in care (73 percent), therapeutic duplication (16 percent), drug intolerance or interactions (14 percent), and formulary opportunity or indication for concern (15 percent).

HRRP program activities conducted for 53 Arizona and Virginia enrollees between July and March 2019 resulted in cost savings of $114,613 in pharmacy and medical costs. Savings were based on six-month pre- and post-claims review for these enrollees and were validated by our Medical Economics team. Additionally, out of 50 enrollees who received services from June 2018 through July 2019, only 3 were readmitted to the hospital within 30 days. This represents a readmission rate of 6 percent, which is significantly lower than the overall health plan all-cause readmission rate of 10.5 percent.

Additional examples of integration of pharmacy information and resources and collaboration of our Pharmacy, Medical Management, Care Management, and Utilization Management teams is found in **Table C.21-2**, which displays our interdisciplinary team's collaborative work to improve health outcomes for our enrollees.

Table C.21-2: Collaboration between Aetna's Pharmacy and Internal Departments

Team	Collaborative Challenge	Strategy to Overcome Challenge
Care Management	• Identify enrollees with SUD medication. Engage with care management to ensure adherence to therapy and increase access to MAT. • Identify enrollees utilizing Makena® to prevent preterm delivery and engage in care management services. • Identify enrollees with complex medical conditions in need of care management assistance to navigate health care resources.	Utilize weekly or monthly pharmacy claims reports from RxNavigator tool to identify enrollees for targeted outreach for engagement in care management services. Reports include the following: • SUD First Fill • Makena® First Fill • Specialty Drug Fill
Compliance	Address and resolve enrollee-related concerns that are presented to Compliance from the Department.	Utilize pharmacy systems (RxClaim, PeopleSafe®, and Clinical Authorization System) to investigate enrollee medication use activities and address concerns regarding medication access (i.e., formulary, PA, quantity limits) and provide resolution. Provide education to provider and enrollee consistent with enrollee-centric care principles. Work directly with enrollee's pharmacy to resolve processing issues.
Quality Management	Assist with identification of enrollees with specific needs consistent with performance improvement programs. • Identify pediatric enrollees new to attention-deficit/hyperactivity disorder (ADHD) therapy. Engage parent/guardian and provide information regarding additional services available. • Identify foster care enrollees new to antipsychotic therapy. Engage guardian and provide information regarding additional services available. • Identify new mothers filling antidepressant medications and provide information regarding additional services available. • Identify pregnant enrollees filling smoking cessation medications. Engage and provide information regarding additional services available.	Utilize weekly or monthly pharmacy claims reports to identify enrollees for targeted outreach. Reports include the following: • ADHD Fill Report • Antipsychotic Fill Report • Postpartum Depression (PPD) Fill Report • Smoking Cessation Fill Report Support Quality Management team's enrollee and provider outreach programs, and if needed, provide feedback based on change in prescription use. In 2019, mailings to educate and engage enrollees were completed and included: 5,489 enrollees identified on ADHD, 3,378 enrollees identified on PPD report, and 203 enrollees identified on smoking cessation.

In addition to these examples, Aetna's pharmacy director and Care Management collaborate with our PBM to ensure the needs of our enrollees are being met. Our care managers have access to PeopleSafe®, our pharmacy claims system, which allows them to view enrollee prescription fill information that can be incorporated into their enrollee care plans. Additionally, we utilize select PBM provider outreach programs such as the Retrospective Safety Review and Safety and Monitoring Solutions programs to communicate relevant and timely information to our providers that will ensure enrollee safe medication use. We utilize reports generated by these PBM clinical programs to target enrollees in need for specific care management intervention. For example, we utilize the Safety and Monitoring Solutions report and referrals from our PBM clinical team to support the identification of enrollees for Aetna's Supportive Managed Care Program (SMCP), formerly known as the lock-in program.

The Safety and Monitoring Solutions program targets high-risk controlled substance use patterns such as polypharmacy, provider shopping, and high-total controlled substance claims volume. On a quarterly

basis, our PBM clinical pharmacists evaluate controlled substance claims and available supporting medical data to identify potential medication misuse and refer enrollees to Aetna for further action. The SMCP Care Coordination team utilizes these referrals from the PBM as well as other Aetna resources to validate the concern and identify enrollees in need of intervention. The SMCP Care Coordination team also utilizes an Aetna-developed Controlled Substance Poly-Pharmacy/Poly-Prescriber Report tool to assist in identifying members that may be over-utilizing services for pharmacy. The report identifies enrollees utilizing 5 to 10 different pharmacies and/or 5 to 10 different prescribers during a quarter. Utilizing the PBM and Aetna enrollee target lists as resources, the SCMP program works to put pharmacy and prescriber assignments in place to coordinate enrollee care and access to medications. **In 2019, 596 enrollees had their medications locked into a selected prescriber and pharmacy to ensure coordination of care consistent with the Aetna SMCP team's case determinations and provider and enrollee agreements.**

Supporting Integration between Aetna and the Commonwealth

Our pharmacy director works collaboratively with the Department as demonstrated in this section. Our pharmacy director participates in monthly Department workgroups that focus on identifying opportunities to provide more efficient and cost-effective pharmacy services. We collaborate with other Kentucky Medicaid plans to share our successes and lessons learned.

Examples of our collaborations and their results are as follows:

- In July 2013, we demonstrated our commitment and devotion to fellow Kentuckians and the power of collaboration with the Department and other Commonwealth agencies at a critical time. On July 6th (the Saturday of the Fourth of July holiday weekend), our health plan (operating then as Coventry Health and Life Insurance Company) welcomed 68,000 new enrollees when one of three Medicaid managed care organizations (MCOs) in the Commonwealth, Kentucky Spirit (Centene), ceased operations. Through diligent planning, expert execution, and unmatched passion by our experienced staff, we provided a smooth transition for our new enrollees and providers, while continuing to provide the best service for our existing membership. Our staff addressed the needs of our new membership, including processing enrollment and identification cards, conducting enrollee and provider calls, managing PA, and more. We urgently and necessarily achieved the following:
  - Monitored and loaded special enrollee files from July 5 through July 8
  - Managed an almost 50 percent increase in fax/call volumes for our PA and Health Services staff
  - Maintained the highest service levels and the best average speed to answer rates, with an average abandonment rate of less than 1 percent
  - Conducted care management outreach
  - Contacted new transplant enrollees and conducted medical review for each enrollee
  - Identified high-risk obstetrics patients and conducted outreach
  - Loaded enrollee eligibility files at the PBM within 24 hours to allow new enrollees uninterrupted access to needed medications
  - Made sure of no interruptions in therapy for medications that required PA for the new enrollees through our transition of care policy
  - Managed transition of care for and contacted enrollees with behavioral health needs
  - Maintained strong service levels for claims processing

  To this day, our health plan takes great pride in how we stepped up for our new enrollees and providers and collaborated with the Department to manage this rapid development and provide an opportunity for everyone involved. The outcomes of this transition proved that we will stop at nothing to serve and support our fellow Kentuckians.
- In November 2017, Aetna became the first of the Kentucky MCOs to implement a modified hepatitis C clinical pharmacy policy that increased access to hepatitis C medications by removing barriers such as drug and alcohol abstinence requirements, fibrosis score threshold, and once-per-lifetime treatment

restrictions as recommended by the American Association for the Study of Liver Diseases clinical guidelines. As a result of this change, **we observed an increase in enrollees accessing and completing curative hepatitis C treatment** demonstrated by the following data: **120 enrollees were treated in 2017, 308 in 2018, and 368 in 2019 (a 300 percent increase over 3 years)**. . Additionally, our care managers successfully worked with enrollees to ensure compliance with their treatment, resulting in 94.8 percent of enrollees who started hepatitis C medications in 2018 completing therapy.

Our care managers engaged our enrollees and counseled them on medication adherence and possible side effects, as well as addressed and resolved SDOH issues (if present). During conversations between care managers and enrollees, care managers assessed the SDOH of enrollees through the administration and completion of a comprehensive biopsychosocial assessment that identified enrollee needs and barriers to better health. Trauma history was assessed and evaluated for opportunities to support enrollee resilience and recovery. For some of our enrollees receiving hepatitis C treatment, Aetna care managers partnered with University of Kentucky-Gastroenterology to create interdisciplinary care plans for enrollees to support their treatment needs.

- Beginning in 2017, our pharmacy director partnered with the Department via the pharmacy workgroup to develop strategies to demonstrate our commitment to combatting the opioid epidemic sweeping Kentucky. To support the project's overall goal of increasing the health and wellness of enrollees and offering education to our providers, Aetna developed and shared with the Department our modified short and long-acting opioid clinical pharmacy coverage policy, which places emphasis on opioid dosages based on morphine milligram equivalent (MME). The results of this policy change, based on data analyzed by our Informatics teams from January 2018 to December 2019, reveals that **average MME/day has decreased 19.5 percent**. Additional programs we shared or collaborated with the Department include the following:
  - Allowing access without PA for preferred buprenorphine products for treatment of opioid use disorder (OUD) to increase access to care
  - Increasing access to naloxone nasal spray (Narcan®) through restriction removal and education on availability. Analysis of prescriptions from January 2018 to December 2019 shows a 31.9 percent increase in the number of Narcan prescriptions filled.
  - Providing education to 59 providers and enrollees on proper opioid prescribing and pain management
  - Increasing the availability of alternative therapies for pain relief on our PDL
  - Outreaching to dental providers about enrollees utilizing more than three days' supply of opioids. In 2019, 240 dental prescribers received letters and education which resulted in 52.9 percent no longer prescribing greater than a three-day supply measured eight months post-outreach.

Improved Health Outcomes

A 40-year-old male enrollee with multiple incarcerations, a history of intravenous drug use and alcohol abuse, diagnosis of stage IV liver disease with a model for end-stage liver disease score of 14, and hepatitis C of rare genotype 3 was referred for Aetna hepatitis C care management services at the University of Kentucky Medical Center (UKMC) clinic. He started therapy for hepatitis C in October 2016 and engaged with care management services to stay compliant with therapy. Despite compliance with therapy, his hepatitis C is resistant and he is still in need of a liver transplant.

The enrollee has continued to engage with care management services after his hepatitis C therapy by setting goals with his care manager for his holistic health care needs. He has maintained sobriety, decreased smoking by half, had his diseased teeth pulled and received dentures, attended all his provider appointments, and is taking steps to qualify for the liver transplantation program at UKMC. Additionally, the enrollee has attended his final parole visit and is spending time with his teenage daughter and pursuing other meaningful interests.

- Removing (effective July 1, 2019) PA requirements for Vivitrol® used for the treatment of OUD, which will decrease barriers to care and promotes our commitment to addressing the opioid epidemic in Kentucky. Six months prior to the prior authorization removal on July 1, 2019, there were 550 prescriptions filled by 206 enrollees for Vivitrol as compared to 700 Vivitrol prescriptions filled by 258 enrollees after removal which is a 27 percent increase in prescriptions and 25 percent increase in member access.
- We also recently developed and released an opioid dashboard which we will share with the Commonwealth.

- In July 2017, we removed all PAs on smoking cessation products to increase access for our enrollees. From January 1, 2017, to December 31, 2019, a total of 18,072 enrollees filled prescriptions for smoking cessation products. Removal of the PA increased both the number of smoking cessation product prescriptions by 31 percent and number of enrollees filling prescriptions for smoking cessation products by 14 percent, measured by pharmacy claims six months pre/post the PA removal; this increase was sustained through 2018 and 2019. Of note, Chantix® prescriptions increased by more than 500 percent, from on average 57 scripts per month to greater than 300 scripts per month.
- In 2018, during the hepatitis-A outbreak, Aetna collaborated with the Commonwealth to increase access to the hepatitis-A vaccine to our enrollees by adding it to the covered vaccines available at point of sale (POS) pharmacy with no PA.

Assuring Transparency in Pricing and Reporting

We disclose all contract terms we have with CaremarkPCS. Aetna and CaremarkPCS submitted a proposed contract amendment on February 26, 2019 to move to a transparent pricing model. Once approved by the Department, a complete changeover could be executed in 60 days. This arrangement can be implemented prior to the renewal contract effective date of January 1, 2021. The transparent model will pay pharmacies and Aetna at the same rate. The contract with CaremarkPCS Health also will provide full cooperation with data requests from the Department. Aetna and our PBM are actively engaged in drafting a new model contract that will comply with all existing and new pharmacy requirements in the **Draft Medicaid Managed Care Contract and Appendices Section 31.14**.

Aetna complies with all Commonwealth reporting and transparency. To date, we have complied with the following financial reporting requirements as required in KRS 205.647 (SB5) for the following:

- Calendar year 2017
- Calendar year 2018
- Monthly reporting on the 15th of each month

In addition to the reporting requirements, Aetna and CaremarkPCS complied with the Department to reset the maximum allowed cost (MAC) pricing levels back to April 1, 2019 with a June 1, 2019 deadline, and was able to execute the change inclusive of pharmacy reprocessing. We will continue to work collaboratively with the Department.

a.ii. Methods to Ensure Access to Covered Drugs and Adherence to the Preferred Drug List

Aetna utilizes PDL and utilization management (UM) programs that are fully compliant with the Social Security Act (SSA), the Code of Federal Regulations, and the Department contract that guides access to covered outpatient medications.

> By effectively managing the Aetna PDL, we provided clinically appropriate and cost-effective medications that helped reduce unnecessary costs of $16,144,671 ($5.55 PMPM), from January 2017 through December 2019, for PDL changes implemented in 2017 and 2018. Savings of 35.9 percent were related to promotion of clinically appropriate hepatitis C treatments. Continuing into 2019, Aetna has implemented new formulary initiatives, and as of December 2019, we have realized $3,099,135 ($1.57 PMPM) in savings.

Access to Covered Drugs

Aetna makes our PDL available to enrollees and providers in two ways through our website: 1) an online searchable formulary tool that is updated daily; and 2) an electronic copy (available in PDF format) that is updated each month.

Our PDL is developed and maintained through a robust process that includes national and local Pharmacy and Therapeutics (P&T) committees. Decisions on the composition of our PDL are made by our local P&T Committee under the guidance of Aetna's national P&T Committee. Both committees utilize the following six domains of care as outlined by the United States Institute of Medicine to ensure access to clinically appropriate cost-effective care:

- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively)
- **Safe:** Avoiding harm to enrollees from the care that is intended to help them
- **Enrollee-centered:** Providing care that is respectful of and responsive to individual enrollee preferences, needs, and values and ensuring that enrollee values guide all clinical decisions
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

For each medication on the PDL, the P&T committees take into account the medication's clinical efficacy and safety as demonstrated by scientific evidence documented in AHFS Clinical Drug Information, United States Pharmacopoeia Dispensing Information, Micromedex DRUGDEX®, and the National Comprehensive Cancer Network, as well as peer-reviewed medical literature, pharmacoeconomic studies, outcomes research, and standards of practice including treatment protocols and evidence-based practice guidelines such as Institute for Clinical Systems Improvement.

Final decisions on the composition of the Aetna PDL are made by our local P&T Committee under the guidance of the Aetna National P&T Committee after a careful review of the following principles:

- Proven effectiveness as documented in the medical literature noted above.
- Maximal safety and minimal potential for errors by selecting products with safer use profiles as documented in medical literature and our providers input and experience with the medication.
- Optimal clinical value for those we serve by taking into account direct and indirect pharmacy and medical costs when considering coverage of a medication. We preference those agents that optimize the use of financial and service resources over the largest potential population.
- Presence in national standards of care treatment guidelines and protocols.
- Long-term stability of coverage decisions that minimized enrollee disruption and do not jeopardize enrollee continuity of care.

Our PDL excludes only medication categories required to be excluded under Section 1927(d) of the SSA as amended and is no more restrictive than the fee-for-service Medicaid coverage of outpatient medications. The specific medication categories excluded from coverage for Aetna are DESI (drug efficacy study implementation) drugs, erectile dysfunction medications, fertility medications, and weight loss medications. When the PDL prefers generic equivalents, Aetna provides a brand name 'formulary exception' process for prescribers to pursue when brand name products are required for enrollees due to medical necessity. The PDL formulary exception process is clearly documented within enrollee and providers materials; forms and criteria are available on our website. Providers are able to submit requests for non-PDL medications via the pharmacy PA submission process, which includes fax, phone, and electronic PA (ePA). The formulary exception process ensures access to all medically necessary covered outpatient medications consistent with Section 1927 of the SSA and as amended regardless of the PDL status of the covered outpatient medication. Aetna's PDL therapeutic classes are reviewed at least annually, and new-to-market medications and/or medication formulations will in 2020 be reviewed within 75 days of market availability.

Our PDL employs UM programs such as PA using evidence-based clinical coverage criteria, step edits, prescriber specialty edits, quantity limits, and age limits developed consistent with the Act, the Code of Federal Regulations, and Department contract to promote appropriate utilization. All Aetna clinical PA criteria are evidence-based and follow best clinical practice standards and/or other national standards. When and as directed by the Department, we align our clinical coverage criteria with Department-sponsored clinical criteria, pharmacy-based programs, and other initiatives. This alignment of criteria and processes occurs no later than 30 days after written notification is sent to Aetna from the Department and occurs at no cost to the Department.

Ensuring Adherence to the PDL

Aetna ensures adherence to the PDL in numerous ways. We provide tools and communication avenues for our providers and enrollees to assist with the identification of PDL-preferred products and to augment access to covered medications. These resources are available on our website in designated enrollee and provider locations and can be downloaded electronically or linked via other electronic applications, such as electronic medical records and mobile devices including smartphones, etc. Aetna publishes the PDL for our enrollees, providers, and the public on our website in multiple formats, including a printable PDF document, an online search tool, and an electronic machine-readable file formatted as specified in 42 C.F.R. 438.10. The PDL documents display medications' PDL status (preferred, non-preferred), an indication if PA is required, applicable UM tools such as quality limits, step therapy, and information necessary to initiate a request for PA, or access to a non-preferred medication. We provide a hard copy of the PDL upon the request of an enrollee or provider. The PDL is updated no less than quarterly throughout the year; new generic products and product line extensions are, if appropriate, added monthly to ensure medication access.

Enrollee communication is an essential part of our PDL management program. We notify our enrollees of approved formulary changes through enrollee newsletters, our website, and individual letter notifications at least 30 days prior to change. In cases when we must remove medications from the PDL, we send letters to enrollees who are receiving those medications to inform them of formulary status change, and to contact their prescriber for a replacement prescription or PA. Letters are sent at least 30 days prior to the change.

Providers have access to PA request (PAR) forms on our website under the provider website, along with the PA clinical coverage criteria for PDL and non-PDL medications ('formulary exception'). Aetna gives the providers the option to use the designated Kentucky Medicaid pharmacy universal PA form or an Aetna-specific PAR form to initiate the pharmacy PA process. In 2020, Aetna will work with the Department to acquire approval of an Aetna-specific non-PDL medication ('formulary exception') PAR

form, if required. Additionally, our provider manual provides directions to prescribing providers on the pharmacy PA request process, including our ePA process. Our website provides access to our ePA system and e-prescribing tool through a web link.

The ePA process involves a simple transaction established in the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard that enables enrollee and drug-specific PA criteria and real-time approval process. As shown in **Figure C.21-1**, prescribers can utilize electronic tools such as their computer or tablet to access our clinical criteria, submit the PA request, and receive a decision on their request, which allows the enrollee quick access to the medications they need.

Our electronic prescribing (e-prescribe) tool allows the prescriber to see the preferred drug status, therapeutic alternatives, and clinical criteria on the selected medication (e.g., PA, step therapy, quantity limits).

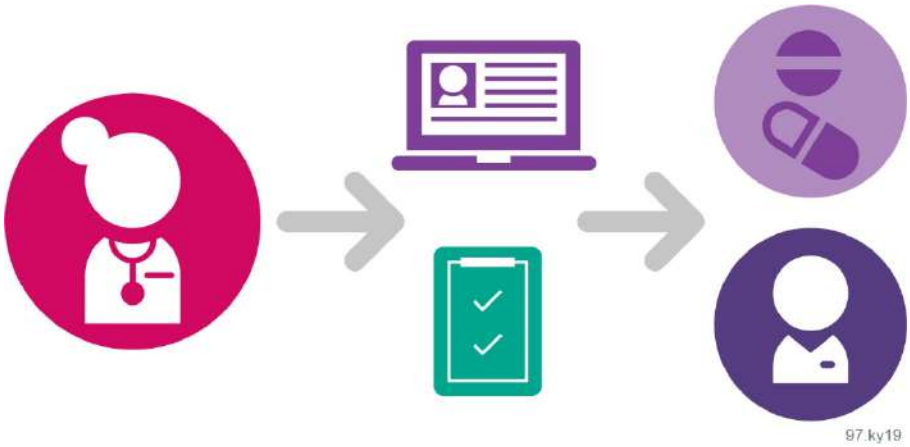

Figure C.21-1: Aetna's ePA Process
Prescribers can submit PA requests electronically via our ePA process.

In 2018, Aetna launched an ePA tool which was quickly adopted. As of December 31, 2019, 62.5 percent of all PA requests are received via ePA, exceeding our goal of 50 percent. A provider feedback survey revealed that 97 percent of responding providers stated that ePA saved their practice time compared to using other mediums (e.g., fax, phone calls), that coverage criteria questions were clear and easy to use, and decisions were received faster. Nationally evidenced, electronic prescribing has proven to be a safer and more efficient way of communicating prescriptions between providers and pharmacies. Our e-prescribe tool, which is widely used by our prescribers, improves prescribing efficiency and safety. In 2018, our prescribers sent 69 percent of prescriptions to pharmacies via e-prescribe. In 2019, our prescribers sent 72 percent of prescriptions to pharmacies via e-prescribe.

Another tool available to our providers that we deploy is the CaremarkPCS Health real-time benefits tool which helps them access pharmacy benefit information which fosters our enrollees' ability to access covered medications and stay on a path to better health. This tool seamlessly connects to physicians' offices through electronic health records. It is expected to be connected to more than 250,000 physicians' offices by the end of 2019.

This proprietary tool engine, Script Intelligence, powers our unique database of clinically mapped medications and provides clinically appropriate brand or generics alternatives specific to the enrollee's pharmacy benefit defined by category of aid. The tool provides cost transparency and supports more informed decisions by providers (prescribers). Prescribers can see enrollee-specific information, including: medication coverage, clinically appropriate therapeutic alternatives specific to the enrollee's PDL, restrictions on the selected medication (e.g., PA), and if the selected pharmacy is in the network.

a.iii. Responsibilities and Composition of the Pharmacy and Therapeutics Committee

Aetna utilizes a national and a local P&T Committee to guide and make decisions on PDL content and drug coverage criteria for Kentucky Medicaid enrollees. Our local P&T committee is led by our Kentucky CMO, who in addition to being a cardiologist, is also a pharmacist. Our local CMO oversees and directs all local P&T Committee activities. Our Kentucky pharmacy director serves as content expert and advisor to the CMO and the committee. In 2020, we will add at least one Kentucky-licensed physician and one Kentucky-licensed pharmacist to our local committee membership who provides services to Kentucky Medicaid recipients. Currently, our local committee composition and meeting requirements are as follows:

- Voting members: the CMO or designated medical director (as chairperson) and at least three practitioners from various specialties that represent Aetna's membership (i.e., high-volume specialists) appointed by the CMO.
- Non-voting members: the Aetna pharmacy director and other Aetna clinical staff as determined appropriate by the CMO or designee.
- Committee member appointments are for one year and may be renewed. If a committee member is unable to fulfill a one-year commitment, the CMO appoints a replacement.
- Committee members are required to sign a Confidentiality and Conflict of Interest Statement annually and reveal economic or other relationships with entities affected by medication coverage decisions that could influence committee decisions.
- A quorum, which is defined as a majority of voting members present in person or by video or teleconference, is needed to conduct committee business.
- Meetings occur at least quarterly, or as requested by the CMO, are open to the public, and are conducted and documented according to established processes, in conformance with applicable federal and Commonwealth laws, rules, and regulations concerning the practice of pharmacy.
- Committee meeting minutes are documented in writing and posted on the Aetna website.

Additionally, we provide to the Department and post on our website the time, date, and location as well as the agenda of the scheduled P&T Committee meetings; dates are coordinated with other health plans to allow attendance at the meeting.

Clinical decisions of the local P&T Committee are based on scientific evidence and standards of practice, including peer-reviewed medical literature, well-established clinical practice guidelines, and pharmacoeconomic studies as well as other sources of appropriate information (e.g., drug compendia such as clinical pharmacology, etc.) and are made under the guidance of Aetna's National P&T Committee. The National P&T Committee utilizes robust and structured sources of information that assimilate information on evidence-based medication use practices from key clinical work groups and the Clinical Subcommittee (which is comprised of physicians from multiple specialties in medicine) found within Aetna Medicaid organization services. **Figure C.21-2** illustrates the P&T Committee workflow.

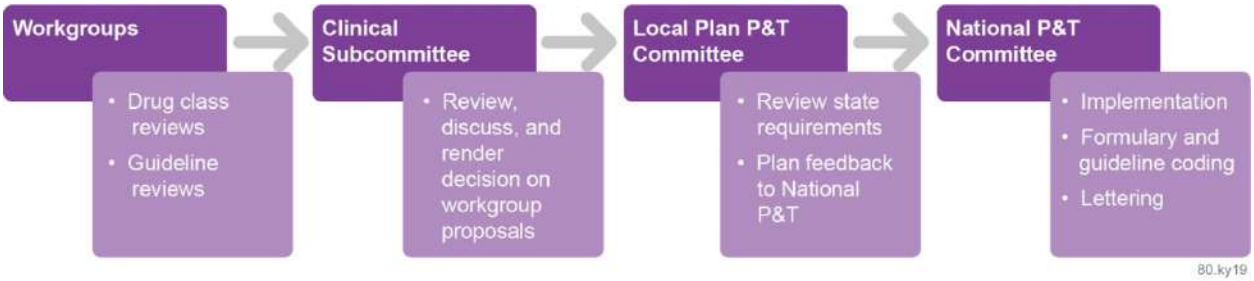

Figure C.21-2: Aetna's Pharmacy and Therapeutics Committee Workflow
Clinical decisions made by the P&T Committee are based on scientific evidence.

Responsibilities of the local committee include the following:

- Developing and maintaining PDL (formulary) and clinical coverage (PA) criteria, other UM edits such as quantity limits, step therapy, and safety edits.
- Reviewing medication use, monitoring for medication trends, and establishing programs to improve quality of care and ensure appropriate utilization. Programs are created through collaboration with UM and quality management (QM) committees and independent physicians (including behavioral health providers) who give us valuable information and insight on the needs of our enrollees.
- Guiding the development and implementation of pharmacy education and outreach programs including DUR programs to ensure medications provided are used safely and effectively by enrollees and providers.
- Conducting activities consistent with regulatory requirements, which includes, but is not limited to, annual review and approval of PDL (formulary) composition and UM tools applied to PDL drugs (e.g., PA, quantity limits, step edits, etc.)

Our local P&T Committee policy, 7600.30 "Pharmacy & Therapeutics Committee", is consistent with National Committee for Quality Assurance (NCQA) HP 2018 & 2019 UM11 A3 and D; **Draft Medicaid Managed Care Contract and Appendices**.

a.iv. Proposed Drug Utilization Review Programs, including Approaches to Collaborate with the Department on Pharmacy Initiatives

Consistent with 42 CFR 438.3(s)(4) and (5), Aetna operates DUR programs that comply with the requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K. Our collaborative, coordinated, and integrated enrollee-centered approach to DUR programs promotes appropriate medication use, decreases fragmentation, and increases integration across providers and care settings while building shared capacity to improve health care quality and minimizing wasteful spending. This approach includes programs conducted by the Aetna Pharmacy team, which is led by our pharmacy director and clinical PMMP under the guidance of our CMO and in collaboration with CaremarkPCS Health clinical pharmacists, retail, or independent community-based pharmacists and other Aetna clinical staff, specifically Care Management and Medication Management teams.

Aetna delivers enrollee-centric DUR programs to our enrollees, providers, and the Commonwealth that utilize principles of execution that further our purpose of delivering pharmacy benefits and services that are collaborative with our MCO colleagues and the Department and consistent with Centers for Medicare and Medicaid Services (CMS) Medicaid requirements; structured in the approach to development and execution to ensure outcomes measurement; deployed through local Kentucky providers that can bring enrollee-centric pharmacy care models into their communities; utilize proven prospective DUR tools (e.g., SMART PA/sophisticated POS edits) to improve efficiency at the pharmacy; and retrospective DUR strategies to identify targets for intervention and education. In the following narrative, we describe how our previous and current clinical programs as well as future programs meet our intended purpose as stated previously.

Aetna's pharmacy director works collaboratively with the Department and other Kentucky Medicaid MCOs by sharing our pharmacy DUR program initiatives, results, and lessons learned, thus providing real-world experience that can be used to further develop our DUR program portfolio and support future universal policy and/or DUR program implementations.

- An example of a program Aetna shared with the Department is our Buprenorphine Preferred Provider program, in which we partnered with 10 prescribers at the University of Kentucky who specialize in treating OUD. The program was implemented in March 2018 and removed barriers to drug therapy by removing PA requirements for preferred buprenorphine medications for medication-assisted treatment (MAT) for enrollees with opioid abuse disorder. When comparing 12 months of pharmacy

claims for 100 enrollees before and after implementation of this change, **we saw a 32.6 percent increase in number of enrollees with access, a 38.8 percent increase in days of therapy, and a 42.7 percent increase in the number of prescriptions for MAT filled**. At the time of our program implementation, the Department, through the pharmacy workgroup, was in the process of developing criteria for a preferred provider program for MAT that would be shared across all MCOs. However, instead of pursuing a preferred provider program, the Department requested that effective February 15, 2019, all Medicaid MCOs remove PA requirements for MAT for preferred buprenorphine products. Additionally, on July 1, 2019, per the Department's request, Aetna implemented a SMART PA edit that allows Vivitrol® prescriptions to process without PA when the diagnosis of opioid use disorder is present.

- Aetna's pharmacy director provided a detailed description of our DUR program activities on dates communicated by the Department and in sufficient time to gather the information necessary to comply with and time submit the CMS Annual DUR report. We are committed to providing all data necessary for appropriate CMS Annual DUR report submissions by completing our portion of the actual annual report template furnished by CMS within the requested timeframe. Additionally, Aetna provides quarterly written reports of DUR activities at the request of the Department.

Aetna Medicaid DUR Board and Programs

To ensure our DUR programs are appropriately vetted, in 2018 Aetna's Pharmacy team utilized the newly established Aetna National Medicaid Organization DUR board to guide DUR activities. The Aetna National Medicaid Organization DUR Board is responsible for monitoring and reviewing Aetna Medicaid organization DUR program activities, which includes oversight and approval of enrollee and provider educational outreach programs (EOP) proposals. The DUR board has established criteria for EOP proposals to ensure clinical and operational integrity of implemented programs. The criteria for programs require that all EOPs have the following elements:

- Established predetermined criteria (e.g., desired drug utilization pattern)
- Utilize retrospective drug reviews against predetermined criteria
- Develop a process to correct prescribing or drug utilization patterns identified as suboptimal through EOP, including metrics to be captured
- Include educational materials directed to prescribers, enrollees, and/or pharmacies
- Monitor and measure responses to educational outreach
- Report outcomes/metrics (e.g., percent change in response, cost saving/cost avoidance)

In 2018, Aetna implemented the following DUR board-directed programs:

- Triptan Management Program, which identified enrollees over utilizing triptan medications and at risk for medication overuse headache
- Opioid MME DUR, which identified providers writing prescriptions with greater than 150 MME per day of an opioid to an enrollee who was not treated for malignant cancer pain or in palliative care
- Asthma Medication Ratio Program, which identified suboptimal utilization of asthma controller medications using prescriptions claims of controller medications +/- rescue inhalers.

The detailed information in this section on these programs demonstrates the impact that these DUR interventions had on improving medication access and utilization for our enrollees with specific medical needs.

Aetna's Triptan Management Program

This program educated prescribers on the appropriate use of triptans for chronic migraine therapy to reduce higher than recommended cumulative doses of triptans without prior prophylactic medication. Mailings were sent to prescribers with enrollees without prior prophylactic therapy and who were exceeding the maximum recommended cumulative triptan dose per month. The goal of the program was

to reduce excessive utilization of triptans and reduce medication-overuse headaches. The results are as follows:

- In October 2018, educational letters were mailed to prescribers representing 85 enrollees. The response post-mailing was tracked.
- Ninety and 180-day follow-up by reviewing pharmacy paid claims revealed the following:
  - Seventy-eight percent reduction in excessive utilization of triptans with only 19 enrollees continued higher than recommended doses of triptans without a prophylactic medication.
  - 14.7 percent (10 of 69) enrollees evaluated post-intervention had prophylactic therapy added.

Opioid MME DUR Program

This program educated prescribers to carefully justify prescriptions beyond 90 MME per day based on the Centers for Disease Control and Prevention guidelines for opiate prescribing. Mailings were sent to prescribers whose patient's claims exceeded 150 MME per day; mailing included a controlled substance prescribing profile. The goal of the program was to reduce utilization of opioids and improve enrollee safety. The results are as follows:

- The pharmacy director and clinical pharmacist worked collaboratively with Aetna's national clinical pharmacy teams who conducted this program to ensure communications and interventions were known by our Care Management and Medical Management teams and that if questions were received from enrollees and providers they could be answered effectively and consistent with the message of the communications. FAQ documents were created and distributed prior to the program.
- In October 2018, educational and informational letters were mailed to prescribers representing 57 enrollees.
- Ninety-day follow-up data revealed the following:
  - Ninety-eight percent reduction in number of prescriptions greater than 150 MME.
  - Only one enrollee continued on opioid prescriptions exceeding 150 MME per day.

Asthma Medication Ratio DUR Program

This program is designed to improve asthma medication ratio (AMR), an NCQA/Healthcare Effectiveness Data and Information Set (HEDIS) measure that evaluates adherence to asthma controller medications by members with persistent asthma. Higher AMRs are associated with improved asthma control and decreased risk of emergency hospital care. In this program, we identified enrollees not utilizing controller medications consistent with guidelines and then implemented clinically appropriate next steps to engage enrollees and providers to improve the management of asthma consistent with national evidence-based clinical guidelines.

In the fall of 2018, the Aetna Pharmacy Clinical Strategies team conducted the following interventions:

- Educated care managers on appropriate asthma management, including medication utilization. In-services were conducted for the care manager. **Post-education survey responses revealed very positive feedback with greater than 96 percent of respondents rating the quality of presentation as 'excellent' or 'good**.' Survey questions focused on the in-service providing information and resources to be used to care for enrollees, and the care manager's assessment as to whether the resources provided lead to improved asthma outcomes in enrollees.
- Educated providers on the prescription fill history for their patients with a suboptimal AMR. **Five-hundred eight provider call to action educational communications were sent via fax**.
- Educated enrollees on appropriate asthma management, including medication use and strategies to improve adherence: Numerous education modalities and combinations were used for 531 Aetna enrollees. Education modalities included a combination of prescriber call to action via fax communication, enrollee care manager assignment, and a clinical pharmacist conducted enrollee education via a phone consultation. All prescribers received call-to-action fax education; care

managers were involved in 11 enrollee interventions and telephonic outreaches by the PMMP clinical pharmacist occurred for 49 enrollees.

Outcome Measurements

- An average percent change increase in AMR of 4 percent across all intervention types and combinations was observed. For enrollees who received a clinical pharmacist intervention, a weighted average AMR increase of 17.5 percent was observed.
- Six-month pre/post (October 2018 to April 2019) intervention analysis for 531 enrollees revealed the following (Note: medical data takes several months to mature; claims involving medical data may fluctuate over coming months):
  - ER utilization ('all cause'): decrease by 87 claims, decrease in $58,099.25.
  - Outpatient utilization ('all cause'): decrease by 151 claims, decrease in $5,750.44.
  - Inpatient utilization ('all cause'): decrease by nine claims, decrease in $60,003.21.
  - Pharmacy utilization: decrease by 1,608 claims, increase in $13,847.72.

Aetna is proposing to continue the above DUR programs and to add more clinical programs by expanding provider and enrollee education and outreach through the work of our PMMP clinical pharmacist, which was key in the delivery of DUR programs.

Prospective DUR—Point of Service Safety Edits

Aetna's pharmacy director works with our PBM and our clinical staff to enhance our enrollee and provider experience. This collaboration optimizes enrollee outcomes by ensuring access to safe and clinically appropriate medications and providing innovative support to enrollees, prescribers, and pharmacies.

We use a systematic, ongoing process to review the prescribing and dispensing of medications that preserve enrollee access to clinically appropriate medications. Our approach involves a comprehensive review of the enrollee's medication history before and during dispensing to achieve an appropriate therapeutic regimen and positive outcomes.

Aetna utilizes evidence-based, quality driven, and safety messages at the pharmacy to **decrease waste and harm to enrollees**. Our POS system utilizes computerized algorithms built into claim adjudication that sends soft alerts and hard-block alerts to pharmacists that prevent dispensing medications without further review and/or action by the dispensing pharmacists. These blocks enable us to certify appropriate utilization, safety, and avoid duplications.

Edits currently in place for our enrollees that resulted in messages that needed to be addressed by pharmacists include the following:

- Dose check, max dose, and low dose alert
- Drug-age, drug-disease, drug-drug interaction, drug-gender, drug-pregnancy
- Excessive duration alert
- Ingredient duplication; therapeutic duplication
- Multiple pharmacies; multiple prescribers
- Under use alert

Pharmacists servicing our enrollees utilize professional knowledge and enrollee-specific information when responding to safety alerts or rejects occur. After receiving the alert during a POS transaction our network pharmacists take action, which includes but is not limited to the following:

- Evaluating the enrollee's complete medication profile and offering suggestions for consideration and discussion with his or her providers (i.e., potential drug-drug interactions, therapeutic duplication, age drug edits, high-risk medications leading to increases in risk of falls)
- Offering the enrollee counseling regarding appropriate medication use

- Consulting with the prescriber about the appropriateness of the medication
- Submitting a professional DUR response code to provide information about the enrollee to satisfy the edits requirements

In 2018, our ProDUR safety edit alert activity averaged 353,000 alerts/rejects for 65,000 enrollees per quarter. Rejects or alerts resulted in no payment of claim or change in therapy for **on average 125,000 claims per quarter**. Top alerts or rejects addressed included underuse precaution, therapeutic duplication, and ingredient duplication. Pharmacist professional responses on place of service edits for cumulative acetaminophen dose and cumulative morphine equivalent dose revealed that on **average 82 to 87 percent of edited claims were filled after prescriber consultation and approval**. In 2019, our ProDUR safety edit alert activity per quarter **averaged 352,700 alerts/rejects for 66,500 enrollees.** Rejects or alerts resulted in no payment of claim or change in therapy for on average 170,000 claims per quarter. Top alerts or rejects addressed included underuse precaution, therapeutic duplication, and ingredient duplication. Pharmacist professional responses on POS edits for cumulative acetaminophen dose and cumulative morphine equivalent dose revealed **that on average 87.7 to 89 percent of edited claims were filled after prescriber consultation and approval.**

Additionally, Aetna implemented numerous SMART PA edits in 2017,2018 and 2019, which consider the enrollee's pharmacy claim history and medical diagnosis (which is loaded from Aetna's medical claims adjudication system) and the prescriber's specialty type in the evaluation of prescribed medications at the POS. The use of pharmacy and/or medical claims history to adjudicate drug claims that would standardly reject at point of service and require PA allows an enrollee quick access to the medication and eliminates unnecessary delays when the enrollee presents the prescription to the pharmacist.

The following SMART PA POS edits used by Aetna to improve safety of medication use while easing the burden on the prescribing provider using known information and pharmacist actions include the following:

- Long-acting opioids; SMART edits to bypass PA for diagnosis of cancer or palliative care
- MME dose edit for opioids except buprenorphine product; SMART PA MME edit bypass PA if diagnosis of cancer and palliative care
- Vivitrol® access with ICD 10 for opioid use disorder implemented July 1, 2019

Aetna's Clinical Guideline and PA Operations teams have created and implemented numerous SMART PA edits that can be implemented by any of our Medicaid plans. Edits currently available include, but are not limited to, the following:

- Naltrexone concurrent use with opioids requires diagnosis code F10.2 and F11.2
- Eculizumab (Soliris®) diagnosis code of D59.3, D59.5, G70.0 for coverage
- Paroxetine (Brisdelle®) diagnosis code of E28.310, E89.41 and N95.1 for coverage
- Oral contraceptive diagnosis edit Z30, F32.81, and N92
- Aripiprazole and risperidone diagnosis requirement with appropriate ICD 10 code
- Nuplazid diagnosis of Parkinson's Disease G20
- MME dose edit for opioids except buprenorphine product and MME edit exemption if diagnosis of burn diagnosis (T20.2-25.7) or sickle cell crisis

Our pharmacy director will share these edits and the results they achieve in other Aetna Medicaid plans with the Department and other Kentucky Medicaid plans to determine applicability to Kentucky Medicaid enrollees. Additionally, our pharmacy director can work with the Commonwealth to build new SMART PA edits to meet the PDL requirements of covered medication PA criteria and improve efficiency of claims processing while ensuring appropriate drug coverage.

Retrospective DUR Strategy and Programs

To support a comprehensive retrospective DUR process for all enrollees and prescribers, our pharmacy director and clinical pharmacist (using pharmacy claims data) collaborates with our CMO and QM and UM teams to monitor and analyze utilization patterns and trends through reports generated daily, weekly, monthly, and quarterly; these reports have detailed claim information, comparative data points, and summary trends.

Based on the clinical teams' assessment of our enrollees and prescribers needs for safer medication use, we deployed programs provided by our PBM and programs developed and vetted by the Aetna DUR Board. These programs are coordinated and integrated to maximize outcomes. The following examples describe PBM safety programs utilized and recent activity and results of these programs:

- The Retrospective Safety Review program acts as safety net for situations that may have a negative clinical impact on an enrollee. Prescriptions are reviewed daily for serious drug-to-drug interactions. The prescriber is notified with an actionable, enrollee-specific fax communication within 72 hours of the claim processing. This program provides near real-time review and intervention focused on increased enrollee safety and increased prescriber engagement: In 2018, 3,908 drug interaction alert opportunities were sent to prescribers within 72 hours of fill; an 8 percent prescriber response rate noted that prescribers found intervention information useful 33 percent of the time, and not useful less than 10 percent of the time. From January to September 30, 2019, 1,995 drug interaction alert opportunities were sent to prescribers within 72 hours of fill; a six percent prescriber response rate noted that prescribers found intervention information useful 42 percent of the time, and not useful less than 4 percent of the time.
- The Safety and Monitoring Program targets high-risk drug classes, focusing on controlled substances and inappropriate use and misuse related indicators such as polypharmacy, provider shopping, and high-total controlled substance claims volume: drugs at risk for fraud, waste, and abuse. On a quarterly basis, clinical pharmacists evaluate controlled substance claims and any available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. During subsequent quarters, pharmacists conduct follow-up activities utilizing physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to our pharmacy director, a case manager, and/or Aetna's SMCP team (formerly lock-in), for further action. Target medications include opiates, anti-anxiety and sedative hypnotic agents, muscle relaxants, central nervous system stimulants, and other controlled substances (e.g., testosterone):
- From April 2018 to September 30, 2019, 409 enrollees were targeted for monitoring. Two hundred one of 409 enrollee cases (49.1 percent) were closed with outcomes, including decreased number of prescribers and pharmacies (46.3 percent), care coordination conducted (17.0 percent), decreased use of target medication (20.9 percent), and prescriber validation of the therapy (13.9 percent). Changing behavior resulted in minimal pharmacy savings of $8,447; however, improved safety of medication use was noted.

Based on our enrollees' needs related to medication adherence and gaps in care across targeted chronic conditions (i.e., asthma, diabetes, heart failure, COPD, etc.), the Aetna Pharmacy team utilizes programs supported by our PBM, namely pharmacy advisor support programs that focus on identifying and alerting providers via written communications to adherence concerns or gaps in medication therapy experienced by our enrollees. These programs have achieved the following results:

- In 2018, gap-in-care concerns for 770 enrollees with diabetes, 11 with rheumatoid arthritis, 3 with osteoporosis, 74 with asthma/COPD, 2 with heart failure, and 17 with ischemic heart disease, were intervened upon with providers. The projected program savings based on a validated algorithm was $366,206. The gap-in-care resolution rate averaged 30 percent with 875 enrollees having at least one

gap resolved. The most successful gap closures of adding a statin to a diabetes or immunosuppressive drug therapy regimen averaged 39 percent quarterly.

- In 2019, gap-in-care concerns for 2,453 unique enrollees with diabetes, rheumatoid arthritis, osteoporosis, asthma/COPD, heart failure, and/or ischemic heart disease, were intervened upon with providers. The projected program medical and pharmacy savings determined by the application of medical outcomes savings models that demonstrate the positive benefit of more appropriate management of chronic conditions was $113,022. Medication care gaps were resolved for 266 enrollees. The most successful care gap closures were the addition of statin therapy to enrollees with diabetes and/or ischemic heart which averaged 32 percent.

In addition to utilizing the gaps in care program by the PBM, Aetna will implement additional programs to address gaps in enrollee drug therapy. The first Aetna-based initiative under development is a gap in care program developed with Aetna Medicaid organization pharmacy residents and will focus on statin therapy in enrollees with diabetes. The initiative will focus on making sure, when clinically appropriate, enrollees with diabetes are receiving statin therapy and when on statin therapy they are adherent to the therapy. We will target enrollees via phone consultation with a Pharmacy team member, and providers with both fax and phone follow up outreaches. Our goal is to achieve a HEDIS rating of 75th percentile for both measures on statin therapy in enrollees with diabetes. Aetna is also developing a gap in care program that will target enrollees with a diagnosis of atrial fibrillation who do not have pharmacy claims for anti-thrombotic therapy (if indicated). Literature shows less than 50 percent of patients with an indication for an anti-thrombotic medication are actually prescribed or adhering to therapy.

Our comprehensive DUR process requires our Pharmacy and Clinical teams to develop, implement, and conduct ongoing educational programs for the Kentucky Medicaid pharmacy provider community. Educational initiatives and programs created and conducted include, but are not be limited to, provider letters and bulletins on the U.S. Food and Drug Administration approval process for follow-on drugs, drug recall process, and monitoring metabolic risks of antipsychotic medications, POS messaging for concurrent benzodiazepines, treatment duration limits on butalbital containing products, and age restriction on products containing codeine, hydrocodone, and tramadol to limit use to adults; and provider training sessions, webinars, quarterly newsletters, and other training activities as requested by the Department.

Our pharmacy director, working collaboratively with our CMO and clinical staff, has developed a systematic and ongoing process of reviewing the prescribing, dispensing, and use of medications that preserves enrollee access to clinically appropriate medications and works to prevent overutilization and underutilization of targeted drug classes, as described previously.

a.v. Proposed Maximum Allowable Cost Program

Our PBM established and maintains a medication MAC program to promote generic utilization and cost containment. The established program complies with all MAC laws and administrative regulations promulgated by the Department of Insurance, the Department, or otherwise promulgated by Commonwealth or federal law.

CaremarkPCS' analytical process to establish a MAC is at a drug product level for generics and multisource brand products. The analytical process involves a review of marketplace dynamics, including new generic launches, generic exclusivity status, the number of available generic vendors, as well as product availability, and different pricing sources. Pricing sources may include Medi-Span (or any other similar nationally recognized reference), wholesalers, MAC lists published by CMS (i.e., FUL), and retail pharmacies via invoices if provided. These factors are all taken into consideration in order to establish a MAC price. Typically, products with limited competition due to exclusivity, supply issues, etc., will have less competitive MAC price points than products with an abundance of generic vendors available.

MAC prices are subject to change as often as weekly based on marketplace trends and dynamics and to meet client commitments. New bioequivalent (i.e., A-rated) generic products will be added to the MAC list for the CaremarkPCS Health generic pricing program applicable to Aetna not more than 30 days after they are readily available from more than two generic vendors. CaremarkPCS Health's pharmacy providers may access the pharmacy portal to obtain MAC prices as well as submit MAC appeals. CaremarkPCS Health complies with all applicable federal and Commonwealth requirements related to pharmacy claim pricing. CaremarkPCS Health has developed a Kentucky-specific policies and procedures that comply with all aspects of KRS 304.17A-162 and has been approved by the Kentucky Department of Insurance. More recently, CaremarkPCS Health has been working closely with the Department and Myers and Stauffer in order to develop a mutually agreeable process in order to comply with the SB5 requirement to notify the Department in advance of any proposed change of over 5 percent for a given product's reimbursement to a pharmacy provider licensed in the Commonwealth.

a.vi. Approach to Operation of our Pharmacy Call Centers

Aetna makes call center services available to our pharmacy and medical providers to ensure access to information on covered pharmacy products and services. Additionally, for enrollees with clinical questions about their medications or pharmacy benefit that cannot be answered by Enrollee Services, we make a pharmacist available as described at the end of this section. All call center staff members participate in annual and ongoing training modules and activities, as well as quality assurance checks with follow-up, as needed, to ensure compliance with regulatory requirements and Aetna business standards. **Table C.21-3** provides an overview of our call centers.

Table C.21-3: Call Center Overview

Call Center Name	Service Audience	Service Provided By
Pharmacy Help Desk	Pharmacists	CaremarkPCS Health
Pharmacy PA Call Center	Medical Providers	Aetna Medicaid Organization Pharmacy
Enrollee Services Call Center	Enrollees	Aetna Enrollee Services

CaremarkPCS Health Pharmacy Help Desk

Aetna collaborates with our PBM to operate a toll-free pharmacy help desk 24/7/365 for access to live agents by our pharmacy providers. To ensure consistency and accuracy of help desk staff functions and activities, all help desk staff members participate in the following training modules:

- New Hire Orientation
- PBM Industry Orientation
- Policies/Procedures/Process Modules
- Systems Training
- Drug Information/Plan Designs Modules
- Medicare Part D/Government programs
- Famous for Service Training

Annually, all staff members are required to participate in the following compliance courses:

- Federal Trade Commission Order Acknowledgement
- Privacy Training
- Security Awareness
- CVS Health Code of Conduct
- CVS Health Firewall training

The Aetna Pharmacy team monitors the CaremarkPCS Health help desk through review of statistical reports, telephone calls, or onsite visits, and maintains a pharmacy help desk quality assurance program

which has been approved by the Department. CaremarkPCS Health, on the behalf of Aetna, has a call-tracking system that retains information collected on each call that is retrievable using personal information for the individual from whom the call was received. Individual call information can be provided to Aetna and the Department upon request. This information allows Aetna to resolve specific pharmacy help desk concerns that may be presented and assess routine performance of call center personnel.

Additionally, the CaremarkPCS Health pharmacy help desk systems have the capability to monitor and report all required call management metrics to ensure we meet the following performance standards as measured by monthly averages and ensure first-call resolution.

Over the last six quarters, **the CaremarkPCS Health pharmacy help desk has exceeded performance standards for all help desk metrics.** Additionally, quality performance based random audit of 10 percent of cases revealed average performance score of 94 percent with scores ranging from 89 to 98 percent. Any issues identified during the quality performance audit are further researched and resolved. **Table C.21-4** illustrates our help desk metrics for Kentucky.

Table C.21-4: CaremarkPCS Health Pharmacy Help Desk Metrics for Kentucky

Pharmacy Help Desk Metrics	Kentucky Metric	Third Quarter 2019	Second Quarter 2019	First Quarter 2019	Fourth Quarter 2018	Third Quarter 2018	Second Quarter 2018
Number of Calls Offered to a Customer Service Representative	No Requirement	3168	3248	3,633	2,934	2,675	2,717
Percent of Calls Abandoned at Greater than 0 Seconds	<=5%	1.9%	2.2%	1.30%	0.10%	0.40%	0.6%
Average Speed of Answer-Average Time (in Seconds) for Rep to Answer Call	<=30 seconds	9.1	9.0	5.6	1.8	2.2	1.1
Calls answered in 30 Seconds or Less as a Percentage of Total Calls Offered	>=80%	97.5%	97.3%	98.4%	99.5%	99.3%	99.2%

Information on help desk statistics and audit activities are reviewed and discussed during quarterly Joint Operating Committee (JOC) meetings between Aetna and our PBM, and appropriate actions are taken if necessary. The meetings are specifically attended by the Kentucky pharmacy director, senior pharmacy director, Medicaid executive pharmacy director, chief executive officer, CMO, vice president of medical affairs, and enrollee services lead as well as our PBM's strategic account executive, strategic account director, clinical advisor, analytic consultant, and specialty account executive. This information is also shared with the Delegated Oversight Committee and action is taken if concerning patterns are identified.

Over the last three years of our contract with the Department, Aetna has not identified any concerning issues or trends within our pharmacy help desk. We have been working collaboratively with our PBM account management and help desk teams to add clarity to help desk staff instructional documents to assist with access to medications and to prevent enrollee and pharmacy provider miscommunication issues. Examples include the following:

- Updating our instructions on coordination of benefits for dual enrollees. Our guidance now clearly explains which medications are available through our Medicaid benefit and which are the responsibility of the primary Medicare Part D plan.
- Clarifying that a prescriber must complete the PA process for duplicate therapy rejects.

- Instructing help desk staff on specific override steps during medication shortages. We have allowed the help desk staff to provide overrides for brand Tamiflu®, Epi-Pen® analogs, and suboxone to allow access for enrollees in need. By allowing branded products to be covered during generic product shortages, we are preventing therapy disruptions and decreasing barriers to care for the enrollee.

Our PBM's help desk for pharmacy services is adequately staffed to ensure accurate and timely responses as defined by service warranties and consistent with performance metrics are met. The help desk operates phone lines 24/7/365 and is staffed to accommodate first call resolution performance. CaremarkPCS Health's help desk utilizes a workforce management system which monitors and manages call volume to ensure all calls are answered. Therefore, callers do not need the ability to leave a voice message on a pharmacy help desk automated voice message system. All calls received are acted upon at time of inquiry and no calls are blocked or refused.

The CaremarkPCS Health help desk includes a Retail Customer Care team that works with and supports the network pharmacies participating in our national network by troubleshooting point of service online claim transmissions. Retail customer care representatives have access to retail pharmacy electronic transactions, allowing them to assist with eligibility concerns, rejected claim resolution, and clarification of adjudicated claims. The retail customer care representatives also provide triage support on inquiries regarding pharmacy payment, network enrollment, and other general contract support, providing the retail pharmacist with a single point of contact.

Pharmacists can dial our toll-free number to select options from the retail services interactive voice response (IVR) menu for assistance. The options available from that menu include eligibility, rejected claim re-processing, and network questions. Pharmacy inquiries are authenticated prior to the release of any protected health information. Pharmacies always have the option to speak to a pharmacy help desk representative if they have additional questions or if the IVR is unable to provide the answer or direction needed to adjudicate the claim.

Our PBM has policies and procedures for operation of the pharmacy provider help desk that address staffing requirements and ratios, orientation and education of call center staff, hours of operation, performance standards, and methods that Aetna and our PBM has implemented to monitor calls and comply with standards. For common topics, we have developed scripts for use by help desk staff in providing consistent responses to pharmacy provider inquiries. Additionally, help desk staff are instructed to follow all contractually required policies, procedures, and scope of services documents created for the plan. The pharmacy help desk is led by a management team that is in constant communication with our Account Services unit, Customer Care unit, and other supporting areas, which results in greater consistency and the availability of the most up-to-date information needed to resolve questions and concerns. Help desk supervisory staff conducts audits of calls; the results of these audits are tracked and reported to call CaremarkPCS Health account management and Aetna staff. If an issue is identified that requires resolution, the CaremarkPCS Health and Aetna teams will collaborate toward a resolution. Actions and outcomes of audit activities and issue resolution are reported and discussed at quarterly JOC and Delegated Oversight Committee meetings.

Aetna Pharmacy PA Call Center

Our Pharmacy PA call center for providers is staffed adequately with certified technicians and licensed pharmacists (and physicians) to assist with PA case requests and questions and ensure qualified and timely responses. The Pharmacy PA call center operates a toll-free phone line that is staffed Monday through Friday, 7 a.m. to 7 p.m. Eastern Time. Staff members are available to speak with providers any time during open hours.

Our Pharmacy PA call center supports all our network medical and pharmacy providers (including behavioral health) with pharmacy PA requests and inquiries as defined in the section on pharmacy PA as

well as assists pharmacists with enrollee-specific pharmacy claims processing inquiries related to coordination of benefits, eligibility, formulary/benefit inquiry, hospital/emergency room discharge/emergency supply, vacation override, and lost/destroyed override requests. The Pharmacy PA call staff provides triage support for pharmacy claims process/payment, pharmacy PA processing as well as appeal and grievance inquiries and other general pharmacy benefit support. Pharmacy PA call center staff are instructed to provide assistance to support all contractually required pharmacy PA functions consistent with defined policies and procedures for the unit.

Aetna's Pharmacy PA call center maintains a suite of operational documents and tools that guide the operations of the pharmacy PA call center and addresses staffing requirements and ratios, orientation and education of staff, hours of operation, performance standards, and methods that Aetna has implemented to monitor calls and comply with standards. For common topics, we have developed scripts for use by call center staff in providing consistent responses to provider inquiries. All Pharmacy PA call center staff are involved in annual compliance and operations training consistent with Aetna policies and are required to participate in quarterly refresher trainings each year. This standardized comprehensive refresher training program is intended improve and address inefficiencies through training and coaching. Topics are gathered through technician- and leadership-identified areas of concern, as well as visual side-by-sides by subject matter expert-identified inconsistencies in the application of rules.

Our Pharmacy PA call center is led by a tiered management team, specifically team leads and supervisors who are in constant communication with our director of pharmacy service operations, the Kentucky pharmacy director and medical directors, and other supporting areas, which results in greater consistency and availability of the most up-to-date information needed to resolve questions and concerns.

The Pharmacy PA call center systems have the capability to track and report metrics. Performance standards consistent with contract requirements and/or Aetna Medicaid organization pharmacy department standards currently measured monthly include the following as shown in **Table C.21-5**.

Table C.21-5: Aetna's Pharmacy PA Call Center Metrics

Pharmacy PA Call Center Metrics	Kentucky Standards	Fourth Quarter 2018	First Quarter 2019	Second Quarter 2019	Third Quarter 2019	Fourth Quarter 2019
Calls Taken	N/A	3,545	3,730	3,176	3,170	2,836
Average Speed Answer	< 30 secs	15.43	2.93	2.5	0.9	0.3
Abandonment Rate % (<5%)	5.00%	1.40%	0.33%	0.20%	0.20%	0.00%
Percentage (Total Service Factor)	75%	89.43%	97.63%	98.00%	99.10%	99.70%

As demonstrated above, **over the five quarters described the pharmacy PA call center has exceeded performance standards for call center metrics**. Additionally, quality performance-based random audit of cases revealed average performance score 98.6 percent with scores ranging from 97 to 99 percent. Any issues identified during the quality performance audit are further researched and resolved with the involved technician, pharmacist, or the management team.

Our Pharmacy PA call center system does not block calls; all calls are allowed into the system during our business hours. Additionally, we apply first-call resolution principles and practices; therefore, 100 percent

of call center inquiries are completed at time of inquiry and/or within the 24- to 72-hour decision requirement for PA requests (pended requests have up to 72 hours).

Enrollee Access to Aetna Pharmacists

Aetna provides access to Aetna pharmacists for our enrollees if they have clinical pharmacy questions about drug-drug interactions, common side effects and/or generic availability, or substitutions. Enrollees can access our pharmacists via our Enrollee Services staff who are available via Aetna's Pharmacy PA call center. Our Enrollee Services call center is equipped to work with enrollees to respond to pharmacy benefit questions; the staff is educated on pharmacy benefit topics and their performance is monitored consistent with Aetna policies. **When enrollees have clinical questions about their medications, the Enrollee Services staff makes a warm transfer of the call to one of the Aetna pharmacists** who are available Monday through Friday, 7 a.m. to 7 p.m. Eastern Time, to speak to enrollees.

b. Pharmacy Claims Payment Administration, including an Overview of the Point of Sale System and Processes for Complying with Dispensing Fee Requirements

Aetna collaborates with our PBM to deliver state-of-the-art pharmacy claims adjudication and payment system to serve our Medicaid enrollees and providers. To support claims adjudication for our enrollees, we have established a unique Medicaid-specific Processor Identification (BIN)/Issuer Identification Number (IIN), Processor Control Number (PCN), and Group Number Combination for POS pharmacy claims processing, to ensure Medicaid Claims are not the same as Aetna's commercial and/or Medicare Part D business lines. The BIN/IIN and PCN number appears on all enrollees' identification cards along with the toll-free phone number for pharmacy provider assistance as well as enrollee assistance.

The POS pharmacy claims system provides functionality that allows our pharmacy providers to submit claims 24/7/365, and provides us the ability to apply an Internal Control Number (ICN) to each claim and its supporting documentation, regardless of submission format, to track claims, conduct research, perform reconciliations, and for audit purposes, ensure the system is capable of adding, changing, or removing claim adjudication processing rules to accommodate Commonwealth- and federal-required changes to the pharmacy program within 30 days, unless otherwise approved.

> In 2018 and 2019, the POS pharmacy claims processing system has been available 99.99% of its scheduled time during 24/7/365 operations; the system provides average response time of one second or less for all processed transactions calculated over a 12-month period.

The online, real-time POS system adjudicates pharmacy claims, including reversals and full or partial adjustments, by using the current NCPDP format. It denies claims that contain invalid provider numbers (including where the National Provider Identifier or provider number is missing or is invalid), identifies any liable third party, ensures that Medicaid is the appropriate payer of last resort, and allows for resubmission of a claim with further information and/or documentation. If a claim is denied, the system provides messaging to the pharmacy provider specifying all reasons for the denial (reject). We validate the Medicaid identification number.

Aetna's PBM requires all contracted network pharmacies to use the NCPDP POS methodology including the original 10-digit National Drug Code (NDC) when submitting outpatient drug claims. Our PBM will load a daily Medi-Span file that provides pricing and descriptive drug information on name brand, generic, and over-the-counter (OTC) medications; it includes industry standard identifiers for all brand and generic drugs on the market including NDC, Universal Product Code (UPC), and Health Related Item (HRI) numbers. Invalid NDC number submission will be rejected with a message back to the submitting pharmacy for correction. To monitor overall claims processing and obtain real-time statistical data, the Aetna Pharmacy team has access to our PBM's reporting system. Reports are reviewed weekly, monthly, and quarterly to identify outliers and take action if needed.

Aetna's PBM has functionality in place to support the pharmacy claims systems ability to process claims on batch electronic media and paper (manual) claims submitted directly for processing. Paper claims may include, but are not limited to, those submitted in situations when an enrollee has to visit an out-of-network pharmacy in an emergency. Paper claims submitted on the NCPDP Universal Claim Form Version D.0 are processed and adjudicated within 10 days of receipt, assigned ICNs within 24 hours of receipt, maintained as electronic backup for the duration of the Contract, and adjudicated through the same processing logic as the POS claims. Our PBM maintains performance objectives and measurement mechanisms to oversee the entire paper claims process. Internal reports, as well as online data, are utilized to track both turnaround times and the volume of claims processed and suspended.

Our POS pharmacy claims processing system includes a suite of modules or rules for pharmacy claims processing to meet the changing needs of the Medicaid pharmacy benefit. It is built with features that allow us to rapidly adjust the configuration to provide flexibility while minimizing downtime and providing greater platform responsiveness to our pharmacy providers. The modular nature of the system ensures that rules governing benefit design, pricing, network coverage, prospective DUR, or other edits, can be configured through a rules engine that eliminates the need for hard coding. Rules can be deployed without the need to bring the system down to implement new programming. The edits are used at the point of service and are designed to confirm pharmacy and the submitted claims' compliance with the Department's program parameters even before prescriptions are dispensed.

A report is produced daily by our PBM to check claims for inconsistencies in quantity, days' supply, dispensing fee, etc. When pharmacy submission errors are detected, an outreach is completed to the submitting network pharmacy to have them reverse the claim and submit a corrected claim with the appropriate data. When errors are found in claims processing suggesting specific parameters (e.g., formulary status, reimbursement, etc.) are not functioning consistent with the required benefit, immediate action is taken to identify, resolve, and remediate the issue(s) of concern.

If we identify any POS processing and/or claims adjudication issue that is or has the potential to significantly impact processing time for claims submissions, claims adjudication, claims adjudication accuracy, and/or continuity of enrollee drug therapy, Aetna notifies the Department in writing no later than one day from discovery. A significant impact means for this purpose a threshold of 100 or more enrollees' claims are impacted by the issue. Notification shall be followed by a written explanation of the root cause and corrective and future preventive action.

Lastly, the pharmacy claims systems captures detailed claims information that allows Aetna to comply with pharmacy benefit reporting requirements and ad hoc reports and data requested by the Department and those set forth by applicable statutory or regulatory authority. At the request of the Department, Aetna provides both summary and detailed reports; detailed reports include claim-level details as requested by the Department. The Aetna Pharmacy team works closely with our PBM to ensure the pharmacy claims adjudication system is configured to support all requirements of the Department and federal government. Numerous checks and balances are in place to ensure the system is functioning consistent with the regulatory requirements of the pharmacy benefit and our contract with the Department. Upon initiation of a new benefit component as well as on an ongoing basis, paid pharmacy claim reports and reject reports can be reviewed weekly by the pharmacy director to identify outliers to the desired benefit.

Our robust claims adjudication system platform allows Aetna in collaboration with our PBM the ability to set, create, and change at any time reimbursement rates between our PBM and a pharmacy provider, or an entity which contracts on behalf of a pharmacy consistent with contractual requirements. Aetna confirms that pharmacy provider reimbursement rates include dispensing fees which adhere to applicable CMS guidance and any Department requirements.

Aetna works collaboratively with our PBM and the Department to define and deliver on the requirement to notify the Department directly, no less than 30 days in advance of any proposed change of over five percent in the product reimbursement rates for a pharmacy provider licensed in the Commonwealth. Aetna acknowledges that the Department may disallow such a change by notifying Aetna at any time prior to the implementation date of the change. If the Department disallows the proposed change, Aetna requires its subcontracted pharmacy benefit manager to reprocess all affected Claims without undue delay at the old reimbursement rate.

Consistent with the previous narrative, and pursuant to 18 RS HB 200, Medicaid Benefits, section (16), Aetna will comply and ensure that any subcontractor engaged to reimburse for medication products through POS/retail claims complies with all dispensing fee requirements set by this Contract. Specifically, on July 1, 2018, Aetna did comply and worked with CaremarkPCS Health to add an additional $2 dispensing fee to all pharmacy claims. After implementation claims were tested and monitored for compliance via reporting, Aetna and its PBM will continue to follow dispensing fee guidance as outlined by the Commonwealth.

Our claims adjudication system properly supports and increases successful provider participation due to our ability to pay all submitted pharmacy claims on a timely basis. Our pharmacy provider payment process is automated, and it adheres to all Commonwealth and federal prompt pay requirements. In the event a claim is paid beyond required timeframes, applicable interest is automatically calculated and paid. On a monthly basis, Aetna receives and reviews prompt pay reports to validate compliance with provider payment requirements. In 2017 and 2018, CaremarkPCS Health paid pharmacies for prescriptions dispensed within 11 days (on average) from the date of fill, surpassing the Department's requirements of 15 days. In 2019, CaremarkPCS Health paid pharmacies within 9.56 days (on average) from date of fill.

c. Process and Procedures to Provide Timely, Accurate, and Complete Data to Support the Department's Rebate Claiming Process and Ensure the Department Maintains Current Rebate Levels

Aetna supports the Department's rebate claims process by providing timely and accurate data through our robust encounter process. Our Encounter Management team, in collaboration with CaremarkPCS Health and our Medical Claims department, works diligently to ensure timely and accurate submission of pharmacy encounters for outpatient prescription medications processed at the pharmacy and medical drug encounters for medications administered by network providers in an office or clinic meet requirements set forth in the Affordable Care Act and 42 C.F.R. 438.3(s) in which CMS requires states to collect CMS level rebates on all Medicaid MCO utilization.

To safeguard the accuracy of our encounter process, Aetna has in place medical and pharmacy claims processing systems and checks that mitigate the risk of incorrect claim payment. Aetna currently has configured within our pharmacy claims processing system real-time edit checks that require the submission of valid NDC numbers, units, and effective dates, and will in 2019 have in place edit checks that will reject pharmacy claims for NDCs not federally rebatable. Our PBM requires all contracted network pharmacies to use the NCPDP POS methodology including the original 10-digit NDC when submitting outpatient drug claims. Our PBM loads a daily Medi-Span file that provides pricing and descriptive drug information on name brand, generic, and OTC medications; it includes industry standard identifiers for all brand and generic drugs on the market including NDC, UPC, and HRI numbers. Invalid NDC number submission will be rejected with a message back to the submitting pharmacy for correction. To monitor overall claims processing and obtain real-time statistical data, Aetna has access to our PBM's reporting system which is used by the pharmacy team to identify claims of concern.

For medications administered by network providers in an office or clinic, Aetna has claims processing checks that occur prior to payment on medical claims billed for medications. Medications administered by the provider undergo multiple checks to ensure a valid 11-digit NDC is present, the units and number of billable units are accurate (ML, UN, GR), the NDC's effective date is valid for the date of service, and other necessary information such as Healthcare Common Procedure Coding System codes are present. This process conducted by our Claims department is documented in their processing desktop.

Weekly NDC claims reports are generated to ensure that the NDC is present and valid and that the units administered are correct. Medical claims found on the NDC report are put through a validation process in which our claims processing system utilizes a robot job to perform quality checks (e.g., a valid NDCs is 11 digits, NDC is not a sequential number (123456789101), unit type and number are valid for NDC) and then matches the submitted NDC codes with our NDC look-up tool, which references the state Physician Injectable Drug List (PIDL). Additionally, the number of billed units are checked against allowable units and are validated through another editing system, which includes the generation of an NDC pend report prior to each check run (twice a week); the NDC pend report is worked by the Claims team before the check run (provider payment) to ensure valid NDCs are present, units are appropriate, and cost of the claim is as predicted.

Our Encounter Management team understands that covered outpatient or prescribed medications adjudicated by Aetna or our designees, and those products administered by network providers in an office/clinic or other non-institutional setting, are subject to the same manufacturer rebate requirements as Kentucky Medicaid fee-for-service outpatient medications. Therefore, our Encounter Management team works collaboratively with our PBM on pharmacy encounters and our Claims department on medical claim encounters for drugs administered by our network providers to ensure claims for medication and products noted above adjudicate or process correctly.

CaremarkPCS Health, on the behalf of Aetna, creates and submits to our Encounter Management team and unit, NCPDP encounters with NDC, unit of measure, quantity, etc., for each ingredient on the claim consistent with federal and Department requirements. Additionally, CaremarkPCS Health indicates the drug is 340B in accordance with the requirements specified by the Commonwealth of Kentucky. As described in the 340B section below, CaremarkPCS utilizes a series of validation edits to ensure that 340B designations noted on the pharmacy claim are accurate and appropriately represented on the individual encounter. Additionally, Aetna's Encounter Management team will check the encounter files for 340B designations to ensure they are accurate so that when submitted those encounters can be excluded from federal rebate submission by states to ensure no discount duplication occurs.

Similarly, encounters submitted to the Commonwealth for drugs administered in the provider office contain NDC level information on drugs, biologics, and other provider-administered products as directed by the Department, including but not limited to drug codes (e.g., J-Code/ Q-Code/A-Code), units, and conversions consistent with federal and Department requirements.

We have the capability to provide utilization information, which includes the total number of units of each dosage form dispensed or administered, strength, date of service (date dispensed or administered), paid date (actual date claim was paid), and NDC of the covered outpatient medication, and amount paid by the Aetna to the pharmacy or medical provider.

Our Encounter Management team deploys mechanisms to report timely medication utilization data (from pharmacy and medical providers) needed by the Department to bill manufacturers for rebates in accordance with section 1927 (b) (1) (A) of the SSA and Kentucky's supplemental rebate program no later than 45 days or as required by the Department after the end of each quarterly rebate period.

The Encounter Management team transmits files according to the Commonwealth regulatory guidelines detailing file format, data fields, and accepted values, including, but not limited to the following:

- Appropriate NCPDP file layout; Commonwealth proprietary file format; or American National Standard Institute Accredited Standards Committee file format
- Commonwealth pharmacy encounter guidelines, including the Commonwealth Companion Guide and/or Payer Sheet

Based on regulatory guidelines and Aetna's requirements, we have set up a validation process with set parameters to complete the following prior to submission to the Commonwealth:

- Analyze encounters that were previously rejected by the Commonwealth and set up validation points to correct future errors. This process occurs prior to encounter file generation.
- Check the file structure to ensure acceptance of the file as a whole by the Commonwealth. This process occurs after encounter file generation but before submission to the Commonwealth.

Additionally, the CaremarkPCS Health Encounter team analyzes encounters rejected by the Commonwealth to determine trends or issues over time and works with Aetna to make adjustments to correct where available. In 2018, our pharmacy encounter initial submissions acceptance rate was 98.93 percent.

In first quarter 2019, the pharmacy encounter initial submissions acceptance rate was 99.99 percent.

The Encounter Management team provides detailed claim information from our Encounter Management system (and if needed claims management systems) requested by the Department or its contractors to support rebate dispute and resolution activities. In turn, we understand that the Department or its designated contractor will provide Aetna's claim-level detail to manufacturers to assist in dispute resolutions. Our Encounter Management team is available and accessible to work to assist the Department in resolving drug rebate disputes with the manufacturer upon the request of the Department.

Specific Aetna Encounter Management team functions that support the required encounter submission include the following:

- Transfer of claims data from the claims processing system to the encounter management system through a manual or scheduled process where claims in a paid, denied, or reversed status are imported into the encounter management system according to plan specifications.
- Transfer of PBM and other third-party vendor data and claims via electronic data interchange files into the encounter management system:
  - Files are validated for Health Insurance Portability and Accountability Act of 1996 compliance and written to the system data tables.
  - Files that contain unacceptable data, either whole files or individual records, in accordance with the agreements with third-party vendors, are investigated and resolved.
- Create and manage standard tracking and reconciliation reports which are used to validate 100 percent of eligible claims that are imported into the encounter management system for submission.

d. Processes and Procedures to Provide Data and Support Department-based Efforts and Initiatives for 340B Transactions

To support the Department's access to timely, accurate, and complete data, Aetna, in coordination with CaremarkPCS Health, will submit the NCPDP encounters with the NDC, unit of measure, quantity, etc., for each ingredient on the claim within Commonwealth-required timelines. 340B covered entities are required to submit Submission Clarification Code = 20 and Basis of Cost Code = 08 at point-of-sale to identify 340B claims. The codes 20 and/or 08 are passed through to clients on their encounter files and can be excluded from federal rebate submission by states to ensure no discount duplication occurs.

As described, Aetna in collaboration with our PBM maintains systems capability and methodology to appropriately identify 340B claims in real time, prospectively, and retrospectively. We support all Department-based efforts and initiatives for 340B claim identification at a claim-level of detail, including the utilization of the NCPDP field(s) designed for this purpose and require our pharmacies identify 340B purchased drugs on claims in accordance with Department requirements.

Aetna does not reimburse a 340B entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in prescription volume that are not 340B entities, and shall not assess any fee, charge-back, or other adjustment upon the 340B entity on the basis that the 340B entity participates in the program set forth in 42 U.S.C. §256b. For enrollees eligible to receive drugs subject to an agreement under 42 U.S.C. § 256b, Aetna does not discriminate against a 340B entity in a manner that prevents or interferes with the enrollee's choice to receive such drugs from the 340B entity.

Upon receipt of the Department's notice of billing guide changes necessary, Aetna and CaremarkPCS Health will promptly work to make changes to meet the change implementation deadlines. Program changes will be at no cost to the Department.

Aetna and CaremarkPCS Health work together to quickly resolve any questions around encounters or rebate disputes and make a CaremarkPCS Health liaison available to work directly with the Commonwealth to assist in any rebate disputes and appeals. Any questions that arise are tracked, logged, and researched in a timeframe defined by the Commonwealth. If a claim error is identified, CaremarkPCS Health works directly with any submitting pharmacies, and claims will be evaluated for reversal and reprocessing and encounter file updates in accordance with Commonwealth requirements.

e. Pharmacy Prior Authorization Process

Aetna's PA process is designed to encourage appropriate utilization and effective prescribing. We accomplish this through the development and administration of evidence-based clinical criteria that specifically speaks to the needs of our enrollees.

In calendar year 2018, our 24-hour turnaround time compliance rate for our Pharmacy PA program was 99.9% for the greater than 55,900 requests received. In calendar year 2019, our 24-hour turnaround time compliance rate for our Pharmacy PA program was 99.6% for the greater than 53,300 requests received.

e.i. Transparency in Communicating the Conditions for Coverage to Providers

Our Pharmacy PA program complies with the requirements of section 1927(d)(5) of the SSA and with Department requirements. Our program ensures there is no undue disruption of an enrollee's access to care; prevents penalization of the provider or enrollee for PA requests or approvals; and incorporates the following requirements:

- Our clinical PA review criteria are evidence-based and follow best clinical practice standards and/or other national standards and are approved by our P&T Committee.
- Our coverage criteria are readily available to our providers and enrollees on our website as well as through electronic tools such as ePA. This ensures transparency in conditions for coverage.
- Reviewers utilize medical and pharmacy claims information and supporting documents available within our medical claims, information management, and pharmacy systems as well as information provided by the prescriber to determine compliance with the clinical coverage criteria guideline prior to rendering a decision on each case.
- A physician peer review is available upon a physician's request for any denial made at a pharmacist review level: Working with local providers, our medical director conducted 239 peer-to-peer consultations with prescribing providers, resulting in a better understanding of the enrollee-specific needs and coverage criteria requirements, thus resulting in a 39 percent uphold rate of cases discussed in 2019. This is up from a 37 percent uphold rate in 2018.

- PA determinations including those from escalated reviews are made and communicated to the requesting provider within 24 hours from the initial request including weekends in compliance with the provisions of Omnibus Budget Reconciliation Act 1990 mandate, Section 1927 of the Social Security Act, and other federal regulations. Specific Department-approved tolling conditions do apply, thus extending case up to 72 hours from receipt of request.
- All PA activities and decisions are documented in our online pharmacy case management system. Aetna care management and appropriate clinical staff have access to the case information within the PA system. Additionally, the information and all case documents are available for immediate review at the Department's request or other timeframe as specified by the Department.

e.ii. Required Credentials for Staff Reviewing, Approving, and Denying Prior Authorization Requests

Aetna requires all pharmacy PA requests to be reviewed by certified pharmacy technicians, licensed pharmacists, and/or Kentucky-licensed physicians. Pharmacy PA request denials decisions must be made by Kentucky-licensed physicians.

To support real-time processing of prescriptions within minutes of an approval of the PA request, the system loads the authorization into the claims adjudication system. The system tracks the status of the clinical review in real time at any point in the process to ensure it is completed and a decision is rendered within 24 hours. Once the PA approval is loaded in the claims adjudication system, it is available to Aetna staff via the PeopleSafe® program that is utilized by numerous departments to assist providers and enrollee with pharmacy-related questions.

e.iii. Use of Pharmacy and/or Medical Claims History to Adjudicate Prior Authorization Requests

We offer two automated PA review programs (**SMART PA and ePA**) which allow medications to process at the POS after meeting Commonwealth PA criteria. Both automated programs make approved PAs available immediately at the local pharmacy in order to eliminate unnecessary delays when the enrollee presents the prescription to the pharmacist.

SMART PA

The SMART PA edits consider the enrollee's pharmacy claim history and medical diagnosis from medical claims, which is loaded from Aetna's medical claims adjudication system, and the prescriber's specialty type in the evaluation of prescribed medications at the POS. The use of pharmacy and/or medical claims history to adjudicate the PA request at point of service allows an enrollee quick access to the medication and eliminates unnecessary delays when the enrollee presents the prescription to the pharmacist.

> In 2019, 6687 SMART PA edits were processed for our enrollees, allowing access to medication efficiently for pharmacists, enrollees, and prescribers.

Currently, active SMART PA edits include long-acting opioids with edits to bypass PA for diagnosis of cancer or palliative care, MME dose edit for opioids (except buprenorphine products) with edit to bypass PA if diagnosis of cancer and palliative care, and Vivitrol® access with ICD 10 for opioid use disorder (implemented July 1, 2019).

Aetna's Clinical Guidelines and PA Operations teams have created and implemented numerous SMART PA edits that can be implemented by any of our Medicaid plans. Edits currently available include, but are not limited to, the following:

- Naltrexone concurrent use with opioids requires diagnosis code F10.2 and F11.2
- Eculizumab (Soliris®) diagnosis code of D59.3, D59.5, G70.0 for coverage
- Paroxetine (Brisdelle®) diagnosis code of E28.310, E89.41, and N95.1 for coverage

- Oral contraceptive diagnosis edit Z30, F32.81, and N92
- Aripiprazole and risperidone diagnosis requirement with appropriate ICD 10 code
- Nuplazid® diagnosis of Parkinson's Disease G20
- MME dose edit for opioids except buprenorphine product and MME edit exemption if diagnosis of burn diagnosis (T20.2-25.7) or sickle cell crisis

Our pharmacy director will share these edits and the results they achieve in other Aetna Medicaid organization plans with the Department and other Kentucky Medicaid plans to determine applicability to Kentucky Medicaid enrollees. Additionally, our pharmacy director will work with internal clinical teams and the Commonwealth to build new SMART PA edits to meet the PDL requirements of covered medications and to improve efficiency determining drug coverage and claims processing while ensuring appropriate drug coverage.

As of December 31, 2019, Aetna's ePA rate of 62.5% of all PA requests exceeds our Medicaid PA operations center goal of 50% by December 2019. Additionally, our provider satisfaction survey of the top 20 Kentucky providers utilizing ePA revealed that 97% of responses noted that ePA saved the practice time, provided a faster response and decision, and continued use of the service was planned.

Electronic Prior Authorization

Electronic prior authorization allows providers to transmit a PA request electronically, thus eliminating the need for handwritten PA fax forms and/or phone calls. Pharmacy PA requests are submitted via a secure web portal using Surescripts, an information technology company that supports e-prescriptions, and CoverMyMeds, a software company that automates the PA process. The ePA tool enables providers to check approval and denial statuses after submission.

Within the ePA system, the provider is able to view the criteria for coverage and provide enrollee-specific responses to criteria questions and enrollee medical and prescription information that support the use of the medication requested. Final determinations for the PA request are either approved (after meeting clinical criteria) or require further review from a pharmacist and/or medical director. By utilizing the ePA tool, providers should see a decrease in their administrative burden while supporting continued compliance with the PDL and clinical criteria. Electronic prior authorization decreases the provider administrative burden of submitting a PA request while ensuring coverage of medication is appropriate and consistent with clinical practice guidelines.

Consistent with Aetna's goal to ensure appropriate and efficient access to clinically appropriate drugs, Aetna implemented the Pharmacist Review of Medical Drug program in 2018. In this program, clinical pharmacists conduct medical drug PA reviews for physician-administered drugs. Pharmacists' extensive knowledge of medications and drug therapy is a great asset to medical directors and other medical PA staff and ensures efficient use of Aetna resources by preserving clinical staff time and ensuring parity of coverage across pharmacy and medical benefits. The physician administered drugs commonly reviewed by the pharmacy team can be found on the Commonwealth's PIDL.

Between February 1, 2018 and December 31, 2019, Aetna Medicaid organization PA pharmacists conducted 1,501 medical drug case reviews, resulting in 60.0 percent of cases approved, and a 40.0 percent rate of case forwards to medical directors with recommendation to deny (28.6 percent) or to seek more information (11.4 percent) on the case. This decreased the Aetna medical director administrative burden of reviewing all complex medical drugs that require PA.

Non-electronic Prior Authorization

For PAs not submitted through the ePA process, our pharmacy PA call center leverages CaremarkPCS Health's pharmacy PA business application for processing PA requests. To support real-time processing of prescriptions within minutes of an approval of the PA request, the system loads the authorization into the claims adjudication system. The system tracks the status of the clinical review in real time at any point

in the process to ensure it is completed and a decision is rendered within 24 hours. Reports are generated throughout the day to ensure that requests are being completed within the 24-hour turnaround time as well as to identify and intervene if there are areas of concern that could negatively affect compliance with timeliness standards.

Reviewers utilize medical and pharmacy claims information and supporting documents available within our medical claims, information management, and pharmacy systems as well as information provided by the prescriber to determine compliance with the clinical coverage criteria guideline prior to rendering a decision on each case. Additionally, we take steps to acquire from the provider all the information that is necessary to determine the appropriateness of the medication. If required information is not available from the provider and a PA cannot be completed within 24 hours, the dispensing pharmacist can initiate an exception override for a 72-hour supply in emergencies when the prescribing provider cannot be reached. Concurrently, the PA team will continue to acquire the needed information until a decision needs to be made within the 72 hours allowed for tolling for non-urgent requests. All urgent requests are reviewed within 24 hours.

Aetna has established protocols for dispensing emergency supplies of medication to enrollees, which includes accommodating situations when clinician prescribed an amount of drug that is more than a 72 hour supply but is packaged so that it must be dispensed intact; in these instances the pharmacist may dispense the packaged drug, and we pay for this quantity even if it exceeds a calculated 72-hour supply. Network pharmacies are educated via network blast fax, POS messaging on the rejected claim, and our call center staff if engaged by the pharmacy on the conditions for dispensing temporary supplies of drugs when they cannot fill due to a PA requirement.

Our PA team allows the provider the option to use the designated Kentucky Medicaid pharmacy universal form or a Department-approved Aetna-specific PA coverage request form. We may seek additional information before making determination on a particular PA request; however, all such information shall be requested from the provider by way of a supplemental PA information sheet that does not duplicate information found on the Kentucky Medicaid universal pharmacy PA form. We do not deny a PA request submitted on the designated universal pharmacy PA form and require the provider to submit the contractor-specific form, but rather shall suspend the request while awaiting a supplemental information sheet.

Aetna maintains procedures for enrollee appeals and grievances submitted by the enrollee or the prescriber authorized to act on behalf of the enrollee related to PAs denied after the final escalated review in accordance with **Section 24.2 Enrollee Grievance and Appeal Policies and Procedures** and **Section 27.10 Provider Grievances and Appeals of the Draft Medicaid Managed Care Contract and Appendices**.

Pharmacy PA Operations Metrics and Performance Management

The pharmacy director and the PA Call Center Management team trend volume, types of requests, and authorization determination percentages through daily and monthly reports. The data is used to continually identify opportunities for quality and process improvement and/or make recommendations to the Commonwealth related to PA requirements and criteria. Aetna issues an inter-rater reliability exam quarterly to pharmacy technicians, pharmacists, and medical directors. The exam is used to confirm and/or identify areas for education on the appropriate application of the PA criteria. We also audit all denials on a daily and monthly basis to guarantee compliance with the National Committee for Quality Assurance denial notification standards. **Table C.21-6** outlines the tools to monitor appropriate application of clinical criteria by the PA staff.

Table C.21-6: Clinical Criteria Monitoring Tools

Monitoring Tool	Reviewer	Description
PA Clinical Audit	Pharmacists	Clinical audit reviews are completed monthly on a random sample of PA cases reviewed by our PA clinical pharmacists. This standardized tool evaluates the decision and documentation against the approved PA criteria/drug compendia. The audit threshold is 97 percent. Individual results are shared with each team member and those falling below the percentage are reeducated on the criteria and its application; continued noncompliance with audit threshold results in further action with staff members consistent with our Medicaid policies.
Inter-rater reliability (IRR) quarterly and/or annual reviews	Pharmacists and medical directors	Quarterly and annual IRR quizzes are issued to our PA clinical pharmacists to measure their knowledge and understanding of application against identified cases. The intent of the IRR is to measure the consistency with application the criteria and areas of inconsistency to identify opportunities for education to the PA clinical pharmacists and/or potential edit requirements to the PA criteria. Annual IRR quizzes are issued to our PA medical directors to measure their understanding and application of clinical guidelines within PA cases. In 2019, participant average scores exceeded our minimum compliance threshold of 85 percent. • Clinical pharmacists IRR: 96.0 percent for 20 pharmacists • Medical director IRR: 98.6 percent for 14 medical directors
IRR annual review	Technicians	Annual IRR quizzes are issued to our PA technicians to measure their knowledge and understanding of application against identified cases. The intent of the IRR is to measure the consistency with application the criteria and areas of inconsistency to identify opportunities for education to the PA clinical pharmacists and/or potential edit requirements to the PA criteria. In 2019, 14 pharmacy technicians' average score of 91 percent exceeded our minimum compliance threshold of 85 percent.
Retrospective DUR	N/A	National Clinical Subcommittee as part of its criteria development process pulls data on drug claims and utilizes this information, along with the medical evidence on the drugs, to identify opportunities for improving utilization control measures. Such improvement may include but are not limited to the discontinuation of PA requirements that are no longer effective or necessary, the creation of new criteria to control utilization trends identified as suboptimal in the DUR process, or the modification of existing criteria to improve clinical efficacy and operational efficiency.

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60.7.C.22 Special Program Requirements

Kentucky | Transforming Health Care | **Aetna**

60.7.C.22 Special Program Requirements (Section 32 Special Program Requirements)

Aetna supports Kentucky's goals to promote program sustainability while endorsing improved health care for the vulnerable population served by Medicaid through the delivery of integrated, quality, and cost-effective health care. We work with a diverse enrollee population; each enrollee is assessed to determine if they would benefit from any of the identified special programs. We recognize that enrollees needing special program services are among our most vulnerable enrollees requiring these enhanced services. Therefore, we have developed specific strategies to ensure these services are well-known, available, and easily accessible through a comprehensive, geographically convenient provider network. We understand the requirements and expectations as outlined in the **Draft Medicaid Managed Care Contract and Appendices**.

As an existing Kentucky Medicaid managed care health plan, we currently meet the Department's Special Program requirements and we go the extra mile to support the following services:

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Dental services
- Emergency care, urgent care, and post-stabilization care
- Out-of-network emergency care
- Maternity care
- Voluntary family planning
- Nonemergency medical transportation
- Pediatric interface
- Pediatric sexual abuse examination
- Aetna's Supportive Managed Care Program (SMCP) (formerly known as the lock-in program)

For example, in 2019 we achieved the following:

- Conducted outreach to more than 150,000 enrollees to provide education and support for emergency care, urgent care, and post-stabilization care
- Provided care management support to over 995 unique enrollees in the SMCP
- Managed care for 119,000 enrollees under the age of 20 who are eligible for EPSDT care with Commendable Healthcare Effectiveness Data and Information Set (HEDIS®) status
- Sent more than 153,000 mailers to families of our youngest enrollees, educating them on developmental milestones and reminding them of the importance of preventive care
- Provided outreach and screening to 4,000 enrollees on prenatal and postpartum care
- Supported more than 350 pregnant enrollees in care management (2018 figure)

Approach to Meeting Special Program Requirements

Our approach is local, devoted to our enrollees, and focuses on individuals' holistic health needs by providing access to and delivery of special program services. Specifically, our approach includes the following:

- Using an awareness campaign to educate enrollees and providers about each special program and how to access the service including web, mail, text, internet, and social media.
- Developing and implementing medical necessity review processes to facilitate easy access to special program services.
- Outreaching and engaging enrollees through our care management activities and technological solutions that meet the enrollee where they are (e.g., kiosks in local Walmart stores).

- Developing identification and engagement approaches for a compliant SMCP that are not punitive but supportive to encourage high rates of completion
- Coordinating care for enrollees to best provide a seamless experience in accessing and receiving these special program services

a. Approach to Ensuring Enrollees and Providers are Aware of Special Program Services

Aetna's approach to ensuring enrollees and providers are aware of special program services utilizes a multipronged awareness approach to inform and educate enrollees and providers about the special program services through the following ways: written information (e.g., enrollee welcome letter, enrollee handbook), enrollee mobile application and web portal, telephonic outreach, face-to-face training and education, and email and text communication.

> We are deeply dedicated to the enrollee events we support and are active participants, seeking direct enrollee engagement and interaction. We had direct engagement with more than 132,000 people throughout the Commonwealth in 2018 and 2019.

Enrollee Approach

Our approach for educating and communicating with enrollees is based on our belief that empowering enrollees to engage in their health care and improve their health outcomes with enhanced quality of care and the reduction or elimination of health disparities achieves quality management excellence. By engaging enrollees where they are in their health care journey, we can address their medical, behavioral health, and social needs. Our approach localizes resources where our enrollees live so information is readily available and easily accessible in many formats. For example, in our Wellness Centers, our community health workers (CHWs) work with enrollees to identify resources and special program needs the enrollee might have and assist our enrollees in accessing these services. By having access to resources, enrollees can participate in self-care management.

All enrollees are informed of the availability of special program services as part of their welcome packet. We are notified about enrollees needing special programs services through many channels and we use these channels as opportunities to provide further education. For example, we obtain information through the initial health risk assessment (HRA), the enrollee needs assessment, enrollee self-referrals, multidisciplinary care rounds, provider referrals, claims, and analytic review and we use these opportunities to make enrollees aware of services they may be eligible for. We use a multifaceted awareness approach that meets the enrollee where they are. Our **standard awareness strategies** for educating and communicating special program requirements to enrollees are depicted in **Figure C.22-1** and includes the following:

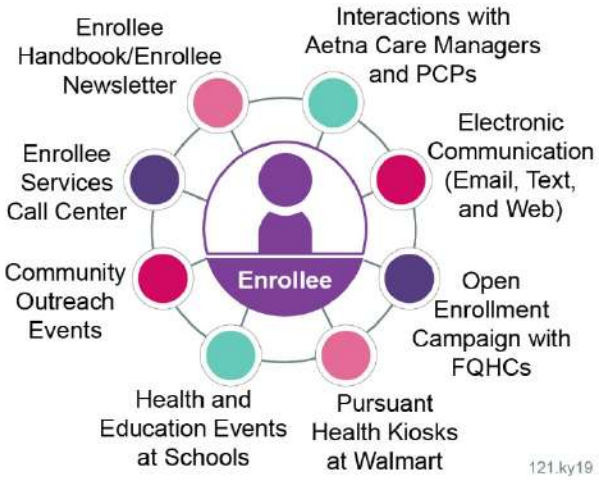

Figure C.22-1: Aetna Enrollee Special Program Awareness Strategies
Aetna uses multiple strategies to make sure all enrollees are aware of special programs.

- Enrollee handbook
- Enrollee newsletters that include articles on promoting the health of Kentucky Medicaid children and adults, other pertinent health topics, and the special program services
- Enrollee Services call center
- Interactions with Aetna care managers
- Community outreach events (conferences, health fairs, other local events)
- Text messaging

- Aetna website
- Participating in health and education events in the community (i.e., school systems)
- Interactions with primary care providers (PCPs)
- Aetna's interactive enrollee web portal
- Pursuant Health kiosks in Walmart
- Open enrollment campaigns with federally qualified health centers (FQHCs)

A sample of our enrollee newsletter communication is provided in **Figure C.22-2**.

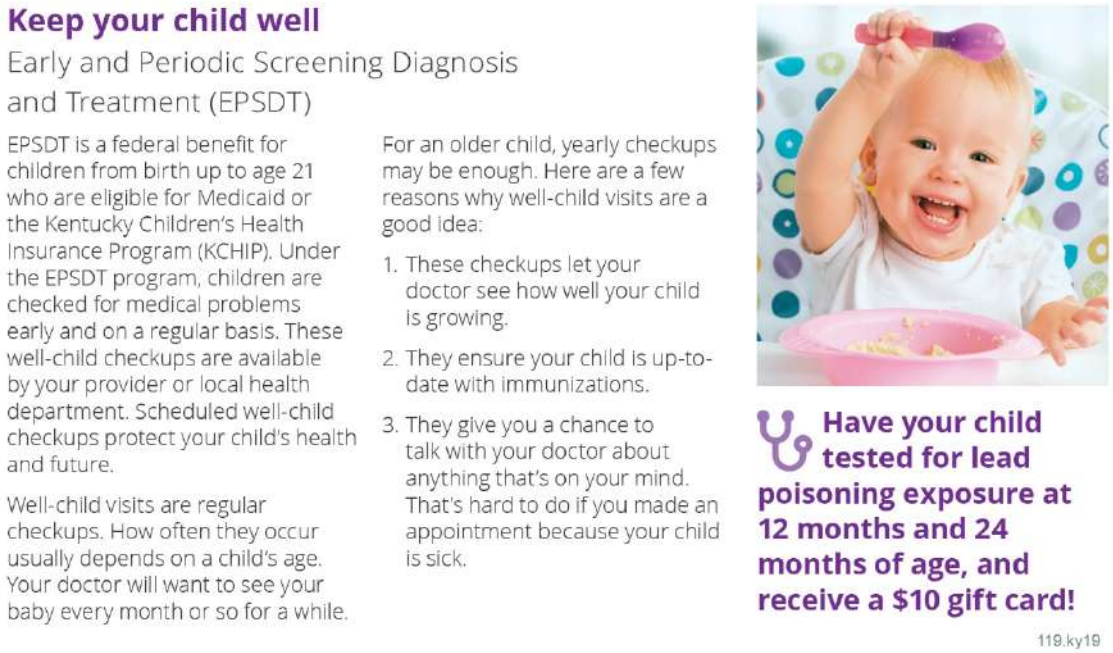

Keep your child well

Early and Periodic Screening Diagnosis and Treatment (EPSDT)

EPSDT is a federal benefit for children from birth up to age 21 who are eligible for Medicaid or the Kentucky Children's Health Insurance Program (KCHIP). Under the EPSDT program, children are checked for medical problems early and on a regular basis. These well-child checkups are available by your provider or local health department. Scheduled well-child checkups protect your child's health and future.

Well-child visits are regular checkups. How often they occur usually depends on a child's age. Your doctor will want to see your baby every month or so for a while.

For an older child, yearly checkups may be enough. Here are a few reasons why well-child visits are a good idea:

1. These checkups let your doctor see how well your child is growing.
2. They ensure your child is up-to-date with immunizations.
3. They give you a chance to talk with your doctor about anything that's on your mind. That's hard to do if you made an appointment because your child is sick.

Have your child tested for lead poisoning exposure at 12 months and 24 months of age, and receive a $10 gift card!

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Figure C.22-2: Aetna Enrollee Newsletter—EPSDT Information

Aetna uses its enrollee newsletter to share information with enrollees about special programs such as EPSDT.

In addition to our standard approaches detailed previously, **Table C.22-1** outlines the following **customized methods** for enrollee awareness of special program services:

Table C.22-1: Customized Enrollee Awareness Approaches by Special Program

Special Program	Enrollee Approach
EPSDT	• EPSDT specific enrollee mailings • Aetna baby showers • Birthday cards with information about annual visits
Dental Services	Prevention and wellness coordinator goes to schools to educate about dental health
Pediatric Sexual Abuse Examination	Community partnerships such as Child Protective Services and Forensic Medicine
Supportive Managed Care Program	Outreach and education about the SMCP and the benefits to engaging in care management

We track our outreach and our customized awareness approaches. In 2018, efforts described in the previous table resulted in improvement in EPSDT HEDIS scores in the Children and Adolescents' Access as detailed in **Table C.22-2**.

Table C.22-2: EPSDT HEDIS Improvement

Children and Adolescents' Access to Primary Care Practitioners (CAP)	2016 HEDIS Actual	2017 HEDIS Actual	2018 HEDIS Actual	2018 HEDIS Percentile	HEDIS 2019 Actual	2019 HEDIS Percentile
12-24 Months	97.28%	97.19%	97.73%	75th	97.91%	**90th**
25 Months-6 Years	89.96%	91.37%	91.41%	75th	92.22%	75th
7-11 Years	94.53%	95.05%	95.37%	75th	95.88%	**90th**
12-19 Years	92.77%	93.93%	93.85%	75th	94.55%	75th

Provider Approach

Aetna implements the following approaches, depicted in **Figure C.22-3** to communicate effectively with our providers about special program services:

- Details regarding special programs are presented during our new **provider orientation** when a provider joins the network.
- **Face-to-face provider visits** to provide education and technical assistance
- Our **provider newsletter** showcases details about special programs
- Aetna's provider communication and education campaign, **Tip Tuesdays**, includes provider tips, reminders, and other educational materials on a weekly basis
- During open **enrollment campaign with FQHCs**, Aetna provided education regarding the available special programs
- Our **care managers communicate** with providers regarding special programs during enrollee care coordination activities
- Electronic communications including **targeted emails, text messaging, fax, and push notifications from the Aetna website**
- Aetna's **provider manual** includes information regarding special programs
- Regularly scheduled **webinars and pre-recorded videos** are always accessible to providers through our website
- We communicate information regarding special programs during our **provider forums**
- For our key provider groups, such as value-based payment providers, hospitals, federally qualified health centers/rural health clinics, and multispecialty groups, we conduct **Joint Operating Committee meetings** no less than monthly to allow for bidirectional communication and training on topics affecting both providers and Aetna including special program services

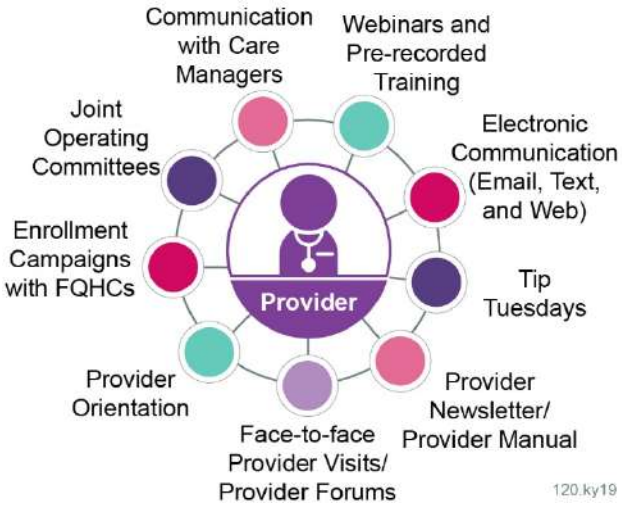

Figure C.22-3: Aetna Provider Special Program Awareness Strategies
Aetna uses a variety of strategies to educate providers about special programs.

b. Description of Medical Necessity Review Process

Services provided to enrollees through one of our special programs are reviewed for medical necessity in the same manner as other services provided to health plan enrollees. There is no differentiation with the medical necessity criteria for these special programs because every enrollee is a unique individual and deserves access to all services required for optimal health.

Aetna UM staff, including our medical directors, are committed to making sure that all enrollees ages 21 and under receive the EPSDT services for which they are eligible. When reviewing PA requests for services for children and adolescents, even if the provider has not indicated that the service is for EPSDT, our UM team determines if the services meet criteria to be covered through EPSDT. To reduce administrative burden to the provider and to promote ease of payment for delivering EPSDT services and track and trend utilization, we automatically add an EPSDT-specific modifier to all EPSDT-eligible service codes.

Our approach for making medical necessity determinations uses nationally recognized, evidence-based criteria that are compliant with the requirements of **Section 20.4 of the Draft Medicaid Managed Care Contract and Appendices** to drive consistency in decision-making. These criteria are applied based on the needs of individual enrollees and characteristics of the Kentucky delivery system. Our utilization management (UM) clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. Criteria sets are reviewed annually for appropriateness to the Kentucky population's needs and updated as applicable when national or community-based clinical practice guidelines are updated. The annual review process involves appropriate physical health and behavioral health medical directors and practitioners in developing, adopting, or reviewing criteria. We advise providers that criteria are available upon request in the notice of action, provider manual, and/or provider newsletters.

We train clinical and service authorization staff members who make medical necessity determinations to use the criteria consistently. The policy of using established decision criteria promotes consistency of reviews. The criteria are consistently applied and referenced for consultations with requesting providers/practitioners when appropriate. As part of the service request requirements, requesting providers supply pertinent information such as appropriate medical records. Upon receipt, UM staff reviews the request and then applies the hierarchy of appropriate medical necessity guidelines and evaluates the individual enrollee's circumstances. UM staff first review respective enrollee information in their electronic platforms and may outreach to the requesting provider or care manager to obtain additional information to support the request for services. Our chief medical officer or delegate is available for consultations with staff regarding prior authorization, retrospective review, and concurrent review issues or any case questions. A medical director with appropriate clinical expertise in treating the enrollee's medical or behavioral condition is the only staff member within the UM team that has the ability to deny a service authorization request for medical necessity reasons.

Our medical management clinical criteria policies and procedures define eligible criteria sources and the process for adoption, review, and approval of clinical criteria. The established hierarchy of referenced criteria is included in **Table C.22-3**.

Table C.22-3: UM Clinical Criteria Policies and Procedures

Resource	Description
Regulatory Guidelines	Applicable Centers for Medicare & Medicaid Services local coverage determination guidelines and the health plan agreement; pharmacy PA guidelines and Commonwealth pharmacy prior authorization criteria proprietary guidelines when other guidelines are not available.
InterQual	National, evidence-based clinical guidelines, best practices, and care planning tools across the continuum of care to support clinical decision-making.
Aetna Medicaid Organization Pharmacy Guidelines	Aetna's proprietary pharmacy guidelines follow objective, credible sources, such as the Academy of Managed Care Pharmacy, the American Association of Pharmaceutical Science, and the American Association of Colleges of Pharmacy, best clinical treatment practices, and expert opinions.

Resource	Description
Level-of-Care Utilization System	A level-of-care tool to help behavioral health clinicians determine the resource intensity needs of enrollees who receive behavioral health services.
American Society of Addiction Medicine	Guidelines for placement, continued to stay, and transfer/discharge of enrollees with addiction and co-occurring conditions.
Aetna Clinical Policy Bulletins*	Aetna's proprietary medical necessity guidelines follow objective and credible sources, such as scientific literature, guidelines, consensus statements, and expert opinions.
Aetna Clinical Policy Council	Team of clinical experts responsible for the review of new and emerging technology; this council also provides consultation to Aetna's medical directors.

Aetna's clinical policy bulletins are available at https://www.aetna.com/health-care-professionals/clinicalpolicy-bulletins.html.

Provider Services and UM staff are available to answer questions and provide guidance on the use of clinical guidelines and UM requirements. We are transparent and forthcoming regarding our use and description of guidelines. Aetna proactively educates our enrollees and our provider community about the basis for use and the content of the guidelines. In our experience, this step helps to remove any access to care issues.

Aetna communicates changes and updates to clinical practice guidelines, InterQual, Aetna clinical policy bulletins, and prior authorization requirements through provider forums, newsletters, fax blasts, provider letters, semiannual forums, and regular and ad hoc meetings by network account management. They are also reviewed and approved by the Quality Management/Utilization Management Committee in which providers and enrollees participate. Enrollees can obtain clinical criteria on our website and by contacting our Enrollee Services department.

For **dental services**, our subcontractor, Avēsis, utilizes specific dental medical necessity criteria. In compliance with the Department's requirements, we require notification of **emergency care, urgent care, and post-stabilization care** within 10 days of the service being provided in lieu of prior authorization. Medical necessity requirements are the same for the **SMCP**; however, the PCP serves as the gatekeeper for accessing specialty services for enrollees in the program. To expedite access to **pediatric sexual abuse services**, we train all our UM team members to review and approve this service.

c. Outreach Methods to Engage Enrollees

We value and support our enrollees' choice in how they engage with us and have specifically designed our care management model—an enhanced, regionally based multidisciplinary care team model—to better engage enrollees and families in care management services and improve health outcomes. We organize Care Management teams that are local to the enrollees they support, promoting improved specialty knowledge of special program services and available providers in the area.

We engage enrollees through live-person face-to-face outreach, interactive phone calls, text messaging, mailers, care management enrollee education, and web-based technology including web portals where an enrollee can have access to their health care records. We provide information to new enrollees on how to access available special program services and how to contact a care manager in the enrollee welcome packet, in the enrollee handbook, and on our website and enrollee portal. We also use reporting suites such as UM dashboards and gaps-in-care reports to identify enrollees eligible for special program services and then engage enrollees and offer care management. Increasingly, technology enhances our ability to engage an enrollee. Other technology-based engagement strategies include the following:

- **Outbound texting programs:** We use a personalized mobile program that sends text messages to program enrollees on a variety of topics which include pregnancy, pediatric and developmental,

health promotion, chronic condition management, and smoking cessation. There is no cost to the enrollee and the program links the enrollee to care management services, if needed. We also use text messaging campaigns to encourage families of children receiving EPSDT services to access dental care, well child visits, and to complete lead screenings. Messages are delivered to enrollees in both English and Spanish, depending on their preference.

- **Lifeline smartphone:** Aetna promotes the Lifeline smartphone to link enrollees to improved phone services for better communication between the plan, their physician, and our Care Management team. The health plan now has new smartphone options for eligible enrollees. The smartphone options include a set amount of voice minutes and data and unlimited texting each month.
- **Walmart kiosks:** We have information kiosks in local Walmart stores for enrollees to access benefit information and health education.
- **Remote patient monitoring:** Aetna offers a remote patient monitoring (RPM) program for enrollees with specific chronic or high-risk diseases that can be utilized to outreach enrollees. We use RPM to elicit enrollee empowerment; education, awareness, and improve disease management; improve access, adherence, and compliance; decrease emergency room (ER) utilization; and lower total cost of care. Enrollees who participate receive our in-home remote monitoring technology package, which includes a remote monitoring bundle and iPad mini™ kit with up to two peripheral devices, such as a weight scale, pulse oximeter, blood pressure cuff, and glucometer. The unit is designed for simple setup, with the iPad personalized for each enrollee, listing their name on the landing page with easy-to-follow instructions and videos on how to use the devices, how and when to contact their provider and care manager, and how to seek emergency help. In addition, we personalize the iPad mini further so the enrollee and their family/circle of support can access educational information targeted to their special program needs and condition(s).

d. Approach to Identify, Enroll, and Encourage Compliance with Lock-in Programs

Our approach to identifying, enrolling, and encouraging compliance with Aetna's Supportive Managed Care Program (formerly known as the lock-in program) includes the use of data analytics to identify enrollees, and participation in our integrated care management program for care coordination support and compliance monitoring. The SMCP targets enrollees utilizing 5 to 10 different pharmacies and/or 5 to 10 different prescribers during a quarter and works to put pharmacy and prescriber assignments in place to coordinate their care and access to medications. **The program assists enrollees with better self-care management, thereby increasing their well-being.**

Identifying Enrollees for Participation in the SMCP

Each month, enrollees are identified using criteria to evaluate potential high-risk behavior and overuse and/or misuse of prescriptions and/or services, including, but not limited to, controlled substances and non-emergent care provided in an emergency setting.

An enrollee may be placed in the SMCP if within one consecutive 180-day period the enrollee meets at least one of the following criteria. Please note that this includes a three-month lag of paid claims data in order to give claims time to process. Criteria are as follows:

- Within a 180-day period, the enrollee has met at least one of the following:
  - Received services from at least three different prescribers (with different Taxpayer Identification Number [TIN] numbers)
  - Prescription claims from at least three or more pharmacies (fills at different locations within the same pharmacy chain shall be considered as use of one pharmacy)
  - At least one paid pharmacy claim for a schedule II-V controlled substance from at least three different pharmacies (fills at different locations within the same pharmacy chain shall be considered as use of one pharmacy)

- At least one paid pharmacy claim for a schedule II-V controlled substance from at least three different prescribers (with different TIN numbers)
- Paid pharmacy claims for at least three schedule II-V controlled substances
- Paid pharmacy claims for at least three different opioids
- Two or more paid claims for Narcan

- At least one paid claim for the following:
  - Controlled Substance Overdose
  - Controlled Substance Abuse/Dependence
- Enrollee is referred by any internal or external department or individual(s) who identifies potential inappropriate utilization of plan benefits, medications, and/or services or it is determined to be in the best interest of the enrollee that utilization be reviewed and placed in the SMCP. These referrals will be reviewed by the SMCP Committee.
- Had at least five ER visits for a non-emergent diagnosis condition
- Received services from at least three different hospital emergency rooms for a non-emergent diagnosis condition
- Any pregnant enrollee who has received greater than or equal to a 25-day supply of a schedule II-V controlled substance

Enrollees identified via analytic criteria are automatically placed into the SMCP and given the opportunity to appeal the decision. When the appeal timeframe has been exhausted, the enrollee is assigned a PCP, pharmacy, and/or hospital. Enrollees will not be placed in SMCP until the enrollee's appeal timeframe has been exhausted or the appeals committee decides there is sufficient documentation that supports the enrollee not being placed into the program.

Success Story: Supportive Managed Care Program

Bob was placed in the SMCP due to over-utilization of providers, prescriptions, and pharmacies services. He was court-ordered to participate in a men's residential substance use program for six months or face incarceration. He successfully completed this program and graduated. Once he graduated, he relocated back to his home in Region 7, which is nearly four hours from his Region 8 treatment program. Bob independently located a new PCP and made an initial appointment. Bob chose this provider because his girlfriend receives her health care and Vivitrol with same physician, and the office is very close to his home. Bob became engaged in care management as a result of him contacting the SMCP staff to request assistance with getting the prior authorization for Vivitrol injections, which he received through a grant while residing at the substance use residential program. Bob was very concerned he would relapse without Vivitrol injections and described this treatment as very effective with his urges completely disappearing. **The SMCP care manager immediately began addressing Bob's request for having the Vivitrol injections prior authorized**. The primary care provider team was educated by the SMCP care manager about the authorization process and the prior authorization form was sent to the provider. **Collaboration ensued with the health plan pharmacy director and the SMCP care manager** for discussions related to specialty drug status and requirements to use a specialty pharmacy in network. Over a period of seven weeks, Bob has been engaged in care management and will begin treatment for relapse prevention because the Vivitrol injections are approved for 12 months. **Bob is elated the Vivitrol injections are approved** and his stress level related to relapse is greatly reduced.

Enrolling Enrollees in the SMCP

Upon identification of an enrollee who meets analytic criteria detailed previously, the enrollee is assigned a PCP, a designated pharmacy, and a designated hospital for non-emergent care. The PCP, designated pharmacy, and hospital assignment focus is continuity of care and care coordination. This process takes into account the needs of the enrollee and the importance of maintaining the enrollee's established relationship with the PCP. Any PCP willing to manage the care of our enrollees who are in the SMCP

must ensure that the enrollee is able to receive necessary care, including prescriptions from other specialty providers. For PCPs providing medical management and care management, this is communicated with the health plan which then allows the specialist to be compensated for their services.

The process for enrolling enrollees in the SMCP includes the following steps:

- Enrollees to be enrolled in the SMCP are provided with written notice of their enrollment in the program.
- Enrollment in the SMCP is effective within 60 days from the date the enrollee is provided written notice.
  - Enrollees who meet criteria receive an Initial SMCP Notification Letter by the first of each month.
  - The Initial SMCP Notification Letter includes a description of Aetna's SMCP, the enrollee's assigned PCP, pharmacy, and hospital, their SMCP effective date and information on how the enrollee can file a grievance, appeal, or State Fair Hearing.
  - The initial notification also includes a description of the integrated care management (ICM) program, contact information for the enrollee's care manager, and information concerning the enrollee's time in the SMCP in the event the enrollee chooses to not actively participate and engage in integrated care management.
- Within 30 days of the Initial SMCP Notification Letter being mailed to the enrollee, a care manager contacts the enrollee telephonically to educate them on the SMCP including program requirements, the assigned PCP, pharmacy, and/or hospital as well as provided information about the ICM program.
- The ICM program consists of scheduled calls at least on a monthly basis with a care manager who coordinates care for the enrollee including agreeing to participation in the care plan goals and interventions. If an enrollee chooses to enroll in integrated care management, the enrollee must establish a relationship with their assigned PCP, actively participate in calls with the care manager, and follow the treatment plan agreed upon with the care manager.
- When an enrollee is successful in completing their care plan resulting in a decrease in utilization, the enrollee is reviewed after a minimum of 12 months duration in the program.

Enrollee Compliance with SMCP Requirements

Through our management of the SMCP, we have learned that successful enrollee behavior change is typically achieved in 24 months; however, we recognize that some enrollees embrace positive health changes. When an enrollee demonstrates positive changes, we allow them to graduate from the program in advance of the 24-month timeframe. If an enrollee fails to remain actively engaged in the care management process, the enrollee's time in the program will be extended to a minimum duration of 24 months with annual reviews. An enrollee can decide to actively participate in integrated care management at any time if they refused initially, but they must meet the requirements of agreeing to participate in the care plan goals and interventions. If the enrollee chooses not to participate in care management, the health plan will continue to support their acute needs through care coordination with internal and external resources.

The **Keeping Kids Safe program is a part of Aetna's national campaign to fight the opioid crisis.** This harm reduction intervention is used to support safety by providing enrollees with a **lockbox to secure their medications**. The primary goal is to reduce the number of accidental opioid exposures that could result in poisoning, injury, or even accidental death.

e. Approach to Coordination, including Referral and Follow-up with Service Providers

Aetna is responsible for the coordination and continuity of care of health care services for all enrollees consistent with 42 C.F.R. §438.208. We coordinate services with traditional and non-traditional providers and across all funding sources with a focus on eliminating duplication of services, improving continuity of care, and facilitating the coordination of benefits. Aetna care managers work together through the

multidisciplinary care team process to create a single individualized plan of care. Aetna confers with the other organization's care managers and sets in place wraparound supports to enhance the care plan. We confirm the enrollee has a single point of contact to decrease confusion and enhance continuity of care. Our care managers coordinate with service providers like **Women, Infants, and Children (WIC), Head Start, First Steps, School-Based Services, Department For Community Based Services, and the Kentucky Transportation Cabinet Office of Transportation Delivery**, and other community resources involved in the enrollee's circle of support to coordinate care and assure access to all special program services the enrollee is eligible for. This includes referrals and follow-up services. For example, we refer potentially eligible women, infants, and children to WIC. We provide medical information where permitted by applicable law to assist in qualification for additional benefits. We do not duplicate services; instead, we coordinate benefits and provide medically necessary wraparound supports. Other agencies we regularly coordinate with include the following: Adult Protective Services; Area Agencies on Aging/Aging and Disability Resource Centers; accredited training agencies; advocacy groups; the Department of Guardianship Services; county and/or Commonwealth-based emergency preparedness groups; the Department of Health Services; the Department of Child Protection Services; the Department of Health Facilities, Evaluation, and Licensing; local law enforcement; ombudsman; providers, including non-traditional providers and community-based agencies; and public guardians.

Aetna understands that often social determinants of health (SDOH) are barriers to accessing special programs enrollees are eligible for. Aetna is partnering with Unite Us in a unique collaboration to address the full spectrum of SDOH. **Unite Us** has a fully integrated social service network that will work directly with our CHWs in our Wellness Centers to assist enrollees with any SDOH barriers to care. The partnership establishes new and innovative models that improve the engagement between enrollees, traditional health care providers (e.g., PCPs), and social services providers. This SDOH services integrated model connects enrollees to community-based organizations (CBOs) who participate in a network that Unite Us coordinates. Referrals to Unite Us are tracked and followed to assure service completion. Regardless of where the referral for a social need is identified (e.g., HRA, enrollee services, provider referral, care management referral, or self-referral), Aetna makes certain there is a warm handoff to an Aetna CHW co-located in the communities where our enrollees live, a CHW based at a local community partner agency, or an Aetna care manager. Aetna CHWs will work in the community or be co-located at community agencies (e.g., United Way offices, food banks, etc.). Regardless of the location of the CHWs, they assist with access to enrollment in special programs, federal and Commonwealth benefits, and social needs for enrollees.

If the enrollee is participating in care management, the Care Management team will use current resources and tools such as Aunt Bertha and CBOs to support the enrollee's social service needs. In the Louisville region, the CHW or care manager can also connect the enrollees to Unite Us where they will facilitate a warm handoff of the enrollee to the established network of community providers. The network currently has access to providers in the areas of food, housing, transportation, and domestic violence.

The Unite Us platform provides the unifying infrastructure between health care entities and CBOs. The platform allows for the current ecosystem of health care and social care partners to connect around every enrollee and track the outcomes delivered across each partner in a secure environment. This infrastructure provides the ability to track an individual's journey, regardless if they start their journey post-discharge from medical provider or at a CBO's office. The Unite Us platform also communicates and coordinates with the health plan.

The main themes of the platform include the following:

- Configurable screening for needs with immediate decision support
- Electronic referrals and tracking with external agencies
- Assessment and single care plan management

- Bidirectional communication (between partners and enrollees)
- Alerts and email notifications on referral progress
- Outcome tracking across network partners and each community
- Outcomes by resource including specifics (e.g., long term housing, transitional housing, etc.)

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60.7.C.23 Behavioral Health Services

Kentucky | Transforming Health Care | **Aetna**

60.7.C.23 Behavioral Health Services (Section 33.0 Behavioral Health Services)

Aetna understands, acknowledges, and will comply with all the requirements of **Section 33.0 Behavioral Health Services of the Draft Medicaid Managed Care Contract and Appendices**.

a. Comprehensive Behavioral Health Services

Aetna currently serves over 211,000 Medicaid enrollees in the Commonwealth, providing a comprehensive range of behavioral health (BH) services for our enrollees. In Kentucky, Aetna achieves quality management excellence by empowering enrollees to engage in their health care and improve their health outcomes with enhanced quality of care and the reduction or elimination of health disparities. Services include outpatient treatment options for BH and substance use disorders (SUD); medication management and medication-assisted treatment (MAT); hospital-based services for BH and SUD; and intensive in-home therapy programs and services. Our enrollees will have access to all medically necessary BH services through our fully integrated, whole person model of care and our comprehensive BH provider network.

Our BH provider network consists of the following provider types to serve enrollees at all levels of care:

- Psychiatrists, psychologists, and licensed BH professionals; peer specialists; community health workers; multispecialty groups; hospitals; and BH services organizations
- Federally qualified health centers (FQHCs) and rural health clinics (RHCs): **Aetna holds contracts with 210 FQHCs/RHCs across all 8 regions** of the Commonwealth, as well as in bordering communities in Ohio, Tennessee, and West Virginia
- Community mental health centers (CMHCs): **Aetna contracts with all 13 CMHCs across all regions of the Commonwealth** as indicated in **Table C.23-1**.

Table C.23-1: Contracted Community Mental Health Centers

CMHC	Region Served	CMHC	Region Served
Four Rivers Behavioral Health	Region 1	New Vista	Region 5
LifeSkills	Regions 1, 2 and 4	Comprehend	Region 7
River Valley Behavioral Health	Region 2	Pathways	Region 7
Centerstone	Region 3	Cumberland River Community Care	Region 8
CommuniCare	Region 3	Kentucky River Community Care	Region 8
NorthKey Community Care	Regions 3 and 6	Mountain Comprehensive Care Center	Region 8
Adanta	Region 4		

Fully Integrated Model

Aetna's goal is to positively impact the health status of our enrollees. Our commitment is to **improve enrollee health outcomes, enhance quality of life, and reduce racial and ethnic health disparities by providing care in the most appropriate setting**. Aetna integrates the full spectrum of BH, physical health (PH), and oral health services, while addressing social determinants of health (SDOH) for each enrollee we serve. Our integrated approach is fully compliant with the Mental Health Parity and Addiction Equity Act Final Rule. Aetna's integrated care teams support our integrated care planning process by providing multidisciplinary expertise to efficiently coordinate services that best address each enrollee's individual needs. Our infrastructure supports a fully integrated model of care through collaboration between the Integrated Care Management (ICM) program, Utilization Management (UM), Quality Management (QM), and community health workers to provide seamless care to our enrollees.

Aetna will employ a **recovery and resiliency administrator** with the following responsibilities to support enrollees:

- Build supportive programs for mental health and substance use service delivery
- Participate in integrated rounds
- Collaborate with local, Commonwealth, and national partners and stakeholders
- Collaborate with enrollees and families to identify and remove barriers to services
- Promote the hope for recovery within the health plan

Integrated Care Management Program

Aetna's ICM program serves our most medically complex and vulnerable enrollees with whom we have an opportunity to make a significant difference. We engage enrollees in our ICM program to remove or lessen barriers that limit their ability to manage their own health and well-being, educate them about their chronic conditions, and help them remain in the least restrictive and most integrated environment based on their preferences, needs, safety, burden of illness, and availability of family or other supports. Autonomy and active self-management of acute and chronic conditions is encouraged where clinically appropriate using motivational interviewing skills with tools and education directed at each enrollee's unique needs and health literacy. A well-trained care manager serves as the **single point of contact** for enrollees and guides them toward self-efficacy. We collaborate with enrollees, their supports, and their integrated care teams to create a care plan that includes mutually agreed upon enrollee-centered goals and actions. The care manager and the integrated care team coordinate both covered and non-covered services for the enrollee.

The ICM program reflects our belief that care management must address the enrollee's medical, behavioral, oral health, and social needs in an integrated fashion and must address the continuum of acute, chronic, and long-term service and support needs. Any psychosocial issues and cognitive limitations impacting the enrollee are addressed in their individualized care plan as are the cultural practices and beliefs most important to the enrollee. Barriers to improving health and root causes of poor health outcomes are specifically addressed to help both the care manager and the enrollee better understand what has prevented full engagement with a suggested clinical treatment or plan of care. Once these issues are identified by the enrollee and informed by the integrated care team, truly individualized and collaborative care planning can begin.

Integration of BH in our Quality Assurance and Performance Improvement Program

Integration of quality management BH activities into the Quality Assurance and Performance Improvement program occurs through regular reporting of BH metrics and ongoing monitoring of BH services. The Quality Management Oversight Committee (QMOC) reviews and approves quality management BH reports integrated with health plan reports annually. A BH practitioner serves as a member of the QMOC and Quality Management/Utilization Management (QM/UM) Committee.

a.i. Delegation of Behavioral Health Services

We will have a staff of approximately 250 **Kentuckians caring for Kentuckians**. Aetna currently manages BH services for over 211,000 Medicaid enrollees through our provider network and does not intend to outsource or delegate any BH services to an external entity.

a.ii. Compliance with Access and Care Standards

Aetna currently meets, and will continue to meet, the provider network access and adequacy standards consistent with KRS 304.17A-515 and established by the Department, unless otherwise approved by the Department in accordance with the requirements set forth in **Section 28.0 Provider Network of the Draft Medicaid Managed Care Contract and Appendices** for the full continuum of BH services.

BH Access and Care Standards

Aetna will maintain an adequate BH provider network, so enrollees have access to qualified BH providers at all levels of care. Enrollees will have access to the continuum of BH services to advance person and family self-sufficiency, recovery, and resiliency. We will monitor compliance with the following network access and care standards applicable for BH providers:

- For urban areas, a BH provider at the appropriate level of care is available to all enrollees within 30 miles or 30 minutes of each enrollee's place of residence or work, to the extent that services are available.
- For areas other than urban areas, a BH provider at the appropriate level of care is available to all enrollees within 50 miles or 50 minutes of each enrollee's place of residence or work, to the extent that services are available.
- If Aetna or a BH provider requires a referral before making an appointment for specialty care, any such appointment shall be made within 30 days for routine care or 48 hours for urgent care.
- Emergency BH services by a provider that is most suitable for the enrollee's needs is available and accessible to enrollees 24/7/365, regardless of whether the provider is in our provider network.

Monitoring and Ensuring Compliance with BH Access and Care Standards

If a provider network does not meet every individual's unique supportive and health needs, the network is not adequate. Our provider network complies with 42 C.F.R. § 438.206 requirements for the availability of services and **exceeds National Committee for Quality Assurance (NCQA) requirements for adequacy and availability**. We consider numerous factors that affect adequacy, availability, and accessibility, including network composition; geographic distribution; provider and enrollee needs including travel distances; types and numbers of providers available; access to timely appointments; access to urgent and emergent care; access to culturally and linguistically competent services; and disability access. An enrollee's perception of the network is a key driver of satisfaction with the managed care organization (MCO) and their health improvement goals. We complete two enrollee surveys that measure enrollee satisfaction with their health care in general and enrollee satisfaction with BH services. **Our 2019 BH survey indicates an improvement across all areas surveyed. Enrollees are satisfied with their ability to access BH services. Enrollees are more pleased with the outcomes of their services. Communications with clinicians saw overall improvement and the overall rating of BH providers was approximately 90 percent.** We do not limit ourselves to meeting the required standards; instead, we develop our network to meet our enrollees' needs. We provide a second opinion from a participating provider or we will arrange for one outside the network, if needed, at no cost to enrollees. Information regarding obtaining a second opinion is detailed in our enrollee handbook.

Examples of our innovative contracting approaches include the following:

- **Value-based payment (VBP) contract with KVC Health Systems** for a 4-phase treatment designed to use the wraparound model to avoid youth entering a higher level of care and to successfully stabilize and reunify the youth into their natural home as timely as possible. This model is supported by Aetna as a family-centered, evidence-based practice and recognizes that youth and families do not operate in isolation and services are more effective from a team approach with natural supports and community partners interfacing regularly with them. The 4-phase model includes the following:
  - Assessment phase
  - Stabilization and treatment phase
  - Reunification phase
  - Transition to in-home services phase
- **VBP contract with Addiction Recovery Care (ARC)** for a multi-phase SUD treatment model that includes the following:
  - Karen's Place Maternity Center, where expectant mothers receive treatment throughout their pregnancy and three months after delivery

- Transitional services/intensive outpatient program (IOP) with boarding
- Outpatient services with housing assistance
- Job training at ARC's Peer Support Academy

Tools to Monitor Network Compliance

We use a variety of mechanisms to verify compliance with network standards and develop interventions to address gaps as appropriate. We use our suite of monitoring tools and reports to identify network gaps as follows:

> "Aetna Better Health of Kentucky is an outstanding company. You don't run across it very often in this business and do not get it from other MCOs. You provide great service and I appreciate you taking the time to help us start our program on the right foot."
>
> **—Mary Hicks**
> **Clinical Director**
> **Kentucky's Choice**

- **BH enrollee satisfaction survey:** Both the adult and child versions include questions related to enrollee experience with accessibility, communication, provider satisfaction, enrollee services, and overall satisfaction with BH services.
- **UM reports:** We use many UM reports to identify outliers and develop action plans to address them, including emergency room (ER) utilization, pharmacy reports, opioid dashboard reports, and readmission rates. For example, we found high readmission rates at Our Lady of the Peace, so we **embedded a care manager** there to assist with discharge planning and offer intensive care management.
- **UM monitoring:** We monitor quality and compliance with Commonwealth regulations through our UM processes. For example, we identified a provider starting a new SUD IOP who did not have all the components needed. We walked the provider through the program requirements and worked with them to create a plan to get them up to speed.
- **Provider access telephonic survey:** Provider telephonic surveys to monitor timely access to care. Monthly, we query providers on appointments and after-hours care, including 24/7/365 availability monthly.
- **Network panel studies using open/closed panel report:** Annual panel studies demonstrate network access and availability needs.
- **Provider directory audits**: Monthly audits confirm the accuracy of listings; we make updates to online directories for changes in demographics and panel status.
- **Quest Analytics reports:** We use monthly reports to measure against Department access standard requirements at the ZIP code level.
- **Interdisciplinary care team collaboration:** We identify any access or capacity concerns and address special needs on an ongoing basis.
- **Network adequacy:** We review utilization data for prevalent conditions, single-case agreements, provider referral issues (availability of specialties), providers-gained-and-lost report, and unplanned network exits report to confirm sufficiency of the type and number of providers on an ongoing basis to assess compliance with network time and travel distance and appointment wait time standards described in **Draft Medicaid Managed Care Contract and Appendices, Section 28.4 Provider Network Access and Adequacy.**
- **Provider-to-enrollee status:** We review ratios by provider type and region to confirm availability of an adequate number of providers on a quarterly basis.
- **Providers' panel status:** We review open panel status to confirm where we can assign new enrollees and identify providers who reached their capacity and/or referral limits on an ongoing basis.
- **Grievances and feedback:** We review quarterly analysis and trending of enrollee grievances to identify potential availability or accessibility issues, including access to BH services, perform root-cause analysis, and develop corrective action plans as needed. Specifically, we monitor for any concerns related to access to BH providers who may be identified as a shortage to implement our network strategies to close any gaps. We receive committee findings and survey results on access,

appointment availability and wait times, non-participating prior authorizations, and out-of-network requests.

Success Story: Value of Collaboration

A 27-year-old female enrollee was referred to Aetna's ICM program following discharge from a BH setting. At the time, the referral mentioned she faced challenges with respect to housing and financial insecurity. She was diagnosed with asthma, paranoid schizophrenia, autism spectrum disorder, obsessive compulsive disorder, and anorexia nervosa. She had experienced trauma as a child and her fears related to this trauma led to her refusal of inpatient hospitalization. Over time, her providers became most concerned with her eating behaviors and related body mass index and body weight. Her Aetna care manager coordinated with several community providers and internal departments to identify appropriate support and treatment options. She participated in various partial hospitalization programs, intensive outpatient programs, outpatient programs at The Ridge for approximately three months, and was on the waiting list for the Louisville Center for Eating Disorders outpatient program. The care manager coordinated with Bluegrass Care Navigators℠, which provided in-home weekly support visits while she was on the waiting list. Further evaluation resulted in the recommendation that she attend an inpatient eating disorder program. The care manager explored inpatient options and contacted the Center for Change inpatient program in Utah, which agreed to admit her. The enrollee agreed to attend this program and **the care manager facilitated the single-case agreement for her admission**. She was eager to begin her process of healing and excited to stabilize her medical, dietary, and psychological health. The care manager remains involved and will assist with treatment and transition planning when she returns home.

How We Use the Data Collected

Reports based on the data collected through our monitoring methods are submitted to several committees to make sure we meet network requirements. Data is collected on a regular basis by individuals who also sit on these various committees providing their expertise and knowledge of the processes, procedures, and ability to assess areas for improvement. Committees review recommendations, make suggestions, monitor status of corrective actions, and assist in prioritizing resources within the organization to achieve the Department's goals. We use the data reviewed in committees to drive policy change as well as expand our BH network through innovate strategies such as adding telehealth opportunities and engaging BH providers in VBP arrangements.

A multi-tier committee structure oversees the network monitoring processes, meeting on a monthly or quarterly basis and includes the following:

- **Quality and Member Access Committee:** Provides feedback on appointments and network providers (who are not meeting standards or who have issues or concerns) and provides input on additional network needs or opportunities for improvement. The committee meets monthly and is responsible for promoting collaborative efforts with providers. Aetna staff and leadership use this feedback to enhance the service delivery system in local communities while maintaining a focus on enrollees and allowing input on policy and network adequacy. Network staff engages in recruitment efforts with non-participating providers who are identified through the MAC.
- **Service Improvement Committee:** Consists of various members of Aetna's leadership and operational teams. The committee meets monthly, reviews data, and reports on monitoring activities, including timely access standards. The committee presents status and concerns on appointment availability survey results, trended complaints and survey data, and other findings from routine activities. The committee advises and makes recommendations to the QMOC on enrollee and provider issues and is supported by the Grievance and Appeals Committee.

- **QMOC:** Chaired by the chief executive officer, the QMOC has the ultimate authority and responsibility to validate that monitoring requirements are met. The committee meets quarterly and reports to senior leadership. Participating physicians and other providers are contractually obligated to adhere to Medicaid access and appointment standards and to provide services in the same manner as they would provide to commercial or other non-Medicaid enrollees. Standards are communicated through the provider manual, enrollee handbook, newsletters, and onsite visits. Provider training addresses wait times and appointment standards; disability access, competency, and expertise; cultural needs; and hours of operation. Network staff present network contracting activity and overall network adequacy performance to the QMOC.

Timely Availability and Access to Covered Services

Aetna has a full suite of monitoring tools and processes to assess timeliness, access to care, and wait times for BH providers on an ongoing basis. We also monitor and report on BH providers' hours of operation and include this information in our provider directory. If we determine that more providers or specialties are needed in a specific area, we proactively outreach to expand our BH network and mitigate any potential network gaps. When we identify an issue involving appointment access or wait times, our provider services representatives, care managers, and Enrollee Services staff are able to assist in resolving the issue by contacting the BH provider or locating another BH provider for enrollees, and then working closely with the provider to resolve any future access issues.

a.iii. Innovative Strategies to BH Network Adequacy and Access

Aetna demonstrates our ingenuity and collaborative spirit by developing innovative VBP solutions with providers. We are committed to providers being true partners in taking care of our enrollees and their patients. Our goal and strategy are to build a comprehensive region-specific, experienced, and high-quality network that offers provider selection, preserves existing community referral patterns, and ensures access to care for the underserved. Our innovations are designed to implement delivery system reforms to improve quality and outcomes. We implement innovative contracting approaches for BH services as an integral part of our whole-person model of care. We identify providers from several different sources. We will use our comprehensive contracting methodology, VBP programs, technology/telemedicine services, and an ongoing level of engagement and diligence to continuously recruit providers and scale our provider network to meet the needs of Kentuckians.

We recognize that long-term success relies on a combined statewide and regional network strategy. From a statewide perspective, we identify and document all BH providers in our network, so our staff have easy access for quick referral resources. **We serve as a critical link between the enrollee and the BH provider**. Our goal is to make sure the BH providers serving our enrollees have a full understanding of the physical and BH needs, as well as any issues we have identified in the home and/or facility environment, including family dynamics and social issues, which may influence the enrollee's health. We monitor the quality of care and utilization trends for each BH provider and identify opportunities to enhance care when appropriate. We work in constant partnership with our providers, so our enrollees experience the highest quality, appropriate level of care to achieve their short- and long-term goals. Examples of strategies we will implement to maintain access to services across the BH continuum of care include the following:

- Collaboration with **Children's Alliance of Kentucky Independent Provider Association, LLC (CA-IPA)** with the mission to increase access and improve quality of BH services for Kentucky's at-risk children and families. Aetna was the first MCO to initiate a partnership with the CA-IPA to create and execute a VBP services contract for BH services.

- **Guardian Angel Program** identifies enrollees with emergency room claims due to non-fatal opioid-related overdose. A designated care manager outreaches the enrollee to offer evidence-based SUD services and educate about community resources and supports. We connect them with resources for care and support, so they can reduce the risk of another overdose.
- **Aetna partners with hospitals by embedding care managers in psychiatric hospitals and ERs** to engage and support enrollees throughout their continuum of care. **In 2018, the final Commonwealth incentive model rates indicate Aetna outperformed all other MCOs for meeting the 7-day follow-up with a BH provider following discharge for enrollees engaged through this partnership.**
- We conducted a regional analysis of our contracted **Applied Behavior Analysis (ABA)** providers to identify possible gaps in access to ABA therapy. We compared our contracted providers to the Commonwealth's listing of licensed behavioral analysts. We are outreaching providers for contracting in those regions of the Commonwealth with identified need.
- Our care managers refer families to the **Families in Transition** program, which offers parents and children a six-hour educational program on how to effectively cope with the problems resulting from divorce. The program has two main goals. The first goal is to prevent or reduce divorce-related anxiety, aggression, depression, and behavioral problems in children. The second goal is to improve the social skills that help children adjust to divorce and enhance their chances for a healthy future.
- **Start Strong Initiative** (northern Kentucky) promotes transition planning for enrollees scheduled for release from incarceration prior to the release date. Transition planning prior to release helps to make sure enrollees have immediate access to community-based services and supports upon release. Aetna has in place processes to bypass prior authorization requirements so services can be arranged and available immediately upon release.
- Aetna authorizes **up to eight hours of neuropsychological testing** without medical necessity review for the purposes of testing for autism spectrum disorder and for enrollees with acute brain injury to improve timely access to critical services.

> "Aetna's leadership and staff have been exceptional to work with and they have worked diligently to develop a contract that will move the health care of its members forward. It seems measuring outcomes and working to improve medical care has been implemented in Kentucky for many years. However, most of those value-based contracts have been centered around physical health. Because behavioral health is often more complex, regarding measuring outcomes, the MCOs have been hesitant to engage with CA-IPA, apart from Aetna. Aetna leaders expressed their concern and commitment to specifically helping the most vulnerable children and families in Kentucky, which are those cared for by CA-IPA members."
>
> **—Michelle M. Sanborn, President, Children's Alliance**

Aetna Medicaid's Strategy to Address the Opioid Crisis

Aetna is committed to reversing the rising trend of opioid abuse. Aetna will execute strategic solutions that focus on the needs of our enrollees and will make sure initiatives and programs integrate pharmacy, BH, and PH. Our programs connect providers and give enrollees seamless access to the right support—for both mind and body—to fight addiction, while saving millions of dollars for the health care system.

By 2022, in alignment with the State Health Improvement Plan, Aetna is committed to the following goals:

- Increase enrollees with chronic pain treated by non-opioid treatment alternatives by 50 percent
- Reduce inappropriate opioid prescribing for our enrollees by 50 percent
- Increase enrollees with opioid use disorder treated with MAT and other evidence-based treatments by 50 percent

The Aetna Medicaid organization builds on current initiatives to impact every aspect of awareness, delivery, and use of opioids. We are expanding a series of initiatives to reduce the supply of opioids and to decrease the rates of overdose, as well as increase the identification of enrollees with SUD and promote the adoption of MAT. The Aetna Medicaid organization's strategic solutions to address the opioid crisis include **prevention, intervention,** and **support** components—for both enrollees and providers—to address the continuum of needs in a holistic and enrollee-centered manner.

Prevention: The Aetna Medicaid organization helps providers and enrollees avoid unnecessary opioid use and effectively manage opioid use when needed with the following approach:

- Increase the availability of **alternative therapies** for pain relief such as physical therapy, chiropractic/osteopathic manipulative treatment, acupuncture, massage, cognitive behavioral therapy, and other effective alternative modalities.
- Offer education to providers and enrollees on **proper opioid prescribing and pain management**:
  - Academic detailing "If at First You Don't Prescribe" and the companion booklet for enrollees, "Power Over Pain," are central to a comprehensive educational campaign aimed at providing education for both providers and the public on the treatment of pain.
  - Standard provider and enrollee newsletter guides on pain management, prescription management, and MAT for regular distribution in all Aetna markets including Kentucky.
- Promote the **COPE approach (Collaborative Opioid Prescribing Education)**, a clinically tested course that teaches a collaborative care model for opioid therapy for enrollees with chronic pain. COPE-REMS aims to prevent opioid misuse, abuse, and deaths from opioid overdose by providing knowledge concerning the efficacy and risks of opioid therapy and training in communication skills needed to develop an effective collaboration with enrollees[1]. Training is free of charge.
- Implementing **pharmacy deterrence:**
  - Approve only the least amount of opioid possible for the shortest period necessary
  - Clinical review for doses exceeding 120 mg morphine equivalent daily dosing (MEDD)
  - Pain management contract for all long-acting opioids consisting of completion of an addiction risk assessment; requiring prescribers to check the Commonwealth prescription drug monitoring program database; and an agreement to only use one pharmacy. **In Kentucky, results from this clinical review alone resulted in a reduction in utilization by 30 percent between 2015-2016**.
- Support the **Special Investigations Unit** inquiries prompted by the pharmacy opioid prescriber outlier report

Intervention: The Aetna Medicaid organization promotes effective intervention strategies and activities through the following:

- Clinicians and health plan medical directors take mandated SUD recognition and treatment training through an external expert organization. Training also includes the use of trauma screening, such as **adverse childhood experiences**, as it is critical for enrollees' comprehensive integrated care.
- Endorse the use of **SBIRT (Screening, Brief Intervention, Referral to Treatment**) by providers through increased promotion of available training and coverage.
- Offer a standard **Neonatal Abstinence Syndrome Prevention Program**: Pregnant enrollees using illicit drugs are identified through multiple sources. High-risk care management is triggered, and SUD treatment initiated. The newborn is followed for one year post-delivery.
- Identify **high-risk SUD enrollees for care management** through pharmacy reports that are based on multiple critical metrics including high average MEDD, concurrent opioid and benzodiazepine use,

[1]"About COPE," University of Washington (April 11, 2011): retrieved from Collaborative Opioid Prescribing Education website: accessed June 20, 2109; http://www.coperems.org/about-page/.

use of a controlled substance with a history of dependence, abuse or overdose, multiple prescribers (doctor shopping), and others.

- **Pharmacy restriction program**: Enrollees are restricted to a single pharmacy and/or possibly a single prescriber due to MAT or identification as being at high risk for SUD (uses pharmacy metrics as well as medical management reports of high ER utilization, overdoses, hospitalizations, and others).
- Promote the **availability of naloxone (Narcan®)** to enrollees by partnering with governors and Commonwealth leaders to train first responders on proper administration. **Aetna, through the Aetna Foundation, will donate additional Narcan kits via a state-by-state distribution initiative including Kentucky**. A second phase will introduce soft transfers of enrollees to a SUD, MAT, or 12-step programs after response to an overdose.

Support: The Aetna Medicaid organization works with diverse stakeholders and employs the following comprehensive approach to ensure its support-related strategies and activities are effective:

- **Outreach high-risk enrollees** and those on Suboxone®/MAT as part of the care management standard operating procedure on opioid management
- **Increase mental health awareness and reduce stigma**: Aetna is funding research in SUD treatment and promoting education around SUD and mental health issues and trains our staff in Mental Health First Aid
- **Develop VBP contracts with SUD treatment providers** to promote evidence-based approaches to SUD and centers of excellence, which we have implemented in the Commonwealth
- Encourage use of the **Aetna provider directory** to increase ease for enrollees to search for and identify in-network providers who specialize in pain management, MAT, office-based opioid treatment, SBIRT, first episode psychosis/early episode psychosis, and integrated dual disorder treatment
- **Partner with our Commonwealth and national government** by participating in SUD and opioid task force panels

Preferred Provider Program: Aetna was heavily involved with the Buprenorphine Preferred Provider Program, in partnership with the University of Kentucky, for select University of Kentucky providers. This program was initiated in March 2018 and continues today. This group of providers can issue prescription to our enrollees being discharged from their inpatient care for the buprenorphine/naloxone sublingual tablets and bypass the prior authorization process. The specific need for the program arose from hospitalized enrollees needing the medication prescribed at discharge. Partnership with the University of Kentucky team was sought because of the high-quality, state-of-the-art MAT program offered.

Distribution of 720 doses of Narcan to first responders: As pictured in **Figure C.23-1**, Aetna representatives, Commonwealth staff and local officials at Hazard City Hall announced a **partnership that provided 720 doses of Narcan to first responders in eastern Kentucky** to help prevent opioid overdose-related deaths. The kits, donated by Aetna, include two doses of nasal spray Narcan, also known as naloxone, and a pamphlet with directions on how to use it. When administered after an overdose, naloxone can counteract the life-threatening effects of opioid drugs and keep individuals who have overdosed alive until emergency medical help arrives.

Figure C.23-1: Narcan Demonstration
Aetna Chief Medical Officer Dr. David Hiestand participates in a demonstration on the administration of Narcan.

The Aetna Medicaid organization values the health and welfare of its enrollees and their communities. To be successful, we must reduce barriers that restrict access to SUD, MAT, support programs, and alternative therapies. We are dedicated to alleviating the opioid crisis through a multifunctional integrated care management program in partnership with our local, state, and federal government. Through innovation and the sharing of best practices, the Aetna Medicaid organization will lead the charge in this endeavor. **At Aetna, we care about our enrollees**.

Aetna Donates $150,000 to Volunteers of America to Support New Freedom House Program in Southeastern Kentucky

Freedom House provides state-of-the-art and nationally recognized addiction recovery treatment and care to pregnant and parenting mothers working to overcome substance use disorder. On February 11, Volunteers of America is scheduled to open a new 16-bed facility located in Clay County—the first program of its kind in the region.

The Aetna gift will be critical to funding the comprehensive services and care pregnant and parenting mothers receive at Freedom House. At Volunteers of America, recovery is viewed as a full-time job, and the comprehensive treatment plan focuses on individual and group therapy, parenting support, high-risk prenatal health care, and so much more. With Volunteers of America, the treatment program also includes classes and training on life skills as well as preparation to enter the job market and attend school.

"I'm very pleased to collaborate with Aetna and Volunteers of America to bring this important service to Clay County and Southeastern Kentucky. Freedom House will provide much needed and effective addiction recovery care that is sought by so many families. I'll continue working to make this project a reality, and I'm so appreciative that these groups are partnering with us in this endeavor," said Senate President Robert Stivers.

Value-based Payment Strategy

Aetna's approach to network development includes the offering of VBP arrangements as a means to build collaborative contractual relationships with providers to increase adequacy of our network and improve access. Many high-quality providers find VBP arrangements an attractive means to join a network. For example, in our affiliated Pennsylvania health plan, a large, respected children's facility joined the Aetna Medicaid network when offered a VBP arrangement. Through Aetna's VBP arrangements, we can incentivize cost, utilization, and quality improvement through a reduction in potentially preventable events (e.g., primary, specialty, and hospital-based) such as hospital readmissions, avoidable ER visits, avoidable inpatient visits, and preventable complications.

From a regional perspective, we understand that access to providers may vary across regions and we will use multiple strategies to ensure access where most appropriate. Aetna recognizes a unique approach is needed to improve enrollee access in rural and other areas. For this reason, **we will implement a rural strategy for Kentucky predicated on our extensive experience nationwide**. This approach includes the use of rural network adequacy metrics, which we monitor and analyze. We believe specific populations and geographies necessitate organic growth of metric development. We have developed different types of measures to help us accurately evaluate differences in rural versus urban adoption of VBP. For example, we analyze the number of providers in rural areas and trend their numbers over time to understand the adoption of VBP programming. Finally, we compare rural and urban trends to understand adoption rates.

Telehealth Services

To improve access to services in traditionally underserved remote or urban areas, we will execute telehealth strategies. Telehealth can be used as an alternative to or to complement traditional service delivery. Telehealth has been proven to improve care treatment compliance, decrease both ER and

inpatient hospitalization utilization, reduce disease burden in communities, and promote the concurrent use of advanced specialty capabilities in coordination with an enrollee's local primary care provider (PCP), thereby improving available quality and continuity of care. **Available telehealth services promote the integration of PH and BH and enables provider-to-provider consultation between PCPs and specialists**. The traditional approach of forcing individuals to make appointments for office visits results in many missed appointments. Telehealth allows both doctors to extend their services to enrollees outside reasonable commuting distances and extends services to individuals who may lack reasonable access to BH providers and/or are challenged with transportation or commuting barriers. Telehealth alternatives make ongoing care and follow-ups more convenient and easier to schedule. Enrollees can more easily schedule recurring appointment at preferred times. In addition, the use of mobile devices and applications makes telehealth and remote patient monitoring (RPM) devices and applications more acceptable to a growing number of individuals who are already comfortable with the technology. Moreover, studies have shown that BH patients often feel stigmatized and thus avoid treatment to hide their conditions from others. Telehealth services and RPM allow enrollees to seek treatment from the comfort of their own surroundings—reducing stigma and increasing the chances they will seek treatment.

In alignment with Commonwealth regulations, specific services available to adults and children will include **consultation; mental health evaluation and management; individual and group psychotherapy; pharmacologic management; psychiatric/psychological/mental health diagnostic interview examinations; and individual medical nutrition therapy consultation services**. Additionally, when PCPs need support and resources to screen and treat persons with low acuity BH conditions, they can conduct consultations with specialists via telehealth. In-network BH providers may use their own approved technology, may join the network of the vendor, or will be given the opportunity to utilize a plan-sponsored technology platform to enhance access to their enrollees via telehealth. Alternatively, if indicated, preferred Kentucky-licensed vendor partner telehealth practitioners using evidence-based protocols will be utilized as per Kentucky state regulations to assist in meeting the BH needs of our enrollees. Unless otherwise agreed upon or directed by the Department, provider reimbursement for telehealth services will be equivalent to that given for the same in-person services.

In addition, to assist rural providers whose enrollees may not have geographical accessible BH providers, and to provide ease of access for providers in need of BH specialty consultations access to BH specialists, virtual provider-to-provider consultations (i.e., e-consults) will also be available via our comprehensive telehealth services approach. Consultations may occur face-to-face via technology or via 'store and forward' asynchronous technologies as the standard practice of care. Consultation services assist with diagnosis and medication management and provide recommendations for ongoing treatment. **This improves the integration of BH services in primary care, increases care coordination, and decreases avoidable psychiatric hospitalizations**.

We will enable access to BH providers as allowed by law for both adults and children both in and not in CMHCs which may include the following practitioners: psychiatrists, psychiatric medical residents, psychiatric registered nurses, licensed clinical social workers, psychologists, licensed professional clinical counselors, licensed marriage and family therapists, physicians, advanced practice registered nurses, and licensed dieticians or nutritionists.

Remote patient monitoring: Aetna offers an RPM program for enrollees with specific chronic or high-risk diseases for certain BH conditions such as depression, anxiety, and SUD. For treatment to be successful, enrollees must participate and be engaged. Through RPM, enrollees are encouraged and enabled to participate in regular data collection and input into apps, increasing enrollee involvement and keeping them engaged in their care. The data collected through RPM systems can help doctors better understand behavioral and emotional triggers, allowing them to deliver more effective care. RPM is

especially helpful for situations where medication monitoring and adherence is imperative and for monitoring for side effects of psychotropic meds. For example, providers treating SUD can monitor their patients for relapse and ensure compliance in MAT programs. In addition, it has been found beneficial for enrollees with co-occurring conditions such as a psychotic disorder and diabetes to monitor effects of anti-psychotics on blood sugar.

Our approach promotes the enrollee's provider involvement in monitoring the enrollee and engaging in RPM programming, either directly or in concert with the health plan vendor. **RPM has been found effective for eliciting enrollee empowerment; improving disease management; improving access, adherence and compliance; decreasing hospitalizations; and lowering total cost of care**.

Enrollees who participate receive our in-home RPM technology package, which includes a remote monitoring bundle which includes an iPad mini™ kit with up to two peripheral devices, such as a weight scale, pulse oximeter, blood pressure cuff, or glucometer. The unit is designed for simple setup, with the iPad personalized for each enrollee, listing their name on the landing page with easy-to-follow instructions and videos on how to use the devices, how and when to contact their provider and care manager, and how to seek emergency help. In addition, we personalize the iPad mini further so the enrollee and their family/circle of support can access educational information targeted to their condition(s).

Telehealth and RPM help make sure more BH enrollees receive the care they require, while helping to address shortages in mental health professionals and potential enrollee-experienced barriers to care access. The key to providing better care lies in making services available and ensuring enrollees seek help when necessary; telehealth and RPM assist in achieving those objectives.

a.iv. Follow-up After Hospitalization

Aetna offers enrollees a **$20 incentive** for completing the 7-day follow-up appointment after hospitalization.

Discharge planning starts at the time of admission. Aetna contractually requires our providers to schedule enrollees receiving inpatient BH services for outpatient follow-up and/or continuing treatment **prior to discharge**. Outpatient treatment must occur within 7 days from the date of discharge, with another follow-up appointment within 30 days of discharge. BH providers contact enrollees who have missed an appointment within 24 hours to reschedule the appointment.

During initial and continued stay review, UM clinicians actively engage in discharge planning with facility Utilization Review staff. Together with the enrollee, they collaboratively develop an appropriate discharge plan that addresses the root cause of their inpatient stay and is individualized to meet the enrollee's needs. If SDOH are identified during discharge planning, UM clinicians initiate a referral to care management to connect the enrollee to community resources, assess for and assist with any transportation needs, and link the enrollee to peer support services. Collaboration occurs among all health plan departments to facilitate continuity of care between medical and BH practitioners. Examples of this collaboration include working closely with network hospitals and practitioners to confirm that enrollees hospitalized with a BH diagnosis are scheduled for a timely follow-up appointment prior to discharge.

Following enrollee discharge from an inpatient hospital, UM clinicians notify Care Management so they can follow up with the enrollee within one business day of discharge. Additionally, Aetna's **care managers follow up with enrollees discharged from an inpatient substance use treatment setting**. If an enrollee was not already in care management, they are evaluated for enrollment. Care managers follow up with enrollees and providers to facilitate appointments and provide other supports needed by enrollees. Care managers assist with scheduling BH appointments within required timeframes and linking enrollees to community resources as indicated in the discharge plan. Care managers follow up with enrollees and providers after the 7-day appointment and assist with scheduling the 30-day follow up appointment as

needed. We track adherence to the 7-day and 30-day follow-up appointments through our Healthcare Effectiveness Data and Information Set measures. We maintain close collaboration with our outpatient BH providers, which helps with successful discharge planning follow-through.

Our UM clinicians remind facility staff to be proactive in securing medication prior authorizations as indicated in the discharge plan. They make sure a medication reconciliation is completed prior to discharge and that the medications are appropriately authorized and available to the enrollee at the pharmacy.

Embedded clinical care managers: Aetna embeds clinical care managers within some of our high-volume hospitals to facilitate an integrated approach to seamless, coordinated discharge to the community. Transition of Care staff complete face-to-face visits with enrollees, which provides us with valuable access to the treating physicians and other hospital staff so we can help shape the discharge as well as manage discharge orders and referrals as seamlessly as possible for our enrollee. Care managers function as the transition care manager to provide continuity of care and maintain the single point of contact for enrollees discharging from hospitals without embedded staff. Follow-up appointments are scheduled with a BH provider prior to discharge to occur within seven days of discharge.

We are continually looking for opportunities to partner with hospitals and facilities to embed care managers to facilitate effective discharge planning. The clinical care managers participate with UM clinicians, hospital staff, and our integrated care teams in discharge planning to address the physical, behavioral, and oral health needs as well as SDOH prior to discharge. We have embedded clinical care managers at the following hospitals:

- Our Lady of Peace in Louisville
- University of Kentucky Hospital
- University of Kentucky: dedicated neonatal intensive care unit clinical care manager
- Eastern State Hospital: State-operated hospital

During an acute stay, the integrated care team examines medical, behavioral, social determinants, and health literacy indicators for readmission and begins to address the root cause of the primary admission.

Enrollee Success Story: Value of Embedded Care Managers

Our enrollee, a 61-year-old single male, was admitted to Our Lady of Peace Hospital in January 2019 due to suicidal and homicidal ideation and diagnosed with depression. He was living with his sister and brother-in-law prior to the admission but it was questionable whether he could return to their home upon discharge from the hospital. Per hospital staff, there was a concern about the enrollee's cognitive functioning and possible dementia.

Aetna has an embedded care manager at Our Lady of Peace Hospital. Working together with the assigned social worker at the hospital, the Aetna care manager was able to get the contact information of the enrollee's sister and was successful in obtaining a signed release to allow health plan staff to communicate with the sister to address housing, outpatient care, and medication compliance. The care manager was able to engage Aetna staff with our Homeless Initiative and make referrals to housing resources for the enrollee in case returning to his sister's home was not an option. Our enrollee was able to return to his sister's home upon discharge. Over the course of four months, with the support of health plan care management staff, he began receiving services through the local community mental health center. The care manager coordinated services including neuropsychological testing and application for financial support. He and his sister were connected with the Alzheimer's Association and she was provided with information about guardianship and is exploring this option. She has also received information for local nursing homes and senior care centers and verified that she has located possible openings. Communication with his sister continues, and she shared that he is taking his medications, resulting in a decrease in his behavioral disturbances. The enrollee's sister reports she has been supported with resources as she cares for her brother.

a.v. Ensuring Continuity of Care Upon Discharge from a Psychiatric Hospital

Discharge planning begins on day one of admission. Enrollees identified for transition from a psychiatric hospital to the community will receive transitional care management services from an assigned behavioral health care manager as part of their discharge planning process. Our transitional care managers have full sight to enrollee's claims and work with hospital Utilization Review staff to 'shape the discharge' by **becoming involved prior to discharge** to arrange integrated community-based services and supports so they do not lose contact with the enrollee following discharge. Our transitional care managers work with the providers who were treating the enrollee prior to admission, and if the enrollee agrees to maintain the same provider, include them as part of the discharge plan to assure continuity of care following discharge. We conduct interdisciplinary rounds for all enrollees in acute or post-acute settings to make sure their transition is to the most appropriate setting within the continuum of care in a timely manner.

> "Aetna is a valued partner in the endeavor of providing much needed treatment to the individuals that we serve at New Vista. For example, their care managers play an important role in assisting individuals discharged from psychiatric hospitalization with engagement in outpatient services. This service provides a significant resource in enhancing the continuity of care."
>
> **— Don Rogers, M.A.**
> **Chief Clinical Officer, New Vista**

Aetna ensures, by entering into collaborative contractual agreements with state psychiatric hospitals and behavioral health providers, that members have continuity of care upon discharge from the hospital. Our contractual agreements specify the responsibilities of the behavioral health service providers to ensure successful transition back into community-based supports. In addition, we require providers to participate in quarterly continuity of care meetings hosted by the state psychiatric hospitals. Also, our contractual agreements require that providers assign a case manager prior to or on the day of discharge. Aetna's care managers also attend these quarterly meetings, as well as the regional transition of care meetings to assist with monitoring compliance and improving the provision of continuity of care for our members.

Aetna believes psychiatric admissions are preventable with the appropriate outpatient services and supports in place. During discharge planning, facility staff or our care managers additionally assess for trauma to determine if the enrollee needs trauma treatment and/or trauma-informed providers who would be sensitive to the enrollee's issues to allow for the highest level of engagement and follow up on all the enrollee's health issues.

The following innovative strategies make sure enrollees have continuity of integrated care post-discharge:

- To make sure our young enrollees have access to placements at the appropriate level of care to meet their needs, Aetna participates on the **Commonwealth's Difficult to Place Calls** for foster youth. Aetna is the only health plan that includes UM staff who are licensed BH practitioners on the calls to provide clinical recommendations and address treatment concerns.
- For our **Pharmacy Restriction Program** enrollees, our care managers coordinate care with UM clinicians and collaborate with providers **prior to discharge to make sure medications are ready to fill**. Care managers and UM clinicians collaborate with our pharmacy benefit manager, CaremarkPCS, to make sure medications are ready to fill as prescribed without any delays.
- Aetna will engage **peer support services while enrollees are inpatient** through collaboration with community organizations providing peer support services. We have realized impressive outcomes for

> Aetna collaborates with **Addiction Recovery Care**, which operates a **Peer Support Academy**, as a certified peer support trainer in partnership with Sullivan University. Outcome data indicates 80 percent of enrollees completing the peer certification program remain in recovery and transition to private insurance.

reduced readmissions by including peers in the discharge planning process. Peers remain with enrollees providing continued support following discharge to the community.

- Aetna collaborates with **Bluegrass Care Navigators** to provide community-based supports for enrollees following discharge from a psychiatric admission. They provide a 6-week program that begins before the enrollee is discharged. The program includes face-to-face support over the 6-week program to make sure enrollees are connected to the services and supports indicated in their discharge plan to prevent ER usage and readmissions.
- Aetna staff dedicated to the homeless population participate with our transitional care managers in discharge planning while the enrollee is still inpatient to help them **transition to a safe placement following discharge**. They remain with the enrollee through follow-up to assist with any other supports needed post-discharge, such as nurse visits and continued assistance with addressing SDOH.

b. Operating 24/7/365 Emergency and Crisis Hotline

Aetna's internal 24/7/365 toll-free Behavioral Health Services Hotline is a key element in our comprehensive, integrated system of care for all enrollees throughout the Commonwealth. The Behavioral Health Services Hotline provides enrollees immediate access to qualified BH services professionals to assess, triage, and address specific BH emergencies and link them to the appropriate level of services in the highest-quality, least restrictive manner possible. Our current Behavioral Health Services Hotlines meet the requirements set forth in **Section 33.6 of the Draft Medicaid Managed Care Contract and Appendices**.

Hours of operation: Aetna does and will continue to offer enrollees throughout the Commonwealth a dedicated, toll-free Behavioral Health Services Hotline 24/7/365. The Behavioral Health Crisis Services Hotline will include routine assistance with benefits and referrals, as well as BH crisis and emergency services. We will handle crisis, urgent, and routine requests from enrollees or their legally authorized representative and remain on every call as long as necessary to address all the caller's needs.

Staffing: Our BH clinicians are licensed, experienced, and trained to serve the needs of our enrollees. The following are the minimum required clinical credentials for the Behavioral Health Services Hotline staff:

- Master's degree in social work, psychology, counseling, or related BH field, or a nursing degree from an accredited school
- An unencumbered license to practice
- At least three years of experience working in a BH setting
- Knowledge and experience working with diverse populations prevalent in the service areas

Additionally, Aetna's team includes an **ER/crisis administrator** with the following responsibilities to support enrollees:

- Enhance collaborative relationships with fire, police, emergency medical services, and hospital emergency departments
- Collaboration with duties related to complex enrollee populations and collaboration of services with community programs
- Collaborate with medical management on transition of care for enrollees discharging from inpatient settings and mitigate system gaps
- Enhance collaborative protocols with first responders
- Enhance systems for transitioning enrollees in crisis to and from hospital emergency rooms

Training: Behavioral Health Services Hotline staff receives initial training during onboarding with Aetna. Additionally, they receive BH-specific training and must demonstrate an understanding of the initial training and then receive on-the-job training including shadowing and mentoring facilitated by Kentucky experienced management, supervisory, or other senior BH staff. BH-specific training covers the following topics:

- **Our staff are certified in Mental Health First Aid, an evidence-based practice**
- Aetna crisis policy and effective crisis call management, administering suicide risk assessments, and screening and triaging calls to determine level of care needs including processes for immediate crisis intervention and/or emergency response for enrollees at risk of harm to themselves or others
- Community-based resources including mobile crisis teams and face-to-face emergency services
- Mock scenarios of crisis calls and actual crisis calls presented during case rounds
- Appropriate identification, management, and reporting of quality of care/service concerns, complaints, or potential abuse, neglect, or exploitation

Behavioral Health Services Hotline staff may only answer calls for those programs for which they have received specific training.

BH crisis calls: A live Behavioral Health Services Hotline staff member answers BH crisis calls immediately—**we never answer BH crisis calls through an automated call system**. The Behavioral Health Services Hotline staff assess, screen, and triage through telephonic crisis intervention to make sure the enrollee is safe. This staff coordinate the most appropriate level of care needed, including hospital-based ER services, mobile crisis unit services, face-to-face stabilization services, or other care.

Our system can immediately connect to the local Suicide Hotline's telephone number and other crisis response systems and has patch capabilities to 911 Emergency Services. Our staff stay on the line with the caller until emergency response arrives and supports conference calling for consults with the medical director or others regarding complex clinical situations. After hours, weekends, and holidays, calls are routed to Aetna's call center. The call center is staffed 24/7/365 with BH clinicians and access to psychiatrists.

Behavioral Health Services Hotline staff work in collaboration with the interdisciplinary care team to coordinate management of the crisis and make sure follow-up occurs after crisis resolution. Care managers see a crisis note and follow up with enrollees following a BH crisis intervention to address their current needs.

Consistently Exceeding Performance Measures

Aetna consistently exceeds performance requirements for our current BH call center. Since 2015, we have answered **100 percent of calls by the fourth ring and 0 calls receive a busy signal with an average call abandonment rate of 2.3 percent, much lower than the standard of 7 percent or less**.

We will continue to monitor our performance against the performance requirements for quality assurance purposes and to provide Behavioral Health Services Hotline reports as indicated, demonstrating consistently exceeded Department standards in all service areas. We monitor call performance requirements monthly through our QMOC. If performance requirements are not met, corrective actions are implemented, which may include staff education and live call monitoring by supervisory staff.

Culturally Competent Behavioral Health Services Hotline

Aetna's recruiting and hiring practices include strategies to hire personnel that represent similar cultural considerations to our enrollees. We certify bilingual staff as bilingually competent through third-party competency testing prior to taking calls in another language. We employ Behavioral Health Services Hotline staff who are certified bilingual in Spanish and Portuguese. Our Behavioral Health Services Hotline staff are also supported by Accipio Language Services for 24/7/365 real-time interpretation of more than 200 languages.

c. Coordination and Collaboration with the Contractor, PCPs, and BH Providers

Aetna's integrated approach to addressing each enrollee's unique, whole person needs is centered around coordination and collaboration between enrollees' PCPs, BH providers, and Aetna care management staff.

For many enrollees, BH conditions such as depression, anxiety, psychosomatic disorders, and substance use are initially seen and diagnosed at a PCP's office during a routine appointment. While some PCPs manage the enrollee's BH condition, time constraints and lack of knowledge can limit the enrollee's care. Ideally, the enrollee will be referred to a BH specialist. **Care managers invite PCPs and BH providers to participate in the enrollee's integrated care teams and share care plans with them with enrollee consent**. Care plans address PH and BH needs as well as SDOH.

Collaboration between PH and BH providers has been shown to increase adherence to medications and prevent progression or worsening of the enrollee's current condition. Numerous factors prevent clear communication between these providers including federal and Commonwealth laws, incompatibilities between electronic medical records, and lack of knowledge regarding the importance of this communication among provider groups. Kentucky requires that explicit written permission be given from the enrollee prior to the PCP and BH provider sharing records.

Using our integrated model, Aetna monitors participating BH providers to improve coordination between medical and BH care for enrollees with complex care needs. Aetna acts, as necessary, to improve continuity and coordination of care across the health care network based on routine assessments. Continuity and coordination of care activities between medical and BH care include the following:

- Monitoring data trends for opportunities to improve the exchange of information
- Assessment of the appropriate diagnosis, treatment, and referral of BH disorders commonly seen in primary care
- Assessment of the appropriate uses of psychopharmacological medications
- Assessment of the management of treatment access and follow-up for enrollees with coexisting medical and BH disorders
- Implementation of primary or secondary preventive BH programs
- Assessment of needs of enrollees with severe and persistent mental illness

Per contractual requirements, BH providers send PCPs initial and quarterly summary reports with the consent of the enrollee's guardian additionally described in our provider manual. To address challenges with obtaining this consent, we will use our **embedded care managers within BH facilities to assist with obtaining consent so we can share information BH information with the PCP**.

We educate PCPs about how to screen and refer for BH services and educate BH providers to refer enrollees to their PCP as indicated for known or suspected and untreated PH concerns. Evidence shows that one in five individuals who die by suicide saw their PCP within 24 hours of their death.[2] To prepare PCPs to screen and address for depression and suicidality, Aetna utilizes evidence-based practices designed specifically for non-BH providers (e.g., PCPs) such as the QPR (Question, Persuade, Refer) approach. Aetna utilizes web-based education and manuals for its providers, providing tools and materials that are easily accessible to PCPs and BH providers. Training topics for BH providers include the following:

- Specific medical information required for court-ordered requests and judicial review of medical care
- Appropriate utilization of psychotropic medications
- Evidence-based behavioral health treatment interventions and specific behavioral and physical health needs of our enrollees
- Trauma-informed care
- Crisis intervention techniques and supports
- High Fidelity Wraparound approach
- Impact of Adverse Childhood Experiences

[2] QPR Institute (2019): https://qprinstitute.com/professional-training; accessed January 16, 2020

- Neonatal abstinence syndrome
- Substance-exposed infants
- Screening for and identification of behavioral health disorders

Additional strategies to promote collaboration between PCPs and BH providers include the following:

- **SBIRT:** An early intervention approach that targets individuals with non-dependent substance use to provide effective strategies, like motivational interviewing, for intervention prior to the need for more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of individuals with more severe substance use or those who meet the criteria for diagnosis of a SUD.

  Aetna provides SBIRT training and encourages the use of this evidence-based service. Additionally, we educate providers about a toolkit for PCPs on SBIRT, an insurance reimbursable approach to screening and treatment for people with SUD and those at risk of developing them developed as part of KORE, the Kentuckian Health Collaborative (https://www.khcollaborative.org/SBIRT/). The focus is on SBIRT's application for opioid use disorder.
- Collaboration with **Bluegrass Care Navigators**: Aetna collaborates with Bluegrass Care Navigators to provide community-based supports for enrollees following discharge from a psychiatric admission. They provide a six-week program that begins before the enrollee is discharged. The program includes face-to-face support over the six-week program to make sure enrollees are connected to the services and supports indicated in their discharge plan to prevent emergency room usage and readmissions. The Bluegrass Care Navigators facilitate coordination and collaboration among PCPs and BH providers serving enrollees and participating in discharge planning.
- Our dental benefits administration subcontractor, Avēsis, has a relationship with the founder of **P.A.N.D.A (Prevent Abuse and Neglect through Dental Awareness)**. P.A.N.D.A is dedicated to engaging dentists and dental professionals in identifying child abuse and neglect, elder abuse, domestic violence, and human trafficking. Avēsis' vice president of dental quality and former chief dental officer for Centers for Medicare & Medicaid Services, Dr. Lynn Mouden, is a P.A.N.D.A. trainer and can deliver professional development for network dental providers on the following:
  - Understanding the problem of abuse and neglect of persons of any age
  - Understanding the clinical signs and symptoms of possible abuse and neglect
  - Understanding the responsibilities for dental professionals in preventing family violence

  This training covers important topics like precipitating causes and contributing factors to child abuse, the clinical signs of abuse and neglect one might encounter in the dental office, and professional liability. Through our relationship with DrBicuspid, Dr. Mouden's presentation of P.A.N.D.A. content has been recorded and is available for continuing education administered by IMV, Ltd., an American Dental Association CERP-recognized provider.
- Collaboration occurs amongst the providers participating in the **Difficult to Place Calls** with the Department to identify opportunities for youth in need of placement.

As an NCQA-accredited MCO, we analyze collaboration of our PCPs and BH providers annually. Aetna recognizes that opportunities exist within the plan to improve coordination of care overall. As our Provider Services teams spends more time in the field during 2019, the goal is to provide education and encouragement in coordination of care and improve provider satisfaction. Sharing of information across the plan, especially feedback from the Provider Services teams to our care managers and Network Operations teams, will also help keep these areas top of mind when speaking to enrollees and providers. Enrollees, through awareness of the importance of using their PCP as their medical home, can request that their BH providers communicate their care back to their PCP. Providers can also speak to the importance of this coordination of care during appointments when they make referrals. Achieving these small tasks has great potential to positively impact our coordination of care results between PCPs and BH clinicians.

60.7.C.24 Population Health Management (PHM) Program

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60.7.C.24 Population Health Management (PHM) Program (Section 34.0 Population Health Management Program)

Aetna's Population Health Management (PHM) program is fundamental to Aetna's commitment to our enrollees and to achieving the Triple Aim of improving health outcomes, improving enrollees' experience of care, and reducing health care costs in Kentucky.

a. Introduction: Aetna's Commitment to Population Health Management

Aetna achieves population health management excellence by understanding drivers of health inequities and the impact of prevention and early intervention. Aetna empowers enrollees to engage in their health care and improve their health outcomes with enhanced quality of care and the reduction or elimination of health disparities. General strategies we use to accomplish our PHM program goals are as follows:

- We partner with the Commonwealth in the move to PHM, quality outcomes, health equity, and wellness
- We build strong partnerships with providers including community-based organizations (CBOs) to address social risks
- We have the data infrastructure required to support PHM
- We empower and engage enrollees with the help of CBOs and local community health workers (CHWs)
- We integrate trauma-informed care across our organization
- We use value-based payments to drive delivery system reform

In addition to these strategies, **we know the population we serve and have solutions to address their local, regionally specific needs.** With our experience serving Kentuckians since 2011[1], Aetna understands the diverse needs of the local population; we are deeply invested in Kentucky's local communities. We are aligned with the Kentucky State Health Improvement Plan, focused on the following key populations: substance use disorders (SUD), smoking cessation, obesity, adverse childhood experiences (ACEs), and integration to health access. **Table C.24-1** demonstrates Kentucky's current national rank for several factors related to these Commonwealth priorities[2]. Aetna develops solutions through our PHM program to impact these rankings and improve the health of our enrollees and the population of the Commonwealth as a whole.

Table C.24-1: Kentucky Health Rankings, 2019

Measure	KY Ranking
Preventable Hospitalizations	50th
Smoking	49th
Premature Deaths	47th
Drug Deaths	46th
Obesity	46th
Children in Poverty	44th

Aetna understands that our populations face social inequities that impact accessing health care, achieving optimal health outcomes, and meeting personal goals for health and wellness. Understanding trends throughout the Commonwealth and within our own enrollees informs our population health strategy and priorities and allows us to provide the best support to the enrollees when and where they need it. Approximately 21 percent of Kentuckians are covered by Medicaid with enrollment varying by region.

[1] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

[2] County Health Rankings and Roadmaps, "Kentucky Rankings Data": https://www.countyhealthrankings.org/rankings/data/ky; Accessed June 1, 2019

For example, nearly 50 percent of adults and children in Region 8 were covered by Medicaid in 2018.[3] This region also represents the highest rate of food insecurity with 12 counties in eastern Kentucky experiencing food insecurity rates 25 percent or higher.[4] We also understand that each of the eight regions in Kentucky has its own unique population. Some examples of conditions that are prevalent in specific regions of Kentucky are presented in **Table C.24-2**:

Table C.24-2: Region-specific Health Outcomes

Region	Preventable Hospitalizations per 1000	Children in Poverty	Adult Smoking	Adult Obesity	Drug Overdose Mortality
1	68.65	25%	21%	34%	15%
2	56.85	23%	22%	36%	17%
3	58.18	18%	21%	34%	28%
4	73.01	30%	24%	35%	24%
5	54.46	23%	22%	35%	39%
6	58.00	17%	20%	35%	58%
7	65.05	31%	24%	37%	38%
8	97.40	41%	26%	39%	34%

Aetna's Population Health Management Program

The core of our population health strategy is our integrated System of Care model and Integrated Care Management (ICM) program (see **Attachment S** for our ICM program description). The model is based on the identified needs of the community, the Commonwealth, the enrollees, and the overall population of Kentucky. We seek to understand each enrollee in the context of their lives, their environment, and their genetics, while co-facilitating a holistic model of supports and services that enhances their quality of life and assists them to reach their individual person-centered goals. Our innovative integrated system of care approach is based on a whole-person view of our enrollees' physical health (PH), behavioral health (BH), oral health, health literacy, functional needs, and social determinants of health (SDOH). **Figure C.24-1** depicts our integrated system of care demonstrating our comprehensive focus on meeting enrollees' needs and goals by wrapping around them with Aetna covered services, their circle of support, and community-based support while focusing on cultural sensitivity, recovery and resiliency, and adopting trauma-informed practices.

[3] Kaiser Family Foundation, "Medicaid in Kentucky," (2018); http://files.kff.org/attachment/fact-sheet-medicaid-state-KY: Accessed June 1, 2019

[4] Feeding America, "Food Insecurity in Kentucky"; https://map.feedingamerica.org/county/2017/overall/kentucky: Accessed June 1 ,2019

Figure C.24-1: Aetna's Integrated System of Care

Aetna's integrated system of care includes all health care and related services and supports necessary for enrollees with special health care needs to achieve improved health outcomes.

Aetna has built a System of Care model that is comprised of multiple local staff with specialized experience in areas identified in our population health strategy as opportunities to improve health. **Table C.24-3** summarizes the system of care positions in Kentucky that serve to support the PHM program.

Table C.24-3: Aetna System of Care Staff

System of Care Position	Role in Supporting Kentucky Enrollees
Adult system of care administrator	• Build key stakeholder relationships and processes based on market needs and populations needing a system of care approach • Build community-based services and supports • Leverage full partnership with social supports and caregivers in all aspects of the planning and delivery of their own services.
Children's system of care administrator	• Build key stakeholder relationships and processes based on market needs and children's populations needing a system of care approach • Bridge with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes • Build community-based services and supports
Recovery and resiliency administrator	• Build supportive programs to mental health and substance use delivery • Participate in integrated rounds to emphasize enrollee voice and choice • Collaborate with local, Commonwealth, and national partners and stakeholders • Collaborate with enrollees and family to identify and remove barriers to services • Promote the hope for recovery within the health plan
Emergency room/ crisis administrator	• Build collaborative relationships with fire, police, emergency medical services, hospital emergency rooms (ERs) • Collaboration with duties related to complex patient populations and collaboration of services with community programs • Collaborate with medical management on transition of care for enrollees discharging from inpatient settings and mitigate system gaps • Build collaborative protocols with first responders • Build systems for transitioning individuals in crisis to and from hospital emergency departments

System of Care Position	Role in Supporting Kentucky Enrollees
Justice system liaison	• Collaborate with the Department of Juvenile Justice, Department of Corrections, county jails, Sheriff's Office, Correctional Health Services Office of the Courts, and Probation Departments and Department of Behavioral Health and Developmental Disability to identify systemic changes and promote community integration • Trauma-informed expert • Understand Reclaiming Futures framework and work closely with other systems that serve youth and with the community • Bridge communication with the health plan staff, court, and the justice systems
Trauma system of care administrator	• Communicates and collaborates with enrollees and families to identify concerns and remove barriers that affect service delivery and enrollee satisfaction • Participates in integrated rounds for the purpose of identifying trauma approaches and modalities that can assist the enrollee in building and maintaining health outcomes • Leads and establishes structure and mechanisms to drive the trauma transformation and principles in the health plan, provider network, and Commonwealth of Kentucky regulators and stakeholders • Supports the development of trauma-informed social-emotional programs within Kentucky

The System of Care team identifies gaps in care (GIC) for our enrollees, barriers, and inefficiencies that impact our enrollees' success in achieving health, and work to resolve these issues through program, policy, and initiative development in a trauma-informed way. Aetna brings clinical claims data, financial data, SDOH data, and operational data together to create actionable analytics that identify and address health disparities in at-risk populations. For example, Aetna has a proprietary dashboard that identifies disparities around our enrollees that frequent emergency rooms. Aligning with National Committee for Quality Assurance (NCQA) standards, the framework of our total population health management program supports the Commonwealth's goals of advancing the population's access to and engagement in care, recovery, and resiliency. Best practice principles guide our program to influence the health of the population at the socio-cultural, economic, and individual level. Our approach to PHM includes the following: person-centered approaches, prevention and early intervention, accessible programming, integrative partnerships, accounting for holistic factors affecting enrollee's health, commitment to health equity, and data and evidence-driven strategies. Our processes are grounded in trauma-informed care (TIC) and trauma-informed approaches, culturally and disability-competent linguistically appropriate services, and recovery principles that guide our care management service delivery model.

a.i. Innovations and Program Elements to Support Overall Program Goals

Aetna's PHM model combines integrated services, collaborations with key stakeholders, and advanced technologic and mobile supports to promote positive outcomes and reduce population health disparities. Key innovations and program components of Aetna's PHM model are highlighted in this section.

Innovations

Aetna's PHM strategy uses a wide range of innovations determined by the needs of our enrollees and our review of internal and external data. Some of our innovations include our transformation into a trauma-informed organization; innovative programs to engage at-risk enrollees through collaboration with Commonwealth agencies and providers; and technology to increase service efficiency and effectiveness.

Component #1—Aetna's transformation into a trauma-informed organization: Multiple research studies, including the Adverse Childhood Experiences Study, have confirmed exposure to severe stress and trauma such as abuse, neglect, discrimination and violence can increases an individual's risk for serious and lifelong physical and behavioral health issues, poor health outcomes, reduced quality of life, and increased cost of care. Individuals exposed to violence are not only more likely to have diabetes,

obesity, heart disease, mental illness, substance use disorders, and asthma, but their symptoms are also more severe.[5] Exposure to traumatic events as a child can result in poor performance at school, inability to maintain employment, and inability to sustain social relationships. According to the most recent report from Child Trends, 53 percent of children in Kentucky have experienced at least one adverse childhood event (this is the second poorest outcome in the nation, following Arkansas).[6]

Aetna is undertaking a system-wide transformation initiative to enhance our system of care into a system that includes trauma-informed practices and providers. This transformation is occurring at all levels of the organization from the chief executive officer (CEO) to care managers as well as Enrollee Services staff, human relations, and all aspects of the health care company. In Kentucky, our entire staff has begun the trauma transformation training and we will be initiating a year-long collaborative with local providers of both health and social services to expand the availability of trauma-informed resources for the Kentucky populations. Aetna subscribes to the following tenets as established by the National Institute for Trauma-Informed Care: "We realize that trauma is common; we recognize how trauma affects individuals seeking care; we are committed to implementing TIC best practices; and at all costs avoiding re-traumatization."

Addressing Trauma with the Help of an Industry Leader

Aetna has partnered with National Council for Behavioral Health (National Council) to implement our organization-wide Trauma-Informed Transformation. Aetna leadership at the national and local levels are thrilled to collaborate with an industry leader such as National Council. Aetna recognizes the importance of being the first managed care organization nationwide to join forces with National Council to strategically map out and operationalize the end-to-end process, and to then produce a sustainable and replicable model for all Aetna Medicaid organization health plans and the Aetna Enterprise.

As a trauma-informed organization, our Care Management, Enrollee Services, and Community Outreach staff receive comprehensive and ongoing training established in partnership with the National Council for Behavioral Health. Some of the comprehensive training includes the following: motivational interviewing (MI) and Mental Health First Aid (MHFA) for our enrollee-facing staff.

As part of our trauma transformation, Aetna is looking at prevention and early intervention for the foster population, a group with a high prevalence of a history of ACEs. Aetna is in development of a proprietary predictive modeling tool to look at rising risk for foster placement as well as risk of entering into the social service system. For more description on this model, please see the **Methods and Data for Predictive Modeling** section below. Understanding that the root cause of many challenging population outcomes is a history of trauma, having trauma-informed communities, providers, and staff and making resources available is key to an effective Population Health Strategy.

Component #2—Innovative programs to engage at-risk enrollees through collaboration with Commonwealth agencies and providers: Based on Commonwealth goals, population-based data, and community and population needs, Aetna has facilitated several programs to engage at-risk enrollees and populations, to address population gaps, disparities, and inequities. For example, some of these innovative population health programs include (see **Attachment S** for our current PHM program description):

[5] Dolezal, Theresa, McCollum, David, and Callahan, Michael, "Hidden Costs in Health Care: The Economic Impact of Violence and Abuse," (2009): accessed June 1, 2019; http://www.ccasa.org/wp-content/uploads/2014/01/Economic-Cost-of-VAW.pdf
[6] Sacks, Vanessa and Murphey, David, "The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity," (2018): https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity; accessed June 1, 2019

- **The population health data in Kentucky has identified that a higher percentage of pregnant women in rural Appalachian regions smoke, reaching over 40 percent in Lee and Owsley counties.**[7] Quit Incentives & Tailored Support (QUITS) is an incentives-based tobacco cessation program for pregnant enrollees of Kentucky Medicaid. The goal of the program is to develop a best-in-country strategy to reduce smoking during pregnancy for Kentucky Medicaid enrollees. QUITS is being delivered in a provider's office chosen from the Aetna network specifically focusing on those providers who serve pregnant women from rural Appalachian areas.
- In addition, **with pre-diabetes rates at 35.5 percent in Kentucky, our population health strategy aims to reduce the number of new diabetics through early identification and early services.**[8] HealthRunsDEEP is an intervention that identifies individuals with pre-diabetes and incorporates face-to-face educational sessions held in community-based sites, remote patient monitoring for early evaluation for enrollees with providers in the community, weekly touchpoints with a health coach, and incentives such as meal delivery service and vouchers for fresh fruits and vegetables to address SDOH and ensure continued engagement. The key to this program is activating communities to focus on early intervention and provide local organizations with resources to help our enrollees.
- **Aetna's population health strategy focuses on our criminal justice population.** Start Strong is a re-entry program focused on improving the lives of individuals that have become involved in the criminal justice system. Each Aetna enrollee taken into custody at Kenton County Detention Center in northern Kentucky receives an Aetna Start Strong Brochure and a letter stating how to get in touch with the re-entry coach who is co-located at the detention center. Services include treatment, housing, and job training. We provide additional supports to make sure enrollees can continue their treatment without any gaps. **The success rate for the Aetna Start Strong program is 91 percent.** The justice system liaison will continue to develop partnerships with community stakeholders to increase resources available to enrollees.
- **In order to address pre-diabetes through collaboration with our community dental and vision vendor, Aetna has developed the Oral and Ocular Care Coordination (O2C2) program.** Aetna implemented O2C2 to expand access to preventive services for enrollees at risk of or diagnosed with diabetes. The O2C2 program reaches enrollees who would benefit from regular screening and preventive services to help prevent the development of expensive medical complications. This program goes beyond identifying gaps and providing education. We help our enrollees find providers and schedule their appointments for dental and vision services based on their preferences and needs.

Component #3—Innovative technology to increase service efficiency and effectiveness: Aetna's technologic supports to advance service delivery include the following:

- **Self-service options to improve access to preventive care:** Aetna enrollees can utilize kiosks, through our vendor Pursuant, in Walmart stores across the Commonwealth to complete an attestation of completion of a diabetic retinal eye exam to be eligible for an incentive.
- **Electronic population health management platform:** Aetna uses integrated information management tools, including predictive modeling and our proprietary electronic population health management platform, to identify and stratify our enrollees by risk, capture information relevant to care gaps and transitions, and share information and data with providers. We co-locate population health specialists with a select group of our providers to help expand their quality outcomes, improve

[7] Foundation for a Healthy Kentucky, "Foundation Statement: Fewer Kentucky Women Smoking While Pregnant," (2018): https://www.healthy-ky.org/newsroom/news-releases/article/258/foundation-statement-fewer-kentucky-women-smoking-while-pregnant?; accessed June 1, 2019

[8] American Diabetes Association, "The Burden of Diabetes in Kentucky": http://www.diabetes.org/assets/pdfs/advocacy/state-fact-sheets/kentucky-state-fact-sheet.pdf; accessed June 1, 2019.

their incentive recognition, and develop more opportunities for value-based contracting to improve quality and reduce cost.

- **Remote patient monitoring:** Aetna offers a remote patient monitoring program for enrollees with specific chronic or high-risk diseases, such as diabetes, high-risk pregnancy, asthma/respiratory disorders, and certain behavioral health conditions. We use remote monitoring to elicit enrollee empowerment; improve disease management; improve access, adherence, and compliance, decrease ER utilization; and lower total cost of care. Enrollees who participate receive our in-home remote monitoring technology package. Enrollees collect and submit biometric data daily and engage in regular sessions with nurse health coaches. If submitted biometric data is deemed out of range, their practitioner is notified by phone and appropriate interventions implemented. Health plan care managers may be actively involved. Aetna utilizes remote patient monitoring to support the needs of specific high-risk enrollees with conditions such as diabetes, hypertension, chronic heart failure, asthma, and high-risk pregnancies that are engaged with a primary care provider (PCP) and have barriers to both access end day-to-day condition management
- **Telehealth and telemedicine:** One of the key barriers to population health is access to care. To address access, Aetna has included some virtual strategies to reduce the inequities to access rural Kentuckians face. Kentucky ranks 40th nationwide for access to primary care services within the Commonwealth.[9] To improve access to services in traditionally underserved areas, we utilize telehealth and telemedicine strategies. Telehealth services, available 24/7/365, support our populations by increasing the opportunity to both provide access and integrate care with an enrollee's selected PCP. All telehealth visits are documented and become part of the enrollees' health record with a copy sent to the PCP of record with enrollee consent.

Program Elements incorporated into Population Health Strategy

Aetna has created its population health strategy to support the overall goals of improving health outcomes for the population and empowering individuals to improve their health and engage in their health care. The PHM program, supported by our system of care described above, is integrated with our value-based payment (VBP) programs, and supported by our use of powerful analytics to deliver actionable data to support enrollee identification and risk stratification.

VBP program: Our VBP program is incorporated with our PHM strategy to engage providers and advance improvements in the delivery of quality, access, and evidence-based services with the goal of improving the health of our enrollee population and for specific subpopulations as well. Our VBP arrangements are designed to align providers and incentives with Commonwealth-specific quality and performance goals to optimize outcomes and results. In addition, as a part of our VBP program, Aetna's Population Health team informs providers with predictive modeling reports, gaps in care information, and claims data. These reports and provider input is utilized to target enrollee level intervention related to ER utilization, inpatient admissions, risk for readmission, and enrollees who are not engaged in follow-up care. Population health specialists work with designated providers to utilize these reports to close gaps and improve enrollees' quality of care. We frequently engage enrollees with chronic disease who are not consistently seeing their PCP and coordinate follow-up appointments. We consult with providers to review reports with data specific to the enrollees they serve with information broken down by clinic, PCP, and region to assist providers with targeted interventions. Our VBP programs are successful for key Kentucky priority populations and have improved health outcomes. For example, there has been a 25 percent improvement in Adolescent Well Care (AWC) visits over a four-year period for enrollees served by providers in VBP arrangements. Please refer to the **Value-Based Payment (VBP) Model to Support**

[9] United Health Foundation, "America's Health Rankings: Kentucky Summary 2018": https://www.americashealthrankings.org/explore/annual/state/KY; accessed June 1, 2019

the PHM Program section that follows for more details on how our VBP model supports our PHM program.

Powerful analytics for targeted intervention: Aetna conducts predictive modeling and stratification for all enrollees to identify enrollees who may benefit from targeted interventions at three levels of risk: complex care management, management of chronic conditions, and population health and wellness activities. We use integrated information management tools, including data from our proprietary Consolidated Outreach and Risk Evaluation (CORE™) electronic predictive modeling platform (for enrollees with prior utilization) and our electronic population health management platform, to identify indicators of enrollee needs and service management level needs based on enrollees' medical history. We also review claim-specific information to identify services; diagnosis and condition; PH, BH, and therapy needs; use of durable medical equipment (DME); medical supply needs; and pharmacy use. For example, we identify gaps in care for enrollees with diabetes who are in in need of statin therapy for hypertension by reviewing pharmacy data against enrollee diagnoses. Our program resulted in change in medication regimen with increase in statin use by 39 percent. A full description of these analytics follows in this response.

Supporting an Enrollee to Quit Smoking and Manage Her Diabetes

Diana (not her real name) is a 56-year-old female who was enrolled in the Supportive Managed Care Program (formerly known as the lock-in program). Amy was assigned as Diana's care manager and partnered with Diana to address her concerns including smoking cessation, weight loss, and DME needs.

Amy discussed medications that were available to Diana to assist with smoking cessation. After reviewing the options, Diana determined that Chantix would be her best choice and successfully stopped smoking with ongoing support from Amy.

Diana needed a glucometer and nebulizer and Amy educated her on the process for obtaining the durable medical DME. Diana contacted the PCP who faxed the script to the pharmacy and DME company and the enrollee was able to obtain both a nebulizer and glucometer.

Amy worked with Diana to discuss benefits of weight loss and improve Diana's self-efficacy around weight management. Amy sent information on weight management to Diana's home and the enrollee lost 49 pounds, moving from a body mass index (BMI) of 45.8 to 37. Diana's overall health improved, and she was released from Supportive Managed Care Program based on to her ability to manage her health based on her partnership with Amy.

a.ii. Incorporation of the National Committee for Quality Assurance PHM Model

Aetna's person-centered Population Health Management program facilitates enhanced quality of care and effective management of the health of defined populations by empowering enrollees to engage and drive their health care and to improve their health outcomes. **The elements of our program are in alignment with NCQA's population health management model and standards and Kentucky's target populations and conditions** (please refer to **Attachment S).** Aetna has completely integrated the NCQA PHM standards into the fabric of our PHM plan. Aetna will address the Population Health Standards during our next renewal in May 2020 since these standards will now be part of the Health Plan Accreditation. This process will incorporate a survey that covers the PHM standards. Aetna will submit its written PHM program plan for review and approval within 30 days of contract

award. Aetna's PHM program plan will cover all NCQA PHM standards outlined in the *Population Health Management: Resource Guide*,[10] which are as follows:

Aetna has a defined **Population Health Management Strategy**, described throughout this response that establishes the following:

- Goals for clinical outcomes and processes, cost/utilization, and enrollee experience
- Targeted populations identified through population assessment and enrollee risk stratification
- Programs and services offered (including covered and non-covered benefits)
- Health plan activities in addition to enrollee interventions (e.g., staffing, VBP arrangements)
- Program coordination (internal and with external agencies) to minimize repeated contacts with enrollees and can reduce enrollee confusion
- Person-centered and holistic approaches that encourage enrollee engagement and empowerment to drive their individualized health care needs

> "The future is integration: integration across providers and practices, integration between health plans and the delivery system, integration of strategies to support patients. These standards take the first step toward that integration, encouraging and rewarding health plans for aligning with the delivery system in pursuit of better population health outcomes."
>
> **—Patricia M. Barrett**
> **Vice President for Product Design & Support, NCQA**

We conduct **population stratification and resource integration** through the following:

- Population assessment to systematically assess a population for significant characteristics and needs
- Data integration through combining data from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational).
- Risk stratification to separate enrollee populations into different risk groups, with the goal of determining enrollee eligibility for programs or specific services, including specific tiers of care management
- PHM activities and resources that meet the needs of the enrollee population
- Assessing SDOH necessary to fully understand a population's characteristics and needs

We provide **targeted, person-centered interventions** through Medicaid and non-covered services to meet the needs of individual enrollees based on their risk and of the population as a whole, including the following:

- Wellness and prevention interventions focused on preventing illness and injury, promoting health and productivity, increasing health awareness, and reducing risk
- Chronic condition management to address comorbidity issues that can arise when treating chronic conditions to help avoid hospitalizations and complications and instead emphasize wellness
- Complex care management, including interventions that are typically more intensive than enrollees in other risk categories and which are critical to reducing escalating expenditures such as person-centered care planning and coordination with other entities to close care gaps
- Behavioral health interventions to address co-occurring BH and PH issues that contribute to a poor quality of life and may make appropriate chronic disease management difficult, such as coordination of care and communication with all providers on the interdisciplinary care team

[10] National Committee for Quality Assurance, "Population Health Management: Resource Guide," (2018): https://www.ncqa.org/wp-content/uploads/2018/08/20180827_PHM_PHM_Resource_Guide.pdf; accessed June 1, 2019.

Aetna contributes to **delivery system support and alignment** to improve quality outcomes and reduce unnecessary health care costs, including the following:

- VBP arrangements to assist providers to implement strategies to improve quality of care and reduce costs
- Data sharing between providers and the health plan to improve decisions providing care for enrollees
- Patient-centered medical homes have demonstrated their commitment to quality improvement and a patient-centered approach to care that result in happier, healthier patients
- Shared decision-making aids to help enrollees engage in a discussion of their options with a provider

We conduct a variety of **measurement** and evaluation activities to continuously monitor the success of our programs and determine how to improve them, including the following:

- Types of measures include process and outcome measures
- Tools to set attainable goals, such as SMART Goals, and to conduct impact analysis of a PHM strategy

The challenges of population health management, particularly in a diverse state such as Kentucky, include tailoring intervention delivery methods and support to meet the needs of our enrollees and addressing the social determinants that make it difficult for our enrollees to prioritize their health. Traditionally, supportive services for low and emerging risk enrollees place the burden of seeking care on the enrollee by encouraging them to reach out for support. We know that our enrollees manage many competing demands and we need make healthy choices easy to incorporate into their daily lives. When we set out to create a supportive framework for our enrollees who are at risk of developing type 2 diabetes, we decided to bring the content to their doorstep. We are conducting supportive education courses for managing prediabetes risk factors within a housing authority complex in Bowling Green through our HealthRunsDEEP program. The course incorporates local initiatives such as the Mobile Grocery Store and community gardens in the Bowling Green area. We eliminated transportation barriers and access to healthy food through our incentives and the location of program delivery.

a.iii. Plan to Maintain High Levels Participation across Priority Populations and Conditions

In 2019, we achieved an 88% success rate with enrollee engagement in care management services. One hundred percent of enrollees who were successfully contacted through interactive voice response outreach opted to complete the health risk assessment (HRA).

Aetna's enrollees are our Kentucky family, neighbors, friends, and acquaintances. Aetna values an enrollee's choice in how they engage with us and how they engage with care management services. We specifically designed our care management model—an enhanced locally based multidisciplinary team model—to better engage enrollees and families in care management services and sustain health outcomes. Since 2011 in Kentucky, our use of person-centered approaches formulates our understanding of the needs of our enrollees and their families and informs the condition and population-specific tactics and activities that we use to establish and promote high level participation. We organize Care Management teams locally, where our enrollees live, reducing travel time barriers for enrollees using knowledge of services and providers in the area. Our local approach and local staff with specialty skills more successfully engage our enrollees.

Care managers are cross-trained in physical and behavioral health, act as a single point of contact for the enrollee, and work with other members of the multidisciplinary team (e.g., PCP, licensed behavioral health clinicians, nurses, pharmacists, and peer support specialists) to engage the enrollee in services. Engaging enrollees and their supports is a key tenant of motivational interviewing and a cornerstone skill for all staff interfacing with enrollees. **Aetna's integrated care management approach identifies our most complex and vulnerable enrollees with whom we have an opportunity to make a significant**

difference. We engage these enrollees in care management programs to remove or mitigate barriers that limit their ability to manage their own health and well-being. We educate them about population health initiatives, enhance their engagement, and help them remain in the least restrictive and most integrated environment. We coordinate services based on their preferences, needs, safety, burden of illness, and availability of family or other supports in a manner consistent with each person's personal and cultural values, beliefs, and preferences. We help individuals develop resiliency, move toward recovery, and reach their self-defined level of optimal functioning.

Communication Strategies: We use multiple modalities to reach and engage our enrollees, including the following:

- **Community health workers and community-based organizations:** We rely on our CHWs and community-based peer support workers who are fully integrated into the communities where our enrollees live to address social service needs and to serve as liaison between Aetna and our community-based organization (CBO) resource partners. Our CHWs, located in our community Wellness Centers, are resources available to help direct enrollees with any issues they may need. Our CHWs are trauma-trained, trained in MHFA and MI, and serve as enrollee advocates. Our CBOs engage enrollees to understand their individual and unique needs so that we can integrate resources between community partners and Aetna benefits. We have established relationships with over 1,500 CBOs across the Commonwealth who provide supports for our enrollees. Our CHWs work to link our enrollees and our CBOs, especially in more remote areas.
- **In-person visits**: Our care managers complete face-to-face visits in the enrollee's home, in a provider's office, or other confidential settings for enrollees who need additional support. We will meet enrollees in the hospital to assist our multidisciplinary team with discharge planning. Our care managers can meet enrollees at shelters and halfway houses, wherever enrollees reside. Community-based peer support workers and community CHWs also conduct face-to-face visits in a community setting of the enrollee's choice with a focus on helping enrollees achieve their person-centered goals for their health and wellness.
- **Provider coordination:** Our goal is to understand provider challenges and communicate with providers to engage enrollees. We will facilitate follow-up appointments for our enrollees or assist with selecting a PCP. We engage a multidisciplinary care team meeting including the enrollee, their circle of support, their PCP, and other providers, including specialists, representatives from community-based agencies, and non-traditional providers to discuss a specific health issue or to review the overall care. We also engage our provider community through regular communications called "Tip Tuesdays" where we educate our providers on a variety of topics, such as the importance of addressing enrollee's SDOH needs and addressing barriers to accessing PCPs through use of non-emergency transportation.
- **Lifeline smartphone:** Aetna launched the Lifeline smartphone to link enrollees to improved phone services for better communication between the plan, their physician, and our Care Management team. The health plan now has new smartphone options for eligible enrollees. The smartphone options include a set amount of voice minutes and data and unlimited texting each month.
- **Text messaging:** Our educational text-messaging program consists of the Lifeline smartphone and messages to remind enrollees to get tests and screenings done. It sends routine reminders to enrollees to support their health goals related to weight management diabetes, cervical cancer screening, opioid use, prenatal and postpartum care, well-child visits, breast cancer screening, flu shots, adult body mass index, controlling blood pressure, and chlamydia screening. Many of these text campaigns can be personalized and serve as virtual health coaches and allow enrollees to interact and be educated on their specific conditions. Some of the unique monthly broadcast messages we have sent to enrollees include reminders on keeping contact information current with the local child protective services office or even ER diversion and the importance of seeking their PCP first. With an average delivery

rate of 65 percent, we have utilized these messages to communicate with enrollees about open enrollment and events.

- **Social media offerings:** We will offer outreach and engagement opportunities through social media platforms, such as Facebook. We want to collaborate with Department and community-based providers on their social media offerings to offer yet another avenue for enrollee engagement.
- **Phone:** Care managers reach out to enrollees with certain risk factors to offer support and resources to engage enrollees in their health care. For example, we have dedicated nurses who reach out to enrollees within one week of a visit to the ER for enrollees who have a diagnosis of asthma, chronic obstructive pulmonary disorder, congestive heart failure, depression, or diabetes to ensure enrollees have proper access to follow-up care and the support they need to manage their current challenges. High-risk enrollees receive monthly outreach for complex care management support.
- **Mail:** We mail information to enrollees to remind them of our value-added benefits. Depending on risk level stratification, we mail bi-annual condition specific newsletters that contain information about local supports and resources that can help them reach their health goals. We also send enrollees information on resources and other supports that may benefit them and are relevant to their personal needs.
- **Website:** Enrollees have access to the health plan website and links to resources including health assessment and self-management tools.

Completion opportunities for HRA and enrollee needs assessment (ENA): Aetna's enrollees receive automated telephone calls to complete the HRA screening as our first attempt to complete the HRA with the enrollee. There are multiple attempts in multiple formats and times to engage enrollees. With multiple entry points and enrollee contacts, we maximize opportunities to engage enrollees to complete screenings.

Aetna outreaches 100 percent of new enrollees who have not been enrolled in a health plan in the previous 12 months to attempt to complete the screening within 30 calendar days of the enrollee's effective date of enrollment and again annually. Through an initiative to improve interdepartmental communication, Aetna's **HRA completion rate increased by 8 percent in 2019 compared to 2018 due to expanded outreach efforts by Aetna's care management teams as well as increased referrals from the Utilization Management (UM) to the Care Management team**. We screen enrollees with special health care needs within 30 calendar days of the date of identification. In addition, Aetna's behavioral health providers conduct an assessment for eligibility based on level of care needed within 3 business days of referral by provider or a care manager, based on the enrollee's unique needs.

To maximize the number of enrollees completing the screening process, Aetna uses multiple telephonic and written engagement strategies. Aetna makes two attempts to contact the enrollee by phone, each occurring on different days and different times to improve the probability of contact. After two attempts, a letter is sent to the enrollee stating that the telephonic outreach attempts have been unsuccessful and sends the enrollee a copy of the HRA along with a self-addressed return envelope and invite the enrollee to complete the assessment and return to the health plan. Aetna makes every effort to provide the HRA in at a reading level and language that is accessible to each enrollee. In addition, to bring resources local, we have developed a model of community-based Wellness Centers with CHWs co-located in CBOs. The CHWs work in communities in which they reside, act as trusted resources to engage our enrollees, and can complete the HRA and connect enrollees to an Aetna care manager to complete the ENA, if indicated.

Aetna documents all attempts to contact the enrollee utilizing various methods (e.g. telephone, letter, email, authorized caregiver channels) on different dates and at different times of the day. We also utilize other Care Management staff, CHWs, and community-based peer support workers to visit the enrollee's home or contact the enrollee's PCP or pharmacy. Care Management staff will work with enrollee's PCP or other health care providers to obtain usable contact information. We also reach out to local homeless

shelters, hospitals, food pantries, libraries, and clinics in an attempt to locate enrollees in need of our ICM program.

Innovative methods of contact: Aetna has established several practices to increase HRA completion success with multiple points of access, including the following:

- **Face-to-face outreach:** Aetna care managers, CHWs, Enrollee Services staff, or community-based peer support workers conduct face-to-face outreach for hard-to-reach enrollees in their home or at a provider's office. We have experience with co-location as a means to complete HRAs with our criminal justice population. Our Start Strong program in the Kenton County jail system where our care managers have become part of the release process to ensure our enrollees have the support they need for reentry into the community.
- **Kiosks at Walmart stores:** Enrollees will be able to complete the Aetna HRA at kiosks, through our vendor Pursuant, at Walmart stores across the Commonwealth.
- **Aetna mobile application:** Enrollees will be able to complete the HRA through our secure mobile application. The HRA data will feed directly into our population health management platform. This system provides the information technology to conduct care and care management from a single platform connecting external providers and multi-system stakeholders in near real time.
  When data is collected via self-report, it is verified by care managers during face-to-face or telephonic contacts with enrollees and updates are made in the electronic care management record, if necessary.

Quick Thinking by Aetna Associates Identifies a Heart Condition and Avoids Emergent Situation

Steven (not his real name), a new Aetna enrollee, called Care Management requesting assistance to locate a PCP. Aetna's care management associate, Katie, assisted the enrollee and seized the opportunity to also complete an HRA and ENA. In gathering this data from the enrollee, Katie noted that the enrollee was retaining a lot of fluid weight and reported a medical history of heart disease in 2006. Katie immediately reached out to a clinical nursing staff member. The care manager, Jackie, reached out to the enrollee who complained of pitting edema and weeping from his bilateral lower extremities with a significant weight gain. Jackie worked with the enrollee to understand the need for urgent care based on his description and urged him to been seen at an urgent care center or ER and provided a list of local urgent care centers that could to see him that day. The enrollee went to an urgent care center, which subsequently sent him to his local hospital. The enrollee received cardiac stents, and an emergency was avoided thanks to the detailed assessment and critical thinking of the care management associate and his assigned care manager.

Engaging difficult-to-reach enrollees: Through our experience, we recognize that certain enrollees will be particularly difficult to contact such as enrollees experiencing homelessness, persons in non-traditional family or residential settings, refugees, or young adults in a transition stage. Depending upon the need, the intensity of our contact efforts may vary based on enrollee information and clinical judgment. Any time we are unable to contact an enrollee we may attempt to find them through any of the following means, as appropriate:

- Publicly available sources such as telephone listings and online directories
- Pharmacies where an enrollee may have recently filled a prescription
- Our inpatient census tool and real-time pharmacy claims system
- Enrollee's PCP or other providers
- Emergency contacts, family, friends, property owners, or others we know to have previously been in contact with the enrollee
- Other Commonwealth government agencies providing financial or service support to the enrollee

- Community-based organizations such as homeless shelters, food kitchens, and faith-based organizations
- Alert within enrollee services and care management system to notify staff if a difficult-to-reach enrollee calls into Aetna

a.iv. Approach to PHM Program-defined Risk Levels

Aetna's PHM program aims for equitable health care and services that are person-centered, accessible, holistic, and evidence-based. Programs are designed to engage enrollees with the right level of clinical and social support depending on many factors that affect an individual's health status, overall well-being, and ability to self-manage and function optimally in their preferred setting. We define population health management as a collaborative process of holistic assessment, person-centered planning, care coordination, and advocacy for service and support options to meet an enrollee's comprehensive care needs to promote quality and cost-effective outcomes.

Enrollees are stratified into three levels as indicated by the needs identified in assessment and screening processes and informed by their CORE score:

- **Health promotion and wellness:** The level is focused on low-risk enrollees and offers programs to engage enrollees to become proactive in their health care to stay healthy.
- **Management of chronic conditions:** The level is focused on medium risk enrollees and offers programs to manage emerging risk and chronic conditions, and address comorbidities and complications.
- **Complex care management:** The level is focused on high-risk enrollees and offers programs that are more intensive and include managing multiple conditions.

Some enrollees require fewer health services and prefer to interface with self-management tools at their own convenience but may also need reminders for, or notifications of, missed preventive services like flu vaccines, well child visits and cancer screenings. Others require some support to manage chronic disease such as culturally appropriate health education materials or low-frequency one-to-one support or direct coordination with health care practitioners. There are others who frequently utilize high-cost services; they may require a higher level of integrative support to help manage serious, debilitating, or co-occurring health conditions, and transitions between health care settings and the community and to receive the appropriate clinical care and community resources to have fewer days outside of their communities.

We utilize our proprietary stratification model, to stratify each enrollee into the level of care management that best meets their needs. This process segments enrollees in the enrollee population within our population health model which is aligned with NCQA standards (see **Figure C.24-2**). As enrollees are stratified, their conditions, diagnoses, risk for future ER visits or inpatient admissions, and gaps in care are integrated into the 360-degree view of the enrollee. Resources are distributed to enrollees based on characteristics identified through population assessment, factors that influence stratification level, and subsequent individual level assessments.

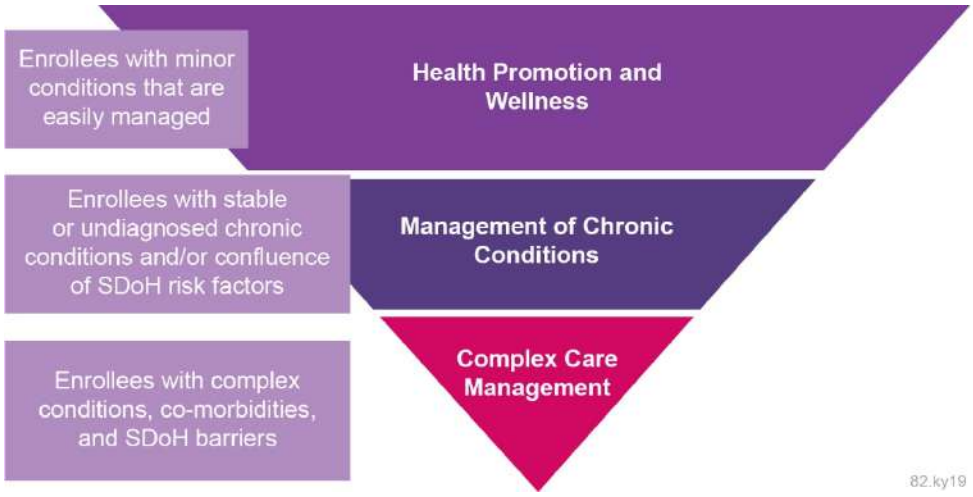

Figure C.24-2: Population Health Management Stratification Levels

Aetna's stratification levels for PHM align with NCQA standards and make sure we can provide care management based on enrollees' needs and level of risk.

a.iv.a. Tools the Contractor Will Use to Identify Enrollees and Their Risk Levels

Tool #1—Stratification tools: Aetna uses predictive modeling as an analytic method to rank all plan enrollees from highest to lowest risk in our General Risk Model. The model identifies people at risk of high cost and/or high utilization in the future by using medical, behavioral, laboratory, and pharmacy diagnoses and claims data, and the likelihood of integrated care management making an impact. Additional predictive modeling techniques are used to identify enrollees at risk for emergency department or inpatient utilization in the next 12 months. The predictive modeling shows that our highest risk enrollees have multiple physical health conditions, and 70 percent to 90 percent had co-morbid behavioral health conditions.

Beginning in June 2019, CORE includes census track and zip code data to incorporate social determinant elements at the population level in its predictive modeling. Aetna uses several indicators in addition to CORE, including the HRA and ENA, surveillance or referrals, concurrent review, and real-time utilization data. We run the model for our entire population monthly.

Predictive Model of CORE

CORE results are predictive in multiple dimensions, as follows:

- The ER model has a positive predictive value of 72.1 percent, meaning that 72.1 percent of the time, the predicted ER utilization occurs in the next 12 months
- Our inpatient modeling is exceptional, with a positive predictive value of 95.4 percent.
- These factors, coupled with our UM and quality management surveillance strategies, enable us to assign enrollees to the most appropriate level of care management.

Tool #2—HRA: Aetna agrees to use the standardized HRA tool, as designated by the Department (pursuant to **Section 34.3 of the Draft Medicaid Managed Care Contract and Appendices**). Aetna conducts the HRA with new enrollees within thirty days of enrollment or earlier if the enrollee is identified via other information or self identifies as having specific health care or social needs. We conduct the HRA within 30 days for pregnant enrollees, so they are quickly linked to prenatal care. We annually assess enrollees for any new health care or social needs, but conduct reassessment more often as indicated by a change in condition or as deemed appropriate by the Department. Aetna makes contact with enrollees to complete the HRA in-person, by mail or email, and by telephone. As part of the HRA process, Aetna Care Management staff explain the purpose to enrollees and available PHM program services should they be determined in need of such services. With enrollee consent, we share all screening results with the assigned PCP via the provider portal or Department upon request. As described in the following response, the HRA is the first step to our care management identification and stratification, assessment, and individual care planning process. The HRA is intended to be an initial screener for enrollees new to the health plan to help identify if they need more in-depth assessment of needs and opportunity for care management support.

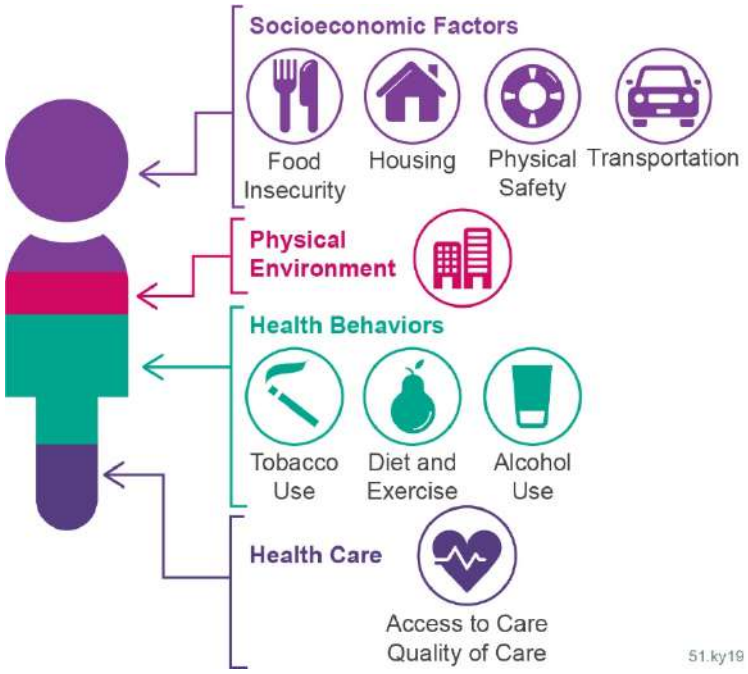

Figure C.24-3: Social Determinants of Health
Aetna's HRA screens for social determinants of health needs.

We offer our HRA in English and Spanish (please refer to **Attachment S** for a copy of the HRA). Translation into other languages is available. These are administered in-person, web-based, print, and telephonically. We obtain enrollee consent before conducting the HRA and disclose to the enrollee how we will use the information gathered in the HRA. The HRA screens for SDOH needs, including food security, housing/utilities challenges, transportation needs, and interpersonal safety and domestic violence concerns. **Figure C.24-3** shows the social service needs screened by Aetna's HRA.

Health Care Equity Dashboard

The Health Care Equity (HCE) Dashboard is a proprietary Aetna tool for analyzing population health data to understand population characteristics such as race/ ethnicity and how these correspond to geographic areas, CORE risk level, and prevalence of certain health conditions or of gaps in recommended health services. This tool is used to help inform planning activities to improve population health and interventions to address health disparities. The dashboard is a visually rich and dynamic tool which synthesizes Aetna's population demographics, based on monthly enrollment data; Healthcare Effectiveness Data and Information Set (HEDIS) data; and utilization data from medical, behavioral, and pharmacy claims. Health plan staff use the tool to understand dominant population characteristics across these factors. The tool features several filters that users can apply to several reports meant to dissect prevalence and distribution of characteristics and factors across population groups.

Tool #3—ENA: Aetna completes a comprehensive ENA to further identify care needs and engage the enrollee in the Aetna PHM program, including ICM (see **Attachment S** for a copy of Aetna's ENA). The ENA is conducted within 30 days of indication that the enrollee may be in need of care management services. The ENA is more detailed and assesses more thoroughly than the HRA which is intended to be an initial screener. It addresses the following: enrollee's immediate, current and past health care, mental health and SUD needs; psychosocial, functional, and cognitive needs; SDOH, including employment and housing status; ongoing conditions or needs that require treatment or care monitoring; current care being receiving, including health care services or other care management; current medications, prescribed and taken; support network, including caregivers and other social supports; and other areas as identified by the Aetna or the Department. Aetna makes outreach attempts to enrollees to encourage completion of the ENA according to Department standards, outlined in **Section 34.3 of the Draft Medicaid Managed Care Contract and Appendices.**

Tool #4—Health Care Equity Contact Event: The HCE Contact Event assists with documenting, tracking, and reporting on enrollees' SDOH needs, inclusive of housing, transportation, food insecurity, and personal safety/domestic violence, and identifies enrollees who may benefit from additional interventions and education to address them. The demographic characteristics included in the Health Care Equity Contact Event include race, ethnicity, gender, sexual orientation, and geographic location, among others. Staff on the enrollee's MCT conducts the Health Care Equity Contact Event for all enrollees engaged in care management, and documents self-reported SDOH data in our electronic care management system. The intent is for the captured SDOH data to be incorporated into the development of the individualized person-centered care plan. When they identify a SDOH need, they can use our resources, such as Aunt Bertha and Unite Us, connect with Aetna's Systems of Care team, or engage CBOs to identify resources to meet their needs. Through the HCE Contact Event, we have identified food insecurity as the top SDOH need for our enrollees. To support those who are experiencing hunger, we connect them with local food pantries which we have partnered with to stock shelves with healthy options, and through our Wellness Center we assist them with enrollment to Commonwealth and federal food assistance programs and make referrals to other community-based resources in the Unite Us network.

a.iv.b. Risk Stratification Methodology and Data Sources

We stratify enrollees into levels for care management and population health initiative engagement based on a range of data sources, including CORE, claims data, and our Healthcare Equity Contact Event.

CORE: With the goal of making enrollees healthier, Aetna uses CORE in conjunction with the data sources described below to determine each enrollee's potential risk level. Using all this data, care managers determine whether care management interventions can effectively improve the enrollee's outcomes, and at which level of intensity those should be provided. CORE It is based on three risk metrics (refer to **Figure C.24-4**):

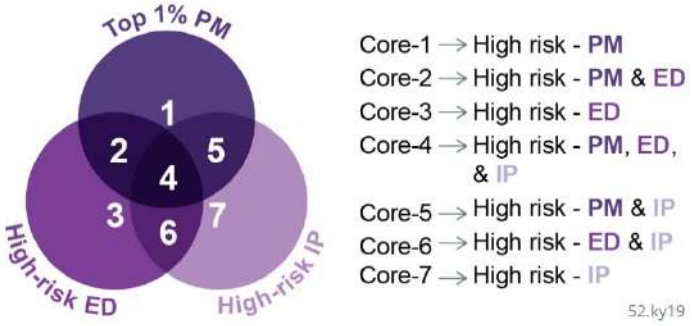

Figure C.24-4: Aetna's CORE Model
CORE allows Aetna to identify enrollees with a potentially high risk for costly utilization who may benefit from enrollment in care management.

- Predictive Modeling (PM) General Risk Score: Enrollees in top 1 percent of population based on medical and behavioral health diagnoses, medical service utilization, and pharmacy use
- Emergency Department (ED) Risk Score: Risk of an ED visit within the next 12 months

- Inpatient (IP) Admission Risk Score: Risk of an IP admission within the next 12 months

Claims and pharmacy data: Claims data and medical information captures demographics, enrollee costs, disease condition prevalence, and PCP and specialist activity. For example, women who report tobacco use and are pregnant are automatically placed into our high-risk category for intensive outreach; we attempt to partner high-risk pregnant women with a community-based CHW to address opportunities to achieve wellness, tobacco cessation and linkage to community-based resources and organizations.

In addition, Aetna uses pharmacy claims data to identify risks related to non-adherence and other medication management issues that engagement in care management can influence. We derive approximately 40 percent of an enrollee's risk assessment from pharmacy utilization and claims. The risks identified include the following:

- The complexity and number of medications in an enrollee's drug therapy, which is a major driver of inpatient admission risk
- An enrollee's adherence to critical maintenance medications to treat conditions like asthma, diabetes, heart failure, or a behavioral health condition
- Potential overlapping therapy or drug contraindications that may impact enrollee safety
- Use of multiple pharmacies or prescribers to obtain controlled substances

Health Care Equity Dashboard: The dashboard includes enrollees' self-reported data on their demographics, conditions, and needs. **We are developing capability to track use of non-Medicaid services (e.g., enrollee use of services for unmet social resource needs like housing, food, transportation) through Unite Us network of providers, which aim to incorporate in our risk stratification methodology in the near future.**

Aetna is developing predictive modeling tools for at-risk children and enrollees at risk of opioid use:

- **Rising risk predictive modeling for children in foster care:** Aetna's rising risk model uses 28 different measures to stratify and score enrollees age 17 and under based on a multitude of measures including specific behavioral health disorders, opioid use, physical/sexual/psychological abuse, self-harm claims, co-morbidities, risk stratification score, engaged in care management, PCP assignment, frequency of changing PCP over the course of a year, total medical spend, ER utilization, pregnancy, sexually transmitted disease diagnoses, household opioid use, household self-harm claims, and household physical/sexual/psychological abuse. Using this method, we can identify enrollees who are at elevated risk that may need additional resources from the health plan. In addition to identification of specific enrollees, we use demographic and geographic information to focus resources on areas of rising risk concentration.
- **Predictive modeling for opioid use disorder:** Aetna is exploring advanced analytics approaches to identify the enrollees at high risk of opioid use disorder (OUD). Data sources include the following: eligibility data, medical claims data, pharmacy claim data, approved diagnosis codes, procedure codes, and drug codes. Using this data, a multivariate logistic regression model was developed to assess the likelihood of an enrollee developing OUD using person-level data. The final model includes the following variables: age, rate group, ethnicity group, chronic pain, alcohol abuse, tobacco abuse, first opioid prescription lasting more than seven days, opioid days' supply, and unnecessary ER visits. The model accuracy of prediction is 89 percent and high-risk enrollees with OUD are flagged by a selected cutoff value.

a.iv.c. Identifying Enrollees for Each of Kentucky's Priority Conditions or Populations

Enrollees with priority conditions (e.g. asthma, heart disease, diabetes, obesity, tobacco use, cancer, infant mortality, low birthweight, mental health, substance use disorder), or those who are part of priority populations (adults and children with special health care needs, high-risk pregnant women, homeless enrollees), are identified using the following data sources and methods:

- **Method #1—Enrollment file analysis:** Aetna analyzes our Kentucky enrollment file to identify enrollees with priority conditions or who are in a priority population. Our care managers also use the enrollment file to gather data that may indicate participation in non-covered programs and services. This serves to reduce confusion to the enrollee and their family and prevents duplication and resource waste.
- **Method #2—Review of Aetna data:** Aetna's Care Management team review claim-specific information to identify capitated services; diagnosis and condition; physical, behavioral health, and social risk needs; use of durable medical equipment; medical supply needs, etc., all of which may indicate the enrollee has a priority condition or is in a priority population.
- **Method #3—Reviewing HRA and ENA results and conducting conditional assessments:** Our care managers review the results of initial HRAs/ENAs. Based on initial findings, we may conduct additional assessments to evaluate physical and behavioral health, therapies, functional, or durable medical equipment needs. We also review available information from targeted case management assessments and other provider-related data.
- **Method #4—Enrollee self-identification:** Enrollees can self-identify for care management through Enrollee Services or any of Aetna's enrollee hotlines. To assist with enrollee self-identification, we use targeted pharmacy outreach, in which enrollees receive a pre-populated message on their prescription bags, directing them to contact Aetna care management, if they are not currently enrolled in care management but fill a prescription at a network pharmacy.
- **Method #5—Electronic system notifications:** Our care managers receive automatic notifications for inpatient admission alerts.
- **Method #6—24-hour Health Information line:** Enrollees are also identified for care management through their contact with a 24-hour Health Information line. After the health information line nurse completes a call or email exchange, information via an intake form is entered into the electronic care management system to trigger screening for possible enrollment into care management.
- **Method #7—Outreach to VBP providers:** We conduct outreach with our VBP partners to identify enrollees for stratification and evaluate year-over-year gaps in care.
- **Method #8—Referrals:** Aetna uses referrals from internal resources and our strong community partnerships to identify individuals that may benefit from care management services. These referral sources include the following:
  - Enrollee Services and Grievances staff referral and referrals resulting from historical data that we assess and trend at the enrollee level
  - Providers, including primary care, behavioral health, and specialist providers. Through our partnership with the Community Pharmacy Enhanced Services Network (CPESN), community pharmacists assist in identifying enrollees who need more supportive services and refer them to Aetna for care management.
  - Commonwealth staff, including Medicaid, the Department of Behavioral Health, Developmental and Intellectual Disabilities, and the Department of Community Based Services
  - Utilization Management, Quality Management, Enrollee Services, or other internal departments services
  - CBOs and social services organization such as food banks and homeless shelters

a.iv.d. Services and Information Available within Each Risk Level

Our integrated system of care uses **multidisciplinary, locally based Care Management teams to meet all levels of care management needs of our enrollees**. Supported by Aetna's system of care model, care managers form strategic relationships with key stakeholders (e.g., community providers, care transition networks, families, peer support services, and care navigators) to address enrollee social determinants and to promote health care equity. **Table C.24-4** describes types of information and support Aetna offers for enrollees at each level of care management.

Table C.24-4: Care Management Levels and Associated Interventions

CM Level	Care Management Information and Interventions Available
Level I: Health Promotion and Wellness	**Information available:** • Disease specific information to promote self-management (e.g., Krames® educational materials) • Community resource availability • Covered benefits and value-added services • Aetna website
	Services available: • Population health initiatives and educational material and communication • Support with education, housing, transportation, and personal safety • Ongoing surveillance for status change • Wellness and prevention services • Semiannual health information and reminders
Level II: Management of Chronic Conditions	**Information available—all of what is described for the Level 1 plus:** wraparound services

	Services available—all of what is described for Level 1 plus:
	• Evidence-based practices, including trauma-informed care, medication-assisted treatment, and assertive community treatment
	• Support from Aetna CHWs and community-based peer support workers
	• Collaboration with care management agencies and community-based services for integrated care plan development
	• Collaboration with system stakeholders
	• Information-sharing between providers and system stakeholders
	• Transitional care management
	• Pharmacy Medication Management Program and Pharmacy Supported Comorbid Condition Management Program
	• Chronic condition/disease management
	  - Monthly, at minimum, disease management coaching interventions for enrollees and/or their guardian
	  - Collaborate with the enrollee and circle of support to establish measurable objectives based on condition-specific assessments and evidence-based guidelines and address social determinant needs
	  - Provide telephonic coaching and education to the enrollee and/or their circle of support using disease-specific clinical practice guidelines to improve care plan adherence and promote healthy behaviors
	  - Assist enrollees and their circle of support to develop self-management action plans, and to cultivate a relationship with the PCP and to communicate about their conditions and treatment

Level III: Complex Care Management	**Information available–all of what is available for Levels 1 and 2, plus:** remote patient monitoring options

	Services available–all of what is available for Levels 1 and 2, plus:
	• Complex physical health, behavioral health, specialty, and DME services
	• Opioid use or other co-occurring substance use disorder treatment and follow-up for naloxone training
	• CHW and peer support workers (through engagement of community-based organizations)
	• Readmission and ambulatory-sensitive admission and ER diversion
	• Linkage to resources addressing social determinants of health
	• Gaps-in-care resolution
	• Treatment adherence support
	• Hospital Readmission Reduction Program
	• Chronic condition/disease management
	  - Face-to-face and telephonic interventions with enrollees and their guardians, customized to their needs
	  - Expand the availability of enrollee-specific resources to include remote patient monitoring, associated care management education, and coaching to drive behavior change and improve health outcomes
	  - Regularly scheduled reevaluation of exacerbations and barriers to adherence

Complex Care Management (Intensive): Aetna provides enrollees engaged in complex care management the most focused attention to support their clinical care and SDOH needs. These enrollees have the highest level of need and have complex medical and/or behavioral health conditions in addition

to disease or condition management support and preventive care programs. The area of focus for high-risk enrollees is managing multiple conditions and outcomes across various health care settings. We initiate a plan of care within 60 calendar days of identification. This process includes an assessment of the enrollee's physical and behavioral health conditions along with home environment and priority SDOH health including housing, food insecurity, physical safety, and transportation. Care managers, community-based peer support workers, and CHWs are available to meet with enrollees at least monthly, in person, in the enrollee's preferred setting. Care managers will update the plan of care at least monthly and conduct a reassessment annually.

Management of Chronic Conditions (Supportive): Aetna offers enrollees chronic condition support for their whole health needs. Enrollees in chronic condition management need a lower level of support than those enrollees in complex care management, but still need significant care coordination and care management to manage chronic or complex medical and/or behavioral health conditions. These enrollees have not yet exhibited high risk utilization trends but likely may in the future if left unmanaged. These enrollees receive disease management education materials and programs, supports to access health services effectively, and supportive care management. The area of focus for medium risk enrollees and programs directed toward them is primarily managing emerging risk, but also includes all other focuses in the appropriate situations including keeping enrollees healthy, managing multiple chronic conditions and outcomes across settings where enrollees require support to coordinate care. Together with the enrollee, we initiate the plan of care in person within 60 calendar days of identification. Care managers update the plan of care at least quarterly and provide a comprehensive annual reassessment.

Retinal Eye Exams for Enrollees with Diabetes—Eye SPI

The Eye SPI (screen, prevent, improve) project is designed to encourage enrollees who have diabetes but who have not had a dilated retinal exam (DRE) to get their eyes examined by an optometrist and use a kiosk within a Walmart in the Commonwealth to attest to the completion of their eye exam. Targeted enrollees receive a mailer explaining how diabetes damages the eyes over time and reminds them to go to a local Walmart to attest to the completion of their DRE exam. Upon completion of the attestation of the DRE exam, the enrollee receives a $10 Walmart gift card.

Health Promotion and Wellness (Population Health): These enrollees are considered low risk based on available information and generally have minimal gaps in care, limited ER or inpatient utilization, few prescription medications. These enrollees receive health promotion interventions focused on maintaining health and keeping risk low, such as annual visits to their PCP, virtual access to care, recommended screenings, and self-management tools.

Aetna's Flu Shot Campaign in Kentucky to Support Enrollee Health and Wellness

In our Population Health Management strategy, Aetna identified the need to increase flu shot utilization and educate enrollees on the benefits and common myths of receiving flu shots. In 2018, we launched a targeted flu campaign with our Enrollee Analytics team to take a scientific approach to marketing by tracking responses to marketing campaigns based on a call to action. We developed content for six different emails. Three emails contained an emotional call to action, while the remaining three contained a rational call to action. The enrollee analytics team tracked which emails generated the best responses and interaction. These campaigns differ from previous efforts in that the focus is on behavioral economic concepts and testing and learning which ones work with different audiences or for different topics. Behavioral economics is the science of decision-making and has shape our enrollee outreach strategies to increase engagement. For example, in 2019 we continued the rational call to action approach through an email and text message-based flu shot campaign.

a.iv.e. Care Planning Process

Our integrated system of care uses **multidisciplinary, locally based Care Management teams to meet all levels of care management needs for our enrollees**. These locally based teams are the start of the person-centered care planning process. Please refer to **Figure C.24-5** for a holistic description of the care planning process and refer to **Attachment S** for our Care Plan Development and Updating policy.

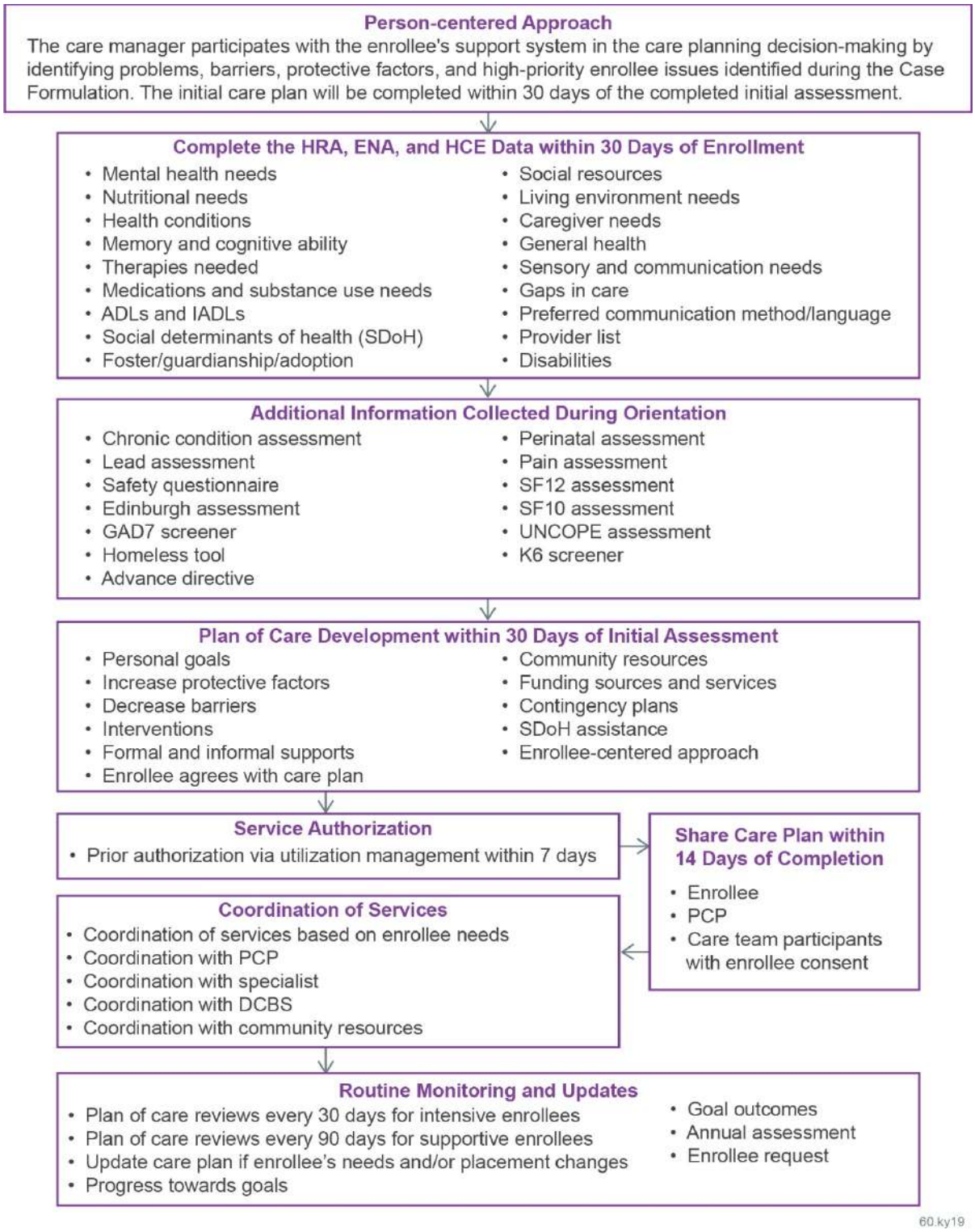

Figure C.24-5: Aetna's Care Planning Process

Aetna's person-centered care planning process uses assessment data to understand an enrollee's holistic needs and creates a care plan to address each need in an integrated, whole-person approach.

Method #1—Trauma-informed approach to care planning: All Aetna care managers complete training in TIC, resiliency, and ACEs in alignment with our TIC Transformation. We understand the steps necessary and the tools needed to support enrollees locally by using trauma-informed practices, driving care to CBOs, and providing wraparound support. This trauma-informed foundation supports our overall plan of care planning process.

> The Aetna Medicaid organization is the first managed care organization to collaborate with the National Council for Behavioral Health to implement an enterprise-wide TIC initiative.

Method #2—Using assessments in care planning: Dedicated, local care managers conduct comprehensive assessments with the enrollee and their caregiver and social services stakeholder, if applicable and desired by the enrollee. HRA and ENA results, predictive modeling, and referral information trigger need for completion of the comprehensive assessment. We conduct comprehensive assessments in a location and setting dictated by convenience for the enrollee, whether it is in the home, with the PCP, telephonically, or another identified private location. Through the comprehensive assessment, care managers gain an understanding of the enrollee's health and conditions across all physical, behavioral, and social systems. The comprehensive assessment is extensive in its evaluation of SDOH, trauma, access to and historical utilization of services, health behaviors (inclusive of substance use, mental health, chronic health conditions, physical activity, and nutrition), and medications. The assessment also includes discussion of social supports and caregiver resources and identification of enrollee strengths and barriers that impact the enrollee's ability to achieve optimum health.

We conduct additional assessments customized to a variety of populations, including age- and gender-specific preventive screening questions and assessments specific to disease or priority populations. For example, we assess pregnant women using internally developed and evidence-based validated tools to evaluate further conditions of the pregnancy, obstetrical history, family supports, and psychosocial issues, including the Edinburgh Postnatal Depression Scale. Children with special health care needs also receive specialized assessments, including the Survey for the Well-Being of Young Children. Additional assessments informing care planning include the UNCOPE and PHQ-9, as well as assessments of anxiety, pain, and weight management.

Method #3—Enrollee-directed care planning: Our dedicated, locally based care manager develops the care plan in partnership with the enrollee based on their goals for care and what outcomes they hope to achieve and shares it with the enrollee, their PCP, and their multidisciplinary care team within 60 days of the initial comprehensive assessment. All participants are of the multidisciplinary care team are collaborators with the enrollee in the development of the care plan. Therefore, the process is enrollee-driven and provider-informed.

Figure C.24-6: Enrollee-directed Care Planning
Aetna's care planning process meets enrollees' unique needs.

Figure C.24-6 illustrates how our care planning process meets enrollees' unique needs. In addition to primary physical health and behavioral health providers, members of the care team may include family

members/circles of support, school representatives, staff from community-based organizations, and pharmacists. Goals, objectives, and services identified during care planning address all factors that affect health to foster improved health outcomes. **The care planning process focuses on closing care gaps and ensuring continuity of care, particularly for enrollees with special health care needs, pregnant women, and enrollees needing or using DME.**

The interventions identified in the assessment and care planning process produces an individualized care plan, which includes an enrollee's person-centered care plan and any referrals to community-based organizations and other programs that can provide needed services. Members of the System of Care team participate in care plan development, based on the enrollees' holistic needs. These services include tobacco cessation programs, Kentucky Tobacco Quitline, the Special Supplemental Nutrition Program for Women, Infants, and Children, and permanent supportive housing. We also refer enrollees to internal specialty care management programs like our transplant and homeless care management program.

The action plan includes the enrollee's own language with respect to their personal goals and self-management objectives. The enrollee and/or guardian must approve the care plan and will have ongoing real-time access to current care plans via the enrollee portal. Aetna's care plan meets health literacy guidelines and includes all elements established by the Department. Copies of the care plan are mailed to the enrollee and the involved providers. We store copies of the current and prior care plans in the electronic care management system. Care plans are also accessible by care team enrollees via the provider portal.

Method #4—Care conferences: To facilitate enrollee health, it may be necessary to have a multidisciplinary care team meeting. The enrollee, their circle of support, their PCP, and other providers, including specialists, representatives from community-based agencies, and non-traditional providers may attend a meeting to discuss a specific health issue or to review the overall are plan.

Method #5—Care plan updates: Ongoing multidisciplinary team communications allow for continual review of progress toward care plan goals and objectives. Assessment for progress toward overcoming barriers, functional needs, meeting goals and compliance with the care plan, as well as identifying further needs occurs at a frequency based on the enrollee's care management needs. Aetna's electronic care management system has a trigger to alert care managers when **annual assessment and care plan updates** are due. We also update care plans when an enrollee's circumstances or needs change significantly; at the request of the enrollee, their legal guardian, or a member of the multidisciplinary care team; and whenever a reassessment occurs.

> "New and innovative ways to engage vulnerable populations will always be a primary goal for us at Kenton County Detention Center. Research and experience tells us that individuals are most at-risk during the first few weeks of the re-entry process. Courtney Ham, Aetna's Start Strong targeted care manager, has taken the re-entry process to levels of success we have never seen before. The Start Strong Re-entry Program has reduced recidivism, while increasing the safety and wellness of our communities. We are very proud of our partnership with Aetna Better Health of Kentucky. Making our mutual goals a reality."-
>
> **—Jason Merrick,**
> **Director of Addiction Services,**
> **Kenton County Detention Center**

a.iv.f. Stakeholder Engagement Strategies

As one of the original Medicaid managed care organizations in Kentucky, we have been engaging community partners since 2011 to improve the quality of care and address health care inequality throughout the Commonwealth. We have employed the following strategies to partner with the community to address the needs within our local communities.

Strategy #1—Stakeholder input: Aetna's Continuous Quality Improvement Committee is informed by stakeholder feedback. Our Quality Management Committee uses stakeholder feedback to understand areas for improvement that we need to address. Stakeholders have input to Aetna key governance committee meetings and we have an active Medicaid Advisory Committee. We maintain a comprehensive Quality Assessment and Performance Improvement (PI) Program and conduct ongoing monitoring to ensure the system is efficient, coordinated, and results in improved health outcomes. We review feedback from the QM/PI data in our multidisciplinary committees, and then recommended actions are implemented and traced to ensure strategies effectively improve access to and the quality of enrollee care. We hear the voices of our stakeholders.

Strategy #2—Engaging and supporting our community partners: We support our community partners through sponsorships and grant awards that assist with the day-to-day operations of their business and through those partnerships we collaborate to support the needs of our enrollees. Aetna provided over $350,000 in grants and sponsorships over the past 18 months to support community organizations and initiatives with over $240,000 going to support programs related to ACEs (e.g., Hope Hill Youth Services, Orphan Care Alliance, and Prevent Child Abuse Kentucky). Aetna's local employees take an active role in their communities through volunteer opportunities such as the Every 1 Reads program and participation in local health coalitions such as the Diabetes Coalition and Advocacy Group.

We host regional job and resource fairs where we provide resume writing assistance, free business attire, and interview skills-building to provide our community members with the skills and confidence they need to pursue a career.

Our community partners rely on us to provide the support that they need to fulfill their mission. Most recently, we provided a grant to Volunteers of America Volunteers of America Mid-States in support of its new Freedom House program in Southeastern Kentucky. Freedom House provides addiction recovery treatment and care to pregnant and parenting mothers working to overcome substance use disorder. A new facility will be located in Clay County and will be the first program of its type in the region. The Aetna gift will be critical to funding the comprehensive services and care pregnant and parenting mothers receive at Freedom House.

Testimonial: The Kentucky Nonprofit Network

"Aetna has been a corporate member of Kentucky Nonprofit Network, the state association of nonprofits, since 2012. Over the years, they have invested in a number of important Kentucky Nonprofit Network initiatives that support and strengthen Kentucky's nonprofit sector.

Aetna has made important investments in helping to create a more effective nonprofit sector in Kentucky. Their support has helped Kentucky Nonprofit Network provide valuable professional development for nonprofit executives and strengthened nonprofit efforts to better share their stories of impact and value. Both are important to creating an environment where the work and expertise of nonprofits is valued."

—Danielle Clore
Chief Executive Officer,
Kentucky Nonprofit Network

Likewise, Aetna relies on our community partners to help us fulfill our mission of innovation to meet the needs of our enrollees. Aetna is the only Medicaid managed care organization in the Commonwealth with a re-entry coach (care manager) embedded in a justice system facility. The Start Strong Reentry Program in Kenton County, a 90-day jail substance abuse program with six months of follow-up support, supports individuals to move beyond addiction and establish healthy, productive lives.

Our population health strategy is enhanced and supported by ongoing, regular stakeholder input. Local stakeholder collaboration and support is key to improving Kentuckians' health.

Strategy #3—Involvement of providers to meet unmet social needs: Aetna is committed to providers being true partners in taking care of our enrollees and their patients. For example, Aetna engages with the CPESN to offer support to our enrollees utilizing local, neighborhood pharmacists and important relationships they have established with our enrollees. The local pharmacist-enrollee relationship has identified key social barriers our enrollees have and helps identify resources available locally and at Aetna. CPESN deliver medications to enrollees' homes when transportation is a barrier. We discovered that medication home delivery drivers often identified SDOH needs within the homes of our community members. As a result, we equipped drivers with 750 emergency care packages containing hygiene supplies, food, water, blankets, batteries, and children's books to distribute to any community member that exhibited a need. In addition, our drivers are able to identify key contacts for enrollees to assure continuity in their care (refer to **Figure C.24-7**).

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Figure C.24-7: CPESN Pharmacy Drivers Preparing to Deliver Care Packages
Aetna has provided drivers of local CPESN pharmacies with kits of necessities to deliver to our enrollees with social needs.

Strategy #4—Delegation of case management: We hold regular strategy meetings with Kentucky Primary Care Association (KPCA) to identify novel approaches to engaging enrollees and ensuring they have the right level of support to manage their health priorities properly. Our partnership led to an effort to delegate case management activities within five of their clinics. This supports relationships that have been established and gives enrollees the opportunity to not duplicate needed assessments and surveys. Using Aetna stratification and analytics, we identified 475 enrollees for outreach by KPCA care managers. This will allow us to partner for increased engagement if needed and capitalize on existing care management relationships and in-person encounters with the PCP in the enrollee's local community.

a.iv.g. Technology and Methods for Information Exchange

Our population health strategy relies on availability of near real-time data for communicating with our providers and coordinating efforts to best manage care of our enrollees. Improved adoption of electronic health records (EHR) and subsequent full connectivity to the Kentucky Health Information Exchange (KHIE) is an essential component as it will give us access to data that we can share with our providers via

our population health management platform. We will partner with the Commonwealth to improve EHR adoption among our provider community and will require KHIE connectivity as part of our contractual arrangement with providers. Improving interoperability of data within the Commonwealth will lead to improvements in the quality and cost of care. **Population health management platform:** Our electronic population health management platform (please refer to **Table C.24-5**) is a collaborative information platform that shares and aggregates actionable enrollee information across multiple systems, promoting effective and efficient care management, especially for complex, high-risk individuals.

Table C.24-5: Uses of Aetna's Population Health Management Platform

Data Storage	Identifying Gaps in Care	Care Transitions	Dashboards
• KHIE • Claims data • Pharmacy data • Continuity of care documents	• Open HEDIS and quality gaps • Identifying high and emerging risk enrollees	• Admission, discharge, and transfer data • Care paths to support care and service plan coordination across organizations • Medication lists	• Cost and utilization dashboards • Inpatient and key clinical events • HEDIS opportunities

HIE: Aetna is ready to participate with KHIE and make use of available data and we plan to partner with the Commonwealth to assist our providers to connect to KHIE. Aetna currently has 13 of its 16 plans on HIEs and is identifying opportunities for HIE eligible plans to connect to an HIE in the future. Aetna understands the importance of an integrated source of data and has experience in engaging single and multiple HIEs in many of its Medicaid plans.

a.iv.h. Frequency of Provision of Services

Table C.24-6 shows the minimal frequency of provision of program services and care management interventions for enrollees at each level of risk in our PHM program.

Table C.24-6: PHM Populations and Timeliness of Services and Interventions, by Risk Level

Population	Program Services	Care Management Interventions
Complex Care Management		
• Behavioral and physical health comorbidities • Higher risk for inpatient/ER utilization and unplanned transitions • New or unstable chronic condition management incorporated	• Monthly contact, face-to-face visits, frequent visits during acute or transitional episodes, and an annual comprehensive assessment by a licensed care manager	• Monthly enrollee contact and care plan reviews and updates based on progress toward prioritized goals and communication of the care plan with the enrollee, PCP, and others of the enrollees' choosing • Enrollee contacts, including face-to-face visits, based on enrollee needs and/or change in condition • Annual reassessments based on enrollee needs and as indicated by a change in condition
Chronic Condition Management		
• Enrollees with chronic conditions of high-risk pregnancy • Enrollees who have lesser clinical and biopsychosocial complexity • Commonwealth-required populations	• Quarterly (minimum) care plan review, goal discussion, and updates • Enrollee contacts as clinically indicated by the enrollee's needs, change in condition, or care manager's judgment (every 90 days at minimum)	• Quarterly (minimum) care plan review with discussion of goals and progress toward achieving them, revisions, and communication of updated care plan with the enrollee, PCP, and others at the request of the enrollee • Enrollee contacts as clinically indicated by the enrollee's needs, change in condition, or care manager's judgment (every 90 days at minimum) • Annual reassessments based on enrollee needs or as indicated by a change in condition

Population	Program Services	Care Management Interventions
Health Promotion and Wellness		
• Low-risk pregnant mothers • Low-risk chronic condition	• Individualized services to enrollees who require routine screening, monitoring, and follow-up • Quarterly screening for low-risk pregnant mothers	• Biannual condition specific newsletter • Health plan website and links to resources • Online resources including health appraisal and self-management tools

a.iv.i. Priority Areas

Aetna continually evaluates their programming to ensure it aligns with the priorities of the State. Current priority conditions and our efforts to address and support include the following priority areas:

Priority #1—Combating opioid use: Aetna has developed a multifaceted, national strategy for combating the complex issue of inappropriate use of opioids, focused on prevention, intervention, and support. We are implementing this strategy in Kentucky and 15 other states where we operate Medicaid plans. We bring our national expertise to our partnerships with local, Commonwealth, and federal governments, as well as local stakeholder groups, such as first responders and public health agencies. Aetna emphasizes care coordination and continuity of care by reducing barriers that restrict access to SUD treatment, medication-assisted treatment, support programs, and non-pharmaceutical alternatives through our extensive provider network, use of telemedicine, remote patient monitoring, and our comprehensive Medicaid and value-added benefits package. We have created our opioid dashboard, which uses pharmacy and medical claims data to trend key metrics to help us combat inappropriate use of opioids in Kentucky. Data from our opioid dashboard demonstrate our success in Kentucky. For example, data from our opioid dashboard demonstrate that between June 2016 and August 2019 we have achieved the following:

- Increased the rate of non-opioid treatment for chronic pain by 52.9 percent
- Decreased the rate of opioid prescriptions for enrollees with OUD by 44.4 percent
- Decreased the rate of opioid prescriptions for enrollees with a previous overdose by 62.7 percent
- Decreased the rate of 7-day opioid prescription after an acute procedure by 88.6 percent

Priority #2—Addressing SDOH needs: Aetna is partnering with Unite Us in a unique collaboration to address the full spectrum of SDOH. The partnership, currently in Louisville, establishes new and innovative models that improve the engagement between enrollees, traditional health care providers (e.g., PCPs), and social services providers. Aetna's intent is to expand this partnership statewide. This SDOH services integrated model connects enrollees to community-based organizations who participate in the closed-loop referral network, including all types of social service agencies. Enrollee referrals for integrated service needs (PH, BH, SDOH) are triggered through multiple sources; there are not any limitations on how enrollee referrals are triggered. One example is an HRA which is attempted to be completed for 100 percent of enrollees within thirty calendar days of eligibility with the health plans; three outreach attempts are made to complete the HRA. Additional tools, such as the Health Care Equity Contact Assessment, are completed in combination with the HRA which includes SDOH and bio-psychosocial questions. Enrollees determined to have socially or medically complex needs (multiple chronic conditions, SDOH barriers, gaps in care, health disparities) are warm transferred to a care manager for evaluation based upon defined criteria for potential enrollment into our ICM program. Enrollees that are identified to have SDOH needs not requiring care management intervention are warm transferred to a CHW located at the Wellness Center in the community where the enrollee resides. The CHW will connect with the enrollee with Unite Us via telephonic outreach to complete referral for SDOH needs identified. Unite Us has engaged a full network of social service providers including food banks, transportation vendors, education organizations, etc. The enrollee is able to access any of the resources in

the Unite Us network and a service referral and episode is created. If the enrollee's needs have been met, the enrollee, the care manager and the PCP are informed. If the enrollee has further needs, Unite Us and Aetna CHWs and care managers continue to work with the enrollee and communicate with the care team until all needs are met. Reporting is completed by Unite Us and provided to Aetna as well as to the enrollee's PCP.

The Unite Us platform provides the unifying infrastructure between health care entities and community-based organizations. The platform allows for the current ecosystem of health care and social care partners to connect around every enrollee and track the outcomes delivered across each partner in a secure environment. This infrastructure provides the ability to track an individual's journey, regardless if they start their journey post-discharge from medical provider or at a community-based organization's office. The main themes of the platform include the following:

- Configurable screening for needs with immediate decision support
- Electronic referrals and tracking with external agencies
- Assessment and single care plan management
- Bidirectional communication (between partners and enrollees)
- Alerts and email notifications on referral progress
- Outcome tracking across network partners and each community

Outcomes by resource including specifics (e.g., long-term housing, transitional housing, etc.)

Aetna enrollees residing outside Louisville have access to referral services for identified SDOH needs through current processes such as Aunt Bertha, a comprehensive online directory of social service organizations, and care management processes to facilitate connecting enrollees with appropriate community-based resources to address identified enrollee needs. Our Care Management teams, enrollee support teams, and CHWs continue to work closely with our enrollees to assure their social resource needs are met. In addition, CHWs will offer enrollees assistance with enrollment in federal and Commonwealth benefit programs such as Women, Infants, and Children, Kentucky Transportation Assistance Program, Kentucky Low Income Home Energy Assistance Program, and Continuum of Care Homeless Assistance Program to provide enrollees with sustainable resources. If the social or medical complexity of an enrollee increases or if there has been a significant care transition to the point where care management intervention is needed, the enrollee will be warm transferred to care management for care manager re-assessment and intervention.

Priority #3—Addressing ACEs: A healthy environment is integral to the proper development of our youth. As described above, Aetna is undertaking a system-wide transformation to include trauma-informed practices into all areas of our healthcare company. Local Aetna staff are educated through completion of the Darkness to Light training via the Exploited Children Help Organization (ECHO) to identify and address ACEs. In addition, our care managers complete monthly training which incorporates ACEs, sexual abuse education, and TIC. We integrate ACEs and depression screenings into enrollee assessment for foster care and child intake. Our care plans incorporate the entire family and circle of support to address any behaviors occurring in the household which might expose a child to

Local Collaborations to Address ACEs

In collaboration with ECHO, Aetna renovated a room at the Jefferson County Courthouse for children of families attending court proceedings. The **Aetna Safe Zone** provides a safe haven for children during a time that could be traumatic without proper support (please refer to **Figure C.24-8**).

Aetna partners with **Bounce** to address ACEs by working with children to cultivate the skills they need to bounce back from difficult situations. This includes implementing a trauma-informed model for Jefferson County public schools. Bounce also promotes policy changes related to ACEs and has created the Building Resilience in our Community's Kids (BRICK) network to promote awareness of ACEs in the Louisville area.

ACEs. We work to equip parents to handle difficult situations and to promote supportive relationships which are integral to childhood development. It is key that all our providers, and when possible, vendors understand the commonality of ACEs in the Medicaid population.

Our dental benefits administration subcontractor, Avēsis, works closely with the founder of Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A), engaging dentists and dental professionals in identifying child abuse and neglect, elder abuse, domestic violence and human trafficking. Avēsis' Vice President of Dental Quality and former Chief Dental Officer for CMS, Dr. Lynn Mouden, is a P.A.N.D.A. trainer and provides professional development for our network dental providers on topics like precipitating causes and contributing factors to child abuse and the clinical signs of abuse and neglect.

As described extensively throughout this document, Aetna understands the importance of educating and training our communities of enrollees and providers to the importance of understanding the impact of trauma. Aetna has developed a minimum year-long provider collaborative created with the National Council on Behavioral Health and is committed to expand the trauma-informed providers for Kentuckians.

Priority #4—Helping enrollees manage obesity and diabetes: The rates of obesity continue to climb within our state despite many multi-pronged efforts to address the risk factors that contribute to the disease. Kentucky ranks 46th nationally with 36.6 percent of adults with a body mass index of 30.0 or higher.[11] Inequities exist within the Commonwealth with rural areas in the eastern region experience risk factors that promote obesity such as food deserts, lack of transportation, and lower rates of education. Obesity is a precursor for the development of type 2 diabetes. One in three adults in Kentucky has pre-diabetes and most are not aware of this risk. It is possible to reduce the risk of developing type 2 diabetes by over 50 percent with modest weight loss and increased physical activity. Our enrollees who are at risk of developing type 2 diabetes need intensive support to address the social and clinical elements of delaying or avoiding the condition.

Figure C.24-8: ECHO's Safe Zone for Kids
The Jefferson County Courthouse Safe Zone in Region 3 provides a place for children.

Our plan has developed and deployed an intervention called HealthRunsDEEP, which is modeled after the Diabetes Prevention Program but refined to meet the unique needs of our population. Elements of this program that are tailored to our enrollees' needs in Kentucky include the following:

- Partnership with local pharmacies to identify, recruit, and retain participants
- In-person sessions held onsite at a local housing authority complex
- Inclusion of mobile grocery store which was developed to combat food deserts in Bowling Green

[11] United Health Foundation, "America's Health Rankings: Kentucky: 2019 Annual Report," (2019): https://www.americashealthrankings.org/explore/annual/measure/Overall/state/KY; accessed January 15, 2020

- Remote patient monitoring to track blood glucose and frequent contact with certified diabetes educator
- Participation incentives which address SDOH, such as meal delivery service and vouchers for healthy food
- Local community garden as volunteer opportunity

In Kentucky, program goals include 5-7 percent of weight loss and 150 minutes of weekly activity, in line with Diabetes Prevention Program outcome targets. Aetna's adult BMI assessment HEDIS score is currently in the 95th percentile. In addition, our rates for counseling for nutrition and physical activity have consistently increased over the most recent three-year period.

Avēsis' Innovative Dental and Eye Care for Enrollees with Diabetes

Avēsis' Oral and Ocular Care Coordination program helps prevent the development of ocular and dental complications for enrollees with diabetes through the following:

Screening: O2C2 engages eye care providers in screening enrollees for diabetes through by increasing the rates of annual diabetic retinopathy exam, which screens for the onset of diabetes through identification of vision-related complications of the disease. For those enrollees who may not see an eye care provider but do visit a dentist, O2C2 promotes screening for diabetes through a simple HbA1c test administered in the dental office. If an enrollee is identified as having diabetes in either setting, the data is shared through Aetna with the enrollee's primary care provider. Enrollees who are already identified as having diabetes may also participate in O2C2.

Care coordination: Avēsis makes sure enrollees identified as having diabetes have a regular source of both dental and eye care by matching them with qualified, network providers. They will also support the execution of data-driven outreach to ensure enrollees with diabetes are receiving 1) their annual diabetic retinopathy exam to screen for ocular complications and 2) diagnostic, and if relevant, therapeutic care to prevent the onset of oral complications. Using advanced analytics and data sharing, Avēsis will work with us to continuously monitor enrollees' health and program operations to ensure we are improving overall health outcomes for our enrollees with diabetes.

Priority #5—Smoking cessation: With the smoking rate in Kentucky at 24.6 percent, which ranks 48th in the nation,[12] Aetna dedicates many of its efforts and resources to smoking cessation and education. To inform enrollees, Aetna relies on text messages, enrollee newsletter articles and Active Health, an easily accessible archive of health and wellness videos to promote quitting. Aetna's 'QUIT NOW' hotline also provides education on benefits to quitting smoking, as well as informs enrollees of availability of nicotine replacement patches, gum, and medication with prescription from PCP.

As part of Aetna's smoking cessation initiatives, Aetna participated in a CMS Tobacco Cessation Affinity Group in 2016 with other MCOs and the Department in efforts to learn about the best

CVS and Aetna are Committed to Smoking Cessation

In 2019, CVS Health supported educational programs to create and distribute educational materials for middle and high school students on the risks of e-cigarette use. A $100,000 grant was given to the Society of Health and Physical Educators to help distribute educational games from the Yale Center for Health and Learning to schools across the country.

The CVS Health Foundation also granted $600,000 to support the American Academy of Family Physicians Foundation to support its efforts to address the rising emergence of Electronic Nicotine Delivery Systems. Additionally, the Aetna Foundation worked to enhance education and training for children's health care professionals.

[12] United Health Foundation, "America's Health Rankings: Kentucky Summary 2018": https://www.americashealthrankings.org/explore/annual/state/KY; accessed June 1, 2019

practices for tobacco cessation. Since 2016, Aetna has also partnered with different advocacy groups such as the Foundation for Health Kentucky in which the outcome was $.50 increase in tax on cigarettes. Additionally, the Adolescent Screening/Counseling HEDIS measure for Tobacco Screening and/or Counseling has seen a major improvement since Aetna's first HEDIS project. Between 2013 and 2019 the HEDIS score for Adolescent Screening/Counseling increased from 36.4 percent to 75.0 percent, an increase of 106 percent.

Smoking is among the most prevalent, modifiable causes of adverse pregnancy outcomes. Kentucky Medicaid enrollees who smoke are 27 percent more likely to deliver preterm and 39 percent more likely to have adverse perinatal outcomes (placental abruption, placenta previa, small-for-gestational age, stillbirth, or preterm delivery[13]). Aetna is partnering with the University of Pennsylvania (UPenn) to pilot a program called Quit Incentives & Tailored Support (QUITS) to test a sustainable incentives-based tobacco cessation program for pregnant enrollees of Kentucky Medicaid. The goal of this program is to develop a best-in-country strategy to reduce smoking during pregnancy. Financial incentives have been proven to aid in smoking cessation among pregnant women, but logistics have prevented this approach from being utilized. Aetna selected a provider in rural Appalachian area to specifically focus on women in that region where smoking rates are much higher than the average in the Commonwealth.

Priority #6—Improving health access in Kentucky: Health access remains a top priority for Aetna and we strive to provide robust access through a full network of providers throughout the Commonwealth. Incorporation of telehealth particularly for enrollees with behavioral health needs will further promote our mission of increasing access, service efficiency, and effectiveness.

We provide enrollees face-to-face practitioner encounters via access to real-time interactive audio and video technology. Enrollees will be able to access their PCP or specialty telehealth provider from their home or specified secure location. The service has proven to improve provider ease of access and decrease avoidable ER visits and hospitalizations.

Additionally, when PCPs need support and resources to screen and treat persons with low acuity conditions, they can conduct consultations with specialists via telehealth. Consultations may occur face-to-face via technology or via 'store and forward' asynchronous technologies as the standard practice or care or where images are sent to a specialist for evaluation. Consultation services assist with diagnosis and medication management and provide recommendations for ongoing treatment. This improves the integration of behavioral health services in primary care, increases care coordination, and decreases avoidable use of emergency room services.

Data reporting by our providers is critical to identifying public health trends. We are committed to partnering with the Commonwealth to promote connectivity to the KHIE within our provider community to improve health surveillance efforts. We have demonstrated our commitment to the revamped KHIE which will serve to enhance our ability to target interventions based on regional need using robust data sources. See more in **The Kentucky Health Information Exchange** section.

We also understand the importance of collaborating with local health departments to provide updates where connectivity is limited.

Access to preventive services is improving for our VBP providers. Trends show improvement with our VBP provider partners in several areas including breast cancer and cervical cancer screenings in the most

[13] National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health, "The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General." (2014): https://www.ncbi.nlm.nih.gov/books/NBK294307/; accessed June 1, 2019

recent three-year period. This is due in part to our enhanced gaps in care reporting distributed monthly in user-friendly reports. PCPs can easily identify improvement opportunities and engage in quality improvement strategies based on the data in the reports. The gaps in care report compares an individual practitioner's performance to practitioner group performance and overall health plan network performance, as well as NCQA benchmarks on the included set of HEDIS measures. Practitioner feedback on the utilization of GIC reports has been positive since the tool was launched in the fourth quarter of calendar year 2015. Aetna continues to refine the tool to be more user-friendly with interactive formats accessible on both computers and mobile devices.

Recovery and access to recovery resources is the first step to becoming independent from drugs. To aid in this effort, **Aetna contributed $150,000 to Volunteers of America Mid-States** in support of its new Freedom House program in Southeastern Kentucky. Freedom House provides state-of-the-art and nationally recognized addiction recovery treatment and care to pregnant and parenting mothers working to overcome substance use disorder. On February 11, Volunteers of America is scheduled to open a new 16-bed facility located in Clay County, marking the first program of its kind in the region. **Figure C.24-9** is a photo of the check presentation from Aetna to the Volunteers of America Mid-States.

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Figure C.24-9: Check Presentation to the Volunteers of America Mid-states

Aetna CEO Jonathan Copley joins Jennifer Hancock, president and chief executive officer of Volunteers of America Mid-States, and Governor Andy Beshear to open the Recovery Community Center and Freedom House program in Clay County. This program brings greatly needed addiction recovery services to the people of southeastern Kentucky.

Access and dental care is a key for our enrollees and especially critical for pregnant women. Several studies have shown a link between periodontal disease in pregnant women and preterm or low birthweight deliveries. Children who are born early or who have low birth weight are at higher risk for long-term health problems. To combat these complications for our pregnant enrollees, we provide enhanced services through the Avēsis Dental Delivery™ program. This program offers incentives for prenatal dental screenings which allow for close monitoring of periodontal disease and its complications. Each Dental Delivery program participant receives a baby book, infant oral health hygiene kit, and a special Dental Delivery diaper bag after the birth of her baby. This program increases utilization of dental services and reduces preterm or low birthweight deliveries.

a.iv.j. Staffing for Each Risk Level

In addition to matching enrollees' care needs to the care manager with the most relevant experience, appropriate staffing ratios are essential to a balanced and successful PHM program. The staffing ratio tool we use to develop caseloads is based on workload studies that consider time elements, such as how long it takes to schedule and complete an assessment, call an enrollee, or drive to an enrollee's home, as well as time for case rounds with the medical director, community-based service collaboration, interdisciplinary care team meetings, personal development enrichment, training, supervision, and documentation. When we approach the caseload maximum thresholds, our leadership team conducts a staffing review. Based on the results of this review, we submit a requisition to hire additional care managers or reallocate resources, without exceeding the maximum target ratios, described in **Table C.24-7**, in a manner that enables us to provide enrollees the services they need.

Table C.24-7: Staff to Enrollee Ratios by Care Management Program and Subpopulation

Level of Care Management	Care Manager to Enrollee Ratio
Health Promotion and Wellness	1:400
Chronic Condition Management	1:125
Complex Care Management	1:41

The Population Health Management department is led by the director of population health management and operates in collaboration with the chief medical officer. Population Health staff report to a supervisor or manager, who in turn reports to a director. The number of supervisors and managers depends on the size and complexity of the health plan population as well as any Commonwealth-mandated requirements (e.g., ratios). Care manager caseloads align with their education, licensure, experience, and expertise. In addition, caseloads vary by service level for complexity of enrollee needs and frequency and mode of the interactions with the enrollee and their care team. If care managers carry a mixed caseload, a case weight is applied to ensure they have the appropriate capacity to meet the needs of their enrollees. All directors, managers, supervisors, and staff have an intimate knowledge with their service areas and resources available within each region. The population health team is comprised of several departments which interface regularly, including Quality Management, Care Management, Utilization Management, and Community Outreach.

Population Health Management staff are described in **Table C.24-8**:

Table C.24-8: Aetna Staffing Resources to Support Population Health

Staffing Resources	Role and How They Interface with Enrollees
Director of Population Health (1 FTE) (MPH, RD)	The director is responsible for coordination and oversight of the Population Health Management Program and services. This unique position studies the behavior and needs of our enrollees and strategizes with providers and CBOs to improve population outcomes based on these findings.
Chief Medical Officer (1 FTE) (MD, PharmD, MBA)	The medical director physician oversees the health plan's clinical functions and is actively involved in all major health programs of the health plan. This position is responsible for treatment policies, protocols, quality improvement activities, population health management activities, and utilization management decisions.
Director of Quality (1 FTE) (RN)	The director is responsible for driving results which ultimately improve health outcomes. This position encourages interdepartmental collaboration and fosters provider partnerships in advancing our efforts in quality improvement.
Director of Care Management and Behavioral Health (1 FTE) (MD)	The director of care management and behavioral health integrates both physical and behavioral health initiatives for our enrollees with complex and chronic disease. This dynamic role was created to align our care management team with a focus on integrating PH and BH for to address whole-person care.

Staffing Resources	Role and How They Interface with Enrollees
Director of SDOH (1 FTE) (PhD)	The director drives SDOH (including but not limited to food insecurity, housing, physical safety, and transportation), health equity, and outreach innovation and education activities at the health plan.
Director of Utilization Management (1 FTE) (RN)	This position is responsible for the operation of the health plan's UM program and any subcontractors performing services relevant to UM. They drive referrals into care management by ensuring staff are well-versed in population health priorities and care management service tiers. They engage our highest risk enrollees to prevent costly readmissions.
Care Management Managers (2 FTEs) (RNs)	These managers provide oversight for the care management team to assist with clinical decision making and direction for staff. They coordinate interdisciplinary rounds to address high risk situation and to ensure ongoing education of all care managers.
Care Managers (41 FTEs) (RNs, LCSWs)	Care managers serve as primary points of contact to their assigned enrollees. These licensed staff lead the collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's comprehensive health needs. Care managers interface with their enrollees via in-person visits, telephonic, email, and text based on enrollee preference.
Care Management Associates (10 FTEs)	This role is integral to ensuring enrollee engagement. The CMA team assists enrollees and the care management team with non-clinical activities such as HRA completion and screening for higher levels of care management need.
Clinical Pharmacist (1 FTE) (PharmD)	This role provides strategic direction for program goals with an emphasis on pharmacological impact on population health initiatives. The clinical pharmacist conducts enrollee outreach for medication reconciliation and provides education in line with our population health priorities.
Prevention and Wellness Coordinator (1 FTE) (MPH)	This position focuses on educating enrollees on preventive care. The areas of focus for preventive care include cancer screenings, well childcare, diabetes prevention, smoking cessation, and nutrition/healthy weight. This role directly interfaces with enrollees through in-person education.
Community Development Representatives (8 FTEs)	This position offers ongoing evidence-based and internally developed education courses throughout the community which improves the quality and promotes healthy living for all enrollees. Education courses include topics such as slow cooking nutrition, diabetes self-management and resiliency and focus on addressing SDOH.
Community Health Workers (4 FTEs)	The CHW will engage with the enrollee with Unite Us via telephonic outreach to complete referral for social risks identified. Enrollees that are identified to have social risks not requiring care management intervention are warm transferred to a CHW located in the community where the enrollee resides to obtain social service support including food banks, transportation vendors, and education organizations.
Systems of Care Administrators (6 FTEs)	Roles include system of care administrators for children, recovery and resiliency, emergency department/crisis, juvenile justice, trauma, and adult. These positions build key stakeholder relationships within their respective specialty to ensure all service needs, including community-based supports are available. They work in tandem with our care managers to service enrollee needs.
Quality Improvement Manager (1 FTE) (MS)	The quality improvement manager role is critical in studying our enrollee behavior, population demographics, and seeking community partnerships. These partnerships work to create resources for our enrollees and drive efforts in research for health outcomes.
HEDIS Manager (1 FTE) (RN)	The HEDIS manager is responsible for driving outcomes related to NCQA measures, Healthy Kentucky measures, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) initiatives. The manager coordinates campaigns to address enrollee behavior and gaps in care.

Staffing Resources	Role and How They Interface with Enrollees
QM Nurse Consultants (4 FTEs) (RN)	The QM nurse consultants support all quality activities and include quality of care outcomes, trends in utilization, provider education, HEDIS record review, and enrollee engagement and education.
HEDIS Outreach Consultants (7 FTEs)	The outreach coordinators support HEDIS outreach to enrollees for identified gaps in care. Additionally, they support and work on campaigns that align with our population health priorities and provider initiatives.

a.iv.k. VBP Model to Support the PHM Program

Aetna has an established VBP program in Kentucky, currently with 38 percent of our provider network impacting 43 percent of our enrollees. Aetna collaborates with high-volume providers to develop, promote, and implement targeted, evidence-based interventions for subpopulations experiencing health disparities and link payment to outcomes. We deploy staff members and population health specialists (PHSs) to work directly with providers to educate them on the adoption and use of our population health management platform and with the design and analysis of clinical workflows. Specifically, PHSs support our VBP providers to collect and understand population health data of their enrollees, with the aim of closing gaps in care and improving HEDIS measures on targeted outcomes. We are determining the feasibility of deploying a Pay-for-Reporting program to incentivize providers to collect social determinant data for enrollees using Z-codes. Our PHSs have access to a comprehensive suite of technology to support our providers. This includes access to Unite Us and Aunt Bertha, our repositories for social needs, telehealth, and remote patient monitoring technology.

Our population health team provides VBP providers with the following to support out population health management goals: monthly HEDIS dashboard of core metrics, practice core metrics, and care gaps with enrollee information for follow-up; and provider care gap reports identifying enrollees on their panel in need of a health screen/test. These reports can be filtered by the provider to examine their performance by provider, by location, and for each enrollee.

Incentive payments are tied to HEDIS measures associated with our PHM programs. Aetna has increased the number of providers engaged in VBP arrangements over the past several years and will continue to advance our contracted providers along VBP continuum. Aetna currently complies with Commonwealth value-based services (VBS) requirements and will continue to comply with these requirements as specified in the RFP. From 2016 to 2020, Aetna has increased our VBP shared savings contracts in Kentucky from three to nine. Our current providers with a VBP shared savings arrangement include the following: Kentucky Primary Care Association (KPCA); Big Sandy Health Care, Inc.; St. Elizabeth Healthcare; Association of Primary Care Physicians; The Physicians' Network; Norton Healthcare; KentuckyOne Health Partners; Baptist Health Louisville; and Children's Alliance (Behavioral Health).

For these providers, **Table C.24-9** demonstrates that for HEDIS 2018 measures incorporated in VBP contract agreements, the aggregated score for all VBS providers exceeded that for non-VBS providers for all measures.

Table C.24-9: 2019 HEDIS Scores by Status

Measure	VBS Rate	Non VBS Rate	Percent Difference (VBS over Non-VBS)
AWC—Adolescent Well Care	47.25%	40.03%	18.04%
BCS—Breast Cancer Screening	50.40%	46.49%	8.41%
CCS—Cervical Cancer	57.16%	47.73%	19.76%
CDC Eye Exam—Diabetes Eye Exam	46.42%	39.36%	17.94%
CHL Chlamydia Total—Chlamydia Screening	54.39%	51.47%	5.67%
CIS Combo 10—Combo 10 Immunizations	24.63%	15.83%	55.59%
W15—Well Child 15 Months	59.26%	55.99%	5.84%
CDC Testing—HbA1c Testing	87.11%	82.87%	5.11%

a.iv.l. Evaluating Success of Services Provided

Aetna uses a wide range of process and impact measures to evaluate the success of the PHM services we provide our enrollees. We strive to use SMART criteria to make sure the goals we establish are meaningful to our understanding of how well are serving our enrollees through PHM. The goals of our PHM program for services provided to all enrollees, and the methods we use to evaluate the degree to which they are successful are presented in **Table C.24-10**:

Table C.24-10: General PHM Program Goals and Outcomes

PHM Program Goals	Outcomes
Goal I: Aetna evaluates its populations to define health service needs and ensure health care is available, accessible, and appropriate	• Populations are evaluated as follows: – Enrollee profile (population assessment) conducted per process described in PHM Strategy Framework – Evaluation of processes and resources as evidenced by care management program – Evaluation report and related discussion found in QA/PI Committee minutes
Goal II: Enrollees are identified for ICM and aligned with the appropriate level of care determined by their individual needs	• Using established criteria, evaluate monthly and quarterly reports: – Percent enrollees reached for enrollment in care management (CM) – Percent of enrollees enrolled in CM programs – Percent of enrollees enrolled in CM who are also engaged (Target: >85 percent) – Percent of enrollees enrolled in complex care management identified with a chronic condition who receive condition specific assessments (Target: 75 percent) – Percent of enrollees receiving timely initial assessments – Percent of enrollees receiving timely annual reassessments (Target: 100 percent)
Goal III: Enrollees access a continuum of services and supports based on the intensity and complexity of their needs and utilize those services in an efficient and effective manner	• Decrease avoidable ER utilization by 2 percent annually: – ER utilization per thousand (monthly review) – Increase use of specialty care and services targeted to specific enrollee needs – Specialist visits per thousand (monthly review) • Evaluate monthly: – Hospital admissions per 1000 transition of care between inpatient and home settings are coordinated and free of avoidable adverse outcomes – Percent enrollees discharged from acute inpatient facility to home or community-based setting who receive post discharge questionnaire screening – Hospital readmissions within 30 days per 1000 for enrollees enrolled in care – Hospital readmissions within 30 days with PCP visit within 7 days of initial discharge – Hospital readmission within 30 days with PCP visit within 8-14 days of initial discharge

PHM Program Goals	Outcomes
Goal IV: Care plan interventions are timely with performance goals that support enrollees receiving care in the most integrated, least restrictive, and cost-effective setting while encouraging optimal functioning and acknowledging personal preferences	• File audits conducted on a statistically valid volume of enrollee files, including at least three files per care manager quarterly per Staff Quality Review policy (Target: CM supervisors complete prescribed number of file audits per staff person) • Conduct quarterly file audits using an approved audit tool that evaluates the documentation of all essential CM activities (Target: >85 Percent of staff scoring 90 percent or more on file audits)
Goal V: ICM promotes and facilitates behavioral changes that supports self-management and improved health outcomes	• Enrollees receive education and information about their conditions, medications, available services and resources, and/or options that will help them to achieve their identified plan of care goals (Target: 100 percent enrollees enrolled in ICM receive education and/or materials) • Evaluate enrollees' perception of their quality of life measured through the use of the pre/post SF10 and/or SF12 questionnaire within 90 days of enrollees' enrollment in ICM and at least annually thereafter (Target: 90 percent of enrollees receive evaluation)
Goal VI: Social, educational, environmental, racial and ethnic disparities in health care are identified and reduced through care coordination, collaboration, and network management	• Complete evaluation of monthly gaps in care and interim HEDIS data at least quarterly • Meet or exceed targeted HEDIS benchmarks for enrollees engaged in ICM • Facilitate and support integrative clinical programs and HEDIS-based initiatives that address cultural and disability-competent linguistic needs of Aetna enrollees (Target: 1 program per year) • Participate in initiatives to address racial and ethnic disparities in health care
Goal VII: Enrollees receive interventions that promote health literacy	• Create and distribute pre-printed enrollee facing information meet 'easily readable' criteria (Target: 100 percent enrollee-facing pre-printed materials at or below 6th grade reading level)
Goal VIII: Collaboration and coordination is promoted to integrate enrollee health information across all departments	• Determine effectiveness in the following areas (evidenced by the annual evaluation of care management program and the quality management/utilization management annual evaluation): HEDIS gaps in care; health appraisals; health care equity findings; SDOH data; Health Information line; and interdisciplinary case rounds
Goal IX: Enrollees experience improvement with health care delivery	• Percent of grievances related to non-long-term services and supports care management activities (Goal: 2 percent improvement per year) • Percent positive responses (response ratings of 4 or 5) to the satisfaction with CM services to the following questions: - "I am happy with the care management services I've received." (Target: 90 percent) - "My care manager helped me get all of the services that I needed." (Target: 90 percent)
Goal X: Promote health and wellness through the use of preventive and routine care and services	• Written enrollee information/education on the value of preventive and care aimed at promoting health and wellness are provided to enrollees through culturally aligned quarterly enrollee newsletter articles at least quarterly (Target: 100 percent) • Care plans include documented promotion of health and wellness related activities as evidenced in file reviews and visits (as part of treatment goals) (Target: 75 percent) • Improved use of preventive measures such as well woman, well man, EPSDT, and immunizations

For enrollees in chronic condition management, specific goals and methods of measurement are described in **Table C.24-11**.

Table C.24-11: PHM Program Goals and Outcomes for Management of Chronic Conditions

PHM Program Goals	Chronic Condition Management Outcomes
Goal I: Staff will promote enrollee participation in chronic condition management programs.	• Percent of enrollees with identified chronic conditions who participate in at least one chronic condition management program specific to the enrollees' condition
Goal II: Enrollees will demonstrate improvement in their ability to self-manage their identified condition.	• Evidence of distribution of culturally aligned chronic condition management related information to all identified enrollees (Target: Materials sent to 100 percent of identified enrollees) • Percent of enrollees engaged in care management with identified chronic conditions that receive active care management for their specific condition within a given year

a.iv.m. Methods for Communicating and Coordinating with PCPs and Other Providers

Method #1—Involving providers in care planning process: We include providers in case conferences that are used to coordinate care plans. Care plans are posted on our enrollee and provider portals and providers are assigned interventions in the care plan. Our Care Management team frequently calls, emails, and faxes providers to advocate for the needs of our enrollees. We also will send the ENA to providers who are involved in the enrollee directed care plan. Providers receive updated care plans any time there is a change.

> "KentuckyOne Health and CHI Saint Joseph Health would like to extend full support for Aetna Better Health of Kentucky's bid to remain in the Kentucky Medicaid Managed Care program. Aetna Better Health works collaboratively with our providers to ensure our patients, their enrollees, have access to and receive quality health care services. Our value-based arrangement aligns our organizations around improving the health of the communities we both serve. We are excited to continue this partnership and recommends that the State keep Aetna Better Health as one of their managed care organizations."
>
> **—Lynn Tanner, Vice President of Payer Strategy, KentuckyOne Health**

Method #2—Care collaborations for VBP: Our Population Health Specialist team participates in care collaboration meetings with individual VBP partners to address enrollees with complex needs as identified through our population health management platform. Care collaborations have defined workflows for managing high and emerging risk enrollees through frequent touch points and utilization review. Aetna population health specialists in our Michigan market saw a 24.7 percent reduction in ER visits and 16.1 percent reduction in inpatient admissions nine months post-collaboration for enrollees whose care was coordinated through close partnership between Aetna and provider.

Method #3—JOC meetings: We hold monthly JOCs with our major subcontractors to ensure effective, ongoing communication, including the following:

- Avēsis: provides dental and vision services, as well as the innovative program O2C2 to screen pre-diabetics and connect them with a PCP
- Bluegrass Care Navigator℠: provides physical health and behavioral health discharge planning
- Eviti: provides cancer care planning and UM best practices
- Pursuant Health: provides enrollee communications and innovations, including kiosks, text messaging, gift cards, and geo-fencing for targeted messaging
- Eliza: HRA process
- Kentucky Primary Care Association: provides delegated care management proof-of-concept for third quarter 2019 implementation

We have strategy meetings with KPCA, St. Elizabeth, and KentuckyOne to identify and collaborate on a quality strategy, discuss trends and performance, and work through GIC reports to drill down on enrollee behavior and closing gaps. We seek innovative solutions with our partners; specifically, with KPCA we

are pursuing a delegated care management arrangement to have a direct enrollee impact on their care. KPCA also works with us on NCQA and strategies to impact the provider network data accuracy. We are collaborating with KentuckyOne on our electronic population health management platform to create efficient communication between our Care Management teams (Aetna and KHP) as well as providing GIC reporting through our electronic population health management platform. Through our close collaboration, all our value-based payment (VBP) provider partners have shown improvement on their VBP rates.

Method #4—Bluegrass Care Navigators (BCN): Aetna collaborates with Bluegrass Care Navigators to provide continuity of care and integrated, person-centered discharge planning for enrollees following an admission to an inpatient hospital, including behavioral health. BCN meets enrollees face-to-face after discharge to connect our enrollees to the services and supports indicated in their discharge plan that will help prevent emergency department usage and re-admissions. Close coordination with BCN and our care managers ensures our enrollees are fully supported and barriers addressed. We have regularly scheduled meetings with BCN to review enrollees and to identify any potential needs the enrollee may have that would make it difficult for the enrollee to adhere to discharge plans after they have completed the transition support program with BCN. This allows a seamless transition to an Aetna care manager for continued support and assistance.

Method #5—Community Pharmacy Enhanced Services Network: Aetna developed a pharmacy-specific strategy to reduce access disparities. Aetna offers support to enrollees through the CPESN comprised of community-based pharmacies that develop relationships with enrollees and support medication management, social services needs identification, and care management. Aetna's Pharmacy team has direct vendor oversight, acts as a liaison between the community pharmacy and Aetna ICM teams, and supports identification of enrollees for referral. The program focuses on identifying enrollees at risk for adverse medication and health outcomes due to non-adherence and gaps in care, and actions are implemented to create a care plan that is shared with the enrollee's care team. CPESN pharmacists support enrollees to manage chronic conditions. In North Carolina, which has a significant rural population, CPESN pharmacies increased medication adherence rates by 4 to 5 percent over a 3-year period compared to non-CPESN pharmacies. Specifically, CPESN pharmacies saw a 5.8 percent increase in adherence to diabetes medications. Pharmacies in the CPESN network identify enrollees at high risk of opioid misuse and provide enrollee-specific education about their individual risk factors, dispense naloxone, and provide education to the enrollee or caregiver(s) about how to administer medications.

a.iv.n. Kentucky Health Information Exchange

Aetna believes in the power of comprehensive data sharing within the provider community to allow for better quality and cost outcomes of our enrollees. Our population health management strategy includes access to comprehensive enrollee records to provide high-quality care timely. Aetna fully supports the new KHIE platform launching this fall and is honored to be co-sponsoring the Kentucky eHealth "Renovate to Innovate" summit in August. As part of our population health strategy, we will connect our population health management system to KHIE and will encourage our providers to connect and share records (public health and ADT at a minimum) to improve joint care coordination, disease management and wellness and prevention efforts.

Aetna connection to KHIE: We will leverage EHR data through KHIE when connected to our **highly innovative population health management technology solution,** a dynamic, web-based software application that creates a single place to view enrollee care information and connect the entire care community around an individual enrollee or group of assigned enrollees. Our population health platform is both an internal tool for our population health management program and care managers as well as a provider-facing solution that will interface with our primary care, hospital, and community service partners. The system aggregates actionable data in one place across systems and organizations with the

purpose to promote effective and efficient care coordination, virtually bringing together all individuals on an enrollee's care team. The strength of this system rests in the ability to timely expose a variety of actionable clinical data and other critical pieces of the care record including: **electronic service plans, care plans, visit notes, clinical/life event notifications, behavioral health, quality reports, HEDIS gaps in care, pharmacy, total cost of care, and social determinants.**

Our electronic population health management platform provides an enriched data source that will empower providers to be more proactive with access to a complete profile of enrollees with greater visibility into the entire complexity of each enrollee. This information will provide valuable insights and increase opportunities to tailor care individually while also promoting well-coordinated handoffs that reduce duplication of services and improve the care experience.

Promotion of KHIE and EHR with provider partners: Aetna commits to leading an initiative among Kentucky MCOs to coordinate incentive payments to providers for adoption of EHR technology and connectivity to KHIE. This will allow us to **build upon successful initiatives such as the KHIE opioid overdose project.** Aetna is ready and willing to partner with the Department, our provider community, the Department of Public Health, and other MCOs to leverage the full functionality of the enhanced KHIE system to address the serious health concerns that our enrollees face in Kentucky. We welcome representation from KHIE at our upcoming provider forums and our advisory councils to continue joint efforts to expand EHR adoption and KHIE connectivity throughout the Commonwealth.

Aetna will actively encourage providers to adopt EHR and will require connectivity to HIE within the first 30 days of contract execution. We have a targeted strategy to identify and educate providers who are not currently connected to KHIE. Our training strategy includes the elements described in **Table C.24-12**:

Table C.24-12: Provider KHIE Training

Provider Training—Encouraging Connection to KHIE will include the following components:
Promoting enrollee benefits that result with near real-time access to data across settings and facilities including education on how to take action on admission, discharge, and transfer data
Provider efficiencies that result from access to data KHIE, including expedited testing results, decrease in duplicative services, and more comprehensive enrollee records
Best practices from our experience facilitating KHIE utilization with high-volume/high-performing providers
User access setup and training provided by our Population Health Specialist team on use of Aetna's population health management system for managing enrollee care and accessing enrollee records through our system
Education on importance of KHIE connectivity for public health surveillance initiatives and improving health outcomes in the Commonwealth of Kentucky
Orientation to data sharing solutions, including our suite of remote patient monitoring tools
Value of full connectivity with KHIE beyond minimum standards of public health reporting for providers and ADT and public health reporting for hospitals
Connecting providers to a regional KHIE outreach coordinator to help act as an advisor for support on technology innovations, performance improvement possibilities, and health care transformation
New providers will have training as part of their provider onboarding; evaluation and verification of connectivity will occur during initial onsite visit

a.v. Coordination with Other Authorized Providers

Aetna is responsible for the coordination and continuity of care of health care services for all enrollees consistent with 42 C.F.R. §438.208. We coordinate services with traditional and non-traditional providers and across all funding sources with a focus on eliminating duplication of services, improving continuity of care, and facilitating the coordination of benefits. We coordinate with the Department for Behavioral Health, Developmental and Intellectual Disabilities for the behavioral health needs enrollees with

developmental and intellectual disabilities. For example, Aetna care managers work together through the multidisciplinary care team process to create a single individualized plan of care. Aetna defers to the other organization's care manager and sets in place wraparound supports to enhance the care plan. We confirm the enrollee has a single point of contact to decrease confusion and enhance continuity of care. In addition, we make sure to do the following:

- Train Aetna care managers on the unique needs and services of Kentucky enrollees
- Deploy population health specialists to assist organizations in preventing duplication of efforts
- Engage in formal council meetings, as invited, to facilitate ongoing coordination

Aetna also coordinates care for enrollees receiving services from other Commonwealth agencies or organizations. For example, we refer potentially eligible enrollees to Women, Infants, and Children and to the Supplemental Nutrition Assistance Program. We provide medical information where permitted by applicable law to assist in qualification for additional benefits. Aetna Care Management and Enrollee Services staff educate enrollees about programs for which they may be eligible, such as the following:

- Head Start
- Family Resource and Youth Services Centers
- Kentucky Low Income Home Energy Assistance Program
- Kentucky Transportation Assistance Program

Aetna refers enrollees into the Health Access Nurturing Development Services (HANDS) program a home visitation program for new or expecting parents that reside in Kentucky. The focus is to support families building a healthy and safe environment for the proper growth and development of their children. Nurses visit enrollees in their homes to support, educate, and coordinate community supports for the family. In partnership with the HANDS program, Aetna offered enrollee appreciation baby showers during open enrollment. A total of 29 events were held throughout the Commonwealth over the past two years.

We do not duplicate services; instead, we coordinate benefits and provide medically necessary wraparound supports. Agencies we regularly coordinate with include the following: Adult Protective Services; Area Agencies on Aging/Aging and Disability Resource Centers; accredited training agencies; advocacy groups; the Department of Guardianship Services; county and/or Commonwealth-based emergency preparedness groups; the Department of Health Services; the Department of Child Protection Services; the Department of Health Facilities, Evaluation, and Licensing; local law enforcement; ombudsman; providers, including non-traditional providers and community-based agencies; and public guardians.

Aetna is actively expanding the reach of the Metro United Way network through our partnership with Unite Us, our closed loop referral solution for addressing enrollees' social needs. Through this approach, Aetna enrollees have access to all programs and providers in the United Way network.

a.vi. Ongoing Review of the PHM Program

The evaluation of the PHM program requires a multidimensional approach to continuous quality and process improvement. Aetna conducts an annual quantitative analysis of our population health strategy using relevant clinical, cost, utilization, and enrollee experience measures. The analysis evaluates the impact of the programs implemented by Aetna on outcomes for enrollees who were stratified and segmented for receipt of targeted interventions.

Measuring effectiveness of the population health strategy requires an intricate approach inclusive of identification of evidence-based clinical process and outcome measurements, utilization trends and/or associated costs, and overall enrollee satisfaction with the programs being offered. Each selected

evaluation component addresses the target population's ongoing needs as identified in Aetna's population assessment and program objectives.

Aetna selects the most appropriate, meaningful, and impactful measures for each initiative in the PHM program to ensure that ongoing program development can be implemented in an efficient and effective manner while keeping enrollees at the center.

Aetna uses evidence-based process and outcome measures to evaluate the clinical components of the programs offered. Measures are selected to align with the objectives of the programs for the target population and include but are not limited to NCQA's HEDIS performance datasets and SF12® outcome surveys. Aetna also evaluates program-specific utilization trends and/or associated costs that are relevant to the objectives of each program.

Aetna understands that data aggregation and visualization are key to understanding population health trends affecting the enrollees we serve and the broader population of the Commonwealth. We use near real-time dashboards (please refer to **Figure C.24-10**) to summarize, in an easy-to-use manner, data about health care utilization (e.g., ER use, opioid prescribing, etc.), the demographic characteristics of our enrollees, and trends in the SDOH of our enrollees. We use these reporting capabilities to track and trend data about our enrollees that inform our ongoing review of our PHM program. We leverage the advanced data visualization capability of Tableau to provide a more interactive, user-driven self-serve experience in accessing and analyzing data.

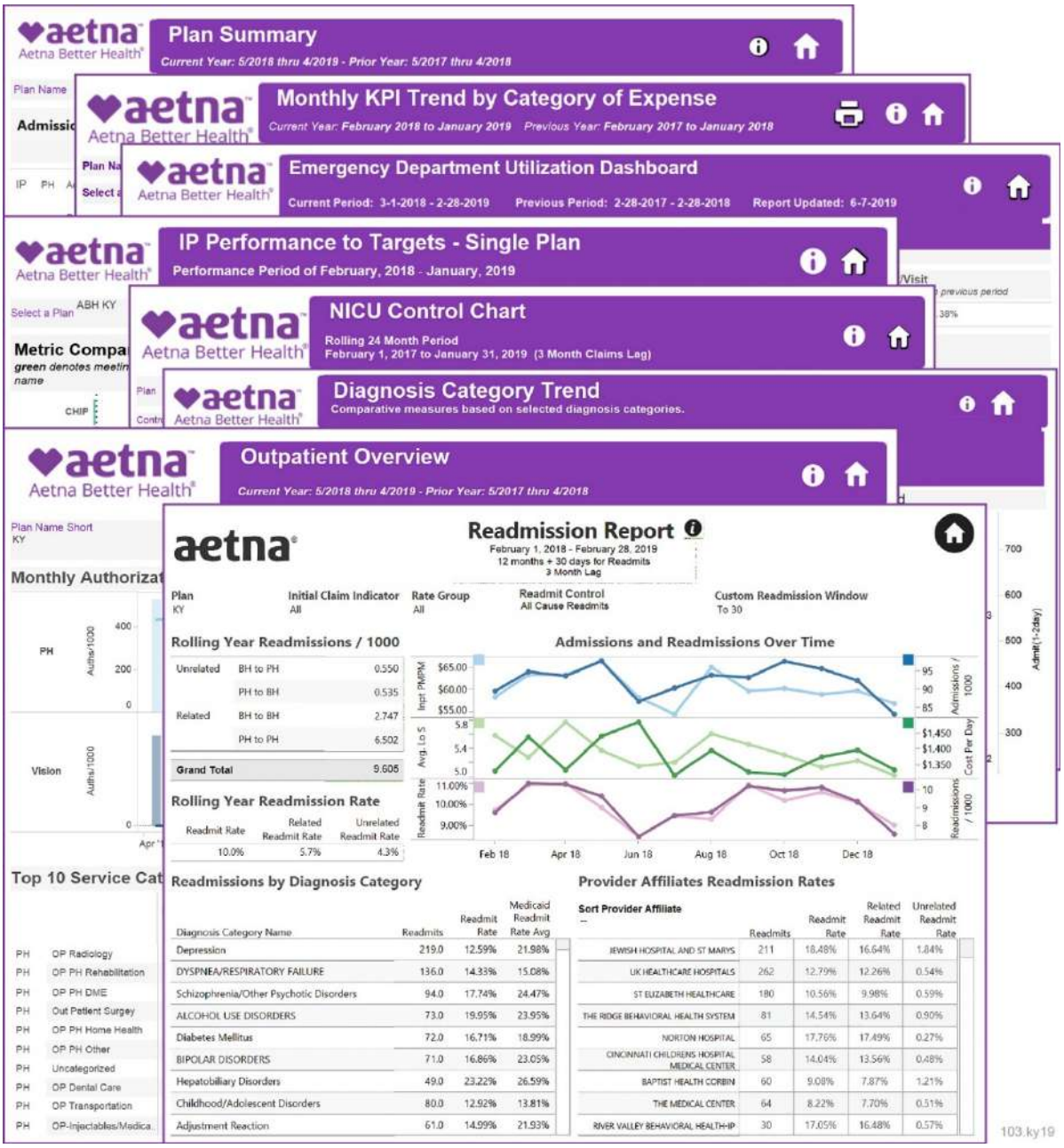

Figure C.24-10: Aetna Data Aggregation and Visualization Dashboards

Aetna has extensive data aggregation and visualization dashboard capabilities that PHM information users can process reliably and quickly.

An additional component of measuring effectiveness that will be used is to assess our performance by obtaining feedback from the enrollees through the use of focus groups or satisfaction surveys. Aetna uses enrollee experience results from its care management program and assesses the diabetes management program via the monthly Condition Management Survey. At a minimum, feedback covers the following:

- Information about the overall program
- Program staff
- Usefulness of the information disseminated

- Enrollee's ability to adhere to recommendations
- Percentage of enrollees indicating that the program helped them achieve health goals

This feedback facilitates the implementation of an effective population health management strategy that meets the characteristics and needs of the enrollee population.

Based on the results of the annual multifaceted quantitative analysis, which evaluates the ongoing programs targeting various population subsets, Aetna will complete a qualitative analysis in order to identify opportunities for improvement and develop and implement programmatic changes designed to improve performance.

60.7.C.25 Enrollees with Special Health Care Needs

Kentucky | Transforming Health Care | **Aetna**

60.7.C.25 Enrollees with Special Health Care Needs (Section 35.0 Enrollees with Special Health Care Needs)

Nationally, Aetna has over 30 years of experience delivering successful solutions to complex problems for Medicaid populations, including Individuals with Special Health Care Needs (ISHCNs), with heritage in Medicaid managed care innovation dating to 1986. We currently serve approximately 2 million Temporary Assistance for Needy Families, Children's Health Insurance Program, Supplemental Security Income (SSI), dual-eligible, and Long Term Services and Supports enrollees in Kentucky and 15 other states (Arizona, California, Florida, Illinois, Kansas, Louisiana, Maryland, Michigan, New Jersey, New York, Ohio, Pennsylvania, Texas, Virginia, and West Virginia). Through our vast local and national experience, we have learned important lessons about delivering person-centered, whole-person care for ISHCNs that both improves their holistic health outcomes and contributes to more effective and efficient delivery of care as system reforms occur. This section describes our multifaceted approach to serving ISHCNs, including: our person-centered planning principles; addressing trauma and Adverse Childhood Experiences (ACEs); integrated service delivery; our system of care; collaboration with Commonwealth agencies; value-based purchasing (VBP); and our technology-based innovations. Aetna prioritizes a robust set of national evidence-based practices (EBPs) and develops local, specialized programs to serve Kentuckians.

The Centers for Disease Control and Prevention (CDC) indicates that 29.9 percent of Kentuckians are adults with special health care needs as compared to an average of 22.5 percent for the United States.[1] According to a 2016 issue brief from the Kaiser Family Foundation, an estimated 14.2 million children, or 19 percent of all children in the United States, have special health care needs with an estimated 255,900 living in Kentucky.[2]

Annual Medicaid spending for children with special health care needs is over seven times higher than it is for children without special needs. The 2016/2017 National Survey of Children Health[3] revealed that one-quarter of these children had trouble getting a needed referral and 43.6 percent did not receive effective care coordination when needed. In 2016, the Kentucky Commission on Children with Special Health Care Needs (CCSHCN) stated that of the Commonwealth's estimated number of children with special health care needs, 70,000 receive enabling and preventive health services and 8,400 meet eligibility criteria for the CCSHCN clinics.[4]

Aetna recognizes that Individuals with Special Health Care Needs requires a whole-person approach to care which includes access and care management for regular primary care, preventive care, diagnostic care, and treatment. Our local approach is making a commitment to all enrollees. Our extended history serving ISHCN has taught us to keep enrollees at the heart of our work, focusing on individuals' holistic health needs by providing access to and delivery of cost-effective health care services. In Kentucky, for

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[1] Centers for Disease Control and Prevention, "Disability & Health U.S. State Profile Data for Kentucky (Adults 18+ years of age)": https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/kentucky.html; accessed June 1, 2019

[2] Kaiser Family Foundation, "How Do Medicaid/CHIP Children with Special Health Care Needs Differ from Those with Private Insurance?"; http://files.kff.org/attachment/Issue-Brief-How-Do-Medicaid-CHIP-Children-with-Special-Health-Care-Needs-Differ-from-Those-with-Private-Insurance; accessed June 1, 2019

[3] Data Resource Center for Child and Adolescent Health, "National Survey of Children's Health (2016 – present)": https://www.childhealthdata.org/browse/survey; accessed June 1, 2019

[4] Kentucky Rural Health Association, "Commission for Children with Special Health Care Needs Improving Access to Care in Rural Kentucky: Initiatives, Partnerships and Innovation": https://kyrha.org/resources/Documents/Karen%20Rundall,%20Judith%20Theriot,%20Ivy%20Alexander%20and%20Catharine%20Lester.pdf; Accessed June 1, 2019

more than seven years we have worked with enrollees with special health care needs. From the lessons we have learned, we understand that the needs of people with special health care needs and their families often are too diverse and extensive to be met solely by the primary care provider using standard methods of practice. Aetna embraces the principles of person-centered care for ISHCNs advocated by The Commonwealth Fund,[5] including the following:

- Individualized, ongoing, goal-oriented care planning based on the enrollees' strengths and preferences
- Whole-person care supported by an interdisciplinary care team (ICT), of which the enrollee is the central participant and an Aetna care manager serves as a single point of contact for the enrollee
- Active coordination among all physical health (PH), behavioral health (BH), functional supports, and social services providers to include continual information sharing and integrated communication
- Education and training for providers to understand the unique circumstance ISHCNs face and for enrollees to assist them to access service that meet their needs and preferences

As an organization we are committed to educating our staff and contracted providers on the principles and practices of trauma-informed care (TIC).

a. Innovative Approaches to and Evidence-based Practices for Serving Individuals with Special Health Care Needs

Aetna embraces innovation in its approaches to supporting the whole-person care needs of ISHCNs, focusing on the integration of the physical health, behavioral health, functional, and unmet social resource needs, while adopting EBPs and developing specialized programs.

Approaches to Serving Individuals with Special Health Care Needs

Our specific innovative approaches for ISHCNs in Kentucky are as follows: our person-centered planning principles; addressing trauma and ACEs; integrated service delivery; our system of care; collaboration with Commonwealth agencies; value-based purchasing (VBP); and our technology-based innovations.

Person-centered care planning principles: Our experience serving ISHCNs in Kentucky, and through our other Medicaid plans across the country, taught us about the importance of person-centered, culturally sensitive care that truly places the enrollee at the center of their care planning process. The following lessons have been learned through our experience and will be the basis of Aetna's integrated, and trauma-informed approach:

- We acknowledge and recognize the valuable role each person in an enrollee's circle of support plays within their social system.
- We recognize that the enrollee is an expert on their health and their health care needs, and their preferences are incorporated throughout the care planning process
- We work together with enrollees and their circle of support to create a clear vision of a positive quality of life and develop an attainable path toward those goals, understanding enrollee's life stages are influenced by past experiences.
- We move beyond planning for an enrollee's physical health and behavioral health by focusing on helping enrollees and families increase their capacity to live a self-determined life in the community of their choice, while building social capital and economic stability by addressing function and unmet social resource needs (e.g., housing, transportation, food insecurity, personal safety/domestic violence).

[5] Shah,Tanya, Lewis, Corinne, Tsega Mekdes, and Abrams, Melinda, "Quick Reference Guide to Promising Care Models for Patients with Complex Needs," (2019); https://www.commonwealthfund.org/sites/default/files/2019-03/Inventory_of_HNHC_Models_final_2.20.19.pdf; accessed June 1, 2019

- We recognize that our enrollees can and do lead complex, multifaceted lives and we account for this interconnectedness in our integrated care management approach by focusing on daily life and employment, community living, safety and security, healthy living, social and spirituality networks, and citizenship and advocacy.
- We value the strengths and assets of our enrollees and their families and support them to discover new opportunities and navigate their lives by sustaining and/or making new connections with the community, and by linking them to innovative goods and services available both internal and external to the disability support system.
- We provide opportunities and support for our enrollees and their families to self-advocate and provide crucial feedback to Aetna through formal and informal stakeholder engagement channels. Aetna incorporates stakeholder experiences as a critical component of our continuous quality improvement process.
- We recognize that the enrollee is better served within the community setting of their choice versus inpatient care. Thus, we will partner with the enrollee to support their ability to maintain community tenure and access to care resources.

Since 2011, Aetna[6] has collaborated with the Kentucky Office of for Children with Special Health Care Needs, the Kentucky Cabinet for Health and Family Services regional officers, and the clinics operated with by the Commission for Children with Special Health Care Needs, among others. Through this experience we will leverage established relationships to continue and expand our commitment to person- and family-centered, multidisciplinary approaches to ISHCNs.

Addressing trauma and ACEs: Aetna has learned that many ISHCNs have had trauma in their lives and are best served to receive all aspects of their care from a trauma informed perspective, including both Aetna staff and from our provider network. According to the most recent report from Child Trends, 53 percent of children in Kentucky have experienced at least one adverse childhood event (this is the second poorest outcome in the nation, following Arkansas).[7] Aetna understands that trauma is often a part of our enrollees' history and has incorporated a trauma-informed system of care into its integrated care delivery model. We know that adult outcomes associated with ACEs include increased risk for: heart disease; diabetes; obesity; cancer; intimate partner violence; depression; smoking, substance abuse; and early death.[8] In alignment with the Kentucky State Health Improvement Plan, 2017-2022, Aetna's system of care includes trauma-trained care managers and a network of providers that includes providers providing trauma-informed services. Where there are gaps in the network, Aetna provides training for providers to ensure Individuals with Special Health Care Needs have access to trauma-informed services. We meet enrollees and those who support them where they are on their journey.

Our trauma-informed approaches include partnering with Bounce, a Kentucky-based organization, to offer train-the-trainer trainings for Mental Health First Aid (MHFA). To assist our enrollees with more easily identifying providers that are both trained and trauma-informed, Aetna has modified its provider directory to include searchable attributes from a drop down menu that includes the election of a provider

[6] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to the Vendor, Aetna Better Health of Kentucky.

[7] Sacks, Vanessa and Murphey, David, "The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity," (2018): https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity; accessed June 1, 2019

[8] Sacks, Vanessa, Murphey, David, and Moore, Kristin, Child Trends, "Research Brief; Adverse Childhood Experiences, National and State-level Prevalence," (2014): https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf; accessed June 29, 2019

with trauma training, medication-assisted treatment (MAT) certification and a series of other specific references to assist enrollees in navigating the health care delivery system that meets their needs and their cultural preferences.

Local Aetna staff are prepared to identify ACEs by completing the Darkness to Light training through the Exploited Children Help Organization (ECHO). Our care managers complete monthly training which incorporates ACEs, sexual abuse education, and TIC. We integrate ACEs and depression screenings into enrollee assessment for foster care and child intake. Our care plans incorporate the entire family circle to support the family unit and address any behaviors occurring in the household which might expose a child to ACEs. We work to equip parents to handle difficult situations, address the social resource needs and promote supportive relationships which are integral to childhood development.

Integrated service delivery: Due to the large percentage of ISHCNs who have co-occurring behavioral health and/or substance use treatment needs, person-centered models that incorporate behavioral health, primary care services, and functional and social determinant needs are integral to improving the lives of ISHCN enrollees and their families in Kentucky. Aetna recognizes that individuals with mental health and/or substance use disorder needs often have comorbid physical health conditions that require medical attention; more than half of the Medicaid-enrollees in the top 5 percent of expenditures who had asthma or diabetes also had a behavioral health condition (Medicaid.gov). We understand that it is imperative that Aetna's contracting and network development efforts as well as provider education and training be informed by the associations between behavioral and physical health. We understand the following:

- Poor mental health is a risk factor for chronic physical conditions.
- Individuals with serious mental health conditions are at high risk of experiencing chronic physical conditions.
- People with chronic physical conditions are at risk of developing poor mental health.

Aetna's integrated approach toward mental and physical health involves anticipating how and when physical health conditions might have an impact on mental health (or vice versa) and suggesting pre-emptive action. There are often missed opportunities to identify problems at an early stage and offer proactive support. Aetna has educated its PCPs on the use of Screening, Brief Intervention, and Referral to Treatment. Aetna utilizes embedded nurse reviewers at several medical hospitals who are trained to monitor for co-occurring behavioral health diagnosis and ensure referrals for mental health services occur. Our suite of screening tools utilized by our Care Management department helps to identify risks for both physical health and behavioral health conditions and allows for a fully integrated approach to multidisciplinary team care coordination.

Aetna also recognizes the role of enrollees themselves in quality of life improvement and self-management of their physical and behavioral health. Enrollees can manage their physical and behavioral health more effectively if they are provided with necessary information about their conditions coupled with tools and resources which support recovery and resiliency. Aetna utilizes Krames® educational materials, direct care management contact, and newsletters on disease management conditions to provide education to enrollees. The difficulties that enrollees often face, such as the effect of psychotropic medications on weight gain, are well-established and predictable, and therefore potentially avoidable. Aetna's comprehensive and integrated approach to medication management and coordination allows for explanation and monitoring of these side effects, ensures education to providers and enrollees about what to expect, and can support self-management behaviors that could mitigate some of the worst effects.

Aetna currently contracts with a range of providers that are able to offer person-centered models that incorporate enrollees' holistic health needs (e.g., physical health, behavioral health, functional needs and unmet social resource needs), including the following: 10 specialized children's services clinics across the Commonwealth, covering all regions except Region 1 where no such provider is enrolled with Kentucky

Medicaid. Our network for the Medicaid program also includes 9 federally qualified health centers (FQHCs) that provide comprehensive preventative health, dental, mental health and substance use services, and 50 rural health clinics (RHCs). Aetna supports bridging the gaps between primary and secondary care, contracting with all 13 of the community mental health centers (CMHCs) in Kentucky, two of which have received specialized funding to integrate primary care and behavioral health care via collaborative clinical practices, improved care models, and a comprehensive service continuum. This increases rural access to integrated health care for our enrollees while also developing collaborative relationships with a variety of community stakeholders and partners. In addition, Aetna has partnered with the Kentucky Primary Care Association, in a value-based arrangement, to assure our enrollees are able to see providers that assure both behavioral health and physical health in one location. The KPCA represents the FQHCs, assuring comprehensive, integrated services for our enrollees.

Bluegrass Care Navigators℠

Aetna collaborates with Bluegrass Care Navigators (BCN) to provide continuity of care and integrated, person-centered discharge planning for enrollees following an admission to an inpatient hospital, including behavioral health. BCN meets enrollees face-to-face after discharge to connect our enrollees to the services and supports indicated in their discharge plan that will help prevent emergency department (ED) usage and readmissions. Close coordination with BCN and our care managers ensures our enrollees are fully supported and barriers addressed. We have regularly scheduled meetings with BCN to review enrollees and to identify any potential needs the enrollee may have that would make it difficult for the enrollee to adhere to discharge plans after they have completed the transition support program with BCN. This allows a seamless transition to an Aetna care manager for continued support and assistance.

Aetna's Integrated Care Management (ICM) model supports the complexity and integration which is a key component of our care model for ISHCNs. Our written policies and procedures and ICM description outline our strategies to identify and provide individualized services for Individuals with Special Health Care Needs in the following classifications:

- Children in/or receiving foster care or adoption assistance
- Blind/disabled children under age 19 and related populations eligible for SSI
- Adults over the age of 65
- Homeless
- Chronic physical health illnesses
- Chronic behavioral health illnesses
- Children receiving EPSDT special services
- Children receiving services in a Pediatric Prescribed Extended Care facility or unit
- Adults who are under guardianship

Aetna's model provides a seamless system of integrated services and supports that address enrollees' whole-person needs, including their physical health, behavioral health, functional, and social determinant needs. Our approach is designed to meet enrollee expectations, enhance quality of life, and improve health outcomes for ISHCNs, while emphasizing collaboration with providers to help them move enrollees toward optimal health. Aetna's program for ISHCN includes enhanced care coordination through collaboration with organizations such as the Community Pharmacy Enhanced Services Network (CPESN) and the Kentucky Primary Care Association (supporting FQHCs). This program gives our ISHCN enrollees access to community-based pharmacists that become part of the care team for our enrollees.

In our integrated care management rounds, the single-most common non-medical need for our enrollees with SHCNs are those social services that are often difficult to find. The top need of our enrolled ISHCNs is food security. Aetna has entered into a partnership with Unite Us to assist in serving all our enrollees

with SHCNs and our general enrollee population with access to a fully integrated social service resource network. Through this integrated social determinant integration model care managers and community health workers have access to both our medical network and our social determinants of health (SDOH) network to connect enrollees to local, community-based resources to address their unmet social resource needs. Care managers offer ISHCNs assistance with enrollment in federal and Commonwealth benefit programs such as, Department of Housing and Urban Development waivers, Women, Infants, and Children, the Supplemental Nutrition Assistance Program, Kentucky Transitional Assistance Program, Kentucky Low Income Home Energy Assistance Program, and the Homeless Assistance Program, as examples.

Our Care Management team understands the ISHCNs' complex situations and engages our enrollees and their families through a collaborative process in programs to reduce barriers to managing their own health and well-being or that of their children. This includes offering enrollee and evidence-based treatment-specific resources on condition management, BH symptoms, and accessing community-based services and supports. Our team also identifies enrollees that may qualify for waivers and coordinates application when applicable. Individuals with special health care needs require an integrated team to assure their needs are met. Care managers receive intensive clinical training in the areas of engagement and relationship building, assessment, chronic condition management, evaluation of social and behavioral issues affecting enrollees' health, trauma informed care, resiliency and wellness, care planning, and care management, including supporting enrollees with special health care needs and care coordination. The care manager acts a single point of contact for the enrollee, but is supported by an interdisciplinary care team (ICT) comprised of the enrollee, members of their circle of support, the PCP and other medical providers, behavioral health specialists, and representatives from community-based organization that address enrollee's social care needs and other social support as directed by the enrollee or the enrollees' guardian.. In addition, to support enrollees with SHCNs in Kentucky, Aetna's integrated care delivery model includes the System of Care staff. Each of these systems of care specialists participates on the ICT to help, as needed, to support the care management team to help each ISHCN along their journey to health and wellness, in addition to building organizational capacity to support the needs of all enrollees.

Aetna's system of care: We strive to understand each enrollee in the context of their lives, while co-designing a holistic model of supports and services that enhances their quality of life and assists them to reach their individual goals. Our innovative integrated system of care approach is based on a whole -person view of our enrollees' PH, BH, and SDOH. **Figure C.25-1** depicts our integrated system of care demonstrating our comprehensive focus on the enrollee and their circle of support's (i.e., the people the enrollee wants to be

Figure C.25-1: Aetna's Integrated System of Care
Aetna's integrated system of care includes all health care and related services and supports necessary for enrollees with special health care needs to achieve improved health outcomes.

involved from outside of the health care system) primary needs and goals. We know that people with multiple chronic conditions often do not improve until their underlying BH needs are met and/or their functional activities of daily living support needs are considered/met. To address these issues in Kentucky, Aetna uses several Systems of Care staff, each of whom plays a vital role in supporting the Integrated Care Management team to provide whole-person care to ISHCNs and strengthen Aetna's overall organizational capacity. **Table C.25-1** summarizes the system of care positions in Kentucky and their role in supporting our enrollees.

Table C.25-1: Aetna Systems of Care Staff

Position	Role in Supporting Kentucky ISHCNs
Adult System of Care Administrator	• Build key stakeholder relationships and processes based on market needs and populations needing a system of care approach • Build community-based services and supports • Leverage full partnership with social supports and caregivers in all aspects of the planning and delivery of their own services.
Children's System of Care Administrator	• Build key stakeholder relationships and processes based on market needs and children's populations needing a system of care approach • Bridge with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes • Build community-based services and supports
Recovery and Resiliency Administrator	• Build supportive programs to mental health and substance use delivery • Collaboration participating in integrated rounds • Collaborate with local, Commonwealth, and national partners and stakeholders • Collaborate with enrollees and family to identify and remove barriers to services • Promote the hope for recovery within the health plan
Emergency Room/ Crisis Administrator	• Build collaborative relationships with fire, police, emergency medical services, hospital EDs • Collaboration with duties related to complex enrollee populations and collaboration of services with community programs • Collaborate with medical management on transition of care for enrollees discharging from inpatient settings and mitigate system gaps • Build collaborative protocols with first responders • Build systems for transitioning individuals in crisis to and from hospital emergency departments.
Justice System Liaison	• Collaborate with the Department of Juvenile Justice (DJJ), Department of Corrections (DOC), County Jails, Sheriff's Office, Correctional Health Services Office of the Courts (OC) and Probation Departments and Department of BH and Developmental Disability (DBHDID) to identify systemic changes and promote community integration • Trauma-informed expert • Understand Reclaiming Futures framework and work closely with other systems that serve youth, and with the community. • Bridge communication with the health plan staff, court and the justice systems
Trauma System of Care Administrator	• Communicates and collaborates with enrollees and families to identify concerns and remove barriers that affect service delivery and enrollee satisfaction. • Participates in integrated rounds for the purpose of identifying trauma approaches and modalities that can assist the enrollee in building and maintaining health outcomes. • Provides expert consultation regarding complex situations and addresses challenging cases in a collaborative setting • Builds rapport, collaborative and strengths-based approaches for decision-making with Kentucky contracted providers, Commonwealth and local agencies • Participates in conferences with supervisory/managerial personnel, other professionals (including physicians, psychiatrists, psychologists, and educators) and with representatives of Kentucky government and non-government agencies

Collaboration with Commonwealth agencies: As team members with the Department of Community Based Services (DCBS) to assist with placing children that are difficult to place in foster care home we

have identified that many of these children have special health care needs. In working with these difficult to place children, a large proportion with experiences trauma or ACEs, we identified the critical need for TIC coordination due to their physically and behaviorally complex conditions. Aetna's ICM model assists these children with the highest level of support required to meet their individual, holistic needs to be more likely to find stable, loving foster homes.

Similarly, care coordination is important for our enrollees with SHCNs that are involved with the criminal justice system. To support the transition of enrollees from incarceration back to the community, Aetna has co-located staff in the Kenton County Detention Center (KCDC). Through this model, Aetna is aware of pending discharges from KCDC prior to it occurring. This allows our re-entry care manager to begin care planning and coordination of care to make sure the enrollee has access to all services and supports to meet their unique, whole person needs. The enrollee is then assigned an Aetna care manager who serves as their advocate throughout their healthcare journey.

Value-based purchasing: We have learned about the power of value-based purchasing (VBP) arrangements in incentivizing providers to improve the care they provide to ISHCNs. For example, in support of providing integrated, whole person care for ISHCNs, Aetna offers providers a variety of alternative payment arrangements through our Aetna Better Value program. To date, Aetna has entered into an alternative payment arrangement with several providers such as Children's Alliance Independent Provider Association (CA-IPA), Kentucky Primary Care (KPCA) and KentuckyOne Health (KHP), to name a few. The outcomes Aetna uses to monitor performance and determine incentives depending on the VBP agreement include, but are not limited to the following Healthcare Effectiveness Data and Information Set (HEDIS) measures:

> Aetna was the first MCO to initiate a partnership with the Children's Alliance Independent Provider Association to create and execute a value-based services contract that is designed to incentivize behavioral health care providers to achieve specific outcomes and improve the overall care and well-being of children and families in Kentucky.

- AWC—Adolescent Well-Care Visits
- BCS—Breast Cancer Screening
- CCS—Cervical Cancer Screening
- CHL—Chlamydia Screening in Women
- CDC Eye Exams—Comprehensive Diabetes Care
- CDC HgA1c Testing—Comprehensive Diabetes Care
- CIS Combo 10—Childhood Immunization Status
- W15 6+ Visits—Well-Child Visits in the First 15 Months of Life
- AMBED—Ambulatory Care (ED Visits)
- PCR—Plan All-Cause Readmissions
- FUH 7 Day—Follow-Up After Hospitalization for Mental Illness
- APP Total—Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- ADD Continuation Phase—Follow-Up Care for Children Prescribed ADHD Medication

> "Aetna is the MCO willing to partner with us with an innovative approach that illustrates their openness and desire to provide the best care possible—first—for our mutually served children with complex medical needs. It is our joint goal to also effectively manage costs to Kentucky Medicaid and other government subsidies. Our relationship enables the provision of the comprehensive daily care necessary to improve their overall health and progress toward their futures. The Commonwealth will have better health outcomes through this unique partnership. We feel this progressive approach to complex and chronic pediatric patients is the way of the future."
>
> **—Lee Zimmerman**
> **President and CEO**
> **The Kidz Club**

Aetna is also developing a VBP contract with The Kidz Club to provide community pediatric health care services for children who are medically complex, requiring a multidisciplinary approach to address their whole-person needs. Examples of the diagnoses or conditions the medically complex children the Kidz Club will serve

include ventilator dependence, spina bifida, hemophilia, cerebral palsy, cystic fibrosis, and neonatal abstinence syndrome. In lieu of prior authorization, Aetna will dedicate a care manager to the enrollees served by the Kidz Club. This Aetna care manager will be embedded at the agency to enhance clinical conversations and care coordination with non-covered services to meet enrollees' and their families' social determinant needs. The Aetna care manager will make in-home visits to each enrollee on initial intake and twice per

month, or when there has been a change in the child's condition. Aetna anticipates that outcomes of the VBP arrangement with the Kidz Club will include the following: reductions in hospitalizations and ED visits; increased medication compliance and medicine reconciliation; and decreased overall costs of care for enrollees.

Technology-based innovations: Aetna has learned that technological innovation is key to increasing our ability provide integrated, whole person care to ISHCNs, while advancing person and family self-sufficiency, recovery, and resiliency. Our technology-based innovations help us identify enrollees with SHCNs early to engage them proactively, support them to receive care in their homes and increase their ability to self-manage their conditions, engage them in their care through text messaging solutions, increase access to services through telehealth and telemedicine, and allow us to use our data in meaningful ways to address health disparities. They are as follow:

- **Advances in predictive modeling:**
  - **Rising risk predictive modeling for at-risk children**: Aetna's rising risk model uses 28 different elements, including demographics, socio-economic status, diagnosis, medications, and other measures to stratify and score enrollees with special health care needs who have experienced trauma or disability. We stratify enrollees who are age 17 and under based on a multitude of measures including other more specific behavioral health disorders, opioid use, physical/sexual/psychological abuse, self-harm claims, comorbidities, risk stratification score, engaged in care management, primary care provider assignment (PCP), frequency of changing PCP over the course of a year, total medical spend, ED utilization, pregnancy, sexually transmitted disease diagnoses, household opioid use, household self-harm claims and household physical/sexual/psychological abuse.

    Using this method, we have weighted the elements and using a proprietary formula have developed a scoring system so we can rapidly identify enrollees to determine who is at an elevated risk and move the system to early intervention and ultimately prevention. This helps us to understand the level of care coordination that is needed and to identify additional resources the health plan can provide for individuals prior to a greater involvement in the health care and /or criminal justice system and to support their high school graduation goals as well as their financial and health literacy needs. In addition to identification of specific enrollees we use demographic and geographic information to focus resources on areas of rising risk concentration. As part of our population health strategy our goal is to early identify ISHCN and direct services to communities with enrollees with early and less complex illnesses prior to them appearing as higher risk and higher spend.
  - **Predictive modeling for opioid use disorder**: Aetna is exploring advanced analytics approaches to identify the enrollees at high risk of opioid use disorder (OUD)**.** Data sources include the following: eligibility data, medical claims data, pharmacy claim data, approved diagnosis codes, procedure codes, and drug codes. Using this data, a multivariate logistic regression model was developed to assess the likelihood of an enrollee developing OUD using person-level data. The final model includes the following variables: age, rate group, ethnicity group, chronic pain, alcohol abuse, tobacco abuse, first opioid prescription lasting more than 7 days, opioid days' supply, and unnecessary ED visits. The model accuracy of prediction is 89 percent and high-risk

enrollees with OUD are flagged by a selected cutoff value, so that our pharmacy and care coordination teams can collaborate regarding outreach strategies to the enrollee.

- **Remote patient monitoring:** Understanding that access to primary care and specialty providers is often more challenging for ISHCNs, Aetna offers remote monitoring statewide to specific high-risk enrollees with conditions such as diabetes, hypertension, chronic heart failure, asthma, and high-risk pregnancies. Remote patient monitoring has been shown to be effective in preventing hospitalization and health regression with early detection and intervention and is a particularly valuable strategy for supporting enrollees residing in rural areas that do not have easy access to their PCPs. We contract with a national remote monitoring expert to provider enrollees with an iPad mini™ and up to four peripheral devices, such as a weight scale, pulse oximeter, blood pressure cuff, and glucometer. These devices are 4G-enabled with call center and delivery support both to and from the enrollee's home. The unit is designed for a simple setup, with the iPad personalized for each enrollee, listing his or her name on the device with easy-to-follow instructions and videos on how to use the devices, how and when to contact the provider and care manager, and how to seek emergency help. To date, Aetna's experience indicates that remote monitoring is particularly helpful in rural areas of the Commonwealth where access to services may create burdens to the enrollee and their families.

> An enrollee in our affiliated Louisiana health plan who is diagnosed with diabetes and heart failure received a phone call from a remote patient monitoring vendor clinician after she completed her remote monitoring. The clinician completed a triage and helped her get to an urgent care provider who changed her medications. The enrollee was happy as she avoided a crisis that would have caused her to miss her own birthday party.

- **Text messaging solutions:** To assist enrollees in remembering regular visits and communicating with staff, Aetna uses opt-out text messaging (i.e., enrollees can choose not to receive text messages) in the following ways. First, to support campaigns to encourage families of children receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to access dental care, well child visits, and to complete lead screenings. In addition, adult enrollees with diabetes can receive reminders to complete HbA1c testing. Messages are delivered to enrollees in both English and Spanish, depending on their preference.
- **Telehealth and telemedicine:** One of the key barriers to health care for ISHCNs is access to care. To address access, Aetna has included some virtual strategies to reduce the inequities to access rural Kentuckians face. To improve access to services in traditionally underserved areas, we utilize telehealth and telemedicine strategies. Telehealth services, available 24/7/365, support our populations by increasing the opportunity to both provide access and integrate care with an enrollee's selected PCP through their medical home. All telehealth visits are documented and become part of the enrollees' health record with a copy sent to the PCP of record with enrollee consent.
- **Data integration and dashboards:** Aetna understands that data aggregation and visualization are key to understanding trends affecting the enrollees we serve, including the population of ISHCNs. We use dashboards to summarize, in an easy-to-use manner, data about health care utilization (e.g., ED use, opioid prescribing, etc.), the demographic characteristics of our enrollees, and trends in the social determinant needs of our enrollees.

  Figure C.25-2 shows our Demographic Distribution for ED Utilization dashboard, which allows our Integrated Health team to review ED utilization data through demographic and health equity lens. Aetna's Integrated Health team is a multidisciplinary group of interdepartmental staff from Care Management, Utilization Management, Community Outreach, Population Health Management, Pharmacy, etc., that specializes in supporting enrollees to receive integrated, holistic health care. This dashboard includes a variety of tools that our Population Health Management team can use to filter enrollee ED utilization data to identify and address possible demographic related disparities. The dashboard allows the Integrated Health team to filter all ED Utilization in a rolling 12-month period

by gender, age, race, ethnicity, language and county. The Dashboard also allows the Integrated Health team to drill down to enrollee-level data and generate custom enrollee lists based on filter selections. The enrollee level data is also filterable by care management level.

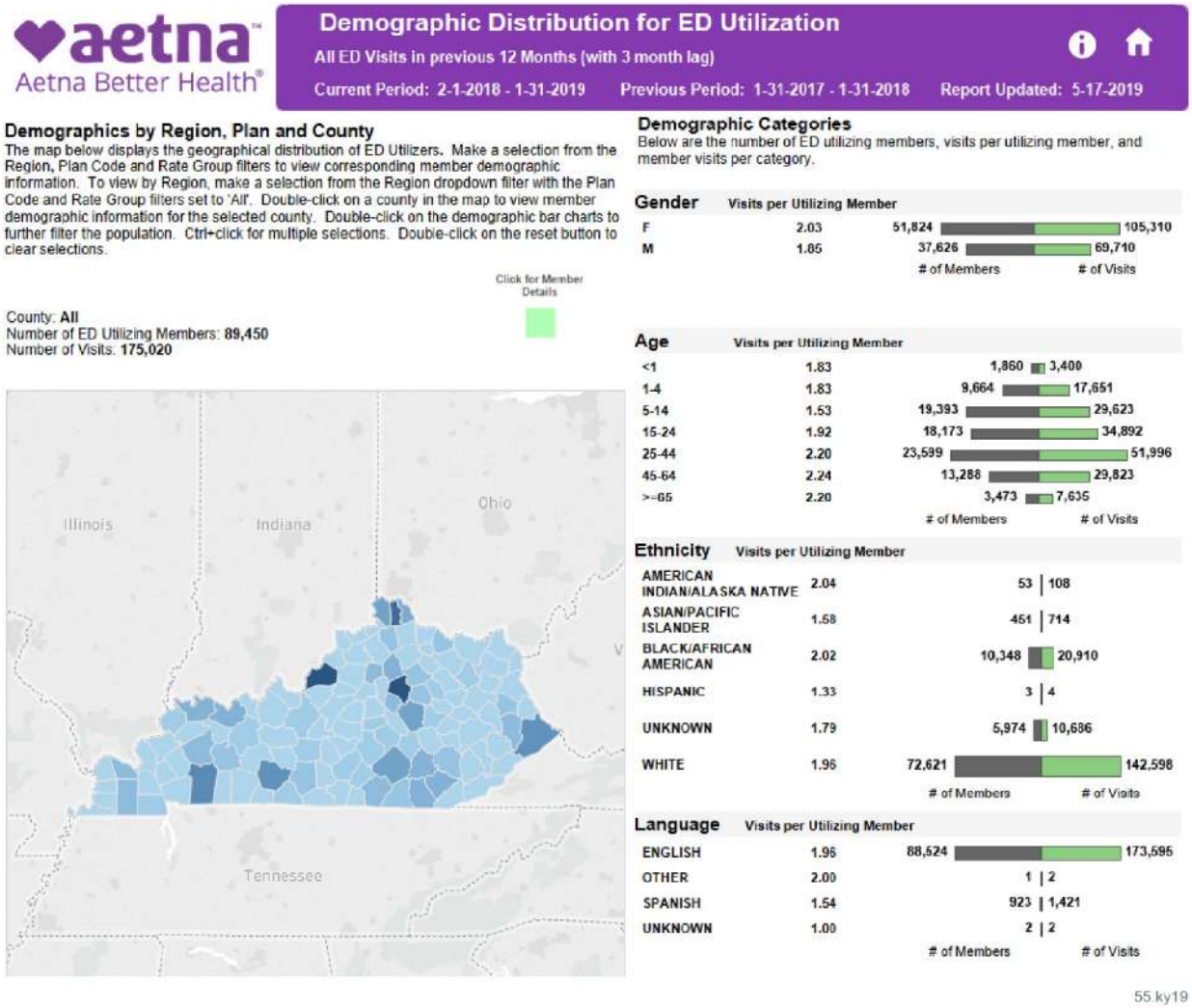

Figure C.25-2: Aetna's Demographic Distribution for ED Utilization Dashboard

Aetna's data integration capabilities and use of dashboards allow us to better understand our local population, including ED use for enrolled ISHCNs.

Evidence-based Practices

Aetna encourages the use of evidence-based practices to support the individualized treatment goals as identified by each enrollee, with an emphasis on recovery and resiliency. Evidence-based approaches contributes to improved health outcomes, while increasing cost efficiency of care delivery, and decreasing utilization of avoidable or ineffective interventions. Aetna continues to build upon its list of EBPs as emerging practices are identified to best meet an enrollee's needs. The following EBPs are currently in place:

- **Applied Behavior Analysis (ABA):** ABA is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful

degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior

- **Dialectical Behavioral Therapy (DBT)**: DBT is cognitive behavioral therapy (CBT) which supports an array of chronic or severe mental health issues, including self-harm, eating and food issues, addiction, and posttraumatic stress, as well as personality traits. DBT can ultimately inspire enrollees that change is possible and provides tools and resources to support that change.
- **Trauma-Focused CBT**: Trauma-focused CBT is a component-based model of psychotherapy that addresses the unique needs of enrollees with PTSD symptoms, depression, behavior problems, and other difficulties related to traumatic life experiences. Moreover, it is sensitive to the needs of individuals who have experienced trauma and seeks to find comprehensive solutions to address the impact of traumatic experiences.
- **Multisystemic Therapy (MST):** MST is an intensive evidenced-based family and community-based therapy program in treating youth with serious behaviors and substance abuse ages 11-17.
- **Functional Family Therapy (FFT):** FFT is an intensive home-based family therapy program for youth who have difficulty adjusting to their environment and/or in social interactions. The program has demonstrated capacity in multiple arenas including substance abuse for youth 11-17 years old.
- **Motivational interviewing (MI):** MI is a person-centered, directive therapeutic style to enhance readiness for change by helping clients explore their options, identify person-centered solutions and develop goals for change.
- **Matrix Model:** The Matrix Model provides a framework for engaging stimulant (e.g., methamphetamine and cocaine) abusers in treatment and helping them achieve abstinence. Therapists are trained to conduct treatment sessions in a way that promotes the enrollee's self-esteem, dignity, and self-worth.
- **Nurse-Family Partnership (NFP):** NFP is a community health program that serves low-income women pregnant with their first child. Each vulnerable new mom is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits.
- **The Seven Challenges:** The Seven Challenges Program is a SAMSHA (Substance Abuse and Mental Health Services Administration)-recognized evidence-based treatment that provides a comprehensive counseling program for youth with alcohol and drug problems.
- **Play Therapy:** Play therapy is designed to help children learn to communicate better, change their behavior, develop problem-solving skills, and relate to others in positive ways.
- **Developmental, Individual-differences, and Relationship (DIR)/Floortime:** DIR/Floortime is a specific technique to both follow children's' natural emotional interests (lead) and at the same time challenge the child toward greater and greater mastery of the social, emotional, and intellectual capacities.
- **Parent Child interaction Therapy (PCIT):** PCIT is a dyadic behavioral intervention for children (ages 2-7 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child relationship.

Tailored services for Individuals with Special Health Care Needs in Kentucky: Aetna tailors programs and services to meet the whole person needs of ISHCNs, in addition to the therapeutic EBPs described previously. We know that ISHCNs must navigate numerous systems, such as, education, health care, social services, and require multiple providers, prescriptions, and home and community-based services and supports. Our specialized solutions for this population help address some of the struggles they may face in their day-to-day lives and on their journey to health and wellness. **Table C.25-2** describes some of Aetna's locally tailored initiatives for serving ISHCNs.

Table C.25-2: Aetna Services for Specific Populations with Special Health Care Needs

ISHCN Population	Aetna Programs and Services
Children in/or receiving foster care or adoption assistance	• Birthday boxes and duffle bags • Resource packets provided to DCBS offices to be shared with Aetna enrollees, including contact information for local care managements, safety plug outlets, medicine droppers, etc.
Blind/disabled children under age 19 and related populations eligible for SSI	Care managers identify enrollees whose conditions and situations may make them eligible for SSI and make referrals to Change Healthcare which coordinates required materials to submit applications for SSI—relieve burden of families
Adults over the age of 65	• Enrollments in care management • Referrals to Area Agencies on Aging and Independent Living (AAAILs) and assistance with applications to Medicaid waiver programs for HCBS
Homeless	• Vending machine for free access to personal care items • Food pantries to combat food insecurity • Referral to and application assistance for local, Commonwealth, and federal supports, such as Women, Infants, and Children, food stamps, and Social Security • Two clinics (Hazard, Bowling Green) supply personal care items • Care management in-person in shelters and other community-based agencies (e.g., 46 agencies) • Homeless Count initiative—packages of personal care items • Use of the Kentucky Homeless Management Information System
Chronic physical health needs	• Remote patient monitoring • Medication review through CPESN
Chronic behavioral health needs	• Contracting with Assertive Community Therapy providers to support enrollees with serious mental illness (SMI) • Embedded care managers at inpatient behavioral health facilities to assist with transitions of care • Coordination with community-based organizations to provide wraparound services and address social determinant needs, such as food insecurity and housing instability
Children receiving EPSDT special services	• Reminders to parents for Well Child visits via text campaigns and by mail • Care management follow-up based on lead screening results • Coordination with School-based Health Centers • VBP agreement with KPCA
Children receiving services in a Pediatric Prescribed Extended Care facility or unit	• Care management to put in place wraparound for enrollees, their caregivers, and families • VBP agreement with The Kidz Club, a Prescribed Pediatric Extended Care provider
Adults who are under guardianship (DAIL)	Care Management outreaches to Department for Aging and Independent Living (DAIL) enrollees to collaborate and address needs of high utilizers, enroll in care management

b. Facilitating Access to Appropriate Services for Individuals with Special Health Care Needs

Our innovative approach to care management and care coordination ensures timely access to quality care through a cost effective, coordinated network of services designed to meet each individual enrollee's needs, particularly those with special health care needs. Aetna facilitates access to appropriate services for Individuals with Special Health Care Needs through our integrated system of care and comprehensive approaches to identifying enrollees to be identified as Individuals with Special Health Care Needs, person-centered, holistic approaches to screening and assessing for their individual needs, providing education to enrollees and caregivers, and supporting enrollees in transition of care.

b.i. Approach to Identifying Enrollees

Adults and children meet the criteria to be identified as Individuals with Special Health Care Needs based on their diagnosis, health status, patterns of utilization, and/or participation in specific programs, as defined in **Section 35.1 of Appendix F, Draft Medicaid Managed Care Contract and Appendices.**

The Aetna team uses many data sources to identify and track Individuals with Special Health Care Needs, and to assign them to a level of care management that meets their needs (e.g., complex care management, management of chronic conditions, or wellness and prevention) and in accordance with their choices for the level of care they request:

- **Enrollment file analysis:** Aetna analyzes our enrollment file to identify Individuals with Special Health Care Needs and to prioritize outreaching to them for assessment. Our care managers also use the enrollment file to gather data that may indicate the appropriate care management level based on historically identified care management levels, current service authorizations, and active individual service plans (ISPs).
- **Screening and assessment process:** Described in full detail in this section, Aetna uses its initial screening and assessment process to identify ISHCNs who are new enrollees from whom Aetna does not have historical data and who are not indicated on the enrollment file.
- **Analysis of Aetna data:** Our care managers conduct stratification for all enrollees to identify those enrollees at highest risk. We use integrated information management tools, including data from our proprietary Consolidated Outreach and Risk Evaluation (CORE™) predictive modeling platform (for enrollees with prior utilization) and our electronic population health management platform, to identify indicators of enrollee needs and care management level needs based on enrollees' medical history. We also review claim-specific information to identify services; diagnosis and condition; PH, BH, and therapy needs; use of durable medical equipment (DME); medical supply needs; and pharmacy use. For example, we identify gaps in care for enrollees with diabetes who are in in need of statin therapy for hypertension by reviewing pharmacy data against enrollee diagnoses.
- **Conducting assessments:** Based on health risk assessment (HRA) findings, we may conduct an enrollee needs assessment (ENA) and additional condition-specific assessments to evaluate PH and BH, therapies, functional, or DME needs.
- **Referrals:** Enrollees may be referred for assessment to determine if they have SHCNs by their PCP, other providers, community-based organizations, or their caregiver or circle of support; enrollees may also self-refer. For example, Aetna has co-located care managers who refer enrollees to be assessed at the Kenton County Detention Center, Our Lady of Peace, and the University of Kentucky Neo-natal Intensive Care Unit. In addition, an Aetna care manager works onsite at Eastern State Hospital (a psychiatric facility) when an enrollees' needs require in, and they also refer enrollees for assessment

Supporting an Enrollee with Chronic Physical Health Needs

Thomas (not his real name), a 44-year-old man, was referred to Aetna care management for education and assessment of treatment needs relative to a diagnosis of hepatitis-C. Thomas had a history of a positive drug screen and reported anxiety and panic attacks. He wondered whether he needed to continue medication for hyperlipidemia. After discussing with Thomas his goals for care and addressing collaboratively any concerns he may have, the care manager coordinated with Thomas's PCP for evaluation and treatment of anxiety and cholesterol. Thomas received education on stress management techniques and his care manager helped him identify treatment goals related to abstinence relative to historical substance use. As a result of frequent contact with his care manager and commitment to treatment plan recommendations, Thomas reported reduced anxiety and stress and was able to lower his cholesterol through diet modification. His cholesterol medication was discontinued, and he maintained sobriety for 6 months. After 12 weeks of medication therapy for hepatitis C, there was no evidence of the disease. He has since found employment and no longer receives Medicaid benefits.

of the SHCNs. Aetna collaborates with School-Based Health Centers and connects enrollees to the Unite Us network of social care providers, both of which refer enrollees who may have SHCNs for assessment.

- **Real-time coordination of care:** Aetna's utilization management care teams track inpatient census daily. We also identify enrollees with multiple inpatient admissions or ED visits within a rolling 12-month period. A case synopsis is created for enrollees who have been in the hospital for 10 days or more and that have multiple comorbidities, and for those with high inpatient and ED utilization. Weekly, a multidisciplinary group of medical directors, the chief medical officer (CMO), physical health and behavioral health care team enrollees, and representatives from UM, CM, and discharge planning convene to discuss these enrollees. Decisions are made as a group on the best approach to take with these enrollees (e.g., whether care management outreach would be beneficial, what potential BH needs can be addressed, and potential discharge planning needs, such as home modifications and durable medical equipment needs).

Aetna provides information to the Commonwealth identifying ISHCNs in the format and requested timeline.

b.ii. Process for Screening and Assessing Individual Enrollee Needs

Our ICM model engages enrollee and their circle of support (including caregivers) in a comprehensive assessment process to identify individualized needs, which guide development of person-centered care plan. We use our assessments to understand enrollees' PH, BH, pharmacy use, service needs, and social determinants of health to pinpoint opportunities to address care gaps. We also review claims-specific information to identify diagnoses/conditions, PH, BH, and therapy needs, and use of DME and medical supply needs to determine if enrollees are receiving the appropriate services.

We conduct stratification of all enrollees to identify individuals at highest risk, those who present a more moderate risk, and those who are at lower risk for an adverse event in the near term. Our stratification process uses multiple data sources including predictive modeling to identify indicators of enrollees' needs and possible care management needs; information from medical and pharmacy claims review; input from the enrollee, provider, and family/caregivers as appropriate; information from the transferring plan, if applicable; and assessments performed by care managers in the areas of chronic condition and social determinants of health which a focus on stable housing, transportation, food resources, and social support. We also review claims-specific information to identify capitated services, diagnosis/condition, physical, behavioral health and therapy needs, and use of durable medical equipment and medical supply needs to determine if the enrollees are receiving the appropriate services.

Initial assessment: The aim of our initial enrollee assessment, which occurs within 30 days of identification as an Individual with Special Health Care Needs, is to explain the purpose and goals of care management and service plans, the timeframe to complete the care plan information the enrollee's family should be prepared to discuss, and to assess the needs of the enrollee and prioritize enrollees for care management. Our care managers seek to understand what the enrollee and family know about their condition and to provide information regarding care management and the service plan development process including information to be discussed such as the enrollee's medical and social history, needs, goals and cultural preferences. The care manager identifies and addresses any immediate needs in collaboration with the enrollee and/or circles of support. Based upon the complexity of the person's needs and their level of risk, we may offer a face-to-face visit as a better way to build a relationship with the enrollee and to assess their environment effectively.

The initial assessment process begins with an outreach questionnaire and a health risk questionnaire. Depending on the outcome of the initial and comprehensive assessments, our care managers use applicable condition-specific screening tools and assessments. Care managers conduct culturally

competent, person-centered assessments that identify physical heath, BH, functional, cognitive, and social needs. Care managers have appropriate training and education to understand the complex needs of enrollees and their specific disease conditions. They all have training in Motivational Interviewing (MI) and MHFA and undergo a two-week onboarding that educates them on meaningful documentation and communication techniques, identifying how enrollees are enrolled and supported in care management, and how to use the electronic care management system for tracking goals and tasks for enrollees. In addition, care managers are trained on assessing enrollees, creating and monitoring a person-centered care plan, and levels of care for each enrollee enrolled in care management. All Aetna care managers are Kentucky-licensed registered nurses or licensed behavioral health professionals and due to their training in the field; they use their professional knowledge to decide which specialty assessments to conduct with enrollees with SHCNs. In addition, care managers use an algorithmic approach to choosing screening options. As they enter required assessments (e.g., the HRA which is attempted for all enrollees, and the ENA which is completed for those with a need identified by a care manager during review of the HRA results of other referral mechanism) into the electronic care management system the responses re-populate in other assessments with the same/similar questioning. The system provides suggestions to care managers about additional detail to solicit during the assessment process. Care managers are educated on spending time efficiently with enrollees and by skillfully using MI they obtain the information necessary to complete special assessments without overburdening the enrollee with multiple questions. Our condition-specific assessments, questionnaires, and screeners are listed in **Table C.25-3.**

Table C.25-3: Specialty Assessments, Screeners, and Questionnaires

ISHCNs Assessment Tools	ISHCN Screeners and Questionnaires
• Anxiety assessment • Asthma assessment • Cancer assessment • Depression assessment • Diabetes assessment • Heart failure assessment • Hepatitis-C assessment • HIV/AIDS assessment • Hypertension assessment • Infant assessment • Pain assessment • Pre-and post-transplant assessment • SF12 assessment • Sickle cell assessment • Weight management assessment	• CRAFFT screener • Edinburgh postpartum depression screener • Generalized anxiety disorder 7 screener • Kessler Screening Scale for Psychological Distress (K6) screener • Patient Health Questionnaire-9 screener • Postpartum questionnaire • Pregnancy and trimester screener • PSC17 screener • Safety questionnaire • UNCOPE screener (SUD)

Periodic reassessment: Care managers prioritize enrollees for reassessment by adhering to all contractual requirements and based on the enrollees' acuity of need, changes in condition (e.g., new diagnoses, changes in the level or location of care, changes in caregiver), and triggering events, such as ED visits or inpatient admissions. Care managers are trained upon hire and annually thereafter on tracking and prioritizing reassessments and follow Aetna's care management protocols and procedures. In addition, care managers and their supervisors track and reassessment due dates using Aetna's electronic care management system that contains internal workflows to generate reminders for upcoming reassessment and overseeing weekly review of turnaround time reports. By prioritizing assessments and reassessment by their due dates, we can obtain a high rate of compliance to required reassessment timeframes.

b.iii. Approach to Providing Education to Enrollees and Caregivers

A key strategy for assuring ISHCNs receive needed health care services in a trauma-informed way is through enrollee and care giver education. Our goal is to assure our enrollees understand and control their health care and guide us on their journey.

Formalized consents and agreement: The circle of support is critical in identifying all the enrollee's health and specialty care needs in addition to understanding social determinants of health, and the unmet needs impacting the enrollee as they achieve their health care goals. Individuals within the circle of support often help inform and usually augment the cultural and personal aspects of each enrollee's decision-making and goal setting. Upon receipt of consent from the enrollee or guardian, the approved individuals are included in the enrollee's integrated care team and they receive invitations to participate in assessment and service planning meetings until/unless consent is revoked by the enrollee or guardian.

Our care managers encourage and facilitate participation of enrollees, caregivers, providers, Department for Aging and Independent Living and legal guardians, and family enrollees in care planning. We begin by eliciting the enrollee's or guardian's consent for their social network and/or health team to participate in the assessment and care planning process.

Identifying learning styles and cultural preferences: Through our initial assessment and care planning process, Aetna care managers use motivational interviewing to identify the learning styles, cultural and linguistic preferences and choices of the person, their family/guardian, and their caregiver(s). We take all of this into account when work with the enrollee, their health care providers, their family, and when applicable, legal guardians to develop a seamless package of education and care to address enrollee goals and effectively meet primary and specialty service needs. For example, Aetna translates enrollee materials into the language of preference (including braille) of the enrollee or member of their circle of support, when requested, in additional to making all materials available in Spanish. Aetna's makes translation and interpretation services available in over 200 languages, which include Kentucky's top 15 non-English languages and American Sign Language. We engage economically challenged individuals understanding they may have poor access to the internet, cell phone and other necessities of modern access to healthcare. To mitigate these challenges, we support the federal program to provide LifeLine mobile phones to enrollees to access Aetna customer service, data texting use, and the Aetna mobile app. Aetna provides telecommunication options for enrollees who are deaf and hard of hearing through the 711-national service.

Seamless package of education and care: Care management includes coordination of services with the goal to bring together the enrollee's entire circle of support to understand, review, and address all aspects of the enrollee's needs. Care managers use motivational communication strategies, such as reflective listening, to encourage active enrollee, family, and/or guardian participation in assessment and care planning, including identifying goals and preferences most important to them, while generating additional opportunities for enrollee education. Some enrollee education opportunities Aetna provides include the following:

- **Promotion of self-management through ActiveHealth**: ISHCNs and their circle of support have access to a digital health appraisal, self-management tools, online digital coaching, personal health records, and health trackers through the Active Health Management, Inc. (ActiveHealth) portal, MyActiveHealth link on the secure Aetna web portal. My Action Plan of ActiveHealth directs enrollees or their parents/caregivers to different areas to work on their action plan and reach their health goals. Action Items are enrollee-specific and related to areas generated by the health appraisal results. The enrollee or their guardian choose what action item(s) they want to work on as they develop their specific health goals and overall wellness activities. The enrollee, their circle of support/guardian, specialists, PCPs, and appropriate selected community supports chosen by the enrollee assist in the development and ongoing monitoring of the person-centered care plan. Enrollees

can complete digital coaching programs and access a library of health information, which includes articles, video and audio clips, interactive tools, and recipes. They can follow health-related web links based on clinical insights and access tools to track their health.

- **HealthRunsDEEP:** HealthRunsDEEP is an intervention that identifies individuals with pre-diabetes and incorporates face-to-face educational sessions, remote patient monitoring for early evaluation with providers in the community, weekly touchpoints with a health coach, and incentives such as meal delivery service and vouchers for fresh fruits and vegetables to address SDOH and ensure continued engagement. The key to this program is activating communities to focus on early intervention and provide local organizations with resources to help our enrollees.
- **Remote patient monitoring**: RPM, described in-depth in the Approaches to Serving Individuals with Special Health Care Needs section above, enhances our ability to support disease self-management for enrollees.
- **Microclinic:** Microclinic is an initiative designed to empower enrollees to lead healthier lives and manage chronic conditions such as diabetes and cardiovascular disease (CVD) with the goal of improving quality indicators of HbA1c testing, HbA1c poor control (>9.0%), body mass index, statin therapies, and persistent medications. This program also reaches out to enrollees who are at risk for diabetes or cardiovascular disease. Enrollees learn how to decipher nutrient labels, cook healthy meals, take part in group fitness activities, and reach health goals. Meetings are held weekly for 16 weeks by a facilitator who is trained with the curriculum. The meetings are held in the community settings where enrollees and their families can join these classes. The program encourages enrollees with positive reinforcement through small performance rewards and comprehensive teamwork. After the 16-week program is completed the enrollees can continue in a program called My Health Matters where they check in once a month for 8 months.
- **Health literacy through value-added services:** Aetna's health literacy courses are delivered in collaboration with our community outreach partners:
  - **Slow-cooking nutrition**: Slow-cooking nutrition is a free course taught at various venues throughout the community, consisting of a 1 or 2 class series. The course offers nutrition 101, wellness activities, healthy meals/recipes for a crock pot and Aetna benefits overview. The course focuses on nutritious and affordable meals using a slow cooker. At completion of the course participants receive an Aetna branded crock pot. This benefit aims to foster awareness and capability of participating enrollees of low-cost nutritious food choices.
  - **Diabetes nutrition:** Aetna offers a free basic diabetes course taught at various venues throughout the communities in Regions 4 and 8, where need is high. It is offered as a 6-8-week series.

Educating enrollees about their access to PCPs and specialists: In support of Aetna's person-centered approaches to support evidence-based care, we allow Individuals with Special Health Care Needs direct access to network specialists without health plan authorizations and care managers educate Individuals with Special Health Care Needs on how to use the network. Care managers educate enrollees on the availability of and how to use the provider directory to identify specialists who can provide the services necessary to meet their unique needs.

We have learned that often, enrollees and families agree that a specialist who is most familiar with the enrollee and the enrollee's specific needs may provide the best experience for the enrollee as their PCP. We inform enrollees of their option to request a specialist to serve as their PCP in the enrollee handbook and during care management contacts by members of the ICT. If the enrollee or guardian makes a request for the specialist to serve as the PCP to Aetna, the specialist must agree to perform all the services required of a PCP, be an authorized Medicaid provider, and be credentialed, as documented in our provider manual. The CMO or designee reviews the request and reaches out to the specialist to gather additional information, as needed. If all conditions are met, the CMO approves the request within seven business days. If an enrollee with a specialist already acting as their PCP transitions to Aetna, the CMO

approves the request within **one business day** to support continuity of care; the specialist can serve as the enrollee's PCP without further application. The enrollee's care manager communicates regularly with the specialist to offer information and support and monitor that they are meeting the PCP requirements

Enrollee mobile application: We support the right of every enrollee and guardian to have the information they need to make good decisions through our no-cost Aetna application for both iOS and Android smartphones, described in detail previously in this section. The application increases the ability of enrollees and their guardian to participate in the care planning process by giving them access to pertinent information and communication tools.

b.iv. Approach to Providing Transition Support Services

Transitioning from one setting to another can be difficult for enrollees and their family members or caregivers. Aetna understands that effective transitions of care are paramount to maintaining and improving enrollees' quality of care, quality of outcomes, and most importantly, quality of life. We work to promote a seamless transition of care with the aim of improving enrollees' health and recovery, effectively coordinating their care, and reducing future admissions. In addition, Aetna recognizes the importance of an enrollee's home environment in their recovery and success. When requested and when deemed appropriate, in home therapeutic services are provided that focus on engaging the enrollee, their immediate supports, and anyone else identified within their circle of supports.

We modeled our transitional care management program on the Coleman Model, pioneered by Eric Coleman, M.D., M.P.H., from the University of Colorado. Aetna uses the model's four pillars to promote high-quality transitional care management. They are as follows:

- **Medication self-management:** We educate the enrollee on medications and help the enrollee develop a medication management system that fits with their needs.
- **Use of a dynamic enrollee-centered record:** Aetna works with enrollees to utilize the enrollee portal to facilitate communication and ensure continuity of care across providers and settings.
- **PCP and specialist follow-up:** Care managers support enrollees to schedule and complete follow-up visits with PCPs or specialists, and they educate enrollees on how to be an active participant in their care.
- **Knowledge of 'red flags':** We help enrollees to identify when their condition is worsening and educate them on how to seek the appropriate level of care.

Because enrollees are at significant risk when moving from one setting to another, effective care transitions are vital to decreasing potentially preventable events. **Our integrated care management model encompasses a strengths-based approach that empowers enrollees to achieve their optimal level of functioning**. The enrollee, along with their family and circle of support, are the principal voices and decision-makers in the transition process. We serve as very strong advocates to coordinate care that incorporates evidence-based care and community services with a wraparound approach that addresses social determinants of health. Emphasis is also placed on the provision of in-home services to ensure that enrollee's needs are met within their immediate family, social, and cultural environment. Aetna care managers work with Bluegrass Care Navigators and CPESN pharmacists to assess and support enrollees to make local connections that can support their journey to wellness.

Emphasizing continuity and coordination of care, Aetna care managers participate in transition-focused interdisciplinary care team meetings involving the enrollee, their circle of support, PCP and other providers and discharge planners to gain a holistic understanding of each enrollee's unique whole person needs related to transitions of care. Our care managers collaborate with discharge planners at inpatient facilities to make sure each enrollee receives the highest level of service and oversight to address their unique clinical and care management needs. We routinely monitor metrics (e.g., number of face-to-face visits, adverse incidents, number of enrollees engaged in care management) to help make sure our

transition of care program is effective in ensuring positive outcomes and to guarantee we have quality, knowledgeable staff necessary to meet the specific needs of our enrollees in each of the eight diverse regions of the Commonwealth. Working in concert with our locally based multidisciplinary care management teams, Aetna assigns care managers focused on transitions of care to specific hospitals and facilities to manage our enrollees' transitions from one setting to another. Discharge planning starts at the time of admission. Transition of care staff complete face-to-face visits with enrollees and their families/caregivers, which provides us with valuable access to the treating physicians and other hospital staff so that that we manage discharge orders and referrals as seamlessly as possible for our enrollee. Care managers serving enrollees in complex care management function as the transition care manager to provide continuity of care and maintain the single point of contact for the enrollee. We enhance this offering with support from telehealth, telemedicine, remote patient monitoring for at-risk enrollees, and post-discharge nurse visits. We will incent physical health and behavioral health providers to increase collaboration when the enrollee's care requires it.

We are in the process of developing the capability to interface with Kentucky Health Information Exchange (KHIE). Through KHIE, the care manager can retrieve the enrollee's information, including primary care visits, unmet health-related resource needs, and medication and pharmacy history to determine risk. This will enable our care providers to collaborate on creating a comprehensive, real-time data set to share across the provider continuum to promote achieving quality outcomes such as HEDIS scores and preventable readmission reduction.

Aetna care managers review all elements of the provided data and coordinate discharge activities with Aetna UM staff, which conducts concurrent reviews as enrollees' transition to new levels of care. The UM nurse coordinates with the care manager and housing specialist for all discharge needs so there is an efficient and safe discharge plan meeting the needs of the enrollee in the least restrictive setting, with all services ready for the enrollee immediately upon discharge. We provide transitional care management for enrollees to support transitions back to the enrollee's own/family home, between institutional and community care settings, including transitions to/from inpatient hospitals, nursing facilities, psychiatric facilities, psychiatric residential treatment facilities (PRTFs), therapeutic group homes, permanent supportive housing, intermediate care facilities, residential substance use disorder settings, and transitions out of incarceration**. Table C.25-4** highlights key components of our program.

Table C.25-4: Care Transition Approaches for Facilities across the Continuum of Care

Facility	Approach
Rehabilitation services, PRTFs, and therapeutic group homes	Aetna's online referral platform allows rehabilitation providers the ability to make real-time referrals to Aetna transitional care management. Care managers engage enrollees to determine their readiness to transition to a less restrictive, more integrated environment, with the goal of assisting enrollees to remain in their home whenever possible.
Psychiatric hospitals	Aetna partners with Kentucky's psychiatric hospitals, which provide real-time discharge summary information to Aetna to allow for immediate transitional care management follow-up. Upon discharge, Aetna care managers and the recovery and resiliency administrator connect enrollees to resources in their local community, including primary care, behavioral health, and non-medical resources.
Skilled nursing facilities and residential settings	Aetna notifies skilled nursing facilities and other residential facilities when they have admitted an enrollee who is receiving transitional care management. Together, the facility care team and the dedicated local Aetna care manager identify and implement any additional needed coordination tasks. Care managers reassess enrollees quarterly to determine if a transition to a less restrictive, more integrated environment, such as the home or an assisted living facility, is feasible. If a transition out of the skilled nursing facility or residential facility is determined to be appropriate, the care manager begins discharge planning to make sure all necessary services and supports are in place to support the enrollee post-transition.

Facility	Approach
Inpatient facilities	Transition from inpatient facilities is critical for enrollees to succeed. Aetna's care managers coordinate with discharge staff at the hospital to serve enrollees where they are—close to their homes and circle of support. Aetna will continue to coordinate with hospitals to allow for timely implementation of transitional care management.
Other transitions such as permanent supportive housing and transitions out of incarceration	Aetna's care management staff and the justice system liaison work closely with the housing specialist and other members of an enrollee's regional multidisciplinary team to coordinate care and implement transitional care management activities. Care managers connect with incarcerated enrollees before they are released to ensure connection to services upon release.

Success Story: Enrollee with Anorexia and Other Behavioral Health Conditions

Julia (not her real name), a 27-year-old female, was referred to Aetna care management following her discharge from an inpatient hospital, behavioral health setting. She was diagnosed with Asthma at age 8, Paranoid Schizophrenia at age 19, Autistic Spectrum Disorder at age 7, Obsessive Compulsive Disorder at age 14, Anorexia Nervosa at age 13 and she had experienced sexual trauma starting at age 5 and lasting through age 12. Julia wants to have her health stabilized so that she can get her own apartment and get a job working with animals.

Over time, her providers became most concerned with her restrictive eating behaviors and drastically declining body weight. Her Aetna care manager collaborated with Julia on her personal treatment goals and coordinated with several community providers and the System of Care staff, internal to Aetna, in order to identify appropriate support and treatment options. Julia participated in various partial hospitalization programs in the past with mixed response, intensive outpatient programs with no noticeable benefit, and outpatient programs which she seemed to enjoy the most. During Julia's course of outpatient treatment, the care manager coordinated with an agency to provide in-home weekly support visits to Julia. Further in-home evaluation of Julia resulted in the recommendation by the treatment provider that she attend an inpatient eating disorder program that could address her trauma history and eating disorder in a holistic approach. As the care manager discussed inpatient options with Julia during face-to-face visits, evaluated the pros and cons with her, addressed her concerns and questions and assisted her to make a decision based on what was best for her. A program in Utah was contacted and agreed to admit Julia. Though this program would separate Julia from her current family and supports, she agreed to attend the Avalon Hills Eating Disorder program in Utah and the care manager facilitated the single-case agreement for her admission. Julia was eager to begin her process of healing and excited to stabilize her medical, dietary, and psychological health because she wants to live independently and get a job working with animals. Julia is making progress on resolving her behavioral issues and seems to be gaining insight into the connection between her history of trauma and her eating disorder. The discharge plan is set for Julia to return to Kentucky to a group home setting while she looks for a job and saves money to get her own apartment. Her care manager is working on building a network of supports for Julia when she returns to include outpatient group therapy, vocational rehabilitation, peer supports, and housing supports.

Pharmacy support for transitions: Aetna has assembled a team of health professionals to manage and coordinate the transitional care of enrollees discharged from inpatient and outpatient facilities. This integrated team focuses on individual planning for each enrollee's return home and coordination of appropriate care and discharge follow-up. The care team includes a pharmacist, who conducts medication reconciliation for the enrollee. Medication reconciliation consists of comparing a list of medications used prior to admission compared to medications prescribed at discharge and resolving any conflicts in therapy. A clinical pharmacist participates in daily transitional care management rounds as appropriate. Enrollees have access to their care manager and the Aetna pharmacist for additional follow-up.

Transitions for enrollees with serious mental illness: As required by **Section 35.4 of the Draft Medicaid Managed Care Contract and Appendices (Enrollees with SMI Residing in Institutions or At Risk of Institutionalization)**, our care managers provide enrollee-focused, holistic supports to assist

enrollees with SMI to transition out of institutions whenever possible or to avoid institutionalizing if they are at risk by:

- Actively participate in transition planning and continued care coordination for enrollees who are transitioning from licensed personal care homes, psychiatric hospitals and other institutional settings to integrated, community-based housing
- Support the enrollee in identifying their needs in ensuring seamless transition and that they have the supports and services in place to maintain community tenure and achieve recovery and resiliency
- Conduct a comprehensive physical and behavioral assessment to support transition success within 14 days of the transition. Care managers support this activity by reviewing the enrollee's person-centered recovery plan and level of care determination in alignment with our UM activities.
- Authorize medically necessary services recommended in the person-centered recovery plan within 14 days

New enrollees' access to non-PCP out-of-network (OON) specialists: Although prior authorization is usually required for OON providers, we grant accommodations during transitions of care to allow new enrollees and their families to maintain established relationships with providers who may be OON for 90 days as we work to establish in-network options. Aetna establishes single case agreements with OON specialists in our proposed service areas, and outside our service areas or outside Kentucky when medically necessary specialty care is not available within our network. For example, Aetna was able locate an OON provider to treat an enrollee who had lost all his teeth and much of his jaw due to cancer treatments. The OON provider was able to address the enrollee's needs with dental implants which significantly increased his ability to eat and supported his nutritional needs.

60.7.C.26 Program Integrity

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60.7.C.26 Program Integrity (Section 36.0 Program Integrity)

Aetna is committed to ensuring the effective use and management of public resources in the delivery of services to Medicaid managed care enrollees. It is imperative that we protect the funds that enable the program to provide services and verifying delivery of services. This translates to the need for a robust program integrity (PI) program that consists of **written policies, procedures, practices, and standards of conduct** that proactively prevent fraud, waste, and abuse (FWA). Aetna's Kentucky Medicaid health plan maintains a strong commitment to identifying improper payments and other potential FWA to make certain that Commonwealth and federal tax dollars are appropriately spent.

Active, Collaborative Engagement in Program Integrity

Aetna participates in monthly collaboration calls and quarterly meetings with other Kentucky Medicaid MCOs' Special Investigations Unit (SIU) staff to share information about fraud schemes and other relevant issues. Most recently, we hosted a meeting of MCO SIUs, Department Program Integrity Unit, Office of the Inspector General, and US Attorney's office in March 2019.

Aetna understands, acknowledges, and will comply with all the requirements of **Section 36** of the **Draft Medicaid Managed Care Contract and Appendices**, including but not limited to **Appendix M Program Integrity Requirements**, and **Appendix D Reporting Requirements**. Aetna will comply with all applicable federal and Commonwealth laws and regulations including, but not limited to, Article 51 of Chapter 1 of the General Statutes, 42 C.F.R. part 455, 42 C.F.R. § 438.608, and Section 6032 of the Federal Deficit Reduction Act of 2005.

We will continue to elevate the awareness in Kentucky within our organization and across our provider network of methods to prevent, detect, and report potential FWA. Aetna has a demonstrated history of success in working with Commonwealth and federal oversight agencies to meet the shared goal of ensuring the effective use and management of public resources. In Kentucky, we routinely collaborate with other Medicaid managed care organizations (MCOs), Cabinet for Health and Family Services Office of the Inspector General, Department Program Integrity, Office of Medicaid Fraud and Abuse (Attorney General), and the U.S. Attorney's Office to prevent, deter, and eradicate FWA and **ensure the financial sustainability** of the Medicaid program.

a. Detailed Summary of Program Integrity Plan

Aetna's Kentucky PI plan establishes internal controls, along with policies and procedures to ensure the prevention, detection, and deterrence of FWA in accordance with Commonwealth and federal requirements. Our approach consists of best practices—sound, proven policies and procedures that proactively prevent and reduce FWA. We enforce a **zero-tolerance policy** toward any form of FWA by staff, subcontractors, providers, enrollees, or others. The plan includes detection and prevention program activities for staff, enrollees, caregivers, and providers, including reporting and follow-up; continuous monitoring of compliance; identification and reporting of issues to all required parties; and ongoing training.

Compliance Staff

Our Kentucky compliance officer, **Kentucky native LaRhanda Trammell**, reports to Chief Executive Officer (CEO) Jonathan Copley and the board of directors. The responsibilities of the compliance officer include maintaining effective lines of communication with our PI staff by way of meetings, brown bag sessions, and compliance week activities. Located in Louisville, Ms. Trammell is the point of contact for the Commonwealth and DMS PIU staff as well as internal Aetna staff regarding compliance and program integrity. The Program Integrity staff is in Kentucky, fully dedicated to the Kentucky contract, and works directly with the national SIU and Compliance teams regarding FWA activities and Aetna's local

prevention and detection efforts. In collaboration with Compliance, this team also works with the Kentucky SIU team on timely responses to Department requests for compliance information. All company issues, suggestions, and communications are submitted to a Compliance inbox and addressed accordingly.

Our two **Kentucky-based senior investigators**, Kimberly Gentry and Phyllis Wells, are **100 percent dedicated to our Kentucky Medicaid health plan** and report directly to the health plan CEO. Our entire team has extensive knowledge of Kentucky, its regions and providers, and is devoted to our enrollees.

The primary functions of the Kentucky SIU team include the following:

- Prevent fraud, waste and abuse by identifying vulnerabilities in the contractor's program including identification of enrollee and provider fraud, waste, and abuse and then taking appropriate action including but not limited to the following:
  - Recovery of overpayments
  - Changes to policy
  - Dispute resolution meetings
  - Appeals
- Proactively detect incidents of fraud, waste, and abuse that exist within the contractor's program using algorithms, investigations, and record reviews
- Determine the factual basis of allegations concerning fraud or abuse made by enrollee
- Initiate appropriate administrative actions to collect overpayments adhering to Commonwealth requirements
- Work in collaboration with the Department PI and other agencies for resolution/next steps of the investigational case

a.i. Program Integrity Plan: Fraud and Abuse Detection/Prevention Program Activities for Employees, Caregivers, and Providers

Aetna's PI plan requires that we maintain the investigatory capacity, expertise, and experience necessary to comply with all applicable requirements and standards under the contract as well as all federal and Commonwealth requirements and standards to detect FWA. Aetna will comply with all standards defined by the Department for the health plan's Program Integrity Unit (PIU), including the following:

- Responsibilities for SIU Kentucky investigators:
  - Identifying a minimum of 2 percent in provider overpayments and prepayment cost avoidance on Report 64
  - Conducting a minimum of three onsite visits per quarter
  - Attending any training or meeting given by the Commonwealth
  - Collecting outstanding debt owed to the Department
  - Responding to informational or reporting requests timely
  - Requesting permission to administratively collect overpayments in excess of $500
  - Ensuring formal case-tracking and case management of provider and enrollee cases
  - Maintaining two full-time investigators with a minimum of three years of Medicaid FWA investigatory experience located in Kentucky and dedicated 100 percent to the Kentucky Medicaid program
  - Notifying the Department's program integrity director of any absence or vacancy that is more than 30 days along with a contingency plan to remain compliant with the other contract requirements in the interim
  - Meeting the requirements of **Appendix M of the Draft Medicaid Managed Care Contract, Program Integrity Requirements, Section IV(k)**

- Responsibilities for providers:
  The Kentucky-based SIU team collaborates with the Provider Services team to participate in provider forums that are held annually, at minimum, as well as sharing information via the provider manual that is updated annually.
- Responsibilities for staff:
  The SIU team leads quarterly meetings hosted by SIU with Kentucky staff to discuss trends, cases, and what to look for when identifying possible FWA, and to share other information regarding active cases and investigations.
- Caregivers/enrollees:
  The SIU team shares FWA information via the enrollee newsletters, the Aetna website, and Enrollee Advisory Committee meetings.

Our Compliance program contains robust PI processes designed to reduce or neutralize the deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification of services; prior authorization (PA) of services; or claiming payment for a service that was never delivered or received (refer to **Table C.26-1**). Our major FWA activities include the following: **prevention**—prepayment claim review and routing to avoid fraudulent payments; **detection**—using proactive data analysis to identify providers of interest based on behaviors within their peer groups; **investigation**—thoroughly exploring historical/current provider billing/practice behavior; **recovery**—working with providers to understand, educate, and pursue recovery; and **reporting and compliance**—operational and financial results reporting and mandated Commonwealth and federal fraud reporting.

Table C.26-1: Types of Potential Provide and Enrollee Fraud, Waste, and Abuse that Aetna Investigates

Provider Fraud, Waste and Abuse Schemes	Enrollee Fraud, Waste and Abuse Schemes
Aetna investigates providers if there is suspicion of the following: • Knowingly billing for services not furnished or supplies not provided, including billing Medicaid for appointments an enrollee failed to keep • Billing for nonexistent prescriptions • Knowingly altering claim forms, medical records, or receipts to receive a higher payment • Unknowingly billing for unnecessary medical services • Unknowingly billing for brand name drugs when generics are dispensed • Unknowingly excessively charging for services or supplies • Unknowingly misusing codes on a claim, such as upcoding or unbundling codes • Conducting excessive office visits or writing excessive prescriptions • Prescribing more medications than necessary for treating a specific condition • Ordering excessive laboratory tests	**Aetna investigates enrollees if there is suspicion of the following:** • Loaning or using another person's identification card to get medical services • Changing or forging an order or prescription, medical record, or referral form • Selling prescription drugs or supplies obtained under health care benefits • Providing false information when applying for benefits or services • Using transportation services to do something other than medical services • 'Doctor-shopping' for prescriptions • Residing in one state while using benefits for another state

We focus on practices that are inconsistent with sound fiscal business or medical practices that result in unnecessary cost to the Commonwealth's Medicaid program. Our PI program is supported by our unique local leadership and Aetna Medicaid organization that offers 30 years of national, robust experience in 16 states.

Identifying and Addressing Potential Fraud Impacting an Enrollee

Recently our SIU team became aware of and investigated a potential stolen identity case involving one of our enrollees who is 10 years old. We learned that someone was scheduling appointments under the child's name. We immediately acted by reviewing medical and pharmacy claims to ensure there had been no claims submitted fraudulently. A memorandum was sent to DMS PIU alerting them of the issue and the appropriate actions that SIU took to resolve the concern. Our SIU team responds urgently to any concerns related to FWA that may impact our enrollees. We work closely with our Enrollee Services Call Center and care management teams to identify potential issues as they are in close communication with enrollees.

Grounded in the U.S. Department of Health and Human Services and the Office of the Inspector General's *Seven Elements of an Effective Compliance Program,* we continually prevent FWA and neutralize challenges to PI by doing the following:

- Using Aetna's approved policies and procedures
- Maintaining sufficient staff and resources that include a dedicated medical director and accredited health care fraud investigators to investigate incidents and develop corrective action plans, when necessary
- Delivering provider, subcontractor, enrollee, caregiver, and staff training and education
- Maintaining effective communication by collaborating with the Department to track and neutralize FWA, receiving support from our parent organizations (CVS Health Corporation [CVS] and Aetna Inc.), Compliance, and SIUs, and following federal and Commonwealth regulations and guidance
- Publicizing appropriate disciplinary guidelines to all staff and providers
- Employing sophisticated, market-savvy technology to audit, monitor, and measure compliance with program requirements
- Deriving a prompt response through investigating, referring, and reporting suspected and confirmed fraud and/or abuse to the Department's Program Integrity Unit and State Medicaid Fraud Control Unit (MFCU), and creating robust corrective action plans—we have over **150 national full-time staff dedicated to FWA, including the two investigators dedicated specifically to Kentucky**.

Aetna is a founding member of the National Health Care Anti-Fraud Association.

In Kentucky, Aetna is committed to collaborating with the Commonwealth and various federal agencies to combat Medicaid FWA. We have a highly effective system for escalating and resolving issues, and our oversight and monitoring programs adhere to our policies. We stay current on FWA and related issues by participating with the National Health Care Anti-Fraud Association (NHCAA), the National Association for Medicaid Program Integrity, the Centers for Medicare and Medicaid Services (CMS) Healthcare Fraud Prevention Partnership, and multiple health care anti-fraud task forces at state and federal levels.

Aetna's Kentucky PIU in Action

In Kentucky, the Aetna SIU team is currently working on a project to review overutilization and wasteful billing by ambulance providers submitting claims for potentially medically unnecessary urgent care transportation costs. We are reviewing costs specifically in rural areas of Kentucky.

Our Program Integrity team is supported by the Aetna Medicaid organization's SIU team. In addition to supporting the health plan, this team also identifies schemes occurring in other Medicaid plans then mines data for those schemes within Aetna. Working collaboratively creates synergy with our corporate investigators who monitor commercial and Medicare lines of business to leverage corporate-wide data. This economy of scale improves Aetna's ability to detect and remedy incidents of FWA. For example, if a provider improperly bills Medicare, investigators check all lines of business for the same allegation, including Medicaid, which gives us

additional leads through data mining we may not otherwise find. Similarly, Aetna's national Medical Economics department advises the local health plan regarding current trends and schemes occurring around the country.

Reporting and Follow-up

Aetna has a variety of tools designed to promote the reporting of suspected FWA, including the following:

- A dedicated toll-free 24-hour telephone hotline, CVS Health Ethics Line, accessible to any stakeholder (including staff, enrollees, and providers) for making confidential, anonymous, and non-retaliatory verbal reports of actual or suspected FWA
- An email address and web form for enrollees and providers to report FWA
- Easy internal online access for staff to report FWA concerns confidentially to the SIU
- Information on the intranet for staff about how to report concerns to the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Medicaid Fraud Control Units (MFCU), or other regulatory agencies
- Written materials about the compliance program, such as ways to report suspected or known fraud and abuse, and disciplinary guidelines for compliance violations and failure to report
- Web-based training on Aetna's compliance policies, programs, disciplinary standards, and operational guidelines, as well as Commonwealth-specific rules and regulations

Our Kentucky-based SIU team members diligently safeguard against the potential for suspected FWA by staff, subcontractors, providers, and others with whom we do business and promptly investigate any allegation. Once potential FWA is detected, our SIU staff is responsible for the investigative process and reporting to the Department. After the investigation is complete, a final report including an executive summary, case notes, and recommendations, including any recovery figure, is presented to the compliance officer and the FWA Committee, when appropriate. This committee reviews the case and develops a corrective action plan. If we find a credible allegation of fraud at any point in the process, the case is reported to the Department by way of referral.

Continuous Monitoring of Program Integrity

In Kentucky, Aetna routinely monitors and audits enrollee, provider, and compliance risks using a variety of technologies and methods to prevent and detect questionable billing practices and to avoid fraudulent claims payments such as business intelligence software to identify providers whose billing, treatment, or patient demographic profiles differ significantly from those of their peers. We run a weekly report and manually review 100 percent of all claims submitted with dollar amounts of $50,000 or more and paid amounts of $30,000 or more. We also review the OIG work plan continuously and follow CMS recommendations on high-risk provider types. Investigators review the data mining report and take appropriate action. Specific methods include the following:

Stopping Dental FWA

In mid-July 2018, our dental vendor Avēsis, received a tip that one dentist was billing for services at two locations that were performed by non-credentialed dentists. After verifying the tip, Avēsis staff met with both practices to re-educate them on the contractual requirement that they only bill for services performed by credentialed dentists. At this time, they opened a formal fraud investigation. After a four-month investigation, Avēsis affirmed that a total of $1,942.11 in Medicaid dental services were rendered by non-credentialed dentists at each of the sites. The results of the investigation were sent to our team, who forwarded the information to DMS along with a request to proceed with recoupment. Two months later, in January 2019, both cases were referred to the Office of the Inspector General and our teams closed their work on the cases.

- **Internal applications** such as Healthcare Fraud Shield run enrollee analytics including the following: eligibility to determine if the home address is a P.O. Box; checking for multiple enrollees living at the same address/using the same phone number; verifying enrollee address and phone number during provider visits; pulling any enrollees with high emergency department use; and sorting through obituary files or investigatory news articles that may include enrollees or providers, among others.
- **Prior authorization** enables Aetna to monitor the use of defined outpatient services and procedures as well as non-emergency or elective hospitalizations before the enrollee receives the service. PAs confirm requested services are for eligible enrollees and are included in the defined benefits; provided at an appropriate level of care and place of service; appropriate, timely, and cost-effective; coordinated with medical management; communicated to applicable operations areas (e.g., finance, enrollee services, provider services) or per contractual requirement with external vendors; and documented accurately to facilitate timely reimbursement and reporting.
- **Drug utilization reviews (DUR)** are performed by Aetna's pharmacy benefit manager, CaremarkPCS Health. We perform prospective, concurrent, and retrospective DURs as methods for identifying suspicious activity. DURs also enable enrollees to achieve improved health outcomes, help prevent negative outcomes, improve quality of care, and reduce costs by preventing inappropriate or unsafe drug use. The prospective and concurrent DUR processes are executed using computerized algorithms built into CaremarkPCS Health's claim history. The system prevents dispensing without further review and/or action by the dispensing pharmacists at the point of sale and creates alerts such as the following:
  - **Soft block alerts** so the pharmacist evaluates the enrollee's drug profile. The alerts offer considerations to the enrollee for discussion with their provider, counseling on appropriate drug use, and/or consultation with the provider concerning the appropriateness of the medication.
  - **Hard block alerts** result in a rejection that would require the pharmacist to reach out to the prescribing provider to submit a request for PA and/or to contact the pharmacy help desk for an override prior to dispensing the requested medication
  - **Retrospective DUR** adds a second layer of safety for situations that may have a negative clinical impact on an enrollee. Retail and specialty prescriptions are reviewed daily for serious drug-to-drug interactions. The prescriber is notified with an actionable, enrollee-specific communication within 72 hours of the claim processing. This program provides near real-time review and intervention focused on increased enrollee safety and increased prescriber engagement. In 2018, 3,908 drug interaction alert opportunities were sent to prescribers within 72 hours of fill; an 8 percent prescriber response rate noted that prescribers found intervention information useful 33 percent of the time, and not useful less than 10 percent of the time. From January to September 30, 2019, 1,995 drug interaction alert opportunities were sent to prescribers within 72 hours of fill; a 6 percent prescriber response rate noted that prescribers found intervention information useful 42 percent of the time, and not useful less than 4 percent of the time**.** A third layer of safety is applied through a program from CaremarkPCS Health to target high-risk drug classes, focusing on controlled substances and inappropriate use and misuse-related indicators such as polypharmacy, provider shopping, high-total controlled substance claims volume, and drugs at risk for FWA. On a quarterly basis, clinical pharmacists evaluate controlled substance claims and available supporting medical data to identify potential medication misuse and inappropriate claims for appropriate intervention. Pharmacists also conduct follow-up activities using physician responses and current claim activity. Situations identified as being potentially inappropriate may be referred to our pharmacy director and case manager for further action. Target drugs include opiates, anti-anxiety and sedative hypnotic agents, muscle relaxants, and central nervous system stimulants.
  - Aetna's Kentucky PI staff communicates with the health plan pharmacy director, April Cox, on any issues of suspected pharmacy FWA. Ms. Cox can make referrals to the FWA team as needed regarding prescribers or pharmacies that may need some type of outreach/investigation. Our PBM

does audits on pharmacies only and makes recommendations/removals from the pharmacy network.

- **Pharmacy Supportive Managed Care Program** (formerly known as the lock-in program) allows Aetna to control the over-use of opioids by only allowing an enrollee to obtain their opioids prescription from the same physician and same pharmacy. Some of the enrollees referred to case management are participants in our Supportive Managed Care program. Based on the various monitoring and trend analyses described previously, we implement or refine interventions to improve prescribing and utilization patterns and to control costs. These interventions may include but are not limited to the following:
  - Identifying prescribing patterns of specific practitioners that warrant outreach and/or education to review inconsistency with nationally recognized treatment protocols
  - Making referrals to the review committee to evaluate identified enrollees' utilization to determine whether they are candidates for pharmacy or prescriber lock-in
  - Making referrals to FWA, the OIG, or law enforcement agencies for further investigation of enrollees, prescribing practitioners, and pharmacies
  - Identifying and making referrals of enrollees to service coordination for outreach and engagement with a focus on adherence to medication regimens; pharmacy refers enrollees to lock in based on informatics reports that check for utilization of enrollees utilizing 5-10 different pharmacies and/or 5-10 different prescribers during the quarter as well as referrals from the PBM Safety and Monitoring program.
- **Targeted audits** (e.g., contract, benefit, provider, diagnosis, procedure, specific service, and place of service). Aetna audits 2 percent of manually adjudicated claims and 0.15 percent of auto-adjudicated claims. We run a weekly report and manually review 100 percent of all claims submitted with dollar amounts of $50,000 or more and paid amounts of $30,000 or more. Each audit includes key departmental issues identified in addition to a summary of financial and procedural accuracy. Aetna finalizes, publishes, and distributes monthly and quarterly audit results to the business units. The reports include trends by error type, claim identification, and analyst identification, which enable the Claim Operations department to conduct continuous quality improvement discussions. Based on audit findings, management staff provide or track additional training as needed.
- **Post-payment reviews** are conducted in collaboration with the SIU team and Aetna leadership. Potential cases are presented with recommendations for next steps. Additionally, data mining analyses, with validation of diagnosis-related group accuracy, is performed by Cotiviti, which can also complete post-pay review for all claims. These reviews can identify and recover overpayments and could lead to active investigations and cases. Cotiviti will collaborate with the SIU team if there is a possibility for adjustments or recoupments pertaining to FWA activities. This teamwork may also be utilized by Cotiviti performing a clinical chart review if improper billing or potential FWA is identified.

We also detect FWA through several other activities and sources, including the following:

- Universal Web Information Delivery, an application that investigators use to pull reports directly from their desktops; these reports can be pulled by provider tax ID, national provider identifier, enrollee ID, and procedure codes, among others, and are used to supplement investigations as well as identify new providers and/or schemes
- TIPS report reviewed during monthly FWA collaboration calls with other MCOs and Department PI
- Quarterly meetings with other MCOs, Department PI, Attorney General's office, Commonwealth OIG, and MFCU
- Referrals of suspected FWA by enrollees, providers, and Aetna departments outside the FWA area
- Referrals from law enforcement/Commonwealth regulatory agencies such as MFCU and OIG
- Monitoring of national trends and specific case referrals through Aetna affiliations with national industry groups, including the NHCAA

Working Together to Prevent and Detect Fraud, Waste, and Abuse

Each of our departments plays a vital role in our compliance efforts, including promoting program integrity and monitoring for FWA. Armed with the knowledge they gain through compliance training, Aetna team members in every department know they play a key role in promoting program integrity and monitoring for FWA; they know their FWA responsibilities in the context of their roles within the health plan. Their expertise within their disciplines, along with provider and enrollee referrals, complement the automated pre- and post-payment edits, audits, and analytics performed by the FWA team. For example, reports by our Medical Management team sometimes highlight unusual patterns that indicate potential FWA. The director of pharmacy and the director of clinical health services both play a role in detecting polypharmacy and overprescribing issues. Our Provider Services and Quality Management teams are trained to identify FWA indicators during routine office visits. The Enrollee Services department tracks and documents enrollee complaints and survey results that may suggest FWA issues or emerging fraud trends.

Additionally, our Credentialing department validates provider credentials and evaluates provider information from a variety of sources, including federal and state licensing, quality, and exclusions databases. Aetna's Kentucky staff is highly aware of who our investigators who are here at the health plan. They reach out when concerns of FWA occur to discuss if a case needs to be referred to the Department. There is a daily Department compliance call at which representatives from each department attend and discuss any issues. If there is a concern, staff can reach out directly to the investigators and/or the compliance officer.

Identification and Reporting of Issues to all Required Parties

In 30 years of experience serving Medicaid programs, Aetna's Medicaid organization has learned that education, outreach, and hotlines, along with robust data management and analytics, are the keys to FWA identification and reporting. Our Kentucky health plan's team members diligently safeguard against the potential for, and promptly investigate reports of, suspected FWA by staff, subcontractors, providers, and others with whom we do business.

Once potential FWA is detected, our SIU staff is responsible for the investigative process and reporting to the Department. After the investigation is complete, a final report including an executive summary, case notes, and recommendations, including any recovery figure, is presented to the compliance officer and the FWA Committee, when appropriate. This committee reviews the case and develops a corrective action plan. If we find a credible allegation of fraud at any point in the process, the case is reported to the Department. For each complaint that warrants full investigation conducted in accordance with 42 C.F.R. §455.15 and §455.16, we will provide the Department, at a minimum, with all information required in **Appendix M, Program Integrity Requirements, Section IV(k)** of the **Draft Medicaid Managed Care Contract and Appendices**. We send a monthly report to the Department on all audits performed and overpayments identified and recovered by Aetna or its subcontractors as well as a monthly report stating all unsolicited provider refunds. We also report any overpayments made to us by the Department within 60 days of identification. Examples of reports we use include the following:

- The MCO **Member Investigative Report** is used to evaluate an enrollee case to determine if a referral to the Department is warranted based on the findings. If the investigator has an allegation they cannot validate, yet details of the allegation are substantial, a referral will be made.
- The MCO **Provider Investigation Report** is used for validated allegations of fraud or abuse. A workflow is initiated, reviewed, and approved by the SIU supervisor, an email is sent to the Department, and then it is passed onto local law enforcement.
- The **Provider Fraud Referral** is used to validate suspected fraud and determine if further action is required. If action is required, it is sent to the Department for evaluation of sanctions and to MFCU to determine if a criminal investigation is warranted. Once workflows are established, reviewed, and approved, the SIU supervisor will send the information on the provider fraud referral to the Department MFCU for evaluation and local law enforcement review.

- The **SIU Medicaid Data Analytics** reports that track new, active, ongoing, and closed cases.
  - The first one is a monthly TIPS report with data coming from the Case Tracker system (the SIU application that holds all referral/case detailed information and documentation). This report includes any active, open, or closed referrals/cases from the previous month, and is submitted to the Department by the SIU supervisor.
  - Quarterly reports showing provider FWA and enrollee FWA

Ongoing Training

Training is a key component to our prevention and detection. We deliver effective training programs and awareness initiatives to staff, subcontractors, enrollees, caregivers, and providers through a variety of forums.

Employee Training Programs and Awareness

We encourage collaboration, cross-training, and the exchange of best practices among all our staff. Our staff training supports our internal fraud prevention. Training begins on the first day of employment and continues with Aetna's yearly education and training requirements. This annual education includes all our FWA and PI policies, our Code of Conduct, and ethics via a combination of in-person and online training modules. Trainings include the following: FWA mission and purpose; definitions and explanations of FWA; high-level overview of applicable federal and Commonwealth regulations (such as the False Claims Act and anti-kickback regulations); how staff can report FWA to Compliance and FWA investigators; actions of an investigation (such as data mining, claims analysis, and medical record reviews); examples of successful FWA investigations; and overview of FWA partners (such as Commonwealth MFCUs, the NHCAA, and CMS).

Our Kentucky FWA training and policies are designed to help ensure that all staff conduct business in a legal and ethical manner and to prevent, detect, and investigate embezzlement, internal theft, and other forms of staff fraud in addition to provider and enrollee FWA. All new Aetna Kentucky staff must complete this training within 30 days of hire. Upon completion of initial and ongoing compliance training, our team members acknowledge that they participated and understood the information we provided and that they will adhere to compliance program requirements. **Our compliance officer, Program Integrity team, SIU investigators, and other essential personnel receive specialized and mandatory trainings** on the investigative process; key Commonwealth and federal regulations, processes, and procedures for addressing suspicious claims; and the procedure for facilitating communication among the health plan, appropriate authorities, and the Department. Our in-person and web-based NHCAA- and industry-specific training includes coding clinics, fraud schemes in the behavioral health (BH) arena, medical record review strategies, prescription drug fraud schemes, and intensive outpatient therapy, among others. Our compliance officer and Program Integrity team conduct ongoing FWA training at staff town halls, departmental meetings, monthly

Ongoing Learning and Collaboration

Aetna's internal SIU team holds monthly meetings to discuss caseloads, the status of cases, recent news articles and or follow-up from collaboration calls with the Department's Program Integrity Unit and the other MCOs' SIU teams. Aetna's goal is to collaborate internally to mitigate fraud, waste, and abuse and to be good stewards of Department funds and Commonwealth resources. These meetings have resulted in a project to develop an algorithm to allow us to mine data involving multiple hospitals in Kentucky and surrounding states where inappropriate revenue codes are being billed and services for enrollees are being billed multiple times for the same date of service.

We also have monthly "Brown Bag Sessions" led by the compliance team for the entire Aetna staff located in Kentucky. We use this time to educate our staff on compliance related issues, including FWA and the functions of the SIU.

newsletters, and upon request. We also participate in all Commonwealth trainings at the quarterly meetings.

Aetna publishes our **Code of Conduct training** on the intranet and on the Compliance and Regulatory Affairs home page. All staff are required to complete an attestation acknowledging that they understand and will comply with PI and compliance standards upon hire and annually as a component of their required compliance training. As set forth in our Code of Conduct, all business lines will be conducted based on the highest ethical standards and in strict compliance with applicable federal and Commonwealth laws and regulations. Our Code of Conduct explains to all staff that disciplinary action will be taken, up to and including but not limited to termination, for the following:

- Failing to follow the Code of Conduct, other related policies, or breaking any laws or regulations
- Telling staff to violate the code of conduct, an Aetna policy, a law, or a regulation
- Failing to share information, or providing false information in connection with an investigation, about a violation of the Code of Conduct, a law, or a regulation
- Retaliating against a staff member who, in good faith, reports a suspected violation or who cooperates or helps with an investigation
- Neglecting to address or report a violation of the Code of Conduct, or a law or regulation, committed by someone an Aetna staff member manages

We also reinforce that each staff member is required to report any suspected violations of the Code of Conduct to their immediate supervisor, an Aetna compliance officer, or the CVS Health Ethics Line, which supports anonymous reporting via toll-free phone call, email, or written letter.

Provider Training

Initial provider training takes place during orientation, with ongoing/supplemental training occurring through online provider forums, our secure online provider portal (where content is available 24/7/365), the provider handbook, and through individual communications with the Provider Services team. Our providers are encouraged to request individual supplemental training via our Provider Services staff any time they need additional information. Providers are educated on the definitions of FWA, provider PI and compliance responsibilities, methods for preventing FWA, and methods to report potential issues. Training also includes applicable laws such as the False Claims Act, Anti-Kick Back Statute, Stark Law, Office of Inspector General's List of Excluded Individuals/Entities, the General Services Administration System for Award Management, and the Health Insurance Portability and Accountability Act. Should providers have audit findings of potential FWA, we also provide FWA training to prevent further occurrences. Our SIU staff works closely with the Provider Services staff on cases, including communication, onsite visits, and medical records requests.

Subcontractor Training

All our subcontractors and their employees are required to participate in compliance and FWA training. We train our subcontractors in all areas of accountability and oversight for all functions and responsibilities that we delegate to them. In turn, we review their employee FWA program and verify that they provide FWA training to their employees. We monitor FWA activity, including whether the subcontractor is delivering the required reports and training, through subcontractor meetings. SIU staff conduct monthly meetings with Avēsis, our dental and vision subcontractor, and with our pharmacy benefit manager.

FWA Prevention through Enrollee and Caregiver Engagement and Training

Aetna's person-centered approach in Kentucky encourages enrollees to assume responsibility for their health, wellness, and care. We use the enrollee handbook, enrollee newsletters, website, and Enrollee Advisory Committee meetings as well as our verification of services process as ways to communicate with enrollees and their caregivers (if applicable) about their responsibilities in preventing and reporting

instances of FWA. The enrollee handbook and website provide information on various types of fraud and abuse such as identification card fraud, inappropriate use of emergency department services, and prescription drug use and benefits. Each of these tools informs enrollees on the definition of fraud and abuse, their responsibilities, the responsibilities of others, and how and where to report suspected or known fraud and abuse. Enrollees are encouraged to report all suspected FWA by calling Aetna's fraud hotline, calling the Department's fraud and abuse hotline, or by submitting an online fraud and abuse form via our website. Our Care Management team works with the enrollees to ensure they understand how to read their explanation of benefits (EOB).

Aetna is serious about tracking services and services billed to verify that the proper claims are being tracked to the enrollees receiving care and that no additional service claims are being billed for an enrollee who did not receive the service. We communicate information on FWA to our enrollees. Enrollees receive education on how to report FWA by calling the fraud hotline or using the online web form, as instructed in their enrollee materials and through EOB letters mailed to a random sampling of enrollees every month. The following highlights our enrollee communications vehicles concerning claims and FWA. All contacts display the amount billed, the enrollee rate, whether the claim is pending or not payable, deductible (if applicable), and copay, and include the following:

- **Enrollee mobile app:** Through a secure application, enrollees can view and verify their claims for primary care provider, pharmacy, specialist, transportation, BH, and other visits.
- **Enrollee secured portal:** Claims and pharmacy information is available for review.
- **EOB:** Enrollees can call our Enrollee Services staff and discuss the explanation of benefits and its significance; refer to their enrollee handbook, enrollee education materials, or the enrollee website; or discuss the EOB with their doctor. Enrollee EOB training includes how to track services received and confirmation that they will not have any balanced billing from us or their providers. Training also covers their responsibility to let us know if there are charges for services they did not receive.

a.ii. Regulatory Compliance Committee

The Aetna Better Health of Kentucky Board of Directors Regulatory Compliance Committee is charged with oversight of compliance activities at the plan to ensure contractual requirements as well as Commonwealth and federal regulations are met. They will review audit findings and other compliance efforts and report to the board. This committee is comprised of the health plan chief executive officer, chief financial officer, and two appointed board members. The compliance officer serves in a contributor role to the Regulatory Compliance Committee but does not have voting rights.

At the senior management level, the compliance officer chairs the Regulatory Compliance Committee, which meets quarterly or more often as appropriate to review trends, data mining, and specific allegations of FWA as well as risk and risk mitigation, training (compliance and FWA), and contract compliance issues. The committee is comprised of senior executive leadership from Medical Management, Quality Management, Health Services, Provider Services, Enrollee Services, the Special Investigations Unit, Operations, Grievance and Appeal, Pharmacy, and Provider Network. The PI/SIU staff present information to the committee to create awareness to all other departments of potential risk and further identification of prevention opportunities, training, or trends pursuant to the contract in accordance with Commonwealth and federal law.

The committee identifies potential compliance gaps and reports any instances of noncompliance to the Quality Management Oversight Committee on a monthly basis. The compliance officer also provides a quarterly compliance report to the board of directors. PI staff participates during these meetings and shares information on FWA activities.

In addition to our Regulatory Compliance Committee, Aetna's compliance team meets twice a week with the SIU team members and other staff including leaders from Informatics, Network Relations, and

Utilization Management. The interdepartmental PIU group reviews cases and discusses trends and concerns arising with contracted providers and in claims data. A primary focus of this meeting is to generate new data mining algorithms that assist in the identification of potential FWA. This committee also collaborated with the SIU team to review data from Healthcare Fraud Shield (HCFS). HCFS is a platform that comes equipped with approximately 600 business rules and algorithms that are maintained and updated quarterly. They are customizable at the health plan level to account for benefit variations and can be applied pre- and post-payment. This platform identifies providers with potential FWA behaviors and assigns them a risk score. The Aetna interdepartmental PIU group uses HCFS information to identify and discuss potential FWA with our contracted providers. By meeting twice a week we make sure that we discuss issues of concerns timely and take proper action, which includes notifying the Department's PIU and making recommendations for next steps. For example, through interdepartmental collaboration Aetna recently identified a provider that informed our care management team on a call of the possibility of FWA occurring at their agency. Due to this information, we were able to meet and discuss appropriate action for Aetna to take.

a.iii. Appeals Process

Upon completion of either a prepayment or post-payment review in which an allegation is substantiated by evidence, the investigator is responsible for pursuing recovery of overpaid benefits resulting from the submission of improper claims containing FWA. The investigator calculates the overpayment after confirming fee schedule amounts using the published fee schedules for the investigative period and determining whether to apply extrapolation to the overpayment. If necessary, the investigator works with our Data Analytics team to calculate the extrapolation using the distribution of errors in the sample along with the proper error ratios. Aetna uses the business analytics software procedure, SURVEYSELECT, which is a simple random sampling method that provides equal probability sampling. An overpayment letter to the provider is drafted, outlining the findings of the investigation, overpayment amount, investigator contact information, instructions on the appeals process, and the mailing address for remittances. All overpayment letters and overpayment schedules are reviewed and approved by the SIU supervisor prior to sending them to the provider requesting reimbursement. We request permission from the Department prior to requesting any overpayment of $500 or more and submit the reimbursement request letter to the Department for review.

The provider has 30 days to submit additional documentation or rebut the determination or extrapolation. The provider may request and receive a copy of the findings of the medical review that we conducted of the records provided. The provider may also request a peer-to-peer discussion with the chief medical officer (CMO) who conducted the review. Providers are given specific information regarding the findings and education where appropriate. Providers have the option of remitting the overpayment in a single payment or enter a payment plan if necessary. If the provider does not respond, the investigator follows up with letters, phone calls, or requests assistance from Provider Services staff. The provider may be placed on a negative balance to recoup the funds from future payments if they fail to repay the health plan. Aetna will engage in legal remedies if all other efforts fail.

Please refer to **Figure C.26-1** for a process flow of our appeals process and **Attachment T** for a copy of sample provider letters.

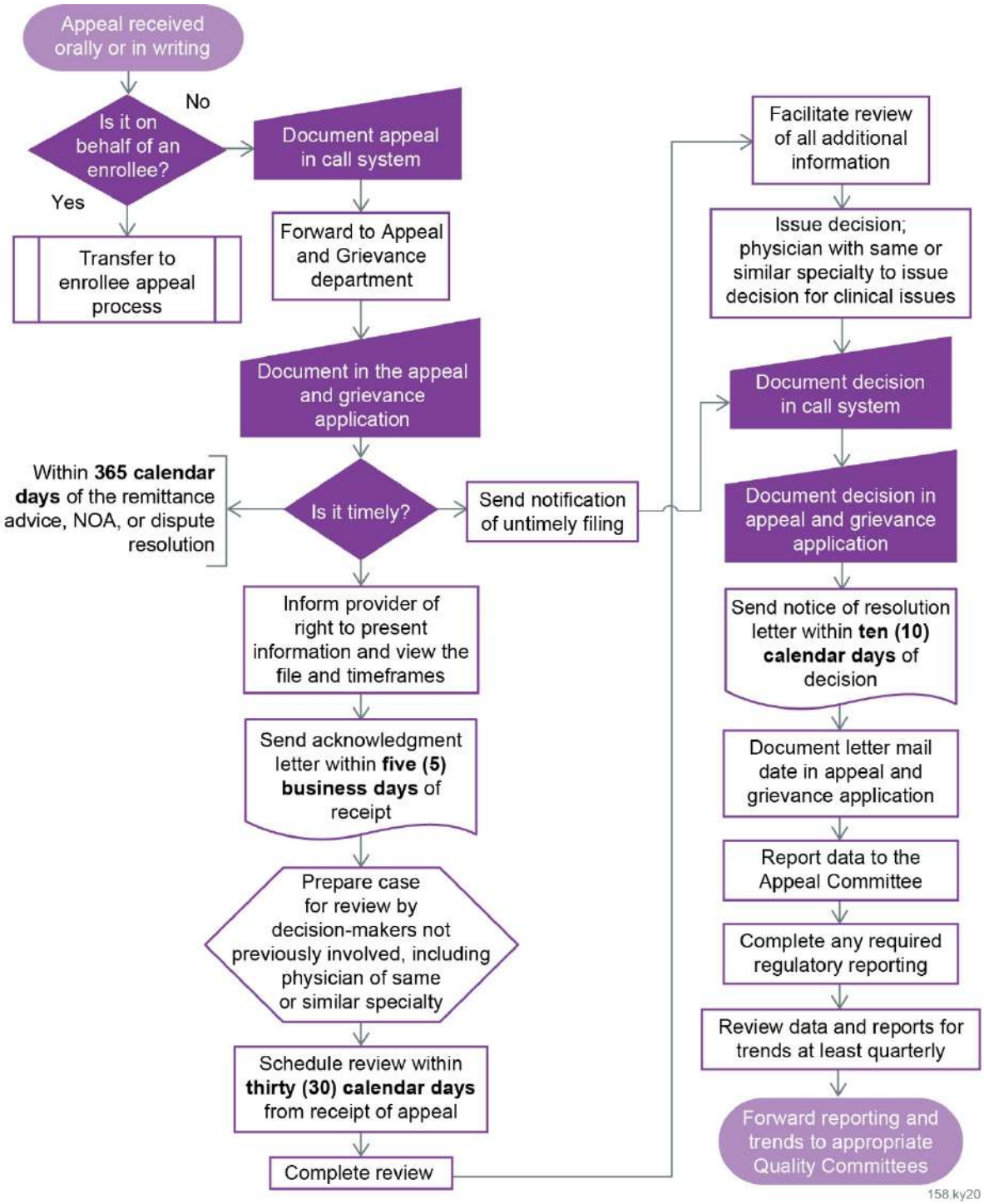

Figure C.26-1: Appeals Process Flow

Aetna's appeals process assures timely review of all Program Integrity and SIU appeals.

a.iv. Data Reporting Innovations

At Aetna, innovation is at the heart of our efforts to prevent and reduce fraud, waste, and abuse. Drawing on the strength and power of the national Aetna organization, and through collaboration with our affiliate

Medicaid health plans in other states; we continually advance our role as good stewards of the Commonwealth's resources.

Aetna has enhanced our reporting of FWA metrics by creating a Tableau dashboard in early 2019 which includes visualizations for both case metrics and financial metrics. This information is shown for the current month as well as year-over-year trending. We have a variety of visualizations for all categories broken down by individual provider and investigator. The case metric categories included in visualizations are referrals received, cases opened, and cases closed. The financial metrics included in visualizations include prepay and post-payment savings, recoveries and prevented losses. The results in the Tableau dashboard are reviewed in detail with the Aetna's senior leadership on a monthly basis.

Using Data Analytic Algorithms to Detect and Prevent Fraud

Aetna innovates in the use of data analytics and auto-identification of potentially fraudulent claims to facilitate detection and mitigation of enrollee, provider, subcontractor, and vendor FWA throughout the claims lifecycle from prepayment to recovery. The team performs an annual review of the plan to identify high-dollar specialties, providers, and procedures codes. This can show which specialties to review for outlier behavior. In addition, **on a quarterly basis, we run a minimum of 25 tailored outlier reports of known fraudulent schemes** based on specialty and CPT codes to identify the top providers of certain services. The reports are referred to investigators for further review and appropriate action. At data mining meetings, FWA staff members, the medical director, clinicians, and certified coders discuss and prioritize data mining studies to analyze trends and schemes identified through various sources.

> Aetna shares its findings regarding outlier behavior and fraudulent schemes with the Department and other Kentucky Medicaid MCOs through regular collaborative meetings.

Table C.26-1 provides an overview of the 25 billing outlier reports that highlight fraudulent schemes.

Table C.26-1: Outlier Billing Reports to Identify Known Fraudulent Schemes

Scheme/Allegation	Report
Upcoding	• High-level Office Visits • High-level New Patient Visits • High-level Psychotherapy • High-level Emergency Room Services • Ambulance Advanced Life Support Non-Emergency • Ambulance Advanced Life Support Emergency • High-level Physical Therapy Evaluation • High-level Occupational Therapy Evaluation
Modifier Misuse or Abuse	Top Modifier 25 Providers
Misrepresentation of Services	• High Percentage Prolonged E&M (add-on code) • High Percentage Psychotherapy (add-on code) • After-hours Services • Allergy Antigens 95165 • Allergy Percutaneous Tests 95004
Excessive Charges/Billing	• Top Growth DME Providers • Top Home Care Providers • Top Adult Day Care Providers
Over-utilization	Top 20 Place of Service Home Members (Location 12)
Doctor Shopping	• Rx Member Outliers • Emergency Room Frequent Flyers
Non-covered Service	Top Athletic Training Evaluation

Scheme/Allegation	Report
Not Medical Necessity	• Lab 81479 – Unlisted Molecular Pathology • Lab 81226 – Molecular Pathology Procedures
Experimental/Investigational—Pass-through Billing	• Bill Type 131 • Bill Type 141

Examples of red flags that may trigger further investigation include the following:

- Discrepancy between the submitted diagnosis and the treatment
- Claims that are resubmitted with coding changes to gain benefits
- Alterations on claim submissions
- Questions about the medical necessity of services rendered
- High volume or high percentage of dollars paid in one or two procedures
- Providers using a post office box as their service address
- Pressure for quick claim payment

As discussed previously, our data mining is enhanced by Healthcare Fraud Shield (HCFS). We use the HCFS application screens to visualize all leads and billing activity as well as download the past 24 months' worth of claims for each lead. This helps us further avoid inappropriate billing, identifies and mitigates provider confusion, and deters criminal activities, among others.

We also receive and use leads provided by the Aetna Enterprise Analytics Fraud team. Our data analytics system provides efficient and proactive discovery of new fraudulent schemes, allowing for near real-time prepayment review capabilities to flag suspicious claims prior to adjudication. The data analytics of all Aetna plans are shared among the plans to leverage the information on commonly used providers and provider types. This saves money by reducing the need for pay-and-chase methods of recovery, fostering a comprehensive approach to addressing both enrollee and provider fraud by leveraging all available data sources to detect emerging fraudulent patterns. Our rules-based claims adjudication system maintains and processes health care administration data, providing increased efficiency. The provider module contains a unique provider identification number generated by the system, plus all billing and tax reporting information. The claims module shows the date of receipt, the history of actions taken on the claim, and the date of payment, including the check number. The system stores claims by specific benefit limits/lifetime benefit rules. It scrubs/edits this data for accuracy during claims processing and payment. Aetna's Medicaid Claim Quality Control department independently assesses the effectiveness of the Medicaid claims system configuration and claim procedures against the resulting adjudication process.

Innovation Example from Louisiana

Our Kentucky health plan leadership collaborates and shares innovative ideas with leadership from Aetna's other Medicaid health plans on a regular basis. For example, Aetna's Louisiana Medicaid health plan is presently working on an enrollee-focused reporting innovation through the creation of a pending claims notification phone application. Claim notifications and other popup information will be provided in the enrollee mobile application to catch inappropriate claim billing after payment. This will allow the enrollee to either confirm or deny that the claim was theirs. The app will provide easy-to-follow instructions when an enrollee believes the claim was fraudulently submitted.

We will monitor the Louisiana health plan's progress in making this app a reality and actively investigate the possibility of implementing this innovation in Kentucky. Aetna encourages enrollees to contact us when they suspect FWA is occurring related to their benefits. The SIU team works proactively to identify fraud when an enrollee is suspected of committing such acts. Additionally, understanding that enrollees may not be aware when their identification is stolen or being used in a fraudulent scheme, the alerts this app may provide will assist in collaborating with our SIU team and enrollees when incidents may occur.

b. Prepayment Reviews

Person-centered care and innovations in the industry bring new data, new patterns, and potentially complex reimbursement models that must be analyzed as part of an evolving and proactive FWA compliance program. As part of our comprehensive program, Aetna uses prepayment review processes to detect potential enrollee, provider, and out-of-network provider FWA. We use data analytics and predictive modeling to monitor provider utilization practices and identify those falling outside the norm. Aetna detects FWA by collaborating with industry leaders such as Cotiviti for front-end automation of correct-coding and medical policy decisions specific to Medicaid and Medicare. These activities support the detection of coding irregularities, conflicts, or errors as well as help us identify opportunities for remediation.

Prepayment policy: Aetna has processes in place in Kentucky to ensure that providers are put on prepayment only for claims relevant to identified issues. We monitor the providers on prepay to ensure they do not stay on prepay for long periods of time (i.e., no "payment purgatory"). Under our current process, any provider identified as a possible prepayment case is reviewed with health plan senior leadership. If health plan leadership approves, the information is sent to the Department PIU, to provide notice of our actions. Once an acknowledgement is received, the letter to the provider is mailed.

Cost Avoidance Related to Prepayment Review

Aetna has an active investigation regarding a provider who settled a Federal False Claims Act case in 2017 to the amount of $751,681.16. Our SIU team identified that this provider continues to have potentially fraudulent billing practices. We performed an onsite review and placed the provider on prepayment review for one CPT code, which our SIU team identified as being billed without documentation to substantiate the charges. Aetna referred the provider to the Department PIU for additional review. Due to concerns identified by another MCO, Aetna is exploring putting this provider on a full- prepayment review for all CPT codes. Aetna has reviewed claims data for billed services (in excess of $500K) vs. paid ($262K) and anticipate large savings from an extended prepayment review as well as collaborating with the other MCOs, and the Department PIU and OIG for further review of this provider's actions.

Because FWA detection and prevention methods often uncover patterns of provider error and confusion, we conduct annual provider training about program integrity and compliance electronically by way of online provider training modules and webinars. Our Provider Services department disseminates information about FWA training to providers via fax blasts and emails each year and collects the providers' signed attestations for themselves and their staff. This information is provided to the Department during the annual compliance program review process and in the board report. The Provider Services department also conducts provider forums every year and the SIU team will participate in these forums to give providers information about trends, FWA training, and other information to increase their knowledge and reduce abuse across the Commonwealth.

Aetna's SIU formed a Prepayment Review team in 2017 to specifically identify and investigate FWA through active and innovative data mining for specific procedure codes and code combinations that warrant additional review. The Prepayment Review team includes analysts that are certified in medical coding and investigators who work with the data analytics group to identify providers and schemes in Medicaid plans. The prepayment investigator reviews leads and determines which providers should be placed on prepayment review, following our Medicaid SIU prepayment case process desktop.

This process begins with research by the investigator into all relevant Aetna and Department policies and into provider contracts, relationships, and the type and location of the enrollees they serve. Considerations for prepayment review include, but are not limited to, high volume of services, dramatic change in frequency of use, and high-risk, problem-prone areas. When the SIU investigator identifies prepayment

review as the appropriate course of action, she informs the appropriate key personnel at the health plan (e.g., Provider Services, Data Management, and Compliance departments), notifies the Department and sends a notification to the provider. The provider notification includes the specific reason for the review, the specific CPT/Healthcare Common Procedures Coding System codes being reviewed, description of documentation needed, method of submitting documentation, length of expected prepayment review, and contact information should the provider have questions or would like information on how to be removed from prepayment review. Once a prepayment notification has been sent to the provider, we stop payment of all claims (with the appropriate CPT codes) related to the scheme under review. The claims are denied until the provider submits medical records for the specific service and the records are reviewed by a certified coder and/or the CMO to determine if the records support the claims billed.

Prepayment reviews are not indefinite; the investigator assigns a period of review at the time of initiating the prepayment review, typically 90 days. The provider is given 45 calendar days to submit documents in support of claims under prepayment review. The contractor shall deny claims for which the requested documentation was not received by day 46. The SIU team will also deny a claim when the submitted documentation lacks evidence to support the service or code. Aetna may extend the length of a prepayment review when it is determined necessary to prevent improper payments. If the provider has sustained a 90 percent error-free claims submission rate to Aetna for 45 calendar days, SIU team will request permission to continue prepayment review from health plan senior leaders with collaboration and final approval given by the DMS PIU team and the Director of Program Quality and Outcomes.

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60.7.C.27 Contractor Reporting Requirements

Kentucky | Transforming Health Care | **Aetna**

60.7.C.27 Contractor Reporting Requirements (Section 37.0 Contractor Reporting Requirement)

Aetna is fully committed to the supporting the Commonwealth's goals, as well as participating in a successful collaboration with all Medicaid managed care stakeholders to provide a comprehensive reporting package that is in the best interest of all parties. Our dedication to being a collaborative and innovative partner to Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier Kentucky. The specific elements of our approach discussed throughout this section demonstrate that Aetna not only fully meets the requirements of **Section 37** of the **Draft Medicaid Managed Care Contract and Appendices**, including **Appendix D Reporting Requirements**, but will exceed the Department's expectations.

a. Developing a Comprehensive Reporting Package through Collaboration

Aetna looks forward to a productive relationship with all entities involved in the process as we exchange ideas, provide feedback, and learn from our counterparts while developing streamlined reporting and reducing administrative burden for the Commonwealth. We fully support this initiative, which aligns with the Cabinet for Health and Family Services' goal of enhancing use of technology to increase service efficiency and effectiveness.

a.i. Proposed Reports and Report Templates

We look forward to all the collaborators utilizing their years of experience, as that allows for consistent reporting for benchmarks and outcome measurements. The development of benchmarks and consistent reporting allows for a clearer vision of the positive impact Medicaid managed care has on our enrollees, as well as areas of opportunity to improve the health outcomes of enrollees. We utilize internal benchmarks such as trends in approved prior authorization requests and overturned appeals to identify areas of success and opportunities for change and growth as we manage the care of our enrollees. Aetna believes translating those benchmarks to a program-wide reporting suite would allow the Department and Medicaid managed care organizations (MCOs) the best vantage point for evaluating the success of the Medicaid program. **Figure C.27-1** illustrates some of the Tableau reports that Aetna uses to track enrollee outcomes.

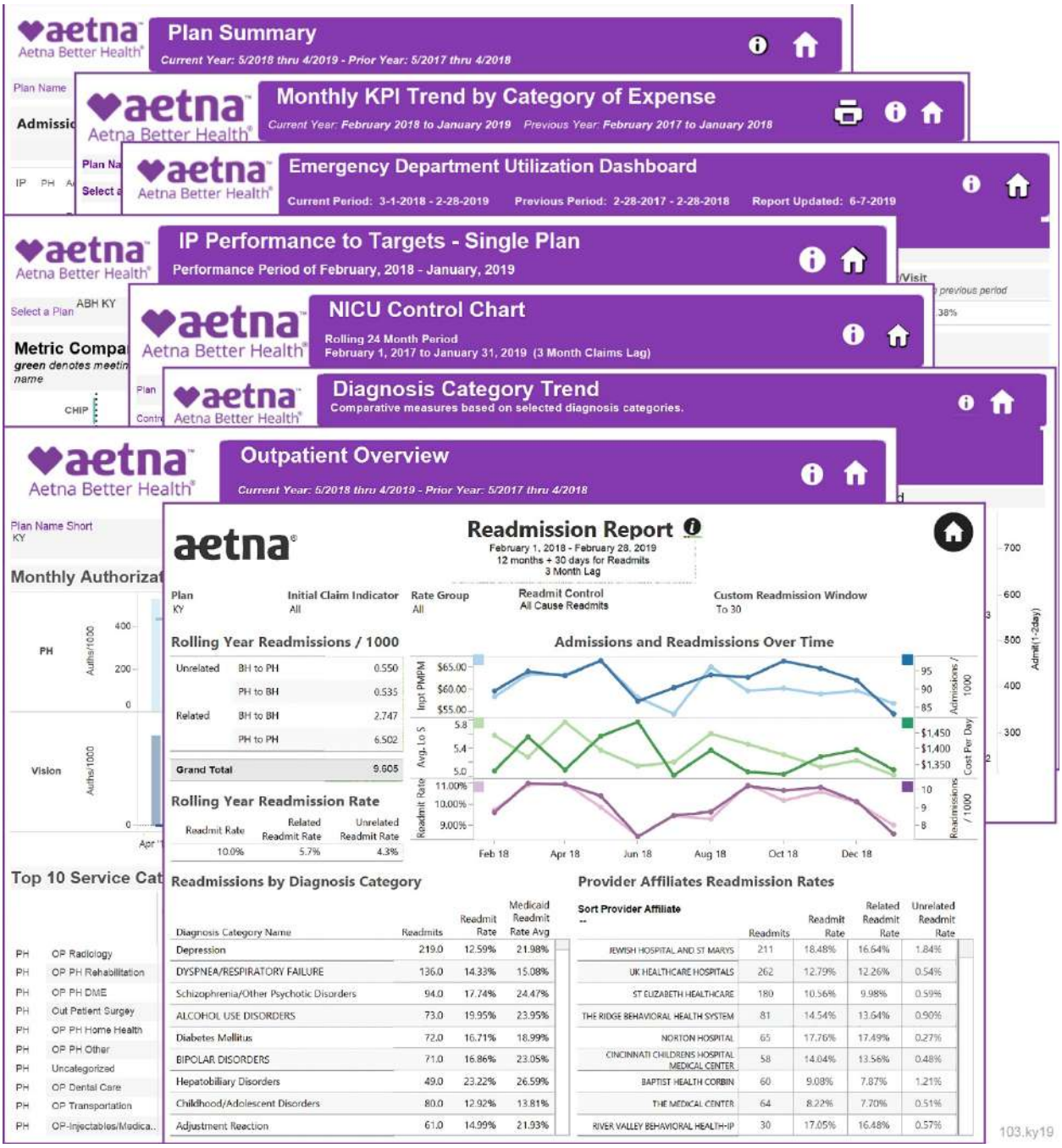

Figure C.27-1: Sample Tableau Reports

Tableau reporting allows users to review and analyze data and outcomes.

This reporting suite should include reports that demonstrate approved and denied authorizations for services, overturned appeals, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, timeliness of claims adjudication and claims rework, claims payment metrics, paid claims, coordination of benefits, telehealth services, and provider and enrollee grievances.

A breakdown of the reports we propose includes the following:

- **Trend and utilization management:** utilization management, readmissions, observations vs. one-/two-day inpatient stays, emergency room, neonatal intensive care unit, outpatient urine drug testing, medical claims trends, authorization trends, inpatient performance-to-target, and opioid dashboard reports
- **Population health:** eligibility trends, demographics, enrollee conditions, Consolidated Outreach and Risk Evaluation (CORE™) predictive analytics for risk stratification, risk adjustment, month-over-month risk adjustment
- **Operations:** utilization management, claims key indicators, case management executive, care management, Healthcare Effectiveness and Data Information Set (HEDIS®) trends in case management, and call tracking
- **Pharmacy:** prescription claims, pharmacy summary, weekly prescription lite, pharmacy high-utilizer, and pharmacy market share
- **Quality and value-based services:** gaps in care and value-base services quality
- **Opioid**: Performance summary and improved trends related to decreased utilization of Opioids

a.ii. Proposed Ideas for Collaborating across MCOs

Aetna believes bringing both reporting and business experts from the specific operational areas of each MCO and the Department into the collaboration while developing consistent and comparable reports is beneficial to all involved. Their combined expertise brings a wealth of knowledge to the discussion, as the reporting experts provide all of the necessary and historical data as well as an understanding of the MCOs' databases and systems, while the business expert bring the expertise of the operational area they oversee and the metrics used to identify success and opportunities.

Using appeals as an example, the appeals manager routinely monitors the number and percentage of appeals that are overturned and is familiar enough to recognize when the data may not be accurate. The appeals manager then engages the reporting manager to identify which elements of the report may be causing the errant data. Both types of experts from each MCO would contribute valuable insight and perspective to the Department as it determines the reports that best depict success and opportunities within the Medicaid program.

For example, we recommend monthly meetings with all stakeholders present as the reporting package is developed. The agenda for each meeting should include the specific operational area for which reports are to be developed, e.g., at the first meeting the reports to be developed and defined could be the financial reports and enrollee services reports, including call center metrics and enrollment metrics. The relevant subject matter experts/operational owner will attend the applicable meeting. The reporting expert should be present at every meeting to capture the definitions of the reports, highlight any potential concerns or limitation, and to ensure consistency. By involving the appropriate subject matter expert from each MCO to engage in the discussion and defining the process for each type of report to be developed, the Department and the MCOs will achieve consistency and comparable data that is to be submitted.

In addition to our strong partnership with the Commonwealth, Aetna is a leader in collaboration across industries, communities, and initiatives. Chief Executive Officer Jonathan Copley has been chosen by his peers to serve as the chairman of the Kentucky Association of Health Plans, a trade association that monitors issues related to managed care organizations and commercial insurers, health care policy, and tax reform. Further, Mr. Copley chairs the Opioid Response Program for Business, an initiative of the Kentucky Chamber of Commerce's Workforce Center which works directly with employers to help audit their policies and recommend best practices to maintain a drug-free workplace while supporting a recovery-friendly culture. The initiative focuses on destigmatizing the addiction epidemic and supporting employers' role in opioid prevention, treatment and recovery in the workplace.

Both of these roles give Aetna a unique opportunity to unite people who may otherwise have never worked together. By breaking down traditional silos, we have identified opportunities to improve not only our member's health and well-being, but the greater well-being of Kentuckians across the Commonwealth.

a.iii. Requirement of Subcontractors to Participate and/or Comply

The chief executive officer, chief medical officer, compliance officer, chief operating officer, director of clinical health services, director of quality management, and selected leadership staff from our Enrollee Services, Provider Services, Network Management, and Grievance and Appeals departments comprise the local-level Delegate Oversight Committee (DOC). These local, executive-level plan leaders and key leaders from functional areas meet with subcontractors on a monthly or quarterly basis, depending upon the type of subcontractor, **to monitor service delivery, troubleshoot problems, review and resolve enrollee complaints, and most importantly, identify opportunities to collaborate on new or enhanced services for enrollees**. The DOC approves all delegates and delegation reports, and monitors subcontractor performance at the plan level.

> When Aetna enrolled 68,000 Kentucky Spirit (Centene) members over the July 4th holiday in 2013, we worked closely with our pharmacy benefit manager (PBM) to ensure there were no delays in enrollees receiving their prescriptions. We worked closely with the PBM to correctly load the eligibility file to our system and ensure it was compatible with their system so that all pharmacy claims processed appropriately and without delay.

Aetna views this requirement as another opportunity to oversee the activities of our subcontractors. We continuously ensure that all our subcontractors are providing the exact data that is required by the Department and responsive to its requests. Currently, Aetna meets with subcontractors on a weekly, monthly, or quarterly basis, depending on the subcontractor, to review data, metrics, and trends that are tracked and identified by the subcontractor and reported to the Department.

As an interested party and participant, we would also expect and require our subcontractors to participate in all discussions and meetings as consistent reports are developed and maintained. Our subcontractors participate in providing whole-person care to our enrollees and they are crucial in the collaboration, exchange of ideas, and best practices to give a clear picture of the health of each of our enrollees.

b. Detailed Description of the Contractor's Capability to Produce Reports

As a participant, Aetna brings both our national organization's expertise in Medicaid and our local understanding of the Kentucky Medicaid program to help clearly define the requirements.

We build new reports as well as adapting existing reports to meet the Department's specific needs. New requests for data and reports are received by the Informatics Project Management team, and they are tracked using a QuickBase application called the Informatics Management Operating System (IMOS). IMOS is a custom-developed application for tracking work, capturing requirements, facilitating discussion, and providing a mechanism for approval. A separate informatics work request is submitted for each new report, ad hoc report, or report modification. Project management team members collaborate with health plan reporting managers or other business customers to complete all known information, including data sources, methodology, and desired report format. The QuickBase tool allows request submitters to attach report specifications and documentation, which ensures complete understanding of the intended report contents.

After initial submission of a written request, the informatics work request is triaged to the appropriate informatics manager for subsequent assignment to a report developer. The manager and developer work together to review the information, formulate outstanding questions, and if necessary, draft follow-up written communications or schedule meetings with the data requestors to clarify the intent and contents of

the desired report. The report developer also determines the appropriate data source, interprets report specifications, and maps data elements to existing data sources.

Each informatics work request is assigned a unique numeric identifier. This identifier is incorporated into all phases of the report development process, including the naming of the network folders, report code, report deliverables, and stored procedures. This allows the team to locate reports and track revisions more easily over time. The Development team uses a variety of reporting tools for data querying, including Structured Query Language (SQL) and SAS software. Comments at the top of each code program are used to record information on the date and nature of logic changes. Version control software is also used to track changes over time.

Aetna has extensive business intelligence reporting and dashboard capabilities that information users can process reliably and quickly. Our reports identify key performance indicators (KPIs) or trends via dashboards for plan leaders/executives, summary-level data details of the KPIs for the power users (data savvy), and drilldowns for more actionable/operational information. We use an extensive array of software and tools in dashboard development that include Tableau, Crystal Reports, SQL Server Reporting Studios, Excel, and Cognos. In addition, our dedicated team of .Net developers design custom applications to display these dashboards as a self-serve environment that makes it easy for leadership to navigate through the information and create reports that aid in problem-solving. These applications have been customized for each state's data access needs in an internet-based interface that can be simply shared without compromising security or violating Health Insurance Portability and Accountability Act rules regarding protected health information.

c. Processes to Review Report Accuracy and Completeness Prior to Submission

We have an experienced understanding of reporting requirements as defined in the **Draft Medicaid Managed Care Contract and Appendices**. The Informatics team employs a peer review process to review newly developed code for completeness and accuracy. Once internal review has been completed, initial test reports are developed and shared with the local health plan reporting manager and business owners for additional review and user acceptance testing. During the report development or report revision process, Aetna's national Informatics staff consults with the local health plan reporting manager, business owners, and compliance officer to gather report specifications, develop and review draft reports, and finalize report deliverables. Depending on the volume of reports, ongoing regular touchpoint meetings may be established between the health plan and the Informatics teams. This creates a forum for regular sharing of information regarding report modifications and ad hoc report requests.

The Informatics Project Management team also communicates changes to compliance reporting specifications to report developers by way of the IMOS QuickBase application. Draft reports undergo user acceptance testing with the health plan business owners, and when appropriate, the compliance officer. This ensures adherence with all required specifications. Our user acceptance testing includes two phases. In the first round of testing/validation, Informatics provides access to the test versions and answers any tester questions; testers confirm the reports are accurate and usable, report on defects found during testing, and then send the reports back to Informatics for correction. In the second round of testing/validation, testers ensure reported defects are corrected.

Once our reports are developed, we maintain a report matrix that details each required report. The matrix includes a designated health plan preparer, a designated reviewer, and timelines for submission as set forth by the Department. A project manager is responsible for the oversight of the matrix, and therefore assures the completeness and timeliness of reporting submissions. The preparers and reviewers of each report are subject matter experts as it relates to the content contained in each report. Multiple levels of review ensure the accuracy and reasonableness of the material submitted to the Department.

d. Aetna's Examples

The following examples provide insight into our processes for conducting comparative data analyses, interpreting trends, and summarizing findings in a manner that is easily interpreted by the Department; use of dashboard reporting to monitor, track, and evaluate performance metrics, including dashboard level data we propose to submit to the Department, including a sample dashboard report; and the use of findings from reports to make program improvements and to identify corrective action.

d.i. Processes for Conducting Comparative Data Analyses, Interpreting Trends, Summarizing Findings

Aetna continuously monitors data, trends, and results for all its operational areas. Each data set rolls into a monthly dashboard that is reviewed and analyzed by the executive leadership team during a monthly meeting. We analyze both medical management metrics, including several prior authorizations requested compared to the number that met medical necessity, average length of inpatient stay, emergency department utilization, and readmission rates. We also review and analyze operational metrics, including monitoring claims inventory, denial trends, and front-end rejection trends to ensure that our systems are functioning correctly, claims are processing correctly and timely, and provider payments are being issued.

In addition, we hold weekly medical management opportunity meetings and quarterly medical expense reviews. This is another opportunity and avenue for us to look at, interpret, and respond to trends. These meetings focus on identified trends, and our team takes into consideration any opportunities to improve the care provided to our enrollees.

We find our internal processes effective for identification and remediation of any areas that require improvement. Using the reporting package that is to be developed as the starting point for analysis of the Medicaid program, we recommend similar processes for the Commonwealth to implement, and we are able to assist with the framework development.

d.ii. Use of Dashboard Reporting

Aetna executive leadership uses the dashboard in **Figure C.27-2** to review and analyze high-level data and metrics at a glance. We recommend the use of a similar dashboard for all MCOs, as it provides a comparable overview of the key aspects of the health plan's success and opportunities to make sure enrollees and providers are receiving optimal service from Aetna and the other contracted MCOs.

	Metric	Frequency	Benchmark	2018					2019			
				Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Enrollee Services	Call Quality	Monthly	95%	96.0%	96.7%	96.6%	95.5%	96.9%	95.5%	95.6%	95.7%	96.4%
	Average Speed of Answer (sec)	Monthly	30	17.7	18.3	17.2	13.9	12.3	18.1	12.2	6.4	8.0
	Telephone Service Factor %	Monthly	80%	83.3%	82.2%	85.5%	86.5%	88.4%	84.6%	89.7%	95.6%	96.1%
	Abandonment Rate %	Monthly	5%	1.5%	1.5%	1.4%	1.4%	1.3%	1.6%	1.1%	0.8%	0.9%
	Blocked Call - No Answer %	Monthly	<1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
Appeals and Grievances	Enrollee	Monthly	95%	96.0%	96.7%	96.6%	95.5%	96.9%	95.5%	95.6%	95.7%	96.4%
	Resolved Appeals Timeliness %	Quarterly	100%	N/A	100.0%	N/A	N/A	97.8%	N/A	N/A	100.0%	N/A
	Resolved Appeals Overturn Rate %	Quarterly	n/a	53.4%	36.8%	51.3%	48.3%	54.8%	40.7%	56.4%	56.4%	56.4%
	Resolved Grievances Timeliness %	Quarterly	100%	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	-
	Provider											
	Resolved Appeals Timeliness %	Quarterly	100%	N/A	100.0%	N/A	N/A	99.9%	N/A	N/A	100.0%	N/A
	Resolved Appeals Overturn Rate %	Quarterly	n/a	52.3%	55.9%	50.6%	48.6%	59.7%	48.3%	52.5%	52.5%	52.5%
	Resolved Grievances Timeliness %	Quarterly	100%	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A
Medical Management	Readmission Rates	Monthly	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Outpatient Average Length of Stay	Monthly	-	-	-	-	-	-	0.0	0.0	0.0	0.0
				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

86.ky19

Figure C.27-2: Aetna's Dashboard Reporting

Dashboard reporting allows users to review and analyze data and metrics.

d.iii. Use of Findings from Reports to Make Program Improvements and to Identify Corrective Action

Aetna identifies trends through our reports. Therefore, we take a closer look at what could be causing those trends and how we can address them. For example, after studying reports surrounding prior authorization, Aetna's clinical staff identified that certain T-codes required an authorization but were approved 95 percent of the time. When the trend was identified, the clinical staff swiftly reacted to remove the authorization, thereby reducing administrative burden and ensuring enrollees receive the required supplies as expediently as possible. We also use our Service Improvement Committee (SIC) to identify trends through both reporting and provider and enrollee feedback. This committee monitors trends related to appeals and grievances reports. Once trends are identified on a particular appeal topic, our provider liaison is assigned to investigate further on the root cause of this trend. The provider liaison will then reach out directly to the provider and/or facility and provide education on that topic.

An example of a corrective action is through monitoring and denial trends that our operational leadership noticed. A particular set of S-codes (per diem codes for EPSDT physical therapy, occupational therapy and speech therapy services for children) were being denied at a higher rate than expected. We researched the denials and determined these codes should be allowed to support EPSDT providers. Executive leadership made the decision to add the codes to our fee schedule, and all impacted claims were reprocessed and paid.

e. Processes for Monitoring, Tracking, and Validating Data from Subcontractors

As an example of our process for monitoring, tracking, and validating data, we receive regular reporting from our subcontractors, including Avēsis, that is then submitted to the Commonwealth. We review this data for accuracy and reasonableness at the time of receipt and submission. As a second step, we also review the submitted data and metrics during our quarterly JOC with Avēsis to discuss and issues, errors, or anomalies that arose during that reporting period. Please refer to **Figure C.27-3** for sample reporting from a quarterly Joint Operating Committee meeting with Avēsis.

2019 Dental Performance Measures

Performance Category	Target	4th Qtr. 2018	1st Qtr. 2019	2nd Qtr. 2019	3rd Qtr. 2019
UM: Mandated TAT	100% decision within 2 business days for standard	100%	100%	100%	100%
UM: Enrollee notifications of UM decision	100% notification generated within 2 business days for decision date	100%	100%	100%	100%
UM: Provider notification of UM decision	100% notification generated within the same day of the decision date	100%	100%	100%	100%

162.ky20

Figure C.27-3: 2019 Dental Performance Measures

This type of reporting is reviewed with our subcontractors during quarterly JOC meetings.

Aetna receives reports from CaremarkPCS Health, eviCore, and Avēsis that provide whole dollar and per member per month claims spend, along with the corresponding utilization total or by provider. Health plan leadership meets on a regular basis with each subcontractor to review all reports as well as discuss and analyze the trends associated with them. We review all reports prepared by our subcontractors to make sure the information provided aligns with what was discussed with the health plan.

Monitoring Data

Timely and accurate data is essential to obtaining meaningful information on enrollees and promoting better health outcomes. Therefore, Aetna meets with subcontractors on a weekly, monthly, or quarterly basis (depending on the subcontractor) to review and discuss data, metrics, and trends that are tracked and identified by the subcontractor and reported to the Department.

Tracking and Validating Data

Subcontractor data is tracked and validated in the same manner as Aetna's data. In addition, subcontractor reports are maintained on the same report matrix. The reports are received and reviewed routinely to ensure they present complete and accurate data.

Further, we meet with our vendors on a regular basis to make certain we address any questions, issues, and to discuss error resolution. Aetna uses contractual requirements and service performance agreements to monitor provider and subcontractor compliance with all contractual responsibilities.

We regularly communicate and work continuously with our subcontractors to promote compliance with reporting requirements. To correct behaviors, reporting and deliverables are discussed as part of the Joint Operating Committee meetings we conduct with our subcontractors. If subcontractors fail to submit complete, timely, and accurate reports, we use training, oversight, corrective action, as well as contractually appropriate sanctions, to address the deficiency.

As an example, we receive dental dashboard reports from Avēsis on a monthly basis. The reports are submitted to our Informatics team via their shared mailbox. The Informatics team prepares the reports for internal distribution. Aetna's Compliance and Finance departments, as well as our chief medical officer, are copied on the reports.

f. Proposed Process for the Receipt, Generation, Interpretation, and Provision of Ad Hoc Reports

Our ability to produce ad hoc requests is satisfied by employing data analysts at the health plan who are trained and skilled with Aetna's systems and have the ability to query data and generate reports as needed. We can generate additional, recurring, and ad hoc reports, as requested by the Commonwealth.

Ad hoc reports are received by Aetna's compliance mailbox and assigned to a subject matter expert within the appropriate department. We review each report submission as a cross-functional team to ensure we have captured the data requested and the narrative that explains the data included.

Figure C.27-4 provides an overview of our response process to the Department.

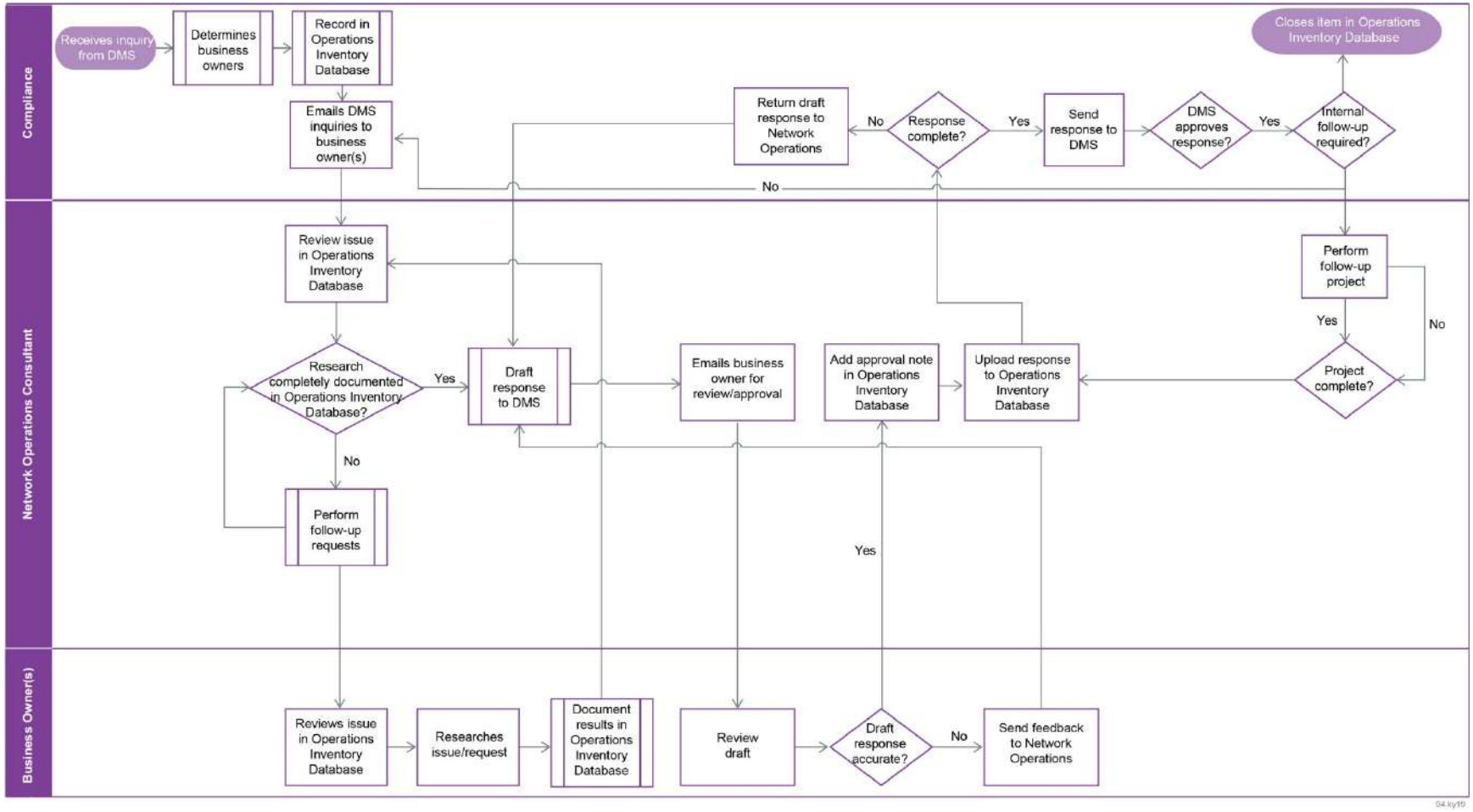

Figure C.27-4: Aetna's Response Process to the Department

Our response process tracks Department inquiries.

Creating Ad Hoc Reports

To meet the Commonwealth's reporting requirements, our Reporting and Analytics teams employ rigorous processes to track new regulatory requests, generate reports, review and test reports, and submit reports. For quality purposes, we strive to produce automated, system-generated reports to help ensure consistent results. During the report development phase, the Informatics staff consults with the business owner to gather report specifications, develop and review draft reports, and approve finalized reports. For high-volume or highly complex reports, ongoing touchpoint meetings are scheduled between the business owner and Informatics teams to regularly share information regarding report modifications and ad hoc report requests. Aetna can also alter reporting formats, content, and reporting frequencies at any time.

Our ability to produce ad hoc requests is satisfied by employing data analysts at the health plan who are trained and skilled with Aetna's systems and have the ability to query data and generate reports as needed. We can generate additional, recurring, and ad hoc reports, as requested by the Commonwealth.

Reporting is a regular agenda topic at our monthly meetings with the Department. We discuss the following items:

- Our current reports
- Any challenges we are experiencing
- Reports that are recently assigned, as well as any future reports that the Department might find helpful.

The reporting piece is part of our monthly meeting with the Department, at which we discuss any questions or concerns we have with the reports, and the Department is responsive to our input. If any issues arise, we collaborate with the Department to address those issues.

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60.7.C.28 Records Maintenance and Audit Rights

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60.7.C.28 Records Maintenance and Audit Rights (Section 38.0 Records Maintenance and Audit Requirements)

Aetna understands, acknowledges, and will comply with all the requirements to support **Section 38.1, Records Maintenance and Audit Requirements, of the Draft Medicaid Managed Care Contract and Appendices**.

a. Aetna's Methods to Assess Performance and Compliance to Medical Record Standards

As a proven Commonwealth partner, Aetna is dedicated to continuing our collaborative and innovative partnership to the Department, Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders to create a healthier Kentucky. Protecting our enrollees' medical records and protected health information (PHI) are of primary importance in the delivery of quality health care services. We do this through strict adherence to all federal, Commonwealth, and regulatory requirements and all National Committee for Quality Assurance (NCQA) standards and guidelines for the accreditation of health plans. Our network providers are contractually obligated to adhere to the terms of their provider agreement with Aetna, including the requirements outlined in our provider manual. Network providers also comply with federal and Commonwealth requirements governing Aetna. Our subcontractors, such as our dental provider, Avēsis, also comply with these requirements as well as being governed by our National Oversight Committee and their Utilization Management (UM) department.

Medical Record Reviews for Primary Care Providers (PCPs)/PCP sites, High-risk/High-volume Specialists, and Ancillary Services Providers

Our Quality Management (QM) department administers a medical records documentation review on an annual basis for practitioners (primary care providers [PCPs] and PCP sites), often assessing more than one provider at every site (usually between 10 to 15 providers in each region). We choose more providers in larger regions such as Region 8. We select more providers in these regions so that the sample remains statistically significant. We administer medical records reviews for high-risk/high-volume specialists, ancillary services providers, and our behavioral health (BH) providers who participate in our provider network. These provider groups are reviewed once every three years on a rotating basis so that in a three-year timeframe each specialty or BH provider is audited at least once.

For our network providers, rotating samples for the audit are created. Audits of delegated providers are conducted annually. Rotating samples for the audit are created by running a claims report within a certain timeframe such as August 2018 to August 2019. We create a random selection that is used to create the sample. The review aims to facilitate communication, coordination, and continuity of care for our enrollees. Our reviews focus on medical record criteria and documentation standards for participating practitioners' medical records to promote effective and confidential enrollee care and quality review. Reviews encompass provider charts, hospital records, consulting provider notes, lab results, and other findings as relevant to the review. Examples of medical records assessments include the following:

- Follow-up care and reasons to call indicated with specific time noted in days/weeks
- Immunization record/history is up to date
- Preventive screenings and services offered
- Documentation about advance directives
- Evidence physician has reviewed lab, X-ray, or biopsy results (signed or initialed) and that the enrollee has been notified of results
- Documentation of communication with referred specialist

Assessment results are communicated to the health plan's QM/UM Committee with recommendations for follow-up. Contractually, participating practitioners agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Additionally, practitioners must maintain their records according to the Medical Record Management Standards listed in the Provider's Manual. This review measures the effectiveness of practitioners' documentation against the current recommended standards with the goal of each practitioner receiving an overall score of more than 85 percent.

Medical record documentation audits have been conducted annually by the plan since 2012. Documentation deficits are noted for trends, with interventions implemented as needed. Barriers are identified and an action plan developed. Results are communicated to all participating practitioners. If a practitioner does not meet the 85 percent goal, then suggestions for improvement are made with a follow-up audit scheduled within one year. To support our contractual obligations, we review specialists as well so that all high-impact providers are audited at least once in a three-year period.

The 2019 review audited behavioral health, dental, obstetrics/gynecology and pulmonology providers. Out of the 84 practitioners audited, 80 (95%) received a passing score of ≥85%, with 4 (5%) that did not pass. There were 37 (44%) practitioners that received a score of 100% on the audit. For providers that score less than 85%, the audit tool is used to indicate ways to improve documentation; these providers receive a follow up audit within the year.

Barriers and interventions: Details and examples of barriers identified and areas for improvement by audited provider type in 2018 include the following:

- Pediatricians:
  - Documentation of communications with specialist: compliance rate of 80 percent
  - For enrollees less than 14 years old, notation about cigarette, alcohol, and substance use: compliance rate of 85 percent
  - Immunization records present: compliance rate of 86 percent
- Oncologists: Medication, including dosages, date of initial, or refills: compliance rate of 87 percent
- Cardiologists: Medication, including dosages, date of initial, or refills: compliance rate of 88 percent

Aetna staff completes follow-up to identified barriers. For 2018 audit results, interventions resulting in the audit outcomes included the following:

- Follow-up letters to specialty practitioners identified as having deficits in their documentation in order to provide education and opportunities for improvement
- Education to practitioners on the contractually required guidelines for medical record documentation standards
- Fax blasts to all specialty practitioners and PCPs to encourage them to view and download the provider manual, which includes our documentation guidelines, from our website
- Encouragement to practitioners to view website for newsletters, Healthcare Effectiveness Data and Information Set documentation tips, and incentives for improved documentation on charts
- Support on medical record documentation training for provider offices

Medical Record Reviews for Dental Providers

Our National Vendor Delegated Oversight Committee is responsible for performing general privacy and security assessment audits for new and existing major subcontractors such as Avēsis, our dental provider. They use an outside assessment tool, which looks at how to handle enrollees' data and parallels our global security requirements addressed in the following **Section C** of this response, **Approach to Application Vulnerability Assessments.** Started in late 2017, all delegates have been included as of October 2018. If the subcontractor fails the audit, a corrective action plan is recommended, a timeframe is set to fully correct the low scores, and review date is set. Providers are also directed to seek additional information on

how to improve their record keeping via criteria in our Office Manual for Health Care Professionals on our enterprise-wide website; the network manager is notified of the corrective action.

Avēsis has a Quality Assurance Committee that oversees their utilization review (UR) program. The program ensures quality of services delivered to enrollees is in line with appropriate guidelines. The UR program committee meets at least quarterly. The primary components of their UR program include the following:

- Establishing and incorporating peer review and review of quality of care issues into the recredentialing process
- Annual review, establishment, and approval of clinical criteria and protocols (by the appropriate advisory board)
- Annual work plan evaluation
- Complaint resolution for both providers and enrollee
- Review of provider satisfaction surveys
- Monitoring accessibility
- Periodic review of enrollee rights and responsibilities
- Review of frequency and service utilization from claim data
- Review of over- and under-utilization of procedures as compared to established norms
- Claims payment accuracy and processing

When the results indicate a potentially negative outcome, such as upcoding on a routine basis, the provider is contacted by a member of the Avēsis Dental Advisory Board or the Kentucky dental director. When indicated, an audit process is undertaken. The process may include chart audits by Avēsis personnel, the provider receiving education necessary to adjust the practice pattern or the provider may be terminated from the network. If necessary, the vice president/national dental director and/or the clinical director or Kentucky dental director may develop a corrective action plan for a provider's office. All utilization review reports are reviewed by the UR Committee, the chief dental officer, Avēsis dental director, and Commonwealth dental director to evaluate the effectiveness of the recommendations.

b. Preventing and Identifying Data Breaches

Aetna has proven, time-tested, and documented procedures in place to protect enrollee information that prevent, identify, respond, and report security incidents. Our core system is fully compliant with Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health in 42 USC 17931, Section 6504(a) of the Affordable Care Act, and other applicable Commonwealth and federal laws and regulations. Our system is now and will continue to be compliant with Commonwealth and federal regulations within the timeframe stipulated by the regulatory body. Aetna's information security program involves creating, administering, and overseeing policies to help ensure the prevention, detection, containment, and correction of security breaches. A comprehensive solution is in place for handling incidents 24/7/365. Issues that come in from a variety of methods are discussed during our daily threat calls; there are response time requirements based on the levels of potential risk for each incident. Splunk is the security information and event management solution in place to provide monitoring of incidents.

Aetna's Security Program Exceeds Benchmarks

Our security program has exceeded industry benchmarks for four consecutive years. We have scored 4.70 of 5.00, where the prior year's industry average was below 3.50.

Our Internal Audit department periodically performs assessments of the company's confidentiality and privacy policies and procedures. Whenever privacy is included within another department's internal audit return, privacy receives additional assessments as well. In addition, Aetna's information technology security program is evaluated periodically by external consultants. In additional to policies and

procedures, we use proprietary robust information systems to prevent security breaches and mitigate any potential losses. Aetna uses a network-based intrusion detection/intrusion prevention system (IDS/IPS) to monitor intrusion attempts to access Aetna's internal or external network servers and devices. IDS/IPS signatures are updated immediately upon release by the IDS/IPS vendor. Additionally, Relsecure is used to monitor network traffic from the internet to the DMZ (perimeter network), business-to-business partner networks, the trusted virtual private network, and a sampling of the internal network.

Aetna follows a rigorous process to halt a security breach immediately and to mitigate the impact of the event to our enrollees, the Department, providers, and community partners. Depending on the size and scope of a breach, the incident may be managed by our privacy office investigators or by our chief privacy and security officer. As appropriate, a Rapid Response team comprised of security experts, investigative services, business continuity, legal, compliance, business subject matter experts, and customer-facing representatives is convened to handle a security breach.

Privacy Breach Notification Process

Aetna takes the following steps to identify, assess, and handle privacy breaches and potential breaches. All potential breaches are evaluated as quickly as possible to minimize the impact to our enrollees.

Identification

Aetna staff members are routinely educated to be able to identify any issue that may be or could become a potential breach of enrollee personal information. One of our corporate goals every year is to promote compliance as a core competency. Part of that effort includes educating staff members to be aware of their actions and potential issues that they encounter. Staff members are encouraged to raise issues and are reminded regularly how to identify a potential privacy breach and where to send it for proper handling. Discovery of a breach can come from a variety of sources (e.g., enrollee calls into customer service to report the incident, plan sponsor reports the incident to the account executive, Aetna staff identifies an error, etc.). Staff are instructed to notify privacy office of any potential breaches.

The steps outlined are followed as part of the investigation. As needed, a Rapid Response team may be assembled to assist the privacy office investigator with the investigation and resolution. During a data breach in 2019, Aetna followed these same procedures for a breach that affected our dental subcontractor, Avēsis. We followed our policies and processes concerning a vendor data breach and maintained contact with Avēsis as well as the Department from discovery through the investigation, mitigation, and completion of resolution with the Department. The issue was resolved within a timely fashion as confirmed by written letter from the Department.

Investigation of a Breach

The privacy office investigator will thoroughly investigate a potential breach and collect the following information to perform a risk assessment of the potential breach:

- What type of personal information was disclosed (e.g. banking data, Social Security Number, clinical information, etc.)?
- Was the information in paper or electronic format? If electronic, was the information encrypted or otherwise secured during transmission?
- Who received the information (e.g., covered entity, business associate, or individual, etc.)?
- Was the information opened and/or distributed further?
- Was the information returned to Aetna unopened?

Risk Assessment

Based on the information collected, a risk assessment is performed to determine if a breach occurred. The fact pattern is vetted against both the HIPAA privacy definition of a breach and the definitions contained in any applicable Commonwealth breach notification laws. A breach is, generally, an impermissible use

or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information. While not specifically defined, 'compromise' requires consideration of, at a minimum, the following:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification
- The unauthorized person who used the PHI or to whom the disclosure was made
- Whether the PHI was acquired or viewed
- The extent to which the risk to the PHI has been mitigated

We consider all these factors together to determine the overall probability that PHI was compromised. If we conclude that the burden of proof is low, no notice is needed to the individual or the Department. However, if this conclusion is questioned by the Commonwealth, we will produce evidence of the analysis.

Incidents that are deemed not to be a breach as defined by the HIPAA Privacy Breach Notification Rule and/or applicable Commonwealth laws are updated in the HIPAA accounting database to track as impermissible disclosures. Incidents that are confirmed breaches are handled as outlined in the following mitigation, notification, and corrective actions sections.

Mitigation

The privacy office investigator will fully quantify the breach by determining all impacted enrollee names and products. This information is used to identify additional regulatory requirements and contractual commitments for notification. Examples of these include reporting Medicaid breaches to the Centers for Medicare and Medicaid Services, notifying certain Commonwealth regulatory agencies, notifying plan sponsors within 5 or 10 days of discovery, etc. The privacy office investigator will determine steps Aetna and/or the impacted enrollee(s) should take to mitigate possible harm. If financial information was compromised, free credit monitoring is offered to impacted enrollees.

Notification

The privacy office investigator and corporate communications work together to develop the appropriate communication strategy. Notification steps include the following:

- Creating enrollee notification letters that comply with applicable Commonwealth and federal requirements for breach notification
- Obtaining regulatory approval of enrollee notification letter, when required (e.g., by the Department for Medicaid Services)
- Determining if Aetna will notify the enrollee (all fully insured plan sponsors and self-funded plan sponsors who have delegated the function to Aetna)
- Considering whether telephonic outreach is appropriate
- Notifying Commonwealth and federal regulatory agencies, if required
- Considering if immediate notification is required if more than 500 enrollees are impacted
- Sending letters
- Monitoring returned mail to determine if additional notification is required

Corrective Action

After a thorough review to determine the root cause(s) of an incident, the privacy manager and/or the privacy office investigator works with the applicable business area(s) to create and implement action steps to prevent a reoccurrence. Corrective actions often include system enhancements that are tested regularly to ensure a permanent and long-term fix has been implemented. In addition, the privacy manager and/or the privacy office investigator works with the business area to update applicable workflows or procedures and/or work with the Learning and Performance team to create new training modules to educate staff. While corrective steps are situation-specific, the privacy manager and privacy office also look to extend

lessons learned from a situation that have broader application outside that area. Finally, the Human Resources and Investigative Services teams are consulted, as needed, to consider any possible sanctions if the breach was caused by staff misconduct. The privacy office investigator updates the breach in the HIPAA accounting database.

Our Response Process

Our cybersecurity incident response process is essential to enrollee, subcontractor, and enterprise data protection, as it is impossible to prevent every cybersecurity threats. They can only be mitigated by appropriate response and control methods. Our incident response process includes the following:

- **Triage:** Our Incident Response team triages reported security events, engages on-call subject matter experts, and initiates department level involvement.
- **Facts:** Incident Response leads and scribes document the facts of the case and actions taken during incident response. The primary reporter of an incident and the Incident Response lead remain in communication throughout the investigation to facilitate accurate documentation.
- **Business impact:** Incident Response determines how and if the security incident had any impact to the business. This is a critical component for Global Security to track overall risk for the Aetna business with reporting available on a monthly basis.
- **Root cause:** Root cause identification is required for each incident record. Corrective actions and remediation plans would not be complete without an understanding of why a security incident occurred. Identifying the root cause of a security incident makes it possible to mitigate repeated occurrences.
- **Corrective actions:** Corrective actions involve an immediate response to a security incident in which estimated completion dates and progress can be tracked. All corrective actions must be documented and completed in order to close an incident record.
- **Remediation plans:** Some incidents require long-term projects to reduce the risk of similar threats in the future. Remediation plan details, progress, and completion dates are tracked to support corrective actions with permanent solutions.
- **Lessons learned:** Lessons learned by the investigation of an incident inform improvements to existing security processes and controls to help prevent and mitigate future incidents.

c. Aetna's Approach to Application Vulnerability Assessments

As required by **Section 38.6 of the RFP Attachment C of the Draft Medicaid Managed Care Contract and Appendices**, Aetna maintains effective vulnerability management processes that ensure our web applications and web services align to key controls to manage current risks to Aetna's secure environment and information security. Our robust threat and vulnerability assessment framework focuses on identifying, prioritizing, and tracking emerging threats. This allows us to better understand what new threats may be on the horizon as well as discuss how best to mitigate. Our application(s) vulnerability assessment will include the following items as well as other Department-required assessments and any assessments Aetna deems appropriate to fully secure our web applications and services:

- Injection
- Broken authentication and session management
- Cross-site scripting
- Insecure direct object references
- Security misconfiguration
- Sensitive data exposure
- Missing function level access
- Cross-site request forgery
- Using known vulnerable components
- Invalidated redirects and forwards

Inputs

A threat and vulnerability assessment begins with gathering comprehensive security threat data from a wide variety of inputs. We gather threat data from many inputs including threat intelligence, vulnerability assessment (including shared industry knowledge on vulnerabilities), active monitoring of operating environments, reported security policy and standard exceptions, security incident data, information sharing and analysis centers, current Commonwealth assessments (including audits) of Aetna's control environments, and third-party risk management activities.

Aggregation and Correlation

We aggregate all security risk input data and then correlate it using control categories to ensure all relevant risk data for a given control set is considered for each control and category.

Threat Scoring and Rating

Collecting security threats and the severity of each is part of the data input. We hold daily meetings with teams throughout the company to discuss previously identified threats, as well as emerging threats. We discuss all newly identified threats and then determine and assign a rating. We update scoring as risk factors change on previously identified threats.

Treatment Identification and Prioritization

Aetna Global Security and all involved stakeholders collaborate with special focus on treatment options for the top ranked threats.

Security Threat Remediation Tracking

Key performance indicators for the Aetna security program include threat remediation plans and progress against threat. We conduct vulnerability assessments at Aetna locations periodically based upon a tiered risk level as determined by several factors for each individual site. We use a scoring mechanism to evaluate the risk level and assign a tier level based upon the score. We evaluate tier-one locations annually and tier-two locations biannually. We may also conduct assessments when special circumstances arise, such as major construction projects, to help ensure Aetna standards are met.

The assessment process includes a comprehensive evaluation of the facility security, security systems, security officer services, sensitive information controls, crime rate analysis, law enforcement liaison, interviews with staff members, and compliance with Aetna standards and regulatory requirements. We conduct assessments in accordance with the American Society of Industrial Security guidelines. We identify and address findings with the appropriate stakeholders and then implement corrective actions.

Implementing Aetna Security Modifications

Patch management is essential to maintaining the integrity and security of our systems and products and is an integral part of the vulnerability management process. Commitment to maintaining system currency and security is exhibited through diligence and cooperation across Management Information System departments.

Highly critical vulnerabilities (emergencies) initiate greatly expanded activity to complete the patching process within five days.

Subcontractors generally communicate major releases well in advance of the planned release date and have a regular schedule for minor releases. This enables the engineering and service areas within Aetna's Information Services department to develop yearly schedules for planned implementations and incorporate them with other plans for an encompassing annual schedule. No less than three times a year, minor releases and security patches that are considered non-critical are rolled out according to the schedule. Changes that carry a higher level of risk are implemented on an as-needed basis still using change management.

Procedures are in place to roll-out patches for critical vulnerabilities within 10 days of the patches being released; patches for highly critical vulnerabilities are completed within 5 days. Users are notified of patch installation dates as well as the estimated amount of time the installation process will take.

Vulnerability Assessment Application

We confirm that the Department will have a copy of the application vulnerability assessment within 14 business days of its execution. Aetna will provide a mediation plan which meets risk assignment and will be in agreement with the Commonwealth's requirements.

60.7.C.29 Use Cases

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60.7.C.29 Use Cases: USE CASE 1

Aetna supports Rhonda, Amanda, and their circle of support through our integrated care management program providing access to and delivery of cost-effective health care services to meet their unique needs.

Rhonda's and Amanda's Needs and Capabilities

Aetna works with Rhonda to understand her needs, personal desires, and hopes to offer an array of **integrated, holistic services delivered in ways that work for her, Amanda, the baby, and their circle of support now and into the future**. Rhonda has a history of high-risk pregnancies, with one child, Amanda, who is now 10 months old. She currently smokes cigarettes and reports drinking two to three beers a week. She and Amanda have been to a family shelter in the past due to domestic violence. They moved away from the abuse and are currently staying with a friend in Lexington with limited social support. Rhonda went to the emergency room (ER) at the University of Kentucky Hospital with severe nausea and dehydration and found out she was pregnant. The Aetna Utilization Management (UM) department received notification by the Kentucky Health Information Exchange (KHIE) when the ER nurse updated Rhonda's electronic medical record. Aetna recognizes that **face-to-face contact and supports** lead to a higher level of follow-up and engagement with our enrollees. Based on Rhonda's need, UM immediately notified the Care Management (CM) department to outreach to Rhonda while she was in the ER. Additionally, Rhonda called Enrollee Services at the recommendation of the ER nurse to find out what supports would be available to her and Amanda. When Enrollee Services received the call, they noted that CM had been called by UM and completed a warm transfer to CM.

Collaborative Solution

Our **enrollee-centered approach focuses on individuals' holistic health needs** by providing access to and delivery of cost-effective health care services. Our goal is to facilitate seamless delivery of person-centered, trauma-informed care that aligns with Rhonda's preferences, needs, and goals. As part of our standard, statewide approach, we assign **local care managers** to enrollees based on their unique needs. Within one day, Rhonda was assigned to Vicki, a high-risk pregnancy care manager. Vicki is a registered nurse with extensive background in high-risk maternal-child care management. Based on the presenting needs, Vicki met with Rhonda in the ER and explored her interest in participating in care management, explaining that she would be a partner with Rhonda, as well as with her providers, and her circle of support as their **single point of contact**. Rhonda agrees to participate in CM, understanding she has the right to decline at any time. Vicki began to obtain a full understanding of Rhonda's unique circumstances, connection to services to address her goals, provision of ongoing support, and leveraging of infrastructure and resources to maximize positive health outcomes for Rhonda, Amanda, and the baby.

Rhonda and Amanda's Safety is Top Priority

Rhonda expressed her most immediate need was their safety as she feared her former partner would be angry about the pregnancy. Vicki completes a full safety and biopsychosocial assessment, including specific questions about behavioral health to identify Rhonda's strengths and needs to immediately align support and resources. Vicki provides education and resources to address Rhonda's concerns and history of domestic violence, including connection to community resources, recommendations for residential, and permanent housing options. Rhonda is interested in learning more about the supports but feels she and Amanda are safe for now at the friend's house because her former partner does not know where her friend lives. Vicki and Rhonda create a safety plan to proactively prepare in case her situation changes.

a. Aetna's Evidence-based Care Management Program

Our evidence-based care management practices support individuals and families like Rhonda and Amanda to encourage engagement in prenatal care and understanding the importance of treatment and

follow-up on health outcomes. **Our care managers focus on our enrollees' journey and how we facilitate their success and joy.** The program design is based on professional care management standards, guidelines, and research published by agencies such as the following:

- Case Management Society of America
- Centers for Medicare & Medicaid Services
- National Committee for Quality Assurance
- National Coalition of Care Coordination
- Agency for Healthcare Research and Quality
- Kaiser Family Foundation

Our tiered care management approach moves through the continuum from low risk (general population) to high risk, our most intensive care management for the most vulnerable enrollees with physical, behavioral, and social complexities. We use predictive modeling methods to rank all enrollees from highest to lowest risk in our general risk model. The model identifies people at risk of high cost and/or high utilization in the future by using medical, behavioral, laboratory, and pharmacy diagnoses and claims data, and the likelihood of integrated care management (ICM) making an impact. The risk rankings feed directly into our electronic care management platform to allow Aetna to identify and prioritize enrollees for outreach into intensive or supportive care management, as well as those who would benefit from chronic condition management. Based on Rhonda's history, meetings with Vicki, and shared care planning, Rhonda was assigned to intensive care management.

Aetna utilizes a combination of enterprise-developed and standardized assessments and tools. Assessments and screening tools used by case managers were developed using evidence-based clinical practice guidelines promulgated by nationally recognized entities including, but not limited to, the following:

- Centers for Disease Control and Prevention
- National Heart, Lung, and Blood Institute
- American Psychiatric Association
- American Congress of Obstetricians and Gynecologists
- American Diabetes Association
- Substance Abuse and Mental Health Services Administration

b. High-risk Pregnancy Initiatives

In addition to our specialized care management approach to high-risk pregnancies, Aetna leads multiple initiatives to address the needs of enrollees with high-risk pregnancies. Vicki coordinates with the Enrollee Outreach department to invite Rhonda, her family, and circle of support to a regional Aetna-sponsored baby shower where she receives baby supplies, education, and meets other pregnant enrollees in her area. These fun and supportive baby showers offer Rhonda an opportunity to celebrate her pregnancy and develop friendships.

Prenatal Smoking Cessation

Aetna has participated in the collaborative performance improvement project (PIP) to address prenatal smoking since 2017. The PIP goals include increasing the percentage of pregnant women assessed for smoking status starting at the first prenatal visit, decreasing the percentage of pregnant women with a positive tobacco screen, increasing the percentage of prenatal smokers who received cessation intervention, and increasing the percentage of prenatal smokers who received cessation intervention and who abstained through delivery. In 2019, the Department requested all the Kentucky managed care organizations (MCOs) work with the University of Pennsylvania (UPenn) on the Quit Incentives & Tailored Support (QUITS) program. Recognizing prenatal smoking is one of the most prevalent, modifiable causes of adverse pregnancy outcomes, **Aetna was the only MCO to agree** and began immediate collaboration with UPenn and a large-volume provider (Big Sandy Health Care, Inc.) to

implement the evidence-based prenatal smoking cessation intervention. Feedback is positive and expected outcomes are that between 20 to 30 percent of women enrolled will have a successful quit attempt. Our care managers ask all pregnant women about tobacco use following 'the 5 A's': ask about tobacco use at the initial prenatal visit, advise to quit, assess willingness to make a quit attempt, assist in quit attempt, arrange follow-up visits to monitor smoking status, and provide support for quit attempts. Vicki uses the 5A's to guide discussions with Rhonda about smoking; she asks about tobacco use at every contact, providing education on the harmful effects of smoking on the baby, secondhand smoke on Amanda, and promoting use of the Quit Now Kentucky line.

17P

Aetna supports the administration of 17P, a progesterone medicine to prevent preterm birth. Working together as a care team, Vicki contacted the provider to see if 17P would be appropriate for Rhonda. The provider agreed to see Rhonda. Vicki worked with Rhonda to reinforce the benefit of the injection that the provider prescribed and explained potential side effects. Vicki arranged transportation for the obstetrics and gynecology (OB/GYN) appointments and injections while educating Rhonda on how to access transportation independently to advance her self-sufficiency, recovery, and resiliency.

Incentives

Incentives are an opportunity for us to engage our enrollees in their care, and communicate the importance of visits, tests, screenings, and healthy behaviors. Vicki helps Rhonda access all of Aetna's pregnancy incentives as described in **Table 30.1-1**.

Table 30.1-1: Maternity Matters Preventive Health Program for Pregnant Enrollees and New Mothers

Incentive	Description
Gift cards for attending prenatal and postpartum visits	• $25 gift card for completing initial prenatal visit • $10 gift card for subsequent prenatal visits • $25 gift card for postpartum visit
Family transportation	Transportation is provided for the entire family and includes car seats for children.
Portable crib	Portable crib incentive for pregnant enrollees at 37 weeks of pregnancy if an enrollee meets the following: if a new enrollee, enrollee must visit the doctor within 42 days of visiting plan, and attend 7 or more prenatal provider visits during pregnancy.

c. Health Risk Assessment and Care Planning

Our care team works closely with Rhonda and her circle of support to identify strengths and understand her priorities for herself, Amanda, and the pregnancy. Rhonda's desires and hopes are explored so that we can match them with an enrollee-centered approach that addresses physical and behavioral health, psychosocial needs, and collaboration with her circle of support and relationships.

Health Risk Assessment

Rhonda and Vicki completed the health risk assessment (HRA) together during Vicki's visit to the ER. Rhonda responded positively to questions about behavioral health concerns, domestic violence, and having several social determinants of health (SDOH) barriers, particularly related to housing, food, and transportation needs. Based on the results of the HRA, Vicki and Rhonda continue to meet to complete the enrollee needs assessment to determine service needs, as well as trauma screening and mental health and substance abuse screenings. Together over the course of several visits, Rhonda and Vicki complete the Used, Neglected, Cut Down, Objected Preoccupied, Emotional Discomfort (UNCOPE screener), Patient Health Questionnaire 9 (PHQ9), and Generalized Anxiety Disorder 7 item scale (GAD 7). Vicki was able to use her motivational interviewing skills to build rapport with Rhonda and help her articulate the priorities that are key for her. Rhonda reported that being safe, being a good mom, and having a healthy baby were her top priorities. Vicki helps Rhonda select a primary care provider (PCP), OB/GYN, pediatrician for Amanda, and the Kentucky Counseling Center to assess anxiety, depression, and

substance use/drinking. They reviewed options in Rhonda's neighborhood that are trauma-informed and offer flexible hours and childcare.

Care Planning

Aetna goes beyond just referring to a service; we walk hand-in-hand with Rhonda on her journey to help her find her individual source of strength. Rhonda's individualized care plan includes specific interventions including covered and non-covered services and supports. Vicki facilitates an interdisciplinary care team (ICT) approach to care planning by partnering with Rhonda herself, the PCP, OB/GYN, Rhonda's family/circle of support as chosen by her and selected providers including Chrysalis House, and Kentucky Counseling Center. The **single care plan** includes the assessment of Rhonda's immediate, short-term, and long-term needs, individual preferences, and barriers across all involved providers and resources. It addresses safety and other factors contributing to health challenges, including monitoring for any signs of depression, as well as opportunities for health such as food, housing, social supports, and community services. Rhonda is the driver of what her care planning is, including the services selected, which providers, and who is involved. The care plan is entered into the Aetna electronic care management platform and shared with the entire ICT.

Vicki ensures all barriers to treatment are addressed, as well as all of Amanda's needs are met, including screening for Adverse Childhood Experiences (ACEs), and monitoring to ensure Amanda receives all Early and Periodic Screening, Diagnostic and Treatment checkups, as they are critically important for early detection of potential developmental and intellectual disabilities. If Amanda presents with any challenges, we would assign her own dedicated Aetna care manager and coordinate closely to avoid duplication or burden for Rhonda.

d. Environmental Assessment

Vicki requested a home visit at a time convenient for them at the friend's house where Rhonda and Amanda were staying to conduct an environmental assessment; Rhonda and her friend agreed. Vicki uses this opportunity to gain an understanding about what Rhonda and Amanda are experiencing and to ensure their safety and needs are met. Vicki completes a full assessment, including examining for bedbugs, food insecurities, fire alarms, and locks, and enters the findings into the electronic care management platform. Vicki and Rhonda discuss that having unstable housing may trigger Rhonda into returning to her former partner. Aetna has a statewide network of supportive facilities for enrollees like Rhonda. Vicki offers alternative short-term options to staying with her friend, and Rhonda chooses Chrysalis House in Lexington, which offers services from a multidisciplinary team including case managers, nurses, domestic violence counselors, as well as housing and vocational specialists. The ICT begin exploring options for permanent independent housing immediately upon her move to Chrysalis House.

e. Behavioral Health Services

Aetna understands ACEs can have a direct effect on a person's health and the associated cost of care. Aetna's goal is to **stop the cycle of intergenerational trauma** for enrollees including Rhonda and Amanda. Vicki and Rhonda discuss her ACEs and history of trauma, along with other SDOH as well as the effects of smoking and drinking on her pregnancy. Rhonda expresses that she worries about the effects of smoking on the baby as well as secondhand smoke around Amanda. Using the QUITS program's 5 A's, Rhonda and Vicki devise a plan for how Rhonda can stop smoking, including surrounding herself with others who do not smoke. She can also use resources such as Quit Now Kentucky, and in coordination with her provider, nicotine replacement therapy and medication. The ICT discusses Rhonda's goal of having a healthy baby and the discrepancy with her behavior, and they explore any ambivalence. At the next PCP appointment, the provider completes Screening, Brief Intervention, and Referral to Treatment with Rhonda. As a result of Vicki's building rapport and using motivational interviewing, Rhonda confides that she underreported her substance use; Rhonda agrees to treatment at Chrysalis House, Kentucky Counseling Center, and a local 12-step group. The ICT monitors

the potential for postpartum depression throughout the pregnancy, letting Rhonda know there is support for her.

f. Family Planning

Vicki works with Rhonda to understand what her desire is with this and future pregnancies. Vicki explains all the services and supports available and offers her continued support for any of her choices. In a culturally sensitive manner, seamless coordination of family planning services is available to Rhonda and education is provided on various birth control options for the future, including the Long-Acting Reversible Contraception (LARC) program. Rhonda is connected to educators that provide additional tools and resources. Aetna has contracts in place with hospitals to ensure LARC is readily available for any enrollee who chooses it. Vicki encourages Rhonda to speak to her OB/GYN prior to delivery, should she be interested in LARC or any other form of contraception after the birth.

g. Enrollee and Family Engagement

Rhonda expresses to Vicki that she feels isolated and misses her family in Texas. Vicki helps Rhonda identify a comprehensive list of all the people she has in her life, as well as those she wants to re-engage. With the help of Vicki, Rhonda begins calling the individuals identified, including Rhonda's friend that she and Amanda have been living with, and Rhonda's sister, who both agree to support Rhonda and be a part of the care team. Rhonda calls her parents in Texas and they agree to come to Lexington to visit more often and commit to helping during and after the delivery. Rhonda also expresses that prior to Amanda's pregnancy, she enjoyed morning walks through the neighborhood with friends. Vicki encourages Rhonda to start walking again. Vicki and Rhonda talk about some local community resources and agree to refer her to an Aetna Wellness Center, where community health workers are co-located with community agencies to provide a one-stop shop for enrollees to meet all their social needs.

h. Linkage to Community Resources and Support

Vicki works with Rhonda and the ICT **starting at admission** to Chrysalis House to identify linkages to community resources when she is ready for discharge. With so much available, Rhonda is overwhelmed, and Vicki helps her sort and prioritize her needs and resources. Through a tiered approach, Vicki coordinates all referrals and appointments to space them out for Rhonda, including the following:

- The Nest-Center for Women, Children and Families, a resource center for talk therapy where childcare services are provided; includes parenting classes like Triple P and parent-child interaction therapy; she can also access baby supplies here
- HANDS program, which provides home visits with education on parenting and fetal development, breastfeeding, and home safety
- Activities for Rhonda and Amanda, including 'mommy and me' classes and an infant swim program

Should Vicki encounter any barriers to accessing community resources and supports, she will collaborate with the **adult system of care administrator.** This is an Aetna staff member with specific systems-level experience and expertise who can assist the ICT with connection to resources throughout the continuum of care, including non-covered services to prevent potential service gaps and improve overall health.

i. Social Determinants of Health

Evaluation of SDOH is an ongoing relational process with Rhonda to ensure she has equal access to benefits and services. Any determinants of health impacting Rhonda are incorporated into her individualized care plan, as are the cultural practices and beliefs that are most important to her. Rhonda is concerned about supporting her family, including safety, housing, and food.

Safety: The ICT team regularly revisits the safety plan to ensure their ongoing safety. We know reports of abuse to Adult Protective Services may escalate her danger and use clinical judgment regarding their involvement. We assess for any known or suspected abuse toward Amanda and make referrals to Child Protective Services and notify the pediatrician as needed. Vicki discusses support from legal aid to

address any actions based upon past abuse, explore need for a restraining order, and the former partner's obligations for child support payments.

Housing: The team supports building Rhonda's resiliency and independence by securing a safe home environment. Rhonda and Amanda move into the Chrysalis House for six months. In collaboration with the staff at Chrysalis, Rhonda, Vicki, and the ICT explore housing options including income-based and Section 8. Rhonda receives an escalated ranking on the waitlist for being considered homeless due not having access to her apartment because of the threat of violence from her former partner.

Food: Vicki and the ICT ensure Rhonda's and Amanda's nutritional needs by confirming that she connects with the nutrition program for Women, Infants, and Children; Supplemental Nutrition Assistance Program; and Temporary Cash Assistance for Needy Families.

j. Provider Engagement

Vicki acts as the **single point of contact** for all members of the ICT, including all medical and behavioral health providers. She invites them to the ICT meetings and ensures they have the initial and all updates to the care plan. Vicki ensures all providers are sharing pertinent information at the ICT, including the PCP and behavioral health provider. She advocates with the providers on Rhonda and Amanda's behalf and provides ongoing communication on progress and Rhonda's life changes and goals. Through KHIE, the providers share and maintain up-to-date information on the care provided.

k. Transportation

Vicki explores and coordinates all transportation options for Rhonda, including taxis and gas vouchers, community public transportation, and the Commonwealth's Medicaid transportation benefits. Vicki also arranges connection with community resources for a free child car seat through The Nest-Center for Women, Children and Families. Vicki provides Rhonda the contact information for Federated Transportation Services of the Bluegrass and ensures that Rhonda feels comfortable scheduling her transportation.

Outcomes

Rhonda: Throughout the prenatal period, the ICT supports Rhonda through regular and ongoing communication. Vicki arranges and monitors all services on the care plan. Rhonda has some initial missed appointments but with the continued support and contact from Vicki, Rhonda became actively engaged and participated with care management and her treatment. Although Rhonda faced challenges and setbacks, the team continued to support her by reassessing and addressing her changing needs. She has been regularly attending appointments, including receiving her full course of 17P, and maintaining relationships with her providers. The team arranged for childcare for Amanda, which allowed Rhonda to receive services. She has started regularly walking again with her sister and is due to deliver in seven weeks. The ICT team regularly discusses the possibility of postpartum depression and the availability of continued support. Rhonda is appreciative and hopes that through ongoing counseling at the Kentucky Counseling Center, she will continue increasing her self-sufficiency.

Amanda: Vicki ensures Amanda is safe and is receiving all her regular checkups, as well as specialty follow-up care. Amanda's developmental progression for physical and social needs continues to be monitored with services coordinated with Amanda's pediatrician.

60.7.C.29 Use Cases: USE CASE 2

Aetna guides our enrollee, Katy, on her journey to achieve optimal health outcomes through our person-centered Integrated Care Management (ICM) program tailored to help Katy manage her own care. We support Katy, with her permission, in all areas she deems important to her, her family, and circle of support (i.e., primary care, weight management, and nutrition support).

Katy's Needs and Capabilities

Katy, a 20-year-old Caucasian female, lives in the south-central Kentucky area with her mother and younger brother. Katy is always thirsty and has been experiencing dizziness and has elevated glucose and blood pressure. Katy has the supports of her family and is a motivated college student helping to take care of her brother.

Region 4 Health Risks[1]

Region 4 data frequently ranks low in measures related to obesity and diabetes, such as the following:

- 21.92% of adults reported fair or poor health: **Ranked 7 out of 8**
- 12.53% of the population had diabetes: **Ranked 5 out of 8**
- 33.54% of adults considered obese: **Ranked 5 out of 8**
- 30.49% of the adults considered physically inactive: **Ranked 6 out of 8**
- 16.37% of the population did not have access to a reliable source of food during the past year: **Ranked 6 out of 8**

Collaborative Solution

Our approach is Katy-centered to first help her get the care she needs to feel better and then to give her the skills and tools to help her learn how to interact with her health care providers and keep herself healthy for years to come. While doing so, we will help her to manage her health care costs, get her preventive care, and develop healthy social relationships that will help her in the future.

a. Aetna's Evidence-based Integrated Care Management Program

When Katy contacts our Enrollee Services call center, our enrollee services representative trained in trauma-informed care, Mental Health First Aid, and customer service skills conducts a brief triage to determine the urgency of Katy's situation. Using motivational interviewing skills such as open-ended questions and reflection, the Aetna representative identifies that Katy has not yet completed her health risk assessment (HRA) despite multiple outreach attempts. She explains to Katy the benefit of completing the HRA and our care management program and asks Katy if it is a good time to complete the HRA. Katy agrees to completing the HRA, so the representative conducts a warm transfer to care management. The representative confirms Katy has no other needs, updates her contact information, and informs Katy we have 24/7/365 access for immediate crisis intervention or health information, if needed, and provides the numbers for her on the call.

Our care management model is an enhanced, locally based multidisciplinary team model—to better engage enrollees and families in care management services and improve health outcomes. If Katy agrees to enroll in care management, we will match her with a local care manager to increase knowledge of services and providers in her area. Her care manager will be Katy's single point of contact and is comprehensively trained to assess Katy's physical health (PH), behavioral health (BH), and social determinants of health (SDOH), and to coordinate with the members of her **interdisciplinary care team (ICT). Katy's ICT** includes her primary care provider (PCP), BH providers, nurses, pharmacists, her designated friends/personal supports, and peer specialists.

[1] Kentucky Rankings Data, County Health Rankings & Roadmaps: accessed June 25, 2019; https://www.countyhealthrankings.org/rankings/data/ky

Katy's care manager works closely with Katy and the ICT members to remove barriers that limit Katy's ability to manage her own health and well-being. Katy's care manager coordinates services based on her preferences, needs, safety, burden of illness, and availability of family or other supports in a manner consistent with her personal and cultural values, beliefs, and preferences.

b. Health Risk Assessment and Care Planning and Monitoring

After our support for Katy transitions to care management to better meet her needs, a care management associate uses motivational interviewing techniques, such as active listening and validating Katy's feelings and emotions, to complete the HRA, SDOH screening, and enrollee needs assessment to identify Katy's most immediate needs. Katy says the urgent care referred her to see a PCP as soon as possible based on her elevated blood glucose reading and hypertension. The care manager associate identifies Katy has ongoing needs for support and would benefit from the support of a care manager. We match Katy with her care manager, Ava, who will address Katy's individual biopsychosocial and service needs. After a warm transfer, Ava can immediately help schedule a PCP appointment. Katy had not yet selected a PCP, so Ava helps her choose a PCP close to her. She offers to coach Katy on a three-way call with the PCP office to schedule an appointment. Katy agrees and they contact the PCP to schedule an urgent appointment within 48 hours. Ava addresses potential barriers to care informing Katy about available transportation and childcare for her to attend appointments. Ava coaches Katy and helps guide some of the issues for Katy to discuss with her PCP, such as her health symptoms and any other Early and Periodic Screening, Diagnostic and Treatment-related services Katy has missed including family planning, screen for smoking, and drug/alcohol use. The PCP evaluates Katy for diabetes and Ava will help her coordinate appointments if her PCP refers her to an endocrinologist, dietician, or any other specialists, as needed. Ava also discusses Katy's family circumstances and inquires if Katy's younger brother has seen a PCP. They plan to discuss with Katy's mother addressing both her and her brother's care needs as well.

Ava takes the information obtained from the HRA and completes assessments that screen for Adverse Childhood Experiences (ACEs), including a trauma history, and for depression, which includes changes to sleep habits. Our care managers understand the implications that a history of trauma may be contributing to Katy being overweight. Using this information, Ava develops an initial individualized care plan for Katy. Based on Katy's current PH and BH concerns (blood pressure, body mass index [BMI], and glucose levels) and SDOH, Katy would be in our **intensive care management level.** At this level Katy receives a highly individualized range of interventions to help her and her family manage her potentially serious, complex condition that can be persistent and substantially disabling or life-threatening. Ava also offers Katy participation in chronic condition management since Katy likely has diabetes and explains the opportunities to limit her complications. Katy has the right to decline participation in either program. All her rights are clearly explained and re-explained so **Katy is clear she guides her journey with us**. Because of the support and assistance Katy is receiving with Ava, she accepts the offer to engage in the ICM program.

Interdisciplinary Care team: Within 24 hours after her scheduled PCP visit, Ava contacts Katy to continue to build rapport, discuss how the appointment went, and assure her that she will help her manage her health. Ava discusses the ICT model and that it supports the care planning process by providing expertise to efficiently coordinate and integrate services to best address Katy's individual needs and desires. Katy indicates she would like to have her PCP and the pharmacist join as the primary participants on her ICT and she also selects her mother and aunt to participate in her ICT. Ava will add/remove ICT members based on Katy's needs and preferences. We train Ava to facilitate ICT meetings, and in turn, she educates Katy and the ICT members about care planning and the ICT process.

Care planning: During the follow-up call, Ava and Katy agree on a date, time, and location based on Katy's preferences for an ICT meeting. They choose the PCP's office since it is close to Katy's college

and is easier for the PCP to participate. The initial care plan is based on the HRA and other screens and Katy's identified priorities about her health care concerns, but Ava will engage Katy and the ICT to continue further assessment of Katy's biopsychosocial situation, her health care, and her understanding to guide care planning. Ava invites the ICT members, who may attend in person or remotely if more convenient, to join her and Katy. During the ICT meeting, Ava encourages Katy to discuss her thoughts on how the care plan meets her needs and preferences. Ava engages Katy and the ICT in the care plan formulation to identify and understand Katy's current situation and barriers to better health. Ava obtains information from members unable to attend the ICT meeting and follows up after the ICT meeting to provide feedback. After input by Katy and all the ICT members, Ava completes the care plan and shares it with the ICT members as permitted by Katy. Katy identifies her priorities as continuing her education and getting help with her brother as key primary goals. Katy is also very concerned about the possibility of diabetes and wants to work with her PCP to address her concerns. Katy's strengths include the ability to successfully manage her schoolwork while helping her family by taking care of her brother; she has a good role model for success in her mother, who is working hard to support the family.

Chronic condition management: Due to Katy's health concerns identified in the urgent care visit, Ava offers Katy chronic condition management as part of her participation in the ICM program. Chronic condition management interventions include telephonic and print education on self-monitoring; healthy behaviors such as exercise, smoking cessation, and vaping; referral for appropriate medical testing; assistance with techniques to better adhere to medication regimens and treatment plans addressing enrollee rationale for non-adherence; collaboration (with enrollee's consent) with providers and caregivers; and linking to community-based resources. Katy accepts the offer and Ava uses care plan interventions as opportunities to help address Katy's chronic condition goals.

Ongoing monitoring: Through the ICM program, we continually review all aspects of Katy's care. Ava coordinates services to avoid duplication and identifies any gaps in care. At the **intensive care management level**, Ava initially engages with Katy at a minimum of one face-to-face visit and weekly telephonic contact. The care plan is a living document and is reviewed and updated at least monthly with Katy. Additional contacts and visits occur based on Katy's needs; Ava will update the care plan if Katy experiences a significant change in her health condition or if any SDOH change. Ava understands the importance of SDOH and the effect on Katy's health, such as access to healthy foods, skills in meal prep, and time to be more active. Ava continually assesses Katy's goals in her care plan and her changing priorities to adjust her level of care management accordingly as she progresses to self-management of her health care. Ava monitors Katy's understanding of her health condition and ability to manage her care, including making and attending appointments and follow through with the care plan. Ava also monitors the following chronic condition management outcomes for Katy: appropriate testing of cholesterol LDL level, dilated retinal eye exam, HgA1c, urine protein, blood pressure, and appropriate management of abnormal results. Additionally, Ava monitors the following measures for improvement in Katy's care: correct use of diabetic medications, in both frequency and dosing; adherence to diabetes treatment guidelines, participation in community diabetes education programs, and use of an assessment scale to monitor treatment response.

c. Provider Engagement

Care management interventions also include provider engagement to encourage the use of evidence-based guidelines and protocols and encourage additional educational and training support. We make information about diabetes and hypertension best practices information available to Katy's PCP. Additionally, we make resources available to our providers specifically focusing on healthy behaviors, including weight reduction resources. Katy's PCP can engage one of our medical directors or our chief medical officer as needed for assistance; our doctors may reach out to Katy's PCP if they feel they can be of any assistance or see an urgent need. We send direct mail notifications to providers for enrollees in all levels of our ICM program. **With Katy's consent, copies of her care plan are mailed to her providers and are available**

on our provider portal to enhance coordination and collaboration of care. Providers can refer enrollees to our ICM program using a form found on our website. Additionally, we leverage our value-based payment (VBP) agreements with providers to encourage provider engagement, ultimately leading to **improved enrollee outcomes**. For example, we have a VBP arrangement with Fairview Community Health Center in Bowling Green that we leveraged to make sure Katy got an urgent appointment that met our network access standards.

Community Pharmacy Enhanced Services Network (CPESN) Kentucky is a clinically integrated network of community-based pharmacies which 'act as one'—delivering case management and population health initiatives across the Commonwealth. Participating pharmacies **engage complex patients an average of 35 times per year**. Ava recommends Katy for CPESN knowing she will likely have ongoing medication needs to manage her health. Katy accepts, so Ava helps her find the one closest to her home. The CPESN pharmacist works collaboratively with Ava to coordinate care to meet Katy's needs. CPESN conducts a diabetic medication/pharmacy review; educates Katy on therapeutic lifestyle changes (i.e., weight control, healthy food choices, physical activity, smoking cessation); queries about health exams; coordinates services with Katy's PCP; and educates and encourages self-care behaviors. Enrollee Experience surveys conducted in January 2019 through September 2019 for the program revealed that participants in the survey rated their overall experience with the CPESN pharmacy as "EXCELLENT," averaging 4.8 on a 5 point scale, and "STRONGLY AGREED" that they would recommend the pharmacy to a family member or friend 100 percent of time, with an average score of 5 on a 5 point scale.

d. Cultural Competency

Our goal is to address specific cultural and language needs that might challenge Katy's ability to access care or understand practices that lead to optimum health outcomes. There are questions in our assessments to elicit cultural beliefs so Ava can begin to understand how these are impacting Katy's health and how she can coordinate services to meet the Katy's cultural needs. Cultural competency is a part of all care management training and is an integral part staff mentoring. **Ava and Katy's CPESN pharmacist are local** and have a vested interest in the health of her and her community. They are also familiar with the resources available to Katy in her community and refer her to those that match her cultural preferences. Katy lives in south central Kentucky, which has identified health risks related to high rates of obesity, low access to exercise opportunities, and lack of access to nutritional foods. Ava guides Katy and the ICT members to brainstorm ideas to help Katy beat these challenges and improve her health.

e. Patient Engagement and Education

Ava provides Katy her phone number and email upon assignment verbally, through a culturally aligned welcome letter, and in the care plan. Ava outreaches Katy via her chosen contact method of text first and then call. Ava uses her motivational interviewing skills to understand what Katy needs and makes sure she receives our culturally aligned biannual enrollee newsletter for those in chronic condition management. Ava provides Katy with Krames® educational sheets health information tailored to Katy's needs written in easily understood language. She also informs Katy that the Aetna website is a great resource for information regarding chronic condition management programs and interventions. Ava helps Katy to understand the materials provided by her PCP and her CPESN pharmacist. Ava makes sure Katy is getting transportation to her CPESN pharmacy and reinforces the treatment plan from the pharmacist, who has been coordinating with Katy's PCP through the ICT.

Aetna's Diabetes/Obesity Interventions Yield Improved HEDIS® Scores

- BMI Assessment for Adults is currently in the **95th percentile** and improving
- Counseling for Nutrition—**significant upward trends**
- Counseling for Physical Activity—**on track for upward trends**
- A1c Poor Control (>9.0%)—**90th percentile**
- A1c Control (<7.0%)—50**th percentile**

Katy expresses concerns about managing her weight and diabetes. Ava works with her to educate and mentor her about preventive measures to help manage her health, such as short- and long-term goals regarding her weight loss in her care plan with evidence-based weight management practices to meet her goals. Ava reinforces Katy's strengths as she coaches her to manage her health care.

Technology enhances our ability to engage enrollees in their health care. Examples of technology-based engagement strategies available to Katy to assist with her specific health concerns include the following:

- **Lifeline smartphone:** Ava ask Katy if she needs a smartphone and Katy indicates she does. Ava helps Katy apply for a Lifeline-sponsored smartphone. Aetna launched the Lifeline smartphone to link enrollees to improved phone services for better communication between the plan, their physician, and care managers. Katy can use free apps about exercise/fitness, healthy cooking, and nutrition.
- **Social media and texting:** In Kentucky, Katy can engage in her health care through social media platforms, such as Facebook, and our **Welltok text messaging.** Our educational text-messaging program consists of a Lifeline smartphone and messages to remind enrollees to get tests and screens done. It sends routine reminders to Katy to support her health goals. **Our average rate of delivered messages for Welltok is 65 percent**.
- **MySugr:** Ava educates Katy about this no-cost smartphone app to help manage her diabetes-related health information, including estimated HgA1c and insulin calculations.
- **Remote patient monitoring (RPM):** We offer Katy our RPM to prevent hospitalizations, avoid readmissions, and health regression by focusing on early detection and intervention. Since Katy does have internet access in her home, she will receive an iPad mini™ kit with up to two peripheral devices, such as a weight scale, pulse oximeter, blood pressure cuff, and glucometer. Katy logs her blood glucose daily, which is shared with a certified diabetes educator who reviews her log weekly. We program upper and lower end thresholds into Katy's system to produce an alert should she indicate hypo or hyperglycemic.
- **HealthRunsDEEP:** Aetna's HealthRunsDEEP (Diabetes Empowerment Education Program) intervention alongside our partnership with independent pharmacies incorporates face-to-face sessions, RPM, weekly touchpoints with a health coach, and incentives to ensure continued engagement. The program integrates local resources to promote sustained engagement with self-monitoring and improved healthy behaviors.

Katy participates in other initiatives Ava offers as she chooses to educate and engage her, some of which are **enrollee incentives and value-adds**, including the following examples:

- **Coaching and mentoring:** Ava and the CPESN pharmacist educate Katy about her health conditions and self-management of her medications during regular contacts with each. The CPESN pharmacist is in Katy's ICT and her pharmacy care plan is incorporated into her overall care plan.
- **Slow cooking nutrition program:** Katy can take free courses taught throughout the community offering nutrition 101, wellness activities, healthy meals and recipes for a slow cooker, along with the following topics: BMI, diabetes, hypertension, heart disease, and dietary guidelines. Katy receives a slow cooker after attending. Ava encourages Katy to teach her mother the recipes, too, so they can make healthy meals together that are more affordable, nutritious, and tastier than fast food. **Aetna has provided over 400 slow cookers to enrollees.**
- **Diabetes nutrition**: Katy can take free basic diabetes course taught throughout the community.
- **CVS weight management program**: Katy can access nutritional/weight loss counseling at a CVS MinuteClinic. The initial visit assesses weight loss efforts, physical condition, and lifestyle factors. Katy would be evaluated and offered the opportunity to join the DASH for Health online program, where her personalized goals and plan are established. The individualized plan delivers up to 16 visits over the course of 26 weeks; every week for the first 4 visits; every other week for remaining visits.
- **Enhanced transportation**: Katy can use 10 round-trips (up to 60 miles per round-trip) per year via a transportation vendor or mileage reimbursement for transportation to activities such as job interviews,

job training, shopping for professional attire, shopping for food at a grocery store or food bank, and accessing community health services not otherwise covered.

- **Aetna Better Way to Health**: Katy can receive incentives (provided via digital and physical single use Walmart gift cards) to promote wellness and preventive care.
- **HRA**: Katy completed her HRA within 30 days of enrollment and received a **$25 incentive**.
- **My Rewards:** Katy can receive monetary incentives for improving her health, getting active in her community, and improving her job skills. Similar to a health savings account, My Rewards is a special savings account available to Katy for items like a fitness tracker.
- **Avēsis:** Aetna is partnering with Avēsis to complete retinal scans for our enrollees with diabetes at kiosks in Walmart stores located conveniently within the community. This solution helps close a gap in care for Katy and is convenient since she shops at Walmart.
- **24-hour Health Information line (nurse line):** Features 24-hour, toll-free, and email access to registered nurses experienced in providing information on a variety of PH and BH topics and a health library of more than 2,000 health topics available in English and Spanish. We integrate reports on enrollees accessing the Health Information line into care management.

f. Community Resources

Based on the information learned from Katy and her mother during the SDOH screening, Ava makes referrals for the following community resources to meet the goals of Katy and her family. Ava helps connect Katy to the resources she is interested in and what works for her life:

- **Access to healthy foods:** Initiatives in Katy's community include food pilots, gardening projects, mobile grocery store, vouchers for fruits/vegetables, supplementing community food pantries, and the Supplemental Nutrition Assistance Program. Ava informs Katy she can get fresh fruits and vegetables at a local food pantry along her bus line. She also tells her about a gardening project she and her brother can enjoy together. The enhanced transportation value-add can help Katy go to the grocery store or food pantry.
- **Getting active:** Katy can access the gym at her college as well as the free apps on her phone to help her to be active and begin to practice a healthier lifestyle.
- **Childcare assistance:** Ava works with Katy and her mother to assist with researching eligibility for childcare assistance to relieve some of the burden from Katy of caring for her younger brother. Katy could also use her My Rewards funds for childcare to attend appointments.

g. Social Determinants of Health

Ava acknowledges lack of money contributes to Katy's health problems, but she will help them locate resources to meet their needs. She facilitates discussions about Katy's and her mother's strengths, needs, and goals and they prioritize them together to develop Katy's care plan. Ava informs Katy's mother about the Earned Income Tax Credit and legal support available to her. Some root causes of SDOH identified include lack of access to healthy foods in her area; economic impact on obtaining health foods and exercise options; lack of healthy meal prep skills; and economic impact on childcare. The engagement strategies and community resources will help to resolve Katy and her family's identified SDOH. Ava explores if Katy is eligible for a scholarship through the **Work Ready Kentucky program**. The program, provides tuition-free access to over 350 programs to prepare individuals for a career.

Outcomes

Katy was diagnosed with diabetes and hypertension by her PCP. She is engaged in the numerous opportunities offered to her to educate herself and manage her health care, and she especially likes the technology-based tools such as RPM and MySugr. She has learned healthy cooking and helps with meal prep at home for herself, her brother, and mother. She stays in regular contact with Ava, her CPESN pharmacist, and facilitates her own ICT meetings thanks to the coaching and mentoring she received by Ava. She is still in college and she and her friend both go to the gym there before class three times per week. Katy is on track to a healthy weight and is excited to attain her associate degree next semester.

60.7.C.29 Use Cases: USE CASE 3

Aetna's overall approach for a successful partnership and an incentive-based initiative includes collaborating and listening to our providers. We provide user-friendly and easily accessible reporting tools, technical assistance, and data support including our electronic population health management platform and data exchanges. We assist providers in improving health outcomes at the point of care and facilitate achievement of incentives for delivering quality service. Our approach leverages strong payer-provider relationships built on trust and transparency supported by data, reporting, and connectivity.

To measure the success of the initiative, we identified five quality measures unique to the practice area for which providers receive financial incentives for meeting targeted improvements as well as staff as the single point of contact to work with the providers. These measures were chosen for their emphasis on physical and behavioral health integration, social determinants of health, and critical community resources. To simplify provider burden, we have chosen to implement quality metrics that are significant to their enrollee population. The selected quality measures are related to electronic health record (EHR) functionality, Kentucky Health Information Exchange (KHIE) connectivity, substance use disorder, tobacco use, and diabetes. Our provider services representative will assist with tracking data to support the identified quality measures.

Aetna has listened to the concerns of the provider group and conducted a strategy meeting where both parties agreed to reevaluate the process of implementation of the value-based payment (VBP) arrangement related to this initiative. During our strategy meeting we discussed the challenges experienced by the provider group in detail and developed approaches to address each challenge.

a. Provider Engagement at Local, Regional, and Statewide Levels

Through our comprehensive provider support model, led by a dedicated local provider services representative, the Aetna team will assist providers in overall population health management, including providing a minimum of monthly reports on all performance trends including total cost, quality, and utilization with guidance on actions to achieve targets, while supporting advanced care coordination.

Example of Successful Provider Engagement

Avēsis, our dental subcontractor, began working with us in early 2018 on a joint project to analyze the opioid-prescribing patterns of our providers. Avēsis analyzed 12 months of data and determined there were 240 unique Kentucky dental providers in their network who prescribed greater than three days of opioids for one treatment in 780 unique enrollee encounters. After all data was analyzed, a co-branded provider notification letter was mailed to these providers in mid-December 2018. Data processed in late May 2019, nearly six months after the letter was mailed, shows a 70% decrease in the overall prescription rates among the cohort being monitored.

Locally and Regionally

We understand that some practitioners are highly engaged in this initiative, but others are finding it complicated and burdensome; we know it is critical to address these concerns immediately. Our Provider Services team is in the community to support our providers. In addition to the monthly Joint Operating Committee (JOC), the Aetna provider services representative for eastern Kentucky will have regular face-to-face meetings and can relay any of their concerns and frustrations immediately to the Aetna care team. We will collaborate with the providers to identify successes and assess challenges and then develop action steps to address each challenge. Our experience is that providers enjoy working directly with our teams in their community.

Providers demonstrating high-performing/high-volume activities are selected as provider champions. We then identify the less engaged providers needing additional support and implement a peer-to-peer engagement action plan. Our engagement action plan will incorporate a collaborative effort with provider

champions to showcase successful processes and practices. Aetna staff will assist providers in implementing identified best practices. Aetna physicians will also participate in this process.

To supplement the provider engagement, we will also establish connectivity support. Recognizing that certain provider groups have issues with onboarding, our strategy will be to partner with the regional KHIE outreach coordinators to facilitate the process of data sharing and making information directly available to the providers. If EHR enhancements are not possible for specific providers within the group, Aetna can receive KHIE information on our electronic population health management platform and through the care teams can communicate with the providers without their direct access to KHIE. We know that the foundation to optimal health care is the relationship between those providing care and the people they serve.

Statewide

Aetna is actively participating on the Performance Measurement Alignment Committee (PMAC) through the Kentucky Health Collaborative (KHC) with the Department, other managed care organizations (MCOs), providers, and key stakeholders for measure alignment. Through this collaboration, we aim to reduce administrative burden by agreeing to common measures. We will facilitate this provider group's inclusion on the PMAC to increase their engagement and satisfaction.

As an additional opportunity to engage this provider group, we will use our Aetna Provider Partnership Program (**AP^3**) Advisory Council. The **AP^3** includes representatives from various provider groups, including primary care providers (PCPs) and specialty groups, to obtain feedback about our processes to aid in identifying opportunities to reduce administrative burdens and solve issues before they are accelerated. Close contact and close feedback to and with our providers is critical.

b. Provider Education, Communications, and Support

Aetna's passion for and dedication to serving Kentucky's Medicaid population translates into authentic and meaningful provider relationships that result in our ability to make a significant and positive difference in the lives of our enrollees. An integral part of improving enrollees' health outcomes is our strong provider communication that begins at the top of our organization and extends to every staff member. Aetna has strengthened our model for educating, communicating, and supporting providers by using a deliberate and thoughtful approach to working with provider communities.

In support of this initiative, we agreed to monthly Joint Operating Committee meetings with the provider group where the previous month's reporting would be reviewed in detail in a collaborative manner. JOC meetings allow for bidirectional communication and training on topics affecting both providers and Aetna in areas such as quality, care management, social risk screening and navigation, and plan operations. Given the challenges experienced by the provider group, we have also identified a provider services representative as a single point of contact for the provider to contact between JOC meetings. The JOC meetings, which are comprised of the executive teams from both Aetna and the provider group, work collaboratively to achieve the contract's stated goals and assure accountability while working to improve care, improve health, and lower costs. Aetna also provides opportunities for provider education and training as well as technical assistance in any areas identified. During the JOC meetings, action plans to address these opportunities are developed along with plans for monitoring.

In addition to our JOCs, we host on-demand educational webinars that can be accessed at a provider's convenience. Aetna's Healthcare Effectiveness Data and Information Set (HEDIS®) field staff offers educational resources such as our HEDIS Toolkit, which includes tips on how to appropriately close gaps in care inclusive of proper coding and HEDIS guideline interpretation. Other resources include provider newsletters, provider manual, fax blasts, and our Tip Tuesday campaign, which highlights weekly educational topics.

As part of our reevaluation process with the provider group, we completed an assessment of the provider's EHR systems for its functionality to capture and report data related to the initiative. It was determined that while they were receiving admission discharge transfer data from some of their facilities, not all the EHR features were activated. The provider indicated that cost was a barrier to turning on the features. As part of our realignment strategy, Aetna agreed to build in an incentive to the providers to activate all the missing features. In turn, the providers have agreed to full connectivity to KHIE. Recognizing that inefficiencies create significant administrative burden, these enhancements to the EHR will create more streamlined processes resulting in increased provider engagement.

To positively influence provider behavior, Aetna and the provider group agreed to modify the incentive payment structure for Year 1. We agreed to use the data from the first six-month of the project as a baseline and implement a tiered incentive payment model for the remaining six months of Year 1. Agreed upon levels of improvement achieved in the third quarter will be eligible for an incentive payment. The same incentive payment structure will be applied for the fourth quarter of Year 1. Improvement achieved in Year 2 will be assessed on a 12-month measurement period.

As an additional support for the provider group, our community outreach coordinator that resides in this region has established relationships with key resource partners and leaders in the community. Our outreach coordinator is actively involved with the local community housing agency and will utilize this relationship to facilitate communication with the provider group and establish ongoing meetings between Aetna, the provider group, and the community housing agency. Aetna community health workers located in the community at Wellness Center offices will use resources and tools such as Unite Us to improve the connection to available community resources, including community housing.

c. Simplification of Provider Administrative Burden

Aetna continually looks for innovative strategies to engage, satisfy, incentivize, and retain providers. We use performance improvement projects, educational initiatives, and community forums to help providers improve their practices, create better health outcomes for enrollees, and reduce administrative costs and burdens. We used the following strategies to engage and retain the providers in this initiative and simplify the administrative burden:

- Identified a provider services representative as a single point of contact for the provider group to simplify and streamline issue resolution
- Explored opportunities for a Gold Card program
- Identified a dedicated support team inclusive of medical, utilization management, care management, quality management, and finance representatives who are accessible through the provider services representative for provider issue resolution
- Implementation of the **AP³** Advisory Council consisting of three external provider councils: the Practice Management Advisory Council, Ancillary Management Advisory Council, and Behavioral Health Management Advisory Council
- Evaluated our requirements for opportunities to simplify processes and requirements, such as reducing unnecessary prior authorizations
- Assessed other MCO requirements to identify opportunities to reduce duplication while still obtaining required information
- Provided EHR support through the regional extension centers; additionally, we offer the provider the use of Aetna's electronic population health management platform
- Utilized the secure data messaging component of KHIE to share the statistics of the initiative in order to help our providers see the data on impact in their communities

d. Enrollee Engagement

Enrollee engagement is critical to the success of the initiative. It is often hard to follow up with enrollees due to challenges regarding current contact information. We addressed these challenges by initiating a robust communication strategy. This strategy consists of the following:

- Text messaging and email campaigns
- Gathering updated demographic data through enrollee interaction with Care Management, Enrollee Services, Utilization Management, and KHIE to facilitate communication
- Community outreach events
- Promotion of Lifeline cell phone program
- Pursuant kiosks at Walmart with prompts to verify contact information
- Reminder to update contact information via enrollee communication
- Maximizing the relationships established with the local community pharmacists through the Community Pharmacy Enhanced Services Network (CPESN)

As updated contact information is received from enrollees, Aetna will generate a weekly report to share with the provider group to enhance outreach efforts and enrollee engagement. This will be provided to the providers with their designated single point of contact.

We understand that enrollee engagement is not only limited by communication channels but also by enrollee behavior. To address some these concerns, we have implemented the following strategies:

- Enrollee incentive program with value-adds including health spending account, transportation assistance, and cell phones
- Delegated care management embedded with the provider group; a single point of contact
- Co-located community health workers for enrollees to access in the communities where they live
- Regionally based outreach coordinators who are familiar with southeastern Kentucky

We also recognize that enrollee attribution challenges can contribute to decreased compliance and engagement. Our commitment is to work with the providers to make certain enrollee attribution is appropriate. Our strategy will assess PCP availability, Quest Analytics parameters, and enrollee demographics to assist the providers in meeting enrollee preferences. We will also make the provider attributes more readily available to the enrollee. If the enrollee develops a relationship with a preferred PCP, they will be more engaged and compliant.

Innovations in Engagement

In addition to the strategies described previously, Aetna is a leader in creating new and innovative ways to engage our enrollees. Aetna is developing community co-located Wellness Centers with community-based community health workers who live and work in the area for easy access and building relationships. We train our staff with evidenced-based programs that help us better serve our enrollees and seek solutions with our providers. With this in mind, we are implementing staff trainings on the Bridges Out of Poverty program to better understand the beliefs, mindset, and behaviors seen in a community that is rife with poverty. By taking this training, our staff can devise opportunities and education tailored to the needs of these communities. Along with Bridges out of Poverty, all staff are trained in motivational interviewing and Mental Health First Aid, so they are effective in engaging enrollees in communities. Our staff receive constant feedback on how well they utilize motivational interviewing, as well as monthly refresher training. We also bring a poverty simulation experience to the community so that all stakeholders are offered an opportunity to better understand the challenges of our enrollees.

Additionally, we utilize community-based pharmacies through our CPESN model, so that enrollees feel comfortable with their pharmacists and safe to express concerns and needs. Capitalizing on this relationship, we can utilize the CPESN independent pharmacies as an additional method to outreach to enrollees and assess their needs.

Aetna has a unique partnership with Unite Us to integrate, coordinate, and monitor our enrollees' social needs. Aetna's co-located community health workers in our Wellness Centers throughout Kentucky link our care delivery system to the Unite Us social service network. This helps connect the enrollee to services that address barriers to their social determinants of health. We will have access to completion rates of referrals and reports that can be provided to providers on their enrollees to assure their social needs are met.

e. Vendor Assessment of Internal Operation Challenges and Mitigation Strategies

Our primary goal is to improve our relationship with the provider, reduce administrative burden, and meet the needs of our enrollees. To address the provider challenges that have been outlined, Aetna's leadership assessed our internal operations and initiated the following mitigation strategies:

- **Timeframe for incentive payments:** We restructured the VBP arrangement to a tiered approach and redefined the baseline and measurement period, resulting in a timelier payout to the provider group.
- **Required reports:** To improve efficiencies, we implemented a monthly JOC to review all required reports. Additionally, we have identified an Aetna provider services representative as the single point of contact for the provider to facilitate communication.
- **Reduced administrative burden through Gold Card program:** We assessed our claims history with the provider group to identify opportunities to improve and streamline the prior authorization process, including removal of prior authorization for certain codes.
- **Regionalized community health worker model:** To improve communication between Aetna and the provider, as well as provide real-time feedback and support in the area of enrollee engagement, we co-located community health workers with the provider.

With the strategies and initiatives described, we were able to address the provider group's concerns as well as improve overall provider and enrollee engagement in the initiative.

aetna™

60.7.D Implementation Plan

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60.7.D Implementation Plan

> Aetna has passed 16 consecutive readiness reviews on the strength of our proven implementation process.

The Aetna Medicaid organization is a loyal partner to the Commonwealth as one of the original Medicaid managed care organizations (MCOs). Providing services since 2011, we partner for solutions during critical times (e.g., enrolling 68,000 Kentucky Spirit enrollees in 2013) and by taking on new opportunities (e.g., Quit Incentives for Tailored Support program for pregnant smokers) in the current contract. Aetna has a long history of successfully implementing new Medicaid programs, and we have learned and improved our processes over time. We will use Aetna's national experience and work plan process, in partnership with our existing Kentucky health plan team to implement the Kentucky Medicaid managed care program in a timely and compliant manner. Along the implementation pathway, we will stay focused on enrollee, provider, and community organization feedback to gauge opportunities for enhanced communication or education. Our dedication to being a collaborative and innovative partner to Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier Kentucky.

1. Proposed Approach to Support the Readiness Review Process

> Aetna's primary implementation goal is to execute seamlessly the priority of improving delivery of health and family services through quality customer service.

Aetna has developed and refined its implementation approach and brought best practices based on three decades of Medicaid managed care experience and lessons learned. Our process enables us to serve the needs of enrollees as we work to achieve full compliance and a seamless transition to new regulatory and contractual requirements. Similar to Deloitte's Intelligent Program Management Office™ methodology, our Medicaid Implementation Team utilizes a Project Management Body of Knowledge (PMBOK) model and will bring together a team of subject matter experts from both our existing Kentucky health plan and our national Shared Services teams. This combined team will both have the necessary expertise and project management skill sets for a successful implementation that will meet the Department's goals. Aetna's Program Management Office (PMO) team will provide the governance structure for the implementation of the new contract. Our PMO creates and maintains the implementation project documentation and best practices, and tracks metrics and progress. Aetna's implementation team, driven by the PMO, reports on a bi-weekly basis to executive leadership. This governance provides needed direction and clarification to help move the overall implementation process forward.

Engaging with all stakeholders early is our key to a successful implementation, because each implementation is unique, as is each community and state. Our existing community collaborations feature initiatives across the Commonwealth, encouraging health education and actions to address the medical and non-medical drivers of health. Aetna looks forward to working with the Department to support the goals of helping Kentuckians achieve healthier lives.

Governance and Implementation Kickoff

We will establish project management governance for the project prior to implementation kickoff. We use the following multitiered approach that ensures transparency, integration, timely decision-making, and action execution to deliver the implementation requirements from project initiation to operational performance:

- **Level 3:** Aetna's chief executive officer (CEO) chairs the Implementation Steering Committee, which is facilitated by the implementation director. The committee members include the regional vice presidents, department heads and CEOs of each health plan. These committee members have voting rights and are the chief decision-makers of all contingency and mitigation plans and resources. The

Implementation Steering Committee makes key decisions, reviews major risks and their mitigations, addresses critical and escalated issues, and aligns resources to deliver the program's implementation requirements on a timely basis.

- **Level 2:** This governance committee will be chaired by the regional vice president, whom the Kentucky health plan CEO reports into. This meeting is also facilitated by the implementation director. This committee will be focused on any significant changes involving the Department and mitigation of those changes. Key Aetna Shared Services department heads also participate in this committee.
- **Level 1 (or Lead team):** This governance committee will be chaired by the Kentucky CEO and chief operating officer (COO), and again facilitated by the implementation director. This is a weekly meeting which consists of all the business owners both in the health plan and in Shared Services to meet and discuss the progress with their individual project plans, and raise any concerns, issues, risks, potential contingency plans to the larger group. The functional areas involved include, but is not limited to, the following:
  - Account Management/Finance
  - System and benefit configuration for enrollment, care management, and utilization management
  - Care Management
  - Provider Services
  - Enrollee Services
  - Quality Management and value
  - Stakeholder Engagement
  - Program Operations
  - Claims and Encounter Management
  - Compliance/Program Integrity
  - Technology/Reporting/Data Management/Informatics
  - Grievance and Appeals
  - Human Capital/Learning and Performance
  - Real Estate
  - Vendor Management

Each functional area has separate work streams and manages issues and risks through our levels of governance and reporting process.

Our governance approach is facilitated through standard project work stream and overall project reporting templates, project plans, and a global issues and risk management log, which is one component of our comprehensive implementation management system. Similar to Deloitte's Intelligent Program Management Office methodology, Aetna's implementation process communicates risks in a timely manner to the outlined governance committees and presents remediation strategies to overcome these risks.

Another crucial part of our implementation process is gathering, confirming, and incorporating all Commonwealth regulatory and technical requirements into our clinical services, administrative operations, transactional platforms, and program management. We will follow this approach in Kentucky to make certain our existing health plan processes meet the requirements of the new request for proposal (RFP). Our business systems and processes support our staff in a manner that serves the individual needs of each enrollee and provider. We conduct a focused, intensive, multiday review of the contract with all subject matter experts as described previously to ensure a consistent understanding of the Commonwealth requirements and to identify ownership of programmatic requirements. Based on the direction established in this requirement review session, each functional area work group updates its operational and technical work plan document and begins to fulfill deliverables. This includes review and update of policies and procedures, enrollee and provider materials, system applications, testing, and training materials.

Readiness Reviews

Through our years of experience implementing managed care programs across the country, we understand that implementing a new program takes time and requires an intense focus on enrollee care. Aetna will engage with the Department, providers, and community partners continuously to form collaborative relationships that foster readiness. We will partner with the Department upon contract award to participate in a continual Department-led readiness review process that will include, at a minimum, the following:

- Review and approval of all our policies and procedures and enrollee materials
- Demonstration of our systems
- Thorough review of our health plan's understanding of the contractual requirements
- Onsite reviews, desktop reviews, policy reviews, system demonstrations, staff interviews, and self-audit evaluations
- Pre-delegation audit and readiness of vendors

We expect and prepare for increased call volume by providing additional staff members who have been trained on the Kentucky Medicaid program requirements and are ready to answer enrollee questions and avoid gaps in care. Providers are engaged through face-to-face, educational seminars and group interfaces, and recruited through outreach initiatives to manage, support, and maintain continuity of care. Our provider communication efforts reduce confusion about contract details and assure practitioners that we will honor prior authorizations during the transition period. Enrollees can see their preferred practitioners even when they are out of network, while we work to contract with the provider or enter into a single-case agreement to reduce disruption for enrollees.

Thirty days prior to the contract effective date, we conduct a detailed internal deployment readiness review during which senior leadership, health plan staff, and the Implementation team review the following for completeness and accuracy:

- Status of completion of all major tasks and deliverables
- Systems functionality
- Staffing and training
- Resolution of any significant issues

Two weeks prior to the detailed internal deployment readiness review, we prepare our day-by-day deployment schedule of activities, including promotion of our applications to production, receipt, and processing of the enrollment file, transmission of enrollment information to our vendors, generation and distribution of enrollee identification cards and materials, and numerous other activities.

One week prior to the effective date, we assemble a Deployment Command Center team and schedule daily meetings. Together, health plan leaders and the Implementation team review the status of key startup activities and deliverables and identify any potential issues or risks.

Additionally, the Deployment Command Center staff (key health plan and implementation leads) monitors all key performance metrics for the program, such as clinical services, operations, file exchanges, and regulatory reporting. Measures are monitored daily to ensure our performance complies with and meets the needs of enrollees and providers. Any issues identified will be managed through our issue-tracking log within in our system. We prioritize and monitor resolution based on the impact to enrollees and providers and regulatory or contract compliance.

1.a. Proposed Program Implementation Plan

Implementing a new program can present challenges and requires a methodical and proven approach to addressing potential barriers and setbacks. Therefore, we develop a comprehensive work plan to address all activities, work streams, and variables as part of our approach to a successful implementation. As an existing Kentucky Medicaid health plan, we recognize that a strong working relationship with the

Department is critical, and if awarded, we will continue to collaborate with the Department as we refine the implementation work plan and address all areas of sensitivity and concern, such as enrollee transitions, outreach, and communication.

The brief summary of our implementation timeline is presented in **Figure D-1**.

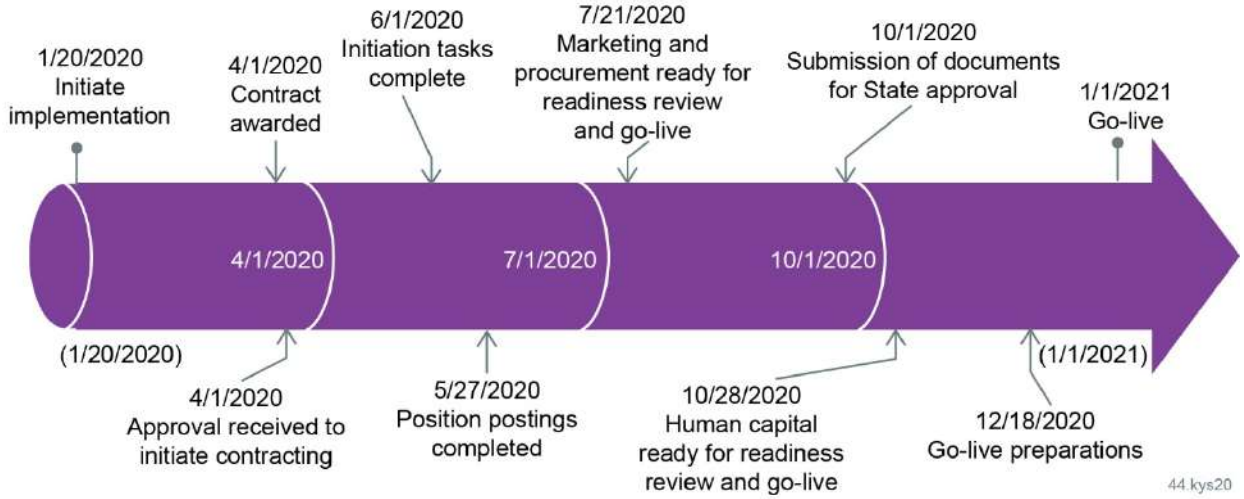

Figure D-1: Aetna's Implementation Timeline

Aetna is prepared for contract start on 1/1/2021.

Aetna's Kentucky implementation plan provided in **Attachment U** includes but is not limited to the following implementation activities described in **Table D-1**, many of which are already in place due to our existing health plan status:

Table D-1: Key Implementation Activities

Required Implementation Activity	Status
Establishing an Office Location and Call Centers	Our health plan office has been located at 9900 Corporate Campus Drive, Louisville, KY 40223 since August 2011. Our Enrollee Services, Provider Services and Behavioral Health call centers have been operational since 2011 as well. Currently, Aetna leadership and our Real Estate team is evaluating the need for additional space for any increased staffing.
Provider Recruitment Activities	Aetna's existing Medicaid provider network is 100 percent compliant with network adequacy requirements. We have 29,355 contracts representing 33,794 providers at 118,977 locations. On a monthly basis we monitor and assess our network for adequacy and to determine potential provider recruitment opportunities.
Staff Hiring and a Training Plan	Our current staffing plan assumes total enrollees of over 211,000. Under this scenario, we expect to maintain our present staffing levels, with more than 250 staff members in Kentucky supporting the Medicaid program. All staff have already been trained on the Kentucky Medicaid program as well as on job specific training.
Developing Required Materials	As an existing Kentucky health plan, we have policies and procedures as well as enrollee and provider materials in place that meet the Department's requirements. As part of our overall implementation approach, we will review these documents and make any necessary revisions based on the RFP and contract.
Establishing Interfaces to Information Systems Operated by Subcontractors, the Department, or Others	We have already established interfaces to the information systems operated by our subcontractors, the Department, and other entities interfacing with our Kentucky health plan. We continuously monitor these interfaces and collaborate with these organizations as appropriate.

We utilize the information from the contract, stakeholders' feedback, and information from our focused, intensive, and multiday review with our Medicaid subject matter experts to develop the work plan and interdepartmental timeframes. This high-level work plan will be updated based on final negotiations upon award and as directed by the Commonwealth.

We also develop a must-and-shall list of contractual elements to help ensure we enhance our policies, procedures, reporting, and systems to be compliant with the Medicaid managed care contract and requirements. Working with the Department, Aetna will leverage our experience in in Kentucky, as well as other program implementations, accounting for the complexities and changing environment of managed health care programs to deliver on time and in alignment with the Commonwealth requirements.

1.b. Proposed Staffing to Support Implementation Activities and Readiness Reviews

The Aetna Medicaid organization's 30 years of experience serving Medicaid enrollees and successful management of a Kentucky Medicaid health plan since 2011, will help position us for a seamless implementation of the Medicaid managed care program in Kentucky. We view the Department as a partner in ensuring successful implementation and minimizing disruption to enrollees. Aetna's Implementation team is comprised of highly experienced, integrated, functional leaders, subject matter experts, and employees from physical health, behavioral health and information technology functional areas. Comparable to Deloitte's Intelligent Program Management Office methodology, Aetna's Implementation team will be focused on the strategic vision of this Kentucky implementation while providing oversight of the various teams' project plans which make up the implementation program.

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Figure D-2: Implementation Director
Joe Eberwein has experience with Kentucky implementations.

Aetna will utilize three dedicated members of its Implementation team to be solely focused on the Kentucky implementation. These Implementation team members will consist of a director, senior project manager, and a project manager who will work in partnership with the local Kentucky health plan team and the supporting areas to develop a comprehensive project plan, which will span through 90 days post-go-live. This full program management will include securing weekly updates from the Kentucky health plan and the various Shared Services areas to ensure individual functional area project plans are proceeding accordingly and all risks are identified and resolved.

The roles and responsibilities of these three key positions are as follows:

- The director will be responsible for organizing weekly command center meetings with both the health plan and the shared services throughout the implementation.
- The director with support from the senior project manager will coordinate all the document readiness components including determining ownership, quality review, compliance review, and formal submission.
- The Implementation team will coordinate all activities related to the readiness review.
- The Implementation team will also develop and maintain full program management of the Kentucky implementation.

Joe Eberwein (please refer to Figure D-2), our implementation director, has over a decade of experience implementing Medicaid programs, including the current Kentucky program. The Implementation Lead team includes the following members:

- Aetna's regional vice president
- Chief executive officer
- Chief operating officer
- Chief medical officer

- Chief financial officer
- Implementation director
- Implementation senior project manager
- Implementation project manager
- Compliance officer
- After-hours manager
- Check run manager
- Claims project manager

1.c. Overview of System Operational Implementation Requirements and Related Milestones

As an existing health plan in Kentucky, our operational systems are already in place and fully functional. We do not anticipate the implementation of any new systems for the managed care program currently. As part of the implementation process, we will review the RFP and contract requirements to determine if any modifications are needed to existing systems and incorporate those modifications into our implementation plan.

If at any point during the life of the contract we determine a new system is needed to manage health plan operations, we would conduct extensive system testing internally with our vendors and with the Commonwealth to ensure operational readiness prior to contract implementation. We would use our dedicated User Acceptance Testing team with a detailed plan to govern all testing. The plan specifies the test data set, expected results, and test protocols and rules. At each stage, testers document any identified defects, coordinate the correction of those defects with the appropriate team members, and document their approval of the system test results at 100 percent before they move to the next stage in the process. Our testing process encompasses the following:

- Functional area testing (e.g., comprehensive assessment, integrated service coordination
- team functionality, utilization management functionality, benefit/covered services)
- Performance testing (e.g., enrollment of new and transitioning enrollees, identification card process, claims testing, reporting)
- User acceptance testing and end-to-end testing
- System-specific tests, including Section 508 testing of our external websites to ensure accessibility for enrollees with disabilities and all Commonwealth-required testing, including the 834-file exchange

As we proceed through the implementation of any new systems, we prepare by updating existing and developing policies and procedures, as applicable and our readiness review tool, which maps each contractual requirement to our activities and deliverables in preparation for our pre-readiness review. Our pre-review helps validate our preparation, identify any gaps, and specify actions to resolve gaps prior to the contractual readiness review.

1.d. Required MCO, Department, and Other Resources to Ensure Readiness

As described previously in the proposed staffing of this response, we will utilize our Implementation team consisting of dedicated implementation staff, local Kentucky health plan staff, and subject matter experts from across the organization to ensure readiness.

As we have in the past, we will collaborate closely with other Kentucky Medicaid MCOs, as appropriate, during the readiness process to ensure a seamless implementation for enrollees, providers and the communities we serve. Additionally, our team will participate in all workgroups and readiness meetings led by the Department to monitor our implementation progress.

2. Potential Planning and Readiness Limitations or Risks and Strategies to Address

Aetna does not foresee any limitations or risks to meeting the Department's expectations or requirements for planning and readiness. Aetna has the experience and expertise needed to comply fully with all requirements. In the event new expectations or requirements are identified by the Department, we will quickly assess the impact of the new requirements to health plan operations, develop a plan for ensuring full compliance, and identify the appropriate resources necessary to implement the requirement

Aetna's History of Success Implementing and Transitioning Programs in Kentucky

In 2018, we demonstrated our ability to successfully implement newly identified requirements while implementing a new program. We were commended for our preparation and documentation during the readiness review process. In addition, our successful testing capabilities were recognized by the Commonwealth. We demonstrated flexibility as we navigated frequent changes during the implementation process.

Additionally, we demonstrated our commitment and devotion to fellow Kentuckians and the power of collaboration with the Department and other Commonwealth agencies at a critical time in July 2013. On July 6—Saturday of the July 4 holiday weekend—our health plan (operating then as Coventry Health and Life Insurance Company) welcomed 68,000 new enrollees when one of three Medicaid managed care organizations in the Commonwealth, Kentucky Spirit (Centene), ceased operations. Through diligent planning, expert execution, and unmatched passion by our experienced staff, we provided a smooth transition for our new enrollees and providers, while continuing to provide the best service for our existing enrollees.

Our staff addressed the needs of our new enrollees, including processing enrollment and identification cards, conducting enrollee and provider calls, managing prior authorization, and more. We urgently and necessarily achieved the following:

- Monitored and loaded special enrollee files from July 5 through July 8
- Managed an almost 50 percent increase in fax/call volumes for our Prior Authorization and Health Services staffs
- Maintained the highest service levels and the best average speed to answer rates, with an average abandonment rate of less than 1 percent
- Conducted care management outreach
- Contacted new transplant enrollees and conducted medical review for each enrollee
- Identified high-risk obstetrics patients and conducted outreach
- Loaded enrollee eligibility files at the pharmacy benefit manager within 24 hours to allow newly acquired enrollees uninterrupted access to needed medications
- Ensured no interruptions in therapy for medications that required prior authorization for the new enrollees through our transition of care policy
- Managed transition of care for and contacted enrollees with behavioral health needs
- Maintained strong service levels for claims processing

To this day, our health plan takes great pride in how we stepped up for our new enrollees and providers and collaborated with the Department to manage this rapid development and provide an opportunity for everyone involved. The outcomes of this transition proved that we will stop at nothing to serve and support our fellow Kentuckians.

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60.7.E Emergency Response and Disaster Recovery Plan

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60.7.E Emergency Response and Disaster Recovery Plan

Aetna is committed to maintaining the availability of provided services to its enrollees, providers, and stakeholders across every region in the Commonwealth through the deployment of comprehensive, effective, and proven plans addressing business continuity and emergency response/disaster recovery. Our local team, backed by the **strength, power, and vast resources of the national Aetna organization**, supports the Commonwealth in its goals of **protecting Kentucky's communities** and **improving the delivery of health and family services through quality enrollee service**.

These plans cover our critical business work group operations and mitigate the effects of brief or extended system outages, including third-party data loss and any outreach required for enrollees. Our security management plan covers our analytical services database, case management system, claims and eligibility management system, physical security facilities, and information security. We update our detailed data retention, business continuity, and disaster recovery plans quarterly, with in-depth tests conducted annually. All processes and plans are compliant with the requirements and suggestions in the **Draft Medicaid Managed Care Contract and Appendices, Appendix Q, Cabinet for Health and Family Services Contractor Security Requirements**.

Aetna's Exercise Requirement

Exercising or testing of the Business Continuity Plan (BCP) are important in maintaining business readiness and availability. Each business area is required to exercise their BCP annually to assure the team and operations are prepared and capable of responding to and managing a business disruption. The following examples satisfy the annual requirement:

- **Tabletop exercises developed by the enterprise Business Continuity department and made available in the Aetna Learning Center**. These are self-delivered scenario-based videos that provide the leadership team with discussion topics. There are multiple scenarios available to test knowledge.
- **Corporate Business Continuity Management (BCM) program-delivered exercises**. Comprehensive exercises that provide an opportunity for the team to coordinate with key stakeholders.
- **A real-world emergency or incident that requires invocation of the BCP**. These require a documented debrief that includes lessons learned.

Aetna's Business Resiliency program provides the organization with appropriate business continuity capabilities to deliver services during events that negatively affect operations. Our program aligns with industry standards and leading practices to provide a consistent methodology throughout the organization. Program elements include the following:

- **Site risk assessment:** Identifies the most probable threat scenarios, vulnerabilities, or risks ensuring appropriate controls are in place
- **Business impact analysis:** Validates business processes and determines recovery time objectives based upon qualifiable and quantifiable results
- **Business recovery strategies:** Includes planning for loss of staff, information technology services, critical suppliers, primary work location, or a multi-loss scenario
- **Business continuity plan:** Documents the recovery procedures for each recovery strategy; attested to quarterly
- **Required annual exercising:** Validates plan readiness and quality
- **Ongoing maintenance:** Provides state of resiliency readiness, reporting, and program oversight
- **Awareness campaigns and training program:** Promotes accountability, education, and program adoption

1. Essential Operational Functions and Responsible Staff Members

Led by Chief Executive Officer Jonathan Copley and Chief Operating Officer Paige Mankovich, Aetna's local management team leads business continuity and disaster recovery/emergency response activities at the health plan. Our seasoned staff brings deep knowledge of the needs of Kentuckians in all regions of the Commonwealth to the development of BCPs tailored specifically to each operational area. **Table E-1** lists essential operational functions and responsible staff members with ownership of BCPs.

Table E-1: Essential Operational Functions and Responsible Staff Members

Operational Function	Responsible Staff Member (BCP Owner)
Prior Authorization—Utilization Management	Scott Hunt, Director of Utilization Management
Prior Authorization—Clinical	Scott Hunt, Director of Utilization Management
Enrollee Services	Samantha Thurman, Enrollee Services Manager
Concurrent Review	Scott Hunt, Director of Utilization Management
Grievances and Appeals	Paula Fellows, Enrollee and Provider Grievances and Appeals Director
Health Plan Administration and Operations	Paige Mankovich, Chief Operating Officer

Business Recovery Team

At the local/operational function level, each Business Recovery team is comprised of key personnel necessary to implement recovery operations for the business. Based on the situation and impact to operations, this team determines recovery strategies, timeframe to implement, and team members needed to support the businesses recovery needs. At the national level, Aetna's Business Continuity team provides support and guidance to local staff and has the ability to escalate incident response activities to the Corporate Event Response team as needed. Roles and responsibilities of the Business Recovery team include the following:

- **Plan Owner/Alternate:**
  - Activate BCP to activate response and recovery actions
  - Direct the business unit's response and recovery activities
  - Gather and evaluate information related to the situation
  - Participate in site Incident Management team calls as directed
  - Activate business recovery team as needed
  - Ensure appropriate notification is made (Team, Leadership, Enrollees, Corporate Business Continuity team, and Technical Support)
  - Assign task owners
  - Implement plan recovery strategies
  - Ensure dissemination of information to Business Recovery team
  - Establish recovery priorities, objectives, and actions for team based on operational needs
  - Request, coordinate, and allocate resources with site Incident Management team and Corporate Business Continuity team
- **Business Recovery team lead:**
  - Support plan owner in implementation of recovery strategies for dedicated team
  - Provide operational status to plan owner including impacts or issues
  - Identify resource needs for team based on recovery strategies
  - Ensure team understands expected actions and communication plan
- **Business Recovery team:**
  - Follow direction from team lead/plan owner
  - Implement recovery action as directed by team leads

  - Ensure personal and family preparedness and safety
  - Share known or potential operational impacts and issues with team lead
  - Monitor site operational status as directed by team lead
- **Corporate Business Continuity team:**
  - Support and guide site leadership and Incident Management team during emergencies and situations
  - Update internal Aetna office outage and closing communication portals
  - Coordinate and communicate with corporate leadership
  - Determine Corporate Event Response team escalation, coordination, and support needed
- **Workforce management (call coordinators):**
  - Support business lines functional recovery needs as required
  - Implement predefined alternate operating models based on impact

Table E-2 defines the levels of risk and corresponding timelines for events that negatively affect operations.

Table E-2: Description of Risk Levels for Business Impact Events

Focus Area	Monitoring	Level 3 (Low) Impact/Risk	Level 2 (Moderate) Impact/Risk	Level 1 (Major) Impact/Risk
	Anytime	<24 hours	>24 hours—5 days	>1 Week
Operational	Threat (Weather events such as hurricanes, winter storms, tornadoes, etc.)	• Loss of local information technology infrastructure • Limited operational impact to Aetna business	Moderate operational impact	Multiple sites/regional impact
Operational vendors	Threat (Weather events such as hurricanes, winter storms, tornadoes, etc.)	Critical vendor outage with limited impact	Vendor outage with moderate impact to Aetna business	Critical operational vendor outage affecting multiple business lines
Employee safety/well-being	Situation threatens employees	No risk	Moderate risk	Significant risk
Operations	Situation threatens operations	Minimal impact	Impacts multiple business segments	Widespread impact to business segments
Site	Situation threatens assets	• Single-site event • Low impact on operations • Tier 3 site	• Multiple-site event • Single Tier 1 site with moderate impact to operations • Tier 2 site	• Multiple site event • Single Tier 1 site impact with extended outage and impact to operations
Systems/Telephony	Situation threatens information	• Localized impact • <24 hours or less outage duration	• Multi-business impact • >24-hour outage duration • Tier 1 systems	• Multiple Tier 1 application or system outages • Significant infrastructure impact • Loss of data center

Focus Area	Monitoring	Level 3 (Low) Impact/Risk	Level 2 (Moderate) Impact/Risk	Level 1 (Major) Impact/Risk
Vendor	Situation threatens critical vendors	• Minimal impact on Aetna operations and low duration outage • Tier 3 Vendor	• Moderate impact on Aetna operations with greater outage impact • Tier 2 vendor	• High impact to Aetna operations • Outage greater than 5 days • Tier 1 vendor

2. Plans to Ensure Critical Functions and Continuity of Services to Providers and Enrollees Will Be Met

In keeping with Aetna's commitment to provide the highest level of service to our providers and enrollees, Aetna has developed a comprehensive Business Continuity Management program to assist in meeting our goals and commitments during situations that disrupt business operations. Our business approach is based on flexibility, with detailed procedures that allow our staff to quickly adapt to any situation and continue to work without any interruptions or limitations. Our plans contain team information, contact numbers, and recovery strategies as well as resources that may be necessary to recover operations. These plans focus on the following components:

- Identification and documentation of all pertinent information relative to business operations:
  - Critical business processes/functions and associated maximum allowable downtime, recovery time/point objectives
  - Recovery priorities for business functions, systems, and support services; prioritization of business functions
  - Staff and skilled support personnel who are required to recover and sustain business functions
  - Vital data, files, manuals, forms, and documentation
  - Information technology: hardware and software
- Voice and data communication requirements: these include, but may not be limited to, phones, faxes, modems, leased lines, LANs, VANs, WANs, and mainframe applications
- Critical vendors
- Workspace requirements (e.g., number of workstations, furniture, and special equipment)

Disaster Recovery Protocols in Action

When Hurricane Harvey struck in August 2017 with devastating flooding in Texas, Aetna invoked our disaster recovery protocols to make it easier for our enrollees to receive Aetna services. Some key protocols included the following: phone tree notifications/mass emails; allowing staff to work at home; use of backup resources to augment work-at-home staff for critical functions (enrollee services, prior authorization); collaboration with the Facilities department to evaluate the extent of damage and determine the outage period; and collaboration with Management Information Systems staff to ensure access to critical systems.

At the local health plan level in Kentucky, we maintain detailed BCPs for all applicable operational segments to ensure we meet critical functions and continuity of services to providers and enrollees. Aetna has established the following program objectives for business continuity planning:

- Help ensure the safety and well-being of employees, visitors, and contractors
- Mitigate operational impact through effective recovery strategies
- Restore critical business processes within predefined recovery times
- Provide appropriate and timely communications to stakeholders (enrollees, providers, Commonwealth regulators, etc.)

- Resume normal business operations as efficiently as possible
- Safeguard the integrity and availability of critical information

Ensuring Enrollee Access to Essential Health Care Services

Aetna's business continuity and disaster recovery plans include standard processes and procedures, including policy liberalization processes, to ensure that our enrollees are able to receive needed care in times of natural disasters and emergencies.

> In Kentucky, Aetna has deployed our business continuity and disaster recovery processes and procedures on several occasions, most recently during the April 2019 floods.

During state or federally declared emergencies, we adhere to the Centers for Medicare & Medicaid Services requirements for our Medicaid enrollees. This includes the suspension of prior authorization requirements for medical care and allowing our enrollees to use out of network providers, in addition to making available Aetna's employee assistance program for anyone to use. Aetna Behavioral Health offers our behavioral health resource, Aetna Resources for Living, to everyone in affected areas. People affected by emergencies or natural disasters can receive telephone consultations, referrals for care, and information on how to support loved ones impacted by a disaster. Our Enrollee Services staff receives scripting to assist enrollees and providers in affected areas; we are mindful of the fact that, in many cases, our enrollees have been evacuated from their homes and are in a state of transition.

Because we are devoted to our enrollees, we know that it is also imperative that they receive their medications during a state of emergency or natural disaster. When the governor declares a state of emergency, the plan removes the Refill Too Soon edit from the pharmacy claims adjudication system so enrollees can refill medications that might have been lost or left behind. Aetna also has the ability to remove the drug prior authorization requirements and pharmacy network restrictions. Our pharmacy benefit manager, CaremarkPCS Health, can lift the 'Refill Too Soon' edit within 24 hours of the emergency declaration. We also publish information for enrollees, providers, and pharmacies on our website before, during, and after the disaster on how to receive services, contact information for emergencies, payment processes, and any information required by the Commonwealth.

Focusing on Enrollee Needs During a Disaster

In 2017, Hurricane Irma struck our Florida communities, affecting the lives of many of our enrollees. Aetna was there to support them before, during, and after the storm, delivering emergency shelf-stable meals, water, and medical supplies, locating housing, and providing transportation as needed for as long as necessary. Aetna's senior leadership—as well as senior leadership of Aetna Inc., including President Karen Lynch, who met with leadership daily throughout the hurricane—focused on helping the team on the ground secure and mobilize resources and supplies. Aetna also waived authorization requirements for providers during Hurricane Irma and implemented a transition of care period that allowed our enrollees to see providers outside of the network if their provider was unable to provide care. Pharmacy restrictions like Refill Too Soon were waived, allowing enrollees who were being evacuated to get medications prior to leaving the area. In addition, we supported our most impacted staff by securing housing and providing stipends. Post-hurricane, we donated water and food for distribution by local food banks and police departments.

3. Staff Training

We require all employees to complete our **Introduction to Business Continuity Exercise** and **Crisis Management and Business Continuity Training** on an annual basis. Additionally, we provide department-specific training on processes and procedures around departmental BCPs including staff

responsibilities and communication methods in a disaster or emergency. All employees are required to complete annual training on **recognizing and preventing workplace violence** as well.

A key component of Aetna's security program is staff education and awareness of the critical role each of us plays in protecting Aetna's assets. Front-line personnel stay well informed about current threats via communication channels and receive training on how to validate inquiries to personal data. To ensure all staff and contingent workers are aware and understand the importance of their role in protecting Aetna's information and resources, all employees are required to complete **security awareness and education training.**

4. Contingency Plans for Covering Essential Operational Functions

Aetna's BCM program includes detailed contingency plans for covering essential operational functions in the event key staff members are incapacitated or the primary workplace is unavailable. The BCM program focuses continuity strategy and planning on the following scenarios:

- **Scenario One—Systems OK, No Building:** This scenario assumes partial or total loss of the building in which one or more critical operations are located. The planning strategies focus on short-term and long-term outages where critical services are performed.
- **Scenario Two—Building OK, No Systems:** This scenario assumes loss of critical systems/applications affecting business dependent operations or the entire enterprise.
- **Scenario Three—Third-party Business Disruption:** This scenario assumes loss of a key third-party service.
- **Scenario Four—Severe Widespread Staffing Shortage:** This scenario assumes staffing shortages because of a regional or global pandemic, bioterrorism, or event that limits staff availability for an extended period. As part of Aetna's pandemic planning, the assumption focuses on loss of employees for a period of six to eight weeks at a time, with two to three waves over an 18-month period.
- **Scenario Five—Loss of Telework Capability:** This situation assumes a loss of telework members' capability due to an infrastructure disaster or a widespread natural disaster. It includes loss of broadband internet, power, connectivity, telephony, and individual worksites.

At the local health plan level, our BCPs include loss of workforce recovery strategies and tasks. During a disaster or emergency, we implement workforce recovery strategies and contingency plans as needed for critical operations. This includes determining resource needs to support staffing strategies and developing restoration plans and staffing models based on each situation to minimize impacts to employees and operations while supporting the work-down of backlogs. For example, in a loss of office/workplace, current work-from-home staff assumes departmental workloads while we implement rapid deployment to telework procedures for the office staff. In a loss of teleworker capability, we implement rapid deployment to office processes for work-at-home staff.

Aetna's Enrollee Service Organization (ESO) maintains engagement with our Kentucky call center. In the event of an incident affecting the call volume coming into the local call center, we can reallocate calls to other ESO locations where staff is cross-trained to support the local plan. This type of backup helps ensure plan-specific enrollee and provider access to Aetna at all times. Our BCP applies to physical assets, business records, and communication via any medium (e.g., paper, electronic, audio) for our employees or others conducting Aetna business.

5. Approach to Maintaining Data Security

Resiliency forms the core of Aetna's approach to data security at all times and during an event. We design our data centers and key applications to withstand any natural disaster or state of emergency as to prevent any type of data loss that could obstruct standard operating procedures. Where use of alternate temporary locations and/or other recovery processes are required to ensure business continuity, data security controls

are consistent with those in place at the main site. Our Disaster Backup and Recovery Plan addresses restoration of service timing expectations; failover site and technical staffing coverage; and data replication and recovery processes.

In addition, our Global Security Plan addresses our mission to safeguard confidential information and protect employees in the workplace. We continuously explore innovative solutions in an effort to keep up with new security challenges.

Restoration of Service Timing Expectations

In the event of a core Aetna data center disaster, the recovery time objective (RTO) to resume the portfolios of highly available applications (e.g., core data processing and pharmacy services) is immediate and no later than 24 hours. These applications utilize mirroring and/or load balancing and Active/Active technologies between the data centers to facilitate the achievement of more aggressive RTOs. Our voice and data network are fully redundant, using synchronous optical networking ring and Multiprotocol Label Switching. Technologies are recovered within one hour of a data center outage.

Failover Site Approach and Technical Staffing Coverage

In the event of an office outage, we transfer processing to alternative Aetna offices within our network with little or no disruption to service levels. When alternate temporary locations are used for business continuity planning purposes, security controls are employed consistent with the main site and approved by the security organization. We plan for area-wide disruptions by separating the critical business functions into primary and alternate sites situated in different zones. This mitigates the risk of losing both sites in an area-wide disruption. For critical business processes and information processing services that require an RTO within 24 hours and a restart of all remaining operations within three calendar days following a natural or manmade disaster, a geographically separate hot alternate site (business-ready alternate site) is used.

We deem critical business processes as hot when they are associated with time-sensitive back office operations, or if they are business services (e.g., call center, pharmacy access, and care management functions) that are required to be continuously accessible.

Data Replication and Recovery Processes

We design Aetna's disaster data replication and recovery strategy to provide and maintain an internal disaster recovery capability. The strategy leverages the internal computer processing capacity of our robust, state-of-the-art, and hardened computer data centers in multiple states. The facilities are equipped with fire suppression systems, dual incoming power feeds, Uninterruptible Power Supply (UPS), and backup diesel generators, which provide 24/7/365 operations. Physical access is strictly controlled and monitored, and access to vital areas is segregated by floor and business function where appropriate. The data centers house computer-processing capabilities of major platforms including mainframe (Z/OS), mid-range, UNIX, Linux, Citrix, and Windows. The redundant data centers are load balanced and supplemented by equipment quick-ship in the event of a disaster. We maintain contracts with national vendors to obtain replacement equipment and supplemental capacity as needed to ensure the achievement of recovery time objectives.

We use multiple storage array-based replication technologies for core applications built in the disaster recovery environment. Our backup data is protected and retrievable wherever and whenever we need it. We back up critical data daily, which are stored in our secure, generator-equipped offsite storage vault in Connecticut to protect it from corruption, contamination, or exposure. Our strategy to maintain the highest levels of security includes inside and outside perimeter security cameras, security badge and identification requirements, limited and authorized staff-only access to the storage facility and its data, password-protection of backup tapes by authorized staff, and continuous inspection/audit.

Safeguarding Confidential Information from Cyber Threats

Cybersecurity threats continue to increase, and the diversity of threat actor and tactics in health care has evolved significantly in recent years. With new technologies introduced constantly, adaptability and resiliency to respond are critical for the changing landscape. As such, data security has become a cornerstone of Aetna's operating model, influencing how Aetna chooses to do business.

We take a risk-based approach to information security management. The company determines the appropriate level of protection by assessing the relative importance and classification of data and manages risk by reviewing threats and vulnerabilities on a daily and quarterly basis. Risk management activities help keep Aetna abreast of industry and environmental events and promote adaptability to a rapidly changing environment.

Aetna's security program uses NIST 800-53 as its control framework while maintaining solutions to proactively address cyber threats and protect customer data. We use the NIST Critical Security Framework to align business priorities and security requirements. The control environment lays the foundation for protection, and our innovative solutions result in a level of protection typically found within the financial industry and other highly regulated environments.

Aetna leverages a framework known as the Building Security in Maturity Model to measure organizational practices pertaining to software security against those implemented by some of the most mature software security organizations in the world, including well-known financial institutions and software vendors. We have implemented a series of technical, procedural, and educational controls designed to help eliminate security defects at the time of software deployment, as well as continually assess production environments to identify and remediate new application vulnerabilities.

Over the past several years, we have realized a substantial decline in the rates of identified security defects and vulnerabilities as both the effectiveness of technical controls has increased and the benefits of our application security awareness and training initiatives have manifested themselves.

6. Communication Methods with Staff, Subcontractors, Other Key Suppliers, and the Department when Normal Systems are Unavailable

When normal systems are unavailable, we implement a call tree from the leadership team to front line staff, as detailed in our departmental BCPs. Additionally, we have established single points of contact between the health plan and subcontractors/key suppliers for communication updates when normal systems are unavailable. The larger Aetna organization has implemented Aetna Alerts via text and email to ascertain employee safety and whereabouts in a disaster or emergency, and toll-free telephone number employees can monitor for status updates.

We will continue to place a high emphasis on providing timely, accurate, and thorough communication during an emergency or crisis that could affect our operations or the health and safety of enrollees and their caregivers, providers, and our staff. Our business continuity and disaster recovery plans include detailed communication protocols to facilitate message consistency and optimal communication to all stakeholders, as well as provide assurance that enrollees and providers are properly managed.

Depending on the situation, our tactics may include activities such as the following:

- **Communication and coordination with the Department** (which will always continue to occur regardless of the issue)
- **Communication and assistance to enrollees:**
  - Provide materials to educate enrollees on how to access their medical records if their provider office is closed or destroyed, how and where to obtain services from providers, telemedicine options, and how to contact the 24-hour nurse line (Health Information line) in an emergency

  - Call center scripts for staff to activate before, during, and after an emergency
  - Information on local shelter listings, dealing with special health needs, evacuation information, and information for caregivers communicated via a variety of modes such as texting, email, interactive voice response (IVR), updates on social media platforms, telephone outreach, public announcements, and other methods as needed
- **Communication to providers:** Provide information on claims processing/payment status, obtaining authorizations, and other day-to-day operational status that may affect their ability to serve enrollees via IVR, fax, or email blasts, postings to the provider website, and other communication modes; communication of waivers of authorization requirements if under state of emergency
- **Communication and assistance to staff and their emergency contacts:** We provide communication to staff such as whether to shelter in place; report to backup sites or work from home; location of shelters if evacuation is required; and how to contact the command center or security 24/7/365. As appropriate, we also facilitate essential supplies and relocation resources.

7. Testing Plan

Aetna's detailed business continuity and disaster recovery plans for each of our health plans and business locations are updated on a quarterly basis and tested on an annual basis. The tests verify our ability to resume business operations within 72 hours of the activation of our disaster recovery plan. We regularly and independently test a variety of applications and infrastructure components on an annual basis to promote ongoing disaster recovery readiness, and routinely test recovery elements of third-party relationships, including technology components, critical processes, and access points.

Aetna's Business Continuity Management program actively delivers exercises, testing, and maintenance process requirements. Each plan conducts an annual tabletop exercise and validates plan content and team contacts quarterly. The plan reviews confirm all major plan components remain current.

Aetna tests BCPs during simulation exercises that are conducted on an ongoing basis with at least three delivered annually to field offices. We also test the BCPs during actual events like severe wildfires, floods, hurricanes, and other natural or man-caused disaster events. Following an event, we conduct a thorough review of the BCP and recovery capabilities, identifying what worked well and opportunities for improvement.

Aetna's dedication to being a collaborative and innovative partner to Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to **create a healthier Kentucky**. We pride ourselves on being a **reliable partner** to the Department at all times, including during times of natural disasters, emergencies, and cybersecurity threats. Our Business Continuity Plans ensure impacted business areas can recover their most critical operations through timely resource and infrastructure allocations within their predefined recovery times.

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60.7.F Turnover Plan

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60.7.F Turnover Plan

Operating in all 50 states with over 160 years of experience, the Aetna organization is among the nation's leading diversified health care benefits companies, serving an estimated 38 million individuals. Aetna offers a broad range of traditional, voluntary, and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life and disability plans, medical management capabilities, Medicaid health care management services, workers' compensation administrative services, and health information technology products and services. As is the case with many large organizations, there are rare instances when a contract might be terminated or not renewed for any number of reasons over time. No matter the reason, **we keep our focus on the enrollee** and work diligently to provide a seamless transition when contracts change.

1. Support for Turnover Activities

Aetna understands and will comply with the requirements outlined in the **Draft Medicaid Managed Care Contract and Appendices Section 39.12.** Our dedication to be a collaborative and innovative partner to Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier Kentucky. To assist the Department in achieving this mission, we are committed to working closely with the Commonwealth and new contractors to facilitate a smooth transition that avoids disruptions to enrollees' care in the event of contract termination or expiration.

Transition Team

In the event of contract termination or expiration, representatives from all departments participate in the transition processes. Aetna conducts team meetings weekly or more often, if needed, at multiple management levels to plan, implement, and provide oversight. Overall responsibility for the transition plan and the transmission of information and enrollment falls to the chief executive officer and chief medical officer of the Aetna health plan with the assistance of the Transition team. The Transition team is comprised of seasoned professionals who have worked in Medicaid for decades and who understand the issues and expectations of the Department and other stakeholders during the transition process.

The Transition team is responsible for management, oversight, and monitoring of transition processes and activities. The team is composed of subject matter experts from a variety of Aetna departments such as Information Technology, Medical Management, Quality Management, Grievance and Appeals, Enrollee Services, Provider Services, Human Resources, Encounters, and Marketing. **Table F-1** provides an overview of the responsibilities of various teams and sub-groups that participate in the Transition team. Through Aetna's multifunctional work plan and meeting structure, Transition team members can identify risks quickly for rapid resolution and escalation to appropriate leadership and to the Commonwealth as needed.

Table F-1: Transition Teams and their Responsibilities

Team Name	Team Members	Responsibilities
Steering team	Senior segment leaders, regional vice presidents, and health plan executives	• Provide key milestone status updates • Escalate risks/issues
Leadership team	Health plan leadership; legal, compliance, and project team members	• Discuss overall status and potential issues to be escalated • Communicate updates from regulators; communicate business decisions; discuss risks and issues

Team Name	Team Members	Responsibilities
Lead team	Representatives from all functional areas	• Provide updates and review overall project status • Report progress by each functional area • Identify downstream impacts • Identify, resolve, or escalate risks
Functional Area Sub-groups	Functional area team members	• Discuss progress on work plan tasks • Communicate updates and issues to and from leaders and employees • Identify, resolve, or escalate potential risks
Kentucky Transition Team	Health plan leadership team	• Meet with the Department on project plan, transition activities, and timelines • Provide Department updates to transition risks, barriers, and mitigation plan

Throughout the transition process, Aetna's focus is on preventing disruption to the enrollee. All transition tasks performed by every department are planned and executed with the enrollee's wellbeing in mind. The Transition team works closely with the health plan care managers to help ensure continuity of care and quality for enrollees during the transition period.

Transition Plan

We will submit a Transition Plan for the Department's approval within 10 days of receiving a Notice of Termination. As shown in **Table F-2**, the Transition Plan will identify transition activities to be accomplished by each functional area. During the transition period, Aetna will work cooperatively with the Department and any managed care organization (MCO) with whom the Department may contract for similar services and assume the costs relating to the transfer of materials and responsibilities, as required.

Table F-2: Sample Transition Plan Activities by Functional Area

Functional Area	Key Transition Activities
Care management (CM)	• Manage CM cases until termination date • Identify and transfer agreed-upon CM information
Claims and Finance	• Manage claim adjudication and payment through agreed-upon runout period • Manage payments to any vendors through agreed-upon runout period • Continue to provide needed claims data and reporting during agreed-upon runout period • Continue to provide needed provider data and reporting during agreed-upon runout period • Research and resolve claims issues • Complete or close pending claims projects • Reconcile corrective action plans (CAPs), if applicable
Compliance/Special Investigations Unit (SIU)	• Complete contract deliverables by termination date and identify any deliverable to continue during agreed upon runout period • Continue SIU functions through termination date and as applicable through agreed upon runout period
Encounters	• Continue to submit encounter data during agreed upon runout period • Process encounters through agreed upon runout period • Resolve encounter file errors • Coordinate vendor encounter file submissions

Functional Area	Key Transition Activities
Enrollee Services	• Send Department-approved enrollee communication letter • Identify priority enrollees that are under treatment or at risk to ensure continuity of care • Create and use Commonwealth-approved call script for enrollees • Take inbound calls from enrollees until termination date. Discuss options of automated response on enrollee call line or short extension of call line post-termination.
Enrollment	• Establish agreed-upon shutoff date for enrollee enrollment in plan • Process enrollment file and exceptions through termination date • Apply termination date for all enrollees in claim system • Determine last date for processing identification cards and welcome packets
Grievances and Appeals	• Process grievances and appeals through agreed-upon runout period
Human Resources	• Ensure there is adequate staffing throughout the transition period, identifying and using temporary staffing resources if needed
Information Technology, Informatics, and Reporting	• Support required report processing and generation through termination date and agreed upon run-out period • Confirm Secure File Transfer Protocol (SFTP) process will continue • Support required data submissions to Commonwealth through termination date and agreed upon run-out period • Manage return of employee equipment
Marketing	• Cancel any open orders for marketing materials
Network Management	• Notify delegated entities of contract term
Performance Bond	• Meet contractual requirements for return or forfeiture of guaranty
Pharmacy	• Process prescription prior authorizations though termination date • Process prescription claims through agreed upon runout period
Provider Experience	• Send Department-approved Provider Communication Letter • Create and use Commonwealth-approved call script for providers • Conduct a Transition Education webinar for providers • Take inbound calls from enrollees, providers, and utilization management (UM) until termination date. Maintain number for providers during agreed-upon claims runout period.
Quality Management	• Identify and support needed Healthcare Effectiveness and Data Information Set activities post termination
Records Retention	• Establish and implement procedures and accountabilities for communicating and meeting regulatory requirements for preserving and making available books, papers, records, and other evidence involving transactions related to the terminating contract
Reporting	• Determine required reports during agreed-upon runout period
Subrogation/Third-Party Liability (TPL)/Recovery	• Maintain services and support throughout agreed-upon runout period to optimize savings and recoveries • Establish and implement procedures and accountabilities for submitting TPL data through agreed-upon runout period
Utilization Management (UM)	• Process prior authorizations through termination date • Provide census of individuals who are inpatient as of termination date • Manage inpatient admits until discharge • Transition authorizations • Identify and transfer agreed-upon UM information

Notice to Enrollees and Providers

In the event the contract is terminated or expires without the parties executing a new contract, Aetna will work with the Department to develop a notification letter to be sent to enrollees and providers within the timeframe established by the Department. During times of transition, reducing confusion and uncertainty for enrollees and providers is of the utmost importance. We appreciate that the transition to a new MCO can cause concerns for enrollees who may fear they will lose benefits. Aetna will collaborate with the Department to help enrollees receive the information they need to make another choice, while reassuring them that they will not lose benefits. For enrollees who are undergoing treatment for an acute condition, the transition notice will describe the process for enrollees to obtain a complete transition-of-care plan to ensure the continuation of care prior to termination or expiration of the contract.

Continuity and Coordination of Care during Transition Period

Aetna will work with the Department and new contractors to support the transition fully and will appoint a liaison for post-transition concerns. For example, the Kentucky Transition team will review inpatient admissions at time of health plan closure to ensure enrollees are managed during their care and transitioned to the MCO of their choice; monitor claims runout to ensure providers are paid accurately and timely; and ensure post-transition reporting is delivered upon contractual timeline.

Effective care transitions are critical to maintaining the enrollee's continuity of care, quality of care, quality of outcomes, and most importantly, quality of life. Because enrollees can be at significant risk when transitioning between delivery systems, effective care transitions are vital to preventing adverse enrollee events. Emphasizing continuity and coordination of care, our goal is to maintain the stability and quality of enrollees' care and services during the transition period. Our processes help to ensure all enrollee populations receive the highest level of service and oversight to address their unique clinical and service coordination needs seamlessly.

The transition from one MCO to another is a critical time for enrollees. Enrollees frequently require assistance accessing the health care system when there is a change. Aetna will manage all aspects of transition from our plan to another using our dedicated Kentucky staff and Medicaid subject matter experts, which we call the Transition team, until closure. This includes assisting enrollees in service coordination to transition to their new providers and their new care managers, thus ensuring all aspects of each plan of service transfers to the new plan.

Aetna will provide sufficient staff in all operational areas across all enrollee populations to ensure a smooth transition. Aetna Better Health of Kentucky's Human Resources department will work directly with the chief operating officer to help ensure adequate staff is in place to manage transition and runout activities, especially in functional areas having an impact on enrollees such as enrollment, claims processing, grievances and appeals, enrollee services, and provider experience. To help maintain adequate staffing levels throughout the transition, the Human Resources department will work with staff to find internal transfer opportunities or offer a severance package.

Aetna will continue providing covered services to all enrollees until midnight on the last day of the calendar month for which a capitation payment has been made by the Department. We will maintain services throughout the runout period. As required, Aetna will continue providing all covered services to all infants of female enrollees who have not been discharged from the hospital following birth until each infant is discharged. Additionally, Aetna will continue providing inpatient hospital services to any enrollees who are hospitalized on the termination date until each enrollee is discharged. To support continuity of care for enrollees, Aetna will arrange for the transfer of enrollees and their medical records to other appropriate providers.

Aetna understands we are responsible for resolving enrollee grievances and appeals with respect to claims with dates of service prior to the date of contract termination or expiration, including those grievances and appeals filed on or after the day of termination or expiration for those dates of service. Aetna will be financially responsible for enrollee appeals of adverse decisions rendered by Aetna concerning treatment of services requested prior to termination or expiration of the contract which are subsequently upheld on behalf of the enrollee after an appeal proceeding or after a State Fair Hearing.

2. Identification and Submission of Necessary Documentation

Aetna will work collaboratively with the Department to identify and submit necessary documentation in the Department's preferred format. Aetna's Information Technology, Informatics, Reporting, and Compliance departments are responsible for identifying and submitting of all documentation, records, files, methodologies, and data necessary for the Department to continue the program in the event of termination, as depicted in **Figure F-1**. This functional area sub-group will identify required reports, support required report processing and generation, and support data submissions through the termination date and the agreed-upon runout period. Aetna will submit the proposed list of documentation to the Department for review and approval. Aetna reviews file layout and data mapping details with the MCO/Department as part of transition. As part of their transition tasks, the Information Technology, Informatics, Reporting, and Compliance team will confirm that the file transfer process will continue. Aetna will continue to comply with regulatory requirements for preserving and making available required records (e.g., enrollee, financial, etc.). As required, Aetna's Transition team will do the following:

- Submit encounter data for all claims incurred for dates of service prior to contract termination
- Submit all reports necessary to facilitate the collection of pharmacy rebates and assist in the resolution of all drug rebate disputes with the manufacturer for all claims incurred prior to the contract termination date
- Submit all performance data with a due date following the termination or expiration of the contract, but covering a reporting period prior to termination or expiration of the contract
- Promptly supply to the Department such information as requested respecting any unpaid claims submitted by out-of-network providers and arrange for the payment of such claims within the required time periods
- Take such action as may be necessary, or as the Department may direct, for the protection of property related to the contract, which is in Aetna's possession and in which the Department has or may acquire an interest

Aetna will provide the Department with all information requested in the format and within the timeframe set forth by the Department, which shall be no later than 30 days of the request. Additionally, Aetna will provide for the maintenance of all records for audit and inspection by the Department, the Centers for Medicare and Medicaid Services, and other authorized government officials, in accordance with terms and conditions specified in this contract including the transfer of all such data and records, or copies thereof, to the Department or its agents as may be requested by the Department; and the preparation and delivery of any reports, forms or other documents to the Department as may be required pursuant to this contract or any applicable policies and procedures of the Department.

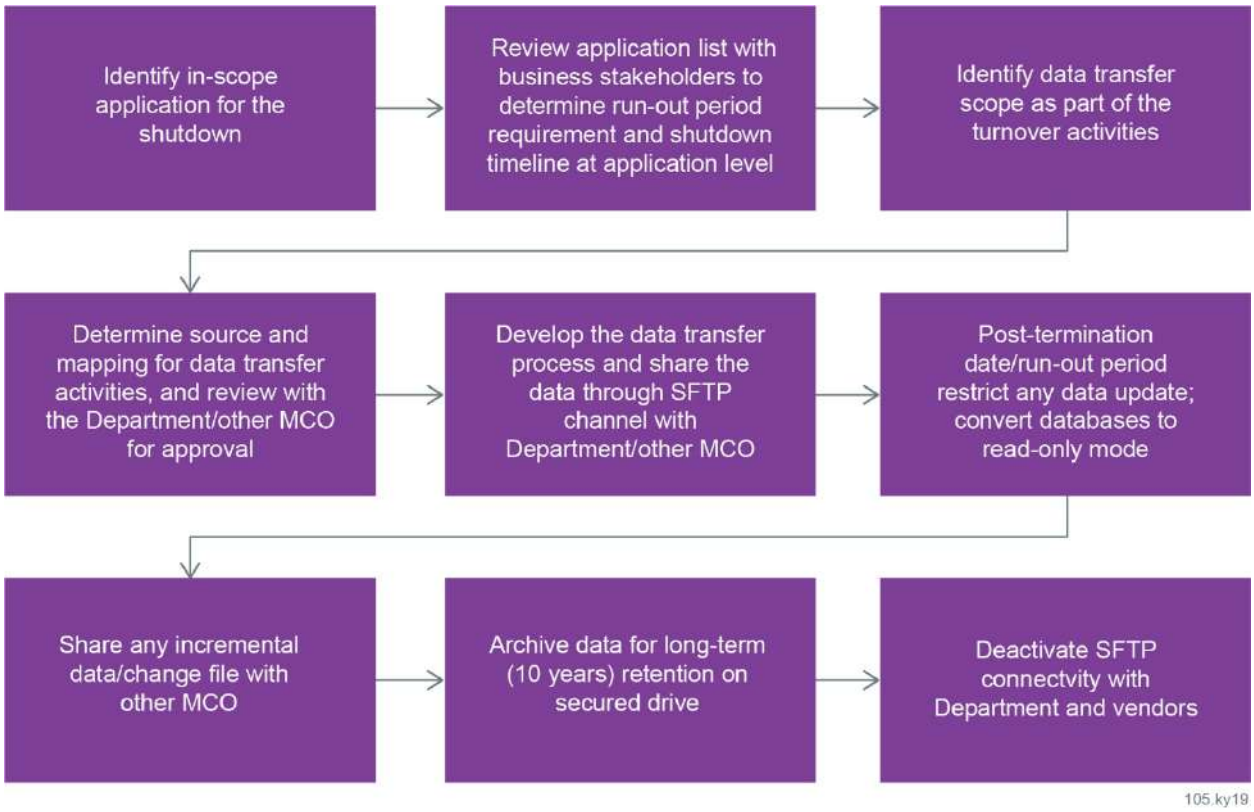

Figure F-1: Transition Plan Information Technology Workflow

Aetna will collaborate with the Department and other MCOs to support information technology applications through the runout process.

3. Resources and Training

Aetna will provide the necessary resources and training the Department requires to ensure a smooth transition of enrollee data. Training sessions will be scheduled post data transfer with the Department and incoming MCOs to review and ensure full understanding of all relevant data. We will also collaborate with incoming MCOs that do not have a current contract with the Finance and Administration Cabinet to educate them on the Kentucky market; enrollees (specifically the administration of the lock-in program); historical claims data; personnel talent share; and provider landscape, given our institutional knowledge as an original statewide MCO since 2011. Further, we will participate in enrollee town hall meetings with incoming MCOs to ensure enrollees are educated regarding the changes in the Medicaid program.

When Kentucky Spirit (Centene) abruptly ceased operations in Kentucky, Aetna absorbed approximately 68,000 enrollees within a short time. This experience gave us an appreciation of the importance of receiving the appropriate resource materials as the receiving health plan. Our enrollee transition policy provides for the transfer of information from one health plan to another, such as providing the new MCO with information about enrollees' prior authorized covered services, including physical health, behavioral health, home- and community-based services, medications, and specialty referrals. With the Department's guidance and approval, Aetna will provide necessary information to the Department and any MCO during the transition period to ensure a smooth transition of responsibility, including but not limited to, prior-authorized covered services, historical utilization data, enrollee assessments, and person-centered service plans for care and service coordination. Aetna is committed to working collaboratively with the Department and other MCOs to help ensure a smooth transition.

4. Methods for Tracking and Reporting Turnover Results

Communication and reporting of status are key to effective, successful turnover plans. Within our extensive and rigorous transition governance framework, we use status reporting and meetings to monitor turnover results. Our Transition team, which consists of seasoned experts in their functional areas who have been through the process before, will complete a weekly status report that is reviewed with our Kentucky health plan and leadership from Aetna's Medicaid organization. This status report is a tool for leadership recommendations, approvals, and decisions. Any identified risk that requires immediate intervention is communicated and acknowledged within one business day. The team works collaboratively across departments and functional areas to identify risks, discuss mitigation strategy, and resolve issues as quickly as possible.

> We will continue to process claims throughout the runout period to ensure there is no impact to our enrollees and that providers are correctly reimbursed.

Aetna employs a strong project management methodology, based upon the Project Management Institute's framework, for tracking and reporting turnover results, including documentation of completion of tasks at each step of the turnover. We have adapted and refined this methodology based upon 30 years of experience in program implementations and transitions, continually honing our approach to address the complexities and changing environment of managed health care programs. The Department-approved Transition Plan will provide the framework for developing, tracking, and completing transition tasks, as depicted in **Figure F-2.** The Transition Lead team is responsible for tracking completion of activities. We will meet regularly with the Department and incoming MCOs to review the turnover plan activities to ensure an understanding of the transition, discuss and solve for any issues, and remove barriers to continuity of care for enrollees.

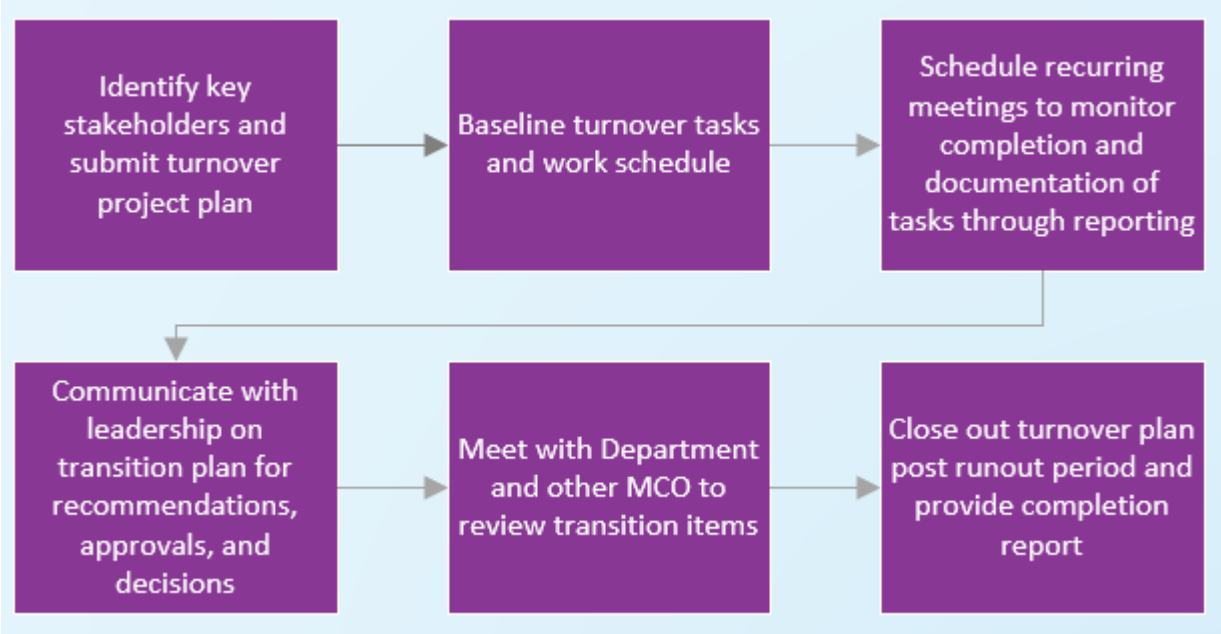

Figure F-2: Transition Plan Framework

Aetna will collaborate with the Department and other MCOs to ensure a smooth transition.

5. Secure Data Transfer

Aetna will maintain the confidentiality, integrity, and availability (CIA) standard throughout the turnover. Aetna follows a secure and proven process for establishing and maintaining all our electronic data

interchange (EDI) interfaces. We utilize a TLS 1.2-compliance SFTP server to handle file exchanges. Also, if required, Aetna can support with additional encryption/decryption algorithm and exchange public key token with the trading partner. For data archival and long-term retention, Aetna stores data in secured environment for 10 years with restricted access to maintain data integrity and to ensure data availability.

We collaborate with our partners to exchange key information required to establish the secure connection for exchanging files on both sides. This information includes file paths and naming conventions, secure shell or secure socket layer configurations, internet protocol and domain name system information, acknowledgement responses, and file ownership information. We use this information to create the connection for transferring files. Aetna configures file monitoring software to alert automatically in the event of a failure at any point in the process. If a failure occurs, production support is immediately engaged to research and resolve the issue and ensure all data is transferred successfully and securely to the receiving party.

aetna™

60.7.G Kentucky SKY

Kentucky | Transforming Health Care | **Aetna**

60.7.G.1 Executive Summary

Kentucky | Transforming Health Care | **Aetna**

60.7.G.1 Executive Summary

Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health® of Kentucky Inc. (Aetna)[1] is looking forward to partnering with the Commonwealth and stakeholders to assist with the transformation of the system of care and services provided to the Kentucky SKY population. The Aetna Medicaid organization has proudly served child welfare enrollees since 1995, and individual staff at all levels of the organization have the deep expertise and commitment necessary to serve the vulnerable populations included in Kentucky SKY through the full scope of work. Currently, we serve approximately 5,300 child welfare enrollees in Kentucky.

We have a child welfare model that achieves the Commonwealth's goals, notably our full integration of a more robust and holistic System of Care (SOC) framework that aligns with Charting the LifeCourse™, evidence-based assessments, planning and services, and adoption of technology, including our FamilyConnect on-demand medical record data home. These programs and systems are guided by a team of child welfare experts that understand the resources needed and system-framed strategies that work collaboratively to support stability, build on enrollees' capabilities, and help them achieve their life goals. Additionally, we will draw from the Aetna Medicaid organization's experience and resources implementing a child welfare program in West Virginia with a March 1, 2020 go-live date. We are steadfast in our mission to support Kentucky as a national leader engaging in a system-wide transformation using a preventive-focused approach to support Kentucky's kids.

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Figure G.1-1: Our Support for Volunteers of America (VOA) Mid-States

Aetna CEO Jonathan Copley presents a check for Volunteers of America Mid-States to VOA CEO Jennifer Hancock at a ceremony in Frankfort in May 2019. VOA's Freedom House provides state-of-the-art and nationally recognized addiction recovery treatment and care to pregnant and parenting mothers working to overcome substance use disorder.

Successful implementation of Kentucky SKY relies on the commitment of the entire Aetna Better Health of Kentucky staff including our leadership. **Chief Executive Officer (CEO) Jonathan Copley** (please refer to **Figure G.1-1**) is a proud fifth-generation Kentuckian from Taylor County with a long history of volunteering his time to support efforts that protect vulnerable children and youth. He has served as a board member of Prevent Child Abuse Kentucky in 2013, an organization instrumental in the establishment of the Kentucky Child Fatality and Near Fatality review panel. This panel reviews cases when children die or are seriously injured as a result of abuse or neglect and makes recommendations for improvements to prevent child deaths in the future. This legislation was one of the early catalysts in the Commonwealth to drive change in the child welfare system to keep kids safe from harm. **We are here. We are local.**

As one of the original incumbent Medicaid managed care organizations in the Commonwealth since the program inception in 2011, it has been the Aetna Medicaid organization's heartfelt

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its parents, Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Kentucky to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of Kentucky's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Kentucky. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

privilege to serve Kentucky's most vulnerable citizens, improving health and helping them improve their well-being for nearly a decade. We are prepared to combine our longstanding expertise with our newly proposed SOC approach to support Kentucky SKY to complement ongoing Commonwealth priorities and efforts.

Aetna's SOC approach provides evidence-based, trauma-informed treatment and recovery services based on the **Universal Precautions** model that serves each enrollee as if they had been traumatized. Our SOC model includes a full spectrum of effective, community-based physical, behavioral, vision, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support.

> "We have always valued our relationship with Aetna and really look forward to continuing to innovate together. Aetna has been a willing partner in KVC Health System's efforts to provide safety and well-being for children and families in our community, supporting our development of a specialized Therapeutic Support Foster Care Program to avoid youth entering higher levels of care to successfully stabilize and reunify youth into a home seeing as timely as possible.
>
> KVC has a rich 20-year history of service provision in Kentucky and our work with the children and families of Kentucky is enhanced by collaborative partnerships like we have with Aetna. We value dignity, respect, honesty, and integrity and deliver our innovative and effective services in a culturally sensitive manner, respectful of a child and family's strengths and values. Aetna has been a mutual partner in achieving these goals."
>
> **—Gina Klyachkin**
> **CEO and President, KVC Kentucky**

Additionally, Aetna is committed to working with Commonwealth stakeholders to build on the following recent legislative actions that support Kentucky SKY enrollees:

- HB 2 from 2019 improves state supports and data reporting for kinship caregivers
- HB 158 from 2019 establishes a bill of rights for children in foster care and begins to align state child welfare laws with the federal Family First Act
- HB 1 from 2018 keeps Kentucky kids safe by improving how the Commonwealth responds to child abuse and ensures that every kid has a family
- HB 527 from 2018 supports the educational stability of children who have experienced abuse or neglect
- SB 133 from 2018 will help improve the outcomes of pregnant inmates and their babies by allowing access to substance use treatment
- SB 137 from 2018 allows judges to consider testimony from a trustworthy adult when a child has disclosed abuse to them

We share in the commitment to implement the legislative initiatives in support of the Commonwealth's goals. Aetna has built the knowledge and capacity to be an effective partner, and we engage our internal expertise on the child welfare system to enhance our approach and outcomes.

a. Summary of Technical Approach, Staffing and Organizational Structure, and Implementation Plan

Aetna's technical approach, staffing and organizational structure, and implementation plan for Kentucky SKY draw from our established presence as a Medicaid managed care organization (MCO) in the Commonwealth combined with an experienced and innovative leadership team with a transformative vision for the child welfare system.

Statement of Understanding

The health care and social needs of the Kentucky SKY population are vast and compounded by their circumstances. Kentucky's kids are often at the intersection of multiple public systems including behavioral health, child welfare, education, juvenile justice, and primary care. Behavioral health is the

single-most unmet need among the populations including in SKY.[2] These individuals likely have a history of trauma, frequent life changes, difficulties in their biological family, and issues with psychotropic medications. Aetna understands that all these factors impact the overall well-being of the enrollee. The intense behavioral health needs, combined with physical and oral health issues that have resulted often from a lack of consistent health care, results in a population that requires high-touch approaches with easy access to comprehensive services that meet their needs.

In addition to understanding the unique individual needs of the Kentucky SKY population, we understand that Department for Community Based Services (DCBS) is working diligently to be a leader in implementing Family First in Kentucky. The core models and practices in our Kentucky SKY approach are designed to prevent unnecessary placements of children, maximize the use of kinship care where children cannot safely live with parents, and buffer the effects of extended out-of-home care stays with the addition of a family and community team—engaging and supporting children to have membership in a family and community while services and permanency planning are occurring. By keeping families safely together, children in the Kentucky SKY population will experience less trauma, which leads to better outcomes.

Children in State custody are among the most vulnerable individuals in our society. They face unique challenges that require our unwavering commitment, collaboration, and compassion. Along with youth in foster care and their families, our integrated Care Coordination teams create holistic, person-centered care plans focused on evidence-based best practices, trauma-informed care, and social determinants of health that result in a positive impact on each child's life. Every day, Aetna Better Health of Kentucky aims to achieve safety and permanency for children, reduce psychotropic medication use, and improve health outcomes for these youth.

Technical Approach

Our approach to supporting Kentucky SKY enrollees is based on our national child welfare model, enhanced and aligned to meet the Commonwealth's goals. Our approach includes full integration of a robust and holistic SOC framework that aligns with Charting the LifeCourse, evidence-based assessments, planning and services, and adoption of technology, including our FamilyConnect on-demand medical record data home. These enhancements are guided by a team of child welfare experts that understand the resources needed and system-framed strategies that work collaboratively to support stability, build on enrollees' capabilities, and help them achieve their life goals.

> "Kansas Department for Children and Families has appreciated the opportunity presented to us by Aetna Better Health to implement the Family Finding modality into our child welfare system this past year. Aetna has collaborated with the State and key State partners to enhance the lives of children and youth in families to develop strategies for positive impact on stability and well-being outcomes: preventing and reducing the need for formal foster care, increasing children living with relatives, and reducing reliance on institutional care. We are excited and look forward in this collaboration transforming our approaches alongside families, Aetna Better Health, and community partners."
>
> **—Tanya Keys**
> **Deputy Secretary,**
> **Kansas Department of Children and Families**

Our **SOC framework** improves trauma-informed care throughout the delivery system and breaks down the silos to help enrollees achieve positive and holistic physical, behavioral, and social health outcomes. This approach includes a full spectrum of effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support that are organized into a coordinated network-within-a-network functioning as a virtual team.

[2] Source: Healthy Foster Care America, 2019.

University of Missouri-Kansas City Institute for Human Development's **Charting the LifeCourse™** framework facilitates person-centered thinking, planning, and living when working with our enrollees and their circle of supports. With these tools, we work closely with enrollees and their families to identify key life stages and provide thoughtful anticipatory guidance around major milestones to sustain enrollee quality of life, avoid unnecessary transitions, and ensure continuity of care.

Aetna's approach is informed by **evidence-based, trauma-informed treatment and recovery** services. Our commitment to providing care through a trauma-informed lens includes the mobilization of a trauma system of care administrator who will lead and establish structure and mechanisms to drive the trauma transformation principles in the health plan. Our ongoing collaboration with the National Council for Behavioral Health (National Council) represents our unique commitment to implement an organization-wide Trauma-Informed Transformation in support of serving our vulnerable enrollees and supporting their resiliency.

Aetna has designed a proprietary information management system called **FamilyConnect** for the purpose of integrating all components of the delivery of care to the Kentucky SKY enrollees. Access will be available for all key players involved in children, youth, and young adults enrolled in Kentucky SKY care, including the members of the integrated care team, educators, representatives from community-based organizations and social services organizations, and staff at agencies of the Commonwealth. The platform will facilitate the rapid inclusion of disparate documentation, including paper reports, enrollment lists, school transcripts, foster parent notes, training media, case notes, and any other support documentation related to the child, and will be done in collaboration with DCBS so that we can minimize duplication and streamline the process.

Our dedication to being a **collaborative and innovative partner to State agencies**, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier Kentucky.

Collaboration with Schools

We collaborate with schools to make sure we are fully supporting a child's Individualized Education Program (IEP) and addressing any gaps in care that support both the child and the school. We will attend IEP reviews and invite school personnel to our monthly care planning meetings with enrollee and caregivers. To enhance coordination, we will visit enrollees and IEP providers onsite at school.

We will seek to collaborate with educational systems to connect children with hobbies or extracurricular activities such as sports and outdoor activities, which can teach them lifelong habits to keep them physically and mentally fit, promote healthy ways of dealing with stress, avoid trouble, and encourage well-being.

Aetna's **provider network is designed to support the complex needs of Kentucky SKY enrollees** by extending beyond traditional facilities, clinics, and practitioners to include community advocates, peer and professional support organizations, specialty pharmacies, and family/caregivers. Our considerable network of contracted hospitals and specialists, including an array of pediatric specialists and sub-specialists, ancillary, and behavioral health providers, serves as the foundation of our network to meet the needs of Kentucky SKY enrollees.

We provide **high-quality care** through our network contracting strategies, provider training, and coordination with internal departments. We have developed and will continue to assess mechanisms to support accountability and transparency against quality of care outcomes. This includes aligning financial incentives and value-based payment (VBP) with implementation of innovative care models to support system transformation and improve care outcomes in a cost-effective manner.

Proposed Staffing and Organizational Structure

The cornerstone of our staffing plan is highly experienced leadership with extensive local, program-specific knowledge. An onsite, local Aetna leadership team will manage the delivery and operations of

our Kentucky SKY program, leveraging our longstanding, positive relationships with the Department, DCBS, Department of Juvenile Justice (DJJ), providers, community resources, advocacy groups, regulatory agencies, and other Medicaid-focused organizations throughout the Commonwealth. Our proposed Kentucky SKY key personnel collectively bring a wealth of experience in working toward better outcomes, better enrollee experiences with health care, and lower total cost of care.

> Aetna's Kentucky SKY Executive Director Kelly Gannon has a deeply personal understanding navigating the foster care system as her 5-year-old daughter was adopted out of Kentucky's foster care system. This personal experience provided her with a keen sense of appreciation for the challenges families and children face while navigating the system.

We have several key Aetna staff with extensive knowledge of the child welfare system that position us to have the local knowledge to build out our staffing model effectively. **Kelly Gannon, Master of Business Administration, Licensed Clinical Social Worker,** will serve as executive director for the Kentucky SKY program and will play a key role in identifying, hiring, and retaining key personnel. Ms. Gannon is an experienced executive leader in behavioral health with 30 years of community mental health and nonprofit experience. Ms. Gannon has experience with operational oversight of key programs that intersect with DCBS, such as Children's Review Program, while serving as director of clinical health services at Bluegrass MH-MR Board.

Ms. Gannon will work closely with two senior advisors, who offer the following child and welfare credentials to Aetna and the Kentucky SKY program:

- **Andrea Bennett, PhD, Master of Social Work (MSW),** previously the chief external affairs officer specializing in child health and welfare for Kentucky Youth Advocates, will serve as the local senior advisor to the executive director. Ms. Bennett will assist and advise Ms. Gannon on program operations before and after contract implementation, offering extensive knowledge of the child welfare system in Kentucky and nationally. Ms. Gannon has strong relationships with key stakeholders in the health and child welfare arenas in the Commonwealth.
- **Josh Boynton, Master of Science,** will serve as the national senior advisor to the executive director. Mr. Boynton has more than 20 years of community-based health care industry leadership experience and 7 years of managed Medicaid experience. He is responsible for segment strategy for the Aetna Medicaid organization's child welfare/foster care program. In this role, Mr. Boynton serves as the current segment lead for strategy and implementation of West Virginia Mountain Health Promise (sole source Child Welfare/Foster Care contract awarded to Aetna Better Health of West Virginia in 2019).

The foundation of our staffing model is collaboration, convening, and boundary spanning. We are excited to announce that **Susan Vickers, MSW, Clinical Social Worker,** will be the Kentucky SKY chief of staff and director of stakeholder engagement and education. Ms. Vickers is an experienced quality improvement specialist with 18 years of health care industry experience and 5 years of managed Medicaid experience. Her expertise includes extensive work in the quality, leadership, and hospice arenas. Prior to joining Aetna, Susan served as a hospice and palliative care social worker for St. Anthony's Hospice in Hendersonville, Kentucky. Her educational background includes a Master of Social Work degree, a graduate certificate in Gerontology from the University of Kentucky School of Social Work, and a Bachelor of Science in Psychology from Centre College.

Stephanie Whyte, MD, Master of Business Administration, Certified in Health Care Quality Management, Certified Healthcare Insurance Executive, will serve as the Kentucky SKY chief medical officer. Dr. Whyte is an accomplished health care executive with more than 20 years of successful health care industry experience and 5 years of managed Medicaid experience. In 2012, Dr. Whyte was selected as the inaugural chief health officer for Chicago Public Schools, overseeing critical

student health and wellness programming within Chicago Public Schools, while collaborating with Chicago Department of Public Health on the city's first public health agenda, Healthy Chicago.

Our SOC model is an innovative approach that relies upon improving trauma-informed care throughout the delivery system and breaks down the silos to help enrollees achieve positive and holistic physical, behavioral, and social health outcomes. This model includes a full spectrum of effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support that are organized into a coordinated network-within-a-network functioning as a virtual team.

To support this contract, we are committed to attracting additional professional staff with significant experience serving populations like those covered by SKY. Executive Director Kelly Gannon will seek local candidates from rural and urban parts of the Commonwealth who are experienced and familiar with the local Medicaid health care delivery system and culture in the Commonwealth. All staff will have the Kentucky licensures and certifications required by law and the **Draft Medicaid Managed Care Contract and Appendices**. Our staffing plan for the Kentucky SKY program assumes total enrollees of approximately 24,000. Under this scenario, we will scale up our present staffing to **more than 200 staff members who are 100 percent dedicated to the Kentucky SKY program.** All SKY-specific staff will be in our Louisville office or based in communities within the regions they serve throughout the Commonwealth.

Organizational Structure: Supporting Innovative Solutions and Stakeholder Groups

Aetna proposes a governance and leadership structure that parallels our care coordination model and offers an innovative approach to transforming the present system. We designed our organizational structure to provide the framework for our Kentucky staff to implement innovative solutions to empower our Kentucky SKY enrollees and their families and ultimately transform the system to keep families and kids safe from harm. To drive a culture of innovation and collaboration, our staff participates in cross-functional teams aimed at improving performance across every area of the organization. We communicate initiatives through all-staff town hall meetings, email notifications, staff member website articles, web-based learning modules, and demonstrations. Examples of ways that our organizational structure supports innovative solutions and stakeholder groups include our cross-functional Service Improvement Committee, our robust Quality Management staff, our Population Health staff, and our System of Care staff supporting a full spectrum of effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support.

In addition, through a formal partnership with **Kentucky Youth Advocates (KYA),** we will work with state agencies, providers, child welfare organizations, juvenile justice, and consumers across Kentucky on innovative solutions to transform care for the Kentucky SKY population. KYA is the state's leading child advocacy organization with over 40 years of experience working with public, private, and nonprofit agencies to advance policies that are good for kids. KYA is an expert in building effective coalitions that advance systems-level changes and offers a wealth of expertise in the child welfare arena. The organization is already partnering with DCBS and Casey Family Programs on several initiatives related to advancing Family First in the Commonwealth. KYA is an ideal collaborating agency as we are in alignment on objectives related to strengthening families, keeping kids safe, enhancing supports for kinship families, and promoting resiliency and stability for youth that are in or aging out of foster care. KYA will help us ensure we have the right stakeholders at the table to offer insight and feedback during planning and implementation of the Kentucky SKY program.

> "Kentucky Youth Advocates is committed to working with Aetna Better Health of Kentucky in a collaborative approach to advance policies and practices that keep families safely together and promote healing and stability for children and youth who experience abuse. We will work together to enhance efforts already underway in the Commonwealth to transform the Commonwealth's approach to child welfare, including implementation of Family First. We know that Aetna Better Health of Kentucky is uniquely positioned to work with us to meet the health and non-health needs of the Kentucky SKY population."
>
> **—Dr. Terry Brooks, Executive Director, Kentucky Youth Advocates**

Figure G.1-2 illustrates the organizational design we propose to manage the Aetna Kentucky SKY program.

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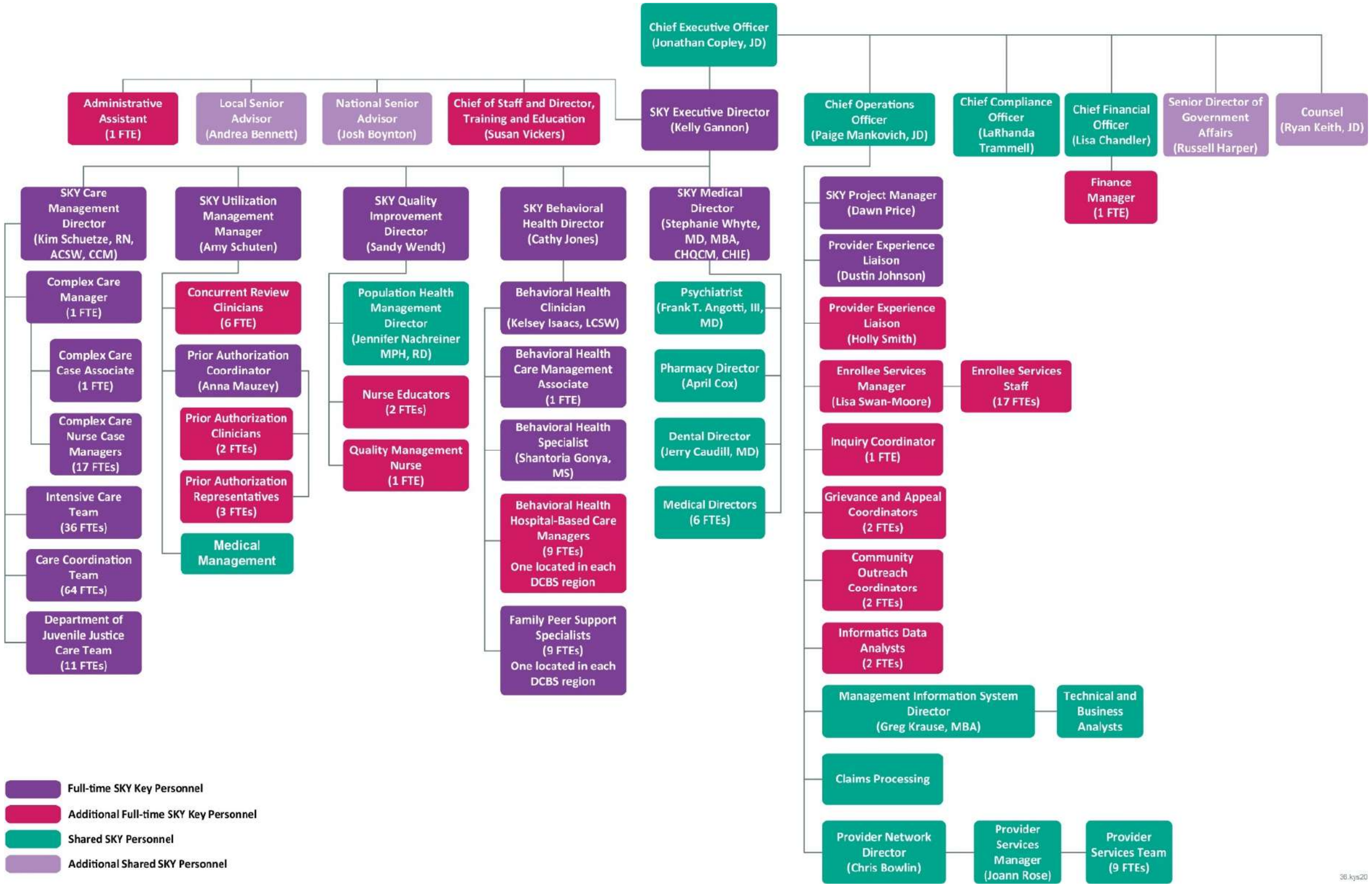

Figure G.1-2: Aetna Kentucky SKY Organizational Design

Aetna's organizational design for the Kentucky SKY program emphasizes experience, flexibility, and putting the right resources toward serving Kentucky's child protection and juvenile justice populations.

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Implementation Plan

As an original Medicaid MCO operating in the Commonwealth since 2011, we are well-positioned to meet and implement the requirements of the **Draft Medicaid Managed Care Contract and Appendices.** Aetna has a long history of successfully implementing new Medicaid programs, and we have refined and improved our processes over time. In fact, using our proven implementation process, **Aetna has passed 16 consecutive state readiness reviews and achieved go-live within required timeframes.**

We will use Aetna's national Implementation team, in partnership with Kentucky child welfare subject matter experts and our existing Kentucky health plan team, to implement Kentucky SKY in a timely and compliant manner. We will draw from the Aetna Medicaid organization's experience implementing similar programs in Kansas and West Virginia recently. Along the implementation pathway, we will stay focused on enrollees and providers, building relationships with DCBS, DJJ, sister agencies, advocates, and community organizations, and will obtain ongoing feedback to gauge opportunities for enhanced communication and education. What defines us is our dedication to a collaboration and developing innovative partnerships.

As we establish partnerships with criminal justice, juvenile justice, and law enforcement, we are preparing to engage in facilitating the necessary systemic change. Strong communities and healthy families rely on these strong cross-system partnerships. One of the innovative models we propose to test is a co-response pilot in a community with poor outcomes across systems such as health, child welfare, and public safety. We are the process of identifying a pilot community with various local city and police representatives.

Implementation of the Kentucky SKY program, which represents a significant change in the care model for the child protection and juvenile justice population, requires trusted, proven partners like Aetna. We have consistently served fellow Kentuckians, especially during critical moments. For example, on July 6—Saturday of the July 4th holiday weekend—**our health plan (operating then as Coventry Health and Life Insurance Company) welcomed 68,000 new enrollees when one of three Medicaid managed care organizations in the Commonwealth, Kentucky Spirit (Centene), abruptly ceased operations over a legal dispute.** Through diligent planning, expertly smooth execution, and the unmatched passion of our exceptional staff, we provided a smooth transition for our new enrollees and providers while continuing to provide the best service for our existing enrollees. The outcomes of this transition proved that we will stop at nothing to serve and support our fellow Kentuckians with enthusiasm and heart.

Aetna Kentucky's SKY implementation plan parallels the program plan and direct care planning process. The values-based care plan proposed by Aetna makes certain voice, choice, and preference for youth and families, which lead to successful outcomes. We ground our project management activity in the framework of the Deloitte's Intelligent Program Management methodology™, and we have adapted and refined it based upon 30 years of experience in program implementations, accounting for the complexities and changing environment of managed health care programs.

Our business systems and processes support our staff in a manner that serves the individual needs of each enrollee and provider. We conduct focused, intensive, multiday reviews of the contract with key subject matter experts. The participants include Aetna Kentucky SKY team staff and subject matter experts from the Aetna Implementation team as well as Aetna Medicaid organization leaders, collaborating to mutually understand the program requirements and achieve shared ownership of program requirement development, related deliverables, testing, and deployment. Aetna Kentucky SKY's Implementation team is comprised of highly experienced, integrated, cross-functional leaders, and staff members from physical

health, behavioral health, and information technology functional areas. Key elements of Kentucky SKY implementation plan are in **Table G.1-1.**

Table G.1-1: Aetna Kentucky SKY Implementation Activities

Required Implementation Activity	Status
Establishing an Office Location and Call Centers	Our current health plan office is located at 9900 Corporate Campus Drive, Louisville, Kentucky 40223 since August 2011. Our Enrollee Services, Provider Services, and Behavioral Health call centers have been operational since 2011 as well. Currently, leadership and our Real Estate team are evaluating the need for additional space for any increased staffing.
Provider Recruitment Activities	Aetna's Network and Provider Experience teams are evaluating any gaps in our provider network to manage the Kentucky SKY enrollee. Once those providers are identified, recruitment, contracting, and training will begin.
Staff Hiring and a Training Plan	Aetna is utilizing our current staffing algorithm, along with evaluating the complexity of the Kentucky SKY population to develop a comprehensive staffing plan and job descriptions; once awarded, recruitment will be initiated.
Developing Required Materials	As an existing Kentucky health plan, we have policies and procedures as well as enrollee and provider materials in place that we will utilize as our bases and enhance as required for the Kentucky SKY implementation. As part of our overall implementation approach, we will review these documents and make any necessary revisions and enhancements based on the Kentucky SKY RFP and contract.
Establishing Interfaces to Information Systems Operated by the Department, DCBS, and Others	Aetna will work collaboratively with the Department, DCBS, and others to ensure connectivity with required systems for the continuity and coordination of the Kentucky SKY enrollees.

Our implementation plan for the Kentucky Medicaid and Kentucky SKY program targets key activities required for readiness of Aetna's program and information systems. We utilize the information from the contract, stakeholders' feedback, and information from our focused, intensive, and multiday review with our entire team.

Aetna will utilize dedicated Kentucky SKY subject matter experts within the Implementation team to be solely focused on the Kentucky SKY implementation. These Implementation team members will consist of a director and clinical staff who will work in partnership with the local Kentucky health plan team, DCBS staff, DJJ staff, and other supporting community organization to enhance our project plan, which will span through 90 days post-go-live. This full Kentucky SKY program management will include securing weekly updates from the Kentucky SKY team and the various shared services areas to ensure individual functional area project plans and work streams are proceeding timely and all contractual requirements are being built accurately and that risks are identified and resolved promptly.

In addition to our commitment and implementation experience, we also understand the commitment of DCBS to transform the child welfare system and be a leader in implementing the federal **Family First** legislation. Aetna has built the knowledge and capacity to be a partner in the goals related to Family First in Kentucky. Our model of care focuses on strengthening families and focusing on preventing crisis as the first line of support. We have internal expertise on the child welfare system. As previously mentioned, we will partner with **Kentucky Youth Advocates**, the Commonwealth's leading child advocacy organization, to build our internal capacity to advance the goals of Family First in partnership with the Commonwealth. We will also work to expand our knowledge of efforts already underway to implement Family First, such as prevention initiatives, and identify ways we can build capacity where needed. We will not reinvent the wheel, but instead find ways to add value and fill gaps.

Our core innovations in this Kentucky SKY proposal are collaborative at heart and support enrollees and system innovations and continuous feedback as a collective and respectful approach to opportunities and

challenges. Aetna is poised to engage a vast array of stakeholders for successful implementation including the Department, DCBS, providers, advocates, and Kentucky SKY enrollees and their families. We will also partner with KYA to engage in statewide coalitions that include Kentucky SKY enrollees in order to obtain firsthand feedback on the successes and areas for improvement in the Kentucky SKY program.

b. Our Understanding of the Unique Needs of Medicaid Enrollees in the Commonwealth Enrolled in the Kentucky SKY Program

Families and communities in Kentucky have been under severe pressures from economic hardship resulting from loss of historic industry, associated unemployment/under-employment, and growing economic and social inequality for more than a decade. This unrelenting and prolonged stress exposure has taken a severe toll on the well-being of families and children in Kentucky as well as in other states. The statistic that Kentucky has the second-highest rate of child abuse in the country is but one indicator of the depth, direction, duration, and development of these social and economic challenges. An outcome of such stress is the high rate of substance use and opioid-related overdose deaths, only further complicating the child welfare landscape.

Aetna is committed to reversing the rising trend of opioid abuse. We will execute strategic solutions that focus on the needs of our Kentucky SKY enrollees and make sure initiatives and programs integrate pharmacy, behavioral health, and physical health. Our programs connect providers and give enrollees seamless access to the right support—mind and body—to fight addiction, while saving millions of dollars for the health care system. By 2022, in alignment with the State Health Improvement Plan, Aetna is committed to the following goals:

- Increase enrollees with chronic pain treated by non-opioid treatment alternatives by 50 percent
- Reduce inappropriate opioid prescribing for our enrollees by 50 percent
- Increase enrollees with opioid use disorder treated with medication-assisted treatment and other evidence-based treatments by 50 percent

Aetna understands that each population is complex, with unique service needs. We remain committed to collaborating with the Department and other Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders to provide excellent service to each of them. The health care and social needs of the Kentucky SKY population are vast and compounded by their circumstances. They are often at the intersection of multiple public systems including behavioral health, child welfare, education, juvenile justice, and primary care. Behavioral health is the single most unmet need among the populations including in SKY.[3] These individuals likely have a history of trauma, frequent life changes, difficulties in their biological family, and issues with psychotropic medications. Aetna understands that all these factors impact the overall well-being of the enrollee. The intense behavioral health needs, combined with physical and oral health issues that have resulted often from a lack of consistent health care, results in a population that requires high-touch approaches with easy access to comprehensive services that meet their needs.

Our goal is to engage and support children to have membership in a family and community while services and permanency planning are occurring. By keeping families safely together, children in the Kentucky SKY population will experience less trauma, which leads to better outcomes.

c. Our Ability to Provide Coordinated Services for the Kentucky SKY Program

We support each of our enrollees to reach and maintain a meaningful quality of life, optimal health, and overall wellness. To do so, we strive to **understand each unique enrollee in the context of their lives,**

[3] Source: Healthy Foster Care America, 2019

while partnering with them to design a person-centered holistic model of supports and services that enhance their quality of life and assists them to reach their individual life goals. While this approach is universally applied to our entire population, we leverage supplemental tools and practices such as the Wraparound Life Domain Planning Process and the University of Missouri-Kansas City (UMKC) Institute for Human Development's **Charting the LifeCourse** framework to facilitate person-centered thinking, planning, and living when working with our enrollees and their circle of supports. With these tools, we work closely with enrollees and their families to identify key life stages and provide thoughtful anticipatory guidance around major milestones to sustain enrollee quality of life, avoid unnecessary transitions, and ensure continuity of care.

> "The LifeCourse framework and tools are designed to help individuals and their families plan for and navigate a life that makes sense to them with the support they need. It is exciting that a national health care leader like Aetna recognizes its value and will be using the LifeCourse framework as it develops its person-centered, holistic model to support children in the child welfare system in Kentucky."
>
> **—Michelle C. Reynolds, PhD, Associate Director of Training, UMKC Institute of Human Development.**

Likewise, Aetna has selected a national award-winning framework for promoting and strengthening collaborative practice between child protection professionals and community and family partners called **Collaborative Family Engagement**. This type of respectful, responsive, and collaborative practice framework has been shown to improve the coordination, satisfaction, and efficiency where multiple systems are involved in the lives of children and their families and caregivers.

To meet all contract requirements and meet the needs of the Kentucky SKY population, Aetna will hire additional care coordinators to provide services across the three tiers of the care coordination stratification. **Care coordinators will be located within each region of the state and strategically co-located in stakeholders' offices to provide support and care coordination.** Circle of Support teams will be comprised of the youth, parents, family, and extended family members, friends, and community members as well as professionals at a 50/50 natural enrollee-to-professional ratio (per National Wraparound Standards). Please refer to **Table G.1-2** for our proposed staffing model.

Table G.1-2: Aetna Kentucky SKY Care Coordination Staffing Model

Care Coordination Tier/(NCQA Level)	Population Served	Staffing Ratio	Services Provided
Complex Care Coordination (including due to behavioral health needs)	Enrollees with the highest needs such as those with previous behavioral health admissions and Kentucky SKY enrollees with special health care needs and medically complex children	12:1	• Two face-to-face visits (monthly) • One weekly contact • A minimum of two hours per week of care coordination • One meeting with the Kentucky SKY enrollee and caregivers (monthly) • One care plan update (monthly)
Intensive Care Coordination (Management of Chronic Conditions)	Enrollees with moderate acuity, but who are not at risk of crisis	32:1	• One face-to-face visit (monthly) • One weekly contact • One meeting with Kentucky SKY enrollee and caregivers (monthly) • One care plan update (monthly)
Care Coordination (Prevention and Wellness)	Enrollees with limited health care needs	400:1	• All Kentucky SKY enrollees will have access to care coordination services and a Care Coordination team • Aetna will outreach Kentucky SKY enrollees quarterly to assess any changes in social risks, health conditions, or any other needs • Aetna will educate enrollees and their caregivers

Care Coordination Tier/(NCQA Level)	Population Served	Staffing Ratio	Services Provided
			on how to contact the health plan should needs arise prior to outreach • Health risk assessment will be completed (at least annually)

The Aetna Kentucky SKY structure will employ the RFP-required leadership, management, direct care, and ancillary support positions as well as other positions that will be integral to the success of the collaborative model, such as a new **chief of staff and director of stakeholder engagement and education.** The Aetna Kentucky SKY department leads will provide facilitation of design, implementation, and oversight in an inclusive and collaborative manner within cross-departmental work teams. Each facilitator will be fully trained in managed care business acumen, strategic planning, and oversight competencies to ensure high-quality care, continuous quality improvement, efficiencies and effectiveness, and sustainability over time.

To provide coordinated services for the Kentucky SKY enrollees, we focus on ongoing collaboration with all the stakeholders. We build a sustainable model that relies on a foundation of collaboration. Aetna uses a convener, catalyst, and facilitation approach to supporting the creation of innovative solutions with enrollees, partners, and the community. We have learned though experience the power of building on what is strong in our enrollees, partners, and communities to find sustainable and welcome change embraced by those most affected a challenges or opportunity. A welcomed and valued innovation is created collaboratively, not imposed or brought from the outside. Rather than a short-sighted approach, we are building collaboration the right way—knowing that even though we are an important part of effective ongoing coordination for enrollees, we are part of a larger circle of support. **We are here. We are collaborators.**

d. Our Strategy and Approach for Administering Services for Kentucky SKY Enrollees

Aetna's SOC approach (illustrated in **Figure G.1-3**) provides evidence-based, trauma-informed treatment and recovery services based on the **Universal Precautions model** that serves each enrollee as if they had been traumatized. Our SOC model includes a full spectrum of effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support. Aetna's system of care provides all the services children in protective services and/or with juvenile justice involvement need, including but not limited to the following:

- Covered services managed by a health plan
- Physical and behavioral health services not managed by the health plan and/or not covered by the plan
- Wraparound treatments, services, and supports available from other government agencies or offered by community-based organizations

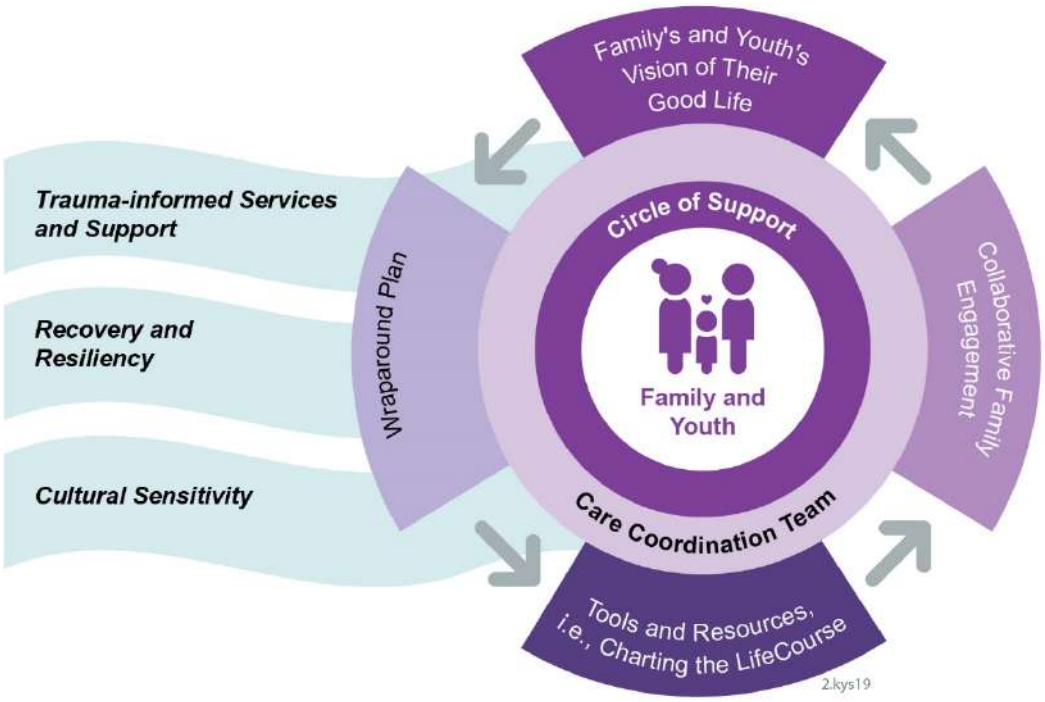

Figure G.1-3: System of Care

Our SOC model includes effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support.

An **onsite, local Aetna leadership team** will manage the delivery and operations of our Kentucky SKY program, leveraging our longstanding, positive relationships with the Department, providers, community resources, advocacy groups, regulatory agencies, and other Medicaid-focused organizations throughout the Commonwealth. Aetna is prepared to successfully manage designing and launching a large system change effort while opening services to many new and transitioning referred children. Upon award of contract, Aetna will employ a strategic planning process in collaboration with all referring department leads and key stakeholders that fully fleshes out needs on multiple levels—outcomes with objectives, work teams, resources, and timelines to ensure that the project plan is inclusive of all necessary outcomes—this includes urgent yet feasible deliverables, accountability, and formal rapid change methods to course correct as needed.

Additionally, our historical experience and success in the Kentucky Medicaid program allows us to leverage successes in the following areas on behalf of enrollees:

- Resolving enrollment and eligibility issues
- Managing enrollee primary care provider (PCP) assignment
- Facilitating PCP selection and auto-assignment
- Collaborating with stakeholders to assign PCPs
- Tracking data to confirm enrollee PCP assignment
- Communicating with Kentucky SKY enrollees about PCP and dental assignments
- Encouraging enrollees to keep appointments
- Providing ID cards in required timeframes
- Managing the replacement of lost IDs
- Maintaining written processes, protocols, and guidelines supporting warm transfers

Finally, Aetna provides all the infrastructure and supports necessary to achieve optimal outcomes for Kentucky SKY enrollees. Aetna services and support includes an emergency/crisis liaison along with adult and child administrators, **a unique and dedicated DJJ liaison**, and a director of recovery resiliency. The goal of our team members is to facilitate the most integrated setting as possible, appropriate use of emergency rooms, and higher levels of care while promoting the overall health and wellness of our Kentucky SKY enrollees by promoting PCP/enrollee relationships and offering a comprehensive network of specialty and behavioral health providers. We do this through our understanding of the needs and risks of our Kentucky SKY enrollees and by comprehensively training staff, adhering to written policies and procedures and desktops, and by following evidence-based guidelines.

e. Strategy and Approach for Establishing a Comprehensive Provider Network able to Meet the Unique Physical and Behavioral Health Needs of Kentucky SKY Enrollees

Aetna's network strategy focuses on making sure each enrollee has access to high-quality, integrated, personalized health care services. We continually work to make sure providers are available at the right location and within the appropriate timeframe to meet the needs of Kentucky SKY enrollees and their fictive kin (including enrollees, family, caregiver, community supports, and others who assist with care support and enrollee wellness) with a focus on improving whole health outcomes. For more than eight years, Aetna has worked collaboratively with Kentucky health care providers to deliver services to Medicaid enrollees, with a special focus on medically fragile and chronically ill infants, children, and young adults with complex physical and behavioral health care needs. We are continually enhancing our network to expand the number, scope, and types of practitioners to meet the unique care needs of Kentucky SKY enrollees, including geographic distribution and specialty providers. Our Kentucky Medicaid **provider network is 100 percent compliant with the Department's adequacy standards.** We have **29,355 contracts representing 33,794 providers at 118,977 locations.**

Our network solutions and approaches to a provider delivery system for Kentucky SKY enrollees are built around the following four principles:

- **Maximizing enrollee choice:** We understand that enrollee choice is particularly important to meeting the unique needs of Kentucky SKY enrollees, and we continually work to offer enrollees options when selection providers for their health care including location, gender, quality, experience, availability, cultural competence, and clinical preparation.
- **Easily accessible services:** We have ongoing processes to monitor our network and identify innovative solutions to provide health care services that are locally available and convenient to access, taking into consideration how our Kentucky SKY enrollees access services and how providers support Kentucky SKY enrollees. Examples of solutions include offering financial incentives to encourage provider to expand services and hours of operation; assistance in identifying and implementing accommodations to support enrollee accessibility needs; and use of telehealth.
- **High-quality care:** Through our network contracting strategies, provider training, and coordination with internal departments, we have developed and will continue to assess mechanisms to support accountability and transparency against quality of care outcomes. This includes aligning financial incentives and VBP with implementation of innovative care models to support system transformation and improve care outcomes in a cost-effective manner.
- **Enrollee-focused provider services:** Assisting our providers in navigating the system transformation and implementing new care models is a critical component to the effectiveness of the Kentucky SKY model and improved enrollee outcomes. Aetna's highly trained and experienced Provider Services department has a combined 172 years of experience working in provider offices and over 90 combined years of experience in Kentucky Medicaid. Our provider services representatives are

locally situated in communities across the state to ensure strong and collaborative provider relationships and support coordination with care advocacy groups. To further support our providers, we have dedicated Behavioral Health Network Management and Operations staff who understand the nature of behavioral health services and can respond to the unique experience of behavioral health providers. Our provider relations liaison has 15 years of experience working for with Kentucky's behavioral health providers.

Recruitment Strategy

Our recruitment strategy is to build a comprehensive, region-specific, experienced, and high-quality network that offers provider selection, preserves existing community referral patterns, and ensures access to care for those with complex needs. When possible, Aetna is committed to using local providers; however, when local providers are not available, we will draw on our national expertise to deploy innovative alternative models as we have with telehealth services. Over the past nine years, we have been successful in developing and maintaining a mature and comprehensive statewide provider network by listening to providers, enrollees, communities, and system partners, and working collaboratively to develop and implement solutions that addresses the needs of Kentucky Medicaid enrollees. Our strong community relationships with providers, integrated network analysis and recruitment processes, and high-touch model of network management assist us in making sure Kentucky SKY enrollees have timely access to competent primary and specialty care, as well as non-traditional services.

Approach to Contracting

Aetna's approach to provider contracting is to design strategies that are an integrated component of the overall system transformation. For example, our contracting strategies will be developed to align with and support implementation of the trauma-informed care model, provider training initiatives, inclusion of non-traditional providers, and State departmental goals. While we will leverage current contracting strategies, we understand the need to modify these strategies to incentivize and support the unique needs of Kentucky SKY enrollees. For example, Aetna offers providers a variety of alternative payment arrangements through our **Aetna Better Value** program. To date, Aetna has entered into an alternative payment arrangement with key providers to improve quality of care to children with complex needs, including Children's Alliance Independent Provider Association, the Kidz Club, and KVC Health Systems.

Kentucky SKY enrollees have complex needs, which Aetna's network is designed to support, by extending beyond traditional facilities, clinics, and practitioners to include community advocates, peer and professional support organizations, specialty pharmacies, and family/caregivers. Our considerable network of contracted hospitals and specialists, including an array of pediatric specialists and sub-specialists, ancillary, and behavioral health providers, serves as the basis for Aetna of Kentucky and Aetna Kentucky SKY enrollees for exceeding adequacy requirements and provider accessibility in advance of go-live for the Kentucky SKY program. Our strategy and approach—to continually assess network needs and recruit and retain high-quality providers through innovative approaches and contracts— is the path through which Aetna will enhance our current network to meet the unique needs of Kentucky SKY enrollees and support system transformation. We will also adopt successful recruitment and retention strategies for therapeutic foster care (TFC) providers from Mercy Care, a Medicaid managed care plan administered by Aetna in Arizona. These strategies including sponsoring targeted trainings and recruitment events, collaborating with providers to develop tailored funding to meet individual enrollee needs, and working with State agencies to reduce barriers to licensing of new TFC providers.

f. Our Innovations and Trauma-informed Initiatives

Health starts where we live, learn, work and play, and every one of us should live in a safe home and community with supportive and trusting relationships. Difficult events do happen to children separated from their natural families: events often overwhelm a person's coping capacity and cause their health to suffer. These children may get sick more often and for longer periods of time, and standard medical care practices may not work as effectively or they choose to avoid medical care altogether, leading to a life of chronic disease and poor health.

'Universal Precautions' Model

Aetna's approach provides evidence-based trauma-informed treatment and recovery services based on the 'universal precautions' model that serves each enrollee as if they had been traumatized. Our innovative approach is taking an organizational trauma transformation that provides training and education and responds to the results of an organizational assessment that helps each part of Aetna to focus on various principles of the trauma transformation. We are working with the National Council for Behavioral Health in a 2.5-year engagement for this cultural transformation, working with all levels of the organization including our national Shared Services staff, Health Plan staff, and health plan providers to affect the outcome of our enrollees in all areas of interaction.

Our plans also include the mobilization of a **trauma system of care administrator** who will lead and establish structure and mechanisms to drive the trauma transformation principles in the health plan, provider network, and Commonwealth regulators and stakeholders.

Although the effects of trauma are detrimental, we know that trauma is treatable. Our relationships with National Council for Behavioral Health to implement an organization-wide trauma-informed transformation will prepare the whole continuum of care to be trauma-informed. All our staff, especially our Care Coordination teams, will take special care not to re-traumatize during any interaction. We ensure that all our staff and providers understand the impact of adverse childhood experiences and the importance of creating an environment of safety.

Training and Monitoring Providers

Aetna has also developed a multi-step, trauma-informed regimen to train, audit, and monitor our existing and new providers. The three levels include trauma-aware, trauma-informed, and trauma-transformed. In addition to training, key providers will engage in a year-long learning collaborative with the National Council to assist them in their transformation. We are looking to help providers have a trauma-informed recognition in our provider directory.

The Aetna team is trained in advanced coursework on trauma-informed care, Mental Health First Aid, the fundamentals of development, including age-appropriate and stress-related behaviors, adolescent substance use, and permanency training. We have trained approximately 3,000 Medicaid staff in foundational trauma training since 2018. Some the topics include the following:

- Defining trauma
- Prevalence and impact of trauma and adverse childhood experiences
- Building resiliency and hope for recovery in the face of trauma and self-care
- Introducing trauma-informed care
- The importance of trauma-informed care for the populations served by the Aetna Medicaid organization
- Four assumptions of trauma-informed care
- Six principles of trauma-informed care
- Application for staff and enrollees

The Aetna Kentucky SKY approach to improving health outcomes for enrollees begins with a focus on understanding the experiences and relationships that have shaped the young person's life and how these have affected the course of their childhood development. Health and development are built in relationships over time and across critical and sub-critical periods of development. With each enrollee, we seek to understand how their health trajectories have been affected and work with parents, youth, foster parents, and caseworkers to support basic health practices, which support and strengthen development and growth. This provides a strong foundation for cost-effective delivery of preventive and primary health and mental health care, reducing risks for acute and emergency care.

Other Cost-effective Innovations

The following are additional cost-effective innovations:

Life Course Health Trajectory Approach

With each enrollee, we consider health care and health practices, which support the possibility of a good life well into adulthood. Strong childhood development experiences build resilience and supportive relationships with caring adults buffer the effects of everyday adversities; these are core concepts in our Kentucky SKY approach.

While most children and youth involved with child protection/juvenile justice systems have faced significant adversities that may have altered their developing brains and bodies, they have not yet developed chronic conditions related to poor diet, severe and prolonged substance abuse, and other health-damaging lifestyle practices. The principle of **what is predictable is preventable** supports the concept of planning for and anticipating life and health trajectories that build resilience and capabilities. A short-term response to immediate safety and placement stability promotes fragmented childhood experiences and chronic discontinuity of care support. From the first contact with children, we must be considering and anticipating enrollees' well-being and health across the life course.

A significant challenge to implementing this evidenced approach is the history in public child protection of limited caseworker time with the child and a culture of crisis. Our unique strategy to this is moving health care coordination to the center of child protection rather than at the periphery. As it relates to these innovations, we have significant experience with addressing similar challenges in Kentucky and in other states across the country, and it all comes down to finding alignment, a shared mission, and a commitment to a transparent and collaborative relationship.

Risk Stratification

Risk stratification and establishing an appropriate level and intensity of services is critical to supporting improved safety, relationships, and the opportunity for learning and practicing emotion regulation. Research offers new insights into predicting health and mental health trajectories based on specific information about the number and composition of early life adversities and the duration of exposure during or across multiple critical periods. This adds a dimension to risk assessment beyond presenting challenges. There are four trajectories by age 18 for youth based on early life experiences and the number and composition of adversities: Competent and Connected or Emerging Adult, Hindered and Homebound, Troubled and Troubling. Aetna uses these trajectories to assign the level of intensive case management appropriate to the intensity of services necessary to support the enrollee and compliment the Child Protection Agencies service plan.

Support and care needs of children and youth require more than an immediate response to present concerns and basic care. Children who face the highest levels of adversities early in life and across periods of critical and subcritical periods of development are at the greatest risk for developing health and mental health conditions. A tier system that considers not only immediate or acute needs, but also how past experiences have shaped health and developmental trajectories, provides the best chance for

delivering the right evidenced-based care at the right time and in the doses that make contributions to improved health and building resilience. **The question we confront is not whether our care is helpful, but whether our care is helpful *enough* to make a difference in improving the lives of our enrollees.** Appropriate risk stratification is critical component of our strategy.

Our anticipated challenge is timely and complete access to enrollee family and health history. To appropriately stratify the level of care coordination need, we must have access to enrollees, know their whereabouts, and receive authorization to deliver assessment and care. Our approach to standing with child protection caseworkers is sharing responsibility for the overall support of the enrollee. This creates a collaborative engagement experience that will significantly improve our collective abilities to coordinate and deliver health and well-being related care to our enrollees.

Collaborative Family Engagement

Collaborative Family Engagement is a national award-winning variant of Family Finding specifically created to address a major anticipated challenge in the Kentucky SKY implementation. The practice of a highly participatory and strong family engagement practice in child protection is a radical shift from traditional practice. It is a difficult change, which if not thoughtfully addressed, can result in fragmentation and duplication of services, and in some situations, conflict between professionals and systems. Collaborative Family Engagement has been shown in independent evaluation to be an effective framework for building strong collaborative relationships and integrated and complimentary practices.

Figure G.1-4: Family Finding Boot Camp
Family Finding Boot Camps are a multi-day immersion in learning the philosophy, framework and skills of Family Finding practice. This boot camp took place in Kansas. Photo courtesy of The Topeka Capital-Journal.

A key to a successful implementation will be the decision by the Commonwealth of Kentucky to commit to co-training between child protection partners and Aetna care coordinators.

Wraparound

Wraparound is a promising practice created as a planning process and set of steps to support children and families involved with multiple systems. Multiple system involvement for families is prone to duplication of efforts and multiple and often competing plans and priorities. Wraparound seeks to achieve a single collaborative plan in the voice of the enrollee and enrollee's family and other informal supports. Wraparound is successful due to the values and standards of practice supported by robust training, coaching, and measurement tools. The Wraparound Life Domain Planning process has shown a reduction of length of stay from 3 years (intensive residential) down to an average of 10 months for youth with the highest acuity levels. The intensive community-based model ensures that children remain safe with their families as services are tailored to specific needs, correct dosages, and delivered accurately resulting in more efficient and effective care. Wraparound is the only specifically designed and evidenced approach shown to improve outcomes for a multi-system involving children, adults, and families. Forty years of experience and developing evidence support this planning process as a critical framework for success.

The challenge will be to make sure all stakeholders see the importance of Wraparound team meeting attendance and participation. Our use of Collaborative Family Engagement will significantly address this

well-understood challenge and opportunity. Our experience addressing such a challenge is to make sure everyone is involved in the implementation of the initiative from the beginning.

Charting the LifeCourse

Charting the LifeCourse from University of Missouri-Kansas City is a well-supported model and tool kit designed to support the enrollee and/or enrollees' family to identify the life they want to life; this is referred to as 'a good life.' Enrollees communicate through these tools their choices and goals leading to a good life. Enrollees also reflect and share what they do not want in their lives. These are shown as trajectories and serve to organize all services and supports in respecting and helping enrollees to find the good life.

Charting the LifeCourse provides a complementary set of tools and frameworks to use in our Wraparound model approach as an integration of a LifeCourse Health Trajectory approach, which is person-centered and highly participatory. These tools are highly effective in raising the voice of enrollees and their primary caregivers in creating their plans for a good life and communicating to systems and services where they can do the good. These visual tools are effective at communicating needs and capabilities from the perspective of Aetna enrollees, families, and their circles of support.

We anticipate a challenge in making sure that we are increasing the level of participation and voice by our enrollees as this is a new model in a traditional system. Our use of Collaborative Family Engagement, Charting the LifeCourse, and Wraparound will significantly increase the opportunity for enrollees to participate and guide the path to a good life. One of the ways we address challenges such as this is to continuously tie it back to real-life examples, enrollee success stories, and experience through the enrollee's point of view.

University of Kentucky Adoption Support for Kentucky-Virtual Interaction Program

University of Kentucky Adoption Support for Kentucky-Virtual Interaction Program (ASK-VIP): Aetna understands there is innovative work already underway to support foster, kinship, and adoptive parents in the Commonwealth. We will support existing efforts and help to build capacity of those efforts where there is a need. A major area of interest is to support efforts to expand virtual supports offered to adoptive parents and other caregivers of the Kentucky SKY population. For example, we know that ASK-VIP has been a helpful resource in some parts of Kentucky to support caregivers who are unable to attend support groups in person.

ASK-VIP uses technology to organize group and individual support sessions for caregivers in a safe space. It allows caregivers to share their personal experiences without fear of judgment. Caregivers in the program can also receive specialized training provided by a peer facilitator, who is also an adoptive parent. Aetna will work with the University of Kentucky to help expand ASK-VIP statewide in order to serve areas of the Commonwealth not currently served. In addition, we will work with the program to help identify and address other barriers to caregivers attending meetings (i.e., lack of high-speed broadband; lack of understanding of how to use the technology). Our support in this area will help bolster existing services and expand on the technology solutions already underway. We will also connect the caregivers we serve with the free training and resources already offered by the University of Kentucky Training Resource Center, such as the Adoption Support for Kentucky program. In order to ensure we are not reinventing the wheel, one of our first steps upon procurement will be to meet with key players, including Dr. Jay Miller, Dean of the School of Social Work at the University of Kentucky, in order to further understand the work already underway and how we can support those efforts.

Changing Course

The goal of the *Changing Course* model and curriculum is to provide innovative training, coaching, and sustainability for the Kentucky child welfare system, ensuring each child and family realizes their own

vision of a good life as quickly as possible while ending the cycle of compound trauma. The *Changing Course* curricula include the following over-arching topics which each have modules that can be taught separately depending on the needs of various audiences. These courses each have train-the-trainer components which will ensure sustainability.

The *Changing Course* curriculum topics are each scalable and include the following:

- Overview
- Principles and Standards of Care
- Engagement
- Collaboration
- Facilitation
- Proactive/Responsive Safety Planning
- Creating Community Capacity and Community-based Resourcing
- Visionary Leadership and Management
- Transition Planning and Celebrations
- Outcome-based Quality Assurance-Continuous Quality Improvement

The methodology employed for the design of these draft curricula includes adult learning principles, collaborative stakeholder involvement, train-the-trainer, competencies-based experientials, in-the-field practicums and observations, as well as pre- and post-test competency certification.

The primary sources of innovation that came to bear on these curricula include but are not limited to the following:

- Wraparound
- Collaborative Family Engagement
- Family Seeing and Engagement
- Trauma-informed Care
- ACES Research and Findings
- Neuroplasticity and Trauma Transformation
- HERO Workshops
- Early Childhood Education
- Differential Response
- Crisis Intervention Team Models
- Mental Health First Aid

Faith-based CarePortal and Hope Hill Youth Services

Aetna is dedicated to engaging local faith-based community organizations to create a network of support for our foster care enrollees and families who are in need or in crisis. Through our work, we have identified two potential pilot partners, the Global Orphan Project and Hope Hill Youth Services (Hope Hill Youth Services is a 501(c)(3) behavioral health service organization based out of Hope, Kentucky). Hope Hill's ministry focuses its resources primarily on foster care and adoption, independent living, and juvenile diversion in-home services). Collaboratively, we will connect children and families affected by the child welfare system to faith-based organizations, using an online platform called CarePortal.

The CarePortal platform (see **Table G.1-3**) allows for basic and complex requests from caseworkers at government child welfare agencies or other child-serving organizations to be submitted online for review by participating organizations. Each request is then responded to by local faith-based organizations participating in the CarePortal. Every response supports foster care children and families in one of nine ways.

Table G.1-3: CarePortal Platform

Support	Preserve	Unite
Improve a child's well-being	Help prevent a child from entering care	Help reunify a biological family
Strengthen a biological family	Help preserve foster/kinship placement	Help place a child in foster/kinship care
Support youth aging out of foster care	Help preserve an adoptive placement	Help unite a child with an adoptive family

Aetna will work directly with the Global Orphan Project and Hope Hill Youth Services to oversee the implementation of CarePortal and ensure our Kentucky SKY enrollees are being supported in a meaningful way. Over time, if the pilot is successful, we will support the overall growth and expansion of CarePortal throughout Kentucky.

Peer Support and HERO Workshops

Peer support and our HERO Workshops are two-day events with multiple youth attendees facilitated by peers who have been trained and supported to lead transition-aged youth through an active process of identifying, engaging, and convening their own networks of supportive relationships. In these networks, the Charting the LifeCourse tools are used by enrollees to organize their circle of support and begin building a community of genuine support.

Figure G.1-5: Aetna Hero Workshop
Aetna hosts HERO workshops to give children and youth in foster care the opportunity to connect with peers.

Across the health, mental health, and disabilities serving systems, the value and evidence for peer-led practices are well established. A key challenge in supporting transition-aged youth in child protection systems has been their choice to leave services and health systems within one year of becoming eligible in most states. At Aetna, we see this as evidence of a need to improve youth engagement in their own building of a good life. **We believe a peer-led engagement and support approach is a powerful strategy for youth engagement.** We will use HERO Workshops across Kentucky to build and sustain a cohort of youth peer leaders to support young people to lead their own process of Wraparound, Charting the LifeCourse, and Collaborative Family Engagement practices. Youth-led, youth-driven, and youth-created LifeCourse trajectory plans are at the center of youth development and engagement.

We anticipate a challenge of current independent living practices that promote a fragmented and disconnected skills development approach to transition-aged youth. We will address the intervention of our innovations using Collaborative Family Engagement tools and training with Independent Living case workers and program staff. One of the ways we address a challenge such as this is by taking an outcomes-based approach to show value (both financial and quality-of-life) at every step of the process.

Trauma-informed Provider Network

Aetna's commitment to implement a trauma-transformed health and social services system in Kentucky is a core capacity building strategy in our Kentucky SKY proposal. Beyond trauma treatment, the Aetna Kentucky SKY system of care will be a trauma-informed model ensuring that youth and families will

receive care from a system that is prepared to respond to their trauma histories with compassion, informed skills, and a focus on trauma transformation.

Aetna welcomes the opportunity to serve the youth and families involved in the foster care, juvenile justice, and post-adoption systems. Aetna stands ready to deliver on a Kentucky SKY system of care that will be holistic, person-centered, values-based, and supported by standards of care that will change the trajectory of children's lives. Aetna has proposed a technical approach, staffing, and organizational structure as well as an implementation plan that demonstrates a full understanding of the needs of the population. The proposal ensures Aetna has the capability to serve these children and to improve their physical and behavioral health through the implementation of a full continuum of care firmly rooted in collaboration.

Aetna proposes at the heart of every practice and model to function as a convener, catalyst, and facilitator through a local, regional, and state governance structure down to individual Wraparound teams to build on the lessons and evidence from models like self-healing and trauma-informed communities to find recovery and restore resilience. **Over the course of the Kentucky SKY contract, our intention is to facilitate strengthened capabilities in Kentucky by having Kentuckians invent it, build it, and do it.**

Our model builds on the strengths of the family and community and we believe trauma is treated in relationships and experiences, not in therapist offices and pharmacies. We also know, however, that clinicians and providers of trauma models will be essential partners in supporting these families and communities. Our proposal capitalizes upon training, education, and working with the National Council on a 12-month learning collaborative with providers. We will verify that from the top of our national organization to individual health plan providers, we are all operating under the same trauma-informed transformation.

We also look forward to a partnership with the Center for Adoption Support and Education, using their certified workforce training model to build critical competencies about the complexities of adoption and foster care into the mental health provider community as well as within the community of foster care professionals. We will implement recognition leveling at the provider level that is measurable, auditable, and monitorable.

We anticipate challenges during the change process; however, our strategy is multifaceted, using complementary core innovations that are by design capacity-building and highly participatory. A high level of competency in understanding trauma and adversity and including this knowledge in practices and programs is critical in moving to a 21st century system of care and support for Aetna Kentucky SKY enrollees.

Summary

Aetna's goal mirrors that of the Commonwealth—that no child will have to be removed from their home due to abuse or neglect. We believe that kids are best raised by their parents, and we are committed to working with the State of Kentucky to advance those goals. However, when tragic events happen and children enter foster care and/or the DJJ system, we commit to doing everything in our power to ensure those children not only have their health needs met, but they have a care coordinator that is fully connected to their loving and supportive caregivers and others in their circle of support; they have access to providers and resources that support them to heal and find hope; and if possible, they are safely reunified with their families. We have learned through experience, practice, and evidence that building on what is strong in our enrollees and partners is more effective than what is wrong. Our model for Kentucky SKY is built on a collection of core innovations that place enrollees at the center of imagining, creating, and living a good life. With Aetna, we are more than a managed care company; we have a model that provides access to resources and holistic care for each child, just as we would wish for our own.

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aetna™

60.7.G.2 Company Background

Kentucky | Transforming Health Care | **Aetna**

60.7.G.2.a Corporate Experience

Improving the lives of Kentuckians through our focus on quality and health outcomes inspires everything we do at Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health® of Kentucky Inc. (Aetna)[1]. For over 30 years, Aetna's Medicaid organization has honed its approach to serving high-acuity, medically frail, and low-income populations with diverse, enrollee-focused benefits. The Aetna Medicaid organization currently serves approximately 2.3 million people in 16 states. In our extensive Medicaid managed care experience, we have served families and children receiving adoption assistance, children in foster care, justice-involved youth, youth in transition, and Affordable Care Act former foster care children.

Aetna has extensive experience in the provision of managed care services similar to those in the Kentucky SKY populations. In the Commonwealth, Aetna has proudly served children and youth in foster care, those receiving adoption assistance, and justice-involved youth and youth in transition since 2011. Aetna's vision is transformative and our model for enhanced care coordination and service integration enhances the care of youth in foster care, adoption assistance, children in transition, and enrollees involved in the juvenile justice system, and wraps around their circle of support.

Aetna understands that each population is unique, with unique service needs, and our local, enrollee-devoted approach focuses on our individual enrollees' holistic health needs. We are fully aligned with the Department's mission to "ensure access to and improve delivery of high-quality, cost-effective health care services." We are committed to collaborating with the Department and other Kentucky agencies, enrollees, providers, and community-based organizations, and we are excited to leverage our local and national experience to provide individualized, quality care and exceptional customer service for enrollees, caregivers, and providers.

Aetna is led by Kentuckians who understand the Commonwealth and its people. **Our Chief Executive Officer, Jonathan Copley, is a fifth-generation Kentuckian,** hailing from Taylor County. Mr. Copley has 16 years of Medicaid experience, having served as undersecretary for the Cabinet for Health and Family Services and in an executive leadership role for a local behavioral health provider.

We recognize that these vulnerable populations should have access to comprehensive benefits covering physical and behavioral health, dental care, and socially necessary services; the highest quality of care; seamless coordination of services to achieve an improvement in wellbeing; and the best health, protective factors, and safety outcomes. This approach promotes resiliency and helps to build upon family and community systems of support, ultimately contributing to reducing poverty, child maltreatment, and their effects.

Our commitment to providing the appropriate care and comprehensive services necessary to meet the unique and diverse needs of this population requires us to engage in the continuous improvement of our established programs. **A key component of our child welfare program improvement effort is seeking expert advice and engaging Kevin Campbell, an internationally known youth permanency expert.** Building upon our experience serving children and youth in foster care, those receiving adoption

[1] For simplicity throughout this proposal, we will use "Aetna" to refer to the vendor, one of its parents, Aetna Inc., and/or any Aetna Inc. subsidiary that has conducted Medicaid/CHIP business or has participated in any other line of business discussed in this proposal. Where clarity dictates differentiating between Aetna entities, we will refer to the entity by name, which will include using Aetna Better Health of Kentucky to refer to the vendor, and Aetna Inc. to refer to one of Aetna Better Health of Kentucky's indirect parents. On November 28, 2018, CVS Health Corporation acquired Aetna Inc. and its subsidiaries, including Aetna Better Health of Kentucky. Throughout the proposal, we will refer to our new ultimate parent as CVS Health Corporation or CVS Health.

assistance, and justice-involved youth, Mr. Campbell works with us to enhance and improve our child and family health strategies, programs, and training curriculum for our staff and providers.

Mr. Campbell is the founder of the Center for Family Finding and Youth Connectedness and developer of the Family Finding model, a set of strategies now utilized throughout the United States and Canada to establish lifelong supports for youth in foster care. Prior to developing Family Finding, Mr. Campbell was an administrator, director, and vice president in the social service sector for nearly 30 years. Mr. Campbell continues to develop strategies to address the epidemic levels of loneliness that youth in foster care experience while waiting for a chance to go home to their relatives or to be adopted.

a.i. Experience Providing Similar Managed Care Services

Aetna has experience providing similar managed care services in nine states (Kentucky, Arizona, Kansas, Louisiana, Maryland, Michigan, New Jersey, Pennsylvania, and Virginia). Additionally, Aetna Better Health of West Virginia is currently implementing the West Virginia Mountain Health Promise to serve approximately 19,000 individuals in the State's child welfare system. Aetna is on track for a successful go-live of first quarter 2020. Please refer to **Section a.ii Aetna Contracts Serving Populations Similar to Those Enrolled in Kentucky SKY** for a count of similarly situated enrollees Aetna covers by state.

Internationally Recognized Consultant Guiding Our Approach

Kevin Campbell (**Figure G.2-1**) is an internationally known youth permanency expert, founder of the Center for Family Finding and Youth Connectedness, and developer of the Family Finding model, a set of strategies now utilized throughout the United States and Canada to establish lifelong supports for youth in foster care. Prior to developing Family Finding, Kevin was an administrator, director, and vice president in the social service sector for nearly 30 years. He has helped over 10,000 youth achieve permanency and continues to help up to 80 foster youth per week through his advanced permanency trainings and technical assistance with agencies nationwide. To date, he has worked with over 200 jurisdictions across over 40 states and Canada.

Figure G.2-1: Kevin Campbell
Kevin Campbell leads a Family Finding Boot Camp sponsored by Aetna Better Health of Kansas.

Children in State custody are among the most vulnerable individuals in our society. They face unique challenges that require our unwavering commitment, collaboration, and compassion. Along with youth in the child welfare system and their families, our integrated Care Coordination teams (CCTs) create holistic, person-centered care plans focused on evidence-based best practices, trauma-informed care, and social determinants of health that result in a positive impact on each child's life. Every day, Aetna aims to achieve safety and permanency for children, reduce psychotropic medication use, and improve health outcomes for these youth. In our experience with children, youth, and young adults, we have identified several core elements to a person-centered, integrated care coordination approach:

- Collaboration with schools to ensure we are fully supporting a child's individualized education program (IEP) and addressing any gaps in care that support both the school and the child
- Referrals to Head Start for children under the age of five for enhancement of the child's cognitive, social, and emotional development; monitoring progress of children in Head Start
- Monitoring and tracking all enrollee care and service providers to ensure service continuity and prevent placement disruptions and addressing barriers that may impact permanency
- Collaboration with the primary care providers (PCPs)/medical health homes, foster parents, and others to ensure timely completion of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including well-child visits, dental visits, and immunizations

- Family and caregiver support (from birth parents, siblings, or other family members) to make certain that all families have access to needed services and information so they can make informed decisions about the child they are caring for, thereby ensuring each child receives the love and care they need.
- Collaboration with child welfare agencies, criminal and juvenile justice systems, community service organizations, targeted case management agencies, educational systems, and community-based provider organizations to develop initiatives with community-based organizations to improve accessibility, close health care gaps, promote health literacy, and address the social determinants of health.
- Collaboration with community service organizations and educational systems to connect children with hobbies or extracurricular activities such as sports and outdoor activities, which can teach them lifelong habits to keep them physically and mentally fit, promote healthy ways of dealing with stress, avoid trouble, and encourage well-being.

Collaboration with Schools

We collaborate with schools to make sure we are fully supporting a child's IEP and addressing any gaps in care that support both the child and the school. We will attend IEP reviews and invite school personnel to our monthly care planning meetings with enrollee and caregivers. To enhance coordination we will visit enrollees and IEP providers onsite at school.

We will seek to collaborate with educational systems to connect children with hobbies or extracurricular activities such as sports and outdoor activities, which can teach them lifelong habits to keep them physically and mentally fit, promote healthy ways of dealing with stress, avoid trouble, and encourage well-being.

a.i.a. Experience Coordinating and Providing Trauma-Informed Services

Aetna's system of care approach provides evidence-based, trauma-informed treatment and recovery services**.** Aetna has learned that many Kentucky SKY enrollees have had trauma in their lives and are best served to receive all aspects of their care from a trauma-informed perspective, including from Aetna staff and our provider network. According to the most recent report from *Child Trends*, 53 percent of children in Kentucky have experienced at least one adverse childhood event; this is the second highest rate in the nation, following Arkansas. Aetna understands that trauma is often a part of our enrollees' history and has incorporated a trauma-informed system of care into its integrated care delivery model. We know that adult outcomes associated with ACEs include increased risk for heart disease, diabetes, obesity, cancer, intimate partner violence, depression, smoking, substance abuse, and early death. In alignment with the Kentucky State Health Improvement Plan, 2017–2022, Aetna's system of care includes trauma-trained care managers and a network of providers that includes providers providing trauma-informed services. Where there are gaps in the network, Aetna provides training for providers to ensure at-risk youth have access to trauma-informed services. We meet enrollees and those who support them where they are on their journey.

Approximately 3,000 Aetna Medicaid organization staff have received foundation trauma training since 2018.

Children are traumatized by separation and loss when removed from their natural family. As children in foster care have already experienced trauma, our CCTs take special care not to re-traumatize them and understand the importance that failure to acknowledge trauma may lead to further challenges as children enter adulthood. This begins by recognizing and respecting the attachments children form with their parents and other caregivers. Aetna works proactively to provide services and support to children and their families. In some situations, particularly when in imminent danger, the child welfare agencies may need to move a child to a different placement. Aetna's goal is to prevent such situations by proactively providing ongoing support and services to a child and family to facilitate a successful and loving

environment. Only if it is in the best interest of the child and he/she must be moved, we establish a transition plan for the child, developed with the child's age and attachment needs in mind, as well as the depth of the child's attachment to the foster parents and foster siblings.

Our interdisciplinary CCTs act as a resource for both enrollees and all participants of the Kentucky child welfare system of care, including community organizations, family support, and foster care providers. This step helps to coordinate collaborative services and promotes access and continuity of care. Our local and community-based team has a knowledgeable team of social workers, registered nurses, and counselors who have a wide variety of expertise, including experience caring for youth (sometimes lived experience), and who are fully trained to assess a comprehensive profile of each enrollee. We ensure that our care coordinators understand the impact of Adverse Childhood Experiences (ACEs) and the importance of creating an environment of safety that does not cause re-traumatization. We apply trauma-informed standards and our training emphasizes the roles and responsibilities of the Department and other children's services agencies and those of foster parents in making decisions on behalf of children in foster care. In addition, the Aetna team is trained in advanced coursework on trauma-informed care, Mental Health First Aid (MHFA), the fundamentals of development, including age-appropriate and stress-related behaviors, adolescent substance use, and permanency training. We have trained approximately 3,000 staff in foundation trauma training across the Medicaid segment since 2018. Some of the topics include the following:

- Defining trauma
- Prevalence and impact of trauma and ACEs
- Building resiliency and hope for recovery in the face of trauma and self-care
- Introducing trauma-informed care
- The importance of trauma-informed care for the populations served by the Aetna Medicaid organization
- Four assumptions of trauma-informed care
- Six principles of trauma-informed care
- Application for staff and enrollees

Connecting Enrollees to the Right Services Using a Trauma-informed Lens

"Amanda's" life is a struggle. She suffers from mental health issues and experiences ongoing, invasive memories of trauma, anxiety, and heightened reactions to everyday events. Amanda is enrolled in Aetna Medicaid organization services, but she does not participate regularly in outpatient care. She is not enrolled in care coordination or health care services in her local community and has been accessing the emergency intake department at a local behavioral health facility for her care needs. Amanda accessed the behavioral health facility twice in the past few weeks for problems related to her anxiety and trauma but was not admitted. On the third visit, the facility social worker contacted Jennifer, an Aetna intensive care manager, to collaborate on how to connect Amanda to outpatient care, and to share information about Amanda's presentation at the emergency room. The facility social worker participates in Aetna's trauma-transformation learning collaborative—an Aetna-led initiative that includes collaboration between Aetna and their providers to increase to train staff on understanding the impact of trauma on health, recognizing trauma symptoms, and how to screen, assess, and refer to trauma-informed providers. Based on her understanding and training, the facility social worker recognizes Amanda's trauma symptoms through use of a trauma screener. She explains that Amanda is not following up with outpatient physical health care due to her fear and likelihood that it will trigger invasive memories and further anxiety. The Aetna care manager coordinated efforts to enroll Amanda in Aetna care coordination services and offered several referrals for physical health care to a trauma-informed medical home provider who can meet both Amanda's physical and behavioral health needs. This success relied on the partnership and collaboration of several different departments within the health plan along with support from the local facility. Amanda received compassionate, integrated support for her health needs, and is now actively participating in the care she needs to continue her journey of recovery and building resiliency.

Aetna looks forward to collaborating with the Department to ensure children in out-of-home placement are screened for adverse childhood experiences and behavioral health needs and are connected to providers using trauma-informed treatment practices. We are committed to offering MHFA and trauma-informed care training to our providers and community-based partners.

Educating Providers on Trauma-informed Care, ACEs, and Evidenced-based practices: Throughout the Aetna Medicaid organization's 30 years of managing Medicaid provider networks, we understand the importance of training and education as the foundation that gives providers the tools and resources they need to serve our enrollees.

Through ongoing communication, assistance, guidance, and expertise gathered over the course of our experience in Kentucky and across plans nationally, we continuously develop, reinforce, and retain long-term relationships with providers. We understand that providers are our most valuable service delivery assets. Our job is to empower them by providing education, assistance, and the resources needed to achieve quality enrollee engagement.

Aetna Kentucky SKY Model two-week intensive training: The purpose of a two-week intensive training for the Kentucky SKY program is to prepare Aetna staff, including Kentucky SKY CCTs, to implement our program infrastructure and engage Kentucky youth and families involved in foster care, juvenile justice, and post-adoption systems in person-centered care planning. Consultants, the Kentucky SKY training director, parent and peer partners, Aetna department leads, network provider leads, and referring department trainers will complete the two-week program. The training director will have recruited and launched the training collaborative 60-90 days prior to the two-week intensive. Participants will have agreed to and collaborated on curriculum they will train on during the two-week intensive. The parameters for this initial two-week intensive will be designed and offered in collaboration with the Department, Department for Community Based Services (DCBS), and Department of Juvenile Justice (DJJ), among other key system partners. This training will also be offered as training and education for law enforcement officials, the courts, judges, attorneys, group home providers, and foster care licensing agencies.

Aetna offers several provider trainings and educational opportunities to our integrated providers in order to increase overall knowledge and better serve our vulnerable enrollees such as children and youth in foster care, those receiving adoption assistance, and justice-involved youth. Our training and educational opportunities on trauma-informed care, ACEs, and evidence-based practices give providers the information and tools they need to serve our enrollees efficiently. To allow providers to take full advantage of our training resources, we provide multiple training venues, both electronic and leader led.

Aetna is collaborating with the Bounce Coalition, based in Louisville, to help build children's resilience to toxic stressors and keep our children thriving throughout their life. This collaborative will work with the coalition as they move to educate rural communities on ACEs. Bounce's goal is to develop a trauma train-the-trainer program to create a system of self-sufficiency.

Examples of educating providers on trauma-informed care, ACEs, and evidenced-based practices: Mercy Care, a Medicaid managed care plan administered by Aetna in Arizona, provides behavioral health services to all children and adolescents in foster, adoptive, and kinship care. Mercy Care works to connect them, and the families who have opened their homes and hearts to them, with high-quality care. To achieve this goal, Mercy Care works directly with community provider agencies, the Department of Child Safety (DCS), and the Comprehensive Medical and Dental Program (CMDP), the health plan responsible for ensuring, in partnership with foster care providers, the provision of appropriate and quality health care services for the well-being of Arizona's children in foster care. Mercy Care implemented focused initiatives providing education and training to DCS, foster care providers, adoptive parents, kinship

placements, group home providers, caregivers, attorneys, foster care licensing agencies, and biological families. In collaboration with DCS Office of Licensing and Regulation (OLR), Mercy Care offers online technology-based trainings. Mercy Care offers the following trainings and forums to various stakeholders and community groups throughout the State:

- **Foster Care Behavioral Health Navigation Forum:** This monthly forum invites foster, adoptive, kinship, and group home caregivers to learn about the behavioral health services available to children and youth in foster and adoptive care. Available to be viewed online through YouTube, this presentation is used by agencies to train and orient staff or foster care providers. The presentation is available in Spanish and English. Navigation Forum has become a regular part of the Arizona's Children Association Kinship Monthly Training provided for DCS kinship out-of-home providers new to that role. Through collaborative efforts as part of the Pinal County Juvenile Justice System's Strategic Planning Committees, Mercy Care has provided Pinal County Juvenile Court leadership with access to Relias trainings, and plans are in place to make that training available to stakeholders involved in the crossover youth project.
- **Foster, adoptive, and kinship training series:** This three-part monthly training series covers an overview of trauma-informed care, trauma-informed care birth to age 5, and trauma-informed care strategies and techniques. As a result of feedback, expressed needs, and interests of the caregivers attending the Foster-Adoptive Trauma-Informed Care training series, Mercy Care continues to add or modify trainings and make them more accessible. Mercy Care continues to take a significant role in the development of the DCS SAFE-Model training for behavioral health and DCS providers. Mercy Care requested that all provider staff that have contact with children and families to complete the online DCS SAFE-Model and that the training be provided to all new staff hired by providers as part of their onboarding process.
- **Child and Family Advisory Partnership (CFAP) Community Forum:** Connects foster, adoptive, kinship, and group home caregivers to what is happening in the local behavioral health community and provides the ability to talk directly with providers. Attendees are encouraged to share ideas on how to improve the children's system of care. Dinner, Spanish interpretation, and childcare are provided.
- **Training for youth transitioning through the DCS Welcome Center:** Mercy Care collaborated with DCS Welcome Center leadership to design ongoing training and support tools that assist Welcome Center staff in meeting the needs of youth transitioning through the Welcome Center. In addition to Mercy Care providing support to the Placement Unit staff in working with providers to meet the specialized needs of youth who are struggling with placement stability, training will be developed to support the Placement Unit to assist in understanding the behavioral health support that can be offered for youth and how to reach out to obtain services and supports through the Child and Family Team process.
- **Sex Trafficking 101:** In collaboration with Arizona law enforcement, Mercy Care made significant efforts to expand initiatives both within Maricopa County and statewide by providing several Human Trafficking Project trainings throughout Arizona; **more than 880 people were trained between July 2018 and June 2019**. Attendees were representatives of the following stakeholders: foster/adoptive/kinship caregivers, DCS group home providers, law enforcement, family advocacy centers, hospitals, DCS staff, behavioral health providers, judges, court staff, juvenile probation, attorneys, and others. Trainings included presentations during statewide conferences.

Cindy McCain was the keynote speaker at the Medicaid Health Plans of America Annual Conference on September 2019. Ms. McCain spoke about the collaborative efforts in Arizona among Mercy Care (an Aetna-administered Medicaid managed care plan), the Phoenix Police Department, Arizona State University, and other local stakeholders to combat human trafficking. In doing so, this collaborative is being shared with Medicaid health plans and managed care stakeholders across the country. Mercy Care's program received recognition from Ms. McCain and the Governor's Office as a Best Practices Model.

  - In partnership with the Phoenix Police Department, Mercy Care is in the process of providing training to all DCS offices on Human Trafficking and the Human Trafficking Collaborative Protocol, which also provides training on meeting the complex behavioral health and support needs of this population.
  - These trainings have significantly supported the referral of youth to the collaborative as indicated by the increase of referrals from participants of the trainings. The services and supports from a trained and committed provider network as assisted in the development of stable, supported placement options for youth, dramatically decreasing the number of youths enrolled with CMDP that go absent without leave to less than 10 percent.
- **Onsite community trainings for group home and foster care providers:** Mercy Care Children's System of Care and Learning and Performance department have partnered with the DCS OLR to work with DCS group home providers to offer core training opportunities online through Mercy Care's Relias Learning Management System training contract.

a.i.b. Initiatives Supporting Improved Outcomes

Aetna serves thousands of children, youth, and young adults similar to the Kentucky SKY population in Kentucky and in Arizona (via Mercy Care, a health plan administered by Aetna). Each health plan has developed local best practice initiatives to serve this vulnerable population and demonstrated sustained improvements in enrollee outcomes (health outcomes or social outcomes such as family reunification) associated with cost-efficiency.

Example 1: Kentucky's Six Points of Care Program

Aetna has developed a model of care for children, youth, and young adults that will be served through Kentucky SKY. To ensure that all children are provided with excellent care, Aetna adopts the following Children Defense Fund's recommendations:[2]

- At-risk young people fare best when they are raised in families that are equipped to either meet or understand how to assist them to meet their holistic needs, including addressing physical and behavioral health conditions, and supporting function and unmet social resource needs. For example, Aetna understands that the EPSDT benefit can help equip families to care for abused and neglected children in foster or kinship care and adoption assistance programs by giving them access to the range of physical and mental health services they need. We include linking enrollees to EPSDT services when their unique needs indicate that is would help improve their health and wellness or prevent a potential risk from worsening.
- Young people who age out of foster care are eligible for Medicaid to age 26, and Aetna supports their access to care as they transition into young adulthood and pursue school and work.
- Children's health and development depends on their physical environment, their family situation and personal relationships, and their unmet social needs. Aetna plays an important role in meeting enrollees' whole person needs and in supporting families/parents' health needs to strengthen families. For example, for Kentucky SKY youth, parental access to mental health and substance use disorder treatment through Medicaid can help to alleviate health needs that can lead to children being placed in foster care.

Within our Kentucky SKY care team, we employ Aetna's **Six Points of Care** approach aimed at engaging, assessing, and meeting the needs of children that face multiple challenges by building an interdisciplinary team composed of professionals from different areas of specialization each enrollee focusing on a particular subpopulation. These include the following:

- Behavioral health conditions

[2] Children's Defense Fund, "Medicaid Matters for Children in Foster Care," (2018); https://www.childrensdefense.org/wp-content/uploads/2018/06/child-welfare-and-medicaid.pdf: Accessed June 14, 2019

- Medically complex conditions
- Adoption assistance and foster care children and youth
- Aging out/transition
- Neonatal abstinence syndrome
- Juvenile justice

Early on, Aetna identified the benefits of proactively outreaching children, youth, and young adults involved in care. Children that are deemed medically complex by the state or an infant with a diagnosis of neonatal abstinence syndrome are paired with an Aetna registered nurse care manager and placed in complex care coordination. Children with a behavioral health diagnosis or claims are paired with an Aetna licensed behavioral health care manager. All six of the categories of children served in this program are supported with regular care management and care coordination by their interdisciplinary care team. Upon being eligible with Aetna, the DCBS social services worker and foster parents are outreached, and the health risk assessment (HRA) and an Aetna proprietary Foster Care Assessment is completed. In an integrated, person-centered planning process, where the child and their family act as the lead participants, each child's unique whole person needs are assessed, prioritized, and addressed as quickly as possible. To increase coordination of care, when applicable and if desired by the child or their family, a member of the Care Management team attends face-to-face meetings with PCPs, specialty physicians, and counseling sessions. For example, they accompany pregnant young women to appointments at treatment facilities for expecting mothers with a history of substance use. With Aetna's Six Points of Care, we assist with covering and caring for all the child's needs (please refer to **Figure G.2-2)**.

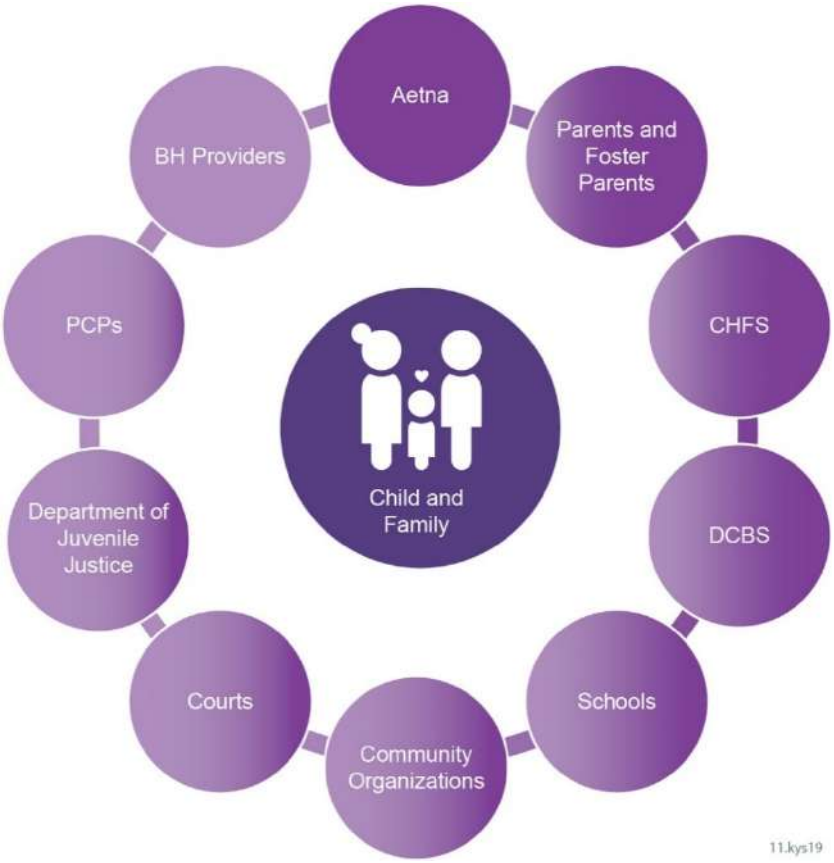

Figure G.2-2: Supporting At-Risk Children, Youth, and Young Adults

Aetna supports the young people served in our Six Points of Care model through collaboration with a full range of health care providers, social services, and other system stakeholders.

Being proactive in our outreach has ensured all individuals working with the youth and associated stakeholders have a single point of contact at the health plan. This is a resource of support for DCBS social workers, DJJ workers, or foster/adoptive parents who may experience a barrier to their child receiving care. For example, a foster parent had difficulty getting a medication filled because the previous

placement did not send the medication with the child, and it was too soon for a refill. Because Aetna outreached the enrollee's foster parent, they called the health plan for support and were able to receive the medications timely. With this relationship built, we can provide support and advocate to ensure there is no treatment disruption. Additionally, we remind DCBS social workers, DJJ workers, and/or foster/adoptive parents of any gaps in care, to ensure enrollees get the care they need. This has led to improved HEDIS outcomes, but most importantly, youth are getting the care they need.

Aetna has developed numerous interventions that align with the Six Points of Care model to better serve enrollees in the youth and family welfare system, including the Kentucky programs described in **Table G.2-1**:

Table G.2-1: Aetna Programs and Initiatives for Children, Youth, and Young Adults in Kentucky

Program	Description
Kentucky Family Safe Zone	This program provides children a safe place to stay while their parents or their parents/guardians attend court hearings.
Exploited Children's Help Organization (ECHO)	Aetna partners with the community-based organization that works to reduce the impact of child abuse. Aetna sponsors a children's room in the Louisville courthouse. The room is designed as a children's environment and provides children with a safe place to play while their caregivers attend court proceedings. Without this room, many children either must sit in the courtroom or listen to the court cases or their parents/guardians will miss court all together because they do not have anywhere to send their children.
Aetna Points of Care Duffle Bag Program	This program provides basic necessities for children as they come into the foster care system. Kentucky has 500 bags targeted at kids ages 8 through teenage years (over half of their 5,300 foster care children are teenagers). The duffle bags include a water bottle, shampoo, conditioner, toothbrush, toothpaste, hairbrush or comb, body wash, fleece blanket, and comfort and stress reduction items (journals, coloring books, colored pencils, stress balls, and fidget spinners).
Aetna Birthday Box Program	This program recognizes children's birthdays (focuses on medically fragile and transition-age children that would otherwise not be acknowledged). Each child receives a "birthday in a box" that includes party supplies (paper goods, minimal party decorations), balloons, book/journal, puzzle/game, and a large cupcake. The Birthday in a Box is arranged and delivered by the foster care manager.
Health Literacy Program	Aetna's health literacy program for foster youth is called Getting on T.R.A.C.K. This program provides budgeting and basic life skills for children that transition out of care. The courses are taught in partnership with organizations that deliver different components of the curriculum.

Example 1 Results: Aetna's Six Points of Care program leads sustained improved health outcomes for our foster care children. **Table G.2-2** demonstrate Aetna's Healthcare Effectiveness Data and Information Set (HEDIS) measures for foster care children that have remained above the national benchmark (at the 50th percentile) for each of the past three years. In addition, our 2018 Antipsychotics in Children and Adolescents rate was 0.03 percent, compared to 2.09 percent for the national benchmark (note: for this measure a lower percent is considered favorable.) **Tables G.2-3 and G.2-4** indicate Healthy Kentuckian HEDIS (2018) measures for which Aetna's Six Points of Care model contributes to more positive outcomes for our foster care population than our general enrollee population or all children, respectively.

Table G.2-2: Sustained Outcomes for Foster Care Children

Measure	Aetna 2017	2017 National HEDIS Benchmark	Aetna 2018	2018 National HEDIS Benchmark	Aetna 2019 Foster Care	2019 National HEDIS Benchmark
One dental visit: 2-21 years	75.7%	54.9%	75.8%	56.6%	66.3%	58.0%

Measure	Aetna 2017	2017 National HEDIS Benchmark	Aetna 2018	2018 National HEDIS Benchmark	Aetna 2019 Foster Care	2019 National HEDIS Benchmark
Enrollees with one or more well-child visits: CAP 25 months – 6 years	95.1%	87.9%	93.4%	87.5%	95.1%	72.8%
Children's access to primary care: CAP 12-19 years	94.8%	89.5%	94.8%	89.6%	94.5%	90.2%
Comprehensive well-care visit with a PCP or an OB/GYN: 12-21 years	55.4%	50.1%	56.4%	54.6%	49.0%	54.3%
Children's access to primary care: CAP 12-24 months old	100%	95.7%	96.3%	95.7%	97.2%	95.6%
Children's access to primary care: CAP 7-11 years old	91.7%	90.7%	95.3%	90.7%	97.0%	91.0%

Table G.2-3: Aetna Foster Care HEDIS Score Compared to the Membership as a Whole, Kentucky 2019

Measure	Foster Care Score	Population Score	Percent Difference
One dental visit: 2-21 years	66.3%	62.2%	6.5%
Enrollees with one or more well-child visits with a PCP: 3-6 years	72.6%	67.9%	6.9%
Comprehensive well-care visit with a PCP or an OB/GYN: 12-21 years	49.0%	48.9%	0.2%
Enrollees with a visit with a PCP: CAP 25 months - 6 years	95.1%	92.2%	3.1%
Children's access to primary care: CAP 7-11 years old	97.0%	95.9%	1.1%

Table G.2-4: Aetna Foster Care HEDIS Scores Compared to All Children, Kentucky 2019

Table Column Heading	All Foster Care Enrollees 2019	All Child Enrollee HEDIS Administrative Rates 2019	Percent Difference
Chlamydia Screening: 16-20 Years	52.2%	47.4%	10.1%
Comprehensive Diabetes Care – Eye Exam	50.0%	41.5%	20.5%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutrition Counseling	24.1%	21.2%	13.7%
Asthma Medication Ration – Total PD 50	90.9%	71.1%	27.9%
Childhood Immunization Status – Hepatitis B	81.4%	74.8%	8.8%
Childhood Immunization Status – Combo 4	50.0%	43.3%	15.5%
Initiation and Engagement of AOD Abuse or Dependence – Other drug abuse or dependence: Initiation of AOD Treatment: Total	58.4%	42.5%	37.4%

All the positive outcomes for our enrollees similar to the Kentucky SKY population are also associated with the delivery of cost-efficient care.

Example 2: Supports for Vulnerable Youth in Arizona

Mercy Care, an Aetna-administered Medicaid managed care plan, established initiatives to provide wraparound supports to foster care children and justice-involved youth in Arizona to increase the penetration rate of behavioral health services and decrease the number of children in out-of-home placement. For both initiatives, Mercy Care increased emphasis and expectations for trauma-informed care and regular trauma assessments. Mercy Care required all youth who were in child welfare programs to have at least one assessment per year, with a minimum of one trauma-informed contact each month. This allowed for a proactive approach so that services and supports could be put in place at the onset of any concerns identified by the caregiver prior to it becoming a crisis.

Initiative 1: Increasing the Penetration Rate of Behavioral Health Services

Mercy Care worked together with DCS child welfare specialists to identify youth that were receiving foster care services and not active in behavioral health treatment. Mercy Care coordinated engagement and outreach so that an intake was offered to the caregiver and youth with a local behavioral health provider. Throughout the care coordination process, Mercy Care staff met with child welfare specialists to review caseloads and identify youth that are eligible, as well as review the youth in shelters and group homes to identify if they were engaged in behavioral health services including care coordination, behavior coaching, and/or therapy. When a youth was identified as not being connected, outreach was completed by direct care providers to the caregivers for engagement.

Each month, Mercy Care compares the list of youth removed from child welfare against the children and families that had a Rapid Response Assessment[3] completed and identifies children and families who may have been missed. For any children and families that were not offered an assessment, Mercy Care conducts outreach and engagement activities. Mercy Care tracks all children and youth from the rapid response assessment to ongoing services to monitor that youth were engaged in behavioral health services. This allows both Mercy Care and DCS to feel confident that all children that are placed in child welfare are connected to behavioral health services and receiving ongoing trauma-informed services and supports to help them through their family's journey while they are involved in child welfare.

Results of initiative 1: This Mercy Care initiative resulted in sustained improvements in service delivery for this vulnerable population. For example, the child welfare behavioral health penetration rate was 39 percent in 2014, increased to 69 percent in 2015, and has stabilized at around 78 percent since 2017, indicating a penetration improvement of 100 percent.

Initiative 2: Reducing the Number of Children in Out-of-home Care

Mercy Care developed a plan to increase the number of youths in foster care closing out of DCS and foster care services, to reflect completion of their treatment goals, family reunification, or establishing permanency in a foster placement or through adoption. Mercy Care's goal was also to decrease children's time to permanency and stability by working aggressively with youth and their families to complete their care plan goals, inclusive of behavioral health treatment needs. The steps Mercy Care took to accomplish this include the following:

- Mercy Care increased collaborative efforts with DCS and local providers, which led to an increase in family reunification after their completion of their behavioral health service needs. All families that chose to continue with Arizona Health Care Cost Containment System eligibility were offered

[3] Rapid Response is an assessment completed within 72 hours of removal where the child and family participate in a comprehensive trauma-informed assessment and education is provided to the caregiver.

continued services after reunification to offer support during the transition and address ongoing behavioral health needs.

- Mercy Care increased emphasis and support on adoption program efforts and assisting parents with increasing the efficiency of the guardianship process. This process led to placement permanency, which was a primary reason that youth in child welfare achieved permanency before one year.
- Through the Mercy Care-DCS Collaborative, Mercy Care discussed and focused on provider efforts to engage biological parents and relatives into activities and treatment to address the reasons why their child (or children) was removed. Mercy Care has created programs and processes to have family support partners (parents with lived experience) engage biological families early in the process, or as soon as DCS is involved, to create a bridge to outreach and draw those parents into the reunification process early. Discussions through the collaborative and through regular educational and training efforts with providers focus on engagement and reunification efforts being made as part of the care planning process.
- Mercy Care implemented efforts to increase the provider competency and capacity to meet the needs of younger children and their parents or other caregivers, while supporting the goals of safety and permanency.
- The development of the 'no wrong door' policy allowed family support agencies to directly enroll biological families that have children in the child welfare system into their services. This initiative removed barriers to access to care by allowing clients to quickly and easily seek out services and enroll in treatment services. This policy has increased the use of family support partners to provide additional support to foster parents and biological parents.
- Mercy Care recognized that early engagement of the child's biological family when their child is removed is essential to a successful reunification process. In order to accomplish this goal, Mercy Care's providers who were co-located with the DCS sites partnered with family-run organizations and their own family support partners to implement a process that would connect with youth's family/caregiver at time of removal. The family support partner would begin engagement of the biological family and to provide support for the families' identified needs. The goal is to reunify the youth with their family and reduce the time the youth is in care under the DCS.
- Mercy Care's collaboration with Jewish Family and Child Services developed the Family Center of Excellence. The Family Center of Excellence is located in an area where there is a high volume of youth being placed in DCS custody. The goals of this program are to provide support to both the youth and their families in order to prevent placement in the DCS system or to help support the reunification process and decrease the time a youth is in DCS care for those youth who are already in DCS custody.

> Mercy Care's efforts to expand the use of family support partners through initiatives such as 'no wrong door,' which allows family support agencies to directly enroll youth in the custody of DCS in their services, have been very successful. A 39% increase in family support to engage out-of-home foster parents and biological parents has been a significant step in supporting stable, more permanent placements for youth. Biological parents are being engaged at a higher rate, which supports parent recovery and decreasing time to family reunification.

Results of initiative 2: Mercy Care began serving more than 12,000 children and youth in foster and residential care in 2014. Between 2014 and 2019, the number of children and youth in out-of-home care has safely reduced to 8,000 and continues to fall. Assisting foster care children to move on from child protection, preferably back to their birth families if possible, results in cost savings to the State. Mercy Care estimates that the reduction in children and youth in foster care and out-of-home placements contributes to a savings **of over $3.5 million per year to the state Medicaid agency**.

Example 3: Mercy Care Plan Co-location with Juvenile Justice

Mercy Care established an initiative to co-locate dedicated health plan staff within the county juvenile department as the first point of identification and diversion for detained juveniles enrolled in or eligible for Mercy Care services. The following initiative were put in place to make certain planning is occurring and that needs are identified prior to being released from detention.

Mercy Care employs two master's level clinicians to serve as juvenile justice liaisons (JJLs) within the Juvenile Justice Engagement Team (JJET). JJET staff, co-located with Maricopa County Juvenile Probation, act as first point of identification and diversion for detained juveniles and functions as a liaison to the range of justice stakeholders: DJJ, juvenile probation, law enforcement, the courts, legal advocates, county attorney, and court-appointed special advocates. The JJL partners with regional care coordinators, participates in the wraparound treatment team, attend court hearings, and assist eligible youth enroll in behavioral health services. This justice-focused staff is experienced working at the intersection of the legal, justice, systems, health care, and child welfare systems, and provide technical assistance to key stakeholders regarding processes on how to navigate through the behavioral health system.

All referrals to JJET are initiated by the juvenile probation officer (JPO) to determine behavioral health eligibility and rapidly initiate needed behavioral health services. If a child is placed in DCS custody, a Rapid Response referral is initiated. Once a referral is made, the following occurs:

- Initial case meeting (DCS specialist and JPO) held within 5 working days
- Discuss the crossover case to ensure exchange of all relevant case information regarding the child and family
- Develop the 5-Day Discussion Guide to provide consistency and uniformity in the type of information shared, gathered, and exchanged
- JPOs include the Mercy Care JJET in all information exchanges
- Initial monthly crossover team meeting with the child and family at the conclusion of the initial meeting
- All crossover meetings are designed to ensure families, probation, DCS, Mercy Care, education, and other service providers share information and collaborate to keep families engaged and connected to care and track with services, resulting in better outcomes for families

Crossover team meetings and planning are guided by the Crossover Youth Practice Model Family Plan for Success. This plan tracks progress on goals, new information related to the case, new court orders, updates on parent and/or child's progress on identified behavioral changes, treatment or other services, results of substance abuse tests for child and/or parent, and any other family's concerns, barriers, or needs. The team will collaboratively identify ways to resolve the concerns, barriers, and needs and develop a joint court recommendation for the child's services and placement. Lastly, there will be a review of upcoming meetings, court hearings, and appointments to avoid duplication. Presiding judges are very complimentary of this model as it provides real-time information, which informs their decisions and provides confidence that all children will be connected and served by a community-based provider.

Example 3 Results: From the beginning of the JJET program, the percentage of children who are both served through the foster care and juvenile justice system whose disposition was diversion as opposed to probation increased by 37 percent from 9.5 percent to 13 percent.

a.i.c-d. Lessons Learned Serving Similar Populations and Approach to Implementation in Kentucky

The Aetna Medicaid organization has learned from operating in multiple states that our ability to be agile and flexible is key. **We listen. We learn. We change.** Aetna is experienced in working with our state government, local provider network, and provider associations to meet the unique needs of child, adolescent, and young adult populations, as well as the diverse treatment needs and diverse geographic

locations in which services are needed. Our experience serving foster children and youth in other states as well as in Kentucky, strengthened by the information we have obtained in discussions with our local community advocates and providers, has helped us to understand what the vulnerable youth population, their families, and caregivers need from their providers.

Comprehensive Services Guided by a Person-Centered Care Plan

Aetna has learned that youth should have access to a comprehensive array of services across life domains that address physical, emotional, social, and educational needs, guided by an individualized service plan. Aetna is committed to ensuring the integration of personal goals into the care plan and as a result we focus on the needs of the youth rather than the needs of the service system. Kentucky youth should be empowered to have their own views on what is best for them and their own priorities in life. Aetna has learned we must be flexible to meet the needs of enrollees and to make our system suit them, rather than the other way around. Youth should be an equal partner in the planning of care and know that their opinions are important and are respected. Traumatic histories, disability, and mental health conditions make this communication of goals and priorities challenging, so Aetna has learned that we have to engage youth to ask them what they want, using appropriate communication methods to actively encourage them to participate in their own care and to be real partners in the decisions that are made. To do this, Aetna makes sure to get the information that is needed to help them and their supports make decisions about their care and treatment. Services are to be provided in accordance with the unique needs and potentials of each youth and guided by person-centered care plan. Our experience serving at-risk youth in Kentucky, and through our Medicaid plans, taught us about the importance of person-centered, culturally sensitive care that truly places the enrollee at the center of their care planning process.

> "We have always valued our relationship with Aetna and really look forward to continuing to innovate together. Aetna has been a willing partner in KVC Health System's efforts to provide safety and well-being for children and families in our community, supporting our development of a specialized Therapeutic Support Foster Care Program to avoid youth entering higher levels of care to successfully stabilize and reunify youth into a home seeing as timely as possible.
>
> KVC has a rich 20-year history of service provision in Kentucky and our work with the children and families of Kentucky is enhanced by collaborative partnerships like we have with Aetna. We value dignity, respect, honesty, and integrity and deliver our innovative and effective services in a culturally sensitive manner, respectful of a child and family's strengths and values. Aetna has been a mutual partner in achieving these goals."
>
> **—Gina Klyachkin**
> **CEO and President, KVC Kentucky**

Application to Kentucky SKY: Infants, children, and adolescents placed in foster and residential care may have experienced substantially more childhood adversities across critical periods of development than any other group of children in America as a group, according to the American Academy of Pediatrics. The impacts of more than three adversities in the first three years of life are well understood in science today. In addition, we know today how various types of adversities, when combined, may raise the risks for poor outcomes in adulthood and across the life course when unrecognized and untreated. Aetna offers enrollees a comprehensive assessment of early life adversities and resilience factors to assist in effectively implementing our Charting the LifeCourse™ model for recovery and living a good life.

Aetna will use the LifeCourse™ model to help us build our person-centered thinking, planning, and living culture. Aetna's care coordination model for youth in foster care and DJJ is a specialized, person-centered, biopsychosocial approach based on the LifeCourse™ framework, as well as other national evidence-based best practices and self-determination tools, along with a coordinated network of physical, behavioral health, and community service providers. We start early, supporting and engaging pre-adolescents in the development of soft skills that will form the foundations to independence and help

them to understand the choices they can make as their formal transition plans are developed. We support them through their transition to exiting care and through adulthood as Kentuckians. Youth who are facing aging out of the child-welfare system have potentially the biggest opportunity and the biggest challenge of their young lives. Many have spent all their years in foster care or in out-of-home placement and have developed few skills that set them up to successfully live independently. Through our comprehensive care management program, we will aid them in their transition and identify community resources available to assist them in transitioning into adulthood. We will work with all youth, even when not in foster care, to transition smoothly through similar challenges to independent care or when transitioning off our health plan.

Integrated Service Delivery

Aetna recognizes that youth should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services. Due to the large percentage of young people who will be served by Kentucky SKY that have co-occurring behavioral health and/or substance use treatment needs, person-centered models that incorporate behavioral health, primary care services, and functional and social risk needs (e.g., housing, education, including food security, housing/utilities challenges, transportation needs, and interpersonal safety, etc.) are integral to improving the lives of Kentucky SKY enrollees and their families in Kentucky.

Application to Kentucky SKY Program: In addition to the principles of the LifeCourse™ framework, the core of our strategy for Kentucky SKY enrollees is our integrated system of care model and integrated care management program, which includes predictive analytics and a focus on prevention and wellness in addition to caring for enrollee's acute needs. Aetna's integrated system of care forms the foundation and collaborative structure necessary to support enrollees with the most immediate services needed to achieve their vision of a good life. The model is based on the identified needs of the community, the state, Kentucky SKY enrollees, and the overall population of Kentucky. We will seek to understand each enrollee in the context of their lives, their environment, and their genetics, while co-facilitating a holistic model of supports and services that enhances their quality of life and assists them to reach their individual goals. Our innovative integrated system of care approach is based on a whole-person view of our enrollees' physical health, behavioral health, oral health, health literacy, functional needs, and social determinants of health. Aetna's integrated system of care will focus on meeting enrollees' needs and goals by wrapping around them with Aetna covered services, their circle of support, and community-based support while focusing on cultural sensitivity, recovery, and resiliency, and adopting trauma-informed practices.

Aetna's model will provide a seamless system of integrated services and supports that address enrollees' whole-person needs, including their physical health, behavioral health, functional, and social determinant needs. Our approach is designed to meet enrollee expectations, enhance quality of life, and improve health outcomes for Kentucky SKY enrollees, while emphasizing collaboration with providers to help them move enrollees toward optimal health. Our model includes offering enrollee and evidence-based treatment-specific resources on condition management, behavioral health (BH) symptoms, and accessing community-based services and supports. Our team will also identify enrollees that may qualify for waivers and coordinate application when applicable. Aetna's program for Kentucky SKY enrollees will include enhanced care coordination through collaboration with organizations such as the Community Pharmacy Enhanced Services Network and the Kentucky Primary Care Association (supporting federally qualified health centers). This program will give our Kentucky SKY enrollees access to community-based pharmacists that become part of the care team for our enrollees. Aetna currently contracts with many organizations that are dedicated to the delivery of integrated care, including 10 specialized children's services clinics across the state, covering all regions except Region 1 where no such provider is enrolled with Kentucky Medicaid. Our network for the Medicaid program also includes 9 federally qualified

health centers, 50 rural health clinics, and all 14 of the community mental health centers in Kentucky, which increases rural access to integrated health care for our enrollees.

System of Care

Aetna has learned of the importance to understand each enrollee in the context of their lives, while co-designing a holistic model of supports and services that enhances their quality of life and assists them to reach their individual goals. Our innovative integrated system of care approach is based on a whole-person view of our enrollees' physical health, BH, and social determinants of health. **Figure G.2-3** depicts our integrated system of care demonstrating our comprehensive focus on the enrollee and their circle of support's (i.e., the people the enrollee wants to be involved from outside of the health care system) primary needs and goals. We know that people with multiple chronic conditions often do not improve until their underlying BH and social needs are met and/or their functional support needs are considered/met.

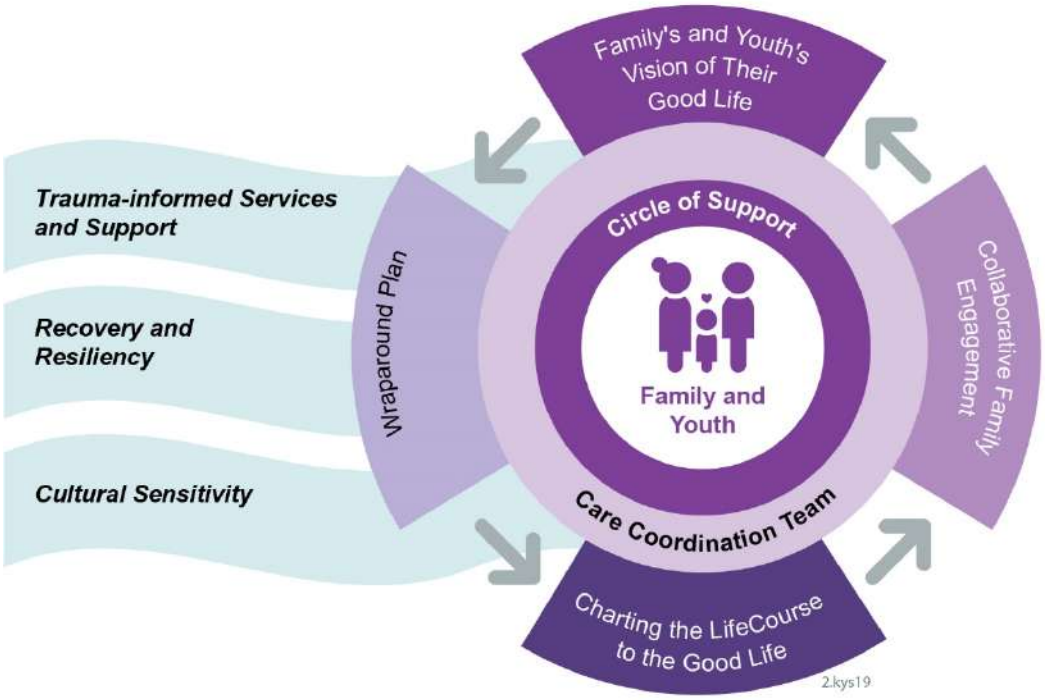

Figure G.2-3: Aetna's Integrated System of Care

Aetna's integrated system of care includes all health care and related services and supports necessary for enrollees with special health care needs to achieve improved health outcomes.

Application to Kentucky SKY Program: To address the vital needs of Kentucky SKY enrollees, Aetna will hire staff with experience in the areas of expertise and who have a deep understanding of integrated, whole-person care, trauma expertise, relationship management skills, and will attend case rounds. Aetna will hire highly qualified individuals in the roles described in **Table G.2-5**. Each of these systems of care specialists will participate on the interdisciplinary care team (ICT) to help, as needed, to support the CCT to help each Kentucky SKY enrollee along their journey to health and wellness, in addition to building organizational capacity to support the needs of all enrollees. Aetna has also hired a clinical pharmacy advisor who will assist with medication management, including the review of psychotropic prescribing.

Table G.2-5: Aetna System of Care Personnel and Their Role in Supporting Kentucky SKY

System of Care Team	How They Support Children and Youth Enrolled in Kentucky SKY
Children's System of Care Administrator	• Builds key stakeholder relationships and processes with the Department and DCBS and attends various meetings, including State Interagency Council • Meets with service staff in service regions and community districts to address gaps, concerns, problem resolution, education needs, and risk management • Support and facilitate the youth boot camps and Governance Committee • Bridges health promotion, prevention, and early identification and intervention to improve long-term outcomes state-wide • Builds community-based services and supports specific to the Kentucky SKY population • Participates in the development and delivery of Kentucky SKY curriculum
Recovery and Resiliency Administrator	• Builds supportive programs and intervention to address mental health, substance use, foster care delivery, and coordination including resiliency training and development, advocacy, foster family and biological family support, and recovery maintenance • Participates in integrated rounds • Collaborates with all enrollees, families, and stakeholders to help to ensure all Kentucky SKY enrollees have advocacy support • Collaborates with local, state, and national partners and stakeholders like Bounce Coalition • Collaborates with enrollees and family to identify and remove barriers to service • Promotes the hope for recovery within the health plan • Collaborate with Provider Relations to drive coordinated peer support network and other non-traditional providers to service special populations like Kentucky SKY enrollees • Participates in the development and delivery of Kentucky SKY curriculum • Chairs Member Advisory Committee
Emergency Department/Crisis Administrator	• Develop the crisis plan development process and identify gaps and solutions (develop crisis response teams) • Collaborate with Medical Management to mitigate gaps in crisis service delivery including solutions to emergency room holds, reduction in out-of-state placements, and difficult-to-place enrollees • Coordinate system approach to enrollees needing emergency services for domestic violence victims, unaccompanied minors, etc. • Builds collaborative relationships with fire, police, emergency medical services, and hospital emergency departments (EDs) to advance trauma-informed care approaches across systems • Collaborates with Medical Management on transition of care for enrollees like aging out needs, discharging from inpatient settings, and mitigating system gaps • Participates in the development and delivery of Kentucky SKY curriculum
Juvenile Justice Liaison	• Collaborates with the Department of Juvenile Justice, Department of Corrections, county jails, Sheriff's Office, Correctional Health Services Office of the Courts and probation departments, and Department of Behavioral Health and Developmental Disability to identify systemic changes and promote community integration • Proficient on Reclaiming Futures framework to promote within systems and communities serving youth • Develops workflows for Kentucky SKY enrollees transitioning out of detention • Collaborates with instructional design to develop and deliver required training for judges, law enforcement, district. and county attorneys, Department of Public Advocacy, etc. • Collaborate with the Start Strong program to strengthen re-entry for our enrollees • Develops workflows for all required state assessments • Works with care coordinators in all regions to maximize system improvements through the RIACs • Provides/coordinates training and technical assistance to legal professionals working at the intersection of health/justice

System of Care Team	How They Support Children and Youth Enrolled in Kentucky SKY
Trauma System of Care Administrator	• Builds key stakeholder relationships with the Department, DCBS, etc., for the planning and delivery of services • Ensure that all service needs, including community-based supports, are available in Kentucky SKY regional areas and identify gaps and solutions, especially for those enrollees aged 18-26 • Collaborates to develop integration of records: information technology (IT), communication, single care plan development, coordination with TWIST, etc. • Collaborate with Provider Relations to drive coordinated networks to service special populations like Kentucky SKY enrollees, enrollees with childhood trauma, etc. • Develops workflows for all required State assessments • Participates in the development and delivery of Kentucky SKY curriculum
Adult System of Care Administrator (Transitional age/ enrollee-focused, e.g., 18-26 years old)	• Builds key stakeholder relationships with the Department, DCBS, etc., for the planning and delivery of services • Ensure that all service needs, including community-based supports, are available in Kentucky SKY regional areas and identify gaps and solutions, especially for those enrollees aged 18-26 • Collaborates to develop integration of records: information technology (IT), communication, single care plan development, coordination with TWIST, etc. • Collaborate with Provider Relations to drive coordinated networks to service special populations like Kentucky SKY enrollees, enrollees with childhood trauma, etc. • Collaborate with DCBS and DJJ to assist enrollees with waiver applications, durable medical equipment, referrals for independent living skills supports, etc. • Develops workflows for all required State assessments • Participates in the development and delivery of Kentucky SKY curriculum

Comprehensive Continuity of Care Planning by an Experienced, Specialized Care Team

Aetna understands that youth should be provided with care coordination to ensure that multiple services are delivered in a coordinated and effective manner and that they can move through the system of services and resources in accordance with their changing needs. Children in adoptive families with subsidized care require comprehensive continuity of care plans to address ongoing behavioral and physical health needs, possible developmental, intellectual, and physical disabilities, and supportive services for families. At-risk youth and their families in Kentucky must navigate numerous systems, such as education, health care, and social services, and require multiple providers, prescriptions, and home- and community-based services and supports, which makes care coordination essential to a child's health and quality of life. Integrated care coordination can help facilitate access to medical and social services across a variety of systems to avoid duplication of services and unnecessary costs and improve outcomes for at-risk youth.

Children unable to live safely with parents and relatives who reside in foster and residential care have been identified as a special health care population by the American Academy of Pediatricians and the U.S. Department of Health and Human Services. We know today that children and youth in care face the greatest vulnerabilities to health and mental health conditions and require access to comprehensive assessments and specialty care.

Application to Kentucky SKY Program: Our approach recognizes the significant risk to health equity for children separated from stable and committed adults in their lives. Our CCTs understand Kentucky SKY enrollees' complex situations and will engage our enrollees and their families in programs to reduce barriers to managing their own health and well-being or that of their children. Care managers will receive intensive clinical training in the areas of engagement and relationship building, assessment, chronic condition management, evaluation of social and behavioral issues affecting enrollees' health, trauma-informed care, resiliency and wellness, care planning, and care coordination. The care manager will act as a single point of contact for the enrollee, but will be supported by an ICT comprised of the enrollee, members of their circle of support, the PCP and other medical providers, behavioral health specialists, and

representatives from community-based organization that address the enrollee's social care needs and other social support as directed by the enrollee or their guardian.

A key innovation in Aetna is the creation and facilitation of a Circle of Support Wraparound team for each enrollee served in our Mercy Care plan in Arizona and proposed in Kentucky SKY. These teams provide continuity of care and an organized and active group of caring adults to support and advocate for enrollees to ensure their health, childhood development, and well-being needs are met. The Arizona experience is similar to that of Kentucky, with large numbers of children entering the system. Mercy Care has been an effective partner in stabilization of this trend. Mercy Care's continuity of care focus on collaboration and wrap around has demonstrated success in reducing the number of children in care and increasing children with permanent homes. Kentucky SKY will build on the Arizona experience by developing collaborative strategies which will defragment and engage stakeholders effectively. Stakeholders will be engaged in town halls, meetings, and other forums for the purpose of listening to their voice prior to developing solutions. Collaboration will occur once the stakeholders identify needs and concerns and solutions will be tailored to that voice rather than imposed without prior input. Relationships and communication pathways will be developed with stakeholders. The focus will be to start with the enrollee and working toward the solution to insure true collaboration.

Early Identification and Intervention

Aetna recognizes that early identification and intervention for youth should be provided by the system of care in order to enhance the likelihood of positive outcomes. We have learned that youth currently in state care are particularly vulnerable and have more serious and complex physical health, mental health, and developmental problems, and these problems occur at a higher rate than the national average.[4] A large portion of children entering foster care have significant emotional and behavioral problems as well. These troubling facts clearly indicate the need for procedures and processes that lead to comprehensive early assessment and intervention. Kentucky SKY youth require comprehensive evaluations and assessments to determine what gaps may have occurred in their care and what services they need to address any presenting issues. These services should include preventive care, such as immunizations; mental health screenings to evaluate for trauma and identify potential mental health diagnosis; and dental exams, treatment, and possible restorative care.

Application to Kentucky SKY Program: Early identification and help are the keys to our Aetna strategy for Kentucky SKY. Protecting and promoting healthy childhood development and where needed catch up are critical to promoting health and improved health across the life course. Our vision is to consider health trajectories to the midpoint of life as we invest in care and support of our enrollees rather than a traditional approach in child protection of a moment in time assessment of acute health needs and immediate safety. Aetna will establish early identification and intervention by utilizing the following measures.

Comprehensive evaluations and assessments: As part of the enrollee needs assessment and evaluation process, Aetna Better Health of Kentucky will consult and collaborate with the people who are important in the youth's life, such as biological parents, extended family members, foster parents, social workers, teachers, PCPs, and any professional providing treatment or legal representation. Our comprehensive evaluation and assessment process will address the following:

- Cognitive and educational needs/strengths
- Medical needs
- Mental health issues
- Identification of other special needs

[4] Simms, M. D., Dubowitz, H., & Szilagyi, M., "Health Care Needs Of Children In The Foster Care System," Pediatrics, 106 (4; PART 2) 909-918 (2000): accessed June 1, 2019 https://www.ncbi.nlm.nih.gov/pubmed/11044143.

Identification of appropriate family and support resources: Aetna will provide screening tools, like the Adverse Childhood Experience questionnaire, to primary care/medical health homes PCPs so that they can assess the level and impact of trauma on enrollees. To prevent gaps in care, upon consent we will share information with PCPs, families, and agencies regarding immunizations, well-care visits, and EPSDT. We educate providers on trauma-informed care, including how to identify associated symptoms, signs, behavior, and risk factors. We will use adult and adolescent-specific specialty, physical, mental health and substance use disorder screening tools outlined in **Table G.2-6**

Table G.2-6: Aetna Screening and Assessment Tools

Comprehensive Screening Tools	
• Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) Screener	• Pediatric Symptom Checklist (PSC)- 17 Screener
• EPSDT Mental Health Assessment	• Safety Questionnaire
• Environmental Safety Survey	• Child Health Questionnaire Short Form (SF)-10
• Generalized Anxiety Disorder (GAD)-7 Screener	• SF-12 Pre and Post
• Health Risk Assessment Tool, Child, TANF, ABD Duals	• Trimester Screener V2
• Outreach Questionnaire	• Teen Addiction Severity Index (T-ASI)
• Adverse Childhood Experiences Questionnaire (ACES-Q)	• Substance Abuse Subtle Screening Inventory (SASSI)
• K6 Screener	• Beck Depression Scale
• Patient Health Questionnaire 9 (PHQ-9)	• Youth Assessment and Screening Instrument (YASI)
• Post-Discharge Questionnaire	• Used, Neglected, Cut Down, Objected, Preoccupied, Emotional Discomfort (UNCOPE) Screener
• Postpartum Screener	

In addition, Aetna recognizes the unique clinical needs of this population and will include additional screening tools specifically for the DJJ population, including the following:

- Criminogenic Needs Questionnaire
- Risk and Criminogenic Needs Assessment
- Reclaiming Futures Selective Screening and Assessment
- Global Appraisal of Individual Need (GAIN) Questionnaire
- GAIN-Short Screener
- GAIN I
- Youth Level of Service

Collaborating with DCBS Staff: Aetna will build on the existing Kentucky DCBS infrastructure with additional resources for community engagement and problem-solving that support early intervention. This includes a governance structure with these dedicated positions within our system of care that will support shared accountability for outcomes:

- Children's System of Care Administrator
- Emergency Department/Crisis Administrator
- Recovery and Resiliency Administrator

For detailed descriptions of how these roles will support Kentucky SKY, please refer to **Table G.2-5**.

Aetna will co-locate staff that specialize in the Kentucky SKY population in the juvenile justice system to expedite and better coordinate service delivery and ensure that needs are identified prior to being released from detention. This effort will build upon our process of co-locating staff in Kenton County Detention Center to provide transitional care coordination. Aetna is the only Medicaid Managed Care organization in the State that has staff embedded in a state-operated justice system facility. This close collaboration provides opportunities to identify and collaborate with training needs and develop training programs for staff in the Detention Center. These co-located staff members specialize in serving high-needs enrollees, and those enrolled in the highest level of our integrated care management program who have similarities to the Kentucky SKY population.

The use of technology for early interventions: Because Aetna believes in a prevention and early intervention approach wherever possible, we will use many data sources to identify and assess Kentucky SKY enrollees, and to assign them to a level of care coordination that meets their needs (e.g., complex care management, management of chronic conditions, or wellness and prevention). This enhanced use of our technology increases our service efficiency and effectiveness to our enrollees.

Our rising risk model will identify children and youth at risk for crisis episodes. This practice allows the shared Children, Youth, and Family teams to convene at an earlier point in new children, youth, and young adults enrolled in Kentucky SKY in need of increased support and services to avert potential traumatic events, including being placed out of their home. Aetna's rising risk model uses 28 different measures to stratify and score enrollees age 17 and under based on a multitude of measures including specific behavioral health disorders, opioid use, physical/sexual/psychological abuse, self-harm claims, co-morbidities, risk stratification score, engaged in care management, PCP assignment, frequency of changing PCP over the course of a year, total medical spend, emergency room utilization, pregnancy, justice system involvement, sexually transmitted disease diagnoses, household opioid use, household self-harm claims, and household physical, sexual, or psychological abuse**.** Using this method, we will rapidly identify enrollees and who are at elevated risk that may need additional resources from the health plan. In addition to identification of specific enrollees we will use demographic and geographic information to focus resources on areas of rising risk concentration. As part of our population health strategy, our goal is to early identify individuals with special health care needs, which includes enrollees served through Kentucky SKY, and direct services to communities with enrollees with early and less complex illnesses prior to them appearing as higher risk and higher spend.

Additionally, if we receive a referral for a Kentucky SKY enrollee who requires a 48-hour assessment, we will be able to expedite enrollment by forcing a manual enrollment in our system. This would be a safeguard against delayed enrollment via 834 and initiate the work to secure the appropriate services.

Transition Planning for Teens and Young Adults

Aetna has learned that youth should be ensured smooth transitions to the adult service system as they reach maturity. Many children in the child welfare system require transition services to assist them to access covered benefits and non-Medicaid services when they reach adulthood—when life changes associated with aging and maturing may add complexity. They have very little perceived or real control over their lives and how they will receive the medical services they need. Former foster children, particularly transitional age youth who have aged out of the system, require health care appropriate to their developmental stage. We have found that young adults in this category (18 to 26 years old) often need primary preventive care and screening; mental health services; education regarding healthy sexuality, sexually transmitted infections, and substance use; and the need to address social determinants of health, such as access to housing, education, job training and opportunities, and transportation options.

Application to Kentucky SKY Program: Aetna will engage adolescents in the development of their care plan and help them to understand the choices they can make as their plans are developed. We follow them until they age out. Children, youth, and young adults served through Kentucky SKY will not only need care management for their medical services and for their psychosocial services, but also their social service needs. Early attention to transition care planning supports our enrollees in their transition to independence. Aetna has entered into a partnership with Unite Us to assist in serving enrollees in the Louisville area (with plans to expand statewide in the future); our CCTs use their local knowledge and our community resource guides to assist enrollees to access to a fully integrated social service resource network. Through this social determinant integration model, care managers and community health workers will have access to both our medical network and our social determinants of health network to connect enrollees to local, community-based resources to address their unmet social resource needs. Care managers will offer Kentucky SKY enrollees assistance with enrollment in federal and state benefit

programs such as Department of Housing and Urban Development waivers, Women, Infants, and Children, the Supplemental Nutrition Assistance Program, Kentucky Transitional Assistance Program, Kentucky Low Income Home Energy Assistance Program, and the Continuum of Care Homeless Assistance Program, as examples.

Aetna's partnerships with Unite Us, in addition to our CCTs and community resource guides, will assist in serving our adolescent enrollees with access to a fully integrated social service resource network. Through this integrated social determinant integration model, care managers and community health workers will have access to both our medical network and our social determinants of health network to connect our adolescent enrollees to local, community-based resources to address their unmet social resource needs.

The Role of Advocacy in Protecting the Rights of Youth

Through our monthly participation in the State Interagency Council (SIAC) meetings, we have gained understanding that youth want to be heard, but more importantly, youth want to be viewed as a partner for change. During SIAC meetings, a representative from Kentucky Youth MOVE (Motivating Others through Voices of Experience)—a statewide chapter of Youth MOVE National—shared initiatives and goals of the organization. Kentucky Youth MOVE understands the unique needs of individuals in the state of Kentucky and developed a Youth Behavioral Health Bill of Rights. In order to promote positive and meaningful change in a fragmented system, we need to collaborate with the youth who have first-hand experience, understanding of what needs to change, and motivation to see the change to fruition.

Application to Kentucky SKY Program: The best advocates for enrollees are enrollees themselves and those that care for and about them. Throughout Aetna's approach to serving the Kentucky SKY population, we will focus on enrollee-centered, informed, and tailored strategies. All our proposed constructs are about capacity building with enrollees, families, partners, communities, and state systems.

Aetna understands there is a disproportionate degree to which lesbian, gay, bisexual, transgender, self-identifying queer, intersex (LGBTQ), and other sex and gender diverse individuals are represented in the foster care system. To best address the needs of LGBTQ enrollees in foster care, care managers and foster parents will need training and experience working with this population to have a robust understanding of the cultural values and practices within the community. We will subscribe to the standards set forth in our LGBTQ Cultural Competency Framework to address this membership, making sure providers and staff are trained and demonstrate skills to serve the population; that the enrollees are screened for BH needs since they are at a higher risk; that discrimination is addressed both at an individual and system level; that understanding language is essential, like using correct identifying pronouns, forms, and resources that account for diverse perceptions of sexuality, sex, and gender; and strict confidentiality practices will be used to create an inclusive and safe environment. In addition, building of a community to support the LGBTQ enrollees, especially as they are aging out of the foster system, will help these children and young adults build families of choice that can provide long lasting support. Aetna's policies and procedures are aligned with this framework.

Value-based Purchasing

Aetna understands the power and effectiveness of value-based purchasing (VBP) arrangements in incentivizing providers to engage in delivery system reforms to improve quality and outcomes for at-risk children, youth, and young adults**.** For example, in support of providing integrated, whole-person care for these enrollees, Aetna offers providers a variety of alternative payment arrangements through our Aetna Better Value program. To date, Aetna has entered into an alternative payment arrangement with several providers such as Children's Alliance Independent Provider Association, Kentucky Primary Care, Kidz Club, and KentuckyOne, to name a few. The outcomes Aetna uses to monitor performance and determine

incentives depending on the VBP agreement include but are not limited to the following HEDIS measures:

- AWC – Adolescent Well-Care Visits
- CIS Combo 10 – Childhood Immunization Status
- W15 6+ Visits – Well-Child Visits in the First 15 Months of Life
- AMBED – Ambulatory Care (emergency room visits)
- PCR – Plan All-Cause Readmissions
- FUH 7 Day – Follow-Up After Hospitalization for Mental Illness
- APP Total – Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- ADD Continuation Phase – Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication

Application to Kentucky SKY: Aetna is developing a VBP contract with the Kidz Club to provide community pediatric health care services for children who are medically complex, requiring a multidisciplinary approach to address their whole person needs. Examples of the diagnoses or conditions of the medically complex children the Kidz Club serves include ventilator dependence, spina bifida, hemophilia, cerebral palsy, cystic fibrosis, and neonatal abstinence syndrome. In lieu of prior authorization, Aetna will dedicate a care manager to the enrollees served by Kidz Club. This Aetna care manager will be embedded at the agency to enhance clinical conversations and care coordination with non-covered services to meet enrollees' and their families' social determinant needs. The Aetna care manager will make in-home visits to each enrollee on initial intake and twice per month, or when there has been a change in the child's condition. Aetna anticipates that outcomes of the VBP arrangement with the Kidz Club will include reductions in hospitalizations and emergency room visits; increased medication compliance and medicine reconciliation; and decreased overall costs of care for enrollees.

Aetna is currently exploring opportunities to include trauma assessments in future VBP arrangements to encourage this activity as a standard of care for all children, but especially foster children.

a.ii. Aetna Contracts Serving Populations Similar to Those Enrolled in Kentucky SKY

Table G.2-7 describes our full-risk Medicaid contracts for populations similar to Kentucky SKY.

Table G.2-7: Medicaid Managed Care Contracts Serving Individuals in the Foster Care

State Name	Contract Start/End Dates	Number of Covered Lives	Statewide or Regional
Arizona RBHA & ALTCS	• 4/2014 – Present (RBHA) • 5/2002 – Present (ALTCS)	7,762	Regional
Kansas Medicaid	1/2019 – Present	3,800	Statewide
Kentucky Medicaid	7/2011 – Present	5,803	Statewide
Louisiana Medicaid	2/2015 – Present	341	Statewide
Maryland Medicaid	11/2017 – Present	128	Statewide
Michigan Medicaid	10/2004 – Present	397	Regional
New Jersey Medicaid	12/2014 – Present	400	Regional
Pennsylvania Medicaid	4/2010 – Present	115	Regional
Virginia Medicaid	7/2016 – Present	400	Statewide
West Virginia Medicaid[5]	1/2020 – Present	19,000	Statewide

[5] Scheduled go-live for the West Virginia Mountain Health Promise program is first quarter, 2020.

60.7.G.2.b Office in the Commonwealth

Aetna's transformative vision drives our model for enhanced care coordination and service integration supporting the children/youth in foster care, adoption assistance, and the juvenile justice populations. Collaborative relationships are at the center of Aetna's approach to serving the Kentucky SKY population. Collaboration is more than a word or value—it is an action which needs a framework. Aetna selected a nationally award-winning model called **Collaborative Family Engagement** as a framework and methodology to strengthening and sustaining a partnership with the Department for Community Based Services (DCBS) staff and leadership. This will be a unique approach to build a collaborative effort to stand a health system and child protection system shoulder-to-shoulder in supporting and strengthening the safety of children and the well-being of families. Collaborative Family Engagement is under study by the University of Texas at Austin and is proven to be an effective, high-quality practice change strategy for Child Protection Practice. The methodologies address the challenges of collaboration between public child welfare internal cultures and external community-based partners. This is a critical dynamic which, if not addressed, will weaken or undermine the value and impact of health and mental health care and planning for children.

Collaborative Family Engagement is one of the first in the nation to approach building a collaborative effort to stand a health system and child protection system standing shoulder to shoulder in supporting and strengthening the safety of children and the well-being of families. Aetna has a history of success in co-locating staff at State agency offices that serve enrollees similar to the Kentucky SKY population in both Kentucky and in other states. Our decisions are based on our experience and solutions for the future and we will adopt some of our best practices from all Aetna plans to the Kentucky SKY plan. Within this framework we will implement delivery system reforms to improve quality and outcomes.

Collaboration: Aetna and Kenton County Detention Center

"New and innovative ways to engage vulnerable populations will always be a primary goal for us at Kenton County Detention Center. Research and experience tell us that individuals are most at-risk during the first few weeks of the re-entry process. Courtney Ham, Aetna's START STRONG targeted case manager, has taken the re-entry process to levels of success we have never seen before. The START STRONG Re-entry Program has reduced recidivism, while increasing the safety and wellness of our communities. We are very proud of our partnership with Aetna Better Health of Kentucky. Making our mutual goals a reality."

—Jason Merrick,
Director of Addiction Services,
Kenton County Detention Center

Aetna will build on this success by working with State agencies to locate Kentucky SKY staff in the main offices in each of the eight regions, in each of the four Department of Juvenile Justice offices, and the Commission for Medically Complex Children. Co-location meets the needs of the DCBS staff with frequent evaluation to assure successful collaboration. Additionally, our regional-based representatives from the Care Management team will make monthly visits with Commonwealth workers to explain and offer services. We also will offer days in which families visit with us and ask questions.

Upon award, Aetna will submit a request in writing to the Department and DCBS with an implementation plan and summary of key considerations related to co-location**.** Aetna understands and will comply with the requirements for Office in the Commonwealth, described in **Section 9.1 of Attachment F—Draft Medicaid Managed Care Contract and Appendices.**

Co-location within Kentucky

Aetna currently co-locates staff in Kenton County Detention Center, in psychiatric hospitals, and neonatal intensive care units (NICUs) to provide transitional care management and support discharge planning for

our enrollees. These co-located staff specialize in serving high-needs enrollees, those enrolled in the highest level of our integrated care management program, who have similarities to the Kentucky SKY population. The Aetna care coordinator collaborates closely with the Commission for Medically Complex Children and has built that relationship to allow Aetna to go above and beyond in support of these children and youth.

In addition, an Aetna care manager works onsite at Eastern State Hospital (a psychiatric facility) to support enrollees.

Co-location within the Justice System

We already have the success of Kenton County and will leverage this success for foster children in Juvenile Justice. Aetna will leverage its successful experience with co-locating staff within the Kentucky criminal justice system and our **Start Strong** program in our approach to serving Kentucky SKY enrollees with justice involvement. Start Strong is a re-entry program focused on improving the lives of individuals involved in the criminal justice system. Aetna is the only Medicaid managed care organization in the state with a re-entry coach (care manager) embedded in a justice system facility. The Start Strong reentry program, a 90-day jail substance abuse program with 6-months of follow-up support, helps people move beyond addiction and establish healthy, productive lives.

Through experience with enrollees in the justice system, Aetna identified that transition back to the community is challenging and that access to transition support could provide the support enrollees need to secure basic services in the community and avoid lapses in health care and medication. The Start Strong program was developed to address these issues. Each Aetna enrollee in custody at Kenton County Detention Center in northern Kentucky receives an Aetna Start Strong brochure and letter stating how to get in touch with the re-entry coach who is co-located at the detention center. Aetna Start Strong provides transition planning to ensure identification of community needs and linkages to the appropriate community services and supports once the enrollee returns to the community. We provide additional supports to make sure enrollees can continue their treatment without any gaps. **Start Strong has a 91 percent success rate.**

Smooth Transition for an Aetna Enrollee from Detention to Sober Living

Tara, not her real name, an enrollee with anxiety disorder, depression, and substance use disorder (opiates), was incarcerated at the Kenton County Detention Center (KCDC) when Aetna received a care management referral for the onsite care manager. When her Aetna case manager (CM) met with her at KCDC, Tara initially thought she would be leaving detention within two weeks' time. However, the judge required that she complete 90 days of Comprehensive Opioid Response with the Twelve Steps (COR-12™) program and then discharge to Sober Living after graduation. She was also expected to attend Mental Health Court as a rule of her probation. Tara told her care manager that her mental health issues contributed to the behavior which landed her in KCDC and requested mental health assistance. She had received Sublocade (i.e., buprenorphine) injections as part of Aetna's Gold Standard program during her incarceration. On the day she was released from KCDC to Oxford House Rose for Sober Living, her care manager facilitated the attainment of prior authorization for the injections so they could be ordered in enough time to keep her on her medication regimen. The CM met with her and her Mental Health Court representative at the Sober Living facility and arrange for her to attend group therapy and AA meetings. Tara stated she is very grateful for the services she has received and how fast she's been able to accomplish tasks that can sometimes feel overwhelming when a person is first released.

Co-location in Other States

Aetna has had success with co-location with Juvenile Justice in Arizona as well as Kentucky. Aetna and Maricopa County Juvenile Probation Department recognized there was a gap in behavioral health services for detained youth. The Juvenile Justice Engagement Team (JJET) team was created to fill the gap and provide timely behavioral health services to the child and family and support informed court dispositions.

Mercy Care, an Aetna-administered Medicaid managed care plan, employs two master's level clinicians to serve as the JJET. JJET staff, co-located within Maricopa County Juvenile Probation Department, act as first point of identification and diversion for detained juveniles enrolled in or eligible for Mercy Care services. JJET maintains a detention roster database for all Mercy Care enrolled youth and follows protocol to make sure needs assessments are completed and discharge planning occurs prior to being released from detention.

JJET liaises with the Maricopa County Juvenile Probation Department and is an invaluable resource to Judicial Officers, legal advocates, county attorney, and court appointed special advocates. JJET staff are members of Child and Family Teams, attend court hearings, and assist TXIX/TXXI eligible youth enroll in behavioral health services. They also provide technical assistance to key stakeholders regarding navigating the behavioral health system.

All referrals to JJET are initiated by the Juvenile Probation Officer (JPO) to determine behavioral health eligibility and rapidly initiate needed behavioral health services. If a child is placed in Department of Child Safety (DCS) custody, a Rapid Response Referral is initiated. Once a referral is made the following occurs:

- Initial case meeting (DCS Specialist and JPO) held within five working days
- Discuss the crossover case to ensure exchange of all relevant case information regarding the child and family
- Develop the 5-Day Discussion Guide to provide consistency and uniformity in the type of information shared, gathered, and exchanged
- JPOs include the Mercy Care JJET in all information exchanges
- Initial monthly crossover team meeting with the child and family at the conclusion of the initial meeting
- All crossover meetings are designed to ensure families, probation, DCS, Mercy Care, education, and other service providers share information and collaborate to keep families engaged and connected to care and track with services, resulting in better outcomes for families.

JJET Staff Co-Location Prevents Unnecessary Out- of-home Placement

JJET staff co-located at the juvenile court centers proved to be a success for one case in particular. A court hearing was set, and the provider case manager was in an emergency and unable to make the hearing. The judge called for a recess and advised the assigned JPO to locate the JJET staff in her office upstairs. The JPO was clear and concise with the information the assigned case manager was going to provide in court which related to a request for an out-of-home intervention. JJET was able to review the decision from Medical Management, reach the case manager supervisor, and attend court. JJET staff reported the decision to the judge along with the wraparound plan established since medical necessity was not met for the out of home intervention. The judge allowed for the wraparound plan to be implemented. We were able to avoid a potential court order for an unnecessary out-of-home intervention due to the ability of the JJET staff to provide sufficient information to the court and satisfy the court. Co-location made this rapid response to the judge possible. The child was released from detention and able to return home with supports and services in place for the child and family.

Crossover team meetings and planning are guided by the **Crossover Youth Practice Model** (CYPM) Family Plan for Success. This plan tracks progress on goals, new information related to the case, new court orders, updates on parent and/or child's progress on identified behavioral changes, treatment or other services, results of substance abuse tests for child and/or parent, and any other family's concerns, barriers, or needs. The team will collaboratively identify ways to resolve the concerns, barriers, and needs and develop a joint court recommendation for the child's services and placement. Lastly, there will be a review of upcoming meetings, court hearings, and appointments to avoid duplication. Presiding judges are very complimentary of this model as it provides real-time information which informs their decisions and provides confidence that all children will be connected and served by a community-based provider. As of February 28, 2019, 455 youth went through CYPM program since May 2016. Data shows that from 2016

to 2018, there was a **37 percent increase in youth placed in diversion programs and a reduction in the percentage placed in probation** (9.5 percent in 2013 compared to 13 percent in 2018).

Embedded Clinical Care Managers at State and Community Health Care Facilities

Aetna's success embedding staff in State and community hospitals and substance abuse treatment facilities will inform its approach to co-location with State agencies.

Kentucky

In Kentucky, Aetna embeds clinical care managers within hospitals to facilitate an integrated approach to seamless, coordinated discharge to the community for enrollees like the Kentucky SKY population. We are continually looking for opportunities to partner with hospitals and facilities to embed clinical care managers to facilitate effective discharge planning. The clinical care managers participate with UM clinicians, hospital staff, and our integrated care teams in discharge planning to address the physical, behavioral, and oral health needs as well as social determinants of health prior to discharge. We have embedded clinical care managers at the following hospitals:

- University of Kentucky NICU (dedicated neonatal intensive care unit)
- Eastern State Hospital (State psychiatric hospital staff member is onsite when there are needs for Aetna Care Management)
- Our Lady of Peace Hospital—both inpatient and outpatient service

We identify real-time hospital admissions and emergency room visits and begin analyzing the cause of the admission and discharge planning needs on Day 1. During an acute stay, the integrated care team examines medical, behavioral, social determinants, and health literacy indicators for readmission and begins to address the root cause of the primary admission. This approach has resulted in reduction in avoidable readmissions

Florida

In Florida, Aetna has a transition of care program that includes visit with an Aetna clinician in the hospital setting. The clinician assists the hospital with complex discharge planning. The purpose is to reduce avoidable readmissions and increase adherence to post discharge plan of care. The readmission rate for enrollees in this program is very low.

West Virginia

In West Virginia Aetna has care managers embedded in High Risk OB practices that offer medication-assisted treatment for substance use disorder. Our care managers meet with the mothers, enroll them in care coordination, and follow the mother throughout her pregnancy and concurrent treatment for substance use disorder. Following birth, the baby is also enrolled in care management and followed through their first year. We have had success in keeping the mother engaged in prenatal care as well as engagement in substance use disorder treatment. Most importantly, most babies are remaining with their birth mother. For 2018, 59 percent of mothers stayed engaged in opioid treatment and/or counseling during pregnancy and through the first year after delivery and **82 percent of babies have remained with their birth mother** and were not removed from the home and/or placed in foster care. For the first quarter 2019, 87 percent of neonatal abstinence syndrome mothers remaining on opioid treatment and/or counseling during pregnancy and through the first year after delivery and **78 percent of babies have remained with birth mother** and were not removed from the home and/or placed in foster care.

Additionally, in West Virginia, care managers for the Aetna Medicaid plan are co-located among over 20 providers throughout the state and the foster care plan will adopt a similar model.

60.7.G.2.c Staffing

In Kentucky, Aetna's staffing model is predicated on our successful experience proudly serving children and youth in foster care, those receiving adoption assistance, and justice-involved youth since 2011. **Aetna's transformative, whole-person vision of care drives our model for enhanced care coordination and service integration supporting the children/youth in foster care, adoption assistance, and juvenile justice populations.** Our approach is locally based, with staff dedicated to serving our enrollees in the child welfare system together with the Department for Community Based Services (DCBS). Our staffing model will build on this collaboration with a roundtable governance structure incorporating all aspects of the community in support of enrollees in our care. Care coordinators will be conveners of resources and solutions dedicated to resolving challenges with trauma-informed care and a holistic approach to best serve and meet each individual's unique needs.

We recognize that to achieve the best possible, integrated health outcomes, these vulnerable populations need access to comprehensive, integrated care covering physical and behavioral health, dental care, and socially necessary services; the highest quality of care; and seamless coordination of services to achieve the best health outcomes. This approach, implemented by our dedicated staff, promotes resiliency and helps to build upon family and community systems of support.

Kelly Gannon,
Executive Director, Aetna Kentucky SKY

Figure G.2-4: Personally Invested in Foster System
Kelly Gannon and her 5-year-old daughter.

Kelly Gannon is an experienced executive leader in behavioral health with 30 years of community mental health and nonprofit experience. Ms. Gannon has experience with operational oversight of key programs that intersect with DCBS, such as Children's Review Program, while serving as director of clinical health services at Bluegrass MH-MR Board.

Ms. Gannon has a deeply personal understanding navigating the foster care system as her 5-year-old daughter was adopted out of Kentucky's foster care system. This personal experience provided her with a keen sense of appreciation for the challenges families and children face while navigating the system.

i. Proposed Staffing Approach the Kentucky SKY Program

The cornerstone of our staffing plan is highly experienced leadership with extensive local, program-specific knowledge. Kelly Gannon, MBA, LCSW, will serve as executive director for the Kentucky SKY program, and will play a key role in identifying, hiring, and retaining key personnel. Ms. Gannon (shown in **Figure G.2-4**) is supported by Aetna's highly experienced, qualified, talented leadership team and our Implementation Talent Acquisition team. To support this contract, we are committed to attracting additional professional

staff with significant experience serving populations similar to Kentucky SKY. Ms. Gannon will seek local candidates who are experienced and familiar with the local Medicaid health care delivery system and culture in the Commonwealth and have all the Kentucky licensures and certifications required by law and the **Draft Medicaid Managed Care Contract and Appendices**.

Ms. Gannon will work closely with two senior advisors, who offer the following child and welfare credentials to Aetna and the Kentucky SKY program:

- Andrea Bennett, PhD, MSW, previously the chief external affairs officer specializing in child health and welfare for Kentucky Youth Advocates, will serve as the local senior advisor to the executive director. Ms. Bennett will assist and advise Ms. Gannon on program operations before and after contract implementation, offering extensive knowledge of the child welfare system in Kentucky and nationally. Ms. Gannon has strong relationships with key stakeholders in the health and child welfare arenas in the Commonwealth.
- Josh Boynton, MS, will serve as the national senior advisor to the executive director. Mr. Boynton has more than 20 years of community-based health care industry leadership experience and 7 years of managed Medicaid experience. He is responsible for segment strategy for the Aetna Medicaid organization's child welfare/foster care program. In this role, he serves as the current segment lead for strategy and implementation of WV Mountain Health Promise (sole source Child Welfare/Foster Care contract awarded to Aetna Better Health of WV in 2019.)

One of the cornerstones of our staffing model is collaboration and convening resources through stakeholder engagement to best support enrollees and their circles of support. We are excited to announce that Susan Vickers, MSW, CSW, will be chief of staff and director of training and education. Ms. Vickers is an experienced quality improvement specialist with 18 years of health care industry experience and 5 years of managed Medicaid experience.

Ms. Vickers is a leader of successful training programs and program implementation for health care entities and focuses on ensuring program excellence through evaluation and assessment of program operations. Her expertise includes extensive work in the quality, leadership, and hospice arenas. Her educational background includes a Master of Social Work and Graduate Certificate in Gerontology from the University of Kentucky School of Social Work and a Bachelor of Science in Psychology from Centre College. Prior to joining Aetna, Ms. Vickers served as a Hospice and Palliative Care Social Worker for St. Anthony's Hospice in Hendersonville, Kentucky.

Frank T. Angotti, MD, Psychiatrist

Dr. Angotti is an experienced psychiatrist and behavioral health management professional with 10 years of health care industry experience and 6 years of managed Medicaid experience. His expertise includes leadership roles in child and adolescent psychiatry, behavioral clinic health, and substance use/trauma arenas. He also has extensive experience managing children with complex behavioral health needs under the Medicaid system.

Approach Focuses on Primary Prevention and Early Intervention

Aetna's local staffing approach supports children, young people, parents, and other important adults involved with child protection systems in a highly participatory family engagement practice emphasizing primary prevention and early intervention. This approach drives our System of Care (SOC) model infused within the effort of every Aetna staff member through our whole-person, whole-family approach to physical, behavioral, and social well-being. Our vision is to construct local, regional, and state-level representatives to create a shared, in-common vision of health promoting and resilience building approaches to families remaining safely together and children growing up safely in families rather than in systems and services alone.

The SOC model incorporates a defragmentation strategy built to assist children and families with the challenges created in a fragmented care delivery system to manage children and families through integrated and coordinated care addressing systemic challenges through the voices of youth we serve, their circle of support, and stakeholder and resource engagement. We create horizontal, integrated collaborations to break down the existing vertical silos of governmental and private human service systems. This new integrated system of care creates an "and both" approach with Aetna as the convener in both systems of care work and with enrollees, families, and communities. Our robust, integrated approach to engagement with the foster and juvenile justice populations will also help the Commonwealth leverage federal funding through the Family First Prevention Services Act and the newly signed Kentucky Families First Act.

Staffing Plan

Our staffing plan for Kentucky SKY assumes approximately 24,000 enrollees. Under this scenario, we will scale up our present staffing to **more than 200 dedicated Kentucky SKY staff members in the Commonwealth, including key personnel 100 percent dedicated to the Kentucky SKY Program**. All Kentucky SKY-specific staff will be located in our Louisville office and in communities within the regions they serve.

Based on our years of experience providing Medicaid services across 16 states, Aetna continuously reevaluates and revises staffing levels to ensure consistent delivery of services. We have the flexibility to hire and train additional staff, refine processes, provide backup resources, and institute other changes to meet the Commonwealth's requirements. We base our staffing analysis on our applicable care management ratios to support Commonwealth goals and transforming the system of care, which projects staff needed by proven ratios or other metrics appropriate to each position type.

While our extensive experience serving similar populations in nine states—currently implementing No. 10—across the nation drives our Kentucky SKY staffing model, we also use evidence-based guidelines built on time studies and complexity of care. Our experience serving children, including youth in foster care, is informed by our relationships with local community advocates and providers, and their voice has helped us understand this vulnerable youth population, their families, and caregivers. **We reach beyond ensuring access to quality health care by focusing on complete healing and resiliency for children and their families.** We are not seeking better results because of a crisis in child welfare. Instead, we see a crisis in family engagement and focus on the multitude of impacts that breakdown families including, poverty, substance abuse, lack of social support, and other factors not historically addressed in the child protective services (CPS) system. Aetna seeks to enhance and refine both the child and family welfare system as well as how managed care organizations interact with community partners involved in child protection. We will augment staffing in our Louisville office and in each region as necessary so that we can meet all needs of enrollees, providers, and the Commonwealth.

i.a. Organizational Structure: Supporting Innovative Solutions and Stakeholder Groups

Aetna proposes a governance and leadership structure which parallels our care coordination model in an innovative approach to transforming the present system. Our organizational structure is program- and population-centric, beginning with an executive directive charged with nurturing a culture of collaboration and engagement across departments and stakeholders. Through our trauma-informed, whole-person care model, we will put the enrollee first by addressing specific challenges they have incurred. Our approach ensures that every level of staff involved in serving enrollees is trained in and adhering to values and standards that mirror the new experience for the youth and family. Ingrained within our System of Care model is collaboration and respect for divergent perspectives, creating governance efficiencies and effectiveness to guarantee sustainability and progress over time. Change cannot occur at the direct care level only; instead we infuse it within our approach at every level. In collaboration with the DCBS and other departments in monthly meetings we will demonstrate our

innovative approach to preventing family separation through enhancement of existing relationships with community stakeholders fortifying families through engagement of all persons within our enrollee's circle of support, and not the enrollee in isolation. Our organizational structure will build on the efforts already underway at DCBS to improve the child welfare system into an effective, nationally recognized approach that strengthens families and keeps kids safe.

Through a formal partnership with **Kentucky Youth Advocates (KYA),** we will work with Commonwealth agencies, providers, child welfare organizations, and consumers across Kentucky on innovative solutions to transform care for the Kentucky SKY population. KYA is the Commonwealth's leading child advocacy organization with over 40 years of experience working with public, private, and nonprofit agencies to advance policies that are good for kids. KYA is an expert in building effective coalitions that advance systems-level changes and offers a wealth of expertise in the child welfare arena. The organization is already partnering with DCBS and Casey Family Programs on several initiatives related to advancing Families First in the Commonwealth. KYA is an ideal collaborating agency as we are in alignment on objectives related to strengthening families, keeping kids safe, enhancing supports for kinship families, and promoting resiliency and stability for youth that are in or aging out of foster care.

> "Kentucky Youth Advocates is committed to working with Aetna Better Health of Kentucky in a collaborative approach to advance policies and practices that keep families safely together and promote healing and stability for children and youth who experience abuse. We will work together to enhance efforts already underway in the Commonwealth to transform the Commonwealth's approach to child welfare including implementation of Family First. We know that Aetna Better Health of Kentucky is uniquely positioned to work with us to meet the health and non-health needs of the Kentucky SKY population."
>
> **—Dr. Terry Brooks,**
> **Executive Director,**
> **Kentucky Youth Advocates**

Although we communicate with and assist individual enrollees on a regular basis, we recognize the power of hearing firsthand stories from individuals who have been directly impacted by the child welfare system and/or foster care outside of our direct enrollee interactions. KYA coordinates multiple enrollee-focused coalitions that include individuals in the Kentucky SKY population including the Kinship Families Coalition of Kentucky and the Youth Leadership Council. Aetna also has established foster parent advisory councils which allow us to hear from foster parents directly. We will work with KYA to engage these individuals through coalition meetings and focus groups on a regular basis. We will use these opportunities to hear from those impacted by the child welfare system firsthand and develop collaborative solutions that address the unique situations facing this population. Solutions will not only allow us to continuously improve our model of care for the Kentucky SKY population, but also will support broader reforms in child welfare already underway. These interactions can also help Aetna identify ways to advance Family First across the Commonwealth.

Aetna's approach to supporting children, young people, parents and other important adults involved with child protection systems is a highly participatory family engagement practice emphasizing locally based primary prevention and early intervention. This approach drives our SOC model incorporating our whole-person, whole-family approach to physical, behavioral and social well-being. SOC model components work together to help each enrollee achieve important clinical and functional outcomes: at home, in school, at work, in the community, and throughout life. Operationally, the model is driven by our Aetna conveners advocating, supporting, and connecting youth and families to resources and supports including relatives, friends, community members, and new relationships of support. This person-centered, whole person approach finds solutions that exist within our enrollees, their families, and communities, not through imposing one size fits all solutions upon them.

In Kentucky, Aetna holds a unique position in the intersection of individual enrollees and families involved with multiple systems. The SOC model approach breaks down barriers to effective outcomes, creating a comprehensive approach to assist all children and families. By centering care around the child, focusing on their goals and aspirations while engaging their full complement of support together we will achieve health and social outcomes that will build toward a successful and resilient adulthood. Our enrollees will see success resulting from our creation of **horizontal, integrated collaborations to break down the existing vertical silos** of governmental and private human service systems.

System of Care Model Staffing

Aetna's organizational structure will build on the efforts already underway at DCBS to transform the child welfare system into an effective, nationally recognized approach that strengthens families and keeps kids safe. Our organizational structure is program and population centric, beginning with an executive directive charged with nurturing a culture of collaboration and engagement across departments and stakeholders. We start with the enrollee and build solutions vs. starting with solutions and hoping are effective.

Another component of our governance structure will include collaborating with KYA to advance policies and practices that will keep families safely together and reduce the need for out-of-home placements in the child welfare system. KYA is experienced in policy development and advancement through coalition building, public education and engagement, and other advocacy activities. Specifically, in the child welfare arena, Aetna will become active participants in the Blueprint for Kentucky's Children and the Face It Movement to end child abuse to engage stakeholders in discussions around innovative solutions to help Kentucky move to a Family First approach. Aetna supports the following initiatives:

- The **Blueprint for Kentucky's Children (Blueprint)**, led by Kentucky Youth Advocates, is a coalition of non-profit, public, and private organizations across the Commonwealth that speaks with a common voice to create brighter futures for Kentucky kids. The Blueprint stands on three pillars: thriving communities launch strong families, strong families launch successful kids, and successful kids launch a prosperous future for Kentucky. Several of the Blueprint priorities are focused on advancing the priorities of Families First including family preservation and reunification. Aetna is already a partner of the Blueprint; however, we plan to grow our partnership with the Blueprint. We will actively engage Blueprint partners in advancing child welfare policies that supports Family First and on specific ways that Aetna can enhance the care it provides youth in foster care. We will engage with Blueprint partners at regular meetings and through ad hoc child welfare workgroups.
- The **Kosair Charities® Face It® Movement** directly addresses the unacceptable incidences of child abuse and neglect in Kentucky with the promotion of best practices in child abuse prevention and intervention, engaging the community, and advocating for effective policies to improve the child welfare system. Aetna will partner with KYA through Face It to support more extensive training of child abuse prevention across the Commonwealth. We will engage with the over 50 partners that actively serve on subcommittees to address the multiple prongs of child abuse prevention.

The Commonwealth has made strides in recent years to begin transforming the child welfare system. Aetna recognizes the progress and understands there are additional areas for improvement. Our partnership with KYA will not only result in better health care for the Kentucky SKY population, it will help us play a larger role in addressing the needs of Kentucky SKY that go beyond health care to ways we can keep families safely together.

Our SOC model is an innovative approach to improving delivery system capability that relies upon improving trauma-informed care throughout the delivery system and breaks down the silos to help enrollees achieve positive and holistic physical, behavioral, and social health outcomes. This model includes a full spectrum of effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and

circles of support that are organized into a coordinated network-within-a-network functioning as a virtual team. Working together, this team achieves the following:

- Drives collaboration across systems, agencies, and community-based organizations
- Builds meaningful partnerships with enrollees and their families/circle of support
- Addresses enrollees' cultural, ethnic understanding, and linguistic needs such as language and cultural differences which can create barriers for individuals with Limited English Proficiency
- Addresses disability- including those with mobility, cognitive, and communication disabilities and access to care needs ensuring equal access and understanding
- Includes consideration of enrollees with visual and hearing impairments/disabilities; need for American Sign Language, braille, etc.

More than simply a collection of various resources, we bring all the pieces together, wrapped around the enrollee, supporting them inclusively to achieve important clinical and functional outcomes: at home, in school, at work, in the community, and throughout life. Our integrated system of care demonstrates our comprehensive focus on meeting enrollees' needs through the care planning and convening process engaging their circle of support and addressing social determinants. Together, we develop solutions to resolve obstacles by wrapping around them with Aetna covered services and community-based support while focusing on cultural sensitivity, recovery, and resiliency, and adopting trauma-informed practices. Delivery system capability is a result of how available resources are organized and managed. Service gaps are common, including both the absence of specific services and practitioners, and inadequate service capacity. Fragmentation creates challenges, especially in rural areas, but our solutions break down these silos bringing together resources creating resilience both in the system at large and within individual care outcomes. Our innovative integrated system of care approach shown in **Figure G.2-5** illustrates our system of care approach and is based on a whole-person view of our enrollees' physical health, behavioral health, oral health, health literacy, functional needs, and social determinants of health.

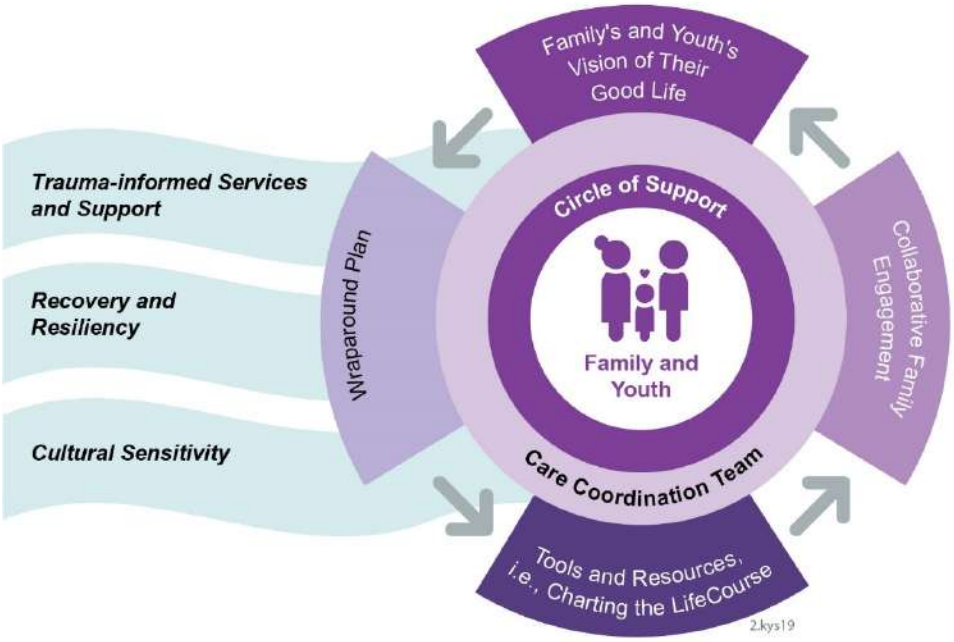

Figure G.2-5: System of Care Model and Approach

Aetna's System of Care model lays the foundation for our person and family-centered staffing approach.

Table G.2-8 summarizes the system of care positions in Kentucky that serve to support the Population Health Management (PHM) program:

Table G.2-8: Aetna System of Care Staff

System of Care Position	Role in Supporting Kentucky Enrollees
Adult System of Care Administrator	• Build key stakeholder relationships and processes that support enrollees, their families, and entire circle of support through a system of care approach • Aligning with new and upcoming state and federal policy • Facilitate and convene system level person-centered thinking, planning, and living when working with our enrollees and their circle of supports creating resilient, innovative solutions and within the aging-out process • Build community-based services and supports • Leverage full partnership with social supports and caregivers in all aspects of the planning and delivery of their own services.
Children's System of Care Administrator	• Build key stakeholder relationships and processes based on market needs and children's populations needing a system of care approach • Facilitate and convene system level person-centered thinking, planning, and living when working with our enrollees and their circle of supports, foster parents, kin providers, and guardians creating resilient, innovative solutions • Establish HERO Workshops and other peer support opportunities • Bridge with mental health promotion, prevention, and early identification and intervention to improve long-term outcomes • Build community-based services and supports
Recovery and Resiliency Administrator	• Build supportive programs to mental health and substance use delivery • Participate in integrated rounds to emphasize enrollee voice and choice • Facilitate and convene system level person-centered thinking, planning, and living when working with our enrollees and their circle of supports creating resilient, innovative solutions • Collaborate with local, state, and national partners and stakeholders • Collaborate with enrollees and family to identify and remove barriers to services • Promote the hope for recovery within the health plan
Emergency Department/Crisis Administrator	• Build collaborative relationships with fire, police, emergency medical services, hospital EDs • Collaboration with duties related to complex patient populations and collaboration of services with community programs • Collaborate with medical management on transition of care for enrollees discharging from inpatient settings and mitigate system gaps • Build collaborative protocols with first responders • Build systems for transitioning individuals in crisis to and from hospital emergency departments.
Juvenile Justice Liaison	• Collaborate with the Department of Juvenile Justice (DJJ), Department of Corrections (DOC), County Jails, Sheriff's Office, Correctional Health Services Office of the Courts (OC) and Probation Departments, and Department of Behavioral Health and Developmental Disability (DBHDID) to identify systemic changes and promote community integration • Facilitate and convene person-centered thinking, planning, and living when working with our enrollees and their circle of supports creating resilient, innovative solutions for completing justice requirements integrated within care plans and aging-out processes • Trauma informed expert • Understand Reclaiming Futures framework and work closely with other systems that serve youth, and with the community • Bridge communication with the health plan staff, court, and the justice systems
Trauma System of Care Administrator	• Communicates and collaborates with enrollees and families to identify concerns and remove barriers that affect service delivery and enrollee satisfaction • Participates in integrated rounds for the purpose of identifying trauma approaches and modalities that can assist the enrollee in building and maintaining health outcomes • Collaborate in system level person-centered thinking, planning, and living when working with our enrollees and their circle of supports creating resilient, innovative solutions • Leads and establishes structure and mechanisms to drive the trauma transformation and principles in the health plan, provider network and Commonwealth regulators and stakeholders • Supports the development of trauma-informed social-emotional programs within the Commonwealth of Kentucky

The staff members listed in the table are **trauma champions**. They include Jennifer Largen, a-quality management nurse consultant who leads and establishes structure and mechanisms to drive the trauma transformation and principles in the health plan, provider network and Commonwealth of Kentucky regulators and stakeholders. Ms. Largen and these trauma champions provide needed expertise in a trauma-informed organization to promote trauma-informed policies, staff development, and trauma-based services consistent with the mission of the organization.

Who Is a Trauma Champion?

"A champion understands the impact of violence and victimization on the lives of people seeking mental health or addiction services and is a front-line worker who thinks 'trauma first.' When trying to understand a person's behavior, the champion will ask, 'is this related to abuse and violence?' A champion will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor. The champion is there to do an identified job—he is a case manager or a counselor or a residential specialist—but in addition to his or her job, a champion is there to shine the spotlight on trauma issues." [6]

i.b. Organizational Structure: Supporting Whole-Person Integrated Care, Population Health, and Overall Improvement in Health Outcomes

Aetna has learned in its broad experience, that in every case, our enrollees hold the solution to a good life. We exist in service to our enrollees and in partnership with state child protection professionals. We strongly believe this is exactly where the promise of precision medicine intersects with a good life for our enrollees. In every step of the way, our health plan seeks to build on the capabilities of enrollees and partners and collectively we will be steadfast in our mission to support Kentucky become the national leader in preventative system transformation for all families.

Aetna's proposed organization structure for the Kentucky SKY program supports holistic whole-person care, population health and overall improvements in health outcomes in a cost-effective manner by employing evidence-based practices that are individualized, community-based, and outcomes driven while being governed and lead through a collaborative infrastructure.

We support each of our enrollees to reach and maintain a meaningful quality of life, optimum health, and overall wellness. To do so, we strive to **understand each unique enrollee in the context of their lives, their family and their community while partnering with them to design a**

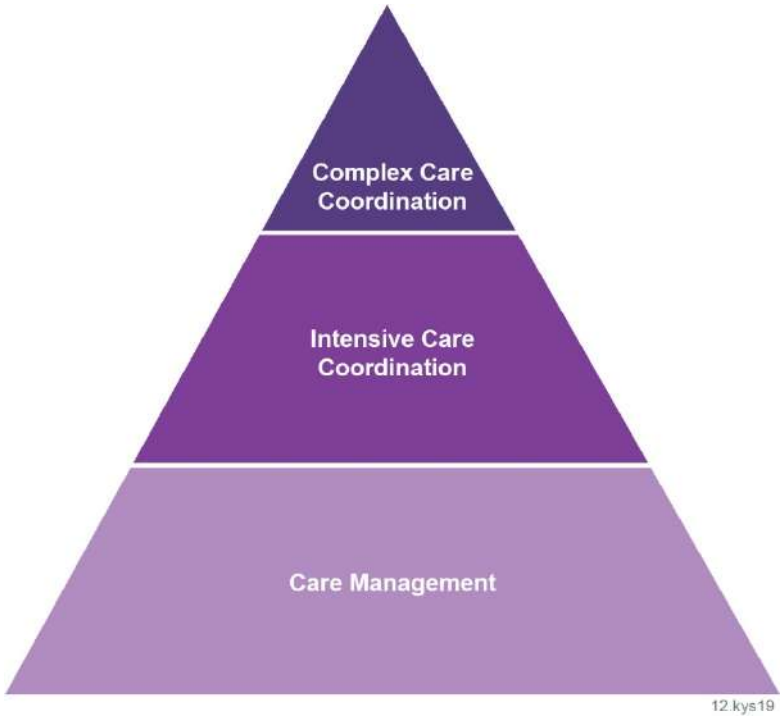

Figure G.2-6: Integrated Care Management Risk Stratification
Aetna uses population risk-level assessments to determine the appropriate level of care management services for enrollees.

[6] Source: Harris M, Fallot RD, "Using Trauma Theory to Design Service Systems." San Francisco: Jossey-Bass; 2001

person-centered holistic model of supports and services that enhances their quality of life and assists them to reach their individual life goals. While this approach is universally applied to all enrollees, we leverage supplemental tools, like the University of Missouri–Kansas City Institute for Human Development's **Charting the LifeCourse™** framework, to facilitate person-centered thinking, planning, and living when working with our enrollees and their circle of supports. With these tools, we work closely with enrollees and their families to identify key life stages and provide thoughtful anticipatory guidance around major milestones to sustain enrollee quality of life, avoid unnecessary transitions, and ensure continuity of care.

Within our Kentucky SKY care team, we employ Aetna's **Six Points of Care** approach – an interdisciplinary team composed of professionals from different areas of specialization collaborates to identify specific enrollee care management needs. Our analysis comprehensively considers individual health and care needs and challenges and classifies them into care coordination categories identified in **Figure G.2-6** and related to the following six points of care approach:

1. Behavioral health conditions
2. Medically complex conditions
3. Adoptive
4. Aging-out/transition
5. Neonatal abstinence syndrome
6. DJJ

To meet all contract requirements and meet the needs of the Kentucky SKY population, Aetna will hire additional care managers to provide services across the three tiers of the care management stratification. Care coordinators will be located within each region of the Commonwealth to provide support and care management. We will assure sufficient staffing levels of nurse care coordinators to meet the needs of the Kentucky SKY populations through effective population risk-level assessments as described and stratified in **Table G.2-9**, especially those enrollees designated as Medically Complex Children. We will comply with the Kentucky SKY enrollee to nurse care coordinator ratio as determined by the Department, DCBS, and DJJ, if needed.

Table G.2-9: Population Risk Stratification in Care Coordination Approach

Population Risk Level	Staffing Ratios	ICM Stratification	Services Provided
Complex Care Coordination: Enrollees with previous behavioral health admissions and Kentucky SKY enrollees with Special Health Care Needs	12:1	Complex Care Management (Intensive Care Management) Includes Children with Special Health Care Needs dependent on complexity of healthcare needs	• Two face-to-face visits (monthly) • One weekly contact • A minimum of two hours per week of care Coordination • One meeting with the Kentucky SKY Enrollee and caregivers (monthly) • One care plan update
Intensive Care Coordination: Enrollees with moderate or emergent needs and acuity	32:1	Chronic Condition Management (Supportive Care Management) Includes Children with Special Health Care Needs dependent on complexity of healthcare needs	• One face-to-face visit (monthly) • One weekly contact • One meeting with Kentucky SKY enrollee and caregivers (monthly) • One care plan update (monthly)
Care Management: Prevention and very early intervention and enrollees with limited unmet needs	400:1	Prevention and Wellness	• All Kentucky SKY enrollees will have access to care coordination services and a Care Coordination team; enrollees can request more intensive care coordination if their status changes at any time

Population Risk Level	Staffing Ratios	ICM Stratification	Services Provided
			• Aetna will outreach Kentucky SKY enrollees quarterly to assess any changes in SDOH, conditions, or any other need • Aetna will educate enrollees and their caregivers on how to contact the health plan should needs arise prior to outreach • Health risk assessment (HRA) and other screenings and assessments as needed will be completed

Population Health Management (PHM)

Aetna recently added a highly qualified population health management director, Jennifer Nachreiner, MPH, RD, to our Kentucky staff. Charged with implementing our population health strategy, Ms. Nachreiner recognizes that health is more than the optimal delivery of clinical care; it encompasses the "health of the population, including the distribution of health outcomes and disparities in the population" as defined by the National Quality Forum[7]. It is made up of the factors that influence the health of a population at the socio-cultural, economic, and individual levels. Following from this understanding of population health, Ms. Nachreiner works collaboratively with team members to develop programs guided by the following principles:

- **Person-centered:** Our strategy is a personalized approach that emphasizes empowering enrollees to achieve health goals by recognizing and elevating the individual's expertise and central role in their own health. Our PHM programs meet enrollees with the right level of services for each person and enable enrollees to use those services to achieve their individual health goals.
- **Accessible:** Our programs ensure convenience and easy-to-access resources that are targeted to meet the needs of our populations. Our programs are coordinated so all benefits and resources can be accessed regardless of point of access, cultural orientation, health literacy, preferred language, or social determinants of health factors that impact accessibility.
- **Integrated:** We aim to increase integration of enrollees' care across internal and external partners and providers, including care managers, patient-centered medical homes, specialist care, and community resources. An effective strategy is one that coordinates to minimize silos in our system.
- **Holistic:** Our PHM strategy is holistic. We seek to recognize the unique biological, cognitive, social, and cultural factors that culminate in enrollee and community health outcomes. We deploy personalized care planning and programs that incorporate an enrollee's assets and attend to their needs stemming from each of these intersecting factors.
- **Health Care Equity:** Our Health Care Equity effort underlies a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. We pursue health equity for all individuals and give special attention to the needs of those at greatest risk of poor health, based on social conditions. We understand enrollees in particular groups experience major obstacles to health due to socio-economic disadvantages and injustices. These enrollees may face social inequities based on race, gender, class, sexual orientation, or immigration status and economic inequities that may limit educational or job opportunities. The environment or area in which the enrollee lives may also contribute to inequity particularly for rural areas where access to health care and economic opportunity including employment and education may be limited. We

[7] National Association of Community Health Centers, "Population Health Management," (2016): accessed June 25, 2019; http://www.nachc.org/wp-content/uploads/2015/12/NACHC_pophealth_factsheet_FINAL.pdf.

believe it is important to identify the root causes of health and to solve these inequities our PHM strategy strives to reduce the disparities and lack resources and opportunities for our low-income enrollees, and their inability to access needed services.

- **Data and evidence-driven:** Programs follow from a locally rooted understanding of population health priorities, needs, and assets while having the underpinnings of a national structure driven by population data analytics and evidence-based practices that focus our PHM activities for distinct enrollee populations throughout the continuum of care.

Improved Health Outcomes

Aetna brings the full complement of our local and national quality improvement infrastructure and resources in alignment with the Department's goals in transforming the Kentucky Medicaid program. We empower enrollees in achieving their optimal healthcare outcomes and quality of life, while honoring their culture, goals, and need for self-determination. We fully engage our providers and enrollees through our quality initiatives, targeting Kentucky communities experiencing health disparities. As a **National Committee for Quality Assurance (NCQA) Commendable accredited organization,** we have demonstrated our commitment to continuous quality improvement and improved health outcomes as evidenced by our substantial improvement trajectory in quality measures since 2015.

Our foster care HEDIS scores are typically greater than our general Medicaid children population. **The following measures in Table G.2-10 are a few examples of the most significant variances between the foster care population and the total HEDIS population for HEDIS 2019.**

Table G.2-10: 2018 HEDIS Measure Comparisons Foster Care Enrollees vs all Child Enrollees

HEDIS Measure	All Foster Care Enrollees 2019	All Child Enrollee HEDIS Administrative Rates 2019	Percent Difference
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total	34.4%	28.7%	19.9%
Medication Management for People with Asthma Age 12-18 PD 75	51.1%	34.5%	48.3%
Childhood Immunization Status – Combo 5	34.8%	21.5%	61.7%
Cervical Cancer Screening	68.9%	50.4%	36.6%
Annual Dental Visits - Total	76.4%	62.2%	23.0%
Initiation and Engagement of AOD Abuse or Dependence – Initiation Total	53.2%	46.0%	15.7%

Sandra Wendt will serve as QI director for Kentucky SKY. Ms. Wendt's expertise includes managing large scale teams and projects, building and executing strategies collaborating with all operational areas, and reengineering business processes. In her role as Quality Improvement Director for Aetna, Ms. Wendt is responsible for developing and implementing the Quality Assessment and Performance Improvement (QAPI) programs and policies in addition to running the department's operations. The permanent QI director will have the appropriate education, training and licensure, as applicable, and will also have experience with strategic planning, the foster care and juvenile justice systems, and trauma-informed care.

ii. Prior Experience

Aetna's staffing model and selection of our Kentucky SKY staff is based on these individuals' passion and expertise in innovative, evidence-based program implementation and strong belief in our system of care approach to services for foster care and juvenile justice enrollees. Our Kentucky SKY staff in required positions will be 100 percent dedicated to the Kentucky SKY population. We will require all staff dedicated to the Kentucky SKY program to have prior experience serving populations similar to those to be served by the Kentucky SKY program (children and youth in foster care, those receiving adoption assistance, and justice-involved youth). Our project leadership will seek local candidates who are experienced and familiar with the local Medicaid health care delivery system and culture in the Commonwealth and have the Kentucky licensures and certifications required by law and the contract.

Our staffing approach in Kentucky will be guided by the Aetna Medicaid organization's implementation of the new Specialized Managed Care for Children and Youth program in West Virginia. We framed staff hiring on expertise in trauma-informed practice, clinical knowledge, and deep whole-person and family engagement skills, which were assessed during the interview and onboarding process. Staffing included identification of at least one Master's-level social worker for each region, as well as one social work supervisor.

Aetna builds key stakeholder relationships and processes based on market needs and children's populations needing a system of care approach. To accomplish this, our staff bring to Aetna Kentucky SKY successful previous experience in facilitating and convening system level person-centered thinking, planning, and living to bring resources and solutions when working with our enrollees and their circle of supports in creating resilient, innovative solutions. Our experienced staff will leverage previous experience in building integrated care solutions with a whole-person and trauma-informed approach. To best serve these populations, we will make certain our staff have vast expertise and experience in working with foster care and juvenile justice populations to meet all requirements pertaining to staff experience, including those pertaining to key personnel as identified in **Table G.2-12.**

Our proposed staffing plan is continuous, integrated, and scalable. It is built on the principle of Kentuckians serving Kentuckians—developing a staff with a personal and professional passion for serving children in foster care and similar populations and managed by key staff and health plan leaders to help ensure adequacy of staffing to a growing membership or any new contract requirements.

iii. Staff Recruitment

Aetna has named staff for 19 of 19 key leadership positions that will be dedicated to Kentucky SKY. As an incumbent Medicaid health plan in Kentucky, Aetna will draw some staff (including care coordinators who are presently serving the Kentucky SKY populations) from our current managed Medicaid operations as part of the transition plan. Key personnel positions (as noted in **Table G.2-12**) will be filled on an interim basis from highly qualified staff within the Aetna Medicaid organization. All permanent staff will be hired and in place within 90 days of contract execution unless otherwise authorized by the Department and DCBS. Aetna uses proven methodologies to recruit local Kentucky health care experts who know Kentucky Medicaid whenever possible. We hire experienced professionals who meet our qualifications and requirements of success and expertise in serving vulnerable Medicaid populations with empathy and integrity.

iii.a. Recruitment Sources

We use hiring tools and techniques that define the position by the knowledge, education, skills, and competencies candidates should possess. Our "boots on the ground" recruitment strategies include the following:

- Capitalizing on our extensive relationships throughout the Commonwealth
- Engaging in outreach with stakeholders across the Commonwealth and networking with local advocacy organizations like KYA and educational institutions like Murray State University, Kentucky Wesleyan University, Morehead State University, University of Kentucky, University of Louisville, Western Kentucky University, and others to recruit candidates completing master's level programs in applicable fields
- Using local and national talent acquisition staff
- Using detailed job descriptions to define and communicate our job expectations, required knowledge, skills, and competencies and to assist us further in the targeted selection of qualified candidates
- Posting of position availability on both internal and external job sites
- Utilizing our employee referral program to reward employees at every level when they help us achieve our goal of attracting and retaining top talent. Our colleagues who refer an external candidate that is hired are eligible to receive a monetary award. History has shown us that referrals from our staff and former colleagues usually result in strong candidates.
- Posting positions specific to experience serving children, youth, and foster care populations and publications, websites, and other outlets such as organizations that assist those with disabilities and those that support diversity; postings will be available on both internal and external job sites, advertising on recruiting websites, job boards, and niche sites
- Launching activities that include virtual job fairs and open houses; social sharing of job postings on LinkedIn, leadership networking, resume mining, and web sourcing
- Participating in employment fairs
- Reviewing candidate applications by our hiring team
- Conducting interviews of candidates by our Human Resources team and plan leadership
- Seeking approval from the Department for key position hires

Aetna recognizes the importance of organization-wide support and active involvement in workforce, hiring, development, and retention for Kentucky SKY personnel. This means we bring national expertise locally to actively engaging in outreach and meet the specific needs of enrollees in each region. In this effort we engage enrollee advocacy groups, recovery-oriented programs, community and faith-based organizations, and former enrollees with the intention of recruiting potential staff members whose knowledge and expertise comes from their lived experience of trauma, resilience, and recovery.

Support staff members, community health workers (CHWs), and SOC staff can be recruited from this population and offered incentives, such as tuition reimbursement, training stipends, and professional mentoring with the goal of developing a trauma-informed workforce from within the demographic served. Our philosophy is most health occurs in the community where our enrollees live, and we strive to hire Kentuckians to serve Kentucky. In addition to hiring locally, we support paraprofessionals like peers and CHWs and have developed internal CHW training classes to offer to our staff that wish to advance in their careers. Talent development is key and through our staffing, staff development, and training we strive to increase the availability of trauma informed qualified staff at all levels of the community and our organization.

Aetna understands the need to involve line personnel in the design and implementation phase as this not only ensures a smoother transition to ongoing operations but also full ownership and avoidance of unnecessary resistance to changes in practice.

iii.b. Contingency Plans

As an original Medicaid managed care organization in the Commonwealth since 2011, Aetna has a proven record of successfully staffing new programs. Aetna aggressively recruits and trains individuals to provide needed services and health care access for our Kentucky enrollees. If we are unable to recruit sufficient numbers of adequately trained staff in a timely basis, we will allocate staff from other Aetna

Medicaid organization health plans on an interim basis to assure appropriate coverage of Kentucky SKY's needs. We also have experience integrating expert consultants to provide services.

We met our staff goals within the first two months of implementation for the child and youth program in West Virginia. With Medicaid managed care operations in 16 states including serving the foster care population in 10 states, we can leverage staff with the expertise needed to address contingencies without disruption. Should a position become vacant during the implementation of this contract, we are able to draw upon the vast resources from other Aetna state health plans and staff of the national Aetna Medicaid organization to ensure seamless continuity of service to our enrollees, providers, and the Department.

iii.c. Ensuring Experience, Licensures, and Training of Personnel

We require that all staff have the experience, licensures, and training to support the implementation and ongoing administration of the Kentucky SKY program. To make certain all staff have required credentials and licensing we will conduct thorough checks with licensing bodies and verify all training and credentialing have been attained and kept current as prescribed by the specific regulations for each professional designation.
These licensures and credentials include the following:

- Certified Alcohol and Drug Abuse Counselors
- Certified peer specialists
- Certified social workers
- Licensed clinical social workers
- Licensed professional counselors and licensed professional counselor associates
- Registered nurses

Our care coordinators are required to have a master's degree. They have the appropriate experience, education, and in-depth knowledge of community supports and resources necessary to serve our Kentucky enrollees. Our written job descriptions for Aetna and delegated community care coordinators outline position requirements, responsibilities, and qualifications, including when professional licensure is required. Through the workflows in our electronic care coordination system, we monitor and track licensure expiration dates, notifying staff so that they complete processes for renewals timely. For non-licensed care coordinators, our goal is to ensure our community service workers have the background, experience, and commitment necessary to support the population they are serving.

iii.d. Seamless Transition of Staff from Implementation to Ongoing Operations

Aetna's primary implementation goal is to execute seamlessly Kentucky's vision of assuring all children have safe and nurturing homes and communities. Our staff's transition from implementation to ongoing operations occurs over many weeks, and it includes the following steps:

- Manage a shadowing phase with staff during which subject matter experts confirm transitioned processes are being executed correctly
- Conduct a formal handoff of any open issues on the implementation project's issue-tracking log
- Complete a checklist to confirm key operational activities have been successfully transitioned

Table G.2-11 provides an overview of the transition process from implementation to daily operations.

Table G.2-11: Transition from Implementation to Operations

Timing	Actions
Week Prior to Go-live Date	• Implementation team will begin daily command conference calls with both the health plan entities and the Shared Services departments. These command center conference calls are designed to report out on individual team performance and to raise/elevate any significant issue that it is impacting our enrollees and providers. • The Implementation team not only tracks and reports these issues to the executives, but also takes an active role in organizing a cross-functional team to resolve the issue.
Weekly	• The Implementation team provides weekly updates to the executive team on performance and on escalated issue resolution. Once individual team performance moves back to optimal performance and issue mitigation is no longer needed, the Implementation team will close the daily command center.
First 30 days of Live Program	• The Implementation team is responsible in the first 30 days to ensure the requirements in the RFP and the promises made in the response are both documented and operational. • At the conclusion of both the command center and the verification that all requirements and promises are documented and operational, the Implementation team meets with the health plan COO and chief compliance officer to transition all future oversight to the health plan. • The documentation of the processes secured by the Implementation team are transitioned over to the health plan's SharePoint site. • Once the Health Plan has signed off on these documents and processes, the Implementation team makes a formal request to executive leadership on the transition to the health plan. If the executive leadership approves, this concludes the work of the Implementation team.

iv.a-c. Key Personnel

An **onsite, local Aetna leadership team** will manage the delivery and operations of our Kentucky SKY program, leveraging our longstanding, positive relationships with the Department, providers, community resources, advocacy groups, regulatory agencies, and other Medicaid focused organizations throughout the Commonwealth. Our proposed interim Kentucky SKY key personnel together bring a wealth of experience in working toward better outcomes, better patient experiences with health care, and lower total cost of care. As detailed in **Table G.2-12**, our proposed key personnel will be **dedicated 100 percent** to the Kentucky SKY program, with no other responsibilities outside of the Kentucky SKY program. Resumes of key personnel within our Aetna Kentucky SKY staffing plan are attached in **Attachment V**.

Table G.2-12: Aetna Better Health of Kentucky Key Personnel

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Dawn Price, MBA, PMP	Project Manager	This position is experienced project manager who shall lead the Kentucky SKY program planning and implementation and facilitate ongoing operations until such time the Department and Kentucky SKY Contractor mutually agree to discontinue the project management services. The project manager shall have experience with implementation of new programs or products for a population of a similar size and complexity as Kentucky SKY. The project manager shall be located at the Kentucky SKY MCO's Kentucky office and be onsite at the Department and DCBS offices in Frankfort, Kentucky at times specified by the Department and DCBS during the planning, implementation and deployment phases of the contract.	Over 14 years of health care industry experience in Program and Project Management and 8 years of managed Medicaid experience. Ms. Price is currently serving as a Business Development Manager in Aetna's Medicaid organization. She has extensive experience leading large scale, fast-paced projects for Medicaid and Medicare as well as pharmacy/pharmacy benefits management (PBM) implementations.	1	Louisville, Kentucky	Employee of Aetna Medicaid Administrators
Kelly Gannon, MBA, LCSW	Executive Director, SKY Program	This position shall be a full-time administrator with responsibilities for directing and overseeing implementation of SKY and successfully managing all aspects of ongoing program operations.	Experienced executive leader in behavioral health with more than 30 years of community mental health and non-profit experience. Expertise in strategic planning and implementation, process improvement, and creating strategic partnerships to achieve results. Experience with operational oversight of key programs that intersect with DCBS, such as Children's Review Program, while serving as Director of Clinical Health Services at Bluegrass MH-MR Board. *(Continued on next page)*	1	Louisville, Kentucky	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Kelly Gannon, MBA, LCSW	Executive Director, SKY Program		*(continued)* Proven record with outcome based clinical programming places her in a great position for setting the bar for healthier kids and families in Kentucky. Firsthand understanding navigating the foster care system as her 5-year-old daughter was adopted out of Kentucky's foster care system. This personal experience provided her with a keen sense of appreciation for the challenges families and children face while navigating the system. Previously COO for Centerstone, largest CMHC in Kentucky. Oversaw $100 million operations budget. Identified client trends and areas for service growth, while working with community stakeholders to address social determinants of health. Bachelor's and Master's degrees in Social Work, Master's in Business Administration. She is a doctoral candidate in the College of Social Work at the University of Southern California focusing on social innovation for complex problems.			

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Susan Vickers, MSW, CSW	Chief of Staff and Director of Stakeholder Engagement and Education	This full-time position provides strategic counsel to the SKY executive director regarding operations, working across all internal departments both at the health plan and national level to develop and implement best practices in health services and plan operations. This position also engages stakeholders across the Commonwealth and provides training and education on the Kentucky SKY foster program. Education efforts will entail foster care, adoption assistance, kinship care, and juvenile justice, among others.	Ms. Vickers is an experienced quality improvement specialist with 18 years of health care industry experience and 5 years of managed Medicaid experience. Ms. Vickers is a leader of successful training programs and program implementation for health care entities and focuses on ensuring program excellence through evaluation and assessment of program operations. Her expertise includes extensive work in the quality, leadership, and hospice arenas. Her educational background includes a Master of Social Work and Graduate Certificate in Gerontology from the University of Kentucky School of Social Work and a Bachelor of Science in Psychology from the Centre College. Prior to joining Aetna, Ms. Vickers served as a Hospice and Palliative Care Social Worker for St. Anthony's Hospice in Hendersonville, Kentucky.	1	Louisville, KY	Employee of Aetna Medicaid Administrators
Andrea Bennett, PhD, MSW	Local Senior Advisor	This position assists and advises the executive director on program operations before and after contract implementation offering extensive knowledge of the child welfare system in Kentucky. The senior advisor will develop strong relationships with key stakeholders in the health and child welfare arenas in the Commonwealth to enhance program operations and collaboration with stakeholders.	Ms. Bennett is a seasoned policy specialist with over 10 years of experience working on public policy issues with a focus on health and child well-being. Her expertise includes policy development and implementation, advocacy, coalition building, and Medicaid program design.	1	Louisville, Kentucky	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Josh Boynton, MS	National Senior Advisor	This position assists and advises the executive director on program operations before and after contract implementation offering extensive knowledge of the child welfare system in Kentucky. The senior advisor will develop strong relationships with key stakeholders in the health and child welfare arenas nationally to enhance program operations and collaboration with stakeholders.	Mr. Boynton has more than 20 years of community-based health care industry leadership experience and 7 years of managed Medicaid experience. He serves as the current segment lead for strategy and implementation of WV Mountain Health Promise (sole source Child Welfare/Foster Care contract awarded to Aetna Better Health of West Virginia in 2019). Mr. Boynton's expertise includes managing business change processes and strategic planning. He is a successful entrepreneur who founded LifeShare, a nationally recognized, multi-million-dollar company that supports people with intellectual and developmental disabilities and children in the child welfare system.	1	Louisville, Kentucky	Employee of Aetna Medicaid Administrators
Stephanie Whyte, MD, MBA, CHQCM, CHIE	SKY Medical Director	The medical director shall be a physician licensed and in good standing to practice in the Commonwealth of Kentucky. The medical director shall be a pediatrician certified by the American Board of Pediatrics. The medical director shall be actively involved in all major health programs of the Kentucky SKY Contractor. All clinical directors, including those employed by subcontractors, shall report to the medical director for all responsibilities of the Kentucky SKY Contract. The medical director shall also be responsible for treatment policies, protocols, quality improvement activities, population health management activities, and utilization management decisions related to the Kentucky SKY program and devote	Dr. Whyte is an accomplished health care executive with more than 20 years of successful health care industry experience and 5 years of managed Medicaid experience. In 2012, Dr. Whyte was selected as the inaugural chief health officer for Chicago Public Schools, overseeing critical student health and wellness programming within CPS, while collaborating with Chicago Department of Public Health (CDPH) on the city's first public health agenda - Healthy Chicago.	1	Louisville, Kentucky	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
		sufficient time to ensure timely clinical decisions. The medical director shall also be available for after-hours consultation, if needed.	Dr. Whyte's achievements with Aetna include serving as chair for the HEDIS Child Health Quality team, lead for the neonatal abstinence syndrome program, and membership with the national health care equity group and the Medicare-Medicaid National Pharmacy & Therapeutics Committee.			
Sandra Wendt, MA, CPHQ	SKY Quality Improvement (QI) Director	This position is responsible for the operation of the Quality Improvement program for the Kentucky SKY program. The QI Director shall have experience with strategic planning, the foster care and juvenile justice systems, and trauma-informed care. The QI Director must have the appropriate education, training and licensure, as applicable, and must have and maintain training and experience in rapid cycle Improvement.	Ms. Wendt is an innovative and versatile leader with over 20 years of health care industry experience and more than 5 years of managed Medicaid experience. Her expertise includes managing large scale teams and projects, building and executing strategies collaborating with all operational areas, and reengineering business processes.	1	Louisville, KY	Employee of Aetna Medicaid Administrators
Cathy Jones, MSW, LCSW	SKY Behavioral Health (BH) Director	This position is a behavioral health practitioner licensed and in good standing in the Commonwealth of Kentucky. The BH director shall be actively involved in all programs or initiatives relating to BH services for Kentucky SKY enrollees. The BH director shall also coordinate efforts to provide behavioral health services by the Kentucky SKY contractor or any behavioral health subcontractors.	Ms. Jones is an experienced behavioral health management professional with 17 years of health care industry experience and 12 years of managed Medicaid experience. Her expertise includes leadership roles in the utilization management, behavioral health and social work arenas. She has forged several relationships in the Kentucky community as it relates to appropriate therapeutic care for clients and available programs for those in need.	1	Louisville, KY	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Amy Schuten, MA, LISAC	SKY Utilization Management (UM) Director	This position is responsible for oversight of the UM functions for the Kentucky SKY program and any subcontractors performing services relevant to utilization management. The UM manager must have experience with behavioral health services, foster care and juvenile justice systems, crisis intervention services, and trauma-informed care.	Ms. Schuten has 20 years of behavioral health care industry experience and 10 years of managed Medicaid experience. She is a leader of successful teams, initiatives, and operations that have served Medicaid populations in several states. She focuses most of her work on leading and implementing behavioral health programs focused on quality and cost-effective care.	1	Louisville, KY	Employee of Aetna Medicaid Administrators
Kim Schuetze, RN, ACSW, CCM	SKY Care Management Director	This position is responsible for the oversight of the Care Coordination teams serving all service regions and community districts. The director will ensure the Care Coordination teams are assigned within one business day of enrollment in Kentucky SKY. Oversight of all activities of the Care Coordination teams and make updates as necessary as determined by the Kentucky SKY enrollee's service plan.	Ms. Schuetze is a Registered Nurse and Certified Social Worker with more than 30 years of experience developing and implementing best practice approaches. In her role as director of care management for the SKY program with Aetna Better Health of Kentucky, Ms. Schuetze is responsible for supervising care management services for the Kentuckians in the foster care program. Prior to joining Aetna, Ms. Schuetze provided direct patient care in a clinical inpatient facility and, as a social worker, provided support and care coordination in an outpatient setting. Her educational background includes a bachelor and master's degree in Social Work and her associate degree for Registered Nurse. Kim is a Certified Case Manager through the Commission for Case Management Certification.	1	Louisville, KY	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Kelsey Isaacs, LCSW	SKY Behavioral Health Clinician	This position is a master's-level BH clinician specializing in BH. The BH clinician will coordinate all enrollee BH needs and coordinate for integrated care with care managers who facilitate physical health need. The BH clinician also develops and maintains enrollee integrated care plans.	Ms. Isaacs has more than 5 years of health care industry experience and 5 years of Medicaid experience. Her expertise includes instructional leadership, clinical case management and strategic insights in the behavioral health and social work arena. She has forged several relationships in the Kentucky community as it relates to juveniles and their behavioral care.	1	Louisville, KY	Employee of Aetna Medicaid Administrators
Shantoria Gonya, MS	SKY Behavioral Health Specialist	This position is a BH specialist with at least five years of BH experience. The BH specialist assists in care planning and collaborating with physical health care managers to assure BH enrollee needs are met.	Ms. Gonya is an experienced behavioral health specialist with 8 years of health care industry experience and 5 years of managed Medicaid experience. Her expertise includes extensive work in both the behavioral health and social work arenas.	1	Louisville, KY	Employee of Aetna Medicaid Administrators
Erneshia Pinder, MS	Family/Youth Peer Support Specialist	Peer support services means an evidence-based model of care involving a qualified peer support specialist, a person with "lived experience," who supports individuals with mental health issues, trauma, and substance use disorders; knowledge and expertise comes from their lived experience of trauma, resilience, and recovery; Peer support specialist means an individual who has successfully completed the initial and ongoing training approved by DBHDID under Kentucky statute. Peer support services can be provided by an adult peer support specialist, youth peer support specialist, or family peer support specialist.	Ms. Pinder is a health care professional with 14 years of health care industry experience and 4 years of managed Medicaid experience. Her expertise includes building partnerships to promote recovery and wellness and advocating for service environments that are supportive and welcoming for enrollees.	1	Louisville, KY	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Anna Mauzey, MA, LPCC	Prior Authorization /Pre-Certification Coordinator	This position is a health professional licensed in the Commonwealth of Kentucky and experienced in the delivery of behavioral health services. This position shall be responsible for coordinating prior authorizations and pre-certifications and convening meetings with DCBS and DJJ professionals at the service region and community district level, as needed, to ensure appropriate and timely care for Kentucky SKY enrollees.	Ms. Mauzey is an experienced behavioral health and clinical specialist with 9 years of health care industry experience and 7 years of Medicaid managed care experience. Her expertise includes utilization management and strategic insights in the behavioral health and social work arena.	1	Louisville, KY	Employee of Aetna Medicaid Administrators
Dustin Johnson, MS	SKY Provider Relations Liaison	This position is responsible for supporting the resolution of provider access and availability issues. This position must have knowledge of Kentucky providers, including BH providers, and patterns of care/referral in Kentucky.	Mr. Johnson is an experienced behavioral health professional with more than 15 years of health care industry experience. His expertise includes many leadership roles in both the behavioral health and social work arenas. He has focused most of his work on organizational leadership and knows how to develop relationships to improve the outcomes of the enrollees.	1	Louisville, KY	Employee of Aetna Medicaid Administrators
Jessica Hillyard, RN, BSN	SKY Complex Care Management Manager	Oversight and Management of health services team processes including the organization and development of high performing teams. Development and design of policies and procedures that improve medical management operations while meeting regulatory requirements.	Ms. Hillyard is an experienced case management nurse with a demonstrated history of working in the health and wellness industry. Jessica has a Bachelor of Science in Nursing from the University of Louisville.	1	Work at Home	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Janna Cheek, RN, BSN	SKY Intensive Care Management Manager	Oversight and management of health services team processes including the organization and development of high-performing teams. Development and design of policies and procedures that improve medical management operations while meeting regulatory requirements.	Ms. Cheek is a Registered Nurse with more than 22 years of experience providing clinical care, case management and care coordination in a variety of pediatric settings. Prior to joining Aetna, Janna served as a staff nurse within a hospital and clinic setting. Her educational background includes a Bachelor of Science in Nursing from Indiana Wesleyan University.	1	Work at Home	Employee of Aetna Medicaid Administrators
Monica Thompson, BSN, RN, CCM	SKY Intensive Care Management Manager	Oversight and management of health services team processes including the organization and development of high performing teams. Development and design of policies and procedures that improve medical management operations while meeting regulatory requirements.	Ms. Thompson is a Certified Case Manager, with more than 8 years of experience providing coordination of care. In her role as a pediatric nurse case manager for Aetna Better Health of Kentucky, In previous positions, Monica has worked in acute settings providing direct patient care. Her educational background includes a Bachelor of Science in Nursing, a Bachelor of Arts in Biology and is a Certified Case Manager.	1	Work at Home	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Robin Holloway, RN	SKY Care Management Manager	Oversight and management of health services team processes including the organization and development of high performing teams. Development and design of policies and procedures that improve medical management operations while meeting regulatory requirements.	Ms. Holloway is an RN with more than 10 years of experience in the nursing. Her nursing experience prior to working at Aetna was in med-surg and neurology. Prior to becoming an RN, she was a social worker. As a social worker she worked for the Cabinet for Health and Family Services in Child Protection. She received a Bachelor of Arts in Social Work from the University of Kentucky and an Associate Degree in Nursing from Jefferson Community and Technical College.	1	Work at Home	Employee of Aetna Medicaid Administrators
McKenzie Clarke, LCSW	SKY Care Management Manager	Oversight and management of health services team processes including the organization and development of high performing teams. Development and design of policies and procedures that improve medical management operations while meeting regulatory requirements.	Ms. Clarke is a Licensed Clinical Social Worker (LCSW) with six years of experience providing case management, individual and group therapy, and crisis intervention. Prior to her current role with Aetna, Ms. Clarke served as a Psychiatric Social Worker at Eastern State Hospital. Ms. Clarke's educational background includes a Bachelor of Arts in Psychology and a Master of Clinical Social Work.	1	Work at Home	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Rachel Fox, LPCC	SKY Care Management Manager	Oversight and management of health services team processes including the organization and development of high performing teams. Development and design of policies and procedures that improve medical management operations while meeting regulatory requirements.	Ms. Fox is a Licensed Professional Clinical Counselor (LPCC) with more than 7 years of experience providing both case management and therapeutic counseling treatment to children and adults Her educational background includes a Bachelor of Arts in Psychology and a Master in Counseling and Personnel Services with concentration in Counseling Psychology. Rachel maintains her independent behavioral health license as an LPCC.	1	Work at Home	Employee of Aetna Medicaid Administrators
Lynne Kain, RN, BSN	SKY Care Management Manager	Oversight and management of health services team processes including the organization and development of high performing teams. Development and design of policies and procedures that improve medical management operations while meeting regulatory requirements.	Ms. Kain is a Registered Nurse with 15 years of pediatric experience focusing on neonatal nursing care. Prior to joining Aetna, Ms. Kain was a bedside nurse in multiple hospital NICU's one being level 4 NICU and a Neonatal/Pediatric Flight nurse at Kentucky Children's Hospital. She has a Bachelor of Science in Nursing.	1	Work at Home	Employee of Aetna Medicaid Administrators

Name	Title	Brief Job Description	Qualifications	FTE	Office Location	Staff member or Subcontractor
Sally Wylie, BSN, RN	SKY Department of Juvenile Justice Care Management Manager	Oversight and management of health services team processes including the organization and development of high performing teams. Development and design of policies and procedures that improve medical management operations while meeting regulatory requirements.	Ms. Wylie is a Registered Nurse with more than 35 years of experience providing clinical care, case management and care coordination. Prior to joining Aetna, Ms. Wylie provided case management services to members at a managed care organization and hospital. Her educational background includes a Bachelor of Science in Nursing from Illinois Wesleyan University and a Master of Science in Health and Physical Education from Illinois State University.	1	Work at Home	Employee of Aetna Medicaid Administrators

Please refer to **Attachment V** for key personnel resumes.

v. Staff Training

Our Kentucky SKY staff training will provide all applicable staff members with comprehensive information on the Kentucky SKY program, including the roles and responsibilities of the Department, DCBS, and DJJ as well as our contractual requirements under the Kentucky SKY program. The training will also provide a detailed review of the organization, staffing, and infrastructure of our Kentucky SKY program and support of the Kentucky SKY program bringing local resources to bear to bring a Kentucky-centric approach. To ensure good understanding of Kentucky SKY processes and interactions on behalf of Kentucky SKY enrollees the training will include detailed processes and workflows.

Training Topics

In addition to processes and requirements, the Kentucky SKY training will also provide training on the unique physical health and behavioral and social needs of youth in child welfare, foster care, and juvenile justice systems. Key components of the training will include the following:

- Trauma-informed care
- Adverse Childhood Experiences (ACEs)
- Neonatal abstinence syndrome (NAS) crisis intervention services
- Evidence-based practices to provide understanding and empathy to our staff on the trauma and stress often inherent within the Kentucky SKY populations served under this contract.

In developing a thorough understanding of the Kentucky SKY program for our staff, we will also provide a comprehensive review of the Family First Prevention Services Act and other federally mandated services for the Kentucky SKY population within the training. Creating successful outcomes for the Kentucky SKY population is a primary goal and therefore assisting youth in successfully aging-out and transitioning to an effective, fulfilling adult life is paramount. Our training of our staff to provide the best possible support in the process and services available to youth aging-out is core to our program's success and to the success of the youth we serve.

We believe it is critical to provide our enrollees a standardized, evidence-based CHW program that is fully integrated into the current system of care and that provides our enrollees with a trusted person that shares their sociodemographic characteristics. CHWs are trained to serve individuals in a person-centered, holistic manner, localized approach in alignment with the foundational principles of our population health program. This localized and comprehensive approach ensures that if a social need is identified, our CHWs have access to the complete care team to assist our enrollees.

In addition to CHW training, Aetna proposes a large-scale Training and Coaching Strategic Planning Process that draws on the perspectives and expertise of stakeholders, partners and parents. After the completion of a strategic design and implementation plan, Kentucky SKY will direct that key leaders and staff from Aetna as well as partners spend two weeks in a custom designed learning process focused on implementation and organization change process to embed the practice framework and model.

The person-centered and values-based Kentucky SKY model requires a training plan that integrates adult learning best practices as well as a comprehensive set of trainings backed by coaching on key components of the model from over-arching principles and standards to practical interventions and competencies. Aetna takes this learning to the next level and ensures that each staff member is skilled in training colleagues, youth, and parents as well as community members thus cementing the new skills in daily practice and habits. This transfer of practical knowledge to youth and families leads to shorter lengths of service, increased confidence, and the ability to navigate life on their own no matter what lies ahead. The

proposed training program will provide a framework based on audience and dosage with the following goals:

- System change and collaboration
- Whole-person care efficacy
- Kentucky SKY and network provider effectiveness
- Full enrollee participation.

The cadre of training themes will include; Kentucky SKY Overview and Orientation, Kentucky SKY Vision, Goals and Model, Business Case for Foster Care Transformation, Trauma Informed and Transformed Care, Governance, Leadership, System and Kentucky SKY Structures and Interdependencies, Roles and Responsibilities, Evidence based Practices, EPSDT, Collaboration and Communication, Outcomes Driven Care/Quality Assurance (QA)/QI/Continuous Quality Improvement (CQI), Proactive/Reactive Safety Planning, and Crisis System of Care.

New Staff Training vs. Ongoing Training

New staff member onboarding is differentiated from ongoing training. The initial intensive training and in-the-field coaching will entail two weeks of didactics followed by 30 to 60 days of competency building coaching.

The ongoing training will be focused on topics requiring periodic dosing as well as topics specific to youth needs and life domain areas. The variety of venues for ongoing training include all staff and team meetings, supervisions, cross-departmental meetings, and community outreach events. Topic themes include the following: evidence-based practices tune-ups, continuous quality improvement-specific topics, care coordination enhancements, documentation and auditing, etc. There are those set topics that will require regular dosing and those that will arise during implementation and ongoing operations. It is the responsibility of the Training Collaborative to assess the ongoing needs of the Kentucky SKY Continuum of Care and respond with ongoing curriculum development and delivery.

Aetna understands how vital it is to have the Board of Directors, senior leadership, and community stakeholders trained in the Kentucky SKY program vision, standards of care, and service delivery principles. Informed oversight and guidance ensure that system change is well-supported by a group of mission driven leaders prepared to remove barriers to success, garner resources and share in the celebrations of success for Kentucky's children and families. As such, the Kentucky SKY training director will provide regular reports out to the governance body on the annual training plan and key performance indicators, seeking assistance with any significant barriers to success.

Please refer to **Attachment V** for our proposed training program and curriculum for all staff specific to areas of responsibility, including information about the topics for which staff will receive training, how trainings will differ for new staff members versus ongoing trainings, and related training schedules.

vi. Monitoring Subcontractors

Our Quality Assurance and Performance Improvement (QAPI) program has a comprehensive set of policies and procedures to manage the delegation of responsibility for any delegated program function. We understand all processes required for effective oversight of subcontractor performance, and we are successful at conducting these activities as part of our daily business. We have extensive experience with subcontractor oversight, with selecting subcontractors, and with ongoing monitoring of subcontractor performance. By leveraging this experience, we ensure the successful completion of all delegated functions under the Kentucky Medicaid program, including the recruiting and training of subcontractor staff.

Although we may delegate the authority to perform functions in support of the Kentucky Medicaid

managed care program, we do not delegate accountability for the quality of care or services the subcontractor provides. We provide our subcontractors with initial training and, when necessary, retrain in aspects of contract requirements that are included in their scope of work. We require our subcontractors to comply with all Commonwealth requirements.

We meet with subcontractors on a weekly, monthly, or quarterly basis, depending on the subcontractor, and perform a comprehensive review annually in which we measure performance efforts that address past concerns identified by the Department. If any deficiencies or areas for improvement are identified, we require the subcontractor to take corrective action. Aetna provides the Department with a copy of the annual review and any corrective action plans developed as a result.

Subcontractor Monitoring and Oversight Activities

Monitoring is performed as follows:

- ✓ Monitoring and evaluating delegated functions through at least semiannual reports
- ✓ Conducting pre-assessments prior to delegation, with annual desk audits or web conference reviews conducted with a random sampling of files thereafter
- ✓ Confirming (no less than annually) that delegated functions/services are carried out consistently and in compliance with both Aetna's and other applicable accredited standards (i.e., NCQA and others as indicated) and the mutually agreed upon delegation agreement
- ✓ Performing, at minimum, an annual file review audit, if applicable, to confirm compliance with Aetna and applicable standards
- ✓ Monitoring ongoing corrective actions to address identified deficiencies, promote progress, and take necessary action, if improvements do not occur
- ✓ Reviewing the delegated organization's program that oversees the delegated functions and its quality program to verify it is in alignment with Aetna's quality improvement processes
- ✓ Monitoring the subcontractor downstream provider agreements to ensure they comply with the regulatory requirements of the Commonwealth contract

National Oversight

At the national level, we have a centralized team of delegation oversight experts that manages the oversight process across Aetna Medicaid lines of business to make certain that all of our multi-state delegated agreements are represented and that all requirements, such as Commonwealth- and contract-required elements for each plan and delegate, are accounted for. This team includes members from our national Delegation Management, Quality Management, and Finance departments. The appropriate national Medical Management, Credentialing, Grievance and Appeals, and other teams conduct audits as directed by the Medicaid-specific Quality Management department. The audit team reports audit findings to Aetna's National Vendor Delegation Oversight Committee (DOC), National Medicaid DOC, and the local health plan DOC in order to identify opportunities for improvement and solutions that are disseminated across our health plans.

Local Oversight

The chief executive officer, chief medical officer (CMO), compliance officer, chief operating officer, director of clinical health services, director of quality management, and selected leadership staff from our Enrollee Services, Provider Services, Network Management, and Grievance and Appeals departments comprise the local-level DOC. These local, executive-level plan leaders and key leaders from functional areas meet with subcontractors on a monthly or quarterly basis, depending upon the type of subcontractor, to monitor service delivery, troubleshoot problems, review and resolve enrollee complaints, and most importantly, identify opportunities to collaborate on new or enhanced services for enrollees. The DOC approves all delegates and delegation reports, and monitors subcontractor performance at the plan level. Executive-level leaders monitor the success of corrective action plans and handle escalated issues when the corrective actions are not producing satisfactory results.

Please refer to **Figure G.2-7** for an illustration of how each subcontractor will be integrated into Aetna's services.

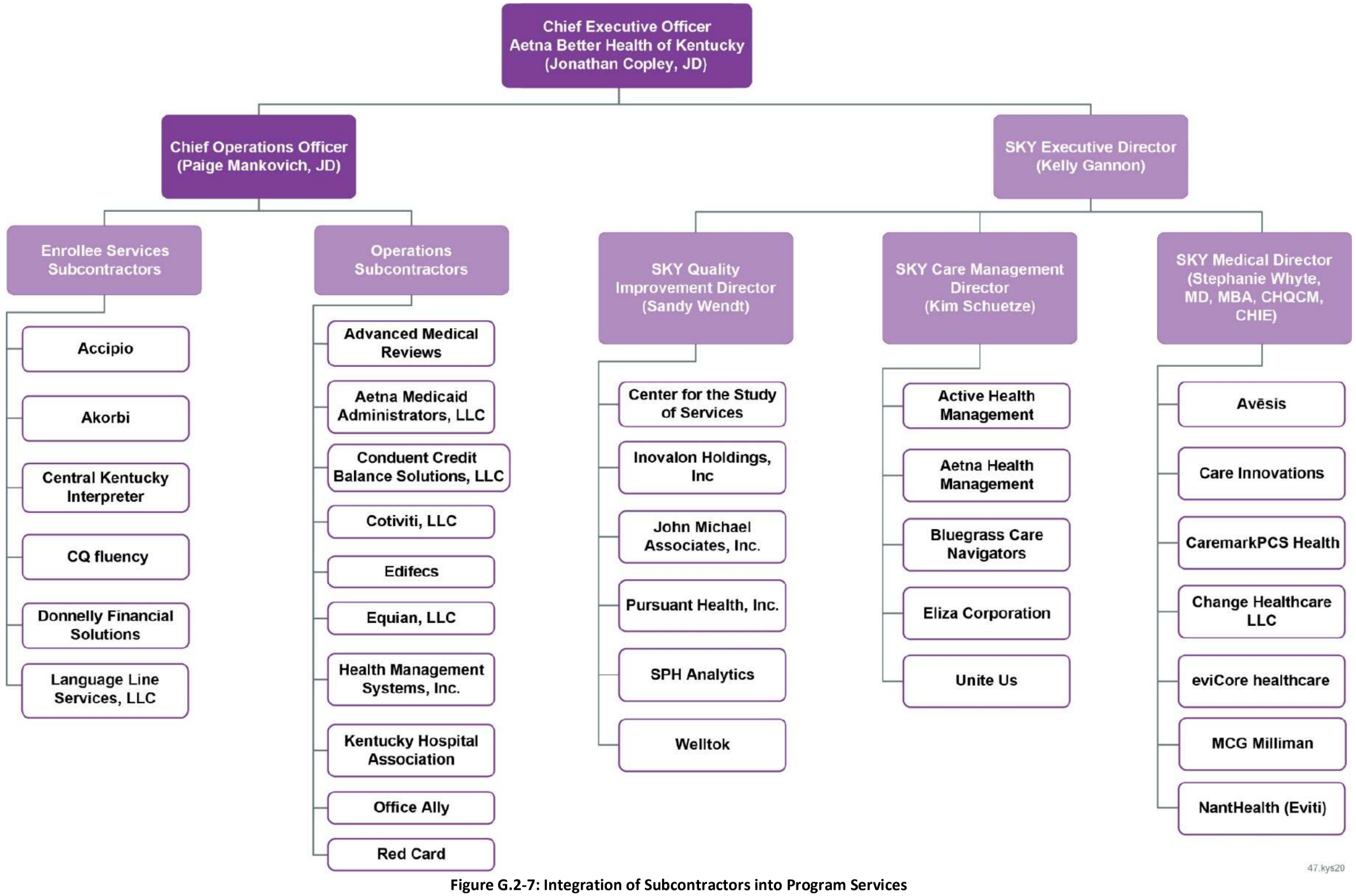

Figure G.2-7: Integration of Subcontractors into Program Services

Subcontractor oversight is integrated into the health plan organizational structure with clear lines of responsibility and oversight to ensure a streamlined experience for enrollees, providers, and the Department.

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Table G.2-13 describes the role of each Aetna subcontractor.

Table G.2-13: Subcontractors Supporting Aetna Better Health of Kentucky

Subcontractor's Name	Role
Accipio Language Services	Provides translation services for enrollees
ActiveHealth Management, Inc. (subsidiary of CVS Health)	ActiveHealth will provide an online member website to Aetna that includes the following products: Personal Health Record, Health Assessment for adults, and online Disease Management and Health Coaching
Advanced Medical Reviews, LLC (subsidiary of ExamWorks Group, Inc.)	Provides advisory medical reviews and recommendations for medical necessity or medical appropriateness of treatment
Aetna Health Management, LLC	After-hours call center; credentialing for certain types of network providers; pharmacy benefit management administrative services (when not performed by CVS Health or the Health Information line [Nurse line])
Aetna Medicaid Administrators LLC	Enrollment processing, claims payment administration, and actuarial and reporting functions
Akorbi Consulting	Provides qualified and professional interpreters for onsite, sign language, video, and telephone interpretation
Avēsis	Dental and eye care benefits administration
Bluegrass Care Navigators	Transitional care for enrollees, including post-hospital discharge intervention, planning, and assessment, development of a care plan for post-discharge, and home follow-up visits; coordinates with Aetna case managers to ensure safe transition from acute care to the enrollee's home
Care Innovations	Provides remote patient monitoring for enrollees including programs and devices for disease conditions
CaremarkPCS Health	Pharmacy benefit manager
Center for the Study of Services	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey administrator, including mailing survey to enrollees, telephonic follow-ups
Central Kentucky Interpreter	Provides services to enrollees who are deaf or require other special communication techniques
Change Healthcare LLC	SSI Advocate, Medical Network EDI Claims/Real-time, Payments, CPS/Print and InterQual Medical Necessity Criteria
Conduent Credit Balance Solutions, LLC (parent Conduent Inc)	Hospital credit balance identification and recovery at hospitals in Kentucky
Cotiviti, LLC	Performs data mining and recovery audit services, as well as software for claims edits
CQ fluency	Enrollee material translation services
Donnelley Financial Solutions	Printing, inventory, and mailing of enrollee enrollment materials
Edifecs	Encounter validation and submission vendor
Eliza Holdings Corp. (Eliza)—part of HMS Holdings Corp.	Provides automated communications including telephone and email/text messaging for new enrollee onboarding, health risk assessment, appointment and service reminders, and post-discharge assessments

Subcontractor's Name	Role
Equian, LLC	Reviews claims for possible overpayments and subsequent resolution and recovery; also pursues subrogation claims in cases of third-party liability
eviCore healthcare MSI, LLC d/b/a eviCore healthcare (f/k/a MedSolutions, Inc.)	Medical necessity review for radiology and musculoskeletal pain management services
Health Management Systems, Inc. (HMS)—part of HMS Holdings Corp.	Performs coordination of benefits and third-party liability identification and recovery services
Inovalon Inc.	Healthcare Effectiveness and Data Information Set data management system
John Michael Associates Inc.	Mail vendor for enrollee incentive gift cards
Kentucky Hospital Association	Delegated credentialing of network providers
Language Line Services,Inc.	On-demand language access provider with remote interpretation and translation solutions
MCG/Milliman	Medical necessity criteria
Nanthealth (Eviti)	Provides utilization management review for oncology treatment as well as access to and use of web-based decision platform for Aetna providers to obtain evidence-based treatment plans and prior authorizations
Office Ally	Claim intake vendor: identify, validate, and recover or resolve claim payment variances
Pursuant Health Inc.	Provides multichannel access points and communication to educate and engage enrollees about incentivized activities, covered services, and wellness topics
Red-Card Systems, LLC/Red Card Holdings, LLC	Provides print production and mailing of enrollee identification cards
Symphony Performance Health, Inc. d/b/a SPH Analytics	SPH Analytics partners with Aetna Better Health of Kentucky to administer an annual provider satisfaction survey and an annual behavioral health enrollee satisfaction survey. The provider satisfaction survey targets health care providers in the Aetna Better Health of Kentucky network to measure their satisfaction with the health plan.
Unite USA, Inc., dba Unite Us	Provides a network and coordination of services to enrollees including housing assistance, nutrition counseling, and transportation
Welltok	Provides multichannel communication to educate and engage enrollees about incentivized activities, covered services, and wellness topics

vii. Retention Approach for Key Personnel

Aetna is committed to attracting and retaining professional key personnel with experience managing care for the Kentucky SKY population. We achieve this through a strong workplace culture **(refer to Figure G.2-8, Figure G.2-9 and Figure G.2-10)** and personal and professional development opportunities. Our salaries and benefits are market-competitive, with bonuses for high achievers. We recognize the importance of family and provide eligible colleagues with up to 4 weeks of leave time with 100% of pay to bond with a new baby, adoption or foster care child. Further, our benefits come with many choices aimed at helping our staff achieve health and financial well-being. We increased our U.S. minimum base wage to $16 per hour for both hourly and salaried staff. Eligible Aetna employees can qualify for an enhanced medical benefits program that could save some families thousands of dollars.

Figure G.2-8: Demonstrating Teamwork at Community Event
Aetna staff members participated in the Louisville Corporate Games, which is a community-wide event that brings together employees from Louisville-area businesses for a day of friendly competition and employee camaraderie.

Figure G.2-9: Award for Accomplishments in Wellness
Aetna Better Health of Kentucky was awarded Silver Wellness status by the Aetna enterprise, honoring the staff for its participation and accomplishments in the area of wellness.

As part of our commitment to retaining our key personnel, Aetna is always looking for ways to enhance our culture of the plan. Our Kentucky Medicaid Appreciation Committee (KMAC) is a dedicated group of volunteers focused on showing Aetna's appreciation of our staff and all the work they do to support our enrollees, providers, and other stakeholders. This committee meets monthly to plan activities and share information about various opportunities to get involved within the community. A staff survey is completed annually to get feedback on the KMAC's activities, to determine a workplan, and to determine the priority of future topics and activities.

Figure G.2-10: Bowling for a Great Cause
Aetna staff gather for after-work fun, competing against other MCOs to raise money for Big Brothers Big Sisters of Kentuckiana.

From an engagement perspective, Aetna Better Health of Kentucky is a leader across all Medicaid plans thanks to our very successful employee engagement survey results year-over-year. We were often looked to for ideas because of our successes.

Our employee referral program rewards employees at every level when they help us achieve our goal of attracting and retaining top talent. Our colleagues who refer an external candidate that is hired are eligible to receive a monetary award. History has shown us that referrals from our staff and former colleagues usually result in strong candidates. Aetna also provides telework opportunities for qualified individuals, enabling us to recruit the most qualified individuals from a larger pool across the Commonwealth.

Additionally, Aetna shows personnel that they care about the health of the staff and their families. The focus on wellness provides a great morale booster and focuses on several areas of mental and physical health, as well as areas of life that affect our overall well-being and whole person health. Our intranet and wellness benefits provide a location to store health and wellness information and tips, as well as a place for staff to get health or work-related questions answered. This platform also provides personal ways to improve health.

Aetna's Best Practices for Employee Retention

- Incentives and comprehensive benefits package
- Aetna nationwide mentoring program to provide additional support
- Thorough recruitment practices for candidates that are a good fit minimizes early turnover and enhances retention
- Conduct interviews with newly hired staff to obtain feedback about the hiring process and training curriculum to gain feedback for continuous improvement
- Values in Action program is an interactive tool used to implement timely appreciation and acknowledgement of employees performance. Colleagues as well as managers utilize this system to award employees points in areas such as Caring, Collaboration, and Innovation.
- Sponsor wellness programs, self-care promotion, and programs to help deal with stress
- Offer flexibility, realistic workloads, and promote healthy work life balance
- Opportunities for promotion as well as additional learning opportunities
- Routine staff satisfaction surveys
- Identify turnover trends, workforce supply and demand, workforce gaps and create action steps to strategically address these gaps and how to enhance and support the current workforce for future growth

Aetna focuses on empowering staff and incentivizes several opportunities to get involved in our own health and increase engagement. A few of the activities include, but are not limited to the following: events with massages offered to staff to promote relaxation, walking and weight loss challenges to promote health eating/ activities, and healthy eating cooking classes.

Aetna also has a platform, Values in Action, that allows management and staff to acknowledge each other for their hard work to promote our values (collaboration, accountability, innovation, integrity, and caring). This platform allows others to see and appreciate the work of their co-workers. This platform is also tied to incentives, with different actions accumulating points that can then be spent on various items related to health and well-being.

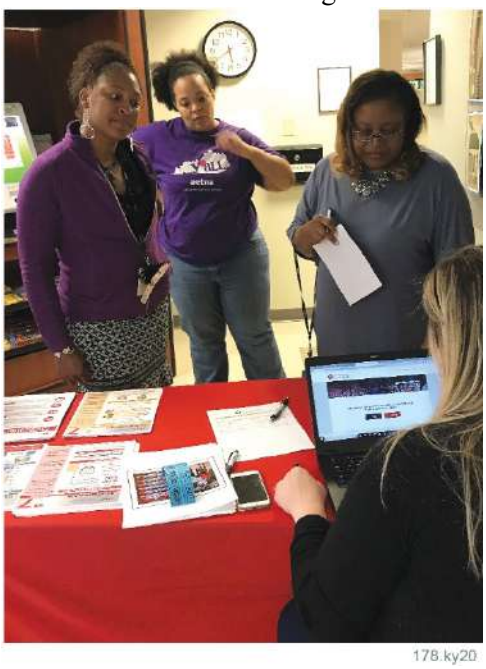

Figure G.2-11: Heart Health Fair
Aetna staff had an opportunity to learn about heart health at the 2019 Employee Heart Health Fair.

Aetna promotes a culture that understands the importance of a 'happy' workplace focused on helping staff to be their best self professionally and personally. We have a Learning Center, Wellness Classes and Resource for Living catalog that enables staff to develop. These resources allow staff to gain knowledge and skills that will aid in their current role (as an employee/ community member) and advancement in life. This promotes an environment of learning and sharing.

Finally, we understand that there is more to life than the workday and Aetna provides opportunities for staff to volunteer in numerous activities year round. These volunteer activities typically focus on supporting our community-based organization network, such as the "Everyone Reads" program with Jefferson County Public Schools, the Homeless Street Count with the Coalition for the Homeless, and the Heart Walk with American Cancer Society. The following list of activities and volunteer opportunities we have participated in demonstrates our commitment to our staff and the communities we serve:

- Blood drives
- Flu clinic: onsite flu shots offered to staff
- Mindfulness sessions: guided meditations and massages for staff
- 'Canstruction' Event: canned food drive where staff used canned food to create different displays, which were then judged by staff
- Corporate games: Family fun outside of work that promotes teamwork
- Heart walk
- National Alliance on Mental Illness walk
- Kidney walk
- Breast cancer walk
- Cold turkey event: wellness event that promoted the Great American Smoke Out and celebrated staff who quit smoking and provided motivation for those who were thinking about quitting smoking.
- Holiday trainings and celebrations: events are hosted around holidays that helps staff with wellness both physical and mental during holidays
- Resource for Living: resource that provides webinars that cover topics from parenting skills to managing finances.
- Financial wellness event: webinar on planning for the future

Our reputation as an employer of choice enables us to attract and retain the best-qualified candidates, as evidenced by the recognition we have received from a variety of organizations. For example, the United States Business Leadership Network recently recognized the Aetna organization as a best place to work and the American Association of People with Disabilities honored Aetna for our disability-inclusive business practices. Additionally, **we were included for the 11th time since 2001 on the list of the Top 50 Companies for Diversity[8].**

Aetna is a Recognized Employer of Choice

- Human Rights Campaign Foundation Corporate Equality
- Index: 100% rating
- United States Business Leadership Network Best Place to Work
- American Association of People with Disabilities Disability
- Equality Index: 100% Rating
- Diversity Inc's Top 50 Companies for Diversity
- National Association of Female Executives Top 60 Companies for Executive Women
- Military Friendly® Silver Status
- Black EOE Journal named Aetna to its 2018 Best of the Best lists: Top Employer and Top LGBTQ-Friendly Employer
- Latina Style 50 list for 2018: Recognizes the best companies for Latinas to work in the U.S.

Our Aetna our core values of **integrity, excellence, caring, and inspiration** shape our culture. Aetna conducts business using a clear, strongly held set of core beliefs and values that reflect who we are and how we approach the hiring, development, and retention of our staff. Our culture is positive, transparent, and inclusive. Routine management planning and strategy meetings, all-staff town hall meetings in which all levels of management present updates and new projects, and the implementation of various engagement and recognition programs have all served us well to improve satisfaction and retention year over year.

viii.a-c. Organizational Structure

Aetna's organizational structure for the Kentucky SKY program provides expert personnel committed to ensuring quality and innovative programming in fulfillment of all contract requirements. The leadership team is responsible for maintaining a level of staffing necessary to perform and carry out all the functions, requirements, roles, and duties described, regardless of the level of staffing included in our proposal. Aetna's locally oriented hiring approach considers the size and demographic makeup of our enrollees and the Commonwealth to ensure we have qualified team members in all roles to contribute to the successful operation of our Kentucky SKY program in Kentucky.

Aetna Better Health of Kentucky's organizational structure provides clear lines of authority and accountability, including direct functional connections between departments and positions. This fosters open communication and coordination of effort among executive leadership, management, and staff serving the Kentucky SKY program.

As illustrated in the Kentucky SKY program organizational chart in **Figure G.2-12**, our **onsite, local Aetna Kentucky SKY leadership team** will be led by Executive Director Kelly Gannon. Ms. Gannon will report to the health plan's CEO, Jonathan Copley. The Kentucky SKY program will fit into the organizational structure of the parent company through Ms. Gannon's direct reporting relationship with Mr. Copley.

[8] National Black MBA Association, "The 2018 Diversity Inc Top 50 Companies for Diversity," (2018): accessed June 25, 2019; https://nbmbaa.org/the-2018-diversityinc-top-50-companies-for-diversity.

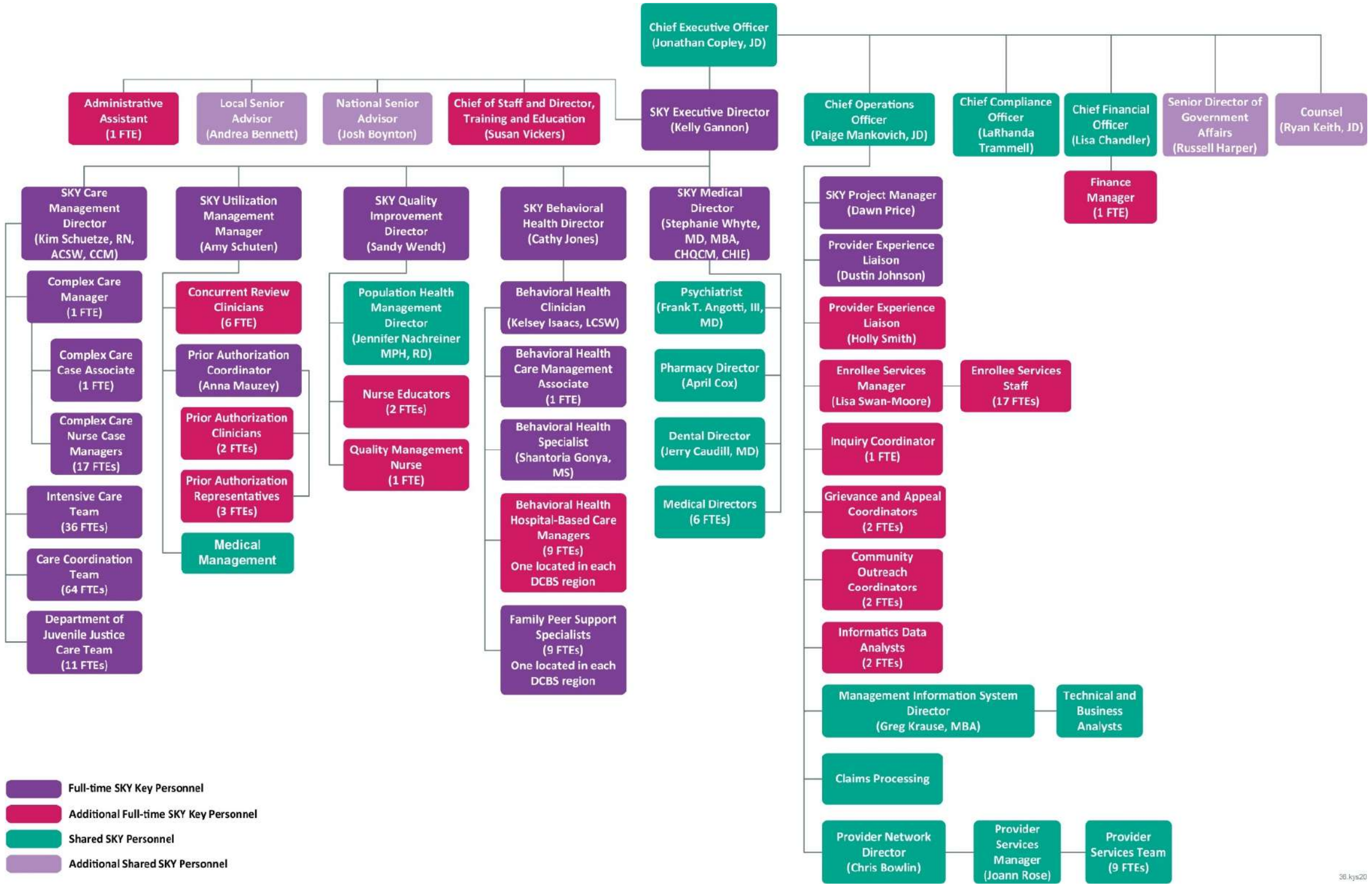

Figure G.1-12: Aetna Kentucky SKY Organizational Design

Aetna's organizational design for the Kentucky SKY program emphasizes experience, flexibility, and putting the right resources toward serving Kentucky's child protection and juvenile justice populations.

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Our integrated, collaborative team will support the Kentucky SKY program through consultation including lessons learned from previous implementations and programs managed. The Kentucky SKY leadership team will manage the delivery and operations of the Kentucky SKY program, leveraging our longstanding, positive relationships with providers, community resources, advocacy groups, regulatory agencies, and other organizations throughout the Commonwealth. Our Kentucky SKY team will leverage and gain from foster care program experience gained in other states through connections within the organization. Plan leadership is empowered to make rapid-cycle decisions, ensuring timely and responsive action while delivering high-quality care and services. Regular meetings, clear responsibilities, and a positive rapport enable the team to function as a cohesive, productive unit to meet all contract requirements.

We use well-qualified, experienced subcontractors only when necessary because of our high level of confidence in the professional team we have assembled and our ability to hire locally to provide services in support of our current Kentucky Medicaid program. Please refer to **Table G.2-14** for a complete list of subcontractors and the functional areas in which they will provide services to Aetna enrollees and providers.

Figure G.2-14: Description of Subcontractors by Functional Areas

Functional Area	Name of Subcontractor
Enrollee Services	• Accipio • Akorbi Consulting • Central Kentucky Interpreter • CQ fluency • Donnelley Financial Solutions • Language Line Services, Inc.
Case Management Benefits	• Active Health Management • Aetna Health Management • Bluegrass Care Navigators • Eliza Corporation • Unite Us
Medical Benefits	• Avēsis • Care Innovations • CaremarkPCS Health • Change Healthcare LLC • eviCore healthcare • MCG Milliman • Nanthealth (Eviti)
Quality Improvement	• Center for the Study of Services • Inovalon Holdings, Inc • John Michael Associates Inc • Pursuant Health Inc • SPH Analytics • Welltok

Functional Area	Name of Subcontractor
Operations	• Advanced Medical Reviews • Aetna Medicaid Administrators, LLC • Conduent Credit Balance Solutions, LLC • Cotiviti, LLC • Edifecs • Equian LLC • Health Management Systems, Inc • Kentucky Hospital Association • Office Ally • Red Card

ix. Integration of Subcontractors

The integration of subcontractors into our program model is an integral part of implementation activities—ensuring they have the correct staff to support our contract with the Department is of primary importance.

We conduct implementation and ongoing meetings with subcontractors to ensure alignment and full understanding of the SKY program and the requirements of our contract with the Department. For example, we hosted ongoing implementation meetings, culminating in hosting Unite Us at our office in Louisville to discuss ways to optimize our collaboration and deliver new and innovative models that improve the engagement between enrollees, traditional health care providers, and social services providers.

We host monthly and quarterly meetings with our subcontractors, including Unite Us, to ensure ongoing compliance. We ensure each employee of our subcontractors that work on our contract are fully trained and understanding of our commitments to the Department via these regular touchpoints. If a subcontractor fails to meet its obligations, we have the discretion to issue a corrective action plan or penalty under our agreement with these subcontractors.

Additionally, we engage our subcontractors to participate in face-to-face and complex care coordination meetings with enrollees and providers as well regional meetings with DCBS. We also invite subcontractors to Aetna town hall events for deeper integration into the program.

Our quality management program includes formal, multilayered processes and comprehensive policies and procedures to monitor contract compliance, quality of care, services, and reporting provided under any subcontract. All aspects of the contract are evaluated through our Compliance Committee to ensure compliance with contractual requirements.

Please refer to **Figure G.2-13** for an illustration of how each subcontractor will be integrated into Aetna's services for the Kentucky SKY program

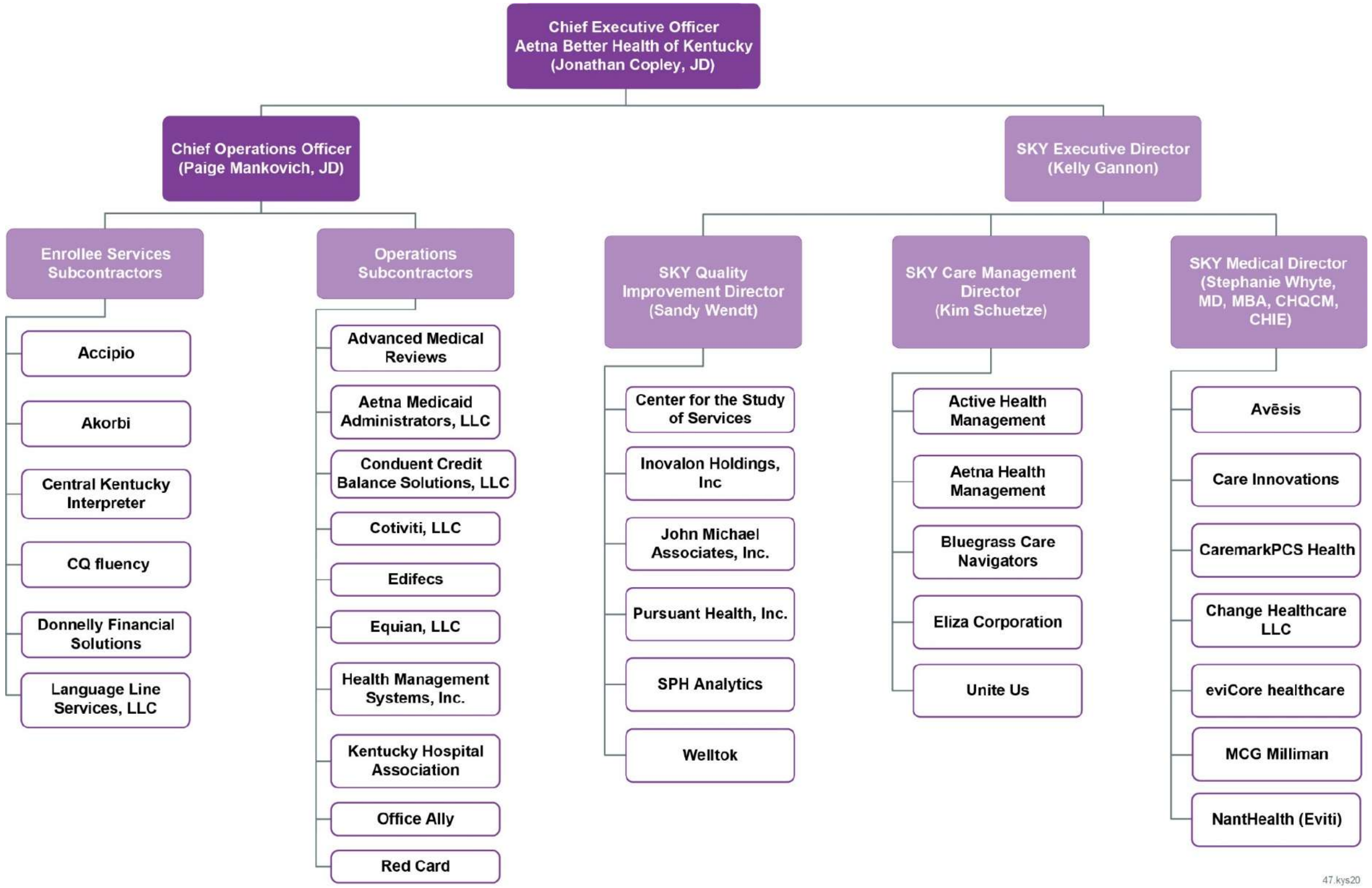

Figure G.2-13: Integration of Subcontractors into Program Services

Subcontractor oversight is integrated into the health plan organizational structure with clear lines of responsibility and oversight to ensure a streamlined experience for enrollees, providers, and the Department.

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Table G.2-15 provides a summary of how each subcontractor will be integrated into Aetna's services for the Kentucky SKY program.

Table G.2-15: Subcontractors Supporting Aetna Better Health of Kentucky

Subcontractor's Name	Role
Accipio Language Services	Provides translation services for enrollees
ActiveHealth Management, Inc. (subsidiary of CVS Health)	ActiveHealth will provide an online member website to Aetna that includes the following products: Personal Health Record, Health Assessment for adults, and online Disease Management and Health Coaching
Advanced Medical Reviews, LLC (subsidiary of ExamWorks Group, Inc.)	Provides advisory medical reviews and recommendations for medical necessity or medical appropriateness of treatment
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Bluegrass Care Navigators	Transitional care for enrollees, including post-hospital discharge intervention, planning, and assessment, development of a care plan for post-discharge, and home follow-up visits; coordinates with Aetna case managers to ensure safe transition from acute care to the enrollee's home
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Cotiviti, LLC	Performs data mining and recovery audit services, as well as software for claims edits
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Eliza Holdings Corp. (Eliza)—part of HMS Holdings Corp.	Provides automated communications including telephone and email/text messaging for new enrollee onboarding, health risk assessment, appointment and service reminders, and post-discharge assessments

Subcontractor's Name	Role
Equian, LLC	Reviews claims for possible overpayments and subsequent resolution and recovery; also pursues subrogation claims in cases of third-party liability
eviCore healthcare MSI, LLC d/b/a eviCore healthcare (f/k/a MedSolutions, Inc.)	Medical necessity review for radiology and musculoskeletal pain management services
Health Management Systems, Inc. (HMS)—part of HMS Holdings Corp.	Performs coordination of benefits and third-party liability identification and recovery services
Inovalon Inc.	Healthcare Effectiveness and Data Information Set data management system
John Michael Associates Inc.	Mail vendor for enrollee incentive gift cards
Kentucky Hospital Association	Delegated credentialing of network providers
Language Line Services,Inc.	On-demand language access provider with remote interpretation and translation solutions
MCG/Milliman	Medical necessity criteria
Nanthealth (Eviti)	Provides utilization management review for oncology treatment as well as access to and use of web-based decision platform for Aetna providers to obtain evidence-based treatment plans and prior authorizations
Office Ally	Claim intake vendor: identify, validate, and recover or resolve claim payment variances
Pursuant Health Inc.	Provides multichannel access points and communication to educate and engage enrollees about incentivized activities, covered services, and wellness topics
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Symphony Performance Health, Inc. d/b/a SPH Analytics	SPH Analytics partners with Aetna Better Health of Kentucky to administer an annual provider satisfaction survey and an annual behavioral health enrollee satisfaction survey. The provider satisfaction survey targets health care providers in the Aetna Better Health of Kentucky network to measure their satisfaction with the health plan.
Unite USA, Inc., dba Unite Us	Provides a network and coordination of services to enrollees including housing assistance, nutrition counseling, and transportation
Welltok	Provides multichannel communication to educate and engage enrollees about incentivized activities, covered services, and wellness topics

Subcontractor oversight is integrated into the health plan organizational structure with clear lines of responsibility and oversight to ensure a streamlined experience for enrollees, providers, and the Department. Aetna does not install subcontractors in key positions or in providing key services and when subcontractors are used, it is with thorough and extensive oversight.

x. Staff Positions and their Locations

We plan to have **over 200 staff dedicated** to the Kentucky SKY program, including the following:

(1) 69 Dedicated SKY Staff in Kentucky Office:

Aetna plans to have the following 69 dedicated staff positions based in the Kentucky office. These positions are as follows:

- 1 Executive Director
- 1 Chief of Staff
- 1 SKY Project Manager
- 1 SKY Care Management Director
- 1 Complex Care Management Manager
- 7 Care Management Associates
- 2 Intensive Care Management Managers
- 4 Care Management Managers
- 1 Department of Juvenile Justice Care Management Manager
- 1 Department of Juvenile Justice Care Management Associate
- 1 SKY Utilization Manager
- 1 SKY Quality Improvement Director
- 1 Quality Management Nurse
- 1 SKY Behavioral Health Director
- 1 SKY Behavioral Health Clinician
- 1 SKY Behavioral Health Care Management Associate
- 1 SKY Behavioral Health Specialist
- 1 SKY Medical Director
- 2 Provider Relations Liaisons
- 1 Prior Authorization Coordinator
- 3 Prior Authorization Representatives
- 2 Prior Authorization Clinicians
- 6 Concurrent Review Clinicians
- 2 Grievance and Appeals Coordinators
- 2 Nurse Educators
- 1 Administrative Assistant
- 1 Inquiry Coordinator
- 1 Finance Manager
- 2 Informatics Data Analysts
- 1 Enrollee Services Manager
- 17 Enrollee Services Staff

(2) 134 Dedicated Field-based SKY Staff

Aetna plans to have 134 field-based staff dedicated to the Kentucky SKY program. **Figure G.2-14** shows our field-based SKY staff that is located throughout the Commonwealth by DCBS region.

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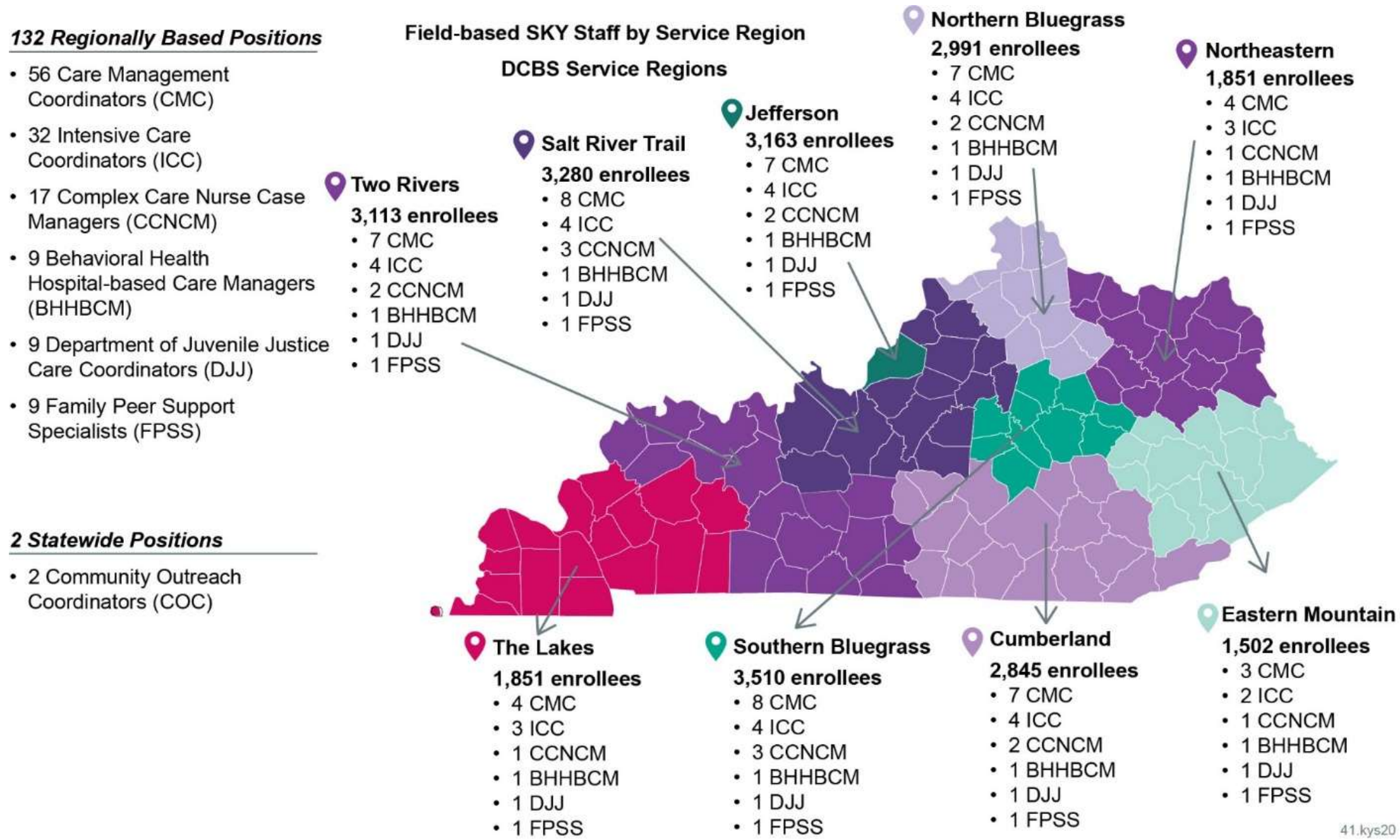

Figure G.2-14: Aetna's Field-based SKY Staff in Kentucky

This map illustrates the depth and breadth of Aetna's resources in all nine regions of the Commonwealth.

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(3) 22 Shared Staff Supporting SKY Contract Based in Kentucky Office

We have 22 shared staff in the Kentucky office supporting the SKY contract, and other staff available to support the SKY population as needed. These positions are as follows:

- 1 CEO
- 1 Chief Operations Officer
- 1 Local Senior Advisor
- 1 National Senior Advisor
- 1 Management Information System Director
- 1 Dental Director
- 1 Chief Financial Officer
- 1 Chief Compliance Officer
- 1 Psychiatrist
- 1 Provider Network Director
- 1 Provider Services Manager
- 9 Provider Services Team Members
- 1 Population Health Management Director
- 1 Pharmacy Director

Additionally, we will utilize Aetna Better Health of Kentucky and Shared Services employees, and subcontractors across the country to provide services for the Kentucky SKY program, as illustrated in **Figure G.2-15**.

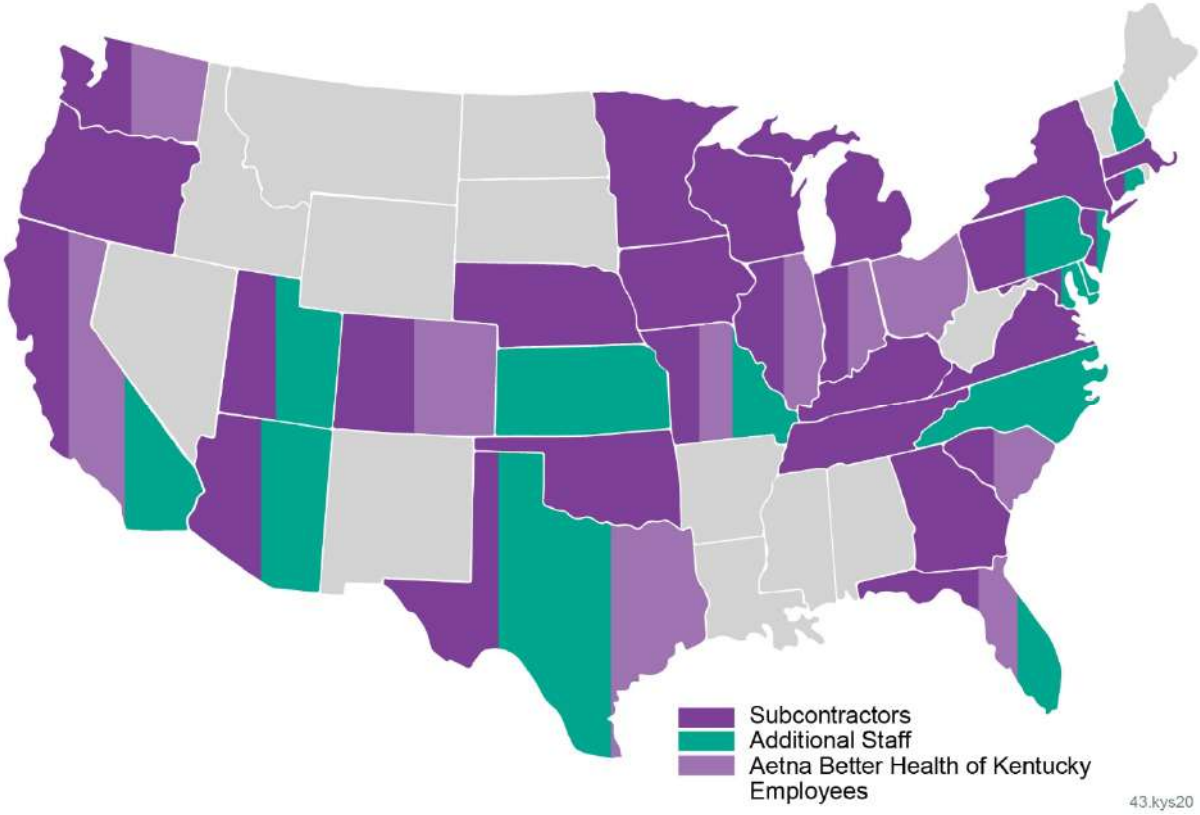

Figure G.2-15: Depth of Aetna's Operations across the United States

The map illustrates Aetna's capability of leveraging a wide array of resources to provide the best services for enrollees and providers in Kentucky.

xi. Number of FTE

We plan to have over 200 staff dedicated to the Kentucky SKY program, including the following listed in **Table G.2-16**:

Table G.2-16: FTE by Position Type and Operational Area

Operational Area	Position Type and Number of FTE
Leadership (4 FTE)	• Executive Director (1) • Chief of Staff (1) • Finance Manager (1) • Administrative Assistant (1)
Case Management (153 FTE)	• Care Management Director (1) • Complex Care Manager (1) • Complex Care Nurse Case Managers (17) • Complex Care Case Associate (1) • Intensive Care Managers (2) • Intensive Care Management Associates (2) • Intensive Care Coordinators (32) • Behavioral Health Director (1) • Behavioral Health Clinician (1) • Behavioral Health Care Management Associate (1) • Behavioral Health Specialist (1) • Behavioral Health Hospital-based Care Coordinators (9) • Family Peer Support Specialists (9) • Department of Juvenile Justice (DJJ) Care Management Manager (1) • DJJ Care Management Associate (1) • DJJ Care Coordinators (9) • Care Management Managers (4) • Care Management Associates (4) • Care Coordinators (56)
Medical (14 FTE)	• Medical Director (1) • Utilization Management Manager (1) • Prior Authorization Coordinator (1) • Concurrent Review Clinicians (6) • Prior Authorization Clinicians (2) • Prior Authorization Representatives (3)
Enrollee Services (18 FTE)	• Enrollee Services Manager (1) • Enrollee Services Staff (17)
Operations (10 FTE)	• Project Manager (1) • Provider Relations Liaison (2) • Inquiry Coordinator (1) • Grievance and Appeal Coordinators (2) • Community Outreach Coordinators (2) • Informatics Data Analyst (2)
Quality Improvement (4 FTE)	• Quality Improvement Director (1) • Nurse Educators (2) • Quality Management Nurse (1)

We base our staffing analysis on our proprietary Aetna Medicaid organization standard operating model, which projects staff needed by proven ratios or other metrics appropriate to each position type. Our model captures level of care, category of covered services, category of aid, unique contractual requirements, enrollment levels, use of subcontractors, and other components. While our more than 30 years of experience operating Medicaid plans across the nation drives our staffing model, we also use evidence-based guidelines built on time studies and complexity of care.

To maximize our successful approach to implement best practices for SKY enrollees we thoroughly reviewed the Families 360 Model delivered to Fosters, Adoptive Assistance and Department of Juvenile Justice MCO enrollees in the state of Georgia. The goals of Families 360 mirrored our goals. They are as follows:

- Improve access to health care services
- Improve continuity of care
- Improve health outcomes

Each enrollee is assigned to a Regional-based Care Coordination team and assigned a care coordinator based on assessments that address health needs and social determinants each enrollee will be assigned a care coordinator. We believe in developing teams based in the region they serve. Because we are in the community, we build better relationships with DCBS, DJJ, and providers. We base our ratios of Complex Care 1:12, Intensive Care 1:32, and Care Coordination 1:400 on the Georgia experience and Families 360 Model. The ratios seek to offer care according to the acuity and need of the individual enrollee.

xii. Care Coordination Team

Regional-based Care Coordination teams are at the center of care for Kentucky SKY enrollees. We use dedicated multidisciplinary teams in each of the Commonwealth's nine regions to cover the diverse needs of enrollees. This model creates continuity of care, enhances collaboration with community stakeholders, and increases access to behavioral health providers. Our Regional Care Coordination teams include the following:

- Behavioral health hospital-based care managers
- Department of Justice Juvenile Care team
- Family peer support specialists

Our integrated care teams and quality improvement staff work together to empower Kentucky SKY enrollees in achieving their optimal health care outcomes and quality of life, while honoring their culture, goals, and need for self-determination. We fully engage our providers and enrollees through our quality initiatives, targeting Kentucky communities experiencing health disparities. By focusing on the unique needs inherent within individual regions and communities, we make certain our solutions are local and devoted to improving each enrollee's outcomes. As an **NCQA Commendable accredited organization**, we have demonstrated our commitment to continuous quality improvement and improved health outcomes as evidenced by our substantial improvement trajectory in quality measures since 2015. Through integration of care we address the whole person- their physical, behavioral, and social needs to include natural supports.

Role of Care Coordinators and Care Coordination Team

Care coordinators facilitate the whole-person care planning process and implementation. Roles and responsibilities of care coordinators include the following:

- Assuring that care is delivered in a manner that respects family culture, supports voice and choice, and maintains a strengths-based focus throughout the care coordination process
- Offering consultation and education to all providers regarding the values of the wraparound process, monitors progress toward goals, and assures that all necessary data for evaluation are gathered and entered
- Responsibility for completing a comprehensive strengths-based assessment of the individual and family, working in full partnership with team members to develop and implement a service plan, identifying providers of services and natural supports, facilitating team meetings, making regular home visits, monitoring all services, and maintaining fiscal accountability
- Helping youth and his or her family develop and integrate their natural support system and to manage their own services, supports, and plan

Figure G.2-16 provides an illustration of our care management organization.

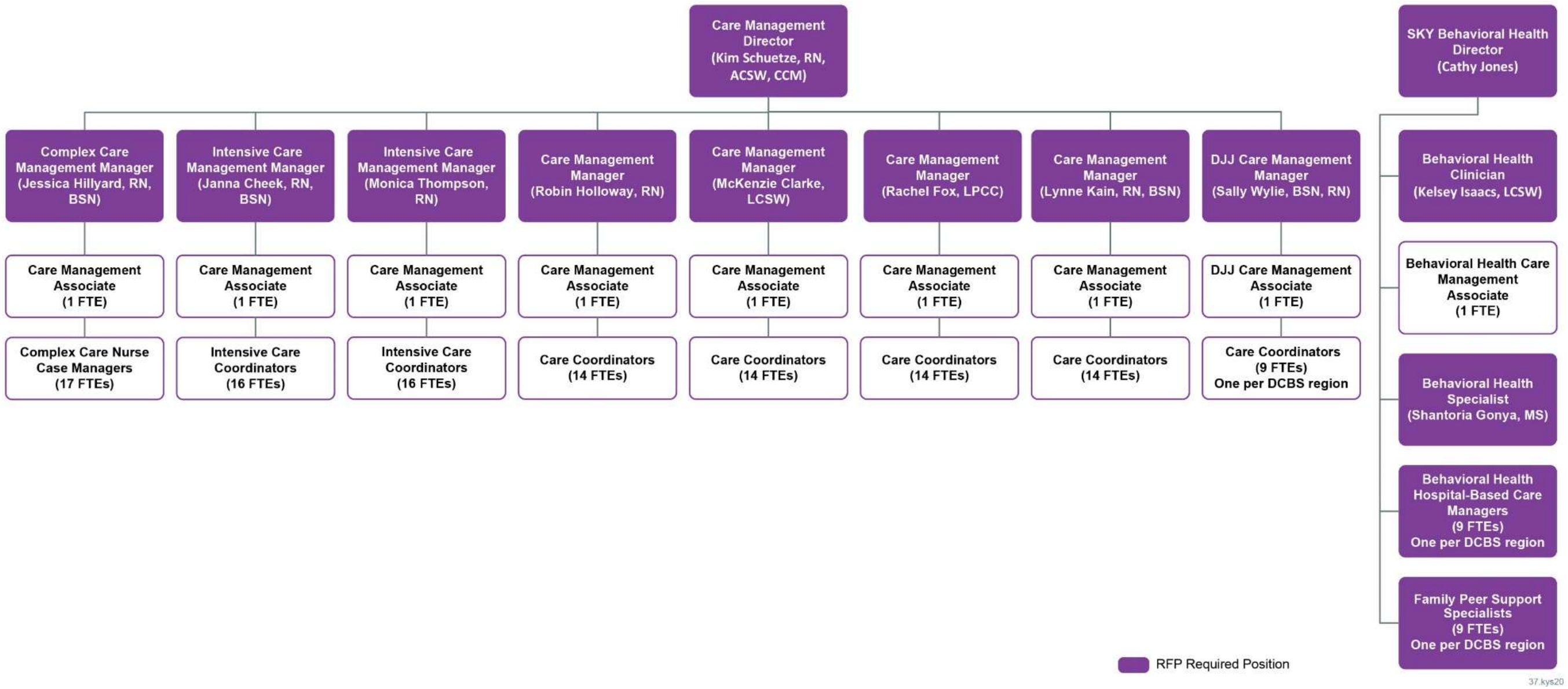

Figure G.2-16: Aetna's Care Management Organization

This organizational chart illustrates the positions and reporting relationships of our Care Management team.

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Aetna will employ experienced professional staff to participate in Care Coordination teams serving all service regions and community districts accomplishing integrated, holistic care. We will assign the Care Coordination team within one business day of enrollment in Kentucky SKY and center supports according to the enrollee's preferences involving their entire support circle to include the following:

- Kentucky SKY enrollee
- Adoptive parent(s)
- Foster care parent(s)
- Caregivers
- Fictive kin

Each circle of support member will be integral to the care coordination processes, care planning, and care plan implementation. The Care Coordination team will be updated routinely and as necessary as determined by the Kentucky SKY enrollee's care plan. The Aetna staff available to participate in care coordination shall include at a minimum:

- Masters-level licensed behavioral health clinician
- Nurse care coordinator to assist Kentucky SKY enrollees designated as Medically Complex Children
- Behavioral health specialist with at least five years of behavioral health experience
- Family peer support specialist and/or youth peer support specialist
- Care coordinator

Maintaining Adequate Ratios and Number of Care Coordination Staff

Aetna understands the evolving needs of our enrollees in Kentucky. Our approach is proactive and relationship-based ensuring each enrollee's care coordination support follows our person-centered whole person approach and is committed to achieving successful outcomes for each child and the Kentucky SKY contract overall. As a result, we are flexible and supportive to meet our enrollee's needs as they evolve. We recognize that in providing intense and complex care coordination that it is important for children and their families to be at the center of care decisions and have appropriate support and care interventions based in their level of risk. Our proposed ratios align with these risks to effectively support Kentucky's kids. The ratios are as follows:

- **Children in complex care coordination:** 12 children for each care coordinator
- **Children in intensive care coordination:** 32 children for each care coordinator.

Our care coordination ratios and risk level assignments are based on individual children's needs and our whole person approach informs these staffing levels. The ratios are a beginning estimate with flexibility to adjust and make accommodations in real-time as necessary based on the needs of the enrollees we serve. We base and align these staffing ratios on the scope and requirements for care coordination for each of the three categories of care including medically complex, and management of the Kentucky SKY contract, and appendices. Our approach ensures that each child will be safe and successful, living their best life.

Approach to Locating Care Coordinators

Aetna will locate our care coordinators in the regions they serve, including being the only contracted Medicaid managed care organization embedded within the justice system. We are ingrained in the community living and working alongside DCBS staff and the individuals in our care. Determinations of placement of staff will be assessed by region based on prevalence of enrollees, access to services, and local needs for enhanced care coordination. We understand that successful care coordination begins with effective collaboration with DCBS and community agencies. Our staff will hold weekly office hours at local DCBS offices to make sure we are accessible and have routine contact and collaboration with DCBS staff to enhance coordination and consultation. **A key element of our approach is co-locating care coordinators in regional DCBS and DJJ offices possible to effectively integrate and create streamlined approaches in the community working together, rather than as an adjunct contractor.** We will be co-locating staff within a police department in eastern Kentucky as well. Community-based care coordinators will support enrollees, their families, and their circle of support meeting with them where they are, in the community and in their living rooms. This holistic approach to care planning and finding solutions serves to best meet individual enrollee's needs with customized solutions

60.7.G.3 Kentucky SKY Implementation

Kentucky | Transforming Health Care | **Aetna**

60.7.G.3 Kentucky SKY Implementation

Aetna[1] is a loyal partner to the Commonwealth, one of the original Medicaid managed care organizations (MCOs) providing services to Kentucky Medicaid enrollees since 2011. We partner for solutions during critical times (e.g., only plan involved in the transition of Centene enrollees in 2013) and by taking on new opportunities (e.g., Quality Incentive for Pregnant Smokers program) in the current contract. Aetna has a long history of successfully implementing new Medicaid and specialty programs, and we have learned and improved our processes over time. We will use Aetna's National Implementation team, in partnership with Kentucky Child Welfare subject matter experts and our existing Kentucky health plan team, to implement the Kentucky SKY program in a timely and compliant manner. Along the implementation pathway, we will stay focused on enrollees; providers; building relationships with the Department for Community Based Services (DCBS), Department of Juvenile Justice (DJJ), sister agencies, advocates, and community organizations; and obtaining ongoing feedback to gauge opportunities for enhanced communication and education. Statewide and regional meetings will occur at least twice a month upon contract award to ensure that all stakeholders are involved in the planning process and that implementation issues are addressed upon identification. What defines us as a loyal organization driving the statewide mission to create a healthier Kentucky is our dedication to be a collaborative and innovative partner with State agencies, enrollees, providers, social services/community-based organizations, and key stakeholders.

a. Approach to Project Management

The Kentucky SKY implementation plan will make sure voice, choice, and preference for all key stakeholders are considered, thus modeling the program design in full collaboration at the governance and leadership levels. Aetna finds this approach to be most effective as it demonstrates a congruent adherence to principles and standards at all levels of leadership, management, and direct care.

Approach to Project Management Process

Aetna has developed and refined its implementation approach and honed best practices based on three decades of Medicaid managed care experience and lessons learned. Our process enables us to serve the needs of enrollees as we work to achieve full compliance and a seamless transition to new regulatory and program contractual requirements. Much like Deloitte's Intelligent Program Management Office™ methodology, our Aetna Medicaid organization's Implementation team utilizes a Project Management Body of Knowledge model and will bring together a team of local and national child welfare subject matter experts from both our existing Kentucky health plan and our national Shared Services teams. This combined team will have the necessary expertise and project management skill sets for a successful implementation that will meet the Department's Kentucky SKY program goals.

> Aetna's Kentucky SKY primary implementation goal is to seamlessly execute the delivery of health and family services through quality-driven processes, provider and community stakeholder collaboration, and exemplary customer service.

Engaging with stakeholders early is our key to a successful implementation. Each implementation is unique, as is each program, community, and state. Our existing community collaborations feature initiatives across the Commonwealth encouraging health education and actions to address the medical and non-medical drivers of Kentucky SKY enrollees' health needs. Aetna looks forward to working with the Department, DCBS, DJJ, and community support systems to support the goals of helping Kentucky SKY

[1] Aetna Better Health of Kentucky's affiliate, Coventry Health and Life Insurance Company (CHLIC), served Kentucky Medicaid enrollees from the inception of the Commonwealth's Medicaid managed care program in 2011 until February 1, 2016, when CHLIC assigned its Medicaid contract to Vendor, Aetna Better Health of Kentucky.

enrollees achieve enhanced education, training, and communication but ultimately to receive the care and services in a coordinated, unduplicated process to achieve a healthier outcome.

Project Management Governance

We have established a project management governance for the Kentucky SKY implementation project prior to kickoff. We use a multitiered approach to make sure through transparency, integration, timely decision-making, and action execution we deliver the implementation requirements from project initiation to operational performance and go-live.

- **Level 3:** The Aetna Medicaid organization's chief executive officer (CEO) chairs the Implementation Steering Committee, which is facilitated by the implementation director. The committee members include the regional vice presidents, department heads, and CEOs of each health plan. These committee members have voting rights and are the chief decision-makers of all contingency and mitigation plans and resources. The Implementation Steering Committee makes key decisions, reviews major risks and their mitigations, addresses critical and escalated issues, and aligns resources to deliver the program's implementation requirements in a timely, compliant manner.
- **Level 2:** The regional vice president chairs the Governance Committee, which is facilitated by the implementation director. The Level 2 committee members are the directors of all the Implementation departments, including the Kentucky SKY executive director and compliance. These members discuss risks and issues, develop contingency and mitigation plans, and decide which items are reported into the Level 3 Steering Committee.
- **Level 1 (or Lead Team):** The Governance Committee is chaired by the Aetna Medicaid organization's CEO, Kentucky SKY executive director, and chief operating officer, and is facilitated by the implementation director. This team meets weekly and consists of all business owners both in the health plan and in shared services to discuss progress with their individual project plans and raise any concerns, issues, risks, and potential contingency plans to the larger group. The functional areas involved include, but are not limited to the following:
  - Account management/finance
  - System and benefit configuration for enrollment, case management, and utilization management
  - Care coordination
  - Kentucky SKY team
  - Provider experience
  - Enrollee services
  - Quality and value
  - Stakeholder engagement
  - Program operations
  - Claims and encounter management
  - Compliance/program integrity
  - Technology/reporting/data management/informatics
  - Grievance and appeals
  - Human capital/learning and performance
  - Real estate
  - Vendor management

Each functional area has separate work streams and manages issues and risks through our levels of governance and reporting process. We track these issues and risks in our weekly meeting minutes through OneNote and on our Issue and Risk Log (Excel spreadsheet), which are both housed on our implementation SharePoint site.

Our governance approach is facilitated through standard project work streams and overall project reporting templates, project plans, and a global issues and risk management log, which is one component of our comprehensive implementation management system. Aetna's implementation process

communicates risks in a timely manner to the outlined governance committees and presents mitigation strategies to overcome these risks.

Another crucial part of our implementation process is gathering, confirming, and incorporating all regulatory and technical requirements into our clinical services, administrative operations, transactional platforms, and program management. We will follow this approach in the Commonwealth to make certain our existing health plan processes meet the requirements of the Kentucky SKY RFP. Our business systems and processes support our staff in a manner that serves the individual needs of each enrollee and provider. We conduct a focused, intensive, multiday review of the contract with all subject matter experts as described previously to ensure a consistent understanding of the Kentucky SKY requirements and to identify ownership of programmatic requirements. Based on the direction established in this review session, each functional area work group updates its operational and technical work plan document and begins to fulfill deliverables. This includes review and update of policies and procedures, enrollee and provider materials, system applications, testing, and training materials.

Readiness Review

Through our years of experience implementing managed care and new programs across the country, we understand implementing a new program takes time and requires an intense focus on enrollee care. Aetna will engage with the Department, providers, and community stakeholders continuously to form collaborative relationships that foster readiness for our programs and processes through our dedicated Kentucky SKY Implementation team. We will partner with the Department upon contract award to participate in a continual Department-led readiness review process that will include, at a minimum, the following:

- Submission and approval of our network development plan, which includes the enhancement of our pediatricians, behavioral health providers, and providers experienced in trauma-informed care
- Submission and approval of our dedicated Kentucky SKY staffing plan
- Review and approval of all our policies and procedures to include, but not limited to, the following:
  - Transition policies and procedures on collaboration with DCBS and DJJ to identify medically complex and children with special health care needs
  - Care coordination assessments/screening policies, procedures, and timelines
  - Care coordination initial assessments policies, procedures, and timelines
  - Care Coordination team policies and procedures including health records and privacy.
  - Policies and procedures on reporting Kentucky SKY enrollee health outcomes
  - Policies and procedures for our Enrollee Services team
  - Policies and procedures for our Provider Experience team
  - Policies and procedures for our Appeals and Grievance team
  - Policies and procedures for training and re-training staff and providers on privacy
- Submission and approval of the Enrollee Education and Outreach Plan
- Submission and approval of the Provider Education and Re-training and Outreach Plan
- Submission and approval of the Staff Training and Re-training Plan
- Submission and approval of the Education Plan for court order personnel, law enforcement personnel, and trauma-informed care personnel
- Submission and approval of Aetna's evidence-based practices that include Kentucky SKY enrollee practices
- Submission and approval of our medical records and privacy policies and procedures that include our Kentucky SKY enrollees, staff, and provider requirements
- Submission and approval of all enrollee services policies and procedures
- Submission and approval of Aetna's 24/7/365 policies and procedures
- Submission and approval of Aetna's policies and procedures regarding the ability to share care coordination and case management information electronically with DCBS and DJJ staff

- Submission and approval of Aetna's collaboration and coordination with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Department of Public Health, and Department of Education
- Submission of our detailed plan on how Aetna will develop relationships with the regional and county DCBS staff; the DCBS units dedicated to Interstate Compact on Adoption and Medical Assistance and Interstate Compact on the Placement of Children
- Submission of our detailed plan on how Aetna will develop relationships with the DJJ staff at the community district level
- Demonstration of our systems and processes
- Thorough review of our health plan's understanding of the contractual requirements
- Onsite reviews, desktop reviews, policy reviews, system demonstrations, staff interviews, and self-audit evaluations
- Pre-delegation audit and readiness of vendors
- Kentucky SKY program components

We expect and prepare for increased call volume by adding additional staff members to our current team who are trained on the Kentucky Medicaid and Kentucky SKY program requirements and are ready to answer enrollee questions to avoid gaps in care. Providers are engaged through face-to-face meetings, educational seminars, and group interfaces and are educated through outreach initiatives to manage, support, and maintain continuity of care. Our provider communication efforts reduce confusion about contract details and assure practitioners that we will honor prior authorizations during the 90-day transition period. Enrollees can see their preferred practitioners even when they are out of network, while we work to contract with the provider or enter into a single-case agreement to encourage continuity of care and reduce disruption for enrollees.

Thirty days prior to the contract effective date, we conduct a detailed internal deployment readiness review during which senior leadership, health plan staff, and the Implementation team review the following for completeness and accuracy:

- Status of completion of all major tasks and deliverables
- Systems functionality
- Staffing and training
- Resolution of any significant issues

Two weeks prior to the detailed internal deployment readiness review, we prepare our day-by-day deployment schedule of activities, including promotion of our applications to production, receipt, and processing of the enrollment file, transmission of enrollment information to our vendors, generation and distribution of enrollee identification cards and materials, and numerous other activities.

One week prior to the effective date, we assemble a Deployment Command Center team and schedule daily meetings. Together, health plan leaders and the Implementation team review the status of key startup activities and deliverables and identify any potential issues or risks.

Additionally, the Deployment Command Center team staff (key health plan, Kentucky SKY, and implementation leads) monitor all key performance metrics for the program, such as clinical services, operations, file exchanges, and regulatory reporting. The monitor measures daily to make sure our performance complies with and meets the needs of enrollees and providers. Any issues identified are managed through our issue-tracking log within in our system. We prioritize and monitor resolution based on the impact to enrollees and providers and regulatory or contract compliance.

Proposed Kentucky SKY Implementation Plan

Our approach to implementing SKY is to use our local Kentucky Medicaid team supported by our corporate Implementation team resources. Our implementation plan for the Kentucky Medicaid and

Kentucky SKY programs draws upon the implementation plan and lessons learned from our recent Children and Youth program implementation in West Virginia and our related work with child welfare practitioners in Kansas. In developing this plan, we conduct key activities required for program readiness (staffing, network, policies and procedures, and information systems) including:

- Thorough review of contract requirements
- Stakeholder outreach and feedback
- Focused, intensive, multiday review with our Medicaid and Kentucky SKY subject matter experts
- Meetings and information exchange with DCBS, DJJ, DBHDID, and others

Aetna uses this process to develop a comprehensive work plan complete with interdepartmental timeframes. The high-level work plan shown below will be revised upon contract award and submitted per the required timeframes. Upon award, we will refine our preliminary implementation plan to develop a comprehensive and region-specific work plan that incorporates the Kentucky SKY requirements. This plan will address all activities, work streams, and variables as part of our approach to a successful implementation, including action items, timelines, task relationships, milestones, and responsible parties.

> "The Kansas Department for Children and Families has appreciated the opportunity presented to us by Aetna Better Health to implement the Family Finding modality into our child welfare system this past year. Aetna has collaborated with the state and key state partners to enhance the lives of children and youth in families to develop strategies for positive impact on stability and wellbeing outcomes: preventing and reducing the need for formal foster care, increasing children living with relatives, and reducing reliance on institutional care.
> We are excited and look forward in this collaboration transforming our approaches alongside families, Aetna Better Health, and community partners."
>
> **—Tanya Keys**
> **Deputy Secretary**
> **Kansas Department for Children and Families**

The Kentucky SKY implementation plan is part of the larger Medicaid implementation plan processes and governance. Implementing a new program can present challenges and requires a methodical and proven approach to addressing potential barriers and setbacks. We recognize that SKY implementation, as a new program, requires concerted efforts by the Aetna team to ensure a successful launch. As an existing Kentucky Medicaid health plan, we recognize that a strong working relationship with the Department is critical and, if awarded, we will continue to collaborate with the Department, DCBS, DJJ, DBHDID, and the community to enhance the implementation plan and address all areas of Kentucky SKY sensitivity and concern, such as enrollee transitions, outreach, and communication.

Aetna's Kentucky SKY implementation plan is described in **Table G.3-1.**

Table G.3-1: Aetna's Kentucky SKY Implementation Activities

Required Implementation Activity	Status
Establishing an Office Location and Call Centers	Our current health plan office has been located at 9900 Corporate Campus Drive, Louisville, Kentucky, 40223 since August 2011. Our Enrollee Services team, Provider Experience team, and behavioral health call centers have been operational since 2011 as well. Currently, leadership and our Real Estate team are evaluating the need for additional space for any increased staffing.
Provider Recruitment Activities	Aetna's Network and Provider Experience teams are evaluating any gaps in our provider network to manage the Kentucky SKY enrollees. If any network gaps are identified, recruitment and contracting will begin.
Staff Hiring and Training Plan	Aetna is utilizing our current staffing algorithm, along with evaluating the complexity of the Kentucky SKY population to develop a comprehensive staffing plan and job descriptions. Once awarded, recruitment will be initiated.

Required Implementation Activity	Status
Developing Required Materials	As an existing Kentucky health plan, we have policies and procedures as well as enrollee and provider materials in place that we will utilize as our basis and enhance as required for the Kentucky SKY implementation. As part of our overall implementation approach, we will review these documents and make any necessary revisions and enhancements based on the RFP and contract and conduct a compliance review before submission.
Establishing Interfaces to Information Systems Operated by the Department, DCBS, and Others	Aetna will work collaboratively with the Department, DCBS, and others to ensure connectivity with required systems for the continuity and coordination of the Kentucky SKY enrollees.

Figure G.3-1 illustrates key milestones for Aetna's Kentucky SKY implementation. A complete implementation plan is included as **Attachment W.**

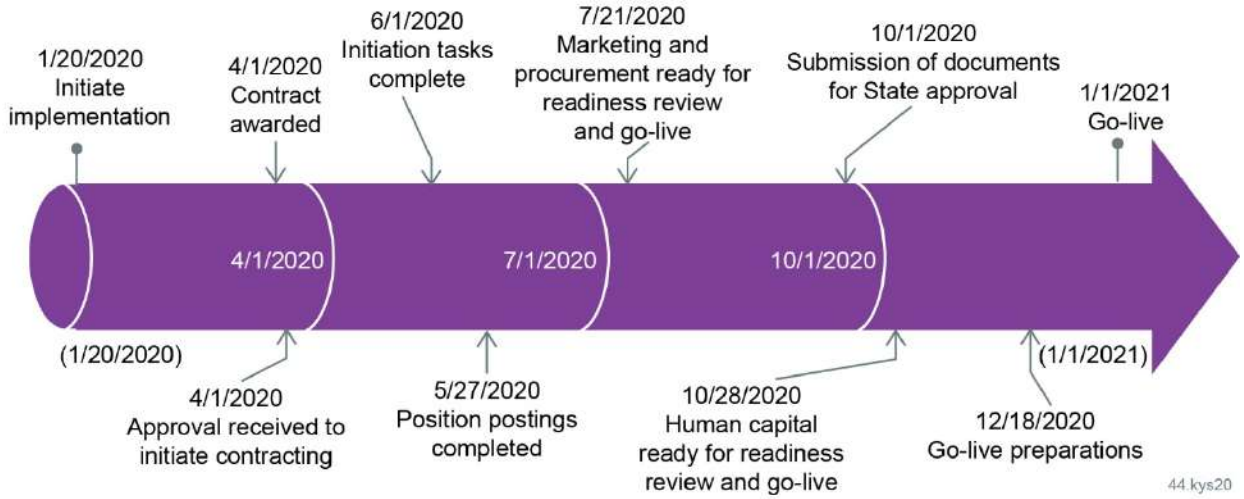

Figure G.3-1: Aetna's SKY Implementation Timeline

This timeline illustrates key steps to prepare Aetna for the Kentucky SKY go-live 1/1/2021.

We also develop a must-and-shall list of contractual elements to make sure we enhance our policies, procedures, and reporting and our systems are compliant with the Kentucky SKY contract and requirements. Aetna will leverage our experience in Kentucky, as well as other program implementations, accounting for the complexities to deliver on time and in alignment with the Commonwealth's Kentucky SKY requirements.

Proposed Staffing to Support Implementation Activities and Readiness Reviews

The Aetna Medicaid organization's 30 years of experience serving Medicaid enrollees and our 9 years as a Kentucky Medicaid health plan help position us for a seamless implementation of the Kentucky SKY program in Kentucky.

Susan Vickers, Aetna's Kentucky SKY team's chief of staff, will lead our implementation efforts. She will be supported by Joe Eberwein, executive director of Aetna's National Implementation team. Together, they will utilize a dedicated Implementation team, including Kentucky SKY subject matter experts who will be solely focused on the Kentucky SKY implementation. These Implementation team members will consist of our Kentucky SKY Executive Director, Kelly Gannon, and clinical staff who will work in partnership with the local Kentucky health plan team; DCBS, DJJ, and DBHDID staff; and other supporting community organizations to enhance our project plan, which will span through 90 days post-go-live. This full Kentucky SKY program management will include securing weekly updates from the

Kentucky SKY team and the various shared services areas to ensure individual functional area project plans and work streams are proceeding timely and all contractual requirements are being built accurately and that risks are identified and resolved promptly.

The roles and responsibilities of these Kentucky SKY positions include, but are not limited to, the following:

- Identify Kentucky SKY contractual requirements to make sure we implement a complaint program
- Coordinate weekly meetings with both the health plan and shared services throughout the implementation
- Coordinate all the documents required for readiness review, including determining ownership, quality review, compliance review, and formal submission
- Develop relationships with DCBS, DJJ, and community organizations
- Develop educational materials
- Develop and enhance policies and procedures
- Develop and enhance website materials (both enrollee and provider)
- Develop and enhance provider training materials
- Coordinate and support the development of enrollee training materials

Potential Planning and Readiness Limitations or Risks and Strategies

Aetna does not foresee any limitations or risks to meeting the Department's expectations or requirements for planning and readiness of the Kentucky SKY program. Aetna has the experience and expertise needed to comply fully with all requirements. If new expectations or requirements are identified by the Department, we will quickly assess the impact of the new requirements to health plan operations, develop a plan for ensuring full compliance, and identify the appropriate resources necessary to implement the requirement.

Tracking Action Items

Aetna's local Implementation Lead team is responsible for the comprehensive oversight of the implementation and its success. Our local Implementation team leader, Susan Vickers, will use our detailed implementation work plan as the basis for tracking our task progress against established timeframes and milestones. She will meet with her Implementation team staff on a weekly basis to review progress and will meet with Department staff on a schedule agreeable to both parties. Our Implementation team will meet the following timeframes for implementation activities (please refer to **Table G.3-2**).

Table G.3-2: Implementation Timeframes

Required Implementation Activity	Timeframe
Staffing Plan	30 days from date of Contract Execution
Organizational Charts	30 days from date of Contract Execution
Job Descriptions	30 days from date of Contract Execution
Care Coordination Team Staffing Plan	30 days from date of Contract Execution
Plan for Completion of Background Checks	30 days from date of Contract Execution
Psychiatric Residential Treatment Facility Certification and Decertification Business Process and Workflow	30 days from date of Contract Execution
Staff Located in Kentucky Office	90 days from date of Contract Execution
Educational and Training Plan	120 days from date of Contract Execution

a.i. Establishing an Office Location and Call Centers

Currently, Aetna leadership is evaluating the staffing plan and current space for the expansion of the Kentucky SKY requirements. We have a dedicated Implementation Real Estate team currently evaluating and will be the point team for any expansion or new building needs. Our current location is 9900 Corporate Campus Drive in Louisville, Kentucky. This Implementation Real Estate team will work with the local Kentucky health plan leadership to secure additional space if required.

Aetna currently has a centralized call center in Kentucky and Aetna will expand the call center staff to include dedicated Kentucky SKY enrollee services. The Aetna Medicaid organization's phone number will remain the same and the call tree will include Kentucky SKY prompts to ensure enrollees, their caregivers, and providers can reach the appropriate crisis staff and or Aetna Kentucky SKY team members.

The Implementation Real Estate team will work with the Aetna leadership to determine the best office location(s), including strategic co-location, we will ensure our Kentucky SKY Care Coordination staff and our call center staff are located in a site to maximize access for Kentucky SKY enrollees and families as well as to facilitate ongoing cross-departmental operations and oversight teams. Aetna Kentucky SKY shall locate all Kentucky SKY-specific staff in the Aetna office within 90 days of contract execution unless otherwise authorized by the Department and DCBS.

a.ii. Provider Recruitment Activities

Aetna is a current MCO in Kentucky and as such will have current personnel who are drawn to work with the Kentucky SKY model. Currently, **Aetna has contracts with over 29,355 provider organizations, which includes over 6,496 primary care providers, 33,794 specialty physicians, 7,731 behavioral health specialists, and providers with experience in the provision of trauma-informed care.**

As part of our recruitment and retention strategy, Aetna offers providers a variety of alternative payment arrangements through our Aetna Better Value program. To date, Aetna has entered into an alternative payment arrangement with key providers to improve quality of care for children with complex needs, including Children's Alliance Independent Provider Association, Kidz Club, and KVC Kentucky. Our programs are customizable, allowing us to combine the most applicable components for a particular provider into a comprehensive and effective, innovative alternative payment model that can be tailored to enhance access and delivery of services that are responsive to the unique needs of Kentucky SKY enrollees. We regularly monitor and assess our network to assure adequacy and determine potential provider recruitment opportunities.

Aetna's goal is to develop and manage a comprehensive primary, specialty, and behavioral health provider network of qualified and clinically advanced care providers so each enrollee receives the very best in health care services. We deeply value and depend on our provider partnerships across the Commonwealth in collaborating with providers to create programs and practices that are fair and simple to implement so providers can stay focused on what they do best, providing high-quality, trauma-informed care to our enrollees. For more than eight years, Aetna has worked collaboratively with Kentucky health care providers to deliver services to Medicaid enrollees, with a special focus on medically fragile and chronically ill infants, children, and young adults with complex physical and behavioral health care needs. Through this experience, we have learned that developing and maintaining an all-inclusive integrated care network requires continuous assessment of network gaps, ongoing efforts to recruit and maintain providers, and innovative solutions to improve access and quality of services for our enrollees.

The Kentucky SKY enrollees have complex needs, which Aetna's network supports by extending beyond traditional facilities, clinics, and practitioners to include community advocates, peer and professional

support organizations, specialty pharmacies, and family/caregivers. Our considerable network of contracted hospitals, specialists, including an array of pediatric specialists and sub-specialists, ancillary, and behavioral health providers serves as the basis for Aetna of Kentucky and Aetna Kentucky SKY enrollees for exceeding adequacy requirements and provider accessibility in advance of go-live for the Kentucky SKY program.

Our locally based Provider Experience team works collaboratively with providers to make sure covered services are holistic, accessible, person-centered, and evidence-based and span both required covered services as well as expanded care services. Our **Provider Experience team** is responsible for establishing our provider network; contracting and negotiations; ensuring network adequacy and network accessibility to covered services throughout our service areas; and monitoring such adequacy to identify gaps to maintain access to care and avoid disruptions to enrollee access to covered services.

We are currently evaluating and will be expanding our existing network to expand the number, scope, and types of practitioners to meet the unique care needs of Kentucky SKY enrollees, including geographic distribution and specialty providers. We accomplish this by working collaboratively with DCBS and other community organizations to identify providers not in our current network that Aetna can recruit for contracting. Our network solutions and approaches to a provider delivery system for Kentucky SKY enrollees are built around the following key elements:

- Enrollee choice must be maximized when selecting providers for their health care, including location, gender, quality, experience, availability, culturally competent, and clinically prepared
- Health care services must be delivered locally taking into consideration how our Kentucky SKY enrollees access care delivery and how providers manage Kentucky SKY enrollees
- Accountability and transparency against quality of care outcomes
- High-touch provider relations experts embedded in the provider community to cultivate strong relationships and continued collaboration
- Community-specific knowledge that works with care advocacy groups
- Assessment of number of enrollees, patterns of care, and anticipated utilization
- Identification of appropriate providers who provide appropriate care
- Encourage providers to expand services, hours of operation, and compliance with accessibility for all enrollees
- Use of innovative care models and reimbursement approaches to increase positive care outcomes and control of costs
- Monitor the network for adequacy, satisfaction, cultural, and specialty population considerations in care delivery

To the meet specialized needs and required assessment timeframes for the Kentucky SKY population, Aetna is proposing a dedicated network of trauma-informed providers that will be recruited through a value-based approach to meet the required turn around assessment timeline. In developing this specialized network of providers, Aetna Kentucky SKY enrollees will have rapid entry into care and receive the state-required assessments as outlined in **Section 4.26 of the DCBS Standard Operating Procedure Manual.**

Finally, in helping new providers transition to a managed care program, Aetna and specifically for the Kentucky SKY program, has developed simple, streamlined processes and educational programs to help providers understand key elements of managed care, such as continuity of care, integrated care, and enrollee outcomes. Aetna will offer opportunities for providers, guardians, enrollees, and caregivers a voice and participation by creating an Enrollee Advisory Board for the Kentucky SKY population. This board is comprised of community stakeholders, plan enrollees, family members, guardians, and providers with the central goal to offer enrollees and providers the opportunity to impact change.

a.iii. Staff Hiring and Training Plan

The Aetna Kentucky SKY hiring and training plan will be developed and implemented by the Training Collaborative. Implementation of the training plan will occur after baseline assessments of need occur in relationship to the new Kentucky SKY model. The Aetna Kentucky SKY Training Collaborative will conduct initial and ongoing staff training to address the unique needs of the Aetna Kentucky SKY youth and families.

Staffing Plan

The cornerstone of our staffing plan is highly experienced leadership with extensive local, program-specific knowledge. To support this contract, we are committed to attracting additional professional staff with significant experience serving populations like Kentucky SKY. Aetna Kentucky SKY Leadership will seek local candidates who are experienced and familiar with the local Medicaid health care delivery system and culture in the Commonwealth and have the Kentucky licensures and certifications required by law and the **Draft Medicaid Managed Care Contract and Appendices.**

Our local staffing plan for the Kentucky SKY program assumes a total enrollment of approximately 24,000 enrollees. The determination of appropriate staffing levels for the Kentucky SKY program is dependent upon several factors including, but not limited to, number of projected enrollees and consideration of the special needs of the populations being served. Aetna's staffing plan utilizes our staffing ratio algorithm that includes clinical, non-clinical, and community-based support workers. Under this scenario, we will scale up our present staffing to ensure adequate number of staff members, including **key personnel 100 percent dedicated to the Kentucky SKY program**. All Kentucky SKY-specific staff will be located in our Louisville office and in communities within the regions they serve.

Based on our years of experience providing Medicaid services across 16 states, Aetna continuously reevaluates and revises staffing levels to make sure consistent delivery of services. We have the flexibility to hire and train additional staff, refine processes, provide backup resources, and institute other changes to meet the Department's requirements. We base our staffing analysis on the Aetna Medicaid organization's standard operating model, which projects staff needed by proven ratios or other metrics appropriate to each position type. While our extensive experience serving similar populations in nine states across the nation drives our Kentucky SKY staffing model, we also use evidence-based guidelines built on time studies and complexity of care. **We will augment staffing in our Louisville office and in each region as necessary** so we meet all needs of enrollees, providers, and the Commonwealth.

In addition to meeting the staffing requirements, as outlined in **Section 42.6.2.C.,** the Aetna Kentucky SKY program will build out the internal System of Care (SOC) team and its resources and expertise to assist in addressing the unique need of the Kentucky SKY population. Each SOC position plays a vital role in coordinating with outside stakeholders, families, and non-covered services (please refer to **Table G.3-3).**

Table G.3-3: System of Care Administrators

System of Care Administrator	Roles and Responsibilities
Adult Administrator – (transitional age enrollee-focused)	• Builds key stakeholder relationships with the Department, DCBS, DJJ, etc. for the planning and delivery of Kentucky SKY enrollees aging out of enrollee services • Ensure that all service needs, including community-based supports, are available in the Kentucky SKY regional areas and identify gaps and solutions (especially those enrollees aged 18-26) • Collaborates to develop integration of records—information technology, communication, single integrated care plan development, coordination with DCBS' The Worker Information System (TWIST), etc. • Collaborates with provider services to coordinate networks to serve special populations like Kentucky SKY enrollees, enrollees with childhood trauma, etc. • Develops workflows for all required state assessments • Participates in the development and delivery of Kentucky SKY curriculum
Children's Administrator	• Builds key stakeholder relationships and processes with the Department and DCBS and attends various meetings including State Interagency Council • Meets with service staff in service regions and community districts to address gaps, concerns, problem resolution, education needs, and risk management • Supports and facilitates the youth boot camps and Governance Committee • Bridges health promotion, prevention, and early identification and intervention in order to improve long-term Kentucky SKY enrollee outcomes state-wide • Builds community-based services and supports specific to the Kentucky SKY population • Participates in the development and delivery of Kentucky SKY curriculum
Recovery and Resiliency Administrator (person or family enrollee with lived experience)	• Builds supportive programs and interventions to address mental health, substance use, and foster care delivery and coordination, including resiliency training and development, advocacy, foster family and biological family support, recovery maintenance, etc. • Collaborates with Kentucky SKY enrollees, families, and stakeholders to help to ensure all Kentucky SKY enrollees have advocacy support • Collaborates with local, state, and national partners and stakeholders like Bounce Coalition • Collaborates with enrollees and families to identify and remove barriers to service • Promotes the hope for recovery within the health plan • Collaborate with provider services to coordinate peer support network and other non-traditional providers to serve special populations like Kentucky SKY enrollees • Participates in the development and delivery of Kentucky SKY curriculum • Chairs Kentucky SKY Enrollee Advisory Committee
Trauma Administrator	• Communicates and collaborates with Kentucky SKY enrollees and families to identify concerns and remove barriers that affect service delivery and enrollee satisfaction • Participates in integrated rounds for the purpose of identifying trauma approaches and modalities that can assist the enrollee in building and maintaining health outcomes • Leads and establishes structure and mechanisms to drive the trauma transformation and principles in the health plan, provider network, and State of Kentucky regulators and stakeholders • Supports the development of trauma-informed social-emotional programs within the Commonwealth • Ensures Kentucky SKY care plans are responsive to trauma needs of our enrollees

System of Care Administrator	Roles and Responsibilities
Emergency Room/Crisis Administrator	• Develops the crisis plan development process and identify gaps and solutions (develop Crisis Response teams) • Collaborates with medical management to mitigate gaps in Kentucky SKY crisis service delivery including solutions to emergency room (ER) holds, reduction in out-of-state placements, and difficult-to-place enrollees • Coordinates system approach to enrollees needing emergency services for domestic violence victims, unaccompanied minors, etc. • Builds collaborative relationships with fire, police, emergency medical services, and hospital emergency rooms to advance trauma-informed care (TIC) approaches across systems and outcomes for our Kentucky SKY enrollees • Collaborates with medical management on transition of care for enrollees like aging out needs and discharging from inpatient settings and mitigates system gaps • Participates in the development and delivery of Kentucky SKY curriculum
Juvenile Justice Liaison	• Collaborates with the DJJ, Department of Corrections (DOC), county jails, Sheriff's Office, Correctional Health Services Office of the Courts and Probation Departments, and Department of Behavioral Health and Developmental Disability to identify systemic changes and promote community integration • Proficient on Reclaiming Futures framework to promote within systems and communities serving youth • Develops workflows for Kentucky SKY enrollees transitioning out of detention • Collaborates with instructional design to develop and deliver required training for judges, law enforcement, district and county attorneys, Department of Public Advocacy, etc. • Collaborate with the Start Strong program to strengthen reentry for our enrollees • Develops workflows for all required state assessments • Works with care coordinators in all regions to maximize system improvements through the Regional Interagency Councils • Provides/coordinates training and technical assistance to legal professionals working at the intersection of health/justice

Training Plan

Aetna proposes a large-scale training and coaching strategic planning process that draws on the perspectives and expertise of stakeholders, partners, and parents. After the completion of a strategic design and implementation plan, Kentucky SKY will direct that key leaders and staff from Aetna as well as partners spend two weeks in a custom designed learning process focused on implementation and organization change process to embed the practice framework and model. Aetna is a continuous learning organization. Aetna believes that each person is a life-long learner. Aetna also believes that our enrollees can learn competencies and skills leading to health and well-being. The organization understands that adults learn and retain information when it is presented in a multi-faceted approach including presentations, experiential, in-vivo demonstrations, and in the field coaching among other modalities. A tenet that drives our training plan is the need for each Aetna staff member to teach others.

Aetna's Kentucky SKY program design represents the convergence of numerous best practices, innovative national trends in foster care reform, and the goal of the Commonwealth to reduce the number of children in foster care and prevent system involvement on the front end. With over 11,000 children in foster care, the Commonwealth has put a stake in the ground for foster care and juvenile probation reform and transformation. Aetna has proposed a model of care that will deliver on that transformation in collaboration with state and local partners who know that we can do better by children and families.

The person-centered and values-based Kentucky SKY model requires a training plan that integrates adult learning best practices as well as a comprehensive set of trainings backed by coaching on key components of the model from over-arching principles and standards to practical interventions and competencies.

Aetna takes this learning to the next level and makes certain that each staff member is skilled in training colleagues, youth, and parents as well as community members, thus cementing the new skills in daily practice and habits. This transfer of practical knowledge to youth and families leads to shorter lengths of service, increased confidence, and the ability to navigate life on their own no matter what lies ahead. The proposed training program will provide a framework based on audience and dosage with the goals of system change and collaboration, whole-person care efficacy, Kentucky SKY and provider experience effectiveness, and full enrollee participation. The cadre of training themes will include Kentucky SKY overview and orientation, Kentucky SKY vision, goals, and model, business case for foster care transformation, trauma-informed and transformed care, governance, leadership, system and Kentucky SKY structures and interdependencies, roles and responsibilities, evidence-based practices, Early and Periodic Screening, Diagnosis, and Treatment, collaboration and communication, outcomes-driven care/quality assurance/quality improvement/clinical quality improvement, proactive/reactive safety planning, and crisis system of care.

New staff member onboarding is differentiated from ongoing training. The initial intensive training and in-the-field coaching will entail two weeks of didactics followed by 30-60 days of competency building coaching. The ongoing training will be focused on topics requiring periodic dosing as well as topics specific to youth needs and life domain areas. The wide variety of venues for ongoing training includes all staff and team meetings, supervisions, cross-departmental meetings, and community outreach events. Topic themes include evidence-based practice tune-ups, clinical quality improvement specific topics, care coordination enhancements, documentation, and auditing, etc. There are those set topics that will require regular training and those that will arise during implementation and ongoing operations. It is the responsibility of the training collaborative to assess the ongoing needs of the Kentucky SKY continuum of care and respond with ongoing curriculum development and delivery.

Aetna understands how vital it is to have the board of directors, senior leadership, and community stakeholders trained in the Kentucky SKY program vision, standards of care, and service delivery principles. Informed oversight and guidance make sure that system change is well supported by a group of mission-driven leaders prepared to remove barriers to success, garner resources, and share in the celebrations of success for Kentucky's children and families. As such, the Kentucky SKY training director will provide regular reports to the governance body on the annual training plan and key performance indicators, seeking assistance with any significant barriers to success.

a.iv. Establishing Interfaces to Information Systems Operated by the Department and DCBS

Aetna's implementation plan focuses on an integrated care model. For this model of care to be successful, information systems must be established to share relevant information pertaining to Kentucky SKY enrollees. This information needs to be readily accessible as this is a high-risk population and may need immediate and rapid access to services.

Management Information System

Our system is designed and well positioned to scale and evolve to benefit the health care and service provider needs for all enrollees across Kentucky's eight regions. Leveraging our deep, local experience and national resources and expertise, Aetna delivers to the Department an inclusive suite of innovative technologies and tools to drive advanced care coordination and delivery transformation. Our proprietary system delivers best-in-class capabilities and performance using the highest industry standards, controls, business continuity, security, and redundancy features to assure the highest level of data protection. Aetna has a local, Kentucky-based Management Information System (MIS) director supported by a national team of MIS staff members. All stakeholders benefit from ready access to local, dedicated, and comprehensive MIS staff expertise in our Kentucky Medicaid program. Our Aetna-designated MIS

personnel participate regularly in the Department's MIS scan calls and other MIS-related work groups (i.e., eligibility, electronic visit verification), and adhere to the Department's policies and procedures regarding at least 180-day advance notification of major systems changes and implementations, communication of changes within the MIS organization structure within 30 days, and prompt updates to point-of-contact information. We are fully capable of adapting our systems to changes in business practices/policies within required timelines and our history and experience show we stand ready to assist with any required desk or onsite readiness review. The following narrative addresses the enrollee, third-party liability, encounter/claims processing, financial, utilization data/quality improvement, surveillance utilization review, reporting, and testing subsystems.

Establishing Interfaces to Support Program Participation and Program Goals

To support continuity of care, we are creating **Aetna FamilyConnect**—the shared, electronic health record implemented in collaboration with DCBS, Kentucky Health Information Exchange (KHIE), and providers, which serves as the single source of truth for youth and their circles of support. We have already established interfaces to the information systems operated by our subcontractors, the Department, and other entities interfacing with our Kentucky health plan. In addition, the Aetna Kentucky SKY team has access to the **DCBS TWIST** system. This information is readily available to all departments in a read-only view. In addition, the Kentucky SKY team will interface with the **KHIE** to pull down and upload information relevant to the Kentucky SKY enrollees' health care needs. In addition, the **Medical Passport** will be made into a digital capacity as well as hard copy for foster parents.

Sharing/Receiving Information with the Department

To verify successful inbound and outbound file transmission, we employ an extensive combination of automated processes which provide end-to-end validation to make certain successful exchange of inbound and outbound files and to alert our production services of any issues. To augment these processes, our Production Support team uses a proprietary dashboard that provides an end-to-end view of a file's status through each intake step. This process identifies new enrollee enrollments, disenrollment, discrepancies, and file fallout management, among other elements. In addition, file monitoring software is configured to automatically alert in the event of a failure at any point in the process, which allows our production support to immediately research and resolve. This process also allows us to request ad hoc file resubmission from the enrollment broker, Maximus, if necessary while ensuring uninterrupted service operations for our enrollees. An audit trail for all inbound and outbound files and data processed is generated and retained in a separate audit database that is retrievable for audit and compliance purposes.

Aetna maintains an eligibility and enrollment subsystem that updates with information received both from the Department and directly from the enrollee. This system allows Aetna to monitor enrollment and identify enrollees requiring immediate services and/or service coordination and identify opportunities to engage new enrollees and maintain continuity of care. Benefits are available immediately upon enrollment for every individual who selects or who is assigned to our plan.

Using Department Files and Sharing with Subcontractors, Providers, and Supporting Entities

Aetna's Enrollment department and Enrollee Services department have extensive experience communicating with state agencies like the Division of Health Benefits, enrollment brokers, local Department of Social Services offices, and federally recognized tribes like the Eastern Band. Interfaces: To validate compliance with the Health Insurance Portability and Accountability Act of 1996 and seamless connectivity/minimal interruption of services provided by all vendors/subcontractors, Aetna is currently in compliance with the recently released Statement on Standards for Attestation Engagements No. 18 (SSAE 18), which has enhanced requirements for adequate control environments for vendors/subcontractors.

a.v. Communicating with and Educating Network Providers and Kentucky SKY Enrollees

Aetna is committed to being a catalyst, convener, and collaborator and is deeply committed to engaging divergent perspectives at all levels in order to promote Kentucky program goals. During implementation, Aetna will share information in a variety of forms, from one-pagers developed as polestars to provide at events with the State, providers, or families, to statewide informational webinars about the convening relationship, the philosophy of our shared practice, and the Kentucky SKY program. Additionally, Aetna will collaborate weekly with Department staff to discuss communications needs and challenges during implementation.

Aetna also plans to utilize the longstanding relationships built by the plan Community Engagement team to enhance collaboration, including attendance at community and partnership events. For example, Aetna will attend family resource network meetings, where information and problem-solving techniques are shared, and town halls offered at least quarterly at regional locations throughout the State to gather information and engage with community stakeholders.

On the provider side, Aetna intends to hold meetings with providers during transition, as well as invite providers to participate in the Training Collaborative (described in this section). Providers will also engage with Aetna during the Member Advisory Council (MAC) meetings quarterly during the program's first year, and at least twice a year thereafter. The MAC seeks to gather divergent perspectives for models and practices and inform Aetna of any issues needing correction. Recommendations from this group will be posted on the Aetna website and disseminated to the State for review of progress.

As providers are deeply engaged, so are enrollees. In addition to access of care coordinators within the Aetna plan and Enrollee Services call center, enrollees will have representation on the MAC, described previously. The MAC will serve as a learning space as well as an advisory group to inform process within the plan and will be facilitated by the SKY executive director.

Aetna recognizes that divergent voices are essential to ever-evolving and improving practices. We will conduct focus groups appropriate to trends and needs of the community; focus groups will gather information on enrollees' experiences, areas needing improvement, and sharing of information to benefit the enrollees and plan staff. Focus group membership relies on developed and developing relationships with enrollees and providers.

Upon award of contract, Aetna Kentucky leadership and the Kentucky SKY director of stakeholder engagement and education will develop and implement a Kentucky SKY Training Collaborative to provide accessible, in-depth education to all staff, partners, and providers. The Aetna Kentucky SKY Training Collaborative assures that all system partners, community leaders, youth, and families have voice, choice, and preference in the design, implementation, and sustainability of a training and coaching model. The Training Collaborative also allows for training expertise across multiple disciplines and departments. The Training Collaborative will also request guest presenters from law enforcement, the courts, judges, and attorneys to present during Kentucky SKY all staff meetings, community forums, and provider network training sessions on their areas of expertise in relationship to Kentucky SKY youth and families.

Training Collaborative Course Description

Our Training Collaborative, comprised of trainers from each key stakeholder entity, will design, deliver, and improve trainings and coaching models for each regional service delivery area. Aetna will facilitate the collaborative as well as provide train-the-trainer and capacity-building curricula.

Aetna and the Training Collaborative will provide initial and ongoing training for all advocates and other stakeholders with comprehensive details on the following:

- Foster care system best practices
- Community, state, and federal resources
- The unique physical health, behavioral health, and social needs of youth in child welfare, foster care, and juvenile justice systems

Key components of the training will include TIC, adverse childhood experiences (ACEs), neonatal abstinence syndrome (NAS) crisis intervention services, and evidence-based practices to provide understanding and empathy to our staff on the trauma and stress often inherent within the Kentucky populations served under this contract. Trainers will be well-versed in adult learning styles and include multimodal approaches to curriculum design ranging from visual, kinesthetic, and auditory components. Aetna and the Training Collaborative will also provide a comprehensive review of the Family First Prevention Services Act and other federally mandated services for the Kentucky SKY population within the training.

Our initial meetings with Commonwealth leadership will provide opportunities to discuss the design, delivery, and content of training for Commonwealth personnel. Upon executing a Kentucky SKY contract, Aetna will continue to collaborate with various experts, including our Commonwealth partners, to inform our approach and refine the curriculum. This will be incorporated into our overall Training Collaborative education and training plan, which will be submitted to the Commonwealth within the first 120 days of the contract. At minimum, the training curriculum will include contractual requirements and operation of the Kentucky SKY program and roles and responsibilities of the Department, DCBS, and DJJ; MCO organization and staffing; Kentucky SKY processes and workflows; and the aging out process to include the MCO role in support of enrollees who are aging out.

The Kentucky SKY director of stakeholder engagement and education will be responsible for relationship management, instructional design/curriculum development, knowledge of state systems, and assessment of community training needs and outcomes. The director of stakeholder engagement and education will identify necessary competencies and associated training needs for the new model of care and address identified gaps in training, incorporating provider identified training needs.

At time of the award, existing Kentucky SKY network providers will be oriented to the new program and our requirements around service delivery expectations, reporting, communication, and training. For newly contracted providers, education begins with an initial orientation provided by webinar within 30 days of a provider joining the network. Provider education is provided on an ongoing basis through provider forums, webinars, and face-to-face visits. We also have and will maintain an extensive training plan that includes a variety of topics each month. We have also implemented a Tips Tuesday campaign that provides ongoing provide tips and education. Additionally, we conduct various provider forums and webinars. A description of new and ongoing trainings are described in **Table G.3-4**.

Table G.3-4: New and Ongoing Provider Training

Training Topic	Training Description/Topics Included
New Kentucky SKY Provider Training	
New Provider Orientation	Aetna's new provider orientation training covers a broad range of topics designed to make sure new providers understand program requirements and how to access resources. Topics include a Kentucky Medicaid overview; provider services and enrollee services functions and contact information; the provider website, secure provider portal, and provider manual; covered services including medication coverage and prior authorization, medical prior authorization, authorization timelines, and medical necessity; claims processing including clearinghouse, clean claims, claim submission; fraud, waste, and abuse; provider communications; enrollee rights and responsibilities, access and availability standards, cultural sensitive standards, non-discrimination and reasonable accommodations for enrollees with disabilities; medical record standards; appeal and grievance; population health programs; and Healthcare Effectiveness Data and Information Set (HEDIS).
Kentucky SKY Orientation	The Kentucky SKY new provider orientation will educate providers on the system transformation and design, as well as program requirements. Topics will, at a minimum, include roles and responsibilities of the Department, DCBS, DJJ, and DBHDID, and Aetna and how Aetna coordinates and collaborates with these agencies; Family First Prevention Services Act, and other federally mandated services and programs impacting Kentucky SKY enrollees; Kentucky SKY covered services and the provider's responsibility for providing and coordinating services with special emphasis on Kentucky SKY-specific requirements that vary from Medicaid coverage and processes; the aging-out process and support available through Aetna; and continuity of care training will emphasize Health Insurance Portability and Accountability Act of 1996 requirements support compliant sharing of enrollee health information.
Requirements for Providing Health Care Services and Behavioral Health Care Services to Kentucky SKY Enrollees	The purpose of this training will be to make sure providers serving Kentucky SKY enrollees understand specific requirements applicable to this population. Training topics will, at a minimum, include medical consent requirements; required timelines for services and assessments; specific medical information required for court-ordered requests and judicial review of medical care; appropriate utilization of psychotropic medications; evidence-based behavioral health treatment interventions and specific behavioral and physical health needs of the Kentucky SKY populations; trauma-informed care; Child and Adolescent Needs and Strengths (CANS); crisis intervention services; high fidelity wraparound approach; impact of ACEs; NAS; substance-exposed infants; screening for and identification of behavioral health disorders; Care Coordination teams for Kentucky SKY enrollees and how to access the care coordinator; and performance measures and health outcomes.
New and Ongoing Kentucky SKY Provider Training **(Mercy Care, a Medicaid managed care organization administered by Aetna in Arizona, and Aetna Better Health of Kentucky will collaborate with Department, DCBS, DJJ, DBHDID, and Department of Education to modify and adopt materials for the Kentucky SKY program)**	
Foster Care Behavioral Health Navigation Forum	This will be a monthly forum for foster, adoptive, kinship, and group home caregivers to learn about the behavioral health services available to children and youth in foster and adoptive care.
Foster, Adoptive, and Kinship Training Series	This will be a three-part monthly training series covers an overview of trauma-informed care, trauma-informed care birth to age 5, and trauma-informed care strategies and techniques.
Child and Family Advisory Partnership (CFAP) Community Forum	These forums will be used to connect foster, adoptive, kinship, and group home caregivers to what's happening in the local behavioral health community and offer an opportunity to talk directly with providers. Attendees will be encouraged to share ideas on how to improve the delivery of care to enrollees, their families, and supports.
Training for Youth Transitioning	This will be an ongoing development of training and support tools that assist Kentucky SKY providers in meeting the needs of youth transitioning through the DCBS. This will also include support and training for DCBS staff in working with providers to meet the specialized needs of

	youth who are struggling with placement stability. Training will include such topics as understanding the behavioral health support that can be offered for youth and how to reach out to obtain services and supports through the Care Coordination teams.
Sex Trafficking 101	Aetna will work with Kentucky law enforcement to develop and offer training on human trafficking, including training on meeting the complex behavioral health and support needs of this population. Mercy Care, a Medicaid managed care organization administered by Aetna in Arizona, implemented a similar initiative and has provided training to foster/adoptive/kinship caregivers, Department of Child Services (DCS) group home providers, law enforcement, family advocacy centers, hospitals, DCS staff, behavioral health providers, judges, court staff, juvenile probation, attorneys, and others. These trainings have significantly supported the referral of youth to the collaborative as indicated by the increase of referrals from participants of the trainings. The services and supports from a trained and committed provider network have assisted in the development of stable, supported placement options for youth, dramatically decreasing the number of youth enrolled with Comprehensive Medical and Dental Program, the health plan for Arizona's children in foster care, that AWOL to less than 10%.
LGBTQ Cultural Competency	Aetna understands there is a disproportionate degree that lesbian, gay, bisexual, trans/transgender, intersex, and other sexuality, sex, and gender-diverse (LGBTQ) are represented in the foster care system. To best address the needs of LGBTQ enrollees in foster care, care coordinators and foster parents will need training and experience working with this population in order to have a robust understanding of the cultural values and practices within the community. This training will be designed to make sure providers are trained and demonstrate skills to serve the LGBTQ population; to provide appropriate screening of enrollees for behavioral health needs since they are at a higher risk; to provide education on addressing discrimination at both an individual and system level; and that providers understand language is essential, such as using correct identifying pronouns, and that forms and resources account for diverse perceptions of sexuality, sex, and gender; and to understand that strict confidentiality practices are critical to creating an inclusive and safe environment for LGBTQ enrollees.

In addition to the trainings identified in **Table G.3-4**: New and Ongoing Provider Training, we will collaborate with the Department, DCBS, DJJ, DBHDID, and Department of Education to identify additional training topics such as abuse and neglect; infant, child, and adolescent development; the impact of foster care on families and children; managing significant behavioral and psychiatric disorders in cooperation with mental health professionals; the child and family welfare system and its policies and procedures and how to navigate through its bureaucratic structure; working closely with health care coordinators; adoption competency; and family-based sexual trauma competency.

Virtual Provider Office Hours

The purpose of the virtual office chat sessions is to update non-traditional child welfare providers on program-related matters and give participants an opportunity to raise questions or issues they may have regarding network participation. Sessions will be hosted by the Provider Experience staff and organized around a featured topic. Depending on the content to be addressed, i.e. medical management, billing, claims adjudication, etc., there will be other Aetna subject matter experts joining the call.

Providers will be encouraged to suggest topics they would like addressed.

We communicate policy and program changes to providers in a timely manner (e.g., periodic newsletters) along with additional trainings offered around policy changes. Supplemental trainings will also be offered as determined by provider needs, or as requested by the Department. Additional training will be provided if providers request it or if they are identified as needing more direction and guidance through enrollee, provider, or Quality Improvement Committees, or have issues with administrative or clinical documentation. Technical assistance will also be provided via the phone, face-to-face, webinar, forums, and all available channels. Following training, provider experience representatives follow up with

providers to address any questions they may have and to make certain they know how to reach us for assistance.

Website and Required Materials

As an existing Kentucky health plan, we have policies and procedures as well as enrollee and provider materials in place that meet the Department's requirements.

Provider Website

Aetna has an established a provider services website[2] that includes webpages specifically designated for providers that offers each to use access to current program information, as well as provider-specific information. Information available on the provider services website includes contact information for our call centers and hotlines, including the provider services call center, searchable provider manual and provider directory, current and clearly defined prior authorization requirements, pharmacy preferred drug list (PDL), pharmacy conditions for coverage and utilization limits, information on enrollee rights and responsibilities, information about KHIE, provider updates such as What's New updates, and links to other websites include CHFS, the Department, and credentialing verification organization once established. Aetna will develop a **user-friendly** Kentucky SKY-specific tab for providers to access information specific to the program requirements and Kentucky SKY enrollee resources.

Aetna's secure web-based provider portal offers access to through secure, single sign-on functionality that improves efficiencies for providers and offers complete accessibility to provider and enrollee data and reports. The portal contains information on the following:

- Provider and enrollee record
- Claim or authorization status information
- Electronic explanations of benefits outlining claim services payment or denials, dates of service, procedure codes, amount billed and allowed, and amount paid
- The ability to submit prior authorizations, claims, and appeals and grievances

This web-based platform allows us to communicate enrollee health care information directly with providers in real time, highlighting enrollee identification (ID) cards; enrollees' panel roster; and searches for specific providers, claims status, and remittance advice by provider user account ID. It also offers a prior authorization lookup tool designed to perform ID-specific searches for authorizations by enrollee, provider, authorization data, or submission/service dates; review prior authorization requirement by specific procedures or service groups and show details on codes and any noted prior authorization exception information; export Current Procedural Terminology/Healthcare Common Procedure Coding System code results and information to Excel; check the status of the enrollee's compliance with HEDIS measures; and submit grievances and appeals. Provider training materials and the provider manual are also located on the portal. Providers may also submit inquiries through the provider portal, which we will respond to within one business day.

During new provider orientation, we review the provider services webpage functionality and assist providers in registering for the portal. Providers may also request ongoing or refresher guidance, as well as assistance with logging into the portal either by contacting their provider representative or our provider call center. Providers can also register for the portal through our website. Additional information regarding the portal is available through the navigation guide on our website.

We review and update the website as needed, but at least monthly, to make sure information available is accurate and up-to-date. Unless otherwise agreed to in writing, we will submit and obtain prior approval from the Department, all materials that will be posted to the website, as well as screenshots of any website

[2] Available at https://www.aetnabetterhealth.com/kentucky/providers/

changes. We will not modify the provider website with prior receipt of approval, unless the modifications are upgrades that support the ordinary operation, administration, and maintenance of the website or unless otherwise agreed upon by both parties.

On the Aetna Kentucky website, contracted Kentucky SKY providers have access to the following:

- Contact information for contractor call center(s) and hotline(s)
- Searchable provider manual
- Searchable provider directory
- Current and clearly defined prior authorization requirements
- Pharmacy PDL and pharmacy conditions for coverage and utilization limits
- Enrollee rights and responsibilities
- Information about KHIE
- What's New updates
- Links to other websites such as DCBS, DJJ, and Department of Behavioral Health and Developmental Disability
- Links to online resources and toolkits, such as psychotropic medication administration and identifying victims of human trafficking

Enrollee Website

Aetna maintains a user-friendly, mobile-optimized website. As part of Web Content Accessibility Guidelines 2.0 AA compliance, all information on our website is digitally readable. To make sure maximum readability for the visually impaired, our color scheme also abides by these guidelines. The website is available at a sixth-grade reading level. Our website is adaptable to the device it is viewed on and includes the current enrollee handbook and enrollee newsletter, searchable list of network providers (updated in real time), and information on grievance and appeals process for both enrollees and providers.

Our website is available in both English and Spanish and contains instructions for requesting information in another language. All information on our website can be translated, printed, or made available in another format upon enrollee request at no charge to the enrollee.

In addition, Kentucky SKY enrollees will have access to resources relevant to age and needs. Please refer to **Figure G.3-2** for screen shots of Kentucky SKY enrollee website resources.

Figure G.3-2: Aetna Kentucky SKY's Web-based Resources

Aetna Kentucky SKY enrollees will have access to resources relevant to their age and need.

Required Materials

Aetna Kentucky SKY is committed to building a strong communication model in support of better outcomes for youth and families. An Aetna Kentucky SKY webpage, embedded in the current Aetna of Kentucky website, will allow for current updates on operations, resources, and trainings for enrollees and their families, Provider Experience staff, and system partners.

The following information in the provider manual, along with routine updates, will be accessible to all contracted providers within the Aetna website or in hardcopy (based on the provider's request):

- Provider rights and responsibilities
- Covered services
- Enrollee rights and responsibilities and cost-sharing requirements
- Information for PCPs about advance medical directives and their responsibilities for informing enrollees
- Contractor's policies and procedures
- Information for accessing the contractor and program materials through the contractor's call center(s), toll-free hotlines, and website
- Provider credentialing and re-credentialing
- Provider and enrollee grievances and appeals processes
- Claims submission process and requirements
- Provider program integrity requirements and reporting suspected fraud and abuse
- Utilization management and prior authorization procedures
- Medicaid federal and State laws and regulations
- Overview of the Quality Assurance and Performance Improvement program
- Overview of value-based payment models, when implemented
- Standards for preventive health services

- Foster Care Bill of Rights and other new legislative overviews

The Kentucky SKY portion of the Aetna Kentucky website will be updated monthly or more frequently as needed to make sure information is accurate and up to date. Any required or necessary updates to the website will be in compliance with **Section 42.6.3 of the Draft Medicaid Managed Care Contract and Appendices.**

b. Building Relationships with DCBS and DJJ

Collaborative relationships are at the heart of Aetna's implementation plan just as they are the basis of successful care plans for children and families. The most successful and dynamic Care Coordination teams (CCTs) are comprised of people who matter most to the family and youth working closely with providers. The Aetna Kentucky SKY model of design and implementation is reliant on the development of stakeholder relationships at all levels as described in **Table G.3-5**.

Table G.3-5: Aetna's Key Stakeholder Relationships

Stakeholder Relationships	Examples of Stakeholder Organizations and Agencies
State Collaborators	• DBHDID • Department of Community Based Services • Department of Juvenile Justice • Interstate Compact on Adoption and Medical Assistance • Interstate Compact on the Placement of Children • Department for Public Health • Department of Education
Advisory and Advocacy Organizations	• Youth Leadership Council (YLC) • The Kentucky Youth Advocates (KYA) including the following: – The Kosair Charities® Face It® Movement – The Blueprint for Kentucky's Children – Kinship Families Coalition of Kentucky – Bounce Coalition – Kentucky Oral Health Coalition – Kentucky Council of Church's – University of Kentucky and other Academic partners • Kentucky Court Appointed Special Advocates Network • ECHO • Kentucky Partnership for Families and Children • FRYSCKy (Network of Family Resource and Youth Services Coalition of Kentucky Coordinators)
Social Service Entities	• United Way • Boys and Girls Club • YMCA • Big Brothers/Big Sisters • Women, Infants, and Children • Supplemental Nutrition Assistance Program

Roundtables

A central challenge in catalyzing, convening, and facilitating effective, timely, and tailored support and services with enrollees and their families at the center is the complexity of multiple systems, missions, and funding streams. The consequence of multiple systems and services is the fragmentation and discontinuity experienced by children, youth, and parents in the very times when they may be most vulnerable to life-altering experiences, which have or could lead to parental and family separation. Aetna believes that the convening of local, regional, and state level system and services roundtables is a critical framework to supports our enrollees and their families to receive integrated, effective, and timely support during critical periods of risk and the resulting opportunity of receiving sufficient high-quality health,

mental health, and social services. These roundtables will be made up of leaders from government agencies at the local, regional, and state level, as well as service providers, legal system professionals, schools, kinship, adoptive and foster parents, organizations supporting parents, youth lead organizations, law enforcement, mental health, public assistance, housing, etc.

These roundtables will convene to explore actions and coordination between systems, agencies, and individuals to support families and children at the earliest opportunity to safely stay together and build on the individual and family well-being. Local and regional roundtables will be represented through appointed members on the state level roundtable to help increase the equity experienced by rural and multi-stressed neighborhoods and communities. The goal of the roundtable approach is in common view of the importance and components of services, supports, programs and policies that reach families early and focus on build individual child and family well-being as a primary outcome.

Building Relationships with DCBS Staff at the Service Region and County Level

With experience in behavioral and physical health integrated managed care in nine Medicaid states serving children in protective services, Aetna understand a comprehensive approach is essential to meeting their needs in the right way, place, and time. In this experience with diverse populations in DCBS, we understand program nuances and the multiple avenues as families become engaged in DCBS; whether it be those identified as at risk, those in early removal (or parents are still working on getting them back), those who have had their parental rights terminated, and across the youth age continuum from infant to aging out. Because we serve over 3 million persons in Medicaid, we understand the challenges adults face due to trauma they incurred as children.

Kentucky Youth Advocates

Aetna Kentucky aims to build on the efforts already underway at DCBS to transform the child welfare system into an effective, nationally recognized approach that strengthens families and keeps kids safe. In recent years, the Commonwealth, with the collaboration of the DCBS, the Kentucky Legislature, and key stakeholders, has made several policy advancements that will keep families safely together and protect children from abuse and neglect and we want to help build on those positive advancements.

Through a formal collaboration with KYA, we will work with state agencies, providers, DCBS, and enrollees across the Commonwealth on innovative solutions to transform care for the Kentucky SKY population. KYA is the state's leading child advocacy organization with over 40 years of experience working with public, private, and nonprofit agencies to advance policies that are good for kids. KYA is an expert in building effective coalitions that advance systems-level changes and offers a wealth of expertise in the child welfare arena. The organization is already working with DCBS and Casey Family Programs on several initiatives related to advancing Families First in the Commonwealth.

Aetna Kentucky has worked with KYA previously through being an active coalition member of the Blueprint for Kentucky's Children and supporting Children's Advocacy Day at the Capitol. We plan to deepen our relationship with KYA to help us provide the best care for the Kentucky SKY population and play a broader role in transforming the child welfare system to work better for children and families. KYA is an ideal organization to collaborate with as we are in alignment on current commonwealth priorities, including strengthening families, keeping kids safe, enhancing supports for kinship families, and promoting resiliency and stability for youth that are in or aging out of foster care. Our formal collaboration with KYA will include the following components:

- **Training and technical assistance of Kentucky SKY staff:** KYA has extensive knowledge of the child welfare system in Kentucky and the work underway to improve Kentucky's response to families at-risk of crisis. KYA will provide training to all Kentucky SKY staff to ensure a knowledgebase of the state-of-the-state of Kentucky children in foster care, the landscape of the child welfare system across the Commonwealth, and Kentucky priorities related to strengthening families and keeping kids

safe from harm. KYA staff will meet with Aetna Kentucky SKY staff on a regular basis (at least monthly) in a learning collaborative setting to share information, troubleshoot issues, and collaboratively develop policy and practice solutions that can be advanced in the Commonwealth. KYA will also provide educational training opportunities through webinars and briefings on the status of the child welfare arena in Kentucky and nationally to larger cohorts of Aetna staff outside of Kentucky SKY personnel in order to advance Aetna's understanding of this complex issue. Collaborating with KYA will strengthen the knowledge base already within Aetna Kentucky and will facilitate areas for innovation.

- **Youth and Family Engagement:** Aetna listens to and meets the unique needs of our enrollees, especially those in foster care. Although we communicate with and assist individual enrollees on a regular basis, we recognize the power of hearing firsthand stories from individuals who have been directly impacted by the child welfare system and/or foster care outside of our direct enrollee interactions. KYA coordinates multiple consumer-focused coalitions that will include individuals in the Kentucky SKY population. We will collaborate with KYA to engage these individuals through coalition meetings and focus groups on a regular basis. We will use these opportunities to hear from those impacted by the child welfare system firsthand and develop collaborative solutions that address the unique situations facing this population. These interactions can also help Aetna identify ways to advance Family First across the Commonwealth.

Aetna will work with KYA to identify specific opportunities for engagement. Specifically, we plan to engage the following groups for listening sessions:

- **Kinship Families Coalition of Kentucky:** The Kinship Families Coalition of Kentucky is a community group dedicated to raising awareness of the issues surrounding kinship care in Kentucky and forwarding recommendations for policy changes to increase supports for kinship families. Several kinship families are involved in the coalition and previous focus groups have helped to shape the policy priorities of the coalition.
- **Youth Leadership Council (YLC):** The YLC consists of 18 young people ranging in age from 13 to 22 years old from across the commonwealth, including from Covington, Glasgow, Owensboro, Louisville, Franklin, Barbourville, Stanford, Albany, and Hazard. Members of the council represent a cross-section of Kentucky youth who either have a special interest in advocating for children who have been abused or neglected or have been personally involved in the child welfare system. All members express an interest in speaking up for the voiceless.
- **Advancing Families First Policies and Practices:** Aetna will work with KYA to advance policies and practices that will keep families safely together and reduce the need for out-of-home placements in the child welfare system. KYA is experienced in policy development and advancement through coalition building, public education and engagement, and other advocacy activities. Specifically, in the child welfare arena, Aetna Kentucky will become active participants in the Blueprint for Kentucky's Children, the Face It Movement to end child abuse, and local kids count conversations to help build on the Families First successes already advancing in the Commonwealth.
  - **The Blueprint for Kentucky's Children (Blueprint)**, led by KYA, is a coalition of nonprofit, public, and private organizations across the Commonwealth that speaks with a common voice to create brighter futures for Kentucky kids. The Blueprint stands on three pillars: thriving communities launch strong families, strong families launch successful kids, and successful kids launch a prosperous future for Kentucky. Several of the Blueprint priorities are focused on advancing the priorities of Families First, including family preservation and reunification. Aetna Kentucky is already a member of the Blueprint; however, we plan to grow our commitment to the Blueprint. We will actively engage Blueprint members in advancing child welfare policies that supports Family First and on specific ways that Aetna can enhance the care it provides youth in foster care. We will engage with Blueprint members at regular meetings and through ad hoc child welfare workgroups.

- **The Kosair Charities® Face It® Movement** directly addresses the unacceptable incidences of child abuse and neglect in Kentucky with the promotion of best practices in child abuse prevention and intervention, engaging the community, and advocating for effective policies to improve the child welfare system. Aetna will collaborate with KYA through Face It to support more extensive training of child abuse prevention across the Commonwealth. We will engage with the over 50 members that actively serve on subcommittees to address the multiple prongs of child abuse prevention.

The Commonwealth has made strides in recent years to begin transforming the child welfare system. Aetna recognizes the progress and understands there are additional areas for improvement. Our collaboration with KYA will not only result in better health care for the Kentucky SKY population, it will help us play a larger role in addressing the needs of Kentucky SKY that go beyond health care to ways we can keep families safely together.

Building Relationships with DBHDID and the Community Mental Health Centers

We recognize the problems with access to behavioral health services and believe partnering with DBHDID is essential to successful outcomes for SKY enrollees. According to the Centers for Disease Control and Prevention[3], nearly one in five children have a mental, emotional, or behavioral disorder, such as anxiety or depression, attention-deficit/hyperactivity disorder, disruptive behavior disorder, or Tourette syndrome. Children with these disorders benefit from early diagnosis and treatment. Unfortunately, only about 20 percent of children with mental, emotional, or behavioral disorders receive care from a specialized mental health care provider.

Our behavioral health manager functions as a liaison to the range of behavioral health stakeholders: 13 community mental health centers, DBHDID, psychiatric hospitals, private child care providers, and psychiatric residential treatment facilities. The behavioral health manager will conduct ongoing monthly meetings with key staff to facilitate timely delivery of needed services, problem-solve health plan related issues, and identify needed process improvements. Working in concert with these agencies, our behavioral health manager will support the delivery of preventive services, early identification and intervention, appropriate treatment modalities, and recovery services and supports. For example, discharge planning from residential and psychiatric facilities will start at the time of entry into the facility. Our behavioral health manager will assign a CCT to work closely with the facility staff, family, and enrollee to facilitate a care plan that provides for the needs of the enrollee and the family. Ideally, the CCT will attend onsite discharge meetings as a full participant of the team to coordinate care for post-discharge services.

Regional Interagency Council

Aetna has strong relationships with the Regional Interagency Council (RIAC) in the commonwealth's DCBS regions, which meet monthly and are comprised of community partners and led DCBS staff. Each RIAC takes on different issues that affect foster children in their region. Two of the RIACs that Aetna foster team members attend focuses on transition-age youth and planning events to impact this population. Aetna participates in the collaborative meetings to offer support and assistance with planning and collaboration of services and supports at the local level to children, adolescents, and transition-age youth and their families, and to help them function better at home, in school, in the community, and throughout life. Aetna proposes to partner with DCBS in all RIACs to provide a regional approach to cross-sector planning and system improvement. Please refer to **Table G.3-6** for RIAC goals.

[3] https://www.cdc.gov/childrensmentalhealth/access.html

Table G.3-6: Goal for Regional Interagency Councils

RIAC Goals	Targeted Activities
System Assessment and Improvement	• Reduce silos and build cross-sector partnerships • Develop capacity to leverage these meeting and use of data from the region to identify system gaps and drive change
Case Conference	• Improve response to youth by tracking specific situations and/or cases • Identify system issues to improve future responses

As needed, the Aetna Kentucky SKY teams shall meet with regional staff in the service regions and community districts to address concerns, problem resolution, educational needs, and risk management. Aetna currently participates in the monthly collaborative meetings with the **State Interagency Council for Services and Supports to Children and Transition-age Youth** to assist with coordinated policy development, comprehensive planning, and collaborative budgeting for services and supports to children and transition-age youth with or at risk of developing behavioral health needs and their families.

In addition, we collaborate with school and community resources, engaging with them on a routine basis through our Care Coordination team. On a more system-wide basis, we will establish and engage local, regional, and statewide governance roundtables actively working to integrate allied systems and governmental branches to facilitate a common understanding of family and community networks and best practices in family safety, healing, and health. These include systems such as the courts, behavioral health, physical health, education, child and family welfare, and other managed care organizations as needed.

Aetna contracted providers will be responsible to make certain appropriate coordination and collaboration occur with the assigned DCBS social workers. The Aetna Kentucky SKY team will coordinate and collaborate with behavioral health providers and DCBS and at all levels to identify potential barriers to accessing behavioral health services and the causes of those barriers, and to implement strategies to overcome them.

Building Relationship with the Department for Juvenile Justice Staff at the Community District Level

Aetna Kentucky SKY utilizes our **unique and dedicated juvenile justice liason (JJL)** to gather eligibility information for DJJ-involved youth. The JJL acts as the first point of identification and diversion for detained juveniles enrolled in or eligible for the Aetna Kentucky SKY program. Kentucky SKY will develop and maintain a detention roster database for all Kentucky SKY enrolled youth and follow protocol to make certain that planning is occurring and that needs are identified prior to being released from detention. The juvenile justice liaison, as well as a regional care coordinator in each region (10 staff total), will have strong collaboration with DJJ and presence in the DJJ facilities.

The JJL functions as a liaison to the range of justice stakeholders: DJJ, juvenile probation, law enforcement, the courts, legal advocates, county attorney, and court-appointed special advocates. The Aetna Kentucky SKY JJL, partnering with the nine regional care coordinators, will participate in the Wraparound Treatment team, attend court hearings, and assist eligible youth enroll in behavioral health services. Aetna justice-focused staff will be experienced working at the intersection of the legal/justice systems/health care/child welfare systems/professional 'boundary spanners' and provide technical assistance to key stakeholders regarding processes on how to navigate through the behavioral health system.

Discharge planning and reintegration start at the time of system entry, so ideally, Aetna's nine regional care coordinators will participate in every youth's DJJ discharge planning from the time they enter DJJ, or shortly after enrollment with Kentucky SKY. We will have a system where the assigned juvenile justice

worker will alert the Kentucky SKY care coordinators at least 30 days prior to the Kentucky SKY enrollee's release from detention. The intention is to have the care coordinator participate in the discharge planning process and to coordinate care for post-release services.

The JJL's role is based on Mercy Care's Juvenile Justice Engagement Team. Mercy Care, a health plan managed by the Aetna Medicaid organization in Arizona, utilizes a detention roster protocol to identify and serve youth in detention. This protocol will be adapted for the Kentucky SKY population and managed by the JJL who will be responsible for the following;

- Collaborating with the DJJ, DOC, county jails, Sheriff's Office, Correctional Health Services Office of the Courts, and Probation Departments and DBHDID to identify systemic changes and promote community integration
- Understanding the **Reclaiming Futures** framework and working closely with their team, other systems that serve youth, and with the community
- Bridging communications with health plan staff, court, justice systems, and youth/families

Kentucky's approach illustrates the innovative changes made by states. Kentucky's SB 200 (2014) [4] required that youth appearing on their first misdemeanor offense be offered pre-court diversion. This means that after intake and before referral to court, these youth are offered an opportunity to have their cases handled outside the formal court process; if successful, diverted cases do not result in an adjudication of delinquency. Kentucky's policy severely limits the practice of allowing prosecutors and judges to override these diversion decisions. For high-needs youth and those who do not initially succeed in diversion, a **Family Accountability, Intervention, and Response (FAIR)** team is deployed to give youth and families additional resources and services. As stated above, research has shown that court interventions in the juvenile justice system can increase the likelihood of criminal justice involvement in adulthood; the multidisciplinary FAIR team program seeks to minimize court contact to mitigate that risk. If youth are unsuccessful in their diversion plan, they can be referred to court. Since the implementation of SB 200, 90 percent of diversions have been successfully kept out of court, and more than 3,000 cases have been reviewed through the FAIR program.

Supporting Enhanced Coordination of Care

Aetna has been a provider in Kentucky since 2011 and has created strong relationships in support of the enrollees currently being served. Aetna Kentucky SKY will employ the following approach to fostering collaborative relationships:

- Identify specific executive sponsors, leaders, and managers in all applicable departments and organizations integral to the desired success of a transformative managed care model
- Schedule individual and group meetings within 30 days of contract award for the purpose of engagement, hearing the perspective of our partners, crafting of a shared vision, and establishing full involvement in the planning and implementation process moving forward
- Survey stakeholders within 30 days of contract award to gather data on the barriers to success, unmet needs, and potential resources that will inform a responsive model
- Host a strategic planning retreat during which stakeholders, partners, and community members will be introduced to the Kentucky SKY vision and model. This will be followed by a current success story presented by a family who has already experienced values-based collaboration between Aetna Kentucky, partners, and the family. There will be a review of the collated data brainstorming on any missing data. The convening will contribute to the Kentucky SKY vision of success. The attendees

[4] Druma, J., Olseon, R., Harvell, S., "State-Led Juvenile Justice Systems Improvements; Implementation Progress and Early Outcomes" (2018); accessed June 2019,https://www.urban.org/sites/default/files/publication/98321/state-led_juvenile_justice_systems_improvement_3.pdf

will be informed of roles and responsibilities in accordance with the RFP requirements. Finally, the attendees will commit to the various committees and work groups before hearing of next steps.

- The following are Aetna Kentucky SKY leadership positions and work team topics:
  - Project Manager—Kentucky SKY Program Planning and Implementation
  - Executive Director/Administrator—Governance, Communication, Workforce
  - Medical Director/Assistant Medical Director—Clinical Department Design
  - Quality Improvement Director—Quality Improvement Program and Clinical Quality Improvement Sustainability Model
  - Behavioral Health Director—Behavioral Health Services and Training Model
  - Utilization Management Manager—UM Model and Provider UM Oversight
  - Prior Authorization/Pre-Certification Coordinator—Prior Authorizations/Pre-certifications
  - Provider Experience Liaison—Access and Availability Resolution
  - Pharmacy Director—Kentucky SKY Enrollee Specific Pharmacy
  - Dental Director—Kentucky SKY Enrollee Specific Dental Care Model
  - Provider Experience Director—Provider Experience and Development Model
  - Population Health Management Director— Population Health Management Model
  - Enrollee Services Manager—Enrollment Data Tracking-Problem Resolution
  - Inquiry Coordinator—Ombudsman Access and Barrier Busting Plan
  - Chief Compliance Officer Contract and Regulatory Compliance Plan Management Information
  - Systems Director—Operations, Analytics, Website
  - Stakeholder Engagement and Education Director—Comprehensive Training/Coaching and Sustainability Plan

All work teams will have cross-departmental and provider membership. Project plans will adhere to the Aetna Kentucky SKY project methodology. Each team meeting will conduct a formal process evaluation. Members will resolve problems directly and avoid sidebars and other distracting behaviors. Work teams will help to ensure that all products support the Kentucky SKY vision of success and principles and standards of care will be embedded in all products. Any team member can call for emergency meetings as well as governance barrier busting as needed when facing concerns that may derail timely outcomes.

All Aetna Kentucky SKY project and work team leads agree to adhere to the following principles and standards when facilitating, developing partnerships, and addressing barriers:

- We will collaborate strongly with DCBS case managers and engage the family and community for each out-of-state youth and will bring then them home to Kentucky. Our model is a complimentary force multiplier; these out-of-state youth never had this power of intervention available in the past.
- Children living out-of-state require intensive support and monitoring and as part of our structure we will assign dedicated care coordinators who focus on these children in a collaborative approach. We will review each placement monthly with DCBS and provide oversight and when possible targeted support to develop strategies to bring children back to their community as soon as possible.
- Aetna recognizes the critical role of community child protection professionals in supporting parents, families, and children to safely stay together and when it is not possible for children and young people to grow and develop as members of a permanent family. We believe that a strong collaborative relationship, with Aetna Kentucky SKY care coordinators and DCBS social workers, is the key to delivering on our promises in this RFP. To do this, Aetna is bringing a nationally award winning, and research tested model know as **Collaborative Family Engagement** to Kentucky, which is designed and proven to specifically build strong collaborative practice between child protection professionals and community partners assigned to children and families. We look forward to a journey together to transform the futures of children and families enrolled in Sky.

A critical step in establishing relationships, as outlined in **Section 41.6.6 of the Draft Medicaid Managed Care Contract and Appendices** includes joint meetings with DJJ, the Department, and DCBS

to collaborate on issues, ideas, and innovations for the efficient and economical delivery of quality services to the Kentucky SKY enrollees. These regularly scheduled meetings will be used for the following purposes:

- Consider opportunities in areas such as improving health outcomes of Kentucky SKY enrollees
- Advance trauma-informed care
- Implement and monitor evidence-based practices and best practices in educating providers
- DCBS performance and reporting outcomes, including timeliness reporting for assessments and services
- Identify variances to required DJJ timeframes related to DJJ commitment
- Address access to network providers and opportunities for improving access to services

Reducing Duplication of Services

Aetna Kentucky SKY is guided by a philosophy of cross-sector partnerships and collaboration that drives to reduce silos and duplication, instead taking a community approach to supporting the success of youth in foster care and/or juvenile-justice involvement. Aetna demonstrates its ingenuity and collaborative spirit by developing innovative, value-based payment solutions with providers. We are committed to providers being true partners in taking care of our enrollees and their patients. In partnership with state agencies, we achieve safety and permanency for children, reduce psychotropic medication use, and improve health outcomes for these youth. We will address the effects of trauma and focus services on the family, both of which are essential to the effectiveness of our person-centered, integrated service coordination model.

Aetna Kentucky SKY care coordinators will have lower caseloads, which will allow for better coordination of services, including those in community-based organizations. In addition, Aetna Kentucky SKY will develop information technology solutions that allow for sharing of records among various community stakeholder groups for those youth involved in DJJ and DCBS. The Aetna Kentucky SKY team will have access to a main crisis line where the operators will be able to access view centralized databases for both populations.

As previously mentioned, the Kentucky SKY team will coordinate with sister agencies, and an access information through the TWIST (an electronic data repository for youth involved with DCBS information system) to gather past assessments and clinical information needed to build the care plan. The Kentucky HIE is also used to access the youth's information and possibly past treatment and services. The youth's identified circle of support, with permission from the guardian, will be invited to the CCT meetings to make certain all relevant information is shared with the team and can be integrated into the care plan. CCT will also partner with DJJ and courts to make sure any screening and assessments completed in either setting are incorporated into the care plan. By accessing this information and using an integrated approach to care planning, the enrollee, their circle of support and other professionals can coordinate a plan in which services are not duplicative.

Improved Access to the Most Appropriate Services to Meet the Needs of Sky Enrollees

Aetna Kentucky SKY believes there is 'no wrong door' to services. Enrollees can be referred into services from array external providers, including, but not limited to the following:

- Directly from parents or caregivers
- Community service organizations
- School systems
- DCBS
- DJJ
- Medical practitioners

Aetna Kentucky SKY believes this high-risk population requires rapid entry into care and therefore has developed a front-end process that allows for a quick and clinically appropriate rapid assessment. All Kentucky SKY enrollees will undergo a self-report screening using the trauma symptom checklist, CANS comprehensive trauma assessment, the health risk assessment, and the trauma screening questionnaire. The tools will allow Aetna Kentucky SKY to appropriately stratify the enrollees, based on level of need and risk, into the care coordination tier system (please refer to **Table G.3-7**).

Table G.3-7: Aetna Kentucky SKY Care Coordination Tiers

Population Risk Level	Kentucky SKY Care Coordination Services	ICM Stratification
Prevention and Very Early Intervention and Enrollees with Limited Unmet Needs	Care coordination	Prevention and wellness (population health care management)
Moderate Acuity Stage	Intensive care coordination	Chronic condition management (supportive care management)
Intense or Compounded Symptoms and Stressors	Complex care coordination	Complex care management (intensive care management)

Those youth identified as high complexity will undergo a more in-depth clinical assessment process. The results of the screening will also stratify Kentucky SKY enrollees into the care management model. This care model, along with strength-based planning, is based on the combined wraparound and Charting the LifeCourse™ framework (University of Missouri-Kansas City); the results of the screening will also stratify the Kentucky SKY enrollees into the care management model. This care model will assist the Aetna Kentucky SKY care coordinators to determine the most appropriate level, type, and intensity of services necessary to support stability in the youth's life.

Aetna's care coordination model for Kentucky SKY youth and those involved with DJJ is a specialized, strength-based, person-centered, biopsychosocial approach based on the on the combined wraparound and LifeCourse framework, as well as other national evidence-based best practices and self-determination tools; it includes a coordinated network of physical, behavioral health, and community service providers. By linking Kentucky SKY enrollees to a comprehensive network, the full complement of Medicaid and non-Medicaid services and supports are available to best support enrollees and their families.

In order to establish priority levels of care, the Kentucky SKY program will implement strategies to make certain collaboration with DCBS are in place to identify the medically complex. Aetna Kentucky SKY will establish processes to follow each child from the time they are removed by DCBS to ongoing behavioral health services. Aetna Kentucky SKY team members will complete monthly DCBS reconciliations comparing a list of youth removed from DCBS against a referral report to identify children who may have been missed. In addition, Aetna Kentucky SKY will track all children and youth from the initial screening and assessment to ongoing services to monitor that youth are engaged in behavioral health services. This allows both the health plan and DCBS to feel confident that all children placed in child welfare are connected to behavioral health services and receiving ongoing trauma-informed services and supports to help them through their families' journey while they are involved in child welfare.

Education, Training, and Communications

In order to support or facilitate a wraparound and person-centered approach to care for Kentucky SKY enrollees, both internal Aetna Kentucky SKY staff and external partners will need to be trained appropriately. This training will provide an opportunity to continue building on the relationships between Aetna Kentucky SKY teams and DBCS and DJJ.

The part of the Aetna Kentucky SKY program implementation, the training plan highlights education and training of the Department, DCBS, DJJ, DBHDID, and Cabinet Sister Agency Personnel, in addition to Law Enforcement Officials and Judges. Education and training of these community partners, as outlined in **Section 41.6.3 of the Draft Medicaid Managed Care Contract and Appendices**, will be provided in accordance with times and locations designated by the Department. These trainings include but are not limited to the following:

- Training of the Department, DCBS, DJJ, DBHDID, and Cabinet Sister Agency Personnel
  - The initial and ongoing education of Commonwealth personnel
  - An understanding of the Kentucky SKY program and the roles and responsibilities of the Department, DCBS, and DJJ
  - The contractual requirements of the Kentucky SKY program
  - The organization, staffing, and infrastructure the MCO must provide to support the Kentucky SKY program
  - The Kentucky SKY business processes and workflows
  - The aging-out process and support from the Kentucky SKY contractor
- Training for law enforcement officials and judges
  - An understanding of the Kentucky SKY program and the roles and responsibilities of the Department, DCBS, DJJ, and DBHDID, and how these agencies will coordinate and collaborate with the Kentucky SKY contractor
  - Role and responsibilities of the Kentucky SKY contractor
  - Needs of the Kentucky SKY populations
  - High-fidelity wraparound approach
  - Family First Prevention Services Act
  - Trauma-informed care
  - Impact of ACEs
  - Aging-out process and support from the Kentucky SKY contractor

The Aetna Kentucky SKY Training Collaborative will conduct training for all new hires and current staff requiring remedial training. The training approach for the Aetna Kentucky SKY staff will address at a minimum the following:

- Detailed understanding of the Kentucky SKY program and the roles and responsibilities of the Department, DCBS, and DJJ
- New Kentucky legislation including the following:
  - **HB 1** will keep Kentucky kids safe by improving how the commonwealth responds to child abuse and ensures that every kid has a family
  - **HB 527** will support the educational stability of children who have experienced abuse or neglect
  - **SB 133** will improve the outcomes of pregnant inmates and their babies by allowing access to substance use treatment
  - **SB 137** will allow judges to consider testimony from a trustworthy adult when a child has disclosed abuse to them
- The contractual requirements of Aetna Kentucky SKY
- The organization, staffing, and infrastructure Aetna Kentucky SKY will provide to support the program
- The Aetna Kentucky SKY business processes and workflows
- The unique physical health and behavioral needs of the Aetna Kentucky SKY population
- The Family First Prevention Services Act and any other federally mandated services or programs impacting Aetna Kentucky SKY enrollees
- Trauma-informed care, ACEs, NAS, crisis intervention services, and evidence-based practices applicable to the Aetna Kentucky SKY population
- The aging-out (transition) process and support from the Aetna Kentucky SKY program

Aetna Kentucky SKY management and leadership, in conjunction with the Training Collaborative, will design a comprehensive staff training and coaching plan to include the following:

- Onboarding intensives
- In-the-field coaching and competency building
- Orientation to the Kentucky SKY model of care
- Position-specific skills and system collaboration
- Proactive-reactive safety planning
- Trauma-informed care
- Charting the LifeCourse™ framework
- Bounce train-the-trainer
- Certification in the high-fidelity wraparound model

Aetna Kentucky SKY staff will receive ongoing trainings as well as annual refresher intensives. The full cadre of required topics will be developed by the Training Implementation team.

Process Development

As part of the implementation process, Aetna Kentucky SKY will help to ensure that the responsible business area will be charged with creating the policies and procedures. Aetna's chief executive officer, chief operating officer, chief medical officer, and Kentucky SKY executive director will review and approve all policies. Staff will be oriented and trained on Kentucky SKY specific polices mentioned in the readiness review section above.

Process development is a critical stage in an implementation process. Aetna Kentucky SKY will participate in the development and documentation of Kentucky SKY business processes and workflows to promote consistency and set performance expectations across all parties, including the Kentucky SKY teams, the Department, DCBS, DJJ, and others as needed. The Aetna Kentucky SKY team members and leadership will also participate in a workflow development team as established by DCBS. In addition, we will collaborate with the Department, DCBS, and DJJ in modifying existing processes and workflows or adding new business processes and workflows, as needed.

60.7.G.4 Kentucky SKY Contractor Educational and Training Requirements

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60.7.G.4 Kentucky SKY Contractor Educational and Training Requirements

The Commonwealth of Kentucky and Aetna are committed to improving outcomes for children and families involved in the foster care and juvenile justice systems. Our dedication to being a collaborative and innovative partner to Commonwealth agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to create a healthier Kentucky.

Staff, provider, and cross-system training is an important part of our System of Care (SOC) approach to support children, young people, parents, and other important adults involved in these systems through a highly participatory family engagement practice emphasizing primary prevention and early intervention. In order to achieve our SOC goals, Aetna requires a workforce, provider network, and system partner Training and Coaching Plan that is robust, comprehensive, and sustainable over time. Training itself needs to be envisioned differently from the beginning with attention paid to adult learning methodologies, an inter-departmental collaborative, continuous learning informed by outcomes data, coaching, and mentoring.

Aetna places its members at the center of everything we do and believe in. Collaborative relationships and the creation of family and community networks are at the center of Aetna's approach to serving Kentucky SKY children, youth, and young adults. Collaboration is more than a word or value—it is an action which needs a framework. Aetna selected a national award-winning model called Collaborative Family Engagement as a framework and methodology to strengthen and sustain a partnership with Department for Community Based Services (DCBS) staff and leadership. This will be a unique approach to build a collaborative effort to stand a health system and child protection system shoulder to shoulder in supporting and strengthening the safety of children and the well-being of families. The goal is to reduce out-of-home placements of children, strengthen families, and foster a process of healing and recovery for families affected by toxic stress, social determinants of health, and other Adverse Childhood Experiences (ACEs).

Collaborative Family Engagement is under study by the University of Texas at Austin and proven to be an effective high-quality practice change strategy for child protection practice.[1] The methodologies address the challenges of collaboration between public child welfare internal cultures and external community-based partners. This is a critical dynamic which, if not addressed, will weaken or undermine the value and impact of health and mental health care and planning for children.

Upon award of contract, Aetna leadership and the Kentucky SKY director of stakeholder engagement and education will develop and implement a **Kentucky SKY Training Collaborative (TC)** to provide accessible, in-depth education to all staff, partners, and providers. **Aetna is a continuous learning organization**, and we believe each person is a lifelong learner. Aetna also understands that adults learn and retain information when it is presented in a multifaceted approach, including presentations, experiential, in-vivo demonstrations, and in-the-field coaching among other modalities. A tenet that drives our training is the need for each Aetna staff member to teach others. Our approach to the child welfare system draws from numerous best practices, innovative national trends in child welfare reform, and the goals of the Commonwealth to reduce the number of children in the child welfare system and prevent system involvement on the front end.

[1]Texas Court Appointed Special Advocates, "Collaborative Family Engagement (CFE) Training Resources" (n.d.): accessed June 10, 2019; https://texascasa.org/collaborative-family-engagement-cfe-training-resources/

The Kentucky SKY TC assures that all system partners, community leaders, youth, and families have voice, choice, and preference in the design, implementation, and sustainability of a training and coaching model. The TC also allows for training expertise across multiple disciplines and departments.

Our initial meetings with Commonwealth leadership will provide opportunities to discuss the design, delivery, and content of training for Commonwealth personnel. Upon executing a Kentucky SKY contract, Aetna will continue to collaborate with various experts, including our Commonwealth partners, to inform our approach and refine the curriculum. This will be incorporated into our overall Training Collaborative education and training plan which will be submitted to the Commonwealth within the first 120 days of the contract. At minimum, the training curriculum will include contractual requirements and operation of the Kentucky SKY program; roles and responsibilities of the Department, DCBS, and the Department of Juvenile Justice (DJJ); managed care organization (MCO) configuration and staffing; Kentucky SKY processes and workflows; the allowable exchange of information in a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant organization; and the aging out process to include the MCO's role in support of enrollees who are aging out. Other training topics include but are not limited to the following:

- Foster care system best practices
- Community, Commonwealth, and federal resources
- The unique physical health and behavioral and social needs of youth in child welfare, foster care, and juvenile justice systems

Key components of the training will include trauma-informed care, ACEs, neonatal abstinence syndrome (NAS), crisis intervention services, and evidence-based practices to provide understanding and empathy to our staff on the trauma and stress often inherent within the Kentucky populations served under this contract. Trainers will be well-versed in adult learning styles and include multimodal approaches to curriculum design ranging from visual, kinesthetic, and auditory components. Aetna and the TC will also provide a comprehensive review of the Family First Prevention Services Act and other federally mandated services for the foster care population.

Aetna has demonstrated proven experience partnering with states around education and training, as described in this section. The success of our training initiatives is illustrated in the following testimonial from Deputy Secretary of the Kansas Department for Children and Families Tanya Keys.

> "Kansas Department for Children and Families has appreciated the opportunity presented to us by Aetna Better Health to implement the Family Finding modality into our child welfare system this past year. Aetna has collaborated with the state and key state partners to enhance the lives of children and youth in families to develop strategies for positive impact on stability and wellbeing outcomes: preventing and reducing the need for formal foster care, increasing children living with relatives, and reducing reliance on institutional care.
>
> We are excited and look forward in this collaboration transforming our approaches alongside families, Aetna Better Health, and community partners."
>
> **—Tanya Keys**
> **Deputy Secretary, Kansas Department for Children and Families**

a. Collaborating with Experts including the Department, DCBS, and DJJ to Identify Provider Training Needs

Aetna has proposed a system of care for youth involved in foster care, juvenile justice, or post-adoption that will change the trajectory of their lives. In order to accomplish this change, Kentucky SKY

recognizes the need for culture change, innovation, and collaboration. The need for a comprehensive training and coaching model that ushers in new practices, new strategies, and methods of service is essential to accomplish the objectives and to provide much needed change for these children and their families. In addition, Aetna will partner with known academic leaders in the field to define state-of-the-art practices in supporting youth and families.

Provider training needs will be identified through a variety of means to include, but not limited to, meetings with the Department, DCBS, and DJJ. Provider feedback will be obtained via provider surveys, quarterly meetings, town hall listening sessions, face-to-face sessions with providers, and webinars for providers in less populated areas.

Training will also be provided to Commonwealth personnel at times and location(s) designated by the Department.

Aetna proposes a governance and leadership structure which parallels our care coordination model in an innovative approach to transforming the present system. We designed our organizational structure to provide the framework for our Kentucky staff to implement innovative solutions to empower our Kentucky SKY enrollees and their families on their life journeys and ultimately transform the system to strengthen families and keep kids safe from harm. To drive a culture of innovation and collaboration, our staff participates in cross-functional teams aimed at improving performance across every area of the organization. We communicate initiatives through all-staff town hall meetings, email notifications, staff website articles, web-based learning modules, and hands on demonstrations. Examples of ways that our organizational structure supports innovative solutions and stakeholder groups include our cross-functional Service Improvement Committee, our robust Quality Management staff, our Population Health staff, and our SOC staff supporting a full spectrum of effective, community-based physical, behavioral, and oral health care treatment services along with psychosocial services and supports for individuals, their families, and circles of support.

> "Kentucky Youth Advocates is committed to working with Aetna in a collaborative approach to advance policies and practices that keep families safely together and promote healing and stability for children and youth who experience abuse. We will work together to enhance efforts already underway in the Commonwealth to transform the […] approach to child welfare including implementation of Family First. We know that Aetna is uniquely positioned to work with us to meet the health and non-health needs of the Kentucky SKY population "
>
> **—Dr. Terry Brooks, Executive Director, Kentucky Youth Advocates**

In addition, through a formal partnership with **Kentucky Youth Advocates (KYA)**, we will work with state agencies, providers, child welfare organizations, and consumers across Kentucky on innovative solutions to transform care for the Kentucky SKY population. KYA is the state's leading child advocacy organization with over 40 years of experience working with public, private, and nonprofit agencies to advance policies that are good for kids. KYA is an expert in building effective coalitions that advance systems-level changes and offers a wealth of expertise in the child welfare arena. The organization is already collaborating with DCBS and Casey Family Programs on several initiatives related to advancing Families First in the Commonwealth. KYA is an ideal collaborating agency, as we are in alignment on objectives related to strengthening families, keeping kids safe, enhancing supports for kinship families, and promoting resiliency and stability for youth that are in or aging out of foster care.

Upon award of the Kentucky SKY contract, Aetna will undertake the following steps, guided by our internationally recognized foster care expert, Kevin Campbell, to collaborate with experts to identify provider training needs and ensure we submit our education and training plan within 120 days and achieve the following:

- Meet with the Department, DCBS, and DJJ leadership as well as any other key partners to garner input on the training needs from a system, agency, provider, and staff perspective.
- Contract with any training consultant necessary to assist in training plan design and/or content.
- Host and facilitate a 2-week intensive Kentucky SKY Training and Coaching Collaborative Retreat resulting in the Kentucky SKY Training and Coaching Strategic Plan.
- Follow the Aetna RFP procurement process to secure evidence-based practice (EBP) providers and trainers as well as to procure outcome measurements.
- Produce Kentucky SKY model training manuals.
- Design and implement a Training Quality Assurance and Quality Improvement Model with continuous quality improvement protocol based on data gathered from course evaluations, customer surveys, youth and family satisfaction surveys, and in-the-field observation evaluations.
- Lead the Kentucky SKY Training Collaborative in the design of the annual training outcomes report with approval from the Kentucky SKY Governance Committee.
- Partner with our flagship university, the University of Kentucky, to assist us in defining curricular content, and work with our regional universities to deliver it. In addition, we will work closely with the College of Justice and Safety at Eastern Kentucky University to assist in DJJ educational initiatives.

The Kentucky SKY director of stakeholder engagement and education will be responsible for relationship management, instructional design/curriculum development, knowledge of state systems, and assessment of community training needs and outcomes. The director of stakeholder engagement and education will identify necessary competencies and associated training needs for the new model of care and address identified gaps in training, incorporating provider identified training needs.

We believe it would be beneficial to include expanded content as the Kentucky SKY program design represents the convergence of numerous best practices, innovative national trends in child welfare reform, and the goal of the Commonwealth of Kentucky to reduce the number of children in foster care and prevent system involvement on the front end. With over 24,000 children in child welfare, Kentucky has acknowledged the need for change, putting a stake in the ground for foster care and juvenile probation reform and transformation—and we are excited to be a true partner.

Aetna has proposed a model of care that delivers on that transformation in collaboration with Commonwealth and local partners who know that we can do better by children and families. The holistic, person-centered, and values-based Kentucky SKY model requires a training plan that integrates adult learning best practices as well as a comprehensive set of trainings backed by coaching on key components of the model from overarching principles and standards to practical interventions and competencies. Aetna takes this learning to the next level and prepares each staff member to train colleagues, youth, and parents as well as community members, thus cementing the new skills in daily practice and habits. This transfer of practical knowledge to youth and families leads to shorter lengths of service, increased confidence, and the ability to navigate life on their own no matter what lies ahead.

We strongly believe that learning is continuous. Anticipating change in staff and providers, the director of stakeholder engagement and education will make sure trainings are refined and repeated so all staff and providers receive the education, insight, and opportunity to expand their perspective and practice. Further, the director of stakeholder engagement and education will convene quarterly meetings to monitor the overall performance and impact of the Training Collaborative. These meetings will inform an annual education and training report, which will be the basis of annual conversations with the Commonwealth regarding the future for education and training. We will work with the following:

- KYA
- University of Kentucky

- Other stakeholders such as the Youth Leadership Council, KYA's Kosair Charities® Face It® Movement, the Blueprint for Kentucky's Children, Kinship Families Coalition of Kentucky, Bounce Coalition, the Kentucky Court Appointed Special Advocates Network, ECHO, the Kentucky Partnership for Families and Children, and the Family Resource Youth Services Coalition of Kentucky

These collaborations will include conducting ongoing listening sessions, focus groups, and town halls to inform our education strategy.

Internationally Recognized Child Welfare Expert Guiding the Approach

Kevin Campbell is an internationally known youth-permanency expert, founder of the Center for Family Finding and Youth Connectedness, and developer of the Family Finding model, a set of strategies now utilized throughout the United States and Canada to establish lifelong supports for youth in foster care. Prior to developing Family Finding, Mr. Campbell was an administrator, director, and vice president in the social service sector for over 28 years. He has helped over 10,000 youth achieve permanency, and he continues to help up to 80 foster youth per week through his advanced permanency trainings and technical assistance nationwide. To date, he has worked with over 200 jurisdictions across 40 states and Canada. Mr. Campbell also played a major role in the passing of the Fostering Connections to Success and Increasing Adoptions Act of 2008, one of the most significant pieces of child welfare legislation in the last 15 years. Mr. Campbell collaborates with the Seneca Family of Agencies, a nonprofit California-based agency that seeks to improve the lives of families and their children in the area education, mental health, and child welfare. Together, they work to provide training and technical assistance on the implementation of Family Finding.

Training Collaborative

Upon award of contract, our director of stakeholder engagement and education will immediately begin to develop the unique and innovative Training Collaborative. The TC serves as the mechanism through which we will assure that key stakeholders and partners share in the design, development, and implementation of training activities.

The director of stakeholder engagement and education will recruit membership and launch the TC 60-90 days before the Kentucky SKY intensive 2-week training for purposes of identifying trainers, developing curriculum, and to provide training oversight. The use of a TC brings together all stakeholders and assures that key stakeholders and partners share in the identification of all training needs, the design of all pertinent curriculum, and in the actual training of direct care, management, and leadership from Kentucky SKY, referring departments, and network providers. We will develop formal partnerships with KYA and other Kentucky advocacy organizations to help advise us on the Training Collaborative.

The TC will be held twice a month for the first year of the new foster care model moving to monthly for every year thereafter with the option of ad hoc convenings as needed.

Kentucky SKY leadership and the Kentucky SKY director of stakeholder engagement and education takes a train-the-trainer approach. We will routinely identify external stakeholders including providers, advocates, academics, youth and families, and internal Aetna staff who demonstrate the enthusiasm and aptitude to be ongoing thought leaders and trainers for the Kentucky SKY system of care. These individuals will participate in the 2-week intensive prepared to both learn the topics as well as assume responsibility for providing training on specific topics between scheduled intensives or refreshers offered by the consultants.

Because we consider this training of utmost importance, we want to recognize providers for the extra time they take to be trained; therefore, we will incentivize providers in various steps along the way related to their self-directed learning.

Experience Collaborating with State Agencies

Aetna understands how important collaboration is with our stakeholder partners, especially state agencies. In Kentucky and in other state plans, Aetna collaborates with state agencies to identify training opportunities through ongoing meetings with the state agencies, forums, staff co-location at state agencies, and joint quality improvement projects. Aetna builds upon that success in the design and implementation of the Kentucky SKY training program. One example of such success is the strong relationship Aetna has with the Regional Interagency Council (RIAC) in the Commonwealth's DCBS regions, which meet monthly and are comprised of community partners and lead DCBS staff.

Figure G.4-1: Family Finding Boot Camp
Groups of Kansas Department for Children and Families' social workers work as teams at a Family Finding boot camp. Photo courtesy of The Topeka Capital-Journal.

Another example of our strong collaborations occurred in Kansas. Recently, over 100 child welfare professionals participated in the four-day Family Finding Boot Camp sponsored by Aetna Better Health of Kansas, the Kansas Department of Children and Families, and Casey Family Programs. Attendees expressed how the boot camp training had an immediate impact on their practice with families and their individual outlook (refer to **Figure G.4-1**). Sample words used to describe experiences included hopeful, moved, excited, inspired, connected, empowered, optimistic, transformative, motivated, challenged, refreshed, and appreciative, among others. The picture on the right illustrates the positive interactions that occurred during the boot camp.

Mercy Care Stakeholder Training

Mercy Care, a Medicaid managed health plan managed by Aetna, is an example of our experience collaborating with state agencies and multiple key stakeholders across sectors to identify and address training needs. Mercy Care began an oversight workgroup called the Foster Care, Kinship, and Adoptive Oversight Workgroup to bring together multiple participants to guide the care, training, and oversight for the child welfare community. The workgroup has representation from child welfare, foster parents, kinship families, adoptive community, young adults that have aged out of child welfare, advocate, and providers. The workgroup came together to develop recommendations and a plan for training opportunities for youth, staff, and caregivers connected to the child welfare community.

As a result of this collaboration, Mercy Care has implemented focused initiatives throughout the valley to provide the recommended education and training to the Department of Child Safety (DCS), foster care providers, adoptive parents, kinship placements, group home providers, caregivers, attorneys, foster care licensing agencies, and biological families. Mercy Care has increased technical assistance to all caregivers and DCS placements, utilized Comprehensive Medical and Dental Program enrollment efforts to educate caregivers on behavioral health, and shared information with the DCS and our provider community on how to access additional support through behavioral health providers, as well as Mercy Care. Additionally, Mercy Care, in coordination with DCS Licensing and Administration, increased the training for all caregivers for youth in child welfare and staff. Training topics included Overview of Trauma, Birth to Five Development, Crisis Techniques, Trauma-informed Care, Cultural Discovery, Positive Behavior Support, Communicable Diseases in Children, and Psychopharmacology for Group Home Workers.

A trend identified from discussions with stakeholders, providers, caregivers, and families and system partners was related to DCS out-of-home placement disruptions. Through collaboration with the child and

family teams, it was discovered that caregivers of youth in child welfare, inclusive of group home staff, benefit from skills training and education on trauma to appropriately meet the specialized needs of DCS-involved youth. Areas of opportunity included education on how to collaborate with the child and family team to implement behavioral health services in the community placement and how to decrease behavioral health placements in acute settings. An area of success identified by DCS and Mercy Care is that those group homes actively engaged in the training opportunities have reported fewer disruptions.

Criminal Justice Engagement Team

Mercy Care participates in monthly collaborative meetings with Juvenile Justice and Juvenile Probation and monthly meetings with executive leadership and Juvenile Probation. At these meetings, program issues are identified and initiatives developed to address those issues. Mercy Care partnered with Maricopa County Correctional Health Services, Public Defender's Office, County Attorney's Office, County Manager's Office, and the Sheriff's Office to implement the Smart Justice Committee to promote best practices to improve public safety. This collaboration with the county agencies was initiated as a result of mutual identification of the unmet needs of our shared enrollees and a mutual desire to join together to develop solutions through collaboration. From these meetings, the Criminal Justice Engagement team was developed.

Mercy Care worked with Smart Justice Partners to create the Criminal Justice Engagement team, which in 2016-2017 resulted in successful jail diversion for 229 enrollees 2016-2017. The Smart Justice partners received the 2016 Desert Peaks Award for Public Partnership from the Maricopa Association of Governments.

Infant Toddler Mental Health Series

Mercy Care has a high awareness of how important collaboration is with our state partners is in meeting the needs of our shared enrollee. Mercy Care participates in monthly collaborative meetings with DCS, and monthly meetings with executive leadership and the DCS. At these meetings, joint issues are identified and joint agenda setting is done. Training needs are identified and programs developed to meet those needs. Collaboration with DCS led to the development of the Infant Toddler Mental Health Series.

In August 2014, Mercy Care conducted an environmental scan of the Birth to 5 staffing, training, supervision, services, and strengths. Immediately after the scan was complete, Mercy Care facilitated a group called the Birth to 5 Learning Consortium, as we were aware there are unique needs for this population, and it was growing rapidly. We wanted to bring those that were connected to this population together to collaborate to create a system that supported this population in the right way. The consortium had representation from contracted Birth to 5 providers, the courts, child welfare, and the community. In the committee, data was reviewed for all populations but specifically Birth to 5. Through review of the data, it was identified that more than 52 percent of the youth being removed by child welfare were between the ages of birth to five. In collaboration, the Consortium identified the need to make sure we were able to meet the needs of this population and brainstormed ways to achieve this. The Consortium identified staff training and competency as critical to address the issue. Mercy Care partnered with one of our specialty Birth to 5 providers to develop a 10-week training series specific to Infant Toddler Mental Health and Birth to 5 children in child welfare. The training improved Mercy Care provider network in assessing and treating this emerging population. The ratio of Birth to 5 trained providers to Birth to 5 youth in child welfare is 3 to 1. Mercy Care led the initiative to make sure that our workforce had the right training and competency to serve the unique needs of this population.

In 2016, Mercy Care collaborated with Southwest Human Development (SWHD) to identify caregiver training needs and trained over 140 staff on the unique needs of the 0-5 population in Maricopa County. The participants' response to training was overwhelmingly positive, and results from the most recent participants (71 evaluations) indicated that 99 percent of participants assessed the course as 'Very Good'

or 'Excellent.' In addition, the implementation of this training increased knowledge and understanding of working with infants and toddlers, who represent 50 percent or greater of the total youth entering DCS custody.

Throughout FY17 Q1, Mercy Care collaborated with SWHD to refine the existing training and schedule four additional sessions of the 10-week Infant Toddler Mental Health series. Mercy Care is committed to increasing sustainability and informed supervision by requesting that providers send staff and supervisors to attend. The training offered in 2017 focused on working with infants and toddlers involved with DCS and the unique needs of this population.

Kentucky

Aetna greatly values the meaningful relationships with state agencies and participates in quarterly meetings with DCBS/the Department to review quality data that speaks to the physical and behavioral health needs of youth in the child welfare system, as well as psychotropic medication utilization. Through this collaboration and consultation with the DCBS medical director, prescribing and utilization trends of psychotropic medications are explored. Recommended utilization guidelines from the DCBS medical director have been integrated into our provider outreach calls, training, and education where our behavioral health medical director and clinical pharmacy advisor use these guidelines to inform providers about the appropriate prescribing of these medications for children/adolescents.

> Good things happen when we come together! As an example of collaboration with the Department's medical director, our antipsychotics in children and youth rate in 2017 was **0.03%**, compared to 2.09% for the national benchmark (for this measure, a lower percent is considered favorable).

We are stronger standing together. Aetna is the only Medicaid MCO with staff embedded in a Commonwealth-operated justice system facility. Aetna currently co-locates staff in Kenton County Detention Center to provide transitional care coordination. These co-located staff specialize in serving high-needs enrollees: those enrolled in the highest level of our integrated care management program who have similarities to justice involved youth who are part of the Kentucky SKY population. This close collaboration provides opportunities to identify and collaborate with the justice system on training needs and develop training programs for staff in the Detention Center. Co-located staff identify gaps in enrollee and provider education through the daily interaction and identification of enrollee needs. Each enrollee interaction is different, and both Kenton County Detention Center and Aetna staff use these unique encounters to identify training needs and develop training for both Aetna providers and staff and the Kenton County Detention staff.

b. Training Aetna Staff and Network Providers to Understand the Needs of Kentucky SKY Enrollees

Aetna will train both staff and network providers on all key components of the Kentucky SKY program, in compliance with the **Draft Medicaid Managed Care Contract and Appendices, 41.6.3.**

Staff Training

Using the Kentucky SKY TC as the framework, we believe in continuous learning. Aetna believes that each person is a lifelong learner. Aetna also believes our enrollees can learn competencies and skills leading to health and well-being. We understand adults learn and retain information when it is presented in a multifaceted approach including presentations, experiential exercises, in-vivo demonstrations, and in-the-field coaching among other modalities. A tenet that drives our training plan is the need for each Aetna staff member to teach others. Staff training for existing staff begins prior to the health plan go-live via classroom presentations and self-directed learning modules.

Our Kentucky SKY staff training provides all applicable staff members with comprehensive details on the Kentucky SKY program, including the roles and responsibilities of the Department, DCBS, and DJJ as well as our contractual requirements under the Kentucky SKY program. The training will also provide a detailed review of the organization, staffing, and infrastructure of our Kentucky SKY program and support of the Kentucky SKY program, bringing local resources to bear to bring a Kentucky-centric approach. Staff will be trained on the allowable exchange of information in a HIPAA-compliant organization, including what is and is not allowable exchange of information to preserve and support continuity of care**.** To ensure good understanding of Kentucky SKY processes and interactions on behalf of Kentucky SKY enrollees, the training includes detailed processes and workflows.

In addition to processes and requirements, the Kentucky SKY training also provides training on the unique physical health, behavioral health, and social needs of youth in child welfare, foster care, and juvenile justice systems. Key components of the training include trauma-informed care, ACEs, NAS, substance-exposed infants, crisis intervention services, and evidence-based practices to provide understanding and empathy to our staff on the trauma and stress often inherent within the Kentucky SKY populations served under this contract. In developing a thorough understanding of the Kentucky SKY program for our staff, we also provide a comprehensive review of the Family First Prevention Services Act and other federally mandated services for the Kentucky SKY population within the training. Creating successful outcomes for the Kentucky SKY population is a primary goal and therefore assisting youth in successfully aging out and transitioning to an effective, fulfilling adult life is paramount. Training our staff to provide the best possible support in the process and services available to youth aging out is core to our program's success and to the success of the youth we serve.

New staff on-boarding is differentiated from ongoing training. The initial intensive training and in-the-field coaching entails two weeks of didactics followed by 30-60 days of competency building and coaching. The ongoing training is focused on topics requiring periodic dosing as well as topics specific to youth needs and life domain areas. The wide variety of venues for ongoing training include all staff and team meetings, supervisions, cross-departmental meetings, and community outreach events. Topic themes include EBP tune-ups, clinical quality improvement specific topics, care coordination enhancements, documentation, and auditing, etc. There are those set topics that require regular training and those that arise during implementation and ongoing operations. It is the responsibility of the Training Collaborative to assess the ongoing needs of the Kentucky SKY continuum of care and respond with ongoing curriculum development and delivery.

Aetna uses the Relias™ system to support its training plan. This platform is available to enrollee-facing staff, both clinical and non-clinical in health plans, and Shared Services staff. The goals for this learning platform access are to assist our Medicaid Shared Services and health plan staff in the following:

- Standardize behavioral health education and practice across our organization
- Close gaps within the integrated system of care by assigning courses and certifications to support this initiative
- Provide a staff benefit by enhancing existing training and continuing education requirements for staff
- Meet cultural competency needs of our enrollees
- Reinforce continuous learning as critical to our culture

Provider Training

Throughout the Aetna Medicaid organization's 30 years of managing Medicaid provider networks, we understand the importance of training and education as the foundation that gives providers the tools and resources they need to serve our enrollees. Through ongoing communication, assistance, guidance, and expertise gathered over the course of our experience in Kentucky and across plans nationally, we continuously develop, reinforce, and retain long-term relationships with providers. We understand that providers are our most valuable service delivery assets. Our job is to empower them by providing

education, assistance, and the resources needed to achieve quality enrollee engagement. Our training and orientation programs give providers a comprehensive understanding of the plan, along with Department's requirements, and information on how we can assist in meeting enrollees' needs. Our orientation programs give providers the information and tools they need to serve our enrollees as efficiently as possible, providing multiple training venues, both electronic and leader-led. We are aware that each enrollee is unique, and that some may have disabilities, language, or cultural differences or other characteristics requiring accommodations. Our training efforts focus on making these enrollees' unique needs a priority and improve delivery of health and family services. **Table G.4-1** describes our provider orientations.

Table G.4-1: Provider Orientations

Training Topic	Training Description/Topics Included
New Provider Orientation	Aetna's new provider orientation training covers a broad range of topics designed to make sure new providers understand program requirements and how to access resources. Topics include a Kentucky Medicaid overview; provider experience and enrollee services functions and contact information; the provider website, secure provider portal, and provider manual; covered services including medication coverage and prior authorization, medical prior authorization, authorization timelines, and medical necessity; claims processing including clearinghouse, clean claims, claim submission; fraud, waste, and abuse; provider communications; enrollee rights and responsibilities, access and availability standards, cultural sensitive standards, non-discrimination, and reasonable accommodations for enrollees with disabilities; medical record standards; appeal and grievance; population health programs; and Healthcare Effectiveness Data and Information Set.
Kentucky SKY Orientation	The Kentucky SKY new provider orientation educates providers on system transformation and design as well as program requirements. Topics at a minimum include roles and responsibilities of the Department, DCBS, DJJ, and Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and Aetna and how these Aetna coordinates and collaborates with these agencies; Family First Prevention Services Act and other federally mandated services and programs impacting Kentucky SKY enrollees; Kentucky SKY covered services and the provider's responsibility for providing and coordinating services, with special emphasis on Kentucky SKY-specific requirements that vary from Medicaid coverage and processes; aging out process and support available through Aetna; and continuity of care training will emphasize HIPAA requirements support compliant sharing of enrollee health information.
Requirements for Providing Health Care Services and Behavioral Health Care Services to Kentucky SKY Enrollees	The purpose of this training is to make sure providers serving Kentucky SKY enrollees understand specific requirements applicable to this population. Training topics at a minimum include medical consent requirements; required timelines for services and assessments; specific medical information required for court-ordered requests and judicial review of medical care; appropriate utilization of psychotropic medications; evidence-based behavioral health treatment interventions and specific behavioral and physical health needs of the Kentucky SKY populations; trauma-informed care; Child and Adolescent Needs and Strengths; crisis intervention services; High Fidelity Wraparound approach; impact of adverse childhood experiences; neonatal abstinence syndrome; substance exposed infants; screening for and identification of behavioral health disorders; Care Coordination teams for Kentucky SKY enrollees and how to access the care coordinator; and performance measures and health outcomes.

Aetna will collaborate with Department, DCBS, DJJ, DBHDID, and Department of Education to modify and adopt materials that are used for new and ongoing provider training for the Kentucky SKY program. **Table G.4-2** describes our new and ongoing provider training.

Table G.4-2: New and Ongoing Provider Training

Training Topic	Training Description/Topics Included
Foster Care Behavioral Health Navigation Forum	This is a monthly forum for foster, adoptive, kinship, and group home caregivers to learn about the behavioral health services available to children and youth in foster and adoptive care.
Foster, Adoptive and Kinship Training Series	This is a 3-part, monthly training series covering an overview of trauma-informed care, trauma-informed care birth to age 5, and trauma-informed care strategies and techniques.

Training Topic	Training Description/Topics Included
Child and Family Advisory Partnership Community Forum	These forums are used to connect foster, adoptive, kinship, and group home caregivers to what's happening in the local behavioral health community and offer an opportunity to talk directly with providers. Attendees will be encouraged to share ideas on how to improve the delivery of care to enrollees, their families, and supports.
Training for Youth Transitioning	This is be an ongoing development of training and support tools that assist Kentucky SKY providers in meeting the needs of youth transitioning through the DCBS. This will also include support and training for DCBS staff in working with providers to meet the specialized needs of youth who are struggling with placement stability. Training will include such topics as understanding the behavioral health support that can be offered for youth and how to reach out to obtain services and supports through the Care Coordination teams.
Sex Trafficking 101	Aetna will work with Kentucky law enforcement to develop and offer training on human trafficking, including training on meeting the complex behavioral health and support needs of this population. Mercy Care, a Medicaid managed care organization administered by Aetna in Arizona, implemented a similar initiative and has provided training to foster/adoptive/kinship caregivers, DCS group home providers, law enforcement, family advocacy centers, hospitals, DCS staff, behavioral health providers, judges, court staff, juvenile probation, attorneys, and others. These trainings have significantly supported the referral of youth to the collaborative as indicated by the increase of referrals from participants of the trainings. The services and supports from a trained and committed provider network has assisted in the development of stable, supported placement options for youth, dramatically decreasing the number of youth enrolled with Comprehensive Medical and Dental Program, the health plan for Arizona's children in foster care, that leave without permission to less than 10%.

Aetna uses a high-touch collaborative approach to provider training and the Training Collaborative will include representatives from several different provider types. We meet with providers in the field to conduct training sessions and we train providers at town hall meetings, and via traveling lunch and learn sessions. We conduct provider training in the community on an ongoing basis. In addition to personal contact and outreach, we offer a variety of self-directed learning opportunities using the provider link on the Kentucky SKY website. The provider training package brings providers high-quality leader-led classes and self-study options using best practices and state of the art technology. We publicize all trainings and educational opportunities through marketing materials, on our provider web portal, and through fax blast communications. For large provider groups and organizations, provider services liaisons conduct monthly or quarterly Joint Operating Committee meetings onsite to address any concerns, discuss quality metrics, and review new initiatives.

Training and education materials and toolkits will, at a minimum, be available to providers through a variety of resources to include the Kentucky Aetna website, live and pre-recorded WebEx training, traveling lunch and learn sessions, regionally based townhall training series, training in regional offices, individual provider onsite training and telephonic outreach, email blasts, provider notices, monthly newsletters, and a provider training blog.

Aetna trains new provider staff on an ongoing basis and conduct refresher training every quarter using traveling lunch and learns with key stakeholder providers and web-based training. Aetna monitors and tracks provider web training using tracking reports.

Provider onboarding and training begins with an initial orientation provided by webinar prior to the health plan go-live, and when a provider joins the network and continues in an ongoing basis through provider forums, webinars, and face-to-face visits. The two-week intensive training program will include network provider leads participating in the Training Collaborative. Additional trainings are offered as determined by provider needs, or as requested by the Department. Orientations are tailored to the provider's preferences and needs and include information on the unique needs of the Kentucky SKY population and

specific Kentucky SKY and Kentucky requirements, policies and procedures, training and technical assistance on all specific administrative and clinical practices, procedures, policies, and programs, including requirements specific to network providers. Continuity of care training emphasizes HIPAA requirements as they pertain to maintaining continuity of care. Training materials are online and are available upon request and can be downloaded from either our secure web portal or main website. Materials are also made available to the Department upon request. Additionally, all our provider education materials are be available to all providers including Indian Health Care providers upon their request. Examples of additional trainings that may be provided include those on abuse and neglect, infant, child, and adolescent development, the impact of foster care on families and children, managing significant behavioral and psychiatric disorders in cooperation with mental health professionals, the child and family welfare system and its policies and procedures and how to navigate through its bureaucratic structure, working closely with health care managers, adoption competency, and family-based sexual trauma competency.

c. Educating Law Enforcement Officials, the Courts, Judges, and Attorneys about the Kentucky SKY Program

The Aetna Training Collaborative will design and provide a Kentucky SKY orientation and ongoing training tailored to the specific needs of law enforcement, probation, the courts, judges, and attorneys, for instance; this training will advance best practices and enhance the goals of the Department. The Department, DCBS, DJJ, and other sister agencies may also participate in these education and training sessions. The Training Collaborative will utilize multiple methods of training to engender the most participation, including face-to-face meetings, webinars, or other tutorials.

> Over 19 percent of LGBTQ (lesbian, gay, bisexual, transgender, and queer or questioning) youth were moved from their placement because of a caregiver request, compared to 8.6% of heterosexual and/or gender-conforming counterparts. In addition, 1 of 5 fosters identify as LGBTQ, twice the rate of LGBTQ youth in society.[2] Aetna believes the foster care placement process can be improved by screening youth for sexual orientation and gender identity.

To ensure all systems partners are familiar with Kentucky SKY, the TC will offer a Kentucky SKY orientation as well as ongoing training tailored to the specific needs of law enforcement, probation, the courts, judges, and attorneys. At a minimum, the TC Kentucky SKY orientation will cover the following training topics: an understanding of the Kentucky SKY program, generally, and the role and responsibilities of Kentucky SKY; the roles and responsibilities of the Department, DCBS, DJJ, and DBHDID and how these agencies will coordinate and collaborate with Aetna Kentucky SKY; and the needs of the Kentucky SKY populations, including how these may differ from the general Medicaid children/youth population, emphasizing the following:

- High Fidelity Wraparound approach
- Family First Prevention Services Act
- The impact of ACEs and trauma-informed care
- Human trafficking
- Crisis intervention training overview and the criminogenic risk/need/responsivity framework
- Behavioral health 101
- Aging out process and support from the Kentucky SKY contractor
- Crossover Youth Practice Model and Reclaiming Futures
- Keys to effective youth engagement
- Other key topics suggested by Commonwealth partners

[2] Scraggins, Terry, "For LGBTQ Youth in Foster Care, Finding Home is Hard" (2018); accessed June 10, 2019; https://chronicleofsocialchange.org/analysis/for-lgbtq-youth-in-foster-care-finding-home-is-hard/32813

Kentucky SKY sees partnership with law enforcement, the courts, judges, and attorneys as critical to changing the trajectory for all Kentucky SKY youth, especially juvenile justice-involved youth. Aetna, through the Training Collaborative, provides cross-systems training and support to Kentucky's workforce at the intersection of child welfare, juvenile justice, and health. The TC training for our partners advances the skills and best practices necessary to address the complex issues and needs of youth and families involved in multiple systems. The TC advances the goals of our partners and the Commonwealth to reduce recidivism and enhance public safety, while promoting wellness and success for our youth and families by using our Kentucky SKY program.

Co-location with Juvenile Probation—Collaboration and Training

The Mercy Care Juvenile Justice Engagement team liaises with the Maricopa County Juvenile Probation Department and is an invaluable resource to judicial officers, legal advocates, county attorney, and court-appointed special advocates. Juvenile Justice Engagement team staff are members of the Child and Family teams, attend court hearings, and assist eligible youth to enroll in behavioral health services. They also provide technical assistance to key stakeholders regarding navigating the behavioral health system.

A collaborative approach to the design and implementation of these trainings make certain topics are relevant and useful. All TC content is developed from best practices around the country and design sessions with key leads from DCBS, DJJ, and the courts and law enforcement. The TC will also seek to incorporate law enforcement, probation officers, judges, and co-facilitators to maximize authority with the audience.

As we establish partnerships with the criminal justice, juvenile justice, and law enforcement organizations, we are preparing to engage in facilitating necessary systemic change. Strong communities and healthy families rely on cross-system partnerships such as these. One innovative model we propose to test is a co-response pilot in a community with poor outcomes across systems such as health, child welfare, and public safety. We are in the process of identifying a pilot community with various local city and police representatives.

SKY orientation meetings will be offered at minimum quarterly, but considering workforce turnover, travel issues, and other factors, we can offer training more frequently through employing multiple methods of training including face-to-face meetings, webinars, on-demand, etc. Other opportunities for training may include leveraging existing meetings, including but not limited to the RIACs, as well as quarterly forums with law enforcement. The Training Collaborative will request guest presenters from law enforcement, the courts, judges, and attorneys, to present during Kentucky SKY all staff meetings, community forums, and provider network training sessions on their areas of expertise in relationship to Kentucky SKY youth and families. These presentations raise attendee awareness of the perspective of law enforcement and the courts, the legal process and mandates, and specific areas of focus that will contribute to the success of youth and their families.

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60.7.G.5 Kentucky SKY Enrollee Services

Kentucky | Transforming Health Care | **Aetna**

60.7.G.5 Kentucky SKY Enrollee Services.

As a Kentucky quality leader with a **Commendable rating from the National Committee for Quality Assurance**, Aetna exemplifies a commitment to the Commonwealth and the provider community to being true partners in taking care of Kentucky SKY enrollees' needs. Aetna's transformative vision drives our model for enhanced care coordination and service integration supporting the children/youth in foster care, adoption assistance, and juvenile justice populations, in line with Kentucky's new Child Protection Legislation (i.e., House Bill 158 and the Foster Child Bill of Rights). Our local, enrollee-centered approach focuses on individuals' holistic health needs by providing access to and delivery of cost-effective health care services, which leads to a healthier Kentucky. With an understanding that the Kentucky SKY enrollees are particularly vulnerable due to intensive health care needs and past lack of primary behavioral health and dental care, Aetna strives to create a compassionate, collaborative, yet efficient process for new and returning Kentucky SKY enrollees. Aetna understands every Kentucky SKY enrollee has a different story, whether because of neglect, adverse events, instability, or justice issues, and we will combine Aetna's best practices along with the Commonwealth's insight to develop a Kentucky SKY-specific model. This process will ensure the necessary and swift coordination between the Department, the Department of Community Based Services (DCBS), and the Department of Juvenile Justice (DJJ) will occur to allow Kentucky SKY enrollees to begin receiving services immediately upon entering the Kentucky SKY program.

a. Proposed Approach for Coordination

Aetna has selected a national award-winning framework for promoting and strengthening collaborative practice between child protection professionals and community and family partners called **Collaborative Family Engagement** to improve coordination, satisfaction, and efficiency.

> "Our purpose in Family Finding is to restore the opportunity to be unconditionally loved, to be accepted, and to be safe in a community and a family."
>
> **—Kevin Campbell**
> **Developer, Family Finding Model**

This approach was selected for several reasons including the following:

- Children who have been abused or neglected often come to foster care having endured a variety of traumatic events in their life. However, being removed from their family and taken out of their community and schools they are familiar with is also very traumatic for children, sometimes even more so than the abuse or neglect they have experienced. Placing children with relatives or kin such as family friends, teachers, or coaches helps reduce trauma for children because they get to stay with people with which they are familiar. It also has the following benefits:
  - Reduces reliance on foster homes
  - Prevents children from needing group home or congregate care placements
  - Keeps them in a family-like setting, which is better for child development

  Family Finding gives individuals working with families the tools to locate the child's extended family as well as other important adults that have been in the child's life and engage them in being part of a support network to aid in the child's healing.
- Frequent moves to different foster homes is another challenge that children in foster care face. Not only is this difficult for children and their educational goals, but it disrupts their medical and mental health services and makes it challenging for children to get comprehensive and consistent treatment. Family Finding helps locate and engage relatives and kin to support children and possibly open their homes to them if they enter foster care.

- Struggling families who come into contact with child welfare services often can benefit from more engaging, less punitive practices, including assistance helping them engage their own support system and the ability to make decisions that are best for their family. Family Finding aims to give child welfare investigators and other service providers the tools to empower families to make safe decisions and create a support network of caring people in addition to services provided by the state.
- Children who have been in foster care for a significant amount of time may have lost contact with family and friends that had been a support to them in the past. Family Finding helps re-engage this support network to become involved in the child's life.
- Children in foster care who are placed with relatives or kin achieve permanency faster and spend less time in foster care.

Family Finding helps the child welfare system by adding supports they previously didn't have access to and engage the larger community. The bigger goal is to help children stay connected to adults in their life that love and care about them. Kin care results in better outcomes, including the following:

- Improved placement stability
- Reduced trauma
- Reinforced child's sense of identity
- Helping keep siblings together
- Expanded permanency options

Community Partnerships and Collaboration

Aetna's approach is guided by a philosophy of cross-sector partnerships and collaboration to reduce silos and duplication, taking a 'community' approach to supporting the success of youth in foster care and/or juvenile-justice involvement. Aetna's innovative population health management program includes enhanced care coordination through collaboration with organizations such as the Community Pharmacy Enhanced Services Network and the Kentucky Primary Care Association supporting federally qualified health centers (FQHCs). As such, we will employ a governance roundtable model composed of the following: youth partners; parent partners; the Department, DCBS, juvenile justice leaders; providers; community representatives; Aetna executives and staff; as well as other key stakeholders. Each member of the governance body brings a unique perspective on the needs of families involved in the foster care, juvenile justice, and post-adoption systems of care. A governance structure that includes divergent perspectives by design mirrors the person-centered care coordination model. This robust model of oversight also ensures that decisions are informed by broad and divergent perspectives, creating solutions far more viable than those derived from a narrow/homogeneous stakeholder planning process.

Roundtable Approach

Building on the many successful Kentucky collaborative frameworks that exist today, our commitment to convening local, regional, and state-level roundtables serves as a governance framework to inform our work and make sure the children and families served receive top-level services that help them achieve the outcomes they want and deserve for their lives. Aetna believes that the roundtable is a critical governance framework to support enrollees and their families in receiving integrated, effective, and timely support during critical periods of risk and the resulting opportunity of receiving sufficient high-quality health, mental health, and social services. These roundtables will be made up of leaders from government agencies at the local, regional, and state level, as well as service providers, legal system professionals, schools, fictive kin, adoptive and foster parents, organizations supporting parents, youth lead organizations, law enforcement, juvenile justice, mental health, public assistance, housing, human trafficking prevention groups, colleges, employment and vocational programs, creative arts, and any representatives nonprofit organizations or businesses that work specifically to support and enhance the quality of life for the youth enrolled in the Kentucky SKY program. The roundtables convene on a routine basis exploring actions and coordination between systems, agencies, and individuals to support families

and transition age youth at the earliest opportunity to safely stay together and build on the individual and family well-being. These coordination efforts are aimed at the goal of advancing person and family self-sufficiency, recovery, and resiliency.

Focus on coordination and communication: The goal of the roundtable approach is in common view of the importance and components of services, supports, programs, and policies that reach families early and focus on building individual child and family well-being as a primary outcome. Roundtable sessions will specifically address needs of former foster youth and youth aging out of the foster care and juvenile justice systems. These roundtables are made up of leaders from government agencies at the local, regional and state level, youth-led organizations, parents/family groups, law enforcement, mental health organizations, public assistance, employment, and housing. Aetna proposes to partner with DCBS and DJJ in all 18 Regional Interagency Councils to provide a local community approach to cross-sector planning and system improvement with the following goals:

- System assessment and improvement
  - Reduce silos and build cross-sector partnerships
  - Develop capacity to leverage local intelligence and use of data from the region to identify system gaps and drive change
- Case conference
  - Improve response to youth by tracking specific situations and/or cases
  - Identify process issues to improve future responses

Collaboration with Commonwealth agencies: Aetna has selected a national award-winning framework for promoting and strengthening collaborative practice called Collaborative Family Engagement between child protection professionals and community and family partners. This type of respectful, responsive, and collaborative practice framework has been shown to improve the coordination, satisfaction, and efficiency where multiple systems are involved in the lives of children and their families and caregivers.

We will convene meetings with the Department, DCBS, and DJJ immediately following contract award. Our Kentucky SKY project manager, the lead for all program planning and implementation efforts, will coordinate meetings with state agencies to discuss our overall approach in more detail, including an overview of our Kentucky SKY implementation project, network, and Care Coordination team staffing plans. With input from the state agencies, we expect these initial meetings will serve as a stepping off point to initiate our renewed partnership with each agency as the Kentucky SKY contract is implemented. Aetna assigns a point of contact for each agency and as necessary assigns regional and or community district leads that include the following:

- **Department:** Aetna Kentucky SKY executive director who has both the authority and autonomy to oversee implementation and the general operation of our Kentucky SKY contract
- **DCBS:** Aetna systems of care administrator oversees the Interstate Compact on Adoption and Medical Assistance and the Interstate Compact on the Placement of Children services
- **DJJ:** Aetna juvenile justice liaison with our project manager and executive director
- **Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID):** Aetna behavioral health (BH) liaison with our project manager and executive director

To support coordination with the Department, DCBS, and DJJ during implementation, Aetna will provide detailed written plans regarding tactics for building relationships at the community district level. Aetna staff will also set up an introductory meeting in person, by phone, or by video conferencing to begin dialogue regarding enrollee services and needs. These tactics will include, but will not be limited to immediate contact between Aetna points of contact and agency staff; coordination of care between the Department, DCBS, and DJJ to ensure initiation of appointments and attendance; and coordination between system of care leaders following the development of designated workflows. Our plans will include details on the execution of our training program for the Department, DCBS, DJJ, DBHDID, and

cabinet sister agency personnel which will be provided at the times and location requested by the department. Training topics include the following:

- Initial and ongoing education of Commonwealth personnel:
- Description of the Aetna Kentucky SKY model and the roles and responsibility of Aetna, the Department, DCBS, and DJJ
- Aetna's organizational structure, staffing, and infrastructure for Kentucky SKY
- Description of Aetna's Kentucky SKY business processes and workflows
- Aging out processes and Aetna's role
- Accessing Aetna's key contacts and crisis line

Our quarterly education and training program for law enforcement officials and judges also demonstrates coordination with key organizations such as the Kentucky Administrative Office of the Courts, the Kentucky County Attorneys Association, and the Kentucky Department of Public Advocacy.

Training topics include the following:

- A description of our Kentucky SKY program and the roles and responsibilities of the Department, DCBS, DJJ, and DBHDID, and how we will coordinate and collaborate with each of these agencies
- Aetna's role and responsibilities
- Needs of the Kentucky SKY populations
- Description of high-fidelity wraparound evidence-based program
- Accessing Aetna's key contacts and crisis line
- Description of Family First Prevention Services
- Trauma-informed care
- Impact of Adverse Childhood Experiences
- Aetna's role in the aging-out process
- 101 overview of the community health and behavioral health system

With the goal of promoting consistency in our enrollee operations and services during implementation, our Kentucky SKY project manager oversees development of Aetna's policies and procedures, workflows, and business processes. In coordination with our Kentucky SKY quality management director, performance expectations will be established across Aetna's Kentucky SKY operations. By coordinating with the Department, DCBS, DJJ, and others, our project manager and QM director will develop a clear scope of work for each stakeholder agency and for Aetna's Kentucky SKY program. This step is designed to facilitate seamless transitions and defined processes for problem-solving. Aetna leaders, including adult and child system of care administrators and the juvenile justice, emergency/crisis, and recovery/resilience liaisons, will also participate in workflow development teams or workgroups as established by DCBS. These workflows are developed in collaboration with DCBS, the Department, and DJJ.

Following implementation, to support our partnership approach, Aetna will maintain the use of designated points of contact for each agency as described earlier. Aetna leadership will participate in separate or joint monthly and ad hoc meetings as requested by the Department, DCBS, and DJJ to collaborate on issues, ideas, and innovations for the efficient and economical delivery of quality services to Kentucky SKY enrollees. Our collaborative efforts with the Department, DCBS, and DJJ include the modification of existing processes and workflows and adding new business processes and workflows, as requested by the state through the course of our Kentucky SKY contract. Aetna leadership will reach out to local provider agencies directly to ensure that any identified enrollee needs are met. This contact will include a request for a scheduled intake within 24 hours and an immediate initiation of services.

Experience Expediting Enrollment

Aetna has experience within Kentucky and in our other markets expediting enrollment to ensure enrollees have immediate access to care. We have processes in place to handle large enrollment segments as well as urgent individual cases. Our Enrollment department processes 834 files and provides necessary primary care provider (PCP) auto-assignment within a day. Upon urgent notice from the Department, DCBS, or DJJ, Aetna is able to enroll an enrollee in our system within two hours. Enrollment is updated in our business application system as well as our pharmacy benefit management system so that those benefits can be accessed upon enrollment. We can also work directly with our dental vendor and our other subcontractors who administer services to our enrollees to get enrollment expeditiously updated in their respective systems as needed. All our ancillary applications and enrollment exports are then updated overnight. Our main goal when handling expedited enrollments is ensuring that our enrollees do not experience any barriers to care. We will utilize telephone calls, email, and/or fax to notify the selected PCP of a new Kentucky SKY enrollee within 24 hours and our Care Coordination team (CCT) will contact the enrollee or their representative in person or on the phone to set up an initial thorough physical exam within 48 hours; if injury or illness that might have been the result of maltreatment is identified, the child's treatment will begin within 24 hours. Aetna will designate select high-quality providers as 'Kentucky SKY Priority Providers'. If a new Kentucky SKY enrollee or representative does not select a PCP, we will utilize our hierarchy structure first, searching for an available Kentucky SKY Priority Provider in the Kentucky SKY enrollee's area and utilizing a logic based on the Department's guidance including location, distance, family history, etc.

During the initial contact, the CCT will instruct the Kentucky SKY enrollee and their representatives on how to obtain medical, mental, behavioral, and dental services. The CCT informs the Kentucky SKY enrollee that their ID card will be mailed within five days and that their ID card image is available on the Aetna mobile app and secured portal for their immediate use. The CCT member will provide their direct contact number as well as toll-free emergency services and enrollee services numbers with instructions to call for assistance 24/7/365 for help finding an available resource to meet their needs. A CCT member will be on call 24 hours a day, 7 days a week, 365 days a year. If the Kentucky SKY enrollee's PCP choice is not available for the initial exam within 48 hours, Aetna is contracted with local health departments and others to fulfill the time requirement.

> We demonstrated our commitment and devotion to fellow Kentuckians and the power of collaboration with the Department and other State agencies at a critical time in July 2013. On July 6—Saturday of the July 4 holiday weekend—**our health plan (operating then as Coventry Health and Life Insurance Company) welcomed 68,000 new enrollees** when one of 3 Medicaid managed care organizations in the Commonwealth, Kentucky Spirit (Centene), abruptly ceased operations over a legal dispute. Through diligent planning, expert execution, and unmatched passion by our experienced staff, we provided a smooth transition for our new enrollees and providers, while continuing to provide the best service for our existing enrollees. Our staff spent long hours addressing the needs of our new enrollees, including processing enrollment and identification cards, conducting enrollee and provider calls, managing prior authorization, and more.

Our local enrollee-centered approach focuses on individual's holistic health needs by providing access to and delivery of cost-effective health care services. Aetna's person-centered approach is aimed at improving delivery of health and family services through quality customer service. Throughout the country, the Aetna Medicaid organization consistently works with special needs and specialty populations. Our experience includes expediting enrollment of specialty populations.

The following examples are from Mercy Care, a health plan Aetna manages in Arizona:

- In Arizona, Mercy Care coordinates expedited enrollment of children assigned to foster care by the Department of Child Safety (DCS). To facilitate the process, a daily census of new foster care

enrollees is provided to Aetna by DCS daily. Rapid Response crisis teams contracted through provider agencies are contacted within two hours of DCS notification and sent to the foster home within 24 hours to complete an intake.

- Also in Arizona, expedited enrollment occurs for children and youth new to foster care who are brought to Mercy Care's children's crisis facility at St. Luke's hospital in Phoenix. In this case, Rapid Response teams contracted through provider agencies see the children in less than 24 hours to expedite enrollment.

b. Process for Resolving Enrollment and Eligibility Issues

Aetna uses Healthcare Insurance Portability and Accountability Act (HIPAA)-compliant benefit enrollment and maintenance (834) transactions to process and reconcile enrollment data. We follow standard, documented, and approved processes and procedures for receiving and processing enrollment data. Aetna accepts and processes the standard X12 Benefit Enrollment and Maintenance (834), Version 5010 enrollment file provided by the Department as the mechanism to update enrollee enrollment and disenrollment information. Our core system uses the enrollee data contained in these data files to verify eligibility requests, authorize services, and process claim transactions.

We meet the criteria for the timely loading of enrollee data. The Enrollment Services team resolves daily 834 change files in one business day and reconciliation files within five business days. We reconcile enrollee eligibility information between the 834 file and the enrollee files in the core system. The Enrollment Services team identifies, researches, and validates exceptions, making the appropriate updates in the core system and notifying the Department, DCBS, and DJJ as required.

The Information Systems department receives and downloads daily 834 transactions each weekday, as well as reconciliation files monthly. The daily files contain enrollee changes, including enrollee additions and terminations, as well as demographic changes for current enrollees. Our proprietary rules-based logic can match enrollees from a file to our system on 24 different combinations of data—in the event that an enrollee's information has changed, our system's logic is prepared to field the changes to make sure that we maintain a single system record for an enrollee. The monthly files contain a full enrollee roster that is used to reconcile enrollment data with the core system. Information technology processes the files sequentially and notifies the Enrollment department when it is complete.

In situations where an enrollee has not been sent to us on an 834 file or there is a discrepancy on the 834 preventing an enrollee from accessing their care, we will proactively coordinate with the Department, DCBS, and DJJ so our systems reflects the most accurate enrollee and enrollment data. Enrollment discrepancies will not impact a Kentucky SKY enrollees' ability to access services as Aetna CCT will work with the provider and enrollee to dissolve any administrative issue in order to have services rendered while at the same time working with our Enrollment team to resolve and correct errors.

Success with Rapid Enrollment

Steven (not his real name), an 8-year-old boy, was placed into foster care after being removed from his mother's parental custody. Steven was diagnosed with attention-deficit/hyperactivity disorder (ADHD) at age 3 and is currently prescribed Adderall XR by his pediatrician. Upon Steven's placement into foster care services, it was discovered that Steven did not have his Adderall XR medication and the foster mother Kim (not her real name) indicated concerns regarding Steven's behavioral issues and outbursts, all related to Steven's traumatic experiences with being removed from his mother's care and his ADHD concerns. To assist Steven with obtaining his needed medication, the Aetna care coordinator and the DCBS social worker collaborated to work with Kim, the Walgreens pharmacy, and Steven's pediatrician to resolve Steven's medication needs. The Aetna care coordinator made contact with Kim to provide support and to communicate that steps were being taken to resolve their concerns. The Aetna care coordinator contacted the Walgreens pharmacy that Steven and his foster parents preferred and received notification that it was too early to refill Steven's Adderall prescription and they were unwilling to request a prior authorization. The Aetna care manager then proceeded to contact Steven's pediatric office, and after providing information about Steven's current needs and concerns, the pediatric staff agreed to submit a prior authorization (PA). To continue coordination of care, the Aetna care coordinator contacted Steven's foster care coordinator who proceeded to contact the pharmacist to expedite and override the PA request. Once completed, the foster care coordinator and Aetna care coordinator communicated with the Walgreens pharmacy who informed them of the PA approval and indicated that Steven's prescription is currently being filled. The Aetna care coordinator then reached out to Kim (foster mother) who was able to confirm that they were able to obtain Steven's Adderall XR with a $0 copay. **Steven's needs were met within 24 hours through coordination of care between Aetna, foster care staff, and the local pharmacy**. Steven and his foster parent Kim were kept informed throughout the process to ensure that they received the necessary support requested.

Resolving Discrepancies and Processing Errors

After the system imports and accepts the data in the 834 file, the data is available for use by the core system for further enrollee eligibility verification such as claim adjudication.

The Department determines managed care enrollee eligibility and health plan assignment. They send us an enrollment file with enrollee assignments, demographics, and other eligibility data via the 834 transactions that we load into our core system. We process 834 files and monitor accuracy daily to keep our eligibility data in sync with the Department's data. Current and accurate enrollee data is critical to timely, accurate premium payment processing as well as accurate, appropriate eligibility verification and claims processing.

After we upload the file, the system produces an edit report of errors and exceptions. Errors are 834 file records that do not process into the core system and require manual review and reconciliation; exceptions are 834 file records that process in the core system but require manual validation of the changes made by file processing. Each day, the Enrollment department manually reviews the errors/exceptions report and reconciles the 834 data with system data in the core system. If the 834 file contains insufficient information, the Enrollment department will use the Department's online eligibility verification system to determine the correct eligibility information. If any 834 file records cannot be reconciled in the core system using the file and/or the eligibility verification system, a report of those file records will be generated by the Enrollment department and communicated with the Department in a format and at a frequency determined by the Department.

Resolving Enrollment Issues

Our goal is to make enrollment as seamless as possible for our Kentucky SKY enrollees by leveraging our extensive experience managing the enrollment process in Kentucky. Our system is tailored to accommodate the requests and requirements of Kentucky's Medicaid managed care program as administered by the Department, which maintains the sole authority in determining eligibility and

enrollee, thereby creating a positive experience for our enrollees. As part of the enrollment process, we provide our subcontractors with updated eligibility files daily and perform oversight of those subcontractors.

Rapid access, changing placements, and drops in access lead to enrollment gaps for Kentucky SKY enrollees. To customize our successful enrollment program for Kentucky SKY, Aetna CCT will serve as point person to resolve enrollment and eligibility issues, engage peers in the community, and resolve issues using existing community resources where feasible and appropriate. The CCT will work with the Department, DJJ, and other managed care organizations (MCOs) to resolve eligibility issues and work with co-located staff at DCBS offices in real time to address enrollment discrepancies. We will also establish a monthly meeting with representatives of these entities to discuss issues, trends, best practices, and other current topics. Our focus is to ensure that the enrollee experiences no gap in care.

Success with Eligibility Issues

Larry (not his real name) is a foster child who is currently placed in a foster home. He has a diagnosis of depression, ADHD, and autism spectrum disorder. He is on multiple medications and receives physical and occupational therapy on an outpatient basis and speech therapy through his school. He is also supported by his foster mother, foster agency case manager, DCBS worker, as well as his Aetna Better Health of Kentucky foster care case manager (CM).

The foster mom received a bill from a lab company for $334 indicating insurance would not pay. After extensive research, the Aetna Better Health of Kentucky CM was able to identify that a primary insurance was on file from the biological mom prior to the enrollee being removed. The lab company had attempted to submit the claim through this company, but they pushed back stating they needed additional information. The Aetna Better Health of Kentucky CM spoke with Aetna Enrollment/Eligibility to assist with determining who the primary insurance provider was at the time of service. Eligibility staff were able to update the insurance to accurately reflect that Aetna Better Health of Kentucky was in fact the primary insurance at the time the lab work was completed. Through collaboration and teamwork, the claim was paid and the enrollee's insurance accurately reflected in the system, enabling the foster mom to obtain the necessary care, treatment, and medication for this enrollee.

As a result of the foster care case management and care coordination program, the DCBS worker said she felt confident that a resolution would occur without her worrying that the enrollee would not receive necessary medications or services. The foster agency case manager thanked Aetna Better Health of Kentucky for playing an active role in finding a resolution to the issue and freeing the foster mom from worrying about having to pay the bill.

All transitions can be traumatic, and we are conscientious about making sure each transition is supported thoughtfully and appropriately. Using our experience-tested approach, we will work with the Department and other MCOs leading up to the transition of children and youth served under Kentucky SKY to obtain the following:

- Necessary medical records
- Prior authorizations
- Medication lists
- Any additional pertinent details to discern enrollees with immediate need

The timeliness of obtaining these records, as documented in our transition of care policy, is essential to minimizing disruption in services for a population that requires our unwavering commitment, collaboration, and compassion.

A specialized CCT comprised of interdisciplinary staff who are experienced serving children, youth, and young adults similar to the population served through Kentucky SKY will outreach to the enrollee's care coordination and transition specialist at the previous MCO. We ensure that our care coordinators understand the impact of previous trauma in the Kentucky SKY population and the importance of creating an environment of safety that does not cause re-traumatization.

When we identify changes in demographic information of a Kentucky SKY enrollee, using person-centered approaches including motivational interviewing and brief solution focused interventions, our Enrollee Services staff advise the child and foster family of the need to report the changes to the DCBS to prevent any delay in services. A flag in our management information system enables us to link and track the daily HIPAA 834 for changes. If change does not appear on the HIPAA 834 within 60 days, we report the conflict to the Department for evaluation and action regarding the inconsistency. If necessary, we can immediately update an enrollee in our system, so services or medications will not be delayed until the 834 file is received.

c. Process for Kentucky SKY Enrollee PCP Assignment

Through the provision of preventive and routine care, quality PCPs are critical to good health outcomes. The active selection of a PCP often helps to establish more enrollee engagement in their own health care. The comprehensive physical, behavioral, developmental, and social needs of Kentucky SKY enrollees create an imperative to expedite PCP assignment within two days of enrollment. Kentucky SKY represents a vulnerable population who often lack preventive and routine care. Aetna's approach to PCP assignment is proactive. We provide the Department with the most comprehensive PCP file update on a weekly basis.

c.i. Assistance with PCP Selection and Auto-assignment

Aetna's Enrollee Services team is trained and equipped to answer any inquiries for enrollees and their guardians 24/7/365 via our Enrollee Services line. For those needing specialized assistance, Aetna's CCT works in the field with the enrollee and family to support PCP enrollment. Bringing our person-centered approaches to the enrollee, the CCT is knowledgeable of our PCP network, understands the importance of the cultural and demographic preferences of the enrollee, and assists the enrollee and guardian to match the enrollee to the PCP that is aligned with the desired attributes and meets access and availability standards.

Aetna's PCP auto-assignment for Kentucky SKY enrollees is supported by our use of The Worker Information System (TWIST) to review encounters showing previous PCPs. TWIST is Kentucky's state-automated child welfare information system that provides information about children who enter into the child welfare system with a history of referrals for maltreatment, out-of-home placement, services and permanency, and a child's care plans. The system also provides data that can be utilized and implemented by the Children's Review Program, Court of Justice, and Kentucky Justice and Public Safety Cabinet. Utilization of the TWIST system will enable Aetna to provide continuity of care when a previous PCP is within access standards. The system can also be utilized to assist with auto-assignment using the following criteria:

- **Foster Care Enrollees:** Assignment will be based on where the enrollee's DCBS case is located (which is usually the Medicaid region where the child's family of origin resides). The Kentucky SKY enrollee will be auto assigned to their current PCP if a PCP if currently identified. If the Kentucky SKY enrollee does not have a currently assigned PCP, the DCBS social worker, caregiver, or foster parent can voluntarily select a PCP. Alternately, Aetna will auto-assign the Kentucky SKY enrollee a PCP within two business days of receipt of notification of the Kentucky SKY enrollee's enrollment in the Kentucky SKY program utilizing Kentucky SKY-specific system logic containing the Department's guidelines and our Kentucky SKY Priority Providers.

- **Adoption Assistance (AA) Enrollees:** The AA enrollee's Medicaid region of residence is determined by the adoptive parent's official residence. If an adoptive parent or AA enrollee does not voluntarily select a PCP upon enrollment in the Kentucky SKY program, we auto-assign the AA enrollee a PCP within two business days of receipt of notification of the enrollment in our Kentucky SKY program utilizing Kentucky SKY-specific system logic containing the Department's guidelines and our Kentucky SKY Priority Providers.
- **Juvenile Justice Enrollees:** If the DJJ social worker does not voluntarily select a PCP upon enrollment in our Kentucky SKY program, we will auto-assign the juvenile justice (JJ) enrollee a PCP within two business days of receipt of notification of the DJJ enrollee's enrollment in the Kentucky SKY program utilizing Kentucky SKY-specific system logic containing the Department's guidelines and our Kentucky SKY Priority Providers.
- **Former Foster Children:** PCP assignment is managed through our Enrollee Services department. If an enrollee does not specifically identify a PCP, the team reviews claims to see if there is a provider being utilized. If there is, that provider is assigned. If there are no claims, the enrollee is auto-assigned to a PCP based on the enrollee's location.

If an enrollee does not select a PCP with the Department during open enrollment or at the time of initial enrollment, we assign a PCP, as illustrated in **Figure G.5-1**, based on the enrollee's location, language needs, and cultural needs, as well as any prior PCP relationship (if known).

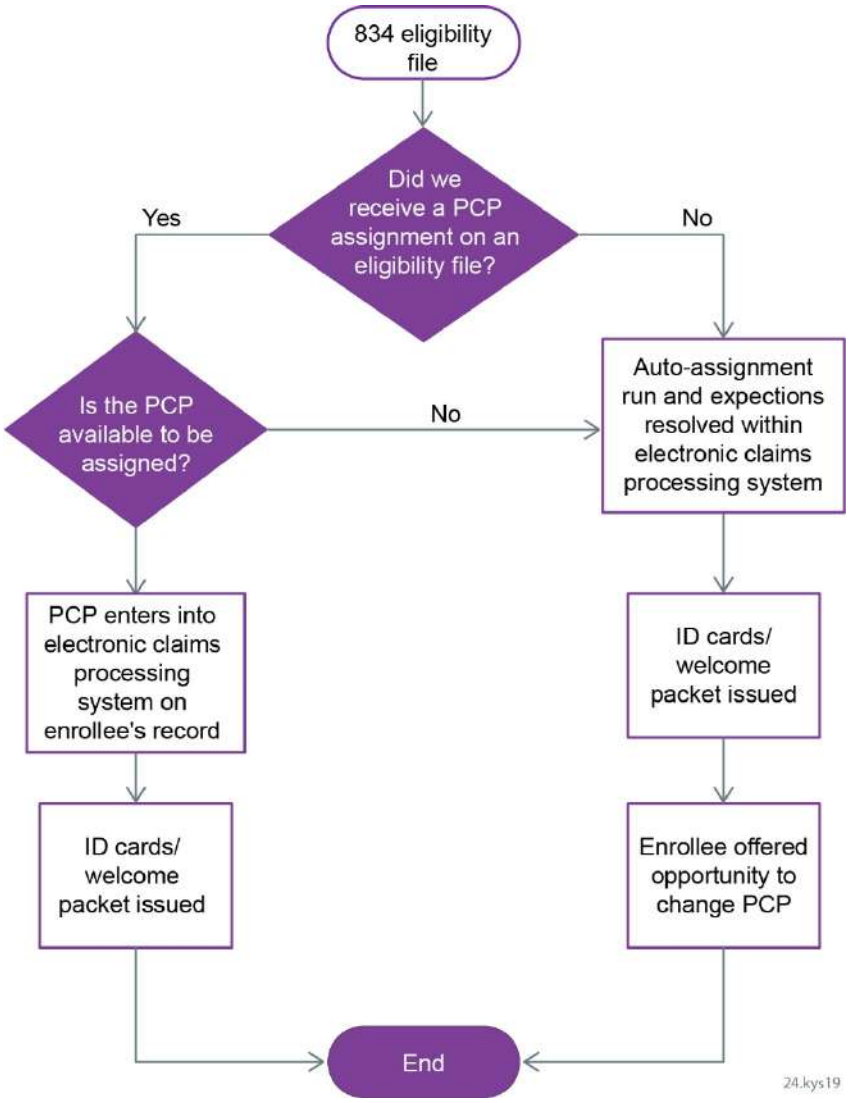

Figure G.5-1: PCP Assignment Workflow

Aetna works closely with enrollees to identify a PCP who matches their individual needs.

c.ii. Collaborating with the Department, DCBS, DJJ, Foster Parents, and Adoptive Parents to assign PCPs

Aetna, the Department, DCBS, DJJ, foster parents, and adoptive parents will coordinate all communications to ensure that enrollees are assigned to a PCP/practice that best meets their individual needs and presenting concerns. If the foster care enrollee currently assigned PCP is identified as a good fit for the enrollees needs, the enrollee will continue care with the PCP. If requested by the enrollee, foster parents, and/or adoptive parents, the enrollee will be reassigned to a PCP that best meets their treatment needs.

Our Kentucky experience helps us to understand that in some cases, the Department, DCBS, DJJ, foster parents, and adoptive parents can assign a PCP. All requests from the Department, DCBS, DJJ, foster parents, and/or adoptive parents for PCP reassignment will be fulfilled within two days of the initial request. Notification of the reassignment will be sent to the enrollee and their foster/adoptive parents within 24 hours and then a new ID card is issued. Collaboration can also be completed with any existing

subcontractors who administer services to enrollees to update their enrollment information in their respective systems.

c.iii. Tracking Data to Confirm Enrollee PCP Assignment

Upon receipt of the 834 file, we determine if the enrollee has selected a PCP. If the enrollee has not selected a PCP, the records appear on the Unassigned PCP report. The Unassigned PCP report is reviewed daily and a PCP auto-assigned or manually assigned.

Any enrollee that errors out from PCP auto assignment is assigned a PCP manually. Manual PCP assignment follows the same auto-assignment rules:

- If an enrollee had a PCP assigned to them on previous eligibility, the previous PCP will be assigned
- If we have a new enrollee, the PCP is assigned according to the Department's guidelines and age (drives PCP specialty, pediatrician, internal medicine, etc.) and mileage

Enrollees or stakeholder agencies can contact our Enrollee Services department to request a PCP change at any time. The PCP change requests can also be made via our secured Enrollee Services website or mobile application.

c.iv. Inform PCPs of New Kentucky SKY Enrollees Within the Required Timeframes

Aetna will have standardized processes in place to ensure Kentucky SKY PCPs are well versed and prepared to serve Kentucky SKY enrollees within the first 24 hours of enrollment and thereafter. We will utilize email, fax, and telephone calls to notify the selected PCP of a new Kentucky SKY enrollee within 24 hours by our CCT. Our electronic care coordination platform will track the contacts.

Our secured web portal updates provider panels daily and will indicate Kentucky SKY enrollees. Utilizing the Aetna secured provider portal, PCPs have access to their panel rosters daily. The information is updated in almost real-time from our main enrollment system. Enrollment panel roster reports will include enrollee name, enrollee ID, eligibility segment, date of birth, address, and home phone.

c.v. Confirm that PCPs Received the List of Assigned Kentucky SKY Enrollees

Aetna will track PCP access to portal and the portal information viewed. When the list is not viewed within two days, we outreach the PCP to review and discuss the assignment list. Aetna will also work with the local medical community and advocacy groups to ensure that best practices are in place. These practices may include integrated and holistic care, trauma-informed care, and family systems treatment. **Figure G.5-2** displays a snapshot of a report that provider service representatives use to verify that PCPs have viewed the list of their assigned enrollees.

Provider Name	Provider No.	Provider Login	Search Claims	Search Enrollees	Search Auths	Search Remittance	Search Provider	View Provider Panel
Medical Center	[redacted]	393	327	346	0	243	1	5
Pediatrician	[redacted]	24	26	136	0	3	0	13
Medical Services	[redacted]	518	973	84	6	17	8	3
Pediatrician Group	[redacted]	76	0	887	0	0	0	29

Note: Gray-shaded fields indicate manufactured data for privacy

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Figure G.5-2: Provider Service Detail on PCP Viewing of their Assignment Panel

Aetna Provider Services staff are able to verify whether providers have checked their panel of assigned enrollees.

c.vi. Report Used To Notify PCPs of their Assigned Kentucky SKY Enrollees

Figure G.5-3 shows the Excel report Aetna uses to inform PCPs of their assigned enrollees. We will continue to use feedback from providers to inform how we communicate with them and meet their needs.

Enrollee Name	Enrollee ID	Eligibility	DOB	Gende	Benefit	Address	Home Phone
		01/01/2019-12/31/2078		Female	74026/74027/74028/74029 - Copay		
		01/01/2017-12/31/2078		Male	74026/74027/74028/74029 - Copay		
		01/01/2016-12/31/2078		Male	74026/74027/74028/74029 - Copay		
		07/01/2018-12/31/2078		Male	74026/74027/74028/74029 - Copay		
		06/01/2017-12/31/2078		Male	74026/74027/74028/74029 - Copay		

Note: Gray-shaded fields indicate manufatured data for privacy

Figure G.5-3: PCP Assignment Report

Aetna provides details to PCPs on their assigned enrollees via an Excel spreadsheet.

d. Communicating with Kentucky SKY Enrollees about PCP and Dental Assignments and Encouraging Enrollees to Keep Appointments

Because the enrollee/PCP relationship is critical to successful treatment and coordination of care, our CCTs work with enrollees' families/circles of support to make sure they are comfortable with their choices. Information on how to change a PCP is available to enrollees and families in each enrollee's Kentucky SKY enrollment packet. Our assigned CCT will outreach the new Kentucky SKY enrollee in the first 24 hours.

Aetna's CCTs outreach new enrollees/guardians/system stakeholders to inform them of their PCP assignment, make changes as needed, and identify and assist making appointments for status updates and to provide reminder calls. When telephonic outreach is not successful, Aetna will use several strategies, including email, text, and mobile app; as an example, they could use TWIST to locate alternate contact information or previous providers based on enrollee encounter history.

We provide all enrollees information on alternative delivery methods with a focus on primary care and dental care. Other alternative delivery methods will include the following: access to urgent care and the Health Information line as part of their welcome packets, on our website, and on our mobile application. For enrollees working with our Care Coordination staff, we identify any potential telemedicine and telemonitoring service options that are appropriate in the treatment of their condition(s) and work with the enrollee to make a provider appointment.

Our CCTs work with the enrollee, stakeholder agency, or guardian to resolve barriers that may contribute to missed appointments. Based on the enrollee's location, a CCT visit, peer support, or a community health worker may be assigned to engage with the enrollee using person-centered, trauma-informed approaches. Our care coordinators collaborate with the Department, DCBS, and DJJ to eliminate identified barriers such as transportation or unavailable guardian to attend the appointment. If the enrollee is in the community and needs assistance, the enrollee will be assigned to a peer support team enrollee who has similar experiences to assist the enrollee to overcome the issue. Our care coordinators and community health workers are trained to identify social determinants that may be creating barriers to the enrollee receiving care; when social determinants are found, we use person-centered approaches to work with the enrollee and appropriate agency to identify community resources. Aetna is partnering with Unite Us in a unique collaboration to address the full spectrum of social determinants of health (please refer to **Figure G.5-4**). This network serves Louisville and will be expanded to cover the rest of the Commonwealth. It establishes new and innovative models that improve the engagement between enrollees, traditional health care providers (e.g., PCPs) and social services providers. In addition, Aetna is offering value-added benefits to assist in eliminating barriers; for instance, we can offer asthma homecare.

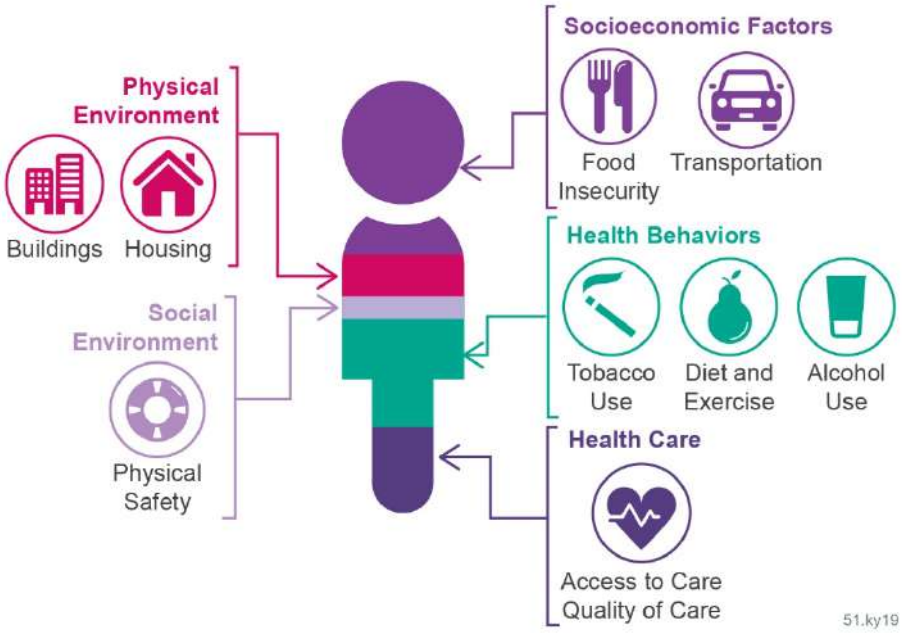

Figure G.5-4: The Social Resource Needs Aetna Addresses for Kentucky SKY Enrollees through our Partnership with Unite Us

Aetna links children, youth, and young adults served through Kentucky SKY and their families with our social determinants of health integration model.

When communicating with Kentucky SKY enrollees, guardians, and system stakeholders about enrollment to a dental provider, Aetna's care coordinators encourage the identification and consideration of past dental trauma, the enrollee's cultural beliefs, and environmental/office needs. As an example, if an enrollee has autism or a developmental disability, we emphasize the importance of choosing a dentist experienced in meeting the enrollee's needs and an office that includes the environmental setting most appropriate to meet the individual's needs. Our care coordinators s conduct warm hand-offs to the dental subcontractor to obtain further support. Care coordinators will also coordinate care between dental providers, DCBS and/or DJJ staff, foster parents, adoptive parents, the enrollee, and other dental professionals. These coordination efforts are vital to ensuring that the enrollee receives all necessary dental services and that all services are provided in a trauma-informed and trauma-sensitive manner.

Aetna has implemented innovative solutions to our dental program to offer adaptability and ease of access to services for all enrollees. In 2018, Aetna implemented an innovative approach to broaden the accessibility of dental services throughout Pennsylvania. We began donating portable dental units to FQHCs to provide flexible access to preventive dental services. These units include one Express II portable dental system, one chair with case, one advanced portable operator's stool, one LED light system, a Nomad Pro 2 handheld X-ray with case, one motor slow-speed handpiece and air motor, a lead-free X-ray protective apron with thyroid collars, and one intraoral imaging system.

Physically traveling to a dental provider's office can be a major barrier to care for individuals with special needs. The availability of portable dental units for practitioners who visit FQHCs, schools, state agencies, and community events offers additional service availability to enrollees. Since 2018, Aetna has purchased and donated 12 portable dental units in Pennsylvania. All residents within the areas where portable units are available may make use of them, including enrollees of other MCOs.

Aetna Kentucky SKY care coordinators will work with our dental contractor to provide outreach and education, help enrollees schedule appointments, and provide mobile units to increase access to and

utilization of preventive care for foster children. The dental contractor offers Sensi-Dentistry, emergency room diversion, and intravenous sedation when appropriate for the Kentucky SKY enrollees.

e. Assessing Access after Changes in Placement or Assignment of New PCP or Dental Providers

When enrollee location changes are noted on the daily eligibility file or through Department or DCBS notification, we use Quest Analytics tools to evaluate the enrollee's access to their current PCP and dental provider within one day of notification. During that same day we notify the DCBS social worker, caregiver, foster parent, or enrollee if the PCP and/or dental provider no longer meets access standards. After receiving notification, these individuals have two days to choose a PCP and/or dentist. If no PCP or dental provider is chosen within three days of identification of the demographic change, Aetna will apply the auto-enrollment process described earlier in this section. When assisting enrollees to select a new PCP or auto-assigning members to a new PCP, we focus on guaranteeing continuity of care.
To ensure continuity of care, we help enrollees make the most appropriate PCP selection based on the following:

- Previous or current PCP relationship
- Providers of other family members
- Medical history
- Language needs
- Provider's proximity to enrollee's location
- Providers who are trauma-informed
- Americans with Disabilities Act accommodations
- Additional factors that are important to each enrollee

f. Engaging Adoptive Parents Who Request to Opt Out of Kentucky SKY

We understand that for a variety of reasons adoptive parents may request to opt out of Kentucky SKY. However, Aetna is committed to facilitating relationships with adoptive parents and will engage them through multiple platforms (i.e., newsletters, educational sessions, phone calls).

f.i. Process for Outreach and Engagement of Adoption Assistance (AA) Enrollees

Aetna will work with leaders like Dr. Jay Miller, Dean of the School of Social Work at the University of Kentucky, to implement adoption resource outreach centers for the purpose of establishing and maintaining relationships with adoptive parents. This approach is designed to decrease the numbers of adoptive parents wishing to opt out of Kentucky SKY and keep those wishing to opt out in the program. These outreach resource centers will include specialty trained individuals supported by the CCT. Staff will be trained in trauma-informed care approaches including present focused attendance, empathy, supportive problem-solving, and positive encouragement. The staff will have working understanding of loss, attachment, trauma, and brain development and other issues associated with adoption. Using face-to-face and telephonic outreach, we will work with the enrollee and the adoptive parents. Through motivational interviewing and person-centered and trauma-informed approaches, we will collaborate with and educate adoptive parents concerning the benefits of Kentucky SKY. We will also use continuous quality improvement processes to problem-solve issues and affect solutions. Outreach center staff will continue to engage adoptive parents through informational newsletters that will be emailed and mailed out to enrollees. These newsletters will include program updates, information about community resources, and upcoming trainings that provide psycho-educational training for adoptive parents and parents seeking out information about the adoptive process. Drop-in educational sessions will be hosted by resource staff once a month. These educational sessions will be co-facilitated by a clinician and adoption staff enrollee and topics including adaptive and maladaptive behaviors, child issues with family assimilation, and the adoptive process will be reviewed.

University of Kentucky Adoption Support for Kentucky—Virtual Interaction Program

Aetna understands that there is innovative work already underway to support foster, kinship, and adoptive parents in the Commonwealth. We will support existing efforts and help to build capacity of those efforts where there is a need. A major area of interest is to support efforts to expand virtual supports offered to adoptive parents and other caregivers of the Kentucky SKY population. For example, we know that the University of Kentucky Adoption Support for Kentucky—Virtual Interaction Program (ASK-VIP) has been a helpful resource in some parts of Kentucky to support caregivers who are unable to attend support groups in-person. ASK-VIP uses technology to organize group and individual support sessions for caregivers in a safe space. It allows caregivers to share their personal experiences without fear of judgment. Caregivers in the program can also receive specialized training provided by a peer facilitator, who is also an adoptive parent. Aetna will partner with the University of Kentucky to help expand ASK-VIP statewide in order to serve areas of the Commonwealth not currently served. In addition, we will work with the program to help identify and address other barriers to caregivers attending meetings (i.e., lack of high-speed broadband; lack of understanding of how to use the technology). Our support in this area will help bolster existing services and expand on the technology solutions already underway. We will also connect the caregivers we serve with the free training and resources already offered by the University of Kentucky Training Resource Center such as the Adoption Support for Kentucky program. In order to ensure we are not reinventing the wheel, one of our first steps upon procurement will be to meet with key players, including Dr. Jay Miller, Dean of the School of Social Work at the University of Kentucky, in order to further understand the work already underway and how we can support those efforts.

f.ii. Use of Surveys to Determine Opt-out Reasons

Aetna will use our enrollee call center to perform outbound calls to survey adoptive parents to determine the reasons for Kentucky SKY opt-out. Our survey tool will be scripted for consistency and administered using person-centered, culturally responsive approaches in compliance with the directives of the Department and DCBS. A copy of the survey will be submitted to the Department for review and approval prior to use. Our survey will focus on satisfaction with our provider network, the MCO, ease of process, and whether they are aware of all the Kentucky SKY benefits and value-added services offered.

Additionally, we will complete an enrollee survey yearly to assess enrollee satisfaction with care management. The goal is program enhancement to minimize opt-out of SKY services and identify areas for process improvement.

f.iii. Periodic Re-engagement after Disenrollment

Aetna will reengage adoptive parents in compliance with the directives of the Department and DCBS. We will outreach telephonically to adoptive parents quarterly to determine if there are unmet needs or encourage reengagement. We will conduct an annual webinar (and make it available on our website) for community partners, including adoption support groups and faith-based organizations, that provides information to adoptive families on the SKY program and its benefits. If concerns are identified during re-engagement activities, the Department or DBCS will be notified and follow-up activities coordinated.

f.iv. Using Survey Results to Improve the Program

Aetna utilizes all data possible to review and analyze enrollee and provider satisfaction. Fields from Aetna's call center documentation system will be used to generate survey reports. Data will be collated quarterly with year-over-year trending. Data will be reported to the Quality Management/Utilization Management Committee for discussion. Based on the analysis of findings, a variety of actions may occur, including discussing the findings at monthly and ad hoc meetings with the Department and other system stakeholders, establishing performance improvement workgroups, and revising the survey tool if questions are determined to be faulty.

g. Providing Kentucky SKY Enrollees with ID Cards in Required Timeframes

Aetna's Enrollment department is responsible for facilitating the provision of timely ID cards within the timelines referenced in **Section 41.11.5 of the Draft Medicaid Managed Care Contract and Appendices.** A card will be provided for every Kentucky SKY enrollee. The ID card will include the Kentucky SKY name and logo. It will also include the enrollee's identification number and the name of the enrollee's PCP. Aetna has a strong history of meeting enrollment turnaround time goals for enrollee receipt of the card. We provide the cards as part of the welcome packet in combination with the enrollee handbook; it is delivered within five business days of receipt of the HIPAA 834 file containing the enrollee's information. Enrollees ID card images are available upon enrollment on our secured mobile application and our secured portal.

Our enrollee services call routing provides timely, accurate responses to enrollee inquiries. When they call the toll-free hotline, callers are greeted and advised to call 911 if they are having a life-threatening emergency. They are then advised that all calls are recorded. Our interactive voice response (IVR) system offers the opportunity to self-service. If they want benefit information, a new ID card, or eligibility verification, they can select those options and obtain the information that is pulled from our operating system. At any time the enrollee wishes to speak to a representative, they can opt out of the IVR. The enrollee selects the option they want, and the phone system directs them to the person or department. Behavioral health issues always route to a live enrollee services representative who will warm transfer them to the correct department.

g.i.-iv. Lost ID Card, Name Change, New PCP Assignment, Card Replacement

Aetna recognizes that the populations covered by the Kentucky SKY program may have frequent transitions, increasing the likelihood of a lost ID card. We will reissue an ID card within five days of the request in the following circumstances:

- For foster and former foster enrollees:
  - An enrollee, DCBS staff, caregiver, or foster parent reports a lost card
  - An enrollee has a name change
  - An enrollee, DCBS staff, caregiver, or foster parent requests a new PCP or dental provider
  - The enrollee moves to a new placement
  - Any other reason that results in a change to the information disclosed on the foster care enrollee's ID card
- For AA enrollees:
  - The enrollee or adoptive parent reports a lost card
  - The enrollee has a name change
  - The enrollee or adoptive parent requests a new PCP
  - Any other reason that results in a change to the information disclosed on the AA enrollee's ID card.
- For JJ enrollees:
  - The JJ or designated DJJ staff reports a lost card
  - The JJ enrollee has a name change
  - The JJ enrollee or designated DJJ staff member requests a new PCP
  - The enrollee moves to a new placement
  - Any other reason that results in a change to the information disclosed on the JJ enrollee's ID card
- To reduce administrative burden and facilitate access to care, Aetna facilitates multiple methods to replace a Kentucky SKY enrollee's ID card. These include the following:
  - Printing an ID card via our portal
  - View ID card via Aetna's mobile app
  - Operating an IVR line that is specific to ID card replacement
  - Offering a Community Engagement team to directly support enrollee and stakeholder requests

- Providing a specific email mailbox for lost ID cards that is monitored by a care coordinator
- When requested, connect the enrollee with a care coordinator to ensure that the enrollee receives their initial and any replacement ID's in an expeditious manner

Our enrollee services call routing provides timely, accurate responses to enrollee inquiries. Enrollees use one telephone number to access all Kentucky Medicaid services. When they call the toll-free hotline, callers are greeted and advised to call 911 if they are having a life-threatening emergency. They are then advised that all calls are recorded. Our IVR system offers the opportunity to self-service. If they want benefit information, a new ID card, or eligibility verification, they can select those options and obtain the information that is pulled from our operating system. At any time the enrollee wishes to speak to a representative, they can opt out of the IVR. The enrollee selects the option they want, and the phone system directs them to the person or department. Behavioral health issues always route to a live representative who will triage and handle the matter.

h. Addressing and Managing Crisis Calls

Aetna believes a proactive approach to crisis is the most effective approach and that developing genuine and thoughtful relationships with our enrollees is the first step to disrupting a crisis from occurring in the first place. People often use behaviors to communicate, and the more we can truly listen and respond holistically, the better off everyone will be. In fact, sometimes it may look like an enrollee is having a crisis, but it is actually the system in crisis and taking a system-level approach to crisis is imperative. Kentucky will be a national leader in developing Family First initiatives, services, and system change, and this provides a perfect opportunity to front-load preventive services to address crisis situations before they occur.

Aetna realizes the need for Kentucky SKY enrollees to receive rapid and local care during a crisis to improve services to children, a key strategy in serving children and young adults in the child welfare system (e.g., foster care or former foster care). Crisis situations are a critical and vulnerable time for our enrollees and their families. Responding rapidly in a crisis can have the result of better stabilization for the child and family, which impacts outcomes.

We propose an evolving partnership with community mental health centers (CMHCs) to ensure Kentucky SKY enrollees are swiftly assessed for the most appropriate care in the most appropriate setting. Ultimately, we seek to avoid inappropriate and unnecessary placements, emergency care, and hospital admissions that can increase trauma for these enrollees. The goal of this program is to support individuals in remaining safe in their community. Mobile crisis response teams are an untapped resource that could greatly assist Kentucky SKY enrollees and their families.

During business hours, crisis calls will be managed by the direct Kentucky SKY CCT staff and after hours call coverage is provided by the BH crisis call center. This allows for Kentucky SKY experienced personnel coverage 24/7/365. The Aetna Kentucky SKY care coordinators will collaborate with the BH crisis call center staff to identify and locate the CMHC within the closest proximity of the enrollee. The mobile crisis team will be dispatched, 24/7/365 when needed. All crisis calls are followed up by the assigned Kentucky SKY care coordinator. This process ensures that continuity of care is provided and any follow-up treatment is completed.

Community Mental Health Centers

Aetna truly values the relationship with the CMHCs and see them as valuable partners. Aetna will incentivize the thirteen CMHCs in the Commonwealth to provide mobile crisis unit services for all Kentucky SKY enrollees. The goal of this program is to support individuals in remaining safe in their community.

Crisis Mobile Team: The crisis mobile team will provide the following services:

- Conduct risk assessments, provide crisis interventions, and connect the individual to ongoing behavioral health services or other community resources/supports
- Provide crisis services of triage, assessment, and immediate stabilization of acute symptoms of mental illness, substance use, and emotional distress
- Make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual's needs
- When clinically indicated, assist and transport the individual to a more appropriate facility for further care
- Provide two-person mobile teams with at least behavioral health technician (BHT)-level crisis workers
- Engage peer and family support services as preferred and identified by the enrollee and DCBS social worker

Following a mobile crisis intervention, Aetna will work with CMHCs to do intensive outpatient care with the family (foster) and child post-mobile crisis event, including the following:

- Assist the individual to utilize community and family/support systems with the intent of preventing the reoccurrence of similar events in the future
- Assess the immediate crisis and facilitate resolution and de-escalation
- Engage the individual to identify follow-up services and assist the individual to access these services that are necessary to manage and/or prevent further BH crisis experiences

Collaborating with Providers

Aetna will also partner with various providers throughout the State to provide quality care to our enrollees. An example of this partnership is TAYLRD (Transition Age Youth Launching Realized Dreams), which has multiple locations or 'drop-in centers' throughout the Commonwealth. TAYLRD is a federally funded initiative aimed at positively affecting the lives of Kentuckians 16-25 years old who have, or are at risk of developing, behavioral health challenges. The drop-in centers are staffed by youth peer support specialists and youth coordinators who are in the transition age group themselves and have had some form of system involvement in their past. There are various services provided at the drop-in centers such as case management, court support, life skills, and vocational services. Aetna has worked with TAYLRD by providing hygiene items (i.e., shampoo, body wash, toothbrushes, and toothpaste). Having hygiene items available is another way to get individuals to come into a drop-in center and increase the opportunity for engagement. With this enhanced collaboration, the mobile crisis response may include the following:

- Initial assessment and ongoing assessment of behavioral health symptoms and crisis-related needs
- Involvement of identified family and friends to resolve the individual's crisis
- Therapeutic communication and interaction to alleviate psychiatric or substance use symptoms
- Development of a safety plan or crisis prevention plan
- Psychiatric consultation and urgent psychopharmacology intervention
- Referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care, including crisis respite
- Linkage to stabilization and/or substance use disorder 24/7/365 access centers/BH urgent care
- Secure access to higher levels of care if required
- Certified peer services that provide the following:
  - Engagement
  - Assistance with developing crisis diversion plans or relapse prevention plans
  - Assistance with the identification of natural supports and access to community services during and after a crisis

Aetna will work with all stakeholders to explore new models that will support people before, during, and after a crisis occurs, including building capacity around positive behavioral support, creating short-term respite, and taking a prevention-first approach. Aetna firmly believes that the solutions to a robust crisis support strategy is in the enrollees and the Kentucky providers and stakeholders who work so hard every day. By developing ongoing partnerships, leveraging new and preventive Family First services, and 'thinking outside the box,' Kentucky will be a national leader in disrupting the crisis cycle at all levels of the system.

i. Achieving Maximum Stability and the Best Outcomes for Enrollees

Aetna provides all the infrastructure and supports necessary to achieve optimal outcomes for Kentucky SKY enrollees. Aetna services and support includes an emergency/crisis liaison along with adult and child administrators, a JJD liaison, and a director of recovery resiliency. The goal of our team is to facilitate appropriate use of emergency rooms and higher levels of care while promoting the overall health and wellness of our Kentucky SKY enrollees by promoting PCP/enrollee relationships and offering a comprehensive network of specialty and behavioral health providers. We do this through our understanding the needs and risks of our Kentucky SKY enrollees and by comprehensively training staff, following evidence-based guidelines, and utilizing innovative care management techniques.

> "The training is really about how do you heal children who have had such harm done to them? And how do you heal the whole family? Because this kind of generational experience has to stop somewhere."
>
> **—Kevin Campbell**
> **Developer, Family Finding Model**

Training: As mentioned previously, we will utilize the Family Finding approach developed by Kevin Campbell, child and family welfare expert, to train plan, state, and community staff, family members, and other stakeholders to ensure that enrollees have the family support they need. This training helps the child welfare system by adding supports they previously did not have access to and engaging the larger community. The bigger goal is to help children stay connected to adults in their life that love and care about them, which in turn could help prevent them from going to foster care and potentially prevent them from experiencing additional trauma, or at least being a positive connection to them to help them heal from the trauma they have endured.

Figure G.5-5: Family Finding Boot Camp
Kevin Campbell, child and family welfare expert, addresses key methods and strategies to locate and engage relatives of children currently living in out-of-home care. Photo courtesy of The Topeka Capital-Journal.

Kin care results in better outcomes, including the following:

- Improved placement stability
- Reduced trauma
- Reinforced child's sense of identity
- Helping keep siblings together
- Expanded permanency options

Recently, over 100 social workers in Kansas participated in the Family Finding boot camp led by Kevin Campbell. Aetna Better Health of Kansas, the Kansas Department of Children and Families, and Casey Family Programs sponsored the four-day event. As the founder of the Family Finding model, Campbell spoke about key methods and strategies to locate and engage relatives of children currently living in out-of-home care. Over the years of developing Family Finding, Campbell found that most foster children have a large extended family, and if they could connect with five to eight adults who would make a 'permanent relational commitment' to the child, it could change outcomes significantly. During the boot camp, Campbell empowered attendees with information on how each of

them can help extend the overall safety networks of the children they work with. He also discussed how to facilitate a community of unconditional love and healing to combat and lower the toxic stress these children and their families are experiencing, thereby improving mental and physical health outcomes.

Organized into 27 teams, social workers collaborated throughout the week to apply the Family Finding model to their current cases. Based on a series of criteria, they prioritized the children who were their biggest worry. By the end of the training, participants reported locating an average of 19 contacts per child, for a total of 500 contacts across all teams combined—an increase of 84 percent from the beginning of the week. This number broke the American record for the average number of relatives identified in a Family Finding boot camp, which typically averages 14 connections per child.

Process, Protocols, and Guidelines: Our project manager will work with the care management managers and care teams to develop policies and procedures following Aetna's rigorous policy development process. Our project manager will begin with current Aetna policies and design SKY-specific protocols to guide SKY services to successful implementation. All policies will receive approval from appropriate leadership and Compliance staff.

Crisis calls: Working with our emergency/crisis liaison, our policies, procedures, and job aids will meet Kentucky SKY requirements and clearly outline the management of crisis call from the moment the call comes into our call tree. Our job aids and desktops outline the circumstances dictating our steps. Policies and procedures will be reviewed and approved by the Department prior to deployment. For example, if a life-threatening situation is determined, we conduct a warm transfer to 911 dispatchers. When the situation is determined to not be a life-threatening issue, such as an enrollee mental/behavioral health crisis requiring crisis intervention, a warm transfer is made to their assigned care coordinator while the enrollee remains on the line.

If the enrollee's care coordinator is not available, the enrollee services representative will speak with a designated care manager or supervisor to ensure that the enrollee's needs are addressed. Evidence-based care coordination protocols dictate that our care managers access available crisis plans housed in our information management system and assist the caller to implement the plan. When a care plans does not yet exist, our care coordinators assist the callers using de-escalation strategies. Based on the time of the calls and situations, our workflows include warm transfers to providers without call release until the individual receiving the call is on the line and the situation is explained. Our case coordinator processes include following up with the caller and referral source within 24 hours of the crisis call to make sure that the situation is resolved and that immediate treatment or follow-up appointments have occurred. Aetna is also planning on incentivizing the 13 CMHCs in the state to provide mobile crisis unit services for all Kentucky SKY enrollees, which we will dispatch after receiving certain crisis calls. This can help the families and ensure the enrollee and situation are stable, as well as avoid inappropriate and unnecessary emergency room visits or hospitalizations. The Mobile Crisis team will be responsible for the following:

- Conduct risk assessments, provide crisis interventions, and connect the individual to ongoing behavioral health services or other community resources/supports
- Provide crisis services of triage, assessment, and immediate stabilization of acute symptoms of mental illness, substance use, and emotional distress
- Make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual's needs
- Assist and transport the individual to a more appropriate facility for further care
- Provide two-person mobile teams with at least behavioral health technician-level crisis workers
- Engage peer and family support services as preferred and identified by the enrollee and DCBS social worker

Prioritize emergency or crisis calls: When an enrollee or their fictive kin call Aetna in an emergency or crisis, they can quickly exit our call tree and get directly connected with a member of our care team, day or night. Aetna care coordinators also make sure their enrollees all have their direct lines as well.

Warm transfer/direct connectivity: All of Aetna's phones have the capability for warm transfer; all staff is trained on features. Our process is to stay engaged with the caller and the third party unless asked to leave the conversation. Aetna's staff are trained on how to handle emergency situations; procedures are in place to obtain quick assistance in the case of a crisis. The team member will stay on with the caller and have an associate or supervisor call 911 or an appropriate resource. Quick reference guides are available for our team with other numbers for support, such as the suicide prevention line, poison control, etc. Aetna has an enterprise-wide protocol in the case a 911 call is made from our site, in which case our national security team will call a designated health plan contact to engage and assist as needed.

j. Trainings and Resources the Contractor will Provide to Call Center Staff

Aetna is dedicated to educating, empowering, and deploying a highly skilled workforce. This approach is part of Aetna's mission to recruit and retain a workforce and partners that operate with integrity and transparency. BH Services Hotline staff receives initial training during onboarding with Aetna. Additionally, they receive BH-specific training and must demonstrate an understanding of the initial training and then receive on-the-job training including shadowing and mentoring facilitated by Kentucky experienced management, supervisory, or other senior BH staff. BH-specific training covers the following topics:

- Kentucky SKY overview, including local and state level resources and systems, and an overview of the Family First and other pertinent policies related to supporting someone in crisis
- Mental Health First Aid for all staff—our staff are certified in this evidence-based training
- Aetna crisis policy and effective crisis call management, administering suicide risk assessments, and screening and triaging calls to determine level of care needs, including processes for immediate crisis intervention and/or emergency response for enrollees at risk of harm to themselves or others
- Community-based resources, including mobile crisis teams and face-to-face emergency services
- Mock scenarios of crisis calls and actual crisis calls presented during case rounds
- Appropriate identification, management, and reporting of quality of care/service concerns, complaints, or potential abuse, neglect, or exploitation

BH Services Hotline staff may only answer calls for those programs for which they have received specific training. Care coordination and enrollee services staff are also trained in the following:

- Mental Health First Aid
- Trauma-informed care
- Training desktops for the management of crisis calls (warm handoffs to 911, care coordinators, and providers)
- Motivational interviewing
- Behavioral health call center training
- Crisis intervention
- Adverse childhood experiences
- Relias Learning Management System training courses
- Crisis plan training
- Crisis de-escalation

Aetna's call center and care coordination training processes are both didactic and virtual through the use of our Relias learning management systems. Pre- and post-tests are used. Representatives are not approved to respond to crisis calls until successfully completing the program and achieving a passing score on tests. Didactic training includes successful completion of our 'nesting' program with an experienced representative or supervisor. The initial three hours of trauma-informed care training will be

provided via in-person trainings. These training will be facilitated by a BHT or behavioral health professional with at least two years of experience in providing direct care services. Training will revolve around how to handle low- and high-intensity crisis calls that may involve threatening situations; crisis call risk stratification to determine the need for emergency services; and crisis de-escalation protocol. The in-person training will require that all staff demonstrate through role-playing their ability to calmly address a caller's needs and concerns along with their ability to coordinate with their call center staff during life-threatening situations (i.e., coordination with emergency services while the call center representative engages the enrollee). Role-plays will be facilitated by which the trainers will role-play with each staff member and will also observe staff role-playing with one another to simulate crisis call scenarios. Specific procedures the staff are trained on include the following:

- HIPAA enrollee requests for copies of enrollee protected health information (PHI)
- HIPAA privacy release request
- Sending and processing privacy authorization forms
- HIPAA enrollee PHI restriction and confidential communication requests
- Enrollee assistance with PCP selection
- Enrollee without active coverage
- Processing demographic change requests
- Enrollees with other insurance
- Enrollees out of area address
- Enrollee bills and reimbursements
- Processing ID card requests
- Processing PCP change requests
- Responding to authorization inquiries
- Responding to benefit inquiries
- Responding to claims status inquiries
- Responding to e-referral requests
- Responding to financial responsibility inquiries
- Responding to enrollee Rx exception requests
- Responding to referral inquiries
- Responding to Rx benefit inquiries
- Enrollee Rx reimbursement request
- Pharmacy enrollment updates
- Member pharmacy complex calls
- Requests for materials in alternate formats
- Interpreter and translation services
- Member inquiry of non-participating provider
- Taking enrollee complaints, grievances, or appeals
- Returned undeliverable enrollee mail
- Identification of potential quality of care concerns
- Death notification to enrollee services
- Responding to enrollee calls
- Care management referral
- Enrollee do not contact
- Working enrollee services email box
- Enrollee services outbound calls
- Accessing enrollee messages in Medicaid web portal
- Retro-enrolled enrollee reimbursement requests
- Verification of service inquiry
- Emergent and non-emergent transportation

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60.7.G.6 Provider Network

Kentucky | Transforming Health Care | **Aetna**

60.7.G.6 Provider Network

Aetna's network strategy focuses on ensuring enrollees have access to high-quality, integrated, personalized health care services. We continuously work to make sure providers are available at the right location within the appropriate timeframe to meet the needs of Kentucky SKY enrollees and their fictive kin (including enrolled, family, caregiver, community supports, and others who assist with care support and enrollee wellness) with a focus on improving whole health outcomes. The key elements of our network strategy include the following:

- Building a network of high-quality, enrollee-focused providers
- Offering a comprehensive network to maximize Kentucky SKY enrollee choice and accessibility
- Collaborating with governance body (including peer support partners, parent partners, the Department, Department for Community Based Services [DCBS], and Department of Juvenile Justice [DJJ] leadership), as well as Aetna System of Care (SOC) staff and other internal departments to identify needs and opportunities for network enhancements

a. Approach to Develop a Comprehensive Provider Network

Aetna's goal is ensuring development and ongoing management of a comprehensive primary, specialty, and behavioral health provider network of qualified and clinically advanced care providers so each enrollee receives the very best in health care services. We deeply value and depend on our provider partnerships to create programs and practices that are fair and simple to implement so that providers can stay focused on what they do best, providing high-quality care to their patients. For more than eight years, Aetna has worked collaboratively with Kentucky health care providers to deliver services to Medicaid enrollees, with a special focus on medically fragile and chronically ill infants, children, and young adults with complex physical and behavioral health care needs. Through this experience, we have learned that developing and maintaining an all-inclusive integrated care network requires continuous assessment of network gaps, ongoing efforts to recruit and maintain providers, and innovative solutions to improve access and quality of services to our enrollees.

The Kentucky SKY enrollees have complex needs, which Aetna's network supports by extending beyond traditional facilities, clinics, and practitioners to include community advocates, peer and professional support organizations, specialty pharmacies, and family/caregivers. Our comprehensive network of contracted hospitals, and specialists, including an array of pediatric specialists and sub-specialists, ancillary, as well as behavioral health providers serves as the basis for the Aetna Kentucky SKY network. This existing network already exceeds adequacy requirements and provider accessibility in advance of go-live for the Kentucky SKY program.

Aetna's provider service representatives (PSRs) are located throughout the Commonwealth, working and living in the communities they service. These locally based PSRs have established close relationships with our providers, allowing them to work collaboratively to make sure covered services are accessible, person-centered, evidenced-based, and span both required and covered services, as well as expanded care services. Our Provider Experience team is responsible for establishing and maintaining our provider network, contracting and negotiations, ensuring network adequacy and network accessibility to covered services throughout our service areas, and monitoring such adequacy to identify gaps and emerging needs to maintain access to care and avoid disruptions to enrollee access to covered services.

We are continually enhancing our network to expand the number, scope, and types of practitioners to meet the unique care needs of enrollees, including geographic distribution and specialty providers. **Our existing Kentucky Medicaid provider network includes 29,355 contracts representing 33,794 providers at 118,977 locations.** Our network solutions and approaches to a provider delivery system for Kentucky SKY enrollees are built around the following four principles:

- **Maximizing enrollee choice:** We understand that enrollee choice is particularly important to meeting the unique needs of Kentucky SKY enrollees, and continually work to offer enrollees options when selecting providers for their health care including location, gender, quality, experience, availability, cultural competency, and clinical preparation.
- **Easily accessible services:** We have ongoing processes to monitor our network and identify innovative solutions to provide health care services that are locally available and convenient to access, taking into consideration how our Kentucky SKY enrollees access services and how providers manage Kentucky SKY enrollees. Examples of solutions include offering financial incentives to encourage providers to expand services and hours of operation, assistance in identifying and implementing accommodations to support enrollee accessibility needs, and the use of telehealth.
- **High-quality care:** Through our network contracting strategies, provider training, and coordination with internal departments, we have developed and will continue to assess mechanisms to support accountability and transparency against quality of care outcomes. These strategies include aligning financial incentives and value-based payments (VBP) with implementation of innovative care models to support system transformation and increase positive care outcomes in a cost-effective manner.
- **Enrollee-focused provider services:** Assisting our providers in navigating the system transformation and implementing new care models is a critical component to the effectiveness of the Kentucky SKY model and improved enrollee outcomes. **Aetna's highly trained and experienced Provider Services team has a combined 200 years of experience working in provider offices, and over 115 combined years of experience in Kentucky Medicaid.** Our PSRs are locally situated in the statewide community to ensure strong and collaborative provider relationships and will support coordination with care advocacy groups. To further support our providers, we have dedicated behavioral health network management and operations staff who understand the nature of behavioral health services and can respond to the unique experience of behavioral health providers. **Our provider relations liaisons have 15 years of experience working for and with Kentucky's behavioral health providers.**

For our Aetna Kentucky SKY program, we have developed simple, streamlined processes and educational programs to help providers understand key elements of managed care, such as continuity of care, integrated care, and enrollee outcomes. We also offer opportunities for participation by creating a Governance Board comprised of community stakeholders, plan enrollees, family members, and providers, with the central goal of offering enrollees and providers the opportunity to impact change.

As part of our recruitment and retention strategy, Aetna offers providers a variety of alternative payment arrangements through our **Aetna Better Value** program. To date, Aetna has entered into an alternative payment arrangement with key providers to improve quality of care to children with complex needs, including Children's Alliance Independent Provider Association (CA-IPA), the Kidz Club, and KVC Health Systems. Our programs are customizable, allowing us to combine the most applicable components for a particular provider into a comprehensive and effective, innovative alternative payment model that can be tailored to enhance access and delivery of services that are responsive to the unique needs of the Kentucky SKY enrollees.

a.i. Approach to Contracting with Experienced PCP and Specialty Providers

Aetna is uniquely positioned to utilize our experience and knowledge of the state, regional, and local challenges, our established provider relationships, and staff throughout our Aetna Medicaid organization who are experienced in developing and maintaining similar networks in other states, to leverage effective practices and modify them to fit the unique needs of Kentucky's provider, children's systems, and Kentucky SKY enrollees.

Multilevel Assessment

Our approach to contracting with primary care providers and specialty providers who are trained and experienced in trauma-informed care (TIC), or who are willing to be trained and experienced in treating children in the Kentucky SKY population, will include a multilevel assessment and response to support system transformation and statewide capacity by working with the providers to evolve their practices over time. Our multilevel assessment enables our team to strategically identify and recruit providers for Kentucky SKY. We will leverage our existing practices for continually monitoring our provider network to identify potential gaps and opportunities for enhancement. Through these practices, we not only analyze standard reports, we incorporate feedback from providers, key stakeholders, and enrollees to identify needs for additional enrollee choice and to improve access.

Aetna's SOC approach provides evidence-based trauma-informed treatment and recovery services based on the **'universal precautions' model that serves each enrollee as if they had been traumatized.** We have dedicated SOC staff with distinct responsibilities aligned to the key impact areas, including our recovery and resiliency administrator. All SOC staff liaise closely with clinical, community health workers, and peer support specialists to form a solid foundation to build a strong SOC with competent and empathetic providers. Our SOC staff will work closely with our Provider Services team, including the provider services liaison and locally based PSRs, to identify and report on network gaps and opportunities to enhance the network through recruitment of providers who are experienced in working with Kentucky SKY enrollees.

Through these established process and relationships, we will continually assess our network to identify the following:

- Gaps and areas where there are additional needs for TIC-experienced providers
- Providers who are already in the Aetna network, to assess the providers' experience and where they are in implementing the TIC model, or who are interested in implementing the TIC model
- Providers who are not yet in the network, but who have experience working with the Kentucky SKY population, or have begun the process of implementing TIC practices or are interested in doing so

Our goal is to have 100 percent of the providers who serve Kentucky SKY enrollees adopt the TIC model. To achieve this goal, we conduct ongoing provider outreach and engagement and will offer a comprehensive training and coaching plan informed by experts including the Department, DCBS, and DJJ, among other community leaders. Aetna will provide multiple orientations to providers on the new model before beginning a baseline assessment of the provider's gaps and needs as a part of our TIC credentialing model. We meet providers where they are, conducting the National Council for Behavioral Health's Organizational Self-Assessment: Adopting of Trauma-Informed Care Practice[1] to assist individual practitioners and provider organizations to understand their knowledge and capacity in trauma-informed care and design a program to assist them in their development of trauma-informed practice. In addition, Aetna has developed a proprietary Trauma-Informed Provider Organization Audit Tool that includes the following domains:

- Respecting enrollee voice and choice
- Staff beliefs, attitudes, and behaviors
- Commitment of leadership to TIC
- Disclosure readiness
- Staff well-being

[1] National Council for Behavioral Health, "Organizational Self-Assessment: Adopting of Trauma-Informed Care Practice": accessed June 1, 2019; https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/OSA-FINAL_2.pdf

- Staff knowledge and skills in TIC
- Hospitality to diversity

Aligning Contract Strategies to Provider Trauma-informed Care

Our approach to provider contracting is to design strategies that are an integrated component of the overall system transformation. For example, our contracting strategies will be developed to align with and support implementation of the TIC recognition model, provider training initiatives, inclusion of non-traditional providers, and Commonwealth departmental goals. While we will leverage current contracting strategies, we understand they will need to be modified to incentivize and support the unique needs of Kentucky SKY enrollees. Based on the system needs and assessment of provider readiness and stage of transformation, we will utilize different contracting strategies designed to maintain, recruit, and support the development of a network of experienced TIC providers that expands beyond behavioral health focused providers to include both traditional and non-traditional providers.

Aetna is committed to leading capacity-building in TIC in the Commonwealth. We assist providers to move along the continuum from being trauma-aware to being trauma-transformed, as described in **Table G.6-1** Becoming a trauma-informed organization requires committing to organizational transformation over a period of years. To facilitate this transformation, we have adopted a TIC recognition model with six levels to identify providers at different stages of development and to recognize progress over time.

Table G.6-1: Levels of Trauma-informed Care

Level	Description
Trauma-aware Level 1: Foundational Awareness	• Individual practitioners are well-informed about ubiquity of trauma and its likely impact on their patients/clients. They understand the critical role of social determinants of health (SDOH) as drivers of clinical, functional, and quality of life outcomes. • Provider organizations are committed to becoming trauma-informed. Both clinical and non-clinical staff describe this as "a good place to work." Enrollees describe this is "a good place to come for care" expressed as feelings of safety, trust in clinical and non-clinical staff, being listened to, and being welcomed and respected.
Trauma-aware Level 2: Enhancing Routine Clinical Practice	• Individual practitioners have integrated Level 1 knowledge into routine clinical practice using evidence-based tools. "I'm doing the clinical work I've always done and have added clinical tools that address trauma and SDOH to my routine toolbox." • Provider organizations promote trauma-informed primary prevention as a routine practice for all enrollees, analogous to childhood vaccinations, flu shots, etc. Routine clinical care includes: – Enrollee education about how to thrive and flourish, build resiliency, enhance protective factors, and minimize the risks of trauma – Assessment and inclusion of SDOH as standard elements of a person's treatment/recovery plan
Trauma-informed Level 3: Basic Trauma-informed Care	• Individual practitioners expand routine clinical practice by integrating treatments, services, and supports that explicitly address trauma. The scope of practice is expanded by either of the following: – Adding qualifications in evidence-based and/or promising trauma-specific treatments, services and supports – Integrating Level 2 practices into serving populations at high risk of trauma, people with complex needs, and/or marginalized populations • Provider organizations perform trauma-informed secondary prevention for all people they serve, using universal screening for early adversity, historical, and ongoing trauma, and for SDOH risk factors. They have identified resources to respond to a person's immediate and ongoing needs, including but not limited to trauma-specific services. They collaborate with trauma-informed Level 3 individual practitioners. Current Joint Commission standards for accreditation for behavioral health require use a trauma screening tool during the admission process.
Trauma-informed Level 4: Advanced-Trauma-	• Individual practitioners include considerations of complex trauma and SDOH within routine clinical practice, using a biopsychosocial model of care that integrates physical and behavioral health. • Provider organizations are Trauma-Informed Center of Excellence (COE) for at least one high

Level	Description
informed Care	risk/rising risk population, marginalized population, or for people with complex needs. COEs are provider organizations that offer state-of-the-art and innovative treatments, services, and supports for people with complex needs. They may focus on improving health outcomes for a well-defined population, develop and implement practices and clinical pathways that may be adopted as clinical standards of care, and are often referral consultation centers embedded within a larger system of care. There is close collaboration with trauma-informed (Level 3-4) individual practitioners.
Trauma-transformed Level 5: Close/Full Collaboration in a Merged Practice	Provider organizations include trauma-informed (Level 3-4) individual practitioners on interdisciplinary care teams, in addition to the usual treatment team members for that provider organization. There are high levels of collaboration and integration between behavioral and physical health providers, consistent with Substance Abuse and Mental Health Services Administration's Integrated Care Level 5 or 6[2].
Trauma-transformed Level 6: Trauma-informed System of Care	Provider organizations: • Collaborate across sectors to meet the complex needs of people they serve within a larger community context • Implement a broad, community-wide focus on the underlying social and economic conditions in which people live, in addition to supporting people to meet their immediate individual needs • Bridges the dichotomy between individual-level 'social needs' and community-level 'social determinants' While targeted, small-scale social interventions provide invaluable assistance for individuals and the provider organization remains focused on the social determinants that perpetuate poor health at the community level.

Trauma-aware providers: We will work with providers who are interested in adopting TIC by decreasing early barriers, allowing provider choice regarding the model or approach to adoption, and providing financial incentives designed to facilitate a simple start to implementation. Our contracting strategy will be supplemented with access to training materials, toolkits, and individualized education as needed, to make sure providers have access to the resources necessary to successfully achieve TIC Level 1: Foundational Awareness. As providers achieve Level 1, we will continue to utilize financial incentives and resources to support achieving Level 2: Enhanced Routine Clinical Practices. Provider contracts may also include performance metrics designed to support system transformation initiatives, such as improved care coordination and use of the Aetna single source of truth—a single electronic health record that allows for sharing of data across providers, hospitals, the Department, and Aetna. In regions or counties with identified network gaps, or where enrollees would benefit from additional provider choice and access, incentives may also be offered for expanded office hours.

Trauma-informed providers: As providers progress from trauma-aware to trauma-informed, contracting strategies will also progress from incentives based on adoption of TIC practices to incentives for achieving performance metrics and outcomes. We will collaborate with providers to make sure this transformation is supported with access to provider performance data and reports, as well as training and guidance to confirm providers understand how to effectively utilize interim reports to monitoring and identify risks to achieving contracted performance goals. The provider training and support will also be designed to aid providers in preparing for VBP.

[2] Substance Abuse and Mental Health Services Administration, "A Standard Framework for Levels of Integrated Healthcare and Update Throughout the Document": accessed June 19, 2019; https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf;

Trauma-transformed providers: Once providers achieve Trauma Transformed status, we will work with them to assess their overall readiness and interest to adopt VBP, to further support achieving the Commonwealth's goal to improve quality and health outcomes in cost effective manner.

a.ii. Recruitment Strategy

Our goal and strategy are to build a comprehensive region-specific, experienced, and high-quality network that offers provider selection, preserves existing community referral patterns, and ensures access to care for the underserved. When possible, Aetna is committed to using local providers; however, when local providers are not available, we will draw on our national expertise to deploy innovative alternative models as we have with telehealth services. We will continue to use our comprehensive contracting methodology, VBP programs, technology/telehealth services, and an ongoing level of engagement and diligence to continuously recruit providers and scale our provider network to meet the needs of our Kentucky SKY enrollees.

Aetna's Provider Services team is crucial in identifying needs to expand the network to increase timely availability for enrollees across all provider types. Upon notification of a provider need, we immediately initiate recruitment efforts. These notifications may be received from a variety of sources, such as referrals from the integrated care team/Medical Management, SOC staff, Governance Board members, or other community agencies. Once notified, the Network team conducts outreach to providers in that area or specialty. Our strategy is to build the most effective, experienced, and highest-quality network that offers provider selection and meets the needs of Kentucky SKY enrollees.

Process for Identifying Network Gaps

Aetna continually assesses our network and makes sure the network evolves to proactively meet identified needs. To assess and identify Kentucky SKY needs, we will utilize a variety of internal reports, as well as data and feedback from our SOC staff and other internal departments, the Governance Board members, community organizations, and other system partners. Our strategy for monitoring provider network compliance uses a holistic approach to obtain a comprehensive view of system needs and potential network gaps and to identify network development opportunities to support system transformation. It is imperative that the network not only achieve adequacy, but also be user-friendly to our enrollees in as close to real time as possible. Data and reports are reviewed on a daily, weekly, monthly, quarterly, and ad hoc, as described in **Table G.6-2**.

Table G.6-2: Network Monitoring Data and Reports

Reporting and Monitoring Activity	Data or Report Description	Frequency
Quest Analytics Reports	We review Quest Analytics reports to measure compliance with the Department's access standard requirement for each ZIP code	Monthly
PCP-to-Enrollee Ratios	We review ratios by provider type and region to confirm availability of an adequate number of primary care providers (PCP)	Monthly
Network Adequacy	We review utilization data including prevalent conditions, single-case agreements, provider referral issues (availability of specialties), providers-gained-and-lost report, and unplanned network exit report to confirm sufficiency of the type and number of providers	Weekly
Emergency Room (ER) Utilization Dashboard	Continuous monitoring is performed using operational dashboards that measure and trend enrollee utilization, including ER care. These dashboards allow us to identify opportunities to enhance our network by location, disease state, and enrollee type.	Daily
Network Panel Studies	Network panel studies are performed, using the open/closed panel report, to assist in assessing network access and availability needs and identify providers who have reached their capacity	Monthly

Reporting and Monitoring Activity	Data or Report Description	Frequency
Provider Director Audits	These audits confirm the accuracy of provider listings and are used to make weekly updates to online directories, including changes in demographics and panel status	Weekly/Monthly
Provider Appointment Availability Phone Surveys	We query providers on appointment availability, open scheduling, and after-hours care	Annually
Interdepartmental Reporting	We have implemented a formal interdepartmental process that allows Provider Services to collect, trend, and respond to network needs our staff may identify outside of the other data and reporting mechanisms, such as challenges identified by our care coordinators or informal discussions with community organizations, including access or capacity concerns related to special needs	Daily, Weekly, Monthly
Call Center Encounters Data	Our call center collects information regarding enrollee calls about network provider availability and access, and shares the call information with the Provider Services team to assess potential network gaps, barriers, and opportunities for network development	Weekly
Enrollee and Provider Appeal and Grievance Data	We review analysis and trending of appeal and grievance cases to identify potential availability or accessibility issues, perform root-cause analysis, and develop corrective action plans, if necessary	Monthly
Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey	We review and analyze CAHPS survey results and create action plans for opportunities for improvement identified through the survey	Annually

When we identify a network gap or opportunity for enhancement, our Provider Services team formulates a plan to improve the network. The results of our monitoring efforts are reviewed by our Service Improvement Committee, which also monitors any action plans to make sure identified gaps are addressed.

Our goal is to maintain a comprehensive network of traditional and non-traditional providers that demonstrate a pattern of practice that understands the unique needs of our Kentucky SKY enrollees. We continually work to offer our enrollees the highest quality providers in close proximity to where they live, work, and play. Our success is based on our demonstrated commitment to engage and collaborate with key stakeholders, community organizations, providers, enrollees, and their families.

Recruitment Plan

We have been successful in developing and maintaining a mature and comprehensive statewide provider network by listening to providers, enrollees, communities, and system partners, and working collaboratively to develop and implement solutions that address the unique needs of Kentucky. **Our Kentucky Medicaid provider network exceeds the Department's adequacy standards.** We will adopt these same approaches to further develop our network to support Kentucky SKY.

Our strong community relationships with providers, integrated network analysis and

> "KentuckyOne Health and CHI Saint Joseph Health would like to extend full support for Aetna Better Health of Kentucky's bid to remain in the Kentucky Medicaid Managed Care program. Aetna Better Health works collaboratively with our providers to ensure our patients, their enrollees, have access to and receive quality health care services. Our value-based arrangement aligns our organizations around improving the health of the communities we both serve. We are excited to continue this partnership and recommends that the State keep Aetna Better Health as one of their managed care organizations."
>
> **—Lynn Tanner**
> **Vice President of Payer Strategy, KentuckyOne Health**

recruitment processes, and high-touch model of network management assist us in maintaining a network sufficient to meet the needs of Kentucky residents. We will continually monitor our network strategies and implement improvements and processes to provide timely access to culturally competent primary, specialty care, and non-traditional services necessary to promote the Kentucky SKY program.

Our model of provider engagement is designed in support of the philosophy that developing long-term relationships built on mutual trust improves provider retention. Aetna continually looks for **innovative approaches** to engage, satisfy, incentivize, and retain providers. We use performance improvement projects, educational initiatives, community forums, and pilot projects to help providers improve their practices, support system transformation, create better health outcomes for enrollees, and reduce administrative costs and burdens. Examples of strategies to recruit and retain providers include, but are not limited to, the following:

- A dedicated Provider Services call center
- Simplified contracting using streamlined agreements that are fully compliant with Commonwealth requirements, and the ability to sign an electronic agreement using Apttus contract management software, making it convenient for a provider to return and sign their document within hours
- Face-to-face engagement activities including one-on-one meetings with our Provider Services staff to help them understand their managed care contract, Aetna's policies and procedures, how to file claims, and receive electronic payments
- No requirement to submit paper or electronic referrals for services
- Technical assistance and training related to Medicaid managed care claims submissions and the technical interfaces providers will have with Aetna
- Online tools through the provider portal that make it easier for providers to interface with Aetna

Value-based Transformation as an Innovative Approach to Provider Recruitment and Maintaining a Provider Network

Aetna remains committed to continuous quality improvement to fulfill the Department's mission of improving the health of enrollees in a cost-efficient and effective manner. Many high-quality providers find VBP arrangements an attractive means through which to join a network. Through Aetna's value-based payment arrangements, we can incentivize cost, utilization, and quality improvement through a reduction in potentially avoidable events, such as out-of-home placement, unsuccessful family reunification, or juvenile justice recidivism. Using quality and performance measures in the VBP contracts helps us to determine the provider's success, and together we make continuous progress toward the Department's goals for enrollee access to quality care.

> Aetna was the first managed care organization to initiate a partnership with the Children's Alliance-IPA to create and execute a value-based services contract that is designed to incentivize behavioral health care providers to achieve specific outcomes and improve the overall care and well-being of children and families in Kentucky.

As part of our current recruitment and retention strategy, Aetna offers providers a variety of alternative payment arrangements through our **Aetna Better Value** program. To date, Aetna has entered into an alternative payment arrangement with several providers such as Children's Alliance-IPA, the Kidz Club, KVC Health Systems, KentuckyOne Health, and Big Sandy Health Care, Inc., to name a few. **Since 2012, we have grown from 41 provider groups contracted through a VBP arrangement to 581 groups today.** Our programs are customizable, allowing us to combine the most applicable components for a particular provider into a comprehensive and effective, innovative alternative payment model. We will apply these same approaches to support the Kentucky SKY program and system transformation.

Additional recruitment strategies that we will use to close identified network gaps include the following:

- **Monitoring provider facility changes:** Our local provider service representatives have established open lines of communications with providers in their communities. Through these relationships, we

are aware of and able to identify providers who may be considering leaving the network. In these situations, we are able to reach out to the provider before they take formal action and work with them to resolve barriers or concerns to maintain their network status. Additionally, if we receive notice that a provider is leaving a contracted facility or group, we outreach to the provider and attempt to contract with them as an individual provider, when appropriate.

- **Recruiting out-of-network providers:** To proactively provide consistent access to services and avoid gaps in care, we recruit out-of-network providers with whom we have authorized care or executed a single-case agreement. We assess use of out-of-network services on a weekly basis to verify that our network contains adequate numbers and types of providers and use this information to evaluate recruitment opportunities.
- **Recruiting providers through key stakeholder identification:** Enrollees, families, advocates, and system partners, such as Families First, are highly successful in identifying potential providers in the community. Our Provider Services team has successful strategies to recruit those providers into the managed Medicaid network, such as working with providers who have these enrollees in their established panels.
- **Using telehealth and E-consult:** We will utilize telehealth to provide real-time interactive communication between the enrollee, provider, and care team, as well as live video consultation between practitioners to address the enrollee's care plan. The primary care setting has become the gateway to behavioral health services, such as mental health and substance use. PCPs need support and resources to screen and treat persons with low acuity conditions. E-consult provides PCPs access to United States-licensed, board-certified specialists from major academic centers across the country via an electronic health record-linked portal, which increases overall capacity.

a.iii. Strategy for Contracting and Retaining Kentucky SKY Specialists

Through our experience in developing Medicaid networks for child welfare programs, we understand that while many types of service providers are already included in our comprehensive network, an adequate supply of behavioral management specialists, therapists, child and adolescent psychiatrists, and family and peer support workers are needed. Although we will leverage our current network and out-of-network providers who are treating Kentucky SKY enrollees, we know it is not uncommon for the current providers to not offer the capacity and geo-access necessary to meet the needs of the covered population. Therefore, provider recruitment will be essential as early as possible. Prior to and upon award Aetna we will complete a Quest Analytics® review of provider types to determine network needs and to develop contracting solutions. A network of telemedicine and telehealth providers will be a component of our network development plan, especially in addressing access to professional staff in rural areas. Aetna considers several factors when recruiting network providers for this specialty population, including the following:

- Clinical expertise
- Ability to accept new patients
- Potential for high-volume referrals
- Specialties that best meet enrollee needs
- Geographic location: considering distance, travel time, means of transportation, and access for enrollees with physical disabilities
- Expertise in working with the diverse needs of the Kentucky SKY population

A challenge for network adequacy in providing Kentucky SKY services is the recruitment of Therapeutic Foster Care (TFC) providers. Mercy Care, a Medicaid managed care plan administered by Aetna in Arizona, has developed specialized recruitment strategies to increase the number of qualified TFC providers, which will be model in Kentucky. These TFC provider recruitment strategies include the following:

- Sponsoring an annual treatment foster care training and recruitment event that offers trainings for TFC providing families, family foster home providers, kinship, and adoptive families. Providers are there to answer questions and recruit families who are not licensed but are interested in becoming a TFC or foster care provider.
- Working with providers on specialized recruitment and developing individually tailored creative funding based on the needs of a child—for example, paying a TFC home for an empty bed to accommodate the needs of a youth with sexual maladaptive behavior who cannot be placed with other children. Other examples of specialized recruitment to meet the individualized enrollee needs include the following:
  - Placements for victims of human trafficking
  - Use of TFC families who are experienced with adult TFC to better meet the needs youths with psychosis
  - Placements for enrollees with complex medical and behavioral health conditions
- Collaborating with state agencies to reduce barriers to licensing of new FTC homes. Examples of Mercy Care's collaborative activities include the following:
  - Working with the state Medicaid agency to remove the names and addresses of TFC families/providers from the publicly available Medicaid provider database, due to concerns from prospective and current TFC families that public availability of such information may put their families at risk
  - Participating in the Medicaid and child services TFC meetings, which are utilized to develop statewide policies on the administration of TFC services
- Development and effective use of TFC provider reports to identify licensed providers, bed capacity, and specialty providers, and to drive specialty recruitment for specific populations
- Mercy Care is also designing a training series for prospective and current TFC families that will include training focused on youth engagement, TIC, managing aggressive behaviors, and cultural competency

We will leverage the approach the Aetna Medicaid organization uses in its management of Mercy Care in Arizona, which involves using contracts with specialists, that include individualized scopes of work to accommodate the unique nature of services and tailor agreed upon performance and outcome metrics to the specialty provider. For example, in Arizona, Rapid Response providers are utilized to provide priority clinical evaluations for the Department of Child Safety (DCS) for children in the custody of DCS or under in-home dependency investigations. The Rapid Response provider contracts include scopes of work that are tailored to the services provided, program requirements, and performance metrics, such as completion of evaluations within 24 hours for immediate dispatch and 72 hours for all other Rapid Response referrals, and referral of all eligible children for a full behavioral health assessment. We will use a similar approach to work collaboratively with our Kentucky SKY providers to develop tailored performance metrics.

a.iv. Process for Continuous Network Improvement and Ensuring Provider Compliance with Availability and Appointment Requirements

Aetna's network director will be responsible for identifying network gaps and opportunities for improving and monitoring to make sure identified needs are promptly acted upon. SOC staff, including the children and adult SOC administrators, emergency room/crisis administrator, and juvenile justice manager will meet routinely with the network director and provider services liaison to review network adequacy data, identify opportunities for network enhancement and growth, and review the status of the recruitment plan.

Aetna will implement steps to support compliance with required time, distance, and appointment wait time standards under the Kentucky SKY program. All participating providers in our network are contractually obligated by provider agreements to adhere to timely access and appointment standards,

including specific standards for specialty, urgent, and crisis services. In addition to contract requirements and performance metrics, through our financial incentives program, we also offer enhanced payment for those offering after-hours and weekend care. Aetna monitors its providers regularly to determine compliance with these requirements. If a contracted provider does not comply with these standards, we meet with the provider face-to-face and we will also take corrective action through our quality management program structure. Standards for wait times and appointments, disability access, competency, expertise, cultural sensitivity, and hours of operation are communicated through the provider manual newsletters, during site visits, and in training documents.

In addition to our standard monitoring activities, we will monitor compliance with Kentucky SKY requirements through our integrated SOC model to support enrollees and providers. In instances where enrollees are not able to make appointments with the appropriate provider, Aetna care coordinators and Enrollee Services representatives will step in, facilitate the request, and even make the appointment if necessary. In addition, if a provider is attempting to assist an enrollee with getting an appointment with another provider, Provider Services staff will assist in obtaining the appointment so that the enrollee can receive the care they need in a timely manner. We will also provide intensive wraparound services, as appropriate, that are designed to support the enrollee staying in their community.

a.v. Approach to Meeting Access Standards when Care Cannot be Accessed in the Network

As described previously, we continually monitor and assess the adequacy of our network and work collaboratively with external stakeholders and Commonwealth agencies to anticipate care needs to make sure enrollees have access to needed services. **If an enrollee cannot access a pharmacy, hospital, PCP, or other specialist, then the network is not adequate (useable) for that enrollee, regardless of whether our network technically meets the Department's definition of adequate.**

Aetna will comply with the requirements to allow adequate, timely, and medically necessary covered services through a non-participating provider if our participating providers are unable to provide these services on a timely basis. If a qualified provider is available outside of the network for a specialized, medically necessary covered service (such as in a bordering state), we will either contract with that provider or allow the enrollee to seek services from that non-participating provider using a single case agreement. Our Provider Services team engages and encourages non-participating providers to join by conducting telephonic engagement and in-person visits to the provider's office to discuss becoming a contracted provider.

For our enrollees with complex medical needs and who are under the specialty care of a non-participating provider for the entire episode of care (e.g., transplants, rare forms of cancer), the care coordinator coordinates care with the non-participating providers and engages the Utilization Management department to review and authorize services according to the enrollee's care plan. An enrollee being treated for a behavioral health disorder with a non-participating provider follows the same transition plan. Enrollees are educated about how to access out-of-network services through the enrollee handbook, our Enrollee Services staff, and Care Coordination staff. The care coordinator collaborates with the provider, ensuring appropriate care, until we can assist our enrollee by transferring care to an in-network provider or the existing provider contracts to our network.

b. Contracting Specialty Networks

Nationally, for more than 30 years, Aetna has been a leader in partnering with state Medicaid agencies to improve access to high-quality specialty and behavioral health care services. We have broadly developed and continue to carefully manage fully integrated health plans and provider networks for our Medicaid and Medicare Advantage Dual-Eligible Special Needs Plans health plans across the country. Given our

experience in Kentucky and our knowledge of the needs/challenges facing Medicaid and Kentucky SKY populations, we are well-positioned to further deliver our provider network and practitioner solutions to accelerate the transformation of the health care delivery system in Kentucky.

Example of Contracting a Similar Network

Mercy Care, a Medicaid managed care plan administered by Aetna in Arizona, has developed an extensive specialty provider network to support populations similar to those who will be served in the Kentucky SKY program, including children and youth in Arizona's foster care system. Mercy Care's provider network is designed to encompass a comprehensive set of services available through traditional and non-traditional specialty service providers. Examples of specialty services providers available to Mercy Care enrollees include the following:

- **In-home and community-based services:** These services are offered in varying intensity level levels and are designed to assist in keeping children and families together; they support families with children that are at risk of being placed out of home and have frequent use of crisis services and hospitals or are involved with juvenile justice. In-home and community-based services providers also include adult and youth peer support providers who are individuals with experience receiving behavioral health or services through one of the child-serving systems, respectively, and who have completed State-approved certification training.
- **Parent services:** A variety of specialty providers are contracted to offer a range of services to parents and other family supports, which are aimed at improving outcomes for children and maintaining children in their home environment, through parental education, counseling, and supportive services. Providers of parent services include counselors experienced in facilitating group discussions, using role-play technics, and providing parents with training on topics such as TIC, active parenting, Mental Health First Aid, self-care for the caregiver, and navigating the child welfare and juvenile justice systems. Parent and family support providers who are individuals with personal experience raising a child with behavior health and involved in one or more of the child-serving systems are also utilized to assist and support families in navigating the system.
- **Phase-of-life services**: These services are designed to meet the needs of children and youth based on various developmental stages. Examples of specialty providers that used for phase-of-life services include, non-licensed individuals, acting under the supervision of independently license behavioral health professionals, who are trained to provide education and training to transitional age youth (age 16 to 18+) on topics such as job preparedness, independent living skills, college preparation, and to provide employment support.
- **Sexually maladaptive behaviors:** Specialty providers experienced and knowledgeable in therapeutic interventions, such as cognitive treatment intervention and Multi-Systemic Therapy for Problem Sexual Behaviors are available to provide services designed to address sexually maladaptive behaviors. These specialty providers include providers who are knowledgeable in family-centered treatment modalities to facilitate family preservation or reunification when appropriate.
- **Stabilization services:** There are a range of stabilization services that are supported through contracts with several different specialty providers. These include child crisis hospital teams, crisis response for youth that are dually diagnosed, inpatient children behavioral health facilities, and outpatient peer parent and family support service providers.
- **Substance use disorder treatment:** Specialty child and youth substance abuse providers include providers who are knowledgeable and experienced treatment approaches, such as Adolescent and Community Reinforcement Approach, Multisystemic Therapy, and Functional Family Therapy.

Mercy Care has been successful in developing and growing these services through the use of community and provider collaborations and ongoing efforts to support innovative services programs and practices, that are supported by flexible contracting strategies. These specialty provider contracts include scopes of work that are tailored to the services and the populations being served by each provider. These scopes of

work include provider-specific performance metrics and outcomes goals, including standards and requirements. Mercy Care routinely monitors provider performance against the agreed upon metrics, which allows for early detection of concerns to avoid significant issues.

Kentucky SKY Network Work Plan

Upon award, and commencement of implementation, Aetna will continually assess the current state of available providers who are experienced in working with this population, identified opportunities for network development, and has begun working with key stakeholders, communities, and providers to enhance enrollee choice. We understand the network plan must support the SOC initiatives and goals to achieve the following:

- Develop network providers equipped to deliver intensive in-home services, such as behavior coaching to aid in keeping kids in their homes and current placements.
- Identify and implement innovative programs, such as KVC Health Systems—a therapeutic foster care program that works to stabilizes children and youth in crisis foster care setting with reunification within 30 days.
- Support the transition and development of coordination of care mechanisms with Developmental and Intellectual Disability system providers and waiver organizations.
- Continue to identify VBP opportunities, such as our contract with the Children's Alliance-IPA and the Kidz Club, as a mechanism to increase access to and improve the quality of behavioral health services and treatment of medically complex children.
- Expansion of our Community Pharmacy Enhanced Services Network to include foster care population, which utilizes community-based pharmacies that develop relationships with our enrollees and support medication management, social determinant needs identification, and care coordination to support effective care coordination and quality driven outcomes.
- Working to expand training for dental providers on adverse childhood experiences screening to recognize the impact of trauma and make appropriate referrals.

Innovative Approach to TFC

Aetna has initiated a VBP contract with KVC Health Systems, who is implementing a model of TFC Support Home services that focus on intensive wraparound services and supports to successfully stabilize and reunify foster children in their homes. This model was carefully selected as the family-centered, evidence-based practice for Kentucky foster care youth and families. Wraparound service philosophy includes implementing a flexible, team-driven continuum of services using natural supports and community resources. It is individualized, strengths-based, and aligns with the complex needs of vulnerable youth and families. This model promotes the collaboration needed to create long-lasting, effective change and promote timely reunification and permanency for foster children.

We have established a provider work plan to contract with additional Kentucky SKY network providers, that include accountabilities and timelines, which is included in **Attachment X**. The workplan includes key activities to support the development of the Kentucky SKY provider network including, conducting ongoing comprehensive network gap assessments, implementation of recruitment activities, provider enrollment in Kentucky Medicaid, credentialing and contract negotiation, onboarding, and training.

Given the complex needs of our Kentucky SKY enrollees, our network of provider partners extends well beyond traditional facilities, clinics, and practitioners to include specialists, sub-specialists, physicians with extensive training and experience managing complex care cases and have demonstrated best-in-class health care outcomes. We also carefully select community advocates, peer and professional support organizations, specialty pharmacies, and families and caregivers. By leveraging our already established comprehensive Kentucky Medicaid network, our local knowledge and established provider relationships, and our vast national experience building networks, we will improve outcomes for Kentucky SKY enrollees.

High-need/high-cost enrollees often have a high incidence of complex comorbid medical conditions (e.g., diabetes, chronic obstructive pulmonary disorder) that are poorly managed, including behavioral health, substance use, and developmental delays. They are also at increased risk for involvement with DCBS, DJJ, SDOH, and use of crisis services. Identifying and supporting enrollees with complex medical, behavioral health, developmental disabilities, and life care issues requires unique and innovative approaches to maintain enrollee wellness and maintain family stability. These innovative approaches include the following:

- Developing relationships with detention centers, law enforcement, and courts to assist in coordination or care and transition from the juvenile justice system, including using technology and information data exchange to identify and engage incarcerated enrollees.
- Developing with our providers a crisis transition navigator peer program to assist Kentucky SKY enrollees in transition from higher levels of care
- Establishing an opioid taskforce, including potential pharmacy lock-in programs, to better address the opioid crisis consuming our youth and emphasis through our integrated system of care to deliver enrollee-centered, local, and culturally responsive solutions to at-risk Kentucky SKY enrollees.
- Proactive identification of at-risk enrollees and management of behavioral health conditions to prevent crisis, minimize additional trauma to enrollees, and prevent or minimize emergency room use.
- Utilize holistic approaches to managed care, such as those aging out of the foster system or children who are at-risk following adoption or lingering trauma, each of which demand clinically focused supports and care to bring about positive care outcomes and resiliency

Our locally based network teams have already begun the early identification of providers within our networks who are qualified and trained to provide covered services that are accessible, person-centered, and evidenced based for our Kentucky SKY enrollees. Ensuring network adequacy at all times throughout the service area but also ensuring we have the right providers for Kentucky SKY enrollees within the right system of care, we believe is the best approach to meeting the unique care needs of Kentucky SKY enrollees. Our network development plan revolves around the following solutions and approaches:

- Enrollee choice must be maximized when selecting providers for their health care, including location, access, cultural sensitivity and awareness, being trauma-informed and trauma-prepared, as well as more subtle aspects of rapport, trust, mutual respect, emphasis on specialized care, and successful paths to wellness and recovery.
- Health care is delivered locally; therefore, we account for the unique patterns in which Kentucky SKY enrollees in both urban and rural communities seek care and how providers in these communities manage Kentucky SKY enrollees.
- Accountability, transparency, and tireless monitoring and engagement by both Aetna and providers will drive improved outcomes throughout all parts of this segment of the delivery system.
- High-touch provider relations supports and population health specialists clinically trained to advance care improvement initiatives within the physician practice setting builds strong, lasting, and dependable relationships that ensure strong outcomes for Kentucky SKY enrollees.
- Local network teams carefully situated where our providers practice and Kentucky SKY enrollees seek care allow for network development and provider engagement that is agile and effective and goes beyond transactional support.

Central to our network development plan is an understanding of what we are truly working towards, a comprehensive system of care that is centered on Kentucky SKY enrollees and their needs. As we continue to build our specialty and behavioral health network of providers for Kentucky SKY enrollees, we employ the following key elements as shown in **Table G.6-3**.

Table G.6-3: Network Development Overview

Task	Network Development Activities
Assess	• Assess estimated number of Kentucky SKY enrollees within each county, city, and ZIP code (prior to award) • Identify all additional providers needed for Kentucky SKY network of providers throughout the Commonwealth • Evaluate current and expected utilization of specialty services considering the unique health care needs of Kentucky SKY enrollees • Analyze demographics, cultural, language, race, ethnicity impacting Kentucky SKY enrollees • Analyze Quest Analytics coverage of our current network and isolate where additional specialty providers are needed to serve Kentucky SKY enrollees.
Identify	• Provider contracting and Provider Experience team to outreach providers with contracting • Value-based solutions, care coordination integration for innovative engagement, and accessibility processes • Contracting templates, introduction materials, FAQ program guides, and provider manual materials that address the Kentucky SKY program
Engage	• Recruit identified and qualified providers • Work with providers in the current network to provide enhanced services; expand hours of operation and service offerings to support Kentucky SKY enrollees • Recruit vendor and ancillary providers such as non-emergency medical providers for specialty care needs of Kentucky SKY enrollees • Establish a Provider Advisory Board • Leverage and expand existing relationship with providers, facilities, advocacy groups, and associations for specialty access and care programs • Collaborate with state and local leaders for establishing a governance board of advisors
Monitor	• Monitor current network against targets based on business analytics to ensure provider adequacy, accessibility, and acceptance of Kentucky SKY enrollees • Review metrics, including time/distance access standards, timely scheduling of appointments, hours of operations, panel capacity, and wait times • Incorporate Integrated Health Neighborhood experiences to Kentucky SKY network of providers to better refine network configuration • Enrollee and provider satisfaction surveys to analyze and modify program to ensure satisfaction

The Aetna network development strategy delivers a system of providers that extends beyond routine network accessibility. Our design to support a network of providers for Kentucky SKY enrollees carefully considers their unique care requirements and leverages the service and provider options throughout Kentucky to deliver an innovative delivery system as indicated above and within the time and accountable requirements as described in our network work plan in **Attachment X**.

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60.7.G.7 Provider Services

Kentucky | Transforming Health Care | **Aetna**

60.7.G.7 Provider Services

A positive and collaborative provider experience is in our DNA. We bring to Kentucky our national expertise and experience in creating new and innovative ways to collaborate with providers, creating a new culture and mindset about delivering high-quality, integrated care to children and youth in foster care, adoption assistance, and juvenile justice populations and their support systems. Our dedication to be a collaborative, responsive and innovative partner to state agencies, enrollees, providers, community-based organizations, and other stakeholders defines us as a loyal organization driving the statewide mission to ensure access to and improve delivery of high-quality, cost-effective health care services.

Aetna's provider services representatives (PSRs) are the cornerstone of our provider outreach and engagement activities. In the past eight years, Aetna's Medicaid organization has developed an in-depth understanding of Kentucky providers and enrollees at the state, regional, and local levels. We have actively recruited provider representatives and network operations staff who have worked for providers, know Kentucky Medicaid, and live in the communities where they work. Our PSRs are embedded in the community to ensure strong and collaborative provider relationships and will support coordination with care advocacy groups. To further support our providers, we have dedicated behavioral health network management and operations staff who understand the nature of behavioral health services and can respond to the unique experience of behavioral health providers. **Our provider services liaison has 15 years of experience working for and with Kentucky's behavioral health providers**.

> Aetna's highly trained and experienced Provider Services team of 15 staff have combined 200 years of experience working in provider offices, and over 115 combined years of experience in Kentucky Medicaid.

Approach to Provider Outreach and Education

Our approach to provider orientation and education is to give our providers the information they need in the most convenient method available. Aetna's Kentucky SKY provider training program will be designed to aid providers in delivering high quality of services to meet this population's unique needs, while minimizing provider burden. Aetna's director of stakeholder engagement and education will be responsible for developing and maintaining the Kentucky SKY Training and Education Plan and will coordinate with the Training Collaborative, Governance Board, and other stakeholders to identify opportunities and needs for initial and ongoing training.

Aetna has implemented several activities to engage our providers when they initially contract with us and on an ongoing basis. Our formal initial engagement practices include sending our welcome packet, which is an effective way to convey important information quickly and in a functional, easy-to-follow format. Our welcome information is sent within five days of becoming a contracted provider and includes information about how to attend our provider training orientations and information/instructions on how to access our provider manual and portal. The welcome packet also includes a welcome letter, orientation schedule, identification of and contact information for their assigned PSR, as well as contact information for all PSRs, copy of the provider contract, and portal enrollment forms.

Our PSRs directly contact new provider either in person or by phone to begin establishing a relationship and to review any questions or concerns the provider may have. Additionally, PSRs will have personalized greeting cards that they will give to any newly assigned providers. As show in **Figure G.7-1**, these greeting cards include the PSR's picture, contact information, and brief biography, as well as key contacts.

aetna BETTER Together

Abbi Wilson
Network Manager
Email: Wilsona8@aetna.com
Phone: 270-816-0893

Our approach to working with providers is based on our Aetna Better Together philosophy. Our Network Relations team works with partners like you every day to create a community built on quality, relationships, growth and collaboration.

Abbi Wilson is an experienced Network Manager for Region 4. Abbi's responsibilities include educating and supporting our providers as they serve the medical needs of Kentuckians. Driven by a desire to connect members to the best possible care, she takes pride in providing the best possible service. Abbi has 19 years' experience in the provider setting and 6 years' experience in Medicaid managed care. Abbi is excited to service our providers located in Region 4, including providers in the state of Tennessee.

Abbi enjoys playing the piano and spending time with her two small children. She holds her Bachelor of Science degree in Management from Western Kentucky University.

Our toll-free number **855-300-5528**

aetna

Caller Type - Press star for Provider

Claims (option 1)
- Check Status (option 1)
- Submit (option 2)
- Something Else (option 3)

Eligibility/Benefits (option 2)
- Medical (option 1)
- Vision (option 2)
- Dental (option 3)
- Mental Health (option 4)
- Something Else (option 5)

Authorizations (option 3)
- Submit One (option 1)
- Concurrent Review (option 2)
- Retro Review (option 3)
- Peer to Peer Review (option 4)
- Fax Authorization Request (option 5)

More Options (option 4)
- Report Fraud and Abuse (option 1)
- Pharmacy Help Desk (option 2)
- Care Manager (option 3)
- **Provider Services** (option 4)
- Something Else(option 5)

Claim Submission Information
EDI Payer ID (Claim): 128KY
P.O. Box 65195
Phoenix, AZ 85082-5195

Secure Web Portal: http://aetnabetterhealth.com/kentucky
* Claim status * Remittance Advice * PCP roster of members * Verify member eligibility * Request authorizations * ERA & EFT submissions

Network Relations
Email: KYProviderRelations@aetna.com
Aetna Better Health of Kentucky
9900 Corporate Campus Drive, Ste 1000
Louisville, KY 40223

Prior Authorization
Medical Phone 888-725-4969
Medical Fax 855-454-5579
Behavioral Health Phone 888-604-6106
Behavioral Health Fax 1-855-301-1564

Dental / Vision
Avesis—855-214-6776

111.ky19

Figure G.7-1: Provider Services Representative Greeting Card

Our PSRs foster close, collaborative relationships to better engage, support, and listen to our providers.

Aetna continues to engage our providers through the following:

- **Site visits (face-to-face):** Our PSRs visit each hospital on monthly basis and visits the individual primary care provider and specialist offices at least once a year. We offer ad hoc trainings on topics such as basic billing and provider re-orientations via internal or external request.
- **Provider scorecards:** We will utilize provider scorecards to allow appropriate trending and provide feedback to address areas of opportunity.
- **Training webinars:** We have a provider education plan that includes a new topic each month. Supplemental trainings are routinely offered and hosted via webinars. To improve provider access to the orientation information and training, Aetna is in the process of making pre-recorded trainings

available to providers, so they and their staff can complete the training at times that are most convenient to the provider and when staff turnover occurs.

- **Email blasts:** We notify providers of policy and program changes through email blasts that are sent as frequently as needed, and PSRs follow up to reiterate and confirm providers received the information and address any questions.
- **Newsletters:** Providers receive education and updated information through our quarterly newsletter.
- **Feedback from our call center:** We utilize call center data to track, trend, and identify opportunities for additional provider education topics.
- **Appeals and grievances analysis:** Upon review of appeals and grievances, we provide education through outreach to individual providers, newsletter articles, and email blasts, and use trends to inform topics included in our provide training plan.

Aetna's Kentucky SKY provider training will be developed and implemented in a collaborative manner that aligns with the direct care service delivery model. The director of stakeholder engagement and education will be responsible for relationship management, including obtaining recommendations and any required approvals from the Department, the Department of Community Based Services (DCBS), the Department of Juvenile Justice (DJJ), Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and the Kentucky Department of Education on relevant information for training modules. The director of stakeholder engagement and education will also be responsible for instructional design/curriculum development, knowledge of State systems, assessment of community training needs, and outcomes. The director of stakeholder engagement and education will identify necessary competencies and associated training needs for the new model of care and address identified gaps in training, incorporating provider identified training needs. Provider training needs will be identified via surveys and quarterly meetings and close collaborative relationships with providers. Additional provider training needs will be identified through a variety of means to include but is not limited to town hall listening sessions with providers immediately following contract award, face-to-face sessions, and webinars for less populated areas. Provider sessions will re-occur with program or staffing changes and will include frequently used providers across state borders.

Innovative Solutions through Provider Collaboration

Through a formal partnership with Kentucky Youth Advocates (KYA), we will work with Commonwealth agencies, providers, child welfare organizations, and consumers across Kentucky on innovative solutions to transform care for the Kentucky SKY population. KYA is an expert in building effective coalitions that advance systems-level changes and offers a wealth of expertise in the child welfare arena. The organization is already partnering with DCBS and Casey Family Programs on several initiatives related to advancing Families First in the Commonwealth. KYA is an ideal collaborating agency as we are in alignment on objectives related to strengthening families, keeping kids safe, enhancing supports for kinship families, and promoting resiliency and stability for youth that are in or aging out of foster care.

We conduct new provider orientation training within 30 days of the provider joining the network. Materials are sent directly to the provider and reviewed during either an onsite or webinar-based meeting. Training and education materials and toolkits will, at a minimum, be available to providers through a variety of resources including live and pre-recorded WebEx training, individual provider onsite training and telephonic outreach, email blasts, and provider notices.

We understand that providers are our most valuable service delivery assets. Our job is to empower them by providing education, assistance, and the resources needed to achieve quality enrollee engagement. We will focus our ongoing Kentucky SKY provider training initiatives to support providers as they evolve their practices to better meet needs of the Kentucky SKY enrollees and to improve system coordination and transformation. Our SKY training and education plan will be a living document that changes to

respond to system transformation and provider needs. A description of new and ongoing trainings is contained in **Table G.7-1**.

Table G.7-1: New and Ongoing Provider Training

Training Topic	Training Description/Topics Included
New Kentucky SKY Provider Training	
New Provider Orientation	Aetna's new provider orientation training covers a broad range of topics designed to make sure new providers understand program requirements and how to access resources. Topics include a Kentucky Medicaid overview; Provider Services and Enrollee Services functions and contact information; the provider website, secure provider portal, and provider manual; covered services including medication coverage and prior authorization, medical prior authorization, authorization timelines, and medical necessity; claims processing including clearinghouse, clean claims, and claim submission; fraud, waste, and abuse; provider communications; enrollee rights and responsibilities, access and availability standards, cultural sensitive standards, non-discrimination, and reasonable accommodations for enrollees with disabilities; medical record standards; appeal and grievance; population health programs; and Healthcare Effectiveness Data and Information Set.
Kentucky SKY Orientation	The Kentucky SKY new provider orientation educates providers on system transformation and design, as well as program requirements. Topics will, at a minimum, include the following: roles and responsibilities of the Department, DCBS, DJJ, and DBHDID and Aetna and how Aetna coordinates and collaborates with these agencies; Family First Prevention Services Act, and other federally mandated services and programs impacting Kentucky SKY enrollees; Kentucky SKY covered services and the provider's responsibility for providing and coordinating services, with special emphasis on Kentucky SKY-specific requirements that vary from Medicaid coverage and processes; aging out process and support available through Aetna; and continuity of care training will emphasize Healthcare Insurance Portability and Accountability Act requirements support compliant sharing of enrollee health information.
Requirements for Providing Health Care Services and Behavioral Health Care Services to Kentucky SKY Enrollees	The purpose of this training will be to make sure providers serving Kentucky SKY enrollees understand specific requirements applicable to this population. Training topics will at a minimum include the following: medical consent requirements; required timelines for services and assessments; specific medical information required for court-ordered requests and judicial review of medical care; appropriate utilization of psychotropic medications; evidence-based behavioral health treatment interventions and specific behavioral and physical health needs of the Kentucky SKY populations; trauma-informed care; child and adolescent needs and strengths; crisis intervention services; high-fidelity wraparound approach; impact of adverse childhood experiences (ACEs); neonatal abstinence syndrome (NAS); substance-exposed infants; screening for and identification of behavioral health disorders; Care Coordination teams for Kentucky SKY enrollees and how to access the care coordinator; and performance measures and health outcomes.
New and Ongoing Kentucky SKY Provider Training [1]	
Foster Care Behavioral Health Navigation Forum	This will be a monthly forum for foster, adoptive, kinship, and group home caregivers to learn about the behavioral health services available to children and youth in foster and adoptive care.
Foster, Adoptive and Kinship Training Series	This will be a 3-part monthly training series covers an overview of trauma-informed care (TIC), trauma-informed care birth to age 5, and trauma-informed care strategies and techniques.
Child and Family Advisory Partnership Community Forum	These forums will be used to connect foster, adoptive, kinship, and group home caregivers to what is happening in the local behavioral health community and offer an opportunity to talk directly with providers. Attendees will be encouraged to share ideas on how to improve the delivery of care to enrollees, their families, and supports.

[1] Aetna Better Health of Kentucky along with Mercy Care, an Arizona Medicaid MCO administered by Aetna, will collaborate with the Department, DCBS, DJJ, DBHDID, and Department of Education to modify and adopt the following successful training materials for the Kentucky SKY program.

Training for Youth Transitioning	This will be an ongoing development of training and support tools that assist Kentucky SKY providers in meeting the needs of youth transitioning through the DCBS. This will also include support and training for DCBS staff in working with providers to meet the specialized needs of youth who are struggling with placement stability. Training will include such topics as understanding the behavioral health support that can be offered for youth and how to reach out to obtain services and supports through the Care Coordination teams.
Sex Trafficking 101	Aetna will work with Kentucky law enforcement to develop and offer training on human trafficking, including training on meeting the complex behavioral health and support needs of this population. Mercy Care, a Medicaid managed care organization administered by Aetna in Arizona, implemented a similar initiative and has provided training to foster/adoptive/kinship caregivers, Department of Child Safety (DCS) group home providers, law enforcement, family advocacy centers, hospitals, DCS staff, behavioral health providers, judges, court staff, juvenile probation, attorneys, and others. These trainings have significantly supported the referral of youth to the collaborative as indicated by the increase of referrals from participants of the trainings. The services and supports from a trained and committed provider network has assisted in the development of stable, supported placement options for youth, dramatically decreasing the number of youth enrolled with Comprehensive Medical and Dental Program, the health plan for Arizona's children in foster care, that leave without permission to less than 10%.
LGBTQ Cultural Competency	Aetna understands there is a disproportionate degree that lesbian, gay, bisexual, trans/transgender, intersex and other sexuality, sex, and gender diverse (LGBTQ) represented in the foster care system. To best address the needs of LGBTQ enrollees in foster care, care coordinators and foster parents will need training and experience working with this population in order to have a robust understanding of the cultural values and practices within the community. This training will be designed to make sure providers are trained and demonstrate skills to serve the LGBTQ population; to provide appropriate screening of enrollees for behavioral health needs since they are at a higher risk; to provide education on addressing discrimination at both an individual and system level; and that providers understand language is essential, such as using correct identifying pronouns, and that forms and resources account for diverse perceptions of sexuality, sex, and gender; and to understand that strict confidentiality practices are critical to creating an inclusive and safe environment for LGBTQ enrollees.

In addition to the trainings identified in **Table G.7-1**, we will collaborate with the Department, DCBS, DJJ, DBHDID, and Department of Education to identify additional training topics such as abuse and neglect, infant, child, and adolescent development, the impact of foster care on families and children, managing significant behavioral and psychiatric disorders in cooperation with mental health professionals, the child and family welfare system and its policies and procedures and how to navigate through its bureaucratic structure, working closely with health care managers, adoption competency, and family-based sexual trauma competency.

Policy and program changes are communicated to providers in a timely manner (e.g., periodic newsletters and email blasts) along with additional trainings. Supplemental trainings will be available upon request or if a provider is identified as needing more direction and guidance through enrollee, provider, or quality improvement committees, or as requested by the Department. Technical assistance may also be provided via the phone, face-to-face, webinar, forums, and other available channels. Following training, PSRs will follow up with providers to address any questions they may have and to make certain they know how to reach us for assistance.

Description of Proposed Training Materials

Our training materials will be developed to give providers the information they need to effectively coordinate care, understand, and access system partner programs, and implement evidence-based care to meet the unique needs of Kentucky SKY enrollees. A description of key training materials includes the following:

- **(a) Coordinating services:** This training will support the goal of improving outcomes for children and youth in foster care through educating providers on key aspects of effective service coordination. The training will address the following:
  - Risk indicators that lead to foster care involvement and interventions based on identified risk factors, such as child characteristics (age, race, ethnicity, etc.), existence of maltreatment, family dynamics and characteristics, caregiver characteristics, and community, neighborhood, and available resource characteristics
  - Integration of all elements of care under one umbrella, including physical and behavioral health, social elements, and trauma-informed care, building success and longevity by adapting and alleviating those health concerns
  - Partnering with community-based organizations to augment primary prevention activities, and to assist in implementing and adopting solutions to meet family needs through formal and informal supports
  - Coordination of services with other providers of non-covered services, such as schools and educational institutions
  - Individualized, person-centered care planning
- **(b) Care Coordination teams (CCTs):** CCT training will be focused on making sure providers have the information to effectively participate in and coordinate with enrollee CCTs. The training will provide information, including to the following:
  - CCT members and their roles and responsibilities
  - Utilization of peer navigators to aid those in foster care to navigate their health, behavioral, and social needs, with an emphasis on resiliency and goal setting
  - Orientation to available resources, including how to access such resources, and resources for specific populations
- **(c) TIC:** Becoming a trauma-informed organization requires committing to organizational transformation over a period of years. We have adopted a model with six levels to identify providers at different stages of development and to recognize progression over time and will provide training based on the provider need and stage of development. Sample materials for our TIC training are included in **Attachment Y.** TIC training will address model design features including the following:
  - Integration of all personalized health domains in one model, including intersectionality of TIC and social determinants of health, cultural competency, health equity, and systems of care
  - Prioritization of the enrollee's experience
  - Integration of behavioral and physical health, mirroring broadly accepted Substance Abuse and Mental Health Services Administration model
  - Utilization of a simple start and be agnostic regarding the model or approach, to minimize entry barriers
  - Information on the behaviorally anchored descriptions of each TIC level
  - Information on incentives and value-based payments, that may be available, related to progression through the six levels and achievement of performance metrics and outcomes.

TIC Credentialing Model Design

- **Trauma Aware:**
  - Level 1—Foundational Awareness
  - Level 2—Enhancing Routine Clinical Practice
- **Trauma Informed:**
  - Level 3—Basic TIC
  - Level 4—Advanced TIC
- **Trauma Transformed:**
  - Level 5—Close/Full Collaboration in a Merged Practice
  - Level 6—Trauma-informed System of Care

- **(d) Crisis services:** The goal of this training will be to educate Kentucky SKY providers on available crisis services to make sure providers are equipped to appropriately identify and support enrollee access to such services when needed. Training materials will include the following:
  - A description of available crisis services, guidance on applicable service criteria, and how to access or refer enrollees and their families to such services.

  - Identification of risk factors, such as suicide, self-harm, sexual assault, medical advocacy, and human trafficking.
  - Information on rapid response services to make sure children and youth entering the foster care system are appropriately and timely assessed for behavioral health needs
  - Information on services designed to support families at risk of separation and avoid placement into foster or residential care.
- **(e) Child and Adolescent Needs and Strengths (CANS):** Our CANS training materials will teach providers how to effectively conduct a CANS assessment and incorporate the assessment outcomes into a personalized integrated care plan. Providers currently receive training on CANS through DCBS. Aetna will coordinate with DCBS on transitioning this training and to obtain DCBS's insight and feedback on effective approaches to delivering this training, based on their experience.
- **(f) High Fidelity Wraparound Approach:** This training will be provided by care coordinators who are certified in the High Fidelity Wraparound model for assessing and providing individualized, comprehensive, home- and community-based care designed to avoid long-term out-of-home care or hospitalization. The training materials will include information on the following:
  - Development of a single plan of care to address the problem of system fragmentation, extended timeframes for decision-making, and addressing conflicting goals and redundant services
  - Utilization of natural and community resources, rather than sole reliance on clinical services, with a strength-based, youth- and family-focused approached
  - Focusing attention and action on both the response to the impacts of multiple systems and response to biological and neurological needs critical for healthy childhood development and the development of resilience
  - Roles and responsibilities of team members, including the are coordinator's role in assisting the family with designing a team of people comprised of natural members (non-paid family connections) and professionals who participate on a CCT
- **(g) Impact of ACEs:** This training will be designed with the goal of making sure providers understand the impact of ACEs, are equipped to detect the signs of ACEs, and have the tools and techniques to reduce toxic stress associated with ACEs. The training materials will include an overview of the model, as well as the model components.
- **(h) NAS:** The goal of this training will be to better equip our providers with the background, knowledge, skills, and best practices to address the impacts of NAS on families and infants. Aetna has a NAS pilot focused on reducing the tragic impacts of NAS on families and infants, including driving child welfare placements. We are currently studying an innovative early identification and care coordination pilot, and early results are demonstrating success measured by adherence to medication-assisted treatment and/or counseling and avoiding foster care placement. Our training materials on NAS will continue to be updated based on the findings of our pilot and emerging best practices.

> Aetna is collaborating with the **Bounce Coalition**, based in Louisville, to help build children's resilience to toxic stressors and keep our children thriving throughout their life. This collaborative will work with the coalition as they move to educate rural communities on ACEs. Bounce's goal is to develop a trauma train-the-trainer program to create a system of sufficiency.

- **(i) Six Seconds Emotional Intelligence (SEI):** Provider training on SEI will provided with the goal of improving the development of collaborative relationships between providers, parents and guardians (including foster and adoptive parents), the Department, DCBS, DJJ, CASAS, judges, law enforcement officials, and other Department sister agencies. Training materials will include information on the SEI assessment and how to utilize the SEI model to support development of collaborative relationships and achieve improved health outcomes for Kentucky SKY enrollees.
- **(j) Screening for and identification of behavioral health needs:** Aetna's initial orientation training provides overview on integrated care, including but not limited to appropriate utilization of basic

behavioral health screens in the primary care setting and basic physical health screenings for the behavioral health special needs of the enrollees the provider serves. Examples of evidence-based tools that will be included in the training materials include the Brief Screener for Alcohol, Tobacco, and other Drugs, the Screening, Brief Intervention, and Referral to Treatment for substance use, and the PHQ9 (Patient Health Questionnaire-9).

- **Fictive kin education and training resources:** This training will focus on making sure providers are equipped to work with foster and adoptive families, as well as others supporting children and youth, to connect them to educational resources designed to support those caring for the child. Training topics may include youth engagement, TIC, managing aggressive behaviors, and cultural competency.

We understand the importance of an effective training program to support the system transformation, and will engage in ongoing collaboration with providers, key stakeholders, and partners to make sure our training program evolves to meet the changing needs.

60.7.G.8 Covered Services

Kentucky | Transforming Health Care | **Aetna**

60.7.G.8 Covered Services

Our dedication to being a collaborative and innovative partner to state agencies, enrollees, providers, community-based organizations, and other stakeholders defines Aetna as a loyal organization driving the statewide mission to create a healthier Kentucky. The assessment for and identification of health and developmental needs of children is best practiced with parents, relatives, or other primary caregivers. Children's needs are best understood in the context of their family and community. The assessment of a child after placement in foster or residential care away from the family may provide a narrower view of the child's functioning or exposures to doses of adversity across critical periods of development. Further assessment of the family and community is an additional opportunity to gather information about the presence of resilience and protective factors buffering the impact of adversities on the child's development and health trajectory.

Aetna's transformative vision drives our model for enhanced care coordination and service integration supporting the children/youth in foster care, adoption assistance, and juvenile justice populations. Youth enter the Kentucky SKY program in various ways, including the following:

- Directly from parents or caregivers
- Community service organizations
- School systems
- Department for Community Based Services (DCBS) social workers
- Department of Juvenile Justice (DJJ)
- Medical providers

> Leah Rembold has been a foster parent in Kansas for seven years. She talks about Aetna Better Health of Kansas' level of engagement: "This is the first time I have received a phone call from an insurance company and had a face-to-face visit and I really appreciated the support."

a. Approach for Completing Required Assessments and Screenings

Aetna's approach for completing required assessments and screenings is person-centered and strength-based. Kentucky SKY enrollees will be assigned a care manager who functions as a single point of contact, initiates necessary assessments upon enrollment, and leads the Care Coordination team (CCT) to manage all enrollees' needs through persistent outreach efforts via telephone, email, and face-to-face visits. Understanding that repetitive telling their story can become a re-traumatizing event, Aetna care coordinators will take every step to collaborate with case workers at DCBS and DJJ, with families, school systems, and providers to make sure that assessments are completed in a manner that minimizes duplication. Remaining conscious of the child's clinical presentation at the time of enrollment, we will make certain the completion of assessments and screenings for all Kentucky SKY youth upon enrollment program meet the requirements specified in **Section 4.26 of the DCBS Standard Operating Procedure Manual**.

Aetna recognizes that Kentucky SKY enrollees may have, or may be at high risk for, a chronic physical, developmental, behavioral, social, neurological, or emotional condition requiring a broad range of evidence-based primary, specialized medical or behavioral health, and/or related services. These needs are assessed at the initial contact with the Kentucky SKY enrollee and their circle of support and on an ongoing basis as circumstances change.

Aetna believes it is important to get the enrollees into care quickly. We also understand that a lengthy and cumbersome intake process can be counterproductive to a child who may be in crisis or has urgent needs. The most important goal for the initial contact with the enrollee is to build trust in the service provider and to stabilize the crisis. The initial screening process is modified if the youth is experiencing a crisis.

Prior to any assessments conducted in Kentucky SKY, children and families experience engagement conversations that effectively establish relationships based on trust and hope for a better future. All

screening and assessments will fare better when relationships are forged based on values and a shared vision of a better life. After full and deep engagement, explanation of the purpose for each tool, translation services and support for completing them, and families and youth tend to adhere to regulatory timelines for all documentation.

a.i. Coordination with Kentucky SKY Enrollees, the Department, DCBS, DJJ and Families

Aetna care coordinators will engage outside stakeholders, including DCBS and the DJJ, and members of the child's circle of support to ensure the successful completion of required assessments and screenings for Kentucky's kids involved in the child welfare system, always with permission from the enrollee's guardian. This coordination allows Aetna care coordinators to gather pertinent information related the youth's social history, medical history, education needs, etc., that will be added to the information gathered in Aetna's initial screening to identify the most appropriate course of care and to initiate urgent referrals to services that support immediate stabilization. Being proactive in our outreach ensures all individuals working with the youth and associated stakeholders have a single point of contact at the health plan. This is a resource of support for state social workers, DJJ workers, or foster/adoptive parents who may experience a barrier to their child receiving care. It is critical for the assigned Kentucky SKY care coordinator to conduct outreach at initiation of the referral into services. The DCBS workers have access to critical information about the youth's history that will be important to gather prior to or at the initial screening.

> "I really appreciate the support that Aetna care coordinators are providing. This is the second Aetna care coordinator that I have gotten to work alongside and historically I have never had an managed care organization (MCO) even give me a call. I hope that I am able to work more with Aetna care coordinators in the future."
>
> **—Sarah Meier, Foster Care Case Manager**
> **St. Francis Ministries (Kansas)**

If the enrollee is determined by the Department as medically complex, the initial screening process will differ slightly than for other Kentucky SKY enrollees. **Figure G.8-1** details the front-end process flow on initial screening and assessment processes for the Kentucky SKY enrollees determined medically or behaviorally complex. **Figure G.8-2** details the process for non-medically or behaviorally complex Kentucky SKY enrollees.

> **Assisting a Medically Complex Child and Her Family**
>
> McKenzie (not her real name) is a 13-year-old with several complex medical conditions, including visual impairment and frequent seizures, averaging one to two times per day. She is incontinent of both the bowel and bladder, has severe developmental delays, and is unable to walk independently. Due to her complex medical conditions, McKenzie cannot stay by herself after school or when school is out and is unable to go to a traditional day care. McKenzie's father is her sole caregiver and has not been able to work because of the care he provides for her. The Aetna care manager and McKenzie's father discussed the option of services in a Pediatric Prescribed Extended Care (PPEC) unit that serves as a medical daycare center. McKenzie's care manager sent a referral to the PPEC provider and her father set up and participated with the care manager in her initial assessment. McKenzie was approved for services for after school and when school is out, which has allowed her father to return to work.

In addition to the initial screening, Aetna will make sure the DCBS worker and the DJJ benefit worker receives the enrollee information packet within five days of receipt of the 834 or referral into services. The DBCS worker may give permission for Aetna to send the packet directly to the foster parent, caregiver, or the DJJ residential placement. This packet includes the following:

- Foster Care Bill of Rights (if applicable)
- A welcome letter that includes the name and contact information for the Aetna care coordinator
- Kentucky SKY enrollee handbook

- Kentucky SKY identification card
- Information on selecting and changing primary care providers and dental providers
- Information on how the enrollee can share special health care needs and specific services for which the CCT may need to coordinate services
- Information on the role of the CCT and how to seek assistance in scheduling appointments and accessing care coordination services
- Information about the role of the Kentucky SKY call center and how to access the call center
- Information about the role of the inquiry coordinator

DJJ Collaboration: The CCT will also partner with DJJ and courts help to ensure any screening and assessments completed in either setting are incorporated into the initial screening and assessment process. The key is that by completing this process, Aetna will not duplicate assessments already done. We believe that in completing this important step of gathering historical information, we reduce the burden upon the youth to duplicate assessments. This is particularly important for juvenile justice-involved youth who may receive specialized risk/need assessments in the courts or DJJ. Aetna is the only Medicaid managed care organization in the state with a re-entry coach (care manager) embedded in a justice system facility. The Start Strong re-entry program, a 90-day jail substance abuse program with 6 months of follow-up support, helps people move beyond addiction and establish healthy, productive lives.

Aetna Kentucky Success Story of DJJ Collaboration

Julie (not her real name) is an enrollee who is currently in DJJ custody. She was placed in a DJJ residential group home for six months and was sent back home on an ankle monitor. While home, she was attending a day treatment program. In the weeks following, Julie violated the conditions of probation and was court-ordered into a drug treatment program and admitted to substance use residential program at Rivendell. The care coordinator was notified of the admission due to the enrollee being in DJJ custody and promptly outreached to the DJJ worker. Per the DJJ worker, Julie was court-ordered into the 45-day substance use residential program, which she successfully completed. Then she returned home to her parents (still in the custody of DJJ on an ankle monitor). Julie continued attending outpatient treatment and the care coordinator was able to complete the **health risk assessment (HRA) with the DJJ worker** and make certain all the enrollee's medical and mental health needs were being met. Collaborating with the DJJ worker enabled the care coordinator to provide needed information to include her parents to make sure the enrollee's physical and mental health were not barriers to care or treatment.

Collaborating to support LGBTQ youth: We recognize that enrollees who identify as LGBTQ (lesbian, gay, bisexual, transgender, and queer) are over-represented in the child welfare system and face unique challenges and that the experience of LGBTQ youth in foster care is often more difficult than their peers. They experience far more placements than non-LGBTQ youth, and according to a recent survey, 19.6 percent of LGBTQ youth in foster care were moved from their first placement because of a caregiver request, compared to 8.6 percent of their heterosexual peers in foster care.[1] Therefore, Aetna will partner with local LBGTQ organizations, such as Lexington Pride Community Services Organization, TransKentucky, and Louisville Youth Group, to help ensure this population is identified early in the screening process and additional risk screenings are administered, as clinically appropriate.

Data sharing: In addition, we will coordinate with sister agencies to access information through DCBS' electronic data repository, The Worker Information System (TWIST), to gather past assessments and clinical information. The Kentucky Health Information Exchange is also used to access the youth's information and possibly past treatment and services.

[1] Sraggins, T., "For LGBTQ Youth in Foster Care, Finding Home is Hard," The Chronical of Social Change (2018): accessed June 22, 2019, https://chronicleofsocialchange.org/analysis/for-lgbtq-youth-in-foster-care-finding-home-is-hard/32813

Aetna's System of Care: To support collaboration between Aetna, the Department, DCBS, DJJ, and other child welfare stakeholders, Aetna's children's system of care administrator builds key relationships and processes and attends various meetings, including the State Interagency Council and Regional Interagency Councils. We participate in monthly meetings with the DCBS liaison in each region. Aetna will also coordinate an annual forum in each region to bring the child welfare agencies and other stakeholders together for planning and collaborating on issues regarding children in substitute care.

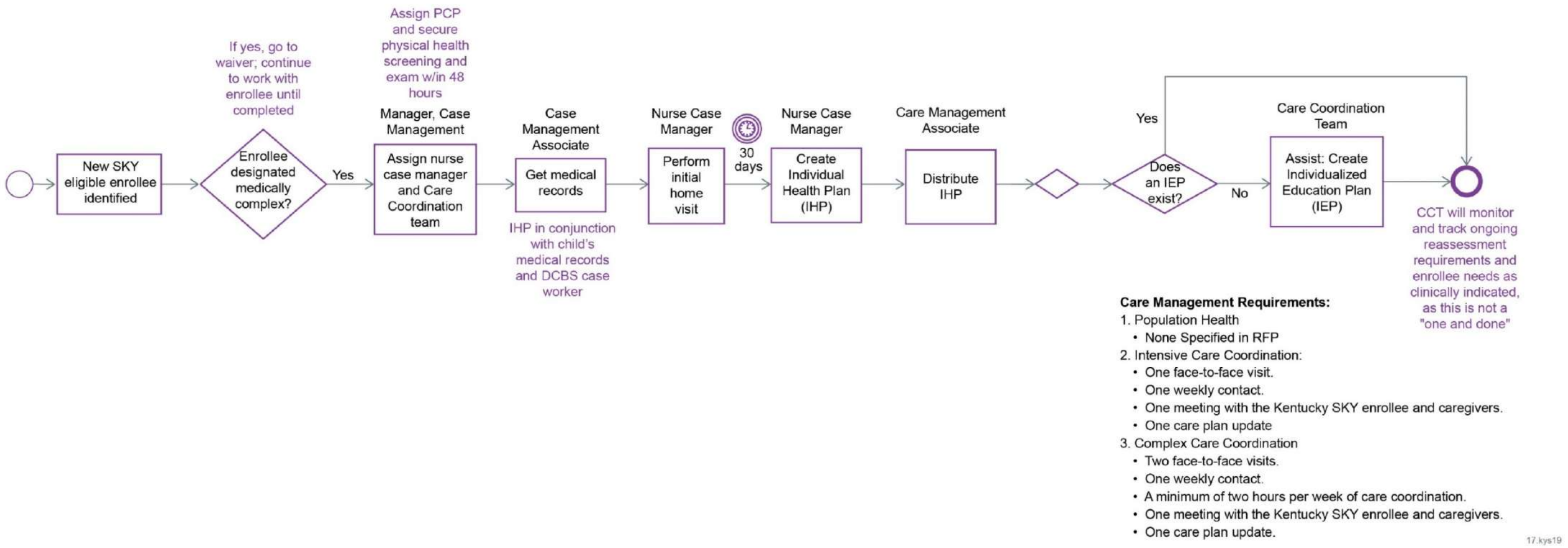

Figure G.8-1: Proposed Front-End Process for Medically or Behaviorally Complex Enrollees

Aetna's process for initiating screenings for youth determined to be medically or behaviorally complex by the Department.

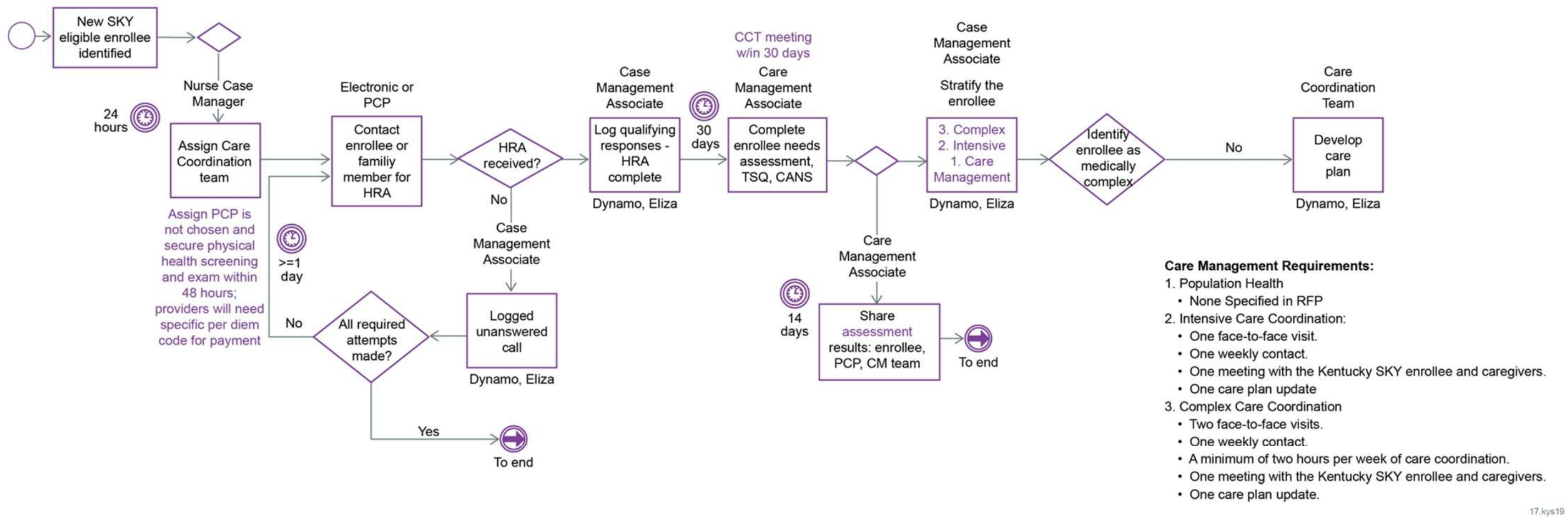

Figure G.8-2: Proposed Front-End Process for Non-Medically Complex Enrollees

Aetna's process for initiating screenings for youth determined to be medically or behaviorally complex by the Department.

a.ii. Initiation of Assessments upon Enrollment in the Kentucky SKY Program

The Aetna care coordinator, the single point of contact for enrollees, families, stakeholders, and the CCT, will help to ensure that all required assessments are initiated upon enrollment and completed for all enrollees within the State-specified timeframes (please refer to **Section 4.26 of the DCBS Standard Operating Procedure Manual-Meeting Basic Health Care Needs**) as follows:

- Coordinates the assignment of a PCP and facilitates scheduling a physical health screening within 48 hours of an order, in which a child enters the custody of the Cabinet for Health and Family Services and treatment for any injury/illness that may be the result of maltreatment within 24 hours of the order
- Makes arrangements, including scheduling transportation as needed, for the child to attend the following appointments within 2 weeks of an order in which a child enters the custody of the Cabinet, either via a temporary order of custody or commitment:
  - Medical exam (documented on the DPP-106D-Medical Appointment)
  - Dental examinations (documented on the DPP-106E-Dental Appointment)
  - Visual exam (documented on the DPP-106F-Visual Screening)
- Facilitates completion of the child's mental health screening performed by a qualified mental health professional (documented on the DPP-106G-Mental Health Services) within 30 days of a child's entry into out-of-home care
- Makes arrangements and documents service provision when the screening indicates that further assessment or treatment is needed
- Arranges for a child to have a complete medical, dental, and visual examination no less than once per year:
  - Uses the medical passport guidelines to document the physical and mental health care services for a child in out-of-home care
  - Follows guidelines for authorization for medical services for a child in out-of-home care
  - Follows guidelines for medical care for a medically or behaviorally complex child

Aetna uses the **Reclaiming Futures framework**[2] as a basis for the screening and assessment process. The Reclaiming Futures framework presents a six-component process to successfully identify youth with complex needs or high-risk behaviors. Our internal care coordination processes align with this model. The initial screening with the HRA and the thorough Aetna foster care assessment (which includes physical, behavioral, and social needs), allows our care coordinators to move quickly from the initial screening to the service coordination phase.

In addition, Aetna recognizes the unique clinical needs of this population and includes the following screening tools specifically for the **DJJ population**:

- Criminogenic Needs Questionnaire
- Risk and Criminogenic Needs Assessment
- Reclaiming Futures Selective Screening and Assessment
- Global Appraisal of Individual Need (GAIN) Questionnaire
- GAIN-Short Screener
- GAIN I
- Youth Level of Service

The screening and assessment process will occur over the course of the youth's involvement with the program. We recognize the youth involved in the program may experience a high level of disruption and aim to reduce, invasive, unnecessary, and redundant screening and assessment processes. It is our goal to

[2] Kentucky Youth Advocates, "Reclaiming Futures in Kentucky": accessed June 23, 2019; http://www.njjn.org/uploads/digital-library/Reclaiming%20Futures%20in%20KY,%20KYA,%209.11.pdf.

make certain the youth enrollees are provided screening, assessment, and treatment services in the right place and at the right time for the current situation and clinical presentation.

a.iii. Meeting Standards for Early and Periodic Screening, Diagnostic and Treatment

Aetna staff, including the Early and Periodic Screening Diagnostic and Treatment (EPSDT) coordinator, care managers, and other support staff, will work closely with providers to ensure SKY enrollees who are eligible for EPSDT receive proper assessments, health care treatment, and follow-up in compliance with **Sections 41.17 Required Assessments and Screening** of the **Draft Medicaid Managed Care Model Contract and Appendices**. Given our experience coordinating EPSDT services to eligible Kentucky kids currently, we will build on our process for SKY enrollees given their unique situations and needs. Aetna staff will operate a seamless protocol to support SKY enrollees in obtaining EPSDT services, including the following:

- Identify primary care providers that meet the requirements to serve as an EPSDT provider within 48 hours of identifying a need for a provider for SKY enrollees.
- Develop subcontracts, if necessary, with out-of-network providers to ensure a provider is available in close proximity to the SKY enrollee.
- Proactively communicate with SKY enrollees and their caregivers, including meeting in-person, phone calls, and text messages, to ensure they understand eligibility for EPSDT services.
- Facilitate scheduling appointments with EPSDT providers for SKY enrollees.
- Attend appointments if requested by the SKY enrollee or caregiver to offer personalized support in navigating the process for EPSDT screening and treatment.
- Maintain at least monthly contact with SKY enrollees, caregivers, and DCBS case workers to ensure SKY enrollees are receiving eligible services after screening has been completed. This also promotes adherence to treatment and aligns with Aetna's Population Health Management program.
- Closely collaborate with Aetna providers to ensure EPSDT screenings and services are provided to SKY enrollees.
- Maintain a single, comprehensive record for each eligible SKY enrollee, including communication with the enrollee about EPSDT, all support provided in scheduling appointments and referral follow-up, and information about the SKY enrollee's treatment and follow-up.
- Establish and maintain a tracking system, through an Aetna-maintained provider dashboard, to monitor which providers are actively accepting EPSDT-eligible members and the follow-through of providing necessary assessments and treatments, including EPSDT special services when needed.
- Provide a monthly gap in care report for providers to alert them of missing EPSDT services and the need for additional outreach to SKY enrollees.
- Establish and maintain a protocol for coordination of physical health services and behavioral health services for eligible Kentucky SKY enrollees with behavioral health or developmentally disabling conditions. Coordination procedures shall be established for other services that are outside the usual scope of contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, and Women, Infants, and Children (WIC), Head Start, and DCBS.
- Participate in any state or federally required chart audit or quality assurance study.
- Maintain an effective education/information program for health professionals on EPSDT compliance
- Submit encounter record for each EPSDT service provided according to requirements provided by the Department.

> With the help of the onsite EPSDT program manager, Aetna's 2019 rates for the Centers for Medicare & Medicaid Services 416 measures on dental services for EPSDT-eligible children were above the statewide average for all sub-measures. Additionally, Aetna received full overall determination for EPSDT as it relates to access/timeliness.

- Provide an EPSDT coordinator staff function with adequate staff or subcontract staff to serve the projected enrollment.

Because Aetna Kentucky SKY staff will be physically located throughout the state, we will be able to work closely with SKY enrollees to connect them with providers located in close proximity for EPSDT services that meet timeframes required by the terms as indicated in **Appendix L "EPSDT.**" We will also make sure providers will comply with 907 KAR 11:034, which delineates the requirements of all EPSDT providers participating in the Medicaid program.

Aetna's child and preventive care measures showed improvement in most rates. Documentation of height and weight **increased by 17.63 percentage points for ages 3-17 over a 3-year period by Healthcare Effectiveness Data and Information Set (HEDIS) 2019; rates for healthy weight for height likewise increased over a 3-year period by HEDIS 2019, with an increase of 17.55 percentage points for ages 3-17 years.**

Enrollees and their families will be informed about EPSDT and the right to appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where enrollees have not accessed services during the year.

Assisting an Adolescent Enrollee in Needs of New Glasses

Barbara (not her real name), an Aetna care manager, received a request from the Department to assist Tommy (not his real name) who was in need of a third pair of glasses within a one-year timeframe. The care manager collaborated with Avēsis, our vision vendor, and arranged for Tommy to return to the provider where he had obtained eyeglasses previously. The provider agreed to submit an EPSDT prior authorization (PA) request and to contact the care manager when the PA was submitted to facilitate timely processing of the PA. Barbara verified with Avēsis that PA was submitted and approved and informed Tommy's guardian of its approval. The provider office had questions regarding billing for the third pair of eyeglasses and Barbara collaborated with Avēsis' representative who contacted the provider's office to explain how to bill for the glasses. Barbara verified that Tommy received his new pair of glasses with his guardian. We were able to get Tommy his new glasses within two days of receiving the request from the Department and he was so excited to get a pair that he really loved. Tommy's mother expressed her appreciation to the health plan for their support and quick response.

a.iv. Anticipated Challenges in and Solutions for Completing Required Assessments

Aetna anticipates that the most important challenge we will face for completing the required assessment for children and youth engaged in foster care and juvenile justice will be connecting with them and their families to get them engaged in services. Our unwavering commitment, collaboration, and compassion drive us to find solutions to this challenge. For example, Aetna uses our system of care approach, with specialized staff to address barriers to engagement and care. We are hiring CHWs in each region of the Commonwealth who will focus on finding hard-to-reach enrollees, especially those residing in rural areas, and engaging them in needed services. We collaborate with Bluegrass Care Navigators to provide transitional care for enrollees, including post-hospital discharge intervention, planning, and assessment; development of a care plan for post-discharge and home follow-up visits; and coordination with Aetna CCTs to ensure safe transition from acute care to the Kentucky SKY enrollee's home.

In addition, Aetna has identified potential solutions to the largest challenges they will face with making sure all Kentucky SKY enrollees receive required assessments in the appropriate timeframes (please refer to **Table G.8-1**.

Table G.8-1: Anticipated Challenges and Proposed Solutions

Anticipated Challenge	Proposed Solutions
Ensuring physical exams are conducted within required timeframes	• Build a trauma-informed care network of providers through an incentive program to conduct the assessments within 48 hours • Utilize the Department for Public Health to provide the exams • Utilize the existing value-based payment relationships such as Kentucky Primary Care Association to incentive appointment availability
The ability of Aetna CCTs to obtain appropriate guardian consents for services (including medical, behavioral, health, vision, and dental)	• Engaging DCBS leadership, Aetna will collaborate to develop strategies to provide temporary consent by either the youth's placement or a centralized DCBS worker assigned to consenting
The ability of Aetna CCTs to meet all required screening and assessment timeframes	• Help to ensure that clinical personnel are located throughout regional offices, allowing for sufficient time to complete assessments • Utilize access to providers in the Department for Public Health
Current interfacing barriers in the ability to integrate and share electronic medical records	• **Aetna FamilyConnect** will be the shared electronic health record which serves as the single source of truth
Face-to-face visit frequency requirement: twice a week	• Utilize telehealth services • Include parent partners as support for the family

a.v. Experience Providing Assessments Required for Kentucky SKY Enrollees

Across all nine states in which Aetna serves the foster child population, we have experience providing the HRA, the enrollee needs assessment (ENA), and a full range of specialty assessments enrollees in the child welfare system. Because Aetna understands the importance of the initial HRA to identify enrollees' needs, we incentivize the completion of the HRA for newly eligible Kentucky enrollees through a $25 gift card. Aetna has also developed its own Foster Care Assessment in which a care manager documents information related to topics that include, but are not limited to the following:

- Demographic information
- Details about the child's placement and foster family
- Medications
- PCP, specialty providers, and therapeutic services
- Permanency plan
- Medical and BH diagnoses
- Activities and instrumental activities of daily living
- Durable or specialized medical equipment
- Participation in programs such as WIC, HANDS, First Steps, etc.

In addition, Aetna has utilized the following assessment tools used for the child, adolescent, and young adult populations who will be served in the Kentucky SKY program:

- Anxiety Assessment
- Depression Assessment V2
- Diabetes Assessment V2
- EPSDT Mental Health Assessment
- Hepatitis C Assessment
- HIV Assessment
- Infant Assessment V2
- Interval Assessment
- Pediatric Asthma Assessment V2

- Perinatal Assessment V2
- Weight Management Assessment

a.vi. Assessment and Screening Tools Recommended to Identify Trauma

Kentucky SKY populations are at higher risk of exposure to traumatic events; it is estimated that 90 percent[3] of children in foster care have been exposed to trauma, with nearly half reporting exposure to four or more types of traumatic events (Stein et al. 2001). For the DCBS-involved population, this risk increases as removal from the home is a traumatic event in of itself. Aetna recommends utilizing the following specific tools to assess and identify trauma:

- Adverse Childhood Experience Questionnaire
- Child and Adolescent Needs and Strengths Trauma Screen
- University of California Los Angeles Child/Adolescent Post-traumatic Stress Disorder Reaction Index
- Trauma Specific Questionnaire

Understanding that repetitive telling their story can become a re-traumatizing event, Aetna care coordinators will take every step to collaborate with case workers at DCBS and DJJ, with families, school systems, and providers to make sure that assessments are completed in a manner that minimizes duplication.

Addressing Trauma with the Help of an Industry Leader

Aetna has partnered with the National Council for Behavioral Health (National Council) to implement our organization-wide Trauma-Informed Transformation. Aetna leadership at the national and local levels are thrilled to collaborate with an industry leader such as National Council. Aetna recognizes the importance of being the first managed care organization nationwide to join forces with National Council to strategically map out and operationalize the end-to-end process, and to then produce a sustainable and replicable model for all Aetna Medicaid health plans and the Aetna enterprise.

Our trauma-informed care (TIC) training and provider recognition process allows foster youth and families access to appropriate services no matter their point-of-system entry, i.e., no wrong door. This approach allows all providers—physical, behavioral, dental, and social—the opportunity to change organizational culture that supports understanding of and addressing the impacts of toxic stress and trauma on our enrollees, their families, and their circles of support. We have trained 2,000 Medicaid staff, including staff in Kentucky, on foundational trauma training and "Darkness to Light" advanced training. Approximately 100 Kentucky staff participated in adult or youth Mental Health First Aid training (depending on their area of clinical expertise) in 2016, and we continued support through train-the-trainer provider opportunities. Over 63 percent of our staff are trained on TIC, each of which has completed at least three separate trainings. We introduced a technology-based training on TIC this year and 56 staff have completed the training, as of December 31, 2019. The National Council will train all staff in person onsite in the second quarter of 2020, with additional training geared towards member-facing staff.

b. Proposed Screening Tool for Kentucky SKY Enrollees

Aetna proposes to use the proprietary foster care assessment for enrollees. Please refer to **Attachment Z** for a copy of the assessment.

[3] The Centers for Medicare and Medicaid Services (CMS). Tri-Agency Letter on Trauma Informed Treatment, Guidance Letter to State Medicaid Directors. Administration for Children and Families, Centers for Medicare and Medicaid Services, Substance Abuse and Mental Health Services Administration. Washington, D.C.: July 13, 2011. Accessible at: http://medicaid.gov/Federal-PolicyGuidance/Downloads/SMD-13-07-11.pdf

How the Foster Care Assessment will be Used to Develop the Care Plan

We will use the foster care assessment, which is part of the person-centered, wraparound needs assessment process, to develop the enrollee's care plan. The CCT will also review all other assessment and screening tools conducted on behalf of the enrollee in support of a clear understanding of unmet needs. Our assessment of unmet needs through using the foster care assessment and HRA screening tools are shared in a supportive manner so that interventions and strategies are accurate and effectively integrated into the centralized care plan. As with any assessment process, the Kentucky SKY youth will be reassessed on an ongoing basis, as clinically indicated to make certain any newly identified needs are addressed and included in the care plan.

Aetna understands youth and families may become overwhelmed with providing responses to various screeners and assessments. In an effort to reduce any trauma associated with answering questions on these assessments/screeners, as well as to reduce redundancy and duplicative efforts, the enrollee's CCT will reach out to previous providers, facilities, and sister agencies to obtain the results of these assessments and screeners. The results will be incorporated into the enrollee's file, ensuring the care coordinator has access when needed. Additionally, and if appropriate, providers, facilities, and sister agencies will be invited to the CCT, and to provide insight into building a comprehensive care plan which will take into account the unique needs of the enrollee.

Using our Foster Care Assessment to Identify a Child's Medical Needs

Five-year-old Martha (not her real name) and her two siblings live in a foster home. She was admitted as a behavioral health (BH) inpatient due to increased physical aggression toward others resulting in injuries, as well as acts of self-strangulation. She also sees a specialist for a developmental delay which requires her to wear specialty glasses. The Aetna BH care manager began action coordinating with a DCBS worker, foster care agency and therapist, foster parents, and provider offices to complete a Foster Care Assessment and identify other complex needs and support services. She already had an autism assessment and individualized education program services scheduled to help in school. The BH care manager consulted with an optometrist to successfully attain a new pair of specialty glasses, due to the last pair being broken. The BH care manager connected not only Martha to a neuropsychiatrist and developmental psychologist to determine autism presence, but her siblings, as well, to assess their possible needs. Martha and her siblings are all receiving the assistance, support, and services needed to decrease placement disruption.

Aetna has experience developing comprehensive care plans for enrollees with unique needs. To make sure all areas of an enrollee's needs are assessed, our care coordinator completes a care plan interview (CPI) with the enrollee and/or their family/support. The CPI addresses the following domains: clinical history and utilization, medications, living environment/support, functional level, self-care, and providers and other services. Completing the HRA, ENA, Health Care Equity Event for social determinants of health (SDOH), and appropriate condition-specific assessments, along with the CPI has ensured enrollee needs are evaluated and assessed. Another tool utilized to ensure enrollee needs are met and incorporated into the care plan is the gaps-in-care. Addressing gaps in care leads to improved HEDIS outcomes. Finally, through this process, Aetna Better Health of Kentucky has achieved a **Commendable** status with the National Committee for Quality Assurance. In addition, Aetna will use Charting the LifeCourse™ tools (i.e., Life Trajectory Worksheet, Tool for Developing a Vision, and Integrated Supports Star Worksheet) to support enrollees and their circle of support develop a plan for a good life.

Aetna believes this high-risk population requires rapid entry into care. As a result, we have developed a front-end process that allows for a quick and clinically appropriate rapid assessment. As mentioned earlier, all Kentucky SKY enrollees will undergo a screening and assessment process. The screening tools, including the foster care assessment, will allow Aetna to appropriately stratify the enrollees into the

care management tier system, which will help drive the person-centered care planning process and timelines (please refer to **Table G.8-2**). Those youth identified as high complexity will undergo a more in-depth clinical assessment process. The results of the screening will also stratify the enrollees into the care management model. This care model, along with strength-based wraparound planning, will assist the Aetna care coordinators to determine the most appropriate level, type, and intensity of services necessary to support stability in the youth's life.

Table G.8-2: Integrated Care Management Tiers

Population Risk Level	Care Management Services	Integrated Care Management Stratification
Prevention and very early intervention and enrollees with limited unmet needs	Care management	Prevention and wellness (population health care management)
Moderate acuity stage	Intensive care coordination	Chronic condition management (supportive care management)
Intense or compounded symptoms and stressors	Complex care coordination	Complex care management (intensive care management)

c. Comprehensive Approach to Providing Crisis Services

Aetna follows the person-centered wraparound care planning process, which includes an individualized approach to **crisis planning and response**. This model helps to ensure the reduction of intensity and frequency of crises over time. Crisis response is handled during the design and implementation of the proactive/reactive safety planning process.

A proactive approach to crisis is most effective; developing genuine and thoughtful relationships with our enrollees is the first step to disrupting a crisis from occurring in the first place. People often use behaviors to communicate and the more we can truly listen and respond holistically, the better off everyone will be. In fact, sometimes it may look like an enrollee is having a crisis, but it is actually the system in crisis—and so taking a system-level approach to crisis is imperative. Kentucky will be a national leader in developing Family First initiatives, services, and system change. This provides a perfect opportunity to frontload preventive services to address crisis situations before they occur.

Aetna realizes the need for Kentucky SKY enrollees to receive rapid and local care during a crisis to improve services to children, a key strategy in serving children and young adults in the child welfare system, i.e., foster care or former foster care. Crisis situations are a critical and vulnerable time for our enrollees and their families. Responding rapidly in a crisis can result in better stabilization for the child and family, which impacts outcomes.[4]

We propose an evolving partnership with community mental health centers (CMHCs) to ensure enrollees are swiftly assessed for the most appropriate care and the most appropriate setting. Ultimately, we seek to avoid inappropriate and unnecessary emergency care and hospital admissions, which can increase trauma for these enrollees. The goal of this program is to support individuals in remaining safe in their community through services such as Mobile Crisis Response teams.

We provide coverage for urgent and crisis calls 24/7/365. During business hours, crisis calls will be managed directly by the Aetna staff in Kentucky; after-hours call coverage is provided by the BH crisis call center. Aetna care coordinators will collaborate with the BH crisis call center staff to identify and locate the CMHCs within the closest proximity of the enrollee. The Mobile Crisis team will be dispatched 24/7/365 when needed. All crisis calls are followed up by the assigned care coordinator. This process ensures that continuity of care is provided and any follow-up treatment is completed.

[4]Casey Family Programs (2018); accessed June 2019; https://www.casey.org/strategies-improve-placement-stability/.

Community mental health centers: Aetna values the relationship with the CMHCs and will incentivize the 13 of them in the state to provide mobile crisis unit services for all Kentucky SKY enrollees through pay-for-performance arrangements (please refer to **Figure G.8-3**). The goal of this program is to support individuals in remaining safe in their community.

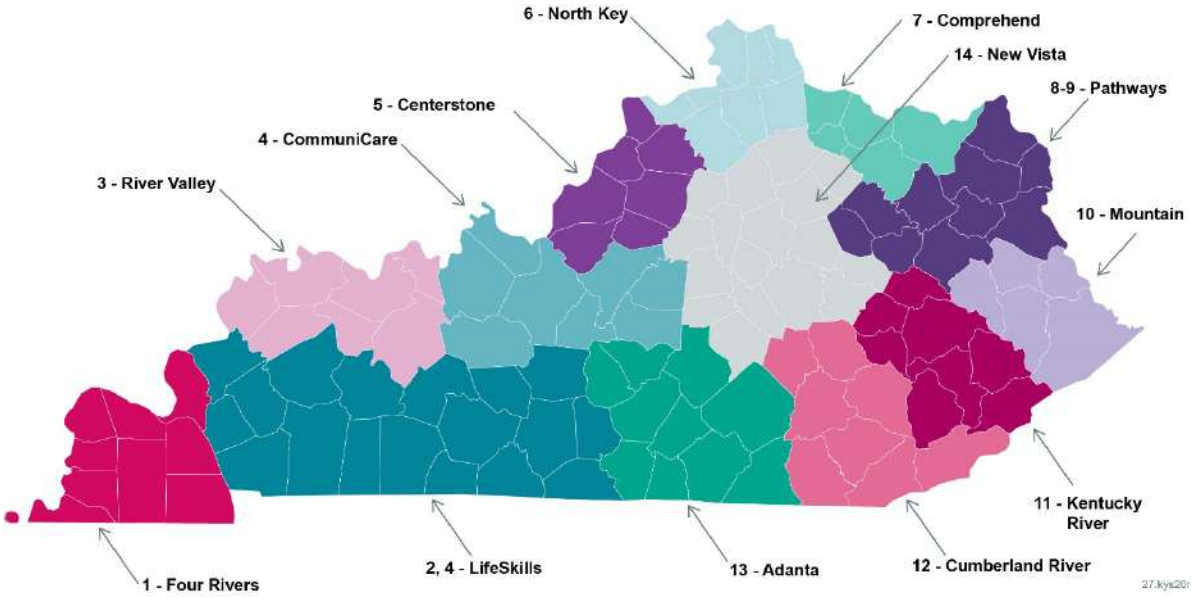

Figure G.8-3: Kentucky-contracted CMHCs

Aetna's contract network of CMHCs will offer mobile crisis interventions to enrollees.

The **Mobile Crisis team** will assure the following:

- Conduct risk assessments, provide crisis interventions, and connect the individual to ongoing behavioral health services or other community resources/supports
- Provide crisis services of triage, assessment, and immediate stabilization of acute symptoms of mental illness, substance use, and emotional distress
- Make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual's needs
- Assist and transport the individual to a more appropriate facility for further care
- Provide two-person mobile teams with at least behavioral health technician-level crisis workers
- Engage peer and family support services as preferred and identified by the enrollee and DCBS social worker

Following a mobile crisis intervention, Aetna will work with CMHCs to do intensive outpatient care with the family (foster) and child after a mobile crisis event. This includes the following:

- Assisting the individual to utilize community and family/support systems with the intent of preventing the reoccurrence of similar events in the future
- Assessing the immediate crisis and facilitating resolution and de-escalation
- Engaging the individual to identify follow-up services and assist the individual to access these services that are necessary to manage and/or prevent further BH crisis experiences

Aetna will also partner with various providers throughout the state to provide quality care to our enrollees. An example of this partnership is TAYLRD (Transition Age Youth Launching Realized Dreams), which has multiple locations or drop-in centers throughout the Commonwealth. TAYLRD is a

federally funded initiative aimed to positively impact the lives of Kentuckians 16- to 25-years-old who have or are at risk of developing behavioral health challenges. The drop-in centers are staffed by youth peer support specialists and youth coordinators who are in the transition age group themselves and have had some form of system involvement in their past. There are various services provided at the drop-in centers such as case management, court support, life skills, and vocational services. Aetna has worked with TAYLRD by providing hygiene products (e.g., shampoo, body wash, toothbrushes, and toothpaste). Having these items available was another way to incentivize individuals to come into a drop-in center and increase the opportunity for engagement. With this enhanced collaboration the mobile crisis response may include the following:

- Initial assessment and ongoing assessment of behavioral health symptoms and crisis-related needs
- Involvement of identified family and friends to resolve the individual's crisis
- Therapeutic communication and interaction to alleviate psychiatric or substance use symptoms
- Development of a safety plan or crisis prevention plan
- Psychiatric consultation and urgent psychopharmacology intervention
- Referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care, including crisis respite
- Linkage to stabilization and/or substance abuse disorder 24/7/365 access centers or BH urgent care
- Secure access to higher levels of care, if required
- Certified peer services for the following:
  - Engagement
  - Assistance with developing crisis diversion plans or relapse prevention plans
  - Assistance with the identification of natural supports and access to community services during and after a crisis

Aetna will work with all stakeholders to explore new models that will support people before, during, and after a crisis occurs, including building capacity around positive behavioral support, creating short-term respite, and taking a prevention-first approach.

Aetna firmly believes that the solutions to a robust crisis support strategy are in the enrollees and the Kentucky providers and stakeholders that work hard every day. By developing ongoing partnerships, leveraging new and preventive Family First services, and by 'thinking outside the box,' Kentucky will be a national leader in disrupting the crisis cycle at all levels of the system.

d. Experience in Providing Services through a Holistic, Person-centered Approach

Aetna has experience providing its enrollees care coordination and support with a holistic, person-centered approach. Aetna recognizes the importance of utilizing a trauma-informed framework, a comprehensive biopsychosocial assessment, and identification of SDOH needs for enrollees. For our enrollees with particularly complex and intensive service coordination needs, we have been able to identify the benefits of collaborating with the enrollee, the enrollee's supports, health plan staff, and our system partners, in an effort to remove barriers and develop meaningful goals to improve health outcomes.

Aetna plans to implement a High-Fidelity Wraparound Certification initiative, training staff in this model to enhance our person-centered approach to supporting the enrollee's needs. In addition, Aetna considers regional needs and the services and offerings that will bring the most value to enrollees and to Kentucky. These services, coupled with covered services, aim to improve quality of life and health outcomes for enrollees.

Aetna utilizes the approach of Charting of the LifeCourse™ framework (please refer to **Figure G.8-4**) as tools and resources to support the wraparound foundational model of care. This serves youth in foster care

and juvenile justice systems, in concert with their circle of support. This collective approach to family safety, healing and thriving, resulting in the creation of an individual care plan that addresses covered and non-covered services and focuses on the youth's circle of support (caregivers, family, foster parents, etc.).

The care plan helps the circle of support identify what they need to be successful and what they would find useful to them in helping them provide quality care to the enrollee. This approach helps youth by considering what is predictable is preventable and that the individual's biography is their biology. To address an individual's physical and behavioral health challenges, we must consider the impact their health has in their life story and if we can predict difficulties, we can collaborate to prevent them. Charting the LifeCourse assists the youth in navigating through challenges to negate isolation by creating encouragement and support.

> "The LifeCourse framework and tools are designed to help individuals and their families plan for and navigate a life that makes sense to them with the support they need… It is exciting that a national health care leader like Aetna recognizes its value and will be using the LifeCourse framework as it develops its person-centered, holistic model to support children and families in the child welfare system in Kentucky."
>
> **—Michelle C. Reynolds, PhD**
> **Associate Director of Training**
> **UMKC Institute of Human Development**

To assure a holistic, person-centered approach, Aetna's goal for Kentucky is to create collaborative groups with other involved managed care organizations to address and break down barriers that arise as a result of the youth's biological family and other caregivers receiving services elsewhere. We will assign a care coordinator to support the enrollee's family.

Our care coordination model for youth in foster care is a specialized, person-centered, biopsychosocial approach based on the LifeCourse framework, as well as other national evidence-based best practices and self-determination tools, and it includes a coordinated network of physical, behavioral health, and community service providers. By linking enrollees to a comprehensive network, the full complement of Medicaid and non-Medicaid services and supports are available to best support enrollees and their families.

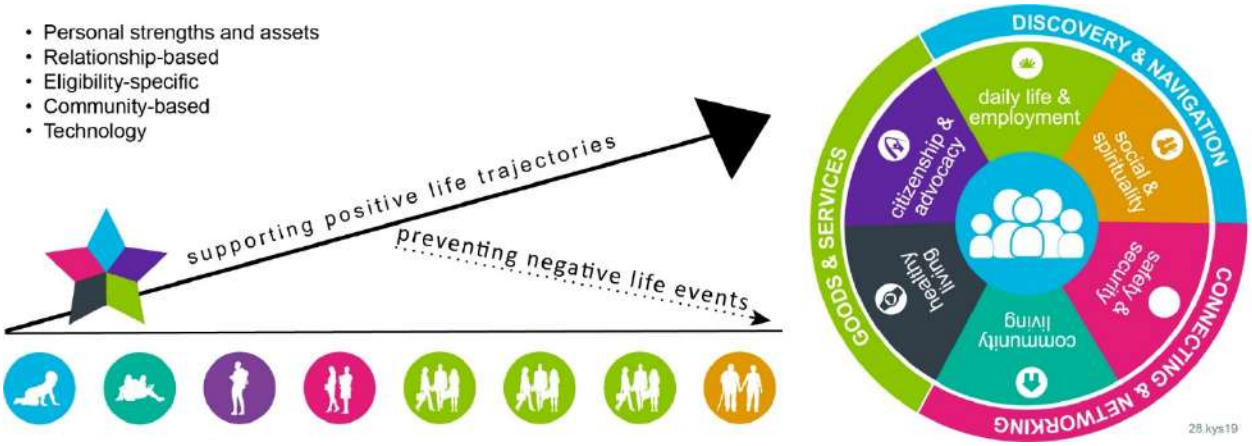

Figure G.8-4: Charting the LifeCourse Framework
Aetna uses this framework to drive the care planning process.

The LifeCourse process guides care coordination to use enrollee-centered planning to build positive life plans rich with resilience and averting loneliness. Our CCTs will include peer support specialists, as they play a critical role in our services to all enrollees experiencing the foster care/adoption and juvenile justice systems. Peer support specialists, as well as community service coordinators, DCBS case workers,

adoption competent therapists, and care coordinators can be an essential part of the healing process for these most vulnerable young people. CCTs are responsible for creating aging out transition plans for enrollees involved with DCBS and DJJ and will coordinate care planning meeting with the circle of supports identified by the youth and their primary caregiver.

In addition to the holistic approaches our care teams provide, Aetna will build on the efforts already underway at DCBS to transform the child welfare system into an effective, nationally recognized Family First approach that strengthens families and keeps kids safe.

Through collaboration with **Kentucky Youth Advocates (KYA)**, we will work with State agencies, providers, child welfare organizations, and consumers across Kentucky on innovative solutions to transform care for the Kentucky SKY population. KYA is the state's leading child advocacy organization with over 40 years of experience working with public, private, and nonprofit agencies to advance policies that are good for kids. KYA is an expert in building effective coalitions that advance systems-level changes and offers a wealth of expertise in the child welfare arena. The organization is already working with DCBS and Casey Family programs on several initiatives related to advancing Families First in the Commonwealth.

Aetna has worked with KYA previously through being a coalition member of the Blueprint for Kentucky's Children and supporting Children's Advocacy Day at the Capitol. We plan to deepen our relationship with KYA to help us provide the best, holistic care for the Kentucky SKY population and play a broader role in transforming the child welfare system to work better for children and families. KYA is an ideal organization to collaborate with as we are in alignment on current commonwealth priorities, including strengthening families, keeping kids safe, enhancing supports for kinship families, and promoting resiliency and stability for youth that are in or aging out of foster care.

KYA has extensive knowledge of the child welfare system in Kentucky and the work underway to improve Kentucky's response to families at risk of crisis. KYA will provide training to Aetna's staff to ensure a knowledge base of the state-of-the-state of Kentucky children in foster care, the landscape of the child welfare system across the Commonwealth, and Kentucky priorities related to strengthening families and keeping kids safe from harm. KYA will meet with our staff on a regular basis (at least monthly) in a learning collaborative setting to share information, troubleshoot issues, and collaboratively develop policy and practice solutions. KYA will also provide educational training opportunities through webinars and briefings on the status of the child welfare arena in Kentucky and nationally to larger cohorts of Aetna Medicaid organization staff outside of Kentucky. Collaborating with KYA will strengthen the knowledge base already within Aetna and will facilitate areas for innovation. It will also help us continually improve the model of holistic services we provide to the Kentucky SKY population and their families.

Aetna listens to and meets the unique needs of our enrollees, especially those in foster care. Although we communicate with and assist individual enrollees on a regular basis, we recognize the power of hearing firsthand stories from individuals who have been directly impacted by the child welfare system and/or foster care outside of our direct enrollee interactions. We will collaborate with KYA to engage these individuals through coalition meetings and focus groups on a regular basis. We will use these opportunities to hear from those impacted by the child welfare system firsthand and adapt our holistic model of care to address the unique situations facing this population. These interactions can also help Aetna identify ways to advance Family First across the Commonwealth.

Aetna has experience in West Virginia adopting and implementing a successful High-Fidelity Wraparound Model™. The general approach involves the following:

- Risk identification via broad-based health and social service predictive modeling
- Combining health and human service funding streams to leverage private market for measurable outcomes

- Risk mitigation through enhanced management of social determinants

In serving at-risk children holistically, our affiliate plan, Aetna Better Health of West Virginia maximized its resources for children, attached case managers to foster children and at-risk children/parents, and improved outcomes related to child safety, reduced childhood trauma, and empowerment of parents and kinship placements.

Their wraparound model integrates a large collaborative network to make certain the child's needs are met and the right people are at the table in the person-centered care-planning process. Some of these collaborators include the following:

- Circuit judges
- Lawmakers
- Families
- Prosecutors
- Law enforcement
- Education officials
- Providers: medical, social service, and behavioral health
- Payers
- Child advocates
- Probation officers
- Education officials
- Child protective services
- Social workers

e. Interventions to Develop Resiliency in Enrollees Exposed to Trauma and Adverse Childhood Experiences

Aetna employs an integrated model of care (please refer to **Figure G.8-5**) to support improved whole-person outcomes for enrollees involved with DCBS and DJJ systems. In using this model of care, Aetna is better suited to assess the youth's holistic needs and to identify the appropriate course of care for the population. With Aetna's integrated care management model, the key is to build protective factors, which is essentially building resiliency. The more protective factors a child has in place, the more likely that child is to have healthy outcomes. Protective factors are highly tied to the development of self-management skills and autonomy.

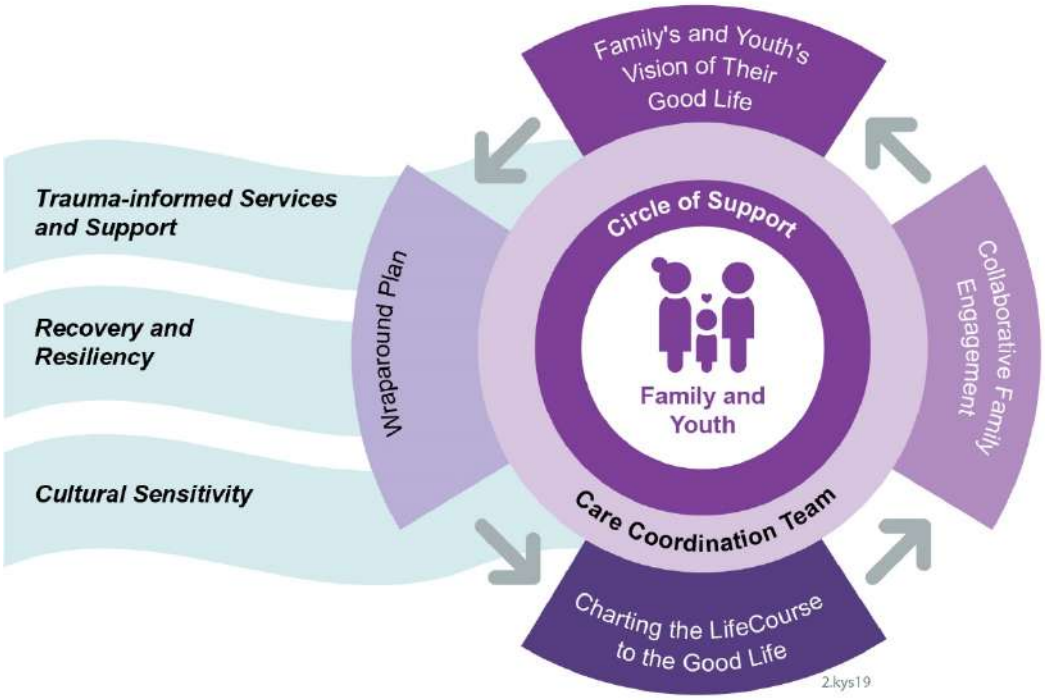

Figure G.8-5: Aetna's Integrated Care Model

Aetna's approach to providing person-centered holistic care to enrollees.

Some examples to consider when identifying protective factors can be found in **Attachment Z** and include but are not limited to the following:

- My child has an active and supportive family/parental involvement
- My child has a safe and stable place to live
- My child has friends/peers who are a positive influence

Through a fully integrated model, the care coordinator identifies and builds the protective factors with the enrollee and their circle of support. These protective factors lay the framework for resiliency. In addition, the Aetna team is being trained in the **Bounce/Brick program**[5] to further build resiliency.

Bounce/Brick Program

- Educates and trains to build resilient children and families
- Strengthens referral networks when more help is needed
- Measures impact by providing consultation and evaluation services to measure impact and institutionalize healing-centered practices
- Advocates for policies that support trauma-informed communities

Our teams will also be trained on addressing trauma. We have collaborated with the National Council for Behavioral Health and Relias, a national training vendor, for these foundational trainings and have implemented trauma curriculum in our onboarding and ongoing training for all enrollee-facing staff. Relias is a learning platform that Aetna has had a contract with for the past five years. This platform is available to enrollee-facing clinical and non-clinical staff, including peer support staff and CHWs in health plans. In 2019, the focus on continuing education in Kentucky was TIC.

We have trained approximately 3,000 staff in foundational trauma training across the Medicaid segment since 2018. Some the topics include the following:

- Defining trauma

[5] Accessed June 20, 2019; https://www.bouncelouisville.org/

- Prevalence and impact of trauma and adverse childhood experiences (ACEs)
- Building resiliency and hope for recovery in the face of trauma and self-care
- Introducing trauma-informed care
- Importance of trauma-informed care for the populations served by the Aetna Medicaid organization
- Four assumptions of trauma-informed care
- Six principles of trauma-informed care
- Application for staff and enrollees

Ongoing provider training: Our ongoing provider training is designed to be responsive to provider educational needs, such as the importance of developing resiliency in enrollees exposed to trauma and ACEs in a manner that is convenient and easily accessible to all providers, including those located in remote or rural areas. For example, our providers let us know they preferred webinar-based trainings, as they were the most convenient and easiest to attend due to busy schedules. As a result, starting in January 2018, we have used webinars as a primary medium for provider trainings. Since January 2018, Aetna has offered Kentucky providers 69 training opportunities via targeted onsite trainings, webinars, and provider forums. We continue to also offer training through a variety of other settings, including face-to-face visits and provider forums, to make sure we address the preferences of all our providers. Our locally based provider service representatives are available to meet with providers and their staff to assist with training and education needs at times that are convenient to the providers.

Training Dental Provider to Identify Trauma

Our dental benefits administration subcontractor, Avēsis, works closely with the founder of Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A), engaging dentists and dental professionals in identifying child abuse and neglect, elder abuse, domestic violence, and human trafficking. Avēsis's Vice President of Dental Quality and former Chief Dental Officer for CMS, Dr. Lynn Mouden, is a P.A.N.D.A. trainer and provides professional development for our network dental providers on topics like precipitating causes and contributing factors to child abuse and the clinical signs of abuse and neglect.

Aetna has, and will continue to maintain, a provider training program based on what our providers tell us they need. Our program goes beyond the minimum requirements to address these provider needs and support Commonwealth initiatives and system changes. As an example, we have provided, and continue to offer, trainings on a variety of topics, such as TIC. We are continually working to identify opportunities to expand our training in ways that go beyond simply offering education to provide trainings that will impact provider operations and quality of services. One initiative that we are currently exploring are assessing the ability to offer trainings with Continuing Medical Education and Continuing Education Units for our licensed providers.

Changing Course training collaborative: To support system change and innovation in caring for Kentucky SKY enrollees, Aetna will establish a training collaborative, comprised of a diverse group of Aetna leads as well as external representatives from numerous stakeholders, parents, and youth, which will be led by the Aetna Kentucky SKY executive director. The purpose of the training collaborative is to oversee the ongoing design and delivery of high-quality, Changing Course trainings across the Commonwealth. The Changing Course model will work within a train-the-trainer framework, assuring scalability and sustainability. We will adapt the curriculum, as necessary, to reflect the needs of Kentucky stakeholders and communities based on feedback from the training collaborative. Trainings in the curriculum are comprehensive and inclusive of divergent and blended perspectives and are co-led and offered in partnerships. The Changing Course curricula include the following over-arching topics which each have modules that can be taught separately depending on the needs of various audiences:

- Principles and Standards of Care

- Engagement
- Collaboration
- Facilitation
- Proactive/Responsive Safety Planning
- Creating Community Capacity and Community-based Resourcing
- Visionary Leadership and Management
- Transition Planning and Celebrations
- Outcome-based Quality Assurance-Continuous Quality Improvement

The primary sources of innovation that came to bear on these curricula include but are not limited to:

- Wraparound
- Collaborative Family Engagement
- Family Seeing and Engagement
- TIC
- ACEs research and findings
- Neuroplasticity and trauma transformation
- HERO workshops
- Early Childhood Education
- Differential Response
- Crisis Intervention Team Models
- Mental Health First Aid

The goal of the Changing Course model and curricula is to provide innovative training, coaching, and sustainability for the Kentucky child welfare system, ensuring each child and family realizes their own vision of a good life as quickly as possible while ending the cycle of compound trauma.

f. Addressing Non-medical Factors Driving Inappropriate Utilization of Medical Resources

There are any number of non-medical factors that can drive inappropriate utilization of medical resources by foster care, juvenile justice, and adoption assistance-involved youth such as lack of access to healthy food and transportation, unsafe housing conditions, etc. For each child and family, those factors can be different and compounded by poverty, lack of responsive and effective care, exposure to toxic stressors, and isolation as well as placement changes (among other factors). When a child and family experience a combination of these factors, there is a tendency to over-rely on medical resources, especially emergency services. We will account for these factors through the wraparound life domain planning process. The CCT will gather information from other assessments and screening tools such as EPSDT MH, ACES-Q, and therapeutic behavioral services, all in the interest of fully understanding unmet needs across multiple life domains. The domain planning process considers all social determinants of health equally to make certain that plans are individualized and comprehensive. Many of the goals and strategies effectively address unmet needs that directly or indirectly reduce the reliance on medical services.

In an effort to reduce the over-utilization of medical resources to meet these other life domain needs, Aetna partners with Unite Us in a unique collaboration to address the full spectrum of SDOH (please refer to **Figure G.8-6**). The partnership, currently in Louisville, Kentucky, establishes connectivity to a fully integrated social service network to provide the identified SDOH needs of our enrollees. Aetna's intent is to expand this collaboration statewide. This SDOH services integrated model connects enrollees to community-based organizations that participate in the closed-loop referral network, including all types of social service agencies.

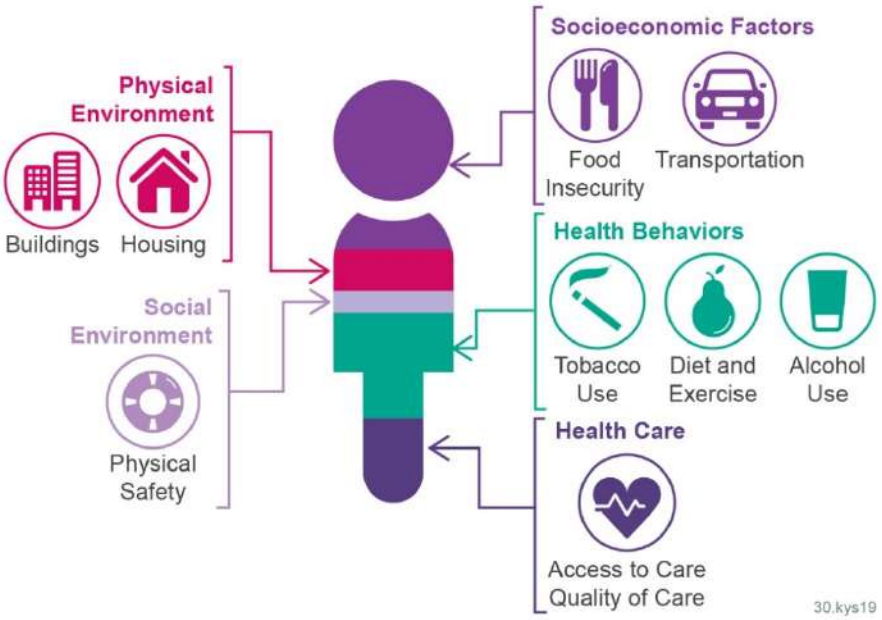

Figure G.8-6: Social Determinants of Health

Aetna uses an HRA screen for social determinants of health.

Enrollee referrals for integrated service needs (physical health, behavioral health, and SDOH) are initiated through multiple sources. One example is an HRA, for which Aetna makes at least three attempts for all enrollees within 30 calendar days of eligibility with the health plans. Additional tools, such as the foster care assessment, are completed in combination with the HRA, which includes SDOH and biopsychosocial questions. Enrollees determined to have socially or medically complex needs (multiple chronic conditions, SDOH barriers, gaps in care, health disparities) will be given a care coordinator for a comprehensive evaluation based upon defined criteria for potential enrollment into our integrated care management program.

Unite Us Platform

Aetna is partnering with **Unite Us** in a unique collaboration to address the full spectrum of SDOH. Unite Us enables providers in a community to work together in real time to coordinate care and track actual care outcomes that result from inter-agency referrals. Community-based organizations, public agencies, health care providers, and behavioral health providers use Unite Us to send and receive referrals to and from each other, and to maintain visibility as their enrollees access care. As individuals interact with community services across organizations and sectors, Unite Us makes it possible to build a longitudinal record of the care that is delivered and the outcomes of each touchpoint. Unite Us provides both a hands-on approach in communities coupled with a robust coordination technology connecting health care and social service providers. This approach includes high-touch project management and boots-on-the-ground community engagement by a team of public health experts who have launched coordinated care networks in over 50 communities across the country.

Aetna believes it is critical to connect health and social service providers into a coordinated and accountable network, delivering greater visibility into the care that is provided and better outcomes for the DCBS and DJJ involved aging-out population. Through the Unite Us platform, Aetna delivers the following:

- Continuity of quality access and care once enrollees leave the clinical setting through real-time connections with trusted, accountable, and quality community partners
- An approach under which multiple social needs are identified, addressed, and resolved with structured outcomes for every need fulfilled
- Full visibility into total enrollee journey and the resolution status of each need, regardless of Aetna personnel or clinical role, whether service delivery is only social or only acute care
- A flexible but standardized approach providing robust data to support reductions in avoidable utilization while measuring the return on investment impact on cost avoidance and revenue opportunity

Figure G.8-7: Hope's Closet
Hope's Closet provides free clothing and other necessities for foster care and adopted young adults.

Community-Based Organizations

In addition to partnering with Unite Us, Aetna collaborates with a broad range of community-based organizations to support enrollees with their non-medical needs. For example, Hope's Closet is a non-profit that provides free clothing and other necessities for foster care and adopted young adults. Aetna has given donations of items identified by Hope's Closet as a need, including backpacks and school supplies. In addition, we volunteered with Hope's Closet during their recent remodel (please refer to **Figure G.8-7**). Some of the other community-based organizations Aetna collaborates, though certainly not an exhaustive list, are described in **Table G.8-3**:

Table G.8-3: Kentucky CBOs to Address Non-Medical Needs

Organization	Description of Services for Kentucky SKY Enrollees
Family Resource Youth Service Centers (FRYSCs)	FRYSCs are a primary resource in helping to address the SDOH needs of Kentucky SKY enrollees. A division of the Cabinet for Health and Family Services, FRYSCs are in schools across the Commonwealth with the primary goal of removing non-academic barriers to learning. Each center provides unique and tailored services to meet the needs of the population served. For SKY enrollees, FRYSCs can serve as a connection between the enrollee's educational needs and other necessary services ranging from clothing to food. They can also help address educational and learning barriers. Aetna is already enhancing our relationship with FRYSCs through our partnership with Unite Us, which will further help us use this vital resource for Kentucky kids in the SKY program.
First Steps	First Steps is a statewide early intervention program through the Cabinet for Health and Family Services that provides services to children with developmental disabilities from birth to age 3 and their families. Aetna will use First Steps to help the Kentucky kids in SKY up to age 3 connect with early intervention services which involve an individualized plan of care for each child and incorporates a coaching approach to help caregivers support children's development. First Steps is an essential partner and expands the services already provided by Aetna through our care managers and support staff.
Grant County Community Collaborative	Grant County Champions for a Drug-Free Grant County works with the community to reduce and prevent substance use and violence among youth, their families, and those in future generations. They provide all families, including Aetna families, resources, training opportunities and health fairs to promote living a healthy, drug-free lifestyle. We partner with the organization to support events and provide Aetna-specific benefits and services information.

Organization	Description of Services for Kentucky SKY Enrollees
Head Start	Head Start is a federal program aimed at ensuring at-risk children are prepared to enter kindergarten ready to learn. Kentucky's Head Start program serves all 120 counties. The program focuses on caring for the while child and building family strengths. Aetna will coordinate with Head Start programs serving SKY enrollees to ensure the needs of Kentucky kids in this program are met. We will also work collaboratively to promote complementary services between the Family Service Workers in Head Start and Aetna case managers. We specifically anticipate coordinating with Head Start on addressing SDOH needs of SKY enrollees as this is a core function of Head Start services.
Fostering Futures: Kentucky Foster & Adoptive Care Association	Fostering Futures is dedicated to the empowerment and encouragement of foster and adoptive families through advocacy and support. Aetna will work with Fostering Futures to ensure foster and adoptive families are connected to support groups, resources, and advocacy opportunities to help them thrive. We will also work with Fostering Futures on effective connections and strategies during the aging out process of SKY enrollees, as this is an expertise of this organization.
Kentucky Protection and Advocacy	Kentucky Protection and Advocacy is an organization dedicated to promoting the rights of Kentuckians with disabilities through legally based individual and systemic advocacy and education. This organization can be helpful for SKY enrollees with disabilities and their caregivers navigate legal issues and provide support for caregivers of this population. Kentucky Protection and Advocacy also provides training that will be important for Aetna staff on special education and transitioning SKY enrollees with disabilities transition smoothly into adulthood.
WIC	WIC is a federally funded, state-administered health and nutrition program that provides healthy foods to children under age five. All children in the foster care system under age five are automatically eligible for WIC. Aetna care managers will partner with DCBS case workers and foster and adoptive families to ensure eligible SKY enrollees are signed up and receiving WIC. This program will help the youngest SKY enrollees have access to proper and adequate nutrition, addressing a core social determinant of health issue. We will provide hands-on support to the foster and adoptive families in the application process for WIC if needed.

Collaboration with State Staff

Aetna is committed to standing shoulder-to-shoulder with the state child welfare system throughout our implementation of the Kentucky SKY program. Deep collaboration with this group ensures effective communication, including identifying appropriate and efficient response to behavioral, mental, emotional, and health needs of our children.

For Kentucky SKY, Aetna plans to replicate work being done by Aetna Better Health of West Virginia, including interactive webinars during implementation that allow Kentucky state workers to ask questions, identify specific roles in the partnership, and continue an ongoing conversation. In West Virginia, these webinars, along with in-person regional meetings and comprehensive identification of resources, such as those identified in **Table G.8-3**, have allowed Aetna Better Health of West Virginia to clearly identify how care coordination supports and convenes teams and partners with the State.

FamilyConnect serves as a central point-of-contact and care coordination hub. Use of FamilyConnect ensures that instead of duplication or inappropriate use of service, children are being quickly and appropriately matched with the services they need during traumatic experience, like placement change or disruption. Clearly defined processes and collaboration in these scenarios encourage better collaborative decision-making with family focus at the center.

Value-added Services

Our Medicaid experience across the nation indicates that the health and well-being of enrollees are enhanced by their ability to access the services and supports not covered by Medicaid. These services, coupled with covered services, aim to improve quality of life and health outcomes for enrollees. Our value-added services are designed to assist our promotion of individual and family self-sufficiency,

recovery, resiliency, and community sustainability for the betterment of the vulnerable population, and to improve participants' health and help them be responsible for their health.

Aetna is committed to offering all value-added services (VAS) listed below to its enrollees. We believe these are a critical component of the overall program and will provide another path that leads to our enrollees achieving optimal health. The value-added services proposed are based on our 30 years of experience working with vulnerable populations, coupled with lessons we have learned in the Commonwealth since 2011. For example, Aetna's overarching approach to value-added services has moved away from creating incentives for enrollees to participate in programs with the end goal of closing gaps in care to increase HEDIS scores, and has adopted a strategy of increasing VAS that improve the enrollee experience and address their social determinant needs. We believe this approach to VAS is more person-centered and aligns with our whole person approach to integrated care, as described above.

Our VAS below are tailored to the Kentucky population's health and social determinant needs, such as transportation, and align with the State Health Improvement Plan (e.g., programs to address risks associated with opioids, obesity, poverty, and more). Aetna commits to providing all the value-added services proposed in this response for the entire 65-month term of the initial contract and for any extensions, if applicable. **Table G.8-4** presents VAS specifically for children and youth. **Table G.8-5** lists our VAS that are most appropriate for former foster care children but for which children may also be eligible depending on their situation.

Table G.8-4: Value-added Services Designed for Children and Youth

Benefit	Description
Back-to-school program	Overall, 22 percent of Kentucky children are below the poverty line.[6] Aetna's community outreach through school-based family resource coordinators offer backpacks filled with school supplies. This value-added service will increase student access to school supplies and decrease functional limitations.
Aetna Birthday Box program	This program recognizes children's birthdays (focuses on medically fragile and transition-age children that would otherwise not be acknowledged). Each child receives a "birthday in a box" that includes party supplies (e.g., paper goods, minimal party decorations), balloons, book/journal, puzzle/game, and a large cupcake. The Birthday in a Box is arranged and delivered by the foster care manager.
Foster Care Duffle Bags	Children in the foster care system without stable housing often lack a way to carry their belongings. To help with this, Aetna will provide personalized duffle bags filled with personal hygiene items, supplies, and a blanket to foster care enrollees that are transitioning from one home to another. Some items include full size shampoo, conditioner, journal, and coloring book.
Asthma Home Care	Asthma is also one of the most common chronic diseases among children, and in Kentucky 10.6 percent of children under age 18 have asthma.[7] Enrollees with an asthma diagnosis can receive one set of hypoallergenic bedding and one carpet cleaning annually. This is an important benefit because dust and pollen, common allergens that induce an asthma attack, can often be found in bedding and around the home. This value-added service will be provided to reduce asthma-related emergency room utilization and other asthma-related complications.
Aetna Better Way to Health – Children	Our innovative incentive programs offered to children and teens are designed to encourage enrollees to obtain important preventive services, while emphasizing personal responsibility and ownership of healthy living. For a follow-up visit with mental health practitioner, enrollees 6 years and older will receive a $20 incentive card for a follow-up visit.

[6] County Health Rankings & Roadmaps, "Kentucky Rankings Data," (2019):http://www.countyhealthrankings.org/rankings/data/KY; accessed June 1, 2019
[7] Kentucky Public Health, "Kentucky State Plan for Addressing Asthma," (2016-2018): https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Documents/2016KentuckyStatePlanforAddressingAsthmarevised.pdf

Benefit	Description
Smile Kentucky Program	Children's dental health is important but access to care is often difficult. In fact, according to the 2011-2012 National Survey of Children's Health, 18.6 percent of children in Kentucky ages 1 to 17 had one or more oral health problems or had unmet needs for dental care during the past 12 months.[8] Additionally, only 40-50 percent of children in Kentucky are receiving any dental services.[9] Aetna, in partnership with the University of Louisville Dental School, will offer free mobile dental clinics and dental screenings to elementary children in Region 3. This value-added service will be provided to increase preventive oral care, detection of tooth decay, and other oral health issues while also reducing functional limitations to care.
Connections for Life	Foster children, especially those in high-poverty areas, often lack the digital and cellular technology necessary to establish and maintain vital social connections, participate in school, find a job, and access resources. Aetna Connections for Life aims to bridge the digital and cellular disparity faced by these vulnerable enrollees and empowers them to stay connected and engaged with their world. Eligible enrollees can receive a free cell phone and wireless plan, laptop, education, and training around technology literacy, and help connect to key local and national resources. • **Smartphones and Wireless Plan**: Foster youth often cannot afford a steady wireless plan, which results in significant isolation from their support circle, and puts them at risk of not being able to contact emergency services when needed[10]. In addition to the isolation, unpaid wireless bills lead to negative credit report results that prevent many of them from qualifying for loans, apartment rental, and more. To address this, we will provide eligible foster care enrollees (ages 13-17) who are not in a stable placement home a free smartphone and wireless plan. This value-added service will help to reduce the isolation barriers they face and will help maintain the lines of communication with their support network including their caseworkers, therapists, mentors, and friends. • **Laptops**: The lack of access to technology in today's world is a significant social barrier that cuts those impacted off from opportunities in school and in the workforce. Those in foster care are disproportionately impacted by this inequity and often lack the resources and knowledge to make a change. To help bridge this digital divide, Aetna will provide a laptop to foster care enrollees (ages 18+) who are aging out to equip them with one of the key tools necessary for independent living in the modern world.
Insulin pumps	Studies have shown the significant value of the ongoing monitoring and support provided through modern insulin pumps, but they are often unaffordable for most individuals.[11] Furthermore, Kentuckians have a higher percentage of people with diabetes than the U.S.[12] For our enrollees with Type 1 diabetes, we will offer free Omnipod® insulin pumps to help them with the day-to-day management of their insulin levels, reduce episodes of severe hypoglycemia, and to empower self-care.

[8] Centers for Disease Control and Prevention, "The National Survey for Children's Health," (2011): https://mchb.hrsa.gov/nsch/2011-12/health/pdfs/nsch11child.pdf
[9] Center for Health Workforce Studies, "Oral Health in Kentucky," (2016): http://www.oralhealthworkforce.org/wp-content/uploads/2016/02/Oral_Health_Kentucky_Technical_Report_2016.pdf; accessed June 1, 2019
[10] The Chronicle of Social Change, "Why Calif.'s Lifeline Wireless is a Big Deal for Foster Youth," (2014): https://chronicleofsocialchange.org/analysis/why-calif-s-lifeline-wireless-is-a-big-deal-for-foster-youth/4949; assessed June 2019
[11] Medical News Today, "Type 2 diabetes and life expectancy," (2019): https://www.medicalnewstoday.com/articles/317477.php; accessed June 1, 2019
[12] Kentucky Public Health, "State Health Assessment," (2017): https://chfs.ky.gov/agencies/dph/Documents/The2017KentuckyStateHealthAssessmentUpdate31517.pdf; accessed June, 2019

Benefit	Description
Getting on T.R.A.C.K. (Transition Ready Assistance & Core Knowledge)	Aetna's health literacy program for foster youth is called Getting on T.R.A.C.K. This program provides budgeting and basic life skills for children that transition out of care. The courses are taught in partnership with organizations that deliver different components of the curriculum.
"Keeping Kids Safe" Lockbox Program	Opioid-involved deaths are a concern in Kentucky, with deaths per 100,000 persons at 27.9 (nearly two times the national average), and the state also ranks among the top ten in prescription rate.[13] Further, as discussed in Kentucky's State Health Improvement Plan, more than half (57 percent) of the state's opioid overdose emergency room visits were billed to Medicaid. This harm reduction intervention is used to support safety by providing enrollees or parents/caregivers of an enroll with a lockbox to secure their medications. The Keeping Kids Safe program is part of Aetna's national campaign to fight the opiate crisis. The primary goal is to reduce the number of accidental opioid exposures that could result in poisoning, injury, or even accidental death.

Table G.8-5: Value-added Services Designed for Former Foster Care Children

Benefit	Description
Alternatives to Opioids	According to the National Institute on Drug Abuse, in 2017 there were 1,160 reported opioid-involved deaths in Kentucky—a rate of 27.9 deaths per 100,000 persons, compared to the average national rate of 14.6 deaths per 100,000 persons.[14] With opioid addiction on the rise, providers are seeking effective alternative pain management options for their patients. To support these efforts, Aetna will offer coverage for acupuncture, massage therapy, dry-needling, and yoga. Former foster care children, up to age 26, can receive up to $150 to use towards these services. This value-added service is provided to reduce opioid utilization and promote healthy and sustainable pain management.
Eyeglasses and Fittings	More than 12 million Americans need prescription eyewear yet do not wear it, often because they cannot afford it.[15] Over 140,000 Kentuckians have reported vision difficulty and many face a similar challenge.[16] This is why we offer eligible former foster care children, up to age 26, one free pair of eyeglasses every two years, including fittings. This value-added service will be provided to reduce vision distortion headaches, increase eye comfort, and improve quality of life.
Hearing Benefits	An estimated 35 million Americans suffer from hearing loss, yet only 28.5 percent use hearing aids.[17] Current statistics show that 694,301 Kentuckians are deaf/hard of hearing.[18] Additionally, enrollees who have even mild hearing loss have an increased risk of fall; those who wear hearing aids are less likely to go to the hospital or emergency room and those who are hospitalized have shorter stays.[19] Former foster care children (up to age 26) enrollees will be eligible for an annual exam and one hearing aid per year with unlimited visits for hearing aid fittings. This value-added service will be provided to reduce falls and hospitalization stays and improve quality of life.

[13] National Institute on Drug Abuse, "Kentucky Opioid Summary" (2019): https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary; accessed June 1, 2019
[14] National Institute on Drug Abuse, "Kentucky Opioid Summary," (2017): https://www.drugabuse.gov/opioid-summaries-by-state/kentucky-opioid-summary; assessed June 2019
[15] MES Vision, "Vision Facts and Statistics," (2006): (https://www.mesvision.com/includes/pdf_Broker/MESVision%20Facts%20and%20Statistics.pdf; accessed, June 1, 2019
[16] American Foundation for the Blind, "Expanding possibilities for people with vision loss," (2018): https://www.afb.org/research-and-initiatives/statistics/state-specific-stats/kentucky#2016; accessed June 1, 2019
[17] Hear-it, "35 Million Americans suffering from hearing loss," (2008): https://www.hear-it.org/35-million-Americans-suffering-from-hearing-loss; accessed June 1, 2019
[18] Kentucky Commission on the Deaf and Hard of Hearing, " Kentucky Def and Hard of Hearing Demographics,: (2015): https://www.kcdhh.ky.gov/ois/demographics.html; accessed June 1, 2019
[19] AARP, "7 Amazing Ways Hearing Aids Can Improve Your Life," (2019): https://www.aarp.org/health/conditions-treatments/info-2019/hearing-aids-benefits.html?CMP=KNC-DSO-Adobe-Bing-Hearing-Aids-

Benefit	Description
Weight Management Program	Kentucky has the 8th highest adult obesity rate in the nation and the 14th highest obesity rate for youth ages 10 to 17.[20] To help our enrollees achieve a healthy and active lifestyle, we offer a free nutritional/ weight loss counseling program through CVS Health that is provided at local MinuteClinic locations. The initial visit assesses weight loss efforts, physical condition, and lifestyle factors. Enrollees are evaluated and offered the opportunity to join the DASH for Health online program where personalized goals and plan are established. Subsequent visits focus on coaching and support of enrollees and the lifestyle and behavioral changes necessary to adopt healthy eating patterns. An individualized plan delivers up to a total of 16 visits over the course of 26 weeks, every week for the first 4 visits, and every other week for remaining visits. This value-added service will be provided to reduce obesity rates and the progression of related chronic disease, and to improve blood pressure, cholesterol, and blood sugar levels.
Aetna Better Way to Health – Former Foster Care Children	Our innovative incentive programs—offered to former foster children up to age 26—are designed to encourage enrollees to obtain important preventive services, while emphasizing personal responsibility and ownership of healthy living. For completing a health risk assessment, enrollees who are pregnant or newly eligible will receive a $20 incentive card.
Enhanced Transportation	A recent survey found that 27.4 percent of households do not have a motor vehicle and enrollees who rode a bus to receive health care were twice as likely to miss appointments as enrollees who drove cars. Additionally, 25 percent of those with low incomes missed an appointment due to transportation.[21] Additionally, this benefit aligns with state priority to Invest in Education and Workforce Development. Aetna provides 10 round trips (up to 60 miles total per round trip) per year via a transportation vendor for enrollees to have transportation services to activities such as job interviews, job training, shopping for professional attire, making a trip for food at a grocery store or food bank, and accessing community health services not otherwise covered. Transportation to job interviews is one of the more common uses of this benefit. This value-added service will increase access to non-clinical services for whole-person care and decrease the functional limitations of our enrollees.
Maternity Matters	Premature birth and its complications are the largest contributors to infant death in the U.S. and a major cause of long-term health problems in children who survive. March of Dimes Premature Birth Report Cards rate the Commonwealth of Kentucky a "D" at 11.1 percent of births premature.[22] Maternity Matters will be offered as a preventive health program for pregnant enrollees and new mothers and is filled with benefits and incentives to reduce premature births and mortality and encourage care. Incentives are received via reloadable card. The funds earned can be used for healthy foods, maternity supplies, and diapers at a variety of local and online stores: • Initial prenatal visit incentive: Pregnant enrollees can receive $25 for completing their initial prenatal visit. • Subsequent prenatal visits incentives: Pregnant enrollees can receive an additional $10 for each visit (10 visit incentives maximum). • Cribs for moms: Pregnant enrollees can also earn a portable crib at 37 weeks of pregnancy for seeing their doctor regularly during their pregnancy. • Postpartum visit: New mothers can receive $25 for attending a postpartum visit within 21-50 days after the baby is born. • Family transportation: Enrollees enrolled in Maternity Matters program can receive transportation provided for entire family that includes a car seat for children.

Improveands_kwcid=AL!4520!10!73461334267527!73461283940878andef_id=XPGhfwAAFNMq4_vR:20190605144040:s; accessed June 1, 2019

[20] Kentucky Public Health, "KENTUCKY State Health Improvement Plan," (2017 – 2022): https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf; accessed June 1, 2019

[21] Shawnee Christian Healthcare Center, "Addressing Social Determinants of Health and Improving Quality Through Patient Engagement," (2012): https://chambermaster.blob.core.windows.net/userfiles/UserFiles/chambers/9322/CMS/2018_Fall_Conference_/Monday/Addressing-Social-Determinants-of-Health-and-Improving-Quality%281%29.pdf; accessed June 1, 2019

[22] March of Dimes, "2018 Premature Birth Report Card," (2018): https://www.marchofdimes.org/peristats/tools/reportcard.aspx?frmodrc=1andreg=21; accessed, June 1, 2019

Benefit	Description
Simple Necessities Vending Machines	The United States Interagency Council on Homelessness estimates the point-in-time homeless population in Kentucky at 3,688. According to the National Health Care for the Homeless Council, homeless persons are three to four times more likely to die prematurely than their housed counterparts, largely because their conditions are exacerbated by life on the streets or in shelters.[23] To begin addressing some of the practical daily needs of these enrollees, Aetna has set up a vending machine for basic needs utilizing a card-based access system that is located inside an outpatient mental health clinic Region 3. It contains transportation passes and personal hygiene items that include toothpaste and toothbrushes, shampoo and conditioner, body wash for men and women, deodorant, shaving kits, hairbrushes, socks for men and women, underwear, baby wipes, warm hats, Aetna drawstring bags, and Aetna water bottles. Additionally, in partnership with the Street Medicine program, Aetna will continue to deliver hats and gloves to enrollees in need. These value-added services will increase enrollee access to toiletry items, transportation passes, and other items of necessity.
General Education Development certification	As called out in Kentucky's State Health Improvement Plan, 13.5 percent of adult residents have not graduated from high school.[24] Aetna provides an online prep course. This value-added service will increase General Education Development completion rate and improve overall quality of life and future opportunities of Kentuckians.
Health Literacy Program—Former Foster Care Children	This program is aligned with the state priority of *Creating a Healthier Kentucky* by "fostering higher health awareness through education that engages all individuals and communities." Aetna's health literacy courses are delivered in collaboration with our quality and community development partners for course facilitation; occasionally host community partners in Regions 3 and 5. • **Slow-cooking nutrition:** Food insecurity is a concern faced by 15.8 percent of Kentucky households.[25] Slow-cooking nutrition is a free course taught at various venues throughout the community, consisting of a one- or two-class series. The course offers nutrition 101, wellness activities, healthy meals/recipes for a crockpot, and Aetna benefits overview. The course focuses on nutritious and affordable meals using a slow cooker. At completion of the course, participants receive an Aetna-branded crockpot. This benefit aims to foster awareness and capability of participating enrollees of low-cost nutritious food choices. Additionally, this value-added service will reduce obesity rates; improve lab values; provide better control of daily glucose levels; improved blood pressure levels; and a reduction of morbidity. • **Diabetes nutrition:** An estimated 567,000 Kentuckians have diabetes, and the rate is up to three times as high for those with household incomes of less than $25,000 compared to those with household incomes over $50,000.[26] Some estimates have placed the reduction in life expectancy to be 10 years for type 2 diabetes and twenty years for type 1. Aetna offers a free basic diabetes course taught at various venues throughout the communities in Regions 4 and 8, where need is high. It is offered as a 6-8-week series. This value-added service will improve HbA1c levels in diabetic enrollees.

Mobile enhancement to VAS: Aetna is developing innovative enhancements to our enrollee mobile application and web portal to engage and educate enrollees about these value-added services. They will be able to see the value-added services for which they are eligible, as well as view information on their utilization of those benefits, and where applicable, request to receive the benefits or get more information. Enrollees can also receive assistance accessing these services through our Enrollee Services and Care Coordination staff who receive training about Aetna's VAS, with the goal of increasing enrollee access to and use of VAS.

[23] United States Interagency Council on Homelessness, "Kentucky Homelessness Statistics," (2018): https://www.usich.gov/homelessness-statistics/ky; accessed June 1, 2019
[24] Kentucky Public Health, "KENTUCKY State Health Improvement Plan," (2017 – 2022): https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf; accessed June 1, 2019
[25] County Health Rankings and Roadmaps, "Kentucky Rankings Data," (2019): http://www.countyhealthrankings.org/rankings/data/KY; accessed June 1, 2019
[26] Kentucky Public Health, "KENTUCKY State Health Improvement Plan," (2017 – 2022): https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf; accessed June 1, 2019

Additionally, to improve the quality and impact of these benefits, we are developing our new health innovation engine platform that will improve our ability to track and monitor eligibility, engagement, effectiveness, and spend for all enrollee value-added services. This innovative and proprietary web-based tool will be available at contract implementation. It streamlines all oversight functions, including the following:

- Addressing health disparities by proactively monitoring underutilization trends among key at-risk populations
- Preventing fraud, waste, and abuse through benefit design management
- Identifying opportunities to better promote and improve our value-added services to meet the needs of our enrollees
- Measuring benefit impact through enrollee satisfaction, and where applicable, health outcomes

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60.7.G.9 Health Outcomes

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60.7.G.9 Health Outcomes

Aetna recognizes that having a meaningful impact on the health outcomes of Kentucky SKY enrollees goes beyond improving performance on traditional Healthcare Effectiveness and Data Information Set (HEDIS) scores. Our approach to supporting children and families enrolled in Kentucky SKY is **immediate family engagement** emphasizing primary prevention and early intervention. Aetna's transformative vision drives our model for enhanced care coordination and service integration supporting the children, youth, and young adults in foster care, dually committed in both the foster care and juvenile justice systems, former foster youth under age 26, and post-adoptive children with subsidized care. This approach drives our System of Care (SOC) model incorporating our whole person, whole family approach to physical, behavioral, and social well-being. We reach beyond ensuring access to quality health care by focusing on **complete healing and resiliency** for children and their families. In alignment with Kentucky SKY program priorities, we implement delivery system reforms to improve quality and outcomes. We closely monitor that our care management, care coordination, and utilization management services and policies align to our person-centered model of care to promote the best possible outcomes for Kentucky SKY enrollees and their circle of support.

In helping providers transition to a managed care program, Aetna has developed a simple, streamlined process and educational program for Kentucky SKY to help providers understand key elements of managed care, including care management, care coordination, utilization management, and enrollee outcomes. Aetna will offer opportunities for providers, guardians, enrollees, and caregivers to have a voice by creating an Enrollee Advisory Board for the Kentucky SKY population. This committee will be comprised of community stakeholders, enrollees, family members, guardians, and providers with the central goal of effecting positive change to the health outcomes of Kentuckians.

Measuring Beyond Traditional HEDIS Scores

Aetna Kentucky SKY will measure an enrollee's health on multiple levels beyond traditional HEDIS scores. Our comprehensive coordinated care team approach strives to achieve the following overarching goals:

- Fewer children in foster care
- Increasing adoption rates
- Increase in family permanency (decrease in placement disruption)
- Fewer instances of termination of parental rights
- Increase in school attendance
- Decrease in arrest, status offenses, detention placements, and incarceration
- Increase in behavioral health screenings and early intervention
- Increase use of peer services to enhance connections
- Reduction in crisis and homelessness

The Charting the LifeCourse™ framework focuses on serving individuals enrolled in Kentucky SKY in concert with their circle of support. This framework creates and documents a single care plan that addresses much more than covered services and paid/unpaid support. The care plan also addresses the enrollee's likes and dislikes, gaps, and other life goals and objectives that promote self-efficacy and personal satisfaction, living in the community of their preference, and participation in socially rewarding life activities. The LifeCourse framework focuses on the enrollee's circle of support and assists them to identify what they need to be successful in providing quality care to the child. We address all challenges by engaging the child's circle of support including bio-parents, adoptive parents, relatives, non-related kin, or other caring adults in a collective approach to family safety, healing and thriving.

We are committed to improving outcomes for Kentucky SKY enrollees and will explore adding value-based payment arrangements to contractually incentivize recommended alternative outcome measures. All adopted measures will be incorporated into our Aetna Kentucky SKY toolkit and distributed to applicable providers with supplemental education and technical assistance.

Aetna utilizes sophisticated internal tools, technology infrastructure, and databases as described in **Table G.9-1** to identify, analyze, track, and improve quality and performance metrics beyond traditional HEDIS scores to determine that our care management, care coordination, and utilization management services and policies are having a meaningful impact on the health outcomes of Kentucky SKY enrollees.

Table G.9-1: Internal Aetna Tools and Technology Infrastructure

Data Source Type	Description
Claims Management System	Collection of medical claims for inpatient, outpatient, and professional services
HEDIS National Committee for Quality Assurance (NCQA) Certified Data Platform	For generation of annual HEDIS and non-standard HEDIS rates, and creation of monthly trend reports and provider gap in care lists
Hotspot Analytics	Identification of enrollee presence by gender, race, ethnicity, culture, HEDIS, and non-standard performance indicators by regional and statewide levels
Population Health Management	Identifies enrollee health risk factors and social determinant of health indicators, and alerts care coordinator of gaps in services, emergency department disparity dashboard, and health equity dashboard at the regional and statewide levels
Surveys/Assessments	Annual and post-call enrollee and provider surveys to measure their satisfaction and experience with our programs and services, social determinants, and care needs
Medical Record Audits	Provider adherence to medical record, HEDIS standards, and clinical practice guidelines
Grievances and Appeals Data Platform	Collection and tracking of enrollee and provider satisfaction with the plan and services rendered
Quality Data Platform	Tracking of provider preventable conditions, health care-acquired conditions, and potential quality of care concerns

Care Coordination Services and Policies

Our tiered care coordination approach moves through the continuum from low risk (general population), to high risk, our most intensive care coordination for the most vulnerable enrollees with biopsychosocial complexities. Our proprietary and evidence-based Consolidated Outreach and Risk Evaluation model identifies people at risk of high cost and/or high utilization in the future by using medical, behavioral, laboratory, and pharmacy diagnoses and claims data, and the likelihood of integrated care coordination making an impact. The risk rankings feed directly into our electronic care coordination platform to identify and prioritize enrollees for outreach into intensive or supportive care coordination as well as those who would benefit from chronic condition management.

Our care coordinators act as the **single point of contact** for the enrollee, family, and entire circle of support resulting in less system confusion, more connection to high quality services and supports, and increased satisfaction. Our specialized care coordinators are trained to serve targeted populations, such as pregnant women who use opiates through our Neonatal Abstinence Syndrome program.

At case closure, we ensure a successful transition including oversight and planning related to housing, nutrition, education, and employment (if applicable), whether it is to biological, kinship care, adoptive, or foster parents. Post-case closure, we remain available for assistance and continue to track the child's

outcomes. In Aetna's experience, most children aging out of the foster care system will remain eligible for Medicaid benefits, creating the need for effective health care access as well as transitions to stable housing, employment or employment training, and/or educational services. The Patient Protection and Affordable Care Act stipulates that youth formerly in foster care are eligible for Medicaid until age 26 and we assist in assuring continuity of access to care in these transitions. **Table G.9-2** outlines our recommended measures to determine if care coordination is having a meaningful impact on the health outcomes of Kentucky SKY enrollees.

Table G.9-2: Recommended Measures for Care Coordination

Recommended Care Coordination Measure	Description
Percent of individuals who move to lower care coordination tiers	Based on the support of the care coordinator and circle of support, individuals will move from higher risk tiers to lower risk tiers.
Rate of grievances and complaints	Having a single point of contact for issue resolution will result in fewer grievances and complaints.
Rate of adverse outcomes/potential quality of care concerns	The dedicated care coordinator will work to understand the family's needs, connect them with high-quality evidenced based treatment in their community, and be the first point of contact to resolve any issues or barriers.
Results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) adult and child survey and the foster care-specific satisfaction surveys for youth and circle of support	Close communication and coordination with the dedicated care coordinator will result in high rates of satisfaction as gathered from the CAHPS adult and child survey, as well as from our foster care-specific satisfaction survey for youth and their circle of support.
Percent of children/youth that stay engaged with services past age 18	The care coordinator will build a relationship with the children/youth and family to encourage ongoing participation in services up to 26 years old.
Percent of children completing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) appointments per the recommended schedule	Care coordinators provide education and reminders to parents/caregivers to increase compliance with EPSDT well-child visits with referrals to and follow-up with specialists for any concerns about developmental milestones.
Percent of early warning indicators, including screening positive for Adverse Childhood Experiences (ACES), sleep problems, and developmental anomalies	Care coordinators screen for and address ACES, anomalies in growth/development, sleep problems, and social emotional disorders.
Percent of at-risk youth connected to evidence-based substance use disorder (SUD) services	Based on screening and assessment for SUD, the care coordinator will secure linkages to treatment resulting in more youth being identified and engaged in SUD care.

Care Coordination Services and Policies

Aetna employs an SOC approach for care coordination to reduce fragmentation, with the goal of helping enrollees experience a seamless process while obtaining specialized services available from different funding streams, programs, and plans. Our SOC model is driven by the Aetna care coordinator providing care coordination through convening, advocating, supporting, and connecting youth and families to resources and supports including relatives, friends, community members, and new relationships. We leverage and maximize supports and services beyond physical and behavioral health needs; we work with the child and family to identify other areas of interest and activities that bring them joy and connect them with matching community resources to build resiliency.

Aetna is committed to supporting the **enrollee as the lead voice in the care planning process**. The enrollee and family identify individuals in their circle of support including which family members, caregivers, representatives, or other important people in their lives to join the care team for the purposes of ongoing gathering of assessment information and development of a single care plan. We use a 'calendar review' approach with the child and family—pulling out a calendar and writing down everything the child and family has planned. From there, we have discussions about the services and supports they need, as well as finding opportunities for balance and incorporating joy and play.

Children and youth enrolled in Kentucky SKY experience high rates of ACEs often resulting in challenges with mood regulation, attachment, behavioral control, and other areas of diminished functioning. They are often misdiagnosed or have multiple diagnosis (at times conflicting) and are prescribed psychotropic medications, when they have untreated trauma. We engage psychiatrists trained to understand the role of ACEs and trauma to evaluate and review medications and adjust accordingly as well as connect the enrollee to trauma treatment to avoid misdiagnoses and inappropriate prescribing. Assisting in this process is our unique clinical pharmacist program; we will have a full-time clinical pharmacist dedicated to the needs of Kentucky SKY enrollees, who will assist in appropriate medication prescribing, including reviewing for duplicative medications, polypharmacy, drug-drug interactions, and assuring for required metabolic monitoring for anti-psychotics.

Because of our focus on social determinants of health and their impact on health care access and quality of life, Aetna includes attention to socioeconomic status, and access to housing, nutrition, education, and employment. Engaging the youth's circle of support leads to greater understanding of the family's financial situation in this process as it impacts their access to quality housing, nutrition, transportation, and numerous other factors in creating and sustaining a healthy life. We believe it is important to understand the family finances and discuss interventions for potential household revenue creation, including access to all the benefits for which they are eligible to maximize household income. A lack of access to any of these important determinants of health leads to stress within families and can exacerbate health and social difficulties and lead to family disruption. Our focus centers on providing access to care and social determinant resources supporting kinship care whenever possible over foster care. We believe relatives are the preferred source of care for children who must be removed from their birth parents as kinship care maintains familial connections for the child. **Table G.9-3** outlines our recommended measures to determine if care coordination is having a meaningful impact on the health outcomes of Kentucky SKY enrollees.

Table G.9-3 Recommended Measures for Care Coordination

Recommended Care Coordination Measure	Description
Percent of care plans that include community engagement activities	Many of these children and families live in cultural and social isolation. Connection with community and activities increases the likelihood of healthy behaviors and outcomes. Our care coordinators encourage activities the child and family might like including sports, music, and cultural or faith-based events.
Rate of improvement in quality of life indicators	In partnership with the Harvard Lee Kum Sheung Center for Health and Happiness, Aetna has embraced that measurement of quality of life includes a combination of objective well-being measures (education, physical and built environment, community, and economy), and subjective well-being measures (psychological, social, and spiritual). Our care coordination services and policies connect enrollees and their circle of support to both types of resources to improve health outcomes and overall quality of life.

Recommended Care Coordination Measure	Description
Percent of school-based measures, including attendance, grades, high school graduation rate, and absenteeism	With increased support and connection to the school and school-based services, we expect a positive impact on attendance, reports from school, progression in grades, high school graduation rates, and absenteeism.
Social determinants of health (e.g. physical activity, consumption of healthy foods, pro-social activities, etc.)	Health is measured based on environmental factors, including but not limited to, increased access to healthy foods, regular exercise, time with family and friends, and the overall reduction in toxic stress.
Self-sufficiency domains	Mobility/disabilities/physical health, legal, safety, life skills, network support, family relations, intimate relationship(s) and parent-child relations.
Behavioral health challenges (mental health and substance use) including crisis and inpatient stays	The care coordinator works closely with all involved providers including mental health and substance abuse to decrease crisis and inpatient stays.
Number of children placed in out of care/residential/detention	The care coordinator works closely with the child, family, providers, and community resources to ensure all needs are met, resulting in decreased number of children placed outside the home.
Length of stay in out of home care, residential, and detention	When the enrollee requires out of home care, residential, or detention, the care coordinator works closely with the child, family, providers, and community resources to ensure all needs will be met upon discharge, resulting in reduced lengths of stay.
Rates of incidence of arrest, status offenses, detention, and incarceration	With close care coordination between all involved parties and support for the enrollee and family, we expect lower rates of arrest, status offenses, detention, and incarceration.
Inappropriate prescribing and polypharmacy	Through our electronic care coordination platform, we can access all information about the enrollee and family, including but not limited to service plans, HEDIS measures addressed, school-based services, prior authorizations, behavioral health, EPSDT services, transportation, inpatient admissions, notification of adoption, transition to adulthood, and health risk assessment. We closely track pharmacy and medications to reduce the risk of inappropriate prescribing and polypharmacy.

Utilization Management Services and Policies

Aetna's Utilization Management (UM) program will coordinate and pay for whole-person care for our Kentucky SKY enrollees in the most appropriate setting. We identify, evaluate, manage, and improve clinical care and services through our UM services and policies. As directed by the chief medical officer, physical health and behavioral health medical directors provide oversight of Aetna's clinical functions including quality management, utilization management, care coordination, and credentialing. The medical directors provide clinical leadership for the Quality Management/Utilization Management Committee, conduct medical necessity reviews, conduct peer-to-peer reviews, and provide mentoring and clinical leadership for the integrated care coordination program. We will have policies in place to make sure that Kentucky SKY enrollees are not denied important services for long term safety, stability, and normal development.

Our staffing includes qualified health professionals who **live in Kentucky with active Kentucky professional licenses** with applicable experience and training. This enables the team to be familiar with resources/services specific to their area and leads to the following:

- Increased resource expertise
- Increases in enrollee/family engagement
- Collaboration

- Quality of care/referrals
- Enrollee outcomes
- Improved access and preventive care

This also allows for relationship building with providers/practitioners in the area resulting in increased continuity of care and engagement with enrollees. Our care coordinators and utilization managers are assigned to cases until resolution; they conduct weekly rounds to continually stay informed of the enrollee and family's needs. **Table G.9-4** outlines our recommended measures to determine if utilization management is having a meaningful impact on the health outcomes of Kentucky SKY enrollees.

Table G.9-4 Recommended Measures for Utilization Management

Recommended Utilization Management Measure	Description
Rate of inappropriate denials/overturn on appeals	Aetna recognizes the care team and circle of support promote what is best for the enrollee and family. Aetna will collaborate with care team and communicate directly with providers, including peer-to-peer discussions.
Percent compliance with authorization timelines	We complete service authorization requests timely and efficiently in compliance with established NCQA turnaround timeframes and the requirements indicated in **42 CFR 438.210(d).**
Rates of emergency department utilization, hospital readmission, length of stay, and neonatal intensive care unit (NICU) admissions	We use nine UM dashboards, which provide data reports on readmissions, observations versus one-to-two-day stays, emergency department utilization, NICU admission patterns, outpatient urine drug testing patterns, medical claims trends, authorization trends, outpatient utilization trends, and inpatient performance targets. Through these reports, we can identify and engage high utilizers into lower levels of care.
Rates of gaps in care	We evaluate gaps in care every time we interact with an enrollee. This allows us the opportunity to not only encourage needed care but also assist in getting the enrollee to the visit. We share gap in care reports with our provider partners and work with them to assess enrollee needs in closing gaps in care.
Drug over- and under-utilization patterns	We conduct retrospective drug utilization reviews (RetroDUR) to detect pharmacy over-utilization. Aetna applies RetroDUR to assess drug over- and under-utilization patterns to drive the development of interventions and/or educational activities.

60.7.G.10 Population Health Management and Care Coordination

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60.7.G.10 Population Health Management and Care Coordination

Aetna has learned in its broad experience that in every case, our enrollees hold the solution to a good life. We exist in service to our enrollees and in partnership with state child protection professionals. We strongly believe this is exactly where the promise of precision medicine intersects with a good life for our enrollees. In every step of the way, our health plan seeks to build on the capabilities of enrollees and partners and collectively we will be steadfast in our mission to support Kentucky become the national leader in preventive system transformation for all families.

Aetna has demonstrated success addressing the whole-person needs of children and young adults who comprise the Kentucky SKY population (as defined in **Section 41.2 Eligibility for Enrollment in Kentucky SKY** of the **Draft Managed Care Model Contract and Appendices**). We advance person and family recovery and resiliency, using person-centered approaches. We are committed to partnering with the State in its movement to a population health-based model of care, which seeks to maximize preventive services at the primary, secondary, and tertiary levels and both focus on and strive to eliminate health disparities for Kentuckians, specifically for at-risk children and youth. Aetna understands that the Kentucky SKY population faces social inequities (e.g., increased likelihood of having experienced adverse childhood experiences [ACEs], instability in parenting attachment, etc.) that impact accessing health care, achieving optimal health outcomes, and meeting personal goals for health and wellness. We understand that addressing social risks for Kentucky SKY children and youth is integral and often the first step to assisting them to move up the continuum from being disengaged to engaged health care seekers who take an active role in maintaining their well-being. We recognize that these vulnerable children, youth, and young adults should have the highest quality of care and seamless coordination of services to achieve the best health outcomes. This approach promotes resiliency and helps to build upon family and community systems of support.

Aetna's Population Health Management (PHM) program recognizes that health is more than the optimal delivery of clinical care, and is about the health of the population, including the distribution of health outcomes, disparities, genetics, and environment in the population. Aetna achieves population health management excellence by understanding drivers of health inequities and the impact of prevention and early intervention. Through collaborative partnerships, Aetna empowers all enrollees, including at-risk children and youth, to engage in their health care and improve their health outcomes with enhanced quality of care and the reduction or elimination of health disparities. Aetna has served children and youth in Kentucky who are involved with the foster care system, adoption assistance, and juvenile justice since 2011, as depicted in **Figure G.10-1**.

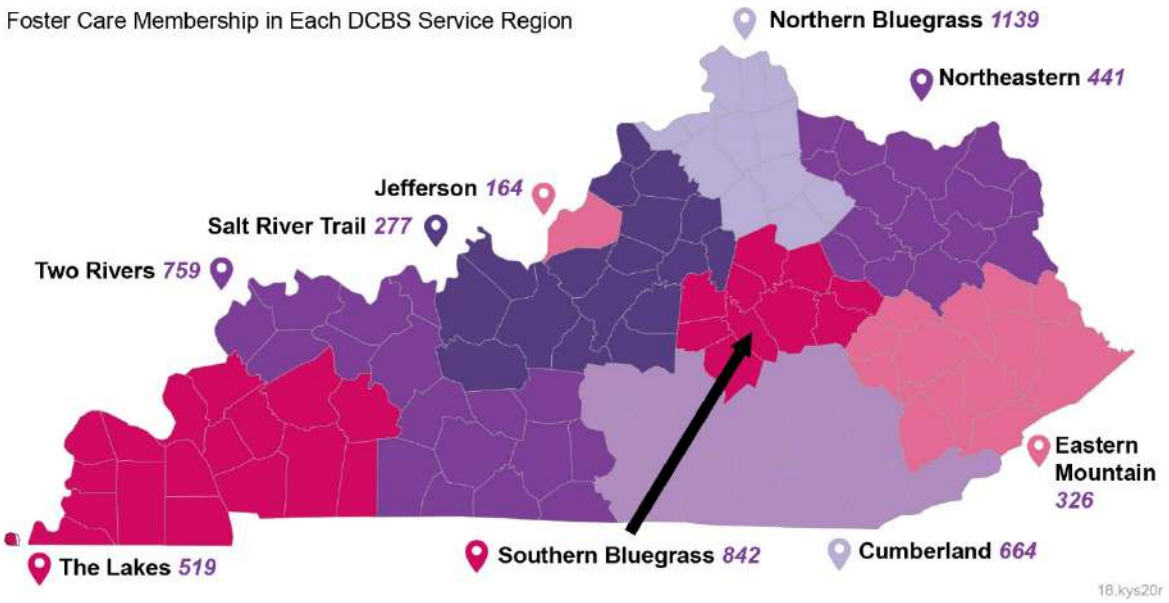

Figure G.10-1: Aetna's Foster Care Enrollees throughout Kentucky

Aetna has experience serving foster care enrollees in Kentucky throughout the Commonwealth.

We know the issues facing the Kentucky SKY population are complex and require a multidisciplinary approach to care coordination. It is estimated that upwards of 80 percent of children in foster care have a significant mental health need.[1] **Table G.10-1** summarizes some of the primary behavioral health conditions our current enrollees in foster care face, segmented by their risk based on our rising risk model for at-risk youth, which is described fully in this section.

Table G.10-1: Summary of Health Concerns of Aetna Foster Care Youth, by Risk Group

Category	Top 1%	Top 5%	Top 10%	Top 20%	All
Enrollees with four or more behavioral health conditions	100%	80%	49%	25%	5%
Enrollees with bipolar disorder	76%	47%	31%	18%	4%
Enrollees with attention-deficit/hyperactivity disorder (ADHD)	92%	91%	88%	85%	38%
Enrollees with depression	96%	78%	64%	45%	11%
Enrollees with anxiety	94%	85%	80%	69%	21%
Enrollees with oppositional defiant disorder	52%	37%	34%	29%	8%

At Aetna, we support our enrollees to reach and maintain a meaningful quality of life, optimum health, and overall wellness. To do so, we strive to **understand each unique enrollee in the context of their lives, while partnering with them to design a person-centered holistic model of supports and services that enhances their quality of life and assists them to reach their individual life goals.** For example, through our arrangement with Community Pharmacy Enhanced Services Network, a local pharmacist develops relationships with enrollees and supports medication management, unmet social needs identification, and opportunities with engagement integrated care coordination. Our approach is local and devoted to enrollees; it places vulnerable children and youth at the heart of our work, addressing

[1]US News and World Report, "Meeting the Health Needs of Foster Kids," (2018); https://www.usnews.com/news/healthiest-communities/articles/2018-08-24/health-needs-persist-for-foster-kids-despite-medicaid-coverage; accessed June 13, 2019

their holistic health needs by providing access to and delivery of cost-effective health care services. **Table G.10-2** demonstrates Aetna's success in serving foster care youth in Kentucky.

Table G.10-2: Aetna Foster Care Healthcare Effectiveness Data and Information Set (HEDIS®) Scores Compared to All Children, Kentucky 2019

HEDIS Measure	All Foster Care HEDIS Enrollees 2019	All Child Enrollee HEDIS Rates 2019	Percent Difference
Chlamydia Screening: 16-20 Years	52.2%	47.4%	10.1%
Comprehensive Diabetes Care – Eye Exam	50.0%	41.5%	20.5%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutrition Counseling	24.1%	21.2%	13.7%
Asthma Medication Ration – Total PD 50	90.9%	71.1%	27.9%
Childhood Immunization Status – Hepatitis B	81.4%	74.8%	8.8%
Childhood Immunization Status – Combo 4	50.0%	43.3%	15.5%
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence – Other Drug Abuse or Dependence: Initiation of AOD Treatment: Total	58.4%	42.5%	37.4%

a. Identifying and Coordinating Care for Kentucky SKY Enrollees

Aetna's transformative vision drives our model for enhanced care coordination and service integration supporting the children and youth in foster care, adoption assistance, and juvenile justice populations. To identify and coordinate care for children, youth, and young adults enrolled in Kentucky SKY transitioning from another managed care organization (MCO), Aetna will develop transition policies and procedures with the Department for Community Based Services (DCBS) and the Department of Juvenile Justice (DJJ) to identify enrollees with medically complex needs and children with special health care needs, and other populations that have the most immediate service need. Our transition plan for enrollees with the most immediate service needs is outlined.

Identifying Kentucky SKY enrollees during transition: All transitions can be traumatic, and we are serious about making sure each transition is supported thoughtfully and appropriately. We will work with the Department and other MCOs leading up to the transition of children and youth served under Kentucky SKY to obtain necessary medical records, prior authorizations, medication lists, and any additional pertinent details that we can use to discern enrollees with immediate need. Ideally, we would have this information far enough in advance of implementation to identify immediate needs and gaps in care. The timeliness of obtaining these records, as documented in our Transition of Care policy, is essential to minimizing disruption in services in a population that requires our unwavering commitment, collaboration, and compassion.

In addition to collaborating with the Department and other MCOs, we will utilize the following strategies:

- **Enrollee's Level of Care from the Children's Review Program:** Utilize state ranking (1-5) focusing on enrollees assigned a higher number and identified as having greater need.
- **Access to The Worker Information System (TWIST):** Allows the health plan to have full access to enrollee information including medications, last appointments, providers, and diagnoses.
- **Kentucky Health Information Exchange (KHIE):** We will obtain prior medical history, testing, pharmacy, labs and other pertinent clinical information through the KHIE and accessed through our PHM platform.

A specialized Care Coordination team (CCT), comprised of interdisciplinary staff who are experienced serving children, youth, and young adults similar to the population served through Kentucky SKY, will outreach the enrollee's care coordination and transition specialist at the previous MCO. We ensure that our care coordinators understand the impact of previous trauma in the Kentucky SKY population and the importance of creating an environment of safety that does not cause re-traumatization. With this in mind, at each step, they involve the enrollee and/or their representative, providers, and the enrollee's CCT in the transition process to ensure the enrollee feels supported and heard throughout the change. During the initial conversation, the care coordinator obtains information about existing services and the enrollee's ongoing support needs and any current concerns. Our Transition Coordination staff works to develop a comprehensive transition plan, with a systematic guide outlining how transition continues the enrollee's existing services. The care coordinator will review the enrollee's person-centered care plan (if applicable), enrollment file, and any other functional assessment and health and service authorization records provided by the former MCO. Aetna's existing Medicaid provider **network is 100 percent compliant with Department's network adequacy requirements. We have 29,355 contracts representing 33,794 providers at 118,977 locations,** making it likely that a Kentucky SKY enrollee may not need to change providers if they are enrolled with Aetna. Aetna's goal is that when there will be an insurance transition, it will be seamless and almost imperceptible to the member and their caregivers.

Aetna Care Duffle Bag and Birthday Box Programs

Aetna provides necessities for children as they come into the foster care system. We have duffle bags available for kids ages 8 through teenage years (over half of our foster care children are teenagers). The duffle bags include a water bottle, shampoo, conditioner, toothbrush, toothpaste, hairbrush or comb and body wash, and fleece blanket.

Through our Birthday Box program, we recognize birthdays for medically fragile and transition age children that would otherwise not be acknowledged on their special day. Each child receives "a birthday in a box" including party supplies, balloons, book/journal, puzzle/game, and a large cupcake. The Birthday in a Box is arranged and delivered by the foster care coordinator.

See **Figure G.10-2** for a depiction of our integrated System of Care (SOC) model of care for Kentucky SKY.

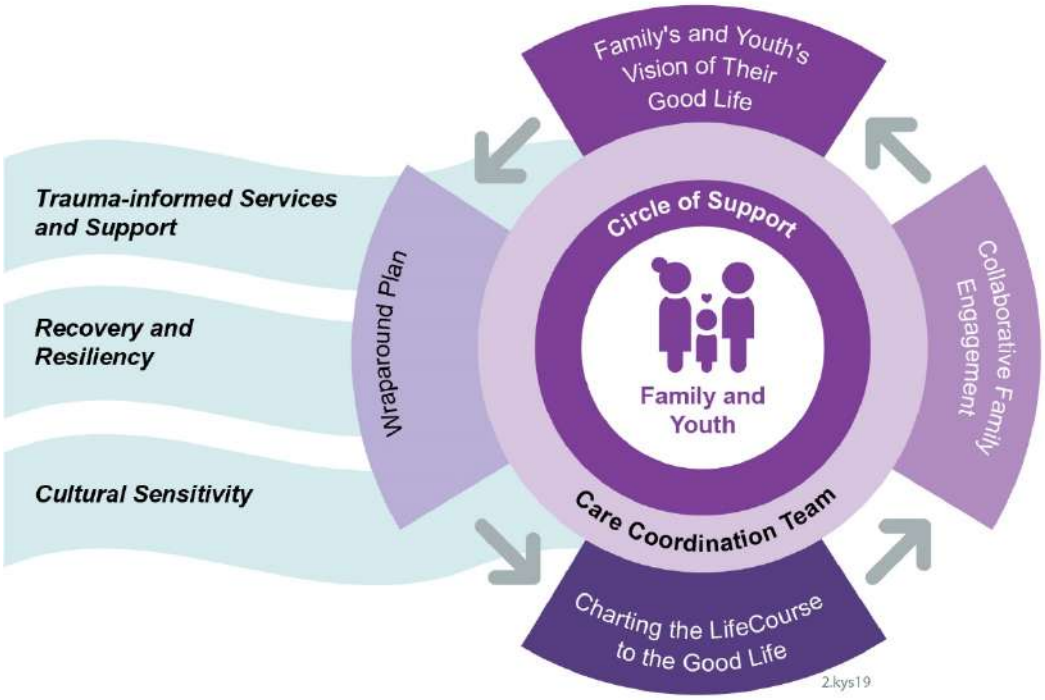

Figure G.10-2: Aetna's Integrated System of Care

Aetna's integrated SOC includes all health care and related services and supports necessary for enrollees with special health care needs to achieve improved health outcomes.

Coordinating care through transition: We recognize that a change in a service model can be challenging and we want to provide a seamless transition for children, youth, and young adults enrolled in Kentucky SKY as they transition to managed care and/or between MCOs. Transitioning between managed care organizations requires a well thought-out and prepared approach. Our enrollee transition policy supports the smooth transfer of information and continuation of care. When transitioning enrollees, we do the following:

- Determines immediate needs by conducting Aetna's proprietary foster care and condition-specific assessments, including PAM-10, Charting the LifeCourse™, and other self-determination tools, to coordinate all necessary Medicaid and non-covered services
- Obtains prior authorization files and service plans from the previous health plan so that all services and supports, including access to prescriptions, can continue for up to six months after the transfer or until the end of the current authorization period, or until a new assessment is completed (within 90 days of enrollment) and a new service plan is authorized
- Collaborates with providers and specialists of prior MCOs to request the plan of care, medical records, and clinical information, ensuring continuity of care
- If the DCBS social service worker (SSW), caregiver, foster parent, or foster care child does not select a primary care provider (PCP), Aetna will assign a PCP with consideration of an individual's needs such as location, transportation, and cultural factors within two business days, making every effort to keep the enrollee with their previous provider
- Monitors continuity and quality of care, transition activities, services, and reporting for each enrollee
- Ensures enrollee receives a physical health screening within 48 hours of an order in which a child enters the custody of the Cabinet for Family and Health Services and treatment for any injury/illness that may be the result of maltreatment within 24 hours of the order

- Makes arrangements for the youth to attend medical, dental, and vision appointments within two weeks of an order in which a child enters the foster program and annually thereafter
- Facilitates completion of the mental health screening performed by a qualified mental health professional within 30 days of enrollment
- Makes arrangements and documents service provision when the screening indicates that further assessment or treatment is needed
- Uses the medical passport guidelines to document the physical and mental health care services for enrollee
- Mails a Foster Child Enrollee Information Packet to the SSW for foster care children or the Juvenile Justice (JJ) Enrollee Information Packet to DJJ children's benefit worker within five calendar days of receipt of the eligibility file from the Department
- Mails the Adoption Assistance Enrollee Information Packet to the adoption assistance child or adoptive parent within five calendar days of receipt of the eligibility file from the Department

Assigning a local care coordinator: In addition, each child, youth, or young adult enrolled in Kentucky SKY will be assigned to a regionally-based care coordinator, who is supported by a specialized CCT, and Aetna's children's system of care and recovery and resiliency administrators (other SOC staff are described in this section). The Kentucky SKY care coordinator acts as a single point of contact responsible for coordination of care with all necessary physical health, behavioral health, functional, and wraparound social support services to promote improved health outcomes and enrollee quality of life. The Aetna SKY CCT is assembled within 24 hours of enrollment in the program and tailors services to each child, youth, or young adult enrolled in Kentucky SKY's individual needs, emphasizing enrollee and family voice and choice through a comprehensive ongoing needs assessment and person-centered care planning process. The CCT coordinates all necessary health assessments, through face-to-face contact, within the timeframes specified in **Section 34 of the Draft Medicaid Managed Care Model Contract and Appendices**, to identify enrollees' whole-person needs. The CCT develops a care plan within 30 calendar days of enrollment with Aetna and will refer for care management where appropriate based on need. The care coordinator assists enrollees and families to schedule provider appointments to meet all timeliness requirements including a follow-up phone call within 24 hours of a missed appointment to assist in rescheduling. The support care coordinators assist children, youth, and young adults enrolled in Kentucky SKY and their circle of support with cross-system navigation to ensure every young person receives needed treatment and support. The SKY-specialized CCTs coordinate all aspects of person and family-centered care, including the following: primary care via a medical and dental home; care provided at school-based health centers; specialty provider services, including respite for caregivers; medication management; seamless support and care transition across settings (DJJ); management of chronic conditions; peer support services; and services and supports from specialized community-based organizations and programs to meet enrollees' social determinant needs.

Specific steps Aetna takes to coordinate care for children, youth, and young adults enrolled in Kentucky SKY with the most immediate service seeds leading up to and following implementation of the Kentucky SKY program include the following:

- Regionally based meetings, which we call **Shared Children, Youth and Family Teams,** with all relevant stakeholders (e.g., DCBS, DJJ, prior MCO care coordination staff, members of the CCT, etc.) weekly, or more often if necessary, to prioritize and organize an urgent, coordinated response to children and youth with immediate needs who are not in immediate crisis. These meetings will facilitate the safe transition of children, youth, and young adults enrolled in Kentucky SKY from their previous health plans to their Aetna Kentucky SKY CCT.
- Access to a robust **mobile crisis stabilization team** contacted through local community mental health centers for any Kentucky SKY children, youth, and families in need of immediate crisis; their care coordination will begin in response to their urgent health and/or mental health needs

- For inpatient behavioral health or psychiatric treatment (e.g., a psychiatric residential treatment facility), we contract with hospitals and providers (including PCPs, specialists, and urgent care providers) who understand the needs of children, youth, and young adults enrolled in Kentucky SKY. All enrollees are assigned to a care coordinator who works on their behalf (and on behalf of their family or support system) to facilitate coordination of services in collaboration with facility discharge planning staff. This active collaboration is critical to ensuring all necessary services are in place for the enrollee prior to discharge, most importantly securing an appointment with their behavioral health (BH) provider within seven days of discharge.
- For enrollees with medically complex needs, we will provide both care management and nursing consultative services. We will convene to create an individual health plan (IHP) within 30 calendar days of the youth being deemed medically complex to include an in-person home visit to assess for trauma, social determinant needs, as well as physical and behavioral health. The CCT team, including the social service worker and nurse consultant, will meet every three months to assess ongoing needs. Updates to the IHP will occur at a minimum of every six months. The nurse care coordinator will meet with the enrollee in their home at least once per month.
- Aetna will provide training to the Department, DCBS, DJJ, other Cabinet sister agencies, law enforcement officials, and the juvenile judicial system on trauma-informed care (TIC), ACEs, and evidence-based practices applicable to the children, youth, and young adults enrolled in Kentucky SKY. In addition, Aetna provides all required trainings to contracted Kentucky SKY providers as outlined in **Section 41.6.3 Kentucky SKY Contractor Educational and Training Requirements of the Draft Medicaid Managed Care Contract**.

Aetna's SOC team includes six staff members each focused on delivering specific supports to children and youth enrolled in Kentucky SKY. **Table G.10-3** summarizes the role of each SOC administrator:

Table G.10-3: Aetna System of Care Personnel and Their Role in Supporting Kentucky SKY

Systems of Care Team	How They Support Children and Youth Enrolled in Kentucky SKY
Children's System of Care Administrator	• Builds key stakeholder relationships and processes with the Department and DCBS and attends various meetings including State Interagency Council • Meets with service staff in service regions and community districts to address gaps, concerns, problem resolution, education needs, and risk management • Supports and facilitates the youth boot camps and governance committee • Bridges health promotion, prevention, and early identification and intervention in order to improve long term outcomes statewide • Builds community-based services and supports specific to the Kentucky SKY population • Participates in the development and delivery of Kentucky SKY curriculum
Recovery and Resiliency Administrator	• Builds supportive programs and intervention to address mental health, substance use, and foster care delivery and coordination including resiliency training and development, advocacy, foster family and biological family support, recovery maintenance, etc. • Participates in integrated rounds • Collaborates with all enrollees, families, and stakeholders to help to ensure all Kentucky SKY enrollees have advocacy support • Collaborates with local, state, and national partners and stakeholders like Bounce Coalition • Collaborates with enrollees and family to identify and remove barriers to service • Promotes the hope for recovery within the health plan • Collaborates with Provider Services to coordinate peer support network and other non-traditional providers to service special populations like Kentucky SKY enrollees • Participates in the development and delivery of Kentucky SKY curriculum • Chairs Member Advisory Committee

Systems of Care Team	How They Support Children and Youth Enrolled in Kentucky SKY
Emergency Room/Crisis Administrator	• Develops the crisis plan development process and identify gaps and solutions (develop crisis response teams) • Collaborates with Medical Management to mitigate gaps in crisis service delivery including solutions to emergency room (ER) holds, reduction in out-of-state placements, and difficult-to-place enrollees • Coordinates system approach to enrollees needing emergency services for domestic violence victims, unaccompanied minors, etc. • Builds collaborative relationships with fire, police, emergency medical services, and hospital emergency rooms to advance TIC approaches across systems and outcomes for our enrollees • Collaborates with medical management on transition of care for enrollees like aging out needs and discharging from inpatient settings and mitigates system gaps • Participates in the development and delivery of Kentucky SKY curriculum
Juvenile Justice Liaison	• Collaborates with the DJJ, Department of Corrections, county jails, sheriff's office, Correctional Health Services Office of the Courts and Probation Departments, and Department of Behavioral Health and Developmental Disability to identify systemic changes and promote community integration • Remains proficient on Reclaiming Futures framework to promote within systems and communities serving youth • Develops workflows for Kentucky SKY enrollees transitioning out of detention • Collaborates with instructional design to develop and deliver required training for judges, law enforcement, district and county attorneys, Department of Public Advocacy, etc. • Collaborates with the Start Strong program to strengthen reentry for our enrollees • Develops workflows for all required state assessments • Works with care coordinators in all regions to maximize system improvements through the Regional Interagency Councils • Provides/coordinates training and technical assistance to legal professionals working at the intersection of health/justice
Trauma System of Care Administrator	• Builds key stakeholder relationships with the Department, DCBS, etc. for the planning and delivery of services • Ensures that all service needs, including community-based supports, are available in the Kentucky SKY regional areas, and identify gaps and solutions—especially those enrollees aged 18-26 • Collaborates to develop integration of records—information technology, communication, single care plan development, coordination with TWIST, etc. • Collaborates with Provider Services to coordinate networks to service special populations like Kentucky SKY enrollees, enrollees with childhood trauma, etc. • Develops workflows for all required state assessments • Participates in the development and delivery of Kentucky SKY curriculum
Adult System of Care Administrator (transitional age enrollee focused, e.g. 18–26 years old)	• Builds key stakeholder relationships with the Department, DCBS, etc. for the planning and delivery of services specifically around youth transitioning to adulthood. • Ensures that all service needs, including community-based supports, are available in the Kentucky SKY regional areas identify gaps and solutions—especially those enrollees aged 18-26 • Collaborates to develop integration of records—information technology, communication, single care plan development, coordination with TWIST, etc. • Collaborates with provider relations to drive coordinate networks to service special populations like Kentucky SKY enrollees, enrollees with childhood trauma, etc. • Collaborates with DCBS and DJJ to assist enrollees with waiver applications, durable medical equipment, referrals for independent living skills supports, etc. • Develops workflows for all required state assessments • Participates in the development and delivery of Kentucky SKY curriculum

Enrollees Involved in the Justice System

Aetna will leverage our experience with the justice system to design and implement programs to support justice-involved youth among our children, youth, and young adults enrolled in Kentucky SKY. Aetna's Start Strong is a re-entry program focused on improving the lives of individuals that have become involved in the criminal justice system. Each Aetna enrollee taken into custody at Kenton County Detention Center in northern Kentucky receives an Aetna Start Strong brochure and a letter stating how to get in touch with the re-entry coach who is co-located at the detention center. Services include treatment, housing, and job training. We provide additional supports to make sure enrollees can continue their treatment without any gaps. The **success rate for the Aetna Start Strong program is 91 percent among 77 participants in the program since November 2017.**

b. Identification and Monitoring New Kentucky SKY Enrollees with High Health Needs to Ensure Continuity of Care

Early identification and intervention are the key to our strategy for Kentucky SKY; protecting and promoting healthy childhood development and catchup, when needed, is critical to promoting improved health across the life course. Aetna has a proven track record of delivering coordinated care to the Kentucky SKY population in Kentucky. Aetna's HEDIS measures for foster care children have remained above the national benchmark (at the 50th percentile) for each of the past three years. In addition, our 2018 Antipsychotics in Children and Adolescents rate was 0.03 percent, compared to 2.09 percent for the national benchmark (note: for this measure, a lower percent is considered favorable.)

Aetna uses a multipronged strategy to identify and monitor new children, youth, and young adults enrolled with Kentucky SKY who have high physical (e.g., 24.4 percent of our enrollees in foster care have nutritional concerns and 43.8 percent have a respiratory condition) or behavioral health needs, which are described previously in **Table G.10-3**. To ensure continuity of care, a single point of contact uses the following methods to identify and monitor enrollees: internal and external referrals; Aetna screening and assessment tools; our rising risk predictive modeling approach for children and youth at risk for crisis episodes; policies and procedures for transitioning between MCOs; and processes for when an enrollee's provider is leaving the network. Aetna CCTs understand the types of challenges facing children, youth, and young adults enrolled in Kentucky SKY and have the resources available to link them to services and supports to address their holistic needs. For example, referrals to community-based nutritional resources and information and access to our transportation-focused value-added service can assist with continuity of care. The CCT also collaborates with the SOC team identified above for the purpose of identifying additional community-based resources that support the holistic needs of the enrollee, due to their experience working in the community.

We use tools, like the University of Missouri-Kansas City Institute for Human Development's Charting the LifeCourse™[2] framework, to facilitate person-centered decision-making, problem-solving, and planning when working with our enrollees. With these as guiding principles, and by using the related tools and resources, we work closely with enrollees and their families to navigate key life stages and provide thoughtful anticipatory guidance around major life experiences to sustain enrollee quality of life, avoid unnecessary transitions, and ensure continuity of care.

Aetna Kentucky SKY endorses the 'no wrong door' approach for our enrollees. Youth may enter the Kentucky SKY program in various ways, including through referrals from DJJ, DCBS, and directly from the youth's primary caregivers and family. We will work with all system partners and use all available information systems to identify and outreach the very vulnerable young people included within the aging

[2] "LifeCourse Principles," Charting the LifeCourse™; http://www.lifecoursetools.com/principles/: accessed February 2018

out and juvenile justice populations. Our innovated integrated systems approach is based on whole person view of our Kentucky SKY enrollees' physical health, behavioral health, oral health, health literacy, and social determinants of health. Specific means of identification are outlined in this section.

Internal and external referrals: Aetna uses referrals from internal resources and our strong community partnerships to identify individuals that may benefit from care management services. These referral sources include the following:

- Enrollee Services and Grievances staff referrals resulting from historical data that we assess and trend at the enrollee level
- Providers, including primary care, behavioral health, and specialist providers. Through our partnership with the Community Pharmacy Enhanced Services Network, community pharmacists assist in identifying enrollees who are in need of more supportive services and refer them to Aetna for care coordination.
- State staff, including Medicaid, the Department of Behavioral Health, Developmental and Intellectual Disabilities, DCBS, DJJ, the Kentucky Social Service Department, and the Cabinet for Health and Family Services Department of Public Health (for referrals for Women, Infant, and Child programs, for example)
- Local law enforcement agencies
- Utilization Management, Quality Management, Enrollee Services, or other internal departments services
- Alert within care coordination system upon Kentucky SKY enrollee discharge from in-patient stay prompting care coordinator to connect with enrollee to assess for barriers to receiving care
- Juvenile justice liaison will coordinate with DJJ facilities regarding enrollees who are leaving their facilities and will be eligible for Medicaid services, allowing for a more seamless transition
- School-based health centers, faith-based groups, and social service organizations, such as food banks and homeless shelters

Aetna screening and assessment process: Aetna conducts all required assessments and screening, as outlined in **Section 41.17 Required Assessments and Screenings of the Draft Medicaid Managed Care Model Contract and Appendices**, including the health risk assessment (HRA) and enrollee needs assessment (ENA) and foster care assessment (See **Attachment AA** for sample assessments). From these we gather data on each enrollee's whole-person needs, including their physical health, behavioral health, and functional needs, and, social risks. In addition, we conduct our proprietary specialized foster care screening and the Child and Adolescent Needs and Strengths-Trauma (CANS) screen. Aetna conducts all Early and Periodic Screening, Diagnosis and Treatment (EPSDT) periodicity schedule requirements relevant to the Kentucky SKY enrollee's age. We will identify individuals in the enrollee's circle of support for the purposes of ongoing gathering of assessment information and care planning. We believe that in completing this important step of gathering historical information, we reduce the burden upon the youth to repeat what is likely a history of traumatic events. This is particularly important for juvenile justice-involved youth who may receive specialized risk/need assessments in the courts or DJJ. To monitor the needs of children, youth, and young adults enrolled in Kentucky SKY, Aetna conducts re-assessment of enrollees at least annually (for lower risk enrollees, such as stable former foster children), and more often when required by a high risk level (e.g., children and youth for whom risks are changing rapidly due to aging or changes in the family situation) or change in functional, health, or social determinant need, placement, or other triggering event occurs.

Rising risk model: Because Aetna believes in a prevention and early intervention approach wherever possible**, we have developed a rising risk model to identify children and youth at risk for crisis episodes**. This practice allows the Shared Children, Youth, and Family teams to convene at an earlier point in new children, youth, and young adults enrolled in Kentucky SKY's need for increased support and services to avert potential traumatic events including being placed out of their home. Aetna's rising

risk model uses 28 different measures to stratify and score enrollees age 17 and under based on a multitude of measures including specific behavioral health disorders, opioid use, physical/sexual/psychological abuse, self-harm claims, comorbidities, risk stratification score, engaged in care coordination, PCP assignment, frequency of changing PCP over the course of a year, total medical spend, ER utilization, pregnancy, justice system involvement, sexually transmitted disease diagnoses, household opioid use, household self-harm claims, and household physical, sexual, or psychological abuse**.** Using this method, we can rapidly identify enrollees and who are at elevated risk that may need additional resources from the health plan. In addition to identification of specific enrollees, we use demographic and geographic information to focus resources on areas of rising risk concentration.

Continuity of care when a provider leaves the network: When a provider expresses a desire to leave our network, Aetna works to understand the underlying reason(s) and addresses the issue proactively to keep the provider in our network and reduce disruption in services, including exploration of the feasibility of a single-case agreement, out-of-network authorization, or continuity of care agreement. If an enrollee does require a new provider, the care coordinator convenes a person-centered care planning meeting, assists with identifying a new provider, makes sure that the new provider can meet the individual's needs and preferences, and updates the service plan. In addition, the CCT partners with the family to inform them of the change, what will occur with the change, and to learn their needs regarding a new provider (e.g. whether there are transportation barriers). If the assignment of a PCP does not meet the needs of a Kentucky SKY enrollee or their family, the CCT collaborates with them to identify a provider that does.

Continuity of care when an enrollee changes placement: Should there be a change in placement, Aetna will evaluate the enrollee's access to currently assigned providers within one business day of receipt of notification of change in status. Within two business days, a new PCP and/or dental provider will be selected by the enrollee or caregivers or auto-assigned by Aetna. Enrollees or their guardian can request a new PCP if they do not wish to remain with the auto-assigned PCP.

Monitoring new enrollees with high physical or behavioral health needs: Aetna is committed to partnering with and supporting enrollees with high needs in a coordinated and comprehensive monitoring program that emphasizes person-centered care and strengths-based approaches. These strengths-based approaches are integral when supporting enrollees with high needs as it is recognized that the individual may have experienced difficulties with accessing and receiving care due to a variety of variables and thus needs to be engaged in the care delivery process to drive optimal health outcomes. These strengths-based approaches will focus on cultural sensitivity, peer-to-peer support, coordinated care, and goal setting. Thus, enrollee care will be monitored closely to ensure the CCT is apprised of any changes in status and need for more or less supportive services. Before final determinations and/or changes are made, the CCT and the enrollee will collaborate to discuss all potential options in a collaborative fashion. The CCT will also partner with the enrollee to discuss progress toward care plan goals, address any barriers the enrollee may have, and additional individual needs will be assessed informing whether more or less intensive services and supports are needed based on the enrollee's feedback. We will leverage our relationships with community partners to stay connected to enrollees during critical times ensuring a seamless system of care. For example, the CCT can go onsite to a facility if an enrollee is in inpatient or residential care and convene with all partners, the enrollee, and the enrollee's supports, to ensure the best plan is in place.

To support continuity of care, we are creating **Aetna FamilyConnect**—the shared, electronic health record implemented in collaboration with DCBS, KHIE, and providers which serves as the single source of truth for youth and their circles of support. The Medical Passport, a tool utilized by foster parents, relatives, fictive kin, and caregivers to document all appointments and medical history will be housed within FamilyConnect in digital copy which will significantly improve timely communication during instances of placement change.

c. Stratification of Kentucky SKY Enrollees into Tiers for Care Coordination

We know today that children, youth, and young adults in the child welfare system face the greatest vulnerabilities to physical and mental health conditions and require access to comprehensive assessments and trauma-informed care. Our approach recognizes the significant risk to health equity for children who will be served by through Kentucky SKY. Aetna utilizes a comprehensive suite of assessments and tools to evaluate early life adversities, acute needs, and resilience factors to assist in effectively stratifying into care coordination and facilitating implementation of our Charting the LifeCourse model for recovery and living a good life.

Aetna uses a range of tools to stratify children, youth, and young adults enrolled in Kentucky SKY into a level of care coordination that meets their unique, holistic needs. We use our stratification algorithm in conjunction with Kentucky SKY population specific assessments, to determine whether care coordination, intensive care coordination, or complex care coordination will best allow our CCTs to provide each child, youth, or young adult with integrated, whole-person care.

Predictive Model of CORE

- CORE results are predictive in multiple dimensions.
- The ER model has a positive predictive value of 72.1%, meaning that 72.1% of the time, the predicted ER utilization occurs in the next 12 months.
- Our inpatient modeling is exceptional, with a positive predictive value of 95.4%.
- These factors, coupled with our utilization management and quality management surveillance strategies, enable us to assign enrollees to the most appropriate levels of care coordination.

Consolidated Outreach and Risk Evaluation (CORE™): Proprietary and evidence-based, CORE is a stratification tool that uses time-tested analytic methods honed for more than 10 years. Specifically tailored for Medicaid populations, CORE contributes to enrollee stratification from internally developed algorithms based on Medicaid population data and our clinical and informatics expertise. In June 2019, CORE started including census track and ZIP code data to incorporate social determinant elements at the population level in its predictive modeling. Aetna uses several indicators in addition to CORE, including the HRA, ENA, foster care assessment, surveillance or referrals, concurrent review, and real-time medical and pharmacy utilization data. We run the model for our entire population monthly.

Assessments for stratification: For new enrollees where we lack historical claims data, assessments will be performed in collaboration with youth and/or their caregivers, within the first 30 days of enrollment or earlier if the enrollee is identified as having specific health care or social needs. We will include the enrollee's circle of support to complete these assessments where appropriate to avoid re-traumatization of youth reliving past traumatic experiences. These assessments include our HRA, the ENA, Health Care Equity Contact Event, CANS, and other evidence-based assessments as needed based on initial screen. This initial dialogue and assessment serve to create a comprehensive view of our enrollees' strengths and needs so that we can mobilize the best team of support to address their unique circumstance.

KHIE: We will obtain prior medical history, testing, pharmacy, lab tests, and other pertinent clinical information through the KHIE and accessed through our population health management platform. Access to prior medical history will expedite the process of stratification and will greatly reduce the need for

enrollees and caregivers to self-report information. This will improve accuracy of information and protect the enrollee from reliving past trauma and the burden of recounting past events.

Aetna also leverages information collected from PCPs and specialty providers, community-based and enrollee referrals, prior authorization processes, and real-time utilization data to assist in stratifying enrollees into the level of care coordination that meets their needs.

The results of stratification allow Aetna to segment children, youth, and young adults enrolled in Kentucky SKY into our comprehensive three-tiered care coordination program, a component of our PHM approach which is aligned with the National Committee for Quality Assurance (NCQA). The PHM model and is aligned with **Section 41.10.2 Care Coordination Teams of the Draft Medicaid Managed Care Model Contract and Appendices** (please refer to **Table G.10-4**). In this model, children, youth, and young adults enrolled in Kentucky SKY are stratified into three tiers. Some subpopulations, such as children who are designated as medically complex by DCBS, are automatically assigned an Aetna CCT. For all children, youth, and young adults enrolled in Kentucky SKY, the CCT will do the following:

- Complete comprehensive assessments of an enrollee's whole-person needs and educate enrollee/foster parents on their whole-person care needs
- Coordinate care and services that are specified in the care plan and/or identified by enrollee/family, provider, or care coordinator
- Facilitate access to care and advocate for enrollee with Aetna, providers, and community or Department supports

Table G.10-4: Aetna Kentucky SKY Care Management Tiers

Kentucky SKY Care Management Tier/ (NCQA Level)	Population Served	Services Provided
Complex Care Coordination (including due to BH needs) (Complex Care Management)	Enrollees with the highest needs such as those with previous BH admissions and Kentucky SKY enrollees with special health care needs and medically complex children	• Two face-to-face visits (monthly) • One weekly contact • A minimum of two hours per week of care coordination • One meeting with the Kentucky SKY enrollee and caregivers (monthly) • One care plan update (monthly)
Intensive Care Coordination (Management of Chronic Conditions)	Enrollees with moderate acuity, but who are not at risk of crisis	• One face-to-face visit (monthly) • One weekly contact • One meeting with Kentucky SKY enrollee and caregivers (monthly) • One care plan update (monthly)
Care coordination (Prevention and Wellness)	Enrollees with limited health care needs	• All Kentucky SKY enrollees will have access to care coordination services and a CCT • Aetna will outreach Kentucky SKY enrollees quarterly to assess any changes in social risks, health conditions, or any other need • Aetna will educate enrollees and their caregivers on how to contact the health plan should needs arise prior to outreach • HRA will be completed (at least annually)

d. Evidence-based Approaches Applicable to Kentucky SKY Populations

Ongoing assessment and certification of network providers and their adherence to fidelity standards for evidence-based practices (EBPs) will be monitored by an independent external evaluator contracted by

Aetna. In addition, Aetna relies on provider relationships with organizations in good standing with recognized accreditation bodies to serve children, youth, and young adults with EBPs. All Aetna care coordinators are Kentucky-licensed registered nurses or licensed behavioral health professionals with experience working with the Kentucky SKY population.

Aetna incorporates EBPs which complement our whole-person, whole-family approach to the support of enrollees in our health plans. We adopt specific EBPs for behavioral health treatment and screening and assessment for at-risk youth, and generally adopt Charting the LifeCourse and person-centered planning principles. We use a SOC model and our integrated care coordination model to support children, youth, and young adults with their whole-person needs and we use value-based payment strategies to incentivize providers to improve the quality of care they provide to Aetna enrollees, such as our agreements with the Children's Alliance in Kentucky.

Mercy Care, a health plan in Arizona administered by Aetna, began serving more than 12,000 children and youth in the custody of child welfare in foster and residential care in 2014. Between 2014 and September 2019, through several innovative and collaborative process and strategies, including the adoption of a wraparound approach, the number of children and youth in out-of-home care has safely reduced to 8,000 and continues to fall.

Behavioral health treatment: About 14 percent of all children served by Kentucky Medicaid are prescribed antipsychotic medication and the rate increases to 42 percent for children in foster care. Some reports indicate between 20 and 30 percent of children in foster care who are using psychotropic medications do not receive identifiable behavioral health services in addition to these medications.[3] Aetna includes the following EBPs for behavioral health treatment that work in conjunction with our person-centered PHM program model, and Aetna will convene providers to discuss the most impactful approach to providing the following EBPs in this contract:

- Motivational Interviewing
- High-Fidelity Wraparound
- Trauma-Focused Cognitive Behavioral Therapy
- Multisystemic Family Therapy
- Dialectical Behavioral Therapy
- Functional Family Therapy
- Peer Support Services
- Therapeutic Behavioral Services
- Nurse-Family Partnership
- Mental Health First Aid
- The Seven Challenges
- Play Therapy
- Parent Child Interaction Therapy
- Transition to Independence

Assessment and screening: Aetna uses a range of screenings and assessments that are tailored to the Kentucky SKY population. We use these upon initial assessment, and during regular reassessments (or reassessments triggered by a change in the child, youth, or young adult's functional or health status, or a change in their placement or residence). Due to their training in the field, they use their professional knowledge to decide which specialty assessments to conduct. In addition, care coordinators use an algorithmic approach to choosing screening options. As they enter required assessments (the HRA and ENA) into the electronic care coordination system, the responses re-populate in other assessments with

[3] (Government Accountability Office, "2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue," (2012); https://www.gao.gov/assets/590/588818.pdf: accessed June 1, 2019).

the same/similar questioning. The system provides suggestions to care coordinators about additional detail to solicit during the assessment process. Care coordinators are educated on spending time efficiently with enrollees. By skillfully using motivational interviewing, they obtain the information necessary to complete special assessments without retraumatizing the enrollee with multiple questions. The evidence-based assessments and screenings we may require include the following:

- EPSDT Mental Health Assessment
- ACES-Q
- Child and Adolescent Needs and Strengths
- Child and Adolescent Service Intensity Instrument (CASII)
- UCLA Child/Adolescent Post-Traumatic Stress Disorder Reaction Index

Aetna has learned in its broad experience that in every case, our enrollees hold the solution to a good life. We exist in service to our enrollees and in partnership with state child protection professionals. We strongly believe this is exactly where the promise of precision medicine intersects with a good life for our enrollees. In every step of the way, our health plan seeks to build on the capabilities of enrollees and partners and collectively we will be steadfast in our mission to support Kentucky in becoming the national leader in preventive system transformation for all families.

"The LifeCourse framework and tools are designed to help individuals and their families plan for and navigate a life that makes sense to them with the support they need," said Michelle C. Reynolds, PhD, associate director of training at the UMKC Institute of Human Development. "It is exciting that a national health care leader like Aetna recognizes its value and will be using the LifeCourse framework as it develops its person-centered, holistic model to support children in the child welfare system in Kentucky."

Charting the LifeCourse: Aetna uses the Charting the LifeCourse framework to inform how we serve children and youth in foster care and the juvenile justice system. This framework is a collective approach to family safety, healing, and thriving, which results in the creation of an individual care plan that addresses covered and non-covered services and focuses on the young person's circle of support. The person-centered care plan, which is also family-centered, includes identifying what the individuals in the circle of support and families need to be successful helping them support the children, youth, and young adults in their lives who are enrolled in Kentucky SKY. For example, the care plan may identify the need for a Kentucky SKY enrollee's caregiver to access community-based resources (e.g., faith-based groups, peer support, etc.). To address an individual's physical and behavioral health challenges, we must consider the impact their health has in their life story; if we can predict difficulties, we can collaborate to prevent them. In addition, this approach emphasizes supporting youth in navigating through challenges to negate isolation by creating encouragement and support.

We understand that children, youth, and young adults enrolled in Kentucky SKY often have a rich and personal relationship with providers and community advocacy groups, while also having long-term connections with staff with the DCBS and the DJJ. We will work with and support the DCBS and DJJ per the contract and will engage them to collectively work together to ensure the care planning process for children, youth, and young adults enrolled in Kentucky SKY is inclusive, integrated, and collaborative. In alignment with national best practices around person-centered thinking, and using the LifeCourse framework, Aetna and our Kentucky SKY CCTs are trained to understand and embrace the core principles of person-centered thinking, planning, and most importantly, living, as follows:

- We acknowledge and recognize the valuable role each person in an enrollee's circle of support plays within their social system.
- We consider the impact of major life stages on enrollees and their family and understand that their roles transform as they age.

- We work together with enrollees and their circle of support to create a clear vision of a positive quality of life and develop an attainable path toward those goals, understanding enrollee's life stages are influenced by past experiences.
- We move beyond planning for an enrollee's health and safety by focusing on helping enrollees and families increase their capacity to live a self-determined life in the community of their choice, while building social capital and economic stability.
- We recognize that our enrollees can and do lead complex, multifaceted lives and we account for this interconnectedness in our integrated service planning process by focusing on daily life and employment, community living, safety and security, healthy living, social and spirituality networks, and citizenship and advocacy.
- We value the strengths and assets of our enrollees and their families and support them to discover new opportunities and navigate their lives by sustaining and/or making new connections with the community, and by linking them to innovative goods and services available both internal and external to the formal support system.
- We provide opportunities and support for our enrollees and their families to self-advocate and provide crucial feedback to Aetna through formal and informal stakeholder engagement channels. Aetna incorporates stakeholder experiences as a critical component of our continuous quality improvement process.

System of Care model and integrated care coordination: The core of our population health strategy for children, youth, and young adults enrolled in Kentucky SKY is our integrated system of care model and integrated care coordination (ICM) program. Aetna's integrated system of care forms the foundation and collaborative structure necessary to support enrollees with the most immediate services needs to achieve their vision of a good life. The model is based on the identified needs of the community, the state, children, youth, and young adults enrolled in Kentucky SKY and the overall population of Kentucky. We seek to understand each enrollee in the context of their lives, their environment, and their genetics, while co-facilitating a holistic model of supports and services that enhances their quality of life and assists them to reach their individual goals. Our innovative integrated system of care approach is based on a whole-person view of our enrollees' physical health, behavioral health, oral health, health literacy, functional needs, and social determinants of health. Aetna's integrated system of care focuses on meeting enrollees' needs and goals by wrapping around them with Aetna covered services, their circle of support, and community-based support while focusing on cultural sensitivity, recovery and resiliency, and adopting trauma-informed practices.

For example, Mercy Care, a health plan administered by Aetna in Arizona, worked together with child welfare specialists to identify on an individual level youth that were in custody and not active in behavioral health treatment. Mercy Care coordinated engagement and outreach so that an intake was offered to the caregiver and youth with a local behavioral health provider. Throughout the care coordination process, Mercy Care staff met with child welfare specialists to review caseloads and identify youth that are eligible, as well as review the youth in shelters and group homes to identify if they were engaged in behavioral health services including care coordination, behavior coaching, and/or therapy. When a youth was identified as not being connected, outreach was completed by direct care providers to the caregivers for engagement. This Mercy Care initiative resulted in sustained improvements in service delivery for this vulnerable population. For example, the child welfare behavioral health penetration rate was 39 percent in 2014, increased to 69 percent in 2015, and has stabilized at around 81 percent since 2017, indicating a penetration improvement of 100 percent. This initiative has also led to reduced cost of service provision in relation to a decrease in out-of- home services and hospital admissions and decrease in disruptions for children who were in foster or kinship placements.

Value-based payments: We have learned about the power of value-based payment (VBP) arrangements in incentivizing providers to improve the care they provide to enrollees with high needs and high costs.

For example, in support of providing integrated, whole-person care, Aetna offers providers a variety of alternative payment arrangements through our Aetna Value program. To date, Aetna has entered into an alternative payment arrangement with several providers such as Children's Alliance Independent Provider Association, Kentucky Primary Care, and KentuckyOne Health, to name a few. The outcomes Aetna uses to monitor performance and determine incentives depending on the VBP agreement include, but are not limited to the following HEDIS measures:

- AWC—Adolescent Well-Care Visits
- CIS Combo 10—Childhood Immunization Status
- W15 6+ Visits—Well-Child Visits in the First 15 Months of Life
- PCR—Plan All-Cause Readmissions
- FUH 7 Day-Follow-Up After Hospitalization for Mental Illness
- APP Total—Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- ADD Continuation Phase—Follow-Up Care for Children Prescribed ADHD Medication
- AMR—Asthma Medication Ratio

e. Approach to Providing Trauma-informed Care to Kentucky SKY Enrollees

Multiple research studies, including the Adverse Childhood Experiences Study, have confirmed exposure to severe stress and trauma such as abuse, neglect, discrimination and violence increases an individual's risk for serious and lifelong physical and behavioral health issues, poor health outcomes, reduced quality of life, and increased cost of care. Exposure to traumatic events as a child can result in poor performance at school, inability to maintain employment, inability to sustain social relationships, and place young person at risk for future homelessness and justice involvement. According to the most recent report from Child Trends, 53 percent of children in Kentucky have experienced at least one adverse childhood event (this is the second poorest rate in the nation, following Arkansas).[4] Young people and adults with justice system involvement highly correlate to experiencing ACEs.

Addressing Trauma with the Help of an Industry Leader

Aetna has partnered with the National Council for Behavioral Health (National Council) to implement our organization-wide Trauma Informed Transformation. Aetna leadership at the national and local levels are thrilled to collaborate with an industry leader such as National Council. Aetna recognizes the importance of being the first managed care organization nationwide to join forces with National Council to strategically map out and operationalize the end-to-end process, and to then produce a sustainable and replicable model for all Aetna Medicaid health plans and the Aetna enterprise.

Aetna is committed to leading capacity-building in trauma-informed care in the Commonwealth. We aim to assist providers to move along the continuum from being trauma-aware to being trauma-transformed. As all Aetna enrollee-facing staff are trained in trauma-informed principle and care, we also provide training in trauma-informed care providers and community stakeholders. We meet providers where they are, conducting the National Council for Behavioral Health's *Organizational Self-Assessment: Adopting of Trauma-Informed Care Practice*[5] to assist individual practitioners and provider organizations to

[4] Sacks, Vanessa and Murphey, David, "The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity," (2018): https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity; accessed June 1, 2019

[5] National Council for Behavioral Health, "Organizational Self-Assessment: Adopting of Trauma-Informed Care Practice": https://www.nationalcouncildocs.net/wp-content/uploads/2014/01/OSA-FINAL_2.pdf; accessed June 1, 2019

understand their knowledge and capacity in trauma-informed care and design a program to assist them in their development of trauma-informed practice.

In addition, Aetna has developed a proprietary Trauma-Informed Provider Organization Audit Tool that includes domains such as the following:

- Respecting enrollee voice and choice
- Staff beliefs, attitudes, and behaviors
- Commitment of leadership to TIC
- Disclosure readiness
- Staff well-being
- Staff knowledge and skills in TIC
- Hospitality to diversity

We offer providers incentives for committing to a trauma transformation, at three levels, based on how much they have adopted trauma-informed principles and practices:

- **Trauma-aware**
  - Plan budgeted incentive for screening for trauma and reporting to the plan via appropriate Z-codes, or any other approved format
  - Enhanced evaluation and management service reimbursement for visits designed for trauma screening
- **Trauma-informed**
  - PCPs receive a specified per-member/per-month (PMPM) payment for their assigned enrollee population
    - Part of the PMPM is for being designated as trauma-informed
    - Part of the PMPM is for conducting screenings and assessments on at least 50 percent of the enrollee panel and assessments on 95 percent of those enrollees screened positive for trauma
  - Non-PCPs receive a plan budgeted amount for trauma screenings and assessments for those screened and found to have trauma
- **Trauma-transformed:** Providers are awarded financial incentives that result from reduced utilization and cost of certain services following care coordination that occurs from the identification of trauma by the provider

Our work with providers is one element of the system-wide transformation Aetna is undertaking to enhance our system of care into a system that includes trauma-informed practices. This transformation is occurring at all levels of the organization from the chief executive officer to care coordinators as well as Enrollee Services staff, human relations, and all aspects of the health care company. In Kentucky, our entire staff has begun the trauma transformation training and we will be initiating a year-long collaborative with local providers of both health and social services to expand the availability of trauma-informed resources for the Kentucky populations. Aetna subscribes to the following tenets as established by the National Institute for Trauma-Informed Care: We realize that trauma is common; we recognize how trauma affects individuals seeking care; we are committed to implementing TIC best practices; and at all costs avoiding re-traumatization.

As a trauma-informed organization, our Care Coordination, Enrollee Services, and Community Outreach staff receive comprehensive and ongoing training established in partnership with the National Council for Behavioral Health. Some of the comprehensive training includes motivational interviewing and Mental Health First Aid for our enrollee-facing staff.

In addition, we support our community partners to strengthen the local resources available to our enrollees to build help them build resiliency skills. Aetna provided over $350,000 in grants and sponsorships over the past 18 months to support community organizations and initiatives with over

$240,000 going to support programs related to ACEs (e.g., Hope 982 Hill Youth Services, Orphan Care Alliance, Prevent Child Abuse Kentucky).

f. Telemedicine and Telehealth to Improve Quality or Access to Services

To improve access to services in traditionally underserved remote or urban areas, we utilize a range of telehealth strategies. Telehealth can be used as an alternative to or to complement traditional service delivery. In alignment with state regulations, specific available services include consultation; mental health evaluation and management; individual and group psychotherapy; pharmacologic management; psychiatric/psychological/mental health diagnostic interview examinations; and individual medical nutrition therapy consultation services. In-network providers may use their own approved technology or will be given the opportunity to utilize a plan-sponsored technology platform to enhance access to their enrollees via telehealth. Alternatively, if indicated, preferred Kentucky-licensed vendor partner telehealth practitioners will be utilized, as per Kentucky state regulations to meet both the physical and behavioral health needs of our enrollees using evidence-based protocols. Unless otherwise agreed upon or directed by the Department, provider reimbursement for telehealth services will be equivalent to that given for the same in-person services.

Our virtual partner's telehealth platform offers a 24/7/365 accessible virtual platform that has served 20-plus million enrollees with licensed, qualified professionals. Enrollees can schedule appointments or request immediate e-visits and if they request immediate visits, do not wait long, express satisfaction with services, and report their issues are resolved on the first visit. **Enrollees typically wait no longer than 10 minutes for a doctor, 95% of enrollees are satisfied, and 92% of enrollee issues are resolved after the e-visit.**

Telehealth has been proven to improve care treatment compliance, decrease both ER and inpatient hospitalization utilization, reduced disease burden in communities, and promote the concurrent use of advanced specialty capabilities in coordination with an enrollee's local PCP, thereby improving available quality and continuity of care. Moreover, available telehealth services promote the integration of physical and behavioral health care and enable provider-to-provider consultation between PCPs and specialists. We will offer the following telehealth options:

Remote patient monitoring: Aetna offers a remote patient monitoring (RPM) program for children, youth, and young adults enrolled in Kentucky SKY with specific chronic or high-risk diseases, such as diabetes, high-risk pregnancy, asthma/respiratory disorders, and certain behavioral health conditions. For the Kentucky SKY population, RPM serves to support parents and families as well as enrollees. It helps children and youth access care in the home, reducing the need for transportation to appointments, which may be long distances from their residence. We use remote monitoring to elicit enrollee empowerment; improve disease management; improve access, adherence, and compliance, decrease ER utilization; and lower total cost of care. Children, youth, and young adults enrolled in Kentucky SKY who participate receive our in-home remote monitoring technology package, which includes a remote monitoring bundle and iPad mini™ kit with up to two peripheral devices, such as a weight scale, pulse oximeter, blood pressure cuff, and glucometer. Participating children, youth, and young adults enrolled in Kentucky SKY collect and submit biometric data daily and engage in regular sessions with nurse health coaches. If submitted biometric data is deemed out of range, their practitioner is notified by phone and appropriate interventions implemented. Health plan care coordinators may be actively involved. To date, RPM programs in other Aetna markets have been successful. For example, for those graduating from Louisiana's 2018 RPM program, the cost of ER care decreased by 23 percent and the cost of inpatient hospitalization care decreased by 34 percent during the 12-month period after beginning RPM compared to the 12 months prior.

Outbound text messaging: Our educational text-messaging program consists of the Lifeline smartphone and messages to remind enrollees to get tests and screenings done. It sends routine reminders to enrollees to support their health goals related to weight management, diabetes, substance use, prenatal and postpartum care, well-child visits, and flu shots. Many of these text campaigns serve as virtual health coaches and allow enrollees to interact and be educated on their specific conditions. Some of the unique monthly broadcast messages we have sent to enrollees include reminders on keeping contact information current with the local Department of Child Protective Services office or even ER diversion and the importance of seeking their PCP first. With an average reach rate of 65 percent, we have utilized these messages to communicate with enrollees about open enrollment, their benefits, and programs.

Mobile applications: Aetna offers a mobile application permitting real-time interactive communication that allows enrollees to speak on the phone or via Health Insurance Portability and Accountability Act-compliant secure video teleconferencing with PCPs and specialists to diagnose symptoms, prescribe medication, and send prescriptions to the enrollee's network pharmacy of choice. In addition, we will employ a variety of mobile applications which are tailored to the needs of our enrollees to cover topics like meditation and mindfulness, cognitive behavioral therapy, and acceptance commitment therapy methods to help people cope with depression, anxiety, anger, and stress. We will leverage the Breathe2Relax mobile app designed by the National Center for Telehealth & Technology to teach breathing techniques to manage stress. The skills taught may be applied to those with anxiety disorders, stress, and post-traumatic stress disorder.

Enrollee e-visit and provider-to-provider e-consults: We provide children, youth, and young adults enrolled in Kentucky SKY face-to-face practitioner encounters via access to real-time interactive audio and video technology. Children, youth, and young adults enrolled in Kentucky SKY will be able to access their PCP or specialty telehealth provider from their home or desired secure location. The service has proven to improve provider ease of access and decrease avoidable ER visits and hospitalizations.

g. Capturing and Using Data Related to Social Determinants of Health

Aetna collects and utilizes data regarding social determinants of health (SDOH) (e.g., food and nutrition, housing, transportation, violence, social connections, etc.) to improve the health status of our enrollees. Aetna's approach to data collection and utilization fosters enrollee engagement and educates enrollees and their guardians on reporting social determinant needs as well as input from care coordination, enrollee services staff, PCPs, and other relevant providers. In 2018, Aetna began stratifying data across demographic characteristics to identify social determinant of health disparities in our population and subpopulations. We are continuously developing new ways to stratify social determinant data to identify disparities and learn from best practices developed in Aetna health plans across the country.

Getting on T.R.A.C.K. for Youth Transitioning Out of Foster

Aetna collaborates with community-based organizations to provide our Getting on T.R.A.C.K. (Transition Ready Assistance & Core Knowledge) program to young adults transitioning out of the foster care system. The program focuses on addressing social determinant needs as well as building skills for independence and joining the workforce. Our Community Development team partners with various organizations to offer the course onsite in the communities where our Kentucky SKY enrollees live.

Aetna uses enrollee-level demographic and social risk data to target interventions to improve population health. Our approach to the collection of SDOH data includes collection of both individual-level, self-report (or reported by the foster parent), and claims data and internal and publicly available population-level data. We analyze this data annually, and it informs the development of our proprietary Regional Health Profiles, Population Assessment, and Membership Profile where specific references to Kentucky SKY enrollee food, housing, transportation, and personal safety/domestic violence are addressed. The specific strategies Aetna uses to collect SDOH data include the following:

HRA: Aetna agrees to use the standardized HRA tool, as designated by the Department (pursuant to **Section 34.3 of the Draft Medicaid Managed Care Contract**). Aetna conducts the HRA with new children, youth, and young adults enrolled in Kentucky SKY within 30 days of enrollment or earlier if the enrollee is identified via other information or self identifies as having specific health care or social needs. By completing the HRA within 30 days, we can ensure Kentucky SKY enrollees needs are more rapidly identified and met, i.e., if they are pregnant, need durable medical equipment, etc. We annually assess enrollees for any new health care or social needs, but conduct reassessment more often as indicated by a change in condition or as deemed appropriate by the Department. Aetna makes contact with children, youth, and young adults enrolled in Kentucky SKY to complete the HRA in person, by mail or email, and by telephone. As part of the HRA process, Aetna Care coordination staff explain the purpose to enrollees and available PHM program services should they be determined in need of such services. With enrollee consent, we share all screening results with the assigned PCP via the provider portal or the Department upon request. As described in the following response, the HRA is the first step to our care coordination identification and stratification, assessment, and individual care planning process.

We offer our HRA in English and Spanish. Translation into other languages is available. These are administered in person, web-based, in print, and telephonically. The HRA completion process will be tailored to the capabilities and needs of children, youth, and young adults in the Kentucky SKY program. For example, for foster care children the HRA will be completed by their foster parent on behalf of the child. Former foster children will complete the HRA themselves, unless they choose the enlist support from someone in their circle of support. For transition age youth, the guardian may complete the HRA, or the youth may do it independently, depending on what suits the desires of the family. In all cases, Aetna discloses to the enrollee or their guardian how we will use the information gathered in the HRA. The HRA screens for social determinants of health needs, including food security, housing/utilities challenges, transportation needs, and interpersonal safety concerns. **Figure G.10-3** shows the social determinants of health needs screened by Aetna's HRA.

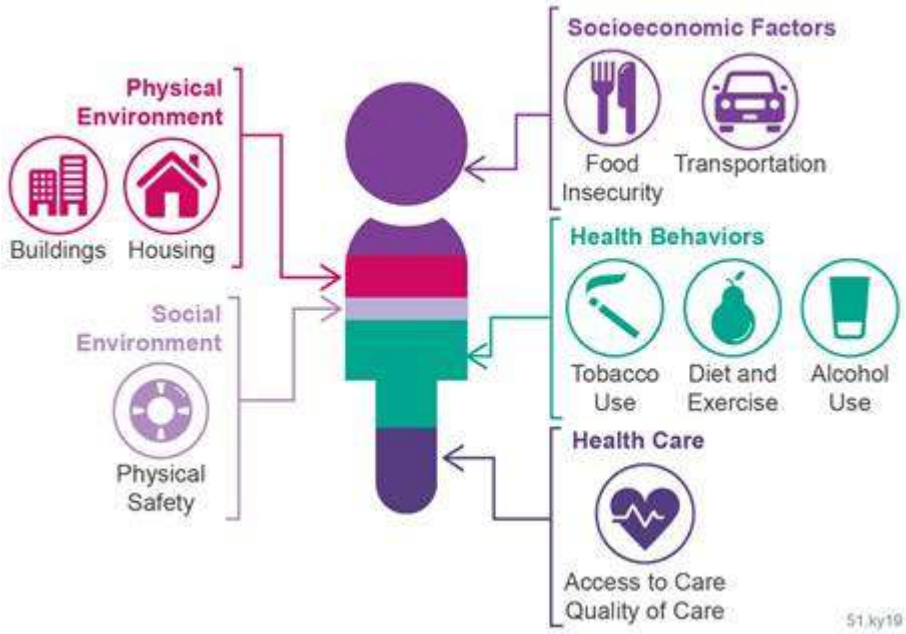

Figure G.10-3: Social Determinants of Health
Aetna's HRA screens for SDOH.

ENA: Aetna completes a comprehensive enrollee needs assessment (i.e., ENA, our outreach questionnaire) to further identify care needs and engage children, youth, and young adults enrolled in Kentucky SKY in care coordination (see **Attachment AA** for a copy of Aetna's current ENA, which will be customized for the Kentucky SKY population). The CCT educates enrollees and their guardian/circle of support on the tool and its purpose to establish a relationship before asking questions that can be considered intrusive by the enrollee. They take account of the cultural needs of enrollees and families

when completing the tool. The ENA is conducted within 30 days of indication that the Kentucky SKY enrollee may need care coordination or care coordination services. It addresses: 1) immediate, current. and past health care, mental health, and substance abuse disorder needs; 2) psychosocial, functional, and cognitive needs; 3) social determinants of health, including education and housing status; 4) ongoing conditions or needs that require treatment or care monitoring; 5) current care being receiving, including health care services or other care coordination; 6) current medications, prescribed and taken; 7) support network, including caregivers and other social supports; and 8) other areas as identified by the Aetna or Department. Aetna values the roles of peer support workers in conducting assessments with at-risk youth, and will explore recruiting, training, and coaching former foster care children to serve on the Care Coordination team. Aetna makes outreach attempts to children, youth, and young adults enrolled in Kentucky SKY to encourage completion of the ENA according to Department standards, outlined in **Section 34.3 of the Draft Medicaid Managed Care Contract.**

Health Care Equity Contact Event: The Health Care Equity Contact Event, housed in our electronic care coordination system, assists with documenting, tracking, and reporting on enrollees' social determinants needs, inclusive of housing, transportation, food insecurity, and personal safety, and identifies enrollees who may benefit from additional interventions and education to address them. The demographic characteristics included in the Health Care Equity Contact Assessment include age, race, ethnicity, gender, sexual orientation, and geographic location, among others. Staff on the enrollee's Kentucky SKY CCT complete the Health Care Equity Contact Event for all children, youth, and young adults enrolled in Kentucky SKY engaged in care coordination, and documents self-reported SDOH data in our electronic care coordination system. The intent is for the captured SDOH data to be incorporated into the development of the individualized person-centered care plan. When they identify a social determinant need, they can use our technology, such as Unite Us and Aunt Bertha, connect with Aetna's children's system of care, and recovery and resiliency administrators, or engage community-based organizations to identify resources to meet their needs.

Aetna's innovative Social Determinants of Health Services Integrated Model: Aetna is partnering with Unite Us in a unique collaboration to address the full spectrum of social determinants of health. The partnership, currently in Louisville, establishes new and innovative models that improve the engagement between enrollees, traditional health care providers (e.g., PCPs) and social services providers. Aetna's intent is to expand this partnership statewide. This SDOH services integrated model connects enrollees to community-based organizations who participate in the closed-loop referral network, including all types of social service agencies. Enrollee referrals for integrated service needs (physical health, behavioral health, SDOH) are triggered through multiple sources; there are not any limitations on how enrollee referrals are triggered. One example is a health risk questionnaire (HRQ), which is attempted to be completed for 100 percent of enrollees within 30 calendar days of eligibility with the health plans; three outreach attempts are made to complete the HRQ.

Program Tools

Additional tools, such as the Health Care Equity Contact Assessment, are completed in combination with the HRQ, which includes social risks. Enrollees determined to have socially or medically complex needs, (multiple chronic conditions, SDOH barriers, gaps in care, health disparities), are will be warm transferred to a care coordinator for evaluation based upon defined criteria for potential enrollment into our ICM program. Enrollees that are identified to have social risks not requiring care management intervention are warm transferred to a community health worker (CHW) located at the Wellness Center in the community where the enrollee resides. The CHW will engage with the enrollee with Unite Us via telephonic outreach to complete referral for social risks identified.

Unite Us Platform

Unite Us has engaged a full network of social service providers including food banks, transportation vendors, education organizations, etc. Aetna enrollees residing outside of Louisville have access to

referral services for identified social risks through current processes such as Aunt Bertha, a comprehensive online directory of social service organizations, and care coordination processes to facilitate connecting enrollees with appropriate community-based resources to address identified enrollee needs. In addition, CHWs will connect Kentucky SKY enrollees to community-based programs such as Bounce, which helps children and families cultivate the skills they need to bounce back from difficult situations. CHWs will also offer enrollees assistance with enrollment in federal and state benefit programs such as Department of Housing and Urban Development waivers, Women, Infants, and Children, the Supplemental Nutrition Assistance Program, Kentucky Transitional Assistance Program, Kentucky Low Income Home Energy Assistance Program, and the Continuum of Care program Homeless Assistance Program, as examples. Aetna care coordinators and CHWs offer assistance with addressing other social determinant needs and with referring enrollees to our fully integrated network when necessary. Aetna care coordinators and CHWs partner with enrollees in this process and educate them throughout to develop a meaningful dialogue that meets the needs of the enrollee.

If the social or medical complexity of an enrollee increases, or if there has been a significant care transition to the point where care coordination intervention is needed, the enrollee will be warm transferred to care coordination for care coordinator assessment and intervention.

The Unite Us platform provides the unifying infrastructure between health care entities and community-based organizations. This robust, collaborative approach equips health care and community service providers with a shared platform that they can use to identify available resources for enrollees, while simultaneously tracking outcomes within a single, integrated network of care and social services. The Unite Us platform combines medical and social care through integrations with existing electronic health records designed to enhance—not impede—workflows. It integrates with the most commonly used medical, social, and community tools to streamline methods and increase efficiency.

Unite Us

Unite Us currently powers the United Community Network—a network of health care providers, payers, government services, and community-based organizations—which serves the Louisville metropolitan area and is sponsored by Metro United Way. Network users who generate and receive referrals in this integrated community network include government, leading health systems, clinical providers, and community-based organizations across Jefferson County and the Louisville metropolitan area. The network continues to grow, with plans underway to integrate the network with the Jefferson County public schools and additional community-based organizations and stakeholders.

The main functions of the platform include the following:

- Configurable screening for needs with immediate decision support
- Electronic referrals and tracking with external agencies
- Assessment and single care plan management
- Bidirectional communication (between partners and enrollees)
- Alerts and email notifications on referral progress
- Outcome tracking across network partners and each community
- Outcomes by resource including specifics (e.g., long term housing, transitional housing, etc.)

CVS Health and Aetna are Committed to Smoking Cessation

In 2019, CVS Health will support educational programs to create and distribute educational materials for middle and high school students on the risks of e-cigarette use. A $100,000 grant will be given to the Society of Health and Physical Educators to help distribute educational games from the Yale Center for Health and Learning to schools across the country. The CVS Health Foundation is also granting $600,000 to support the American Academy of Family Physicians Foundation to support its efforts to address the rising emergence of Electronic Nicotine Delivery Systems. Additionally, the Aetna Foundation will work to enhance education and training for children's health care professionals.

h. Coordination to Ensure Providers Have Access to Up-to-date Medical Records

To support continuity of care, the Aetna care coordinator uses **Aetna FamilyConnect, the shared electronic health record implemented in collaboration with DCBS, KHIE, and providers which serves as the single, source of truth for foster care children.** Aetna understands the fragmented nature of current foster environments in terms of clinical, social, and programmatic documentation, and is prepared to address this significant gap. Aetna has designed an information management system for the purpose of integrating all components of the delivery of care to the Kentucky SKY enrollees. The system has the capability to securely store and transmit information, interface with subcontractors (e.g., Avēsis for dental and vision care), and other relevant systems, including the Kentucky Health Information Exchange, DCBS' TWIST, and report data in a format specified by the Department, DCBS, and DJJ. The Aetna Medicaid organization has years of experience with HL7 transaction format and will be Fast Healthcare Interoperability Resources-compliant as directed by the Centers for Medicare & Medicaid Services. The data systems will be integrated so that Kentucky SKY enrollees' data can be compiled in one central source. **The Medical Passport will be housed within the FamilyConnect system as well as in hardcopy for the foster parents** to assist in continuity of care.

All information is only shared with the consent of the Kentucky SKY enrollee or their guardian. This proprietary integrated digital system serves as a records repository with access for all key players involved in a children, youth, and young adults enrolled in Kentucky SKY care, including the members of the CCT, educators, representatives from community-based organizations and social services organizations, and staff at state agencies. This supports our person-centered model of care in which one care plan is developed that incorporates service and support needs identified by each stakeholder, such as the enrollee's individualized education program, terms of probation, and social determinant needs. This approach contributes to defragmentation of the health care delivery system for children, youth, and young adults enrolled in Kentucky SKY and reduces both provider and enrollee and family burden to make the health care system navigable for parents and children.

This system is currently used in a similar capacity today at Aetna and will be expanded to meet the needs of all stakeholders. This care coordination platform is web-accessible today for providers and will be expanded to grant appropriate data and document visibility for foster kids, their peer and care circles, clinical staff, biological parents, kin, and other guardians. The platform designed for fosters will facilitate the rapid inclusion of disparate documentation, including paper reports, enrollment lists, school transcripts, foster parent notes, training media, case notes, and any other support documentation related to the child.

60.7.G.11 Utilization Management

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60.7. G.11 Utilization Management

Aetna recognizes that communication among the care team and collaboration with the Department, Department for Community Based Services (DCBS), the Department of Juvenile Justice (DJJ), and network providers is especially important when children are prescribed psychotropic medications and at times of transition where gaps in communication could negatively impact outcomes. To foster consistent communication and collaboration both internally and with external stakeholders focused on issues related to psychotropic prescribing and transition in care for Kentucky SKY enrollees, we will do the following:

- Assign a care manager who functions as a single point of contact, initiates necessary assessments upon enrollment, and leads the Care Coordination team (CCT) to manage all the enrollee's needs through persistent outreach efforts via telephone, email, and face-to-face visits
- Conduct regular CCT meetings with Aetna staff (e.g., utilization management nurses, care managers, pharmacists, medical directors, etc.), the enrollee or their guardian, their providers and circle of support, to identify enrollees' needs and develop, monitor, and update care plans. CCT meetings are used to monitor psychotropic medication use and assess psychotropic medication reconciliation based on the enrollee's evolving needs.
- Participate in monthly meetings with the DCBS liaison in each region
- Collaborate with care workers at DCBS and DJJ, families, school systems, and providers to make sure assessments are completed and services are provided in a manner that meets the enrollee's needs and minimizes duplication
- Build key relationships and processes and attend various meetings including the State Interagency Council and Regional Interagency Councils
- Coordinate an annual forum in each region to bring the child welfare agencies and other stakeholders together for planning and collaborating on issues regarding children in substitute care

a. Coordinated Care for Kentucky SKY Enrollees Accessing Psychotropic Medications

Aetna's utilization management (UM) program improves our enrollees' health, supports their stability in the community, promotes recovery and resiliency, and addresses unmet health and social needs. Aetna's approach to coordinating care for enrollees accessing psychotropic medication management includes the following:

- Engagement of youth, families, and state guardians in decision-making regarding treatment
- Assurance that enrollees, providers, families, and caregivers are informed of potential risks, alternatives, and treatment options
- Adherence to guidelines for appropriate use of psychotropic medications and clinical side effect monitoring
- Careful monitoring of psychotropic medication use

Aetna is recognized as quality leader with a **Commendable** rating from the National Committee for Quality Assurance. Our clinical leadership will provide oversight in the development and implementation of ongoing quality improvement initiatives, including addressing utilization trends through collaborative efforts with the DCBS, DJJ, and their families.

Several published studies have demonstrated that children in the child welfare system are prescribed psychotropic medications at rates three to four times higher than rates for other Medicaid-insured youth. The rates of use of an antipsychotic medication for children in Kentucky on Medicaid are about twice the national average. About 14 percent of all children served by Kentucky Medicaid are prescribed antipsychotic medication and the **rate increases to 42 percent for children in foster care**. Some reports

indicated that between 20 and 30 percent of children in foster care using psychotropic medications do not receive identifiable behavioral health services in addition to these medications.[1] Others may receive both medication and behavioral health services but could benefit from more applicable or evidence-based therapies.

Serious quality issues are present given the long-term side effects of these medications and many of these medications are used for treatment of non-U.S. Food and Drug Administration-approved indications. In addition, youth in the child welfare system typically experience abuse, neglect, or other traumatic stressors at rates significantly higher than the general population. These troubling statistics point to opportunities to improve the quality, effectiveness, availability, and collaboration of social and health care services in relation to medication information and informs Aetna's model for including comprehensive medication management services in our integrated person-centered care.

Aetna's transformative vision drives our UM program to enhance care coordination and service integration to support Kentucky's children/youth in foster care, receiving adoption assistance, and engaged with the juvenile justice system. Using the physical health-behavioral health integrated model, Aetna collaborates with participating behavioral health specialists to monitor and improve coordination between medical and behavioral health care for children and youth with complex care needs. Our model assures that care is provided in the least restrictive setting. Our UM program for these children and youth expedites and promotes the delivery of integrated, holistic, person-centered, trauma-informed care seamlessly in the least restrictive and most integrated setting possible. Our unique national experience and local leadership demonstrate our ability to assist vulnerable children while reducing complexity and administrative burden while serving as responsible stewards of Commonwealth resources.

Medication management cannot be effective unless all our children and youth's providers are informed and care is coordinated with their CCT. Aetna's comprehensive medication management model includes an individualized care plan that achieves the intended goals of therapy with appropriate follow-up to determine outcomes. Aetna's model of care is delivered in the context of the medical home and is fully integrated with the work of the integrated CCT to achieve coordinated enrollee care.

Care coordination in the primary care practice must involve deliberately organizing enrollee care activities and sharing information among all the participants involved with an enrollee's care to achieve safer and more effective care. We train Aetna contracted providers on the unique needs of the Kentucky SKY population to support the highest level of care coordination. Aetna contracted providers securely access enrollees' electronic health records through the provider portal. Aetna shares information through integrated case rounds in which all members of the enrollee's interdisciplinary care team meet to discuss the enrollee's unique circumstances and consider their physical health, behavioral health, functional, and social determinant needs. Aetna also makes a full range of enrollee data available to our value-based providers through our electronic population health management platform.

Identifying Utilization Trends and Overprescribing

Aetna monitors the utilization and prescribing of psychotropic medications for enrollees via a monthly claims report from our Pharmacy department. Our Quality Management department filters this data to identify foster care and adoption assistance enrollees prescribed antipsychotic medications. When multiple antipsychotic medications are prescribed, our care coordinators perform targeted outreach to the enrollee's state guardian and foster parents/caregivers to provide education, determine if the enrollee is having any medication-related problems, and to ensure that behavioral health therapy services are in

[1] Government Accountability Office, "2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue" (2012): accessed June 1, 2019; https://www.gao.gov/assets/590/588818.pdf

place. Aetna's behavioral health medical director and/or clinical pharmacy advisor also outreach to the prescriber to provide consultation and education on appropriate parameters for psychotropic medication use.

Our pharmacy analytics for the Kentucky SKY program shift the focus of care to the person-centered needs of the child or youth. In Kentucky, we are aware of the following three specific UM issues concerning psychotropic medications that must be addressed:

- Overprescribing of psychotropics medications when non-medical clinical interventions are appropriate
- Gaps in prescriptions for children/adolescents with conditions in need of continuity of psychotropic medications when placement transitions occur
- Lack of appropriate metabolic monitoring for those prescribed certain medications

Our data analytics include algorithms to identify inappropriate prescribing in response to trauma and other behaviors commonly experienced by children and youth engaged in the foster care and juvenile justice system and identify gaps in appropriate prescriptions. Our enterprise-wide data warehouse includes information from multiple disparate data sets and analytic and reporting tools supporting this capability. Through system flags, we will notify the child/youth's assigned care coordinator so that a multidisciplinary care team meeting can be convened, including our pharmacist and medical director, to discuss options. Based on the issue, our pharmacist and medical director may reach out directly to the prescriber to expedite a treatment change or medication refill to promote continuity of care and stability for our Kentucky SKY enrollees.

Aetna proposes to expand on this initiative to create a dashboard to report claims data to monitor the use of psychotropic medications in children and adolescents in the Kentucky SKY program and of those who are receiving behavioral health care services. The dashboard will have the following features:

- Include tracking and monitoring of lab tests and key health indicators
- Produce annual reports to analyze progress in closing health care gaps
- Serve as a quality improvement tool to look at outcomes of health care and psychotropic medication improvement

Psychotropic medication utilization review plan: Aetna has created steps to monitor psychotropic drugs and prevent inappropriate utilization for our enrollees. We currently perform psychotropic medication utilization review (PMUR) via our retrospective DUR (RetroDUR) reports and prospective DUR (ProDUR) programs. RetroDUR occurs via reports generated quarterly, although each report is continuously monitored throughout the quarter. ProDUR occurs at the point of sale via our subcontracted pharmacy benefit manager's (PBM) adjudication system on psychotropic medications for our Kentucky Medicaid enrollees. The RetroDUR program identifies Kentucky SKY enrollees with potentially unsafe or inappropriate prescription utilization for psychotropic medications. Outreach will include internal medicine physicians, family practice physicians, physician assistants, and advanced nurse practitioners. Outreach will also occur if there are two or more prescribers in a particular class. Aetna will select the following five categories to be included in Aetna's PMUR for Kentucky SKY enrollees:

- Any psychotropic medications in a member less than six years of age
- Antidepressant, atypical antipsychotic, or mood stabilizer prescriptions in someone 6-12 years old
- Psychotropic prescriptions with no documented behavioral health (BH) visits
- Two or more psychotropic prescriptions under the age of 18
- If an enrollee fills a psychotropic medication for three or more months with no BH visits

Helping and Educating a Family about Psychotropic Medications Post-discharge

Within 7 days of inpatient discharge, our clinical pharmacist assisted a 17-year-old member, Mary (not her actual name), and her mother with her medications (aripiprazole and citalopram are being prescribed for major depression with post-traumatic stress disorder due to recent sexual assault). Upon discharge, Mary received her citalopram. However, the aripiprazole prescription required prior authorization for coverage to ensure safe and monitored use, as it is an antipsychotic medication. Mary's mother informed the pharmacist that after discharge, Mary's therapist, Mary, and she decided to hold off on continuing the aripiprazole and to implement behavioral and lifestyle changes to remove some of Mary's stressors. The clinical pharmacist offered to speak with Mary, her mother, and Mary's provider about medications that could be considered in the future instead of aripiprazole. During the call, the clinical pharmacist discussed with Mary and her mother the importance of taking her citalopram daily and being patient because it may take up to 4 weeks to see improvement in symptoms; the pharmacist cautioned Mary that stopping the medication abruptly could cause a recurrence of severe symptoms as well as anxiety and agitation. Mary's mother confirmed that she gives Mary her medications and watches her take them. The pharmacist answered the mother's questions about the therapist's comments about medication 'trial and failure' and that time will be needed to find the medication that works best for Mary. At the end of the call, the pharmacist provided Mary and her mother contact information for Mary's Aetna care manager and explained that Aetna has resources available to her, her family, and her daughter. Mary has been able to take her citalopram regularly and has not yet needed to take additional antipsychotic medications as her behavioral treatments have been effective.

When any anomalies are identified, Aetna's chief medical officer and director of pharmacy or clinical pharmacist will review prescribing patterns to identify opportunities for provider consultation via letter, fax, or peer-to-peer telephonically, or the prescriber may contact Aetna for a peer-to-peer review. Through provider-pharmacist-medical director interactions, we may successfully modify enrollees' medication plans by educating providers about safer options in their behavioral health medication regimens.

Interventions that Drive Collaboration and Appropriate Prescribing

Aetna's clinical pharmacists and clinical pharmacy advisor work in collaboration with our Kentucky SKY enrollees, their providers, the Integrated Care team, and the CCT to deliver comprehensive medication management that optimizes their health outcomes. Care is coordinated among providers and across systems of care as our enrollees transition in and out of various settings.

When medication issues and concerns about polypharmacy are identified, a collaborative systematic process is initiated by which medication regimens are reconciled, enrollee information is acquired and reviewed to assess the appropriateness of medication therapy, and medication-related problems are addressed. Our clinical pharmacy advisor works with enrollees, providers, and care coordinators to develop a plan for the resolution of any medication-related problems. The enrollee's medication record is available to the enrollee (if appropriate), guardians, and caregivers. The person-centered care plan is updated to reflect the list of actions to resolve medication-related problems that were identified during the medication reconciliation process. The clinical pharmacy advisor provides education and medication adherence counseling. The

Aetna was the first managed care organization to initiate a partnership with Children's Alliance-IPA (CA-IPA) to create and execute a value-based services contract in Kentucky. As CA-IPA is a clinically integrated network, our VBP arrangement is designed to achieve specific outcomes and improve the holistic health care, including physical health and unmet social resource needs, of children and families in Kentucky. An important component of this partnership is including the Healthcare Effectiveness Data and Information Set measure of Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics as part of our agreement.

collaboration and intervention from the clinical pharmacy advisor and CCT members are documented in the enrollee's care plan, allowing for tracking and follow-up on any unresolved medication-related issues.

Aetna proposes to continue to develop interventions that foster collaboration in the medication management process and improve treatment outcomes. We will achieve this by creating a mental health consultation program to provide prescribers access to child and adolescent psychiatry/clinical pharmacy expertise. This approach will enable the following:

- Make available continuing education for prescribers via webinars on best practice standards about psychotropic medication utilization and trauma-informed care to educate primary care providers, which can be archived and utilized after live events
- Develop in-person and online training modules on the appropriate use of psychotropic medications for DCBS/DJJ workers, birth parents, kinship and foster parents, courts, and judges
- Expedite medication prior authorizations for enrollees discharging from inpatient psychiatric hospitals
- Enhance management of the Medical Passport by making it an electronic record that can be accessed by state agents, providers, etc.
- Develop protocols on appropriate psychotropic medication prescribing for Kentucky SKY enrollees

Aetna recognizes the importance of reducing the use of multiple psychotropic medications in children and adolescent populations. Aetna offers support to our enrollees and families through the Community Pharmacy Enhanced Services Network (CPESN), comprised of community-based pharmacies experienced in supporting the pharmacy needs of children/youth engaged in the foster care system. As part of our strategy, Aetna is collaborating with the CPESN to increase member touchpoints and provide a higher level of care for shared members, addressing things like medication reconciliation, synchronization, optimization, and care coordination. In collaboration with Aetna's adult and child system of care administrator, behavioral health medical director, and clinical pharmacy advisor, CPESN is developing and refining protocols to guide their relationships with our currently enrolled children and youth engaged in child welfare and/or juvenile justice, and their families (including foster and adoptive families), supporting medication management, social determinants of health needs assessment, and care coordination. The pharmacists contribute to the enrollee's care plan, which can be utilized by any of the interdisciplinary care team members supporting the child/youth's total health care needs, including wraparound service providers when appropriate. The CPESN program utilizes local community pharmacists to engage enrollees and create individual enrollee pharmacy care plans that define interventions based on a comprehensive assessment of enrollee medication use and health needs. Enrollees are identified for outreach based on potential inappropriate prescribing of psychotropic medications, commonly seen with complex behavioral health conditions.

Due to Aetna's demonstrated success with this innovative, community-based pharmacy program, we have expanded the CPESN program to multiple communities across the Commonwealth and will continue to grow in 2020. The CPESN pharmacists, Aetna care managers, pharmacy director, and clinical pharmacy advisor have worked collaboratively to plan and coordinate care for numerous enrollees in need of medication optimization strategies, care coordination, education on specific health topics, and assistance with issues resulting from social determinants of health and health plan resource needs Also, Aetna's CCTs, including the pharmacy director, clinical pharmacists, and medical director, conduct monthly care conferences to discuss and strategize on next steps needed to support the enrollees we serve.

Collaborating with CPESN to Assure Appropriate Prescribing

Ellen (not her real name) is caring for her three grandchildren, all between 12 to 15 years of age, as a foster mother. All three children have BH and medical conditions related to traumatic life events. The Aetna care manager referred the children to the CPESN program in October 2019, triggered by the complex behavioral health medications present on each child's profile. The community CPESN pharmacist immediately connected with the grandmother and children and conducted comprehensive reviews of each child's medication regimen. The pharmacist verified that all medications were appropriate for each child's health conditions, the medications were working consistent with the treatment plans, symptoms were well-controlled, and no side effects were present. To assist the grandchildren to take their medications as prescribed and decrease refill complexity, the pharmacist implemented the medication synchronization and packaging programs, which provide all medications on a same-day refill schedule for monthly chronic medications. Additionally, the pharmacist provided the grandmother with information on side effects to look for with the medications and information on resources that are available to her and her grandchildren to assist with daily living and address their social needs (e.g., transportation). Since being referred to CPESN, the children have not had a single emergency room visit or inpatient admission for their BH and medical conditions.

Targeted interventions: Aetna's written policies and procedures help establish consistency in the processes we will use to detect the inappropriate use of psychotropic medications to treat Kentucky SKY enrollees. For example, Aetna applies PMUR retrospective drug utilization review (RetroDUR) to assess enrollee and provider psychotropic medication over-utilization patterns and to drive the development of interventions and educational activities. Drug utilization review also includes fraud, waste, and abuse prevention; identification of trends that may influence change to the Medicaid programs common list of covered drugs; and educating health care professionals and pharmacies about drug utilization. Based on the various monitoring and trend analysis described, we implement or refine interventions to further improve prescribing and utilization patterns as well as control costs.

A goal of our PMUR program is to reduce the risk of potential complications caused by inappropriate use of medications. Pharmacy claims data is analyzed to identify Kentucky SKY enrollees whose utilization data contains psychotropic medications that may not be appropriate for their conditions and could place the enrollee at risk. Outreach to those practitioners prescribing medications for the identified enrollee can occur to alert them of our findings. We will contact the nurse practitioner's or physician assistant's supervisor if necessary.

These interventions may include, but are not limited to, the following:

- PBM analytics identify outlier prescribers, including those overprescribing and inappropriately prescribing. Our **algorithms will match national drug code, primary and secondary diagnosis, and place of service to support identification of use of psychotropic medications** by Kentucky SKY enrollees. Providers receive information describing the risks of use of psychotropic medications for this population and the benefits of non-pharmaceutical alternatives.
- Referrals to the Patient Utilization Management and Safety Committee to evaluate identified enrollees' utilization to determine whether they are candidates for pharmacy/prescriber assignment
- Aetna's Special Investigations Unit (SIU) reviews cases of outlier prescribing to identify potential fraud, waste, and abuse (FWA). The SIU recovers identified overpayments. The SIU refers cases of FWA to the Health and Human Services Office of Inspector General for further investigation and potential sanctions.
- Communication with the Kentucky SKY CCT to coordinate medication management activities
- Our Care Coordination, Utilization Management, Drug Utilization Review, and Grievance and Appeals teams submit **quality of care referrals for outlier prescribers.** Aetna's medication therapy management program focuses on high-risk enrollees with the most complex and costly medication regimens to identify potential quality of care concerns associated with drug interactions.

- Aetna has identified events that trigger a review of the enrollee's care to identify instances of inappropriate use of psychotropic medications. When we identify an emergency room visit or inpatient admission for enrollees who are being treated with psychotropic medications, our health plan medical director confers both with the acute care treating physician and with the physician at the facility about preferred clinical practices. Depending on the treating clinician's response, we might schedule a follow-up peer-to-peer discussion or face-to-face follow-up with an advanced practice registered nurse at the facility.

Our chief medical officer and/or the pharmacy director/clinical pharmacist contacts the identified practitioner for a review of their prescribing patterns. Outreach to the identified practitioner focuses on review of the analysis and education on appropriate prescribing practices. This outreach is completed by letter, fax, or telephonically. This information is brought to Quality Management/Utilization Management Committee for review and action, including corrective action plans, claims denial, or termination from the network. Physicians who do not respond to colleague mentoring may be brought to the attention of appropriate state agencies.

b. Collaboration on Discharge Planning

Aetna recognizes that discharge planning should begin when a Kentucky SKY enrollee enters a hospital or treatment facility, juvenile justice setting, a new level of care or a has a placement change. In order to ensure high quality care, Aetna engages in an integrated multidisciplinary approach to discharge planning.

Shaping the Discharge during the UM Process

Through our experience working with the Kentucky SKY population, Aetna recognizes the importance of collaboration between providers, guardians, enrollees, custodial agents (DJJ, when applicable) and their caregivers/support system to ensure development of a comprehensive aftercare plan. Our UM clinicians begin discharge planning on the day of admission by notifying DCBS upon admission of an enrollee committed to the State to an inpatient level of care. The assigned Kentucky SKY care coordinator will also be notified of the admission to ensure that comprehensive discharge planning, including the enrollee, their caregivers, and their medical and non-medical providers, begins promptly. This step facilitates the inclusion of the CCT in our comprehensive evaluation and discharge planning processes.

During the UM review process, UM clinicians assess the physical, mental, and developmental health, functional, and social determinant needs of the enrollee, identifying past and current traumas and the family dynamics and social determinant barriers that potentially impact the stability of the transition. Our UM clinicians also actively make case shaping recommendations regarding aftercare planning and advocate for inclusion of the enrollee's guardians, family members, and additional supports in the treatment process while in the inpatient setting. UM clinicians also make sure referrals are made to community resources by directly communicating with the assigned care manager and will continue this process with Kentucky SKY care coordinators. Embedded within our medical necessity criteria are best practices for inpatient treatment settings, including use of step-down models to decrease the number of days spent in facilities and to promote access to trauma-informed community-based wraparound services. This comprehensive process supports the Commonwealth's goal of keeping Kentucky SKY enrollees in the community and in homes. The information obtained through the comprehensive UM review process is discussed during integrated behavioral health and interdisciplinary rounds prior to discharge in order to facilitate transition to the appropriate level of care. This step serves to promote individualized person-centered care planning and expedites the resolution of medication related issues and ensures trauma-informed best practices are utilized.

Interdisciplinary Approach to Discharge Planning

We conduct discharge case rounds with our medical director, System of Care staff, and care managers weekly. Care coordinators and the medical director conduct inpatient rounds daily. Rounds include an integrated review of all medications along with evaluations of level of care and setting needs. The interdisciplinary care team (ICT) is involved and engaged in care coordination prior to discharge to coordinate care, while meeting the whole-health needs of the child/youth, in consideration of trauma-informed principles. The ICT includes the following team members: the child/youth, foster, therapeutic-foster or adoptive parent, natural family when possible, DCBS or DJJ representative, and Aetna care coordinator. As appropriate, the behavioral health, pediatrician or specialty provider, Aetna medical director, and pharmacist are also of the ICT.

For DJJ-involved youth, ideally, discharge planning and reintegration should start at the time of system entry, or shortly after enrollment with Kentucky SKY. Aetna's juvenile justice liaison and representative from the Kentucky SKY CCT will be active partners in developing and executing discharge planning. At minimum, request the assigned juvenile justice worker notify the Kentucky SKY team at least 30 days prior to the Kentucky SKY enrollee's release from detention to ensure appropriate coordination of post-release services.

Aetna has initiated an active participation in communicating and collaborating with State agencies regarding enrollees who need alternative placements and treatment options. We participate with the Children's Review Program in the 'difficult to place' and 'placement disruption' calls in order to collaborate with DCBS in identifying placements and treatment providers. Behavioral health clinicians participate in these calls to provide clinical recommendations and insight into options for these enrollees and to provide case shaping and discharge planning assistance. Aetna's relationships with stakeholder organizations, community resources, and the Kentucky SKY provider network strengthen our collaborative efforts.

Upon readiness for discharge from the hospital or lower level of care, the care coordinator will manage the following process:

- Facilitate discussion of the enrollee's information, coordination, and discharge plan with the enrollee's CCT
- Make sure a copy of the discharge plan is provided to CCT members and that it includes a detailed safety/crisis plan
- Make sure the CCT understands the discharge plan and recommended after-care plan
- Address any concerns that the CCT may have regarding aftercare

At the time of transition to a new placement, the care coordinator will manage the following process:

- Facilitate discussion of the enrollee's information, coordination, and care plan with the enrollee's current CCT or with the new CCT if a new team is established due to change in placement
- Make sure a copy of the updated care plan is provided to CCT members and that it includes a detailed safety/crisis plan
- Make sure the CCT understand the new service plan
- Address any concerns that the CCT may have regarding change in placement

Once notified of that the discharge has occurred, UM clinicians will notify state agencies as well as the assigned care coordinator, so follow-up care occurs and supportive services are in place.

We are continually looking for opportunities to partner with hospitals and facilities to embed care managers to facilitate effective discharge planning. The clinical care managers participate with UM clinicians, hospital staff, and our integrated care teams in discharge planning to address the physical, behavioral, and oral health needs as well as social determinants of health prior to discharge. Embedded

care managers will coordinate with the Kentucky SKY care coordinator for our children/youth in foster care in these hospitals and facilities. We have embedded clinical care managers at the following hospitals:

- Our Lady of Peace in Louisville
- University of Kentucky Hospital
- University of Kentucky—dedicated neonatal intensive care unit clinical care manager
- Eastern State Hospital—State-operated hospital

During an acute stay, the integrated care team examines medical, behavioral, social determinants and health literacy indicators for readmission and begins to address the root cause of the primary admission.

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60.7.G.12 Aging Out Services

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60.7.G.12 Aging Out Services

Aetna understands the transition from adolescence into adulthood is a pivotal developmental stage as youth learn the skills needed to be healthy and productive adults. That transition is often especially challenging for those who are leaving foster care without a permanent family. Nationally, data shows that transition age youth experience higher rates of homelessness and lower rates of finishing high school than their peers who were not in foster care.[1] In Kentucky, about 1 in 3 youth who spent time in foster care had experienced homelessness in the past 2 years by age 21. Further, 66 percent of youth who spent time in foster care had finished high school or received their General Education Diploma (GED) at age 19 compared with 88 percent of youth in the general population. These troubling outcomes for this vulnerable population of Kentucky youth transitioning out of foster care highlight the need for programs and services that will promote a positive trajectory for this population as they transition out of foster care.

Youth aging out of foster care face multifaceted needs; they continue to heal from the childhood trauma they experienced and lack social and financial supports to achieve their vision of a good life. To address the holistic needs of this population, Aetna will implement powerful and individualized **strategies** to support the development of Kentucky SKY youth and promote healing.

Aetna offers an **innovative, integrated, and evidence-based** approach to the challenges of supporting Kentucky's young people who are transitioning out of foster care and juvenile justice systems. The **Charting the LifeCourse™** framework helps individuals and families of all abilities and all ages develop a vision for a good life. In using the LifeCourse framework and supporting the transition age youth in identifying these goals, the Care Coordination team (CCT) can make certain to include the enrollee's voice and choice in the care planning process. Aetna is also continually expanding its knowledge and capacity to expand and improve the supports we offer transition age youth. The following initiatives help us in this area of capacity building:

- **Aetna has created Foster Parent Advisory Councils** to facilitate a way to hear directly from foster parents. We want to hear what works, what barriers they struggle with, and to obtain general feedback/insight that foster parents may have regarding the overall needs within the foster care community.
- **Aetna commits to convening local, regional, and state-level community conversations** to inform our processes and make certain transition age youth receive quality services that will help them to reach the goals they have set for themselves.
- **Aetna engages foster care, former foster care, and Department of Juvenile Justice (DJJ) involved youth** via youth focus groups and partnering with foster care advocacy groups to help to ensure voice and choice is heard at all levels of the Kentucky SKY program. We will partner with Kentucky Youth Advocates to grow our connection with these groups throughout the Commonwealth.
- **Aetna sponsors and supports community partners and youth advocacy groups** to support transitioning youth connect with mentors and provide employment and educational opportunities so they can live in their own communities.

Holistic care coordination is central to our approach. Aetna will employ an integrated model of care to support improved whole-person outcomes for youth aging out of state care. In using this model of care, Aetna is better suited to assess the youth's holistic needs and to help youth identify their own course of care for the transition part of their journey. Aetna recognizes that youth in state care are at higher risk for a chronic physical, developmental, behavioral, neurological, or emotional condition and may require a

[1] Source: Child Trends, 2017.

broad range of evidence-based primary, specialized medical, behavioral health, and related services. Aetna's integrated care management model aims to advance personal and family recovery and resiliency for Kentucky SKY enrollees. The model emphasizes making sure all youth have safe and nurturing homes and communities by providing a seamless system of services and supports to enhance quality of life and improve health outcomes for youth in state care while collaborating with providers to help them gain independence and functional stability (please refer to **Figure G.12-1**).

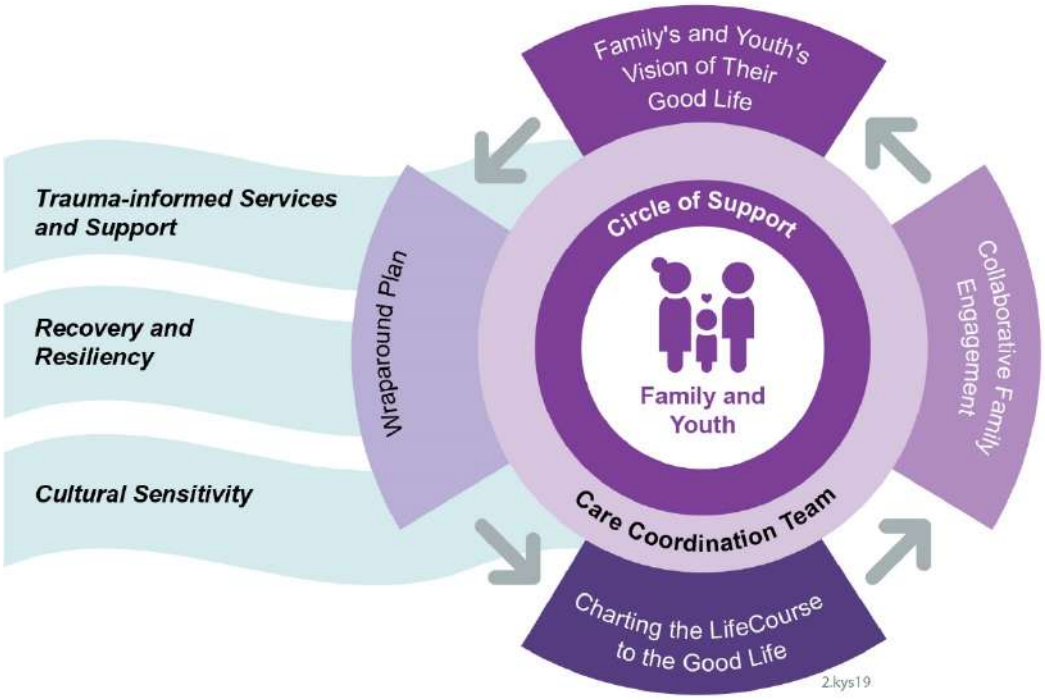

Figure G.12-1: Aetna's Integrated Care Management Model

Aetna's integrated care management model aims to advance personal and family recovery and resiliency

Kentucky SKY enrollees' transitional care plan will be holistic and person-centered, created with a team approach, and will include goals related to the following:

- Specific options for housing
- Health insurance
- Education
- Mentoring/peer support opportunities
- Continuing support services
- Workforce supports
- Employment services

Please refer to **Attachment BB** for our ICM Program Description.

Recommendations to Enhance Transitional Services

Aetna is in a unique position to help Kentucky youth prepare to live their best life. Aetna offers our recommendations for Kentucky's youth transitioning into adulthood by leveraging experience gained in nine states: Kentucky, Arizona, Kansas, Louisiana, Maryland, Michigan, New Jersey, Pennsylvania, and Virginia. We will support the development of the youth's transitional care plan and develop services and supports that build skills and knowledge that can improve the youth's ability to carry out his or her personal plan for their future. In addition, we will support Kentucky SKY youths' growing independence

and provide an array of services that will guide and encourage new skills while also helping youth develop a cushion of support.

Strategy 1: Start Early

Aetna understands the knowledge and life skills that Kentucky SKY youth will need to successfully transition into adulthood. It is crucial that these enrollees receive support and services guiding them through the transition process well before they leave care, beginning in adolescence or even earlier. Aetna's model for transitional services embodies the understanding that preparing for adulthood does not occur overnight and we should not wait until youth are ready to age to begin transition planning.

For youth ages **12 to 15**, Aetna will support Kentucky SKY youth in developing independent living soft skills, such as problem solving, anger management, and decision-making. We also support the youth in working on basic daily living skills such as cooking, household responsibilities, doing laundry, and money management. Our care coordinators (CC) will educate the enrollee and their circle of support on how to access these resources for skills development through our community-based nutritional courses in slow cooking and diabetes management and Aetna's **Getting on T.R.A.C.K (Transition Ready Assistance & Core Knowledge) program.**

Aetna has a developed formal skills training classes via the Getting on T.R.A.C.K program. This health literacy program is designed specifically for young adults transitioning out of foster and DJJ care. The program is an ideation of Aetna's Community Outreach team and was created by an Aetna staff member. The Community Outreach team partners with and supports the endeavors of various organizations across the Commonwealth that offers services to children in the foster or DJJ system. These organizations collaborate with our Community Outreach team to offer the courses and provide various components of the program. The curriculum is robust and can be customized to fit the needs of the specific youth. Youth will be engaged via their care coordinator and the courses will be held at community partner facilities throughout the Commonwealth.

We have identified the following specific partners for the Getting on T.R.A.C.K. program that will facilitate specific classes and provide components:

- **Woodforest National Bank** will present the budgeting and tax prep class and provides written materials on independent living and personal banking
- **Goodwill Industries** will provide finance forms to support the budgeting classes
- **County Clerk and Driver License Bureau** will provide driver's license manual
- **Cooperative Extension Offices and Medical Independent Living (Sunrise)** will facilitate a class on the Supplemental Nutrition Assistance Program, Independent Living, and Medicaid enrollment
- **Western Kentucky University** will facilitate a class on higher education opportunities, completing Free Application for Federal Student Aid (FAFSA), and other funding resources
- **The Learning Villa** will offer education on alternative traditional housing
- **Workforce Development** will offer a class on obtaining employment
- Aetna will continue to provide education on **enrollee benefits, chronic disease management, nutrition,** and access to resources.

At **15** years of age, the Kentucky SKY youth, if in agreement and with permission from the Department for Community Based Services (DCBS) social worker, is referred to formal Life Skills classes and has the opportunity to complete aptitude tests and job interest surveys using tools such as the U.S. Department of Labor's O*NET Interest Profiler. When the youth is **16** years old, the care coordinator collaborates with DCBS and DJJ (if involved) to make certain that youth become enrolled in state formal life skills classes (John H. Chafee Foster Care Independence Program). At this stage in their development, it is imperative that the CCT helps the enrollee to build a support network or formal and information relationships within their local community.

Strategy 2: Help Kentucky SKY Youth Build Supportive Relationships and Connections

Aetna understands that permanent, supportive relationships and connections are critical to a young adult's well-being. Aetna is a facilitator of relationships and acts a liaison in help to establish lifelong connections for youth. Research and practice show that having ongoing support from at least one permanent caring adult can make an enormous difference in the life of a vulnerable youth[2]. Aetna also recognizes the importance of preparing youth for independent living.

> Children in foster care who are transitioning to adulthood are most successful in achieving independence when they have established relationships with caring adults who will support them over time.

Kentucky youth in foster care and DJJ often have not had the same opportunities as other youth to develop social skills and supportive, lasting relationships. Aetna supports enrollees in building their circle of support by supporting the following steps:

- Help the youth to identify at least one reliable, caring adult who can serve as a stable, ongoing connection and can provide support as they transition to adulthood. This happens as part of care planning conducted by the care coordinator. Once the need is identified, the CCT will come together to help the youth identify this person and invite them to be part of the ongoing planning process. If the youth is unable to identify such a person, the team will help them get involved in activities of their choice, in the community where they live to help facilitate the development of these informal, long last relationships.
- Where appropriate, support youth in exploring connections with their biological family members (e.g., siblings, parents, grandparents) and in maintaining healthy relationships with them
- Encourage youth's development of peer support networks through participation in group activities with youth having similar experiences (e.g., foster youth advocacy groups) or similar interests (e.g., sports, dance, cooking, business)

To avoid housing instability and unemployment, we engage community resources such as local housing authorities, peer support specialists, and employment training resources to assist these individuals in organizing a family and community network of support. In support of youth aging out, Aetna participates in the annual "Soaring in Life" symposium offering young adults aged 17-21 connections to resources such as employment, housing, educational, college planning, and more. These resources aide our enrollees in planning their future as they successfully transition into adulthood.

When the youth turns **17**, Aetna also supports enrollees, as well as DCBS and DJJ, in the formal transition planning process. To help youth work on their transition plans, Aetna will utilize easy-to-use tools such as the **Department of Education's Foster Care Transition Toolkit and the Planning Tool for Transition Planning for Youth with Disabilities from the Child Welfare System to Adulthood** (Juvenile Law Center) to help youth plan their next steps. Transition planning will be incorporated into CCT meetings.

[2] Thompson, Greeson, & Brunsink, "Natural mentoring among older youth in and aging out of foster care: A systematic review," Children and Youth Services Review, 61(c), 40-50 (2016): accessed June 20, 2019; https://ideas.repec.org/a/eee/cysrev/v61y2016icp40-50.html

Strategy 3: Empower Youth

With the involvement of the informal supports and starting the care planning process early, the CCT's goal is to empower the youth in using their strengths to meet their needs through resources of their choice. Youth in foster care often have been left out of critical decisions about their lives. It is important to let the young person take charge of his or her own future while providing guidance and support.

Aetna Kentucky Transition Planning Success Story

Beth (not her real name) is in foster care and just turned 18, and she will be moving into a dormitory at Morehead State University. Beth will stay with her foster family on holidays. She is currently undecided about her major but is thinking about nursing or neuroscience. Beth was receiving counseling twice per week and feels she no longer needs the services as she is doing well. Since being away at college, Beth has reconnected with her biological family and is considering moving closer to her biological family. An Aetna care coordinator assisted Beth and her foster family to help ensure her Medicaid coverage continued in the event she relocates closer to her biological family. As a result of Aetna's self-direction program, Beth reports that she is more confident and independent. Her foster mother reports that Beth is more open; she shares information openly with her CCT and follows up on referrals. Beth also plans to take classes at a Center for Independent Living.

The average **18-year-old** still needs support and assistance as they enter adulthood. It is unrealistic to expect young people at this age to be completely independent and self-reliant. Recognizing the need for more time to develop critical life skills and support systems, DCBS involved youth have the option to extend their involvement in the foster care system. This extension allows 18- to 21-year-olds to stay in or re-enter foster care, which can close the gap between youth in foster care and their peers. For those youth who choose to end commitment at 18, the CC will tap into the identified informal relationships built through the care planning process to help the youth identify and prioritize their needs. Kentucky SKY enrollees will have access to community supports, including **Regional Independent Living Coordinators**, to assist with the transition planning.

For youth that are **20 years old,** the CCT will help to ensure that care coordination, housing, education, and financial support are included in the transitional care plan. These are critical skills that help to ensure Kentucky SKY enrollees will be empowered to make decisions regarding their services needed during and after their transition into adulthood

In FFY 2015, 86% of Kentucky youth ages 16-26 receiving independent living skills services received some type of educational support.

For youth that are **21 years of age**, the CCT's primary focus will be on aftercare planning (when the youth transitions out of the children's system). Aetna's internal **System of Care (SOC)** model supports the youth in transitioning between the Children's SOC and the Adult SOC. The following SOC administrators will collaborate to empower the youth in having voice and choice regarding their decision to transition from one system to the other (please refer to **Table G.12-1).**

Table G.12-1: System of Care Administrators for Transitioning Youth

System of Care Administrator	Role and Responsibilities
Adult SOC Administrator (Transitional age, enrollee-focused, e.g. 18-26 years old)	• Builds key stakeholder relationships with the Department, DCBS, and DJJ for the transition planning and delivery of services • Ensure that all service needs, including community-based supports, are available in the Kentucky SKY region, especially for those enrollees aged 18-26 • Collaborates with the CCT to help to ensure all information technology (IT) needs are met to transition youth's records from DCBS system to the centralized Aetna FamilyConnect (the shared electronic health record which serves as the single source of truth for foster care children)

System of Care Administrator	Role and Responsibilities
Children's SOC Administrator	• Builds key stakeholder relationships and processes with the Department and DCBS and attends various meetings, including SIAC, to help ensure children aging out have access to needed resources • Builds community-based services and support for transition age youth involved in DJJ and DCBS
Recovery and Resiliency Administrator (person or family enrollee with lived experience)	• Builds supportive programs to mental health, substance use, and foster care delivery and coordination including resiliency training and development, advocacy, foster family and biological family support, recovery maintenance, etc. • Collaborate with Provider Relations to coordinate peer support network and other non-traditional providers to service special populations like Kentucky SKY enrollees • Collaborates to help to ensure all Kentucky SKY enrollees have advocacy support • Collaborates with enrollees and family to identify and remove barriers to services specific to transitioning youth
Juvenile Justice Liaison	• Proficient on Reclaiming Futures framework to promote within systems and communities serving transition age youth • Collaborates with the DJJ, Department of Corrections (DOC), county jails, Sheriff's Office, Correctional Health Services Office of the Courts and Probation Departments, and Department of Behavioral Health and Developmental Disability to identify systemic changes and promote community integration
Emergency Department/ Crisis Administrator	• Develop the crisis plan and identify gaps and solutions • Collaborate with Medical Management to mitigate gaps in crisis service delivery including solutions to ED over utilization • Coordinate system approach to enrollees needing emergency services for domestic violence victims, sexual assault victims, etc. • Builds collaborative relationships with fire, police, emergency medical services, and hospital emergency departments to advance TIC approaches across systems and outcomes for our enrollees • Collaborates with medical management on transition of care needs for enrollees • Develops plans to mitigates system gaps when enrollees are discharging from inpatient settings • Participates in the development and delivery of SKY training curriculum
Trauma System of Care Administrator	• Builds key stakeholder relationships with the Department, DCBS, etc. for the planning and delivery of services • Ensure that all service needs, including community-based supports, are available in every region • Identify gaps and solutions specifically for those enrollees aged 18 – 26 • Collaborates to develop integration of records – IT, communication, single care plan development, coordination with TWIST, etc. • Develops workflows for all required state assessments • Participates in the development and delivery of SKY curriculum

The juvenile justice liaison role was developed from our success working with the juvenile justice population at Mercy Care, a health plan managed by the Aetna Medicaid organization in Arizona. The Arizona model utilizes a detention roster protocol to identify and serve youth in detention. This protocol will be adapted for the Kentucky SKY population and managed by the juvenile justice liaison, who will be responsible for the following:

- Collaborating with the DJJ, DOC, county jails, Sheriff's Office, Correctional Health Services Office of the Courts and Probation Departments and Department of Behavioral Health and Developmental Disability to identify systemic changes and promote community integration
- Understanding the **Reclaiming Futures** framework and working closely with other systems that serve youth and the community

- Bridging communication with the health plan staff, court and justice systems, and the youth and family

More than simply a collection of various resources, our model of trauma-informed SOC work together to help each transition age youth achieve important clinical and functional outcomes: at home, in school, at work, in the community, and throughout life. Aetna's SOC is an empowering tool for aging out youth involved with DCBS and DJJ and includes the following components:

- Person-centered, inclusive of each enrollee's family/circle of support, and respectful of each enrollee's cultural community
- Includes all the health care and related services and supports Kentucky SKY enrollees' need to improve their health including physical health, behavioral health, oral health, social determinants of health (SDOH), illness, and disability
- Services available locally from community-based organizations
- Aligns and coordinates multiple care coordinators from multiple agencies, simplifying the transition process for all aging out enrollees
- Matches each transition age youth with the services that best meet their needs, regardless of the source or origin of those services, eliminating duplication and service gaps
- Includes effective working relationships among all stakeholders within each integrated SOC
- Capable of fully serving aging out Kentucky SKY enrollees of special needs populations, each of which has its own dedicated SOC and 'network within a network,' including enrollees with multiple diagnoses

Assessing Home and Community Support Needs

Aetna understands that transitional services should be provided according to the unique developmental needs of our aging out enrollees and their differing stages of independence. Aetna's transitional services model represents a series of activities designed over time to support the youth in achieving their vision of a good life. Aetna identifies the needs of enrollees involved with DCBS and DJJ who are aging out through a comprehensive range of assessments and tools, such as the following:

- Health risk assessment (HRA)
- Enrollee needs assessment
- Condition-specific assessments (e.g., lead poisoning, infant assessment, pediatric asthma, anxiety)
- Health Care Equity Event (for identifying Social Determinants of Health)
- Foster care assessment
- Home safety assessment

In addition, a broad array of specialized tools for assessing the needs of transition age youth are described throughout this section.

Assessing Needs Using Evidence-based Assessments

As part of the ongoing assessment process, the transition age enrollees of the Kentucky SKY program will be continually assessed for an array of needs. Aetna believes that early intervention planning is the key to a successful transition into adulthood. The earlier these needs are identified, the earlier the CCT can support the youth and their circle of support to engage right services, at the right time and in the right place. Aetna will conduct all required assessments, as outlined in **Section 41.17 Required Assessments and Screenings of the Draft Medicaid Managed Care Model Contract**.

The evidence-based assessments we use to best determine the needs for the aging out population include the following:

- Early and Periodic Screening, Diagnosis, and Treatment Mental Health Assessment
- ACES-Q
- Child and Adolescent Needs and Strengths

- Child and Adolescent Service Intensity Instrument
- UCLA Child/Adolescent PTSD Reaction Index

Aetna recognizes the unique needs of the DBCS- and DJJ-involved youth. Of youth who spent time in Kentucky foster care,[3] 21 percent by the age of 19 and 25 percent by the age of 21 had been incarcerated in the last two years. Aetna will train all staff on the screenings and assessments used by DJJ (e.g., Risk and Criminogenic Needs Assessment and the Criminogenic Needs Questionnaire [Needs-Q]), and other justice entities, to help to ensure we are best serving juvenile justice-involved youth. Our experience with and understanding of the Risk/Need/Responsivity principles along with a strong DJJ partnership will allow Aetna to incorporate the specific dynamic risk factors identified for each youth and incorporate action steps to address in the youth's transition care plan.

Kentucky SKY enrollees involved with DJJ will be screened using the mentioned tools, as appropriate. In addition, Aetna recognizes the unique needs of the DJJ-involved population and may include additional tools, such as the **Youth Level of Service/Case Management Inventory**.

> "The LifeCourse framework and tools are designed to help individuals and their families plan for and navigate a life that makes sense to them with the support they need… It is exciting that a national health care leader like Aetna recognizes its value and will be using the LifeCourse framework as it develops its person-centered, holistic model to support children in the child welfare system in Kentucky."
>
> **—Michelle C. Reynolds, PhD**
> **Associate Director of Training,**
> **UMKC Institute of Human Development**

We will use both internal and partnership agency tools to assist the aging out in the needs assessment and transition planning processes. These tools will be offered to all Kentucky SKY enrollees to better help them plan for a successful transition into adulthood. In addition, Kentucky SKY enrollees will receive Charting the LifeCourse™ resources and tools[4] (please refer to **Figure G.12-2**); this will assist in the design of their own life plans as they can read and review as they progress through the transition process. Aetna utilizes the approach of Charting of the LifeCourse framework to serve youth in foster care and juvenile justice systems, in concert with their circle of support. The care plan will help the aging out youth and their circle of support (formal and informal supports) to identify what they need to successfully transition into adulthood.

[3] Data on outcomes of youth who spent time in foster care comes from the National Youth in Transition Database (NYTD). Data for 19-year-olds is from FFY 2013 and for 21-year-olds is from FFY 2015.
4 "Charting the LifeCourse," accessed June 17, 2019; https://www.lifecoursetools.com/planning/.

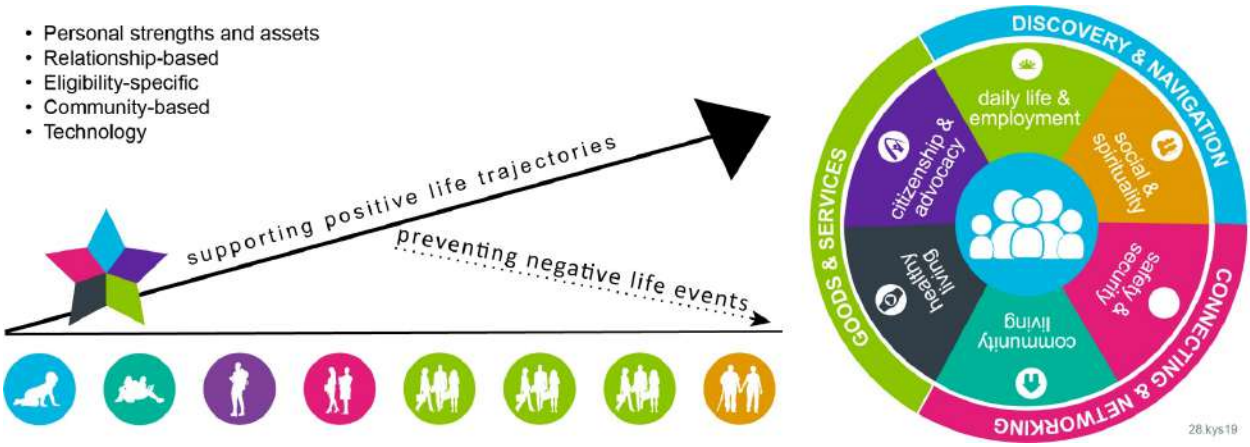

Figure G.12-2: Charting the LifeCourse™ Model

Aetna's approach to transitional care planning for aging-out youth.

Aetna's Experience Using Tools to Assess the Specific Needs of the Aging-out Population

Mercy Care, a health plan managed by the Aetna Medicaid organization in Arizona, covers 8,000 foster care youth in Maricopa County in its transition to independence model maintaining connections and encouraging them to continue treatment. Mercy Care provides training to providers and successfully retains the enrollees through transition to adulthood with a person-centered approach with its Transition to Independence Program (TIP). Person-centered planning helps the youth develop and reach goals through established support relationships youth to stay with programs to explore their options. The Arizona model includes a peer governance structure with the Youth Leadership Council, which serves to help inform on policy and program development and help providers to inform their service delivery models. With Arizona Transition Age Youth (TAY), we have developed outcome measurements that all TAY provider programs use. We use two different tools within the program. Two of our providers use the TIP model assessment called the TAPIS and the other providers use a measurement tool that was created internally.

Through the TIP model assessment tool, Arizona is able to assess individual enrollee needs, develop a customized, person-centered plan, and begin engaging supports and resources encircling the youth within a detailed transition plan. The assessment tool encompasses a detailed interview and questionnaire to determine the youth's level of life and planning skills and barriers to self-support and sustainability such as knowledge and ability to manage their sexual health, financial literacy, and employability. The assessment helps create guideposts for care coordinators to facilitate the person-centered planning process and discern the plan's essential elements and goals led by the enrollee.

Former Foster Care Success Story

Whitney (not her real name), a former foster youth, was pregnant with her third child. She was residing at a homeless shelter with her two children and little support. Whitney was introduced to the Homeless Initiative Team by one of the community organizations with whom we partner. At the time, Whitney had not had any prenatal care. On top of battling with securing housing, Whitney's two children were placed into foster care due to allegations of abuse. Aetna's care coordinator (CC) connected with Whitney's care coordinator at the homeless shelter, and they worked together on finding secure housing in order to get her children out of foster care. In the meantime, Whitney continued to attend her prenatal visits. The CC met Whitney at her prenatal appointments and was also able to help her work through some prior authorization issues. Over the course of 2-3 months, Whitney's CC was able to keep her motivated and focused on her end goals. While she was working on securing housing, she was granted weekly visits with her kids. After Whitney's apartment was approved, she continued to receive appropriate prenatal care and her two children were returned to her care.

Determining Youth's Eligibility Criteria for Home and Community Based Services (HCBS) Waiver Program

The Kentucky SKY assessment process will also include a thorough check of the transitioning youth's health status and other appropriate factors to determine if they meet the general eligibility criteria for entering a HCBS waiver program. If the youth meets the eligibility requirements, the CCT will initiate the waiver application processes and walk these individuals through the process, especially while they are on waiting lists.

> In Mercy Care's program for children in the custody of the child welfare agency, the Wraparound team approach provides a vital support, as 80% of enrollees ages 16 and above have active behavioral health services.

Initiating the Waiver Application for Aging-out Youth

If the enrollee has a developmental and intellectual disabilities diagnosis, the CCT will search for potential Supports for Community Living providers. For the aging-out population, the enrollee should already be on the wait list, if identified early. Through the person-centered care planning process, the CCT may identify community partners that will provide for the needs of the enrollee, such as assistive technology, personal care attendants, special services and equipment funds, community-based work transition programs, family care homes, nursing facilities, or vocational rehabilitation. Please see **Figure G.12-3** for details on how the CCT will initiate the waiver processes for eligible aging out youth Kentucky SKY enrollees.

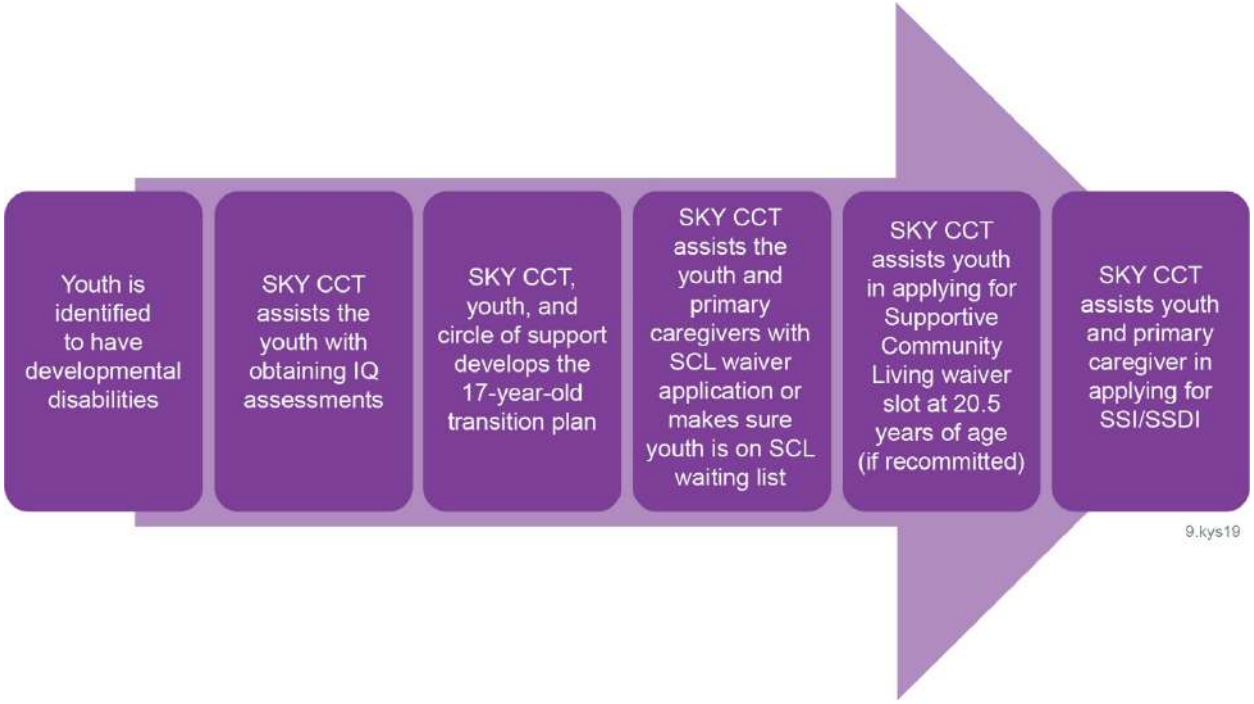

Figure G.12-3: Initiation of Waiver Program

Aetna's initiation of the waiver program for aging-out youth with disabilities.

Assessing Needs for Specialized Supports

Through the transition planning process, the CCT members will assist in identifying any needs for specialized supports. The specialized supports may include medication adherence, acquisition of necessary durable medical equipment (DME), communications needs, and vehicle and home adaptations.

DME and Vehicle/Home Adaptations

For the aging out population, specialized needs may include access to DME and vehicle and home adaptations. This equipment or adaptation may be critical in empowering the enrollee in being independent. Aetna will implement the following steps to help ensure these specialized needs are assessed and resources provided:

- CCT members will use our existing **DME checklist** to assess the youth's long-term durable needs versus their short-term functional needs.
- Through our **Foster Care Advisory Council** and work with other consumer groups through Kentucky Youth Advocates, Aetna team members will know of any challenges the families face, which enables the CCT to make certain those needs are being addressed and met through the care planning process.
- Aetna works with and educate the providers on how to write a DME request that is thorough and can be approved.
- Aetna also assesses the youth's need for home modifications and helps to ensure these needs are addressed through the CCT planning process.

> For youth identified as medically complex, the Aetna Kentucky SKY CCTs partner with the commission nurse and assist them with meeting the child's needs prior to aging out. This includes ensuring that medical coverage will continue and that necessary medical appointments are scheduled, DMEs are obtained, and that medications' prior authorizations are obtained so there will be no gaps in care.

Communication Devices

Some enrollees may struggle with communication needs. In order to help ensure these needs are met for the aging out population, the CCT will partner with the **Kentucky Assisted Technology Services Network**, which links youth in need to **Assistive Technology Resource Centers** in their area. The Assistive Technology Resource Centers provide assessments and other services. They also provide lending libraries of equipment and help learning how to use the equipment.

> Paula (not her real name), a transition-age enrollee, said her physical therapist told her she needs DME in order to sustain her progress. Sally (not her real name), Paula' s care coordinator, explained that she could go to the doctor appointments to help get the DME covered under the plan. Paula explained that oftentimes they just need to walk the doctors through the steps necessary to help to ensure the needs are covered.

Assessing Risk

The aging out population may face unique challenges during their transition out of the Children's SOC. Included in this transition process must be an assessment of risk, including **medication adherence**, **ongoing health care coverage**, and overall safety and stability. The mentioned screenings will assist the CCT in identifying any high-risk areas and will help ensure the appropriate community resources are in place to help mitigate these risks. The aging out enrollee has a voice in this process and will help direct the CCT in determining if the desire to stay with Aetna or chose to move to another health plan. If the youth requires assistance in planning for a transition to another health plan, the CCT will make certain the appropriate paperwork and application processes are followed, with the assistance from the DCBS social worker.

When needed, additional tools are used to assess risk for the aging-out population, including the following:

- Environmental Safety Survey
- Generalized Anxiety Disorder (GAD)-7 Screener
- Outreach Questionnaire
- ACES-Q
- K6 Screener
- Patient Health Questionnaire 9 (PHQ-9)
- Postpartum Screener

- Safety Questionnaire
- SF-12 Pre and Post
- Trimester Screener V2
- Used, Neglected, Cut Down, Objected, Preoccupied, Emotional Discomfort (UNCOPE) Screener

Assessing Medication Risk and Planning for Support

With the Kentucky SKY population, specifically the aging out youth, Aetna will make certain that the Clinical Pharmacy team is involved in the transition planning process. In addition, the following steps will be taken by the CCT to help ensure the aging out enrollee has ample support to be successful in their medication adherence:

- Assess for risk in the same way for each age bracket that is aging out (age 17, 18-21, 22-26).
- The transitional care plan for this population includes a section of medication adherence and risk assessment.
- Care coordinators will collaborate and partner with pharmacists to help to ensure everyone is on the same page and that the youth has support to be successful in medication adherence and compliance during and after the transition phase.
- Utilize a questionnaire in the electronic care coordination system called **Morisky Medication Adherence Scale** (a validated assessment tool used to measure non-adherence in a variety of populations) to assess level of compliance risk.
- Using the Community Pharmacy Enhance Services Network (CPESN), the CCTs can identify pharmacies that are in our network who can get involved with the transition age Kentucky SKY enrollees:
  - Pharmacists in CPESN network will give an early indication of what issues the transition age youth may face and work collaboratively with the Kentucky SKY team to proactively plan for such issues.
  - Pharmacists in CPESN will also be trained in how to identify substance abuse issues and notify the CCT immediately.
  - Aetna currently partners with six CPESN pharmacies, with expansion plans scheduled for July 2019.

Assessing Aging-out Youth's Social Determinants of Health

The enrollees' social needs are assessed and gaps identified through the HRA and ongoing CCT person-centered care planning process (please refer to **Figure G.12-4**). Enrollee referrals for integrated service needs (physical health, behavioral health, and SDOH) will be initiated through multiple sources. Additional tools, such as the Health Care Equity Contact Assessment, may be completed in combination with the HRA, which includes SDOH and biopsychosocial questions. The SDOH services integrated model will connect enrollees to community-based organizations that participate in the closed-loop referral network, including all types of social service agencies.

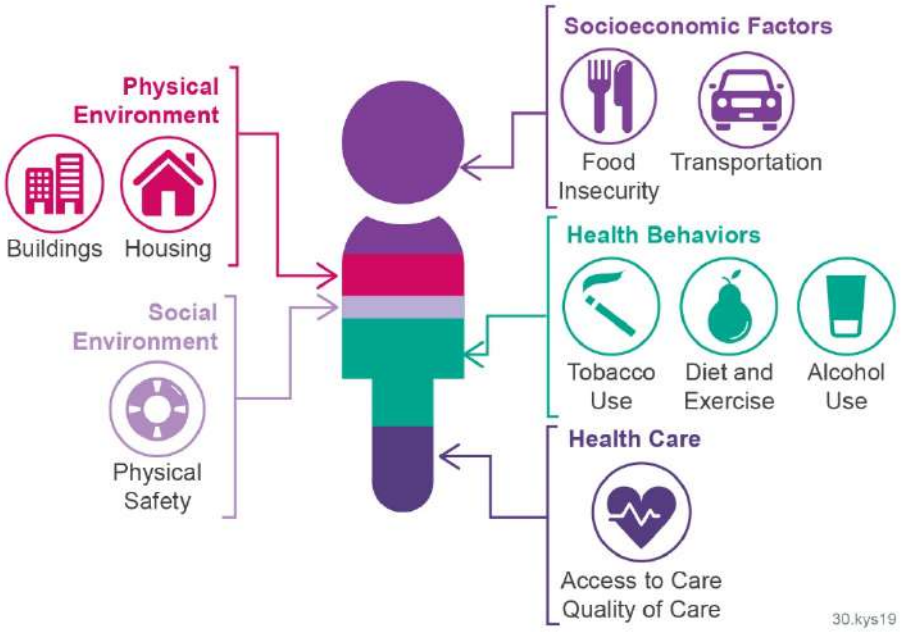

Figure G.12-4: Social Determinants of Health
Aetna's screen for social determinants of health.

Unite Us Platform

Aetna is partnering with **Unite Us** in a unique collaboration to address the full spectrum of SDOH. Unite Us enables providers in a community to work together in real-time to coordinate care and track actual care outcomes that result from inter-agency referrals. Community-based organizations, public agencies, health care providers, and behavioral health providers use Unite Us to send and receive referrals to and from each other and to maintain visibility as their enrollees access care. As individuals interact with community services across organizations and sectors, Unite Us makes it possible to build a longitudinal record of the care that is delivered and the outcomes of each touchpoint. Unite Us provides both a hands-on approach in communities, coupled with a robust coordination technology, connecting health care and social service providers. This approach includes high-touch project management and boots-on-the-ground community engagement by a team of public health experts who have launched coordinated care networks in over 50 communities across the country.

Aetna believes it is critical to connect health and social service providers into a coordinated and accountable network, delivering greater visibility into the care that is provided and better outcomes for the DCBS and DJJ involved aging out population. Through the Unite Us platform, Aetna will deliver the following:

- Continuity of quality access and care once enrollees leave the clinical setting through real-time connections with trusted, accountable, and quality community partners
- An approach under which multiple social needs are identified *and* addressed *and* resolved with structured outcomes for every need fulfilled, increasing efficiency between Aetna and community providers by 88 percent
- Full visibility into total enrollee journey and the resolution status of each need, regardless of Aetna personnel or clinical role, whether service delivery is only social, or only acute care
- A flexible but standardized approach providing robust data to support reductions in avoidable utilization while measuring the return on investment impact on cost avoidance and revenue opportunity

Aetna will utilize the Unite Us platform to address the SDOH for transition age youth involved in DCBS and DJJ. The Unite Us platform provides the unifying infrastructure between health care entities and community-based organizations. The platform allows for the current ecosystem of health care and social care partners to connect around every enrollee and track the outcomes delivered across each partner in a secure environment. This infrastructure provides the ability to track an individual's journey, regardless if they start their journey post-discharge from medical provider or at a community-based organization's office. The main themes of the platform include the following:

- Configurable screening for needs with immediate decision support
- Electronic referrals and tracking with external agencies
- Assessment and single care plan management
- Bidirectional communication (between partners and enrollees)
- Alerts and email notifications on referral progress
- Outcome tracking across network partners and each community
- Outcomes by resource including specifics (e.g., long-term housing, transitional housing, etc.)

In addition, Aetna Kentucky SKY CC will help Kentucky SKY aging out youth to enroll in federal and state benefit programs such as **Women, Infants, and Children, Kentucky Transitional Assistance Program, Kentucky Low Income Home Energy Assistance Program, and Continuum of Care (CoC) Homeless Assistance Program**. Aetna Kentucky SKY care coordinators will offer assistance with addressing other social determinant needs and with referring enrollees to our fully integrated network when necessary.

Housing Support Services

Foster care enrollees that have exited care struggle with paying for housing and experience frequent changes in living arrangements. They are also at increased risk for homelessness, with National Youth in Transition Database (NYTD) data showing 26 percent of the young people surveyed had been homeless at least once within the past 2 years (Health and Human Services, Administration for Children & Families, Children's Bureau).[5] Using our SOC approach, we can address housing needs in a proactive and systematic manner. According to data from NYTD[6] in 2015, housing education and home management training is the most commonly received services by transition age youth in Kentucky. According to this data, 33 percent of Former Foster Care youth in Kentucky had experienced homelessness in the past two years.

Accessing Referrals Outside Louisville

Referrals will be initiated using the Aunt Bertha tool. This is a comprehensive online directory of social service organizations and care coordination processes to facilitate connecting enrollees with appropriate community-based resources to address identified enrollee needs.

The CCT must take into consideration that independent living programs, education, and training voucher programs, as well as the process for securing publicly funded housing, can take considerable time. This is why **starting the transition planning process early** will be important: to assist the Kentucky SKY enrollees in identifying long-term goals and services to meet those goals, and to support them in beginning the application and referral process for any of the selected services. Aetna's care coordinators will work to address housing needs as part of the transition planning process. They will assist the DCBS social worker and Kentucky SKY enrollee in exploring various options, such as transitional group homes,

[5] Children's Bureau: An Office of the Administration for Children and Families, "Child Maltreatment," Resource Library, (2018): accessed June 20, 2019; https://www.acf.hhs.gov/cb/resource/child-maltreatment-2016

[6] Data from the National Youth in Transition Database (NYTD). Young people, age 16 through 26, who received independent living services in FFY 2015 paid for or provided by the state agency that administers the Chafee Foster Care Independence Program.

subsidized supportive housing, shared housing, and independent living programs. Funding for housing may be available from a variety of federal, state, and local initiatives, such as the **U.S. Housing and Urban Development's Section 8 program and Family Unification Program**. The care coordinators can assist the enrollees through the following transition plan tasks related to securing housing:

- Collaborating with the DCBS social worker and the enrollee to completing applications for the above-mentioned housing programs
- Educate the enrollee on Aetna's Getting on T.R.A.C.K. program courses the teach skills about responsibilities related to housing (e.g., providing a security deposit, paying rent on time, keeping the apartment clean)
- With permission from the DCBS social worker, assist the youth in enrolling in the Getting on T.R.A.C.K. program

John H. Chafee Foster Care Independence Program

One of the programs Aetna will coordinate with for housing support is the **John H. Chafee Foster Care Independence Program**. This program is a federally funded program designed to teach youth aged 12 and over, who are in out-of-home care or who were formerly in care, the skills they need to achieve their vision of a good life when they leave care. These services are provided to all eligible youth. The CCT will coordinate with the **Regional Independent Living Coordinators** to help ensure the aging out youth have support surrounding their housing needs and goals.[7] Chafee room and board assistance is contracted through Kentucky Housing Corporation. Eligible participants are able to receive up to six months of housing assistance including rent, utilities, and household start-up costs. To qualify for housing assistance, the youth must have aged out of foster care at or after age 18, but be younger than 20 years, 6 months old, and currently be homeless or will be homeless without assistance.

Transition Age Youth Launching Realized Dreams

In FFY 2015, 89% of Kentucky youth ages 16-26 receiving independent living skills services received some type of educational support.

Our system of care approach includes individuals conducting outreach to the homeless population. This team works with **Transition Age Youth Launching Realized Dreams (TAYLRD)**. This program is a federally funded initiative aimed to positively impact the lives of Kentucky's **16- to 25-year-olds** who have, or are at risk of developing, behavioral health challenges. TAYLRD provides case management, but we work with them for additional resources and housing. This is a day program drop-in center. TAYLRD's five program goals include the following:

- An enhanced infrastructure of sustainable supports and services for transition age youth
- More public awareness of signs and symptoms for serious behavioral health challenges facing young people and the developmentally appropriate responses to those challenges
- Increased outreach and engagement to youth, young adults, and their families by service providing agencies
- Improved access to service for young adults that meet cultural and linguistic needs
- A continuous quality improvement system, which includes data collection that improves the service that Kentucky's young people receive

In addition, as part of the transitional care planning process, the CCT will provide resources to other housing services, such as public and assisted housing options.

[7] Kentucky Cabinet for Health and Family Services, Out of Home Care Branch "Independent Living Programs,": accessed June 20, 2019; https://chfs.ky.gov/agencies/dcbs/dpp/oohc/Pages/independent-living.aspx

Educational Supports

According to data from the NYTD,[8] academic support is one of the most commonly received services by transition age youth in Kentucky. Having ongoing interaction and collaboration with the schools is critically important.

Educational achievement can help prepare youth for life success, with benefits ranging from enhanced skills and self-confidence to increased earnings potential. However, many youths in foster care are not prepared for training or college after high school. While in care, frequent school changes and learning and behavioral difficulties may interfere with educational achievement. By age 21, only 67 percent of former foster youth have received either a high school diploma or GED, as compared to 92 percent of their peers who were not in foster care[9]. After leaving care, youth may be further disadvantaged because they lack knowledge about educational opportunities and how to navigate the individualized education plan (IEP) process (if applicable), skills to navigate the enrollment processes, financing to pay for tuition and housing, or encouragement from the adults in their lives.

> Results from the Mercy Care TAY assessment in Arizona indicated 97% reported being homeless at some point within the previous 90 days. The TAY outcomes survey found improvement in several measures for enrollees in the program, including improved percentage of youth in permanent housing and identification of community supports. Integrated data is one of the keys to Arizona's success in improving outcomes for youth in foster care.

In collaboration with DCBS and DJJ, we will educate our aging out enrollees about options for services and supports available after eligibility terminates. Such options may include post-secondary options. The Kentucky SKY enrollees will be informed on how to access disability services available from educational institutions and employers where appropriate. For youth aging out of foster care and the DJJ system, needed supports may include an educational assessment, IEPs, and possible referral for GED services, which are explored through the transitional care planning process.

Aetna recognizes that college is not for everyone. Other options might include certificate programs, vocational or technical training, or the military. Youth in and transitioning out of foster care may be eligible for financial support through **Educational and Training Vouchers** program through the Chafee program (which can provide support for education and employment preparation for individuals ages 14-26 for up to 5 years).

If the youth decides to pursue post-secondary education, Aetna will help to ensure that the care coordinator educates the youth and the care plan includes the following resources:

- Assistance in completing FAFSA applications
- Grant opportunities
- Kentucky Educational Excellence Scholarship
- Tuition waiver programs
- Tuition assistance programs
- Independent living programs that provide educational support services

[8] Data from the National Youth in Transition Database (NYTD). Young people, age 16 through 26, who received independent living services in FFY 2015 paid for or provided by the state agency that administers the Chafee Foster Care Independence Program.

[9] Denby-Brinson, Gomez, & Reeves, "Care and Connections: Bridging Relational Gaps for Foster Youths," Brooking Report, (2017): accessed June 20, 2019; https://www.brookings.edu/research/care-and-connections-bridging-relational-gaps-for-foster-youths/

As part of the CCT process, care coordinators, in collaboration with DCBS social workers, will assist enrollees by following Aetna's recommended educational planning steps:

- Talk with youth about their educational and career goals, how their goals fit with their talents and interests, possible barriers to achieving their goals, and next steps
- Help youth determine if they are on the path to meet the prerequisites for their educational and career goals (e.g., completion of certain classes, taking specific tests, acquiring necessary skills)
- Help youth organize school records and other important documents, such as transcripts, test scores, IEPs (if any), and special recognition awards
- Offer youth assistance in exploring various educational or vocational options (e.g., talking to school counselors, conducting campus visits, determining which programs or apprenticeships are available in the community)
- Assist youth in identifying financial aid opportunities (e.g., scholarships, grants, student loans, work-study programs) and in applying for financial assistance
- Support youth in preparing for required tests, completing applications, writing essays, and securing recommendations

Arizona Model: Transition Success Story

Albert (not his real name) grew up with most of his family in trouble with the law and his parents in and out of his life. He struggled with substance use, depression, and learning disabilities. Albert entered into services at the age of 17 years old due to being placed with his grandmother through the foster care system. With wraparound services and a plan for transition to adulthood, Albert was able to learn problem-solving and decision-making skills. By getting connected to community supports through formal services and with medication monitoring, Albert was able to gain employment and find stable living as an adult. Albert was able to stay out of future trouble with law enforcement.

Financial Education and Support Services

Many young adults have little experience managing money and have much to learn about developing and sticking to a budget, paying bills and taxes, obtaining credit, and saving for the future. This is a gap that the CCT transition care planning process can help address. With early identification of this need, the team can put in place necessary resources for the youth to build financial management skills and sustainable success.

Workforce Development and Employment Supports

Getting and keeping a job is critical to a young adult's ability to achieve economic security and sustainable progress as they transition into adulthood. A job that fits with personal interests and talents also can contribute to greater life satisfaction. Youth formerly in care have high unemployment rates, and those who are employed often earn low wages.[10] Experience helps; young people in foster care who have worked before their 18th birthday may be more likely to find consistent and higher paying work after they transition out of care.

Aetna recognizes the importance of supporting the youth's preparation into the workforce. As part of the initial assessment process, needs around vocational skills are identified and addressed through the transitional care planning process. Aetna will partner with **Office of Vocational Rehabilitation**, and if applicable, the **Center for Independent Living** for education and employment support to aging out youth with a disability.

Another resource available to the CCT in planning for the aging out youth's transition into adulthood and the workforce is the **Work Ready Kentucky** program, which consists of over 350 programs in health care, advanced manufacturing, construction/trades, IT/business, and logistics. The care coordinator can

[10] Stewart, C. J., Kum, H.-C., Barth, R. P., & Duncan, D. F., "Former foster youth: Employment outcomes up to age 30," Children and Youth Services Review, 36, 220-229, (2014): accessed June 20, 2019; https://psycnet.apa.org/record/2014-00790-029.

help the enrollee to apply for the Work Ready Scholarship. In order to qualify, the youth must meet the following requirements: they are a U.S. citizen and a Kentucky resident, have a high school diploma or GED (or working towards a GED with Accelerating Opportunity Kentucky), have not earned an associate degree or higher, are enrolled in or accepted to an eligible postsecondary institution in an approved program of study, and not in default on any obligation to Kentucky Higher Education Assistance Authority.

Steps that the CCT members can take to support the development of the aging out youth's employment and workforce skills include the following:

- Helping youth identify interests and talents and how they connect to possible job choices through vocational assessments provided by local **community mental health centers**
- Assisting youth in exploring various career paths by encouraging and supporting them in conducting research, attending career fairs, speaking to a career counselor, or arranging a visit to a work site
- Help youth understand and practice important processes for obtaining a job, such as developing a resume, finding job listings, completing applications, and interviewing
- Support youth in gaining firsthand experience through volunteer activities, job shadowing (i.e., following someone at a workplace to watch a typical workday), technical classes that increase skills, internships and apprenticeships, or entry-level jobs
- Identify community partners, such as **Vocational Rehabilitation** providers and **Job Corps**, which can provide guidance and support in a specific interest area

Peer Supports

Through our experience in numerous child and family welfare systems Aetna sees the value in providing peer support to the aging out population. Enlisting the experience of peers fortifies those living through these experiences with the knowledge and insights gained from those with similar experience in child and family welfare, including crisis interventions.

Figure G.12-5: Aetna Hero Workshop
Aetna hosts HERO workshops to give children and youth in foster care the opportunity to connect with peers.

As part of our CCT care planning process, Aetna can enlist young adults who can better support and engage the DCBS and DJJ involved youth transitioning into adulthood. As part of this process, Aetna recognizes the value of families connecting to other families with lived experience of the youth and/or adult systems of care. Aetna will partner with local and state organizations to help to ensure that the aging out enrollees have access to peer support that matches their culture, life experience, stage of life, and specific circumstances. For enrollees with disabilities, the we will connect with **the National Community of Practice on Supporting Families, National Parent-to-Parent USA, Adult Sibling Leadership Network, and Sib Shops** to make sure that the partnership and specific peer support practices follow best practices and are enhancing new or existing structures in the state for this type of support.

Aetna will enhance the array for service for enrollees who are of transition age by creating open access to the **HERO Workshops** (see **Figure G.12-5**). The goal through HERO Workshops, and the process of individual network meetings that follow as part of the process, is to facilitate the development and

sustainability of lifelong unconditional relationships for youth who are in care. This approach intends to support improved outcomes for youth in the areas of social relationships and other domains such as health, mental health, and overall well-being. This is an innovative approach connecting youth with family, kin, and other informal supports that they identify as important to them through participating in the HERO Workshop. The Workshop utilizes a peer navigator model of 'youth helping youth' and a network meeting model subsequent to the Workshop. Some youth participants evolve as youth leaders through the process and then act as peer navigators and supports to other youth who engage the process—assisting them through HERO Workshops while supporting the navigators in their sense of value and worth in who they are and the unlimited capacities they have.

HERO Workshops

Help aging out youth by developing family, kinship/community, friendship-based networks of support that far outweigh the importance of professional, conditional paid relationships and their limitations.

Maintaining Health and Wellness Supports

Youth leaving foster care and DJJ must learn how to maintain good physical and mental health habits, including accessing needed services, and how to secure health insurance. Aetna recognizes the transition from pediatric care to a family practitioner can be a lengthy and complex process. Whether the Kentucky SKY enrollee chooses to stay with Aetna and transition to a primary care within our network, or decides to transfer care elsewhere, the CCT will assist the youth in identifying the most appropriate medical provider (taking into consideration any specialized care needs), in a preferable location. In addition, with support from the DCBS social worker, the care coordinator will assist in transferring of medical records to the new provider.

Enrollees Involved in the Justice System

The care coordinator can assist the aging out youth by discussing critical health and mental health issues and identifying any unmet needs. These needs can be included in the transitional care plan and resources identified to connect the Kentucky SKY enrollee. Some of topics to review through the care planning process include the following:

Almost one-third of children and youth in foster care have one or more disabilities, which can have implications for the medical, mental health, and other care they require.

- How to promote a healthy diet and lifestyle and involve youth in meal preparation and physical exercise
- Exploring positive ways to reduce stress, including yoga, meditation, and exercise
- Identifying positive ways for coping with stress and outlets for dealing with problems
- Educating on risks associated with substance use and abuse and vulnerabilities if biological family members struggled with addiction issues
- Providing information on sexuality and healthy sexual decision-making
- Providing information on the signs and symptoms of mental illnesses and the impact of life experiences and family histories of mental health problems on a young adult's mental health
- Educating on the safe use of medication and healthy alternatives
- Help youth understand when to seek medical attention and how to find affordable health and mental health services through community health centers, student health centers, or other resources

Aetna will leverage existing technology tools to support the health and wellness of the aging out youth as they plan for their transition into adulthood. Aetna is an industry leader in the usage of state-of art technology and innovative programs to aid in the transformation of health care delivery to promote achievement of optimal health outcomes and care experience for our enrollees. Our virtual health care delivery approach incorporates evidence-based practices to enhance our enrollees' health across the continuum of care and focuses on prevention, wellness, early intervention, and comprehensive care.

Access to telehealth services will be explored during the care planning process and accessed if the enrollee identifies it as a preferred method for accessing health care.

Crisis Supports

Aetna understands the unique needs of the aging out enrollees and that these needs, if unmet, may result in a crisis. As part of the transitional care planning process, the CCT will help to ensure the youth has a working knowledge of how to access Aetna's crisis support systems. Aetna utilizes its internal resources and local community partners to help to ensure enrollees and their families have immediate access to telephonic and in-person crisis interventions.

Aetna realizes the need for enrollees to receive rapid and local care during a crisis to improve services to children—a key strategy in serving children and young adults in foster care or former foster care. Crisis situations are a critical and vulnerable time for our enrollees and their families. Responding rapidly in a crisis can have the result of better stabilization for the child and family, which impacts outcomes.[11]

We propose a partnership with community mental health centers (CMHCs) to help to ensure aging out enrollees will be swiftly assessed for the most appropriate care in the most appropriate setting. Ultimately, we seek to avoid inappropriate and unnecessary emergency care and hospital admissions, which can increase trauma for these enrollees. The goal of this program is to support individuals in remaining safe in their community. Mobile Crisis Response teams are an untapped resource that could greatly assist the aging out population and their families. The Mobile Crisis team will be dispatched 24/7/365. All crisis calls are followed up by the assigned care coordinator to help ensure continuity of care is provided and any follow-up treatment is completed.

Aetna will incentivize the 13 CMHCs (please refer to **Figure G.12-6**) in the state to provide mobile crisis unit services for all enrollees, including the aging out population. The goal of this program is to support individuals in remaining safe in their community. The Crisis Mobile team will:

- Conduct risk assessments, provide crisis interventions, and connect the individual to ongoing behavioral health services or other community resources/supports
- Provide crisis services of triage, assessment, and immediate stabilization of acute symptoms of mental illness, substance use, and emotional distress
- Make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual's needs
- When clinically indicated, assist and transport the individual to a more appropriate facility for further care
- Provide two-person mobile teams with at least behavioral health technician-level crisis workers
- Engage peer and family support services as preferred and identified by the enrollee and DCBS social worker

[11] https://www.casey.org/strategies-improve-placement-stability/

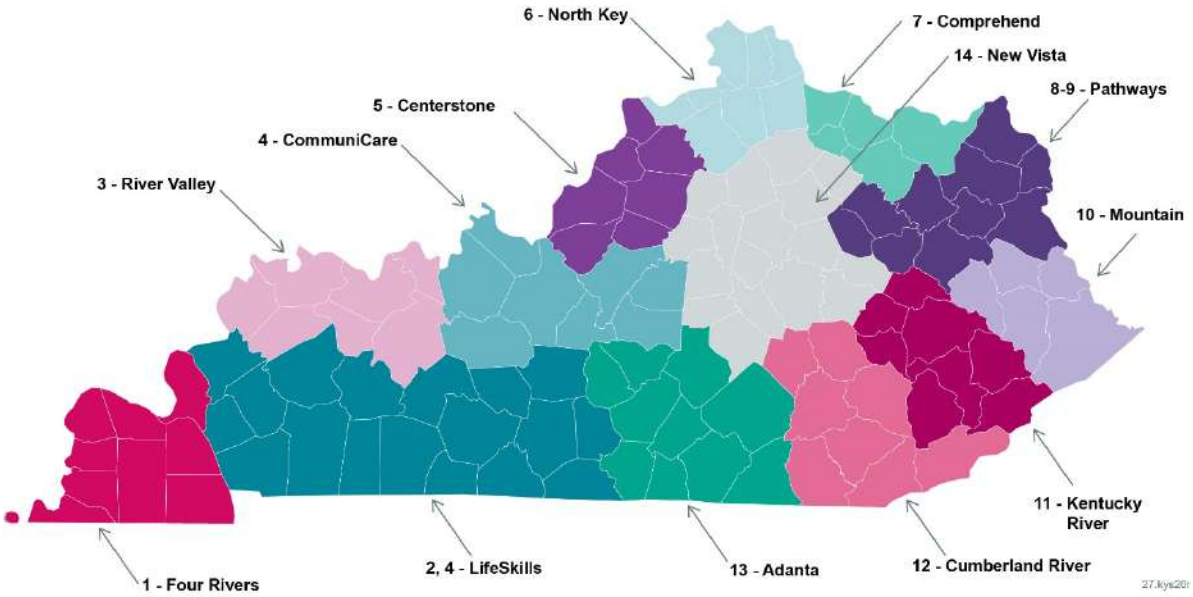

Figure G.12-6: CMHCs Across Kentucky

Aetna's incentivized network of CMHCs providing mobile crisis care.

Following a mobile crisis intervention, we will work with CMHCs to conduct intensive outpatient care with the family (foster) and child with the following goals—post-mobile crisis event:

- Assist the individual to utilize community and family/support systems with the intent of preventing the reoccurrence of similar events in the future
- Assess the immediate crisis and facilitating resolution and de-escalation
- Engage the individual to identify follow-up services and assisting the individual to access these services that are necessary to manage and/or prevent further BH crisis experiences

Aetna will also partner with various facilities throughout the state to provide quality care to our aging out population who are experiencing a crisis. An example of this partnership is TAYLRD, which has multiple locations, or 'drop-in centers' throughout the Commonwealth. TAYLRD is a federally funded initiative aimed to positively impact the lives of Kentuckians, 16-25 years old who have, or are at risk of developing behavioral health challenges. The drop-in centers are staffed by Youth Peer Support Specialists and Youth Coordinators who are in the transition age group themselves and have had some form of system involvement in their past. There are various services provided at the drop-in centers such as: case management, court support, life skills, and vocational services. Aetna has worked with TAYLRD by providing hygiene items (e.g., shampoo, body wash, toothbrushes, and toothpaste). Having hygiene items available is a way to get individuals to come into a drop-in center and increase the opportunity for engagement. With this enhanced collaboration, the mobile crisis response may include the following:

- Initial assessment and ongoing assessment of behavioral health symptoms and crisis-related needs
- Involvement of identified family and friends to resolve the individual's crisis
- Therapeutic communication and interaction to alleviate psychiatric or substance use symptoms
- Development of a safety plan or crisis prevention plan
- Psychiatric consultation and urgent psychopharmacology intervention
- Referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care, including crisis respite
- Linkage to stabilization and/or substance use disorder 24/7/365 access centers/behavioral health urgent care
- Secure access to higher levels of care if required
- Peer support services:

- Engagement
- Assistance with developing crisis diversion plans or relapse prevention plans
- Assistance with the identification of natural supports and access to community services during and after a crisis

Technology Supports

Aetna recognizes the growing use of technology in engaging the aging out youth population. Access to websites, resources, and applications will assist the us in effectively and efficiently communicating with the aging out population. The following apps will be introduced as tools during the transitional care planning process. If the youth chooses to utilize these applications, the care coordinator will help to ensure they have training and education on how to safely access and use them. Enrollees will also have access to internal resources through **Aetna's Connections for Life program**, which include the following:

- **Aetna Connections for Life:** Foster children, especially those in high-poverty areas, often lack the digital and cellular technology necessary to establish and maintain vital social connections, participate in school, find a job, and access resources. Aetna Connections for Life aims to bridge the digital and cellular disparity faced by these vulnerable enrollees and empowers them to stay connected and engaged with their world. Eligible enrollees can receive a no-cost smartphone and wireless plan, laptop, education and training around technology literacy, and help connecting to key local and national resources.
- **Smartphones and wireless plan:** Foster youth often cannot afford a steady wireless plan, which results in significant isolation from their support circle, and puts them at risk of not being able to contact emergency services when needed[12]. In addition to the isolation, unpaid wireless bills lead to negative credit report results that prevent many of them from qualifying for loans, apartment rental, and more. To address this, we will provide eligible foster care enrollees (ages 13-17) who are not in a stable placement home a no-cost smartphone and wireless plan. This value-added service will help to reduce the isolation barriers they face and will help maintain the lines of communication with their support network including their caseworkers, therapists, mentors, and friends.
- **Laptops:** The lack of access to technology in today's world is a significant social barrier that cuts those impacted off from opportunities in school and in the workforce. Those in foster care are disproportionately impacted by this inequity and often lack the resources and knowledge to make a change. To help bridge this digital divide, Aetna will provide a laptop to foster care enrollees (ages 18+) who are aging out to equip them with one of the key tools necessary for independent living in the modern world.

Kentucky RISE Web-based Portal

The Kentucky Cabinet for Health and Family Services has set up a new website for transition age youth in the foster care system. This web-based portal (www.kyrise.ky.gov) **Kentucky RISE**[13] (Resources for Independence, Success, and Empowerment) will contain the following links:

- Access to complete application
- Request and receive vital records
- Information about the Cabinet for Health and Family Services summer employment initiative

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[12] The Chronicle of Social Change, "Why Calif.'s Lifeline Wireless is a Big Deal for Foster Youth," (2014): https://chronicleofsocialchange.org/analysis/why-calif-s-lifeline-wireless-is-a-big-deal-for-foster-youth/4949; assessed June 2019

[13] The Associated Press, (2109): accessed June 20, 2019; https://www.wkyt.com/content/news/Kentucky-designs-new-web-portal-for-foster-care-kids-511174351.html

Web-based Applications

Aetna anticipates supporting Kentucky's foster and juvenile justice-involved youth improve their lives and transition out of the systems, it will be important to research mental and physical health online applications that are showing promising outcomes for engagement and re-engagement in treatment.[1] Young people have online lives, and that fact raises concerns about internet addiction; at the same time it poses a challenge for Aetna to explore the positive benefits of using the number one access point for teens in support of full engagement in treatment.[14]

> Aetna has developed communication tools, including outward and inward-facing online health portal applications, so parents and caregivers can have access to a child's health information—especially helpful when children in foster care move frequently.

Headspace
Meditation has been shown to help people stress less, focus more, and even sleep better. The Headspace app makes meditation simple. The app teaches the life-changing skills of meditation and mindfulness in just a few minutes a day. We will make this app available to our enrollees who are in a life transition.

What's Up?
What's Up? is a free app utilizing some of the best cognitive behavioral therapy and acceptance commitment therapy methods to help people cope with depression, anxiety, anger, and stress.

Breathe2Relax
A simple, intuitive, and attractive mobile app designed by the National Center for Telehealth and Technology to teach breathing techniques to manage stress. The skills taught may be applied to those with anxiety disorders, stress, and PTSD. This app can be personalized to a pace that the user finds relaxing; it includes a video demo, reading materials, and charts to map personal progress. This app is also helpful for self-starters or those working with a therapist to include breathing techniques in their overall treatment.

Foster Care Hackathon
Aetna believes that foster youth are an untapped source of talent, yet too many of them never realize their potential because the system is failing them. We have identified the need to leverage direct feedback from our foster care youth and engage them in a meaningful way to developing solutions for their care. To further support these youth and look at innovative ways to engage with the foster care community, Aetna will host a Foster Care Hackathon event that brings together technology companies, government agencies, non-profits, and foster youth advocates to focus on technology support needed for foster youth. The two-day event will be focused on developing and/or enhancing innovative tech solutions like smartphone apps, social networking tools, and engaging digital resources. At the same time, youth will take the lead and identify best practices and ways to remove barriers to care for this population.

These are just a few of the applications that are proving to be good augmentations for adolescent treatment plans. Aetna will approach the research and choices for the best applications to include in the care plans through the training collaborative planning process. The training collaborative, led by the Kentucky SKY training director, will have this task among others on its agenda for the design and implementation phase after first convening. The young people enrolled in Kentucky SKY will have tools available to them that will increase engagement and support their self-sufficiency with symptom reduction, attendance at appointments, and adherence to medication routines as needed.

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[14] Chandrashekar, Pooja , "Do mental health mobile apps work: evidence and recommendations for designing high-efficacy mental health mobile apps," mHealth, 4(6) (2018): accessed June 20, 2019; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5897664

Determining and Identifying Array of Services

Delivery system capability is a result of how available resources are organized and managed. Service gaps are common, including both the absence of specific services and practitioners, and inadequate service capacity. Overcoming these challenges requires innovative strategies, particularly in rural and frontier regions as well as impoverished urban locations. Fragmentation of health care and human services resources is pervasive. When required resources are not available and/or not working well together, aging out youth will not obtain the care they need, compromising their health and well-being. **Table G.12-2** shows examples of Aetna's current community resources, which can be leveraged to fill identified gaps in services for the transition age youth.

Table G.12-2: Examples of Types of Communities Supports

Type of Support	Community Supports		
Supports and Services	• Assistive Technology	• Centers for Independent Living	• Community Mental Health Centers
General Adult Services	• Hart-Supported Living • Home and Community Based Waiver • Kentucky Partnership for Families and Children • Hope's Closet	• Personal Care Attendant Program • Social Security Disability Insurance • Special Services and Equipment Fund	• Supplemental Security Income • Supports for Community Living • Therapeutic Rehabilitation
Education	• Community-based Work Transition Program • Kentucky Department of Education	• Kentucky Special Education Cooperative Network	• Programs covered in other sections
Health Care	• Commission for Children with Special Health Care Needs	• Underwood and Lee Dental Clinic	
Living Arrangements	• Community Housing for Persons Diagnosed with Serious Mental Health Issues	• Housing resource guides • Intermediate care facilities for individuals with developmental and intellectual disabilities	• Nursing facilities • Personal care homes • Family care homes
Legal Issues	• Court-appointed special advocates	• Guardianship (and alternatives)	• Mental health advance directives
Employment	• Employment Options • Job Corps	• Sheltered workshops	• Vocational Rehabilitation
Disability Resources	• University Centers of Excellence	• Protection and advocacy organizations	• Developmental Disabilities Council
Self-advocacy	• Peer supports groups		

Determining Needed Providers of these Services

As previously discussed, there is an array of potential needs for the aging out youth involved in the DCBS and DJJ systems. Some of these needs can be met through services provided via their health plan, yet some fall under non-covered services, where outreach and connection with community-based organizations will be critical.

We are committed to enhancing the existing network for providers to include a specialized group of clinicians, trained in trauma-informed care. This specialized network of providers will be established using a value-based approach and will be available to meet the unique needs of the aging out population, including meeting the required timeframe for assessments and screenings.

In addition, Aetna has established partnerships throughout the state that will help meet the unique needs for the aging out population. Aetna Kentucky SKY teams will leverage these existing partnerships to identify and engage needed providers to serve our aging out population. In keeping with the state requirements in **Section 41.6.5 of the Draft Medicaid Managed Care Model Contract and Appendices**, the key partnerships include the following:

- Interstate Compact on Adoption and Medical Assistance
- Interstate Compact on the Placement of Children
- Peer Advocacy/Parent Association (Foster Parent Advisory)
- Kentucky Housing Corporation
- Administrative Office of the Courts
- Department of Community Based Services
- Kentucky Department of Education
- Kentucky Workforce Innovation Board
- Office of Vocational Rehabilitation
- Department for Behavioral Health, Developmental and Intellectual Disabilities
- Department of Public Health
- Kentucky Partnership for Families and Children

Often, enrollees will encounter tremendous challenges in finding appropriate services and providers to meet their unique needs. Partnerships with organizations and placements for difficult-to-place youth assist us to make certain that our aging out population is in the most appropriate setting to maximize their likelihood of a successful transition into adulthood.

Engaging with supportive community agencies to leverage their tools is a key component of our strategy to create a sustainable circle of support around our enrollees. This support is important to establish services reinforcing resiliency and averting loneliness in youth within the family and child welfare system but is particularly crucial as youth age out to the community. Without community supports, this transition is challenging. Aetna works to negate those challenges with our community partners.

As youth age out of foster care with the sustained support of the CCT care planning process, they will be provided with additional community-based resources to meet their needs as they transition into adulthood. Some of the community partnerships that Aetna has created and may be accessed to fill gaps in the identified needs of the aging out population include the following:

- **Family Scholar House** has a project goal to equip families and youth to excel in education and obtain independence. The facility accommodates low-income families, single-parent families, and young adults formerly in foster care.
- **All God's Children** is a residential facility in Nicholasville that cares for pregnant teens and their infants. Aetna has donated to this facility on numerous occasions and even assisted with their 'Mom Prom,' which is a social event for the residents. We not only provided financial support, but we also provided support of staff time. Aetna staff coordinated the event, pulling together all the resources necessary to make the event successful.

- **Hope's Closet** is a non-profit that provides free clothing and other necessities for foster care and adopted young adults. Aetna has given donations of items identified by Hope's Closet as a need, including backpacks and school supplies. In addition, we volunteered with Hope's Closet during their recent remodel (please refer to **Figure G.12-7**).

Figure G.12-7: Hope's Closet
Hope's Closet provides free clothing and other necessities for foster care and adopted young adults.

In addition, Aetna is committed to engaging and outreaching to the Former Foster Care population. These engagement activities include the following:

- Youth focus groups to assist and support the development of the system of care
- Day-long HERO Workshops for youth and their circle of support, with meaningful incentives for participation
- Peer-to-peer roundtables
- Aetna Kentucky SKY Former Foster Care advocacy groups

Aetna understands that the journey to adulthood for a youth exiting foster or DJJ care can be both exciting and frightening. Aetna will help youth be better prepared to take advantage of available opportunities and resources and overcome likely challenges as a young adult. We will accomplish this by starting work with the youth early and providing ample opportunities for youth to design their own path. By working together with the youth, the youth's DCBS social worker/DJJ worker, and other caring individuals in the youth's circle of support, we can help build a strong foundation for a successful transition to adult life outside of foster care and juvenile justice.

60.7.G.13 Use Cases for Kentucky SKY

Kentucky | Transforming Health Care | **Aetna**

60.7.G.13 Use Cases for Kentucky SKY: USE CASE 1

As an experienced Medicaid managed care organization in the state of Kentucky, we understand the unique challenges and barriers providers, including emergency departments (ED), face in serving the complex needs of youth in the child welfare system. Aetna has undertaken a system-wide transformation to address the impact of physical, emotional, and social trauma and we extend this end-to-end process to implement a trauma-transformed system of care in the Eastern Mountain Service Region. In doing so, the system of care paradigm moves the service paradigm from "what's wrong with you," to "what happened to you," and supports Commonwealth goals to improve the delivery of health and family services through a whole-person approach driven by quality benchmarks and care outcomes.

Aetna's Approach to Assess Providers' Knowledge of Trauma-informed Care

Aetna ensures the delivery of trauma-informed care (TIC) in the eastern region and across the state of Kentucky through our trauma-transformation initiative. All Kentucky SKY providers learn compassionate assessment techniques that include respect for each individual family's culture and beliefs, and result in mutually understood collaboration and care planning. Aetna's approach includes engaging providers in discussions about the impact of trauma on health, assessing the provider organization to determine their level of trauma-informed acumen, and collaboratively developing a plan of action. **Figure G.13-1 Aetna's Steps for TIC Transformation** depicts how Aetna supports provider progression along the TIC continuum.

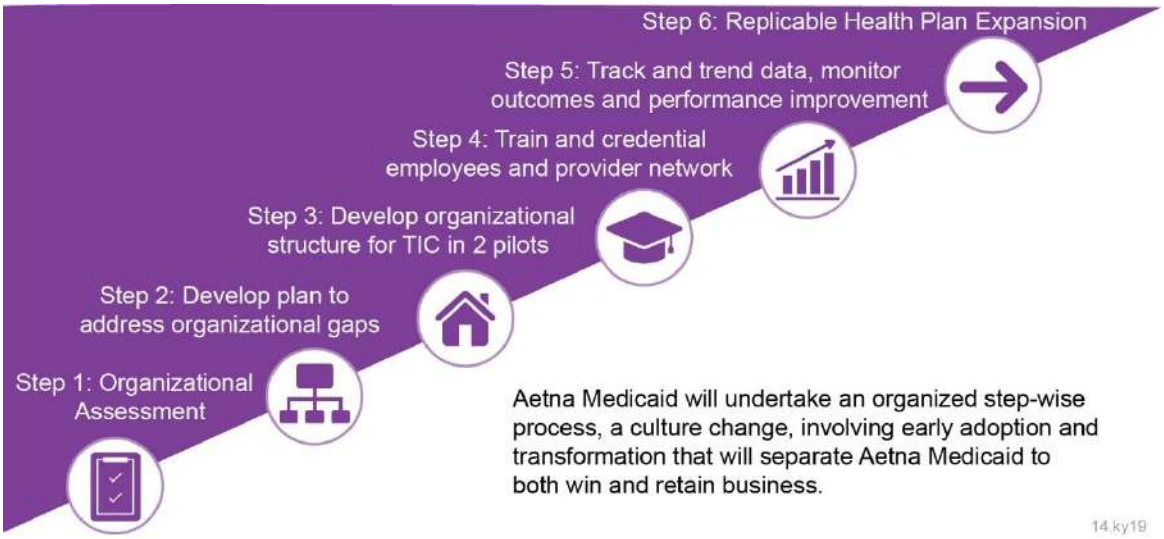

Figure G.13-1: Aetna's Steps for TIC Transformation

Aetna is committed to transforming our provider network toward a culture that offers our Kentucky SKY enrollees trauma-informed practice standards in health care.

To accomplish this, we partnered with the **National Council on Behavioral Health (NCBH)** to develop our approach based on realization that trauma is common, recognition on trauma's impact to seeking care, responsiveness implementing TIC best practices, and prevention for causing additional trauma. Nationally, **Aetna is the only managed care organization collaborating with a highly recognized partner who has proven success** helping over 400 national organizations become trauma informed. Together in early 2019, we conducted an Organizational Self-Assessment (OSA) survey in our national Medicaid department to determine our internal level of trauma informed acumen. Analysis of survey results allowed us to identify gaps and opportunities and create action plans on how to implement trauma-informed practices at our local health plan level. We have targeted two Aetna health plans—Louisiana and West Virginia—to launch our learning collaborative initiative. Kickoff includes onsite, in-person foundational training for all health plan staff conducted by the NCBH. TIC foundational training curriculum includes defining trauma, trauma prevalence,

impacts of trauma, building resiliency, introducing TIC, importance of TIC for Medicaid populations, and the four assumptions and six principles of TIC. Our core implementation team will provide an overview of strategy and tactics for each region. **Aetna has invited key Kentucky providers to participate in our West Virginia learning collaborative based on the unique needs of the Kentucky SKY population and population health reports on gaps in care.** Our goal is to engage Kentucky providers in discussions on their organizational TIC culture and acumen using targeted training curriculums based on provider needs, explaining our TIC credentialing process, and measuring TIC acumen using leading and lagging indicators and outcomes. Lessons learned will be brought to future Kentucky TIC initiatives.

Approach to Delivering Targeted Provider Education

Aetna will have a **dedicated Kentucky SKY training director** who oversees regional and statewide training efforts. Our regional and statewide approach to providing targeted education includes mandating all required trainings identified in the Request for Proposal (RFP) scope of work for Kentucky SKY providers, targeted training for the Eastern Mountain Service Region, and engaging key providers for inclusion in the learning collaborative. The Kentucky SKY training director, Aetna System of Care (SOC) administrators, provider services liaison, and provider services representatives will offer in-person and webinar-based training opportunities on RFP required topics and based on Kentucky SKY provider needs. Aetna offers additional technology-based training via Aetna's website and provider portal. In addition to mandatory training, Aetna currently provides Adverse Childhood Experiences (ACEs) and trauma-related training to the Eastern Mountain Service Region providers, law enforcement, and judicial system at minimum once every three months. In the spring of 2020, Aetna will begin inviting providers to attend a one-day Trauma Informed Care training being provided by the National Council. This will first be available to providers in Eastern Kentucky in February 2020, followed by training in Louisville scheduled for April 2020. Training includes completion of an OSA for each provider or ED, assuring an understanding of each organization's unique needs, and action plan development for enhancing TIC culture and practices. We have identified key providers based on Eastern Mountain regional needs and population health gaps in care reports for participation in the West Virginia learning collaborative. Training includes completion of an OSA for each provider or ED, assuring an understanding of each organization's unique needs, and action plan development for enhancing TIC culture and practices. Aetna-contracted pproviders will receive training on screeners (e.g. screeners that allow recognition of trauma responses and support referral to Aetna's specialty providers who use evidenced-based practices such as Trauma-Focused Cognitive Behavioral Therapy and Eye Movement Desensitization Reprocessing). This includes training for ED staff with focus on sensitivity to how examinations can re-traumatize individuals receiving care.

We will offer training on navigating Aetna's Kentucky SKY managed care system and provider assessments used to the Department, Department for Community Based Services (DCBS), Department of Juvenile Justice (DJJ), Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Cabinet Sister Agency Personnel, law enforcement, judicial agencies, and stakeholders on topics required in the RFP scope of work. The Kentucky SKY training director, Aetna SOC administrators, provider services liaison, and provider services representatives will conduct onsite and webinar-based trainings at times and locations designated by the Department.

Aetna's Approach to Collaborating with DCBS Staff

Aetna will build on the existing Kentucky DCBS infrastructure with additional resources for community engagement and problem-solving that support family preservation and early intervention. This includes the following governance structure with dedicated positions that support shared accountability for outcomes:

- **Trauma system of care administrator** responsible for collaboration with foster children and families to identify and remove barriers that affect service delivery, participation in integrated case rounds with Care Coordination teams, and leads the trauma transformation in the provider network
- **Children's system of care administrator** responsible for building relationships with DCBS and DCBS regional staff, promoting early intervention and community engagement, building community-based resources and supports, and participating in foster parent recruiting activities
- **Juvenile justice liaison** responsible for collaboration with DCBS, DJJ, and all Commonwealth agencies involved in juvenile justice, aligns the Reclaiming Futures framework with service delivery, assures effective relationships and training on Aetna's service delivery and practices, develops workflows and rapid enrollment for foster care children transitioning out of detention, and facilitates the implementation of additional innovative, quality-driven programs such as Start Strong to the foster care children's system
- **ED/crisis administrator** responsible for developing early intervention, responsive crisis system, collaboration with medical management to mitigate gaps in crisis service delivery including ED holds and reduction of out-of-state placements, collaboration on difficult-to-place enrollees, build collaborative relationships with law enforcement, emergency medical services, and ED, and oversees the 24/7/365 Kentucky SKY crisis line
- **Recovery and resiliency administrator** responsible for building peer and family support programs in collaboration with DCBS, foster families, and community advocates, facilitating the Enrollee Advisory Committee assuring youth and foster family voice and choice, and assuring resiliency and recovery concepts are embedded in the system of care
- **Adult system of care administrator:** responsible for assuring service needs for foster care youth transitioning to adulthood, ages 18 to 26, and collaborates to develop a shared, electronic health record that supports data-sharing amongst Aetna, families, contracted providers, DCBS, DJJ, and ED.

a. Promoting Evidence-based Practices and TIC for Kentucky SKY Membership

Aetna promotes the following evidence-based practices (EBPs) and TIC for Kentucky SKY enrollees:

- **Immediate enrollment in care coordination:** Aetna approaches all children in foster care as children with special healthcare needs and immediately enrolls foster care children into our Care Coordination program. Foster care children are further stratified into Intensive Care Coordination or Complex Care Coordination based on physical, behavioral, social, and emotional needs.
- **Mental Health First Aid (MHFA):** Aetna has trained approximately **35 certified MHFA instructors** and more than **2,000 staff members** nationally and multiple Kentucky first responders, providers, specialists and faith-based agencies. We have a Kentucky MHFA community training program and will expand to Eastern Mountain Service Region using a train-the-trainer approach where applicable.
- **Crisis Intervention team (CIT) for law enforcement:** Aetna will build on existing Kentucky CIT initiatives and collaborate with local law enforcement agencies for expansion of this community partnership program that supports individuals with behavioral health issues and provides a foundation necessary for rapid enrollment into the health care system.

b. Unique Needs of Children and Youth in the Kentucky SKY Foster Care Population

Health starts where youth live, learn, and play. Exposure to traumatic events is common, as evidenced by the statistic that one-in-four children have experienced abuse or neglect[1], with Kentucky ranking as

[1] Center for Disease Control and Prevention "Adverse Childhood Experiences," accessed June 25, 2019; http://www.cdc.gov/violenceprevention/acestudy.

second highest in the U.S.[2] Children in foster care face significantly more health and social challenges. A study by Child Trends found that almost 60 percent of children ages two months to two years in foster care were at a high risk for a developmental delay or neurological impairment[3]. Nearly half of children in foster care, another study reports, had four or more "adverse experiences"— potentially traumatic events associated with multiple poor outcomes— as children and adults[4]. The Adverse Childhood Experiences (ACEs) study has confirmed that exposure to severe stress and trauma such as abuse, neglect, discrimination, and violence can increase an individual's risk for serious, lifelong physical and behavioral health issues, poor health outcomes, reduced quality of life, and increased cost of care.[5] ACEs often have the following consequences:

- Individuals exposed to violence are more likely to have severe diabetes, heart disease, mental illness and asthma
- Exposure to traumatic events as a child can result in poor performance at school, inability to maintain employment, and inability to sustain social relationships

c. Access to and Sharing of Medical Records

Aetna will implement **FamilyConnect**, **a shared, single electronic health record that serves as the single source of truth for youth and their circles of supports** in collaboration with DCBS, DJJ, providers, and ED providers. We have the technological capability to integrate multiple data-sharing systems including the Kentucky Health Information Exchange (KHIE), The Worker Information System (TWIST), admission, discharge, and treatment (ADT) data, and clinical platforms utilized by care coordinators, providers, and ED into one, single platform accessed by all stakeholders involved in a foster child's care—allowing **near, real-time information sharing 24/7/365**. This solution provides actionable data and event notifications with easy-to-follow workflows for collaborative, team-oriented care, reducing duplicative testing and services. The care plan is stored and shared as often as needed with all members of the Care Coordination team who can easily access using our **web-based portal or mobile application**. Providers can perform many functions within this web-based platform such as eligibility searches, claims status, remittance advice, identifying gaps in care, and prior authorization lookup and submission.

d. Provider Contracting

Aetna will include mandatory training for all requirements outlined in the Kentucky SKY RFP scope of work for contracted providers including participation in KHIE, and will add the following:

- Participation in Aetna's designed training on TIC
- For specialty providers serving foster care youth (e.g. community mental health centers (CMHCs), participation in Aetna's intensive, boot camp training designed for clinicians using evidence-based practices that support foster care children and families

Because access to trauma informed providers is paramount, we have incentivized three specialty providers to adopt trauma-informed practice standards using value-based payment (VBP) arrangements that support quality driven outcomes. We have letters of agreement for **KVC Health Systems, Children's Alliance Independent Provider Association , and The Kidz Club** as follows:

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[2] American Academy of Pediatrics, "Child Abuse and Neglect,", accessed June 25, 2019; https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Child-Abuse-and-Neglect/Pages/Child-Abuse-and-Neglect.aspx.

[3] Child Trends Data Bank, "Foster Care indicators on Children and Youth," (2015): accessed June 25, 2019. https://www.childtrends.org/wp-content/uploads/2014/07/12_Foster_Care.pdf.

[4] Adverse Family Experiences Among Children in Non-parental Care, Lifting the Veil, (2014): accessed June 25, 2019. http://blog.liftingtheveil.org/2014/05/17/new-study-adverse-family-experiences-among-children-in-nonparental-care.

[5] Center for Disease Control and Prevention, "Adverse Childhood Experiences," accessed June 25, 2019; http://www.cdc.gov/violenceprevention/acestudy.

- **KVC:** intensive wraparound services that mitigate children entering inpatient and residential levels of care through provision of in-home services and support uniquely designed for foster families and children; services are evidence-based, family-centered and build on the strengths of families' circle of support and local community
- **Children's Alliance:** established a separate limited liability company in collaboration with Aetna that increases access and improves quality for services delivered to foster care children and families; going forward, Children's Alliance will coordinate efforts to create specific VBP arrangements with CMHC depending on region, needs, and gaps in care
- **Kidz Club:** specialized program designed uniquely for children designated as medically complex that includes an Aetna nurse care coordinator co-located at the Kidz Club location who collaborates with all facilities and providers on care; program includes claims analysis and data sharing resulting in reports that outline effective care and cost; incentives were mutually agreed upon and include achievement of reduction in ED and inpatient visits

Aetna will implement contracted **telehealth options via Project ECHO®** in rural and underserved regions offering existing providers access to specialty services e.g. trauma-informed behavioral health or psychiatric e-consultation for primary care providers (PCP). We have met with leadership at **Stamina**, a youth advocacy and mentoring agency, exploring joining Aetna's network as a peer support provider.

e. Provider Education and Ongoing Support

Provider education and support is an ongoing, continuous, quality-driven process based on regional and local provider needs and gaps in care. For example, Aetna population health department runs ED and inpatient utilization reports allowing opportunity to identify regional strategies to address gaps in care. Examples of strategies we have implemented in Kentucky include embedding care coordinators in inpatient facilities to assist with discharge planning. Focus includes strengthening Kentucky's existing child welfare system and creating shared accountability to move the foster care early intervention and prevention continuum forward through our trauma-transformation approach. Our TIC training successfully integrates all personalized health domains in one model, which is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). Specifically, we include how TIC, social determinants of health, cultural competency, health equity, and systems of care approached work together. Our model prioritizes the foster child's experience and mirrors the accepted SAMHSA approach for behavioral health/physical health integration. As an example, we have completed training the staff of **Pikeville Medical, a level II trauma center in eastern Kentucky**. This approach addressed barriers to care and recognizes and rewards individual practitioners as well as provider organizations.

When we are engaged and involved in our care, we thrive. Aetna supports engagement and health literacy by assuring we improve each foster child's engagement in and knowledge of health and wellness. We assess for capabilities and build on strengths in our whole-person, care management approach for each individual foster child, guiding providers on a trauma-informed continuum of care. One of our local staff in Kentucky developed a life skills training program—**Getting on T.R.A.C.K. (Transition Ready Assistance & Core Knowledge)**—implemented in June 2019 to educate community stakeholders, providers, and advocacy organization about what foster children need to know as they transition to adulthood such as identifying trauma and its impact on health and decision making. Our local program includes understanding Medicaid vs. commercial insurance, managing a budget, and planning career choices. Current efforts, to be implemented in the third quarter of 2020, include beginning a train-the-trainer series with the **Bounce Coalition program** that supports building children's resilience to toxic stressors and collaboration to educate schools on use trauma screenings.

f. Performance Monitoring

Aetna monitors performance through TIC credentialing, provider designation in our online portal, auditing, VBP arrangements, and population health reports. A key component of TIC success includes

establishing system identification of trauma informed providers and clinicians. Because there is currently no TIC certification program available, we are **working with NCBH to establish a credentialing standard**. We've developed TIC performance measures, added a designation for TIC certified providers within our provider portal and electronic care coordination platform, for quick identification, and are collaboratively developing an audit tool with NCBH to measure provider fidelity—supporting key State goals for improving the quality of Kentucky's health delivery system. Our foster care VBP providers have agreed to quality outcomes that support wellness, permanency, and family reunification. Aetna's population health department offers reports such as ED utilization used to identify provider network strategies for building capacity. For example, frequent ED utilization can indicate the lack of TIC behavioral health providers in certain regions. Findings are communicated internally and collaboratively with stakeholders to address the gaps in care. Solutions such as adding behavioral health counselors via telehealth to a PCP's office can then be initiated.

g. Cultural Competency

Aetna supports and develops provider capacity to effectively provide trauma-informed assessment and intervention that acknowledges and integrates each child and family's cultural values and beliefs. Each child and family uniquely experiences and responds to trauma through cultural variations in their families and communities. Our trauma-transformation initiative allows providers to recognize variations and help restore a sense of safety through trust building. Aetna contracted providers learn to attend to a child and family's distress in a way the family defines it, working within the family structure to adopt coping skills and promote social and emotional support. By providing assessment and intervention with a trauma-informed lens, Aetna providers offer the trusting relationship necessary to lessen the negative impact of traumatic experiences, and move children and families toward healing, recovery and wellness.

h. Community Engagement

Our experience serving Kentucky youth in foster care is informed by our relationships with local community advocates, and their voice has helped us understand. Through community engagement we learn of challenges within the care delivery system and proactively work to address obstacles to care. Our **SOC administrators** will be engaged in all regional communities, listening, collaborating, and identifying resources that support the well-being of foster children and their families. This includes participation in the Eastern Mountain Service Region as a member of two citizen foster care review boards. Aetna's staff have demonstrated their deep level of caring and involvement in Kentucky's communities. **Building Solid Stones**, a community-based program by two Aetna staff, is a six-week program for students to help at-risk youth change the course of their lives through empowerment and successful thinking. The program provides understanding of trauma and practice of fundamental core values such as empathy, self-control, teamwork, moral reasoning and social responsibility. Building Solid Stones also hosted a **community Standing Against Violence Education (SAVE) Day.** Attended by youth, parents, and community and city officials, the event provided education by qualified professionals on various types of violence, how to prevent conflict without resorting to violence, and a Louisville Metro Police escorted Peace Walk around Western Middle School. Aetna continues to sponsor community engagement events and is a presenting **sponsor for an annual fundraiser to Hope Hill in Mt. Sterling in the Eastern Mountain Service Region.**

Outcomes

Aetna's transformative vision drives our model for increasing community engagement and building provider capacity that supports integrated, trauma-informed care for children/youth in foster care, adoption assistance, and juvenile justice populations. We mandate all Eastern Mountain contracted providers to participate in training and to demonstrate ongoing advancement in trauma transformation. We expect targeted providers to use evidence-based, trauma-informed practices that support health and wellness outcomes for foster care youth, and shared accountability across the larger system of care, resulting in comprehensive service delivery that empowers each child and family to fully engage in their health and wellness.

60.7.G.13 Use Cases for Kentucky SKY: USE CASE 2

Our care coordinators listen, understand, and intervene early and collaboratively to address each foster child's needs - assuring **Kimberly has a safe and nurturing home and community and opportunities for recovery and resiliency**. We do this by assuring the support necessary to thrive and experience personal well-being through integrated care coordination, grounded in comprehensive, whole-person, evidence-based practices for children with special health care needs, and innovative, local programs that address the unique needs of Kimberly and her family.

Kimberly's Needs and Capabilities

Childhood abuse or trauma increases the risk of suicide, and adolescents in foster care are four times more likely than their peers to attempt suicide.[6] Kimberly's suicidality, overdose attempt, and admission to the emergency department (ED) indicate an immediate need for crisis stabilization, comprehensive, integrated interventions, and safety planning. Kimberly has experienced multiple adverse experiences in her young life including removal from her mother's home and siblings, multiple placements in foster care, and difficulty adjusting to her current school environment. She has observed violence and drug use but has shown great resiliency and strength taking on responsibility for her siblings and finding resources to meet her siblings' basic needs.

Collaborative Solution

Aetna, as a **trauma-informed organization,** understands her experiences and supports Kimberly, her foster family, and her mother not only in recovery but in creating a meaningful, hopeful life driven by Kimberly's goals and beliefs. Aetna uses **evidence-based clinical practices and Charting the LifeCourse ™ framework**[7]—a best-in-class, person-centered approach based on the core belief that **all people have a right to live, love, work, play and pursue their life aspirations in their community**—to guide assessment and multidisciplinary care planning. **Table G.13-1** provides an outline of the interventions Aetna's care coordinator facilitates to support Kimberly and her family.

Table G.13-1: Summary of Aetna Care Management Interventions for Kimberly

Needs	Interventions
Whole Health Needs	• Rapid enrollment in intensive care management, entry for immediate crisis assessment • 24/7/365 Behavioral Health Crisis Services hotline and safety planning • Transitional care to community mental health center (CMHC) crisis stabilization unit (CSU) • Inclusion of Aetna's clinical pharmacy advisor on Kimberly's Care Coordination team • Referral for KVC Therapeutic Foster Care (TFC) Support Home • Referral for trauma-informed, physical and behavioral health (BH) services, telehealth, and peer support • Life skills training, HIV/STD education, and transition planning
Education	• Coordination with school and development of an Individualized Education Program (IEP)
Social Determinants of Health	• Aetna Better Access Enhanced Transportation for Kimberly • Assessment of housing and violence-free living for Kimberly's mother
Family	• Use of LifeCourse framework and child and family voice and inclusion • KVC TFC, intensive wraparound services provided in-home

[6] Suicide Prevention Resource Center (SPRC), "Foster Care Providers: Helping Youth at Risk for Suicide," SPRC, March 2014, http://www.sprc.org/sites/default/files/resource-program/Fostercare.pdf, accessed June 2019.

[7] University of Missouri Kansas City (UMKC) Institute for Human Development, "Charting the LifeCourse™ Framework, UMKC, http://www.lifecoursetools.com/principles, accessed May 2019.

a. Care Management and Coordination with the Foster Parents and Mother

Jane, Kimberly's Department for Community Based Services (DCBS) worker, contacted **Aetna's 24/7/365 Behavioral Health Crisis Services Hotline** afterhours to request immediate support prior to discharge from the ED. The hotline clinician, who has been trained on the SKY program and available resources, assisted Jane in exploring and locating an available bed at the CMHC CSU. She explains CSUs are community-based, stabilization programs that offer comprehensive assessment, treatment planning, individual, group and family therapy, and peer support in effort to stabilize a crisis. The hotline clinician coordinated admission and expedites the prior authorization process assuring a timely transition. She documents her interactions including Kimberly's suicide attempt, call to the hotline, and referral and admission at the CSU.

Sara is an **experienced care coordinator** with previous employment working as a specialist providing in-home support services for foster children while she sought her counseling degree and license. The next business day following Kimberly's admission to the CSU, Sara initiates Kimberly's referral for Intensive Care Coordination. Sara follows up with the CSU clinical team to request a collaborative care team meeting. Sara reviews the initial assessment and interventions, and contacts her DCBS social worker, Jane, Kimberly's foster parents, Sam and Faith, and arranges a care planning meeting via teleconference. The care planning meeting coincides with the CSU treatment team meeting allowing communication and collaboration with the CSU psychiatrist. Following a comprehensive assessment of Kimberly's needs including her previously prescribed anti-depressant medication, Sara notifies the Aetna clinical pharmacy advisor that she may need to include her in the consultation if Kimberly is prescribed any psychotropic medications to ensure integrated coordination of medication management services.

While at the CSU, a **comprehensive safety plan** is discussed, documented, and implemented. During the assessment, the CSU clinician explores the events that occurred prior to Kimberly posting suicidal thoughts on social media. Aetna's providers are trained in **trauma-informed care**, and the practitioner listens compassionately, discovering that Kimberly did not know how to reach out or who to reach out to for help. The practitioner validates Kimberly's experience and assures immediate support and referral to others who will provide ongoing support. The clinician asks Kimberly if she would be willing to reach out to a person if she has suicidal thoughts in the future, and helps Kimberly identify people she trusts. The clinician assures the safety plan includes Kimberly's identified contacts and their phone numbers. This includes the foster parents, Jane, and a classmate Kimberly identified as trustworthy. The clinician educates Kimberly, her foster parents and mother on the use of **Aetna's 24/7/365 Behavioral Health Crisis Services Hotline and the local Community Mental Health Crisis Hotline**, both staffed with licensed counselors and social workers who are experts in crisis intervention and trained in local, Kentucky services and resources.

Sara participates in the Children's Review Program's **'difficult-to-place' calls**—a mechanism for consult when there is difficulty finding placement for foster children. With that experience in mind, she guides the Care Coordination team meeting at the CSU toward a collaborative discussion on the events that led up to the ED visit, and she carefully seeks input on needs, capabilities, and goals for greater stability and reduction of suicidal thoughts. She maintains a **person-centered focus**, factoring in Kimberly, her foster parents, and her mother's unique needs and perspectives. Sara asks Kimberly, her foster parents, and mother what they need to address the recent crisis. Kimberly states she misses her sisters but acknowledges there is a lot of conflict between her and her mother, Linda. The foster parents share they don't know how to support Kimberly's depression or safety but want her return to their home. Sara engages the team in discussion of treatment options after Kimberly is discharged from the CSU, including a referral to **KVC's TFC Support Home services,** in-home, intensive wraparound services that ensure safety and support Kimberly and her foster parents by teaching resiliency, parenting, and life skills for a stable, safe home. She states KVC supports Kimberly's transition to living with Linda, and includes wrapping Linda with services, parenting training, and life skills support. Kimberly agrees that ultimately this is what she wants, to rejoin her mother and her siblings and be a family again. Kimberly will be in the CSU for approximately seven days, allowing the Care Coordination team time to adequately plan for

comprehensive services that provide safety and support. Sara also offers an **Aetna Better Living "Keeping Kids Safe" lockbox** which is a locked storage container for securing pain medication that the foster parents can store in the home—**a no-cost, Aetna value-added service**. Sara introduces other critical items for Kimberly's care such as foster family in-home needs, coordination with her PCP, and family reunification, while prioritizing her immediate safety needs first. She asks Jane, the DCBS worker to sign a multi-agency consent form for **coordination with the PCP and other providers**.

After the care planning meeting at the CSU, Sara contacts Sam and Faith to explain and educate them on the Intensive Care Coordination program. She states care coordination services include **access to a multi-disciplinary team of experts**, and that she would be the **single point of contact**—including other team participants when their expertise was needed—and collaborating with other parts of the larger system including BH specialists, DCBS, and the school. Sara states the next step is to get to know Kimberly's support system and performs a needs assessment. She determines preferred dates, times, and locations for scheduling, and explains what would happen in the next visit—she will facilitate an **enrollee needs assessment (post-HRA) specifically designed for Kentucky foster children and their families**. Sara reviews all the contractually required items such as enrollee rights, enrollee grievance and appeals, and how to contact Aetna including direct contact information for her as the assigned care coordinator with the team. She asks how Kimberly is doing and what else the family needs to support any immediate needs. Sara advises how to use services and how eligibility works and answers any questions the family has. She explains the frequency of ongoing care planning meetings—a collaborative process with Kimberly's PCP, BH specialists, the school counselor, Jane, Kimberly, foster parents and mother where Kimberly's needs, care, and services are discussed. Sara states the Care Coordination team process is **holistic and person centered**—all needs are addressed whether physical health, BH, oral health, education, safety, skill building, or personal and family goals—and will be listed on the care plan. She asks about dates, times, and a preferred location to schedule the first meeting and advises she will coordinate with other team participants for scheduling.

Sara is extensively trained in care planning **best practices**, including using the **Charting the LifeCourse framework.** She calls Kimberly during her CSU stay and establishes a plan for additional in-person and telephonic visits, assuring time for relationship building and comprehensive assessment, and coordinates all arrangements with the CSU treatment team. Sara explores the support that Kimberly wants for her life—**her positive life trajectory**—through discussions about her strengths, abilities, desires, needs, struggles, and connections. Sara elicits additional detail using skills developed in **motivational interviewing**–a counseling method that helps people resolve ambivalent feelings and find internal motivation to change behavior—that Kimberly is afraid and excited to be reunified with Linda and validates Kimberly's feelings. She talks with Kimberly about skills she can learn such as understanding her feelings, learning how to express feelings, and effective communication that will aid in connecting with Linda. She prioritizes skill-building as a critical goal on Kimberly's care plan. During the flow of asking informal questions, Sara uses **evidence-based assessments tailored to the specific needs of Aetna's foster care population** and to Kimberly's needs to gather additional detail including use of the following assessments:

- Health and condition-specific issues and substance-use risk including using appropriate evidenced based screeners such as PHQ9[8], Trauma CANS,[9] and CRAFFT[10]

[8] American Psychological Association (APA), "Patient Health Questionnaire-PHQ9 and PHQ2," APA, 2019, https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health, accessed May 2019.
[9] The National Child Traumatic Stress Network (NCTSN), "NCTSN CANS Comprehensive Trauma Version," NCTSN, https://www.nctsn.org/measures/nctsn-cans-comprehensive-trauma-version-cans-trauma, accessed June 2019.
[10] Harvard Medical School Teaching Hospital, "About the CRAFFT," Harvard Medical School Teaching Hospital, http://www.crafft.org, accessed May 2019.

- Kimberly's clinical history, activities of daily living, and functional status
- Level of cognitive functioning using the Pediatric Symptom Checklist (PSC-17)[11]
- Health literacy, psychosocial issues and linguistic, cultural and spiritual needs and preferences
- Visual and hearing status, needs, and preferences
- Connection to school, school-based resources, and school functioning
- Kimberly and family's strengths, needs, and culture, and informal supports

b. Discharging Planning Between Levels of Care

Sara assures care coordination across all levels of Kimberly's care—ED to CSU, CSU to foster home, foster home to biological mother's home. She prioritizes needs accordingly and shares care plan information frequently, and as often as change occurs, with Kimberly's providers. This includes making certain the CSU psychiatrist and PCP communicate about Kimberly's BH needs, assessment information, diagnosis, interventions, and medication needs, and referring Kimberly to resources that educate on developmentally appropriate topics such as human immunodeficiency virus/sexually transmitted disease (HIV/STD) education and sexual communication skills. Sara reminds the team of Kimberly's goal to reunify with Linda, her strengths, and the need for skill development, and connects Kimberly to the **Bounce Coalition program** which supports understanding of trauma and developing youth resiliency through skill-building.

c. Network Adequacy and Availability of Services

Aetna demonstrates its ingenuity and collaborative spirit by developing innovative, value-based payment solutions with providers. Aetna initiated a **value-based payment arrangement with KVC Health Systems** on June 1, 2019, a specialty BH provider in Kimberly's region who provides in-home BH services via a specialized TFC Support Home to families. Aetna incentivized KVC to support outcome measures that stabilize foster children in their natural homes and avoid inpatient and residential treatment stays using evidence-based, in-home therapeutic practices that wrap services and supports around youth at risk of being placed in state's custody or disrupting their current placement. This model of TFC proposes to avoid youth entering a higher level of care ant to successfully and safely stabilize and reunify the youth into their home. As part of our continuous quality improvement process, Aetna analyzes data on ER and inpatient utilization. Data analysis drives strategy development on ways to increase access to care and availability of services. We currently co-locate an Aetna care coordinator in targeted facilities in Kentucky, for example, Our Lady of Peace, after data analysis revealed they had the longest length of stay and highest readmission rates in our network. The care coordinator assists with discharge planning, assuring follow-up appointments, care coordination, and identifying community resources.

Sara supports flexible scheduling and telephonic participation with direct follow-up to facilitate collaboration with Kimberly's school via participation in Care Coordination team meetings. She assures Kimberly's voice, and preferences are heard. As a local Kentuckian, Sara is aware pending legislation offering Medicaid funding for mental health support in schools, and recognizes her critical, current role to link existing BH services and school resources in the care coordination process e.g., assuring **support for Kimberly's emotional needs in the development of her IEP** and offering 1:1 BH support in Kimberly's classroom if needed. Sara observed Kimberly's need to be understood and feel hopeful. She offers Kimberly a referral for **peer support**—a youth with similar, lived experience who can share in her experiences and promote hope for recovery and a good life.

d. Availability and Utilization of Telehealth for Behavioral Health Services

Sara validates the concern about the lengthy travel distance to BH providers. Based on Kimberly and the foster family's preferences, KVC in-home, TFC support resolves distance barriers for BH services. If KVC is not

[11] W. Gardner and K. Kelleher, "Pediatric Symptom Checklist (PSC-17), W. Gardner and K. Kelleher, 1999, https://www.prohealthmd.com/windhampediatrics-dev/wp-content/uploads/sites/25/2015/01/PSC-17.pdf, accessed May 2019.

preferred, Sara offers a referral for **telehealth services**—access to licensed psychiatrists and counselors—as a viable option to support Kimberly's needs. She shares an overview of Aetna's telehealth approach and explains what to expect, how it works, and identifies available, local providers. Sara confirms scheduled appointments and educates on how to schedule transportation via the local Medicaid vendor.

e. Applicable EBP and Psychotherapeutic Interventions

Table G.13-2, Evidence-Based Practices for Kimberly, includes a summary of the evidence-based practices and psychotherapeutic interventions mentioned in this scenario.

Table G.13-2: Evidence-Based Practices for Kimberly

Holistic Support			
• KVC TFC Support Home	• CSU Services	• Peer Support	• Trauma-Informed Care
• Addressing SDOH	• Trauma-focused CBT	• Family Planning	• Motivational interviewing

Jane signed a release of information for coordination with Sara and Linda's mom, and Sara assures coordination of care. Aetna supports evidence-based practices for substance use disorders such as medication assisted treatment, opioid prescribing pattern analysis and education to providers, and endorsing the use of Screening, Brief Intervention, and Referral to Treatment with PCPs. Linda's care coordinator will identify her needs in collaboration with Jane and Kimberly's Care Coordination team, and initiates referral to clinically appropriate services. Sara and Linda's care coordinator meet often with Jane to review progress toward family reunification.

f. Prescribing Psychotropic Medications and Documentation in Medical Records

Aetna supports adherence to best practices and **clinical guidelines**, including prescribing psychotropic medications in children, and offers education to providers via online tools and as needed for corrective action. Aetna has a **clinical pharmacy advisor** available for consult and intervention. Sara requested her Provider Experience team and clinical pharmacy advisor review Kimberly's PCP intervention to assure adherence to clinical practices and provide any necessary training or corrective action as needed. The clinical pharmacy advisor also provides direct coordination and intervention with Kimberly's PCP if, for example, he remains the primary prescriber). Sara has been trained in Aetna's national **Zero Suicide** initiative—a long-term commitment and continuous quality improvement initiative that provides leadership, training, engagement, and treatment supporting suicide prevention. She monitors support carefully, and assures any change in needs, care, or safety planning is shared with Kimberly's team via the **FamilyConnect,** the shared, single electronic health record used by Kimberly's team.

g. Coordination of Transportation

Sara assures resolution to transportation barriers through the referral for KVC in-home, BH support and telehealth services. She offers Kimberly **Aetna Better Care Enhanced Transportation** which provides 10 roundtrips per year to the Bounce Coalition, life skills training program—an Aetna value-added service.

h. Provider Contracting

Aetna demonstrates its ingenuity and collaborative spirit by developing innovative, value-based payment solutions with providers. We are committed to providers being true partners in taking care of our enrollees and their patients. Aetna has initiated a value-based payment arrangement with KVC to implement a model of TFC Support Home services that focus on the use of intensive wraparound services and support to successfully stabilize and reunify foster children in their homes. This model was carefully selected as the family-centered, evidence-based practice for Kentucky foster care youth and families. Wraparound service philosophy includes implementing a flexible, team-driven continuum of services using natural supports and community resources. It is individualized, strengths-based, and aligns with the complex needs of vulnerable youth and families. This model promotes the collaboration needed to create long-lasting, effective change and promotes timely reunification and permanency for foster children.

Aetna and KVC support the tenets of Kentucky's Building Bridges Initiative and know that successful stabilization and reunification is achieved by most readily promoting youth voice and assuring the natural family has a central role in guiding and participating in services. Aetna continues exploration statewide with other providers willing to expand services that support foster care.

i. Provider Education and Support

Aetna has developed a customized approach for supporting and educating SKY providers that includes a comprehensive toolkit for meeting SKY enrollees' unique needs. We've partnered with the **National Council for Behavioral Health** to develop and implement trauma-informed care (TIC) training and provider recognition process allowing foster youth and families access to appropriate services no matter their point of system entry—**no wrong door**. This approach allows all providers – physical, behavioral, dental, and social – opportunity to change organizational culture that supports understanding of and addressing the impacts of toxic stress and trauma on our enrollees, their families, and their circles of support. We have trained 2,000 Medicaid staff including staff in Kentucky on foundational trauma training and "Darkness to Light" advanced training. Approximately 100 Kentucky staff participated in Mental Health First Aid training in 2016, and we continued support through train-the-trainer provider opportunities. Over 63 percent of our staff are trained on TIC, each of which has completed at least three separate trainings. We introduced a technology-based training on TIC this year and 56 staff have completed the training as of December 31, 2019. The National Council will train all staff in person onsite in the second quarter of 2020, with additional training geared towards member facing staff.

j. Access to and Sharing of Medical Records

To support continuity of care, Sara uses **FamilyConnect**, the shared, electronic health record Aetna implemented in collaboration with DCBS, providers, and ER which serves as the single source of truth for youth and their circles of supports. She shares care plan updates and medical record information in FamilyConnect as often as change occurs which Kimberly, foster parents, Kimberly's circle of support, providers, and DCBS can easily access at any time 24/7/365 using our **web-based portal or mobile application**. FamilyConnect integrates data from DCBS' The Worker Information System and the Kentucky Health Insurance Exchange, providing the care team a near, real-time, holistic view of Kimberly's needs.

k. Maintenance of the Care Plan

Sara is the **single point of contact** for Kimberly's care plan. She reviews the care plan with Kimberly, her foster parents, Linda, and the Care Coordination team at least monthly, making certain progress, barriers, and change in needs are monitored and documented. The care plan is updated any time there is a change in Kimberly's needs, as requested by Kimberly or her foster parents, per contract requirements, and at minimum, annually. If there is a significant change, Sara conducts an in-person visit with Kimberly, her foster parents, and any others to assure reassessment and updates to the care plan. Sara documents her interactions in FamilyConnect, assuring all involved have near, real-time access to updates.

Outcomes

Aetna's innovative, collaborative provider solutions promote optimal health outcomes, creating a healthier Kentucky. Kimberly was able to transition from the CSU to a KVC TFC Support home in close proximity to her mother's home, progressing through the four program phases in close collaboration with the care. Although Kimberly's foster parents were sad to see her leave, they were supportive and committed to remaining a source of support for both Kimberly and her mother. Sara's oversight of seamless discharge planning has adequately linked Kimberly and her circle of support to comprehensive, whole-person services and support. Future strategies support Kimberly's safe return to her mother's home, actively participating in BH services, and assuring adequate support for future crises, school success, and engagement in whole-health care through continued transition planning to adulthood, and support that offers opportunities for purpose and a meaningful life.

60.7.G.13 Use Cases for Kentucky SKY: USE CASE 3

Our care coordinators **listen, understand, and intervene early and collaboratively** to address each foster child's needs, assuring Shakira and her baby have a safe and nurturing home, connection to the local community, and that Shakira has opportunities for recovery and resiliency. We do this by assuring the support necessary to thrive and experience personal well-being through integrated care coordination grounded in comprehensive, whole-person, evidence-based practices for children with special health care needs, and innovative local programs that address the unique needs of Kentucky foster youth and families.

Shakira's Needs and Capabilities

Shakira has experienced intense traumatic events in her young life, including the death of her grandmother, the loss of relationships with her mother and her boyfriend Mike, and the loss of her identity, hopes, and dreams. She needs whole-person care that addresses and integrates her physical, behavioral, social, and emotional needs; educational support; resources that help her transition to adulthood and parenting; and support that builds a meaningful life filled with purpose. Shakira has many strengths and capabilities such as caring, healthy relationships, success at school, participation and enjoyment in extracurricular activities, and future career aspirations—all of which have been buried by her current circumstances.

Collaborative Solution

We will support Shakira in rebuilding a meaningful life filled with purpose, achievement of dreams, and a sense of belonging using **integrated, holistic, trauma-informed care**. We use evidence-based clinical practices and the **Charting the LifeCourse ™ framework**[12]: a best-in-class approach that guides those working with vulnerable individuals based on the core belief that all people have a right to live, love, work, play, and pursue their life aspirations in their community—to guide assessment, care planning, and care coordination tasks. **Table G.13-3** outlines interventions Aetna's care coordinator facilitates to support Shakira and her family.

Table G.13-3: Summary of Aetna Care Coordination Interventions for Shakira

Concerns	Interventions
Whole-person health	• Referrals for Early and Periodic Screening, Diagnostic and Treatment (EPSDT), prenatal, and family-planning care • Referrals for trauma-informed behavioral health providers, including Children's Alliance, the Behavioral Health Services Hotline, grief support groups, and peer support • Linkage to Healthy Start program: prenatal, parenting, and basic health needs training
Education	• Individualized Education Program and connection to previous school relationships and successes
Family	• Referral to Health Access Nurturing Development Services (HANDS): parenting skills training • Crib and gift card incentives for prenatal care attendance: an Aetna value-added service
Social Determinants of Health	• Referral to Women, Infants, and Children (WIC)
Aging Out	• Aetna Getting on T.R.A.C.K. (Transition Ready Assistance and Core Knowledge) life skills training and laptop for health literacy: an Aetna value-added service

a. Care Management

Jen, a licensed clinical social worker on Aetna's Care Coordination team, makes a referral for Shakira's enrollment into care coordination when Megan, Shakira's Department for Community Based Services (DCBS) social worker, notifies Jen that Shakira was moved to her private foster home in Bowling Green.

[12] University of Missouri Kansas City (UMKC) Institute for Human Development, Charting the LifeCourse™ Framework, UMKC: accessed May 2019; http://www.lifecoursetools.com/principles.

Megan knows Jen and Aetna care coordination well and leverages that collaborative relationship to connect Shakira to services. Jen is an **experienced care coordinator** who has been with Aetna for five years. While completing her master's degree in social work, Jen was a high school teacher in Bowling Green and coached the girls' basketball team. Jen is aware that foster children qualify as children with special health care needs, and she coordinates with Megan to assure Shakira's enrollment in Aetna's **intensive care coordination services**. Jen contacts Shakira's foster parents, Ross and Amy, to welcome them to the program and explain intensive care coordination services, including access to a multidisciplinary team of experts. She states she is their **single point of contact**—accessing other team participants when their expertise was needed and collaborating with other parts of the foster care system. Jen explains the first step is to get to know the family and what they need. She asks Ross and Amy for their preferred date, time, and location for scheduling, and explains what will happen in that first visit: she will facilitate an **enrollee needs assessment (post-health risk assessment) specifically designed for Aetna's foster children and their families**, making certain she captures all the family's needs and capabilities.

Prior to the initial visit, Jen reviews available information in the DCBS worker's information system (TWIST) and calls Megan to ask follow-up questions, ask about the family's needs, and gather names and contact information. During the initial visit, Jen starts the conversation by **welcoming the family to the program**, introducing herself, and reviewing all contractually required items such as enrollee rights, enrollee grievance and appeals, and how to contact Aetna, including her direct contact information. Jen provides an **overview of care coordination**—how to use services and how eligibility works—and answers any questions the family has. Jen is trained in trauma-informed care, an approach that involves listening empathically using guiding principles of safety, choice, collaboration, trustworthiness, and empowerment. She listens compassionately and empathically to Shakira as she describes her losses. She validates Shakira's experiences and assures that she is here to provide support. Jen asks about Shakira's beliefs, needs, likes, dislikes, abilities, and struggles. She approaches the topic of her boyfriend gently, allowing Shakira to share as trust is built. Shakira is reluctant to share her feelings, but eventually describes extreme loneliness, feelings of isolation, ambivalence about her decision to keep the baby without her grandmother, and a desire to talk with Mike again. Jen is an excellent listener who has been trained in **motivational interviewing**—techniques such as active listening and validating feelings. After some active listening, she helps Shakira identify her priorities, discussing decisions about the baby with her foster parents and Mike's family, and addressing her loneliness as a result of recent losses and moving to a new city.

Jen describes how the care planning process works, and that meetings involve a multidisciplinary team comprised of Shakira, Ross, Amy, her providers, school counselors, and anyone else important to Shakira's well-being: that is, her **circle of support**. She explains this is part of Aetna's **System of Care model**: we focus on working together to address gaps and assure available resources. She explains that her **voice**, and her family's voice, help the care team understand her needs and prioritize care, and that Aetna's approach is **holistic and integrated**: all needs are addressed from prenatal care to school resources to help with healthy eating. She asks about dates, times, and a preferred location to schedule the first care coordination meeting and advises she will coordinate with the care team for scheduling.

Jen is extensively trained in **foster care approaches and best practices**, including using the **Charting the LifeCourse framework**. Jen explores goals that support what Shakira wants for her life—her **positive life trajectory**—through discussions about her hopes and dreams. Jen asks Shakira to describe what life was like when her grandmother was alive. She listens patiently as Shakira describes her studies, participating on the swim team, missing her old friends, and her dreams of becoming a veterinarian. Jen validates Shakira's experiences and multiple losses and asks questions about Shakira's desire to move back to Lexington. Shakira is ambivalent, and Jen uses her skills in **motivational interviewing** to elicit Shakira's true feelings. Shakira states that she wants to live with Ross and Amy but wonders if she is allowed to change her mind. Jen assures that she is here to support Shakira, including helping her explore life decisions like moving back to Lexington, and that she has a right to change her mind at any time.

During the flow of asking informal questions, Jen uses her **evidence-based assessments tailored to the specific needs of Aetna's foster care population** to gather additional detail including the following:

- Health- and condition-specific issues including using the PHQ-9[13]
- Shakira's clinical history, activities of daily living, and functional status
- Level of cognitive functioning using the Pediatric Symptom Checklist (PSC-17)[14]
- Health literacy, psychosocial issues, and linguistic, cultural, and spiritual needs and preferences
- Visual and hearing status, needs, and preferences
- School-based performance and resources, informal family supports, family strengths and culture, family needs, and Shakira's hopes, dreams, goals, and preferences

Aetna demonstrates its ingenuity and collaborative spirit by developing innovative, value-based payments with providers. We are committed to providers being true partners in taking care of our enrollees and their patients.
"The Children's Alliance Board of Directors authorized the Children's Alliance to establish a separate limited liability company to promote innovative, efficient, and effective behavioral health services in Kentucky. The Children's Alliance established the Children's Alliance Independent Provider Association, LLC (CA-IPA), with the mission to increase access and improve quality of behavioral health services for Kentucky's at-risk children and families. The goal of the CA-IPA is to work in partnership with Kentucky managed care organizations (MCOs) and eventually, commercial insurance carriers, to contract with our CA-IPA member agencies for value-based behavioral health services. The CA-IPA has talked with several MCOs regarding this approach. However, Aetna was the first MCO to initiate a partnership with the CA-IPA to create and execute a value-based services contract. The idea of the contract is to incentivize behavioral health care providers to achieve specific outcomes and improve the overall care and well-being of children and families in Kentucky."

—Michelle M. Sanborn, MSW; President; Children's Alliance

b. Access to and Coordination between PH and BH Providers

Jen asks Ross and Amy what support they need as foster parents. Amy explains she would like Shakira and the baby to live with her and Ross, but is concerned about Shakira's parenting skills, school performance, and depression. Jen validates Amy's concerns and connects Shakira to **Healthy Start**, a federally funded program that provides training on prenatal, parenting, and basic health needs using empowerment and positive parenting methods. She states her role is to assure the team communicates and works toward the same goals. If change occurs, she is responsible to manage the related communication, making certain everyone is updated on goals. She asks Megan to sign a release of information form so she can coordinate care with the obstetrician/gynecologist (OB/GYN) and Shakira's current school. Jen adds that her Aetna Care Coordination department meets regularly for **integrated case rounds**: twice-a-month meetings with nurses, social workers, counselors, and medical directors from the Care Coordination and Utilization Management teams and providers as a means to get expert help on care.

c. Access to Network Providers

Jen explores referrals for behavioral health services to assist Shakira in recovering from grief and depression. She takes the opportunity to explain a recent **partnership between Aetna and Children's Alliance**, which was created to assure there are behavioral health services that get results for foster children and families. Jen guides the family through a list of available specialists and assists to choose one that provides treatment

[13] American Psychological Association (APA), "Patient Health Questionnaire-PHQ9 and PHQ2," APA, 2019: accessed May 2019; https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.
[14] W. Gardner and K. Kelleher, "Pediatric Symptom Checklist (PSC-17)," W. Gardner and K. Kelleher, 1999: accessed May 2019; https://www.prohealthmd.com/windhampediatrics-dev/wp-content/uploads/sites/25/2015/01/PSC-17.pdf.

customized to Shakira's needs: for example, **trauma-focused, cognitive behavioral therapy,15** an evidence-based approach that addresses the unique needs of trauma and depression. Jen asks if Shakira is participating in **family planning** activities with her OB/GYN and offers to coordinate to get her enrolled. She explains Shakira's OB/GYN provider has resources to guide in understanding her pregnancy and prenatal care. She advises that once she has the baby, the family planning nurse can guide her through decisions and resources on preventing future, unplanned pregnancies, and prevention supplies, e.g., **long-acting reversible contraceptives** as needed.

Jen has heard firsthand about Shakira's loneliness and isolation. She offers a referral for a new Aetna **peer support** program, which would provide a person with similar lived experience who can share in Shakira's experiences. Jen states that often services can address our health symptoms, but do not always make us feel better or like we belong in a community. She explains that a peer support staff member would be someone close to her age who understands what depression is like and can listen when she feels hopeless.

> Aetna is collaborating with StAMINA (Student Alliance for Mental Health Innovation and Action), a student-run program that advocates for youth mental health, to provide peer support services to Aetna enrollees.

d. Discharge Planning All Levels of Care

Jen facilitates frequent care coordination meetings and the team has prioritized her concerns as follows:

- Ongoing comprehensive assessment, connection to services, prenatal care, and parenting skill development
- Screening and referral for trauma-informed behavioral health services
- Explore and connect to appropriate educational support and school resources
- Explore and build a circle of support inclusive of family reunification, re-establishing friendships, and Shakira's hopes and dreams
- Develop a transition plan for aging out of the foster care system

At this time, Shakira's and her foster family's needs reflect outpatient care, but Jen understands how quickly that can change. Jen educates Shakira, Ross, and Amy on **Aetna's 24/7/365 Behavioral Health Crisis Services Hotline**—the hotline is staffed with licensed counselors and social workers who are trained and experts in mental health and Kentucky services and resources—and she provides the hotline number. Jen knows from her **extensive training on best practices for foster care** that children and families have a greater chance of optimal outcomes and a meaningful life if they live with purpose in their community. She asks Shakira about her loneliness, distance from past friends and Mike, and the events surrounding her grandmother's death. Shakira is very tearful and unable to speak. Jen uses her **trauma-informed care skills** to patiently sit with Shakira as her family provides assurance. She elicits additional detail to assess for how this trauma has impacted Shakira and validates Shakira's experiences. Jen offers **grief support groups**, which are community-based groups that provide forums for sharing and connecting with others who have lost a loved one. Jen asks if Shakira would like reestablishing friendships and talking to Mike as needed on her care plan, and she prioritizes according to what is most important to Shakira.

e. Coordination of School-based Services and Individualized Education Program

Jen **knows her community well**—as a former teacher, she has collaborative relationships with Shakira's previous and current schools. Jen asks Megan to sign a release of information for both school counselors and states that she will coordinate care. Ross and Amy ask why a release is needed for the previous school counselor. Jen explains that it is **critical to understand and use Shakira's strengths**—her previous success

[15] Judith A. Cohen, MD, Esther Deblinger, PhD, Anthony P. Mannarino, PhD, "Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)," TF-CBT: accessed June 2019; https://tfcbt.org/about-tfcbt.

with grades, being a member of the swim team, and playing the clarinet—**as opportunities to rebuild a meaningful life**. Jen states that including the previous school counselor creates an **opportunity for hope,** a reminder of the meaning and success of life that once was and can be again. She links hope for a better future as a critical step in addressing Shakira's school performance and life skills. Jen advises that the existing school can provide resources such as an **Individualized Education Program** at the onset of care planning, allowing for more support, resources, and structure around Shakira's school performance while she is recovering from depression and rebuilding her identity. Jen asks Shakira about her dream of becoming a veterinarian. Shakira is hesitant, but as a **skilled motivational interviewer,** Jen listens patiently, acknowledging ambivalent feelings and leveraging this as behavior change. Jen asks how Shakira would like this prioritized on her care plan. Jen observes tearfulness and slouching body language. Using her skills in trauma-informed care, she reinforces that she is here to help, and that we will take this one step at a time. She states that the first step is to acknowledge this is a life goal on the care plan. The second step is to use the **LifeCourse framework** to determine how we get to the end result.

f. Community Services for Parenting Skills

Jen shares that there are **high schools specifically designed for pregnant teens**, which includes support such as parenting classes, childcare, and opportunities to build connections. Shakira is not certain at this time about switching high schools, and Jen responds to prioritize behind the other needs Shakira has identified. As an alternative, Jen describes the **HANDS program**—an in-home, parenting education program—and offers to help Shakira enroll.

> Aetna celebrates important milestones such as having a baby by offering **community baby showers**—an Aetna value-added service—to help mothers celebrate before the baby is born. Aetna staff utilizes this opportunity to educate enrollees on new mom topics like breastfeeding.

g. Applicable Evidence-Based Practices

Table G.13-4 includes a summary of the other evidence-based practices and psychotherapeutic interventions mentioned in this scenario.

Table G.13-4: Evidence-based Practices for Shakira

Holistic Support		
• Intensive care coordination • Evidence-based proprietary assessments	• Child/family voice and inclusion • Addressing social determinants of health	• Trauma-focused cognitive behavioral therapy • Family planning • Motivational interviewing

h. Coordination of Transportation

Jen asks if the family needs transportation assistance to scheduled appointments, and educates on the Human Service Transportation Delivery program, the transportation hotline, and use of services. She offers **Aetna Better Access enhanced transportation**, a value-added service that includes 10 roundtrips per year to activities such as life skills and parenting training.

i. Options for Aging Out of Foster Care and Risk Management

Jen explores Shakira's needs for aging out of foster care and develops a transition plan that includes services and resources to build a meaningful life filled with purpose and achievement of dreams. She educates about Aetna benefits such as EPSDT benefits through age 26. Jen uses the Charting the LifeCourse framework to create a positive life trajectory to facilitate the team discussion on Shakira's dreams of becoming a veterinarian and identifies resources for the care plan: the local Ready Kentucky work program and Dream Scholars, the University of Kentucky Center for Health Equities Transformation

> Aetna Connections for Life offers a **no-cost laptop** as a key tool necessary for independent living. This value-add is available to foster care youth ages 18+, enhancing connection to school and work opportunities.

scholarship opportunity. **Aetna is committed to Kentucky SKY**, and our transformative vision drives our model for enhanced care coordination and service integration supporting each child in foster care, adoption assistance, and juvenile justice populations. Jen educates Shakira about Getting on T.R.A.C.K (Transition Ready Assistance & Core Knowledge), a program uniquely designed by an Aetna staff member for improving health literacy in Kentucky foster youth, offering topics on life skills such as how to manage a budget and navigating insurance companies, and provides Shakira with a no-cost laptop after her 18th birthday.

j. Social Determinants of Health

Jen made sure Shakira had an **Aetna duffle bag**—which includes a water bottle, shampoo, conditioner, a toothbrush and toothpaste, a hairbrush, body wash, a blanket, and a personal writing journal—when she was first enrolled in care. She also provides a **no-cost, portable crib (an Aetna value-added service)** near the end of Shakira's pregnancy. She refers Shakira to her local WIC, the federal food and nutrition program.

k. Provider Education and Support

Aetna supports its providers and the larger Commonwealth in striving to be **trauma-transformed**—which means understanding the effects of toxic stress and negative impact on health, especially in foster children—and **Aetna is training providers on how to screen for trauma and make appropriate referrals.** She explains that certain providers, like the ones in the **Children's Alliance** network, have not only agreed to change their approach, but agreed to make sure that the people using their services get results.

l. Access to and Sharing of Medical Records

To support continuity of care, Jen uses **Aetna FamilyConnect,** the shared electronic health record implemented in collaboration with DCBS, Kentucky Health Information Exchange (KHIE), and providers; it serves as the single source of truth for youth and their circles of supports. Jen shares care plan updates and medical record information in FamilyConnect as often as change occurs, which Shakira, her foster parents, her circle of support, providers, and DCBS can easily access at any time 24/7/365 using Aetna's web-based portal or mobile application. FamilyConnect integrates data from TWIST and KHIE, providing the Care Coordination team a near real-time, holistic view of Shakira's unique needs.

> Aetna has the technological capability to integrate multiple data-sharing systems including KHIE, TWIST, admission, discharge, and treatment data, and clinical platforms utilized by care coordinators, providers, hospitals, and emergency rooms into a single platform accessed by all stakeholders involved in a foster child's care—**allowing near real-time information sharing 24/7/365.**

m. Maintenance of the Care Plan

Jen is the **single point of contact** for Shakira's care plan. She reviews the care plan with Shakira, her foster parents, and the team at least monthly, making certain progress, barriers, changes in needs, and concerns are monitored and documented. The care plan is updated in **FamilyConnect, the single, shared, electronic health record platform,** any time there is a change in Shakira's needs, as requested by Shakira or her foster parents, per contract requirements, and at minimum, annually. If there is a significant change, Jen conducts an in-person visit with Shakira, her foster parents, and others involved to assure reassessment and updates to the care plan. Jen documents her interactions with Shakira, the foster family, and team participants, in FamilyConnect, assuring the care plan is updated as change occurs.

Outcomes

Aetna's innovative, collaborative provider solutions promote optimal health outcomes, creating a healthier Kentucky. Jen's care coordination and Aetna's integrated comprehensive services have connected Shakira and her to assessments and care. Shakira is experiencing recovery and building a meaningful life filled with purpose. The foster family has the support and resources they need to provide care. Shakira is participating in prenatal and EPSDT care, excelling in school, and pursuing her veterinary dream. Future strategies include continued transition planning to adulthood, coordination of whole-person care for Shakira and her baby, and exploration to connect Shakira to her natural family.

60.7.G.13 Use Cases for Kentucky SKY: USE CASE 4

Our care coordinators listen, understand, and intervene early and collaboratively to address each foster child's needs—assuring Kirk has a safe and nurturing home and community. Aetna supports our enrollees and families involved with Commission for Children with Special Health Care Needs (CCSHCN) through an integrated System of Care (SOC) model to effectively coordinate care to meet all their physical and behavioral needs as well as address any social determinants of health (SDOH).

Kirk's Needs and Capabilities

Kirk is 3 years old and after being in six different foster homes, is now living with a dedicated foster family in a rural community in Webster County. Kirk has cerebral palsy (CP), hydrocephalus with a ventriculoperitoneal (VP) shunt, and seizures, and is on multiple medications to manage these chronic conditions. With Kirk's complex medical needs, access to services have been challenging. The foster family is committed to providing a safe and stable home for Kirk and is considering adoption but is concerned about Kirk's long-term care needs. Kirk and his foster family need increased access to local clinical specialists (e.g., pediatric neurosurgeons), specialists to support his cognition, behavior, communication and developmental needs, medications to treat his CP symptoms and associated conditions, physical therapy, educational support and durable medical equipment. Kirk's foster parents need education and support on navigating the complex health care system and in identifying community resources to meet all of Kirk's unique needs.

Collaborative Solution

Aetna's transformative vision drives our model for enhanced care coordination and service integration supporting the children in foster care. We use a **person-centered approach** in our **SOC model** for children in foster care, incorporating a whole-person, whole-family approach to physical, behavioral, and social well-being. The SOC model components will work together to help Kirk and his foster family achieve important clinical and functional outcomes throughout life in alignment with the Department for Community Based Services (DCBS) goal that all children have safe and nurturing homes and communities. Due to his medical complexity, Kirk is identified as needing **Complex Care Coordination** and identifies the following care coordination activities (see **Table G.13-5).**

Table G.13-5: Summary of Aetna Care Coordination for Kirk

Need	Intervention
Whole-Person Health	• Referral to local specialists to assess for medical, medication and durable medical equipment (DME) related needs related to his CP, hydrocephalus with a ventriculoperitoneal (VP) shunt, and seizures • Referrals for physical health assessment and intervention including primary care, dental, and nutritional services • Referral for cognitive, behavioral and developmental assessments • Connection with Community Pharmacy Enhanced Services Network (CPESN) for medication benefit management • Engagement of circle of support
Family	• In-home equipment that supports Kirk's safety • Referrals for skilled nursing respite services • Transportation services for Kirk's family to get to and from medical appointments
Communication	• Referrals for communication and developmental support (communication boards, and adaptive technology) • Family Advisory groups
Education	• Coordination for an Individualized Education Program (IEP) and appropriate school-based resources that support community inclusion
Social Determinants of Health	• Referral to Aetna's Wellness Center and community health worker (CHW) service program • Aunt Bertha and other community resource guides

a. Care Management Coordination

Aetna became aware of Kirk's current situation when we received the 834-file (on our daily uploads) from the Department. As Aetna's goal is to rapidly engage with at risk children, a **care coordinator** was assigned to begin the screening process to enroll Kirk in services. The care coordinator, Sue, is a registered nurse with experience with medically complex children and families; she is also trained in trauma-informed care and the Charting the LifeCourse™ framework.

Prior to the initial visit, Sue reviews available information in the DCBS' The Worker Information System (TWIST) and calls the **DCBS social worker** and Kirk's assigned **commission nurse** to gather pertinent information regarding Kirk's needs. Once Sue receives permission from the DCBS social worker, she reaches out to Kirk's foster parents and schedules a time meet them. During the initial visit, Sue starts the conversation by **welcoming the family to the program**, introducing herself, and reviewing all contractually required items. She also provides an **overview of intensive care coordination services**—how to use services and how eligibility works—and answers any questions the foster family has. During this visit, Sue completes our initial screenings of the health risk assessment (HRA) and enrollee needs assessment. Sue takes responsibility for arranging all the needed evaluations and offers to accompany the family to the assessments. See **Table G.13-6** for a list of evaluations recommended for Kirk. This includes using evidence-based assessments tailored to the specific needs of Kentucky's foster care population and children designated as medically complex.

Table G.13-6: Assessment to Determine Kirk's Needs

Domain	Specialist/Providers	Assessments	Assessments
General Physical Health	Pediatrician/Pediatric Nurse Practitioner	• Growth parameters and general nutrition/diet • Immunization status	• Lead level • Anemia check • Sleep patterns • Elimination
Developmental-Behavioral Status	Developmental-Behavioral Pediatrician, Speech Therapist, Pediatric Ophthalmologist	Formal testing of gross motor, fine motor, cognitive, speech and language and socio-emotional skills	• Formal testing of hearing and vision • Behavior Screening Tools
Neurological Status	Pediatric Neurologist (Pediatric Neurosurgeon if indicated)	Evaluation of shunt function (baseline magnetic resonance imaging)	Evaluation of seizure status and medication regimen (electroencephalogram, blood levels of medications)
Family Needs	Pediatric Social Worker or Psychologist	• Social Supports • Stressors	• Coping strategies • Resources

Sue will be the **single point of contact** to lead the **Care Coordination team (CCT).** Working with the DCBS case worker and Kirk's foster family, they identify supports and providers to be part of his CCT which will drive the holistic and person-centered car planning process. As the single point of contact and based on the family's preference and need, Sue will ensure ongoing communication with the CCT members and as well as completing at least two face-to-face visits per month, frequent contact with Kirk and his foster family, and ongoing integrated care planning with the CCT.

Care Planning

Aetna's model is based on holistic and whole- person care which intends to serve individuals in foster care in concert with their circle of support. This framework feeds into the care plan that addresses much more than covered services and paid/unpaid support. Kirk's care plan also addresses his likes and dislikes, eventual life goals and objectives that promote self-efficacy and personal satisfaction, living in the community of his preference, cultural practices and beliefs that are most important to the foster family and participation in socially rewarding life activities. Sue utilizes the approach of Charting of the

LifeCourse framework to build the care plan that addresses covered and non-covered services and focuses on his circle of support (care givers, foster parents, etc.).

Using the LifeCourse framework and her motivational interviewing skills to quickly build rapport with the foster family; they were able to articulate their treatment priorities and their main goal of stabilizing Kirk's hydrocephalus and the problems with the V/P shunt so that Kirk can participate in preschool continue to improve his language skills, and enjoy time with his family. Sue provides education and information about Kirk's conditions, medications, available services, resources, and options that will help the foster family to achieve their long-term vision of adoption. With the help of the DCBS social worker and Kirks' foster family, Sue convenes the following team of providers and support workers to begin the care planning; currently involved medical providers, the Commission nurse, specialists to support his cognition, behavior, communication and developmental needs (such as his speech, occupational, and physical therapists), primary care and dental providers, and his current clinical specialists (such as his pediatric neurosurgeon). Sue will collaborate with additional supports as Kirk's non-medical needs are identified through the LifeCourse conversations and the integrated centralized care planning process.

Fragmented Care

A family supporting a 3-year old with CP and seizures may get very little rest and have very little capacity to navigate systems. By having Sue as the main point of contact for the CCT, she can act as a liaison for the foster family by; coordinating with Kirk's pediatrician to ensure that follow up appointments are scheduled, identifying local dental services and assisting in securing appointment for days and times that work for the family, ensuring in home services (such physical, speech and occupational therapies) are provided as outlined in the care plan, help to ensure medication needs are met and engage educational supports to help meet Kirk's future schooling needs. Once Sue has collected follow up information about upcoming appointments, she communicates this information to the foster family and helps with any roadblocks to care including transportation services.

At times, this fragmentation in service delivery can be difficult to overcome. Sue connects Kirk's foster parents to our resiliency and recovery SOC administrator to help them advocate for accessible, local and clinically appropriate care. The SOC administrator also suggests that the foster family join the Parent Advisory Council to connect with other caregivers. Participation in this council will help them build formal and informal relationships with other caregivers who have similar experience and can help them navigate the system. Sue will help to ensure that the Integrated Health Plan, created and housed by the CCSHCN, will be integrated into the CCT centralized care plan to promote continuity of care. In the future, this will be housed with the CCT. Sue will also work with the CPESN to make certain that the pharmacy care plan aligns with the integrated centralized CCT care plan.

Access to Care

Sue helps to ensure that Kirk and his foster family have quick access to the services they need closer to home. Currently, they are traveling to Cincinnati Children's Hospital, which is more than a nine-hour commute, and the foster family shares with Sue their desire to transition Kirk's specialty care to Norton's Children's hospital due to its closer proximity and the care coordination services embedded in the system. This embedded care coordination system can help by having the embedded care coordinator act as a liaison between the hospital providers and the CCT. Sue reaches out to the Norton care coordinator staff to assist in making appointments for the family, and with DCBS and the foster parent's permission, invites the Norton care coordinator to join the CCT. In addition, for more frequent medical monitoring, Sue reaches out the children's SOC administrator to engage local pediatricians in Webster County to join Aetna's network of providers. These providers will be close to Kirk's home and help meet his medical needs between trips to Norton's Children's Hospital and will work with the specialist at Norton's to ensure continuity of care for Kirk.

b. Availability of Services and Network Access, including Out-of-State Providers

Kirk's complex needs make the ease of access to medically necessary services imperative. With his medical condition, mobility is an issue; therefore, physically going out of state is a significantly stressful event for the entire family. By engaging with trauma informed medical providers **and home-based** therapists, Sue is able to successfully breakdown the transportation barriers while improving timely access to care. Another way Sue will help the family with ease of access to needed services and supports is by coordinating a change of pharmacies to a **CPESN-affiliated pharmacy,** which delivers medication directly to their home. The CCT will continually assess the medical needs for Kirk and if necessary, will work with the children's SOC administrator to assist in securing single case agreements with local Webster County medical providers.

c. Availability of Skilled Nursing Services

Raising a young child with complex medical needs can be tiring and stressful, therefore Sue introduced Kirk's foster family to the Aetna's value based contracted program **The Kidz Club**, a community **pediatric daycare** for children who are medically complex. The Kidz Club will be expanding throughout the Commonwealth, and therefore will be a good option for Kirk's foster family as there will be closer locations. In the meantime, Kirks foster parents went with Sue to tour the Louisville facility and to give them an opportunity to talk to the physical therapy (PT) and occupational therapy (OT) staff, among other support and nursing staff about the program. This initial engagement helped the foster parents feel comfortable sending Kirk a few days per week. Sue completed all enrollment paperwork set Kirk up to start attending when the local facility opens. In addition, Sue coordinates with Kirk's DCBS social worker to set up nursing services through their internal **CCSHCN network** of skilled nurses. If any gaps in nursing care are identified through the CCT process, Sue will reach out to our internal children's SOC Administrator to assist in completing a request for a single-case agreement with provider in the local community.

d. Access to School-based Services

The CCT team identifies that at Kirk's age, his future educational needs to be addressed. Sue suggests to the DCBS social worker and his foster parents that he should be referred for a **special education evaluation** at the local school. She also informs them that and if Kirk is eligible for **federal Individuals with Disabilities Education Act services**, then he will be prioritized for **Head Start**. Sue offers to coordinate this evaluation with the school district. In addition, based on the outcome of these assessments Kirk may qualify for up to 20 to 30 hours of school per week. Sue helps to ensure that any educational services Kirk qualifies for will be integrated into the centralized care plan.

e. Applicable Evidence-based Practices

Aetna believes using evidence-based practices (EBPs) is most appropriate way to ensure the foster care youth are treated using the most clinically appropriate interventions. Kirk's treating providers will use the following EBPs, which are added to integrated CCT care plan (**See Table G.13-7**):

Table G.13-7: EBPs for Kirk and His Foster Family

Conditions Addressed	Evidence-based Approaches	
Cerebral Palsy	Use of Baclofen, Botox and/or surgery to relieve spasticity and enhance the value of PT and OT	• In addition to consistent traditional PT and OT, aquatic therapy can enhance the development of motor skills • Adaptive DME (assistive communication devices, gait trainers, custom walkers, custom orthotics, standers and custom wheelchairs/strollers)

Conditions Addressed	Evidence-based Approaches	
Seizures	Newer anti-epileptic drugs designed to maximize seizure control and minimize side-effects; co-managed by Pediatric Neurologist, Pharmacist and PCP	If maximized medication treatment does not adequately control the seizures, epilepsy surgery can dramatically improve the child's functioning by decreasing/eliminating seizures and increasing awake/alert time for education, therapy and developmental stimulation
Communication/ Education/Speech and Language	If indicated, optimize hearing with BiCross hearing aids or cochlear implants	Needs IEP built around needed assistive communication devices to maximize cognitive and socio-emotional development

f. Coordination of Transportation

In collaboration with the Commission nurse and DCBS social service worker, Sue assists in arranging transportation options for Kirk's foster family to attend care appointments, keeping in mind he needs a **specialized car seat** to ensure his safety. For any covered service, not provided in the home, Sue educates the foster parent on how to access services through the **Human Service Transportation Delivery program,** which provides non-emergency, non-ambulance medical transportation using public and private transportation providers. Through the **Aetna Better Access, Enhanced Transportation Benefit**, Sue can assist the family with transportation needs that may not fall under covered services. This transportation service provides up to 10 roundtrips per year via a transportation vendor or mileage reimbursement for enrollees to have transportation services to activities such as making a trip for food at a grocery store or food bank, day care, etc. For the occasions when Kirk and his foster family have to travel to Norton's hospital, Sue helps to ensure they have access to no cost accommodations in Louisville.

g. Community Resources

As guided by the CCT and the care plan, Sue connects Kirk and his foster parents with local community resources to meet his needs. **See Table G.13-8** for a list of community-based resources for Kirk and his foster family.

Table G.13-8: Community Resources Available to Kirk around Webster County

Social Determinant of Health Needs	Community Resources	
Family Supports	• Kentucky Foster Adoptive Care Association • Kentucky Special Parent Involvement Network	• Family Advisory Council • Webster County Family Resource Network • Parent information Network of Kentucky
Education	• Head Start • Webster County Early Childhood programs	
Disability Supports	• Kentucky Assistive Technology Service (KATS) Network • Council on Developmental Disabilities • Service member and Family Support Program	

h. Social Determinants of Health

Evaluation of Kirk's SDOH is an ongoing relational process with the foster family to ensure they have access to benefits and services. In an effort to reduce the over-utilization of medical resources to meet other life domain needs. Through the ongoing assessment process, as well as during every contact, Sue is inquiring about and addressing Kirk's SDOH, including social support networks and connection to culture, as well as access to health care. Any SDOH impacting Kirk is incorporated into his integrated centralized care plan.

i. Planned Respite Care

With Sue's background and training, she understands that when a child has significant health challenges, the entire family is affected. Part of Kirk's ongoing care planning process includes assessing for caregiver burnout and incorporating respite and other services for caregivers. As mentioned earlier, based on Kirk's complex medical needs, Sue will coordinate planned respite care through **The Kidz Club** to give the foster parents' time to take care of their needs. Sue also works with Kirk's DCBS social worker to explore and facilitates **waiver services** enrollment as a means for future respite care options.

j. Provider Education and Support

Aetna supports its providers and the larger Commonwealth in striving to become **trauma-transformed**—understanding the effects of toxic stress and negative impact on health, especially in foster children, and that **Aetna is training providers how to screen for trauma and make appropriate referrals.** Being trained in trauma informed care, Sue understands the value in having specialists working with Kirk trained in this approach and works with the family to identify appropriate and local providers. Having a nursing background, Sue understands the unique medical needs and works with the DCBS social worker and the Commission nurse to coordinate with his specialists and their recommended course of treatment for his hydrocephalus. Together, they work to assure that these issues are addressed by his pediatric providers.

k. Access to and Sharing of Medical Records

To support continuity of care, Sue uses **Aetna's FamilyConnect** system (the shared, electronic health record implemented in collaboration with DCBS, Kentucky Health Information Exchange (KHIE), and providers which serves as the single, source of truth for youth and their circles of supports). CCT members, including Kirk's family will have access to Kirk's integrated centralized care plan. Sue shares care plan updates and medical record information in this system as often as change occurs. Aetna **FamilyConnect** integrates data from **TWIST** and **KHIE**, providing the CCT a near, real-time, holistic view of Kirk's complex needs. In addition, Sue outreaches to all identified current and prior providers to gather medical records to supplement the **Medical Passport** and pass this information onto the Commission nurse, DCBS social worker, medical providers, and education team members and his foster parents.

l. Maintenance of the Care Plan

The CCT reviews the care plan at least monthly, with updates made when there are any significant changes and making certain progress, barriers, and changes in needs and concerns are monitored and documented. Kirk's foster parents are directly involved in the content of the care plan to ensure voice, choice, and preference each step of the way during care. If there is a significant change, Sue conducts and documents any in-person visit with Kirk and his foster parents, and others involved to assure reassessment and updates to the integrated centralized care plan. This CCT care plan will be aligned with any others developed with outside stakeholders, including the IEP, the Commission's Integrated Health Plan (IHP), and the CPESN pharmacy care plan.

Outcomes

In collaboration with the Commission nurse and DCBS social service worker, Sue has facilitated all the identified covered and non-covered services on Kirk's care plan. The foster family reports being happy with the selection of providers available in close proximity, via in-home services. With connection to Norton Kirk's shunt was replaced, which has stabilized his medical conditions. Kirk's foster parents report to Sue that he has been enrolled in early childhood education through Webster County special education, has received necessary DME, mobility and communication technologies, all which will allow him the opportunity to grow and develop independence. The foster family has begun the process to formally adopt Kirk and even begun having play dates with Kirk's new friend he met through his foster mom's involvement with the Family Advisory Council. Sue and the CCT team continue to work with the family on an ongoing basis to ensure that Kirk maintains his safe and nurturing homes and community.

60.7.G.13 Use Cases for Kentucky SKY: USE CASE 5

Our enrollee, Enrico, is at a critical time as he nears adulthood and is uncertain of his future. Aetna will support Enrico to learn to manage his behaviors and health care through our System of Care (SOC) model of enhanced care coordination and service integration to help him achieve his goals, and to make certain he and his circle of support are successful in attaining person and family recovery and resiliency.

Enrico's Needs and Capabilities

Enrico is a 16-year-old Hispanic male living in Louisville in a group home for foster kids. In addition to medical treatment need to address asthma and his high body mass index (BMI), Enrico needs support in managing his aggressive behaviors in the home and educational settings. Enrico is receiving treatment to address these needs, which includes being prescribed two psychotropic medications. Although unsure about his future, Enrico has a desire to rebuild a relationship with biological family, including his siblings and want to one day return home.

Collaborative Solution

Aetna supports our enrollees involved with Child Protection Services (CPS) through an integrated System of Care model to effectively coordinate care to meet all their physical and behavioral needs as well as address any social determinants of health (SDOH). Enrico and his family will be supported through our SoC model which incorporates our whole-person, whole-family approach to physical, behavioral, and social well-being. The SOC model components work together to help each enrollee achieve important clinical and functional outcomes: at home, in school, at work, in the community, and throughout life. While recognizing that Enrico is not currently living with his parents, Aetna's SOC approach values the involvement of the family and will utilize techniques, such as motivational interviewing (MI) to engage his parents in the planning and treatment process.

a. Aetna's Evidence-based Integrated Care Management Program

Aetna became aware of Enrico's current situation when we received the 834-file (on our daily uploads) from the Department. Aetna's goal is to rapidly engage with at risk youth; a care coordinator (CC) was assigned to begin the screening process to enroll Enrico into wraparound services. Amy, the assigned CC, has experience working with youth in foster care with comorbid physical and behavioral health conditions as well as SDOH and is certified and trained in the delivery of wraparound care. The Care Coordinator team (CCT) outreached to the Department for Community Based Services (DCBS) social worker to get permission to meet face-to-face with Enrico to complete the health risk assessment (HRA) and enrollee needs assessment (ENA). In addition, knowing that Enrico has experimented with drugs and alcohol, administers the CRAFFT substance use screening tool to assess the severity of the substance use. The DCBS social worker and Enrico identified Enrico's Aunt Mia (whom he has been close with growing up) and a member of the group home staff to attend the initial meeting with our care coordinator.

During the initial face-to-face visit, Amy began to build rapport with Enrico and provided an overview of the care coordination process. Aetna's holistic, person-centered approach considers physical, behavioral, dental, and social needs of Enrico's natural and community supports which may also include community resources in addition to those offered by traditional health care entities. Aetna is committed to supporting Enrico as the lead voice in the care planning process. Enrico identifies individuals in his circle of support to include his parents, his aunt Mia, and his best friend. The DCBS social worker provides permission for them to join the CCT for the purposes of ongoing care planning. The CCT will also include his integrated service provider, child psychiatrist, trauma informed therapist, his DCBS social worker, peer support, school representative, and group home staff. Since the charges were dropped by the Department of Juvenile Justice (DJJ), Amy will connect with Aetna's juvenile justice liaison to assist in keeping the lines of communication open in case there is further involvement.

Based on Enrico's initial HRA and ENA, completed during the initial face-to-face visit, Amy assigned Enrico to our **Intensive Care Management level**. Amy will engage with Enrico at a minimum as follows, but more frequently based on his needs: one face-to-face visit monthly; one weekly contact; one meeting with Enrico and his care team (including his primary caregivers and others in his circle of support) monthly; and one monthly care plan update.

Enrico's care coordinator, Amy, trained in motivational interviewing, recovery, and resiliency, as well as trauma-informed care, actively engages Enrico and his chosen circle of support to continue ongoing involvement and feedback in the care planning process. Care plans do not exist in a static state, but instead change as needed with Enrico's progress. Amy customizes solutions based on Enrico's priorities, individual trauma experiences, and in treating not just Enrico, but his family as a whole is a vital step in breaking the cycle of trauma which is often intergenerational which is creating a path to healing. A supportive environment includes a wide circle of support including the community, the health system, schools, law enforcement, judicial system, and many others. Aetna seeks to engage numerous resources to encircle the family and create the best possible outcomes including natural supports, where possible. This is why we see Aetna's role as activating communities to create opportunities to empower those communities and families to better care for themselves.

Enrico remembers one or two teachers from his past that liked him and saw his potential. Enrico knows who they are but lost track. Amy takes on the inquiry and search task, finding both of them and enlisting them onto the CCT in support of Enrico because they still like him and have worried about him for a long time. One teacher offers Enrico specific tutoring and the other one offer to assist with individualized education program (IEP) advocacy needs.

b. Discharge Planning

Enrico's vision of a good life is to be reunited with his family, at least so they are in his life even if he does not return home to live. While he is at the group home and with the DCBS social worker's decision, Amy invites Enrico's parents as well as his Aunt Mia to attend CCT meetings and encourages them to participate in identifying services and supports for themselves as well as Enrico. His Aunt Mia was also involved in the DCBS system, found recovery, and already made restitution to family and community and will engage with Enrico, share his story, and work with him on his own restitution plan as well as function as the bridge back to his parents. During the CCT meetings to develop Enrico's **care plan**, Amy facilitated development of a transition plan for when Enrico leaves the group home. The transition planning includes developing outcome goals for each life domain strategy with timelines as well as for ancillary services and ultimately for the **care plan**. The DCBS social worker and Amy ask about the possibility for Enrico to move in with his Aunt Mia, who lives close to his family. Enrico and his Aunt Mia agree that would be an acceptable discharge option as long as he remains engaged in behavioral health services to address his behaviors. Additionally, appropriate wraparound services would need to be in place to support him in this kinship placement.

Our focus centers on providing access to care and social determinant resources supporting kinship care whenever possible over foster care. We believe relatives are the preferred source of care for children who must be removed from their birth parents as kinship care maintains familial connections for the child and achieves the following:

- Provides birth parents a sense of hope that they will still have a connection to the family
- Allows a child to form a trusting relationship more easily in contrast to an unknown foster family
- Provides the child with access to cultural beliefs, practices, and traditions

Amy understands her role is to facilitate uninterrupted and seamless care between care settings, effectively communicate between providers, identify unmet needs, and address those needs. When Enrico

is ready to be discharged, Amy implements the following practices to facilitate the safe transition of Enrico from the group home to his Aunt Mia's house:

- Provides care coordination by supporting and arranging services for Enrico, Aunt Mia, his parents, and providers as soon as the transition is identified and continuing through the transition period as indicated based on Enrico's and the family's needs
- Collaborates and communicates with Enrico, Aunt Mia, his parents, advocates, his usual providers, any sending and receiving providers, and other CCT members throughout the transition process
- Reassesses Enrico's needs and the appropriateness of an existing care coordination plan post transition, modification of that plan as indicated, and discussion of changes with him and the CCT as indicated by Enrico's needs but no later than 30 days post-transition
- Conducts medication reconciliation after transition between care settings, documenting each medication with Enrico, Aunt Mia as his guardian, and his parents and communicating any identified discrepancies with the appropriate provider(s)
- Connects with Enrico's former teacher to provide weekly in-home tutoring to help him get back on track with his educational goals

c. Language Accessibility

Aetna strives to understand the cultural and linguistic needs of our enrollees. This understanding enables us to provide culturally competent services and the ability to assess where disparities in health care outcomes exist. Enrico's parents speak Spanish and he has been serving as an interpreter for them when talking with health care professionals, school officials, and law enforcement when he was arrested. Aetna does not support the use of children as interpreters for their parents in such critically importation conversations as these. We will employ Kentucky SKY personnel with bilingual skills as well as using language interpretation lines to ensure full involvement of any family member who speaks another language. Amy assesses Enrico's need for interpreter services himself and makes sure he understands he has access to interpreter services at no cost during any of his appointments and CCT meetings for himself, or for his parents. Aetna provides written materials, including our website, at a sixth-grade reading level (as determined by Flesch-Kincaid readability tests). Our communications are culturally aware, accommodating of special needs, and inclusive of diverse communities. All enrollee materials are translated and available in Spanish.

d. Psychotropic Medications and Documentation in Medical Records

Enrico has been prescribed two psychotropic medications at high dose and has not been evaluated in over a year. Amy requests medical records from known prior providers, with the DCBS social worker's permission, to determine who prescribed the medications over a year ago. With the DCBS social worker's consent, Amy contacts a child psychiatrist to make an urgent appointment for Enrico, by means of Aetna's value based contracted network of trauma informed providers. The child psychiatrist will assess any immediate actions needed related to the psychotropic medications, including efficacy of medications, diagnosis, and assessing for any side effects Enrico may be experiencing. The child psychiatrist will also conduct a comprehensive evaluation and diagnosis and recommend follow-up assessment, and we will offer evidence-based clinical practice guidelines (CPGs) for prescribing psychotropic medications for youth from nationally recognized sources (which can be found on our provider resource tab of the Aetna Kentucky website). Amy also schedules an integrated health care provider visit to address any Early and Periodic Screening, Diagnostic and Treatment (EPSDT)-related services, monitor his asthma symptoms, and address his body mass index of 25. According to Turney and Wildeman, children placed in foster care were twice as likely to be diagnosed with asthma (18.0 percent vs. 8.7 percent) and obesity (24.1 percent

vs. 15.7 percent)[16]. Documentation in his medical record is the responsibility of each medical care professional and follows Medicaid EPSDT policies and protocols, and these records will be accessible to Amy, with permission from the DCBS social worker, to integrate any medical needs into his care plan.

e. Evidence-based Psychotherapeutic Interventions

Amy referred Enrico to a behavioral health (BH) provider trained in trauma-informed care to address his history of trauma and behavioral issues. Additionally, the BH provider will address his experimentation with drugs and alcohol and his feelings of loneliness. Recognizing that Kentucky SKY is a holistic, person-centered and trauma-informed model of care and based on Enrico's clinical and SDOH needs, the therapist recommends using and trauma-focused cognitive behavioral therapy and a referral for a peer support specialist, to best assist him in meeting his care plan goals and long-term vision.

f.-g. Social Determinants of Health and Community Resources

Enrico, his parents, and Aunt Mia will be fully involved in the assessment of his strengths and unmet needs across multiple life domains as will his family. A dynamic care plan will be developed with him addressing needs in health/family/education/restitution/vocation/social/recreation, and cultural preferences. Amy facilitates a discussion to help prioritize their goals and needs in Enrico's care plan. Amy is trained in utilizing the SDOH Health Care Equity Event in our care management system. This SDOH event was developed based on the Healthy People 2020 report and aligns with the **Kentucky State Health Improvement Plan**. Screening for Enrico and his family's needs regarding SDOH includes identifying root causes of the SDOH, assessing the family dynamics, and resolving barriers to achieving Enrico's and the family's goals. After the care plan is developed and resource needs are identified in each life domain, CCT members commit to resourcing tasks with deadlines and reminders between CCT meetings. Amy informs Enrico and his caregivers, group home, aunt, and DCBS social worker of the following community resources available to address the identified SDOH needs and meet their goals, as illustrated in **Table G.13-9**:

Table G.13-9: Community Resources Available to Enrico

SDOH Gap	Community Resources
Family supports	• St. Rita's church—provides supports for Hispanic families within the community • Americana World Community Center—provides family supports for diverse, low-income communities in Louisville • Big Brothers Big Sisters • Link family to National Alliance on Mental Illness for family supports • Peer supports for both Enrico and his parents to address feelings of hopelessness and possible reunification of the family • State interagency council provides youth peer support services for our youth enrollees with involvement of the DJJ • Bounce Academy—the Building Resiliency in our Community's Kids (BRICK) program—identify opportunities in community for kids to attend this program • Health literacy courses
Financial	• Assess Enrico's and his family's economic situation and identify areas of need, such as housing, food insecurity, childcare, employment, transportation

[16] Turney, Kristin and Wildeman, Christopher, "Mental and Physical Health of Children in Foster Care," AAPublications, 138(5) (2016): accessed June 20, 2019; https://pediatrics.aappublications.org/content/138/5/e20161118.

SDOH Gap	Community Resources
Education/ Vocation	• Assess the possibility of Enrico enrolling at the West End School that focuses on kids with behavioral needs • Identify mentoring opportunities for Enrico from coaches, teachers, other positive role models • Identify opportunities to participate in vocational training to provide employment opportunities post high school
Social/ Recreation/Culture	• Identify opportunities to participate in sports and extracurricular activities to provide exercise and appropriate socialization • YMCA for community social integration opportunity for the children in the family • Family member takes Enrico to church, family celebrations, and community events • Enrico can provide service to his own community which capitalizes on his translation skills

h. Aging Out of Foster Care

Enrico and his family will transition to the next experience of life together within their own family and community circle. This transition will be discussed at the beginning of Kentucky SKY enrollment as this vision of success is the overarching goal of the care plan and should drive all interventions and timelines. The care plan will be measured against whether Enrico and his family have achieved their vision. Services and supports will be identified for ongoing support of Enrico's health and those referrals and linkages will be assisted by CCT members moving Enrico toward graduation from intensive system involvement.

Enrico has indicated he is unsure about his future when he turns 18. When he discharges from the group home to live with his Aunt Mia, he will be in kinship foster care and can remain in the program until the age of 26. His DCBS social worker educates him about the benefits of remaining in foster care after he turns 18, such as continued support and monitoring of his transition plan by Amy to make sure his needs are being met and he has continued access to services and supports as identified in the transition plan. Enrico's transition plan will include his education and employment-related goals and will identify resources to assist him in attaining these goals. The transition plan will address Enrico's needs related to housing, education, employment, finances, transportation, and community integration. Once Enrico has finished high school or attained his GED, he will be able to apply for a scholarship to attend the Kentucky Community and Technical College Systems, or other state community colleges, through the **Work Ready Kentucky Program**. The partnership provides tuition-free access to over 350 programs across Kentucky to prepare individuals for a career.

As Enrico approaches adulthood, Amy will inform him about skills training provided by Aetna across the Commonwealth on topics such as housing, finance, education, employment, and socialization. Amy refers Enrico to **Getting on T.R.A.C.K—Transition Ready Assistance & Core Knowledge**. This health literacy program is designed specifically for young adults transitioning out of the foster care system. As Enrico nears the age of 18, Amy will work with him and his CCT to identify adult providers and make a warm handoff to transition him from any pediatric providers to adult providers as necessary.

i. Access to and Sharing of Medical Records

Aetna Kentucky SKY will actively address the current barrier to electronic health records access shared across Enrico's providers. Amy, with permission from his DCBS social worker, has access to the TWIST, which is a data repository for youth involved in the DCBS systems. In addition, in the care planning process for Enrico, Amy, once again with permission, will use the Kentucky Health Information Exchange (KHIE) to pull down any relevant information related to Enrico's history and past services and interventions.

Amy will outreach, in person, telephonically or via secure email to identified prior providers of Enrico to gather historical health information for his medical record, with the permission of the DCBS social

worker. She will share pertinent information during CCT meetings to guide assessment and care planning. Aetna stores Enrico's health information, including Aetna claims history, in one system which is available to providers. Amy educates Enrico's providers how to request access. Additionally, each member of the CCT, with the DCBS social worker's permission, will receive copies of his care plan. As the KHIE continues to expand the information available and accessibility to providers, Amy will use the KHIE to gather historic and current health information about Enrico to inform his care planning.

j. Maintenance of the Care Plan

Enrico, Aunt Mia, his parents and others identified in his circle of support (including his teachers) will be directly involved in the content of the care plan to ensure voice, choice and preference each step of the way during care. Collaborative documentation may be employed as Kentucky SKY personnel integrate remote access out in the field. Amy reviews Enrico's care plan at least monthly with Enrico and the CCT to ensure that progress and concerns are captured and that the care plan is updated accordingly based on feedback from Enrico and his CCT. Amy will also update the care plan if Enrico experiences a significant change in condition or status, including physical or behavioral health, formal or informal support needs, and/or SDOH. Amy contacts or visits Enrico to address the root cause of the change in condition or status and stabilize the home environment with services and supports if appropriate. As Amy works with Enrico to meet his goals, she will identify and use all available resources including budgeting, how to access health care and information on accessing his medical records. Amy encourages Enrico and the CCT participants to contact her with any needs or changes in condition. Additionally, each participant of the CCT, with the DCBS social worker's permission, will receive copies of his initial care plan and updates.

Outcomes

Enrico remained actively engaged with his circle of support and continued with the services and supports prioritized with his CCT. After six months in the group home, he transitioned to his Aunt Mia's home. He has regular visits with his parents and siblings. His medications were discontinued due to his improvement, but he continues to be monitored closely by his integrated healthcare provider in the case that the need for psychotropic medications re-emerges. Trauma treatment and focus on reunification with his family provide symptom relief and remain an ongoing support for Enrico and his family to ensure long term success. He is self-managing his asthma medications and has had no emergency department visits or hospitalizations. He is still in high school and he plays baseball and has enrolled to start vocational classes during his senior year to become a welder. He has made friends on the baseball team and is active socially and physically, which has helped with his weight. He continues in care coordination and is very excited for his senior year of high school and a bright future with his family and community supporting him all the way!

60.7.G.13 Use Cases for Kentucky SKY: USE CASE 6

Our care coordinators listen, understand, and intervene early and collaboratively to address each foster child's needs—assuring Mary has a safe and nurturing home and community. We do this by assuring foster children and families have the support needed to thrive and experience personal well-being by offering integrated care coordination, grounded in comprehensive, whole-person, evidence-based practices for children with special health care needs, and innovative, local programs that address the unique needs of foster families.

Mary's Needs and Capabilities

Mary is a young child who is deaf, has significant communication delays, cognitive delays, and flat affect, impacting her ability to interact with her foster family, and she is experiencing dental and nutritional issues. Mary's immediate needs include assessment of deafness and hearing, development of communication, immediate, ongoing healthcare assessment and intervention, and opportunities to build caring, lasting relationships including at school, during play, and family reunification.

Collaborative Solution

Aetna uses **best-in-class approach to person-centered planning, Charting the LifeCourse™ framework**[17]—based on the core belief that **all people have a right to live, love, work, play and pursue their life aspirations in their community**—to guide assessment, care planning, and care coordination tasks. **Table G.13-10** provides a high-level outline of the interventions Aetna's care coordinator facilitates to support Mary and her family.

Table G.13-10: Summary of Aetna Care Coordination for Mary

Needs	Interventions
Whole-Person Health	• Referral to access services for deafness, hearing aids and/or cochlear implant and coordination of needed communication supports • Referrals for physical health assessment and intervention including primary care, dental, nutritional, and speech therapy services • Referral for behavioral health assessment and interventions • Referral for cognitive assessment • Referral for care coordination and substance-use services for Mary's mom
Communication	• Immediate assessment of deafness, hearing aids, and/or cochlear implant and referral to appropriate services • Referrals for communication support, for example, American Sign Language (ASL) education, communication board, and training for foster parents by Kentucky School for the Deaf outreach coordinator
Education	• Coordination for an Individualized Education Program (IEP) and appropriate school-based resources that support community inclusion
Family	• In-home equipment that supports Mary's safety • Referrals linking foster family to Kentucky DeaFestival • Transitional support for family reunification
Social Determinants of Health	• Referral to Community Health Worker at Aetna's Unite Us program • Freedom House support for Mary's mom

[17] University of Missouri Kansas City (UMKC) Institute for Human Development, "Charting the LifeCourse™ Framework", UMKC (2017): accessed June 25, 2019; http://www.lifecoursetools.com/principles.

a. Care Management and Coordination of Multispecialty, Developmental Evaluations and Care

When Mary was moved to her foster home in Louisville, her Department for Community Based Services (DCBS) social worker, Dee, contacts Bob, a licensed clinical social worker, on Aetna's integrated Care Coordination team (CCT) to make a referral. **Dee knows Bob and Aetna's Care Coordination team well** and leverages that collaborative relationship to connect Mary to services. Bob is an **experienced care coordinator** who was previously employed as a coordinator in a youth advocacy agency. Bob has been with Aetna for eight years. His initial position was a representative in Aetna's Enrollee Services department. Bob completed his master's degree in Social Work and was promoted to a care coordinator position. Bob is aware that foster children qualify as children with special health care needs, and he coordinates with Dee to assure Mary's enrollment in Aetna's **Intensive Care Coordination services**. At the time of enrollment, Bob contacts Mary's foster parents, Joe and Sue, to welcome them to the program, explain intensive care coordination services including access to a **multidisciplinary team** of experts. Bob states he would be the **single point of contact**—accessing other team participants when their expertise was needed—and collaborating with other parts of the foster care system including DCBS, any new providers, and the school. Bob explains the first step is to get to know the family and what they need. He asks Joe and Sue for their preferred date, time, and location for scheduling a visit, and explains what will happen in that first visit—he will facilitate an **enrollee needs assessment (post-health risk assessment) specifically designed for Aetna foster children and their families**—making certain he captures all the family's needs. Bob asks Joe and Sue if they have a primary care provider (PCP) for Mary. If they do not, he assists selection of a **trauma-informed PCP** in Aetna's network based on their preferences – and explains it is critical to approach Mary's care holistically, with consideration for her emotional needs as well.

Prior to the initial visit, Bob reviews health record information in **FamilyConnect,** which includes data from The Worker Information System (TWIST) and calls Dee with follow-up questions. Dee states Mary was born at Norton Hospital and advises that she would like the CCT to explore family reunification. During the initial visit, Bob starts the conversation by **welcoming the family to the program**, introducing himself, and reviewing all contractually required items such as enrollee rights, enrollee grievance and appeals, and how to contact Aetna including his direct contact information. Bob provides an **overview of Intensive Care Coordination services—**how to use services and how eligibility works—and answers any questions the family has. Bob is trained in **trauma-informed care**—an approach that involves listening empathically using guiding principles of safety, choice, collaboration, trustworthiness, and empowerment. He listens compassionately to Joe and Sue describe the family experience with Mary in the home. Bob validates their feelings and assures that he is here to provide support and connection to resources. Bob asks Joe and Sue to describe a typical day with Mary, informally assessing her functioning and activities of daily living. Joe and Sue appear hesitant to describe how difficult it has been. Bob is an excellent listener who has been trained in **motivational interviewing**——techniques such as active listening and validating feelings. After some listening, validating, and discussion, he is able to elicit Joe and Amy's true feelings of fear, concern, and a strong desire to care and support Mary.

Bob describes how the care planning process works and explains that meetings involve a multidisciplinary team comprised of Mary, Joe, Sue, and eventually, Mary's providers, a representative from her school, and anyone else important to Mary's well-being—her **circle of support**. He explains this is part of Aetna's **System of Care (SOC) model**—an approach that provides a 'virtual team' which focuses collaboratively on the family's needs, working together to address gaps and assure resources are available. Bob explains that Joe and Sue are the **voice** that helps the team understand Mary's needs, priorities, and care. He explains Aetna's approach is **holistic and integrated**—all the family's needs from hearing assessments and accommodations to medical services to connecting Mary to a school and family. Bob asks about dates, times, and a preferred location to schedule the first CCT meeting. He asks about the

family's informal supports—other family members, friends, caregivers, or any one significant in Mary's life, and invites Mary's circle of support to the CCT meeting.

Bob is extensively trained in **foster care approaches and best practices**, including using the **Charting the LifeCourse framework.** Bob discusses family reunification with Joe and Sue and explores the type of supports Mary would need to successfully transition to her biological mother's home. He explains guiding principles in the LifeCourse framework—including building a **positive life trajectory** for Mary through discussions about her needs, likes, strengths, and abilities. Bob brought some age-appropriate toys with him to the visit—a technique he learned in **Aetna's training on best practice guidelines for engaging young, foster care children.** Bob sits on the floor where Mary is playing and spends some time playing with Mary and the toys.

During the flow of informal questions, Bob uses age-relevant, **evidence-based assessments tailored to the specific needs of Aetna's foster care population** and appropriate for Mary's deafness, and coordinates referrals for multispecialty, developmental assessments. He gathers additional detail from Joe and Sue, while observing Mary playing, including the following:

- Mary's clinical history, hearing, communication, and other condition-specific needs, activities of daily living, behaviors, and functional status
- Child and Adolescent Needs and Strengths Scale (CANS)[18]
- Level of behavioral functioning using the Pediatric Symptom Checklist (PSC-17)[19]
- Psychosocial issues—Joe and Sue's beliefs, preferences and perceived barriers; linguistic, cultural and spiritual needs and preferences; and family strengths, informal family supports, and family needs

Bob explains that he will begin **researching Mary's medical history** starting with records from Norton Hospital where she was born, assuring he puts together a record the foster family can use for her care. He explains most Kentucky hospitals perform congenital hearing tests at birth, and congenital hearing tests—paired with a request from Aetna to pull a claims report on Mary's service history—are a good place to start addressing Mary's hearing needs. Bob asks if Mary has been scheduled for an appointment with her PCP. He states Mary needs a full medical evaluation to address her physical, cognitive, nutritional, and hearing needs, immunizations, and assessments for any other physical health issues. He assures Joe and Sue have a scheduled appointment and transportation to the appointment before the end of his visit. Lastly, Bob explains his role in coordinating care for family reunification. He states he will be Joe and Sue's single point of contact, assuring he communicates all updates.

b. Discharge Planning for All Levels of Care

Bob facilitates frequent care coordination meetings to address Mary's concerns. The CCT has prioritized her concerns as follows:

- Immediate assessment and referral for physical, dental, and nutritional health needs
- Assessment of hearing needs and hearing aids or cochlear impact and referrals for appropriate communication support including sign language support for Mary's foster parents if needed
- Assessment of cognitive delays and appropriate referrals
- Screening and referral for trauma-informed, behavioral health services
- Coordination of IEP eligibility evaluation and appropriate education placement, services and supports

[18] The National Child Traumatic Stress Network (NCTSN), "Child and Adolescent Needs and Strengths (CANS)," NCTSN: accessed June 25, 2019; https://www.nctsn.org.

[19] Gardner, William and Kelleher, Kelly, "Pediatric Symptom Checklist (PSC-17)", (1999): accessed June 25, 2019; https://www.prohealthmd.com/windhampediatrics-dev/wp-content/uploads/sites/25/2015/01/PSC-17.pdf.

- Once immediate needs are addressed, exploration of family reunification including addressing biological mom's needs and SDOH

Bob calls Sue on the same day of Mary's PCP appointment to inquire about his recommendations. Sue advises that the PCP recommended reassessment for Mary's hearing by an audiologist, a speech and language therapist, an ear, nose, and throat (ENT) physician, and assessment by a registered dietician. Bob assists in coordinating the appropriate arrangements and as assessment information is shared, shares information with Mary's school. This includes arranging for an assistive technology evaluation. In addition, Bob helps Mary's foster parents explore whether Mary is a candidate for a cochlear implant or hearing aids. A referral for speech therapy will be expedited and a determination will be made whether she needs communication support devices or ASL education. If the cost for a communication device is greater than $500, Bob coordinates with Aetna's Utilization Management (UM) department to secure prior authorization, assuring timely delivery to the family.

Assessment is ongoing, and Bob monitors and coordinates Mary's needs continuously amongst the care team. He assures Joe and Sue have the support and resources needed to increase the family's chances of achieving communication care plan goals. For example, he contacts Joe and Sue following delivery of the communication device and asks about their comfort and ability to use the device and offers additional support as needed. Bob works closely with Mary's school, making sure appropriate communication resources are in place. If appropriate, Bob coordinates for special education evaluation, referral to related services, and development of an IEP.

Mary's **PCP is a trauma-informed practice**—Aetna has provided education on understanding the impact of toxic stress and trauma on health and wellness, the use of trauma screening tools, and when and where to refer. Sue states Mary's PCP recommended a behavioral health assessment for further understanding of Mary's flat affect and behavioral health needs. Bob educates Joe and Sue about Aetna's provider network, that there are several trauma-informed providers who use evidence-based assessments and interventions effectively. For example, Mary may need evaluation and intervention for attachment issues including approaches such as **Play Therapy**[20]—therapeutic play that aids children with social and emotional deficits to communicate better, develop problem solving skills, and positively relate to others, and **Circle of Security**[21]—a program for parents and children which emphasizes relationships. Bob monitors all provider needs, assuring each provider has support necessary to work with Mary's deafness e.g. assuring the behavioral health provider can navigate a communication device, and linking providers to the audiologist or speech therapist as needed. Bob asks Joe and Sue if they have a preferred pediatric dental provider for Mary. He refers to **Avēsis dental network**—Aetna's preferred dental network for children under age 21, and shares a second referral, **Aetna Better Care Smile KY Program—**a partnership with the University of Louisville Dental School that offers free mobile dental clinics and screenings to elementary children, an Aetna value-added service. He assists in selection of their preferred provider including scheduling appointments and transportation and assures the dental provider and registered dietician resolves Mary's malnourishment.

Bob delivers an Aetna birthday box to Mary on her birthday—party supplies, balloons, puzzles, games, and a large cupcake—an Aetna value-added service.

Bob asks the CCT to share findings from Mary's recent provider assessments and elicits detailed feedback from Joe and Sue, who describe Mary's typical day. The CCT identifies the need for **safety**

[20] Play Therapy International (PTI), "How Does Play Therapy Work?," PTI, (2018): accessed June 25, 2019; http://playtherapy.org.
[21] Circle of Security International, "An Early Intervention Program for Parents and Children," Circle of Security International: accessed June 25, 2019; https://www.circleofsecurityinternational.com,.

equipment appropriate to Mary's deafness e.g. fire alarms in the home environment. Bob makes a referral for in-home, safety equipment to a durable medical equipment (DME) provider, coordinates with his UM department on the authorization, and notifies Joe and Sue once authorized the name and contact information for the DME provider.

Bob uses the **LifeCourse framework to** guide discussion about Mary's communication needs and reminds of her right to live and play in a meaningful way in her community. He elicits ideas from the CCT on how she is functioning at school and home, emphasizing the importance of learning what she likes and desires, as she communicates more effectively with her family over time.

Planning for Mary's transitions is a critical component of Mary's care. After Mary's immediate needs are addressed, Bob asks Dee to share some detail about Mary's mom and this goal. Bob understands that we increase Mary's opportunity for successful reunification by supporting Mary's mom with appropriate treatment, support, and removal of barriers that impact her ability to engage in health care including SDOH—housing or lack of food. If not already enrolled, and family reunification is a care plan goal, Bob and Dee assure Mary's mom is assigned to intensive care coordination services. Dee provides updates on Mary's mom during Mary's CCT meetings, for example, that she referred Mary's mom for substance use treatment, and that she is progressing well. The CCT plans for Mary's **transition** to reunifying with her mom by identifying what Mary and her mom need to be successful such as teaching Mary's mom how to use the communication device or ASL, assuring coordination of Mary's physical and behavioral health needs, addressing housing instability, assuring DME, understanding and participating in Mary's IEP, strengthening her engagement and parenting skills, and linking her to community resources.

c. Applicable Evidence-based Practices

Aetna supports the following additional evidence-based practices for Mary's care as outlined in **Table G.13-11.**

Table G.13-11: Evidence-based Practices for Mary

Holistic Support		
• Access to communication supports • Evidence-based, proprietary assessments	• Motivational Interviewing • Circle of Security • Trauma-informed care	• Assistive technologies • Play Therapy • Address biological mom's SDOH needs

d. School-based Services

Bob coordinates the referral for Mary's IEP eligibility evaluation. If eligible, he assures Mary has the necessary services and support, and distributes updates regularly to Mary's Care Coordination team. Bob participates in all IEP meetings making certain the IEP is developed and aligned with Mary's care plan, eliminating duplication where needed. For example, if Mary needs assistive technology, Bob assures the right technology for Mary's needs is used in all her environments. Bob assures that Mary attends school in the most integrated school environment possible, assuring community inclusion, and if that is not possible, coordinates for a specialized school based on the IEP team decision. He makes certain the foster family's preferences and needs are prioritized as school coordination occurs in the IEP. When the family reunification goal becomes a reality, he also assures Mary's mom participates in Mary's IEP and that her preferences are communicated and prioritized.

> Aetna Better Living offers no-cost, backpack filled with school supplies for foster care children enrolled in Aetna services. This value-added service is available to foster care youth who are referred by their school-based family resource coordinator.

e. Social Determinants of Health

As it relates to the family reunification goal, the CCT discusses Mary's mom history of moving from place-to-place, relation to her drug use, and the lack of food typically present in her past home environments. The team

identifies **Freedom House**, a holistic and comprehensive program that offers sober living, twelve step support, and training for life skills such as cooking and healthy eating habits. Bob assures he has regular updates on progress, and shares updates with Mary's team. When appropriate, he assists Dee in community resources and support for Mary's mom.

f. Community Resources

As Mary improves in social development, communication, and emotional expression, the foster family identifies a need to be connected to and included in the deaf community—they would like to support Mary in making some friends. Aetna is committed to Kentucky SKY—our transformative vision drives our model for enhanced care coordination supporting each child in foster care. Bob connects Joe and Sue to the **Aetna Kentucky Wellness Center** where our **locally based community health worker (CHW)** is available to help. Our CHW meets with Joe and Sue and assess needs—for each family member individually. Our CHW connects Joe and Sue to our **fully integrated social network, Unite Us.** Aetna, in collaboration with the Unite Us and the local, established network, operate as a 'hub-and-spoke' model, offering a distinct, effective way to make sure the foster family is connected to appropriate community resources. Through the CHW and Unite Us, Bob is able to link Joe, Sue, and Mary to the **Kentucky Annual DeaFestival** and other support such as outreach and parent education on hearing loss by the **Kentucky School for the Deaf.** As family reunification becomes a reality, the CCT identifies a need to continue supporting Mary's mom sober living and life goals. Bob coordinates appropriate referral with the **Freedom House** coordinator such as support for job placement or meal planning skills and assists to identify resources that support her goal when needed.

g. Access to and Sharing of Medical Records

To support continuity of care, Bob uses **FamilyConnect,** the shared, electronic health record Aetna implemented in collaboration with DCBS, the Kentucky Health Information Exchange (KHIE), and providers which serves as the single source of truth for youth and their circles of supports. Bob shares assessment and medical record information in FamilyConnect as often as change occurs. Mary's foster parents, circle of support, providers, and DCBS can easily access FamilyConnect at any time 24/7/365 using Aetna's web-based portal or mobile application. FamilyConnect integrates data from TWIST and KHIE, providing the care team a near, real-time, holistic view of Mary's unique needs.

h. Maintenance of the Care Plan

Bob is the **single point of contact** for Mary's care plan. He reviews the care plan with Joe, Sue, the school staff, and the Care Coordination team at least monthly, making certain continued focus using the LifeCourse framework, and progress, barriers, changes in needs, and concerns are monitored and documented. Bob updates FamilyConnect any time there is a change in Mary's needs, as requested by Joe or Sue, per contract requirements, and at minimum, annually. If there is a significant change, Bob conducts an in-person visit with Joe and Sue and/or the school to assure reassessment and updates the care plan in FamilyConnect.

Outcomes

Aetna's transformative, evidence-based care coordination and best-in-class foster care approaches promote timely, quality-driven outcomes for our most vulnerable youth. Bob's care coordination and Aetna's integrated, comprehensive services have helped Mary and her family understand each other and interact in a meaningful way. Mary is developing communication skills, interacting with her foster family, and participates in school. The foster family has the communication support and resources they need as a strong, loving family. Mary's mom is making progress in treatment with a future transition to sober living and reunification with her daughter. Future strategies include continued transition planning and support for family reunification.

60.7.G.13 Use Cases for Kentucky SKY: USE CASE 7

Our **care coordinators listen, understand, and intervene early and collaboratively** to address each foster child's needs—assuring Julie has a safe and nurturing home, a supportive community, and opportunities for resiliency. We do this by assuring foster children and families have the support needed for to thrive and experience personal well-being by offering integrated care coordination, grounded in comprehensive, whole-person, evidence-based practices for children with special healthcare needs, and innovative, local programs that address the unique needs of Julie and her circle of support.

Julie's Needs and Capabilities

Julie is an adolescent girl transitioning to adulthood who has a long-standing history in foster care, an intellectual disability, emotional instability, and does not seemingly have connections to friends, family, or her community. It would be hard for any youth to go through the foster care system, but having a disability makes it more difficult for Julie to understand what is going on in her life. She needs someone she can trust, talk to, and who can explain in a way that she can understand. Julie is prescribed multiple anti-psychotics and there is a critical need immediately assess and find the appropriate medication regimen and psychotherapeutic interventions. She also needs support navigating legal and juvenile justice systems and communicating with her court designated worker (CDW).

Collaborative Solution

Julie, as an individual with developmental and intellectual disabilities (DID), deserves a care team that approaches her needs holistically and using person-centered planning, has knowledge of the law, services, and supports that individuals with DID need as they transition to adulthood from the child welfare system. Aetna's collaborative solution for Julie includes engaging Julie, building trust, finding her circle of support, and assuring immediate and ongoing, comprehensive assessment of her whole-person needs including understanding the circumstances around her aggressive episode and incarceration. The first and immediate priority is to engage all providers in a comprehensive medication reconciliation process with the goal of assuring appropriate medication prescribing and achieving safer, more appropriate care. Additional solutions include transition to adulthood planning including residential and community supports appropriate to Julie's needs and connecting to waiver services and adult Supplemental Security Income (SSI) benefits. Aetna uses evidence-based clinical practices and Charting the LifeCourse™ framework[22]—a best-in-class approach to person-centered planning all people have a right to live, love, work, play, and pursue their life aspirations in their community—to guide the assessment, care planning, and care coordination tasks for Julie. **Table G.13-12** provides a high-level outline of care coordination interventions.

[22] University of Missouri Kansas City (UMKC) Institute for Human Development, "Charting the LifeCourse™ Framework, UMKC, http://www.lifecoursetools.com/principles, accessed May 2019.

Table G.13-12: Summary of Aetna Care Coordination Interventions for Julie

Needs	Interventions
Whole Health Needs	• Rapid enrollment via Aetna's juvenile justice liaison into Aetna's Complex Care Coordination services • Immediate and ongoing assessment and reconciliation of Julie's medication regimen • Immediate physical, behavioral, developmental, emotional, and social assessments and interventions that guide decision making for levels of care and support • Referral for trauma-informed, behavioral health (BH) services and peer support • Aging-out/transition planning including referrals to Kentucky DID programs and health literacy support including an Aetna laptop with developmentally appropriate features • Use of the LifeCourse framework to guide coordination with DID services • Eligibility evaluation for DID programs and benefits such as waiver services or SSI/SSDI
Education	• Coordination with school systems for development of an Individualized Education Program (IEP) including participation at the Admissions Release Committee (ARC)
Social Determinants of Health (SDoH)	• Referral to Aetna CHW and Unite Us Wellness Center • Aetna value-added service (VAS) duffle bag upon enrollment
Family	• Use of Family Finding framework to identify Julie's family and circle of support

a. Care Management

Julie is new to Aetna's Kentucky SKY program. When Julie was briefly incarcerated, Aetna's juvenile justice liaison, contacted Ray, her Department for Community Based Services (DCBS) social worker, to recommend rapid enrollment into Aetna's Complex Care Coordination services. The juvenile justice liaison contacted Pam, an Aetna licensed professional counselor and Julie's assigned care coordinator for rapid initiation of Complex Care Coordination services. Pam has been employed as a care coordinator for three years. She is an **experienced care coordinator** with nine years of previous employment working as a therapist for residential and in-home, youth services. Pam is aware that foster children and children who are DID are considered children with special health care needs. On the day of enrollment, Pam reviews Julie's health information in DCBS' The Worker Information System (TWIST) and relevant medical and BH information that the DCBS social worker has shared via access to **FamilyConnect, the shared, single electronic health record** that Aetna and DCBS implemented for Kentucky SKY foster care coordination. Pam calls Ray to gather additional information about family involvement, and names and contact information for the residential facility. She advises Ray of the need to immediately address Julie's clinical condition and medications, asking Ray to sign releases of information for Julie's current providers. Pam contacts the residential facility social worker that same day, and speaks to Kim, Julie's social worker, and Julie's CDW, advising of rapid enrollment into Complex Care Coordination services. She gathers initial information, including the name and contact information for Julie's psychiatrist, and asks for the first available meeting date and time to schedule an in-person visit with Julie and a care planning meeting.

c. Prescribing Psychotropic Medications and Documentation in Medical Records[23]

Given that Julie was prescribed multiple medications without access to psychotherapy services, Pam assures immediate attention and planning regarding this issue. She facilitates and addresses all clinical discussions about Julie's medications, drug interactions, side effects, and changes in behavior and emotional reactivity. She invites all current prescribers to participate in Julie's care coordination meetings. Since the use of multiple medications may be an underlying, contributing factor to Julie's mood and behavioral issues—especially if Julie's intellectual disability affects her ability to communicate—careful attention and prioritization for this care plan goal occurs first in each care planning meeting.

[23] Please note the order of items b. and c. are reversed in our narrative to set up Julie's discharge planning.

Pam has received extensive training on the national and Kentucky-specific phenomenon that children prescribed multiple, anti-psychotic medications are at risk for drug-to-drug interactions that can impact an individual's emotional and physical health, and cause serious health concerns such as weight gain, metabolic disorders, and extrapyramidal side effects. She makes a referral to Aetna's **clinical pharmacy advisor** for participation on Julie's Care Coordination team (CCT) and oversight of medication reconciliation. The clinical pharmacy advisor's role includes reviewing prescriber history using current and historical claims data, establishing a multidisciplinary team meeting with Julie's current prescriber, recommend discontinuation of clinically inappropriate medications, and coordination with the pharmacy providers—cancel any auto-refill of discontinued medications, education on documentation standards in the medical record, and resolve barriers to authorization such as assuring medications prescribed align with Aetna's formulary as needed. She engages the help of the **Community Pharmacy Enhanced Services Network (CPESN)**, a specialty network of pharmacies that aid in medication adherence and care coordination, and coordinates efforts for selection of a local pharmacy that will participate in Julie's needs across levels of care. Pam assures medication reconciliation is thoroughly documented in the **shared, single electronic health record** created for Aetna's foster children, and distributed to all care coordination team members.

During face-to-face visits, Pam spends time talking with Julie, getting to know her, and inquiring about her clinical, social, and emotional needs using informal, open-ended questions that Julie can understand, taking into consideration her developmental needs and ability. Pam explains **Complex Care Coordination services**—how to use services and answers any questions Julie has. She explains about the **interdisciplinary care team (Care Coordination) meetings**—a collaborative process where Julie and her providers and supports, Pam, Ray, and Kim, help Julie identify anyone else she feels is important in her life. Pam explains that she is there to help her address all her needs whether it's about care at the residential facility or personal goals she has such as how to cook. Pam initiates the CANS-DP-ASP Child and Adolescent Needs and Strengths Developmental Profile version with Julie in order to help develop the holistic team approach. Completion of this assessment tool will allow for communication of this shared vision for use at all levels of Julie's care and is meant to guide and establish priorities. This includes what she needs and what is important to her as she transitions to an adult.

Pam is extensively trained in **foster care and DID approaches**, including using the **Charting the LifeCourse™ framework**. She explores what Julie wants for her life—**her positive life trajectory**—capturing past dreams and future aspirations, supporting Julie to fully participate in the discussion about her strengths, abilities, desires, needs, struggles, and friendships. Julie is guarded and hesitant, not sharing personal information. Pam uses her skills learned in **motivational interviewing**—a counseling approach that involves identifying feelings and validating experiences to build trust. Pam schedules as many face-to-face visits as necessary to develop a rapport and build trust with Julie—communication is essential to collect Julie's full story and develop a comprehensive understanding of Julie's complex needs.

During the flow of asking informal questions, Kim uses her evidence-based assessments tailored to the specific needs of the Kentucky SKY and DID population to gather additional details including use of the following assessments and strategies for collateral information:

- Health and condition-specific issues—what Julie remembers about the providers who prescribed her medications and what Kim or the residential psychiatrist knows
- Activities of daily living and functional status
- Review of available files to determine most recent Wechsler Intelligence Scale for Children (WISC) and adaptive testing and assessments necessary for application to adult services including SSI/SSDI
- Health literacy and psychosocial issues—Julie's values, beliefs and perceived barriers
- Linguistic, cultural, and spiritual needs and preferences
- Visual and hearing status, needs, and preferences
- Connection to school, school-based resources, and school functioning

- Experience with DCBS involvement
- Friendships and connections to the community
- Assistance for Ray with the application for Supports for Community Living (SCL) waiver
- Assurance that a physician's statement from a qualified professional is secured for treatment, collaborating with CMHC staff
- An invitation to the CMHC representative to CCT meetings
- Options for guardianship, alternatives to guardianship, and incorporate qualified legal counsel to the CCT as needed

b. Discharging Planning All Levels of Care

After several meetings with Julie, Pam learns Julie has developed a close friendship with Nikki in her current residential placement. Pam recognizes how critical Nikki is to Julie's life—**fictive kin**—and adds her to the CCT. Pam facilitates frequent care coordination meetings to address Julie's concerns, needs, preferences, and goals. The CCT includes Julie, Ray, Pam, and Nikki, the residential psychiatrist, her DCBS worker, CDW and recently added physical and BH providers. They have prioritized her concerns as follows:

- Immediate, ongoing assessment of Julie's medication regimen and drug-to-drug interactions, and a plan for ongoing monitoring
- Prevent future, aggressive outbursts and interaction with law enforcement or the legal system by understanding unmet needs and underlying causes of Julie's behaviors
- Coordinate efforts for seamless transition to an alternative residence that meets her complex needs
- Connect Julie to family, friendships, and a circle of support that supports her positive life trajectory

Pam coordinates efforts for ongoing care plan assessment—clinical, medication, therapeutic, social, residential, and educational information. She convenes the CCT to address the need for reassessment of Julie's medical, BH, oral health and disability needs, and makes **certain providers have the tools and resources needed to evaluate her condition and engage appropriate resources at a level that Julie understands.** For example, she reviews psychiatric and therapeutic records from Julie's residential provider, assures assignment of a primary care provider who completes a full medical assessment, refers Julie to a neurologist, coordinates with all prescribers and pharmacies, and coordinates with Ray on history with disability or waiver services. Pam participates in **integrated case staffings** twice a month with her multidisciplinary team of nurses, counselors, social workers, and medical directors—including the clinical pharmacy advisor and CPESN—and reviews Julie's case as frequently as needed in effort to support appropriate clinical interventions and address barriers to care. Pam guides the CCT toward a collaborative discussion on Julie's transitional needs and carefully seeks input on identifying strategies aimed to reduce emotional and aggressive behaviors. She maintains a **person-centered focus**, factoring in Julie's desires, capabilities, and needs.

During court proceedings, Pam made arrangements with Julie's CDW and Ray allowing Julie to stay in the **Kentucky Family Safe Zone**—a dedicated space for children located in the courthouse where children stay during court proceedings—while Pam and Ray shared the care plan with the judge. As a result of coordination with Ray, the residential provider, and Julie's CDW, Pam was able to minimize the negative impact of retraumatizing Julie by minimizing her exposure to the proceedings and assuring communication after the proceedings in a manner that was easy for Julie to understand. She requests assignment of a **Court Appointed Special Advocate (CASA)** knowing Julie needs additional support to transition to adulthood. Pam shares the findings with Julie after the hearing, assuring Julie understands next steps e.g. charges were dropped.

Pam is extensively trained in Kentucky's standards and programs for persons with DID. She invites the **Chafee Independent Living Coordinator** to participate on Julie's care planning meetings, assuring developmentally appropriate transition to adulthood is considered in all decisions. After comprehensive

reassessment and understanding of Julie's needs, the team identifies a 24/7/365 supported independent living program suitable to Julie's complex needs. If Julie is eligible for services to a person with a serious mental health issue or is identified as needing personal care for physical health issues, Pam coordinates with the Chafee Independent Living Coordinator to secure appropriate residential support e.g. community housing for persons diagnosed with serious mental health issues or a personal care home. Julie and the Care Coordination team assure additional supports are readily available to ensure Julie's stability in her new residence. Pam assures Julie is linked to Kentucky's independent living skills programs Julie may have missed such as Independent Living Formal Life Skills classes and aptitude surveys. She participates in Julie's first class, assuring Julie's comfort and needs are met.

Pam manages Julie's transitions carefully, attending to the **continuum of care** in each change to create a seamless experience for Julie. As a foster child, Julie is eligible for enrollment in Medicaid services until she is 26 years old, and includes access to **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits** for preventive and treatment services. As a result of Julie's engagement with **Family Finding and Network for Life**, Julie joined a youth book club available at her residential facility, one of her favorite things to do, and made another close friend. Pam notes that Julie has begun to ask about volunteering at the youth book club, and she helps Julie prioritize this as a goal on her care plan. As Julie ages out of foster care, Aetna's clinical pharmacy advisor continues to monitor the care coordination **CPESN pharmacy** provides as Julie moves across the care continuum, sharing progress and updates with Pam in care coordination meetings. Pam supports Julie to manage aspects of her health care as she is capable, using person-centered, health literacy tools to guide her approach.

Pam uses **Family Finding and Network for Life**—nationally-accepted best practices in foster care—to locate family, additional friends, and community support for Julie. She assists the CCT to creatively explore who has been in Julie's life, who Julie would like in her life, and how to build a caring network of informal support. Pam offers **peer support** services to Julie—a youth with lived experience like Julie's that can provide understanding and compassion for Julie's experiences.

> "Kansas Department for Children and Families (KDCF) has appreciated the opportunity presented to us by Aetna to implement the Family Finding modality into our child welfare system this past year. Aetna has collaborated with the state and key state partners to enhance the lives of children and youth in families to develop strategies for positive impact on stability and wellbeing outcomes. We are excited and look forward in this collaboration transforming our approaches alongside families, Aetna Better Health and community partners."
>
> **—Tanya Keys, Deputy Secretary KDCF**

d. Evidence-based Psychotherapeutic Interventions

Table G.13-13 includes a summary of the evidence-based psychotherapeutic interventions available for Julie's care.

Table G.13-13: Evidence-based Psychotherapeutic Interventions for Julie

Psychotherapeutic Interventions		
• 24/7/365 Supported independent living skills residential services	• Trauma-informed BH services • Complex Care Coordination	• Motivational interviewing • Peer and behavioral supports

e. Viability of Aging Out of Foster Care

The CCT works closely with the Chafee Independent Living Coordinator when planning Julie's transition to independent, supported living. Pam considers ongoing assessment information that impacts Julie's residential options, for example, if she has a serious mental health issue or a physical disorder that impacts activities of daily living. Pam and Ray identify legal counsel to assist in determining guardianship for Julie. She invites legal counsel to participate on Julie's CCT and facilitates a discussion about guardianship and alternatives to guardianship in easy-to-understand terms. Pam uses the **Planning Tool and Protocol for Transition Planning for Youth with Disabilities from the Child Welfare**

System to Adulthood[24] to assure Julie's complex, transition needs are identified and planned for. She makes certain Julie participates in all Kentucky Independent Living Skills training programs with support for her developmental needs. For example, Pam assures Julie has access to attendant care that can participate with Julie in training, aiding in her comfort and understanding of the training curriculum.

f. Option for Transitioning to an Applicable Waiver

Pam and Ray collect the necessary assessments and records necessary for Julie's eligibility evaluation in the Supports for Community Living (SCL) waiver and when appropriate, place her on the SCL Future Planning list. Pam shares updates with the CCT regularly using FamilyConnect, assuring all CCT members have near, real-time access to Julie's updates. Pam and the care team identify contingency plans due to the extensive wait list such as using behavioral support, Julie's informal supports, and community-based resources.

g. Access to and Sharing of Medical Records

To support continuity of care, Pam gathers as much clinical history from Julie and her providers as possible. She requests a claims report going back 10 years, and reviews for interface with providers, inpatient services, and pharmacy. She secures releases of information for each new provider. Pam uses **FamilyConnect**, the shared, electronic health record Aetna implemented in collaboration with DCBS, KHIE, and providers which serves as the single source of truth for youth and their circles of supports. She shares care plan updates and medical record information in FamilyConnect as often as change occurs, which her CCT can easily access at any time 24/7/365 using Aetna's web-based portal or mobile application. FamilyConnect **integrates data from TWIST and KHIE**, providing the care coordination team a near, real-time, holistic view of Julie's unique needs.

h. Maintenance of the Care Plan

Pam is the **single point of contact** for Julie's person-centered care plan developed with her preferences in mind. She reviews the care plan with Julie, Ray, Kim, and the CCT at least monthly, making certain progress, barriers, changes in needs, and concerns are monitored and documented. The care plan is updated in **FamilyConnect** any time there is a change in Julie's needs, as requested by Julie or Ray, per contract requirements. If there is a significant change, Pam conducts an in-person visit with Julie and others involved to assure reassessment and updates to the care plan. Pam documents all interactions with Julie and the team in FamilyConnect, making certain Ray, Kim, providers, and other members of Julie's CCT can view updates in near, real-time as change occurs.

Outcome

Aetna's innovative, collaborative provider solutions promote optimal health outcomes, creating a healthier Kentucky. Aetna's rapid enrollment, integrated care coordination, immediate attention to Julie's medication needs, and referral to a comprehensive provider network that uses evidence-based assessments and interventions have supported Julie's emotional stability and health. Her medication regimen has been simplified and supports include psychotherapeutic interventions. She has transitioned to a supportive living environment where she is engaged in her health, life, and wellness, and making friendships in her community. Future strategies include continued transition planning to adulthood, enrollment in waiver services, and continued Family Finding, connecting Julie to a Network for Life.

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24 Juvenile Law Center, "Planning Tool and Protocol for Transition Planning for Youth With Disabilities from the Child Welfare System to Adulthood," Juvenile Law Center, https://jlc.org/sites/default/files/attachments/2018-03/Planningtool, accessed June 2019.

60.7.G.13 Use Cases for Kentucky SKY: USE CASE 8

Our **care coordinators listen, understand, and intervene early and collaboratively** to address each foster child's needs—assuring a safe, nurturing home and whole-health stability. We do this by assuring foster families have the support needed to thrive by offering integrated care coordination, grounded in comprehensive, whole-person, evidence-based practices (EBPs) for children with special health care needs, and innovative, local programs that address the unique needs of Amanda and her family.

Amanda's Needs and Capabilities

Amanda is designated as a medically complex child pursuant to 922 KAR 1:350., Aetna is compliant with the Kentucky SKY contractor requirements for providing care coordination and nursing consultative services based on this designation. Amanda is young girl with complex medical, daily living, and health needs. She has experienced intense bouts of physical health issues that include emergency department (ED) visits, hospital stays, and around-the-clock caregiving—daily and constant reminders that her life is different than most kids her age. Her needs include building strength for surgery or transplant, ongoing comprehensive assessment and care, support for activities of daily living, medication management, monitoring oxygen levels, nutrition, stability, school, transportation, and connection to a family that loves and care for her. Aetna's role in helping Amanda includes not only assuring **comprehensive, integrated, coordinated health care,** but supporting Amanda and her foster family to achieve and maintain stability and pursue a **meaningful life filled with a sense of belonging and community**.

Collaborative Solution

Aetna uses EBPs and **Charting the LifeCourse ™ framework**[25]—a best-in-class, person-centered approach based on the core belief that all people have a right to live, love, work, and play in their community—to guide assessment and care planning. **Table G.13-14** provides an outline of Aetna's interventions.

Table G.13-14: Summary of Aetna Care Coordination Interventions for Amanda

Needs	Interventions
Whole Health Needs	• Ongoing monitoring of in-home services and coordination with the pediatric cardiologist, primary care provider (PCP), dentist, registered dietician and behavioral health providers • Referral for behavioral health assessment and intervention including telehealth services • Referral for remote patient monitoring (RPM) program • Inclusion of Community Pharmacy Enhanced Services Network (CPESN) pharmacy and Aetna's clinical pharmacy advisor on Amanda's Care Coordination team (CCT) • If needed, support via Aetna's dedicated transplant care coordinator
Family	• Use of the LifeCourse framework to address critical decision making and family needs • Coordination with the Department for Community Based Services (DCBS) for respite services for children with complex conditions • Linkage to Aetna Better Access Enhanced Transportation value-added service • Training and support on complex medication conditions, therapeutic treatments, and caregiver burnout
Education	• Coordination for development of an Individualized Education Program (IEP) and linkage to school-based resources and community support

a. Care Management and the Assignment of a Nurse Case Manager

When Amanda was moved to her second foster home in eastern Kentucky, her DCBS social worker, Jeff, contacted Ann, a registered nurse, on Aetna's integrated care coordination team to make a referral. **Jeff knows Ann and Aetna care coordination well** and leverages that collaborative relationship to connect

[25] University of Missouri Kansas City (UMKC) Institute for Human Development, "Charting the LifeCourse™ Framework", UMKC (2017): accessed June 25, 2019; http://www.lifecoursetools.com/principles.

Amanda to services. Ann is an **experienced care coordinator** who has been with Aetna for four years and previously worked in as a nurse supervisor in the emergency department. Ann is aware that foster children qualify as children with special health care needs and that Amanda has a medically complex designation. She coordinates with Jeff to **assure Amanda's enrollment** into Aetna's **Complex Care Coordination services**. Prior to the initial visit, Ann reviews Amanda's health record information in **FamilyConnect—**Aetna's shared electronic health record which is integrated with DCBS' The Workers Information System (TWIST)—and contacts Jeff to ask follow-up questions. Ann inquires about the location of the Medical Passport, the aunt's involvement and family reunification, the family's needs, and gathers names and contact information. Ann contacts Amanda's foster parents, Fred and Irma, to welcome them to the program. She listens empathically, as they explain frustration with managing complex detail across multiple providers and caregivers. Ann is trained in trauma-informed care—an understanding of how trauma impacts personal well-being and health—as she validates their feelings. Ann offers reassurance that her role as the single point of contact—accessing other team participants when their expertise was needed and collaborating with other parts of the larger foster care system including the care coordinator, the pediatric cardiologist, behavioral health specialist, caregivers, and any new providers—becomes her responsibility. Ann says she would like to get to know the family better and what they need. She asks Fred and Irma for their preferred date, time, and location for scheduling, and explains what happens in that first visit. She facilitates an **enrollee needs assessment (post-health risk assessment) specifically designed for Aetna foster children who have serious medical conditions** in collaboration with the care coordinator—making certain she captures all needs unique to Amanda, Fred, and Irma. This includes feeling burnout or frustration and opportunities for self-care and taking a break from parenting. Ann gathers the following:

- Health and condition-specific issues, clinical history including emergency department (ED) and inpatient stays, recommendations by the cardiologist for transplant surgery, medications and side effects
- PHQ-9[26]
- Activities of daily living, functional status, nutritional needs, and caregiver support
- Level of cognitive functioning using the Pediatric Symptom Checklist (PSC-17)[27]
- The family's health literacy, psychosocial issues, linguistic, cultural and spiritual needs and preferences, feelings of burnout and frustration, and informal family supports
- Visual and hearing status, needs, and preferences
- School-based performance, resources, and the need for an IEP

During the initial visit with Amanda, Fred, Irma, and the care coordinator, Ann reviews contractually required items such as enrollee rights, enrollee grievance and appeals, and how to contact Aetna including her direct contact information. Ann provides an **overview of care coordination services—**how to use services and how eligibility works—and answers any questions the family has, including the care coordinator's role. Ann describes how the care planning process is designed to support exactly what the family needs and addresses frustration and burnout. She explains that the meetings involve a **multidisciplinary team** comprised of Amanda, Fred, Irma, the care coordinator, Amanda's providers, caregivers, required staff per contract such as the medically complex liaison, and anyone else important to Amanda, Fred, or Irma's well-being—their **circle of support**. She states this is part of Aetna's **System of Care (SOC) model,** an approach that provides a 'virtual team' that focuses collaboratively on addressing system gaps while securing services. She explains the **family is the voice** to steer the team in understanding needs, priorities, and care. She explains Aetna's approach is **holistic and integrated. S**he uses the LifeCourse framework to address all needs from cardiology

[26] American Psychological Association (APA), "Patient Health Questionnaire-PHQ9 and PHQ2," APA, (2019): accessed June 25, 2019; https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.
[27] Gardner, William and Kelleher, Kelly, "Pediatric Symptom Checklist (PSC-17)", (1999): accessed June 25, 2019; https://www.prohealthmd.com/windhampediatrics-dev/wp-content/uploads/sites/25/2015/01/PSC-17.pdf.

to caregiver burnout to respite support. She asks about dates, times, and a preferred location to schedule the first care planning meeting, and explains we use the term individual health planning (IHP). Ann coordinates with other team participants for scheduling and makes sure the first IHP meeting is completed within the mandated 30-day timeline.

b. Involvement of the Medically Complex Service Team

Ann has been thoroughly **trained on Kentucky regulations** for children designated as medically complex and involvement of the medically complex service team. She monitors her work making sure she is compliant with all contractually required tasks and timelines. When Amanda was initially enrolled, Ann contacted the care coordinator to introduce herself, offer contact information, and coordinate care. Ann schedules frequent, ongoing monthly visits with Amanda, the care coordinator and all contractually required staff, and her foster family, making certain continued assessment, status updates, and services reflect Amanda's needs. Ann distributes information as often as needed and required within contractual timelines, assuring the team is aware of any status updates, progress, and change.

c. Discharge Planning Between Levels of Care

Ann facilitates frequent care coordination meetings to address Amanda's concerns, assuring DCBS goal that all children have safe and nurturing homes and communities. The CCT has explored family reunification and decided there are other, immediate priorities to address first including the following:

- Stabilize Amanda's condition and provide appropriate medical services, in-home caregiving support, and resources to reduce unnecessary ED visits and hospitalizations
- Facilitate person-centered discussions for informed decision-making regarding open heart surgery or transplant surgery, and coordinate care with DCBS as the legal guardian, appropriately
- Coordinate care with the cardiologist nurse practitioner (NP) to build Amanda's strength prior to surgery including managing referrals and monitoring services for nutritional specialists
- Refer for behavioral health assessment and appropriate interventions and supports

Ann convenes the CCT every two weeks to address Amanda's physical, behavioral, social and emotional health needs including a referral for a nutritional assessment, making certain providers and participants have the tools and resources needed to stabilize her condition. For example, if a provider needs a prior authorization, Ann proactively coordinates with her Utilization Management (UM) department. She uses the Aetna **integrated case staffing meeting** to address any clinical or provider barriers impacting Amanda's care, and assures appropriate referrals are available during the course of Amanda's recovery. Ann offers and explains referrals for Aetna's unique **clinical pharmacy advisor and use of CPESN** pharmacy services as tools for stabilizing Amanda's condition and assuring continuity of care, stating both join as participants of the CCT. The clinical pharmacy advisor provides consultation and intervention between the pharmacy and the CCT by consolidating pharmacy to one specialty for continuity of care and sharing updates and progress in care planning meetings and FamilyConnect. CPESN is a community-based pharmacy that supports families with complex medication needs and will work collaboratively with the clinical pharmacy advisor. The CCT carefully and strategically weighs the benefits and consequences of open heart and transplant surgery. If the legal guardian decides transplant surgery is a viable option, Amanda is assigned a transplant care coordinator who joins the CCT. Aetna has a **designated transplant care coordinator who has been employed with Aetna in this role since 2011,** and demonstrates the experience, education, and community relationships that support individuals in need of transplant services—she knows her community well. The transplant coordinator assures continuity of care and oversight of transplant care and support needs. For example, she coordinates care with the transplant hospital, durable medical equipment (DME) providers, and Aetna's UM—she supports single-case agreements as necessary, monitors Amanda's transition to and from the transplant hospital including discharge planning and transportation home, educates caregivers, Fred, and Irma on discharge instructions, how to use DME, and who to contact in case oxygen or medication measures are

not as expected. The transplant care coordinator stays involved for up to **one-year post-discharge**—a service unique to Aetna—making certain Amanda, Fred, and Irma adjusted and have the support they need e.g. family counseling that supports recovery from the traumatic experience of transplant surgery.

d. Health Plan Development and Maintenance within Specified Timeframes

Ann **adheres to the requirements and timeframes** for IHP development and maintenance. She reviews the IHP monthly with all contractually required staff as change occurs and at minimum once every three months per contract requirement. Prior to each IHP meeting, Ann requests written recommendations from all involved and documents in **FamilyConnect,** which provides near real-time updates. She addresses each recommendation individually and re-evaluates Amanda's medically complex status during each IHP meeting. Ann understands the importance of including Amanda's cardiologist in IHP planning. She calls frequently for updates and requests medical records at minimum every six months. Ann uses the contractually required DPP-104B IHP form and shares signed copies and a copy of the Medical Support Section of Protection and Permanency policy and procedure via FamilyConnect after each IHP meeting. If the medically complex designation is no longer needed, Ann contacts the Medical Support Section for review and decision-making, and coordinates findings with Amanda's CCT.

e. Availability of and Access to Providers

Ann facilitates discussions in care coordination meetings about Aetna's ongoing implementation of **telehealth** services statewide and offers referrals when appropriate. This includes referrals for behavioral or occupational therapy telehealth, if recommended, and Amanda's participation in Aetna's **remote patient monitoring (RPM) program**. Ann offers a referral to Aetna's new program with **The Kidz Club** and educates how this program can benefit children with complex medical needs, specifically children with congenital heart defects. She states benefits include individualized, clinical care coordination and detailed monitoring and reporting by a dedicated nurse Aetna nurse.

f. Medical Passport

Ann adheres to the contractual requirements for medically complex children that she is responsible for maintenance of the Medical Passport, documenting Amanda's ongoing care, and distributing medical record information to Amanda's CCT. Ann asks Jeff to contact Amanda's aunt to locate the paper Medical Passport. If Amanda was previously enrolled with a different managed care organization, she coordinates efforts for transfer of electronic health records at the time of enrollment. She supports **continuity of care and addresses barriers** by coordinating access to lost Medical Passports and collecting medical record information and creating and distributing via **FamilyConnect, which can be easily accessed 24/7/365 via Aetna's web portal or mobile application.**

g. Training and Support for Caregivers

Ann knows that Fred and Irma participated in the Medically Complex Training Program, using standards established by the DCBS. She specifically asks about their understanding of Amanda's complex medications and conditions, therapeutic treatments, and **caregiver burnout**, noting Irma's requirement to not have outside employment. Irma is ambivalent as she describes her feelings. Ann uses her training in **motivational interviewing and trauma-informed care (TIC)** to elicit Irma's feelings, listen compassionately, and validate her experiences. She assures support through additional training and available respite options and offers use of Aetna's **online caregiver burnout training resources and trauma education**—e.g., how stress impacts our well-being and what we can do to reduce stress—for the family and Amanda's caregivers. Ann offers a visit by an animal-assisted therapy dog through Pet Partners, a nonprofit that combines the unconditional love and EBP to address health and well-being. Aetna assures **contracted providers are thoroughly trained as experts** in their field. Ann asks if Amanda's caregivers are meeting Amanda's needs and if the family satisfied with services. If Fred and Irma express dissatisfaction, she contacts the agency and her Provider Experience

team to address the issue, making sure appropriate corrective action within the foster parent's preferences such as additional training or a finding a new provider.

h. Coordination of Transportation

Ann recognizes Fred and Irma's difficulty getting to appointments. She facilitates discussion in care coordination meetings to engage local community resources for assistance. She assures Fred and Irma can access the Human Service Transportation Delivery program and offers **Aetna Better Access Enhanced Transportation**—10 roundtrips per year for activities related to Amanda's care – an Aetna value-added service. If Amanda's PCP refers Amanda for specialty services outside the regional area, Ann will coordinate transportation for those visits. Ann advises a benefit of using the CPESN pharmacy is pharmacy delivery of medications and assists Fred and Irma to enroll in this option. If needed, the transplant care coordinator offers transportation support for facilities greater than 120 miles from the family home. Support includes reimbursement for gas, lodging, and a food allowance. Ann describes the transportation hotline number and instructs Fred and Irma on how to use this program—including coordination with DCBS and the required form for transplant services—and Aetna Better Access.

i. Coordination of Physical and Behavioral Health Services

Ann offers referral to a **trauma-informed, behavioral health provider** who is **co-located via telehealth** at Amanda's PCP office for assessment and intervention. She explains the designation as trauma-informed is unique to Aetna who developed a **credentialing system for behavioral health providers**, that allows families to easily identify these expert providers. She educates Fred and Irma on trauma approaches, stating the importance of recognizing the impact of trauma on physical and emotional health. She elicits information from Fred and Irma using a compassionate, active listening approach learned in her trauma-informed Aetna training, to assess the family's response to Amanda's needs, and suggests family counseling services. As the **single point of contact** for care, Ann shares progress and updates with Amanda's care coordination team assuring all medical providers, the clinical pharmacy advisor, and CPESN offer consult on medication interactions as they monitor Amanda's progress. She assures the team is aware of new services and progress such as family counseling. Ann updates health record information in **FamilyConnect**, allowing near, real-time access to progress, updates, and care.

j. Community Resources

Ann explores the family's needs and identifies relevant community resources, such as support for caregiver burnout and education on parenting children with complex needs. Ann offers Fred and Irma opportunity to join the local **foster parent advisory council, which is** a regular, local meeting where foster parents provide input and feedback into Aetna's services.

k. Assistance with the Individualized Education Plan

Ann completed training on IEPs during her Aetna care coordinator orientation and learned about the Kentucky-specific requirements. She includes the IEP as a need in her IHP discussions and solicits feedback from Amanda's team to maximize support. Since Amanda received homebound education via the public school system, Ann educates Fred and Irma that Jeff, as the DCBS guardian, will ask for an Admissions and Release Committee (ARC) meeting for development of the IEP. Amanda's CCT and the school participate in the ARC meeting, creating specific teaching instructions and identifying support such as therapy or additional staff during classroom instruction time. Ann requests Amanda's teachers receive additional training on supporting a medically complex child, and coordinates with Jeff getting teachers' permission to attend the Medically Complex Training Program.

l. Social Determinants of Health

Ann coordinates Amanda's nutritional needs amongst providers making certain continuity across her cardiologist, dietician, and behavioral health providers. She uses a **whole-person approach** and addresses additional social determinants of health as an ongoing component in her IHP meetings. Ann contacts the

registered dietician for local, community-based organizations, educational programs, or online resources, and offers a referral to **Aetna's slow cooker, healthy cooking classes**, taught by Aetna's Community Outreach staff. She educates Fred and Irma about **Aetna's online resources** on healthy eating and wellness, demonstrating how to navigate the Aetna website during an in-person visit.

m. Planned Respite Care

Ann coordinates planned respite support for the foster family in collaboration with DCBS available respite resources and through **The Kidz Club** program for medically complex children. She assures ongoing assessment of caregiver burnout and monitors provider performance by including Fred and Irma's feedback. If necessary, she arranges for an in-person visit with the transplant care coordinator, who is thoroughly educated and experienced in medically complex children, to provide training for continuity of care. Ann explores and facilitates **waiver services** enrollment as means for future respite care options.

n. Applicable Evidence-based Practices

Aetna supports the following for Amanda's care:

- CPESN care coordination
- Trauma-informed, BH, and telehealth services
- Nutritional assessment and intervention
- Telehealth services
- Motivational interviewing
- Addressing SDOH
- Remote patient monitoring

o. Access to and Sharing of Medical Records

To support continuity, Ann is the single point of contact that responsible for coordinating information contained in all records including the Medical Passport and communicating updates as they occur. She uses **FamilyConnect, the shared, electronic health record that Aetna implemented in collaboration with DCBS which serves as the single source of truth for youth and their circles of supports**. Ann shares care plan updates and medical record information in FamilyConnect as often as change occurs which Fred, Irma, Amanda's circle of support, providers, and DCBS can easily access at any time **24/7/365 using Aetna's web-based portal or mobile application.** FamilyConnect integrates data from **TWIST and KHIE,** providing the care coordination team a near real-time, holistic view of Amanda's unique needs.

p. Maintenance of the Care Plan

Ann is the **single point of contact** for Amanda's IHP/care plan. She reviews the care plan with Fred, Irma, and the team at least monthly, and at minimum, every three months per contract requirements, making certain progress, barriers, changes, and concerns are monitored and documented in **FamilyConnect.** She uses the designated form DPP-104B, assures proper signatures, and documents appropriately. The IHP is updated any time there is a change in Amanda's needs, as requested by Fred, Irma, or Jeff, and at minimum every six months following the initial IHP meeting per contract requirements. If there is a significant change, Ann conducts an in-person visit with Amanda, the care coordinator, her foster parents, and others involved to assure reassessment and updates to the IHP. Ann makes certain the IHP and mandated Medical Support Section of Protection and Permanency policy and procedure is distributed via **FamilyConnect** after each IHP meeting or update.

Outcomes

Ann's care coordination and Aetna's integrated, comprehensive, innovative services have stabilized Amanda's condition and supported DCBS, Fred, and Irma to make decisions best suited for their family. Amanda spends more time at home and less time in the ED. The foster family has the resources needed to provide care and strengthen the family. Future strategies include ongoing monitoring of Amanda's condition, analysis of The Kidz Club data, and linkage to additional support and community resources.

60.6.J Proof of Ability to Obtain Performance Bond

Kentucky | Transforming Health Care | **Aetna**

TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA
One Tower Square, Hartford, CT 06183

GENERAL CLIENT PREQUALIFICATION LETTER

January 21, 2020

State of Kentucky
Finance and Administration Cabinet

Re: Aetna Better Health of Kentucky Insurance Company
Medicaid Managed Care Organization (MCO) – All Regions
Solicitation No: RFP 758 2000000202

To Whom It May Concern:

Travelers Casualty and Surety Company of America, a corporation under the laws of the State of Connecticut, with an office and place of business located at One Tower Square, Hartford, CT 06183, represents Aetna Better Health of Kentucky Insurance Company for its surety bonding needs. As of the date of this writing, Aetna Better Health of Kentucky Insurance Company remains in good standing with Travelers Casualty and Surety Company of America, which is affording continued surety credit for bonded obligations with single project sizes up to $30,000,000.00 within an aggregate bonded surety program of $500,000,000.00.

This letter is not to be construed as an agreement to provide surety bonds for any particular project, but is offered as an indication of Travelers Casualty and Surety Company of America's past experience and confidence in the firm. Travelers Casualty and Surety Company of America reserves the right to review terms and conditions of any proposals, contract documents, bond forms, financial arrangements and other underwriting considerations at the time the contract is awarded.

If you have any questions or need any additional information, please do not hesitate to contact me.

Sincerely,

April D. Perez

April D. Perez, Attorney-In-Fact
Travelers Casualty and Surety Company of America
A++ (Superior) by A.M. Best, Financial Size Category XV ($2 Billion or greater)

TRAVELERS

Travelers Casualty and Surety Company of America
Travelers Casualty and Surety Company
St. Paul Fire and Marine Insurance Company

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company are corporations duly organized under the laws of the State of Connecticut (herein collectively called the "Companies"), and that the Companies do hereby make, constitute and appoint April D. Perez, of Morristown, New Jersey, their true and lawful Attorney-in-Fact to sign, execute, seal and acknowledge any and all bonds, recognizances, conditional undertakings and other writings obligatory in the nature thereof on behalf of the Companies in their business of guaranteeing the fidelity of persons, guaranteeing the performance of contracts and executing or guaranteeing bonds and undertakings required or permitted in any actions or proceedings allowed by law.

IN WITNESS WHEREOF, the Companies have caused this instrument to be signed, and their corporate seals to be hereto affixed, this **3rd** day of **February, 2017.**

HARTFORD, CONN. — TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA — HARTFORD, CONN. — TRAVELERS CASUALTY AND SURETY COMPANY — ST. PAUL FIRE AND MARINE INSURANCE COMPANY — CORPORATE SEAL

State of Connecticut

City of Hartford ss.

By: _____
Robert L. Raney, Senior Vice President

On this the **3rd** day of **February, 2017**, before me personally appeared **Robert L. Raney**, who acknowledged himself to be the Senior Vice President of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, and that he, as such, being authorized so to do, executed the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

In Witness Whereof, I hereunto set my hand and official seal.

My Commission expires the **30th** day of **June, 2021**

MARIE C. TETREAULT — NOTARY PUBLIC — CONNECTICUT

Marie C Tetreault
Marie C. Tetreault, Notary Public

This Power of Attorney is granted under and by the authority of the following resolutions adopted by the Boards of Directors of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, which resolutions are now in full force and effect, reading as follows:

RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President, any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary may appoint Attorneys-in-Fact and Agents to act for and on behalf of the Company and may give such appointee such authority as his or her certificate of authority may prescribe to sign with the Company's name and seal with the Company's seal bonds, recognizances, contracts of indemnity, and other writings obligatory in the nature of a bond, recognizance, or conditional undertaking, and any of said officers or the Board of Directors at any time may remove any such appointee and revoke the power given him or her; and it is

FURTHER RESOLVED, that the Chairman, the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President may delegate all or any part of the foregoing authority to one or more officers or employees of this Company, provided that each such delegation is in writing and a copy thereof is filed in the office of the Secretary; and it is

FURTHER RESOLVED, that any bond, recognizance, contract of indemnity, or writing obligatory in the nature of a bond, recognizance, or conditional undertaking shall be valid and binding upon the Company when (a) signed by the President, any Vice Chairman, any Executive Vice President, any Senior Vice President or any Vice President, any Second Vice President, the Treasurer, any Assistant Treasurer, the Corporate Secretary or any Assistant Secretary and duly attested and sealed with the Company's seal by a Secretary or Assistant Secretary; or (b) duly executed (under seal, if required) by one or more Attorneys-in-Fact and Agents pursuant to the power prescribed in his or her certificate or their certificates of authority or by one or more Company officers pursuant to a written delegation of authority; and it is

FURTHER RESOLVED, that the signature of each of the following officers: President, any Executive Vice President, any Senior Vice President, any Vice President, any Assistant Vice President, any Secretary, any Assistant Secretary, and the seal of the Company may be affixed by facsimile to any Power of Attorney or to any certificate relating thereto appointing Resident Vice Presidents, Resident Assistant Secretaries or Attorneys-in-Fact for purposes only of executing and attesting bonds and undertakings and other writings obligatory in the nature thereof, and any such Power of Attorney or certificate bearing such facsimile signature or facsimile seal shall be valid and binding upon the Company and any such power so executed and certified by such facsimile signature and facsimile seal shall be valid and binding on the Company in the future with respect to any bond or understanding to which it is attached.

I, **Kevin E. Hughes**, the undersigned, Assistant Secretary of Travelers Casualty and Surety Company of America, Travelers Casualty and Surety Company, and St. Paul Fire and Marine Insurance Company, do hereby certify that the above and foregoing is a true and correct copy of the Power of Attorney executed by said Companies, which remains in full force and effect.

Dated this 21st day of January, 2020.

HARTFORD, CONN. — TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA — HARTFORD, CONN. — TRAVELERS CASUALTY AND SURETY COMPANY — ST. PAUL FIRE AND MARINE INSURANCE COMPANY — CORPORATE SEAL

Kevin E. Hughes
Kevin E. Hughes, Assistant Secretary

To verify the authenticity of this Power of Attorney, please call us at 1-800-421-3880.
Please refer to the above-named Attorney-in-Fact and the details of the bond to which the power is attached.

Marsh

TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA

HARTFORD, CONNECTICUT 06183

FINANCIAL STATEMENT AS OF DECEMBER 31, 2018

CAPITAL STOCK $ 6,480,000

ASSETS		LIABILITIES & SURPLUS	
CASH AND INVESTED CASH	$ 36,728,596	UNEARNED PREMIUMS	$ 979,007,378
BONDS	3,507,432,239	LOSSES	750,995,504
STOCKS	294,199,598	LOSS ADJUSTMENT EXPENSES	166,673,871
INVESTMENT INCOME DUE AND ACCRUED	38,287,129	COMMISSIONS	45,868,584
OTHER INVESTED ASSETS	3,507,839	TAXES, LICENSES AND FEES	14,584,663
PREMIUM BALANCES	250,478,792	OTHER EXPENSES	43,858,534
NET DEFERRED TAX ASSET	48,781,239	CURRENT FEDERAL AND FOREIGN INCOME TAXES	10,143,037
REINSURANCE RECOVERABLE	29,278,755	REMITTANCES AND ITEMS NOT ALLOCATED	21,277,153
SECURITIES LENDING REINVESTED COLLATERAL ASSETS	14,277,262	AMOUNTS WITHHELD / RETAINED BY COMPANY FOR OTHERS	30,289,553
RECEIVABLES FROM PARENT, SUBSIDIARIES AND AFFILIATES	27,813,266	RETROACTIVE REINSURANCE RESERVE ASSUMED	810,360
ASSUMED REINSURANCE RECEIVABLE AND PAYABLE	626,488	POLICYHOLDER DIVIDENDS	10,410,755
OTHER ASSETS	4,936,229	PROVISION FOR REINSURANCE	7,641,356
		ADVANCE PREMIUM	1,608,777
		REINSURANCE PAYABLE ON PAID LOSSES & LOSS ADJ. EXPENSES	868,002
		PAYABLE FOR SECURITIES LENDING	14,277,262
		CEDED REINSURANCE NET PREMIUMS PAYABLE	46,469,976
		OTHER ACCRUED EXPENSES AND LIABILITIES	335,489
		TOTAL LIABILITIES	$ 2,145,120,254
		CAPITAL STOCK	$ 6,480,000
		PAID IN SURPLUS	433,803,760
		OTHER SURPLUS	1,670,943,418
		TOTAL SURPLUS TO POLICYHOLDERS	$ 2,111,227,178
TOTAL ASSETS	$ 4,256,347,432	TOTAL LIABILITIES & SURPLUS	$ 4,256,347,432

STATE OF CONNECTICUT)

COUNTY OF HARTFORD) SS.

CITY OF HARTFORD)

MICHAEL J. DOODY, BEING DULY SWORN, SAYS THAT HE IS SECOND VICE PRESIDENT, OF TRAVELERS CASUALTY AND SURETY COMPANY OF AMERICA, AND THAT TO THE BEST OF HIS KNOWLEDGE AND BELIEF, THE FOREGOING IS A TRUE AND CORRECT STATEMENT OF THE FINANCIAL CONDITION OF SAID COMPANY AS OF THE 31ST DAY OF DECEMBER, 2018.

Michael J. Doody

VICE PRESIDENT, FINANCE

SUBSCRIBED AND SWORN TO BEFORE ME THIS
28TH DAY OF MARCH, 2019

Susan M. Weissleder

NOTARY PUBLIC

SUSAN M. WEISSLEDER
Notary Public
My Commission Expires November 30, 2022

SUSAN M. WEISSLEDER NOTARY PUBLIC CONNECTICUT

Attachment A

Kentucky | Transforming Health Care | **Aetna**

Attachment A
B.2 – Corporate Information

Additional Office Locations ..... Att A-3

Corporate Organizational Charts ..... Att A-9

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Additional Office Locations

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Additional Office and P.O. Box Addresses

CVS Corporate Office Addresses

444 North 44th Street, Phoenix, AZ, 85008
9501 E Shea Boulevard, Scottsdale, AZ, 85260
555 17th St, Ste 1500, Denver, CO, 80202
1275 Pennsylvania Avenue, NW, Suite 700, Washington, DC, 20004
2211 Sanders Road, Northbrook, IL, 60062
4900 Koger Boulevard #100, Greensboro, NC, 27407
200 Campus Drive, Suite 310, Florham Park, NJ, 07932
29100 Aurora Road, Solon, OH, 44139
100 Scenic View Drive, Cumberland, RI, 02864
200 Highland Corporate Drive, Cumberland, RI, 02864
100 Highland Corporate Drive, Cumberland, RI, 02864
4 Blackstone Valley Place, Lincoln, RI, 02865
11 Blackstone Valley Place, Lincoln, RI, 02865
25 Blackstone Valley Place, Lincoln, RI, 02865
695 George Washington Highway, Lincoln, RI, 02865
935 Douglas Pike, Smithfield, RI, 02917
One CVS Drive, Woonsocket, RI, 02895
1026 Park East Drive, Woonsocket, RI, 02895
475 Park East Drive, Woonsocket, RI, 02895
750 W John Carpenter Freeway, Suite 1200, Irving, TX, 75039
909 E Collins Boulevard, Richardson, TX, 75081

CVS Health Corporation and its subsidiaries (including CVS Pharmacy, Inc.) operate over 10,000 retail pharmacy, LTC pharmacy, mail service pharmacy, specialty pharmacy, PDP, infusion provider and clinical provider locations. Addresses for such additional business locations can be provided upon request.

Aetna Addresses

2300 Yonge Street, Toronto, ON M4P1E4
5F Standard Charter Tower, Shanghai, 31 200120
757 Meng Zi Rd, Huangpu, Shanghai, 200023
No. 50 Liangmaqiao Rd, Beijing, 11 100125
50 Cannon St, London, GT LON EC4V2BE
25 Templar Avenue, Farnborough, HANTS GU146FE
No. 25 Westlands Road, Quarry Bay, 00000
213-B Okhla Indust Ph 3, New Delhi, 110020
Sagar Tech Plaza, Mumbai, 000000
Sentral Senayan 11 W-16, Jakarta, 12 10270
Alexandra House-The Sweepstakes, Dublin, 00000
373 Gangnam-daero seocho-gu, Seoul, 11 100843
330 Lambton Quay, Wellington, 01 6011
112 Robinson Rd 9-01, Singapore, 068902
1277 Mike Crawford Ave, Centurion, 00000
Media One Tower, Plot A008-001, Dubai, 00000
North Twr - Emirates Finl Tower, Dubai, 03 00000
2525 C Street, Anchorage, AK 99503
One Sealaska Plaza, Juneau, AK 99801
4350 E. Cotton Center Blvd., Phoenix, AZ 85040
1830 N. 95th Avenue, Phoenix, AZ 85037
18444 North 25th Ave, Phoenix, AZ 85023
4500 E. Cotton Center Blvd, Phoenix, AZ 85040
4025 E. Cotton Center Blvd, Phoenix, AZ 85040
9801 S. 51st Street, Phoenix, AZ 85044
4750 S 44TH Place, Phoenix, AZ 85040
3535 E. Valencia Rd., Tucson, AZ 85706
4141 N Scottsdale Road, Scottsdale, AZ 85251
8969 West McCartney Road, Casa Grande, AZ 85194
1333/1385 East Shaw Avenue, Fresno, CA 93710
10370/10390 Commerce Ctr Dr, Rancho Cucamonga, CA 91730
515 South Flower Street, Los Angeles, CA 90071
750 Riverpoint Drive, W. Sacramento, CA 95605
2677 North Main Street, Santa Ana, CA 92705
2850 Shadelands Dr, Walnut Creek, CA 94598
10260 Meanley Drive, San Diego, CA 92131
One Sansome Street, San Francisco, CA 94104
21215 Burbank Blvd, Woodland Hills, CA 91367
1500 Wynkoop Street, Denver, CO 80202
4582 S Ulster St, Denver, CO 80237
20 Glover Avenue, Norwalk, CT 06850
29 South Main Street, West Hartford, CT 06107
100 Signature Way, E Granby, CT 06026

151 Farmington Ave Rogers Bldg, Hartford, CT 06156
151 Farmington Ave, C&T Annex, Hartford, CT 06156
151 Farmington Avenue, Atrium Bldg, Hartford, CT 06156
570 Pigeon Hill Rd, Data Center, Windsor, CT 06095
930 Middle St, Data Center, Middletown, CT 06457
252 Chapman Rd., Newark, DE 19702
750 Prides Crossing Ste 200, Newark, DE 19713
789 SW Federal Hwy, Stuart, FL 34994
1340 Concord Terrace, Sunrise, FL 33323
8200 NW 41st St, Doral, FL 33166
9000 Southside Blvd Bld 100, Jacksonville, FL 32256
503 Sunport Lane, Orlando, FL 32809
502 Sunport Lane, Orlando, FL 32809
4630 Woodland Corporate Blvd, Tampa, FL 33614
3611 Queen Palm Drive, Tampa, FL 33619
1820 E Park Ave, Tallahassee, FL 32301
1301 N. Congress Ave., Boynton Beach, FL 33426
1600 SW 80th Terrace, Plantation, FL 33324
1100 Abernathy Rd, NE Bldg 500, Atlanta, GA 30328
1100 Circle 75 Parkway Ste 1400, Atlanta, GA 30339
2000 Riveredge Parkway, Atlanta, GA 30328
3600 Mansell Road, Alpharetta, GA 30022
333 W Wacker Dr, Chicago, IL 60606
550 W Washington Blvd, Chicago, IL 60661
10 S Riverside Plaza, Chicago, IL 60606
2110 Fox Drive, Champaign, IL 61820
4507 N. Sterling Ave., Peoria, IL 61615
One Overlook Point, Lincolnshire, IL 60069
3200 Highland Ave., Downers Grove, IL 60515
3800 Golf Road, Rolling Meadows, IL 60008
111 SE 3rd St, Evansville, IN 47708
3500 Coliseum Blvd East, Ft Wayne, IN 46805
8910 Purdue Rd, Indianapolis, IN 46268
4320 NW 114th St, Urbandale, IA 50322
8535 East 21st St N, Wichita, KS 67206
9401 Indian Creek Parkway, Overland Park, KS 66210
9900 Corporate Campus Dr., Louisville, KY 40223
10000 Perkins Rowe, Bldg G, Ste 500, Baton Rouge, LA 708101527
920 Pierremont Rd, Shreveport, LA 71106
3838 N. Causeway Blvd., Metairie, LA 70002
2400 Veterans Memorial Blvd, Kenner, LA 70062
175 Running Hill Road, South Portland, ME 04106
6720-B Rockledge Drive, Bethesda, MD 20817
13511 Label Lane, Hagerstown, MD 21740
15400 Calhoun Drive, Rockville, MD 20855
509 Progress Dr., Linthicum, MD 21090
53 State St, Boston, MA 02109
77 S. Bedford Street, Burlington, MA 01803
93 Worcester St, Wellesley, MA 02481
2725 Airview Blvd, Kalamazoo, MI 49002
1333 Gratiot Ave, Detroit, MI 48207
3200 Eagle Park Dr NE, Grand Rapids, MI 49525
1044 Eastbury Drive, Lansing, MI 48917
2612 Ashman Street, Midland, MI 48640
2356/2370 Science Parkway, Okemos, MI 48864
28588 Northwestern Highway, Southfield, MI 48034
1405 Xenium Lane North, Plymouth, MN 55441
10991 NW Airworld Drive, Kansas City, MO 64153
4520 South National Ave, Springfield, MO 65810
550 Maryville Centre Drive, St Louis, MO 63141
10802 Farnam Dr, Omaha, NE 68154
15950 W Dodge Road, Omaha, NE 68118
639 Isbell Rd, Reno, NV 89509
1140 Town Center Drive, Las Vegas, NV 89144
475 E Capovilla Ave, Las Vegas, NV 89119
303 Fellowship Road, Mt. Laurel, NJ 08054
100 Willowbrook Road, Freehold, NJ 07728
9 Entin Road, Parsippany, NJ 07054
3 Independence Way, Princeton, NJ 08540
15 Columbia Circle, Albany, NY 12203
1333 Broadway, New York, NY 10018
100 Park Avenue, New York, NY 10017
55 West 125th Street, New York, NY 10027
350 Madison Ave, New York, NY 10017
36 West 25th St, New York, NY 10010
101 Park Ave, New York, NY 10178
100 Park Ave - 27th Fl, New York, NY 10017
88 Froehlich Farms Blvd, Woodbury, NY 11797
300 Corporate Parkway, Amherst, NY 14226
2815 Coliseum Centre Drive, Charlotte, NC 28217
4050 Piedmont Parkway, High Point, NC 27265
2700 X-Ray Drive, Gastonia, NC 28054
2801 Slater Road, Morrisville, NC 27560
1800 East Interstate Avenue, Bismarck, ND 58503
2841 Woodburn Ave, Cincinnati, OH 45206
178 E. State St, Columbus, OH 43215
7400 West Campus Road, New Albany, OH 43054
3015 Glendale Ave, Toledo, OH 43617
3805 Edwards Rd, Cincinnati, OH 45209
4059 Kinross Lakes Parkway, Richfield, OH 44286
3201 Enterprise Parkway, Beachwood, OH 44122
3030 N.W. Expwy Ste 625, Oklahoma City, OK 73112
6120 South Yale Avenue, Tulsa, OK 74136
222 S.W. Columbia Street, Portland, OR 97201
120 E Kensinger Drive, Cranberry, PA 16066
2222 Ewing Road, Moon Township, PA 15108
1425 Union Meeting Road, Blue Bell, PA 19422
3721 TecPort Drive, Harrisburg, PA 17111
1550 Pond Road, Allentown, PA 18104
2000 Market Street, Philadelphia, PA 19103

730 Holiday Dr, Pittsburgh, PA 15220
11 Stanwix Street, Pittsburgh, PA 15222
221 Dawson Rd, Columbia, SC 29224
5350 Poplar Ave, Memphis, TN 38119
1801 West End Avenue, Nashville, TN 37203
800 Crescent Centre Drive, Franklin, TN 37067
2777 Stemmons Freeway, Dallas, TX 75207
135 Oyster Creek, Lake Jackson, TX 77566
Three Sugar Creek Center, Sugar Land, TX 77478
14955 Heathrow Forest Pkwy, Houston, TX 77032
4400 NW Loop 410, San Antonio, TX 78229
3900 Rogers Road, San Antonio, TX 78251
2800 N Dallas Parkway, Plano, TX 75093
9606 N. Mopac Expressway, Austin, TX 78759
4300 Centreway Place, Arlington, TX 76018
257 E 200 S, Salt Lake City, UT 84111
10150 South Centennial Parkway, Sandy, UT 84070
250 W Center St, Provo, UT 84601
630 Peter Jefferson Pkwy, Charlottesville, VA 22911
100 Linden Square Drive, Bristol, VA 24202
6387 Center Dr, Norfolk, VA 23502
9881 Mayland Drive, Richmond, VA 23233
310 1st St SW, Roanoke, VA 24011
1380-1382 Town Square Boulevard NW, Roanoke, VA 24012
2010 Corporate Ridge Road, McLean, VA 22102
14155 Newbrook Drive, Chantilly, VA 20151
600 University St, Seattle, WA 98101
20 F Street, NW, Washington, DC 20001
500 Virginia St East, Charleston, WV 25301

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B.2.a.(iii) – Corporate Organization Charts

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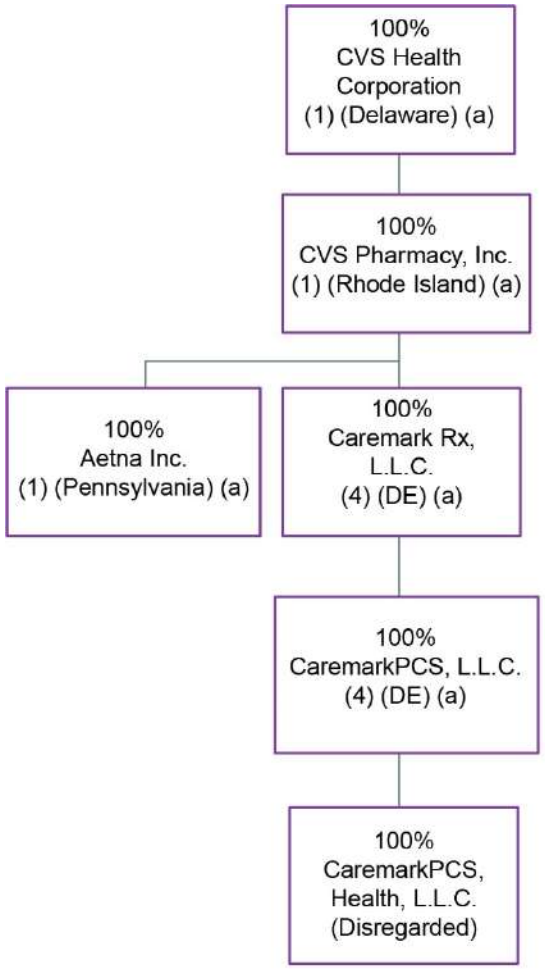

- This organizational chart reflects Aetna Better Health of Kentucky's relationship to its parent entities and its affiliated entities that are subsidiaries of Aetna Inc., and/or CVS Health Corporation that provide PBM services (CaremarkPCS Health, L.L.C.), and that are parents of CaremarkPCS Health, L.L.C. Aetna Better Health of Kentucky's ultimate parent company, CVS Health Corporation, is a Fortune 10 company with subsidiaries that are not included in this organizational chart because they do not have any ownership interests in the Aetna entities listed in this organizational chart.
- Percentages are rounded to the nearest whole percent and based on ownership of voting rights.
- Double borders indicate entity has subsidiaries shown on the same page.

64.ky20r

Commonwealth of Kentucky
Medicaid Managed Care Organization (MCO) – All Regions
RFP 758 2000000202

aetna™

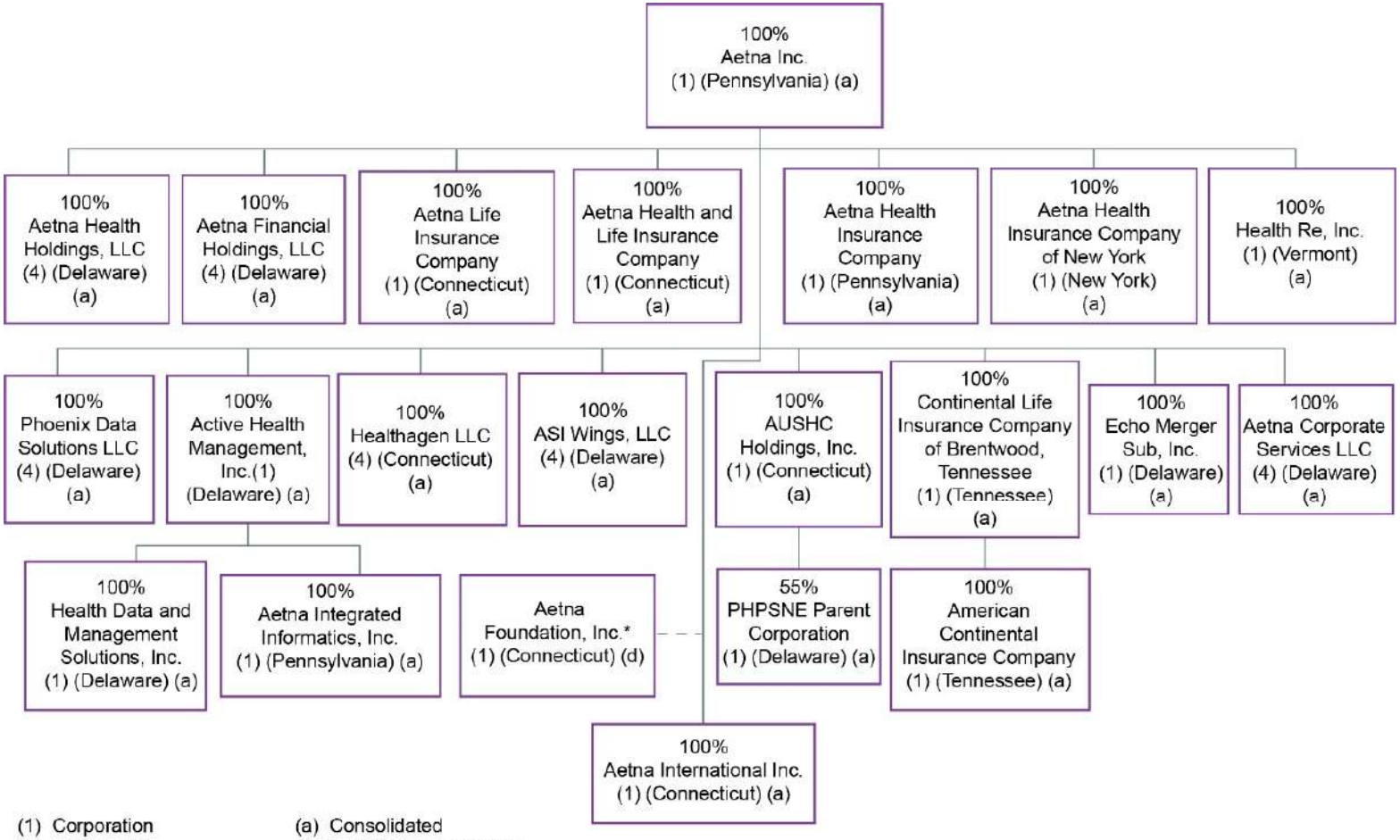

(1) Corporation
(2) Partnership
(3) Joint venture
(4) Limited liability company
(5) Trust

(a) Consolidated
(b) One-line consolidation (i.e., equity method)
(c) Separate account asset
(d) Not consolidated

Percentages are rounded to nearest whole percent and are based on ownership of voting rights.
* Non-stock corporation: Aetna does not control this entity. Stand-alone.

70.ky20r

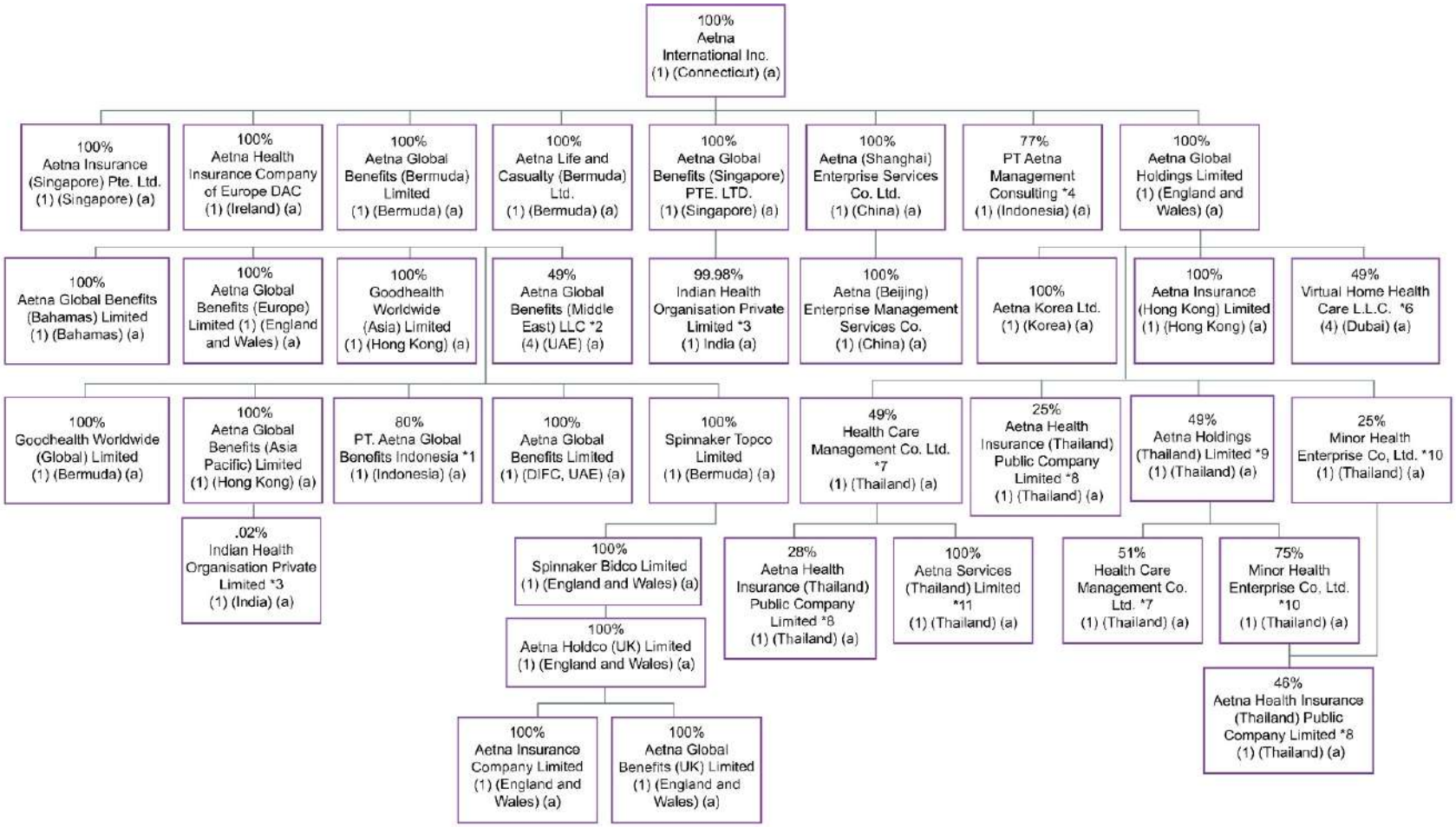

*1 PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee
*2 Aetna Global Benefits (Middle East) LLC is also 51% owned by Euro Gulf LLC, Aetna's Nominee
*3 Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific); 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
*4 PT Aetna Management Consulting is also 23% owned by PT Asuransi Central Asia
*5 Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd
*6 Virtual Home Health Care L.L.C. is 51% owned by CBD Commercial Brokers LLC, Aetna's Nominee
*7 Health Care Management Co. Ltd. is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited
*8 Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 share), Mr. Jitphasong Itsaraphakded (1 share), Mrs. Suphee Wattana (1 share), Mr. Buncha Tamphragom (1 share)
*9 Aetna Holdings (Thailand) Limited is also 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Global Benefits (Bermuda) Limited owns 1 share
*10 Minor Health Enterprise Enterprise Co, Ltd is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited
*11 Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited and (1 share) owned by Aetna Global Holdings Limited

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Commonwealth of Kentucky
Medicaid Managed Care Organization (MCO) – All Regions
RFP 758 2000000202

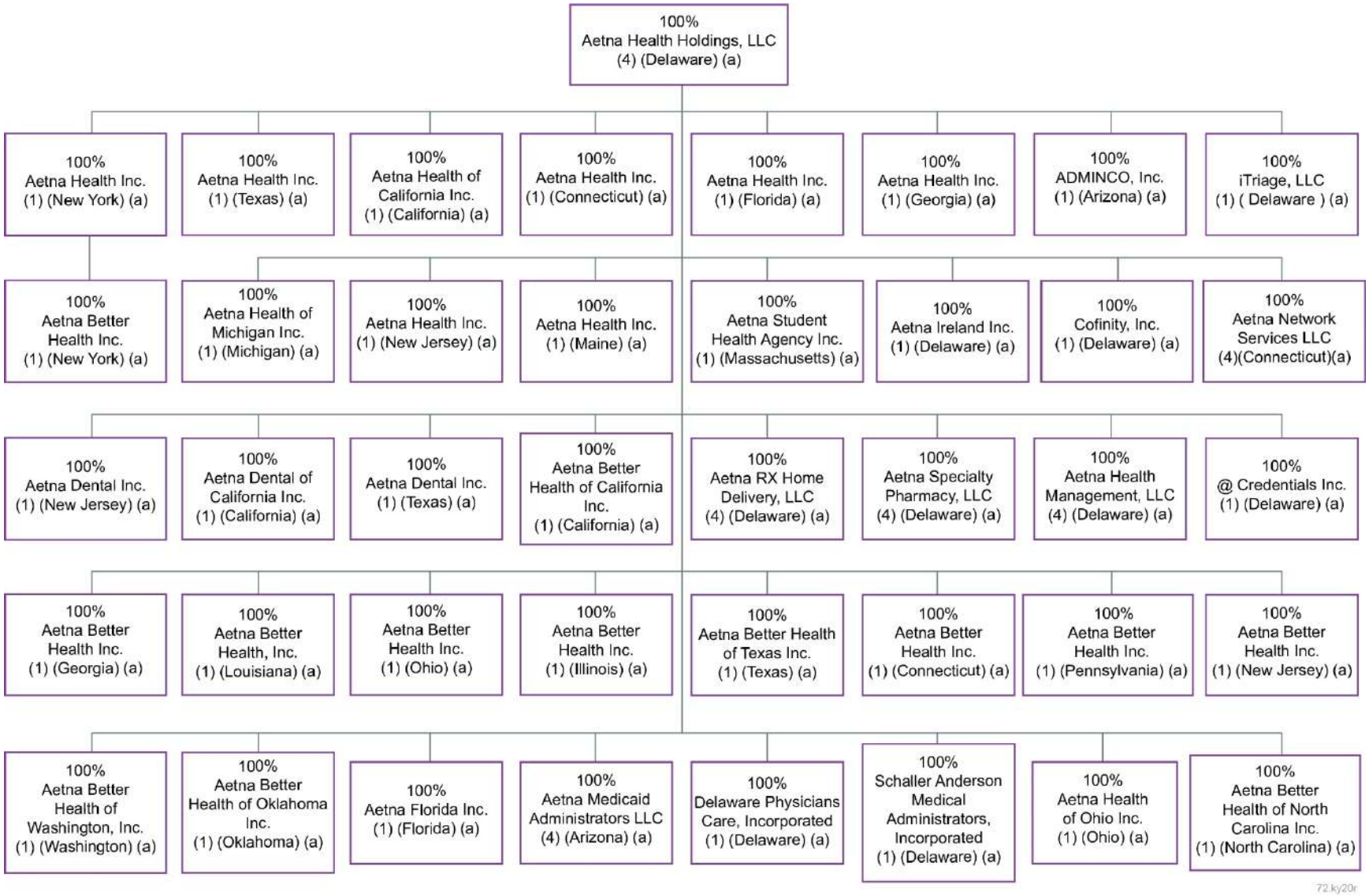

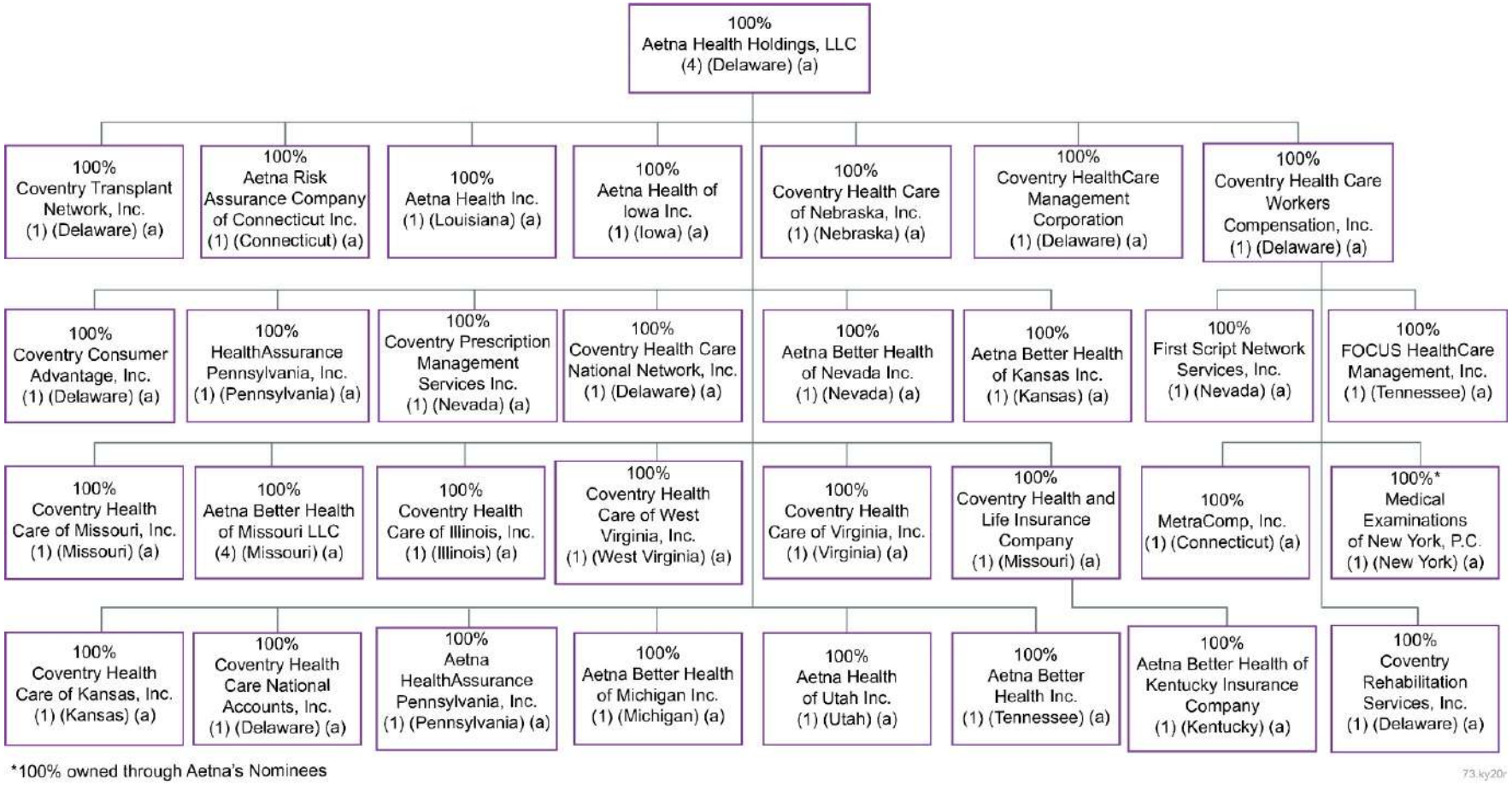
100% Aetna Health Holdings, LLC (4) (Delaware) (a)
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100% Aetna Risk Assurance Company of Connecticut Inc. (1) (Connecticut) (a)
100% Aetna Health Inc. (1) (Louisiana) (a)
100% Aetna Health of Iowa Inc. (1) (Iowa) (a)
100% Coventry Health Care of Nebraska, Inc. (1) (Nebraska) (a)
100% Coventry HealthCare Management Corporation (1) (Delaware) (a)
100% Coventry Health Care Workers Compensation, Inc. (1) (Delaware) (a)
100% Coventry Consumer Advantage, Inc. (1) (Delaware) (a)
100% HealthAssurance Pennsylvania, Inc. (1) (Pennsylvania) (a)
100% Coventry Prescription Management Services Inc. (1) (Nevada) (a)
100% Coventry Health Care National Network, Inc. (1) (Delaware) (a)
100% Aetna Better Health of Nevada Inc. (1) (Nevada) (a)
100% Aetna Better Health of Kansas Inc. (1) (Kansas) (a)
100% First Script Network Services, Inc. (1) (Nevada) (a)
100% FOCUS HealthCare Management, Inc. (1) (Tennessee) (a)
100% Coventry Health Care of Missouri, Inc. (1) (Missouri) (a)
100% Aetna Better Health of Missouri LLC (4) (Missouri) (a)
100% Coventry Health Care of Illinois, Inc. (1) (Illinois) (a)
100% Coventry Health Care of West Virginia, Inc. (1) (West Virginia) (a)
100% Coventry Health Care of Virginia, Inc. (1) (Virginia) (a)
100% Coventry Health and Life Insurance Company (1) (Missouri) (a)
100% MetraComp, Inc. (1) (Connecticut) (a)
100%* Medical Examinations of New York, P.C. (1) (New York) (a)
100% Coventry Health Care of Kansas, Inc. (1) (Kansas) (a)
100% Coventry Health Care National Accounts, Inc. (1) (Delaware) (a)
100% Aetna HealthAssurance Pennsylvania, Inc. (1) (Pennsylvania) (a)
100% Aetna Better Health of Michigan Inc. (1) (Michigan) (a)
100% Aetna Health of Utah Inc. (1) (Utah) (a)
100% Aetna Better Health Inc. (1) (Tennessee) (a)
100% Aetna Better Health of Kentucky Insurance Company (1) (Kentucky) (a)
100% Coventry Rehabilitation Services, Inc. (1) (Delaware) (a)
*100% owned through Aetna's Nominees
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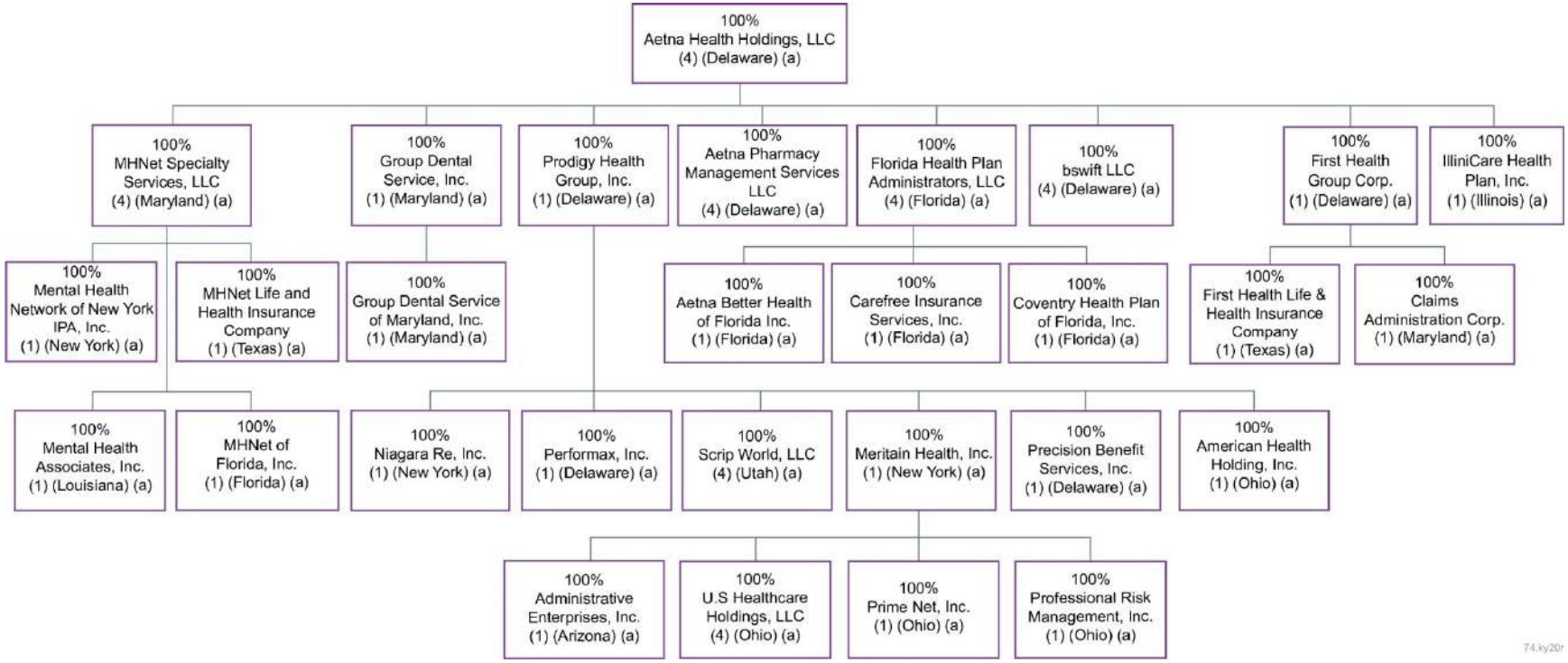
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100% MHNet Specialty Services, LLC (4) (Maryland) (a)
100% Group Dental Service, Inc. (1) (Maryland) (a)
100% Prodigy Health Group, Inc. (1) (Delaware) (a)
100% Aetna Pharmacy Management Services LLC (4) (Delaware) (a)
100% Florida Health Plan Administrators, LLC (4) (Florida) (a)
100% bswift LLC (4) (Delaware) (a)
100% First Health Group Corp. (1) (Delaware) (a)
100% IlliniCare Health Plan, Inc. (1) (Illinois) (a)
100% Mental Health Network of New York IPA, Inc. (1) (New York) (a)
100% MHNet Life and Health Insurance Company (1) (Texas) (a)
100% Group Dental Service of Maryland, Inc. (1) (Maryland) (a)
100% Aetna Better Health of Florida Inc. (1) (Florida) (a)
100% Carefree Insurance Services, Inc. (1) (Florida) (a)
100% Coventry Health Plan of Florida, Inc. (1) (Florida) (a)
100% First Health Life & Health Insurance Company (1) (Texas) (a)
100% Claims Administration Corp. (1) (Maryland) (a)
100% Mental Health Associates, Inc. (1) (Louisiana) (a)
100% MHNet of Florida, Inc. (1) (Florida) (a)
100% Niagara Re, Inc. (1) (New York) (a)
100% Performax, Inc. (1) (Delaware) (a)
100% Scrip World, LLC (4) (Utah) (a)
100% Meritain Health, Inc. (1) (New York) (a)
100% Precision Benefit Services, Inc. (1) (Delaware) (a)
100% American Health Holding, Inc. (1) (Ohio) (a)
100% Administrative Enterprises, Inc. (1) (Arizona) (a)
100% U.S Healthcare Holdings, LLC (4) (Ohio) (a)
100% Prime Net, Inc. (1) (Ohio) (a)
100% Professional Risk Management, Inc. (1) (Ohio) (a)
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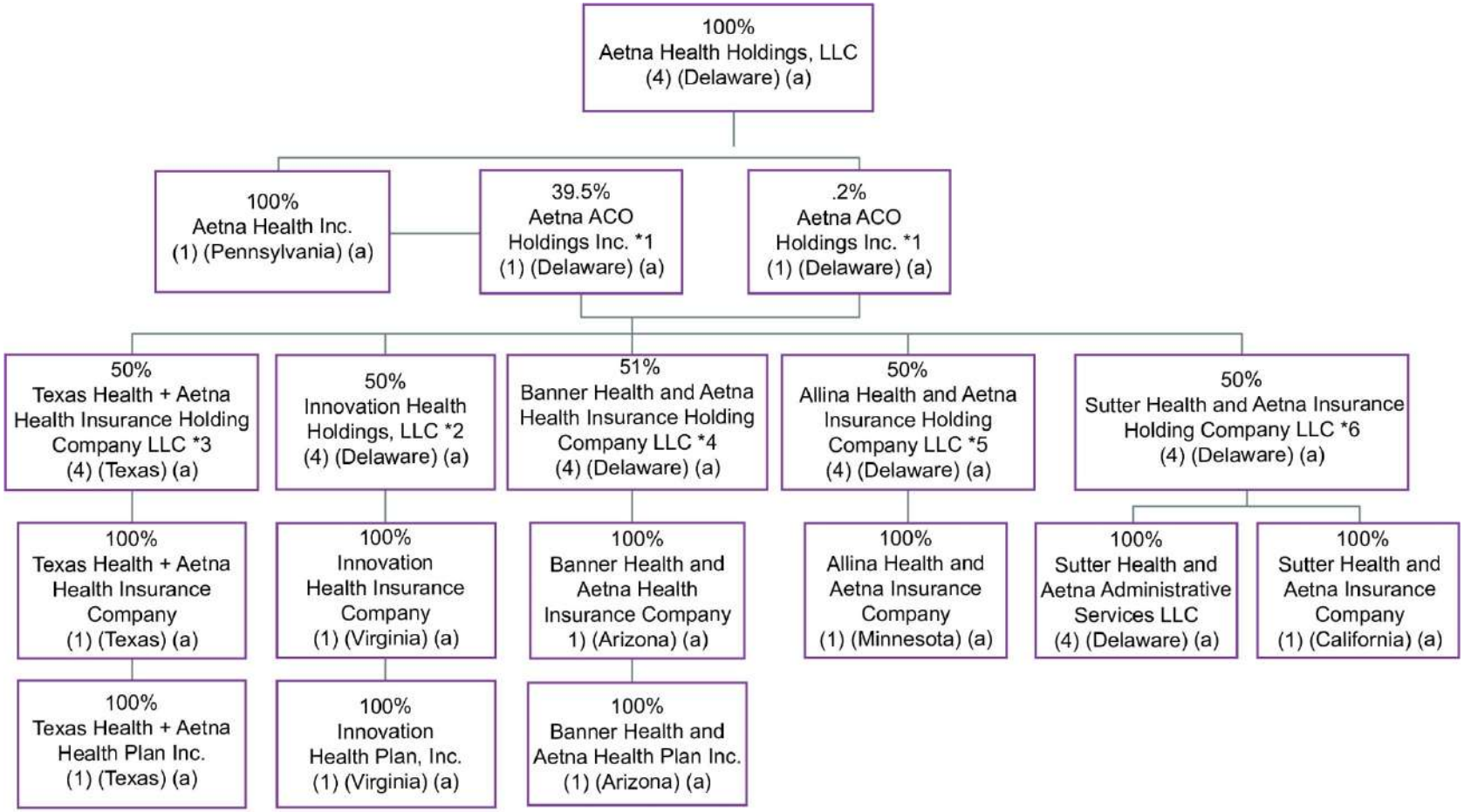

*1 Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share)
*2 Innovation Health Holdings, LLC is also 50% owned by Inova Health System Foundation
*3 Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources
*4 Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health
*5 Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health
*6 Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC

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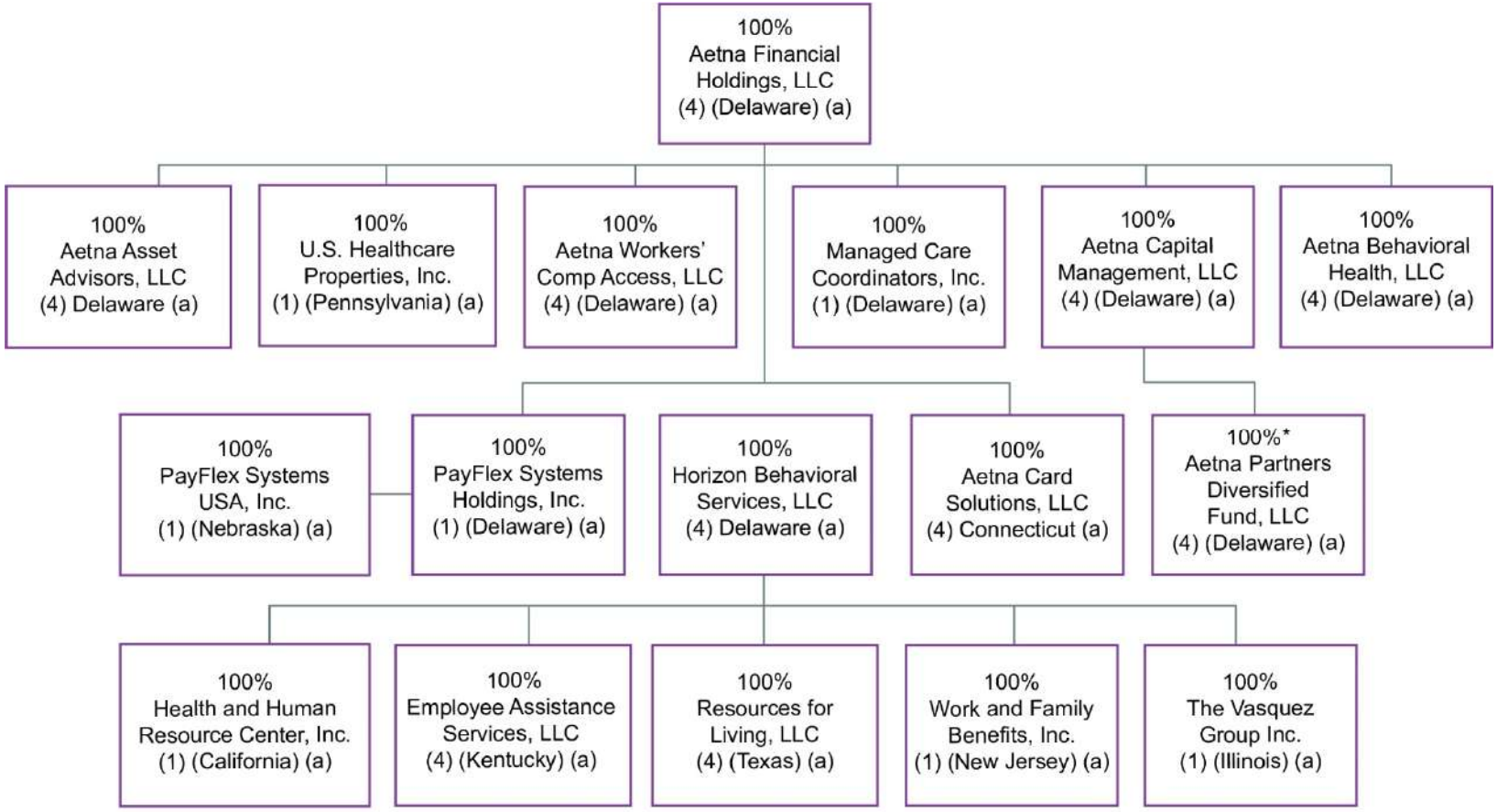

* Aetna Life Insurance Company owns substantially all of the non-managing member interests of Aetna Partners Diversified Fund, LLC.

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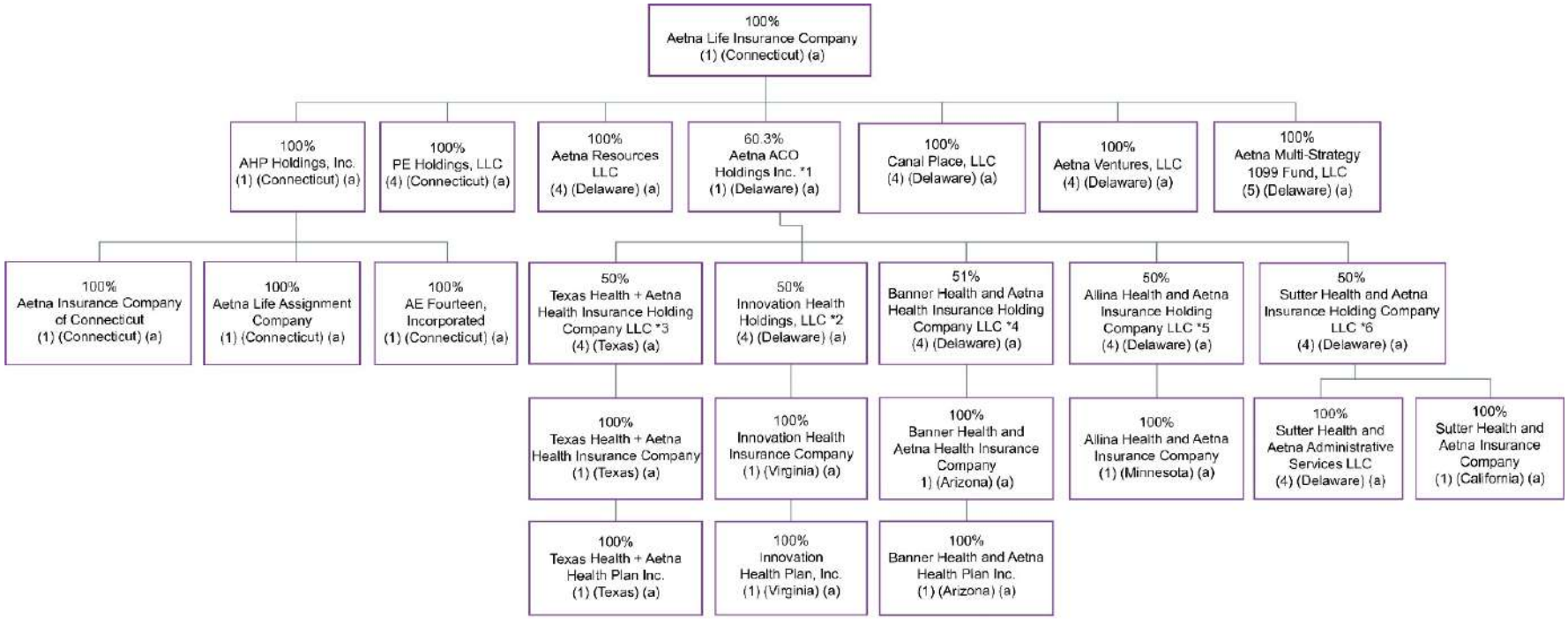

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*5 Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health
*6 Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC

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Attachment B

Kentucky | Transforming Health Care | **Aetna**

Attachment B
B.2.a.(iii) – Management Agreements

Administrative Services Agreement between Aetna Medicaid Administrators LLC and Aetna Better Health® of Kentucky ..... Att B-3

Administrative Services Agreement between Aetna Health Management LLC and Aetna Life Insurance Company ..... Att B-45

Administrative Services Agreement between Aetna Health Management LLC and Aetna Life Insurance Company ..... Att B-91

Program Agreement Between Aetna Medicaid Administrators LLC and Aetna Health Management LLC..... Att B-125

Amended Administrative Services Agreement between Aetna Medicaid Administrators LLC and Aetna Better Health® of Kentucky ..... Att B-149

Amended Administrative Services Agreement between Aetna Health Management LLC and Aetna Life Insurance Company..... Att B-163

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Administrative Services Agreement between Aetna Medicaid Administrators LLC and Aetna Better Health® of Kentucky

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ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement (together with any exhibits and attachments attached hereto, this "Agreement") is dated as of February 1, 2016, between Aetna Medicaid Administrators LLC ("Subcontractor"), and Aetna Better Health of Kentucky Insurance Company ("Purchaser" or "Company"), and shall become effective on the Effective Date (as defined below).

WHEREAS, Purchaser is a licensed insurer in the Commonwealth of Kentucky; and

WHEREAS, Purchaser has entered into the State Contracts (as defined below); and

WHEREAS, Subcontractor has the experience, trained personnel, knowledge, technical know-how, proprietary information and other resources and capability to develop, operate and market Purchaser's Plans (as defined below), as applicable; and

WHEREAS, to negotiate, arrange and administer the Services (as described below), Subcontractor makes use of important intangible property for the benefit of Purchaser.

NOW, THEREFORE, the parties hereto, intending to be legally bound, agree as follows:

1. Definitions. As used in this Agreement, the following terms have the respective meanings assigned to them in this Section 1:

"AAA" means the American Arbitration Association.

"Administrative Fees," for any period, means the product of (a) the Administrative Rate for such period and (b) the Premium Revenue Earned by Purchaser with respect to such period. Administrative Fees include without limitation broker and agent fees and commissions, if any. Administrative Fees exclude bad debt expenses, premium taxes (if any), state and/or guaranty fund assessments, statutory audit fees and expenses, intercompany interest expense, all taxes that are based on Purchaser's income, outside counsel fees and settlements and judgments.

"Administrative Rate" means the percentage rate to be mutually agreed to in writing by Purchaser and Subcontractor upon execution of a Rate Addendum in the form attached hereto as Attachment E.

"Administrative Services" has the meaning assigned to it in Section 2(a).

"Affiliate" means, with respect to any legal entity, any other legal entity or natural person that controls, is controlled by or is under common control with that legal entity.

"C.F.R." means the Code of Federal Regulations.

"Designated Record Set" has the meaning assigned to such term in 45 C.F.R. § 164.501.

"Effective Date" means the earliest date which Purchaser is obligated to provide services for the benefit of the Members under the State Contracts and after the receipt of approval or non-disapproval of this Agreement from all applicable State regulators.

"HHS" means the United States Department of Health and Human Services.

"Individual" shall have the same meaning as the term "individual" in 45 C.F.R. § 164.501 and shall include a person who qualifies as personal representative in accordance with 45 C.F.R. § 164.502(g).

"Investments" means debt securities, certificates of deposit, U.S. Treasury obligations and/or other investment vehicles that Purchaser is permitted to purchase under applicable law.

"Members" means, collectively and as applicable, subscribers and their dependents covered under the Plans, or such other members served under a State Contract, as applicable.

"Plans" shall mean, collectively and as applicable, the health plans or programs that are offered by Purchaser pursuant to the State Contracts, as applicable.

"Privacy Rules" means the regulations at 45 C.F.R. Parts 160–64, implementing the privacy requirements set forth in the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

"Protected Health Information" shall have the same meaning as the term "Protected Health Information," as defined by 45 C.F.R. § 160.103, limited to the information created or received by Subcontractor from or on behalf of Purchaser.

"Providers" means hospitals, physicians, dentists, pharmacies and other health care providers.

"Rebate" means payments from pharmaceutical manufacturers, the amount of which is based upon utilization of pharmaceutical products, if any, by Members of Purchaser.

"Rebate Services" has the meaning assigned to it in Section 3.

"Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.501.

"Revenue Earned," for any period, means, with respect to any legal entity and any period, gross premium revenue earned by such entity during such period on government sponsored or subsidized business, before ceded premium revenue incurred by such entity during such period, each as determined pursuant to statutory accounting principles and/or practices prescribed or permitted by the Commonwealth of Kentucky.

"Rules" means the AAA's Commercial Arbitration Rules as in effect on January 1, 2013.

"Secretary" shall mean the Secretary of HHS or his or her designee.

"Services" means Administrative Services and/or Rebate Services, if any.

"State" means Commonwealth of Kentucky.

"State Contracts" shall mean, individually and collectively, as applicable, (i) the *Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company*, effective July 1, 2015, pursuant to which Purchaser, as successor in interest to Coventry Health and Life Insurance Company ("CHLIC"), serves as a managed-care organization that provides managed Medicaid services in connection with the State's Medicaid program; (ii) all predecessor contracts to the foregoing, including without limitation the *Amended Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company* and the *Amended Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company (Region 3)*, both effective on or about October 4, 2013, as amended; and (iii) any successor contracts to or amendments of any of the foregoing and/or any analogous contracts with the State, whether issued by request for proposal or otherwise.

2. Administrative Services.

(a) Subcontractor will provide Purchaser with the administrative services and resources specified in Attachment A (collectively "Administrative Services") for the fees set forth in Attachment B. Purchaser may revoke delegation of services performed by Subcontractor under this Agreement, or impose other sanctions, if Subcontractor's performance is inadequate.

(b) In addition to Administrative Fees, Purchaser shall reimburse Subcontractor for all out of pocket expenses incurred by Subcontractor or its affiliates on behalf of Purchaser pursuant to this Agreement. Such out of pocket expenses shall include without limitation premium taxes, taxes that are based on Purchaser's income, statutory audit fees and expenses, debt collection costs, state and/or guaranty fund assessments, outside counsel fees and settlements and judgments payable by Purchaser.

(c) In consideration of Subcontractor's provision of the Administrative Services, (i) Purchaser hereby makes available to Subcontractor, and grants Subcontractor and each of Subcontractor's affiliates access to, as necessary or desirable, Purchaser's Provider network; and (ii) at Subcontractor's request, Purchaser shall enforce its agreements with the Providers in Purchaser's Provider network for the benefit of Subcontractor and/or Subcontractor's affiliates.

(d) Purchaser shall be responsible for any sales, use, value-added or other similar taxes, federal, state or otherwise, that may be levied on the Administrative Services.

(e) If the performance of all or any part of the Services to be provided under this Agreement is delayed or interrupted by a governmental authority or any entity other than Purchaser or Subcontractor, amounts payable under this Agreement

will be adjusted as agreed by the parties to reflect any increase in the cost of performance of this Agreement caused by the delay or interruption. Any delivery and performance dates and any other terms or conditions of this Agreement affected by such delay or interruption also will be adjusted by mutual agreement of Subcontractor and Purchaser. If such delay or interruption results in the termination of this Agreement by Purchaser, Subcontractor shall receive an amount equal to six (6) months of Administrative Fees (calculated pursuant to Attachment B based on the calendar month immediately preceding the delay or interruption), all implementation costs and other reasonable charges or expenses. Notwithstanding any other provision of this paragraph, no adjustment will be made for any delay or interruption to the extent that performance of all or any part of the Services to be provided under this Agreement would have been delayed or interrupted by any other cause, including the fault or negligence of Subcontractor. Throughout the period of any delay or interruption of all or any part of the Services to be provided under this Agreement, Purchaser will continue to pay to Subcontractor the Administrative Fees.

3. Rebate Services: If required by the terms of the State Contracts, Subcontractor shall provide the Purchaser with the following services (the "Rebate Services"), as necessary and subject to applicable law and the terms of the State Contracts, for the fees set forth in Attachment C:

(a) Subcontractor will develop, negotiate and contract, as necessary, for any Rebates and similar arrangements with pharmaceutical manufacturers and/or pharmaceutical benefits managers (each, a "PBM") relating to the utilization of pharmaceutical products by Members of Purchaser. Subcontractor makes no representation or warranty as to the total amount of any Rebates offered by or received from any particular PBM or by all contracted PBMs in the aggregate.

(b) Subcontractor will manage all aspects of any such Rebate arrangements with PBMs and administer such arrangements. The Rebate Services, if any, shall include as necessary, without limitation, collecting the data necessary for obtaining the Rebates; processing that data and periodically submitting it in a non-Member specific format to the applicable PBMs. The Rebate Services, if any, also may include without limitation the collection by Subcontractor of all Rebate amounts payable under the various PBMs' Rebate arrangements that Subcontractor has established. Subcontractor shall remit to Purchaser all such Rebates generated by Purchaser's Members' utilization of pharmaceutical products within forty-five (45) calendar days after the end of the calendar quarter during which Subcontractor earns such Rebates.

(c) Subcontractor shall develop, implement, maintain and support, as necessary, a formulary strategy for the Plans, as applicable.

(d) Subcontractor shall develop and maintain as necessary software systems to administer and increase the efficiency of the administration of any PBMs' rebate arrangements. Subcontractor will manage and fund the implementation of such

systems. Subcontractor shall be responsible for the maintenance and updates associated with such systems.

(e) Purchaser shall be responsible for any sales, use, value-added or other similar taxes, federal, state or otherwise, that may be levied on such Rebate Services.

(f) The Subcontractor shall maintain appropriate licensure and certifications required in order to perform its obligations under this Agreement.

4. Term and Termination.

(a) The initial term of this Agreement shall be for a period of one (1) year commencing on the Effective Date, and continuing to but excluding the first anniversary of the Effective Date. The term of this Agreement automatically shall be extended for additional periods of one year, unless either party shall notify the other party in writing at least ninety (90) days prior to the expiration of the term then in effect.

(b) This Agreement may be terminated prior to the end of the term then in effect by a written agreement executed by both parties. This Agreement also may be terminated at any time by Subcontractor upon Purchaser's breach of any of Purchaser's obligations under this Agreement or the State Contracts following ninety (90) calendar days' prior written notice of such breach and Purchaser's failure to cure such breach within such ninety (90) calendar days. This Agreement also may be terminated at any time by Purchaser upon Subcontractor's breach of any of Subcontractor's obligations under this Agreement following ninety (90) calendar days' prior written notice of such breach and Subcontractor's failure to cure such breach within such ninety (90) calendar days. This Agreement also will be terminated automatically upon the expiration, withdrawal, or termination of all State Contracts; provided, however, if not all State Contracts are terminated, this Agreement shall remain in full force and effect with respect to the remaining State Contracts.

(c) If at any time Subcontractor ceases to be an affiliate of Purchaser, this Agreement may be terminated by either party upon ninety (90) calendar days prior written notice without further liability, except for the payment of all amounts earned or otherwise due under this Agreement with respect to periods ending on or before the effective date of such termination.

(d) The parties mutually agree that it is essential for Protected Health Information to be maintained after the expiration of this Agreement for regulatory and other business reasons. The parties further agree that it would not be feasible for Purchaser to maintain such records because Purchaser lacks the necessary systems and expertise. Accordingly, Purchaser hereby appoints Subcontractor as Purchaser's custodian for the safe keeping of any record containing Protected Health Information that Subcontractor may determine it is appropriate to retain. Notwithstanding the expiration or termination of this Agreement, Subcontractor

shall extend the protections of this Agreement to such Protected Health Information, and limit further use or disclosure of such Protected Health Information to those purposes that make the return or destruction of the Protected Health Information not feasible.

5. Purchaser's Obligations.

(a) From time to time, Subcontractor may recommend to Purchaser policies and procedures for the operation of Purchaser's business. Purchaser shall consider implementation of such recommendations and shall review, comment upon and approve or provide notice of any objection to such policies and procedures, unless prohibited or restricted by applicable law or regulation. Purchaser acknowledges and agrees that time is of the essence in the review and approval of such policies and procedures and that it will dedicate such staff as necessary to meet Subcontractor's time frames.

(b) Purchaser shall cooperate with Subcontractor in the development and negotiation of any Rebate arrangements and provide Subcontractor with such data as may be reasonably necessary for Subcontractor to perform any Rebate Services.

(c) Purchaser hereby appoints Subcontractor as its agent to act on behalf of Purchaser in connection with the Services. As Purchaser's agent, Subcontractor is hereby authorized by Purchaser, among other things, to hire employees and to negotiate and enter into agreements and contracts on behalf of Purchaser. Purchaser shall perform its obligations with respect to, and be responsible for, all such employees and agreements. Nothing in this Agreement shall be construed to transfer or divest any obligation or responsibility of Purchaser which transfer or divestiture is prohibited by law or regulation.

6. Prohibition Against Assignment and Delegation. Neither Subcontractor nor Purchaser may assign this Agreement or its rights hereunder or delegate or subcontract any of its duties hereunder without the express prior written consent of the other party. Any attempted assignment or delegation in violation hereof shall be null, void and ineffective. Notwithstanding the foregoing, Subcontractor may perform the Services directly or indirectly through one or more of its affiliates or independent contractors, provided Subcontractor shall remain liable to Purchaser for the discharge of Subcontractor's obligations hereunder. Purchaser is responsible for the fulfillment of its obligations under the State Contracts. This Agreement shall in no way be construed as a guaranty by Subcontractor with respect to Purchaser's performance of any of Purchaser's obligations under the State Contracts.

7. Confidentiality of Data and Systems. During the term of this Agreement, each party will receive and have access to proprietary data and systems of the other party. Unless otherwise approved by the other party or unless otherwise required by law, each party agrees (i) to keep all such data and systems confidential and not to disclose or reveal any such data or system to any persons or entities, and (ii) not to use such data or systems for any purpose other than as required to perform Services pursuant to this Agreement. Each party also acknowledges that the other party is the owner of all such data and systems and agrees that they constitute confidential and

trade secret information which the recipient will treat as such and will provide security for and take reasonable measures to insure their protection. Upon termination of this Agreement, each party will return all copies of the other party's material in its possession or control or will destroy them, as requested by the other party. The owner of the material will bear reasonable costs for the return or destruction of its material.

8. Indemnification. Each party agrees to indemnify and hold the other harmless from and against any and all claims, actions, liabilities, losses, damages, costs and expenses (including without limitation reasonable attorneys' fees) incurred by reason of any legal or administrative action arising out of or caused by the negligence or other culpable wrongdoing of the indemnifying party or by any breach of the indemnifying party's obligations hereunder. Such indemnification is contingent upon prompt notice from the party seeking to be indemnified of the existence of any such claim or action and such party's full cooperation with the defense of any such claim or action, which shall be controlled by the indemnifying party at its election. The indemnifying party shall, at its election, also have full control over any settlement.

9. Obligations and Activities of Subcontractor Regarding Protected Health Information.

(a) Subcontractor agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law. Subcontractor, as a "business associate" under HIPAA, shall also comply with any further limitations on uses and disclosures agreed by Purchaser, as a "covered entity" under HIPAA, in accordance with 45 C.F.R. § 164.522, provided that such agreed-upon limitations have been communicated to Subcontractor.

(b) Subcontractor agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement, including without limitation the safeguards described in this Agreement.

(c) Subcontractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Subcontractor of a use or disclosure of Protected Health Information by Subcontractor in violation of this Agreement.

(d) Subcontractor agrees to promptly report to Purchaser any use or disclosure of Protected Health Information not permitted by this Agreement of which Subcontractor becomes aware.

(e) Subcontractor agrees to report to Purchaser any breach of unsecured Protected Health Information without unreasonable delay and in no case later than five (5) calendar days after discovery of the breach. Subcontractor's notification of a breach under this section shall comply in all respects with each applicable provision of Section 13400 of Subtitle D (Privacy) of the American Recovery and Reinvestment Act of 2009, of 45 C.F.R. § 164.410, and of related guidance issued by the Secretary from time to time.

(f) Subcontractor agrees to ensure that any agents, including any subcontractors, that create, receive, maintain, or transmit Protected Health Information on behalf of Subcontractor agree in writing to the same restrictions and conditions that apply

through this Agreement to Subcontractor with respect to such Protected Health Information. In no event shall Subcontractor, without Purchaser's prior written approval, provide Protected Health Information to any employee or agent, including any subcontractor, if such employee, agent, or subcontractor receives, processes, or otherwise has access to the Protected Health Information outside of the United States.

(g) Subcontractor agrees to provide access, at the request of Purchaser, and in the time and manner designated by Purchaser, to Protected Health Information in a Designated Record Set, to Purchaser or, as directed by Purchaser, to an Individual in order to meet the requirements of 45 C.F.R. § 164.524.

(h) Subcontractor agrees to make any amendments to Protected Health Information in a Designated Record Set that Purchaser directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of Purchaser or an Individual, and in the time and manner designated by Purchaser.

(i) Subcontractor agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Subcontractor on behalf of, Purchaser available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Purchaser's compliance with the Privacy Rule.

(j) Subcontractor agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Purchaser to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

(k) Subcontractor agrees to provide to Purchaser the information collected in accordance with this Section 9 to permit Purchaser to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

(l) Subcontractor agrees that it shall request from Purchaser and so disclose to its affiliates, agents and subcontractors or other third parties, (i) the information contained in a "limited data set," as such term is defined at 45 C.F.R. § 164.514(e)(2), or, (ii) if needed by Purchaser, the minimum necessary to accomplish the intended purpose of such requests or disclosures.

(m) With respect to Electronic Protected Health Information, Subcontractor shall implement and comply with (and ensure that its subcontractors implement and comply with) the administrative safeguards set forth at 45 C.F.R. § 164.308, the physical safeguards set forth at 45 C.F.R. § 310, the technical safeguards set forth at 45 C.F.R. § 164.312, and the policies and procedures set forth at 45 C.F.R. § 164.316 to reasonably and appropriately protect the confidentiality, integrity, and

availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Purchaser. Subcontractor acknowledges that the foregoing safeguard, policies, and procedures requirements shall apply to Subcontractor in the same manner that such requirements apply to Purchaser.

(n) With respect to Electronic Protected Health Information, Subcontractor shall ensure that any subcontractors that create, receive, maintain, or transmit Electronic Protected Health Information on behalf of Subcontractor agree to comply with the applicable requirements of Subpart C of 45 C.F.R. Part 164 by entering into a contract that complies with 45 C.F.R. § 164.314.

(o) Subcontractor shall report to Purchaser any Security Incident of which it becomes aware, including breaches of unsecured Protected Health Information as required by 45 C.F.R. § 164.410.

(p) To the extent Subcontractor is to carry out one or more of Purchaser's obligation(s) under Subpart E of 45 C.F.R. Part 164, Subcontractor shall comply with the requirements of Subpart E that apply to Purchaser in the performance of such obligation(s).

(q) Subcontractor shall use commercially reasonable efforts to maintain the security of Protected Health Information and to prevent unauthorized uses or disclosures of Protected Health Information. If Subcontractor conducts any Standard Transactions on behalf of Purchaser, Subcontractor shall comply with the applicable requirements of 45 C.F.R. Part 162.

10. Permitted Uses and Disclosures of Protected Health Information by Subcontractor.

(i) General Use and Disclosure. Except as otherwise limited in this Agreement, Subcontractor may use or disclose Protected Health Information to perform Subcontractor's obligations under this Agreement, provided that such use or disclosure would not violate (i) the Privacy Rule if done by Purchaser or (ii) the minimum necessary policies and procedures of Purchaser.

(ii) Specific Use and Disclosure Provisions. Except as otherwise limited by this Agreement, Subcontractor may use Protected Health Information for the proper management and administration of Subcontractor or to carry out the legal responsibilities of Subcontractor. Except as otherwise limited by this Agreement, Subcontractor may disclose Protected Health Information for the proper management and administration of Subcontractor, provided that disclosures are Required By Law, or Subcontractor obtains reasonable assurances from the person to whom the information is disclosed that the information disclosed will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Subcontractor of any instances of which such person is aware in

which the confidentiality of the information has been breached in accordance with the breach and security notification requirements of this Agreement.

(iii) Subcontractor shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an Individual without Purchaser's prior written approval and notice from Purchaser that it has obtained from the Individual, in accordance with 45 C.F.R. § 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by Subcontractor. The foregoing shall not apply to Purchaser's payments to Subcontractor for services delivered by Subcontractor to Purchaser.

(iv) Except as otherwise limited in this Agreement, Subcontractor may use Protected Health Information to provide Data Aggregation services to Purchaser as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B). Subcontractor may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).

11. Certain Obligations of Purchaser Regarding Protected Health Information.

(a) Provisions for Purchaser to Inform Subcontractor of Privacy Practices and Restrictions.

(i) Purchaser shall notify Subcontractor of any limitation(s) in its notice of privacy practices of Purchaser in accordance with 45 C.F.R. § 164.520, to the extent that such limitation(s) may affect Subcontractor's use or disclosure of Protected Health Information.

(ii) Purchaser shall provide Subcontractor with any change in, or revocation of, permission by any Individual to use or disclose Protected Health Information, to the extent that such change and/or revocation affects Subcontractor's uses and/or disclosures of Protected Health Information.

(iii) Purchaser agrees that Purchaser will not furnish or impose by arrangements with third parties or other Covered Entities or Business Associates special limits or restrictions to the uses and disclosures of Purchaser's Protected Health Information that may impact in any manner the use and disclosure of Protected Health Information by Subcontractor under this Agreement, including without limitation restrictions on the use and/or disclosure of Protected Health Information as provided for in 45 C.F.R. § 164.522.

(b) Permissible Requests by Purchaser. Purchaser shall not request Subcontractor to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Purchaser.

12. Miscellaneous.

(a) Regulatory References. A reference in this Agreement to a section in the Privacy Rules means the section as in effect or as amended, and for which compliance is required.

(b) Amendments. Except as set forth below in this Section 11(b), this Agreement may be amended solely by written agreement of the parties hereto, subject to any required government approvals. Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend this Agreement in such manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such amendment, it shall so notify the first party in writing within thirty (30) calendar days of the notice. If the parties are unable to agree on an amendment within thirty (30) calendar days thereafter, then either of the parties may terminate this Agreement on thirty (30) calendar days' written notice to the other party.

(c) Survival. The respective rights and obligations of Subcontractor under Section 4(d) of this Agreement shall survive the termination of this Agreement.

(d) Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Purchaser to comply with the Privacy Rules.

(e) No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors and permitted assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

(f) Notices. Any notice required to be given pursuant to this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or by email or facsimile:

to Subcontractor at:

Aetna Inc.
Law & Regulatory Affairs, RE6A
151 Farmington Avenue
Hartford, CT 06156
P: 860-273-2810
F: 860-902-7738
Attention: Legal Department

and to Purchaser at:

Aetna Better Health of Kentucky Insurance Company
Law & Regulatory Affairs, RE6A
151 Farmington Avenue
Hartford, CT 06156
P: 860-273-2810
F: 860-902-7738
Attention: Legal Department

The above addresses may be changed at any time by either party upon written notice.

(g) Waiver. No waiver of any term or provision of this Agreement shall be valid unless in writing and executed by the waiving party. It is expressly understood that if any party shall fail to perform any term or condition of this Agreement and the other shall not enforce or give notice of default, the failure to enforce or give notice of default shall not prevent enforcement of any other term or condition of this Agreement or the giving of notice of any other failure to perform or any other default.

(h) Integration. This Agreement, including the attachments hereto, constitutes the entire agreement between the parties with respect to the subject matter hereof.

(i) No Violation of Law. This Agreement shall not be interpreted to impose obligations or responsibilities upon a Subcontractor which require the Subcontractor to violate the statutes or rules governing licensure of the Subcontractor if the Subcontractor is to comply with the terms of this Agreement.

(j) Validity of Agreement/Choice of Law. The validity, enforceability and interpretation of this Agreement will be determined and governed by the laws of the Commonwealth of Kentucky without regard for the conflicts of laws principles thereof. The invalidity or unenforceability of any term or provision hereof will not, unless otherwise specified herein, affect the validity or enforceability of any other term or provision hereof.

(k) Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, and all of which, together, constitute one and the same instrument. This Agreement shall become binding when one or more counterparts, individually or taken together, bears the signature of both parties.

(l) Headings for Convenience. The underlined headings contained in this Agreement are for convenience of reference only and are not part of this Agreement.

(m) Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity of this Agreement, except for temporary,

preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the AAA and conducted by a sole arbitrator, who shall be unaffiliated with each party, in accordance with the Rules. The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1–16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. Except as may be required by law or to the extent necessary in connection with a judicial challenge, or enforcement of an award, neither a party nor the arbitrator may disclose the existence, content, record or results of an arbitration. Fourteen (14) calendar days before the hearing, the parties will exchange and provide to the arbitrator (i) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (ii) premarked copies of all exhibits they intend to use at the hearing. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary relief and is not empowered to award damages other than compensatory damages. The location of the arbitration shall be in Kentucky or any other location acceptable to both parties.

(n) Management of Purchaser. Notwithstanding any other provision of this Agreement, it is understood that the business and affairs of Purchaser shall be managed by its Board of Directors and, to the extent delegated by such Board and applicable law, by Purchaser's officers. Neither Subcontractor nor any of its officers or agents shall have any management authority or prerogatives with respect to the business affairs and/or operations of Purchaser except as specifically set forth in this Agreement.

(o) Non-Discrimination. All services provided pursuant to this Agreement shall be provided without regard to the Member's race, color, sex, age, religion, national origin or source of payment.

(p) Independent Contractors. The relationship of Subcontractor to Purchaser, as well as Subcontractor's employees and agents, is that of independent contractors, and except as expressly provided herein to the contrary, Subcontractor shall not be considered an agent or representative of Purchaser for any purpose, nor shall Subcontractor hold itself out to be an agent or representative of Purchaser for any purpose.

(q) Reports. Records and Audits. The books and records of Purchaser as they pertain directly to this Agreement will be available for review and audit by the Secretary, by the State's Department of Medicaid Services, by any other governmental authority with jurisdiction over the State Contracts, and/or by any of their respective designees. To the extent required by law and to the extent consistent with the appropriate jurisdiction of the foregoing agencies, the books and records of Subcontractor as they pertain directly to this Agreement will be available for review in the Commonwealth of Kentucky.

(r) Subcontractor Regulatory Addendum. The parties shall comply with the terms set forth in Attachment D attached hereto and made a part hereof, as applicable.

(s) Severability. Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither party shall assert or claim that this Agreement or any provision hereof is void or voidable if such party performs under this Agreement without prompt and timely written objection.

THE NEXT PAGE IS THE SIGNATURE PAGE

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date and year first set forth above.

AETNA MEDICAID ADMINISTRATORS LLC, an Arizona limited liability company

By: Aetna Health Holdings, LLC
Its: Manager

By: _____

Name: Edward C. Lee

Title: Vice President & Secretary

Date: Dec. 21, 2015

AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY, a Kentucky corporation

By: Allison S. MacInnis

Name: Allison S. MacInnis

Title: Assistant Secretary

Date: Dec. 21, 2015

ATTACHMENT A
ADMINISTRATIVE SERVICES

Specific Responsibilities and Services. As agreed to between Purchaser and Subcontractor from time to time, Subcontractor's duties may include without limitation the following, as necessary and subject to applicable law and the terms of the State Contracts:

(a) Finance. The following finance functions related to Purchaser's business to the fullest extent permitted by applicable law: All accounting and reporting functions, including without limitation billing, accounts receivable, accounts payable, payroll, budgets, premium rates, financial and statutory reporting, tax return preparation and cash management. All financial records shall be available to Purchaser at all times. As more fully set forth in Section (u) of this Attachment A, Subcontractor shall deposit in a bank (or banks) all receipts and monies arising from the operation of Purchaser and make disbursements on behalf of Purchaser in such amounts and at such times as the same are required. Signatures and approvals as to the amounts of all checks shall be in accordance with duly adopted policies of Purchaser. Subcontractor shall supervise and direct the collection of all accounts receivable due to Purchaser, taking all commercially reasonable steps to minimize the number and amount of bad debts.

(b) Human Resources. Human resource and personnel administrative and recruiting services. Purchaser (through its Board of Directors in the case of officers) shall have the right to approve the hiring, termination or disciplining of any officer, department head or medical director of Purchaser.

(c) Operational Services. General operational services, including without limitation telephone and computer system design services, mail services and microfilm services.

(d) Procurement. Procurement services, including without limitation the extension of Subcontractor's volume vendor discounts, to the extent available.

(e) Legal Services. Subject to the direction of Purchaser's Board of Directors, Subcontractor shall arrange for provision of the legal services necessary to meet the needs of Purchaser except with respect to any legal dispute between Subcontractor and Purchaser relating to this Agreement. Without limiting the generality of the foregoing, (i) Subcontractor shall arrange for the legal review and analysis of enrollee, benefit, Provider, and marketing contracts, regulatory compliance matters, management and coordination of Purchaser's litigation, arbitration, and subrogation activities, and general corporate and healthcare related legal work; and (ii) Subcontractor shall coordinate the defense of any litigation or claims related to the Services or Purchaser's operations, although Purchaser shall remain liable for any ultimate settlements or judgments, as set forth in Section 2(b).

(f) Claims Payment. Payment of claims and benefits incurred by Members.

(g) Quality Assessment/Utilization Review/Disease Management/ Patient Management/Case Management. Medical support functions in the nature of quality assessment services, including without limitation the preparation of quality assessment services, practice guidelines, National Committee for Quality Assurance ("NCQA") accreditation, disease management services, utilization review services, patient management and case management services, and risk management programs, and Member grievance policies and procedures to enable Member access to cost effective health care.

(h) Customer Services. Employer and Member customer services, including without limitation new Member telephone calls, Member surveys, servicing Member inquiries and problems and Member enrollment.

(i) Provider Network Services. Support functions in the nature of Provider contracting services, including without limitation the service obligations and quality aspects of agreements with Providers and Provider relations services. In addition, Subcontractor hereby makes available to Purchaser, and grants Purchaser access to, as necessary or desirable, any Subcontractor Provider network (including without limitation contracts that Subcontractor negotiates with national and regional vendors and providers, contracts that Subcontractor negotiates with centers of excellence outside of Purchaser's service area, and those portions of Subcontractor's Provider network that are made available to Subcontractor by agreements and/or other arrangements between Subcontractor and its affiliates). At Purchaser's request, Subcontractor shall enforce and/or use commercially reasonable efforts to cause its affiliates to enforce their respective agreements with the Providers in Subcontractor's Provider network for the benefit of Purchaser. Subcontractor will provide credentialing and recredentialing functions provided on behalf of Company for participating providers who are or who apply to become contracted with Company or its affiliate to provide services to Plan members.

(j) Facilities. Negotiating such terms and agreements as may be necessary or advisable for the furnishing of facilities, utilities, services, concessions and supplies for the maintenance and operation of Purchaser.

(k) Marketing. Subcontractor shall produce advertising, public relations and marketing materials on behalf of Purchaser for distribution by Purchaser and/or by Purchaser's duly licensed agents and shall support Purchaser in its marketing efforts. Purchaser acknowledges that any solicitation documents used by Purchaser are subject to filing with, and approval by, state regulatory agencies. Subcontractor also shall produce website marketing and other internet services and materials for Purchaser.

(l) Insurance and Risk Management. Subcontractor shall negotiate and maintain general and professional liability insurance, naming Purchaser as an additional insured thereunder, in amounts reasonably acceptable to Purchaser. Subcontractor shall deliver memorandum copies of its insurance certificates to Purchaser upon request.

(m) Data Processing. Subcontractor shall provide the computer and MIS resources necessary to perform the Services. Subcontractor shall provide access to adequate management information systems to carry out this Agreement.

(n) Pharmacy Services. Subcontractor may provide Purchaser with pharmacy benefit management services under Subcontractor's pharmacy benefit management program, including without limitation the following:

- Direct reimbursement of pharmacy claims to pharmacy Providers;
- Sales, marketing and account support services;
- Customer and provider services;
- Development and operation of a pharmacy precertification unit;
- Development and supply of management reports;
- Performance of drug utilization review programs, quality management programs and audit programs;
- Development and operation of a Pharmacy and Therapeutics Committee;
- Development, installation and implementation of a medication formulary;
- Management of Purchaser's pharmacy Provider network; and
- Provision of such other pharmacy-related benefit program management services as may be agreed upon by the parties from time to time.

(o) Ancillary and Other Agreements. Subcontractor shall negotiate and enter into such ancillary agreements on behalf of Purchaser as Subcontractor may deem necessary or advisable for the maintenance and operation of Purchaser.

(p) Licenses and Permits. Subcontractor shall apply for and maintain on behalf of Purchaser all necessary licenses and permits required by the Commonwealth of Kentucky, or by any other regulatory body with jurisdiction over Purchaser.

(q) Benefit Contracts. Subcontractor shall prepare the agreements and other documents relating to the Plans and State Contracts, as applicable, including without limitation coverage documents reflecting the benefit to be provided by Purchaser.

(r) Fees and Expenses. Subcontractor shall pay all fees and expenses of actuarial, auditing and/or accounting consultants of any type retained by Subcontractor to perform the Services, including without limitation any consultant used to obtain federal qualification or competitive medical plan status. Such fees and expenses are included in the Administrative Fees.

(s) Agents Fees and Commissions. On behalf of Purchaser, Subcontractor and/or its affiliates shall pay all broker and agent fees and/or commissions due with respect to Purchaser's business placed by such brokers and/or agents, if any. As set forth in

Section 2(a) of the Agreement, such fees and commissions (if any) are included in the Administrative Fees.

(t) Out-of-Pocket Corporate Maintenance Expenses. On behalf of Purchaser, Subcontractor and/or its affiliates shall pay the following out of pocket corporate maintenance expenses of Purchaser: costs of periodic state or federal securities or corporate reports, amendments to corporate documents, any expenses for fees of Purchaser's Board of Directors, and costs associated with meetings of the Board of Directors or shareholders or committee meetings. Such expenses are included in the Administrative Fees.

(u) Cash Management Services. Purchaser shall participate in Subcontractor's centralized cash management system (the "System"), and Subcontractor shall administer the System in accordance with the terms and conditions set forth below:

1. Procedures. The procedures for the System are as follows:

   a. All claims, expenses and other disbursement requests submitted for payment by Purchaser shall be processed and paid by Subcontractor through a centralized disbursement account or accounts held as specified herein.

   b. All premiums (if any) and other payments made to Purchaser by third parties shall be received and processed by Subcontractor through a centralized depository account or accounts (e.g., lock box(es)) held as specified herein.

   c. All of the foregoing transactions shall be recorded on the books of Purchaser in an intercompany account with Subcontractor and recorded on the books of Subcontractor in an intercompany account with Purchaser.

   d. The System also shall account for the reimbursement by Purchaser to Subcontractor of costs expended by Subcontractor and/or its affiliates on behalf of Purchaser using applicable statutory accounting principles and/or practices prescribed or permitted by the Commonwealth of Kentucky and/or accounting principles generally accepted in the United States of America.

   e. Subcontractor shall follow such directions and instructions as may be given to Subcontractor by Purchaser from time to time with respect to the funds of Purchaser and the participation of Purchaser in the System.

2. Condition of Participation. The participation of Purchaser in the System, as described in this Agreement, is expressly conditioned upon all investment accounts holding assets of Purchaser being in the name of Purchaser. Depository, disbursement and other non-investment accounts holding assets of Purchaser may be in the name of Purchaser and/or Subcontractor.

3. Settlement of Accounts. Intercompany balances resulting from the operation of the System shall be settled as to Purchaser within 15 calendar days after the end of each calendar month (where possible) and in no event more than 45 calendar days after the end of each calendar quarter.

4. Interest on Balances. Interest shall be charged or credited monthly on all intercompany cash balances resulting from the operation of the System as set forth in Section (b) of Attachment B.

(v) Investments. Subcontractor may, from time to time, buy Investments for Purchaser and place such Investments in the name of or for the account of Purchaser for the purpose of settling intercompany balances. Such Investments shall be held in the name of Purchaser. Unless specifically permitted by an investment policy by Purchaser's Board of Directors, Subcontractor shall not place the funds of Purchaser in any Investment that is not secured or backed by the full faith and credit of the United States or insured by a U.S. Government agency (e.g., the FDIC).

(w) Audit Rights. Purchaser shall have the right, at its expense, to audit the books, records and accounts of Subcontractor related to this Agreement after giving reasonable notice to Subcontractor of Purchaser's intent to conduct such an audit. In the event of such audit, Subcontractor shall give Purchaser reasonable cooperation and access to all books, records and accounts necessary to the audit.

(x) Records. Each party shall be the sole owner of its financial and accounting records, regardless of the use or possession by a party of any other party's records. Subcontractor and Purchaser shall each individually maintain separate books, accounts and records with respect to Services provided under this Agreement. The books and records of Purchaser shall be maintained at such location or locations, within or without the Commonwealth of Kentucky, as Subcontractor and Purchaser may agree from time to time. Subcontractor and Purchaser each shall maintain their own books, accounts and records in such a way as to disclose clearly and accurately the nature and detail of the transactions between them.

(y) Reports. Subcontractor shall submit to Purchaser such reports regarding the Services at such times as Purchaser shall reasonably request or as Subcontractor shall deem necessary or appropriate to keep Purchaser apprised of Subcontractor's performance of the Services.

(z) Additional Notices. Subcontractor shall promptly notify Purchaser upon (i) receipt of any summons, complaint or process before any legal or regulatory body relating to this Agreement or (ii) obtaining knowledge of any legal or administrative claim, action, investigation or proceeding against Subcontractor relating to this agreement.

ATTACHMENT B
FEES FOR ADMINISTRATIVE SERVICES

(a) For the Administrative Services, Purchaser shall pay Subcontractor the Administrative Fees within forty-five (45) calendar days after the end of the calendar quarter with respect to which such Administrative Fees are payable.

(b) Except as set forth on Attachment C, all intercompany balances under this Agreement shall be settled within forty-five (45) calendar days after the end of each calendar quarter. Interest shall be charged monthly on all intercompany balances (including without limitation Administrative Fees and cash balances resulting from the operation of the System) at a rate equal to the monthly average overnight interest rate earned on Subcontractor's investments during the month for which interest on such intercompany balances is being calculated.

(c) Each of Subcontractor and Purchaser shall have the right to offset all intercompany receivable and payable balances (including without limitation Administrative Fees) with the other party.

(d) The Administrative Fees are based upon the current federal and state laws and regulations that govern Subcontractor and/or Purchaser. The parties hereto acknowledge that if any of such laws or regulations are amended, the cost and expenses of operating Purchaser may change. Therefore, upon any such amendment or replacement, the parties shall renegotiate in good faith and agree on revised Administrative Fees hereunder.

ATTACHMENT C
REBATE SERVICES

(a) Pursuant to Section 3 of this Agreement, Subcontractor shall collect the Rebate amounts, if any, from the applicable manufacturers and remit 100% of the Rebates to Purchaser.

(b) All Rebate transactions shall be recorded on the books of Purchaser in an intercompany account with Subcontractor and recorded on the books of Subcontractor in an intercompany account with Purchaser.

(c) Intercompany balances for any Rebates shall be settled within forty-five (45) calendar days after the end of the calendar quarter during which Subcontractor earned the Rebates. If Subcontractor fails to forward the correct sum to Purchaser, or Purchaser fails to pay Administrative Fees, within the specified time, the party to whom the payment is due may charge interest at a rate equal to the monthly average overnight interest rate earned on Subcontractor's investments during the period for which interest on such amount is being calculated, along with any costs of collection and reasonable attorneys' fees.

(d) Each of Subcontractor and Purchaser shall have the right to offset all intercompany receivable and payable balances (including without limitation Administrative Fees) with the other party.

(e) Subcontractor shall submit to Purchaser on a quarterly basis a statement with any Rebates collected and remaining Rebate amounts to be forwarded to Purchaser, if any.

(f) The Administrative Fees are based upon the current federal and state laws and regulations that govern Subcontractor and/or Purchaser. The parties hereto acknowledge that if any of such laws or regulations are amended, the cost and expenses of operating Purchaser may change. Therefore, upon any such amendment or replacement, the parties shall renegotiate in good faith and agree on revised Administrative Fees hereunder.

ATTACHMENT D

Regulatory Compliance Addendum
Governing Kentucky Medicaid Services

This Regulatory Compliance Addendum Governing Kentucky Medicaid Services (the "Kentucky Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under the *Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company* (the "State Contract"), under which contract Coventry Health and Life Insurance Company or its successor in interest (the "Company") serves as a managed-care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract.

The Commonwealth of Kentucky, its Finance and Administration Cabinet, its Cabinet for Health and Family Services, and/or its Department for Medicaid Services (collectively, the "State"), require that specific terms and conditions be incorporated into the Agreement. As such, this Kentucky Medicaid Addendum is incorporated by reference into the Agreement and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof) must comply with the requirements set forth herein. Note that this Kentucky Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in Company's policies, procedures, and provider manual. This Kentucky Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this Kentucky Medicaid Addendum, the individuals who are enrolled with Company under the State Contract will be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Kentucky Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Kentucky Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Kentucky Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contract and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract. Except as provided herein, all other provisions of the Agreement not inconsistent with this Kentucky Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Kentucky Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement acknowledges and agrees that all provisions of this Kentucky Medicaid Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who are eligible and covered under the State Contract, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the State Contract, and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Kentucky Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this Kentucky Medicaid Addendum:

a. "Medically Necessary" or "Medical Necessity" – Nothwithstanding any definition thereof set forth in the Agreement, the foregoing terms shall mean Covered Services that are medically necessary as defined

under Section 2 of 907 KAR 3:130, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. § 1396d(r). [State Contract § 1.0]

b. "Provider" – Any person or entity under contract with Company or Company's contractual agent that provides Covered Services to Members. [State Contract § 1.0]

c. "Subcontract" – Any agreement entered into, directly or indirectly, by Company to provide or arrange for the provision of Covered Services. The term "Subcontract" does not include a policy of insurance or reinsurance purchased by Company or its Subcontractor to limit its specific or aggregate loss with respect to Covered Services provided to Members under the State Contract, so long as Company or its risk-assuming Subcontractor assumes some portion of the underwriting risk for providing health care services to Members. [State Contract § 1.0]

d. "Subcontractor" – Any entity other than a Provider, a physician health organization, or a provider network, with which Company has entered into a written agreement for the purpose of fulfilling an obligation of Company under the State Contract. [State Contract § 1.0]

B. Requirements Applicable to Contracts and Services

1. Provision of Covered Services. Provider agrees to provide Covered Services to Members as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:

a. If a Member requires emergency medical services, Provider will provide such services on a twenty-four (24) hour per day, seven (7) day per week basis. Provider will provide urgent care services within 48 hours of request. [907 KAR 17:015, § 2; State Contract §§ 29.7, 33.3]

b. If a Member requires the services of a specialist, Provider will provide such specialty services within thirty (30) days from the referral for routine care or within forty-eight (48) hours from the referral for urgent care. [907 KAR 17:015, § 2; State Contract § 29.7]

c. Provider shall provide Covered Services to Members in accordance with the State Medicaid plan, applicable State regulations, and the relevant policies and procedures applicable to each category of Covered Services. [State Contract § 31.1]

d. Provider shall provide basic, targeted, or intensive case management services as Medically Necessary to foster children who are discharged from a hospital or other residential facility, and shall thereafter participate in appropriate discharge planning that is focused on ensuring that the needed supports and services to meet the Member's behavioral-health and physical-health needs will be provided outside of the hospital or other residential facility. [State Contract § 36.4]

e. If Provider is a PCP, Provider shall perform the PCP functions set forth in Section 28.3 of the State Contract. [State Contract § 28.3]

f. Company shall not require Provider to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. § 438.102. Instead, Company shall have a referral process for situations in which a Provider declines to perform a service for ethical reasons. [State Contract § 28.12]

2. Claims; Payment; Coordination of Benefits.

a. Company shall only accept from Provider the uniform claim forms that have been approved by the State and that have been completed according to State guidelines. Provider acknowledges and agrees that the date of Company's receipt of any Provider claim shall be the date as indicated on its

date stamp on the claim or other notation as appropriate to the medium used to file a claim, and that the date of payment shall be the date of the check or other form of payment. [State Contract §§ 30.1. 30.2]

b. Provider acknowledges and agrees that with respect to any Covered Services provided to Dual Eligible Members (as that term is defined in the State Contract), Company shall pay to Provider the lesser amount of: (1) Company's allowed amount minus the Medicare payment, or (2) the Medicare co-insurance and deductible up to Company's allowed amount. [State Contract § 30.4]

c. Provider/Subcontractor acknowledges and agrees that with respect to any Covered Services, Company shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) that is: (1) furnished by any individual or entity during any period when that individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act; (2) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); (3) furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments; (4) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (5) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Medicaid plan; or (6) for home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in section 1861(o)(7) of the Social Security Act. [State Contract § 3.7(A)]

d. Upon request of Provider, Company shall provide or make available to Provider, when contracting or renewing this Agreement with such Provider, the payment or fee schedule or other information sufficient to enable Provider to determine the manner and amount of payments under the Agreement for Provider's services prior to the final execution or renewal of the Agreement, and shall provide any change in such schedules at least ninety (90) days prior to the effective date of any such amendment; provided, however, that Company may make periodic, non-material changes to its payment or fee schedules, such as updates to standard codes and guidelines developed by the American Medical Association or a similar organization, or such as changes required by the State or CMS, without prior written notice. [KRS 304.17A-527(1)(d); KRS 304.17A-577(1)(a); KRS 304.17A-577(2)]

e. In no event shall the State or any Member be liable for the payment of any debt or fulfillment of any obligation of Company, Provider/Subcontractor, or any subcontractor to any Provider/Subcontractor, supplier, out-of-network provider, or any other party, for any reason whatsoever, including the insolvency of Company or any Provider/Subcontractor. Provider/Subcontractor agrees that any contracts that Provider/Subcontractor has with its subcontractors will contain a hold harmless provision and will comply with all provisions of the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract § 13.2]

f. Provider/Subcontractor shall not directly receive payment or any type of compensation from Members for providing Covered Services. Provider/Subcontractor may not bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or any persons acting on their behalf, for services rendered in accordance with the Agreement. This prohibition applies even if Company becomes insolvent, fails to pay Provider/Subcontractor for services rendered, or otherwise breaches the Agreement. This provision does not prohibit the collection from Members of State-authorized co-pays, co-insurance, or deductibles for providing Covered Services. Member co-pay, co-insurance, or deductible amounts cannot exceed the amounts specified in 907 KAR 1:604. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract §§ 11.8, 14.2, and 31.4]

g. Provider/Subcontractor shall not bill a Member for Medically Necessary Covered Services, with the exception of applicable co-pays or other cost sharing requirements provided under the State Contract. If Provider/Subcontractor knowingly and willfully bills a Member for a Medicaid Covered Service, Provider/Subcontractor shall be guilty of a felony and upon conviction may be fined as defined in Section 1128B(d)(1), 42 U.S.C. § 1320a-7b of the Social Security Act. This provision shall remain in effect even if Company becomes insolvent. If a Member agrees, in advance, to pay for a service that is not a Covered Service under the State Contract, Company or Provider/Subcontractor may bill the Member for that service. The standard release form signed by a Member at the time of services does not relieve Company or Provider/Subcontractor from the prohibition against billing a Member in the absence of a knowing assumption of liability for a non-Covered Service. The form or other type of acknowledgement relevant to the Member's liability for non-Covered Services shall specifically state the services or procedures that are not covered by Medicaid. [State Contract § 31.4]

h. If Provider/Subcontractor is involved in coordination-of-benefits collections, Provider/Subcontractor shall report coordination-of-benefits information to Company. Provider/Subcontractor shall not pursue collection from the Member, but rather must pursue collection directly from the third party payer or the provider. Access to Covered Services shall not be restricted due to coordination-of-benefits collection. The State has the right to review all billing histories and other data related to coordination-of-benefits activities for Members. [State Contract § 14.1]

i. Company shall process all health care claims submitted for the provision of Covered Services to Members in accordance with KRS 304.17A-726. [KRS 304.17A-726]

j. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition that meets the following criteria: (1) is identified in the State Medicaid plan; (2) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (3) has a negative consequence for the Member; (4) is auditable; and (5) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise be made. [State Contract § 31.7]

k. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver.

l. Company shall not be liable to make any payments for Covered Services for which Provider/Subcontractor fails to follow the preadmission authorization and eligibility verification (for inpatient or outpatient services) procedures set forth in the Agreement, the State Contract, or the Medicaid program. Furthermore, all or a portion of payment due to the Provider/Subcontractor may be denied by Company if such payment is specifically attributable to Provider/Subcontractor's rendering or ordering: (i) services that are not Medically Necessary; (ii) elective hospitalization not authorized by Company; (iii) services provided other than at an authorized level of care; (iv) services that are not Covered Services; or (v) services related to complications from a non-Covered Service. In the event Provider/Subcontractor does not agree with a denial of payment determination made, Provider/Subcontractor may file an appeal in accordance with applicable procedures. [State Contract § 28.9]

3. Any Willing Provider; Provider Application; No Discrimination. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall comply with the "any willing provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270, as amended. Neither Company nor such Subcontractor shall require a Provider to enroll exclusively with its network to provide Covered Services under the State Contract. Nothing in the Agreement shall require or be construed to require a Provider, as a condition of participation in the Medicaid product that is the subject of the State Contract, to participate in any other products offered by Company. Company and Subcontractor (if Subcontractor manages a

network of providers as part of the services it provides to Company under the Agreement) shall comply with the terms and obligations set forth in KRS 304.17A-525, and shall allow all providers who desire to apply for network participation an opportunity to apply at any time during the year or, where Company or such Subcontractor does not conduct open continuous provider enrollment, shall conduct a provider-enrollment period at least annually with the date publicized to providers located in the geographic service area of the plan at least thirty (30) days in advance of such enrollment period. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall not discriminate against providers that serve high-risk populations or that specialize in conditions that require costly treatment, and shall not discriminate against a provider based upon that provider's licensure or certification. If Company or such Subcontractor declines to include a provider within its network, it shall give that affected provider written notice of the reason for its decision. Any option to terminate this Agreement without cause, or to non-renew this Agreement, that Company possesses under the terms thereof shall be subject to the "any willing provider" statute and to Provider's right to reapply for network participation, and Company will consider any such Provider reapplication consistent with the internal standards, policies, and procedures for provider participation that Company has developed in accordance with KRS 304.17A-270 and KRS 304.17A-525. [KRS 304.17A-150; KRS 304.17A-270; KRS 304.17A-525; State Contract § 29.1]

4. Anti-Gag Clause; No Retaliation. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall not limit a Provider's disclosure to a Member, or to another person on the Member's behalf, of any information relating to the Member's medical condition, health status, medical care, or treatment options (regardless of whether benefits for such care are provided under the State Contract), and shall not prohibit Provider from discussing all treatment options with the Member. Provider shall not be penalized, and no agreement with a Provider may be terminated, because Provider discusses Medically Necessary or clinically appropriate care with a Member or another person on the Member's behalf. Other information determined by Provider to be in the Member's best interest may be disclosed by Provider to Member or to another person on Member's behalf. Provider shall not be penalized for discussing with a Member any financial incentives and arrangements between the Provider and Company/Subcontractor, nor shall Company take any punitive action against a Provider that either supports, or requests an expedited resolution of, a Member's appeal. [KRS 304.17A-530; State Contract §§ 28.1, 28.12, 31.1]

5. Provider Grievances. Provider shall submit any grievance against Company on the State-approved provider grievance form. [State Contract § 28.9]

6. Connectivity to KHIE. If Provider is a PCP, Provider shall establish connectivity to the Kentucky Health Information Exchange ("KHIE") within one year of the effective date of this Agreement, or as otherwise determined by the State. If Provider is not a PCP, Company still encourages Provider to establish connectivity to KHIE. [State Contract § 17]

7. HEDIS and Encounter Data. Provider/Subcontractor shall submit all reports and clinical information required by Company, including but not limited to, HEDIS, EPSDT, etc., in such manner and pursuant to such timeframes requested by Company. Notwithstanding anything herein to the contrary, Provider/Subcontractor shall provide all necessary data, including but not limited to encounter and claims data, to Company in a format specified by the State in accordance with 42 C.F.R. § 438, unless otherwise agreed by the parties. Provider/Subcontractor shall report and/or submit all encounter records in an accurate and timely fashion. [State Contract §§ 16.1, 20.2, 33.1]

8. Amendments; Notice of Material Change. Company may unilaterally amend the Agreement to the extent necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards, or licensing guidelines or rules ("Regulatory Amendment"). Company shall give advance written notice to Provider of such Regulatory Amendment and the effective date thereof. With respect to amendments other than Regulatory Amendments, Company shall give advance written notice to any "participating provider" of any "material change" to this Agreement, as those terms are used and defined in KRS 304.17A-578, at least ninety (90) days prior to the effective date of the amendment. If Provider is a "participating provider" as that term is used and defined in KRS 304.17A-578: (i) the material-change notice shall include a description of the material change and a statement that Provider has the option to withdraw from the Agreement prior to the material change becoming effective; and (ii) Provider shall send written notice no later than forty-five (45) days prior to the effective date of the material change

if Provider opts to withdraw following notice of a material change; provided, however, if Company has not received notice of such withdrawal within that forty-five (45) day period, Provider's silence shall constitute acceptance of such amendment. If any change to the Agreement is with respect to an existing prior authorization, precertification, notification, or referral program, or changes to an edit program or specific edits, Company shall provide notice of the change to Provider at least fifteen (15) days prior to the change. [KRS 304.17A-578]

9. Assignment. The Agreement, being intended to secure the services of and be personal to Provider/Subcontractor, shall not be assigned or transferred by Provider/Subcontractor without the prior written consent of Company. Company may assign this Agreement without the consent of Provider/Subcontractor to any Affiliate or any other entity upon thirty (30) days' prior written notice. [State Contract § 6.2(H)]

10. Provider Subcontracts. If otherwise permissible under the Agreement, if Provider enters into a subcontract agreement with another provider to provide its licensed health care services to Members where the subcontracted provider will bill Company or Members directly for the subcontracted services, the subcontract agreement must meet all requirements of Ky. Rev. Stat. Chapter 304.17A and shall be filed with the Commissioner of the Kentucky Department of Insurance in accordance with Ky. Rev. Stat. § 304.17A-527(1)(e). [KRS 304.17A-527(1)(e)]

11. State Contract Creates No Third-Party Rights. Provider/Subcontractor acknowledges that the State Contract does not, and is not intended to, create any rights, benefits, or interests to Provider/Subcontractor. [State Contract § 4.5]

12. Subcontracts. With respect to any and all Subcontracts:

a. Subcontractor shall indemnify, defend, and hold harmless the State, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with the State Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor. [State Contract § 6.1]

b. Subcontractor, in the performance of its obligations, shall use only Medicaid-enrolled providers in accordance with the Agreement and the State Contract. [State Contract § 6.2(D)]

c. Subcontractor is prohibited from receiving any incentive, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services. In addition, a Subcontractor that performs utilization management activities is prohibited from receiving, and from providing to any individual or entity that performs such utilization management activities, any incentives for the denial, limit, or discontinuance of Medically Necessary Covered Services to a Member, all consistent with 42 C.F.R. §§ 422.208 and 438.6(h). [State Contract §§ 6.2(G), 21.2, 29.7]

d. Subcontractor is prohibited from assigning the Agreement or from further subcontracting without the prior written consent of the State. [State Contract § 6.2(H)]

e. The State is the intended third-party beneficiary of this Agreement and, as such, the State is entitled to all remedies that are afforded to third-party beneficiaries under the law. [State Contract § 6.2(I)]

f. Subcontractor, as required, shall timely submit encounter records in the format specified by the State so the Company can meet the specifications required by the State Contract. Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [State Contract §§ 6.2(J), 15.1]

g. Subcontractor shall comply with all provisions of the State Contract that relate to the services or activities that Company has delegated to Subcontractor under the Agreement, and Subcontractor shall furthermore comply with all applicable federal and State law and regulations, including but not limited to KRS 205.8451 through KRS 205.8483, all rules, policies, and procedures of the State, and all standards governing the provision of Covered Services and information to Members, all Quality

Assessment/Performance Improvement (QAPI) requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of the State, the Office of Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and State agents to inspect, investigate, monitor, and audit operations, all indemnification and insurance requirements, and all obligations upon termination. [State Contract § 6.2(K)]

h. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, on an ongoing basis, Subcontractor's performance and accreditation. Subcontractor shall be subjected to formal review by Company. [State Contract §§ 4.3(C), 6.2(L)]

i. Any Subcontractor with NCQA/URAC or other national accreditation shall provide Company with a copy of its current certificate of accreditation, along with a copy of the survey report. [State Contract § 6.2(M)]

j. Subcontractor shall report suspected fraud and abuse to Company. [State Contract § 6.2(P)]

k. If Company delegates to Subcontractor any activities or obligations of Company under the State Contract, Company may revoke such delegation or impose other sanctions if the Subcontractor's performance is inadequate, all in accordance with the terms set forth in the Agreement. [State Contract § 4.3(A)]

l. If Company identifies deficiencies or areas for improvement in the Subcontractor's performance under the Agreement, Subcontractor shall cooperate with Company in taking all necessary corrective action. [State Contract §§ 4.3(D), 6.2(N)]

m. If Company delegates to Subcontractor the selection of Providers under the Agreement, Company shall retain the right to approve, suspend, or terminate any Provider selected by that Subcontractor. [State Contract § 4.3(E)]

n. Subcontractor shall at all times remain in compliance with the requirements of 42 C.F.R. § 438. [State Contract § 4.3(F)]

o. A Subcontractor that provides Covered Services shall inform Company if that Subcontractor itself engages a subcontractor in any transaction or series of transactions, in performance of any term of the State Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense. [State Contract § 6.3]

p. Subcontractor acknowledges that the State shall have the right to invoke against Subcontractor any remedy that is set forth in the State Contract, including the right to require the termination of any Subcontract, for each and every reason for which the State may invoke such a remedy against Company or for which the State may require the termination of the State Contract. [State Contract § 6.4]

q. If Company delegates to Subcontractor any utilization-management activities or obligations, Subcontractor shall ensure that all utilization-management programs, processes, and timeframes are in accordance with 42 C.F.R. §§ 431, 438, and 456, with the private-review agent requirements of Ky. Rev. Stat. Chapter 304.17A, and with the State Contract. Such Subcontractor shall adopt Interqual or Milliman for Medical Necessity, except in the event that Interqual or Milliman is not applicable to the specific service being provided, in which case Subcontractor may use other appropriate criteria so long as (1) that criteria or standard is a nationally recognized standard of which the State Department for Medicaid Services has received prior notice, and (2) Subcontractor has confirmed that Interqual or Milliman do not, in fact, contain standards applicable to the specific service being provided. With respect to behavioral-health Medical Necessity determinations, Subcontractor shall adopt the following standardized tools: for adults, Level of Care Utilization System (LOCUS); for children, Child

and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children, Early Childhood Service Intensity Instrument (ECSII); and for substance use, American Society of Addiction Medicine (ASAM). [State Contract § 21.2]

r. If Company delegates to Subcontractor any credentialing or recredentialing activities/obligations, Subcontractor shall conduct all such activities/obligations in compliance with National Committee for Quality Assurance (NCQA) standards, with 907 KAR 1:672, with applicable federal law, and with the State Contract. [State Contract § 28.2]

s. Subcontractor acknowledges (1) that neither it nor its agents, officers, or employees shall be construed to be officers or employees of the State by virtue of the Agreement or the State Contract, and (2) that neither the Agreement nor the State Contract shall be construed as a partnership or joint venture between Subcontractor and the State. [State Contract § 41.7]

t. Subcontractor acknowledges that it is aware of the requirements and penalties outlined in KRS 45A.485, has properly disclosed all information required by this statute, and will continue to comply with such requirements for the duration of the State Contract. [KRS 45A.485]

u. Subcontractor acknowledges that it is aware of the requirements of Executive Order 2015-370 (Minimum Wage for State Employees and the Commonwealth's Service Providers) and that it will pay all workers working on or in connection with the State Contract a minimum of $10.10 per hour for all regular, hourly employees and a minimum of $4.90 per hour for all tipped employees for the duration of the State Contract. [Executive Order 2015-370]

13. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services:

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of Section 32.1 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 32.1]

b. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 32.0 of the State Contract. [State Contract §§ 32.0–32.11]

c. Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to process, adjudicate, and pay pharmacy claims in accordance with Section 32.4 of the State Contract, and to submit National Drug Code (NDC) level information on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. [State Contract §§ 32.4, 32.5]

d. Provider/Subcontractor shall comply with the pharmacy prior-authorization provisions and requirements set forth in Section 32.6 of the State Contract. [State Contract § 32.6]

e. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract to (1) establish and maintain a generic-drug Maximum Allowance Cost (MAC) program, and (2) manage specialty pharmacy drugs. [State Contract §§ 32.7, 32.8]

14. Behavioral-Health Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to behavioral-health Covered Services:

a. Provider/Subcontractor shall administer all behavioral-health benefits in accordance with the provisions and requirements of Section 34.3 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 34.3]

b. If Company delegates to Provider/Subcontractor any behavioral-health-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 34.0 of the State Contract. [State Contract §§ 34.0–34.12]

c. Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record. [State Contract § 34.3]

d. If Provider is a PCP, Provider shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavior-health problems and disorders. PCPs may provide any clinically appropriate behavior-health services within the scope of their practice. [State Contract § 34.7]

e. Provider shall provide behavioral-health services (1) within twenty-four (24) hours of the referral if that service requires crisis stabilization, and (2) within forty-eight (48) hours of the referral if that service is for behavioral-health urgent care. A behavioral-health service appointment following a discharge from an acute psychiatric hospital shall occur within seven (7) days of discharge, and any behavioral-health service appointment not otherwise specified in this subparagraph shall occur within sixty (60) days of the referral. [907 KAR 17:015, § 2; State Contract § 34.8]

f. Provider that is providing behavioral-health services (1) shall refer a Member with known or suspected and untreated physical-health problems to the Member's PCP for examination and treatment with the consent of the Member or the Member's legal guardian; (2) may only provide physical-health services if it is licensed to do so; (3) shall send initial and quarterly (or more frequently if clinically indicated) summary reports of the Member's behavioral-health status to the PCP with the consent of the Member or the Member's legal guardian; and (4) shall ensure that all Members receiving inpatient behavioral-health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge, with Provider ensuring that such outpatient treatment occurs within seven (7) days from the date of discharge and with Provider contacting Members who have missed an appointment within twenty-four (24) hours to reschedule that appointment. [State Contract §§ 34.7, 34.8]

g. A Provider that is providing behavioral-health services: (1) shall ensure continuity of care for successful transition of Members back into community-based supports; (2) shall participate in quarterly continuity-of-care meetings hosted by State-operated or State-contracted psychiatric hospitals; (3) shall assign a case manager prior to or on the date of discharge and provide basic, targeted, or intensive case management services as Medically Necessary to Members with severe mental illness ("SMI") and co-occuring developmental disabilities who are discharged from a State-operated or State-contracted psychiatric facility for Members with SMI; (4) shall participate in discharge planning meetings to ensure compliance with federal *Olmstead* and other applicable laws, with discharge planning focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion; (5) shall thereafter ensure the community supports are meeting the needs of the Member discharged from a State-operated or State-contracted psychiatric hospital; and (6) shall assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs. [State Contract § 34.10]

15. Access to Premises. Subcontractor shall allow duly authorized agents or representatives of the State or federal government or the independent external quality-review organization required by Section 1902(a)(30)(c) of the Social Security Act, 42 U.S.C. § 1396a(a)(30), access to Subcontractor's premises during normal business hours to inspect, audit, investigate, monitor, or otherwise evaluate Subcontractor's performance. If such access to Subcontractor is requested, Subcontractor shall provide and make staff available to assist in the audit or inspection effort, and shall provide adequate space on its premises to reasonably accommodate the State, federal, or external quality-review personnel conducting the audit, investigation, or inspection effort. In addition, Subcontractor shall produce all records, documents, or other data requested as part of such review, investigation, or audit. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Subcontractor's activities. [State Contract § 5.6]

16. Physician Incentive Plan Requirements. In the event compensation to Provider under the Agreement includes Physician Incentive Plans as defined by federal law, those Physician Incentive Plans shall comply with 42 C.F.R. §§ 417.479, 422.208, 422.210, and 438.6(h). Company shall make no specific payment directly or indirectly under a Physician Incentive Plan to Provider as an inducement to reduce or limit Medically Necessary Covered Services furnished to a Member. The Physician Incentive Plans shall not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. Company shall disclose to CMS information on Physician Incentive Plans in accordance with 42 C.F.R. §§ 417.479(h)(1) and 417.479(l) and at the times indicated in 42 C.F.R. § 417.479(d)–(g). Provider further acknowledges and agrees that in the event Provider is deemed to be at substantial financial risk under applicable Physician Incentive Plan regulations, Provider shall (i) cooperate and assist Company in conducting satisfaction surveys of Members using the Provider's services, and (ii) obtain, at Provider's sole expense, any additional stop loss insurance required pursuant to the Physician Incentive Plan regulations. In the event Provider must obtain stop loss insurance pursuant to the Physician Incentive Plan regulations, Provider shall obtain a stop loss policy with the following terms: (i) the policy is guaranteed renewable; (ii) termination of the policy shall not affect or reduce the policy insurer's obligation to cover, or responsibility for coverage of, the Provider's claims for Covered Services provided to Members during the term of such policy and which are covered under the applicable Plan; and (iii) the policy insurer will provide notice of termination or cancellation of the policy to Company. Bonus amounts paid pursuant to the Agreement, if any, shall not exceed 33% of the maximum payments possible to Provider for services that Provider furnishes directly to Members. [State Contract §§ 11.6, 11.7]

17. Stop-Loss Coverage. If Provider assumes substantial financial risk for contracted services, Provider shall maintain adequate stop-loss protection, sufficient proof of which, including the amount and type of stop-loss coverage maintained, shall be provided to Company by Provider upon request. [State Contract § 13.5]

18. Quality Assessment/Performance Improvement (QAPI) Program. Provider/Subcontractor shall participate in Company's Quality Assessment/Performance Improvement program activities (including but not limited to submission of complete encounter records), shall cooperate with Company with respect to Company's QAPI obligations under the State Contract, and shall cooperate with Company's Quality Improvement Committee. [907 KAR 17:025, § 6; State Contract §§ 19.1–19.4, 38.5]

19. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Provider/Subcontractor shall provide (and if Company delegates to Subcontractor the selection of Providers under the Agreement, Subcontractor shall ensure that its contracted Providers provide) EPSDT services to Members in compliance with the State Contract (and in particular Section 33.1 thereof), with 907 KAR 1:034, and with any policy statements issued by the State or CMS during the term thereof. Provider/Subcontractor shall also cooperate with Company with respect to Company's obligations under the State Contract to submit EPSDT reports to the State. [State Contract §§ 33.1, 38.9]

20. Third Party Liability. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contract or otherwise, is secondary to other sources of payment for Covered Services provided to Members, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required by the State Contract to "cost avoid" (*i.e.*, deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payor. [State Contract § 14.2]

21. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to assist the State with its planning process for the State's CMS/CMMI State Innovative Model Design Award initiative, which involves the State partnering with health-system stakeholders to develop a State Healthcare Innovation Plan (SHIP). [State Contract § 5.7]

b. Company's obligation to notify the State of the existence and nature of any capitation agreement that Company has with Provider/Subcontractor pursuant to which Provider/Subcontractor

assumes risk, including without limitation information relating to how Provider/Subcontractor pays its downstream providers/subcontractors for providing Covered Services to Members. [State Contract § 6.5]

c. Company's obligation to cooperate with the State as part of any readiness review under the State Contract. [State Contract § 8.1]

d. Company's obligation to submit financial and expense-related reports/data to the State relating to the Risk Corridor Payment Adjustment and the Medical Loss Ratio Adjustment set forth in the State Contract. [State Contract §§ 11.4, 11.5]

e. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [State Contract §§ 14.1, 14.2, 38.4]

f. Company's obligation to assist the State with verification that Providers are meeting the requirements of the Electronic Health Records Incentive Payment Program. [State Contract § 18.0]

g. Company's obligation to submit HEDIS reports/data to the State as set forth in the State Contract. [State Contract §§ 20.1–20.3]

h. Company's obligation to develop and implement Performance Improvement Projects as set forth in the State Contract. [State Contract § 20.5]

i. Company's obligation to provide orientation, education, and training for Providers as set forth in the State Contract. [State Contract § 28.5]

j. Company's obligation to reduce unnecessary emergency room visits so that the determination of non-emergent visits is reduced to no more than two (2%) percent in a rolling three (3) month period for that particular Medicaid region in the State. [State Contract § 29.7(J)]

k. Company's obligation to submit to the State claims-level cost data for payment-verification purposes relating to the State's supplemental payments, if any, under Section 30.11 of the State Contract. [State Contract § 30.11]

l. Company's obligation to conduct health risk assessments (HRAs) of Members as set forth in the State Contract. [State Contract § 35.1]

m. Company's obligation to perform care coordination and develop care plans for Members as set forth in the State Contract. [State Contract § 35.3]

n. Company's obligation to assist the State with its development of health homes for Company's medically complex Members. Once approved by CMS, Provider/Subcontractor shall comply with any health home program developed by the State. [State Contract § 35.4]

o. Company's obligation to coordinate with the Women, Infants and Children (WIC) program, including provision of medical information to the WIC program by Providers if requested by WIC agencies and if permitted by applicable law. [State Contract § 35.5]

p. Company's obligation to participate in transition planning and continued care coordination for Members with SMI who are transitioning from licensed personal-care homes, psychiatric hospitals, or other institutional settings to integrated, community-based housing, including the performance of a comprehensive physical and behavioral-health assessment designed to support the successful transition to community-based housing within fourteen (14) days of the transition. [State Contract § 36.6]

q. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Subcontractor or the services that are within the scope of the Agreement. [State Contract § 40.4]

22. Hospitalists. Nothing in the Agreement shall require, or be construed to require, the mandatory use of a hospitalist (defined as a physician of record at a hospital for a patient of a participating physician and who may return the care of the patient to that physician at the end of the hospitalization). [KRS 304.17A-532]

23. Licensing/Certification. Provider/Subcontractor shall meet all appropriate licensing and contract requirements specified in applicable State and federal laws and regulations. This includes certification, where required, to provide those health care services in the State as set forth in the Agreement, including certification under CLIA, if applicable. Where applicable, Provider/Subcontractor shall have a valid Drug Enforcement Agency registration number and valid NPI and taxonomy. [State Contract § 3.5]

24. Notice of Legal Action. Subcontractor shall provide written notice to Company of any legal action or notice listed below, within ten (10) days following the date Subcontractor receives written notice of:

a. Any action, proposed action, lawsuit, or counterclaim filed against Subcontractor related in any way to the Agreement or the State Contract;

b. Any administrative or regulatory action, or proposed action, respecting the business or operations of Subcontractor related in any way to the Agreement or the State Contract;

c. Any notice received by Subcontractor from the Kentucky Department of Insurance or the Kentucky Cabinet for Health and Family Services;

d. Any claim made against Subcontractor by a Member having the potential to result in litigation related in any way to the Agreement or the State Contract;

e. The filing of a petition in bankruptcy by or against Subcontractor, or the insolvency of Subcontractor; and

f. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in Subcontractor, or who is an agent or managing employee of Subcontractor, of a criminal offense related to that person's involvement in a program under Medicare, Medicaid, or Title XX of the Social Security Act, or of fraud, or unlawful manufacture, distribution, prescription, or dispensing of a controlled substance, as specified in 42 U.S.C. § 1320a-7.

[State Contract 41.4]

25. Termination of Agreement and Effect Thereof. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the Parties. Furthermore, in the event this Kentucky Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties. In addition:

a. In the event of a breach of the Agreement by Company, the termination of the Agreement, or the insolvency of Company, Provider/Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Agreement for the remainder of any month for which the State has made payments to Company, and shall fulfill all of its obligations respecting the transfer of Members to other Providers/Subcontractors, including record maintenance, access, and reporting requirements, all such covenants, agreements, and obligations of which shall survive the termination of the State Contract and the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(c); State Contract §§ 6.1, 40.8]

b. In the event of termination for any reason other than a quality of care issue or fraud, Company shall continue to reimburse Provider/Subcontractor in accordance with the Agreement until the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater; and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement is terminated. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(b)–(c); State Contract § 40.8]

c. Company and/or Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall terminate from participation any Provider that (i) engaged in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked, or suspended; (iii) has medical staff privileges at any hospital terminated, revoked, or suspended; or (iv) engaged in behavior that is a danger to the health, safety, or welfare of Members. Company and such Subcontractor may also terminate the participation of any Provider that has materially breached the Agreement and has failed to timely and adequately cure such breach. [State Contract § 29.6]

26. Protected Health Information. Provider/Subcontractor shall abide by the same statutes and regulations regarding the confidentiality of protected health information that Company is itself subject to under the State Contract and state and federal law, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d) and 45 CFR Parts 160 and 164. Company shall conduct HIPAA privacy and security audits of Provider/Subcontractor as prescribed by the State. This confidentiality provision shall survive termination of the Agreement. [State Contract § 39.1, 39.2, 41.15]

27. Access to Records**.** Provider/Subcontractor shall make all of its books, documents, papers, records, medical records, data, surveys, computer databases, or other evidence (collectively, the "Records") available for examination, audit, and/or program review by the State, the Finance and Administration Cabinet, the Auditor of Public Accounts, the Legislative Research Commission, the Attorney General of the State, the Kentucky Department of Insurance, the U.S. Department of Health and Human Services, CMS, the Office of Inspector General Comptroller, authorized federal or State personnel, and the authorized representatives of the governments of the United States and the State including, without limitation, any employee, agent, or subcontractor of the State, CMS, or the State's fiscal agent, for a period of five (5) years after termination of the State Contract, except when an audit has been conducted or audit findings are unresolved. In such case, Records shall be kept for a period of five (5) years in accordance with 907 KAR 1:672, or as amended or until all audit issues are finally resolved, whichever is later. Access shall be at the discretion of the requesting authority and shall be either through onsite review of Records or by submission of Records to the office of the requesting authority. Any Records requested shall be produced immediately for onsite reviews or sent to the requesting authority by mail within fourteen (14) days following a request. All Records shall be provided at the sole cost and expense of Provider/Subcontractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping, and/or mailing of records. The State shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by Provider/Subcontractor. [State Contract §§ 38.2, 39.1, 41.17, 41.21]

28. Medical Records. With respect to medical records:

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Member medical records on paper or in an electronic format. Provider/Subcontractor shall maintain Member medical records in a timely, legible, current, detailed, and organized manner to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the State Contract. Medical records shall be signed by the Provider/Subcontractor, as the case may be. [907 KAR 17:015, § 12; State Contract § 28.7]

b. Although the medical records are the property of the Provider/Subcontractor that generates the record, each Member or the Member's representative is entitled to one (1) free copy of his/her medical record. Additional copies shall be made available at cost. Provider/Subcontractor shall preserve and maintain Member medical records for no less than five (5) years unless federal requirements mandate a longer retention period (*i.e.,* immunization and tuberculosis records shall be maintained for a Member's lifetime). [907 KAR 17:015, § 12; State Contract § 28.7]

c. Provider/Subcontractor's medical records shall meet the medical record standards that Company and the State Contract require for medical-chart organization and documentation, for the contents of the medical record, and for individual clinical-encounter documentation. Medical records will reflect all aspects of patient care, including ancillary services. Additionally, a PCP's primary medical record for each Member must contain sufficient medical information from all providers involved in that Member's care to ensure continuity of care. [State Contract § 28.7]

d. If any Covered Service provided by Provider/Subcontractor requires completion of a specific form (*e.g.*, hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation (KAR). Provider/Subcontractor shall retain that form in the event of an audit and a copy shall be submitted to the State upon request. [State Contract § 31.1]

e. If a Member changes PCPs, Provider/Subcontractor shall forward the medical records or copies thereof to the new PCP or provider within ten (10) days of the request. The PCP shall have the Member sign a release of medical records before a medical record transfer occurs. [State Contract § 39.1]

29. Licensing Requirements; Malpractice Insurance.

a. Provider/Subcontractor shall be properly licensed in accordance with all applicable State laws and regulations and shall have in effect a current policy of malpractice insurance as Company may require. [State Contract, Appendix J]

b. Provider/Subcontractor shall comply with Company's verification of Provider/Subcontractor's credentials and insurance coverage, including without limitation completing a credentialing application in accordance with the State's policies and procedures. [907 KAR 17:015, § 4; State Contract, Appendix J]

c. Provider cannot enroll or continue participation in Company's network if Provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if the Provider's required licenses and certifications are not current, if the Provider owes money to the Medicaid Program, if the office of the Attorney General has an active fraud investigation involving the Provider, or if the Provider otherwise fails to satisfactorily complete the credentialing process. [State Contract § 29.3]

30. Disclosure of Ownership and Control.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time this Agreement is executed and annually thereafter, and any time there are changes to such information. [State Contract § 38.15]

b. No Provider, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider, and no officer, director, agent, or managing employee (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider or who directly or indirectly conducts the day-to-day operation of that Provider) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social SecurityAct (42 U.S.C. § 1320a-7(b)(1)–(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [State Contract § 3.6]

31. Orientation and Training. Provider shall require its officers and medical staff to attend initial orientation conducted by Company within thirty (30) days after Provider is placed on active status, and shall require same to attend any ongoing orientation and education required by Company as necessary to ensure full compliance with the State Contract and all applicable federal and State requirements. [907 KAR 17:015, § 7; State Contract § 28.5]

32. Advances and Loans. Company shall not, without thirty (30) days' prior written notice to and approval of State, make any advances to Subcontractor (not including capitation payments or payments made by Company to Company's network for the provision of Covered Services). [State Contract § 13.4]

33. Marketing Activities. Provider/Subcontractor shall comply with all allowable and unallowable marketing activities and practices pursuant to 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contract, prior to disseminating same. The State shall have the same approval authority for Subcontractor marketing materials as over Company's materials. [State Contract §§ 26.1, 26.2]

34. Advance Medical Directives. If Provider is a PCP, Provider shall have the responsibility to discuss advance medical directives with all adult Members at the first medical appointment of a Member and chart that discussion in the medical record of such Member. [State Contract §§ 28.3 & 28.8]

35. Accounting System. Provider/Subcontractor shall maintain its accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between Company and Provider/Subcontractor. These transactions shall include, but not be limited to, claims payment, refunds, and adjustment of payments. [State Contract § 38.14]

36. Compliance with Laws. Provider/Subcontractor shall adhere to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; the Americans with Disabilities Act of 1990, as amended; the Rehabilitation Act of 1973, as amended; Sec. 202 of Executive Order 11246, as amended; and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. Provider/Subcontractor shall not discriminate in the rendering of services to and/or employment of individuals because of race, gender, color, religion, sex, age, national origin, sexual orientation, gender identity, handicap, political beliefs, disabled veteran status, veteran status, or any other non-merit factor. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, through quality-assurance audits and otherwise, Subcontractor's compliance with the nondiscrimination provisions set forth in this Kentucky Medicaid Addendum. Subcontractor must also comply with the rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741, and regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*) and its implementing regulation at 45 C.F.R. Part 80, Provider/Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement.

Provider/Subcontractor's locations shall meet all requirements of the Americans with Disabilities Act and all State and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures that are applicable to health care facilities. [State Contract §§ 5.3, 5.4]

37. State Hold Harmless. Provider/Subcontractor shall indemnify, defend, save, and hold harmless the State and its officers, agents, and employees (collectively, the "State Indemnified Parties") from all claims, demands, liabilities, suits, judgments, or damages, including court costs and attorney fees made or asserted against or assessed to the State Indemnified Parties, arising out of or connected in any way with the State Contract or the performance or nonperformance by Company, by Provider/Subcontractor, or by any officers, agents, employees, suppliers, subcontractors, or providers of any of the foregoing, including without limitation any claim attributable to:

a. The improper performance of any service, or improper provision of any materials or supplies, irrespective of whether the State knew or should have known such service, supplies, or materials were improper or defective;

b. The erroneous or negligent acts or omissions, including without limitation the disregard of federal or State law or regulations, irrespective of whether the State knew or should have known of such erroneous or negligent acts;

c. The publication, translation, reproduction, delivery, collection, data processing, use, or disposition of any information to which access is obtained pursuant to the State Contract in a manner not authorized by the State Contract or by federal or State law or regulations, irrespective of whether the State knew or should have known of such publication, translation, reproduction, delivery, collection, data processing, use, or disposition; or

d. Any failure to observe federal or State law or regulations, including but not limited to insurance and labor laws, irrespective of whether the State knew or should have known of such failure.

[State Contract § 13.2]

ATTACHMENT E
RATE ADDENDUM

Aetna Medicaid Administrators LLC ("Subcontractor") and Aetna Better Health of Kentucky Insurance Company ("Purchaser") hereby agree that the Administrative Rate set forth in the Administrative Services Agreement between Subcontractor and Purchaser (the "Agreement") shall be the following:

Kentucky Medicaid & CHIP Plans: [redacted]

AETNA MEDICAID ADMINISTRATORS LLC, an Arizona limited liability company

By: Aetna Health Holdings, LLC
Its: Manager

By: _____

Name: Edward C. Lee

Title: Vice President & Secretary

Date: Dec. 21, 2015

AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY, a Kentucky corporation

By: Allison S. MacInnis

Name: Allison S. MacInnis

Title: Asst. Secretary

Date: Dec. 21, 2015

Administrative Services Agreement between Aetna Health Management LLC and Aetna Life Insurance Company

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AMENDED AND RESTATED ADMINISTRATIVE SERVICES AGREEMENT

This Amended and Restated Administrative Services Agreement (this "Agreement") is dated as of October 7, 2005 (the "Effective Date"), between Aetna Health Management, LLC, a Delaware limited liability company ("AHM"), and Aetna Life Insurance Company, a Connecticut corporation ("Purchaser").

WHEREAS, AHM and Purchaser are parties to that certain Administrative Services Agreement dated as of January 1, 2004 (the "Existing ASA"); and

WHEREAS, AHM and Purchaser desire to amend and restate the Existing ASA in its entirety; and

WHEREAS, Purchaser is a licensed insurer with business in each of the United States and the District of Columbia and, among other things, offers group health insurance products; and

WHEREAS, AHM has the experience, trained personnel, knowledge, technical know-how, proprietary information and other resources and capability to develop, operate and market Purchaser's group health insurance products; and

WHEREAS, to negotiate, arrange and administer the Services (as defined below), AHM makes use of important intangible property for the benefit of Purchaser; and

WHEREAS, with respect specifically to the Rebate Services (as defined below) AHM has the experience, trained personnel, knowledge, proprietary information, volume of manufacturers' rebates and other resources and capabilities to manage the formularies for different plans, develop, negotiate and arrange for manufacturers' rebate arrangements with the pharmaceutical industry and to administer such relationships for Purchaser; and

WHEREAS, to negotiate, arrange and administer the manufacturers' rebate arrangements with the pharmaceutical industry, AHM makes use of important intangible property for the benefit of Purchaser and AHM's intangible property involved in the negotiation process and in the administration of these complex arrangements includes its national formulary, plan designs and information technology/software systems; and

WHEREAS, Purchaser has established a PM Program (as described more fully below) and a QM Program (as defined below); and

WHEREAS, AHM has completed an on-site review of Purchaser's PM Program and Purchaser's QM Program and has reviewed Purchaser's documentation of same; and

WHEREAS, AHM has determined that Purchaser's PM Program and Purchaser's QM Program each meet AHM's standards and requirements, applicable state requirements, and those standards established by the NCQA, and, if applicable, the URAC; and

WHEREAS, AHM wishes to delegate to Purchaser and Purchaser wishes to perform certain PM functions on behalf of AHM; and

WHEREAS, Purchaser has requested delegation of certain QM functions from AHM to Purchaser with respect to certain Providers; and

WHEREAS, Purchaser and AHM are parties to the Existing Agreements and desire to terminate each of the Existing Agreements and replace each of the Existing Agreements with this Agreement.

NOW, THEREFORE, the parties hereto, intending to be legally bound, agree as follows:

1. Definitions. As used in this Agreement, the following terms have the respective meanings assigned to them in this Section 1:

"AAA" means the American Arbitration Association.

"Administrative Fees" has the meaning assigned to it in Section 2(a).

"Administrative Services" has the meaning assigned to it in Section 2(a).

"Adverse Action" has the meaning assigned to it in Attachment E, Section 4.

"affiliate" means, with respect to any legal entity, any other legal entity or natural person that, directly or indirectly, controls, is controlled by or is under common control with that legal entity.

"Aggregate Administrative Cost", for any period, means AHM's unreimbursed actual cost of providing the Administrative Services during such period. Aggregate Administrative Cost includes without limitation expenses incurred by AHM's affiliates for the benefit of Purchaser and allocated to AHM in accordance with generally accepted accounting principles. Aggregate Administrative Cost excludes bad debt expenses, premium taxes, state and/or guaranty fund assessments, statutory audit fees and expenses and intercompany interest expense.

"Aggregate Purchaser Cost", for any period, means Purchaser's unreimbursed actual cost of providing the Purchaser Provided Services during such period. Aggregate Purchaser Cost includes without limitation expenses incurred by Purchaser's affiliates for the benefit of AHM and allocated to Purchaser in accordance with generally accepted accounting principles. Aggregate Purchaser Cost excludes bad debt expenses, premium

taxes, state and/or guaranty fund assessments, statutory audit fees and expenses and intercompany interest expense.

"Brokerage Agreement" means an insurance brokerage agreement between AHM and/or one or more of AHM's HMO affiliates and a Broker.

"Brokers" means insurance brokers to whom AHM or one or more of AHM's HMO affiliates owes brokerage fees and/or commissions in connection with such insurance brokers' marketing of the group health benefit plans of such HMOs.

"Business" means, collectively, Purchaser's self-insured and fully insured health insurance businesses, including Purchaser's Medicare business and other health related businesses, including discount programs.

"Case Management" means a process under which health care benefits are assessed, coordinated, evaluated and monitored to meet an individual Member's needs.

"C.F.R." means the Code of Federal Regulations.

"Concurrent Review" means a telephonic or on-site assessment of the necessity of continued inpatient stay/level of care after the initial length of stay/course of treatment assignment has expired.

"Designated Record Set" has the meaning assigned to such term in 45 C.F.R. 164.501.

"Emergency Services" means, unless otherwise defined in the Member's Plan, medically necessary services to preserve life or stabilize health, available on an inpatient or outpatient basis, twenty-four (24) hours per day, seven (7) days a week.

"Existing Agreements" means, individually and collectively, (a) that certain Utilization and Network Management Services Agreement dated as of January 1, 1991, among Purchaser, Aetna Health and Life Insurance Company (formerly known as Aetna Life Insurance Company of Illinois) and AHM (then known as Aetna Health Management), as amended; (b) that certain Agency Agreement dated as of November 1, 1991, between AHM (then known as Aetna Health Management) and Purchaser; (c) that certain Delegated Patient Management Agreement dated as of September 1, 2000 between Parent and Purchaser and assumed by AHM pursuant to an Assignment and Assumption Agreement dated as of January 1, 2004, among Parent, AHM and Purchaser; (d) that certain Delegated Quality Management Agreement dated as of September 1, 2000 between Parent and Purchaser and assumed by AHM pursuant to an Assignment and Assumption Agreement dated as of January 1, 2004, among Parent, AHM and Purchaser; and (e) any other written agreement to which Purchaser and AHM are the only parties that is dated prior to the Effective Date.

"Fees" means the Administrative Fees and/or the Rebate Fees.

"HHS" means the United States Department of Health and Human Services.

"HMO" means health maintenance organization.

"including" means including without limitation.

"Individual" shall have the same meaning as the term "individual" in 45 C.F.R. 164.501 and shall include a person who qualifies as personal representative in accordance with 45 C.F.R. 164.502(g).

"Investments" means marketable debt securities, certificates of deposit and/or U.S. Treasury obligations.

"Members" means subscribers and their dependents covered under a health benefits plan, product or program that is issued, administered or serviced by Purchaser and/or one or more of Purchaser's affiliates, including participants in self-insured plans and discount programs.

"NCQA" means the National Committee for Quality Assurance and any successor thereto.

"Parent" means Aetna Inc., a Pennsylvania corporation.

"Participating Provider" means any Provider who or which has entered into and continues to have a current valid provider agreement with Purchaser and/or one or more of Purchaser's affiliates.

"Patient Management" or "PM" means the process of monitoring and evaluating on a prospective, concurrent and/or retrospective basis the medical necessity of health care services that are provided by Providers to Members, including Case Management, Precertification and disease management.

"Plan" means any health benefit plan, product or program issued, administered, or serviced by Purchaser and/or one of its affiliates, including: HMO, POS, PPO, indemnity, Medicaid, Medicare, Worker's Compensation and discount programs.

"PM Program" means the processes by which Purchaser monitors and evaluates on a prospective, concurrent and/or retrospective basis the medical necessity of health care services that are provided by Providers to Members, including such processes used in Case Management, Precertification and disease management.

"PM Services" has the meaning assigned to it in Section 5(a).

"POS" means point of service.

"PPO" means preferred provider organization.

"Precertification" means a process of assessing the medical necessity and appropriateness of proposed services and level of service, such as inpatient hospitalizations, outpatient surgeries, diagnostic procedures or specific medications, prior to the Provider rendering of such services to the Member.

"Privacy Rules" means the regulations at 45 C.F.R. Parts 160-64, implementing the privacy requirements set forth in the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

"Protected Health Information" shall have the same meaning as the term "Protected Health Information", as defined by 45 C.F.R. 160.103, limited to the information created or received by AHM from or on behalf of Purchaser.

"Provider" means a hospital, physician, skilled nursing facility, dentist, pharmacy and/or other person or legal entity involved in the delivery of health care or ancillary services.

"Purchaser Fees" has the meaning assigned to it in Section 7(a).

"Purchaser Provided Services" has the meaning assigned to it in Section 7(a).

"Purchaser System" has the meaning assigned to it in Attachment F, Section (g).

"QM Program" means the processes by which Purchaser evaluates and verifies (x) Providers' qualifications and competence to practice their profession without restriction and to provide health care services to Members and (y) Providers' satisfaction of Purchaser's and/or AHM's applicable participation criteria.

"QM Services" has the meaning assigned to it in Section 6(a).

"Quality Management" or "QM" means the evaluation and verification of (x) Providers' qualifications and competence to practice their profession without restriction and to provide health care services to Members and (y) Providers' satisfaction of Purchaser's and/or AHM's applicable participation criteria.

"Rebate" means payments from pharmaceutical manufacturers, the amount of which is based upon utilization of pharmaceutical products by Members of Purchaser.

"Rebate Fees" has the meaning assigned to it in Section 3.

"Rebate Services" has the meaning assigned to it in Section 3.

"Registration" is a process initiated by the primary care physician, specialist physician, or facility under which the Provider notifies Purchaser of proposed procedures, treatments or referrals, and Purchaser issues a length of stay assignment.

"Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. 164.501.

"Rules" means the AAA's Commercial Arbitration Rules as in effect on the Effective Date.

"Secretary" shall mean the Secretary of HHS or his or her designee.

"Services" means Administrative Services and/or Rebate Services.

"System" has the meaning assigned to it in Attachment A, Section (l).

"URAC" means the Utilization Review Accreditation Commission and any successor thereto.

2. Administrative Services Provided by AHM.

(a) AHM will provide Purchaser with the administrative services and resources specified in Attachment A (collectively "Administrative Services") for the fees set forth in Attachment B (collectively "Administrative Fees"). Administrative Fees excludes bad debt expenses, premium taxes, state and/or guaranty fund assessments, statutory audit fees and expenses, intercompany interest expense and all taxes that are based on Purchaser's income.

(b) In addition to Administrative Fees, Purchaser shall reimburse AHM for all out of pocket expenses incurred by AHM or its affiliates on behalf of Purchaser. Such out of pocket expenses shall include without limitation premium taxes, taxes that are based on Purchaser's income, statutory audit fees and expenses, debt collection costs, state and/or guaranty fund assessments, outside counsel fees and settlements and judgments payable by Purchaser.

(c) In consideration of AHM's provision of the Administrative Services, (i) Purchaser hereby makes available to AHM, and grants AHM and each of AHM's affiliates access to, as necessary or desirable, Purchaser's Provider network (including contracts that Purchaser negotiates with vendors and Providers); and (ii) at AHM's request, Purchaser shall enforce its agreements with the Providers in Purchaser's Provider network for the benefit of AHM and/or AHM's affiliates.

(d) Purchaser shall be responsible for any taxes, federal, state or otherwise, that may be levied on the Administrative Services.

(e) It is understood and agreed that Purchaser may sell some or all of the Administrative Services it receives from AHM to Purchaser's customers, as determined by Purchaser in its sole discretion.

3. Rebate Services: AHM shall provide Purchaser with the following services (the "Rebate Services") for the fees set forth in Attachment C (the "Rebate Fees"):

(a) AHM will develop, negotiate and contract for Rebates and similar arrangements with pharmaceutical manufacturers relating to the utilization of pharmaceutical products by Members of Purchaser. AHM makes no representation or warranty as to the total amount of Rebates offered by or received from any particular pharmaceutical manufacturer or by all contracted pharmaceutical manufacturers in the aggregate.

(b) AHM will manage all aspects of the Rebate arrangements with pharmaceutical manufacturers and administer such arrangements. The Rebate Services shall include without limitation collecting the data necessary for obtaining the Rebates; processing that data and periodically submitting it in a non-Member specific format to the applicable pharmaceutical manufacturers. The Rebate Services also shall include without limitation the collection by AHM of all Rebate amounts payable under the various pharmaceutical manufacturers' Rebate arrangements that AHM has established. AHM shall remit to Purchaser all Rebates generated by Purchaser's Members' utilization of pharmaceutical products within forty-five (45) calendar days after the end of the calendar quarter during which AHM earns such Rebates.

(c) AHM shall develop, implement, maintain and support a national formulary strategy, including the development of plan, product and program (including discount program) designs, to support Purchaser's Business.

(d) AHM shall develop and maintain software systems to administer and increase the efficiency of the administration of its pharmaceutical manufacturers' rebate arrangements. AHM will manage and fund the implementation of such systems. AHM shall be responsible for the maintenance and updates associated with such systems.

(e) Purchaser shall be responsible for any taxes, federal, state or otherwise, that may be levied on the Rebate Services.

(f) It is understood and agreed that Purchaser may sell some or all of the Rebate Services it receives from AHM to Purchaser's customers, as determined by Purchaser in its sole discretion.

4. Broker Fees and Commissions.

(a) Purchaser shall pay brokerage fees and commissions on behalf of AHM and AHM's affiliates. Such brokerage fees and commissions shall be calculated by either AHM or Purchaser on a monthly basis. AHM and/or AHM's affiliates shall reimburse Purchaser on a monthly basis for all payments made by Purchaser to Brokers on behalf of AHM and AHM's affiliates pursuant to this Agreement. Purchaser also shall file reports of such payment on behalf of AHM and/or AHM's affiliates as may be required by the Internal Revenue Service or other applicable taxing authorities. Purchaser's obligation to make such payments and to file such reports on AHM's and/or AHM's affiliates' behalf shall continue only so long as both this Agreement and the Brokerage Agreements are in effect.

(b) Purchaser does not, by this or any other agreement, assume any other right or duty with respect to the Brokerage Agreements and/or any Broker, including compliance with broker licensing and/or appointment regulations, that AHM and/or AHM's affiliates may have pursuant to applicable laws and/or the Brokerage Agreements, except as specifically set forth in Section 4(a).

(c) Any commission account debts incurred by Brokers shall be the sole responsibility of AHM and/or AHM's affiliates, as applicable, unless such debts are the result of or caused solely by the gross negligence or intentional misconduct of Purchaser's employees.

5. PM Services.

(a) Purchaser shall provide the PM services described in Attachment D (collectively, the "PM Services") on behalf of AHM. Purchaser warrants and agrees that its PM Program is and shall remain in compliance with all AHM standards, policies and procedures, and the standards of any applicable accrediting organization (including the NCQA and URAC), Medicare, Medicaid and all other applicable state and federal statutes and regulations, including CMS regulations. If AHM's or an accrediting organization's standards or any state or federal statutory or regulatory provisions are materially changed or revised, Purchaser agrees to comply with or implement, as applicable, to the satisfaction of AHM, any such change or revision within sixty (60) calendar days of receiving notice of such change or within such time frame as may be required by the NCQA, URAC or applicable law or regulation. The parties agree that any such

change or revision shall not be considered an amendment for purposes of this Agreement.

(b) Purchaser shall allow AHM to maintain oversight of the PM Services furnished by Purchaser on behalf of AHM. Such oversight shall include activities mutually agreed upon by the parties, but at a minimum shall include:

(i) review and approval of all review activities identified in Attachment D;

(ii) permission for AHM to conduct annual site visits upon thirty (30) calendar days prior written notice, unless a shorter period is necessary to ensure AHM's compliance with applicable law, including Medicare requirements;

(iii) permission for AHM to audit, during regular business hours upon at least thirty (30) calendar days prior written notice, unless a shorter period is necessary to ensure AHM's compliance with applicable law, including Medicare requirements, all documents and materials related to PM Services rendered under this Agreement; and

(iv) submission to AHM of periodic reports on PM Services provided by Purchaser on AHM's behalf, as described in Attachment D.

(c) If requested by NCQA, URAC and/or CMS, Purchaser shall allow, during regular business hours, NCQA, URAC and/or CMS to conduct an on-site review of any documents related to PM Services provided by Purchaser under this Agreement during an accreditation survey of AHM by NCQA or URAC or a plan survey by CMS.

(d) Purchaser shall notify AHM in writing thirty (30) calendar days prior to the enactment of any changes or modifications to Purchaser's PM Program.

(e) Upon notification in writing by AHM to Purchaser of material problems concerning the provision of PM Services pursuant to this Agreement, Purchaser agrees that it shall comply with AHM's request to develop and implement an action plan designed to correct such problems and agreeable to AHM within ten (10) calendar days of Purchaser's receipt of such notice. Purchaser agrees that AHM may also increase audits of Purchaser's performance to ensure compliance with such action plan. Purchaser agrees that it shall be considered a material breach of this Agreement if an action plan agreeable to AHM cannot be developed or

implemented within said time period. If such material problems cannot be corrected within thirty (30) calendar days of notice by AHM to Purchaser that such problems exist, AHM may terminate this Agreement in accordance with Section 8.

(f) Purchaser shall provide, in a format acceptable to AHM, timely, accurate and appropriate data and information (including demographics) with respect to the PM Services to enable AHM to fulfill NCQA, URAC and state and federal regulatory filing requirements, including Medicare requirements, and meet HEDIS standards.

(g) Each of Purchaser and AHM is authorized to obtain Member Information from Providers without additional written release by the Member in accordance with the Privacy Rules.

6. QM Services.

(a) Purchaser shall provide the Quality Management services described in Attachment E (collectively, the "QM Services") on behalf of AHM for Providers who are applying to become Participating Providers. Purchaser warrants and agrees that its QM Program is and shall remain in compliance with all AHM standards, policies and procedures and the standards of any applicable accrediting organization (including the NCQA), Medicare, Medicaid and all other applicable state and federal statutes and regulations. If AHM's or an accrediting organization's standards or any state or federal statutory or regulatory provisions are materially changed or revised, Purchaser agrees to comply with or implement, as applicable, to the satisfaction of AHM, any such change or revision within sixty (60) calendar days of receiving notice of such change or within such time frame as may be required by the NCQA or the applicable law or regulation. The parties agree that any such change or revision shall not be considered an amendment for purposes of this Agreement.

(b) Purchaser shall allow AHM to maintain oversight of the QM Services furnished by Purchaser on behalf of AHM. Such oversight shall include activities mutually agreed upon by the parties, but at a minimum shall include:

(i) submission of copies of Purchaser's QM criteria, QM policies and procedures and any revisions thereto to AHM on an annual basis, and at such other times as AHM may request, for AHM's review;

(ii) permission for AHM to conduct annual site visits and/or reviews of QM files upon thirty (30) calendar days prior written notice, unless

a shorter period is necessary to ensure AHM's compliance with applicable law, including Medicare requirements. Unless otherwise agreed to by AHM, such review shall be of the lesser of 50 files, or 5% of Participating Provider files, but in no event shall be less than 30 files;

(iii) permission for AHM to audit, during regular business hours upon at least thirty (30) calendar days prior written notice, unless a shorter period is necessary to ensure AHM's compliance with applicable law, including Medicare requirements, all documents and materials related to QM Services rendered under this Agreement; and

(iv) submission to AHM of periodic reports on credentialing and recredentialing QM Services provided by Purchaser on AHM's behalf. Said reports shall be provided quarterly and at such other times as AHM shall request or as Purchaser shall deem necessary or appropriate to ensure that AHM is fully apprised of Purchaser's credentialing and recredentialing activities on behalf of AHM. The contents of said report shall be mutually agreed upon by the parties, but shall, at a minimum, include the following information:

(A) Names and number of Providers approved, terminated, suspended, or denied under Purchaser's QM Program.

(B) Statistical information which is mutually agreed upon by the parties.

(C) The results of any studies or quality improvement projects related to Purchaser's credentialing or recredentialing program which were conducted or implemented.

(c) Purchaser shall notify all of AHM's and Purchaser's participating Providers and Provider applicants that AHM will be allowed access to such Provider's QM files, when requested. Purchaser further agrees that it will obtain prior written approval or release from AHM's and Purchaser's participating Providers and Provider applicants, as needed, for the purposes of this Agreement and to permit AHM to review such files.

(d) Purchaser shall provide, in a format acceptable to AHM, timely, accurate and appropriate data and information (including demographics) with respect to the QM Services to enable AHM to fulfill NCQA and state and federal regulatory filing requirements, including Medicare requirements, and meet the HEDIS standards.

7. Administrative Services Provided by Purchaser.

(a) Purchaser will provide AHM with the administrative services and resources specified in Attachment F (collectively, the "Purchaser Provided Services") for the fees set forth on Attachment G (collectively, the "Purchaser Fees"). Purchaser Provided Services include PM Services and QM Services.

(b) In addition to Purchaser Fees, AHM shall reimburse Purchaser for all out of pocket expenses incurred by Purchaser or its affiliates on behalf of AHM.

(c) AHM shall be responsible for any taxes, federal, state or otherwise, that may be levied on the Purchaser Provided Services.

(d) It is understood and agreed that AHM may sell some or all of the Purchaser Provided Services it receives from Purchaser to AHM's customers, as determined by AHM in its sole discretion.

8. Term and Termination; Termination of Existing Agreements.

(a) The initial term of this Agreement shall be for a period of one (1) year commencing on the Effective Date. The term of this Agreement automatically shall be extended for additional periods of one year, unless either party shall notify the other party in writing at least sixty (60) calendar days prior to the expiration of the term then in effect.

(b) This Agreement may be terminated at any time prior to the end of the term then in effect by a written agreement executed by both parties. This Agreement also may be terminated at any time by AHM upon Purchaser's breach of any of Purchaser's obligations under this Agreement following thirty (30) calendar days' prior written notice of such breach and Purchaser's failure to cure such breach within such thirty (30) calendar days. This Agreement also may be terminated at any time by Purchaser upon AHM's breach of any of AHM's obligations under this Agreement following thirty (30) calendar days' prior written notice of such breach and AHM's failure to cure such breach within such thirty (30) calendar days.

(c) If at any time AHM ceases to be an affiliate of Purchaser, this Agreement may be terminated by either party upon thirty (30) calendar days prior written notice without further liability, except for the payment of all amounts earned or otherwise due under this Agreement with respect to periods ending on or before the effective date of such termination.

(d) The parties mutually agree that it is essential for Protected Health Information to be maintained after the expiration of this Agreement for regulatory and other business reasons. The parties further agree that it would not be feasible for Purchaser to maintain such records because Purchaser lacks the necessary systems and expertise. Accordingly, Purchaser hereby appoints AHM as Purchaser's custodian for the safe keeping of any record containing Protected Health Information that AHM may determine it is appropriate to retain. Notwithstanding the expiration or termination of this Agreement, AHM shall extend the protections of this Agreement to such Protected Health Information, and limit further use or disclosure of such Protected Health Information to those purposes that make the return or destruction of the Protected Health Information not feasible.

(e) Immediate Termination or Suspension. (i) Any of the following events shall result in the immediate termination or suspension of this Agreement by Purchaser, upon written notice to AHM at Purchaser's sole discretion at any time: (a) the bankruptcy or receivership of AHM, or an assignment by AHM for the benefit of creditors; (b) the loss or limitation of AHM's liability insurance; (c) a determination by Purchaser that AHM's performance of delegated services could result in harm to Members; or (d) the debarment or suspension of AHM from participation in any government sponsored program, including Medicare or Medicaid. AHM shall provide prompt notice to Purchaser of any of the aforesaid events.

(ii) Any of the following events shall result in the immediate termination or suspension of this Agreement by AHM, upon written notice to Purchaser at AHM's sole discretion at any time: (a) the bankruptcy or receivership of Purchaser, or an assignment by Purchaser for the benefit of creditors; (b) the loss or limitation of Purchaser's liability insurance; (c) a determination by AHM that Purchaser's performance of delegated services could result in harm to Members; or (d) the debarment or suspension of Purchaser from participation in any government sponsored program, including Medicare or Medicaid. Purchaser shall provide prompt notice to AHM of any of the aforesaid events.

(f) Each of the Existing Agreements was terminated by the Existing ASA and as a result became of no further force or effect as of January 1, 2004, the effective date of the Existing ASA.

9. Purchaser's Obligations; AHM's Obligations.

(a) (i) From time to time, AHM will recommend to Purchaser policies and procedures for the operation of Purchaser's business. Purchaser shall

consider implementation of such recommendations unless prohibited or restricted by applicable law or regulation.

(ii) Purchaser shall cooperate with AHM in the development and negotiation of Rebate arrangements and provide AHM with such data as may be reasonably necessary for AHM to perform the Rebate Services.

(iii) Purchaser hereby appoints AHM as its agent to act on behalf of Purchaser in connection with the Services. As Purchaser's agent, AHM is hereby authorized by Purchaser, among other things, to hire employees and to negotiate and enter into agreements and contracts on behalf of Purchaser. Purchaser shall perform its obligations with respect to, and be responsible for, all such employees and agreements. Nothing in this Agreement shall be construed to transfer or divest any obligation or responsibility of Purchaser which transfer or divestiture is prohibited by law or regulation.

(b) (i) AHM shall maintain oversight and conduct an annual review and approval of Purchaser's PM Services that are provided on behalf of AHM under this Agreement.

(ii) This section intentionally omitted.

(iii) AHM shall furnish to Purchaser information received by AHM, including member surveys or complaints, which is relevant, as reasonably determined by AHM, to the PM Services provided under this Agreement.

(iv) AHM shall retain the right to review/audit, on at least an annual basis, a sample of Purchaser's files, to monitor the effectiveness of Purchaser's PM Program and compliance with NCQA, URAC and any applicable state or federal law requirements, including Medicare requirements.

(v) If AHM has reason to believe that Purchaser has failed to carry out the PM Services in accordance with the terms of this Agreement, AHM may take such steps as AHM deems necessary, including the following:

(A) Audit Purchaser's performance of the PM Services, upon advance notice.

(B) Require Purchaser to submit, within a specified time frame, a corrective action plan to address any compliance or other problems with the PM Services identified by AHM.

(C) Require Purchaser to implement by a specified time a corrective action plan approved by AHM with respect to the PM Services.

(D) Immediately terminate this Agreement and revoke the delegation of PM Services to Purchaser, upon notice to Purchaser.

(vi) AHM shall maintain oversight and, unless otherwise determined by AHM, conduct an annual review of Purchaser's QM Services that are provided on behalf of AHM under this Agreement.

(vii) Notwithstanding anything to the contrary contained in this Agreement or Attachment E, AHM shall retain the right to approve or disapprove Providers who apply to become Participating Providers and to terminate or suspend the Participating Provider status of any individual Provider upon notice to Purchaser and to the affected Participating Provider for failure to abide by the requirements of Purchaser's credentialing or recredentialing program or to satisfy the credentialing or recredentialing or participation criteria of AHM. Providers who are disapproved, terminated, or suspended by AHM shall not provide services to Members.

(viii) Notwithstanding anything to the contrary contained in this Agreement or Attachment E, AHM shall retain the right to require a Provider to undergo AHM's credentialing or recredentialing process in order to continue or be considered for acceptance as a Participating Provider, regardless of the status of this Agreement.

(ix) AHM shall furnish to Purchaser information received by AHM, including member surveys or complaints, which is relevant, as reasonably determined by AHM, to the credentialing or recredentialing of a Provider or any other QM Services provided under this Agreement.

(x) AHM shall review/audit, on an annual basis, unless otherwise determined by AHM, a sample of Purchaser's QM files of Participating Providers including data from member complaints, results of quality audits, utilization management, and member satisfaction surveys to monitor the effectiveness of Purchaser's

QM Program and such Program's compliance with NCQA and any applicable state or federal law requirements, including Medicare requirements.

(xi) If AHM has reason to believe that Purchaser has failed to carry out the QM Services in accordance with the terms of this Agreement, AHM may take such steps as AHM deems necessary, including the following:

(A) Audit Purchaser's performance of the QM Services, upon advance notice.

(B) Require Purchaser to submit, within a specified time frame, a corrective action plan to address any compliance or other problems with the QM Services identified by AHM.

(C) Require Purchaser to implement by a specified time a corrective action plan approved by AHM with respect to the QM Services.

(D) Immediately terminate this Agreement and revoke the delegation of QM Services to Purchaser, upon notice to Purchaser.

10. Prohibition Against Assignment and Delegation. Neither AHM nor Purchaser may assign this Agreement or its rights hereunder or delegate or subcontract any of its duties hereunder without the express prior written consent of the other party. Any attempted assignment or delegation in violation hereof shall be null, void and ineffective. Notwithstanding the foregoing, (a) AHM may perform the Services directly or indirectly through one or more of its affiliates or independent contractors, provided AHM shall remain liable to Purchaser for the discharge of AHM's obligations hereunder; and (b) Purchaser may perform the Purchaser Provided Services directly or indirectly through one or more of its affiliates or independent contractors, provided Purchaser shall remain liable to AHM for the discharge of Purchaser's obligations hereunder.

11. Confidentiality of Data and Systems. During the term of this Agreement, each party will receive and have access to proprietary data and systems of the other party. Unless otherwise approved by the other party or unless otherwise required by law, each party agrees (i) to keep all such data and systems confidential and not to disclose or reveal any such data or system to any persons or entities, and (ii) not to use such data or systems for any purpose other than as required to perform Services pursuant to this Agreement. Each party also acknowledges that the other party is the owner of all such data and systems and agrees that they constitute confidential and trade secret information which the recipient will treat as such and

will provide security for and take reasonable measures to insure their protection. Upon termination of this Agreement, each party will return all copies of the other party's material in its possession or control or will destroy them, as requested by the other party. The owner of the material will bear reasonable costs for the return or destruction of its material.

12. Indemnification. Each party agrees to indemnify and hold the other harmless from and against any and all claims, actions, liabilities, losses, damages, costs and expenses (including reasonable attorneys' fees) incurred by reason of any legal or administrative action arising out of or caused by the negligence or other culpable wrongdoing of the indemnifying party or by any breach of the indemnifying party's obligations hereunder. Such indemnification is contingent upon prompt notice from the party seeking to be indemnified of the existence of any such claim or action and such party's full cooperation with the defense of any such claim or action, which shall be controlled by the indemnifying party at its election. The indemnifying party shall, at its election, also have full control over any settlement. AHM shall obtain written releases from Providers which releases hold Purchaser harmless from any loss, claim, damage or liability associated with PM activities or decisions made in good faith and without malice. AHM shall obtain written Release and Authorization forms, as supplied by Purchaser, from Providers, which hold Purchaser harmless from any loss, claim, damage or liability associated with credentialing or recredentialing activities or decisions made in good faith and without malice.

13. Obligations and Activities of AHM Regarding Protected Health Information.

(a) AHM agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law.

(b) AHM agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement.

(c) AHM agrees to mitigate, to the extent practicable, any harmful effect that is known to AHM of a use or disclosure of Protected Health Information by AHM in violation of this Agreement.

(d) AHM agrees to report to Purchaser any use or disclosure of Protected Health Information not permitted by this Agreement of which AHM becomes aware.

(e) AHM agrees to ensure that any agent, including a subcontractor, to whom AHM provides Protected Health Information received from, or created or received by AHM on behalf of Purchaser agrees to the same restrictions

and conditions that apply through this Agreement to AHM with respect to Protected Health Information.

(f) AHM agrees to provide access, at the request of Purchaser, and in the time and manner designated by Purchaser, to Protected Health Information in a Designated Record Set, to Purchaser or, as directed by Purchaser, to an Individual in order to meet the requirements of 45 C.F.R. 164.524.

(g) AHM agrees to make any amendments to Protected Health Information in a Designated Record Set that Purchaser directs or agrees to pursuant to 45 C.F.R. 164.526 at the request of Purchaser or an Individual, and in the time and manner designated by Purchaser.

(h) AHM agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by AHM on behalf of, Purchaser available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Purchaser's compliance with the Privacy Rule.

(i) AHM agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Purchaser to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

(j) AHM agrees to provide to Purchaser the information collected in accordance with this Section 13 to permit Purchaser to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

(k) AHM shall use commercially reasonable efforts to maintain the security of Protected Health Information and to prevent unauthorized uses or disclosures of Protected Health Information. If AHM conducts any Standard Transactions on behalf of Purchaser, AHM shall comply with the applicable requirements of 45 C.F.R. Part 162.

14. Permitted Uses and Disclosures of Protected Health Information by AHM.

(a) General Use and Disclosure. Except as otherwise limited in this Agreement, AHM may use or disclose Protected Health Information to perform AHM's obligations under this Agreement, provided that such use or disclosure would not violate (i) the Privacy Rule if done by Purchaser or (ii) the minimum necessary policies and procedures of Purchaser.

(b) Specific Use and Disclosure Provisions.

(i) Except as otherwise limited by this Agreement, AHM may use Protected Health Information for the proper management and administration of AHM or to carry out the legal responsibilities of AHM.

(ii) Except as otherwise limited by this Agreement, AHM may disclose Protected Health Information for the proper management and administration of AHM, provided that disclosures are Required By Law, or AHM obtains reasonable assurances from the person to whom the information is disclosed that the information disclosed will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies AHM of any instances of which such person is aware in which the confidentiality of the information has been breached.

(iii) Except as otherwise limited in this Agreement, AHM may use Protected Health Information to provide Data Aggregation services to Purchaser as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).

(iv) AHM may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. 164.502(j)(1).

15. Certain Obligations of Purchaser Regarding Protected Health Information.

(a) Provisions for Purchaser to Inform AHM of Privacy Practices and Restrictions.

(i) Purchaser shall notify AHM of any limitation(s) in its notice of privacy practices of Purchaser in accordance with 45 C.F.R. 164.520, to the extent that such limitation(s) may affect AHM's use or disclosure of Protected Health Information.

(ii) Purchaser shall provide AHM with any change in, or revocation of, permission by any Individual to use or disclose Protected Health Information, to the extent that such change and/or revocation affects AHM's uses and/or disclosures of Protected Health Information.

(iii) Purchaser agrees that Purchaser will not furnish or impose by arrangements with third parties or other Covered Entities or

Business Associates special limits or restrictions to the uses and disclosures of Purchaser's Protected Health Information that may impact in any manner the use and disclosure of Protected Health Information by AHM under this Agreement, including restrictions on the use and/or disclosure of Protected Health Information as provided for in 45 C.F.R. 164.522.

(b) Permissible Requests by Purchaser. Purchaser shall not request AHM to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Purchaser.

16. Insurance. AHM shall, with respect to all of the actions AHM engages in pursuant to this Agreement, obtain and maintain, throughout the term of this Agreement, insurance at minimum levels required from time to time by Purchaser, but in no event less than comprehensive general liability insurance in minimum amounts of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate. AHM shall have Purchaser named as an additional insured on all such insurance. AHM shall provide to Purchaser certificates of insurance evidencing such coverage and shall provide Purchaser with five (5) calendar days prior written notice of any modification or termination of such coverage. AHM's obligations under this Section 16 may be satisfied through self-insurance arrangements.

17. Miscellaneous.

(a) Regulatory References. A reference in this Agreement to a section in the Privacy Rules means the section as in effect or as amended, and for which compliance is required.

(b) Amendments. Except as set forth below in this Section 17(b), this Agreement may be amended solely by written agreement of the parties hereto, subject to any required government approvals. Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend this Agreement in such manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such amendment, it shall so notify the first party in writing within thirty (30) calendar days of the notice. If the parties are unable to agree on an amendment within thirty (30) calendar days thereafter, then either of the parties may terminate this Agreement on thirty (30) calendar days written notice to the other party.

(c) Survival. The respective rights and obligations of AHM under Section 8(d) of this Agreement shall survive the termination of this Agreement.

(d) Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Purchaser to comply with the Privacy Rules.

(e) No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors and permitted assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

(f) Notices. Any notice required to be given pursuant to this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid:

to AHM at:

Aetna Health Management, LLC
151 Farmington Avenue, RC4A
Hartford, CT 06156
Attention: General Counsel

and to Purchaser at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
Attention: President

The above addresses may be changed at any time by either party upon written notice.

(g) Waiver. No waiver of any term or provision of this Agreement shall be valid unless in writing and executed by the waiving party. It is expressly understood that if any party shall fail to perform any term or condition of this Agreement and the other shall not enforce or give notice of default, the failure to enforce or give notice of default shall not prevent enforcement of any other term or condition of this Agreement or the giving of notice of any other failure to perform or any other default.

(h) Integration. This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof.

(i) Validity of Agreement/Choice of Law. The validity, enforceability and interpretation of this Agreement will be determined and governed by the laws of the State of Connecticut without regard for the conflicts of laws principles thereof. The invalidity or unenforceability of any term or provision hereof will not, unless otherwise specified herein, affect the validity or enforceability of any other term or provision hereof.

(j) Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, and all of which, together, constitute one and the same instrument. This Agreement shall become binding when one or more counterparts, individually or taken together, bears the signature of both parties.

(k) Headings for Convenience. The underlined headings contained in this Agreement are for convenience of reference only and are not part of this Agreement.

(l) Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity of this Agreement, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the AAA and conducted by a sole arbitrator, who shall be unaffiliated with each party, in accordance with the Rules. The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. Except as may be required by law or to the extent necessary in connection with a judicial challenge, or enforcement of an award, neither a party nor the arbitrator may disclose the existence, content, record or results of an arbitration. Fourteen (14) calendar days before the hearing, the parties will exchange and provide to the arbitrator (i) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (ii) premarked copies of all exhibits they intend to use at the hearing. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary relief and is not empowered to award damages other than compensatory damages. The location of the arbitration shall be in Connecticut or any other location acceptable to both parties.

(m) Management of Purchaser. Notwithstanding any other provision of this Agreement, it is understood that the business and affairs of Purchaser shall be managed by its Board of Directors and, to the extent delegated by such Board and applicable law, by Purchaser's officers. Neither AHM nor any of its officers or agents shall have any management authority or

prerogatives with respect to the business affairs and/or operations of Purchaser except as specifically set forth in this Agreement.

(n) Non-Discrimination. All services provided pursuant to this Agreement shall be provided without regard to the Member's race, color, sex, age, religion, national origin or source of payment.

(o) The relationship between Purchaser and AHM, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose.

(p) AHM and Purchaser shall ensure that all Member medical records are treated as confidential so as to comply with all state and federal laws regarding, among other things, the confidentiality of patient records. According to the terms of Purchaser's enrollment forms, agreements with Members and applicable law, Purchaser is authorized to obtain information from AHM's Providers without additional written release by the Member. Purchaser shall have the right, upon request, to inspect at all reasonable times any accounting, administrative, Member information, and medical records maintained by AHM or AHM's Providers pertaining to Purchaser, Members or services conducted by AHM under this Agreement. This Section 17(p) shall survive the termination of this Agreement, regardless of the cause of termination.

THE NEXT PAGE IS THE SIGNATURE PAGE

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date and year first set forth above.

AETNA HEALTH MANAGEMENT, LLC

By:_____
Name: William C. Baskin III
Title: Vice President and Secretary

AETNA LIFE INSURANCE COMPANY.

By:_____
Name: Thomas C. Strohmenger
Title: Vice President, Counsel and Chief Compliance Officer

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ATTACHMENT A
ADMINISTRATIVE SERVICES

Specific Responsibilities and Services. AHM's duties shall include without limitation the following, as and when requested by Purchaser from time to time:

(a) Finance. The following finance functions related to Purchaser's Business and to Purchaser's other businesses to the fullest extent permitted by applicable law: All accounting and reporting functions, including billing, accounts receivable, accounts payable, payroll, budgets, premium rates, financial and statutory reporting, tax return preparation and cash management. All financial records shall be available to Purchaser at all times. As more fully set forth in Section (l) of this Attachment A, AHM shall deposit in a bank (or banks) all receipts and monies arising from the operation of Purchaser and make disbursements on behalf of Purchaser in such amounts and at such times as the same are required. Signatures and approvals as to the amounts of all checks shall be in accordance with duly adopted policies of Purchaser. AHM shall supervise and direct the collection of all accounts receivable due to Purchaser, taking all commercially reasonable steps to minimize the number and amount of bad debts.

(b) Claims Payment. Payment of claims and benefits incurred by Members.

(c) Intentionally omitted.

(d) Customer Services. Employer and Member customer services necessary for the operation of the Business, including new Member telephone calls, Member surveys, servicing Member inquiries and problems and Member enrollment.

(e) Provider Network Services. Support functions necessary for the operation of the Business in the nature of Provider contracting services, Provider relations services, development and updating of Provider contract forms, Provider contract negotiations, entering into Provider contracts on behalf of Purchaser and its affiliates. In addition, AHM hereby makes available to Purchaser, and grants Purchaser access to, as necessary or desirable, AHM's Provider network (including contracts that AHM negotiates with national and regional vendors and Providers, contracts that AHM negotiates with centers of excellence outside of Purchaser's service area, and those portions of AHM's Provider network that are made available to AHM by agreements and/or other arrangements between AHM and its affiliates). At Purchaser's request, AHM shall enforce and/or use commercially reasonable efforts to cause its affiliates to enforce their respective agreements with the Providers in AHM's Provider network for the benefit of Purchaser.

(f) Marketing. AHM shall produce advertising, public relations and marketing materials necessary for the operation of the Business on behalf of Purchaser for distribution by Purchaser and/or by Purchaser's duly licensed agents and shall

support Purchaser in its marketing efforts. Purchaser acknowledges that any solicitation documents used by Purchaser are subject to filing with, and approval by, state regulatory agencies. AHM also shall produce website marketing and other internet services and materials necessary for the operation of the Business for Purchaser.

(g) Insurance and Risk Management. AHM shall negotiate and maintain general and professional liability insurance, naming Purchaser as an additional insured thereunder, in amounts reasonably acceptable to Purchaser. AHM shall deliver memorandum copies of its insurance certificates to Purchaser upon request.

(h) Pharmacy Services. AHM shall provide Purchaser with pharmacy benefit management services under AHM's pharmacy benefit management program, including the following:

- Direct reimbursement of pharmacy claims to pharmacy Providers;
- Sales, marketing and account support services;
- Customer and Provider services;
- Development and operation of a pharmacy Precertification unit;
- Development and supply of management reports;
- Performance of drug utilization review programs, QM programs and audit programs;
- Development and operation of a Pharmacy and Therapeutics Committee;
- Development, installation and implementation of a medication formulary;
- Management of Purchaser's pharmacy Provider network; and
- Provision of such other pharmacy-related benefit program management services as may be agreed upon by the parties from time to time.

(i) Benefit Contracts. AHM shall develop health care coverage products for Purchaser to offer to groups and individuals in connection with the Business, and AHM shall prepare the agreements, including individual and group contracts, and evidences or certificates of coverage reflecting the benefit to be provided by Purchaser in connection with the Business.

(j) Fees and Expenses. AHM shall pay all fees and expenses of actuarial, auditing and/or accounting consultants of any type retained by AHM to perform the Services, including any consultant used to obtain federal qualification or competitive medical plan status. Such fees and expenses are included in the Administrative Fee.

(k) Intentionally omitted.

(l) Cash Management Services. Purchaser may participate in AHM's centralized cash management system (the "System"), and AHM shall administer the System in accordance with the terms and conditions set forth below:

1. Procedures. The procedures for the System are as follows:

   a. All claims, expenses and other disbursement requests submitted for payment by Purchaser shall be processed and paid by AHM through a centralized disbursement account or accounts held as specified herein.

   b. All premiums and other payments made to Purchaser by third parties shall be received and processed by AHM through a centralized depository account or accounts (e.g., lock box(es)) held as specified herein.

   c. All of the foregoing transactions shall be recorded on the books of Purchaser in an intercompany account with AHM and recorded on the books of AHM in an intercompany account with Purchaser.

   d. The System also shall account for the reimbursement by Purchaser to AHM of costs expended by AHM and/or its affiliates on behalf of Purchaser using applicable statutory accounting principles and/or practices prescribed or permitted by the State of Connecticut and/or accounting principles generally accepted in the United States of America.

   e. AHM shall follow such directions and instructions as may be given to AHM by Purchaser from time to time with respect to the funds of Purchaser and the participation of Purchaser in the System.

2. Condition of Participation. The participation of Purchaser in the System, as described in this Agreement, is expressly conditioned upon all investment accounts holding assets of Purchaser being in the name of Purchaser. Depository, disbursement and other non-investment accounts holding assets of Purchaser may be in the name of Purchaser and/or AHM.

3. Settlement of Accounts. Intercompany balances resulting from the operation of the System shall be settled as to Purchaser within 15 calendar days after the end of each calendar month (where possible) and in no event more than 45 calendar days after the end of each calendar quarter.

4. Interest on Balances. Interest shall be charged or credited monthly on all intercompany cash balances resulting from the operation of the System as set forth in Section (b) of Attachment B.

5. Investments. AHM may, from time to time, buy Investments for Purchaser and place such Investments in the name of or for the account of Purchaser for the purpose of settling intercompany balances. Such Investments shall be held in the name of Purchaser.

(m) Premium Collection Services. AHM shall collect such premiums as Purchaser from time to time may request (including premiums unrelated to the Business and/or premiums due to Purchaser's affiliates) and deposit the resulting funds in such account or accounts and/or transfer such funds in such manner as Purchaser shall direct from time to time.

(n) Audit Rights. Purchaser shall have the right, at its expense, to audit the books, records and accounts of AHM related to this Agreement after giving reasonable notice to AHM of Purchaser's intent to conduct such an audit. If such an audit occurs, AHM shall give Purchaser reasonable cooperation and access to all books, records and accounts necessary to the audit.

(o) Records. Each party shall be the sole owner of its financial and accounting records, regardless of the use or possession by a party of any other party's records. AHM and Purchaser shall each individually maintain separate books, accounts and records with respect to Services provided under this Agreement. The books and records of Purchaser shall be maintained at such location or locations, within or without the State of Connecticut, as AHM and Purchaser may agree from time to time. AHM and Purchaser each shall maintain their own books, accounts and records in such a way as to disclose clearly and accurately the nature and detail of the transactions between them.

(p) Reports. AHM shall submit to Purchaser such reports regarding the Administrative Services at such times as Purchaser shall reasonably request or as AHM shall deem necessary or appropriate to keep Purchaser apprised of AHM's performance of the Administrative Services.

(q) Additional Notices. AHM shall promptly notify Purchaser upon (i) receipt of any summons, complaint or process before any legal or regulatory body relating to this Agreement or (ii) obtaining knowledge of any legal or administrative claim, action, investigation or proceeding against AHM relating to this Agreement.

ATTACHMENT B
FEES FOR ADMINISTRATIVE SERVICES

(a) For the Administrative Services, for each calendar quarter, Purchaser shall pay AHM Administrative Fees equal to the Aggregate Administrative Cost for such calendar quarter within forty-five (45) calendar days after the end of the calendar quarter with respect to which such Administrative Fees are payable.

(b) Except as set forth on Attachment C, all intercompany balances under this Agreement shall be settled within forty-five (45) calendar days after the end of each calendar quarter. Interest shall be charged monthly on all intercompany balances (including Fees and cash balances resulting from the operation of the System) at a rate equal to the monthly average overnight interest rate earned on AHM's investments during the month for which interest on such intercompany balances is being calculated.

(c) Each of AHM and Purchaser shall have the right to offset all intercompany receivable and payable balances (including Fees) arising with the other party under this Agreement.

(d) The Fees are based upon the current federal and state laws and regulations that govern AHM and/or Purchaser. The parties hereto acknowledge that if any of such laws or regulations are amended, the cost and expenses of operating Purchaser may change. Therefore, upon any such amendment or replacement, the parties shall renegotiate in good faith and agree on revised Fees hereunder.

ATTACHMENT C
FEES FOR REBATE SERVICES AND PAYMENT OF REBATE FEES

(a) Purchaser shall pay AHM a Rebate Fee of [redacted] of all Rebates earned by Purchaser through AHM's Rebate agreements. For the avoidance of doubt, "Rebates earned by Purchaser" excludes any Rebates remitted to Purchaser by AHM that Purchaser remits or is obligated to remit to third parties.

(b) Pursuant to Section 3 of this Agreement, AHM shall collect the Rebate amounts from the applicable manufacturers and remit 100% of the Rebates to Purchaser.

(c) All Rebates and Rebate Fee transactions shall be recorded on the books of Purchaser in an intercompany account with AHM and recorded on the books of AHM in an intercompany account with Purchaser.

(d) Intercompany balances for Rebates earned by Purchaser and Rebate Fees shall be settled within forty-five (45) calendar days after the end of the calendar quarter during which AHM earned the Rebates. If AHM fails to forward the correct sum to Purchaser, or Purchaser fails to pay Rebate Fees, within the specified time, the party to whom the payment is due may charge interest at a rate equal to the monthly average overnight interest rate earned on AHM's investments during the period for which interest on such amount is being calculated, along with any costs of collection and reasonable attorneys' fees.

(e) Each of AHM and Purchaser shall have the right to offset all intercompany receivable and payable balances (including Fees) arising with the other party under this Agreement.

(f) AHM shall submit to Purchaser on a quarterly basis a statement with the Rebates earned by Purchaser collected, Rebate Fees due to AHM and remaining Rebates earned by Purchaser to be forwarded to Purchaser.

(g) The Fees are based upon the current federal and state laws and regulations that govern AHM and/or Purchaser. The parties hereto acknowledge that if any of such laws or regulations are amended, the cost and expenses of operating Purchaser may change. Therefore, upon any such amendment or replacement, the parties shall renegotiate in good faith and agree on revised Fees hereunder.

ATTACHMENT D
PATIENT MANAGEMENT SERVICES

Purchaser will provide PM Services as follows:

1. PM Program
Purchaser shall maintain a written PM Program description which includes policies and procedures to evaluate criteria, information sources and processes used to review and approve the provision of services to Members. These policies and procedures must be consistent with AHM policies and procedures and must comply with the accreditation standards of NCQA and URAC (when applicable), as well as statutory and regulatory requirements and contractual obligations. Purchaser's PM Program description should be revised as needed and submitted in writing to AHM for review and approval at least annually, and more often if required by AHM to keep AHM apprised on Purchaser's obligations under this Agreement.

2. PM Committee
Purchaser shall establish a PM committee which shall be responsible for overseeing PM activities. Purchaser's PM committee membership should include at least three (3) members who are physicians, one of whom shall be a senior medical director of Purchaser, and who are representative of the primary and/or specialty care being reviewed. The PM committee shall meet on a regular monthly basis, with additional meetings as necessary. A PM representative from AHM shall be entitled to attend any PM committee meeting. Minutes of the committee meetings shall be maintained in a secure manner by Purchaser and made available to AHM for review.

3. PM Recommendations/Decisions
Purchaser agrees to comply with AHM's benefit coverage guidelines. Purchaser shall utilize qualified medical professionals to make benefit coverage decisions and to supervise review decisions. PM review decisions must be made in a timely manner, in accordance with timeframes mutually agreed upon between Purchaser and AHM. Timeframes shall accommodate clinical urgencies. Purchaser agrees to monitor its compliance with such timeframes, and shall take all actions as are necessary to ensure compliance with such timeframes. All PM review decisions by Purchaser shall reflect professional judgment exercised with that degree of care and skill customarily exercised by providers of health care services and in accordance with generally accepted medical standards. PM recommendations by Purchaser shall be based upon the review of the entire record available and such additional information that Purchaser determines to be necessary and appropriate to conduct PM services. A physician shall conduct a review of any denial recommendation based on medical necessity and shall use board-certified consultants when necessary to conduct the review of such denials. Purchaser shall ensure that the reason for any denial is clearly documented and is part of

the notification sent to the Member and attending physician. Notification of a denial shall include appeal process information. Purchaser's physician reviewer shall make the initial denial/determination, and AHM retains the responsibility for the final decision on the denial determination and the appeal process.

4. Written PM Review Decision Guidelines
Purchaser shall maintain a set of PM review decision protocols that are based on reasonable medical evidence and consistent with AHM standards and guidelines. Purchaser agrees to review and update the criteria as needed, but no less than annually, and to provide AHM with a written copy of any revision within ten (10) calendar days. Purchaser agrees to maintain and monitor consistent application of the criteria through monitoring review mechanisms of physicians and other reviewers. Purchaser agrees to inform Providers of PM decision guidelines and to provide criteria to Providers upon request.

5. Medical Technology
Purchaser shall have written policies and procedures in place to distribute and implement AHM's guidelines/protocols pertaining to the appropriate use of new medical technologies or new applications of established technologies, including medical procedures, drugs and devices. AHM retains the final authority over all decisions relating to coverage policy relating to new medical technologies and new applications of established technologies.

6. Performance Functions
Purchaser shall perform various PM functions identified by AHM, which may be subject to change. Any such change in PM functions shall not be considered an amendment to this Agreement. PM functions shall include, but not be limited to:

a. Registration.

b. Authorization of referrals in accordance with Purchaser's PM plan as approved by AHM.

c. Precertification of hospital admissions for non-Emergency Services and certain elective outpatient procedures.

d. Precertification of items or services to be provided by a skilled nursing facility or other subacute facility, durable medical equipment, home health agency, hospice, or diagnostic testing facility, in accordance with Member's benefit plan.

e. Concurrent Review.

f. Case Management services for catastrophic disease and injury.

g. Disease management.

Purchaser agrees that, except in an emergency, all services shall be provided through Participating Providers.

7. Case Management/Disease Management
Case Management and Disease Management shall be managed jointly by AHM's Case Management Department and Purchaser. Detailed procedures for ongoing Case Management and disease management shall be determined on a case-specific basis. In all such cases, AHM shall be provided with weekly (or such other mutually agreed upon specified interval) status of the Member's care. Purchaser agrees to promptly notify AHM of all Members that would benefit from Case Management or disease management. These include, but are not limited to:

a. Members whose cost of care is approaching or is anticipated to reach the threshold in a stop-loss insurance plan.

b. Members who are receiving services associated with catastrophic conditions.

c. Members who are receiving services associated with AHM's Disease Management programs.

8. Reporting Requirements
AHM shall monitor and evaluate PM reports from Purchaser on a regular basis. Purchaser shall provide AHM with PM information, including:

a. PM plan and any updates or revisions, as applicable.

b. Annual written evaluation of PM Program.

c. PM committee minutes describing PM activity.

d. Quarterly summary report containing data which is mutually agreed upon by the parties, which shall at a minimum include data on admissions, types of care, denials, referrals and utilization measures (including HEDIS utilization management measures).

e. Weekly summary to AHM of the following items:

- Copies of all denials.

- Precertifications completed for all non-emergency hospital admissions and elective outpatient procedures.

- Certifications completed for all services which are non-capitated or require processing by AHM's claim system.

f. Other reports, data and information requested from time to time by AHM and in a format acceptable to AHM, including timely, accurate and appropriate data and information (including demographics) to enable AHM to fulfill NCQA, URAC and state and federal regulatory filing requirements and meet the HEDIS standards.

g. Encounter Data
Purchaser shall provide AHM with complete and accurate encounter data by type of Primary Care Service rendered to Members in the form and manner as specified by AHM. Purchaser certifies that such encounter data is truthful and complete.

9. Contact Person for Members
Purchaser agrees to provide Members with access to an individual in Purchaser's organization who is available to receive communications from, and to provide necessary services to, Members relating to Purchaser's responsibilities under this Agreement.

10. Surveys
Purchaser shall conduct regular surveys no less frequently than every two (2) years involving Members and Participating Providers to determine satisfaction with Purchaser's PM activities provided pursuant to this Agreement. Purchaser shall develop and implement actions plans to improve any PM processes which have been identified as problems through the Member or Participating Provider surveys.

11. Notification of Complaints
Purchaser shall notify AHM, within 24 hours of receipt, of any complaints, either oral or written, received by Purchaser from Participating Providers and all attorney contacts involving Members.

ATTACHMENT E
QUALITY MANAGEMENT SERVICES

Purchaser will provide Quality Management as described in the current Quality Management Program Description, including credentialing and recredentialing services for Providers who are or who apply to become Participating Providers as more fully described below.

1. Written policies and Procedures. Purchaser will establish and maintain written policies and procedures for the Credentialing and triennial Recredentialing (unless otherwise required by state law or regulation) of Providers who apply to become Participating Providers. The policies and procedures will also set forth the scope of the QM Program (i.e. what categories of Providers are credentialed). Said policies and procedures and any substantive revisions thereto will be subject to the review by and approval of AHM.

2. Quality Management Committees. Purchaser shall establish or maintain a Quality Advisory Committee and a Credentialing Committee, the latter to make recommendations regarding credentialing and recredentialing decisions. Said committees shall include an appropriate number of Providers who are physicians, as required by NCQA and any applicable state law or regulation.

3. Credentialing and Recredentialing Standards. Purchaser shall adopt Credentialing and Recredentialing criteria that include at a minimum primary verification (including verification in writing, via telephone, microfiche, or on-line query) of the following:

    a. Current valid license to practice in each state where Provider will provide services to Members.

    b. Clinical privileges in good standing at a participating hospital.

    c. Valid DEA or state narcotics certification, as applicable.

    d. (i) Graduation from an accredited medical school and completion of an accredited residency or board certification, as applicable, for physicians, or

       (ii) Graduation from a nationally accredited program and/or completion of appropriate clinical training or education for non-physicians.

    e. Work history.

f. Current, adequate malpractice insurance in accordance with AHM's policy.

g. Professional liability claims history.

h. Data supplied to AHM shall include the initial date of the credentialing decision of Purchaser, the initial date of Provider participation at Purchaser and the last date of recredentialing at Purchaser.

4. Application Process. Purchaser shall establish or maintain a formal application process which requires that each Provider complete either: (a) AHM's application to become a Participating Provider or, when approved by AHM, Purchaser's own application; or (b) a state-mandated Provider application or a nationally recognized and Purchaser-approved Provider application, such as an application approved by the Council for Affordable Quality Healthcare.

Purchaser shall include an attestation by the applicant to the accuracy and completeness of the information on the QM applications. If Purchaser uses its own application, it must also obtain an executed AHM release/authorization form, consistent with the obligations set forth in Section 6 of this Agreement.

Purchaser shall report to AHM within five (5) calendar days any Adverse Action taken by, or notice of such action received by, Purchaser with respect to the licensure, medical staff privileges or membership status of any Participating Provider. For purposes of this Section 4, "Adverse Action" means an action that denies, restricts, encumbers, revokes, suspends, probates, or constitutes a censure or reprimand (whether public or private), the voluntary surrender of licensure or privileges to avoid such actions, voluntary payment of fines or consent to other disciplinary actions, and the initiation of any investigation that could result in such action.

5. Querying Process. The QM process shall include obtaining information on the Provider from the National Practitioner Data Bank ("NPDB"); information to ascertain whether Provider has been the subject of investigation or sanction activity by any government health program including Medicare, Medicaid or CHAMPUS; and information concerning any disciplinary action by any licensing agency.

6. Recredentialing. In addition to the requirements stated above, Purchaser shall conduct ongoing triennial recredentialing (unless otherwise required by state law or regulation) which includes the standards in Sections 3 through 5 of this Attachment E and a review of data from (i) member complaints: (ii) quality or performance information; (iii) utilization management; and (iv) member satisfaction surveys, as applicable.

7. Sanctions, Terminations, and Suspensions. Purchaser shall adopt policies and procedures which, at a minimum, comply with the requirements of the Health Care Quality Improvement Act of 1986. OIG/OPM standards, and any applicable state peer review law and are acceptable to AHM, to reduce, suspend, or terminate the Participating Provider status of a Provider. Such policies and procedures shall include: a mechanism for reporting to appropriate authorities, including the NPDB and the Healthcare Integrity and Protection Data Bank and applicable state regulatory agency, serious quality deficiencies leading to suspension or termination and an appeal process for adversely affected Participating Providers. Purchaser shall notify AHM within five (5) calendar days of any report submitted pursuant to this Section 7 of this Attachment E.

8. Monitoring and Notification. Purchaser shall monitor state board sanction lists, U.S. Department of Health and Human Services Office of the Inspector General sanction lists and Office of Personnel Management debarment lists within thirty (30) calendar days of their respective publication. Purchaser shall notify AHM when any participating Provider is found on any of such sanction or debarment lists.

9. Reviews. Purchaser shall perform ongoing reviews of complaints against and/or relating to all participating Providers.

ATTACHMENT F
PURCHASER PROVIDED SERVICES

Specific Responsibilities and Services. Purchaser's duties shall include the following:

(a) Personnel. Purchaser shall make available to AHM the services of such personnel for whom Purchaser acts as common paymaster as AHM deems necessary or advisable for AHM to perform its contractual and other obligations, including AHM's obligations under the various Administrative Services Agreements to which AHM is a party.

(b) Facilities. Negotiating such terms and agreements as may be necessary or advisable for the furnishing of facilities, utilities, services, concessions and supplies for the maintenance and operation of AHM, including the performance of AHM's obligations under the various Administrative Services Agreements to which AHM is a party.

(c) Procurement. Procurement services, including the extension of Purchaser's volume discounts to the extent available, as may be necessary or advisable for the maintenance and operation of AHM, including the performance of AHM's obligations under the various Administrative Services Agreements to which AHM is a party.

(d) Operational Services. General operational services, including telephone and computer system design services, mail services and microfilm services, as may be necessary or advisable for the maintenance and operation of AHM, including the performance of AHM's obligations under the various Administrative Services Agreements to which AHM is a party.

(e) Data Processing. The computer and MIS resources necessary or advisable for the maintenance and operation of AHM, including the performance of AHM's obligations under the various Administrative Services Agreements to which AHM is a party.

(f) Audit Rights. AHM shall have the right, at its expense, to audit the books, records and accounts of Purchaser related to this Agreement after giving reasonable notice to Purchaser of AHM's intent to conduct such an audit. If such an audit occurs, Purchaser shall give AHM reasonable cooperation and access to all books, records and accounts necessary to the audit.

(g) Cash Management Services. AHM (on behalf of itself and/or one or more of its affiliates) may participate in Purchaser's centralized cash management system (the "Purchaser System"), and Purchaser shall administer the Purchaser System in accordance with the terms and conditions set forth below:

1. Procedures. The procedures for the Purchaser System are as follows:

   a. To the extent requested by AHM, claims, expenses and other disbursement requests submitted for payment by AHM shall be processed and paid by Purchaser through a centralized disbursement account or accounts held as specified herein.

   b. To the extent requested by AHM, premiums and other payments made to AHM and/or one or more of its affiliates by third parties shall be received and processed by Purchaser through a centralized depository account or accounts (e.g., lock box(es)) held as specified herein.

   c. All of the foregoing transactions shall be recorded on the books of Purchaser in an intercompany account with AHM and recorded on the books of AHM in an intercompany account with Purchaser.

   d. The Purchaser System also shall account for the reimbursement by AHM to Purchaser of costs expended by Purchaser and/or its affiliates on behalf of AHM using applicable statutory accounting principles and/or practices prescribed or permitted by the State of Connecticut and/or accounting principles generally accepted in the United States of America.

   e. Purchaser shall follow such directions and instructions as may be given to Purchaser by AHM from time to time with respect to the funds of AHM and the participation of AHM in the Purchaser System.

2. Condition of Participation. The participation of AHM in the Purchaser System, as described in this Agreement, is expressly conditioned upon all investment accounts holding assets of AHM being in the name of AHM. Depository, disbursement and other non-investment accounts holding assets of AHM may be in the name of Purchaser and/or AHM.

3. Settlement of Accounts. Intercompany balances resulting from the operation of the Purchaser System shall be settled as to AHM within 15 calendar days after the end of each calendar month (where possible) and in no event more than 45 calendar days after the end of each calendar quarter.

4. Interest on Balances. Interest shall be charged or credited monthly on all intercompany cash balances resulting from the operation of the Purchaser System as set forth in Section (b) of Attachment B.

5. Investments. Purchaser may, from time to time, buy Investments for AHM and place such Investments in the name of or for the account of AHM for the purpose of settling intercompany balances. Such Investments shall be held in the name of AHM.

(h) PM Services. The PM Services.

(i) QM Services. The QM Services.

(j) Agents Fees and Commissions. On behalf of AHM, Purchaser and/or its affiliates shall pay all broker and agent fees and/or commissions in accordance with Section 4(a).

(k) Account Administration. Purchaser shall administer health savings accounts, health reimbursement accounts and/or similar accounts as may be necessary or advisable for the performance of AHM's obligations under the various Administrative Services Agreements to which AHM is a party, including managing and paying disbursements from such accounts.

(l) Reports. Purchaser shall submit to AHM such reports regarding the Purchaser Provided Services at such times as AHM shall reasonably request or as Purchaser shall deem necessary or appropriate to keep AHM apprised of Purchaser's performance of the Purchaser Provided Services.

(m) Additional Notices. Purchaser shall promptly notify AHM upon (i) receipt of any summons, complaint or process before any legal or regulatory body relating to this Agreement or (ii) obtaining knowledge of any legal or administrative claim, action, investigation or proceeding against Purchaser relating to this Agreement.

ATTACHMENT G
PURCHASER FEES

(a) For the Purchaser Provided Services, for each calendar quarter, AHM shall pay Purchaser a Purchaser Fee equal to the Aggregate Purchaser Cost within forty-five (45) calendar days after the end of the calendar quarter with respect to which such Purchaser Fees are payable.

(b) The Purchaser Fees are based upon the current federal and state laws and regulations that govern AHM and/or Purchaser. The parties hereto acknowledge that if any of such laws or regulations are amended, the cost and expenses of operating AHM may change. Therefore, upon any such amendment or replacement, the parties shall renegotiate in good faith and agree on revised Purchaser Fees hereunder.

MEDICARE AMENDMENT

This Amendment to the Amended and Restated Administrative Services Agreement ("Amendment") is made as of August 1, 2008 by and between, Aetna Life Insurance Company (hereinafter referred as "Company") and Aetna Health Management, LLC (hereinafter referred to as "AHM").

WHEREAS, the Company and AHM are parties to that certain Amended and Restated Administrative Services Agreement dated October 7, 2005 ("Agreement") pursuant to which AHM and the Company provide or arrange for the provision of administrative services to each other; and

WHEREAS, Company is contracted with the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage and Medicare prescription drug plans (collectively "Medicare Plans"); and

WHEREAS, under the Agreement, in addition to the services AHM provides with respect to the Company's commercial lines of business, AHM provides certain services for Company's Medicare Plans ("Medicare Services"); and

WHEREAS, the Company and AHM wish to amend the Agreement to comply with certain requirements set forth in Medicare laws, rules and regulations that apply solely to AHM's performance of Medicare Services.

NOW, THEREFORE, in consideration of the mutual covenants and promises stated in this Amendment and other good and valuable consideration, and intending to be legally bound, Company and AHM agree that the following shall apply solely to the Medicare Services AHM provides to Company pursuant to the Agreement:

1. AHM agrees to comply with all applicable federal laws and regulations (including Medicare laws and regulations) and CMS instructions. AHM agrees that all Medicare Services performed by AHM under the Agreement will be consistent and comply with Company's obligations under its contract(s) with CMS to offer Medicare Plans. AHM agrees to allow Company to monitor AHM's performance of Medicare Services under the Agreement on an ongoing basis. Upon request, AHM shall immediately provide to Company any information required by Company to meet its reporting obligations to CMS. AHM agrees to abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health information relating to individuals enrolled in a Medicare Plan ("Medicare Members"), including the privacy and security provisions set forth at 42 C.F.R. Section 423.136 and any Company or CMS requirements designed to ensure Company's compliance with such laws, rules and regulations.

2. Solely with respect to all Medicare Plans, AHM agrees to provide Company and the United States Department of Health and Human Services ("HHS"), the Comptroller General or their designees access to any pertinent contracts, books, documents, papers, and records directly relating to Medicare Services performed by AHM under the Agreement ("Information and Records"), and that this right of inspection, evaluation and audit will continue for the longer of: (i) a period of ten (10) years from the end of the contract period of the contract of Company to offer Medicare Plans, (ii) the date that HHS, the Comptroller General or their designees complete an audit, or (iii) the period required under applicable laws, rules or regulations. Solely with respect to all Medicare Plans, AHM also agrees to maintain Information and Records for the longer of: (i) ten (10) years from the end of the contract period of the contract of Company to offer Medicare Plans, (ii) the date HHS, the Comptroller General or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 2 shall survive the termination of the Agreement, regardless of the cause of the termination.

3. AHM shall not hold any Medicare Member liable for payment of any fees that are the legal obligation of Company.

In no event, including without limitation, non-payment by Company, insolvency of Company or breach of the Agreement or this Amendment, shall AHM bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Medicare Member or persons (other than the Company) acting on a Medicare Member's behalf for Medicare Services covered by the Agreement.

AHM further agrees that: (a) this provision shall survive termination of the Agreement and this Amendment regardless of the cause giving rise to termination and shall be construed for the benefit of Medicare Members, and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between AHM and a Medicare Member or persons acting on a Medicare Member's behalf.

No modification of this provision shall be effective without the prior written approval of the appropriate state and/or federal regulatory entities.

4. AHM agrees that Company oversees and is accountable to CMS for any responsibilities that are contained in Company's contracts with CMS to offer Medicare Plans. AHM acknowledges that Company may only delegate activities or functions to AHM in a manner consistent with applicable Medicare laws, rules and regulations. In addition to the remedies available to Company that are set forth in the Agreement, AHM acknowledges and agrees that Company may revoke any delegated activities or reporting responsibilities performed by AHM under the Agreement with respect to Medicare Plans if Company or CMS determines that AHM's performance of such delegated activities or reporting responsibilities is not satisfactory. If AHM has subcontract arrangements with other entities to deliver Medicare Services, AHM shall ensure that its contracts with those subcontracted entities contain all of the provisions in this Amendment and shall provide proof such to Company upon request.

5. Under the Agreement, AHM has agreed to evaluate and verify network pharmacies' qualifications and competence to practice their profession without restriction and to provide pharmacy services to Medicare Members in satisfaction of Company's applicable participation criteria ("Credentialing and Recredentialing"). AHM agrees to provide Credentialing and Recredentialing services under the Agreement in accordance with all applicable Medicare laws, rules and regulations, including, without limitation, all applicable Medicare Part D credentialing requirements. AHM agrees to comply with the following Medicare Part D requirements:

   a. AHM will review the credentials of pharmacies who will participate in the Medicare pharmacy networks in accordance with Medicare, laws, rules and regulations, including, without limitation, CMS instructions; and

   b. AHM agrees to permit Company to review and approve the credentialing process used by AHM to perform Credentialing and Recredentialing of Medicare Part D pharmacy networks under the Agreement, and to audit the credentialing process on an ongoing basis.

6. AHM agrees to enter into written agreements with providers who AHM selects to participate in the Medicare Plan provider and pharmacy networks ("Participating Providers") that meet all applicable requirements set forth in this Amendment and Medicare laws, rules and regulations, and requires that Participating Providers comply with this Amendment, the Agreement and all applicable Medicare laws, rules and regulations and CMS instructions. To the extent that the Agreement requires that AHM select providers or pharmacies to participate in the Medicare Plan provider and/or pharmacy networks, AHM agrees that Company retains the right to approve, suspend, or terminate any such provider or pharmacy selected by AHM as described in the Agreement.

7. AHM agrees to provide compliance training or attend compliance training programs conducted by Company in accordance with 42 C.F.R. Sections 422.504(b)(4)(vi)(C) and 423.504(b)(4)(vi)(C).

8. AHM agrees to report one hundred percent (100%) of any drug manufacturer rebates that AHM receives for prescription drugs covered under Company's Medicare prescription drug plans ("PDPs) and/or Medicare Advantage plans with Medicare prescription drug coverage ("MA-PD plans"), including the portion of the drug manufacturer rebates retained by AHM as part of the price concession for performing Medicare Services for Company's PDPs and MA-PDs.

Capitalized terms not otherwise defined herein shall have the meaning given such terms in the Agreement. All other terms and provisions of the Agreement not amended hereby shall remain in full force and effect, without modification. In the event of any inconsistency between the terms of this Amendment and the Agreement, the terms of this Amendment shall govern and control.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed below.

Accepted By:

AETNA LIFE INSURANCE COMPANY

BY: _____
(Signature)

Printed Name: Judith H. Jones

Title: Vice President and Corporate Secretary

Date: August 26, 2008

AETNA HEALTH MANAGEMENT, LLC

BY: _____
(Signature)

Printed Name: Edward C. Lee

Title: Vice President and Secretary

Date: August 26, 2008

Amended and Restated Intercompany Master Agreement between Aetna Medicaid Administrators LLC and Aetna Health Management LLC

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Amended and Restated Intercompany Master Agreement

This Amended and Restated Intercompany Master Agreement (this "Agreement") is dated as of May 1, 2012 (the "Effective Date"), between Schaller Anderson, LLC, an Arizona limited liability company, ("Company") and Aetna Health Management, LLC, a Delaware, limited liability company, ("AHM Affiliate").

WHEREAS, Company and AHM Affiliate are parties to an Intercompany Master Agreement effective as of January 1, 2011 (the "First Agreement") and both parties desire to amend and restate the First Agreement;

WHEREAS, Company provides management services to health plans that offer Medicaid Services and dual Medicaid and Medicare Services in various states in the United States; and

WHEREAS, Company has completed a review of AHM Affiliate's Credentialing and Recredentialing Program (as described more fully below) and has reviewed AHM Affiliate's documentation of same; and

WHEREAS, Company has determined that AHM Affiliate's Credentialing and Recredentialing Program meets Company's requirements and applicable state requirements; and

WHEREAS, Company wishes AHM Affiliate to perform, and AHM Affiliate wishes to perform, certain Credentialing and Recredentialing functions on behalf of Company;

WHEREAS, AHM Affiliate has the experience, trained personnel, knowledge, technical know-how, proprietary information and other resources and capability to assist Company in its health plan management business; and

WHEREAS, to negotiate, arrange and administer the Services (as described below), AHM Affiliate makes use of important intangible property for the benefit of Company; and

WHEREAS, with respect specifically to the Rebate Services (as described below) AHM Affiliate has the experience, trained personnel, knowledge, proprietary information, volume of manufacturers' rebates and other resources and capabilities to manage the formularies for different plans, develop, negotiate and arrange for manufacturers' rebate arrangements with the pharmaceutical industry and to administer such relationships for Company; and

WHEREAS, to negotiate, arrange and administer the manufacturers' rebate arrangements with the pharmaceutical industry, AHM Affiliate makes use of important intangible property for the benefit of Company and AHM Affiliate's intangible property involved in

the negotiation process and in the administration of these complex arrangements includes its national formulary, plan designs and information technology/software systems; and

NOW, THEREFORE, the parties hereto, intending to be legally bound, agree as follows:

1. Definitions. As used in this Agreement, the following terms have the respective meanings assigned to them in this Section 1:

"AAA" means the American Arbitration Association.

"Administrative Fees" for any period, means AHM Affiliate's unreimbursed actual cost of providing, with respect to Members who participate in plans, products and/or programs of health plans managed by the Company, administrative services to Company and each of Company's Affiliates to whom AHM Affiliate provides services similar to the Administrative Services during such period. Administrative Fees includes without limitation expenses incurred by AHM Affiliate's Affiliates for the benefit of Company and/or Company's Affiliates and allocated to AHM Affiliate in accordance with generally accepted accounting principles (including broker and agent fees and commissions). Administrative Fees excludes bad debt expenses, premium taxes, state and/or guaranty fund assessments, statutory audit fees, intercompany interest expense and all taxes that are based on Company's income.

"Administrative Services" has the meaning assigned to it in Section 2(a).

"Affiliate" means, with respect to any legal entity, any other legal entity or natural person that controls, is controlled by or is under common control with that legal entity.

"Business Associate" shall have the same meaning as the term Business Associate in 45 C.F.R. 160.103.

"C.F.R." means the Code of Federal Regulations.

"Designated Record Set" has the meaning assigned to such term in 45 C.F.R. 164.501.

"Electronic Protected Health Information" means information that comes within paragraphs 1 (i) or 1 (ii) of the definition of "Protected Health Information", as defined in 45 C.F.R. 160.103.

"Fees" means the Administrative Fees and/or the Rebate Fees.

"HHS" means the United States Department of Health and Human Services.

"Individual" shall have the same meaning as the term "individual" in 45 C.F.R. 164.501 and shall include a person who qualifies as personal representative in accordance with 45 C.F.R. 164.502(g).

"Investments" means debt securities, certificates of deposit, U.S. Treasury obligations and/or other investment vehicles that Company is permitted to purchase under applicable law.

"Members" means subscribers and their dependents covered under a health benefits plan, product or program issued, administered or serviced by Company and/or one or more of Company's Affiliates, including without limitation participants in self-insured plans.

"Privacy Rules" means the regulations at 45 C.F.R. Parts 160-64, implementing the privacy requirements set forth in the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

"Protected Health Information" shall have the same meaning as the term "Protected Health Information", as defined by 45 C.F.R. 160.103, limited to the information created or received by AHM Affiliate from or on behalf of Company.

"Providers" means hospitals, physicians, dentists, pharmacies and other health care providers.

"Rebate" means payments from pharmaceutical manufacturers, the amount of which is based upon utilization of pharmaceutical products by Members of Company.

"Rebate Fees" has the meaning assigned to it in Section 3.

"Rebate Services" has the meaning assigned to it in Section 3.

"Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. 164.501.

"Rules" means the AAA's Commercial Arbitration Rules as in effect on the Effective Date.

"Secretary" shall mean the Secretary of HHS or his or her designee.

"Security Breach" means the unauthorized acquisition, access, use or disclosure of Protected Health Information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information. Security Breach does not include:

(i) any unintentional acquisition, access, or use of Protected Health Information by an employee or individual acting under the authority of Business Associate if:

(a) such acquisition, access or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual, respectively, with Business Associate; and

(b) such information is not further acquired, accessed, used or disclosed by any person; or

(ii) any inadvertent disclosure from an individual who is otherwise authorized to access Protected Health Information at a facility operated by Business Associate another similarly situated individual at the same facility; and

(iii) any such information received as a result of such disclosure is not further acquired, accessed, used or disclosed without authorization by any person.

"Security Incident" shall have the same meaning as the term "security incident" in 45C.F.R. 164.304."

"Services" means Administrative Services and/or Rebate Services.

"Unsecured Protected Health Information" means Protected Health Information that is not secured through the use of a technology or methodology specified by guidance issued by the Secretary from time to time.

2. Administrative Services.

(a) AHM Affiliate will provide Company with the administrative services and resources specified in Attachment A and Attachment B (collectively "Administrative Services") in accordance with the method of payment of Administrative Fees set forth in Attachment C.

(b) In addition to Administrative Fees, Company shall reimburse AHM Affiliate for all out of pocket expenses incurred by AHM Affiliate or its Affiliates on behalf of Company. Such out of pocket expenses shall include without limitation premium taxes, taxes that are based on Company's income, statutory audit fees and expenses, debt collection costs, state and/or guaranty fund assessments, outside counsel fees and settlements and judgments payable by Company.

(c) Company shall be responsible for any taxes, federal, state or otherwise, that may be levied on the Administrative Services.

3. Rebate Services: AHM Affiliate shall provide the Company, if requested by the Company, with the following services (the "Rebate Services") for the fees set forth in Attachment D (the "Rebate Fees"):

(a) AHM Affiliate will develop, negotiate and contract for Rebates and similar arrangements with pharmaceutical manufacturers relating to the utilization of pharmaceutical products by Members of Company. AHM Affiliate makes no representation or warranty as to the total amount of Rebates offered by or received from any particular pharmaceutical manufacturer or by all contracted pharmaceutical manufacturers in the aggregate.

(b) AHM Affiliate will manage all aspects of the Rebate arrangements with pharmaceutical manufacturers and administer such arrangements. The Rebate Services shall include without limitation collecting the data necessary for obtaining the Rebates; processing that data and periodically submitting it in a non-Member specific format to the applicable pharmaceutical manufacturers. The Rebate Services also shall include without limitation the collection by AHM Affiliate of all Rebate amounts payable under the various pharmaceutical manufacturers' Rebate arrangements that AHM Affiliate has established. AHM Affiliate shall remit to Company all Rebates generated by Company's Members' utilization of pharmaceutical products within forty-five (45) calendar days after the end of the calendar month during which AHM Affiliate earns such Rebates.

(c) AHM Affiliate shall develop, implement, maintain and support a national formulary strategy, including without limitation the development of plan designs to support Company's business.

(d) AHM Affiliate shall develop and maintain software systems to administer and increase the efficiency of the administration of its pharmaceutical manufacturers' rebate arrangements. AHM Affiliate will manage and fund the implementation of such systems. AHM Affiliate shall be responsible for the maintenance and updates associated with such systems.

(e) Company shall be responsible for any taxes, federal, state or otherwise, that may be levied on the Rebate Services.

4. Term and Termination; Termination of Existing Agreements.

(a) The initial term of this Agreement shall be for a period of one (1) year commencing on the Effective Date. The term of this Agreement automatically shall be extended for additional periods of one year, unless

either party shall notify the other party in writing at least sixty (60) days prior to the expiration of the term then in effect.

(b) This Agreement may be terminated prior to the end of the term then in effect by a written agreement executed by both parties. This Agreement also may be terminated at any time by AHM Affiliate upon Company's breach of any of Company's obligations under this Agreement following thirty (30) calendar days' prior written notice of such breach and Company's failure to cure such breach within such thirty (30) calendar days. This Agreement also may be terminated at any time by Company upon AHM Affiliate's breach of any of AHM Affiliate's obligations under this Agreement following thirty (30) calendar days' prior written notice of such breach and AHM Affiliate's failure to cure such breach within such thirty (30) calendar days.

(c) If at any time AHM Affiliate ceases to be an Affiliate of Company, this Agreement may be terminated by either party upon thirty (30) calendar days prior written notice without further liability, except for the payment of all amounts earned or otherwise due under this Agreement with respect to periods ending on or before the effective date of such termination.

(d) The parties mutually agree that it is essential for Protected Health Information to be maintained after the expiration of this Agreement for regulatory and other business reasons. The parties further agree that it would not be feasible for Company to maintain such records because Company lacks the necessary systems and expertise. Accordingly, Company hereby appoints AHM Affiliate as Company's custodian for the safe keeping of any record containing Protected Health Information that AHM Affiliate may determine it is appropriate to retain. Notwithstanding the expiration or termination of this Agreement, AHM Affiliate shall extend the protections of this Agreement to such Protected Health Information, and limit further use or disclosure of such Protected Health Information to those purposes that make the return or destruction of the Protected Health Information not feasible.

5. Company's Obligations.

(a) From time to time, AHM Affiliate will recommend to Company policies and procedures for the operation of Company's business. Company shall consider implementation of such recommendations unless prohibited or restricted by applicable law or regulation.

(b) Company shall cooperate with AHM Affiliate in the development and negotiation of Rebate arrangements and provide AHM Affiliate with such

data as may be reasonably necessary for AHM Affiliate to perform the Rebate Services.

(c) Company hereby appoints AHM Affiliate as its agent to act on behalf of Company in connection with the Services. As Company's agent, AHM Affiliate is hereby authorized by Company, among other things, to hire employees and to negotiate and enter into agreements and contracts on behalf of Company. Company shall perform its obligations with respect to, and be responsible for, all such employees and agreements. Nothing in this Agreement shall be construed to transfer or divest any obligation or responsibility of Company which transfer or divestiture is prohibited by law or regulation.

6. Prohibition Against Assignment and Delegation. Neither AHM Affiliate nor Company may assign this Agreement or its rights hereunder or delegate or subcontract any of its duties hereunder without the express prior written consent of the other party. Any attempted assignment or delegation in violation hereof shall be null, void and ineffective. Notwithstanding the foregoing, AHM Affiliate may perform the Services directly or indirectly through one or more of its Affiliates or independent contractors, provided AHM Affiliate shall remain liable to Company for the discharge of AHM Affiliate's obligations hereunder.

7. Confidentiality of Data and Systems. During the term of this Agreement, each party will receive and have access to proprietary data and systems of the other party. Unless otherwise approved by the other party or unless otherwise required by law, each party agrees (i) to keep all such data and systems confidential and not to disclose or reveal any such data or system to any persons or entities, and (ii) not to use such data or systems for any purpose other than as required to perform Services pursuant to this Agreement. Each party also acknowledges that the other party is the owner of all such data and systems and agrees that they constitute confidential and trade secret information which the recipient will treat as such and will provide security for and take reasonable measures to insure their protection. Upon termination of this Agreement, each party will return all copies of the other party's material in its possession or control or will destroy them, as requested by the other party. The owner of the material will bear reasonable costs for the return or destruction of its material.

8. Indemnification. Each party agrees to indemnify and hold the other harmless from and against any and all claims, actions, liabilities, losses, damages, costs and expenses (including without limitation reasonable attorneys' fees) incurred by reason of any legal or administrative action arising out of or caused by the negligence or other culpable wrongdoing of the indemnifying party or by any breach of the indemnifying party's obligations hereunder. Such indemnification is contingent upon prompt notice from the party seeking to be indemnified of the existence of any such claim or action and such party's full cooperation with the

defense of any such claim or action, which shall be controlled by the indemnifying party at its election. The indemnifying party shall, at its election, also have full control over any settlement.

9. Obligations and Activities of AHM Affiliate Regarding Protected Health Information.

(a) AHM Affiliate agrees to not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law.

(b) AHM Affiliate agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement.

(c) AHM Affiliate agrees to mitigate, to the extent practicable, any harmful effect that is known to AHM Affiliate of a use or disclosure of Protected Health Information by AHM Affiliate in violation of this Agreement.

(d) AHM Affiliate agrees to report to Company any use or disclosure of Protected Health Information not permitted by this Agreement of which AHM Affiliate becomes aware.

(e) AHM Affiliate agrees to report to Company any Security Breach of Unsecured Protected Health Information without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a Security Breach. Such report shall include the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed, to have been, accessed, acquired, or disclosed in connection with such Security Breach. In addition, AHM Affiliate shall provide any additional information reasonably requested by Company for purposes of investigating the Security Breach. AHM Affiliate's notification of a Security Breach under this section shall comply in all respects with each applicable provision of Section 13400 of Subtitle D (Privacy) of ARRA and related guidance issued by the Secretary from time to time.

(f) AHM Affiliate agrees to ensure that any agent, including a subcontractor, to whom AHM Affiliate provides Protected Health Information received from, or created or received by AHM Affiliate on behalf of Company agrees to the same restrictions and conditions that apply through this Agreement to AHM Affiliate with respect to Protected Health Information. In no event shall AHM Affiliate without Company's prior written approval, provide Protected Health Information received from, or created or received by AHM Affiliate on behalf of Company, to any employee or agent, including a subcontractor, if such employee, agent or subcontractor

receives, processes or otherwise has access to the Protected Health Information outside of the United States.

(g) AHM Affiliate agrees to provide access, at the request of Company, and in the time and manner designated by Company, to Protected Health Information in a Designated Record Set, to Company or, as directed by Company, to an Individual in order to meet the requirements of 45 C.F.R. 164.524. Company's determination of what constitutes "Protected Health Information" or a "Designated Record Set" shall be final and conclusive.

(h) AHM Affiliate agrees to make any amendments to Protected Health Information in a Designated Record Set that Company directs or agrees to pursuant to 45 C.F.R. 164.526 at the request of Company or an Individual, and in the time and manner designated by Company. AHM Affiliate shall not charge any fee for fulfilling requests for amendments. Company's determination of what Protected Health Information is subject to amendment pursuant to 45 C.F.R. 164.526 shall be final and conclusive.

(i) AHM Affiliate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by AHM Affiliate on behalf of, Company and (ii) policies, procedures, and documentation relating to the safeguarding of Electronic Protected Health Information available to Company, or at the request of Company to the Secretary, in a time and manner designated by the Company or the Secretary, for purposes of the Secretary determining Company 's compliance with the Privacy and Security Rules.

(j) AHM Affiliate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Company to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

(k) AHM Affiliate agrees to provide to Company the information collected in accordance with this Section 9 to permit Company to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528. In addition, with respect to information contained in an Electronic Health Record, AHM Affiliate shall document, and maintain such documentation for three (3) years from date of disclosure, such disclosures as would be required for Company to respond to a request by an Individual for an accounting of disclosures of information contained in an electronic Health Record, as required by Section 13405(c) of Subtitle D (Privacy) of ARRA and related regulations issued by the Secretary from time to time.

(l) AHM Affiliate acknowledges that it shall request from Company and so disclose to its Affiliates, agents and subcontractors or other third parties, (i) the information contained in a "limited data set," as such term is defined at 45 C.F.R. 164.514(e)(2), or, (ii) if needed by AHM Affiliate, to the minimum necessary to accomplish the intended purpose of such requests or disclosures. In all cases, AHM Affiliate shall request and disclose Protected Health Information only in a manner that is consistent with guidance issued by the Secretary from time to time.

(m) With respect to Electronic Protected Health Information, AHM Affiliate shall implement and comply with (and ensure that its subcontractors implement and comply with) the administrative safeguards set forth at 45 C.F.R. 164.308, the physical safeguards set forth at 45 C.F.R. 310, the technical safeguards set forth at 45 C.F.R. 164.312, and the policies and procedures set forth at 45 C.F.R. 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Company.

(n) With respect to Electronic Protected Health Information AHM Affiliate shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate safeguards to protect it.

(o) AHM Affiliate shall report to Company any Security Incident of which it becomes aware.

(p) If AHM Affiliate conducts any Standard Transactions on behalf of Company AHM Affiliate shall comply with the applicable requirements of 45 C.F.R. Parts 160-162.

(q) During the term of this Agreement, AHM Affiliate may be asked to complete a security survey and/or attestation document designated to assist Company in understanding and documenting AHM Affiliate's security procedures and compliance with the requirements contained herein. AHM Affiliate's failure to complete either of these documents within the reasonable timeframe specified by Company shall constitute a material breach of this Agreement.

(r) AHM Affiliate shall use commercially reasonable efforts to maintain the security of Protected Health Information and to prevent unauthorized uses or disclosures of Protected Health Information.

10. Permitted Uses and Disclosures of Protected Health Information by AHM Affiliate.

(a) General Use and Disclosure. Except as otherwise limited in this Agreement, AHM Affiliate may use or disclose Protected Health Information to perform AHM Affiliate's obligations under this Agreement, provided that such use or disclosure would not violate (i) the Privacy Rules if done by Company or (ii) the minimum necessary policies and procedures of Company.

(b) Specific Use and Disclosure Provisions.

(i) Except as otherwise limited by this Agreement, AHM Affiliate may use Protected Health Information for the proper management and administration of AHM Affiliate or to carry out the legal responsibilities of AHM Affiliate.

(ii) Except as otherwise limited by this Agreement, AHM Affiliate may disclose Protected Health Information for the proper management and administration of AHM Affiliate, provided that disclosures are Required By Law, or AHM Affiliate obtains reasonable assurances from the person to whom the information is disclosed that the information disclosed will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies AHM Affiliate of any instances of which such person is aware in which the confidentiality of the information has been breached, in accordance with the Security Breach and Security Incident Notification of previsions of this Agreement.

(iii) Except as otherwise limited in this Agreement, AHM Affiliate may use Protected Health Information to provide Data Aggregation services to Company as defined in and as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).

(iv) AHM Affiliate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. 164.502(j)(1).

(v) AHM Affiliate shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an individual without Company's prior written approval and notice from Company that it has obtained from the individual, in accordance with 45 C.F.R. 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be

further exchanged for remuneration by AHM Affiliate. The foregoing shall not apply to Company's payments to AHM Affiliate for services delivered by AHM Affiliate to Company.

11. Certain Obligations of Company Regarding Protected Health Information.

(a) Provisions for Company to Inform AHM Affiliate of Privacy Practices and Restrictions.

(i) Company shall notify AHM Affiliate of any limitation(s) in its notice of privacy practices of Company in accordance with 45 C.F.R. 164.520, to the extent that such limitation(s) may affect AHM Affiliate's use or disclosure of Protected Health Information.

(ii) Company shall provide AHM Affiliate with any change in, or revocation of, permission by any Individual to use or disclose Protected Health Information, to the extent that such change and/or revocation affects AHM Affiliate's uses and/or disclosures of Protected Health Information.

(iii) Company shall notify AHM Affiliate of any restriction to the use or disclosure of Protected Health Information that Company has agreed to in accordance with 45 C.F.R. 164.522, to the extent that such restriction may affect AHM Affiliate's use or disclosure of Protected Health Information.

(iv) Company agrees that Company will not furnish or impose by arrangements with third parties or other Covered Entities or Business Associates special limits or restrictions to the uses and disclosures of Company's Protected Health Information that may impact in any manner the use and disclosure of Protected Health Information by AHM Affiliate under this Agreement, including without limitation restrictions on the use and/or disclosure of Protected Health Information as provided for in 45 C.F.R. 164.522.

(b) Permissible Requests by Company. Company shall not request AHM Affiliate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rules if done by Company.

12. Miscellaneous.

(a) Regulatory References. A reference in this Agreement to a section in the Privacy Rules means the section as in effect or as amended, and for which compliance is required.

(b) Amendments. Except as set forth below in this Section 12(b), this Agreement may be amended solely by written agreement of the parties hereto, subject to any required government approvals. Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend this Agreement in such manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such amendment, it shall so notify the first party in writing within thirty (30) calendar days of the notice. If the parties are unable to agree on an amendment within thirty (30) calendar days thereafter, then either of the parties may terminate this Agreement on thirty (30) calendar days written notice to the other party.

(c) Survival. The respective rights and obligations of AHM Affiliate under Section 4(d) of this Agreement shall survive the termination of this Agreement.

(d) Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Company to comply with the Privacy Rules.

(e) No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors and permitted assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

(f) Notices. Any notice required to be given pursuant to this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid:

to AHM Affiliate at:

151 Farmington Avenue
Hartford, CT 06156

and to Company at:

4645 E. Cotton Center Blvd.
Building 1
Phoenix, AZ 85040

The above addresses may be changed at any time by either party upon written notice.

(g) Waiver. No waiver of any term or provision of this Agreement shall be valid unless in writing and executed by the waiving party. It is expressly understood that if any party shall fail to perform any term or condition of this Agreement and the other shall not enforce or give notice of default, the failure to enforce or give notice of default shall not prevent enforcement of any other term or condition of this Agreement or the giving of notice of any other failure to perform or any other default.

(h) Integration. This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior agreements between the parties with respect to the subject matter hereof.

(i) Validity of Agreement/Choice of Law. The validity, enforceability and interpretation of this Agreement will be determined and governed by the laws of the State of Delaware without regard for the conflicts of laws principles thereof. The invalidity or unenforceability of any term or provision hereof will not, unless otherwise specified herein, affect the validity or enforceability of any other term or provision hereof.

(j) Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, and all of which, together, constitute one and the same instrument. This Agreement shall become binding when one or more counterparts, individually or taken together, bears the signature of both parties.

(k) Headings for Convenience. The underlined headings contained in this Agreement are for convenience of reference only and are not part of this Agreement.

(l) Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity of this Agreement, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the AAA and conducted by a sole arbitrator, who shall be unaffiliated with each party, in accordance with the Rules. The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. Except as may be required by law or to the extent necessary in connection with a judicial challenge, or enforcement of an award, neither a party nor the arbitrator may disclose the existence, content, record or results of an arbitration.

Fourteen (14) calendar days before the hearing, the parties will exchange and provide to the arbitrator (i) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (ii) premarked copies of all exhibits they intend to use at the hearing. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary relief and is not empowered to award damages other than compensatory damages. The location of the arbitration shall be in Delaware or any other location acceptable to both parties.

(m) Management of Company. Notwithstanding any other provision of this Agreement, it is understood that the business and affairs of Company shall be managed by its Board of Directors and, to the extent delegated by such Board and applicable law, by Company's officers. Neither AHM Affiliate nor any of its officers or agents shall have any management authority or prerogatives with respect to the business affairs and/or operations of Company except as specifically set forth in this Agreement.

(n) Non-Discrimination. All services provided pursuant to this Agreement shall be provided without regard to the Member's race, color, sex, age, religion, national origin or source of payment.

(o) Audit Rights. Company shall have the right, at its expense, to audit the books, records and accounts of AHM Affiliate related to this Agreement after giving reasonable notice to AHM Affiliate of Company's intent to conduct such an audit. In the event of such audit, AHM Affiliate shall give Company reasonable cooperation and access to all books, records and accounts necessary to the audit.

(p) Records. Each party shall be the sole owner of its financial and accounting records, regardless of the use or possession by a party of any other party's records. AHM Affiliate and Company shall each individually maintain separate books, accounts and records with respect to Services provided under this Agreement. The books and records of Company shall be maintained at such location or locations, within or without the State of Connecticut, as AHM Affiliate and Company may agree from time to time. AHM Affiliate and Company each shall maintain their own books, accounts and records in such a way as to disclose clearly and accurately the nature and detail of the transactions between them.

THE NEXT PAGE IS THE SIGNATURE PAGE

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date and year first set forth above.

SCHALLER ANDERSON, LLC

By: _____
Name: Wendy M. Cianci
Title: Assistant Secretary

AETNA HEALTH MANAGEMENT, LLC

By: _____
Name: Edward C. Lee
Title: Vice President and Secretary

ATTACHMENT A
ADMINISTRATIVE SERVICES

Specific Responsibilities and Services. AHM Affiliate's duties may include without limitation the following as agreed to from time to time between the parties hereto

(a) Finance and Tax Services. The following finance functions related to Company's business to the fullest extent permitted by applicable law: All accounting and reporting functions, including without limitation billing, accounts receivable, accounts payable, payroll, budgets, premium rates, financial and statutory reporting, tax return preparation, investment consulting, execution of Company's investment decisions and cash management. All financial records shall be available to Company at all times. As more fully set forth in Section (u) of this Attachment A, AHM Affiliate shall deposit in a bank (or banks) all receipts and monies arising from the operation of Company and make disbursements on behalf of Company in such amounts and at such times as the same are required. Signatures and approvals as to the amounts of all checks shall be in accordance with duly adopted policies of Company. AHM Affiliate shall supervise and direct the collection of all accounts receivable due to Company, taking all commercially reasonable steps to minimize the number and amount of bad debts.

(b) Human Resources. Human resource and personnel administrative and recruiting services. Company (through its Board of Directors in the case of officers) shall have the right to approve the hiring, termination or disciplining of any officer, department head or medical director of Company.

(c) Operational Services. General operational services, including without limitation telephone and computer system design services, mail services and microfilm services.

(d) Procurement. Procurement services, including without limitation the extension of AHM Affiliate's volume vendor discounts, to the extent available.

(e) Legal/Compliance/Privacy Services. Subject to the direction of Company's Board of Directors, AHM Affiliate shall arrange for provision of the legal/compliance/privacy services necessary to meet the needs of Company except with respect to any to any legal dispute between AHM Affiliate and Company relating to this Agreement. Without limiting the generality of the foregoing, (i) AHM Affiliate shall arrange for the legal review and analysis of enrollee, benefit, Provider, and marketing contracts, regulatory compliance matters, management and coordination of Company's litigation, arbitration, and subrogation activities, and general corporate and healthcare related legal work; and (ii) AHM Affiliate shall coordinate the defense of any litigation or claims related to the Services or Company's operations, although Company shall remain liable for any ultimate settlements or judgments, as set forth in Section 2(b).

(f) Claims Payment. Payment of claims and benefits incurred by Members.

(g) Quality Assessment/Utilization Review/Disease Management/ Patient Management/Case Management. Medical support functions in the nature of quality assessment services, including without limitation the preparation of quality assessment services, practice guidelines, National Committee for Quality Assurance ("NCQA") accreditation, disease management services, utilization review services, patient management and case management services, and risk management programs, and Member grievance policies and procedures to enable Member access to cost effective health care.

(h) Customer Services. Employer and Member customer services, including without limitation new Member telephone calls, Member surveys, servicing Member inquiries and problems and Member enrollment.

(i) Provider Network Services. Support functions in the nature of Provider contracting services, including without limitation the service obligations and quality aspects of agreements with Providers and Provider relations services. In addition, AHM Affiliate hereby makes available to Company, and grants Company access to, as necessary or desirable, AHM Affiliate's Provider network (including without limitation contracts that AHM Affiliate negotiates with national and regional vendors and providers, contracts that AHM Affiliate negotiates with centers of excellence outside of the Company's service area, and those portions of AHM Affiliate's Provider network that are made available to AHM Affiliate by agreements and/or other arrangements between AHM Affiliate and its Affiliates). At Company's request, AHM Affiliate shall enforce and/or use commercially reasonable efforts to cause its Affiliates to enforce their respective agreements with the Providers in AHM Affiliate's Provider network for the benefit of Company.

(j) Facilities. Negotiating such terms and agreements as may be necessary or advisable for the furnishing of facilities, utilities, services, concessions and supplies for the maintenance and operation of Company.

(k) Marketing. AHM Affiliate shall produce advertising, public relations and marketing materials on behalf of Company for distribution by Company and/or by Company's duly licensed agents and shall support Company in its marketing efforts. Company acknowledges that any solicitation documents used by Company are subject to filing with, and approval by, state regulatory agencies. AHM Affiliate also shall produce website marketing and other internet services and materials for Company.

(l) Insurance and Risk Management. AHM Affiliate shall negotiate and maintain general and professional liability insurance, naming Company as an additional

insured thereunder, in amounts reasonably acceptable to Company. AHM Affiliate shall deliver memorandum copies of its insurance certificates to Company upon request.

(m) Information Technology Data Processing. The computer and MIS resources necessary to perform the Services. AHM Affiliate shall provide access to adequate management information systems to carry out this Agreement.

(n) Pharmacy Services. AHM Affiliate shall provide Company with pharmacy benefit management services under AHM Affiliate's pharmacy benefit management program, including without limitation the following:

- Direct reimbursement of pharmacy claims to pharmacy Providers;
- Sales, marketing and account support services;
- Customer and provider services;
- Development and operation of a pharmacy precertification unit;
- Development and supply of management reports;
- Performance of drug utilization review programs, quality management programs and audit programs;
- Development and operation of a Pharmacy and Therapeutics Committee;
- Development, installation and implementation of a medication formulary;
- Management of Company's pharmacy Provider network; and
- Provision of such other pharmacy-related benefit program management services as may be agreed upon by the parties from time to time.

(o) Ancillary and Other Agreements. AHM Affiliate shall negotiate and enter into such ancillary agreements on behalf of Company as AHM Affiliate may deem necessary or advisable for the maintenance and operation of Company.

(p) Licenses and Permits. AHM Affiliate shall apply for and maintain on behalf of Company all necessary licenses and permits required by any state or by any other regulatory body with jurisdiction over Company.

(q) Benefit Contracts. AHM Affiliate shall develop health care coverage products for Company to offer to groups and individuals, and AHM Affiliate shall prepare the agreements, including without limitation individual and group contracts, and evidences or certificates of coverage reflecting the benefit to be provided by Company.

(r) Fees and Expenses. AHM Affiliate shall pay all fees and expenses of actuarial, auditing and/or accounting consultants of any type retained by AHM Affiliate to perform the Services, including without limitation any consultant used to obtain

federal qualification or competitive medical plan status. Such fees and expenses are included in the Administrative Fee.

(s) Agents Fees and Commissions. On behalf of Company, AHM Affiliate and/or its Affiliates shall pay all broker and agent fees and/or commissions due with respect to Company's business placed by such brokers and/or agents. As set forth in Section 2(a), such fees and commissions are included in the Administrative Fees.

(t) Out-of-Pocket Corporate Maintenance Expenses. On behalf of Company, AHM Affiliate and/or its Affiliates shall pay the following out of pocket corporate maintenance expenses of Company: costs of periodic state or federal securities or corporate reports, amendments to corporate documents, any expenses for fees of Company's Board of Directors, and costs associated with meetings of the Board of Directors or shareholders or committee meetings. Such expenses are included in the Administrative Fees.

(u) Investigation and Fraud and Abuse Services.

(v) Cash Management Services. Company shall participate in AHM Affiliate's centralized cash management system (the "System"), and AHM Affiliate shall administer the System in accordance with the terms and conditions set forth below:

1. Procedures. The procedures for the System are as follows:

a. All claims, expenses and other disbursement requests submitted for payment by Company shall be processed and paid by AHM Affiliate through a centralized disbursement account or accounts held as specified herein.

b. All premiums and other payments made to Company by third parties shall be received and processed by AHM Affiliate through a centralized depository account or accounts (e.g., lock box(es)) held as specified herein.

c. All of the foregoing transactions shall be recorded on the books of Company in intercompany account with AHM Affiliate and recorded on the books of AHM Affiliate in an intercompany account with Company.

d. The System also shall account for the reimbursement by Company to AHM Affiliate of costs expended by AHM Affiliate and/or its Affiliates on behalf of Company using applicable statutory accounting principles and/or practices prescribed or permitted by the State of Connecticut and/or accounting principles generally accepted in the United States of America.

e. AHM Affiliate shall follow such directions and instructions as may be given to AHM Affiliate by Company from time to time with respect to the funds of Company and the participation of Company in the System.

2. Condition of Participation. The participation of Company in the System, as described in this Agreement, is expressly conditioned upon all investment accounts holding assets of Company being in the name of Company. Depository, disbursement and other non-investment accounts holding assets of Company may be in the name of Company and/or AHM Affiliate.

3. Settlement of Accounts. Intercompany balances resulting from the operation of the System shall be settled as to Company within 15 calendar days after the end of each calendar month (where possible) and in no event more than 45 calendar days after the end of each calendar quarter.

4. Investments. AHM Affiliate may, from time to time, buy Investments for Company and place such Investments in the name of or for the account of Company for the purpose of settling intercompany balances. Such Investments shall be held in the name of Company. Unless specifically permitted by an investment policy adopted by Company's Board of Directors, AHM Affiliate shall not place the funds of Company in any Investment that is not secured or backed by the full faith and credit of the United States or insured by a U.S. Government agency (e.g., the FDIC).

ATTACHMENT B

Program Credentialing Agreements in effect on or before May 1, 2012 shall become Exhibits to this Attachment B. Program Credentialing Agreements which become effective after May 1, 2012 shall become Exhibits of this Attachment B on their respective effective dates.

1. Definitions.

For purposes of this Attachment B, the following definitions apply. All other defined terms used in this Attachment shall have the same meaning as in the Definition section of the Agreement:

1.1 "Credentialing and Recredentialing " means the peer review, evaluation and primary source verification of providers' qualifications and competence to practice their profession without restriction and to provide behavioral health care and/or physical health care services, as applicable, to Members and providers' satisfaction of Company's applicable participation criteria.

1.2 "Credentialing and Recredentialing Program" means the process by which AHM Affiliate evaluates and verifies providers' primary source qualifications and competence to practice their profession without restriction and to provide behavioral health care and/or physical health care services, as applicable, to Members and providers' satisfaction of Company's applicable participation criteria.

1.3 "Program Credentialing Agreement" means an agreement entered into by Company and AHM Affiliate for the provisions of Credentialing or Recredentialing by AHM Affiliate in a state where Company is providing Medicaid or dual Medicaid/Medicare Services. All such agreements shall be exhibits to this Attachment B.

2. Obligations of AHM Affiliate With Respect to Credentialing and Recredentialing.

2.1 AHM Affiliate shall provide all or a portion of the Credentialing and Recredentialing services described in Exhibit 1, attached hereto and made a part hereof, on behalf of Company for Providers who are applying to become Participating Providers. AHM Affiliate warrants and agrees that its Credentialing and Recredentialing Program is and shall remain in compliance with NCQA standards.

2.2 AHM Affiliate shall allow Company to maintain oversight of the Credentialing and Recredentialing services furnished by AHM Affiliate on behalf of Company.

2.3 Notwithstanding anything to the contrary in the Agreement or this Attachment B, copies of member's records and Credentialing and Recredentialing files and records must be made available to Company.

2.4 Upon request of Company, AHM Affiliate shall provide, in a format acceptable to Company, timely, accurate and appropriate data and information to enable Company to fulfill applicable state and federal regulatory filing requirements.

3. Obligations of Company.

Company shall maintain oversight of Participating Provider Credentialing and Recredentialing. Notwithstanding anything to the contrary contained in the Master Agreement or this Attachment B, Company shall retain the right to: (i) override a credentialing determination made by AHM Affiliate; (ii) approve or disapprove Providers who apply to become Participating Providers; (iii) terminate, reduce or suspend the Participating Provider status of any individual Provider upon notice to AHM Affiliate and to the affected Participating Provider for failure to abide by the requirements of the Credentialing or Recredentialing participation criteria of Company; and (iv) require a Provider to undergo Company's Credentialing or Recredentialing process in order to continue or be considered for acceptance as Participating Provider, regardless of the status of this Master Agreement. Providers who are disapproved, terminated, or suspended by Company shall not provide services to Members.

4. Termination.

4.1 Termination of Program Credentialing Agreements. The termination or expiration of any particular Program Credentialing Agreement alone will not result in the termination of the Master Agreement or any other Program Credentialing Agreement, absent any other grounds for termination under the Master Agreement or the respective Program Credentialing Agreements.

5. General Provisions.

5.1 AHM Affiliate and Company will execute a Program Credentialing Agreement for each Plan for which AHM Affiliate will perform Credentialing and Recredentialing functions on behalf of Company, as set forth in such Program Credentialing Agreement. Unless otherwise agreed to in a Program Credentialing Agreement, AHM Affiliate shall provide to Company upon request a copy of all original materials produced by AHM Affiliate directly related to and necessary for the performance of the Credentialing and Recredentialing functions provided under this Agreement and the applicable Program Credentialing Agreement, or otherwise required for Company to meet its contractual obligations to the Plan.

ATTACHMENT C
FEES FOR ADMINISTRATIVE SERVICES

(a) Company shall pay AHM Affiliate the Administrative Fees within forty-five (45) calendar days after the end of the calendar quarter with respect to which such Fees are payable. Payments shall be made through accounting entries in the general ledger of AHM Affiliate and Company or other cost allocation processes.

(b) All intercompany balances under this Agreement shall be settled within forty-five (45) calendar days after the end of each quarter.

(c) Each of AHM Affiliate and Company shall have the right to offset all intercompany receivable and payable balances (including without limitation Fees) with the other party.

(d) The Fees are based upon the current federal and state laws and regulations that govern AHM Affiliate and/or Company. The parties hereto acknowledge that if any of such laws or regulations are amended, the cost and expenses of operating Company may change. Therefore, upon any such amendment or replacement, the parties shall renegotiate in good faith and agree on revised Fees hereunder.

ATTACHMENT D
FEES FOR REBATE SERVICES AND
PAYMENT OF REBATE FEES

(a) Company shall pay AHM Affiliate a Rebate Fee of [redacted] of all Rebates earned by Company through AHM Affiliate's Rebate agreements.

(b) Pursuant to Section 3 of this Agreement, AHM Affiliate shall collect the Rebate amounts from the applicable manufacturers and remit 100% of the Rebates to Company.

(c) All Rebates and Rebate Fee transactions shall be recorded on the books of Company in an intercompany account with AHM Affiliate and recorded on the books of AHM Affiliate in an intercompany account with Company.

(d) Intercompany balances for Rebates and Rebate Fees shall be settled within forty-five (45) calendar days after the end of the calendar quarter during which AHM Affiliate earned the Rebates. If AHM Affiliate fails to forward the correct sum to Company, or Company fails to pay Rebate Fees, within the specified time, the party to whom the payment is due may charge interest at a rate equal to the monthly average overnight interest rate earned on AHM Affiliate's investments during the period for which interest on such amount is being calculated, along with any costs of collection and reasonable attorneys' fees.

(e) Each of AHM Affiliate and Company shall have the right to offset all intercompany receivable and payable balances (including without limitation Fees) with the other party.

(f) AHM Affiliate shall submit to Company on a quarterly basis a statement with the Rebates collected, Rebate Fees due to AHM Affiliate and remaining Rebate amounts to be forwarded to Company.

(g) The Fees are based upon the current federal and state laws and regulations that govern AHM Affiliate and/or Company. The parties hereto acknowledge that if any of such laws or regulations are amended, the cost and expenses of operating Company may change. Therefore, upon any such amendment or replacement, the parties shall renegotiate in good faith and agree on revised Fees hereunder.

Subcontractor Addendum for Medicare-Medicaid Dual Eligible Members
(For Administrative/Management Services)

This Subcontractor Addendum for Medicare-Medicaid Dual Eligible Members ("Addendum") shall govern Contractor's provision of services in connection with Company's contract offer Medicare-Medicaid Dual Eligible Plans ("Services"). For purposes of this Addendum, the term "Contractor" shall mean the Contractor executing the Agreement to which this Addendum is attached, and the term "Company" shall mean the Aetna affiliate that is part to the Agency Contract (or its designee, as applicable), each as identified on the first page of the Agreement. If there is any conflict between the terms of this Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits and/or addenda made part of this Agreement, the terms of this Addendum will govern and control (except as stated in paragraph 3); provided, however, if there is any conflict between any of the terms of this Agreement, including this Addendum, and the Agency Contract (as defined in the Agreement), then the terms of the Agency Contract will govern and control. To the extent possible under applicable law, the terms below shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the remainder of the Agreement.

1. Contractor agrees to comply with all applicable state and federal laws, rules, regulations, and Centers for Medicare and Medicaid Services (CMS) instructions, as well as Company requirements designed to ensure Company's compliance with such laws, rules, regulations, including, without limitation, laws, rules and regulations relating to the protection of Member privacy and confidentiality and the accuracy of Member health records, which Contractor shall safeguard and ensure. Contractor agrees to abide by state and federal privacy and security requirements, including the confidentiality and security provisions stated in 42 C.F.R. §§ 422.118 and 423.136. Contractor agrees that all Services and other activities performed by Contractor under the Agreement will be consistent and comply with Company's obligations under its contract(s) with CMS and other Government Sponsors to offer Plans for Medicare-Medicaid dually-eligible members. Upon request, Contractor shall immediately provide to Company any information required by Company to meet its reporting obligations to CMS and other Government Sponsors. Contractor acknowledges and agrees to allow CMS, other Government Sponsors and Company to monitor Contractor's performance under this Agreement on an ongoing basis, in accordance with applicable laws, rules and regulations.

2. Contractor acknowledges and agrees that all provisions of this Addendum and of the Agreement shall apply equally to any employees, independent contractors and subcontractors of Contractor who provide or may provide Services, and Contractor represents and warrants that Contractor shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply with this Addendum and the Agreement and all applicable laws and regulations, and perform all requirements applicable to Medicare and Medicaid programs.

3. This paragraph 3 applies only if payment timeframes are not specified elsewhere in the Agreement: Company agrees to pay Contractor for Services within forty-five (45) calendar days of actual receipt by Company of a Clean Claim. Payments for non-capitated Services are subject to any and all valid and applicable laws related to claims payment. Contractor acknowledges that compensation under the Agreement for Services constitutes receipt of federal funds. Contractor shall pay on a timely basis all employees, independent contractors and subcontractors who render Services to Members for which Contractor is financially responsible pursuant to the Agreement.

4. Contractor acknowledges and agrees that Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Contractor any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Contractor further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the Agency is responsible for paying such Cost Sharing Amounts, and will, instead, either accept

the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or, bill the applicable Agency source for the appropriate Cost Sharing Amounts owed by the State Medicaid plan. Contractor should be aware that pursuant to the Agency Contract, Company may be the applicable Agency source, and in such case Contractor shall only bill Company.

5. Contractor agrees to provide Company and federal, state and local governmental authorities having jurisdiction, or their designees (including the U.S. Department of Health and Human Services (HHS), the Comptroller General or their designees), upon request, access to all books, contracts, computer or other electronic systems, (including, but not limited to, medical and financial records) and information relating to the Agreement and to those Services rendered by Contractor and its employees, independent contractors and subcontractors ("Information and Records"), and that this right of inspection, evaluation and audit exists through ten (10) years from the final date of any contract period or the date of completion of any audit, whichever is later. Contractor also agrees to maintain Information and Records for ten (10) years from the final date of any contract period or the date of completion of any audit, whichever is later. This Section shall survive the termination of the Agreement, regardless of the cause of the termination.

6. Contractor agrees to comply with the following, as applicable and as amended from time to time: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, HIPAA administrative simplification rules at 45 C.F.R. parts 160, 162, and 164, the Americans with Disabilities Act, Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. §§ 3729 *et. seq.*), and the anti-kickback statute (section 1128B(b) of the Social Security Act), and any other laws applicable to recipients of Federal funds.

7. In no event, including without limitation, non-payment by Company, insolvency of Company or breach of the Agreement or this Addendum, shall Contractor bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or persons (other than the Company) acting on a Member's behalf for Services provided under the Agreement. This provision shall not prohibit collection of deductibles, coinsurance or copayments from Members in accordance with the terms of the Member's agreement with Company, and, for Medicaid members, only if permitted by applicable law. Contractor further agrees that: (a) this provision shall survive termination of the Agreement and this Addendum regardless of the cause giving rise to termination and shall be construed for the benefit of Members, and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Contractor and a Member or persons acting on a Member's behalf. No modification of this provision shall be effective without the prior written approval of the appropriate state and/or federal regulatory entities.

8. Contractor acknowledges that Company may only delegate activities or functions to Contractor in a manner consistent with Medicare laws, rules and regulations. Contractor acknowledges and agrees that if any of Company's activities or responsibilities under Company's contract with CMS and Government Sponsor to offer Plans is delegated by Company to Contractor, such activity or responsibility may be revoked if CMS or Company determines that Contractor has not performed satisfactorily. To the extent Company has delegated activities or functions to Contractor pursuant to a separate delegation agreement, such agreement shall specify the duties and reporting obligations of Contractor, and the terms of this Addendum shall be incorporated therein, if not already expressly stated therein.

   If Company consents, Contractor may sub-delegate a portion of its responsibilities under the Agreement to a third party approved by Company ("Sub-Delegate"); provided, however, Contractor agrees that it is responsible for ensuring that any Sub-Delegate adheres to the

requirements of this Addendum and the Agreement; provided, further, Contractor and any Sub-Delegated entity shall enter into an agreement setting forth the respective responsibilities of the parties, which shall comply with applicable accreditation standards. Such sub-delegation shall not relieve Contractor of its obligations under this Addendum or the Agreement. Contractor acknowledges and agrees that all provisions of this Agreement shall apply equally to any Sub-Delegate that provides any Services under this Agreement, and Contractor represents and warrants that it shall take all steps necessary to cause such Sub-Delegates to comply with the Agreement, this Addendum, and all applicable laws, rules and regulations

Contractor further acknowledges and agrees that any contract that Contractor enters into with a Sub-Delegate relating to any Services ("Delegated Subcontract"): (i) must contain provisions that require the Sub-Delegate to comply with any and all obligations and duties imposed on Contractor in this Agreement including this Addendum (ii) must contain all provisions required under Medicare laws, rules and regulations, and (iii) is subject to all of Company's obligations under Medicare laws, rules and regulations related to such Delegated Subcontract.

9. The credentials of medical professionals affiliated with Contractor will be reviewed by Company in accordance with Company's polices as stated in the Agreement. If such credentialing process has been delegated to Contractor as a part of this Agreement or in a separate Agreement, the credentialing process will be reviewed and approved by Company and Company shall audit the credentialing process on an ongoing basis. If Company has delegated a selection of providers, contractors, or subcontractors, Company shall retain the right to approve, suspend or terminate any arrangement with a provider, contractor or subcontractor.

10. Contractor agrees that it is bound by 2 C.F.R. Part 376 and attests that it is not excluded by the HHS Office of the Inspector General ("OIG") or by the General Services Administration ("GSA"). Contractor agrees to immediately notify Company in the event that Contractor, any participating provider, or any of Contractor's employees, contractors, subcontractors, agents or any other individual or entities that assist or are involved in Contractor's performance of services for under the Agreement ("Contractor Related Parties") are or become disbarred, excluded, suspended, or otherwise determined to be ineligible to participate in a federal health care program. At a minimum, Contractor agrees to review the OIG and GSA exclusion lists ("Exclusion Lists") on an annual basis (unless more frequently required under applicable laws, rules and/or regulations) to ensure that Contractor Related Parties are not included on the Exclusion Lists. Contractor shall not employ or contract with, with or without compensation, any individual or entity that has been disbarred, excluded, suspended or otherwise determined to be ineligible to participate in a federal health care program. Contractor agrees that if a Contractor Related Party appears on an Exclusion List and/or is excluded from participation in any federal health care program, Contractor will immediately remove the Contractor Related Party from any work related directly or indirectly to services under this agreement and take all corrective actions required under applicable laws, rules or regulations. Company may immediately terminate or suspend the Agreement upon notice to Contractor, at Company's sole discretion at any time if Contractor is debarred, sanctioned or suspended from participation in any federal health care program, including, but not limited to, the Medicare or Medicaid programs.

11. In no event shall Contractor, without Company's prior written approval, perform any Services under the Agreement through any individual or entity (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity), if such individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Entity"). Contractor further agrees that Contractor may not utilize the services of any Offshore Entity not audited by Company prior to the provision of services.

In the event that Company provides Contractor with prior written approval to use an Offshore Entity to perform any services for Plans, Contractor shall take all steps necessary to ensure that: (a) Offshore Entity complies with the requirements of this Agreement and any related amendment, and (b) Contractor and Offshore Entity comply with all laws, rules and regulations, including, without limitation, CMS instructions, applicable to the performance of any services for Plans outside of one of the fifty United States or one of the United States Territories.

In no event shall Contractor, without Company's prior written approval, provide Protected Health Information (as that term is defined below) received from, or created or received by Contractor on behalf of Company, to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes or otherwise has access to the Protected Health Information outside of the United States of America. 'Protected Health Information' shall have the same meaning as the term 'Protected Health Information,' as defined by 45 C.F.R. 160.103, limited to the information created or received by Delegated Entity from or on behalf of Company.

Amendment to the Intercompany Master Agreement

This Amendment to the Intercompany Master Agreement ("Amendment") is between Aetna Medicaid Administrators LLC ("Affiliate") and Aetna Health Management, LLC ("Company") and shall be effective as of September 22, 2014 ("Effective Date").

WHEREAS, Affiliate and Company have entered into an intercompany master agreement (the "Agreement") that is subject in part to the regulations promulgated under 45 C.F.R. Parts 160 and 164 (the "Privacy and Security Rules") of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA");

WHEREAS, the American Recovery and Reinvestment Act of 2009 ("ARRA") establishes additional provisions that must be incorporated into all existing agreements subject to its purview;

WHEREAS, the Department of Health and Human Services ("DHHS") finalized certain modifications to the Privacy and Security Rules via a final rule promulgated January 25, 2013 (the "Omnibus Rule"), which modifications require covered entities and business associates to make certain adjustments to existing agreements subject to its purview; and

WHEREAS, Affiliate and Company wish to comply with ARRA and the Omnibus Rule requirements by amending the Agreement(s) as follows.

NOW, THEREFORE, the following new provisions are added to each Agreement:

1. "Affiliate acknowledges and agrees that, as of the applicable effective dates for such provisions, Affiliate shall comply with each provision of the American Recovery and Reinvestment Act of 2009 ("ARRA") that extends a HIPAA Privacy Rule or Security Rule requirement to Business Associates of Covered Entities. The terms "Business Associate" and "Covered Entity" shall have the meanings given such terms at 45 C.F.R. § 160.103."

2. "To the extent Affiliate is to carry out one or more of Company's obligation(s) under Subpart E of 45 CFR Part 164, Affiliate shall comply with the requirements of Subpart E that apply to Company in the performance of such obligation(s)."

3. "In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, Affiliate agrees to ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of Affiliate agree in writing to the same restrictions and conditions that apply through this Agreement to Affiliate with respect to such information."

Accepted and agreed to by:

Aetna Health Management, LLC

By: _____
Name: WendyAnn Cianci
Title: Assistant Secretary
Date: December 4, 2014

Aetna Medicaid Administrators LLC

By: _____
Name: Edward C. Lee
Title: Vice President & Assistant Secretary
Date: December 3, 2014

Program Agreement Between Aetna Medicaid Administrators LLC and Aetna Health Management LLC

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PROGRAM AGREEMENT

This Program Agreement (the "Program Agreement") is made and entered into by and between Aetna Medicaid Administrators LLC, an Arizona limited liability company (formerly Schaller Anderson, LLC) ("Company"), and Aetna Health Management, LLC, a Delaware limited liability company ("AHM Affiliate"), and is effective as of February 1, 2016. Capitalized terms used and not defined herein shall have the meaning assigned to them in the Amended and Restated Intercompany Master Agreement, effective as of May 1, 2012, by and between AHM Affiliate and Company, as it may be amended from time to time (the "Master Agreement").

WHEREAS, Company and AHM Affiliate are Affiliates, under common ownership of Aetna Inc. as the ultimate parent; and

WHEREAS, Company has completed a review of AHM Affiliate's Credentialing and Recredentialing Program and has reviewed AHM Affiliate's documentation of same; and

WHEREAS, Company has determined that AHM Affiliate's Credentialing and Recredentialing Program meets Company's requirements and applicable state requirements; and

WHEREAS, Company wishes AHM Affiliate to perform, and AHM Affiliate wishes to perform, certain Credentialing and Recredentialing functions on behalf of Aetna Better Health of Kentucky Insurance Company, Kentucky corporation d/b/a Aetna Better Health of Kentucky ("Aetna Better Health") for the Program (defined below); and

WHEREAS, Company and AHM Affiliate have entered into the Master Agreement, incorporated herein by reference, setting forth the Credentialing and Recredentialing functions to be performed by AHM Affiliate for Company on behalf of Aetna Better Health (the "Services"); and

NOW, THEREFORE, in consideration of the undertakings of the parties to each other as stated herein the parties agree as follows:

I. Controlling Provisions.
This terms and conditions set forth in the Master Agreement are incorporated into this Program Agreement by reference. Any provisions of the Master Agreement which directly conflict with the terms and provisions of this Program Agreement will be deemed waived as it relates to this Program Agreement and the Program (defined below), unless such conflict may be resolved through construction or amendment as provided herein. In the event of any inconsistency between the terms of this Program Agreement and the Master Agreement, the terms of this Program Agreement shall govern and control as it relates to this Program Agreement and the Program (defined below), and all other terms and provisions of the Master Agreement not affected by this Program Agreement shall remain in full force and effect. Upon the enactment of any law or regulation impacting credentialing or recredentialing services, either party may, by written notice to the other, amend this Program Agreement in such a manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such amendment, it shall so notify the first party in writing within thirty (30) calendar days of the notice. If the parties are unable to agree on an amendment within thirty (30) calendar days thereafter, then either of the parties may terminate this Program Agreement on thirty (30) calendar days notice.

II. Termination.
This Program Agreement may be terminated: (i) in accordance with the terms of the Master Agreement; (ii) upon the mutual agreement of AHM Affiliate and Company; or (iii) by any party at any time for any reason upon sixty (60) days prior written notice to the other party.

III. Program Participation.
As may be agreed to between the parties hereto from time to time, AHM Affiliate will provide the services described in this Program Agreement, including the Credentialing and Recredentialing functions provided on behalf of Aetna Better Health for Participating Providers who are or who apply to become contracted with Aetna Better Health or with Company or its affiliate to provide services to Plan Members enrolled with the following programs relating to (collectively, the "Program"):

(a) the *Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company*, effective July 1, 2015, pursuant to which Aetna Better Health, as successor in interest to Coventry Health and Life Insurance Company ("CHLIC"), serves as a managed-care organization that provides managed Medicaid services in connection with the Medicaid program of the Commonwealth of Kentucky (the "State");

(b) all predecessor contracts to the foregoing, including without limitation the *Amended Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company* and the *Amended Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company (Region 3)*, both effective on or about October 4, 2013, as amended; and

(c) any successor contracts to or amendments of any of the foregoing and/or any analogous contracts with the State, whether issued by request for proposal or otherwise.

IV. Credentialing and Recredentialing Services.
AHM Affiliate will provide Credentialing and Recredentialing services for Providers who are or who apply to become Participating Providers as more fully described below.

1. Written policies and procedures. AHM Affiliate will establish and maintain written policies and procedures for the Credentialing and triennial Recredentialing of Providers who apply to become Participating Providers. The policies and procedures will also set forth the scope of the Credentialing and Recredentialing Program (*i.e.*, what categories of Providers are credentialed). Said policies and procedures and any substantive revisions thereto will be subject to the review by and approval of Company.

2. Credentialing committee. AHM Affiliate shall establish or maintain a credentialing committee to make recommendations regarding Credentialing and Recredentialing decisions. Said committee shall include an appropriate number of Providers who are physicians or dentists, as required by state law or regulation.

3. Credentialing and Recredentialing standards. AHM Affiliate shall adopt Credentialing and Recredentialing criteria in accordance with NCQA standards.

4. Application process. AHM Affiliate shall establish or maintain a formal application process as required by state law.

AHM Affiliate shall include an attestation by the applicant to the accuracy and completeness of the information on the credentialing and recredentialing applications.

AHM Affiliate shall promptly report to Company any "adverse action" taken by, or notice of such action received by, AHM Affiliate with respect to the licensure or membership status of any Participating Provider. For purposes of this section, "adverse action" means an action that denies, restricts, encumbers, revokes, suspends, probates, or constitutes a censure or reprimand (whether public or private), the voluntary surrender of licensure or privileges to avoid such action, voluntary payment of fines or consent to other disciplinary actions, and the initiation of any investigation that could result in such action.

5. Querying process. The Credentialing and Recredentialing process shall include obtaining information on the provider from the National Practitioner Data Bank and the applicable state licensing dental board; information to ascertain whether Provider has been the subject of investigation or sanction activity by any governmental health program including but not limited to Medicare, Medicaid or, if applicable, CHAMPUS; and information concerning any disciplinary action by any licensing agency.

6. Recredentialing. In addition to the requirements stated above, AHM Affiliate shall conduct ongoing triennial recredentialing which includes the standards in Sections 3 through 5 of this Program Agreement and a review of data from performance indicators as determined by Company.

7. Sanctions, terminations and suspensions. AHM Affiliate shall adopt policies and procedures, which, at a minimum, comply with the requirements of any applicable state peer review law and are acceptable to Company, to reduce, suspend, or terminate the Participating Provider status of a Provider. Such policies and procedures shall include a mechanism for reporting to appropriate authorities, including but not limited to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and applicable state regulatory agency, serious quality deficiencies leading to suspension or termination and an appeal process for adversely affected participating Providers. AHM Affiliate shall notify Company of any report submitted pursuant to this section.

8. Minimum Program Requirements. AHM Affiliate hereby agrees to perform its obligations under this Program Agreement in accordance with the terms and conditions set forth in the **Program Requirements Schedule**, attached to this Program Agreement and made a part hereof.

V. Governing Law.
This Program Agreement shall be governed in all respects by the laws of the Commonwealth of Kentucky.

VI. Additional Services.
AHM Affiliate may provide or cause to be provided the following additional services for the benefit of the Program as more fully described below; provided, however, such services shall be performed in accordance with applicable laws and governmental regulations for the appropriate Program:

i. Management of after-hours behavioral health calls from providers, as applicable. Such services shall include (i) intake of clinical information and data entry into the QNXT system, and (ii) authorization of requests for patient stays of one day, pending any additional days until full review can be completed during normal business hours. Denials will not be issued as part of these after-hour services.

ii. Radiology benefit management services, which may include patient management and call center management.

iii. Such other services provided or caused to be provided by AHM Affiliate for the benefit of the Program, as agreed upon by the parties from time to time.

In addition to the services set forth in Attachment B of the Master Agreement, Company will also obtain and review, or cause AHM Affiliate to obtain and review, the completed Disclosure Forms from all providers, subcontractors and subcontractor providers that provide services for or on behalf of Aetna Better Health.

VII. Participating Providers.
Notwithstanding any other provision of the Master Agreement, for purposes of this Program Agreement "Participating Provider" shall include any psychiatrist, psychologist, physician, dentist, or other individual or entity involved in the delivery of behavioral health care, physical health care and/or dental services, as applicable, who or which has entered into and continues to have a valid and effective Provider Participation Agreement or Individual Provider Addendum with Aetna Better Health or Company.

VIII. Change of Name.
All references to Schaller Anderson, LLC shall refer to Aetna Medicaid Administrators LLC.

THE NEXT PAGE IS THE SIGNATURE PAGE

IN WITNESS WHEREOF, intending to be legally bound, this Program Agreement may be executed in one or more counterparts and after at least one counterpart has been signed by each officer of the respective company.

AETNA MEDICAID ADMINISTRATORS LLC, an Arizona limited liability company

By: Aetna Health Holdings, LLC
Its: Manager

By: _____

Name: Edward C. Lee

Title: Vice President

Date: Dec. 21, 2015

AETNA HEALTH MANAGEMENT, LLC, a Delaware limited liability company

By: Aetna Health Holdings, LLC
Its: Manager

By: _____

Name: Wendy Ann M. Cianci

Title: Asst. Secretary

Date: Dec. 21, 2015

PROGRAM REQUIREMENTS SCHEDULE

The provisions set forth in this **Program Requirements Schedule**, including the Regulatory Compliance Addenda hereto, shall be attached to, and constitute a part of, the Program Agreement, as applicable. Notwithstanding any other provision of the Program Agreement or the Master Agreement, if any provision of the Program Agreement, the Master Agreement or any application thereof conflicts with the terms of this **Program Requirements Schedule** with respect to the Program, the relevant provisions of this **Program Requirements Schedule** shall control to the extent necessary to resolve such conflict, and the remaining portions of the Program Agreement and the Master Agreement, as applicable, shall remain in full force and effect. AHM Affiliate shall cause any entity that is subcontracted with AHM Affiliate for purposes of performing services under this Program Agreement to adhere to the terms of this **Program Requirements Schedule**, and shall include the following provision and Regulatory Compliance Addenda in any such subcontract, as applicable:

> ***Conformance with Law.*** *The parties shall carry out the terms of this Agreement, including* ***Addendum A*** *attached hereto and made a part hereof, in accordance with all applicable laws and the program policies stipulated by the government agencies with jurisdiction over the Program.*

Company may include as part of this Program Requirements Schedule, without obtaining the consent of AHM Affiliate, such other terms and conditions as such agencies may find necessary and appropriate.

Addendum A

Regulatory Compliance Addendum
Governing Kentucky Medicaid Services

This Regulatory Compliance Addendum Governing Kentucky Medicaid Services (the "Kentucky Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under the *Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Coventry Health and Life Insurance Company* (the "State Contract"), under which contract Coventry Health and Life Insurance Company or its successor in interest (the "Company") serves as a managed-care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract.

The Commonwealth of Kentucky, its Finance and Administration Cabinet, its Cabinet for Health and Family Services, and/or its Department for Medicaid Services (collectively, the "State"), require that specific terms and conditions be incorporated into the Agreement. As such, this Kentucky Medicaid Addendum is incorporated by reference into the Agreement and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof) must comply with the requirements set forth herein. Note that this Kentucky Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in Company's policies, procedures, and provider manual. This Kentucky Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this Kentucky Medicaid Addendum, the individuals who are enrolled with Company under the State Contract will be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Kentucky Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Kentucky Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Kentucky Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contract and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract. Except as provided herein, all other provisions of the Agreement not inconsistent with this Kentucky Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Kentucky Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement acknowledges and agrees that all provisions of this Kentucky Medicaid Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who are eligible and covered under the State Contract, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the State Contract, and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Kentucky Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this Kentucky Medicaid Addendum:

a. "Medically Necessary" or "Medical Necessity" – Nothwithstanding any definition thereof set forth in the Agreement, the foregoing terms shall mean Covered Services that are medically necessary as defined

under Section 2 of 907 KAR 3:130, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. § 1396d(r). [State Contract § 1.0]

b. "Provider" – Any person or entity under contract with Company or Company's contractual agent that provides Covered Services to Members. [State Contract § 1.0]

c. "Subcontract" – Any agreement entered into, directly or indirectly, by Company to provide or arrange for the provision of Covered Services. The term "Subcontract" does not include a policy of insurance or reinsurance purchased by Company or its Subcontractor to limit its specific or aggregate loss with respect to Covered Services provided to Members under the State Contract, so long as Company or its risk-assuming Subcontractor assumes some portion of the underwriting risk for providing health care services to Members. [State Contract § 1.0]

d. "Subcontractor" – Any entity other than a Provider, a physician health organization, or a provider network, with which Company has entered into a written agreement for the purpose of fulfilling an obligation of Company under the State Contract. [State Contract § 1.0]

B. Requirements Applicable to Contracts and Services

1. Provision of Covered Services. Provider agrees to provide Covered Services to Members as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:

a. If a Member requires emergency medical services, Provider will provide such services on a twenty-four (24) hour per day, seven (7) day per week basis. Provider will provide urgent care services within 48 hours of request. [907 KAR 17:015, § 2; State Contract §§ 29.7, 33.3]

b. If a Member requires the services of a specialist, Provider will provide such specialty services within thirty (30) days from the referral for routine care or within forty-eight (48) hours from the referral for urgent care. [907 KAR 17:015, § 2; State Contract § 29.7]

c. Provider shall provide Covered Services to Members in accordance with the State Medicaid plan, applicable State regulations, and the relevant policies and procedures applicable to each category of Covered Services. [State Contract § 31.1]

d. Provider shall provide basic, targeted, or intensive case management services as Medically Necessary to foster children who are discharged from a hospital or other residential facility, and shall thereafter participate in appropriate discharge planning that is focused on ensuring that the needed supports and services to meet the Member's behavioral-health and physical-health needs will be provided outside of the hospital or other residential facility. [State Contract § 36.4]

e. If Provider is a PCP, Provider shall perform the PCP functions set forth in Section 28.3 of the State Contract. [State Contract § 28.3]

f. Company shall not require Provider to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. § 438.102. Instead, Company shall have a referral process for situations in which a Provider declines to perform a service for ethical reasons. [State Contract § 28.12]

2. Claims; Payment; Coordination of Benefits.

a. Company shall only accept from Provider the uniform claim forms that have been approved by the State and that have been completed according to State guidelines. Provider acknowledges and agrees that the date of Company's receipt of any Provider claim shall be the date as indicated on its date stamp on the claim or other notation as appropriate to the medium used to file a claim, and that the date of payment shall be the date of the check or other form of payment. [State Contract §§ 30.1. 30.2]

b. Provider acknowledges and agrees that with respect to any Covered Services provided to Dual Eligible Members (as that term is defined in the State Contract), Company shall pay to Provider the lesser amount of: (1) Company's allowed amount minus the Medicare payment, or (2) the Medicare co-insurance and deductible up to Company's allowed amount. [State Contract § 30.4]

c. Provider/Subcontractor acknowledges and agrees that with respect to any Covered Services, Company shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) that is: (1) furnished by any individual or entity during any period when that individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act; (2) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); (3) furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments; (4) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (5) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Medicaid plan; or (6) for home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in section 1861(o)(7) of the Social Security Act. [State Contract § 3.7(A)]

d. Upon request of Provider, Company shall provide or make available to Provider, when contracting or renewing this Agreement with such Provider, the payment or fee schedule or other information sufficient to enable Provider to determine the manner and amount of payments under the Agreement for Provider's services prior to the final execution or renewal of the Agreement, and shall provide any change in such schedules at least ninety (90) days prior to the effective date of any such amendment; provided, however, that Company may make periodic, non-material changes to its payment or fee schedules, such as updates to standard codes and guidelines developed by the American Medical Association or a similar organization, or such as changes required by the State or CMS, without prior written notice. [KRS 304.17A-527(1)(d); KRS 304.17A-577(1)(a); KRS 304.17A-577(2)]

e. In no event shall the State or any Member be liable for the payment of any debt or fulfillment of any obligation of Company, Provider/Subcontractor, or any subcontractor to any Provider/Subcontractor, supplier, out-of-network provider, or any other party, for any reason whatsoever, including the insolvency of Company or any Provider/Subcontractor. Provider/Subcontractor agrees that any contracts that Provider/Subcontractor has with its subcontractors will contain a hold harmless provision and will comply with all provisions of the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract § 13.2]

f. Provider/Subcontractor shall not directly receive payment or any type of compensation from Members for providing Covered Services. Provider/Subcontractor may not bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or any persons acting on their behalf, for services rendered in accordance with the Agreement. This prohibition applies even if Company becomes insolvent, fails to pay Provider/Subcontractor for services rendered, or otherwise breaches the Agreement. This provision does not prohibit the collection from Members of State-authorized co-pays, co-insurance, or deductibles for providing Covered Services. Member co-pay, co-insurance, or deductible amounts cannot exceed the amounts specified in 907 KAR 1:604. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract §§ 11.8, 14.2, and 31.4]

g. Provider/Subcontractor shall not bill a Member for Medically Necessary Covered Services, with the exception of applicable co-pays or other cost sharing requirements provided under the State Contract. If Provider/Subcontractor knowingly and willfully bills a Member for a Medicaid Covered Service, Provider/Subcontractor shall be guilty of a felony and upon conviction may be fined as defined in Section 1128B(d)(1), 42 U.S.C. § 1320a-7b of the Social Security Act. This provision shall remain in

effect even if Company becomes insolvent. If a Member agrees, in advance, to pay for a service that is not a Covered Service under the State Contract, Company or Provider/Subcontractor may bill the Member for that service. The standard release form signed by a Member at the time of services does not relieve Company or Provider/Subcontractor from the prohibition against billing a Member in the absence of a knowing assumption of liability for a non-Covered Service. The form or other type of acknowledgement relevant to the Member's liability for non-Covered Services shall specifically state the services or procedures that are not covered by Medicaid. [State Contract § 31.4]

h. If Provider/Subcontractor is involved in coordination-of-benefits collections, Provider/Subcontractor shall report coordination-of-benefits information to Company. Provider/Subcontractor shall not pursue collection from the Member, but rather must pursue collection directly from the third party payer or the provider. Access to Covered Services shall not be restricted due to coordination-of-benefits collection. The State has the right to review all billing histories and other data related to coordination-of-benefits activities for Members. [State Contract § 14.1]

i. Company shall process all health care claims submitted for the provision of Covered Services to Members in accordance with KRS 304.17A-726. [KRS 304.17A-726]

j. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition that meets the following criteria: (1) is identified in the State Medicaid plan; (2) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (3) has a negative consequence for the Member; (4) is auditable; and (5) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise be made. [State Contract § 31.7]

k. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver.

l. Company shall not be liable to make any payments for Covered Services for which Provider/Subcontractor fails to follow the preadmission authorization and eligibility verification (for inpatient or outpatient services) procedures set forth in the Agreement, the State Contract, or the Medicaid program. Furthermore, all or a portion of payment due to the Provider/Subcontractor may be denied by Company if such payment is specifically attributable to Provider/Subcontractor's rendering or ordering: (i) services that are not Medically Necessary; (ii) elective hospitalization not authorized by Company; (iii) services provided other than at an authorized level of care; (iv) services that are not Covered Services; or (v) services related to complications from a non-Covered Service. In the event Provider/Subcontractor does not agree with a denial of payment determination made, Provider/Subcontractor may file an appeal in accordance with applicable procedures. [State Contract § 28.9]

3. Any Willing Provider; Provider Application; No Discrimination. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall comply with the "any willing provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270, as amended. Neither Company nor such Subcontractor shall require a Provider to enroll exclusively with its network to provide Covered Services under the State Contract. Nothing in the Agreement shall require or be construed to require a Provider, as a condition of participation in the Medicaid product that is the subject of the State Contract, to participate in any other products offered by Company. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall comply with the terms and obligations set forth in KRS 304.17A-525, and shall allow all providers who desire to apply for network participation an opportunity to apply at any time during the year or, where Company or such Subcontractor does not conduct open continuous provider enrollment, shall conduct a provider-enrollment period at least annually with the date publicized to providers located in the geographic service area of the plan at least thirty (30) days in advance of such enrollment period. Company and Subcontractor (if Subcontractor manages a network of providers as part of

the services it provides to Company under the Agreement) shall not discriminate against providers that serve high-risk populations or that specialize in conditions that require costly treatment, and shall not discriminate against a provider based upon that provider's licensure or certification. If Company or such Subcontractor declines to include a provider within its network, it shall give that affected provider written notice of the reason for its decision. Any option to terminate this Agreement without cause, or to non-renew this Agreement, that Company possesses under the terms thereof shall be subject to the "any willing provider" statute and to Provider's right to reapply for network participation, and Company will consider any such Provider reapplication consistent with the internal standards, policies, and procedures for provider participation that Company has developed in accordance with KRS 304.17A-270 and KRS 304.17A-525. [KRS 304.17A-150; KRS 304.17A-270; KRS 304.17A-525; State Contract § 29.1]

4. Anti-Gag Clause; No Retaliation. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall not limit a Provider's disclosure to a Member, or to another person on the Member's behalf, of any information relating to the Member's medical condition, health status, medical care, or treatment options (regardless of whether benefits for such care are provided under the State Contract), and shall not prohibit Provider from discussing all treatment options with the Member. Provider shall not be penalized, and no agreement with a Provider may be terminated, because Provider discusses Medically Necessary or clinically appropriate care with a Member or another person on the Member's behalf. Other information determined by Provider to be in the Member's best interest may be disclosed by Provider to Member or to another person on Member's behalf. Provider shall not be penalized for discussing with a Member any financial incentives and arrangements between the Provider and Company/Subcontractor, nor shall Company take any punitive action against a Provider that either supports, or requests an expedited resolution of, a Member's appeal. [KRS 304.17A-530; State Contract §§ 28.1, 28.12, 31.1]

5. Provider Grievances. Provider shall submit any grievance against Company on the State-approved provider grievance form. [State Contract § 28.9]

6. Connectivity to KHIE. If Provider is a PCP, Provider shall establish connectivity to the Kentucky Health Information Exchange ("KHIE") within one year of the effective date of this Agreement, or as otherwise determined by the State. If Provider is not a PCP, Company still encourages Provider to establish connectivity to KHIE. [State Contract § 17]

7. HEDIS and Encounter Data. Provider/Subcontractor shall submit all reports and clinical information required by Company, including but not limited to, HEDIS, EPSDT, etc., in such manner and pursuant to such timeframes requested by Company. Notwithstanding anything herein to the contrary, Provider/Subcontractor shall provide all necessary data, including but not limited to encounter and claims data, to Company in a format specified by the State in accordance with 42 C.F.R. § 438, unless otherwise agreed by the parties. Provider/Subcontractor shall report and/or submit all encounter records in an accurate and timely fashion. [State Contract §§ 16.1, 20.2, 33.1]

8. Amendments; Notice of Material Change. Company may unilaterally amend the Agreement to the extent necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards, or licensing guidelines or rules ("Regulatory Amendment"). Company shall give advance written notice to Provider of such Regulatory Amendment and the effective date thereof. With respect to amendments other than Regulatory Amendments, Company shall give advance written notice to any "participating provider" of any "material change" to this Agreement, as those terms are used and defined in KRS 304.17A-578, at least ninety (90) days prior to the effective date of the amendment. If Provider is a "participating provider" as that term is used and defined in KRS 304.17A-578: (i) the material-change notice shall include a description of the material change and a statement that Provider has the option to withdraw from the Agreement prior to the material change becoming effective; and (ii) Provider shall send written notice no later than forty-five (45) days prior to the effective date of the material change if Provider opts to withdraw following notice of a material change; provided, however, if Company has not received notice of such withdrawal within that forty-five (45) day period, Provider's silence shall constitute acceptance of such amendment. If any change to the Agreement is with respect to an existing prior authorization, precertification, notification, or referral program, or changes to an edit program or specific edits, Company shall provide notice of the change to Provider at least fifteen (15) days prior to the change. [KRS 304.17A-578]

9. Assignment. The Agreement, being intended to secure the services of and be personal to Provider/Subcontractor, shall not be assigned or transferred by Provider/Subcontractor without the prior written

consent of Company. Company may assign this Agreement without the consent of Provider/Subcontractor to any Affiliate or any other entity upon thirty (30) days' prior written notice. [State Contract § 6.2(H)]

10. Provider Subcontracts. If otherwise permissible under the Agreement, if Provider enters into a subcontract agreement with another provider to provide its licensed health care services to Members where the subcontracted provider will bill Company or Members directly for the subcontracted services, the subcontract agreement must meet all requirements of Ky. Rev. Stat. Chapter 304.17A and shall be filed with the Commissioner of the Kentucky Department of Insurance in accordance with Ky. Rev. Stat. § 304.17A-527(1)(e). [KRS 304.17A-527(1)(e)]

11. State Contract Creates No Third-Party Rights. Provider/Subcontractor acknowledges that the State Contract does not, and is not intended to, create any rights, benefits, or interests to Provider/Subcontractor. [State Contract § 4.5]

12. Subcontracts. With respect to any and all Subcontracts:

a. Subcontractor shall indemnify, defend, and hold harmless the State, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with the State Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor. [State Contract § 6.1]

b. Subcontractor, in the performance of its obligations, shall use only Medicaid-enrolled providers in accordance with the Agreement and the State Contract. [State Contract § 6.2(D)]

c. Subcontractor is prohibited from receiving any incentive, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services. In addition, a Subcontractor that performs utilization management activities is prohibited from receiving, and from providing to any individual or entity that performs such utilization management activities, any incentives for the denial, limit, or discontinuance of Medically Necessary Covered Services to a Member, all consistent with 42 C.F.R. §§ 422.208 and 438.6(h). [State Contract §§ 6.2(G), 21.2, 29.7]

d. Subcontractor is prohibited from assigning the Agreement or from further subcontracting without the prior written consent of the State. [State Contract § 6.2(H)]

e. The State is the intended third-party beneficiary of this Agreement and, as such, the State is entitled to all remedies that are afforded to third-party beneficiaries under the law. [State Contract § 6.2(I)]

f. Subcontractor, as required, shall timely submit encounter records in the format specified by the State so the Company can meet the specifications required by the State Contract. Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [State Contract §§ 6.2(J), 15.1]

g. Subcontractor shall comply with all provisions of the State Contract that relate to the services or activities that Company has delegated to Subcontractor under the Agreement, and Subcontractor shall furthermore comply with all applicable federal and State law and regulations, including but not limited to KRS 205.8451 through KRS 205.8483, all rules, policies, and procedures of the State, and all standards governing the provision of Covered Services and information to Members, all Quality Assessment/Performance Improvement (QAPI) requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of the State, the Office of Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and State agents to inspect, investigate, monitor, and audit operations, all indemnification and insurance requirements, and all obligations upon termination. [State Contract § 6.2(K)]

h. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, on an ongoing basis, Subcontractor's performance and accreditation. Subcontractor shall be subjected to formal review by Company. [State Contract §§ 4.3(C), 6.2(L)]

i. Any Subcontractor with NCQA/URAC or other national accreditation shall provide Company with a copy of its current certificate of accreditation, along with a copy of the survey report. [State Contract § 6.2(M)]

j. Subcontractor shall report suspected fraud and abuse to Company. [State Contract § 6.2(P)]

k. If Company delegates to Subcontractor any activities or obligations of Company under the State Contract, Company may revoke such delegation or impose other sanctions if the Subcontractor's performance is inadequate, all in accordance with the terms set forth in the Agreement. [State Contract § 4.3(A)]

l. If Company identifies deficiencies or areas for improvement in the Subcontractor's performance under the Agreement, Subcontractor shall cooperate with Company in taking all necessary corrective action. [State Contract §§ 4.3(D), 6.2(N)]

m. If Company delegates to Subcontractor the selection of Providers under the Agreement, Company shall retain the right to approve, suspend, or terminate any Provider selected by that Subcontractor. [State Contract § 4.3(E)]

n. Subcontractor shall at all times remain in compliance with the requirements of 42 C.F.R. § 438. [State Contract § 4.3(F)]

o. A Subcontractor that provides Covered Services shall inform Company if that Subcontractor itself engages a subcontractor in any transaction or series of transactions, in performance of any term of the State Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense. [State Contract § 6.3]

p. Subcontractor acknowledges that the State shall have the right to invoke against Subcontractor any remedy that is set forth in the State Contract, including the right to require the termination of any Subcontract, for each and every reason for which the State may invoke such a remedy against Company or for which the State may require the termination of the State Contract. [State Contract § 6.4]

q. If Company delegates to Subcontractor any utilization-management activities or obligations, Subcontractor shall ensure that all utilization-management programs, processes, and timeframes are in accordance with 42 C.F.R. §§ 431, 438, and 456, with the private-review agent requirements of Ky. Rev. Stat. Chapter 304.17A, and with the State Contract. Such Subcontractor shall adopt Interqual or Milliman for Medical Necessity, except in the event that Interqual or Milliman is not applicable to the specific service being provided, in which case Subcontractor may use other appropriate criteria so long as (1) that criteria or standard is a nationally recognized standard of which the State Department for Medicaid Services has received prior notice, and (2) Subcontractor has confirmed that Interqual or Milliman do not, in fact, contain standards applicable to the specific service being provided. With respect to behavioral-health Medical Necessity determinations, Subcontractor shall adopt the following standardized tools: for adults, Level of Care Utilization System (LOCUS); for children, Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children, Early Childhood Service Intensity Instrument (ECSII); and for substance use, American Society of Addiction Medicine (ASAM). [State Contract § 21.2]

r. If Company delegates to Subcontractor any credentialing or recredentialing activities/obligations, Subcontractor shall conduct all such activities/obligations in compliance with National Committee for Quality Assurance (NCQA) standards, with 907 KAR 1:672, with applicable federal law, and with the State Contract. [State Contract § 28.2]

s. Subcontractor acknowledges (1) that neither it nor its agents, officers, or employees shall be construed to be officers or employees of the State by virtue of the Agreement or the State Contract, and

(2) that neither the Agreement nor the State Contract shall be construed as a partnership or joint venture between Subcontractor and the State. [State Contract § 41.7]

t. Subcontractor acknowledges that it is aware of the requirements and penalties outlined in KRS 45A.485, has properly disclosed all information required by this statute, and will continue to comply with such requirements for the duration of the State Contract. [KRS 45A.485]

u. Subcontractor acknowledges that it is aware of the requirements of Executive Order 2015-370 (Minimum Wage for State Employees and the Commonwealth's Service Providers) and that it will pay all workers working on or in connection with the State Contract a minimum of $10.10 per hour for all regular, hourly employees and a minimum of $4.90 per hour for all tipped employees for the duration of the State Contract. [Executive Order 2015-370]

13. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services:

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of Section 32.1 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 32.1]

b. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 32.0 of the State Contract. [State Contract §§ 32.0–32.11]

c. Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to process, adjudicate, and pay pharmacy claims in accordance with Section 32.4 of the State Contract, and to submit National Drug Code (NDC) level information on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. [State Contract §§ 32.4, 32.5]

d. Provider/Subcontractor shall comply with the pharmacy prior-authorization provisions and requirements set forth in Section 32.6 of the State Contract. [State Contract § 32.6]

e. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract to (1) establish and maintain a generic-drug Maximum Allowance Cost (MAC) program, and (2) manage specialty pharmacy drugs. [State Contract §§ 32.7, 32.8]

14. Behavioral-Health Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to behavioral-health Covered Services:

a. Provider/Subcontractor shall administer all behavioral-health benefits in accordance with the provisions and requirements of Section 34.3 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 34.3]

b. If Company delegates to Provider/Subcontractor any behavioral-health-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 34.0 of the State Contract. [State Contract §§ 34.0–34.12]

c. Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record. [State Contract § 34.3]

d. If Provider is a PCP, Provider shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavior-health problems and disorders. PCPs may provide any clinically appropriate behavior-health services within the scope of their practice. [State Contract § 34.7]

e. Provider shall provide behavioral-health services (1) within twenty-four (24) hours of the referral if that service requires crisis stabilization, and (2) within forty-eight (48) hours of the referral if that

service is for behavioral-health urgent care. A behavioral-health service appointment following a discharge from an acute psychiatric hospital shall occur within seven (7) days of discharge, and any behavioral-health service appointment not otherwise specified in this subparagraph shall occur within sixty (60) days of the referral. [907 KAR 17:015, § 2; State Contract § 34.8]

f. Provider that is providing behavioral-health services (1) shall refer a Member with known or suspected and untreated physical-health problems to the Member's PCP for examination and treatment with the consent of the Member or the Member's legal guardian; (2) may only provide physical-health services if it is licensed to do so; (3) shall send initial and quarterly (or more frequently if clinically indicated) summary reports of the Member's behavioral-health status to the PCP with the consent of the Member or the Member's legal guardian; and (4) shall ensure that all Members receiving inpatient behavioral-health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge, with Provider ensuring that such outpatient treatment occurs within seven (7) days from the date of discharge and with Provider contacting Members who have missed an appointment within twenty-four (24) hours to reschedule that appointment. [State Contract §§ 34.7, 34.8]

g. A Provider that is providing behavioral-health services: (1) shall ensure continuity of care for successful transition of Members back into community-based supports; (2) shall participate in quarterly continuity-of-care meetings hosted by State-operated or State-contracted psychiatric hospitals; (3) shall assign a case manager prior to or on the date of discharge and provide basic, targeted, or intensive case management services as Medically Necessary to Members with severe mental illness ("SMI") and co-occuring developmental disabilities who are discharged from a State-operated or State-contracted psychiatric facility for Members with SMI; (4) shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws, with discharge planning focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion; (5) shall thereafter ensure the community supports are meeting the needs of the Member discharged from a State-operated or State-contracted psychiatric hospital; and (6) shall assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs. [State Contract § 34.10]

15. Access to Premises. Subcontractor shall allow duly authorized agents or representatives of the State or federal government or the independent external quality-review organization required by Section 1902(a)(30)(c) of the Social Security Act, 42 U.S.C. § 1396a(a)(30), access to Subcontractor's premises during normal business hours to inspect, audit, investigate, monitor, or otherwise evaluate Subcontractor's performance. If such access to Subcontractor is requested, Subcontractor shall provide and make staff available to assist in the audit or inspection effort, and shall provide adequate space on its premises to reasonably accommodate the State, federal, or external quality-review personnel conducting the audit, investigation, or inspection effort. In addition, Subcontractor shall produce all records, documents, or other data requested as part of such review, investigation, or audit. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Subcontractor's activities. [State Contract § 5.6]

16. Physician Incentive Plan Requirements. In the event compensation to Provider under the Agreement includes Physician Incentive Plans as defined by federal law, those Physician Incentive Plans shall comply with 42 C.F.R. §§ 417.479, 422.208, 422.210, and 438.6(h). Company shall make no specific payment directly or indirectly under a Physician Incentive Plan to Provider as an inducement to reduce or limit Medically Necessary Covered Services furnished to a Member. The Physician Incentive Plans shall not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. Company shall disclose to CMS information on Physician Incentive Plans in accordance with 42 C.F.R. §§ 417.479(h)(1) and 417.479(l) and at the times indicated in 42 C.F.R. § 417.479(d)–(g). Provider further acknowledges and agrees that in the event Provider is deemed to be at substantial financial risk under applicable Physician Incentive Plan regulations, Provider shall (i) cooperate and assist Company in conducting satisfaction surveys of Members using the Provider's services, and (ii) obtain, at Provider's sole expense, any additional stop loss insurance required pursuant to the Physician Incentive Plan regulations. In the event Provider must obtain stop loss insurance pursuant to the Physician Incentive Plan regulations, Provider shall obtain a stop loss policy with the following terms: (i) the policy is guaranteed renewable; (ii) termination of the policy shall not affect or reduce the policy insurer's obligation to cover, or responsibility for coverage of, the Provider's claims for Covered Services provided to Members during

the term of such policy and which are covered under the applicable Plan; and (iii) the policy insurer will provide notice of termination or cancellation of the policy to Company. Bonus amounts paid pursuant to the Agreement, if any, shall not exceed 33% of the maximum payments possible to Provider for services that Provider furnishes directly to Members. [State Contract §§ 11.6, 11.7]

17. Stop-Loss Coverage. If Provider assumes substantial financial risk for contracted services, Provider shall maintain adequate stop-loss protection, sufficient proof of which, including the amount and type of stop-loss coverage maintained, shall be provided to Company by Provider upon request. [State Contract § 13.5]

18. Quality Assessment/Performance Improvement (QAPI) Program. Provider/Subcontractor shall participate in Company's Quality Assessment/Performance Improvement program activities (including but not limited to submission of complete encounter records), shall cooperate with Company with respect to Company's QAPI obligations under the State Contract, and shall cooperate with Company's Quality Improvement Committee. [907 KAR 17:025, § 6; State Contract §§ 19.1–19.4, 38.5]

19. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Provider/Subcontractor shall provide (and if Company delegates to Subcontractor the selection of Providers under the Agreement, Subcontractor shall ensure that its contracted Providers provide) EPSDT services to Members in compliance with the State Contract (and in particular Section 33.1 thereof), with 907 KAR 1:034, and with any policy statements issued by the State or CMS during the term thereof. Provider/Subcontractor shall also cooperate with Company with respect to Company's obligations under the State Contract to submit EPSDT reports to the State. [State Contract §§ 33.1, 38.9]

20. Third Party Liability. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contract or otherwise, is secondary to other sources of payment for Covered Services provided to Members, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required by the State Contract to "cost avoid" (i.e., deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payor. [State Contract § 14.2]

21. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to assist the State with its planning process for the State's CMS/CMMI State Innovative Model Design Award initiative, which involves the State partnering with health-system stakeholders to develop a State Healthcare Innovation Plan (SHIP). [State Contract § 5.7]

b. Company's obligation to notify the State of the existence and nature of any capitation agreement that Company has with Provider/Subcontractor pursuant to which Provider/Subcontractor assumes risk, including without limitation information relating to how Provider/Subcontractor pays its downstream providers/subcontractors for providing Covered Services to Members. [State Contract § 6.5]

c. Company's obligation to cooperate with the State as part of any readiness review under the State Contract. [State Contract § 8.1]

d. Company's obligation to submit financial and expense-related reports/data to the State relating to the Risk Corridor Payment Adjustment and the Medical Loss Ratio Adjustment set forth in the State Contract. [State Contract §§ 11.4, 11.5]

e. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [State Contract §§ 14.1, 14.2, 38.4]

f. Company's obligation to assist the State with verification that Providers are meeting the requirements of the Electronic Health Records Incentive Payment Program. [State Contract § 18.0]

g. Company's obligation to submit HEDIS reports/data to the State as set forth in the State Contract. [State Contract §§ 20.1–20.3]

h. Company's obligation to develop and implement Performance Improvement Projects as set forth in the State Contract. [State Contract § 20.5]

i. Company's obligation to provide orientation, education, and training for Providers as set forth in the State Contract. [State Contract § 28.5]

j. Company's obligation to reduce unnecessary emergency room visits so that the determination of non-emergent visits is reduced to no more than two (2%) percent in a rolling three (3) month period for that particular Medicaid region in the State. [State Contract § 29.7(J)]

k. Company's obligation to submit to the State claims-level cost data for payment-verification purposes relating to the State's supplemental payments, if any, under Section 30.11 of the State Contract. [State Contract § 30.11]

l. Company's obligation to conduct health risk assessments (HRAs) of Members as set forth in the State Contract. [State Contract § 35.1]

m. Company's obligation to perform care coordination and develop care plans for Members as set forth in the State Contract. [State Contract § 35.3]

n. Company's obligation to assist the State with its development of health homes for Company's medically complex Members. Once approved by CMS, Provider/Subcontractor shall comply with any health home program developed by the State. [State Contract § 35.4]

o. Company's obligation to coordinate with the Women, Infants and Children (WIC) program, including provision of medical information to the WIC program by Providers if requested by WIC agencies and if permitted by applicable law. [State Contract § 35.5]

p. Company's obligation to participate in transition planning and continued care coordination for Members with SMI who are transitioning from licensed personal-care homes, psychiatric hospitals, or other institutional settings to integrated, community-based housing, including the performance of a comprehensive physical and behavioral-health assessment designed to support the successful transition to community-based housing within fourteen (14) days of the transition. [State Contract § 36.6]

q. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Subcontractor or the services that are within the scope of the Agreement. [State Contract § 40.4]

22. Hospitalists. Nothing in the Agreement shall require, or be construed to require, the mandatory use of a hospitalist (defined as a physician of record at a hospital for a patient of a participating physician and who may return the care of the patient to that physician at the end of the hospitalization). [KRS 304.17A-532]

23. Licensing/Certification. Provider/Subcontractor shall meet all appropriate licensing and contract requirements specified in applicable State and federal laws and regulations. This includes certification, where required, to provide those health care services in the State as set forth in the Agreement, including certification under CLIA, if applicable. Where applicable, Provider/Subcontractor shall have a valid Drug Enforcement Agency registration number and valid NPI and taxonomy. [State Contract § 3.5]

24. Notice of Legal Action. Subcontractor shall provide written notice to Company of any legal action or notice listed below, within ten (10) days following the date Subcontractor receives written notice of:

a. Any action, proposed action, lawsuit, or counterclaim filed against Subcontractor related in any way to the Agreement or the State Contract;

b. Any administrative or regulatory action, or proposed action, respecting the business or operations of Subcontractor related in any way to the Agreement or the State Contract;

c. Any notice received by Subcontractor from the Kentucky Department of Insurance or the Kentucky Cabinet for Health and Family Services;

d. Any claim made against Subcontractor by a Member having the potential to result in litigation related in any way to the Agreement or the State Contract;

e. The filing of a petition in bankruptcy by or against Subcontractor, or the insolvency of Subcontractor; and

f. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in Subcontractor, or who is an agent or managing employee of Subcontractor, of a criminal offense related to that person's involvement in a program under Medicare, Medicaid, or Title XX of the Social Security Act, or of fraud, or unlawful manufacture, distribution, prescription, or dispensing of a controlled substance, as specified in 42 U.S.C. § 1320a-7.

[State Contract 41.4]

25. Termination of Agreement and Effect Thereof. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the Parties. Furthermore, in the event this Kentucky Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties. In addition:

a. In the event of a breach of the Agreement by Company, the termination of the Agreement, or the insolvency of Company, Provider/Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Agreement for the remainder of any month for which the State has made payments to Company, and shall fulfill all of its obligations respecting the transfer of Members to other Providers/Subcontractors, including record maintenance, access, and reporting requirements, all such covenants, agreements, and obligations of which shall survive the termination of the State Contract and the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(c); State Contract §§ 6.1, 40.8]

b. In the event of termination for any reason other than a quality of care issue or fraud, Company shall continue to reimburse Provider/Subcontractor in accordance with the Agreement until the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater; and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement is terminated. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(b)–(c); State Contract § 40.8]

c. Company and/or Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall terminate from participation any Provider that (i) engaged in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked, or suspended; (iii) has medical staff privileges at any hospital terminated, revoked, or suspended; or (iv) engaged in behavior that is a danger to the health, safety, or welfare of Members. Company and such Subcontractor may also terminate the participation of any Provider that has materially breached the Agreement and has failed to timely and adequately cure such breach. [State Contract § 29.6]

26. Protected Health Information. Provider/Subcontractor shall abide by the same statutes and regulations regarding the confidentiality of protected health information that Company is itself subject to under the State Contract and state and federal law, including the Health Insurance Portability and Accountability Act (42

U.S.C. § 1320d) and 45 CFR Parts 160 and 164. Company shall conduct HIPAA privacy and security audits of Provider/Subcontractor as prescribed by the State. This confidentiality provision shall survive termination of the Agreement. [State Contract § 39.1, 39.2, 41.15]

27. Access to Records. Provider/Subcontractor shall make all of its books, documents, papers, records, medical records, data, surveys, computer databases, or other evidence (collectively, the "Records") available for examination, audit, and/or program review by the State, the Finance and Administration Cabinet, the Auditor of Public Accounts, the Legislative Research Commission, the Attorney General of the State, the Kentucky Department of Insurance, the U.S. Department of Health and Human Services, CMS, the Office of Inspector General Comptroller, authorized federal or State personnel, and the authorized representatives of the governments of the United States and the State including, without limitation, any employee, agent, or subcontractor of the State, CMS, or the State's fiscal agent, for a period of five (5) years after termination of the State Contract, except when an audit has been conducted or audit findings are unresolved. In such case, Records shall be kept for a period of five (5) years in accordance with 907 KAR 1:672, or as amended or until all audit issues are finally resolved, whichever is later. Access shall be at the discretion of the requesting authority and shall be either through onsite review of Records or by submission of Records to the office of the requesting authority. Any Records requested shall be produced immediately for onsite reviews or sent to the requesting authority by mail within fourteen (14) days following a request. All Records shall be provided at the sole cost and expense of Provider/Subcontractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping, and/or mailing of records. The State shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by Provider/Subcontractor. [State Contract §§ 38.2, 39.1, 41.17, 41.21]

28. Medical Records. With respect to medical records:

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Member medical records on paper or in an electronic format. Provider/Subcontractor shall maintain Member medical records in a timely, legible, current, detailed, and organized manner to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the State Contract. Medical records shall be signed by the Provider/Subcontractor, as the case may be. [907 KAR 17:015, § 12; State Contract § 28.7]

b. Although the medical records are the property of the Provider/Subcontractor that generates the record, each Member or the Member's representative is entitled to one (1) free copy of his/her medical record. Additional copies shall be made available at cost. Provider/Subcontractor shall preserve and maintain Member medical records for no less than five (5) years unless federal requirements mandate a longer retention period (i.e., immunization and tuberculosis records shall be maintained for a Member's lifetime). [907 KAR 17:015, § 12; State Contract § 28.7]

c. Provider/Subcontractor's medical records shall meet the medical record standards that Company and the State Contract require for medical-chart organization and documentation, for the contents of the medical record, and for individual clinical-encounter documentation. Medical records will reflect all aspects of patient care, including ancillary services. Additionally, a PCP's primary medical record for each Member must contain sufficient medical information from all providers involved in that Member's care to ensure continuity of care. [State Contract § 28.7]

d. If any Covered Service provided by Provider/Subcontractor requires completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation (KAR). Provider/Subcontractor shall retain that form in the event of an audit and a copy shall be submitted to the State upon request. [State Contract § 31.1]

e. If a Member changes PCPs, Provider/Subcontractor shall forward the medical records or copies thereof to the new PCP or provider within ten (10) days of the request. The PCP shall have the Member sign a release of medical records before a medical record transfer occurs. [State Contract § 39.1]

29. Licensing Requirements; Malpractice Insurance.

a. Provider/Subcontractor shall be properly licensed in accordance with all applicable State laws and regulations and shall have in effect a current policy of malpractice insurance as Company may require. [State Contract, Appendix J]

b. Provider/Subcontractor shall comply with Company's verification of Provider/Subcontractor's credentials and insurance coverage, including without limitation completing a credentialing application in accordance with the State's policies and procedures. [907 KAR 17:015, § 4; State Contract, Appendix J]

c. Provider cannot enroll or continue participation in Company's network if Provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if the Provider's required licenses and certifications are not current, if the Provider owes money to the Medicaid Program, if the office of the Attorney General has an active fraud investigation involving the Provider, or if the Provider otherwise fails to satisfactorily complete the credentialing process. [State Contract § 29.3]

30. Disclosure of Ownership and Control.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time this Agreement is executed and annually thereafter, and any time there are changes to such information. [State Contract § 38.15]

b. No Provider, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider, and no officer, director, agent, or managing employee (i.e., general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider or who directly or indirectly conducts the day-to-day operation of that Provider) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social SecurityAct (42 U.S.C. § 1320a-7(b)(1)–(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [State Contract § 3.6]

31. Orientation and Training. Provider shall require its officers and medical staff to attend initial orientation conducted by Company within thirty (30) days after Provider is placed on active status, and shall require same to attend any ongoing orientation and education required by Company as necessary to ensure full compliance with the State Contract and all applicable federal and State requirements. [907 KAR 17:015, § 7; State Contract § 28.5]

32. Advances and Loans. Company shall not, without thirty (30) days' prior written notice to and approval of State, make any advances to Subcontractor (not including capitation payments or payments made by Company to Company's network for the provision of Covered Services). [State Contract § 13.4]

33. Marketing Activities. Provider/Subcontractor shall comply with all allowable and unallowable marketing activities and practices pursuant to 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contract, prior to disseminating same. The State shall have the same approval authority for Subcontractor marketing materials as over Company's materials. [State Contract §§ 26.1, 26.2]

34. Advance Medical Directives. If Provider is a PCP, Provider shall have the responsibility to discuss advance medical directives with all adult Members at the first medical appointment of a Member and chart that discussion in the medical record of such Member. [State Contract §§ 28.3 & 28.8]

35. Accounting System. Provider/Subcontractor shall maintain its accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between Company and Provider/Subcontractor. These transactions shall include, but not be limited to, claims payment, refunds, and adjustment of payments. [State Contract § 38.14]

36. Compliance with Laws. Provider/Subcontractor shall adhere to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; the Americans with Disabilities Act of 1990, as amended; the Rehabilitation Act of 1973, as amended; Sec. 202 of Executive Order 11246, as amended; and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. Provider/Subcontractor shall not discriminate in the rendering of services to and/or employment of individuals because of race, gender, color, religion, sex, age, national origin, sexual orientation, gender identity, handicap, political beliefs, disabled veteran status, veteran status, or any other non-merit factor. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, through quality-assurance audits and otherwise, Subcontractor's compliance with the nondiscrimination provisions set forth in this Kentucky Medicaid Addendum. Subcontractor must also comply with the rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741, and regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.) and its implementing regulation at 45 C.F.R. Part 80, Provider/Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement. Provider/Subcontractor's locations shall meet all requirements of the Americans with Disabilities Act and all State and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures that are applicable to health care facilities. [State Contract §§ 5.3, 5.4]

37. State Hold Harmless. Provider/Subcontractor shall indemnify, defend, save, and hold harmless the State and its officers, agents, and employees (collectively, the "State Indemnified Parties") from all claims, demands, liabilities, suits, judgments, or damages, including court costs and attorney fees made or asserted against or assessed to the State Indemnified Parties, arising out of or connected in any way with the State Contract or the performance or nonperformance by Company, by Provider/Subcontractor, or by any officers, agents, employees, suppliers, subcontractors, or providers of any of the foregoing, including without limitation any claim attributable to:

a. The improper performance of any service, or improper provision of any materials or supplies, irrespective of whether the State knew or should have known such service, supplies, or materials were improper or defective;

b. The erroneous or negligent acts or omissions, including without limitation the disregard of federal or State law or regulations, irrespective of whether the State knew or should have known of such erroneous or negligent acts;

c. The publication, translation, reproduction, delivery, collection, data processing, use, or disposition of any information to which access is obtained pursuant to the State Contract in a manner not authorized by the State Contract or by federal or State law or regulations, irrespective of whether the State

knew or should have known of such publication, translation, reproduction, delivery, collection, data processing, use, or disposition; or

d. Any failure to observe federal or State law or regulations, including but not limited to insurance and labor laws, irrespective of whether the State knew or should have known of such failure.

[State Contract § 13.2]

Amended Administrative Services Agreement between Aetna Medicaid Administrators LLC and Aetna Better Health® of Kentucky

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FIRST AMENDMENT
TO
ADMINISTRATIVE SERVICES AGREEMENT
BY AND BETWEEN
AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY.
AND
AETNA MEDICAID ADMINISTRATORS LLC

This First Amendment ("**Amendment**") is entered into January 1, 2020 ("**Effective Date**"), by and between Aetna Medicaid Administrators LLC, ("**Subcontractor**") and Aetna Better Health of Kentucky Insurance Company, a Kentucky corporation ("**Purchaser**" or "**Company**"), and amends the Administrative Services Agreement ("**Agreement**") entered into February 1, 2016, by and between Subcontractor and Purchaser.

RECITALS

WHEREAS, pursuant to the Agreement, Purchaser has contracted with Subcontractor for Subcontractor to provide certain services to Purchaser;

WHEREAS, CVS Health Corporation ("**CVS Health**") through CVS Pharmacy, Inc. has acquired Aetna Inc. and its subsidiaries effective November 28, 2018;

WHEREAS, Subcontractor has arranged for other Aetna affiliated entities, including CVS Health entities, to provide services to Purchaser;

WHEREAS, Purchaser and Subcontractor desire to amend the Agreement for Subcontractor and certain Subcontractor affiliates to provide certain administrative services with respect to Purchaser's businesses that are applicable to receive the services;

WHEREAS, Purchaser and Subcontractor desire to update the existing languages in the Agreement concerning Health Insurance Portability and Accountability Act (**HIPAA**) by adding a new Business Associate Addendum to the Agreement; and

NOW, THEREFORE, in consideration of the mutual promises expressed herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged and confessed, the parties hereto agree as follows:

1) The Agreement is hereby amended by adding the following section to the end of Section 2. Administrative Services., as the new Section 2(f):

   (f) Subcontractor has arranged for certain Affiliates to provide certain services specifically outlined in the Affiliates Services and Fees Exhibit on Attachment F. Purchaser agrees to compensate Subcontractor for these affiliated services pursuant to Attachment F.

2) Affiliates Services and Fees. **Exhibit B.** - **Affiliates Services and Fees,** attached hereto, is herby added to the end of the Agreement as the new Attachment F.

3) Business Associate Agreement. **Exhibit C** - **Business Associate Addendum** attached hereto, is hereby added to the end of the Agreement as the new Attachment G.

4) All capitalized terms used in this Amendment and not otherwise defined shall have the meanings set forth in the Agreement. All other terms of the Agreement remain in full force and effect.

5) To the extent any provision of this Amendment conflicts with any of the provisions of the Agreement (including prior amendments), the provisions of this Amendment shall govern. Except for the amendments made hereby, the above referenced Agreement remains in full force and effect.

[SIGNATURE PAGE IS THE NEXT PAGE]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY

By: _____
(signature)

Name: Caitlin M. Gould

Title: Assistant Secretary

AETNA MEDICAID ADMINISTRATORS LLC

By: _____
(signature)

Name: WendyAnn M. Cianci

Title: Assistant Secretary

EXHIBIT B

ATTACHMENT F

AFFILIATES SERVICES AND FEES

PHARMACY BENEFIT MANAGEMENT

Pharmacy Benefit Management ("PBM")*

CVS Caremark will dispense prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by CVS Caremark will be analyzed, processed and documented by CVS Caremark's proprietary prescription management systems. These systems provide essential features and functionality to allow a plan member to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, overutilization and potential fraud.

Plan Design Offerings and Administration

CVS Caremark will administer pharmacy benefit plans for Purchaser to facilitate prescription drug coverage and claims processing for their eligible plan members. CVS Caremark will assist Purchaser in designing pharmacy benefit plans that help improve health outcomes while minimizing costs to Purchaser. CVS Caremark will also assist Purchaser in monitoring the effectiveness of its plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

CVS Caremark will make recommendations to help Purchaser design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps Purchaser control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Purchaser will also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management

CVS Caremark will utilize an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet CVS Caremark's standards of safety and efficacy for inclusion on one of CVS Caremark's template formularies. CVS Caremark's formularies will provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under Purchaser's pharmacy benefit plan, while helping to drive the lowest net cost for Purchaser. To help improve clinical outcomes for Purchaser, CVS Caremark will conduct ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products. CVS Caremark will offer real time benefits information for Purchaser's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Retail Pharmacy Network Management Services

CVS Caremark's proprietary prescription management systems, which verify relevant plan member data and eligibility, will perform drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. CVS Caremark will build Purchaser customized pharmacy networks and managed pharmacy network solutions to further drive savings for Purchaser.

[redacted]

*Subcontractor or its affiliate also has provider agreements with affiliated pharmacies for mail order and specialty prescriptions and such services are charged to Purchaser at Subcontractor's cost. Administration fee for specialty prescriptions dispensed by non-affiliated pharmacies is the same as above.

EXHIBIT C

ATTACHMENT G

BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "**Addendum**") is made by and between Aetna Medicaid Administrators LLC ("**Administrator**") on behalf of itself and its affiliates that are providing services to Purchaser (collectively, "**Business Associate**"), and Purchaser for which Business Associate provides services pursuant to one or more service agreements entered into between the Purchaser and Administrator (referred to herein, collectively, as the "**Service Agreement**").

WHEREAS, Administrator provides third-party administrative services to affiliated Aetna insurance and HMO companies that provide health insurance for covered individuals;

Administrator and Business Associate hereby mutually agree to the terms of this Addendum in order to comply with the HIPAA Rules and other applicable HIPAA Rules, as defined below.

This Addendum is effective no later than the Effective Date of the Services Agreement to which this Addendum is attached.

Definitions

"Breach" shall have the same meaning as the term "Breach" in 45 CFR 164.402.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 CFR parts 160 and 164.

"Individual" shall have the same meaning as the term "Individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g) or other applicable federal or state law.

"Protected Health Information" or "PHI" shall have the same meaning as such term as defined in 45 CFR 160.103, but limited to information created, accessed or received on behalf of ADMINISTRATOR.

"Secure" shall mean to render unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of the HITECH Act.

"Successful Security Incident" shall mean any Security Incident (as defined in 45 CFR 164.304) that results in the unauthorized use, access, disclosure, modification or destruction of electronic PHI.

All capitalized terms used in this Addendum and not defined elsewhere herein or in the Services Agreement shall have the same meaning as those terms as used or defined in the HIPAA Rules.

Obligations of Business Associate

Business Associate agrees to comply with the HIPAA Rules that apply to Business Associates concerning the confidentiality, privacy, and security of PHI. To the extent Business Associate carries out any obligations under the Privacy Rule (45 CFR Subpart E of Part 164) for Administrator, Business Associate shall comply with the requirements of the Privacy Rule that apply to the performance of such obligations.

Business Associate shall not use or disclose PHI except as permitted or required by this Addendum or as Required by Law and only in compliance with the HIPAA Rules.

Business Associate shall enter into a written agreement meeting the requirements of 45 C.F.R. 164.504(e) and 164.314(a)(2) with any agent or Subcontractor that may have access to PHI prior to the agent or Subcontractor obtaining such access. Any such agreement shall contain restrictions, conditions and requirements that are at least as restrictive as those that apply to Business Associate in this Addendum.

Business Associate agrees that it shall request, use and disclose only the minimum necessary PHI to perform or fulfill a specific function required or permitted under this Addendum. Business Associate agrees to comply with any guidance issued by the Secretary regarding minimum necessary.

If Business Associate conducts, in whole or in part, any Transactions electronically on behalf of Administrator, Business Associate shall comply with the applicable requirements of 45 CFR 162 and shall require that any agents or Subcontractors that perform, in whole or in part, such Transactions on its behalf, agree in writing to comply with such requirements.

Business Associate agrees to report any use or disclosure of PHI not permitted by this Addendum and any Successful Security Incident (each a "Potential Breach") to Administrator promptly, but in no event later than within ten (10) business days, after it is discovered (within the meaning of 45 CFR 164.410(a)(2)). Business Associate shall provide the information concerning the Potential Breach as required by 45 CFR 164.410(c). If such information is not available to Business Associate at the time the Potential Breach is required to be reported to Administrator, Business Associate shall provide such information to Administrator promptly as it becomes available. The Business Associate shall maintain complete records regarding the Potential or actual Breach for the period required by 45 CFR 164.530(j) or such longer period required by state law, and shall make such records available to Administrator promptly upon request, and to the extent required by applicable law. Notice is hereby deemed given for unsuccessful Security Incidents.

Within ten (10) business days of receipt of a request from Administrator, Business Associate shall provide to Administrator or, at its direction, to an Individual, PHI relating to that individual held by Business Associate or its agents or Subcontractors in a Designated Record Set in accordance with 45 CFR 164.524. In the event any Individual requests access to his or her PHI directly from Business Associate, Business Associate shall, within five (5) business days of receipt of such request, forward the request to Administrator unless the Privacy Rule requires Business Associate to receive and respond to such requests directly, in which case Business Associate shall respond directly as required by and in accordance with 45 CFR 164.524, and shall send a copy of such response to Administrator.

Within ten (10) business days of receipt of a request from Administrator, Business Associate agrees to make any requested amendment(s) to PHI held by it or any agent or Subcontractor in a Designated Record Set in accordance with 45 CFR 164.526. In the event any individual requests an amendment to his or her PHI directly from Business Associate, Business Associate shall within five (5) business days of receipt thereof, forward such request to Administrator.

Within ten (10) business days after Business Associate, its agents or Subcontractors makes any disclosure of PHI for which an accounting may be required under 45 CFR 164.528, Business Associate agrees to provide in writing via email to Administrator the information related to such disclosure as would be required to respond to a request by an Individual for an accounting in accordance with 45 CFR 164.528. If any Individual requests an accounting of disclosures under 45 CFR 164.528(a) directly from Business Associate, Business Associate shall, within ten (10) business days of receipt of such request, forward the request to Administrator unless the Privacy Rule requires that Business Associate receive and respond to such requests directly, in which case Business Associate shall respond directly as required by and in accordance with 45 CFR 164.528, and shall send a copy of such response to Administrator.

Within ten (10) business days of receipt of a request from Administrator, Business Associate agrees to comply with any request for confidential communication of, or restriction on the use or disclosure of, PHI held by it or any agent or Subcontractor as requested by Administrator and in accordance with 45 CFR 164.522.

Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services or her/his designees or other government authorities in a time and manner designated by Administrator or such governmental authorities, for purposes of determining compliance with the HIPAA Rules. Business Associate shall provide a copy of such books and records to Administrator at the same time as these are provided to the Secretary or other government authority.

Business Associate shall maintain documentation of its obligations hereunder to the extent and for the period required by the HIPAA Rules, including 45 CFR 164.530(j).

Security of Protected Health Information

Business Associate agrees to implement appropriate administrative, physical, and technical safeguards to prevent the unauthorized use and disclosure of PHI, and to protect the confidentiality, integrity, and availability of Electronic PHI, as required by the HIPAA Rules.

Business Associate will regularly test and monitor the effectiveness of its safeguards, controls, systems and procedures, and will periodically identify reasonably foreseeable internal and external risks to the security, confidentiality, integrity and availability of the PHI, and ensure that these risks are addressed.

Business Associate shall train Workforce members on the responsibilities under this Addendum, including the responsibilities to safeguard and, where appropriate or required, Secure PHI, and consequences for failing to do so.

As healthcare industry and other applicable security best practices evolve, Business Associate agrees to adjust its safeguards accordingly so that they continue to reflect the then-current industry best practices.

Permitted Uses and Disclosures of Protected Health Information

Business Associate agrees not to use or disclose Protected Health Information other than as permitted or required by this Addendum or as Required by Law.

Business Associate may use and disclose Protected Health Information as necessary in order to provide its services as described in the Services Agreement.

Business Associate may use Protected Health Information if necessary for its proper management and administration or to carry out its legal responsibilities. In addition, Business Associate may disclose Protected Health Information as necessary for its proper management and administration or to carry out its legal responsibilities provided that: any such disclosure is required by Law or is made in compliance with the HIPAA Rules.

Term and Termination

The term of this Addendum shall continue for so long as the Services Agreement remains in effect.

Upon a material breach of this Addendum, Administrator shall provide an opportunity for Business Associate to cure the breach or end the violation and if Business Associate does not cure the breach or if a cure is not possible, end the violation, within thirty (30) days or receipt of written notice by Administrator then Administrator may terminate this Addendum.

Effect of Termination. (1) Except as provided in paragraph (2) of this subsection, upon termination of the Services Agreement for any reason, Business Associate shall return to Administrator or destroy all Protected Health Information in its possession or that of its Subcontractors or agents. Business Associate and its agents and Subcontractors shall retain no copies of the Protected Health Information. (2) If returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Administrator written notification within ten (10) business days after termination of the Services Agreement of the conditions that make return or destruction infeasible. In such event, and Business Associate shall extend the protections of this Addendum to the Protected Health Information, and limit further uses and disclosures of it to those purposes that make the return or destruction infeasible, for so long as Business Associate or its agents or Subcontractors hold such Protected Health Information.

Mitigation of Breach

If there is a Breach of PHI under the control of Business Associate or its agents or Subcontractors, Business Associate agrees to perform any reasonable mitigation or remediation services requested by Administrator.

Miscellaneous

Business Associate agrees to take such action as the parties deem mutually necessary to amend this Addendum from time to time to comply with the requirements of any HIPAA Rules.

A reference in this Addendum to a section in the HIPAA Rules means the section as in effect or as amended, and as of its effective date.

Any ambiguity in this Addendum shall be resolved to permit compliance with the HIPAA Rules.

The terms and conditions of this Addendum shall override and control any conflicting term or condition of the Services Agreement. All non-conflicting terms and conditions of the Services Agreement remain in full force and effect.

Print Control Provisions

A. Administrator's print attestation process shall include: (1) printing and mailing in accordance with the Tap Test, Slip Sheet/Fly Sheet and No Fly Zone specifications (the "**Print Specifications**") as defined below; and (2) cooperating with Administrator's proofing process to confirm adherence to the Print Specifications.

"**Tap test**" means, when shaking or tapping the contents of a mailing within its envelope, the contents of the mailing (other than the recipient address) cannot be viewed through the envelope window. To complete a tap test, tap envelopes from top, bottom and each side to confirm that content shifting does not result in contents of mailing appearing in the window, or that delivery name/address falls out of the window position. Tap tests are to be performed if no slip sheet or fly sheet is utilized.

"**Slip sheet**" or "**fly sheet**" means a cover page that obscures the contents of the mailing. May be a full or partial page, provided that the contents of the mailing are not visible through the envelope window.

"**No Fly Zone**" means areas of a printed page in which member identifiable information (PHI or Personally Identifiable Information other than recipient address) cannot be printed in accordance with the following specs:

PHI/PII NO FLY ZONE SPECIFICATIONS

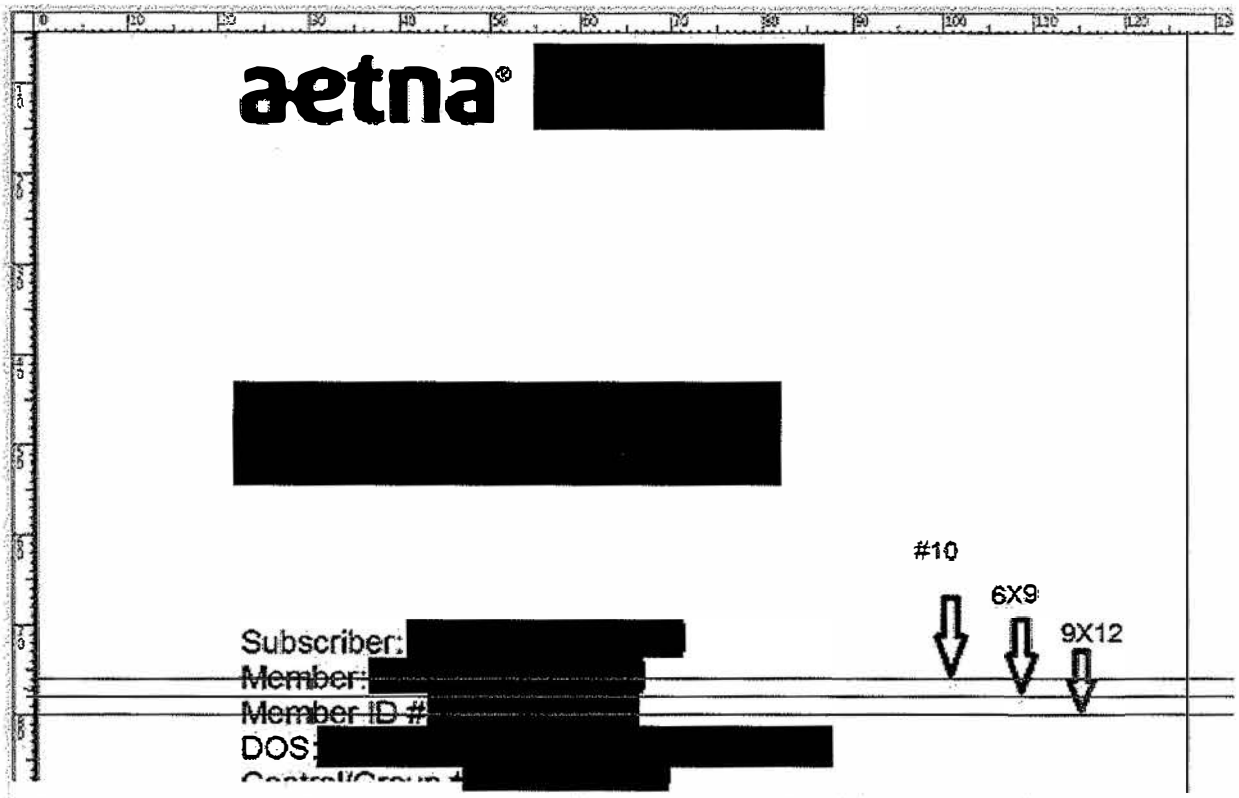

#10 No Fly Zone:(x0,y0,w128,h74) Window Size:(x11,y12,w115,h65) Y+H=Height
6X9 No Fly Zone:(x0,y0,w128,h76) Window Size:(x11,y12,w115,h67) Y+H=Height
9X12 No Fly Zone:(x0,y0,w128,h80) Window Size:(x11,y12,w115,h72) Y+H=Height

The X/Y coordinates above are based on printed pages placed within each designated envelope size.

B. Business Associate shall use automated insertion equipment which involves utilization of a 2D Barcode on all printed materials for mailings containing Member information or that are otherwise mailed to a Member. Proofs provided should show evidence of use of 2D barcode. Business Associate shall disclose to Administrator any vendor of Business Associate executing mailings on behalf of Business Associate. For control purposes, Administrator's preference is for Business Associate to not utilize a vendor for Member mailings.

C. Prior to subcontracting any print services and/or mailings that contain Member information or are otherwise mailed to a Member, Business Associate shall obtain Administrator's prior written authorization. Business Associate shall be responsible for its subcontractors' compliance with these terms and the terms of this Agreement.

Matthew G. Bevin
Governor

PUBLIC PROTECTION CABINET
Department of Insurance
P.O. Box 517
Frankfort, Kentucky 40602-0517
1-502-564-3630
http://insurance.ky.gov

K. Gail Russell
Secretary

Nancy G. Atkins
Commissioner

September 17, 2019

Edward C. Lee
Executive Director, Senior Counsel
Aetna Inc., a CVS Health Company
Aetna Law and Regulatory Affairs, RW61
151 Farmington Avenue
Hartford, CT 06156 RW 61

RE: Administrative Service Agreement Amendment

Dear Mr. Lee,

We received the form D request dated September 3, 2019 on behalf of Aetna Better Health of Kentucky Insurance Company and Aetna Medicaid Administrators LLC to amendment the February 1, 2016 agreement to include Pharmacy Benefits Management.

After review of the accompanying information with the Form D filing and pursuant to KRS 304.37-030, the Kentucky Department of Insurance approves the amendment to the agreement to take effect January 1, 2020.

If you have any questions, please feel free to contact me at (502) 782-5299 or via e-mail at Sandra.Batts@ky.gov.

Sincerely,

Sandra A. Batts
Director-The Financial Standards and Examinations Division

Amended Administrative Services Agreement between Aetna Medicaid Administrators LLC and Aetna Better Health® of Kentucky

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AMENDMENT TO ADMINISTRATIVE SERVICES AGREEMENT BY AND BETWEEN AETNA LIFE INSURANCE COMPANY AND AETNA HEALTH MANAGEMENT, LLC.

This Amendment ("Amendment") is entered into January 1, 2020 (the "Effective Date"), by and between Aetna Life Insurance Company, a Connecticut corporation ("ALIC" or "Purchaser"), and Aetna Health Management, LLC, a Delaware limited liability company ("AHM" or "Service Provider"), and amends the Amended and Restated Administrative Services Agreement (the "Agreement") entered into October 7, 2005, by and between ALIC and AHM.

RECITALS

WHEREAS, pursuant to the Agreement, ALIC has contracted with AHM for AHM to provide certain services to ALIC;

WHEREAS, CVS Health Corporation ("CVS Health") through CVS Pharmacy, Inc. has acquired Aetna Inc. and its subsidiaries effective November 28, 2018;

WHEREAS, AHM has arranged for other affiliated entities, including CVS Health entities, to provide services to ALIC;

WHEREAS, Purchaser and AHM desire to amend the Agreement for AHM and certain AHM affiliates to provide certain services with respect to Purchaser's businesses;

WHEREAS, Purchaser and AHM desire to update the existing languages in the Agreement concerning Health Insurance Portability and Accountability Act (HIPAA) by adding a new Business Associate Agreement to the Agreement; and

NOW, THEREFORE, in consideration of the mutual promises expressed herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged and confessed, the parties hereto agree as follows:

1) Amendment to the Agreement. The Agreement is hereby amended by replacing the **Aetna Affiliates Services and Fees Exhibit** that became effective as of January 1, 2018 with the **Affiliates Services and Fees Exhibit** attached hereto to the end of the Agreement.

2) Amendment to the Business Associate Agreement. The Agreement is hereby amended by replacing the **Business Associate Addendum Exhibit** that became effective as of January 1, 2018 with the **Business Associate Addendum Exhibit** attached hereto to the end of the Agreement.

3) All capitalized terms used in this Amendment and not otherwise defined shall have the meanings set forth in the Agreement. All other terms of the Agreement remain in full force and effect.

4) To the extent any provision of this Amendment conflicts with any of the provisions of the Agreement, the provisions of this Amendment shall govern. Except for the amendments made hereby, the above referenced Agreement remains in full force and effect.

5) To the extent any provision of this Amendment conflicts with any of the provisions of the Agreement (including prior amendments), the provisions of this Amendment shall govern. Except for the amendments made hereby, the above referenced Agreement remains in full force and effect.

[SIGNATURE PAGE IS THE NEXT PAGE]

IN WITNESS WHEREOF, the parties have executed this Amendment as of the Effective Date.

AETNA LIFE INSURANCE COMPANY

By: _____
(Signature)

Name: Edward C. Lee

Title: Vice President and Secretary

AETNA HEALTH MANAGEMENT, LLC.

By: _____
(Signature)

Name: WendyAnn Cianci

Title: Assistant Secretary

AFFILIATES SERVICES AND FEES

(A) CARE AND UTILIZATION MANAGEMENT SERVICES

1) Provides a suite of services related to health improvement initiatives with incentive rewards in a three-pronged approach:

- Clinical Analytics - identifying people at risk;
- Engagement - contracting with customers (Employers, Health Plans, ACOs);
- Clinical Services - rendering services (Disease Management, Care Management, Utilization Management).

Products and Services	Description	Maximum Fee
Care management for complex and/or rare health conditions	A care management solution that provides proactive support for members with complex and/or rare health conditions. Our Comprehensive solution supports value-based care and population health management strategies.	[redacted]
Community Care ("CC")	CC is a next generation complex chronic care management program that provides personalized, community based high touch support, taking into account members' medical, social, behavioral health, functional, financial, or environmental barriers that might prevent them from successfully reaching health and life goals.	[redacted]
Advocacy Care Program	Provides a range of clinical and advocacy services in order to create a simpler, seamless one-on-one experience with the member by creating a single place for the member to go to have all of their needs (service and clinical) addressed.	[redacted]
Core Care Management	Core Care Management provides care management services to members. Members are identified by an algorithm who are then engaged in different programs.	[redacted]
Breast Health Education	This program is available to fully insured Purchaser HMO/HNO plan members unless there is a specific plan exclusion. The program delivers educational information to eligible women with breast health concerns including breast cancer, within one (1) year of diagnosis.	[redacted]
NeoCare	Yearlong program for qualifying families of babies admitted into the neonatal ICU, providing individualized coaching and support by experienced NICU Nurses and Licensed Clinical Social Workers via telephone or through a mobile app.	[redacted]
National Medical Excellence (NME)	Deliver individualized support through all phases of transplant, from evaluation through follow-up care managing solid organ, bone marrow and stem cell transplants along with CAR-T Cellular Therapy.	[redacted]
Case and Care Solution	Provides medical management products, programs, and services to a variety of member segments including self-insured and fully insured commercial, public and labor, and federal FFS and fully insured.	[redacted]

Products and Services	Description	Maximum Fee
Chronic Kidney Disease Management Program	Provides holistic support for patients with Kidney Disease. The Chronic Kidney disease (CKD) management program provides telephonic care coordination, medication management, face-to-face modality education, and predictive analytics to support patients.	[redacted]
24/7 Hotline	Call Line that provides symptom triage and health information-related services 24 hours a day, 7 days a week, 365 days per year.	[redacted]
Health Index	An analytic health index reporting tool that reflects the health of an individual or a population based on assessment of ten dimensions of health.	[redacted]
Maternity Management	The Maternity Management program focuses on early risk identification, prevention and education to help members have healthy, full-term babies and control maternity care costs.	[redacted]
Care Considerations Outreach	Care considerations alert physicians to opportunities for improved care by applying evidence-based clinical rules to the medical information derived from claims, pharmacy claims, biometric feeds and demographic information.	[redacted]
Challenges	Corporate challenge offering that joins together employees within an organization to compete in 4-6 fitness and nutrition challenges each year.	[redacted]
Clinical Scoring & Identification (CSID)	The CSID Predictive Model, generated by technology tools, is a clinical predictive model used primarily as a patient registry and selection tool for care management programs, including complex case management, condition management, lifestyle coaching and other programs, and also used to segment populations in standard engagement & outcomes reports.	[redacted]
Health Decision Support	Health Decision Support is a library of online learning programs we offer our members to help them make informed decisions on their health.	[redacted]
Chronic Condition Coaching Only	A population health program that takes an integrated approach to coaching for chronic conditions, and that addresses member needs in a holistic fashion across the spectrum of health.	[redacted]
Lifestyle Conditions Only	A population health program that takes an integrated approach to coaching for lifestyle risks, and that addresses member needs in a holistic fashion across the spectrum of health.	[redacted]
Tobacco Cessation Only	A population health program that takes an integrated approach to coaching for lifestyle risks, and that addresses member needs in a holistic fashion across the	[redacted]

Products and Services	Description	Maximum Fee
	spectrum of health.	
Lifestyle and Chronic Condition Coaching	A population health program that takes an integrated approach to coaching for both chronic condition and lifestyle risks, and that addresses member needs in a holistic fashion across the spectrum of health.	[redacted]
Member Messaging	Optional buy-up to have care considerations delivered via mail if email address is not on file for the member.	[redacted]
Member Engagement Platform	Member Engagement Platform is a digital member/patient engagement platform. The platform serves up a personalized action plan for each member that is designed to engage individuals in their health and drive positive behavior change.	[redacted]
Reward Center	Rewards Center is a fully integrated rewards tracking and incentives distribution platform. The platform is flexible to support a variety of rewards/loyalty programs.	[redacted]
Personal Health Record	A full featured, claims-populated repository of health information which helps members maintain accurate records of medical tests/procedures, hospital visits, immunizations, and medication and supplements in one centralized location.	[redacted]
Telephonic/Paper supported HRA	Telephonic HRA (THRA) is a product option available to clients whose population may require assistance with understanding the HRA questions and available responses. The Paper HRA product option is available to clients whose population may not have access to desktop or mobile devices or who prefer answering HRA questions in paper and pencil format.	[redacted]
Member Assistance Management	The Member Assistance Management program is to assist members in accessing the right care, at the right level of care and for the right length of time by evaluating the appropriateness, medical need and efficiency of the health care services they are either currently receiving or plan to receive.	[redacted]
Value Based Insurance Design (VBID)	Service Provider's VBID program encourages medication adherence by aligning patients' out-of-pocket costs with the clinical severity of their medical condition(s).	[redacted]
Lifestyle and Chronic Condition Coaching - "Light"	A population health program that takes an integrated approach to coaching for both chronic condition and lifestyle risks, and that addresses member needs in a holistic fashion across the spectrum of health.	[redacted]
Member Engagement Platform (includes Personal Health Record)	Member Engagement Platform is a digital member/ patient engagement platform. The platform serves up a personalized action plan for each member that is designed to engage individuals in their health and drive positive behavior change.	[redacted]

Products and Services	Description	Maximum Fee
Digital Coaching		[redacted]
Enhanced Diabetes Program	Holistic and fully integrated care management program for diabetic members. Includes a seamless consumer-centric experience with focus on self-management, including device monitoring and integration capabilities.	
File Updates for Dental Claims		
File Updates for Vision Claims		
Implementation Fee for External Lab Results and/or Biometrics		
Implementation Fee for External Membership		
Implementation Fee for Medical Claims 24-month Historical View		
Implementation Fee for Pharmacy Claims 24-month Historical View		
Implementation Fee for Preventative Vaccine Integration		
Implementation Fee for Third Party Vendor Arrangements		
Implementation Fee for Work Site Clinic Encounters		
Ongoing File Updates for Medical Claims (up to weekly files)		
Ongoing File Updates for Pharmacy Claims (up to weekly files)		
Ongoing File Updates for Pharmacy Claims (up to weekly files)		
Ongoing File Updates for Pharmacy Claims (up		

Products and Services	Description	Maximum Fee
to weekly files)		
Ongoing File Updates for Pharmacy Claims (up to weekly files)		[redacted]
Third Party Vendor Ongoing File Maintenance for Electronic Submissions		
Third Party Vendor Ongoing File Maintenance for Manual Submissions		

2) In-store Messaging Services

Delivers messages to members through CVS retail, pharmacy, or MinuteClinic. Delivery of each message will have a specific start date and end date (each referred to herein as a "Campaign"), which will be agreed upon by Service Provider and Purchaser; provided, however, that messages will be available for up to a maximum of ninety (90) days from an agreed upon start date (each such period of time referred to herein as a "Campaign Period"). Service Provider shall communicate to Purchaser, with reasonable advance notice, lead times and available delivery dates for Campaigns.

Each Campaign is communicated to Members in one of three delivery methods, namely: (i) Pharmacy Label Only, (ii) Pharmacy Label plus verbal notification of message from Pharmacy Technician and (iii) Pharmacy Label plus verbal message from Pharmacist. Additional delivery methods may be developed and implemented, in each case, subject to the mutual agreement of Service Provider and Purchaser.

Rate Card

Delivery Channel	Per Delivered Message Fees (Maximum)		
	CVS Retail	CVS Retail with Managed Network	MinuteClinic
CVS/Pharmacy: Rx Label Only	[redacted]		
CVS/Pharmacy: Rx Label + Tech			
CVS/Pharmacy: Rx Label + RPh			
Nurse Practitioner (includes print out)			

3) Utilization Management Services

Utilization Management will provide utilization management review of outpatient services and inpatient admissions for appropriate issuance of denials, identification of inappropriate or experimental treatments, step-therapy, focusing on potentially avoidable admissions, case rounds, and peer-to-peer oversight for fully-insured and self-insured plan sponsors (non-dedicated/designated). Utilization Management will also provide clinical and automated claim review for certain professional and outpatient procedures, including application of medical policies and coding criteria.

Products and Services	Description	Maximum Fee
Utilization Management	Provides utilization management review of outpatient services and inpatient admissions for appropriate issuance of denials, identification of inappropriate or	[redacted]

	experimental treatments, step-therapy, focusing on potentially avoidable admissions, case rounds, and peer-to-peer oversight for fully-insured and self-insured plan sponsors (non-dedicated/designated). Utilization Management will also provide clinical and automated claim review for certain professional and outpatient procedures, including application of medical policies and coding criteria.	

Provides utilization management services using its online pre-authorization tool to help identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs. Four components of the services are:

Products and Services	Description	Maximum Fee
Automated Rx Prior Authorization	Prior Authorization (PA) solution allows clients to automate the review of their medical specialty drug's clinical criteria, thereby increasing efficiency, consistency, and savings.	[redacted]
Rx Claims Editing	Claim Pricing and Editing solution provides financial consistency in pricing and identification of clinical and administrative issues for medical specialty drug claims.	

Services provided to certain customers and plan sponsors (including public and private sectors) are negotiated directly by the Service Provider and that customer based on the customer's specific criteria and the Purchaser is acting as a pass-through for pricing. Purchaser is not incurring the costs for the services provided and the fees are paid 100% to the Service Provider.

Service Provider may provide additional or custom services not otherwise covered in the above fee schedules. Fees for these services will be determined based on prices charged by Service Provider to third party clients under comparable circumstances. If such third party prices are not available, Service Provider will charge Purchaser a fee determined based on costs incurred [redacted].

Shared Savings Arrangement	To the extent applicable and agreed to by Service Provider and Purchaser, they will jointly realize any savings derived from the program implementation. Annual savings will be measured using a mutually-agreeable method, codified in writing and approved by Service Provider and Purchaser. Once annual savings are determined, Service Provider and Purchaser will realize those savings as follows: • [redacted] [redacted] [redacted]
Return on Investment Guarantee	[redacted]

(B) AMBULATORY CARE/OUTPATIENT

(1) MinuteClinic

CVS MinuteClinic are locations staffed by practitioners who specialize in ambulatory / family health care, and are open 7 days a week (including weekends and evenings). MinuteClinic offers a broad range of services including treatments for minor illnesses, minor injuries, providing screenings and monitorings, treatment for skin conditions, travel health support, administering injections, providing wellness and physical support services, and women's health services.

Products and Services	Maximum Fee (Per Unit)
Basic metabolic panel (calcium, total)	[redacted]
Cholesterol Screen	[redacted]
Urine Dip Stick	[redacted]
Pregnancy Test	[redacted]
Blood Sugar (glucose)	[redacted]
HbA1c (hemoglobin)	[redacted]
Mono Test	[redacted]
TB Test - (CASH PAY SERVICE)	[redacted]
Antibody; HIV-1 and HIV-2, single assay	[redacted]
Hepatitis C antibody	[redacted]
Influenza test for influenza A strain	[redacted]
Infectious agent; adenodetector test for conjunctivitis .	[redacted]
Quick Strep Test	[redacted]
Vaccine Injection, Administration	[redacted]
Additional Vaccine Injection, administration	[redacted]
Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	[redacted]
Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use	[redacted]
Hep A Shot Adult	[redacted]
Hep A Child - 2 dose	[redacted]
Hep A Child - 3 dose	[redacted]
Hepatitis A and Hepatitis B Vaccine	[redacted]
HPV 4 (Human Papillomavirus) Vaccine (Gardasil)	[redacted]
HPV 9 (Human Papillomavirus) Vaccine (Gardasil)	[redacted]
Flu Shot (36 mo+) no preservative	[redacted]
Flu Shot - Fluzone High Dose	[redacted]

Products and Services	Maximum Fee (Per Unit)
Prevnar 13 (Pneumococcal Conjugate, 13 valent)	[redacted]
Flucelvax Quadrivalent PFS IM; Without Preservative (48+ mo)	[redacted]
Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use (Flublok)	[redacted]
Flu Shot-Quadrivalent (6-35 mo) split virus preservative free	[redacted]
Flu Shot-Quadrivalent (3 yrs +) split virus preservative free	[redacted]
Flu Shot-Quadrivalent (6-35 mo) split virus contains preservative	[redacted]
Flu Shot-Quadrivalent (3 yrs +) split virus contains preservative	[redacted]
Typhoid Vaccine	[redacted]
DTaP Vaccine	[redacted]
MMR Vaccine	[redacted]
IPV Vaccine	[redacted]
Tetanus/Diptheria Vaccine	[redacted]
TDaP Vaccine 7yrs. Old and up (MA:Adults only)	[redacted]
Varicella Vaccine	[redacted]
Pneumovax Vaccine	[redacted]
Meningococcal conjugate vaccine, serogroups A, C, Y	[redacted]
Hep B Shot Child	[redacted]
Hep B Shot Adult	[redacted]
Shingrix Vaccine	[redacted]
Therapeutic, prophylactic, or diagnostic injection	[redacted]
New Patient Visit	[redacted]
New Patient Expanded Visit	[redacted]
New Patient Detailed Visit	[redacted]
New Patient Comprehensive	[redacted]
New Patient High Complex	[redacted]
Established Patient Minimal Visit	[redacted]
Established Patient Visit	[redacted]
Established Patient Expanded Visit	[redacted]
Established Patient Detailed Visit	[redacted]
Established Patient Comprehensive	[redacted]

Products and Services	Maximum Fee (Per Unit)
INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION	[redacted]
INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION	
ESTABLISHED COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION	
ESTABLISHED COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION	
Preventive Medicine counseling/risk factor reduction – 15 minutes	
Preventive Medicine counseling/risk factor reduction – 30 minutes	
Preventive Medicine counseling/intervention to treat the risk factors of tobacco use up to 10 min	
Preventive Medicine counseling/intervention to treat the risk factors of tobacco use greater than 10 min	
Ceftriaxone	
Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	
Garamicin (Gentamicin)	
Injection, Vitamin B-12 Cyanocobalamin, up to 1000 MCG	

Service Provider may provide additional or custom services not otherwise covered in the above schedule. Fees for these services will be determined based on prices charged by Service Provider to third party clients under comparable circumstances. If such third party prices are not available, Service Provider will charge Purchaser the Fee determined based on costs incurred [redacted]

(C) PHARMACY BENEFIT MANAGEMENT

Pharmacy Benefit Management ("PBM")

CVS Caremark will dispense prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by CVS Caremark will be analyzed, processed and documented by CVS Caremark's proprietary prescription management systems. These systems provide essential features and functionality to allow a plan member to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, overutilization and potential fraud.

Plan Design Offerings and Administration

CVS Caremark will administer pharmacy benefit plans for Purchaser to facilitate prescription drug coverage and claims processing for their eligible plan members. CVS Caremark will assist Purchaser in designing pharmacy benefit plans that help improve health outcomes while minimizing costs to Purchaser. CVS Caremark will also assist Purchaser in monitoring the effectiveness of its plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

CVS Caremark will make recommendations to help Purchaser design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps Purchaser control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Purchaser will also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
CVS Caremark will utilize an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet CVS Caremark's standards of safety and efficacy for inclusion on one of CVS Caremark's template formularies. CVS Caremark's formularies will provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under Purchaser's pharmacy benefit plan, while helping to drive the lowest net cost for Purchaser. To help improve clinical outcomes for Purchaser, CVS Caremark will conduct ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products. CVS Caremark will offer real time benefits information for Purchaser's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Retail Pharmacy Network Management Services
CVS Caremark's proprietary prescription management systems, which verify relevant plan member data and eligibility, will perform drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. CVS Caremark will build Purchaser customized pharmacy networks and managed pharmacy network solutions to further drive savings for Purchaser.

*Subcontractor or its affiliate also has provider agreements with affiliated pharmacies for mail order and specialty prescriptions and such services are charged to Purchaser at Subcontractor's cost. Administration fee for specialty prescriptions dispensed by non-affiliated pharmacies is the same as above.

Service Provider may provide additional or custom services not otherwise covered in the above schedule, fees for these services will be determined based on prices charged by Service Provider to third party clients under comparable circumstances. If such third party prices are not available, Service Provider will charge Purchaser the Fee determined based on costs incurred .

Shared Savings Arrangement	To the extent applicable and agreed to by Service Provider and Purchaser, they will jointly realize any savings derived from the program implementation. Annual savings will be measured using a mutually-agreeable method, codified in writing and approved by Service Provider and Purchaser. Once annual savings are determined, Service Provider and Purchaser will realize those savings as follows: • • •
Return on Investment Guarantee	

	[redacted]

(D) TECHNOLOGY SOLUTIONS

1) Benefit Administration

Provides software-as-a-service ("SAAS") benefits administration platform offering a broad range of technology and services to businesses of all sizes in both commercial and government health plans. Simplifies the benefits administration processes including forwarding eligibility information to downstream payers and provides industry leading decision support tools to guide consumers through shopping and benefits enrollment.

Products and Services	Tier	Fee Information (Maximum)
Small Group	1-50,000	[redacted]
	50,0001-250,000	
	250,001-750,000	
	750,000-2,000,000	
	200,000,001+	
Middle Market	1-50,000	
	50,001-250,000	
	250,001-500,000	
	500,000+	
	Monthly Fee of [redacted]	

2) Healthcare analytics and reporting

Provides a comprehensive healthcare analytics and reporting application that provides approved users online access to their data on demand via both standard and ad hoc interactive reporting, flexible data integration, analytic enrichments and highly customizable outputs, which are delivered in a highly secure, role-based interface.

Based on each client's individual needs, disparate data sources are consolidated in the database to support robust financial, utilization, claimant and clinical reporting and data analysis. It offers a single point of access to all reporting subject areas, enabling users to analyze the database in a multitude of ways across vendors, providers, populations and time periods for a comprehensive picture of employee health and productivity.

Data Integration & Processing

The platform is a member-centric solution, integrating and linking data from a comprehensive range of claims-based, clinical, and other non-traditional health benefits sources. Any data that ties to a member and is provided in the data can be integrated into the platform for reporting.

Rate Card	
Monthly License Fees (Maximum)	
PMPM < 1M members - Internal User Access	[redacted]
PMPM > 1M members - Internal User Access	
External User License Fee	
Data Processing Fees	
Eligibility File; Medical Claims; Pharmacy Claims; and Other Data Sources	[redacted]

Optional Services:	
Symmetry ETG/ERG Only	[redacted]
Analytic Support/Consulting	

Single Payer Product Capabilities

Provides a powerful analytics environment that allows users to engage directly and visually with their data through an intuitive user experience. Users have access to data-driven insights to support decision-making and action planning for Member populations.

Products and Services	Fee (Maximum)
	[redacted]

3) Accounts Administration

Products and Services	Description
COBRA	Provides Benefit Continuation Services provides participating clients with the tools necessary to comply with Federal COBRA laws and streamline Retiree Billing processing. COBRA laws require organizations with twenty or more employees to offer the continuation of group health benefits (medical, dental, vision and medical reimbursement account) to employees (and covered dependents) upon experiencing a qualifying event. Benefit Continuation specialists handle COBRA/Retiree Billing issues daily, allowing them to efficiently and accurately manage COBRA/Retiree Billing participants' needs and maintain compliance for PayFlex clients.
HSA	Provides a Health Savings Account (HSA) that is designed to help an employer to provide a vehicle to their employees to pay for their current eligible health care costs and save for future health care expenses. Employees can save or invest the account funds. Paired with a qualified high deductible health plan (HDHP), an HSA is a powerful financial tool that gives employees more control of their health care decisions.
Reimbursement Accounts	**Flexible Spending Account (FSA)** is a type of tax-advantaged financial accounts that is set up through a cafeteria plan by a customer to reimburse IRS qualified medically eligible expenses. **Dependent Care Accounts (DCA)** is a type of tax-advantaged financial accounts that is set up by a customer to reimburse IRS qualified childcare expenses incurred by the member while at work. **Health Reimbursement Arrangement (HRA)** is an IRS-approved, employer-funded, tax-advantaged employer health benefit plan that reimburses employees for out-of-pocket medical expenses and individual health insurance premiums. **Commuter Benefits** is an IRS-approved tax-advantage account that is set up by a customer to reimburse members for transportation as part of their daily commute to work.
Direct Billing Administration	Direct Billing Administration provides services to clients to streamline the administrative function for direct billing and collection for retiree populations, employees out on disability or employees taking a leave of absence. These services include: 1) billing and collection of premiums; 2) optional late notices to ensure coverage is not dropped; 3) notification of rate or benefit changes; 4) generation of employer reports; 5) monitoring and tracking of payments and activities; and 6) optional carrier eligibility reporting.

Products and Services	Tier	Fees (Maximum)
HSA	0-499	[redacted]
	500-2,499	
	2,500-4,999	
	5,000-9,999	
	10,000+	
FSA	0-499	
	500-2,499	
	2,500-4,999	
	5,000-9,999	
	10,000+	
HRA/RRA	0-499	
	500-2,499	
	2,500-4,999	
	5,000 - 9,999	
	10,000+	
Commuter	0-10,000+	
COBRA	20-499	
	500-999	
	1,000-4,999	
	5,000+	
Direct Bill	2-2,499	
	2,500+	

Service Provider may provide additional or custom services not otherwise covered in the above schedules. Fees for these services will be determined based on prices charged by Service Provider to third party clients with comparable circumstances. If such third party prices are not available, Service Provider will charge Purchaser the Fee determined based on costs [redacted].

(E) Reasonableness Assessment

The parties may agree to conduct a review of the Service Provider's Fees with respect to the Services described in this Affiliates Services and Fees Exhibit to determine whether the Fees received by Service Provider during the prior year has caused the Service Provider to earn a margin within the Reasonable Compensation Range as described below. The parties may agree to conduct an interim review prior to the end of the year if there is a substantial change in the expenses that the Service Provider incurs in providing the Services.

If the margin earned by Service Provider is outside the Reasonable Compensation Range, the parties will agree to a lump-sum adjustment of the Fees, as applicable, in an amount that will cause the Service Provider to have earned a margin that is within the Reasonable Compensation Range. Such adjustments to the Fees may be performed in any manner permitted under applicable law and statutory accounting or general accounting principles.

The adjustment will be paid during the quarter immediately following the conclusion of the Reasonableness Assessment. If the Reasonableness Assessment results in an adjustment of the Fees, then the parties shall negotiate in good faith to determine whether the Fees for the Services described in this Affiliates Services and Fees Exhibit should be amended prospectively to avoid the need for future adjustments. If an amendment of the Fees is required, the parties will make the applicable regulatory filings with the applicable state regulatory bodies to effect the amendment.

Reasonable Compensation Range:

Means an arm's length mark-up on costs incurred by Service Provider in providing the Services to be agreed by Service Provider and Purchaser in a manner consistent with I.R.C. § 482 and the Treasury Regulations promulgated thereunder and other applicable state tax requirements.

BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "**Addendum**") is made by and between Aetna Medicaid Administrators LLC ("**Administrator**") on behalf of itself and its affiliates that are providing services to Purchaser (collectively, "**Business Associate**"), and Purchaser for which Business Associate provides services pursuant to one or more service agreements entered into between the Purchaser and Administrator (referred to herein, collectively, as the "**Service Agreement**").

WHEREAS, Administrator provides third-party administrative services to affiliated Aetna insurance and HMO companies that provide health insurance for covered individuals;

Administrator and Business Associate hereby mutually agree to the terms of this Addendum in order to comply with the HIPAA Rules and other applicable HIPAA Rules, as defined below.

This Addendum is effective no later than the Effective Date of the Services Agreement to which this Addendum is attached.

Definitions

"Breach" shall have the same meaning as the term "Breach" in 45 CFR 164.402.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification and Enforcement Rules at 45 CFR parts 160 and 164.

"Individual" shall have the same meaning as the term "Individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g) or other applicable federal or state law.

"Protected Health Information" or "PHI" shall have the same meaning as such term as defined in 45 CFR 160.103, but limited to information created, accessed or received on behalf of ADMINISTRATOR.

"Secure" shall mean to render unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of the HITECH Act.

"Successful Security Incident" shall mean any Security Incident (as defined in 45 CFR 164.304) that results in the unauthorized use, access, disclosure, modification or destruction of electronic PHI.

All capitalized terms used in this Addendum and not defined elsewhere herein or in the Services Agreement shall have the same meaning as those terms as used or defined in the HIPAA Rules.

Obligations of Business Associate

Business Associate agrees to comply with the HIPAA Rules that apply to Business Associates concerning the confidentiality, privacy, and security of PHI. To the extent Business Associate carries out any obligations under the Privacy Rule (45 CFR Subpart E of Part 164) for Administrator, Business Associate shall comply with the requirements of the Privacy Rule that apply to the performance of such obligations.

Business Associate shall not use or disclose PHI except as permitted or required by this Addendum or as Required by Law and only in compliance with the HIPAA Rules.

Business Associate shall enter into a written agreement meeting the requirements of 45 C.F.R. 164.504(e) and 164.314(a)(2) with any agent or Subcontractor that may have access to PHI prior to the agent or Subcontractor obtaining such access. Any such agreement shall contain restrictions, conditions and requirements that are at least as restrictive as those that apply to Business Associate in this Addendum.
Business Associate agrees that it shall request, use and disclose only the minimum necessary PHI to perform or fulfill a specific function required or permitted under this Addendum. Business Associate agrees to comply with

any guidance issued by the Secretary regarding minimum necessary.

If Business Associate conducts, in whole or in part, any Transactions electronically on behalf of Administrator, Business Associate shall comply with the applicable requirements of 45 CFR 162 and shall require that any agents or Subcontractors that perform, in whole or in part, such Transactions on its behalf, agree in writing to comply with such requirements.

Business Associate agrees to report any use or disclosure of PHI not permitted by this Addendum and any Successful Security Incident (each a "Potential Breach") to Administrator promptly, but in no event later than within ten (10) business days, after it is discovered (within the meaning of 45 CFR 164.410(a)(2)). Business Associate shall provide the information concerning the Potential Breach as required by 45 CFR 164.410(c). If such information is not available to Business Associate at the time the Potential Breach is required to be reported to Administrator, Business Associate shall provide such information to Administrator promptly as it becomes available. The Business Associate shall maintain complete records regarding the Potential or actual Breach for the period required by 45 CFR 164.530(j) or such longer period required by state law, and shall make such records available to Administrator promptly upon request, and to the extent required by applicable law. Notice is hereby deemed given for unsuccessful Security Incidents.

Within ten (10) business days of receipt of a request from Administrator, Business Associate shall provide to Administrator or, at its direction, to an Individual, PHI relating to that individual held by Business Associate or its agents or Subcontractors in a Designated Record Set in accordance with 45 CFR 164.524. In the event any Individual requests access to his or her PHI directly from Business Associate, Business Associate shall, within five (5) business days of receipt of such request, forward the request to Administrator unless the Privacy Rule requires Business Associate to receive and respond to such requests directly, in which case Business Associate shall respond directly as required by and in accordance with 45 CFR 164.524, and shall send a copy of such response to Administrator.

Within ten (10) business days of receipt of a request from Administrator, Business Associate agrees to make any requested amendment(s) to PHI held by it or any agent or Subcontractor in a Designated Record Set in accordance with 45 CFR 164.526. In the event any individual requests an amendment to his or her PHI directly from Business Associate, Business Associate shall within five (5) business days of receipt thereof, forward such request to Administrator.

Within ten (10) business days after Business Associate, its agents or Subcontractors makes any disclosure of PHI for which an accounting may be required under 45 CFR 164.528, Business Associate agrees to provide in writing via email to Administrator the information related to such disclosure as would be required to respond to a request by an Individual for an accounting in accordance with 45 CFR 164.528. If any Individual requests an accounting of disclosures under 45 CFR 164.528(a) directly from Business Associate, Business Associate shall, within ten (10) business days of receipt of such request, forward the request to Administrator unless the Privacy Rule requires that Business Associate receive and respond to such requests directly, in which case Business Associate shall respond directly as required by and in accordance with 45 CFR 164.528, and shall send a copy of such response to Administrator.

Within ten (10) business days of receipt of a request from Administrator, Business Associate agrees to comply with any request for confidential communication of, or restriction on the use or disclosure of, PHI held by it or any agent or Subcontractor as requested by Administrator and in accordance with 45 CFR 164.522.

Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services or her/his designees or other government authorities in a time and manner designated by Administrator or such governmental authorities, for purposes of determining compliance with the HIPAA Rules. Business Associate shall provide a copy of such books and records to Administrator at the same time as these are provided to the Secretary or other government authority.

Business Associate shall maintain documentation of its obligations hereunder to the extent and for the period required by the HIPAA Rules, including 45 CFR 164.530(j).

Security of Protected Health Information

Business Associate agrees to implement appropriate administrative, physical, and technical safeguards to prevent the unauthorized use and disclosure of PHI, and to protect the confidentiality, integrity, and availability of Electronic PHI, as required by the HIPAA Rules.

Business Associate will regularly test and monitor the effectiveness of its safeguards, controls, systems and procedures, and will periodically identify reasonably foreseeable internal and external risks to the security, confidentiality, integrity and availability of the PHI, and ensure that these risks are addressed.

Business Associate shall train Workforce members on the responsibilities under this Addendum, including the responsibilities to safeguard and, where appropriate or required, Secure PHI, and consequences for failing to do so.

As healthcare industry and other applicable security best practices evolve, Business Associate agrees to adjust its safeguards accordingly so that they continue to reflect the then-current industry best practices.

Permitted Uses and Disclosures of Protected Health Information

Business Associate agrees not to use or disclose Protected Health Information other than as permitted or required by this Addendum or as Required by Law.

Business Associate may use and disclose Protected Health Information as necessary in order to provide its services as described in the Services Agreement.

Business Associate may use Protected Health Information if necessary for its proper management and administration or to carry out its legal responsibilities. In addition, Business Associate may disclose Protected Health Information as necessary for its proper management and administration or to carry out its legal responsibilities provided that: any such disclosure is required by Law or is made in compliance with the HIPAA Rules.

Term and Termination

The term of this Addendum shall continue for so long as the Services Agreement remains in effect.

Upon a material breach of this Addendum, Administrator shall provide an opportunity for Business Associate to cure the breach or end the violation and if Business Associate does not cure the breach or if a cure is not possible, end the violation, within thirty (30) days or receipt of written notice by Administrator then Administrator may terminate this Addendum.

Effect of Termination. (1) Except as provided in paragraph (2) of this subsection, upon termination of the Services Agreement for any reason, Business Associate shall return to Administrator or destroy all Protected Health Information in its possession or that of its Subcontractors or agents. Business Associate and its agents and Subcontractors shall retain no copies of the Protected Health Information. (2) If returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Administrator written notification within ten (10) business days after termination of the Services Agreement of the conditions that make return or destruction infeasible. In such event, and Business Associate shall extend the protections of this Addendum to the Protected Health Information, and limit further uses and disclosures of it to those purposes that make the return or destruction infeasible, for so long as Business Associate or its agents or Subcontractors hold such Protected Health Information.

Mitigation of Breach

If there is a Breach of PHI under the control of Business Associate or its agents or Subcontractors, Business Associate agrees to perform any reasonable mitigation or remediation services requested by Administrator.

Miscellaneous

Business Associate agrees to take such action as the parties deem mutually necessary to amend this Addendum from time to time to comply with the requirements of any HIPAA Rules.

A reference in this Addendum to a section in the HIPAA Rules means the section as in effect or as amended, and as of its effective date.

Any ambiguity in this Addendum shall be resolved to permit compliance with the HIPAA Rules.

The terms and conditions of this Addendum shall override and control any conflicting term or condition of the Services Agreement. All non-conflicting terms and conditions of the Services Agreement remain in full force and effect.

Print Control Provisions

A. Administrator's print attestation process shall include: (1) printing and mailing in accordance with the Tap Test, Slip Sheet/Fly Sheet and No Fly Zone specifications (the "**Print Specifications**") as defined below; and (2) cooperating with Administrator's proofing process to confirm adherence to the Print Specifications.

"**Tap test**" means, when shaking or tapping the contents of a mailing within its envelope, the contents of the mailing (other than the recipient address) cannot be viewed through the envelope window. To complete a tap test, tap envelopes from top, bottom and each side to confirm that content shifting does not result in contents of mailing appearing in the window, or that delivery name/address falls out of the window position. Tap tests are to be performed if no slip sheet or fly sheet is utilized.

"**Slip sheet**" or "**fly sheet**" means a cover page that obscures the contents of the mailing. May be a full or partial page, provided that the contents of the mailing are not visible through the envelope window.

"**No Fly Zone**" means areas of a printed page in which member identifiable information (PHI or Personally Identifiable Information other than recipient address) cannot be printed in accordance with the following specs:

PHI/PII NO FLY ZONE SPECIFICATIONS

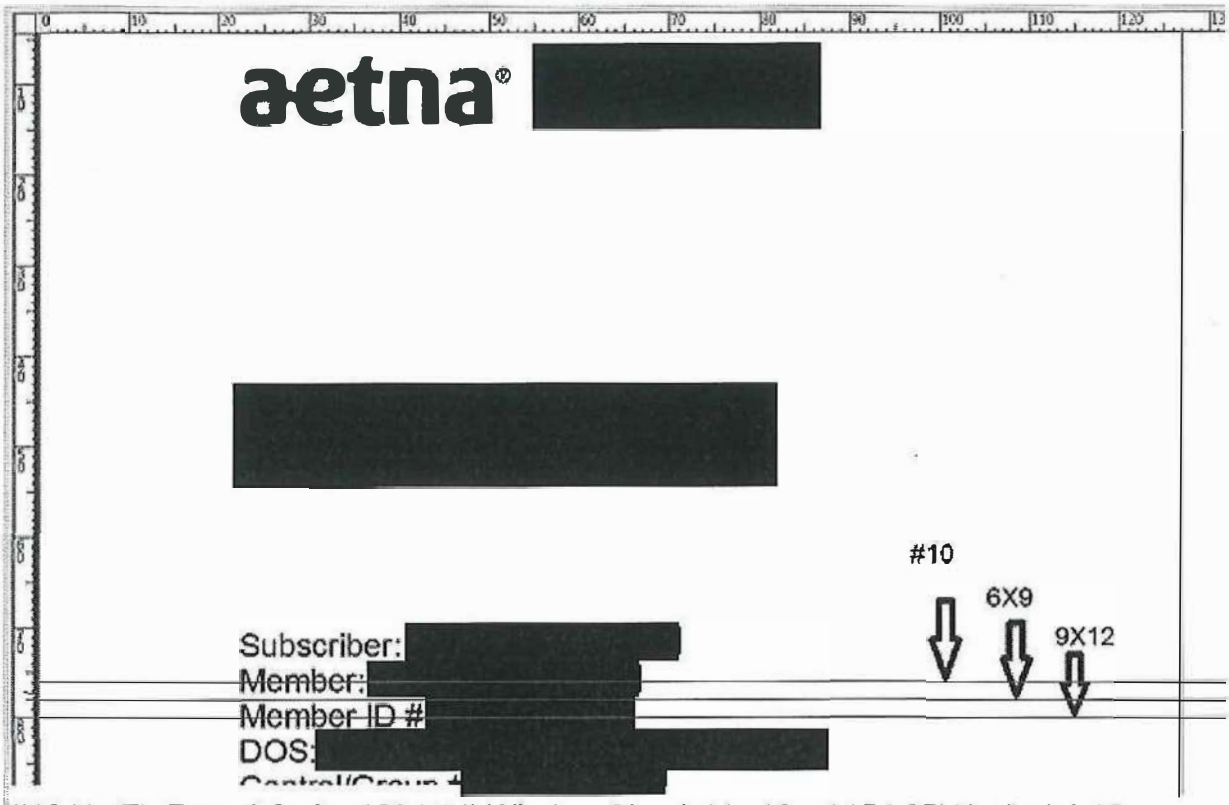

#10 No Fly Zone:(x0,y0,w128,h74) Window Size:(x11,y12,w115,h65) Y+H=Height
6X9 No Fly Zone:(x0,y0,w128,h76) Window Size:(x11,y12,w115,h67) Y+H=Height
9X12 No Fly Zone:(x0,y0,w128,h80) Window Size:(x11,y12,w115,h72) Y+H=Height

The X/Y coordinates above are based on printed pages placed within each designated envelope size.

B. Business Associate shall use automated insertion equipment which involves utilization of a 2D Barcode on all printed materials for mailings containing Member information or that are otherwise mailed to a Member. Proofs provided should show evidence of use of 2D barcode. Business Associate shall disclose to Administrator any vendor of Business Associate executing mailings on behalf of Business Associate. For control purposes, Administrator's preference is for Business Associate to not utilize a vendor for Member mailings.

C. Prior to subcontracting any print services and/or mailings that contain Member information or are otherwise mailed to a Member, Business Associate shall obtain Administrator's prior written authorization. Business Associate shall be responsible for its subcontractors' compliance with these terms and the terms of this Agreement.

Attachment C

Kentucky | Transforming Health Care | **Aetna**

Attachment C
B.2.a.(iv.) – Corporate Information

ABH-KY Articles of Incorporation ..... Att C-3

ABH-KY Bylaws ..... Att C-13

CHL Amended & Restated Articles of Incorporation ..... Att C-27

CHL Amended & Restated Bylaws ..... Att C-33

Aetna Health Holdings, LLC Certificate of Formation ..... Att C-47

Aetna Health Holdings, LLC Operating Agreement ..... Att C-51

Aetna Inc. Articles of Incorporation ..... Att C-61

Aetna Inc. Bylaws ..... Att C-67

CVS Pharmacy Inc. Articles of Amendment ..... Att C-75

CVS Pharmacy Inc. Bylaws ..... Att C-103

CVS Health Corporation Restated Certificate of Incorporation ..... Att C-113

CVS Pharmacy Inc. Bylaws ..... Att C-131

CHL Amended and Restated Articles of Incorporation – 10/2019 ..... Att C-157

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B.2.a.(iv.) – ABH-KY Articles of Incorporation

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APPROVED FOR FORM AND LEGALITY OFFICE
OF THE ATTORNEY GENERAL, FRANKFORT, KENTUCKY

BY [signature] 2/12/15
Joseph A. Newberry, II Asst. Atty. Gen.

0915057.09 amcray ADD

Alison Lundergan Grimes
Kentucky Secretary of State
Received and Filed:
2/24/2015 3:48 PM
Fee Receipt: $6,740.00

ARTICLES OF INCORPORATION
OF
AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY

d/b/a Aetna Better Health of Kentucky

The undersigned, acting as incorporators and being over the age of eighteen years, execute these Articles of Incorporation for the purpose of forming and do hereby form a stock insurer corporation pursuant to the provisions of the Kentucky Business Corporation Act, Kentucky Revised Statutes Chapter 271B.010 et seq. ("KRS Chapter 271B") and the Kentucky Insurance Code, Kentucky Statutes Chapter 304 ("KRS Chapter 304), as follows:

ARTICLE I
CORPORATE NAME

The name of the corporation is AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY d/b/a AETNA BETTER HEALTH OF KENTUCKY (the "Corporation").

ARTICLE II
CORPORATE PURPOSE

The purpose for which the Corporation is organized is to engage in any activity within the purposes for which corporations may be organized under KRS Chapter 271B. The Corporation shall be authorized to transact the following kinds of insurance, as presently defined in KRS Chapter 304 or as hereafter authorized and defined under the laws of the Commonwealth of Kentucky: "life", "health" and "annuities".

APPROVED
FEB 24 2015
FINANCIAL STANDARDS
KY DEPT OF INSURANCE

ARTICLE III
CAPITAL STOCK

The aggregate number of shares which the corporation shall have authority to issue is three million (3,000,000) shares of common stock, all of which shall have a par value of $1.00 per share.

ARTICLE IV
REGISTERED AGENT AND REGISTERED ADDRESS

The address of the corporation's initial registered office is 306 West Main Street, Suite 512, Frankfort, Kentucky 40601, and the name of the corporation's initial registered agent at such address is CT Corporation System. The corporation's initial principal place of business is 9900 Corporate Campus Drive, Suite 1000, Louisville Kentucky 40223.

ARTICLE V
INITIAL BOARD OF DIRECTORS

The number of directors constituting the first board of the Corporation is three (3), and the names and mailing addresses of the persons who are to serve as such directors are:

Pamela Sedmak
4645 E. Cotton Center Blvd.
Building 1
Phoenix, Arizona 85040

Debra Bacon
4645 E. Cotton Center Blvd.
Building 1
Phoenix, Arizona 85040

Michael Murphy
1440 Pacland Place
Chesterfield, Missouri 63005

The number of directors of the board of the Corporation shall be governed by the by-laws of the Corporation.

ARTICLE VI
INDEMNIFICATION

The corporation shall indemnify its officers and directors and former officers and directors and any person serving at the request of the corporation as an officer, director, employee or agent of another corporation, association, partnership, joint venture, trust, or other enterprise, against all expenses, liability and loss (including attorneys' fees, judgments, fines, ERISA excise taxes, penalties and amounts paid in settlement) incurred in connection with any pending or threatened action, suit, or proceeding, whether civil, criminal, administrative or investigative, with respect to which such officer, director or other person is a party, or is threatened to be made a party, to the fullest extent authorized by the Act, as the same exists or may hereafter be amended (but, in the case of any such amendment, only to the extent that such amendment permits the corporation to provide broader indemnification rights than such law permitted the corporation to provide prior to such amendment). Notwithstanding the foregoing, the corporation shall not be obligated to indemnify any such indemnitee in connection with a proceeding (or part thereof) initiated by such indemnitee unless such proceeding (or part thereof) was authorized by the board of directors of the corporation, except as provided below with respect to proceedings to enforce rights to indemnification. The right to indemnification conferred in this Article VI shall include the right to be paid by the corporation the expenses (including attorney's fees) incurred in defending any such proceeding in advance of its final disposition. If required under the Act, an advancement of expenses incurred by an indemnitee in his or her capacity as a director or officer (and not in any other capacity in which service was or is rendered by such indemnitee, including, without limitation, service to an employee benefit

plan) shall be made only upon delivery to the corporation of an undertaking, by or on behalf of such indemnitee, to repay all amounts so advanced if it shall ultimately be determined by final judicial decision from which there is no further right to appeal (hereinafter a "final adjudication") that such indemnitee is not entitled to be indemnified for such expenses under this Article VI or otherwise. The rights to indemnification and to the advancement of expenses conferred in this Article VI shall be contract rights and such rights shall continue as to an indemnitee who has ceased to be a director, officer or agent and shall inure to the benefit of the indemnitee's heirs, executors and administrators.

The corporation may, to the extent authorized from time to time by the board of directors, grant rights to indemnification and to the advancement of expenses to any employee or agent of the corporation to the fullest extent of the provisions of this Article VI with respect to the indemnification and advancement of expenses of directors and officers of the corporation.

The indemnification provided herein shall not be deemed exclusive of any other right to which any person seeking indemnification may be entitled under any by-law, agreement, or vote of shareholders or disinterested directors or otherwise, both as to action in his official capacity and as to action in another capacity, and shall inure to the benefit of the heirs, executors, and the administrators of any such person. The corporation shall have the power to purchase and maintain insurance on behalf of any persons enumerated above against any liability asserted against him or her and incurred by him or her in any such capacity, arising out of his or her status as such, whether or not the corporation would have the power to indemnify him or her against such liability under the provisions of this Article VI.

ARTICLE VII
EXCULPATION

To the full extent from time to time permitted by law, no director or officer of the corporation shall be personally liable to the corporation or to any of its shareholders for damages for breach of any duty owed to the corporation or its shareholders except for liability for any breach of duty based upon an act or omission (a) in breach of such director's or officer's duty of loyalty to the corporation or its shareholders, (b) not in good faith or involving a knowing violation of law, (c) resulting in receipt by such director or officer of an improper personal benefit, (d) in which the director's or officer's personal financial interest is in conflict with the financial interests of the Corporation or its shareholders, or (e) that is a vote for or assent to an unlawful distribution to shareholders as prohibited by KRS 271B.8-330. Neither the amendment or repeal of this Article VII, nor the adoption of any provision of these Articles of Incorporation inconsistent with this Article VII, shall eliminate or reduce the protection afforded by this Article VII to a director or officer of the corporation in respect to any matter which occurred, or any cause of action, suit or claim which but for this Article VII would have accrued or arisen, prior to such amendment, repeal or adoption.

ARTICLE VIII
NAME AND ADDRESS OF THE INCORPORATOR

The names and resident addresses of the incorporators, each Kentucky residents and all of whom are more than eighteen (18) years of age are:

Greg E. Mitchell
303 Stonegate Drive
Nicholasville, Kentucky 40356

Jay Holley
316 Ravenwood Place
Richmond, Kentucky 40475

Martha Staude
2209 Shannawood Dr.
Lexington, Kentucky 40513

The authority and power of such incorporators shall cease upon the filing of these Articles of Incorporation.

IN WITNESS WHEREOF, the undersigned incorporators have executed these Articles of Incorporation on the dates indicated below and made effective as of the 9th day of February 2015.

Greg E. Mitchell, Incorporator

Jay Holley, Incorporator

Martha Staude, Incorporator

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF FAYETTE)

The foregoing instrument was subscribed, sworn to and acknowledged before me by GREG E. MITCHELL this 9th day of February, 2015.

My Commission Expires: 12.4.2016

NOTARY PUBLIC

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF FAYETTE)

The foregoing instrument was subscribed, sworn to and acknowledged before me by JAY HOLLEY this 9th day of February, 2015.

My Commission Expires: 12.4.2016

NOTARY PUBLIC

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF FAYETTE)

The foregoing instrument was subscribed, sworn to and acknowledged before me by MARTHA STAUDE this 9th day of February, 2015.

My Commission Expires: 12.4.2016

NOTARY PUBLIC

0122331.0593381 4852-1215-59375937v11

B.2.a.(iv.) – ABH-KY Bylaws

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Bylaws of

Aetna Better Health of Kentucky Insurance Company

a Kentucky corporation

ARTICLE I
OFFICES AND AGENT

1.01 Principal Office. The principal office of the Corporation shall be located in Louisville, Kentucky (the "Home Office"), and the same shall be registered with the Insurance Commissioner of each State in which the Corporation now or hereafter is authorized to transact business.

1.02 Registered Office and Agent. The initial registered office of the Corporation and the name of the initial registered agent of the Corporation are as set forth in the Corporation's Articles of Incorporation. From time to time, the Board of Directors may change the registered office and/or the registered agent of the Corporation in accordance with the provisions of the Kentucky Business Corporation Act, Kentucky Revised Statutes Chapter 271B.010 et seq. ("KRS Chapter 271B") and the Kentucky Insurance Code, Kentucky Statutes Chapter 304 ("KRS Chapter 304).

1.03 Other Offices. The Corporation may have other offices at such places within and without the Commonwealth of Kentucky as from time to time the Board of Directors may determine or the business of the Corporation may require.

ARTICLE II
MEETINGS OF SHAREHOLDERS

2.01 Annual Meetings. An annual meeting of the shareholders shall be held as determined by the Board of Directors. At each such meeting the shareholders shall elect a Board of Directors and transact such other business as may properly be brought before the meeting.

2.02 Call for Special Meetings. Special meetings of the shareholders, for any purpose or purposes, may be held at such time and place, within or without the Commonwealth of Kentucky, as shall be stated in the notice of the meeting or in a duly executed waiver of notice thereof. Unless otherwise prescribed by the Code, by the Articles of Incorporation, or by these Bylaws, special meetings of the shareholders may be called by the President, the Board of Directors, or by one or more shareholders, the aggregate of whose shares comprise not less than ten percent (10%) of all shares entitled to vote at such meetings. Business transacted at all special meetings shall be confined to the subjects stated in the notice of the meeting, unless such notice shall have been waived.

2.03 Notice of Meetings; Waiver.

(a) Notice. Unless notice is waived, the President, the Secretary, or the officer or person calling the meeting shall deliver or direct the delivery of written or printed notice of a shareholder meeting, personally or by mail/electronic mail, to each shareholder of record entitled to vote at the meeting. Such notice shall be delivered not less than ten (10) nor more than sixty (60) days before the date of the meeting, shall state the place, date, and time of the meeting, shall state the means of any remote communication by which shareholders may be considered present and may vote at the meeting, and in case of a special meeting, shall state the purpose or purposes for which the meeting is called.

(b) Waiver. Notice may be waived in writing signed by the person or persons entitled to such notice. Such waiver may be executed at any time before or after the holding of such meeting. Attendance at a meeting shall constitute a waiver of notice, except where the person attends for the express purpose of objecting to the transaction of any business on the ground that the meeting was not validly called.

2.04 Record Date. For the purpose of determining shareholders entitled to notice of or to vote at any meeting of shareholders or any adjournment of any meeting of shareholders, or entitled to receive payment of any dividend, the board of directors may in advance establish a record date which must be at least ten (10) but not more than sixty (60) days prior to such meeting. If the board of directors fails to establish a record date, the record date shall be the date on which notice of the meeting is given.

2.05 Intentionally Omitted.

2.06 Quorum. The holders of a majority of the shares issued and outstanding and entitled to vote, present in person or represented by proxy, shall constitute the requisite quorum at all meetings of the shareholders for the transaction of business except as otherwise provided by the Code, by the Articles of Incorporation, or by these Bylaws. Once the presence of a quorum has been confirmed, business may continue notwithstanding any failure to maintain a quorum during the remainder of the meeting.

2.07 Manner of Acting. With respect to any matter, other than the election of directors or a matter for which the affirmative vote of the holders of a specified portion of the shares entitled to vote is required by the Code or unless otherwise provided in the Articles of Incorporation or these Bylaws, the affirmative vote of the holders of a majority of the shares entitled to vote on that matter, represented in person or by proxy at a meeting of shareholders at which a quorum is present, shall be the act of the shareholders with respect to that matter. With respect to the election of directors, directors shall be elected by a plurality of the votes cast by the holders of shares entitled to vote in the election of directors at a meeting of shareholders at which a quorum is present, unless otherwise provided in the Articles of Incorporation.

2.08 Method of Voting.

(a) Generally. Unless otherwise provided in the Articles of Incorporation or the Code, each outstanding share, regardless of class, shall be entitled to one vote on each matter submitted to a vote at a meeting of shareholders. Any shareholder may vote either in person or by proxy executed in writing by the shareholder. No proxy shall be valid after 11 months from the date of its execution unless otherwise provided in the proxy.

(b) Board of Directors Elections. Unless otherwise provided in the Articles of Incorporation, each shareholder shall have the right at every election of directors to vote the number of voting shares owned by such shareholder for as many persons as there are directors to be elected. No shareholder of the Corporation shall have the right of cumulative voting at any election of directors or upon any other matter.

2.09 Presiding Officials at Meeting. The President shall preside at and conduct each meeting of shareholders, and the Secretary shall prepare minutes thereof, unless some other person or persons are elected to so act by a vote of a majority of the shares present and entitled to vote at that particular meeting of shareholders.

ARTICLE III
DIRECTORS

3.01 Powers. The business and affairs of the Corporation shall be managed by its officers with oversight by the Board of Directors, who may exercise all such powers of the Corporation and do all such lawful acts and things as are not directed or required to be exercised or done by the shareholders pursuant to the terms of the Code, the Articles of Incorporation, or these Bylaws.

3.02 Number and Election. The Board of Directors shall consist of not less than three (3), and no director need be a shareholder or a resident of the Commonwealth of Kentucky. The Board of Directors shall determine the number of directors from time to time, and each such determination shall continue in force until changed by the Board of Directors. If the Board of Directors fails to make such a determination, the number of directors shall be the same as the initial Board of Directors set forth in the Articles of Incorporation. The directors shall be elected at the annual meeting of the shareholders, except as hereinafter provided, and each elected director shall hold office until such director's successor shall be elected and shall qualify. Any vacancy occurring in the Board of Directors may be filled by the affirmative vote of a majority of the remaining directors, notwithstanding that the remaining directors constitute less than a quorum of the Board of Directors, or by the holders of a majority of the shares then entitled to vote in election of directors. A director elected to fill a vacancy shall be elected for the unexpired term of such director's predecessor in office. Any directorship to be filled by reason of an increase in the number of directors may be filled by election at an annual meeting or a special meeting of the shareholders called for that purpose, or may be filled by the Board of Directors for a term of office continuing only until the next election of one or more of the directors by the shareholders, provided that the Board of Directors may not fill more than two

(2) such newly-created directorships during the period between any two (2) successive annual meetings of shareholders.

3.03 Removal and Resignation. Any director may be removed, with or without cause, at any duly constituted meeting of shareholders called expressly for that purpose, by the affirmative vote of the holders of a majority of the shares then entitled to vote in the election of directors. Any director may resign at any time by giving written notice to the president or secretary. Such resignation shall take effect at the time specified in the notice, and unless otherwise specified in such notice, the acceptance of such resignation shall not be necessary to make it effective.

3.04 Meetings, Notice and Waiver. Regular meetings of the Board of Directors may be held without notice at such time and place as determined by the Board. Special meetings of the Board of Directors may be called by the President on three (3) days notice to each director, either personally, by mail, or by electronic communication. The purpose or purposes of such meeting need not be stated in the notice thereof, except as is specifically provided in **Section 10.01** hereof for amendments. Attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends for the express purpose of objecting to the transaction of any business on the ground that the meeting was not validly called.

3.05 Quorum. At all meetings of the Board of Directors, the presence of a majority of the number of directors fixed in the manner prescribed by these Bylaws shall be necessary and sufficient to constitute a quorum for the transaction of business. If a quorum shall not be present at any meeting, the directors present may adjourn the meeting from time to time without notice other than announcement at the meeting, until a quorum shall be present.

3.06 Manner of Acting. The act of a majority of the directors present at any meeting at which there is a quorum shall be the act of the Board of Directors, except as otherwise may be specifically provided by the Code, by the Articles of Incorporation, or by these Bylaws.

3.07 Compensation of Directors. Directors shall not receive any stated salary for their services as directors, but the Board may allow by resolution a fixed sum and expenses of attendance, if any, for attendance at each regular or special meeting of the Board. Nothing contained herein shall be construed to preclude any director from serving the Corporation in any other capacity and receiving compensation for such service.

3.08 Committees. The Board of Directors, by resolution adopted by a majority of the full Board, may designate from among its members one or more committees, each of which shall be comprised of one or more Board members. The Board may also designate one or more of its members as alternate members of any committee who may replace absent or disqualified members at any meeting of that committee, subject to any limitation imposed by the Board of Directors. To the extent provided in such resolution, any such committee shall have and may exercise all of the authority of the Board of Directors, except that no such committee shall have the authority to amend the Articles of Incorporation; to propose a reduction of the

Corporation's stated capital; to approve a plan of merger or share exchange of the Corporation; to recommend to the shareholders the sale, lease, or exchange of all or substantially all of the Corporation's property and assets other than in the usual and regular course of its business; to recommend to the shareholders a voluntary dissolution of the Corporation or a revocation thereof; to amend, alter, or repeal the Corporation's bylaws or to adopt new bylaws for the Corporation; to fill vacancies in the Board of Directors; to fill vacancies in or designate alternate members of any committee; to fill any directorship that is vacant by reason of an increase in the number of directors; to elect or remove officers of the Corporation or any member or alternate member of any committee; to fix the compensation of any member or alternate member of any committee; or to alter or repeal any resolution of the Board of Directors that provides by its terms that it shall not be so amendable or repealable. Unless the resolution designating that particular committee or the Articles of Incorporation expressly so provide, no committee shall have any power or authority to authorize a distribution or issuance of shares of the Corporation. The designation of any such committee and the delegation of authority thereto shall not operate to relieve the Board of Directors or any of its members of any responsibility imposed by law.

ARTICLE IV
NOTICES

4.01 Formalities of Notices. Whenever notice is required to be given to any director or shareholder pursuant to the provisions of the Code, the Articles of Incorporation, or these Bylaws and no provision is made as to how such notice shall be given, such provision shall not be construed to require personal notice but rather that such notice may be given in writing and delivered by mail, postage prepaid, and addressed to such director or shareholder at the address on file in the records of the Corporation. Any notice required or permitted to be given by mail shall be deemed to be given at the time when such notice shall have been deposited in the United States mails as previously described.

4.02 Notice by Electronic Transmission. Upon authorization by the Board of Directors, any notice required to be given to any shareholder pursuant to the Code, the Articles of Incorporation, or these Bylaws may be delivered via electronic or facsimile transmission to the full extent provided by the Code, provided the shareholder consents to the delivery of notice by such means. A shareholder may consent to the delivery of notice by electronic transmission by providing a written, signed request to the Secretary of the Corporation. The shareholder may revoke such consent at any time by means of a written, signed notice to the Secretary of such revocation. Upon the electronic or facsimile transmission of notice to all consenting shareholders, the Secretary, Assistant Secretary, transfer agent, or other person responsible for transmitting such notice shall execute an affidavit that such notice was given, and the Secretary shall file the affidavit in the records of the Corporation.

4.03 Written Waiver of Notices. Whenever any notice is required to be given to any shareholder or director of the Corporation pursuant to the provisions of the Code, the Articles of Incorporation, or these Bylaws, a written waiver thereof, signed by the person or persons

entitled to such notice, shall be deemed equivalent to the giving of such notice, regardless of whether such waiver is executed before or after the time that is or would be stated in such notice.

ARTICLE V
OFFICERS

5.01 Officers. The officers of the Corporation shall be elected by the directors and shall include a President and a Secretary. The Board of Directors may also elect or appoint one or more other officers, assistant officers, or agents as it deems necessary. Any two or more offices may be held by the same person.

5.02 Election of Officers; Term; Removal. The Board of Directors shall elect the officers at its first meeting after each annual meeting of shareholders. None of the elected officers need be members of the Board. Each officer of the Corporation shall hold office until such officer's successor is elected and qualified or until such officer's death, resignation, or removal from office. Any officer or agent elected or appointed by the Board of Directors may be removed at any time by the affirmative vote of a majority of the whole Board of Directors, but such removal shall be without prejudice to the contract rights, if any, of the person so removed, provided that election or appointment of an officer shall not of itself create contract rights. If the office of any officer becomes vacant for any reason, the vacancy may be filled by the Board of Directors.

5.03 The President. The President shall be the chief executive officer of the Corporation. The President shall exercise general and active management of the business and affairs of the Corporation, shall see that all orders and resolutions of the Board are carried into effect, shall perform such other duties as the Board of Directors shall prescribe, and subject to the provisions of **Section 2.09** hereof, shall preside at all meetings of the shareholders.

5.04 The Vice Presidents. In the event the Board of Directors elects or appoints one or more Vice Presidents, each Vice President shall have such powers and perform such duties as from time to time the Board of Directors may prescribe or the President may delegate.

5.05 The Secretary and Assistant Secretaries. The Secretary shall report to and operate under the President's supervision. The Secretary shall attend all sessions and meetings of the Board of Directors and of the shareholders and shall record all votes and the minutes of all proceedings in a book to be kept for that purpose. The Secretary further shall keep a record of the original issuance of shares issued by the Corporation and a record of each transfer of those shares presented to the Corporation for registration of transfer, such records to be maintained at the Corporation's registered office, principal place of business, or at the office of its transfer agent or registrar. Such records shall contain the names and addresses of all past and current shareholders of the Corporation and the number and class of shares issued by the Corporation held by each of them. Any books, records, minutes, and share transfer records may be in written or printed form or in any other form capable of being converted into written or printed form within a reasonable time. The Secretary shall give or cause to be given notice

of all meetings of the shareholders and special meetings of the Board of Directors and shall perform such other duties as may be prescribed by the Board of Directors or delegated by the President. The Secretary shall keep in safe custody the seal of the Corporation and, when authorized by the Board, shall affix the same to any instrument requiring it. When so affixed, the Corporation's seal shall be attested by the Secretary's signature or by the signature of the Treasurer or an Assistant Secretary. Each Assistant Secretary, if any, shall have such powers and perform such duties as from time to time the Board of Directors may prescribe or the President may delegate.

5.06 The Treasurer and Assistant Treasurers. In the event the Board of Directors elects or appoints a Treasurer, the Treasurer shall have custody of the corporate funds and securities, shall keep full and accurate accounts of the Corporation's receipts and disbursements, and shall deposit all moneys and other valuable effects in the name and to the credit of the Corporation in such depositories as may be designated by the Board of Directors. The Treasurer shall disburse the funds of the Corporation as may be ordered by the Board of Directors, taking proper vouchers for such disbursements, and shall render to the President and directors an account of all the Treasurer's transactions and the financial condition of the Corporation at the regular meetings of the Board or whenever the Board may require it. The Treasurer additionally shall perform such other duties as the Board of Directors may prescribe. If required by the Board of Directors, the Treasurer shall give the Corporation a bond in such form, in such sum, and with such surety or sureties as shall be satisfactory to the Board for the faithful performance of the Treasurer's duties of office and for the restoration to the Corporation, in case of the Treasurer's death, resignation, retirement, or removal from office, of all books, papers, vouchers, money, and other property of whatever kind belonging to the Corporation in the Treasurer's possession or under the Treasurer's control. Each Assistant Treasurer, if any, shall have such powers and perform such duties as from time to time the Board of Directors may prescribe or the President may delegate.

ARTICLE VI
CERTIFICATES REPRESENTING SHARES

6.01 Delivery, Form, and Content. The Board of Directors shall cause to be delivered to the shareholders certificates in such form as may be determined by the Board of Directors representing all shares to which such shareholders are entitled. Certificates shall be consecutively numbered by classes and shall be entered in the books of the Corporation as they are issued. Each certificate shall state on the face thereof that the Corporation is organized under the laws of the Commonwealth of Kentucky, the name of the person to whom the certificate is issued, the number and class of shares, the designation of the series, if any, which such certificate represents, and the par value of such shares or a statement that such shares are without par value. Each certificate shall be signed by the President or a Vice President and the Secretary or an Assistant Secretary and may be sealed with the seal of the Corporation or a facsimile thereof. If any certificate is countersigned by a transfer agent or an assistant transfer agent or registered by a registrar other than the Corporation or an employee thereof, the signature of any officer may be by facsimile.

6.02 Pavment; Issuance. Shares may be issued for such consideration, not less than the par value of such shares, as may be fixed from time to time by the board of directors. The consideration for the payment of shares shall consist of money paid, labor done or property actually received. Shares may not be issued until the full amount of the consideration fixed for such shares has been paid.

6.03 Lost Certificates. The Board of Directors may direct a new certificate representing shares to be issued in place of any previously-issued certificate alleged to have been lost or destroyed upon the making of an affidavit of that fact by the person claiming the certificate to be lost or destroyed. When authorizing the issuance of a new certificate, the Board of Directors, in its discretion and as a condition precedent to the issuance thereof, may require the owner of such lost or destroyed certificate or such person's legal representative to advertise the same in such manner as it shall require, to give the Corporation a bond in such form, in such sum, and with such surety or sureties as it may direct as indemnity against any claim that may be made against the Corporation with respect to the certificate alleged to have been lost or destroyed, and/or to agree to indemnify the Corporation against any such claim.

6.04 Transfer. Shares of stock shall be transferable only on the books of the Corporation by the holder thereof in person or by such person's duly authorized attorney. Upon surrender to the Corporation of the certificate representing shares duly endorsed or accompanied by proper evidence of succession, assignment, or authority to transfer, it shall be the Corporation's duty to issue a new certificate to the person entitled thereto, to cancel the old certificate, and to record the transaction upon its books.

6.05 Record Holder. The Corporation shall be entitled to treat any person in whose name any issued shares are registered upon the Corporation's share transfer records at any particular time (including, without limitation, as of a record date fixed pursuant to law) as the owner of those shares at that time for purposes of voting those shares, receiving distributions thereon or notices in respect thereof, transferring those shares, exercising rights of dissent with respect to those shares, exercising or waiving any preemptive right with respect to those shares, entering into agreements with respect to those shares in accordance with the Code, or giving proxies with respect to those shares. Neither the Corporation nor any of its officers, directors, employees, or agents shall be liable for regarding that person as the owner of those shares at that time for those purposes, regardless of whether that person does not possess a certificate for those shares.

ARTICLE VII
DIVIDENDS

7.01 Dividends. Subject to the provisions of the Articles of Incorporation, the Board of Directors may declare dividends on the Corporation's outstanding shares at any regular or special meeting. Dividends may be paid in cash, in property, or in shares of the Corporation, subject to statutory provisions and the Articles of Incorporation. The Board of Directors may fix a record date in advance of such dividend or may close the Corporation's share transfer records for such purpose for a period of not more than thirty (30) days prior to the payment date of

such dividend. In the absence of any action by the Board of Directors, the date on which the Board adopts the resolution declaring such dividend shall be the record date.

7.02 Reserves. Before payment of any dividend, the board of directors, by resolution, may create a reserve or reserves out of the Corporation's surplus or designate or allocate any part or all of such surplus in any manner for any proper purpose or purposes, and may increase, create, or abolish any such reserve, designation, or allocation in the same manner.

ARTICLE VIII
ACTION BY CONSENT; MEETINGS BY ELECTRONIC MEANS

8.01 Directors' Action by Consent. Any action required or permitted by the Articles of Incorporation, these Bylaws, or the Code to be taken at a meeting of the Board of Directors may be taken without a meeting if all the directors sign a written consent setting forth the action so taken.

8.02 Shareholders' Action by Consent.

(a) Action by Unanimous Consent. Any action required or permitted by the Articles of Incorporation, these Bylaws, or the Code to be taken at a meeting of the shareholders of the Corporation may be taken without a meeting if all the shareholders entitled to vote with respect to the subject matter sign a written consent setting forth the action so taken.

(b) Action by Non-Unanimous Consent. If the Corporation's Articles of Incorporation so provides, any action required or permitted by the Articles of Incorporation, these Bylaws, or the Code to be taken at any annual or special meeting of shareholders may be taken, subject to any further statutory requirements, without a meeting, without prior notice, and without a vote, if the holder or holders of shares having not less than the minimum number of votes that would be necessary to take such action (had the matter arisen at a shareholder meeting at which the holders of all shares entitled to vote on the action were present and voted) sign a written consent or consents setting forth the action so taken.

(c) Form of Shareholder Consent. Every written consent executed pursuant to **Section 8.02(b)** shall bear the date of signature of each shareholder who signs the consent. No written consent shall be effective to take the action that is the subject of the consent unless, within sixty (60) days after the date of the earliest-dated consent delivered to the Corporation as described below, one or more written consents, signed by the holder or holders of shares having not less than the minimum number of votes that would be necessary to take the action that is the subject of the consent, are delivered to the Corporation's registered office, its principal place of business, or an officer or agent of the corporation having custody of the minute book. Delivery shall be by hand or by certified or registered mail, return receipt requested. Delivery to the Corporation's principal place of business shall be addressed to the President of the Corporation. A telegram, telex, cablegram, electronic mail or similar transmission by a shareholder, or a photographic, photostatic, facsimile, or similar reproduction

of a writing signed and dated by a shareholder shall be regarded as a duly signed shareholder consent for purposes of this **Section 8.02(c)**. If such action is authorized by the Articles of Incorporation, prompt notice of the taking of any action by shareholders without a meeting by less than unanimous written consent shall be given to those shareholders who did not consent in writing to the action. If any action by shareholders is taken by written consent, any articles or documents filed with the Secretary of State as a result of the taking of the action shall state, in lieu of any statement required by the Code concerning any vote of shareholders, that written consent and notice thereof has been given in accordance with the Code, as applicable.

8.03 Meetings by Conference Telephone, or Electronic Communication. Subject to any notice requirements in these Bylaws or pursuant to the Code, shareholders, members of the Board of Directors, or members of any committee designated by the Board may participate in and hold a meeting of such shareholders, directors, or committee members by means of a conference telephone or similar communications equipment, the Internet, or any combination thereof that allows all persons participating in the meeting to communicate with each other. Participation in such a meeting shall constitute presence in person at such meeting, except where a person participates in the meeting for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened. Minutes of any such meeting shall promptly be prepared by the Secretary, circulated to all members entitled to vote at the meeting (whether they participated or not), placed in the regular corporate records containing similar meeting minutes, and called to the attention of such shareholders, Board of Directors, or committee at its next regular meeting.

ARTICLE IX
GENERAL PROVISIONS

9.01 Fiscal Year. The fiscal year of the Corporation shall be fixed as the calendar year.

9.02 Official Records; Seal. The share transfer records, the minute book, and the Corporation's financial records shall be of the type determined and established by the Board of Directors and may be changed from time to time in the Board's discretion. The Board of Directors may provide for a corporate seal of the Corporation, but no seal shall be required.

9.03 Indemnification. The Corporation shall indemnify any current or former director, officer, or employee of the Corporation, or any person who may have served at the Corporation's request as a director, officer, or employee of another corporation or entity in which it owns shares of stock or other ownership interest or of which it is a creditor, against expenses actually and necessarily incurred by such person and any amount paid in satisfaction of judgments in connection with any action, suit, or proceeding, whether civil, criminal, arbitrative, or investigative in nature, in which such person was, is, or is threatened to be made a named defendant or respondent by reason of being or having been such a director, officer, or employee (whether or not the person is or was such at the time such costs or expenses are incurred by or imposed upon such person) as is required by the Code. The Corporation may

indemnify any such person against and for any such expenses or costs and may advance expenses to any such person as is permitted by and according to the terms of the Code.

9.04 Invalid Provisions. If any part of these Bylaws shall be held invalid or inoperative for any reason, the remaining parts shall be valid and operative so far as possible and reasonable.

9.05 Headings. The headings used in these Bylaws have been inserted for administrative convenience only and do not constitute matters to be construed or interpreted.

ARTICLE X
AMENDMENTS

10.01 Alteration, Amendment, or Repeal. Unless otherwise provided in the Articles of Incorporation, the power to alter, amend, or repeal these Bylaws or to adopt new Bylaws shall be vested in the Board of Directors, subject to repeal or change by action of the shareholders. The Board of Directors may make such alteration, amendment, or repeal by the affirmative vote of a majority of the directors present at any meeting at which a quorum is present, provided notice of the proposed alteration, amendment or repeal is contained in the notice of such meeting (or such notice shall have been waived).

SECRETARY'S CERTIFICATE

The undersigned Secretary of the Corporation hereby certifies that the foregoing Bylaws were adopted by the Board of Directors of the Corporation effective as of February 24, 2015.

BY: _____

Robert M. Kessler, Secretary

Date Signed: March 9, 2015

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B.2.a.(iv.) – CHL Amended and Restated Articles of Incorporation

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Amended and Restated Articles of Incorporation
Coventry Health and Life Insurance Company

Article I

The name of the life insurance corporation shall be Coventry Health and Life Insurance Company

Article II

The statutory home office address is 1285 Fern Ridge Parkway, Suite 200, St. Louis, Missouri 63141. The executive offices of the Corporation are located at 15400 Calhoun Drive, Rockville, Maryland 20855.

Article III

Coventry Health and Life Insurance Company was originally incorporated in the State of Texas under the name American Service Life Insurance Company with a continuous date of incorporation of April 5, 1968, and continued to actively conduct its business in the State of Texas as domiciled insurance corporation until May 14, 1999 when Coventry Health and Life Insurance Company redomesticated to the State of Delaware to conduct business as a domiciled insurance corporation and continued to conduct business in the State of Delaware until the Shareholder and Board of Directors of the corporation approved a plan to redomesticate the Coventry Health and Life Insurance Company to the State of Missouri. Effective December 20, 2012, CHL was redomesticated to the State of Missouri.

Article IV

The corporation is authorized to issue only one class of capital stock, which shall be common stock. The total number of authorized shares is one thousand (1,000), and the par value of the each of such shares is $2,500; all of which have been subscribed and fully paid.

Article V

The existence of the Corporation shall be perpetual.

Article VI

The Corporation is formed for the following purposes: To make insurance upon the live of individuals and every assurance pertaining thereto or connected therewith; to grant, purchase, and dispose of annuities and endowments of every kind and description whatsoever; to provide for contracts of indemnity against death and for weekly and other periodic indemnities for disability occasioned by accident or sickness to the person of the insured, and such accident and health insurance shall be mad a separate department of the business of the Corporation; and to do such other things as may be permitted a corporation of this kind by law, and not prohibited by the Revised Statues of Missouri, Sections 375.908, 376.010 to 376.120, both inclusive, as amended.

In order to carry out the purposes for which it is organized, the Corporation shall have the following rights and powers to the extent not inconsistent with nor prohibited by the provisions of law applicable to life insurance companies or applicable to all insurance companies:

(a) to sue and be sued, complain and defend in any court of law or equity;

(b) to have a corporate seal which may be altered at the pleasure of the Corporation and to use the such seal by causing it or a facsimile thereof to be impressed or affixed or any manner reproduced;

(c) to purchase, hold or convey such real estate as the purposes of the Corporation shall require, and to take, hold or convey other property, real, personal or mixed, as shall be necessary in the transaction of its business, all to the extent permitted by law and more particularly as provided by Sections 375.320, 375.330, and 375.340, Revised Statues of Missouri, as amended;

(d) to sell, convey, mortgage, loan, pledge or otherwise dispose of and otherwise use and deal in and with shares, or the interests in or obligations of other domestic and foreign corporations, associations, partnerships, or individuals, all to the extent permitted by law to life, health and accident insurance companies;

(e) to see, lease, exchange or otherwise dispose of, all or substantially all, of the property and assets of the Corporation, with or without the goodwill of the Corporation, upon such terms and conditions and for such consideration as may consist in whole or in part, of money or property, real or personal, including shares of any other domestic or foreign corporation, subject to all the provisions of the law applicable to such transfer with respect to manufacturing and business corporations, and subject also to any and all provisions of law applicable to all insurance companies;

(f) to make contracts and incur liabilities which may be appropriate to enable it to accomplish any or all of its purposes, to issue its notes, bonds and other obligations; to secure any of its obligations by mortgage, deed of trust, or pledge of any or all of its property, franchises, or income; to issue notes or bonds secured or unsecured, which by their terms are convertible to shares of stock of any class upon such terms and conditions and at such rates of prices as may be therein provided; to enter into contracts of reinsurance, either as reinsurer or otherwise, pertaining to life, health and accident insurance to the extent permitted by law to a corporation of this kind;

(g) to invest its capital, reserve, and surplus funds of whatever kind or character from time to time and to lend money for its corporation purposes, and to take and hold real and personal property as security for the payment of funds so invested or loaned, all to the extent that such investments and loans may be permitted by the provisions of law applicable to life, health and accident insurance companies or applicable to all insurance companies;

(h) to elect or appoint officers and agents of the Corporations; to enter into agency contacts and to define their duties and fix their compensation – the officers of the Corporation shall be a President, one or more Vice Presidents, Secretary, Assistant Secretary, Treasurer and such other officers as the Board of Directors may deem necessary;

(i) to make and alter bylaws not inconsistent with the Articles of Incorporation or with the laws of this State for the administration and regulations of the affairs of the Corporation;

(j) to terminate its corporate activities and to surrender its corporate franchise;

(k) to make contributions to corporations or other organizations formed for civic, charitable or benevolent purposes or to any incorporated or unincorporated association, United Fund or community funds not operated or used for profit to its members, but operated for the purposes of raising funds for and of distributing funds to other civic, charitable or benevolent organizations or agencies; and

(l) to have and exercise all of the powers necessary or convenient to effect or accomplish any or all of the purposes for which the corporation was formed; to exercise all powers, now or hereafter permitted by law to a corporation of this character, and prohibited by Sections 376.010 to 376.890, inclusive, Revised Statutes of Missouri, as amended.

Article VII

The corporation is authorized to issue only one class of capital stock, which shall be common stock. The total number of authorized shares is 1,000, and par value of each of such shares is $2,500.00; all of which have been subscribed and fully paid.

Article VIII

The property and business of the corporation shall be managed and controlled by the Board of Directors, which shall consist of not less than nine (9) or more than twenty-one (21) persons who shall be elected at each annual meeting of the shareholders. Vacancies on the Board of Directors may be filled by a majority vote of the remaining Directors. The Board of Directors may repeal or amend the By-laws, but such By-laws shall not be inconsistent with these Articles of Incorporation nor with the laws of the State of Missouri. Meetings of the Board of Directors may be held within or without the State as the Board of Directors may decide. Five (5) members of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the board of Directors, provided that if less than (5) members are present at said meeting, a majority of the Directors present may adjourn the meeting from time to time without further notice.

Article IX

Amended and Restated of the Articles of Incorporation and plan of redomestication were adopted by the unanimous written resolution of the Sole Shareholder and the Board of Directors of the Corporation who are entitled to vote if such a formal meeting of the Sole Shareholder and Board of Directors were held for such purpose.

B.2.a.(iv.) – CHL Amended and Restated Bylaws

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AMENDED AND RESTATED BYLAWS
OF
COVENTRY HEALTH AND LIFE INSURANCE COMPANY
(a Missouri Corporation)

ARTICLE I
OFFICES

SECTION 1. PRINCIPAL OFFICE. The principal office of the Corporation in the State of Missouri shall be located in the city of St. Louis. The Corporation may have such other offices, either within or without the State of Missouri, as the business of the Corporation may require from time to time.

SECTION 2. REGISTERED OFFICES. The registered office of the Corporation required by the Applicable Law of the Corporation's state of incorporation ("**Applicable Law**"), to be maintained in such state, may, but not need be, identical with the principal office of the Corporation. The Corporation shall maintain such other registered offices as the laws of such other jurisdictions as the property or assets of the Corporation may, from time to time, require. The address of the registered office may be changed from time to time by the Board of Directors or the registered agent of the Corporation in accordance with the Applicable Law.

ARTICLE II
SHAREHOLDERS

SECTION 1. ANNUAL MEETING. Annual meetings of shareholders shall be held at such date and time as shall be designated from time to time by the board of directors and state in the notice of the meeting, at which they shall elect, by a plurality vote, a board of directors and transact such other business as may properly be brought before the meeting.

SECTION 2. SPECIAL MEETINGS. Special meetings of the shareholders may be called either by the President, by the Board of Directors, or by the holders of not less than one-fifth (1/5th) of the outstanding shares entitled to vote on the matter for which the meeting is called.

SECTION 3. PLACE OF MEETING. Meetings of shareholders may be held at such place, either within or without the state of incorporation, as may be designated in the notice for any annual or for any special meeting. If no designation is made, or if a special meeting be otherwise called, the place of meeting shall be the principal offices of the Corporation.

SECTION 4. NOTICE OF MEETINGS. Written notice stating the place, date, and hour of the meeting, and in the case of a special meeting, the purpose or purposes for which the meeting is called, shall be delivered not less than ten (10), and not more than sixty (60) days before the date of the meeting, or in the case of a meeting at which is to be considered a merger, consolidation, share exchange, dissolution or sale, lease or exchange of assets, not less than twenty (20), and not more than sixty (60) days before the date of the meeting, either personally or by mail, by or at the direction of the President, or the Secretary, or the officer or persons calling the meeting, to each shareholder of record entitled to vote at such meeting. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, addressed to the shareholder at his address as it appears on the records of the Corporation, with postage thereon prepaid. When a meeting is adjourned to another time or place, notice need not be given of the adjourned meeting if the time and place thereof are announced at the meeting at which the adjournment is taken.

SECTION 5. FIXING OF RECORD DATE. For the purpose of determining the shareholders entitled to notice of, or to vote at, any meeting of shareholders or any adjournment thereof, or to express consent to corporate action in writing without a meeting, or to receive payment of any dividend, or other distribution or allotment of any rights, or to exercise any rights in respect of any change, conversion or exchange of shares or for the purpose of any other lawful action, the Board of Directors of the Corporation may fix in advance a record date which shall not be more than sixty (60) days and, for a meeting of shareholders, not less than ten (10) days, or in the case of a meeting at which is to be considered a merger, consolidation, share exchange, dissolution or sale, lease or exchange of assets, not less than twenty (20) days, before the date of such meeting. If no record date is fixed, the record date for the determination of shareholders entitled to notice of, or to vote at, a meeting of shareholders shall be on the date which notice of the meeting is mailed, and the record date for the determination of shareholders for any other purpose shall be the date on which the Board of Directors adopts the resolution relating thereto. A determination of shareholders of record entitled to notice of, or to vote at, a meeting of shareholders shall apply to any adjournment of the meeting.

SECTION 6. VOTING LISTS. The officer or agent having charge of the transfer books for shares of the Corporation shall make, within twenty (20) days after the record date for a meeting of shareholders, but, in no event, less than ten (10) days before such meeting of shareholders, a complete list of the shareholders entitled to vote at such meeting, arranged in alphabetical order, showing the address of and the number of shares registered in the name of each shareholder, which list, for a period of ten (10) days prior to such meeting, shall be kept on file at the registered office of the Corporation and shall be open to inspection by any shareholder for any purpose germane to the meeting, and to copying at the shareholder's expense, at any time during usual business hours. Such list shall also be produced and kept open at the time and place of the meeting and may be inspected by any shareholders during the whole time of the meeting. The original share ledger or transfer book, or duplicate thereof kept in this State, shall be evidence as to the shareholders entitled to examine such list or share ledger, or transfer book or to vote at any meeting of shareholders.

SECTION 7. QUORUM. The shareholders of a majority of the outstanding shares of the Corporation, present in person or represented by proxy, shall constitute a quorum at any meeting of the shareholders; provided, that if less than a majority of the outstanding shares are represented at said meeting, a majority of the shares so represented may adjourn the meeting at any time without further notice. If a quorum is present, the affirmative vote of the majority of the shares represented at the meeting shall be the act of the shareholders, unless the vote of a greater number or voting by classes is required by the Applicable Law, the Articles of Incorporation of the Corporation or these Bylaws. At any adjourned meeting at which a quorum shall be present, any business may be transacted which might have been transacted at the original meeting. Withdrawal of shareholders from any meeting shall not cause failure of a duly constituted quorum at that meeting.

SECTION 8. PROXIES. Each shareholder entitled to vote at a meeting of shareholders or to express consent or dissent to corporate action in writing, without a meeting, may authorize another person or persons to act for him by proxy, but no such proxy shall be valid after eleven (11) months from the date of its execution, unless otherwise provided in the proxy.

SECTION 9. VOTING OF SHARES. Each outstanding share, regardless of class, shall be entitled to one vote upon each matter submitted to vote at a meeting of shareholders.

SECTION 10. VOTING OF SHARES BY CERTAIN HOLDERS. Shares standing in the name of another corporation, domestic or foreign, may be voted by such officer, agent or proxy as the Bylaws of such corporation may prescribe, or in the absence of such provision, as the Board of Directors of such corporation may determine.

Shares standing in the name of a deceased person, a minor ward, or an incompetent person, may be voted by his administrator, executor, court appointed guardian or conservator, either in person or by proxy without a transfer of such shares into the name of such administrator, executor, court appointed guardian or conservator. Shares standing in the name of a trustee may be voted by him, either in person or by proxy.

A shareholder whose shares are pledged shall be entitled to vote such shares until the shares have been transferred into the name of the pledgee, and thereafter the pledgee shall be entitled to vote the shares so transferred.

Any number of shareholders may create a voting trust for the purpose of conferring upon a trustee or trustees the right to vote or otherwise represent their shares, for a period not to exceed ten (10) years, by entering into a written voting trust agreement specifying the terms and conditions of the voting trust, and transferring their shares to such trustee or trustees for the purpose of the agreement. Any such voting trust agreement shall not become effective until a counterpart of the agreement is deposited with the Corporation at its registered office. The counterpart of the voting trust agreement so deposited with the Corporation shall be subject to the same right of examination by a shareholder of the Corporation, in person or by agent or attorney, as are the books and records of the Corporation, and shall be subject to examination by any holder of a beneficial interest in the voting trust, either in person or by agent or attorney, at any reasonable time for any proper purpose.

Shares of its own stock belonging to this Corporation shall not be voted, directly or indirectly, at any meeting and shall not be counted in determining the total number of outstanding shares at any given time, but shares of its own stock held by it in a fiduciary capacity may be voted and shall be counted in determining the total number of outstanding shares at any given time.

SECTION 11. INSPECTORS. At any meeting of the shareholders, the presiding officer may, or upon the request of any shareholder, appoint one or more persons as inspector(s) for such meeting.

Such inspector(s) shall (a) ascertain and report the number of shares represented at the meeting, based upon their determination of the validity and effect of proxies; (b) count all votes and report the results; and (c) do such other acts, as are proper to conduct the election and voting with impartiality and fairness to all the shareholders.

Each report of an inspector shall be in writing and signed by him or a majority of them if there be more than one inspector acting at such meeting. If there is more than one inspector, the report of a majority shall be the report of the inspectors. The report of the inspector or inspectors on the number of shares represented at the meeting and the results of the voting shall be prima facie evidence thereof.

SECTION 12. VOTING BY BALLOT. Voting at any meeting on any question or in any election may be by voice unless the presiding officer shall order, or any shareholder shall demand, that voting be by ballot.

SECTION 13. CUMULATIVE VOTING. In all elections for directors, every shareholder shall have the right to vote, in person or by proxy, the number of shares owned by him, for as many persons as there are directors to be elected, or to cumulate said shares, and give one candidate as many votes as the number of directors multiplied by the number of his shares shall equal, or to distribute them on the same principle among as many candidates as he shall see fit.

SECTION 14. INFORMAL ACTION BY SHAREHOLDERS. Any action required under Applicable Law to be taken at a meeting of the shareholders, or any other action which may be taken at a meeting of the shareholders, may be taken without a meeting, if a consent in writing, setting forth the action so taken, shall be signed by the holders of outstanding shares having not less than the minimum number of votes which would be necessary to authorize or take such action at a meeting at which all shares entitled to vote thereon were present and voting so long as any notice required under Applicable Law is given to those shareholders not so consenting, but who are entitled under Applicable Law to notice of the action taken.

ARTICLE III
DIRECTORS

SECTION 1. GENERAL POWERS. The business of the Corporation shall be managed by or under the direction of its Board of Directors.

SECTION 2. NUMBER, TENURE AND QUALIFICATIONS. The Board of Directors shall consist of not less than nine (9) members and not more than eleven (11) members. Within the limit of the above specified, the number of directors shall be determined from time to time by resolution of the shareholders. Each director shall hold office until the next annual meeting of shareholders or until his or her successor shall have been elected and qualified. Directors need not be residents of the State of Missouri or shareholders of the Corporation. The number of directors may be increased or decreased, from time to time, by amendment of this Section, but no decrease shall have the effect of shortening the term of any incumbent director.

SECTION 3. REMOVAL; VACANCIES. Any director may be removed with, or if not prohibited by Applicable Law, without cause, at any meeting of the shareholders, by the affirmative vote of the holders of a majority of the shares of stock of the Corporation then entitled to vote at an election of directors; provided, however, that no director shall be removed at a meeting of shareholders unless the notice of such meeting shall state that a purpose of the meeting is to vote upon the removal of one or more directors named in the notice, and only the named director or directors may be removed at such meeting. A vacancy in the Board of Directors caused by such removal may be filled by the shareholders at such meeting.

Any other vacancy in the Board of Directors occurring for any reason whatsoever, except for a vacancy created by removal of a director, may be filled for the unexpired term by the Board of Directors.

SECTION 4. ANNUAL MEETINGS; OTHER REGULAR MEETINGS. An annual meeting of the Board of Directors shall be held without other notice than this bylaw, immediately after the annual meeting of shareholders. The Board of Directors may provide by resolution, the time and place for the holding of other regularly scheduled meetings of the Board of Directors without other notice except such resolution.

SECTION 5. SPECIAL MEETINGS. Special meetings of the Board of Directors may be called by or at the request of the President or any director. The President shall fix the place for holding any special meeting of the Board of Directors. Written notice of any special meeting shall be given not less than two (2) days prior to the meeting if the meeting is called by the President and not less than five (5) days prior to the meeting if the meeting is otherwise called and delivered to each director at the address for him or her set forth on the records of the Corporation. If mailed, such notice shall be deemed delivered on the second day after being deposited in the United States mail so addressed, with postage thereon prepaid. If notice is given by telegram, such notice shall be deemed to be delivered on the day of the delivery shown by the telegraph company. If notice is delivered by courier service, such notice shall be deemed to be delivered on the day delivery is shown by such courier. Unless an alternate address for notice is given by a director to the

President, notice delivered in accordance with this paragraph shall be effective whether or not the director to whom notice is addressed actually receives such notice, notwithstanding the knowledge of the sender that the addressee was not, for any reason, available at the address provided for notice under this Section. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, unless a director attends such meeting for the sole express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. Neither the business to be transacted at nor the purpose of any annual or special meeting of the Board of Directors need be specific in the notice or waiver of notice of such meeting.

SECTION 6. QUORUM. A majority of the number of directors fixed by these Bylaws shall constitute a quorum for transaction of business at any meeting, whether annual or special, of the Board of Directors; provided, that if less than such number of directors are present at said meeting, a majority of the directors present may adjourn the meeting at any time without further notice.

SECTION 7. MANNER OF ACTING. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, unless the act of a greater number is required by statute, these Bylaws, or the Articles of Incorporation of the Corporation.

The Chairman of the meeting of the Board of Directors shall have a vote on any matter to come before such meeting, notwithstanding any contrary rule which might otherwise require that the Chairman of the meeting vote only in case of a tie vote.

SECTION 8. ACTION WITHOUT A MEETING. Any action required to be taken at a meeting of the Board of Directors or a committee thereof, or any other action which may be taken at a meeting of the Board, may be taken without a meeting if a consent in writing, setting forth the action so taken, shall be signed by all directors entitled to vote with respect to the subject matter thereof or by all the members of such committee, as the case may be. Any such consent signed by all the directors or all the members of the committee shall have the same effect as a unanimous vote and may be stated as such in any document filed with any person, private entity or public agency. Regardless of any personal interest in any matter being consented to, any director may consent to such matter, so long as he has disclosed his personal interest on such matter in accordance with Applicable Law.

SECTION 9. COMPENSATION. The Board of Directors, by the affirmative vote of a majority of directors then in office, and irrespective of any personal interest of any of its members, shall have authority to establish reasonable compensation of all directors for services to the Corporation as directors, officers or otherwise and reimbursement of their costs and expenses, if any, of attendance at each meeting of the Board. No such payment mentioned in these Bylaws shall preclude any director from serving the Corporation in any other capacity and receiving compensation therefor.

SECTION 10. PRESUMPTION OF ASSENT. A director of the Corporation who is present at a meeting of the Board of Directors at which action on any corporate matter is taken shall be conclusively presumed to have assented to the action taken, unless his dissent shall be entered in the minutes of the meeting or unless he shall file his written dissent to such action with the person acting as the Secretary of the meeting before the adjournment thereof, or shall forward such dissent by certified or registered mail to the Secretary of the Corporation immediately after the adjournment of the meeting. The right to dissent as to any action shall not accrue to any director who voted in favor of such action.

SECTION 11. COMMITTEES. The Board of Directors may designate such committees as the Board of Directors deems appropriate and appoint the members thereof. Each committee shall have two or more members. Service on such committees shall be at the pleasure of the Board of Directors, which may by a majority vote taken in accordance with these Bylaws, increase or decrease committee membership, remove a committee member and appoint members to fill vacancies in a committee. Each committee shall keep regular minutes of its proceedings and report the same to the Board of Directors when required. To the extent specified by the Board of Directors, each committee may exercise the powers of the Board of Directors; provided, however, that a committee may not take any action which a committee of the Board of Directors is prohibited from taking under Applicable Law.

In addition to the authority vested in the Board of Directors pursuant to this Section, the board may designate an executive committee consisting of two or more directors, which committee, to the extent provided by the board and otherwise permitted by law, shall have and exercise all of the authority of the Board of Directors in the management of the Corporation, such committee to keep minutes of its proceedings and report the same to the Board when required.

Nothing in this Section shall be construed as precluding the Board of Directors or officers from appointing such other committees, whether or not including board members, as they deem necessary and proper to aid in the management and operation of the Corporation's business.

ARTICLE IV
OFFICERS

SECTION 1. OFFICERS. The officers of the Corporation shall be a President and Secretary, and may also include a Treasurer, and such Vice President or Vice Presidents, Assistant Secretary or Assistant Secretaries, and Assistant Treasurer or Assistant Treasurers as may be elected by the Board of Directors. Any two or more offices may be held by the same person if permitted by Applicable Law.

SECTION 2. ELECTION AND TERM OF OFFICE. The officers of the Corporation shall be elected annually by the Board of Directors at the annual meeting of the Board of Directors held after each annual meeting of shareholders. If the election of officers shall not be held at such meeting, such election shall be held as soon thereafter as may be convenient. Vacancies may be filled or new offices may be created and filled at any meeting of the Board of Directors. Each officer shall hold office until his successor shall have been duly elected and qualified, or until his death or other inability to serve, or until he shall resign or shall have been removed from office in the manner hereinafter provided. Election of an officer shall not in itself be deemed in any manner to vest any express or implied contract right or any other right to continuing employment in such offices.

SECTION 3. REMOVAL; VACANCIES. Any officer elected or appointed by the Board of Directors may be removed by the Board of Directors, with or, if not prohibited by Applicable Law, without cause, whenever in its judgment, the best interests of the Corporation would be served thereby, but such removal shall be without prejudice to express contract rights, if any, held by the person so removed.

A vacancy in any office occurring for any reason including, without limitation, removal of an officer and the creation of any new office, may be filled for the unexpired portion of the term by the Board of Directors.

SECTION 4. PRESIDENT. The President shall be the Chief Executive Officer of the Corporation. The President shall preside at all meetings of the shareholders and of the Board of Directors, shall perform such other duties as are usually performed by a Chief Executive Officer and shall exercise such other powers and perform such other duties as the Board of Directors may from time to time assign him or as may be prescribed by these Bylaws. Except in those instances in which the authority to execute is expressly delegated to another officer or agent of the Corporation, or a different mode of execution is expressly prescribed by the Board of Directors or these Bylaws, he may execute, for the Corporation, certificates for its shares, and any contracts, deeds, mortgages, bonds or other instruments which the Board of Directors have authorized to be executed, and he may accomplish such execution, either under or without the seal of the Corporation, or either individually or with the Secretary, any Assistant Secretary or any other officer so authorized by the Board of Directors, according to the requirements of the form of the instrument to be executed. He may vote all securities which the Corporation is entitled to vote, except as and to the extent such authority shall be vested in a different officer or agent of the Corporation by the Board of Directors.

SECTION 5. THE VICE PRESIDENTS. The Vice President (or in the event there be more than one Vice President, each of the Vice Presidents), if any, shall assist the President in the discharge of his duties as the Vice Presidents may be directed by the President or the Board of Directors and shall perform other such duties, as from time to time, may be assigned to him by the President or the Board of Directors. Anything herein to the contrary notwithstanding, the Board of Directors may designate a Vice President with such functional or hierarchical designations as the Board of Directors may determine, and otherwise delegate such duties to a President or to the person serving in any such office as the Board of Directors determines. In the absence of the President or in the event of his inability to act, the Vice President (or in the event there be more than one Vice President, the Vice Presidents in the order designated by these Bylaws, or otherwise by the President if the Board of Directors has not made such a designation, or in the absence of any designation, then in the order of seniority of tenure as Vice President) shall perform and discharge the duties of the President and when so acting, shall have all the powers of and be subject to all of the restrictions imposed upon the President. Each Vice President may execute on behalf of the Corporation certificates for its shares and any contracts, deeds, mortgages, bonds or other instruments to the extent authorized or permitted by action of the Board of Directors or authorized by the President under a grant of authority by the Board of Directors, and may accomplish such execution either under or without the seal of the Corporation, and either individually or with the Secretary, any Assistant Secretary or any other officer thereunto authorized by the Board of Directors, according to the requirements of the form of the instrument to be executed.

SECTION 6. SECRETARY. The Secretary shall: (a) record the minutes of the shareholders' and of the Board of Directors' meetings in one or more books provided for that purpose; (b) see that all notices are duly given in accordance with the provisions of these Bylaws or as required by law; (c) be custodian of the corporate records and of the seal of the Corporation; (d) keep a register of the post office addresses of each shareholder, which shall be furnished to the Secretary by such shareholder; (e) sign with the President, or a Vice President, or any other officer thereunto authorized by the Board of Directors, certificates for shares of the Corporation, the issue of which shall have been authorized by the Board of Directors, and any contracts, deeds, mortgages, bonds or other instruments which the Board of Directors have authorized to be executed, according to the requirements of the form of the instrument, except when a different mode of execution is expressly prescribed by the Board of Directors or these Bylaws; (f) have general charge of the stock transfer books and records of the Corporation; (g) have authority to certify the Bylaws, resolutions of the shareholders and Board of Directors and committees thereof, and other documents of the Corporation as true and correct copies thereof, and (h) perform all duties incident to the office of Secretary and such other duties as from time to time as may be assigned to him by the President, or Vice President or any other officer thereunto authorized by the Board of Directors.

SECTION 7. THE TREASURER. The Treasurer, if any, shall be the principal accounting and financial officer of the Corporation. The Treasurer shall: (a) have charge of and be responsible for the maintenance of adequate books of accounts and records for the Corporation; (b) have charge and custody of all funds and securities of the Corporation, and be responsible for the receipt and disbursement thereof, and (c) perform all the duties incident to the office of Treasurer and such other duties from time to time as may be assigned to him by the President or by the Board of Directors. If required by the Board of Directors, the Treasurer shall give a bond for faithful discharge of his duties in such a sum and with such surety or sureties as the Board of Directors may determine.

SECTION 8. ASSISTANT TREASURERS AND ASSISTANT SECRETARIES. The Assistant Treasurers and Assistant Secretaries, if any, shall be elected, shall perform such duties as assigned to them by the Treasurer or Secretary, respectively, or by the President, or a Vice President or any other officer thereunto authorized by the Board of Directors. The Assistant Secretaries may sign with the President, or a Vice President, or any other officer thereunto authorized by the Board of Directors, certificates for shares of the Corporation, the issue of which shall have been authorized by the Board of Directors, and any contracts, deeds, mortgages, bonds or other instruments which the Board of Directors have authorized to be executed, according to the requirements of the form of the instrument, except when a different mode of execution is expressly prescribed by the Board of Directors or these Bylaws. The Assistant Treasurers shall, if required by the Board of Directors, give bonds for the faithful discharge of their duties in such sums and with such sureties as the Board of Directors shall determine.

SECTION 9. SALARIES. The salaries of the officers shall be fixed from time to time by the Board of Directors and no officer shall be prevented from receiving such salary by reason of the fact that he is also a director of the Corporation.

SECTION 10. OPERATING EMPLOYEES. The Board of Directors may designate or by resolution, permit the President to designate operating employees to employ such titles in undertaking their duties as is deemed necessary and proper without the power and authority to take actions other than are encompassed by the employee's employment duties.

ARTICLE V
CONTRACTS, LOANS, CHECKS AND DEPOSITS

SECTION 1. CONTRACTS. The Board of Directors may authorize any officer or officers, agent or agents, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the Corporation, and such authority may be general or confined to specific instances.

SECTION 2. LOANS. No loans shall be contracted on behalf of the Corporation and no evidences of indebtedness shall be issued in its name, unless authorized by a resolution of the Board of Directors. Such authority may be general or confined to specific instances.

SECTION 3. CHECKS, DRAFTS, ETC. All checks, drafts or any other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Corporation, shall be signed by such officer or officers, or agent or agents, of the Corporation and in such manner as shall from time to time be determined by resolution of the Board of Directors.

SECTION 4. DEPOSITS. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depositories as the Board of Directors may select.

ARTICLE VI
CERTIFICATE FOR SHARES AND THEIR TRANSFER

SECTION 1. CERTIFICATES FOR SHARES. Certificates representing shares of the Corporation shall be signed by the President or a Vice President or by such other officer as shall be designated by resolution of the Board of Directors, and by the Secretary or any Assistant Secretary, and may be sealed with the seal or a facsimile of the seal of the Corporation. If both of the signatures of the officers be by facsimile, the certificate shall be executed by or on behalf of a duly authorized transfer agent or clerk. Each certificate representing shares shall be consecutively numbered or otherwise identified, and shall also state the name of the person to whom issued, the number and class of shares (with designation of series, if any), the date of issuance, and the par value or a statement that the shares are without par value. If the Corporation is authorized and issues any shares of more than one class or of any series within class, the certificate shall contain such information or as may be required by Applicable Law.

The name and address of each shareholder, the number and class of shares held and the date on which the certificates for the shares were issued, shall be entered on the books and records of the Corporation.

No certificate shall be issued for any share until such share is fully paid.

SECTION 2. LOST CERTIFICATES. If a certificate representing shares has allegedly been lost or destroyed, the Board of Directors may, in their sole discretion, except as may be required by law, direct that a new certificate be issued upon such indemnification and other reasonable requirements as it may impose.

SECTION 3. TRANSFER OF SHARES. Transfers of shares of the Corporation shall be recorded on the books and records of the Corporation and, except in the case of a lost or destroyed certificate, on surrender for cancellation of the certificate for such shares. A certificate presented for transfer must be duly endorsed and accompanied by proper guaranty of signature and other appropriate assurances that the endorsement is effective.

ARTICLE VII
FISCAL YEAR

The fiscal year if the Corporation shall begin on the first day of January each year, and shall end of the last day of December of each year.

ARTICLE VIII
DIVIDENDS

The Board of Directors may, from time to time, declare, and the Corporation may pay, dividends on its outstanding shares in cash, property or its own shares or dividends on its treasury shares in its own shares, in the manner and upon the terms and conditions provided by law and the Articles of Incorporation of the Corporation.

ARTICLE IX
TELEPHONIC MEETINGS

Any meeting of shareholders, Directors or a committee of the Board of Directors may be conducted by means of voice communication equipment, whereby all persons participating in the meeting, whether in person or from a remote location, are in oral and aural communication. Participation in a meeting by means of such equipment shall constitute presence in person at such meeting.

ARTICLE X
SEAL

The Board of Directors may provide for a corporate seal which shall have inscribed thereon the name of the Corporation.

ARTICLE XI
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of these Bylaws, or under the provisions of the Articles of Incorporation of the Corporation or under Applicable Law, a waiver thereof in writing, signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XII
INDEMNIFICATION

Unless the Board of Directors establishes a different basis for indemnification for any or all of the below described indemnities, each person who at any time is or shall have been a director, officer, employee or agent of the Corporation, or is or shall have been serving at the request of the Corporation as a director, officer, employee, partner or agent of another corporation, partnership, joint venture, trust or other enterprise, shall be indemnified by the Corporation in accordance with and to the fullest extent permitted by Applicable Law as in effect at the time of adoption of these Bylaws; provided, however, that indemnity shall not be extended as to any expense incurred by an indemnity based upon or attributable to such indemnities' dishonesty, personal profit or personal advantage to which he was not legally entitled. The phrase "at the request of the Corporation" refers, without limitation, to any formal or informal election, appointment, request, requirement, deputation, delegation or devolution of or by the Corporation, by action of its Board of Directors, officers or shareholders, to serve in any office or position, or to undertake any act or duty, and shall also include any capacity or duty imposed or implied at law or arising under any charter instrument of the Corporation or any other entity. The foregoing right of indemnification shall not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under by any bylaw, agreement, vote of shareholders or vote of disinterested directors. The Corporation may purchase and maintain insurance on behalf of any person to the fullest extent permitted under Applicable Law as in effect at the time of the adoption of these Bylaws or as amended from time to time.

Notwithstanding any provision in this Article XII to the contrary, in the event the Applicable Law is either amended to provide, or interpreted by judicial or other binding legal decisions to provide, broader indemnification rights than those contained herein, such broader indemnification rights shall be.

ARTICLE XIII
AMENDMENTS

Unless otherwise provided in the Articles of Incorporation of the Corporation, these Bylaws may be altered, amended or repealed and new Bylaws, not inconsistent with the Articles of Incorporation of the Corporation or the Applicable Law (except in the case of emergency Bylaws adopted under the Applicable Law), may be adopted at any properly constituted meeting of the Board of Directors by a majority vote of the directors present at the meeting, except that in the case of a matter which requires greater than a majority vote of the directors, any amendment with respect to such matter must be approved by a vote of directors equal to or greater than the number of votes required under these Bylaws to effectuate the matter in question; provided, further, that no bylaw adopted by the shareholders may be altered, amended or repealed by the Board of Directors if the bylaw adopted by action of the shareholders so restricts such alteration, amendment or repeal.

Dated: May 1, 2019

B.2.a.(iv.) – Aetna Health Holdings, LLC Certificate of Formation

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Delaware

The First State

I, HARRIET SMITH WINDSOR, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "AETNA HEALTH HOLDINGS, LLC", FILED IN THIS OFFICE ON THE TWENTY-FIFTH DAY OF OCTOBER, A.D. 2002, AT 2:30 O'CLOCK P.M.

Harriet Smith Windsor

Harriet Smith Windsor, Secretary of State

3584086 8100

AUTHENTICATION: 2055338

020661022

DATE: 10-28-02

CERTIFICATE OF FORMATION

OF

AETNA HEALTH HOLDINGS, LLC

This Certificate of Formation of AETNA HEALTH HOLDINGS, LLC (the "LLC"), dated as of October 25, 2002, is being duly executed and filed by AETNA INC., as an authorized person, to form a limited liability company under the Delaware Limited Liability Company Act (6 Del.C. §18-101, et seq.).

FIRST. The name of the limited liability company formed hereby is AETNA HEALTH HOLDINGS, LLC.

SECOND. The address of the registered office of the LLC in the State of Delaware is 1209 Orange Street, Wilmington, New Castle County, Delaware 19801.

THIRD. The name and address of the registered agent for service of process on the LLC in the State of Delaware are The Corporation Trust Company, 1209 Orange Street, Wilmington, New Castle County, Delaware 19801.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation as of the date first above written.

AETNA INC.
Authorized Person

By: W J Casazza
Name: William J. Casazza
Title: Vice President and Corporate Secretary

STATE OF DELAWARE
SECRETARY OF STATE
DIVISION OF CORPORATIONS
FILED 02:30 PM 10/25/2002
020661022 – 3584086

B.2.a.(iv.) – Aetna Health Holdings, LLC Operating Agreement

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LIMITED LIABILITY COMPANY AGREEMENT

OF

AETNA HEALTH HOLDINGS, LLC

This Limited Liability Company Agreement (this "Agreement") of AETNA HEALTH HOLDINGS, LLC is entered into by AETNA INC., a Pennsylvania corporation, as the sole member (the "Member").

The Member, by execution of this Agreement, hereby forms a limited liability company pursuant to and in accordance with the Delaware Limited Liability Company Act (6 Del.C.§18-101, et seq.) as amended from time to time (the "Act"), and hereby agrees as follows:

1. **Name**. The name of the limited liability company formed hereby is AETNA HEALTH HOLDINGS, LLC (the "Company").

2. **Certificates**. The Member, as an authorized person, within the meaning of the Act, shall execute, deliver and file, or cause the execution, delivery and filing of, all certificates required or permitted by the Act to be filed in the Office of the Secretary of the State of Delaware.

3. **Purposes**. The Company is formed for the object and purpose of, and the nature of the business to be conducted and promoted by the Company is, engaging in any lawful act or activity for which limited liability companies may be formed under the Act.

4. **Powers**. In furtherance of its purposes, but subject to all of the provisions of this Agreement, the Company shall have the power and is hereby authorized to:

(a) Acquire by purchase, lease, contribution of property or otherwise, own hold, sell, convey, transfer or dispose of any real or personal property that may be necessary, convenient or incidental to the accomplishment of the purposes of the Company;

(b) Act as a trustee, executor, nominee, bailee, director, officer, agent or in some other fiduciary capacity for any person or entity and to exercise all of the powers, duties, rights and responsibilities associated therewith;

(c) Take any and all actions necessary, convenient or appropriate as trustee, executor, nominee, bailee, director, officer, agent or other fiduciary, including the granting or approval of waivers, consents or amendments of rights or powers relating thereto and the execution of appropriate documents to evidence such waivers, consents or amendments;

(d) Operate, purchase, maintain, finance, improve, own, sell, convey, assign, mortgage, lease or demolish or otherwise dispose of any real or personal property that may be necessary, convenient or incidental to the accomplishment of the purposes of the Company;

(e) Borrow money and issue evidences of indebtedness in furtherance of any or all of the purposes of the Company, and secure the same by mortgage, pledge or other lien on the assets of the Company;

(f) Invest any funds of the Company pending distribution or payment of the same pursuant to the provisions of this Agreement;

(g) Prepay, in whole or in part, refinance, recast, increase, modify or extend any indebtedness of the Company and, in connection therewith, execute any extensions, renewals or modifications of any mortgage or security agreement securing such indebtedness;

(h) Enter into, perform and carry out contracts of any kind, including, without limitation, contracts with any person or entity affiliated with the Member, necessary to, in connection with, convenient to, or incidental to the accomplishment of the purposes of the Company;

(i) Employ or otherwise engage employees, managers, contractors, advisors, attorneys and consultants and pay reasonable compensation for such services;

(j) Enter into partnerships, limited liability companies, trusts, associations, corporations or other ventures with other persons or entities in furtherance of the purposes of the Company; and

(k) Do such other things and engage in such other activities related to the foregoing as may be necessary, convenient or incidental to the conduct of the business of the Company, and have and exercise all of the powers and rights conferred upon limited liability companies formed pursuant to the Act.

5. **Principal Business Office**. The principal business office of the Company shall be located at such location as may hereafter be determined by the Member.

6. **Registered Office**. The address of the registered office of the Company in the State of Delaware is 1209 Orange Street, Wilmington, New Castle County, Delaware 19801.

7. **Registered Agent**. The name and address of the registered agent of the Company for service of process on the Company in the State of Delaware are The Corporation Trust Company, 1209 Orange Street, Wilmington, New Castle County, Delaware 19801.

8. **Member**. The name and the mailing address of the Member are as follows:

Name	Address
Aetna Inc.	151 Farmington Avenue Hartford, CT 06156

9. **Limited Liability**. Except as otherwise provided by the Act, the debts, obligations and liabilities of the Company, whether arising in contract, tort or otherwise, shall be solely the debts, obligations and liabilities of the Company, and the Member shall not be obligated personally for any such debt, obligation or liability of the Company solely by reason of being a member of the Company.

10. **Capital Contributions**. The Member is deemed admitted as the member of the Company upon its execution and delivery of this Agreement. The member has contributed $2,000, in cash, and no other property, to the Company.

11. **Additional Contributions**. The Member is not required to make any additional capital contribution to the Company. However, the Member may at any time make additional capital contributions to the Company.

12. **Allocation of Profits and Losses**. The Company's profits and losses shall be allocated solely to the Member.

13. **Distributions**. Distributions shall be made to the Member at the times and in the aggregate amounts determined by the Member. Notwithstanding any provision to the contrary contained in this Agreement, the Company shall not make a distribution to the Member on account of its interest in the Company if such a distribution would violate Section 18-607 of the Act or other applicable law.

14. **Management**. In accordance with Section 18-402 of the Act, management of the Company shall be vested in the Member. The Member shall have the power to do any and all acts necessary, convenient or incidental to or for the furtherance of the purposes described herein, including all powers, statutory or otherwise, possessed by members of a limited liability company under the laws of the State of Delaware. The Member has the authority to bind the Company. Notwithstanding any other provision of this Agreement, the Member or any person authorized by the Member, including without limitation any Officer (as hereinafter defined), is authorized to execute and deliver any document on behalf of the Company without any vote or consent of any other person.

15. **Officers**. The Member may, from time to time as it deems advisable, select natural persons who are employees or agents of the Company and designate them as officers of the Company (the "Officers") and assign titles (including, without limitation, President, Vice President, Secretary, and Treasurer) to any such person. Unless the Member decides otherwise, if the title is one commonly used for officers of a business corporation formed under the Delaware General Corporation Law, the assignment of such

title shall constitute the delegation to such person of the authorities and duties that are normally associated with that office. Any delegation pursuant to this Section 15 may be revoked at any time by the Member. An Officer may be removed with or without cause by the Member.

16. **Other Business.** The Member may engage in or possess an interest in other business ventures of every kind and description, independently or with others. The Company shall not have any rights in or to such independent ventures or the income or profits therefrom by virtue of this Agreement.

17. **Exculpation and Indemnification.** No member or Officer shall be liable to the Company or any other person or entity who has an interest in the Company for any loss, damage or claim incurred by reason of any act or omission performed or omitted by such member or Officer in good faith on behalf of the Company and in a manner reasonably believed to be within the scope of the authority conferred on such member or Officer by this Agreement, except that a member or Officer shall be liable for any such loss, damage or claim incurred by reason of such member's or Officer's willful misconduct. To the full extent permitted by applicable law, a member or Officer shall be entitled to indemnification from the Company for any loss, damage or claim incurred by such member or Officer by reason of any act or omission performed or omitted by such member or Officer in good faith on behalf of the Company and in a manner reasonably believed to be within the scope of the authority conferred on such member or Officer by this Agreement, except that no member or Officer shall be entitled to be indemnified in respect of any loss, damage or claim incurred by such member or Officer by reason of willful misconduct with respect to such acts or omissions; provided, however, that any indemnity under this Section 17 shall be provided out of and to the extent of Company assets only, and no member shall have personal liability on account thereof.

18. **Assignments.** The Member may at any time assign in whole or in part its limited liability company interest in the Company. If the Member transfers all of its interest in the Company pursuant to this Section 18, the transferee shall be admitted to the Company upon its execution of an instrument signifying its agreement to be bound by the terms and conditions of this Agreement. Such admission shall be deemed effective immediately prior to the transfer, and, immediately following such admission, the transferor Member shall cease to be a member of the Company. Notwithstanding anything to the contrary contained herein, the Member may merge with and into an other business entity (as defined in Section 18-209(a) of the Act). Upon such merger, the surviving entity automatically shall be admitted to the Company as a member of the Company, and the business of the Company shall continue without dissolution.

19. **Merger**. The Company may merge with, or consolidate into, another Delaware limited liability company or other business entity (as defined in Section 18-209(a) of the Act) upon the approval of the Member, without any further act, vote or approval of any other member of the Company. In accordance with Section 18-209 of the Act (including Section 18-209(f)), notwithstanding anything to the contrary contained in this Agreement, an agreement of merger or consolidation approved by the Member, may (i) effect any amendment of this Agreement or (ii) effect the adoption of a new limited

liability company agreement for the Company if the Company is the surviving or resulting limited liability company in the merger or consolidation. The provisions of this Section 19 shall not be construed to limit the accomplishment of a merger or consolidation or any of the matters referred to herein by any other means otherwise permitted by law.

20. **Resignation.** The Member may at any time resign from the Company. If the Member resigns pursuant to this Section 20, an additional member shall be admitted to the Company, subject to Section 21 hereof, upon its execution of an instrument signifying its agreement to be bound by the terms and conditions of this Agreement. Such admission shall be deemed effective immediately prior to the Member's resignation, and, immediately following such admission, the resigning Member shall cease to be a member of the Company.

21. **Admission of Additional Members.** One or more additional members of the Company may be admitted to the Company with the written consent of the Member.

22. **Dissolution.**

(a) The Company shall dissolve and its affairs shall be wound up upon the first to occur of the following: (i) the written consent of the Member, (ii) at any time there are no members of the Company unless, within 90 days of the occurrence of the event that terminated the continued membership of the last remaining member of the Company (the "Termination Event"), the personal representative of the last remaining member agrees in writing to continue the Company and to the admission to the Company of such personal representative or its nominee or designee as a member, effective as of the occurrence of the Termination Event, and such successor or its nominee or designee shall be admitted upon its execution of an instrument signifying its agreement to be bound by the terms and conditions of this Agreement, or (iii) the entry of a decree of judicial dissolution under Section 18-802 of the Act.

(b) The bankruptcy of the Member shall not cause the Member to cease to be a member of the Company and upon the occurrence of such an event, the business of the Company shall continue without dissolution.

(c) In the event of dissolution, the Company shall conduct only such activities as are necessary to wind up its affairs (including the sale of the assets of the Company in an orderly manner), and the assets of the Company shall be applied in the manner, and in the order of priority, set forth in Section 18-804 of the Act.

23. **Tax Characterization of Company.** So long as there is only one Member of the Company, the Company will be treated as a "disregarded entity" for applicable federal, state and local income tax purposes ("Tax Purposes"), and the Company will not elect to be treated as an association taxable as a corporation. Consequently, all items of income, gain, deduction, loss and credit for Tax Purposes shall be considered to be earned or incurred, as the case may be, directly by the sole Member, and all of the assets and liabilities of the Company shall, solely for Tax Purposes, be considered to be assets and liabilities of the sole Member. If an additional Member is ever admitted to the

Company, the Member shall amend this Agreement appropriately to reflect the Company's status as a partnership for Tax Purposes.

24. **Separability of Provisions.** Each provision of this Agreement shall be considered separable, and if for any reason any provision or provisions herein are determined to be invalid, unenforceable or illegal under any existing or future law, such invalidity, unenforceability or illegality shall not impair the operation of or affect those portions of this Agreement that are valid, enforceable and legal.

25. **Entire Agreement.** This Agreement constitutes the entire agreement of the Member with respect to the subject matter hereof.

26. **Governing Law.** This Agreement shall be governed by, and construed under, the laws of the State of Delaware (without regard to conflict of laws principles), all rights and remedies being governed by said laws.

27. **Amendments.** This Agreement may not be modified, altered, supplemented or amended except pursuant to a written agreement executed and delivered by the Member.

28. **Sole Benefit of Member.** The provisions of this Agreement (including Sections 11 and 12) are intended solely to benefit the Member and, to the fullest extent permitted by applicable law, shall not be construed as conferring any benefit upon any creditor of the Company (and no such creditor shall be a third-party beneficiary of this Agreement), and the Member shall have no duty or obligation to any creditor of the Company to make any contributions or payments to the Company.

IN WITNESS WHEREOF, the undersigned, intending to be legally bound hereby, has duly executed this Agreement as of the 25th day of October, 2002.

AETNA INC.

By: _____
Name: William J. Casazza
Title: Vice President and Corporate Secretary

B.2.a.(iv.) – Aetna Inc. Articles of Incorporation

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SECOND AMENDED AND RESTATED

ARTICLES OF INCORPORATION

OF

AETNA INC.
(A Pennsylvania Corporation)

1. **Name.** The name of the corporation is Aetna Inc. (the "Corporation").

2. **Registered Office.** The address of the Corporation's registered office in the Commonwealth of Pennsylvania is the Corporation's principal office at 1425 Union Meeting Road, Blue Bell, PA 19422 (which is located in Montgomery County).

3. **Incorporation.** The Corporation is incorporated under the provisions of the Pennsylvania Business Corporation Law of 1988, as amended (the "PA BCL").

4. **Purpose**. The purpose of the Corporation shall be to engage in any lawful act and activity for which corporations may be organized and incorporated under the PA BCL.

5. **Authorized Capital.**

5.1. **Authorized Shares.** The aggregate number of shares of stock that the Corporation shall have authority to issue is 100 Common Shares, par value $0.01 ("Common Stock").

5.2. **Common Stock.** The following is a statement of the designations, preferences, qualifications, limitations, restrictions and special or relative rights granted or imposed upon the shares of Common Stock of the Corporation:

5.2.1. **Dividends.** Holders of Common Stock shall be entitled to receive ratably such dividends (payable in cash, stock or otherwise) as may be declared by the board of directors of the Corporation (the "Board of Directors") on Common Stock out of funds legally available for the payment thereof.

5.2.2. **Distribution of Assets.** In the event of the voluntary or involuntary liquidation, dissolution or winding up of the Corporation, the holders of Common Stock will be entitled to receive pro rata all of the remaining assets of the Corporation.

5.2.3. **Voting Rights.** The holders of Common Stock shall have the general right to vote for all purposes, including the election of directors, as provided by law. Each holder of Common Stock shall be entitled to one vote for each share thereof held.

6. **Bylaws.** In furtherance and not in limitation of the powers conferred by law, the Board of Directors is authorized to adopt, amend or repeal the bylaws of the Corporation (the "Bylaws"), except as otherwise specifically provided therein, subject to the powers of the shareholders of the Corporation to amend or repeal any bylaws adopted by the Board of Directors.

7. **Number; Election of Directors.** The Board of Directors shall consist of at least one director, or such other number of directors as determined in accordance with the Bylaws of the Corporation. Unless and except to the extent that the Bylaws shall so require, the election of directors of the Corporation need not be by written ballot.

8. **Indemnification.**

8.1. **Indemnification.** The Corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action or proceeding, including without limitation actions by or in the right of the Corporation, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was a director or officer of the Corporation, or is or was serving while a director or officer of the Corporation at the request of the Corporation as a director, officer, employee, agent, fiduciary or other representative of another corporation (for profit or not-for-profit), limited liability company, partnership, joint venture, trust, employee benefit plan or other enterprise, against all liabilities, expenses (including without limitation attorneys' fees), judgments, fines, excise taxes and amounts paid in settlement in connection with such action or proceeding unless the act or failure to act by such person giving rise to the claim for indemnification is determined by a court to have constituted willful misconduct or recklessness. The Corporation shall have the power to indemnify employees and agents of the Corporation on the same basis as provided above in this Article 8.1, and to advance expenses to employees and agents on the same basis as provided in Article 8.2, as the Board of Directors may from time to time determine or authorize.

8.2. **Advancement of Expenses.** Expenses (including without limitation attorneys' fees) incurred by any person who was or is an officer or director of the Corporation in defending any action or proceeding referred to in Article 8.1 shall automatically be paid by the Corporation, without the need for action by the Board of Directors, in advance of the final disposition of the action or proceeding upon receipt of an undertaking by or on behalf of such person to repay such amount if it shall ultimately be determined that such person is not entitled to be indemnified by the Corporation.

8.3. **Exception.** Notwithstanding anything in this Article 8 to the contrary, the Corporation shall not be obligated to indemnify any person under Article 8.1 or advance expenses under Article 8.2 with respect to proceedings, claims or actions commenced by such person, other than mandatory counterclaims and affirmative defenses.

8.4. **Interpretation.** The indemnification and advancement of expenses provided by or pursuant to this Article 8 shall not be deemed exclusive of any other rights to which any person seeking indemnification or advancement of expenses may be entitled under any insurance policy, agreement, vote of shareholders or directors, or otherwise, both as to

actions in such person's official capacity and as to actions in another capacity while holding an office, and shall continue as to a person who has ceased to be a director or officer and shall inure to the benefit of the heirs, executors and administrators of such person. If the PA BCL is amended to permit a Pennsylvania corporation to provide greater rights to indemnification and advancement of expenses for its directors and officers than the express terms of this Article 8, this Article 8 shall be construed to provide for such greater rights.

8.5. **Contract.** The duties of the Corporation to indemnify and to advance expenses to a director or officer as provided in this Article 8 shall be in the nature of a contract between the Corporation and each such person, and no amendment or repeal of any provision of this Article 8 shall alter, to the detriment of such person, the right of such person to the advancement of expenses or indemnification related to a claim based on an act or failure to act that took place prior to such amendment or repeal or the termination of the service of the person as a director or officer, whichever is earlier.

9. **Limitation of Directors' Liability.** No person who is or was a director of the Corporation shall be personally liable, as such, for monetary damages (other than under criminal statutes and under federal, state and local laws imposing liability on directors for the payment of taxes) unless the person's conduct constitutes self-dealing, willful misconduct or recklessness. No amendment or repeal of this Article 9 shall apply to or have any effect on the liability or alleged liability of any person who is or was a director of the Corporation for or with respect to any acts or omissions of the director occurring prior to the effective date of such amendment or repeal. If the PA BCL is amended to permit a Pennsylvania corporation to provide greater protection from personal liability for its directors than the express terms of this Article 9, this Article 9 shall be construed to provide for such greater protection.

10. **Limitation of Officers' Liability.** No person who is or was an officer of the Corporation shall be personally liable, as such, for monetary damages (other than under criminal statutes and under federal, state and local laws imposing liability on officers for the payment of taxes) unless the person's conduct constitutes self-dealing, willful misconduct or recklessness. No amendment or repeal of this Article 10 shall apply to or have any effect on the liability or alleged liability of any person who is or was an officer of the Corporation for or with respect to any acts or omissions of the officer occurring prior to the effective date of such amendment or repeal. If the PA BCL is amended to permit a Pennsylvania corporation to provide greater protection from personal liability for its officers than the express terms of this Article 10, this Article 10 shall be construed to provide for such greater protection.

11. **Right to Amend.** Except as otherwise provided herein or by applicable law, the Corporation reserves the right to amend or repeal any provision contained in this Second Amended and Restated Articles of Incorporation as the same may from time to time be in effect, in the manner now or hereafter prescribed by law, and all rights, preferences and privileges conferred on shareholders hereunder are subject to such reservation.

November 28, 2018

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B.2.a.(iv.) – Aetna Inc. Bylaws

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BYLAWS

OF

AETNA INC.

(A Pennsylvania Business Corporation)

ARTICLE I

SHAREHOLDERS

1.1 Meetings.

1.1.1 Place. Meetings of the shareholders shall be held at such place within or without the Commonwealth as may be designated by the Board of Directors.

1.1.2 Annual Meeting. An annual meeting of the shareholders for the election of directors and for other business shall be held at such time in each year as may be designated by the Board of Directors.

1.1.3 Special Meetings. Special meetings of the shareholders may be called at any time by the Board of Directors, president, or shareholders entitled to cast at least one-fifth of the votes that all shareholders are entitled to cast at the meeting.

1.1.4 Notice. Written notice of the time and place of every meeting of shareholders and of the general nature of the business to be transacted at each special meeting of shareholders shall be given to each shareholder of record entitled to vote at the meeting.

1.1.5 Quorum. The presence of shareholders entitled to cast at least a majority of the votes that all shareholders are entitled to cast on a particular matter shall constitute a quorum for the purpose of consideration and action on the matter.

1.1.6 Voting Rights. Except as otherwise provided herein, in the articles of incorporation or by applicable law, every shareholder shall have the right at every shareholders' meeting to one vote for every share standing in his name on the books of the corporation which is entitled to vote at such meeting. Every shareholder may vote either in person or by proxy.

ARTICLE II

DIRECTORS

2.1 Number and Term. Subject to the provisions of applicable law, the Board of Directors shall have authority to determine the number of directors to constitute the Board of Directors. Each director elected to the Board of Directors shall hold office until the next annual meeting of the shareholders unless he sooner resigns or is removed or disqualified.

2.2 Powers. All corporate powers shall be exercised by or under authority of, and the business and affairs of the corporation shall be managed under the direction of, the Board of Directors.

2.3 Meetings.

2.3.1 Place. Meetings of the Board of Directors shall be held at such place as the Board of Directors may from time to time appoint or as may be designated in the notice of the meeting.

2.3.2 Regular Meetings. Regular meetings of the Board of Directors shall be held at such times as the Board of Directors may designate. Notice of regular meetings need not be given.

2.3.3 Special Meetings. Special meetings of the Board of Directors may be called at any time by the president and shall be called by him on the written request of at least one-third of the directors. Notice of the time and place of each special meeting shall be given to each director at least two days before the meeting.

2.3.4 Quorum. A majority of the directors in office shall constitute a quorum for the transaction of business at any meeting and except as otherwise provided herein the acts of a majority of the directors present at any meeting at which a quorum is present shall be the acts of the Board of Directors.

2.4 Vacancies. Vacancies in the Board of Directors may be filled by vote of a majority of the remaining members of the Board of Directors.

2.5 Committees. The Board of Directors may by resolution adopted by a majority of the directors in office establish one or more committees, each committee to consist of one or more directors and such alternate members (also directors) as may be designated by the Board of Directors. To the extent provided in such resolution, any such committee shall have and exercise the powers of the Board of Directors except as may be limited by the Pennsylvania Business Corporation Law of 1988, as amended ("BCL"). Unless otherwise determined by the Board of Directors, in the absence or disqualification of any member or alternate member or members of a committee, the member or members thereof present at any meeting and not disqualified from voting, whether or not he or they constitute a quorum, may unanimously appoint another director to act at the meeting in the place of any such absent or disqualified member.

2.6 Limitation of Directors' Liability. No person who is or was a director of the corporation shall be personally liable, as such, for monetary damages (other than under criminal statutes and under federal, state and local laws imposing liability on directors for the payment of taxes) unless the person's conduct constitutes self-dealing, willful misconduct or recklessness. No amendment or repeal of this Article 2.6 shall apply to or have any effect on the liability or alleged liability of any person who is or was a director of the corporation for or with respect to any acts or omissions of the director occurring prior to the effective date of such amendment or repeal. If the BCL is amended to permit a Pennsylvania corporation to provide greater protection from personal liability for its directors than the express terms of this Article 2.6, this Article 2.6 shall be construed to provide for such greater protection.

ARTICLE III

OFFICERS

3.1 Election. The Board of Directors shall elect a president, treasurer, secretary and such other officers or assistant officers as it deems advisable. Any number of offices may be held by the same person.

3.2 Authority, Duties and Compensation. The officers shall have such authority, perform such duties and serve for such compensation as may be determined by or under the direction of the Board of Directors. Except as otherwise provided by the Board of Directors (a) the president shall be the chief executive officer of the corporation, shall have general supervision over the business and operations of the corporation, may perform any act and execute any instrument for the conduct of such business and operations and shall preside at all meetings of the Board of Directors and shareholders, (b) the other officers shall have the duties usually related to their offices and (c) the vice president (or vice presidents in the order determined by the Board of Directors) shall in the absence of the president have the authority and perform the duties of the president.

3.3 Limitation of Officers' Liability. No person who is or was an officer of the corporation shall be personally liable, as such, for monetary damages (other than under criminal statutes and under federal, state and local laws imposing liability on officers for the payment of taxes) unless the person's conduct constitutes self-dealing, willful misconduct or recklessness. No amendment or repeal of this Article 3.3 shall apply to or have any effect on the liability or alleged liability of any person who is or was an officer of the corporation for or with respect to any acts or omissions of the officer occurring prior to the effective date of such amendment or repeal. If the BCL is amended to permit a Pennsylvania corporation to provide greater protection from personal liability for its officers than the express terms of this Article 3.3, this Article 3.3 shall be construed to provide for such greater protection.

ARTICLE IV

INDEMNIFICATION

4.1 Indemnification The corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending or completed action or proceeding, including without limitation actions by or in the right of the corporation, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was a director or officer of the corporation, or is or was serving while a director or officer of the corporation at the request of the corporation as a director, officer, employee, agent, fiduciary or other representative of another corporation (for profit or not-for-profit), limited liability company, partnership, joint venture, trust, employee benefit plan or other enterprise, against all liabilities, expenses (including without limitation attorneys' fees), judgments, fines, excise taxes and amounts paid in settlement in connection with such action or proceeding unless the act or failure to act by such person giving rise to the claim for indemnification is determined by a court to have constituted willful misconduct or recklessness. The corporation shall have the power to indemnify employees and agents of the corporation on the same basis as provided above in this Article 4.1, and to advance expenses to employees and agents on the same basis as provided in Article 4.2, as the Board of Directors may from time to time determine or authorize.

4.2 Advancement of Expenses. Expenses (including without limitation attorneys' fees) incurred by any person who was or is an officer or director of the corporation in defending any action or proceeding referred to in Article 4.1 shall automatically be paid by the corporation, without the need for action by the Board of Directors, in advance of the final disposition of the action or proceeding upon receipt of an undertaking by or on behalf of such person to repay such amount if it shall ultimately be determined that such person is not entitled to be indemnified by the corporation.

4.3 Exception. Notwithstanding anything in this Article 4 to the contrary, the corporation shall not be obligated to indemnify any person under Article 4.1 or advance expenses under Article 4.2 with respect to proceedings, claims or actions commenced by such person, other than mandatory counterclaims and affirmative defenses.

4.4 Interpretation. The indemnification and advancement of expenses provided by or pursuant to this Article 4 shall not be deemed exclusive of any other rights to which any person seeking indemnification or advancement of expenses may be entitled under any insurance policy, agreement, vote of shareholders or directors, or otherwise, both as to actions in such person's official capacity and as to actions in another capacity while holding an office, and shall continue as to a person who has ceased to be a director or officer and shall inure to the benefit of the heirs, executors and administrators of such person. If the BCL is amended to permit a Pennsylvania corporation to provide greater rights to indemnification and advancement of expenses for its directors and officers than the express terms of this Article 4, this Article 4 shall be construed to provide for such greater rights.

4.5 Contract. The duties of the corporation to indemnify and to advance expenses to a director or officer as provided in this Article 4 shall be in the nature of a contract between the corporation and each such person, and no amendment or repeal of any provision of this Article 4 shall alter, to the detriment of such person, the right of such person to the advancement of expenses or indemnification related to a claim based on an act or failure to act that took place prior to such amendment or repeal or the termination of the service of the person as a director or officer, whichever is earlier.

ARTICLE V

SHARE CERTIFICATES AND TRANSFERS

5.1 Share Certificates. Every shareholder of record shall be entitled to a share certificate representing the shares held by him. Every share certificate shall bear the signature of the president or a vice president and the secretary or an assistant secretary or the treasurer or an assistant treasurer of the corporation. Where a certificate is signed by a transfer agent or registrar the signature of any corporate officer may be a facsimile.

5.2 Transfers. Transfers of share certificates and the shares represented thereby shall be made on the books of the corporation only by the registered holder or by duly authorized attorney. Transfers shall be made only on surrender of the share certificate or certificates.

ARTICLE VI

AMENDMENTS

6.1 Except as restricted by applicable law, the authority to adopt, amend and repeal the bylaws of the corporation is expressly vested in the Board of Directors, subject to the power of the shareholders to change such action.

November 28, 2018

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B.2.a.(iv.) – CVS Pharmacy Inc. Articles of Amendment

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Filing Fee $50.00

State of Rhode Island and Providence Plantations

ARTICLES OF AMENDMENT
TO THE
ARTICLES OF INCORPORATION
OF

CVS, Inc.

Pursuant to the provisions of Section 7-1.1-56 of the General Laws, 1956, as amended, the undersigned corporation adopts the following Articles of Amendment to its Articles of Incorporation :

FIRST: The name of the corporation is CVS, Inc.

SECOND: The shareholders of the corporation on January 28, 19 97, in the manner prescribed by Chapter 7-1.1 of the General Laws, 1956, as amended, adopted the following amendment(s) to the Articles of Incorporation:

[Insert Amendment(s)]

The name of the corporation shall be changed to:

CVS Pharmacy, Inc.

FORM 12A

(R.I. - 2155 - 2/2/93)

STATE OF RHODE ISLAND
COUNTY OF Providence } Sc.

At Providence in said county on this 7th day of February, 1997, personally appeared before me Zenon P. Laukowsky and Diane McDonough-Gibson, who, being by me first duly sworn, declared that they are the Vice President and Assistant Secretary of CVS, Inc.

that they signed the foregoing document as Vice President and Assistant Secretary of the corporation, and that the statements therein contained are true.

Jill M. Goddard
Notary Public

(NOTARIAL SEAL)

JILL M. GODDARD
Notary Public of Rhode Island
My Commission Expires: 10-04-00

FILED
FEB 10 1997
By [illegible]
Ch 178321

(R.I. - 2155 - 2/2/93)

Filing fee: $100.00

ARTICLES OF MERGER
OF DOMESTIC CORPORATIONS
INTO

CVS DISTRIBUTION, INC.
(to be known as CVS, INC. following the merger)

Pursuant to the provisions of Chapter 7-1.1 of the General Laws, 1956, as amended. the undersigned corporations adopt the following Articles of Merger for the purpose of merging them into one of such corporations:

FIRST: The following Plan of Merger was approved by the shareholders of each of the undersigned corporations in the manner prescribed by said Chapter 7-1.1:

(Insert Plan of Merger)

(SEE ATTACHED)

FILED
SEP 2 , 1995
By
167527

FORM 17A

SECOND: As to each of the undersigned corporations, (except one whose shareholders are not required to approve the agreement under § 7-1.1-67, in which event that fact shall be set forth), the number of shares outstanding, and the designation and number of outstanding shares of each class entitled to vote as a class on such Plan, are as follows:

	Name of Corporation	Number of Shares Outstanding	Entitled to Vote as a Class: Designation of Class	Entitled to Vote as a Class: Number of Shares
1.	CVS, INC.	100	COMMON	100
2.	CVS MERGER, INC.	1	COMMON	1
3.	CVS DISTRIBUTION, INC.	1,000	COMMON	1,000

THIRD: As to each of the undersigned corporations, the total number of shares voted for and against such Plan, respectively, and, as to each class entitled to vote thereon as a class, the number of shares of such class voted for and against such Plan, respectively, are as follows:

	Name of Corporation	Number of Shares: Total Voted For	Number of Shares: Total Voted Against	Entitled to Vote as a Class: Class	Entitled to Vote as a Class: Voted For	Entitled to Vote as a Class: Voted Against
1.	CVS, INC.	100	0	COMMON	100	0
2.	CVS MERGER, INC.	1	0	COMMON	1	0
3.	CVS DISTRIBUTION, INC.	1,000	0	COMMON	1,000	0

FOURTH: Time merger to become effective (§ 7-1.1-69): SEPTEMBER 29, 1996

Dated September 26, 1996

CVS, INC.

By THOMAS M. RYAN
Its President

and ZENON P. LANKOWSKY
Its Secretary

CVS MERGER, INC.

By THOMAS M. RYAN
Its President

and ZENON P. LANKOWSKY
Its Secretary

CVS DISTRIBUTION, INC.

By: THOMAS M. RYAN
Its President

By: ZENON P. LANKOWSKY

Aetna Better Health® of Kentucky

STATE OF RHODE ISLAND
COUNTY OF PROVIDENCE } Sc.

At Woonsocket, Rhode Island in said County on the 26th day of September 1996, before me personally appeared Thomas M. Ryan, who being by me first duly sworn, declared that he is the President of CVS, INC., that he signed the foregoing document as such President of the corporation, and that the statements therein contained are true.

Ellen E Putnam
Notary Public

(NOTARIAL SEAL)

Ellen E. Putnam, Notary Public
Pascoag, Providence Co., RI
My Commission Expires: 07-02-97

STATE OF RHODE ISAND
COUNTY OF PROVIDENCE } Sc.

At Woonsocket, Rhode Island in said county on the 26th day of September 1996, before me personally appeared Thomas M. Ryan, who being by me first duly sworn, declared that he is the President of CVS MERGER, INC., that he signed the foregoing document as such President of the corporation, and that the statements therein contained are true.

Ellen E Putnam
Notary Public

(NOTARIAL SEAL)

Ellen E. Putnam, Notary Public
Pascoag, Providence Co., RI
My Commission Expires: 07-02-97

PLAN AND AGREEMENT OF MERGER

This PLAN AND AGREEMENT OF MERGER entered into this 26th day of September, 1996, made pursuant to Title 7, Chapter 1.1, Section 65 of the Rhode Island General Laws of 1956, as amended and Section 368(a)(1)(A) of the Internal Revenue Code of 1986, as amended by and among CVS Distribution, Inc., a Rhode Island corporation having its principal place of business in the City of Woonsocket, County of Providence and State of Rhode Island, said corporation is hereinafter referred to as "Distribution" and CVS, Inc. and CVS Merger, Inc., both Rhode Island corporations having their principal places of business in the City of Woonsocket, in the County of Providence and State of Rhode Island, said corporations are hereinafter referred to as "Inc." and "Merger", respectively.

W I T N E S S E T H:

WHEREAS, Distribution, Merger and Inc. deem it advisable and generally for the welfare of said corporations and their respective shareholders that they merge into a single corporation.

NOW, THEREFORE, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged and in consideration of the mutual covenants herein contained, the parties do hereby agree upon and prescribe the terms and conditions of said merger and of carrying the same into effect as follows:

1. Merger and Inc. shall be and hereby are merged into Distribution pursuant to Title 7, Chapter 1.1, Section 65 of The Rhode Island General Law of 1956, as amended and Section 368 (a)(1)(A) of the Internal Revenue Code of 1986, as amended.

2. Distribution (hereinafter sometimes called the "Surviving Corporation") shall continue to exist under and by virtue of, and shall be governed by, the laws of the State of Rhode Island.

3. The Surviving Corporation shall be known by the name of CVS, Inc.

4. The Surviving Corporation shall be located in the City of Woonsocket, in the County of Providence and State of Rhode Island.

5. The purposes for which the Surviving Corporation is organized are:

(a) Those purposes set forth in the Surviving Corporation's Articles of Incorporation.

(b) The transaction of any or all lawful business for which corporations may be incorporated under Title 7, Chapter 1.1 of the Rhode Island General Laws of 1956, as amended.

In addition to the foregoing, the Surviving Corporation shall have and possess all of the powers and authorities conferred by the Rhode Island General Laws of 1956, as amended upon every business corporation incorporated under the laws of the State of Rhode Island and the Articles of Incorporation of Distribution shall be Articles of Incorporation of the Surviving Corporation.

6. The registered office of the Surviving Corporation shall be 170 Westminster Street, Suite 900, Providence, Rhode Island and the Registered Agent of the Corporation at such office shall be United States Corporation Company.

7. There shall be no authorized capital stock of the Surviving Corporation with par value.

The amount of authorized capital stock of the Surviving Corporation without par value shall be 1,000 shares of Common Stock.

Each share of Common Stock shall be entitled to one (1) vote.

Said stock (or portions thereof) shall be issued by the Surviving Corporation in exchange for shares of Merger and Inc. as hereinafter provided.

8. The period of duration of the Surviving Corporation shall be perpetual.

9. The by-laws of Distribution shall remain and be the by-laws of the Surviving Corporation until the same shall be altered or amended according to the provisions thereof.

10. There shall be a Board of Directors of the Surviving Corporation which shall have and possess all of the powers and authorities which have been heretofore conferred upon the Board of Directors of Distribution.

11. The Board of Directors of Distribution shall be the Board of Directors of the Surviving Corporation and shall continue in office until their successors shall have been duly elected and qualified.

12. The officers of Distribution shall be the officers of the Surviving Corporation and shall continue in office until their successors shall have been duly elected and qualified.

13. Subsequent to the effective time of the merger the capital stock of Distribution shall be converted into the capital stock of the Surviving Corporation as follows:

Nashua Hollis CVS, Inc. ("Nashua Hollis"), the holder of all of the issued and outstanding shares of common stock of Distribution and Inc., shall surrender for cancellation all of said shares to the Surviving Corporation which shall in turn issue shares of its common stock for such

surrendered shares on the following basis: Nashua Hollis shall hold the percentage of stock of the Surviving Corporation determined by multiplying the issued and outstanding stock of the Surviving corporation by a fraction, the numerator being the combined value of Distribution and Inc., as set forth in the valuation reports to be issued by Gordon Associates, Inc., and the denominator being the total value of the Surviving Corporation and its subsidiaries as determined by (i) calculating the average of the high and low trading price of Melville Corporation ("Melville") on the New York Stock Exchange (as reported in the Wall Street Journal) on the first day of trading after the stock of Footstar, Inc. is distributed by Melville to its shareholders, and (ii) subtracting from the value derived in clause (i) the book value of Melville and all of its direct and indirect subsidiaries, excluding the direct and indirect subsidiaries of CVS Center, Inc. ("CVS Center"). Because the denominator can not be calculated until after the merger is effective, good faith estimates will initially be used to calculate the amount of stock to be issued to Nashua Hollis, with such amount being adjusted as promptly as practicable after a final calculation of the denominator can be performed. CVS Center, the holder of all of the issued and outstanding shares of common stock of Merger shall surrender for cancellation all of said shares to the Surviving Corporation which shall in turn issue to CVS Center shares of the Surviving Corporation representing the remaining percentage of stock in the Surviving Corporation.

Any and all of the issued common stock of Merger and Inc. held in their respective treasuries at the effective time of the merger shall be cancelled and shall not be converted.

14. Upon the merger becoming effective, all the property rights, privileges, franchises, patents, trade secret processes, trademarks, licenses, powers and other assets of every kind and description of Merger and Inc. shall be transferred to, vested in and devolve upon the Surviving Corporation without further act or deed; and all property, rights and every other interest of the Surviving Corporation, Merger and Inc. shall be as effectively the property of the Surviving Corporation as they were of the Surviving Corporation, Merger and Inc. respectively. Merger and Inc. each hereby agree from time to time, as and when requested by the Surviving Corporation or by its successors and assigns, to execute and deliver or cause to be executed and delivered all such deeds and instruments and to take or cause to be taken such further or other action as of the Surviving Corporation may deem necessary or desirable in order to vest in and confirm to the Surviving Corporation title to and possession of any property Merger and/or Inc. acquired or to be acquired by reason of or as a result of the merger herein provided for and otherwise to carry out the intent and purposes hereof and the proper officers and directors of Merger and/or Inc. and the proper officers and directors of the Surviving Corporation are fully authorized in the name of Merger and/or Inc. or otherwise to take any and all such action.

15. The Surviving Corporation assumes and agrees to pay and satisfy all of the expenses incurred by the parties hereto for the purposes of consummating the transaction contemplated hereby and to pay and satisfy in accordance with their terms all debts, liabilities and obligations of Merger and Inc. including without limitation, tax liabilities, and all rights of creditors, taxing authorities and all liens upon the property of Merger and Inc. shall be preserved unimpaired and all debts, liabilities and duties, including without limitation tax liabilities of Merger and Inc. from and after the date of merger shall

attach to the Surviving Corporation and may be enforced against it to the same extent as if said debts, liabilities and duties including without limitation, tax liabilities had been incurred or contracted by it.

16. An executed copy of this Agreement shall be filed in the Office of the Secretary of State of the State of Rhode Island. The merger provided for herein shall become effective on September 29, 1996 at 12:01 A.M. and upon the issuance of a Certificate of Merger by the Rhode Island Secretary of State.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their respective corporate officers hereunto duly authorized as of the day and year first above set forth.

CVS DISTRIBUTION, INC.

By: _____
Name: Thomas M. Ryan
Title: President

By: _____
Name: Zenon P. Lankowsky
Title: Secretary

CVS, INC.

By: _____
Name: Thomas M. Ryan
Title: President

By: _____
Name: Zenon P. Lankowsky
Title: Secretary

CVS MERGER, INC.

By: _____
Name: Thomas M. Ryan
Title: President

By: _____
Name: Zenon P. Lankowsky
Title: Secretary

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration
DIVISION OF TAXATION
One Capitol Hill
Providence, RI 02908-5800

FAX (401) 277-6006

September 24, 1996

TO WHOM IT MAY CONCERN:

Re: CVS, INC.

It appears from our records that the abovenamed corporation has filed all of the required Business Corporation Tax Returns due to be filed and paid all taxes indicated thereon and is in good standing with this Division as of this date regarding any liability under the Rhode Island Business Corporation Tax Law.

This letter is issued pursuant to the request of the abovenamed corporation for the purpose of:

A MERGER - CORPORATION IS THE NONSURVIVOR

Very truly yours,

R. Gary Clark
Tax Administrator

Ernest A. DeAngelis
Chief Revenue Agent
Corporations

TDD (401) 277-6287 (Telecommunication Device for the Deaf)

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Administration
DIVISION OF TAXATION
One Capitol Hill
Providence, RI 02908-5800

FAX (401) 277-6006

September 24, 1996

TO WHOM IT MAY CONCERN:

Re: CVS MERGER, INC.

It appears from our records that the abovenamed corporation has filed all of the required Business Corporation Tax Returns due to be filed and paid all taxes indicated thereon and is in good standing with this Division as of this date regarding any liability under the Rhode Island Business Corporation Tax Law.

This letter is issued pursuant to the request of the abovenamed corporation for the purpose of:

A MERGER - CORPORATION IS THE NONSURVIVOR

Very truly yours,

R. Gary Clark
Tax Administrator

Ernest A. DeAngelis
Chief Revenue Agent
Corporations

TDD (401) 277-6287 (Telecommunication Device for the Deaf)

-30 50

Filing Fee $30.00

14414

State of Rhode Island and Providence Plantations

ARTICLES OF AMENDMENT
TO THE
ARTICLES OF INCORPORATION
OF

Mark Steven Service Merchandisers, Inc.

Pursuant to the provisions of Section 7-1.1-56 of the General Laws, 1956, as amended, the undersigned corporation adopts the following Articles of Amendment to its Articles of Incorporation:

FIRST: The name of the corporation is Mark Steven Service Merchandisers, Inc.

SECOND: The shareholders of the corporation on June 27, 1995, in the manner prescribed by Chapter 7-1.1 of the General Laws, 1956, as amended, adopted the following amendment(s) to the Articles of Incorporation:

[Insert Amendment(s)]

FIRST: "The name of the Corporation is: CVS Distribution, Inc.

FILED

OCT 27 1995

By [illegible]

150749

FORM 12A

STATE OF RHODE ISLAND
COUNTY OF Providence } Sc.

At Woonsocket in said county on this 11th day of July, 1995, personally appeared before me Charles Conaway, who, being by me first duly sworn, declared that he is the Vice President of Mark Steven Service Merchandisers, Inc.

that he signed the foregoing document as Vice President of the corporation, and that the statements therein contained are true.

Suzanne R. Pusiel
Notary Public

(NOTARIAL SEAL)

Suzanne R. Pusiel, Notary Public
Woonsocket, Providence Co., RI
My Commission Expires 8-5-96

CVS/PHARMACY
DIVISION OF MELVILLE CORPORATION

September 6, 1995

Dear Sir/Madam:

I, Zenon Lankowsky, Vice President of CVS, Inc., do hereby consent to the Amendment and use of the Name Mark Steven Service Merchandisers, Inc. to CVS Distributions, Inc. and it will in no way interfere with the name CVS, Inc.

Thank you.

Very truly yours,

Zenon Lankowsky
Vice President of
CVS, Inc.

ONE CVS DRIVE • WOONSOCKET, RHODE ISLAND 02895 • (401)765-1500

January 8, 1973

MARK STEVEN WAREHOUSE STORE, INC.
400 Founders Drive
Woonsocket, Rhode Island 02895

TO WHOM IT MAY CONCERN:

MARK STEVEN WAREHOUSE STORE, INC. hereby consents to the change of the name of Mark Steven, Inc. to Mark Steven Service Merchandisers, Inc. and to the use by such corporation of the new name Mark Steven Service Merchandisers, Inc.

MARK STEVEN WAREHOUSE STORE, INC.

By _____
President

Filing fee: $20.00

State of Rhode Island and Providence Plantations

ARTICLES OF AMENDMENT
TO THE
ARTICLES OF INCORPORATION
OF

Mark Steven, Inc.

Pursuant to the provisions of Section 7-1.1-56 of the General Laws, 1956, as amended, the undersigned corporation adopts the following Articles of Amendment to its Articles of Incorporation:

FIRST: The name of the corporation is Mark Steven, Inc.

SECOND: The shareholders of the corporation on January 5, 1973, in the manner prescribed by Chapter 7-1.1 of the General Laws, 1956, as amended, adopted the following amendment(s) to the Articles of Incorporation:

[Insert Amendment(s)]

Article First of the Articles of Incorporation is hereby amended to read:

"The name of the corporation is Mark Steven Service Merchandisers, Inc."

All other provisions of the Articles of Incorporation shall remain unchanged.

The foregoing amendment shall be effective upon the issuance by the Secretary of State of the State of Rhode Island of the Certificate of Amendment.

FORM 12A 10M 1-70

THIRD: The number of shares of the corporation outstanding at the time of such adoption was 1,000; and the number of shares entitled to vote thereon was 1,000

FOURTH: The designation and number of outstanding shares of each class entitled to vote thereon as a class were as follows: (If inapplicable, insert "none")

Class	Number of Shares
None	

FIFTH: The number of shares voted for such amendment was 1,000; and the number of shares voted against such amendment was None.

SIXTH: The number of shares of each class entitled to vote thereon as a class voted for and against such amendment, respectively, was: (If inapplicable, insert "none")

Class	Number of Shares Voted	
	For	Against
None		

SEVENTH: The manner, if not set forth in such amendment, in which any exchange, reclassification, or cancellation of issued shares provided for in the amendment shall be effected, is as follows: (If no change, so state)

No Change

EIGHTH: The manner in which such amendment effects a change in the amount of stated capital, and the amount of stated capital as changed by such amendment, are as follows: (If no change, so state)

No Change

Dated January 8, 1973

Mark Steven, Inc.

By [illegible]

Its President

and [illegible]

Its Secretary

STATE OF RHODE ISLAND
COUNTY OF PROVIDENCE } Sc.

At Woonsocket in said county on this 8th day of January, 19 73 personally appeared before me Sidney S. Goldstein, who, being by me first duly sworn, declared that he is the President of Mark Steven, Inc.

that he signed the foregoing document as President of the corporation, and that the statements therein contained are true.

Notary Public

(NOTARIAL SEAL)

My Commission Expires June 30, 1976

State of Rhode Island and Providence Plantations

ORIGINAL ARTICLES OF ASSOCIATION

(BUSINESS CORPORATION)

Know all Men by these Presents, That we Michael A. Silverstein, John M. Parsons and Max Wistow

all of lawful age, hereby agree to and with each other:

FIRST. To associate ourselves together with the intention of forming a corporation under and by virtue of the powers conferred by Chapters 7-1 to 7-5 (inclusive), 7-9 and 7-10 of the General Laws of Rhode Island, as amended.

SECOND. Said corporation shall be known by the name of

Mark Steven, Inc.

THIRD. Said corporation is formed (as permitted by § 7-2-3 of the General Laws) for the purpose of

In addition to the foregoing, said corporation shall have the following powers and authority, viz:—(See § 7-2-10 of the General Laws.)

To do any lawful act which is necessary or proper to accomplish the purposes of its incorporation. Without limiting or enlarging the effect of this general grant of authority, it is hereby specifically provided that every corporation shall have power:

(a) to have perpetual succession in its corporate name, unless a period for its duration is limited in its articles of association or charter;

(b) to sue and be sued in its corporate name;

(c) to have and use a common seal, and alter the same at pleasure;

(d) to elect such officers and appoint such agents as its business requires, and to fix their compensation and define their duties;

(e) to make by-laws not inconsistent with the Constitution or laws of the United States or of this state, or with the corporation's charter, or articles of association, determining the time and place of holding and the manner of calling and of conducting meetings of its stockholders and directors, the manner of electing its officers and directors, the mode of voting by proxy, the number, qualifications, powers, duties and term of office of its officers and directors, the number of directors and of shares of stock necessary to constitute a quorum, which number may be less than a majority, and the method of making demand for payment of subscriptions to its capital stock, and providing for an executive committee to be elected from and by the board of directors and defining its powers and duties, and containing any other provisions, whether of the same or of a different nature, for the management of the corporation's property and the regulation and government of its affairs;

(f) to make contracts, incur liabilities and borrow money;

(g) to acquire, hold, sell and transfer shares of its own capital stock; provided, that no corporation shall use its funds or property for the purchase of its own shares of capital stock when such use would cause any impairment of the capital of the corporation;

(h) to acquire, hold, sell, assign, transfer, mortgage, pledge or otherwise dispose of any bonds, securities or evidences of indebtedness created by, or the shares of the capital stock of, any other corporation or corporations of this state or of any other state, country, nation or government, and while owner of said stock to exercise all the rights, powers and privileges of ownership, including the right to vote thereon;

(i) to guarantee, ~~if authorized by the holders of a majority of the outstanding capital stock of any other corporation~~ any bonds, securities or evidences of indebtedness created by or dividends on or a certain amount per share in liquidation of the capital stock of any other corporation or corporations created by this state or by any other state, country, nation or government;

(j) to acquire, hold, use, manage, convey, lease, mortgage, pledge or otherwise dispose of within or without this state any other property, real or personal, which its purposes shall require;

(k) to conduct business and have offices in this state and elsewhere; provided, however, that nothing in this section contained shall authorize any corporation to carry on the business of a bank, savings bank or trust company.

(OVER)

FOURTH. Said corporation shall be located in Woonsocket, Rhode Island.
(City or Town)

FIFTH. The TOTAL amount of authorized capital stock of said corporation, with par value, shall be ($) dollars as follows, viz: Common stock in the amount of ($) dollars to be divided into ( ) shares of the par value of ($) dollars each; and Preferred stock in the amount of ($) dollars, to be divided into ( ) shares, of the par value of ($) dollars each.

(Or if capital stock is without par value)

The TOTAL number of shares of capital stock authorized, without par value, shall be One Thousand (1,000) shares as follows, viz:— One Thousand (1,000) shares of Common stock, without par value; and None ( ) shares of Preferred stock, without par value.

(If capital stock is divided into two or more classes) Description of several classes of stock, including terms on which they are created, and voting rights of each, viz:—

SIXTH. (If not perpetual) The period of duration of said corporation shall ~~terminate~~ Be perpetual

(Further provisions not inconsistent with law)

SEVENTH

EIGHTH

NINTH

In Testimony Whereof, We have hereunto set our hands and stated our residences this 5th day of November, A. D. 1969

NAME	RESIDENCE (No. Street, City or Town)
Michael A. Silverstein	28 Kennedy Boulevard, Lincoln, R.I.
John M. Parsons	8 Ferncrest Drive, Cumberland, R.I.
Max Wistow	179 Oakley Road, Woonsocket, R.I.

STATE OF RHODE ISLAND, COUNTY OF Providence } In the City/Town of Woonsocket

in said county this 5th day of November, A. D. 19 69

then personally appeared before me Michael A. Silverstein, John M. Parsons and Max Wistow

each and all known to me and known by me to be the parties executing the foregoing instrument, and they severally acknowledged said instrument by them subscribed to be their free act and deed.

Notary Public

1285

(BUSINESS CORPORATION)

ORIGINAL

ARTICLES OF ASSOCIATION OF

Mark Steven, Inc.

215 CD*****5.00

FILED IN THE OFFICE OF THE
SECRETARY OF STATE

NOV 7 1969 19

Buying, selling, packaging, manufacturing, processing, distributing, consigning and otherwise dealing in articles generally sold in health and beauty aid stores, drug stores and markets, including without limitation, drugs, drug sundries, patent medicines, pharmaceutical supplies, dental items, surgical apparatus, physicians' and hospital supplies; cosmetics, perfumeries, deodorants, soaps, lotions, and toilet articles; baby care supplies; cigarettes, cigars, tobaccos, tobacco products and smokers' accessories; ladies' hosiery, women's wearing apparel and costume jewelry; newspapers, books, including paperbacks, magazines and periodicals; greeting cards, gift wrappings, stationery, office and school supplies and paper products; candies, nuts, confections, food specialties and non-alcoholic beverages; pet supplies; party goods, fancy goods, notions, gift items and glassware; musical records and tapes; cameras, film and photographic supplies; household and hardware items; and other similar articles.

To acquire by purchase, exchange, lease, or otherwise and to own, hold, use, operate, sell, assign, lease, transfer, convey, exchange, mortgage, pledge or otherwise dispose of or deal in and with, personal property of every class or description and such real property and all interests therein as may be required for the furtherance of the business of the corporation.

To draw, make, accept, endorse, discount, execute, and issue promissory notes, drafts, bills of exchange, warrants, bonds, debentures, and other negotiable or transferable instruments and evidences of indebtedness whether secured by mortgage or otherwise, as well as to secure the same by mortgage or otherwise, so far as may be permitted by the laws of the State of Rhode Island.

To apply for, register, obtain, purchase, lease, take licenses in respect of or otherwise acquire, and to hold, own, use, operate, develop, enjoy, turn to account, grant licenses and immunities in respect of, manufacture under and to introduce, sell, assign, mortgage, pledge or otherwise dispose of, and, in any manner deal with and contract with reference to:

(a) inventions, devices, formulae, processes and any improvements and modifications thereof;

(b) letters patent, patent rights, patented processes, copyrights, designs, and similar rights, trade-marks, trade symbols and other indications of origin and ownership granted by or recognized under the laws of the United States of America or of any state or subdivision thereof, or of any foreign country or subdivision thereof, and all rights connected therewith or appertaining thereunto;

(c) franchises, licenses, grants and concessions.

To purchase or otherwise acquire, and to hold, mortgage, pledge, sell, exchange or otherwise dispose of, securities (including, without limitation of the generality thereof, any shares of stock, bonds, debentures, notes, mortgages, or other obligations, and any certificates,

receipts or other instruments representing rights to receive, purchase or subscribe for the same, or representing any other rights or interests therein or in any property or assets) created or issued by any persons, firms, associations, corporations, or governments or subdivisions thereof; to make payment therefor in any lawful manner; and to exercise, as owner or holder of any securities, any and all rights, powers and privileges in respect thereof.

To make, enter into, perform and carry out contracts of every kind and description with any person, firm, association, corporation or government or subdivision thereof.

To acquire by purchase, exchange or otherwise, all, or any part of, or any interest in, the properties, assets, business and good will of any one or more persons, firms, associations or corporations heretofore or hereafter engaged in any business for which a corporation may now or hereinafter be organized under the laws of the State of Rhode Island; to pay for the same in cash, property or its own or other securities; to hold, operate, reorganize, liquidate, sell or in any manner dispose of the whole or any part thereof; and in connection therewith, to assume or guarantee performance of any liabilities, obligations or contracts of such persons, firms, associations, or corporations, and to conduct the whole or any part of any business thus acquired.

To lend its uninvested funds from time to time to such extent, to such persons, firms, associations, corporations, governments or subdivisions thereof, and on such terms and on such security, if any, as the Board of Directors of the corporation may determine.

To endorse or guarantee the payment of principal, interest or dividends upon, and to guarantee the performance of sinking fund or other obligations of any bonds, securities or evidence of indebtedness, and to guarantee in any way permitted by law the performance of any of the contracts or other undertakings in which the corporation may otherwise be or become interested, of any persons, firm, association, corporation, government or subdivision thereof, or of any other combination, organization or entity whatsoever.

To borrow money for any of the purposes of the corporation, from time to time, and without limit as to amount; from time to time to issue and sell its own securities in such amounts, on such terms and conditions, for such purposes and for such prices, now or hereafter permitted by the laws of the State of Rhode Island and by the Articles of Association of this corporation, as the Board of Directors of the corporation may determine; and to secure such securities by mortgage upon, or the pledge of, or the conveyance or assignment in trust of, the whole or any part of the properties, assets, business and good will of the corporation, then owned or thereafter acquired.

To purchase, hold, cancel, reissue, sell, exchange, transfer or otherwise deal in its own securities from time to time to such an extent and in such manner and upon such terms as the Board of Directors of the corporation shall determine, provided that the corporation shall not use its funds or property for the purchase of its own shares of capital stock when such use would cause any impairment of its capital, except to the extent permitted by law; and provided further that shares of its own capital stock belonging to the corporation shall not be voted upon directly or indirectly.

To organize or cause to be organized under the laws of the State of Rhode Island, or of any other state of the United States of America, or of the District of Columbia, or of any territory, dependency, colony or possession of the United States of America, or of any foreign country, a corporation or corporations for the purpose of transacting, promoting or carrying on any or all of the objects or purposes for which the corporation is organized, and to dissolve, wind up, liquidate, merge or consolidate any such corporation or corporations, or to cause the same to be dissolved, wound up, liquidated, merged or consolidated.

To conduct its business in any and all of its branches and maintain offices both within and without the State of Rhode Island, in any and all States of the United States of America, in the District of Columbia, in any or all territories, dependencies, colonies or possessions of the United States of America, and in foreign countries.

To such extent as a corporation organized under the laws of the State of Rhode Island may now or hereafter lawfully do, to do either as principal or agent and either alone or in connection with other corporations, firms, or individuals, all and everything necessary, suitable, convenient or proper for, or in connection with, or incident to, the accomplishment of any of the purposes or the attainment of any one or more of the objects herein enumerated, or designed directly or indirectly to promote the interests of the corporation or to enhance the value of its properties; and in general to do any and all things and exercise any and all powers, rights and privileges which a corporation may now or hereafter be organized to do or to exercise under the laws of the State of Rhode Island or under any act amendatory thereof, supplemental thereto or substituted therefor.

The foregoing provisions hereof shall be construed both as purposes and powers and each as an independent purpose and power. The foregoing enumeration of specific purposes and powers shall not be held to limit or restrict in any manner the purposes and powers of the corporation, and the purposes and powers herein specified shall, except when otherwise provided for herein, be in no wise limited or restricted by reference to, or inference from, the terms of any provisions of this or any other portion of the Articles of Association; provided that the corporation shall not carry on any business or exercise any power in any state, territory or country which under the laws thereof the corporation may not lawfully carry on or exercise.

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B.2.a.(iv.) – CVS Pharmacy Inc. Bylaws

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BY-LAWS
OF
CVS PHARMACY, INC.

(Amended July 8, 2014)

OFFICES

1. The corporation may have offices at such places within or without the state as the Board of Directors may from time to time determine or the business of the corporation may require.

MEETINGS OF STOCKHOLDERS

2. All meetings of the stockholders shall be held at One CVS Drive, Woonsocket, Rhode Island, or such other place as the Directors may determine.

3. The annual meeting of the stockholders of the corporation shall be held on the second Wednesday of December in each year if not a legal holiday and, if a legal holiday, then on the next secular day following, when they shall elect a Board of Directors and transact such other business as may properly come before the meeting. In the event that the annual meeting is not held, a special meeting may be called and held in lieu thereof and for the purposes of such annual meeting.

4. Special meetings of the stockholders for any purpose or purposes, unless otherwise expressly provided by law, may be called by resolution of the Board of Directors or by the President or by the holder or holders of record of not less than one-tenth part in interest of the stock entitled to vote on any proposal to be submitted at such meeting.

5. Written notice of every meeting of stockholders, stating the purpose or purposes for which the meeting is called, the time when and the place where it is to be held, shall be served, either personally or by mail, upon each stockholder entitled to vote at such meeting at least ten days before the meeting, unless a different notice is required by statute. If mailed, such notice shall be directed to a stockholder at his address as it shall appear on the books of the corporation.

6. The holders of a majority of the stock issued and outstanding and entitled to vote thereat, present in person or represented by proxy, shall be requisite and shall constitute a quorum at all meetings of the stockholders for the transaction of business, except as otherwise expressly provided. If a quorum shall not be present or represented, the stockholders entitled to vote thereat, present in person or represented by proxy, shall have power to adjourn the meeting from time to time without notice other than announcement at the meeting, until a quorum shall be present or represented. At such adjourned meeting at which a quorum shall be present or represented any business may be transacted which might have been transacted at the meeting as originally notified.

7. When a quorum is present or represented at any meeting, the vote of the holders of a majority of the stock having voting power, present in person or represented by proxy, shall decide any question brought before such meeting, unless the question is one upon which, by express provision of the statutes or of the Certificate of Articles of Incorporation, or of these By-Laws, a different vote is required, in which case such express provision shall govern and control the decision of such question.

8. Unless the statute otherwise expressly provides, each stockholder of record having the right to vote shall be entitled at every meeting of the stockholders of the corporation to one vote for each share of stock having voting power standing in the name of such stockholder on the books of the corporation, and such votes may be cast either in person or by proxy.

9. Meetings of stockholders shall be presided over by the President, or, if he is not present, by a chairman to be elected at the meeting. The Secretary of the corporation, or in his absence, a secretary appointed at the meeting, shall act as secretary of such meetings.

DIRECTORS

10. The Board of Directors shall consist of not less than one (1), but no more than six (6) directors, who shall have such qualifications as the statute may require. They shall be elected at the annual meeting of the stockholders and each director shall be elected to serve for one year and until his successor shall be elected and shall qualify.

11. If the office of any director becomes vacant for any reason, the directors in office, although less than a quorum, may choose a successor or successors, who shall hold office for the unexpired term in respect to which such vacancy occurred or until the next election of directors, or any vacancy may be filled by the stockholders at any meeting thereof.

12. The business of this corporation shall be managed by its Board of Directors which may exercise all such powers of the corporation and do all such lawful acts and things as are not otherwise required to be exercised or done by the stockholders.

MEETINGS OF THE BOARD

13. The Directors may hold their meetings at One CVS Drive, Woonsocket, Rhode Island, or at such other places as they may from time to time determine.

14. Regular meetings of the Board may be held without notice at such time and place as shall from time to time be determined by resolution of the Board.

15. Special meetings of the Board may be called by the President on one day's notice to each director either personally or by mail or by wire; special meetings shall be called by the President or Secretary in a like manner on the written request of two directors.

16. At all meetings of the Board the presence of a majority of the entire number of directors shall be necessary to constitute a quorum and sufficient for the transaction of business and any act of a majority present at a meeting at which there is a quorum shall be the act of the Board of Directors, except as may be otherwise specifically provided. If a quorum shall not be present at any meeting of directors, the directors present thereat may adjourn the meeting from time to time without notice other than announcement at the meeting, until a quorum shall be present.

COMPENSATION OF DIRECTORS

17. Directors, as such, shall not receive any stated salary for their services but, by resolution of the Board, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each regular or special meeting of the Board. Nothing herein contained shall be construed to preclude any director from servicing the corporation in any other capacity and receiving compensation therefor.

18. Any one or more or all of the directors may be removed, either with or without cause, at any time, by the vote of the stockholders holding a majority of the stock of the corporation, at any meeting called for the purpose, and thereupon the term of each director or directors, who shall have been so removed, shall forthwith terminate, and there shall be a vacancy or vacancies in the Board of Directors, to be filled as provided in these By-Laws.

WAIVER OF NOTICE

19. Whenever the stockholders or the Board of Directors are authorized to take any action after notice, such notice may be waived, in writing, before or after the holding of the meeting, by the person or persons entitled to such notice.

COMMITTEES

20. The Board of Directors may from time to time, by resolution passed by a majority of the whole Board, designate one (1) or more committees which shall be standing in nature, each Standing Committee to consist of one (1) or more directors and any number of officers of the Corporation. Any such Standing Committee shall have and may exercise the powers of the Board of Directors in the management of the business and affairs of the corporation for whatever purpose they see fit.

21. A majority of all of the members of any such Standing Committee may determine its action and fix the time and place of its meetings, unless the Board of Directors shall otherwise provide. The Board of Directors shall have the power to change the members of any Standing Committee at any time, to fill vacancies and to discharge any such Standing Committee, either with or without cause, at any time. The Board of Directors may delegate such power to the members of any Standing Committee or one (1) or more principal officers.

22. The Board of Directors may, by resolution passed by a majority of the whole Board, designate one (1) or more directors as alternate members of any committee who may replace any absent or disqualified member at any meeting of the committee; provided, however, that in the absence of any such designation of alternates the member or members of any committee present at any meeting and not disqualified from acting, whether or not he, she or they constitute a quorum, may unanimously appoint another member of the Board to act at the meeting in the place of any absent or disqualified member.

23. The Board of Directors, any Standing Committee, or any principal officer or director may from time to time create such additional committees of directors, officers, employees or other persons designated by it (or any combination of such persons) for such business purposes as they deem necessary and for advising with the Board and the principal officers of the Corporation in all such matters as the Board and the principal officers shall deem advisable.

OFFICERS

24. The officers of the corporation shall be a President, a Vice-President, a Secretary and a Treasurer, who shall be appointed by the Board of Directors immediately after each annual meeting of stockholders.

25. The corporation may have such vice-presidents, assistant treasurers, assistant secretaries and such other officers as may from time to time be appointed by the directors, who shall have such authority and shall perform such duties as from time to time shall be prescribed by the Board.

26. The salaries of all officers of the corporation shall be fixed by the Board of Directors.

27. Any officer elected or appointed by the Board of Directors may be removed at any time with or without cause, by the affirmative vote of a majority of the directors. If the office of any officer becomes vacant for any reason, the vacancy shall be filled by the Board of Directors. Except as otherwise provided by law, any person may hold two or more offices.

THE PRESIDENT

28. The President shall be the executive officer of the corporation; he shall preside at all meetings of the stockholders and directors; he shall have the management of the business of the corporation; he shall see that all orders and resolutions of the Board are carried into effect; and he may sign, in the name of the corporation, all authorized contracts, documents, bonds or other obligations.

VICE-PRESIDENT

29. The Vice-President in the absence or disability of the President shall perform the duties and exercise the powers of the President and shall perform such other duties as the Board of Directors shall prescribe.

THE SECRETARY

30. The Secretary shall attend all sessions of the Board of directors and all meetings of the stockholders and record all votes and the minutes of all proceedings in a book to be kept for that purpose. He shall give or cause to be given notice of all meetings of stockholders and special meetings of the Board of Directors and shall perform such other duties as may be prescribed by the Board of Directors. He shall keep in safe custody the seal of the corporation and affix it to any instrument when authorized by the Board of Directors. He may sign, in the name of the corporation, all authorized contracts, documents, bonds or other obligations.

THE TREASURER

31. The Treasurer shall give such bond for the faithful discharge of his duties as the directors may require. He shall, subject to the control of the directors, keep the accounts of the corporation, and shall perform such additional duties as the directors may designate.

32. Each officer of the corporation shall have authority to sign tax returns on behalf of the corporation.

INDEMNIFICATION OF DIRECTORS AND OFFICERS

33. The corporation shall indemnify and save harmless all or any of the officers and directors of the corporation from and against expenses actually and necessarily incurred by them in connection with the defense of any action, suit or proceeding in which any such director or officer by virtue of his office may be made a party, except if such officer or director is finally adjudged in such action, suit or proceeding to be liable for negligence or misconduct in the performance of his duties he shall not be so indemnified and held harmless.

EXECUTION OF CONTRACTS, ETC.

34. Unless the Board of Directors shall otherwise determine, the Chairman of the Board, the President, any Executive Vice President, Senior Vice President, Vice President or the Treasurer and the Secretary or any Assistant Secretary may enter into any contract or execute any contract or other instrument, the execution of which is not otherwise specifically provided for, in the name and on behalf of the Corporation. The Board of Directors, or any committee designated thereby with power so to act, except as otherwise provided in these By-Laws, may authorize any other or additional officer or officers, employees or agent or agents of the Corporation to enter into any contract or execute and deliver any instrument in the name and on behalf of the Corporation, and such authority may be general or confined to specific instances. Unless authorized so to do by these By-Laws or by the Board of Directors or by any such committee, no officer, agent or employee shall have any power or authority to bind the Corporation by any contract or engagement or to pledge its credit or to render it liable pecuniarily for any purpose or to any amount.

CERTIFICATES OF STOCK

35. Certificates of stock shall be in the form approved by the directors, shall be signed by the President or a Vice President and by the Treasurer or an Assistant Treasurer or the Secretary or an Assistant Secretary of the corporation and shall be sealed with its seal.

36. The shares of stock of this corporation shall not be subject to any liability or assessments other than that imposed by the statute under which this corporation is organized.

37. The Board of Directors may cause a new stock certificate to be issued in lieu of a stock certificate lost or destroyed to the person entitled thereto upon satisfactory proof of such loss or destruction and the Board of Directors may require such indemnity by the person claiming such certificates as it may deem necessary or proper.

TRANSFERS OF STOCK

38. Shares of stock shall be transferable only on the books of the corporation upon the surrender of the certificate therefor duly endorsed for transfer. The corporation may require proof of the genuineness of the signature and of the capacity of the party executing the transfer.

39. The corporation shall not be required to recognize any partial or equitable interest in its shares but may treat the registered holder thereof as the absolute owner.

40. The Board of Directors may close the stock books for transfer for such time prior to the day fixed for the payment of any dividend or to the day fixed for the annual meeting or any special meeting of the stockholders as may appear to it to be reasonable.

SEAL

41. The seal of the corporation shall be circular in form and contain the name of the corporation, the year of its organization and the words "Corporate Seal" and the name of the state of incorporation.

CHECKS

42. All checks or demands for money and notes of the corporation shall be signed by such officer or officers or such other person or persons as the Board of Directors may from time to time designate.

FISCAL YEAR

43. The fiscal year shall end on December 31st.

AMENDMENTS

44. These By-Laws, or any of them, may be repealed, altered or amended by the affirmative vote of a majority of the shares present, either in person or by proxy, at any meeting duly called for that purpose.

B.2.a.(iv.) – CVS Health Corporation Restated Certificate of Incorporation

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Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE RESTATED CERTIFICATE OF "CVS HEALTH CORPORATION", FILED IN THIS OFFICE ON THE FOURTH DAY OF JUNE, A.D. 2018, AT 6:12 O`CLOCK P.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE NEW CASTLE COUNTY RECORDER OF DEEDS.

Jeffrey W. Bullock, Secretary of State

2656078 8100
SR# 20184951719

Authentication: 202817923
Date: 06-04-18

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Secretary of State
Division of Corporations
Delivered 06:12 PM 06/04/2018
FILED 06:12 PM 06/04/2018
SR 20184951719 - File Number 2656078

RESTATED

CERTIFICATE OF INCORPORATION

OF

CVS HEALTH CORPORATION

CVS Health Corporation, a corporation organized and existing under the laws of the State of Delaware (the "Corporation"), hereby certifies as follows:

1. The name of the Corporation is "CVS Health Corporation" and the name under which the Corporation was originally formed is "CVS Corporation." The original Certificate of Incorporation was filed with the Secretary of State of the State of Delaware on August 22, 1996.

2. This Restated Certificate of Incorporation (this "Restated Certificate") has been duly adopted by the Board of Directors of the Corporation in accordance with Sections 242 and 245 of the General Corporation Law of the State of Delaware.

3. Pursuant to Sections 242 and 245 of the General Corporation Law of the State of Delaware, this Restated Certificate of Incorporation restates and integrates and does not further amend the provisions of the Certificate of Incorporation of the Corporation and there is no discrepancy between the provisions of the Certificate of Incorporation as heretofore amended and supplemented and the provisions of this Restated Certificate.

4. The text of the Certificate of Incorporation as heretofore amended is hereby integrated and restated to read in its entirety as hereinafter set forth:

FIRST: The name of the Corporation is "CVS Health Corporation".

SECOND: The address of its registered office in the State of Delaware is Corporation Trust Center, 1209 Orange Street, City of Wilmington, County of New Castle, Delaware 19801. The name of its registered agent at such address is The Corporation Trust Company.

THIRD: The purpose of the Corporation is to engage in any lawful act or activity for which corporations may be organized under the General Corporation Law of the State of Delaware as the same exists or may hereafter be amended ("Delaware Law").

FOURTH: The authorized capital stock of the Corporation consists of 3,200,000,000 shares of Common Stock, par value $0.01 per share ("Common Stock"), (ii) 120,619 shares of Cumulative Preferred Stock, par value $0.01 per share ("Preferred Stock"), and (iii) 50,000,000 shares of Preference Stock, par value $1 per share ("Preference Stock").

All the designations, preferences, privileges and voting powers of the shares of each class, and the restrictions or qualifications thereof, shall be as follows:

I. Provisions Generally Applicable To Capital Stock

I.A. Voting Rights of Common Stock

Each holder of Common Stock shall be entitled to one vote for each share thereof held of record by such holder.

I.B. Ranking of Capital Stock

The Preferred Stock shall be senior to the Preference Stock and the Common Stock, and the Preference Stock and the Common Stock shall be subject to all the rights and preferences of the Preferred Stock as hereafter set forth. The Preference Stock shall be senior to the Common Stock, and the Common Stock shall be subject to all the rights and preferences of the Preference Stock as hereafter set forth.

I.C. No Preemptive Rights

No stockholder of the Corporation shall be entitled as such, as a matter of right, to subscribe for or purchase any part of any new or additional issue of stock of any class or series whatsoever, any rights or options to purchase stock of any class or series whatsoever, whether now or hereafter authorized and whether issued for cash or other consideration or by way of dividend.

I.D. Fractional Interests

In case any person shall become entitled to a fractional interest in a share of Preferred Stock, of Preference Stock or of Common Stock, the Corporation may deliver a scrip certificate representing such fractional interest, which together with other similar scrip certificates aggregating a whole share, may be surrendered in exchange for a stock certificate representing one full share of Preferred Stock, Preference Stock or Common Stock, as the case may be; provided, however, that the rights of the holders of such scrip certificates shall be subject to any conditions and limitations prescribed by the Board of Directors, which may include a provision that after a specified date the scrip certificate shall become absolutely void.

II. Preferred Stock

II.A. Provisions Generally Applicable to Preferred Stock

II.A.(i) The Preferred Stock may be issued from time to time in one or more series, the shares of each series to have such designations, preferences, privileges, and voting powers, and the restrictions or qualifications thereof, as are stated and expressed herein or in a resolution or resolutions providing for the issue of such series adopted by the Board of Directors as hereafter provided.

II.A.(ii) Authority is hereby expressly granted to the Board of Directors, subject to the provisions of this Restated Certificate and Delaware Law, to authorize the issue of one or more series of Preferred Stock and with respect to each such series to fix by resolution or resolutions providing for the issue of such series:

(1) The number of shares of Preferred Stock which shall comprise such series and the distinctive designation thereof;

(2) The dividend rate on the shares of such series (not exceeding $6 a share per annum) and the date or dates from which dividends shall accumulate;

(3) Whether or not the shares of such series shall be subject to purchase and to redemption and the amount of premium, if any (not exceeding $7 a share), which the holders of shares of such series shall be entitled to receive over and above $100 a share and any accrued dividends thereon upon the redemption thereof or upon the voluntary liquidation, dissolution or winding up of the Corporation;

(4) Whether or not the shares of such series shall be subject to the operation of a sinking fund to be applied to the purchase or redemption of the shares of such series for retirement and, if such sinking fund be established, the terms and provisions relative to the operation thereof;

(5) Whether or not the shares of such series shall be made convertible into or exchangeable for any other class or classes or for any other series of the same class of stock of the Corporation and, if made so convertible or exchangeable, the conversion price or prices or rates of exchange at which such conversion or exchange may be made and the method, if any, of adjusting the same;

(6) The restrictions, if any, on the payment of dividends upon, and the making of distributions to, any class of stock ranking junior to the shares of Preferred Stock, and the restrictions, if any, on the purchase or redemption of the shares of any such junior class; and

(7) The voting rights, if any, of the shares of such series other than those voting rights provided for in Section II.A.(viii) of this Article FOURTH.

II.A.(iii) All shares of any one series of Preferred Stock shall be identical with each other in all respects except that shares of any one series issued at different times may differ as to the dates from which dividends thereon shall accumulate; and all series shall rank equally and be identical in all respects except as permitted in the foregoing provisions of Section II.A.(ii) of this Article FOURTH.

II.A.(iv) The holders of shares of Preferred Stock of each series shall be entitled to receive, when and as declared by the Board of Directors, dividends payable in cash in, but not exceeding, the amount fixed for such series. Such dividends shall be cumulative, so that if dividends on all outstanding Preferred Stock of each series in the amount fixed therefor shall not have been paid or declared and set apart for payment for all past dividend periods, and for the dividend period current at the time, the deficiency shall be fully paid, or dividends equal thereto declared and set apart for payment, but without interest thereon, before any dividends on any class of stock of the Corporation junior to the Preferred Stock shall be paid or declared and set apart for payment.

Dividends shall not be declared or paid on the Preferred Stock of any one series for any dividend period unless dividends have been or are contemporaneously paid or declared and set apart for payment on the Preferred Stock of all series for the dividend periods terminating on the same and all earlier dates.

Any dividend paid in an amount less than full cumulative dividends accrued or in arrears on all Preferred Stock then outstanding shall be divided between the outstanding Preferred Stock in proportion to the amounts which would be distributable per share to the Preferred Stock if full cumulative dividends were declared and paid thereon.

After full cumulative dividends as aforesaid upon the Preferred Stock of all series then outstanding shall have been paid for all past dividend periods, and full dividends on the Preferred Stock then outstanding for the current dividend period shall have been declared and paid or set apart for payment, and after complying with all the provisions with respect to any sinking fund or funds for any one or more series of Preferred Stock, then, and not otherwise, dividends may be declared and paid upon any class of stock of the Corporation junior to the Preferred Stock.

II.A.(v) In the event of any liquidation, dissolution or winding up of the Corporation the Preferred Stock shall be preferred as to assets as well as dividends and upon any such dissolution, liquidation or winding up, the holders of the Preferred Stock of each series shall be entitled to receive and be paid for each share thereof out of the assets of the Corporation (whether capital or surplus) $100, together with an amount equal to the accrued and unpaid dividends thereon computed to the date of payment, plus a premium of such additional amount per share as shall have been fixed for such series in the event the dissolution, liquidation or winding up is voluntary, before any distribution of the assets shall be made to the holders of any class of stock of the Corporation junior to the Preferred Stock. All assets remaining after such distribution to the Preferred Stock shall then be distributed exclusively among the holders of any class or classes of stock of the Corporation junior to the Preferred Stock. If, upon any such dissolution, liquidation or winding up, the assets of the Corporation distributable among the holders of Preferred Stock shall be insufficient to pay in full the preferential amount aforesaid, then such assets or the proceeds thereof shall be distributed ratably among the holders of Preferred Stock then outstanding until there shall have been paid in full and in order, first, the sum of $100 in respect of each share; second, an amount ratably in proportion to the amounts to which they are respectively entitled by reason of accrued and unpaid dividends computed to the date of distribution; and third, the balance ratably in proportion to the amounts to which they are respectively entitled by way of premium.

II.A.(vi) The Corporation, at its option to be exercised by its Board of Directors, may redeem the whole or any part of any series of Preferred Stock which by its terms is subject to redemption, at the time or times provided in the terms of such series, at a redemption price per share for each series thereof, equal to: $100 plus a premium, if any, of such additional amount as shall have been fixed as payable in case of redemption in respect of each share of such series and an amount equal to any accrued and unpaid dividends thereon computed to the date of redemption. If at any time less than all of the Preferred Stock then outstanding and subject to redemption shall be called for redemption, the Board of Directors may select the series of such Preferred Stock to be redeemed and if less than all the Preferred Stock of any series is to be called for redemption, the shares to be redeemed may be selected by lot or by such other equitable method as the Board of Directors in its discretion may determine. Notice of every such redemption, stating the redemption date, the redemption price, and the place of payment thereof, shall be given by mailing a copy of such notice at least thirty (30) days and not more than sixty (60) days prior to the date fixed for redemption to the holders of record of the Preferred Stock to be redeemed at their respective addresses as the same appear on the books of the Corporation. A similar notice shall be published at least once in a daily newspaper printed in the English language and published and of general circulation in the Borough of Manhattan, the City of New

York. At any time after notice of redemption has been given in the manner prescribed by the Board of Directors to the holders of stock so to be redeemed the Corporation may deposit with a bank or trust company having capital, surplus and undivided profits of at least $5,000,000 named in such notice, the redemption price, in trust, for payment on or before the date fixed for redemption, as aforesaid, to the respective orders of the holders of the shares so to be redeemed, on such endorsement to the Corporation or its nominee or otherwise, as may be required, and upon surrender of the certificates for such shares. Upon the deposit of the said redemption price as aforesaid, or, if no such deposit is made, upon the said redemption date (unless the Corporation shall default in making payment of the redemption price as set forth in such notice), such holders shall cease to be stockholders with respect to the said shares, and from and after the making of the said deposit, or, if no such deposit is made, after the redemption date (the Corporation not having defaulted in making payment of the redemption price as set forth in such notice), the said shares shall no longer be transferable on the books of the Corporation, and the said holders shall have no interest in or claim against the Corporation with respect to the said shares but shall be entitled only to such conversion rights (if any) on or before the date fixed for redemption as may be provided with respect to such shares or to receive payment of the redemption price without interest thereon, upon endorsement; provided, that any funds so deposited by the Corporation and unclaimed at the end of one year from the date fixed for such redemption shall be repaid to the Corporation upon its request, after which repayment the holders of such shares so called for redemption shall look only to the Corporation for the payment of the redemption price thereof. Any funds so deposited, which shall not be required for such redemption because of the exercise of any right of conversion or otherwise subsequently to the date of such deposit, shall be returned to the Corporation forthwith. Any interest accrued on any funds so deposited shall belong to the Corporation and shall be paid to it from time to time.

In order to facilitate the redemption of any shares of Preferred Stock, the Board of Directors is authorized to cause the transfer books of the Corporation to be closed as to the shares to be redeemed.

The Corporation shall have the right, provided full cumulative dividends on the Preferred Stock shall have been paid for past dividend periods and the Corporation shall not then be in default as to any payment required for any sinking fund created with respect to any series of Preferred Stock, to purchase Preferred Stock of any series which is subject to purchase by the terms of such series, at prices not in excess of the then redemption price thereof, either for the purpose of redemption or retirement or to be held, used and disposed of as treasury shares.

II.A.(vii) If at any time the Corporation shall have failed to pay dividends in full on the Preferred Stock, thereafter and until dividends in full, including all accrued and unpaid dividends, on Preferred Stock outstanding shall have been paid, or declared and set aside for payment, the Corporation shall not redeem any Preferred Stock except as a whole and shall not purchase any Preferred Stock except in accordance with a purchase offer made in writing or by publication (as determined by the Board of Directors) to all holders of the Preferred Stock upon the same terms as to any series, and shall not purchase or redeem any other shares of any class ranking on a parity with or junior to the Preferred Stock as to dividends or as to assets.

II.A.(viii) Special Voting Rights of Preferred Stock

(1) The Corporation shall not, without the affirmative vote at a meeting, or the written consent with or without a meeting, of the holders of at least two-thirds of the then outstanding Preferred Stock of all series:

(a) Change the express terms and provisions applicable to all series of the Preferred Stock in any material respect prejudicial to the holders thereof; or

(b) Create any class of stock which shall be preferred as to dividends or as to assets over the Preferred Stock.

(2) The Corporation shall not, without the affirmative vote at a meeting, or the written consent with or without a meeting, of the holders of at least two-thirds of the outstanding Preferred Stock of any particular series, change the express terms of the special provisions for such series as provided in this Restated Certificate or in the resolution or resolutions of the Board of Directors providing for the issue of such series in any material respect prejudicial to the holders of shares of such series.

(3) The Corporation shall not without the affirmative vote at a meeting, or the written consent with or without a meeting, of the holders of at least a majority of the then outstanding Preferred Stock of all series, increase the authorized number of shares of Preferred Stock or create any class of stock which shall rank on a parity with the Preferred Stock as to dividends or as to assets.

(4) If the Corporation shall have failed to pay dividends upon the Preferred Stock in an aggregate amount equal to four full quarterly dividends on any series of the Preferred Stock at the time outstanding, the holders of Preferred Stock shall have the right, voting separately as a class at the annual meeting of stockholders, to elect one-third (or the nearest number thereto) of the members of the Board of Directors of the Corporation until such time as all dividends accumulated on the Preferred Stock shall have been paid in full; and upon such payment in full of all dividends accumulated on the Preferred Stock, such special voting rights of holders thereof shall cease, subject to re-vesting in the event of each and every subsequent default of the character above mentioned.

III. Preference Stock

III.A. Provisions Generally Applicable to Preference Stock

III.A.(i) The Preference Stock may be issued from time to time by the Board of Directors as shares of one or more series. Subject to the provisions hereof and the limitations prescribed by law, the Board of Directors is expressly authorized, prior to issuance, by adopting resolutions providing for the issuance of shares of any particular series and, if and to the extent from time to time required by law, by filing a certificate pursuant to the Delaware Law (or other laws hereafter in effect relating to the same or substantially similar subject matter), to establish the number of shares to be included in each such series and to fix the designations, relative rights, preferences and limitations of the shares of each such series. The authority of the Board of Directors with respect to each series shall include, but not be limited to, determination of the following:

(1) the distinctive serial designation of such series and the number of shares constituting such series (provided that the aggregate number of shares constituting all series of Preference Stock shall not exceed 50,000,000);

(2) the dividend rate, or basis for determining such rate, if any, on shares of such series, whether dividends shall be cumulative and, if so, from which date or dates;

(3) whether the shares of each series shall be redeemable and, if so, the terms and conditions of such redemption, including the date or dates upon and after which such shares shall be redeemable, and the amount per share payable in case of redemption, which amount may vary under different conditions and at different redemption dates;

(4) the obligation, if any, of the Corporation to retire shares of such series pursuant to a sinking fund;

(5) whether shares of such series shall be convertible into, or exchangeable for, shares of stock of any other class or classes or any other series of the same class of stock and, if so, the terms and conditions of such conversion or exchange, including the price or prices or the rate or rates of conversion or exchange and the terms of adjustment, if any;

(6) whether the shares of such series shall have voting rights, in addition to the voting rights provided by law, and, if so, the terms of such voting rights;

(7) the rights of the shares of such series in the event of voluntary or involuntary liquidation, dissolution or winding up of the Corporation;

(8) the restrictions, if any, on the payment of dividends upon, and the making of distributions to, any class of stock ranking junior to the shares of Preference Stock, and the restrictions, if any, on the purchase or redemption of the shares of any such junior class; and

(9) any other designations, relative rights, preferences and limitations of such series.

FIFTH: (i) In addition to any affirmative vote required by law or otherwise, the affirmative vote of the holders of at least a majority of the outstanding shares of Voting Stock, voting together as a single class, held by stockholders other than a Related Person shall be required for the approval, authorization or effectuation directly or indirectly, of any Business Combination with such Related Person (such affirmative vote being required notwithstanding the fact that no vote may be required or that a lesser percentage may be specified by law, this Restated Certificate, any resolution or resolutions adopted by the Board of Directors pursuant to this Restated Certificate, any agreement with any national securities exchange or otherwise); provided, however, that such voting requirement shall not be applicable if:

(1) The Continuing Directors, by at least a majority vote of such Continuing Directors, have expressly approved such Business Combination either in advance of or subsequent to such Related Person's having become a Related Person; or

(2) All of the following conditions shall have been satisfied:

(a) The Fair Market Value as of the date of consummation of the Business Combination of the consideration to be received per share by holders of shares of each class or series of Capital Stock (regardless of whether or not such Related Person is the Beneficial Owner of shares of any such class or series of Capital Stock) in the Business Combination is not less than the Highest Per Share Price;

(b) The form of consideration to be received by holders of shares of each class or series of Capital Stock in the Business Combination shall be United States currency or the form of consideration used by such Related Person in acquiring the largest aggregate number of shares of the Capital Stock which such Related Person has previously acquired;

(c) After such Related Person shall have first become a Related Person and prior to the consummation of such Business Combination:

(x) Except as approved by at least a majority of the Continuing Directors, there shall not have been any failure to declare and pay at the regular dates therefor the full amount of all dividends (whether or not cumulative) payable on the Preferred Stock, the Preference Stock or any other class or series of stock having a preference over the Common Stock as to dividends or upon liquidation;

(y) There shall not have been (A) any reduction in the annual rate of dividends paid on the Common Stock (except as necessary to reflect any subdivision of the Common Stock) except as approved by at least a majority of the Continuing Directors or (B) any failure to increase such annual rate of dividends, to the extent necessary to prevent any such reduction, in the event of any reclassification (including any reverse stock split), recapitalization, reorganization or any similar transaction that has the effect of reducing the number of outstanding shares of Common Stock, unless the failure so to increase such annual rate shall have been approved by at least a majority of the Continuing Directors; and

(z) Such Related Person shall not have become the Beneficial Owner of additional shares of Voting Stock, except as part of the transaction that results in such Related Person becoming a Related Person and except in a transaction that, giving effect thereto, would not result in any increase in the percentage of Voting Stock of which such Related Person is the Beneficial Owner; and

(d) A proxy statement describing the proposed Business Combination and complying with the requirements of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and the rules and regulations thereunder, or any acts, rules or regulations that at least a majority of the Continuing Directors determine are successors thereof, shall (whether or not such a proxy statement is required to be mailed pursuant to such acts, rules or regulations) have been mailed to all holders of Voting Stock at least thirty (30) days prior to the date of the meeting called to consider such Business Combination and such statement shall have contained, at the front thereof, in a prominent place such recommendations and other information concerning the Business Combination as at least a majority of the Continuing Directors may determine so to include.

(ii) For purposes of this Article FIFTH:

(1) The terms "Affiliate" and "Associate" shall have the same meaning as in Rule 12b-2 of the General Rules and Regulations under the Exchange Act as in effect on the date of this Restated Certificate (the term "registrant" in said Rule 12b-2 meaning in this case the Corporation), and shall include any Person that, giving effect to a Business Combination, would become such an Affiliate or Associate.

(2) The term "Beneficial Owner" shall mean any Person which beneficially owns any Capital Stock within the meaning ascribed in Rule 13d-3 of the General Rules and Regulations under the Exchange Act as in effect on the date of this Restated Certificate, or who has the right to acquire any such beneficial ownership (whether or not such right is exercisable immediately, with the passage of time or subject to any condition) pursuant to any agreement, contract, arrangement or understanding or upon the exercise of any conversion, exchange or other right, warrant or option, or otherwise. A Person shall be deemed the Beneficial Owner of all Capital Stock of which any Affiliate or Associate of such Person is the Beneficial Owner.

(3) The term "Business Combination" shall mean (a) any merger or consolidation of the Corporation or a Subsidiary with or into a Related Person, (b) any sale, lease, exchange, transfer or other disposition, including without limitation by way of a mortgage or any other security device, of any Substantial Amount of the assets of the Corporation, one or more Subsidiaries or the Corporation and one or more Subsidiaries to a Related Person, (c) the adoption of any plan or proposal for the liquidation or dissolution of the Corporation proposed by or on behalf of any Related Person, (d) any sale, lease, exchange, transfer or other disposition, including without limitation by way of a mortgage or any other security device, of any Substantial Amount of the assets of a Related Person to the Corporation, one or more Subsidiaries, or the Corporation and one or more Subsidiaries, (e) the issuance of any securities of the Corporation, one or more Subsidiaries or the Corporation and one or more Subsidiaries to a Related Person or to a Person that giving effect thereto, would be a Related Person other than the issuance on a pro rata basis to all holders of stock of the same class pursuant to a stock split or stock dividend, (f) any reclassification of securities, recapitalization of the Corporation, or any merger or consolidation of the Corporation with or into one or more Subsidiaries or any other transaction that would have the effect, directly or indirectly, of increasing the voting power or other equity interest of a Related Person in the Corporation, (g) any loan, advance, guaranty, pledge or other financial assistance by the Corporation, one or more Subsidiaries or the Corporation and one or more Subsidiaries to or for the benefit, directly or indirectly (except proportionately as a stockholder), of a Related Person, (h) any agreement, contract or other arrangement providing for any Business Combination and (i) any series of transactions that a majority of Continuing Directors determines are related and that, taken together, would constitute a Business Combination.

(4) For the purposes of Section (i)(2) of this Article FIFTH, the term "consideration to be received" shall include, without limitation, Capital Stock of the Corporation retained by its existing stockholders other than Related Persons in the event of a Business Combination that is a merger and in which the Corporation is the surviving corporation.

(5) The term "Continuing Director" shall mean a Director of the Corporation who is not the Related Person, or an Affiliate or Associate of the Related Person (or a representative or nominee of the Related Person or such Affiliate or Associate), that is involved in the relevant Business Combination and (a) who was a member of the Board of Directors of the Corporation immediately prior to the time that such Related Person became a Related Person or (b) whose initial election as a Director of the Corporation was recommended by the affirmative vote of a least a majority of the Continuing Directors then in office, provided that, in either such case, such Continuing Director has continued in office after becoming a Continuing Director.

(6) The term "Fair Market Value" shall mean (a) in the case of United States currency, the amount thereof, (b) in the case of stock, (x) the closing sale price per share thereof on the last trading day preceding the date as of which the determination thereof is to be made, or the highest closing sale price per share thereof during the specified period, on the Composite Tape for New York Stock Exchange-Listed Stocks or, if such stock is not quoted on the Composite Tape, on the New York Stock Exchange, or if such stock is not listed on such exchange, on the United States securities exchange registered as a national securities exchange under the Exchange Act on which such stock is listed or principally traded, (y) if such stock is not so listed, the closing bid quotation per share thereof on the last trading day preceding the date as of which the determination thereof is to be made, or the highest closing bid quotation per share thereof during the specified period, on the National Association of Securities Dealers Inc. Automated Quotation System, or any system then in use or (z) if no such quotations are then available, the fair market value thereof, as of the date of which the determination thereof is to be made, as determined by at least a majority of the Continuing Directors and (c) in the case of securities, property or assets other than such currency or stock, the fair market value thereof, as of the date of which the determination thereof is to be made, as determined by at least a majority of the Continuing Directors.

(7) The term "Highest Per Share Price" shall mean with respect to any class or series of Capital Stock the highest of (a) the highest price per share that can be determined to have been paid at any time by the Related Person involved in the relevant Business Combination for any share or shares of such class or series of Capital Stock, or if such Related Person has not acquired any Capital Stock of such class or series, the highest equivalent, as determined by at least a majority of the Continuing Directors for a share of such class or series of such highest price for any other class or series of Capital Stock, (b) the highest preferential amount, if any, per share payable with respect to shares of such class or series of Capital Stock in the event of a voluntary or involuntary liquidation of the Corporation, or the highest redemption price, if any, to which the holders of shares of such class or series of Capital Stock would be entitled, whichever is higher, and (c) the Fair Market Value per share of such Capital Stock during the period of twenty (20) trading days immediately preceding the time the relevant Business Combination is first publicly announced, or during the period of twenty (20) trading days immediately preceding the time at which the Related Person became a Related Person, whichever is higher. In determining the Highest Per Share Price, (x) all purchases by the Related Person shall be taken into account regardless of whether the shares were purchased before or after the Related Person became a Related Person and (y) the Highest Per Share Price shall include any brokerage commissions, transfer taxes and soliciting dealers' fees or other value paid in connection with such purchases.

A Related Person shall be deemed to have acquired a share of Capital Stock at the time when such Related Person became the Beneficial Owner thereof. The price deemed to have been paid by a Related Person for Capital Stock of which an Affiliate or Associate is the Beneficial Owner shall be the price that is the highest of (a) the price paid upon the acquisition thereof by the relevant Affiliate or Associate (if any, and whether or not such Affiliate or Associate was an Affiliate or Associate at the time of such acquisition), and (b) the Fair Market Value per share of such Capital Stock during the period of twenty (20) trading days immediately preceding the time when the Related Person became the Beneficial Owner thereof.

In any determination of the price or prices paid or deemed to have been paid by any Person, and in any determination of the Highest Per Share Price or Fair Market Value,

appropriate adjustment shall be made to reflect the relevant effect of any stock dividends, splits and distributions and any combination or reclassification of Capital Stock.

(8) The Term "Related Person" shall mean (a) any Person (other than the Corporation or any wholly owned Subsidiary) that, alone or together with any Affiliates and Associates, is or becomes the Beneficial Owner of an aggregate of 10% or more of the outstanding Voting Stock, and (b) any Affiliate or Associate of any such Person, provided, however, that the term "Related Person" shall not include (x) a Person whose acquisition of such aggregate percentage of Voting Stock was approved in advance by at least a majority of the Continuing Directors or (y) any pension, profit sharing, employee stock ownership or other employee benefit plan of the Corporation or any Subsidiary, all of the capital stock of or equity interest in which Subsidiary is owned by the Corporation, one or more Subsidiaries or the Corporation and one or more Subsidiaries, or any trustee or fiduciary when acting in such capacity with respect to any such plan. The term "Person" shall mean any individual, corporation, partnership or other entity, including, any group comprised of any person and any other Person, or any Affiliate or Associate thereof, with whom such Person, or any Affiliate or Associate thereof, has any agreement, arrangement or understanding, directly or indirectly, for the purpose of acquiring, holding, voting or disposing of Voting Stock and each Person, and any Affiliate or Associate thereof, that is a member of such group.

(9) The term "Subsidiary" shall mean any Person a majority of the capital stock of or other equity interest in which is owned by the Corporation, one or more Subsidiaries or the Corporation and one or more Subsidiaries.

(10) The term "Substantial Amount" shall mean an amount of stock, securities or other property having a Fair Market Value equal to ten percent (10%) or more of the Fair Market Value of the total consolidated assets of the Corporation and its Subsidiaries taken as a whole, as of the end of the Corporation's most recent fiscal year ended prior to the time as of which the determination is being made.

(11) The term "Voting Stock" shall mean all outstanding Common Stock and all other outstanding Capital Stock of the Corporation, if any, entitled to vote on each matter on which the holders of record of Common Stock shall be entitled to vote, and each reference to a proportion of shares of Voting Stock shall refer to such proportion of the votes entitled to be cast by the holders of such Common Stock and other Capital Stock, if any, and the term "Capital Stock" shall mean all outstanding capital stock of the Corporation issued pursuant to this Restated Certificate or any resolution or resolutions of the Board of Directors of the Corporation adopted pursuant to this Restated Certificate.

(12) The Continuing Directors by at least a majority vote, shall have the power to make any and all determinations provided for in this Article FIFTH and to interpret the provisions and definitions in this Article FIFTH, which determinations and interpretations shall, to the fullest extent permitted by law, be conclusive.

(iii) In addition to the requirements of law and any other provisions of this Restated Certificate or any resolution or resolutions of the Board of Directors adopted pursuant to this Restated Certificate (and notwithstanding the fact that a lesser percentage may be specified by law, this Restated Certificate, any such resolution or resolutions or otherwise), the affirmative vote of the holders of at least a majority of the outstanding shares of Voting Stock held by

stockholders other than any Related Person shall be required to amend, alter or repeal, or adopt any provision inconsistent with the provisions of this Article FIFTH.

SIXTH: The number of directors of the Corporation shall not be less than three nor more than eighteen, as determined by action of the Board of Directors.

SEVENTH: (i) A director of the Corporation shall not be liable to the Corporation or its stockholders for monetary damages for breach of fiduciary duty as a director to the fullest extent permitted by Delaware Law.

(ii)(1) Each person (and the heirs, executors or administrators of such person) who was or is a party or is threatened to be made a party to, or is involved in any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative, by reason of the fact that such person is or was a director or officer of the Corporation or is or was serving at the request of the Corporation as a director or officer of another corporation, partnership, joint venture, trust or other enterprise, shall be indemnified and held harmless by the Corporation to the fullest extent permitted by Delaware Law. The right to indemnification conferred in this Article SEVENTH shall also include the right to be paid by the Corporation the expenses incurred in connection with any such proceeding in advance of its final disposition to the fullest extent authorized by Delaware Law. The right to indemnification conferred in this Article SEVENTH shall be a contract right.

(2) The Corporation may, by action of its Board of Directors, provide indemnification to such of the employees and agents of the Corporation to such extent and to such effect as the Board of Directors shall determine to be appropriate and authorized by Delaware Law.

(iii) The Corporation shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise against any expense, liability or loss incurred by such person in any such capacity or arising out of his status as such, whether or not the Corporation would have the power to indemnify him against such liability under Delaware Law.

(iv) The rights and authority conferred in this Article SEVENTH shall not be exclusive of any other right which any person may otherwise have or hereafter acquire.

(v) Neither the amendment nor repeal of this Article SEVENTH, nor the adoption of any provision of this Restated Certificate or the by-laws of the Corporation, nor, to the fullest extent permitted by Delaware Law, any modification of law, shall eliminate or reduce the effect of this Article SEVENTH in respect of any acts or omissions occurring prior to such amendment, repeal, adoption or modification.

EIGHTH: (a) Action by Written Consent. Except as provided in the certificate of designation for any series of preferred stock, any action required or permitted to be taken at any annual or special meeting of stockholders may be taken without a meeting by the written consent of the stockholders of the Corporation, but only if such action is taken in accordance with the provisions of this Article Eighth and the Corporation's by-laws.

(b) Request for Record Date. The record date for determining stockholders entitled to express consent to corporate action in writing without a meeting shall be as fixed by the Board of Directors or as otherwise established under this Article. Any person other than the Corporation seeking to have the stockholders authorize or take corporate action by written consent without a meeting shall, by written notice addressed to the secretary of the Corporation and delivered to the Corporation and signed by holders of record of at least twenty-five percent (25%) of the voting power of the outstanding capital stock of the Corporation entitled to express consent on the relevant action, request that a record date be fixed for such purpose. The written notice must contain the information required by Section 1.07 of the by-laws. Following receipt of the notice, the Board of Directors shall promptly, but in all events within ten (10) business days after the date the notice is received, determine the validity of the request and whether the request relates to an action that may be taken by written consent pursuant to this Article and, if appropriate, adopt a resolution fixing the record date for such purpose. The record date for such purpose shall be no more than ten (10) days after the date upon which the resolution fixing the record date is adopted by the Board of Directors and shall not precede the date such resolution is adopted. If no record date has been fixed by the Board of Directors within ten (10) business days following the Corporation's receipt of the notice to fix a record date for such purpose, the record date shall be the day on which the first signed written consent is delivered to the Corporation in the manner described in paragraph (f) of this Article; except that, if prior action by the Board of Directors is required under the provisions of Delaware law and the Board determines to take such prior action, the record date shall be at the close of business on the day on which the Board of Directors adopts the resolution taking such prior action, and except that no record date shall be set for any action that is not a proper subject for action by written consent pursuant to paragraph (c) or for which consents are not to be solicited as provided in paragraph (d).

(c) Actions Which May Be Taken by Written Consent. The Board of Directors shall not be obligated to set a record date for an action by written consent if (i) the record date request does not comply with this Article Eighth and the Corporation's by-laws, (ii) such action is not a proper subject for stockholder action under applicable law, (iii) the request for a record date for such action is received by the Corporation during the period commencing ninety (90) days prior to the first anniversary of the date of the immediately preceding annual meeting and ending on the date of the next annual meeting, (iv) an annual or special meeting of stockholders that included an item of business substantially the same as or substantially similar to such action ("Similar Item") was held not more than one hundred twenty (120) days before such request for a record date was received by the secretary of the Corporation, (v) a Similar Item is to be included in the Corporation's notice as an item of business to be brought before a meeting of the stockholders that is to be called within forty (40) days after the request for a record date is received and held as soon as practicable thereafter, or (vi) such record date request or any solicitation of consents to such action was made in a manner that involved a violation of Regulation 14A under the Exchange Act or other applicable law. For purposes of this paragraph, the nomination, election or removal of directors shall be deemed to be a Similar Item with respect to all actions involving the nomination, election or removal of directors, changing the size of the Board of Directors and filling of vacancies and/or newly created directorships resulting from any increase in the authorized number of directors. The Board of Directors shall determine in good faith whether a record date is required to be set under the provisions of this Article Eighth.

(d) Manner of Consent Solicitation. Stockholders may take action by written consent only if consents are solicited pursuant to a consent solicitation conducted pursuant to Regulation

14A of the Exchange Act, without reliance upon the exemption contained in Rule 14a-2(b)(2) of the Exchange Act.

(e) Date of Consent. Every written consent purporting to take or authorize the taking of corporate action (each such written consent is referred to in this paragraph and in paragraph (f) as a "Consent") must bear the date of signature of each stockholder who signs the Consent, and no Consent shall be effective to take the corporate action referred to therein unless, within sixty (60) days of the earliest dated Consent delivered in the manner required by paragraph (f) of this Article and not later than one hundred twenty (120) days after the record date, Consents signed by a sufficient number of stockholders to take such action are so delivered to the Corporation.

(f) Delivery of Consents. No Consents may be delivered to the Corporation or its registered office in the State of Delaware until fifty (50) days after the record date. Consents must be delivered to the Corporation by delivery to its registered office in the State of Delaware or its principal place of business. Delivery must be made by hand or by certified or registered mail, return receipt requested.

NINTH: Special meetings of the stockholders may be called (i) by the Board of Directors, the Chair of the Board of Directors or the Chief Executive Officer of the Corporation or (ii) upon written request from holders of record of at least fifteen percent (15%) of the voting power of the outstanding capital stock of the Corporation entitled to vote on the matter or matters to be brought before the proposed special meeting, filed with the Secretary of the Corporation and otherwise in accordance with the By-laws, and may not be called by any other person or persons. Notwithstanding the foregoing, whenever holders of one or more classes or series of Preferred Stock or Preference Stock shall have the right, voting separately as a class or series, to elect directors, such holders may call, to the extent provided in Article FOURTH (or pursuant to the terms of the resolution or resolutions adopted by the Board of Directors pursuant to Article FOURTH hereof), special meetings of holders of such Preferred Stock or Preference Stock.

TENTH: The Corporation's by-laws or any of them, may be altered, amended or repealed, or new by-laws may be made, by the stockholders entitled to vote thereon at any annual or special meeting thereof or by the Board of Directors.

ELEVENTH: The Corporation reserves the right to amend this Restated Certificate in any manner permitted by Delaware Law and, with the sole exception of those rights and powers conferred under the above Article SEVENTH, all rights and powers conferred herein on stockholders, directors and officers, if any, are subject to this reserved power.

[*Remainder of this page intentionally left blank.*]

IN WITNESS WHEREOF, the Corporation has caused this Restated Certificate of Incorporation to be executed by its President and Chief Executive Officer and attested by its Senior Vice President, Secretary and Assistant General Counsel on this 4th day of June, 2018.

CVS HEALTH CORPORATION

By: _____
Name: Larry J. Merlo
Title: President and Chief Executive Officer

Attest: _____
Name: Colleen M. McIntosh
Title: Senior Vice President, Secretary and Assistant General Counsel

B.2.a.(iv.) – CVS Health Restated Bylaws

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BY-LAWS

OF

CVS HEALTH CORPORATION

(as amended and restated June 4, 2018)

ARTICLE 1

STOCKHOLDERS

Section 1.01 ANNUAL MEETING. The annual meeting of the stockholders of the corporation for the purpose of electing directors and for the transaction of such other business as may be brought before the meeting, shall be held at the principal office of the corporation, or at such other place within or without the State of Delaware stated in the notice of the meeting as the Board of Directors may determine, on such day and at such time, as the Board of Directors may determine.

Section 1.02 SPECIAL MEETINGS.

(i) Special meetings of stockholders may be called by the Board of Directors, the Chair of the Board or the Chief Executive Officer.

(ii) A special meeting of stockholders shall be called by the Secretary at the written request or requests (each, a "Special Meeting Request" and, collectively, the "Special Meeting Requests") of holders of record of at least fifteen percent (15%) of the voting power of the outstanding capital stock of the corporation entitled to vote on the matter or matters to be brought before the proposed special meeting (the "Special Meeting Requisite Percentage"). A Special Meeting Request to the Secretary shall be signed and dated by each stockholder of record (or a duly authorized agent of such stockholder) requesting the special meeting (each, a "Requesting Stockholder"), shall comply with Sections 1.02 and 1.10, and shall include (a) a statement of the specific purpose or purposes of the special meeting, (b) the information required by Section 1.10(i)(c), (c) an acknowledgement by the Requesting Stockholders and the beneficial owners, if any, on whose behalf the Special Meeting Request are being made that a disposition of shares of the corporation's capital stock owned of record or beneficially as of the date on which the Special Meeting Request in respect of such shares is delivered to the Secretary that is made at any time prior to the special meeting shall constitute a revocation of such Special Meeting Request with respect to such disposed shares, and (d) documentary evidence that the Requesting Stockholders own the Special Meeting Requisite Percentage as of the date of such written request to the Secretary; *provided*, *however*, that if the Requesting Stockholders are not the beneficial owners of the shares representing the Special Meeting Requisite Percentage, then to be valid, the Special Meeting Request must also include documentary evidence (or, if not simultaneously provided with the Special Meeting Request, such documentary evidence must be delivered to the Secretary within ten (10) business days after the date on which the Special Meeting Request are delivered to the Secretary) that the beneficial owners on whose behalf the Special Meeting Request are made beneficially own the Special Meeting Requisite Percentage as of the date on which such Special Meeting Request are delivered to the Secretary. In addition, the Requesting Stockholders and the beneficial owners, if any, on whose behalf the Special Meeting Request are being made shall promptly provide any other information reasonably requested by the corporation.

(iii) Notwithstanding the foregoing provisions of this Section 1.02, a special meeting requested by stockholders shall not be held if (a) the Special Meeting Request does not comply with this Section 1.02, (b) the Special Meeting Request relates to an item of business that is not a

proper subject for stockholder action under applicable law, (c) the Special Meeting Request is received by the corporation during the period commencing ninety (90) days prior to the first anniversary of the date of the immediately preceding annual meeting and ending on the date of the next annual meeting, (d) an annual or special meeting of stockholders that included an identical or substantially similar item of business ("Similar Business") was held not more than one hundred twenty (120) days before the Special Meeting Request was received by the Secretary, (e) the Board of Directors has called or calls for an annual or special meeting of stockholders to be held within ninety (90) days after the Special Meeting Request is received by the Secretary and the business to be conducted at such meeting includes the Similar Business, or (f) the Special Meeting Request was made in a manner that involved a violation of Regulation 14A under the Securities Exchange Act of 1934 (as amended from time to time, the "Exchange Act") or other applicable law. For purposes of this Section 1.02(iii), the nomination, election or removal of directors shall be deemed to be Similar Business with respect to all items of business involving the nomination, election or removal of directors, changing the size of the Board of Directors and filling of vacancies and/or newly created directorships resulting from any increase in the authorized number of directors. The Board of Directors shall determine in good faith whether the requirements set forth in this Section 1.02(iii) have been satisfied.

(iv) In determining whether a special meeting of stockholders has been requested by the record holders of shares representing in the aggregate at least the Special Meeting Requisite Percentage, multiple Special Meeting Requests delivered to the Secretary will be considered together only if (a) each Special Meeting Request identifies substantially the same purpose or purposes of the special meeting and substantially the same matters proposed to be acted on at the special meeting (in each case as determined in good faith by the Board of Directors), and (b) such Special Meeting Requests have been dated and delivered to the Secretary within sixty (60) days of the earliest dated Special Meeting Request. A Requesting Stockholder may revoke a Special Meeting Request at any time by written revocation delivered to the Secretary and if, following such revocation, there are outstanding un-revoked requests from Requesting Stockholders holding less than the Special Meeting Requisite Percentage, the Board of Directors may, in its discretion, cancel the special meeting. If none of the Requesting Stockholders appears or sends a duly authorized agent to present the business to be presented for consideration that was specified in the Special Meeting Request, the corporation need not present such business for a vote at such special meeting.

(v) Only such business shall be conducted at a special meeting of stockholders as shall have been brought before the meeting pursuant to the corporation's notice of meeting pursuant to Section 1.03. Nothing contained herein shall prohibit the Board of Directors from submitting matters to the stockholders at any special meeting requested by stockholders.

(vi) Special meetings shall be held at such date and time as may be fixed by the Board of Directors in accordance with these by-laws; *provided, however*, that in the case of a special meeting requested by stockholders, the date of any such special meeting shall not be more than ninety (90) days after a Special Meeting Request that satisfies the requirements of this Section 1.02 is received by the Secretary. Special meetings shall be held at such place within or without the State of Delaware as is specified in the notice of meeting.

Section 1.03 NOTICE OF MEETING; WAIVER. Unless otherwise required by statute, the notice of every meeting of the stockholders shall be in writing and signed by the Chair of the Board or the Chief Executive Officer (or the President or a Vice President or the Secretary or an Assistant Secretary, in each case acting at the direction of the Chair of the Board or the Chief Executive Officer) and shall state the date and time when and the place where it is to be held, and a copy thereof shall be served, either personally or by mail, upon each stockholder of record entitled to vote at such meeting, not less than ten (10) nor more than sixty (60) days before the meeting. If the meeting to be held is other than the annual meeting of stockholders, the notice shall also state the purpose or purposes for which the meeting is called and shall indicate that it is being issued by or at the direction of the person or persons calling the meeting. If, at any

meeting, action is proposed to be taken which would, if taken, entitle stockholders to receive payment for their shares pursuant to Section 262 of the General Corporation Law of the State of Delaware (the "DGCL"), the notice of such meeting shall include a statement of that purpose and to that effect. If the notice is mailed, it shall be directed to a stockholder at the stockholder's address as it appears on the record of stockholders unless the stockholder shall have filed with the Secretary a written request that notices intended for the stockholder be mailed to some other address, in which case it shall be mailed to the address designated in such request.

Notice of a meeting need not be given to any stockholder who submits a signed waiver of notice, in person or by proxy, whether before or after the meeting. The attendance of a stockholder at a meeting, in person or by proxy, without protesting prior to the conclusion of the meeting the lack of notice of such meeting, shall constitute a waiver of notice by the stockholder.

Section 1.04 QUORUM. At any meeting of the stockholders the holders of a majority of the shares entitled to vote and being present in person or represented by proxy shall constitute a quorum for all purposes, unless the representation of a different number shall be required by law or by another provision of these by-laws, and in that case the representation of the number so required shall constitute a quorum.

If the holders of the amount of shares necessary to constitute a quorum shall fail to attend in person or by proxy, the holders of a majority of the shares present in person or represented by proxy at the meeting, or the chair of the meeting, may adjourn from time to time without further notice of the adjourned meeting if the time and place thereof are announced at the meeting in which the adjournment is taken.

Furthermore, after the meeting has been duly organized, the chair of the meeting may adjourn any meeting of stockholders, annual or special, from time to time, to reconvene at the same or some other place, and notice need not be given of any such adjourned meeting if the time and place thereof are announced at the meeting at which the adjournment is taken. At any such adjourned meeting, any business may be transacted which might have been transacted at the meeting as originally called. If the adjournment is for more than thirty (30) days, or if after the adjournment a new record date is fixed for the adjourned meeting, a notice of the adjourned meeting shall be given to each stockholder of record entitled to vote at the meeting. Any previously scheduled meeting of stockholders may be postponed by the Board of Directors prior to the date previously scheduled for such meeting and the corporation shall publicly announce such postponement.

Section 1.05 ORGANIZATION. The Chair of the Board or, in his or her absence, the Chief Executive Officer or, in his or her absence, the President, any Executive Vice President, Senior Vice President or Vice President in the order of their seniority or in such other order as may be designated by the Board of Directors, shall call meetings of the stockholders to order and shall act as chair of such meetings. The Board of Directors or the Executive Committee may appoint any stockholder to act as chair of any meeting in the absence of any of such officers and in the event of such absence and the failure of such board or committee to appoint a chair, the stockholders present at such meeting may nominate and appoint any stockholder to act as chair.

The Secretary, or, in his or her absence, an Assistant Secretary, shall act as secretary of all meetings of stockholders, but, in the absence of said officers, the chair of the meeting may appoint any person to act as secretary of the meeting.

The date and time of the opening and the closing of the polls for each matter upon which the stockholders will vote at a meeting shall be announced at such meeting by the person presiding over the meeting. The Board of Directors may adopt by resolution such rules or regulations for the conduct of meetings of stockholders as it shall deem appropriate. Except to the extent inconsistent with such rules and regulations as adopted by the Board of Directors, the chair of any meeting of stockholders shall have the right and authority to prescribe such rules, regulations and procedures and to do all such acts as, in the judgment of such chair, are appropriate for the proper conduct of the meeting. Such rules, regulations or procedures, whether adopted by the Board of Directors or prescribed by the chair of the meeting, may include, without limitation, the following: (i) the establishment of an agenda or order of business for the meeting; (ii) rules and procedures for maintaining order at the meeting and the safety of those present; (iii)

limitations on attendance at or participation in the meeting, to stockholders of record of the corporation, their duly authorized and constituted proxies or such other persons as the chair shall permit; (iv) restrictions on entry to the meeting after the time fixed for the commencement thereof; and (v) limitations on the time allotted to questions or comments by participants. Unless and to the extent determined by the Board of Directors or the chair of the meeting, meetings of stockholders shall not be required to be held in accordance with rules of parliamentary procedure.

Section 1.06 VOTING. At each meeting of the stockholders every stockholder of record having the right to vote shall be entitled to vote either in person or by proxy. Unless a greater number of affirmative votes is required by the certificate of incorporation of the corporation (the "Certificate of Incorporation"), these by-laws, the rules or regulations of the principal U.S. exchange upon which the shares of the corporation are listed, or as otherwise required by law or pursuant to any regulation applicable to the corporation, if a quorum exists at any meeting of stockholders, stockholders shall have approved any matter, other than the election of directors pursuant to Section 2.03, if the matter receives the vote of the majority of the votes cast with respect to that matter. For purposes of this Section 1.06, a majority of votes cast means that the number of votes "for" a matter must exceed fifty percent (50%) of the votes cast with respect to that matter.

Section 1.07 ACTION BY WRITTEN CONSENT.

(i) Any action required or permitted to be taken by the stockholders of the corporation must be effected at a duly called annual or special meeting of such holders or may be effected by a consent in writing by stockholders as provided by, and subject to the limitations in, the Certificate of Incorporation and this Section 1.07.

(ii) A request by a stockholder for a record date in accordance with Article Eighth of the Certificate of Incorporation must be delivered by the holders of record of at least twenty five percent (25%) of the voting power of the outstanding capital stock of the corporation entitled to express consent on the relevant action (the "Consent Requisite Percentage"), must describe the action that the stockholder proposes to take by consent (the "Action") and must contain (a) the text of the proposal (including the text of any resolutions to be effected by consent), (b) the information required by Section 1.10(i)(c) of these by-laws, to the extent applicable, as though the stockholders making the request were making a Special Meeting Request in furtherance of the Action, (c) an acknowledgment by the stockholders making the request and the beneficial owners, if any, on whose behalf the request is being made that a disposition of shares of the corporation's capital stock, owned of record or beneficially as of the date on which the request in respect of such shares is delivered to the Secretary, that is made at any time prior to the delivery of the first written consent with respect to the Action shall constitute a revocation of such request with respect to such disposed shares, (d) a statement that the stockholder intends to solicit consents in accordance with Regulation 14A of the Exchange Act, without reliance on the exemption contained in Rule 14a-2(b)(2) of the Exchange Act, and (e) documentary evidence that the stockholders making the request own the Consent Requisite Percentage as of the date that the request is delivered to the Secretary; *provided, however*, that if the stockholders making the request are not the beneficial owners of the shares representing the Consent Requisite Percentage, then to be valid, the request must also include documentary evidence (or, if not simultaneously provided with the request, such documentary evidence must be delivered to the Secretary within ten (10) business days after the date on which the request is delivered to the Secretary) that the beneficial owners on whose behalf the request is made beneficially own the Consent Requisite Percentage as of the date on which such request is delivered to the Secretary. In addition, the requesting stockholders and the beneficial owners, if any, on whose behalf the request is being made shall promptly provide any other information reasonably requested by the corporation.

(iii) In determining whether a record date has been requested by stockholders of record representing in the aggregate at least the Consent Requisite Percentage, multiple requests delivered

to the Secretary will be considered together only if (a) each identifies substantially the same proposed action and includes substantially the same text of the proposal (in each case as determined in good faith by the Board of Directors), and (b) such requests have been dated and delivered to the Secretary within sixty (60) days of the earliest dated request. Any stockholder may revoke a request with respect to his or her shares at any time by written revocation delivered to the Secretary.

Section 1.08 INSPECTORS OF ELECTION.

(i) The Board of Directors, in advance of any stockholders' meeting, shall appoint one or more inspectors of election (each, an "Inspector" or "Inspector of Election" and, collectively, "Inspectors" or "Inspectors of Election") to act at the meeting or any adjournment thereof. If Inspectors are not so appointed, the person presiding at a stockholders' meeting shall appoint one or more Inspectors. In case any person appointed fails to appear or act, the vacancy may be filled by appointment made by the Board of Directors in advance of the meeting or at the meeting by the person presiding thereat. Inspectors shall be sworn.

(ii) In the event of the delivery, in the manner provided by Section 1.07 and applicable law, to the corporation of written consent or written consents to take corporate action and/or any related revocation or revocations, the corporation shall appoint one or more Inspectors of Election for the purpose of performing promptly a ministerial review of the validity of the consents and revocations. For the purpose of permitting the Inspectors to perform such review, no action by written consent and without a meeting shall be effective until such Inspectors have completed their review, determined that the requisite number of valid and unrevoked consents delivered to the corporation in accordance with Section 1.07 and applicable law have been obtained to authorize or take the action specified in the consents, and certified such determination for entry in the records of the corporation kept for the purpose of recording the proceedings of meetings of stockholders. Nothing contained herein shall in any way be construed to suggest or imply that the Board of Directors or any stockholder shall not be entitled to contest the validity of any consent or revocation thereof, whether before or after such certification by the Inspectors, or to take any other action (including, without limitation, the commencement, prosecution or defense of any litigation with respect thereto, and the seeking of injunctive relief in such litigation).

Section 1.09 CONDUCT OF ELECTION. At each meeting of the stockholders, votes, proxies, consents and ballots shall be received, and all questions touching the qualification of voters, the validity of proxies and the acceptance or rejection of votes, shall be decided by the Inspectors of Election.

Section 1.10 NOTICE OF NOMINATIONS AND STOCKHOLDER BUSINESS.

(i) *Annual Meetings of Stockholders*.

(a) Nominations of persons for election to the Board of Directors or the proposal of other business to be transacted by the stockholders may be made at an annual meeting of stockholders only (1) pursuant to the corporation's notice of meeting (or any supplement thereto), (2) by or at the direction of the Board of Directors or any committee thereof, (3) by any stockholder of the corporation who is a stockholder of record at the time of giving of notice provided for in this Section 1.10(i), who shall be entitled to vote at the meeting and who complies with the notice procedures set forth in this Section 1.10(i), or (4) pursuant to Section 1.11.

(b) For nominations or other business to be properly brought before an annual meeting of stockholders by a stockholder pursuant to clause (3) of paragraph (i)(a) of this Section 1.10, the stockholder must have given timely notice thereof in writing to the Secretary, and any such proposed business (other than the nominations of persons for election to the Board of Directors) must constitute a proper matter for stockholder action. To be timely, a stockholder's notice shall be delivered to, or mailed and received by, the Secretary at the principal office of the corporation not earlier than the close of business on the one hundred twentieth (120th) day nor

later than the close of business on the ninetieth (90th) day prior to the first anniversary of the preceding year's annual meeting of stockholders; *provided, however*, that in the event that the date of the annual meeting is advanced more than thirty (30) days prior to such anniversary date or delayed more than seventy (70) days after such anniversary date, or if no annual meeting was held in the preceding year, then to be timely such notice must be received by the corporation no earlier than the close of business on the one hundred twentieth (120th) day prior to such annual meeting and no later than close of business on the later of (x) the ninetieth (90th) day prior to such annual meeting or (y) the tenth (10th) day following the day on which public announcement of the date of such meeting is first made by the corporation. In no event shall the public announcement of an adjournment or postponement of an annual meeting of stockholders commence a new time period (or extend any time period) for the giving of a stockholder's notice as described above.

(c) A stockholder's notice to the Secretary under this Section 1.10 shall set forth (1) as to each person whom the stockholder proposes to nominate for election or reelection as a director, all information relating to such person that is required to be disclosed in solicitations of proxies for election of directors, or is otherwise required, in each case pursuant to Regulation 14A under the Exchange Act (including such person's written consent to being named in the proxy statement as a nominee and to serving as a director if elected), (2) as to any other business that the stockholder proposes to bring before the meeting, a brief description of the business desired to be brought before the meeting, the text of the proposal or business (including the text of any resolutions proposed for consideration and in the event that such business includes a proposal to amend these by-laws, the language of the proposed amendment), the reasons for conducting such business at the meeting and any material interest in such business of such stockholder and the beneficial owner, if any, on whose behalf the proposal is made and (3) as to the stockholder giving the notice and the beneficial owner, if any, on whose behalf the proposal is made:

(A) the name and address, as they appear on the corporation's books, of such stockholder and any such beneficial owner;

(B) the class or series and number of shares of capital stock of the corporation which are held of record or are beneficially owned by such stockholder and by any such beneficial owner;

(C) a description of any agreement, arrangement or understanding between or among such stockholder and any such beneficial owner, any of their respective affiliates or associates, and any other person or persons (including their names) in connection with the proposal of such nomination or other business;

(D) a description of any agreement, arrangement or understanding (including any derivative or short positions, profit interests, options, warrants, convertible securities, stock appreciation or similar rights, hedging transactions and borrowed or loaned shares) that has been entered into by or on behalf of, or any other agreement, arrangement or understanding that has been made, the effect or intent of which is to mitigate loss to, manage risk or benefit of share price changes for, or increase or decrease the voting power of, such stockholder or any such beneficial owner (including any affiliate of such stockholder or any such beneficial owner) or any such nominee with respect to the corporation's securities;

(E) a representation that the stockholder is a holder of record of stock of the corporation entitled to vote at such meeting and intends to appear in person or by proxy at the meeting to bring such nomination or other business before the meeting; and

(F) a representation as to whether such stockholder or any such beneficial owner intends or is part of a group that intends to (I) deliver a proxy statement and/or form of

proxy to holders of at least the percentage of the voting power of the corporation's outstanding capital stock required to approve or adopt the proposal or to elect each such nominee and/or (II) otherwise to solicit proxies from stockholders in support of such proposal or nomination. If requested by the corporation, the information required under clauses (i)(c)(B), (C) and (D) of this Section 1.10 shall be supplemented by such stockholder and any such beneficial owner not later than five (5) business days after the record date for the meeting to disclose such information as of the record date.

(ii) *Special Meetings of Stockholders*. Nominations of persons for election to the Board of Directors of the corporation at a special meeting of stockholders may be made by stockholders only (a) in accordance with Section 1.02 or (b) if the election of directors is included as business to be brought before a special meeting in the corporation's notice of meeting, then by any stockholder who is a stockholder of record at the time of giving of notice provided for in this Section 1.10(ii), who shall be entitled to vote at the meeting and who complies with the notice procedures set forth in this Section 1.10(ii). The proposal by stockholders of other business to be conducted at a special meeting of stockholders may be made only in accordance with Section 1.02. For nominations to be properly brought by a stockholder before a special meeting of stockholders pursuant to Section 1.10(ii)(b), the stockholder must have given timely notice thereof in writing to the Secretary. To be timely, a stockholder's notice shall be delivered to, or mailed and received by, the Secretary at the principal office of the corporation (1) not earlier than the close of business on the one hundred twentieth (120th) day prior to the date of the special meeting nor (2) later than the close of business on the later of (x) the ninetieth (90th) day prior to the date of the special meeting or (y) the tenth (10th) day following the day on which public announcement of the date of the special meeting was first made. A stockholder's notice to the Secretary shall comply with the notice requirements of Section 1.10(i)(c).

(iii) *General*.

(a) At the request of the Board of Directors, any person nominated by the Board of Directors for election as a director shall furnish to the Secretary the information that is required to be set forth in a stockholder's notice of nomination under this Section 1.10 that pertains to the nominee. No person shall be eligible to be nominated by a stockholder to serve as a director of the corporation unless nominated in accordance with the procedures set forth in this Section 1.10, Section 1.11 (in the case of an annual meeting), and in Section 1.02 (in the case of a special meeting) or Section 1.07 (in the case of a written consent). No business shall be conducted except in accordance with the procedures set forth in this Section 1.10 and in Section 1.02 (in the case of a special meeting) or Section 1.07 (in the case of a written consent). The chair of the meeting shall, if the facts warrant, determine and declare to the meeting that a nomination was not made in accordance with the procedures prescribed by this Section 1.10 or that business was not properly brought before the meeting, and if he or she should so determine, he or she shall so declare to the meeting and the defective nomination shall be disregarded or such business shall not be transacted, as the case may be. Notwithstanding the foregoing provisions of this Section 1.10, unless otherwise required by law, if the stockholder (or a qualified representative of the stockholder) does not appear at the annual or special meeting of stockholders of the corporation to present a nomination or other proposed business, such nomination shall be disregarded or such proposed business shall not be transacted, as the case may be, and no vote shall be taken with respect to such nomination or proposed business, notwithstanding that proxies in respect of such vote may have been received by the corporation. For purposes of this Section 1.10, to be considered a qualified representative of the stockholder, a person must be a duly authorized officer, manager or partner of such stockholder or must be authorized by a writing executed by such stockholder or an electronic transmission delivered by such stockholder to act for such stockholder as proxy at the meeting of stockholders and

such person must produce such writing or electronic transmission, or a reliable reproduction of the writing or electronic transmission, at the meeting of stockholders.

(b) Without limiting the foregoing provisions of this Section 1.10, a stockholder shall also comply with all applicable requirements of the Exchange Act, and the rules and regulations thereunder with respect to the matters set forth in this Section 1.10; *provided, however*, that any references in these by-laws to the Exchange Act or the rules and regulations promulgated thereunder are not intended to and shall not limit any requirements applicable to nominations or proposals as to any other business to be considered pursuant to this Section 1.10, and compliance with paragraphs (i)(a)(3) and (ii) of this Section 1.10 or with Section 1.11 of these by-laws, shall be the exclusive means for a stockholder to make nominations or submit other business (other than as provided in the last sentence of this paragraph (iii)(b)). Notwithstanding anything to the contrary, the notice requirements set forth herein with respect to the proposal of any business pursuant to this Section 1.10 other than a nomination shall be deemed satisfied by a stockholder if such stockholder has submitted a proposal to the corporation in compliance with Rule 14a-8 promulgated under the Exchange Act, and such stockholder's proposal has been included in a proxy statement that has been prepared by the corporation to solicit proxies for the meeting of stockholders.

Section 1.11 PROXY ACCESS.

(i) *Proxy Access Right*.

(a) Subject to the terms and conditions of these by-laws, the corporation shall include in its proxy materials for an annual meeting of stockholders the name of, and the other Required Information (as defined in clause (b) of this Section 1.11(i)) with respect to, any Stockholder Nominee (as defined in Section 1.11(iv)(a) below) nominated by an Eligible Stockholder (as defined in Section 1.11(ii)(a) below) for election or reelection to the Board of Directors at such annual meeting of stockholders in accordance with this Section 1.11.

(b) "Required Information" means (1) the information set forth in the Schedule 14N provided with the Stockholder Notice (as defined in Section 1.11(v)(a) below) concerning each Stockholder Nominee that the corporation determines is required to be disclosed in the corporation's proxy materials by the applicable requirements of the Exchange Act and the rules and regulations thereunder, and (2) if the Eligible Stockholder so elects, a written statement (the "Statement") of the Eligible Stockholder, not to exceed 500 words, in support of each Stockholder Nominee, which must be provided at the same time as the Stockholder Notice for inclusion in the corporation's proxy materials for the annual meeting of stockholders.

(c) This Section 1.11 shall be the exclusive method for stockholders to include nominees for director election in the corporation's proxy materials.

(ii) *Eligible Stockholders*.

(a) "Eligible Stockholder" means one or more stockholders or beneficial owners that (1) expressly elect at the time of the delivery of the Stockholder Notice to have a Stockholder Nominee included in the corporation's proxy materials, (2) Own and have Owned (as defined in Section 1.11(iii) below) continuously for at least three (3) years as of the date of the Stockholder Notice, a number of shares that represents at least three percent (3%) of the outstanding shares entitled to vote as of the date of the Stockholder Notice (the "Required Shares"), and (3) satisfy such additional requirements as are set forth in these by-laws, including subsections (b) and (c) below.

(b) For purposes of determining qualification as an Eligible Stockholder, the outstanding shares Owned by one or more stockholders and beneficial owners that each stockholder and/or beneficial owner has Owned continuously for at least three (3) years as of the date of the Stockholder Notice may be aggregated; provided that the number of stockholders

and beneficial owners whose Ownership of shares is aggregated for such purpose shall not exceed twenty (20) and that any and all requirements and obligations for an Eligible Stockholder set forth in this Section 1.11 are satisfied by each such stockholder and beneficial owner (except as noted with respect to aggregation) or as otherwise provided in this Section 1.11.

(c) For purposes of determining qualification as an Eligible Stockholder, two or more funds that are (1) under common management and investment control, (2) under common management and funded primarily by a single employer, or (3) a "group of investment companies," as such term is defined in Section 12(d)(1)(G)(ii) of the Investment Company Act of 1940, as amended, shall be treated as one (1) stockholder or beneficial owner.

(d) No shares may be attributed to more than one (1) group constituting an Eligible Stockholder (and no stockholder or beneficial owner, alone or together with any of its affiliates, may be a member of more than one (1) group constituting an Eligible Stockholder) under this Section 1.11.

(iii) *Ownership Requirements*.

(a) A stockholder or beneficial owner shall be deemed to "Own" only those outstanding shares as to which such person possesses both (1) the full voting and investment rights pertaining to the shares and (2) the full economic interest in (including the opportunity for profit and risk of loss on) such shares; provided that the number of shares calculated in accordance with clauses (1) and (2) above shall not include any shares (A) sold by such person or any of its affiliates in any transaction that has not been settled or closed, including any short sale, (B) borrowed by such person or any of its affiliates for any purposes or purchased by such person or any of its affiliates pursuant to an agreement to resell, or (C) subject to any option, warrant, forward contract, swap, contract of sale, or other derivative or similar agreement entered into by such person or any of its affiliates, whether any such instrument or agreement is to be settled with shares or with cash based on the notional amount or value of outstanding shares, in any such case which instrument or agreement has, or is intended to have, or if exercised would have, the purpose or effect of (x) reducing in any manner, to any extent or at any time in the future, such person's or its affiliates' full right to vote or direct the voting of any such shares, and/or (y) hedging, offsetting, or altering to any degree any gain or loss arising from the full economic ownership of such shares by such person or its affiliate.

(b) A stockholder or beneficial owner shall be deemed to "Own" shares held in the name of a nominee or other intermediary so long as the person retains the right to instruct how the shares are voted with respect to the election of directors and possesses the full economic interest in the shares.

(c) A stockholder or beneficial owner's Ownership of shares shall be deemed to continue during any period in which the person has delegated any voting power by means of a proxy, power of attorney, or other instrument or arrangement.

(d) A stockholder or beneficial owner's Ownership of shares shall be deemed to continue during any period in which the person has loaned such shares provided that the person has the power to recall such loaned shares on five (5) business days' notice, the person promptly recalls the loaned shares upon being notified that its Stockholder Nominee will be included in the corporation's proxy materials for the relevant annual meeting of stockholders, and the person holds the recalled shares through such annual meeting.

(e) The terms "Owned," "Owning," "Ownership" and other variations of the word "Own," when used with respect to a stockholder or beneficial owner, shall have correlative meanings.

(iv) *Stockholder Nominees*.

(a) "Stockholder Nominee" means any nominee for election or reelection to the Board of Directors who satisfies the eligibility requirements in this Section 1.11, and who is identified in a timely and proper Stockholder Notice.

(b) The maximum number of Stockholder Nominees that may be included in the corporation's proxy materials pursuant to this Section 1.11 shall not exceed the greater of two (2) or twenty percent (20%) of the number of directors in office as of the last day on which a Stockholder Notice may be delivered pursuant to this Section 1.11 with respect to the annual meeting of stockholders, or if such calculation does not result in a whole number, the closest whole number below twenty percent (20%); provided, however, that this maximum number shall be reduced by (1) any Stockholder Nominee whose name was submitted for inclusion in the corporation's proxy materials pursuant to this Section 1.11 but either is subsequently withdrawn or that the Board of Directors decides to nominate as a Board nominee, (2) any director candidate who had been a Stockholder Nominee at any of the preceding two (2) annual meetings of stockholders and whose reelection at the upcoming annual meeting of stockholders is being recommended by the Board of Directors, (3) any director candidate for which the Corporation shall have received one or more valid shareholder notices (whether or not subsequently withdrawn) nominating director candidates pursuant to Section 1.10, other than any such director referred to in this clause (3) who at the time of such annual meeting will have served as director continuously, as a nominee of the Board of Directors, for at least two (2) annual terms, but only to the extent the maximum number after such reduction with respect to this clause (3) equals or exceeds one (1), and (4) any director candidate who will be included in the corporation's proxy materials with respect to such annual meeting as an unopposed (by the corporation) nominee pursuant to any agreement, arrangement or other understanding with any stockholder or group of stockholders (other than any such agreement, arrangement or understanding entered into in connection with an acquisition of shares of capital stock of the corporation, by such stockholder or group of stockholders, from the corporation), other than any such director referred to in this clause (4) who at the time of such annual meeting will have served as a director continuously, as a nominee of the Board of Directors, for at least (2) annual terms, but only to the extent the maximum number after such reduction with respect to this clause (4) equals or exceeds one (1).

(c) In the event that one or more vacancies for any reason occurs after the deadline in Section 1.11(vi) for delivery of the Stockholder Notice but before the annual meeting of stockholders and the Board of Directors resolves to reduce the size of the Board of Directors in connection therewith, the maximum number of Stockholder Nominees shall be calculated based on the number of directors in office as so reduced.

(d) In the event that the number of Stockholder Nominees submitted by Eligible Stockholders pursuant to this Section 1.11 exceeds this maximum number, the corporation shall determine which Stockholder Nominees shall be included in the corporation's proxy materials in accordance with the following provisions: each Eligible Stockholder (or in the case of a group, each group constituting an Eligible Stockholder) will select one (1) Stockholder Nominee for inclusion in the corporation's proxy materials until the maximum number is reached, going in order of the amount (largest to smallest) of shares of the corporation each Eligible Stockholder disclosed as Owned in its respective Stockholder Notice submitted to the corporation. If the maximum number is not reached after each Eligible Stockholder (or in the case of a group, each group constituting an Eligible Stockholder) has selected one (1) Stockholder Nominee, this selection process will continue as many times as necessary, following the same order each time, until the maximum number is reached.

(e) Following the determination of which Stockholder Nominees shall be included in the corporation's proxy materials, if any Stockholder Nominee who satisfies the eligibility requirements in this Section 1.11 is thereafter nominated by the Board of Directors, thereafter

is not included in the corporation's proxy materials or thereafter is not submitted for director election for any reason (including the Eligible Stockholder's or Stockholder Nominee's failure to comply with this Section 1.11), no other nominee or nominees shall be included in the corporation's proxy materials or otherwise submitted for director election in substitution thereof.

(f) Any Stockholder Nominee who is included in the corporation's proxy materials for a particular annual meeting of stockholders will be ineligible to be a Stockholder Nominee pursuant to this Section 1.11 for the next two (2) annual meetings of stockholders if such Stockholder Nominee either (1) withdraws from or becomes ineligible or unavailable for election at the annual meeting of stockholders for any reason, including for the failure to comply with any provision of these by-laws, provided that in no event shall any such withdrawal, ineligibility or unavailability commence a new time period (or extend any time period) for the giving of a Stockholder Notice or (2) does not receive a number of votes cast in favor of his or her election at least equal to twenty-five percent (25%) of the shares present in person or represented by proxy and entitled to vote in the election of directors.

(g) Notwithstanding anything to the contrary contained in this Section 1.11, the corporation may disregard the nomination of a Stockholder Nominee (and may, if the determination is made prior to the mailing of the proxy materials, omit from its proxy materials such Stockholder Nominee), and no vote on such Stockholder Nominee will occur, notwithstanding that proxies in respect of such vote may have been received by the corporation or that such Stockholder Nominee may have been included in the proxy materials, up to and until the certification of the voting results of that annual meeting of stockholders, if:

(1) the Eligible Stockholder (or any member of any group of stockholders that together is such Eligible Stockholder) or Stockholder Nominee breaches any of its respective agreements, representations, or warranties set forth in the Stockholder Notice (or otherwise submitted pursuant to this Section 1.11), any of the information in the Stockholder Notice (or otherwise submitted pursuant to this Section 1.11) was not, when provided, true, correct and complete, or the requirements of this Section 1.11 have otherwise not been met;

(2) the Stockholder Nominee (A) is not independent for purposes of membership on the Board of Directors, the audit committee, management planning and development committee and nominating and corporate governance committee of the Board of Directors under the listing standards of the principal U.S. exchange upon which the shares of the corporation are listed, any applicable rules of the Securities and Exchange Commission, and any publicly disclosed standards used by the Board of Directors in determining and disclosing the independence of the corporation's directors, (B) does not qualify as a "non-employee director" under Exchange Act Rule 16b-3, or as an "outside director" for the purposes of Section 162(m) of the Internal Revenue Code (or any successor provision), (C) is or has been, within the past three (3) years, an officer or director of a competitor, as defined in Section 8 of the Clayton Antitrust Act of 1914, as amended, (D) is a named subject of a pending criminal proceeding (excluding traffic violations and other minor offenses) or has been convicted in a criminal proceeding within the past ten (10) years, (E) is subject to any order of the type specified in Rule 506(d) of Regulation D promulgated under the Securities Act of 1933, as amended; or

(3) the election of the Stockholder Nominee to the Board of Directors would cause the corporation to be in violation of the Certificate of Incorporation, these by-laws, or any applicable state or federal law, rule, regulation or listing standard.

(v) *Stockholder Notice Requirements.*

(a) "Stockholder Notice" means a notice given by or on behalf of an Eligible Stockholder that specifies the name of the Stockholder Nominee(s) nominated for election or reelection to the Board of Directors in accordance with this Section 1.11.

(b) A Stockholder Notice shall include:

(1) the written consent of each Stockholder Nominee to being named in the corporation's proxy materials as a nominee and to serving as a director if elected;

(2) a copy of the Schedule 14N that has been or concurrently is filed with the SEC under Exchange Act Rule 14a-18;

(3) a description of all direct and indirect compensation and other material monetary agreements, arrangements and understandings during the past three years, and any other material relationships, between or among the Eligible Stockholder and its affiliates and associates, or others acting in concert therewith, on the one hand, and each Stockholder Nominee, and each Stockholder Nominee's respective affiliates and associates, or others acting in concert therewith, on the other hand, including, without limitation all information that would be required to be disclosed pursuant to Item 404 of Regulation S-K if the Eligible Stockholder making the nomination or on whose behalf the nomination is made, or any affiliate or associate thereof or person acting in concert therewith, were the "registrant" for the purposes of Item 404 and the Stockholder Nominee were a director or executive officer of such registrant;

(4) the information specified under Section 1.10(i)(c); and

(5) the written agreement of the Eligible Stockholder (or in the case of a group, each stockholder or beneficial owner whose shares are aggregated for purposes of constituting an Eligible Stockholder) addressed to the corporation, which written agreement will include the Eligible Stockholder's:

(A) disclosure of, and certification as to, the number of shares it Owns and has Owned continuously for at least three (3) years as of the date of the Stockholder Notice and agreement to continue to Own such shares through the annual meeting of stockholders, which information shall also be included in the Schedule 14N filed by the Eligible Stockholder with the SEC;

(B) agreement to provide within (5) business days of the record date of the annual meeting of stockholders, (I) the information specified under Section 1.10(i)(c) and (II) written statements from the record holder and intermediaries as required under Section 1.11(vii)(a)(1) verifying the Eligible Stockholder's continuous Ownership of the Required Shares, in each case, through and as of the record date;

(C) representation and warranty that it (I) acquired the Required Shares in the ordinary course of business and not with the intent to change or influence control at the corporation, and does not presently have any such intent, (II) has not nominated and will not nominate for election to the Board of Directors at the annual meeting of stockholders any person other than the Stockholder Nominee(s) being nominated pursuant to this Section 1.11, (III) has not engaged and will not engage in, and has not been and will not be a participant (as defined in Item 4 of Exchange Act Schedule 14A) in, a solicitation within the meaning of Exchange Act Rule 14a-1(l), in support of the election of any individual as a director at the annual meeting of stockholders other than its Stockholder Nominee(s) or a nominee of the Board of Directors, and (IV) will not distribute any form of proxy for the annual meeting of stockholders other than the form distributed by the corporation;

(D) agreement to (I) assume all liability stemming from any legal or regulatory violation arising out of the Eligible Stockholder's communications with the stockholders of the corporation or out of the information that the Eligible Stockholder provided to the corporation, (II) indemnify and hold harmless (jointly with all other group members, in the case of a group member) the corporation and each of its directors, officers and employees individually against any liability, loss, damages, expenses or other costs (including attorney's fees) in connection with any threatened or pending action, suit or proceeding, whether legal, administrative or investigative, against the corporation or any of its directors, officers or employees arising out of any nomination submitted by the Eligible Stockholder pursuant to this Section 1.11, (III) comply with all laws, rules, regulations and listing standards applicable to any solicitation in connection with the annual meeting of stockholders, (IV) file all materials described below in Section 1.11(vii)(a)(3) with the SEC, regardless of whether any such filing is required under Regulation 14A promulgated under the Exchange Act, or whether any exemption from filing is available for such materials thereunder, (V) provide to the corporation prior to the annual meeting of stockholders such additional information as necessary or reasonably requested by the corporation, and (VI) provide a statement of whether or not the Eligible Stockholder intends to maintain Ownership of the Required Shares for at least one (1) year following the annual meeting, which statement shall also be included in the Schedule 14N filed with the SEC;

(E) in the case of a nomination by a group of stockholders or beneficial owners that together is an Eligible Stockholder, the written agreement described in clause (4) of this Section 1.11(v)(b) (or another agreement or instrument) shall include a designation by all group members of one (1) group member that is authorized to act on behalf of all such members with respect to the nomination and matters related thereto, including withdrawal of the nomination; and

(F) agreement to immediately notify the corporation if the Eligible Stockholder ceases to own any of the Required Shares prior to the date of the applicable annual meeting of stockholders.

(vi) *Delivery of Stockholder Notice*.

(a) To be timely under this Section 1.11, the Stockholder Notice shall be delivered to, or mailed and received by, the Secretary at the principal office of the corporation not earlier than the close of business on the one hundred fiftieth (150th) day nor earlier than the close of business on the one hundred twentieth (120th) day prior to the first anniversary of the date (as stated in the corporation's proxy statement) the definitive proxy statement was first sent to stockholders in connection with the preceding year's annual meeting of stockholders; provided, however, that in the event that the date of the annual meeting is advanced more than thirty (30) days prior to the anniversary date of the preceding year's annual meeting or delayed more than seventy (70) days after such anniversary date, or if no annual meeting was held in the preceding year, then to be timely the Stockholder Notice must be received by the corporation no earlier than the close of business on the one hundred fiftieth (150th) day prior to such annual meeting and no later than the close of business on the later of (x) the one hundred twentieth (120th) day prior to such annual meeting and (y) the tenth (10th) day following the day on which public announcement of the date of such meeting is first made by the corporation.

(b) In no event shall the public announcement of an adjournment or postponement of an annual meeting of stockholders commence a new time period (or extend any time period) for the giving of a Stockholder Notice in accordance with this Section 1.11.

(vii) *Agreements of the Eligible Stockholder*.

(a) An Eligible Stockholder must:

(1) within five (5) business days after the date of the Stockholder Notice, provide one or more written statements from the record holder(s) of the Required Shares and from each intermediary through which the Required Shares are or have been held, in each case during the requisite three-year holding period, specifying the number of shares that the Eligible Stockholder Owns, and has Owned continuously, in compliance with this Section 1.11;

(2) include in the Schedule 14N filed with the SEC a statement certifying that it Owns and has Owned the Required Shares in compliance with this Section 1.11;

(3) file with the SEC any solicitation or other communication by or on behalf of the Eligible Stockholder relating to the corporation's annual meeting of stockholders, one or more of the corporation's directors or director nominees or any Stockholder Nominee, regardless of whether any such filing is required under Exchange Act Regulation 14A or whether any exemption from filing is available for such solicitation or other communication under Exchange Act Regulation 14A; and

(4) as to any group of funds whose shares are aggregated for purposes of constituting an Eligible Stockholder, within five (5) business days after the date of the Stockholder Notice, provide documentation reasonably satisfactory to the corporation that demonstrates that the funds satisfy Section 1.11(ii)(c).

(b) The information provided pursuant to this Section 1.11(vii) shall be deemed part of the Stockholder Notice for purposes of this Section 1.11.

(viii) *Agreements of the Stockholder Nominee*.

(a) Within the time period prescribed in Section 1.11(vi) for delivery of the Stockholder Notice, the Eligible Stockholder must also deliver to the Secretary a written representation and agreement (which shall be deemed part of the Stockholder Notice for purposes of this Section 1.11) signed by each Stockholder Nominee and representing and agreeing that such Stockholder Nominee:

(1) is not and will not become a party to any agreement, arrangement, or understanding with, and has not given any commitment or assurance to, any person or entity as to how such Stockholder Nominee, if elected as a director, will act or vote on any issue or question, which such agreement, arrangement, or understanding has not been disclosed to the corporation;

(2) is not and will not become a party to any agreement, arrangement, or understanding with any person with respect to any direct or indirect compensation, reimbursement, or indemnification in connection with service or action as a Stockholder Nominee or as a director, in each case, that has not been disclosed to the corporation; and

(3) if elected as a director, will comply with all of the corporation's corporate governance, business conduct, conflict of interest, confidentiality, insider trading and stock ownership and trading policies and guidelines, and any other corporation policies and guidelines applicable to directors.

(b) At the request of the corporation, the Stockholder Nominee must promptly, but in any event within five (5) business days after such request, submit all completed and signed questionnaires required of the corporation's directors and provide to the corporation such other information as it may reasonably request. The corporation may request such additional

information as necessary to permit the corporation to determine if each Stockholder Nominee satisfies this Section 1.11.

(ix) *Additional Provisions*.

(a) The Board of Directors (and any other person or body authorized by the Board of Directors) shall have the power and authority to interpret this Section 1.11 and to make any and all determinations necessary or advisable to apply this Section 1.11 to any persons, facts or circumstances, including the power to determine (1) whether one or more stockholders or beneficial owners qualifies as an Eligible Stockholder, (2) whether a Stockholder Notice complies with this Section 1.11 and has otherwise met the requirements of this Section 1.11, (3) whether a Stockholder Nominee satisfies the qualifications and requirements in this Section 1.11, and (4) whether any and all requirements of this Section 1.11 (or any applicable requirements of Section 1.10) have been satisfied. Any such interpretation or determination adopted in good faith by the Board of Directors (or any other person or body authorized by the Board of Directors) shall be binding on all persons, including the corporation and its stockholders (including any beneficial owners).

(b) Notwithstanding the foregoing provisions of this Section 1.11, unless otherwise required by law or otherwise determined by the chair of the meeting or the Board of Directors, if (1) the Eligible Stockholder, or (2) a qualified representative of the Eligible Stockholder does not appear at the annual meeting of stockholders of the corporation to present its Stockholder Nominee(s), such nomination or nominations shall be disregarded and no vote shall be taken with respect to such Stockholder Nominee(s), notwithstanding that proxies in respect of such vote may have been received by the corporation. For purposes of this Section 1.11, to be considered a qualified representative of the Eligible Stockholder, a person must be a duly authorized officer, manager or partner of such Eligible Stockholder or must be authorized by a writing executed by such Eligible Stockholder or an electronic transmission delivered by such Eligible Stockholder to act for such Eligible Stockholder as proxy at the annual meeting of stockholders and such person must produce such writing or electronic transmission, or a reliable reproduction of the writing or electronic transmission, at the annual meeting of stockholders.

(c) In the event that any information or communications provided by the Eligible Stockholder or any Stockholder Nominees to the corporation or its stockholders is not, when provided, or thereafter ceases to be, true, correct and complete in all material respects (including omitting a material fact necessary to make the statements made, in light of the circumstances under which they were made, not misleading), each Eligible Stockholder or Stockholder Nominee, as the case may be, shall promptly notify the Secretary and provide the information that is required to make such information or communication true, correct, complete and not misleading; it being understood that providing any such notification shall not be deemed to cure any such defect or limit the corporation's right to omit a Stockholder Nominee from its proxy materials pursuant to this Section 1.11.

(d) Notwithstanding anything to the contrary contained in this Section 1.11, the corporation may omit from its proxy materials any information or Statement (or portion thereof) that it, in good faith, believes would violate any applicable law, rule, regulation or listing standard. Nothing in this Section 1.11 shall limit the ability of the corporation to solicit proxies against any Stockholder Nominee or to include in its proxy materials its own statements or any other additional information relating to any Eligible Stockholder or Stockholder Nominee.

ARTICLE 2

BOARD OF DIRECTORS

Section 2.01 NUMBER OF DIRECTORS. The number of directors of the corporation shall be not less than three (3) nor more than eighteen (18), as determined by action of the Board of Directors.

Section 2.02 TERM AND VACANCIES. Directors shall be elected at the annual meeting of stockholders to hold office until the next annual meeting and until their respective successors have been duly elected and have qualified.

Vacancies in the Board of Directors, from any cause whatsoever, including vacancies created by an increase in the number of directors, shall be filled by the vote of a majority of the remaining directors, though less than a quorum.

Directors need not be stockholders.

Section 2.03 MAJORITY VOTING. Except as otherwise provided in Section 2.04, each director shall be elected by the vote of the majority of the votes cast with respect to that director's election at any meeting for the election of directors at which a quorum is present. For purposes of this Section 2.03, a majority of votes cast means that the number of votes "for" a director's election must exceed fifty percent (50%) of the votes cast with respect to that director's election. Votes "against" a director's election will count as votes cast, but "abstentions" and "broker non-votes" will not count as votes cast with respect to that director's election.

Section 2.04 CONTESTED ELECTIONS. If, as of the record date for a meeting of stockholders for which directors are to be elected, the number of nominees for election of directors exceeds the number of directors to be elected (a "Contested Election"), the nominees receiving a plurality of the votes cast by holders of shares entitled to vote in the election at a meeting at which a quorum is present shall be elected.

Section 2.05 RESIGNATION AND REPLACEMENT OF UNSUCCESSFUL INCUMBENT DIRECTOR.

(i) In order for any incumbent director to become a nominee of the Board of Directors for further service on the Board of Directors, such person must submit an irrevocable resignation, which resignation shall become effective upon (a) that person not receiving a majority of the votes cast in an election that is not a Contested Election, and (b) acceptance by the Board of Directors of that resignation in accordance with the policies and procedures adopted by the Board of Directors for such purpose.

(ii) The Board of Directors, acting on the recommendation of the Nominating and Corporate Governance Committee, shall no later than at its first regularly scheduled meeting following certification of the shareholder vote, determine whether to accept the resignation of the unsuccessful incumbent. Absent a determination by the Board of Directors that a compelling reason exists for concluding that it is in the best interests of the corporation for an unsuccessful incumbent to remain as a director, no such person shall be elected by the Board of Directors to serve as a director, and the Board of Directors shall accept that person's resignation.

(iii) The Board of Directors shall promptly consider and act upon the Nominating and Corporate Governance Committee's recommendation. The Nominating and Corporate Governance Committee, in making this recommendation and the Board of Directors, in acting on such recommendation, may consider any factors or other information that they determine appropriate and relevant.

(iv) If the Board of Directors determines to accept the resignation of an unsuccessful incumbent, the Nominating and Corporate Governance Committee shall recommend a candidate to the Board of Directors to fill the office formerly held by the unsuccessful incumbent, unless the Board of Directors decides to decrease the size of the Board of Directors pursuant to Section 2.01.

(v) The Nominating and Corporate Governance Committee and the Board of Directors shall take the actions required under this Section 2.05 without the participation of any unsuccessful incumbent except that:

(a) If every member of the Nominating and Corporate Governance Committee is an unsuccessful incumbent, then a majority of the Board of Directors shall appoint a Board committee (the "Special Nominating Committee") of independent directors (as defined below) for the purpose of considering the tendered resignations and making a recommendation to the Board of Directors whether to accept or reject them; and

(b) If the number of independent directors who are not unsuccessful incumbents is three or fewer, all directors may participate in the decisions under this Section 2.05.

As used above, the term "independent director" shall mean a director who complies with the "independent director" requirements under the rules of the principal U.S. exchange upon which the shares of the corporation are listed, under law or under any rule or regulation of any other regulatory body or self-regulatory body applicable to the corporation.

(vi) If the Board of Directors accepts the resignation of a director who is an unsuccessful incumbent pursuant to this by-law, or if a nominee for director who is not an incumbent director does not receive more than fifty percent (50%) of the votes cast with respect to that director's election, then the Board of Directors may fill the resulting vacancy pursuant to Section 2.02, or may decrease the size of the Board of Directors pursuant to Section 2.01.

Section 2.06 RESIGNATION. Any director may resign at any time upon notice given in writing or by electronic transmission to the Chair of the Board or to the Secretary. A resignation is effective when the resignation is delivered unless the resignation specifies (i) a later effective date or (ii) an effective date determined upon the happening of an event or events (including but not limited to a failure to receive more than fifty percent (50%) of the votes cast in an election and the Board of Directors' acceptance of the resignation).

Section 2.07 GENERAL POWERS OF DIRECTORS. The business of the corporation shall be managed under the direction of its Board of Directors subject to the restrictions imposed by law and by the Certificate of Incorporation.

Section 2.08 MEETINGS OF DIRECTORS. The directors may hold their meetings and may keep an office and maintain the books of the corporation, except as otherwise provided by statute, in such place or places in the State of Delaware or outside the State of Delaware as the Board may, from time to time, determine.

Any action required or permitted to be taken by the Board of Directors may be taken without a meeting if all of the directors consent in writing to the adoption of a resolution authorizing the action, and in such event the resolution and the written consent of all directors thereto shall be filed with the minutes of the proceedings of the Board of Directors.

Any one or more directors may participate in a meeting of the Board of Directors by means of a conference telephone or similar communications equipment allowing all persons participating in the meeting to hear each other at the same time, and participation by such means shall constitute presence in person at a meeting.

Section 2.09 REGULAR MEETINGS. Regular meetings of the Board of Directors shall be held at the principal office of the corporation in the County of Providence, City of Woonsocket, State of Rhode Island, or at such other place within or without the State of Delaware as shall be designated in the notice of the meeting as follows: one (1) meeting shall be held immediately following the annual meeting of stockholders and further meetings shall be held at such intervals or on such dates as may from time to time be fixed by the Board of Directors, all of which meetings shall be held upon not less than four (4) days'

notice served upon each director by mailing or emailing such notice to the director at the director's address as the same appears upon the records of the corporation, except the meeting which shall be held immediately following the annual meeting of stockholders which meeting shall be held without notice.

Section 2.10 SPECIAL MEETINGS. Special meetings of the Board of Directors shall be held whenever called by the direction of the Chair of the Board, or of the Chief Executive Officer, or of one-third (1/3) of the directors at the time in office. The Secretary shall give notice of each special meeting by mailing such notice not less than four (4) days, or by telegraphing, telecopying or emailing such notice not less than two (2) days, before the date set for a special meeting, to each director.

Section 2.11 WAIVER. Notice of a meeting need not be given to any director who submits a signed waiver of notice whether before or after the meeting, or who attends the meeting without protesting, prior thereto or at its commencement, the lack of notice to him or her.

Section 2.12 QUORUM. At a meeting, a majority of the directors shall constitute a quorum for the transaction of business, but if at any meeting of the Board of Directors there is less than a quorum present, the majority of those present may adjourn the meeting from time to time.

Section 2.13 ORDER OF BUSINESS. At meetings of the Board of Directors business shall be transacted in such order as the Board of Directors may fix and determine.

Section 2.14 ELECTION OF CHAIR, OFFICERS AND COMMITTEES. At the first regular meeting of the Board of Directors in each year, at which a quorum shall be present, held next after the annual meeting of the stockholders, the Board of Directors shall proceed to the election of the Chair of the Board (who may be an executive officer of the corporation), of the executive officers of the corporation, and of the Executive Committee, if the Board of Directors shall provide for such committee under the provisions of Article 3 hereof.

Except as otherwise provided herein, the Board of Directors from time to time may fill any vacancies among the Chair of the Board, the executive officers, members of the Executive Committee and members of other committees, and may appoint additional executive officers and additional members of such Executive Committee or other committees.

Section 2.15 COMPENSATION. Directors who are not officers or employees of the corporation or any of its subsidiaries may receive such remuneration as the Board of Directors may fix, in addition to a fixed sum for attendance at each regular or special meeting of the Board of Directors or a Committee of the Board of Directors; *provided, however*, that nothing herein contained shall be construed to preclude any director from serving the corporation in any other capacity or receiving compensation therefor. In addition, each director shall be entitled to reimbursement for expenses incurred in attending any meeting of the Board of Directors or Committee thereof.

ARTICLE 3

COMMITTEES

Section 3.01 EXECUTIVE COMMITTEE. The Board of Directors by resolution adopted by a majority of the entire Board of Directors may designate an Executive Committee consisting of three (3) directors or more, to serve at the pleasure of the Board of Directors. At all times when the Board of Directors is not in session, the Executive Committee so designated shall have and exercise the powers of the Board of Directors, except that such committee shall have no authority as to the matters set out in Section 3.03.

Meetings of the Executive Committee shall be called by any member of the same, on three (3) days' mailed notice, or one (1) day's telegraphed, telecopied or emailed notice to each of the other members, stating therein the purpose for which such meeting is to be held. Notice of meeting may be waived in writing by any member of the Executive Committee.

All action by the Executive Committee shall be recorded in its minutes and reported from time to time to the Board of Directors.

The Executive Committee shall fix its own rules of procedure and shall meet where and as provided by such rules or by resolution of the Board of Directors.

Any action required or permitted to be taken by the Executive Committee may be taken without a meeting if all of the members of the Executive Committee consent in writing to the adoption of a resolution authorizing the action, and in such event the resolution and the written consent of all members of the Executive Committee thereto shall be filed with the minutes of the proceedings of the Executive Committee.

Any one or more members of the Executive Committee may participate in a meeting of the Executive Committee by means of a conference telephone or similar communications equipment allowing all persons participating in the meeting to hear each other at the same time, and participation by such means shall constitute presence in person at a meeting.

Section 3.02 OTHER COMMITTEES. The Board of Directors may appoint such other committees as the Board shall, from time to time, deem advisable, which committees shall have and may exercise such powers as shall be prescribed, from time to time, by resolution of the Board of Directors, except that such committees shall have no authority as to the matters set out in Section 3.03. Each such committee may be comprised of any number of members as is permitted by the DGCL; *provided, however*, that each of the principal standing committees of the Board shall be comprised of three (3) or more members.

Actions and recommendations by each committee which shall be appointed pursuant to this Section 3.02 shall be recorded and reported, from time to time, to the Board of Directors.

Each such committee shall fix its own rules of procedure and shall meet where and as provided by such rules or by resolution of the Board of Directors.

Any action required or permitted to be taken by any such committee may be taken without a meeting if all of the members of such committee consent in writing to the adoption of a resolution authorizing the action, and in such event the resolution and the written consent of all members of such committee thereto shall be filed with the minutes of the proceedings of such committee.

Any one or more members of any such committee may participate in a meeting of such committee by means of a conference telephone or similar communications equipment allowing all persons participating in the meeting to hear each other at the same time, and participation by such means shall constitute presence in person at a meeting.

Section 3.03 LIMITATIONS. No committee shall have authority as to the following matters:

(i) The approval, adoption, or recommendation to the stockholders of any action or matter (other than the election or removal of directors) that is required by law to be submitted to stockholders for approval.

(ii) The adoption, amendment, or repeal of any by-law of the corporation.

Section 3.04 ALTERNATES. The Board of Directors may designate one or more directors as alternate members of any such committees, who may replace any absent member or members at any meeting of such committees.

Section 3.05 COMPENSATION. Members of special or standing committees may receive such salary for their services as the Board of Directors may determine; *provided, however*, that nothing herein contained shall be construed to preclude any member of any such committee from serving the corporation in any other capacity or receiving compensation therefor.

ARTICLE 4

OFFICERS AND CHAIR

Section 4.01 TITLES AND TERMS OF OFFICE. The executive officers of the corporation shall be a Chief Executive Officer, who shall be a member of the Board of Directors, a President, such number

of Executive Vice Presidents, Senior Vice Presidents and Vice Presidents as the Board of Directors shall determine, and a Controller, a Treasurer and a Secretary, all of whom shall be approved by the Board of Directors.

The Board of Directors may also appoint one or more Assistant Secretaries and one or more Assistant Treasurers, and such other junior officers as it shall deem necessary, who shall have such authority and shall perform such duties as, from time to time, may be prescribed by the Board of Directors.

Any two (2) or more offices except President and Vice President may be held by the same person.

The officers of the corporation shall each hold office for one (1) year and until their successors are chosen and qualified, and, except as set forth herein, shall be subject to removal at any time by the affirmative vote of the majority of the Board of Directors.

Section 4.02 CHAIR OF THE BOARD. The Board of Directors shall designate a Chair of the Board (or one or more Co-Chairs of the Board), who may be an executive officer of the corporation. The Chair of the Board shall preside over the meetings of the Board of Directors and of the stockholders at which he or she will be present. If there are more than one, the Co-Chairs designated by the Board of Directors will perform such duties. The Chair or Chairs of the Board shall perform such other duties as may be assigned to him, her or them by the Board of Directors.

Section 4.03 CHIEF EXECUTIVE OFFICER. The Chief Executive Officer shall have general management and control over the policy, business and affairs of the corporation and shall have such other authority and perform such other duties as usually appertain to a chief executive officer of a business corporation. He or she shall exercise the powers of the Chair of the Board during the Chair's absence or inability to act.

Section 4.04 PRESIDENT. The President, if any, shall have such authority and shall perform such duties as the Board of Directors, the Executive Committee, or the Chief Executive Officer may from time to time determine.

Section 4.05 EXECUTIVE VICE PRESIDENTS, SENIOR VICE PRESIDENTS AND VICE PRESIDENTS. The Executive Vice Presidents, Senior Vice Presidents and Vice Presidents, if any, shall be designated and shall have such powers and perform such duties as may be assigned to them by the Board of Directors, the Executive Committee, the Chief Executive Officer or the President. They shall, in order of their seniority or in such other order as may be designated by the Board of Directors, the Executive Committee, the Chief Executive Officer or the President, exercise the powers of the Chief Executive Officer during the absence or inability to act of the Chief Executive Officer and the President.

Section 4.06 CHIEF FINANCIAL OFFICER. A Chief Financial Officer or other officer designated by the Board of Directors shall be the principal financial officer of the corporation. He or she shall perform such duties as from time to time may be assigned to him or her by the Board of Directors, the Executive Committee, the Chief Executive Officer or the President.

Section 4.07 CONTROLLER. A Controller or other officer designated by the Board of Directors shall be the principal accounting officer of the corporation and, subject to the direction of the Chief Financial Officer, he or she shall have supervision over all the accounts and account books of the corporation. He or she shall have such other powers and perform such other duties as from time to time may be assigned to him or her by the Chief Financial Officer, and shall exercise the powers of the Chief Financial Officer during his or her absence or inability to act.

Section 4.08 TREASURER. The Treasurer shall have custody of the corporation's funds and securities. He or she shall perform such other duties as may be prescribed by these by-laws or as may be assigned to him or her by the Chair of the Board, the Chief Executive Officer, the President or the Board of Directors, and, except as otherwise prescribed by the Board of Directors, he or she shall have such powers and duties incident to the office of Treasurer. He or she shall perform such other duties as from time to time

may be assigned to him or her by the Board of Directors, the Executive Committee, the Chief Executive Officer, the President or the Chief Financial Officer.

Section 4.09 ASSISTANT TREASURER. Each Assistant Treasurer shall have such powers and perform such duties as may be delegated to him or her, and the Assistant Treasurers shall, in the order of their seniority, or in such other order as may be designated by the Board of Directors, the Executive Committee, the Chief Executive Officer, the President or the Chief Financial Officer, exercise the powers of the Treasurer during his or her absence or inability to act.

Section 4.10 SECRETARY. The Secretary shall keep the minutes of all meetings of the Board of Directors and the minutes of all meetings of the stockholders and of the Executive Committee, in books provided for that purpose; he or she shall attend to the giving and serving of all notices of the corporation; and he or she shall have charge of the certificate books, transfer books and records of stockholders and such other books and records as the Board of Directors or Executive Committee may direct. He or she shall in general perform all of the duties incident to the office of Secretary, subject to the control of the Board of Directors, the Executive Committee, the Chair of the Board, the Chief Executive Officer and the President.

Section 4.11 ASSISTANT SECRETARIES. Each Assistant Secretary shall have such powers and perform such duties as may be delegated to him or her, and the Assistant Secretaries shall, in the order of their seniority, or in such other order as may be designated by the Board of Directors, the Executive Committee, the Chair of the Board, the Chief Executive Officer or the President, exercise the powers of the Secretary during his or her absence or inability to act.

Section 4.12 VOTING UPON STOCKS. Unless otherwise ordered by the Board of Directors or by the Executive Committee, the Chief Executive Officer, or a person designated in a proxy executed by him or her, and in the absence of either, the President, or a person designated in a proxy executed by him or her, and in the absence of all such, the Executive Vice Presidents, Senior Vice Presidents or the Vice Presidents of the corporation, in the order of their seniority, shall have full power and authority on behalf of the corporation to attend, act, and vote at meetings of stockholders of any corporation in which this corporation may hold stock, and each such officer of the corporation shall have power to sign a proxy deputizing others to vote the same; and all such who shall be so authorized to vote shall possess and may exercise any and all rights and powers incident to the ownership of such stock and which, as the owner thereof, the corporation might have possessed and exercised, if present.

The Board of Directors or the Executive Committee may, by resolution from time to time, confer like powers on any other person or persons, which shall supersede the powers of those designated in the foregoing paragraph.

Section 4.13 EXECUTION OF CHECKS, ETC. All checks, notes, drafts or other instruments for the payment of money shall be signed on behalf of this corporation by such person or persons and in such manner as the Board of Directors or Executive Committee may prescribe by resolution from time to time.

ARTICLE 5

CERTAIN OTHER GOVERNANCE MATTERS

Section 5.01 NAME OF THE CORPORATION. Any change to the name of the corporation shall require the approval of three-quarters (3/4) of the members of the Board of Directors.

Section 5.02 AMENDMENTS. Any amendment by the Board of Directors of this Article 5, or any other provision contained in these by-laws requiring approval for an action by at least three-quarters (3/4) of the members of the Board of Directors, shall require the approval of three-quarters (3/4) of the members of the Board of Directors.

ARTICLE 6

STOCK; RECORD DATE

Section 6.01 CERTIFICATES FOR STOCK; UNCERTIFICATED SHARES. The certificates for shares of the stock of the corporation shall be in such form as shall be proper or approved by the Board of Directors; provided that the Board of Directors may provide by resolution or resolutions that some or all of any or all classes or series of stock of the corporation shall be uncertificated shares. Notwithstanding the foregoing or the adoption of such a resolution or resolutions by the Board of Directors, each holder of uncertificated shares shall be entitled, upon request, to a certificate representing such shares, to be in such form as the Board shall have approved. Any such resolution shall not apply to any share represented by a certificate theretofore issued until such certificate is surrendered to the corporation. Each certificate shall state (i) that the corporation is formed under the laws of the State of Delaware, (ii) the name of the person or persons to whom issued, (iii) the number and class of shares and the designation of the series, if any, which such certificate represents and (iv) the par value, if any, of each share represented by such certificate. Each certificate shall be signed by the Chair of the Board, Chief Executive Officer, the President, an Executive Vice President or a Vice President, and also by the Treasurer or an Assistant Treasurer or the Secretary or an Assistant Secretary and sealed with the corporation's seal; *provided, however,* that if such certificates are signed by a transfer agent or transfer clerk and by a registrar the signature of the Chair of the Board, the Chief Executive Officer, the President, the Executive Vice President, Vice President, Treasurer, Assistant Treasurer, Secretary and Assistant Secretary and the seal of the corporation upon such certificates may be facsimiles, engraved or printed. Except as otherwise provided by law, the rights and obligations of the holders of uncertificated shares and the rights and obligations of the holders of shares represented by certificates of the same class and series shall be identical.

Section 6.02 TRANSFER OF SHARES. Shares of the stock of the corporation may be transferred on the record of stockholders of the corporation by the holder thereof in person or by his or her duly authorized attorney upon surrender of a certificate therefor properly endorsed or upon receipt of proper transfer instructions from the holder of uncertificated shares.

Section 6.03 AUTHORITY FOR ADDITIONAL RULES REGARDING TRANSFER. The Board of Directors and the Executive Committee shall have power and authority to make all such rules and regulations as respectively they may deem expedient concerning the issue, transfer and registration of certificated or uncertificated shares of the stock of the corporation, as well as for the issuance of new certificates in lieu of those which may be lost or destroyed, and may require of any stockholder requesting replacement of lost or destroyed certificates, bond in such amount and in such form as they may deem expedient to indemnify the corporation, the transfer agents, and/or the registrars of its stock against any claims arising in connection therewith.

Section 6.04 TRANSFER AGENTS AND REGISTRARS. The Board of Directors or Executive Committee may appoint one or more transfer agents and one or more registrars of transfer and may require all stock certificates to be countersigned by such transfer agent and registered by such registrar of transfers. One (1) person or organization may serve as both transfer agent and registrar.

Section 6.05 RECORD DATE. For the purpose of determining the stockholders entitled to notice of or to vote at any meeting of stockholders or any adjournment thereof, or to express consent to or dissent from any proposal without a meeting, or for the purpose of determining stockholders entitled to receive payment of any dividend or the allotment of any rights, or for the purpose of any other action, the Board of Directors shall fix in advance a date as the record date for any such determination of stockholders. Such date shall not be more than sixty (60) nor less than ten (10) days before the date of such meeting, nor more than sixty (60) days prior to any other action.

Section 6.06 LIST OF STOCKHOLDERS AS OF RECORD DATE. The Secretary or the transfer agent of its stock shall make and certify a list of the stockholders as of the record date and number of shares of each class of stock of record in the name of each stockholder and such list shall be present at every meeting of stockholders. If the right to vote at any meeting is challenged, the Inspectors of Elections, or person presiding thereat, shall require such list of stockholders to be produced as evidence of the right of

the persons challenged to vote at such meeting, and all persons who appear from such list to be stockholders entitled to vote thereat, may vote at such meeting.

Section 6.07 DIVIDENDS. Dividends may be declared and paid out as often and at such times and to such extent as the Board of Directors may determine, consistent with the provisions of the Certificate of Incorporation and the DGCL.

Section 6.08 STOCKHOLDER RIGHTS PLANS.

(i) Notwithstanding anything in these by-laws to the contrary, the amendment of any Stockholder Rights Plan (as defined below) which has the effect of extending the term of the Stockholder Rights Plan or any rights or options provided thereunder shall require the approval of at least three-quarters (3/4) of the Board of Directors, and any Stockholder Rights Plan shall expire if not so amended no later than one (1) year following the later of the date of its adoption and the date of its last such amendment.

(ii) Paragraph (i) of this Section 6.08 shall not apply to any Stockholder Rights Plan ratified by the stockholders.

(iii) "Stockholder Rights Plan" refers in this Section 6.08 to any stockholder rights plan, rights agreement or any other form of "poison pill" anti-takeover device or plan which is designed to or has the effect of making an acquisition of large holdings of the corporation's shares of stock more difficult or expensive (but for avoidance of doubt, excluding any issuance or sale of securities or rights in connection with a bona fide financing transaction).

(iv) Nothing in this Section 6.08 should be construed to permit or validate any decision by the Board of Directors to adopt or amend a Stockholder Rights Plan that would otherwise be prohibited or invalid under applicable Delaware law.

ARTICLE 7

CORPORATE SEAL

The Board of Directors shall provide a suitable seal containing the name of the corporation and of the state under the laws of which the corporation was incorporated; and the Secretary shall have the custody thereof.

ARTICLE 8

AMENDMENTS

Subject to Article 5, Section 5.02, these by-laws may be altered, amended or repealed, or new by-laws may be made, by the stockholders entitled to vote thereon at any annual or special meeting thereof or by the Board of Directors.

B.2.a.(iv.) – CHL Amended and Restated Articles of Incorporation – 10/2019

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Amended and Restated Articles of Incorporation

Of

Coventry Health and Life Insurance Company

Coventry Health and Life Insurance Company (the "Company") was originally incorporated in the State of Texas under the name American Service Life Insurance Company with a continuous date of incorporation of April 15, 1968, and continued to actively conduct its business in the State of Texas as a Texas domiciled insurance corporation until May 14, 1999, when the Company redomesticated to the State of Delaware to conduct business as a Delaware domiciled insurance corporation. The Company continued to conduct business in the State of Delaware until the date of filing these Amended and Restated Articles of Incorporation in the State of Missouri pursuant to the adoption of a plan of redomestication approved by the Board of Directors and the Sole Shareholder of the Company. These Articles of Incorporation, as amended by all of the amendments to the Amended and Restated Articles of Incorporation and Certificate of Incorporation filed with the states of Texas and Delaware, respectively, shall become the Amended and Restated Articles of Incorporation of the Company upon the filing of these Amended and Restated Articles of Incorporation in the State of Missouri.

Article I

The name of the corporation shall be Coventry Health and Life Insurance Company.

Article II

The home office address is 1285 Fern Ridge Parkway, Suite 200, St. Louis, Missouri 63141. The executive offices of the Company are located at 15400 Calhoun Drive, Suite 300, Rockville, Maryland 20855.

Article III

The Company is authorized to issue one class of capital stock, which shall be common stock. The total number of authorized shares is one thousand (1,000), and the par value of each share is $2,500.

Article IV

The existence of the Company shall be perpetual.

Article V

The Company is formed for the following purposes: To make life, health and accident insurance upon the lives of individuals and every assurance pertaining thereto or connected

therewith; to grant, purchase, and dispose of annuities and endowments of every kind and description whatsoever; to provide for contracts of indemnity against death and for weekly and other periodic indemnities for disability occasioned by accident or sickness to the person of the insured, and such accident and health insurance shall be made a separate department of the business of the Company; and to do such other things as may be permitted a corporation of this kind by law, and not prohibited by the Revised Statues of Missouri, Sections 375.908, 376.010 to 376.120, both inclusive, as amended.

In order to carry out the purposes for which it is organized, the Company shall have the following rights and powers to the extent not inconsistent with nor prohibited by the provisions of law applicable to life, health and accident insurance companies or applicable to all insurance companies:

(a) to sue and be sued, complain and defend in any court of law or equity;

(b) to have a corporate seal which may be altered at the pleasure of the Company and to use such seal by causing it or a facsimile thereof to be impressed or affixed or in any manner reproduced;

(c) to purchase, hold or convey such real estate as the purposes of the Company shall require, and to take, hold or convey other property, real, personal or mixed, as shall be necessary in the transaction of its business, all to the extent permitted by law and more particularly as provided by Sections 375.320, 375.330, and 375.340, Revised Statues of Missouri, as amended;

(d) to sell, convey, mortgage, loan, pledge or otherwise dispose of and otherwise use and deal in and with shares, or the interests in or obligations of other domestic and foreign corporations, associations, partnerships, or individuals, all to the extent permitted by law to life, health and accident insurance companies;

(e) to see, lease, exchange or otherwise dispose of, all or substantially all, of the property and assets of the Company, with or without the goodwill of the Company, upon such terms and conditions and for such consideration as may consist in whole or in part, of money or property, real or personal, including shares of any other domestic or foreign corporation, subject to all the provisions of the law applicable to such transfer with respect to manufacturing and business corporations, and subject also to any and all provisions of law applicable to all insurance companies;

(f) to make contracts and incur liabilities which may be appropriate to enable it to accomplish any or all of its purposes, to issue its notes, bonds and other obligations; to secure any of its obligations by mortgage, deed of trust, or pledge of any or all of its property, franchises, or income; to issue notes or bonds secured or unsecured, which by their terms are convertible to shares of stock of any class upon such terms and conditions and at such rates or prices as may be therein provided; to enter into contracts of reinsurance, either as reinsurer or otherwise, pertaining to life, health and accident insurance to the extent permitted by law to a corporation of this kind;

(g) to invest its capital, reserve, and surplus funds of whatever kind or character from time to time and to lend money for its corporate purposes, and to take and hold real and personal property as security for the payment of funds so invested or loaned, all to the extent that such investments and loans may be permitted by the provisions of law applicable to life, health and accident insurance companies or applicable to all insurance companies;

(h) to elect or appoint officers and agents of the Company; to enter into agency contracts and to define their duties and fix their compensation, such officers of the Company shall consist of a President and a Secretary, and may consist of such other officers as the Board of Directors may deem necessary, including one or more Vice Presidents, Assistant Secretaries, and a Treasurer or an Assistant Treasurer;

(i) to make and alter bylaws not inconsistent with these Articles of Incorporation, as amended from time to time, or with the laws of this State for the administration and regulation of the affairs of the Company;

(j) to terminate its corporate activities and to surrender its corporate franchise;

(k) to make contributions to corporations or other organizations formed for civic, charitable or benevolent purposes or to any incorporated or unincorporated association, United Fund or community funds not operated or used for profit to its members, but operated for the purposes of raising funds for and of distributing funds to other civic, charitable or benevolent organizations or agencies; and

(l) to have and exercise all of the powers necessary or convenient to effect or accomplish any or all of the purposes for which the corporation was formed; to exercise all powers, now or hereafter permitted by law to a corporation of this character, and not prohibited by Sections 376.010 to 376.890, inclusive, Revised Statutes of Missouri, as amended.

Article VI

The property and business of the Company shall be managed and controlled by the Board of Directors, which shall consist of not less than nine (9) or more than twenty-one (21) persons who shall be elected at each annual meeting of the shareholders. Vacancies on the Board of Directors may be filled by a majority vote of the remaining Directors. The Board of Directors may repeal or amend the By-laws, but such By-laws shall not be inconsistent with these Amended and Restated Articles of Incorporation nor with the laws of the State of Missouri. Meetings of the Board of Directors may be held within or without the State as the Board of Directors may decide. A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors, provided that if less than a majority of the members are present at said meeting, a majority of the Directors present may adjourn the meeting from time to time without further notice.

Article VII

Shareholders of the Company shall not have the right of cumulative voting.

Article VIII

The Board of Directors is expressly authorized to make, alter or amend the Bylaws of the Company or to adopt new Bylaws.

Article IX

Each Director, officer and former Director or officer of the Company, and any person who may have served or who may hereafter serve at the Company's request as a Director or officer of another corporation in which the Company owns shares of capital stock or of which it is a creditor, is hereby indemnified by the Company against expenses actually and necessarily incurred by him or her in connection with the defense of any action, suit or proceeding in which he or she is made a party by reason of being or having been a Director or officer, except in relation to matters as to which he or she shall be adjudged in such action, suit or proceeding to be liable for negligence or misconduct in the performance of their duties. Such indemnification shall not be deemed exclusive of any other right to which such Director, officer or person may be entitled under any Bylaws, amendment, vote of shareholders or otherwise.

Attachment D

Kentucky | Transforming Health Care | **Aetna**

Attachment D
B.2.(a.)v. – Corporate Information

Aetna Better Health® of Kentucky Certificate of Authority .....Att D-3

Aetna Better Health® of Kentucky Q1 2018 Statement .....Att D-7

Aetna Better Health® of Kentucky Q2 2018 Statement .....Att D-63

Aetna Better Health® of Kentucky Q3 2018 Statement .....Att D-117

Aetna Better Health® of Kentucky 2018 Final Statement .....Att D-171

Aetna Better Health® of Kentucky Q1 2019 Statement .....Att D-305

Aetna Better Health® of Kentucky Q2 2019 Statement .....Att D-361

Aetna Better Health® of Kentucky Q3 2019 Statement .....Att D-417

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Aetna Better Health® of Kentucky Certificate of Authority

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COMMONWEALTH OF KENTUCKY

STEVEN L. BESHEAR

GOVERNOR
DEPARTMENT OF INSURANCE

CERTIFICATE OF AUTHORITY

Satisfactory evidence has been furnished to me showing that **Aetna Better Health of Kentucky Insurance Company DBA Aetna Better Health of Kentucky** organized in the State of **Kentucky**, and having its principal office at **Louisville, KY**, is in sound and solvent condition, and has fully complied with all the provisions of the Insurance Laws of the Commonwealth of Kentucky that are applicable thereto. Now, therefore, on behalf of the Department of Insurance of the Commonwealth of Kentucky, I do hereby authorize the said insurance company to transact the business of

Health Insurance

in this Commonwealth for the period beginning on the date shown below and to continue in force as long as the insurer is entitled thereto.

Sharon P. Clark

Commissioner, Department of Insurance

This Certificate of Authority shall, at all times, be the property of the Commonwealth of Kentucky, and upon any expiration, suspension, revocation, or termination thereof, the insurer shall promptly deliver this Certificate to the Department of Insurance

CERTIFICATE NO: 47-3279217 **DATE: 06/16/2015**

Aetna Better Health® of Kentucky Q1 2018 Statement

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QUARTERLY STATEMENT

OF THE

Aetna Better Health of Kentucky Insurance Company

TO THE

Insurance Department

OF THE

STATE OF

FOR THE QUARTER ENDED
JUNE 30, 2018

HEALTH

2018

QUARTERLY STATEMENT

AS OF JUNE 30, 2018

OF THE CONDITION AND AFFAIRS OF THE

Aetna Better Health of Kentucky Insurance Company

NAIC Group Code 0001 (Current) 0001 (Prior) NAIC Company Code 15761 Employer's ID Number 47-3279217

Organized under the Laws of Kentucky, State of Domicile or Port of Entry KY

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health

Is HMO Federally Qualified? Yes [ ] No [ ]

Incorporated/Organized 02/24/2015 Commenced Business 02/01/2016

Statutory Home Office 9900 Corporate Campus Dr., Suite 1000 (Street and Number), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Main Administrative Office 9900 Corporate Campus Dr., Suite 1000 (Street and Number)

Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Mail Address 9900 Corporate Campus Dr., Suite 1000 (Street and Number or P.O. Box), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 9900 Corporate Campus Dr., Suite 1000 (Street and Number)

Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Internet Website Address www.aetnabetterhealth.com

Statutory Statement Contact Scott David Miller (Name), 717-671-2474 (Area Code) (Telephone Number)

StatutoryReporting@aetna.com (E-mail Address), 717-526-2888 (FAX Number)

OFFICERS

Chief Executive Officer and President Laurie Ann Brubaker

Corporate Controller Scott David Miller

Vice President and Secretary Robert Mark Kessler

OTHER

Debra Jean Bacon, Vice President and Assistant Treasurer

Kevin James Casey, Senior Investment Officer

Frank Ferris Chronister III, Assistant Controller

John Patrick Maroney, Vice President and Treasurer

DIRECTORS OR TRUSTEES

Laurie Ann Brubaker, Debra Jean Bacon, Jonathan Edward Copley

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Laurie Ann Brubaker Chief Executive Officer and President	Robert Mark Kessler Vice President and Secretary	Scott David Miller Corporate Controller
State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa	State of..... Pennsylvania County of..... Montgomery
Subscribed and sworn to before me this 20 day of July, 2018	Subscribed and sworn to before me this 18 day of July, 2018	Subscribed and sworn to before me this 26th day of July, 2018
NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)
JANEEN NEWHOUSE Notary Public, State of Arizona Maricopa County My Commission Expires February 08, 2019	JANEEN NEWHOUSE Notary Public, State of Arizona Maricopa County My Commission Expires February 08, 2019	COMMONWEALTH OF PENNSYLVANIA NOTARIAL SEAL KIM E. ROTH, Notary Public Whitpain Township, Montgomery County My Commission Expires April 25, 2021

a. Is this an original filing? ..... Yes [X] No [ ]

b. If no,

1. State the amendment number .....
2. Date filed .....
3. Number of pages attached.....

ASSETS

	Current Statement Date 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 December 31 Prior Year Net Admitted Assets
1. Bonds	447,700,112		447,700,112	479,236,865
2. Stocks:				
2.1 Preferred stocks	0		0	0
2.2 Common stocks	0		0	0
3. Mortgage loans on real estate:				
3.1 First liens	13,105,963		13,105,963	12,979,171
3.2 Other than first liens			0	
4. Real estate:				
4.1 Properties occupied by the company (less $ ..... encumbrances)			0	
4.2 Properties held for the production of income (less $ ..... encumbrances)			0	
4.3 Properties held for sale (less $ ..... encumbrances)			0	
5. Cash ($ 5,461,736), cash equivalents ($ 63,698,436) and short-term investments ($ .....)	69,160,172		69,160,172	14,204,888
6. Contract loans (including $ ..... premium notes)			0	
7. Derivatives			0	0
8. Other invested assets			0	0
9. Receivables for securities	2,040,446		2,040,446	524,756
10. Securities lending reinvested collateral assets			0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	532,006,693	0	532,006,693	506,945,680
13. Title plants less $ ..... charged off (for Title insurers only)			0	
14. Investment income due and accrued	4,677,248		4,677,248	4,135,426
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	1,539,273		1,539,273	1,847,707
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)			0	
15.3 Accrued retrospective premiums ($ .....) and contracts subject to redetermination ($ .....)			0	
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers			0	
16.2 Funds held by or deposited with reinsured companies			0	
16.3 Other amounts receivable under reinsurance contracts			0	
17. Amounts receivable relating to uninsured plans			0	
18.1 Current federal and foreign income tax recoverable and interest thereon			0	
18.2 Net deferred tax asset	9,978,560	141,699	9,836,861	9,836,861
19. Guaranty funds receivable or on deposit			0	
20. Electronic data processing equipment and software			0	
21. Furniture and equipment, including health care delivery assets ($ .....)			0	
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	
23. Receivables from parent, subsidiaries and affiliates	3,056		3,056	2,265,089
24. Health care ($ 6,203,891) and other amounts receivable	36,994,786	30,749,415	6,245,371	1,758,384
25. Aggregate write-ins for other than invested assets	929,793	929,793	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	586,129,409	31,820,907	554,308,502	526,789,148
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	
28. Total (Lines 26 and 27)	586,129,409	31,820,907	554,308,502	526,789,148
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Deposits	500,000	500,000	0	0
2502. Prepaid Expenses	429,793	429,793	0	0
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	929,793	929,793	0	0

LIABILITIES, CAPITAL AND SURPLUS

	Current Period			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less $ ..... reinsurance ceded)	127,465,609	3,268,349	130,733,958	159,039,981
2. Accrued medical incentive pool and bonus amounts	930,141		930,141	190,629
3. Unpaid claims adjustment expenses	2,127,422		2,127,422	3,072,860
4. Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Service Act	6,048,288		6,048,288	0
5. Aggregate life policy reserves	0		0	
6. Property/casualty unearned premium reserve	0		0	
7. Aggregate health claim reserves	0		0	0
8. Premiums received in advance	16,060,696		16,060,696	31,811,757
9. General expenses due or accrued	29,090,347		29,090,347	12,641,664
10.1 Current federal and foreign income tax payable and interest thereon (including $ ..... on realized gains (losses))	2,377,186		2,377,186	8,105,131
10.2 Net deferred tax liability	0		0	
11. Ceded reinsurance premiums payable	0		0	
12. Amounts withheld or retained for the account of others	0		0	
13. Remittances and items not allocated	2,252,864		2,252,864	2,849,167
14. Borrowed money (including $ ..... current) and interest thereon $ ..... (including $ ..... current)	0		0	
15. Amounts due to parent, subsidiaries and affiliates	70,953,264		70,953,264	45,303,713
16. Derivatives	0		0	
17. Payable for securities	7,616,168		7,616,168	
18. Payable for securities lending	0		0	
19. Funds held under reinsurance treaties (with $ ..... authorized reinsurers, $ ..... unauthorized reinsurers and $ ..... certified reinsurers)	0		0	
20. Reinsurance in unauthorized and certified ($ .....) companies	0		0	
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	
22. Liability for amounts held under uninsured plans	0		0	
23. Aggregate write-ins for other liabilities (including $ ..... current)	1,996,607	0	1,996,607	1,851,899
24. Total liabilities (Lines 1 to 23)	266,918,592	3,268,349	270,186,941	264,866,801
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	22,555,000
26. Common capital stock	XXX	XXX	1,000,000	1,000,000
27. Preferred capital stock	XXX	XXX	0	
28. Gross paid in and contributed surplus	XXX	XXX	99,010,001	99,010,001
29. Surplus notes	XXX	XXX	0	
30. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	184,111,560	139,357,346
32. Less treasury stock, at cost:				
32.1 ..... shares common (value included in Line 26 $ .....)	XXX	XXX		
32.2 ..... shares preferred (value included in Line 27 $ .....)	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	284,121,561	261,922,347
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	554,308,502	526,789,148
DETAILS OF WRITE-INS				
2301. Escheat Payable	1,996,607		1,996,607	1,851,899
2302.				
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 through 2303 plus 2398)(Line 23 above)	1,996,607	0	1,996,607	1,851,899
2501. Estimated Health Insurance Fee Accrual	XXX	XXX		22,555,000
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	XXX	XXX	0	22,555,000
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 through 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year To Date		Prior Year To Date	Prior Year Ended December 31
		1 Uncovered	2 Total	3 Total	4 Total
1.	Member Months	XXX	1,410,114	1,530,829	3,018,365
2.	Net premium income (including $ non-health premium income)	XXX	560,023,351	536,572,829	1,092,625,603
3.	Change in unearned premium reserves and reserve for rate credits	XXX	(6,048,288)	19,434,468	31,898,076
4.	Fee-for-service (net of $ medical expenses)	XXX			0
5.	Risk revenue	XXX			0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0	0
8.	Total revenues (Lines 2 to 7)	XXX	553,975,063	556,007,297	1,124,523,679
	Hospital and Medical:				
9.	Hospital/medical benefits	6,935,790	277,431,585	306,848,392	609,008,492
10.	Other professional services	541,131	21,645,247	24,004,977	49,453,749
11.	Outside referrals	0	0		0
12.	Emergency room and out-of-area	992,908	39,716,323	45,695,949	89,732,481
13.	Prescription drugs		106,822,697	110,164,642	220,118,361
14.	Aggregate write-ins for other hospital and medical	0	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts		739,512		(7,740,581)
16.	Subtotal (Lines 9 to 15)	8,469,829	446,355,364	486,713,960	960,572,502
	Less:				
17.	Net reinsurance recoveries				0
18.	Total hospital and medical (Lines 16 minus 17)	8,469,829	446,355,364	486,713,960	960,572,502
19.	Non-health claims (net)		0		
20.	Claims adjustment expenses, including $ 12,893,039 cost containment expenses		13,904,003	13,462,520	28,389,145
21.	General administrative expenses		56,279,147	36,715,363	69,029,357
22.	Increase in reserves for life and accident and health contracts (including $ increase in reserves for life only)		0		0
23.	Total underwriting deductions (Lines 18 through 22)	8,469,829	516,538,514	536,891,844	1,057,991,004
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	37,436,549	19,115,453	66,532,675
25.	Net investment income earned		8,250,168	7,500,177	14,019,102
26.	Net realized capital gains (losses) less capital gains tax of $ (232,335)		(2,038,153)	121,590	637,847
27.	Net investment gains (losses) (Lines 25 plus 26)	0	6,212,015	7,621,767	14,656,949
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $) (amount charged off $)]				
29.	Aggregate write-ins for other income or expenses	0	(2,391,300)	0	(4,535,812)
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	41,257,264	26,737,220	76,653,812
31.	Federal and foreign income taxes incurred	XXX	12,540,737	6,820,857	20,912,254
32.	Net income (loss) (Lines 30 minus 31)	XXX	28,716,527	19,916,363	55,741,558
	DETAILS OF WRITE-INS				
0601.		XXX			
0602.		XXX			
0603.		XXX			
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)	XXX	0	0	0
0701.		XXX			
0702.		XXX			
0703.		XXX			
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798)(Line 7 above)	XXX	0	0	0
1401.					
1402.					
1403					
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498)(Line 14 above)	0	0	0	0
2901.	Regulatory Penalties		(2,391,300)		(4,535,812)
2902.					
2903					
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998)(Line 29 above)	0	(2,391,300)	0	(4,535,812)

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year to Date	2 Prior Year to Date	3 Prior Year Ended December 31
	CAPITAL AND SURPLUS ACCOUNT			
33.	Capital and surplus prior reporting year	261,922,348	213,442,922	213,442,922
34.	Net income or (loss) from Line 32	28,716,527	19,916,363	55,741,558
35.	Change in valuation basis of aggregate policy and claim reserves			
36.	Change in net unrealized capital gains (losses) less capital gains tax of $ (147,621)	(555,335)	159,157	148,249
37.	Change in net unrealized foreign exchange capital gain or (loss)			
38.	Change in net deferred income tax	(147,621)	1,974,442	(7,178,803)
39.	Change in nonadmitted assets	(5,814,358)	(6,068,882)	(231,579)
40	Change in unauthorized and certified reinsurance	0		0
41.	Change in treasury stock	0		0
42.	Change in surplus notes	0		0
43.	Cumulative effect of changes in accounting principles			
44.	Capital Changes:			
	44.1 Paid in	0	990,000	990,000
	44.2 Transferred from surplus (Stock Dividend)	0		
	44.3 Transferred to surplus			
45.	Surplus adjustments:			
	45.1 Paid in	0	(990,000)	(990,000)
	45.2 Transferred to capital (Stock Dividend)			
	45.3 Transferred from capital			
46.	Dividends to stockholders			
47.	Aggregate write-ins for gains or (losses) in surplus	0	0	0
48.	Net change in capital & surplus (Lines 34 to 47)	22,199,213	15,981,080	48,479,426
49.	Capital and surplus end of reporting period (Line 33 plus 48)	284,121,561	229,424,003	261,922,348
	DETAILS OF WRITE-INS			
4701.				
4702.				
4703.				
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798)(Line 47 above)	0	0	0

CASH FLOW

		1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
	Cash from Operations			
1.	Premiums collected net of reinsurance	544,580,724	439,770,882	1,125,954,663
2.	Net investment income	9,166,276	9,346,116	17,511,807
3.	Miscellaneous income	0	0	0
4.	Total (Lines 1 to 3)	553,747,000	449,116,998	1,143,466,470
5.	Benefit and loss related payments	483,827,973	532,137,126	1,002,057,647
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts			
7.	Commissions, expenses paid and aggregate write-ins for deductions	57,071,205	57,635,309	103,782,491
8.	Dividends paid to policyholders			
9.	Federal and foreign income taxes paid (recovered) net of $ ..... tax on capital gains (losses)	18,036,347	17,628,924	27,025,769
10.	Total (Lines 5 through 9)	558,935,525	607,401,359	1,132,865,907
11.	Net cash from operations (Line 4 minus Line 10)	(5,188,525)	(158,284,361)	10,600,563
	Cash from Investments			
12.	Proceeds from investments sold, matured or repaid:			
	12.1 Bonds	129,125,609	59,480,124	116,787,533
	12.2 Stocks	0	0	0
	12.3 Mortgage loans	156,210	0	0
	12.4 Real estate	0	0	0
	12.5 Other invested assets	0	0	0
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	(184)	9	(470)
	12.7 Miscellaneous proceeds	7,650,587	0	0
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	136,932,222	59,480,133	116,787,063
13.	Cost of investments acquired (long-term only):			
	13.1 Bonds	102,081,904	8,251,442	69,990,769
	13.2 Stocks	0	0	0
	13.3 Mortgage loans	221,144	0	12,979,171
	13.4 Real estate	0	0	0
	13.5 Other invested assets	0	0	0
	13.6 Miscellaneous applications	1,515,690	895,905	494,470
	13.7 Total investments acquired (Lines 13.1 to 13.6)	103,818,738	9,147,347	83,464,410
14.	Net increase (or decrease) in contract loans and premium notes	0	0	0
15.	Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	33,113,483	50,332,786	33,322,653
	Cash from Financing and Miscellaneous Sources			
16.	Cash provided (applied):			
	16.1 Surplus notes, capital notes	0	0	0
	16.2 Capital and paid in surplus, less treasury stock	0	0	0
	16.3 Borrowed funds	0	0	0
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0	0
	16.5 Dividends to stockholders	0	0	0
	16.6 Other cash provided (applied)	27,030,325	116,491,023	(34,496,987)
17.	Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	27,030,325	116,491,023	(34,496,987)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS			
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	54,955,283	8,539,448	9,426,229
19.	Cash, cash equivalents and short-term investments:			
	19.1 Beginning of year	14,204,889	4,778,660	4,778,660
	19.2 End of period (Line 18 plus Line 19.1)	69,160,172	13,318,108	14,204,889

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001. Non-Cash Transaction- Tax Free Acquisition	1,052,670	12,655,315	12,655,315

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
	Total	2 Individual	3 Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	243,019	20,142	0	0	0	0	0	0	222,877	0
2. First Quarter	236,325	19,852	0	0	0	0	0	0	216,473	0
3. Second Quarter	230,822	19,709							211,113	
4. Third Quarter	0									
5. Current Year	0									
6. Current Year Member Months	1,410,114	117,384							1,292,730	
Total Member Ambulatory Encounters for Period:										
7 Physician	844,400	50,404							793,996	
8. Non-Physician	480,335	17,896							462,439	
9. Total	1,324,735	68,300	0	0	0	0	0	0	1,256,435	0
10. Hospital Patient Days Incurred	39,240	395							38,845	
11. Number of Inpatient Admissions	8,590	97							8,493	
12. Health Premiums Written (a)	560,023,351	17,403,085							542,620,266	
13. Life Premiums Direct	0	0							0	
14. Property/Casualty Premiums Written	0	0							0	
15. Health Premiums Earned	553,975,063	17,202,656							536,772,407	
16. Property/Casualty Premiums Earned	0	0							0	
17. Amount Paid for Provision of Health Care Services	491,506,999	15,859,632							475,647,367	
18. Amount Incurred for Provision of Health Care Services	446,355,364	13,963,014							432,392,350	

(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ 0

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Claims Unpaid (Reported)						
0299999 Aggregate accounts not individually listed-uncovered	296,199	64,498	(1,018)	0	3,274	362,953
0399999 Aggregate accounts not individually listed-covered	10,625,015	1,099,521	734,944	49,879	1,649,670	14,159,029
0499999 Subtotals	10,921,214	1,164,019	733,926	49,879	1,652,944	14,521,982
0599999 Unreported claims and other claim reserves						116,211,976
0699999 Total amounts withheld						
0799999 Total claims unpaid						130,733,958
0899999 Accrued medical incentive pool and bonus amounts						930,141

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid Year to Date		Liability End of Current Quarter		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid Dec. 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)	2,330,212	13,504,746	685,605	2,677,656	3,015,817	5,259,881
2. Medicare Supplement	0	0	0	0	0	0
3. Dental Only	0	0	0	0	0	0
4. Vision Only	0	0	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0	0	0
6. Title XVIII - Medicare	0	0	0	0	0	0
7 Title XIX - Medicaid	95,335,652	380,336,393	30,240,671	97,130,027	125,576,323	153,780,101
8. Other health	0	0	0	0	0	0
9. Health subtotal (Lines 1 to 8)	97,665,864	393,841,139	30,926,276	99,807,683	128,592,140	159,039,982
10. Healthcare receivables (a)	31,370,254	5,624,532	0	0	31,370,254	19,409,658
11. Other non-health	0	0	0	0	0	0
12. Medical incentive pools and bonus amounts	0	0	109,376	820,765	109,376	190,629
13. Totals (Lines 9-10+11+12)	66,295,610	388,216,607	31,035,652	100,628,448	97,331,262	139,820,953

(a) Excludes $ ..... loans or advances to providers not yet expensed.

NOTES TO FINANCIAL STATEMENTS

1. Summary of significant accounting policies

A. Accounting practices

The accompanying statutory financial statements of Aetna Better Health of Kentucky Insurance Co. (the "Company), a wholly-owned subsidiary of Coventry Health & Life Insurance Co. ('CH&L'), whose ultimate parent is Aetna Inc. ("Aetna"), have been prepared in conformity with accounting practices prescribed or permitted by the Commonwealth of Kentucky Department of Insurance (KY DOI). The KY DOI recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP").

A reconciliation of the Company's net income and surplus between NAIC SAP and practices prescribed and permitted by the Commonwealth of Kentucky for the periods ended June 30, 2018 and December 31, 2017 is as follows:

	SSAP #	F/S Page	F/S Line #	2018	2017
NET INCOME					
(1) State basis (Page 4, Line 32, Columns 2 & 4)	XXX	XXX	XXX	28,716,527	55,741,558
(2) State Prescribed Practices that are an increase/(decrease) from NAIC SAP:					
(3) State Permitted Practices that are an increase/(decrease) from NAIC SAP:					
(4) NAIC SAP (1-2-3=4)	XXX	XXX	XXX	28,716,527	55,741,558
SURPLUS					
(5) State basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	284,121,561	261,922,347
(6) State Prescribed Practices that are an increase/(decrease) from NAIC SAP:					
(7) State Permitted Practices that are an increase/(decrease) from NAIC SAP:					
(8) NAIC SAP (5-6-7=8)	XXX	XXX	XXX	284,121,561	261,922,347

B. Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Kentucky Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenues and expenses. Actual results could differ from those estimates.

C. Accounting policies

No significant change.

D. Going concern

As of August 13, 2018, management has evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

2. Accounting changes and corrections of errors

The Company did not have any accounting changes or corrections of errors in the period ended June 30, 2018.

3. Business combinations and goodwill

No significant change.

4. Discontinued operations

No significant change.

5. Investments

A. – C. No significant change.

D. Loan-Backed Securities

(1) Prepayment assumptions for single class and multi-class mortgage backed/asset backed securities were obtained from industry market sources.

(2) The Company had no other-than-temporary impairment ("OTTI") losses during the first quarter of 2018 on loan-backed and structured securities in which the Company had the (1) intent to sell, (2) did not have the intent and ability to retain for a period of time sufficient to recover the amortized cost basis or (3) present value of cash flows expected to be collected is less than the amortized cost basis of the securities in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 43R, *Loan-Backed and Structured Securities* ("SSAP No. 43R").

(3) The Company had no recognized OTTI on loan-backed and structured securities currently held, in which the present value of cash flows expected to be collected is less than the amortized cost basis, at the reporting date June 30, 2018.

(4) The Company's unrealized loss position on loan-backed and structured securities held by the Company at June 30, 2018 is as follows:

a. The aggregate amount of unrealized losses:
   1. Less than 12 Months 97,671
   2. 12 Months or Longer 765,351
b. The aggregate related fair value of securities with unrealized losses:
   1. Less than 12 Months 8,685,463
   2. 12 Months or Longer 14,477,969

(5) The Company has reviewed the loaned-backed and structured securities in accordance with SSAP No. 43R in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at June 30, 2018 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

E. Repurchase Agreements and/or Securities Lending Transactions

(1) and (2): No significant change.

(3) Neither the Company nor its agent has accepted collateral that is permitted by contract or custom to sell or re-pledge as of June 30, 2018.

(4) through (7): No significant change.

F. The Company did not have any repurchase agreements transactions accounted for as secured borrowing at June 30, 2018.

G. The Company did not have any reverse repurchase agreements transactions accounted for as secured at June 30, 2018.

H. The Company did not have any repurchase agreements transactions accounted for as a sale at June 30, 2018.

I. The Company did not have any reverse repurchase agreements transactions accounted for as a sale at June 30, 2018.

J. through L.: No significant change.

M. The Company did not have any working capital finance investments at June 30, 2018.

N. The Company did not have any offsetting and netting of financial assets or liabilities at June 30, 2018.

O. through R.: No significant change.

6. Joint ventures, partnerships, and limited liability companies

No significant change.

7. Investment income

No significant change.

8. Derivative instruments

No significant change.

9. Income taxes

No significant change.

10. Information concerning parent, subsidiaries, affiliates, and related parties

No significant change.

11. Debt

A. The Company did not have any items related to debt, including capital notes at June 30, 2018.

B. The Company did not have any Federal Home Loan Bank agreements at June 30, 2018.

12. Retirement plans, deferred compensation postemployment benefits and compensated absences and other postretirement benefit plans

The Company did not have a retirement plan, deferred compensation plan, or other postretirement benefit plan at June 30, 2018.

13. Capital and surplus, shareholders' dividend restrictions and quasi-reorganizations

No significant change.

14. Contingencies

No significant change.

15. Leases

No significant change.

16. Information about financial instruments with off-balance sheet risk and financial instruments with concentrations of credit risk

No significant change.

17. Sale, transfer and servicing of financial assets and extinguishments of liabilities

A. Transfers of receivables reported as sales

No significant change.

B. Transfer and servicing of financial assets

(1) No significant change.

(2) and (3): The Company did not have any servicing assets or liabilities at June 30, 2018.

(4) The Company did not have any securitized financial assets at June 30, 2018.

(5) through (7): No significant change.

C. Wash sales

(1) The Company did not have any wash sales for the period ended June 30, 2018.

18. Gain or loss to the reporting entity from uninsured plans and the uninsured portion of partially insured plans

No significant change.

19. Direct premium written/produced by managing general agents/third party administrators

No significant change.

20. Fair value measurements

A. and B.

The Company had no material assets or liabilities measured and reported at fair value at June 30, 2018.

C. Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The carrying values and estimated fair values of the Company's financial instruments at June 30, 2018 were as follows:

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)	Net Asset Value (NAV) Included in Level 2
Bonds, Short Term, and Cash Equivalent	512,083,493	511,398,548	47,450,373	464,633,120			
Mortgage Loans	13,805,881	13,105,963			13,805,881		

There were no materials realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets at June 30, 2018. There were no transfers between the Company's Level 1 or 2 financial assets during June 30, 2018.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

21. Other items

No significant change.

22. Events subsequent

A. Type I - Recognized subsequent events

Subsequent events have been considered through August 13, 2018 for the statutory statement issued on August 13, 2018.

The Company had no known reportable recognized subsequent events.

B. Type II – Non-recognized subsequent events

Subsequent events have been considered through August 13, 2018 for the statutory statement issued on August 13, 2018.

The Company had no known reportable non-recognized subsequent events.

23. Reinsurance

No significant change.

24. Retrospectively rated contracts and contracts subject to redetermination

A. through D.: No significant change.

E. Risk Sharing Provisions of the Affordable Care Act

(1) Did the reporting entity write accident and health insurance premium which is subject to the ACA risk sharing provisions (YES/NO)? No

(2) through (5): Not applicable.

25. Change in incurred claims and claims adjustment expense

As of June 30, 2018, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' decreased by $42,489,691 from $162,303,470 in 2017 to $119,813,779 in 2018. In 2017, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' decreased by $4,903,247 from $203,997,642 in 2016 to $199,094,395 in 2017. The lower than anticipated health care cost trend rates observed in 2018 for claims incurred in 2017, were due to moderating outpatient and physician trends and faster than expected claim payment speed. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends.

Net coordination of benefits is implicit in the claims incurred but not reported calculation and could not be specifically identified.

26. Intercompany pooling arrangements

No significant change.

27. Structured settlements

No significant change.

28. Health care receivables

No significant change.

29. Participating policies

No significant change.

30. Premium deficiency reserves

No significant change.

31. Anticipated salvage and subrogation

No significant change.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Did the reporting entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the State of Domicile, as required by the Model Act? ..... Yes [ ] No [X]

1.2 If yes, has the report been filed with the domiciliary state? ..... Yes [ ] No [ ]

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? ..... Yes [ ] No [X]

2.2 If yes, date of change: .....

3.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? ..... Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1 and 1A.

3.2 Have there been any substantial changes in the organizational chart since the prior quarter end? ..... Yes [ ] No [X]

3.3 If the response to 3.2 is yes, provide a brief description of those changes.

3.4 Is the reporting entity publicly traded or a member of a publicly traded group? ..... Yes [X] No [ ]

3.5 If the response to 3.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0001122304

4.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? ..... Yes [ ] No [X]

4.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

5. If the reporting entity is subject to a management agreement, including third-party administrator(s), managing general agent(s), attorney-in-fact, or similar agreement, have there been any significant changes regarding the terms of the agreement or principals involved? ..... Yes [ ] No [X] N/A [ ]
If yes, attach an explanation.

6.1 State as of what date the latest financial examination of the reporting entity was made or is being made. .....

6.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. .....

6.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). .....

6.4 By what department or departments?

6.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? ..... Yes [ ] No [ ] N/A [X]

6.6 Have all of the recommendations within the latest financial examination report been complied with? ..... Yes [ ] No [ ] N/A [X]

7.1 Has this reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? ..... Yes [ ] No [X]

7.2 If yes, give full information:

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? ..... Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? ..... Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

GENERAL INTERROGATORIES

9.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No [ ]
(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.
9.11 If the response to 9.1 is No, please explain:

9.2 Has the code of ethics for senior managers been amended? Yes [ ] No [X]
9.21 If the response to 9.2 is Yes, provide information related to amendment(s).

9.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [X]
9.31 If the response to 9.3 is Yes, provide the nature of any waiver(s).

FINANCIAL

10.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No [ ]
10.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ 0

INVESTMENT

11.1 Were any of the stocks, bonds, or other assets of the reporting entity loaned, placed under option agreement, or otherwise made available for use by another person? (Exclude securities under securities lending agreements.) Yes [ ] No [X]
11.2 If yes, give full and complete information relating thereto:

12. Amount of real estate and mortgages held in other invested assets in Schedule BA: $ 0
13. Amount of real estate and mortgages held in short-term investments: $ 0
14.1 Does the reporting entity have any investments in parent, subsidiaries and affiliates? Yes [ ] No [X]
14.2 If yes, please complete the following:

	1 Prior Year-End Book/Adjusted Carrying Value	2 Current Quarter Book/Adjusted Carrying Value
14.21 Bonds	$ 0	$
14.22 Preferred Stock	$ 0	$
14.23 Common Stock	$ 0	$
14.24 Short-Term Investments	$ 0	$
14.25 Mortgage Loans on Real Estate	$ 0	$
14.26 All Other	$ 0	$
14.27 Total Investment in Parent, Subsidiaries and Affiliates (Subtotal Lines 14.21 to 14.26)	$ 0	$ 0
14.28 Total Investment in Parent included in Lines 14.21 to 14.26 above	$	$

15.1 Has the reporting entity entered into any hedging transactions reported on Schedule DB? Yes [ ] No [X]
15.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ]
If no, attach a description with this statement.

GENERAL INTERROGATORIES

16. For the reporting entity's security lending program, state the amount of the following as of the current statement date:
    - 16.1 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. $ 0
    - 16.2 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 $ 0
    - 16.3 Total payable for securities lending reported on the liability page. $ 0

17. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No [ ]

17.1 For all agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian Address
State Street Bank and Trust Company	State Street Financial Center; One Lincoln Street; Boston, MA 02111-2900

17.2 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)
All agreements comply.		

17.3 Have there been any changes, including name changes, in the custodian(s) identified in 17.1 during the current quarter? Yes [ ] No [X]

17.4 If yes, give full information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

17.5 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
Kevin J. Casey as Sr. Investment Officer	A

17.5097 For those firms/individuals listed in the table for Question 17.5, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets? Yes [ ] No [X]

17.5098 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 17.5, does the total assets under management aggregate to more than 50% of the reporting entity's assets? Yes [ ] No [X]

17.6 For those firms or individuals listed in the table for 17.5 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
N/A	Kevin J. Casey	N/A	Not registered	NO

18.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No [ ]

18.2 If no, list exceptions:

19. By self-designating 5*GI securities, the reporting entity is certifying the following elements for each self-designated 5*GI security:
    - a. Documentation necessary to permit a full credit analysis of the security does not exist.
    - b. Issuer or obligor is current on all contracted interest and principal payments.
    - c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

    Has the reporting entity self-designated 5*GI securities? Yes [ ] No [X]

GENERAL INTERROGATORIES

PART 2 - HEALTH

1. Operating Percentages:

   1.1 A&H loss percent ..... 82.9 %

   1.2 A&H cost containment percent ..... 2.3 %

   1.3 A&H expense percent excluding cost containment expenses ..... 10.3 %

2.1 Do you act as a custodian for health savings accounts? ..... Yes [ ] No [X]

2.2 If yes, please provide the amount of custodial funds held as of the reporting date ..... $.....

2.3 Do you act as an administrator for health savings accounts? ..... Yes [ ] No [X]

2.4 If yes, please provide the balance of the funds administered as of the reporting date ..... $.....

3. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? ..... Yes [ ] No [X]

3.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? ..... Yes [ ] No [X]

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE S - CEDED REINSURANCE

Showing All New Reinsurance Treaties - Current Year to Date

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Reinsurer	5 Domiciliary Jurisdiction	6 Type of Reinsurance Ceded	7 Type of Reinsurer	8 Certified Reinsurer Rating (1 through 6)	9 Effective Date of Certified Reinsurer Rating

NONE

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

Current Year to Date - Allocated by States and Territories

		1	Direct Business Only							
			2	3	4	5	6	7	8	9
States, etc.		Active Status (a)	Accident and Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Program Premiums	Life and Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama	AL	N							0	
2. Alaska	AK	N							0	
3. Arizona	AZ	N							0	
4. Arkansas	AR	N							0	
5. California	CA	N							0	
6. Colorado	CO	N							0	
7. Connecticut	CT	N							0	
8. Delaware	DE	N							0	
9. District of Columbia	DC	N							0	
10. Florida	FL	N							0	
11. Georgia	GA	N							0	
12. Hawaii	HI	N							0	
13. Idaho	ID	N							0	
14. Illinois	IL	N							0	
15. Indiana	IN	N							0	
16. Iowa	IA	N							0	
17. Kansas	KS	N							0	
18. Kentucky	KY	L	17,403,085	0	542,620,266				560,023,351	
19. Louisiana	LA	N							0	
20. Maine	ME	N							0	
21. Maryland	MD	N							0	
22. Massachusetts	MA	N							0	
23. Michigan	MI	N							0	
24. Minnesota	MN	N							0	
25. Mississippi	MS	N							0	
26. Missouri	MO	N							0	
27. Montana	MT	N							0	
28. Nebraska	NE	N							0	
29. Nevada	NV	N							0	
30. New Hampshire	NH	N							0	
31. New Jersey	NJ	N							0	
32. New Mexico	NM	N							0	
33. New York	NY	N							0	
34. North Carolina	NC	N							0	
35. North Dakota	ND	N							0	
36. Ohio	OH	N							0	
37. Oklahoma	OK	N							0	
38. Oregon	OR	N							0	
39. Pennsylvania	PA	N							0	
40. Rhode Island	RI	N							0	
41. South Carolina	SC	N							0	
42. South Dakota	SD	N							0	
43. Tennessee	TN	N							0	
44. Texas	TX	N							0	
45. Utah	UT	N							0	
46. Vermont	VT	N							0	
47. Virginia	VA	N							0	
48. Washington	WA	N							0	
49. West Virginia	WV	N							0	
50. Wisconsin	WI	N							0	
51. Wyoming	WY	N							0	
52. American Samoa	AS	N							0	
53. Guam	GU	N							0	
54. Puerto Rico	PR	N							0	
55. U.S. Virgin Islands	VI	N							0	
56. Northern Mariana Islands	MP	N							0	
57. Canada	CAN	N							0	
58. Aggregate Other Aliens	OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal		XXX	17,403,085	0	542,620,266	0	0	0	560,023,351	0
60. Reporting Entity Contributions for Employee Benefit Plans		XXX							0	
61. Totals (Direct Business)		XXX	17,403,085	0	542,620,266	0	0	0	560,023,351	0
DETAILS OF WRITE-INS										
58001.		XXX								
58002.		XXX								
58003.		XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page		XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)		XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed Insurance carrier or domiciled RRG 1
R - Registered - Non-domiciled RRGs 0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
Q - Qualified - Qualified or accredited reinsurer 0
N - None of the above - Not allowed to write business in the state 56

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

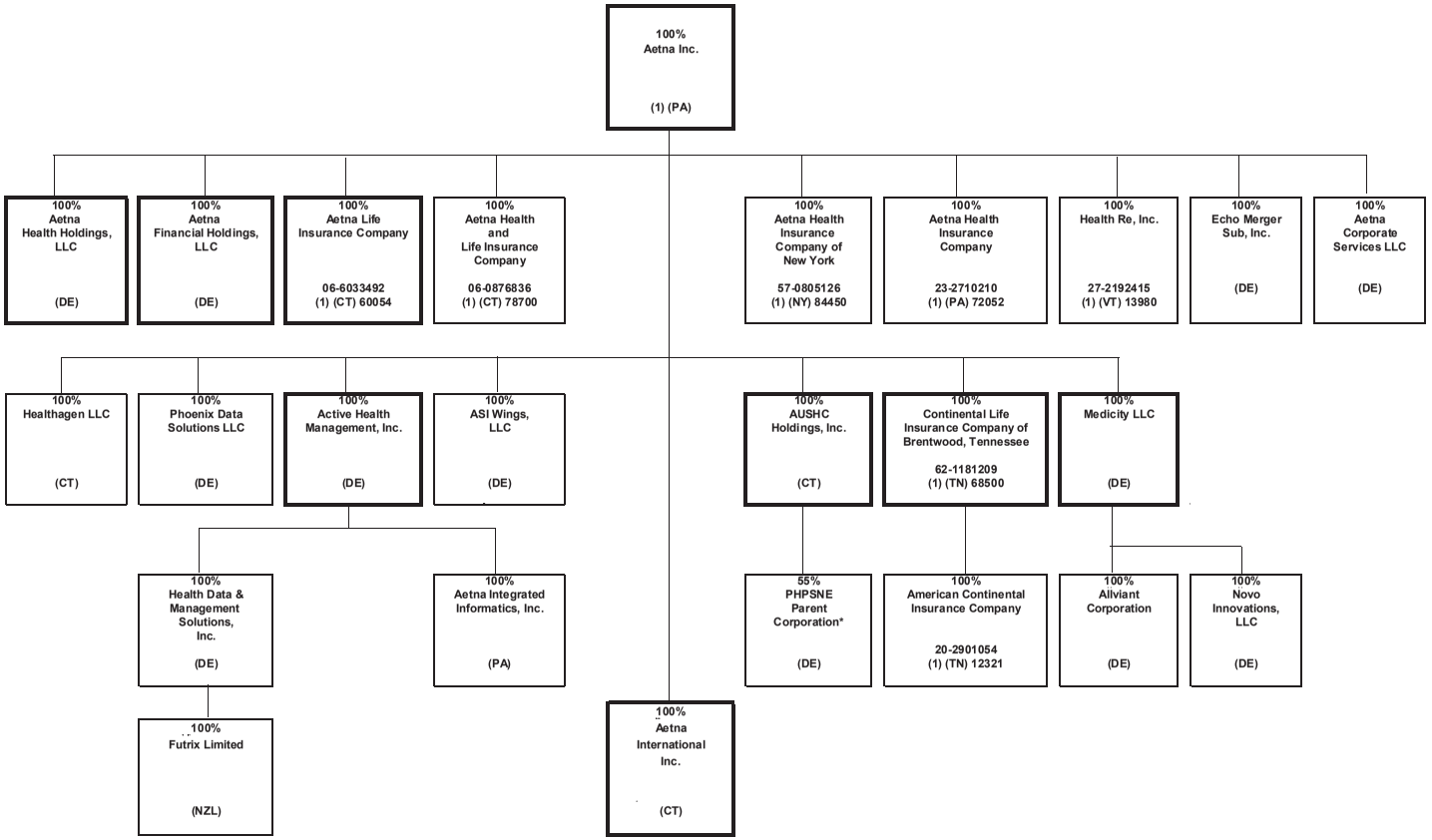

(1) Insurers/HMO's
Percentages are rounded to the nearest whole percent and based on ownership of voting rights.
Double borders indicate entity has subsidiaries shown on the same page.
Bold borders indicate entity has subsidiaries shown on a separate page.

*55% is owned by AUSHC Holdings, Inc. and 45% is owned by third parties.

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

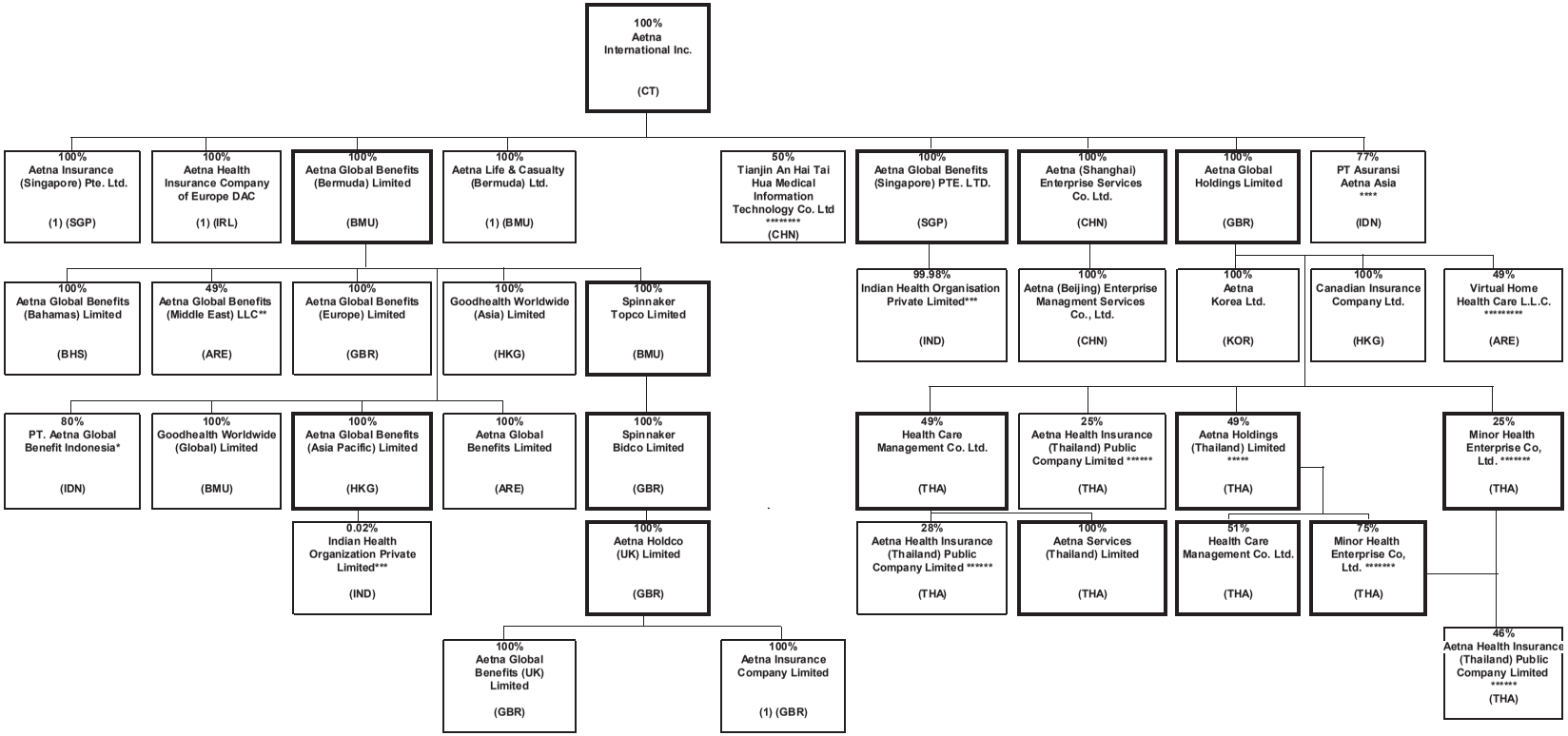

*Aetna Global Benefits Indonesia is 80% owned by Aetna Global Benefits (Bermuda) Limited and 20% is owned by Suhatsyah Rivai, Aetna's Nominee.
**Aetna Global Benefits (Middle East) LLC is 49% owned by Aetna Global Benefits (Bermuda) Limited and 51% is owned by Euro Gulf LLC, Aetna's Nominee.
***Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
****PT Asuransi Aetna Asia is 77% owned by Aetna International Inc. and 23% owned by PT Asuransi Central Asia.
*****Aetna Holdings (Thailand) Limited is 51% owned by Mr. Paiboon Sutantivorakoon
******Aetna Health Insurance (Thailand) Public Company Limited is 46% owned by Minor Health Entreprise Co, Ltd.; 25% owned by Aetna Global Holdings Limited; and 28% owned by Health Care Management Co. Ltd. and total 1% owned by Aetna Global Benefits (Bermuda) Limited (1 Share); Mr. Sansanapongpherchar (1 Share); Mr. Jitphasong Itsaraphakded (1 Share); Mrs. Suphee Wattana (1 Share); and Mr. Buncha Tamphragom (1 Share)
*******Minor Health Entreprise Co, Ltd is 1 share owned by Aetna Global Benefits (Bermuda) Ltd
********Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is 50% owned by Tianjin Hai Tai Group Co., Ltd
*********Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

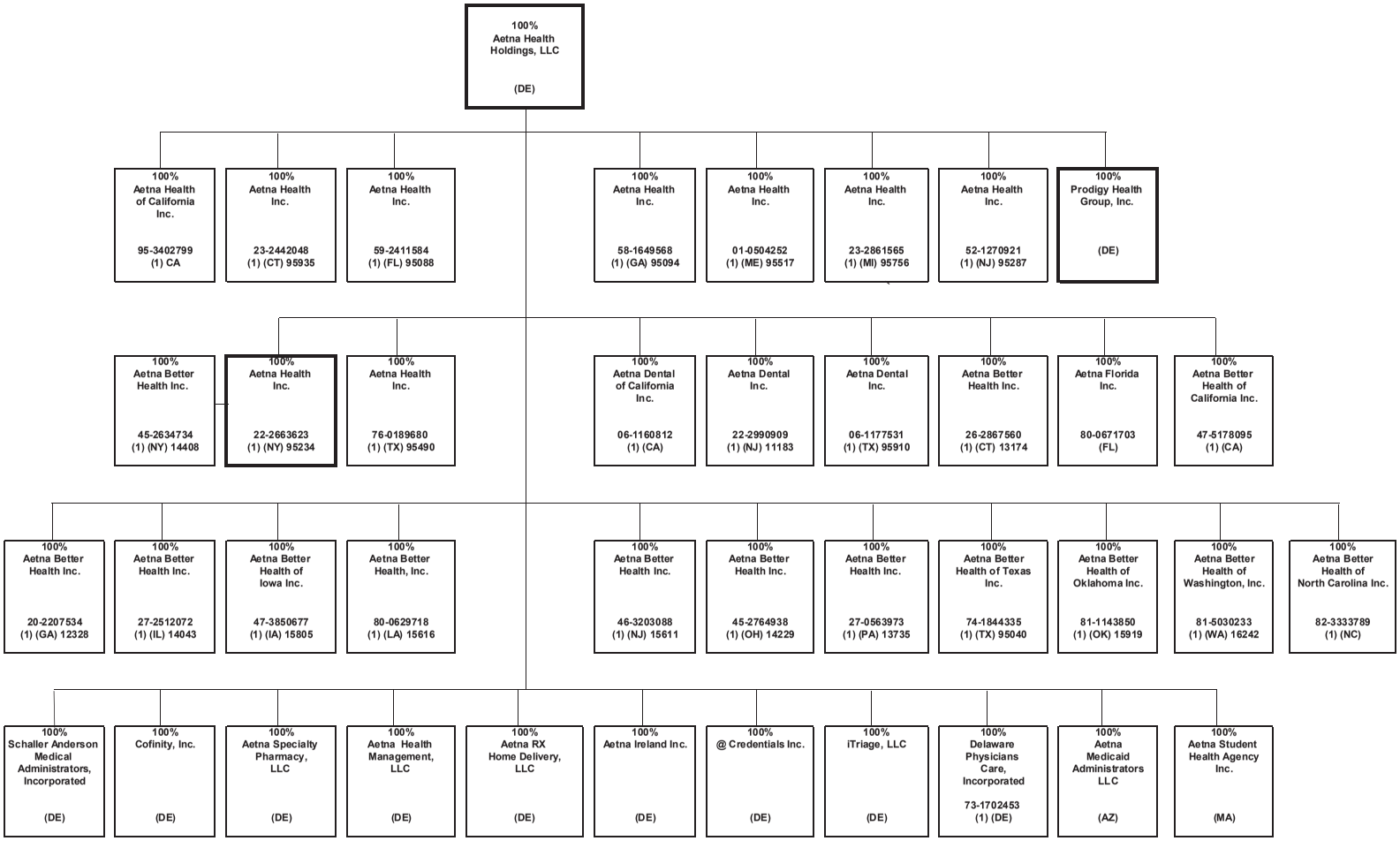

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

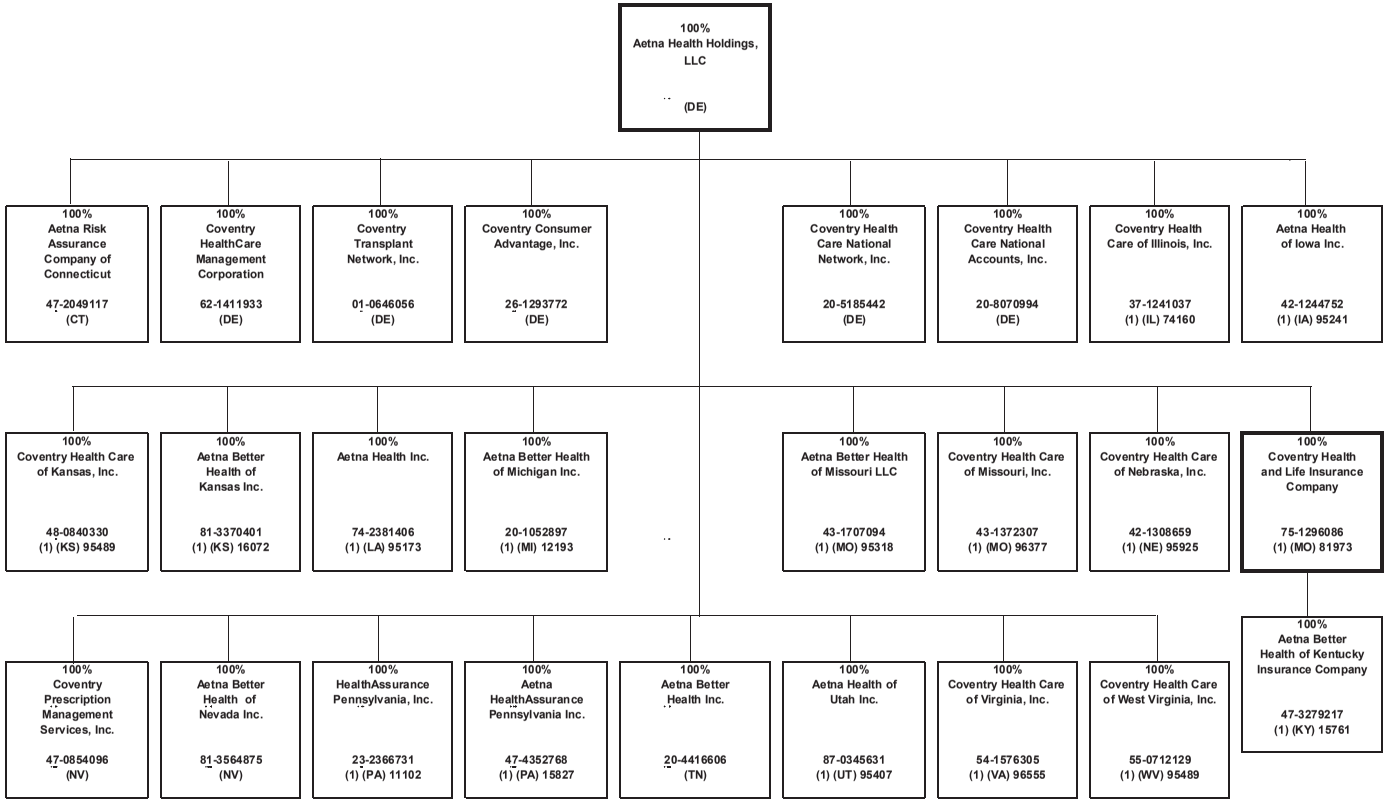

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

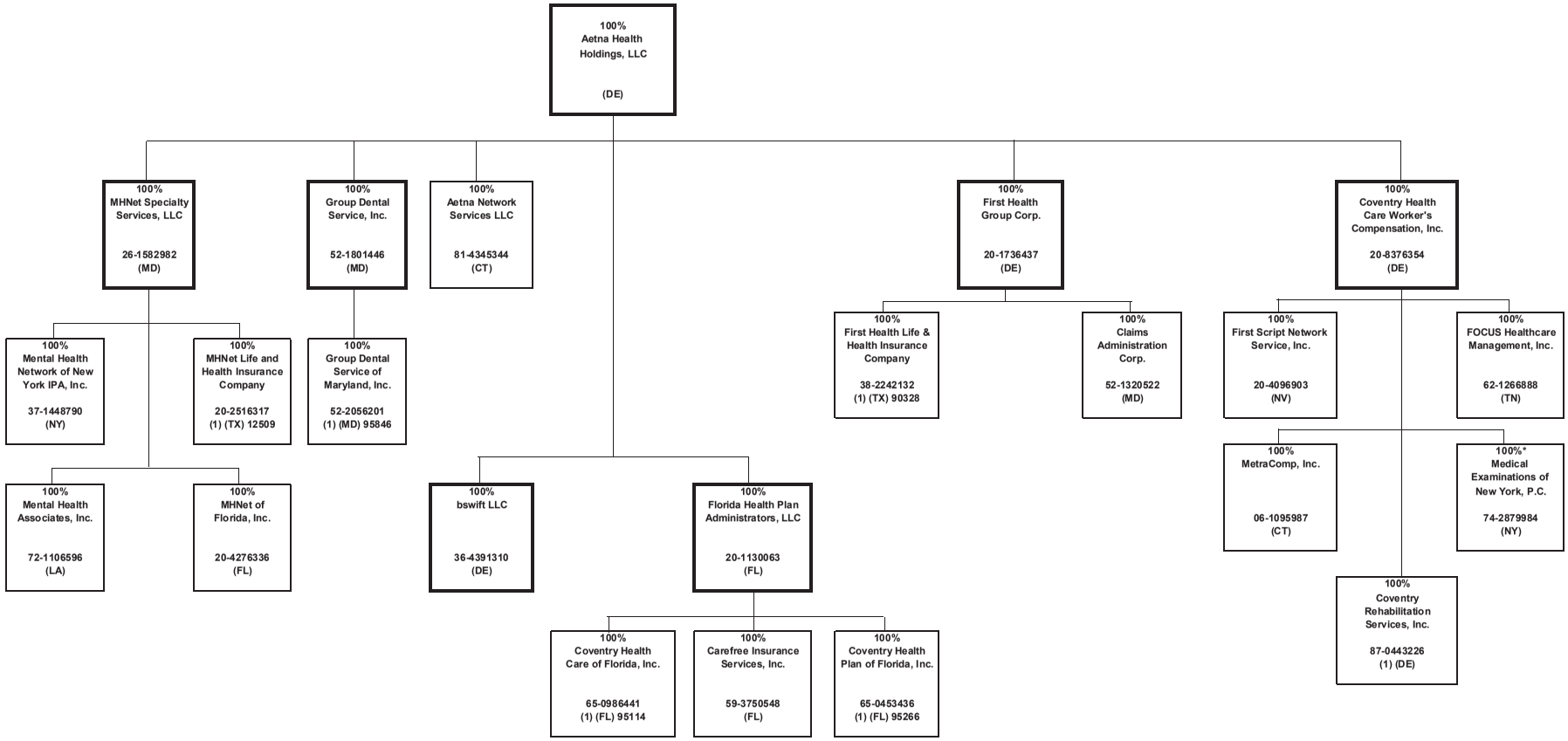

*100% owned through Aetna's nominees

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

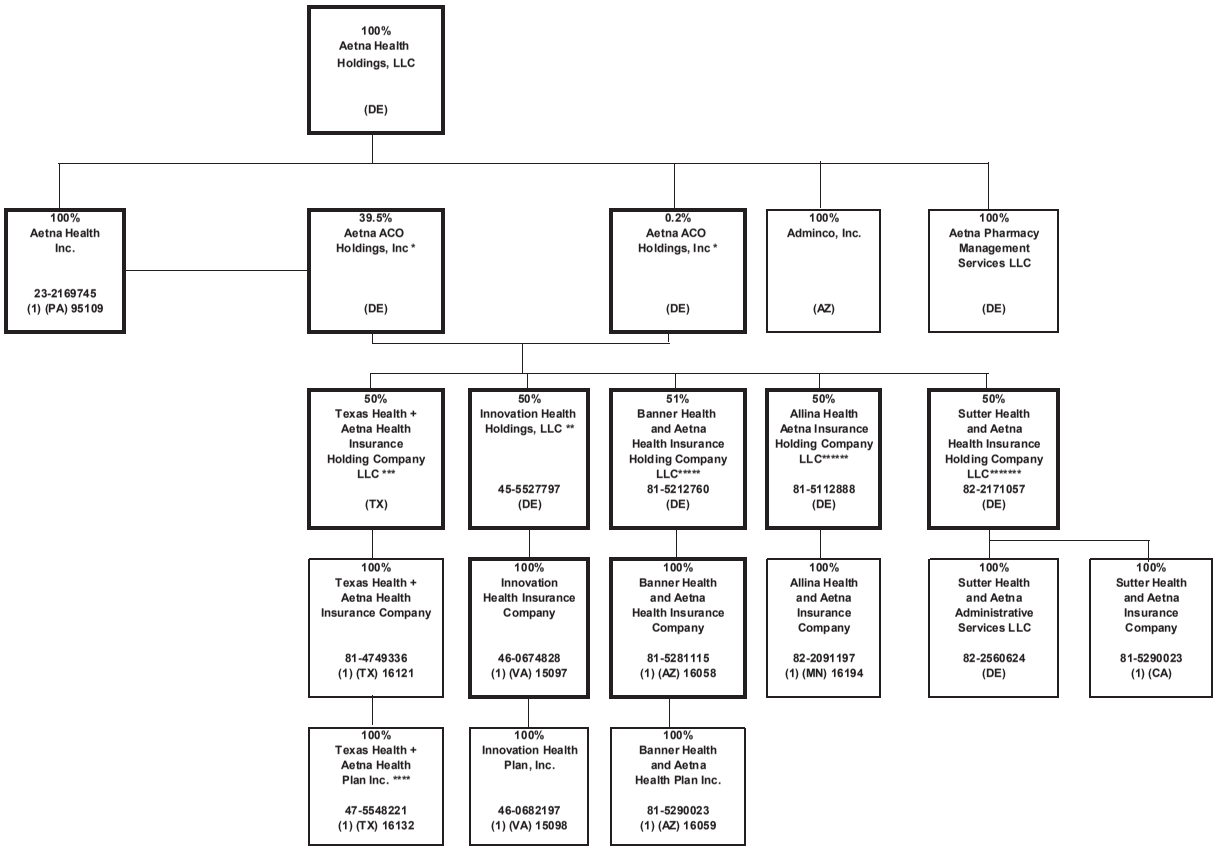

* Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
** Innovation Health Holdings, LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Inova Health System Foundation.
*** Texas Health + Aetna Health Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Texas Health Resources.
**** Texas Health + Aetna Health Plan Inc. became a direct subsidiary of Texas Health + Aetna Health Insurance Company February 2017.
***** Banner Health and Aetna Health Insurance Holding Company LLC is 51% owned by Aetna ACO Holdings Inc. and 49% owned by Banner Health.
****** Allina Health and Aetna Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Allina Health.
*******Sutter Health and Aetna Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Sutter Health Plan Products Organization, LLC.

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

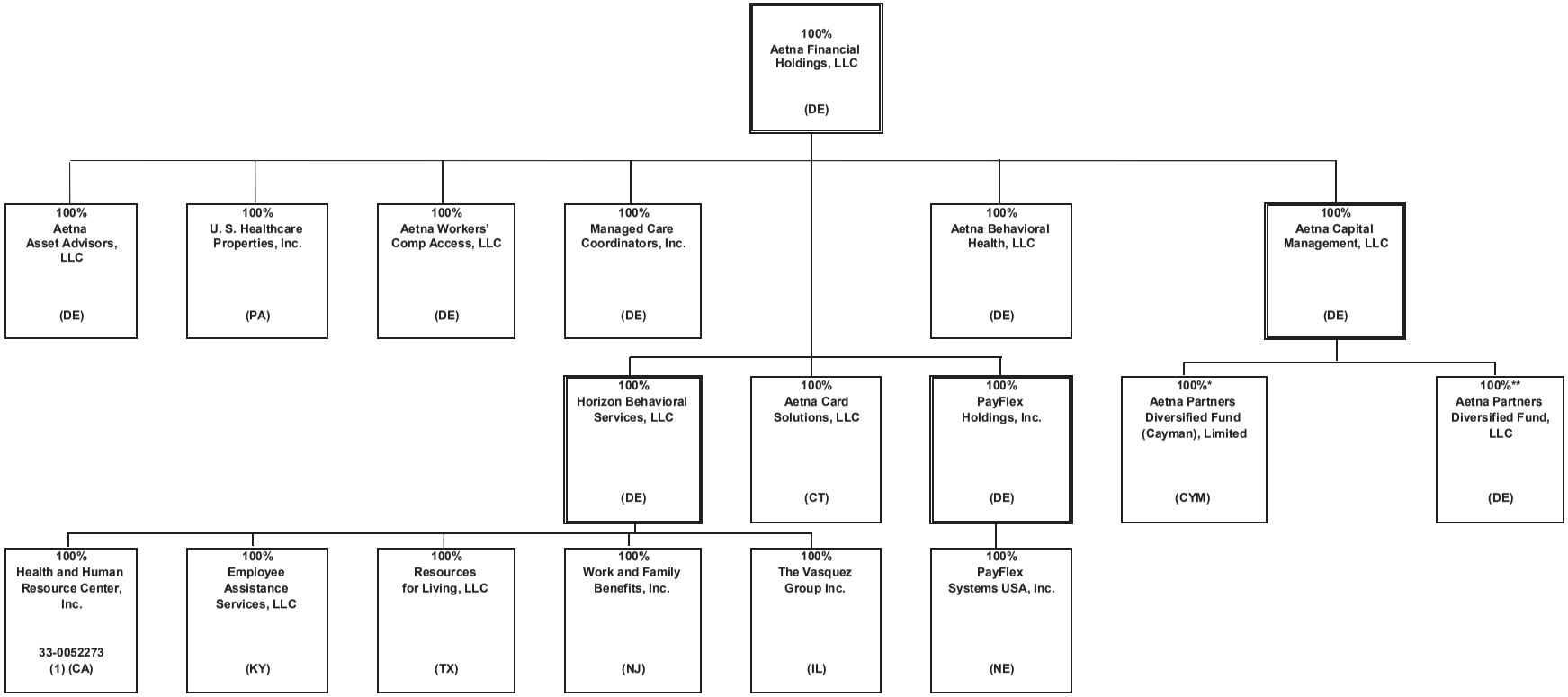

* Aetna Life Insurance Company owns the Class C participating shares of Aetna Partners Diversified Fund (Cayman), Limited.

** Aetna Life Insurance Company, Aetna Health and Life Insurance Company and Aetna Health Management , LLC own substantially all of the non-managing member interests of Aetna Partners Diversified Fund, LLC.

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

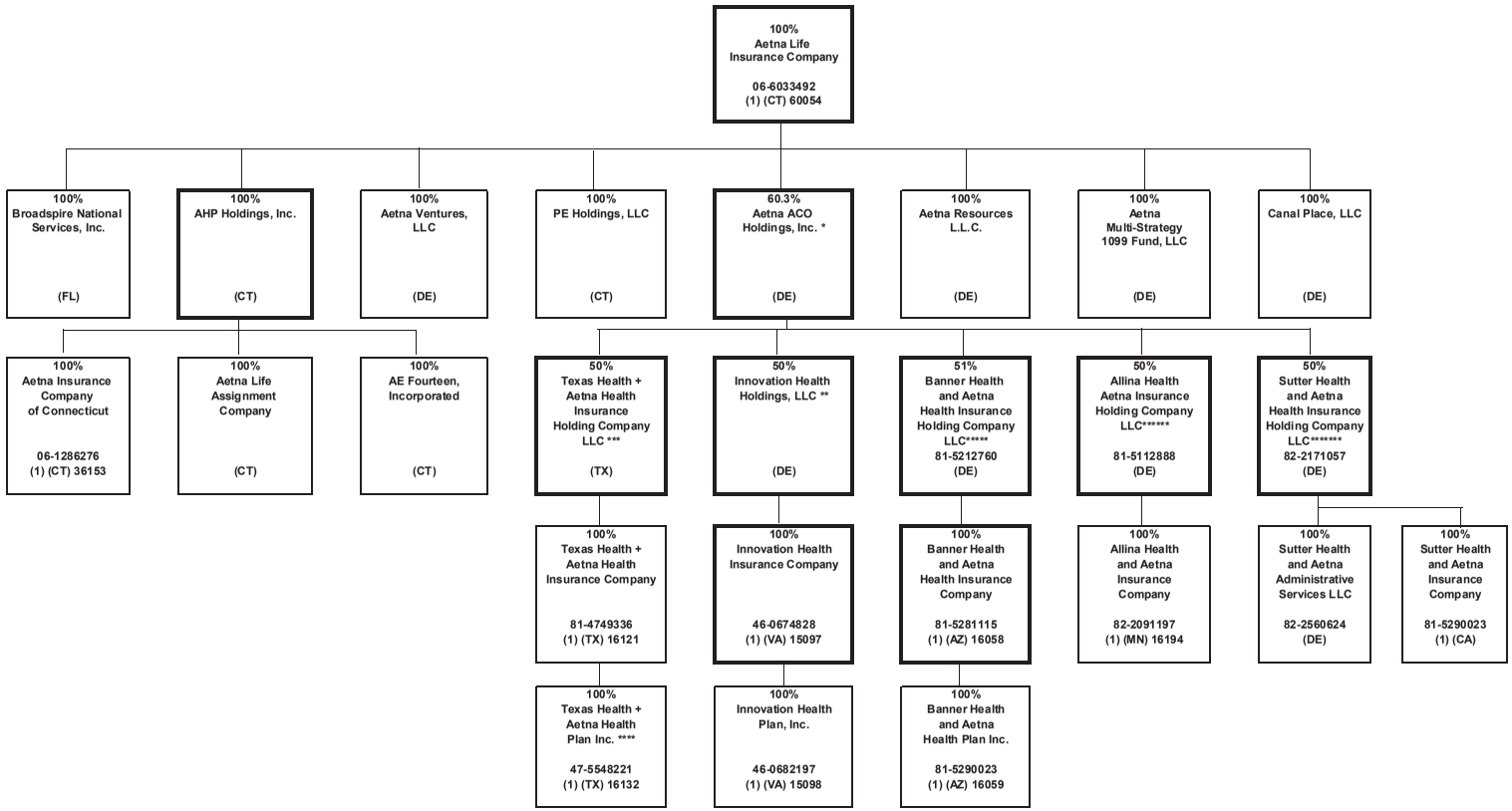

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STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

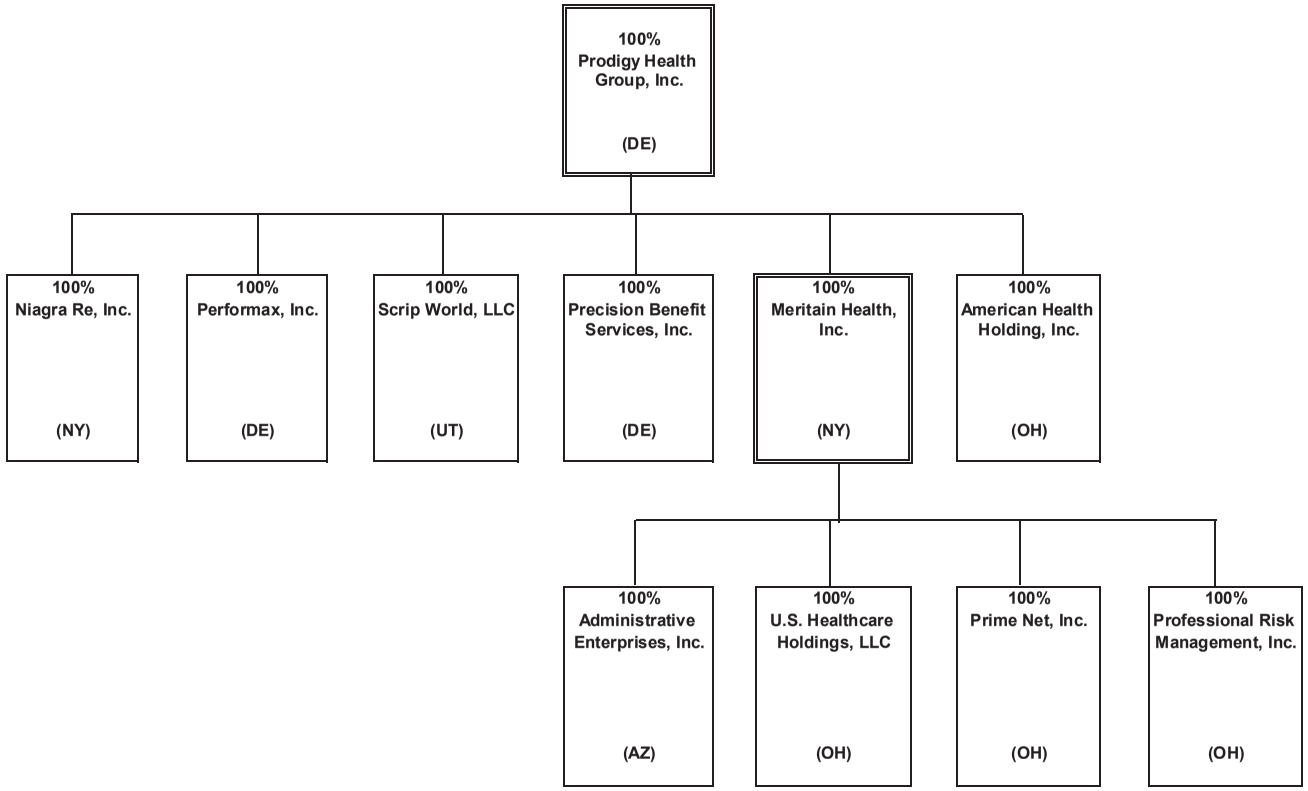

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000	23-2229683	3060706	0001122304	N	Aetna Inc.	PA	UIP	Aetna Inc.		0.000		N	0
0001	AETNA INC.	00000	30-0123754	0	0		Aetna Health Holdings, LLC	DE	UIP	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	95-3402799	0	0		Aetna Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95935	23-2442048	0	0		Aetna Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95088	59-2411584	0	0		Aetna Health Inc.	FL	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95094	58-1649568	0	0		Aetna Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95517	01-0504252	0	0		Aetna Health Inc.	ME	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95756	23-2861565	0	0		Aetna Health Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95287	52-1270921	0	0		Aetna Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95234	22-2663623	0	0		Aetna Health Inc.	NY	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	14408	45-2634734	0	0		Aetna Better Health Inc.	NY	IA	Aetna Health Inc. (NY)	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95490	76-0189680	0	0		Aetna Health Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95040	74-1844335	0	0		Aetna Better Health of Texas Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12328	20-2207534	0	0		Aetna Better Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1160812	0	0		Aetna Dental of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	11183	22-2990909	0	0		Aetna Dental Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95910	06-1177531	0	0		Aetna Dental Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	30-0123760	0	0		Aetna Rx Home Delivery, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	13-3670795	0	0		Aetna Health Management, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	22-3187443	0	0		Aetna Ireland Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	57-1209768	0	0		Aetna Specialty Pharmacy, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-1274723	0	0		Cofinity, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2671370	0	0		@Credentials Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Services (Thailand) Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	13735	27-0563973	0	0		Aetna Better Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	13174	26-2867560	0	0		Aetna Better Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-5178095	0	0		Aetna Better Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	14043	27-2512072	0	0		Aetna Better Health Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15805	47-3850677	0	0		Aetna Better Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15616	80-0629718	0	0		Aetna Better Health, Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	80-0671703	0	0		Aetna Florida Inc.	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	14229	25-2764938	0	0		Aetna Better Health Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15611	46-3203086	0	0		Aetna Better Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15919	81-1143850	0	0		Aetna Better Health of Oklahoma Inc.	OK	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	04-2708160	0	0		Aetna Student Health Agency Inc.	MA	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	73-1702453	0	0		Delaware Physicians Care, Incorporated	DE	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	01-0826783	0	0		Schaller Anderson Medical Administrators, Incorporated	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	86-0842559	0	0		Aetna Medicaid Adminstrators LLC	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-2944270	0	0		iTriage, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	16-1471176	0	0		Prodigy Health Group, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	0.200	Aetna Inc.	Y	4
0001	AETNA INC.	00000	45-5527797	0	0		Innovation Health Holdings, LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	7
0001	AETNA INC.	15097	46-0674828	0	0		Innovation Health Insurance Company	VA	IA	Innovation Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15098	46-0682197	0	0		Innovation Health Plan, Inc.	VA	IA	Innovation Health Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-3789357	0	0		Texas Health + Aetna Health Insurance Holding Company LLC	TX	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	10
0001	AETNA INC.	16121	81-4749336	0	0		Texas Health + Aetna Health Insurance Company	TX	IA	Texas Health + Aetna Health Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16132	47-5548221	0	0		Texas Health + Aetna Health Plan Inc.	TX	IA	Texas Health + Aetna Health Insurance Company	Ownership	100.000	Aetna Inc.	N	11
0001	AETNA INC.	95109	23-2169745	0	0		Aetna Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Inc. (PA)	Ownership	39.500	Aetna Inc.	Y	4
0001	AETNA INC.	00000	20-0438576	0	0		Niagara Re, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000	52-2200070	0	0		Performax, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	87-0632355	0	0		Scrip World, LLC	UT	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-1760756	0	0		Precision Benefit Services, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	31-1368946	0	0		American Health Holding, Inc.	OH	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	16-1264154	0	0		Meritain Health, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	86-0537707	0	0		Adminco, Inc.	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	86-0527428	0	0		Administrative Enterprises, Inc.	AZ	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	16-1684061	0	0		U.S. Healthcare Holdings, LLC	OH	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	34-1670299	0	0		Prime Net, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	34-1348032	0	0		Professional Risk Management, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	68500	62-1181209	0	0		Continental Life Insurance Company of Brentwood, Tennessee	TN	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12321	20-2901054	0	0		American Continental Insurance Company	TN	IA	Continental Life Insurance Company of Brentwood, Tennessee	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	60054	06-6033492	0	0		Aetna Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Life Insurance Company	Ownership	60.300	Aetna Inc.	Y	4
0001	AETNA INC.	00000	06-1270755	0	0		AHP Holdings, Inc.	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	36153	06-1286276	0	0		Aetna Insurance Company of Connecticut	CT	IA	AHP Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1028469	0	0		AE Fourteen, Incorporated	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1373153	0	0		Aetna Life Assignment Company	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-3678339	0	0		PE Holdings, LLC	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1423207	0	0		Aetna Resources L.L.C.	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Canal Place, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-3180700	0	0		Aetna Ventures, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	59-2108747	0	0		Broadspire National Services, Inc.	FL	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0001552250		Aetna Multi-Strategy 1099 Fund, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	79.250	Aetna Inc.	N	0
0001	AETNA INC.	00000	41-2035961	0	0		Aetna Financial Holdings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	26-2030792	0	0		Aetna Asset Advisors, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2354500	0	0		U.S. Healthcare Properties, Inc.	PA	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	38-3704481	0	0		Aetna Capital Management, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	11-3667142	0	0001314522		Aetna Partners Diversified Fund, LLC	DE	NIA	Aetna Capital Management, LLC	Ownership	100.000	Aetna Inc.	N	1
0001	AETNA INC.	00000		0	0001460020		Aetna Partners Diversified Fund (Cayman), Limited	CYM	NIA	Aetna Capital Management, LLC	Ownership	100.000	Aetna Inc.	N	2
0001	AETNA INC.	00000	20-0446676	0	0		Aetna Workers' Comp Access, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-0446713	0	0		Aetna Behavioral Health, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2670015	0	0		Managed Care Coordinators, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	59-3269144	0	0		Horizon Behavioral Services, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	61-1193498	0	0		Employee Assistance Services, LLC	KY	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	33-0052273	0	0		Health and Human Resource Center, Inc.	CA	IA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	75-2420973	0	0		Resources for Living, LLC	TX	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	36-3681261	0	0		The Vasquez Group Inc.	IL	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	22-3178125	0	0		Work and Family Benefits, Inc.	NJ	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-1773021	0	0		Aetna Card Solutions, LLC	CT	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-5216478	0	0		PayFlex Holdings, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	91-1774434	0	0		PayFlex Systems USA, Inc.	NE	NIA	PayFlex Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	78700	06-0876836	0	0		Aetna Health and Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	72052	23-2710210	0	0		Aetna Health Insurance Company	PA	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	84450	57-0805126	0	0		Aetna Health Insurance Company of New York	NY	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1571642	0	0		Aetna International Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	98-0211470	0	0		Aetna Life & Casualty (Bermuda) Ltd.	BMU	IA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Insurance (Singapore) PTE. LTD.	SGP	IA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Bermuda) Limited	BMU	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Goodhealth Worldwide (Global) Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Europe) Limited	GBR	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000		0	0		Goodhealth Worldwide (Asia) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits Limited	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		PT. Aetna Global Benefits Indonesia	IDN	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	80.000	Aetna Inc.	N	5
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Middle East) LLC	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	49.000	Aetna Inc.	N	6
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Asia Pacific) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Spinnaker Topco Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Spinnaker Bidco Limited	GBR	NIA	Spinnaker Topco Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Holdco (UK) Limited	GBR	NIA	Spinnaker Bidco Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		PT Asuransi Aetna Asia	IDN	NIA	Aetna International Inc.	Ownership	77.000	Aetna Inc.	N	15
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (UK) Limited	GBR	NIA	Aetna Holdco (UK) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Insurance Company Limited	GBR	IA	Aetna Holdco (UK) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Asia Pacific) Limited	Ownership	0.020	Aetna Inc.	N	3
0001	AETNA INC.	00000		0	0		Aetna Health Insurance Company of Europe DAC	IRL	IA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna (Shanghai) Enterprise Services Co. Ltd.	CHN	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna (Beijing) Enterprise Management Services Co., Ltd.	CHN	NIA	Aetna (Shanghai) Enterprise Services Co. Ltd.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Singapore) PTE. LTD.	SGP	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Singapore) PTE, LTD.	Ownership	99.980	Aetna Inc.	N	3
0001	AETNA INC.	00000	22-2578985	0	0		AUSHC Holdings, Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Holdings Limited	GBR	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Korea Ltd.	KOR	NIA	Aetna Global Holdings Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Canadian Insurance Company Ltd	HKG	NIA	Aetna Global Holdings Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Futrix Limited	NZL	NIA	Health Data & Management Solutions, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1182176	0	0		PHPSNE Parent Corporation	DE	NIA	AUSHC Holdings, Inc.	Ownership	55.000	Aetna Inc.	N	8
0001	AETNA INC.	00000	52-2182411	0	0		Active Health Management, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-0970432	0	0		Health Data & Management Solutions, Inc.	DE	NIA	Active Health Management, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2604867	0	0		Aetna Integrated Informatics, Inc.	PA	NIA	Active Health Management, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	13980	27-2192415	0	0		Health Re, Inc.	VT	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-0579372	0	0		Phoenix Data Solutions LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	46-2469464	0	0		Healthagen LLC	CT	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	51-0029326	0	0		ASI Wings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	33-0807547	0	0		Medicity LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Echo Merger Sub, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Corporate Services, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-0259978	0	0		Novo Innovations, LLC	DE	NIA	Medicity Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-1170966	0	0		Alliviant Corporation	DE	NIA	Medicity Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	81973	75-1296086	0	0		Coventry Health and Life Insurance Company	MO	UDP	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15761	47-3279217	0	0		Aetna Better Health of Kentucky Insurance Company	KY	RE	Coventry Health and Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	52-1801446	0	0		Group Dental Service, Inc.	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95846	52-2056201	0	0		Group Dental Service of Maryland, Inc.	MD	IA	Group Dental Service, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.		81-4345344	0	0		Aetna Network Services LLC	CT	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95241	42-1244752	0	0		Aetna Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95925	42-1308659	0	0		Coventry Health Care of Nebraska, Inc.	NE	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-2049117	0	0		Aetna Risk Assurance Company of Connecticut Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95173	74-2381406	0	0		Aetna Health Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	11102	23-2366731	0	0		HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

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0001	AETNA INC.	00000	47-0854096	0	0		Coventry Prescription Management Services, Inc.	NV	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16148	81-3564875	0	0		Aetna Better Health of Nevada Inc.	NV	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	96555	54-1576305	0	0		Coventry Health Care of Virginia, Inc.	VA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	01-0646056	0	0		Coventry Transplant Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	96377	43-1372307	0	0		Coventry Health Care of Missouri, Inc.	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95318	43-1702094	0	0		Aetna Better Health of Missouri LLC	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95408	55-0712129	0	0		Coventry Health Care of West Virginia, Inc.	WV	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	62-1411933	0	0		Coventry HealthCare Management Corporation	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15827	47-4352768	0	0		Aetna HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95489	48-0840330	0	0		Coventry Health Care of Kansas, Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16072	81-3370401	0	0		Aetna Better Health of Kansas Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12193	20-1052897	0	0		Aetna Better Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95407	87-0345631	0	0		Aetna Health of Utah Inc.	UT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-4416606	0	0		Aetna Better Health Inc.	TN	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	74160	37-1241037	0	0		Coventry Health Care of Illinois, Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-8070994	0	0		Coventry Health Care National Accounts, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-5185442	0	0		Coventry Health Care National Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	26-1293772	0	0		Coventry Consumer Advantage, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-8376354	0	0		Coventry Health Care Workers' Compensation, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-4096903	0	0		First Script Network Service, Inc.	NV	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1095987	0	0		MetraComp, Inc.	CT	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	74-2879984	0	0		Medical Examinations of New York, P.C.	NY	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	9
0001	AETNA INC.	00000	62-1266888	0	0		FOCUS Healthcare Management, Inc.	TN	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	87-0443226	0	0		Coventry Rehabilitation Services, Inc.	DE	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-1736437	0	0		First Health Group Corp.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	90328	38-2242132	0	0		First Health Life & Health Insurance Company	TX	IA	First Health Group Corp.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	52-1320522	0	0		Claims Administration Corp.	MD	NIA	First Health Group Corp.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-1130063	0	0		Florida Health Plan Administrators, LLC	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95114	65-0986441	0	0		Coventry Health Care of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95266	65-0453436	0	0		Coventry Health Plan of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	59-3750548	0	0		Carefree Insurance Services, Inc.	FL	NIA	Florida Health Plan Administrators, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	36-4391310	0	0		bswift LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Virtual Home Healthcare LLC	ARE	NIA	Aetna Global Holdings Limited	Ownership	49.000	Aetna Inc.	N	19
0001	AETNA INC.	00000	26-1582982	0	0		MHNet Specialty Services, LLC	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	37-1448790	0	0		Mental Health Network of New York IPA, Inc.	NY	NIA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12509	20-2516317	0	0		MHNet Life and Health Insurance Company	TX	IA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	72-1106596	0	0		Mental Health Associates, Inc.	LA	NIA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-4276336	0	0		MHNet of Florida, Inc.	FL	IA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16242	81-5030233	0	0		Aetna Better Health of Washington, Inc.	WA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-5212760	0	0		Banner Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	51.000	Aetna Inc.	N	12
0001	AETNA INC.	16058	81-5281115	0	0		Banner Health and Aetna Health Insurance Company	AZ	IA	Banner Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16059	81-5290023	0	0		Banner Health and Aetna Health Plan Inc.	AZ	IA	Banner Health and Aetna Health Insurance Company	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000	81-5112888	0	0		Allina Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	13
0001	AETNA INC.	16194	82-2091197	0	0		Allina Health and Aetna Insurance Company	MN	IA	Allina Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	82-2171057	0	0		Sutter Health and Aetna Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	14
0001	AETNA INC.	00000	82-2560624	0	0		Sutter Health and Aetna Administrative Services LLC	DE	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-5290023	0	0		Sutter Health and Aetna Insurance Company	CA	IA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Holdings (Thailand) Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	Aetna Inc.	N	16
0001	AETNA INC.	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	Aetna Inc.	N	17
0001	AETNA INC.	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Minor Health Entreprise Co, Ltd.	Ownership	46.000	Aetna Inc.	N	17
0001	AETNA INC.	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	28.000	Aetna Inc.	N	17
0001	AETNA INC.	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	Aetna Inc.	N	18
0001	AETNA INC.	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	75.000	Aetna Inc.	N	18
0001	AETNA INC.	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	51.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Bahamas) Limited	BHS	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Pharmacy Management Services LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	82-3333789	0	0		Aetna Better Health of North Carolina Inc.	NC	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd	CHN	NIA	Aetna International Inc.	Ownership	50.000	Aetna Inc.	N	20

Asterisk	Explanation
1	Aetna Life Insurance Company, Aetna Health and Life Insurance Company and Aetna Health Management, LLC own substantially all of the non-managing membership interests.
2	Aetna Life Insurance Company owns the Class C participating shares.
3	Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
4	Aetna ACO Holdings, Inc. is owned by Aetna Life Insurance Company (60.3%), Aetna Health Inc. (PA) (39.5%) and Aetna Health Holdings, LLC (0.2%).
5	Aetna Global Benefits (Bermuda) Limited owns 80% and 20% is owned by Suhatsyah Rivai, Aetna's Nominee.
6	Aetna Global Benefits (Bermuda) Limited owns 49% and 51% is owned by Euro Gulf LLC, Aetna's Nominee.
7	Aetna ACO Holdings Inc. owns 50% and 50% is owned by Innovation Health System Foundation, an unaffiliated company.
8	55% is owned by AUSHC Holdings, Inc. The remaining 45% is owned by thirteen different hospitals (non-affiliates) which are shareholders with varying degrees of ownership.
9	100% owned through Aetna's nominees.
10	Texas Health + Aetna Health Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% by Texas Health Resources, an unaffiliated company.
11	Texas Health + Aetna Health Plan Inc. became a direct subsidiary of Texas Health + Aetna Health Insurance Company February 2017.
12	Banner Health and Aetna Health Insurance Holding Company LLC is 51% owned by Aetna ACO Holdings Inc. and 49% owned by Banner Health.
13	Allina Health and Aetna Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Allina Health.
14	Sutter Health and Aetna Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Sutter Health Plan Products Organization, LLC.
15	PT Asuransi Aetna Asia is 77% owned by Aetna International Inc. and 23% owned by PT Asuransi Central Asia.
16	Aetna Holdings (Thailand) Limited is 49% owned by Aetna Global Holdings Limited and 51% owned by Mr. Paiboon Sutantivorakoon
17	Aetna Health Insurance (Thailand) Public Company Limited is 46% owned by Minor Health Entreprise Co, Ltd.; 25% owned by Aetna Global Holdings Limited; and 28% owned by Health Care Management Co. Ltd. (Bermuda) and total 1% owned by Aetna Global Benefits Limited (1 Share); Mr. Sansanapongpherchar (1 Share); Mr. Jitphasong Itsaraphakded (1 Share); Mrs. Suphee Wattana (1 Share); and Mr. Buncha Tamphragom (1 Share)
18	Minor Health Entreprise Co, Ltd has 1 share owned by Aetna Global Benefits (Bermuda) Ltd
19	Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

Asterisk	Explanation
20	Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Response
1. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?	NO

Explanation:

1. Business not written

Bar Code:

1. Medicare Part D Coverage Supplement [Document Identifier 365]

OVERFLOW PAGE FOR WRITE-INS

SCHEDULE A - VERIFICATION

Real Estate

NONE

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		
	2.2 Additional investment made after acquisition		
3.	Current year change in encumbrances		
4.	Total gain (loss) on disposals		
5.	Deduct amounts received on disposals		
6.	Total foreign exchange change in book/adjusted carrying value		
7.	Deduct current year's other than temporary impairment recognized		
8.	Deduct current year's depreciation		
9.	Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8)		
10.	Deduct total nonadmitted amounts		
11.	Statement value at end of current period (Line 9 minus Line 10)		

SCHEDULE B - VERIFICATION

Mortgage Loans

		1 Year to Date	2 Prior Year Ended December 31
1.	Book value/recorded investment excluding accrued interest, December 31 of prior year	12,979,171	
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		12,979,171
	2.2 Additional investment made after acquisition	221,144	0
3.	Capitalized deferred interest and other		0
4.	Accrual of discount		0
5.	Unrealized valuation increase (decrease)		0
6.	Total gain (loss) on disposals		
7.	Deduct amounts received on disposals	156,210	
8.	Deduct amortization of premium and mortgage interest points and commitment fees	(61,857)	0
9.	Total foreign exchange change in book value/recorded investment excluding accrued interest		0
10.	Deduct current year's other than temporary impairment recognized		0
11.	Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	13,105,963	12,979,171
12.	Total valuation allowance		
13.	Subtotal (Line 11 plus Line 12)	13,105,963	12,979,171
14.	Deduct total nonadmitted amounts		0
15.	Statement value at end of current period (Line 13 minus Line 14)	13,105,963	12,979,171

SCHEDULE BA - VERIFICATION

Other Long-Term Invested Assets

NONE

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		
	2.2 Additional investment made after acquisition		
3.	Capitalized deferred interest and other		
4.	Accrual of discount		
5.	Unrealized valuation increase (decrease)		
6.	Total gain (loss) on disposals		
7.	Deduct amounts received on disposals		
8.	Deduct amortization of premium and depreciation		
9.	Total foreign exchange change in book/adjusted carrying value		
10.	Deduct current year's other than temporary impairment recognized		
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)		
12.	Deduct total nonadmitted amounts		
13.	Statement value at end of current period (Line 11 minus Line 12)		

SCHEDULE D - VERIFICATION

Bonds and Stocks

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value of bonds and stocks, December 31 of prior year	479,236,865	528,045,638
2.	Cost of bonds and stocks acquired	103,134,574	82,646,084
3.	Accrual of discount	252,071	439,402
4.	Unrealized valuation increase (decrease)	(702,956)	237,476
5.	Total gain (loss) on disposals	(1,399,563)	1,054,133
6.	Deduct consideration for bonds and stocks disposed of	130,477,805	129,442,848
7.	Deduct amortization of premium	1,771,858	3,544,111
8.	Total foreign exchange change in book/adjusted carrying value		
9.	Deduct current year's other than temporary impairment recognized	870,742	198,909
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees	299,526	0
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)	447,700,112	479,236,865
12.	Deduct total nonadmitted amounts		
13.	Statement value at end of current period (Line 11 minus Line 12)	447,700,112	479,236,865

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1B

Showing the Acquisitions, Dispositions and Non-Trading Activity
During the Current Quarter for all Bonds and Preferred Stock by NAIC Designation

NAIC Designation	1 Book/Adjusted Carrying Value Beginning of Current Quarter	2 Acquisitions During Current Quarter	3 Dispositions During Current Quarter	4 Non-Trading Activity During Current Quarter	5 Book/Adjusted Carrying Value End of First Quarter	6 Book/Adjusted Carrying Value End of Second Quarter	7 Book/Adjusted Carrying Value End of Third Quarter	8 Book/Adjusted Carrying Value December 31 Prior Year
BONDS								
1. NAIC 1 (a)	334,154,272	665,291,189	627,684,619	(605,061)	334,154,272	371,155,781	0	350,941,062
2. NAIC 2 (a)	97,631,740	23,642,105	26,357,173	(338,692)	97,631,740	94,577,980	0	100,591,076
3. NAIC 3 (a)	40,310,749	2,000,000	2,654,412	476,157	40,310,749	40,132,494	0	36,468,359
4. NAIC 4 (a)	7,635,279	0	1,332,904	(770,893)	7,635,279	5,531,482	0	6,103,546
5. NAIC 5 (a)	0				0	0		
6. NAIC 6 (a)	0				0	0		
7. Total Bonds	479,732,040	690,933,294	658,029,108	(1,238,489)	479,732,040	511,397,737	0	494,104,043
PREFERRED STOCK								
8. NAIC 1	0				0	0		0
9. NAIC 2	0				0	0		0
10. NAIC 3	0				0	0		0
11. NAIC 4	0				0	0		0
12. NAIC 5	0				0	0		0
13. NAIC 6	0				0	0		0
14. Total Preferred Stock	0	0	0	0	0	0	0	0
15. Total Bonds and Preferred Stock	479,732,040	690,933,294	658,029,108	(1,238,489)	479,732,040	511,397,737	0	494,104,043

(a) Book/Adjusted Carrying Value column for the end of the current reporting period includes the following amount of short-term and cash equivalent bonds by NAIC designation:

NAIC 1 $ 63,697,625 ; NAIC 2 $ 0 ; NAIC 3 $ 0 NAIC 4 $ 0 ; NAIC 5 $ 0 ; NAIC 6 $ 0

SCHEDULE DA - PART 1

Short-Term Investments

NONE

	1 Book/Adjusted Carrying Value	2 Par Value	3 Actual Cost	4 Interest Collected Year-to-Date	5 Paid for Accrued Interest Year-to-Date
9199999 Totals		XXX			

SCHEDULE DA - VERIFICATION

Short-Term Investments

		1 Year To Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	0	2,475
2.	Cost of short-term investments acquired		824,131
3.	Accrual of discount		
4.	Unrealized valuation increase (decrease)		
5.	Total gain (loss) on disposals		
6.	Deduct consideration received on disposals		826,606
7.	Deduct amortization of premium		
8.	Total foreign exchange change in book/adjusted carrying value		
9.	Deduct current year's other than temporary impairment recognized		
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	0	0
11.	Deduct total nonadmitted amounts		
12.	Statement value at end of current period (Line 10 minus Line 11)	0	0

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

SCHEDULE E - PART 2 - VERIFICATION

(Cash Equivalents)

		1 Year To Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	14,867,395	1,005,891
2.	Cost of cash equivalents acquired	1,206,038,235	2,439,590,950
3.	Accrual of discount	473,931	575,019
4.	Unrealized valuation increase (decrease)		
5.	Total gain (loss) on disposals	(184)	(470)
6.	Deduct consideration received on disposals	1,157,680,941	2,426,303,995
7.	Deduct amortization of premium		
8.	Total foreign exchange change in book/adjusted carrying value		
9.	Deduct current year's other than temporary impairment recognized		
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	63,698,436	14,867,395
11.	Deduct total nonadmitted amounts		
12.	Statement value at end of current period (Line 10 minus Line 11)	63,698,436	14,867,395

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE B - PART 2

Showing All Mortgage Loans ACQUIRED AND ADDITIONS MADE During the Current Quarter

1	Location		4	5	6	7	8	9
	2	3						
Loan Number	City	State	Loan Type	Date Acquired	Rate of Interest	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Value of Land and Buildings
2004473	MT LAUREL	NJ		12/18/2017	5.280		221,144	13,100,000
0499999. Mortgages in good standing - Commercial mortgages-insured or guaranteed						0	221,144	13,100,000
0899999. Total Mortgages in good standing						0	221,144	13,100,000
1699999. Total - Restructured Mortgages						0	0	0
2499999. Total - Mortgages with overdue interest over 90 days						0	0	0
3299999. Total - Mortgages in the process of foreclosure						0	0	0
3399999 - Totals						0	221,144	13,100,000

SCHEDULE B - PART 3

Showing All Mortgage Loans DISPOSED, Transferred or Repaid During the Current Quarter

1	Location		4	5	6	7	Change in Book Value/Recorded Investment						14	15	16	17	18
	2	3					8	9	10	11	12	13					
Loan Number	City	State	Loan Type	Date Acquired	Disposal Date	Book Value/ Recorded Investment Excluding Accrued Interest Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Amortization) /Accretion	Current Year's Other Than Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Change in Book Value (8+9-10+11)	Total Foreign Exchange Change in Book Value	Book Value/ Recorded Investment Excluding Accrued Interest on Disposal	Consid-eration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal
2004182	GLEN BURNIE	MD		12/18/2017		6,120,406		(53)			(53)			78,667			0
2004473	MT LAUREL	NJ		12/18/2017		6,858,765		31,051			31,051						0
0299999. Mortgages with partial repayments						12,979,171	0	30,998	0	0	30,998	0	0	78,667	0	0	0
0599999 - Totals						12,979,171	0	30,998	0	0	30,998	0	0	78,667	0	0	0

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

N O N E

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

N O N E

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 3

Show All Long-Term Bonds and Stock Acquired During the Current Quarter

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends	10 NAIC Designation or Market Indicator (a)
912828-4J-6	US TREASURY NOTE/BOND 2.375% 04/30/20		05/18/2018	MIZUHO SECURITIES USA		4,983,594	5,000,000	6,776	1
912828-4N-7	US TREASURY NOTE/BOND 2.875% 05/15/28		06/29/2018	MIZUHO SECURITIES USA		5,017,969	5,000,000	18,750	1
0599999. Subtotal - Bonds - U.S. Governments						10,001,563	10,000,000	25,526	XXX
71654Q-CA-8	PETROLEOS MEXICANOS SR UNSECURED 6.375% 02/04/21	D	06/21/2018	HSBC SEC INC		521,750	500,000	12,484	2FE
91087B-AE-0	UNITED MEXICAN STATES SR UNSECURED 3.750% 01/11/28	D	05/03/2018	HSBC SEC INC		469,000	500,000	6,042	2FE
1099999. Subtotal - Bonds - All Other Governments						990,750	1,000,000	18,526	XXX
3132XY-UX-3	FED HOME LOAN MTGE CORP GOLD POOL NO Q55997 4.000% 05/01/48		05/08/2018	Baird (Robert W)		5,100,000	5,000,000	7,222	1
3199999. Subtotal - Bonds - U.S. Special Revenues						5,100,000	5,000,000	7,222	XXX
00206R-DB-5	AT&T CORP SR UNSECURED 3.800% 03/15/22		04/20/2018	BANC AMERICA		5,052,900	5,000,000	20,583	2FE
05565E-AU-9	BMW US CAPITAL LLC SR UNSECURED 3.100% 04/12/21		04/30/2018	WACHOVIA		1,495,635	1,500,000	2,583	1FE
05565E-AW-5	BMW US CAPITAL LLC SR UNSECURED 3.450% 04/12/23		06/07/2018	FIRST BOSTON CORP		1,491,885	1,500,000	8,481	1FE
07330N-AQ-8	BRANCH BANKING & TRUST SR UNSECURED 2.625% 01/15/22		04/26/2018	HSBC SEC INC		2,925,780	3,000,000	22,969	1FE
1248EP-BM-4	CCO HOLDINGS LLC CAP CORP SR UNSECURED 5.750% 02/15/26		04/03/2018	CHASE SECURITIES		2,000,000	2,000,000	15,972	3FE
161175-BB-9	CHARTER COMM OPT LLC/CAP 1ST LIEN 4.464% 07/23/22		04/25/2018	FIRST BOSTON CORP		1,525,605	1,500,000	17,484	2FE
166764-BG-4	CHEVRON CORP SR UNSECURED 2.100% 05/16/21		04/25/2018	TD Securities (USA)		1,949,620	2,000,000	18,783	1FE
172967-KY-6	CITIGROUP INC. SR UNSECURED 3.200% 10/21/26		05/16/2018	FIRST BOSTON CORP		925,730	1,000,000	2,400	2FE
20030N-BR-1	COMCAST CORP SR UNSECURED 2.750% 03/01/23		04/27/2018	DAIN RAUSCHER INC-69211		968,450	1,000,000	4,583	1FE
24422E-TL-3	DEERE JOHN CAP CORP SR UNSECURED 2.650% 01/06/22		05/03/2018	WACHOVIA		1,962,280	2,000,000	17,814	1FE
26441C-AJ-4	DUKE ENERGY CORP SR UNSECURED 3.050% 08/15/22		05/04/2018	Sumitomo Mitsui Financial Grp		1,968,580	2,000,000	14,064	2FE
30231G-AR-3	EXXON MOBIL CORP SR UNSECURED 2.726% 03/01/23		05/09/2018	MITSUBISHI		979,100	1,000,000	5,301	1FE
316770-BK-4	FIFTH THIRD BANCORP SR UNSECURED 2.200% 10/30/20		06/26/2018	MORGAN STANLEY		1,954,580	2,000,000	7,089	1FE
36159J-DL-2	G E CAP CREDIT CARD MASTER TR SERIES 2012-7 CLASS A 1.760% 09/15/22		06/07/2018	WACHOVIA		1,687,556	1,710,000	2,174	1FE
69353R-FC-7	PNC BANK NA SR UNSECURED 2.000% 05/19/20		05/15/2018	WACHOVIA		1,468,785	1,500,000	14,833	1FE
94988J-5N-3	WELLS FARGO BANK NA SR UNSECURED 2.600% 01/15/21		05/03/2018	WACHOVIA		1,476,465	1,500,000	11,267	1FE
95001N-AY-4	WELLS FARGO COMMERICAL MTGE TR SER 2018-C45 CLASS A4 4.184% 06/15/51		06/28/2018	WACHOVIA		2,574,800	2,500,000	4,649	1Z
01609W-AQ-5	ALIBABA GROUP HOLDING SR UNSECURED 3.600% 11/28/24	D	04/04/2018	MORGAN STANLEY		991,560	1,000,000	12,800	1FE
822582-AV-4	SHELL INTERNATIONAL FIN SR UNSECURED 2.250% 01/06/23	D	05/09/2018	WACHOVIA		3,817,960	4,000,000	31,250	1FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						37,217,271	37,710,000	235,079	XXX
8399997. Total - Bonds - Part 3						53,309,584	53,710,000	286,353	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX
8399999. Total - Bonds						53,309,584	53,710,000	286,353	XXX
8999997. Total - Preferred Stocks - Part 3						0	XXX	0	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	XXX
9799997. Total - Common Stocks - Part 3						0	XXX	0	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	XXX
9999999 - Totals						53,309,584	XXX	286,353	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues .....

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation or Market In-dicator (a)
	GOVT NATL MTGE ASSN I POOL NO GN733720																				
3620AM-DZ-2	4.500% 06/15/40		06/01/2018	Paydown		172,025	172,025	189,443	188,836	0	(16,811)	0	(16,811)	0	172,025	0	0	0	3,228	06/15/2040	1
912810-RZ-3	US TREASURY NOTE/BOND 2.750% 11/15/47		05/29/2018	MIZUHO SECURITIES USA		4,777,344	5,000,000	4,777,053	0	0	1,532	29,879	(28,347)	0	4,777,902	0	(559)	(559)	74,355	11/15/2047	1
912828-XA-3	US TREASURY NOTE/BOND 1.000% 05/15/18		05/15/2018	Maturity		3,000,000	3,000,000	2,997,624	2,996,092	0	4,925	1,017	3,908	0	3,000,000	0	0	0	15,000	05/15/2018	1
912828-XF-2	US TREASURY NOTE/BOND 1.125% 06/15/18		06/15/2018	Maturity		1,240,000	1,240,000	1,246,781	1,241,056	0	(1,056)	0	(1,056)	0	1,240,000	0	0	0	6,975	06/15/2018	1
0599999. Subtotal - Bonds - U.S. Governments						9,189,369	9,412,025	9,210,901	4,425,984	0	(11,410)	30,896	(42,306)	0	9,189,927	0	(559)	(559)	99,558	XXX	XXX
500630-CK-2	KOREA DEV BANK SR UNSECURED 1.375% 09/12/19	D	05/03/2018	DAIN RAUSCHER INC-69211		1,465,950	1,500,000	1,497,450	1,498,535	0	298	0	298	0	1,498,834	0	(32,884)	(32,884)	13,464	09/12/2019	1FE
716540-BZ-4	PETROLEOS MEXICANOS SR UNSECURED 5.500% 02/04/19	D	06/21/2018	MORGAN STANLEY		506,590	500,000	500,000	500,000	0	0	0	0	0	500,000	0	6,590	6,590	24,521	02/04/2019	2FE
91087B-AB-6	UNITED MEXICAN STATES SR UNSECURED 4.350% 01/15/47	D	05/03/2018	HSBC SEC INC		436,500	500,000	461,500	461,777	0	193	0	193	0	461,970	0	(25,470)	(25,470)	17,642	01/15/2047	2FE
V25125-BD-2	IVORY COAST SR UNSECURED 5.750% 12/31/32	D	06/30/2018	Redemption 100.0000		4,900	4,900	4,753	4,777	0	123	0	123	0	4,900	0	0	0	141	12/31/2032	4FE
1099999. Subtotal - Bonds - All Other Governments						2,413,940	2,504,900	2,463,703	2,465,089	0	614	0	614	0	2,465,704	0	(51,764)	(51,764)	55,768	XXX	XXX
25476F-WK-1	COLUMBIA DIST OF SER D 5.000% 06/01/42		04/05/2018	Citigroup		5,751,200	5,000,000	5,866,450	5,864,184	0	(22,011)	0	(22,011)	0	5,842,173	0	(90,973)	(90,973)	75,000	06/01/2042	1FE
574193-KK-3	MARYLAND STATE OF SER 2 C REF 5.000% 08/01/21		04/12/2018	BARCLAY INVESTMENTS		1,097,420	1,000,000	1,184,990	1,114,235	0	(9,054)	0	(9,054)	0	1,105,181	0	(7,761)	(7,761)	35,417	08/01/2021	1FE
1799999. Subtotal - Bonds - U.S. States, Territories and Possessions						6,848,620	6,000,000	7,051,440	6,978,419	0	(31,065)	0	(31,065)	0	6,947,354	0	(98,734)	(98,734)	110,417	XXX	XXX
988176-JJ-3	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 5.000% 08/01/28		04/11/2018	PIPER, JAFFRAY & HOPWOOD		259,744	215,000	267,215	267,174	0	(1,403)	0	(1,403)	0	265,771	0	(6,027)	(6,027)	3,135	08/01/2028	1FE
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						259,744	215,000	267,215	267,174	0	(1,403)	0	(1,403)	0	265,771	0	(6,027)	(6,027)	3,135	XXX	XXX
3132WJ-DV-0	FREDDIE MAC GOLD POOL POOL FG 044615 4.000% 10/01/46		05/08/2018	CITIGROUP		4,539,435	4,457,767	4,669,511	4,664,522	0	(2,056)	0	(2,056)	0	4,662,466	0	(123,031)	(123,031)	80,735	10/01/2046	1
3132WJ-DV-0	FREDDIE MAC GOLD POOL POOL FG 044615 4.000% 10/01/46		05/01/2018	Paydown		315,652	315,652	330,645	330,292	0	(14,640)	0	(14,640)	0	315,652	0	0	0	4,826	10/01/2046	1
3132XY-UX-3	FED HOME LOAN MTGE CORP GOLD POOL NO C55997 4.000% 05/01/48		06/01/2018	Paydown		24,589	24,589	25,081	0	0	(492)	0	(492)	0	24,589	0	0	0	82	05/01/2048	1
3138X8-XG-1	FED NATL MTGE ASSN POOL NO AU8778 3.000% 10/01/28		06/01/2018	Paydown		85,832	85,832	88,956	88,299	0	(2,468)	0	(2,468)	0	85,832	0	0	0	1,129	10/01/2028	1
57584X-8V-6	MASSACHUSETTS STATE DEV FIN REF-PARTNERS HEALTHCARE SYSTEM 4.000% 07/01/41		04/18/2018	PIPER, JAFFRAY & HOPWOOD		1,023,390	1,000,000	1,050,530	1,050,492	0	(1,329)	0	(1,329)	0	1,049,163	0	(25,773)	(25,773)	12,444	07/01/2041	1FE
64469N-AU-3	NEW HAMPSHIRE ST FEDERAL HIGHW REVENUE BONDS 5.000% 09/01/19		06/11/2018	Hilltop Securities		1,300,663	1,250,000	1,517,450	1,314,918	0	(17,347)	0	(17,347)	0	1,297,572	0	3,091	3,091	48,958	09/01/2019	1FE
67886M-MP-1	OKLAHOMA ST HSG FIN AGY SF MTG HOMEOWNERSHIP LN PG SER A 4.750% 03/01/28		04/01/2018	Call 100.0000		5,000	5,000	5,389	5,126	0	(11)	0	(11)	0	5,114	0	(114)	(114)	139	03/01/2028	1FE
915138-KL-4	UNIVERSITY OF TOLEDO OH REVENUE BONDS 5.000% 06/01/18		06/01/2018	Maturity		1,265,000	1,265,000	1,494,585	1,283,781	0	(18,781)	0	(18,781)	0	1,265,000	0	0	0	31,625	06/01/2018	1FE
3199999. Subtotal - Bonds - U.S. Special Revenues						8,559,561	8,403,840	9,182,147	8,737,430	0	(57,124)	0	(57,124)	0	8,705,388	0	(145,827)	(145,827)	179,938	XXX	XXX
00206R-CR-1	AT&T CORP SR UNSECURED 2.800% 02/17/21		04/20/2018	GOLDMAN SACHS & CO		4,939,150	5,000,000	5,112,950	5,074,848	0	(7,499)	0	(7,499)	0	5,067,350	0	(128,200)	(128,200)	96,056	02/17/2021	2FE
02665W-BF-7	AMERICAN HONDA FINANCE SR UNSECURED 1.650% 07/12/21		04/26/2018	WACHOVIA		1,908,620	2,000,000	1,999,340	1,999,524	0	31	0	31	0	1,999,555	0	(90,935)	(90,935)	26,400	07/12/2021	1FE
02665W-BG-5	AMERICAN HONDA FINANCE SR UNSECURED 1.700% 09/09/21		04/26/2018	WACHOVIA		2,382,925	2,500,000	2,495,000	2,496,248	0	328	0	328	0	2,496,575	0	(113,650)	(113,650)	27,271	09/09/2021	1FE
05531F-AV-5	BB&T CORPORATION SR UNSECURED 2.050% 05/10/21		04/26/2018	RBS US		2,898,810	3,000,000	2,996,880	2,997,837	0	227	0	227	0	2,998,064	0	(99,254)	(99,254)	29,042	05/10/2021	1FE
05565E-AK-1	BMW US CAPITAL LLC SR UNSECURED 1.450% 09/13/19		04/30/2018	RBS US		1,472,520	1,500,000	1,498,125	1,498,916	0	212	0	212	0	1,499,128	0	(26,608)	(26,608)	13,715	09/13/2019	1FE
05565E-AU-9	BMW US CAPITAL LLC SR UNSECURED 3.100% 04/12/21		06/07/2018	FIRST BOSTON CORP		1,494,420	1,500,000	1,495,635	0	0	130	0	130	0	1,495,765	0	(1,345)	(1,345)	7,621	04/12/2021	1FE
12593A-BA-2	COMM MORTGAGE TRUST SERIES 2015-CR23 CLASS A4 3.497% 05/10/48		06/28/2018	DEUTSCHE BANK		1,986,563	2,000,000	2,059,836	2,045,306	0	(2,915)	0	(2,915)	0	2,042,392	0	(55,829)	(55,829)	35,164	05/10/2048	1FM
126650-CE-8	CVS CAREMARK CORP SR UNSECURED 2.250% 08/12/19		05/07/2018	US BANCORP		991,870	1,000,000	999,440	999,801	0	36	0	36	0	999,837	0	(7,967)	(7,967)	16,688	08/12/2019	2FE
161175-AX-2	CHARTER COMM OPT LLC/CAP 1ST LIEN 3.579% 07/23/20		04/25/2018	FIRST BOSTON CORP		1,503,555	1,500,000	1,500,000	1,500,000	0	0	0	0	0	1,500,000	0	3,555	3,555	40,860	07/23/2020	2FE

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation or Market In-dicator (a)
166764-BH-2	CHEVRON CORP SR UNSECURED 1.561% 05/16/19		04/25/2018	WACHOVIA		1,980,480	2,000,000	2,000,000	2,000,000	0	0	0	0	0	2,000,000	0	(19,520)	(19,520)	13,962	05/16/2019	1FE
172967-JN-2	CITIGROUP INC. SR UNSECURED 1.700% 04/27/18		04/27/2018	Maturity		1,000,000	1,000,000	996,830	999,633	0	367	0	367	0	1,000,000	0	0	0	8,500	04/27/2018	2FE
17305E-FS-9	CITIBANK CREDIT CARD ISS TR SER 2014-A6 CLASS A6 2.150% 07/15/21		06/07/2018	CITIGROUP		1,490,449	1,500,000	1,513,887	1,505,497	0	(1,579)	0	(1,579)	0	1,503,918	0	(13,469)	(13,469)	29,204	07/15/2021	1FE
17325F-AL-2	CITIBANK NA SR UNSECURED 2.850% 02/12/21		05/16/2018	FIRST BOSTON CORP		985,860	1,000,000	999,940	0	0	(20)	0	(20)	0	999,920	0	(14,060)	(14,060)	7,363	02/12/2021	1FE
20030N-BR-1	COMCAST CORP SR UNSECURED 2.750% 03/01/23		06/11/2018	FIRST BOSTON CORP		478,470	500,000	484,225	0	0	349	0	349	0	484,574	0	(6,104)	(6,104)	3,896	03/01/2023	1FE
20030N-BV-2	COMCAST CORP SENIOR UNSECURED 1.625% 01/15/22		04/27/2018	GOLDMAN SACHS & CO		941,980	1,000,000	999,010	999,260	0	53	0	53	0	999,313	0	(57,333)	(57,333)	12,910	01/15/2022	1FE
24422E-TJ-8	DEERE JOHN CAP CORP SR UNSECURED 1.250% 10/09/19		05/03/2018	MITSUBISHI		1,958,420	2,000,000	1,995,960	1,997,652	0	462	0	462	0	1,998,114	0	(39,694)	(39,694)	14,444	10/09/2019	1FE
25470X-AJ-4	DISH DBS CORP SR UNSECURED 5.875% 07/15/22		05/18/2018	BARCLAY INVESTMENTS		472,500	500,000	477,500	482,372	0	1,285	0	1,285	0	483,657	0	(11,157)	(11,157)	25,050	07/15/2022	4FE
25470X-AL-9	DISH DBS CORP SR UNSECURED 5.000% 03/15/23		04/30/2018	GOLDMAN SACHS & CO		517,500	600,000	541,505	553,810	2,734	2,619	16,816	(11,463)	0	542,347	0	(24,847)	(24,847)	18,917	03/15/2023	4FE
256746-AB-4	DOLLAR TREE INC SR UNSECURED 5.750% 03/01/23		05/05/2018	Call 104.3130		1,043,130	1,000,000	1,061,318	1,043,462	0	(332)	0	(332)	0	1,043,130	0	(43,130)	(43,130)	82,102	03/01/2023	2FE
26441C-AR-6	DUKE ENERGY CORP SR UNSECURED 1.800% 09/01/21		05/04/2018	MITSUBISHI		1,902,760	2,000,000	1,999,800	1,999,842	0	12	0	12	0	1,999,854	0	(97,094)	(97,094)	24,700	09/01/2021	2FE
26817R-AM-0	DYNEGY INC SR UNSECURED 6.750% 11/01/19		05/01/2018	Call 101.6880		307,098	302,000	302,000	302,000	0	0	0	0	0	302,000	0	0	0	15,290	11/01/2019	4FE
30231G-AP-7	EXXON MOBIL CORP SR UNSECURED 1.708% 03/01/19		05/09/2018	GOLDMAN SACHS & CO		994,550	1,000,000	1,000,000	1,000,000	0	0	0	0	0	1,000,000	0	(5,450)	(5,450)	11,861	03/01/2019	1FE
316770-BG-3	FIFTH THIRD BANCORP SR UNSECURED 2.250% 06/14/21		06/26/2018	MORGAN STANLEY		1,945,880	2,000,000	1,998,500	1,998,935	0	147	0	147	0	1,999,082	0	(53,202)	(53,202)	24,250	06/14/2021	1FE
382550-BF-7	GOODYEAR TIRE & RUBBER SR UNSECURED 5.000% 05/31/26		04/24/2018	BANC AMERICA		967,500	1,000,000	1,020,000	1,019,105	0	(835)	0	(835)	0	1,018,270	0	(50,770)	(50,770)	20,278	05/31/2026	3FE
42824C-AU-3	HP ENTERPRISE SR UNSECURED 2.850% 10/05/18		06/29/2018	Call 100.1622		604,980	604,000	604,392	604,161	0	(129)	0	(129)	0	604,032	0	(32)	(32)	13,603	10/05/2018	2FE
65478H-AE-8	NISSAN AUTO RECEIVABLES OWNER SER 17-C CLASS A4 2.280% 02/15/24		05/03/2018	BARCLAY INVESTMENTS		3,181,953	3,250,000	3,249,985	3,249,983	0	2	0	2	0	3,249,985	0	(68,032)	(68,032)	29,228	02/15/2024	1FE
69353R-EV-6	PNC BANK NA SR UNSECURED 1.950% 03/04/19		05/15/2018	WACHOVIA		1,492,620	1,500,000	1,498,485	1,499,379	0	192	0	192	0	1,499,571	0	(6,951)	(6,951)	20,556	03/04/2019	1FE
845467-AH-2	SOUTHWESTERN ENERGY CO SR UNSECURED 4.100% 03/15/22		04/06/2018	FIRST BOSTON CORP		240,625	250,000	230,313	234,204	0	929	0	929	0	235,132	0	5,493	5,493	5,837	03/15/2022	3FE
911365-BH-6	UNITED RENTALS INC SR UNSECURED 4.625% 10/15/25		05/03/2018	FIRST BOSTON CORP		965,000	1,000,000	1,000,000	1,000,000	0	0	0	0	0	1,000,000	0	(35,000)	(35,000)	25,951	10/15/2025	3FE
912909-AK-4	US STEEL CORP 1ST LIEN 8.375% 07/01/21		04/12/2018	Call 107.5125		427,900	398,000	402,478	400,949	0	60	0	60	0	401,009	0	(3,009)	(3,009)	55,918	07/01/2021	3FE
822582-BM-3	SHELL INTERNATIONAL FIN SR UNSECURED 1.625% 11/10/18	D	05/09/2018	WACHOVIA		996,240	1,000,000	989,840	996,909	0	1,298	0	1,298	0	998,207	0	(1,967)	(1,967)	8,170	11/10/2018	1FE
822582-BR-2	SHELL INTERNATIONAL FIN SR UNSECURED 1.375% 05/10/19	D	05/09/2018	WACHOVIA		2,967,270	3,000,000	2,993,340	2,996,934	0	820	0	820	0	2,997,754	0	(30,484)	(30,484)	20,740	05/10/2019	1FE
82620K-AB-9	SIEMENS FINANCIERINGSMAT SR UNSECURED 1.450% 05/25/18	D	05/25/2018	Maturity		1,000,000	1,000,000	999,800	999,964	0	36	0	36	0	1,000,000	0	0	0	7,250	05/25/2018	1FE
82620K-AH-6	SIEMENS FINANCIERINGSMAT SR UNSECURED 1.300% 09/13/19	D	05/07/2018	WACHOVIA		1,958,940	2,000,000	1,997,420	1,998,512	0	307	0	307	0	1,998,819	0	(39,879)	(39,879)	17,044	09/13/2019	1FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						50,400,538	51,404,000	51,513,734	48,495,043	2,734	(3,407)	16,816	(17,489)	0	51,457,354	0	(1,135,924)	(1,135,924)	809,841	XXX	XXX
8399997. Total - Bonds - Part 4						77,671,772	77,939,765	79,689,140	71,369,139	2,734	(103,795)	47,712	(148,773)	0	79,031,498	0	(1,438,835)	(1,438,835)	1,258,657	XXX	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8399999. Total - Bonds						77,671,772	77,939,765	79,689,140	71,369,139	2,734	(103,795)	47,712	(148,773)	0	79,031,498	0	(1,438,835)	(1,438,835)	1,258,657	XXX	XXX
8999997. Total - Preferred Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799997. Total - Common Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation or Market In-dicator (a)
9899999. Total - Preferred and Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9999999 - Totals						77,671,772	XXX	79,689,140	71,369,139	2,734	(103,795)	47,712	(148,773)	0	79,031,498	0	(1,438,835)	(1,438,835)	1,258,657	XXX	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues.....

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

SCHEDULE E - PART 1 - CASH

Month End Depository Balances

1	2	3	4	5	Book Balance at End of Each Month During Current Quarter			9
					6	7	8	
Depository	Code	Rate of Interest	Amount of Interest Received During Current Quarter	Amount of Interest Accrued at Current Statement Date	First Month	Second Month	Third Month	*
Bank of America Charlotte, NC					(257,373)	7,248,723	5,524,964	XXX
0199998. Deposits in 2 depositories that do not exceed the allowable limit in any one depository (See instructions) - Open Depositories	XXX	XXX			(157,589)	(6,643)	(63,228)	XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	(414,962)	7,242,080	5,461,736	XXX
0299998. Deposits in depositories that do not exceed the allowable limit in any one depository (See instructions) - Suspended Depositories	XXX	XXX						XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	(414,962)	7,242,080	5,461,736	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX				XXX
0599999. Total - Cash	XXX	XXX	0	0	(414,962)	7,242,080	5,461,736	XXX

STATEMENT AS OF JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned End of Current Quarter

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
0599999. Total - U.S. Government Bonds						0	0	0
1099999. Total - All Other Government Bonds						0	0	0
1799999. Total - U.S. States, Territories and Possessions Bonds						0	0	0
2499999. Total - U.S. Political Subdivisions Bonds						0	0	0
3199999. Total - U.S. Special Revenues Bonds						0	0	0
	CELGENE CORP CP 4(2) 144A		06/26/2018	2.350	07/17/2018	7,447,211	0	2,431
	CONAGRA FOODS INC CP 4(2) 144A		06/26/2018	2.350	07/26/2018	9,983,675	0	3,259
	EASTMAN CHEMICAL CORP. CP 4-2		06/26/2018	2.330	07/25/2018	8,733,409	0	2,826
	EMERSON ELECTRIC CP 4(2) 144A		06/26/2018	1.950	07/17/2018	1,497,701	0	406
	INTERPUBLIC GROUP COS CP 4(2) 144A		06/26/2018	2.340	07/09/2018	6,915,401	0	2,248
	KANSAS CITY POWER & LIGHT CP 4(2) 144A		06/29/2018	2.270	07/03/2018	594,925	0	75
	MCKESSON CORP CP 4(2) 144A		06/26/2018	2.350	07/23/2018	9,985,634	0	3,259
	OGE ENERGY CORPORATION CP 4(2) 144A		06/26/2018	2.270	07/02/2018	6,007,621	0	1,894
	ORANGE & ROCKLAND UTIL CP 4(2) 144A		06/19/2018	2.300	07/03/2018	2,537,675	0	1,946
	WISCONSIN ENERGY CORP		06/26/2018	2.250	07/10/2018	9,994,373	0	3,123
3299999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations						63,697,625	0	21,467
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						63,697,625	0	21,467
4899999. Total - Hybrid Securities						0	0	0
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0
6099999. Subtotal - SVO Identified Funds						0	0	0
7799999. Total - Issuer Obligations						63,697,625	0	21,467
7899999. Total - Residential Mortgage-Backed Securities						0	0	0
7999999. Total - Commercial Mortgage-Backed Securities						0	0	0
8099999. Total - Other Loan-Backed and Structured Securities						0	0	0
8199999. Total - SVO Identified Funds						0	0	0
8399999. Total Bonds						63,697,625	0	21,467
60934N-50-0	FEDERATED INVESTORS INC TREASURY OBLIGATION FUND		06/29/2018	0.000	XXX	811	3	56
8599999. Subtotal - Exempt Money Market Mutual Funds - as Identified by the SVO						811	3	56
8899999 - Total Cash Equivalents						63,698,436	3	21,523

SUPPLEMENT FOR THE QUARTER ENDING JUNE 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

MEDICARE PART D COVERAGE SUPPLEMENT

(Net of Reinsurance)

NAIC Group Code 0001 NAIC Company Code 15761

	Individual Coverage		Group Coverage		5
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	Total Cash
1. Premiums Collected		XXX		XXX	
2. Earned Premiums		XXX		XXX	XXX
3. Claims Paid		XXX		XXX	
4. Claims Incurred		XXX		XXX	XXX
5. Reinsurance Coverage and Low Income Cost Sharing - Claims Paid Net of Reimbursements Applied (a)	XXX		XXX		
6. Aggregate Policy Reserves - Change		XXX		XXX	XXX
7. Expenses Paid		XXX		XXX	
8. Expenses Incurred		XXX		XXX	XXX
9. Underwriting Gain or Loss		XXX		XXX	XXX
10. Cash Flow Result	XXX	XXX	XXX	XXX	

NONE

(a) Uninsured Receivable/Payable with CMS at End of Quarter: $ ..... due from CMS or $ ..... due to CMS

Aetna Better Health® of Kentucky Q2 2018 Statement

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QUARTERLY STATEMENT

AS OF MARCH 31, 2018
OF THE CONDITION AND AFFAIRS OF THE

Aetna Better Health of Kentucky Insurance Company

NAIC Group Code 0001 (Current) 0001 (Prior) NAIC Company Code 15761 Employer's ID Number 47-3279217

Organized under the Laws of Kentucky, State of Domicile or Port of Entry KY

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health

Is HMO Federally Qualified? Yes [ ] No [ ]

Incorporated/Organized 02/24/2015 Commenced Business 02/01/2016

Statutory Home Office 9900 Corporate Campus Dr., Suite 1000 (Street and Number), Louisville , KY, US 40202 (City or Town, State, Country and Zip Code)

Main Administrative Office 9900 Corporate Campus Dr., Suite 1000 (Street and Number)
Louisville , KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Mail Address 9900 Corporate Campus Dr., Suite 1000 (Street and Number or P.O. Box), Louisville , KY, US 40202 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 9900 Corporate Campus Dr., Suite 1000 (Street and Number)
Louisville , KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Internet Website Address www.aetna.com

Statutory Statement Contact Scott David Miller (Name), 717-671-2474 (Area Code) (Telephone Number)
sdmiller@aetna.com (E-mail Address), 717-526-2888 (FAX Number)

OFFICERS

Chief Executive Officer and President Laurie Ann Brubaker
Vice President and Secretary Robert Mark Kessler
Corporate Controller Scott David Miller

OTHER

Debra Jean Bacon, Vice President and Assistant Treasurer
Frank Ferris Chronister III, Assistant Controller
Kevin James Casey, Senior Investment Officer
John Patrick Maroney, Vice President and Treasurer

DIRECTORS OR TRUSTEES

Laurie Ann Brubaker
Debra Jean Bacon
Jonathan Edward Copley

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Laurie Ann Brubaker Chief Executive Officer and President	Robert Mark Kessler Vice President and Secretary	Scott David Miller Corporate Controller
State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa	State of..... Pennsylvania County of..... Dauphin
Subscribed and sworn to before me this 8th day of May, 2018	Subscribed and sworn to before me this 7th day of May, 2018	Subscribed and sworn to before me this 10th day of May, 2018
NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)

JANEEN NEWHOUSE
Notary Public, State of Arizona
Maricopa County
My Commission Expires
February 08, 2019

JANEEN NEWHOUSE
Notary Public, State of Arizona
Maricopa County
My Commission Expires
February 08, 2019

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
KIM E. ROTH, Notary Public
Whitpain Township, Montgomery County
My Commission Expires April 25, 2021

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number .....
2. Date filed .....
3. Number of pages attached.....

ASSETS

	Current Statement Date 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 December 31 Prior Year Net Admitted Assets
1. Bonds	474,903,711	0	474,903,711	479,236,865
2. Stocks:				
2.1 Preferred stocks			0	0
2.2 Common stocks			0	0
3. Mortgage loans on real estate:				
3.1 First liens	12,932,487	0	12,932,487	12,979,171
3.2 Other than first liens			0	
4. Real estate:				
4.1 Properties occupied by the company (less $ ..... encumbrances)			0	
4.2 Properties held for the production of income (less $ ..... encumbrances)			0	
4.3 Properties held for sale (less $ ..... encumbrances)			0	
5. Cash ($ 5,524,040), cash equivalents ($ 4,828,964) and short-term investments ($ .....)	10,353,004		10,353,004	14,204,888
6. Contract loans (including $ ..... premium notes)			0	
7. Derivatives		0	0	0
8. Other invested assets			0	0
9. Receivables for securities	16,749,063	0	16,749,063	524,756
10. Securities lending reinvested collateral assets		0	0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	514,938,265	0	514,938,265	506,945,680
13. Title plants less $ ..... charged off (for Title insurers only)			0	
14. Investment income due and accrued	4,218,043	0	4,218,043	4,135,426
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	1,915,470	0	1,915,470	1,847,707
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)			0	
15.3 Accrued retrospective premiums ($ .....) and contracts subject to redetermination ($ 0)			0	
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers			0	
16.2 Funds held by or deposited with reinsured companies			0	
16.3 Other amounts receivable under reinsurance contracts			0	
17. Amounts receivable relating to uninsured plans			0	
18.1 Current federal and foreign income tax recoverable and interest thereon			0	
18.2 Net deferred tax asset	9,978,560	141,699	9,836,861	9,836,861
19. Guaranty funds receivable or on deposit			0	
20. Electronic data processing equipment and software			0	
21. Furniture and equipment, including health care delivery assets ($ .....)			0	
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	
23. Receivables from parent, subsidiaries and affiliates	1,918	127	1,791	2,265,089
24. Health care ($ 1,861,812) and other amounts receivable	34,212,253	32,350,441	1,861,812	1,758,384
25. Aggregate write-ins for other than invested assets	500,000	500,000	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	565,764,509	32,992,267	532,772,242	526,789,148
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	
28. Total (Lines 26 and 27)	565,764,509	32,992,267	532,772,242	526,789,148
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Deposits	500,000	500,000	0	0
2502.				
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	500,000	500,000	0	0

LIABILITIES, CAPITAL AND SURPLUS

		Current Period			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ ..... reinsurance ceded)	150,286,864	4,391,699	154,678,563	159,039,981
2.	Accrued medical incentive pool and bonus amounts	1,726,185		1,726,185	190,629
3.	Unpaid claims adjustment expenses	2,530,802		2,530,802	3,072,860
4.	Aggregate health policy reserves, including the liability of $ .....0 for medical loss ratio rebate per the Public Health Service Act			0	0
5.	Aggregate life policy reserves			0	
6.	Property/casualty unearned premium reserve			0	
7.	Aggregate health claim reserves			0	0
8.	Premiums received in advance	24,016,046		24,016,046	31,811,757
9.	General expenses due or accrued	26,091,728		26,091,728	12,641,664
10.1	Current federal and foreign income tax payable and interest thereon (including $ ..... on realized gains (losses))	13,949,841		13,949,841	8,105,131
10.2	Net deferred tax liability			0	
11.	Ceded reinsurance premiums payable			0	
12.	Amounts withheld or retained for the account of others			0	
13.	Remittances and items not allocated	1,971,061		1,971,061	2,849,167
14.	Borrowed money (including $ ..... current) and interest thereon $ ..... (including $ ..... current)			0	
15.	Amounts due to parent, subsidiaries and affiliates	47,350,217		47,350,217	45,303,713
16.	Derivatives			0	
17.	Payable for securities			0	
18.	Payable for securities lending			0	
19.	Funds held under reinsurance treaties (with $ ..... authorized reinsurers, $ ..... unauthorized reinsurers and $ ..... certified reinsurers)			0	
20.	Reinsurance in unauthorized and certified ($ .....) companies			0	
21.	Net adjustments in assets and liabilities due to foreign exchange rates			0	
22.	Liability for amounts held under uninsured plans			0	
23.	Aggregate write-ins for other liabilities (including $ ..... current)	1,874,546	0	1,874,546	1,851,899
24.	Total liabilities (Lines 1 to 23)	269,797,290	4,391,699	274,188,989	264,866,801
25.	Aggregate write-ins for special surplus funds	XXX	XXX	0	22,555,000
26.	Common capital stock	XXX	XXX	1,000,000	1,000,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	99,010,001	99,010,001
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31.	Unassigned funds (surplus)	XXX	XXX	158,573,252	139,357,346
32.	Less treasury stock, at cost:				
	32.1 ..... shares common (value included in Line 26 $ .....)	XXX	XXX		
	32.2 ..... shares preferred (value included in Line 27 $ .....)	XXX	XXX		
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	258,583,253	261,922,347
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	532,772,242	526,789,148
	DETAILS OF WRITE-INS				
2301.	Escheat Payable	1,874,546	0	1,874,546	1,851,899
2302.					
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399.	Totals (Lines 2301 through 2303 plus 2398)(Line 23 above)	1,874,546	0	1,874,546	1,851,899
2501.	Estimated Health Insurance Fee accrual	XXX	XXX	0	22,555,000
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	XXX	XXX	0	22,555,000
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099.	Totals (Lines 3001 through 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year To Date		Prior Year To Date	Prior Year Ended December 31
		1 Uncovered	2 Total	3 Total	4 Total
1.	Member Months	XXX	711,595	767,169	3,018,365
2.	Net premium income (including $ non-health premium income)	XXX	282,764,186	256,841,377	1,092,625,603
3.	Change in unearned premium reserves and reserve for rate credits	XXX		23,486,693	31,898,076
4.	Fee-for-service (net of $ medical expenses)	XXX			0
5.	Risk revenue	XXX			0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0	0
8.	Total revenues (Lines 2 to 7)	XXX	282,764,186	280,328,070	1,124,523,679
	Hospital and Medical:				
9.	Hospital/medical benefits	3,934,538	138,577,046	157,047,324	609,008,492
10.	Other professional services	327,317	11,528,328	12,084,528	49,453,749
11.	Outside referrals				0
12.	Emergency room and out-of-area	553,077	19,479,742	19,552,768	89,732,481
13.	Prescription drugs		57,475,820	58,640,030	220,118,361
14.	Aggregate write-ins for other hospital and medical	0	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts		1,535,556		(7,740,581)
16.	Subtotal (Lines 9 to 15)	4,814,932	228,596,492	247,324,650	960,572,502
	Less:				
17.	Net reinsurance recoveries				0
18.	Total hospital and medical (Lines 16 minus 17)	4,814,932	228,596,492	247,324,650	960,572,502
19.	Non-health claims (net)				
20.	Claims adjustment expenses, including $ 6,596,025 cost containment expenses		7,113,229	6,632,639	28,389,145
21.	General administrative expenses		39,851,106	18,088,717	69,029,357
22.	Increase in reserves for life and accident and health contracts (including $ increase in reserves for life only)				0
23.	Total underwriting deductions (Lines 18 through 22)	4,814,932	275,560,827	272,046,006	1,057,991,004
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	7,203,359	8,282,064	66,532,675
25.	Net investment income earned		4,166,572	3,841,351	14,019,102
26.	Net realized capital gains (losses) less capital gains tax of $ 56,209		(398,285)	(88,803)	637,847
27.	Net investment gains (losses) (Lines 25 plus 26)	0	3,768,287	3,752,548	14,656,949
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $) (amount charged off $)]				
29.	Aggregate write-ins for other income or expenses	0	(1,104,225)	0	(4,535,812)
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	9,867,421	12,034,612	76,653,812
31.	Federal and foreign income taxes incurred	XXX	5,788,501	2,866,038	20,912,254
32.	Net income (loss) (Lines 30 minus 31)	XXX	4,078,920	9,168,574	55,741,558
	DETAILS OF WRITE-INS				
0601.		XXX			
0602.		XXX			
0603.		XXX			
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)	XXX	0	0	0
0701.		XXX			
0702.		XXX			
0703.		XXX			
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798)(Line 7 above)	XXX	0	0	0
1401.					
1402.					
1403					
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498)(Line 14 above)	0	0	0	0
2901.	Regulatory penalties	0	(1,104,225)	0	(4,535,812)
2902.					
2903					
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998)(Line 29 above)	0	(1,104,225)	0	(4,535,812)

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year to Date	2 Prior Year to Date	3 Prior Year Ended December 31
	CAPITAL AND SURPLUS ACCOUNT			
33.	Capital and surplus prior reporting year	261,922,348	213,442,922	213,442,922
34.	Net income or (loss) from Line 32	4,078,920	9,168,574	55,741,558
35.	Change in valuation basis of aggregate policy and claim reserves			
36.	Change in net unrealized capital gains (losses) less capital gains tax of $ (90,782)	(341,515)	63,946	148,249
37.	Change in net unrealized foreign exchange capital gain or (loss)			
38.	Change in net deferred income tax	(90,782)	944,090	(7,178,803)
39.	Change in nonadmitted assets	(6,985,718)	(3,018,303)	(231,579)
40	Change in unauthorized and certified reinsurance	0	0	0
41.	Change in treasury stock	0	0	0
42.	Change in surplus notes	0	0	0
43.	Cumulative effect of changes in accounting principles			
44.	Capital Changes:			
	44.1 Paid in	0	990,000	990,000
	44.2 Transferred from surplus (Stock Dividend)	0		
	44.3 Transferred to surplus			
45.	Surplus adjustments:			
	45.1 Paid in	0	(990,000)	(990,000)
	45.2 Transferred to capital (Stock Dividend)			
	45.3 Transferred from capital			
46.	Dividends to stockholders			
47.	Aggregate write-ins for gains or (losses) in surplus	0	0	0
48.	Net change in capital & surplus (Lines 34 to 47)	(3,339,095)	7,158,307	48,479,426
49.	Capital and surplus end of reporting period (Line 33 plus 48)	258,583,253	220,601,229	261,922,348
	DETAILS OF WRITE-INS			
4701.				
4702.				
4703.				
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798)(Line 47 above)	0	0	0

CASH FLOW

		1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
	Cash from Operations			
1.	Premiums collected net of reinsurance	274,900,712	256,884,536	1,125,954,663
2.	Net investment income	4,851,307	4,947,249	17,511,807
3.	Miscellaneous income	0	0	0
4.	Total (Lines 1 to 3)	279,752,019	261,831,785	1,143,466,470
5.	Benefit and loss related payments	238,545,919	266,979,235	1,002,057,647
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts			
7.	Commissions, expenses paid and aggregate write-ins for deductions	35,160,554	29,474,878	103,782,491
8.	Dividends paid to policyholders			
9.	Federal and foreign income taxes paid (recovered) net of $ ..... tax on capital gains (losses)	0	0	27,025,769
10.	Total (Lines 5 through 9)	273,706,473	296,454,113	1,132,865,907
11.	Net cash from operations (Line 4 minus Line 10)	6,045,546	(34,622,328)	10,600,563
	Cash from Investments			
12.	Proceeds from investments sold, matured or repaid:			
	12.1 Bonds	51,532,949	32,958,065	116,787,533
	12.2 Stocks	0	0	0
	12.3 Mortgage loans	77,543	0	0
	12.4 Real estate	0	0	0
	12.5 Other invested assets	0	0	0
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	(58)	(2)	(470)
	12.7 Miscellaneous proceeds	34,419	545,958	0
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	51,644,853	33,504,021	116,787,063
13.	Cost of investments acquired (long-term only):			
	13.1 Bonds	48,772,320	6,688,942	69,990,769
	13.2 Stocks	0	0	0
	13.3 Mortgage loans	0	0	12,979,171
	13.4 Real estate	0	0	0
	13.5 Other invested assets	0	0	0
	13.6 Miscellaneous applications	16,224,307	70,358	494,470
	13.7 Total investments acquired (Lines 13.1 to 13.6)	64,996,627	6,759,300	83,464,410
14.	Net increase (or decrease) in contract loans and premium notes	0	0	0
15.	Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	(13,351,774)	26,744,721	33,322,653
	Cash from Financing and Miscellaneous Sources			
16.	Cash provided (applied):			
	16.1 Surplus notes, capital notes	0	0	0
	16.2 Capital and paid in surplus, less treasury stock	0	0	0
	16.3 Borrowed funds	0	0	0
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	0		0
	16.5 Dividends to stockholders	0	0	0
	16.6 Other cash provided (applied)	3,454,343	20,744,996	(34,496,987)
17.	Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	3,454,343	20,744,996	(34,496,987)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS			
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	(3,851,885)	12,867,389	9,426,229
19.	Cash, cash equivalents and short-term investments:			
	19.1 Beginning of year	14,204,889	4,778,660	4,778,660
	19.2 End of period (Line 18 plus Line 19.1)	10,353,004	17,646,048	14,204,889

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001. Non-Cash Transaction- Tax Free Acquisition	1,052,670	6,836,064	12,655,315

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
	Total	2 Individual	3 Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	243,019	20,142	0	0	0	0	0	0	222,877	0
2. First Quarter	236,325	19,852	0	0	0	0	0	0	216,473	
3. Second Quarter	0									
4. Third Quarter	0									
5. Current Year	0									
6. Current Year Member Months	711,595	59,632							651,963	
Total Member Ambulatory Encounters for Period:										
7 Physician	431,805	29,788							402,017	
8. Non-Physician	235,283	10,099							225,184	
9. Total	667,088	39,887	0	0	0	0	0	0	627,201	0
10. Hospital Patient Days Incurred	18,846	226							18,620	
11. Number of Inpatient Admissions	4,098	54							4,044	
12. Health Premiums Written (a)	282,764,186	9,234,402							273,529,784	
13. Life Premiums Direct	0	0							0	
14. Property/Casualty Premiums Written	0	0							0	
15. Health Premiums Earned	282,764,186	9,234,402							273,529,784	
16. Property/Casualty Premiums Earned	0	0							0	
17. Amount Paid for Provision of Health Care Services	246,224,957	8,275,574							237,949,383	
18. Amount Incurred for Provision of Health Care Services	228,596,491	8,459,023							220,137,468	

(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Claims Unpaid (Reported)						
0299999 Aggregate accounts not individually listed-uncovered	415,203	6,651	432	155	14,909	437,350
0399999 Aggregate accounts not individually listed-covered	11,961,118	626,889	7,100	28,550	2,342,734	14,966,391
0499999 Subtotals	12,376,321	633,540	7,532	28,705	2,357,643	15,403,741
0599999 Unreported claims and other claim reserves						139,274,822
0699999 Total amounts withheld						0
0799999 Total claims unpaid						154,678,563
0899999 Accrued medical incentive pool and bonus amounts						1,726,185

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid Year to Date		Liability End of Current Quarter		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid Dec. 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)	1,974,181	6,250,159	1,762,922	3,680,413	3,737,103	5,259,881
2. Medicare Supplement	0	0	0	0	0	0
3. Dental Only	0	0	0	0	0	0
4. Vision Only	0	0	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0	0	0
6. Title XVIII - Medicare	0	0	0	0	0	0
7 Title XIX - Medicaid	78,098,921	159,901,693	55,021,927	94,213,300	133,120,848	153,780,101
8. Other health	0	0	0	0	0	0
9. Health subtotal (Lines 1 to 8)	80,073,102	166,151,852	56,784,848	97,893,713	136,857,950	159,039,982
10. Healthcare receivables (a)	31,564,063	2,648,191	0	0	31,564,063	19,409,658
11. Other non-health	0	0	0	0	0	0
12. Medical incentive pools and bonus amounts	0	0	1,369,068	357,117	1,369,068	190,629
13. Totals (Lines 9-10+11+12)	48,509,039	163,503,661	58,153,916	98,250,830	106,662,955	139,820,953

(a) Excludes $ ..... loans or advances to providers not yet expensed.

NOTES TO FINANCIAL STATEMENTS

1. Summary of significant accounting policies

A. Accounting practices

The accompanying statutory financial statements of Aetna Better Health of Kentucky Insurance Co. (the "Company), a wholly-owned subsidiary of Coventry Health & Life Insurance Co. ('CH&L'), whose ultimate parent is Aetna Inc. ("Aetna"), have been prepared in conformity with accounting practices prescribed or permitted by the Commonwealth of Kentucky Department of Insurance (KY DOI). The KY DOI recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP").

A reconciliation of the Company's net income and surplus between NAIC SAP and practices prescribed and permitted by the Commonwealth of Kentucky for the periods ended March 31, 2018 and December 31, 2017 is as follows:

	SSAP #	F/S Page	F/S Line #	2018	2017
NET INCOME					
(1) State basis (Page 4, Line 32, Columns 2 & 4)	XXX	XXX	XXX	4,078,920	55,741,558
(2) State Prescribed Practices that are an increase/(decrease) from NAIC SAP:					
(3) State Permitted Practices that are an increase/(decrease) from NAIC SAP:					
(4) NAIC SAP (1-2-3=4)	XXX	XXX	XXX	4,078,920	55,741,558
SURPLUS					
(5) State basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	258,583,253	261,922,347
(6) State Prescribed Practices that are an increase/(decrease) from NAIC SAP:					
(7) State Permitted Practices that are an increase/(decrease) from NAIC SAP:					
(8) NAIC SAP (5-6-7=8)	XXX	XXX	XXX	258,583,253	261,922,347

B. Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Kentucky Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenues and expenses. Actual results could differ from those estimates.

C. Accounting policies

No significant change.

D. Going concern

As of May 14, 2018, management has evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

2. Accounting changes and corrections of errors

The Company did not have any accounting changes or corrections of errors in the period ended March 31, 2018.

3. Business combinations and goodwill

No significant change.

4. Discontinued operations

No significant change.

5. Investments

A. – C. No significant change.

D. Loan-Backed Securities

(1) Prepayment assumptions for single class and multi-class mortgage backed/asset backed securities were obtained from industry market sources.

(2) The Company had no other-than-temporary impairment ("OTTI") losses during the first quarter of 2018 on loan-backed and structured securities in which the Company had the (1) intent to sell, (2) did not have the intent and ability to retain for a period of time sufficient to recover the amortized cost basis or (3) present value of cash flows expected to be collected is less than the amortized cost basis of the securities in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 43R, *Loan-Backed and Structured Securities* ("SSAP No. 43R").

(3) The Company had no recognized OTTI on loan-backed and structured securities currently held, in which the present value of cash flows expected to be collected is less than the amortized cost basis, at the reporting date March 31, 2018.

(4) The Company's unrealized loss position on loan-backed and structured securities held by the Company at March 31, 2018 is as follows:

a. The aggregate amount of unrealized losses:
   1. Less than 12 Months 183,794
   2. 12 Months or Longer 670,877
b. The aggregate related fair value of securities with unrealized losses:
   1. Less than 12 Months 11,135,333
   2. 12 Months or Longer 14,579,564

(5) The Company has reviewed the loaned-backed and structured securities in accordance with SSAP No. 43R in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at March 31, 2018 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

E. Repurchase Agreements and/or Securities Lending Transactions

(1) and (2): No significant change.

(3) Neither the Company nor its agent has accepted collateral that is permitted by contract or custom to sell or re-pledge as of March 31, 2018.

(4) through (7): No significant change.

F. The Company did not have any repurchase agreements transactions accounted for as secured borrowing at March 31, 2018.

G. The Company did not have any reverse repurchase agreements transactions accounted for as secured at March 31, 2018.

H. The Company did not have any repurchase agreements transactions accounted for as a sale at March 31, 2018

I. The Company did not have any reverse repurchase agreements transactions accounted for as a sale at March 31, 2018.

J. through L.: No significant change.

M. The Company did not have any working capital finance investments at March 31, 2018.

N. The Company did not have any offsetting and netting of financial assets or liabilities at March 31, 2018.

O. through R.: No significant change.

6. Joint ventures, partnerships, and limited liability companies

No significant change.

7. Investment income

No significant change.

8. Derivative instruments

No significant change.

9. Income taxes

No significant change.

10. Information concerning parent, subsidiaries, affiliates, and related parties

No significant change.

11. Debt

A. The Company did not have any items related to debt, including capital notes at March 31, 2018.

B. The Company did not have any Federal Home Loan Bank agreements at March 31, 2018.

12. Retirement plans, deferred compensation postemployment benefits and compensated absences and other postretirement benefit plans

The Company did not have a retirement plan, deferred compensation plan, or other postretirement benefit plan at March 31, 2018.

13. Capital and surplus, shareholders' dividend restrictions and quasi-reorganizations

No significant change.

14. Contingencies

No significant change.

15. Leases

No significant change.

16. Information about financial instruments with off-balance sheet risk and financial instruments with concentrations of credit risk

No significant change.

17. Sale, transfer and servicing of financial assets and extinguishments of liabilities

A. Transfers of receivables reported as sales

No significant change.

B. Transfer and servicing of financial assets

(1) No significant change.

(2) and (3): The Company did not have any servicing assets or liabilities at March 31, 2018.

(4) The Company did not have any securitized financial assets at March 31, 2018.

(5) through (7): No significant change.

C. Wash sales

(1) The Company did not have any wash sales for the period ended March 31, 2018.

18. Gain or loss to the reporting entity from uninsured plans and the uninsured portion of partially insured plans

No significant change.

19. Direct premium written/produced by managing general agents/third party administrators

No significant change.

20. Fair value measurements

A. and B.

The Company had no material assets or liabilities measured and reported at fair value at March 31, 2018.

C. Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The carrying values and estimated fair values of the Company's financial instruments at March 31, 2018 were as follows:

C. Aggregate fair value for all financial instruments and the level within the fair value hierarchy in which the fair value measurements in their entirety fall.

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)	Net Asset Value (NAV) Included in Level 2
Bonds, Short Term, and Cash Equivalent	480,690,511	479,732,675	46,601,196	434,089,314	.....	.....	.....
Mortgage Loans	13,634,643	12,932,487	.....	.....	13,634,643	.....	.....

There were no materials realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets at March 31, 2018. There were no transfers between the Company's Level 1 or 2 financial assets during March 31, 2018.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

21. Other items

No significant change.

22. Events subsequent

A. Type I - Recognized subsequent events

Subsequent events have been considered through May 14, 2018 for the statutory statement issued on May 14, 2018.

The Company had no known reportable recognized subsequent events.

B. Type II – Non-recognized subsequent events

Subsequent events have been considered through May 14, 2018 for the statutory statement issued on May 14, 2018.

The Company had no known reportable non-recognized subsequent events.

23. Reinsurance

No significant change.

24. Retrospectively rated contracts and contracts subject to redetermination

A. through D.: No significant change.

E. Risk Sharing Provisions of the Affordable Care Act

(1) Did the reporting entity write accident and health insurance premium which is subject to the ACA risk sharing provisions (YES/NO)? No

(2) through (5): Not applicable.

25. Change in incurred claims and claims adjustment expense

As of March 31, 2018, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' decreased by $33,157,999 from $162,303,470 in 2017 to $129,145,471 in 2018. In 2017, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' decreased by $4,903,247 from $203,997,642 in 2016 to $199,094,395 in 2017. The lower than anticipated health care cost trend rates observed in 2018 for claims incurred in 2017, were due to moderating outpatient and physician trends and faster than expected claim payment speed. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends.

Net coordination of benefits are implicit in the claims incurred but not reported calculation and could not be specifically identified.

26. Intercompany pooling arrangements

No significant change.

27. Structured settlements

No significant change.

28. Health care receivables

No significant change.

29. Participating policies

No significant change.

30. Premium deficiency reserves

No significant change.

31. Anticipated salvage and subrogation

No significant change.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Did the reporting entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the State of Domicile, as required by the Model Act? Yes [ ] No [X]

1.2 If yes, has the report been filed with the domiciliary state? Yes [ ] No [ ]

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [ ] No [X]

2.2 If yes, date of change:

3.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1 and 1A.

3.2 Have there been any substantial changes in the organizational chart since the prior quarter end? Yes [X] No [ ]

3.3 If the response to 3.2 is yes, provide a brief description of those changes.
On January 1, 2018, Strategic Resource Company merged into Aetna Life Insurance Company. On January 9, 2018, Healthagen International Limited (England) was dissolved. On January 19, 2018, Bupa Health Insurance (Thailand) Public Company Limited changed its name to Aetna Health Insurance (Thailand) Public Company Limited. On January 30, 2018, Aetna Multi-Strategy 1099 Fund was converted to a limited liability company and changed its name to Aetna Multi-Strategy 1099 Fund, LLC. On February 27, 2018, Aetna Services (Thailand) Limited was formed. On March 1, 2018, Aetna Global Holdings Limited acquired Canadian Insurance Company Ltd, a Hong Kong insurance company. On March 6, 2018, Virtual Home Healthcare LLC a Dubai company was incorporated. On March 6, 2018, Corporate Benefit Strategies, Inc. was merged into bswift LLC.

3.4 Is the reporting entity publicly traded or a member of a publicly traded group? Yes [X] No [ ]

3.5 If the response to 3.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0001122304

4.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [ ] No [X]

4.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

5. If the reporting entity is subject to a management agreement, including third-party administrator(s), managing general agent(s), attorney-in-fact, or similar agreement, have there been any significant changes regarding the terms of the agreement or principals involved? Yes [ ] No [X] N/A [ ]
If yes, attach an explanation.

6.1 State as of what date the latest financial examination of the reporting entity was made or is being made.

6.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

6.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

6.4 By what department or departments?

6.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [ ] No [ ] N/A [X]

6.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [ ] No [ ] N/A [X]

7.1 Has this reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [ ] No [X]

7.2 If yes, give full information:

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

GENERAL INTERROGATORIES

9.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No [ ]
(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.
9.11 If the response to 9.1 is No, please explain:

9.2 Has the code of ethics for senior managers been amended? Yes [ ] No [X]
9.21 If the response to 9.2 is Yes, provide information related to amendment(s).

9.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [X]
9.31 If the response to 9.3 is Yes, provide the nature of any waiver(s).

FINANCIAL

10.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No [ ]
10.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ 1,792

INVESTMENT

11.1 Were any of the stocks, bonds, or other assets of the reporting entity loaned, placed under option agreement, or otherwise made available for use by another person? (Exclude securities under securities lending agreements.) Yes [ ] No [X]
11.2 If yes, give full and complete information relating thereto:

12. Amount of real estate and mortgages held in other invested assets in Schedule BA: $ 0
13. Amount of real estate and mortgages held in short-term investments: $ 0
14.1 Does the reporting entity have any investments in parent, subsidiaries and affiliates? Yes [ ] No [X]
14.2 If yes, please complete the following:

	1 Prior Year-End Book/Adjusted Carrying Value	2 Current Quarter Book/Adjusted Carrying Value
14.21 Bonds	$ 0	$
14.22 Preferred Stock	$ 0	$
14.23 Common Stock	$ 0	$
14.24 Short-Term Investments	$ 0	$
14.25 Mortgage Loans on Real Estate	$ 0	$
14.26 All Other	$ 0	$
14.27 Total Investment in Parent, Subsidiaries and Affiliates (Subtotal Lines 14.21 to 14.26)	$ 0	$ 0
14.28 Total Investment in Parent included in Lines 14.21 to 14.26 above	$	$

15.1 Has the reporting entity entered into any hedging transactions reported on Schedule DB? Yes [ ] No [X]
15.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ]
If no, attach a description with this statement.

GENERAL INTERROGATORIES

16. For the reporting entity's security lending program, state the amount of the following as of the current statement date:
    - 16.1 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. ..... $ 0
    - 16.2 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 ..... $ 0
    - 16.3 Total payable for securities lending reported on the liability page. ..... $ 0

17. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? ..... Yes [X] No [ ]

17.1 For all agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian Address
State Street Bank and Trust Company	State Street Financial Center; One Lincoln Street; Boston, MA 02111-2900

17.2 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)
All agreements comply.		

17.3 Have there been any changes, including name changes, in the custodian(s) identified in 17.1 during the current quarter? ..... Yes [ ] No [X]

17.4 If yes, give full information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

17.5 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
Kevin J. Casey as Sr. Investment Officer	A

17.5097 For those firms/individuals listed in the table for Question 17.5, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets? ..... Yes [ ] No [X]

17.5098 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 17.5, does the total assets under management aggregate to more than 50% of the reporting entity's assets? ..... Yes [ ] No [X]

17.6 For those firms or individuals listed in the table for 17.5 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
N/A	Kevin J. Casey	N/A	Not registered	NO

18.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? ..... Yes [X] No [ ]

18.2 If no, list exceptions:

19. By self-designating 5*GI securities, the reporting entity is certifying the following elements for each self-designated 5*GI security:
    - a. Documentation necessary to permit a full credit analysis of the security does not exist.
    - b. Issuer or obligor is current on all contracted interest and principal payments.
    - c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

    Has the reporting entity self-designated 5*GI securities? ..... Yes [ ] No [X]

GENERAL INTERROGATORIES

PART 2 - HEALTH

1. Operating Percentages:

   1.1 A&H loss percent ..... 83.2 %

   1.2 A&H cost containment percent ..... 2.3 %

   1.3 A&H expense percent excluding cost containment expenses ..... 14.3 %

2.1 Do you act as a custodian for health savings accounts? ..... Yes [ ] No [X]

2.2 If yes, please provide the amount of custodial funds held as of the reporting date ..... $.....

2.3 Do you act as an administrator for health savings accounts? ..... Yes [ ] No [X]

2.4 If yes, please provide the balance of the funds administered as of the reporting date ..... $.....

3. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? ..... Yes [ ] No [X]

3.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? ..... Yes [ ] No [X]

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE S - CEDED REINSURANCE

Showing All New Reinsurance Treaties - Current Year to Date

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Reinsurer	5 Domiciliary Jurisdiction	6 Type of Reinsurance Ceded	7 Type of Reinsurer	8 Certified Reinsurer Rating (1 through 6)	9 Effective Date of Certified Reinsurer Rating

NONE

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

Current Year to Date - Allocated by States and Territories

		1	Direct Business Only							
			2	3	4	5	6	7	8	9
States, etc.		Active Status (a)	Accident and Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Program Premiums	Life and Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama	AL	N							0	
2. Alaska	AK	N							0	
3. Arizona	AZ	N							0	
4. Arkansas	AR	N							0	
5. California	CA	N							0	
6. Colorado	CO	N							0	
7. Connecticut	CT	N							0	
8. Delaware	DE	N							0	
9. District of Columbia	DC	N							0	
10. Florida	FL	N							0	
11. Georgia	GA	N							0	
12. Hawaii	HI	N							0	
13. Idaho	ID	N							0	
14. Illinois	IL	N							0	
15. Indiana	IN	N							0	
16. Iowa	IA	N							0	
17. Kansas	KS	N							0	
18. Kentucky	KY	L	9,234,402		273,529,784				282,764,186	
19. Louisiana	LA	N							0	
20. Maine	ME	N							0	
21. Maryland	MD	N							0	
22. Massachusetts	MA	N							0	
23. Michigan	MI	N							0	
24. Minnesota	MN	N							0	
25. Mississippi	MS	N							0	
26. Missouri	MO	N							0	
27. Montana	MT	N							0	
28. Nebraska	NE	N							0	
29. Nevada	NV	N							0	
30. New Hampshire	NH	N							0	
31. New Jersey	NJ	N							0	
32. New Mexico	NM	N							0	
33. New York	NY	N							0	
34. North Carolina	NC	N							0	
35. North Dakota	ND	N							0	
36. Ohio	OH	N							0	
37. Oklahoma	OK	N							0	
38. Oregon	OR	N							0	
39. Pennsylvania	PA	N							0	
40. Rhode Island	RI	N							0	
41. South Carolina	SC	N							0	
42. South Dakota	SD	N							0	
43. Tennessee	TN	N							0	
44. Texas	TX	N							0	
45. Utah	UT	N							0	
46. Vermont	VT	N							0	
47. Virginia	VA	N							0	
48. Washington	WA	N							0	
49. West Virginia	WV	N							0	
50. Wisconsin	WI	N							0	
51. Wyoming	WY	N							0	
52. American Samoa	AS	N							0	
53. Guam	GU	N							0	
54. Puerto Rico	PR	N							0	
55. U.S. Virgin Islands	VI	N							0	
56. Northern Mariana Islands	MP	N							0	
57. Canada	CAN	N							0	
58. Aggregate Other Aliens	OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal		XXX	9,234,402	0	273,529,784	0	0	0	282,764,186	0
60. Reporting Entity Contributions for Employee Benefit Plans		XXX							0	
61. Totals (Direct Business)		XXX	9,234,402	0	273,529,784	0	0	0	282,764,186	0
DETAILS OF WRITE-INS										
58001.		XXX								
58002.		XXX								
58003.		XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page		XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)		XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed Insurance carrier or domiciled RRG 1
R - Registered - Non-domiciled RRGs 0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
Q - Qualified - Qualified or accredited reinsurer 0
N - None of the above - Not allowed to write business in the state 56

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

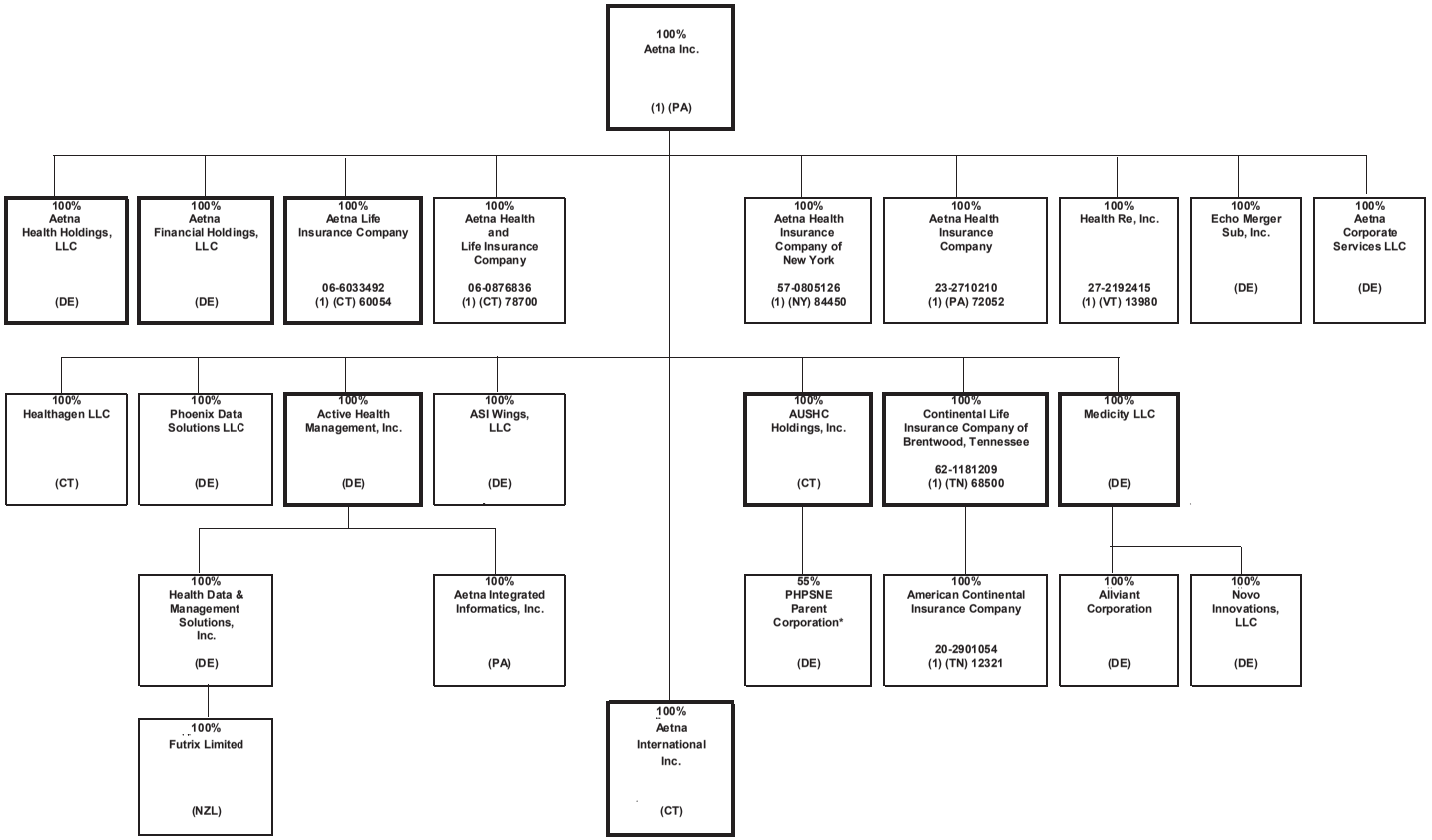

(1) Insurers/HMO's
Percentages are rounded to the nearest whole percent and based on ownership of voting rights.
Double borders indicate entity has subsidiaries shown on the same page.
Bold borders indicate entity has subsidiaries shown on a separate page.

*55% is owned by AUSHC Holdings, Inc. and 45% is owned by third parties.

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

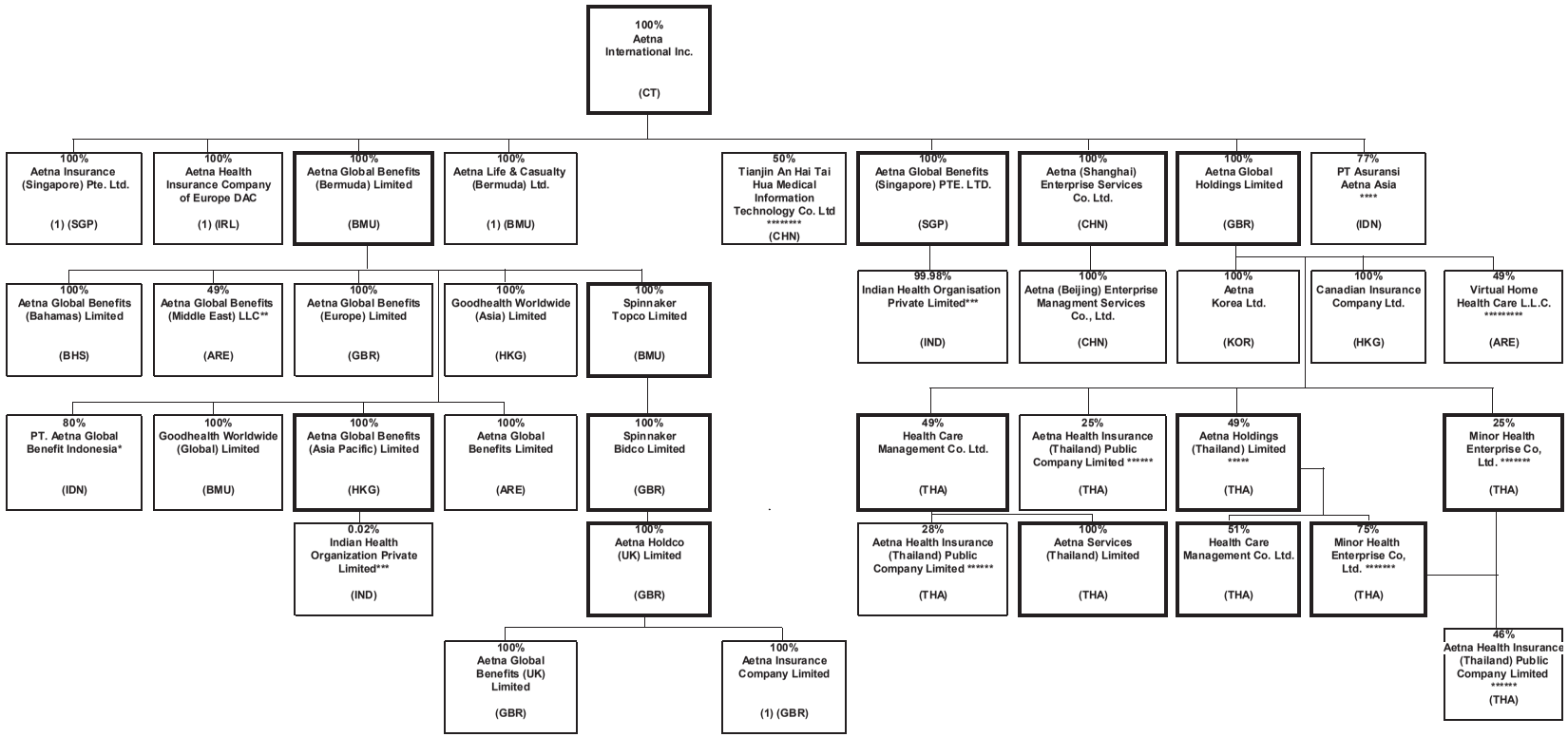

*Aetna Global Benefits Indonesia is 80% owned by Aetna Global Benefits (Bermuda) Limited and 20% is owned by Suhatsyah Rivai, Aetna's Nominee.
**Aetna Global Benefits (Middle East) LLC is 49% owned by Aetna Global Benefits (Bermuda) Limited and 51% is owned by Euro Gulf LLC, Aetna's Nominee.
***Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
****PT Asuransi Aetna Asia is 77% owned by Aetna International Inc. and 23% owned by PT Asuransi Central Asia.
*****Aetna Holdings (Thailand) Limited is 51% owned by Mr. Paiboon Sutantivorakoon
******Aetna Health Insurance (Thailand) Public Company Limited is 46% owned by Minor Health Entreprise Co, Ltd.; 25% owned by Aetna Global Holdings Limited; and 28% owned by Health Care Management Co. Ltd. and total 1% owned by Aetna Global Benefits (Bermuda) Limited (1 Share); Mr. Sansanapongpherchar (1 Share); Mr. Jitphasong Itsaraphakded (1 Share); Mrs. Suphee Wattana (1 Share); and Mr. Buncha Tamphragom (1 Share)
*******Minor Health Entreprise Co, Ltd is 1 share owned by Aetna Global Benefits (Bermuda) Ltd
********Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is 50% owned by Tianjin Hai Tai Group Co., Ltd
*********Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

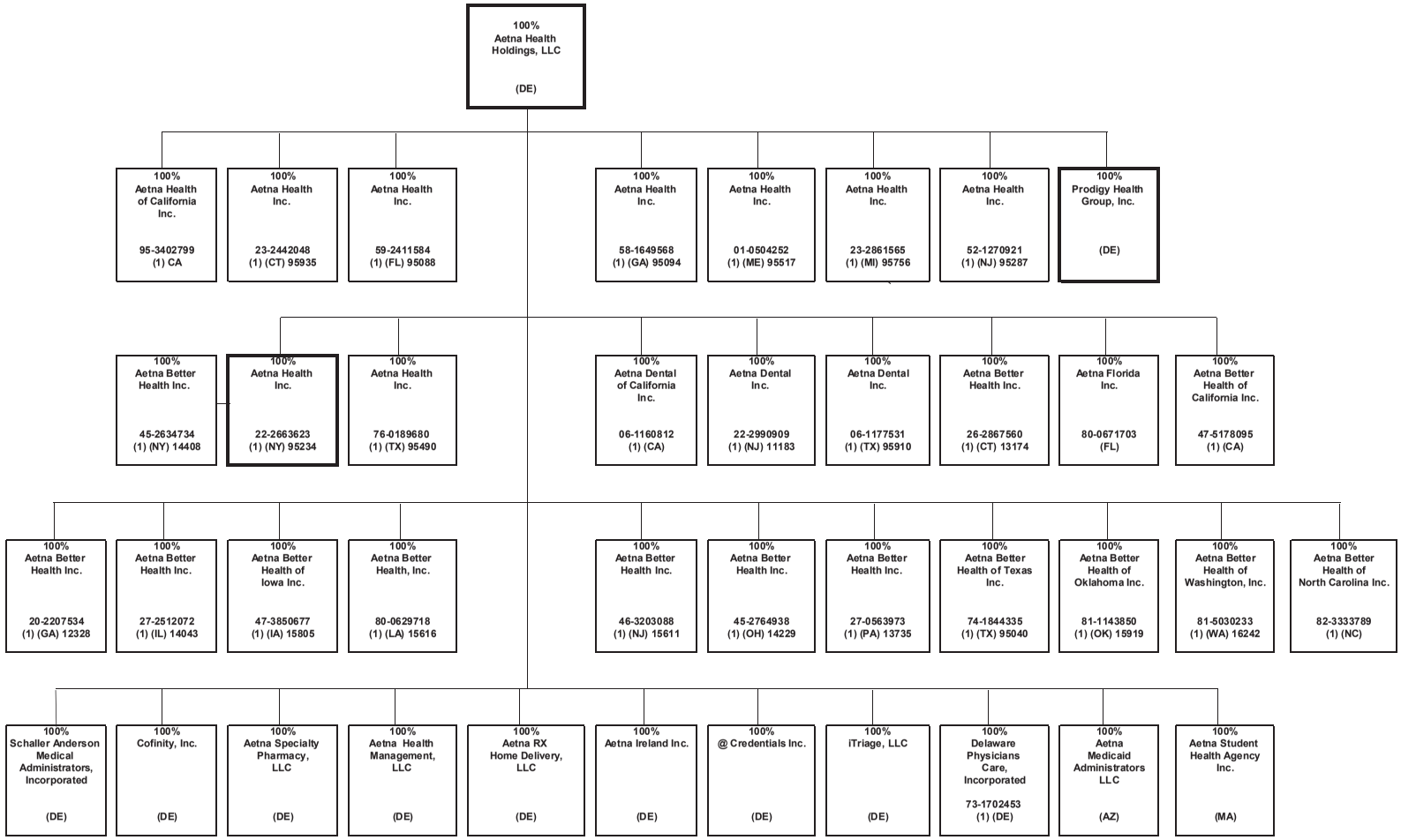

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

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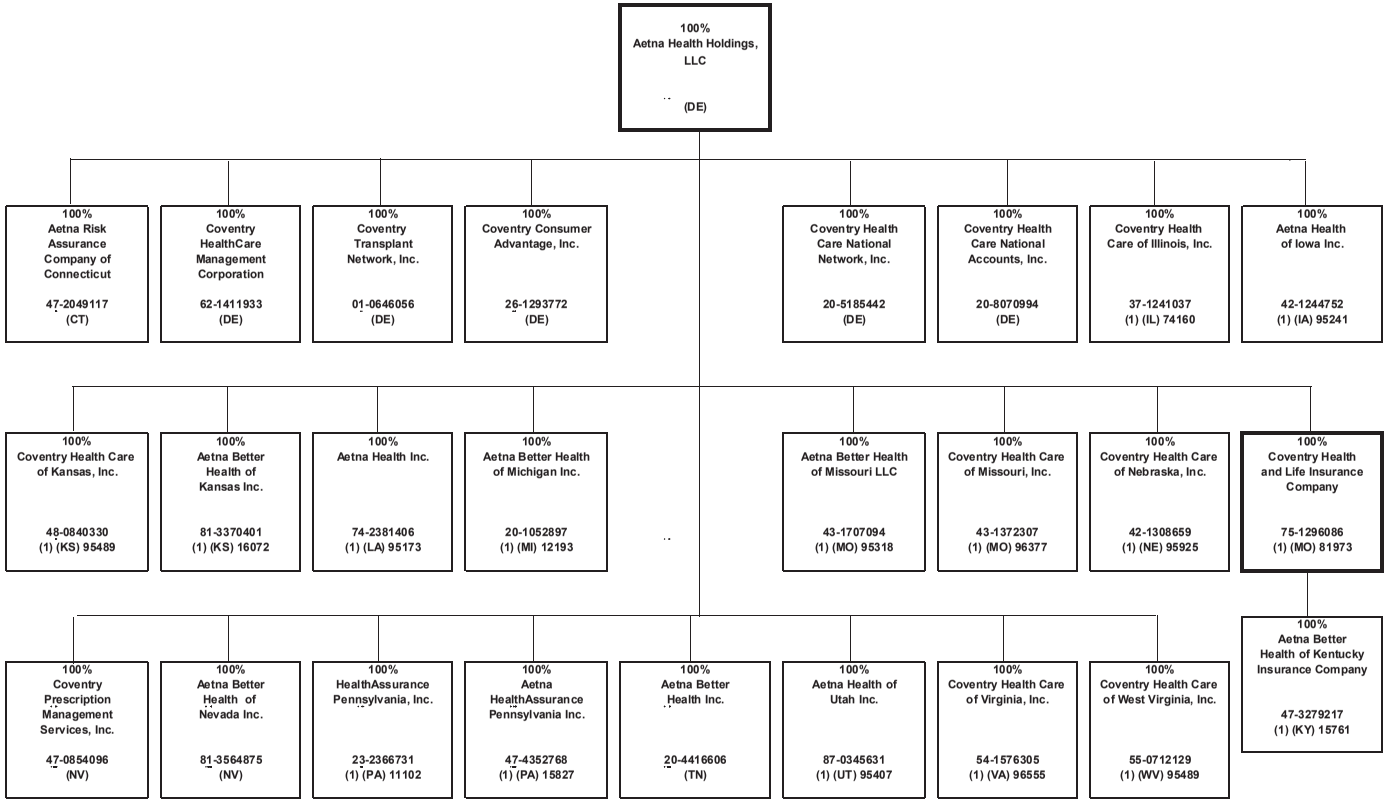

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

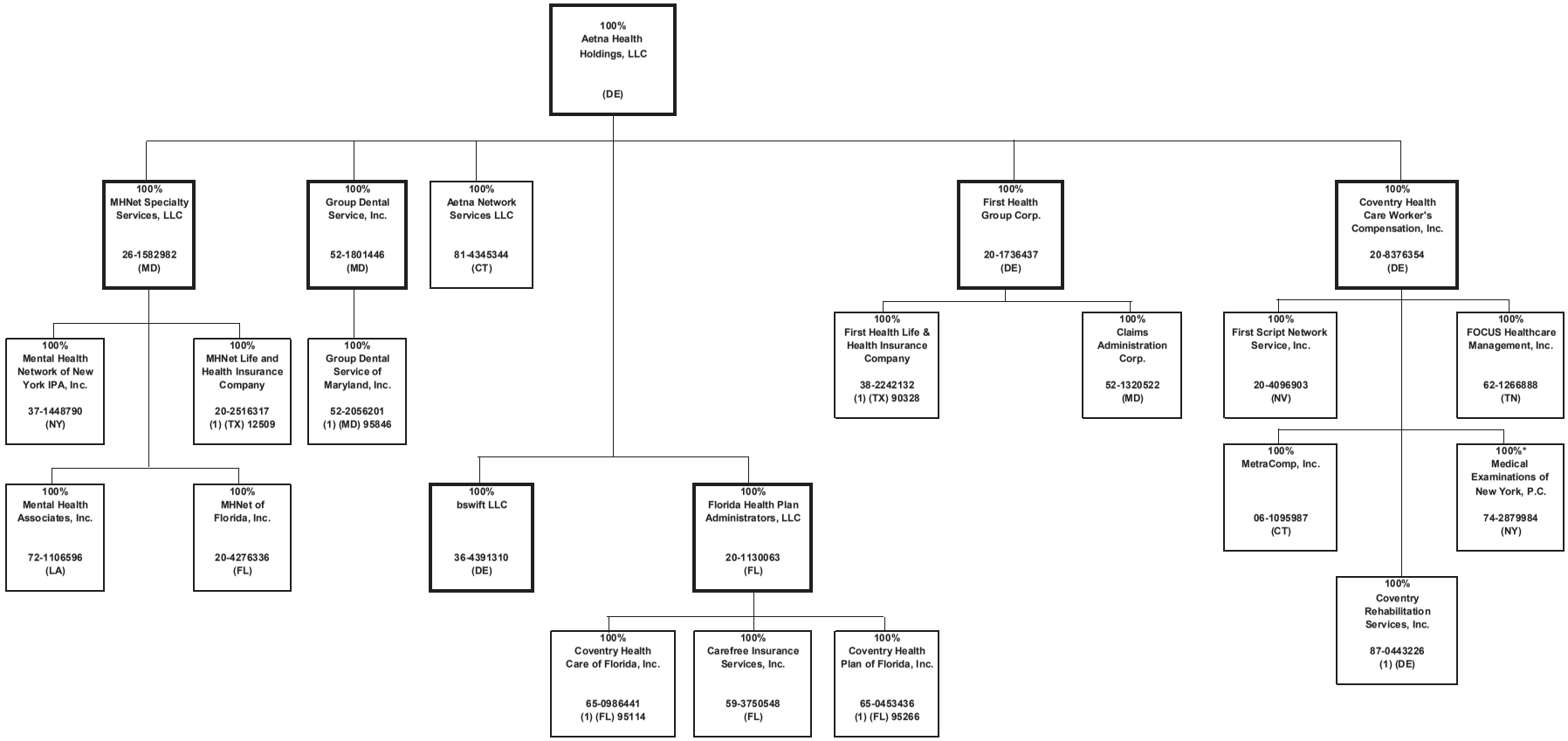

*100% owned through Aetna's nominees

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

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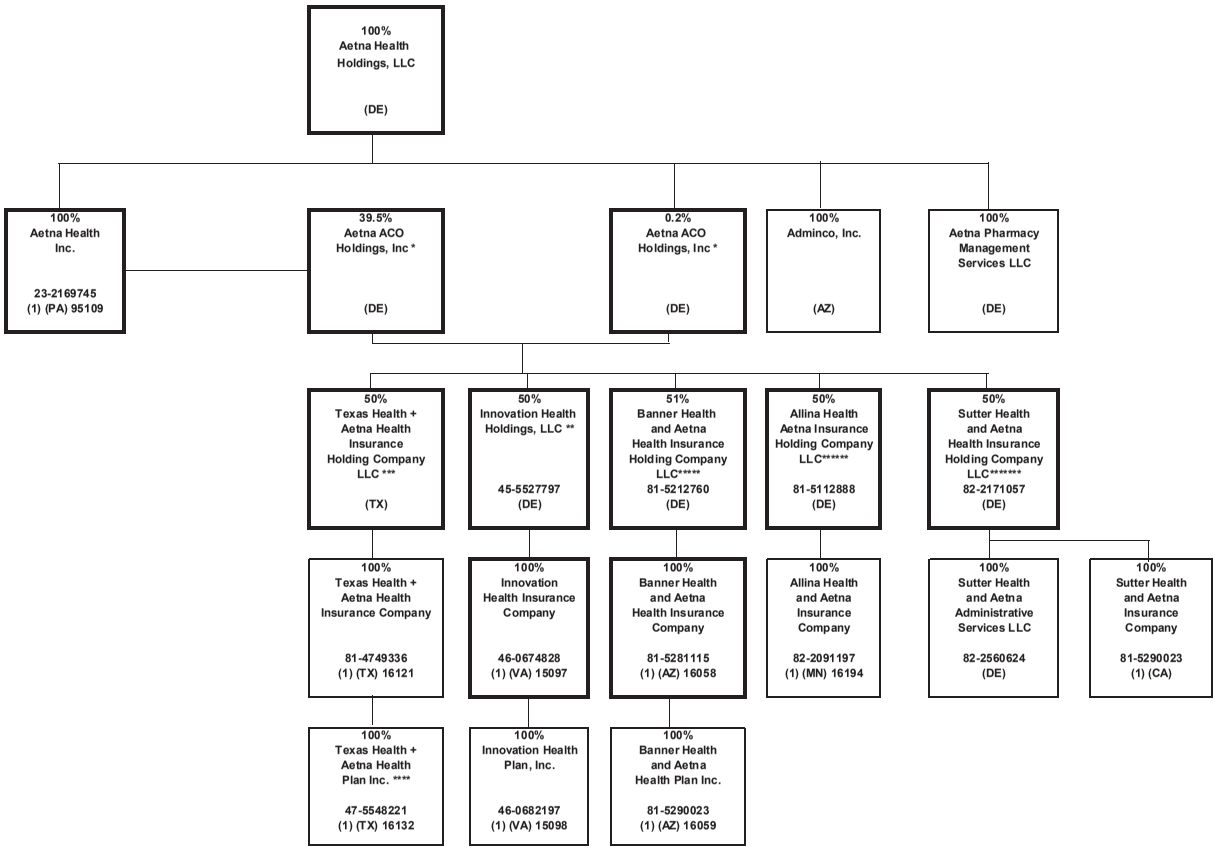

* Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
** Innovation Health Holdings, LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Inova Health System Foundation.
*** Texas Health + Aetna Health Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Texas Health Resources.
**** Texas Health + Aetna Health Plan Inc. became a direct subsidiary of Texas Health + Aetna Health Insurance Company February 2017.
***** Banner Health and Aetna Health Insurance Holding Company LLC is 51% owned by Aetna ACO Holdings Inc. and 49% owned by Banner Health.
****** Allina Health and Aetna Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Allina Health.
*******Sutter Health and Aetna Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Sutter Health Plan Products Organization, LLC.

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

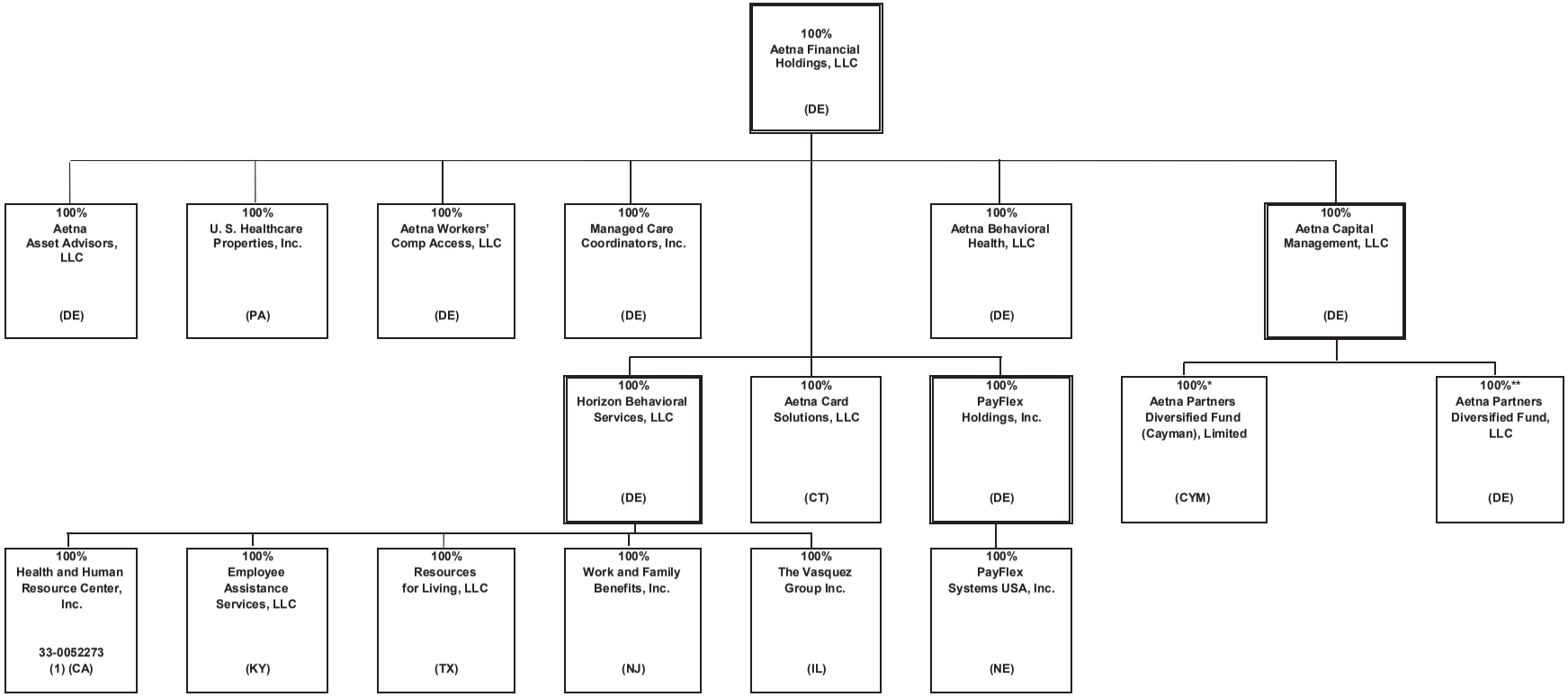

* Aetna Life Insurance Company owns the Class C participating shares of Aetna Partners Diversified Fund (Cayman), Limited.

** Aetna Life Insurance Company, Aetna Health and Life Insurance Company and Aetna Health Management , LLC own substantially all of the non-managing member interests of Aetna Partners Diversified Fund, LLC.

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

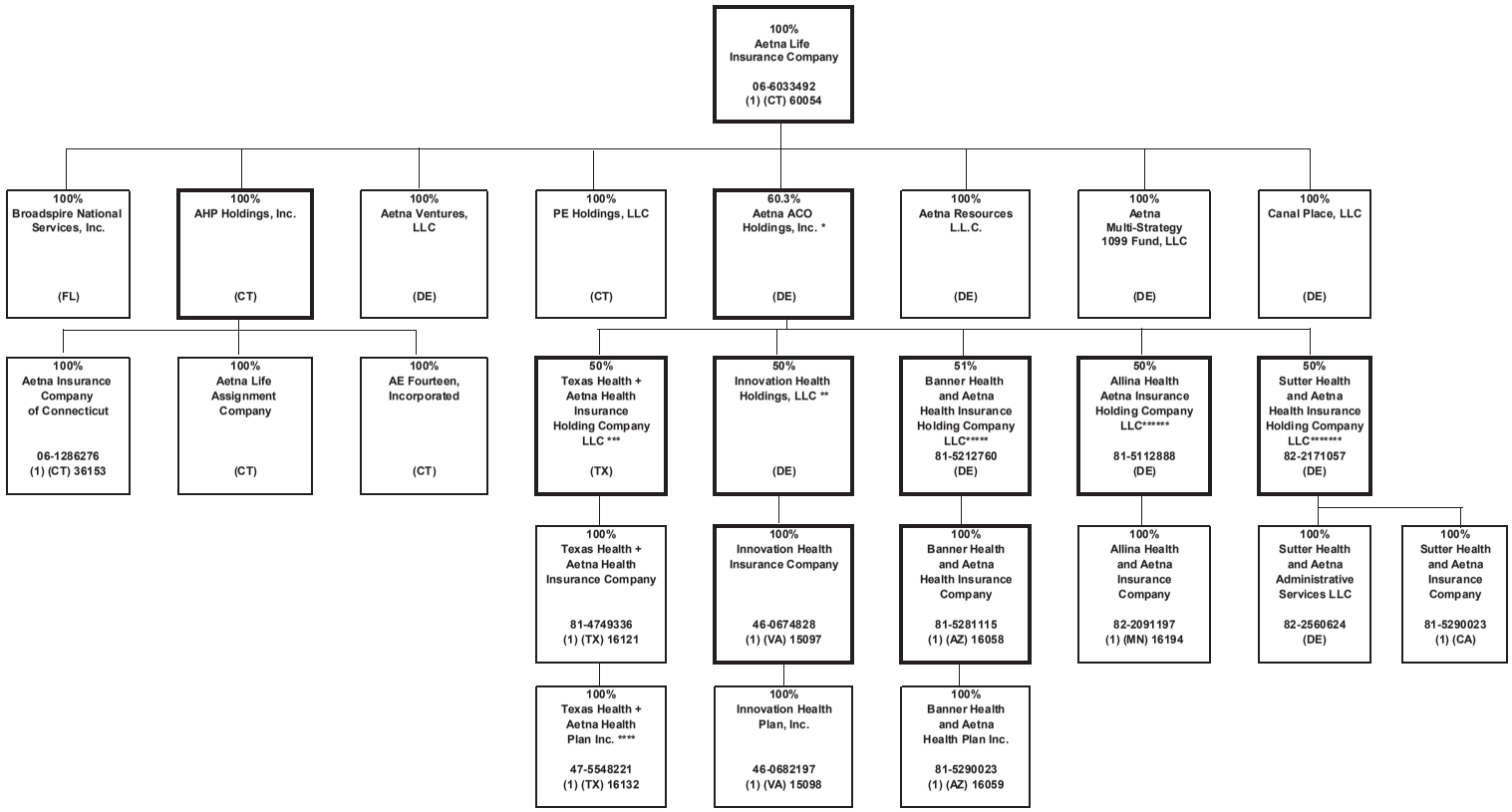

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STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

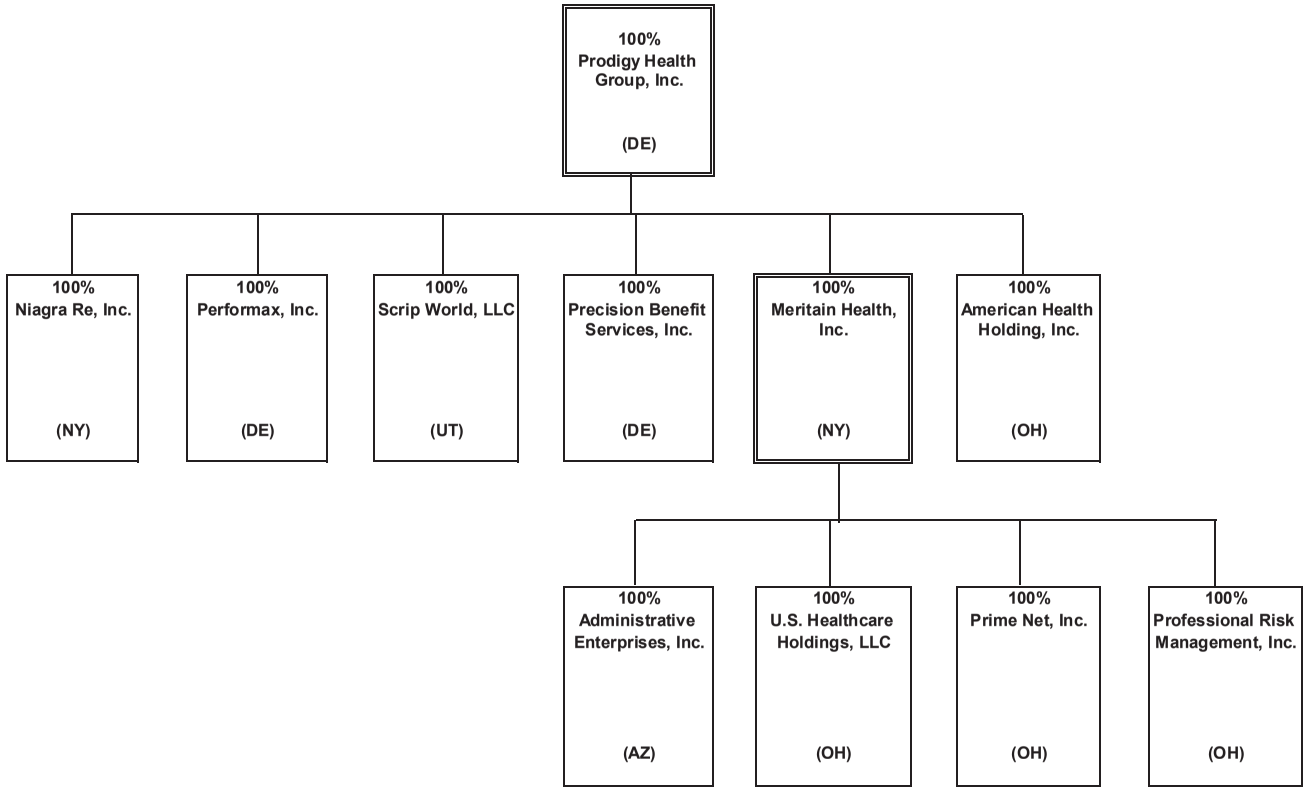

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000	23-2229683	3060706	0001122304	N	Aetna Inc.	PA	UIP	Aetna Inc.		0.000		N	0
0001	AETNA INC.	00000	30-0123754	0	0		Aetna Health Holdings, LLC	DE	UIP	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	95-3402799	0	0		Aetna Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95935	23-2442048	0	0		Aetna Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95088	59-2411584	0	0		Aetna Health Inc.	FL	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95094	58-1649568	0	0		Aetna Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95517	01-0504252	0	0		Aetna Health Inc.	ME	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95756	23-2861565	0	0		Aetna Health Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95287	52-1270921	0	0		Aetna Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95234	22-2663623	0	0		Aetna Health Inc.	NY	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	14408	45-2634734	0	0		Aetna Better Health Inc.	NY	IA	Aetna Health Inc. (NY)	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95490	76-0189680	0	0		Aetna Health Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95040	74-1844335	0	0		Aetna Better Health of Texas Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12328	20-2207534	0	0		Aetna Better Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1160812	0	0		Aetna Dental of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	11183	22-2990909	0	0		Aetna Dental Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95910	06-1177531	0	0		Aetna Dental Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	30-0123760	0	0		Aetna Rx Home Delivery, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	13-3670795	0	0		Aetna Health Management, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	22-3187443	0	0		Aetna Ireland Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	57-1209768	0	0		Aetna Specialty Pharmacy, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-1274723	0	0		Cofinity, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2671370	0	0		@Credentials Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Services (Thailand) Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	13735	27-0563973	0	0		Aetna Better Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	13174	26-2867560	0	0		Aetna Better Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-5178095	0	0		Aetna Better Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	14043	27-2512072	0	0		Aetna Better Health Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15805	47-3850677	0	0		Aetna Better Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15616	80-0629718	0	0		Aetna Better Health, Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	80-0671703	0	0		Aetna Florida Inc.	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	14229	25-2764938	0	0		Aetna Better Health Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15611	46-3203086	0	0		Aetna Better Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15919	81-1143850	0	0		Aetna Better Health of Oklahoma Inc.	OK	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	04-2708160	0	0		Aetna Student Health Agency Inc.	MA	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	73-1702453	0	0		Delaware Physicians Care, Incorporated	DE	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	01-0826783	0	0		Schaller Anderson Medical Administrators, Incorporated	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	86-0842559	0	0		Aetna Medicaid Adminstrators LLC	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-2944270	0	0		iTriage, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	16-1471176	0	0		Prodigy Health Group, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	0.200	Aetna Inc.	Y	4
0001	AETNA INC.	00000	45-5527797	0	0		Innovation Health Holdings, LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	7
0001	AETNA INC.	15097	46-0674828	0	0		Innovation Health Insurance Company	VA	IA	Innovation Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15098	46-0682197	0	0		Innovation Health Plan, Inc.	VA	IA	Innovation Health Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-3789357	0	0		Texas Health + Aetna Health Insurance Holding Company LLC	TX	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	10
0001	AETNA INC.	16121	81-4749336	0	0		Texas Health + Aetna Health Insurance Company	TX	IA	Texas Health + Aetna Health Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16132	47-5548221	0	0		Texas Health + Aetna Health Plan Inc.	TX	IA	Texas Health + Aetna Health Insurance Company	Ownership	100.000	Aetna Inc.	N	11
0001	AETNA INC.	95109	23-2169745	0	0		Aetna Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Inc. (PA)	Ownership	39.500	Aetna Inc.	Y	4
0001	AETNA INC.	00000	20-0438576	0	0		Niagara Re, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000	52-2200070	0	0		Performax, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	87-0632355	0	0		Scrip World, LLC	UT	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-1760756	0	0		Precision Benefit Services, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	31-1368946	0	0		American Health Holding, Inc.	OH	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	16-1264154	0	0		Meritain Health, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	86-0537707	0	0		Adminco, Inc.	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	86-0527428	0	0		Administrative Enterprises, Inc.	AZ	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	16-1684061	0	0		U.S. Healthcare Holdings, LLC	OH	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	34-1670299	0	0		Prime Net, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	34-1348032	0	0		Professional Risk Management, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	68500	62-1181209	0	0		Continental Life Insurance Company of Brentwood, Tennessee	TN	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12321	20-2901054	0	0		American Continental Insurance Company	TN	IA	Continental Life Insurance Company of Brentwood, Tennessee	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	60054	06-6033492	0	0		Aetna Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Life Insurance Company	Ownership	60.300	Aetna Inc.	Y	4
0001	AETNA INC.	00000	06-1270755	0	0		AHP Holdings, Inc.	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	36153	06-1286276	0	0		Aetna Insurance Company of Connecticut	CT	IA	AHP Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1028469	0	0		AE Fourteen, Incorporated	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1373153	0	0		Aetna Life Assignment Company	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-3678339	0	0		PE Holdings, LLC	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1423207	0	0		Aetna Resources L.L.C.	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Canal Place, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-3180700	0	0		Aetna Ventures, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	59-2108747	0	0		Broadspire National Services, Inc.	FL	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0001552250		Aetna Multi-Strategy 1099 Fund, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	79.250	Aetna Inc.	N	0
0001	AETNA INC.	00000	41-2035961	0	0		Aetna Financial Holdings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	26-2030792	0	0		Aetna Asset Advisors, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2354500	0	0		U.S. Healthcare Properties, Inc.	PA	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	38-3704481	0	0		Aetna Capital Management, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	11-3667142	0	0001314522		Aetna Partners Diversified Fund, LLC	DE	NIA	Aetna Capital Management, LLC	Ownership	100.000	Aetna Inc.	N	1
0001	AETNA INC.	00000		0	0001460020		Aetna Partners Diversified Fund (Cayman), Limited	CYM	NIA	Aetna Capital Management, LLC	Ownership	100.000	Aetna Inc.	N	2
0001	AETNA INC.	00000	20-0446676	0	0		Aetna Workers' Comp Access, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-0446713	0	0		Aetna Behavioral Health, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2670015	0	0		Managed Care Coordinators, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	59-3269144	0	0		Horizon Behavioral Services, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	61-1193498	0	0		Employee Assistance Services, LLC	KY	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	33-0052273	0	0		Health and Human Resource Center, Inc.	CA	IA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	75-2420973	0	0		Resources for Living, LLC	TX	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	36-3681261	0	0		The Vasquez Group Inc.	IL	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	22-3178125	0	0		Work and Family Benefits, Inc.	NJ	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-1773021	0	0		Aetna Card Solutions, LLC	CT	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-5216478	0	0		PayFlex Holdings, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	91-1774434	0	0		PayFlex Systems USA, Inc.	NE	NIA	PayFlex Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	78700	06-0876836	0	0		Aetna Health and Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	72052	23-2710210	0	0		Aetna Health Insurance Company	PA	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	84450	57-0805126	0	0		Aetna Health Insurance Company of New York	NY	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1571642	0	0		Aetna International Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	98-0211470	0	0		Aetna Life & Casualty (Bermuda) Ltd.	BMU	IA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Insurance (Singapore) PTE. LTD.	SGP	IA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Bermuda) Limited	BMU	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Goodhealth Worldwide (Global) Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Europe) Limited	GBR	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
0001	AETNA INC.	00000		0	0		Goodhealth Worldwide (Asia) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits Limited	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		PT. Aetna Global Benefits Indonesia	IDN	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	80.000	Aetna Inc.	N	5
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Middle East) LLC	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	49.000	Aetna Inc.	N	6
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Asia Pacific) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Spinnaker Topco Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Spinnaker Bidco Limited	GBR	NIA	Spinnaker Topco Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Holdco (UK) Limited	GBR	NIA	Spinnaker Bidco Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		PT Asuransi Aetna Asia	IDN	NIA	Aetna International Inc.	Ownership	77.000	Aetna Inc.	N	15
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (UK) Limited	GBR	NIA	Aetna Holdco (UK) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Insurance Company Limited	GBR	IA	Aetna Holdco (UK) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Asia Pacific) Limited	Ownership	0.020	Aetna Inc.	N	3
0001	AETNA INC.	00000		0	0		Aetna Health Insurance Company of Europe DAC	IRL	IA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna (Shanghai) Enterprise Services Co. Ltd.	CHN	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna (Beijing) Enterprise Management Services Co., Ltd.	CHN	NIA	Aetna (Shanghai) Enterprise Services Co. Ltd.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Singapore) PTE. LTD.	SGP	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Singapore) PTE, LTD.	Ownership	99.980	Aetna Inc.	N	3
0001	AETNA INC.	00000	22-2578985	0	0		AUSHC Holdings, Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Holdings Limited	GBR	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Korea Ltd.	KOR	NIA	Aetna Global Holdings Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Canadian Insurance Company Ltd	HKG	NIA	Aetna Global Holdings Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Futrix Limited	NZL	NIA	Health Data & Management Solutions, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1182176	0	0		PHPSNE Parent Corporation	DE	NIA	AUSHC Holdings, Inc.	Ownership	55.000	Aetna Inc.	N	8
0001	AETNA INC.	00000	52-2182411	0	0		Active Health Management, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-0970432	0	0		Health Data & Management Solutions, Inc.	DE	NIA	Active Health Management, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2604867	0	0		Aetna Integrated Informatics, Inc.	PA	NIA	Active Health Management, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	13980	27-2192415	0	0		Health Re, Inc.	VT	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-0579372	0	0		Phoenix Data Solutions LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	46-2469464	0	0		Healthagen LLC	CT	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	51-0029326	0	0		ASI Wings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	33-0807547	0	0		Medicity LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Echo Merger Sub, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Corporate Services, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-0259978	0	0		Novo Innovations, LLC	DE	NIA	Medicity Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-1170966	0	0		Alliviant Corporation	DE	NIA	Medicity Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	81973	75-1296086	0	0		Coventry Health and Life Insurance Company	MO	UDP	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15761	47-3279217	0	0		Aetna Better Health of Kentucky Insurance Company	KY	RE	Coventry Health and Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	52-1801446	0	0		Group Dental Service, Inc.	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95846	52-2056201	0	0		Group Dental Service of Maryland, Inc.	MD	IA	Group Dental Service, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.		81-4345344	0	0		Aetna Network Services LLC	CT	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95241	42-1244752	0	0		Aetna Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95925	42-1308659	0	0		Coventry Health Care of Nebraska, Inc.	NE	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-2049117	0	0		Aetna Risk Assurance Company of Connecticut Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95173	74-2381406	0	0		Aetna Health Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	11102	23-2366731	0	0		HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

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0001	AETNA INC.	00000	47-0854096	0	0		Coventry Prescription Management Services, Inc.	NV	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16148	81-3564875	0	0		Aetna Better Health of Nevada Inc.	NV	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	96555	54-1576305	0	0		Coventry Health Care of Virginia, Inc.	VA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	01-0646056	0	0		Coventry Transplant Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	96377	43-1372307	0	0		Coventry Health Care of Missouri, Inc.	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95318	43-1702094	0	0		Aetna Better Health of Missouri LLC	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95408	55-0712129	0	0		Coventry Health Care of West Virginia, Inc.	WV	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	62-1411933	0	0		Coventry HealthCare Management Corporation	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15827	47-4352768	0	0		Aetna HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95489	48-0840330	0	0		Coventry Health Care of Kansas, Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16072	81-3370401	0	0		Aetna Better Health of Kansas Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12193	20-1052897	0	0		Aetna Better Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95407	87-0345631	0	0		Aetna Health of Utah Inc.	UT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-4416606	0	0		Aetna Better Health Inc.	TN	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	74160	37-1241037	0	0		Coventry Health Care of Illinois, Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-8070994	0	0		Coventry Health Care National Accounts, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-5185442	0	0		Coventry Health Care National Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	26-1293772	0	0		Coventry Consumer Advantage, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-8376354	0	0		Coventry Health Care Workers' Compensation, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-4096903	0	0		First Script Network Service, Inc.	NV	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1095987	0	0		MetraComp, Inc.	CT	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	74-2879984	0	0		Medical Examinations of New York, P.C.	NY	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	9
0001	AETNA INC.	00000	62-1266888	0	0		FOCUS Healthcare Management, Inc.	TN	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	87-0443226	0	0		Coventry Rehabilitation Services, Inc.	DE	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-1736437	0	0		First Health Group Corp.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	90328	38-2242132	0	0		First Health Life & Health Insurance Company	TX	IA	First Health Group Corp.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	52-1320522	0	0		Claims Administration Corp.	MD	NIA	First Health Group Corp.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-1130063	0	0		Florida Health Plan Administrators, LLC	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95114	65-0986441	0	0		Coventry Health Care of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95266	65-0453436	0	0		Coventry Health Plan of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	59-3750548	0	0		Carefree Insurance Services, Inc.	FL	NIA	Florida Health Plan Administrators, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	36-4391310	0	0		bswift LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Virtual Home Healthcare LLC	ARE	NIA	Aetna Global Holdings Limited	Ownership	49.000	Aetna Inc.	N	19
0001	AETNA INC.	00000	26-1582982	0	0		MHNet Specialty Services, LLC	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	37-1448790	0	0		Mental Health Network of New York IPA, Inc.	NY	NIA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12509	20-2516317	0	0		MHNet Life and Health Insurance Company	TX	IA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	72-1106596	0	0		Mental Health Associates, Inc.	LA	NIA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-4276336	0	0		MHNet of Florida, Inc.	FL	IA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16242	81-5030233	0	0		Aetna Better Health of Washington, Inc.	WA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-5212760	0	0		Banner Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	51.000	Aetna Inc.	N	12
0001	AETNA INC.	16058	81-5281115	0	0		Banner Health and Aetna Health Insurance Company	AZ	IA	Banner Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16059	81-5290023	0	0		Banner Health and Aetna Health Plan Inc.	AZ	IA	Banner Health and Aetna Health Insurance Company	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000	81-5112888	0	0		Allina Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	13
0001	AETNA INC.	16194	82-2091197	0	0		Allina Health and Aetna Insurance Company	MN	IA	Allina Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	82-2171057	0	0		Sutter Health and Aetna Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	14
0001	AETNA INC.	00000	82-2560624	0	0		Sutter Health and Aetna Administrative Services LLC	DE	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-5290023	0	0		Sutter Health and Aetna Insurance Company	CA	IA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Holdings (Thailand) Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	Aetna Inc.	N	16
0001	AETNA INC.	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	Aetna Inc.	N	17
0001	AETNA INC.	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Minor Health Entreprise Co, Ltd.	Ownership	46.000	Aetna Inc.	N	17
0001	AETNA INC.	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	28.000	Aetna Inc.	N	17
0001	AETNA INC.	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	Aetna Inc.	N	18
0001	AETNA INC.	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	75.000	Aetna Inc.	N	18
0001	AETNA INC.	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	51.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Bahamas) Limited	BHS	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Pharmacy Management Services LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	82-3333789	0	0		Aetna Better Health of North Carolina Inc.	NC	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd	CHN	NIA	Aetna International Inc.	Ownership	50.000	Aetna Inc.	N	20

Asterisk	Explanation
1	Aetna Life Insurance Company, Aetna Health and Life Insurance Company and Aetna Health Management, LLC own substantially all of the non-managing membership interests.
2	Aetna Life Insurance Company owns the Class C participating shares.
3	Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
4	Aetna ACO Holdings, Inc. is owned by Aetna Life Insurance Company (60.3%), Aetna Health Inc. (PA) (39.5%) and Aetna Health Holdings, LLC (0.2%).
5	Aetna Global Benefits (Bermuda) Limited owns 80% and 20% is owned by Suhatsyah Rivai, Aetna's Nominee.
6	Aetna Global Benefits (Bermuda) Limited owns 49% and 51% is owned by Euro Gulf LLC, Aetna's Nominee.
7	Aetna ACO Holdings Inc. owns 50% and 50% is owned by Innovation Health System Foundation, an unaffiliated company.
8	55% is owned by AUSHC Holdings, Inc. The remaining 45% is owned by thirteen different hospitals (non-affiliates) which are shareholders with varying degrees of ownership.
9	100% owned through Aetna's nominees.
10	Texas Health + Aetna Health Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% by Texas Health Resources, an unaffiliated company.
11	Texas Health + Aetna Health Plan Inc. became a direct subsidiary of Texas Health + Aetna Health Insurance Company February 2017.
12	Banner Health and Aetna Health Insurance Holding Company LLC is 51% owned by Aetna ACO Holdings Inc. and 49% owned by Banner Health.
13	Allina Health and Aetna Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Allina Health.
14	Sutter Health and Aetna Insurance Holding Company LLC is 50% owned by Aetna ACO Holdings Inc. and 50% owned by Sutter Health Plan Products Organization, LLC.
15	PT Asuransi Aetna Asia is 77% owned by Aetna International Inc. and 23% owned by PT Asuransi Central Asia.
16	Aetna Holdings (Thailand) Limited is 49% owned by Aetna Global Holdings Limited and 51% owned by Mr. Paiboon Sutantivorakoon
17	Aetna Health Insurance (Thailand) Public Company Limited is 46% owned by Minor Health Entreprise Co, Ltd.; 25% owned by Aetna Global Holdings Limited; and 28% owned by Health Care Management Co. Ltd. (Bermuda) and total 1% owned by Aetna Global Benefits Limited (1 Share); Mr. Sansanapongpherchar (1 Share); Mr. Jitphasong Itsaraphakded (1 Share); Mrs. Suphee Wattana (1 Share); and Mr. Buncha Tamphragom (1 Share)
18	Minor Health Entreprise Co, Ltd has 1 share owned by Aetna Global Benefits (Bermuda) Ltd
19	Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

Asterisk	Explanation
20	Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Response
1. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?	NO

Explanation:

1. Business not written

Bar Code:

1. Medicare Part D Coverage Supplement [Document Identifier 365]

OVERFLOW PAGE FOR WRITE-INS

SCHEDULE A - VERIFICATION

Real Estate

NONE

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		
	2.2 Additional investment made after acquisition		
3.	Current year change in encumbrances		
4.	Total gain (loss) on disposals		
5.	Deduct amounts received on disposals		
6.	Total foreign exchange change in book/adjusted carrying value		
7.	Deduct current year's other than temporary impairment recognized		
8.	Deduct current year's depreciation		
9.	Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8)		
10.	Deduct total nonadmitted amounts		
11.	Statement value at end of current period (Line 9 minus Line 10)		

SCHEDULE B - VERIFICATION

Mortgage Loans

		1 Year to Date	2 Prior Year Ended December 31
1.	Book value/recorded investment excluding accrued interest, December 31 of prior year	12,979,171	
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		12,979,171
	2.2 Additional investment made after acquisition		0
3.	Capitalized deferred interest and other		0
4.	Accrual of discount		0
5.	Unrealized valuation increase (decrease)		0
6.	Total gain (loss) on disposals		
7.	Deduct amounts received on disposals	77,543	
8.	Deduct amortization of premium and mortgage interest points and commitment fees	(30,859)	0
9.	Total foreign exchange change in book value/recorded investment excluding accrued interest		0
10.	Deduct current year's other than temporary impairment recognized		0
11.	Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	12,932,487	12,979,171
12.	Total valuation allowance		
13.	Subtotal (Line 11 plus Line 12)	12,932,487	12,979,171
14.	Deduct total nonadmitted amounts		0
15.	Statement value at end of current period (Line 13 minus Line 14)	12,932,487	12,979,171

SCHEDULE BA - VERIFICATION

Other Long-Term Invested Assets

NONE

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		
	2.2 Additional investment made after acquisition		
3.	Capitalized deferred interest and other		
4.	Accrual of discount		
5.	Unrealized valuation increase (decrease)		
6.	Total gain (loss) on disposals		
7.	Deduct amounts received on disposals		
8.	Deduct amortization of premium and depreciation		
9.	Total foreign exchange change in book/adjusted carrying value		
10.	Deduct current year's other than temporary impairment recognized		
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)		
12.	Deduct total nonadmitted amounts		
13.	Statement value at end of current period (Line 11 minus Line 12)		

SCHEDULE D - VERIFICATION

Bonds and Stocks

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value of bonds and stocks, December 31 of prior year	479,236,865	528,045,638
2.	Cost of bonds and stocks acquired	49,824,990	82,646,084
3.	Accrual of discount	114,072	439,402
4.	Unrealized valuation increase (decrease)	(432,297)	237,476
5.	Total gain (loss) on disposals	39,276	1,054,133
6.	Deduct consideration for bonds and stocks disposed of	52,806,037	129,442,848
7.	Deduct amortization of premium	912,283	3,544,111
8.	Total foreign exchange change in book/adjusted carrying value		
9.	Deduct current year's other than temporary impairment recognized	381,293	198,909
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees	220,418	0
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)	474,903,711	479,236,865
12.	Deduct total nonadmitted amounts		
13.	Statement value at end of current period (Line 11 minus Line 12)	474,903,711	479,236,865

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1B

Showing the Acquisitions, Dispositions and Non-Trading Activity
During the Current Quarter for all Bonds and Preferred Stock by NAIC Designation

NAIC Designation	1 Book/Adjusted Carrying Value Beginning of Current Quarter	2 Acquisitions During Current Quarter	3 Dispositions During Current Quarter	4 Non-Trading Activity During Current Quarter	5 Book/Adjusted Carrying Value End of First Quarter	6 Book/Adjusted Carrying Value End of Second Quarter	7 Book/Adjusted Carrying Value End of Third Quarter	8 Book/Adjusted Carrying Value December 31 Prior Year
BONDS								
1. NAIC 1 (a)	350,941,062	595,128,209	617,154,026	5,239,027	334,154,272	0	0	350,941,062
2. NAIC 2 (a)	100,591,076	8,713,685	6,552,942	(5,120,079)	97,631,740	0	0	100,591,076
3. NAIC 3 (a)	36,468,359	10,703,295	5,394,451	(1,466,454)	40,310,749	0	0	36,468,359
4. NAIC 4 (a)	6,103,546	3,067,500	1,502,206	(33,561)	7,635,279	0	0	6,103,546
5. NAIC 5 (a)	0				0			
6. NAIC 6 (a)	0				0			
7. Total Bonds	494,104,043	617,612,689	630,603,625	(1,381,067)	479,732,040	0	0	494,104,043
PREFERRED STOCK								
8. NAIC 1	0				0			
9. NAIC 2	0				0			
10. NAIC 3	0				0			
11. NAIC 4	0				0			
12. NAIC 5	0				0			
13. NAIC 6	0				0			
14. Total Preferred Stock	0	0	0	0	0	0	0	0
15. Total Bonds and Preferred Stock	494,104,043	617,612,689	630,603,625	(1,381,067)	479,732,040	0	0	494,104,043

(a) Book/Adjusted Carrying Value column for the end of the current reporting period includes the following amount of short-term and cash equivalent bonds by NAIC designation:

NAIC 1 $ 4,828,329 ; NAIC 2 $ 0 ; NAIC 3 $ 0 NAIC 4 $ 0 ; NAIC 5 $ 0 ; NAIC 6 $ 0

SCHEDULE DA - PART 1

Short-Term Investments

NONE

	1 Book/Adjusted Carrying Value	2 Par Value	3 Actual Cost	4 Interest Collected Year-to-Date	5 Paid for Accrued Interest Year-to-Date
9199999 Totals		XXX			

SCHEDULE DA - VERIFICATION

Short-Term Investments

		1 Year To Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	0	2,475
2.	Cost of short-term investments acquired		824,131
3.	Accrual of discount		
4.	Unrealized valuation increase (decrease)		
5.	Total gain (loss) on disposals		
6.	Deduct consideration received on disposals		826,606
7.	Deduct amortization of premium		
8.	Total foreign exchange change in book/adjusted carrying value		
9.	Deduct current year's other than temporary impairment recognized		
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	0	0
11.	Deduct total nonadmitted amounts		
12.	Statement value at end of current period (Line 10 minus Line 11)	0	0

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

SCHEDULE E - PART 2 - VERIFICATION

(Cash Equivalents)

		1 Year To Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	14,867,395	1,005,891
2.	Cost of cash equivalents acquired	568,130,324	2,439,590,950
3.	Accrual of discount	230,737	575,019
4.	Unrealized valuation increase (decrease)		
5.	Total gain (loss) on disposals	(58)	(470)
6.	Deduct consideration received on disposals	578,399,434	2,426,303,995
7.	Deduct amortization of premium		
8.	Total foreign exchange change in book/adjusted carrying value		
9.	Deduct current year's other than temporary impairment recognized		
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	4,828,964	14,867,395
11.	Deduct total nonadmitted amounts		
12.	Statement value at end of current period (Line 10 minus Line 11)	4,828,964	14,867,395

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE B - PART 2

Showing All Mortgage Loans ACQUIRED AND ADDITIONS MADE During the Current Quarter

1	Location		4	5	6	7	8	9
	2	3						
Loan Number	City	State	Loan Type	Date Acquired	Rate of Interest	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Value of Land and Buildings
3399999 - Totals								

NONE

SCHEDULE B - PART 3

Showing All Mortgage Loans DISPOSED, Transferred or Repaid During the Current Quarter

1	Location		4	5	6	7	Change in Book Value/Recorded Investment						14	15	16	17	18
	2	3					8	9	10	11	12	13					
Loan Number	City	State	Loan Type	Date Acquired	Disposal Date	Book Value/ Recorded Investment Excluding Accrued Interest Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Amortization) /Accretion	Current Year's Other Than Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Change in Book Value (8+9-10+11)	Total Foreign Exchange Change in Book Value	Book Value/ Recorded Investment Excluding Accrued Interest on Disposal	Consid- eration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal
2004182	GLEN BURNIE	MD		12/18/2017		6,120,406		(53)			(53)			77,543			0
2004473	MT LAUREL	NJ		12/18/2017		6,858,765		30,912			30,912						0
0299999. Mortgages with partial repayments						12,979,171	0	30,859	0	0	30,859	0	0	77,543	0	0	0
0599999 - Totals						12,979,171	0	30,859	0	0	30,859	0	0	77,543	0	0	0

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

N O N E

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

N O N E

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 3

Show All Long-Term Bonds and Stock Acquired During the Current Quarter

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends	10 NAIC Designation or Market Indicator (a)
912810-RZ-3	US TREASURY NOTE/BOND 2.750% 11/15/47		01/30/2018	MIZUHO SECURITIES USA		4,806,250	5,000,000	29,247	1
912828-3X-6	US TREASURY NOTE/BOND 2.250% 02/15/21		03/05/2018	MIZUHO SECURITIES USA		9,956,250	10,000,000	11,809	1
0599999. Subtotal - Bonds - U.S. Governments						14,762,500	15,000,000	41,056	XXX
500769-GQ-1	KREDIT FUER WIEDERAUFBAU SR UNSECURED 2.000% 05/02/25	D	03/15/2018	RBS US		1,881,840	2,000,000	15,222	1FE
910860-AV-0	UNITED MEXICAN STATES SR UNSECURED 6.050% 01/11/40	D	03/14/2018	BARCLAYS INVEST 7254		2,239,600	2,000,000	21,847	2FE
1099999. Subtotal - Bonds - All Other Governments						4,121,440	4,000,000	37,069	XXX
25476F-VK-1	COLUMBIA DIST OF SER D 5.000% 06/01/42		03/06/2018	DAIN RAUSCHER INC-69211		5,731,350	5,000,000	53,472	1FE
1799999. Subtotal - Bonds - U.S. States, Territories and Possessions						5,731,350	5,000,000	53,472	XXX
646139-Z2-4	NEW JERSEY ST TPK AUTH SER B 5.000% 01/01/20		03/01/2018	Wachovia		15,890	15,000	133	1FE
3199999. Subtotal - Bonds - U.S. Special Revenues						15,890	15,000	133	XXX
038522-AQ-1	ARAMARK SERVICES INC SR UNSECURED 5.000% 02/01/28		01/10/2018	GOLDMAN SACHS & CO		1,000,000	1,000,000	0	3FE
156700-AR-7	CENTURYTEL INC SR UNSECURED 6.450% 06/15/21		03/06/2018	CHASE SECURITIES		1,027,500	1,000,000	14,871	4FE
163851-AD-0	CHEMOURS CO SR UNSECURED 7.000% 05/15/25		01/03/2018	GOLDMAN SACHS & CO		1,092,500	1,000,000	9,722	3FE
17325F-AL-2	CITIBANK NA SR UNSECURED 2.850% 02/12/21		02/08/2018	CITIGROUP		999,940	1,000,000	0	1FE
23283P-AK-0	CYRUSONE LP/CYRUSONE FIN SR UNSECURED 5.375% 03/15/27		01/05/2018	Tax Free Exchange		1,052,670	1,000,000	16,424	3FE
25278X-AJ-8	DIAMONDBACK ENERGY INC SR UNSECURED 5.375% 05/31/25		01/24/2018	WACHOVIA		1,040,000	1,000,000	8,809	4FE
29273V-AF-7	ENERGY TRANSFER EQUITY 1ST LIEN 5.500% 06/01/27		03/16/2018	MORGAN STANLEY		1,025,000	1,000,000	16,653	3FE
53219L-AN-9	LIFEPOINT HOSPITALS INC SR UNSECURED 5.875% 12/01/23		01/31/2018	CHASE SECURITIES		1,006,250	1,000,000	9,955	3FE
59001K-AD-2	MERITOR INC SR UNSECURED 6.250% 02/15/24		03/07/2018	BARCLAY INVESTMENTS		521,875	500,000	2,083	3FE
62957H-AC-9	NABORS INDUSTRIES INC. SR UNSECURED 5.500% 01/15/23		03/01/2018	GOLDMAN SACHS & CO		995,000	1,000,000	7,639	3FE
62957H-AD-7	NABORS INDUSTRIES INC. SR UNSECURED 5.750% 02/01/25		01/17/2018	GOLDMAN SACHS & CO		998,750	1,000,000	0	3FE
86765L-AH-0	SUNOCO LP/FINANCE CORP SR UNSECURED 4.875% 01/15/23		01/10/2018	FIRST BOSTON CORP		1,006,250	1,000,000	0	3FE
86765L-AK-3	SUNOCO LP/FINANCE CORP SR UNSECURED 5.500% 02/15/26		01/10/2018	FIRST BOSTON CORP		1,005,000	1,000,000	0	3FE
912909-AN-8	US STEEL CORP SR UNSECURED 6.250% 03/15/26		03/13/2018	CHASE SECURITIES		1,000,000	1,000,000	0	4FE
958102-AM-7	WESTERN DIGITAL CORP SR UNSECURED 4.750% 02/15/26		01/30/2018	BANC AMERICA		1,000,000	1,000,000	0	3FE
984121-CQ-4	XEROX CORP SR UNSECURED 3.625% 03/15/23		01/31/2018	MORGAN STANLEY		989,740	1,000,000	14,198	2FE
034863-AU-4	ANGLO AMERICAN CAPITAL SR UNSECURED 4.500% 03/15/28	D	03/13/2018	MORGAN STANLEY		1,990,920	2,000,000	0	2FE
056752-AK-4	BAIDU INC SR UNSECURED 3.875% 09/29/23	D	03/22/2018	GOLDMAN SACHS & CO		999,020	1,000,000	0	1Z
251526-BR-9	DEUTSCHE BANK NY SR UNSECURED 3.950% 02/27/23	D	02/22/2018	DEUTSCHE BANK		1,497,105	1,500,000	0	2FE
298785-HM-1	EUROPEAN INV BANK SR UNSECURED 2.375% 05/24/27	D	03/02/2018	TD Securities (USA)		949,970	1,000,000	6,729	1FE
606817-AP-4	MIZUHO FINANCIAL GROUP SR UNSECURED 3.549% 03/05/23	D	02/28/2018	MIZUHO SECURITIES USA		2,000,000	2,000,000	0	1FE
67078A-AA-1	NVENT FINANCE SARL SR UNSECURED 3.950% 04/15/23	D	03/12/2018	BANC AMERICA		1,996,320	2,000,000	0	2FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						25,193,810	25,000,000	107,083	XXX
8399997. Total - Bonds - Part 3						49,824,990	49,015,000	238,813	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX
8399999. Total - Bonds						49,824,990	49,015,000	238,813	XXX
8999997. Total - Preferred Stocks - Part 3						0	XXX	0	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	XXX
9799997. Total - Common Stocks - Part 3						0	XXX	0	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	XXX
9999999 - Totals						49,824,990	XXX	238,813	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues .....

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation or Market In-dicator (a)
3620AM-DZ-2	GOVT NATL MTGE ASSN I POOL NO GN733720 4.500% 06/15/40		03/01/2018	Paydown		214,176	214,176	235,862	235,106	0	(20,930)	0	(20,930)	0	214,176	0	0	0	1,510	06/15/2040	1
912828-04-5	US TREASURY NOTE/BOND		03/31/2018	Maturity		16,725,000	16,725,000	16,703,440	16,702,907				0		16,725,000			0			
0599999. Subtotal - Bonds - U.S. Governments						16,939,176	16,939,176	16,939,302	16,938,013	0	(20,930)	0	(20,930)	0	16,939,176	0	0	0	1,510	XXX	XXX
486661-AG-6	KAZAKHSTAN REPUBLIC OF SR UNSECURED 5.125% 07/21/25	D	02/22/2018	MarketAxess		546,475	500,000	493,125	494,465	0	82	0	82	0	494,547	0	51,928	51,928	15,304	07/21/2025	2FE
715638-BM-3	PERU REPUBLIC OF SR UNSECURED 5.625% 11/18/50	D	01/30/2018	Deutsche Bank - 2485 DTC		630,750	500,000	593,000	591,211	0	(111)	0	(111)	0	591,100	0	39,650	39,650	5,703	11/18/2050	2FE
1099999. Subtotal - Bonds - All Other Governments						1,177,225	1,000,000	1,086,125	1,085,676	0	(29)	0	(29)	0	1,085,647	0	91,578	91,578	21,007	XXX	XXX
249174-QV-8	DENVER COLORADO CITY AND CNTY REF 5.000% 12/01/25		02/15/2018	MORGAN STANLEY		2,230,500	2,000,000	2,383,760	2,266,900	0	(9,040)	0	(9,040)	0	2,257,860	0	(27,360)	(27,360)	21,944	12/01/2025	1FE
988176-JD-6	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 5.000% 08/01/23		02/22/2018	BARCLAY INVESTMENTS		115,197	100,000	117,471	117,446	0	(458)	0	(458)	0	116,988	0	(1,791)	(1,791)	806	08/01/2023	1FE
988176-JE-4	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 5.000% 08/01/24		02/22/2018	BARCLAY INVESTMENTS		187,246	160,000	191,686	191,648	0	(697)	0	(697)	0	190,951	0	(3,705)	(3,705)	1,289	08/01/2024	1FE
988176-JF-1	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 5.000% 08/01/25		02/22/2018	BARCLAY INVESTMENTS		236,986	200,000	244,266	244,220	0	(837)	0	(837)	0	243,384	0	(6,398)	(6,398)	1,611	08/01/2025	1FE
988176-JL-8	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 3.000% 08/01/30		03/15/2018	RAMIREZ		49,375	50,000	50,751	50,750	0	(17)	0	(17)	0	50,733	0	(1,358)	(1,358)	338	08/01/2030	1FE
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						2,819,304	2,510,000	2,987,934	2,870,964	0	(11,049)	0	(11,049)	0	2,859,916	0	(40,612)	(40,612)	25,988	XXX	XXX
187154-AX-7	CLIFTON TX HGR EDU FIN CORP RE REVENUE BONDS 5.000% 03/01/20		02/15/2018	WARBURG DILLON READ		1,331,975	1,250,000	1,531,813	1,336,802	0	(5,338)	0	(5,338)	0	1,331,463	0	512	512	29,340	03/01/2020	1FE
3132WJ-DV-0	FED NATL MTGE ASSN POOL FG 044615 4.000% 10/01/46		03/01/2018	Paydown		59,761	59,761	62,600	62,533	0	(2,772)	0	(2,772)	0	59,761	0	0	0	521	10/01/2046	1
3138X8-XG-1	FED NATL MTGE ASSN POOL NO AU8778 3.000% 10/01/28		03/01/2018	Paydown		112,147	112,147	116,230	115,372	0	(3,224)	0	(3,224)	0	112,147	0	0	0	439	10/01/2028	1
57584X-8E-4	MASSACHUSETTS STATE DEV FIN REF-PARTNERS HEALTHCARE SYSTEM 5.000% 07/01/23		02/23/2018	Mesirow Financial		455,520	400,000	462,972	462,881	0	(1,697)	0	(1,697)	0	461,184	0	(5,664)	(5,664)	3,278	07/01/2023	1FE
57586P-6Q-4	MASSACHUSETTS ST HSG FIN AGY REVENUE BONDS 2.650% 12/01/41		01/26/2018	Call 100.0000		35,000	35,000	36,469	35,783	0	(11)	0	(11)	0	35,772	0	(772)	(772)	142	12/01/2041	1FE
64971W-2T-6	NEW YORK CITY NY TRANSITIONAL REVENUE BONDS 5.000% 11/01/24		02/23/2018	Aegis Capital Corp		952,596	900,000	900,000	900,000	0	0	0	0	0	900,000	0	52,596	52,596	14,500	11/01/2024	1FE
64990E-N4-5	NEW YORK ST DORM AUTH ST PREREFUNDED GEN PURPOSE SER D 5.000% 02/15/20		02/15/2018	Mesirow Financial		490,990	460,000	529,165	493,908	0	(2,137)	0	(2,137)	0	491,771	0	(781)	(781)	11,819	02/15/2020	1
67886M-MP-1	OKLAHOMA ST HSG FIN AGY SF MTG HOMEOWNERSHIP LN PG SER A 4.750% 03/01/28		03/01/2018	Call 100.0000		20,000	20,000	21,557	20,502	0	(15)	0	(15)	0	20,488	0	(488)	(488)	396	03/01/2028	1FE
68276F-AK-6	ONONDAGA CNTY NY TRUST CULTURA SYRACUSE UNIV PROJ - SER B 5.000% 12/01/19		03/01/2018	WARBURG DILLON READ		529,825	500,000	608,905	532,642	0	(2,994)	0	(2,994)	0	529,648	0	177	177	6,528	12/01/2019	1FE
74265L-UY-2	PRIVATE COLLEGES & UNIVS AUTH REVENUE BONDS 5.000% 09/01/19		03/02/2018	MORGAN STANLEY		325,884	310,000	388,002	329,481	0	(2,088)	0	(2,088)	0	327,393	0	(1,509)	(1,509)	7,965	09/01/2019	1FE
927781-A6-1	VIRGINIA COLLEGE BLDG AUTH VA REVENUE BONDS 5.000% 09/01/19		02/21/2018	Wachovia		526,390	500,000	624,030	530,224	0	(2,587)	0	(2,587)	0	527,637	0	(1,247)	(1,247)	11,944	09/01/2019	1FE
927793-D2-2	VIRGINIA TRANSPORTATION REF SER A 5.000% 05/15/24		03/16/2018	JPM-CHASE		1,159,650	1,000,000	1,176,570	1,175,343	0	(5,688)	0	(5,688)	0	1,169,655	0	(10,005)	(10,005)	13,333	05/15/2024	1FE
3199999. Subtotal - Bonds - U.S. Special Revenues						5,999,738	5,546,908	6,458,313	5,995,471	0	(28,551)	0	(28,551)	0	5,966,919	0	32,819	32,819	100,205	XXX	XXX
00130H-BU-8	AES CORP SR UNSECURED 5.500% 03/15/24		03/21/2018	Corporate Actions		503,275	491,000	466,450	471,639	0	615	0	615	0	472,254	0	31,021	31,021	13,953	03/15/2024	3FE
030981-AH-7	AMERIGAS PARTNERS LP SR UNSECURED 5.625% 05/20/24		02/14/2018	SUNTRUST CAP MARKETS		501,250	500,000	522,500	516,927	2,033	(340)	0	1,693	0	518,620	0	(17,370)	(17,370)	6,719	05/20/2024	3FE
042735-BB-5	ARROW ELECTRONICS INC SR UNSECURED 3.000% 03/01/18		03/01/2018	Maturity		500,000	500,000	505,080	500,174	0	(174)	0	(174)	0	500,000	0	0	0	7,500	03/01/2018	2FE
084664-CE-9	BERKSHIRE HATHAWAY FIN SR UNSECURED 1.450% 03/07/18		03/07/2018	Maturity		1,500,000	1,500,000	1,499,415	1,499,926	0	74	0	74	0	1,500,000	0	0	0	10,875	03/07/2018	1FE
198280-AB-5	COLUMBIA PIPELINE GROUP SR UNSECURED 2.450% 06/01/18		03/15/2018	US BANCORP		999,240	1,000,000	1,006,169	1,001,258	0	(674)	0	(674)	0	1,000,584	0	(1,344)	(1,344)	7,350	06/01/2018	2FE
20826F-AS-5	CONOCOPHILLIPS COMPANY SR UNSECURED 4.200% 03/15/21		01/22/2018	Call 104.8680		838,944	800,000	799,600	799,697	0	10	0	10	0	799,708	0	292	292	50,797	03/15/2021	1FE

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation or Market In-dicator (a)
21036P-AH-1	CONSTELLATION BRANDS INC SR UNSECURED 6.000% 05/01/22		02/28/2018	Call 111.7638		480,584	430,000	466,013	450,060	0	(665)	0	(665)	0	449,395	0	(19,395)	(19,395)	58,969	05/01/2022	2FE
23283P-AK-0	CYRUSONE LP/CYRUSONE FIN SR UNSECURED 5.375% 03/15/27		01/29/2018	MORGAN STANLEY		1,040,000	1,000,000	1,052,670	0	0	(434)	0	(434)	0	1,052,236	0	(12,236)	(12,236)	20,306	03/15/2027	3FE
23283P-AN-4	CYRUSONE LP/CYRUSONE FIN SR UNSECURED 5.375% 03/15/27		01/05/2018	Tax Free Exchange		1,052,670	1,000,000	1,053,750	1,049,234	3,504	(68)	0	3,436	0	1,052,670	0	0	0	16,424	03/15/2027	3FE
25272K-AD-5	DIAMOND 1 FIN / DIAMOND 2 PRIVATE PLACEMENT 4.420% 06/15/21		01/09/2018	GOLDMAN SACHS & CO		2,080,420	2,000,000	1,999,420	1,999,578	0	(18)	0	(18)	0	1,999,560	0	80,860	80,860	6,384	06/15/2021	2FE
38141G-FG-4	GOLDMAN SACHS GROUP SR UNSECURED 5.950% 01/18/18		01/18/2018	Maturity		1,500,000	1,500,000	1,672,095	1,501,952	0	(1,952)	0	(1,952)	0	1,500,000	0	0	0	44,625	01/18/2018	1FE
55342U-AG-9	MTP OPER PARTNERSHIP/FINL SR UNSECURED 5.250% 08/01/26		03/05/2018	MORGAN STANLEY		991,250	1,000,000	1,040,000	1,038,626	0	(935)	0	(935)	0	1,037,691	0	(46,441)	(46,441)	31,500	08/01/2026	3FE
553794-AA-6	MUFG AMERICAS HLDGS CORP SR UNSECURED 1.625% 02/09/18		02/09/2018	Maturity		1,000,000	1,000,000	999,330	999,965	0	35	0	35	0	1,000,000	0	0	0	8,125	02/09/2018	1FE
58769B-AD-6	MERCEDES-BENZ AUTO RECEIVABLES SERIES 16-1 CLASS A3 1.260% 02/16/21		01/17/2018	WACHOVIA		4,961,722	5,000,000	4,999,391	4,999,718	0	13	0	13	0	4,999,731	0	(38,012)	(38,012)	5,950	02/16/2021	1FE
64110L-AP-1	NETFLIX INC SR UNSECURED 4.875% 04/15/28		01/23/2018	FIRST BOSTON CORP		992,500	1,000,000	1,000,000	979,406	20,594	0	0	20,594	0	1,000,000	0	(7,500)	(7,500)	12,052	04/15/2028	4FE
690872-AA-4	OWENS-BROCKWAY SR UNSECURED 5.000% 01/15/22		01/25/2018	DEUTSCHE BANK		523,125	500,000	503,750	502,245	0	(39)	0	(39)	0	502,206	0	20,920	20,920	7,222	01/15/2022	4FE
771196-BA-9	ROCHE HLDGS INC SR UNSECURED 2.250% 09/30/19		01/16/2018	BARCLAY INVESTMENTS		999,490	1,000,000	998,540	999,455	0	15	0	15	0	999,470	0	20	20	6,750	09/30/2019	1FE
87264A-AT-2	T MOBILE USA INC SR UNSECURED 5.375% 04/15/27		01/08/2018	DEUTSCHE BANK		268,750	250,000	261,875	261,012	0	(32)	0	(32)	0	260,980	0	7,770	7,770	3,173	04/15/2027	3FE
92347X-AA-4	VERIZON OWNER TRUST SERIES 16-1A CLASS A 1.420% 01/20/21		01/10/2018	WACHOVIA		992,461	1,000,000	999,832	999,924	0	2	0	2	0	999,926	0	(7,465)	(7,465)	868	01/20/2021	1FE
92936Y-AF-8	WF-RBS COMMERCIAL MTGE TRUST SERIES 2012-C8 CLASS B 4.311% 08/15/45		03/06/2018	Baird (Robert W)		511,523	500,000	541,250	533,210	0	(1,314)	0	(1,314)	0	531,896	0	(20,372)	(20,372)	5,808	08/15/2045	1FM
94974B-FG-0	WELLS FARGO CO SR UNSECURED 1.500% 01/16/18		01/16/2018	Maturity		1,000,000	1,000,000	969,030	999,680	0	320	0	320	0	1,000,000	0	0	0	7,500	01/16/2018	1FE
958102-AJ-4	WESTERN DIGITAL CORP SECURED 7.375% 04/01/23		03/01/2018	Call 108.7260		1,630,890	1,500,000	1,523,125	1,515,731	0	2,025	0	2,025	0	1,517,756	0	(17,756)	(17,756)	176,984	04/01/2023	2FE
958102-AM-7	WESTERN DIGITAL CORP SR UNSECURED 4.750% 02/15/26		03/16/2018	CITIGROUP		1,002,500	1,000,000	1,000,000	0	0	0	0	0	0	1,000,000	0	2,500	2,500	4,882	02/15/2026	3FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						25,870,594	25,471,000	25,879,285	23,619,417	26,131	(3,536)	0	22,595	0	25,694,683	0	(44,508)	(44,508)	514,716	XXX	XXX
8399997. Total - Bonds - Part 4						52,806,037	51,467,084	53,350,959	50,509,541	26,131	(64,095)	0	(37,964)	0	52,546,341	0	39,277	39,277	663,426	XXX	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8399999. Total - Bonds						52,806,037	51,467,084	53,350,959	50,509,541	26,131	(64,095)	0	(37,964)	0	52,546,341	0	39,277	39,277	663,426	XXX	XXX
8999997. Total - Preferred Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799997. Total - Common Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9999999 - Totals						52,806,037	XXX	53,350,959	50,509,541	26,131	(64,095)	0	(37,964)	0	52,546,341	0	39,277	39,277	663,426	XXX	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues.....

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

SCHEDULE E - PART 1 - CASH

Month End Depository Balances

1	2	3	4	5	Book Balance at End of Each Month During Current Quarter			9
					6	7	8	
Depository	Code	Rate of Interest	Amount of Interest Received During Current Quarter	Amount of Interest Accrued at Current Statement Date	First Month	Second Month	Third Month	*
Bank of America Charlotte, NC					4,180,790	2,038,953	5,605,491	XXX
0199998. Deposits in 2 depositories that do not exceed the allowable limit in any one depository (See instructions) - Open Depositories	XXX	XXX			(182,830)	(145,701)	(81,451)	XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	3,997,960	1,893,252	5,524,040	XXX
0299998. Deposits in depositories that do not exceed the allowable limit in any one depository (See instructions) - Suspended Depositories	XXX	XXX						XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	3,997,960	1,893,252	5,524,040	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX				XXX
0599999. Total - Cash	XXX	XXX	0	0	3,997,960	1,893,252	5,524,040	XXX

STATEMENT AS OF MARCH 31, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned End of Current Quarter

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
0599999. Total - U.S. Government Bonds						0	0	0
1099999. Total - All Other Government Bonds						0	0	0
1799999. Total - U.S. States, Territories and Possessions Bonds						0	0	0
2499999. Total - U.S. Political Subdivisions Bonds						0	0	0
3199999. Total - U.S. Special Revenues Bonds						0	0	0
	AUTOZONE INC 4-2 CP		03/28/2018	2.310	04/10/2018	477,723	0	123
	NISOURCE INC CP 4(2) 144A		03/26/2018	2.450	04/13/2018	2,803,708	0	1,145
	SPIRE INC CP 4(2) 144A		03/29/2018	2.330	04/12/2018	1,546,898	0	300
3299999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations						4,828,329	0	1,568
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						4,828,329	0	1,568
4899999. Total - Hybrid Securities						0	0	0
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0
6099999. Subtotal - SVO Identified Funds						0	0	0
7799999. Total - Issuer Obligations						4,828,329	0	1,568
7899999. Total - Residential Mortgage-Backed Securities						0	0	0
7999999. Total - Commercial Mortgage-Backed Securities						0	0	0
8099999. Total - Other Loan-Backed and Structured Securities						0	0	0
8199999. Total - SVO Identified Funds						0	0	0
8399999. Total Bonds						4,828,329	0	1,568
60934N-50-0	FEDERATED INVESTORS INC TREASURY OBLIGATION FUND		03/22/2018	0.000	XXX	635	11	24
8599999. Subtotal - Exempt Money Market Mutual Funds - as Identified by the SVO						635	11	24
8899999 - Total Cash Equivalents						4,828,964	11	1,592

Aetna Better Health® of Kentucky Q3 2018 Statement

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QUARTERLY STATEMENT

OF THE

Aetna Better Health of Kentucky Insurance Company

TO THE

Insurance Department

OF THE

STATE OF

FOR THE QUARTER ENDED
SEPTEMBER 30, 2018

HEALTH

2018

QUARTERLY STATEMENT

AS OF SEPTEMBER 30, 2018
OF THE CONDITION AND AFFAIRS OF THE

Aetna Better Health of Kentucky Insurance Company

NAIC Group Code 0001 (Current) 0001 (Prior) NAIC Company Code 15761 Employer's ID Number 47-3279217

Organized under the Laws of Kentucky, State of Domicile or Port of Entry KY

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health

Is HMO Federally Qualified? Yes [ ] No [ ]

Incorporated/Organized 02/24/2015 Commenced Business 02/01/2016

Statutory Home Office 9900 Corporate Campus Dr., Suite 1000 (Street and Number), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Main Administrative Office 9900 Corporate Campus Dr., Suite 1000 (Street and Number)
Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Mail Address 9900 Corporate Campus Dr., Suite 1000 (Street and Number or P.O. Box), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 9900 Corporate Campus Dr., Suite 1000 (Street and Number)
Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Internet Website Address www.aetnabetterhealth.com

Statutory Statement Contact Scott David Miller (Name), 717-671-2474 (Area Code) (Telephone Number)
StatutoryReporting@aetna.com (E-mail Address), 717-526-2888 (FAX Number)

OFFICERS

Chief Executive Officer and President Laurie Ann Brubaker
Corporate Controller Scott David Miller
Vice President and Secretary Robert Mark Kessler

OTHER

Debra Jean Bacon, Vice President and Assistant Treasurer
Kevin James Casey, Senior Investment Officer
Frank Ferris Chronister III, Assistant Controller
John Patrick Maroney, Vice President and Treasurer

DIRECTORS OR TRUSTEES

Laurie Ann Brubaker
Debra Jean Bacon
Jonathan Edward Copley

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Laurie Ann Brubaker Chief Executive Officer and President	Robert Mark Kessler Vice President and Secretary	Scott David Miller Corporate Controller
State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa	State of..... Pennsylvania County of..... Montgomery
Subscribed and sworn to before me this 29 day of October, 2018	Subscribed and sworn to before me this 24 day of October, 2018	Subscribed and sworn to before me this 1st day of November, 2018
NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)

JANEEN NEWHOUSE
Notary Public, State of Arizona
Maricopa County
My Commission Expires
February 08, 2019

JANEEN NEWHOUSE
Notary Public, State of Arizona
Maricopa County
My Commission Expires
February 08, 2019

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
KIM E. ROTH, Notary Public
Whitpain Township, Montgomery County
My Commission Expires April 25, 2021

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number .....
2. Date filed .....
3. Number of pages attached.....

ASSETS

	Current Statement Date 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 December 31 Prior Year Net Admitted Assets
1. Bonds	431,501,249	0	431,501,249	479,236,865
2. Stocks:				
2.1 Preferred stocks	0	0	0	0
2.2 Common stocks	0	0	0	0
3. Mortgage loans on real estate:				
3.1 First liens	13,279,236	0	13,279,236	12,979,171
3.2 Other than first liens	0	0	0	
4. Real estate:				
4.1 Properties occupied by the company (less $ ..... encumbrances)	0	0	0	
4.2 Properties held for the production of income (less $ ..... encumbrances)	0	0	0	
4.3 Properties held for sale (less $ ..... encumbrances)	0	0	0	
5. Cash ($ 2,679,643), cash equivalents ($ 41,250,426) and short-term investments ($ .....)	43,930,069	0	43,930,069	14,204,888
6. Contract loans (including $ ..... premium notes)	0	0	0	
7. Derivatives		0	0	0
8. Other invested assets			0	0
9. Receivables for securities	9,259,023	0	9,259,023	524,756
10. Securities lending reinvested collateral assets		0	0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	497,969,577	0	497,969,577	506,945,680
13. Title plants less $ ..... charged off (for Title insurers only)	0	0	0	
14. Investment income due and accrued	4,093,010	0	4,093,010	4,135,426
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	5,018,020	0	5,018,020	1,847,707
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ ..... earned but unbilled premiums)	0	0	0	
15.3 Accrued retrospective premiums ($ .....) and contracts subject to redetermination ($ .....)	0	0	0	
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	0	0	0	
16.2 Funds held by or deposited with reinsured companies	0	0	0	
16.3 Other amounts receivable under reinsurance contracts	0	0	0	
17. Amounts receivable relating to uninsured plans	0	0	0	
18.1 Current federal and foreign income tax recoverable and interest thereon	4,793,852	0	4,793,852	
18.2 Net deferred tax asset	9,978,560	141,699	9,836,861	9,836,861
19. Guaranty funds receivable or on deposit	0	0	0	
20. Electronic data processing equipment and software	0	0	0	
21. Furniture and equipment, including health care delivery assets ($ .....)	0	0	0	
22. Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	
23. Receivables from parent, subsidiaries and affiliates	27,442	0	27,442	2,265,089
24. Health care ($ 2,267,246) and other amounts receivable	16,018,650	13,751,404	2,267,246	1,758,384
25. Aggregate write-ins for other than invested assets	500,000	500,000	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	538,399,111	14,393,103	524,006,008	526,789,148
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	
28. Total (Lines 26 and 27)	538,399,111	14,393,103	524,006,008	526,789,148
DETAILS OF WRITE-INS				
1101.	0	0	0	0
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Deposits	500,000	500,000	0	0
2502.	0	0	0	0
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	500,000	500,000	0	0

LIABILITIES, CAPITAL AND SURPLUS

		Current Period			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ ..... reinsurance ceded)	130,275,562	5,665,122	135,940,684	159,039,981
2.	Accrued medical incentive pool and bonus amounts	743,544	0	743,544	190,629
3.	Unpaid claims adjustment expenses	2,109,596	0	2,109,596	3,072,860
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Service Act	4,185,848	0	4,185,848	0
5.	Aggregate life policy reserves	0	0	0	
6.	Property/casualty unearned premium reserve	0	0	0	
7.	Aggregate health claim reserves	0	0	0	0
8.	Premiums received in advance	7,116,655	0	7,116,655	31,811,757
9.	General expenses due or accrued	31,362,052	0	31,362,052	12,641,664
10.1	Current federal and foreign income tax payable and interest thereon (including $ ..... on realized gains (losses))	0	0	0	8,105,131
10.2	Net deferred tax liability	0	0	0	
11.	Ceded reinsurance premiums payable	0	0	0	
12.	Amounts withheld or retained for the account of others	0	0	0	
13.	Remittances and items not allocated	2,339,852	0	2,339,852	2,849,167
14.	Borrowed money (including $ ..... current) and interest thereon $ ..... (including $ ..... current)	0	0	0	
15.	Amounts due to parent, subsidiaries and affiliates	40,420,140	0	40,420,140	45,303,713
16.	Derivatives	0	0	0	
17.	Payable for securities	0	0	0	
18.	Payable for securities lending	0	0	0	
19.	Funds held under reinsurance treaties (with $ ..... authorized reinsurers, $ ..... unauthorized reinsurers and $ ..... certified reinsurers)	0	0	0	
20.	Reinsurance in unauthorized and certified ($ .....) companies	0	0	0	
21.	Net adjustments in assets and liabilities due to foreign exchange rates		0	0	
22.	Liability for amounts held under uninsured plans	0	0	0	
23.	Aggregate write-ins for other liabilities (including $ ..... current)	948,251	0	948,251	1,851,899
24.	Total liabilities (Lines 1 to 23)	219,501,500	5,665,122	225,166,622	264,866,801
25.	Aggregate write-ins for special surplus funds	XXX	XXX	0	22,555,000
26.	Common capital stock	XXX	XXX	1,000,000	1,000,000
27.	Preferred capital stock	XXX	XXX	0	
28.	Gross paid in and contributed surplus	XXX	XXX	99,010,001	99,010,001
29.	Surplus notes	XXX	XXX	0	
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31.	Unassigned funds (surplus)	XXX	XXX	198,829,385	139,357,346
32.	Less treasury stock, at cost:				
	32.1 ..... shares common (value included in Line 26 $ .....)	XXX	XXX	0	
	32.2 ..... shares preferred (value included in Line 27 $ .....)	XXX	XXX	0	
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	298,839,386	261,922,347
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	524,006,008	526,789,148
	DETAILS OF WRITE-INS				
2301.	Escheat Payable	948,251	0	948,251	1,851,899
2302.					
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399.	Totals (Lines 2301 through 2303 plus 2398)(Line 23 above)	948,251	0	948,251	1,851,899
2501.	Estimated Health Insurance Fee accrual	XXX	XXX	0	22,555,000
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	XXX	XXX	0	22,555,000
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099.	Totals (Lines 3001 through 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year To Date		Prior Year To Date	Prior Year Ended December 31
		1 Uncovered	2 Total	3 Total	4 Total
1.	Member Months	XXX	2,101,101	2,283,791	3,018,365
2.	Net premium income (including $ ..... non-health premium income)	XXX	837,213,717	800,566,626	1,092,625,603
3.	Change in unearned premium reserves and reserve for rate credits	XXX	(4,185,848)	31,898,076	31,898,076
4.	Fee-for-service (net of $ ..... medical expenses)	XXX	0		0
5.	Risk revenue	XXX	0		0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0	0
8.	Total revenues (Lines 2 to 7)	XXX	833,027,869	832,464,702	1,124,523,679
	Hospital and Medical:				
9.	Hospital/medical benefits	18,862,233	452,619,480	458,102,417	609,008,492
10.	Other professional services	1,361,100	32,661,056	35,573,998	49,453,749
11.	Outside referrals	0	0		0
12.	Emergency room and out-of-area	2,579,011	61,886,135	70,086,773	89,732,481
13.	Prescription drugs	0	162,176,682	162,829,671	220,118,361
14.	Aggregate write-ins for other hospital and medical	0	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts	0	552,915		(7,740,581)
16.	Subtotal (Lines 9 to 15)	22,802,344	709,896,268	726,592,859	960,572,502
	Less:				
17.	Net reinsurance recoveries	0	0		0
18.	Total hospital and medical (Lines 16 minus 17)	22,802,344	709,896,268	726,592,859	960,572,502
19.	Non-health claims (net)	0	0		
20.	Claims adjustment expenses, including $ 19,448,142 cost containment expenses	0	20,973,102	20,246,526	28,389,145
21.	General administrative expenses	0	73,533,368	55,216,894	69,029,357
22.	Increase in reserves for life and accident and health contracts (including $ ..... increase in reserves for life only)	0	0		0
23.	Total underwriting deductions (Lines 18 through 22)	22,802,344	804,402,738	802,056,279	1,057,991,004
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	28,625,131	30,408,423	66,532,675
25.	Net investment income earned	0	12,452,843	11,061,955	14,019,102
26.	Net realized capital gains (losses) less capital gains tax of $ (284,503)	0	(2,505,475)	363,626	637,847
27.	Net investment gains (losses) (Lines 25 plus 26)	0	9,947,368	11,425,581	14,656,949
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $ .....) (amount charged off $ .....)]	0	0		
29.	Aggregate write-ins for other income or expenses	0	(3,014,116)	0	(4,535,812)
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	35,558,383	41,834,004	76,653,812
31.	Federal and foreign income taxes incurred	XXX	9,822,467	12,726,355	20,912,254
32.	Net income (loss) (Lines 30 minus 31)	XXX	25,735,916	29,107,649	55,741,558
	DETAILS OF WRITE-INS				
0601.		XXX			
0602.		XXX			
0603.		XXX			
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)	XXX	0	0	0
0701.		XXX			
0702.		XXX			
0703.		XXX			
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798)(Line 7 above)	XXX	0	0	0
1401.					
1402.					
1403					
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498)(Line 14 above)	0	0	0	0
2901.	Regulatory penalties	0	(3,014,116)	0	(4,535,812)
2902.					
2903					
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998)(Line 29 above)	0	(3,014,116)	0	(4,535,812)

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year to Date	2 Prior Year to Date	3 Prior Year Ended December 31
	CAPITAL AND SURPLUS ACCOUNT			
33.	Capital and surplus prior reporting year	261,922,348	213,442,922	213,442,922
34.	Net income or (loss) from Line 32	25,735,916	29,107,649	55,741,558
35.	Change in valuation basis of aggregate policy and claim reserves	0		
36.	Change in net unrealized capital gains (losses) less capital gains tax of $ (90,788)	(341,536)	178,965	148,249
37.	Change in net unrealized foreign exchange capital gain or (loss)	0		
38.	Change in net deferred income tax	(90,788)	2,183,678	(7,178,803)
39.	Change in nonadmitted assets	11,613,446	(3,620,727)	(231,579)
40	Change in unauthorized and certified reinsurance	0	0	0
41.	Change in treasury stock	0	0	0
42.	Change in surplus notes	0	0	0
43.	Cumulative effect of changes in accounting principles	0		
44.	Capital Changes:			
	44.1 Paid in	0	990,000	990,000
	44.2 Transferred from surplus (Stock Dividend)	0		
	44.3 Transferred to surplus	0		
45.	Surplus adjustments:			
	45.1 Paid in	0	(990,000)	(990,000)
	45.2 Transferred to capital (Stock Dividend)	0		
	45.3 Transferred from capital	0		
46.	Dividends to stockholders	0		
47.	Aggregate write-ins for gains or (losses) in surplus	0	0	0
48.	Net change in capital & surplus (Lines 34 to 47)	36,917,038	27,849,565	48,479,426
49.	Capital and surplus end of reporting period (Line 33 plus 48)	298,839,386	241,292,487	261,922,348
	DETAILS OF WRITE-INS			
4701.				
4702.				
4703.				
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798)(Line 47 above)	0	0	0

CASH FLOW

	1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
Cash from Operations			
1. Premiums collected net of reinsurance	809,348,302	824,533,245	1,125,954,663
2. Net investment income	14,545,547	14,060,325	17,511,807
3. Miscellaneous income	0	0	0
4. Total (Lines 1 to 3)	823,893,849	838,593,570	1,143,466,470
5. Benefit and loss related payments	721,372,612	778,038,792	1,002,057,647
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts			
7. Commissions, expenses paid and aggregate write-ins for deductions	79,763,463	80,606,198	103,782,491
8. Dividends paid to policyholders			
9. Federal and foreign income taxes paid (recovered) net of $ ..... tax on capital gains (losses)	22,436,947	23,970,341	27,025,769
10. Total (Lines 5 through 9)	823,573,022	882,615,331	1,132,865,907
11. Net cash from operations (Line 4 minus Line 10)	320,827	(44,021,761)	10,600,563
Cash from Investments			
12. Proceeds from investments sold, matured or repaid:			
12.1 Bonds	171,021,350	87,661,802	116,787,533
12.2 Stocks	0	0	0
12.3 Mortgage loans	236,016	0	0
12.4 Real estate	0	0	0
12.5 Other invested assets	0	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	128	0	(470)
12.7 Miscellaneous proceeds	34,419	22,079	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	171,291,913	87,683,881	116,787,063
13. Cost of investments acquired (long-term only):			
13.1 Bonds	128,651,606	17,803,802	69,990,769
13.2 Stocks	0	0	0
13.3 Mortgage loans	442,927	0	12,979,171
13.4 Real estate	0	0	0
13.5 Other invested assets	0	0	0
13.6 Miscellaneous applications	8,734,267	0	494,470
13.7 Total investments acquired (Lines 13.1 to 13.6)	137,828,800	17,803,802	83,464,410
14. Net increase (or decrease) in contract loans and premium notes	0	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	33,463,113	69,880,079	33,322,653
Cash from Financing and Miscellaneous Sources			
16. Cash provided (applied):			
16.1 Surplus notes, capital notes	0	0	0
16.2 Capital and paid in surplus, less treasury stock	0	0	0
16.3 Borrowed funds	0	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0	0
16.5 Dividends to stockholders	0	0	0
16.6 Other cash provided (applied)	(4,058,760)	(49,124,581)	(34,496,987)
17. Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	(4,058,760)	(49,124,581)	(34,496,987)
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS			
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	29,725,180	(23,266,263)	9,426,229
19. Cash, cash equivalents and short-term investments:			
19.1 Beginning of year	14,204,889	4,778,660	4,778,660
19.2 End of period (Line 18 plus Line 19.1)	43,930,069	(18,487,604)	14,204,889

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001. Non-Cash Transaction- Tax Free Acquisition	4,051,498	12,655,315	12,655,315

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
	Total	2 Individual	3 Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	243,019	20,142	0	0	0	0	0	0	222,877	0
2. First Quarter	236,325	19,852	0	0	0	0	0	0	216,473	0
3. Second Quarter	230,822	19,709	0	0	0	0	0	0	211,113	0
4. Third Quarter	231,881	8,490							223,391	
5. Current Year	0									
6. Current Year Member Months	2,101,101	137,096							1,964,005	
Total Member Ambulatory Encounters for Period:										
7 Physician	1,244,713	68,776							1,175,937	
8. Non-Physician	717,004	24,765							692,239	
9. Total	1,961,717	93,541	0	0	0	0	0	0	1,868,176	0
10. Hospital Patient Days Incurred	59,087	575							58,512	
11. Number of Inpatient Admissions	13,011	134							12,877	
12. Health Premiums Written (a)	837,213,717	22,614,777							814,598,940	
13. Life Premiums Direct	0	0							0	
14. Property/Casualty Premiums Written	0	0							0	
15. Health Premiums Earned	833,027,869	22,476,066							810,551,803	
16. Property/Casualty Premiums Earned	0	0							0	
17. Amount Paid for Provision of Health Care Services	729,051,646	23,369,013							705,682,633	
18. Amount Incurred for Provision of Health Care Services	709,896,268	21,114,104							688,782,164	

(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ 0

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Claims Unpaid (Reported)						
0299999 Aggregate accounts not individually listed-uncovered	334,681	5,855	6,720	(1,947)	294,362	639,671
0399999 Aggregate accounts not individually listed-covered	12,298,874	128,818	(129,892)	34,034	2,378,099	14,709,933
0499999 Subtotals	12,633,555	134,673	(123,172)	32,087	2,672,461	15,349,604
0599999 Unreported claims and other claim reserves						120,591,080
0699999 Total amounts withheld						0
0799999 Total claims unpaid						135,940,684
0899999 Accrued medical incentive pool and bonus amounts						743,544

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid Year to Date		Liability End of Current Quarter		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid Dec. 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)	2,505,548	20,844,722	186,440	2,818,534	2,691,988	5,259,881
2. Medicare Supplement	0	0	0	0	0	0
3. Dental Only	0	0	0	0	0	0
4. Vision Only	0	0	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0	0	0
6. Title XVIII - Medicare	0	0	0	0	0	0
7 Title XIX - Medicaid	93,755,352	611,946,022	15,621,175	117,314,535	109,376,527	153,780,101
8. Other health	0	0	0	0	0	0
9. Health subtotal (Lines 1 to 8)	96,260,900	632,790,744	15,807,615	120,133,069	112,068,515	159,039,982
10. Healthcare receivables (a)	7,834,727	8,183,924	0	0	7,834,727	19,409,658
11. Other non-health	0	0	0	0	0	0
12. Medical incentive pools and bonus amounts	0	0	117,153	626,391	117,153	190,629
13. Totals (Lines 9-10+11+12)	88,426,173	624,606,820	15,924,768	120,759,460	104,350,941	139,820,953

(a) Excludes $ ..... loans or advances to providers not yet expensed.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying statutory financial statements of Aetna Better Health of Kentucky Insurance Co (the "Company), a wholly-owned subsidiary of Coventry Health & Life Insurance Co. ('CH&L'), whose ultimate parent is Aetna Inc. ("Aetna"), have been prepared in conformity with accounting practices prescribed or permitted by the Commonwealth of Kentucky Department of Insurance (KY DOI) The Commonwealth of Kentucky recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP").

A reconciliation of the Company's net income and surplus between NAIC SAP and practices prescribed and permitted by the Commonwealth of Kentucky for the periods ended September 30, 2018 and December 31, 2017 is as follows:

		SSAP #	F/S Page	F/S Line #	2018	2017
NET INCOME						
(1)	State basis (Page 4, Line 32, Columns 2 & 4)	XXX	XXX	XXX	25,735,916	55,741,558
(2)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
(3)	State Permitted Practices that increase/(decrease) NAIC SAP:					
(4)	NAIC SAP (1-2-3=4)	XXX	XXX	XXX	25,735,916	55,741,558
	SURPLUS					
(5)	State basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	298,839,386	261,922,347
(6)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
(7)	State Permitted Practices that increase/(decrease) NAIC SAP:					
(8)	NAIC SAP (5-6-7=8)	XXX	XXX	XXX	298,839,386	261,922,347

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of these financial statements in conformity with Kentucky Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenues and expenses. Actual results could differ from those estimates.

C. Accounting Policies

(1) through (5) - No significant change.

(6) Securities Lending

The Company engages in securities lending by lending certain securities from its investment portfolio to other institutions for short periods of time. Borrowers must post cash collateral in the amount of 102% to 105% of the fair value of a loaned security. The fair value of the loaned securities is monitored on a daily basis, with additional collateral obtained or refunded as the fair value of the loaned securities fluctuates. The collateral is retained and invested by a lending agent according to the Company's guidelines to generate additional investment income for the Company. Pursuant to Statements of Statutory Accounting Principles ("SSAP") No. 103R - *Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* ("SSAP No. 103R"), collateral required under the Company's securities lending program is carried on the Company's Statutory Statements of Assets and Liabilities, Capital and Surplus as both a receivable and payable. Also pursuant to SSAP No. 103R, if the collateral received from a counterparty is less than 100 percent at the reporting date, the difference between the actual collateral and 100 percent is nonadmitted. Collateral value is measured and compared to the loaned securities in aggregate by counterparty. The Company did not have any loaned securities at September 30, 2018.

(7) through (21) - No significant change.

D. Going Concern

As of November 13, 2018, management has evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

2. Accounting Changes and Corrections of Errors

The Company did not have any accounting changes or corrections of errors in the period ended September 30, 2018.

3. Business Combinations and Goodwill

No significant change.

4. Discontinued Operations

No significant change.

5. Investments

A. - C: No significant change.

D. Loan-Backed Securities

(1) Prepayment assumptions for single class and multi-class mortgage backed/asset backed securities were obtained from industry market sources.

(2) The Company had no other-than-temporary impairment ("OTTI") losses during the third quarter of 2018 on loan-backed and structured securities in which the Company had the (1) intent to sell, (2) did not have the intent and ability to retain for a period of time sufficient to recover the amortized cost basis or (3) present value of cash flows expected to be collected is less than the amortized cost basis of the securities in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 43R, *Loan-Backed and Structured Securities* ("SSAP No. 43R").

(3) The Company had no recognized OTTI on loan-backed and structured securities currently held, in which the present value of cash flows expected to be collected is less than the amortized cost basis, at the reporting date September 30, 2018.

(4) The Company's unrealized loss position on loan-backed and structured securities held by the Company at September 30, 2018 is as follows:

a. The aggregate amount of unrealized losses:		
1. Less than 12 Months	$	63,565
2. 12 Months or Longer	$	823,001
b. The aggregate related fair value of securities with unrealized losses:		
1. Less than 12 Months	$	6,028,697
2. 12 Months or Longer	$	16,413,110

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

(1) and (2): No significant change.

(3) Neither the Company nor its agent has accepted collateral that is permitted by contract or custom to sell or repledge as of September 30, 2018.

(4) through (7): No significant change.

F. The Company did not have any repurchase agreements transactions accounted for as secured borrowing at September 30, 2018.

G. The Company did not have any reverse repurchase agreements transactions accounted for as secured at September 30, 2018.

H. The Company did not have any repurchase agreements transactions accounted for as a sale at September 30, 2018.

I. The Company did not have any reverse repurchase agreements transactions accounted for as a sale at

September 30, 2018.

J. through L: No significant change.

M. The Company did not have any working capital finance investments at September 30, 2018.

N. The Company did not have any offsetting and netting of financial assets or liabilities at September 30, 2018.

O. through R: No significant change.

6. Joint Ventures, Partnerships and Limited Liability Companies

No significant change.

7. Investment Income

No significant change.

8. Derivative Instruments

No significant change.

9. Income Taxes

No significant change.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

No significant change.

11. Debt

A. The Company did not have any items related to debt, including capital notes at September 30, 2018.

B. The Company did not have any Federal Home Loan Bank agreements at September 30, 2018.

12. Retirement Plans, Deferred Compensation Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

The Company did not have a retirement plan, deferred compensation plan, or other postretirement benefit plan at September 30, 2018.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

No significant change.

14. Liabilities, Contingencies and Assessments

No significant change.

15. Leases

No significant change.

16. Information About Financial Instruments With Off-Balance Sheet Risk and Financial Instruments With Concentrations of Credit Risk

No significant change.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

No significant change.

B. Transfer and Servicing of Financial Assets

(1) No significant change.

(2) and (3): The Company did not have any servicing assets or liabilities at September 30, 2018.

(4) The Company did not have any securitized financial assets at September 30, 2018.

(5) through (7): No significant change.

C. Wash Sales

(1) The Company did not have any wash sales for the period ended September 30, 2018.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

No significant change.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No significant change.

20. Fair Value Measurements

A. and B.

The Company had no material assets or liabilities measured and reported at fair value at September 30, 2018

C. Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

Level 1 - Unadjusted quoted prices for identical assets or liabilities in active markets.

Level 2 - Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.

Level 3 - Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The carrying values and estimated fair values of the Company's financial instruments at September 30, 2018 were as follows:

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)	Net Asset Value (NAV) Included in Level 2
Bonds, Short Term, and Cash Equivalents	472,531,811	472,751,675	43,711,314	428,820,497			
Mortgage Loans	13,832,572	13,279,236			13,832,572		

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets at September 30, 2018. There were no transfers between the Company's Level 1 or 2 financial assets at September 30, 2018.
In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

D. The Company did not have any financial instruments where it was not practicable to estimate the fair value.

21. Other Items

No significant change.

22. Events Subsequent

A. Type I - Recognized Subsequent Events

Subsequent events have been considered through November 13, 2018 for the statutory statement issued on November 14, 2018.

The Company had no known reportable recognized subsequent events.

B. Type II - Non-Recognized Subsequent Events

Subsequent events have been considered through November 13, 2018 for the statutory statement issued on November 14, 2018.

On January 1, 2018, the Company was subject to an annual fee under section 9010 of the Federal Affordable Care Act ("ACA"). This annual fee was allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. On October 1, 2018, the Company paid $22,536,420 to the federal government for its portion of the health insurer fee payable on October 1, 2018.

23. Reinsurance

No significant change.

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

A. through D: No significant change.

E. Risk Sharing Provisions of the Affordable Care Act

(1) Did the reporting entity write accident and health insurance premium which is subject to the ACA risk sharing provisions (YES/NO)? Yes [ ] No [X].

(2) through (5): Not applicable.

25. Change in Incurred Claims and Claims Adjustment Expenses

As of September 30, 2018, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' decreased by $35,470,012 from $162,303,470 in 2017 to $126,833,458 in 2018. In 2017, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' decreased by $4,903,247 from $203,997,642 in 2016 to $199,094,395 in 2017. The lower than anticipated health care cost trend rates observed in 2018 for claims incurred in 2017, were due to moderating outpatient and physician trends and faster than expected claim payment speed. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends.

Net coordination of benefits is implicit in the claims incurred but not reported calculation and could not be specifically identified.

26. Intercompany Pooling Arrangements

No significant change.

27. Structured Settlements

No significant change.

28. Health Care Receivables

No significant change.

29. Participating Policies

No significant change.

30. Premium Deficiency Reserves

No significant change.

31. Anticipated Salvage and Subrogation

No significant change.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Did the reporting entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the State of Domicile, as required by the Model Act? Yes [ ] No [X]

1.2 If yes, has the report been filed with the domiciliary state? Yes [ ] No [ ]

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [ ] No [X]

2.2 If yes, date of change:

3.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1 and 1A.

3.2 Have there been any substantial changes in the organizational chart since the prior quarter end? Yes [X] No [ ]

3.3 If the response to 3.2 is yes, provide a brief description of those changes.
On June 29, 2018, member interest in Medicity LLC and its subsidiaries (Novo Innovations, LLC and Allviant Corporation) was transferred to Health Catalyst. On July 11, 2018, Canadian Insurance Company changed its name to Aetna Insurance (Hong Kong) Limited. On August 9, 2018, Aetna Partners Diversified Fund (Cayman) Ltd. was dissolved.

3.4 Is the reporting entity publicly traded or a member of a publicly traded group? Yes [X] No [ ]

3.5 If the response to 3.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0001122304

4.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [ ] No [X]

4.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

5. If the reporting entity is subject to a management agreement, including third-party administrator(s), managing general agent(s), attorney-in-fact, or similar agreement, have there been any significant changes regarding the terms of the agreement or principals involved? Yes [ ] No [X] N/A [ ]
If yes, attach an explanation.

6.1 State as of what date the latest financial examination of the reporting entity was made or is being made.

6.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

6.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

6.4 By what department or departments?

6.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [ ] No [ ] N/A [X]

6.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [ ] No [ ] N/A [X]

7.1 Has this reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [ ] No [X]

7.2 If yes, give full information:

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

GENERAL INTERROGATORIES

9.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? ..... Yes [X] No [ ]
(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

9.11 If the response to 9.1 is No, please explain:

9.2 Has the code of ethics for senior managers been amended? ..... Yes [ ] No [X]

9.21 If the response to 9.2 is Yes, provide information related to amendment(s).

9.3 Have any provisions of the code of ethics been waived for any of the specified officers? ..... Yes [ ] No [X]

9.31 If the response to 9.3 is Yes, provide the nature of any waiver(s).

FINANCIAL

10.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? ..... Yes [X] No [ ]

10.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: ..... $ 0

INVESTMENT

11.1 Were any of the stocks, bonds, or other assets of the reporting entity loaned, placed under option agreement, or otherwise made available for use by another person? (Exclude securities under securities lending agreements.) ..... Yes [ ] No [X]

11.2 If yes, give full and complete information relating thereto:

12. Amount of real estate and mortgages held in other invested assets in Schedule BA: ..... $ 0

13. Amount of real estate and mortgages held in short-term investments: ..... $ 0

14.1 Does the reporting entity have any investments in parent, subsidiaries and affiliates? ..... Yes [ ] No [X]

14.2 If yes, please complete the following:

	1 Prior Year-End Book/Adjusted Carrying Value	2 Current Quarter Book/Adjusted Carrying Value
14.21 Bonds	$ 0	$
14.22 Preferred Stock	$ 0	$
14.23 Common Stock	$ 0	$
14.24 Short-Term Investments	$ 0	$
14.25 Mortgage Loans on Real Estate	$ 0	$
14.26 All Other	$ 0	$
14.27 Total Investment in Parent, Subsidiaries and Affiliates (Subtotal Lines 14.21 to 14.26)	$ 0	$ 0
14.28 Total Investment in Parent included in Lines 14.21 to 14.26 above	$	$

15.1 Has the reporting entity entered into any hedging transactions reported on Schedule DB? ..... Yes [ ] No [X]

15.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? ..... Yes [ ] No [ ]
If no, attach a description with this statement.

GENERAL INTERROGATORIES

16. For the reporting entity's security lending program, state the amount of the following as of the current statement date:
    - 16.1 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. $ 0
    - 16.2 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 $ 0
    - 16.3 Total payable for securities lending reported on the liability page. $ 0

17. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No [ ]

17.1 For all agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian Address
State Street Bank and Trust Company	State Street Financial Center; One Lincoln Street; Boston, MA 02111-2900

17.2 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)
All agreements comply.		

17.3 Have there been any changes, including name changes, in the custodian(s) identified in 17.1 during the current quarter? Yes [ ] No [X]

17.4 If yes, give full information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

17.5 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
Kevin J. Casey as Sr. Investment Officer	A

17.5097 For those firms/individuals listed in the table for Question 17.5, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets? Yes [ ] No [X]

17.5098 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 17.5, does the total assets under management aggregate to more than 50% of the reporting entity's assets? Yes [ ] No [X]

17.6 For those firms or individuals listed in the table for 17.5 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
N/A	Kevin J. Casey	N/A	Not registered	NO

18.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No [ ]

18.2 If no, list exceptions:

19. By self-designating 5*GI securities, the reporting entity is certifying the following elements for each self-designated 5*GI security:
    - a. Documentation necessary to permit a full credit analysis of the security does not exist.
    - b. Issuer or obligor is current on all contracted interest and principal payments.
    - c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

    Has the reporting entity self-designated 5*GI securities? Yes [ ] No [X]

GENERAL INTERROGATORIES

PART 2 - HEALTH

1. Operating Percentages:

   1.1 A&H loss percent ..... 87.6 %

   1.2 A&H cost containment percent ..... 2.3 %

   1.3 A&H expense percent excluding cost containment expenses ..... 9.0 %

2.1 Do you act as a custodian for health savings accounts? ..... Yes [ ] No [X]

2.2 If yes, please provide the amount of custodial funds held as of the reporting date ..... $.....

2.3 Do you act as an administrator for health savings accounts? ..... Yes [ ] No [X]

2.4 If yes, please provide the balance of the funds administered as of the reporting date ..... $.....

3. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? ..... Yes [ ] No [X]

3.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? ..... Yes [ ] No [X]

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE S - CEDED REINSURANCE

Showing All New Reinsurance Treaties - Current Year to Date

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Reinsurer	5 Domiciliary Jurisdiction	6 Type of Reinsurance Ceded	7 Type of Reinsurer	8 Certified Reinsurer Rating (1 through 6)	9 Effective Date of Certified Reinsurer Rating

NONE

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

Current Year to Date - Allocated by States and Territories

	1	Direct Business Only							
		2	3	4	5	6	7	8	9
States, etc.	Active Status (a)	Accident and Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Program Premiums	Life and Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama AL	N							0	
2. Alaska AK	N							0	
3. Arizona AZ	N							0	
4. Arkansas AR	N							0	
5. California CA	N							0	
6. Colorado CO	N							0	
7. Connecticut CT	N							0	
8. Delaware DE	N							0	
9. District of Columbia DC	N							0	
10. Florida FL	N							0	
11. Georgia GA	N							0	
12. Hawaii HI	N							0	
13. Idaho ID	N							0	
14. Illinois IL	N							0	
15. Indiana IN	N							0	
16. Iowa IA	N							0	
17. Kansas KS	N							0	
18. Kentucky KY	L	22,614,777	0	814,598,940				837,213,717	
19. Louisiana LA	N							0	
20. Maine ME	N							0	
21. Maryland MD	N							0	
22. Massachusetts MA	N							0	
23. Michigan MI	N							0	
24. Minnesota MN	N							0	
25. Mississippi MS	N							0	
26. Missouri MO	N							0	
27. Montana MT	N							0	
28. Nebraska NE	N							0	
29. Nevada NV	N							0	
30. New Hampshire NH	N							0	
31. New Jersey NJ	N							0	
32. New Mexico NM	N							0	
33. New York NY	N							0	
34. North Carolina NC	N							0	
35. North Dakota ND	N							0	
36. Ohio OH	N							0	
37. Oklahoma OK	N							0	
38. Oregon OR	N							0	
39. Pennsylvania PA	N							0	
40. Rhode Island RI	N							0	
41. South Carolina SC	N							0	
42. South Dakota SD	N							0	
43. Tennessee TN	N							0	
44. Texas TX	N							0	
45. Utah UT	N							0	
46. Vermont VT	N							0	
47. Virginia VA	N							0	
48. Washington WA	N							0	
49. West Virginia WV	N							0	
50. Wisconsin WI	N							0	
51. Wyoming WY	N							0	
52. American Samoa AS	N							0	
53. Guam GU	N							0	
54. Puerto Rico PR	N							0	
55. U.S. Virgin Islands VI	N							0	
56. Northern Mariana Islands MP	N							0	
57. Canada CAN	N							0	
58. Aggregate Other Aliens OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal	XXX	22,614,777	0	814,598,940	0	0	0	837,213,717	0
60. Reporting Entity Contributions for Employee Benefit Plans	XXX							0	
61. Totals (Direct Business)	XXX	22,614,777	0	814,598,940	0	0	0	837,213,717	0
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)	XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed Insurance carrier or domiciled RRG 1
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
N - None of the above - Not allowed to write business in the state 56
R - Registered - Non-domiciled RRGs 0
Q - Qualified - Qualified or accredited reinsurer 0

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

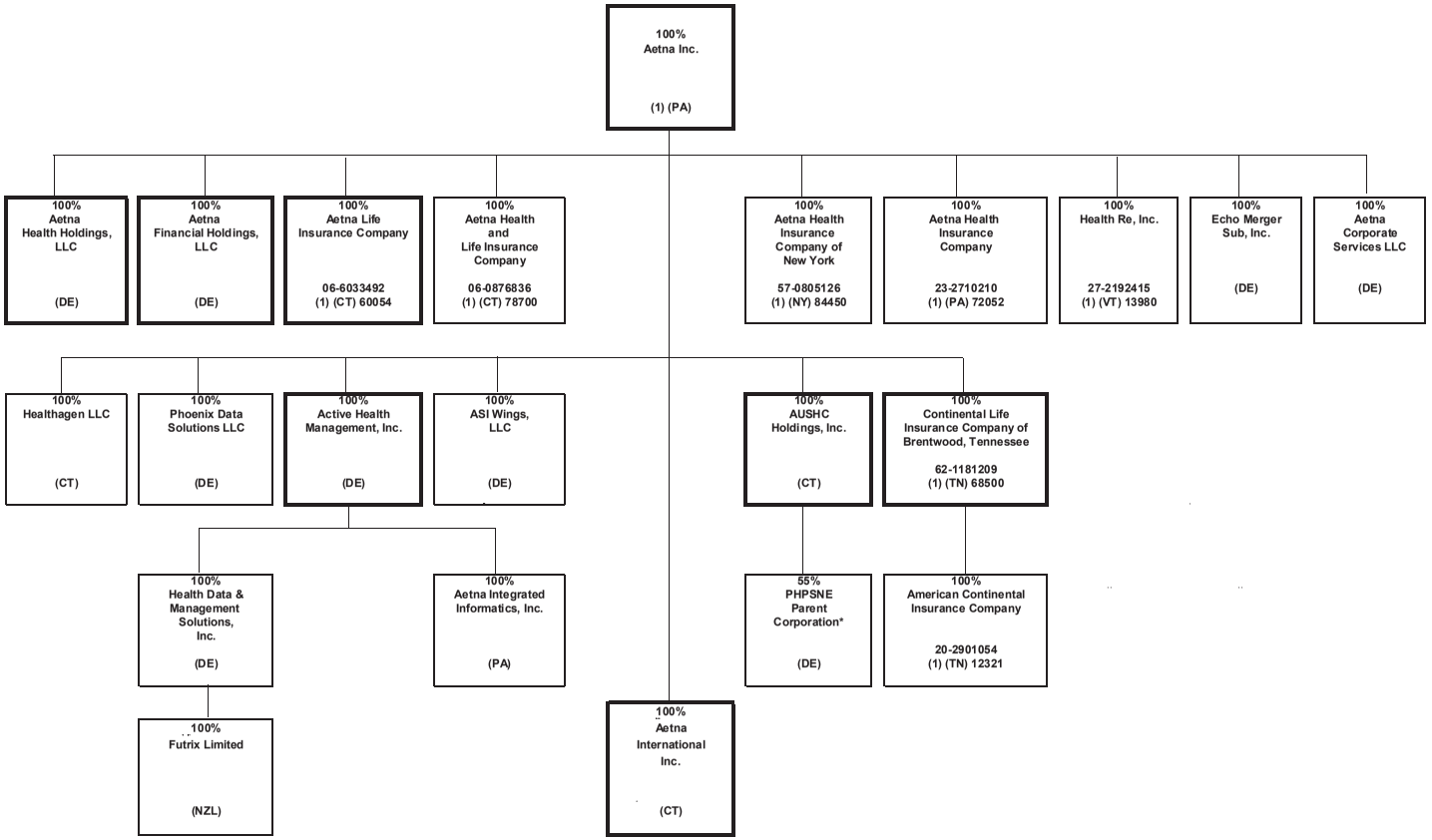

(1) Insurers/HMO's
Percentages are rounded to the nearest whole percent and based on ownership of voting rights.
Double borders indicate entity has subsidiaries shown on the same page.
Bold borders indicate entity has subsidiaries shown on a separate page.

* PHPSNE Parent Corporation is also 45% owned by third parties.

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

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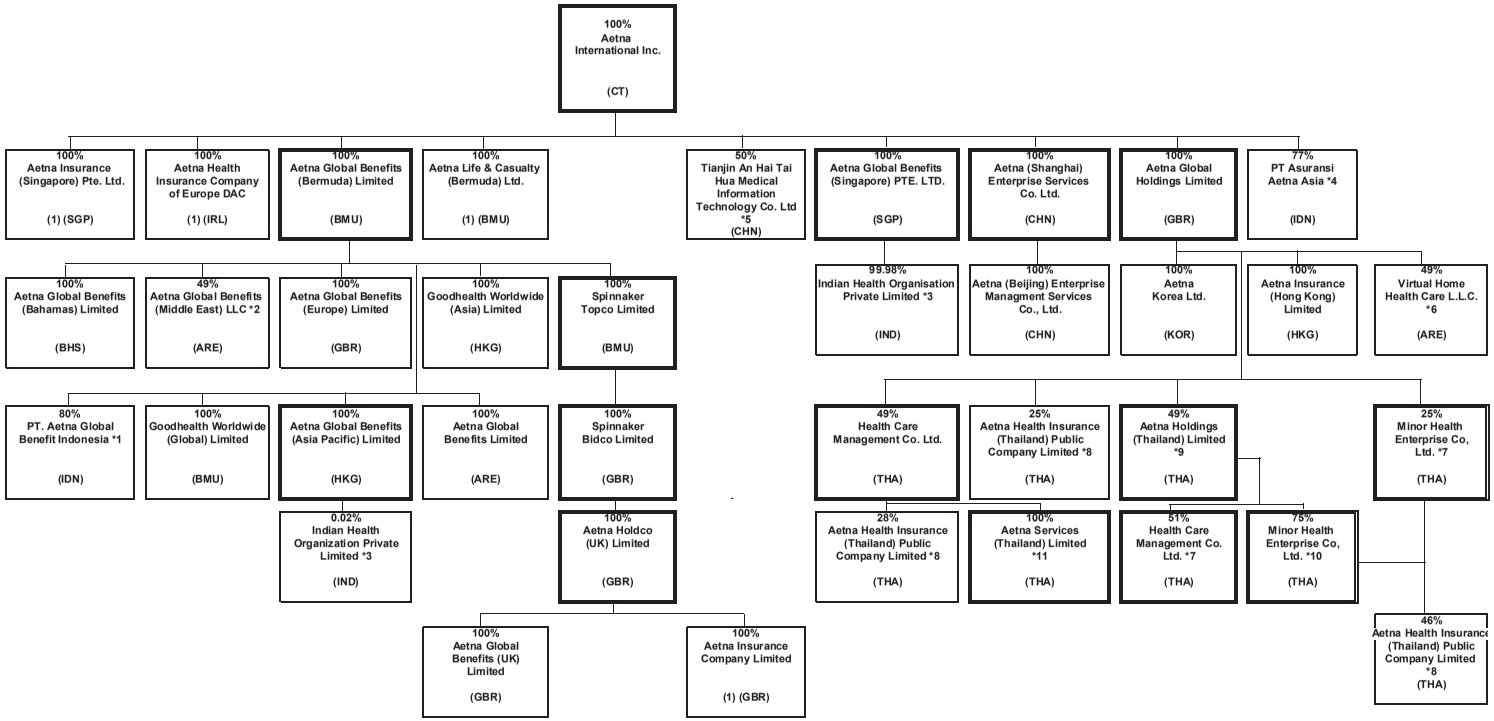

*1 PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
*2 Aetna Global Benefits (Middle East) LLC is also 51% is owned by Euro Gulf LLC, Aetna's Nominee.
*3 Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
*4 PT Asuransi Aetna Asia is also 23% owned by PT Asuransi Central Asia.
*5 Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd
*6 Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC
*7 Health Care Management Co. Ltd. Is also owned by Aetna Global Benefits (Bermuda) Limited (1 share).
*8 Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 Share), Mr. Jitphasong Itsaraphakded (1 Share); Mrs. Suphee Wattana (1 Share); and Mr. Buncha Tamphragom (1 Share)
*9 Aetna Holdings (Thailand) Limited is aslo 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Benefits (Bermuda) Limited owns 1 share.
*10 Minor Health Entreprise Co, Ltd is is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited
*11 Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

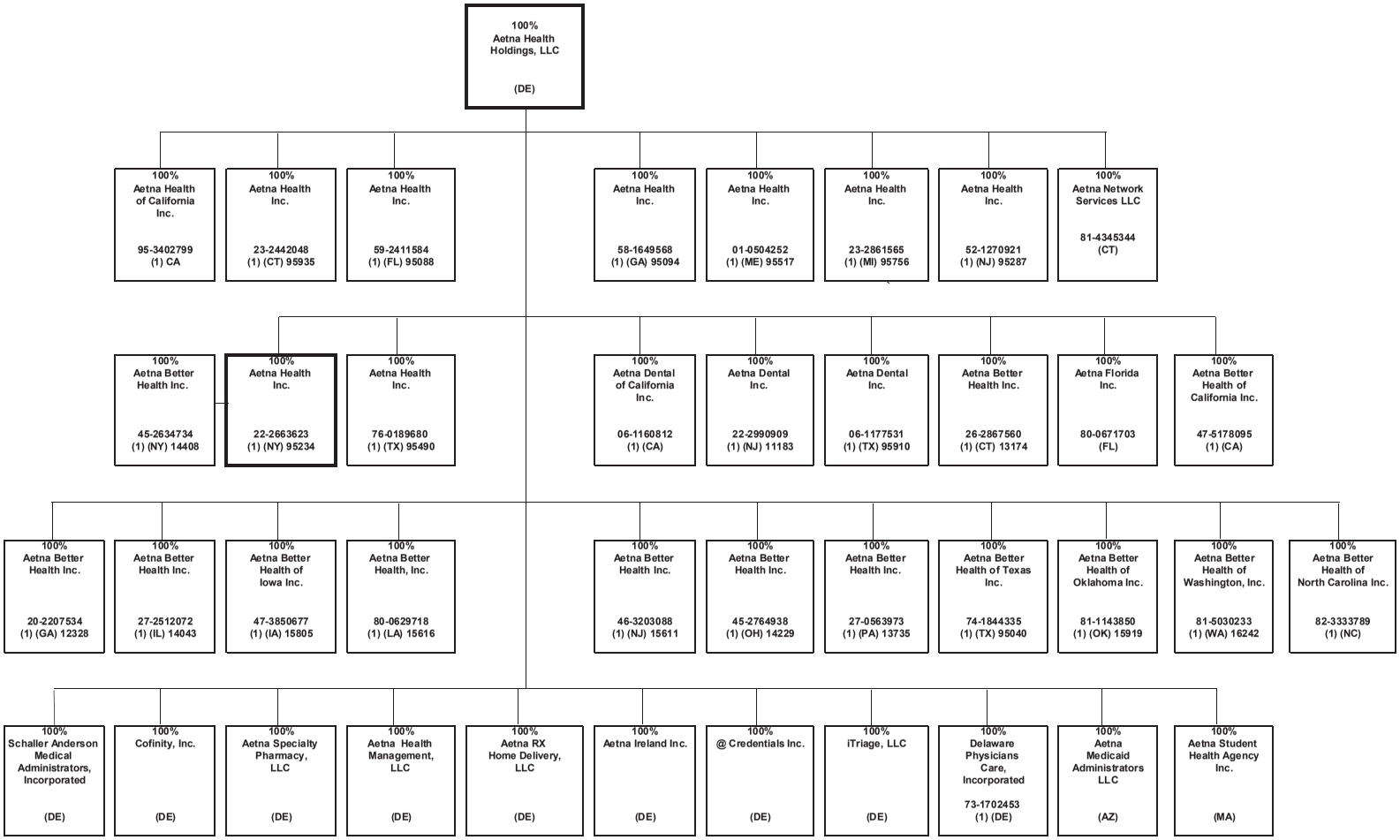

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

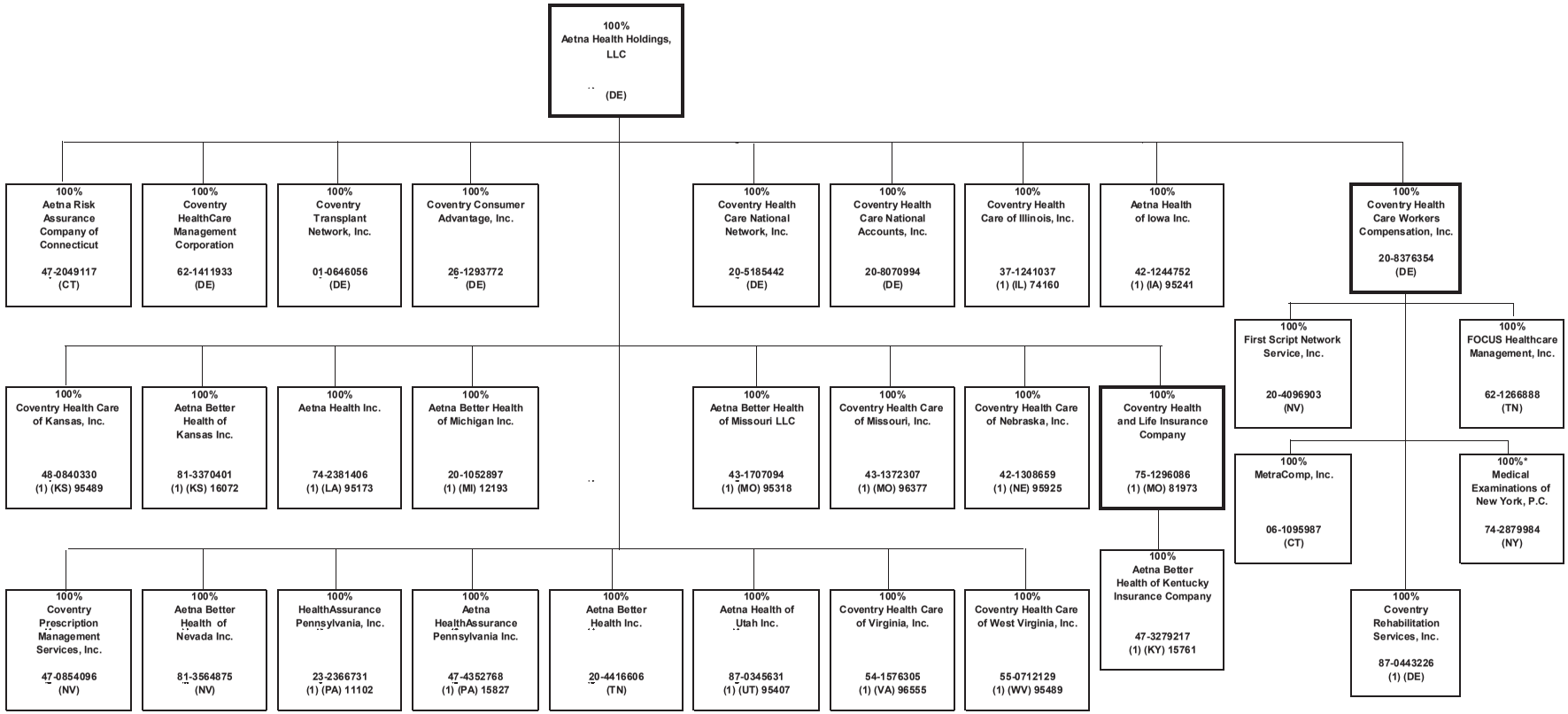

*100% owned through Aetna's nominees

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

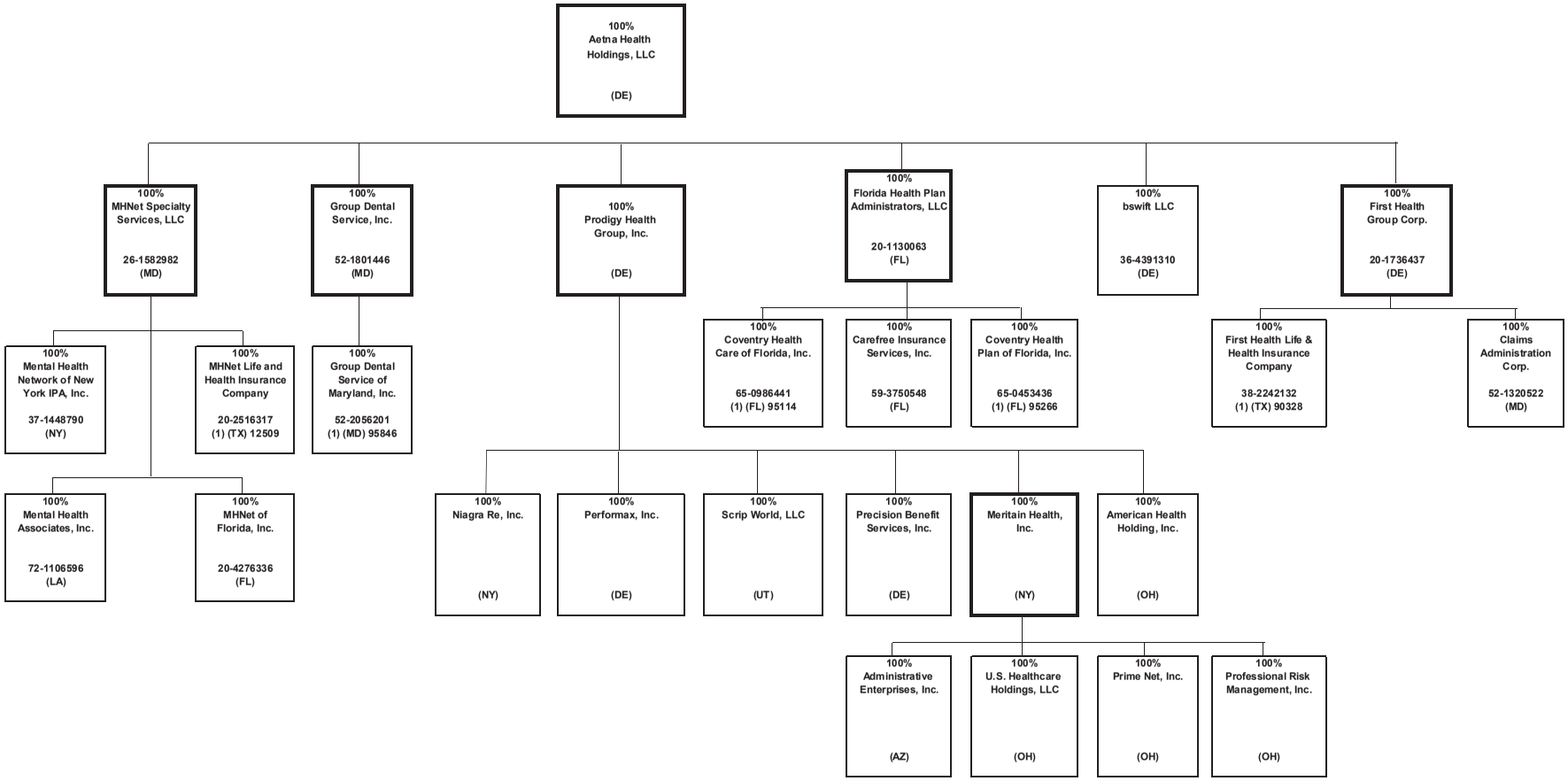

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

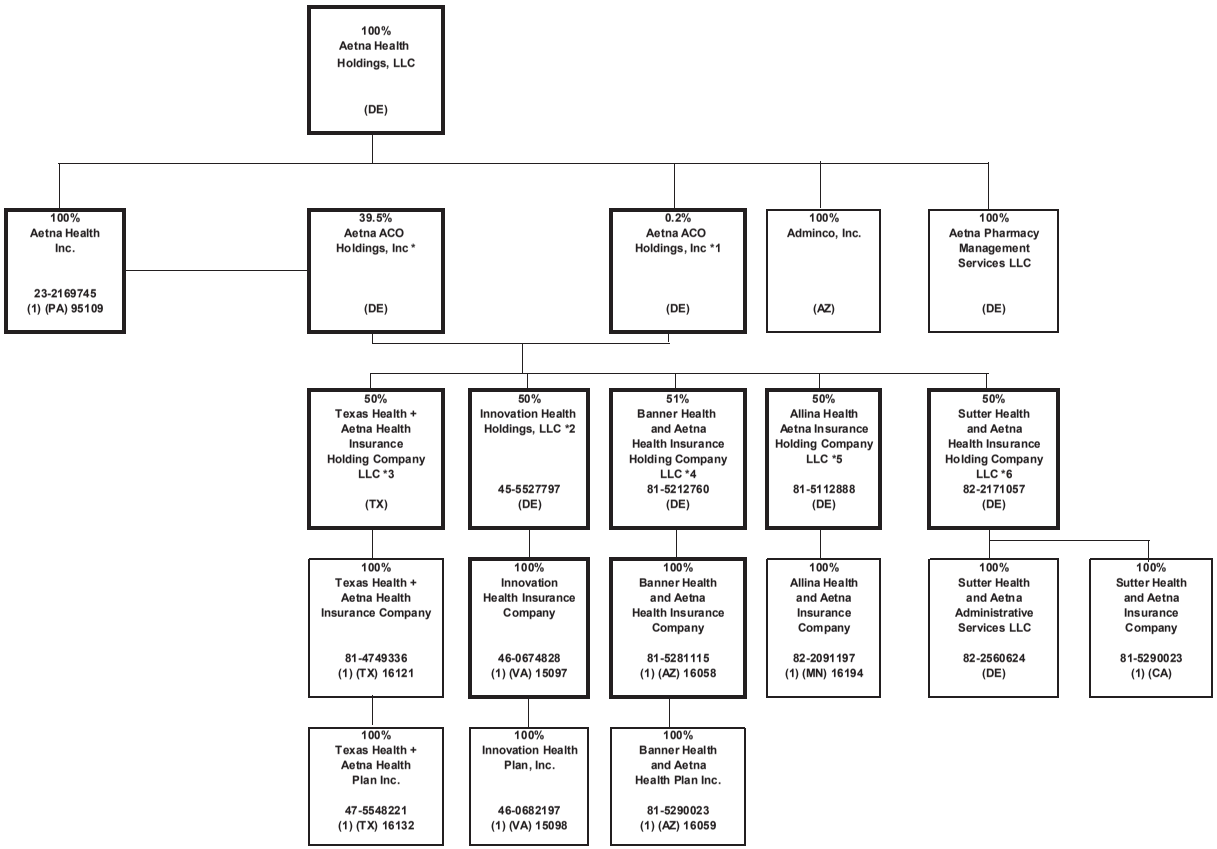

*1 Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
*2 Innovation Health Holdings, LLC is also 50% owned by Inova Health System Foundation.
*3 Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
*4 Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
*5 Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
*6 Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

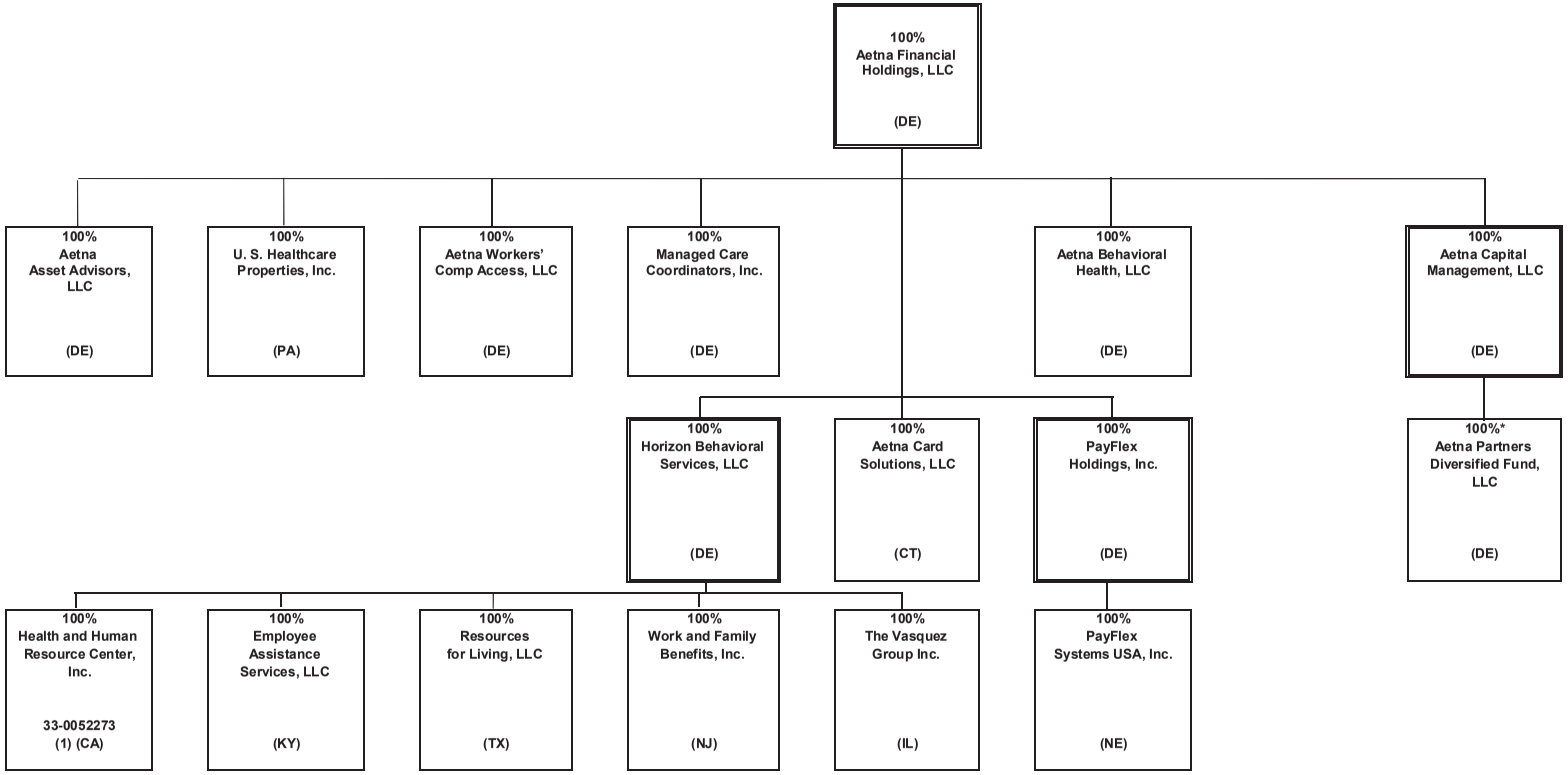

* Aetna Life Insurance Company, Aetna Health and Life Insurance Company and Aetna Health Management , LLC own substantially all of the non-managing member interests of Aetna Partners Diversified Fund, LLC.

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

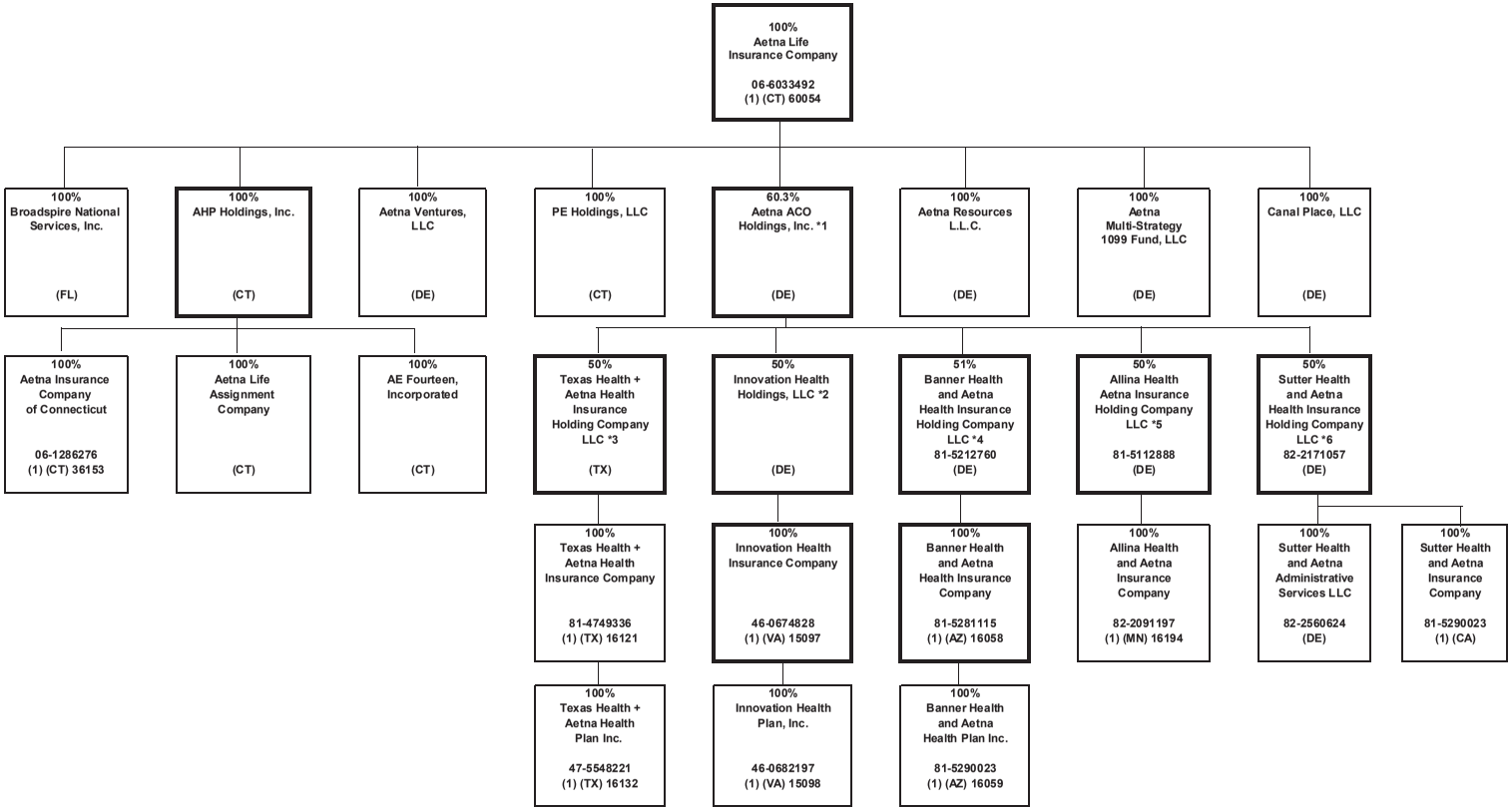

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STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000	23-2229683	3060706	0001122304	N	Aetna Inc.	PA	UIP	Aetna Inc.		0.000		N	0
0001	AETNA INC.	00000	30-0123754	0	0		Aetna Health Holdings, LLC	DE	UIP	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	95-3402799	0	0		Aetna Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95935	23-2442048	0	0		Aetna Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95088	59-2411584	0	0		Aetna Health Inc.	FL	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95094	58-1649568	0	0		Aetna Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95517	01-0504252	0	0		Aetna Health Inc.	ME	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95756	23-2861565	0	0		Aetna Health Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95287	52-1270921	0	0		Aetna Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95234	22-2663623	0	0		Aetna Health Inc.	NY	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	14408	45-2634734	0	0		Aetna Better Health Inc.	NY	IA	Aetna Health Inc. (NY)	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95490	76-0189680	0	0		Aetna Health Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95040	74-1844335	0	0		Aetna Better Health of Texas Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12328	20-2207534	0	0		Aetna Better Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1160812	0	0		Aetna Dental of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	11183	22-2990909	0	0		Aetna Dental Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95910	06-1177531	0	0		Aetna Dental Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	30-0123760	0	0		Aetna Rx Home Delivery, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	13-3670795	0	0		Aetna Health Management, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	22-3187443	0	0		Aetna Ireland Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	57-1209768	0	0		Aetna Specialty Pharmacy, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-1274723	0	0		Cofinity, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2671370	0	0		@Credentials Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Services (Thailand) Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	100.000	Aetna Inc.	N	20
0001	AETNA INC.	13735	27-0563973	0	0		Aetna Better Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	13174	26-2867560	0	0		Aetna Better Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-5178095	0	0		Aetna Better Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	14043	27-2512072	0	0		Aetna Better Health Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15805	47-3850677	0	0		Aetna Better Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15616	80-0629718	0	0		Aetna Better Health, Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	80-0671703	0	0		Aetna Florida Inc.	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	14229	25-2764938	0	0		Aetna Better Health Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15611	46-3203086	0	0		Aetna Better Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15919	81-1143850	0	0		Aetna Better Health of Oklahoma Inc.	OK	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	04-2708160	0	0		Aetna Student Health Agency Inc.	MA	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	73-1702453	0	0		Delaware Physicians Care, Incorporated	DE	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	01-0826783	0	0		Schaller Anderson Medical Administrators, Incorporated	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	86-0842559	0	0		Aetna Medicaid Adminstrators LLC	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-2944270	0	0		iTriage, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	16-1471176	0	0		Prodigy Health Group, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	0.200	Aetna Inc.	Y	3
0001	AETNA INC.	00000	45-5527797	0	0		Innovation Health Holdings, LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	6
0001	AETNA INC.	15097	46-0674828	0	0		Innovation Health Insurance Company	VA	IA	Innovation Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15098	46-0682197	0	0		Innovation Health Plan, Inc.	VA	IA	Innovation Health Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-3789357	0	0		Texas Health + Aetna Health Insurance Holding Company LLC	TX	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	9
0001	AETNA INC.	16121	81-4749336	0	0		Texas Health + Aetna Health Insurance Company	TX	IA	Texas Health + Aetna Health Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16132	47-5548221	0	0		Texas Health + Aetna Health Plan Inc.	TX	IA	Texas Health + Aetna Health Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95109	23-2169745	0	0		Aetna Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Inc. (PA)	Ownership	39.500	Aetna Inc.	Y	3
0001	AETNA INC.	00000	20-0438576	0	0		Niagara Re, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000	52-2200070	0	0		Performax, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	87-0632355	0	0		Scrip World, LLC	UT	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-1760756	0	0		Precision Benefit Services, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	31-1368946	0	0		American Health Holding, Inc.	OH	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	16-1264154	0	0		Meritain Health, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	86-0537707	0	0		Adminco, Inc.	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	86-0527428	0	0		Administrative Enterprises, Inc.	AZ	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	16-1684061	0	0		U.S. Healthcare Holdings, LLC	OH	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	34-1670299	0	0		Prime Net, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	34-1348032	0	0		Professional Risk Management, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	68500	62-1181209	0	0		Continental Life Insurance Company of Brentwood, Tennessee	TN	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12321	20-2901054	0	0		American Continental Insurance Company	TN	IA	Continental Life Insurance Company of Brentwood, Tennessee	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	60054	06-6033492	0	0		Aetna Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Life Insurance Company	Ownership	60.300	Aetna Inc.	Y	3
0001	AETNA INC.	00000	06-1270755	0	0		AHP Holdings, Inc.	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	36153	06-1286276	0	0		Aetna Insurance Company of Connecticut	CT	IA	AHP Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1028469	0	0		AE Fourteen, Incorporated	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1373153	0	0		Aetna Life Assignment Company	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-3678339	0	0		PE Holdings, LLC	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1423207	0	0		Aetna Resources L.L.C.	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Canal Place, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-3180700	0	0		Aetna Ventures, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	59-2108747	0	0		Broadspire National Services, Inc.	FL	NIA	Aetna Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0001552250		Aetna Multi-Strategy 1099 Fund, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	79.250	Aetna Inc.	N	0
0001	AETNA INC.	00000	41-2035961	0	0		Aetna Financial Holdings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	26-2030792	0	0		Aetna Asset Advisors, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2354500	0	0		U.S. Healthcare Properties, Inc.	PA	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	38-3704481	0	0		Aetna Capital Management, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	11-3667142	0	0001314522		Aetna Partners Diversified Fund, LLC	DE	NIA	Aetna Capital Management, LLC	Ownership	100.000	Aetna Inc.	N	1
0001	AETNA INC.	00000	20-0446676	0	0		Aetna Workers' Comp Access, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-0446713	0	0		Aetna Behavioral Health, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2670015	0	0		Managed Care Coordinators, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	59-3269144	0	0		Horizon Behavioral Services, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	61-1193498	0	0		Employee Assistance Services, LLC	KY	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	33-0052273	0	0		Health and Human Resource Center, Inc.	CA	IA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	75-2420973	0	0		Resources for Living, LLC	TX	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	36-3681261	0	0		The Vasquez Group Inc.	IL	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	22-3178125	0	0		Work and Family Benefits, Inc.	NJ	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	27-1773021	0	0		Aetna Card Solutions, LLC	CT	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-5216478	0	0		PayFlex Holdings, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	91-1774434	0	0		PayFlex Systems USA, Inc.	NE	NIA	PayFlex Holdings, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	78700	06-0876836	0	0		Aetna Health and Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	72052	23-2710210	0	0		Aetna Health Insurance Company	PA	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	84450	57-0805126	0	0		Aetna Health Insurance Company of New York	NY	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1571642	0	0		Aetna International Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	98-0211470	0	0		Aetna Life & Casualty (Bermuda) Ltd.	BMU	IA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Insurance (Singapore) PTE. LTD.	SGP	IA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Bermuda) Limited	BMU	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Goodhealth Worldwide (Global) Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Europe) Limited	GBR	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Goodhealth Worldwide (Asia) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits Limited	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
0001	AETNA INC.	00000		0	0		PT. Aetna Global Benefits Indonesia	IDN	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	80.000	Aetna Inc.	N	4
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Middle East) LLC	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	49.000	Aetna Inc.	N	5
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Asia Pacific) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Spinnaker Topco Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Spinnaker Bidco Limited	GBR	NIA	Spinnaker Topco Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Holdco (UK) Limited	GBR	NIA	Spinnaker Bidco Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		PT Asuransi Aetna Asia	IDN	NIA	Aetna International Inc.	Ownership	77.000	Aetna Inc.	N	13
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (UK) Limited	GBR	NIA	Aetna Holdco (UK) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Insurance Company Limited	GBR	IA	Aetna Holdco (UK) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Asia Pacific) Limited	Ownership	0.020	Aetna Inc.	N	2
0001	AETNA INC.	00000		0	0		Aetna Health Insurance Company of Europe DAC	IRL	IA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna (Shanghai) Enterprise Services Co. Ltd.	CHN	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna (Beijing) Enterprise Management Services Co., Ltd.	CHN	NIA	Aetna (Shanghai) Enterprise Services Co. Ltd.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Singapore) PTE. LTD.	SGP	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Singapore) PTE, LTD.	Ownership	99.980	Aetna Inc.	N	2
0001	AETNA INC.	00000	22-2578985	0	0		AUSHC Holdings, Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Global Holdings Limited	GBR	NIA	Aetna International Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Korea Ltd.	KOR	NIA	Aetna Global Holdings Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Insurance (Hong Kong) Limited	HKG	NIA	Aetna Global Holdings Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Futrix Limited	NZL	NIA	Health Data & Management Solutions, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1182176	0	0		PHPSNE Parent Corporation	DE	NIA	AUSHC Holdings, Inc.	Ownership	55.000	Aetna Inc.	N	7
0001	AETNA INC.	00000	52-2182411	0	0		Active Health Management, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-0970432	0	0		Health Data & Management Solutions, Inc.	DE	NIA	Active Health Management, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	23-2604867	0	0		Aetna Integrated Informatics, Inc.	PA	NIA	Active Health Management, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	13980	27-2192415	0	0		Health Re, Inc.	VT	IA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-0579372	0	0		Phoenix Data Solutions LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	46-2469464	0	0		Healthagen LLC	CT	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	51-0029326	0	0		ASI Wings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Echo Merger Sub, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Corporate Services, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	81973	75-1296086	0	0		Coventry Health and Life Insurance Company	MO	UDP	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15761	47-3279217	0	0		Aetna Better Health of Kentucky Insurance Company	KY	RE	Coventry Health and Life Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	52-1801446	0	0		Group Dental Service, Inc.	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95846	52-2056201	0	0		Group Dental Service of Maryland, Inc.	MD	IA	Group Dental Service, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.		81-4345344	0	0		Aetna Network Services LLC	CT	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95241	42-1244752	0	0		Aetna Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95925	42-1308659	0	0		Coventry Health Care of Nebraska, Inc.	NE	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-2049117	0	0		Aetna Risk Assurance Company of Connecticut Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95173	74-2381406	0	0		Aetna Health Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	11102	23-2366731	0	0		HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	47-0854096	0	0		Coventry Prescription Management Services, Inc.	NV	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16148	81-3564875	0	0		Aetna Better Health of Nevada Inc.	NV	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	96555	54-1576305	0	0		Coventry Health Care of Virginia, Inc.	VA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	01-0646056	0	0		Coventry Transplant Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	96377	43-1372307	0	0		Coventry Health Care of Missouri, Inc.	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

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0001	AETNA INC.	95318	43-1702094	0	0		Aetna Better Health of Missouri LLC	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95408	55-0712129	0	0		Coventry Health Care of West Virginia, Inc.	WV	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	62-1411933	0	0		Coventry HealthCare Management Corporation	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	15827	47-4352768	0	0		Aetna HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95489	48-0840330	0	0		Coventry Health Care of Kansas, Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16072	81-3370401	0	0		Aetna Better Health of Kansas Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12193	20-1052897	0	0		Aetna Better Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95407	87-0345631	0	0		Aetna Health of Utah Inc.	UT	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-4416606	0	0		Aetna Better Health Inc.	TN	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	74160	37-1241037	0	0		Coventry Health Care of Illinois, Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-8070994	0	0		Coventry Health Care National Accounts, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-5185442	0	0		Coventry Health Care National Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	26-1293772	0	0		Coventry Consumer Advantage, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-8376354	0	0		Coventry Health Care Workers Compensation, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-4096903	0	0		First Script Network Service, Inc.	NV	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	06-1095987	0	0		MetraComp, Inc.	CT	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	74-2879984	0	0		Medical Examinations of New York, P.C.	NY	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	8
0001	AETNA INC.	00000	62-1266888	0	0		FOCUS Healthcare Management, Inc.	TN	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	87-0443226	0	0		Coventry Rehabilitation Services, Inc.	DE	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-1736437	0	0		First Health Group Corp.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	90328	38-2242132	0	0		First Health Life & Health Insurance Company	TX	IA	First Health Group Corp.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	52-1320522	0	0		Claims Administration Corp.	MD	NIA	First Health Group Corp.	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-1130063	0	0		Florida Health Plan Administrators, LLC	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95114	65-0986441	0	0		Coventry Health Care of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	95266	65-0453436	0	0		Coventry Health Plan of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	59-3750548	0	0		Carefree Insurance Services, Inc.	FL	NIA	Florida Health Plan Administrators, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	36-4391310	0	0		bswift LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Virtual Home Healthcare L.L.C.	ARE	NIA	Aetna Global Holdings Limited	Ownership	49.000	Aetna Inc.	N	17
0001	AETNA INC.	00000	26-1582982	0	0		MHNet Specialty Services, LLC	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	37-1448790	0	0		Mental Health Network of New York IPA, Inc.	NY	NIA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	12509	20-2516317	0	0		MHNet Life and Health Insurance Company	TX	IA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	72-1106596	0	0		Mental Health Associates, Inc.	LA	NIA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	20-4276336	0	0		MHNet of Florida, Inc.	FL	IA	MHNet Specialty Services, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16242	81-5030233	0	0		Aetna Better Health of Washington, Inc.	WA	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-5212760	0	0		Banner Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	51.000	Aetna Inc.	N	10
0001	AETNA INC.	16058	81-5281115	0	0		Banner Health and Aetna Health Insurance Company	AZ	IA	Banner Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	16059	81-5290023	0	0		Banner Health and Aetna Health Plan Inc.	AZ	IA	Banner Health and Aetna Health Insurance Company	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-5112888	0	0		Allina Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	11
0001	AETNA INC.	16194	82-2091197	0	0		Allina Health and Aetna Insurance Company	MN	IA	Allina Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	82-2171057	0	0		Sutter Health and Aetna Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	Aetna Inc.	N	12

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	AETNA INC.	00000	82-2560624	0	0		Sutter Health and Aetna Administrative Services LLC	DE	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	81-5290023	0	0		Sutter Health and Aetna Insurance Company	CA	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Holdings (Thailand) Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	Aetna Inc.	N	14
0001	AETNA INC.	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	Aetna Inc.	N	15
0001	AETNA INC.	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Minor Health Entreprise Co, Ltd.	Ownership	46.000	Aetna Inc.	N	15
0001	AETNA INC.	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	28.000	Aetna Inc.	N	15
0001	AETNA INC.	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	Aetna Inc.	N	19
0001	AETNA INC.	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	Aetna Inc.	N	16
0001	AETNA INC.	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	75.000	Aetna Inc.	N	16
0001	AETNA INC.	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	51.000	Aetna Inc.	N	19
0001	AETNA INC.	00000		0	0		Aetna Global Benefits (Bahamas) Limited	BHS	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Aetna Pharmacy Management Services LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000	82-3333789	0	0		Aetna Better Health of North Carolina Inc.	NC	IA	Aetna Health Holdings, LLC	Ownership	100.000	Aetna Inc.	N	0
0001	AETNA INC.	00000		0	0		Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd	CHN	NIA	Aetna International Inc.	Ownership	50.000	Aetna Inc.	N	18

Asterisk	Explanation
1	Aetna Life Insurance Company, Aetna Health and Life Insurance Company and Aetna Health Management, LLC own substantially all of the non-managing membership interests.
2	Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
3	Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
4	PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
5	Aetna Global Benefits (Middle East) LLC is also 51% owned by Euro Gulf LLC, Aetna's Nominee.
6	Innovation Health Holdings LLC. Is also 50% owned by Inova Health System Foundation.
7	PHPSNE Parent Corporation is 55% owned by AUSHC Holdings, Inc. The remaining 45% is owned by thirteen different hospitals (non-affiliates) which are shareholders with varying degrees of ownership.
8	Medical Examinations of New York, P.C. is 100% owned through Aetna's nominees.
9	Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
10	Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
11	Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
12	Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.
13	PT Asuransi Aetna Asia is also 23% owned by PT Asuransi Central Asia.
14	Aetna Holdings (Thailand) Limited is also 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Global Benefits (Bermuda) Limited owns 1 share
15	Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 share), Mr. Jitphasong Itsaraphakded (1 share); Mrs. Suphee Wattana (1 share); and Mr. Buncha Tamphragom (1 share)
16	Minor Health Entreprise Co, Ltd is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
17	Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC.
18	Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd.
19	Health Care Management Co. Ltd. Is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
20	Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Response
1. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?	NO

Explanation:

1. Business not written

Bar Code:

1. Medicare Part D Coverage Supplement [Document Identifier 365]

OVERFLOW PAGE FOR WRITE-INS

NONE

SCHEDULE A - VERIFICATION

Real Estate

NONE

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		
	2.2 Additional investment made after acquisition		
3.	Current year change in encumbrances		
4.	Total gain (loss) on disposals		
5.	Deduct amounts received on disposals		
6.	Total foreign exchange change in book/adjusted carrying value		
7.	Deduct current year's other than temporary impairment recognized		
8.	Deduct current year's depreciation		
9.	Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8)		
10.	Deduct total nonadmitted amounts		
11.	Statement value at end of current period (Line 9 minus Line 10)		

SCHEDULE B - VERIFICATION

Mortgage Loans

		1 Year to Date	2 Prior Year Ended December 31
1.	Book value/recorded investment excluding accrued interest, December 31 of prior year	12,979,171	
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		12,979,171
	2.2 Additional investment made after acquisition	442,927	0
3.	Capitalized deferred interest and other		0
4.	Accrual of discount		0
5.	Unrealized valuation increase (decrease)		0
6.	Total gain (loss) on disposals		
7.	Deduct amounts received on disposals	236,016	
8.	Deduct amortization of premium and mortgage interest points and commitment fees	(93,154)	0
9.	Total foreign exchange change in book value/recorded investment excluding accrued interest		0
10.	Deduct current year's other than temporary impairment recognized		0
11.	Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	13,279,236	12,979,171
12.	Total valuation allowance		
13.	Subtotal (Line 11 plus Line 12)	13,279,236	12,979,171
14.	Deduct total nonadmitted amounts		0
15.	Statement value at end of current period (Line 13 minus Line 14)	13,279,236	12,979,171

SCHEDULE BA - VERIFICATION

Other Long-Term Invested Assets

NONE

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		
	2.2 Additional investment made after acquisition		
3.	Capitalized deferred interest and other		
4.	Accrual of discount		
5.	Unrealized valuation increase (decrease)		
6.	Total gain (loss) on disposals		
7.	Deduct amounts received on disposals		
8.	Deduct amortization of premium and depreciation		
9.	Total foreign exchange change in book/adjusted carrying value		
10.	Deduct current year's other than temporary impairment recognized		
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)		
12.	Deduct total nonadmitted amounts		
13.	Statement value at end of current period (Line 11 minus Line 12)		

SCHEDULE D - VERIFICATION

Bonds and Stocks

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value of bonds and stocks, December 31 of prior year	479,236,865	528,045,638
2.	Cost of bonds and stocks acquired	132,703,104	82,646,084
3.	Accrual of discount	439,966	439,402
4.	Unrealized valuation increase (decrease)	(432,324)	237,476
5.	Total gain (loss) on disposals	(1,502,178)	1,054,133
6.	Deduct consideration for bonds and stocks disposed of	175,372,374	129,442,848
7.	Deduct amortization of premium	2,583,408	3,544,111
8.	Total foreign exchange change in book/adjusted carrying value		
9.	Deduct current year's other than temporary impairment recognized	1,287,928	198,909
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees	299,526	0
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)	431,501,249	479,236,865
12.	Deduct total nonadmitted amounts		
13.	Statement value at end of current period (Line 11 minus Line 12)	431,501,249	479,236,865

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1B

Showing the Acquisitions, Dispositions and Non-Trading Activity
During the Current Quarter for all Bonds and Preferred Stock by NAIC Designation

NAIC Designation	1 Book/Adjusted Carrying Value Beginning of Current Quarter	2 Acquisitions During Current Quarter	3 Dispositions During Current Quarter	4 Non-Trading Activity During Current Quarter	5 Book/Adjusted Carrying Value End of First Quarter	6 Book/Adjusted Carrying Value End of Second Quarter	7 Book/Adjusted Carrying Value End of Third Quarter	8 Book/Adjusted Carrying Value December 31 Prior Year
BONDS								
1. NAIC 1 (a)	371,155,781	759,831,441	799,853,686	(590,007)	334,154,272	371,155,781	330,543,529	350,941,062
2. NAIC 2 (a)	94,577,980	12,711,649	18,336,458	958,854	97,631,740	94,577,980	89,912,025	100,591,076
3. NAIC 3 (a)	40,132,494	14,057,392	8,021,110	286,130	40,310,749	40,132,494	46,454,906	36,468,359
4. NAIC 4 (a)	5,531,482	4,038,925	2,704,000	(1,027,725)	7,635,279	5,531,482	5,838,682	6,103,546
5. NAIC 5 (a)	0				0	0	0	
6. NAIC 6 (a)	0				0	0	0	
7. Total Bonds	511,397,737	790,639,407	828,915,254	(372,748)	479,732,040	511,397,737	472,749,142	494,104,043
PREFERRED STOCK								
8. NAIC 1	0				0	0	0	0
9. NAIC 2	0				0	0	0	0
10. NAIC 3	0				0	0	0	0
11. NAIC 4	0				0	0	0	0
12. NAIC 5	0				0	0	0	0
13. NAIC 6	0				0	0	0	0
14. Total Preferred Stock	0	0	0	0	0	0	0	0
15. Total Bonds and Preferred Stock	511,397,737	790,639,407	828,915,254	(372,748)	479,732,040	511,397,737	472,749,142	494,104,043

(a) Book/Adjusted Carrying Value column for the end of the current reporting period includes the following amount of short-term and cash equivalent bonds by NAIC designation:

NAIC 1 $ 41,247,893 ; NAIC 2 $ 0 ; NAIC 3 $ 0 NAIC 4 $ 0 ; NAIC 5 $ 0 ; NAIC 6 $ 0

SCHEDULE DA - PART 1

Short-Term Investments

NONE

	1 Book/Adjusted Carrying Value	2 Par Value	3 Actual Cost	4 Interest Collected Year-to-Date	5 Paid for Accrued Interest Year-to-Date
9199999 Totals		XXX			

SCHEDULE DA - VERIFICATION

Short-Term Investments

		1 Year To Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	0	2,475
2.	Cost of short-term investments acquired		824,131
3.	Accrual of discount		
4.	Unrealized valuation increase (decrease)		
5.	Total gain (loss) on disposals		
6.	Deduct consideration received on disposals		826,606
7.	Deduct amortization of premium		
8.	Total foreign exchange change in book/adjusted carrying value		
9.	Deduct current year's other than temporary impairment recognized		
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	0	0
11.	Deduct total nonadmitted amounts		
12.	Statement value at end of current period (Line 10 minus Line 11)	0	0

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

SCHEDULE E - PART 2 - VERIFICATION

(Cash Equivalents)

		1 Year To Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	14,867,395	1,005,891
2.	Cost of cash equivalents acquired	1,967,510,388	2,439,590,950
3.	Accrual of discount	871,392	575,019
4.	Unrealized valuation increase (decrease)		
5.	Total gain (loss) on disposals	128	(470)
6.	Deduct consideration received on disposals	1,941,998,877	2,426,303,995
7.	Deduct amortization of premium		
8.	Total foreign exchange change in book/adjusted carrying value		
9.	Deduct current year's other than temporary impairment recognized		
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	41,250,426	14,867,395
11.	Deduct total nonadmitted amounts		
12.	Statement value at end of current period (Line 10 minus Line 11)	41,250,426	14,867,395

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE B - PART 2

Showing All Mortgage Loans ACQUIRED AND ADDITIONS MADE During the Current Quarter

1	Location		4	5	6	7	8	9
	2	3						
Loan Number	City	State	Loan Type	Date Acquired	Rate of Interest	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Value of Land and Buildings
2004473	MT LAUREL	NJ		12/18/2017	5.280		221,783	13,100,000
0499999. Mortgages in good standing - Commercial mortgages-insured or guaranteed						0	221,783	13,100,000
0899999. Total Mortgages in good standing						0	221,783	13,100,000
1699999. Total - Restructured Mortgages						0	0	0
2499999. Total - Mortgages with overdue interest over 90 days						0	0	0
3299999. Total - Mortgages in the process of foreclosure						0	0	0
3399999 - Totals						0	221,783	13,100,000

SCHEDULE B - PART 3

Showing All Mortgage Loans DISPOSED, Transferred or Repaid During the Current Quarter

1	Location		4	5	6	7	Change in Book Value/Recorded Investment						14	15	16	17	18
	2	3					8	9	10	11	12	13					
Loan Number	City	State	Loan Type	Date Acquired	Disposal Date	Book Value/ Recorded Investment Excluding Accrued Interest Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Amortization) /Accretion	Current Year's Other Than Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Change in Book Value (8+9-10+11)	Total Foreign Exchange Change in Book Value	Book Value/ Recorded Investment Excluding Accrued Interest on Disposal	Consid-eration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal
2004182	GLEN BURNIE	MD		12/18/2017		6,120,406		31,297			31,297			79,807			0
0299999. Mortgages with partial repayments						6,120,406	0	31,297	0	0	31,297	0	0	79,807	0	0	0
0599999 - Totals						6,120,406	0	31,297	0	0	31,297	0	0	79,807	0	0	0

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

N O N E

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

N O N E

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 3

Show All Long-Term Bonds and Stock Acquired During the Current Quarter

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends	10 NAIC Designation or Market Indicator (a)
040114-HL-7	ARGENTINA REPUBLIC OF SR UNSECURED 6.875% 01/26/27	D	07/27/2018	Balanz Capital Intl Inc		643,300	700,000	535	4FE
EK1766-13-9	SUAM FINANCE BV SR UNSECURED 4.875% 04/17/24	D	09/10/2018	Lorrain Vial		1,008,000	1,000,000	19,635	2FE
1099999. Subtotal - Bonds - All Other Governments						1,651,300	1,700,000	20,170	XXX
00287Y-BE-8	ABBVIE INC SR UNSECURED 3.375% 11/14/21		09/13/2018	MORGAN STANLEY		1,996,560	2,000,000	0	2FE
14987R-AA-6	CB ESCROW CORP SR UNSECURED 8.000% 10/15/25		07/25/2018	BANC AMERICA		461,875	500,000	11,333	4FE
16411Q-AC-5	CHENIERE ENERGY PARTNERS SR UNSECURED 5.625% 10/01/26		09/06/2018	CHASE SECURITIES		1,000,000	1,000,000	0	3FE
20030N-BX-8	COMCAST CORP SR UNSECURED 3.000% 02/01/24		07/06/2018	MORGAN STANLEY		479,875	500,000	6,625	1FE
23283P-AK-0	CYRUSONE LP/CYRUSONE FIN SR UNSECURED 5.375% 03/15/27		09/26/2018	DAIN RAUSCHER INC-69211		2,026,260	2,000,000	3,882	3FE
23311V-AF-4	DCP MIDSTREAM OPERATING SR UNSECURED 5.600% 04/01/44		09/18/2018	CHASE SECURITIES		965,000	1,000,000	26,289	3FE
247916-AL-3	DENBURY RESOURCES INC 2ND LIEN 7.500% 02/15/24		08/14/2018	CHASE SECURITIES		1,000,000	1,000,000	0	4FE
25278X-AC-3	DIAMONDBACK ENERGY INC SR UNSECURED 4.750% 11/01/24		09/18/2018	BANC AMERICA		997,500	1,000,000	19,000	3FE
25278X-AH-2	DIAMONDBACK ENERGY INC SR UNSECURED 5.375% 05/31/25		08/20/2018	Tax Free Exchange		1,036,233	1,000,000	11,944	3FE
25470X-AY-1	DISH DBS CORP SR UNSECURED 7.750% 07/01/26		09/24/2018	FIRST BOSTON CORP		933,750	1,000,000	18,299	4FE
29336U-AB-3	ENLINK MIDSTREAM PARTNER SR UNSECURED 4.400% 04/01/24		07/26/2018	BANC AMERICA		958,750	1,000,000	14,544	3FE
29336U-AD-9	ENLINK MIDSTREAM PARTNER SR UNSECURED 5.050% 04/01/45		07/27/2018	BLAIR WM & CO INC		261,555	318,000	5,353	3FE
337738-AR-9	FISERV INC SR UNSECURED 4.200% 10/01/28		09/20/2018	WACHOVIA		998,050	1,000,000	0	2FE
404121-AH-8	HCA INC SR UNSECURED 5.375% 09/01/26		09/06/2018	DEUTSCHE BANK		1,012,000	1,000,000	2,538	3FE
43815H-AC-1	HONDA AUTO RECEIVABLES OWNER SER 18-3 CLASS A3 2.950% 08/22/22		08/21/2018	BANC AMERICA		999,863	1,000,000	0	1FE
46647P-AU-0	JP MORGAN CHASE & CO SR UNSECURED 3.797% 07/23/24		07/16/2018	CHASE SECURITIES		2,000,000	2,000,000	0	1FE
629568-AX-4	NABORS INDUSTRIES INC SR UNSECURED 4.625% 09/15/21		09/11/2018	DEUTSCHE BANK		990,000	1,000,000	22,868	3FE
62957H-AF-2	NABORS INDUSTRIES INC. SR UNSECURED 5.750% 02/01/25		09/27/2018	Tax Free Exchange		998,780	1,000,000	8,944	3FE
641062-AD-6	NESTLE HOLDINGS INC SR UNSECURED 3.350% 09/24/23		09/17/2018	BANC AMERICA		1,499,730	1,500,000	0	1FE
78454L-AP-5	SM ENERGY CO SR UNSECURED 6.625% 01/15/27		08/06/2018	BANC AMERICA		1,000,000	1,000,000	0	3FE
87470L-AE-1	TALLGRASS NRG PRTNR/FIN SR UNSECURED 4.750% 10/01/23		09/24/2018	WACHOVIA		1,000,000	1,000,000	0	3FE
88033G-CR-9	TENET HEALTHCARE CORP 1ST LIEN 4.625% 07/15/24		07/23/2018	DAIN RAUSCHER INC-69211		963,750	1,000,000	1,285	3FE
88033G-CS-7	TENET HEALTHCARE CORP 1ST LIEN 4.625% 07/15/24		07/30/2018	Tax Free Exchange		963,814	1,000,000	1,927	3FE
880349-AR-6	TENNECO INC SR UNSECURED 5.000% 07/15/26		07/17/2018	CHASE SECURITIES		883,750	1,000,000	556	3FE
902494-BG-7	TYSON FOODS INC SR UNSECURED 3.900% 09/28/23		09/25/2018	MORGAN STANLEY		499,305	500,000	0	2FE
904764-BG-1	UNILEVER CAPITAL CORP SR UNSECURED 3.250% 03/07/24		09/04/2018	GOLDMAN SACHS & CO		992,780	1,000,000	0	1FE
960386-AN-0	WABTEC SR UNSECURED 4.150% 03/15/24		09/12/2018	BANC AMERICA		998,050	1,000,000	0	2FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						27,917,230	28,318,000	155,387	XXX
8399997. Total - Bonds - Part 3						29,568,530	30,018,000	175,557	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX
8399999. Total - Bonds						29,568,530	30,018,000	175,557	XXX
8999997. Total - Preferred Stocks - Part 3						0	XXX	0	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	XXX
9799997. Total - Common Stocks - Part 3						0	XXX	0	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	XXX
9999999 - Totals						29,568,530	XXX	175,557	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues .....

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation or Market In-dicator (a)
	GOVT NATL MTGE ASSN I POOL NO GN733720																				
3620AM-DZ-2	4.500% 06/15/40		09/01/2018	Paydown		120,245	120,245	132,420	131,996	0	(11,751)	0	(11,751)	0	120,245	0	0	0	3,735	06/15/2040	1
912828-RH-5	US TREASURY NOTE/BOND 1.375% 09/30/18		09/30/2018	Maturity		3,500,000	3,500,000	3,494,771	3,491,033	0	12,946	3,978	8,968	0	3,500,000	0	0	0	48,125	09/30/2018	1
0599999. Subtotal - Bonds - U.S. Governments						3,620,245	3,620,245	3,627,191	3,623,029	0	1,195	3,978	(2,783)	0	3,620,245	0	0	0	51,860	XXX	XXX
	ARGENTINA REPUBLIC OF SR UNSECURED 6.875%			Balanz Capital Intl Inc																	
040114-GW-4	04/22/21	D	07/27/2018			706,464	704,000	704,000	704,000	0	0	0	0	0	704,000	0	2,464	2,464	37,376	04/22/2021	4FE
	BANCO DE COSTA RICA SR UNSECURED 5.250%																				
05990L-AA-2	08/12/18	D	08/12/2018	Maturity		1,000,000	1,000,000	1,008,500	1,001,104	0	(1,104)	0	(1,104)	0	1,000,000	0	0	0	52,500	08/12/2018	3FE
	COLOMBIA REPUBLIC OF SR UNSECURED 4.000%																				
195325-BQ-7	02/26/24	D	09/10/2018	Lorrain Vial		999,000	1,000,000	1,041,500	1,027,935	0	(2,988)	0	(2,988)	0	1,024,946	0	(25,946)	(25,946)	41,778	02/26/2024	2FE
	PETROLEOS MEXICANOS SR UNSECURED 6.375%																				
71654Q-CA-8	02/04/21	D	07/24/2018	GOLDMAN SACHS & CO		525,000	500,000	521,750	0	0	(656)	0	(656)	0	521,094	0	3,906	3,906	15,229	02/04/2021	2FE
	REPUBLIC OF PARAGUAY SR UNSECURED 4.625%																				
P75744-AA-3	01/25/23	D	09/05/2018	JEFFRIES		509,000	500,000	511,250	507,130	0	(884)	0	(884)	0	506,246	0	2,754	2,754	25,823	01/25/2023	3FE
1099999. Subtotal - Bonds - All Other Governments						3,739,464	3,704,000	3,787,000	3,240,169	0	(5,632)	0	(5,632)	0	3,756,286	0	(16,822)	(16,822)	172,706	XXX	XXX
25476F-VK-1	COLUMBIA DIST OF SER D 5.000% 06/01/42		09/28/2018	Wachovia		5,643,800	5,000,000	5,798,900	2,932,092	0	(50,100)	0	(50,100)	0	5,747,667	0	(103,867)	(103,867)	195,139	06/01/2042	1FE
	PENNSYLVANIA ST GENERAL OBLIGA 5.000%																				
70914P-LB-6	07/01/19		08/21/2018	GOLDMAN SACHS & CO		2,571,675	2,500,000	2,890,375	2,567,579	0	(28,622)	0	(28,622)	0	2,538,958	0	32,717	32,717	142,708	07/01/2019	1FE
1799999. Subtotal - Bonds - U.S. States, Territories and Possessions						8,215,475	7,500,000	8,689,275	5,499,671	0	(78,722)	0	(78,722)	0	8,286,625	0	(71,150)	(71,150)	337,847	XXX	XXX
	HOUSTON TEX PREREFUNDED REF PUBLIC IMPT																				
442331-M7-6	5.000% 03/01/26		09/07/2018	MORGAN STANLEY		1,466,978	1,445,000	1,471,761	1,456,459	0	(6,755)	0	(6,755)	0	1,449,705	0	17,274	17,274	74,257	03/01/2026	1
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						1,466,978	1,445,000	1,471,761	1,456,459	0	(6,755)	0	(6,755)	0	1,449,705	0	17,274	17,274	74,257	XXX	XXX
	FED HOME LOAN MTGE CORP GOLD POOL NO C55997																				
3132XY-UX-3	4.000% 05/01/48		09/01/2018	Paydown		91,389	91,389	93,216	0	0	(1,828)	0	(1,828)	0	91,389	0	0	0	877	05/01/2048	1
	FED NATL MTGE ASSN POOL NO AU8778 3.000%																				
3138X8-XG-1	10/01/28		09/01/2018	Paydown		75,179	75,179	77,916	77,340	0	(2,162)	0	(2,162)	0	75,179	0	0	0	1,524	10/01/2028	1
	MASSACHUSETTS ST HSG FIN AGY REVENUE BONDS																				
57586P-6Q-4	2.650% 12/01/41		07/18/2018	Call 100.0000		130,000	130,000	135,457	132,908	0	(309)	0	(309)	0	132,598	0	(2,598)	(2,598)	2,172	12/01/2041	1FE
	NEW JERSEY ST EDUCTNL FAC AUTH HGR EDU																				
646066-BW-9	CAPITAL IMPT FUND-SER 4.000% 09/01/18		09/01/2018	Maturity		5,700,000	5,700,000	5,921,388	5,749,524	0	(49,524)	0	(49,524)	0	5,700,000	0	0	0	228,000	09/01/2018	2FE
	NEW JERSEY ST TPK AUTH SER B 5.000%																				
646139-Z2-4	01/01/20		09/14/2018	JPM-CHASE		1,576,115	1,515,000	1,726,700	1,599,991	0	(35,622)	0	(35,622)	0	1,580,259	0	(4,144)	(4,144)	91,577	01/01/2020	1FE
	OKLAHOMA ST HSG FIN AGY SF MTG HOMEOWNERSHIP																				
67886M-MP-1	LN PG SER A 4.750% 03/01/28		09/01/2018	Call 100.0000		25,000	25,000	26,947	25,628	0	(150)	0	(150)	0	25,478	0	(478)	(478)	1,188	03/01/2028	1FE
	VIRGINIA ST PUB BLDG AUTH PUB SER A 5.000%																				
928172-J2-2	08/01/22		09/12/2018	GOLDMAN SACHS & CO		2,217,380	2,000,000	2,385,800	2,254,036	0	(37,422)	0	(37,422)	0	2,216,614	0	766	766	111,944	08/01/2022	1FE
3199999. Subtotal - Bonds - U.S. Special Revenues						9,815,063	9,536,568	10,367,424	9,839,427	0	(127,017)	0	(127,017)	0	9,821,517	0	(6,454)	(6,454)	437,282	XXX	XXX
	COMM MORTGAGE TRUST SERIES 2015-CR23 CLASS A4																				
12593A-BA-2	3.497% 05/10/48		07/13/2018	DEUTSCHE BANK		0	0	0	0	0	0	0	0	0	0	0	0	0	40,798	05/10/2048	1FM
	CHENIERE ENERGY PARTNERS SR UNSECURED																				
16411Q-AA-9	5.250% 10/01/25		07/16/2018	BANC AMERICA		993,750	1,000,000	1,000,000	1,000,000	0	0	0	0	0	1,000,000	0	(6,250)	(6,250)	43,750	10/01/2025	3FE
20030N-BR-1	COMCAST CORP SR UNSECURED 2.750% 03/01/23		07/06/2018	MORGAN STANLEY		481,346	500,000	484,225	0	0	578	0	578	0	484,804	0	(3,459)	(3,459)	4,927	03/01/2023	1FE
	DENBURY RESOURCES INC 2ND LIEN 7.500%																				
247916-AL-3	02/15/24		08/17/2018	MIZUHO SECURITIES USA		1,003,750	1,000,000	1,000,000	0	0	0	0	0	0	1,000,000	0	3,750	3,750	0	02/15/2024	4FE
	DIAMONDBACK ENERGY INC SR UNSECURED 5.375%																				
25278X-AJ-8	05/31/25		08/20/2018	Tax Free Exchange		1,036,233	1,000,000	1,040,000	0	0	(3,767)	0	(3,767)	0	1,036,233	0	0	0	38,819	05/31/2025	3FE
	G E CAP CREDIT CARD MASTER TR SERIES 2012-7																				
36159J-DL-2	CLASS A 1.760% 09/15/22		08/14/2018	CITIGROUP		1,689,961	1,710,000	1,687,556	0	0	3,165	0	3,165	0	1,690,721	0	(760)	(760)	7,607	09/15/2022	1FE
	HALLIBURTON CO SR UNSECURED 2.000% 08/01/18																				
406216-BC-4			08/01/2018	Maturity		1,000,000	1,000,000	999,290	999,906	0	94	0	94	0	1,000,000	0	0	0	20,000	08/01/2018	2FE
	HOME DEPOT INC SR UNSEUCRED 2.250% 09/10/18																				
437076-BB-7			09/10/2018	Maturity		1,000,000	1,000,000	1,023,000	1,003,038	0	(3,038)	0	(3,038)	0	1,000,000	0	0	0	22,500	09/10/2018	1FE
	LAMAR MEDIA CORP SR SUBORDINATED 5.000%																				
513075-BE-0	05/01/23		09/20/2018	CHASE SECURITIES		507,500	500,000	518,750	513,259	0	(2,756)	0	(2,756)	0	510,504	0	(3,004)	(3,004)	22,431	05/01/2023	3FE
	LIFEPOINT HOSPITALS INC SR UNSECURED 5.875%																				
53219L-AN-9	12/01/23		07/23/2018	WARBURG		1,040,000	1,000,000	1,006,250	0	0	(717)	0	(717)	0	1,005,533	0	34,467	34,467	38,188	12/01/2023	3FE

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation or Market In-dicator (a)
62957H-AD-7	NABORS INDUSTRIES INC. SR UNSECURED 5.750% 02/01/25		09/27/2018	Tax Free Exchange		998,780	1,000,000	998,750	0	0	30	0	30	0	998,780	0	0	0	38,972	02/01/2025	3FE
87470L-AE-1	TALLGRASS NRG PRTNR/FIN SR UNSECURED 4.750% 10/01/23		09/24/2018	CITIGROUP		1,000,000	1,000,000	1,000,000	0	0	0	0	0	0	1,000,000	0	0	0	0	10/01/2023	3FE
88033G-CR-9	TENET HEALTHCARE CORP 1ST LIEN 4.625% 07/15/24		07/30/2018	Tax Free Exchange		963,814	1,000,000	963,750	0	0	64	0	64	0	963,814	0	0	0	1,927	07/15/2024	3FE
90521A-PJ-1	UNION BANK NA SR UNSECURED 2.625% 09/26/18		09/26/2018	Maturity		1,000,000	1,000,000	999,770	999,943	0	57	0	57	0	1,000,000	0	0	0	26,250	09/26/2018	1FE
912909-AN-8	US STEEL CORP SR UNSECURED 6.250% 03/15/26		09/06/2018	CITIGROUP		988,750	1,000,000	1,000,000	0	0	0	0	0	0	1,000,000	0	(11,250)	(11,250)	30,382	03/15/2026	4FE
984121-CQ-4	XEROX CORP SR UNSECURED 3.625% 03/15/23		07/26/2018	FIRST BOSTON CORP		954,140	1,000,000	989,740	0	0	904	0	904	0	990,644	0	(36,504)	(36,504)	32,122	03/15/2023	2FE
034863-AU-4	ANGLO AMERICAN CAPITAL SR UNSECURED 4.500% 03/15/28	D	07/05/2018	HSBC SEC INC		480,405	500,000	497,730	0	0	28	0	28	0	497,758	0	(17,353)	(17,353)	7,125	03/15/2028	2FE
46115H-AZ-0	INTESA SANPAOLO SPA SR UNSECURED 3.125% 07/14/22	D	09/19/2018	BNP PARIBAS		1,398,915	1,500,000	1,377,858	1,513,665	0	4,750	134,400	(129,650)	0	1,384,015	0	14,900	14,900	55,599	07/14/2022	2FE
75625Q-AA-7	RECKITT BENCKISER TSY SR UNSECURED 2.125% 09/21/18	D	09/21/2018	Maturity		1,500,000	1,500,000	1,490,130	1,498,481	0	1,519	0	1,519	0	1,500,000	0	0	0	31,875	09/21/2018	1FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						18,037,344	18,210,000	18,076,799	7,528,292	0	911	134,400	(133,489)	0	18,062,806	0	(25,463)	(25,463)	463,272	XXX	XXX
8399997. Total - Bonds - Part 4						44,894,569	44,015,813	46,019,450	31,187,047	0	(216,020)	138,378	(354,398)	0	44,997,184	0	(102,615)	(102,615)	1,537,224	XXX	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8399999. Total - Bonds						44,894,569	44,015,813	46,019,450	31,187,047	0	(216,020)	138,378	(354,398)	0	44,997,184	0	(102,615)	(102,615)	1,537,224	XXX	XXX
8999997. Total - Preferred Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799997. Total - Common Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9999999 - Totals						44,894,569	XXX	46,019,450	31,187,047	0	(216,020)	138,378	(354,398)	0	44,997,184	0	(102,615)	(102,615)	1,537,224	XXX	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues.....

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

SCHEDULE E - PART 1 - CASH

Month End Depository Balances

1	2	3	4	5	Book Balance at End of Each Month During Current Quarter			9
					6	7	8	
Depository	Code	Rate of Interest	Amount of Interest Received During Current Quarter	Amount of Interest Accrued at Current Statement Date	First Month	Second Month	Third Month	*
Bank of America Charlotte, NC					12,670,218	8,521,448	2,705,423	XXX
0199998. Deposits in ... 2 depositories that do not exceed the allowable limit in any one depository (See instructions) - Open Depositories	XXX	XXX			(106,402)	(6,410)	(25,780)	XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	12,563,816	8,515,038	2,679,643	XXX
0299998. Deposits in ... depositories that do not exceed the allowable limit in any one depository (See instructions) - Suspended Depositories	XXX	XXX						XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	12,563,816	8,515,038	2,679,643	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX				XXX
0599999. Total - Cash	XXX	XXX	0	0	12,563,816	8,515,038	2,679,643	XXX

STATEMENT AS OF SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned End of Current Quarter

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
0599999. Total - U.S. Government Bonds						0	0	0
1099999. Total - All Other Government Bonds						0	0	0
1799999. Total - U.S. States, Territories and Possessions Bonds						0	0	0
2499999. Total - U.S. Political Subdivisions Bonds						0	0	0
3199999. Total - U.S. Special Revenues Bonds						0	0	0
	AMERICAN ELEC POWER CP 4-2 144A		09/28/2018	2.440	10/23/2018	4,853,750	0	987
	AMPHENOL CORP CP 4(2) 144A		09/26/2018	2.400	10/02/2018	1,999,867	0	667
	CONSOLIDATED EDISON INC CP 4(2) 144A		09/24/2018	2.280	10/01/2018	4,500,000	0	1,995
	DOVER CORP CP 4(2) 144A		09/27/2018	2.350	10/02/2018	3,956,742	0	1,033
	HP INC CP 4(2) 144A		09/24/2018	2.300	10/01/2018	7,500,000	0	3,354
	MCCORMICK & COMPANY INC CP 4(2) 144A		09/28/2018	2.390	10/05/2018	4,748,738	0	946
	MOHAWK INDUSTRIES INC CP 4(2) 144A		09/26/2018	2.250	10/02/2018	1,999,875	0	625
	PPL CAPITAL FUNDING INC CP 4(2) 144A		09/24/2018	2.300	10/01/2018	4,532,000	0	2,027
	PPL CAPITAL FUNDING INC CP 4(2) 144A		09/21/2018	2.310	10/01/2018	6,000,000	0	3,850
	SOUTHERN COMPANY FUNDING CORP CP 4(2) 144A		09/25/2018	2.450	10/02/2018	1,156,921	0	472
3299999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations						41,247,893	0	15,956
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						41,247,893	0	15,956
4899999. Total - Hybrid Securities						0	0	0
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0
6099999. Subtotal - SVO Identified Funds						0	0	0
7799999. Total - Issuer Obligations						41,247,893	0	15,956
7899999. Total - Residential Mortgage-Backed Securities						0	0	0
7999999. Total - Commercial Mortgage-Backed Securities						0	0	0
8099999. Total - Other Loan-Backed and Structured Securities						0	0	0
8199999. Total - SVO Identified Funds						0	0	0
8399999. Total Bonds						41,247,893	0	15,956
60934N-50-0	FEDERATED INVESTORS INC TREASURY OBLIGATION FUND		09/27/2018	0.000	XXX	2,533	30	71
8599999. Subtotal - Exempt Money Market Mutual Funds - as Identified by the SVO						2,533	30	71
8899999 - Total Cash Equivalents						41,250,426	30	16,027

SUPPLEMENT FOR THE QUARTER ENDING SEPTEMBER 30, 2018 OF THE Aetna Better Health of Kentucky Insurance Company

MEDICARE PART D COVERAGE SUPPLEMENT

(Net of Reinsurance)

NAIC Group Code 0001 NAIC Company Code 15761

	Individual Coverage		Group Coverage		5
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	Total Cash
1. Premiums Collected		XXX		XXX	
2. Earned Premiums		XXX		XXX	XXX
3. Claims Paid		XXX		XXX	
4. Claims Incurred				XXX	XXX
5. Reinsurance Coverage and Low Income Cost Sharing - Claims Paid Net of Reimbursements Applied (a)	XXX		XXX		
6. Aggregate Policy Reserves - Change		XXX		XXX	XXX
7. Expenses Paid		XXX		XXX	
8. Expenses Incurred		XXX		XXX	XXX
9. Underwriting Gain or Loss		XXX		XXX	XXX
10. Cash Flow Result	XXX	XXX	XXX	XXX	

NONE

(a) Uninsured Receivable/Payable with CMS at End of Quarter: $ ..... due from CMS or $ ..... due to CMS

Aetna Better Health® of Kentucky 2018 Final Statement

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HEALTH ANNUAL STATEMENT

AS OF DECEMBER 31, 2018
OF THE CONDITION AND AFFAIRS OF THE

Aetna Better Health of Kentucky Insurance Company

NAIC Group Code 0001 (Current) 0001 (Prior) NAIC Company Code 15761 Employer's ID Number 47-3279217

Organized under the Laws of Kentucky, State of Domicile or Port of Entry KY

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health

Is HMO Federally Qualified? Yes [ ] No [ ]

Incorporated/Organized 02/24/2015 Commenced Business 02/01/2016

Statutory Home Office 9900 Corporate Campus Dr., Suite 1000 (Street and Number), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Main Administrative Office 9900 Corporate Campus Dr., Suite 1000 (Street and Number)
Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Mail Address 9900 Corporate Campus Dr., Suite 1000 (Street and Number or P.O. Box), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 9900 Corporate Campus Dr., Suite 1000 (Street and Number)
Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Internet Website Address www.aetnabetterhealth.com

Statutory Statement Contact Scott David Miller (Name), 717-671-2474 (Area Code) (Telephone Number)
StatutoryReporting@aetna.com (E-mail Address), 717-526-2888 (FAX Number)

OFFICERS

President Randy Joo Hwan Hyun #
Chief Financial Officer Debra Jean Bacon
Vice President and Secretary Robert Mark Kessler

OTHER

Scott David Miller, Corporate Controller
Kevin James Casey, Senior Investment Officer
Frank Ferris Chronister III, Assistant Controller
John Patrick Maroney, Vice President and Treasurer

DIRECTORS OR TRUSTEES

Debra Jean Bacon
Jonathan Edward Copley
Randy Joo Hwan Hyun #

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Randy Joo Hwan Hyun Chief Executive Officer and President	Robert Mark Kessler Vice President and Secretary	Debra Jean Bacon Chief Financial Officer
State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa
Subscribed and sworn to before me this 11 day of February, 2019	Subscribed and sworn to before me this 11 day of February, 2019	Subscribed and sworn to before me this 11 day of February, 2019
NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)

JANEEN NEWHOUSE
Notary Public, State of Arizona
Maricopa County
Commission # 557912
My Commission Expires
February 08, 2023

JANEEN NEWHOUSE
Notary Public, State of Arizona
Maricopa County
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My Commission Expires
February 08, 2023

JANEEN NEWHOUSE
Notary Public, State of Arizona
Maricopa County
Commission # 557912
My Commission Expires
February 08, 2023

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number .....
2. Date filed .....
3. Number of pages attached.....

ASSETS

	Current Year 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	Prior Year 4 Net Admitted Assets
1. Bonds (Schedule D)	442,356,086	0	442,356,086	479,236,865
2. Stocks (Schedule D):				
2.1 Preferred stocks	0	0	0	0
2.2 Common stocks	0	0	0	0
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens	13,407,858	0	13,407,858	12,979,171
3.2 Other than first liens	0	0	0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less $ 0 encumbrances)	0	0	0	0
4.2 Properties held for the production of income (less $ 0 encumbrances)	0	0	0	0
4.3 Properties held for sale (less $ 0 encumbrances)	0	0	0	0
5. Cash ($ 7,133,694 , Schedule E - Part 1), cash equivalents ($ 11,486,582 , Schedule E - Part 2) and short-term investments ($ 0 , Schedule DA)	18,620,276	0	18,620,276	14,204,888
6. Contract loans, (including $ 0 premium notes)	0	0	0	0
7. Derivatives (Schedule DB)	0	0	0	0
8. Other invested assets (Schedule BA)	0	0	0	0
9. Receivables for securities	11,415	0	11,415	524,756
10. Securities lending reinvested collateral assets (Schedule DL)	0	0	0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	474,395,635	0	474,395,635	506,945,680
13. Title plants less $ 0 charged off (for Title insurers only)	0	0	0	0
14. Investment income due and accrued	4,621,602	0	4,621,602	4,135,426
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	1,931,674	0	1,931,674	1,847,707
15.2 Deferred premiums and agents' balances and installments booked but deferred and not yet due (including $ 0 earned but unbilled premiums)	0	0	0	0
15.3 Accrued retrospective premiums ($ 0) and contracts subject to redetermination ($ 0)	0	0	0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	0	0	0	0
16.2 Funds held by or deposited with reinsured companies	0	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0	0
17. Amounts receivable relating to uninsured plans	0	0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	0	0	0	0
18.2 Net deferred tax asset	5,204,425	0	5,204,425	9,836,861
19. Guaranty funds receivable or on deposit	0	0	0	0
20. Electronic data processing equipment and software	0	0	0	0
21. Furniture and equipment, including health care delivery assets ($ 0)	0	0	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23. Receivables from parent, subsidiaries and affiliates	7,789,355	0	7,789,355	2,265,089
24. Health care ($ 2,070,247) and other amounts receivable	15,448,760	13,378,513	2,070,247	1,758,384
25. Aggregate write-ins for other than invested assets	500,000	500,000	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	509,891,451	13,878,513	496,012,938	526,789,148
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28. Total (Lines 26 and 27)	509,891,451	13,878,513	496,012,938	526,789,148
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Deposits	500,000	500,000	0	0
2502.				
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	500,000	500,000	0	0

LIABILITIES, CAPITAL AND SURPLUS

	Current Year 1 Covered	Current Year 2 Uncovered	Current Year 3 Total	Prior Year 4 Total
1. Claims unpaid (less $ 0 reinsurance ceded)	123,326,789	3,932,306	127,259,095	159,039,981
2. Accrued medical incentive pool and bonus amounts	1,187,135	0	1,187,135	190,629
3. Unpaid claims adjustment expenses	4,812,094	0	4,812,094	3,072,860
4. Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Service Act	0	0	0	0
5. Aggregate life policy reserves	0	0	0	0
6. Property/casualty unearned premium reserves	0	0	0	0
7. Aggregate health claim reserves	0	0	0	0
8. Premiums received in advance	574,560	0	574,560	31,811,757
9. General expenses due or accrued	11,601,352	0	11,601,352	12,641,664
10.1 Current federal and foreign income tax payable and interest thereon (including $ 0 on realized capital gains (losses))	4,383,990	0	4,383,990	8,105,131
10.2 Net deferred tax liability	0	0	0	0
11. Ceded reinsurance premiums payable	0	0	0	0
12. Amounts withheld or retained for the account of others	3,139,799	0	3,139,799	0
13. Remittances and items not allocated	1,753,757	0	1,753,757	2,849,167
14. Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)	0	0	0	0
15. Amounts due to parent, subsidiaries and affiliates	13,820,266	0	13,820,266	45,303,713
16. Derivatives	0	0	0	0
17. Payable for securities	0	0	0	0
18. Payable for securities lending	0	0	0	0
19. Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)	0	0	0	0
20. Reinsurance in unauthorized and certified ($ 0) companies	0	0	0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates	0	0	0	0
22. Liability for amounts held under uninsured plans	0	0	0	0
23. Aggregate write-ins for other liabilities (including $ 0 current)	982,691	0	982,691	1,851,899
24. Total liabilities (Lines 1 to 23)	165,582,433	3,932,306	169,514,739	264,866,801
25. Aggregate write-ins for special surplus funds	XXX	XXX	0	22,555,000
26. Common capital stock	XXX	XXX	1,000,000	1,000,000
27. Preferred capital stock	XXX	XXX	0	0
28. Gross paid in and contributed surplus	XXX	XXX	99,010,001	99,010,001
29. Surplus notes	XXX	XXX	0	0
30. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	226,488,198	139,357,346
32. Less treasury stock, at cost:				
32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX	0	0
32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX	0	0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	326,498,199	261,922,347
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	496,012,938	526,789,148
DETAILS OF WRITE-INS				
2301. Escheat Payable	982,691	0	982,691	1,851,899
2302.				
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above)	982,691	0	982,691	1,851,899
2501. Estimated Health Insurance Fee accrual	XXX	XXX	0	22,555,000
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	XXX	XXX	0	22,555,000
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year 1 Uncovered	Current Year 2 Total	Prior Year 3 Total
1.	Member Months	XXX	2,773,717	3,018,365
2.	Net premium income (including $ 0 non-health premium income)	XXX	1,121,827,068	1,092,625,603
3.	Change in unearned premium reserves and reserve for rate credits	XXX	0	31,898,076
4.	Fee-for-service (net of $ 0 medical expenses)	XXX	0	0
5.	Risk revenue	XXX	0	0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0
8.	Total revenues (Lines 2 to 7)	XXX	1,121,827,068	1,124,523,679
	Hospital and Medical:			
9.	Hospital/medical benefits	17,879,459	578,623,254	609,008,492
10.	Other professional services	1,341,940	43,428,479	49,453,749
11.	Outside referrals	263,162	8,516,577	0
12.	Emergency room and out-of-area	2,475,962	80,128,217	89,732,481
13.	Prescription drugs	0	218,620,756	220,118,361
14.	Aggregate write-ins for other hospital and medical	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts	0	1,640,478	(7,740,581)
16.	Subtotal (Lines 9 to 15)	21,960,523	930,957,761	960,572,502
	Less:			
17.	Net reinsurance recoveries	0	0	0
18.	Total hospital and medical (Lines 16 minus 17)	21,960,523	930,957,761	960,572,502
19.	Non-health claims (net)	0	0	0
20.	Claims adjustment expenses, including $ 26,712,514 cost containment expenses	0	28,085,901	28,389,145
21.	General administrative expenses	0	93,657,324	69,029,357
22.	Increase in reserves for life and accident and health contracts (including $ 0 increase in reserves for life only)	0	0	0
23.	Total underwriting deductions (Lines 18 through 22)	21,960,523	1,052,700,986	1,057,991,004
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	69,126,082	66,532,675
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)	0	16,076,249	14,019,102
26.	Net realized capital gains (losses) less capital gains tax of $ (480,125)	0	(3,331,896)	637,847
27.	Net investment gains (losses) (Lines 25 plus 26)	0	12,744,353	14,656,949
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $ 0) (amount charged off $ 0)]	0	0	0
29.	Aggregate write-ins for other income or expenses	0	(4,224,851)	(4,535,812)
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	77,645,584	76,653,812
31.	Federal and foreign income taxes incurred	XXX	18,504,307	20,912,254
32.	Net income (loss) (Lines 30 minus 31)	XXX	59,141,277	55,741,558
	DETAILS OF WRITE-INS			
0601.		XXX		
0602.		XXX		
0603		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699.	Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.		XXX		
0702.		XXX		
0703		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799.	Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	0
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499.	Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	0	0
2901.	Regulatory penalties	0	(4,224,851)	(4,535,812)
2902.				
2903				
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999.	Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	(4,224,851)	(4,535,812)

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL AND SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	261,922,348	213,442,922
34.	Net income or (loss) from Line 32	59,141,277	55,741,558
35.	Change in valuation basis of aggregate policy and claim reserves	0	0
36.	Change in net unrealized capital gains (losses) less capital gains tax of $ (408,887)	(1,538,193)	148,249
37.	Change in net unrealized foreign exchange capital gain or (loss)	0	0
38.	Change in net deferred income tax	(5,183,022)	(7,178,803)
39.	Change in nonadmitted assets	12,128,036	(231,579)
40	Change in unauthorized and certified reinsurance	0	0
41.	Change in treasury stock	0	0
42.	Change in surplus notes	0	0
43.	Cumulative effect of changes in accounting principles	0	0
44.	Capital Changes:		
	44.1 Paid in	0	990,000
	44.2 Transferred from surplus (Stock Dividend)	0	0
	44.3 Transferred to surplus	0	0
45.	Surplus adjustments:		
	45.1 Paid in	0	(990,000)
	45.2 Transferred to capital (Stock Dividend)	0	0
	45.3 Transferred from capital	0	0
46.	Dividends to stockholders	0	0
47.	Aggregate write-ins for gains or (losses) in surplus	27,753	0
48.	Net change in capital and surplus (Lines 34 to 47)	64,575,851	48,479,426
49.	Capital and surplus end of reporting period (Line 33 plus 48)	326,498,199	261,922,348
	DETAILS OF WRITE-INS		
4701.	Correction of Prior Year Current Federal Income Tax Incurred	27,753	0
4702.			
4703.			
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0
4799.	Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	27,753	0

CASH FLOW

		1 Current Year	2 Prior Year
	Cash from Operations		
1.	Premiums collected net of reinsurance	1,090,505,904	1,125,954,663
2.	Net investment income	18,140,983	17,511,807
3.	Miscellaneous income	0	0
4.	Total (Lines 1 through 3)	1,108,646,887	1,143,466,470
5.	Benefit and loss related payments	950,102,213	1,002,057,647
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0
7.	Commissions, expenses paid and aggregate write-ins for deductions	125,269,154	103,782,491
8.	Dividends paid to policyholders	0	0
9.	Federal and foreign income taxes paid (recovered) net of $ 0 tax on capital gains (losses)	21,745,323	27,025,769
10.	Total (Lines 5 through 9)	1,097,116,690	1,132,865,907
11.	Net cash from operations (Line 4 minus Line 10)	11,530,197	10,600,563
	Cash from Investments		
12.	Proceeds from investments sold, matured or repaid:		
	12.1 Bonds	197,532,407	116,787,533
	12.2 Stocks	0	0
	12.3 Mortgage loans	316,980	0
	12.4 Real estate	0	0
	12.5 Other invested assets	0	0
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	(722)	(470)
	12.7 Miscellaneous proceeds	547,760	0
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	198,396,425	116,787,063
13.	Cost of investments acquired (long-term only):		
	13.1 Bonds	169,085,405	69,990,769
	13.2 Stocks	0	0
	13.3 Mortgage loans	621,181	12,979,171
	13.4 Real estate	0	0
	13.5 Other invested assets	0	0
	13.6 Miscellaneous applications	0	494,470
	13.7 Total investments acquired (Lines 13.1 to 13.6)	169,706,586	83,464,410
14.	Net increase (decrease) in contract loans and premium notes	0	0
15.	Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	28,689,839	33,322,653
	Cash from Financing and Miscellaneous Sources		
16.	Cash provided (applied):		
	16.1 Surplus notes, capital notes	0	0
	16.2 Capital and paid in surplus, less treasury stock	0	0
	16.3 Borrowed funds	0	0
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
	16.5 Dividends to stockholders	0	0
	16.6 Other cash provided (applied)	(35,804,649)	(34,496,987)
17.	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(35,804,649)	(34,496,987)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	4,415,387	9,426,229
19.	Cash, cash equivalents and short-term investments:		
	19.1 Beginning of year	14,204,889	4,778,660
	19.2 End of year (Line 18 plus Line 19.1)	18,620,276	14,204,889

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001. Non-Cash Transaction - Tax Free Acquisition	8,057,370	12,655,315

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Net premium income	1,121,827,068	30,661,427	0	0	0	0	0	1,091,165,641	0	0
2. Change in unearned premium reserves and reserve for rate credit	0	0	0	0	0	0	0	0	0	0
3. Fee-for-service (net of $ 0 medical expenses)	0	0	0	0	0	0	0	0	0	XXX
4. Risk revenue	0	0	0	0	0	0	0	0	0	XXX
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	1,121,827,068	30,661,427	0	0	0	0	0	1,091,165,641	0	0
8. Hospital/medical benefits	578,623,254	15,265,331	0	0	0	0	0	563,357,923	0	XXX
9. Other professional services	43,428,479	3,818,152	0	0	0	0	0	39,610,327	0	XXX
10. Outside referrals	8,516,577	345,389	0	0	0	0	0	8,171,188	0	XXX
11. Emergency room and out-of-area	80,128,217	2,329,363	0	0	0	0	0	77,798,854	0	XXX
12. Prescription drugs	218,620,756	5,830,162	0	0	0	0	0	212,790,594	0	XXX
13. Aggregate write-ins for other hospital and medical	0	0	0	0	0	0	0	0	0	XXX
14. Incentive pool, withhold adjustments and bonus amounts	1,640,478	69,927	0	0	0	0	0	1,570,551	0	XXX
15. Subtotal (Lines 8 to 14)	930,957,761	27,658,324	0	0	0	0	0	903,299,437	0	XXX
16. Net reinsurance recoveries	0	0	0	0	0	0	0	0	0	XXX
17. Total medical and hospital (Lines 15 minus 16)	930,957,761	27,658,324	0	0	0	0	0	903,299,437	0	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
19. Claims adjustment expenses including $ 26,712,514 cost containment expenses	28,085,901	767,635	0	0	0	0	0	27,318,266	0	0
20. General administrative expenses	93,657,324	2,645,040	0	0	0	0	0	91,012,284	0	0
21. Increase in reserves for accident and health contracts	0	0	0	0	0	0	0	0	0	XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
23. Total underwriting deductions (Lines 17 to 22)	1,052,700,986	31,070,999	0	0	0	0	0	1,021,629,987	0	0
24. Total underwriting gain or (loss) (Line 7 minus Line 23)	69,126,082	(409,572)	0	0	0	0	0	69,535,654	0	0
DETAILS OF WRITE-INS										
0501.										XXX
0502.										XXX
0503.										XXX
0598. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0	XXX
0601.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301.										XXX
1302.										XXX
1303.										XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	XXX

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

PART 1 - PREMIUMS

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1 + 2 - 3)
1. Comprehensive (hospital and medical)	30,661,427	0	0	30,661,427
2. Medicare Supplement	0	0	0	0
3. Dental only	0	0	0	0
4. Vision only	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0
6. Title XVIII - Medicare	0	0	0	0
7. Title XIX - Medicaid	1,091,165,641	0	0	1,091,165,641
8. Other health	0	0	0	0
9. Health subtotal (Lines 1 through 8)	1,121,827,068	0	0	1,121,827,068
10. Life	0	0	0	0
11. Property/casualty	0	0	0	0
12. Totals (Lines 9 to 11)	1,121,827,068	0	0	1,121,827,068

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 - CLAIMS INCURRED DURING THE YEAR

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Payments during the year:										
1.1 Direct	949,458,242	29,770,387	0	0	0	0	0	919,687,855	0	0
1.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
1.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
1.4 Net	949,458,242	29,770,387	0	0	0	0	0	919,687,855	0	0
2. Paid medical incentive pools and bonuses	643,972	69,927	0	0	0	0	0	574,045	0	0
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	127,259,095	3,077,892	0	0	0	0	0	124,181,203	0	0
3.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
3.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
3.4 Net	127,259,095	3,077,892	0	0	0	0	0	124,181,203	0	0
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct	0	0	0	0	0	0	0	0	0	0
4.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
4.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
4.4 Net	0	0	0	0	0	0	0	0	0	0
5. Accrued medical incentive pools and bonuses, current year	1,187,135	0	0	0	0	0	0	1,187,135	0	0
6. Net healthcare receivables (a)	(11,639,928)	0	0	0	0	0	0	(11,639,928)	0	0
7. Amounts recoverable from reinsurers December 31, current year	0	0	0	0	0	0	0	0	0	0
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	159,039,981	5,259,882	0	0	0	0	0	153,780,100	0	0
8.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
8.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
8.4 Net	159,039,981	5,259,882	0	0	0	0	0	153,780,100	0	0
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct	0	0	0	0	0	0	0	0	0	0
9.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
9.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
9.4 Net	0	0	0	0	0	0	0	0	0	0
10. Accrued medical incentive pools and bonuses, prior year	190,629	0	0	0	0	0	0	190,629	0	0
11. Amounts recoverable from reinsurers December 31, prior year	0	0	0	0	0	0	0	0	0	0
12. Incurred Benefits:										
12.1 Direct	929,317,284	27,588,397	0	0	0	0	0	901,728,886	0	0
12.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
12.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
12.4 Net	929,317,284	27,588,397	0	0	0	0	0	901,728,886	0	0
13. Incurred medical incentive pools and bonuses	1,640,478	69,927	0	0	0	0	0	1,570,551	0	0

(a) Excludes $ 0 loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A - CLAIMS LIABILITY END OF CURRENT YEAR

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Reported in Process of Adjustment:										
1.1 Direct	15,035,116	368,634	0	0	0	0	0	14,666,482	0	0
1.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
1.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
1.4 Net	15,035,116	368,634	0	0	0	0	0	14,666,482	0	0
2. Incurred but Unreported:										
2.1 Direct	112,223,979	2,709,258	0	0	0	0	0	109,514,721	0	0
2.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
2.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
2.4 Net	112,223,979	2,709,258	0	0	0	0	0	109,514,721	0	0
3. Amounts Withheld from Paid Claims and Capitations:										
3.1 Direct	0	0	0	0	0	0	0	0	0	0
3.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
3.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
3.4 Net	0	0	0	0	0	0	0	0	0	0
4. TOTALS:										
4.1 Direct	127,259,095	3,077,892	0	0	0	0	0	124,181,203	0	0
4.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
4.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
4.4 Net	127,259,095	3,077,892	0	0	0	0	0	124,181,203	0	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2B - ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred In Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)	2,016,627	27,753,759	55,964	3,021,928	2,072,591	5,259,881
2. Medicare Supplement	0	0	0	0	0	0
3. Dental Only	0	0	0	0	0	0
4. Vision Only	0	0	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0	0	0
6. Title XVIII - Medicare	0	0	0	0	0	0
7 Title XIX - Medicaid	87,570,918	832,116,938	9,152,063	115,029,140	96,722,981	153,780,101
8. Other health	0	0	0	0	0	0
9. Health subtotal (Lines 1 to 8)	89,587,545	859,870,697	9,208,027	118,051,068	98,795,572	159,039,982
10. Healthcare receivables (a)	7,944,805	7,503,955	0	0	7,944,805	27,088,688
11. Other non-health	0	0	0	0	0	0
12. Medical incentive pools and bonus amounts	26,428	617,544	0	1,187,135	26,428	190,629
13. Totals (Lines 9 - 10 + 11 + 12)	81,669,168	852,984,286	9,208,027	119,238,203	90,877,195	132,141,923

(a) Excludes $ 0 loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS

($000 Omitted)

Section A - Paid Health Claims - Comprehensive (Hospital & Medical)

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	0	0	0	0	0
2. 2014	0	0	0	0	0
3. 2015	XXX	0	977	977	977
4. 2016	XXX	XXX	23,297	26,839	26,839
5. 2017	XXX	XXX	XXX	28,735	30,752
6. 2018	XXX	XXX	XXX	XXX	27,824

Section B - Incurred Health Claims - Comprehensive (Hospital & Medical)

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	0	0	0	0	0
2. 2014	0	0	0	0	0
3. 2015	XXX	0	1,482	1,482	1,482
4. 2016	XXX	XXX	27,651	31,780	31,780
5. 2017	XXX	XXX	XXX	33,407	35,480
6. 2018	XXX	XXX	XXX	XXX	30,846

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Comprehensive (Hospital & Medical)

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2014	0	0	0	0.0	0	0.0	0	0	0	0.0
2. 2015	0	977	0	0.0	977	0.0	0	0	977	0.0
3. 2016	49,023	26,839	0	0.0	26,839	54.7	0	0	26,839	54.7
4. 2017	49,157	30,752	1,277	4.2	32,029	65.2	56	0	32,085	65.3
5. 2018	30,661	27,824	768	2.8	28,592	93.3	3,022	132	31,746	103.5

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS

($000 Omitted)

Section A - Paid Health Claims - Title XIX

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	0	0	0	0	0
2. 2014	0	0	0	0	0
3. 2015	XXX	0	35,777	35,777	35,777
4. 2016	XXX	XXX	578,599	751,494	751,494
5. 2017	XXX	XXX	XXX	809,340	888,993
6. 2018	XXX	XXX	XXX	XXX	825,161

Section B - Incurred Health Claims - Title XIX

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	0	0	0	0	0
2. 2014	0	0	0	0	0
3. 2015	XXX	0	58,651	58,651	58,651
4. 2016	XXX	XXX	744,626	929,353	929,353
5. 2017	XXX	XXX	XXX	932,069	1,020,874
6. 2018	XXX	XXX	XXX	XXX	941,377

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XIX

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2014	0	0	0	0.0	0	0.0	0	0	0	0.0
2. 2015	0	35,777	0	0.0	35,777	0.0	0	0	35,777	0.0
3. 2016	1,046,297	751,494	0	0.0	751,494	71.8	0	0	751,494	71.8
4. 2017	1,075,367	888,993	27,112	3.0	916,105	85.2	9,152	0	925,257	86.0
5. 2018	1,091,166	825,161	27,318	3.3	852,479	78.1	116,216	4,680	973,375	89.2

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS

($000 Omitted)

Section A - Paid Health Claims - Grand Total

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	0	0	0	0	0
2. 2014	0	0	0	0	0
3. 2015	XXX	0	36,754	36,754	36,754
4. 2016	XXX	XXX	601,896	778,333	778,333
5. 2017	XXX	XXX	XXX	838,075	919,745
6. 2018	XXX	XXX	XXX	XXX	852,985

Section B - Incurred Health Claims - Grand Total

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2014	2 2015	3 2016	4 2017	5 2018
1. Prior	0	0	0	0	0
2. 2014	0	0	0	0	0
3. 2015	XXX	0	60,133	60,133	60,133
4. 2016	XXX	XXX	772,277	961,133	961,133
5. 2017	XXX	XXX	XXX	965,476	1,056,354
6. 2018	XXX	XXX	XXX	XXX	972,223

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Grand Total

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2014	0	0	0	0.0	0	0.0	0	0	0	0.0
2. 2015	0	36,754	0	0.0	36,754	0.0	0	0	36,754	0.0
3. 2016	1,095,320	778,333	0	0.0	778,333	71.1	0	0	778,333	71.1
4. 2017	1,124,524	919,745	28,389	3.1	948,134	84.3	9,208	0	957,342	85.1
5. 2018	1,121,827	852,985	28,086	3.3	881,071	78.5	119,238	4,812	1,005,121	89.6

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other
1. Unearned premium reserves									
2. Additional policy reserves (a)									
3. Reserve for future contingent benefits									
4. Reserve for rate credits or experience rating refunds (including $ .....) for investment income									
5. Aggregate write-ins for other policy reserves									
6. Totals (gross)									
7. Reinsurance ceded									
8. Totals (Net)(Page 3, Line 4)									
9. Present value of amounts not yet due on claims									
10. Reserve for future contingent benefits									
11. Aggregate write-ins for other claim reserves									
12. Totals (gross)									
13. Reinsurance ceded									
14. Totals (Net)(Page 3, Line 7)									
DETAILS OF WRITE-INS									
0501.									
0502.									
0503.									
0598. Summary of remaining write-ins for Line 5 from overflow page									
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)									
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page									
1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)									

NONE

(a) Includes $ ..... premium deficiency reserve.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

	Claim Adjustment Expenses 1 Cost Containment Expenses	Claim Adjustment Expenses 2 Other Claim Adjustment Expenses	3 General Administrative Expenses	4 Investment Expenses	5 Total
1. Rent ($ 0 for occupancy of own building)	0	21,566	1,326,492	17,156	1,365,214
2. Salary, wages and other benefits	19,201,283	779,111	28,719,942	306,704	49,007,040
3. Commissions (less $ 0 ceded plus $ 0 assumed)	0	0	0	0	0
4. Legal fees and expenses	214,266	8,694	320,484	342	543,786
5. Certifications and accreditation fees	0	0	0	0	0
6. Auditing, actuarial and other consulting services	0	101,276	6,229,242	118,745	6,449,263
7. Traveling expenses	0	21,391	1,315,708	5,108	1,342,207
8. Marketing and advertising	0	24,249	1,491,482	0	1,515,731
9. Postage, express and telephone	0	32,158	1,977,940	3,484	2,013,582
10. Printing and office supplies	0	12,785	786,373	643	799,801
11. Occupancy, depreciation and amortization	0	0	0	0	0
12. Equipment	0	20,859	1,282,964	9,909	1,313,732
13. Cost or depreciation of EDP equipment and software	0	46,076	2,834,022	7,003	2,887,101
14. Outsourced services including EDP, claims, and other services	5,515,403	223,793	8,249,555	45,725	14,034,476
15. Boards, bureaus and association fees	41,788	1,696	62,504	284	106,272
16. Insurance, except on real estate	0	8,980	552,334	259	561,573
17. Collection and bank service charges	0	160	9,844	33,478	43,482
18. Group service and administration fees	0	0	0	0	0
19. Reimbursements by uninsured plans	0	0	0	0	0
20. Reimbursements from fiscal intermediaries	0	0	0	0	0
21. Real estate expenses	0	0	954,196	124	954,320
22. Real estate taxes	0	0	140,383	0	140,383
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes	0	0	0	0	0
23.2 State premium taxes	0	0	0	0	0
23.3 Regulatory authority licenses and fees	0	0	11,082,814	0	11,082,814
23.4 Payroll taxes	1,739,774	70,593	2,602,232	26,670	4,439,269
23.5 Other (excluding federal income and real estate taxes)	0	0	22,544,666	0	22,544,666
24. Investment expenses not included elsewhere	0	0	0	0	0
25. Aggregate write-ins for expenses	0	0	1,174,147	0	1,174,147
26. Total expenses incurred (Lines 1 to 25)	26,712,514	1,373,387	93,657,324	575,634	(a) 122,318,859
27. Less expenses unpaid December 31, current year	4,576,785	235,309	11,601,352	0	16,413,446
28. Add expenses unpaid December 31, prior year	2,849,432	223,428	12,641,664	0	15,714,524
29. Amounts receivable relating to uninsured plans, prior year	0	0	0	0	0
30. Amounts receivable relating to uninsured plans, current year	0	0	0	0	0
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	24,985,161	1,361,506	94,697,636	575,634	121,619,937
DETAILS OF WRITE-INS					
2501. Miscellaneous	0	0	(565,086)	0	(565,086)
2502. Loss adjustment expense	0	0	1,739,233	0	1,739,233
2503.					
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	0	0	1,174,147	0	1,174,147

(a) Includes management fees of $ 86,941,598 to affiliates and $ 0 to non-affiliates.

EXHIBIT OF NET INVESTMENT INCOME

		1 Collected During Year	2 Earned During Year
1.	U.S. government bonds	(a) 1,156,220	1,291,051
1.1	Bonds exempt from U.S. tax	(a) 0	0
1.2	Other bonds (unaffiliated)	(a) 12,990,142	13,292,584
1.3	Bonds of affiliates	(a) 0	0
2.1	Preferred stocks (unaffiliated)	(b) 0	0
2.11	Preferred stocks of affiliates	(b) 0	0
2.2	Common stocks (unaffiliated)	0	0
2.21	Common stocks of affiliates	0	0
3.	Mortgage loans	(c) 880,853	880,853
4.	Real estate	(d) 0	0
5	Contract Loans	0	0
6	Cash, cash equivalents and short-term investments	(e) 1,165,165	1,165,165
7	Derivative instruments	(f) 0	0
8.	Other invested assets	0	0
9.	Aggregate write-ins for investment income	22,230	22,230
10.	Total gross investment income	16,214,610	16,651,883
11.	Investment expenses		(g) 548,964
12.	Investment taxes, licenses and fees, excluding federal income taxes		(g) 26,670
13.	Interest expense		(h) 0
14.	Depreciation on real estate and other invested assets		(i) 0
15.	Aggregate write-ins for deductions from investment income		0
16.	Total deductions (Lines 11 through 15)		575,634
17.	Net investment income (Line 10 minus Line 16)		16,076,249
	DETAILS OF WRITE-INS		
0901.	Misc Interest Income	22,230	22,230
0902.			
0903.			
0998.	Summary of remaining write-ins for Line 9 from overflow page	0	0
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	22,230	22,230
1501.			
1502.			
1503.			
1598.	Summary of remaining write-ins for Line 15 from overflow page		0
1599.	Totals (Lines 1501 thru 1503 plus 1598) (Line 15, above)		0

(a) Includes $ 653,212 accrual of discount less $ 3,328,608 amortization of premium and less $ 995,662 paid for accrued interest on purchases.

(b) Includes $ 0 accrual of discount less $ 0 amortization of premium and less $ 0 paid for accrued dividends on purchases.

(c) Includes $ 0 accrual of discount less $ (124,486) amortization of premium and less $ 0 paid for accrued interest on purchases.

(d) Includes $ 0 for company's occupancy of its own buildings; and excludes $ 0 interest on encumbrances.

(e) Includes $ 1,164,951 accrual of discount less $ 0 amortization of premium and less $ 0 paid for accrued interest on purchases.

(f) Includes $ 0 accrual of discount less $ 0 amortization of premium.

(g) Includes $. 0 investment expenses and $ 0 investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.

(h) Includes $ 0 interest on surplus notes and $ 0 interest on capital notes.

(i) Includes $ 0 depreciation on real estate and $ 0 depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

		1 Realized Gain (Loss) On Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1.	U.S. Government bonds	(559)	(860,130)	(860,689)	0	0
1.1	Bonds exempt from U.S. tax	0	0	0	0	0
1.2	Other bonds (unaffiliated)	(2,448,329)	(502,281)	(2,950,610)	(1,947,081)	0
1.3	Bonds of affiliates	0	0	0	0	0
2.1	Preferred stocks (unaffiliated)	0	0	0	0	0
2.11	Preferred stocks of affiliates	0	0	0	0	0
2.2	Common stocks (unaffiliated)	0	0	0	0	0
2.21	Common stocks of affiliates	0	0	0	0	0
3.	Mortgage loans	0	0	0	0	0
4.	Real estate	0	0	0	0	0
5.	Contract loans	0	0	0	0	0
6.	Cash, cash equivalents and short-term investments	(722)	0	(722)	0	0
7.	Derivative instruments	0	0	0	0	0
8.	Other invested assets	0	0	0	0	0
9.	Aggregate write-ins for capital gains (losses)	0	0	0	0	0
10.	Total capital gains (losses)	(2,449,610)	(1,362,411)	(3,812,021)	(1,947,081)	0
	DETAILS OF WRITE-INS					
0901.						
0902.						
0903.						
0998.	Summary of remaining write-ins for Line 9 from overflow page	0	0	0	0	0
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	0	0	0	0	0

EXHIBIT OF NON-ADMITTED ASSETS

		1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1.	Bonds (Schedule D)	0	0	0
2.	Stocks (Schedule D):			
	2.1 Preferred stocks	0	0	0
	2.2 Common stocks	0	0	0
3.	Mortgage loans on real estate (Schedule B):			
	3.1 First liens	0	0	0
	3.2 Other than first liens	0	0	0
4.	Real estate (Schedule A):			
	4.1 Properties occupied by the company	0	0	0
	4.2 Properties held for the production of income	0	0	0
	4.3 Properties held for sale	0	0	0
5.	Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)	0	0	0
6.	Contract loans	0	0	0
7.	Derivatives (Schedule DB)	0	0	0
8.	Other invested assets (Schedule BA)	0	0	0
9.	Receivables for securities	0	0	0
10.	Securities lending reinvested collateral assets (Schedule DL)	0	0	0
11.	Aggregate write-ins for invested assets	0	34,419	34,419
12.	Subtotals, cash and invested assets (Lines 1 to 11)	0	34,419	34,419
13.	Title plants (for Title insurers only)	0	0	0
14.	Investment income due and accrued	0	0	0
15.	Premiums and considerations:			
	15.1 Uncollected premiums and agents' balances in the course of collection	0	0	0
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due	0	0	0
	15.3 Accrued retrospective premiums and contracts subject to redetermination	0	0	0
16.	Reinsurance:			
	16.1 Amounts recoverable from reinsurers	0	0	0
	16.2 Funds held by or deposited with reinsured companies	0	0	0
	16.3 Other amounts receivable under reinsurance contracts	0	0	0
17.	Amounts receivable relating to uninsured plans	0	0	0
18.1	Current federal and foreign income tax recoverable and interest thereon	0	0	0
18.2	Net deferred tax asset	0	141,699	141,699
19.	Guaranty funds receivable or on deposit	0	0	0
20.	Electronic data processing equipment and software	0	0	0
21.	Furniture and equipment, including health care delivery assets	0	0	0
22.	Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0
23.	Receivable from parent, subsidiaries and affiliates	0	127	127
24.	Health care and other amounts receivable	13,378,513	25,330,304	11,951,791
25.	Aggregate write-ins for other than invested assets	500,000	500,000	0
26.	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	13,878,513	26,006,549	12,128,036
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0
28.	Total (Lines 26 and 27)	13,878,513	26,006,549	12,128,036
	DETAILS OF WRITE-INS			
1101.	Mortgage loan suspense	0	34,419	34,419
1102.				
1103.				
1198.	Summary of remaining write-ins for Line 11 from overflow page	0	0	0
1199.	Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	34,419	34,419
2501.	Deposits	500,000	500,000	0
2502.				
2503.				
2598.	Summary of remaining write-ins for Line 25 from overflow page	0	0	0
2599.	Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	500,000	500,000	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	Current Year Member Months
1. Health Maintenance Organizations	243,019	236,325	230,822	231,881	224,908	2,773,717
2. Provider Service Organizations	0	0	0	0	0	0
3. Preferred Provider Organizations	0	0	0	0	0	0
4. Point of Service	0	0	0	0	0	0
5. Indemnity Only	0	0	0	0	0	0
6. Aggregate write-ins for other lines of business	0	0	0	0	0	0
7. Total	243,019	236,325	230,822	231,881	224,908	2,773,717
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT 2 - ACCIDENT AND HEALTH PREMIUMS DUE AND UNPAID

1 Name of Debtor	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	7 Admitted
0199999 Total individuals	0	0	0	0	0	0
Group Subscribers:						
0299998. Premiums due and unpaid not individually listed	0	0	0	0	0	0
0299999. Total group	0	0	0	0	0	0
0399999. Premiums due and unpaid from Medicare entities	0	0	0	0	0	0
0499999. Premiums due and unpaid from Medicaid entities	1,931,674	0	0	0	0	1,931,674
0599999 Accident and health premiums due and unpaid (Page 2, Line 15)	1,931,674	0	0	0	0	1,931,674

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT 3 - HEALTH CARE RECEIVABLES

1 Name of Debtor	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	7 Admitted
Medicaid rx rebate receivable (CVSH)	690,082	690,082	690,082	4,050,929	4,050,929	2,070,247
0199998. Aggregate Pharmaceutical Rebate Receivables Not Individually Listed	0	0	0	0	0	0
0199999. Total Pharmaceutical Rebate Receivables	690,082	690,082	690,082	4,050,929	4,050,929	2,070,247
0299998. Aggregate Claim Overpayment Receivables Not Individually Listed	176,923	354,822	179,255	1,975,276	2,686,275	0
0299999. Total Claim Overpayment Receivables	176,923	354,822	179,255	1,975,276	2,686,275	0
0399998. Aggregate Loans and Advances to Providers Not Individually Listed	0	0	8,500	1,580,000	1,588,500	0
0399999. Total Loans and Advances to Providers	0	0	8,500	1,580,000	1,588,500	0
0499998. Aggregate Capitation Arrangement Receivables Not Individually Listed	0	0	0	0	0	0
0499999. Total Capitation Arrangement Receivables	0	0	0	0	0	0
0599998. Aggregate Risk Sharing Receivables Not Individually Listed	0	0	0	0	0	0
0599999. Total Risk Sharing Receivables	0	0	0	0	0	0
0699998. Aggregate Other Receivables Not Individually Listed	2,362,317	0	66,894	2,623,598	5,052,809	0
0699999. Total Other Receivables	2,362,317	0	66,894	2,623,598	5,052,809	0
0799999 Gross health care receivables	3,229,322	1,044,904	944,731	10,229,803	13,378,513	2,070,247

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT 3A - ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

Type of Health Care Receivable	Health Care Receivables Collected During the Year		Health Care Receivables Accrued as of December 31 of Current Year		5	6
	1 On Amounts Accrued Prior to January 1 of Current Year	2 On Amounts Accrued During the Year	3 On Amounts Accrued December 31 of Prior Year	4 On Amounts Accrued During the Year	Health Care Receivables in Prior Years (Columns 1 + 3)	Estimated Health Care Receivables Accrued as of December 31 of Prior Year
1. Pharmaceutical rebate receivables	4,758,707	2,317,434	260,206	5,860,970	5,018,913	4,951,806
2. Claim overpayment receivables	912,689	7,366,226	1,001,797	1,684,478	1,914,486	18,033,712
3. Loans and advances to providers	21,500	0	0	1,588,500	21,500	2,205,000
4. Capitation arrangement receivables	0	0	0	0	0	0
5. Risk sharing receivables	0	0	0	0	0	0
6. Other health care receivables	0	0	0	5,052,809	0	1,898,170
7. Totals (Lines 1 through 6)	5,692,896	9,683,660	1,262,003	14,186,757	6,954,899	27,088,688

Note that the accrued amounts in Columns 3, 4, and 6 are the total health care receivables, not just the admitted portion.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT 4 - CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Claims Unpaid (Reported)						
0199999. Individually listed claims unpaid	0	0	0	0	0	0
0299999. Aggregate accounts not individually listed- uncovered	423,653	30,789	1,262	598	8,619	464,921
0399999. Aggregate accounts not individually listed-covered	12,803,997	985,453	(64,163)	228,105	616,804	14,570,196
0499999. Subtotals	13,227,650	1,016,242	(62,901)	228,703	625,423	15,035,117
0599999. Unreported claims and other claim reserves						112,223,978
0699999. Total amounts withheld						0
0799999. Total claims unpaid						127,259,095
0899999 Accrued medical incentive pool and bonus amounts						1,187,135

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT 5 - AMOUNTS DUE FROM PARENT, SUBSIDIARIES AND AFFILIATES

1	2	3	4	5	6	Admitted	
						7	8
Name of Affiliate	1 - 30 Days	31 - 60 Days	61 - 90 Days	Over 90 Days	Nonadmitted	Current	Non-Current
Aetna Medicaid Administrators, LLC	7,789,355	0	0	0	0	7,789,355	0
0199999. Individually listed receivables	7,789,355	0	0	0	0	7,789,355	0
0299999. Receivables not individually listed	0	0	0	0	0	0	0
0399999 Total gross amounts receivable	7,789,355	0	0	0	0	7,789,355	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT 6 - AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

1 Affiliate	2 Description	3 Amount	4 Current	5 Non-Current
AETNA INC. DIVISION	See Notes to the Financial Statements	13,806,924	13,806,924	0
Coventry Health and Life Insurance Company	See Notes to the Financial Statements	13,316	13,316	0
Aetna Life Insurance Company	See Notes to the Financial Statements	26	26	0
0199999. Individually listed payables		13,820,266	13,820,266	0
0299999. Payables not individually listed		0	0	0
0399999 Total gross payables		13,820,266	13,820,266	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT 7 PART 1- SUMMARY OF TRANSACTIONS WITH PROVIDERS

Payment Method	1 Direct Medical Expense Payment	2 Column 1 as a % of Total Payments	3 Total Members Covered	4 Column 3 as a % of Total Members	5 Column 1 Expenses Paid to Affiliated Providers	6 Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups	1,106,146	0.1	0	0.0	0	1,106,146
2. Intermediaries	10,390,528	1.1	224,908	100.0	0	10,390,528
3. All other providers	0	0.0	0	0.0	0	0
4. Total capitation payments	11,496,674	1.2	224,908	100.0	0	11,496,674
Other Payments:						
5. Fee-for-service	29,002,911	3.1	XXX	XXX	0	29,002,911
6. Contractual fee payments	909,602,629	95.7	XXX	XXX	0	909,602,629
7. Bonus/withhold arrangements - fee-for-service	0	0.0	XXX	XXX	0	0
8. Bonus/withhold arrangements - contractual fee payments	0	0.0	XXX	XXX	0	0
9. Non-contingent salaries	0	0.0	XXX	XXX	0	0
10. Aggregate cost arrangements	0	0.0	XXX	XXX	0	0
11. All other payments	0	0.0	XXX	XXX	0	0
12. Total other payments	938,605,540	98.8	XXX	XXX	0	938,605,540
13. TOTAL (Line 4 plus Line 12)	950,102,214	100%	XXX	XXX	0	950,102,214

EXHIBIT 7 - PART 2 - SUMMARY OF TRANSACTIONS WITH INTERMEDIARIES

1 NAIC Code	2 Name of Intermediary	3 Capitation Paid	4 Average Monthly Capitation	5 Intermediary's Total Adjusted Capital	6 Intermediary's Authorized Control Level RBC
	Avesis Third Party Administrators	10,390,528	866,000	0	0
9999999 Totals		10,390,528	XXX	XXX	XXX

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT 8 - FURNITURE, EQUIPMENT AND SUPPLIES OWNED

NONE

Description	1 Cost	2 Improvements	3 Accumulated Depreciation	4 Book Value Less Encumbrances	5 Assets Not Admitted	6 Net Admitted Assets
1. Administrative furniture and equipment						
2. Medical furniture, equipment and fixtures						
3. Pharmaceuticals and surgical supplies						
4. Durable medical equipment						
5. Other property and equipment						
6. Total						

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying statutory financial statements of Aetna Better Health of Kentucky Insurance Co.(the "Company"), indirectly a wholly-owned subsidiary of CVS Health Corporation ("CVS Health"), have been prepared in conformity with accounting practices prescribed or permitted by the Kentucky Department of Insurance (KY DOI). The KY DOI recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP"). On November 28, 2018, CVS Health acquired Aetna Inc. ("Aetna") and at that date became the Company's ultimate parent (the "Aetna Acquisition").

A reconciliation of the Company's net income and capital and surplus between NAIC SAP and practices prescribed and permitted by the Commonwealth of Kentucky for the years ending December 31, 2018 and 2017 is as follows:

	SSAP #	F/S Page	F/S Line #	2018	2017
NET INCOME					
(1) State basis (Page 4, Line 32, Columns 2 & 3)	XXX	XXX	XXX	$59,141,277	$55,741,558
(2) State Prescribed Practices that increase/(decrease) NAIC SAP:					
(3) State Permitted Practices that increase/(decrease) NAIC SAP:					
(4) NAIC SAP (1-2-3=4)	XXX	XXX	XXX	$59,141,277	$55,741,558
SURPLUS					
(5) State basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	$326,498,199	$261,922,347
(6) State Prescribed Practices that increase/(decrease) NAIC SAP:					
(7) State Permitted Practices that increase/(decrease) NAIC SAP:					
(8) NAIC SAP (5-6-7=8)	XXX	XXX	XXX	$326,498,199	$261,922,347

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of these financial statements in conformity with Kentucky Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenue and expenses. Actual results could differ from those estimates.

C. Accounting Policies

The Company applies the following significant accounting policies:

(1) Cash, Cash Equivalents and Short-Term Investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value. Cash accounts with positive balances shall not be reported separately from cash accounts with negative balances. If in the aggregate, the reporting entity has a net negative cash balance, it shall be reported as a negative asset and shall not be recorded as a liability.

(2) Bonds

Bonds, which include special deposits, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections at December 31, 2018 and 2017. Bonds include all investments whose maturity is greater than one year when purchased. Loan-backed and structured securities are carried at amortized cost adjusted for unamortized premiums and discounts. Premiums and discounts on loan-backed and structured securities are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments. All adjustments between amortized cost and carrying value are reflected in unrealized capital gains and losses and are reported as direct adjustments to surplus. Bonds are recorded as purchases or sales on the trade date.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities, an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For loan-backed and structured securities, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from the Company's expectations and the risk that facts and circumstances factored into its assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

(3) Common Stocks

Common stocks of non-affiliates are carried at fair value. Common stocks of affiliates are reported using the equity method. Common stocks of affiliates that are unaudited are nonadmitted. Declines in the cost basis deemed to be OTTI are recognized as realized capital losses. Common stocks are recorded as purchases or sales on the trade date.

(4) The Company did not own any preferred stock at December 31, 2018 or 2017.

(5) Mortgage Loans

Mortgage loans on real estate ("Mortgage Loans") are carried at unpaid principal balances, adjusted for accrual of discounts and amortization of premiums. Mortgage loans funding and repayments are recorded on the closing date. Fair values are estimated by discounting expected mortgage loan cash flows at market rates that reflect the rates at which similar loans would be made to similar borrowers. These rates reflect management's assessment of the credit quality and the remaining duration of the loans. The fair value estimates of mortgage loans of lower credit quality, including problem and restructured loans, are based on the estimated fair value of the underlying collateral. Payment receipts on impaired loans are recorded on the cash basis. The Company recognizes interest income on impaired loans when received. The Company considers a loan impaired when it is probable that the loan will be uncollectible based on its contractual terms.

The Company measures the impairment based on the fair value of the collateral less estimated costs to obtain and sell. The difference between the net value of the collateral and the recorded investment in the mortgage loan is recorded as a valuation allowance with a corresponding charge to unrealized loss. If the impairment is deemed other-than-temporary, a write-down is recognized as a realized loss, and a new cost basis is established. This new cost basis is not changed for subsequent recoveries in value. Mortgage loans for which foreclosure is probable are considered permanently impaired.

(6) Securities Lending

The Company engages in securities lending by lending certain securities from its investment portfolio to other institutions for short periods of time. Borrowers must post cash collateral in the amount of 102% to 105% of the fair value of a loaned security. The fair value of the loaned securities is monitored on a daily basis, with additional collateral obtained or refunded as the fair value of the loaned securities fluctuates. The collateral is retained and invested by a lending agent according to the Company's guidelines to generate additional investment income for the Company. Pursuant to SSAP No. 103R - *Transfers and Servicing of Financial Assets and Extinguishments of Liabilities* ("SSAP No. 103R"), collateral required under the Company's securities lending program is carried on the Company's Statutory Statements of Assets and Liabilities, Capital and Surplus as both a receivable and payable. Also pursuant to SSAP No. 103, if the collateral received from a counterparty is less than 100 percent at the reporting date, the difference between the actual collateral and 100 percent is nonadmitted. Collateral value is measured and compared to the loaned securities in aggregate by counterparty. The Company did not have any loaned securities at December 31, 2018 and 2017.

(7) The Company did not have any investments in subsidiaries, controlled or affiliated companies at December 31, 2018 or 2017.

(8) The Company did not have any investments in any joint ventures, partnerships and limited liability companies at December 31, 2018 or 2017.

(9) The Company did not have any derivatives at December 31, 2018 or 2017.

(10) Aggregate Health Policy Reserves and Related Expenses

Premium deficiency reserves ("PDR") are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Where allowed, anticipated investment income is considered in the calculation of any PDR. For purposes of calculating a PDR, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts. The Company had no PDR at December 31, 2018 and 2017.

(11) Hospital and Medical Costs and Claims Adjustment Expenses and Related Reserves

Hospital and medical costs consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health claim reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Statutory Statements of Assets and Liabilities, Capital and Surplus date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, contract requirement changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in hospital and medical costs in the Statutory Statements of Revenue and Expenses in the period they are determined. Capitation costs, which are recorded in hospital and medical expenses in the Statutory Statements of Revenue and Expenses, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

Claims adjustment expenses, which include cost containment expenses, represent the costs incurred related to the claim settlement process such as costs to record, process and adjust claims. These expenses are included in the Company's management agreement with an affiliate described in Note 10.

(12) As a result of CVS Health's acquisition of Aetna Inc. ("Aetna"), Aetna modified its capitalization policy from the prior period related to furniture and equipment ("F&E") and prepaid assets. Under the revised policy, F&E will be capitalized if greater than $1,000 versus the previous threshold of $500. Under the new policy, prepaid assets will be capitalized if greater than $250,000 versus the previous threshold of $50,000. These revisions

are not expected to have a material impact on the financial results of Aetna or its affiliates, including the Company.

(13) Pharmaceutical Rebate Receivables

The Company estimates pharmaceutical rebate receivables based upon historical payment trends, actual utilization and other variables. Pharmaceutical rebates for a quarter are billed to the vendor within forty five days of the completion of the quarter with any adjustment to previously recorded amounts reflected at the time of billing. The Company reports pharmaceutical rebate receivables as health care receivables. Pharmacy rebate receivables not in accordance with SSAP No. 84 – *Health Care and Government Insured Plan Receivables* or are over 90 days past due are nonadmitted. All rebates are processed and settled with an affiliated entity. The pharmaceutical rebate receivables are more fully discussed in Note 28.

(14) Premiums and Amounts Due and Unpaid

Premium revenue for prepaid health or dental care products is recognized as income in the month in which enrollees are entitled to health or dental care services. Premiums collected before the effective period are reported as premiums received in advance. Premiums related to unexpired contractual coverage periods are reported as unearned premiums in the Statutory Statements of Liabilities, Capital and Surplus (refer to discussion of aggregate health policy reserves and related expenses above).

Nonadmitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances. In addition, for any customer for which the premiums due and unpaid greater than 90 days past due is more than a de minimus portion of the entire balance of premiums due and unpaid for that customer, the entire balance of premiums due and unpaid for that customer is nonadmitted. Management also performs a specific review of accounts and based on the results of the review, additional amounts may be nonadmitted. Uncollectible amounts are generally written-off and charged to revenue in the period in which the customer reconciliations are completed and agreed to by the customer (retroactivity) or when the account is determined to be uncollectible by the Company.

(15) Aggregate Health Claim Reserves

The reserve for future contingent benefits includes the estimated cost of services that will continue to be incurred after the Statutory Statements of Liabilities, Capital and Surplus date if the Company is obligated to pay for such services in accordance with contract provisions or regulatory requirements. These balances are recorded in aggregate health claim reserves in the Statutory Statements of Liabilities, Capital and Surplus and are estimated using a percentage of current hospital and medical costs, which is based on the Company's historical cost experience.

(16) Investment Income Due and Accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2018 and 2017, the Company did not have any nonadmitted investment income due and accrued.

(17) Covered and Uncovered Expenses and Related Liabilities

Covered expenses and related liabilities represent costs for health care expenses for which a member is not responsible in the event of the insolvency of the Company. Uncovered expenses and related liabilities represent costs to the Company for health care services that are the obligation of the Company and for which a member may also be liable in the event of the Company's insolvency.

(18) Fees Paid to the Federal Government by Health Insurers

SSAP No. 106 - *Affordable Care Act Section 9010 Assessment* ("SSAP No. 106") required (1) that the health insurer fee be recognized in full on January 1 of the fee year (the calendar year in which the assessment must be paid to the federal government), in the operating expense category of insurance taxes, licenses and fees, excluding federal income taxes and (2) that in each data year preceding a fee year a reporting entity pro-ratably accrue by reclassifying from unassigned funds (surplus) to aggregate write-ins for special surplus funds an amount equal to its estimated subsequent fee year assessment. This reclassification has no impact on total capital and surplus and is reversed in full on January 1 of the fee year. On January 22, 2018, Public Law No: 115-120 was signed into law and it imposes a moratorium on the health insurer fee for calendar year 2019. As interpreted in INT 18-02: ACA Section 9010 Assessment Moratoriums, because there is not an ACA Section 9010 fee due in September 2019, there is not an accrual of a liability on January 1, 2019 based on 2018 data year net written premiums. Accrual of a liability on January 1, 2020 for the ACA Section 9010 assessment based on 2019 data year net written premiums and the reclassification from unassigned funds (surplus) to aggregate write-ins for special surplus funds equal to the estimated 2020 fee year assessment accrued in data year 2019 will both continue as prescribed under SSAP No. 106. See Note 22 for disclosure of all amounts related to the health insurer fee for the Company.

(19) The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (collectively, "Health Care Reform") Risk Adjustment

Reinsurance

Health Care Reform established a temporary reinsurance program that expired at the end of 2016. Under this program, all issuers of major medical commercial insurance products and self-insured plan sponsors are required to contribute funding in amounts set by the U.S. Department of Health and Human Services ("HHS"). A portion of the funds collected will be utilized to reimburse issuers' high claims costs incurred for qualified individual members. The expense related to this required funding is reflected in insurance, taxes, licenses and fees for all of the Company's insurance products with the exception of products associated with qualified individual members; this expense for qualified individual members is reflected as a reduction of premium revenue. When annual claim costs incurred by the Company's qualified individual members exceed a specified attachment point, the Company is entitled to certain reimbursements from this program. The Company records amounts recoverable for claims paid and unpaid and ceded claim benefit recoveries to reflect its estimate of these recoveries.

Risk Adjustment

Health Care Reform established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable or payable for the current calendar year and reflects the impact as an adjustment to its premium revenue.

Risk Corridor

Health Care Reform established a temporary risk sharing program, which expired at the end of 2016, for qualified individual and small group insurance plans. Under this program the Company makes (or receives) a payment to (or from) HHS based on the ratio of allowable costs to target costs (as defined by Health Care Reform). The Company records a risk corridor receivable or payable as an adjustment to premium revenue based on the Company's estimate of the ultimate risk sharing amount for the current calendar year. In October 2015, HHS announced that 2014 Health Care Reform risk corridor receivables would be funded at 12.6% to the extent HHS fully collects risk corridor payables. In November 2015, INT 15-01 was issued as guidance to address the accounting for risk corridor receivables. In conjunction with this guidance, the Company recorded a risk corridor receivable that coincides with the portion of the 2014 Health Care Reform risk corridor receivables that are considered collectible. The Company did not record any risk corridor receivables for the 2017 and 2016 program years or any amount in excess of HHS' announced pro-rated funding amount for the 2014 program year because payments from HHS are uncertain.

The Company expects to perform an annual final reconciliation and settlement with HHS of the 3Rs in each subsequent year. See Note 24.E. for disclosure of amounts related to the 3Rs for the Company for the periods ending December 31, 2018 and 2017.

(20) Federal and State Income Taxes

The Company was included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries through November 27, 2018 pursuant to the terms of a tax sharing agreement. For the tax period ending December 31, 2018, Aetna and its wholly-owned subsidiaries are included in the consolidated federal income tax return of its parent, CVS Health, pursuant to the terms of a tax sharing agreement (and a Supplemental Tax Sharing Agreement where applicable) between CVS Health and the Company. In accordance with both agreements, the Company's current federal and state income tax provisions are generally computed as if the Company were filing a separate federal and state income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent realized in the consolidated return. Pursuant to these agreements, the Company has the enforceable right to recoup federal and state income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal and state income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets ("DTAs") and liabilities ("DTLs") represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101 - Income Taxes. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized ("adjusted gross DTAs"). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a. b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Service ("IRS") tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the statutory balance sheet adjusted to exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains (losses)", also a separate component of gains and losses in surplus.

The Company is subject to state income taxes in various states. State income tax expense is recorded in general administrative expenses in the Statutory Statements of Revenue and Expenses. For the years ended December 31, 2018 and 2017, The Company's had no state income tax payables at December 31, 2018 and 2017. The Company's had no state income tax expense at December 31, 2018 and 2017. The Company's had no state income tax receivables at December 31, 2018 and 2017.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "TCJA") was enacted. Among other things, the TCJA reduced the federal corporate income tax rate to 21 percent effective January 1, 2018. See Note 9 for the impact that the TCJA had on the Company.

(21) Reinsurance

In the normal course of business, the Company seeks to reduce the loss that may arise from catastrophes or other events that cause unfavorable underwriting results and to help balance its risks and capital by reinsuring certain levels of risk with other insurance enterprises. The reinsurance coverage does not relieve the Company of its primary obligations. Reinsurance premiums and reserves related to reinsured business are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts. Premiums ceded for medical losses and the related unpaid reserves have been reported as reductions of these items. The reinsurance agreements are more fully discussed in Notes 10 and 23.

D. Going Concern

As of March 1, 2019, management evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

2. Accounting Changes and Corrections of Errors

The Company did not have any accounting changes or correction of errors in the years ended December 31, 2018 and 2017.

3. Business Combinations and Goodwill

The Company was not a part of any business combinations that involved the statutory purchase method, a statutory merger, an assumption reinsurance, or an impairment loss in the years ending December 31, 2018 and 2017.

4. Discontinued Operations

The Company did not have any discontinued operations in the years ending December 31, 2018 and 2017.

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans.

(1) There were no new mortgage loans made during 2018.

(2) The maximum percentage of any one loan to the value of security at the time of the loan, exclusive of insured or guaranteed or purchase money mortgages was 61%.

(3) The Company did not hold any mortgages with advanced taxes, assessments or amounts due, not included in the mortgage loan total at either December 31, 2018 or 2017.

(4) Age Analysis of Mortgage Loans and Identification of Mortgage Loans in Which the Insurer is a Participant or Co-lender in a Mortgage Loan Agreement:

	Farm	Residential		Commercial		Mezzanine	Total
		Insured	All Other	Insured	All Other		
a. Current Year							
1. Recorded Investment (All)							
(a) Current					$13,407,858		$13,407,858
(b) 30 - 59 Days Past Due							—
(c) 60 - 89 Days Past Due							—
(d) 90 - 179 Days Past Due							—
(e) 180+ Days Past Due							—
2. Accruing Interest 90 - 179 Days Past Due							
(a) Recorded Investment							—
(b) Interest Accrued							—
3. Accruing Interest 180+ Days Past Due							
(a) Recorded Investment							—
(b) Interest Accrued							—
4. Interest Reduced							
(a) Recorded Investment							—
(b) Number of Loans							—
(c) Percent Reduced							
5. Participant or Co-lender in a Mortgage Loan Agreement							
(a) Recorded Investment							—
b. Prior Year							
1. Recorded Investment					$12,979,171	—	12,979,171
(a) Current							—
(b) 30 - 59 Days Past Due							—
(c) 60 - 89 Days Past Due							—
(d) 90 - 179 Days Past Due							—
(e) 180+ Days Past Due							—
2. Accruing Interest 90 - 179 Days Past Due							
(a) Recorded Investment							—
(b) Interest Accrued							—
3. Accruing Interest 180+ Days Past Due							
(a) Recorded Investment							—
(b) Interest Accrued							—
4. Interest Reduced							
(a) Recorded Investment							—
(b) Number of Loans							—
(c) Percent Reduced							
5. Participant or Co-lender in a Mortgage Loan Agreement							
(a) Recorded Investment							—

(5) The Company had no investment impaired loans with or without allowance for credit losses at December 31, 2018.

(6) The Company had no investment in impaired loans at December 31, 2018.

(7) The Company had no allowance for credit losses at December 31, 2018.

(8) The Company had no mortgage loans derecognized as a result of foreclosure at December 31, 2018

(9) The Company recognizes interest income on its impaired loans upon receipt.

B. The Company did not have any debt restructuring in the years ending December 31, 2018 and 2017.

C. The Company did not have any reverse mortgages at December 31, 2018 or 2017.

D. Loan-Backed Securities

(1) Prepayment assumptions for single class and multi-class mortgage-backed/loan-backed securities were obtained from industry market sources.

(2) The Company did not recognize any other-than-temporary impairments ("OTTI") on loan-backed and structured securities in which the Company had the (1) intent to sell, (2) did not have the intent and ability to retain for a period of time sufficient to recover the amortized cost basis or (3) present value of cash flows expected to be collected is less than the amortized cost basis of the securities in accordance with SSAP No. 43R - *Loan-Backed and Structured Securities* ("SSAP No. 43R") at 2018 on loan-backed and structured securities in which the Company had the (1) intent to sell, (2) did not have the intent and ability to retain for a period of time sufficient to recover the amortized cost basis or (3) present value of cash flows expected to be collected is less than the amortized cost basis of the securities in accordance with SSAP No. 43R - *Loan-Backed and Structured Securities* ("SSAP No. 43R").

(3) The Company had no recognized OTTI on loan-backed and structured securities currently held, in which the present value of cash flows expected to be collected is less than the amortized cost basis at December 31, 2018.

(4) The Company's unrealized loss position on loan-backed and structured securities held by the Company at December 31, 2018 is as follows:

a. The aggregate amount of unrealized losses:	
1. Less than 12 Months	$7,737
2. 12 Months or Longer	$719,126
b. The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 Months	$1,502,474
2. 12 Months or Longer	$18,517,621

(5) The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at December 31, 2018 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

(1) The Company did not have any repurchase agreements or loaned securities transactions at December 31, 2018.

(2) The Company did not pledge any of its assets as collateral, which are classified as securities pledged to creditors as of December 31, 2018.

(3) Neither the Company nor its agent has accepted collateral that is permitted by contract or custom to sell or repledge as of December 31, 2018.

(4) The Company did not have securities lending transactions administered by an affiliated agent which is "one line" reported at December 31, 2018.

(5) The Company did not have any repurchase agreements, loaned securities or dollar repurchase agreements at December 31, 2018.

(6) The Company has not accepted collateral that is not permitted by contract or custom to sell or repledge as of December 31, 2018.

(7) The Company did not have any collateral for transactions that extend beyond one year from the reporting date.

F. The Company did not have any repurchase agreements transactions accounted for as secured borrowing at December 31, 2018 or 2017.

G. The Company did not have any reverse repurchase agreements transactions accounted for as secured at December 31, 2018 or 2017.

H. The Company did not have any repurchase agreements transactions accounted for as a sale at December 31, 2018 or 2017.

I. The Company did not have any reverse repurchase agreements transactions accounted for as a sale at December 31, 2018 or 2017.

J. The Company did not have any real estate at December 31, 2018 or 2017.

K. The Company did not have any low-income housing tax credits at December 31, 2018.

L. Restricted Assets

(1) Restricted assets (including pledged):

Restricted Asset Category	1 Total Gross (Admitted & Nonadmitted) Restricted from Current Year	2 Total Gross (Admitted & Nonadmitted) Restricted from Prior Year	3 Increase/ (Decrease) (1 minus 2)	4 Total Current Year Nonadmitted Restricted	5 Total Current Year Admitted Restricted (1 minus 4)	6 Gross (Admitted & Nonadmitted) Restricted to Total Assets (a)	7 Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown						0.000	0.000
b. Collateral held under security lending agreements						0.000	0.000
c. Subject to repurchase agreements						0.000	0.000
d. Subject to reverse repurchase agreements						0.000	0.000
e. Subject to dollar repurchase agreements						0.000	0.000
f. Subject to dollar reverse repurchase agreements						0.000	0.000
g. Placed under option contracts						0.000	0.000
h. Letter stock or securities restricted as to sale - excluding FHLB capital stock						0.000	0.000
i. FHLB capital stock						0.000	0.000
j. On deposit with states	$1,224,310	$1,241,056	($16,746)	$—	$1,224,310	0.240	0.247
k. On deposit with other regulatory bodies						0.000	0.000
l. Pledged collateral to FHLB (including assets backing funding agreements)						0.000	0.000
m. Pledged as collateral not captured in other categories						0.000	0.000
n. Other restricted assets						0.000	0.000
o. Total Restricted Assets	$1,224,310	$1,241,056	($16,746)	$—	$1,224,310	0.240	0.247

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 divided by Asset Page, Column 3, Line 28

(2) The Company did not have any assets pledged as collateral not captured in other categories at December 31, 2018.

(3) The Company did not have any other restricted assets at December 31, 2018.

(4) The Company did not have any collateral received and reflected within its financial statements at December 31, 2018.

M. The Company did not have any working capital finance investments at December 31, 2018.

N. The Company did not have any offsetting and netting of derivative, repurchase and reverse repurchase, and securities borrowing and securities lending assets or liabilities at December 31, 2018.

O. The Company did not have any structured notes at December 31, 2018.

P. The Company did not have any 5GI* securities at December 31, 2018.

Q. The Company did not have any short sales within the reporting period. December 31, 2018.

R. Prepayment Penalty and Acceleration Fees at December 31, 2018

Prepayment Penalty and Acceleration Fees	General Account
1. Number of CUSIPs	10
2. Aggregate Amount of Investment Income	$313,626

6. Joint Ventures, Partnerships, and Limited Liability Companies

A. The Company did not have any joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at December 31, 2018 or 2017.

B. The Company does not have any impaired investments in joint ventures, partnerships, or limited liability companies at December 31, 2018 or 2017.

7. Investment Income

A. Due and accrued income was excluded from surplus on the following bases:

Bonds - where collection of interest is uncertain.
Preferred stock - where collection of dividends is uncertain.
Mortgage loans - all due and accrued interest on loans delinquent for more than one year and on other loans where collection of interest is uncertain.
Real estate - where rent is in arrears for more than three months.
Contract loans - where accrued interest is in excess of loan value.

B. There was no amount excluded at December 31, 2018 or 2017.

8. Derivative Instruments

The Company did not have any derivative instruments at December 31, 2018 or 2017.

9. Income Taxes

A.

(1) The components of the net DTAs recognized in the Company's Statutory Statements of Assets and Liabilities, Capital and Surplus are as follows:

	As of End of Current Period			12/31/2017			Change		
	(1) Ordinary	(2) Capital	(3) (Col. 1 + 2) Total	(4) Ordinary	(5) Capital	(6) (Col. 4 + 5) Total	(7) (Col. 1 - 4) Ordinary	(8) (Col. 2 - 5) Capital	(9) (Col. 7 + 8) Total
(a) Gross Deferred Tax Assets	$5,412,223	$951,798	$6,364,021	$9,749,774	$228,786	$9,978,560	($4,337,551)	$723,012	($3,614,539)
(b) Statutory Valuation Allowance Adjustment	—	867,381	867,381	—	—	—	—	867,381	867,381
(c) Adjusted Gross Deferred Tax Assets (1a - 1b)	5,412,223	84,417	5,496,640	9,749,774	228,786	9,978,560	(4,337,551)	(144,369)	(4,481,920)
(d) Deferred Tax Assets Nonadmitted			—	28,286	113,413	141,699	(28,286)	(113,413)	(141,699)
(e) Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	5,412,223	84,417	5,496,640	9,721,488	115,373	9,836,861	(4,309,265)	(30,956)	(4,340,221)
(f) Deferred Tax Liabilities	292,215	—	292,215	—	—	—	292,215	—	292,215
(g) Net Admitted Deferred Tax Asset/(Net Deferred Tax Liability) (1e - 1f)	$5,120,008	$84,417	$5,204,425	$9,721,488	$115,373	$9,836,861	($4,601,480)	($30,956)	($4,632,436)

(2) The amount of admitted gross DTAs admitted under each component of SSAP No. 101:

	As of End of Current Period			12/31/2017			Change		
	(1) Ordinary	(2) Capital	(3) (Col. 1 + 2) Total	(4) Ordinary	(5) Capital	(6) (Col. 4 + 5) Total	(7) (Col. 1 - 4) Ordinary	(8) (Col. 2 - 5) Capital	(9) (Col. 7 + 8) Total
Admission Calculation Components SSAP No. 101									
(a) Federal Income Taxes Paid In Prior Years Recoverable Through Loss Carrybacks.	$5,387,246	$84,417	$5,471,663	$9,719,029	$115,373	$9,834,402	($4,331,783)	($30,956)	($4,362,739)
(b) Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	24,977	—	24,977	2,459	—	2,459	22,518	—	22,518
1. Adjusted Gross Deferred Tax Assets Expected to be Realized Following the Balance Sheet Date.	24,977	—	24,977	2,459	—	2,459	22,518	—	22,518
2. Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold.			48,194,066			37,812,823			10,381,243
(c) Adjusted Gross Deferred Tax Assets (Excluding The Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset by Gross Deferred Tax Liabilities.	—	—	—	—	—	—	—	—	—
(d) Deferred Tax Assets Admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	$5,412,223	$84,417	$5,496,640	$9,721,488	$115,373	$9,836,861	($4,309,265)	($30,956)	($4,340,221)

(3)

	2018	2017
a. Ratio Percentage Used To Determine Recovery Period And Threshold Limitation Amount.	911.000	676.000
b. Amount Of Adjusted Capital And Surplus Used To Determine Recovery Period And Threshold Limitation In 2(b)2 Above.	321,293,774	252,085,485

(4) The impact of tax planning strategies is as follows:

	As of End of Current Period		12/31/2017		Change	
	(1) Ordinary	(2) Capital	(3) Ordinary	(4) Capital	(5) (Col. 1 - 3) Ordinary	(6) (Col. 2 - 4) Capital
Impact of Tax Planning Strategies:						
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets, by tax character as a percentage.						
1. Adjusted Gross DTAs amount from Note 9A1(c)	$5,412,223	$84,417	$9,749,774	$228,786	($4,337,551)	($144,369)
2. Percentage of adjusted gross DTAs by tax character attributable to the impact of tax planning strategies	—	—	—	—	—	—
3. Net Admitted Adjusted Gross DTAs amount from Note 9A1(e)	5,412,223	84,417	9,721,488	115,373	(4,309,265)	(30,956)
4. Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax planning strategies	—	—	—	—	—	—

b. Do the Company's tax-planning strategies include the use of reinsurance? Yes [ ] No [X]

B. There are no DTLs that were not recognized at December 31, 2018 or 2017.

C. Current income taxes incurred consist of the following major components:

	(1) As of End of Current Period	(2) 12/31/2017	(3) (Col. 1 - 2) Change
1. Current Income Tax			
(a) Federal	$18,504,307	$20,912,254	($2,407,947)
(b) Foreign			—
(c) Subtotal	18,504,307	20,912,254	(2,407,947)
(d) Federal income tax on net capital gains	(480,125)	216,907	(697,032)
(e) Utilization of capital loss carry-forwards			—
(f) Other			—
(g) Federal and foreign income taxes incurred	18,024,182	21,129,161	(3,104,979)
2. Deferred Tax Assets:			
(a) Ordinary:			
(1) Discounting of unpaid losses	$2,497,708	$2,961,004	($463,296)
(2) Unearned premium reserve	27	1,336,094	(1,336,067)
(10) Receivables - nonadmitted	2,914,488	5,424,390	(2,509,902)
(13) Other (including items <5% of total ordinary tax assets)		28,286	(28,286)
(99) Subtotal	$5,412,223	$9,749,774	($4,337,551)
(b) Statutory valuation allowance adjustment			—
(c) Nonadmitted		28,286	(28,286)
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	5,412,223	9,721,488	(4,309,265)
(e) Capital:			
(1) Investments	951,798	221,558	730,240
(4) Other (including items <5% of total ordinary tax assets)		7,228	(7,228)
(99) Subtotal	951,798	228,786	723,012
(f) Statutory valuation allowance adjustment	867,381		867,381
(g) Nonadmitted		113,413	(113,413)
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	84,417	115,373	(30,956)
(i) Admitted deferred tax assets (2d + 2h)	$5,496,640	$9,836,861	($4,340,221)
3. Deferred Tax Liabilities:			
(a) Ordinary:			
(1) Investments	84,332		84,332
(5) Other (including items <5% of total ordinary tax liabilities)	207,883		207,883
(99) Subtotal	292,215	—	292,215
(b) Capital:			
(3) Other (including items <5% of total capital tax liabilities)			—
(99) Subtotal	—	—	—
(c) Deferred tax liabilities (3a99 + 3b99)	292,215	—	292,215
4. Net deferred tax assets/liabilities (2i - 3c)	$5,204,425	$9,836,861	($4,632,436)

The change in net deferred income taxes is comprised of the following:

	12/31/2018	12/31/2017	Change
Total Deferred Tax Assets	$5,496,640	$9,978,560	($4,481,920)
Total Deferred Tax Liabilities	(292,215)	—	(292,215)
Net Deferred Tax Assets/(Liabilities)	$5,204,425	$9,978,560	($4,774,135)
Tax Effect of Unrealized Gains/(Losses)			(408,887)
Change in Net Deferred Income Tax			($5,183,022)

The valuation allowance adjustment to gross DTAs was $867,381 and $0 for December 31, 2018 and 2017, respectively.

D. The provision for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference were as follows:

	12/31/2018	Effective Tax Rate	12/31/2017	Effective Tax Rate
Provision computed at statutory rate	$16,204,746	21.0 %	$26,904,752	35.0 %
Health Insurer Fee	4,732,648	6.1 %	—	— %
Transfer Pricing Adjustment	(2,217,398)	(2.9)%	(4,811,815)	(6.3)%
Tax-Exempt Interest	(945,532)	(1.2)%	(1,612,753)	(2.1)%
Change in Nonadmitted Assets	2,517,130	3.3 %	(1,170,956)	(1.5)%
Prior Year True-Up	1,161,009	1.5 %	690,147	0.9 %
Change in Valuation Allowance Adjustment	867,381	1.1 %	—	— %
Impact on Deferred Tax for Enacted Rate Change	—	— %	6,646,263	8.6 %
Other	887,220	1.1 %	1,662,326	2.2 %
Total	$23,207,204	30.1 %	$28,307,964	36.8 %
Federal and foreign income taxes incurred	$18,024,182	23.4%	$21,129,161	27.5%
Change in net deferred income taxes	5,183,022	6.7%	7,178,803	9.3%
Total statutory income taxes	$23,207,204	30.1%	$28,307,964	36.8%

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the “TCJA”) was enacted, which among other items, reduces the federal corporate tax rate to 21% effective January 1, 2018. The Company re-measured its deferred income taxes for the year-ended December 31, 2017 and recognized incremental tax expense (benefit) related to the change in its net deferred tax asset/liability. The accounting for income tax effects of the TCJA related to life insurance reserves were provisional at December 31, 2017. Accordingly, the items were recorded at a reasonable estimate at December 31, 2017.

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm’s length prices as compared to what would be charged to an unrelated entity, which results in a permanent deduction for tax reporting purposes.

E.

E.1. At December 31, 2018 and 2017, the Company had no net capital loss or net operating loss carryforwards for tax purposes.

E.2. The amount of federal income taxes incurred that are available for recoupment in the event of future net losses are:

Year	Ordinary	Capital	Total
2018	$1,439,972	$0	$1,439,972
2018	15,839,697	0	15,839,697
2017	N/A	216,907	216,907
Total	$17,279,669	$216,907	$17,496,576

E.3. The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2018 and 2017.

F.

(1) At December 31, 2018, the Company's Federal Income Tax Return was consolidated with the following entities:

Aetna Inc.	CVS Health Corporation
@ Credentials Inc.	Accendo Insurance Company

Accordant Common, LLC
Accordant Health Services, LLC
Accuscript MO, Inc.
ACS Acqco Corp.
Active Health Management, Inc.
Adminco, Inc.
Administrative Enterprises, Inc.
Advanced Care Scripts, Inc.
Advanced Healthcare Distributors, LLC
AdvancePCS Specialty Rx, LLC
ADVANCERX.COM, LLC
Aetna Asset Advisors, LLC
Aetna Behavioral Health, LLC
Aetna Better Health Inc. (Georgia)
Aetna Better Health Inc. (IL)
Aetna Better Health Inc. (NJ)
Aetna Better Health Inc. (NY)
Aetna Better Health Inc. (OH)
Aetna Better Health Inc. (Tennessee)
Aetna Better Health of California, Inc.
Aetna Better Health of Iowa, Inc.
Aetna Better Health of Kansas Inc.
Aetna Better Health of Kentucky Insurance Co.
Aetna Better Health of Michigan, Inc.
Aetna Better Health of Missouri LLC
Aetna Better Health of Nevada Inc.
Aetna Better Health of North Carolina, Inc.
Aetna Better Health of Oklahoma Inc.
Aetna Better Health of Texas, Inc.
Aetna Better Health of Washington, Inc.
Aetna Better Health, Inc. (Connecticut)
Aetna Better Health, Inc. (LA)
Aetna Better Health, Inc. (PA)
Aetna Capital Management, LLC
Aetna Card Solutions, LLC
Aetna Dental Inc. (New Jersey)
Aetna Dental Inc. (Texas)
Aetna Dental of California, Inc.
Aetna Financial Holdings, LLC
Aetna Florida, Inc.
Aetna Health Holdings, LLC
Aetna Health Inc. (Connecticut)
Aetna Health Inc. (Florida)
Aetna Health Inc. (Georgia)
Aetna Health Inc. (LA)
Aetna Health Inc. (Maine)
Aetna Health Inc. (Michigan)
Aetna Health Inc. (New Jersey)
Aetna Health Inc. (NY)
Aetna Health Inc. (Pennsylvania)
Aetna Health Inc. (Texas)
Aetna Health Insurance Company
Aetna Health Insurance Company of New York
Aetna Health Management, LLC
Aetna Health of California Inc.
Aetna Health of Iowa, Inc
Aetna Health of Utah, Inc.
Aetna HealthAssurance Pennsylvania, Inc.
Aetna Integrated Informatics, Inc.
Aetna International Inc.
Aetna Ireland Inc.
Aetna Life & Casualty (Bermuda) Limited
Aetna Medicaid Administrators LLC
Aetna Network Services LLC
Aetna Pharmacy Management Services, LLC
Aetna Risk Assurance Company of Connecticut
Aetna Rx Home Delivery, LLC
Aetna Specialty Pharmacy, LLC
Aetna Student Health Agency, Inc.
Aetna Workers' Comp Access, LLC
Alabama CVS Pharmacy, LLC
Alajasper Realty Services, LLC
Alaska CVS Pharmacy, LLC
Allviant Corporation
AMC - New York, Inc.
AMC - Tennessee, Inc.
American Drug Stores Delaware, LLC
American Health Holding, Inc.
Apria Finance Holdings, Inc.
APS Acquisition LLC
APS-Summit Care Pharmacy, LLC
Arizona CVS Stores, LLC
Arkansas CVS Pharmacy, LLC
ASCO Healthcare of New England Limited Partnership
ASCO HealthCare, LLC
ASI Wings, LLC
AUSHC Holdings, Inc. (CT)
Badger Acquisition LLC
Badger Acquisition of Kentucky, LLC
Badger Acquisition of Minnesota, LLC
Badger Acquisition of Ohio, LLC
Baumel Eisner Neuromedical Institute, LLC
Best Care LTC Acquisition Company, LLC
Bluegrass Pharmacy of Lexington, LLC
BPNY Acquisition Corp
Bruin Acquisition Co., Inc.
bswift, LLC
Busse CVS, LLC #3110
Campo's Medical Pharmacy, Inc.
Care Pharmaceutical Services, LP
Care4, LP
Carecenter Pharmacy, LLC
Carecenter Pharmacy, LLC
Carefree Insurance Services, Inc.
Caremark Arizona Specialty Pharmacy Holding, LLC
Caremark Arizona Specialty Pharmacy, LLC
Caremark California Specialty Pharmacy Holding, LLC
Caremark California Specialty Pharmacy, LLC
Caremark Dallas Pharmacy, LLC
Caremark Hawaii Mail Pharmacy Holding, LLC
Caremark Hawaii Mail Pharmacy, LLC
Caremark Illinois Mail Pharmacy Holding, LLC
Caremark Irving Resource Center Holding, LLC
Caremark Irving Resource Center, LLC
Caremark Ohio Specialty Pharmacy Holding, LLC
Caremark Ohio Specialty Pharmacy, LLC
Caremark PA Specialty Pharmacy Holding, LLC
Caremark PCS, LLC
Caremark Pennsylvania Specialty Pharmacy, LLC
Caremark PHC, LLC
Caremark Puerto Rico Holding, LLC
Caremark Puerto Rico Specialty Pharmacy Holding, LLC
Caremark Puerto Rico Specialty Pharmacy, LLC
Caremark Puerto Rico, LLC
Caremark Redlands Pharmacy, LLC
Caremark Rx, LLC

Caremark Texas Mail Pharmacy Holding, LLC
Caremark Texas Mail Pharmacy, LLC
Caremark Ulysses Holding Corp.
Caremark, LLC
CaremarkPCS Alabama Mail Pharmacy Holding, LLC
CaremarkPCS Alabama Mail Pharmacy, LLC
CaremarkPCS Health, LLC
CaremarkPCS Pennsylvania Mail Pharmacy Holding, LLC
CaremarkPCS Pennsylvania Mail Pharmacy, LLC
CC Advertising & Marketing, LLC
CCRx Holdings, LLC
CCRx of North Carolina Holdings, LLC
CCRx of North Carolina, LLC
Central Rx Services, LLC
Choice Source Therapeutic Of Houston, Texas, LLC
Choice Source, LLC
CHP Acquisition Corp.
Circle Tallahassee Re, LLC
Claims Administration Corporation
Cofinity, Inc.
Compass Health Services, LLC
CompScript, LLC
Connecticut CVS Pharmacy, LLC
Continuing Care RX, LLC
Coram Alternate Site Services, Inc.
Coram Clinical Trials, Inc.
Coram Healthcare Corporation of Alabama
Coram Healthcare Corporation Of Florida
Coram Healthcare Corporation Of Greater D.C.
Coram Healthcare Corporation of Greater New York
Coram Healthcare Corporation of Indiana
Coram Healthcare Corporation of Massachusetts
Coram Healthcare Corporation of Mississippi
Coram Healthcare Corporation of Nevada
Coram Healthcare Corporation of North Texas
Coram Healthcare Corporation of Northern California
Coram Healthcare Corporation of Southern California
Coram Healthcare Corporation Of Southern Florida
Coram Healthcare Corporation of Utah
Coram LLC
Coram Specialty Infusion Services, LLC
CoramRX, LLC
Corporate Benefit Strategies, Inc.
Coventry Consumer Advantage, Inc.
Coventry Health and Life Insurance Company
Coventry Health Care National Accounts, Inc.
Coventry Health Care National Network, Inc.
Coventry Health Care of Florida, Inc.
Coventry Health Care of Illinois, Inc.
Coventry Health Care of Kansas, Inc.
Coventry Health Care of Missouri, Inc.
Coventry Health Care of Nebraska, Inc.
Coventry Health Care of Virginia, Inc.
Coventry Health Care of West Virginia, Inc.
Coventry Health Care Workers Compensation, Inc.
Coventry Health Plan of Florida, Inc.
Coventry HealthCare Management Corporation
Coventry Prescription Management Services, Inc.
Coventry Rehabilitation Services, Inc.
Coventry Transplant Network, Inc.
CP Acquisition Corp.
CP Services LLC
CSR, Inc.
CVS 1001 MA, LLC
CVS 10015 MA, LLC
CVS 10019 AR, LLC
CVS 10024 VA, LLC
CVS 10049 KY, LLC
CVS 10078 FL, LLC
CVS 10099 DE, LLC
CVS 10117 VA, LLC
CVS 10125 MA, LLC
CVS 10154 GA, LLC
CVS 10170 VA, LLC
CVS 10175 OK, LLC
CVS 10196 MA, LLC
CVS 10201 MN, LLC
CVS 10206 AL, LLC
CVS 10208 AL, LLC
CVS 10238 DE, LLC
CVS 10242 NE, LLC
CVS 10251 VA, LLC
CVS 10273 OK, LLC
CVS 10275 OK, LLC
CVS 10279 KY, LLC
CVS 10286 VA, LLC
CVS 10320 VA, LLC
CVS 10326 OK, LLC
CVS 10346 FL, LLC
CVS 10374 OH, LLC
CVS 10376 DE, LLC
CVS 10396 MN, LLC
CVS 1041 MA, LLC
CVS 10410 NE, LLC
CVS 10419 WI, LLC
CVS 10422 VA, LLC
CVS 10430 AR, LLC
CVS 10432 AR, LLC
CVS 10453 VA, LLC
CVS 10454 VA, LLC
CVS 10501 MA, LLC
CVS 10504 FL, LLC
CVS 10515 TN, LLC
CVS 10518 AR, LLC
CVS 10533 WI, LLC
CVS 10534 AR, LLC
CVS 10539 AR, LLC
CVS 10560 OK, LLC
CVS 10563 VA, LLC
CVS 10586 VA, LLC
CVS 10589 GA, LLC
CVS 10644 FL, LLC
CVS 10666 AR, LLC
CVS 10683 KY, LLC
CVS 10684 VA, LLC
CVS 10746 VA, LLC
CVS 10756 MN, LLC
CVS 10768 VA, LLC
CVS 10770 VA, LLC
CVS 10779 AR, LLC
CVS 10781 CO, LLC
CVS 10782 CO, LLC
CVS 10783 CO, LLC
CVS 10784 CO, LLC
CVS 10785 CO, LLC
CVS 10787 SC, LLC

CVS 10788 KY, LLC
CVS 10811 AL, LLC
CVS 10816 AR, LLC
CVS 10831 CO, LLC
CVS 10893 OH, LLC
CVS 10937 VA, LLC
CVS 10958 CO, LLC
CVS 10968 VA, LLC
CVS 10976 OK, LLC
CVS 10992 VA, LLC
CVS 11001 CO, LLC
CVS 11016 AL, LLC
CVS 11019 KY, LLC
CVS 11056 VA, LLC
CVS 11083 VA, LLC
CVS 11089 KY, LLC
CVS 11093 AR, LLC
CVS 11105 CO, LLC
CVS 11155 OH, LLC
CVS 11179 VA, LLC
CVS 1126 FL, LLC
CVS 11337 CO, LLC
CVS 1200 SC, LLC
CVS 1420 GA, LLC
CVS 1435 MD, LLC
CVS 1461 MD, LLC
CVS 1538 VA, LLC
CVS 1556 VA, LLC
CVS 1589 MI, LLC
CVS 180 SC, LLC
CVS 2003 VA, LLC
CVS 2019 VA, LLC
CVS 2065 RI, LLC
CVS 2545 CT, LLC
CVS 2747 FL, LLC
CVS 2829 FL, LLC
CVS 301 MA, LLC
CVS 3121 FL, LLC
CVS 3227 FL, LLC
CVS 3250 FL, LLC
CVS 326 RI, LLC
CVS 3269 FL, LLC
CVS 3301 OH, LLC
CVS 3320 OH, LLC
CVS 3353 OH, LLC
CVS 3380 SC, LLC
CVS 3416 OH, LLC
CVS 3432 OH, LLC
CVS 3460 VA, LLC
CVS 3471 OH, LLC
CVS 3558 NV, LLC
CVS 3625 AZ, LLC
CVS 373 MA, LLC
CVS 3749 AZ, LLC
CVS 3818 FL, LLC
CVS 3833 NC, LLC
CVS 3965 AZ, LLC
CVS 397 RI, LLC
CVS 3987 NC, LLC
CVS 4015 FL, LLC
CVS 4073 MA, LLC
CVS 4110 TN, LLC
CVS 4225 MD, LLC
CVS 1079 GA, LLC
CVS 10812 KY, LLC
CVS 10830 CO, LLC
CVS 10836 MA, LLC
CVS 10898 AL, LLC
CVS 10949 TN, LLC
CVS 10967 VA, LLC
CVS 10975 AR, LLC
CVS 10990 VA, LLC
CVS 11000 CO, LLC
CVS 11002 CO, LLC
CVS 11017 GA, LLC
CVS 11024 CO, LLC
CVS 11070 MN, LLC
CVS 11086 OH, LLC
CVS 11092 OK, LLC
CVS 11104 CO, LLC
CVS 11115 VA, LLC
CVS 11158 AR, LLC
CVS 11233 VA, LLC
CVS 1131 MA, LLC
CVS 1194 SC, LLC
CVS 1383 VA, LLC
CVS 1427, LLC
CVS 1452 MD, LLC
CVS 1525 VA, LLC
CVS 1547 VA, LLC
CVS 1561 VA, LLC
CVS 1743 AZ, LLC
CVS 1803 MA, LLC
CVS 2004 VA, LLC
CVS 2048 RI, LLC
CVS 2212 GA, LLC
CVS 264 NJ, LLC
CVS 2776 VA, LLC
CVS 2948 Henderson, LLC #2948
CVS 3042 DE, LLC
CVS 3186 WV, LLC
CVS 3232 NC, LLC
CVS 3257 FL, LLC
CVS 3268 Gilbert, LLC #3268
CVS 3271 FL, LLC
CVS 3318 FL, LLC
CVS 3343 OH, LLC
CVS 3356 OH, LLC
CVS 3407 OH, LLC
CVS 3418 FL, LLC
CVS 3452 OH, LLC
CVS 3468 OH, LLC
CVS 3537 SC, LLC
CVS 3563 NC, LLC
CVS 3667 FL, LLC
CVS 3745 Peoria, LLC #3745
CVS 3805 SC, LLC
CVS 3831 NC, LLC
CVS 3923 FL, LLC
CVS 3967 AZ, LLC
CVS 3973 NC, LLC
CVS 3988 NC, LLC
CVS 4016 MA, LLC
CVS 410 FL, LLC
CVS 4153 SC, LLC
CVS 4300 OH, LLC

CVS 433 MA, LLC
CVS 4380 WI, LLC
CVS 4480 FL, LLC
CVS 449 MA, LLC
CVS 4523 SC, LLC
CVS 4536 MS, LLC
CVS 4639 FL, LLC
CVS 4672 GA, LLC
CVS 4738 FL, LLC (f/k/a CVS 75462 FL, LLC)
CVS 4795 AZ, LLC
CVS 4840 AL, LLC
CVS 4896 OK, LLC
CVS 4905 AL, LLC
CVS 4976 AL, LLC
CVS 4993 MS, LLC
CVS 5021 VA, LLC
CVS 5089 NY, LLC
CVS 5112 FL, LLC
CVS 5131 AZ, LLC
CVS 5165 FL, LLC
CVS 5180 FL, LLC
CVS 5282 LA, LLC
CVS 5374 LA, LLC
CVS 5382 IL, LLC
CVS 5432 LA, LLC
CVS 5467 VA, LLC
CVS 5492 MN, LLC
CVS 5537 NC, LLC
CVS 5545 NC, LLC
CVS 5568 NC, LLC
CVS 5585 NC, LLC
CVS 5595 NC, LLC
CVS 5622 GA, LLC
CVS 5680 GA, LLC
CVS 5740 MS, LLC
CVS 5783 IL, LLC
CVS 5793 AZ, LLC
CVS 5812 AZ, LLC
CVS 5816 FL, LLC
CVS 5828 CA, LLC
CVS 5849 AZ, LLC
CVS 5851 IL, LLC
CVS 5890 AZ, LLC
CVS 5892 AZ, LLC
CVS 590 RI, LLC
CVS 5934 AZ, LLC
CVS 6012 GA, LLC
CVS 6089 OH, LLC
CVS 612 MA, LLC
CVS 6142 OK, LLC
CVS 6233 OK, LLC
CVS 6305 WV, LLC
CVS 6342 KY, LLC
CVS 6363 TN, LLC
CVS 6395 TN, LLC
CVS 6423, LLC
CVS 6572 IN. II, LLC
CVS 6796 MA, LLC
CVS 6867 NV, LLC
CVS 6874 IN, LLC
CVS 6972 FL, LLC
CVS 7047, LLC
CVS 7070 MS, LLC
CVS 4331 OH, LLC
CVS 4419 WV, LLC
CVS 4485 FL, LLC
CVS 4519 MS, LLC
CVS 4533 TN, LLC
CVS 4544 RI, LLC (f/k/a CVS 75566 RI, LLC)
CVS 4669 GA, LLC
CVS 4695 GA, LLC
CVS 4769 SC, LLC
CVS 4832 AL, LLC
CVS 4853 AL, LLC
CVS 4900 AL, LLC
CVS 4944 AL, LLC
CVS 4981 MA, LLC
CVS 5018 TN, LLC
CVS 5029 AZ, LLC
CVS 5111 FL, LLC
CVS 5113 NV, LLC
CVS 516 VA, LLC
CVS 5168 MS, LLC
CVS 5271 KS, LLC
CVS 5354 LA, LLC
CVS 5375 FL, LLC
CVS 5419 SC, LLC
CVS 5448 FL, LLC
CVS 5469 LA, LLC
CVS 5523 GA, LLC
CVS 5542 SC, LLC
CVS 5552 SC, LLC
CVS 5577 NC, LLC
CVS 5589 FL, LLC
CVS 5616 MN, LLC
CVS 5625 MO, LLC
CVS 5683 GA, LLC
CVS 5779 AZ, LLC
CVS 5791 AZ, LLC
CVS 5801 MS, LLC
CVS 5815 FL, LLC
CVS 582 MA, LLC
CVS 5829 IL, LLC
CVS 5850 MS, LLC
CVS 5856 MA, LLC
CVS 5891 AZ, LLC
CVS 5893 AZ, LLC
CVS 5931 AZ, LLC
CVS 6009 OK, LLC
CVS 6073 NJ, LLC
CVS 6116 KY, LLC
CVS 6135 NJ, LLC
CVS 6201 MN, LLC
CVS 6304 TN, LLC
CVS 6306 WV, LLC
CVS 6349 OH, LLC
CVS 6384 KY, LLC
CVS 6413 TN, LLC
CVS 6429 TN, LLC
CVS 6572 IN., LLC
CVS 6852 VA, LLC
CVS 6869 DE, LLC
CVS 6941 KY, LLC
CVS 7036, LLC
CVS 7057 NC, LLC
CVS 709 FL, LLC

CVS 7109 MA, LLC
CVS 7148 NC, LLC
CVS 7173 FL, LLC
CVS 7200, LLC
CVS 7382 NC, LLC
CVS 75121 SC, LLC
CVS 75129 FL, LLC
CVS 75139 NJ, LLC
CVS 75151 OH, LLC
CVS 75157 MI, LLC
CVS 75161 AZ, LLC
CVS 75163 GA, LLC
CVS 7519 MN, LLC
CVS 75235 RI, LLC
CVS 75257 NJ, LLC
CVS 75275 TN, LLC
CVS 75294 FL, LLC
CVS 75312 VA, LLC
CVS 75363 GA, LLC
CVS 75374 NJ, LLC
CVS 75380 GA, LLC
CVS 75408 FL, LLC
CVS 75441 GA, LLC
CVS 75461 AL, LLC
CVS 75486 KS, LLC
CVS 75536 GA, LLC
CVS 75560 NJ, LLC
CVS 75562 VA, LLC
CVS 75569 GA, LLC
CVS 75583 MA, LLC
CVS 75590 MN, LLC
CVS 75619 NJ, LLC
CVS 75636 NV, LLC
CVS 75651 SC, LLC
CVS 75660 OK, LLC
CVS 75676 KY, LLC
CVS 75707 FL, LLC
CVS 75719 MN, LLC
CVS 75738 RI, LLC
CVS 75743 NJ, LLC
CVS 75771 NC, LLC
CVS 75795 DE, LLC
CVS 75849 NC, LLC
CVS 75905 NJ, LLC
CVS 75935 NV, LLC
CVS 75947 GA, LLC
CVS 75958 MN, LLC
CVS 75961 SC, LLC
CVS 75978 FL, LLC
CVS 7648 KY, LLC
CVS 7701, LLC
CVS 7888 GA, LLC
CVS 8009 MI, LLC
CVS 8071 MI, LLC
CVS 8086 MI, LLC
CVS 8123 MI, LLC
CVS 8165 MI, LLC
CVS 8281 MD, LLC
CVS 8303 TN, LLC
CVS 8549 MI, LLC
CVS 866 FL, LLC
CVS 8776 WI, LLC
CVS 8956 MS, LLC
CVS 7133 FL, LLC
CVS 7157 NC, LLC
CVS 7180 AL, LLC
CVS 7215 AL, LLC
CVS 75024 AL, LLC
CVS 75124 MI, LLC
CVS 75137 MD, LLC
CVS 75144 RI, LLC
CVS 75156 NV, LLC
CVS 75160 SC, LLC
CVS 75162 AZ, LLC
CVS 75165 GA, LLC
CVS 75195 FL, LLC
CVS 75249 FL, LLC
CVS 75269 MI, LLC
CVS 75280 NC, LLC
CVS 75307 KS, LLC
CVS 75334 FL, LLC
CVS 75365 GA, LLC
CVS 75377 NC, LLC
CVS 75393 DE, LLC
CVS 75416 KY, LLC
CVS 75444 NV, LLC
CVS 75485 NC, LLC
CVS 75503 GA, LLC
CVS 75558 FL, LLC
CVS 75561 NJ, LLC
CVS 75563 MD, LLC
CVS 75572 NC, LLC
CVS 75584 MA, LLC
CVS 75615 FL, LLC
CVS 75626 GA, LLC
CVS 75642 VA, LLC
CVS 75659 OK, LLC
CVS 75669 MA, LLC
CVS 75679 SC, LLC
CVS 75718 OH, LLC
CVS 75733 NV, LLC
CVS 75740 NJ, LLC
CVS 75770 NC, LLC
CVS 75774 MA, LLC
CVS 75799 NJ, LLC
CVS 75896 MA, LLC
CVS 75924 FL, LLC
CVS 75946 VA, LLC
CVS 75952 WI, LLC
CVS 75959 MN, LLC
CVS 75977 MN, LLC
CVS 75995 DE, LLC
CVS 770 FL, LLC
CVS 7885 GA, LLC
CVS 8003 MI, LLC
CVS 8067 MI, LLC
CVS 8078 MI, LLC
CVS 8103 MI, LLC
CVS 8133 MI, LLC
CVS 8207 MI, LLC
CVS 8302 MI, LLC
CVS 8415 NE, LLC
CVS 8615 NE, LLC
CVS 8774 WI, LLC
CVS 8909 NC, LLC
CVS 8975 SC, LLC

CVS 8993 MS, LLC
CVS 921 IL, LLC
CVS 962 GA, LLC
CVS 976 FL, LLC
CVS ALBANY, LLC
CVS ARCLIGHT, INC.
CVS Bellmore Avenue, LLC #2154
CVS Caremark Indemnity Ltd.
CVS Durham 7042, LLC
CVS EGL 571 FL, LLC
CVS ETB Holding Company, LLC
CVS Foreign, Inc. #9736
CVS Grand Bay 4782, LLC
CVS Indiana, LLC #0877
CVS Lagrange 4540, LLC
CVS Manchester NH, LLC #0200
CVS Montgomery 6094, LLC
CVS Orlando FL Distribution, LLC
CVS Pharmacy Inc.
CVS PR Center, Inc.
CVS RCI, LLC
CVS Rx Services, Inc. #0886
CVS SC Distribution, LLC
CVS State Capital, LLC #0800
CVS Transportation, LLC
CVS Vero FL Distribution, LLC
CVS Weymouth 1853, LLC
D&R Pharmaceutical Services, LLC
Delaware CVS Pharmacy, LLC
DG Danville KY, LLC
Digital Enterprise Realty, LLC
E.T.B., INC.
Eckerd Corporation Of FL, Inc.
Enloe Drugs, LLC
Escalante Solutions, Llc
Evergreen Pharmaceutical, LLC
First Health Group Corp.
First Script Network Services, Inc.
FOCUS Healthcare Management, Inc.
Generation Health, LLC
Geneva Woods LTC Pharmacy, LLC
Geneva Woods Pharmacy Alaska, LLC
Geneva Woods Pharmacy Wyoming, LLC
Geneva Woods Retail Pharmacy, LLC
German Dobson CVS, LLC #5038
Grand St. Paul CVS, LLC
Group Dental Service of Maryland, Inc.
HCP Acquisition Sub, LLC
Health Data & Managment Solutions, Inc.
Healthagen LLC
Highland Park CVS, LLC
Home Care Pharmacy, LLC
Hook-Superx, LLC
Idaho CVS Pharmacy, LLC
Interlock Pharmacy Systems, LLC
Ironbound CVS Urban Renewal, LLC
JEC Funding, Inc.
Kansas CVS Pharmacy, LLC
Langsam Health Services, LLC
LHS Acquisition Sub, LLC
Lo-Med Prescription Services, LLC
Longs Drug Stores, LLC
Managed Care Coordinators, Inc.
CVS 920 MA, LLC
CVS 932 FL, LLC
CVS 9674 CA, LLC
CVS AL Distribution, LLC
CVS AOC Services, LLC
CVS Bay City 8207 MI, LLC
CVS Caremark Advanced Technology Pharmacy, LLC
CVS Caremark Part D Services, LLC
CVS EGL 5624 MO, LLC
CVS EGL 7958 FL, LLC
CVS Falmouth KY, LLC
CVS Gilbert 3272, LLC #3272
CVS Greensboro, LLC
CVS International, LLC
CVS Logan 3454, LLC
CVS Michigan, LLC #9415
CVS NV Holding Company, LLC
CVS PA Distribution, LLC
CVS PR Center Inc.
CVS PR Holding Company, LLC
CVS RS Arizona, LLC
CVS Safir Sourcing, LLC
CVS SP 5897 FL, LLC
CVS TN Distribution, LLC
CVS TX Holding Company, LLC
CVS Washington 6448, LLC
CVS WWRE, INC.
D.A.W., LLC
Delaware Physicians Care, Inc.
Digital EHealth, LLC
District Of Columbia CVS Pharmacy, LLC
Echo Merger Sub, Inc
Employee Assistance Services, LLC
Enterprise Safety Organization, LLC
Evergreen Pharmaceutical of California, Inc.
Express Pharmacy Services of PA, LLC
First Health Life and Health Insurance Company
Florida Health Plan Administrators, LLC
Garfield Beach CVS, LLC
Geneva Woods Health Services, LLC
Geneva Woods Management, LLC
Geneva Woods Pharmacy Washington, LLC
Geneva Woods Pharmacy, Inc.
Georgia CVS Pharmacy, LLC
Goodyear CVS, LLC #3749
Grandview Pharmacy, LLC
Group Dental Service, Inc.
Health and Human Resource Center, Inc.
Health Re, Inc.
HealthAssurance Pennsylvania, Inc.
Holiday CVS, LLC
Home Pharmacy Services, LLC
Horizon Behavioral Services, LLC
Institutional Health Care Services, LLC
Iowa CVS Pharmacy, LLC
iTriage, LLC
JHC Acquisition, LLC
Kentucky CVS Pharmacy, LLC
LCPS Acquisition, LLC
Lobos Acquisition, LLC
Longs Drug Stores California, LLC
Louisiana CVS Pharmacy, LLC
Managed Healthcare, Inc.

Martin Health Services, Inc.
Massachusetts CVS Pharmacy, Inc.
Medical Arts Health Care, Inc.
Member Health, LLC
Mental Health Network of New York IPA, Inc.
Merwin IV & Specialty Pharmacy, LLC
Merwin Rx-Compounding Pharmacy, LLC
MHHP Acquisition Company, LLC
MHNet of Florida, Inc.
Minuteclinic Diagnostic Of Alabama, LLC
Minuteclinic Diagnostic Of Florida, LLC
Minuteclinic Diagnostic Of Hawaii, LLC
Minuteclinic Diagnostic Of Kentucky, LLC
Minuteclinic Diagnostic Of Maine, LLC
Minuteclinic Diagnostic Of Massachusetts, LLC
Minuteclinic Diagnostic Of New Hampshire, LLC
Minuteclinic Diagnostic Of Ohio, LLC
Minuteclinic Diagnostic Of Oregon, LLC
Minuteclinic Diagnostic Of Rhode Island, LLC
Minuteclinic Diagnostic Of Texas, LLC
Minuteclinic Diagnostic Of Virginia, LLC
Minuteclinic Diagnostic Of Wisconsin, LLC
Minuteclinic Telehealth Services, LLC
Mississippi CVS Pharmacy, LLC
Montana CVS Pharmacy, LLC
NCS Healthcare of Illinois, LLC
NCS Healthcare of Iowa, LLC
NCS Healthcare of Kentucky, Inc.
NCS Healthcare of New Hampshire, Inc.
NCS Healthcare of Ohio, LLC
NCS Healthcare of Tennessee, Inc.
NCS Healthcare, LLC
Nebraska CVS Pharmacy, LLC
NeighborCare of Indiana, LLC
NeighborCare of Virginia, LLC
NeighborCare Pharmacy of Virginia, LLC
NeighborCare Services Corporation
Nevada CVS Pharmacy, LLC
NH Acquisition Sub, LLC
NIV Acquisition, LLC
North Shore Pharmacy Services LLC
NS Acquisition Sub, LLC
Ocean Acquisition Sub, LLC
OCR-RA Acquisition, LLC
Oklahoma CVS Pharmacy, LLC
Omnicare ESC LLC
Omnicare Headquarters LLC
Omnicare Indiana Partnership Holding Company LLC
Omnicare of New York, LLC
Omnicare Pharmacies of Pennsylvania West LLC
Omnicare Pharmacy and Supply Services LLC
Omnicare Pharmacy of Maine LLC
Omnicare Pharmacy of North Carolina, LLC
Omnicare Pharmacy of Tennessee, LLC
Omnicare Pharmacy of Texas 2, LP
Omnicare Property Management, LLC
OPGP Acquisition Sub, LLC
Oregon CVS Pharmacy, LLC
PayFlex Holdings, Inc.
Pennsylvania CVS Pharmacy, LLC
Performax, Inc.
Pharmacare Pharmacy, LLC
Pharmacy Associates of Glens Falls, Inc.
Maryland CVS Pharmacy, LLC
Med World Acquisition Corp.
Melville Realty Co., Inc.
Mental Health Associates, Inc.
Meritain Health, Inc.
Merwin Long Term Care, Inc.
MetraComp, Inc.
MHNet Life and Health Insurance Company
MHNet Specialty Services LLC
Minuteclinic Diagnostic Of Arizona, LLC
Minuteclinic Diagnostic Of Georgia, LLC
Minuteclinic Diagnostic Of Illinois, LLC
Minuteclinic Diagnostic Of Louisiana, LLC
Minuteclinic Diagnostic Of Maryland, LLC
Minuteclinic Diagnostic Of Nebraska, LLC
Minuteclinic Diagnostic Of New Mexico, LLC
Minuteclinic Diagnostic Of Oklahoma, LLC
Minuteclinic Diagnostic Of Pennsylvania, LLC
Minuteclinic Diagnostic Of South Carolina, LLC
Minuteclinic Diagnostic Of Utah, LLC
Minuteclinic Diagnostic Of Washington, LLC
Minuteclinic Online Diagnostic Services, LLC
Minuteclinic, LLC
Missouri CVS Pharmacy, LLC
Mountain Grove Investment Group LLC
NCS Healthcare of Indiana LLC
NCS Healthcare of Kansas, LLC
NCS Healthcare of Montana, Inc.
NCS Healthcare of New Mexico, Inc.
NCS Healthcare of South Carolina, Inc.
NCS Healthcare of Wisconsin, LLC
NCSH Acquisition Sub, LLC
NeighborCare Holdings, Inc.
NeighborCare of New Hampshire, LLC
NeighborCare Pharmacies, LLC
NeighborCare Pharmacy Services, Inc.
NeighborCare, Inc.
New Jersey CVS Pharmacy, LLC
Niagara Re, Inc.
North Carolina CVS Pharmacy, LLC
Novologix, LLC
NSPS Acquisition Sub, LLC
OCR Services Corporation
Ohio CVS Stores, LLC
Omnicare Distribution Center LLC
Omnicare Foundation
Omnicare Holding Company
Omnicare of Nevada, LLC
Omnicare Pharmacies of Pennsylvania East LLC
Omnicare Pharmacies of the Great Plains Holding Company
Omnicare Pharmacy of Florida, LP
Omnicare Pharmacy of Nebraska, LLC
Omnicare Pharmacy of Pueblo, LLC
Omnicare Pharmacy of Texas 1, LP
Omnicare Pharmacy of the Midwest, LLC
Omnicare, Inc.
OPM Acquisition Sub, LLC
Part D Holding Co., LLC
PayFlex Systems USA, Inc.
Pennsylvania Life Insurance Company
Pharmacare Holding Company
Pharmacare Specialty Healthcare Distributors, LLC
Pharmacy Consultants, LLC

Pharmacy Holding #1, LLC
PharmaSource Healthcare, Inc.
Pharmed Holdings, Inc.
Phoenix Data Solutions LLC
PP Acquisition Company, LLC
PrimeNet, Inc.
Procare 4268 Yankee, LLC
Procare Pharmacy, LLC
Professional Pharmacy Services, Inc.
PSI Arkansas Acquisition, LLC
Red Oak Sourcing, LLC
Retrac, Inc. #107
Richmond Heights Acquisition Corp.
Rx Innovations 4439, LLC
RXC Acquisition Company
Scrip World, LLC
Shore Pharmaceutical Providers, LLC
Sky Acquisition LLC
South Wabash CVS, LLC #3674
Specialty Services Holding LLC
Sterling Healthcare Services, Inc.
Suburban Medical Services, LLC
T2 Medical, Inc.
Tennessee CVs Pharmacy, LLC
Thomas Phoenix CVS, LLC #3625
Thundermist Services, LLC
UAC Holding, Inc.
Uni-Care Health Services of Maine, Inc.
Value Health Care Services LLC
Vermont CVS Pharmacy, LLC
Virginia CVS Pharmacy, LLC
Washington CVS Pharmacy, LLC
Weber Medical Systems LLC
West Virginia CVS Pharmacy, LLC
Williamson Drug Company, Incorporated
Woodruff Realty Associates, LLC #2085
Work & Family Benefits, Inc.
ZS Acquisition Company, LLC
Pharmacy Holding #2, LLC
Pharm-Corp of Maine LLC
Pharmore, Inc.
PMRP Acquisition Company, LLC
Precision Benefit Services, Inc.
PRN Pharmaceutical Services, LP
Procare Pharmacy Direct, LLC
Prodigy Health Group, Inc.
Professional Risk Management, Inc.
Puerto Rico CVS Pharmacy, LLC
Resources for Living, LLC
Rhode Island CVS Pharmacy, LLC
Roeschen's Healthcare LLC
RxAMERICA, LLC
Schaller Anderson Medical Administrators Inc
Sheffield Avenue CVS, LLC #3690
Silverscript Insurance Company
South Carolina CVS Pharmacy, LLC
Specialized Pharmacy Services, LLC
Speedwell CVS Urban Renewal, LLC
Strategic Resource Company
Superior Care Pharmacy, Inc.
TCPI Acquistion Corp.
The Vasquez Group, Inc.
Three Forks Apothecary, LLC
U.S. Health Care Properties, Inc.
UC Acquisition Corp.
Utah CVS Pharmacy, LLC
VAPS Acquisition Company, LLC
VHCS Acquisition Sub, LLC
Warm Springs Road CVS, LLC #2928
Washington Lamb CVS, LLC #3172
Wellpartner, LLC
Westhaven Services Co, LLC
Wisconsin CVS Pharmacy, LLC
Woodward Detroit CVS, LLC
WP Smart Holdings, LLC
976 Miami RE, LLC

(2) As explained in Note 1, the Company participates in a tax sharing agreement with its parent and affiliates.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

10. Information Concerning Parent, Subsidiaries, Affiliates, and Other Related Parties

A., B. and C.

The Company did not pay any dividends in 2018 or 2017.The Company did not receive any capital contributions in 2018 or 2017.

D. Amounts due to and due from affiliates shown in the accompanying Statutory Statements of Assets and Liabilities, Capital and Surplus and Other Funds include the Company's net receipts and disbursements processed by affiliates and transactions related to its administrative services agreement with Aetna Health Management, LLC (“AHM”), indirectly a wholly-owned subsidiary of Aetna.

At December 31, 2018 and 2017, the Company had the following amounts due to and due from affiliates, which exclude amounts related to pharmacy rebate transactions as discussed more fully in Note 28 and the Company's reinsurance agreement:

	December	
	2018	2017
Amounts due from affiliates		
Aetna Medicaid Administrators, LLC	$7,789,355	$—
Coventry Health and Life Insurance Company	—	2,260,617
Aetna Health Management, LLC	—	4,471
Aetna Better Health of Missouri LLC	—	127
	$7,789,355	$2,265,215

	December	
	2018	2017
Amounts due to affiliates		
Aetna Inc. Division	$13,806,924	$33,688,103
Aetna Medicaid Administrators LLC	—	11,615,610
Coventry Health and Life Insurance Company	13,316	—
Aetna Life Insurance Company	26	—
	$13,820,266	$45,303,713

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

E. At December 31, 2018, the Company has a guarantor agreement with Aetna. The agreement provides that in the event of the Company's insolvency, Aetna will pay all expenses and claims incurred by the Company during insolvency pursuant to the obligation with employer groups and subscribers until the end of the subscription contract period for which premiums have been received.

F. As of and for the years ended December 31, 2018 and 2017, the Company had the following significant transactions with affiliates:

The Company and AHM are parties to an administrative services agreement, under which AHM provides certain administrative services, including accounting and processing of premiums and claims. Under this agreement, the Company remits a percentage of its earned commercial, Medicaid and Medicare premium revenue, as applicable, to AHM as a fee, subject to an annual true-up mechanism as defined in the agreement. Under the agreement, this true-up is due to be settled with the affiliate by April 15th of the following contract year (which is January 1 to December 31 annually). The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

	2018	2017
AMA Administrative service fee	$86,941,598	$86,588,034

These agreements also provide for interest on all intercompany balances. Interest earned on amounts due from affiliates was $0 in 2018 and $0 in 2017. Interest incurred on amounts due to affiliates was $0 in 2018 and $0 in 2017.

The Company is a party to an agreement which enables the Company to receive manufacturers' pharmacy rebates from AHM under which the Company remits a percentage of its earned pharmaceutical rebates to AHM as a fee. The Company earned pharmaceutical rebates of $8,245,511 and $6,802,903, which were recorded as a reduction of medical costs, in 2018 and 2017, respectively. The Company was charged $0 and $0, which were recorded as administrative expenses, for these services in 2018 and 2017, respectively. At December 31, 2018 and 2017, the Company reported $2,070,247 and $1,758,384, respectively, as amounts due from AHM related to the pharmaceutical rebates which were reflected in health care and other amounts receivable. The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

The amounts reported on the Underwriting and Investment Exhibit, Part 3 represent the expenses incurred under the terms of the administrative agreement, allocated to the Company in accordance SSAP No. 70 - *Allocation of Expenses* ("SSAP No. 70"). SSAP No. 70 states "shared expenses, including expenses under the terms of a management contract, shall be apportioned to the entities incurring the expense as if the expense had been paid solely by the incurring entity. The apportionment shall be completed based upon specific identification to the entity incurring the expense. Where specific identification is not feasible, apportionment shall be based upon pertinent factors or ratios." The Company allocates these expenses

based upon a percentage calculated using actual general and administrative expenses incurred by AHM and AMA.

Effective February 1, 2016, the Company entered into an Assignment Agreement with its parent CH&L, indirectly a wholly-owned subsidiary of Aetna, whereby, CH&L assigned, sold, transferred and set over to ABH-KY all of their assets and liabilities arising out of or relating to Kentucky Medicaid contract.

As explained in Note 1, the Company participates in a tax sharing agreement with Aetna and Aetna's other subsidiaries. All federal income tax receivables/payables are due from/due to Aetna.

G. All outstanding shares of the Company are owned by Coventry Health & Life Insurance Co. whose ultimate parent is CVS Health.

H. At December 31, 2018, the Company did not own shares of any upstream intermediate of CVS Health.

I. At December 31, 2018, the Company did not hold any investments in any subsidiary, controlled or affiliated ("SCA") entity that exceeded 10% of the Company's admitted assets.

J. At December 31, 2018, the Company did not hold any investments in any impaired SCA entity.

K. At December 31, 2018, the Company did not hold any investments in any foreign insurance subsidiaries.

L. At December 31, 2018, the Company did not hold any investments in a downstream noninsurance holding company.

M. At December 31, 2018, the Company did not have any SCA investments.

N. At December 31, 2018, the Company did not have any investments in an insurance SCA

O. The Company did not have any SCA investments where the Company's share of losses in the SCA exceeds its investment in the SCA.

11. Debt

A. The Company did not have any items related to debt, including capital notes at December 31, 2018.

B. The Company did not have any Federal Home Loan Bank agreements at December 31, 2018.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

The Company did not have a retirement plan, deferred compensation plan, or other postretirement benefit plan at December 31, 2018 or 2017.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

(1) The Company had 1,000,000 shares of common capital stock authorized, issued and outstanding with a par value of $1 per share at December 31, 2018.

(2) The Company had no shares of preferred stock issued and outstanding at December 31, 2018 and 2017.

(3) Dividend Restrictions

In accordance with Kentucky statutes, the Company shall not pay any extraordinary dividend unless the Company has notified the Kentucky Department in writing at least 30 days prior thereto or such shorter period as the Kentucky Department may permit and the Kentucky Department has not disapproved it within such period. An extraordinary dividend is any dividend or other distribution which, together with other dividends and distributions made within the preceding 12 months, exceeds the greater of: ten percent of such insurer's surplus as regards policyholders as of the preceding December 31; or the net income of such insurer for the period covered by such statement, but shall not include pro rata distributions of any class of the insurer's own securities. The Company may not make a non-extraordinary dividend without prior notification to the Kentucky Department within five business days following the declaration thereto and at least ten days, commencing from the date of receipt by the Kentucky Department, prior to the payment thereof. Ordinary dividends are ultimately limited to earned surplus.

(4) The Company did not pay any dividends in 2018 or 2017.

(5) Within the limitations of 3) above, there are no other restrictions placed on the portion of the Company profits that may be paid as ordinary dividends to the stockholder.

(6) There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2018 or 2017, except as noted in Note 21.

(7) Not applicable to the Company.

(8) The Company did not hold any stock for any special purposes at December 31, 2018 or 2017.

(9) Changes in the balances of special surplus funds from the prior year are due to the accrual of estimated ACA health insurer fees reclassified from unassigned funds or surplus to aggregate write-ins for special surplus funds as discussed more fully in Note 1.C and Note 22.

(10) At December 31, 2018 and 2017, there was $(1,538,193) and $148,249, respectively, of unassigned funds that was represented or reduced by unrealized gains and losses.

(11) The Company has not issued any surplus notes or debentures or similar obligations at December 31, 2018 or 2017.

(12) The Company did not participate in any quasi-reorganizations during the statement year.

(13) The Company did not participate in any quasi-reorganizations in the past 10 years.

14. Liabilities, Contingencies and Assessments

A. The Company did not have any contingent commitments at December 31, 2018 or 2017.

B. Assessments

Guaranty Fund Assessments

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which CVS Health and certain of its affiliates, including the Company participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payers such as not-for-profit consumer-governed health plans established under Health Care Reform.

The Company had no assets recognized from paid and accrued premium tax offsets and policy surcharges at December 31, 2018 and 2017.

C. The Company did not have any gain contingencies at December 31, 2018 or 2017.

D. The Company did not have any claims related extra contractual obligation and bad faith losses stemming from lawsuits at December 31, 2018 or 2017.

E. The Company did not have any joint and several liability arrangements at December 31, 2018 or 2017.

F. Various liabilities arise in the normal course of the Company's business and have been recorded. In the opinion of management, any ultimate contingent losses will not have a material adverse effect on the Company's future results of operations and financial position. The Company, to the best of its knowledge, has no assets that it considers impaired that are not already recorded in the Company's books.

15. Leases

The Company did not have any material lease obligations at December 31, 2018 or 2017.

16. Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company did not have any financial instruments with off-balance sheet risk or financial instruments with concentrations of credit risk at December 31, 2018 or 2017.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

(1) The Company did not have any transfers of receivables as sales for the years ending December 31, 2018 and 2017.

B. Transfer and Servicing of Financial Assets

(1) The Company's policy for requiring collateral or other security for security lending transactions as required in SSAP No. 103R is discussed in Note 1. Excludes repurchase and reverse repurchase transactions as discussed in Notes 5.F. through 5.I. The Company did not have any loaned securities at December 31, 2018 and 2017.

(2) and (3)

The Company did not have any servicing assets or liabilities at December 31, 2018 or 2017.

(4) The Company did not have any securitized financial assets at December 31, 2018 or 2017.

(5) The Company did not have any transfers of financial assets accounted for as secured borrowing at December 31, 2018 or 2017.

(6) The Company did not have any transfers of receivables with recourse at December 31, 2018 or 2017.

(7) The Company did not have any dollar repurchase or reverse repurchase agreements at December 31, 2018 or 2017.

C. Wash Sales

(1) In the course of the Company's asset management, securities are sold and reacquired within 30 days of the sale date to enhance the Company's yield on its investment portfolio.

(2) The Company had no securities sold during the year for the year ended December 31, 2018 and reacquired within 30 days of the sale date.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

A. The Company did not serve as an Administrative Services Only for uninsured accident and health plans or the uninsured portion of partially insured plans for the period ended December 31, 2018.

B. The Company did not serve as an Administrative Services Contract (ASC) plan administrator for uninsured accident and health plans or the uninsured portion of partially insured plans for the period ended December 31, 2018.

C. The Company did not have any Medicare or other similarly structured cost based reimbursement contracts for the period ended December 31, 2018.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

The Company did not have any material direct premiums written through/produced by managing general agents or third party administrators for the years ended December 31, 2018 and 2017.

20. Fair Value Measurements

A. and B.

The Company had no material assets or liabilities measured and reported at fair value at December 31, 2018 or 2017.

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting the Company's own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

C. The carrying values and estimated fair values of the Company's financial instruments at December 31, 2018 and 2017 were as follows:

December 31, 2018

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Bonds, Short Term, and Cash Equivalents	456,527,887	453,842,667	56,565,551	399,962,336	—		
Mortgage Loans	14,062,100	13,407,858	—	—	14,062,100		

December 31, 2017

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Net Asset Value (NAV)	Not Practicable (Carrying Value)
Bonds, Short Term, and Cash Equivalents	501,987,213	494,104,260	48,822,380	453,164,833	—		
Mortgage Loans	13,845,022	12,979,171	—	—	13,845,022		

The valuation methods and assumptions used by the Company in estimating the fair value of debt securities are discussed in Note 1.

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets during 2018 or 2017. There were no transfers between the Company's Level 1 or 2 financial assets during 2018 or 2017.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

D. The Company did not have any financial instruments where it was not practicable to estimate the fair value.

E. The Company has not elected to use the net asset value practical expedient to fair value to measure its investments.

21. Other Items

A. Unusual or Infrequent Items

The Company did not have any unusual or infrequent items for the years ended December 31, 2018 and 2017.

B. Troubled Debt Restructuring

The Company did not have any troubled debt restructuring in the years ended December 31, 2018 and 2017.

C. Other Disclosures

(1) Minimum Capital and Surplus

Pursuant to the laws of the states in which the Company is licensed to do business, the Company is required to maintain a minimum surplus and capital stock as defined by the statutes and regulations of those states. At both December 31, 2018 and 2017, the Company was in compliance with the minimum surplus and capital stock requirements of the states in which it is licensed to do business.

The NAIC and the Commonwealth of Kentucky adopted risk-based capital ("RBC") standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company's adjusted capital and surplus to its required capital and surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of the company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2018 and 2017, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

(2) Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "Health Care Reform" or the "ACA"), has made broad-based changes to the U.S. health care system. If the ACA is not further amended, repealed or replaced, certain of its components will continue to be phased in until 2022. While the Company anticipates continued efforts in 2019 and beyond to invalidate, modify, repeal or replace Health Care Reform, the Company expects aspects of Health Care Reform to

continue to significantly impact the Company's business operations and financial results, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

While most of the significant aspects of Health Care Reform became effective during or prior to 2014, parts of Health Care Reform continue to evolve through the promulgation of executive orders, regulations and guidance as well as ongoing litigation. Additional changes to Health Care Reform and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing state and federal budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, Health Care Reform and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. For example, if any elements of Health Care Reform are invalidated or repealed at the federal level, the Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

Potential repeal of Health Care Reform, ongoing legislative, regulatory and administrative policy changes to Health Care Reform, the results of congressional and state level elections, the December 2018 U.S. District Court decision invalidating Health Care Reform and other pending litigation challenging aspects of the law or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of Health Care Reform. The pending litigation challenging Health Care Reform includes challenges by various states of the federal government's decision to curtail payments related to the Cost-Sharing Subsidy Program. The time frame for conclusion and final outcome and ultimate impact of this litigation are uncertain. Given the inherent difficulty of foreseeing the nature and scope of future changes to Health Care Reform and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to Health Care Reform. It is reasonably possible that invalidation, repeal or replacement of or other changes to Health Care Reform and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's businesses, financial results and cash flows.

As described above, the availability of funding for Health Care Reform's temporary risk corridor program is an example of this uncertainty. The Company continues to believe that receipt of any risk corridor payment from HHS for the 2018 or 2017 program year and receipt of such payments in excess of the announced prorated amount for the 2014 program year are uncertain. At December 31, 2018, the Company had a $0 receivable for the remaining 2014 program year prorated amount that had not been collected from HHS and had no receivable for either of the 2015 or 2016 program years. 2016 was the last program year for Health Care Reform's risk corridor program. On-going uncertainty regarding the funding of Health Care Reform-related programs and subsidies can be expected to create additional instability in the marketplace.

In addition to efforts to amend, repeal or replace Health Care Reform and the related regulations, the federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's business. The Company cannot predict whether pending or future federal or state legislation or court proceedings, including future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or Health Care Reform or the impact those changes will have on the Company's business operations or operating results, but the effects could be materially adverse.

In addition, Health Care Reform ties a portion of each Medicare Advantage plans' reimbursement to the achievement of favorable CMS quality performance measures ("star ratings"). Since 2015, only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' operating results in 2017 and going forward will be significantly affected by their star ratings.

(3) Medicare

The Company does not have any contracts for Medicare Advantage and Standalone Prescription Drug Plan ("PDP") products with CMS.

(4) Federal Employees Health Benefits Program

The Company does not have any contracts with the OPM to provide managed health care services under the FEHB program in its service areas.

(5) Medicaid

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS contracts and regulations. The Company's Medicaid products, dual eligible products and Children's Health Insurance Program ("CHIP") contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services the Company provides to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual

requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or the Company's contractual requirements. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or financial results, but the effects could be materially adverse.

D. The Company did not have any business interruption insurance recoveries for the years ending December 31, 2018 or 2017.

E. The Company did not have any transferable and non-transferable state tax credits for the years ending December 31, 2018 or 2017.

F. The Company did not have any subprime mortgage related risk exposures at December 31, 2018 or 2017.

G. The Company did not have any retained assets at December 31, 2018 or 2017.

H. The Company did not have any insurance-linked securities ("ILS") contracts at December 31, 2018 or 2017.

22. Events Subsequent

A. Type I - Recognized Subsequent Events

Subsequent events have been considered through February 27, 2019 for the statutory statement issued on March 1, 2019.

The Company had no known reportable recognized subsequent events.

B. Type II - Nonrecognized Subsequent Events

Subsequent events have been considered through February 27, 2019 for the statutory statement issued on March 1, 2019.

As discussed in Note 1, in January 2018, the HIF was suspended for 2019. As a result, there is no annual health insurance industry fee payable on September 30, 2019 and there are no amounts reflected in the Company's aggregate write-ins for special surplus funds related to this payable at December 31, 2018 as a result. There is also no resulting impact to the Company's RBC to assess as of December 31, 2018 as a result of this suspension.

In January 2018, the annual fee was suspended for 2019.

Type II - Nonrecognized Subsequent Events:		Current Year	Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	YES		
B. ACA fee assessment payable for the upcoming year		—	$22,555,000
C. ACA fee assessment paid		$22,536,420	—
D. Premium written subject to ACA 9010 assessment		—	$1,092,625,603
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)		$326,498,199	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)		$326,498,199	
G. Authorized Control Level (Five-Year Historical Line 15)		$35,261,081	
H. Would reporting the ACA assessment as of Dec. 31, 2017 have triggered an RBC action level (YES/NO)?	NO		

23. Reinsurance

The Company did not have any reinsurance recoverables in dispute, reinsurance assumed, uncollectible reinsurance, commutation of ceded reinsurance, or retroactive reinsurance at December 31, 2018 or 2017.

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the company or by any representative, officer, trustee, or director of the company?
Yes ( ) No (X)
If yes, give full details.

(2) Have any policies issued by the company been reinsured with a company chartered in a country other than the United States (excluding U.S. branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?
Yes ( ) No (X)
If yes, give full details.

Fresenius is located in the Cayman Islands and is an affiliate of Fresenius Medicare Care Holdings, Inc. (not primarily engaged in the insurance business).

Section 2 – Ceded Reinsurance Report – Part A

(1) Does the company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than nonpayment of premium or other similar credit?
Yes ( ) No (X)

a. If yes, what is the estimated amount of the aggregate reduction in surplus of a unilateral cancellation by the reinsurer as of the date of this statement, for those agreements in which cancellation results in a net obligation of the reporting entity to the reinsurer, and for which such obligation is not presently accrued? Where necessary, the reporting entity may consider the current or anticipated experience of the business reinsured in making this estimate.
$ N/A.

b. What is the total amount of reinsurance credits taken, whether as an asset or as a reduction of liability for these agreements in this statement?
$ N/A.

(2) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?
Yes ( ) No (X)
If yes, give full details.

Section 3 – Ceded Reinsurance Report – Part B

(1) What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the insurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the company may consider the current or anticipated experience of the business reinsured in making this estimate.
$ 0

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the company as of the effective date of the agreement?
Yes ( ) No (X)
If yes, what is the amount of reinsurance credit, whether an asset or a reduction of liability, taken for such new agreements or amendments? $ N/A

B. The Company did not have uncollectible reinsurance at December 31, 2018.

C. The Company did not have any commutation of ceded reinsurance at December 31, 2018.

D. The Company's certified reinsurer's rating has not been downgraded or its status subject to revocation at December 31, 2018.

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

A. and B.

The Company did not have any retrospectively rated contracts in 2018 or 2017.

C. Contracts Subject to Retrospective Rating Features

The Company did not have any contracts subject to retrospective rating features in 2018 or 2017.

D. Medical Loss Ratio Rebates Required Pursuant to the Public Health Service Act

The Company did not have any medical loss ratios required pursuant to the Public Health Service Act in 2018 or 2017.

E. Risk Sharing Provisions of the Affordable Care Act (ACA)

(1) Did the reporting entity write accident and health insurance premium which is subject to the ACA risk sharing provisions (YES/NO)? No

(2) through (5): Not applicable.

25. Change in Incurred Claims and Claims Adjustment Expense

The following table shows the components of the change in claims unpaid, unpaid claims adjustment expense and aggregate health claim reserves for the years ended December 31, 2018 and 2017.

	2018	2017
Balance, January 1	$162,303,470	$203,997,642
Health care receivable	(27,088,688)	(14,056,403)
Balance, January 1, net of health care receivable	135,214,782	189,941,239
Incurred related to:		
Current year	1,019,452,273	993,864,896
Prior years	(60,408,611)	(4,903,247)
Total incurred	959,043,662	988,961,649
Paid related to:		
Current year	883,762,047	851,662,283
Prior years	92,686,833	192,025,823
Total paid	976,448,880	1,043,688,106
Balance, December 31, net of health care receivable	117,809,564	135,214,782
Health care receivable	15,448,760	27,088,688
Balance, December 31	$133,258,324	$162,303,470

In 2018, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased by $60,408,611 from $162,303,470 in 2017 to $101,894,859 in 2018. In 2017, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased by $4,903,247 from $203,997,642 in 2016 to $199,094,395 in 2017. The lower than anticipated health care cost trend rates observed in 2017 and 2017 for claims incurred in 2017 and 2016, respectively, were due to moderating outpatient and physician trends and faster than expected claim payment speed. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends. The Company experienced $0 of favorable prior year claim development on retrospectively rated policies, which is included in the net 2017 decrease. However, the business to which it relates is subject to premium adjustments. The Company excluded the impact of the change in health care receivables related to pharmacy rebates from the above roll-forward to conform to NAIC Annual Statement presentation.

Net coordination of benefits are implicit in the claims incurred but not reported calculation and could not be specifically identified.

26. Intercompany Pooling Arrangements

The Company did not have any intercompany pooling arrangements at December 31, 2018 or 2017.

27. Structured Settlements

Not applicable to health entities.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

The Company receives pharmaceutical rebates through an agreement with AHM. AHM has contractual agreements with pharmaceutical companies for rebates, which cover the Company's membership as well as the membership of other Aetna affiliates. The Company receives those rebates from AHM that relate to the Company's membership. The Company estimates pharmaceutical rebate receivables based upon the historical payment trends, actual utilization and other variables. Actual rebates collected are applied to the collection periods below, using a first in first out methodology. At December 31, 2018 and 2017, the Company had pharmaceutical rebate receivables of $2,070,247 and $1,758,384, respectively (refer to the Company's accounting practices related to pharmaceutical rebate receivables in Note 1).

The following table discloses the quarterly revenue and subsequent cash collections relating to the pharmaceutical rebates discussed in Note 10.

Date	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
12/31/2018	2,070,247				
09/30/2018	2,045,290	2,070,247			
06/30/2018	1,993,244	2,044,005	458,375		
03/31/2018	1,861,812	1,993,905	524,216	1,334,843	
12/31/2017	1,758,384	1,859,880	816,711	950,456	29,278
09/30/2017	1,746,114	1,756,191	741,775	987,315	2,033
06/30/2017	1,656,531	1,744,103	424,719	1,163,704	59,218
03/31/2017	1,839,409	1,647,286	523,499	1,100,655	1,475
12/31/2016	1,920,365	1,798,304	596,429	1,184,747	1,114
09/30/2016	2,143,692	2,136,477	1,185,618	942,594	842
06/30/2016	1,876,911	1,871,046	640,940	1,051,637	168,809
03/31/2016	696,424	706,184	216,827	361,714	107,152

B. Risk sharing receivables

The Company did not have any admitted risk sharing receivables at December 31, 2018 or 2017.

29. Participating Policies

The Company did not have any participating policies at December 31, 2018 or 2017.

30. Premium Deficiency Reserves

	December 31, 2018
1. Liability carried for premium deficiency reserves	$0
2. Date of the most recent evaluation of this liability	12/31/2018
3. Was anticipated investment income utilized in the calculation?	No

31. Anticipated Salvage and Subrogation

See discussion of hospital and medical costs and claims adjustment expenses and related reserves in Note 1.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES
GENERAL

1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1, 1A and 2

1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent, or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes [X] No [ ] N/A [ ]

1.3 State Regulating? Kentucky

1.4 Is the reporting entity publicly traded or a member of a publicly traded group? Yes [X] No [ ]

1.5 If the response to 1.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0000064803

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [ ] No [X]

2.2 If yes, date of change:

3.1 State as of what date the latest financial examination of the reporting entity was made or is being made.

3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

3.4 By what department or departments?

3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [ ] No [ ] N/A [X]

3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [ ] No [ ] N/A [X]

4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity), receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business? Yes [ ] No [X]
4.12 renewals? Yes [ ] No [X]

4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business? Yes [ ] No [X]
4.22 renewals? Yes [ ] No [X]

5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [ ] No [X]
If yes, complete and file the merger history data file with the NAIC.

5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [ ] No [X]

6.2 If yes, give full information:

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? Yes [ ] No [X]

7.2 If yes,
7.21 State the percentage of foreign control; 0.0 %
7.22 State the nationality(s) of the foreign person(s) or entity(s) or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact; and identify the type of entity(s) (e.g., individual, corporation or government, manager or attorney in fact).

1 Nationality	2 Type of Entity

GENERAL INTERROGATORIES

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
KPMG LLP, One Financial Plaza, 755 Main Street, Hartford, CT 06103

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [ ] No [X]

10.2 If the response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes [ ] No [X]

10.4 If the response to 10.3 is yes, provide information related to this exemption:

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [ ] N/A [ ]

10.6 If the response to 10.5 is no or n/a, please explain

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Jeffrey J. Drzazgowski, FSA, MAAA; 151 Farmington Avenue, RE2R; Hartford, CT 06156

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [ ] No [X]

12.11 Name of real estate holding company

12.12 Number of parcels involved 0

12.13 Total book/adjusted carrying value $ 0

12.2 If, yes provide explanation:

13. **FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:**

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?
N/A

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [ ] No [ ]

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [ ] No [ ]

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [ ] No [ ] N/A [ ]

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No [ ]
(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

14.11 If the response to 14.1 is No, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [X] No [ ]

14.21 If the response to 14.2 is yes, provide information related to amendment(s).
Through November 28, 2018, senior management was subject to the Aetna Inc. Code of Conduct. Effective with the acquisition of Aetna Inc. by CVS Health Corporation, senior management become subject to the CVS Health Code of Conduct.

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

GENERAL INTERROGATORIES

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [ ] No [X]

15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No [ ]

17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No [ ]

18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict with the official duties of such person? Yes [X] No [ ]

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [ ] No [X]

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.11 To directors or other officers $ 0
- 20.12 To stockholders not officers $ 0
- 20.13 Trustees, supreme or grand (Fraternal Only) $ 0

20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.21 To directors or other officers $ 0
- 20.22 To stockholders not officers $ 0
- 20.23 Trustees, supreme or grand (Fraternal Only) $ 0

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [ ] No [X]

21.2 If yes, state the amount thereof at December 31 of the current year:
- 21.21 Rented from others $ 0
- 21.22 Borrowed from others $ 0
- 21.23 Leased from others $ 0
- 21.24 Other $ 0

22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [ ] No [X]

22.2 If answer is yes:
- 22.21 Amount paid as losses or risk adjustment $ 0
- 22.22 Amount paid as expenses $ 0
- 22.23 Other amounts paid $ 0

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No [ ]

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ 0

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03) Yes [X] No [ ]

24.02 If no, give full and complete information relating thereto

24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)
We are not currently investing in the securities lending program as of 12/31/2018.

24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes [ ] No [ ] N/A [X]

24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. $ 0

24.06 If answer to 24.04 is no, report amount of collateral for other programs. $ 0

24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [ ] No [ ] N/A [X]

24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [ ] No [ ] N/A [X]

24.09 Does the reporting entity or the reporting entity 's securities lending agent utilize the Master Securities lending Agreement (MSLA) to conduct securities lending? Yes [ ] No [ ] N/A [X]

GENERAL INTERROGATORIES

24.10 For the reporting entity's security lending program state the amount of the following as December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. $ 0
24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 $ 0
24.103 Total payable for securities lending reported on the liability page. $ 0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes [X] No [ ]

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21 Subject to repurchase agreements $ 0
25.22 Subject to reverse repurchase agreements $ 0
25.23 Subject to dollar repurchase agreements $ 0
25.24 Subject to reverse dollar repurchase agreements $ 0
25.25 Placed under option agreements $ 0
25.26 Letter stock or securities restricted as to sale - excluding FHLB Capital Stock $ 0
25.27 FHLB Capital Stock $ 0
25.28 On deposit with states $ 1,224,310
25.29 On deposit with other regulatory bodies $ 0
25.30 Pledged as collateral - excluding collateral pledged to an FHLB $ 0
25.31 Pledged as collateral to FHLB - including assets backing funding agreements $ 0
25.32 Other $ 0

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [ ] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ] N/A [X]
If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [ ] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year. $ 0

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No [ ]

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
State Street Bank and Trust Company	State Street Financial Center; One Lincoln Street; Boston, MA 02111-2900

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [ ] No [X]
28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

GENERAL INTERROGATORIES

28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
Kevin J. Casey as Sr. Investment Officer	A

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets? Yes [ ] No [X]

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's assets? Yes [ ] No [X]

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
N/A	Kevin J. Casey	N/A	Not registered	NO

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)])? Yes [ ] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 - Total		0

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	442,356,085	445,041,305	2,685,220
30.2 Preferred stocks	0	0	0
30.3 Totals	442,356,085	445,041,305	2,685,220

30.4 Describe the sources or methods utilized in determining the fair values:

Fair value of long term bonds and preferred stocks are determined based on quoted market prices when available, fair values using valuation methodologies based on available and observable market information, or by using matrix pricing. If quoted market prices are not available, we determine fair value using broker quoted or an internal analysis of each investment's financial performance and cash flow projections. Short-term investments are carried at amortized cost which approximated fair value. The carrying value of cash equivalents approximated fair value.

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [X] No [ ]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [X] No [ ]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No [ ]

32.2 If no, list exceptions:

GENERAL INTERROGATORIES

33. By self-designating 5GI securities, the reporting entity is certifying the following elements of each self-designated 5GI security:
    a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
    b. Issuer or obligor is current on all contracted interest and principal payments.
    c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

    Has the reporting entity self-designated 5GI securities? ..... Yes [ ] No [X]

34. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
    a. The security was purchased prior to January 1, 2018.
    b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
    c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as a NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.
    d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.

    Has the reporting entity self-designated PLGI securities? ..... Yes [ ] No [X]

OTHER

35.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any? ..... $ 0

35.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid

36.1 Amount of payments for legal expenses, if any? ..... $ 0

36.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid

37.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any? ..... $ 0

37.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [ ] No [X]

1.2 If yes, indicate premium earned on U.S. business only. $ 0

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? $ 0

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above $ 0

1.5 Indicate total incurred claims on all Medicare Supplement Insurance. $ 0

1.6 Individual policies:

Most current three years:

1.61 Total premium earned $ 0

1.62 Total incurred claims $ 0

1.63 Number of covered lives 0

All years prior to most current three years:

1.64 Total premium earned $ 0

1.65 Total incurred claims $ 0

1.66 Number of covered lives 0

1.7 Group policies:

Most current three years:

1.71 Total premium earned $ 0

1.72 Total incurred claims $ 0

1.73 Number of covered lives 0

All years prior to most current three years:

1.74 Total premium earned $ 0

1.75 Total incurred claims $ 0

1.76 Number of covered lives 0

2. Health Test:

		1 Current Year	2 Prior Year
2.1	Premium Numerator	1,121,827,068	1,092,625,603
2.2	Premium Denominator	1,121,827,068	1,092,625,603
2.3	Premium Ratio (2.1/2.2)	1.000	1.000
2.4	Reserve Numerator	128,446,230	159,230,610
2.5	Reserve Denominator	128,446,230	159,230,610
2.6	Reserve Ratio (2.4/2.5)	1.000	1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [ ] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [X] No [ ]

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [ ] No [ ]

5.1 Does the reporting entity have stop-loss reinsurance? Yes [ ] No [X]

5.2 If no, explain:

'The Company is of sufficient size to absord any large losses and thus does not require reinsurance to protect against the occasional large claim.

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical $ 0

5.32 Medical Only $ 0

5.33 Medicare Supplement $ 0

5.34 Dental & Vision $ 0

5.35 Other Limited Benefit Plan $ 0

5.36 Other $ 0

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:

Provider contracts contain hold harmless and continuity of coverage provisions.

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes [X] No [ ]

7.2 If no, give details

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year 28,667

8.2 Number of providers at end of reporting year 30,303

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [ ] No [X]

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months $ 0

9.22 Business with rate guarantees over 36 months $ 0

GENERAL INTERROGATORIES

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [X] No [ ]

10.2 If yes:

10.21 Maximum amount payable bonuses $ 1,187,135
10.22 Amount actually paid for year bonuses $ 643,972
10.23 Maximum amount payable withholds $ 0
10.24 Amount actually paid for year withholds $ 0

11.1 Is the reporting entity organized as:

11.12 A Medical Group/Staff Model, Yes [ ] No [X]
11.13 An Individual Practice Association (IPA), or, Yes [ ] No [X]
11.14 A Mixed Model (combination of above)? Yes [X] No [ ]

11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes [X] No [ ]
11.3 If yes, show the name of the state requiring such minimum capital and surplus. Kentucky
11.4 If yes, show the amount required. $ 37,303,198
11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [ ] No [X]
11.6 If the amount is calculated, show the calculation
See Notes to Financial Statement - Note 21, Other Items, C., Other Disclosures.

12. List service areas in which reporting entity is licensed to operate:

1 Name of Service Area
License covers the entire State of Kentucky.

13.1 Do you act as a custodian for health savings accounts? Yes [ ] No [X]

13.2 If yes, please provide the amount of custodial funds held as of the reporting date. $ 0

13.3 Do you act as an administrator for health savings accounts? Yes [ ] No [X]

13.4 If yes, please provide the balance of funds administered as of the reporting date. $ 0

14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes [ ] No [ ] N/A [X]
14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded):

15.1 Direct Premium Written $ 0
15.2 Total Incurred Claims $ 0
15.3 Number of Covered Lives 0

*Ordinary Life Insurance Includes
Term(whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary gurarantee)
Universal Life (with or without secondary gurarantee)
Variable Universal Life (with or without secondary gurarantee)

16. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? Yes [ ] No [X]

16.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? Yes [ ] No [X]

FIVE-YEAR HISTORICAL DATA

		1 2018	2 2017	3 2016	4 2015	5 2014
	Balance Sheet (Pages 2 and 3)					
1.	Total admitted assets (Page 2, Line 28)	496,012,938	526,789,148	563,482,728	3,255,676	0
2.	Total liabilities (Page 3, Line 24)	169,514,739	264,866,801	350,039,806	1,986	0
3.	Statutory minimum capital and surplus requirement	37,303,198	37,303,198	0	9,229	0
4.	Total capital and surplus (Page 3, Line 33)	326,498,199	261,922,347	213,442,922	3,253,690	0
	Income Statement (Page 4)					
5.	Total revenues (Line 8)	1,121,827,068	1,124,523,679	1,111,904,880	0	0
6.	Total medical and hospital expenses (Line 18)	930,957,761	960,572,502	832,409,105	0	0
7.	Claims adjustment expenses (Line 20)	28,085,901	28,389,145	26,982,208	0	0
8.	Total administrative expenses (Line 21)	93,657,324	69,029,357	73,586,635	(2,757)	0
9.	Net underwriting gain (loss) (Line 24)	69,126,082	66,532,675	178,926,932	2,757	0
10.	Net investment gain (loss) (Line 27)	12,744,353	14,656,949	10,015,661	2,919	0
11.	Total other income (Lines 28 plus 29)	(4,224,851)	(4,535,812)	0	0	0
12.	Net income or (loss) (Line 32)	59,141,277	55,741,558	122,238,734	3,690	0
	Cash Flow (Page 6)					
13.	Net cash from operations (Line 11)	11,530,197	10,600,563	367,021,599	(839)	0
	Risk-Based Capital Analysis					
14.	Total adjusted capital	326,498,199	261,922,347	213,442,922	3,253,690	0
15.	Authorized control level risk-based capital	35,261,081	37,303,198	37,062,657	9,229	0
	Enrollment (Exhibit 1)					
16.	Total members at end of period (Column 5, Line 7)	224,908	243,019	273,198	0	0
17.	Total members months (Column 6, Line 7)	2,773,717	3,018,365	3,017,701	0	0
	Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18.	Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19.	Total hospital and medical plus other non-health (Lines 18 plus Line 19)	83.0	85.4	74.9	0.0	0.0
20.	Cost containment expenses	2.4	2.3	2.2	0.0	0.0
21.	Other claims adjustment expenses	0.1	0.2	0.2	0.0	0.0
22.	Total underwriting deductions (Line 23)	93.8	94.1	83.9	0.0	0.0
23.	Total underwriting gain (loss) (Line 24)	6.2	5.9	16.1	0.0	0.0
	Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24.	Total claims incurred for prior years (Line 13, Col. 5)	90,877,195	188,856,105	60,132,720	0	0
25.	Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]	132,141,923	193,759,352	0	0	0
	Investments In Parent, Subsidiaries and Affiliates					
26.	Affiliated bonds (Sch. D Summary, Line 12, Col. 1)	0	0	0	0	0
27.	Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)	0	0	0	0	0
28.	Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)	0	0	0	0	0
29.	Affiliated short-term investments (subtotal included in Schedule DA Verification, Col. 5, Line 10)	0	0	0	0	0
30.	Affiliated mortgage loans on real estate	0	0	0	0	0
31.	All other affiliated	0	0	0	0	0
32.	Total of above Lines 26 to 31	0	0	0	0	0
33.	Total investment in parent included in Lines 26 to 31 above.	0	0	0	0	0

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes [ ] No [ ]

If no, please explain:

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION Aetna Better Health of Kentucky Insurance Company 2. Louisville, KY (LOCATION)

NAIC Group Code 0001 BUSINESS IN THE STATE OF Kentucky DURING THE YEAR 2018 NAIC Company Code 15761

	1	Comprehensive (Hospital & Medical) 2	3	4	5	6	7	8	9	10
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	243,019	20,142	0	0	0	0	0	0	222,877	0
2. First Quarter	236,325	19,852	0	0	0	0	0	0	216,473	0
3. Second Quarter	230,822	19,709	0	0	0	0	0	0	211,113	0
4. Third Quarter	231,881	8,490	0	0	0	0	0	0	223,391	0
5. Current Year	224,908	11,289	0	0	0	0	0	0	213,619	0
6. Current Year Member Months	2,773,717	169,452	0	0	0	0	0	0	2,604,265	0
Total Member Ambulatory Encounters for Year:										
7 Physician	1,659,127	88,164	0	0	0	0	0	0	1,570,963	0
8. Non-Physician	943,152	32,018	0	0	0	0	0	0	911,134	0
9. Total	2,602,279	120,182	0	0	0	0	0	0	2,482,097	0
10. Hospital Patient Days Incurred	77,337	786	0	0	0	0	0	0	76,551	0
11. Number of Inpatient Admissions	17,033	182	0	0	0	0	0	0	16,851	0
12. Health Premiums Written (b)	1,121,827,068	30,661,427	0	0	0	0	0	0	1,091,165,641	0
13. Life Premiums Direct	0	0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0	0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	1,121,827,068	30,614,823	0	0	0	0	0	0	1,091,212,245	0
16. Property/Casualty Premiums Earned	0	0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	950,102,214	29,840,314	0	0	0	0	0	0	920,261,900	0
18 Amount Incurred for Provision of Health Care Services	930,957,761	27,658,324	0	0	0	0	0	0	903,299,437	0

(a) For health business: number of persons insured under PPO managed care products 0 and number of persons insured under indemnity only products 0 .
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ 0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION Aetna Better Health of Kentucky Insurance Company 2. Louisville, KY (LOCATION)

NAIC Group Code 0001 BUSINESS IN THE STATE OF Grand Total DURING THE YEAR 2018 NAIC Company Code 15761

	1	Comprehensive (Hospital & Medical) 2	3	4	5	6	7	8	9	10
	Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	243,019	20,142	0	0	0	0	0	0	222,877	0
2. First Quarter	236,325	19,852	0	0	0	0	0	0	216,473	0
3. Second Quarter	230,822	19,709	0	0	0	0	0	0	211,113	0
4. Third Quarter	231,881	8,490	0	0	0	0	0	0	223,391	0
5. Current Year	224,908	11,289	0	0	0	0	0	0	213,619	0
6. Current Year Member Months	2,773,717	169,452	0	0	0	0	0	0	2,604,265	0
Total Member Ambulatory Encounters for Year:										
7 Physician	1,659,127	88,164	0	0	0	0	0	0	1,570,963	0
8. Non-Physician	943,152	32,018	0	0	0	0	0	0	911,134	0
9. Total	2,602,279	120,182	0	0	0	0	0	0	2,482,097	0
10. Hospital Patient Days Incurred	77,337	786	0	0	0	0	0	0	76,551	0
11. Number of Inpatient Admissions	17,033	182	0	0	0	0	0	0	16,851	0
12. Health Premiums Written (b)	1,121,827,068	30,661,427	0	0	0	0	0	0	1,091,165,641	0
13. Life Premiums Direct	0	0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0	0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	1,121,827,068	30,614,823	0	0	0	0	0	0	1,091,212,245	0
16. Property/Casualty Premiums Earned	0	0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	950,102,214	29,840,314	0	0	0	0	0	0	920,261,900	0
18 Amount Incurred for Provision of Health Care Services	930,957,761	27,658,324	0	0	0	0	0	0	903,299,437	0

(a) For health business: number of persons insured under PPO managed care products 0 and number of persons insured under indemnity only products 0 .
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ 0

Schedule S - Part 1 - Section 2

N O N E

Schedule S - Part 2

N O N E

Schedule S - Part 3 - Section 2

N O N E

Schedule S - Part 4

N O N E

Schedule S - Part 4 - Bank Footnote

N O N E

Schedule S - Part 5

N O N E

Schedule S - Part 5 - Bank Footnote

N O N E

Schedule S - Part 6

N O N E

SCHEDULE S - PART 7

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

		1 As Reported (net of ceded)	2 Restatement Adjustments	3 Restated (gross of ceded)
	ASSETS (Page 2, Col. 3)			
1.	Cash and invested assets (Line 12)	474,395,635	0	474,395,635
2.	Accident and health premiums due and unpaid (Line 15)	1,931,674	0	1,931,674
3.	Amounts recoverable from reinsurers (Line 16.1)	0	0	0
4.	Net credit for ceded reinsurance	XXX	0	0
5.	All other admitted assets (Balance)	19,685,629	0	19,685,629
6.	Total assets (Line 28)	496,012,938	0	496,012,938
	LIABILITIES, CAPITAL AND SURPLUS (Page 3)			
7.	Claims unpaid (Line 1)	127,259,095	0	127,259,095
8.	Accrued medical incentive pool and bonus payments (Line 2)	1,187,135	0	1,187,135
9.	Premiums received in advance (Line 8)	574,560	0	574,560
10.	Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19 first inset amount plus second inset amount)	0	0	0
11.	Reinsurance in unauthorized companies (Line 20 minus inset amount)	0	0	0
12.	Reinsurance with Certified Reinsurers (Line 20 inset amount)	0	0	0
13.	Funds held under reinsurance treaties with Certified Reinsurers (Line 19 third inset amount)	0	0	0
14.	All other liabilities (Balance)	40,493,949	0	40,493,949
15.	Total liabilities (Line 24)	169,514,739	0	169,514,739
16.	Total capital and surplus (Line 33)	326,498,199	XXX	326,498,199
17.	Total liabilities, capital and surplus (Line 34)	496,012,938	0	496,012,938
	NET CREDIT FOR CEDED REINSURANCE			
18.	Claims unpaid	0		
19.	Accrued medical incentive pool	0		
20.	Premiums received in advance	0		
21.	Reinsurance recoverable on paid losses	0		
22.	Other ceded reinsurance recoverables	0		
23.	Total ceded reinsurance recoverables	0		
24.	Premiums receivable	0		
25.	Funds held under reinsurance treaties with authorized and unauthorized reinsurers	0		
26.	Unauthorized reinsurance	0		
27.	Reinsurance with Certified Reinsurers	0		
28.	Funds held under reinsurance treaties with Certified Reinsurers	0		
29.	Other ceded reinsurance payables/offsets	0		
30.	Total ceded reinsurance payables/offsets	0		
31.	Total net credit for ceded reinsurance	0		

SCHEDULE T PREMIUMS AND OTHER CONSIDERATIONS

Allocated by States and Territories

		1	Direct Business Only							
			2	3	4	5	6	7	8	9
States, etc.		Active Status (a)	Accident & Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Plan Premiums	Life & Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama	AL	N	0	0	0	0	0	0	0	0
2. Alaska	AK	N	0	0	0	0	0	0	0	0
3. Arizona	AZ	N	0	0	0	0	0	0	0	0
4. Arkansas	AR	N	0	0	0	0	0	0	0	0
5. California	CA	N	0	0	0	0	0	0	0	0
6. Colorado	CO	N	0	0	0	0	0	0	0	0
7. Connecticut	CT	N	0	0	0	0	0	0	0	0
8. Delaware	DE	N	0	0	0	0	0	0	0	0
9. District of Columbia	DC	N	0	0	0	0	0	0	0	0
10. Florida	FL	N	0	0	0	0	0	0	0	0
11. Georgia	GA	N	0	0	0	0	0	0	0	0
12. Hawaii	HI	N	0	0	0	0	0	0	0	0
13. Idaho	ID	N	0	0	0	0	0	0	0	0
14. Illinois	IL	N	0	0	0	0	0	0	0	0
15. Indiana	IN	N	0	0	0	0	0	0	0	0
16. Iowa	IA	N	0	0	0	0	0	0	0	0
17. Kansas	KS	N	0	0	0	0	0	0	0	0
18. Kentucky	KY	L	30,661,427	0	1,091,165,641	0	0	0	1,121,827,068	0
19. Louisiana	LA	N	0	0	0	0	0	0	0	0
20. Maine	ME	N	0	0	0	0	0	0	0	0
21. Maryland	MD	N	0	0	0	0	0	0	0	0
22. Massachusetts	MA	N	0	0	0	0	0	0	0	0
23. Michigan	MI	N	0	0	0	0	0	0	0	0
24. Minnesota	MN	N	0	0	0	0	0	0	0	0
25. Mississippi	MS	N	0	0	0	0	0	0	0	0
26. Missouri	MO	N	0	0	0	0	0	0	0	0
27. Montana	MT	N	0	0	0	0	0	0	0	0
28. Nebraska	NE	N	0	0	0	0	0	0	0	0
29. Nevada	NV	N	0	0	0	0	0	0	0	0
30. New Hampshire	NH	N	0	0	0	0	0	0	0	0
31. New Jersey	NJ	N	0	0	0	0	0	0	0	0
32. New Mexico	NM	N	0	0	0	0	0	0	0	0
33. New York	NY	N	0	0	0	0	0	0	0	0
34. North Carolina	NC	N	0	0	0	0	0	0	0	0
35. North Dakota	ND	N	0	0	0	0	0	0	0	0
36. Ohio	OH	N	0	0	0	0	0	0	0	0
37. Oklahoma	OK	N	0	0	0	0	0	0	0	0
38. Oregon	OR	N	0	0	0	0	0	0	0	0
39. Pennsylvania	PA	N	0	0	0	0	0	0	0	0
40. Rhode Island	RI	N	0	0	0	0	0	0	0	0
41. South Carolina	SC	N	0	0	0	0	0	0	0	0
42. South Dakota	SD	N	0	0	0	0	0	0	0	0
43. Tennessee	TN	N	0	0	0	0	0	0	0	0
44. Texas	TX	N	0	0	0	0	0	0	0	0
45. Utah	UT	N	0	0	0	0	0	0	0	0
46. Vermont	VT	N	0	0	0	0	0	0	0	0
47. Virginia	VA	N	0	0	0	0	0	0	0	0
48. Washington	WA	N	0	0	0	0	0	0	0	0
49. West Virginia	WV	N	0	0	0	0	0	0	0	0
50. Wisconsin	WI	N	0	0	0	0	0	0	0	0
51. Wyoming	WY	N	0	0	0	0	0	0	0	0
52. American Samoa	AS	N	0	0	0	0	0	0	0	0
53. Guam	GU	N	0	0	0	0	0	0	0	0
54. Puerto Rico	PR	N	0	0	0	0	0	0	0	0
55. U.S. Virgin Islands	VI	N	0	0	0	0	0	0	0	0
56. Northern Mariana Islands	MP	N	0	0	0	0	0	0	0	0
57. Canada	CAN	N	0	0	0	0	0	0	0	0
58. Aggregate other alien	OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal		XXX	30,661,427	0	1,091,165,641	0	0	0	1,121,827,068	0
60. Reporting entity contributions for Employee Benefit Plans		XXX	0	0	0	0	0	0	0	0
61. Total (Direct Business)		XXX	30,661,427	0	1,091,165,641	0	0	0	1,121,827,068	0
DETAILS OF WRITE-INS										
58001.		XXX								
58002.		XXX								
58003.		XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page		XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)		XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed insurance carrier or domiciled RRG 1
R - Registered - Non-domiciled RRGs 0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
Q - Qualified - Qualified or accredited reinsurer. 0
N - None of the above - Not allowed to write business in the state 56

(b) Explanation of basis of allocation by states, premiums by state, etc.
Premiums are allocated based on the state of residence of covered members.

SCHEDULE T - PART 2

INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

Allocated by States and Territories

States, Etc.		Direct Business Only					
		1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts	6 Totals
1. Alabama	AL	0	0	0	0	0	0
2. Alaska	AK	0	0	0	0	0	0
3. Arizona	AZ	0	0	0	0	0	0
4. Arkansas	AR	0	0	0	0	0	0
5. California	CA	0	0	0	0	0	0
6. Colorado	CO	0	0	0	0	0	0
7. Connecticut	CT	0	0	0	0	0	0
8. Delaware	DE	0	0	0	0	0	0
9. District of Columbia	DC	0	0	0	0	0	0
10. Florida	FL	0	0	0	0	0	0
11. Georgia	GA	0	0	0	0	0	0
12. Hawaii	HI	0	0	0	0	0	0
13. Idaho	ID	0	0	0	0	0	0
14. Illinois	IL	0	0	0	0	0	0
15. Indiana	IN	0	0	0	0	0	0
16. Iowa	IA	0	0	0	0	0	0
17. Kansas	KS	0	0	0	0	0	0
18. Kentucky	KY	0	0	0	0	0	0
19. Louisiana	LA	0	0	0	0	0	0
20. Maine	ME	0	0	0	0	0	0
21. Maryland	MD	0	0	0	0	0	0
22. Massachusetts	MA	0	0	0	0	0	0
23. Michigan	MI	0	0	0	0	0	0
24. Minnesota	MN	0	0	0	0	0	0
25. Mississippi	MS	0	0	0	0	0	0
26. Missouri	MO	0	0	0	0	0	0
27. Montana	MT	0	0	0	0	0	0
28. Nebraska	NE	0	0	0	0	0	0
29. Nevada	NV	0	0	0	0	0	0
30. New Hampshire	NH	0	0	0	0	0	0
31. New Jersey	NJ	0	0	0	0	0	0
32. New Mexico	NM	0	0	0	0	0	0
33. New York	NY	0	0	0	0	0	0
34. North Carolina	NC	0	0	0	0	0	0
35. North Dakota	ND	0	0	0	0	0	0
36. Ohio	OH	0	0	0	0	0	0
37. Oklahoma	OK	0	0	0	0	0	0
38. Oregon	OR	0	0	0	0	0	0
39. Pennsylvania	PA	0	0	0	0	0	0
40. Rhode Island	RI	0	0	0	0	0	0
41. South Carolina	SC	0	0	0	0	0	0
42. South Dakota	SD	0	0	0	0	0	0
43. Tennessee	TN	0	0	0	0	0	0
44. Texas	TX	0	0	0	0	0	0
45. Utah	UT	0	0	0	0	0	0
46. Vermont	VT	0	0	0	0	0	0
47. Virginia	VA	0	0	0	0	0	0
48. Washington	WA	0	0	0	0	0	0
49. West Virginia	WV	0	0	0	0	0	0
50. Wisconsin	WI	0	0	0	0	0	0
51. Wyoming	WY	0	0	0	0	0	0
52. American Samoa	AS	0	0	0	0	0	0
53. Guam	GU	0	0	0	0	0	0
54. Puerto Rico	PR	0	0	0	0	0	0
55. U.S. Virgin Islands	VI	0	0	0	0	0	0
56. Northern Mariana Islands	MP	0	0	0	0	0	0
57. Canada	CAN	0	0	0	0	0	0
58. Aggregate Other Alien	OT	0	0	0	0	0	0
59. Total		0	0	0	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

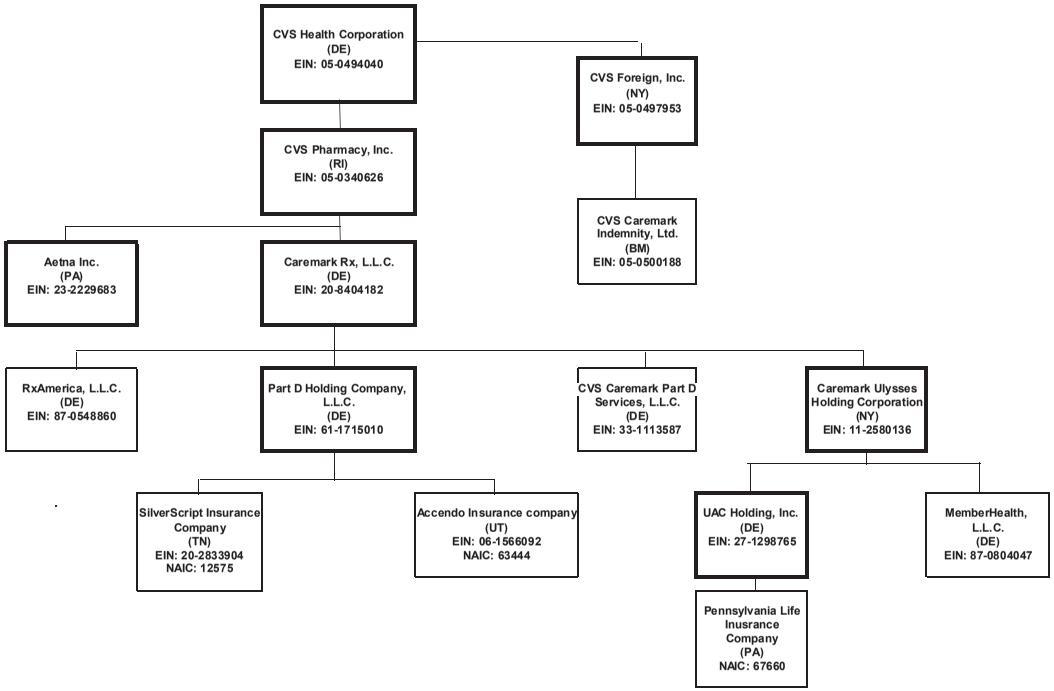

This organizational chart reflects the insurance entity reporting system and identifies the relationship between the ultimate parent and all member insurers.
The ultimate controlling company is a Fortune 7 company with numerous subsidiaries, the majority of which do not interact with the insurance entities.
(1) Insurers/HMO's
Percentages are rounded to the nearest whole percent and based on ownership of voting rights.
Double borders indicate entity has subsidiaries shown on the same page.
Bold borders indicate entity has subsidiaries shown on a separate page.

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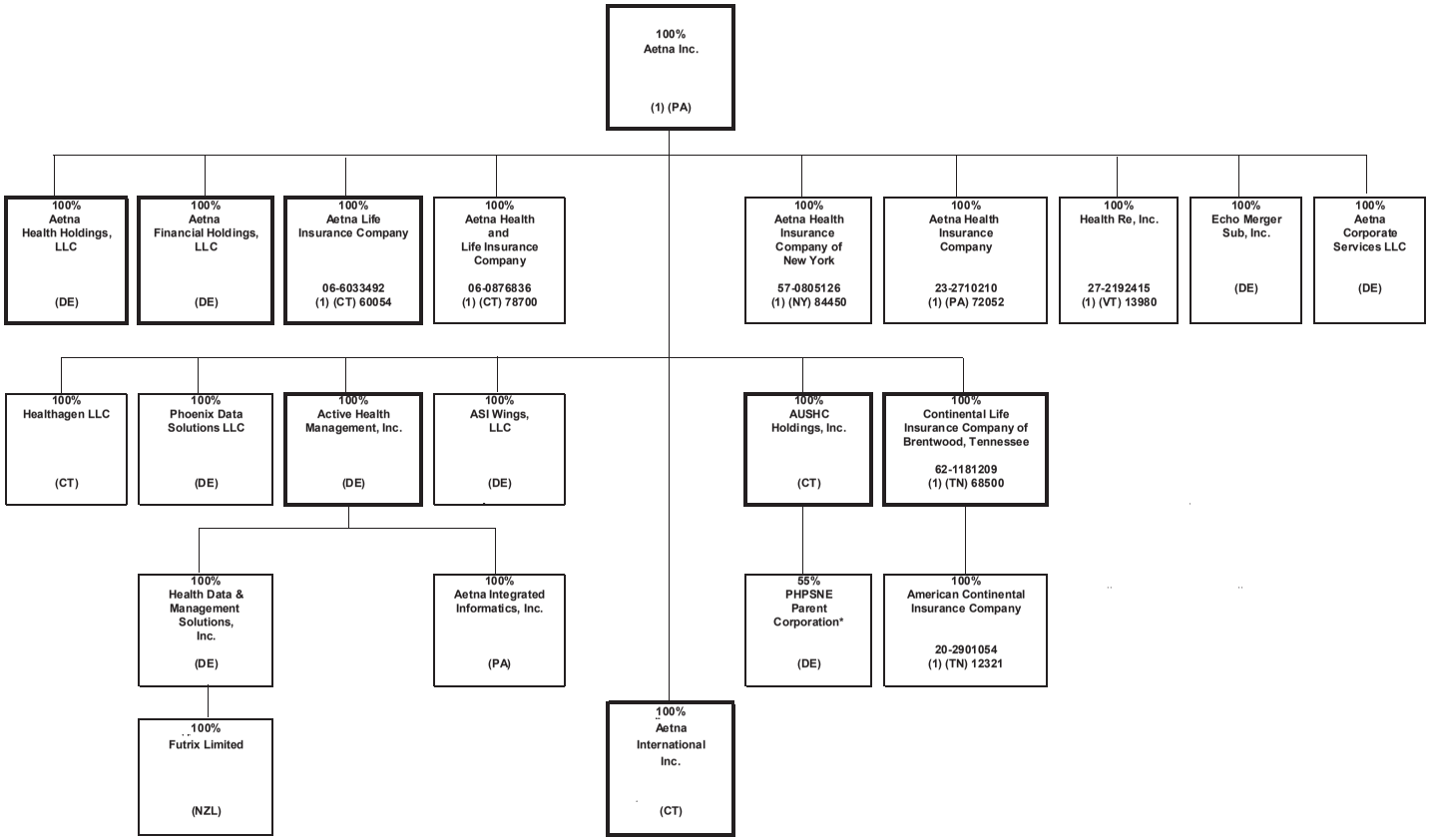

* PHPSNE Parent Corporation is also 45% owned by third parties.

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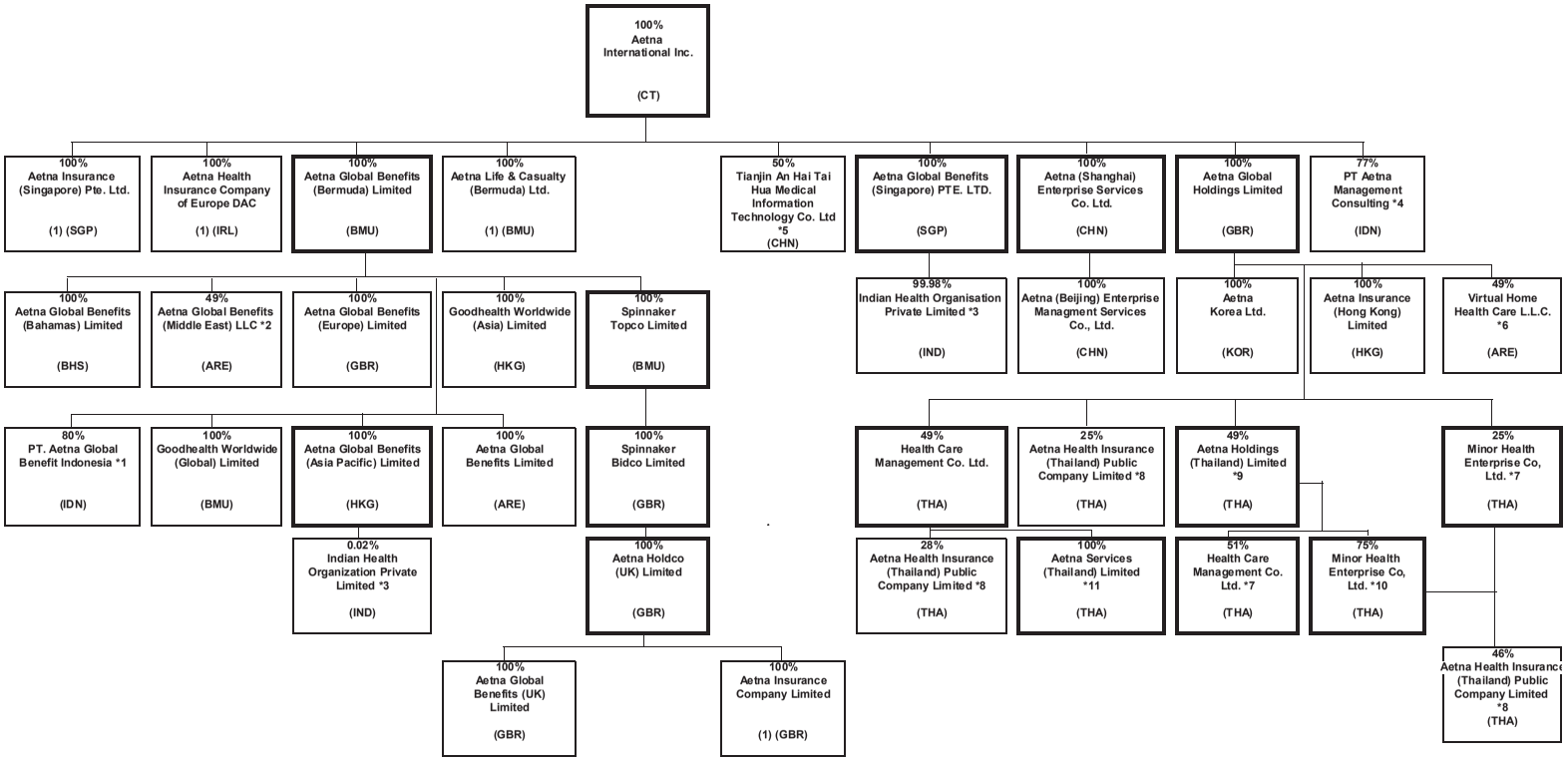

*1 PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
*2 Aetna Global Benefits (Middle East) LLC is also 51% is owned by Euro Gulf LLC, Aetna's Nominee.
*3 Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
*4 PT Asuransi Aetna Asia is also 23% owned by PT Asuransi Central Asia.
*5 Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd
*6 Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC, Aetna's Nominee
*7 Health Care Management Co. Ltd. Is also owned by Aetna Global Benefits (Bermuda) Limited (1 share).
*8 Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 Share), Mr. Jitphasong Itsaraphakded (1 Share); Mrs. Suphee Wattana (1 Share); and Mr. Buncha Tamphragom (1 Share)
*9 Aetna Holdings (Thailand) Limited is aslo 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Benefits (Bermuda) Limited owns 1 share.
*10 Minor Health Entreprise Co, Ltd is is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited
*11 Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited and (1 share) owned by Aetna Global Holdings Limited

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

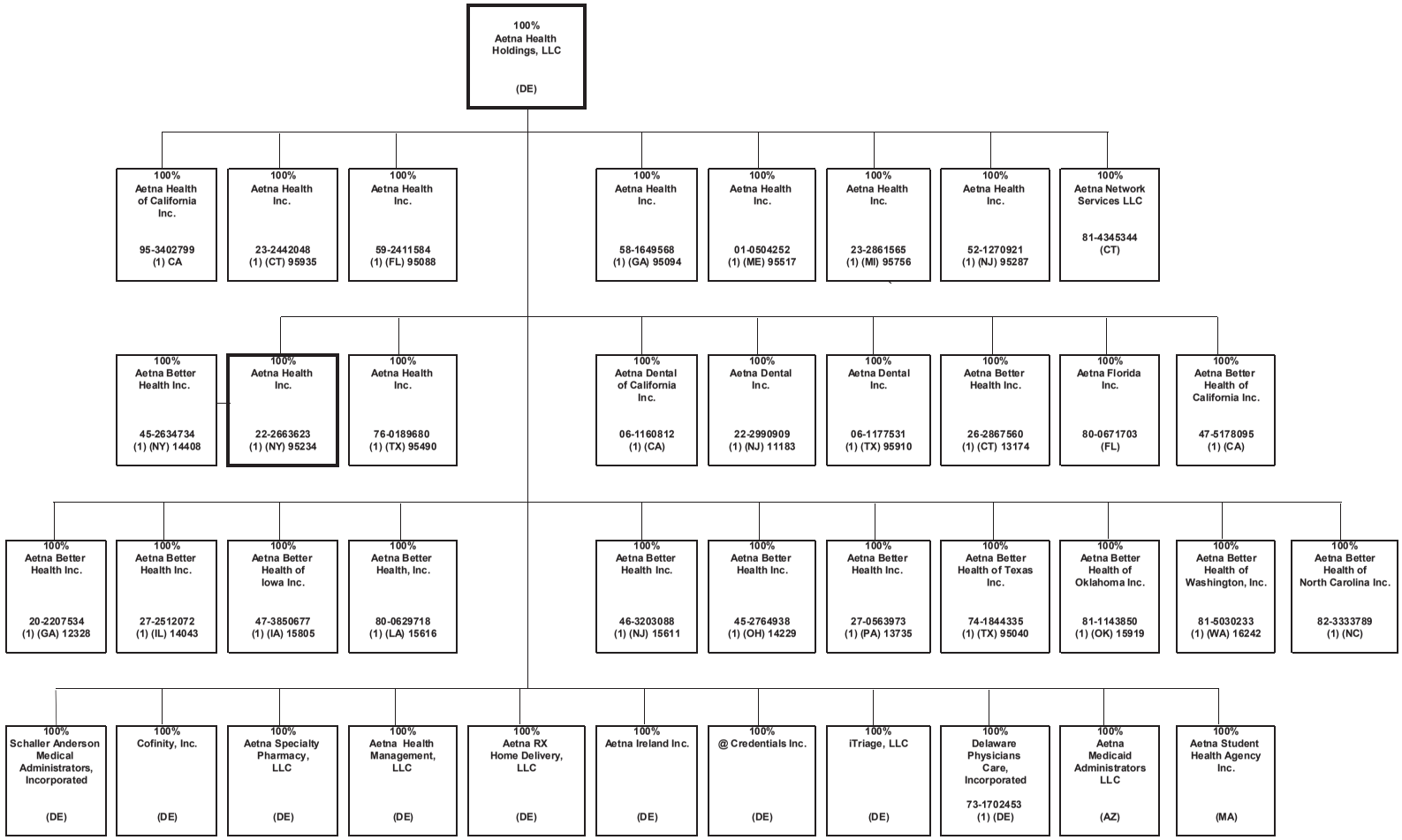

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

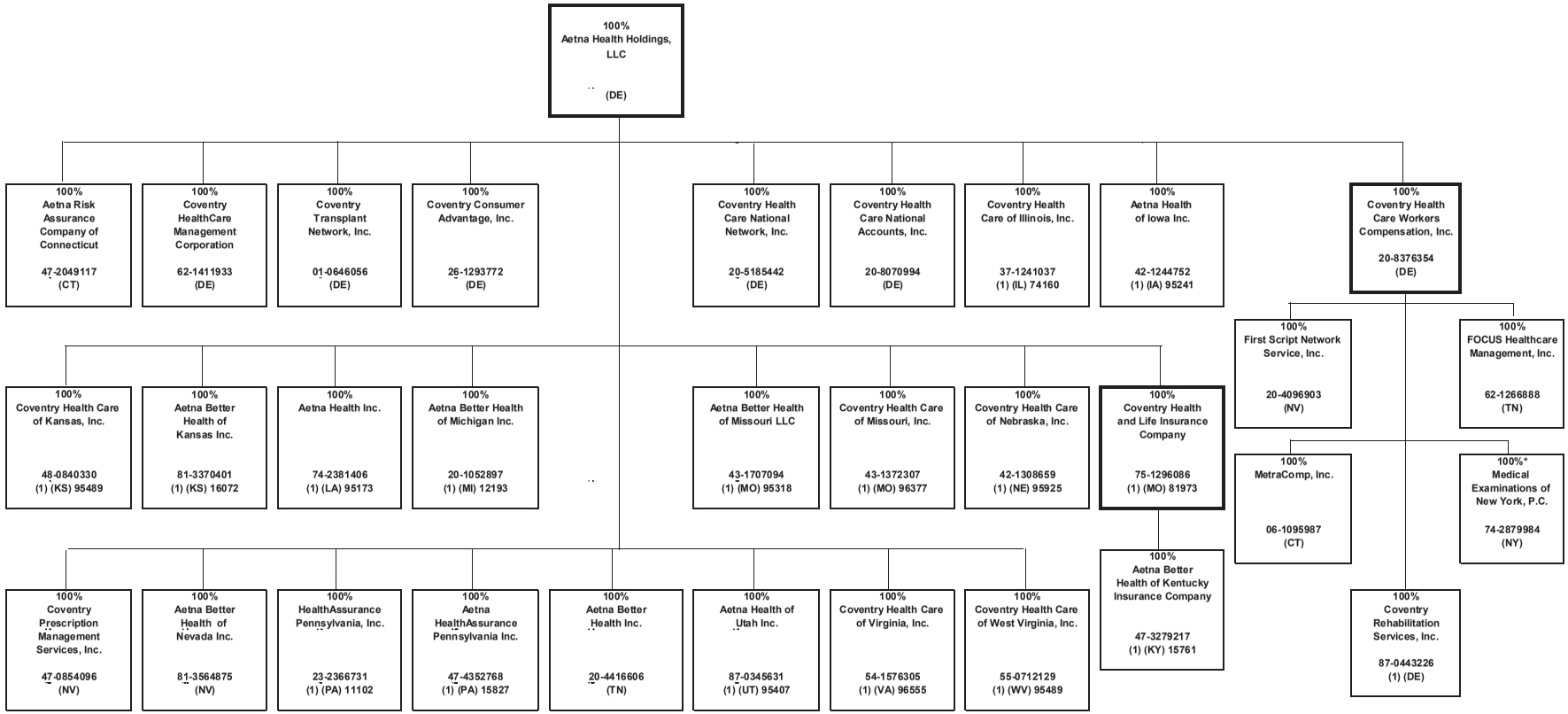

*100% owned through Aetna's nominees

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

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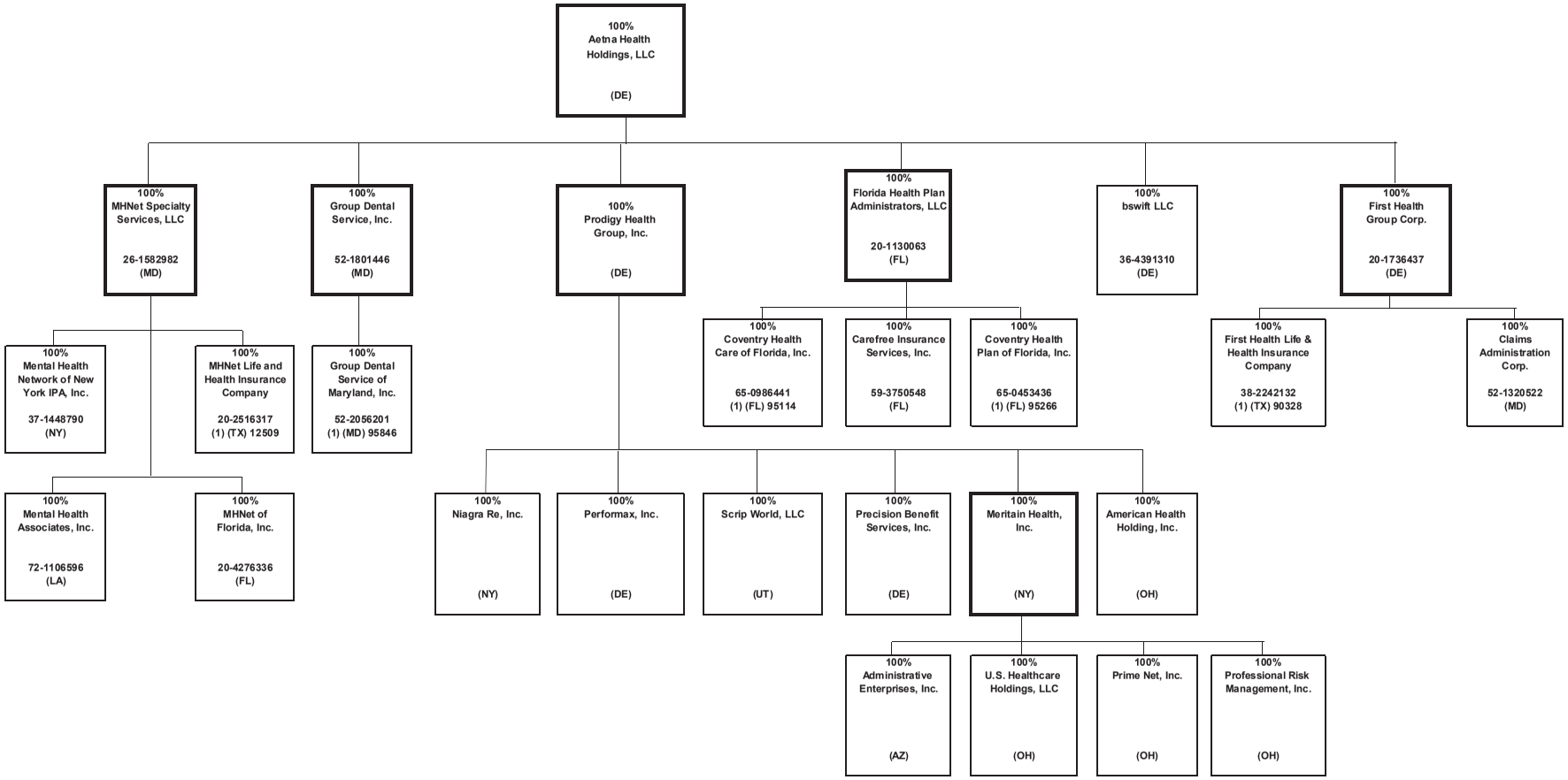

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

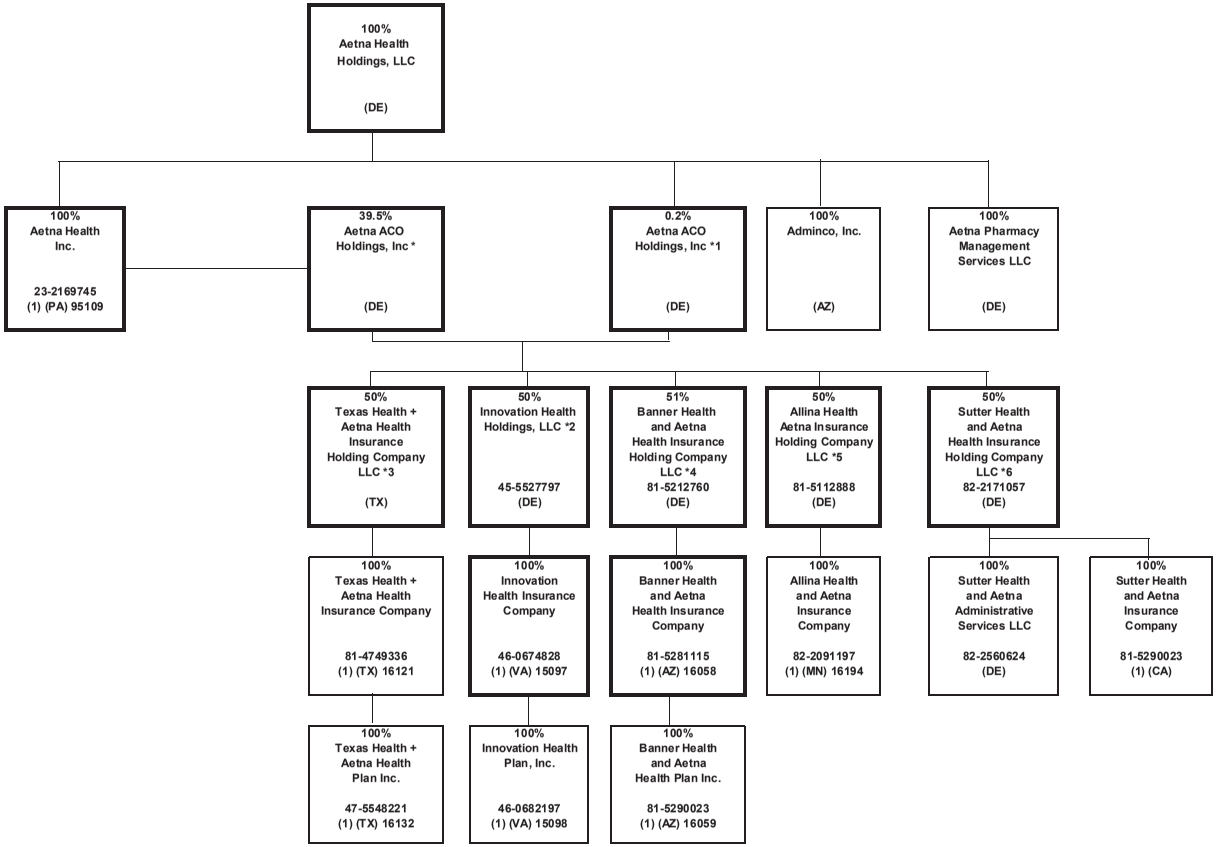

*1 Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
*2 Innovation Health Holdings, LLC is also 50% owned by Inova Health System Foundation.
*3 Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
*4 Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
*5 Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
*6 Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

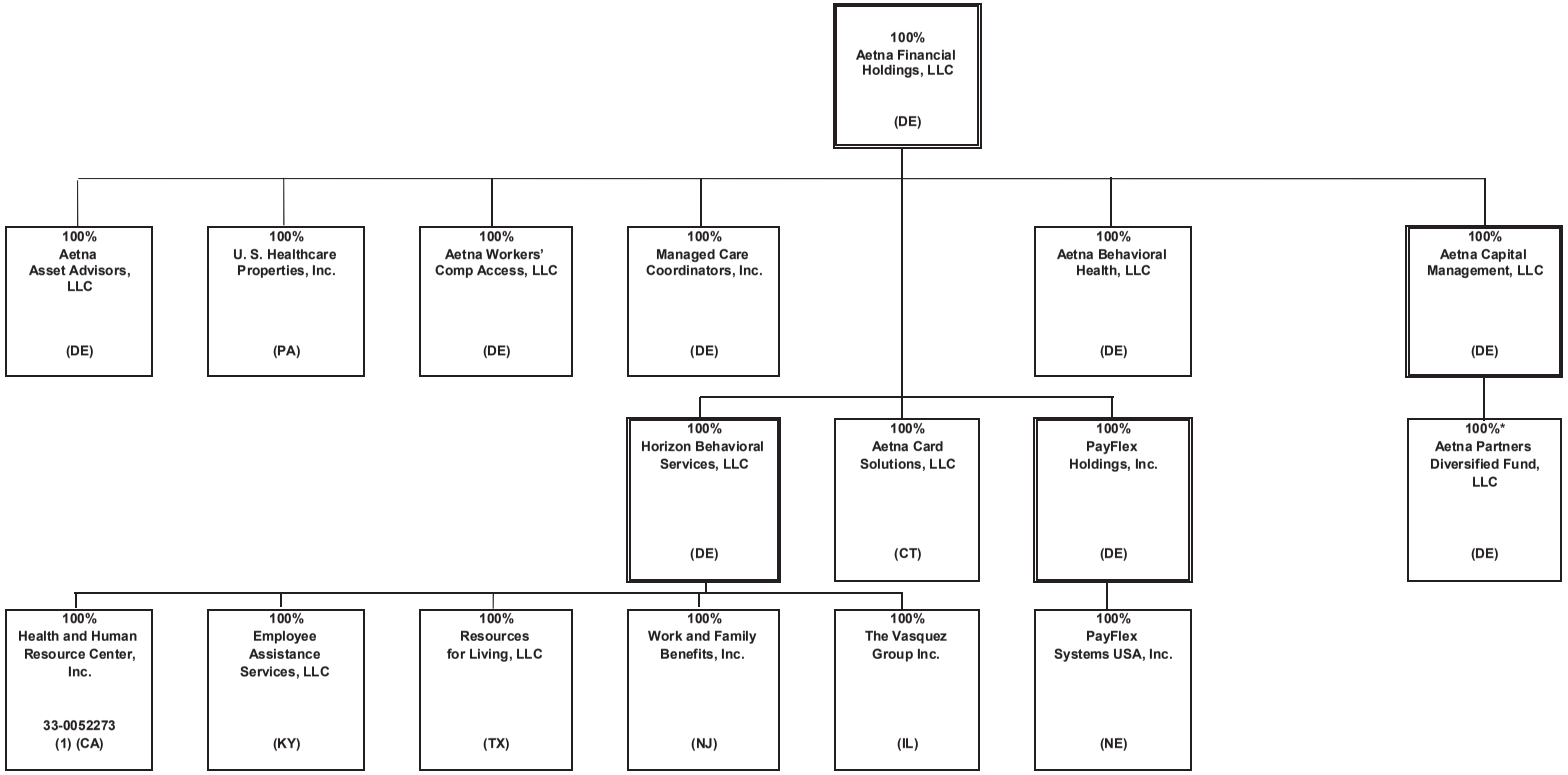

* Aetna Life Insurance Company owns substantially all of the non-managing member interests of Aetna Partners Diversified Fund, LLC.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

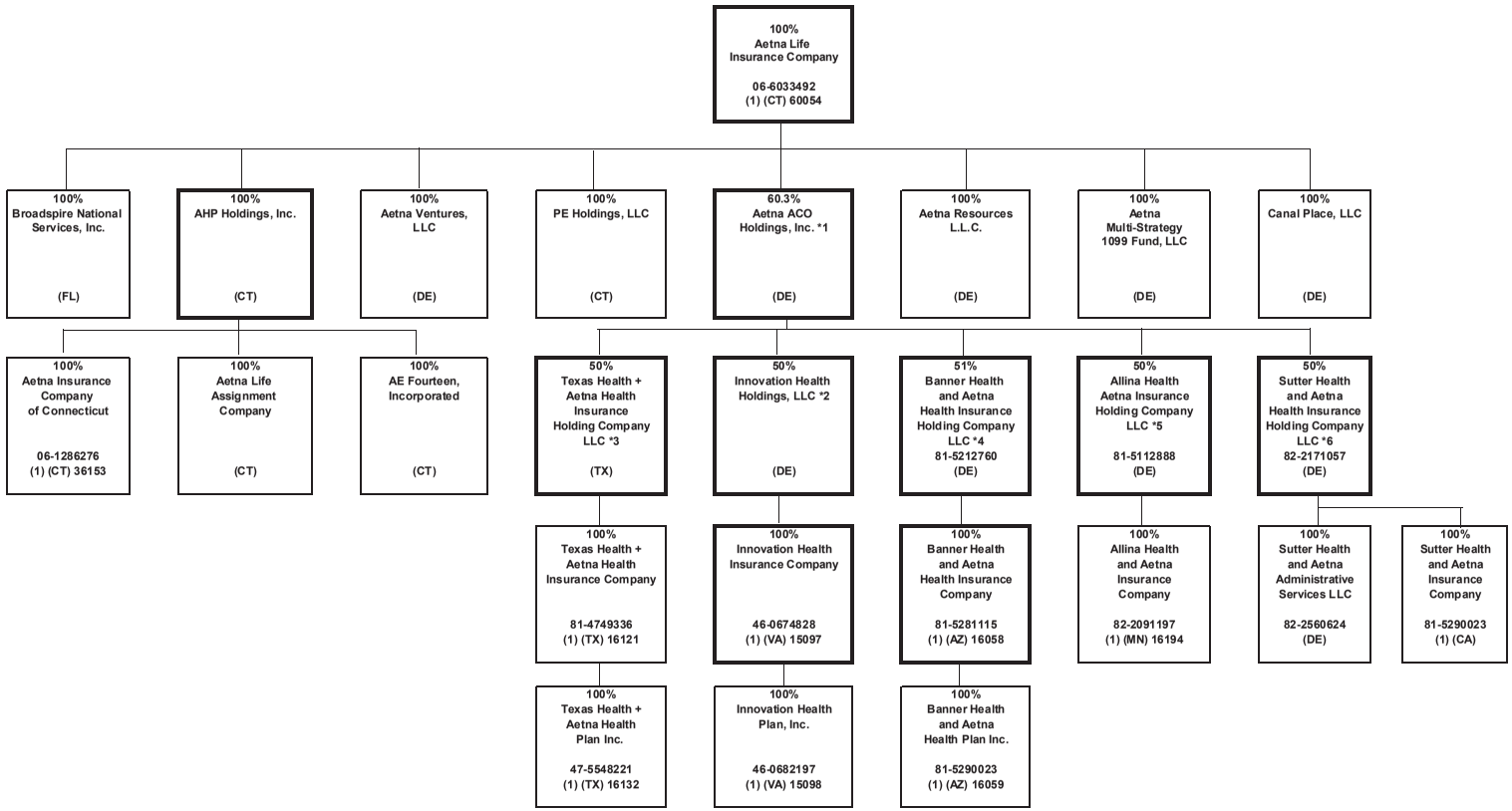

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ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP		05-0494040		0000064803	NYSE	CVS Health Corporation	DE	UIP	Board of Directors	Board of Directors	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	63444	06-1566092				Accendo Insurance Company	UT	IA	Part D Holding Company, L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12575	20-2833904				SilverScript Insurance Company	TN	IA	Part D Holding Company, L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	67660	23-1305366				Pennsylvania Life Insurance Co.	PA	IA	UAC Holding, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0340626				CVS Pharmacy, Inc	RI	UIP	CVS Health Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8404182				Caremark, Rx., L.L.C.	DE	NIA	CVS Pharmacy, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	61-1715010				Part D Holding Company, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	33-1113587				CVS Caremark Part D Services, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0548860				RxAmerica, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	11-2580136				Caremark Ulysses Holding Corporation	NY	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0804047				MemberHealth L.L.C.	DE	NIA	Caremark Ulysses Holding Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0500188				CVS Caremark Indemnity, Ltd.	BMU	IA	CVS Foreign, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1298765				UAC Holding, Inc	DE	NIA	Caremark Ulysses Holding Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0497953				CVS Foreign, Inc.	NY	NIA	CVS Health Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2229683	3060706	0001122304		Aetna Inc.	PA	UIP	CVS Pharmacy, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	30-0123754	0	0		Aetna Health Holdings, LLC	DE	UIP	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	95-3402799	0	0		Aetna Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95935	23-2442048	0	0		Aetna Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95088	59-2411584	0	0		Aetna Health Inc.	FL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95094	58-1649568	0	0		Aetna Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95517	01-0504252	0	0		Aetna Health Inc.	ME	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95756	23-2861565	0	0		Aetna Health Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95287	52-1270921	0	0		Aetna Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95234	22-2663623	0	0		Aetna Health Inc.	NY	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14408	45-2634734	0	0		Aetna Better Health Inc.	NY	IA	Aetna Health Inc. (NY)	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95490	76-0189680	0	0		Aetna Health Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95040	74-1844335	0	0		Aetna Better Health of Texas Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12328	20-2207534	0	0		Aetna Better Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1160812	0	0		Aetna Dental of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	11183	22-2990909	0	0		Aetna Dental Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95910	06-1177531	0	0		Aetna Dental Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	30-0123760	0	0		Aetna Rx Home Delivery, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	13-3670795	0	0		Aetna Health Management, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	22-3187443	0	0		Aetna Ireland Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	57-1209768	0	0		Aetna Specialty Pharmacy, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1274723	0	0		Cofinity, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2671370	0	0		@Credentials Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Services (Thailand) Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	100.000	CVS Health Corporation	N	20
0001	CVS HEALTH GROUP	13735	27-0563973	0	0		Aetna Better Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	13174	26-2867560	0	0		Aetna Better Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-5178095	0	0		Aetna Better Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14043	27-2512072	0	0		Aetna Better Health Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15805	47-3850677	0	0		Aetna Better Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15616	80-0629718	0	0		Aetna Better Health, Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	80-0671703	0	0		Aetna Florida Inc.	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14229	25-2764938	0	0		Aetna Better Health Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15611	46-3203088	0	0		Aetna Better Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15919	81-1143850	0	0		Aetna Better Health of Oklahoma Inc.	OK	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	04-2708160	0	0		Aetna Student Health Agency Inc.	MA	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	73-1702453	0	0		Delaware Physicians Care, Incorporated	DE	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	01-0826783	0	0		Schaller Anderson Medical Administrators, Incorporated	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0842559	0	0		Aetna Medicaid Adminstrators LLC	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-2944270	0	0		iTriage, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP	00000	16-1471176	0	0		Prodigy Health Group, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	0.200	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	45-5527797	0	0		Innovation Health Holdings, LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	6
0001	CVS HEALTH GROUP	15097	46-0674828	0	0		Innovation Health Insurance Company	VA	IA	Innovation Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15098	46-0682197	0	0		Innovation Health Plan, Inc.	VA	IA	Innovation Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-3789357	0	0		Texas Health + Aetna Health Insurance Holding Company LLC	TX	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	9
0001	CVS HEALTH GROUP	16121	81-4749336	0	0		Texas Health + Aetna Health Insurance Company	TX	IA	Texas Health + Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16132	47-5548221	0	0		Texas Health + Aetna Health Plan Inc.	TX	IA	Texas Health + Aetna Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95109	23-2169745	0	0		Aetna Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Inc. (PA)	Ownership	39.500	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	20-0438576	0	0		Niagara Re, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-2200070	0	0		Performax, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0632355	0	0		Scrip World, LLC	UT	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1760756	0	0		Precision Benefit Services, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	31-1368946	0	0		American Health Holding, Inc.	OH	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	16-1264154	0	0		Meritain Health, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0537707	0	0		Adminco, Inc.	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0527428	0	0		Administrative Enterprises, Inc.	AZ	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	16-1684061	0	0		U.S. Healthcare Holdings, LLC	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	34-1670299	0	0		Prime Net, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	34-1348032	0	0		Professional Risk Management, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	68500	62-1181209	0	0		Continental Life Insurance Company of Brentwood, Tennessee	TN	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12321	20-2901054	0	0		American Continental Insurance Company	TN	IA	Continental Life Insurance Company of Brentwood, Tennessee	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	60054	06-6033492	0	0		Aetna Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Life Insurance Company	Ownership	60.300	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	06-1270755	0	0		AHP Holdings, Inc.	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	36153	06-1286276	0	0		Aetna Insurance Company of Connecticut	CT	IA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1028469	0	0		AE Fourteen, Incorporated	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1373153	0	0		Aetna Life Assignment Company	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-3678339	0	0		PE Holdings, LLC	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1423207	0	0		Aetna Resources L.L.C.	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Canal Place, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-3180700	0	0		Aetna Ventures, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-2108747	0	0		Broadspire National Services, Inc.	FL	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0001552250		Aetna Multi-Strategy 1099 Fund, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	79.250	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	41-2035961	0	0		Aetna Financial Holdings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	26-2030792	0	0		Aetna Asset Advisors, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2354500	0	0		U.S. Healthcare Properties, Inc.	PA	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	38-3704481	0	0		Aetna Capital Management, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	11-3667142	0	0001314522		Aetna Partners Diversified Fund, LLC	DE	NIA	Aetna Capital Management, LLC	Ownership	100.000	CVS Health Corporation	N	1
0001	CVS HEALTH GROUP	00000	20-0446676	0	0		Aetna Workers' Comp Access, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-0446713	0	0		Aetna Behavioral Health, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2670015	0	0		Managed Care Coordinators, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-3269144	0	0		Horizon Behavioral Services, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	61-1193498	0	0		Employee Assistance Services, LLC	KY	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	33-0052273	0	0		Health and Human Resource Center, Inc.	CA	IA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	75-2420973	0	0		Resources for Living, LLC	TX	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	36-3681261	0	0		The Vasquez Group Inc.	IL	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	22-3178125	0	0		Work and Family Benefits, Inc.	NJ	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

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0001	CVS HEALTH GROUP	00000	27-1773021	0	0		Aetna Card Solutions, LLC	CT	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-5216478	0	0		PayFlex Holdings, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	91-1774434	0	0		PayFlex Systems USA, Inc.	NE	NIA	PayFlex Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	78700	06-0876836	0	0		Aetna Health and Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	72052	23-2710210	0	0		Aetna Health Insurance Company	PA	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	84450	57-0805126	0	0		Aetna Health Insurance Company of New York	NY	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1571642	0	0		Aetna International Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	98-0211470	0	0		Aetna Life & Casualty (Bermuda) Ltd.	BMU	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance (Singapore) PTE. LTD.	SGP	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Bermuda) Limited	BMU	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Goodhealth Worldwide (Global) Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Europe) Limited	GBR	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Goodhealth Worldwide (Asia) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits Limited	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		PT. Aetna Global Benefits Indonesia	IDN	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	80.000	CVS Health Corporation	N	4
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Middle East) LLC	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	49.000	CVS Health Corporation	N	5
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Asia Pacific) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Spinnaker Topco Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Spinnaker Bidco Limited	GBR	NIA	Spinnaker Topco Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Holdco (UK) Limited	GBR	NIA	Spinnaker Bidco Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		PT Aetna Management Consulting	IDN	NIA	Aetna International Inc.	Ownership	77.000	CVS Health Corporation	N	13
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (UK) Limited	GBR	NIA	Aetna Holdco (UK) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance Company Limited	GBR	IA	Aetna Holdco (UK) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Asia Pacific) Limited	Ownership	0.020	CVS Health Corporation	N	2
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance Company of Europe DAC	IRL	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna (Shanghai) Enterprise Services Co. Ltd.	CHN	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna (Beijing) Enterprise Management Services Co., Ltd.	CHN	NIA	Aetna (Shanghai) Enterprise Services Co. Ltd.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Singapore) PTE. LTD.	SGP	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Singapore) PTE, LTD.	Ownership	99.980	CVS Health Corporation	N	2
0001	CVS HEALTH GROUP	00000	22-2578985	0	0		AUSHC Holdings, Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Holdings Limited	GBR	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Korea Ltd.	KOR	NIA	Aetna Global Holdings Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance (Hong Kong) Limited	HKG	NIA	Aetna Global Holdings Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Futrix Limited	NZL	NIA	Health Data & Management Solutions, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1182176	0	0		PHPSNE Parent Corporation	DE	NIA	AUSHC Holdings, Inc.	Ownership	55.000	CVS Health Corporation	N	7
0001	CVS HEALTH GROUP	00000	52-2182411	0	0		Active Health Management, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-0970432	0	0		Health Data & Management Solutions, Inc.	DE	NIA	Active Health Management, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2604867	0	0		Aetna Integrated Informatics, Inc.	PA	NIA	Active Health Management, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	13980	27-2192415	0	0		Health Re, Inc.	VT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-0579372	0	0		Phoenix Data Solutions LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	46-2469464	0	0		Healthagen LLC	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	51-0029326	0	0		ASI Wings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Echo Merger Sub, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Corporate Services, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	81973	75-1296086	0	0		Coventry Health and Life Insurance Company	MO	UDP	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15761	47-3279217	0	0		Aetna Better Health of Kentucky Insurance Company	KY	RE	Coventry Health and Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-1801446	0	0		Group Dental Service, Inc.	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

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0001	CVS HEALTH GROUP	95846	52-2056201	0	0		Group Dental Service of Maryland, Inc.	MD	IA	Group Dental Service, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP		81-4345344	0	0		Aetna Network Services LLC	CT	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95241	42-1244752	0	0		Aetna Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95925	42-1308659	0	0		Coventry Health Care of Nebraska, Inc.	NE	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-2049117	0	0		Aetna Risk Assurance Company of Connecticut Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95173	74-2381406	0	0		Aetna Health Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	11102	23-2366731	0	0		HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-0854096	0	0		Coventry Prescription Management Services, Inc.	NV	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16148	81-3564875	0	0		Aetna Better Health of Nevada Inc.	NV	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	96555	54-1576305	0	0		Coventry Health Care of Virginia, Inc.	VA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	01-0646056	0	0		Coventry Transplant Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	96377	43-1372307	0	0		Coventry Health Care of Missouri, Inc.	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95318	43-1702094	0	0		Aetna Better Health of Missouri LLC	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95408	55-0712129	0	0		Coventry Health Care of West Virginia, Inc.	WV	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	62-1411933	0	0		Coventry HealthCare Management Corporation	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15827	47-4352768	0	0		Aetna HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95489	48-0840330	0	0		Coventry Health Care of Kansas, Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16072	81-3370401	0	0		Aetna Better Health of Kansas Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12193	20-1052897	0	0		Aetna Better Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95407	87-0345631	0	0		Aetna Health of Utah Inc.	UT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4416606	0	0		Aetna Better Health Inc.	TN	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	74160	37-1241037	0	0		Coventry Health Care of Illinois, Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8070994	0	0		Coventry Health Care National Accounts, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-5185442	0	0		Coventry Health Care National Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	26-1293772	0	0		Coventry Consumer Advantage, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8376354	0	0		Coventry Health Care Workers Compensation, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4096903	0	0		First Script Network Service, Inc.	NV	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1095987	0	0		MetraComp, Inc.	CT	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	74-2879984	0	0		Medical Examinations of New York, P.C.	NY	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	8
0001	CVS HEALTH GROUP	00000	62-1266888	0	0		FOCUS Healthcare Management, Inc.	TN	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0443226	0	0		Coventry Rehabilitation Services, Inc.	DE	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1736437	0	0		First Health Group Corp.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	90328	38-2242132	0	0		First Health Life & Health Insurance Company	TX	IA	First Health Group Corp.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-1320522	0	0		Claims Administration Corp.	MD	NIA	First Health Group Corp.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1130063	0	0		Florida Health Plan Administrators, LLC	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95114	65-0986441	0	0		Coventry Health Care of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95266	65-0453436	0	0		Coventry Health Plan of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-3750548	0	0		Carefree Insurance Services, Inc.	FL	NIA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	36-4391310	0	0		bswift LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Virtual Home Healthcare L.L.C.	ARE	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	17
0001	CVS HEALTH GROUP	00000	26-1582982	0	0		MHNet Specialty Services, LLC	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	37-1448790	0	0		Mental Health Network of New York IPA, Inc.	NY	NIA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12509	20-2516317	0	0		MHNet Life and Health Insurance Company	TX	IA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	72-1106596	0	0		Mental Health Associates, Inc.	LA	NIA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP	00000	20-4276336	0	0		MHNet of Florida, Inc.	FL	IA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16242	81-5030233	0	0		Aetna Better Health of Washington, Inc.	WA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5212760	0	0		Banner Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	51.000	CVS Health Corporation	N	10
0001	CVS HEALTH GROUP	16058	81-5281115	0	0		Banner Health and Aetna Health Insurance Company	AZ	IA	Banner Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16059	81-5290023	0	0		Banner Health and Aetna Health Plan Inc.	AZ	IA	Banner Health and Aetna Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5112888	0	0		Allina Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	11
0001	CVS HEALTH GROUP	16194	82-2091197	0	0		Allina Health and Aetna Insurance Company	MN	IA	Allina Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	82-2171057	0	0		Sutter Health and Aetna Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	12
0001	CVS HEALTH GROUP	00000	82-2560624	0	0		Sutter Health and Aetna Administrative Services LLC	DE	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5290023	0	0		Sutter Health and Aetna Insurance Company	CA	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Holdings (Thailand) Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	14
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Minor Health Entreprise Co, Ltd.	Ownership	46.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	28.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	19
0001	CVS HEALTH GROUP	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	CVS Health Corporation	N	16
0001	CVS HEALTH GROUP	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	75.000	CVS Health Corporation	N	16
0001	CVS HEALTH GROUP	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	51.000	CVS Health Corporation	N	19
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Bahamas) Limited	BHS	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Pharmacy Management Services LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	82-3333789	0	0		Aetna Better Health of North Carolina Inc.	NC	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd	CHN	NIA	Aetna International Inc.	Ownership	50.000	CVS Health Corporation	N	18

Asterisk	Explanation
1	Aetna Life Insurance Company own substantially all of the non-managing membership interests of Aetna Partners Diversified Fund LLC.
2	Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
3	Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
4	PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
5	Aetna Global Benefits (Middle East) LLC is also 51% owned by Euro Gulf LLC, Aetna's Nominee.
6	Innovation Health Holdings LLC. Is also 50% owned by Inova Health System Foundation.
7	PHPSNE Parent Corporation is 55% owned by AUSHC Holdings, Inc. The remaining 45% is owned by thirteen different hospitals (non-affiliates) which are shareholders with varying degrees of ownership.
8	Medical Examinations of New York, P.C. is 100% owned through Aetna's nominees.
9	Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
10	Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
11	Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
12	Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.
13	PT Aetna Management Consulting is also 23% owned by PT Asuransi Central Asia.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

Asterisk	Explanation
14	Aetna Holdings (Thailand) Limited is also 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Global Benefits (Bermuda) Limited owns 1 share
15	Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 share), Mr. Jitphasong Itsaraphakded (1 share); Mrs. Suphee Wattana (1 share); and Mr. Buncha Tamphragom (1 share)
16	Minor Health Enterprise Co, Ltd is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
17	Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC, Aetna's Nominee.
18	Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd.
19	Health Care Management Co. Ltd. Is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
20	Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited and (1 share) owned by Aetna Global Holdings Limited.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	52-2182411	Active Health Management, Inc.	0	0	0	0	111,455,768	0		0	111,455,768	0
		Aetna Behavioral Health, LLC	0	0	0	0	(80,609)	0		0	(80,609)	0
12328	20-2207534	Aetna Better Health Inc. (GA)	0	0	0	0	(11,090)	0		0	(11,090)	0
13174	26-2867560	Aetna Better Health, Inc. (a Connecticut Corporation)	0	0	0	0	(14,625)	0		0	(14,625)	0
13735	27-0563973	Aetna Better Health, Inc (PA)	(62,900,000)	0	0	0	(126,740,039)	0		0	(189,640,039)	0
	95-3402799	Aetna Better Health of California Inc.	0	2,000,000	0	0	(1,777,496)	0		0	222,504	0
15805	47-3850677	Aetna Better Health of Iowa Inc.	0	800,000	0	0	(4,145)	0		0	795,855	0
16072	81-3370401	Aetna Better Health of Kansas Inc	0	0	0	0	(6,975)	0		0	(6,975)	0
15761	47-3279217	Aetna Better Health of Kentucky Insurance Company	0	0	0	0	(110,043,104)	0		0	(110,043,104)	0
12193	20-1052897	Aetna Better Health of Michigan Inc.	(4,100,000)	0	0	0	(40,677,898)	0		0	(44,777,898)	0
95318	43-1702094	Aetna Better Health of Missouri LLC	(80,000,000)	0	0	0	(119,098)	0		0	(80,119,098)	0
16148	81-3564875	Aetna Better Health of Nevada	(2,769,052)	0	0	0	(60,982)	0		0	(2,830,034)	0
15919	81-1143850	Aetna Better Health of Oklahoma Inc	0	0	0	0	(7,141)	0		0	(7,141)	0
95040	74-1844335	Aetna Better Health of Texas Inc.	(19,000,000)	0	0	0	(38,757,421)	0		0	(57,757,421)	0
16242	81-5030233	Aetna Better Health of Washington Inc.	0	0	0	0	0	0		0	0	0
	80-0671703	Aetna Better Health Inc. (FL)	0	0	0	0	(76,708)	0		0	(76,708)	0
15616	80-0629718	Aetna Better Health, Inc. (a Louisiana corporation)	(8,700,000)	0	0	0	(57,120,809)	0		0	(65,820,809)	0
14043	27-2512072	Aetna Better Health Inc. (IL)	(175,000,000)	0	0	0	(51,036,767)	0		0	(226,036,767)	0
15611	46-3203088	Aetna Better Health, Inc (NJ)	0	0	0	0	(38,793,671)	0		0	(38,793,671)	0
14408	45-2634734	Aetna Better Health Inc. (a New York corporation)	0	0	0	0	(37,173,730)	0		0	(37,173,730)	0
14229	45-2764938	Aetna Better Health Inc. (an Ohio corporation)	(46,347,242)	0	0	0	(109,138,060)	0		0	(155,485,302)	0
		Aetna Better Health, Inc. (TN)	0	0	0	0	(11,365)	0		0	(11,365)	0
11183	22-2990909	Aetna Dental Inc. (NJ)	0	0	0	0	(1,673,309)	0		0	(1,673,309)	0
95910	06-1177531	Aetna Dental Inc. (TX)	(4,000,000)	0	0	0	(5,320,415)	(47,384)		0	(9,367,799)	0
	06-1160812	Aetna Dental of California Inc.	(3,000,000)	0	0	0	(1,045,947)	0		0	(4,045,947)	0
78700	06-0876836	Aetna Health and Life Insurance Company	(192,752,633)	0	(1,552,598)	0	(17,887,546)	0		0	(212,192,777)	0
	30-0123754	Aetna Health Holdings, LLC	1,220,316,294	(63,600,000)	0	0	0	0		0	1,156,716,294	0
95935	23-2442048	Aetna Health Inc. (CT)	0	0	0	0	(13,570,969)	0		0	(13,570,969)	0
95088	59-2411584	Aetna Health Inc. (FL)	0	0	0	0	(168,303,629)	0		0	(168,303,629)	0
95094	58-1649568	Aetna Health Inc - Georgia	(45,000,000)	0	0	0	(31,367,450)	0		0	(76,367,450)	0
95241	42-1244752	Aetna Health Inc. (Iowa)	0	0	0	0	(6,734,728)	0		0	(6,734,728)	0
95517	01-0504252	Aetna Health Inc. (ME)	0	0	0	0	(7,891,254)	0		0	(7,891,254)	0
95756	23-2861565	Aetna Health Inc. (MI)	0	800,000	0	0	(1,488)	0		0	798,512	0
95287	52-1270921	Aetna Health Inc. (NJ)	(18,000,000)	0	0	0	(84,306,818)	0		0	(102,306,818)	0
95234	22-2663623	Aetna Health Inc. (NY)	0	0	0	0	(10,003)	0		0	(10,003)	0
95234	22-2663623	Aetna Health Inc. - NY State	0	0	0	0	(11,667,109)	0		0	(11,667,109)	0
95109	23-2169745	Aetna Health Inc. (PA)	(129,300,000)	0	0	0	(387,861,675)	(2,586,716)		0	(519,748,391)	16,198,431
95490	76-0189680	Aetna Health Inc. (TX)	(6,700,000)	20,000,000	0	0	(38,286,857)	0		0	(24,986,857)	0
95173	74-2381406	Aetna Health Inc. (LA)	0	0	0	0	(10,214,233)	0		0	(10,214,233)	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
95109	23-2169745	Aetna Health Insurance Company (PA)	0	0	0	0	(650,382)	219,366		0	(431,016)	0
84450	57-0805126	Aetna Health Insurance Company of New York	0	0	0	0	(47,260)	0		0	(47,260)	0
	13-3670795	Aetna Health Management, LLC	0	0	0	0	(1,323,719,269)	0		0	(1,323,719,269)	0
	95-3402799	Aetna Health of California Inc.	(41,000,000)	0	0	0	(131,425,571)	0		0	(172,425,571)	0
15827	47-4352768	Aetna HealthAssurance Pennsylvania Inc.	0	0	0	0	(37,033,943)	0		0	(37,033,943)	0
	23-2229683	Aetna Inc.	1,572,000,000	(52,000,000)	0	0	580,130,227	0		0	2,100,130,227	0
		Aetna Insurance (Singapore) Pte, Ltd	0	0	0	0	(10,247)	0		0	(10,247)	0
36153	06-1286276	Aetna Insurance Company of Connecticut	0	0	0	0	(66,862)	0		0	(66,862)	0
		Aetna International, Inc.	0	0	0	0	(950,786)	0		0	(950,786)	0
		Aetna Life & Casualty (Bermuda) Ltd	0	0	0	0	(4,009,836)	0		0	(4,009,836)	0
60054	06-6033492	Aetna Life Insurance Company	(1,063,392,013)	2,063,626	(18,995,467)	0	(1,105,957,757)	(327,109,020)		0	(2,513,390,631)	1,406,936,745
	86-0842559	Aetna Medicaid Administrators, LLC	0	0	0	0	341,073,020	0		0	341,073,020	0
		AETNA MULTI STRATEGY FUND, LLC	(1,239,882)	0	199,214	0	0	0		0	(1,040,668)	0
		AETNA PARTNERS DIVERSIFIED FUND (CAYMAN), LIMITED	(231,646)	0	0	0	0	0		0	(231,646)	0
	81-0579372	Aetna Partners Diversified Fund, LLC	(42,384,070)	0	20,348,851	0	0	0		0	(22,035,219)	0
		Aetna Resources LLC	0	0	0	0	2,676,471,469	0		0	2,676,471,469	0
	30-0123760	Aetna RX Home Delivery, LLC	0	0	0	0	438,165,723	0		0	438,165,723	0
	20-3180700	Aetna Ventures, LLC	244	(2,063,626)	0	0	0	0		0	(2,063,382)	0
	57-1209768	Aetna Specialty Pharmacy, LLC	0	0	0	0	18,317,881	0		0	18,317,881	0
		Allina Health and Aetna Insurance Holding Company LLC	0	(13,500,000)	0	0	0	0		0	(13,500,000)	0
16194	82-2091197	Allina Health and Aetna Insurance Company	0	13,500,000	0	0	(65,070)	0		0	13,434,930	0
95407	87-0345631	Aetna Health of Utah, Inc.	(20,000,000)	0	0	0	(23,657,106)	0		0	(43,657,106)	0
12321	20-2901054	American Continental Insurance Company	0	10,000,000	0	0	(85,523,951)	0		0	(75,523,951)	0
		American Health Holding, Inc.	0	0	0	0	218,000	0		0	218,000	0
		Banner Health and Aetna Health Insurance Holding Company LLC	0	(13,250,000)	0	0	0	0		0	(13,250,000)	0
16059	81-5290023	Banner Health & Aetna Health Plan, Inc	0	1,500,000	0	0	(1,481,843)	0		0	18,157	(9,325,092)
16058	81-5281115	Banner Health & Aetna Health Insurance Co,	0	11,750,000	0	0	(30,865,381)	0		0	(19,115,381)	(43,001,856)
		bswift, LLC	0	0	0	0	(2,001,083)	0		0	(2,001,083)	0
74160	37-1241037	Coventry Health Care of Illinois, Inc.	(31,000,000)	0	0	0	(35,270,969)	0		0	(66,270,969)	0
96377	43-1372307	Coventry Health Care of Missouri, Inc.	(50,000,000)	0	0	0	(91,025,928)	0		0	(141,025,928)	0
81973	75-1296086	Coventry Health & Life Insurance Company	(250,000,000)	0	0	0	(181,709,853)	0		0	(431,709,853)	0
68500	62-1181209	Continental Life Insurance Company of Brentwood Tennessee	0	30,000,000	0	0	(110,070,752)	0		0	(80,070,752)	0
95114	65-0986441	Coventry Health Care of Florida, Inc.	(65,000,000)	75,000,000	0	0	(53,123,675)	0		0	(43,123,675)	0
95925	42-1308659	Coventry Health Care of Nebraska, Inc.	(75,000,000)	0	0	0	(1,986,281)	0		0	(76,986,281)	0
96555	54-1576305	Coventry Health Care of Virginia, Inc.	0	40,000,000	0	0	(82,050,800)	0		0	(42,050,800)	0
95408	55-0712129	Coventry Health Care of West Virginia, Inc.	0	0	0	0	(46,602,765)	0		0	(46,602,765)	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1 NAIC Company Code	2 ID Number	3 Names of Insurers and Parent, Subsidiaries or Affiliates	4 Shareholder Dividends	5 Capital Contributions	6 Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	7 Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	8 Management Agreements and Service Contracts	9 Income/ (Disbursements) Incurred Under Reinsurance Agreements	10 *	11 Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	12 Totals	13 Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
95266	65-0453436	Coventry Health Plan of Florida, Inc.	(5,000,000)	0	0	0	(13,287)	0		0	(5,013,287)	0
	62-1411933	Coventry HealthCare Management Corporation	0	0	0	0	0	0		0	0	0
95489	48-0840330	Coventry Health Care of Kansas, Inc.	(40,000,000)	0	0	0	(1,064,244)	0		0	(41,064,244)	0
	47-0854096	Coventry Prescription Mgmt Services, Inc	0	0	0	0	0	0		0	0	0
		First Health Group Corp	90,000,000	0	0	0	0	0		0	90,000,000	0
90328	38-2242132	First Health Life & Health Ins Co.	(90,000,000)	0	0	0	356,390,654	0		0	266,390,654	0
		Florida Health Plan Administrator, LLC	70,000,000	(75,000,000)	0	0	0	0		0	(5,000,000)	0
95846	52-2056201	Group Dental Services of Maryland, Inc.	0	0	0	0	(127,272)	0		0	(127,272)	0
	33-0052273	Health and Human Resources Center, Inc.	0	0	0	0	1,036,771	0		0	1,036,771	0
13980	27-2192415	Health Re, Inc.	(272,000,000)	12,000,000	0	0	(47,836,898)	327,109,020		0	19,272,122	(1,271,370,154)
		Healthagen LLC	0	0	0	0	2,350,000	0		0	2,350,000	0
11102	23-2366731	HealthAssurance Pennsylvania, Inc.	(108,500,000)	0	0	0	(80,129,052)	0		0	(188,629,052)	0
15097	46-0674828	Innovation Health Insurance Company	0	0	0	0	(23,013,325)	0		0	(23,013,325)	(20,855,797)
15098	46-0682197	Innovation Health Plan, Inc	0	0	0	0	(7,432,769)	2,414,734		0	(5,018,035)	(3,834,869)
	26-1582982	MHNet Specialty Services, LLC	0	0	0	0	31,943,316	0		0	31,943,316	0
		PayFlex Systems USA, Inc.	0	0	0	0	29,072,946	0		0	29,072,946	0
		Schaller Anderson of Arizona, L.L.C.	0	0	0	0	327,722,799	0		0	327,722,799	0
		Texas Health + Aetna Health Insurance Holding Company LLC	0	(25,000,000)	0	0	0	0		0	(25,000,000)	0
16132	47-5548221	Texas Health & Aetna Health Plan, Inc	0	7,870,000	0	0	(479,730)	0		0	7,390,270	(3,038,470)
16121	81-4749336	Texas Health & Aetna Health Insurance Co.	0	17,130,000	0	0	(7,149,465)	0		0	9,980,535	(71,708,938)
12575	20-2833904	SilverScript Insurance Co.	0	0	0	0	(451,883,033)	(25,520,020)		0	(477,403,053)	1,011,673
00000	33-1113587	CVS Caremark Part D Services, LLC	0	0	0	0	451,883,034	0		0	451,883,034	0
00000	05-0500188	CVS Caremark Indemnity, Ltd.	0	0	0	0	0	19,077,355		0	19,077,355	(758,755)
00000	20-8404182	Caremark Rx., L.L.C.	0	(10,000,000)	0	0	0	0		0	(10,000,000)	0
67660	23-1305366	Pennsylvania Life Insurance Company	0	0	0	0	0	0		0	0	0
63444	06-1566092	Accendo Insurance Company	0	10,000,000	0	0	0	6,442,665		0	16,442,665	(252,918)
9999999 Control Totals			0	0	0	0	0	0	XXX	0	0	0

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

		Responses
	MARCH FILING	
1.	Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	YES
2.	Will an actuarial opinion be filed by March 1?	YES
3.	Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	YES
4.	Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?	YES
	APRIL FILING	
5.	Will Management's Discussion and Analysis be filed by April 1?	YES
6.	Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7.	Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
	JUNE FILING	
8.	Will an audited financial report be filed by June 1?	YES
9.	Will Accountant's Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	YES
	AUGUST FILING	
10.	Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?	YES

The following supplemental reports are required to be filed as part of your annual statement filing **if your company is engaged in the type of business covered by the supplement. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below.** If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	MARCH FILING	
11.	Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12.	Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13.	Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	SEE EXPLANATION
14.	Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
15.	Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16.	Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
17.	Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
18.	Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
19.	Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO
	APRIL FILING	
20.	Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
21.	Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
22.	Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	NO
23.	Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	NO
24.	Will the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit be filed with the state of domicile and the NAIC by April 1?	YES
25.	Will the Adjustments to the Life, Health & Annuity Guaranty Association Model Act Assessment Base Reconciliation Exhibit (if required) be filed with the state of domicile and the NAIC by April 1?	YES
	AUGUST FILING	
26.	Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	YES

Explanations:

11. The data for this supplement is not required to be filed.
12. The data for this supplement is not required to be filed.
13. Only one stockholder, not required.
14. The data for this supplement is not required to be filed.
15. The data for this supplement is not required to be filed.
16. The data for this supplement is not required to be filed.
17. The data for this supplement is not required to be filed.
18. The data for this supplement is not required to be filed.
19. The data for this supplement is not required to be filed.
20. The data for this supplement is not required to be filed.
21. The data for this supplement is not required to be filed.
22. The data for this supplement is not required to be filed.
23. The data for this supplement is not required to be filed.

Bar Codes:

11. Medicare Supplement Insurance Experience Exhibit [Document Identifier 360]
12. Life Supplement [Document Identifier 205]
14. Participating Opinion for Exhibit 5 [Document Identifier 371]
15. Non-Guaranteed Opinion for Exhibit 5 [Document Identifier 370]
16. Medicare Part D Coverage Supplement [Document Identifier 365]
17. Relief from the five-year rotation requirement for lead audit partner [Document Identifier 224]
18. Relief from the one-year cooling off period for independent CPA [Document Identifier 225]
19. Relief from the Requirements for Audit Committees [Document Identifier 226]

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

20. Long-Term Care Experience Reporting Forms [Document Identifier 306]

21. Life Supplement [Document Identifier 211]

22. Supplemental Health Care Exhibit (Parts 1, 2 and 3) [Document Identifier 216]

23. Supplemental Health Care Exhibit's Expense Allocation Report [Document Identifier 217]

OVERFLOW PAGE FOR WRITE-INS

NONE

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings 1 Amount	2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities	55,762,541	11.754	55,762,541	0	55,762,541	11.754
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies	0	0.000	0	0	0	0.000
1.22 Issued by U.S. government sponsored agencies	0	0.000	0	0	0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	25,670,460	5.411	25,670,460	0	25,670,460	5.411
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations	28,858,343	6.083	28,858,343	0	28,858,343	6.083
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	27,138,786	5.721	27,138,786	0	27,138,786	5.721
1.43 Revenue and assessment obligations	117,503,144	24.769	117,503,144	0	117,503,144	24.769
1.44 Industrial development and similar obligations	0	0.000	0	0	0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	2,884,529	0.608	2,884,529	0	2,884,529	0.608
1.512 Issued or guaranteed by FNMA and FHLMC	7,474,154	1.576	7,474,154	0	7,474,154	1.576
1.513 All other	0	0.000	0	0	0	0.000
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	0	0.000	0	0	0	0.000
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	0	0.000	0	0	0	0.000
1.523 All other	158,172,701	33.342	158,172,701	0	158,172,701	33.342
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	0	0.000	0	0	0	0.000
2.2 Unaffiliated non-U.S. securities (including Canada)	18,891,428	3.982	18,891,428	0	18,891,428	3.982
2.3 Affiliated securities	0	0.000	0	0	0	0.000
3. Equity interests:						
3.1 Investments in mutual funds	0	0.000	0	0	0	0.000
3.2 Preferred stocks:						
3.21 Affiliated	0	0.000	0	0	0	0.000
3.22 Unaffiliated	0	0.000	0	0	0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated	0	0.000	0	0	0	0.000
3.32 Unaffiliated	0	0.000	0	0	0	0.000
3.4 Other equity securities:						
3.41 Affiliated	0	0.000	0	0	0	0.000
3.42 Unaffiliated	0	0.000	0	0	0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated	0	0.000	0	0	0	0.000
3.52 Unaffiliated	0	0.000	0	0	0	0.000
4. Mortgage loans:						
4.1 Construction and land development	0	0.000	0	0	0	0.000
4.2 Agricultural	0	0.000	0	0	0	0.000
4.3 Single family residential properties	0	0.000	0	0	0	0.000
4.4 Multifamily residential properties	0	0.000	0	0	0	0.000
4.5 Commercial loans	13,407,858	2.826	13,407,858	0	13,407,858	2.826
4.6 Mezzanine real estate loans	0	0.000	0	0	0	0.000
5. Real estate investments:						
5.1 Property occupied by company	0	0.000	0	0	0	0.000
5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
6. Contract loans	0	0.000	0	0	0	0.000
7. Derivatives	0	0.000	0	0	0	0.000
8. Receivables for securities	11,415	0.002	11,415	0	11,415	0.002
9. Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.000	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	18,620,276	3.925	18,620,276	0	18,620,276	3.925
11. Other invested assets	0	0.000	0	0	0	0.000
12. Total invested assets	474,395,635	100.000	474,395,635	0	474,395,635	100.000

SCHEDULE A - VERIFICATION BETWEEN YEARS

Real Estate

NONE

1.	Book/adjusted carrying value, December 31 of prior year	
2.	Cost of acquired:	
	2.1 Actual cost at time of acquisition (Part 2, Column 6)	
	2.2 Additional investment made after acquisition (Part 2, Column 9)	
3.	Current year change in encumbrances:	
	3.1 Totals, Part 1, Column 13	
	3.2 Totals, Part 3, Column 11	
4.	Total gain (loss) on disposals, Part 3, Column 18	
5.	Deduct amounts received on disposals, Part 3, Column 15	
6.	Total foreign exchange change in book/adjusted carrying value:	
	6.1 Totals, Part 1, Column 15	
	6.2 Totals, Part 3, Column 13	
7.	Deduct current year's other than temporary impairment recognized:	
	7.1 Totals, Part 1, Column 12	
	7.2 Totals, Part 3, Column 10	
8.	Deduct current year's depreciation:	
	8.1 Totals, Part 1, Column 11	
	8.2 Totals, Part 3, Column 9	
9.	Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8)	
10.	Deduct total nonadmitted amounts	
11.	Statement value at end of current period (Line 9 minus Line 10)	

SCHEDULE B - VERIFICATION BETWEEN YEARS

Mortgage Loans

1.	Book value/recorded investment excluding accrued interest, December 31 of prior year		12,979,171
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition (Part 2, Column 7)	0	
	2.2 Additional investment made after acquisition (Part 2, Column 8)	621,181	621,181
3.	Capitalized deferred interest and other:		
	3.1 Totals, Part 1, Column 12	0	
	3.2 Totals, Part 3, Column 11	0	0
4.	Accrual of discount		0
5.	Unrealized valuation increase (decrease):		
	5.1 Totals, Part 1, Column 9	0	
	5.2 Totals, Part 3, Column 8	0	0
6.	Total gain (loss) on disposals, Part 3, Column 18		0
7.	Deduct amounts received on disposals, Part 3, Column 15		316,980
8.	Deduct amortization of premium and mortgage interest points and commitment fees		(124,486)
9.	Total foreign exchange change in book value/recorded investment excluding accrued interest:		
	9.1 Totals, Part 1, Column 13	0	
	9.2 Totals, Part 3, Column 13	0	0
10.	Deduct current year's other than temporary impairment recognized:		
	10.1 Totals, Part 1, Column 11	0	
	10.2 Totals, Part 3, Column 10	0	0
11.	Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)		13,407,858
12.	Total valuation allowance		0
13.	Subtotal (Line 11 plus 12)		13,407,858
14.	Deduct total nonadmitted amounts		0
15.	Statement value of mortgages owned at end of current period (Line 13 minus Line 14)		13,407,858

SCHEDULE BA - VERIFICATION BETWEEN YEARS

Other Long-Term Invested Assets

NONE

1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition (Part 2, Column 8)		
	2.2 Additional investment made after acquisition (Part 2, Column 9)		
3.	Capitalized deferred interest and other:		
	3.1 Totals, Part 1, Column 16		
	3.2 Totals, Part 3, Column 12		
4.	Accrual of discount		
5.	Unrealized valuation increase (decrease):		
	5.1 Totals, Part 1, Column 13		
	5.2 Totals, Part 3, Column 9		
6.	Total gain (loss) on disposals, Part 3, Column 19		
7.	Deduct amounts received on disposals, Part 3, Column 16		
8.	Deduct amortization of premium and depreciation		
9.	Total foreign exchange change in book/adjusted carrying value:		
	9.1 Totals, Part 1, Column 17		
	9.2 Totals, Part 3, Column 14		
10.	Deduct current year's other than temporary impairment recognized:		
	10.1 Totals, Part 1, Column 15		
	10.2 Totals, Part 3, Column 11		
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)		
12.	Deduct total nonadmitted amounts		
13.	Statement value at end of current period (Line 11 minus Line 12)		

SCHEDULE D - VERIFICATION BETWEEN YEARS

Bonds and Stocks

1.	Book/adjusted carrying value, December 31 of prior year		479,236,865
2.	Cost of bonds and stocks acquired, Part 3, Column 7		177,142,775
3.	Accrual of discount		653,212
4.	Unrealized valuation increase (decrease):		
	4.1. Part 1, Column 12	(1,990,270)	
	4.2. Part 2, Section 1, Column 15	0	
	4.3. Part 2, Section 2, Column 13	0	
	4.4. Part 4, Column 11	43,189	(1,947,081)
5.	Total gain (loss) on disposals, Part 4, Column 19		(2,448,888)
6.	Deduction consideration for bonds and stocks disposed of, Part 4, Column 7		205,903,403
7.	Deduct amortization of premium		3,328,608
8.	Total foreign exchange change in book/adjusted carrying value:		
	8.1. Part 1, Column 15	0	
	8.2. Part 2, Section 1, Column 19	0	
	8.3. Part 2, Section 2, Column 16	0	
	8.4. Part 4, Column 15	0	0
9.	Deduct current year's other than temporary impairment recognized:		
	9.1. Part 1, Column 14	1,176,321	
	9.2. Part 2, Section 1, Column 17	0	
	9.3. Part 2, Section 2, Column 14	0	
	9.4. Part 4, Column 13	186,090	1,362,411
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees, Notes 5R, Line 5R(2)		313,626
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)		442,356,087
12.	Deduct total nonadmitted amounts		0
13.	Statement value at end of current period (Line 11 minus Line 12)		442,356,087

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description			1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
BONDS	1.	United States	58,647,070	59,316,447	58,542,804	59,629,156
Governments	2.	Canada	0	0	0	0
(Including all obligations guaranteed by governments)	3.	Other Countries	25,670,462	26,067,312	26,019,463	25,621,725
	4.	Totals	84,317,532	85,383,759	84,562,267	85,250,881
U.S. States, Territories and Possessions (Direct and guaranteed)	5.	Totals	28,858,342	28,676,680	30,102,774	25,385,000
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6.	Totals	27,138,785	27,546,299	27,929,552	24,300,000
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions	7.	Totals	126,200,245	129,016,491	132,298,809	120,624,333
Industrial and Miscellaneous, SVO Identified Funds, Bank Loans and Hybrid Securities (unaffiliated)	8.	United States	156,949,754	155,730,472	158,842,751	159,337,000
	9.	Canada	0	0	0	0
	10.	Other Countries	18,891,428	18,687,605	18,947,692	19,231,000
	11.	Totals	175,841,182	174,418,077	177,790,443	178,568,000
Parent, Subsidiaries and Affiliates	12.	Totals	0	0	0	0
	13.	Total Bonds	442,356,086	445,041,306	452,683,845	434,128,214
PREFERRED STOCKS	14.	United States	0	0	0	
Industrial and Miscellaneous (unaffiliated)	15.	Canada	0	0	0	
	16.	Other Countries	0	0	0	
	17.	Totals	0	0	0	
Parent, Subsidiaries and Affiliates	18.	Totals	0	0	0	
	19.	Total Preferred Stocks	0	0	0	
COMMON STOCKS	20.	United States	0	0	0	
Industrial and Miscellaneous (unaffiliated)	21.	Canada	0	0	0	
	22.	Other Countries	0	0	0	
	23.	Totals	0	0	0	
Parent, Subsidiaries and Affiliates	24.	Totals	0	0	0	
	25.	Total Common Stocks	0	0	0	
	26.	Total Stocks	0	0	0	
	27.	Total Bonds and Stocks	442,356,086	445,041,306	452,683,845	

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1A - SECTION 1

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
1. U.S. Governments												
1.1 NAIC 1	591,424	50,220,252	7,582,716	247,170	5,509	XXX	58,647,071	12.9	52,347,041	10.6	58,647,070	1
1.2 NAIC 2	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
1.3 NAIC 3	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
1.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
1.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
1.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
1.7 Totals	591,424	50,220,252	7,582,716	247,170	5,509	XXX	58,647,071	12.9	52,347,041	10.6	58,647,070	1
2. All Other Governments												
2.1 NAIC 1	0	0	2,847,558	0	0	XXX	2,847,558	0.6	1,498,535	0.3	2,847,558	0
2.2 NAIC 2	0	3,875,179	1,980,971	1,589,147	3,790,129	XXX	11,235,426	2.5	11,110,878	2.2	10,239,655	995,771
2.3 NAIC 3	0	3,485,424	4,919,977	1,011,760	927,738	XXX	10,344,899	2.3	11,990,993	2.4	7,826,741	2,518,158
2.4 NAIC 4	10,799	47,517	774,992	409,269	0	XXX	1,242,577	0.3	1,442,150	0.3	1,242,577	0
2.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2.7 Totals	10,799	7,408,120	10,523,498	3,010,176	4,717,867	XXX	25,670,460	5.7	26,042,556	5.3	22,156,531	3,513,929
3. U.S. States, Territories and Possessions etc., Guaranteed												
3.1 NAIC 1	0	5,738,276	23,120,067	0	0	XXX	28,858,343	6.4	42,907,202	8.7	28,858,343	0
3.2 NAIC 2	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3.3 NAIC 3	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3.7 Totals	0	5,738,276	23,120,067	0	0	XXX	28,858,343	6.4	42,907,202	8.7	28,858,343	0
4. U.S. Political Subdivisions of States, Territories and Possessions , Guaranteed												
4.1 NAIC 1	0	2,581,257	24,358,163	199,366	0	XXX	27,138,786	6.0	27,016,735	5.5	27,138,786	0
4.2 NAIC 2	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4.3 NAIC 3	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4.7 Totals	0	2,581,257	24,358,163	199,366	0	XXX	27,138,786	6.0	27,016,735	5.5	27,138,786	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed												
5.1 NAIC 1	23,706,875	47,446,939	25,111,726	11,434,361	4,327,461	XXX	112,027,362	24.7	128,903,775	26.1	112,027,362	0
5.2 NAIC 2	5,576,057	5,238,844	2,952,617	0	405,365	XXX	14,172,883	3.1	20,087,349	4.1	14,172,882	1
5.3 NAIC 3	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5.7 Totals	29,282,932	52,685,783	28,064,343	11,434,361	4,732,826	XXX	126,200,245	27.8	148,991,124	30.2	126,200,244	1

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
6. Industrial & Miscellaneous (Unaffiliated)												
6.1 NAIC 1	21,571,481	41,822,285	25,822,647	0	0	XXX	89,216,413	19.7	98,267,774	19.9	76,775,217	12,441,196
6.2 NAIC 2	8,731,182	37,553,360	9,646,687	0	0	XXX	55,931,229	12.3	69,392,849	14.0	53,097,239	2,833,990
6.3 NAIC 3	1,323,419	16,665,678	19,622,219	0	1,101,107	XXX	38,712,423	8.5	24,477,366	5.0	32,235,648	6,476,775
6.4 NAIC 4	0	2,568,431	898,228	0	0	XXX	3,466,659	0.8	4,661,396	0.9	3,051,745	414,914
6.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
6.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
6.7 Totals	31,626,082	98,609,754	55,989,781	0	1,101,107	XXX	187,326,724	41.3	196,799,385	39.8	165,159,849	22,166,875
7. Hybrid Securities												
7.1 NAIC 1	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.2 NAIC 2	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.3 NAIC 3	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.1 NAIC 1	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.2 NAIC 2	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.3 NAIC 3	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
9. SVO Identified Funds												
9.1 NAIC 1	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
9.2 NAIC 2	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
9.3 NAIC 3	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
9.4 NAIC 4	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
9.5 NAIC 5	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
9.6 NAIC 6	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
9.7 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
10. Bank Loans												
10.1 NAIC 1	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.2 NAIC 2	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.3 NAIC 3	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.7 Totals	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
11. Total Bonds Current Year												
11.1 NAIC 1	(d) 45,869,780	147,809,009	108,842,877	11,880,897	4,332,970	0	318,735,533	70.2	XXX	XXX	306,294,336	12,441,197
11.2 NAIC 2	(d) 14,307,239	46,667,383	14,580,275	1,589,147	4,195,494	0	81,339,538	17.9	XXX	XXX	77,509,776	3,829,762
11.3 NAIC 3	(d) 1,323,419	20,151,102	24,542,196	1,011,760	2,028,845	0	49,057,322	10.8	XXX	XXX	40,062,389	8,994,933
11.4 NAIC 4	(d) 10,799	2,615,948	1,673,220	409,269	0	0	4,709,236	1.0	XXX	XXX	4,294,322	414,914
11.5 NAIC 5	(d) 0	0	0	0	0	0	(c) 0	0.0	XXX	XXX	0	0
11.6 NAIC 6	(d) 0	0	0	0	0	0	(c) 0	0.0	XXX	XXX	0	0
11.7 Totals	61,511,237	217,243,442	149,638,568	14,891,073	10,557,309	0	(b) 453,841,629	100.0	XXX	XXX	428,160,823	25,680,806
11.8 Line 11.7 as a % of Col. 7	13.6	47.9	33.0	3.3	2.3	0.0	100.0	XXX	XXX	XXX	94.3	5.7
12. Total Bonds Prior Year												
12.1 NAIC 1	51,903,733	162,843,926	116,322,643	15,061,430	4,809,330	0	XXX	XXX	350,941,062	71.0	334,161,399	16,779,663
12.2 NAIC 2	19,348,658	53,751,569	22,882,063	1,595,155	3,013,631	0	XXX	XXX	100,591,076	20.4	86,476,656	14,114,420
12.3 NAIC 3	1,502,863	15,250,024	17,756,806	1,012,079	946,587	0	XXX	XXX	36,468,359	7.4	29,971,272	6,497,087
12.4 NAIC 4	9,554	3,455,118	1,055,073	1,583,801	0	0	XXX	XXX	6,103,546	1.2	4,621,895	1,481,651
12.5 NAIC 5	0	0	0	0	0	0	XXX	XXX	(c) 0	0.0	0	0
12.6 NAIC 6	0	0	0	0	0	0	XXX	XXX	(c) 0	0.0	0	0
12.7 Totals	72,764,808	235,300,637	158,016,585	19,252,465	8,769,548	0	XXX	XXX	(b) 494,104,043	100.0	455,231,222	38,872,821
12.8 Line 12.7 as a % of Col. 9	14.7	47.6	32.0	3.9	1.8	0.0	XXX	XXX	100.0	XXX	92.1	7.9
13. Total Publicly Traded Bonds												
13.1 NAIC 1	37,421,012	144,816,579	107,842,877	11,880,897	4,332,969	0	306,294,334	67.5	334,161,399	67.6	306,294,334	XXX
13.2 NAIC 2	14,307,239	44,786,304	12,631,592	1,589,147	4,195,494	0	77,509,776	17.1	86,476,656	17.5	77,509,776	XXX
13.3 NAIC 3	1,323,419	19,659,760	16,530,557	1,011,760	1,536,892	0	40,062,388	8.8	29,971,272	6.1	40,062,388	XXX
13.4 NAIC 4	10,799	2,615,948	1,258,306	409,269	0	0	4,294,322	0.9	4,621,895	0.9	4,294,322	XXX
13.5 NAIC 5	0	0	0	0	0	0	0	0.0	0	0.0	0	XXX
13.6 NAIC 6	0	0	0	0	0	0	0	0.0	0	0.0	0	XXX
13.7 Totals	53,062,469	211,878,591	138,263,332	14,891,073	10,065,355	0	428,160,820	94.3	455,231,222	92.1	428,160,820	XXX
13.8 Line 13.7 as a % of Col. 7	12.4	49.5	32.3	3.5	2.4	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13.9 Line 13.7 as a % of Line 11.7, Col. 7, Section 11	11.7	46.7	30.5	3.3	2.2	0.0	94.3	XXX	XXX	XXX	94.3	XXX
14. Total Privately Placed Bonds												
14.1 NAIC 1	8,448,768	2,992,430	1,000,000	0	1	0	12,441,199	2.7	16,779,663	3.4	XXX	12,441,199
14.2 NAIC 2	0	1,881,079	1,948,683	0	0	0	3,829,762	0.8	14,114,420	2.9	XXX	3,829,762
14.3 NAIC 3	0	491,342	8,011,639	0	491,953	0	8,994,934	2.0	6,497,087	1.3	XXX	8,994,934
14.4 NAIC 4	0	0	414,914	0	0	0	414,914	0.1	1,481,651	0.3	XXX	414,914
14.5 NAIC 5	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.6 NAIC 6	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
14.7 Totals	8,448,768	5,364,851	11,375,236	0	491,954	0	25,680,809	5.7	38,872,821	7.9	XXX	25,680,809
14.8 Line 14.7 as a % of Col. 7	32.9	20.9	44.3	0.0	1.9	0.0	100.0	XXX	XXX	XXX	XXX	100.0
14.9 Line 14.7 as a % of Line 11.7, Col. 7, Section 11	1.9	1.2	2.5	0.0	0.1	0.0	5.7	XXX	XXX	XXX	XXX	5.7

(a) Includes $ 25,680,803 freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

(b) Includes $ 0 current year of bonds with Z designations, $ 0 prior year of bonds with Z designations and $ 0 prior year of bonds with Z* designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement. "Z*" means the SVO could not evaluate the obligation because valuation procedures for the security class are under regulatory review.

(c) Includes $ 0 current year of bonds with 5GI designations, $ 0 prior year of bonds with 5* or 5GI designations and $ 0 current year, $ 0 prior year of bonds with 6* designations. "5GI" means the NAIC designation was assigned by the (SVO) in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6*" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.

(d) Includes the following amount of short-term and cash equivalent bonds by NAIC designation: NAIC 1 $ 11,485,543 ; NAIC 2 $ 0 ; NAIC 3 $ 0 ; NAIC 4 $ 0 ; NAIC 5 $ 0 ; NAIC 6 $ 0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1A - SECTION 2

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
1. U.S. Governments												
1.1 Issuer Obligations	0	48,820,757	6,941,783	0	0	XXX	55,762,540	12.3	48,805,151	9.9	55,762,540	0
1.2 Residential Mortgage-Backed Securities	591,424	1,399,494	640,933	247,170	5,509	XXX	2,884,530	0.6	3,541,890	0.7	2,884,529	1
1.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
1.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
1.5 Totals	591,424	50,220,251	7,582,716	247,170	5,509	XXX	58,647,070	12.9	52,347,041	10.6	58,647,069	1
2. All Other Governments												
2.1 Issuer Obligations	10,799	7,408,120	10,523,498	3,010,176	4,717,867	XXX	25,670,460	5.7	26,042,555	5.3	22,156,531	3,513,929
2.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
2.5 Totals	10,799	7,408,120	10,523,498	3,010,176	4,717,867	XXX	25,670,460	5.7	26,042,555	5.3	22,156,531	3,513,929
3. U.S. States, Territories and Possessions, Guaranteed												
3.1 Issuer Obligations	0	5,738,276	23,120,067	0	0	XXX	28,858,343	6.4	42,907,202	8.7	28,858,343	0
3.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3.5 Totals	0	5,738,276	23,120,067	0	0	XXX	28,858,343	6.4	42,907,202	8.7	28,858,343	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed												
4.1 Issuer Obligations	0	2,581,257	24,358,163	199,366	0	XXX	27,138,786	6.0	27,016,735	5.5	27,138,786	0
4.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
4.5 Totals	0	2,581,257	24,358,163	199,366	0	XXX	27,138,786	6.0	27,016,735	5.5	27,138,786	0
5. U.S. Special Revenue & Special Assessment Obligations etc., Non-Guaranteed												
5.1 Issuer Obligations	28,823,504	49,879,105	26,522,701	9,848,293	2,429,540	XXX	117,503,143	25.9	139,701,347	28.3	117,503,143	0
5.2 Residential Mortgage-Backed Securities	459,428	1,583,731	1,541,642	1,586,068	2,303,286	XXX	7,474,155	1.6	8,057,049	1.6	7,474,154	1
5.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
5.4 Other Loan-Backed and Structured Securities	0	1,222,947	0	0	0	XXX	1,222,947	0.3	1,232,727	0.2	1,222,947	0
5.5 Totals	29,282,932	52,685,783	28,064,343	11,434,361	4,732,826	XXX	126,200,245	27.8	148,991,123	30.2	126,200,244	1
6. Industrial and Miscellaneous												
6.1 Issuer Obligations	26,539,854	90,459,033	41,128,405	0	1,101,107	XXX	159,228,399	35.1	163,686,671	33.1	138,061,526	21,166,873
6.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
6.3 Commercial Mortgage-Backed Securities	86,361	393,282	13,861,375	0	0	XXX	14,341,018	3.2	13,348,030	2.7	14,341,018	0
6.4 Other Loan-Backed and Structured Securities	4,999,867	7,757,440	1,000,000	0	0	XXX	13,757,307	3.0	19,764,682	4.0	12,757,306	1,000,001
6.5 Totals	31,626,082	98,609,755	55,989,780	0	1,101,107	XXX	187,326,724	41.3	196,799,383	39.8	165,159,850	22,166,874
7. Hybrid Securities												
7.1 Issuer Obligations	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.1 Issuer Obligations	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 11.7	9 Total from Col. 7 Prior Year	10 % From Col. 8 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
9. SVO Identified Funds												
9.1 Exchange Traded Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
9.2 Bond Mutual Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
9.3 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	0
10. Bank Loans												
10.1 Bank Loans - Issued	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.2 Bank Loans - Acquired	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.3 Totals	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11. Total Bonds Current Year												
11.1 Issuer Obligations	55,374,157	204,886,548	132,594,617	13,057,835	8,248,514	XXX	414,161,671	91.3	XXX	XXX	389,480,869	24,680,802
11.2 Residential Mortgage-Backed Securities	1,050,852	2,983,225	2,182,575	1,833,238	2,308,795	XXX	10,358,685	2.3	XXX	XXX	10,358,683	2
11.3 Commercial Mortgage-Backed Securities	86,361	393,282	13,861,375	0	0	XXX	14,341,018	3.2	XXX	XXX	14,341,018	0
11.4 Other Loan-Backed and Structured Securities	4,999,867	8,980,387	1,000,000	0	0	XXX	14,980,254	3.3	XXX	XXX	13,980,253	1,000,001
11.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	0
11.6 Bank Loans	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
11.7 Totals	61,511,237	217,243,442	149,638,567	14,891,073	10,557,309	0	453,841,628	100.0	XXX	XXX	428,160,823	25,680,805
11.8 Line 11.7 as a % of Col. 7	13.6	47.9	33.0	3.3	2.3	0.0	100.0	XXX	XXX	XXX	94.3	5.7
12. Total Bonds Prior Year												
12.1 Issuer Obligations	68,359,864	213,731,438	142,664,111	16,928,783	6,475,465	XXX	XXX	XXX	448,159,661	90.7	410,286,758	37,872,903
12.2 Residential Mortgage-Backed Securities	1,117,678	3,325,844	2,537,653	2,323,682	2,294,082	XXX	XXX	XXX	11,598,939	2.3	11,598,941	(2)
12.3 Commercial Mortgage-Backed Securities	0	533,209	12,814,821	0	0	XXX	XXX	XXX	13,348,030	2.7	13,348,031	(1)
12.4 Other Loan-Backed and Structured Securities	3,287,265	17,710,144	0	0	0	XXX	XXX	XXX	20,997,409	4.2	19,997,492	999,917
12.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	XXX	XXX	0	0.0	0	0
12.6 Bank Loans	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
12.7 Totals	72,764,807	235,300,635	158,016,585	19,252,465	8,769,547	0	XXX	XXX	494,104,039	100.0	455,231,222	38,872,817
12.8 Line 12.7 as a % of Col. 9	14.7	47.6	32.0	3.9	1.8	0.0	XXX	XXX	100.0	XXX	92.1	7.9
13. Total Publicly Traded Bonds												
13.1 Issuer Obligations	46,925,390	199,521,701	122,219,382	13,057,835	7,756,561	XXX	389,480,869	85.8	410,286,758	83.0	389,480,869	XXX
13.2 Residential Mortgage-Backed Securities	1,050,851	2,983,225	2,182,575	1,833,237	2,308,794	XXX	10,358,682	2.3	11,598,941	2.3	10,358,682	XXX
13.3 Commercial Mortgage-Backed Securities	86,361	393,282	13,861,375	0	0	XXX	14,341,018	3.2	13,348,031	2.7	14,341,018	XXX
13.4 Other Loan-Backed and Structured Securities	4,999,867	8,980,386	0	0	0	XXX	13,980,253	3.1	19,997,492	4.0	13,980,253	XXX
13.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	0	XXX
13.6 Bank Loans	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	XXX
13.7 Totals	53,062,469	211,878,594	138,263,332	14,891,072	10,065,355	0	428,160,822	94.3	455,231,222	92.1	428,160,822	XXX
13.8 Line 13.7 as a % of Col. 7	12.4	49.5	32.3	3.5	2.4	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13.9 Line 13.7 as a % of Line 11.7, Col. 7, Section 11	11.7	46.7	30.5	3.3	2.2	0.0	94.3	XXX	XXX	XXX	94.3	XXX
14. Total Privately Placed Bonds												
14.1 Issuer Obligations	8,448,767	5,364,847	10,375,235	0	491,953	XXX	24,680,802	5.4	37,872,903	7.7	XXX	24,680,802
14.2 Residential Mortgage-Backed Securities	1	0	0	1	1	XXX	3	0.0	(2)	0.0	XXX	3
14.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	(1)	0.0	XXX	0
14.4 Other Loan-Backed and Structured Securities	0	1	1,000,000	0	0	XXX	1,000,001	0.2	999,917	0.2	XXX	1,000,001
14.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	0	0.0	XXX	0
14.6 Bank Loans	0	0	0	0	0	XXX	0	0.0	XXX	XXX	XXX	0
14.7 Totals	8,448,768	5,364,848	11,375,235	1	491,954	0	25,680,806	5.7	38,872,817	7.9	XXX	25,680,806
14.8 Line 14.7 as a % of Col. 7	32.9	20.9	44.3	0.0	1.9	0.0	100.0	XXX	XXX	XXX	XXX	100.0
14.9 Line 14.7 as a % of Line 11.7, Col. 7, Section 11	1.9	1.2	2.5	0.0	0.1	0.0	5.7	XXX	XXX	XXX	XXX	5.7

Schedule DA - Verification - Short-Term Investments

N O N E

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

SCHEDULE E - PART 2 - VERIFICATION BETWEEN YEARS

(Cash Equivalents)

	1 Total	2 Bonds	3 Money Market Mutual funds	4 Other (a)
1. Book/adjusted carrying value, December 31 of prior year	14,867,395	14,867,178	217	0
2. Cost of cash equivalents acquired	2,565,130,542	2,563,958,099	1,172,443	0
3. Accrual of discount	1,164,952	1,164,952	0	0
4. Unrealized valuation increase (decrease)	0	0	0	0
5. Total gain (loss) on disposals	(722)	(722)	0	0
6. Deduct consideration received on disposals	2,569,675,585	2,568,503,962	1,171,623	0
7. Deduct amortization of premium	0	0	0	0
8. Total foreign exchange change in book/adjusted carrying value	0	0	0	0
9. Deduct current year's other than temporary impairment recognized	0	0	0	0
10. Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	11,486,582	11,485,545	1,037	0
11. Deduct total nonadmitted amounts	0	0	0	0
12. Statement value at end of current period (Line 10 minus Line 11)	11,486,582	11,485,545	1,037	0

(a) Indicate the category of such investments, for example, joint ventures, transportation equipment:

Schedule A - Part 1 - Real Estate Owned

N O N E

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE B - PART 1

Showing All Mortgage Loans OWNED December 31 of Current Year

1	2	Location		5	6	7	8	Change in Book Value/Recorded Investment					14	15
		3	4					9	10	11	12	13		
Loan Number	Code	City	State	Loan Type	Date Acquired	Rate of Interest	Book Value/Recorded Investment Excluding Accrued Interest	Unrealized Valuation Increase (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Foreign Exchange Change in Book Value	Value of Land and Buildings	Date of Last Appraisal or Valuation
2004182		GLEN BURNIE	MD		12/18/2017	5.770	5,803,426	0	0	0	0	0	11,500,000	10/23/2018
2004473		MT LAUREL	NJ		12/18/2017	5.280	7,604,432	0	0	0	0	0	13,100,000	08/27/2018
0599999. Mortgages in good standing - Commercial mortgages-all other							13,407,858	0	0	0	0	0	24,600,000	XXX
0899999. Total Mortgages in good standing							13,407,858	0	0	0	0	0	24,600,000	XXX
1699999. Total - Restructured Mortgages							0	0	0	0	0	0	0	XXX
2499999. Total - Mortgages with overdue interest over 90 days							0	0	0	0	0	0	0	XXX
3299999. Total - Mortgages in the process of foreclosure							0	0	0	0	0	0	0	XXX
3399999 - Totals							13,407,858	0	0	0	0	0	24,600,000	XXX

General Interrogatory:

1. Mortgages in good standing $ 0 unpaid taxes $ 0 interest due and unpaid.
2. Restructured mortgages $ 0 unpaid taxes $ 0 interest due and unpaid.
3. Mortgages with overdue interest over 90 days not in process of foreclosure $ 0 unpaid taxes $ 0 interest due and unpaid.
4. Mortgages in process of foreclosure $ 0 unpaid taxes $ 0 interest due and unpaid.

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE B - PART 2

Showing All Mortgage Loans ACQUIRED AND ADDITIONS MADE During the Current Year

1	Location		4	5	6	7	8	9
	2	3						
Loan Number	City	State	Loan Type	Date Acquired	Rate of Interest	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Value of Land and Buildings
2004473	MT LAUREL	NJ			5.280	0	621,181	13,100,000
0599999. Mortgages in good standing - Commercial mortgages-all other						0	621,181	13,100,000
0899999. Total Mortgages in good standing						0	621,181	13,100,000
1699999. Total - Restructured Mortgages						0	0	0
2499999. Total - Mortgages with overdue interest over 90 days						0	0	0
3299999. Total - Mortgages in the process of foreclosure						0	0	0
3399999 - Totals						0	621,181	13,100,000

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE B - PART 3

Showing All Mortgage Loans DISPOSED, Transferred or Repaid During the Current Year

1	Location		4	5	6	7	Change in Book Value/Recorded Investment						14	15	16	17	18
	2	3					8	9	10	11	12	13					
Loan Number	City	State	Loan Type	Date Acquired	Disposal Date	Book Value/ Recorded Investment Excluding Accrued Interest Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Amortization) /Accretion	Current Year's Other-Than-Temporary Impaiment Recognized	Capitalized Deferred Interest and Other	Total Change in Book Value (8+9-10+11)	Total Foreign Exchange Change in Book Value	Book Value/ Recorded Investment Excluding Accrued Interest on Disposal	Consid-eration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal
2004182	GLEN BURNIE	MD		12/18/2017		6,120,406	0	0	0	0	0	0	0	316,980	0	0	0
2004473	MT LAUREL	NJ		12/18/2017		6,858,765	0	124,486	0	0	124,486	0	0	0	0	0	0
0299999. Mortgages with partial repayments						12,979,171	0	124,486	0	0	124,486	0	0	316,980	0	0	0
0599999 - Totals						12,979,171	0	124,486	0	0	124,486	0	0	316,980	0	0	0

Schedule BA - Part 1 - Other Long-Term Invested Assets Owned

N O N E

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

N O N E

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes 3	Codes 4	Codes 5	6	7	Fair Value 8	Fair Value 9	10	11	Change in Book/Adjusted Carrying Value 12	Change in Book/Adjusted Carrying Value 13	Change in Book/Adjusted Carrying Value 14	Change in Book/Adjusted Carrying Value 15	Interest 16	Interest 17	Interest 18	Interest 19	Interest 20	Dates 21	Dates 22
CUSIP Identification	Description	Code	Foreign	Bond Char	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
912828-2F-6	US TREASURY NOTE/BOND				1	7,605,496	96.5440	7,723,533	8,000,000	7,639,005	0	102,715	186,661	0	1.125	1.859	FA	30,580	90,000	09/09/2016	08/31/2021
912828-3X-6	US TREASURY NOTE/BOND	SD			1	1,222,468	99.4870	1,233,644	1,240,000	1,224,310	0	3,358	13,624	0	2.250	2.404	FA	10,538	13,950	03/05/2018	02/15/2021
912828-3X-6	US TREASURY NOTE/BOND				1	8,636,141	99.4870	8,715,100	8,760,000	8,649,156	0	23,724	96,244	0	2.250	2.404	FA	74,448	98,550	03/05/2018	02/15/2021
912828-4J-6	US TREASURY NOTE/BOND				1	4,968,734	99.7510	4,987,529	5,000,000	4,973,731	0	7,896	17,759	0	2.375	2.549	AO	20,338	59,375	05/18/2018	04/30/2020
912828-4N-7	US TREASURY NOTE/BOND				1	4,926,172	101.5710	5,078,529	5,000,000	4,927,895	0	1,342	91,416	0	2.875	2.833	MN	18,664	71,875	06/29/2018	05/15/2028
912828-5D-8	US TREASURY NOTE/BOND				1	9,936,719	101.6360	10,163,626	10,000,000	9,939,248	0	2,529	0	0	2.875	3.008	MS	73,455	0	10/03/2018	09/30/2023
912828-5M-8	US TREASURY NOTE/BOND				1	2,014,063	103.7870	2,075,744	2,000,000	2,013,888	0	(175)	0	0	3.125	3.043	MN	8,115	0	11/20/2018	11/15/2028
912828-M8-0	US TREASURY NOTE/BOND				1	6,742,377	98.1900	6,873,311	7,000,000	6,757,567	0	37,440	212,259	0	2.000	2.205	MN	12,308	140,000	11/29/2017	11/30/2022
912828-P8-7	US TREASURY NOTE/BOND				1	9,595,276	97.1450	9,714,535	10,000,000	9,637,741	0	126,308	207,293	0	1.125	1.716	FA	38,225	112,500	02/26/2016	02/28/2021
0199999. Subtotal - Bonds - U.S. Governments - Issuer Obligations						55,647,446	XXX	56,565,551	57,000,000	55,762,541	0	305,137	825,256	0	XXX	XXX	XXX	286,671	586,250	XXX	XXX
3620AM-DZ-2	GOVT NATL MTGE ASSN I POOL NO GN733720			4	1	2,895,358	104.6300	2,750,896	2,629,156	2,884,529	0	(1,554)	0	0	4.500	1.933	MON	9,859	118,312	09/15/2015	06/15/2040
0299999. Subtotal - Bonds - U.S. Governments - Residential Mortgage-Backed Securities						2,895,358	XXX	2,750,896	2,629,156	2,884,529	0	(1,554)	0	0	XXX	XXX	XXX	9,859	118,312	XXX	XXX
0599999. Total - U.S. Government Bonds						58,542,804	XXX	59,316,447	59,629,156	58,647,070	0	303,583	825,256	0	XXX	XXX	XXX	296,530	704,562	XXX	XXX
040114-HL-7	ARGENTINA REPUBLIC OF SR UNSECURED		D		4FE	643,300	76.4660	535,261	700,000	535,261	(109,977)	1,937	0	0	6.875	8.219	JJ	20,720	0	07/27/2018	01/26/2027
06675Q-AA-1	BANQUE QUEST AFRICAINE D SR UNSECURED		D		2FE	494,635	101.7830	508,914	500,000	497,251	0	1,049	0	0	5.500	5.750	MN	4,201	27,500	04/28/2016	05/06/2021
105756-BK-5	BRAZIL REPUBLIC OF SR UNSECURED		D		3FE	1,012,500	113.0430	1,130,427	1,000,000	1,011,760	0	(319)	0	0	7.125	7.011	JJ	31,865	71,250	04/07/2015	01/20/2037
105756-BR-0	BRAZIL REPUBLIC OF SR UNSECURED		D		3FE	432,500	96.2140	481,070	500,000	435,786	0	1,244	0	0	5.625	6.716	JJ	13,594	28,125	02/26/2014	01/07/2041
105756-BS-8	BRAZIL REPUBLIC OF SR UNSECURED		D		3FE	1,480,320	102.2590	1,533,878	1,500,000	1,491,712	0	3,702	0	0	4.875	5.160	JJ	32,297	73,125	10/01/2015	01/22/2021
195325-BQ-7	COLOMBIA REPUBLIC OF SR UNSECURED		D	1	2FE	520,750	99.0580	495,289	500,000	511,797	0	(2,171)	0	0	4.000	3.472	FA	6,944	20,000	08/19/2014	02/26/2024
195325-CU-7	COLOMBIA REPUBLIC OF SR UNSECURED		D	1	2FE	515,000	95.2900	476,449	500,000	514,677	0	(281)	0	0	5.000	4.801	JD	1,111	25,000	10/02/2017	06/15/2045
226775-AG-9	CROATIA REPUBLIC OF SR UNSECURED		D		3FE	984,880	108.1930	1,081,933	1,000,000	991,355	0	1,402	0	0	6.000	6.200	JJ	25,833	60,000	11/19/2013	01/26/2024
25714P-CW-6	DOMINICAN REPUBLIC SR UNSECURED		D		3FE	512,500	98.3900	491,952	500,000	491,952	(19,926)	(167)	0	0	6.850	6.656	JJ	14,651	34,250	01/29/2015	01/27/2045
25714P-DJ-4	DOMINICAN REPUBLIC SR UNSECURED		D		3FE	1,045,000	104.9720	1,049,722	1,000,000	1,034,851	0	(3,817)	0	0	6.875	6.257	JJ	29,028	68,750	03/03/2016	01/29/2026
298785-HM-1	EUROPEAN INV BANK SR UNSECURED		D		1FE	949,970	96.5950	965,954	1,000,000	953,889	0	3,919	0	0	2.375	3.000	MN	2,441	23,750	03/02/2018	05/24/2027
445545-AJ-5	HUNGARY REPUBLIC OF SR UNSECURED		D		2FE	1,498,125	108.3470	1,625,211	1,500,000	1,498,851	0	180	0	0	5.750	5.767	MN	9,344	86,250	11/20/2013	11/22/2023
455780-BV-7	INDONESIA REPUBLIC OF SR UNSECURED		D		2FE	497,995	101.4390	507,196	500,000	498,521	0	173	0	0	4.750	4.800	JJ	11,413	23,750	12/01/2015	01/08/2026
500769-GQ-1	KREDIT FUER WIEDERAUFBAU SR UNSECURED		D		1FE	1,881,840	95.5910	1,911,818	2,000,000	1,893,669	0	11,829	0	0	2.000	2.925	MN	6,556	40,000	03/15/2018	05/02/2025
718286-BZ-9	PHILIPPINES REPUBLIC OF SR UNSECURED		D		2FE	1,044,900	97.8930	978,929	1,000,000	1,040,573	0	(1,260)	0	0	3.950	3.672	JJ	17,665	39,500	05/13/2015	01/20/2040
836205-AR-5	SOUTH AFRICA REPUBLIC OF UNSECURED		D		3FE	547,250	101.6370	508,185	500,000	508,185	(26,231)	(4,283)	0	0	5.875	4.667	MS	8,568	29,375	11/04/2015	09/16/2025
900123-BY-5	TURKEY REPUBLIC OF UNSECURED		D		3FE	479,950	97.4670	487,336	500,000	487,336	(3,879)	2,396	0	0	5.125	5.725	MS	6,833	25,625	09/06/2013	03/25/2022
900123-CK-4	TURKEY REPUBLIC OF SR UNSECURED		D		3FE	954,500	88.9390	889,386	1,000,000	889,386	(72,020)	3,879	0	0	4.875	5.490	AO	11,104	48,750	02/28/2017	10/09/2026
910860-AV-0	UNITED MEXICAN STATES SR UNSECURED		D		2FE	2,239,600	106.2230	2,124,454	2,000,000	2,234,880	0	(4,720)	0	0	6.050	5.130	JJ	57,139	60,500	03/14/2018	01/11/2040
91087B-AA-8	UNITED MEXICAN STATES SR UNSECURED		D		2FE	474,250	95.6530	478,266	500,000	474,858	0	608	0	0	3.600	4.556	JJ	7,550	0	10/30/2018	01/30/2025
E12021-06-7	IVORY COAST SR UNSECURED		D	4	4FE	215,073	88.1570	195,466	221,725	195,466	(21,017)	325	0	0	5.750	6.151	JD	35	12,749	04/15/2015	12/31/2032
EK1766-13-9	SUAM FINANCE BV SR UNSECURED		D		2FE	1,008,000	99.1400	991,398	1,000,000	1,007,592	0	(408)	0	0	4.875	4.710	AO	10,021	24,375	09/10/2018	04/17/2024
EK5906-74-9	SOCIALIST REP OF VIETNAM SR UNSECURED		D		3FE	1,000,500	100.9970	1,009,965	1,000,000	1,000,340	0	(56)	0	0	4.800	4.792	MN	5,600	48,000	08/07/2015	11/19/2024
EK7108-12-0	DOMINICAN REPUBLIC SR UNSECURED		D		3FE	497,500	99.1720	495,860	500,000	495,860	(2,378)	235	0	0	5.500	5.568	JJ	11,764	27,500	09/23/2015	01/27/2025
G47661-AA-4	INDUSTRIAL SR TR SR UNSECURED		D		3FE	495,000	97.1640	485,821	500,000	485,821	(11,533)	593	0	0	5.500	5.653	MN	4,583	27,500	08/21/2014	11/01/2022
QJ1388-46-2	GHANA REPUBLIC OF UNSECURED		D	4	4FE	513,500	113.3790	566,896	500,000	511,851	0	(588)	0	0	10.750	10.374	AO	11,497	53,750	12/07/2015	10/14/2030
X77765-BK-4	SERBIA REPUBLIC OF SR UNSECURED		D		3FE	1,052,500	107.8010	1,078,005	1,000,000	1,020,555	0	(6,701)	0	0	7.250	6.415	MS	18,729	72,500	07/10/2013	09/28/2021
Y20721-AJ-8	INDONESIA REPUBLIC OF SR UNSECURED		D		2FE	1,618,750	115.8430	1,621,801	1,400,000	1,589,147	0	(6,008)	0	0	6.625	5.442	FA	34,524	92,750	06/07/2013	02/17/2037
Y20721-BH-1	INDONESIA REPUBLIC OF SR UNSECURED		D		2FE	1,408,875	104.6520	1,360,470	1,300,000	1,367,280	0	(12,448)	0	0	5.375	4.171	AO	14,363	69,875	06/22/2015	10/17/2023
0699999. Subtotal - Bonds - All Other Governments - Issuer Obligations						26,019,463	XXX	26,067,312	25,621,725	25,670,462	(266,961)	(9,756)	0	0	XXX	XXX	XXX	429,973	1,214,499	XXX	XXX
1099999. Total - All Other Government Bonds						26,019,463	XXX	26,067,312	25,621,725	25,670,462	(266,961)	(9,756)	0	0	XXX	XXX	XXX	429,973	1,214,499	XXX	XXX
34153P-2R-8	FLORIDA ST BRD ED REF CAPITAL OUTLAY SER C				1FE	2,347,380	112.9360	2,258,720	2,000,000	2,173,746	0	(36,385)	0	0	5.000	2.890	JD	8,333	100,000	12/09/2013	06/01/2023
574193-MT-2	MARYLAND STATE OF FIRST SERIES			2	1FE	5,968,850	109.3580	5,467,900	5,000,000	5,678,538	0	(119,804)	0	0	4.000	1.390	JD	16,667	200,000	07/19/2016	06/01/2025
57582P-3V-0	MASSACHUSETTS ST CONSOL LOAN SER C			2	1FE	1,772,280	110.5080	1,657,620	1,500,000	1,639,673	0	(37,964)	0	0	5.000	2.220	JJ	37,500	75,000	05/21/2015	07/01/2023
57582R-FQ-4	MASSACHUSETTS STATE OF SER E			2	1FE	1,133,737	104.4910	1,149,401	1,100,000	1,132,600	0	(5,577)	15,904	0	4.000	3.269	MS	14,667	44,000	12/01/2015	09/01/2036
70914P-WZ-1	PENNSYLVANIA ST 1ST SER			2	1FE	7,209,652	114.4550	6,907,359	6,035,000	6,874,683	0	(123,371)	0	0	5.000	2.560	MS	88,849	301,750	03/17/2016	03/15/2026
882723-YB-9	TEXAS STATE OF SER F				1FE	2,085,195	110.6240	1,935,920	1,750,000	1,924,856	0	(46,524)	0	0	5.000	2.091	FA	36,458	87,500	05/29/2015	08/01/2022
93974D-Z3-5	WASHINGTON STATE OF REF SER R 20180			2	1FE	9,585,680	116.2470	9,299,760	8,000,000	9,434,246	0	(147,338)	0	0	5.000	2.651	FA	166,667	245,556	12/19/2017	08/01/2033
1199999. Subtotal - Bonds - U.S. States, Territories and Possessions - Issuer Obligations						30,102,774	XXX	28,676,680	25,385,000	28,858,342	0	(516,963)	15,904	0	XXX	XXX	XXX	369,141	1,053,806	XXX	XXX

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes 3	Codes 4	Codes 5	6	7	Fair Value 8	Fair Value 9	10	11	Change in Book/Adjusted Carrying Value 12	Change in Book/Adjusted Carrying Value 13	Change in Book/Adjusted Carrying Value 14	Change in Book/Adjusted Carrying Value 15	Interest 16	Interest 17	Interest 18	Interest 19	Interest 20	Dates 21	Dates 22
CUSIP Identification	Description	Code	Foreign	Bond Char	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
1799999. Total - U.S. States, Territories and Possessions Bonds						30,102,774	XXX	28,676,680	25,385,000	28,858,342	0	(516,963)	15,904	0	XXX	XXX	XXX	369,141	1,053,806	XXX	XXX
178882-LX-2	CLACKAMAS & WASH CNTYS OREGON REF				1FE	1,812,825	115.2060	1,728,090	1,500,000	1,696,643	0	(33,332)	0	0	5.000	2.420	JD	3,333	75,000	05/21/2015	06/15/2024
181059-UY-0	CLARK CNTY NEV SCH DIST REF SER B				1FE	5,370,493	115.7720	5,499,170	4,750,000	5,360,054	0	(10,438)	0	0	5.000	3.060	JD	10,556	118,750	11/07/2018	06/15/2026
184540-6D-9	CLEAR CREEK TEX INDPT SCH DIST SER D			2	1FE	1,126,560	110.9390	1,109,390	1,000,000	1,072,674	0	(12,773)	0	0	5.000	3.440	FA	18,889	50,000	06/12/2014	02/15/2039
235219-KP-6	DALLAS TEXAS REF			2	1FE	1,189,740	111.4150	1,114,150	1,000,000	1,111,797	0	(20,126)	0	0	5.000	2.651	FA	18,889	50,000	12/10/2014	02/15/2031
259291-NC-2	DOUGLAS CNTY NE SCH DIST 1			2	1FE	8,327,756	119.0010	8,181,319	6,875,000	8,064,441	0	(133,078)	0	0	5.000	2.580	JD	15,278	343,750	12/15/2016	12/15/2027
472736-V7-9	JEFFERSON CT COLO SCH DIST REF			2	1FE	1,940,432	118.3890	1,894,224	1,600,000	1,909,227	0	(30,359)	0	0	5.000	2.570	JD	3,556	78,667	12/14/2017	12/15/2031
513174-QU-9	LAMAR TEX CONS INDPT SCH DIST REF SCHOOLHOUSE SER A			2	1FE	1,574,115	108.7730	1,631,595	1,500,000	1,530,733	0	(9,035)	0	0	5.000	4.290	FA	28,333	75,000	09/30/2013	02/15/2041
64966J-RU-2	NEW YORK NY SUBSER D-1			2	1FE	583,290	108.2680	541,340	500,000	537,975	0	(13,273)	0	0	5.000	2.140	AO	6,250	25,000	06/24/2015	10/01/2022
751091-MV-8	RALEIGH NC PUBLIC IMPT-SER B			2	1FE	522,470	101.8810	509,405	500,000	512,548	0	(3,688)	0	0	3.000	2.195	AO	3,750	15,000	03/31/2016	04/01/2028
799055-QN-1	SAN MATEO CA FOSTER CITY SCH ELECTION 2015-SER A			2	1FE	3,408,832	102.7770	3,288,864	3,200,000	3,352,621	0	(20,534)	0	0	4.000	3.191	FA	53,333	128,000	02/26/2016	08/01/2045
845267-WA-7	SOUTHWEST TEX INDPT SCH DIST REF-SCH SCH			2	1FE	1,696,080	111.5120	1,672,680	1,500,000	1,613,328	0	(20,124)	0	0	5.000	3.370	FA	31,250	75,000	07/31/2014	02/01/2036
988176-JL-8	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD			2	1FE	177,627	100.8650	176,514	175,000	177,378	0	(247)	0	0	3.000	2.820	FA	2,188	3,106	12/15/2017	08/01/2030
988176-JM-6	YUBA COMMUNITY COLLEGE GENL OBLIGATION UNLTD			2	1FE	199,332	99.7790	199,558	200,000	199,366	0	34	0	0	3.000	3.030	FA	2,500	3,550	12/15/2017	08/01/2031
1899999. Subtotal - Bonds - U.S. Political Subdivisions - Issuer Obligations						27,929,552	XXX	27,546,299	24,300,000	27,138,785	0	(306,973)	0	0	XXX	XXX	XXX	198,105	1,040,823	XXX	XXX
2499999. Total - U.S. Political Subdivisions Bonds						27,929,552	XXX	27,546,299	24,300,000	27,138,785	0	(306,973)	0	0	XXX	XXX	XXX	198,105	1,040,823	XXX	XXX
010260-AA-9	ALABAMA ECON SETTLEMENT AUTH BP SETTLEMENT REV-SER A			2	1FE	5,349,135	104.1740	5,729,570	5,500,000	5,363,026	0	7,226	0	0	4.000	4.241	MS	64,778	220,000	12/02/2016	09/15/2032
040507-QK-4	ARIZONA HEALTH FACS AUTH REF-SER A-BANNER HEALTH OBLIG				1FE	1,106,150	110.9540	1,109,540	1,000,000	1,100,043	0	(26,093)	14,361	0	5.000	2.031	JJ	25,000	50,000	10/21/2015	01/01/2023
072024-TA-0	BAY AREA TOLL AUTH CALIF TOLL SER S-4				1FE	2,050,340	113.4840	2,269,680	2,000,000	2,024,990	0	(5,231)	0	0	5.000	4.671	AO	25,000	100,000	09/09/2013	04/01/2030
13048R-AE-7	CALIFORNIA MUN FIN AUTH VAR WASTE MGMT INC PROJ SER A				1FE	2,700,000	99.9770	2,699,379	2,700,000	2,700,000	0	0	0	0	1.550	1.550	MS	13,950	41,850	08/29/2014	02/01/2019
162410-DF-8	CHATTANOOGA TN HLTH EDUCTNL REF-STUDENT HSG-CDFI PHASE I				2FE	1,075,619	100.4320	1,034,450	1,030,000	1,039,066	0	(11,922)	0	0	3.000	1.811	AO	7,725	30,900	10/22/2015	10/01/2019
167593-RG-9	CHICAGO ILL OHARE INTL ARPT RE REG SER B			2	1FE	5,598,450	111.9390	5,596,950	5,000,000	5,410,799	0	(60,592)	0	0	5.000	3.471	JJ	125,000	250,000	10/08/2015	01/01/2030
185633-BJ-2	CLEMSON SC UNIV HGR EDU REV SER B			2	1FE	1,720,215	116.5670	1,748,505	1,500,000	1,713,449	0	(28,763)	35,721	0	5.000	2.520	MN	12,500	75,000	12/10/2015	05/01/2029
185633-BN-3	CLEMSON SC UNIV HGR EDU REV SER B			2	1FE	947,930	96.3720	963,720	1,000,000	948,634	0	1,945	35,121	0	3.000	3.150	MN	5,000	30,000	12/10/2015	05/01/2033
196558-RE-2	COLORADO RIVER TX MUNI WTR DIS REVENUE BONDS			2	1FE	552,745	105.9750	529,875	500,000	512,799	0	(6,059)	0	0	5.000	3.661	JJ	12,500	25,000	07/22/2011	01/01/2023
196707-MM-2	COLORADO ST BOARD GOVERNORS REF SER A				1FE	2,073,760	121.7840	2,435,680	2,000,000	2,055,603	0	(3,726)	0	0	5.000	4.677	MS	33,333	100,000	08/27/2013	03/01/2030
207758-PY-3	CONNECTICUT ST SP TAX TRANSN TRANSPRTN INFRASTRUCTURE				1FE	2,323,020	107.8880	2,157,760	2,000,000	2,122,801	0	(38,671)	0	0	5.000	2.850	JJ	50,000	100,000	06/21/2013	01/01/2022
235036-RP-7	DALLAS FORT WORTH TEX INT ARPT REVENUE BONDS			2	1FE	1,629,405	105.2940	1,579,410	1,500,000	1,529,336	0	(15,192)	0	0	5.000	3.881	MN	12,500	75,000	07/22/2011	11/01/2023
246003-NN-3	DELAWARE CNTY PA AUTH REVENUE BONDS				1	851,706	104.2530	854,875	820,000	834,095	0	(9,859)	0	0	5.000	3.700	MN	5,239	41,000	03/08/2017	11/15/2023
246003-NZ-6	DELAWARE CNTY PA AUTH REVENUE BONDS			2	1FE	186,960	104.1620	187,492	180,000	183,094	0	(2,164)	0	0	5.000	3.700	MN	1,150	9,000	03/08/2017	11/15/2023
25477G-HY-4	DISTRICT COLUMBIA INCOME TAX REVENUE BONDS			2	1FE	1,710,495	108.8130	1,632,195	1,500,000	1,569,014	0	(22,186)	0	0	5.000	3.331	JD	6,250	75,000	12/20/2011	12/01/2029
254845-HF-0	DISTRICT COLUMBIA WTR AND SWR REVENUE BONDS			2	1FE	1,188,300	110.9760	1,109,760	1,000,000	1,073,692	0	(18,351)	0	0	5.000	2.910	AO	12,500	50,000	03/14/2012	10/01/2025
34160W-XQ-2	FLORIDA DEPT ENVIRON PROTECTIO REF				1FE	4,803,800	110.2900	4,411,600	4,000,000	4,382,258	0	(104,062)	0	0	5.000	2.151	JJ	100,000	200,000	09/30/2014	07/01/2022
34160W-XS-8	FLORIDA DEPT ENVIRON PROTECTIO REF				1FE	1,834,005	115.0110	1,725,165	1,500,000	1,701,457	0	(33,894)	0	0	5.000	2.380	JJ	37,500	75,000	12/09/2014	07/01/2024
359900-3M-7	FULTON CNTY GA DEV AUTH			2	1FE	2,602,125	109.9350	2,473,538	2,250,000	2,379,149	0	(36,205)	0	0	5.000	3.170	MN	18,750	112,500	03/30/2012	11/01/2027
45203H-PN-6	ILLINOIS ST FIN AUTH REVENUE FRANCISCAN CMNTY'S INC SER A			2	2FE	398,750	103.3740	516,870	500,000	405,365	0	1,512	0	0	5.125	6.713	MN	3,274	25,625	01/10/2014	05/15/2043
452252-KA-6	ILLINOIS ST TOLL HWY AUTH TOLL REF-SER D				1FE	590,810	105.9410	529,705	500,000	531,191	0	(15,179)	0	0	5.000	1.810	JJ	12,500	25,000	11/26/2014	01/01/2021
546456-DX-9	LOUISIANA ST CITIZENS PPTY REF				1FE	3,373,860	101.3020	3,039,060	3,000,000	3,041,490	0	(98,574)	0	0	5.000	1.651	JD	12,500	150,000	07/17/2015	06/01/2019
56045P-BP-7	MAINE ST MUNI BOND BANK INFRAS			2	1FE	1,187,380	102.0970	1,020,970	1,000,000	1,018,064	0	(26,642)	0	0	5.000	2.250	MS	16,667	50,000	03/14/2012	09/01/2021
57563R-KT-5	MASSACHUSETTS ST EDUCTNL SER K-AMT				1FE	2,687,625	106.1850	2,654,625	2,500,000	2,564,898	0	(24,255)	0	0	5.000	3.900	JJ	62,500	125,000	06/21/2013	07/01/2021
57583R-W9-2	MASSACHUSETTS ST DEV FIN AGY			2	1FE	1,459,388	102.4540	1,434,356	1,400,000	1,405,514	0	(7,198)	0	0	5.000	4.451	AO	17,500	70,000	03/04/2010	10/01/2028
57584X-8F-1	MASSACHUSETTS STATE DEV FIN REF-PARTNERS HEALTHCARE SYSTEM				1FE	939,904	114.5360	916,288	800,000	919,462	0	(20,274)	0	0	5.000	2.110	JJ	20,000	20,333	12/15/2017	07/01/2024
57584X-8V-6	MASSACHUSETTS STATE DEV FIN REF-PARTNERS HEALTHCARE SYSTEM			2	1FE	2,101,060	100.7400	2,014,800	2,000,000	2,092,358	0	(8,626)	0	0	4.000	3.400	JJ	40,000	40,667	12/15/2017	07/01/2041
57586P-6Q-4	MASSACHUSETTS ST HSG FIN AGY REVENUE BONDS			2	1FE	474,101	100.4630	457,107	455,000	463,193	0	(1,984)	0	0	2.650	2.168	JD	1,005	12,058	03/08/2013	12/01/2041
592646-5K-5	METROPOLITAN WASHINGTON DC AMT REF SER A			2	1FE	2,084,400	110.4380	2,208,760	2,000,000	2,043,771	0	(8,124)	0	0	5.000	4.482	AO	25,000	100,000	06/28/2013	10/01/2031
59333P-WV-6	MIAMI DADE CNTY FL AVIATION SER-B			4	1FE	5,776,700	102.7300	5,136,490	5,000,000	5,130,214	0	(170,874)	0	0	5.500	1.980	AO	68,750	275,000	02/05/2015	10/01/2036
59447P-6A-4	MICHIGAN FIN AUTH REF-BEAUMONT HLTH CREDIT GROUP				1FE	4,203,990	107.4130	3,759,455	3,500,000	3,788,809	0	(108,431)	0	0	5.000	1.720	FA	72,917	175,000	01/21/2015	08/01/2021

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes 3	Codes 4	Codes 5	6	7	Fair Value 8	Fair Value 9	10	11	Change in Book/Adjusted Carrying Value 12	Change in Book/Adjusted Carrying Value 13	Change in Book/Adjusted Carrying Value 14	Change in Book/Adjusted Carrying Value 15	Interest 16	Interest 17	Interest 18	Interest 19	Interest 20	Dates 21	Dates 22
CUSIP Identification	Description	Code	Foreign	Bond Char	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
605155-AF-7	MISSION TEX ECONOMIC DEV CORP ADJ-WASTE MGMT INC PROJ-REMK			2	1FE	3,000,000	99.6340	2,989,020	3,000,000	3,000,000	0	0	0	0	2.500	2.500	FA	31,250	75,000	07/31/2014	08/01/2020
64577B-KK-9	NEW JERSEY ST ECON DEV AUTH REF SER XX			2	2FE	2,936,250	105.2880	3,158,640	3,000,000	2,952,617	0	5,235	0	0	4.250	4.501	JD	5,667	127,500	08/26/2015	06/15/2026
64577B-KU-7	NEW JERSEY ST ECON DEV AUTH REF SER XX				2FE	3,186,690	101.1680	3,035,040	3,000,000	3,023,554	0	(50,712)	0	0	5.000	3.244	JD	6,667	150,000	08/26/2015	06/15/2019
645916-Z5-9	NEW JERSEY ECONOMIC DEV AUTH REVENUE BONDS				2FE	1,892,715	104.9120	1,573,680	1,500,000	1,600,483	0	(50,082)	0	0	5.250	1.750	JD	3,500	78,750	11/20/2012	12/15/2020
645918-U9-2	NEW JERSEY ECONOMIC DEV AUTH REF SCH FACS CONSTRUCTION				2FE	3,740,590	108.3480	3,792,180	3,500,000	3,638,360	0	(30,017)	0	0	5.000	3.960	MS	58,333	175,000	05/28/2015	03/01/2023
646136-H9-5	NEW JERSEY ST TRANSN TR FD TRANSPRTN PROGRAM-SER A				2FE	1,613,655	101.1680	1,517,520	1,500,000	1,513,437	0	(28,956)	0	0	5.000	3.000	JD	3,333	75,000	05/20/2015	06/15/2019
646136-Z9-5	NEW JERSEY ST TRANSN TR FD FED HWY REIMBURSEMENT NTS				1FE	4,486,160	110.8910	4,435,640	4,000,000	4,359,627	0	(59,455)	0	0	5.000	3.191	JD	8,889	200,000	10/27/2016	06/15/2024
64971W-2D-1	NEW YORK CITY NY TRANSITIONAL PREREFUNDED FUTURE TAX SER B				1	1,400,000	102.7170	1,438,038	1,400,000	1,400,000	0	0	0	0	5.000	5.000	MN	11,667	70,000	03/30/2017	11/01/2024
650010-AD-3	NEW YORK STATE THRUWAY AUTH SER A				1FE	3,423,120	101.0430	3,031,290	3,000,000	3,027,827	0	(82,003)	0	0	5.000	2.201	JJ	75,000	150,000	12/12/2013	05/01/2019
650014-RW-5	NEW YORK ST TWP AUTH SECOND REVENUE BONDS			2	1FE	523,950	100.8140	504,070	500,000	500,684	0	(2,942)	0	0	5.000	4.392	AO	6,250	25,000	06/22/2009	04/01/2022
65825P-DZ-0	NORTH CAROLINA ST CAP IMPT LTD REVENUE BONDS				1FE	1,099,200	107.1190	1,071,190	1,000,000	1,027,836	0	(11,233)	0	0	5.000	3.741	MN	8,333	50,000	11/28/2011	05/01/2029
66285W-LN-4	NORTH TEXAS TWY AUTH REV REF SYS 1ST TIER SER A				1FE	4,099,235	108.4690	3,796,415	3,500,000	3,765,059	0	(84,271)	0	0	5.000	2.370	JJ	87,500	175,000	11/06/2014	01/01/2022
66285W-LP-9	NORTH TEXAS TWY AUTH REV REF SYS 1ST TIER SER A				1FE	1,174,510	110.8230	1,108,230	1,000,000	1,090,623	0	(21,230)	0	0	5.000	2.600	JJ	25,000	50,000	11/06/2014	01/01/2023
67886M-MP-1	OKLAHOMA ST HSG FIN AGY SF MTG HOMEOWNERSHIP LN PG SER A			2	1FE	220,963	102.6200	210,371	205,000	208,273	0	(1,875)	0	0	4.750	3.750	MS	3,246	9,738	04/27/2011	03/01/2028
681793-7L-3	OMAHA PUB PWR DIST NEBRASKA EL REVENUE BONDS			2	1FE	1,062,410	106.8470	1,068,474	1,000,000	1,016,338	0	(7,373)	0	0	5.000	4.171	FA	20,833	50,000	11/16/2011	02/01/2036
708692-BF-4	PENNSYLVANIA ECONOMIC DEV VAR-WASTE MGMT INC PROJ				1FE	2,026,540	99.7520	1,995,040	2,000,000	2,024,175	0	(824)	0	0	2.250	2.182	JJ	22,250	45,000	01/21/2016	07/01/2041
709223-YV-7	PENNSYLVANIA ST TPK REVENUE BONDS			2	1FE	1,172,480	102.8390	1,028,390	1,000,000	1,023,440	0	(25,015)	0	0	5.000	2.397	JD	4,167	50,000	08/22/2012	12/01/2022
735389-SR-0	PORT SEATTLE WASH REV AMT			2	1FE	1,569,465	110.7890	1,661,835	1,500,000	1,536,382	0	(7,162)	0	0	5.000	4.400	JJ	37,500	75,000	12/04/2013	07/01/2027
794665-FS-3	SALES TAX ASSET RECEIVABLE REF-FISCAL 2015-SER A			2	1FE	1,787,535	114.5750	1,718,625	1,500,000	1,676,012	0	(27,657)	0	0	5.000	2.790	AO	15,833	75,000	09/24/2014	10/15/2030
797669-XQ-6	SAN FRANCISCO CA BAY AREA REF GREEN BOND SER A			2	1FE	990,000	98.4090	984,090	1,000,000	990,479	0	477	0	0	3.000	3.078	JJ	15,000	15,250	12/15/2017	07/01/2034
798170-AX-4	SAN JOSE CA REDEV AGY REF-SUB-SER B				1FE	5,899,900	114.2490	5,712,450	5,000,000	5,741,000	0	(154,618)	0	0	5.000	1.631	FA	104,167	152,778	12/08/2017	08/01/2023
808390-DP-0	SCHUYLK ILL CNTY PA INDL DEV PINE GROVE LANDFILL INC			2	1FE	1,001,180	99.5040	995,040	1,000,000	1,000,214	0	(298)	0	0	2.125	2.094	AO	5,313	21,250	09/16/2015	10/01/2019
914318-L5-7	UNIV OF IDAHO ID REVENUES GEN IMPRV			2	1FE	558,750	109.7360	548,680	500,000	526,650	0	(7,622)	0	0	5.250	3.499	AO	6,563	26,250	06/26/2014	04/01/2039
927793-D4-8	VIRGINIA TRANSPORTATION REF SER A				1FE	1,776,150	118.9780	1,784,670	1,500,000	1,752,807	0	(31,805)	28,509	0	5.000	2.251	MN	9,583	68,958	12/01/2017	05/15/2026
928104-MA-3	VIRGINIA ST SMALL BUSINESS REF-HAMPTON UNIVERSITY			2	1FE	489,430	101.8780	509,390	500,000	490,551	0	304	0	0	4.000	4.141	AO	5,000	20,000	11/20/2014	10/01/2038
928172-T8-8	VIRGINIA ST PUB BLDG AUTH PUB AMT SER C				1FE	2,731,544	112.1640	2,658,287	2,370,000	2,624,969	0	(51,885)	0	0	5.000	2.501	FA	49,375	118,500	11/29/2016	08/01/2023
928172-U2-9	VIRGINIA ST PUB BLDG AUTH PUB AMT SER C				1FE	4,068,120	115.8310	4,054,085	3,500,000	3,944,113	0	(60,475)	0	0	5.000	2.871	FA	72,917	175,000	11/29/2016	08/01/2025
2599999. Subtotal - Bonds - U.S. Special Revenues - Issuer Obligations						123,512,670	XXX	120,318,010	112,110,000	117,503,144	0	(1,693,942)	113,712	0	XXX	XXX	XXX	1,624,424	5,032,907	XXX	XXX
3132XY-UX-3	FED HOME LOAN MTGE CORP GOLD POOL NO Q55997			4	1	4,905,354	101.9850	4,904,609	4,809,171	4,903,545	0	(1,809)	0	0	4.000	3.858	MON	16,031	112,214	05/08/2018	05/01/2048
3138X8-XG-1	FED NATL MTGE ASSN POOL NO AU8778			4	1	2,596,365	100.3900	2,514,936	2,505,162	2,570,609	0	(6,580)	0	0	3.000	2.295	MON	6,263	75,155	10/21/2013	10/01/2028
2699999. Subtotal - Bonds - U.S. Special Revenues - Residential Mortgage-Backed Securities						7,501,719	XXX	7,419,545	7,314,333	7,474,154	0	(8,389)	0	0	XXX	XXX	XXX	22,294	187,369	XXX	XXX
196680-FF-7	COLORADO ST BLDG EXCELLENT SCH CERTIFICATE PA			2	1FE	1,284,420	106.5780	1,278,936	1,200,000	1,222,947	0	(9,780)	0	0	5.000	4.082	MS	17,667	60,000	11/30/2011	03/15/2029
2899999. Subtotal - Bonds - U.S. Special Revenues - Other Loan-Backed and Structured Securities						1,284,420	XXX	1,278,936	1,200,000	1,222,947	0	(9,780)	0	0	XXX	XXX	XXX	17,667	60,000	XXX	XXX
3199999. Total - U.S. Special Revenues Bonds						132,298,809	XXX	129,016,491	120,624,333	126,200,245	0	(1,712,111)	113,712	0	XXX	XXX	XXX	1,664,385	5,280,276	XXX	XXX
00130H-BT-1	AES CORP SR UNSECURED			1	3FE	510,000	97.7600	488,801	500,000	488,801	(16,430)	(2,058)	0	0	4.875	4.403	MN	3,115	24,375	08/05/2016	05/15/2023
00164V-AD-5	AMC NETWORKS INC SR UNSECURED			1	3FE	498,750	94.9510	474,755	500,000	474,755	(24,341)	141	0	0	5.000	5.038	AO	6,250	25,000	05/06/2016	04/01/2024
00206R-DB-5	AT&T CORP SR UNSECURED				2FE	5,052,900	100.4140	5,020,700	5,000,000	5,044,002	0	(8,898)	0	0	3.800	3.506	MS	55,944	95,000	04/20/2018	03/15/2022
00287Y-AU-3	ABBVIE INC SR UNSECURED			1	2FE	2,495,650	97.6100	2,440,255	2,500,000	2,497,846	0	861	0	0	2.300	2.337	MN	7,507	57,500	05/09/2016	05/14/2021
00287Y-BE-8	ABBVIE INC SR UNSECURED			1	2FE	1,996,560	99.9520	1,999,034	2,000,000	1,996,776	0	216	0	0	3.375	3.431	MN	19,313	0	09/13/2018	11/14/2021
00440E-AT-4	ACE INA HOLDINGS SR UNSECURED			1	1FE	999,440	98.5350	985,345	1,000,000	999,772	0	112	0	0	2.300	2.312	MN	3,706	23,000	10/27/2015	11/03/2020
00766T-AD-2	AECOM TECHNOLOGY SR UNSECURED			1	3FE	511,250	98.2150	491,075	500,000	491,075	(16,832)	(1,189)	0	0	5.875	5.539	AO	6,201	29,375	01/11/2016	10/15/2024
013817-AU-5	ALCOA INC SR UNSECURED				3FE	232,009	102.0240	229,554	225,000	229,554	(2,243)	(211)	0	0	6.150	4.200	FA	5,228	0	12/12/2018	08/15/2020
013817-AV-3	ALCOA INC SR UNSECURED			1	3FE	253,438	101.0000	252,500	250,000	251,593	0	(724)	0	0	5.400	5.067	AO	2,850	13,500	05/06/2016	04/15/2021
03674X-AC-0	ANTERO RESSOURCES CORP SR UNSECURED			1	3FE	995,900	93.9950	968,151	1,030,000	968,151	(37,608)	1,976	0	0	5.125	5.462	JD	4,399	52,788	12/06/2016	12/01/2022
037833-AZ-3	APPLE INC SR UNSECURED				1FE	998,590	94.5280	945,280	1,000,000	999,085	0	135	0	0	2.500	2.516	FA	9,861	25,000	02/02/2015	02/09/2025
038522-AN-8	ARAMARK SERVICES INC SR UNSECURED			1	3FE	965,000	94.0970	940,971	1,000,000	940,971	(24,142)	113	0	0	4.750	5.325	JD	3,958	0	12/17/2018	06/01/2026

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	Foreign	Bond Char	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
038522-AQ-1	ARAMARK SERVICES INC SR UNSECURED			1	3FE	1,000,000	93.5710	935,710	1,000,000	935,710	(64,290)	0	0	0	5.000	5.000	FA	20,833	26,806	01/10/2018	02/01/2028
05565E-AW-5	BMW US CAPITAL LLC SR UNSECURED			1	1FE	1,491,885	99.0360	1,485,543	1,500,000	1,492,737	0	852	0	0	3.450	3.572	AO	11,356	25,875	06/07/2018	04/12/2023
06051G-GT-0	BANK OF AMERICA NA SR UNSECURED			1	1FE	1,000,000	94.5550	945,545	1,000,000	1,000,000	0	0	0	0	3.093	3.093	AO	7,733	32,047	09/13/2017	10/01/2025
06406F-AD-5	BANK OF NY MELLON CORP SR UNSECURED			2	1FE	1,497,390	94.8700	1,423,049	1,500,000	1,498,213	0	359	0	0	2.200	2.227	FA	12,375	33,000	08/09/2016	08/16/2023
07330N-AQ-8	BRANCH BANKING & TRUST SR UNSECURED			1	1FE	2,925,780	97.9890	2,939,676	3,000,000	2,938,556	0	12,776	0	0	2.625	3.339	JJ	36,313	39,375	04/26/2018	01/15/2022
095370-AB-8	BLUE CUBE SPINCO INC SR UNSECURED			2	3FE	1,043,600	110.0100	1,100,099	1,000,000	1,029,745	0	(6,416)	0	0	9.750	8.802	AO	20,583	97,500	10/03/2016	10/15/2023
1248EP-BM-4	CCO HOLDINGS LLC CAP CORP SR UNSECURED			2	3FE	2,000,000	98.0350	1,960,690	2,000,000	1,960,690	(39,310)	0	0	0	5.750	5.750	FA	43,444	57,500	04/03/2018	02/15/2026
14042R-BS-9	CAPITAL ONE NA SR UNSECURED			2	2FE	999,970	98.8950	988,950	1,000,000	999,983	0	10	0	0	1.850	1.851	MS	5,550	18,500	09/08/2016	09/13/2019
144141-CZ-9	CAROLINA PR & LT FIRST MTGE				1FE	537,040	100.0700	500,352	500,000	500,171	0	(4,785)	0	0	5.300	4.312	JJ	12,219	26,500	11/10/2009	01/15/2019
14987R-AA-6	CB ESCROW CORP SR UNSECURED			1	4FE	461,875	82.9830	414,914	500,000	414,914	(48,577)	1,616	0	0	8.000	9.478	AO	8,444	20,000	07/25/2018	10/15/2025
151020-AN-4	CELGENE CORP SR UNSECURED				2FE	997,510	99.6600	996,598	1,000,000	999,780	0	504	0	0	2.250	2.303	MN	2,875	22,500	05/06/2014	05/15/2019
15189T-AU-1	CENTERPOINT ENERGY RESOU SR UNSECURED			1	2FE	999,280	99.8960	998,960	1,000,000	999,265	0	(15)	0	0	3.850	3.866	FA	9,197	0	10/03/2018	02/01/2024
156700-AR-7	CENTURYTEL INC SR UNSECURED				4FE	1,027,500	99.6170	996,167	1,000,000	996,167	(24,986)	(6,347)	0	0	6.450	5.516	JD	2,867	64,500	03/06/2018	06/15/2021
161175-BB-9	CHARTER COMM OPT LLC/CAP 1ST LIEN			1	2FE	1,525,605	100.9610	1,514,409	1,500,000	1,521,671	0	(3,934)	0	0	4.464	4.005	JJ	29,388	33,480	04/25/2018	07/23/2022
163851-AD-0	CHEMOURS CO SR UNSECURED			2	3FE	1,092,500	101.0510	1,010,510	1,000,000	1,010,510	(58,576)	(23,414)	0	0	7.000	4.262	MN	8,944	70,000	01/03/2018	05/15/2025
16411Q-AC-5	CHENIERE ENERGY PARTNERS SR UNSECURED			1	3FE	1,000,000	94.0800	940,795	1,000,000	940,795	(59,205)	0	0	0	5.625	5.625	AO	17,188	0	09/06/2018	10/01/2026
16412X-AD-7	CHENIERE CORP CHRISTI HD SECURED			1	3FE	1,000,000	105.9390	1,059,391	1,000,000	1,000,000	0	0	0	0	7.000	6.997	JD	194	70,000	05/05/2017	06/30/2024
166764-BG-4	CHEVRON CORP SR UNSECURED			1	1FE	1,949,620	98.0440	1,960,886	2,000,000	1,960,400	0	10,780	0	0	2.100	2.969	MN	5,250	42,000	04/25/2018	05/16/2021
172967-KY-6	CITIGROUP INC. SR UNSECURED			1	2FE	925,730	92.3230	923,227	1,000,000	930,319	0	4,589	0	0	3.200	4.258	AO	6,222	16,000	05/16/2018	10/21/2026
184496-AL-1	CLEAN HARBORS INC SR UNSECURED			1	3FE	504,561	99.4920	497,459	500,000	497,459	(2,541)	(1,759)	0	0	5.125	4.724	JD	2,135	25,625	06/22/2016	06/01/2021
20030N-BX-8	COMCAST CORP SR UNSECURED			1	1FE	479,875	97.3660	486,831	500,000	481,432	0	1,557	0	0	3.000	3.810	FA	6,250	7,500	07/06/2018	02/01/2024
20030N-CR-0	COMCAST CORP SR UNSECURED			1	1FE	999,940	100.5330	1,005,334	1,000,000	999,900	0	(40)	0	0	3.700	3.701	AO	8,839	0	10/02/2018	04/15/2024
22003B-AJ-5	CORPORATE OFFICE PROP LP SR UNSECURED			1	2FE	998,430	99.2420	992,421	1,000,000	999,403	0	223	0	0	3.700	3.725	JD	1,644	37,000	05/14/2014	06/15/2021
228187-AA-8	CROWN AMER/CAP CORP VI SR UNSECURED			1	3FE	1,209,375	94.6350	1,182,943	1,250,000	1,182,943	(26,703)	271	0	0	4.750	5.302	FA	24,740	0	12/10/2018	02/01/2026
228189-AB-2	CROWN AMER/CAP CORP IV SR UNSECURED				3FE	990,000	97.5370	975,367	1,000,000	975,367	(14,784)	151	0	0	4.500	4.770	JJ	20,750	0	12/06/2018	01/15/2023
22819K-AB-6	CROWN AMER/CAP CORP V SR UNSECURED			1	3FE	927,500	90.2740	902,741	1,000,000	902,741	(25,152)	393	0	0	4.250	5.400	MS	10,743	0	12/10/2018	09/30/2026
23283P-AK-0	CYRUSONE LP/CYRUSONE FIN SR UNSECURED			1	3FE	2,026,260	97.6800	1,953,602	2,000,000	1,953,602	(71,644)	(1,014)	0	0	5.375	5.133	MS	31,653	0	09/26/2018	03/15/2027
23311V-AF-4	DCP MIDSTREAM OPERATING SR UNSECURED			1	3FE	965,000	85.2170	852,173	1,000,000	852,173	(112,919)	92	0	0	5.600	5.866	AO	14,000	28,000	09/18/2018	04/01/2044
24422E-TL-3	DEERE JOHN CAP CORP SR UNSECURED				1FE	1,962,280	98.3220	1,966,436	2,000,000	1,968,689	0	6,409	0	0	2.650	3.199	JJ	25,764	26,500	05/03/2018	01/06/2022
25278X-AC-3	DIAMONDBACK ENERGY INC SR UNSECURED			1	3FE	997,500	96.5300	965,295	1,000,000	965,295	(32,281)	76	0	0	4.750	4.797	MN	7,917	23,750	09/18/2018	11/01/2024
25278X-AH-2	DIAMONDBACK ENERGY INC SR UNSECURED			1	3FE	1,036,233	97.5680	975,675	1,000,000	975,675	(58,089)	(2,469)	0	0	5.375	4.522	MN	4,628	26,875	08/20/2018	05/31/2025
26441C-AJ-4	DUKE ENERGY CORP SR UNSECURED			1	2FE	1,968,580	98.0260	1,960,526	2,000,000	1,973,061	0	4,481	0	0	3.050	3.448	FA	23,044	30,500	05/04/2018	08/15/2022
29336U-AB-3	ENLINK MIDSTREAM PARTNER SR UNSECURED			1	3FE	958,750	93.2540	932,537	1,000,000	932,537	(28,856)	2,643	0	0	4.400	5.249	AO	11,000	22,000	07/26/2018	04/01/2024
29336U-AD-9	ENLINK MIDSTREAM PARTNER SR UNSECURED			1	3FE	261,555	78.2810	248,934	318,000	248,934	(12,959)	337	0	0	5.050	6.453	AO	4,015	8,030	07/27/2018	04/01/2045
29444U-AM-8	EQUINIX INC SR UNSECURED			1	4FE	618,120	99.5910	603,521	606,000	603,521	(8,499)	(2,492)	0	0	5.375	4.900	AO	8,143	32,573	06/14/2016	04/01/2023
29444U-AP-1	EQUINIX INC SR UNSECURED			1	3FE	796,875	100.8140	756,106	750,000	756,106	(25,082)	(9,225)	0	0	5.750	4.301	JJ	21,563	43,125	04/04/2017	01/01/2025
30231G-AR-3	EXXON MOBIL CORP SR UNSECURED			1	1FE	979,100	98.3260	983,257	1,000,000	981,697	0	2,597	0	0	2.726	3.198	MS	9,087	13,630	05/09/2018	03/01/2023
31677Q-BF-5	FIFTH THIRD BANCORP SR UNSECURED			2	1FE	2,499,425	99.8750	2,496,870	2,500,000	2,499,879	0	155	0	0	2.300	2.308	MS	16,931	57,500	03/10/2016	03/15/2019
31677Q-BK-4	FIFTH THIRD BANCORP SR UNSECURED			1	1FE	1,954,580	98.0310	1,960,610	2,000,000	1,964,156	0	9,576	0	0	2.200	3.215	AO	7,456	22,000	06/26/2018	10/30/2020
337738-AR-9	FISERV INC SR UNSECURED			1	2FE	998,050	100.1730	1,001,727	1,000,000	998,037	0	(13)	0	0	4.200	4.224	AO	11,200	0	09/20/2018	10/01/2028
34959J-AF-5	FORTIVE CORPORATION SR UNSECURED			1	2FE	1,999,623	97.1570	1,943,130	2,000,000	1,983,108	0	6,561	0	0	2.350	2.708	JD	2,089	47,000	06/14/2017	06/15/2021
35671D-AU-9	FREEPORT-MCMORAN C & G SR UNSECURED			1	3FE	282,500	94.6590	473,294	500,000	362,956	0	31,962	0	0	3.550	14.674	MS	5,917	17,750	02/18/2016	03/01/2022
35671D-AZ-8	FREEPORT-MCMORAN C & G SR UNSECURED			1	3FE	272,500	92.2890	461,447	500,000	339,034	0	26,336	0	0	3.875	14.324	MS	5,705	19,375	02/17/2016	03/15/2023
35671D-CB-9	FREEPORT-MCMORAN C & G SR UNSECURED			1	3FE	1,057,814	103.2760	1,032,764	1,000,000	1,032,764	(11,092)	(9,263)	0	0	6.875	5.660	FA	25,972	68,750	06/20/2017	02/15/2023
364760-AK-4	GAP INC SR UNSECURED			1	2FE	509,375	102.2980	511,492	500,000	504,424	0	(2,006)	0	0	5.950	5.483	AO	6,528	29,750	06/01/2016	04/12/2021
37045X-AY-2	GENERAL MOTORS FINL CO SR UNSECURED			1	2FE	995,850	98.9880	989,883	1,000,000	998,581	0	883	0	0	3.200	3.295	JJ	14,933	32,000	10/22/2015	07/13/2020
37045X-BM-7	GENERAL MOTORS FINL CO SR UNSECURED			1	2FE	2,042,160	97.6300	1,952,598	2,000,000	2,028,717	0	(11,295)	0	0	3.200	2.587	JJ	31,111	64,000	10/18/2017	07/06/2021
382550-BE-0	GOODYEAR TIRE & RUBBER SR UNSECURED			1	3FE	510,625	98.0140	490,071	500,000	490,071	(14,693)	(2,397)	0	0	5.125	4.585	MN	3,274	25,625	06/16/2016	11/15/2023
404119-BN-8	HCA INC 1ST LIEN				3FE	505,625	99.2450	496,226	500,000	496,226	(7,214)	(574)	0	0	5.000	4.847	MS	7,361	25,000	11/24/2014	03/15/2024
404121-AD-7	HCA INC SR UNSECURED				3FE	800,625	106.2170	743,516	700,000	743,516	(20,055)	(18,633)	0	0	7.500	4.355	FA	19,833	52,500	12/14/2016	02/15/2022
404121-AG-0	HCA INC SR UNSECURED				3FE	1,037,500	101.4160	1,014,157	1,000,000	1,014,157	(22,721)	(622)	0	0	5.875	4.918	MN	9,792	0	11/29/2018	05/01/2023
404121-AH-8	HCA INC SR UNSECURED			1	3FE	1,012,000	97.2710	972,707	1,000,000	972,707	(38,840)	(453)	0	0	5.375	5.179	MS	19,111	0	09/06/2018	09/01/2026
421924-BK-6	HEALTHSOUTH CORP SR UNSECURED			1	4FE	476,875	100.0340	500,170	500,000	483,314	0	2,284	0	0	5.750	6.394	MN	4,792	28,750	02/05/2015	11/01/2024
458140-AU-4	INTEL CORP SR UNSECURED			1	1FE	2,493,650	93.9600	2,349,010	2,500,000	2,495,117	0	587	0	0	2.600	2.629	MN	7,583	65,000	05/12/2016	05/19/2026
46625H-JC-5	JP MORGAN CHASE & CO SR UNSECURED				1FE	1,662,420	102.3460	1,535,183	1,500,000	1,552,854	0	(19,130)	0	0	4.350	2.943	FA	24,650	65,250	10/25/2012	08/15/2021
46647P-AU-0	JP MORGAN CHASE & CO SR UNSECURED				1FE	2,000,000	100.0010	2,000,024	2,000,000	2,000,000	0	0	0	0	3.797	3.797	JJ	33,329	0	07/16/2018	07/23/2024
526057-BT-0	LENNAR CORP SR UNSECURED			1	3FE	253,125	99.8220	249,556	250,000	249,556	(647)	(649)	0	0	4.500	4.229	JD	500	11,250	02/19/2014	06/15/2019

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	Foreign	Bond Char	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
52729N-BX-7	LEVEL 3 COMM INC SR UNSECURED			1	4FE	500,000	98.2410	491,207	500,000	491,207	(8,794)	0	0	0	5.750	5.751	MS	9,583	28,750	02/05/2015	12/01/2022
55336V-AE-0	MPLX LP SR UNSECURED			1	2FE	120,409	101.1310	121,357	120,000	120,407	0	(2)	0	0	4.500	4.413	JJ	2,490	0	12/12/2018	07/15/2023
55616X-AL-1	MACYS RETAIL HLDGS INC SR UNSECURED			1	2FE	998,990	92.3830	923,834	1,000,000	999,391	0	96	0	0	3.625	3.637	JD	3,021	36,250	05/20/2014	06/01/2024
571903-AL-7	MARRIOTT INTL SR UNSECURED			1	2FE	1,987,180	99.3030	1,986,066	2,000,000	1,996,384	0	1,888	0	0	3.375	3.478	AO	14,250	67,500	09/24/2013	10/15/2020
582839-AJ-5	MEAD JOHNSON NUTRITION C SR UNSECURED			2	1FE	1,035,980	99.7030	997,027	1,000,000	1,014,896	0	(8,084)	0	0	3.000	2.147	MN	3,833	30,000	05/03/2016	11/15/2020
58502B-AA-4	MEDNAX INC SR UNSECURED			1	3FE	491,972	98.2680	491,342	500,000	491,342	(1,278)	51	12,566	0	5.250	4.957	JD	2,188	26,250	12/07/2015	12/01/2023
59001K-AD-2	MERITOR INC SR UNSECURED			1	3FE	521,875	95.7730	478,863	500,000	478,863	(37,539)	(5,473)	0	0	6.250	4.713	FA	11,806	15,625	03/07/2018	02/15/2024
60871R-AF-7	MOLSON COORS BREWING CO SR UNSECURED			1	2FE	2,998,860	96.3500	2,890,497	3,000,000	2,999,401	0	223	0	0	2.100	2.108	JJ	29,050	63,000	06/28/2016	07/15/2021
61746B-EA-0	MORGAN STANLEY SR UNSECURED				1FE	2,498,950	97.9770	2,449,428	2,500,000	2,499,453	0	208	0	0	2.500	2.509	AO	12,153	62,500	04/18/2016	04/21/2021
626717-AJ-1	MURPHY OIL CORP SR UNSECURED			1	3FE	965,000	93.7640	937,641	1,000,000	937,641	(27,576)	217	0	0	5.750	6.401	FA	21,722	0	12/12/2018	08/15/2025
629377-CE-0	NRG ENERGY INC SR UNSECURED			1	3FE	1,221,875	96.2270	1,202,834	1,250,000	1,202,834	(19,198)	156	0	0	5.750	6.075	JJ	33,142	0	12/11/2018	01/15/2028
629568-AX-4	NABORS INDUSTRIES INC SR UNSECURED				3FE	664,686	89.9810	664,058	738,000	664,058	(628)	640	66,573	0	4.625	4.987	MS	10,050	17,066	09/11/2018	09/15/2021
62957H-AF-2	NABORS INDUSTRIES INC. SR UNSECURED			1	3FE	998,780	75.4690	754,685	1,000,000	754,685	(244,164)	70	0	0	5.750	5.772	FA	23,958	0	09/27/2018	02/01/2025
641062-AD-6	NESTLE HOLDINGS INC SR UNSECURED			1	1FE	1,499,730	100.8900	1,513,356	1,500,000	1,499,692	0	(38)	0	0	3.350	3.354	MS	13,540	0	09/17/2018	09/24/2023
651290-AP-3	NEWFIELD EXPLORATION CO SR UNSECURED				3FE	436,250	101.5000	507,501	500,000	463,493	0	9,966	0	0	5.750	8.490	JJ	12,059	28,750	01/12/2016	01/30/2022
69318F-AE-8	PBF HOLDING CO LLC SECURED			1	4FE	500,000	95.5070	477,537	500,000	477,537	(22,463)	0	0	0	7.000	7.000	MN	4,472	35,000	01/12/2017	11/15/2023
69353R-FC-7	PNC BANK NA SR UNSECURED			1	1FE	1,468,785	98.4270	1,476,407	1,500,000	1,478,246	0	9,461	0	0	2.000	3.078	MN	3,500	30,000	05/15/2018	05/19/2020
69370C-AA-8	PTC INC SR UNSECURED			1	3FE	534,375	100.2650	501,323	500,000	501,323	(22,196)	(6,334)	0	0	6.000	4.480	MN	3,833	30,000	03/30/2017	05/15/2024
717081-DU-4	PFIZER INC SR UNSECURED				1FE	1,997,720	99.4240	1,988,470	2,000,000	1,999,659	0	759	0	0	1.450	1.489	JD	2,256	29,000	05/31/2016	06/03/2019
74834L-AU-4	QUEST DIAGNOSTIC INC SR UNSECURED				2FE	1,998,680	99.8040	1,996,074	2,000,000	1,999,840	0	226	0	0	2.700	2.714	AO	13,500	54,000	03/12/2014	04/01/2019
776743-AA-4	ROPER TECHNOLOGIES INC SR UNSECURED			1	2FE	999,620	99.3280	993,278	1,000,000	999,838	0	75	0	0	3.000	3.008	JD	1,333	30,000	11/30/2015	12/15/2020
78390X-AA-9	SAIC INC SR UNSECURED			1	3FE	501,375	99.0420	495,208	500,000	495,208	(6,117)	(50)	0	0	4.450	4.285	JD	1,854	0	12/12/2018	12/01/2020
785592-AH-9	SABINE PASS LIQUEFACTION 1ST LIEN			1	2FE	535,663	105.1040	525,518	500,000	516,441	0	(5,037)	0	0	6.250	5.038	MS	9,201	31,250	11/19/2014	03/15/2022
816851-BA-6	SEMPRA ENERGY SR UNSECURED			1	2FE	2,765,190	91.8290	2,754,876	3,000,000	2,769,570	0	4,380	0	0	3.250	4.345	JD	4,333	48,750	10/18/2018	06/15/2027
8426EP-AA-6	SOUTHERN CO GAS CAPITAL SR UNSECURED			1	2FE	999,220	94.1110	941,113	1,000,000	999,447	0	105	0	0	2.450	2.462	AO	6,125	24,500	09/08/2016	10/01/2023
858119-BC-3	STEEL DYNAMICS INC SR UNSECURED			1	3FE	500,000	100.5510	502,753	500,000	500,000	0	0	0	0	5.125	5.125	AO	6,406	25,625	05/07/2015	10/01/2021
86765L-AJ-6	SUNOCO LP/FINANCE CORP SR UNSECURED			1	3FE	1,004,943	97.6760	976,756	1,000,000	976,756	(28,092)	(95)	0	0	4.875	4.701	JJ	22,479	0	11/30/2018	01/15/2023
86765L-AL-1	SUNOCO LP/FINANCE CORP SR UNSECURED			1	3FE	1,004,202	94.3590	943,590	1,000,000	943,590	(60,554)	(57)	0	0	5.500	5.385	FA	20,778	0	11/30/2018	02/15/2026
867914-BK-8	SUNTRUST BANK INC. SR UNSECURED			2	2FE	1,496,745	99.1610	1,487,415	1,500,000	1,498,491	0	647	0	0	2.900	2.947	MS	14,258	43,500	02/29/2016	03/03/2021
87165B-AJ-2	SYNCHRONY FINANCIAL SR UNSECURED			1	2FE	1,999,480	99.9690	1,999,370	2,000,000	1,999,970	0	144	0	0	2.600	2.608	JJ	23,978	52,000	12/01/2015	01/15/2019
87612B-AP-7	TARGA RESOURCES PARTNERS SR UNSECURED			1	3FE	474,560	92.8900	464,451	500,000	464,451	(10,339)	229	0	0	4.250	5.441	MN	2,715	0	12/12/2018	11/15/2023
880336-CS-7	TENET HEALTHCARE CORP 1ST LIEN			1	3FE	963,814	93.1490	931,489	1,000,000	931,489	(34,518)	2,192	0	0	4.625	5.342	JJ	21,326	0	07/30/2018	07/15/2024
880349-AR-6	TENNECO INC SR UNSECURED			1	3FE	883,750	76.7640	767,640	1,000,000	767,640	(121,094)	4,984	0	0	5.000	6.918	JJ	23,056	0	07/17/2018	07/15/2026
887317-AT-2	TIME WARNER INC SR UNSECURED				2FE	999,480	99.4590	994,589	1,000,000	999,939	0	99	0	0	2.100	2.111	JD	1,750	21,000	05/20/2014	06/01/2019
902494-AW-3	TYSON FOODS INC SR UNSECURED			1	2FE	999,340	99.4830	994,826	1,000,000	999,898	0	136	0	0	2.650	2.664	FA	10,011	26,500	08/05/2014	08/15/2019
902494-BG-7	TYSON FOODS INC SR UNSECURED			1	2FE	499,305	99.8070	499,034	500,000	499,314	0	9	0	0	3.900	3.931	MS	5,038	0	09/25/2018	09/28/2023
904764-BG-1	UNILEVER CAPITAL CORP SR UNSECURED			1	1FE	992,780	99.4580	994,577	1,000,000	993,129	0	349	0	0	3.250	3.395	MS	10,292	0	09/04/2018	03/07/2024
911365-BG-8	UNITED RENTALS INC SR UNSECURED			1	3FE	1,001,250	87.7880	877,884	1,000,000	877,884	(123,142)	(129)	0	0	4.875	4.857	JJ	22,479	45,229	08/02/2017	01/15/2028
91324P-DM-1	UNITEDHEALTH GROUP INC SR UNSECURED				1FE	1,000,220	100.6350	1,006,347	1,000,000	1,000,209	0	(11)	0	0	3.500	3.496	FA	1,361	0	12/14/2018	02/15/2024
94988J-5N-3	WELLS FARGO BANK NA SR UNSECURED				1FE	1,476,465	98.7020	1,480,526	1,500,000	1,481,984	0	5,519	0	0	2.600	3.213	JJ	17,983	18,633	05/03/2018	01/15/2021
94988J-5T-0	WELLS FARGO BANK NA SR UNSECURED			1	1FE	1,999,780	100.5880	2,011,750	2,000,000	1,999,717	0	(63)	0	0	3.625	3.629	AO	13,694	0	10/16/2018	10/22/2021
960386-AN-0	WABTEC SR UNSECURED			1	2FE	998,050	96.3610	963,606	1,000,000	998,092	0	42	0	0	4.150	4.190	MS	12,335	0	09/12/2018	03/15/2024
962178-AL-3	WEYERHAEUSER REAL ESTATE SR UNSECURED				3FE	594,585	99.1670	595,001	600,000	595,001	(4,306)	1,407	0	0	4.375	4.625	JD	1,167	26,250	06/17/2015	06/15/2019
969457-BW-9	WILLIAMS CO INC SR UNSECURED			1	2FE	502,500	100.9270	504,636	500,000	501,851	0	(303)	0	0	4.550	4.471	JD	442	22,750	09/13/2016	06/24/2024
98978V-AJ-2	ZOETIS INC SR UNSECURED			1	2FE	998,680	100.2950	1,002,954	1,000,000	999,451	0	265	0	0	3.450	3.479	MN	4,600	34,500	11/09/2015	11/13/2020
01609W-AQ-5	ALIBABA GROUP HOLDING SR UNSECURED			D	1FE	991,560	98.1520	981,518	1,000,000	992,402	0	842	0	0	3.600	3.744	MN	3,300	36,000	04/04/2018	11/28/2024
034863-AR-1	ANGLO AMERICAN CAPITAL SR UNSECURED			D	2FE	1,449,510	96.1210	1,441,812	1,500,000	1,450,162	0	652	0	0	4.750	5.249	AO	16,031	0	11/06/2018	04/10/2027
056752-AK-4	BAIDU INC SR UNSECURED			D	1FE	999,020	99.6410	996,411	1,000,000	999,096	0	76	0	0	3.875	3.895	MS	9,903	19,375	03/22/2018	09/29/2023
251526-BR-9	DEUTSCHE BANK NY SR UNSECURED			D	2FE	1,497,105	94.3570	1,415,360	1,500,000	1,497,492	0	387	0	0	3.950	3.993	FA	20,408	29,625	02/22/2018	02/27/2023
46115H-AZ-0	INTESA SANPAOLO SPA SR UNSECURED			D	2FE	1,383,828	92.2480	1,383,726	1,500,000	1,383,828	0	12,473	142,310	0	3.125	2.909	JJ	21,745	46,875	08/01/2017	07/14/2022
552081-AG-6	LYONDELLBASELL IND NV SR UNSECURED			D	2FE	814,583	100.0650	731,478	731,000	731,773	0	(19,641)	0	0	5.000	2.265	AO	7,716	36,550	08/12/2014	04/15/2019
60687Y-AE-9	MIZUHO FINANCIAL GROUP SR UNSECURED			D	1FE	1,500,000	96.8780	1,453,166	1,500,000	1,500,000	0	0	0	0	2.273	2.273	MS	10,229	34,095	09/07/2016	09/13/2021
60687Y-AP-4	MIZUHO FINANCIAL GROUP SR UNSECURED			D	1FE	2,000,000	99.7200	1,994,402	2,000,000	2,000,000	0	0	0	0	3.549	3.549	MS	22,871	35,490	02/28/2018	03/05/2023
62854A-AM-6	MYLAN NV SR UNSECURED			D	2FE	2,497,398	97.9290	2,448,230	2,500,000	2,498,504	0	567	0	0	3.150	3.175	JD	3,500	78,750	01/31/2017	06/15/2021
67078A-AC-7	NVENT FINANCE SARL SR UNSECURED			D	2FE	1,996,728	99.3680	1,987,366	2,000,000	1,996,774	0	46	0	0	3.950	3.990	AO	16,678	0	10/16/2018	04/15/2023
822582-AV-4	SHELL INTERNATIONAL FIN SR UNSECURED			D	1FE	3,817,960	96.3530	3,854,136	4,000,000	3,841,397	0	23,437	0	0	2.250	3.313	JJ	43,750	45,000	05/09/2018	01/06/2023

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes 3	Codes 4	Codes 5	6	7	Fair Value 8	Fair Value 9	10	11	Change in Book/Adjusted Carrying Value 12	13	14	15	Interest 16	17	18	19	20	Dates 21	22
CUSIP Identification	Description	Code	Foreign	Bond Char	NAIC Designation and Administrative Symbol	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
3299999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations						149,607,814	XXX	146,993,784	150,818,000	147,742,856	(1,723,309)	30,295	221,449	0	XXX	XXX	XXX	1,548,820	3,363,667	XXX	XXX
17290Y-AR-9	CITIGROUP COMMERCIAL MTGE TR SERIES 2016-C1 CLASS A4			4	1FM	5,149,633	97.6130	4,880,658	5,000,000	5,113,787	0	(14,186)	0	0	3.209	2.871	MON	13,371	160,450	05/17/2016	05/10/2049
17324D-AU-8	CITIGROUP COMMERCIAL MORTGAGE SERIES 2015-P1 CLASS A5			4	1FM	514,976	100.7110	503,553	500,000	510,211	0	(1,472)	0	0	3.717	3.368	MON	1,549	18,585	08/06/2015	09/15/2048
46590M-AR-1	JP MORGAN CHASE COMMERCIAL MTG SERIES 2016-JP2 CLASS A4			4	1FM	5,149,980	94.9430	4,747,151	5,000,000	5,115,283	0	(14,576)	0	0	2.822	2.480	MON	11,758	141,090	07/08/2016	08/15/2049
90278L-AY-5	UBS COMMERCIAL MTGE TRUST SERIES 2018-C15 CLASS A4			4	1FE	1,030,000	104.2960	1,042,958	1,000,000	1,029,952	0	(48)	0	0	4.341	3.675	MON	3,617	0	12/18/2018	12/15/2051
95001N-AY-4	WELLS FARGO COMMERICAL MTGE TR SER 2018-C45 CLASS A4			4	1FM	2,574,800	103.4340	2,585,840	2,500,000	2,571,786	0	(3,014)	0	0	4.184	3.832	MON	8,717	43,583	06/28/2018	06/15/2051
3499999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Commercial Mortgage-Backed Securities						14,419,389	XXX	13,760,160	14,000,000	14,341,019	0	(33,296)	0	0	XXX	XXX	XXX	39,012	363,708	XXX	XXX
17305E-FR-1	CITIBANK CREDIT CARD ISS TR SERIES 2014-A5 CLASS A5			4	1FE	1,024,219	99.4130	994,129	1,000,000	1,010,665	0	(4,222)	0	0	2.680	2.227	JD	1,787	26,800	09/10/2015	06/07/2023
254683-BP-9	DISCOVER CARD MASTER TRUST SER 2015-A2 CLASS A			4	1FE	990,039	98.5040	985,041	1,000,000	997,183	0	2,133	0	0	1.900	2.131	MON	844	19,000	07/21/2015	10/17/2022
26252E-AC-3	DRYDEN SENIOR LOAN FUND SERIES 18-70A CLASS A2A			4	1FE	1,000,000	99.8920	998,921	1,000,000	1,000,000	0	0	0	0	3.936	4.327	JAJO	547	0	12/07/2018	01/16/2032
34528Q-GH-1	FORDF13-5 A1 SERIES 18-3 CLASS A1			4	1FE	999,777	101.1780	1,011,778	1,000,000	999,788	0	10	0	0	3.520	3.554	MON	1,564	3,520	11/06/2018	10/15/2023
43815H-AC-1	HONDA AUTO RECEIVABLES OWNER SER 18-3 CLASS A3			4	1FE	999,863	100.2150	1,002,146	1,000,000	999,880	0	17	0	0	2.950	2.974	MON	819	9,260	08/21/2018	08/22/2022
87165L-BB-6	SYNCHRONY CREDIT CARD MASTER SERIES 2016-2 CLASS A			4	1FE	1,999,922	98.0280	1,960,552	2,000,000	1,999,963	0	15	0	0	2.210	2.221	MON	1,964	44,200	05/20/2016	05/15/2024
87165L-BJ-9	SYNCHRONY CREDIT CARD MASTER SERIES 2016-3 CLASS A			4	1FE	4,999,447	99.0020	4,950,089	5,000,000	4,999,852	0	185	0	0	1.580	1.589	MON	3,511	79,000	09/14/2016	09/15/2022
92348X-AA-3	VERIZON OWNER TRUST SERIES 18-A CLASS A1A			4	1FE	1,749,973	100.6560	1,761,477	1,750,000	1,749,976	0	3	0	0	3.230	3.252	MON	1,727	10,991	10/02/2018	04/20/2023
3599999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Other Loan-Backed and Structured Securities						13,763,240	XXX	13,664,133	13,750,000	13,757,307	0	(1,859)	0	0	XXX	XXX	XXX	12,763	192,771	XXX	XXX
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						177,790,443	XXX	174,418,077	178,568,000	175,841,182	(1,723,309)	(4,860)	221,449	0	XXX	XXX	XXX	1,600,595	3,920,146	XXX	XXX
4899999. Total - Hybrid Securities						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
6099999. Subtotal - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
6599999. Subtotal -Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7799999. Total - Issuer Obligations						412,819,719	XXX	406,167,636	395,234,725	402,676,130	(1,990,270)	(2,192,202)	1,176,321	0	XXX	XXX	XXX	4,457,134	12,291,952	XXX	XXX
7899999. Total - Residential Mortgage-Backed Securities						10,397,077	XXX	10,170,441	9,943,489	10,358,683	0	(9,943)	0	0	XXX	XXX	XXX	32,153	305,681	XXX	XXX
7999999. Total - Commercial Mortgage-Backed Securities						14,419,389	XXX	13,760,160	14,000,000	14,341,019	0	(33,296)	0	0	XXX	XXX	XXX	39,012	363,708	XXX	XXX
8099999. Total - Other Loan-Backed and Structured Securities						15,047,660	XXX	14,943,069	14,950,000	14,980,254	0	(11,639)	0	0	XXX	XXX	XXX	30,430	252,771	XXX	XXX
8199999. Total - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8299999. Total - Bank Loans						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8399999 - Total Bonds						452,683,845	XXX	445,041,306	434,128,214	442,356,086	(1,990,270)	(2,247,080)	1,176,321	0	XXX	XXX	XXX	4,558,729	13,214,112	XXX	XXX

Schedule D - Part 2 - Section 1 - Preferred Stocks Owned

N O N E

Schedule D - Part 2 - Section 2 - Common Stocks Owned

N O N E

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 3

Showing All Long-Term Bonds and Stocks ACQUIRED During Current Year

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends
912828-3X-6	US TREASURY NOTE/BOND 2.250% 02/15/21		03/05/2018	MIZUHO SECURITIES USA		9,956,250	10,000,000	11,809
912828-4J-6	US TREASURY NOTE/BOND 2.375% 04/30/20		05/18/2018	MIZUHO SECURITIES USA		4,983,594	5,000,000	6,776
912828-4N-7	US TREASURY NOTE/BOND 2.875% 05/15/28		06/29/2018	MIZUHO SECURITIES USA		5,017,969	5,000,000	18,750
912828-5D-8	US TREASURY NOTE/BOND 2.875% 09/30/23		10/03/2018	MIZUHO SECURITIES USA		9,936,719	10,000,000	3,159
912828-5M-8	US TREASURY NOTE/BOND 3.125% 11/15/28		11/20/2018	Strategas Securities, LLC		2,014,063	2,000,000	1,036
0599999. Subtotal - Bonds - U.S. Governments						31,908,595	32,000,000	41,530
040114-HL-7	ARGENTINA REPUBLIC OF SR UNSECURED 6.875% 01/26/27	D	07/27/2018	Balanz Capital Intl Inc		643,300	700,000	535
298785-HH-1	EUROPEAN INV BANK SR UNSECURED 2.375% 05/24/27	D	03/02/2018	TD Securities (USA)		949,970	1,000,000	6,729
500769-GQ-1	KREDIT FUER WIEDERAUFBAU SR UNSECURED 2.000% 05/02/25	D	03/15/2018	RBS US		1,881,840	2,000,000	15,222
910860-AV-0	UNITED MEXICAN STATES SR UNSECURED 6.050% 01/11/40	D	03/14/2018	BARCLAYS INVEST 7254		2,239,600	2,000,000	21,847
91087B-AA-8	UNITED MEXICAN STATES SR UNSECURED 3.600% 01/30/25	D	10/30/2018	Amherst Pierpont Securities LL		474,250	500,000	4,550
EK1766-13-9	SUAM FINANCE BV SR UNSECURED 4.875% 04/17/24	D	09/10/2018	Lorrain Vial		1,008,000	1,000,000	19,635
1099999. Subtotal - Bonds - All Other Governments						7,196,960	7,200,000	68,518
181059-UY-0	CLARK CNTY NEV SCH DIST REF SER B 5.000% 06/15/26		11/07/2018	JPM-CHASE		5,370,493	4,750,000	95,000
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						5,370,493	4,750,000	95,000
3132XY-UX-3	FED HOME LOAN MTGE CORP GOLD POOL ND Q55997 4.000% 05/01/48		05/08/2018	Baird (Robert W)		4,905,354	4,809,171	6,947
3199999. Subtotal - Bonds - U.S. Special Revenues						4,905,354	4,809,171	6,947
00206R-DB-5	AT&T CORP SR UNSECURED 3.800% 03/15/22		04/20/2018	BANC AMERICA		5,052,900	5,000,000	20,583
00287Y-BE-8	ABBVIE INC SR UNSECURED 3.375% 11/14/21		09/13/2018	MORGAN STANLEY		1,996,560	2,000,000	0
013817-AU-5	ALCOA INC SR UNSECURED 6.150% 08/15/20		12/12/2018	Coventry Health Care (KS)		232,009	225,000	4,497
038522-AN-8	ARAMARK SERVICES INC SR UNSECURED 4.750% 06/01/26		12/17/2018	BARCLAY INVESTMENTS		965,000	1,000,000	2,375
038522-AQ-1	ARAMARK SERVICES INC SR UNSECURED 5.000% 02/01/28		01/10/2018	GOLDMAN SACHS & CO		1,000,000	1,000,000	0
05565E-AW-5	BMW US CAPITAL LLC SR UNSECURED 3.450% 04/12/23		06/07/2018	FIRST BOSTON CORP		1,491,885	1,500,000	8,481
07330N-AQ-8	BRANCH BANKING & TRUST SR UNSECURED 2.625% 01/15/22		04/26/2018	HSBC SEC INC		2,925,780	3,000,000	22,969
1248EP-BM-4	CCO HOLDINGS LLC CAP CORP SR UNSECURED 5.750% 02/15/26		04/03/2018	CHASE SECURITIES		2,000,000	2,000,000	15,972
14987R-AA-6	CB ESCROW CORP SR UNSECURED 8.000% 10/15/25		07/25/2018	BANC AMERICA		461,875	500,000	11,333
15189T-AU-1	CENTERPOINT ENERGY RESOU SR UNSECURED 3.850% 02/01/24		10/03/2018	GOLDMAN SACHS & CO		999,280	1,000,000	0
156700-AR-7	CENTURYTEL INC SR UNSECURED 6.450% 06/15/21		03/06/2018	CHASE SECURITIES		1,027,500	1,000,000	14,871
161175-BB-9	CHARTER COMM OPT LLC/CAP 1ST LIEN 4.464% 07/23/22		04/25/2018	FIRST BOSTON CORP		1,525,605	1,500,000	17,484
163851-AD-0	CHEMOURS CO SR UNSECURED 7.000% 05/15/25		01/03/2018	GOLDMAN SACHS & CO		1,092,500	1,000,000	9,722
16411Q-AC-5	CHENIERE ENERGY PARTNERS SR UNSECURED 5.625% 10/01/26		09/06/2018	CHASE SECURITIES		1,000,000	1,000,000	0
166764-BG-4	CHEVRON CORP SR UNSECURED 2.100% 05/16/21		04/25/2018	TD Securities (USA)		1,949,620	2,000,000	18,783
172967-KY-6	CITIGROUP INC. SR UNSECURED 3.200% 10/21/26		05/16/2018	FIRST BOSTON CORP		925,730	1,000,000	2,400
20030N-BX-8	COMCAST CORP SR UNSECURED 3.000% 02/01/24		07/06/2018	MORGAN STANLEY		479,875	500,000	6,625
20030N-CR-0	COMCAST CORP SR UNSECURED 3.700% 04/15/24		10/02/2018	WACHOVIA		999,940	1,000,000	0
228187-AA-8	CROWN AMER/CAP CORP VI SR UNSECURED 4.750% 02/01/26		12/10/2018	GOLDMAN SACHS & CO		1,209,375	1,250,000	21,606
228189-AB-2	CROWN AMER/CAP CORP IV SR UNSECURED 4.500% 01/15/23		12/06/2018	MORGAN STANLEY		990,000	1,000,000	18,125
22819K-AB-6	CROWN AMER/CAP CORP V SR UNSECURED 4.250% 09/30/26		12/10/2018	OPPENHEIMER & CO.		927,500	1,000,000	8,500
23283P-AK-0	CYRUSONE LP/CYRUSONE FIN SR UNSECURED 5.375% 03/15/27		09/26/2018	DAIN RAUSCHER INC-69211		2,026,260	2,000,000	3,882
23311V-AF-4	DCP MIDSTREAM OPERATING SR UNSECURED 5.600% 04/01/44		09/18/2018	CHASE SECURITIES		965,000	1,000,000	26,289
24422E-TL-3	DEERE JOHN CAP CORP SR UNSECURED 2.650% 01/06/22		05/03/2018	WACHOVIA		1,962,280	2,000,000	17,814
25278X-AC-3	DIAMONDBACK ENERGY INC SR UNSECURED 4.750% 11/01/24		09/18/2018	BANC AMERICA		997,500	1,000,000	19,000
25278X-AH-2	DIAMONDBACK ENERGY INC SR UNSECURED 5.375% 05/31/25		08/20/2018	Tax Free Exchange		1,036,233	1,000,000	11,944
26252E-AC-3	DRYDEN SENIOR LOAN FUND SERIES 18-70A CLASS A2A 3.936% 01/16/32		12/07/2018	BARCLAY INVESTMENTS		1,000,000	1,000,000	0
26441C-AJ-4	DUKE ENERGY CORP SR UNSECURED 3.050% 08/15/22		05/04/2018	Sumitomo Mitsui Financial Grp		1,968,580	2,000,000	14,064
29336U-AB-3	ENLINK MIDSTREAM PARTNER SR UNSECURED 4.400% 04/01/24		07/26/2018	BANC AMERICA		958,750	1,000,000	14,544
29336U-AD-9	ENLINK MIDSTREAM PARTNER SR UNSECURED 5.050% 04/01/45		07/27/2018	BLAIR WM & CO INC		261,555	318,000	5,353
30231G-AR-3	EXXON MOBIL CORP SR UNSECURED 2.726% 03/01/23		05/09/2018	MITSUBISHI		979,100	1,000,000	5,301
31677Q-BK-4	FIFTH THIRD BANCORP SR UNSECURED 2.200% 10/30/20		06/26/2018	MORGAN STANLEY		1,954,580	2,000,000	7,089
337738-AR-9	FISERV INC SR UNSECURED 4.200% 10/01/28		09/20/2018	WACHOVIA		998,050	1,000,000	0
34528Q-GH-1	FORDF13-5 A1 SERIES 18-3 CLASS A1 3.520% 10/15/23		11/06/2018	BANC AMERICA		999,777	1,000,000	0
404121-AG-0	HCA INC SR UNSECURED 5.875% 05/01/23		11/29/2018	CHASE SECURITIES		1,037,500	1,000,000	5,222
404121-AH-8	HCA INC SR UNSECURED 5.375% 09/01/26		09/06/2018	DEUTSCHE BANK		1,012,000	1,000,000	2,538
43815H-AC-1	HONDA AUTO RECEIVABLES OWNER SER 18-3 CLASS A3 2.950% 08/22/22		08/21/2018	BANC AMERICA		999,863	1,000,000	0
46647P-AU-0	JP MORGAN CHASE & CO SR UNSECURED 3.797% 07/23/24		07/16/2018	CHASE SECURITIES		2,000,000	2,000,000	0
55336V-AE-0	MPLX LP SR UNSECURED 4.500% 07/15/23		12/12/2018	Coventry Health Care (KS)		120,409	120,000	2,205
59001K-AD-2	MERITOR INC SR UNSECURED 6.250% 02/15/24		03/07/2018	BARCLAY INVESTMENTS		521,875	500,000	2,083
626717-AJ-1	MURPHY OIL CORP SR UNSECURED 5.750% 08/15/25		12/12/2018	GOLDMAN SACHS & CO		965,000	1,000,000	19,007
629377-CE-0	NRG ENERGY INC SR UNSECURED 5.750% 01/15/28		12/11/2018	GOLDMAN SACHS & CO		1,221,875	1,250,000	29,549
629568-AX-4	NABORS INDUSTRIES INC SR UNSECURED 4.625% 09/15/21		09/11/2018	DEUTSCHE BANK		730,620	738,000	16,877
62957H-AF-2	NABORS INDUSTRIES INC. SR UNSECURED 5.750% 02/01/25		09/27/2018	Tax Free Exchange		998,780	1,000,000	8,944
641062-AD-6	NESTLE HOLDINGS INC SR UNSECURED 3.350% 09/24/23		09/17/2018	BANC AMERICA		1,499,730	1,500,000	0
69353R-FC-7	PNC BANK NA SR UNSECURED 2.000% 05/19/20		05/15/2018	WACHOVIA		1,468,785	1,500,000	14,833
78390X-AA-9	SAIC INC SR UNSECURED 4.450% 12/01/20		12/12/2018	Coventry Health Care (KS)		501,375	500,000	680

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 3

Showing All Long-Term Bonds and Stocks ACQUIRED During Current Year

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends
816851-BA-6	SEMPRA ENERGY SR UNSECURED 3.250% 06/15/27		10/18/2018	CITIGROUP		2,765,190	3,000,000	34,396
86765L-AJ-6	SUNOCO LP/FINANCE CORP SR UNSECURED 4.875% 01/15/23		11/30/2018	Tax Free Exchange		1,004,943	1,000,000	18,281
86765L-AL-1	SUNOCO LP/FINANCE CORP SR UNSECURED 5.500% 02/15/26		11/30/2018	Tax Free Exchange		1,004,202	1,000,000	16,042
87612B-AP-7	TARGA RESOURCES PARTNERS SR UNSECURED 4.250% 11/15/23		12/12/2018	Coventry Health Care (KS)		474,560	500,000	1,594
88033G-CS-7	TENET HEALTHCARE CORP 1ST LIEN 4.625% 07/15/24		07/30/2018	Tax Free Exchange		963,814	1,000,000	1,927
880349-AR-6	TENNECO INC SR UNSECURED 5.000% 07/15/26		07/17/2018	CHASE SECURITIES		883,750	1,000,000	556
902494-BG-7	TYSON FOODS INC SR UNSECURED 3.900% 09/28/23		09/25/2018	MORGAN STANLEY		499,305	500,000	0
90278L-AY-5	UBS COMMERCIAL MTGE TRUST SERIES 2018-C15 CLASS A4 4.341% 12/15/51		12/18/2018	PAINE WEBBER		1,030,000	1,000,000	3,256
904764-BG-1	UNILEVER CAPITAL CORP SR UNSECURED 3.250% 03/07/24		09/04/2018	GOLDMAN SACHS & CO		992,780	1,000,000	0
91324P-DM-1	UNITEDHEALTH GROUP INC SR UNSECURED 3.500% 02/15/24		12/14/2018	MORGAN STANLEY		1,000,220	1,000,000	97
92348X-AA-3	VERIZON OWNER TRUST SERIES 18-A CLASS A1A 3.230% 04/20/23		10/02/2018	BANC AMERICA		1,749,973	1,750,000	0
94988J-5N-3	WELLS FARGO BANK NA SR UNSECURED 2.600% 01/15/21		05/03/2018	WACHOVIA		1,476,465	1,500,000	11,267
94988J-5T-0	WELLS FARGO BANK NA SR UNSECURED 3.625% 10/22/21		10/16/2018	WACHOVIA		1,999,780	2,000,000	0
95001N-AY-4	WELLS FARGO COMMERICAL MTGE TR SER 2018-C45 CLASS A4 4.184% 06/15/51		06/28/2018	WACHOVIA		2,574,800	2,500,000	4,649
960386-AN-0	WABTEC SR UNSECURED 4.150% 03/15/24		09/12/2018	BANC AMERICA		998,050	1,000,000	0
01609W-AQ-5	ALIBABA GROUP HOLDING SR UNSECURED 3.600% 11/28/24	D	04/04/2018	MORGAN STANLEY		991,560	1,000,000	12,800
034863-AR-1	ANGLO AMERICAN CAPITAL SR UNSECURED 4.750% 04/10/27	D	11/06/2018	CITIGROUP		1,449,510	1,500,000	5,542
056752-AK-4	BAIDU INC SR UNSECURED 3.875% 09/29/23	D	03/22/2018	GOLDMAN SACHS & CO		999,020	1,000,000	0
251526-BR-9	DEUTSCHE BANK NY SR UNSECURED 3.950% 02/27/23	D	02/22/2018	DEUTSCHE BANK		1,497,105	1,500,000	0
606817-AP-4	MIZUHO FINANCIAL GROUP SR UNSECURED 3.549% 03/05/23	D	02/28/2018	MIZUHO SECURITIES USA		2,000,000	2,000,000	0
67078A-AC-7	NVENT FINANCE SARL SR UNSECURED 3.950% 04/15/23	D	10/16/2018	Tax Free Exchange		1,996,728	2,000,000	219
822582-AV-4	SHELL INTERNATIONAL FIN SR UNSECURED 2.250% 01/06/23	D	05/09/2018	WACHOVIA		3,817,960	4,000,000	31,250
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						90,608,126	91,651,000	573,420
8399997. Total - Bonds - Part 3						139,989,528	140,410,171	785,415
8399998. Total - Bonds - Part 5						37,153,247	36,677,829	210,247
8399999. Total - Bonds						177,142,775	177,088,000	995,662
8999997. Total - Preferred Stocks - Part 3						0	XXX	0
8999998. Total - Preferred Stocks - Part 5						0	XXX	0
8999999. Total - Preferred Stocks						0	XXX	0
9799997. Total - Common Stocks - Part 3						0	XXX	0
9799998. Total - Common Stocks - Part 5						0	XXX	0
9799999. Total - Common Stocks						0	XXX	0
9899999. Total - Preferred and Common Stocks						0	XXX	0
9999999 - Totals						177,142,775	XXX	995,662

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identi-fication	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con-sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ Decrease	Current Year's (Amor-tization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con-tractual Maturity Date
3620AM-DZ-2	GOVT NATL MTGE ASSN I POOL NO GN733720 4.500% 06/15/40		12/01/2018	Paydown		597,426	597,426	657,915	655,808	0	(58,382)	0	(58,382)	0	597,426	0	0	0	12,192	06/15/2040
912828-Q4-5	US TREASURY NOTE/BOND 0.875% 03/31/18		04/02/2018	Maturity		16,725,000	16,725,000	16,702,209	16,702,907	0	22,093	0	22,093	0	16,725,000	0	0	0	73,172	03/31/2018
912828-RH-5	US TREASURY NOTE/BOND 1.375% 09/30/18		09/30/2018	Maturity		3,500,000	3,500,000	3,494,771	3,491,033	0	12,946	3,978	8,968	0	3,500,000	0	0	0	48,125	09/30/2018
912828-XA-3	US TREASURY NOTE/BOND 1.000% 05/15/18		05/15/2018	Maturity		3,000,000	3,000,000	2,997,624	2,996,092	0	4,925	1,017	3,908	0	3,000,000	0	0	0	15,000	05/15/2018
912828-XF-2	US TREASURY NOTE/BOND 1.125% 06/15/18		06/15/2018	Maturity		1,240,000	1,240,000	1,246,781	1,241,056	0	(1,056)	0	(1,056)	0	1,240,000	0	0	0	13,950	06/15/2018
0599999. Subtotal - Bonds - U.S. Governments						25,062,426	25,062,426	25,099,300	25,086,896	0	(19,474)	4,995	(24,469)	0	25,062,426	0	0	0	162,439	XXX
040114-GW-4	ARGENTINA REPUBLIC OF SR UNSECURED 6.875% 04/22/21	D	07/27/2018	Balanz Capital Intl Inc		706,464	704,000	704,000	704,000	0	0	0	0	0	704,000	0	2,464	2,464	37,376	04/22/2021
05990L-AA-2	BANCO DE COSTA RICA SR UNSECURED 5.250% 08/12/18	D	08/12/2018	Maturity		1,000,000	1,000,000	1,008,500	1,001,104	0	(1,104)	0	(1,104)	0	1,000,000	0	0	0	52,500	08/12/2018
195325-BQ-7	COLOMBIA REPUBLIC OF SR UNSECURED 4.000% 02/26/24	D	09/10/2018	Lorrain Vial		999,000	1,000,000	1,041,500	1,027,935	0	(2,988)	0	(2,988)	0	1,024,946	0	(25,946)	(25,946)	41,778	02/26/2024
486661-AG-6	KAZAKHSTAN REPUBLIC OF SR UNSECURED 5.125% 07/21/25	D	02/22/2018	MarketAxess		546,475	500,000	493,125	494,465	0	82	0	82	0	494,547	0	51,928	51,928	15,304	07/21/2025
500630-CK-2	KOREA DEV BANK SR UNSECURED 1.375% 09/12/19	D	05/03/2018	DAIN RAUSCHER INC-69211		1,465,950	1,500,000	1,497,450	1,498,535	0	298	0	298	0	1,498,834	0	(32,884)	(32,884)	13,464	09/12/2019
715638-BM-3	PERU REPUBLIC OF SR UNSECURED 5.625% 11/18/50	D	01/30/2018	Deutsche Bank - 2485 DTC		630,750	500,000	593,000	591,211	0	(111)	0	(111)	0	591,100	0	39,650	39,650	5,703	11/18/2050
71654Q-BZ-4	PETROLEOS MEXICANOS SR UNSECURED 5.500% 02/04/19	D	06/21/2018	MORGAN STANLEY		506,590	500,000	500,000	500,000	0	0	0	0	0	500,000	0	6,590	6,590	24,521	02/04/2019
91087B-AB-6	UNITED MEXICAN STATES SR UNSECURED 4.350% 01/15/47	D	05/03/2018	HSBC SEC INC		436,500	500,000	461,500	461,777	0	193	0	193	0	461,970	0	(25,470)	(25,470)	17,642	01/15/2047
V25125-BD-2	IVORY COAST SR UNSECURED 5.750% 12/31/32	D	12/31/2018	Redemption 100.0000		9,800	9,800	9,506	9,554	0	246	0	246	0	9,800	0	0	0	423	12/31/2032
EJ8700-24-1	AEROPUERTO INTL TOCUMEN SECURED 5.750% 10/09/23	D	12/17/2018	Call 102.9049		499,485	485,385	501,766	496,629	0	(1,883)	0	(1,883)	0	494,746	0	(9,361)	(9,361)	48,623	10/09/2023
P75744-AA-3	REPUBLIC OF PARAGUAY SR UNSECURED 4.625% 01/25/23	D	09/05/2018	JEFFRIES		509,000	500,000	511,250	507,130	0	(884)	0	(884)	0	506,246	0	2,754	2,754	25,823	01/25/2023
1099999. Subtotal - Bonds - All Other Governments						7,310,014	7,199,185	7,321,597	7,292,340	0	(6,151)	0	(6,151)	0	7,286,189	0	9,725	9,725	283,157	XXX
574193-EB-0	MARYLAND STATE OF ST AND LOCAL FACS 1ST SER B 4.000% 03/15/21		11/19/2018	MERRILL LYNCH-MUNI		1,025,040	1,000,000	1,103,500	1,037,903	0	(15,063)	0	(15,063)	0	1,022,840	0	2,200	2,200	47,333	03/15/2021
574193-KK-3	MARYLAND STATE OF SER 2 C REF 5.000% 08/01/21		04/12/2018	BARCLAY INVESTMENTS		1,097,420	1,000,000	1,184,990	1,114,235	0	(9,054)	0	(9,054)	0	1,105,181	0	(7,761)	(7,761)	35,417	08/01/2021
70914P-LB-6	PENNSYLVANIA ST GENERAL OBLIGA 5.000% 07/01/19		08/21/2018	GOLDMAN SACHS & CO		2,571,675	2,500,000	2,890,375	2,567,579	0	(28,622)	0	(28,622)	0	2,538,958	0	32,717	32,717	142,708	07/01/2019
1799999. Subtotal - Bonds - U.S. States, Territories and Possessions						4,694,135	4,500,000	5,178,865	4,719,717	0	(52,739)	0	(52,739)	0	4,666,979	0	27,156	27,156	225,458	XXX
249174-QV-8	DENVER COLORADO CITY AND CNTY REF 5.000% 12/01/25		02/15/2018	MORGAN STANLEY		2,230,500	2,000,000	2,383,760	2,266,900	0	(9,040)	0	(9,040)	0	2,257,860	0	(27,360)	(27,360)	21,944	12/01/2025
25476F-VK-1	COLUMBIA DIST OF SER D 5.000% 06/01/42		09/28/2018	Various		8,573,100	7,500,000	8,799,675	8,796,276	0	(52,540)	0	(52,540)	0	8,743,735	0	(170,635)	(170,635)	172,569	06/01/2042
442331-M7-6	HOUSTON TEX PREREFUNDED REF PUBLIC IMPT 5.000% 03/01/26		09/07/2018	MORGAN STANLEY		1,466,978	1,445,000	1,471,761	1,456,459	0	(6,755)	0	(6,755)	0	1,449,705	0	17,274	17,274	74,257	03/01/2026
64990E-N4-5	NEW YORK ST DORM AUTH ST PREREFUNDED GEN PURPOSE SER D 5.000% 02/15/20		02/15/2018	Mesirow Financial		490,990	460,000	529,165	493,908	0	(2,137)	0	(2,137)	0	491,771	0	(781)	(781)	11,819	02/15/2020
64990E-Q9-1	NEW YORK ST DORM AUTH ST UNREFUNDED GEN PURPOSE SER D 5.000% 02/15/20		12/04/2018	GOLDMAN SACHS & CO		560,007	540,000	621,194	579,805	0	(17,309)	0	(17,309)	0	562,496	0	(2,489)	(2,489)	35,325	02/15/2020
988176-JD-6	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 5.000% 08/01/23		02/22/2018	BARCLAY INVESTMENTS		115,197	100,000	117,471	117,446	0	(458)	0	(458)	0	116,988	0	(1,791)	(1,791)	806	08/01/2023
988176-JE-4	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 5.000% 08/01/24		02/22/2018	BARCLAY INVESTMENTS		187,246	160,000	191,686	191,648	0	(697)	0	(697)	0	190,951	0	(3,705)	(3,705)	1,289	08/01/2024
988176-JF-1	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 5.000% 08/01/25		02/22/2018	BARCLAY INVESTMENTS		236,986	200,000	244,266	244,220	0	(837)	0	(837)	0	243,384	0	(6,398)	(6,398)	1,611	08/01/2025
988176-JJ-3	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 5.000% 08/01/28		04/11/2018	PIPER, JAFFRAY & HOPWOOD		259,744	215,000	267,215	267,174	0	(1,403)	0	(1,403)	0	265,771	0	(6,027)	(6,027)	3,135	08/01/2028
988176-JK-0	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 3.000% 08/01/29		10/11/2018	FIDELITY CAPITAL MARKETS		330,813	335,000	346,882	346,873	0	(883)	0	(883)	0	345,990	0	(15,178)	(15,178)	8,012	08/01/2029

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identi-fication	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con-sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ Decrease	Current Year's (Amor-tization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con-tractual Maturity Date
988176-JL-8	YUBA COMMUNITY COLLEGE GENERAL OBLIGATION UNLTD 3.000% 08/01/30		03/15/2018	RAMIREZ		49,375	50,000	50,751	50,750	0	(17)	0	(17)	0	50,733	0	(1,358)	(1,358)	338	08/01/2030
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						14,500,936	13,005,000	15,023,826	14,811,459	0	(92,076)	0	(92,076)	0	14,719,384	0	(218,448)	(218,448)	331,105	XXX
187154-AX-7	CLIFTON TX HGR EDU FIN CORP RE REVENUE BONDS 5.000% 03/01/20		02/15/2018	WARBURG DILLON READ		1,331,975	1,250,000	1,531,813	1,336,802	0	(5,338)	0	(5,338)	0	1,331,463	0	512	512	29,340	03/01/2020
3132WJ-DV-0	FREDDIE MAC GOLD POOL POOL FG 044615 4.000% 10/01/46		05/08/2018	CITIGROUP		4,539,435	4,457,767	4,669,511	4,664,522	0	(2,056)	0	(2,056)	0	4,662,466	0	(123,031)	(123,031)	80,735	10/01/2046
3132WJ-DV-0	FREDDIE MAC GOLD POOL POOL FG 044615 4.000% 10/01/46		05/01/2018	Paydown		375,413	375,413	393,245	392,825	0	(17,412)	0	(17,412)	0	375,413	0	0	0	5,346	10/01/2046
3138X8-XG-1	FED NATL MTGE ASSN POOL NO AU8778 3.000% 10/01/28		12/01/2018	Paydown		410,706	410,706	425,658	422,514	0	(11,808)	0	(11,808)	0	410,706	0	0	0	6,810	10/01/2028
37580T-AH-9	GILLIAM CNTY ORE SOLID WASTE VAR-WASTE MGMT INC PROJ 1.500% 10/01/18		10/01/2018	Maturity		500,000	500,000	500,000	500,000	0	0	0	0	0	500,000	0	0	0	8,125	10/01/2018
57584X-BE-4	MASSACHUSETTS STATE DEV FIN REF-PARTNERS HEALTHCARE SYSTEM 5.000% 07/01/23		02/23/2018	Mesirow Financial		455,520	400,000	462,972	462,881	0	(1,697)	0	(1,697)	0	461,184	0	(5,664)	(5,664)	3,278	07/01/2023
57584X-BV-6	MASSACHUSETTS STATE DEV FIN REF-PARTNERS HEALTHCARE SYSTEM 4.000% 07/01/41		04/18/2018	PIPER, JAFFRAY & HOPWOOD		1,023,390	1,000,000	1,050,530	1,050,492	0	(1,329)	0	(1,329)	0	1,049,163	0	(25,773)	(25,773)	12,444	07/01/2041
57586P-6Q-4	MASSACHUSETTS ST HSG FIN AGY REVENUE BONDS 2.650% 12/01/41		10/08/2018	Call 100.0000		205,000	205,000	213,606	209,585	0	(454)	0	(454)	0	209,131	0	(4,131)	(4,131)	3,218	12/01/2041
64469N-AU-3	NEW HAMPSHIRE ST FEDERAL HIGHW REVENUE BONDS 5.000% 09/01/19		06/11/2018	Hilltop Securities		1,300,663	1,250,000	1,517,450	1,314,918	0	(17,347)	0	(17,347)	0	1,297,572	0	3,091	3,091	48,958	09/01/2019
646066-BW-9	NEW JERSEY ST EDUCTNL FAC AUTH HGR EDU CAPITAL IMPT FUND-SER 4.000% 09/01/18		09/01/2018	Maturity		5,700,000	5,700,000	5,921,388	5,749,524	0	(49,524)	0	(49,524)	0	5,700,000	0	0	0	228,000	09/01/2018
646139-Z2-4	NEW JERSEY ST TPK AUTH SER B 5.000% 01/01/20		09/14/2018	JPM-CHASE		1,560,510	1,500,000	1,710,810	1,599,991	0	(35,363)	0	(35,363)	0	1,564,629	0	(4,119)	(4,119)	91,042	01/01/2020
64971W-2T-6	NEW YORK CITY NY TRANSITIONAL REVENUE BONDS 5.000% 11/01/24		02/23/2018	Aegis Capital Corp		952,596	900,000	900,000	900,000	0	0	0	0	0	900,000	0	52,596	52,596	14,500	11/01/2024
67886M-MP-1	OKLAHOMA ST HSG FIN AGY SF MTG HOMEOWNERSHIP LN PG SER A 4.750% 03/01/28		11/01/2018	Call 100.0000		85,000	85,000	91,619	87,135	0	(426)	0	(426)	0	86,708	0	(1,708)	(1,708)	3,582	03/01/2028
68276F-AK-6	ONONDAGA CNTY NY TRUST CULTURA SYRACUSE UNIV PROJ - SER B 5.000% 12/01/19		03/01/2018	WARBURG DILLON READ		529,825	500,000	608,905	532,642	0	(2,994)	0	(2,994)	0	529,648	0	177	177	6,528	12/01/2019
74265L-UY-2	PRIVATE COLLEGES & UNIVS AUTH REVENUE BONDS 5.000% 09/01/19		03/02/2018	MORGAN STANLEY		325,884	310,000	388,002	329,481	0	(2,088)	0	(2,088)	0	327,393	0	(1,509)	(1,509)	7,965	09/01/2019
915138-KL-4	UNIVERSITY OF TOLEDO OH REVENUE BONDS 5.000% 06/01/18		06/01/2018	Maturity		1,265,000	1,265,000	1,494,585	1,283,781	0	(18,781)	0	(18,781)	0	1,265,000	0	0	0	31,625	06/01/2018
927781-A6-1	VIRGINIA COLLEGE BLDG AUTH VA REVENUE BONDS 5.000% 09/01/19		02/21/2018	Wachovia		526,390	500,000	624,030	530,224	0	(2,587)	0	(2,587)	0	527,637	0	(1,247)	(1,247)	11,944	09/01/2019
927793-D2-2	VIRGINIA TRANSPORTATION REF SER A 5.000% 05/15/24		03/16/2018	JPM-CHASE		1,159,650	1,000,000	1,176,570	1,175,343	0	(5,688)	0	(5,688)	0	1,169,655	0	(10,005)	(10,005)	13,333	05/15/2024
928172-J2-2	VIRGINIA ST PUB BLDG AUTH PUB SER A 5.000% 08/01/22		09/12/2018	GOLDMAN SACHS & CO		2,217,380	2,000,000	2,385,800	2,254,036	0	(37,422)	0	(37,422)	0	2,216,614	0	766	766	111,944	08/01/2022
3199999. Subtotal - Bonds - U.S. Special Revenues						24,464,337	23,608,886	26,066,494	24,796,696	0	(212,314)	0	(212,314)	0	24,584,382	0	(120,045)	(120,045)	718,717	XXX
00130H-BU-8	AES CORP SR UNSECURED 5.500% 03/15/24		03/21/2018	Corporate Actions		503,275	491,000	466,450	471,639	0	615	0	615	0	472,254	0	31,021	31,021	13,953	03/15/2024
00206R-CR-1	AT&T CORP SR UNSECURED 2.800% 02/17/21		04/20/2018	GOLDMAN SACHS & CO		4,939,150	5,000,000	5,112,950	5,074,848	0	(7,499)	0	(7,499)	0	5,067,350	0	(128,200)	(128,200)	96,056	02/17/2021
02665W-BF-7	AMERICAN HONDA FINANCE SR UNSECURED 1.650% 07/12/21		04/26/2018	WACHOVIA		1,908,620	2,000,000	1,999,340	1,999,524	0	31	0	31	0	1,999,555	0	(90,935)	(90,935)	26,400	07/12/2021
02665W-BG-5	AMERICAN HONDA FINANCE SR UNSECURED 1.700% 09/09/21		04/26/2018	WACHOVIA		2,382,925	2,500,000	2,495,000	2,496,248	0	328	0	328	0	2,496,575	0	(113,650)	(113,650)	27,271	09/09/2021
030981-AH-7	AMERIGAS PARTNERS LP SR UNSECURED 5.625% 05/20/24		02/14/2018	SUNTRUST CAP MARKETS		501,250	500,000	522,500	516,927	2,033	(340)	0	1,693	0	518,620	0	(17,370)	(17,370)	6,719	05/20/2024
042735-BB-5	ARROW ELECTRONICS INC SR UNSECURED 3.000% 03/01/18		03/01/2018	Maturity		500,000	500,000	505,080	500,174	0	(174)	0	(174)	0	500,000	0	0	0	7,500	03/01/2018
05531F-AV-5	BB&T CORPORATION SR UNSECURED 2.050% 05/10/21		04/26/2018	RBS US		2,898,810	3,000,000	2,996,880	2,997,837	0	227	0	227	0	2,998,064	0	(99,254)	(99,254)	29,042	05/10/2021
05565E-AK-1	BMW US CAPITAL LLC SR UNSECURED 1.450% 09/13/19		04/30/2018	RBS US		1,472,520	1,500,000	1,498,125	1,498,916	0	212	0	212	0	1,499,128	0	(26,608)	(26,608)	13,715	09/13/2019

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identi-fication	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con-sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ Decrease	Current Year's (Amor-tization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con-tractual Maturity Date
084664-CE-9	BERKSHIRE HATHAWAY FIN SR UNSECURED 1.450% 03/07/18		03/07/2018	Maturity		1,500,000	1,500,000	1,499,415	1,499,926	0	74	0	74	0	1,500,000	0	0	0	10,875	03/07/2018
12593A-BA-2	COMM MORTGAGE TRUST SERIES 2015-CR23 CLASS A4 3.497% 05/10/48		06/28/2018	DEUTSCHE BANK		1,986,563	2,000,000	2,059,836	2,045,306	0	(2,915)	0	(2,915)	0	2,042,392	0	(55,829)	(55,829)	40,993	05/10/2048
126650-CE-8	CVS CAREMARK CORP SR UNSECURED 2.250% 08/12/19		05/07/2018	US BANCORP		991,870	1,000,000	999,440	999,801	0	36	0	36	0	999,837	0	(7,967)	(7,967)	16,688	08/12/2019
161175-AX-2	CHARTER COMM OPT LLC/CAP 1ST LIEN 3.579% 07/23/20		04/25/2018	FIRST BOSTON CORP		1,503,555	1,500,000	1,500,000	1,500,000	0	0	0	0	0	1,500,000	0	3,555	3,555	40,860	07/23/2020
164110-AA-9	CHENIERE ENERGY PARTNERS SR UNSECURED 5.250% 10/01/25		07/16/2018	BANC AMERICA		993,750	1,000,000	1,000,000	1,000,000	0	0	0	0	0	1,000,000	0	(6,250)	(6,250)	43,750	10/01/2025
166764-BH-2	CHEVRON CORP SR UNSECURED 1.561% 05/16/19		04/25/2018	WACHOVIA		1,980,480	2,000,000	2,000,000	2,000,000	0	0	0	0	0	2,000,000	0	(19,520)	(19,520)	13,962	05/16/2019
172967-JN-2	CITIGROUP INC. SR UNSECURED 1.700% 04/27/18		04/27/2018	Maturity		1,000,000	1,000,000	996,830	999,633	0	367	0	367	0	1,000,000	0	0	0	8,500	04/27/2018
17305E-FS-9	CITIBANK CREDIT CARD ISS TR SER 2014-A6 CLASS A6 2.150% 07/15/21		06/07/2018	CITIGROUP		1,490,449	1,500,000	1,513,887	1,505,497	0	(1,579)	0	(1,579)	0	1,503,918	0	(13,469)	(13,469)	29,204	07/15/2021
198280-AB-5	COLUMBIA PIPELINE GROUP SR UNSECURED 2.450% 06/01/18		03/15/2018	US BANCORP		999,240	1,000,000	1,006,169	1,001,258	0	(674)	0	(674)	0	1,000,584	0	(1,344)	(1,344)	7,350	06/01/2018
20030N-BV-2	COMCAST CORP SENIOR UNSECURED 1.625% 01/15/22		04/27/2018	GOLDMAN SACHS & CO		941,980	1,000,000	999,010	999,260	0	53	0	53	0	999,313	0	(57,333)	(57,333)	12,910	01/15/2022
20826F-AS-5	CONOCOPHILLIPS COMPANY SR UNSECURED 4.200% 03/15/21		01/22/2018	Call 104.8680		838,944	800,000	799,600	799,697	0	10	0	10	0	799,708	0	292	292	50,797	03/15/2021
21036P-AH-1	CONSTELLATION BRANDS INC SR UNSECURED 6.000% 05/01/22		02/28/2018	Call 111.7638		480,584	430,000	466,013	450,060	0	(665)	0	(665)	0	449,395	0	(19,395)	(19,395)	58,969	05/01/2022
23283P-AN-4	CYRUSONE LP/CYRUSONE FIN SR UNSECURED 5.375% 03/15/27		01/05/2018	Tax Free Exchange		1,052,670	1,000,000	1,053,750	1,049,234	3,504	(68)	0	3,436	0	1,052,670	0	0	0	16,424	03/15/2027
24422E-TJ-8	DEERE JOHN CAP CORP SR UNSECURED 1.250% 10/09/19		05/03/2018	MITSUBISHI		1,958,420	2,000,000	1,995,960	1,997,652	0	462	0	462	0	1,998,114	0	(39,694)	(39,694)	14,444	10/09/2019
25272K-AD-5	DIAMOND 1 FIN / DIAMOND 2 PRIVATE PLACEMENT 4.420% 06/15/21		01/09/2018	GOLDMAN SACHS & CO		2,080,420	2,000,000	1,999,420	1,999,578	0	(18)	0	(18)	0	1,999,560	0	80,860	80,860	6,384	06/15/2021
25470X-AJ-4	DISH DBS CORP SR UNSECURED 5.875% 07/15/22		05/18/2018	BARCLAY INVESTMENTS		472,500	500,000	477,500	482,372	0	1,285	0	1,285	0	483,657	0	(11,157)	(11,157)	25,050	07/15/2022
25470X-AL-9	DISH DBS CORP SR UNSECURED 5.000% 03/15/23		04/30/2018	GOLDMAN SACHS & CO		517,500	600,000	541,505	553,810	2,734	2,619	16,816	(11,463)	0	542,347	0	(24,847)	(24,847)	18,917	03/15/2023
256746-AB-4	DOLLAR TREE INC SR UNSECURED 5.750% 03/01/23		05/05/2018	Call 104.3130		1,043,130	1,000,000	1,061,318	1,043,462	0	(332)	0	(332)	0	1,043,130	0	(43,130)	(43,130)	82,102	03/01/2023
26441C-AR-6	DUKE ENERGY CORP SR UNSECURED 1.800% 09/01/21		05/04/2018	MITSUBISHI		1,902,760	2,000,000	1,999,800	1,999,842	0	12	0	12	0	1,999,854	0	(97,094)	(97,094)	24,700	09/01/2021
26817R-AM-0	DYNEGY INC SR UNSECURED 6.750% 11/01/19		05/01/2018	Call 101.6880		307,098	302,000	302,000	302,000	0	0	0	0	0	302,000	0	0	0	15,290	11/01/2019
29273V-AF-7	ENERGY TRANSFER EQUITY 1ST LIEN 5.500% 06/01/27		10/16/2018	FIRST BOSTON CORP		515,625	500,000	498,750	498,941	0	60	0	60	0	499,001	0	16,624	16,624	24,215	06/01/2027
30231G-AP-7	EXXON MOBIL CORP SR UNSECURED 1.708% 03/01/19		05/09/2018	GOLDMAN SACHS & CO		994,550	1,000,000	1,000,000	1,000,000	0	0	0	0	0	1,000,000	0	(5,450)	(5,450)	11,861	03/01/2019
316770-BG-3	FIFTH THIRD BANCORP SR UNSECURED 2.250% 06/14/21		06/26/2018	MORGAN STANLEY		1,945,880	2,000,000	1,998,500	1,998,935	0	147	0	147	0	1,999,082	0	(53,202)	(53,202)	24,250	06/14/2021
345397-WL-3	FORD MOTOR CREDIT CO LLC SR UNSECURED 2.875% 10/01/18		10/01/2018	Maturity		1,000,000	1,000,000	999,630	999,915	0	85	0	85	0	1,000,000	0	0	0	28,750	10/01/2018
38141G-FG-4	GOLDMAN SACHS GROUP SR UNSECURED 5.950% 01/18/18		01/18/2018	Maturity		1,500,000	1,500,000	1,672,095	1,501,952	0	(1,952)	0	(1,952)	0	1,500,000	0	0	0	44,625	01/18/2018
382550-BF-7	GOODYEAR TIRE & RUBBER SR UNSECURED 5.000% 05/31/26		04/24/2018	BANC AMERICA		967,500	1,000,000	1,020,000	1,019,105	0	(835)	0	(835)	0	1,018,270	0	(50,770)	(50,770)	20,278	05/31/2026
406216-BC-4	HALLIBURTON CO SR UNSECURED 2.000% 08/01/18		08/01/2018	Maturity		1,000,000	1,000,000	999,290	999,906	0	94	0	94	0	1,000,000	0	0	0	20,000	08/01/2018
42824C-AU-3	HP ENTERPRISE SR UNSECURED 2.850% 10/05/18		06/29/2018	Call 100.1622		604,980	604,000	604,392	604,161	0	(129)	0	(129)	0	604,032	0	(32)	(32)	13,603	10/05/2018
42824C-AU-3	HP ENTERPRISE SR UNSECURED 2.850% 10/05/18		10/05/2018	Maturity		396,000	396,000	396,257	396,106	0	(106)	0	(106)	0	396,000	0	0	0	11,286	10/05/2018

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identi-fication	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con-sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ Decrease	Current Year's (Amor-tization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con-tractual Maturity Date
437076-BB-7	HOME DEPOT INC SR UNSEUCRED 2.250% 09/10/18		09/10/2018	Maturity		1,000,000	1,000,000	1,023,000	1,003,038	0	(3,038)	0	(3,038)	0	1,000,000	0	0	0	22,500	09/10/2018
50077L-AD-8	KRAFT HEINZ FOODS CO SR UNSECURED 3.000% 06/01/26		10/10/2018	MORGAN STANLEY		2,688,360	3,000,000	2,987,032	2,988,668	0	909	0	909	0	2,989,577	0	(301,217)	(301,217)	77,750	06/01/2026
513075-BE-0	LAMAR MEDIA CORP SR SUBORDINATED 5.000% 05/01/23		09/20/2018	CHASE SECURITIES		507,500	500,000	518,750	513,259	0	(2,756)	0	(2,756)	0	510,504	0	(3,004)	(3,004)	22,431	05/01/2023
527298-BM-4	LEVEL 3 FINANCING INC SR UNSECURED 5.250% 03/15/26		12/20/2018	MORGAN STANLEY		461,250	500,000	503,750	489,066	14,324	(469)	0	13,855	0	502,921	0	(41,671)	(41,671)	31,281	03/15/2026
53219L-AM-1	LIFEPOINT HOSPITALS INC SR UNSECURED 5.500% 12/01/21		11/16/2018	Corporate Actions		246,688	250,000	250,000	250,000	0	0	0	0	0	250,000	0	(3,313)	(3,313)	13,177	12/01/2021
539830-BJ-7	LOCKHEED MARTIN CORP SR UNSECURED 1.850% 11/23/18		11/23/2018	Maturity		1,000,000	1,000,000	998,290	999,473	0	527	0	527	0	1,000,000	0	0	0	18,500	11/23/2018
55342U-AG-9	MTP OPER PARTNERSHIP/FINL SR UNSECURED 5.250% 08/01/26		03/05/2018	MORGAN STANLEY		991,250	1,000,000	1,040,000	1,038,626	0	(935)	0	(935)	0	1,037,691	0	(46,441)	(46,441)	31,500	08/01/2026
553794-AA-6	MUFG AMERICAS HLDGS CORP SR UNSECURED 1.625% 02/09/18		02/09/2018	Maturity		1,000,000	1,000,000	999,330	999,965	0	35	0	35	0	1,000,000	0	0	0	8,125	02/09/2018
58769B-AD-6	MERCEDES-BENZ AUTO RECEIVABLES SERIES 16-1 CLASS A3 1.260% 02/16/21		01/17/2018	WACHOVIA		4,961,719	5,000,000	4,999,391	4,999,718	0	13	0	13	0	4,999,731	0	(38,012)	(38,012)	5,950	02/16/2021
64110L-AP-1	NETFLIX INC SR UNSECURED 4.875% 04/15/28		01/23/2018	FIRST BOSTON CORP		992,500	1,000,000	1,000,000	979,406	20,594	0	0	20,594	0	1,000,000	0	(7,500)	(7,500)	12,052	04/15/2028
65478H-AE-8	NISSAN AUTO RECEIVABLES OWNER SER 17-C CLASS A4 2.280% 02/15/24		05/03/2018	BARCLAY INVESTMENTS		3,181,953	3,250,000	3,249,985	3,249,983	0	2	0	2	0	3,249,985	0	(68,032)	(68,032)	29,228	02/15/2024
690872-AA-4	OWENS-BROCKWAY SR UNSECURED 5.000% 01/15/22		01/25/2018	DEUTSCHE BANK		523,125	500,000	503,750	502,245	0	(39)	0	(39)	0	502,206	0	20,920	20,920	7,222	01/15/2022
69353R-EV-6	PNC BANK NA SR UNSECURED 1.950% 03/04/19		05/15/2018	WACHOVIA		1,492,620	1,500,000	1,498,485	1,499,379	0	192	0	192	0	1,499,571	0	(6,951)	(6,951)	20,556	03/04/2019
771196-BA-9	ROCHE HLDGS INC SR UNSECURED 2.250% 09/30/19		01/16/2018	BARCLAY INVESTMENTS		999,490	1,000,000	998,540	999,455	0	15	0	15	0	999,470	0	20	20	6,750	09/30/2019
842587-CV-7	SOUTHERN CO SR UNSECURED 3.250% 07/01/26		10/18/2018	DEUTSCHE BANK		2,779,230	3,000,000	2,989,140	2,990,717	0	682	0	682	0	2,991,399	0	(212,169)	(212,169)	127,563	07/01/2026
845467-AH-2	SOUTHWESTERN ENERGY CO SR UNSECURED 4.100% 03/15/22		04/06/2018	FIRST BOSTON CORP		240,625	250,000	230,313	234,204	0	929	0	929	0	235,132	0	5,493	5,493	5,837	03/15/2022
87264A-AT-2	T MOBILE USA INC SR UNSECURED 5.375% 04/15/27		01/08/2018	DEUTSCHE BANK		268,750	250,000	261,875	261,012	0	(32)	0	(32)	0	260,980	0	7,770	7,770	3,173	04/15/2027
90521A-PJ-1	UNION BANK NA SR UNSECURED 2.625% 09/26/18		09/26/2018	Maturity		1,000,000	1,000,000	999,770	999,943	0	57	0	57	0	1,000,000	0	0	0	26,250	09/26/2018
911365-BH-6	UNITED RENTALS INC SR UNSECURED 4.625% 10/15/25		05/03/2018	FIRST BOSTON CORP		965,000	1,000,000	1,000,000	1,000,000	0	0	0	0	0	1,000,000	0	(35,000)	(35,000)	25,951	10/15/2025
912909-AK-4	US STEEL CORP 1ST LIEN 8.375% 07/01/21		04/12/2018	Call 107.5125		427,900	398,000	402,478	400,949	0	60	0	60	0	401,009	0	(3,009)	(3,009)	55,918	07/01/2021
92347X-AA-4	VERIZON OWNER TRUST SERIES 16-1A CLASS A 1.420% 01/20/21		01/10/2018	WACHOVIA		992,461	1,000,000	999,832	999,924	0	2	0	2	0	999,926	0	(7,465)	(7,465)	868	01/20/2021
92936Y-AF-8	WF-RBS COMMERCIAL MTGE TRUST SERIES 2012-C8 CLASS B 4.311% 08/15/45		03/06/2018	Baird (Robert W)		511,523	500,000	541,250	533,210	0	(1,314)	0	(1,314)	0	531,896	0	(20,372)	(20,372)	5,808	08/15/2045
94974B-FG-0	WELLS FARGO CO SR UNSECURED 1.500% 01/16/18		01/16/2018	Maturity		1,000,000	1,000,000	969,030	999,680	0	320	0	320	0	1,000,000	0	0	0	7,500	01/16/2018
958102-AJ-4	WESTERN DIGITAL CORP SECURED 7.375% 04/01/23		03/01/2018	Call 108.7260		1,630,890	1,500,000	1,523,125	1,515,731	0	2,025	0	2,025	0	1,517,756	0	(17,756)	(17,756)	176,984	04/01/2023
225433-AT-8	CRED SUIS GP FUN LTD SR UNSECURED 3.800% 06/09/23	D	10/16/2018	FIRST BOSTON CORP		2,460,200	2,500,000	2,493,187	2,494,236	0	720	0	720	0	2,494,955	0	(34,755)	(34,755)	81,278	06/09/2023
46115H-AZ-0	INTESA SANPAOLO SPA SR UNSECURED 3.125% 07/14/22	D	09/19/2018	BNP PARIBAS		1,398,914	1,500,000	1,377,858	1,513,665	0	4,756	134,400	(129,644)	0	1,384,020	0	14,894	14,894	55,594	07/14/2022
75625Q-AA-7	RECKITT BENCKISER TSY SR UNSECURED 2.125% 09/21/18	D	09/21/2018	Maturity		1,500,000	1,500,000	1,490,130	1,498,481	0	1,519	0	1,519	0	1,500,000	0	0	0	31,875	09/21/2018
81180W-AP-6	SEAGATE HDD CAYMAN SR UNSECURED 3.750% 11/15/18	D	11/15/2018	Maturity		1,000,000	1,000,000	1,000,000	1,000,000	0	0	0	0	0	1,000,000	0	0	0	37,500	11/15/2018
822582-BA-9	SHELL INTERNATIONAL FIN SR UNSECURED 2.000% 11/15/18	D	11/15/2018	Maturity		1,000,000	1,000,000	999,720	999,940	0	60	0	60	0	1,000,000	0	0	0	20,000	11/15/2018
822582-BM-3	SHELL INTERNATIONAL FIN SR UNSECURED 1.625% 11/10/18	D	05/09/2018	WACHOVIA		996,240	1,000,000	989,840	996,909	0	1,298	0	1,298	0	998,207	0	(1,967)	(1,967)	8,170	11/10/2018
822582-BR-2	SHELL INTERNATIONAL FIN SR UNSECURED 1.375% 05/10/19	D	05/09/2018	WACHOVIA		2,967,270	3,000,000	2,993,340	2,996,934	0	820	0	820	0	2,997,754	0	(30,484)	(30,484)	20,740	05/10/2019

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identi-fication	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con-sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ Decrease	Current Year's (Amor-tization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con-tractual Maturity Date
82620K-AB-9	SIEMENS FINANCIERINGSMAT SR UNSECURED 1.450% 05/25/18	D	05/25/2018	Maturity		1,000,000	1,000,000	999,800	999,964	0	36	0	36	0	1,000,000	0	0	0	7,250	05/25/2018
82620K-AH-6	SIEMENS FINANCIERINGSMAT SR UNSECURED 1.300% 09/13/19	D	05/07/2018	WACHOVIA		1,958,940	2,000,000	1,997,420	1,998,512	0	307	0	307	0	1,998,819	0	(39,879)	(39,879)	17,044	09/13/2019
83368R-AD-4	SOCIETE GENERALE SR UNSECURED 2.625% 10/01/18	D	10/01/2018	Maturity		1,000,000	1,000,000	998,330	999,714	0	286	0	286	0	1,000,000	0	0	0	26,250	10/01/2018
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						93,217,396	94,521,000	94,883,433	94,749,528	43,189	(3,582)	151,216	(111,609)	0	94,637,919	0	(1,720,048)	(1,720,048)	2,006,268	XXX
8399997. Total - Bonds - Part 4						169,249,244	167,896,497	173,573,515	171,456,636	43,189	(386,336)	156,211	(499,358)	0	170,957,279	0	(2,021,660)	(2,021,660)	3,727,144	XXX
8399998. Total - Bonds - Part 5						36,654,159	36,677,829	37,153,247	0	0	(41,980)	29,879	(71,859)	0	37,081,387	0	(427,228)	(427,228)	876,164	XXX
8399999. Total - Bonds						205,903,403	204,574,326	210,726,762	171,456,636	43,189	(428,316)	186,090	(571,217)	0	208,038,666	0	(2,448,888)	(2,448,888)	4,603,308	XXX
8999997. Total - Preferred Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
8999998. Total - Preferred Stocks - Part 5						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
8999999. Total - Preferred Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9799997. Total - Common Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9799998. Total - Common Stocks - Part 5						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9799999. Total - Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9999999 - Totals						205,903,403	XXX	210,726,762	171,456,636	43,189	(428,316)	186,090	(571,217)	0	208,038,666	0	(2,448,888)	(2,448,888)	4,603,308	XXX

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 5

Showing All Long-Term Bonds and Stocks ACQUIRED During Year and Fully DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	11	Change in Book/Adjusted Carrying Value					17	18	19	20	21
											12	13	14	15	16					
CUSIP Identi-fication	Description	For-eign	Date Acquired	Name of Vendor	Disposal Date	Name of Purchaser	Par Value (Bonds) or Number of Shares (Stock)	Actual Cost	Consid-eration	Book/ Adjusted Carrying Value at Disposal	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amort-ization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Valu (12 + 13 - 14)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Interest and Dividends Received During Year	Paid for Accrued Interest and Dividends
912810-RZ-3	US TREASURY NOTE/BOND 2.750% 11/15/47		01/30/2018	MIZUHO SECURITIES USA	05/29/2018	MIZUHO SECURITIES USA	5,000,000	4,806,250	4,777,344	4,777,902	0	1,532	29,879	(28,347)	0	0	(559)	(559)	74,355	29,247
0599999. Subtotal - Bonds - U.S. Governments							5,000,000	4,806,250	4,777,344	4,777,902	0	1,532	29,879	(28,347)	0	0	(559)	(559)	74,355	29,247
71654Q-CA-8	PETROLEOS MEXICANOS SR UNSECURED 6.375% 02/04/21	D	06/21/2018	HSBC SEC INC	07/24/2018	GOLDMAN SACHS & CO	500,000	521,750	525,000	521,094	0	(656)	0	(656)	0	0	3,906	3,906	15,229	12,484
91087B-AE-0	UNITED MEXICAN STATES SR UNSECURED 3.750% 01/11/28	D	05/03/2018	HSBC SEC INC	10/30/2018	Amherst Pierpont Securities LL	500,000	469,000	461,500	470,247	0	1,247	0	1,247	0	0	(8,747)	(8,747)	15,104	6,042
1099999. Subtotal - Bonds - All Other Governments							1,000,000	990,750	986,500	991,341	0	591	0	591	0	0	(4,841)	(4,841)	30,333	18,526
25476F-VK-1	COLUMBIA DIST OF SER D 5.000% 06/01/42		03/06/2018	DAIN RAUSCHER INC-69211	10/03/2018	Wachovia	5,000,000	5,731,350	5,625,500	5,691,923	0	(39,427)	0	(39,427)	0	0	(66,423)	(66,423)	196,181	53,472
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions							5,000,000	5,731,350	5,625,500	5,691,923	0	(39,427)	0	(39,427)	0	0	(66,423)	(66,423)	196,181	53,472
3132XY-UX-3	FED HOME LOAN MTGE CORP GOLD POOL NO G55997 4.000% 05/01/48		05/08/2018	Baird (Robert W)	12/01/2018	Paydown	190,829	194,646	190,829	190,829	0	(3,817)	0	(3,817)	0	0	0	0	2,476	276
646139-Z2-4	NEW JERSEY ST TPK AUTH SER B 5.000% 01/01/20		03/01/2018	Wachovia	09/14/2018	JPM-CHASE	15,000	15,890	15,605	15,631	0	(259)	0	(259)	0	0	(25)	(25)	535	133
3199999. Subtotal - Bonds - U.S. Special Revenues							205,829	210,536	206,434	206,460	0	(4,076)	0	(4,076)	0	0	(25)	(25)	3,011	409
05565E-AU-9	BMW US CAPITAL LLC SR UNSECURED 3.100% 04/12/21		04/30/2018	WACHOVIA	06/07/2018	FIRST BOSTON CORP	1,500,000	1,495,635	1,494,420	1,495,765	0	130	0	130	0	0	(1,345)	(1,345)	7,621	2,583
17325F-AL-2	CITIBANK NA SR UNSECURED 2.850% 02/12/21		02/08/2018	CITIGROUP	05/16/2018	FIRST BOSTON CORP	1,000,000	999,940	985,860	999,920	0	(20)	0	(20)	0	0	(14,060)	(14,060)	7,363	0
20030N-BR-1	COMCAST CORP SR UNSECURED 2.750% 03/01/23		04/27/2018	DAIN RAUSCHER INC-69211	07/06/2018	Various	1,000,000	968,450	959,815	969,377	0	927	0	927	0	0	(9,562)	(9,562)	8,823	4,583
23283P-AK-0	CYRUSONE LP/CYRUSONE FIN SR UNSECURED 5.375% 03/15/27		01/05/2018	Tax Free Exchange	01/29/2018	MORGAN STANLEY	1,000,000	1,052,670	1,040,000	1,052,236	0	(434)	0	(434)	0	0	(12,236)	(12,236)	20,306	16,424
247916-AL-3	DENBURY RESOURCES INC 2ND LIEN 7.500% 02/15/24		08/14/2018	CHASE SECURITIES	08/17/2018	MIZUHO SECURITIES USA	1,000,000	1,000,000	1,003,750	1,000,000	0	0	0	0	0	0	3,750	3,750	0	0
25278X-AJ-8	DIAMONDBACK ENERGY INC SR UNSECURED 5.375% 05/31/25		01/24/2018	WACHOVIA	08/20/2018	Tax Free Exchange	1,000,000	1,040,000	1,036,233	1,036,233	0	(3,767)	0	(3,767)	0	0	0	0	38,819	8,809
25470X-AY-1	DISH DBS CORP SR UNSECURED 7.750% 07/01/26		09/24/2018	FIRST BOSTON CORP	11/15/2018	DEUTSCHE BANK	1,000,000	933,750	870,000	934,689	0	939	0	939	0	0	(64,689)	(64,689)	29,708	18,299
29273V-AF-7	ENERGY TRANSFER EQUITY 1ST LIEN 5.500% 06/01/27		03/16/2018	MORGAN STANLEY	10/16/2018	FIRST BOSTON CORP	1,000,000	1,025,000	1,031,250	1,023,726	0	(1,274)	0	(1,274)	0	0	7,524	7,524	48,431	16,653
36159J-DL-2	G E CAP CREDIT CARD MASTER TR SERIES 2012-7 CLASS A 1.760% 09/15/22		06/07/2018	WACHOVIA	08/14/2018	CITIGROUP	1,710,000	1,687,556	1,689,961	1,690,721	0	3,165	0	3,165	0	0	(760)	(760)	7,607	2,174
53219L-AN-9	LIFEPOINT HOSPITALS INC SR UNSECURED 5.875% 12/01/23		01/31/2018	CHASE SECURITIES	07/23/2018	WARBURG	1,000,000	1,006,250	1,040,000	1,005,533	0	(717)	0	(717)	0	0	34,467	34,467	38,188	9,955
629568-AX-4	NABORS INDUSTRIES INC SR UNSECURED 4.625% 09/15/21		09/11/2018	DEUTSCHE BANK	12/11/2018	MarketAxess	262,000	259,380	243,005	259,566	0	186	0	186	0	0	(16,561)	(16,561)	9,021	5,991
62957H-AC-9	NABORS INDUSTRIES INC. SR UNSECURED 5.500% 01/15/23		03/01/2018	GOLDMAN SACHS & CO	11/26/2018	MIZUHO SECURITIES USA	1,000,000	995,000	900,000	995,661	0	661	0	661	0	0	(95,661)	(95,661)	47,819	7,639
62957H-AD-7	NABORS INDUSTRIES INC. SR UNSECURED 5.750% 02/01/25		01/17/2018	GOLDMAN SACHS & CO	09/27/2018	Tax Free Exchange	1,000,000	998,750	998,780	998,780	0	30	0	30	0	0	0	0	38,972	0
78454L-AP-5	SM ENERGY CO SR UNSECURED 6.625% 01/15/27		08/06/2018	BANC AMERICA	11/20/2018	BARCLAY INVESTMENTS	1,000,000	1,000,000	950,000	1,000,000	0	0	0	0	0	0	(50,000)	(50,000)	17,115	0
86765L-AH-0	SUNCOO LP/FINANCE CORP SR UNSECURED 4.875% 01/15/23		01/10/2018	FIRST BOSTON CORP	11/30/2018	Tax Free Exchange	1,000,000	1,006,250	1,004,943	1,004,943	0	(1,307)	0	(1,307)	0	0	0	0	41,573	0
86765L-AK-3	SUNCOO LP/FINANCE CORP SR UNSECURED 5.500% 02/15/26		01/10/2018	FIRST BOSTON CORP	11/30/2018	Tax Free Exchange	1,000,000	1,005,000	1,004,202	1,004,202	0	(798)	0	(798)	0	0	0	0	46,903	0
87470L-AE-1	TALLGRASS NRG PRTNR/FIN SR UNSECURED 4.750% 10/01/23		09/24/2018	WACHOVIA	09/24/2018	CITIGROUP	1,000,000	1,000,000	1,000,000	1,000,000	0	0	0	0	0	0	0	0	0	0
88033G-CR-9	TENET HEALTHCARE CORP 1ST LIEN 4.625% 07/15/24		07/23/2018	DAIN RAUSCHER INC-69211	07/30/2018	Tax Free Exchange	1,000,000	963,750	963,814	963,814	0	64	0	64	0	0	0	0	1,927	1,285
912909-AN-8	US STEEL CORP SR UNSECURED 6.250% 03/15/26		03/13/2018	CHASE SECURITIES	09/06/2018	CITIGROUP	1,000,000	1,000,000	988,750	1,000,000	0	0	0	0	0	0	(11,250)	(11,250)	30,382	0
958102-AM-7	WESTERN DIGITAL CORP SR UNSECURED 4.750% 02/15/26		01/30/2018	BANC AMERICA	03/16/2018	CITIGROUP	1,000,000	1,000,000	1,002,500	1,000,000	0	0	0	0	0	0	2,500	2,500	4,882	0

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 5

Showing All Long-Term Bonds and Stocks ACQUIRED During Year and Fully DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	11	Change in Book/Adjusted Carrying Value					17	18	19	20	21
											12	13	14	15	16					
CUSIP Identi-fication	Description	For-eign	Date Acquired	Name of Vendor	Disposal Date	Name of Purchaser	Par Value (Bonds) or Number of Shares (Stock)	Actual Cost	Consid-eration	Book/ Adjusted Carrying Value at Disposal	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amort-ization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Valu (12 + 13 - 14)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Interest and Dividends Received During Year	Paid for Accrued Interest and Dividends
984121-CQ-4	XEROX CORP SR UNSECURED 3.625% 03/15/23		01/31/2018	MORGAN STANLEY	07/26/2018	FIRST BOSTON CORP	1,000,000	989,740	954,140	990,644	0	904	0	904	0	0	(36,504)	(36,504)	32,122	14,198
034863-AU-4	ANGLO AMERICAN CAPITAL SR UNSECURED 4.500% 03/15/28	D	03/13/2018	MORGAN STANLEY	11/06/2018	Various	2,000,000	1,990,920	1,900,230	1,991,223	0	303	0	303	0	0	(90,993)	(90,993)	50,813	0
67078A-AA-1	NVENT FINANCE SARL SR UNSECURED 3.950% 04/15/23	D	03/12/2018	BANC AMERICA	10/16/2018	Tax Free Exchange	2,000,000	1,996,320	1,996,728	1,996,728	0	408	0	408	0	0	0	0	43,889	0
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)							25,472,000	25,414,361	25,058,381	25,413,761	0	(600)	0	(600)	0	0	(355,380)	(355,380)	572,284	108,593
8399998. Total - Bonds							36,677,829	37,153,247	36,654,159	37,081,387	0	(41,980)	29,879	(71,859)	0	0	(427,228)	(427,228)	876,164	210,247
8999998. Total - Preferred Stocks								0	0	0	0	0	0	0	0	0	0	0	0	0
9799998. Total - Common Stocks								0	0	0	0	0	0	0	0	0	0	0	0	0
9899999. Total - Preferred and Common Stocks								0	0	0	0	0	0	0	0	0	0	0	0	0
9999999 - Totals								37,153,247	36,654,159	37,081,387	0	(41,980)	29,879	(71,859)	0	0	(427,228)	(427,228)	876,164	210,247

Schedule D-Part 6-Section 1-Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

N O N E

Schedule D - Part 6 - Section 2

N O N E

Schedule DA - Part 1 - Short-Term Investments Owned

N O N E

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part A - Section 2 - Options, Caps, Floors, Collars, Swaps and Forwards Terminated

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part B - Section 2 - Futures Contracts Terminated

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

SCHEDULE E - PART 1 - CASH

1 Depository	2 Code	3 Rate of Interest	4 Amount of Interest Received During Year	5 Amount of Interest Accrued December 31 of Current Year	6 Balance	7 *
Bank of America Charlotte, NC		0.000	0	0	7,176,597	XXX
0199998 Deposits in ... 1 depositories which do not exceed the allowable limit in any one depository (See instructions) - open depositories	XXX	XXX	0	0	(42,903)	XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	7,133,694	XXX
0299998 Deposits in ... 0 depositories which do not exceed the allowable limit in any one depository (See instructions) - suspended depositories	XXX	XXX	0	0	0	XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	7,133,694	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX	0	XXX
0599999 Total - Cash	XXX	XXX	0	0	7,133,694	XXX

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR

1. January	3,997,960	4. April	(414,962)	7. July	12,563,816	10. October	11,527,714
2. February	1,893,252	5. May	7,242,080	8. August	8,515,038	11. November	19,381,733
3. March	5,524,040	6. June	5,461,736	9. September	2,679,643	12. December	7,133,694

ANNUAL STATEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned December 31 of Current Year

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
0599999. Total - U.S. Government Bonds						0	0	0
1099999. Total - All Other Government Bonds						0	0	0
1799999. Total - U.S. States, Territories and Possessions Bonds						0	0	0
2499999. Total - U.S. Political Subdivisions Bonds						0	0	0
3199999. Total - U.S. Special Revenues Bonds						0	0	0
	CBS CORPORATION CP 4 (2) 144A		12/31/2018	2.850	01/10/2019	1,000,287	0	79
	EVERSOURCE ENERGY CP 4(2) 144A		12/28/2018	2.750	01/07/2019	3,341,467	0	1,021
	SONOCO PRODUCTS CP 3(A)3		12/31/2018	2.650	01/02/2019	3,036,776	0	224
	SOUTHERN COMPANY FUNDING CORP CP 4(2) 144A		12/28/2018	2.900	01/07/2019	4,107,013	0	1,323
3299999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations						11,485,543	0	2,647
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						11,485,543	0	2,647
4899999. Total - Hybrid Securities						0	0	0
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0
6099999. Subtotal - SVO Identified Funds						0	0	0
6599999. Subtotal - Bank Loans						0	0	0
7799999. Total - Issuer Obligations						11,485,543	0	2,647
7899999. Total - Residential Mortgage-Backed Securities						0	0	0
7999999. Total - Commercial Mortgage-Backed Securities						0	0	0
8099999. Total - Other Loan-Backed and Structured Securities						0	0	0
8199999. Total - SVO Identified Funds						0	0	0
8299999. Total - Bank Loans						0	0	0
8399999. Total Bonds						11,485,543	0	2,647
60934N-50-0	FEDERATED INVESTORS INC TREASURY OBLIGATION FUND		12/31/2018	0.000		1,039	7	214
8599999. Subtotal - Exempt Money Market Mutual Funds - as Identified by the SVO						1,039	7	214
8899999 - Total Cash Equivalents						11,486,582	7	2,861

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

	1	2	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3	4	5	6
States, Etc.	Type of Deposit	Purpose of Deposit	Book/Adjusted Carrying Value	Fair Value	Book/Adjusted Carrying Value	Fair Value
1. Alabama AL			0	0	0	0
2. Alaska AK			0	0	0	0
3. Arizona AZ			0	0	0	0
4. Arkansas AR			0	0	0	0
5. California CA			0	0	0	0
6. Colorado CO			0	0	0	0
7. Connecticut CT			0	0	0	0
8. Delaware DE			0	0	0	0
9. District of Columbia DC			0	0	0	0
10. Florida FL			0	0	0	0
11. Georgia GA			0	0	0	0
12. Hawaii HI			0	0	0	0
13. Idaho ID			0	0	0	0
14. Illinois IL			0	0	0	0
15. Indiana IN			0	0	0	0
16. Iowa IA			0	0	0	0
17. Kansas KS			0	0	0	0
18. Kentucky KY	B	RSD by INS CODE KRS 304.3.120	1,224,310	1,233,644	0	0
19. Louisiana LA			0	0	0	0
20. Maine ME			0	0	0	0
21. Maryland MD			0	0	0	0
22. Massachusetts MA			0	0	0	0
23. Michigan MI			0	0	0	0
24. Minnesota MN			0	0	0	0
25. Mississippi MS			0	0	0	0
26. Missouri MO			0	0	0	0
27. Montana MT			0	0	0	0
28. Nebraska NE			0	0	0	0
29. Nevada NV			0	0	0	0
30. New Hampshire NH			0	0	0	0
31. New Jersey NJ			0	0	0	0
32. New Mexico NM			0	0	0	0
33. New York NY			0	0	0	0
34. North Carolina NC			0	0	0	0
35. North Dakota ND			0	0	0	0
36. Ohio OH			0	0	0	0
37. Oklahoma OK			0	0	0	0
38. Oregon OR			0	0	0	0
39. Pennsylvania PA			0	0	0	0
40. Rhode Island RI			0	0	0	0
41. South Carolina SC			0	0	0	0
42. South Dakota SD			0	0	0	0
43. Tennessee TN			0	0	0	0
44. Texas TX			0	0	0	0
45. Utah UT			0	0	0	0
46. Vermont VT			0	0	0	0
47. Virginia VA			0	0	0	0
48. Washington WA			0	0	0	0
49. West Virginia WV			0	0	0	0
50. Wisconsin WI			0	0	0	0
51. Wyoming WY			0	0	0	0
52. American Samoa AS			0	0	0	0
53. Guam GU			0	0	0	0
54. Puerto Rico PR			0	0	0	0
55. U.S. Virgin Islands VI			0	0	0	0
56. Northern Mariana Islands MP			0	0	0	0
57. Canada CAN			0	0	0	0
58. Aggregate Alien and Other OT	XXX	XXX	0	0	0	0
59. Subtotal	XXX	XXX	1,224,310	1,233,644	0	0
DETAILS OF WRITE-INS						
5801.						
5802.						
5803.						
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX	0	0	0	0
5899. Totals (Lines 5801 thru 5803 plus 5898)(Line 58 above)	XXX	XXX	0	0	0	0

SUPPLEMENT FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

DIRECT BUSINESS IN THE STATE OF | DURING THE YEAR 2018

NAIC Group Code 0001 | NAIC Company Code 15761

LIFE INSURANCE

DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS	1 Ordinary	2 Credit Life (Group and Individual)	3 Group	4 Industrial	5 Total
1. Life insurance					
2. Annuity considerations					
3. Deposit-type contract funds		XXX		XXX	
4. Other considerations					
5. Totals (Sum of Lines 1 to 4)					
DIRECT DIVIDENDS TO POLICYHOLDERS					
Life insurance:					
6.1 Paid in cash or left on deposit					
6.2 Applied to pay renewal premiums					
6.3 Applied to provide paid-up additions or shorten the endowment or premium-paying period					
6.4 Other					
6.5 Totals (sum of Line 6.1 to 6.4)					
Annuities:					
7.1 Paid in cash or left on deposit					
7.2 Applied to provide paid-up annuities					
7.3 Other					
7.4 Totals (sum of Lines 7.1 to 7.3)					
8. Grand Totals (Lines 6.5 plus 7.4)					
DIRECT CLAIMS AND BENEFITS PAID					
9. Death benefits					
10. Matured endowments					
11. Annuity benefits					
12. Surrender values and withdrawals for life contracts					
13. Aggregate write-ins for miscellaneous direct claims and benefits paid					
14. All other benefits, except accident and health					
15. Totals					
DETAILS OF WRITE-INS					
1301.					
1302.					
1303.					
1398. Summary of Line 13 from overflow page					
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)					

NONE

DIRECT DEATH BENEFITS AND MATURED ENDOWMENTS INCURRED	Ordinary		Credit Life (Group and Individual)		Group		Industrial		Total	
	1 No.	2 Amount	3 No. of Ind.Pols. & Gr. Certifs.	4 Amount	5 No. of Certifs.	6 Amount	7 No.	8 Amount	9 No.	10 Amount
16. Unpaid December 31, prior year										
17. Incurred during current year										
Settled during current year:										
18.1 By payment in full										
18.2 By payment on compromised claims										
18.3 Totals paid										
18.4 Reduction by compromise										
18.5 Amount rejected										
18.6 Total settlements										
19. Unpaid Dec. 31, current year (16+17-18.6)										
POLICY EXHIBIT					No. of Policies					
20. In force December 31, prior year				(a)						
21. Issued during year										
22. Other changes to in force (Net)										
23. In force December 31 of current year				(a)						

(a) Includes Individual Credit Life Insurance prior year $ ....., current year $ .....

Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year $ ....., current year $ .....

Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year $ ....., current year $ .....

ACCIDENT AND HEALTH INSURANCE

	1 Direct Premiums	2 Direct Premiums Earned	3 Dividends Paid Or Credited On Direct Business	4 Direct Losses Paid	5 Direct Losses Incurred
24. Group Policies (b)					
24.1 Federal Employees Health Benefits Plan premium (b)					
24.2 Credit (Group and Individual)					
24.3 Collectively renewable policies (b)					
24.4 Medicare Title XVIII exempt from state taxes or fees					
Other Individual Policies:					
25.1 Non-cancelable (b)					
25.2 Guaranteed renewable (b)					
25.3 Non-renewable for stated reasons only (b)					
25.4 Other accident only					
25.5 All other (b)					
25.6 Totals (sum of Lines 25.1 to 25.5)					
26. Totals (Lines 24 + 24.1 + 24.2 + 24.3 + 24.4 + 25.6)					

(b) For health business on indicated lines report: Number of persons insured under PPO managed care products ..... and number of persons insured under indemnity only products .....

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Aetna Better Health® of Kentucky Q1 2019 Statement

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QUARTERLY STATEMENT

OF THE

Aetna Better Health of Kentucky Insurance Company

TO THE

Insurance Department

OF THE

STATE OF

Kentucky

FOR THE QUARTER ENDED
MARCH 31, 2019

HEALTH

2019

HEALTH QUARTERLY STATEMENT

AS OF MARCH 31, 2019
OF THE CONDITION AND AFFAIRS OF THE

Aetna Better Health of Kentucky Insurance Company

NAIC Group Code 0001 (Current) 0001 (Prior) NAIC Company Code 15761 Employer's ID Number 47-3279217

Organized under the Laws of Kentucky, State of Domicile or Port of Entry KY

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health

Is HMO Federally Qualified? Yes [ ] No [ ]

Incorporated/Organized 02/24/2015 Commenced Business 02/01/2016

Statutory Home Office 9900 Corporate Campus Drive, Suite 1000 (Street and Number), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Main Administrative Office 9900 Corporate Campus Drive, Suite 1000 (Street and Number)
Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Mail Address 9900 Corporate Campus Drive, Suite 1000 (Street and Number or P.O. Box), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 9900 Corporate Campus Drive, Suite1000 (Street and Number)
Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Internet Website Address www.aetnabetterhealth.com

Statutory Statement Contact Scott David Miller (Name), 717-671-2474 (Area Code) (TelephoneNumber)
StatutoryReporting@aetna.com (E-mail Address), 717-526-2888 (FAX Number)

OFFICERS

President Randy Joo Hwan Hyun
Chief Financial Officer DavidPatrick Delaney #
Vice President and Secretary Robert Mark Kessler

OTHER

Debra Jean Bacon Chief Financial Officer (through 4/1/19)
Kevin James Casey, Senior Investment Officer
Frank Ferris Chroniser III, Assistant Controller
John Patrick Mirroney, Vice President and Treasurer
Scott David Miller, Corporate Controller

DIRECTORS OR TRUSTEES

Debra Jean Bacon
Jonathan Edward Copley
Randy Joo Hwan Hyun

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Randy Joo Hwan Hyun Chief Executive Officer and President	Robert Mark Kessler Vice President and Secretary	David Patrick Delaney Chief Financial Officer
State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa
Subscribed and sworn to before me this 1 day of May, 2019	Subscribed and sworn to before me this 1 day of May, 2019	Subscribed and sworn to before me this 1 day of May, 2019
NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)

JANEEN NEWHOUSE
Notary Public, State of Arizona
Maricopa County
Commission # 557912
My Commission Expires
February 08, 2023

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number .....
2. Date filed .....
3. Number of pages attached.....

ASSETS

	Current Statement Date 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 December 31 Prior Year Net Admitted Assets
1. Bonds	450,518,451	0	450,518,451	442,356,086
2. Stocks:				
2.1 Preferred stocks	0	0	0	0
2.2 Common stocks	0	0	0	0
3. Mortgage loans on real estate:				
3.1 First liens	13,735,561	0	13,735,561	13,407,858
3.2 Other than first liens	0	0	0	0
4. Real estate:				
4.1 Properties occupied by the company (less $ 0 encumbrances)	0	0	0	0
4.2 Properties held for the production of income (less $ 0 encumbrances)	0	0	0	0
4.3 Properties held for sale (less $ 0 encumbrances)	0	0	0	0
5. Cash ($ 11,164,538), cash equivalents ($ 26,092,013) and short-term investments ($ 0)	37,256,551	0	37,256,551	18,620,276
6. Contract loans (including $ 0 premium notes)	0	0	0	0
7. Derivatives	0	0	0	0
8. Other invested assets	8,408,800	0	8,408,800	0
9. Receivables for securities	143,750	0	143,750	11,415
10. Securities lending reinvested collateral assets	0	0	0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	510,063,113	0	510,063,113	474,395,635
13. Title plants less $ 0 charged off (for Title insurers only)	0	0	0	0
14. Investment income due and accrued	4,219,627	0	4,219,627	4,621,602
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	1,939,154	0	1,939,154	1,931,674
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ 0 earned but unbilled premiums)	0	0	0	0
15.3 Accrued retrospective premiums ($ 0) and contracts subject to redetermination ($ 0)	0	0	0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	0	0	0	0
16.2 Funds held by or deposited with reinsured companies	0	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0	0
17. Amounts receivable relating to uninsured plans	0	0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	0	0	0	0
18.2 Net deferred tax asset	5,204,425	0	5,204,425	5,204,425
19. Guaranty funds receivable or on deposit	0	0	0	0
20. Electronic data processing equipment and software	0	0	0	0
21. Furniture and equipment, including health care delivery assets ($ 0)	0	0	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23. Receivables from parent, subsidiaries and affiliates	0	0	0	7,789,355
24. Health care ($ 2,857,018) and other amounts receivable	20,474,364	17,617,346	2,857,018	2,070,247
25. Aggregate write-ins for other than invested assets	548,490	500,000	48,490	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	542,449,173	18,117,346	524,331,827	496,012,938
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28. Total (Lines 26 and 27)	542,449,173	18,117,346	524,331,827	496,012,938
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Deposits	500,000	500,000	0	0
2502. Misc Receivable	48,490	0	48,490	0
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	548,490	500,000	48,490	0

LIABILITIES, CAPITAL AND SURPLUS

		Current Period			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ 0 reinsurance ceded)	113,767,740	5,485,656	119,253,396	127,259,095
2.	Accrued medical incentive pool and bonus amounts	1,562,000	0	1,562,000	1,187,135
3.	Unpaid claims adjustment expenses	3,844,001	0	3,844,001	4,812,094
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Service Act	3,140,488	0	3,140,488	0
5.	Aggregate life policy reserves	0	0	0	0
6.	Property/casualty unearned premium reserve	0	0	0	0
7.	Aggregate health claim reserves	0	0	0	0
8.	Premiums received in advance	6,730,815	0	6,730,815	574,560
9.	General expenses due or accrued	14,276,671	0	14,276,671	11,601,352
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))	7,437,901	0	7,437,901	4,383,990
10.2	Net deferred tax liability	0	0	0	0
11.	Ceded reinsurance premiums payable	0	0	0	0
12.	Amounts withheld or retained for the account of others	0	0	0	3,139,799
13.	Remittances and items not allocated	1,740,063	0	1,740,063	1,753,757
14.	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)	0	0	0	0
15.	Amounts due to parent, subsidiaries and affiliates	26,300,112	0	26,300,112	13,820,266
16.	Derivatives	0	0	0	0
17.	Payable for securities	2,000,000	0	2,000,000	0
18.	Payable for securities lending	0	0	0	0
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)	0	0	0	0
20.	Reinsurance in unauthorized and certified ($ 0) companies	0	0	0	0
21.	Net adjustments in assets and liabilities due to foreign exchange rates	0	0	0	0
22.	Liability for amounts held under uninsured plans	0	0	0	0
23.	Aggregate write-ins for other liabilities (including $ 0 current)	682,194	0	682,194	982,691
24.	Total liabilities (Lines 1 to 23)	181,481,985	5,485,656	186,967,641	169,514,739
25.	Aggregate write-ins for special surplus funds	XXX	XXX	5,515,975	0
26.	Common capital stock	XXX	XXX	1,000,000	1,000,000
27.	Preferred capital stock	XXX	XXX	0	0
28.	Gross paid in and contributed surplus	XXX	XXX	99,010,001	99,010,001
29.	Surplus notes	XXX	XXX	0	0
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31.	Unassigned funds (surplus)	XXX	XXX	231,838,210	226,488,198
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX	0	0
	32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX	0	0
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	337,364,186	326,498,199
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	524,331,827	496,012,938
	DETAILS OF WRITE-INS				
2301.	Escheat Payable	682,194	0	682,194	982,691
2302.					
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399.	Totals (Lines 2301 through 2303 plus 2398)(Line 23 above)	682,194	0	682,194	982,691
2501.	Estimated Health Insurance Fee accrual	XXX	XXX	5,515,975	0
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	XXX	XXX	5,515,975	0
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099.	Totals (Lines 3001 through 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year To Date		Prior Year To Date	Prior Year Ended December 31
		1 Uncovered	2 Total	3 Total	4 Total
1.	Member Months	XXX	654,080	711,595	2,773,717
2.	Net premium income (including $ 0 non-health premium income)	XXX	265,590,785	282,764,186	1,121,827,068
3.	Change in unearned premium reserves and reserve for rate credits	XXX	(3,140,488)	0	0
4.	Fee-for-service (net of $ 0 medical expenses)	XXX	0	0	0
5.	Risk revenue	XXX	0	0	0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0	0
8.	Total revenues (Lines 2 to 7)	XXX	262,450,297	282,764,186	1,121,827,068
	Hospital and Medical:				
9.	Hospital/medical benefits	6,231,616	135,469,913	138,577,046	578,623,254
10.	Other professional services	464,797	10,104,293	11,528,328	43,428,479
11.	Outside referrals	143,329	3,115,855	0	8,516,577
12.	Emergency room and out-of-area	805,140	17,503,050	19,479,742	80,128,217
13.	Prescription drugs	0	61,058,798	57,475,820	218,620,756
14.	Aggregate write-ins for other hospital and medical	0	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts	0	717,598	1,535,556	1,640,478
16.	Subtotal (Lines 9 to 15)	7,644,882	227,969,507	228,596,492	930,957,761
	Less:				
17.	Net reinsurance recoveries	0	0	0	0
18.	Total hospital and medical (Lines 16 minus 17)	7,644,882	227,969,507	228,596,492	930,957,761
19.	Non-health claims (net)	0	0	0	0
20.	Claims adjustment expenses, including $ 4,853,297 cost containment expenses	0	5,102,822	7,113,229	28,085,901
21.	General administrative expenses	0	17,016,250	39,851,106	93,657,324
22.	Increase in reserves for life and accident and health contracts (including $ 0 increase in reserves for life only)	0	0	0	0
23.	Total underwriting deductions (Lines 18 through 22)	7,644,882	250,088,579	275,560,827	1,052,700,986
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	12,361,718	7,203,359	69,126,082
25.	Net investment income earned	0	4,540,605	4,166,572	16,076,249
26.	Net realized capital gains (losses) less capital gains tax of $ 70,512	0	382,509	(398,285)	(3,331,896)
27.	Net investment gains (losses) (Lines 25 plus 26)	0	4,923,114	3,768,287	12,744,353
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $ 0) (amount charged off $ 0)]	0	0	0	0
29.	Aggregate write-ins for other income or expenses	0	(937,647)	(1,104,225)	(4,224,851)
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	16,347,185	9,867,421	77,645,584
31.	Federal and foreign income taxes incurred	XXX	2,983,398	5,788,501	18,504,307
32.	Net income (loss) (Lines 30 minus 31)	XXX	13,363,787	4,078,920	59,141,277
	DETAILS OF WRITE-INS				
0601.		XXX			
0602.		XXX			
0603.		XXX			
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)	XXX	0	0	0
0701.		XXX			
0702.		XXX			
0703.		XXX			
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798)(Line 7 above)	XXX	0	0	0
1401.					
1402.					
1403					
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498)(Line 14 above)	0	0	0	0
2901.	Regulatory penalties	0	(937,647)	(1,104,225)	(4,224,851)
2902.					
2903					
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998)(Line 29 above)	0	(937,647)	(1,104,225)	(4,224,851)

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year to Date	2 Prior Year to Date	3 Prior Year Ended December 31
	CAPITAL AND SURPLUS ACCOUNT			
33.	Capital and surplus prior reporting year	326,498,199	261,922,348	261,922,348
34.	Net income or (loss) from Line 32	13,363,787	4,078,920	59,141,277
35.	Change in valuation basis of aggregate policy and claim reserves	0	0	0
36.	Change in net unrealized capital gains (losses) less capital gains tax of $ 365,617	1,375,416	(341,515)	(1,538,193)
37.	Change in net unrealized foreign exchange capital gain or (loss)	0	0	0
38.	Change in net deferred income tax	365,617	(90,782)	(5,183,022)
39.	Change in nonadmitted assets	(4,238,833)	(6,985,718)	12,128,036
40	Change in unauthorized and certified reinsurance	0	0	0
41.	Change in treasury stock	0	0	0
42.	Change in surplus notes	0	0	0
43.	Cumulative effect of changes in accounting principles	0	0	0
44.	Capital Changes:			
	44.1 Paid in	0	0	0
	44.2 Transferred from surplus (Stock Dividend)	0	0	0
	44.3 Transferred to surplus	0	0	0
45.	Surplus adjustments:			
	45.1 Paid in	0	0	0
	45.2 Transferred to capital (Stock Dividend)	0	0	0
	45.3 Transferred from capital	0	0	0
46.	Dividends to stockholders	0	0	0
47.	Aggregate write-ins for gains or (losses) in surplus	0	0	27,753
48.	Net change in capital & surplus (Lines 34 to 47)	10,865,987	(3,339,095)	64,575,851
49.	Capital and surplus end of reporting period (Line 33 plus 48)	337,364,186	258,583,253	326,498,199
	DETAILS OF WRITE-INS			
4701.	Correction of Prior Year Current Federal Income Tax Incurred	0	0	27,753
4702.				
4703.				
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798)(Line 47 above)	0	0	27,753

CASH FLOW

		1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
	Cash from Operations			
1.	Premiums collected net of reinsurance	271,739,560	274,900,712	1,090,505,904
2.	Net investment income	5,270,677	4,851,307	18,140,983
3.	Miscellaneous income	0	0	0
4.	Total (Lines 1 to 3)	277,010,237	279,752,019	1,108,646,887
5.	Benefit and loss related payments	240,625,945	238,545,919	950,102,213
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0
7.	Commissions, expenses paid and aggregate write-ins for deductions	21,349,493	35,160,554	125,269,154
8.	Dividends paid to policyholders	0	0	0
9.	Federal and foreign income taxes paid (recovered) net of $ 0 tax on capital gains (losses)	0	0	21,745,323
10.	Total (Lines 5 through 9)	261,975,438	273,706,473	1,097,116,690
11.	Net cash from operations (Line 4 minus Line 10)	15,034,799	6,045,546	11,530,197
	Cash from Investments			
12.	Proceeds from investments sold, matured or repaid:			
	12.1 Bonds	42,463,988	51,532,949	197,532,407
	12.2 Stocks	0	0	0
	12.3 Mortgage loans	82,137	77,543	316,980
	12.4 Real estate	0	0	0
	12.5 Other invested assets	0	0	0
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	42	(58)	(722)
	12.7 Miscellaneous proceeds	2,000,000	34,419	547,760
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	44,546,167	51,644,853	198,396,425
13.	Cost of investments acquired (long-term only):			
	13.1 Bonds	49,000,711	48,772,320	169,085,405
	13.2 Stocks	0	0	0
	13.3 Mortgage loans	378,367	0	621,181
	13.4 Real estate	0	0	0
	13.5 Other invested assets	8,200,000	0	0
	13.6 Miscellaneous applications	132,335	16,224,307	0
	13.7 Total investments acquired (Lines 13.1 to 13.6)	57,711,413	64,996,627	169,706,586
14.	Net increase (or decrease) in contract loans and premium notes	0	0	0
15.	Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	(13,165,246)	(13,351,774)	28,689,839
	Cash from Financing and Miscellaneous Sources			
16.	Cash provided (applied):			
	16.1 Surplus notes, capital notes	0	0	0
	16.2 Capital and paid in surplus, less treasury stock	0	0	0
	16.3 Borrowed funds	0	0	0
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0	0
	16.5 Dividends to stockholders	0	0	0
	16.6 Other cash provided (applied)	16,766,722	3,454,343	(35,804,649)
17.	Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	16,766,722	3,454,343	(35,804,649)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS			
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	18,636,275	(3,851,885)	4,415,387
19.	Cash, cash equivalents and short-term investments:			
	19.1 Beginning of year	18,620,276	14,204,889	14,204,889
	19.2 End of period (Line 18 plus Line 19.1)	37,256,551	10,353,004	18,620,276

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001. Non-Cash Transaction - Tax Free Acquisition	1,209,896	1,052,670	8,057,370

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
	Total	2 Individual	3 Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	224,908	11,289	0	0	0	0	0	0	213,619	0
2. First Quarter	213,505	9,987	0	0	0	0	0	0	203,518	0
3. Second Quarter	0	0	0	0	0	0	0	0	0	0
4. Third Quarter	0	0	0	0	0	0	0	0	0	0
5. Current Year	0	0	0	0	0	0	0	0	0	0
6. Current Year Member Months	654,080	32,411	0	0	0	0	0	0	621,669	0
Total Member Ambulatory Encounters for Period:										
7 Physician	444,616	21,203	0	0	0	0	0	0	423,413	0
8. Non-Physician	249,798	7,722	0	0	0	0	0	0	242,076	0
9. Total	694,414	28,925	0	0	0	0	0	0	665,489	0
10. Hospital Patient Days Incurred	20,372	207	0	0	0	0	0	0	20,165	0
11. Number of Inpatient Admissions	4,467	40	0	0	0	0	0	0	4,427	0
12. Health Premiums Written (a)	265,590,785	7,424,292	0	0	0	0	0	0	258,166,493	0
13. Life Premiums Direct	0	0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0	0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	262,450,297	7,342,501	0	0	0	0	0	0	255,107,796	0
16. Property/Casualty Premiums Earned	0	0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	240,625,948	7,553,276	0	0	0	0	0	0	233,072,672	0
18. Amount Incurred for Provision of Health Care Services	227,969,507	6,766,069	0	0	0	0	0	0	221,203,438	0

(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ 0

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Claims Unpaid (Reported)						
0299999 Aggregate accounts not individually listed-uncovered	676,788	57,661	11,943	236	12,179	758,807
0399999 Aggregate accounts not individually listed-covered	13,600,663	1,156,162	55,445	87,572	709,047	15,608,889
0499999 Subtotals	14,277,451	1,213,823	67,388	87,808	721,226	16,367,696
0599999 Unreported claims and other claim reserves						102,885,700
0699999 Total amounts withheld						0
0799999 Total claims unpaid						119,253,396
0899999 Accrued medical incentive pool and bonus amounts						1,562,000

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid Year to Date		Liability End of Current Quarter		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid Dec. 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)	1,703,612	5,812,492	374,947	1,915,739	2,078,559	3,077,892
2. Medicare Supplement	0	0	0	0	0	0
3. Dental Only	0	0	0	0	0	0
4. Vision Only	0	0	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0	0	0
6. Title XVIII - Medicare	0	0	0	0	0	0
7 Title XIX - Medicaid	72,589,592	160,177,518	28,589,994	88,372,716	101,179,586	124,181,203
8. Other health	0	0	0	0	0	0
9. Health subtotal (Lines 1 to 8)	74,293,204	165,990,010	28,964,941	90,288,455	103,258,145	127,259,095
10. Healthcare receivables (a)	16,700,970	3,773,394	0	0	16,700,970	15,448,760
11. Other non-health	0	0	0	0	0	0
12. Medical incentive pools and bonus amounts	1,037	341,696	1,165,860	396,140	1,166,897	1,187,135
13. Totals (Lines 9-10+11+12)	57,593,271	162,558,312	30,130,801	90,684,595	87,724,072	112,997,470

(a) Excludes $ 0 loans or advances to providers not yet expensed.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying statutory financial statements of Aetna Better Health of Kentucky Insurance Co (the "Company), a wholly-owned subsidiary of Coventry Health & Life Insurance Co. ('CH&L') whose ultimate parent is CVS Health Corporation ("CVS Health"), have been prepared in conformity with accounting practices prescribed or permitted by the Commonwealth of Kentucky Department of Insurance (KY DOI). The Commonwealth of Kentucky recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP").

A reconciliation of the Company's net income and surplus between NAIC SAP and practices prescribed and permitted by the Commonwealth of Kentucky for the periods ended March 31, 2019 and December 31, 2018 is as follows:

		SSAP #	F/S Page	F/S Line #	2019	2018
NET INCOME						
(1)	State basis (Page 4, Line 32, Columns 2 & 4)	XXX	XXX	XXX	13,363,787	59,141,277
(2)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
(3)	State Permitted Practices that increase/(decrease) NAIC SAP:					
(4)	NAIC SAP (1-2-3=4)	XXX	XXX	XXX	13,363,787	59,141,277
	SURPLUS					
(5)	State basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	337,364,186	326,498,199
(6)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
(7)	State Permitted Practices that increase/(decrease) NAIC SAP:					
(8)	NAIC SAP (5-6-7=8)	XXX	XXX	XXX	337,364,186	326,498,199

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of these financial statements in conformity with Kentucky Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenues and expenses. Actual results could differ from those estimates.

C. Accounting Policies

(1) No significant change.

(2) Bonds:

Bonds, which include special deposits, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections. Bonds include all investments whose maturity is greater than one year when purchased. Loan-

backed and structured securities are carried at amortized cost adjusted for unamortized premiums and discounts. Premiums and discounts on loan-backed and structured securities are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments. All adjustments between amortized cost and carrying value are reflected in unrealized capital gains and losses and are reported as direct adjustments to surplus. Bonds are recorded as purchases or sales on the trade date.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities, an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For loan-backed and structured securities, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from the Company's expectations and the risk that facts and circumstances factored into its assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

(3) through (7): No significant change.

(8) Joint Ventures, Partnerships and Limited Liability Companies:

Other Invested Assets

Other invested assets consist primarily of partnerships and equity subsidiaries. Partnerships and equity subsidiaries are reported using the equity method. Unaudited other invested assets are nonadmitted as they do not meet the admissibility requirements of SSAP No. 48, *Joint Ventures, Partnerships and Limited Liability Companies* and SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entities*, which requires U.S. generally accepted accounting principles' audited financial statements of the investments. The Company periodically reviews other invested assets for impairment. An impairment shall be considered to have occurred if it is probable that the Company will be unable to recover the carrying amount of the investment or there is evidence indicating the inability of the investee to sustain earnings which would justify the carrying amount of the investment.

(9) through (21): No significant change.

D. Going Concern

As of May 13, 2019, management has evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

2. Accounting Changes and Corrections of Errors

The Company did not have any accounting changes or corrections of errors in the period ended March 31, 2019.

3. Business Combinations and Goodwill

No significant change.

4. Discontinued Operations

No significant change.

5. Investments

A. through C: No significant change.

D. Loan-Backed Securities

(1) Prepayment assumptions for single class and multi-class mortgage backed/asset backed securities were obtained from industry market sources.

(2) The Company had no other-than-temporary impairment ("OTTI") losses during the First quarter of 2019 on loan-backed and structured securities in which the Company had the (1) intent to sell, (2) did not have the intent and ability to retain for a period of time sufficient to recover the amortized cost basis or (3) present value of cash flows expected to be collected is less than the amortized cost basis of the securities in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 43R, *Loan-Backed and Structured Securities* ("SSAP No. 43R").

(3) The Company had no recognized OTTI on loan-backed and structured securities currently held, in which the present value of cash flows expected to be collected is less than the amortized cost basis, at the reporting date March 31, 2019.

(4) The Company's unrealized loss position on loan-backed and structured securities held by the Company at March 31, 2019 is as follows:

a. The aggregate amount of unrealized losses:	
1. Less than 12 Months	($8,457)
2. 12 Months or Longer	($310,401)
b. The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 Months	$1,977,728
2. 12 Months or Longer	$13,918,634

(5) The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R in the table above and have concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at March 31, 2019 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

(1) and (2): No significant change.

(3) Neither the Company nor its agent has accepted collateral that is permitted by contract or custom to sell or repledge as of March 31, 2019.

(4) through (7): No significant change.

F. The Company did not have any repurchase agreements transactions accounted for as secured borrowing at March 31, 2019.

G. The Company did not have any reverse repurchase agreements transactions accounted for as secured at March 31, 2019.

H. The Company did not have any repurchase agreements transactions accounted for as a sale at March 31, 2019.

I. The Company did not have any reverse repurchase agreements transactions accounted for as a sale at March 31, 2019.

J. through L: No significant change.

M. The Company did not have any working capital finance investments at March 31, 2019.

N. The Company did not have any offsetting and netting of financial assets or liabilities at March 31, 2019.

O. through R: No significant change.

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company did not have any joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at March 31, 2019.

B. The Company does not have any impaired investments in joint ventures, partnerships, or limited liability companies at March 31, 2019.

7. Investment Income

No significant change.

8. Derivative Instruments

The Company did not have any derivative instruments at March 31, 2019.

9. Income Taxes

No significant change.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

No significant change.

11. Debt

A. The Company did not have any items related to debt, including capital notes at March 31, 2019.

B. The Company did not have any Federal Home Loan Bank agreements at March 31, 2019.

12. Retirement Plans, Deferred Compensation Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

The Company did not have a retirement plan, deferred compensation plan, or other postretirement benefit plan at March 31, 2019.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

No significant change.

14. Liabilities, Contingencies and Assessments

No significant change.

15. Leases

No significant change.

16. Information About Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

No significant change.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

No significant change.

B. Transfer and Servicing of Financial Assets

(1) No significant change.

(2) and (3): The Company did not have any servicing assets or liabilities at March 31, 2019.

(4) The Company did not have any securitized financial assets at March 31, 2019.

(5) through (7): No significant change.

C. Wash Sales

(1) The Company did not have any wash sales for the period ended March 31, 2019.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

No significant change.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No significant change.

20. Fair Value Measurements

A. and B.

The Company had no material assets or liabilities measured and reported at fair value at March 31, 2019.

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

Level 1 - Unadjusted quoted prices for identical assets or liabilities in active markets.

Level 2 - Inputs other than Level 1 that are based on observable market data. These include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.

Level 3 - Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

C. The carrying values and estimated fair values of the Company's financial instruments at March 31, 2019 were as follows:

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)	Net Asset Value (NAV) Included in Level 2
Bonds, Short Term, and Cash Equivalents	$487,380,774	$476,610,464	$57,103,888	$430,276,886	$—	$—	$—
Mortgage Loans	14,290,173	13,735,561	—	—	14,290,173	—	—

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets at March 31, 2019. There were no transfers between the Company's Level 1 or 2 financial assets at March 31, 2019.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

D. The Company did not have any financial instruments where it was not practicable to estimate the fair value.

E. The Company has not elected to use the net asset value practical expedient to fair value to measure its investments.

21. Other Items

No significant change.

22. Events Subsequent

A. Type I - Recognized Subsequent Events

Subsequent events have been considered through May 13, 2019 for the statutory statement issued on May 14, 2019.

The Company had no known reportable recognized subsequent events.

B. Type II - Non-Recognized Subsequent Events

Subsequent events have been considered through May 13, 2019 for the statutory statement issued on May 14, 2019.

The Company had no known reportable non-recognized subsequent events.

23. Reinsurance

No significant change.

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

A. through D: No significant change.

E. Risk Sharing Provisions of the Affordable Care Act

(1) Did the reporting entity write accident and health insurance premium which is subject to the ACA risk sharing provisions (YES/NO)? Yes [ ] No [X].

(2) through (5): Not applicable.

25. Change in Incurred Claims and Claims Adjustment Expenses

As of March 31, 2019, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased by $24,021,187 from $133,258,324 in December 31, 2018 to $109,237,137 in March 31, 2019. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends.

Net coordination of benefits are implicit in the claims incurred but not reported calculation and could not be specifically identified.

26. Intercompany Pooling Arrangements

No significant change.

27. Structured Settlements

No significant change.

28. Health Care Receivables

No significant change.

29. Participating Policies

No significant change.

30. Premium Deficiency Reserves

No significant change.

31. Anticipated Salvage and Subrogation

No significant change.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Did the reporting entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the State of Domicile, as required by the Model Act? Yes [ ] No [X]

1.2 If yes, has the report been filed with the domiciliary state? Yes [ ] No [ ]

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [ ] No [X]

2.2 If yes, date of change:

3.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1 and 1A.

3.2 Have there been any substantial changes in the organizational chart since the prior quarter end? Yes [X] No [ ]

3.3 If the response to 3.2 is yes, provide a brief description of those changes.
Effective February 13, 2019, Aetna Health Inc. (MI) changed its name to Aetna Health of Michigan Inc.
Aetna Better Health of Iowa Inc. was re-domiciled from Iowa to Ohio on February 22, 2019.
On March 19, 2019, Futrix Limited (New Zealand) was dissolved.

3.4 Is the reporting entity publicly traded or a member of a publicly traded group? Yes [X] No [ ]

3.5 If the response to 3.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0000064803

4.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [ ] No [X]
If yes, complete and file the merger history data file with the NAIC for the annual filing corresponding to this period.

4.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

5. If the reporting entity is subject to a management agreement, including third-party administrator(s), managing general agent(s), attorney-in-fact, or similar agreement, have there been any significant changes regarding the terms of the agreement or principals involved? Yes [ ] No [X] N/A [ ]
If yes, attach an explanation.

6.1 State as of what date the latest financial examination of the reporting entity was made or is being made.

6.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

6.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

6.4 By what department or departments?

6.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [ ] No [ ] N/A [X]

6.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [ ] No [ ] N/A [X]

7.1 Has this reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [ ] No [X]

7.2 If yes, give full information:

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

GENERAL INTERROGATORIES

9.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No [ ]
(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

9.11 If the response to 9.1 is No, please explain:

9.2 Has the code of ethics for senior managers been amended? Yes [X] No [ ]

9.21 If the response to 9.2 is Yes, provide information related to amendment(s).
The Code of Conduct was amended to remove content related to the Caremark Corporate Integrity Agreement ("CIA") with the Office of the Inspector General as the CIA expired in March 2019.

9.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [X]

9.31 If the response to 9.3 is Yes, provide the nature of any waiver(s).

FINANCIAL

10.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [ ] No [X]

10.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ 0

INVESTMENT

11.1 Were any of the stocks, bonds, or other assets of the reporting entity loaned, placed under option agreement, or otherwise made available for use by another person? (Exclude securities under securities lending agreements.) Yes [ ] No [X]

11.2 If yes, give full and complete information relating thereto:

12. Amount of real estate and mortgages held in other invested assets in Schedule BA: $ 0

13. Amount of real estate and mortgages held in short-term investments: $ 0

14.1 Does the reporting entity have any investments in parent, subsidiaries and affiliates? Yes [X] No [ ]

14.2 If yes, please complete the following:

	1 Prior Year-End Book/Adjusted Carrying Value	2 Current Quarter Book/Adjusted Carrying Value
14.21 Bonds	$ 0	$ 0
14.22 Preferred Stock	$ 0	$ 0
14.23 Common Stock	$ 0	$ 0
14.24 Short-Term Investments	$ 0	$ 0
14.25 Mortgage Loans on Real Estate	$ 0	$ 0
14.26 All Other	$ 0	$ 8,408,800
14.27 Total Investment in Parent, Subsidiaries and Affiliates (Subtotal Lines 14.21 to 14.26)	$ 0	$ 8,408,800
14.28 Total Investment in Parent included in Lines 14.21 to 14.26 above	$ 0	$ 0

15.1 Has the reporting entity entered into any hedging transactions reported on Schedule DB? Yes [ ] No [X]

15.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ]
If no, attach a description with this statement.

16. For the reporting entity's security lending program, state the amount of the following as of the current statement date:

16.1 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. $ 0

16.2 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 $ 0

16.3 Total payable for securities lending reported on the liability page. $ 0

GENERAL INTERROGATORIES

17. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No [ ]

17.1 For all agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian Address
State Street Bank and Trust Company	State Street Financial Center; One Lincoln Street; Boston, MA 02111-2900

17.2 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

17.3 Have there been any changes, including name changes, in the custodian(s) identified in 17.1 during the current quarter? Yes [ ] No [X]

17.4 If yes, give full information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

17.5 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
Kevin J. Casey as Sr. Investment Officer	A

17.5097 For those firms/individuals listed in the table for Question 17.5, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets? Yes [ ] No [X]

17.5098 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 17.5, does the total assets under management aggregate to more than 50% of the reporting entity's assets? Yes [ ] No [X]

17.6 For those firms or individuals listed in the table for 17.5 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
N/A	Kevin J. Casey	N/A	Not registered	NO

18.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No [ ]

18.2 If no, list exceptions:

19. By self-designating 5GI securities, the reporting entity is certifying the following elements for each self-designated 5GI security:
    a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
    b. Issuer or obligor is current on all contracted interest and principal payments.
    c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

    Has the reporting entity self-designated 5GI securities? Yes [ ] No [X]

20. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
    a. The security was purchased prior to January 1, 2018.
    b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
    c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as a NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.
    d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.

    Has the reporting entity self-designated PLGI securities? Yes [ ] No [X]

GENERAL INTERROGATORIES

PART 2 - HEALTH

1. Operating Percentages:

   1.1 A&H loss percent ..... 88.7 %

   1.2 A&H cost containment percent ..... 1.8 %

   1.3 A&H expense percent excluding cost containment expenses ..... 6.6 %

2.1 Do you act as a custodian for health savings accounts? ..... Yes [ ] No [X]

2.2 If yes, please provide the amount of custodial funds held as of the reporting date ..... $ 0

2.3 Do you act as an administrator for health savings accounts? ..... Yes [ ] No [X]

2.4 If yes, please provide the balance of the funds administered as of the reporting date ..... $ 0

3. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? ..... Yes [ ] No [X]

3.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? ..... Yes [ ] No [X]

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE S - CEDED REINSURANCE

Showing All New Reinsurance Treaties - Current Year to Date

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Reinsurer	5 Domiciliary Jurisdiction	6 Type of Reinsurance Ceded	7 Type of Reinsurer	8 Certified Reinsurer Rating (1 through 6)	9 Effective Date of Certified Reinsurer Rating

NONE

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

Current Year to Date - Allocated by States and Territories

		1	Direct Business Only							
			2	3	4	5	6	7	8	9
	States, etc.	Active Status (a)	Accident and Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Program Premiums	Life and Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1.	Alabama AL	N	0	0	0	0	0	0	0	0
2.	Alaska AK	N	0	0	0	0	0	0	0	0
3.	Arizona AZ	N	0	0	0	0	0	0	0	0
4.	Arkansas AR	N	0	0	0	0	0	0	0	0
5.	California CA	N	0	0	0	0	0	0	0	0
6.	Colorado CO	N	0	0	0	0	0	0	0	0
7.	Connecticut CT	N	0	0	0	0	0	0	0	0
8.	Delaware DE	N	0	0	0	0	0	0	0	0
9.	District of Columbia DC	N	0	0	0	0	0	0	0	0
10.	Florida FL	N	0	0	0	0	0	0	0	0
11.	Georgia GA	N	0	0	0	0	0	0	0	0
12.	Hawaii HI	N	0	0	0	0	0	0	0	0
13.	Idaho ID	N	0	0	0	0	0	0	0	0
14.	Illinois IL	N	0	0	0	0	0	0	0	0
15.	Indiana IN	N	0	0	0	0	0	0	0	0
16.	Iowa IA	N	0	0	0	0	0	0	0	0
17.	Kansas KS	N	0	0	0	0	0	0	0	0
18.	Kentucky KY	L	7,424,292	0	258,166,493	0	0	0	265,590,785	0
19.	Louisiana LA	N	0	0	0	0	0	0	0	0
20.	Maine ME	N	0	0	0	0	0	0	0	0
21.	Maryland MD	N	0	0	0	0	0	0	0	0
22.	Massachusetts MA	N	0	0	0	0	0	0	0	0
23.	Michigan MI	N	0	0	0	0	0	0	0	0
24.	Minnesota MN	N	0	0	0	0	0	0	0	0
25.	Mississippi MS	N	0	0	0	0	0	0	0	0
26.	Missouri MO	N	0	0	0	0	0	0	0	0
27.	Montana MT	N	0	0	0	0	0	0	0	0
28.	Nebraska NE	N	0	0	0	0	0	0	0	0
29.	Nevada NV	N	0	0	0	0	0	0	0	0
30.	New Hampshire NH	N	0	0	0	0	0	0	0	0
31.	New Jersey NJ	N	0	0	0	0	0	0	0	0
32.	New Mexico NM	N	0	0	0	0	0	0	0	0
33.	New York NY	N	0	0	0	0	0	0	0	0
34.	North Carolina NC	N	0	0	0	0	0	0	0	0
35.	North Dakota ND	N	0	0	0	0	0	0	0	0
36.	Ohio OH	N	0	0	0	0	0	0	0	0
37.	Oklahoma OK	N	0	0	0	0	0	0	0	0
38.	Oregon OR	N	0	0	0	0	0	0	0	0
39.	Pennsylvania PA	N	0	0	0	0	0	0	0	0
40.	Rhode Island RI	N	0	0	0	0	0	0	0	0
41.	South Carolina SC	N	0	0	0	0	0	0	0	0
42.	South Dakota SD	N	0	0	0	0	0	0	0	0
43.	Tennessee TN	N	0	0	0	0	0	0	0	0
44.	Texas TX	N	0	0	0	0	0	0	0	0
45.	Utah UT	N	0	0	0	0	0	0	0	0
46.	Vermont VT	N	0	0	0	0	0	0	0	0
47.	Virginia VA	N	0	0	0	0	0	0	0	0
48.	Washington WA	N	0	0	0	0	0	0	0	0
49.	West Virginia WV	N	0	0	0	0	0	0	0	0
50.	Wisconsin WI	N	0	0	0	0	0	0	0	0
51.	Wyoming WY	N	0	0	0	0	0	0	0	0
52.	American Samoa AS	N	0	0	0	0	0	0	0	0
53.	Guam GU	N	0	0	0	0	0	0	0	0
54.	Puerto Rico PR	N	0	0	0	0	0	0	0	0
55.	U.S. Virgin Islands VI	N	0	0	0	0	0	0	0	0
56.	Northern Mariana Islands MP	N	0	0	0	0	0	0	0	0
57.	Canada CAN	N	0	0	0	0	0	0	0	0
58.	Aggregate Other Aliens OT	XXX	0	0	0	0	0	0	0	0
59.	Subtotal	XXX	7,424,292	0	258,166,493	0	0	0	265,590,785	0
60.	Reporting Entity Contributions for Employee Benefit Plans	XXX	0	0	0	0	0	0	0	0
61.	Totals (Direct Business)	XXX	7,424,292	0	258,166,493	0	0	0	265,590,785	0
	DETAILS OF WRITE-INS									
58001.		XXX								
58002.		XXX								
58003.		XXX								
58998.	Summary of remaining write-ins for Line 58 from overflow page	XXX	0	0	0	0	0	0	0	0
58999.	Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)	XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed Insurance carrier or domiciled RRG 1
R - Registered - Non-domiciled RRGs 0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
Q - Qualified - Qualified or accredited reinsurer 0
N - None of the above - Not allowed to write business in the state 56

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

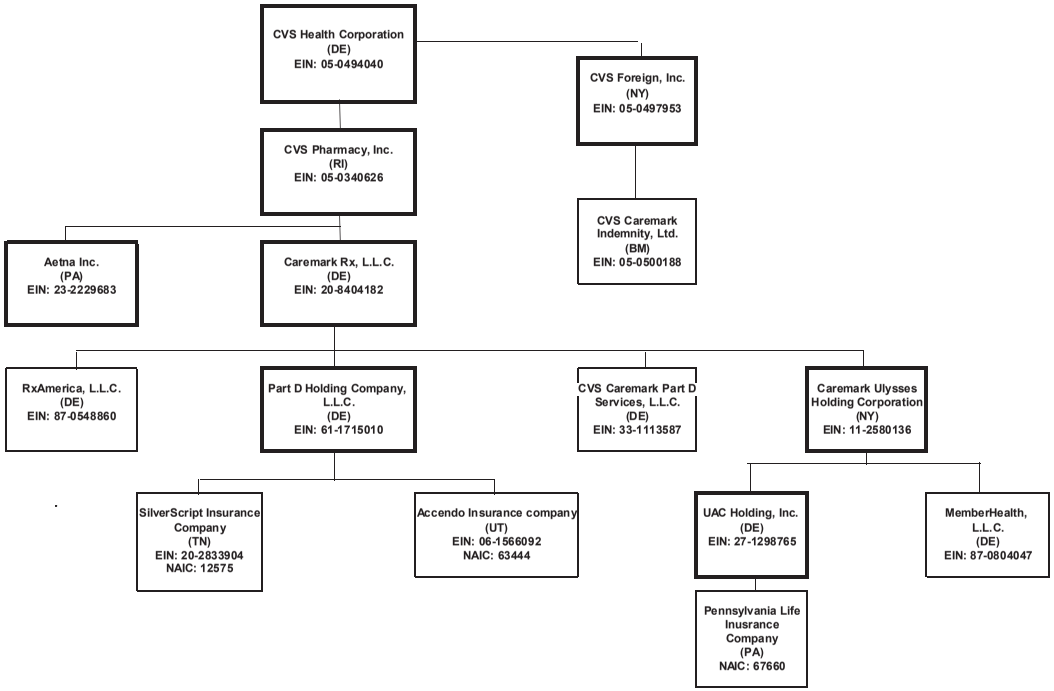

This organizational chart reflects the insurrance entity reporting system and identifies the relationship between the ultimate parent and all member insurers.
The ultimate controlling company is a Fortune 7 company with numerous subsidiaries, the majority of which do not interact with the insurance entities.
(1) Insurers/HMO's
Percentages are rounded to the nearest whole percent and based on ownership of voting rights.
Double borders indicate entity has subsidiaries shown on the same page.
Bold borders indicate entity has subsidiaries shown on a separate page.

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

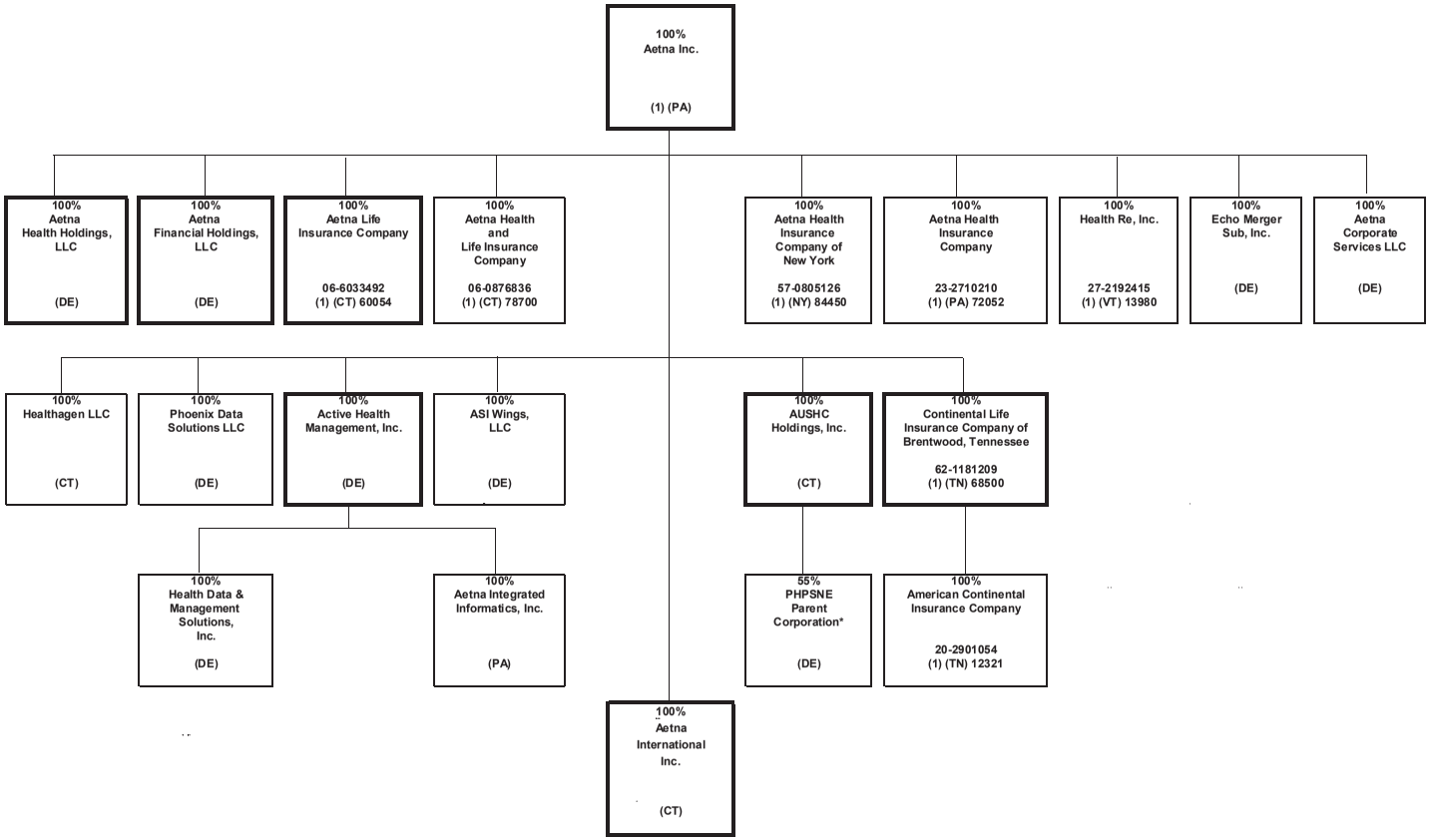

* PHPSNE Parent Corporation is also 45% owned by third parties.

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

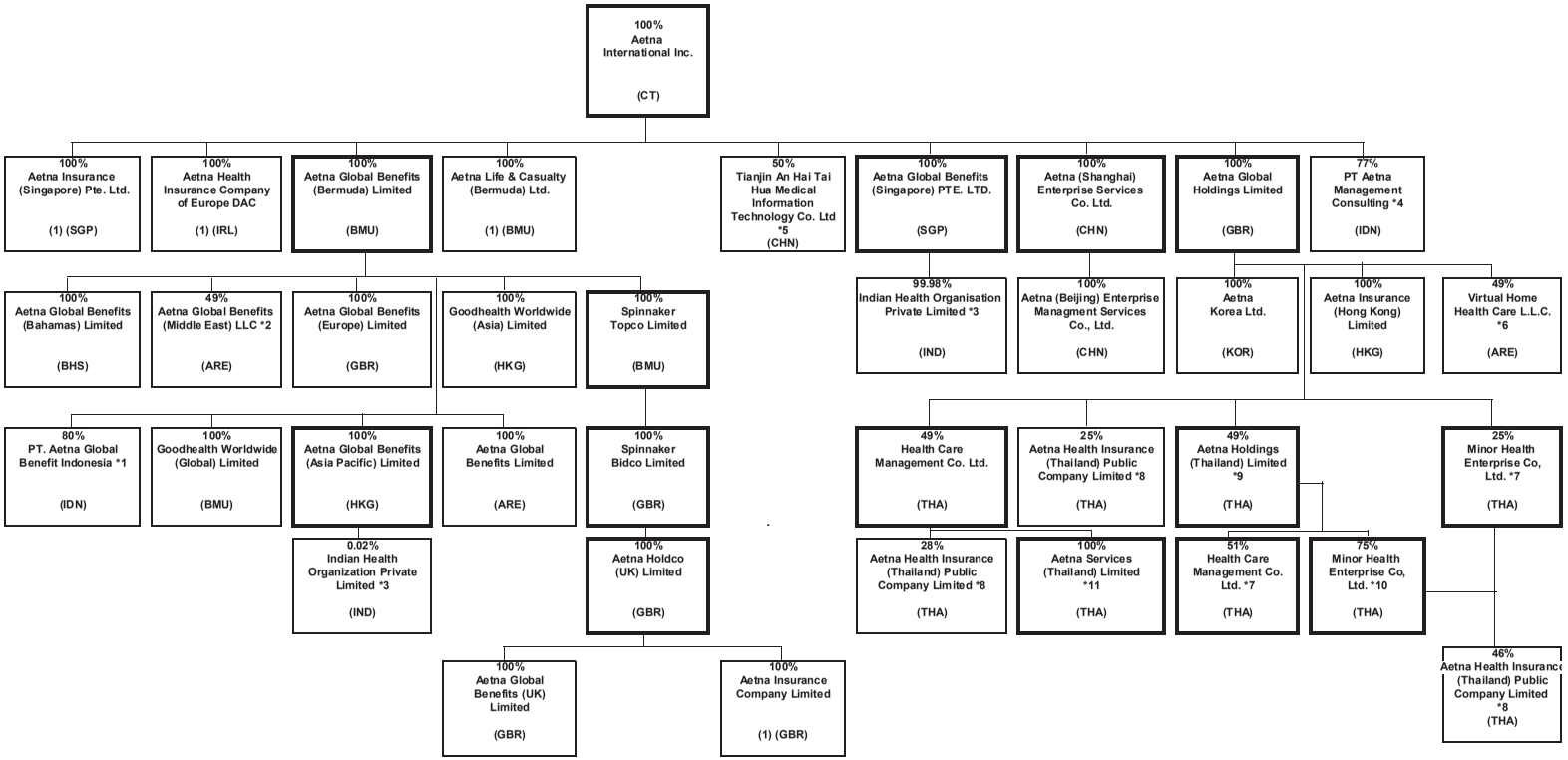

*1 PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
*2 Aetna Global Benefits (Middle East) LLC is also 51% is owned by Euro Gulf LLC, Aetna's Nominee.
*3 Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
*4 PT Asuransi Aetna Asia is also 23% owned by PT Asuransi Central Asia.
*5 Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd
*6 Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC, Aetna's Nominee
*7 Health Care Management Co. Ltd. Is also owned by Aetna Global Benefits (Bermuda) Limited (1 share).
*8 Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 Share), Mr. Jitphasong Itsaraphakded (1 Share); Mrs. Suphee Wattana (1 Share); and Mr. Buncha Tamphragom (1 Share)
*9 Aetna Holdings (Thailand) Limited is aslo 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Benefits (Bermuda) Limited owns 1 share.
*10 Minor Health Entreprise Co, Ltd is is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited
*11 Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited and (1 share) owned by Aetna Global Holdings Limited

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

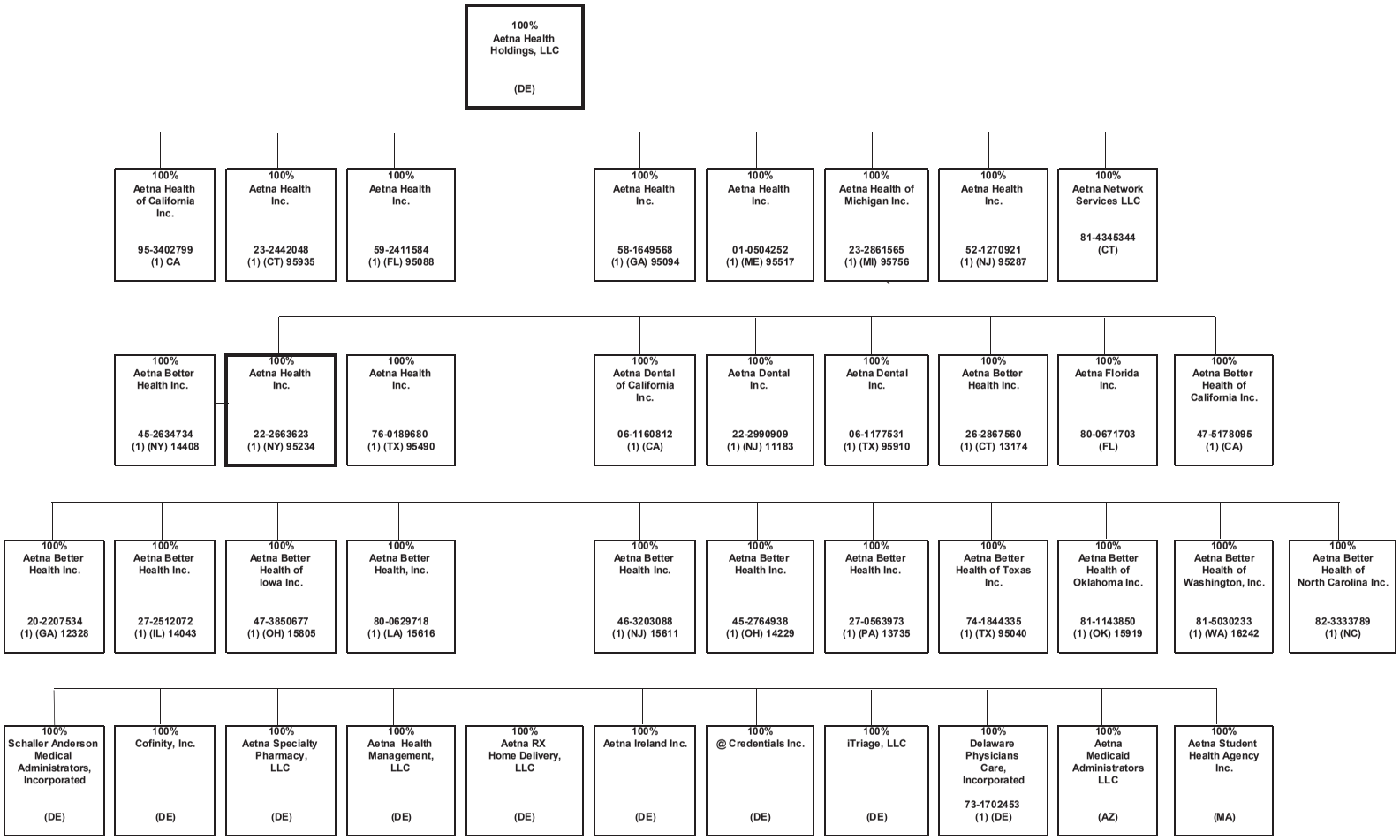

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

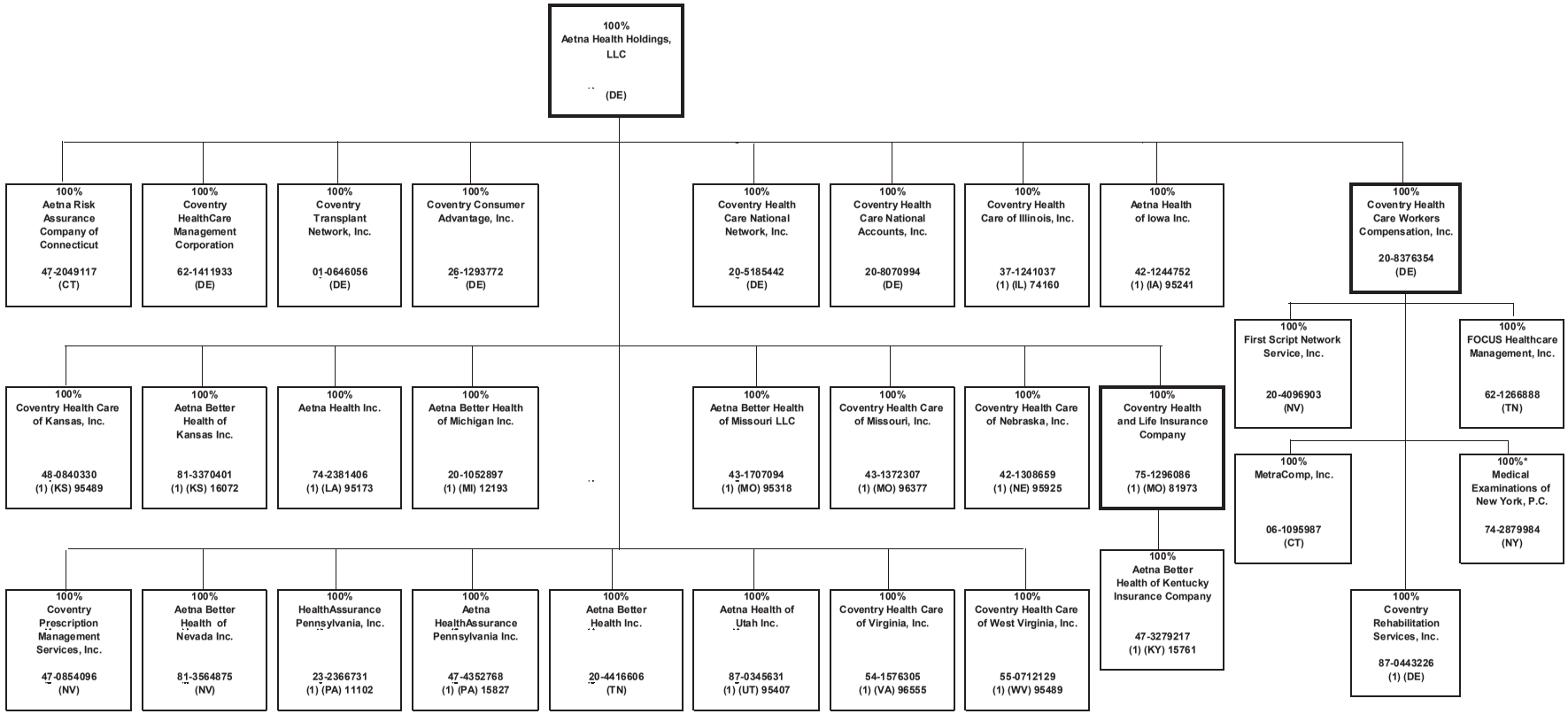

*100% owned through Aetna's nominees

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

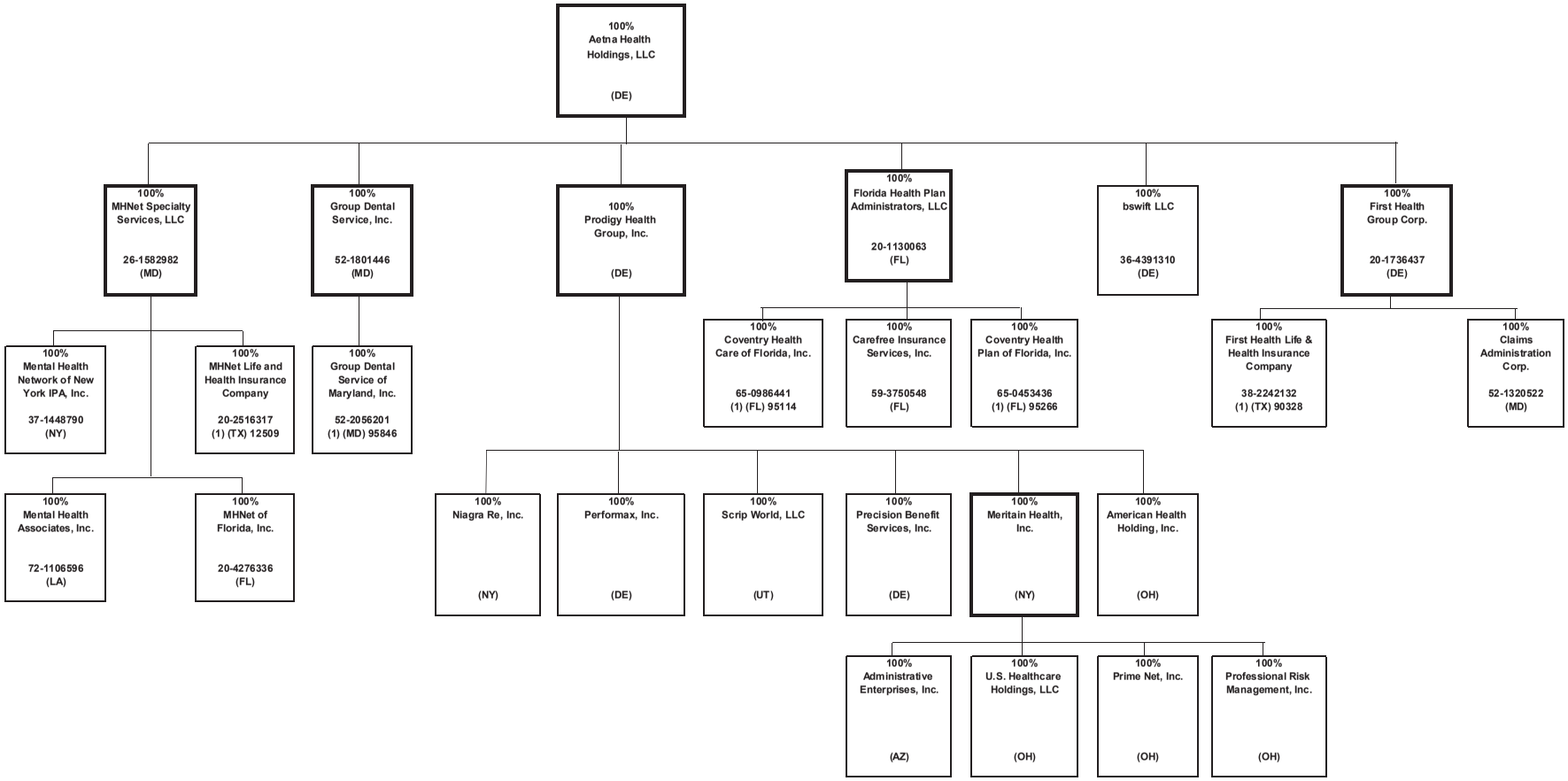

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

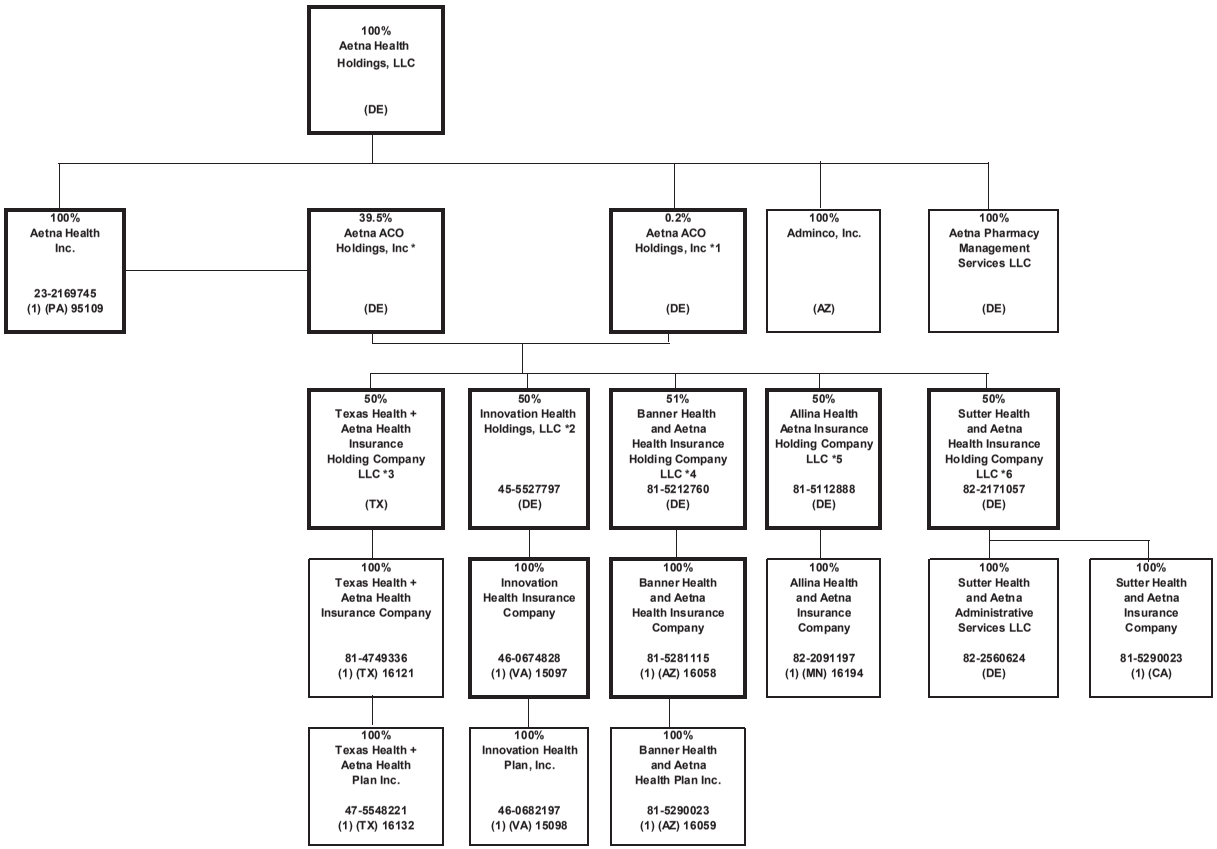

*1 Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
*2 Innovation Health Holdings, LLC is also 50% owned by Inova Health System Foundation.
*3 Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
*4 Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
*5 Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
*6 Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

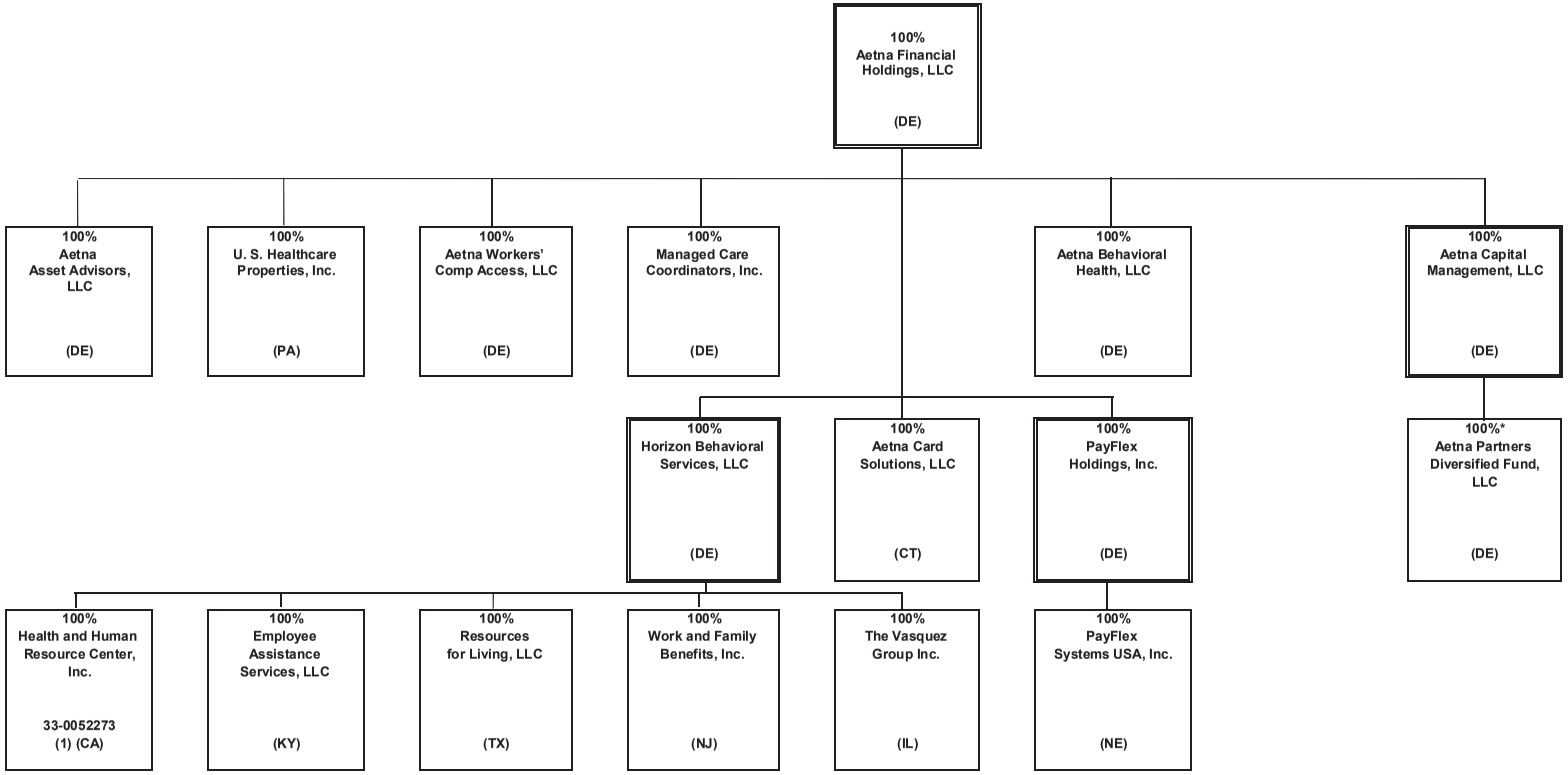

* Aetna Life Insurance Company owns substantially all of the non-managing member interests of Aetna Partners Diversified Fund, LLC.

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

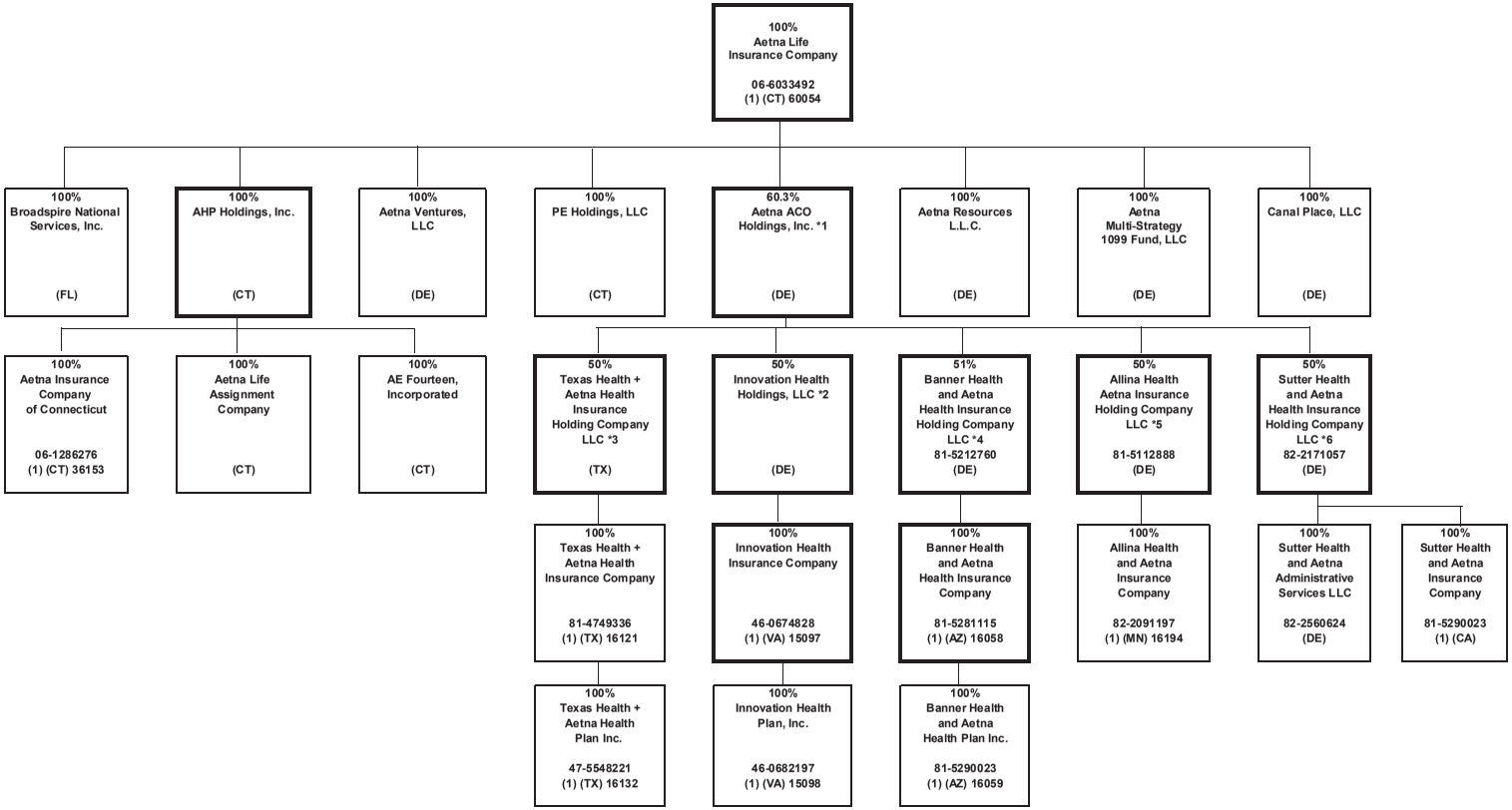

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*6 Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
0001	CVS HEALTH GROUP		05-0494040		0000064803	NYSE	CVS Health Corporation	DE	UIP	Board of Directors	Board of Directors	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	63444	06-1566092				Accendo Insurance Company	UT	IA	Part D Holding Company, L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12575	20-2833904				SilverScript Insurance Company	TN	IA	Part D Holding Company, L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	67660	23-1305366				Pennsylvania Life Insurance Co.	PA	IA	UAC Holding, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0340626				CVS Pharmacy, Inc	RI	UIP	CVS Health Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8404182				Caremark, Rx., L.L.C.	DE	NIA	CVS Pharmacy, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	61-1715010				Part D Holding Company, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	33-1113587				CVS Caremark Part D Services, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0548860				RxAmerica, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	11-2580136				Caremark Ulysses Holding Corporation	NY	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0804047				MemberHealth L.L.C.	DE	NIA	Caremark Ulysses Holding Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0500188				CVS Caremark Indemnity, Ltd.	BMU	IA	CVS Foreign, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1298765				UAC Holding, Inc	DE	NIA	Caremark Ulysses Holding Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0497953				CVS Foreign, Inc.	NY	NIA	CVS Health Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2229683	3060706	0001122304		Aetna Inc.	PA	UIP	CVS Pharmacy, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	30-0123754	0	0		Aetna Health Holdings, LLC	DE	UIP	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	95-3402799	0	0		Aetna Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95935	23-2442048	0	0		Aetna Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95088	59-2411584	0	0		Aetna Health Inc.	FL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95094	58-1649568	0	0		Aetna Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95517	01-0504252	0	0		Aetna Health Inc.	ME	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95756	23-2861565	0	0		Aetna Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95287	52-1270921	0	0		Aetna Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95234	22-2663623	0	0		Aetna Health Inc.	NY	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14408	45-2634734	0	0		Aetna Better Health Inc.	NY	IA	Aetna Health Inc. (NY)	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95490	76-0189680	0	0		Aetna Health Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95040	74-1844335	0	0		Aetna Better Health of Texas Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12328	20-2207534	0	0		Aetna Better Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1160812	0	0		Aetna Dental of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	11183	22-2990909	0	0		Aetna Dental Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95910	06-1177531	0	0		Aetna Dental Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	30-0123760	0	0		Aetna Rx Home Delivery, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	13-3670795	0	0		Aetna Health Management, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	22-3187443	0	0		Aetna Ireland Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	57-1209768	0	0		Aetna Specialty Pharmacy, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1274723	0	0		Cofinity, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2671370	0	0		@Credentials Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Services (Thailand) Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	100.000	CVS Health Corporation	N	20
0001	CVS HEALTH GROUP	13735	27-0563973	0	0		Aetna Better Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	13174	26-2867560	0	0		Aetna Better Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-5178095	0	0		Aetna Better Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14043	27-2512072	0	0		Aetna Better Health Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15805	47-3850677	0	0		Aetna Better Health of Iowa Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15616	80-0629718	0	0		Aetna Better Health, Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	80-0671703	0	0		Aetna Florida Inc.	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14229	25-2764938	0	0		Aetna Better Health Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15611	46-3203088	0	0		Aetna Better Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15919	81-1143850	0	0		Aetna Better Health of Oklahoma Inc.	OK	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	04-2708160	0	0		Aetna Student Health Agency Inc.	MA	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	73-1702453	0	0		Delaware Physicians Care, Incorporated	DE	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	01-0826783	0	0		Schaller Anderson Medical Administrators, Incorporated	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0842559	0	0		Aetna Medicaid Adminstrators LLC	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-2944270	0	0		iTriage, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP	00000	16-1471176	0	0		Prodigy Health Group, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	0.200	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	45-5527797	0	0		Innovation Health Holdings, LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	6
0001	CVS HEALTH GROUP	15097	46-0674828	0	0		Innovation Health Insurance Company	VA	IA	Innovation Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15098	46-0682197	0	0		Innovation Health Plan, Inc.	VA	IA	Innovation Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-3789357	0	0		Texas Health + Aetna Health Insurance Holding Company LLC	TX	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	9
0001	CVS HEALTH GROUP	16121	81-4749336	0	0		Texas Health + Aetna Health Insurance Company	TX	IA	Texas Health + Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16132	47-5548221	0	0		Texas Health + Aetna Health Plan Inc.	TX	IA	Texas Health + Aetna Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95109	23-2169745	0	0		Aetna Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Inc. (PA)	Ownership	39.500	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	20-0438576	0	0		Niagara Re, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-2200070	0	0		Performax, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0632355	0	0		Scrip World, LLC	UT	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1760756	0	0		Precision Benefit Services, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	31-1368946	0	0		American Health Holding, Inc.	OH	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	16-1264154	0	0		Meritain Health, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0537707	0	0		Adminco, Inc.	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0527428	0	0		Administrative Enterprises, Inc.	AZ	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	16-1684061	0	0		U.S. Healthcare Holdings, LLC	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	34-1670299	0	0		Prime Net, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	34-1348032	0	0		Professional Risk Management, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	68500	62-1181209	0	0		Continental Life Insurance Company of Brentwood, Tennessee	TN	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12321	20-2901054	0	0		American Continental Insurance Company	TN	IA	Continental Life Insurance Company of Brentwood, Tennessee	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	60054	06-6033492	0	0		Aetna Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Life Insurance Company	Ownership	60.300	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	06-1270755	0	0		AHP Holdings, Inc.	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	36153	06-1286276	0	0		Aetna Insurance Company of Connecticut	CT	IA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1028469	0	0		AE Fourteen, Incorporated	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1373153	0	0		Aetna Life Assignment Company	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-3678339	0	0		PE Holdings, LLC	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1423207	0	0		Aetna Resources L.L.C.	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Canal Place, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-3180700	0	0		Aetna Ventures, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-2108747	0	0		Broadspire National Services, Inc.	FL	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0001552250		Aetna Multi-Strategy 1099 Fund, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	79.250	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	41-2035961	0	0		Aetna Financial Holdings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	26-2030792	0	0		Aetna Asset Advisors, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2354500	0	0		U.S. Healthcare Properties, Inc.	PA	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	38-3704481	0	0		Aetna Capital Management, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	11-3667142	0	0001314522		Aetna Partners Diversified Fund, LLC	DE	NIA	Aetna Capital Management, LLC	Ownership	100.000	CVS Health Corporation	N	1
0001	CVS HEALTH GROUP	00000	20-0446676	0	0		Aetna Workers' Comp Access, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-0446713	0	0		Aetna Behavioral Health, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2670015	0	0		Managed Care Coordinators, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-3269144	0	0		Horizon Behavioral Services, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	61-1193498	0	0		Employee Assistance Services, LLC	KY	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	33-0052273	0	0		Health and Human Resource Center, Inc.	CA	IA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	75-2420973	0	0		Resources for Living, LLC	TX	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	36-3681261	0	0		The Vasquez Group Inc.	IL	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	22-3178125	0	0		Work and Family Benefits, Inc.	NJ	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

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0001	CVS HEALTH GROUP	00000	27-1773021	0	0		Aetna Card Solutions, LLC	CT	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-5216478	0	0		PayFlex Holdings, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	91-1774434	0	0		PayFlex Systems USA, Inc.	NE	NIA	PayFlex Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	78700	06-0876836	0	0		Aetna Health and Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	72052	23-2710210	0	0		Aetna Health Insurance Company	PA	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	84450	57-0805126	0	0		Aetna Health Insurance Company of New York	NY	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1571642	0	0		Aetna International Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	98-0211470	0	0		Aetna Life & Casualty (Bermuda) Ltd.	BMU	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance (Singapore) PTE. LTD.	SGP	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Bermuda) Limited	BMU	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Goodhealth Worldwide (Global) Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Europe) Limited	GBR	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Goodhealth Worldwide (Asia) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits Limited	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		PT. Aetna Global Benefits Indonesia	IDN	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	80.000	CVS Health Corporation	N	4
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Middle East) LLC	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	49.000	CVS Health Corporation	N	5
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Asia Pacific) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Spinnaker Topco Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Spinnaker Bidco Limited	GBR	NIA	Spinnaker Topco Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Holdco (UK) Limited	GBR	NIA	Spinnaker Bidco Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		PT Aetna Management Consulting	IDN	NIA	Aetna International Inc.	Ownership	77.000	CVS Health Corporation	N	13
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (UK) Limited	GBR	NIA	Aetna Holdco (UK) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance Company Limited	GBR	IA	Aetna Holdco (UK) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Asia Pacific) Limited	Ownership	0.020	CVS Health Corporation	N	2
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance Company of Europe DAC	IRL	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna (Shanghai) Enterprise Services Co. Ltd.	CHN	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna (Beijing) Enterprise Management Services Co., Ltd.	CHN	NIA	Aetna (Shanghai) Enterprise Services Co. Ltd.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Singapore) PTE. LTD.	SGP	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Singapore) PTE, LTD.	Ownership	99.980	CVS Health Corporation	N	2
0001	CVS HEALTH GROUP	00000	22-2578985	0	0		AUSHC Holdings, Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Holdings Limited	GBR	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Korea Ltd.	KOR	NIA	Aetna Global Holdings Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance (Hong Kong) Limited	HKG	NIA	Aetna Global Holdings Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1182176	0	0		PHPSNE Parent Corporation	DE	NIA	AUSHC Holdings, Inc.	Ownership	55.000	CVS Health Corporation	N	7
0001	CVS HEALTH GROUP	00000	52-2182411	0	0		Active Health Management, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-0970432	0	0		Health Data & Management Solutions, Inc.	DE	NIA	Active Health Management, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2604867	0	0		Aetna Integrated Informatics, Inc.	PA	NIA	Active Health Management, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	13980	27-2192415	0	0		Health Re, Inc.	VT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-0579372	0	0		Phoenix Data Solutions LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	46-2469464	0	0		Healthagen LLC	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	51-0029326	0	0		ASI Wings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Echo Merger Sub, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Corporate Services, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	81973	75-1296086	0	0		Coventry Health and Life Insurance Company	MO	UDP	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15761	47-3279217	0	0		Aetna Better Health of Kentucky Insurance Company	KY	RE	Coventry Health and Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-1801446	0	0		Group Dental Service, Inc.	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95846	52-2056201	0	0		Group Dental Service of Maryland, Inc.	MD	IA	Group Dental Service, Inc.	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

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0001	CVS HEALTH GROUP		81-4345344	0	0		Aetna Network Services LLC	CT	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95241	42-1244752	0	0		Aetna Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95925	42-1308659	0	0		Coventry Health Care of Nebraska, Inc.	NE	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-2049117	0	0		Aetna Risk Assurance Company of Connecticut Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95173	74-2381406	0	0		Aetna Health Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	11102	23-2366731	0	0		HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-0854096	0	0		Coventry Prescription Management Services, Inc.	NV	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16148	81-3564875	0	0		Aetna Better Health of Nevada Inc.	NV	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	96555	54-1576305	0	0		Coventry Health Care of Virginia, Inc.	VA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	01-0646056	0	0		Coventry Transplant Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	96377	43-1372307	0	0		Coventry Health Care of Missouri, Inc.	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95318	43-1702094	0	0		Aetna Better Health of Missouri LLC	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95408	55-0712129	0	0		Coventry Health Care of West Virginia, Inc.	WV	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	62-1411933	0	0		Coventry HealthCare Management Corporation	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15827	47-4352768	0	0		Aetna HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95489	48-0840330	0	0		Coventry Health Care of Kansas, Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16072	81-3370401	0	0		Aetna Better Health of Kansas Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12193	20-1052897	0	0		Aetna Better Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95407	87-0345631	0	0		Aetna Health of Utah Inc.	UT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4416606	0	0		Aetna Better Health Inc.	TN	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	74160	37-1241037	0	0		Coventry Health Care of Illinois, Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8070994	0	0		Coventry Health Care National Accounts, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-5185442	0	0		Coventry Health Care National Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	26-1293772	0	0		Coventry Consumer Advantage, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8376354	0	0		Coventry Health Care Workers Compensation, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4096903	0	0		First Script Network Service, Inc.	NV	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1095987	0	0		MetraComp, Inc.	CT	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	74-2879984	0	0		Medical Examinations of New York, P.C.	NY	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	8
0001	CVS HEALTH GROUP	00000	62-1266888	0	0		FOCUS Healthcare Management, Inc.	TN	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0443226	0	0		Coventry Rehabilitation Services, Inc.	DE	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1736437	0	0		First Health Group Corp.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	90328	38-2242132	0	0		First Health Life & Health Insurance Company	TX	IA	First Health Group Corp.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-1320522	0	0		Claims Administration Corp.	MD	NIA	First Health Group Corp.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1130063	0	0		Florida Health Plan Administrators, LLC	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95114	65-0986441	0	0		Coventry Health Care of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95266	65-0453436	0	0		Coventry Health Plan of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-3750548	0	0		Carefree Insurance Services, Inc.	FL	NIA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	36-4391310	0	0		bswift LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Virtual Home Healthcare L.L.C.	ARE	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	17
0001	CVS HEALTH GROUP	00000	26-1582982	0	0		MHNet Specialty Services, LLC	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	37-1448790	0	0		Mental Health Network of New York IPA, Inc.	NY	NIA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12509	20-2516317	0	0		MHNet Life and Health Insurance Company	TX	IA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	72-1106596	0	0		Mental Health Associates, Inc.	LA	NIA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4276336	0	0		MHNet of Florida, Inc.	FL	IA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP	16242	81-5030233	0	0		Aetna Better Health of Washington, Inc.	WA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5212760	0	0		Banner Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	51.000	CVS Health Corporation	N	10
0001	CVS HEALTH GROUP	16058	81-5281115	0	0		Banner Health and Aetna Health Insurance Company	AZ	IA	Banner Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16059	81-5290023	0	0		Banner Health and Aetna Health Plan Inc.	AZ	IA	Banner Health and Aetna Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5112888	0	0		Allina Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	11
0001	CVS HEALTH GROUP	16194	82-2091197	0	0		Allina Health and Aetna Insurance Company	MN	IA	Allina Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	82-2171057	0	0		Sutter Health and Aetna Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	12
0001	CVS HEALTH GROUP	00000	82-2560624	0	0		Sutter Health and Aetna Administrative Services LLC	DE	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5290023	0	0		Sutter Health and Aetna Insurance Company	CA	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Holdings (Thailand) Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	14
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Minor Health Entreprise Co, Ltd.	Ownership	46.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	28.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	19
0001	CVS HEALTH GROUP	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	CVS Health Corporation	N	16
0001	CVS HEALTH GROUP	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	75.000	CVS Health Corporation	N	16
0001	CVS HEALTH GROUP	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	51.000	CVS Health Corporation	N	19
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Bahamas) Limited	BHS	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Pharmacy Management Services LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	82-3333789	0	0		Aetna Better Health of North Carolina Inc.	NC	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd	CHN	NIA	Aetna International Inc.	Ownership	50.000	CVS Health Corporation	N	18

Asterisk	Explanation
1	Aetna Life Insurance Company own substantially all of the non-managing membership interests of Aetna Partners Diversified Fund LLC.
2	Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
3	Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
4	PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
5	Aetna Global Benefits (Middle East) LLC is also 51% owned by Euro Gulf LLC, Aetna's Nominee.
6	Innovation Health Holdings LLC. Is also 50% owned by Inova Health System Foundation.
7	PHPSNE Parent Corporation is 55% owned by AUSHC Holdings, Inc. The remaining 45% is owned by thirteen different hospitals (non-affiliates) which are shareholders with varying degrees of ownership.
8	Medical Examinations of New York, P.C. is 100% owned through Aetna's nominees.
9	Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
10	Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
11	Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
12	Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.
13	PT Aetna Management Consulting is also 23% owned by PT Asuransi Central Asia.
14	Aetna Holdings (Thailand) Limited is also 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Global Benefits (Bermuda) Limited owns 1 share

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

Asterisk	Explanation
15	Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 share), Mr. Jitphasong Itsaraphakded (1 share); Mrs. Suphee Wattana (1 share); and Mr. Buncha Tamphragom (1 share)
16	Minor Health Enterprise Co, Ltd is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
17	Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC, Aetna's Nominee.
18	Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd.
19	Health Care Management Co. Ltd. Is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
20	Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited and (1 share) owned by Aetna Global Holdings Limited.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Response
1. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?	NO

Explanation:

1. Business not written

Bar Code:

1. Medicare Part D Coverage Supplement [Document Identifier 365]

OVERFLOW PAGE FOR WRITE-INS

NONE

SCHEDULE A - VERIFICATION

Real Estate

NONE

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		
	2.2 Additional investment made after acquisition		
3.	Current year change in encumbrances		
4.	Total gain (loss) on disposals		
5.	Deduct amounts received on disposals		
6.	Total foreign exchange change in book/adjusted carrying value		
7.	Deduct current year's other than temporary impairment recognized		
8.	Deduct current year's depreciation		
9.	Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8)		
10.	Deduct total nonadmitted amounts		
11.	Statement value at end of current period (Line 9 minus Line 10)		

SCHEDULE B - VERIFICATION

Mortgage Loans

		1 Year to Date	2 Prior Year Ended December 31
1.	Book value/recorded investment excluding accrued interest, December 31 of prior year	13,407,858	12,979,171
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition	0	0
	2.2 Additional investment made after acquisition	378,367	621,181
3.	Capitalized deferred interest and other	0	0
4.	Accrual of discount	0	0
5.	Unrealized valuation increase (decrease)	0	0
6.	Total gain (loss) on disposals	0	0
7.	Deduct amounts received on disposals	82,137	316,980
8.	Deduct amortization of premium and mortgage interest points and commitment fees	(31,473)	(124,486)
9.	Total foreign exchange change in book value/recorded investment excluding accrued interest	0	0
10.	Deduct current year's other than temporary impairment recognized	0	0
11.	Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	13,735,561	13,407,858
12.	Total valuation allowance	0	0
13.	Subtotal (Line 11 plus Line 12)	13,735,561	13,407,858
14.	Deduct total nonadmitted amounts	0	0
15.	Statement value at end of current period (Line 13 minus Line 14)	13,735,561	13,407,858

SCHEDULE BA - VERIFICATION

Other Long-Term Invested Assets

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	0	0
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition	8,200,000	0
	2.2 Additional investment made after acquisition	0	0
3.	Capitalized deferred interest and other	0	0
4.	Accrual of discount	0	0
5.	Unrealized valuation increase (decrease)	0	0
6.	Total gain (loss) on disposals	0	0
7.	Deduct amounts received on disposals	(208,800)	0
8.	Deduct amortization of premium and depreciation	0	0
9.	Total foreign exchange change in book/adjusted carrying value	0	0
10.	Deduct current year's other than temporary impairment recognized	0	0
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	8,408,800	0
12.	Deduct total nonadmitted amounts	0	0
13.	Statement value at end of current period (Line 11 minus Line 12)	8,408,800	0

SCHEDULE D - VERIFICATION

Bonds and Stocks

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value of bonds and stocks, December 31 of prior year	442,356,087	479,236,865
2.	Cost of bonds and stocks acquired	50,210,607	177,142,775
3.	Accrual of discount	225,024	653,212
4.	Unrealized valuation increase (decrease)	1,741,033	(1,947,081)
5.	Total gain (loss) on disposals	452,978	(2,448,888)
6.	Deduct consideration for bonds and stocks disposed of	43,673,884	205,903,403
7.	Deduct amortization of premium	793,394	3,328,608
8.	Total foreign exchange change in book/adjusted carrying value	0	0
9.	Deduct current year's other than temporary impairment recognized	0	1,362,411
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees	0	313,626
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)	450,518,451	442,356,087
12.	Deduct total nonadmitted amounts	0	0
13.	Statement value at end of current period (Line 11 minus Line 12)	450,518,451	442,356,087

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1B

Showing the Acquisitions, Dispositions and Non-Trading Activity
During the Current Quarter for all Bonds and Preferred Stock by NAIC Designation

NAIC Designation	1 Book/Adjusted Carrying Value Beginning of Current Quarter	2 Acquisitions During Current Quarter	3 Dispositions During Current Quarter	4 Non-Trading Activity During Current Quarter	5 Book/Adjusted Carrying Value End of First Quarter	6 Book/Adjusted Carrying Value End of Second Quarter	7 Book/Adjusted Carrying Value End of Third Quarter	8 Book/Adjusted Carrying Value December 31 Prior Year
BONDS								
1. NAIC 1 (a)	318,735,533	503,374,256	477,261,314	653,284	345,501,759	0	0	318,735,533
2. NAIC 2 (a)	81,339,538	86,069,867	88,732,517	(425,172)	78,251,716	0	0	81,339,538
3. NAIC 3 (a)	49,057,322	8,096,146	11,819,343	1,713,553	47,047,678	0	0	49,057,322
4. NAIC 4 (a)	4,709,236	2,067,500	500,000	(467,915)	5,808,821	0	0	4,709,236
5. NAIC 5 (a)	0	0	0	0	0	0	0	0
6. NAIC 6 (a)	0	0	0	0	0	0	0	0
7. Total Bonds	453,841,629	599,607,769	578,313,174	1,473,750	476,609,974	0	0	453,841,629
PREFERRED STOCK								
8. NAIC 1	0	0	0	0	0	0	0	0
9. NAIC 2	0	0	0	0	0	0	0	0
10. NAIC 3	0	0	0	0	0	0	0	0
11. NAIC 4	0	0	0	0	0	0	0	0
12. NAIC 5	0	0	0	0	0	0	0	0
13. NAIC 6	0	0	0	0	0	0	0	0
14. Total Preferred Stock	0	0	0	0	0	0	0	0
15. Total Bonds and Preferred Stock	453,841,629	599,607,769	578,313,174	1,473,750	476,609,974	0	0	453,841,629

(a) Book/Adjusted Carrying Value column for the end of the current reporting period includes the following amount of short-term and cash equivalent bonds by NAIC designation:

NAIC 1 $ 26,091,523 ; NAIC 2 $ 0 ; NAIC 3 $ 0 NAIC 4 $ 0 ; NAIC 5 $ 0 ; NAIC 6 $ 0

Schedule DA - Part 1 - Short-Term Investments

N O N E

Schedule DA - Verification - Short-Term Investments

N O N E

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

SCHEDULE E - PART 2 - VERIFICATION

(Cash Equivalents)

		1 Year To Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	11,486,582	14,867,395
2.	Cost of cash equivalents acquired	549,469,087	2,565,130,542
3.	Accrual of discount	301,084	1,164,952
4.	Unrealized valuation increase (decrease)	0	0
5.	Total gain (loss) on disposals	42	(722)
6.	Deduct consideration received on disposals	535,164,782	2,569,675,585
7.	Deduct amortization of premium	0	0
8.	Total foreign exchange change in book/adjusted carrying value	0	0
9.	Deduct current year's other than temporary impairment recognized	0	0
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	26,092,013	11,486,582
11.	Deduct total nonadmitted amounts	0	0
12.	Statement value at end of current period (Line 10 minus Line 11)	26,092,013	11,486,582

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE B - PART 2

Showing All Mortgage Loans ACQUIRED AND ADDITIONS MADE During the Current Quarter

1	Location		4	5	6	7	8	9
	2	3						
Loan Number	City	State	Loan Type	Date Acquired	Rate of Interest	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Value of Land and Buildings
2004473	MT LAUREL	NJ		12/18/2017	5.280	0	378,367	13,100,000
0599999. Mortgages in good standing - Commercial mortgages-all other						0	378,367	13,100,000
0899999. Total Mortgages in good standing						0	378,367	13,100,000
1699999. Total - Restructured Mortgages						0	0	0
2499999. Total - Mortgages with overdue interest over 90 days						0	0	0
3299999. Total - Mortgages in the process of foreclosure						0	0	0
3399999 - Totals						0	378,367	13,100,000

SCHEDULE B - PART 3

Showing All Mortgage Loans DISPOSED, Transferred or Repaid During the Current Quarter

1	Location		4	5	6	7	Change in Book Value/Recorded Investment						14	15	16	17	18
	2	3					8	9	10	11	12	13					
Loan Number	City	State	Loan Type	Date Acquired	Disposal Date	Book Value/ Recorded Investment Excluding Accrued Interest Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Amortization) /Accretion	Current Year's Other Than Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Change in Book Value (8+9-10+11)	Total Foreign Exchange Change in Book Value	Book Value/ Recorded Investment Excluding Accrued Interest on Disposal	Consid-eration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal
2004182	GLEN BURNIE	MD		12/18/2017		5,803,426	0	31,473	0	0	31,473	0	0	82,137	0	0	0
0299999. Mortgages with partial repayments						5,803,426	0	31,473	0	0	31,473	0	0	82,137	0	0	0
0599999 - Totals						5,803,426	0	31,473	0	0	31,473	0	0	82,137	0	0	0

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE BA - PART 2

Showing Other Long-Term Invested Assets ACQUIRED AND ADDITIONS MADE During the Current Quarter

1	2	Location		5	6	7	8	9	10	11	12	13
		3	4									
CUSIP Identification	Name or Description	City	State	Name of Vendor or General Partner	NAIC Designation and Administrative Symbol/ Market Indicator	Date Originally Acquired	Type and Strategy	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Amount of Encumbrances	Commitment for Additional Investment	Percentage of Ownership
	AETNA PARTNER DIVERSIFIED LLC	Hartford	CT	DIRECT		01/02/2019	13	8,200,000	0	0	0	0.000
4399999. Any Other Class of Assets - Affiliated								8,200,000	0	0	0	XXX
4499999. Total - Unaffiliated								0	0	0	0	XXX
4599999. Total - Affiliated								8,200,000	0	0	0	XXX
4699999 - Totals								8,200,000	0	0	0	XXX

SCHEDULE BA - PART 3

Showing Other Long-Term Invested Assets DISPOSED, Transferred or Repaid During the Current Quarter

1	2	Location		5	6	7	8	Change in Book/Adjusted Carrying Value						15	16	17	18	19	20
		3	4					9	10	11	12	13	14						
CUSIP Identification	Name or Description	City	State	Name of Purchaser or Nature of Disposal	Date Originally Acquired	Disposal Date	Book/ Adjusted Carrying Value Less Encumbrances, Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Depreciation) or (Amortization)/ Accretion	Current Year's Other Than Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Change in Book/ Adjusted Carrying Value (9+10-11+12)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value Less Encumbrances on Disposal	Consideration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Investment Income
	AETNA PARTNERS DIVERSIFIED LLC	Hartford	CT	PROCEEDS FROM OPERATIONS	01/02/2019	03/31/2019	0	0	0	0	0	0	0	0	(208,800)	0	0	0	0
4399999. Any Other Class of Assets - Affiliated							0	0	0	0	0	0	0	0	(208,800)	0	0	0	0
4499999. Total - Unaffiliated							0	0	0	0	0	0	0	0	0	0	0	0	0

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE BA - PART 3

Showing Other Long-Term Invested Assets DISPOSED, Transferred or Repaid During the Current Quarter

1	2	Location		5	6	7	8	Change in Book/Adjusted Carrying Value						15	16	17	18	19	20
		3	4					9	10	11	12	13	14						
CUSIP Identification	Name or Description	City	State	Name of Purchaser or Nature of Disposal	Date Originally Acquired	Disposal Date	Book/ Adjusted Carrying Value Less Encum-brances, Prior Year	Unrealized Valuation Increase (De-crease)	Current Year's (Depre-ciation) or (Amorti-zation)/ Accretion	Current Year's Other Than Temporary Impair-ment Recog-nized	Capital-ized Deferred Interest and Other	Total Change in Book/ Adjusted Carrying Value (9+10-11+12)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value Less Encum-brances on Disposal	Consid-eration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Invest-ment Income
4599999. Total - Affiliated							0	0	0	0	0	0	0	0	(208,800)	0	0	0	0
4699999 - Totals							0	0	0	0	0	0	0	0	(208,800)	0	0	0	0

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 3

Show All Long-Term Bonds and Stock Acquired During the Current Quarter

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends	10 NAIC Designation and Administrative Symbol/ Market Indicator (a)
180848-YQ-0	CLARK CNTY NEV PKS IMPT 5.000% 12/01/27		02/11/2019	MORGAN STANLEY		3,068,400	2,500,000	28,819	1FE
517210-XC-9	LARIMER WELD & BOULDER CNTY CO 5.000% 12/15/31		01/17/2019	Stifel Nicolaus &Co.		4,294,603	3,570,000	0	1FE
566880-WU-0	MARICOPA CNTY AZ ELEM SCH DIST SCH IMPT-PROJ 2016-SER B 5.000% 07/01/31		01/18/2019	PIPER, JAFFRAY & HOPWOOD		5,702,624	4,755,000	0	1FE
77355P-TA-1	ROCKLAND CNTY NY PUBLIC IMPT-SER C 4.000% 05/01/23		03/07/2019	Wachovia		1,443,495	1,325,000	19,139	1FE
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						14,509,122	12,150,000	47,958	XXX
64972G-SR-6	NEW YORK CITY NY MUNI WTR FIN REF-2ND GEN-RESOLUTION-SUBSER 4.000% 06/15/40		03/12/2019	MERRILL LYNCH-MUNI		3,717,455	3,500,000	0	1FE
79766D-LL-1	SAN FRANCISCO CALIF CITY AMT-REF-2ND SER-SER G 5.000% 05/01/27		02/11/2019	JPM-CHASE		1,199,400	1,000,000	14,167	1FE
79766D-MJ-5	SAN FRANCISCO CALIF CITY SAN FRANCISCO ARPT 5.000% 05/01/27		01/11/2019	JPM-CHASE		3,674,880	3,000,000	0	1FE
3199999. Subtotal - Bonds - U.S. Special Revenues						8,591,735	7,500,000	14,167	XXX
00164V-AE-3	AMC NETWORKS INC SR UNSECURED 4.750% 08/01/25		01/17/2019	CITIGROUP		967,500	1,000,000	22,563	3FE
03523T-BX-5	ANHEUSER-BUSCH INBEV WOR SR UNSECURED 4.150% 01/23/25		01/25/2019	HSBC SEC INC		1,015,190	1,000,000	692	2FE
126307-AZ-0	CSC HOLDINGS LLC SR UNSECURED 6.500% 02/01/29		01/24/2019	FIRST BOSTON CORP		1,000,000	1,000,000	0	3FE
156700-AX-4	CENTURYTEL INC SR UNSECURED 6.750% 12/01/23		02/13/2019	MORGAN STANLEY		1,010,000	1,000,000	13,875	4FE
228187-AB-6	CROWN AMER/CAP CORP VI SR UNSECURED 4.750% 02/01/26		01/18/2019	Tax Free Exchange		1,209,896	1,250,000	27,543	3FE
23311V-AG-2	DCP MIDSTREAM OPERATING SR UNSECURED 5.375% 07/15/25		01/16/2019	MIZUHO SECURITIES USA		1,007,500	1,000,000	448	3FE
24824T-AQ-3	DENALI CAPITAL CLO XII LTD SERIES 16-1A CLASS A1R 3.837% 04/15/31		01/17/2019	BNP PARIBAS		986,250	1,000,000	746	1FE
361886-BK-9	GMF FLOORPLAN OWNER REVOLVING SER 18-2 CLASS A1 3.130% 03/15/23		01/23/2019	WACHOVIA		1,499,824	1,500,000	1,304	1FE
369604-BD-4	GENL ELEC CO SR UNSECURED 2.700% 10/09/22		01/22/2019	CHASE SECURITIES		945,130	1,000,000	7,875	2FE
44929F-BC-5	ICG US CLO LTD SER 14-3A 4.271% 04/25/31		01/04/2019	BNP PARIBAS		970,000	1,000,000	8,534	1FE
49327M-2X-1	KEY BANK NA SR UNSECURED 3.300% 02/01/22		01/24/2019	Keybanc Capital Markets Inc		1,499,325	1,500,000	0	1FE
53117C-AP-7	LIBERTY PROPERTY LP SR UNSECURED 3.375% 06/15/23		01/22/2019	WACHOVIA		1,474,695	1,500,000	5,484	2FE
56844A-AE-9	MARINER CLO LLC SERIES 19-1A CLASS C 5.551% 04/30/32		03/29/2019	CITIGROUP		2,000,000	2,000,000	0	1Z
64110L-AL-0	NETFLIX INC SR UNSECURED 5.875% 02/15/25		01/14/2019	FIRST BOSTON CORP		1,032,500	1,000,000	14,851	3FE
74340X-AW-1	PROLOGIS INC SR UNSECURED 4.250% 08/15/23		03/07/2019	WACHOVIA		1,050,200	1,000,000	3,069	1FE
78454L-AP-5	SM ENERGY CO SR UNSECURED 6.625% 01/15/27		03/18/2019	GOLDMAN SACHS & CO		947,500	1,000,000	11,962	3FE
85207U-AF-2	SPRINT CORP SR UNSECURED 7.875% 09/15/23		01/23/2019	CITIGROUP		1,057,500	1,000,000	28,438	4FE
913017-DB-2	UNITED TECHNOLOGIES CORP SR UNSECURED 3.650% 08/16/23		01/23/2019	FIRST BOSTON CORP		2,009,360	2,000,000	32,242	2FE
92840V-AB-8	VISTRA OPERATIONS CO LLC SR UNSECURED 5.625% 02/15/27		01/22/2019	CHASE SECURITIES		1,000,000	1,000,000	0	3FE
95000U-2C-6	WELLS FARGO & COMPANY SR UNSECURED 3.750% 01/24/24		01/16/2019	WACHOVIA		1,996,380	2,000,000	0	1FE
98162Y-AD-5	WORLD OMNI AUTO RECEIVABLES SERIES 19-A CLASS A3 3.040% 05/15/24		01/23/2019	BANC AMERICA		1,499,751	1,500,000	0	1FE
984121-CQ-4	XEROX CORP SR UNSECURED 4.125% 03/15/23		01/23/2019	PRESSPRICH		931,250	1,000,000	13,090	3FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						27,109,751	27,250,000	192,716	XXX
8399997. Total - Bonds - Part 3						50,210,608	46,900,000	254,841	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX
8399999. Total - Bonds						50,210,608	46,900,000	254,841	XXX
8999997. Total - Preferred Stocks - Part 3						0	XXX	0	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	XXX
9799997. Total - Common Stocks - Part 3						0	XXX	0	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	XXX
9999999 - Totals						50,210,608	XXX	254,841	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues 0

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation and Admini-strative Symbol /Market Indicator (a)
3620AM-DZ-2	GOVT NATL MTGE ASSN I POOL NO GN733720 4.500% 06/15/40		03/01/2019	Paydown		95,957	95,957	105,673	105,277	0	(9,320)	0	(9,320)	0	95,957	0	0	0	894	06/15/2040	1
0599999. Subtotal - Bonds - U.S. Governments						95,957	95,957	105,673	105,277	0	(9,320)	0	(9,320)	0	95,957	0	0	0	894	XXX	XXX
517210-XC-9	LARIMER WELD & BOULDER CNTY CO 5.000% 12/15/31		03/27/2019	Mesirow Financial		4,425,515	3,570,000	4,294,603	0	0	(10,680)	0	(10,680)	0	4,283,923	0	141,592	141,592	29,254	12/15/2031	1FE
77355P-TA-1	ROCKLAND CNTY NY PUBLIC IMPT-SER C 4.000% 05/01/23		03/12/2019	FIDELITY CAPITAL MARKETS		273,570	250,000	272,358	0	0	(43)	0	(43)	0	272,314	0	1,256	1,256	3,694	05/01/2023	1FE
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						4,699,085	3,820,000	4,566,961	0	0	(10,723)	0	(10,723)	0	4,556,237	0	142,848	142,848	32,948	XXX	XXX
072024-TA-0	BAY AREA TOLL AUTH CALIF TOLL SER S-4 5.000% 04/01/30		03/07/2019	MERRILL LYNCH-MUNI		2,281,180	2,000,000	2,050,340	2,024,990	0	(958)	0	(958)	0	2,024,031	0	257,149	257,149	44,444	04/01/2030	1FE
13048R-AE-7	CALIFORNIA MUN FIN AUTH VAR WASTE MGMT INC PROJ SER A 1.550% 02/01/19		02/01/2019	Maturity		2,700,000	2,700,000	2,700,000	2,700,000	0	0	0	0	0	2,700,000	0	0	0	17,438	02/01/2019	1FE
254845-HF-0	DISTRICT COLUMBIA WTR AND SWR REVENUE BONDS 5.000% 10/01/25		02/08/2019	DAIN RAUSCHER INC-69211		1,111,370	1,000,000	1,188,300	1,073,692	0	(2,114)	0	(2,114)	0	1,071,577	0	39,793	39,793	18,194	10/01/2025	1FE
3132XY-UX-3	FED HOME LOAN MTGE CORP GOLD POOL NO 4.000% 05/01/48		03/01/2019	Paydown		75,020	75,020	76,520	76,492	0	(1,472)	0	(1,472)	0	75,020	0	0	0	557	05/01/2048	1
3138X8-XG-1	FED NATL MTGE ASSN POOL NO AU8778 3.000% 10/01/28		03/01/2019	Paydown		70,136	70,136	72,689	71,968	0	(1,832)	0	(1,832)	0	70,136	0	0	0	354	10/01/2028	1
34160W-XS-8	FLORIDA DEPT ENVIRON PROTECTIO REF 5.000% 07/01/24		01/08/2019	Wachovia		1,738,155	1,500,000	1,834,005	1,701,457	0	(868)	0	(868)	0	1,700,589	0	37,567	37,567	39,375	07/01/2024	1FE
57584X-8F-1	MASSACHUSETTS STATE DEV FIN REF-PARTNERS HEALTHCARE SYSTEM 5.000% 07/01/24		01/22/2019	SIEBERT,BRANDFORD & CO		922,584	800,000	939,904	919,462	0	(1,322)	0	(1,322)	0	918,140	0	4,444	4,444	22,556	07/01/2024	1FE
57586P-6Q-4	MASSACHUSETTS ST HSG FIN AGY REVENUE BONDS 2.650% 12/01/41		01/21/2019	Call 100.0000		95,000	95,000	98,988	96,711	0	(24)	0	(24)	0	96,687	0	(1,687)	(1,687)	350	12/01/2041	1FE
67886M-MP-1	OKLAHOMA ST HSG FIN AGY SF MTG HOMEOWNERSHIP LN PG SER A 4.750% 03/01/28		03/01/2019	Call 100.0000		30,000	30,000	32,336	30,479	0	(26)	0	(26)	0	30,453	0	(453)	(453)	614	03/01/2028	1FE
3199999. Subtotal - Bonds - U.S. Special Revenues						9,023,445	8,270,156	8,993,082	8,695,251	0	(8,616)	0	(8,616)	0	8,686,633	0	336,813	336,813	143,882	XXX	XXX
03674X-AC-0	ANTERO RESSOURCES CORP SR UNSECURED 5.125% 12/01/22		02/04/2019	Various		805,000	800,000	787,750	751,962	37,562	(107)	0	37,455	0	789,416	0	15,584	15,584	7,403	12/01/2022	3FE
1248EP-BM-4	CCO HOLDINGS LLC CAP CORP SR UNSECURED 5.750% 02/15/26		01/14/2019	Deutsche Bank - 2485 DTC		1,496,250	1,500,000	1,500,000	1,470,518	29,483	0	0	29,483	0	1,500,000	0	(3,750)	(3,750)	36,177	02/15/2026	3FE
126307-AZ-0	CSC HOLDINGS LLC SR UNSECURED 6.500% 02/01/29		01/25/2019	PRESSPRICH		1,008,750	1,000,000	1,000,000	0	0	0	0	0	0	1,000,000	0	8,750	8,750	0	02/01/2029	3FE
144141-CZ-9	CAROLINA PR & LT FIRST MTGE 5.300% 01/15/19		01/15/2019	Maturity		500,000	500,000	537,040	500,171	0	(171)	0	(171)	0	500,000	0	0	0	13,250	01/15/2019	1FE
16411Q-AC-5	CHENIERE ENERGY PARTNERS SR UNSECURED 5.625% 10/01/26		03/05/2019	CHASE SECURITIES		1,011,250	1,000,000	1,000,000	940,795	59,205	0	0	59,205	0	1,000,000	0	11,250	11,250	27,500	10/01/2026	3FE
184496-AL-1	CLEAN HARBORS INC SR UNSECURED 5.125% 06/01/21		01/17/2019	PRESSPRICH		500,625	500,000	504,561	497,459	2,541	0	0	2,541	0	500,000	0	625	625	3,345	06/01/2021	3FE
228187-AA-8	CROWN AMER/CAP CORP VI SR UNSECURED 4.750% 02/01/26		01/18/2019	Tax Free Exchange		1,209,895	1,250,000	1,209,375	1,182,943	26,703	250	0	26,953	0	1,209,896	0	0	0	27,543	02/01/2026	3FE
23311V-AG-2	DCP MIDSTREAM OPERATING SR UNSECURED 5.375% 07/15/25		02/20/2019	SUNTRUST CAP MARKETS		1,035,000	1,000,000	1,007,500	0	0	(146)	0	(146)	0	1,007,354	0	27,646	27,646	5,524	07/15/2025	3FE
31677Q-BF-5	FIFTH THIRD BANCORP SR UNSECURED 2.300% 03/15/19		03/15/2019	Maturity		2,500,000	2,500,000	2,499,425	2,499,879	0	121	0	121	0	2,500,000	0	0	0	28,750	03/15/2019	1FE
337738-AR-9	FISERV INC SR UNSECURED 4.200% 10/01/28		03/18/2019	Various		980,585	1,000,000	998,050	998,037	0	47	0	47	0	998,084	0	(17,499)	(17,499)	16,800	10/01/2028	2FE
49327M-2X-1	KEY BANK NA SR UNSECURED 3.300% 02/01/22		03/07/2019	MITSUBISHI		1,516,350	1,500,000	1,499,325	0	0	(11)	0	(11)	0	1,499,314	0	17,036	17,036	5,500	02/01/2022	1FE
626717-AJ-1	MURPHY OIL CORP SR UNSECURED 5.750% 08/15/25		03/21/2019	BARCLAY INVESTMENTS		1,043,750	1,000,000	965,000	937,641	27,576	998	0	28,574	0	966,215	0	77,535	77,535	35,139	08/15/2025	3FE
629377-CE-0	NRG ENERGY INC SR UNSECURED 5.750% 01/15/28		03/06/2019	GOLDMAN SACHS & CO		522,500	500,000	488,750	481,134	7,679	145	0	7,824	0	488,958	0	33,542	33,542	18,608	01/15/2028	3FE
62957H-AF-2	NABORS INDUSTRIES INC. SR UNSECURED 5.750% 02/01/25		03/13/2019	CHASE SECURITIES		900,000	1,000,000	998,780	754,685	244,164	13	0	244,177	0	998,862	0	(98,862)	(98,862)	35,778	02/01/2025	3FE
651290-AP-3	NEWFIELD EXPLORATION CO SR UNSECURED 5.750% 01/30/22		03/12/2019	BARCLAY INVESTMENTS		528,600	500,000	436,250	463,493	0	2,110	0	2,110	0	465,603	0	62,997	62,997	17,889	01/30/2022	3FE

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation and Admini-strative Symbol /Market Indicator (a)
69318F-AE-8	PBF HOLDING CO LLC SECURED 7.000% 11/15/23		02/15/2019	GOLDMAN SACHS & CO		518,750	500,000	500,000	477,537	22,463	0	0	22,463	0	500,000	0	18,750	18,750	9,236	11/15/2023	4FE
86765L-AL-1	SUNOCO LP/FINANCE CORP SR UNSECURED 5.500% 02/15/26		02/05/2019	FIRST BOSTON CORP		985,000	1,000,000	1,004,202	943,590	60,554	(40)	0	60,514	0	1,004,105	0	(19,105)	(19,105)	26,278	02/15/2026	3FE
87165B-AJ-2	SYNCHRONY FINANCIAL SR UNSECURED 2.600% 01/15/19		01/15/2019	Maturity		2,000,000	2,000,000	1,999,480	1,999,970	0	30	0	30	0	2,000,000	0	0	0	26,000	01/15/2019	2FE
87165L-BJ-9	SYNCHRONY CREDIT CARD MASTER SERIES 2016-3 CLASS A 1.580% 09/15/22		03/13/2019	CHASE SECURITIES		4,969,922	5,000,000	4,999,447	4,999,867	0	39	0	39	0	4,999,906	0	(29,984)	(29,984)	19,750	09/15/2022	1FE
880349-AR-6	TENNECO INC SR UNSECURED 5.000% 07/15/26		01/03/2019	FIRST BOSTON CORP		767,500	1,000,000	883,750	767,640	121,094	201	0	121,295	0	888,935	0	(121,435)	(121,435)	23,889	07/15/2026	3FE
034863-AR-1	ANGLO AMERICAN CAPITAL SR UNSECURED 4.750% 04/10/27	D	03/22/2019	FIRST BOSTON CORP		1,527,765	1,500,000	1,449,510	1,450,162	0	1,224	0	1,224	0	1,451,384	0	76,379	76,379	32,854	04/10/2027	2FE
251526-BR-9	DEUTSCHE BANK NY SR UNSECURED 3.950% 02/27/23	D	01/14/2019	DEUTSCHE BANK		1,408,845	1,500,000	1,497,105	1,497,492	0	34	0	34	0	1,497,526	0	(88,681)	(88,681)	22,877	02/27/2023	2FE
46115H-AZ-0	INTESA SANPAOLO SPA SR UNSECURED 3.125% 07/14/22	D	01/18/2019	MITSUBISHI		1,388,060	1,500,000	1,383,828	1,383,828	0	1,693	0	1,693	0	1,385,521	0	2,539	2,539	24,392	07/14/2022	2FE
552081-AG-6	LYONDELLBASELL IND NV SR UNSECURED 5.000% 04/15/19	D	02/09/2019	Call 100.0000		731,000	731,000	814,583	731,773	0	(773)	0	(773)	0	731,000	0	0	0	11,574	04/15/2019	2FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						29,855,397	30,281,000	29,963,711	25,730,576	639,024	5,657	0	644,681	0	29,882,079	0	(26,683)	(26,683)	476,056	XXX	XXX
8399997. Total - Bonds - Part 4						43,673,884	42,467,113	43,629,427	34,531,104	639,024	(23,002)	0	616,022	0	43,220,906	0	452,978	452,978	653,780	XXX	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8399999. Total - Bonds						43,673,884	42,467,113	43,629,427	34,531,104	639,024	(23,002)	0	616,022	0	43,220,906	0	452,978	452,978	653,780	XXX	XXX
8999997. Total - Preferred Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799997. Total - Common Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9999999 - Totals						43,673,884	XXX	43,629,427	34,531,104	639,024	(23,002)	0	616,022	0	43,220,906	0	452,978	452,978	653,780	XXX	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues.....0

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

SCHEDULE E - PART 1 - CASH

Month End Depository Balances

1	2	3	4	5	Book Balance at End of Each Month During Current Quarter			9
					6	7	8	
Depository	Code	Rate of Interest	Amount of Interest Received During Current Quarter	Amount of Interest Accrued at Current Statement Date	First Month	Second Month	Third Month	*
Bank of America Charlotte, NC		0.000	0	0	14,799,534	10,083,933	11,188,200	XXX
0199998. Deposits in 1 depositories that do not exceed the allowable limit in any one depository (See instructions) - Open Depositories	XXX	XXX	0	0	(42,864)	(23,660)	(23,662)	XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	14,756,670	10,060,273	11,164,538	XXX
0299998. Deposits in 0 depositories that do not exceed the allowable limit in any one depository (See instructions) - Suspended Depositories	XXX	XXX	0	0	0	0	0	XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	14,756,670	10,060,273	11,164,538	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX	0	0	0	XXX
0599999. Total - Cash	XXX	XXX	0	0	14,756,670	10,060,273	11,164,538	XXX

STATEMENT AS OF MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned End of Current Quarter

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
0599999. Total - U.S. Government Bonds						0	0	0
1099999. Total - All Other Government Bonds						0	0	0
1799999. Total - U.S. States, Territories and Possessions Bonds						0	0	0
2499999. Total - U.S. Political Subdivisions Bonds						0	0	0
3199999. Total - U.S. Special Revenues Bonds						0	0	0
	AMERICAN ELEC POWER CP 4-2 144A		03/26/2019	2.710	04/09/2019	6,527,065	0	2,948
	APACHE CORP CP 4-2		03/29/2019	2.800	04/01/2019	3,500,000	0	817
	AVIATION CAPITAL GROUP CP 4(2) 144A		03/11/2019	2.720	04/08/2019	4,997,351	0	7,929
	CENTERPOINT ENERGY RESOU CP 4(2)		03/20/2019	2.750	04/09/2019	3,136,081	0	2,875
	CENTERPOINT ENERGY RESOU CP 4(2)		03/20/2019	2.770	04/15/2019	2,161,667	0	1,996
	ENTERGY CORP CP 4(2) 144A		03/22/2019	2.710	04/15/2019	2,501,359	0	1,883
	UNION ELECTRIC CO CP 3(A)3		03/29/2019	2.680	04/01/2019	3,268,000	0	730
3299999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations						26,091,523	0	19,178
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						26,091,523	0	19,178
4899999. Total - Hybrid Securities						0	0	0
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0
6099999. Subtotal - SVO Identified Funds						0	0	0
6599999. Subtotal - Bank Loans						0	0	0
7799999. Total - Issuer Obligations						26,091,523	0	19,178
7899999. Total - Residential Mortgage-Backed Securities						0	0	0
7999999. Total - Commercial Mortgage-Backed Securities						0	0	0
8099999. Total - Other Loan-Backed and Structured Securities						0	0	0
8199999. Total - SVO Identified Funds						0	0	0
8299999. Total - Bank Loans						0	0	0
8399999. Total Bonds						26,091,523	0	19,178
60934N-50-0	FEDERATED INVESTORS INC TREASURY OBLIGATION FUND		03/28/2019	0.000		490	6	12
8599999. Subtotal - Exempt Money Market Mutual Funds - as Identified by the SVO						490	6	12
8899999 - Total Cash Equivalents						26,092,013	6	19,190

SUPPLEMENT FOR THE QUARTER ENDING MARCH 31, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

MEDICARE PART D COVERAGE SUPPLEMENT

(Net of Reinsurance)

NAIC Group Code 0001 NAIC Company Code 15761

	Individual Coverage		Group Coverage		5
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	Total Cash
1. Premiums Collected		XXX		XXX	
2. Earned Premiums		XXX		XXX	XXX
3. Claims Paid		XXX		XXX	
4. Claims Incurred				XXX	XXX
5. Reinsurance Coverage and Low Income Cost Sharing - Claims Paid Net of Reimbursements Applied (a)	XXX		XXX		
6. Aggregate Policy Reserves - Change		XXX		XXX	XXX
7. Expenses Paid		XXX		XXX	
8. Expenses Incurred		XXX		XXX	XXX
9. Underwriting Gain or Loss		XXX		XXX	XXX
10. Cash Flow Result	XXX	XXX	XXX	XXX	

NONE

(a) Uninsured Receivable/Payable with CMS at End of Quarter: $ ..... due from CMS or $ ..... due to CMS

Aetna Better Health® of Kentucky Q2 2019 Statement

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QUARTERLY STATEMENT

OF THE

Aetna Better Health of Kentucky Insurance Company

TO THE

Insurance Department

OF THE

STATE OF

Kentucky

FOR THE QUARTER ENDED
JUNE 30, 2019

HEALTH

2019

HEALTH QUARTERLY STATEMENT

AS OF JUNE 30, 2019
OF THE CONDITION AND AFFAIRS OF THE

Aetna Better Health of Kentucky Insurance Company

NAIC Group Code 0001 (Current) 0001 (Prior) NAIC Company Code 15761 Employer's ID Number 47-3279217

Organized under the Laws of Kentucky, State of Domicile or Port of Entry KY

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health

Is HMO Federally Qualified? Yes [ ] No [ ]

Incorporated/Organized 02/24/2015 Commenced Business 02/01/2016

Statutory Home Office 9900 Corporate Campus Drive, Suite 1000 (Street and Number), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Main Administrative Office 9900 Corporate Campus Drive, Suite 1000 (Street and Number)
Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Mail Address 9900 Corporate Campus Drive, Suite 1000 (Street and Number or P.O. Box), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 9900 Corporate Campus Drive, Suite 1000 (Street and Number)
Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Internet Website Address www.aetnabetterhealth.com

Statutory Statement Contact Scott David Miller (Name), 717-671-2474 (Area Code) (Telephone Number)
StatutoryReporting@aetna.com (E-mail Address), 717-526-2888 (FAX Number)

OFFICERS

President Randy Joo Hwan Hyun
Chief Financial Officer David Patrick Delaney #
Vice President and Secretary Robert Mark Kessler

OTHER

Kevin James Casey, Senior Investment Officer
Frank Ferris Chronister III, Assistant Controller
Scott David Miller, Corporate Controller
Tracy Louise Smith, Vice President and Treasurer #

DIRECTORS OR TRUSTEES

Debra Jean Bacon
Jonathan Edward Copley
David Patrick Delaney #
Randy Joo Hwan Hyun

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Randy Joo Hwan Hyun Chief Executive Officer and President	Robert Mark Kessler Vice President and Secretary	David Patrick Delaney Chief Financial Officer
State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa
Subscribed and sworn to before me this 5 day of August, 2019	Subscribed and sworn to before me this 18 day of July, 2019	Subscribed and sworn to before me this 5 day of August, 2019
Lisa M Lambert NOTARY PUBLIC (Seal)	Lisa M Lambert NOTARY PUBLIC (Seal)	Lisa M Lambert NOTARY PUBLIC (Seal)
LISA M LAMBERT Notary Public, State of Arizona Maricopa County Commission # 558484 My Commission Expires January 21, 2023	LISA M LAMBERT Notary Public, State of Arizona Maricopa County Commission # 558484 My Commission Expires January 21, 2023	LISA M LAMBERT Notary Public, State of Arizona Maricopa County Commission # 558484 My Commission Expires January 21, 2023

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number .....
2. Date filed .....
3. Number of pages attached.....

ASSETS

	Current Statement Date 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 December 31 Prior Year Net Admitted Assets
1. Bonds	436,387,583	0	436,387,583	442,356,086
2. Stocks:				
2.1 Preferred stocks	0	0	0	0
2.2 Common stocks	0	0	0	0
3. Mortgage loans on real estate:				
3.1 First liens	15,099,960	0	15,099,960	13,407,858
3.2 Other than first liens	0	0	0	0
4. Real estate:				
4.1 Properties occupied by the company (less $ 0 encumbrances)	0	0	0	0
4.2 Properties held for the production of income (less $ 0 encumbrances)	0	0	0	0
4.3 Properties held for sale (less $ 0 encumbrances)	0	0	0	0
5. Cash ($ 14,281,500), cash equivalents ($ 35,370,831) and short-term investments ($ 0)	49,652,331	0	49,652,331	18,620,276
6. Contract loans (including $ 0 premium notes)	0	0	0	0
7. Derivatives	0	0	0	0
8. Other invested assets	8,753,323	0	8,753,323	0
9. Receivables for securities	47,500	0	47,500	11,415
10. Securities lending reinvested collateral assets	0	0	0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	509,940,697	0	509,940,697	474,395,635
13. Title plants less $ 0 charged off (for Title insurers only)	0	0	0	0
14. Investment income due and accrued	4,568,876	0	4,568,876	4,621,602
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	1,402,011	0	1,402,011	1,931,674
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ 0 earned but unbilled premiums)	0	0	0	0
15.3 Accrued retrospective premiums ($ 0) and contracts subject to redetermination ($ 0)	0	0	0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	0	0	0	0
16.2 Funds held by or deposited with reinsured companies	0	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0	0
17. Amounts receivable relating to uninsured plans	0	0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	1,023,544	0	1,023,544	0
18.2 Net deferred tax asset	5,204,425	0	5,204,425	5,204,425
19. Guaranty funds receivable or on deposit	0	0	0	0
20. Electronic data processing equipment and software	0	0	0	0
21. Furniture and equipment, including health care delivery assets ($ 0)	0	0	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23. Receivables from parent, subsidiaries and affiliates	613	0	613	7,789,355
24. Health care ($ 2,294,127) and other amounts receivable	14,357,620	12,063,493	2,294,127	2,070,247
25. Aggregate write-ins for other than invested assets	515,815	515,815	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	537,013,601	12,579,308	524,434,293	496,012,938
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28. Total (Lines 26 and 27)	537,013,601	12,579,308	524,434,293	496,012,938
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Deposits	500,000	500,000	0	0
2502. Misc Receivable	15,815	15,815	0	0
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	515,815	515,815	0	0

LIABILITIES, CAPITAL AND SURPLUS

	Current Period			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less $ 0 reinsurance ceded)	108,730,219	3,247,349	111,977,568	127,259,095
2. Accrued medical incentive pool and bonus amounts	2,399,891	0	2,399,891	1,187,135
3. Unpaid claims adjustment expenses	3,855,446	0	3,855,446	4,812,094
4. Aggregate health policy reserves, including the liability of $ 24,168,623 for medical loss ratio rebate per the Public Health Service Act	24,168,623	0	24,168,623	0
5. Aggregate life policy reserves	0	0	0	0
6. Property/casualty unearned premium reserve	0	0	0	0
7. Aggregate health claim reserves	0	0	0	0
8. Premiums received in advance	13,766,233	0	13,766,233	574,560
9. General expenses due or accrued	5,741,944	0	5,741,944	11,601,352
10.1 Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))	0	0	0	4,383,990
10.2 Net deferred tax liability	0	0	0	0
11. Ceded reinsurance premiums payable	0	0	0	0
12. Amounts withheld or retained for the account of others	0	0	0	3,139,799
13. Remittances and items not allocated	1,333,284	0	1,333,284	1,753,757
14. Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)	0	0	0	0
15. Amounts due to parent, subsidiaries and affiliates	20,623,217	0	20,623,217	13,820,266
16. Derivatives	0	0	0	0
17. Payable for securities	0	0	0	0
18. Payable for securities lending	0	0	0	0
19. Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)	0	0	0	0
20. Reinsurance in unauthorized and certified ($ 0) companies	0	0	0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates	0	0	0	0
22. Liability for amounts held under uninsured plans	0	0	0	0
23. Aggregate write-ins for other liabilities (including $ 0 current)	780,188	0	780,188	982,691
24. Total liabilities (Lines 1 to 23)	181,399,045	3,247,349	184,646,394	169,514,739
25. Aggregate write-ins for special surplus funds	XXX	XXX	10,964,150	0
26. Common capital stock	XXX	XXX	1,000,000	1,000,000
27. Preferred capital stock	XXX	XXX	0	0
28. Gross paid in and contributed surplus	XXX	XXX	99,010,001	99,010,001
29. Surplus notes	XXX	XXX	0	0
30. Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31. Unassigned funds (surplus)	XXX	XXX	228,813,748	226,488,198
32. Less treasury stock, at cost:				
32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX	0	0
32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX	0	0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	339,787,899	326,498,199
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	524,434,293	496,012,938
DETAILS OF WRITE-INS				
2301. Escheat Payable	780,188	0	780,188	982,691
2302.				
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 through 2303 plus 2398)(Line 23 above)	780,188	0	780,188	982,691
2501. Estimated Health Insurance Fee accrual	XXX	XXX	10,964,150	0
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	XXX	XXX	10,964,150	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 through 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year To Date		Prior Year To Date	Prior Year Ended December 31
		1 Uncovered	2 Total	3 Total	4 Total
1.	Member Months	XXX	1,316,280	1,410,114	2,773,717
2.	Net premium income (including $ 0 non-health premium income)	XXX	537,396,148	560,023,351	1,121,827,068
3.	Change in unearned premium reserves and reserve for rate credits	XXX	(24,168,623)	(6,048,288)	0
4.	Fee-for-service (net of $ 0 medical expenses)	XXX	0	0	0
5.	Risk revenue	XXX	0	0	0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0	0
8.	Total revenues (Lines 2 to 7)	XXX	513,227,525	553,975,063	1,121,827,068
	Hospital and Medical:				
9.	Hospital/medical benefits	8,253,268	284,595,450	277,431,585	578,623,254
10.	Other professional services	589,578	20,330,278	21,645,247	43,428,479
11.	Outside referrals	115,908	3,996,823	0	8,516,577
12.	Emergency room and out-of-area	1,128,758	38,922,699	39,716,323	80,128,217
13.	Prescription drugs	0	114,078,789	106,822,697	218,620,756
14.	Aggregate write-ins for other hospital and medical	0	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts	0	2,085,093	739,512	1,640,478
16.	Subtotal (Lines 9 to 15)	10,087,512	464,009,132	446,355,364	930,957,761
	Less:				
17.	Net reinsurance recoveries	0	0	0	0
18.	Total hospital and medical (Lines 16 minus 17)	10,087,512	464,009,132	446,355,364	930,957,761
19.	Non-health claims (net)	0	0	0	0
20.	Claims adjustment expenses, including $ 12,759,141 cost containment expenses	0	13,415,135	13,904,003	28,085,901
21.	General administrative expenses	0	32,618,719	56,279,147	93,657,324
22.	Increase in reserves for life and accident and health contracts (including $ 0 increase in reserves for life only)	0	0	0	0
23.	Total underwriting deductions (Lines 18 through 22)	10,087,512	510,042,986	516,538,514	1,052,700,986
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	3,184,539	37,436,549	69,126,082
25.	Net investment income earned	0	9,184,950	8,250,168	16,076,249
26.	Net realized capital gains (losses) less capital gains tax of $ 138,195	0	629,206	(2,038,153)	(3,331,896)
27.	Net investment gains (losses) (Lines 25 plus 26)	0	9,814,156	6,212,015	12,744,353
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $ 0) (amount charged off $ 0)]	0	0	0	0
29.	Aggregate write-ins for other income or expenses	0	(1,225,807)	(2,391,300)	(4,224,851)
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	11,772,888	41,257,264	77,645,584
31.	Federal and foreign income taxes incurred	XXX	1,516,831	12,540,737	18,504,307
32.	Net income (loss) (Lines 30 minus 31)	XXX	10,256,057	28,716,527	59,141,277
	DETAILS OF WRITE-INS				
0601.		XXX			
0602.		XXX			
0603.		XXX			
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)	XXX	0	0	0
0701.		XXX			
0702.		XXX			
0703.		XXX			
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798)(Line 7 above)	XXX	0	0	0
1401.					
1402.					
1403					
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498)(Line 14 above)	0	0	0	0
2901.	Regulatory penalties	0	(1,225,807)	(2,391,300)	(4,224,851)
2902.					
2903					
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998)(Line 29 above)	0	(1,225,807)	(2,391,300)	(4,224,851)

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year to Date	2 Prior Year to Date	3 Prior Year Ended December 31
	CAPITAL AND SURPLUS ACCOUNT			
33.	Capital and surplus prior reporting year	326,498,199	261,922,348	261,922,348
34.	Net income or (loss) from Line 32	10,256,057	28,716,527	59,141,277
35.	Change in valuation basis of aggregate policy and claim reserves	0	0	0
36.	Change in net unrealized capital gains (losses) less capital gains tax of $ 364,232	1,370,206	(555,335)	(1,538,193)
37.	Change in net unrealized foreign exchange capital gain or (loss)	0	0	0
38.	Change in net deferred income tax	364,232	(147,621)	(5,183,022)
39.	Change in nonadmitted assets	1,299,205	(5,814,358)	12,128,036
40	Change in unauthorized and certified reinsurance	0	0	0
41.	Change in treasury stock	0	0	0
42.	Change in surplus notes	0	0	0
43.	Cumulative effect of changes in accounting principles	0	0	0
44.	Capital Changes:			
	44.1 Paid in	0	0	0
	44.2 Transferred from surplus (Stock Dividend)	0	0	0
	44.3 Transferred to surplus	0	0	0
45.	Surplus adjustments:			
	45.1 Paid in	0	0	0
	45.2 Transferred to capital (Stock Dividend)	0	0	0
	45.3 Transferred from capital	0	0	0
46.	Dividends to stockholders	0	0	0
47.	Aggregate write-ins for gains or (losses) in surplus	0	0	27,753
48.	Net change in capital & surplus (Lines 34 to 47)	13,289,700	22,199,213	64,575,851
49.	Capital and surplus end of reporting period (Line 33 plus 48)	339,787,899	284,121,561	326,498,199
	DETAILS OF WRITE-INS			
4701.	Correction of Prior Year Current Federal Income Tax Incurred	0	0	27,753
4702.				
4703.				
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798)(Line 47 above)	0	0	27,753

CASH FLOW

		1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
	Cash from Operations			
1.	Premiums collected net of reinsurance	551,117,484	544,580,724	1,090,505,904
2.	Net investment income	9,772,587	9,166,276	18,140,983
3.	Miscellaneous income	0	0	0
4.	Total (Lines 1 to 3)	560,890,071	553,747,000	1,108,646,887
5.	Benefit and loss related payments	476,986,763	483,827,973	950,102,213
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0
7.	Commissions, expenses paid and aggregate write-ins for deductions	54,075,717	57,071,205	125,269,154
8.	Dividends paid to policyholders	0	0	0
9.	Federal and foreign income taxes paid (recovered) net of $ 0 tax on capital gains (losses)	7,062,560	18,036,347	21,745,323
10.	Total (Lines 5 through 9)	538,125,040	558,935,525	1,097,116,690
11.	Net cash from operations (Line 4 minus Line 10)	22,765,031	(5,188,525)	11,530,197
	Cash from Investments			
12.	Proceeds from investments sold, matured or repaid:			
	12.1 Bonds	73,512,602	129,125,609	197,532,407
	12.2 Stocks	0	0	0
	12.3 Mortgage loans	165,465	156,210	316,980
	12.4 Real estate	0	0	0
	12.5 Other invested assets	0	0	0
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	9	(184)	(722)
	12.7 Miscellaneous proceeds	0	7,650,587	547,760
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	73,678,076	136,932,222	198,396,425
13.	Cost of investments acquired (long-term only):			
	13.1 Bonds	66,193,590	102,081,904	169,085,405
	13.2 Stocks	0	0	0
	13.3 Mortgage loans	1,794,478	221,144	621,181
	13.4 Real estate	0	0	0
	13.5 Other invested assets	8,200,000	0	0
	13.6 Miscellaneous applications	36,085	1,515,690	0
	13.7 Total investments acquired (Lines 13.1 to 13.6)	76,224,153	103,818,738	169,706,586
14.	Net increase (or decrease) in contract loans and premium notes	0	0	0
15.	Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	(2,546,077)	33,113,483	28,689,839
	Cash from Financing and Miscellaneous Sources			
16.	Cash provided (applied):			
	16.1 Surplus notes, capital notes	0	0	0
	16.2 Capital and paid in surplus, less treasury stock	0	0	0
	16.3 Borrowed funds	0	0	0
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0	0
	16.5 Dividends to stockholders	0	0	0
	16.6 Other cash provided (applied)	10,813,101	27,030,325	(35,804,649)
17.	Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	10,813,101	27,030,325	(35,804,649)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS			
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	31,032,055	54,955,283	4,415,387
19.	Cash, cash equivalents and short-term investments:			
	19.1 Beginning of year	18,620,276	14,204,889	14,204,889
	19.2 End of period (Line 18 plus Line 19.1)	49,652,331	69,160,172	18,620,276

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001. Non-Cash Transaction - Tax Free Acquisition	1,209,896	1,052,670	8,057,370

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
	Total	2 Individual	3 Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	224,908	11,289	0	0	0	0	0	0	213,619	0
2. First Quarter	213,505	9,987	0	0	0	0	0	0	203,518	0
3. Second Quarter	219,598	9,768	0	0	0	0	0	0	209,830	0
4. Third Quarter	0	0	0	0	0	0	0	0	0	0
5. Current Year	0	0	0	0	0	0	0	0	0	0
6. Current Year Member Months	1,316,280	61,009	0	0	0	0	0	0	1,255,271	0
Total Member Ambulatory Encounters for Period:										
7 Physician	848,894	37,518	0	0	0	0	0	0	811,376	0
8. Non-Physician	489,670	14,091	0	0	0	0	0	0	475,579	0
9. Total	1,338,564	51,609	0	0	0	0	0	0	1,286,955	0
10. Hospital Patient Days Incurred	52,903	563	0	0	0	0	0	0	52,340	0
11. Number of Inpatient Admissions	10,828	101	0	0	0	0	0	0	10,727	0
12. Health Premiums Written (a)	537,396,148	14,459,961	0	0	0	0	0	0	522,936,187	0
13. Life Premiums Direct	0	0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0	0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	513,227,525	13,875,181	0	0	0	0	0	0	499,352,344	0
16. Property/Casualty Premiums Earned	0	0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	476,986,761	13,069,916	0	0	0	0	0	0	463,916,845	0
18. Amount Incurred for Provision of Health Care Services	464,009,132	12,109,703	0	0	0	0	0	0	451,899,429	0

(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ 0

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Claims Unpaid (Reported)						
0299999 Aggregate accounts not individually listed-uncovered	370,210	9,325	17,583	1,061	8,436	406,615
0399999 Aggregate accounts not individually listed-covered	10,440,743	818,522	(280,173)	661,602	2,127,818	13,768,512
0499999 Subtotals	10,810,953	827,847	(262,590)	662,663	2,136,254	14,175,127
0599999 Unreported claims and other claim reserves						97,802,441
0699999 Total amounts withheld						0
0799999 Total claims unpaid						111,977,568
0899999 Accrued medical incentive pool and bonus amounts						2,399,891

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid Year to Date		Liability End of Current Quarter		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid Dec. 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)	1,848,858	11,142,166	177,142	1,940,537	2,026,000	3,077,892
2. Medicare Supplement	0	0	0	0	0	0
3. Dental Only	0	0	0	0	0	0
4. Vision Only	0	0	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0	0	0
6. Title XVIII - Medicare	0	0	0	0	0	0
7 Title XIX - Medicaid	87,906,924	375,216,476	16,943,831	92,916,058	104,850,755	124,181,203
8. Other health	0	0	0	0	0	0
9. Health subtotal (Lines 1 to 8)	89,755,782	386,358,642	17,120,973	94,856,595	106,876,755	127,259,095
10. Healthcare receivables (a)	7,481,788	6,875,832	0	0	7,481,788	15,448,760
11. Other non-health	0	0	0	0	0	0
12. Medical incentive pools and bonus amounts	381,599	490,738	1,616,860	783,031	1,998,459	1,187,135
13. Totals (Lines 9-10+11+12)	82,655,593	379,973,548	18,737,833	95,639,626	101,393,426	112,997,470

(a) Excludes $ 0 loans or advances to providers not yet expensed.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying statutory financial statements of Aetna Better Health of Kentucky Insurance Co (the "Company), a wholly-owned subsidiary of Coventry Health & Life Insurance Co. ('CH&L') whose ultimate parent is CVS Health Corporation ("CVS Health"), have been prepared in conformity with accounting practices prescribed or permitted by the Commonwealth of Kentucky Department of Insurance (KY DOI). The Commonwealth of Kentucky recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP").

A reconciliation of the Company's net income and surplus between NAIC SAP and practices prescribed and permitted by the Commonwealth of Kentucky for the periods ended June 30, 2019 and December 31, 2018 is as follows:

		SSAP #	F/S Page	F/S Line #	2019	2018
NET INCOME						
(1)	State basis (Page 4, Line 32, Columns 2 & 4)	XXX	XXX	XXX	$10,256,057	$59,141,277
(2)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
(3)	State Permitted Practices that increase/(decrease) NAIC SAP:					
(4)	NAIC SAP (1-2-3=4)	XXX	XXX	XXX	$10,256,057	$59,141,277
	SURPLUS					
(5)	State basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	$339,787,899	$326,498,199
(6)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
(7)	State Permitted Practices that increase/(decrease) NAIC SAP:					
(8)	NAIC SAP (5-6-7=8)	XXX	XXX	XXX	$339,787,899	$326,498,199

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of these financial statements in conformity with Kentucky Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenues and expenses. Actual results could differ from those estimates.

C. Accounting Policies

(1) No significant change.

(2) Bonds:

Bonds, which include special deposits, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections. Bonds include all investments whose maturity is greater than one year when purchased. Loan-backed and structured securities are carried at amortized cost adjusted for

unamortized premiums and discounts. Premiums and discounts on loan-backed and structured securities are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments. All adjustments between amortized cost and carrying value are reflected in unrealized capital gains and losses and are reported as direct adjustments to surplus. Bonds are recorded as purchases or sales on the trade date.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities, an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For loan-backed and structured securities, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from the Company's expectations and the risk that facts and circumstances factored into its assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

(3) through (7): No significant change.

(8) Joint Ventures, Partnerships and Limited Liability Companies:

Other Invested Assets

Other invested assets consist primarily of partnerships and equity subsidiaries. Partnerships and equity subsidiaries are reported using the equity method. Unaudited other invested assets are nonadmitted as they do not meet the admissibility requirements of SSAP No. 48, *Joint Ventures, Partnerships and Limited Liability Companies* and SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entities*, which requires U.S. generally accepted accounting principles' audited financial statements of the investments. The Company periodically reviews other invested assets for impairment. An impairment shall be considered to have occurred if it is probable that the Company will be unable to recover the carrying amount of the investment or there is evidence indicating the inability of the investee to sustain earnings which would justify the carrying amount of the investment.

(9) through (21): No significant change.

D. Going Concern

As of August 13, 2019, management has evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

2. Accounting Changes and Corrections of Errors

The Company did not have any accounting changes or corrections of errors in the period ended June 30, 2019.

3. Business Combinations and Goodwill

No significant change.

4. Discontinued Operations

No significant change.

5. Investments

A. through C: No significant change.

D. Loan-Backed Securities

(1) Prepayment assumptions for single class and multi-class mortgage backed/asset backed securities were obtained from industry market sources.

(2) The Company had no other-than-temporary impairment ("OTTI") losses during the second quarter of 2019 on loan-backed and structured securities in which the Company had the (1) intent to sell, (2) did not have the intent and ability to retain for a period of time sufficient to recover the amortized cost basis or (3) present value of cash flows expected to be collected is less than the amortized cost basis of the securities in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 43R, *Loan-Backed and Structured Securities* ("SSAP No. 43R").

(3) The Company had no recognized OTTI on loan-backed and structured securities currently held, in which the present value of cash flows expected to be collected is less than the amortized cost basis, at the reporting date June 30, 2019.

(4) The Company's unrealized loss position on loan-backed and structured securities held by the Company at June 30, 2019 is as follows:

a. The aggregate amount of unrealized losses:	
1. Less than 12 Months	($10,642)
2. 12 Months or Longer	($42,326)
b. The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 Months	$989,358
2. 12 Months or Longer	$5,065,534

(5) The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R in the table above and have concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at June 30, 2019 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

(1) and (2): No significant change.

(3) Neither the Company nor its agent has accepted collateral that is permitted by contract or custom to sell or repledge as of June 30, 2019.

(4) through (7): No significant change.

F. The Company did not have any repurchase agreements transactions accounted for as secured borrowing at June 30, 2019.

G. The Company did not have any reverse repurchase agreements transactions accounted for as secured at June 30, 2019.

H. The Company did not have any repurchase agreements transactions accounted for as a sale at June 30, 2019.

I. The Company did not have any reverse repurchase agreements transactions accounted for as a sale at June 30, 2019.

J. through L: No significant change.

M. The Company did not have any working capital finance investments at June 30, 2019.

N. The Company did not have any offsetting and netting of financial assets or liabilities at June 30, 2019.

O. through Q: No significant change.

R. Prepayment Penalty and Acceleration Fees at June 30, 2019.

Prepayment Penalty and Acceleration Fees

	General Account
1. Number of CUSIPs	1
2. Aggregate Amount of Investment Income	$805

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company did not have any joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at June 30, 2019.

B. The Company does not have any impaired investments in joint ventures, partnerships, or limited liability companies at June 30, 2019.

7. Investment Income

No significant change.

8. Derivative Instruments

The Company did not have any derivative instruments at June 30, 2019.

9. Income Taxes

No significant change.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

No significant change.

11. Debt

A. The Company did not have any items related to debt, including capital notes at June 30, 2019.

B. The Company did not have any Federal Home Loan Bank agreements at June 30, 2019.

12. Retirement Plans, Deferred Compensation Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

The Company did not have a retirement plan, deferred compensation plan, or other postretirement benefit plan at June 30, 2019.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

No significant change.

14. Liabilities, Contingencies and Assessments

No significant change.

15. Leases

No significant change.

16. Information About Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

No significant change.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

No significant change.

B. Transfer and Servicing of Financial Assets

(1) No significant change.

(2) and (3): The Company did not have any servicing assets or liabilities at June 30, 2019.

(4) The Company did not have any securitized financial assets at June 30, 2019.

(5) through (7): No significant change.

C. Wash Sales

(1) The Company did not have any wash sales for the period ended June 30, 2019.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

No significant change.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No significant change.

20. Fair Value Measurements

A. and B.

The Company had no material assets or liabilities measured and reported at fair value at June 30, 2019.

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

Level 1 - Unadjusted quoted prices for identical assets or liabilities in active markets.

Level 2 - Inputs other than Level 1 that are based on observable market data. These include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.

Level 3 - Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

C. The carrying values and estimated fair values of the Company's financial instruments at June 30, 2019 were as follows:

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)	Net Asset Value (NAV) Included in Level 2
Bonds, Short Term, and Cash Equivalents	$488,494,897	$471,758,414	$60,044,883	$428,450,014	$—	$—	$—
Mortgage Loans	15,905,520	15,099,960	—	—	15,905,520	—	—

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets at June 30, 2019. There were no transfers between the Company's Level 1 or 2 financial assets at June 30, 2019.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

D. The Company did not have any financial instruments where it was not practicable to estimate the fair value.

E. The Company has not elected to use the net asset value practical expedient to fair value to measure its investments.

21. Other Items

No significant change.

22. Events Subsequent

A. Type I - Recognized Subsequent Events

Subsequent events have been considered through August 13, 2019 for the statutory statement issued on August 14, 2019.

The Company had no known reportable recognized subsequent events.

B. Type II - Non-Recognized Subsequent Events

Subsequent events have been considered through August 13, 2019 for the statutory statement issued on August 14, 2019.

The Company had no known reportable non-recognized subsequent events.

23. Reinsurance

No significant change.

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

A. through D: No significant change.

E. Risk Sharing Provisions of the Affordable Care Act

(1) Did the reporting entity write accident and health insurance premium which is subject to the ACA risk sharing provisions (YES/NO)? Yes [ ] No [X].

(2) through (5): Not applicable.

25. Change in Incurred Claims and Claims Adjustment Expenses

As of June 30, 2019, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased by $19,571,016 from $133,258,324 on December 31, 2018 to $113,687,308 on June 30, 2019. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends.

Net coordination of benefits are implicit in the claims incurred but not reported calculation and could not be specifically identified.

26. Intercompany Pooling Arrangements

No significant change.

27. Structured Settlements

No significant change.

28. Health Care Receivables

No significant change.

29. Participating Policies

No significant change.

30. Premium Deficiency Reserves

No significant change.

31. Anticipated Salvage and Subrogation

No significant change.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Did the reporting entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the State of Domicile, as required by the Model Act? Yes [ ] No [X]

1.2 If yes, has the report been filed with the domiciliary state? Yes [ ] No [ ]

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [ ] No [X]

2.2 If yes, date of change:

3.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1 and 1A.

3.2 Have there been any substantial changes in the organizational chart since the prior quarter end? Yes [X] No [ ]

3.3 If the response to 3.2 is yes, provide a brief description of those changes.
On May 10, 2019, Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd was dissolved. On June 4, 2019, Broadspire National Services, Inc. was dissolved.

3.4 Is the reporting entity publicly traded or a member of a publicly traded group? Yes [X] No [ ]

3.5 If the response to 3.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0000064803

4.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [ ] No [X]
If yes, complete and file the merger history data file with the NAIC for the annual filing corresponding to this period.

4.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

5. If the reporting entity is subject to a management agreement, including third-party administrator(s), managing general agent(s), attorney-in-fact, or similar agreement, have there been any significant changes regarding the terms of the agreement or principals involved? Yes [ ] No [X] N/A [ ]
If yes, attach an explanation.

6.1 State as of what date the latest financial examination of the reporting entity was made or is being made.

6.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

6.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

6.4 By what department or departments?

6.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [ ] No [ ] N/A [X]

6.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [ ] No [ ] N/A [X]

7.1 Has this reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [ ] No [X]

7.2 If yes, give full information:

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

GENERAL INTERROGATORIES

9.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No [ ]
(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

9.11 If the response to 9.1 is No, please explain:

9.2 Has the code of ethics for senior managers been amended? Yes [X] No [ ]

9.21 If the response to 9.2 is Yes, provide information related to amendment(s).
In the first quarter of 2019, the Code of Conduct was amended to remove content related to the Caremark Corporate Integrity Agreement ("CIA") with the Office of the Inspector General as the CIA expired in March 2019.

9.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [ ] No [X]

9.31 If the response to 9.3 is Yes, provide the nature of any waiver(s).

FINANCIAL

10.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No [ ]

10.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ 0

INVESTMENT

11.1 Were any of the stocks, bonds, or other assets of the reporting entity loaned, placed under option agreement, or otherwise made available for use by another person? (Exclude securities under securities lending agreements.) Yes [ ] No [X]

11.2 If yes, give full and complete information relating thereto:

12. Amount of real estate and mortgages held in other invested assets in Schedule BA: $ 0

13. Amount of real estate and mortgages held in short-term investments: $ 0

14.1 Does the reporting entity have any investments in parent, subsidiaries and affiliates? Yes [X] No [ ]

14.2 If yes, please complete the following:

	1 Prior Year-End Book/Adjusted Carrying Value	2 Current Quarter Book/Adjusted Carrying Value
14.21 Bonds	$ 0	$ 0
14.22 Preferred Stock	$ 0	$ 0
14.23 Common Stock	$ 0	$ 0
14.24 Short-Term Investments	$ 0	$ 0
14.25 Mortgage Loans on Real Estate	$ 0	$ 0
14.26 All Other	$ 0	$ 8,753,323
14.27 Total Investment in Parent, Subsidiaries and Affiliates (Subtotal Lines 14.21 to 14.26)	$ 0	$ 8,753,323
14.28 Total Investment in Parent included in Lines 14.21 to 14.26 above	$ 0	$ 0

15.1 Has the reporting entity entered into any hedging transactions reported on Schedule DB? Yes [ ] No [X]

15.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [ ] No [ ]
If no, attach a description with this statement.

16. For the reporting entity's security lending program, state the amount of the following as of the current statement date:

16.1 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. $ 0

16.2 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 $ 0

16.3 Total payable for securities lending reported on the liability page. $ 0

GENERAL INTERROGATORIES

17. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No [ ]

17.1 For all agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian Address
State Street Bank and Trust Company	State Street Financial Center; One Lincoln Street; Boston, MA 02111-2900

17.2 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

17.3 Have there been any changes, including name changes, in the custodian(s) identified in 17.1 during the current quarter? Yes [ ] No [X]

17.4 If yes, give full information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

17.5 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
Kevin J. Casey as Sr. Investment Officer	A

17.5097 For those firms/individuals listed in the table for Question 17.5, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets? Yes [ ] No [X]

17.5098 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 17.5, does the total assets under management aggregate to more than 50% of the reporting entity's assets? Yes [ ] No [X]

17.6 For those firms or individuals listed in the table for 17.5 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
N/A	Kevin J. Casey	N/A	Not registered	NO

18.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No [ ]

18.2 If no, list exceptions:

19. By self-designating 5GI securities, the reporting entity is certifying the following elements for each self-designated 5GI security:
    a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
    b. Issuer or obligor is current on all contracted interest and principal payments.
    c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

    Has the reporting entity self-designated 5GI securities? Yes [ ] No [X]

20. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
    a. The security was purchased prior to January 1, 2018.
    b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
    c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as a NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.
    d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.

    Has the reporting entity self-designated PLGI securities? Yes [ ] No [X]

GENERAL INTERROGATORIES

PART 2 - HEALTH

1. Operating Percentages:

   1.1 A&H loss percent ..... 92.9 %

   1.2 A&H cost containment percent ..... 2.5 %

   1.3 A&H expense percent excluding cost containment expenses ..... 6.5 %

2.1 Do you act as a custodian for health savings accounts? ..... Yes [ ] No [X]

2.2 If yes, please provide the amount of custodial funds held as of the reporting date ..... $ 0

2.3 Do you act as an administrator for health savings accounts? ..... Yes [ ] No [X]

2.4 If yes, please provide the balance of the funds administered as of the reporting date ..... $ 0

3. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? ..... Yes [ ] No [X]

3.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? ..... Yes [ ] No [X]

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE S - CEDED REINSURANCE

Showing All New Reinsurance Treaties - Current Year to Date

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Reinsurer	5 Domiciliary Jurisdiction	6 Type of Reinsurance Ceded	7 Type of Reinsurer	8 Certified Reinsurer Rating (1 through 6)	9 Effective Date of Certified Reinsurer Rating

NONE

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

Current Year to Date - Allocated by States and Territories

		1	Direct Business Only							
			2	3	4	5	6	7	8	9
States, etc.		Active Status (a)	Accident and Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Program Premiums	Life and Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama	AL	N	0	0	0	0	0	0	0	0
2. Alaska	AK	N	0	0	0	0	0	0	0	0
3. Arizona	AZ	N	0	0	0	0	0	0	0	0
4. Arkansas	AR	N	0	0	0	0	0	0	0	0
5. California	CA	N	0	0	0	0	0	0	0	0
6. Colorado	CO	N	0	0	0	0	0	0	0	0
7. Connecticut	CT	N	0	0	0	0	0	0	0	0
8. Delaware	DE	N	0	0	0	0	0	0	0	0
9. District of Columbia	DC	N	0	0	0	0	0	0	0	0
10. Florida	FL	N	0	0	0	0	0	0	0	0
11. Georgia	GA	N	0	0	0	0	0	0	0	0
12. Hawaii	HI	N	0	0	0	0	0	0	0	0
13. Idaho	ID	N	0	0	0	0	0	0	0	0
14. Illinois	IL	N	0	0	0	0	0	0	0	0
15. Indiana	IN	N	0	0	0	0	0	0	0	0
16. Iowa	IA	N	0	0	0	0	0	0	0	0
17. Kansas	KS	N	0	0	0	0	0	0	0	0
18. Kentucky	KY	L	14,459,961	0	522,936,187	0	0	0	537,396,148	0
19. Louisiana	LA	N	0	0	0	0	0	0	0	0
20. Maine	ME	N	0	0	0	0	0	0	0	0
21. Maryland	MD	N	0	0	0	0	0	0	0	0
22. Massachusetts	MA	N	0	0	0	0	0	0	0	0
23. Michigan	MI	N	0	0	0	0	0	0	0	0
24. Minnesota	MN	N	0	0	0	0	0	0	0	0
25. Mississippi	MS	N	0	0	0	0	0	0	0	0
26. Missouri	MO	N	0	0	0	0	0	0	0	0
27. Montana	MT	N	0	0	0	0	0	0	0	0
28. Nebraska	NE	N	0	0	0	0	0	0	0	0
29. Nevada	NV	N	0	0	0	0	0	0	0	0
30. New Hampshire	NH	N	0	0	0	0	0	0	0	0
31. New Jersey	NJ	N	0	0	0	0	0	0	0	0
32. New Mexico	NM	N	0	0	0	0	0	0	0	0
33. New York	NY	N	0	0	0	0	0	0	0	0
34. North Carolina	NC	N	0	0	0	0	0	0	0	0
35. North Dakota	ND	N	0	0	0	0	0	0	0	0
36. Ohio	OH	N	0	0	0	0	0	0	0	0
37. Oklahoma	OK	N	0	0	0	0	0	0	0	0
38. Oregon	OR	N	0	0	0	0	0	0	0	0
39. Pennsylvania	PA	N	0	0	0	0	0	0	0	0
40. Rhode Island	RI	N	0	0	0	0	0	0	0	0
41. South Carolina	SC	N	0	0	0	0	0	0	0	0
42. South Dakota	SD	N	0	0	0	0	0	0	0	0
43. Tennessee	TN	N	0	0	0	0	0	0	0	0
44. Texas	TX	N	0	0	0	0	0	0	0	0
45. Utah	UT	N	0	0	0	0	0	0	0	0
46. Vermont	VT	N	0	0	0	0	0	0	0	0
47. Virginia	VA	N	0	0	0	0	0	0	0	0
48. Washington	WA	N	0	0	0	0	0	0	0	0
49. West Virginia	WV	N	0	0	0	0	0	0	0	0
50. Wisconsin	WI	N	0	0	0	0	0	0	0	0
51. Wyoming	WY	N	0	0	0	0	0	0	0	0
52. American Samoa	AS	N	0	0	0	0	0	0	0	0
53. Guam	GU	N	0	0	0	0	0	0	0	0
54. Puerto Rico	PR	N	0	0	0	0	0	0	0	0
55. U.S. Virgin Islands	VI	N	0	0	0	0	0	0	0	0
56. Northern Mariana Islands	MP	N	0	0	0	0	0	0	0	0
57. Canada	CAN	N	0	0	0	0	0	0	0	0
58. Aggregate Other Aliens	OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal		XXX	14,459,961	0	522,936,187	0	0	0	537,396,148	0
60. Reporting Entity Contributions for Employee Benefit Plans		XXX	0	0	0	0	0	0	0	0
61. Totals (Direct Business)		XXX	14,459,961	0	522,936,187	0	0	0	537,396,148	0
DETAILS OF WRITE-INS										
58001.		XXX								
58002.		XXX								
58003.		XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page		XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)		XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed Insurance carrier or domiciled RRG 1
R - Registered - Non-domiciled RRGs 0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
Q - Qualified - Qualified or accredited reinsurer 0
N - None of the above - Not allowed to write business in the state 56

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

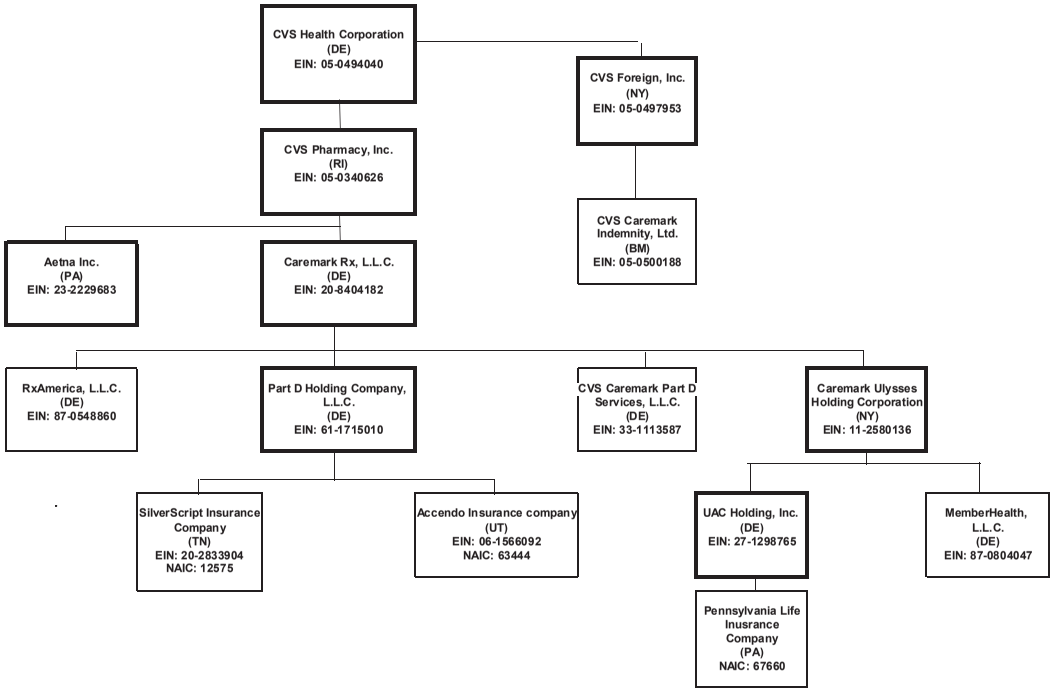

This organizational chart reflects the insurance entity reporting system and identifies the relationship between the ultimate parent and all member insurers.
The ultimate controlling company is a Fortune 7 company with numerous subsidiaries, the majority of which do not interact with the insurance entities.
(1) Insurers/HMO's
Percentages are rounded to the nearest whole percent and based on ownership of voting rights.
Double borders indicate entity has subsidiaries shown on the same page.
Bold borders indicate entity has subsidiaries shown on a separate page.

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

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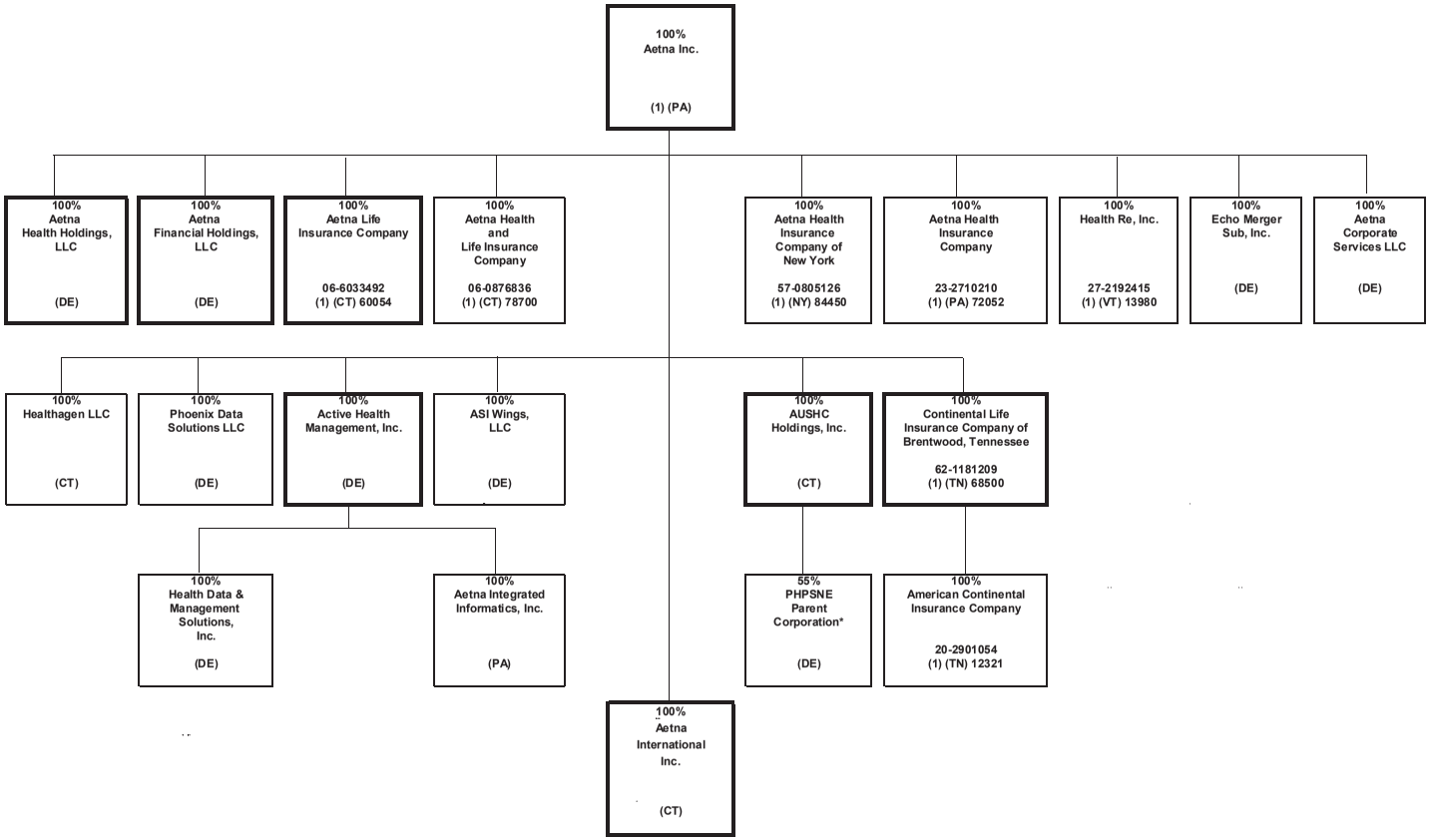

* PHPSNE Parent Corporation is also 45% owned by third parties.

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

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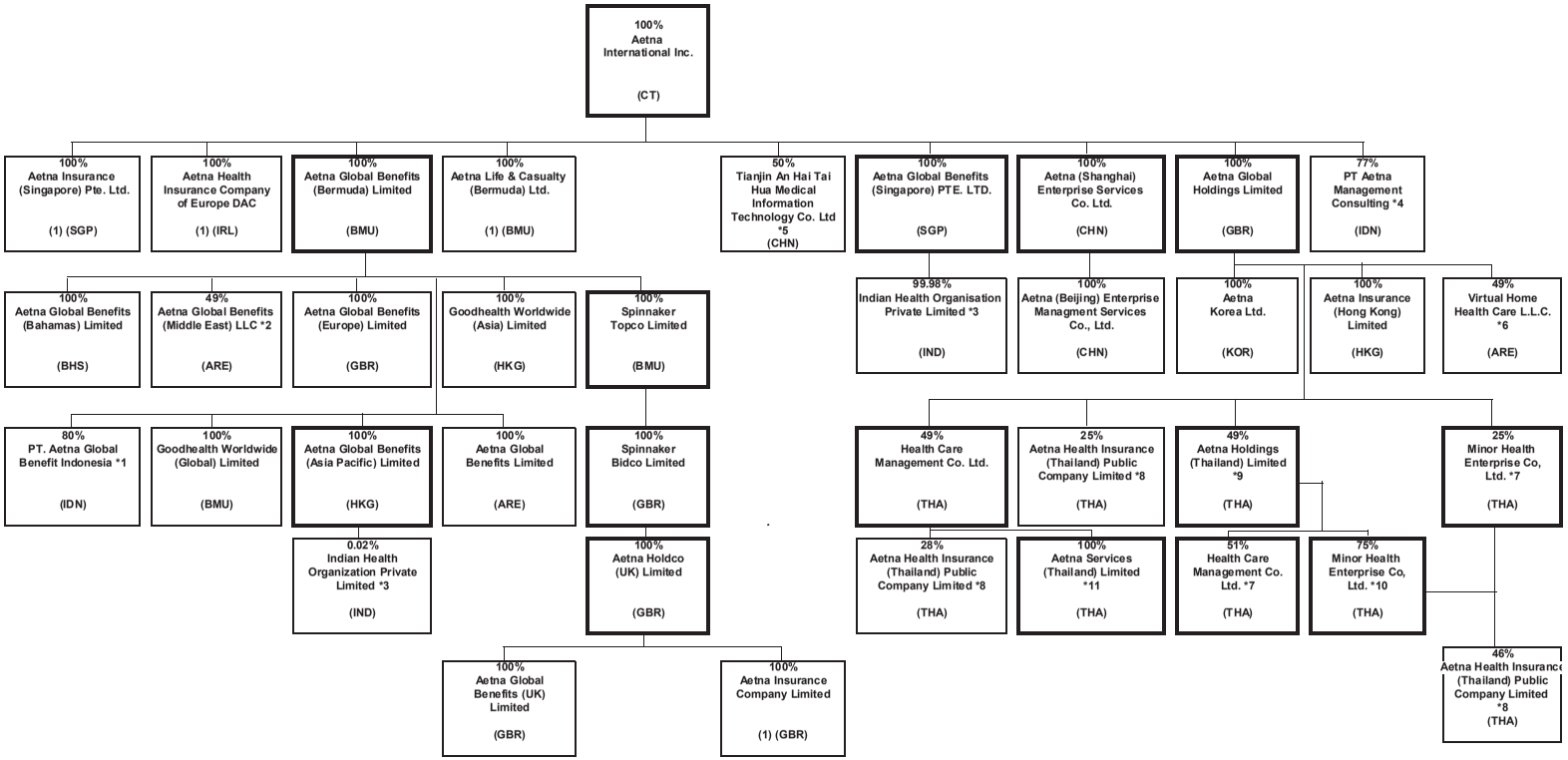

*1 PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
*2 Aetna Global Benefits (Middle East) LLC is also 51% is owned by Euro Gulf LLC, Aetna's Nominee.
*3 Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
*4 PT Asuransi Aetna Asia is also 23% owned by PT Asuransi Central Asia.
*5 Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd is also 50% owned by Tianjin Hai Tai Group Co., Ltd
*6 Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC, Aetna's Nominee
*7 Health Care Management Co. Ltd. Is also owned by Aetna Global Benefits (Bermuda) Limited (1 share).
*8 Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 Share), Mr. Jitphasong Itsaraphakded (1 Share); Mrs. Suphee Wattana (1 Share); and Mr. Buncha Tamphragom (1 Share)
*9 Aetna Holdings (Thailand) Limited is aslo 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Benefits (Bermuda) Limited owns 1 share.
*10 Minor Health Entreprise Co, Ltd is is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited
*11 Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited and (1 share) owned by Aetna Global Holdings Limited

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

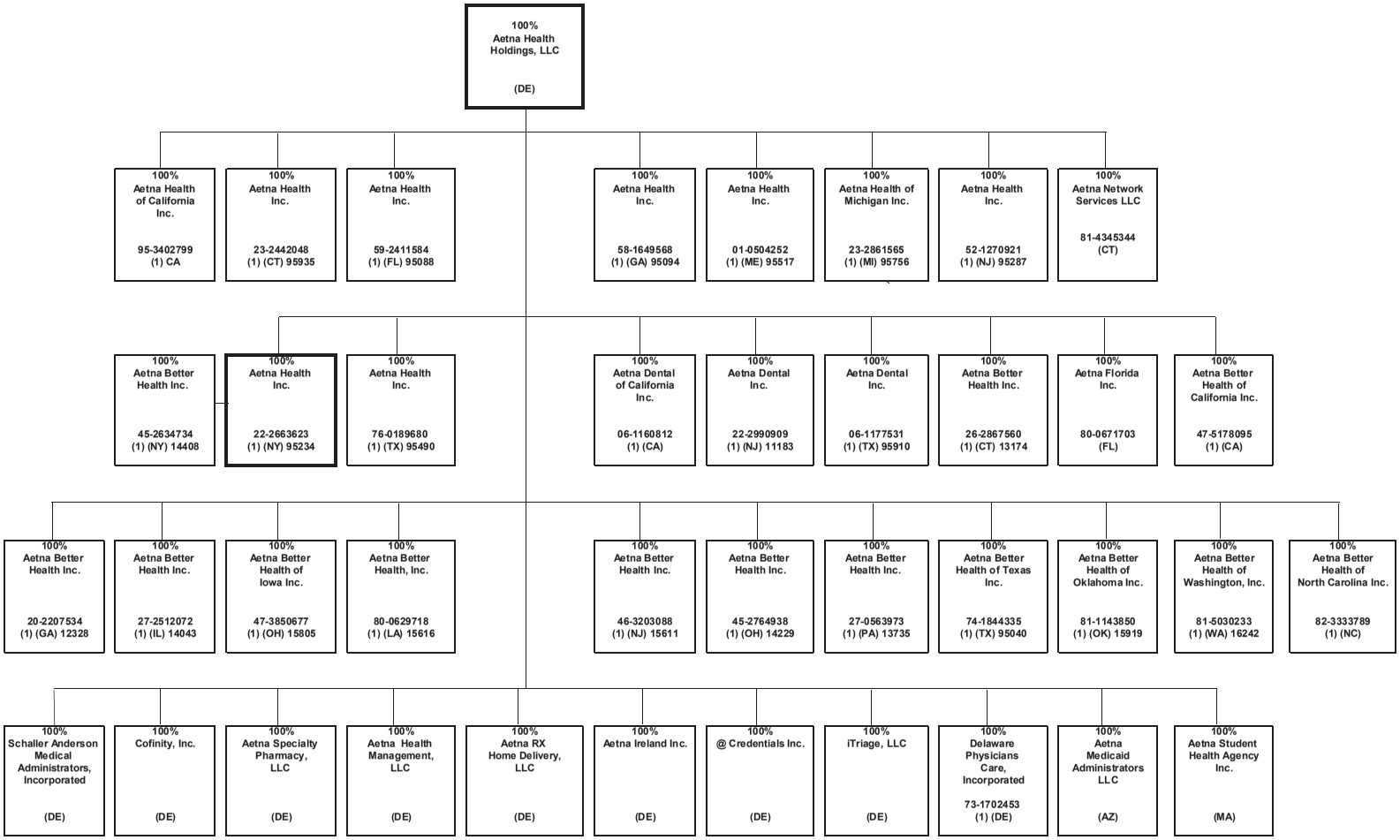

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

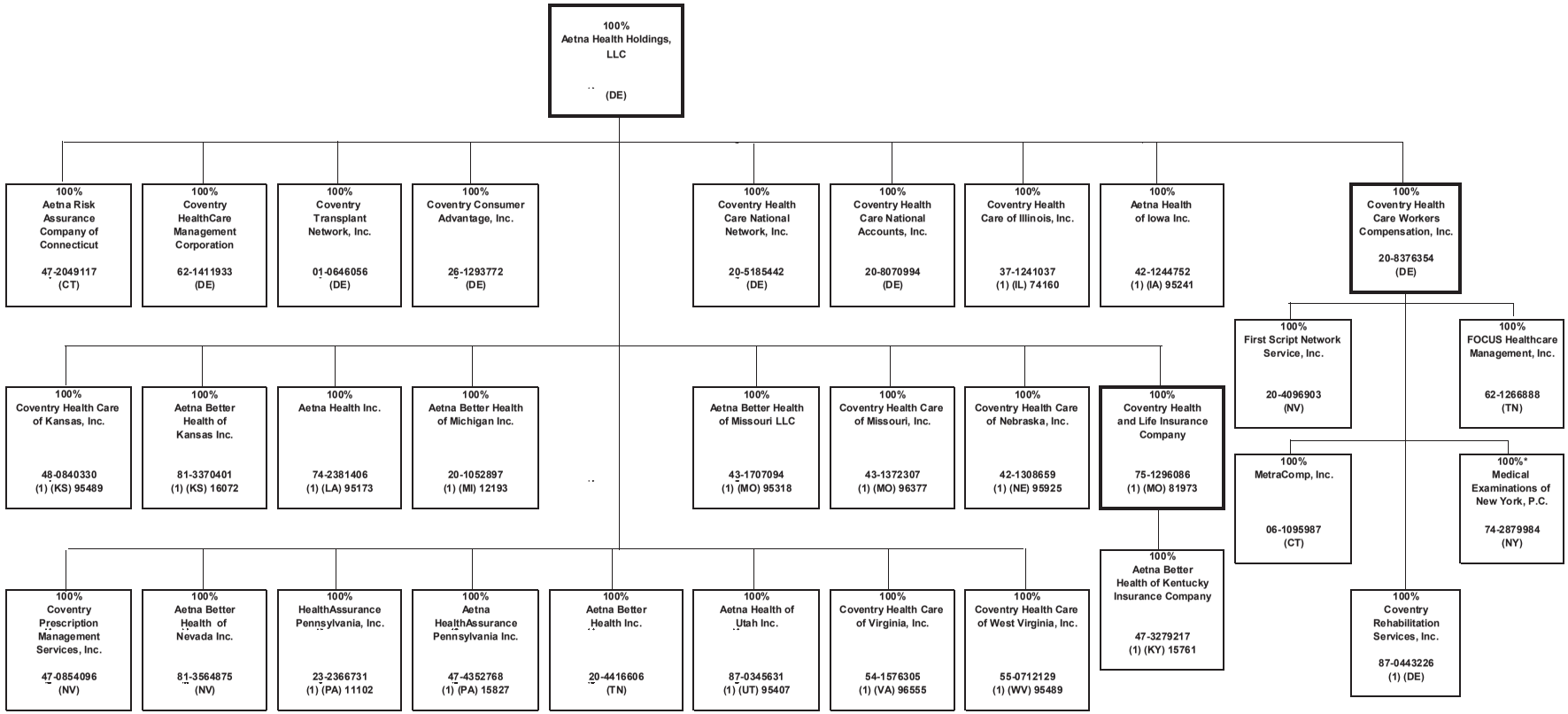

*100% owned through Aetna's nominees

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

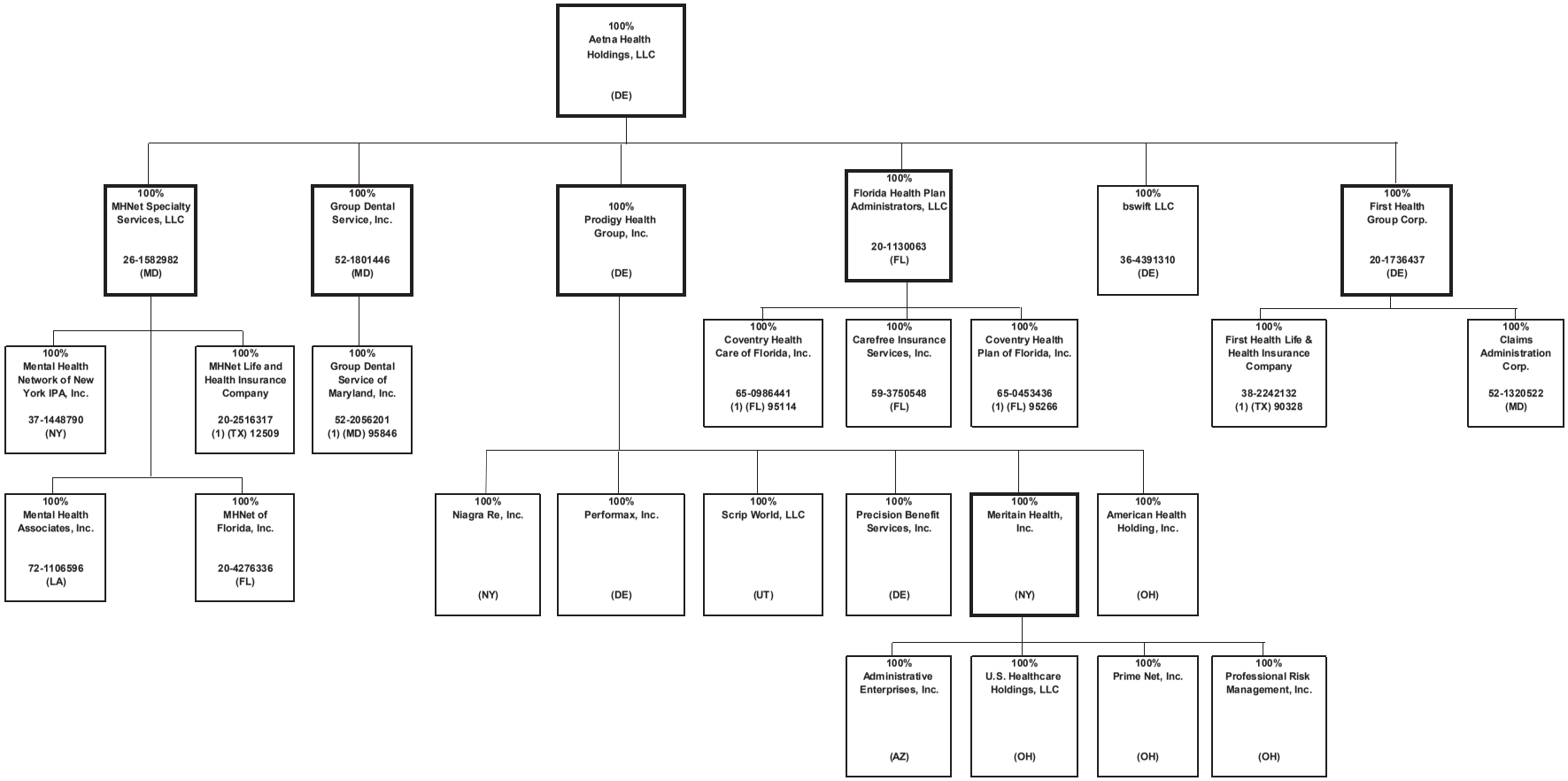

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

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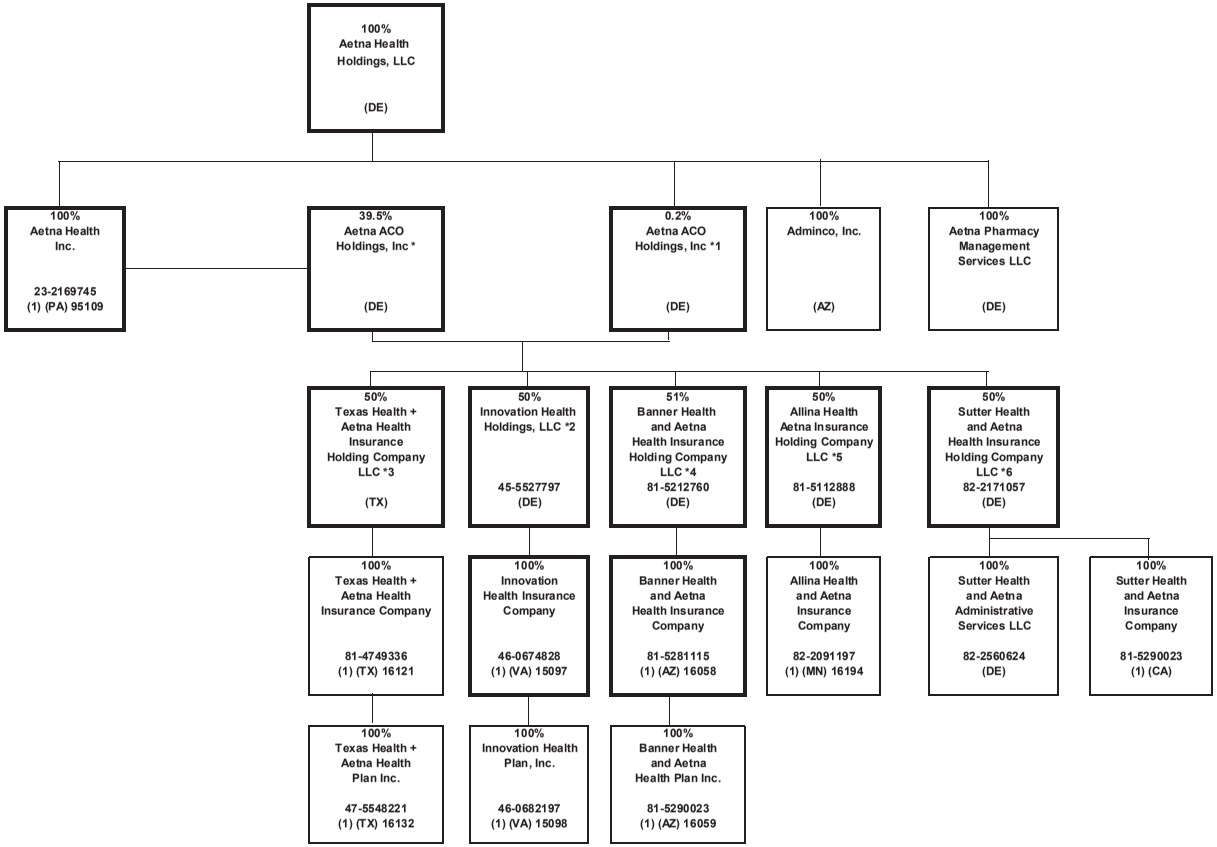

*1 Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
*2 Innovation Health Holdings, LLC is also 50% owned by Inova Health System Foundation.
*3 Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
*4 Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
*5 Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
*6 Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

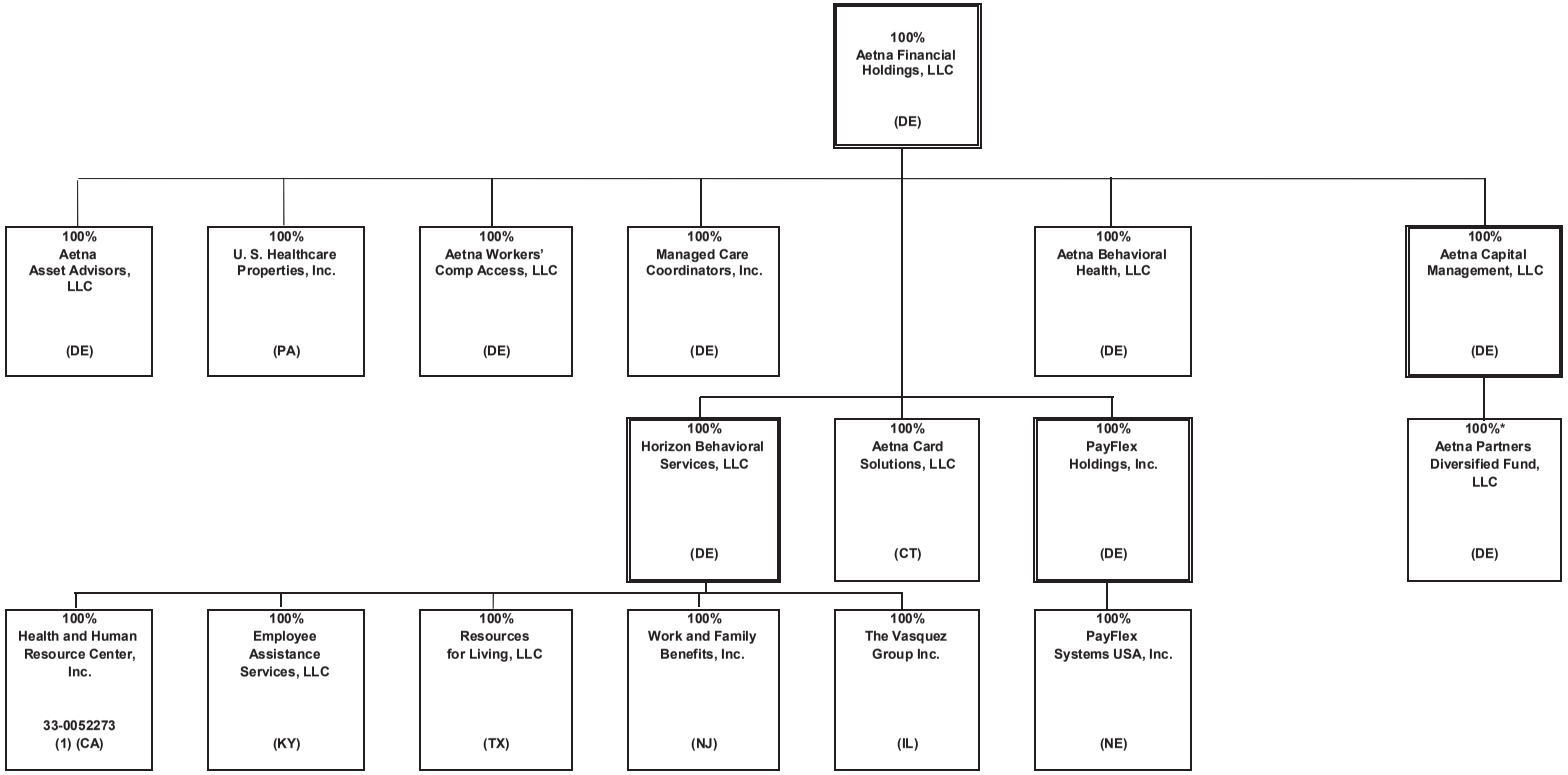

* Aetna Life Insurance Company owns substantially all of the non-managing member interests of Aetna Partners Diversified Fund, LLC.

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

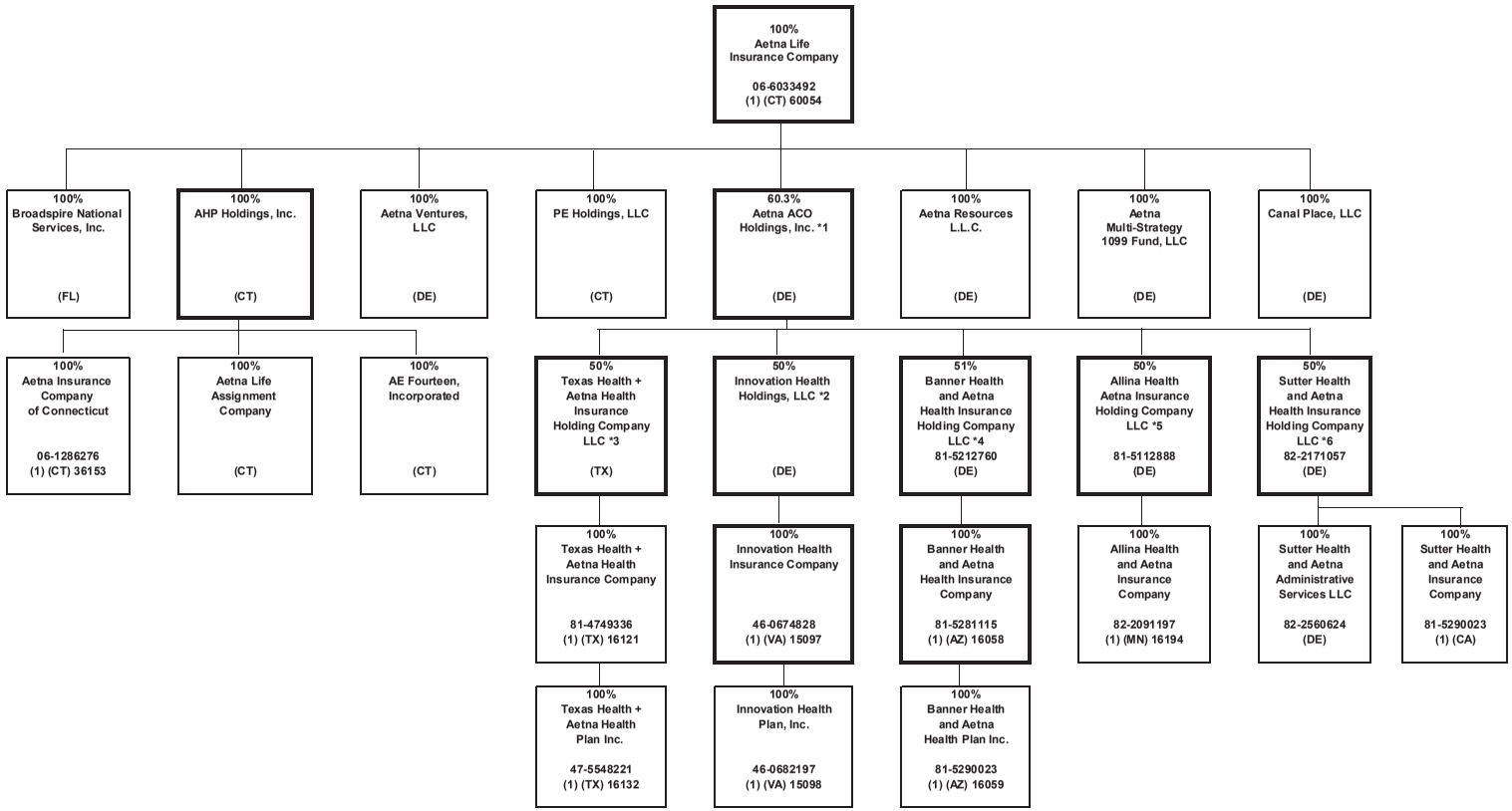

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*5 Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
*6 Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP		05-0494040		0000064803	NYSE	CVS Health Corporation	DE	UIP	Board of Directors	Board of Directors	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	63444	06-1566092				Accendo Insurance Company	UT	IA	Part D Holding Company, L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12575	20-2833904				SilverScript Insurance Company	TN	IA	Part D Holding Company, L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	67660	23-1305366				Pennsylvania Life Insurance Co.	PA	IA	UAC Holding, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0340626				CVS Pharmacy, Inc	RI	UIP	CVS Health Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8404182				Caremark, Rx., L.L.C.	DE	NIA	CVS Pharmacy, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	61-1715010				Part D Holding Company, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	33-1113587				CVS Caremark Part D Services, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0548860				RxAmerica, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	11-2580136				Caremark Ulysses Holding Corporation	NY	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0804047				MemberHealth L.L.C.	DE	NIA	Caremark Ulysses Holding Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0500188				CVS Caremark Indemnity, Ltd.	BMU	IA	CVS Foreign, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1298765				UAC Holding, Inc	DE	NIA	Caremark Ulysses Holding Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0497953				CVS Foreign, Inc.	NY	NIA	CVS Health Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2229683	3060706	0001122304		Aetna Inc.	PA	UIP	CVS Pharmacy, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	30-0123754	0	0		Aetna Health Holdings, LLC	DE	UIP	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	95-3402799	0	0		Aetna Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95935	23-2442048	0	0		Aetna Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95088	59-2411584	0	0		Aetna Health Inc.	FL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95094	58-1649568	0	0		Aetna Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95517	01-0504252	0	0		Aetna Health Inc.	ME	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95756	23-2861565	0	0		Aetna Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95287	52-1270921	0	0		Aetna Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95234	22-2663623	0	0		Aetna Health Inc.	NY	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14408	45-2634734	0	0		Aetna Better Health Inc.	NY	IA	Aetna Health Inc. (NY)	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95490	76-0189680	0	0		Aetna Health Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95040	74-1844335	0	0		Aetna Better Health of Texas Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12328	20-2207534	0	0		Aetna Better Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1160812	0	0		Aetna Dental of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	11183	22-2990909	0	0		Aetna Dental Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95910	06-1177531	0	0		Aetna Dental Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	30-0123760	0	0		Aetna Rx Home Delivery, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	13-3670795	0	0		Aetna Health Management, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	22-3187443	0	0		Aetna Ireland Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	57-1209768	0	0		Aetna Specialty Pharmacy, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1274723	0	0		Cofinity, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2671370	0	0		@Credentials Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Services (Thailand) Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	100.000	CVS Health Corporation	N	19
0001	CVS HEALTH GROUP	13735	27-0563973	0	0		Aetna Better Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	13174	26-2867560	0	0		Aetna Better Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-5178095	0	0		Aetna Better Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14043	27-2512072	0	0		Aetna Better Health Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15805	47-3850677	0	0		Aetna Better Health of Iowa Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15616	80-0629718	0	0		Aetna Better Health, Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	80-0671703	0	0		Aetna Florida Inc.	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14229	25-2764938	0	0		Aetna Better Health Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15611	46-3203088	0	0		Aetna Better Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15919	81-1143850	0	0		Aetna Better Health of Oklahoma Inc.	OK	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	04-2708160	0	0		Aetna Student Health Agency Inc.	MA	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	73-1702453	0	0		Delaware Physicians Care, Incorporated	DE	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	01-0826783	0	0		Schaller Anderson Medical Administrators, Incorporated	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0842559	0	0		Aetna Medicaid Adminstrators LLC	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-2944270	0	0		iTriage, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP	00000	16-1471176	0	0		Prodigy Health Group, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	0.200	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	45-5527797	0	0		Innovation Health Holdings, LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	6
0001	CVS HEALTH GROUP	15097	46-0674828	0	0		Innovation Health Insurance Company	VA	IA	Innovation Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15098	46-0682197	0	0		Innovation Health Plan, Inc.	VA	IA	Innovation Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-3789357	0	0		Texas Health + Aetna Health Insurance Holding Company LLC	TX	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	9
0001	CVS HEALTH GROUP	16121	81-4749336	0	0		Texas Health + Aetna Health Insurance Company	TX	IA	Texas Health + Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16132	47-5548221	0	0		Texas Health + Aetna Health Plan Inc.	TX	IA	Texas Health + Aetna Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95109	23-2169745	0	0		Aetna Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Inc. (PA)	Ownership	39.500	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	20-0438576	0	0		Niagara Re, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-2200070	0	0		Performax, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0632355	0	0		Scrip World, LLC	UT	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1760756	0	0		Precision Benefit Services, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	31-1368946	0	0		American Health Holding, Inc.	OH	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	16-1264154	0	0		Meritain Health, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0537707	0	0		Adminco, Inc.	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0527428	0	0		Administrative Enterprises, Inc.	AZ	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	16-1684061	0	0		U.S. Healthcare Holdings, LLC	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	34-1670299	0	0		Prime Net, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	34-1348032	0	0		Professional Risk Management, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	68500	62-1181209	0	0		Continental Life Insurance Company of Brentwood, Tennessee	TN	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12321	20-2901054	0	0		American Continental Insurance Company	TN	IA	Continental Life Insurance Company of Brentwood, Tennessee	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	60054	06-6033492	0	0		Aetna Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Life Insurance Company	Ownership	60.300	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	06-1270755	0	0		AHP Holdings, Inc.	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	36153	06-1286276	0	0		Aetna Insurance Company of Connecticut	CT	IA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1028469	0	0		AE Fourteen, Incorporated	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1373153	0	0		Aetna Life Assignment Company	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-3678339	0	0		PE Holdings, LLC	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1423207	0	0		Aetna Resources L.L.C.	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Canal Place, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-3180700	0	0		Aetna Ventures, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0001552250		Aetna Multi-Strategy 1099 Fund, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	79.250	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	41-2035961	0	0		Aetna Financial Holdings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	26-2030792	0	0		Aetna Asset Advisors, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2354500	0	0		U.S. Healthcare Properties, Inc.	PA	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	38-3704481	0	0		Aetna Capital Management, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	11-3667142	0	0001314522		Aetna Partners Diversified Fund, LLC	DE	NIA	Aetna Capital Management, LLC	Ownership	100.000	CVS Health Corporation	N	1
0001	CVS HEALTH GROUP	00000	20-0446676	0	0		Aetna Workers' Comp Access, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-0446713	0	0		Aetna Behavioral Health, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2670015	0	0		Managed Care Coordinators, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-3269144	0	0		Horizon Behavioral Services, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	61-1193498	0	0		Employee Assistance Services, LLC	KY	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	33-0052273	0	0		Health and Human Resource Center, Inc.	CA	IA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	75-2420973	0	0		Resources for Living, LLC	TX	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	36-3681261	0	0		The Vasquez Group Inc.	IL	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	22-3178125	0	0		Work and Family Benefits, Inc.	NJ	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1773021	0	0		Aetna Card Solutions, LLC	CT	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
0001	CVS HEALTH GROUP	00000	20-5216478	0	0		PayFlex Holdings, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	91-1774434	0	0		PayFlex Systems USA, Inc.	NE	NIA	PayFlex Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	78700	06-0876836	0	0		Aetna Health and Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	72052	23-2710210	0	0		Aetna Health Insurance Company	PA	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	84450	57-0805126	0	0		Aetna Health Insurance Company of New York	NY	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1571642	0	0		Aetna International Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	98-0211470	0	0		Aetna Life & Casualty (Bermuda) Ltd.	BMU	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance (Singapore) PTE. LTD.	SGP	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Bermuda) Limited	BMU	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Goodhealth Worldwide (Global) Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Europe) Limited	GBR	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Goodhealth Worldwide (Asia) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits Limited	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		PT. Aetna Global Benefits Indonesia	IDN	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	80.000	CVS Health Corporation	N	4
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Middle East) LLC	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	49.000	CVS Health Corporation	N	5
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Asia Pacific) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Spinnaker Topco Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Spinnaker Bidco Limited	GBR	NIA	Spinnaker Topco Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Holdco (UK) Limited	GBR	NIA	Spinnaker Bidco Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		PT Aetna Management Consulting	IDN	NIA	Aetna International Inc.	Ownership	77.000	CVS Health Corporation	N	13
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (UK) Limited	GBR	NIA	Aetna Holdco (UK) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance Company Limited	GBR	IA	Aetna Holdco (UK) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Asia Pacific) Limited	Ownership	0.020	CVS Health Corporation	N	2
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance Company of Europe DAC	IRL	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna (Shanghai) Enterprise Services Co. Ltd.	CHN	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna (Beijing) Enterprise Management Services Co., Ltd.	CHN	NIA	Aetna (Shanghai) Enterprise Services Co. Ltd.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Singapore) PTE. LTD.	SGP	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Singapore) PTE, LTD.	Ownership	99.980	CVS Health Corporation	N	2
0001	CVS HEALTH GROUP	00000	22-2578985	0	0		AUSHC Holdings, Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Holdings Limited	GBR	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Korea Ltd.	KOR	NIA	Aetna Global Holdings Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance (Hong Kong) Limited	HKG	NIA	Aetna Global Holdings Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1182176	0	0		PHPSNE Parent Corporation	DE	NIA	AUSHC Holdings, Inc.	Ownership	55.000	CVS Health Corporation	N	7
0001	CVS HEALTH GROUP	00000	52-2182411	0	0		Active Health Management, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-0970432	0	0		Health Data & Management Solutions, Inc.	DE	NIA	Active Health Management, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2604867	0	0		Aetna Integrated Informatics, Inc.	PA	NIA	Active Health Management, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	13980	27-2192415	0	0		Health Re, Inc.	VT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-0579372	0	0		Phoenix Data Solutions LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	46-2469464	0	0		Healthagen LLC	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	51-0029326	0	0		ASI Wings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Echo Merger Sub, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Corporate Services, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	81973	75-1296086	0	0		Coventry Health and Life Insurance Company	MO	UDP	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15761	47-3279217	0	0		Aetna Better Health of Kentucky Insurance Company	KY	RE	Coventry Health and Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-1801446	0	0		Group Dental Service, Inc.	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95846	52-2056201	0	0		Group Dental Service of Maryland, Inc.	MD	IA	Group Dental Service, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP		81-4345344	0	0		Aetna Network Services LLC	CT	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP	95241	42-1244752	0	0		Aetna Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95925	42-1308659	0	0		Coventry Health Care of Nebraska, Inc.	NE	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-2049117	0	0		Aetna Risk Assurance Company of Connecticut Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95173	74-2381406	0	0		Aetna Health Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	11102	23-2366731	0	0		HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-0854096	0	0		Coventry Prescription Management Services, Inc.	NV	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16148	81-3564875	0	0		Aetna Better Health of Nevada Inc.	NV	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	96555	54-1576305	0	0		Coventry Health Care of Virginia, Inc.	VA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	01-0646056	0	0		Coventry Transplant Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	96377	43-1372307	0	0		Coventry Health Care of Missouri, Inc.	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95318	43-1702094	0	0		Aetna Better Health of Missouri LLC	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95408	55-0712129	0	0		Coventry Health Care of West Virginia, Inc.	WV	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	62-1411933	0	0		Coventry HealthCare Management Corporation	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15827	47-4352768	0	0		Aetna HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95489	48-0840330	0	0		Coventry Health Care of Kansas, Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16072	81-3370401	0	0		Aetna Better Health of Kansas Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12193	20-1052897	0	0		Aetna Better Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95407	87-0345631	0	0		Aetna Health of Utah Inc.	UT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4416606	0	0		Aetna Better Health Inc.	TN	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	74160	37-1241037	0	0		Coventry Health Care of Illinois, Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8070994	0	0		Coventry Health Care National Accounts, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-5185442	0	0		Coventry Health Care National Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	26-1293772	0	0		Coventry Consumer Advantage, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8376354	0	0		Coventry Health Care Workers Compensation, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4096903	0	0		First Script Network Service, Inc.	NV	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1095987	0	0		MetraComp, Inc.	CT	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	74-2879984	0	0		Medical Examinations of New York, P.C.	NY	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	8
0001	CVS HEALTH GROUP	00000	62-1266888	0	0		FOCUS Healthcare Management, Inc.	TN	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0443226	0	0		Coventry Rehabilitation Services, Inc.	DE	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1736437	0	0		First Health Group Corp.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	90328	38-2242132	0	0		First Health Life & Health Insurance Company	TX	IA	First Health Group Corp.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-1320522	0	0		Claims Administration Corp.	MD	NIA	First Health Group Corp.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1130063	0	0		Florida Health Plan Administrators, LLC	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95114	65-0986441	0	0		Coventry Health Care of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95266	65-0453436	0	0		Coventry Health Plan of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-3750548	0	0		Carefree Insurance Services, Inc.	FL	NIA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	36-4391310	0	0		bswift LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Virtual Home Healthcare L.L.C.	ARE	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	17
0001	CVS HEALTH GROUP	00000	26-1582982	0	0		MHNet Specialty Services, LLC	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	37-1448790	0	0		Mental Health Network of New York IPA, Inc.	NY	NIA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12509	20-2516317	0	0		MHNet Life and Health Insurance Company	TX	IA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	72-1106596	0	0		Mental Health Associates, Inc.	LA	NIA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4276336	0	0		MHNet of Florida, Inc.	FL	IA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16242	81-5030233	0	0		Aetna Better Health of Washington, Inc.	WA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP	00000	81-5212760	0	0		Banner Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	51.000	CVS Health Corporation	N	10
0001	CVS HEALTH GROUP	16058	81-5281115	0	0		Banner Health and Aetna Health Insurance Company	AZ	IA	Banner Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16059	81-5290023	0	0		Banner Health and Aetna Health Plan Inc.	AZ	IA	Banner Health and Aetna Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5112888	0	0		Allina Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	11
0001	CVS HEALTH GROUP	16194	82-2091197	0	0		Allina Health and Aetna Insurance Company	MN	IA	Allina Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	82-2171057	0	0		Sutter Health and Aetna Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	12
0001	CVS HEALTH GROUP	00000	82-2560624	0	0		Sutter Health and Aetna Administrative Services LLC	DE	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5290023	0	0		Sutter Health and Aetna Insurance Company	CA	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Holdings (Thailand) Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	14
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Minor Health Entreprise Co, Ltd.	Ownership	46.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	28.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	18
0001	CVS HEALTH GROUP	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	CVS Health Corporation	N	16
0001	CVS HEALTH GROUP	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	75.000	CVS Health Corporation	N	16
0001	CVS HEALTH GROUP	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	51.000	CVS Health Corporation	N	18
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Bahamas) Limited	BHS	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Pharmacy Management Services LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	82-3333789	0	0		Aetna Better Health of North Carolina Inc.	NC	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

Asterisk	Explanation
1	Aetna Life Insurance Company own substantially all of the non-managing membership interests of Aetna Partners Diversified Fund LLC.
2	Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
3	Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
4	PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
5	Aetna Global Benefits (Middle East) LLC is also 51% owned by Euro Gulf LLC, Aetna's Nominee.
6	Innovation Health Holdings LLC. Is also 50% owned by Inova Health System Foundation.
7	PHPSNE Parent Corporation is 55% owned by AUSHC Holdings, Inc. The remaining 45% is owned by thirteen different hospitals (non-affiliates) which are shareholders with varying degrees of ownership.
8	Medical Examinations of New York, P.C. is 100% owned through Aetna's nominees.
9	Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
10	Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
11	Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
12	Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.
13	PT Aetna Management Consulting is also 23% owned by PT Asuransi Central Asia.
14	Aetna Holdings (Thailand) Limited is also 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Global Benefits (Bermuda) Limited owns 1 share
15	Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 share), Mr. Jitphasong Itsaraphakded (1 share); Mrs. Suphee Wattana (1 share); and Mr. Buncha Tamphragom (1 share)
16	Minor Health Enterprise Co, Ltd is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
17	Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC, Aetna's Nominee.

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

Asterisk	Explanation
18	Health Care Management Co. Ltd. Is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
19	Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited and (1 share) owned by Aetna Global Holdings Limited.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Response
1. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?	NO

Explanation:

1. Business not written

Bar Code:

1. Medicare Part D Coverage Supplement [Document Identifier 365]

OVERFLOW PAGE FOR WRITE-INS

NONE

SCHEDULE A - VERIFICATION

Real Estate

NONE

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		
	2.2 Additional investment made after acquisition		
3.	Current year change in encumbrances		
4.	Total gain (loss) on disposals		
5.	Deduct amounts received on disposals		
6.	Total foreign exchange change in book/adjusted carrying value		
7.	Deduct current year's other than temporary impairment recognized		
8.	Deduct current year's depreciation		
9.	Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8)		
10.	Deduct total nonadmitted amounts		
11.	Statement value at end of current period (Line 9 minus Line 10)		

SCHEDULE B - VERIFICATION

Mortgage Loans

		1 Year to Date	2 Prior Year Ended December 31
1.	Book value/recorded investment excluding accrued interest, December 31 of prior year	13,407,858	12,979,171
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition	0	0
	2.2 Additional investment made after acquisition	1,794,478	621,181
3.	Capitalized deferred interest and other	0	0
4.	Accrual of discount	0	0
5.	Unrealized valuation increase (decrease)	0	0
6.	Total gain (loss) on disposals	0	0
7.	Deduct amounts received on disposals	165,465	316,980
8.	Deduct amortization of premium and mortgage interest points and commitment fees	(63,088)	(124,486)
9.	Total foreign exchange change in book value/recorded investment excluding accrued interest	0	0
10.	Deduct current year's other than temporary impairment recognized	0	0
11.	Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	15,099,959	13,407,858
12.	Total valuation allowance	0	0
13.	Subtotal (Line 11 plus Line 12)	15,099,959	13,407,858
14.	Deduct total nonadmitted amounts	0	0
15.	Statement value at end of current period (Line 13 minus Line 14)	15,099,959	13,407,858

SCHEDULE BA - VERIFICATION

Other Long-Term Invested Assets

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	0	0
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition	8,200,000	0
	2.2 Additional investment made after acquisition	0	0
3.	Capitalized deferred interest and other	0	0
4.	Accrual of discount	0	0
5.	Unrealized valuation increase (decrease)	0	0
6.	Total gain (loss) on disposals	0	0
7.	Deduct amounts received on disposals	(553,323)	0
8.	Deduct amortization of premium and depreciation	0	0
9.	Total foreign exchange change in book/adjusted carrying value	0	0
10.	Deduct current year's other than temporary impairment recognized	0	0
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	8,753,323	0
12.	Deduct total nonadmitted amounts	0	0
13.	Statement value at end of current period (Line 11 minus Line 12)	8,753,323	0

SCHEDULE D - VERIFICATION

Bonds and Stocks

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value of bonds and stocks, December 31 of prior year	442,356,087	479,236,865
2.	Cost of bonds and stocks acquired	67,403,486	177,142,775
3.	Accrual of discount	446,184	653,212
4.	Unrealized valuation increase (decrease)	1,734,438	(1,947,081)
5.	Total gain (loss) on disposals	767,392	(2,448,888)
6.	Deduct consideration for bonds and stocks disposed of	74,722,147	205,903,403
7.	Deduct amortization of premium	1,597,506	3,328,608
8.	Total foreign exchange change in book/adjusted carrying value	0	0
9.	Deduct current year's other than temporary impairment recognized	1,156	1,362,411
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees	805	313,626
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)	436,387,583	442,356,087
12.	Deduct total nonadmitted amounts	0	0
13.	Statement value at end of current period (Line 11 minus Line 12)	436,387,583	442,356,087

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1B

Showing the Acquisitions, Dispositions and Non-Trading Activity
During the Current Quarter for all Bonds and Preferred Stock by NAIC Designation

NAIC Designation	1 Book/Adjusted Carrying Value Beginning of Current Quarter	2 Acquisitions During Current Quarter	3 Dispositions During Current Quarter	4 Non-Trading Activity During Current Quarter	5 Book/Adjusted Carrying Value End of First Quarter	6 Book/Adjusted Carrying Value End of Second Quarter	7 Book/Adjusted Carrying Value End of Third Quarter	8 Book/Adjusted Carrying Value December 31 Prior Year
BONDS								
1. NAIC 1 (a)	345,501,759	650,865,654	641,966,789	(207,203)	345,501,759	354,193,421	0	318,735,533
2. NAIC 2 (a)	78,251,716	1,053,240	11,746,051	953,234	78,251,716	68,512,139	0	81,339,538
3. NAIC 3 (a)	47,047,678	513,125	4,302,109	(2,350,906)	47,047,678	40,907,788	0	49,057,322
4. NAIC 4 (a)	5,808,821	1,509,375	527,588	1,353,603	5,808,821	8,144,211	0	4,709,236
5. NAIC 5 (a)	0	0	0	0	0	0	0	0
6. NAIC 6 (a)	0	0	0	0	0	0	0	0
7. Total Bonds	476,609,974	653,941,394	658,542,537	(251,272)	476,609,974	471,757,559	0	453,841,629
PREFERRED STOCK								
8. NAIC 1	0	0	0	0	0	0	0	0
9. NAIC 2	0	0	0	0	0	0	0	0
10. NAIC 3	0	0	0	0	0	0	0	0
11. NAIC 4	0	0	0	0	0	0	0	0
12. NAIC 5	0	0	0	0	0	0	0	0
13. NAIC 6	0	0	0	0	0	0	0	0
14. Total Preferred Stock	0	0	0	0	0	0	0	0
15. Total Bonds and Preferred Stock	476,609,974	653,941,394	658,542,537	(251,272)	476,609,974	471,757,559	0	453,841,629

(a) Book/Adjusted Carrying Value column for the end of the current reporting period includes the following amount of short-term and cash equivalent bonds by NAIC designation:

NAIC 1 $ 35,369,976 ; NAIC 2 $ 0 ; NAIC 3 $ 0 NAIC 4 $ 0 ; NAIC 5 $ 0 ; NAIC 6 $ 0

Schedule DA - Part 1 - Short-Term Investments

N O N E

Schedule DA - Verification - Short-Term Investments

N O N E

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

SCHEDULE E - PART 2 - VERIFICATION

(Cash Equivalents)

		1 Year To Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	11,486,582	14,867,395
2.	Cost of cash equivalents acquired	1,186,492,783	2,565,130,542
3.	Accrual of discount	640,515	1,164,952
4.	Unrealized valuation increase (decrease)	0	0
5.	Total gain (loss) on disposals	9	(722)
6.	Deduct consideration received on disposals	1,163,249,058	2,569,675,585
7.	Deduct amortization of premium	0	0
8.	Total foreign exchange change in book/adjusted carrying value	0	0
9.	Deduct current year's other than temporary impairment recognized	0	0
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	35,370,831	11,486,582
11.	Deduct total nonadmitted amounts	0	0
12.	Statement value at end of current period (Line 10 minus Line 11)	35,370,831	11,486,582

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE B - PART 2

Showing All Mortgage Loans ACQUIRED AND ADDITIONS MADE During the Current Quarter

1	Location		4	5	6	7	8	9
	2	3						
Loan Number	City	State	Loan Type	Date Acquired	Rate of Interest	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Value of Land and Buildings
2004473	MT LAUREL	NJ		12/18/2017	5.280	0	1,416,111	11,000,000
0499999. Mortgages in good standing - Commercial mortgages-insured or guaranteed						0	1,416,111	11,000,000
0899999. Total Mortgages in good standing						0	1,416,111	11,000,000
1699999. Total - Restructured Mortgages						0	0	0
2499999. Total - Mortgages with overdue interest over 90 days						0	0	0
3299999. Total - Mortgages in the process of foreclosure						0	0	0
3399999 - Totals						0	1,416,111	11,000,000

SCHEDULE B - PART 3

Showing All Mortgage Loans DISPOSED, Transferred or Repaid During the Current Quarter

1	Location		4	5	6	7	Change in Book Value/Recorded Investment						14	15	16	17	18
	2	3					8	9	10	11	12	13					
Loan Number	City	State	Loan Type	Date Acquired	Disposal Date	Book Value/ Recorded Investment Excluding Accrued Interest Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Amortization) /Accretion	Current Year's Other Than Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Change in Book Value (8+9-10+11)	Total Foreign Exchange Change in Book Value	Book Value/ Recorded Investment Excluding Accrued Interest on Disposal	Consid-eration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal
2004182	GLEN BURNIE	MD		12/18/2017		5,803,426	0	0	0	0	0	0	0	83,328	0	0	0
2004473	MT LAUREL	NJ		12/18/2017		0	0	31,615	0	0	31,615	0	0	0	0	0	0
0299999. Mortgages with partial repayments						5,803,426	0	31,615	0	0	31,615	0	0	83,328	0	0	0
0599999 - Totals						5,803,426	0	31,615	0	0	31,615	0	0	83,328	0	0	0

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE BA - PART 2

Showing Other Long-Term Invested Assets ACQUIRED AND ADDITIONS MADE During the Current Quarter

1	2	Location		5	6	7	8	9	10	11	12	13
		3	4									
CUSIP Identification	Name or Description	City	State	Name of Vendor or General Partner	NAIC Designation and Administrative Symbol/ Market Indicator	Date Originally Acquired	Type and Strategy	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Amount of Encumbrances	Commitment for Additional Investment	Percentage of Ownership
4699999 - Totals												XXX

NONE

SCHEDULE BA - PART 3

Showing Other Long-Term Invested Assets DISPOSED, Transferred or Repaid During the Current Quarter

1	2	Location		5	6	7	8	Change in Book/Adjusted Carrying Value						15	16	17	18	19	20
		3	4					9	10	11	12	13	14						
CUSIP Identification	Name or Description	City	State	Name of Purchaser or Nature of Disposal	Date Originally Acquired	Disposal Date	Book/ Adjusted Carrying Value Less Encumbrances, Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Depreciation) or (Amortization)/ Accretion	Current Year's Other Than Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Change in Book/ Adjusted Carrying Value (9+10-11+12)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value Less Encumbrances on Disposal	Consideration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Investment Income
	AETNA PARTNERS DIVERSIFIED FUND LLC	Hartford	CT	PROCEEDS FROM OPERATIONS	01/02/2019	06/30/2019	0	0	0	0	0	0	0	0	(344,523)	0	0	0	0
4299999. Any Other Class of Assets - Unaffiliated							0	0	0	0	0	0	0	0	(344,523)	0	0	0	0
4499999. Total - Unaffiliated							0	0	0	0	0	0	0	0	(344,523)	0	0	0	0
4599999. Total - Affiliated							0	0	0	0	0	0	0	0	0	0	0	0	0
4699999 - Totals							0	0	0	0	0	0	0	0	(344,523)	0	0	0	0

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 3

Show All Long-Term Bonds and Stock Acquired During the Current Quarter

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends	10 NAIC Designation and Administrative Symbol/ Market Indicator (a)
912828-6B-1	US TREASURY NOTE/BOND 2.625% 02/15/29		04/12/2019	JEFFRIES		2,014,688	2,000,000	8,557	1
0599999. Subtotal - Bonds - U.S. Governments						2,014,688	2,000,000	8,557	XXX
195325-DL-6	COLOMBIA REPUBLIC OF SR UNSECURED 3.875% 04/25/27	D	05/28/2019	GOLDMAN SACHS & CO		505,750	500,000	1,884	2FE
1099999. Subtotal - Bonds - All Other Governments						505,750	500,000	1,884	XXX
100853-YH-7	BOSTON MASS SER A 5.000% 05/01/32		05/28/2019	Raymond James		4,701,450	3,750,000	15,104	1FE
100853-YJ-3	BOSTON MASS SER A 5.000% 05/01/33		05/28/2019	Raymond James		6,401,060	5,130,000	20,663	1FE
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						11,102,510	8,880,000	35,767	XXX
02587A-AN-4	AMERICAN EXPRESS CREDIT SER 19-2 CLASS A 2.670% 11/15/24		04/22/2019	DAIN RAUSCHER INC-69211		999,941	1,000,000	0	1FE
185899-AC-5	CLEVELAND-CLIFFS INC SR UNSECURED 5.875% 06/01/27		04/29/2019	GOLDMAN SACHS & CO		480,625	500,000	0	4FE
25278X-AC-3	DIAMONDBACK ENERGY INC SR UNSECURED 4.750% 11/01/24		04/16/2019	GOLDMAN SACHS & CO		513,125	500,000	11,017	3FE
404119-BQ-1	HCA INC FIRST LIEN 5.250% 04/15/25		06/14/2019	FIRST BOSTON CORP		547,490	500,000	4,594	2FE
421924-BT-7	HEALTHSOUTH CORP SR UNSECURED 5.750% 09/15/25		04/17/2019	OPPENHEIMER & CO.		1,028,750	1,000,000	5,910	4FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						3,569,931	3,500,000	21,521	XXX
8399997. Total - Bonds - Part 3						17,192,879	14,880,000	67,729	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX
8399999. Total - Bonds						17,192,879	14,880,000	67,729	XXX
8999997. Total - Preferred Stocks - Part 3						0	XXX	0	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	XXX
9799997. Total - Common Stocks - Part 3						0	XXX	0	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	XXX
9999999 - Totals						17,192,879	XXX	67,729	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues 0

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation and Admini-strative Symbol /Market Indicator (a)
3620AM-DZ-2	GOVT NATL MTGE ASSN I POOL NO GN733720 4.500% 06/15/40		06/01/2019	Paydown		93,654	93,654	103,137	102,751	0	(9,097)	0	(9,097)	0	93,654	0	0	0	1,941	06/15/2040	1
0599999. Subtotal - Bonds - U.S. Governments						93,654	93,654	103,137	102,751	0	(9,097)	0	(9,097)	0	93,654	0	0	0	1,941	XXX	XXX
195325-BQ-7	COLOMBIA REPUBLIC OF SR UNSECURED 4.000% 02/26/24	D	05/28/2019	GOLDMAN SACHS & CO		515,250	500,000	520,750	511,797	0	(924)	0	(924)	0	510,873	0	4,377	4,377	15,222	02/26/2024	2FE
91086Q-AV-0	UNITED MEXICAN STATES SR UNSECURED 6.050% 01/11/40	D	06/06/2019	CIBC World Markets		2,305,000	2,000,000	2,239,600	2,234,880	0	(2,865)	0	(2,865)	0	2,232,015	0	72,985	72,985	110,581	01/11/2040	2FE
E12021-06-7	IVORY COAST SR UNSECURED 5.750% 12/31/32	D	06/30/2019	Redemption 100.0000		6,125	6,125	5,941	5,400	581	145	0	726	0	6,125	0	0	0	176	12/31/2032	4FE
X77765-BK-4	SERBIA REPUBLIC OF SR UNSECURED 7.250% 09/28/21	D	06/27/2019	Corporate Actions		489,485	446,000	469,415	455,168	0	(1,531)	0	(1,531)	0	453,636	0	35,849	35,849	24,161	09/28/2021	3FE
1099999. Subtotal - Bonds - All Other Govemments						3,315,860	2,952,125	3,235,706	3,207,245	581	(5,175)	0	(4,594)	0	3,202,649	0	113,211	113,211	150,140	XXX	XXX
57582R-FQ-4	MASSACHUSETTS STATE OF SER E 4.000% 09/01/36		06/18/2019	WARBURG DILLON READ		692,028	630,000	649,322	648,671	0	(1,179)	0	(1,179)	0	647,491	0	44,536	44,536	20,207	09/01/2036	1FE
1799999. Subtotal - Bonds - U.S. States, Territories and Possessions						692,028	630,000	649,322	648,671	0	(1,179)	0	(1,179)	0	647,491	0	44,536	44,536	20,207	XXX	XXX
77355P-TA-1	ROCKLAND CNTY NY PUBLIC IMPT-SER C 4.000% 05/01/23		05/08/2019	OPPENHEIMER & CO.		1,177,018	1,075,000	1,171,137	0	0	(3,663)	0	(3,663)	0	1,167,475	0	9,543	9,543	22,575	05/01/2023	1FE
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						1,177,018	1,075,000	1,171,137	0	0	(3,663)	0	(3,663)	0	1,167,475	0	9,543	9,543	22,575	XXX	XXX
3132XY-UX-3	FED HOME LOAN MTGE CORP GOLD POOL NO 4.000% 05/01/48		06/01/2019	Paydown		126,929	126,929	129,468	129,420	0	(2,491)	0	(2,491)	0	126,929	0	0	0	2,193	05/01/2048	1
3138X8-XG-1	FED NATL MTGE ASSN POOL NO AU8778 3.000% 10/01/28		06/01/2019	Paydown		120,363	120,363	124,745	123,507	0	(3,144)	0	(3,144)	0	120,363	0	0	0	1,572	10/01/2028	1
546456-DX-9	LOUISIANA ST CITIZENS PPTY REF 5.000% 06/01/19		06/01/2019	Maturity		3,000,000	3,000,000	3,373,860	3,041,490	0	(41,490)	0	(41,490)	0	3,000,000	0	0	0	75,000	06/01/2019	1FE
64577B-KU-7	NEW JERSEY ST ECON DEV AUTH REF SER XX 5.000% 06/15/19		06/15/2019	Maturity		3,000,000	3,000,000	3,186,690	3,023,554	0	(23,554)	0	(23,554)	0	3,000,000	0	0	0	75,000	06/15/2019	2FE
646136-H9-5	NEW JERSEY ST TRANSN TR FD TRANSPRTN PROGRAM-SER A 5.000% 06/15/19		06/15/2019	Maturity		1,500,000	1,500,000	1,613,655	1,513,437	0	(13,437)	0	(13,437)	0	1,500,000	0	0	0	37,500	06/15/2019	2FE
650010-AD-3	NEW YORK STATE THRUWAY AUTH SER A 5.000% 05/01/19		05/01/2019	Maturity		3,000,000	3,000,000	3,423,120	3,027,827	0	(27,827)	0	(27,827)	0	3,000,000	0	0	0	125,000	05/01/2019	1FE
650014-RW-5	NEW YORK ST TWP AUTH SECOND REVENUE BONDS 5.000% 04/01/22		04/01/2019	Call 100.0000		500,000	500,000	523,950	500,684	0	(684)	0	(684)	0	500,000	0	0	0	12,500	04/01/2022	1FE
67886M-MP-1	OKLAHOMA ST HSG FIN AGY SF MTG HOMEOWNERSHIP LN PG SER A 4.750% 03/01/28		04/01/2019	Call 100.0000		5,000	5,000	5,389	5,080	0	(12)	0	(12)	0	5,068	0	(68)	(68)	139	03/01/2028	1FE
681793-7L-3	OMAHA PUB PWR DIST NEBRASKA EL REVENUE BONDS 5.000% 02/01/36		06/13/2019	Raymond James		529,425	500,000	531,205	508,169	0	(1,758)	0	(1,758)	0	506,411	0	23,014	23,014	21,944	02/01/2036	1FE
3199999. Subtotal - Bonds - U.S. Special Revenues						11,781,717	11,752,292	12,912,082	11,873,168	0	(114,397)	0	(114,397)	0	11,758,771	0	22,946	22,946	350,848	XXX	XXX
038522-AN-8	ARAMARK SERVICES INC SR UNSECURED 4.750% 06/01/26		05/30/2019	DAIN RAUSCHER INC-69211		980,000	1,000,000	965,000	940,971	24,142	1,680	0	25,822	0	966,793	0	13,207	13,207	24,014	06/01/2026	3FE
038522-AQ-1	ARAMARK SERVICES INC SR UNSECURED 5.000% 02/01/28		05/08/2019	CHASE SECURITIES		1,010,000	1,000,000	1,000,000	935,710	64,290	0	0	64,290	0	1,000,000	0	10,000	10,000	38,750	02/01/2028	3FE
151020-AN-4	CELGENE CORP SR UNSECURED 2.250% 05/15/19		05/15/2019	Maturity		1,000,000	1,000,000	997,510	999,780	0	220	0	220	0	1,000,000	0	0	0	11,250	05/15/2019	2FE
185899-AC-5	CLEVELAND-CLIFFS INC SR UNSECURED 5.875% 06/01/27		06/18/2019	CHASE SECURITIES		485,000	500,000	480,625	0	0	151	0	151	0	480,776	0	4,224	4,224	3,019	06/01/2027	4FE
25278X-AH-2	DIAMONDBACK ENERGY INC SR UNSECURED 5.375% 05/31/25		04/16/2019	GOLDMAN SACHS & CO		1,047,500	1,000,000	1,036,233	975,675	58,089	(2,084)	0	56,005	0	1,031,680	0	15,820	15,820	20,604	05/31/2025	3FE
254683-BP-9	DISCOVER CARD MASTER TRUST SER 2015-A2 CLASS A 1.900% 10/17/22		04/22/2019	BNP PARIBAS		993,281	1,000,000	990,039	997,183	0	679	0	679	0	997,862	0	(4,581)	(4,581)	6,808	10/17/2022	1FE
404119-BN-8	HCA INC 1ST LIEN 5.000% 03/15/24		06/14/2019	FIRST BOSTON CORP		539,600	500,000	505,625	496,226	7,214	(277)	0	6,937	0	503,163	0	36,437	36,437	18,958	03/15/2024	2FE
421924-BK-6	HEALTHSOUTH CORP SR UNSECURED 5.750% 11/01/24		06/07/2019	Call 101.9170		42,805	42,000	40,058	40,598	0	88	0	88	0	40,687	0	1,313	1,313	2,254	11/01/2024	4FE
526057-BT-0	LENNAR CORP SR UNSECURED 4.500% 06/15/19		06/15/2019	Maturity		250,000	250,000	253,125	249,556	647	(203)	0	444	0	250,000	0	0	0	5,625	06/15/2019	3FE
717081-DU-4	PFIZER INC SR UNSECURED 1.450% 06/03/19		06/03/2019	Maturity		2,000,000	2,000,000	1,997,720	1,999,659	0	341	0	341	0	2,000,000	0	0	0	14,500	06/03/2019	1FE
74834L-AU-4	QUEST DIAGNOSTIC INC SR UNSECURED 2.700% 04/01/19		04/01/2019	Maturity		2,000,000	2,000,000	1,998,680	1,999,840	0	160	0	160	0	2,000,000	0	0	0	27,000	04/01/2019	2FE

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SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation and Admini-strative Symbol /Market Indicator (a)
887317-AT-2	TIME WARNER INC SR UNSECURED 2.100% 06/01/19		06/01/2019	Maturity		1,000,000	1,000,000	999,480	999,939	0	61	0	61	0	1,000,000	0	0	0	10,500	06/01/2019	2FE
962178-AL-3	WEYERHAEUSER REAL ESTATE SR UNSECURED 4.375% 06/15/19		06/15/2019	Maturity		600,000	600,000	594,585	595,001	4,306	693	0	4,999	0	600,000	0	0	0	13,125	06/15/2019	3FE
01609W-AQ-5	ALIBABA GROUP HOLDING SR UNSECURED 3.600% 11/28/24	D	05/20/2019	MORGAN STANLEY		1,020,490	1,000,000	991,560	992,402	0	472	0	472	0	992,874	0	27,616	27,616	17,400	11/28/2024	1FE
056752-AK-4	BAIDU INC SR UNSECURED 3.875% 09/29/23	D	05/20/2019	WACHOVIA		1,019,310	1,000,000	999,020	999,096	0	73	0	73	0	999,169	0	20,141	20,141	25,080	09/29/2023	1FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						13,987,986	13,892,000	13,849,260	13,221,636	158,688	2,054	0	160,742	0	13,863,004	0	124,177	124,177	238,887	XXX	XXX
8399997. Total - Bonds - Part 4						31,048,263	30,395,071	31,920,644	29,053,471	159,269	(131,457)	0	27,812	0	30,733,044	0	314,413	314,413	784,598	XXX	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8399999. Total - Bonds						31,048,263	30,395,071	31,920,644	29,053,471	159,269	(131,457)	0	27,812	0	30,733,044	0	314,413	314,413	784,598	XXX	XXX
8999997. Total - Preferred Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799997. Total - Common Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9999999 - Totals						31,048,263	XXX	31,920,644	29,053,471	159,269	(131,457)	0	27,812	0	30,733,044	0	314,413	314,413	784,598	XXX	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues 0

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

SCHEDULE E - PART 1 - CASH

Month End Depository Balances

1	2	3	4	5	Book Balance at End of Each Month During Current Quarter			9
					6	7	8	
Depository	Code	Rate of Interest	Amount of Interest Received During Current Quarter	Amount of Interest Accrued at Current Statement Date	First Month	Second Month	Third Month	*
Bank of America Charlotte, NC		0.000	0	0	15,073,691	9,429,019	14,286,567	XXX
0199998. Deposits in 1 depositories that do not exceed the allowable limit in any one depository (See instructions) - Open Depositories	XXX	XXX	0	0	(23,649)	(5,100)	(5,067)	XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	15,050,042	9,423,919	14,281,500	XXX
0299998. Deposits in 0 depositories that do not exceed the allowable limit in any one depository (See instructions) - Suspended Depositories	XXX	XXX	0	0	0	0	0	XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	15,050,042	9,423,919	14,281,500	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX	0	0	0	XXX
0599999. Total - Cash	XXX	XXX	0	0	15,050,042	9,423,919	14,281,500	XXX

STATEMENT AS OF JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned End of Current Quarter

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
0599999. Total - U.S. Government Bonds						0	0	0
1099999. Total - All Other Government Bonds						0	0	0
1799999. Total - U.S. States, Territories and Possessions Bonds						0	0	0
2499999. Total - U.S. Political Subdivisions Bonds						0	0	0
3199999. Total - U.S. Special Revenues Bonds						0	0	0
	AMERICAN ELEC POWER CP 4-2 144A		03/26/2019	2.710	04/09/2019	0	0	2,948
	AMERICAN ELEC POWER CP 4-2 144A		06/26/2019	2.590	07/22/2019	3,993,954	0	1,437
	APACHE CORP CP 4-2		03/29/2019	2.800	04/01/2019	0	0	817
	ASTRAZENECA PLC CP 4(2) 144A		06/27/2019	2.550	07/08/2019	1,777,118	0	504
	AVIATION CAPITAL GROUP CP 4(2) 144A		03/11/2019	2.720	04/08/2019	0	0	7,929
	CENTERPOINT ENERGY RESOU CP 4(2)		03/20/2019	2.750	04/09/2019	0	0	2,875
	CENTERPOINT ENERGY RESOU CP 4(2)		03/20/2019	2.770	04/15/2019	0	0	1,996
	CONSOLIDATED EDISON INC CP 4(2) 144A		06/26/2019	2.510	07/01/2019	5,000,000	0	1,743
	ENTERGY CORP CP 4(2) 144A		03/22/2019	2.710	04/15/2019	0	0	1,883
	ENTERGY CORP CP 4(2) 144A		06/26/2019	2.560	07/11/2019	6,995,020	0	2,487
	FORTIVE CORPORATION CP 4(2) 144A		06/26/2019	2.610	07/11/2019	3,288,613	0	1,192
	ITC HOLDINGS CORP CP 4(2) 144A		06/26/2019	2.600	07/09/2019	3,527,960	0	1,274
	NEXTERA ENERGY CAP HLDGS CP 4 (2)		06/28/2019	2.540	07/09/2019	498,718	0	106
	PPL ELECTRIC UTILITIES CP4(2) 144A		06/26/2019	2.550	07/17/2019	5,993,198	0	2,123
	UNION ELECTRIC CO CP 3(A)3		03/29/2019	2.680	04/01/2019	0	0	730
	WESTAR ENERGY INC CP 4(2) 144A		06/26/2019	2.570	07/16/2019	4,295,394	0	1,533
3299999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations						35,369,975	0	31,577
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						35,369,975	0	31,577
4899999. Total - Hybrid Securities						0	0	0
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0
6099999. Subtotal - SVO Identified Funds						0	0	0
6599999. Subtotal - Bank Loans						0	0	0
7799999. Total - Issuer Obligations						35,369,975	0	31,577
7899999. Total - Residential Mortgage-Backed Securities						0	0	0
7999999. Total - Commercial Mortgage-Backed Securities						0	0	0
8099999. Total - Other Loan-Backed and Structured Securities						0	0	0
8199999. Total - SVO Identified Funds						0	0	0
8299999. Total - Bank Loans						0	0	0
8399999. Total Bonds						35,369,975	0	31,577
60934N-50-0	FEDERATED INVESTORS INC TREASURY OBLIGATION FUND		06/27/2019	0.000		856	28	46
8599999. Subtotal - Exempt Money Market Mutual Funds - as Identified by the SVO						856	28	46
8899999 - Total Cash Equivalents						35,370,831	28	31,623

SUPPLEMENT FOR THE QUARTER ENDING JUNE 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

MEDICARE PART D COVERAGE SUPPLEMENT

(Net of Reinsurance)

NAIC Group Code 0001 NAIC Company Code 15761

	Individual Coverage		Group Coverage		5
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	Total Cash
1. Premiums Collected		XXX		XXX	
2. Earned Premiums		XXX		XXX	XXX
3. Claims Paid		XXX		XXX	
4. Claims Incurred		XXX		XXX	XXX
5. Reinsurance Coverage and Low Income Cost Sharing - Claims Paid Net of Reimbursements Applied (a)	XXX		XXX		
6. Aggregate Policy Reserves - Change		XXX		XXX	XXX
7. Expenses Paid		XXX		XXX	
8. Expenses Incurred		XXX		XXX	XXX
9. Underwriting Gain or Loss		XXX		XXX	XXX
10. Cash Flow Result	XXX	XXX	XXX	XXX	

NONE

(a) Uninsured Receivable/Payable with CMS at End of Quarter: $ ..... due from CMS or $ ..... due to CMS

Aetna Better Health® of Kentucky Q3 2019 Statement

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QUARTERLY STATEMENT

OF THE

Aetna Better Health of Kentucky Insurance Company

TO THE

Insurance Department

OF THE

STATE OF

Kentucky

FOR THE QUARTER ENDED
SEPTEMBER 30, 2019

HEALTH

2019

HEALTH QUARTERLY STATEMENT

AS OF SEPTEMBER 30, 2019

OF THE CONDITION AND AFFAIRS OF THE

Aetna Better Health of Kentucky Insurance Company

NAIC Group Code 0001 (Current) 0001 (Prior) NAIC Company Code 15761 Employer's ID Number 47-3279217

Organized under the Laws of Kentucky, State of Domicile or Port of Entry KY

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health

Is HMO Federally Qualified? Yes [ ] No [ ]

Incorporated/Organized 02/24/2015 Commenced Business 02/01/2016

Statutory Home Office 9900 Corporate Campus Drive, Suite 1000 (Street and Number), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Main Administrative Office 9900 Corporate Campus Drive, Suite 1000 (Street and Number)

Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Mail Address 9900 Corporate Campus Drive, Suite 1000 (Street and Number or P.O. Box), Louisville, KY, US 40202 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 9900 Corporate Campus Drive, Suite 1000 (Street and Number)

Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

Internet Website Address www.aetnabetterhealth.com

Statutory Statement Contact Scott David Miller (Name), 717-671-2474 (Area Code) (Telephone Number)

StatutoryReporting@aetna.com (E-mail Address), 717-526-2888 (FAX Number)

OFFICERS

President Randy Joo Hwan Hyun

Chief Financial Officer David Patrick Delaney #

Vice President and Secretary Robert Mark Kessler

OTHER

Kevin James Casey, Senior Investment Officer

Peter Keller, Assstant Controller #

Bryan James Lane, Assistant Controller #

William Stephen Maynes, Assistant Controller #

Scott David Miller, Assistant Controller #

Robert Joseph Parslow, Principal Financial Officer and Controller #

Tracy Louise Smith, Vice President and Treasurer #

DIRECTORS OR TRUSTEES

Debra Jean Bacon

David Patrick Delaney #

Jonathan Edward Copley

Randy Joo Hwan Hyun

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices andprocedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Randy Joo Hwan Hyun Chief Executive Officer and President	Robert Mark Kessler Vice President and Secretary	David Patrick Delaney Chief Financial Officer
State of..... Connecticut County of..... Hartford	State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa
Subscribed and sworn to before me this 23rd day of October, 2019	Subscribed and sworn to before me this ____ day of _____, 2019	Subscribed and sworn to before me this ____ day of _____, 2019
NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)

CAITLIN GOULD
Notary Public State of Connecticut
My Commission Expires Jan. 31, 2020

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number .....
2. Date filed .....
3. Number of pages attached .....

HEALTH QUARTERLY STATEMENT

AS OF SEPTEMBER 30, 2019
OF THE CONDITION AND AFFAIRS OF THE

Aetna Better Health of Kentucky Insurance Company

NAIC Group Code 0001 (Current) 0001 (Prior) NAIC Company Code 15761 Employer's ID Number 47-3279217

Organized under the Laws of Kentucky, State of Domicile or Port of Entry KY

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health

Is HMO Federally Qualified? Yes [ ] No [ ]

Incorporated/Organized 02/24/2015 Commenced Business 02/01/2016

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Louisville, KY, US 40202 (City or Town, State, Country and Zip Code), 800-627-4702 (Area Code) (Telephone Number)

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Internet Website Address www.aetnabetterhealth.com

Statutory Statement Contact Scott David Miller (Name), 717-671-2474 (Area Code) (Telephone Number)
StatutoryReporting@aetna.com (E-mail Address), 717-526-2888 (FAX Number)

OFFICERS

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Chief Financial Officer David Patrick Delaney #
Vice President and Secretary Robert Mark Kessler

OTHER

Kevin James Casey, Senior Investment Officer
Peter Kellier, Assstant Controller #
Bryan James Lane, Assistant Controller #
William Stephen Maynes, Assistant Controller #
Scott David Miller, Assistant Controller #
Robert Joseph Parslow, Principal Financial Officer and Controller #
Tracy Louise Smith, Vice President and Treasurer #

DIRECTORS OR TRUSTEES

Debra Jean Bacon
Jonathan Edward Copley
David Patrick Delaney #
Randy Joo Hwan Hyun

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices andprocedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Randy Joo Hwan Hyun Chief Executive Officer and President	Robert Mark Kessler Vice Presidentand Secretary	David Patrick Delaney Chief Financial Officer
State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa	State of..... Arizona County of..... Maricopa
Subscribed and sworn to before me this ____ day of _____, 2019	Subscribed and sworn to before me this 21 day of October, 2019	Subscribed and sworn to before me this 16 day of October, 2019
NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)	NOTARY PUBLIC (Seal)

LISA M LAMBERT
Notary Public, State of Arizona
Maricopa County
Commission # 558484
My Commission Expires
January 21, 2023

LISA M LAMBERT
Notary Public, State of Arizona
Maricopa County
Commission # 558484
My Commission Expires
January 21, 2023

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number .....
2. Date filed .....
3. Number of pages attached.....

ASSETS

	Current Statement Date 1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 December 31 Prior Year Net Admitted Assets
1. Bonds	441,529,997	0	441,529,997	442,356,086
2. Stocks:				
2.1 Preferred stocks	0	0	0	0
2.2 Common stocks	0	0	0	0
3. Mortgage loans on real estate:				
3.1 First liens	15,295,599	0	15,295,599	13,407,858
3.2 Other than first liens	0	0	0	0
4. Real estate:				
4.1 Properties occupied by the company (less $ 0 encumbrances)	0	0	0	0
4.2 Properties held for the production of income (less $ 0 encumbrances)	0	0	0	0
4.3 Properties held for sale (less $ 0 encumbrances)	0	0	0	0
5. Cash ($ 12,570,039), cash equivalents ($ 33,698,594) and short-term investments ($ 0)	46,268,633	0	46,268,633	18,620,276
6. Contract loans (including $ 0 premium notes)	0	0	0	0
7. Derivatives	0	0	0	0
8. Other invested assets	13,664,778	0	13,664,778	0
9. Receivables for securities	583,319	0	583,319	11,415
10. Securities lending reinvested collateral assets	0	0	0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	517,342,326	0	517,342,326	474,395,635
13. Title plants less $ 0 charged off (for Title insurers only)	0	0	0	0
14. Investment income due and accrued	4,239,379	0	4,239,379	4,621,602
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	1,530,237	0	1,530,237	1,931,674
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $ 0 earned but unbilled premiums)	0	0	0	0
15.3 Accrued retrospective premiums ($ 0) and contracts subject to redetermination ($ 0)	0	0	0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	0	0	0	0
16.2 Funds held by or deposited with reinsured companies	0	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0	0
17. Amounts receivable relating to uninsured plans	0	0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	1,906,140	0	1,906,140	0
18.2 Net deferred tax asset	5,204,425	0	5,204,425	5,204,425
19. Guaranty funds receivable or on deposit	0	0	0	0
20. Electronic data processing equipment and software	0	0	0	0
21. Furniture and equipment, including health care delivery assets ($ 0)	0	0	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23. Receivables from parent, subsidiaries and affiliates	0	0	0	7,789,355
24. Health care ($ 6,387,211) and other amounts receivable	17,933,702	11,546,491	6,387,211	2,070,247
25. Aggregate write-ins for other than invested assets	515,815	515,815	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	548,672,024	12,062,306	536,609,718	496,012,938
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28. Total (Lines 26 and 27)	548,672,024	12,062,306	536,609,718	496,012,938
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Deposits	500,000	500,000	0	0
2502. Misc Receivable	15,815	15,815	0	0
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	515,815	515,815	0	0

LIABILITIES, CAPITAL AND SURPLUS

		Current Period			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $ 0 reinsurance ceded)	111,293,557	3,442,069	114,735,626	127,259,095
2.	Accrued medical incentive pool and bonus amounts	3,611,532	0	3,611,532	1,187,135
3.	Unpaid claims adjustment expenses	3,761,754	0	3,761,754	4,812,094
4.	Aggregate health policy reserves, including the liability of $ 0 for medical loss ratio rebate per the Public Health Service Act	1,559,266	0	1,559,266	0
5.	Aggregate life policy reserves	0	0	0	0
6.	Property/casualty unearned premium reserve	0	0	0	0
7.	Aggregate health claim reserves	0	0	0	0
8.	Premiums received in advance	21,016,256	0	21,016,256	574,560
9.	General expenses due or accrued	8,545,067	0	8,545,067	11,601,352
10.1	Current federal and foreign income tax payable and interest thereon (including $ 0 on realized gains (losses))	0	0	0	4,383,990
10.2	Net deferred tax liability	0	0	0	0
11.	Ceded reinsurance premiums payable	0	0	0	0
12.	Amounts withheld or retained for the account of others	0	0	0	3,139,799
13.	Remittances and items not allocated	1,499,063	0	1,499,063	1,753,757
14.	Borrowed money (including $ 0 current) and interest thereon $ 0 (including $ 0 current)	0	0	0	0
15.	Amounts due to parent, subsidiaries and affiliates	15,614,216	0	15,614,216	13,820,266
16.	Derivatives	0	0	0	0
17.	Payable for securities	0	0	0	0
18.	Payable for securities lending	0	0	0	0
19.	Funds held under reinsurance treaties (with $ 0 authorized reinsurers, $ 0 unauthorized reinsurers and $ 0 certified reinsurers)	0	0	0	0
20.	Reinsurance in unauthorized and certified ($ 0) companies	0	0	0	0
21.	Net adjustments in assets and liabilities due to foreign exchange rates	0	0	0	0
22.	Liability for amounts held under uninsured plans	0	0	0	0
23.	Aggregate write-ins for other liabilities (including $ 0 current)	831,301	0	831,301	982,691
24.	Total liabilities (Lines 1 to 23)	167,732,012	3,442,069	171,174,081	169,514,739
25.	Aggregate write-ins for special surplus funds	XXX	XXX	16,266,225	0
26.	Common capital stock	XXX	XXX	1,000,000	1,000,000
27.	Preferred capital stock	XXX	XXX	0	0
28.	Gross paid in and contributed surplus	XXX	XXX	99,010,001	99,010,001
29.	Surplus notes	XXX	XXX	0	0
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX	0	0
31.	Unassigned funds (surplus)	XXX	XXX	249,159,411	226,488,198
32.	Less treasury stock, at cost:				
	32.1 0 shares common (value included in Line 26 $ 0)	XXX	XXX	0	0
	32.2 0 shares preferred (value included in Line 27 $ 0)	XXX	XXX	0	0
33.	Total capital and surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	365,435,637	326,498,199
34.	Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	536,609,718	496,012,938
	DETAILS OF WRITE-INS				
2301.	Escheat Payable	831,301	0	831,301	982,691
2302.					
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399.	Totals (Lines 2301 through 2303 plus 2398)(Line 23 above)	831,301	0	831,301	982,691
2501.	Estimated Health Insurance Fee accrual	XXX	XXX	16,266,225	0
2502.		XXX	XXX		
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599.	Totals (Lines 2501 through 2503 plus 2598)(Line 25 above)	XXX	XXX	16,266,225	0
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099.	Totals (Lines 3001 through 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

STATEMENT OF REVENUE AND EXPENSES

		Current Year To Date		Prior Year To Date	Prior Year Ended December 31
		1 Uncovered	2 Total	3 Total	4 Total
1.	Member Months	XXX	1,961,188	2,101,101	2,773,717
2.	Net premium income (including $ 0 non-health premium income)	XXX	809,425,436	837,213,717	1,121,827,068
3.	Change in unearned premium reserves and reserve for rate credits	XXX	(1,559,266)	(4,185,848)	0
4.	Fee-for-service (net of $ 0 medical expenses)	XXX	0	0	0
5.	Risk revenue	XXX	0	0	0
6.	Aggregate write-ins for other health care related revenues	XXX	0	0	0
7.	Aggregate write-ins for other non-health revenues	XXX	0	0	0
8.	Total revenues (Lines 2 to 7)	XXX	807,866,170	833,027,869	1,121,827,068
	Hospital and Medical:				
9.	Hospital/medical benefits	13,039,412	434,647,059	452,619,480	578,623,254
10.	Other professional services	927,549	30,918,309	32,661,056	43,428,479
11.	Outside referrals	195,779	6,525,956	0	8,516,577
12.	Emergency room and out-of-area	1,809,756	60,325,191	61,886,135	80,128,217
13.	Prescription drugs	0	172,306,165	162,176,682	218,620,756
14.	Aggregate write-ins for other hospital and medical	0	0	0	0
15.	Incentive pool, withhold adjustments and bonus amounts	0	3,852,221	552,915	1,640,478
16.	Subtotal (Lines 9 to 15)	15,972,496	708,574,901	709,896,268	930,957,761
	Less:				
17.	Net reinsurance recoveries	0	0	0	0
18.	Total hospital and medical (Lines 16 minus 17)	15,972,496	708,574,901	709,896,268	930,957,761
19.	Non-health claims (net)	0	0	0	0
20.	Claims adjustment expenses, including $ 19,236,598 cost containment expenses	0	20,225,621	20,973,102	28,085,901
21.	General administrative expenses	0	49,722,399	73,533,368	93,657,324
22.	Increase in reserves for life and accident and health contracts (including $ 0 increase in reserves for life only)	0	0	0	0
23.	Total underwriting deductions (Lines 18 through 22)	15,972,496	778,522,921	804,402,738	1,052,700,986
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	29,343,249	28,625,131	69,126,082
25.	Net investment income earned	0	13,570,755	12,452,843	16,076,249
26.	Net realized capital gains (losses) less capital gains tax of $ 199,598	0	429,214	(2,505,475)	(3,331,896)
27.	Net investment gains (losses) (Lines 25 plus 26)	0	13,999,969	9,947,368	12,744,353
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $ 0) (amount charged off $ 0)]	0	0	0	0
29.	Aggregate write-ins for other income or expenses	0	(1,194,084)	(3,014,116)	(4,224,851)
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	42,149,134	35,558,383	77,645,584
31.	Federal and foreign income taxes incurred	XXX	6,797,563	9,822,467	18,504,307
32.	Net income (loss) (Lines 30 minus 31)	XXX	35,351,571	25,735,916	59,141,277
	DETAILS OF WRITE-INS				
0601.		XXX			
0602.		XXX			
0603.		XXX			
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0	0
0699.	Totals (Lines 0601 through 0603 plus 0698)(Line 6 above)	XXX	0	0	0
0701.		XXX			
0702.		XXX			
0703.		XXX			
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0	0
0799.	Totals (Lines 0701 through 0703 plus 0798)(Line 7 above)	XXX	0	0	0
1401.					
1402.					
1403					
1498.	Summary of remaining write-ins for Line 14 from overflow page	0	0	0	0
1499.	Totals (Lines 1401 through 1403 plus 1498)(Line 14 above)	0	0	0	0
2901.	Regulatory penalties	0	(1,194,084)	(3,014,116)	(4,224,851)
2902.					
2903					
2998.	Summary of remaining write-ins for Line 29 from overflow page	0	0	0	0
2999.	Totals (Lines 2901 through 2903 plus 2998)(Line 29 above)	0	(1,194,084)	(3,014,116)	(4,224,851)

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year to Date	2 Prior Year to Date	3 Prior Year Ended December 31
	CAPITAL AND SURPLUS ACCOUNT			
33.	Capital and surplus prior reporting year	326,498,199	261,922,348	261,922,348
34.	Net income or (loss) from Line 32	35,351,571	25,735,916	59,141,277
35.	Change in valuation basis of aggregate policy and claim reserves	0	0	0
36.	Change in net unrealized capital gains (losses) less capital gains tax of $ 371,629	1,398,031	(341,536)	(1,538,193)
37.	Change in net unrealized foreign exchange capital gain or (loss)	0	0	0
38.	Change in net deferred income tax	371,629	(90,788)	(5,183,022)
39.	Change in nonadmitted assets	1,816,207	11,613,446	12,128,036
40	Change in unauthorized and certified reinsurance	0	0	0
41.	Change in treasury stock	0	0	0
42.	Change in surplus notes	0	0	0
43.	Cumulative effect of changes in accounting principles	0	0	0
44.	Capital Changes:			
	44.1 Paid in	0	0	0
	44.2 Transferred from surplus (Stock Dividend)	0	0	0
	44.3 Transferred to surplus	0	0	0
45.	Surplus adjustments:			
	45.1 Paid in	0	0	0
	45.2 Transferred to capital (Stock Dividend)	0	0	0
	45.3 Transferred from capital	0	0	0
46.	Dividends to stockholders	0	0	0
47.	Aggregate write-ins for gains or (losses) in surplus	0	0	27,753
48.	Net change in capital & surplus (Lines 34 to 47)	38,937,438	36,917,038	64,575,851
49.	Capital and surplus end of reporting period (Line 33 plus 48)	365,435,637	298,839,386	326,498,199
	DETAILS OF WRITE-INS			
4701.	Correction of Prior Year Current Federal Income Tax Incurred	0	0	27,753
4702.				
4703.				
4798.	Summary of remaining write-ins for Line 47 from overflow page	0	0	0
4799.	Totals (Lines 4701 through 4703 plus 4798)(Line 47 above)	0	0	27,753

CASH FLOW

		1 Current Year To Date	2 Prior Year To Date	3 Prior Year Ended December 31
	Cash from Operations			
1.	Premiums collected net of reinsurance	830,268,569	809,348,302	1,090,505,904
2.	Net investment income	15,067,642	14,545,547	18,140,983
3.	Miscellaneous income	0	0	0
4.	Total (Lines 1 to 3)	845,336,211	823,893,849	1,108,646,887
5.	Benefit and loss related payments	721,158,915	721,372,612	950,102,213
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0
7.	Commissions, expenses paid and aggregate write-ins for deductions	75,248,729	79,763,463	125,269,154
8.	Dividends paid to policyholders	0	0	0
9.	Federal and foreign income taxes paid (recovered) net of $ 0 tax on capital gains (losses)	13,287,291	22,436,947	21,745,323
10.	Total (Lines 5 through 9)	809,694,935	823,573,022	1,097,116,690
11.	Net cash from operations (Line 4 minus Line 10)	35,641,276	320,827	11,530,197
	Cash from Investments			
12.	Proceeds from investments sold, matured or repaid:			
	12.1 Bonds	93,392,163	171,021,350	197,532,407
	12.2 Stocks	0	0	0
	12.3 Mortgage loans	261,406	236,016	316,980
	12.4 Real estate	0	0	0
	12.5 Other invested assets	0	0	0
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	(24)	128	(722)
	12.7 Miscellaneous proceeds	0	34,419	547,760
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	93,653,545	171,291,913	198,396,425
13.	Cost of investments acquired (long-term only):			
	13.1 Bonds	91,917,090	128,651,606	169,085,405
	13.2 Stocks	0	0	0
	13.3 Mortgage loans	2,054,302	442,927	621,181
	13.4 Real estate	0	0	0
	13.5 Other invested assets	13,124,775	0	0
	13.6 Miscellaneous applications	571,904	8,734,267	0
	13.7 Total investments acquired (Lines 13.1 to 13.6)	107,668,071	137,828,800	169,706,586
14.	Net increase (or decrease) in contract loans and premium notes	0	0	0
15.	Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	(14,014,526)	33,463,113	28,689,839
	Cash from Financing and Miscellaneous Sources			
16.	Cash provided (applied):			
	16.1 Surplus notes, capital notes	0	0	0
	16.2 Capital and paid in surplus, less treasury stock	0	0	0
	16.3 Borrowed funds	0	0	0
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0	0
	16.5 Dividends to stockholders	0	0	0
	16.6 Other cash provided (applied)	6,021,607	(4,058,760)	(35,804,649)
17.	Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	6,021,607	(4,058,760)	(35,804,649)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS			
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	27,648,357	29,725,180	4,415,387
19.	Cash, cash equivalents and short-term investments:			
	19.1 Beginning of year	18,620,276	14,204,889	14,204,889
	19.2 End of period (Line 18 plus Line 19.1)	46,268,633	43,930,069	18,620,276

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001. Non-Cash Transaction - Tax Free Acquisition	3,905,837	4,051,498	8,057,370

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION

	1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
	Total	2 Individual	3 Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:										
1. Prior Year	224,908	11,289	0	0	0	0	0	0	213,619	0
2. First Quarter	213,505	9,987	0	0	0	0	0	0	203,518	0
3. Second Quarter	219,598	9,768	0	0	0	0	0	0	209,830	0
4. Third Quarter	212,114	9,320	0	0	0	0	0	0	202,794	0
5. Current Year	0	0	0	0	0	0	0	0	0	0
6. Current Year Member Months	1,961,188	90,281	0	0	0	0	0	0	1,870,907	0
Total Member Ambulatory Encounters for Period:										
7 Physician	1,244,650	52,628	0	0	0	0	0	0	1,192,022	0
8. Non-Physician	737,272	20,301	0	0	0	0	0	0	716,971	0
9. Total	1,981,922	72,929	0	0	0	0	0	0	1,908,993	0
10. Hospital Patient Days Incurred	73,096	748	0	0	0	0	0	0	72,348	0
11. Number of Inpatient Admissions	15,341	140	0	0	0	0	0	0	15,201	0
12. Health Premiums Written (a)	809,425,436	21,119,077	0	0	0	0	0	0	788,306,359	0
13. Life Premiums Direct	0	0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0	0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	807,866,170	21,076,922	0	0	0	0	0	0	786,789,248	0
16. Property/Casualty Premiums Earned	0	0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	721,158,915	17,944,949	0	0	0	0	0	0	703,213,966	0
18. Amount Incurred for Provision of Health Care Services	708,574,901	17,196,363	0	0	0	0	0	0	691,378,538	0

(a) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees $ 0

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

Aging Analysis of Unpaid Claims

1 Account	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 91 - 120 Days	6 Over 120 Days	7 Total
Claims Unpaid (Reported)						
0299999 Aggregate accounts not individually listed-uncovered	338,836	4,590	296	3,650	108,581	455,953
0399999 Aggregate accounts not individually listed-covered	11,657,276	347,888	37,345	34,865	2,560,448	14,637,822
0499999 Subtotals	11,996,112	352,478	37,641	38,515	2,669,029	15,093,775
0599999 Unreported claims and other claim reserves						99,641,851
0699999 Total amounts withheld						0
0799999 Total claims unpaid						114,735,626
0899999 Accrued medical incentive pool and bonus amounts						3,611,532

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

UNDERWRITING AND INVESTMENT EXHIBIT

ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid Year to Date		Liability End of Current Quarter		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid Dec. 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)	2,010,799	15,799,172	75,157	2,254,149	2,085,956	3,077,892
2. Medicare Supplement	0	0	0	0	0	0
3. Dental Only	0	0	0	0	0	0
4. Vision Only	0	0	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0	0	0
6. Title XVIII - Medicare	0	0	0	0	0	0
7 Title XIX - Medicaid	81,344,236	620,576,884	12,895,352	99,510,968	94,239,588	124,181,203
8. Other health	0	0	0	0	0	0
9. Health subtotal (Lines 1 to 8)	83,355,035	636,376,056	12,970,509	101,765,117	96,325,544	127,259,095
10. Healthcare receivables (a)	8,075,586	9,858,116	0	0	8,075,586	15,448,760
11. Other non-health	0	0	0	0	0	0
12. Medical incentive pools and bonus amounts	124,777	1,303,047	1,992,238	1,619,294	2,117,015	1,187,135
13. Totals (Lines 9-10+11+12)	75,404,226	627,820,987	14,962,747	103,384,411	90,366,973	112,997,470

(a) Excludes $ 0 loans or advances to providers not yet expensed.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying statutory financial statements of Aetna Better Health of Kentucky Insurance Co (the "Company), a wholly-owned subsidiary of Coventry Health & Life Insurance Co. ('CH&L') whose ultimate parent is CVS Health Corporation ("CVS Health"), have been prepared in conformity with accounting practices prescribed or permitted by the Commonwealth of Kentucky Department of Insurance (KY DOI). The Commonwealth of Kentucky recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP").

A reconciliation of the Company's net income and surplus between NAIC SAP and practices prescribed and permitted by the Commonwealth of Kentucky for the periods ended September 30, 2019 and December 31, 2018 is as follows:

		SSAP #	F/S Page	F/S Line #	2019	2018
NET INCOME						
(1)	State basis (Page 4, Line 32, Columns 2 & 4)	XXX	XXX	XXX	$35,351,571	$59,141,277
(2)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
(3)	State Permitted Practices that increase/(decrease) NAIC SAP:					
(4)	NAIC SAP (1-2-3=4)	XXX	XXX	XXX	$35,351,571	$59,141,277
	SURPLUS					
(5)	State basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	$365,435,637	$326,498,199
(6)	State Prescribed Practices that increase/(decrease) NAIC SAP:					
(7)	State Permitted Practices that increase/(decrease) NAIC SAP:					
(8)	NAIC SAP (5-6-7=8)	XXX	XXX	XXX	$365,435,637	$326,498,199

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of these financial statements in conformity with Kentucky Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenues and expenses. Actual results could differ from those estimates.

C. Accounting Policies

(1) No significant change.

(2) Bonds:

Bonds, which include special deposits, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections. Bonds include all investments whose maturity is greater than one year when purchased. Loan-backed and structured securities are carried at amortized cost adjusted for

unamortized premiums and discounts. Premiums and discounts on loan-backed and structured securities are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments. All adjustments between amortized cost and carrying value are reflected in unrealized capital gains and losses and are reported as direct adjustments to surplus. Bonds are recorded as purchases or sales on the trade date.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities, an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For loan-backed and structured securities, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from the Company's expectations and the risk that facts and circumstances factored into its assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

(3) through (7): No significant change.

(8) Joint Ventures, Partnerships and Limited Liability Companies:

Other Invested Assets:

Other invested assets consist primarily of partnerships and equity subsidiaries. Partnerships and equity subsidiaries are reported using the equity method. Unaudited other invested assets are nonadmitted as they do not meet the admissibility requirements of SSAP No. 48, *Joint Ventures, Partnerships and Limited Liability Companies* and SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entities*, which requires U.S. generally accepted accounting principles' audited financial statements of the investments. The Company periodically reviews other invested assets for impairment. An impairment shall be considered to have occurred if it is probable that the Company will be unabe to recover the carrying amount of the investment or there is evidence indicating the inability of the investee to sustain earnings which would justify the carrying amount of the investment.

(9) through (21): No significant change.

D. Going Concern

As of November 14, 2019, management has evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

2. Accounting Changes and Corrections of Errors

The Company did not have any accounting changes or corrections of errors in the period ended September 30, 2019.

3. Business Combinations and Goodwill

No significant change.

4. Discontinued Operations

No significant change.

5. Investments

A. through C: No significant change.

D. Loan-Backed Securities

(1) Prepayment assumptions for single class and multi-class mortgage backed/asset backed securities were obtained from industry market sources.

(2) The Company had no other-than-temporary impairment ("OTTI") losses during the third quarter of 2019 on loan-backed and structured securities in which the Company had the (1) intent to sell, (2) did not have the intent and ability to retain for a period of time sufficient to recover the amortized cost basis or (3) present value of cash flows expected to be collected is less than the amortized cost basis of the securities in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 43R, *Loan-Backed and Structured Securities* ("SSAP No. 43R").

(3) The Company had no recognized OTTI on loan-backed and structured securities currently held, in which the present value of cash flows expected to be collected is less than the amortized cost basis, at the reporting date September 30, 2019.

(4) The Company's unrealized loss position on loan-backed and structured securities held by the Company at September 30, 2019 is as follows:

a. The aggregate amount of unrealized losses:	
1. Less than 12 Months	($16,651)
2. 12 Months or Longer	$—
b. The aggregate related fair value of securities with unrealized losses:	
1. Less than 12 Months	$2,983,349
2. 12 Months or Longer	$—

(5) The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R in the table above and have concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at September 30, 2019 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

E. Dollar Repurchase Agreements and/or Securities Lending Transactions

(1) and (2): No significant change.

(3) Neither the Company nor its agent has accepted collateral that is permitted by contract or custom to sell or repledge as of September 30, 2019.

(4) through (7): No significant change.

F. The Company did not have any repurchase agreements transactions accounted for as secured borrowing at September 30, 2019.

G. The Company did not have any reverse repurchase agreements transactions accounted for as secured at September 30, 2019.

H. The Company did not have any repurchase agreements transactions accounted for as a sale at September 30, 2019.

I. The Company did not have any reverse repurchase agreements transactions accounted for as a sale at September 30, 2019.

J. No significant change.

K. Low-Income Housing Tax Credits ("LIHTC")

(1) The number of remaining years of unexpired tax credits for the Company's LIHTC portfolio is 5 years. The holding period for the Company's low-income housing tax credit investments, as defined by the IRS, is 10 years.

(2) The Company recognized LIHTC of $760,637 and other tax benefits of $42,534 as of September 30, 2019.

(3) The Company's LIHTC investments were $4,622,477 at September 30, 2019.

(4) The Company's LIHTC investments are not currently subject to any regulatory reviews.

(5) The aggregate of the Company's LIHTC investments is less than 1% of the Company's total admitted assets.

(6) The Company has not recognized any impairment losses on its LIHTC investments at September 30, 2019.

(7) There have been no write-downs or reclassifications at September 30, 2019 resulting from the forfeiture or ineligibility of tax credits.

L. No significant change.

M. The Company did not have any working capital finance investments at September 30, 2019.

N. The Company did not have any offsetting and netting of financial assets or liabilities at September 30, 2019.

O. through Q: No significant change.

R. Prepayment Penalty and Acceleration Fees at September 30, 2019.

Prepayment Penalty and Acceleration Fees	General Account
1. Number of CUSIPs	8
2. Aggregate Amount of Investment Income	$56,582

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company did not have any joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at September 30, 2019.

B. The Company does not have any impaired investments in joint ventures, partnerships, or limited liability companies at September 30, 2019.

7. Investment Income

No significant change.

8. Derivative Instruments

The Company did not have any derivative instruments at September 30, 2019.

9. Income Taxes

No significant change.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. through E: No significant change.

F. As of September 30, 2019, the Company had the following new significant transactions with affiliates:

On July 9, 2019, the Company entered into a Sale and Purchase Agreement (the "Sale and Purchase Agreement") with Aetna Health and Life Insurance Company ("AHLIC"), CH&L and Aetna Health Inc. (a Pennsylvania corporation) whereby the Company purchased an investment in LIHTC from AHLIC, an affiliate. In consideration for this transaction, the Company paid cash of $4,924,775 for the fair market value of the LIHTC investment. The Sale and Purchase Agreement did not require approval by the KY DOI because it was below 3% of admitted assets of the Company.

G. through O: No significant change.

11. Debt

A. The Company did not have any items related to debt, including capital notes at September 30, 2019.

B. The Company did not have any Federal Home Loan Bank agreements at September 30, 2019.

12. Retirement Plans, Deferred Compensation Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

The Company did not have a retirement plan, deferred compensation plan, or other postretirement benefit plan at September 30, 2019.

13. Capital and Surplus, Shareholders' Dividend Restrictons and Quasi-Reorganizations

No significant change.

14. Liabilities, Contingencies and Assessments

No significant change.

15. Leases

No significant change.

16. Information About Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

No significant change.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

No significant change.

B. Transfer and Servicing of Financial Assets

(1) No significant change.

(2) and (3): The Company did not have any servicing assets or liabilities at September 30, 2019.

(4) The Company did not have any securitized financial assets at September 30, 2019.

(5) through (7): No significant change.

C. Wash Sales

(1) The Company did not have any wash sales for the period ended September 30, 2019.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

No significant change.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No significant change.

20. Fair Value Measurements

A. and B.

The Company had no material assets or liabilities measured and reported at fair value at September 30, 2019.

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

Level 1 - Unadjusted quoted prices for identical assets or liabilities in active markets.

Level 2 - Inputs other than Level 1 that are based on observable market data. These include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.

Level 3 - Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market

is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

C. The carrying values and estimated fair values of the Company's financial instruments at September 30, 2019 were as follows:

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)	Net Asset Value (NAV) Included in Level 2
Bonds, Short Term, and Cash Equivalents	$494,344,946	$475,228,591	$60,405,391	$433,939,555	$—	$—	$—
Mortgage Loans	16,046,505	15,295,599	—	—	16,046,505	—	—

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets at September 30, 2019. There were no transfers between the Company's Level 1 or 2 financial assets at September 30, 2019.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

D. The Company did not have any financial instruments where it was not practicable to estimate the fair value.

E. The Company has not elected to use the net asset value practical expedient to fair value to measure its investments.

21. Other Items

No significant change.

22. Events Subsequent

A. Type I - Recognized Subsequent Events

Subsequent events have been considered through November 14, 2019 for the statutory statement issued on November 14, 2019.

The Company had no known reportable recognized subsequent events.

B. Type II - Non-Recognized Subsequent Events

Subsequent events have been considered through November 14, 2019 for the statutory statement issued on November 14, 2019.

The Company had no known reportable non-recognized subsequent events.

23. Reinsurance

No significant change.

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

A. through D: No significant change.

E. Risk Sharing Provisions of the Affordable Care Act

(1) Did the reporting entity write accident and health insurance premium which is subject to the ACA risk sharing provisions (YES/NO)? Yes [ ] No [X].

(2) through (5): Not applicable.

25. Change in Incurred Claims and Claims Adjustment Expenses

A. Reserves as of December 31, 2018 were $133,253,324. As of September 30, 2019, $88,291,906 has been paid for incurred claims and claim adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $14,962,747 as a result of re-estimation of unpaid claims and claim adjustment expenses. Therefore, there has been a $30,003,671 favorable prior-year development since December 31, 2018 to September 30, 2019. The decrease is generally the result of ongoing analysis of recent loss development

trends. Original estimates are increased or decreased, as additional information becomes known regarding individual claims.

B. There has been no significant change in the Company's methodologies and assumptions used in calculating the liability for unpaid losses and loss adjustment expenses.

26. Intercompany Pooling Arrangements

No significant change.

27. Structured Settlements

No significant change.

28. Health Care Receivables

No significant change.

29. Participating Policies

No significant change.

30. Premium Deficiency Reserves

No significant change.

31. Anticipated Salvage and Subrogation

No significant change.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Did the reporting entity experience any material transactions requiring the filing of Disclosure of Material Transactions with the State of Domicile, as required by the Model Act? Yes [ ] No [X]

1.2 If yes, has the report been filed with the domiciliary state? Yes [ ] No [ ]

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [ ] No [X]

2.2 If yes, date of change:

3.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [X] No [ ]
If yes, complete Schedule Y, Parts 1 and 1A.

3.2 Have there been any substantial changes in the organizational chart since the prior quarter end? Yes [X] No [ ]

3.3 If the response to 3.2 is yes, provide a brief description of those changes.
On July 24, 2019, Aetna Better Health of Iowa Inc. changed its name to Aetna Health of Ohio Inc.

3.4 Is the reporting entity publicly traded or a member of a publicly traded group? Yes [X] No [ ]

3.5 If the response to 3.4 is yes, provide the CIK (Central Index Key) code issued by the SEC for the entity/group. 0000064803

4.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [ ] No [X]
If yes, complete and file the merger history data file with the NAIC for the annual filing corresponding to this period.

4.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

5. If the reporting entity is subject to a management agreement, including third-party administrator(s), managing general agent(s), attorney-in-fact, or similar agreement, have there been any significant changes regarding the terms of the agreement or principals involved? Yes [ ] No [X] N/A [ ]
If yes, attach an explanation.

6.1 State as of what date the latest financial examination of the reporting entity was made or is being made.

6.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

6.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

6.4 By what department or departments?

6.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [ ] No [ ] N/A [X]

6.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [ ] No [ ] N/A [X]

7.1 Has this reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [ ] No [X]

7.2 If yes, give full information:

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [ ] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [ ] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

GENERAL INTERROGATORIES

9.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? ..... Yes [X] No [ ]
(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

9.11 If the response to 9.1 is No, please explain:

9.2 Has the code of ethics for senior managers been amended? ..... Yes [X] No [ ]

9.21 If the response to 9.2 is Yes, provide information related to amendment(s).
In the first quarter of 2019, the Code of Conduct was amended to remove content related to the Caremark Corporate Integrity Agreement ("CIA") with the Office of the Inspector General as the CIA expired in March 2019.

9.3 Have any provisions of the code of ethics been waived for any of the specified officers? ..... Yes [ ] No [X]

9.31 If the response to 9.3 is Yes, provide the nature of any waiver(s).

FINANCIAL

10.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? ..... Yes [ ] No [X]

10.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: ..... $ 0

INVESTMENT

11.1 Were any of the stocks, bonds, or other assets of the reporting entity loaned, placed under option agreement, or otherwise made available for use by another person? (Exclude securities under securities lending agreements.) ..... Yes [ ] No [X]

11.2 If yes, give full and complete information relating thereto:

12. Amount of real estate and mortgages held in other invested assets in Schedule BA: ..... $ 4,622,477

13. Amount of real estate and mortgages held in short-term investments: ..... $ 0

14.1 Does the reporting entity have any investments in parent, subsidiaries and affiliates? ..... Yes [X] No [ ]

14.2 If yes, please complete the following:

	1 Prior Year-End Book/Adjusted Carrying Value	2 Current Quarter Book/Adjusted Carrying Value
14.21 Bonds	$ 0	$ 0
14.22 Preferred Stock	$ 0	$ 0
14.23 Common Stock	$ 0	$ 0
14.24 Short-Term Investments	$ 0	$ 0
14.25 Mortgage Loans on Real Estate	$ 0	$ 0
14.26 All Other	$ 0	$ 9,042,301
14.27 Total Investment in Parent, Subsidiaries and Affiliates (Subtotal Lines 14.21 to 14.26)	$ 0	$ 9,042,301
14.28 Total Investment in Parent included in Lines 14.21 to 14.26 above	$ 0	$ 0

15.1 Has the reporting entity entered into any hedging transactions reported on Schedule DB? ..... Yes [ ] No [X]

15.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? ..... Yes [ ] No [ ]
If no, attach a description with this statement.

16. For the reporting entity's security lending program, state the amount of the following as of the current statement date:

16.1 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2. ..... $ 0

16.2 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 ..... $ 0

16.3 Total payable for securities lending reported on the liability page. ..... $ 0

GENERAL INTERROGATORIES

17. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No [ ]

17.1 For all agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian Address
State Street Bank and Trust Company	State Street Financial Center; One Lincoln Street; Boston, MA 02111-2900

17.2 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

17.3 Have there been any changes, including name changes, in the custodian(s) identified in 17.1 during the current quarter? Yes [ ] No [X]

17.4 If yes, give full information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

17.5 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["…that have access to the investment accounts"; "…handle securities"]

1 Name of Firm or Individual	2 Affiliation
Kevin J. Casey as Sr. Investment Officer	A

17.5097 For those firms/individuals listed in the table for Question 17.5, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets? Yes [ ] No [X]

17.5098 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 17.5, does the total assets under management aggregate to more than 50% of the reporting entity's assets? Yes [ ] No [X]

17.6 For those firms or individuals listed in the table for 17.5 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
N/A	Kevin J. Casey	N/A	Not registered	NO

18.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No [ ]

18.2 If no, list exceptions:

19. By self-designating 5GI securities, the reporting entity is certifying the following elements for each self-designated 5GI security:
    a. Documentation necessary to permit a full credit analysis of the security does not exist or an NAIC CRP credit rating for an FE or PL security is not available.
    b. Issuer or obligor is current on all contracted interest and principal payments.
    c. The insurer has an actual expectation of ultimate payment of all contracted interest and principal.

    Has the reporting entity self-designated 5GI securities? Yes [ ] No [X]

20. By self-designating PLGI securities, the reporting entity is certifying the following elements of each self-designated PLGI security:
    a. The security was purchased prior to January 1, 2018.
    b. The reporting entity is holding capital commensurate with the NAIC Designation reported for the security.
    c. The NAIC Designation was derived from the credit rating assigned by an NAIC CRP in its legal capacity as a NRSRO which is shown on a current private letter rating held by the insurer and available for examination by state insurance regulators.
    d. The reporting entity is not permitted to share this credit rating of the PL security with the SVO.

    Has the reporting entity self-designated PLGI securities? Yes [ ] No [X]

GENERAL INTERROGATORIES

PART 2 - HEALTH

1. Operating Percentages:

1.1 A&H loss percent ..... 90.1 %

1.2 A&H cost containment percent ..... 2.4 %

1.3 A&H expense percent excluding cost containment expenses ..... 6.3 %

2.1 Do you act as a custodian for health savings accounts? ..... Yes [ ] No [X]

2.2 If yes, please provide the amount of custodial funds held as of the reporting date ..... $ 0

2.3 Do you act as an administrator for health savings accounts? ..... Yes [ ] No [X]

2.4 If yes, please provide the balance of the funds administered as of the reporting date ..... $ 0

3. Is the reporting entity licensed or chartered, registered, qualified, eligible or writing business in at least two states? ..... Yes [ ] No [X]

3.1 If no, does the reporting entity assume reinsurance business that covers risks residing in at least one state other than the state of domicile of the reporting entity? ..... Yes [ ] No [X]

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE S - CEDED REINSURANCE

Showing All New Reinsurance Treaties - Current Year to Date

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Reinsurer	5 Domiciliary Jurisdiction	6 Type of Reinsurance Ceded	7 Type of Reinsurer	8 Certified Reinsurer Rating (1 through 6)	9 Effective Date of Certified Reinsurer Rating

NONE

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

Current Year to Date - Allocated by States and Territories

		1	Direct Business Only							
			2	3	4	5	6	7	8	9
States, etc.		Active Status (a)	Accident and Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Program Premiums	Life and Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama	AL	N	0	0	0	0	0	0	0	0
2. Alaska	AK	N	0	0	0	0	0	0	0	0
3. Arizona	AZ	N	0	0	0	0	0	0	0	0
4. Arkansas	AR	N	0	0	0	0	0	0	0	0
5. California	CA	N	0	0	0	0	0	0	0	0
6. Colorado	CO	N	0	0	0	0	0	0	0	0
7. Connecticut	CT	N	0	0	0	0	0	0	0	0
8. Delaware	DE	N	0	0	0	0	0	0	0	0
9. District of Columbia	DC	N	0	0	0	0	0	0	0	0
10. Florida	FL	N	0	0	0	0	0	0	0	0
11. Georgia	GA	N	0	0	0	0	0	0	0	0
12. Hawaii	HI	N	0	0	0	0	0	0	0	0
13. Idaho	ID	N	0	0	0	0	0	0	0	0
14. Illinois	IL	N	0	0	0	0	0	0	0	0
15. Indiana	IN	N	0	0	0	0	0	0	0	0
16. Iowa	IA	N	0	0	0	0	0	0	0	0
17. Kansas	KS	N	0	0	0	0	0	0	0	0
18. Kentucky	KY	L	21,119,077	0	788,306,359	0	0	0	809,425,436	0
19. Louisiana	LA	N	0	0	0	0	0	0	0	0
20. Maine	ME	N	0	0	0	0	0	0	0	0
21. Maryland	MD	N	0	0	0	0	0	0	0	0
22. Massachusetts	MA	N	0	0	0	0	0	0	0	0
23. Michigan	MI	N	0	0	0	0	0	0	0	0
24. Minnesota	MN	N	0	0	0	0	0	0	0	0
25. Mississippi	MS	N	0	0	0	0	0	0	0	0
26. Missouri	MO	N	0	0	0	0	0	0	0	0
27. Montana	MT	N	0	0	0	0	0	0	0	0
28. Nebraska	NE	N	0	0	0	0	0	0	0	0
29. Nevada	NV	N	0	0	0	0	0	0	0	0
30. New Hampshire	NH	N	0	0	0	0	0	0	0	0
31. New Jersey	NJ	N	0	0	0	0	0	0	0	0
32. New Mexico	NM	N	0	0	0	0	0	0	0	0
33. New York	NY	N	0	0	0	0	0	0	0	0
34. North Carolina	NC	N	0	0	0	0	0	0	0	0
35. North Dakota	ND	N	0	0	0	0	0	0	0	0
36. Ohio	OH	N	0	0	0	0	0	0	0	0
37. Oklahoma	OK	N	0	0	0	0	0	0	0	0
38. Oregon	OR	N	0	0	0	0	0	0	0	0
39. Pennsylvania	PA	N	0	0	0	0	0	0	0	0
40. Rhode Island	RI	N	0	0	0	0	0	0	0	0
41. South Carolina	SC	N	0	0	0	0	0	0	0	0
42. South Dakota	SD	N	0	0	0	0	0	0	0	0
43. Tennessee	TN	N	0	0	0	0	0	0	0	0
44. Texas	TX	N	0	0	0	0	0	0	0	0
45. Utah	UT	N	0	0	0	0	0	0	0	0
46. Vermont	VT	N	0	0	0	0	0	0	0	0
47. Virginia	VA	N	0	0	0	0	0	0	0	0
48. Washington	WA	N	0	0	0	0	0	0	0	0
49. West Virginia	WV	N	0	0	0	0	0	0	0	0
50. Wisconsin	WI	N	0	0	0	0	0	0	0	0
51. Wyoming	WY	N	0	0	0	0	0	0	0	0
52. American Samoa	AS	N	0	0	0	0	0	0	0	0
53. Guam	GU	N	0	0	0	0	0	0	0	0
54. Puerto Rico	PR	N	0	0	0	0	0	0	0	0
55. U.S. Virgin Islands	VI	N	0	0	0	0	0	0	0	0
56. Northern Mariana Islands	MP	N	0	0	0	0	0	0	0	0
57. Canada	CAN	N	0	0	0	0	0	0	0	0
58. Aggregate Other Aliens	OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal		XXX	21,119,077	0	788,306,359	0	0	0	809,425,436	0
60. Reporting Entity Contributions for Employee Benefit Plans		XXX	0	0	0	0	0	0	0	0
61. Totals (Direct Business)		XXX	21,119,077	0	788,306,359	0	0	0	809,425,436	0
DETAILS OF WRITE-INS										
58001.		XXX								
58002.		XXX								
58003.		XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page		XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)		XXX	0	0	0	0	0	0	0	0

(a) Active Status Counts:

L - Licensed or Chartered - Licensed Insurance carrier or domiciled RRG 1
R - Registered - Non-domiciled RRGs 0
E - Eligible - Reporting entities eligible or approved to write surplus lines in the state 0
Q - Qualified - Qualified or accredited reinsurer 0
N - None of the above - Not allowed to write business in the state 56

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

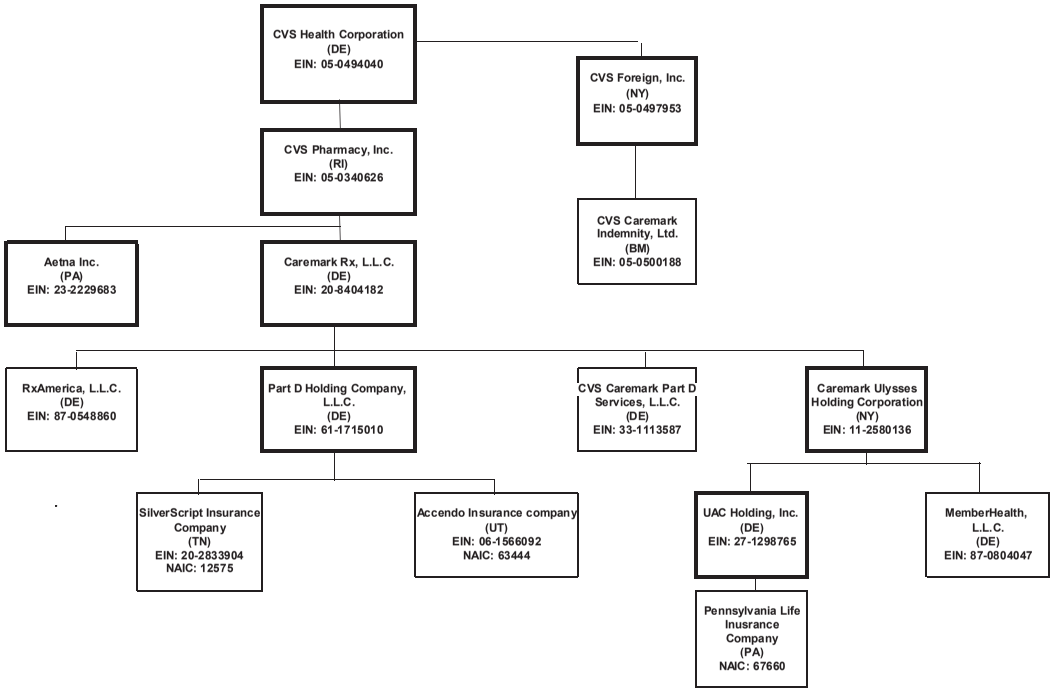

This organizational chart reflects the insurrance entity reporting system and identifies the relationship between the ultimate parent and all member insurers.
The ultimate controlling company is a Fortune 7 company with numerous subsidiaries, the majority of which do not interact with the insurance entities.
(1) Insurers/HMO's
Percentages are rounded to the nearest whole percent and based on ownership of voting rights.
Double borders indicate entity has subsidiaries shown on the same page.
Bold borders indicate entity has subsidiaries shown on a separate page.

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

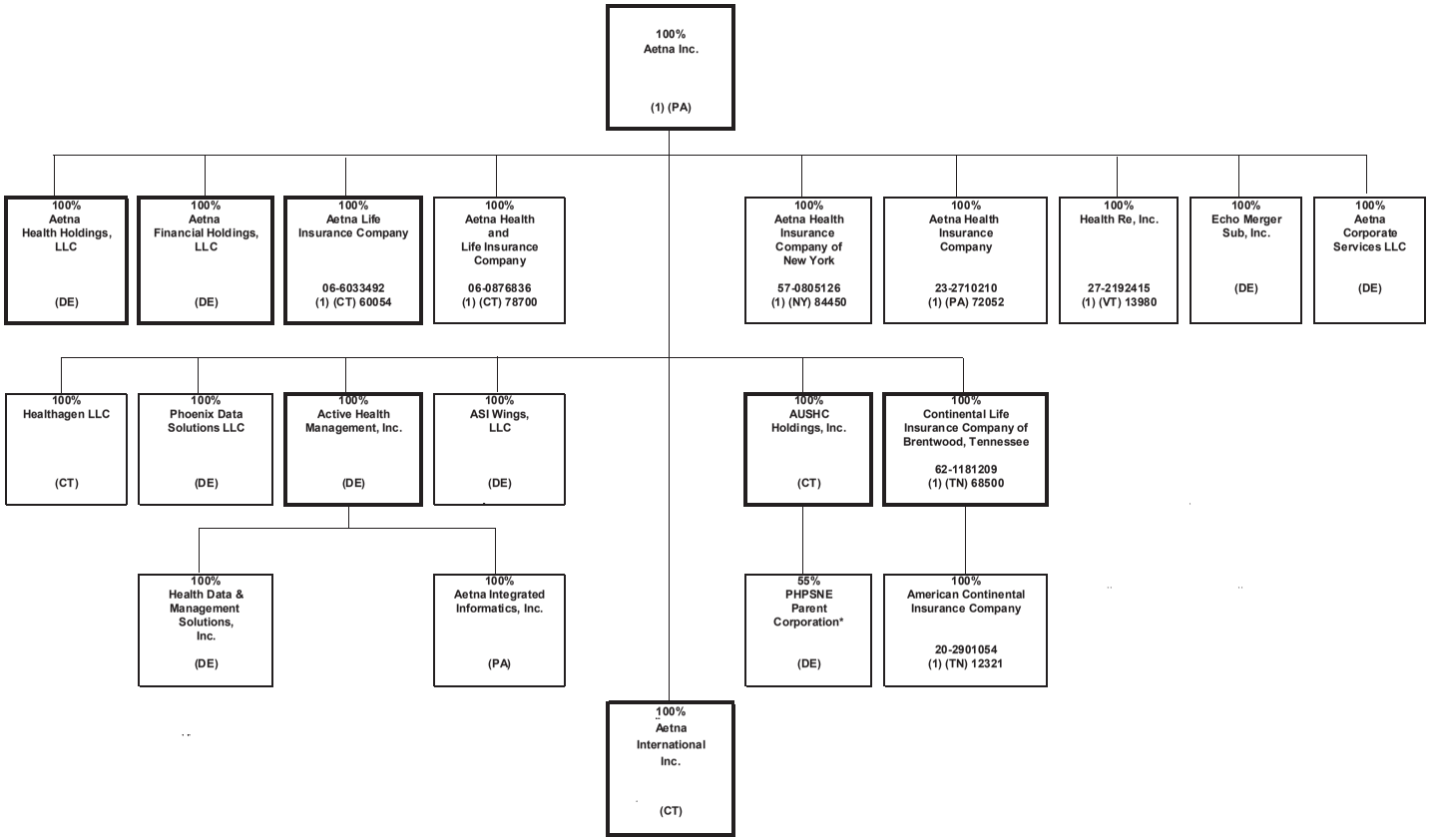

* PHPSNE Parent Corporation is also 45% owned by third parties.

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

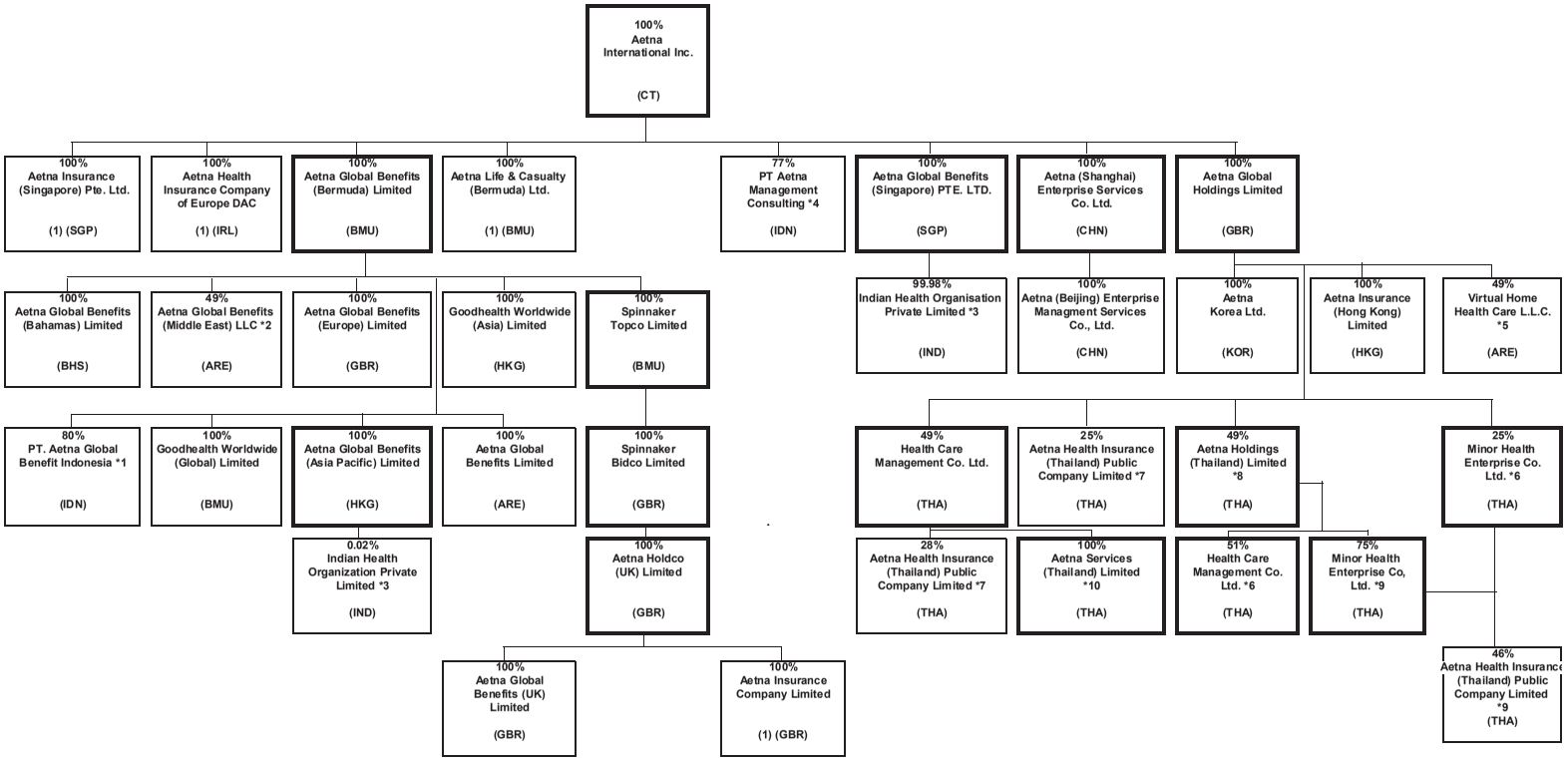

*1 PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
*2 Aetna Global Benefits (Middle East) LLC is also 51% is owned by Euro Gulf LLC, Aetna's Nominee.
*3 Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
*4 PT Asuransi Aetna Asia is also 23% owned by PT Asuransi Central Asia.
*5 Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC, Aetna's Nominee
*6 Health Care Management Co. Ltd. Is also owned by Aetna Global Benefits (Bermuda) Limited (1 share).
*7 Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 Share), Mr. Jitphasong Itsaraphakded (1 Share); Mrs. Suphee Wattana (1 Share); and Mr. Buncha Tamphragom (1 Share)
*8 Aetna Holdings (Thailand) Limited is aslo 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Benefits (Bermuda) Limited owns 1 share.
*9 Minor Health Entreprise Co, Ltd is is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited
*10 Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited and (1 share) owned by Aetna Global Holdings Limited

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

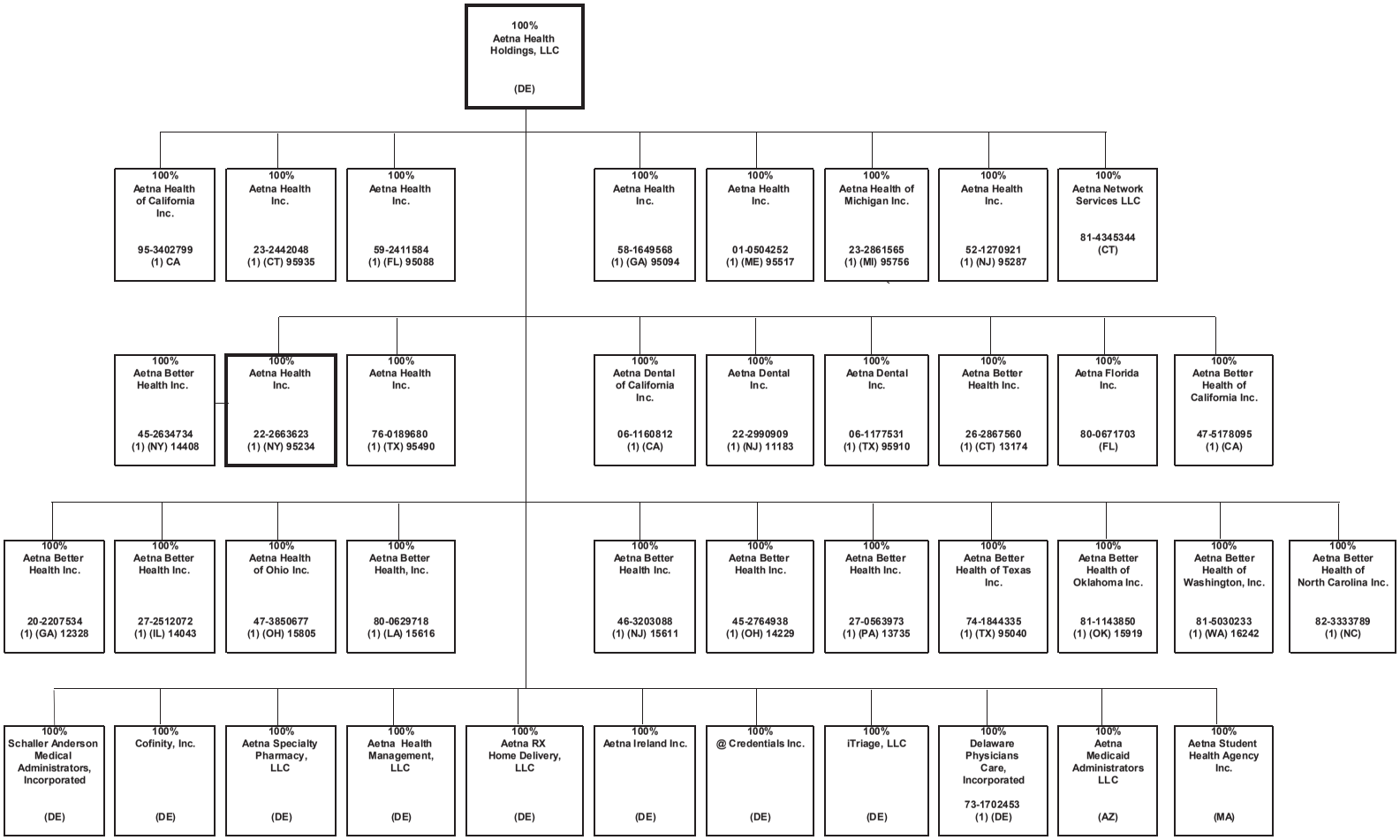

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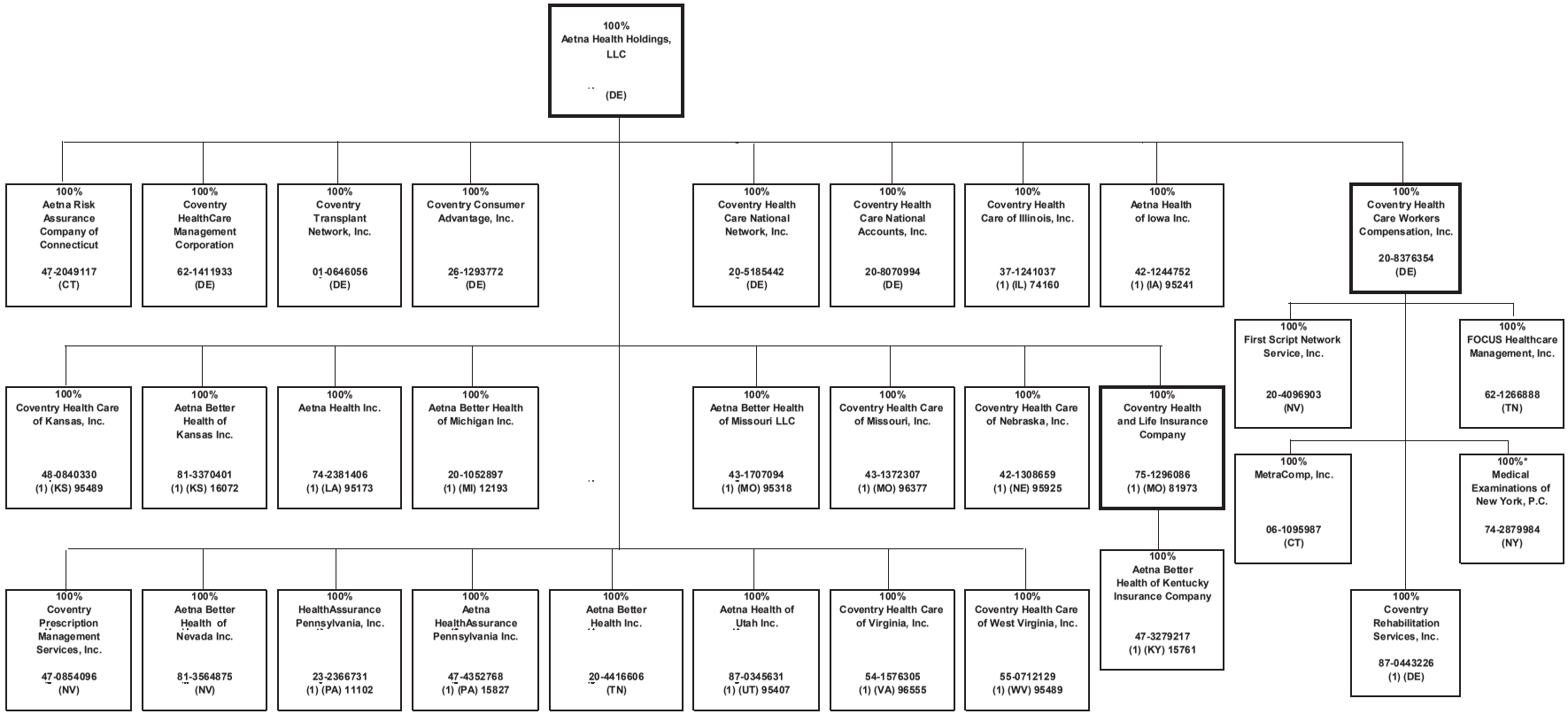

*100% owned through Aetna's nominees

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURANCE MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

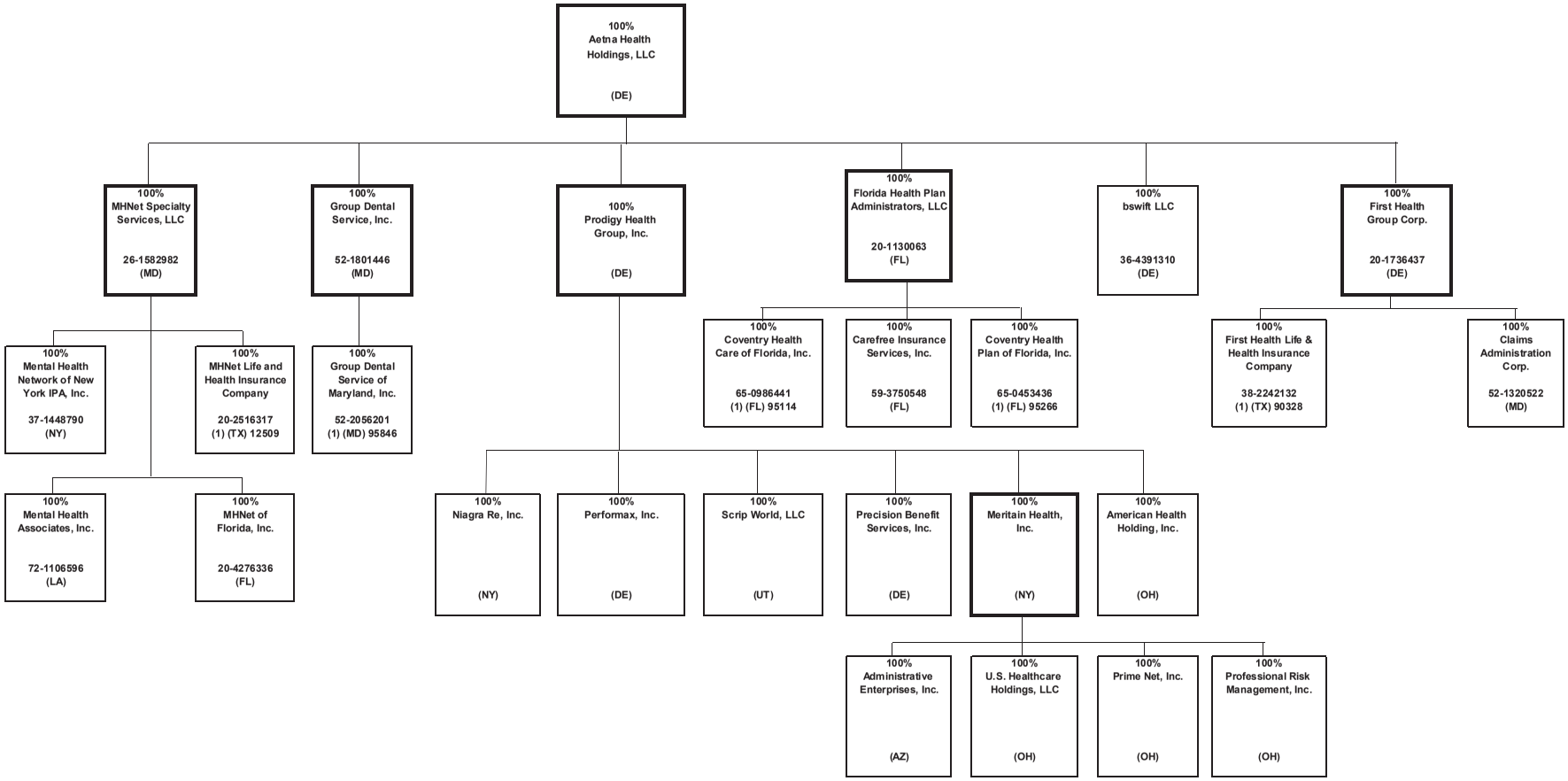

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

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PART 1 - ORGANIZATIONAL CHART

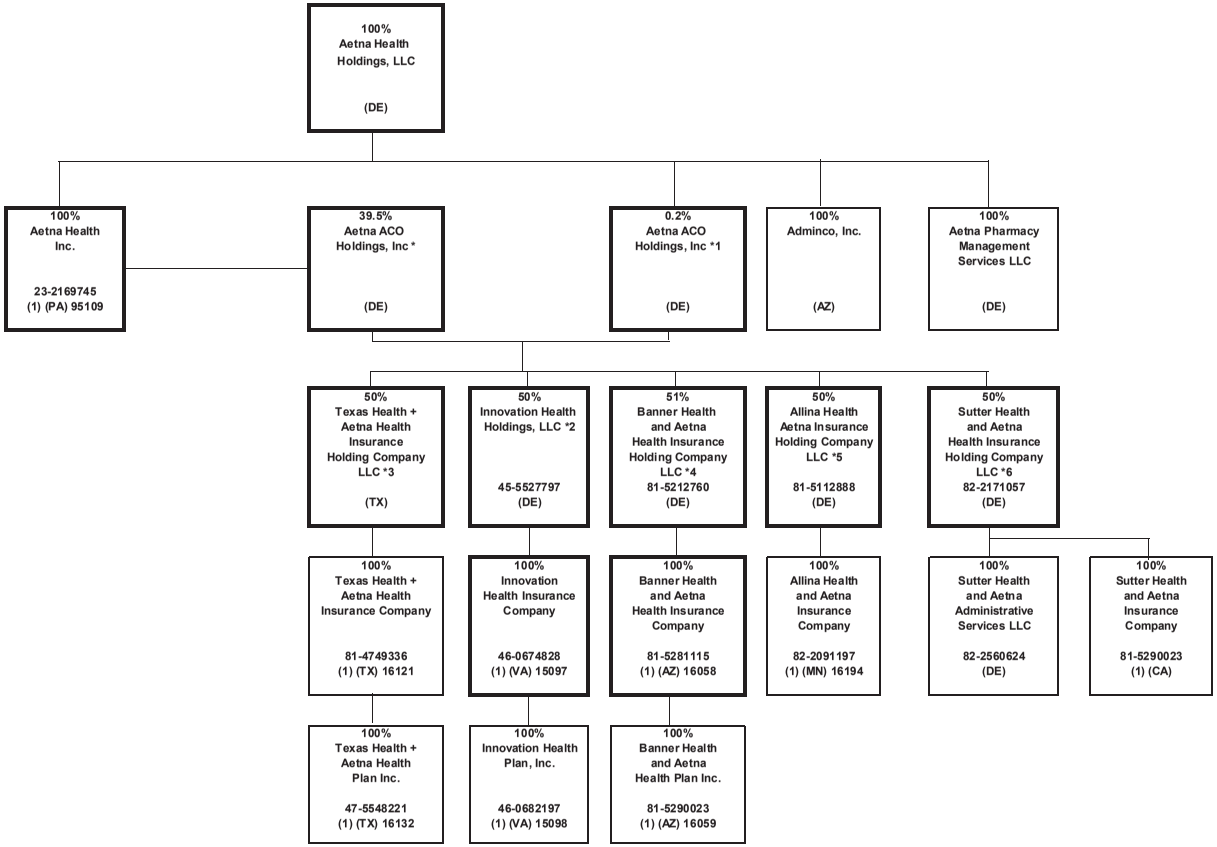

*1 Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
*2 Innovation Health Holdings, LLC is also 50% owned by Inova Health System Foundation.
*3 Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
*4 Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
*5 Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
*6 Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

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PART 1 - ORGANIZATIONAL CHART

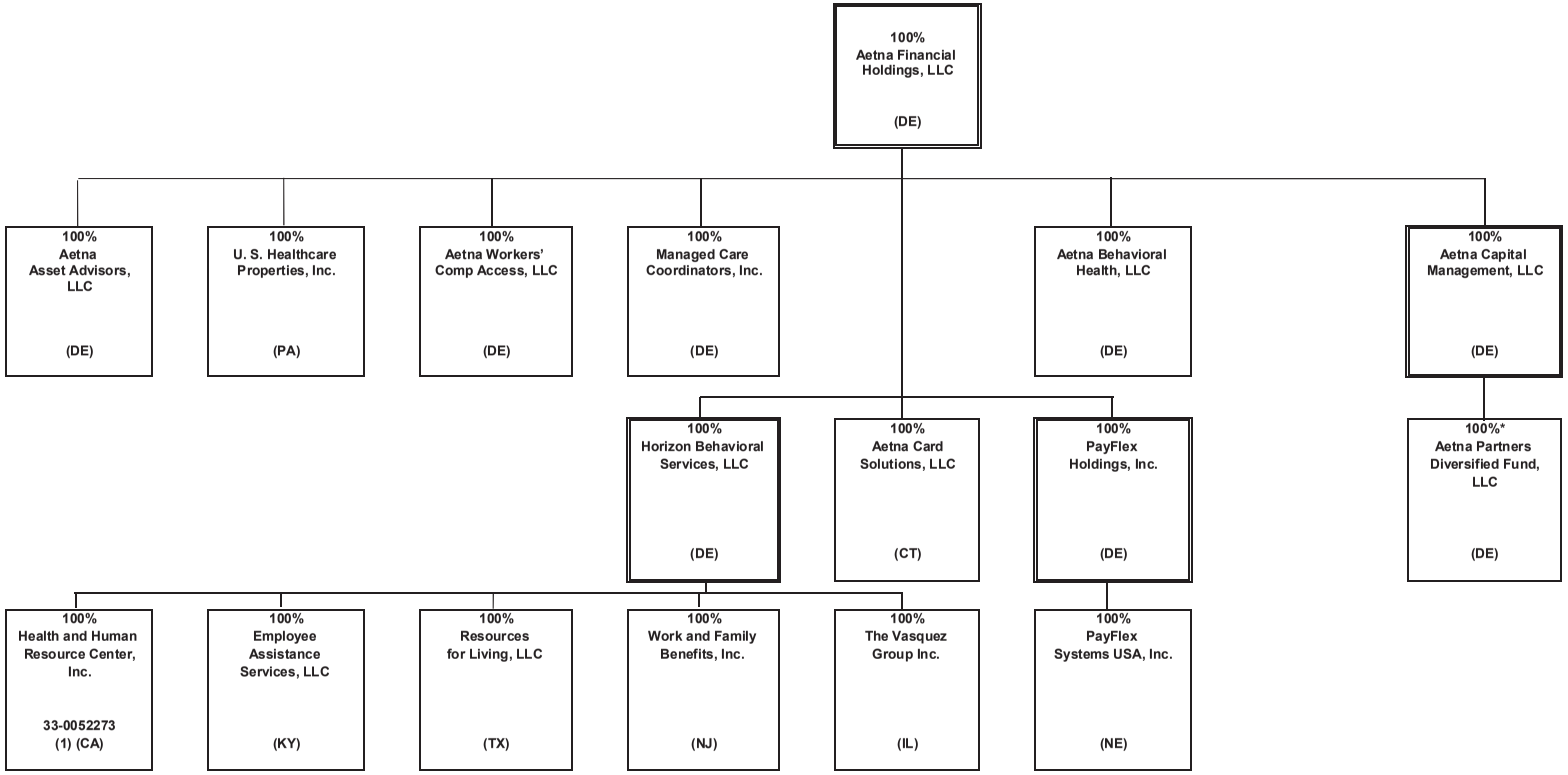

* Aetna Life Insurance Company owns substantially all of the non-managing member interests of Aetna Partners Diversified Fund, LLC.

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

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PART 1 - ORGANIZATIONAL CHART

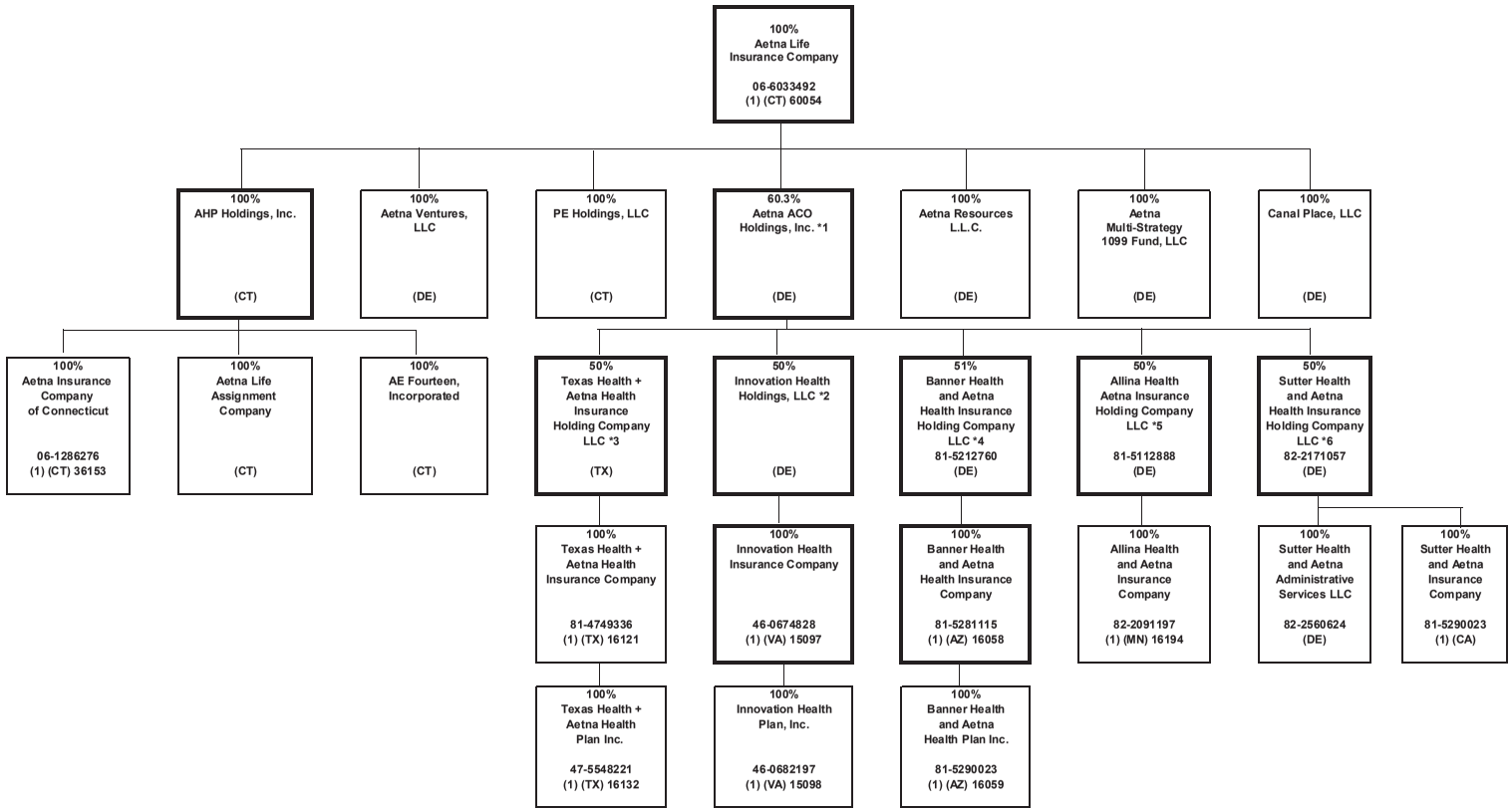

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*5 Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
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STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP		05-0494040		0000064803	NYSE	CVS Health Corporation	DE	UIP	Board of Directors	Board of Directors	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	63444	06-1566092				Accendo Insurance Company	UT	IA	Part D Holding Company, L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12575	20-2833904				SilverScript Insurance Company	TN	IA	Part D Holding Company, L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	67660	23-1305366				Pennsylvania Life Insurance Co.	PA	IA	UAC Holding, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0340626				CVS Pharmacy, Inc	RI	UIP	CVS Health Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8404182				Caremark, Rx., L.L.C.	DE	NIA	CVS Pharmacy, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	61-1715010				Part D Holding Company, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	33-1113587				CVS Caremark Part D Services, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0548860				RxAmerica, L.L.C.	DE	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	11-2580136				Caremark Ulysses Holding Corporation	NY	NIA	Caremark, Rx., L.L.C.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0804047				MemberHealth L.L.C.	DE	NIA	Caremark Ulysses Holding Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0500188				CVS Caremark Indemnity, Ltd.	BMU	IA	CVS Foreign, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1298765				UAC Holding, Inc	DE	NIA	Caremark Ulysses Holding Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	05-0497953				CVS Foreign, Inc.	NY	NIA	CVS Health Corporation	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2229683	3060706	0001122304		Aetna Inc.	PA	UIP	CVS Pharmacy, Inc	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	30-0123754	0	0		Aetna Health Holdings, LLC	DE	UIP	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	95-3402799	0	0		Aetna Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95935	23-2442048	0	0		Aetna Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95088	59-2411584	0	0		Aetna Health Inc.	FL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95094	58-1649568	0	0		Aetna Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95517	01-0504252	0	0		Aetna Health Inc.	ME	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95756	23-2861565	0	0		Aetna Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95287	52-1270921	0	0		Aetna Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95234	22-2663623	0	0		Aetna Health Inc.	NY	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14408	45-2634734	0	0		Aetna Better Health Inc.	NY	IA	Aetna Health Inc. (NY)	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95490	76-0189680	0	0		Aetna Health Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95040	74-1844335	0	0		Aetna Better Health of Texas Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12328	20-2207534	0	0		Aetna Better Health Inc.	GA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1160812	0	0		Aetna Dental of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	11183	22-2990909	0	0		Aetna Dental Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95910	06-1177531	0	0		Aetna Dental Inc.	TX	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	30-0123760	0	0		Aetna Rx Home Delivery, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	13-3670795	0	0		Aetna Health Management, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	22-3187443	0	0		Aetna Ireland Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	57-1209768	0	0		Aetna Specialty Pharmacy, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1274723	0	0		Cofinity, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2671370	0	0		@Credentials Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Services (Thailand) Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	100.000	CVS Health Corporation	N	19
0001	CVS HEALTH GROUP	13735	27-0563973	0	0		Aetna Better Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	13174	26-2867560	0	0		Aetna Better Health Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-5178095	0	0		Aetna Better Health of California Inc.	CA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14043	27-2512072	0	0		Aetna Better Health Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15805	47-3850677	0	0		Aetna Health of Ohio Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15616	80-0629718	0	0		Aetna Better Health, Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	80-0671703	0	0		Aetna Florida Inc.	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	14229	25-2764938	0	0		Aetna Better Health Inc.	OH	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15611	46-3203088	0	0		Aetna Better Health Inc.	NJ	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15919	81-1143850	0	0		Aetna Better Health of Oklahoma Inc.	OK	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	04-2708160	0	0		Aetna Student Health Agency Inc.	MA	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	73-1702453	0	0		Delaware Physicians Care, Incorporated	DE	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	01-0826783	0	0		Schaller Anderson Medical Administrators, Incorporated	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0842559	0	0		Aetna Medicaid Adminstrators LLC	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-2944270	0	0		iTriage, LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

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0001	CVS HEALTH GROUP	00000	16-1471176	0	0		Prodigy Health Group, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	0.200	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	45-5527797	0	0		Innovation Health Holdings, LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	6
0001	CVS HEALTH GROUP	15097	46-0674828	0	0		Innovation Health Insurance Company	VA	IA	Innovation Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15098	46-0682197	0	0		Innovation Health Plan, Inc.	VA	IA	Innovation Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-3789357	0	0		Texas Health + Aetna Health Insurance Holding Company LLC	TX	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	9
0001	CVS HEALTH GROUP	16121	81-4749336	0	0		Texas Health + Aetna Health Insurance Company	TX	IA	Texas Health + Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16132	47-5548221	0	0		Texas Health + Aetna Health Plan Inc.	TX	IA	Texas Health + Aetna Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95109	23-2169745	0	0		Aetna Health Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Health Inc. (PA)	Ownership	39.500	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	20-0438576	0	0		Niagara Re, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-2200070	0	0		Performax, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0632355	0	0		Scrip World, LLC	UT	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1760756	0	0		Precision Benefit Services, Inc.	DE	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	31-1368946	0	0		American Health Holding, Inc.	OH	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	16-1264154	0	0		Meritain Health, Inc.	NY	NIA	Prodigy Health Group, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0537707	0	0		Adminco, Inc.	AZ	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	86-0527428	0	0		Administrative Enterprises, Inc.	AZ	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	16-1684061	0	0		U.S. Healthcare Holdings, LLC	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	34-1670299	0	0		Prime Net, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	34-1348032	0	0		Professional Risk Management, Inc.	OH	NIA	Meritain Health, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	68500	62-1181209	0	0		Continental Life Insurance Company of Brentwood, Tennessee	TN	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12321	20-2901054	0	0		American Continental Insurance Company	TN	IA	Continental Life Insurance Company of Brentwood, Tennessee	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	60054	06-6033492	0	0		Aetna Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	45-4901541	0	0		Aetna ACO Holdings, Inc.	DE	NIA	Aetna Life Insurance Company	Ownership	60.300	CVS Health Corporation	Y	3
0001	CVS HEALTH GROUP	00000	06-1270755	0	0		AHP Holdings, Inc.	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	36153	06-1286276	0	0		Aetna Insurance Company of Connecticut	CT	IA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1028469	0	0		AE Fourteen, Incorporated	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1373153	0	0		Aetna Life Assignment Company	CT	NIA	AHP Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-3678339	0	0		PE Holdings, LLC	CT	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1423207	0	0		Aetna Resources L.L.C.	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Canal Place, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-3180700	0	0		Aetna Ventures, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0001552250		Aetna Multi-Strategy 1099 Fund, LLC	DE	NIA	Aetna Life Insurance Company	Ownership	79.250	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	41-2035961	0	0		Aetna Financial Holdings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	26-2030792	0	0		Aetna Asset Advisors, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2354500	0	0		U.S. Healthcare Properties, Inc.	PA	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	38-3704481	0	0		Aetna Capital Management, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	11-3667142	0	0001314522		Aetna Partners Diversified Fund, LLC	DE	NIA	Aetna Capital Management, LLC	Ownership	100.000	CVS Health Corporation	N	1
0001	CVS HEALTH GROUP	00000	20-0446676	0	0		Aetna Workers' Comp Access, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-0446713	0	0		Aetna Behavioral Health, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2670015	0	0		Managed Care Coordinators, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-3269144	0	0		Horizon Behavioral Services, LLC	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	61-1193498	0	0		Employee Assistance Services, LLC	KY	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	33-0052273	0	0		Health and Human Resource Center, Inc.	CA	IA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	75-2420973	0	0		Resources for Living, LLC	TX	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	36-3681261	0	0		The Vasquez Group Inc.	IL	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	22-3178125	0	0		Work and Family Benefits, Inc.	NJ	NIA	Horizon Behavioral Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	27-1773021	0	0		Aetna Card Solutions, LLC	CT	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1 Group Code	2 Group Name	3 NAIC Company Code	4 ID Number	5 Federal RSSD	6 CIK	7 Name of Securities Exchange if Publicly Traded (U.S. or International)	8 Names of Parent, Subsidiaries Or Affiliates	9 Domiciliary Location	10 Relationship to Reporting Entity	11 Directly Controlled by (Name of Entity/Person)	12 Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	13 If Control is Ownership Provide Percentage	14 Ultimate Controlling Entity(ies)/Person(s)	15 Is an SCA Filing Required? (Y/N)	16 *
0001	CVS HEALTH GROUP	00000	20-5216478	0	0		PayFlex Holdings, Inc.	DE	NIA	Aetna Financial Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	91-1774434	0	0		PayFlex Systems USA, Inc.	NE	NIA	PayFlex Holdings, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	78700	06-0876836	0	0		Aetna Health and Life Insurance Company	CT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	72052	23-2710210	0	0		Aetna Health Insurance Company	PA	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	84450	57-0805126	0	0		Aetna Health Insurance Company of New York	NY	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1571642	0	0		Aetna International Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	98-0211470	0	0		Aetna Life & Casualty (Bermuda) Ltd.	BMU	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance (Singapore) PTE. LTD.	SGP	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Bermuda) Limited	BMU	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Goodhealth Worldwide (Global) Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Europe) Limited	GBR	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Goodhealth Worldwide (Asia) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits Limited	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		PT. Aetna Global Benefits Indonesia	IDN	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	80.000	CVS Health Corporation	N	4
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Middle East) LLC	ARE	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	49.000	CVS Health Corporation	N	5
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Asia Pacific) Limited	HKG	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Spinnaker Topco Limited	BMU	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Spinnaker Bidco Limited	GBR	NIA	Spinnaker Topco Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Holdco (UK) Limited	GBR	NIA	Spinnaker Bidco Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		PT Aetna Management Consulting	IDN	NIA	Aetna International Inc.	Ownership	77.000	CVS Health Corporation	N	13
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (UK) Limited	GBR	NIA	Aetna Holdco (UK) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance Company Limited	GBR	IA	Aetna Holdco (UK) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Asia Pacific) Limited	Ownership	0.020	CVS Health Corporation	N	2
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance Company of Europe DAC	IRL	IA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna (Shanghai) Enterprise Services Co. Ltd.	CHN	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna (Beijing) Enterprise Management Services Co., Ltd.	CHN	NIA	Aetna (Shanghai) Enterprise Services Co. Ltd.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Singapore) PTE. LTD.	SGP	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Indian Health Organisation Private Limited	IND	NIA	Aetna Global Benefits (Singapore) PTE, LTD.	Ownership	99.980	CVS Health Corporation	N	2
0001	CVS HEALTH GROUP	00000	22-2578985	0	0		AUSHC Holdings, Inc.	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Holdings Limited	GBR	NIA	Aetna International Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Korea Ltd.	KOR	NIA	Aetna Global Holdings Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Insurance (Hong Kong) Limited	HKG	NIA	Aetna Global Holdings Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1182176	0	0		PHPSNE Parent Corporation	DE	NIA	AUSHC Holdings, Inc.	Ownership	55.000	CVS Health Corporation	N	7
0001	CVS HEALTH GROUP	00000	52-2182411	0	0		Active Health Management, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-0970432	0	0		Health Data & Management Solutions, Inc.	DE	NIA	Active Health Management, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	23-2604867	0	0		Aetna Integrated Informatics, Inc.	PA	NIA	Active Health Management, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	13980	27-2192415	0	0		Health Re, Inc.	VT	IA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-0579372	0	0		Phoenix Data Solutions LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	46-2469464	0	0		Healthagen LLC	CT	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	51-0029326	0	0		ASI Wings, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Echo Merger Sub, Inc.	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Corporate Services, LLC	DE	NIA	Aetna Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	81973	75-1296086	0	0		Coventry Health and Life Insurance Company	MO	UDP	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15761	47-3279217	0	0		Aetna Better Health of Kentucky Insurance Company	KY	RE	Coventry Health and Life Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-1801446	0	0		Group Dental Service, Inc.	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95846	52-2056201	0	0		Group Dental Service of Maryland, Inc.	MD	IA	Group Dental Service, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP		81-4345344	0	0		Aetna Network Services LLC	CT	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE Y

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0001	CVS HEALTH GROUP	95241	42-1244752	0	0		Aetna Health of Iowa Inc.	IA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95925	42-1308659	0	0		Coventry Health Care of Nebraska, Inc.	NE	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-2049117	0	0		Aetna Risk Assurance Company of Connecticut Inc.	CT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95173	74-2381406	0	0		Aetna Health Inc.	LA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	11102	23-2366731	0	0		HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	47-0854096	0	0		Coventry Prescription Management Services, Inc.	NV	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16148	81-3564875	0	0		Aetna Better Health of Nevada Inc.	NV	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	96555	54-1576305	0	0		Coventry Health Care of Virginia, Inc.	VA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	01-0646056	0	0		Coventry Transplant Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	96377	43-1372307	0	0		Coventry Health Care of Missouri, Inc.	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95318	43-1702094	0	0		Aetna Better Health of Missouri LLC	MO	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95408	55-0712129	0	0		Coventry Health Care of West Virginia, Inc.	WV	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	62-1411933	0	0		Coventry HealthCare Management Corporation	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	15827	47-4352768	0	0		Aetna HealthAssurance Pennsylvania, Inc.	PA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95489	48-0840330	0	0		Coventry Health Care of Kansas, Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16072	81-3370401	0	0		Aetna Better Health of Kansas Inc.	KS	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12193	20-1052897	0	0		Aetna Better Health of Michigan Inc.	MI	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95407	87-0345631	0	0		Aetna Health of Utah Inc.	UT	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4416606	0	0		Aetna Better Health Inc.	TN	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	74160	37-1241037	0	0		Coventry Health Care of Illinois, Inc.	IL	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8070994	0	0		Coventry Health Care National Accounts, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-5185442	0	0		Coventry Health Care National Network, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	26-1293772	0	0		Coventry Consumer Advantage, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-8376354	0	0		Coventry Health Care Workers Compensation, Inc.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4096903	0	0		First Script Network Service, Inc.	NV	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	06-1095987	0	0		MetraComp, Inc.	CT	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	74-2879984	0	0		Medical Examinations of New York, P.C.	NY	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	8
0001	CVS HEALTH GROUP	00000	62-1266888	0	0		FOCUS Healthcare Management, Inc.	TN	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	87-0443226	0	0		Coventry Rehabilitation Services, Inc.	DE	NIA	Coventry Health Care Workers' Compensation, Inc.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1736437	0	0		First Health Group Corp.	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	90328	38-2242132	0	0		First Health Life & Health Insurance Company	TX	IA	First Health Group Corp.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	52-1320522	0	0		Claims Administration Corp.	MD	NIA	First Health Group Corp.	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-1130063	0	0		Florida Health Plan Administrators, LLC	FL	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95114	65-0986441	0	0		Coventry Health Care of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	95266	65-0453436	0	0		Coventry Health Plan of Florida, Inc.	FL	IA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	59-3750548	0	0		Carefree Insurance Services, Inc.	FL	NIA	Florida Health Plan Administrators, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	36-4391310	0	0		bswift LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Virtual Home Healthcare L.L.C.	ARE	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	17
0001	CVS HEALTH GROUP	00000	26-1582982	0	0		MHNet Specialty Services, LLC	MD	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	37-1448790	0	0		Mental Health Network of New York IPA, Inc.	NY	NIA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	12509	20-2516317	0	0		MHNet Life and Health Insurance Company	TX	IA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	72-1106596	0	0		Mental Health Associates, Inc.	LA	NIA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	20-4276336	0	0		MHNet of Florida, Inc.	FL	IA	MHNet Specialty Services, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16242	81-5030233	0	0		Aetna Better Health of Washington, Inc.	WA	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

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0001	CVS HEALTH GROUP	00000	81-5212760	0	0		Banner Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	51.000	CVS Health Corporation	N	10
0001	CVS HEALTH GROUP	16058	81-5281115	0	0		Banner Health and Aetna Health Insurance Company	AZ	IA	Banner Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	16059	81-5290023	0	0		Banner Health and Aetna Health Plan Inc.	AZ	IA	Banner Health and Aetna Health Insurance Company	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5112888	0	0		Allina Health and Aetna Health Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	11
0001	CVS HEALTH GROUP	16194	82-2091197	0	0		Allina Health and Aetna Insurance Company	MN	IA	Allina Health and Aetna Health Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	82-2171057	0	0		Sutter Health and Aetna Insurance Holding Company LLC	DE	NIA	Aetna ACO Holdings, Inc.	Ownership	50.000	CVS Health Corporation	N	12
0001	CVS HEALTH GROUP	00000	82-2560624	0	0		Sutter Health and Aetna Administrative Services LLC	DE	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	81-5290023	0	0		Sutter Health and Aetna Insurance Company	CA	NIA	Sutter Health and Aetna Insurance Holding Company LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Holdings (Thailand) Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	14
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Minor Health Entreprise Co, Ltd.	Ownership	46.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Aetna Health Insurance (Thailand) Public Company Limited	THA	NIA	Health Care Management Co. Ltd.	Ownership	28.000	CVS Health Corporation	N	15
0001	CVS HEALTH GROUP	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	49.000	CVS Health Corporation	N	18
0001	CVS HEALTH GROUP	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Global Holdings Limited	Ownership	25.000	CVS Health Corporation	N	16
0001	CVS HEALTH GROUP	00000		0	0		Minor Health Entreprise Co, Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	75.000	CVS Health Corporation	N	16
0001	CVS HEALTH GROUP	00000		0	0		Health Care Management Co. Ltd.	THA	NIA	Aetna Holdings (Thailand) Limited	Ownership	51.000	CVS Health Corporation	N	18
0001	CVS HEALTH GROUP	00000		0	0		Aetna Global Benefits (Bahamas) Limited	BHS	NIA	Aetna Global Benefits (Bermuda) Limited	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000		0	0		Aetna Pharmacy Management Services LLC	DE	NIA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0
0001	CVS HEALTH GROUP	00000	82-3333789	0	0		Aetna Better Health of North Carolina Inc.	NC	IA	Aetna Health Holdings, LLC	Ownership	100.000	CVS Health Corporation	N	0

Asterisk	Explanation
1	Aetna Life Insurance Company own substantially all of the non-managing membership interests of Aetna Partners Diversified Fund LLC.
2	Indian Health Organisation Private Limited is 0.019857% owned by Aetna Global Benefits (Asia Pacific) and 99.980143% owned by Aetna Global Benefits (Singapore) PTE. LTD.
3	Aetna ACO Holdings Inc. is owned by Aetna Life Insurance Company (302 shares); Aetna Health Inc. (PA) (198 shares); and Aetna Health Holdings, LLC (1 share).
4	PT. Aetna Global Benefits Indonesia is also 20% owned by Suhatsyah Rivai, Aetna's Nominee.
5	Aetna Global Benefits (Middle East) LLC is also 51% owned by Euro Gulf LLC, Aetna's Nominee.
6	Innovation Health Holdings LLC. Is also 50% owned by Inova Health System Foundation.
7	PHPSNE Parent Corporation is 55% owned by AUSHC Holdings, Inc. The remaining 45% is owned by thirteen different hospitals (non-affiliates) which are shareholders with varying degrees of ownership.
8	Medical Examinations of New York, P.C. is 100% owned through Aetna's nominees.
9	Texas Health + Aetna Health Insurance Holding Company LLC is also 50% owned by Texas Health Resources.
10	Banner Health and Aetna Health Insurance Holding Company LLC is also 49% owned by Banner Health.
11	Allina Health and Aetna Insurance Holding Company LLC is also 50% owned by Allina Health.
12	Sutter Health and Aetna Insurance Holding Company LLC is also 50% owned by Sutter Health Plan Products Organization, LLC.
13	PT Aetna Management Consulting is also 23% owned by PT Asuransi Central Asia.
14	Aetna Holdings (Thailand) Limited is also 51% owned by Mr. Paiboon Sutantivorakoon plus Aetna Global Benefits (Bermuda) Limited owns 1 share
15	Aetna Health Insurance (Thailand) Public Company Limited is also owned by Aetna Global Benefits (Bermuda) Limited (1 share), Mr. Sansanapongpherchar (1 share), Mr. Jitphasong Itsaraphakded (1 share); Mrs. Suphee Wattana (1 share); and Mr. Buncha Tamphragom (1 share)
16	Minor Health Enterprise Co, Ltd is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
17	Virtual Home Health Care L.L.C. is also 51% owned by CBD Commercial Brokers LLC, Aetna's Nominee.

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

Asterisk	Explanation
18	Health Care Management Co. Ltd. Is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited.
19	Aetna Services (Thailand) Limited is also (1 share) owned by Aetna Global Benefits (Bermuda) Limited and (1 share) owned by Aetna Global Holdings Limited.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Response
1. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC with this statement?	NO

Explanation:

1. Business not written

Bar Code:

1. Medicare Part D Coverage Supplement [Document Identifier 365]

OVERFLOW PAGE FOR WRITE-INS

NONE

SCHEDULE A - VERIFICATION

Real Estate

NONE

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year		
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition		
	2.2 Additional investment made after acquisition		
3.	Current year change in encumbrances		
4.	Total gain (loss) on disposals		
5.	Deduct amounts received on disposals		
6.	Total foreign exchange change in book/adjusted carrying value		
7.	Deduct current year's other than temporary impairment recognized		
8.	Deduct current year's depreciation		
9.	Book/adjusted carrying value at the end of current period (Lines 1+2+3+4-5+6-7-8)		
10.	Deduct total nonadmitted amounts		
11.	Statement value at end of current period (Line 9 minus Line 10)		

SCHEDULE B - VERIFICATION

Mortgage Loans

		1 Year to Date	2 Prior Year Ended December 31
1.	Book value/recorded investment excluding accrued interest, December 31 of prior year	13,407,858	12,979,171
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition	0	0
	2.2 Additional investment made after acquisition	2,054,302	621,181
3.	Capitalized deferred interest and other	0	0
4.	Accrual of discount	0	0
5.	Unrealized valuation increase (decrease)	0	0
6.	Total gain (loss) on disposals	0	0
7.	Deduct amounts received on disposals	261,406	316,980
8.	Deduct amortization of premium and mortgage interest points and commitment fees	(94,845)	(124,486)
9.	Total foreign exchange change in book value/recorded investment excluding accrued interest	0	0
10.	Deduct current year's other than temporary impairment recognized	0	0
11.	Book value/recorded investment excluding accrued interest at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	15,295,599	13,407,858
12.	Total valuation allowance	0	0
13.	Subtotal (Line 11 plus Line 12)	15,295,599	13,407,858
14.	Deduct total nonadmitted amounts	0	0
15.	Statement value at end of current period (Line 13 minus Line 14)	15,295,599	13,407,858

SCHEDULE BA - VERIFICATION

Other Long-Term Invested Assets

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	0	0
2.	Cost of acquired:		
	2.1 Actual cost at time of acquisition	13,124,775	0
	2.2 Additional investment made after acquisition	0	0
3.	Capitalized deferred interest and other	0	0
4.	Accrual of discount	0	0
5.	Unrealized valuation increase (decrease)	0	0
6.	Total gain (loss) on disposals	0	0
7.	Deduct amounts received on disposals	(540,003)	0
8.	Deduct amortization of premium and depreciation	0	0
9.	Total foreign exchange change in book/adjusted carrying value	0	0
10.	Deduct current year's other than temporary impairment recognized	0	0
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	13,664,778	0
12.	Deduct total nonadmitted amounts	0	0
13.	Statement value at end of current period (Line 11 minus Line 12)	13,664,778	0

SCHEDULE D - VERIFICATION

Bonds and Stocks

		1 Year to Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value of bonds and stocks, December 31 of prior year	442,356,087	479,236,865
2.	Cost of bonds and stocks acquired	95,822,927	177,142,775
3.	Accrual of discount	662,365	653,212
4.	Unrealized valuation increase (decrease)	1,769,660	(1,947,081)
5.	Total gain (loss) on disposals	984,365	(2,448,888)
6.	Deduct consideration for bonds and stocks disposed of	97,354,582	205,903,403
7.	Deduct amortization of premium	2,411,877	3,328,608
8.	Total foreign exchange change in book/adjusted carrying value	0	0
9.	Deduct current year's other than temporary impairment recognized	355,529	1,362,411
10.	Total investment income recognized as a result of prepayment penalties and/or acceleration fees	56,582	313,626
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9+10)	441,529,998	442,356,087
12.	Deduct total nonadmitted amounts	0	0
13.	Statement value at end of current period (Line 11 minus Line 12)	441,529,998	442,356,087

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 1B

Showing the Acquisitions, Dispositions and Non-Trading Activity
During the Current Quarter for all Bonds and Preferred Stock by NAIC Designation

NAIC Designation	1 Book/Adjusted Carrying Value Beginning of Current Quarter	2 Acquisitions During Current Quarter	3 Dispositions During Current Quarter	4 Non-Trading Activity During Current Quarter	5 Book/Adjusted Carrying Value End of First Quarter	6 Book/Adjusted Carrying Value End of Second Quarter	7 Book/Adjusted Carrying Value End of Third Quarter	8 Book/Adjusted Carrying Value December 31 Prior Year
BONDS								
1. NAIC 1 (a)	354,193,421	877,817,732	875,026,858	(120,705)	345,501,759	354,193,421	356,863,590	318,735,533
2. NAIC 2 (a)	68,512,139	6,397,170	2,000,000	475,056	78,251,716	68,512,139	73,384,365	81,339,538
3. NAIC 3 (a)	40,907,788	1,509,789	4,846,838	(584,873)	47,047,678	40,907,788	36,985,866	49,057,322
4. NAIC 4 (a)	8,144,211	0	0	(518,830)	5,808,821	8,144,211	7,625,381	4,709,236
5. NAIC 5 (a)	0	0	0	294,576	0	0	294,576	0
6. NAIC 6 (a)	0	0	0	0	0	0	0	0
7. Total Bonds	471,757,559	885,724,691	881,873,696	(454,776)	476,609,974	471,757,559	475,153,778	453,841,629
PREFERRED STOCK								
8. NAIC 1	0	0	0	0	0	0	0	0
9. NAIC 2	0	0	0	0	0	0	0	0
10. NAIC 3	0	0	0	0	0	0	0	0
11. NAIC 4	0	0	0	0	0	0	0	0
12. NAIC 5	0	0	0	0	0	0	0	0
13. NAIC 6	0	0	0	0	0	0	0	0
14. Total Preferred Stock	0	0	0	0	0	0	0	0
15. Total Bonds and Preferred Stock	471,757,559	885,724,691	881,873,696	(454,776)	476,609,974	471,757,559	475,153,778	453,841,629

(a) Book/Adjusted Carrying Value column for the end of the current reporting period includes the following amount of short-term and cash equivalent bonds by NAIC designation:

NAIC 1 $ 33,623,780 ; NAIC 2 $ 0 ; NAIC 3 $ 0 NAIC 4 $ 0 ; NAIC 5 $ 0 ; NAIC 6 $ 0

Schedule DA - Part 1 - Short-Term Investments

N O N E

Schedule DA - Verification - Short-Term Investments

N O N E

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

N O N E

Schedule DB - Part B - Verification - Futures Contracts

N O N E

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

N O N E

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

N O N E

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of Derivatives

N O N E

SCHEDULE E - PART 2 - VERIFICATION

(Cash Equivalents)

		1 Year To Date	2 Prior Year Ended December 31
1.	Book/adjusted carrying value, December 31 of prior year	11,486,582	14,867,395
2.	Cost of cash equivalents acquired	2,044,027,291	2,565,130,542
3.	Accrual of discount	1,103,081	1,164,952
4.	Unrealized valuation increase (decrease)	0	0
5.	Total gain (loss) on disposals	(24)	(722)
6.	Deduct consideration received on disposals	2,022,918,336	2,569,675,585
7.	Deduct amortization of premium	0	0
8.	Total foreign exchange change in book/adjusted carrying value	0	0
9.	Deduct current year's other than temporary impairment recognized	0	0
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	33,698,594	11,486,582
11.	Deduct total nonadmitted amounts	0	0
12.	Statement value at end of current period (Line 10 minus Line 11)	33,698,594	11,486,582

Schedule A - Part 2 - Real Estate Acquired and Additions Made

N O N E

Schedule A - Part 3 - Real Estate Disposed

N O N E

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE B - PART 2

Showing All Mortgage Loans ACQUIRED AND ADDITIONS MADE During the Current Quarter

1	Location		4	5	6	7	8	9
	2	3						
Loan Number	City	State	Loan Type	Date Acquired	Rate of Interest	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Value of Land and Buildings
2004473	MT LAUREL	NJ		12/18/2017	5.280	0	259,824	20,400,000
0499999. Mortgages in good standing - Commercial mortgages-insured or guaranteed						0	259,824	20,400,000
0899999. Total Mortgages in good standing						0	259,824	20,400,000
1699999. Total - Restructured Mortgages						0	0	0
2499999. Total - Mortgages with overdue interest over 90 days						0	0	0
3299999. Total - Mortgages in the process of foreclosure						0	0	0
3399999 - Totals						0	259,824	20,400,000

SCHEDULE B - PART 3

Showing All Mortgage Loans DISPOSED, Transferred or Repaid During the Current Quarter

1	Location		4	5	6	7	Change in Book Value/Recorded Investment						14	15	16	17	18
	2	3					8	9	10	11	12	13					
Loan Number	City	State	Loan Type	Date Acquired	Disposal Date	Book Value/ Recorded Investment Excluding Accrued Interest Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Amortization) /Accretion	Current Year's Other Than Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Change in Book Value (8+9-10+11)	Total Foreign Exchange Change in Book Value	Book Value/ Recorded Investment Excluding Accrued Interest on Disposal	Consid-eration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal
2004182	GLEN BURNIE	MD		12/18/2017		5,803,426	0	0	0	0	0	0	0	84,535	0	0	0
2004473	MT LAUREL	NJ		12/18/2017		0	0	31,757	0	0	31,757	0	0	11,406	0	0	0
0299999. Mortgages with partial repayments						5,803,426	0	31,757	0	0	31,757	0	0	95,941	0	0	0
0599999 - Totals						5,803,426	0	31,757	0	0	31,757	0	0	95,941	0	0	0

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE BA - PART 2

Showing Other Long-Term Invested Assets ACQUIRED AND ADDITIONS MADE During the Current Quarter

1	2	Location		5	6	7	8	9	10	11	12	13
		3	4									
CUSIP Identification	Name or Description	City	State	Name of Vendor or General Partner	NAIC Designation and Administrative Symbol/ Market Indicator	Date Originally Acquired	Type and Strategy	Actual Cost at Time of Acquisition	Additional Investment Made After Acquisition	Amount of Encumbrances	Commitment for Additional Investment	Percentage of Ownership
	REI 440500 HUNT CAP PTR TCF 2011-4 BHKY	HARTFORD	CT			07/09/2019		4,924,775	0	0	0	0.000
3399999. Non-Guaranteed Federal Low Income Housing Tax Credit - Unaffiliated								4,924,775	0	0	0	XXX
4499999. Total - Unaffiliated								4,924,775	0	0	0	XXX
4599999. Total - Affiliated								0	0	0	0	XXX
4699999 - Totals								4,924,775	0	0	0	XXX

SCHEDULE BA - PART 3

Showing Other Long-Term Invested Assets DISPOSED, Transferred or Repaid During the Current Quarter

1	2	Location		5	6	7	8	Change in Book/Adjusted Carrying Value						15	16	17	18	19	20
		3	4					9	10	11	12	13	14						
CUSIP Identification	Name or Description	City	State	Name of Purchaser or Nature of Disposal	Date Originally Acquired	Disposal Date	Book/ Adjusted Carrying Value Less Encumbrances, Prior Year	Unrealized Valuation Increase (Decrease)	Current Year's (Depreciation) or (Amortization)/ Accretion	Current Year's Other Than Temporary Impairment Recognized	Capitalized Deferred Interest and Other	Total Change in Book/ Adjusted Carrying Value (9+10-11+12)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value Less Encumbrances on Disposal	Consideration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Investment Income
	REI 440500 HUNT CAP PTR TCF 2011-4 BHKY	HARTFORD	CT		07/09/2019	09/30/2019	0	0	0	0	0	0	0	0	302,299	0	0	0	0
3399999. Non-Guaranteed Federal Low Income Housing Tax Credit - Unaffiliated							0	0	0	0	0	0	0	0	302,299	0	0	0	0
	AETNA PARTNERS DIVERSIFIED FUND LLC	Hartford	CT	PROCEEDS FROM OPERATIONS	01/02/2019	09/30/2019	0	0	0	0	0	0	0	0	(288,979)	0	0	0	0
4299999. Any Other Class of Assets - Unaffiliated							0	0	0	0	0	0	0	0	(288,979)	0	0	0	0
4499999. Total - Unaffiliated							0	0	0	0	0	0	0	0	13,320	0	0	0	0

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE BA - PART 3

Showing Other Long-Term Invested Assets DISPOSED, Transferred or Repaid During the Current Quarter

1	2	Location		5	6	7	8	Change in Book/Adjusted Carrying Value						15	16	17	18	19	20
		3	4					9	10	11	12	13	14						
CUSIP Identification	Name or Description	City	State	Name of Purchaser or Nature of Disposal	Date Originally Acquired	Disposal Date	Book/ Adjusted Carrying Value Less Encum-brances, Prior Year	Unrealized Valuation Increase (De-crease)	Current Year's (Depre-ciation) or (Amorti-zation)/ Accretion	Current Year's Other Than Temporary Impair-ment Recog-nized	Capital-ized Deferred Interest and Other	Total Change in Book/ Adjusted Carrying Value (9+10-11+12)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value Less Encum-brances on Disposal	Consid-eration	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Invest-ment Income
4599999. Total - Affiliated							0	0	0	0	0	0	0	0	0	0	0	0	0
4699999 - Totals							0	0	0	0	0	0	0	0	13,320	0	0	0	0

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 3

Show All Long-Term Bonds and Stock Acquired During the Current Quarter

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends	10 NAIC Designation and Administrative Symbol/ Market Indicator (a)
13063D-AY-4	CALIFORNIA STATE VARIOUS PURPOSE 5.000% 11/01/47		07/03/2019	WARBURG DILLON READ		1,200,710	1,000,000	9,306	1FE
13063D-PS-1	CALIFORNIA STATE CONSTRUCTION BONDS 5.000% 10/01/30		09/18/2019	MORGAN STANLEY		5,208,240	4,000,000	1,667	1FE
452152-Q4-6	ILLINOIS STATE SER D 5.000% 11/01/25		09/03/2019	BARCLAY INVESTMENTS		2,284,780	2,000,000	34,444	2FE
677522-G2-4	OHIO ST HGR EDU SER A 5.000% 05/01/34		07/03/2019	MERRILL LYNCH-MUNI		4,863,960	4,000,000	6,667	1FE
1799999. Subtotal - Bonds - U.S. States, Territories and Possessions						13,557,690	11,000,000	52,084	XXX
3140JW-BA-7	FED NATL MTGE ASSN POOL NO BO1832 2.500% 07/01/34		08/07/2019	WACHOVIA		6,047,316	5,951,534	7,439	1
613520-MK-8	MONTGOMERY CNTY OHIO HOSPITAL REF PREMIER HEALTH PARTNERS 4.000% 11/15/42		08/15/2019	BARCLAY INVESTMENTS		1,113,690	1,000,000	0	2FE
79766D-RP-6	SAN FRANCISCO CALIF CITY UNREFUNDED AMT-REF-2ND SER G 5.000% 05/01/27		09/18/2019	Tax Free Exchange		1,186,153	1,000,000	19,028	1FE
927793-D4-8	VIRGINIA TRANSPORTATION REF SER A 5.000% 05/15/26		09/18/2019	PIPER, JAFFRAY & HOPWOOD		6,104	5,000	87	1FE
3199999. Subtotal - Bonds - U.S. Special Revenues						8,353,263	7,956,534	26,554	XXX
03330N-AC-8	ANCHORAGE CAPITAL CLO LTD SER 19-11A CLASS B 4.428% 07/22/32		07/26/2019	WACHOVIA		1,000,000	1,000,000	0	1FE
25278X-AE-9	DIAMONDBACK ENERGY INC SR UNSECURED 4.750% 11/01/24		08/12/2019	Tax Free Exchange		1,509,788	1,500,000	19,989	3FE
30231G-BC-5	EXXON MOBIL CORP SR UNSECURED 2.019% 08/16/24		08/13/2019	MORGAN STANLEY		1,000,000	1,000,000	0	1FE
674599-CW-3	OCCIDENTAL PETROLEUM SR UNSECURED 2.900% 08/15/24		08/06/2019	CITIGROUP		998,700	1,000,000	0	2FE
87250C-AJ-6	TICP CLO LTD SERIES 2019-14A CLASS C 144A 6.178% 10/20/32		08/07/2019	CITIGROUP		2,000,000	2,000,000	0	2FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						6,508,488	6,500,000	19,989	XXX
8399997. Total - Bonds - Part 3						28,419,441	25,456,534	98,627	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX
8399999. Total - Bonds						28,419,441	25,456,534	98,627	XXX
8999997. Total - Preferred Stocks - Part 3						0	XXX	0	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	XXX
9799997. Total - Common Stocks - Part 3						0	XXX	0	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	XXX
9999999 - Totals						28,419,441	XXX	98,627	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues 0

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation and Admini-strative Symbol /Market Indicator (a)
3620AM-DZ-2	GOVT NATL MTGE ASSN I POOL NO GN733720 4.500% 06/15/40		09/01/2019	Paydown		89,214	89,214	98,247	97,880	0	(8,666)	0	(8,666)	0	89,214	0	0	0	2,688	06/15/2040	1
0599999. Subtotal - Bonds - U.S. Governments						89,214	89,214	98,247	97,880	0	(8,666)	0	(8,666)	0	89,214	0	0	0	2,688	XXX	XXX
13063D-AY-4	CALIFORNIA STATE VARIOUS PURPOSE 5.000% 11/01/47		08/15/2019	WARBURG DILLON READ		1,242,910	1,000,000	1,200,710	0	0	(2,498)	0	(2,498)	0	1,198,212	0	44,698	44,698	15,000	11/01/2047	1FE
34153P-2R-8	FLORIDA ST BRD ED REF CAPITAL OUTLAY SER C 5.000% 06/01/23		09/13/2019	LOOP CAPITAL MARKETS		2,263,720	2,000,000	2,347,380	2,173,746	0	(26,553)	0	(26,553)	0	2,147,193	0	116,527	116,527	79,444	06/01/2023	1FE
57582P-3V-0	MASSACHUSETTS ST CONSOL LOAN SER C 5.000% 07/01/23		09/03/2019	Royal Bank and Trust		1,664,745	1,500,000	1,772,280	1,639,673	0	(26,259)	0	(26,259)	0	1,613,414	0	51,331	51,331	88,333	07/01/2023	1FE
677522-G2-4	OHIO ST HGR EDU SER A 5.000% 05/01/34		07/10/2019	Citigroup		1,822,350	1,500,000	1,823,985	0	0	(429)	0	(429)	0	1,823,556	0	(1,206)	(1,206)	3,333	05/01/2034	1FE
1799999. Subtotal - Bonds - U.S. States, Territories and Possessions						6,993,725	6,000,000	7,144,355	3,813,419	0	(55,739)	0	(55,739)	0	6,782,375	0	211,350	211,350	186,110	XXX	XXX
25477G-HY-4	DISTRICT COLUMBIA INCOME TAX REVENUE BONDS 5.000% 12/01/29		09/11/2019	RAMIREZ		1,620,360	1,500,000	1,710,495	1,569,014	0	(16,005)	0	(16,005)	0	1,553,009	0	67,351	67,351	58,750	12/01/2029	1FE
3132XY-UX-3	FED HOME LOAN MTGE CORP GOLD POOL NO 4.000% 05/01/48		09/01/2019	Paydown		355,041	355,041	362,141	362,008	0	(6,967)	0	(6,967)	0	355,041	0	0	0	9,794	05/01/2048	1
3138X8-XG-1	FED NATL MTGE ASSN POOL NO AU8778 3.000% 10/01/28		09/01/2019	Paydown		125,163	125,163	129,720	128,433	0	(3,270)	0	(3,270)	0	125,163	0	0	0	2,662	10/01/2028	1
3140JW-BA-7	FED NATL MTGE ASSN POOL NO BO1832 2.500% 07/01/34		09/01/2019	Paydown		116,524	116,524	118,399	0	0	(1,875)	0	(1,875)	0	116,524	0	0	0	243	07/01/2034	1
452252-KA-6	ILLINOIS ST TOLL HWY AUTH TOLL REF-SER D 5.000% 01/01/21		08/30/2019	BARCLAY INVESTMENTS		524,415	500,000	590,810	531,191	0	(10,414)	0	(10,414)	0	520,777	0	3,638	3,638	29,375	01/01/2021	1FE
56045P-BP-7	MAINE ST MUNI BOND BANK INFRAS 5.000% 09/01/21		08/19/2019	GOLDMAN SACHS & CO		1,002,890	1,000,000	1,187,380	1,018,064	0	(17,316)	0	(17,316)	0	1,000,749	0	2,141	2,141	48,611	09/01/2021	1FE
67886M-MP-1	OKLAHOMA ST HSG FIN AGY SF MTG HOMEOWNERSHIP LN PG SER A 4.750% 03/01/28		09/01/2019	Call 100.0000		10,000	10,000	10,779	10,160	0	(55)	0	(55)	0	10,105	0	(105)	(105)	435	03/01/2028	1FE
708692-BF-4	PENNSYLVANIA ECONOMIC DEV VAR-WASTE MGMT INC PROJ 2.150% 07/01/41		07/01/2019	Call 100.0000		2,000,000	2,000,000	2,026,540	2,024,175	0	(419)	0	(419)	0	2,023,756	0	(23,756)	(23,756)	45,000	07/01/2041	1FE
79766D-LL-1	SAN FRANCISCO CALIF CITY AMT-REF-2ND SER-SER G 5.000% 05/01/27		09/18/2019	Tax Free Exchange		1,186,153	1,000,000	1,199,400	0	0	(13,247)	0	(13,247)	0	1,186,153	0	0	0	44,028	05/01/2027	1FE
3199999. Subtotal - Bonds - U.S. Special Revenues						6,940,546	6,606,728	7,335,664	5,643,045	0	(69,568)	0	(69,568)	0	6,891,277	0	49,269	49,269	238,898	XXX	XXX
00130H-BT-1	AES CORP SR UNSECURED 4.875% 05/15/23		09/25/2019	Call 101.6250		71,138	70,000	71,400	68,432	2,300	(220)	0	2,080	0	70,513	0	(513)	(513)	4,076	05/15/2023	3FE
14042R-BS-9	CAPITAL ONE NA SR UNSECURED 1.850% 09/13/19		09/13/2019	Maturity		1,000,000	1,000,000	999,970	999,983	0	17	0	17	0	1,000,000	0	0	0	18,500	09/13/2019	2FE
16412X-AD-7	CHENIERE CORP CHRISTI HD SECURED 7.000% 06/30/24		09/30/2019	GOLDMAN SACHS & CO		574,375	500,000	500,000	500,000	0	0	0	0	0	500,000	0	74,375	74,375	26,444	06/30/2024	3FE
25278X-AC-3	DIAMONDBACK ENERGY INC SR UNSECURED 4.750% 11/01/24		08/12/2019	Tax Free Exchange		1,509,788	1,500,000	1,510,625	965,295	32,281	(912)	0	31,369	0	1,509,789	0	0	0	55,615	11/01/2024	3FE
29444U-AP-1	EQUINIX INC SR UNSECURED 5.750% 01/01/25		07/23/2019	GOLDMAN SACHS & CO		780,000	750,000	796,875	756,106	25,082	(5,451)	0	19,631	0	775,737	0	4,263	4,263	46,000	01/01/2025	3FE
35671D-AU-9	FREEPORT-MCMORAN C & G SR UNSECURED 3.550% 03/01/22		08/16/2019	Corporate Actions		4,938	5,000	2,825	3,630	0	224	0	224	0	3,854	0	1,083	1,083	170	03/01/2022	3FE
35671D-CB-9	FREEPORT-MCMORAN C & G SR UNSECURED 6.875% 02/15/23		09/03/2019	Call 105.4639		1,054,639	1,000,000	1,057,814	1,032,764	11,092	(6,407)	0	4,685	0	1,037,449	0	(37,449)	(37,449)	126,827	02/15/2023	3FE
78454L-AP-5	SM ENERGY CO SR UNSECURED 6.625% 01/15/27		08/06/2019	GOLDMAN SACHS & CO		827,500	1,000,000	947,500	0	0	1,997	0	1,997	0	949,497	0	(121,997)	(121,997)	37,358	01/15/2027	3FE
902494-AW-3	TYSON FOODS INC SR UNSECURED 2.650% 08/15/19		08/15/2019	Maturity		1,000,000	1,000,000	999,340	999,898	0	102	0	102	0	1,000,000	0	0	0	26,500	08/15/2019	2FE
92348X-AA-3	VERIZON OWNER TRUST SERIES 18-A CLASS A1A 3.230% 04/20/23		08/23/2019	WACHOVIA		1,786,572	1,750,000	1,749,973	1,749,976	0	6	0	6	0	1,749,982	0	36,590	36,590	38,782	04/20/2023	1FE
3899999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						8,608,950	8,575,000	8,636,322	7,076,084	70,755	(10,644)	0	60,111	0	8,596,821	0	(43,648)	(43,648)	380,272	XXX	XXX
8399997. Total - Bonds - Part 4						22,632,435	21,270,942	23,214,588	16,630,428	70,755	(144,617)	0	(73,862)	0	22,359,687	0	216,971	216,971	807,968	XXX	XXX
8399998. Total - Bonds - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8399999. Total - Bonds						22,632,435	21,270,942	23,214,588	16,630,428	70,755	(144,617)	0	(73,862)	0	22,359,687	0	216,971	216,971	807,968	XXX	XXX
8999997. Total - Preferred Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
8999998. Total - Preferred Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8999999. Total - Preferred Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE D - PART 4

Show All Long-Term Bonds and Stock Sold, Redeemed or Otherwise Disposed of During the Current Quarter

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	22
										11	12	13	14	15							
CUSIP Ident-ification	Description	For-eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Consid-eration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor-tization)/ Accretion	Current Year's Other Than Temporary Impairment Recog-nized	Total Change in Book/ Adjusted Carrying Value (11 + 12 - 13)	Total Foreign Exchange Change in Book /Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received DuringYear	Stated Con-tractual Maturity Date	NAIC Desig-nation and Admini-strative Symbol /Market Indicator (a)
9799997. Total - Common Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9799998. Total - Common Stocks - Part 5						XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
9799999. Total - Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX	XXX
9999999 - Totals						22,632,435	XXX	23,214,588	16,630,428	70,755	(144,617)	0	(73,862)	0	22,359,687	0	216,971	216,971	807,968	XXX	XXX

(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues.....0

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

N O N E

Schedule DB - Part B - Section 1 - Futures Contracts Open

N O N E

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

N O N E

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

N O N E

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

N O N E

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

N O N E

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

N O N E

SCHEDULE E - PART 1 - CASH

Month End Depository Balances

1	2	3	4	5	Book Balance at End of Each Month During Current Quarter			9
					6	7	8	
Depository	Code	Rate of Interest	Amount of Interest Received During Current Quarter	Amount of Interest Accrued at Current Statement Date	First Month	Second Month	Third Month	*
Bank of America Charlotte, NC		0.000	0	0	4,224,096	8,893,918	12,555,958	XXX
0199998. Deposits in 1 depositories that do not exceed the allowable limit in any one depository (See instructions) - Open Depositories	XXX	XXX	0	0	(5,071)	(5,077)	14,081	XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	4,219,025	8,888,841	12,570,039	XXX
0299998. Deposits in 0 depositories that do not exceed the allowable limit in any one depository (See instructions) - Suspended Depositories	XXX	XXX	0	0	0	0	0	XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	4,219,025	8,888,841	12,570,039	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX	0	0	0	XXX
0599999. Total - Cash	XXX	XXX	0	0	4,219,025	8,888,841	12,570,039	XXX

STATEMENT AS OF SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned End of Current Quarter

1 CUSIP	2 Description	3 Code	4 Date Acquired	5 Rate of Interest	6 Maturity Date	7 Book/Adjusted Carrying Value	8 Amount of Interest Due and Accrued	9 Amount Received During Year
0599999. Total - U.S. Government Bonds						0	0	0
1099999. Total - All Other Government Bonds						0	0	0
1799999. Total - U.S. States, Territories and Possessions Bonds						0	0	0
2499999. Total - U.S. Political Subdivisions Bonds						0	0	0
3199999. Total - U.S. Special Revenues Bonds						0	0	0
	AMERICAN ELEC POWER CP 4-2 144A		09/25/2019	2.260	10/25/2019	1,654,503	0	623
	BOSTON SCIENTIFIC CP (4)2 144A		09/24/2019	2.330	10/07/2019	2,072,195	0	939
	DOWDUPONT INC CP 4(2) 144A		09/25/2019	2.220	10/08/2019	2,498,920	0	925
	GENERAL MOTORS FINL CO CP 4(2) 144A		09/23/2019	2.350	10/04/2019	399,922	0	209
	GENERAL MOTORS FINL CO CP 4(2) 144A		09/25/2019	2.350	10/16/2019	2,497,551	0	978
	GULF POWER CO CP 3(A)3		09/26/2019	2.220	10/22/2019	4,993,523	0	1,540
	LOUISVILLE GAS & ELEC CP 4(2) 144A		09/23/2019	2.250	10/07/2019	4,854,178	0	2,427
	NASDAQ INC CP 4(2) 144A		09/25/2019	2.210	10/21/2019	657,192	0	242
	WEC ENERGY GROUP INC CP 4(2) 144A		09/26/2019	2.210	10/10/2019	4,997,237	0	1,534
	WESTERN UNION CO CP 4(2)		09/24/2019	2.360	10/03/2019	4,999,343	0	2,294
	WESTERN UNION CO CP 4(2)		09/25/2019	2.350	10/04/2019	3,999,216	0	1,566
3299999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations						33,623,780	0	13,277
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						33,623,780	0	13,277
4899999. Total - Hybrid Securities						0	0	0
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0
6099999. Subtotal - SVO Identified Funds						0	0	0
6599999. Subtotal - Bank Loans						0	0	0
7799999. Total - Issuer Obligations						33,623,780	0	13,277
7899999. Total - Residential Mortgage-Backed Securities						0	0	0
7999999. Total - Commercial Mortgage-Backed Securities						0	0	0
8099999. Total - Other Loan-Backed and Structured Securities						0	0	0
8199999. Total - SVO Identified Funds						0	0	0
8299999. Total - Bank Loans						0	0	0
8399999. Total Bonds						33,623,780	0	13,277
60934N-50-0	FEDERATED INVESTORS INC TREASURY OBLIGATION FUND		09/30/2019	0.000		74,814	5	65
8599999. Subtotal - Exempt Money Market Mutual Funds - as Identified by the SVO						74,814	5	65
8899999 - Total Cash Equivalents						33,698,594	5	13,342

SUPPLEMENT FOR THE QUARTER ENDING SEPTEMBER 30, 2019 OF THE Aetna Better Health of Kentucky Insurance Company

MEDICARE PART D COVERAGE SUPPLEMENT

(Net of Reinsurance)

NAIC Group Code 0001 NAIC Company Code 15761

	Individual Coverage		Group Coverage		5
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	Total Cash
1. Premiums Collected		XXX		XXX	
2. Earned Premiums		XXX		XXX	XXX
3. Claims Paid		XXX		XXX	
4. Claims Incurred		XXX		XXX	XXX
5. Reinsurance Coverage and Low Income Cost Sharing - Claims Paid Net of Reimbursements Applied (a)	XXX		XXX		
6. Aggregate Policy Reserves - Change		XXX		XXX	XXX
7. Expenses Paid		XXX		XXX	
8. Expenses Incurred		XXX		XXX	XXX
9. Underwriting Gain or Loss		XXX		XXX	XXX
10. Cash Flow Result	XXX	XXX	XXX	XXX	

NONE

(a) Uninsured Receivable/Payable with CMS at End of Quarter: $ ..... due from CMS or $ ..... due to CMS

Attachment E

Kentucky | Transforming Health Care | **Aetna**

Attachment E

B.2b – Financial Statements (Parent and Subcontractors)

Aetna Better Health® of Kentucky Audited Financial Statement – 2016 ..... Att E-3

Aetna Better Health® of Kentucky Audited Financial Statement – 2017 ..... Att E-47

Aetna Better Health® of Kentucky Audited Financial Statement – 2018 ..... Att E- 97

Accipio Language Services ..... Att E-151

Active Health ..... Att E-155

Advanced Medical Reviews Inc. ..... Att E-549

Aetna Health Management LLC ..... Att E-587

Aetna Medicaid Administrators LLC ..... Att E-613

Akorbi ..... Att E-639

The Guardian Life Insurance Company of America (Avesis) ..... Att E-643

Bluegrass Care Navigators ..... Att E-723

Care Innovations Financial Statement ..... Att E-761

Center for the Study of Services ..... Att E-765

Central Kentucky Interpreter Referral, Inc. ..... Att E-785

Change Healthcare Holdings, LLC ..... Att E-793

Conduent Credit Balance Solutions, LLC (parent Conduent Inc.) ..... Att E-1069

Cotiviti Holdings, Inc. ..... Att E-1201

CQ Fluency, Inc. ..... Att E-1335

CVS Health Corporation (Caremark PCS) ..... Att E-1345

B.2b – Financial Statements (Parent and Subcontractors) cont.

Donnelley Financial Solutions, Inc. ..... Att E-1739

Edifecs, Inc. and Subsidiaries ..... Att E-1861

Eliza Corporation ..... Att E-1865

Equian, LLC ..... Att E-1959

EviCore ..... Att E-1967

Health Management Systems, Inc,. ..... Att E-2127

Inovalon Holdings, Inc. ..... Att E-2221

John Michael Associates, Inc. ..... Att E-2263

Kentucky Hospital Association and Subsidiaries ..... Att E-2271

Language Line Services, Inc. ..... Att E-2351

MCG Health ..... Att E-2651

Nanthealth, Inc. ..... Att E-2657

Office Ally, Inc. ..... Att E-2863

Pursuant Health, Inc. ..... Att E-2869

Red Card Holdings, LLC ..... Att E-2875

Symphony Performance Health Holdings, Inc. ..... Att E-2879

Unite USA, Inc. ..... Att E-2907

Welltok, Inc. ..... Att E-2929

Aetna Better Health® of Kentucky Audited Financial Statement 2016

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AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY

Statutory Financial Statements

December 31, 2016

(With Independent Auditors' Report Thereon)

NAIC #15761

KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Aetna Better Health Kentucky Insurance Company:

Report on the Financial Statements

We have audited the accompanying financial statements of Aetna Better Health Kentucky Insurance Company, which comprise the statutory statements of assets, liabilities, and capital and surplus as of December 31, 2016, and the related statutory statements of revenue and expenses, changes in capital and surplus, and cash flow for the year then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Kentucky Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by Aetna Better Health Kentucky Insurance Company using statutory accounting practices prescribed or permitted by the Kentucky Department of Insurance, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership and the U.S. member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative ("KPMG International"), a Swiss entity.

The effects on the financial statements of the variances between the statutory accounting practices described in Note 2 and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting practices and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Aetna Better Health Kentucky Insurance Company as of December 31, 2016 , or the results of its operations or its cash flows for the year then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the assets, liabilities, and surplus of Aetna Better Health Kentucky Insurance Company as of December 31, 2016, and the results of its operations and its cash flow for the year then ended, in accordance with statutory accounting practices prescribed or permitted by the Kentucky Department of Insurance described in Note 2.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the Summary Investment Schedule and Supplemental Investment Risks Interrogatories is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Kentucky Department of Insurance. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

KPMG LLP

June 1, 2017

Aetna Better Health of Kentucky Insurance Company

As of December 31, 2016

Statutory Statement of Assets

		Current Year		
		Assets	Nonadmitted Assets	Net Admitted Assets
01	Bonds (Schedule D)	$528,045,639	$0	$528,045,639
02.1	Preferred stocks (Schedule D)	0	0	0
02.2	Common stocks (Schedule D)	0	0	0
03.1	Mortgage loans on real estate: First liens	0	0	0
03.2	Mortgage loans on real estate: Other than first liens	0	0	0
04.1	Properties occupied by the company	0	0	0
04.2	Properties held for the production of income	0	0	0
04.3	Properties held for sale	0	0	0
05	Cash ($3,770,293), cash equivalents ($1,005,891) and short-term investments ($2,475)	4,778,660	0	4,778,660
06	Contract loans	0	0	0
07	Derivatives (Schedule DB)	0	0	0
08	Other invested assets (Schedule BA)	0	0	0
09	Receivables for securities	64,705	0	64,705
10	Securities lending reinvested collateral assets (Schedule DL)	0	0	0
11	Aggregate write-ins for invested assets	0	0	0
12	Subtotals, cash and invested assets (Lines 1 to 11)	532,889,004	0	532,889,004
13	Title plants (for Title insurers only)	0	0	0
14	Investment income due and accrued	4,523,422	0	4,523,422
15.1	Uncollected premiums and agents' balances in the course of collection	3,365,010	0	3,365,010
15.2	Deferred premiums, agents' balances and installments booked but deferred and not yet due	0	0	0
15.3	Accrued retrospective premiums and contracts subject to redetermination	0	0	0
16.1	Amounts recoverable from reinsurers	0	0	0
16.2	Funds held by or deposited with reinsured companies	0	0	0
16.3	Other amounts receivable under reinsurance contracts	0	0	0
17	Amounts receivable relating to uninsured plans	0	0	0
18.1	Current federal and foreign income tax recoverable and interest thereon	0	0	0
18.2	Net deferred tax asset	17,246,590	3,255,711	13,990,879
19	Guaranty funds receivable or on deposit	0	0	0
20	Electronic data processing equipment and software	0	0	0
21	Furniture and equipment, including health care delivery assets	0	0	0
22	Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0
23	Receivables from parent, subsidiaries and affiliates	3,657,643	0	3,657,643
24	Health care ($5,050,758) and other amounts receivable	14,056,403	9,005,645	5,050,758
25	Aggregate write-ins for other than invested assets	13,519,627	13,513,614	6,013
26	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	589,257,699	25,774,970	563,482,728
27	From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0
28	Total (Lines 26 and 27)	$589,257,699	$25,774,970	$563,482,728

	Details of Write-Ins			
2501	Deposits	500,000	500,000	0
2502	Miscellaneous Recoveries	13,019,627	13,013,614	6,013
2503		0	0	0
2599	Totals (Lines 2501 thru 2503) (Line 25 above)	$13,519,627	$13,513,614	$6,013

See accompanying notes to statutory financial statements.

Aetna Better Health of Kentucky Insurance Company

As of December 31, 2016

Statutory Statement of Liabilities, Capital and Surplus

		Current Year Total
01	Claims unpaid (less $0 reinsurance ceded)	181,498,823
02	Accrued medical incentive pool and bonus amounts	19,204,275
03	Unpaid claim adjustment expenses	3,294,544
04	Aggregate health policy reserves, including the liability of $0 for medical loss ratio rebate per the Public Health Service Act	31,898,076
05	Aggregate life policy reserves	0
06	Property/casualty unearned premium reserves	0
07	Aggregate health claim reserves	0
08	Premiums received in advance	0
09	General expenses due or accrued	14,248,157
10.1	Current federal and foreign income tax payable and interest thereon	14,001,739
10.2	Net deferred tax liability	0
11	Ceded reinsurance premiums payable	0
12	Amounts withheld or retained for the account of others	0
13	Remittances and items not allocated	2,725,913
14	Borrowed money and interest thereon	0
15	Amounts due to parent, subsidiaries and affiliates	82,924,556
16	Derivatives	0
17	Payable for securities	0
18	Payable for securities lending	0
19	Funds held under reinsurance treaties (with $0 in unauthorized reinsurers)	0
20	Reinsurance in unauthorized and certified	0
21	Net adjustments in assets and liabilities due to foreign exchange rates	0
22	Liability for amounts held under uninsured plans	0
23	Aggregate write-ins for other liabilities	243,723
24	Total liabilities (Lines 1 to 23)	350,039,806
25	Aggregate write-ins for special surplus funds	0
26	Common capital stock	10,000
27	Preferred capital stock	0
28	Gross paid in and contributed surplus	100,000,001
29	Surplus notes	0
30	Aggregate write-ins for other than special surplus funds	0
31	Unassigned funds (surplus)	113,432,921
32.1	Less treasury stock, at cost: 0 shares common	0
32.2	Less treasury stock, at cost: 0 shares preferred	0
33	Total capital and surplus (Lines 25 to 31 minus Line 32)	213,442,922
34	Total liabilities, capital and surplus (Lines 24 and 33)	$563,482,728

Details of Write-Ins		
2301	Escheat Payable	243,723
2302		0
2399	Totals (Lines 2301 thru 2302) (Line 23 above)	$243,723

See accompanying notes to statutory financial statements.

Aetna Better Health of Kentucky Insurance Company

For the Years Ended December 31, 2016

Statutory Statement of Revenue and Expenses

	Current Year
	Total
02 Net premium income	1,095,320,395
03 Change in unearned premium reserves and reserve for rate credits	16,584,485
04 Fee-for-service	0
05 Risk revenue	0
06 Aggregate write-ins for other health care related revenues	0
07 Aggregate write-ins for other non-health revenues	0
08 Total revenues (Lines 2 to 7)	1,111,904,880
09 Hospital/medical benefits	484,793,030
10 Other professional services	48,894,617
11 Outside referrals	0
12 Emergency room and out-of-area	91,927,078
13 Prescription drugs	206,794,380
14 Aggregate write-ins for other hospital and medical	0
15 Incentive pool, withhold adjustments and bonus amounts	0
16 Subtotal (Lines 9 to 15)	832,409,105
17 Net reinsurance recoveries	0
18 Total hospital and medical (Lines 16 minus 17)	832,409,105
19 Non-health claims (net)	0
20 Claims adjustment expenses	26,982,208
21 General administrative expenses	73,586,635
22 Increase in reserves for life and accident and health contracts	0
23 Total underwriting deductions (Lines 18 through 22)	932,977,948
24 Net underwriting gain (Lines 8 minus 23)	178,926,932
25 Net investment income earned	10,265,995
26 Net realized capital gains less capital gains tax of $538,796	(250,334)
27 Net investment gains (Lines 25 plus 26)	10,015,661
28 Net gain or (loss) from agents' or premium balances charged off	0
29 Aggregate write-ins for other income or expenses	0
30 Net income after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	188,942,593
31 Federal and foreign income taxes incurred	66,703,859
32 Net income	$122,238,734

See accompanying notes to statutory financial statements.

Aetna Better Health of Kentucky Insurance Company

For the Years Ended December 31, 2016

Statutory Statement of Changes in Capital and Surplus

	Current Year
33 Capital and surplus prior reporting year	3,253,690
34 Net income from Line 32	122,238,734
35 Change in valuation basis of aggregate policy and claim reserves	0
36 Change in net unrealized capital (losses) less capital gains tax of ($98,393)	(182,729)
37 Change in net unrealized foreign exchange capital gain or (loss)	
38 Change in net deferred income tax	17,148,197
39 Change in nonadmitted assets	(25,774,970)
40 Change in unauthorized and certified reinsurance	0
41 Change in treasury stock	0
42 Change in surplus notes	0
43 Cumulative effect of changes in accounting principles	0
44.1 Capital Changes: Paid in	0
44.2 Transferred from surplus (Stock Dividend)	0
44.3 Transferred to surplus	0
45.1 Surplus adjustments: Paid in	96,760,001
45.2 Transferred to capital (Stock Dividend)	0
45.3 Transferred from capital	0
46 Dividends to stockholders	0
47 Aggregate write-ins for gains or (losses) in surplus	0
48 Net change in capital and surplus (Lines 34 to 47)	210,189,232
49 Capital and surplus end of reporting period (Line 33 plus 48)	$213,442,922

See accompanying notes to statutory financial statements.

Aetna Better Health of Kentucky Insurance Company

For the Years Ended December 31, 2016

Statutory Statement of Cash Flows

		Current Year
01	Premiums collected net of reinsurance	1,078,899,497
02	Net investment income	8,615,108
03	Miscellaneous income	0
04	Total (Lines 1 to 3)	1,087,514,605
05	Benefit and loss related payments	865,632,083
06	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0
07	Commissions, expenses paid and aggregate write-ins for deductions	95,292,091
08	Dividends paid to policyholders	0
09	Federal and foreign income taxes paid (recovered) net of $0 tax on capital gains (losses)	53,242,902
10	Total (Lines 5 through 9)	1,014,167,076
11	Net cash from operations (Line 4 minus Line 10)	73,347,529
12.1	Proceeds - Bonds	129,894,025
12.2	Stocks	0
12.3	Mortgage loans	0
12.4	Real estate	0
12.5	Other invested assets	0
12.6	Net gains or (losses) on cash, cash equivalents and short-term investments	314
12.7	Miscellaneous proceeds	1,501
12.8	Total investment (Lines 12.1 to 12.7)	129,895,840
13.1	Cost of investments - Bonds	384,131,981
13.2	Stocks	0
13.3	Mortgage loans	0
13.4	Real estate	0
13.5	Other invested assets	0
13.6	Miscellaneous applications	64,705
13.7	Total investments acquired (Lines 13.1 to 13.6)	384,196,686
14	Net increase (or decrease) in contract loans and premium notes	0
15	Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	(254,300,846)
16.1	Surplus notes, capital notes	0
16.2	Capital and paid in surplus, less treasury stock	96,760,001
16.3	Borrowed funds	0
16.4	Net deposits on deposit-type contracts and other insurance liabilities	0
16.5	Dividends to stockholders	0
16.6	Other cash provided (applied)	86,969,596
17	Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	183,729,597
18	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	2,776,280
19.1	Cash, cash equivalents and short term investments - Beginning of year	2,002,380
19.2	Cash, cash equivalents and short term investments - End of period (Line 18 plus Line 19.1)	$4,778,660

Supplemental disclosures of cash flow information for non-cash transactions

20.0001	Non-Cash Bond Transactions	$292,173,965
20.0002	Uncollected premiums and other assets transferred	8,797,261
20.0001	Claims unpaid and other liabilities transferred	(304,631,507)

See accompanying notes to statutory financial statements.

1. Organization and operation

Aetna Better Health of Kentucky Insurance Company Inc. (the "Company" or "ABH-KY") is a wholly-owned subsidiary of Coventry Health and Life Insurance Company, Inc. ("CH&L") whose ultimate parent is Aetna Inc. ("Aetna").

The Company contracts with the Commonwealth of Kentucky Department of Health and Human Services to provide health benefits to Medicaid and Children's Health Insurance Program ("CHIP") members. The Commonwealth of Kentucky expansion of Medicaid services on January 1, 2014 for coverage of populations including individuals, families regardless of status, up to 138% of the Federal Poverty Level. The expansion of this contract operates under the previous Medicaid contract and recipients receive the same benefits. The Company's current contract with Commonwealth runs through December 31, 2017.

Effective February 1, 2016, the Company entered into an Assignment Agreement with CH&L, whereby, CH&L assigned and set over to the Company all of their assets and liabilities arising out of or relating to CH&L's operation of the Kentucky Medicaid plan, whether arising before, on or after the date of the agreement. The purchase price for the assets was the difference between the value of the sum of the assets, $9 million, and the sum of the liabilities, $305 million, on the books of the Company as of February 1, 2016, the effective date.

2. Summary of significant accounting policies

Accounting practices

The accompanying statutory financial statements of the Company have been prepared in conformity with accounting practices prescribed or permitted by the Kentucky Department of Insurance ("KY DOI") (Kentucky Accounting Practices"). KY DOI recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP"). The Company's net income and capital and surplus as stated on a NAIC SAP basis and on the basis of practices prescribed or permitted by the Commonwealth of Kentucky were the same as of and for the years ended December 31, 2016.

Kentucky Accounting Practices vary from U.S. generally accepted accounting principles ("GAAP"). The primary differences include the following:

- Certain assets, designated as non-admitted assets (in part, uncollected premiums are non-admitted in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 6, *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers*) are not recorded as assets, but are charged to surplus. Thus, non-admitting uncollected premiums eliminates the need for a separate allowance for doubtful accounts, which is utilized under GAAP;
- Certain assets, designated as non-admitted assets (health care and other receivables and prepaid deposits, which are non-admitted in accordance with SSAP No. 4, *Assets and Non-admitted Assets*) are not recorded as assets, but are charged to surplus. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests are not recognized on the Statutory Statement of Assets, and are, therefore, considered non-admitted;
- Bonds are recorded at amortized cost except for those with an NAIC designation of 3 through 6, which are reported at the lower of amortized cost or fair value. Therefore, changes in unrealized gains and losses for those securities held at amortized cost are not reflected in the financial statements. Under GAAP, bonds classified as available for sale are recorded at fair value, and related changes in unrealized gains and losses are recorded as a component of equity, net of deferred federal income taxes;
- Deferred tax assets and liabilities are determined and admitted in accordance with SSAP No. 101, *Income Taxes* ("SSAP No. 101"). Changes in net deferred tax assets and liabilities are reflected as changes in surplus, whereas under U.S. GAAP, changes in such assets and liabilities are reflected in net income. In addition, statutory accounting requires

consideration of a statutory allowance adjustment in the calculation of adjusted gross deferred tax assets and an admissibility test for deferred tax assets;

- In accordance with SSAP No. 2, *Cash, Drafts, and Short-term Investments*, certain short-term borrowings are classified as a reduction of cash, cash equivalents, and short-term investments. Under GAAP, these amounts would have been classified as liabilities; and
- Cash, cash equivalents, and short-term investments in the statutory statements of cash flows represents cash balances and investments with remaining maturities of one year or less at the time of acquisition. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less. The statement does not classify cash flows consistent with GAAP and a reconciliation of net earnings to net cash provided by operations is not provided.

There were no permitted practices by the Commonwealth of Kentucky for the year ended December 31, 2016.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Kentucky Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenue and expenses. Actual results could differ from those estimates.

Significant accounting policies

The Company applies the following significant accounting policies:

Cash, cash equivalents and short-term investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value.

Bonds

Bonds, which include special deposits as discussed more fully in Note 4, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections at December 31, 2016. Bonds include all investments whose maturity is greater than one year when purchased.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities ("LB&SS"), an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For LB&SS, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the Statutory Statements of Liabilities, Capital and Surplus date and (1) the Company intends to sell the investment, or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the Statutory Statements of Liabilities, Capital and Surplus date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

Investment income due and accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2016, the Company did not have any non-admitted investment income due and accrued.

Premiums and amounts due and unpaid

Premium revenue for prepaid health or dental care products is recognized as income in the month in which enrollees are entitled to health or dental care services. Premiums collected before the effective period are reported as premiums received in advance. Premiums related to unexpired contractual coverage periods are reported as unearned premiums in the Statutory Statements of Liabilities, Capital and Surplus (refer to discussion of aggregate health policy reserves and related expenses below).

Non-admitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances. In addition, for any customer for which the premiums due and unpaid greater than 90 days past due is more than a de minimus portion of the entire balance of premiums due and unpaid for that customer, the entire balance of premiums due and unpaid for that customer is non-admitted. Management also performs a specific review of accounts and based on the results of the review, additional amounts may be non-admitted. Uncollectible amounts are generally written-off and charged to revenue in the period in which the customer reconciliations are completed and agreed to by the customer (retroactivity) or when the account is determined to be uncollectible by the Company.

Pharmaceutical rebate receivables

The Company estimates pharmaceutical rebate receivables based upon historical payment trends, actual utilization and other variables. Pharmaceutical rebates for a quarter are billed to the vendor within one month of the completion of the quarter with any adjustment to previously recorded amounts reflected at the time of billing. The Company reports

pharmaceutical rebate receivables as health care receivables. Pharmacy rebate receivables not in accordance with SSAP No. 84 – *Health Care and Government Insured Plan Receivables* or are over 90 days past due are non-admitted. All rebates are processed and settled with an affiliated entity. The pharmaceutical rebate receivables are more fully discussed in Note 8.

Hospital and medical costs and claims adjustment expenses and related reserves

Hospital and medical costs consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health claim reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Statutory Statements of Assets and Liabilities, Capital and Surplus date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, contract requirement changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in hospital and medical costs in the Statutory Statements of Revenue and Expenses in the period they are determined. Capitation costs, which are recorded in hospital and medical expenses in the Statutory Statements of Revenue and Expenses, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

Claims adjustment expenses, which include cost containment expenses, represent costs incurred related to the claims settlement process such as costs to record, process and adjust claims. Claims adjustment expenses are calculated based on a percentage of claims unpaid and are an allocated portion of the management fee calculated pursuant to the Administrative Services Agreement with an affiliate in Note 7.

Aggregate health policy reserves and related expenses

Premium deficiency reserves ("PDR") are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Where allowed, anticipated investment income is considered in the calculation of any PDR. For purposes of calculating a PDR, contracts are grouped in manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts. The Company had no PDR accrual at December 31, 2016**.**

As a part of the Company's Kentucky Medicaid business, a risk corridor accrual related to the ACA expansion members has been established. Per the Medicaid contract, the Commonwealth of Kentucky has a symmetrical risk corridor established around a targeted medical loss ratio. Based on the contractual requirements, the Company recorded a liability of $31,898,076 as of December 31, 2016 within the Aggregate Health Policy Reserve line on the Statutory Statement of Liabilities, Capital and Surplus.

Fees Paid to the Federal Government by Health Insurers

SSAP No. 106 – *Affordable Care Act Section 9010 Assessment* ("SSAP No. 106") required (1) that the health insurer fee be recognized in full on January 1 of the fee year (the calendar year in which the assessment must be paid to the federal government), in the operating expense category of insurance taxes, licenses and fees, excluding federal income taxes and (2) that in each data year preceding a fee year a reporting entity pro-ratably accrue by reclassifying from unassigned funds (surplus) to aggregate write-ins for special surplus funds an amount equal to its estimated subsequent fee year

assessment. This reclassification has no impact on total capital and surplus and is reversed in full on January 1 of the fee year beginning with fee years starting on January 1, 2015 and after. In December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the health insurer fee. As interpreted in INT 16-01: ACA Section 9010 Assessment 2017 Moratorium, because there is not an ACA Section 9010 fee due in September 2017, there is not an accrual of a liability on January 1, 2017 based on 2016 data year net written premiums. Accrual of a liability on January 1, 2018 for the ACA Section 9010 assessment based on 2017 data year net written premiums and the reclassification from unassigned funds (surplus) to aggregate write-ins for special surplus funds equal to the estimated 2018 fee year assessment accrued in data year 2017 will both continue as prescribed under SSAP No. 106. See Note 19 for disclosure of all amounts related to the health insurer fee for the Company.

Federal and state income taxes

The Company is included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries pursuant to the terms of a tax sharing agreement. In accordance with a written tax sharing agreement with an affiliate, the Company's current federal and state income tax provisions are generally computed as if the Company were filing a separate federal and state income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent realized in the consolidated return. Pursuant to this agreement, the Company has the enforceable right to recoup federal and state income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal and state income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets ("DTAs") and liabilities ("DTLs") represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized ("adjusted gross DTAs"). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a. b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Service ("IRS") tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the Statutory Statements of Assets, Liabilities, Capital and Surplus adjusted to exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

   The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus

capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains (losses)", also a separate component of gains and losses in surplus.

Going concern

As of June 1, 2017, management has evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

3. Accounting changes and corrections of errors

The Company did not have any accounting changes or corrections of errors in the year ended December 31, 2016.

4. Special deposits

Special deposits, included in bonds, consist of a U.S. Treasury Note with a book value of $1,243,381 at December 31, 2016. This asset is restricted in accordance with certain state requirements relating to HMOs.

5. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments, which include special deposits, cash equivalents, and short-term investments, at December 31, 2016:

December 31, 2016

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$48,921,376	$48,921,376	$58,344	($24,370)	$48,955,350
All other government	32,179,534	31,994,864	936,919	(222,005)	32,709,778
U.S. states, territories and possessions (direct and guaranteed)	31,262,925	31,262,925	105,082	(464,898)	30,903,109
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	44,006,730	44,006,731	813,775	(385,162)	44,435,344
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	133,391,254	133,391,254	2,662,112	(530,150)	135,523,216
Industrial and miscellaneous (unaffiliated)	238,564,944	238,468,490	2,507,928	(2,761,869)	238,214,549
Cash equivalents and short-term investments	1,008,366	1,008,366	-	-	1,008,366
Total	$529,335,129	$529,054,006	$7,084,160	($4,388,454)	$531,749,712

Summarized below are the Company's bonds and other financial instruments, which include special deposits, with unrealized losses at December 31, 2016, along with the related fair values, aggregated by the length of time the investments have been in an unrealized loss position:

December 31, 2016

	Less than 12 months			Greater than 12 months		
	Number of Securities	Fair value	Unrealized losses	Number of Securities	Fair value	Unrealized losses
U.S. government	2	$5,782,198	($24,370)	-	-	-
All other government	12	7,990,505	(222,005)			
U.S. states, territories and possessions (direct and guaranteed)	7	12,508,280	(380,495)	2	1,615,380	(84,403)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	8	15,779,871	(385,162)	-	-	-
U.S. special revenue and assessment obligations and all non–guaranteed obligations of agencies and authorities of governments and their political subdivisions	26	40,044,421	(510,233)	1	888,655	(19,917)
Industrial and miscellaneous (unaffiliated)	69	124,176,634	(2,761,869)	-	-	-
Total	124	$206,281,909	($4,284,134)	3	$2,504,035	($104,320)

December 31, 2016

	Total		
	Number of Securities	Fair value	Unrealized losses
U.S. government	2	$5,782,198	($24,370)
All other government	12	7,990,505	(222,005)
U.S. states, territories and possessions (direct and guaranteed)	9	14,123,660	(464,898)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	8	15,779,871	(385,162)
U.S. special revenue and assessment obligations and all non–guaranteed obligations of agencies and authorities of governments and their political subdivisions	27	40,933,076	(530,150)
Industrial and miscellaneous (unaffiliated)	69	124,176,634	(2,761,869)
Total	127	$208,785,944	($4,388,454)

The Company has reviewed the investments in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. In performing this review, we considered factors such as the quality of the investment security based on research performed by external rating agencies and internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Furthermore, the Company has no intention to sell the investments in the table above at December 31, 2016 before their cost can be recovered and for loan-backed and structured securities the Company has the ability and intent to hold these securities for a period of time sufficient to recover the amortized cost; therefore, no OTTI was determined to have occurred on these investments. In determining if the Company needs to sell before full recovery of value, the Company considers the forecasted recovery period, expected investment returns relative to other funding sources, projected cash flow and capital requirements, regulatory obligations, and other factors. Unrealized losses at December 31, 2016 associated with the Company's bond portfolio were primarily driven by higher U.S. Treasury yields in 2016 over 2015.

The contractual or expected maturities of bonds, cash equivalents and short-term investments at December 31, 2016 were as follows:

	Carrying value	Fair value
Due one year or less	$36,525,553	$36,605,694
Due after one year through five years	274,608,080	276,017,865
Due after five years through ten years	191,893,927	192,559,190
Due after ten years	26,026,446	26,566,963
Total	$529,054,006	$531,749,712

The maturity for a mortgage pass-through security, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association (“FNMA”) and Government National Mortgage Association (“GNMA”) pools.

Proceeds from the sales of bonds were $91,507,321 in 2016. Proceeds from the maturities of bonds were $38,386,677 in 2016. Gross realized gains on sales of bonds were $1,993,677 in 2016. Gross realized losses on sales of bonds were $401,043 in 2016. Net realized capital losses for 2016 were $1,304,172, of OTTI charges on debt securities that were in an unrealized loss position. The Company conducts regular reviews of its bond investments to assess whether a decline in fair value below carrying value in an OTTI. The Company will also recognize and OTTI on debt securities when we intend to sell a security that is in an unrealized loss position. Declines deemed to be OTTI are recognized as realized capital losses. The Company had no individually material realized capital losses on debt or equity securities that impacted its results of operation in 2016.

The Company’s unrealized loss position on loan-backed and structured securities held by the Company at December 31, 2016 is as follows:

December 31, 2016

a. The aggregate amount of unrealized losses:

1. Less than 12 months	$1,168,947
2. 12 months or longer	-

b. The aggregate related fair value of securities with unrealized losses:

1. Less than 12 months	$37,947,977
2. 12 months or longer	-

The Company held no loan-backed and structured securities in an unrealized loss position at 2016.

The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R - *Loan-Backed and Structured Securities* ("SSAP No. 43R") in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at December 31, 2016 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

There was no investment income due and accrued excluded from surplus at December 31, 2016.

Restricted assets (including pledged)

The Company had $1,243,381 on deposit with regulatory bodies, which represented 0.2% of total admitted assets at December 31, 2016.

The Company did not have any 5* securities at December 31, 2016.

The Company did not have any assets pledged as collateral not captured in other categories at December 31, 2016.

The Company did not have any other restricted assets at December 31, 2016.

6. Financial instruments

Financial instruments measured at fair value in the financial statements

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2016 were as follows:

December 31, 2016

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3
Bonds, short--term investments and cash equivalents	$531,749,712	$529,054,006	$44,414,218	$487,335,494	-

The valuation methods and assumptions used by the Company in estimating the fair value of debt securities are discussed in Note 2.

There were no realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets during 2016. There were no transfers between the Company's Level 1 or 2 financial assets during 2016.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

7. Information concerning Parent, subsidiaries, and affiliates

As of and for the year ended December 31, 2016, the Company had the following significant transactions with affiliates:

The Company and Aetna Medicaid Administrators LLC (formerly Schaller Anderson, LLC) ("AMA"), indirectly a wholly-owned subsidiary of Aetna, are parties to an administrative services agreement, under which AMA provides certain administrative services, including accounting and processing of premiums and claims on the Company's Kentucky Medicaid business. Under this agreement, the Company remits a percentage of its earned premium revenue, as applicable, to AMA as a fee. For these services, the Company was charged $85,417,543 in 2016. The agreement also provides for interest on all intercompany balances. There was no interest earned (incurred) on amounts due from (to) affiliates in 2016. This agreement was assigned to ABH-KY as of February 1, 2016.

As explained in Note 2, the Company participates in a tax sharing agreement with Aetna and Aetna's other subsidiaries. All federal income tax receivables/payables are due from/due to Aetna.

Prior to March 1, 2016, the Company has coverage for certain litigation exposures ($10,000,000 per claim and in the aggregate including defense costs) through an affiliated captive insurance company.

At December 31, 2016, the Company had the following amounts due to and due from affiliates:

	December 31, 2016
Amounts due to affiliates	
Aetna, Inc.	$35,846,400
Aetna Medicaid Administrators LLC	47,081,156
	$82,924,556
Amounts due from affiliates	
Coventry Health and Life Insurance Co.	$3,657,643
	$3,657,643

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

8. Health care receivables

Pharmaceutical rebates

The Company is a party to an agreement which enables the Company to receive manufacturers' pharmacy rebates from Aetna Health Management, LLC ("AHM") under which the Company remits a percentage of its earned pharmaceutical rebates to AHM as a fee. The Company earned pharmaceutical rebates of $7,649,870, which were recorded as a reduction of medical costs, in 2016. The Company was charged $327,962, which were recorded as administrative expenses, for these services in 2016. At December 31, 2016, the Company reported $1,920,365, as amounts due from AHM related to the pharmaceutical

rebates which were reflected in health care and other amounts receivable. The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

The following table discloses the quarterly revenue and subsequent cash collections relating to the pharmaceutical rebates discussed in Note 2:

Quarter	Estimated pharmacy rebates as reported on financial statements	Pharmacy rebates as invoiced/ confirmed	Actual rebates collected within 90 days of invoicing/ confirmation	Actual rebates collected within 91 to 180 days of invoicing/ confirmation	Actual rebates collected more than 180 days after invoicing/ confirmation
12/31/2016	$1,920,365	-	-	-	-
9/30/2016	2,143,692	2,143,692	-	-	-
6/30/2016	1,876,911	1,876,906	640,940	-	-
3/31/2016	696,424	708,498	216,827	361,714	-

[1] Represents a portion of the estimated rebates for the quarter ended December 31, 2016, which were paid by AHM to the Company prior to December 31, 2016 and invoicing in 2016.

Other receivables

The Company reported $3,130,393 of provider related claims receivables at December 31, 2016.

9. Income taxes

The components of the net DTAs recognized in the Company's Statutory Statements of Assets and Liabilities, Capital and Surplus are as follows:

	December 31, 2016		
	Ordinary	Capital	Total
Gross DTAs	$16,609,111	$637,479	$17,246,590
Statutory valuation allowance adjustment	-	-	-
Adjusted gross DTAs	16,609,111	637,479	17,246,590
DTAs non-admitted	(2,913,647)	(342,064)	(3,255,711)
Subtotal net admitted DTAs	13,695,464	295,415	13,990,879
DTLs	-	-	-
Net admitted DTAs/(DTLs)	$13,695,464	$295,415	$13,990,879

The amount of admitted gross DTAs admitted under each component of SSAP No. 101 is as follows:

	December 31, 2016		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$13,695,464	$295,415	$13,990,879
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	-	-	-
1. Adjusted gross DTAs expected to be realized following the balance sheet date	-	-	-
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	29,917,806
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	-	-	-
(d) DTAs admitted as the result of application of SSAP No. 101	$13,695,464	$295,415	$13,990,879

	December 31, 2016
(a) Ratio percentage used to determine recovery period and threshold limitation amount	538%
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in (b)2 above	$199,452,043

The impact of tax planning strategies is as follows:

	December 31, 2016		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$16,609,111	$637,479	$17,246,590
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	0%	0%
3. Net admitted adjusted gross DTAs	$13,695,464	$295,415	$13,990,879
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	0%	0%

The Company's tax-planning strategies do not include the use of reinsurance.

There are no DTLs that were not recognized at December 31, 2016.

The provision (benefit) for income taxes for the years ended December 31, 2016 was as follows:

	2016
Federal income tax on operations	$66,703,859
Federal income tax provision on net capital (losses) gains	538,796
Federal income tax incurred	$67,242,655

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2016 were as follows:

	2016
DTAs:	
Ordinary	
Discounting of unpaid losses	$5,813,723
Non-admitted assets	7,881,741
Accrued litigation	2,913,647
Total ordinary DTAs	16,609,111
Statutory valuation allowance adjustment	-
Non-admitted ordinary DTAs	(2,913,647)
Admitted ordinary DTAs	13,695,464
Capital	
Investments	637,479
Total capital DTAs	637,479
Statutory valuation allowance adjustment	-
Non-admitted capital DTAs	(342,064)
Admitted capital DTAs	295,415
Admitted DTAs	13,990,879
DTLs:	
Ordinary	
Other	-
Ordinary DTLs	-
Capital	
Investments	-
Capital DTLs	-
Total DTLs	-
Net admitted DTAs	$13,990,879

The change in net deferred income taxes is comprised of the following:

	2016
Total DTAs	$17,246,590
Total DTLs	-
Net DTAs/(DTLs)	$17,246,590
Tax effect of unrealized gains (losses)	(98,393)
Change in net deferred income tax	$17,148,197

There was no valuation allowance adjustment to gross DTAs as of December 31, 2016, respectively.

The provision (benefit) for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference are as follows:

	December 31, 2016	Effective tax rate
Provision (benefit) computed at statutory rate	$66,318,487	35.0%
Transfer Pricing Adjustment	(5,409,234)	(2.9)%
Tax-Exempt Interest	(1,081,628)	(0.6)%
Transfer of Medicaid business	(3,156,836)	(1.7)%
Non-deductible penalties	1,305,410	0.8%
Change in Non-admitted assets	(7,881,741)	(4.2)%
Total	$50,094,458	(26.4)%
Federal and foreign income tax (benefit) expense incurred	$67,242,655	35.5%
Change in net deferred income taxes	(17,148,197)	(9.1)%
Total statutory income taxes	$50,094,458	26.4%

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm's length prices as compared to what would be charged to an unrelated entity, which results in a permanent deduction for tax reporting purposes.

At December 31, 2016, the Company had no net capital loss or net operating loss carryforwards for tax purposes.

The amount of federal income taxes incurred that are available for recoupment in the event of future net losses are:

Year	Ordinary	Capital	Total
Total	$66,705,845	$538,796	$67,244,641

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2016.

At December 31, 2016, the Company's Federal Income Tax Return was consolidated with the following entities:

Aetna Inc. - Parent Company
@ Credentials Inc.
Active Health Management Inc.
Adminco, Inc.
Administrative Enterprises, Inc.
AE Fourteen Incorporated
Aetna ACO Holdings, Inc.
Aetna Better Health Inc. (Connecticut)
Aetna Better Health Inc. (Georgia)
Aetna Better Health Inc. (Illinois)
Aetna Better Health Inc. (New Jersey)
Aetna Better Health Inc. (New York)
Aetna Better Health Inc. (Ohio)
Cofinity, Inc.
Corporate Benefit Strategies, Inc.
Coventry Consumer Advantage, Inc.
Coventry Health and Life Insurance Company
Coventry Health Care National Accounts, Inc.
Coventry Health Care National Network, Inc.
Coventry Health Care of Delaware, Inc.
Coventry Health Care of Florida, Inc.
Coventry Health Care of Illinois, Inc.
Coventry Health Care of Kansas, Inc.
Coventry Health Care of Missouri, Inc.
Coventry Health Care of Nebraska, Inc.
Coventry Health Care of the Carolinas, Inc.

Aetna Better Health Inc. (Pennsylvania)
Aetna Better Health Inc. (Tennessee)
Aetna Better Health of California Inc.
Aetna Better Health of Iowa Inc.
Aetna Better Health of Kansas, Inc.
Aetna Better Health of Kentucky Insurance Company
Aetna Better Health of Michigan Inc.
Aetna Better Health of Missouri LLC
Aetna Better Health of Nevada, Inc.
Aetna Better Health of Oklahoma, Inc.
Aetna Better Health of Texas Inc.
Aetna Better Health, Inc. (Louisiana)
Aetna Dental Inc. (New Jersey)
Aetna Dental Inc. (Texas)
Aetna Dental of California Inc.
Aetna Florida, Inc.
Aetna Health and Life Insurance Company
Aetna Health Inc. (Connecticut)
Aetna Health Inc. (Florida)
Aetna Health Inc. (Georgia)
Aetna Health Inc. (Louisiana)
Aetna Health Inc. (Maine)
Aetna Health Inc. (Michigan)
Aetna Health Inc. (New Jersey)
Aetna Health Inc. (New York)
Aetna Health Inc. (Pennsylvania)
Aetna Health Inc. (Texas)
Aetna Health Insurance Company
Aetna Health Insurance Company of New York
Aetna Health of California Inc.
Aetna Health of Utah Inc.
Aetna Health of Iowa, Inc.
Aetna HealthAssurance Pennsylvania Inc.
Aetna Insurance Company of Connecticut
Aetna Integrated Informatics, Inc.
Aetna International Inc.
Aetna Ireland Inc.
Aetna Life & Casualty (Bermuda) Ltd.
Aetna Life Assignment Company
Aetna Life Insurance Company
Aetna Risk Assurance Company of Connecticut, Inc.
Aetna Student Health Agency Inc.
AHP Holdings, Inc.
Allviant Corporation
American Health Holding, Inc.
AUSHC Holdings, Inc.
Broadspire National Services, Inc.
Bswift, LLC
Carefree Insurance Services
Claims Administration Corporation
Coventry Health Care of Virginia, Inc.
Coventry Health Care of West Virginia, Inc.
Coventry Health Care Workers Compensation, Inc.
Coventry Health Plan of Florida, Inc.
Coventry HealthCare Management Corporation
Coventry Prescription Management Services, Inc.
Coventry Rehabilitation Services, Inc.
Coventry Transplant Network, Inc.
Delaware Physicians Care, Incorporated
Echo Merger Sub, Inc.
First Health Group Corp.
First Health Life and Health Insurance Company
First Script Network Services, Inc.
Florida Health Plan Administrators, LLC
FOCUS Healthcare Management, Inc.
Futrix, Inc.
Group Dental Service of Maryland, Inc.
Group Dental Service, Inc.
Health and Human Resource Center, Inc.
Health Data & Management Solutions, Inc.
Health Re, Incorporated
HealthAmerica Pennsylvania, Inc.
HealthAssurance Pennsylvania, Inc.
Managed Care Coordinators, Inc.
Medicity Inc.
Mental Health Associates, Inc.
Mental Health Network of New York IPA, Inc.
Meritain Health, Inc.
MetraComp, Inc.
MHNet Life and Health Insurance Co.
MHNet of Florida, Inc.
Niagara Re, Inc.
PayFlex Holdings, Inc.
PayFlex Systems USA, Inc.
Performax, Inc.
Precision Benefit Services, Inc.
Prime Net, Inc.
Prodigy Health Group, Inc.
Professional Risk Management, Inc.
Resources for Living, LLC
Schaller Anderson Medical Administrators,
Strategic Resource Company
The Vasquez Group, Inc.
U.S. Health Care Properties, Inc.
Work and Family Benefits, Inc.

As explained in Note 2, the Company participates in a tax sharing agreement with its parent and affiliates.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

10. Change in claims unpaid, unpaid claims adjustment expense, and aggregate health claim reserves

The following table shows the components of the change in claims unpaid, accrued medical incentive pool and bonus amounts and unpaid claims adjustment expense for the year ended December 31, 2016:

	2016
Balance, January 1	-
Health care receivable	-
Balance, January 1, net of health care receivable	-
Incurred related to:	
Current year	799,258,593
Prior years	60,132,720
Total incurred	859,391,313
Paid related to:	
Current year	632,696,289
Prior years	36,753,785
Total paid	669,450,074
Balance, December 31, net of health care receivable	189,941,239
Health care receivable	14,056,403
Balance, December 31	$203,997,642

Reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' were recorded on CH&L, reserves balances were assigned to Company February 1, 2016. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends. The Company experienced $60,132,720 of unfavorable prior year claim development due to the assignment of the Kentucky Medicaid contract from CH&L to ABH-KY. However, the business to which it relates is subject to premium adjustments.

As of December 31, 2016, accrued claim adjustment expenses were $3,294,544. These amounts have been included in the table above. The reserve is determined as a percentage of claims reserves. The Company periodically reassesses the percentage applied based on historical experience.

Net coordination of benefits is implicit in the claims incurred but not reported calculation and could not be specifically identified.

11. Capital and surplus, shareholder's dividend restrictions and quasi-reorganizations

The Company had 10,000 shares of common stock with a par value of $1.00 per share authorized, issued and outstanding at December 31, 2016.

On February 1, 2016, the CH&L's Kentucky Medicaid business was assigned to its subsidiary, ABH-KY, whereas all Kentucky Medicaid operations will be recorded by ABH-KY. Cash and related Medicaid assets and liabilities were transferred to ABH-KY. The CH&L owns a 100% interest in ABH-KY.

The Company had no shares of preferred stock issued and outstanding at December 31, 2016.

Dividend restrictions

In accordance with Kentucky statutes, the Company shall not pay any extraordinary dividend unless the Company has notified the Kentucky Department in writing at least 30 days prior thereto or such shorter period as the Kentucky Department may permit and the Kentucky Department has not disapproved it within such period. An extraordinary dividend is any dividend or other distribution which, together with other dividends and distributions made within the preceding 12 months, exceeds the greater of: ten percent of such insurer's surplus as regards policyholders as of the preceding December 31; or the net income of such insurer for the period covered by such statement, but shall not include pro rata distributions of any class of the insurer's own securities. The Company may not make a non-extraordinary dividend without prior notification to the Kentucky Department within five business days following the declaration thereto and at least ten days, commencing from the date of receipt by the Kentucky Department, prior to the payment thereof. Ordinary dividends are ultimately limited to earned surplus.

The Company did not pay any dividends to its parent in 2016. The Company received a capital contribution from its parent of $96,760,001 on February 1, 2016.

There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2016, except as noted in Note 15.

The Company did not hold any stock for any special purposes at December 31, 2016.

At December 31, 2016, there was ($182,729) of unassigned funds (surplus) that was represented or reduced by unrealized gains and losses.

The Company did not have any special surplus funds or surplus notes at December 31, 2016.

12. Contingencies

Litigation and regulatory proceedings

The following description of litigation and regulatory proceedings covers Aetna Inc. and certain of its subsidiaries, including the Company. Certain of the proceedings described below may not impact the Company directly but may have indirect impact on the Company as the Company is a member of the Aetna holding company group.

CMS Actions

The Centers for Medicare & Medicaid Services ("CMS") regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing risk adjustment data of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years or the current contract year. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, patent infringement and other intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our commercial business are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our withdrawal from certain states' health insurance exchanges ("Public Exchanges") for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum

medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "*Other Litigation and Regulatory Proceedings*," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Litigation Exposure Coverage

Effective March 1, 2016, the Company has coverage for certain litigation exposures ($10,000,000 per claim and in the aggregate including defense costs) through an unaffiliated insurance company.

Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (as amended, collectively, "Health Care Reform" or "ACA"), has made broad-based changes to the U.S. health care system. On January 20, 2017, the President signed an executive order that gives the regulatory agencies that enforce the ACA the authority to interpret regulations issued under the ACA in a way that limits fiscal burdens on states and financial or regulatory burdens on individuals, providers, health insurers and others. The practical implications of that order are unclear, and the future of the ACA is uncertain. While we anticipate efforts in 2017 and beyond to substantially modify, repeal or replace the ACA, the Company expects aspects of the ACA to continue to significantly impact the Company's business operations and operating results, including the Company's pricing, medical benefit ratios and the geographies in which the Company's products are available. Health Care Reform has presented the Company with business opportunities, but also with financial and regulatory challenges. Most of the ACA's key components were phased in during or prior to 2014, including Public Exchanges, required minimum MLRs in commercial and Medicare products, the individual coverage mandate, guaranteed issue, rating limits in individual and small group products, significant new industry-wide fees, assessments and taxes, enhanced premium rate review and disclosure processes, reduced Medicare Advantage payment rates to insurers, and linking Medicare Advantage payments to a plan's CMS quality performance ratings or "star ratings." The effects of these changes are reflected in the Company's operating results. If the ACA is not amended, repealed or replaced, certain of its components will continue to be phased in until 2020.

The Company has dedicated and expects to continue to be required to dedicate significant resources and incur significant expenses during 2017 to implement and comply with Health Care Reform and changes in Health Care Reform as well as state level health care reform. While most of the significant aspects of Health Care Reform became effective during or prior to 2014, significant parts of Health Care Reform, including aspects of nondiscrimination requirements, continue to evolve

through the promulgation of executive orders, regulations and guidance. Additional changes to Health Care Reform and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing state and federal budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or repeal or replacement of, Health Care Reform and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs will be adverse to us. Given the inherent difficulty of foreseeing the nature and scope of future changes to Health Care Reform and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact to the Company of future changes to Health Care Reform, It is reasonably possible that repeal or replacement of or other changes to Health Care Reform and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's business operations and financial results.

Potential repeal of Health Care Reform, ongoing legislative and regulatory changes to Health Care Reform, other pending efforts in the U.S. Congress to amend or restrict funding for various aspects of Health Care Reform (including risk corridors and Health Care Reform's Cost Sharing Subsidy program), the results of the 2016 presidential, congressional and state level elections, pending litigation challenging aspects of the law and federal budget negotiations continue to create uncertainty about the ultimate impact of Health Care Reform. Examples of recent legislative and regulatory changes include: the January 20, 2017 executive order relating to Health Care Reform; the November 2016 HHS announcement that risk corridor collections for the 2015 program year will be applied first to amounts owed to plans for the 2014 program year; the May 2016 final regulations relating to Health Care Reform's non-discrimination requirements; the December 2015 suspension of the health insurer fee for 2017 and two year delay of the "Cadillac" tax on high-cost employer-sponsored health coverage; the October 2015 PACE, which leaves groups with 51 to 100 employees within the large group category for each state unless the state exercises its option to include these groups within the small group category; and the October 2015 HHS announcement that Health Care Reform's risk corridor receivables for the 2014 program year would only be funded at 12.6%. With respect to pending litigation, in May 2016, the U.S. District Court for the District of Columbia ruled that the U.S. Department of Health and Human Services does not have the authority to make payments under Health Care Reform's Cost Sharing Subsidy program. Implementation of this decision has been stayed pending appeal. A final ruling that adversely impacts the Cost Sharing Subsidy program could cause significant adverse selection in individual Public Exchange products and instability in the individual Public Exchange marketplace and could have a material adverse effect on the Company's business, cash flows, financial condition and operating results as well as hinder the Company's ability to offer Public Exchange products.

As described above, the availability of funding for Health Care Reform's temporary risk corridor program is an example of this uncertainty. The Company continues to believe that receipt of any risk corridor payment from HHS for the 2016 or 2015 program year and receipt of such payments in excess of the announced prorated amount for the 2014 program year are uncertain. At December 31, 2016, the Company had no receivable for the remaining 2014 program year prorated amount that had not been collected from HHS and had no receivable for either of the 2015 or 2016 program years. In addition, these limited risk corridor payments created additional instability in the marketplace for individual commercial products in 2016 and going forward by contributing to decisions by health plans to change or stop offering their Public Exchange products. 2016 was the last program year for Health Care Reform's risk corridor program. On-going uncertainty regarding the funding of Health Care Reform-related programs and subsidies can be expected to create additional instability in the marketplace.

In addition to efforts to amend, repeal or replace Health Care Reform and the related regulations, the federal and state governments also continue to enact and seriously consider many other broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's business. The Company cannot predict whether pending or future federal or state legislation or court proceedings, including future U.S. Congressional appropriations, will change various aspects of the health care and related benefits system or Health Care Reform or the impact those changes will have on the Company's business operations or operating results, but the effects could be materially adverse.

In addition, Health Care Reform ties a portion of each Medicare Advantage plans' reimbursement to the achievement of favorable CMS quality performance measures ("star ratings"). Since 2015, only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' operating results in 2017 and going forward will be significantly affected by their star ratings.

13. Business concentrations

Assets that potentially subject the Company to credit risk consist primarily of investments in bonds and accident and health premiums due and unpaid. The Company's investments are comprised of investment-grade securities as rated by the NAIC. The Company receives advice through or assigns direct management of investments to professional investment managers selected for their expertise in various markets, within guidelines established by the Board of Directors. These guidelines include broad diversification of investments.

As further discussed in Note 17, the Company provided health benefits to Medicaid and CHIP members through its contract with the Commonwealth of Kentucky. For the years ended December 31, 2016, the Company recorded premiums under the Medicaid program of $1,046,297,492 or as a percentage of total premium revenue was 95.5% for 2016. For the years ended December 31, 2016, the Company recorded premiums under the CHIP program of $49,022,903 or as a percentage of total premium revenue was 4.5% for 2016.

14. Contractual arrangements with providers

The Company generally compensates primary care physicians through prospective compensation arrangements which incorporate quality assessment standards, comprehensiveness of care, utilization and office status components. These components are used to adjust the capitation payments to individual physician offices and to determine the amount of additional periodic payments. The Company has prospective compensation arrangements for mental health, substance abuse, diagnostic laboratory, radiology and diagnostic imaging services, podiatric treatment, physical therapy and prescription drug dispensing. The Company has contracts that provide for all-inclusive per diem and per case hospitalization rates and fixed rates for ambulatory surgery, emergency room services and specialist services. The Company has also entered into quality based compensation arrangements with certain hospitals, as well as agreements with certain integrated health delivery systems under which the systems are compensated on a substantially fixed prospective basis for medical services, including primary, specialist and hospital care. The arrangements described above cover the majority of medical expenses.

15. Minimum capital and surplus

Pursuant to the laws of the states in which the Company is licensed to do business, the Company is required to maintain a minimum surplus and capital stock as defined by the statutes and regulations of those states. The Commonwealth of Kentucky requires the Company to maintain minimum statutory surplus of $1,000,000 plus an initial free surplus of $2,000,000. At December 31, 2016, the Company was in compliance with the minimum surplus and capital stock requirements for the states in which it is licensed to do business.

The NAIC and the Commonwealth of Kentucky adopted risk-based capital ("RBC") standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company's adjusted capital and surplus to its required capital and surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of the company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2016, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

16. Retrospectively rated contracts and contracts subject to redetermination

Medical loss ratio rebates required pursuant to the Public Health Service Act

The Company is not subject to MLR rebate calculations.

Accounting for the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (collectively, "Health Care Reform") Reinsurance, Risk Adjustment and Risk Corridor (the "3Rs") pursuant to SSAP No. 107 – *Risk-Sharing Provisions of the Affordable Care Act* ("SSAP No. 107")

Reinsurance

Health Care Reform established a temporary three-year reinsurance program, under which all issuers of major medical commercial insurance products and self-insured plan sponsors are required to contribute funding in amounts set by the U.S. Department of Health and Human Services ("HHS"). A portion of the funds collected will be utilized to reimburse issuers' high claims costs incurred for qualified individual members. The expense related to this required funding is reflected in insurance, taxes, licenses and fees for all of the Company's insurance products with the exception of products associated with qualified individual members; this expense for qualified individual members is reflected as a reduction of premium revenue. When annual claim costs incurred by the Company's qualified individual members exceed a specified attachment point, the Company is entitled to certain reimbursements from this program. The Company records amounts recoverable for claims paid and unpaid and ceded claim benefit recoveries to reflect its estimate of these recoveries.

At December 31, 2016, the Company did not incur a payable or receivable under the temporary three-year reinsurance program.

Risk Adjustment

Health Care Reform established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate 2016 risk adjustment receivable or payable and reflects the impact as an adjustment to its premium revenue.

At December 31, 2016, the Company did not incur a payable or receivable under the risk adjustment program.

Risk Corridor

Health Care Reform established a temporary three-year risk sharing program for qualified individual and small group insurance plans. Under this program the Company makes (or receives) a payment to (or from) HHS based on the ratio of allowable costs to target costs (as defined by Health Care Reform). The Company records a risk corridor receivable or payable as an adjustment to premium revenue based on the Company's estimate of the ultimate 2016 risk sharing amount. At December 31, 2016, the Company did not record any Health Care Reform risk corridor receivables because payment from HHS under this program is uncertain.

At December 31, 2016, the Company did not incur a payable or receivable under the risk corridor program.

The Company will perform a final reconciliation and settlement with HHS of the 3Rs in each subsequent year.

17. Medicaid

Medicaid products are regulated by state Medicaid agencies, which have the right to audit our performance to determine compliance with their regulations. The Company's Medicaid products and CHIP contracts also are subject to federal and state regulations and oversight by state Medicaid agencies regarding the services we provide to Medicaid enrollees, payment for those services, network requirements, and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the company and other participants in Medicaid programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and the Company's Medicaid program compliance efforts will continue to require significant resources. The state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or renew existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to auto assign members to one or more of the Company's Medicaid products, exclude the Company from participating in one or more Medicaid programs and/or institute other sanctions against the Company if it fails to comply with state regulations or our contractual requirements. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or financial results, but the effects could be materially adverse.

Effective February 1, 2016, the Company entered into an Assignment Agreement with CH&L, indirectly a wholly-owned subsidiary of Aetna, whereby, CH&L assigned to ABH-KY all of their assets and liabilities arising out of or relating to Kentucky Medicaid contract.

18. Reconciliation between Audited Financial Statements and the Annual Statement

The following tables are a reconciliation of amounts previously reported to state regulatory authorities in the 2016 Annual Statement to those reported in the accompanying statutory financial statements. For the Statement of Cash Flows, the differences reflect the re-class of the Kentucky Medicaid account transfers out of operations and into non-cash activities.

	December 31, 2016
Statutory statement of cash flows:	
Net cash from operations as reported in the Company's Annual Statement	$367,021,599
Decrease in net cash from operation for Medicaid transfer	(293,674,070)
Total net cash from operation as reported in the statutory statement of cash flows	$73,347,529
Net cash from investments as reported in the Company's Annual Statement	($157,540,846)
Decrease in non-cash for ABH-KY capital contribution	(96,760,000)
Total net cash from investments as reported in the statutory statement of cash flows	($254,300,846)
Net cash from financing and miscellaneous sources as reported in the Company's Annual Statement	($206,704,473)
Increase in non-cash intercompany for ABH-KY capital contribution	96,760,000
Increase in other cash applied for Medicaid transfer	293,674,070
Total net cash from financing and miscellaneous sources as reported in the statutory statement of cash flows	$183,729,597

19. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through June 1, 2017.

The Company had no known reportable recognized subsequent events.

Type II - Non-recognized subsequent events

Subsequent events have been considered through June 1, 2017.

As discussed in Note 2, in December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the health insurer fee. As a result, there is no annual health insurance industry fee payable on September 30, 2017 and there are no amounts reflected in the Company's aggregate write-ins for special surplus funds related to this payable at December 31, 2016 as a result. There is also no resulting impact to the Company's risk based capital ("RBC") to assess as of December 31, 2016 as a result of this suspension. During 2016, the Company did not pay anything to the federal government for its portion of the health insurer fee due on September 30, 2016.

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings 1 Amount	2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities	44,358,183	8.324	44,358,183		44,358,183	8.324
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies		0.000			0	0.000
1.22 Issued by U.S. government sponsored agencies		0.000			0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	31,994,864	6.004	31,994,864		31,994,864	6.004
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations	31,262,925	5.867	31,262,925		31,262,925	5.867
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	44,006,731	8.258	44,006,731		44,006,731	8.258
1.43 Revenue and assessment obligations	124,948,313	23.447	124,948,313		124,948,313	23.447
1.44 Industrial development and similar obligations		0.000			0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	4,563,193	0.856	4,563,193		4,563,193	0.856
1.512 Issued or guaranteed by FNMA and FHLMC	7,200,821	1.351	7,200,821		7,200,821	1.351
1.513 All other	33,172,401	6.225	33,172,401		33,172,401	6.225
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA		0.000			0	0.000
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521		0.000			0	0.000
1.523 All other	21,761,200	4.084	21,761,200		21,761,200	4.084
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	148,253,583	27.821	148,253,583		148,253,583	27.821
2.2 Unaffiliated non-U.S. securities (including Canada)	36,523,425	6.854	36,523,425		36,523,425	6.854
2.3 Affiliated securities		0.000			0	0.000
3. Equity interests:						
3.1 Investments in mutual funds		0.000			0	0.000
3.2 Preferred stocks:						
3.21 Affiliated		0.000			0	0.000
3.22 Unaffiliated		0.000			0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated		0.000			0	0.000
3.32 Unaffiliated		0.000			0	0.000
3.4 Other equity securities:						
3.41 Affiliated		0.000			0	0.000
3.42 Unaffiliated		0.000			0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated		0.000			0	0.000
3.52 Unaffiliated		0.000			0	0.000
4. Mortgage loans:						
4.1 Construction and land development		0.000			0	0.000
4.2 Agricultural		0.000			0	0.000
4.3 Single family residential properties		0.000			0	0.000
4.4 Multifamily residential properties		0.000			0	0.000
4.5 Commercial loans		0.000			0	0.000
4.6 Mezzanine real estate loans		0.000			0	0.000
5. Real estate investments:						
5.1 Property occupied by company		0.000	0		0	0.000
5.2 Property held for production of income (including $ ..... of property acquired in satisfaction of debt)		0.000	0		0	0.000
5.3 Property held for sale (including $ ..... property acquired in satisfaction of debt)		0.000	0		0	0.000
6. Contract loans		0.000	0		0	0.000
7. Derivatives		0.000	0		0	0.000
8. Receivables for securities	64,705	0.012	64,705		64,705	0.012
9. Securities Lending (Line 10, Asset Page reinvested collateral)		0.000	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	4,778,660	0.897	4,778,660		4,778,660	0.897
11. Other invested assets		0.000			0	0.000
12. Total invested assets	532,889,004	100.000	532,889,004	0	532,889,004	100.000

See accompanying independent auditors' report.

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2016
(To Be Filed by April 1)

Of The Aetna Better Health of Kentucky Insurance Company

ADDRESS (City, State and Zip Code) Louisville , KY 40202

NAIC Group Code 0001 NAIC Company Code 15761 Federal Employer's Identification Number (FEIN) 47-3279217

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 563,482,728

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	PENNSYLVANIA ST GENERAL OBLIGA	Bond	$ 11,319,496	2.0 %
2.02	VIRGINIA ST PUB BLDG AUTH PUB SER A	Bond	$ 10,827,041	1.9 %
2.03	DOUGLAS CNTY NE SCH DIST 1	Bond	$ 8,327,394	1.5 %
2.04	MARYLAND STATE OF ST AND LOCAL FACS 1ST SER B	Bond	$ 8,115,898	1.4 %
2.05	SYNCHRONY CREDIT CARD MASTER SERIES 2016-2 CLASS A	Bond	$ 6,999,434	1.2 %
2.06	COMM MTGE TRUST SER 2015-CR24 CLASS A5	Bond	$ 6,457,871	1.1 %
2.07	FLORIDA DEPT ENVIRON PROTECTIO REF	Bond	$ 6,356,631	1.1 %
2.08	NEW JERSEY ST ECON DEV AUTH REF SER XX	Bond	$ 6,065,716	1.1 %
2.09	NEW JERSEY ST TRANSN TR FD TRANSPRTN PROGRAM-SER A	Bond	$ 6,047,172	1.1 %
2.10	NEW JERSEY ST EDUCTNL FAC AUTH HGR EDU CAPITAL IMPT FUND-SER	Bond	$ 5,822,432	1.0 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 385,510,098	68.4 %	3.07	P/RP-1	$	0.0 %
3.02	NAIC-2	$ 93,685,656	16.6 %	3.08	P/RP-2	$	0.0 %
3.03	NAIC-3	$ 40,929,119	7.3 %	3.09	P/RP-3	$	0.0 %
3.04	NAIC-4	$ 8,929,131	1.6 %	3.10	P/RP-4	$	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02 Total admitted assets held in foreign investments $ 66,018,801 11.7 %

4.03 Foreign-currency-denominated investments $ 0 0.0 %

4.04 Insurance liabilities denominated in that same foreign currency $ 0 0.0 %

See accompanying independent auditors' report.

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 35,521,631	6.3 %
5.02	Countries designated NAIC-2	$ 13,769,573	2.4 %
5.03	Countries designated NAIC-3 or below	$ 16,727,597	3.0 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1: Netherlands	$ 12,063,503	2.1 %
6.02	Country 2: United Kingdom	$ 8,487,947	1.5 %
	Countries designated NAIC - 2:		
6.03	Country 1: Indonesia	$ 4,022,414	0.7 %
6.04	Country 2: Colombia	$ 2,577,332	0.5 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1: Brazil	$ 4,161,803	0.7 %
6.06	Country 2: DOMINICAN REPUBLIC	$ 1,999,802	0.4 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01	SHELL INTERNATIONAL FIN SR UNSECURED	1-Bond	$ 4,987,989	0.9 %
10.02	SIEMENS FINANCIERINGSMAT SR UNSECURED	1-Bond	$ 2,997,560	0.5 %
10.03	HSBC HOLDINGS PLC SR UNSECURED	1-Bond	$ 2,989,844	0.5 %
10.04	MYLAN NV SR UNSECURED	2-Bond	$ 2,497,386	0.4 %
10.05	CRED SUIS GP FUN LTD SR UNSECURED	2-Bond	$ 2,493,307	0.4 %
10.06	MIZUHO CORP BANK LTD SR UNSECURED	1-Bond	$ 1,998,429	0.4 %
10.07	LYONDELLBASELL IND NV SR UNSECURED	2-Bond	$ 1,580,568	0.3 %
10.08	GLAXOSMITHKLINE CAP INC CO GTD	1-Bond	$ 1,502,107	0.3 %
10.09	MIZUHO FINANCIAL GROUP SR UNSECURED	1-Bond	$ 1,500,000	0.3 %
10.10	SUNTORY HOLDINGS LTD UNSECURED	2-Bond	$ 1,499,831	0.3 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$	0.0 %
11.03	Canadian-currency-denominated investments	$	0.0 %
11.04	Canadian-denominated insurance liabilities	$	0.0 %
11.05	Unhedged Canadian currency exposure	$	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$	0.0 %
12.04		$	0.0 %
12.05		$	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$	0.0 %
13.03		$	0.0 %
13.04		$	0.0 %
13.05		$	0.0 %
13.06		$	0.0 %
13.07		$	0.0 %
13.08		$	0.0 %
13.09		$	0.0 %
13.10		$	0.0 %
13.11		$	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$	0.0 %
14.04		$	0.0 %
14.05		$	0.0 %

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$	0.0 %
	Largest three investments in general partnership interests:		
15.03		$	0.0 %
15.04		$	0.0 %
15.05		$	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$	0.0 %
16.03		$	0.0 %
16.04		$	0.0 %
16.05		$	0.0 %
16.06		$	0.0 %
16.07		$	0.0 %
16.08		$	0.0 %
16.09		$	0.0 %
16.10		$	0.0 %
16.11		$	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$	0.0 %
16.13	Mortgage loans over 90 days past due	$	0.0 %
16.14	Mortgage loans in the process of foreclosure	$	0.0 %
16.15	Mortgage loans foreclosed	$	0.0 %
16.16	Restructured mortgage loans	$	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.02	91 to 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.03	81 to 90%	$	0.0 %	$	0.0 %	$	0.0 %
17.04	71 to 80%	$	0.0 %	$	0.0 %	$	0.0 %
17.05	below 70%	$	0.0 %	$	0.0 %	$	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$	0.0 %
18.03		$	0.0 %
18.04		$	0.0 %
18.05		$	0.0 %
18.06		$	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$	0.0 %
19.04		$	0.0 %
19.05		$	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
				1st Quarter	2nd Quarter	3rd Quarter
		1	2	3	4	5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$	0.0 %	$ 0	$ 0	$ 0

See accompanying independent auditors' report.

Aetna Better Health® of Kentucky Audited Financial Statement 2017

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Financial Statements - Statutory Basis

Aetna Better Health of Kentucky Insurance Company

Years Ended December 31, 2017 and 2016
with Independent Auditors' Report

KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Aetna Better Health of Kentucky Insurance Company

Report on the Financial Statements

We have audited the accompanying financial statements of Aetna Better Health of Kentucky Insurance Company, which comprise the statutory statements of assets, liabilities, capital and surplus as of December 31, 2017 and 2016, and the related statutory statements of revenue and expenses, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Kentucky Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by Aetna Better Health of Kentucky Insurance Company using statutory accounting practices prescribed or permitted by the Kentucky Department of Insurance, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

KPMG LLP is a Delaware limited liability partnership and the U.S. member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative ("KPMG International"), a Swiss entity.

The effects on the financial statements of the variances between the statutory accounting practices described in Note 2 and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting practices and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Aetna Better Health of Kentucky Insurance Company as of December 31, 2017 and 2016, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the assets, liabilities, and capital and surplus of Aetna Better Health of Kentucky Insurance Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for the years then ended, in accordance with statutory accounting practices prescribed or permitted by the Kentucky Department of Insurance described in Note 2.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the supplemental schedules titled Summary Investment Schedule and Supplemental Investment Risks Interrogatories is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Kentucky Department of Insurance. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

KPMG LLP

May 30, 2018

Aetna Better Health of Kentucky Insurance Company
As of December 31, 2017 and 2016

Statutory Statements of Assets

		Current Year			Prior Year
		Assets	Nonadmitted Assets	Net Admitted Assets	Net Admitted Assets
01	Bonds (Schedule D)	$479,236,865	$0	$479,236,865	528,045,639
02.1	Preferred stocks (Schedule D)	0	0	0	0
02.2	Common stocks (Schedule D)	0	0	0	0
03.1	Mortgage loans on real estate: First liens	12,979,171	0	12,979,171	0
03.2	Mortgage loans on real estate: Other than first liens	0	0	0	0
04.1	Properties occupied by the company	0	0	0	0
04.2	Properties held for the production of income	0	0	0	0
04.3	Properties held for sale	0	0	0	0
05	Cash ($662,507) in 2017 and $3,770,293 in 2016), cash equivalents ($14,867,395 in 2017 and $1,005,891 in 2016) and short-term investments ($0 in 2017 and $2,475 in 2016)	14,204,888	0	14,204,888	4,778,660
06	Contract loans	0	0	0	0
07	Derivatives (Schedule DB)	0	0	0	0
08	Other invested assets (Schedule BA)	0	0	0	0
09	Receivables for securities	524,756	0	524,756	64,705
10	Securities lending reinvested collateral assets (Schedule DL)	0	0	0	0
11	Aggregate write-ins for invested assets	34,419	34,419	0	0
12	Subtotals, cash and invested assets (Lines 1 to 11)	506,980,099	34,419	506,945,680	532,889,004
13	Title plants (for Title insurers only)			0	0
14	Investment income due and accrued	4,135,427	0	4,135,427	4,523,421
15.1	Uncollected premiums and agents' balances in the course of collection	1,847,707	0	1,847,707	3,365,010
15.2	Deferred premiums, agents' balances and installments booked but deferred and not yet due	0	0	0	0
15.3	Accrued retrospective premiums ($0 in 2017 and $0 in 2016) and contracts subject to redetermination $0 in 2017 and $0 in 2016)	0	0	0	0
16.1	Amounts recoverable from reinsurers	0	0	0	0
16.2	Funds held by or deposited with reinsured companies	0	0	0	0
16.3	Other amounts receivable under reinsurance contracts	0	0	0	0
17	Amounts receivable relating to uninsured plans	0	0	0	0
18.1	Current federal and foreign income tax recoverable and interest thereon	0	0	0	0
18.2	Net deferred tax asset	9,978,560	141,699	9,836,861	13,990,879
19	Guaranty funds receivable or on deposit	0	0	0	0
20	Electronic data processing equipment and software	0	0	0	0
21	Furniture and equipment, including health care delivery assets	0	0	0	0
22	Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23	Receivables from parent, subsidiaries and affiliates	2,265,216	127	2,265,089	3,657,643
24	Health care ($1,758,384 in 2017 and $5,050,758 in 2016) and other amounts receivable	27,088,688	25,330,304	1,758,384	5,050,758
25	Aggregate write-ins for other than invested assets	500,000	500,000	0	6,013
26	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	552,795,697	26,006,549	526,789,148	563,482,728
27	From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28	Total (Lines 26 and 27)	$552,795,697	$26,006,549	$526,789,148	$563,482,728

	Details of Write-Ins				
1101	Mortgage loan suspense	$34,419	$34,419	$0	$0
1102		0	0	0	0
1199	Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	34,419	34,419	0	0
2501	Deposits	500,000	500,000	0	0
2502	Miscellaneous Recoveries	0	0	0	6,013
2503		0	0	0	0
2599	Totals (Lines 2501 thru 2503) (Line 25 above)	$500,000	$500,000	$0	$6,013

See accompanying notes to statutory financial statements.

Aetna Better Health of Kentucky Insurance Company

As of December 31, 2017 and 2016

Statutory Statements of Liabilities, Capital and Surplus

		Current Year	Prior Year
		Total	Total
01	Claims unpaid (less $0 in 2017 and $0 in 2016 reinsurance ceded)	$159,039,981	$181,498,823
02	Accrued medical incentive pool and bonus amounts	190,629	19,204,275
03	Unpaid claim adjustment expenses	3,072,860	3,294,544
04	Aggregate health policy reserves, including the liability of $0 in 2017 and $0 in 2016 for medical loss ratio rebate per the Public Health Service Act	0	31,898,076
05	Aggregate life policy reserves	0	0
06	Property/casualty unearned premium reserves	0	0
07	Aggregate health claim reserves	0	0
08	Premiums received in advance	31,811,757	0
09	General expenses due or accrued	12,641,664	14,248,157
10.1	Current federal and foreign income tax payable and interest thereon	8,105,131	14,001,739
10.2	Net deferred tax liability	0	0
11	Ceded reinsurance premiums payable	0	0
12	Amounts withheld or retained for the account of others	0	0
13	Remittances and items not allocated	2,849,167	2,725,913
14	Borrowed money and interest thereon	0	0
15	Amounts due to parent, subsidiaries and affiliates	45,303,713	82,924,556
16	Derivatives	0	0
17	Payable for securities	0	0
18	Payable for securities lending	0	0
19	Funds held under reinsurance treaties (with $0 in 2017 and $0 in 2016 unauthorized reinsurers)	0	0
20	Reinsurance in unauthorized and certified	0	0
21	Net adjustments in assets and liabilities due to foreign exchange rates	0	0
22	Liability for amounts held under uninsured plans	0	0
23	Aggregate write-ins for other liabilities	1,851,899	243,723
24	Total liabilities (Lines 1 to 23)	264,866,801	350,039,806
25	Aggregate write-ins for special surplus funds	22,555,000	0
26	Common capital stock	1,000,000	10,000
27	Preferred capital stock	0	0
28	Gross paid in and contributed surplus	99,010,001	100,000,001
29	Surplus notes	0	0
30	Aggregate write-ins for other than special surplus funds	0	0
31	Unassigned funds (surplus)	139,357,346	113,432,921
32.1	Less treasury stock, at cost: 0 shares common	0	0
32.2	Less treasury stock, at cost: 0 shares preferred	0	0
33	Total capital and surplus (Lines 25 to 31 minus Line 32)	261,922,347	213,442,922
34	Total liabilities, capital and surplus (Lines 24 and 33)	$526,789,148	$563,482,728

	Details of Write-Ins		
2301	Escheat Payable	$1,851,899	$243,723
2302		0	0
2399	Totals (Lines 2301 thru 2302) (Line 23 above)	$1,851,899	$243,723
2501	Estimated Health Insurer Fee Accrual	$22,555,000	$0
2502		0	0
2599	Totals (Lines 2501 thru 2503) (Line 25 above)	$22,555,000	$0

See accompanying notes to statutory financial statements.

Aetna Better Health of Kentucky Insurance Company

For years ended December 31, 2017 and 2016

Statutory Statements of Revenue and Expenses

	Current Year	Prior Year
01 Line not used	Total	Total
02 Net premium income	$1,092,625,603	$1,095,320,395
03 Change in unearned premium reserves and reserve for rate credits	31,898,076	16,584,485
04 Fee-for-service	0	0
05 Risk revenue	0	0
06 Aggregate write-ins for other health care related revenues	0	0
07 Aggregate write-ins for other non-health revenues	0	0
08 Total revenues (Lines 2 to 7)	1,124,523,679	1,111,904,880
09 Hospital/medical benefits	609,008,492	484,793,030
10 Other professional services	49,453,749	48,894,617
11 Outside referrals	0	0
12 Emergency room and out-of-area	89,732,481	91,927,078
13 Prescription drugs	220,118,361	206,794,380
14 Aggregate write-ins for other hospital and medical	0	0
15 Incentive pool, withhold adjustments and bonus amounts	(7,740,581)	0
16 Subtotal (Lines 9 to 15)	960,572,502	832,409,105
17 Net reinsurance recoveries	0	0
18 Total hospital and medical (Lines 16 minus 17)	960,572,502	832,409,105
19 Non-health claims (net)	0	0
20 Claims adjustment expenses	28,389,145	26,982,208
21 General administrative expenses	69,029,357	73,586,635
22 Increase in reserves for life and accident and health contracts	0	0
23 Total underwriting deductions (Lines 18 through 22)	1,057,991,004	932,977,948
24 Net underwriting gain (Lines 8 minus 23)	66,532,675	178,926,932
25 Net investment income earned	14,019,102	10,265,995
26 Net realized capital gains less capital gains tax of $216,907 in 2017 $538,796 in 2016	637,847	(250,334)
27 Net investment gains (Lines 25 plus 26)	14,656,949	10,015,661
28 Net gain or (loss) from agents' or premium balances charged off	0	0
29 Aggregate write-ins for other income or expenses	(4,535,812)	0
30 Net income after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	76,653,812	188,942,593
31 Federal and foreign income taxes incurred	20,912,254	66,703,859
32 Net income	$55,741,558	$122,238,734

Details of Write-Ins		
2901 Regulatory penalties	($4,535,812)	$0
2902	0	0
2999 Totals (Lines 2901 thru 2902) (Line 29 above)	($4,535,812)	$0

See accompanying notes to statutory financial statements.

Aetna Better Health of Kentucky Insurance Company

For years ended December 31, 2017 and 2016

Statutory Statements of Changes in Capital and Surplus

		Current Year	Prior Year
33	Capital and surplus prior reporting year	$213,442,922	$3,253,690
34	Net income from Line 32	55,741,558	122,238,734
35	Change in valuation basis of aggregate policy and claim reserves	0	0
36	Change in net unrealized capital (losses) less capital gains tax of $89,227 in 2017 and ($98,393) in 2016	148,249	(182,730)
37	Change in net unrealized foreign exchange capital gain or (loss)	0	0
38	Change in net deferred income tax	(7,178,803)	17,148,197
39	Change in nonadmitted assets	(231,579)	(25,774,970)
40	Change in unauthorized and certified reinsurance	0	0
41	Change in treasury stock	0	0
42	Change in surplus notes	0	0
43	Cumulative effect of changes in accounting principles	0	0
44.1	Capital Changes: Paid in	990,000	0
44.2	Transferred from surplus (Stock Dividend)	0	0
44.3	Transferred to surplus	0	0
45.1	Surplus adjustments: Paid in	(990,000)	96,760,001
45.2	Transferred to capital (Stock Dividend)	0	0
45.3	Transferred from capital	0	0
46	Dividends to stockholders	0	0
47	Aggregate write-ins for gains or (losses) in surplus	0	0
48	Net change in capital and surplus (Lines 34 to 47)	48,479,425	210,189,232
49	Capital and surplus end of reporting period (Line 33 plus 48)	$261,922,347	$213,442,922

See accompanying notes to statutory financial statements.

Aetna Better Health of Kentucky Insurance Company

For years ended December 31, 2017 and 2016

Statutory Statements of Cash Flows

		Current Year	Prior Year
01	Premiums collected net of reinsurance	$1,125,954,663	$1,078,899,497
02	Net investment income	17,511,807	8,615,108
03	Miscellaneous income	0	0
04	Total (Lines 1 to 3)	1,143,466,470	1,087,514,605
05	Benefit and loss related payments	1,002,057,647	865,632,083
06	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0
07	Commissions, expenses paid and aggregate write-ins for deductions	103,782,491	95,292,091
08	Dividends paid to policyholders	0	0
09	Federal and foreign income taxes paid (recovered) net of $0 in 2017 and $0 in 2016 tax on capital	27,025,769	53,242,902
10	Total (Lines 5 through 9)	1,132,865,907	1,014,167,076
11	Net cash from operations (Line 4 minus Line 10)	10,600,563	73,347,529
12.1	Proceeds - Bonds	116,787,533	129,894,025
12.2	Stocks	0	0
12.3	Mortgage loans	0	0
12.4	Real estate	0	0
12.5	Other invested assets	0	0
12.6	Net gains or (losses) on cash, cash equivalents and short-term investments	(470)	314
12.7	Miscellaneous proceeds	0	1,501
12.8	Total investment (Lines 12.1 to 12.7)	116,787,063	129,895,840
13.1	Cost of investments - Bonds	69,990,769	384,131,981
13.2	Stocks	0	0
13.3	Mortgage loans	12,979,171	0
13.4	Real estate	0	0
13.5	Other invested assets	0	0
13.6	Miscellaneous applications	494,470	64,705
13.7	Total investments acquired (Lines 13.1 to 13.6)	83,464,410	384,196,686
14	Net increase (or decrease) in contract loans and premium notes	0	0
15	Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)	33,322,653	(254,300,846)
16.1	Surplus notes, capital notes	0	0
16.2	Capital and paid in surplus, less treasury stock	0	96,760,001
16.3	Borrowed funds	0	0
16.4	Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5	Dividends to stockholders	0	0
16.6	Other cash provided (applied)	(34,496,988)	86,969,596
17	Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5 plus Line 16.6)	(34,496,988)	183,729,597
18	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	9,426,228	2,776,280
19.1	Cash, cash equivalents and short term investments - Beginning of year	4,778,660	2,002,380
19.2	Cash, cash equivalents and short term investments - End of period (Line 18 plus Line 19.1)	$14,204,888	$4,778,660

Supplemental disclosures of cash flow information for non-cash transactions

20.0001	Non-Cash Bond Transactions	$12,655,315	$292,173,965
20.0002	Uncollected premiums and other assets transferred	0	8,797,261
20.0003	Claims unpaid and other liabilities transferred	0	(304,631,507)

See accompanying notes to statutory financial statements.

1. Organization and operation

Aetna Better Health of Kentucky Insurance Company Inc. (the "Company" or "ABH-KY") is a wholly-owned subsidiary of Coventry Health and Life Insurance Company, Inc. ("CH&L") whose ultimate parent is Aetna Inc. ("Aetna").

The Company contracts with the Commonwealth of Kentucky Department of Health and Human Services to provide health benefits to Medicaid and Children's Health Insurance Program ("CHIP") members. The Commonwealth of Kentucky expansion of Medicaid services on January 1, 2014 for coverage of populations including individuals, families regardless of status, up to 138% of the Federal Poverty Level. The expansion of this contract operates under the previous Medicaid contract and recipients receive the same benefits. The Company's current contract with Commonwealth runs through June 30, 2018.

The Commonwealth of Kentucky enacted the Section 1115 Demonstration Waiver known as Kentucky Helping to Engage and Achieve Long Term Health ("HEALTH") and is scheduled to be implemented July 1, 2018. A new contract to include Medicaid membership as noted above and the Kentucky HEALTH membership is currently being reviewed for contract period of July 1, 2018 to June 30, 2019.

Effective February 1, 2016, the Company entered into an Assignment Agreement with CH&L, whereby, CH&L assigned and sent over to the Company all of their assets and liabilities arising out of or relating to CH&L's operation of the Kentucky Medicaid plan, whether arising before, on or after the date of the agreement. The purchase price for the assets was the difference between the value of the sum of the assets, $9 million, and the sum of the liabilities, $305 million, on the books of the Company as of February 1, 2016, the effective date.

2. Summary of significant accounting policies

Accounting practices

The accompanying statutory financial statements of the Company have been prepared in conformity with accounting practices prescribed or permitted by the Kentucky Department of Insurance ("KY DOI") (Kentucky Accounting Practices"). KY DOI recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP"). The Company's net income and capital and surplus as stated on a NAIC SAP basis and on the basis of practices prescribed or permitted by the Commonwealth of Kentucky were the same as of and for the years ended December 31, 2017 and 2016.

Kentucky Accounting Practices vary from U.S. generally accepted accounting principles ("GAAP"). The primary differences include the following:

- Certain assets, designated as non-admitted assets (in part, uncollected premiums are non-admitted in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 6, *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers*) are not recorded as assets, but are charged to surplus. Thus, non-admitting uncollected premiums eliminates the need for a separate allowance for doubtful accounts, which is utilized under GAAP;
- Certain assets, designated as non-admitted assets (other receivables and prepaid capitation, which are non-admitted in accordance with SSAP No. 4 - *Assets and Non-admitted Assets*) are not recorded as assets, but are charged to surplus. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests are not recognized on the Statutory Statement of Assets, and are, therefore, considered non-admitted;
- Bonds are recorded at amortized cost except for those with an NAIC designation of 3 through 6, which are reported at the lower of amortized cost or fair value. Therefore, changes in unrealized gains and losses for those securities held at amortized cost are not reflected in the financial statements. Under GAAP, bonds classified as available for sale are

recorded at fair value, and related changes in unrealized gains and losses are recorded as a component of equity, net of deferred federal income taxes;

- Deferred tax assets and liabilities are determined and admitted in accordance with SSAP No. 101, *Income Taxes* ("SSAP No. 101"). Changes in net deferred tax assets and liabilities are reflected as changes in surplus, whereas under GAAP, changes in such assets and liabilities are reflected in net income. In addition, statutory accounting requires consideration of a statutory allowance adjustment in the calculation of adjusted gross deferred tax assets and an admissibility test for deferred tax assets;
- In accordance with SSAP No. 2, -Revised- *Cash, Cash Equivalents, Drafts, and Short-term Investments*, certain short-term borrowings are classified as a reduction of cash, cash equivalents, and short-term investments. Under GAAP, these amounts would have been classified as liabilities; and
- Cash, cash equivalents, and short-term investments in the statutory statements of cash flows represents cash balances and investments with remaining maturities of one year or less at the time of acquisition. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less. The statement does not classify cash flows consistent with GAAP and a reconciliation of net earnings to net cash provided by operations is not provided.

There were no permitted practices by the Commonwealth of Kentucky for the year ended December 31, 2017 and 2016.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Kentucky Statutory Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenue and expenses. Actual results could differ from those estimates.

Significant accounting policies

The Company applies the following significant accounting policies:

Cash, cash equivalents and short-term investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value.

Bonds

Bonds, which include special deposits as discussed more fully in Note 4, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections at December 31, 2017 and 2016. Bonds include all investments whose maturity is greater than one year when purchased.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities ("LB&SS"), an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For LB&SS, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the Statutory Statements of Liabilities, Capital and Surplus date and (1) the Company intends to sell the investment, or (2) the Company does not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the Statutory Statements of Liabilities, Capital and Surplus date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

For the Company's bonds and LB&SS that provide for a prepayment penalty or acceleration fee in the event the bond is liquidated prior to its scheduled termination date, the Company reports such fees as investment income when earned.

Mortgage Loans on Real Estate

Mortgage loans on real estate ("Mortgage Loans") are carried at unpaid principal balances, adjusted for accrual of discounts and amortization of premiums. Mortgage loans funding and repayments are recorded on the closing date. Fair values are estimated by discounting expected mortgage loan cash flows at market rates that reflect the rates at which similar loans would be made to similar borrowers. These rates reflect management's assessment of the credit quality and the remaining duration of the loans. The fair value estimates of mortgage loans of lower credit quality, including problem and restructured loans, are based on the estimated fair value of the underlying collateral. Payment receipts on impaired loans are recorded on the cash basis. The Company recognizes interest income on impaired loans when received. The Company considers a loan impaired when it is probable that the loan will be uncollectible based on its contractual terms. The Company measures the impairment based on the fair value of the collateral less estimated costs to obtain and sell. The difference between the net value of the collateral and the recorded investment in the mortgage loan is recorded as a valuation allowance with a corresponding charge to unrealized loss. If the impairment is deemed other-than-temporary, a write-down is recognized as a realized loss, and a new cost basis is established. This new cost basis is not changed for subsequent recoveries in value. Mortgage loans for which foreclosure is probable are considered impaired.

Investment income due and accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2017 and 2016, the Company did not have any non-admitted investment income due and accrued.

Premiums and amounts due and unpaid

Premium revenue for prepaid health care products is recognized as income in the month in which enrollees are entitled to health care services. Premiums collected before the effective period are reported as premiums received in advance.

Non-admitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances.

Pharmaceutical rebate receivables

The Company estimates pharmaceutical rebate receivables based upon historical payment trends, actual utilization and other variables. Pharmaceutical rebates for a quarter are billed to the vendor within one month of the completion of the quarter with any adjustment to previously recorded amounts reflected at the time of billing. The Company reports pharmaceutical rebate receivables as health care receivables. Pharmacy rebate receivables not in accordance with SSAP No. 84 – *Health Care and Government Insured Plan Receivables* or are over 90 days past due are non-admitted. All rebates are processed and settled with an affiliated entity. The pharmaceutical rebate receivables are more fully discussed in Note 8.

Hospital and medical costs and claims adjustment expenses and related reserves

Hospital and medical costs consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health claim reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Statutory Statements of Assets and Liabilities, Capital and Surplus date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, contract requirement changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in hospital and medical costs in the Statutory Statements of Revenue and Expenses in the period they are determined. Capitation costs, which are recorded in hospital and medical expenses in the Statutory Statements of Revenue and Expenses, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

Claims adjustment expenses, which include cost containment expenses, represent costs incurred related to the claims settlement process such as costs to record, process and adjust claims. These expenses are included in the Company's management agreement with an affiliate in Note 7.

Aggregate health policy reserves and related expenses

Premium deficiency reserves ("PDR") are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Where allowed, anticipated investment income is considered in the calculation of any PDR. For purposes of calculating a PDR, contracts are grouped in manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts. The Company had no PDR accrual at December 31, 2017 and 2016.

As a part of the Company's Kentucky Medicaid business, a risk corridor accrual related to the Federal Affordable Care Act ("ACA") expansion members has been established. Per the Medicaid contract, the Commonwealth of Kentucky has a symmetrical risk corridor established around a targeted medical loss ratio. Based on the contractual requirements, the Company recorded a liability of $0 and $31,898,076 at December 31, 2017 and 2016 within the Aggregate Health Policy Reserve line on the Statutory Statement of Liabilities, Capital and Surplus.

Fees Paid to the Federal Government by Health Insurers

SSAP No. 106 – *Affordable Care Act Section 9010 Assessment* ("SSAP No. 106") required (1) that the health insurer fee be recognized in full on January 1 of the fee year (the calendar year in which the assessment must be paid to the federal government), in the operating expense category of insurance taxes, licenses and fees, excluding federal income taxes and (2) that in each data year preceding a fee year a reporting entity pro-ratably accrue by reclassifying from unassigned funds (surplus) to aggregate write-ins for special surplus funds an amount equal to its estimated subsequent fee year assessment. This reclassification has no impact on total capital and surplus and is reversed in full on January 1 of the fee year. In December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the health insurer fee. As interpreted in INT 16-01: ACA Section 9010 Assessment 2017 Moratorium, because there was not an ACA Section 9010 fee due in September 2017, there was not an accrual of a liability on January 1, 2017 based on 2016 data year net written premiums. Accrual of a liability on January 1, 2018 for the ACA Section 9010 assessment based on 2017 data year net written premiums and the reclassification from unassigned funds (surplus) to aggregate write-ins for special surplus funds equal to the estimated 2018 fee year assessment accrued in data year 2017 both continued as prescribed under SSAP No. 106. See Note 17 for disclosure of all amounts related to the health insurer fee for the Company.

Federal and state income taxes

The Company is included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries pursuant to the terms of a tax sharing agreement. In accordance with a written tax sharing agreement with an affiliate, the Company's current federal and state income tax provisions are generally computed as if the Company were filing a separate federal and state income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent realized in the consolidated return. Pursuant to this agreement, the Company has the enforceable right to recoup federal and state income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal and state income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets ("DTAs") and liabilities ("DTLs") represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized ("adjusted gross DTAs"). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a. b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Service ("IRS") tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the Statutory Statements of Assets, Liabilities, Capital and Surplus adjusted to exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains (losses)", also a separate component of gains and losses in surplus.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "TCJA") was enacted. Among other things, the TCJA reduced the federal corporate income tax rate to 21 percent effective January 1, 2018. See Note 9 or the impact that the TCJA had on the Company.

Going concern

As of May 30, 2018, management has evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

3. Accounting changes and corrections of errors

The Company did not have any accounting changes in the year ended December 31, 2017 and 2016 or corrections of errors in the year ended December 31, 2017.

During 2016, the Company corrected the Statement of Cash Flows, for differences reflected in the re-class of the Company's Kentucky Medicaid business transfers out of operations and into non-cash activities.

4. Special deposits

Special deposits, included in bonds, consist of a U.S. Treasury Note with a book value of $1,241,056 and $1,243,381 at December 31, 2017 and 2016. This asset is restricted in accordance with certain state requirements relating to health maintenance organizations ("HMO").

5. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments, which include special deposits, cash equivalents, and short-term investments, at December 31, 2017 and 2016:

December 31, 2017

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$52,347,259	$52,347,259	$20,571	($102,213)	$52,265,617
All other government	26,042,556	26,042,548	2,026,870	(39,748)	28,029,670
U.S. states, territories and possessions (direct and guaranteed)	42,907,202	42,907,202	555,988	(148,042)	43,315,148
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	27,016,736	27,016,735	730,986	(25,943)	27,721,778
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	148,991,123	148,991,125	4,551,898	(185,569)	153,357,454
Industrial and miscellaneous (unaffiliated)	196,843,031	196,799,391	1,956,994	(1,458,839)	197,297,546
Total	$494,147,907	$494,104,260	$9,843,307	($1,960,354)	$501,987,213

December 31, 2016

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$48,923,852	$48,923,852	$58,344	($24,370)	$48,957,826
All other government	32,179,533	31,994,864	936,919	(222,005)	32,709,778
U.S. states, territories and possessions (direct and guaranteed)	31,262,925	31,262,925	105,083	(464,898)	30,903,110
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	44,006,730	44,006,731	813,774	(385,162)	44,435,343
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	133,391,254	133,391,254	2,662,112	(530,150)	135,523,216
Industrial and miscellaneous (unaffiliated)	239,570,834	239,474,380	2,507,928	(2,761,869)	239,220,439
Total	$529,335,128	$529,054,006	$7,084,160	($4,388,454)	$531,749,712

Summarized below are the Company's bonds and other financial instruments, which include special deposits, with unrealized losses at December 31, 2017 and 2016, along with the related fair values, aggregated by the length of time the investments have been in an unrealized loss position:

December 31, 2017

	Less than 12 months			Greater than 12 months		
	Number of Securities	Fair value	Unrealized losses	Number of Securities	Fair value	Unrealized losses
U.S. government	1	$2,995,910	($182)	2	$4,680,916	($102,031)
All other government	2	1,032,592	(9,241)	1	1,468,028	(30,507)
U.S. states, territories and possessions (direct and guaranteed)	-	-	-	1	5,650,300	(148,043)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	4	2,869,797	(25,943)	-	-	-
U.S. special revenue and assessment obligations and all non–guaranteed obligations of agencies and authorities of governments and their political subdivisions	22	31,154,282	(144,093)	3	2,283,852	(41,476)
Industrial and miscellaneous (unaffiliated)	35	40,380,736	(220,522)	29	65,081,155	(1,238,316)
Total	64	$78,433,317	($399,981)	36	$79,164,251	($1,560,373)

December 31, 2017

	Total		
	Number of Securities	Fair value	Unrealized losses
U.S. government	3	$7,676,826	($102,213)
All other government	3	2,500,620	(39,748)
U.S. states, territories and possessions (direct and guaranteed)	1	5,650,300	(148,043)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	4	2,869,797	(25,943)
U.S. special revenue and assessment obligations and all non–guaranteed obligations of agencies and authorities of governments and their political subdivisions	25	33,438,134	(185,569)
Industrial and miscellaneous (unaffiliated)	64	105,461,891	(1,458,838)
Total	100	$157,597,568	($1,960,354)

December 31, 2016

	Less than 12 months			Greater than 12 months		
	Number of Securities	Fair value	Unrealized losses	Number of Securities	Fair value	Unrealized losses
U.S. government	2	$5,782,198	($24,370)	-	-	-
All other government	12	7,990,505	(222,005)			
U.S. states, territories and possessions (direct and guaranteed)	7	12,508,280	(380,495)	2	1,615,380	(84,403)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	8	15,779,871	(385,162)	-	-	-
U.S. special revenue and assessment obligations and all non–guaranteed obligations of agencies and authorities of governments and their political subdivisions	26	40,044,421	(510,233)	1	888,655	(19,917)
Industrial and miscellaneous (unaffiliated)	69	124,176,634	(2,761,869)	-	-	-
Total	124	$206,281,909	($4,284,134)	3	$2,504,035	($104,320)

December 31, 2016

	Total		
	Number of Securities	Fair value	Unrealized losses
U.S. government	2	$5,782,198	($24,370)
All other government	12	7,990,505	(222,005)
U.S. states, territories and possessions (direct and guaranteed)	9	14,123,660	(464,898)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	8	15,779,871	(385,162)
U.S. special revenue and assessment obligations and all non–guaranteed obligations of agencies and authorities of governments and their political subdivisions	27	40,933,076	(530,150)
Industrial and miscellaneous (unaffiliated)	69	124,176,634	(2,761,869)
Total	127	$208,785,944	($4,388,454)

The Company has reviewed the investments in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. In performing this review, we considered factors such as the quality of the investment security based on research performed by external rating agencies and internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Furthermore, the Company has no intention to sell the investments in the table above at December 31, 2017 and 2016 before their cost can be recovered and for loan-backed and structured securities the Company has the ability and intent to hold these securities for a period of time sufficient to recover the amortized cost; therefore, no OTTI was determined to have occurred on these investments December 31, 2017 and 2016. In determining if the Company needs to sell before full recovery of value, the Company considers the forecasted recovery period, expected investment returns relative to other funding sources, projected cash flow and capital requirements, regulatory obligations, and other factors. Unrealized losses at December 31, 2017 and 2016 were generally caused by the widening of market credit spreads for these securities relative to interest rates on U.S. Treasury securities.

The contractual or expected maturities of bonds, and assets receiving bond treatment, (e.g. Cash equivalents and short-term investments) at December 31, 2017 were as follows:

	Carrying value	Fair value
Due one year or less	$72,765,025	$72,772,102
Due after one year through five years	235,300,637	237,658,580
Due after five years through ten years	158,016,585	161,660,398
Due after ten years	28,022,013	29,896,133
Total	$494,104,260	$501,987,213

The maturity for a mortgage pass-through security, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association and Government National Mortgage Association pools.

Proceeds from the sales of bonds were and other financial instruments were $80,611,517 and $91,507,321 in 2017 and 2016 respectively. Proceeds from the maturities of bonds were $36,176,016 and $38,386,677 in 2017 and 2016 respectively. Gross realized gains on sales of bonds were $1,747,772 and $1,993,677 in 2017 and 2016 respectively. Gross realized losses on sales of bonds were $693,639 and $401,043 in 2017 and 2016 respectively. Included in net realized capital losses for 2017 and 2016 were $198,909 and$1,304,172, of OTTI charges on debt securities that were in an unrealized loss position. The Company conducts regular reviews of its bond investments to assess whether a decline in fair value below carrying value in an OTTI. The Company will also recognize and OTTI on debt securities when the Company intend to sell a security that is in an unrealized loss position. Declines deemed to be OTTI are recognized as realized capital losses. The Company had no individually material realized capital losses on debt or equity securities that impacted its results of operation in 2017 or 2016.

The Company's unrealized loss position on loan-backed and structured securities held by the Company at December 31, 2017 and 2016 is as follows:

December 31, 2017

a. The aggregate amount of unrealized losses:

1. Less than 12 months	$34,404
2. 12 months or longer	433,506

b. The aggregate related fair value of securities with unrealized losses:

1. Less than 12 months	$8,730,961
2. 12 months or longer	21,356,860

December 31, 2016

a. The aggregate amount of unrealized losses:

1. Less than 12 months	$1,168,947
2. 12 months or longer	-

b. The aggregate related fair value of securities with unrealized losses:

1. Less than 12 months	$37,947,977
2. 12 months or longer	-

The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R - *Loan-Backed and Structured Securities* ("SSAP No. 43R") in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at December 31, 2017 or 2016 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

There was no investment income due and accrued excluded from surplus at December 31, 2017 or 2016.

Restricted assets (including pledged)

The Company had $1,241,056 on deposit with regulatory bodies, which represented 0.2% of total admitted assets at December 31, 2017. The Company had $1,243,381 on deposit with regulatory bodies, which represented 0.2% of total admitted assets at December 31, 2016.

The Company did not have any assets pledged as collateral not captured in other categories at December 31, 2017 and 2016.

The Company did not have any other restricted assets at December 31, 2017 and 2016.

Prepayment and Acceleration Fees as of December 31, 2017 were:

	General Account
1. Number of CUSIPs	20
2. Aggregate Amount of Investment Income	$208,756

Mortgage Loans

The maximum and minimum lending rates for new mortgage loans made by category during 2017 were:

Type	Maximum	Minimum
Industrial	5.28%	5.28%
Office	5.77%	5.77%

The maximum percentage of any one loan to the value of security at the time of the loan, exclusive of insured or guaranteed or purchase money mortgages was 56%. There were no loans with a loan to value of security at the time of closing over 56% during 2017.

As of December 31, 2017, the Company did not hold any mortgages with interest more than 180 days past due with a recorded investment excluding accrued interest. There was no interest due on mortgages with interest more than 180 days past due as of December 31, 2017. The Company did not own any mortgages as of December 31, 2016.

Payment receipts on impaired loans are recorded on the cash basis. The Company recognizes interest income on impaired loans when received. The Company had no impaired loans investment and reserves at December 31, 2017. The Company did not own any mortgages as of December 31, 2016.

The Company assesses mortgage loans on a regular basis for credit impairments, and annually assigns a credit quality indicator to each loan. The credit quality indicator is internally developed and categorizes the Company's portfolio on a scale from 1 to 7. Category 1 represents loans of superior quality, and Categories 7 represent loans where collections are potentially at risk. All of the Company's mortgage loans fall into the Level 2 - 4 ratings. These ratings represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes. Category 5 and 6 represents loans where credit risk is not substantial but these loans warrant management's close attention. These indicators are based upon several factors, including current loan to value ratios, property condition, market trends, credit worthiness of the borrower and deal structure. The Company did not have any loans in Category 7. Based upon the Company's most recent assessment at December 31, 2017, the Company's mortgage loans were given the following credit rating indicators:

(in millions, except credit rating indicator)	
1	-
2 – 4	$13.0
5 & 6	-
Total	$13.0

As of December 31, 2017, scheduled mortgage loan principal repayments were as follows (in millions):

2018	-
2019	-
2020	-
2021	$6.1
2022	6.9
Thereafter	-

The Company had no mortgage loans derecognized as a result of foreclosure at December 31, 2017.

6. Financial instruments

Financial instruments measured at fair value in the financial statements

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information (“inputs”) that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting our own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, we use these quoted market prices to determine the fair value of financial assets and liabilities and classify these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, we estimate fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, we determine fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2017 and 2016 were as follows:

December 31, 2017

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3
Bonds, short--term investments and cash equivalents	$501,987,213	$494,104,260	$48,822,380	$453,164,833	-
Mortgage Loans	13,845,022	12,979,171	-	-	$13,845,022
Total	$515,832,235	$507,083,431	$48,822,380	$453,164,833	$13,845,022

December 31, 2016

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3
Bonds, short--term investments and cash equivalents	$531,749,712	$529,054,006	$44,414,218	$487,335,494	-
	$531,749,712	$529,054,006	$44,414,218	$487,335,494	-

The valuation methods and assumptions used by the Company in estimating the fair value of debt securities are discussed in Note 2.

During 2017, mortgage loan investments of $13,845,022 were transferred at fair value from Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of Aetna into Level 3 investments. There were no transfers into or out of the Company's Level 3 financial assets during 2016. There were no transfers between the Company's Level 1 or 2 financial assets during 2017 or 2016.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

7. Information concerning Parent, subsidiaries, and affiliates

As of and for the year ended December 31, 2017 and 2016, the Company had the following significant transactions with affiliates:

The Company and Aetna Medicaid Administrators LLC ("AMA"), indirectly a wholly-owned subsidiary of Aetna, are parties to an administrative services agreement, under which AMA provides certain administrative services, including accounting and processing of premiums and claims on the Company's Kentucky Medicaid business. Under this agreement, the Company remits a percentage of its earned premium revenue, as applicable, to AMA as a fee. For these services, the Company was charged $86,588,034 and $85,417,543 in 2017 and 2016. The agreement also provides for interest on all intercompany balances. There was no interest earned (incurred) on amounts due from (to) affiliates in 2017 and 2016. This agreement was assigned to ABH-KY as of February 1, 2016.

As explained in Note 2, the Company participates in a tax sharing agreement with Aetna and Aetna's other subsidiaries. All federal income tax receivables/payables are due from/due to Aetna.

Prior to March 1, 2016, the Company has coverage for certain litigation exposures ($10,000,000 per claim and in the aggregate including defense costs) through an affiliated captive insurance company.

At December 31, 2017 and 2016, the Company had the following amounts due to and due from affiliates:

	December 31, 2017	December 31, 2016
Amounts due to affiliates		
Aetna, Inc.	$33,688,103	$35,846,400
AMA	11,615,610	47,081,156
	$45,303,713	$82,924,556
Amounts due from affiliates		
Coventry Health and Life Insurance Co.	$2,260,618	$3,657,643
Aetna Health Management, LLC ("AHM")	4,471	-
	$2,265,089	$3,657,643

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

8. Health care receivables

Pharmaceutical rebates

The Company receives pharmaceutical rebates through an agreement with AHM. AHM has contractual agreements with pharmaceutical companies for rebates, which cover the Company's membership as well as the membership of other Aetna affiliates. The Company receives those rebates from AHM that relate to the Company's membership. The Company estimates pharmaceutical rebate receivables based upon the historical payment trends, actual utilization and other variables. Actual rebates collected are applied to the collection periods below, using a first in first out methodology. At December 31, 2017 and 2016, the Company had pharmaceutical rebate receivables of $1,758,384 and $1,920,365, respectively (refer to the Company's accounting practices related to pharmaceutical rebate receivables in Note 2).

The following table discloses the quarterly revenue and subsequent cash collections relating to the pharmaceutical rebates discussed in Note 2:

Quarter	Estimated pharmacy rebates as reported on financial statements	Pharmacy rebates as invoiced/ confirmed	Actual rebates collected within 90 days of invoicing/ confirmation	Actual rebates collected within 91 to 180 days of invoicing/ confirmation	Actual rebates collected more than 180 days after invoicing/ confirmation
12/31/2017	$1,758,384	-	-	-	-
9/30/2017	1,746,114	$1,758,384	-	-	-
6/30/2017	1,656,531	1,745,931	$424,719	-	-
3/31/2017	1,839,409	1,656,575	523,499	$1,100,655	-
12/31/2016	$1,920,365	$1,809,621	$596,429	$1,184,747	$1,075
9/30/2016	2,143,692	2,139,809	1,185,618	942,594	6
6/30/2016	1,876,911	1,875,293	640,940	1,051,637	164,813
3/31/2016	696,424	708,367	216,827	361,714	105,284

9. Income taxes

The components of the net DTAs recognized in the Company's Statutory Statements of Assets and Liabilities, Capital and Surplus are as follows:

	December 31, 2017		
	Ordinary	Capital	Total
Gross DTAs	$9,749,774	$228,786	$9,978,560
Statutory valuation allowance adjustment	-	-	-
Adjusted gross DTAs	9,749,774	228,786	9,978,560
DTAs non-admitted	(28,286)	(113,413)	(141,699)
Subtotal net admitted DTAs	9,721,488	115,373	9,836,861
DTLs	-	-	-
Net admitted DTAs/(DTLs)	$9,721,488	$115,373	$9,836,861

	December 31, 2016		
	Ordinary	Capital	Total
Gross DTAs	$16,609,111	$637,479	$17,246,590
Statutory valuation allowance adjustment	-	-	-
Adjusted gross DTAs	16,609,111	637,479	17,246,590
DTAs non-admitted	(2,913,647)	(342,064)	(3,255,711)
Subtotal net admitted DTAs	13,695,464	295,415	13,990,879
DTLs	-	-	-
Net admitted DTAs/(DTLs)	$13,695,464	$295,415	$13,990,879

	Change		
	Ordinary	Capital	Total
Gross DTAs	($6,859,337)	($408,693)	($7,268,030)
Statutory valuation allowance adjustment	-	-	-
Adjusted gross DTAs	(6,859,337)	(408,693)	(7,268,030)
DTAs non-admitted	2,885,361	228,651	3,114,012
Subtotal net admitted DTAs	(3,973,976)	(180,042)	(4,154,018)
DTLs	-	-	-
Net admitted DTAs/(DTLs)	($3,973,976)	($180,042)	($4,154,018)

The amount of admitted gross DTAs admitted under each component of SSAP No. 101 is as follows:

	December 31, 2017		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$9,719,029	$115,373	$9,834,402
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	2,459	-	2,459
1. Adjusted gross DTAs expected to be realized following the balance sheet date	2,459	-	2,459
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	37,812,823
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	-	-	-
(d) DTAs admitted as the result of application of SSAP No. 101	$9,721,488	$115,373	$9,836,861

	December 31, 2016		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$13,695,464	$295,415	$13,990,879
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	-	-	-
1. Adjusted gross DTAs expected to be realized following the balance sheet date	-	-	-
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	29,917,806
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	-	-	-
(d) DTAs admitted as the result of application of SSAP No. 101	$13,695,464	$295,415	$13,990,879

	Change		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	($3,976,435)	($180,042)	($4,156,477)
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	2,459	-	2,459
1. Adjusted gross DTAs expected to be realized following the balance sheet date	2,459	-	2,459
2. Adjusted gross DTAs allowed per limitation threshold	N/A	N/A	7,895,017
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	-	-	-
(d) DTAs admitted as the result of application of SSAP No. 101	($3,973,976)	($180,042)	($4,154,018)

	2017	2016
(a) Ratio percentage used to determine recovery period and threshold limitation amount	676%	538%
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in (b)2 above	$252,085,485	$199,452,043

The impact of tax planning strategies is as follows:

	December 31, 2017		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$9,749,774	$228,786	$9,978,560
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	0%	0%
3. Net admitted adjusted gross DTAs	$9,721,488	$115,373	$9,836,861
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	0%	0%

	December 31, 2016		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$16,609,111	$637,479	$17,246,590
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	0%	0%
3. Net admitted adjusted gross DTAs	$13,695,464	$295,415	$13,990,879
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	0%	0%

	Change		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	($6,859,337)	($408,693)	($7,268,030)
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	0%	0%	0%
3. Net admitted adjusted gross DTAs	($3,973,976)	($180,042)	($4,154,018)
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	0%	0%	0%

The Company's tax-planning strategies do not include the use of reinsurance.

There are no DTLs that were not recognized at December 31, 2017 or 2016.

The provision (benefit) for income taxes for the years ended December 31, 2017 and 2016 was as follows:

	December 31		
	2017	2016	Change
Federal income tax on operations	$20,912,254	$66,703,859	($45,791,605)
Federal income tax provision on net capital (losses) gains	216,907	538,796	(321,889)
Federal income tax incurred	$21,129,161	$67,242,655	($46,113,494)

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2017 and 2016 were as follows:

	December 31		
	2017	2016	Change
DTAs:			
Ordinary			
Discounting of unpaid losses	$2,961,004	$5,813,723	($2,852,719)
Unearned premium reserve	1,336,094	-	1,336,094
Non-admitted assets	5,424,390	7,881,741	(2,457,351)
Accrued litigation	28,286	2,913,647	(2,885,361)
Total ordinary DTAs	9,749,774	16,609,111	(6,859,337)
Statutory valuation allowance adjustment	-	-	-
Non-admitted ordinary DTAs	(28,286)	(2,913,647)	2,885,361
Admitted ordinary DTAs	9,721,488	13,695,464	(3,973,976)
Capital			
Investments	221,558	637,479	(415,921)
Other	7,228	-	7,228
Total capital DTAs	228,786	637,479	(408,693)
Statutory valuation allowance adjustment	-	-	-
Non-admitted capital DTAs	(113,413)	(342,064)	228,651
Admitted capital DTAs	115,373	295,415	(180,042)
Admitted DTAs	9,836,861	13,990,879	(4,154,018)
DTLs:			
Ordinary			
Other	-	-	-
Ordinary DTLs	-	-	-
Capital			
Investments	-	-	-
Capital DTLs	-	-	-
Total DTLs	-	-	-
Net admitted DTAs	$9,836,861	$13,990,879	($4,154,018)

The change in net deferred income taxes is comprised of the following:

	December 31		
	2017	2016	Change
Total DTAs	$9,978,560	$17,246,590	($7,268,030)
Total DTLs	-	-	-
Net DTAs/(DTLs)	$9,978,560	$17,246,590	($7,268,030)
Tax effect of unrealized gains (losses)			89,227
Change in net deferred income tax			($7,178,803)

There was no valuation allowance adjustment to gross DTAs as of December 31, 2017 and 2016, respectively.

The provision (benefit) for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference are as follows:

	December 31, 2017	Effective tax rate	December 31, 2016	Effective tax rate
Provision (benefit) computed at statutory rate	$26,904,752	35.0%	$66,318,487	35.0%
Transfer Pricing Adjustment	(4,811,815)	(6.3)%	(5,409,234)	(2.9)%
Tax-Exempt Interest	(1,612,753)	(2.1)%	(1,081,628)	(0.6)%
Transfer of Medicaid business	-	-	(3,156,836)	(1.7)%
Other Permanent Differences	1,662,326	2.2%	1,305,410	0.8%
Change in Non-admitted assets	(1,170,956)	(1.5)%	(7,881,741)	(4.2)%
Prior Year True-Up	690,147	0.9%	-	-
Impact on Deferred Tax for Enacted Rate Change	6,646,263	8.6%	-	-
Total	$28,307,964	36.8%	$50,094,458	26.4%
Federal and foreign income tax (benefit) expense incurred	$21,129,161	27.5%	$67,242,655	35.5%
Change in net deferred income taxes	7,178,803	9.3%	(17,148,197)	(9.1)%
Total statutory income taxes	$28,307,964	36.8%	$50,094,458	26.4%

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm's length prices as compared to what would be charged to an unrelated entity, which results in a permanent deduction for tax reporting purposes.

At December 31, 2017 and 2016, the Company had no net capital loss or net operating loss carryforwards for tax purposes.

The amount of federal income taxes incurred that are available for recoupment in the event of future net losses are:

Year	Ordinary	Capital	Total
2017	$20,088,898	$216,907	$20,305,805
2016	67,499,460	538,796	68,038,256
	$87,588,358	$755,703	$88,344,061

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2017 and 2016.

At December 31, 2017, the Company's Federal Income Tax Return was consolidated with the following entities:

Aetna Inc.
@ Credentials Inc.
Active Health Management Inc.
Adminco, Inc.
Administrative Enterprises, Inc.
AE Fourteen Incorporated
Aetna ACO Holdings, Inc.
Aetna Better Health Inc. (Connecticut)
Aetna Better Health Inc. (Georgia)
Aetna Better Health Inc. (Illinois)
Aetna Better Health Inc. (New Jersey)
Aetna Better Health Inc. (New York)
Aetna Better Health Inc. (Ohio)
Aetna Better Health Inc. (Pennsylvania)
Aetna Better Health Inc. (Tennessee)
Aetna Better Health of California Inc.
Aetna Better Health of Iowa Inc.
Aetna Better Health of Kansas, Inc.
Aetna Better Health of Kentucky Insurance Company
Aetna Better Health of Michigan, Inc.
Aetna Better Health of Missouri LLC
Aetna Better Health of Nevada Inc.
Aetna Better Health of North Carolina, Inc.
Aetna Better Health of Oklahoma Inc.
Aetna Better Health of Texas, Inc.
Aetna Better Health of Washington, Inc.
Aetna Better Health, Inc. (Louisiana)
Aetna Dental Inc. (New Jersey)
Aetna Dental Inc. (Texas)
Aetna Dental of California Inc.
Aetna Florida Inc. (fka Aetna Better Health Inc. (Florida))
Aetna Health and Life Insurance Company
Aetna Health Inc. (Connecticut)
Aetna Health Inc. (Florida)
Aetna Health Inc. (Georgia)
American Health Holding, Inc.
AUSHC Holdings, Inc.
Broadspire National Services, Inc.
bswift, LLC
Carefree Insurance Services, Inc.
Claims Administration Corporation
Cofinity, Inc.
Continental Life Insurance Company of Brentwood, Tennessee
Corporate Benefit Strategies, Inc.
Coventry Consumer Advantage, Inc.
Coventry Health and Life Insurance Company
Coventry Health Care National Accounts, Inc.
Coventry Health Care National Network, Inc.
Coventry Health Care of Florida, Inc.
Coventry Health Care of Illinois, Inc.
Coventry Health Care of Kansas, Inc.
Coventry Health Care of Missouri, Inc.
Coventry Health Care of Nebraska, Inc.
Coventry Health Care of Virginia, Inc.
Coventry Health Care of West Virginia, Inc.
Coventry Health Care Workers' Compensation, Inc.
Coventry Health Plan of Florida, Inc.
Coventry HealthCare Management Corporation
Coventry Prescription Management Services, Inc.
Coventry Rehabilitation Services, Inc.
Coventry Transplant Network, Inc.
Delaware Physicians Care, Incorporated
Echo Merger Sub, Inc.
First Health Group Corp.
First Health Life and Health Insurance Company
First Script Network Services, Inc.
Florida Health Plan Administrators, LLC
FOCUS Healthcare Management, Inc.
Group Dental Service of Maryland, Inc.
Group Dental Service, Inc.
Health and Human Resource Center, Inc.

Aetna Health Inc. (Louisiana)
Aetna Health Inc. (Maine)
Aetna Health Inc. (Michigan)
Aetna Health Inc. (New Jersey)
Aetna Health Inc. (New York)
Aetna Health Inc. (Pennsylvania)
Aetna Health Inc. (Texas)
Aetna Health Insurance Company
Aetna Health Insurance Company of New York
Aetna Health of California, Inc.
Aetna Health of Iowa Inc. (fka Aetna Health Inc. (Iowa))
Aetna Health of Utah, Inc.
Aetna HealthAssurance Pennsylvania, Inc.
Aetna Insurance Company of Connecticut
Aetna Integrated Informatics, Inc.
Aetna International Inc.
Aetna Ireland Inc.
Aetna Life & Casualty (Bermuda) Ltd.
Aetna Life Assignment Company
Aetna Life Insurance Company
Aetna Risk Assurance Company of. Connecticut, Inc.
Aetna Student Health Agency Inc.
AHP Holdings, Inc.
Allviant Corporation
American Continental Insurance Company
Health Data & Management Solutions, Inc.
Health Re, Incorporated
HealthAssurance Pennsylvania, Inc.
Managed Care Coordinators, Inc.
Medicity Inc.
Mental Health Associates, Inc.
Mental Health Network of New York IPA, Inc.
Meritain Health, Inc.
MetraComp, Inc.
MHNet Life and Health Insurance Co.
MHNet of Florida, Inc.
Niagara Re, Inc.
PayFlex Holdings, Inc.
PayFlex Systems USA, Inc.
Performax, Inc.
Precision Benefit Services, Inc.
Prime Net, Inc.
Prodigy Health Group, Inc.
Professional Risk Management, Inc.
Resources for Living, LLC
Schaller Anderson Medical Administrators, Incorporated
Strategic Resource Company
The Vasquez Group Inc.
U.S. Health Care Properties, Inc.
Work and Family Benefits, Inc.

As explained in Note 2, the Company participates in a tax sharing agreement with its parent and affiliates.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

10. Change in claims unpaid, unpaid claims adjustment expense, and aggregate health claim reserves

The following table shows the components of the change in claims unpaid, accrued medical incentive pool and bonus amounts and unpaid claims adjustment expense for the year ended December 31, 2017 and 2016:

	2017	2016
Balance, January 1	203,997,642	-
Health care receivable	(14,056,403)	-
Balance, January 1, net of health care receivable	189,941,239	-
Incurred related to:		
Current year	993,864,894	799,258,593
Prior years	(4,903,247)	60,132,720
Total incurred	988,961,647	859,391,313
Paid related to:		
Current year	858,774,940	632,696,289
Prior years	184,913,164	36,753,785
Total paid	1,043,688,104	669,450,074
Balance, December 31, net of health care receivable	135,214,782	189,941,239
Health care receivable	27,088,688	14,056,403
Balance, December 31	$162,303,470	$203,997,642

In 2017, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' decreased by $4,903,247 from $203,997,642 in 2016 to $199,094,395 in 2017. In 2016, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years' increased by $60,132,720 from $0 in 2015 to $60,132,720 in 2016. The lower than anticipated health care cost trend rates observed in 2017 for claims incurred in 2016 , were due to moderating outpatient and physician trends and faster than expected claim payment speed. For 2016, reserves for incurred claims and claim adjustment expenses attributable to insured events of the prior years' were recorded on CH&L, reserves balances were assigned to the Company on February 1, 2016. The Company considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends.

Net coordination of benefits is implicit in the claims incurred but not reported calculation and could not be specifically identified.

11. Capital and surplus, shareholder's dividend restrictions and quasi-reorganizations

The Company has 1,000,000 shares of common stock with a par value of $1.00 per share authorized, issued and outstanding at December 31, 2017. CH&L purchased an additional 990,000 shares of common stock in order for the Company to meet the Commonwealth of Kentucky's capital requirements. The payment of the 990,000 by CH&L was satisfied by reclassifying $990,000 of paid in capital of the Company to common stock effective as of March 31, 2017. The Company had 10,000 shares of common stock with a par value of $1.00 per share authorized, issued and outstanding at December 31, 2016.

On February 1, 2016, the CH&L's Kentucky Medicaid business was assigned to its subsidiary, ABH-KY, whereas all Kentucky Medicaid operations will be recorded by ABH-KY. Cash and related Medicaid assets and liabilities were transferred to ABH-KY. The CH&L owns a 100% interest in ABH-KY.

The Company had no shares of preferred stock issued and outstanding at December 31, 2017 and 2016.

Dividend restrictions

In accordance with Kentucky statutes, the Company shall not pay any extraordinary dividend unless the Company has notified the Kentucky Department in writing at least 30 days prior thereto or such shorter period as the Kentucky Department may permit and the Kentucky Department has not disapproved it within such period. An extraordinary dividend is any dividend or other distribution which, together with other dividends and distributions made within the preceding 12 months, exceeds the greater of: ten percent of such insurer's surplus as regards policyholders as of the preceding December 31; or the net income of such insurer for the period covered by such statement, but shall not include pro rata distributions of any class of the insurer's own securities. The Company may not make a non-extraordinary dividend without prior notification to the Kentucky Department within five business days following the declaration thereto and at least ten days, commencing from the date of receipt by the Kentucky Department, prior to the payment thereof. Ordinary dividends are ultimately limited to earned surplus.

At December 31, 2017, there was $55,741,558 of the Company's net income that may be paid as ordinary dividends to its stockholder.

The Company did not pay any dividends to its parent in 2017 or 2016. The Company received a capital contribution from its parent of $0 and $96,760,001 in 2017 and 2016, respectively.

There were no restrictions placed on the Company's surplus, including for whom the surplus was being held at December 31, 2017 or 2016, except as noted in Note 14.

The Company did not hold any stock for any special purposes at December 31, 2017 or 2016.

At December 31, 2017 and 2016, there was $237,476 and ($281,122), respectively, of unassigned funds (surplus) that was represented or reduced by unrealized gains and losses.

Changes in the balances of special surplus funds from the prior year are due to the accrual of estimated 2018 ACA health insurer fees reclassified from unassigned funds or surplus to aggregate write-ins for special surplus funds as discussed more fully in Notes 2 and 17.

12. Contingencies

Guaranty fund assessments

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which Aetna and certain of its affiliates, including the Company (collectively, "we", "our", or "us") participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under Health Care Reform.

Litigation and regulatory proceedings

The following description of litigation and regulatory proceedings covers Aetna Inc. and certain of its subsidiaries, including the Company. Certain of the proceedings described below may not impact the Company directly but may have indirect impact on the Company as the Company is a member of the Aetna holding company group.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our withdrawal from certain states' health insurance exchanges ("Public Exchanges") for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others. We also have produced documents and information to the Civil Division of the Department of Justice in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive

adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "*Other Litigation and Regulatory Proceedings*," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Litigation Exposure Coverage

The Company has coverage for certain litigation exposures ($10,000,000 per claim and in the aggregate including defense costs) through an unaffiliated insurance company.

13. Contractual arrangements with providers

The Company generally compensates primary care physicians through prospective compensation arrangements which incorporate quality assessment standards, comprehensiveness of care, utilization and office status components. These components are used to adjust the capitation payments to individual physician offices and to determine the amount of additional periodic payments. The Company has prospective compensation arrangements for mental health, substance abuse, diagnostic laboratory, radiology and diagnostic imaging services, podiatric treatment, physical therapy and prescription drug dispensing. The Company has contracts that provide for all-inclusive per diem and per case hospitalization rates and fixed rates for ambulatory surgery, emergency room services and specialist services. The Company has also entered into quality based compensation arrangements with certain hospitals, as well as agreements with certain integrated health delivery systems under which the systems are compensated on a substantially fixed prospective basis for medical services, including primary, specialist and hospital care. The arrangements described above cover the majority of medical expenses.

14. Minimum capital and surplus

Pursuant to the laws of the states in which the Company is licensed to do business, the Company is required to maintain a minimum surplus and capital stock as defined by the statutes and regulations of those states. The Commonwealth of Kentucky requires the Company to maintain minimum statutory surplus of $1,000,000 plus an initial free surplus of $2,000,000. At both December 31, 2017 and 2016, the Company was in compliance with the minimum surplus and capital stock requirements for the states in which it is licensed to do business.

The NAIC and the Commonwealth of Kentucky adopted risk-based capital ("RBC") standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company's adjusted capital and surplus to its required capital and surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of the company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2017 and 2016, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

15 Medicaid

The Company's Medicaid products are heavily regulated by state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with regulations. The Company's Medicaid products and Children's Health Insurance Program ("CHIP") contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services the Company provides to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and the Company's Medicaid compliance efforts will continue to require significant resources. State Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid products, exclude the Company from participating in one or more Medicaid programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with state regulations or the Company's contractual requirements. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or financial results, but the effects could be materially adverse.

For the years ended December 31, 2017 and 2016, the Company recorded premiums under the Medicaid program of $1,043,468,548 and $1,046,297,492 or as a percentage of total premium revenue was 95.5% and 95.5% for 2017 and 2016, respectively. For the years ended December 31, 2017 and 2016, the Company recorded premiums under the CHIP program of $49,157,055 and $49,022,903 or as a percentage of total premium revenue was 4.5% and 4.5% for 2017 and 2016, respectively.

16. Reconciliation between Audited Financial Statements and the Annual Statement

There were no reconciling differences between the amounts previously reported to state regulatory authorities in the 2017 Annual Statement and those reported in the accompanying statutory financial statements.

The following tables are a reconciliation of amounts previously reported to state regulatory authorities in the 2016 Annual Statement to those reported in the accompanying statutory financial statements. For the Statement of Cash Flows, the differences reflect the re-class of the Kentucky Medicaid account transfers out of operations and into non-cash activities.

	December 31, 2016
Statutory statement of cash flows:	
Net cash from operations as reported in the Company's Annual Statement	$367,021,599
Decrease in net cash from operation for Medicaid transfer	(293,674,070)
Total net cash from operation as reported in the statutory statement of cash flows	$73,347,529
Net cash from investments as reported in the Company's Annual Statement	($157,540,846)
Decrease in non-cash for ABH-KY capital contribution	(96,760,000)
Total net cash from investments as reported in the statutory statement of cash flows	($254,300,846)
Net cash from financing and miscellaneous sources as reported in the Company's Annual Statement	($206,704,473)
Increase in non-cash intercompany for ABH-KY capital contribution	96,760,000
Increase in other cash applied for Medicaid transfer	293,674,070
Total net cash from financing and miscellaneous sources as reported in the statutory statement of cash flows	$183,729,597

17. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through May 30, 2018.

The Company had no known reportable recognized subsequent events.

Type II - Non-recognized subsequent events

Non-recognized Subsequent events have been considered through May 30, 2018.

On January 1, 2018, the Company will be subject to an annual fee under the Section 9010 of the ACA. This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2017, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2018, and estimates its portion of the annual health insurance industry fee to be payable on September 30, 2018 to be $22,555,000. This amount is reflected in aggregate write-ins for special surplus funds and was estimated based on premiums written subject to the ACA assessment of $1,092,625,603. The Company's total adjusted capital before and after the special surplus adjustment was $261,922,347 and $239,367,347, respectively. The Company's total authorized control level both before and after the special surplus adjustment was estimated to be $37,303,198. As a result, this assessment is expected to impact RBC by 9%. Reporting the ACA assessment as of December 31, 2017 would not have triggered an RBC action level.

As discussed in Note 2, in December 2015, the Consolidated Appropriation Act was enacted which included a one year suspension in 2017 of the health insurer fee. As a result, there is no annual health insurance industry fee payable on September 30, 2017 and there were no amounts reflected in the Company's aggregate write-ins for special surplus funds related to this payable at December 31, 2016 as a result. There was also no resulting impact to the Company's RBC to assess as of December 31, 2016 as a result of this suspension.

In January 2018, the annual fee was suspended for 2019.

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings 1 Amount	2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities	48,805,150	9.627	48,805,150	0	48,805,150	9.627
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies		0.000			0	0.000
1.22 Issued by U.S. government sponsored agencies		0.000			0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	26,042,548	5.137	26,042,548	0	26,042,548	5.137
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations	42,907,202	8.464	42,907,202	0	42,907,202	8.464
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	27,016,735	5.329	27,016,735	0	27,016,735	5.329
1.43 Revenue and assessment obligations	139,701,347	27.557	139,701,347	0	139,701,347	27.557
1.44 Industrial development and similar obligations		0.000			0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	3,541,892	0.699	3,541,892	0	3,541,892	0.699
1.512 Issued or guaranteed by FNMA and FHLMC	8,057,050	1.589	8,057,050	0	8,057,050	1.589
1.513 All other		0.000			0	0.000
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA		0.000			0	0.000
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521		0.000			0	0.000
1.523 All other	34,345,448	6.775	34,345,448	0	34,345,448	6.775
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	127,058,125	25.063	127,058,125	0	127,058,125	25.063
2.2 Unaffiliated non-U.S. securities (including Canada)	21,761,368	4.293	21,761,368	0	21,761,368	4.293
2.3 Affiliated securities		0.000			0	0.000
3. Equity interests:						
3.1 Investments in mutual funds		0.000		0	0	0.000
3.2 Preferred stocks:						
3.21 Affiliated		0.000			0	0.000
3.22 Unaffiliated		0.000			0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated		0.000			0	0.000
3.32 Unaffiliated		0.000			0	0.000
3.4 Other equity securities:						
3.41 Affiliated		0.000			0	0.000
3.42 Unaffiliated		0.000			0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated		0.000			0	0.000
3.52 Unaffiliated		0.000			0	0.000
4. Mortgage loans:						
4.1 Construction and land development		0.000			0	0.000
4.2 Agricultural		0.000			0	0.000
4.3 Single family residential properties		0.000			0	0.000
4.4 Multifamily residential properties		0.000			0	0.000
4.5 Commercial loans	12,979,171	2.560	12,979,171		12,979,171	2.560
4.6 Mezzanine real estate loans		0.000			0	0.000
5. Real estate investments:						
5.1 Property occupied by company		0.000	0		0	0.000
5.2 Property held for production of income (including $ ..... of property acquired in satisfaction of debt)		0.000	0		0	0.000
5.3 Property held for sale (including $ ..... property acquired in satisfaction of debt)		0.000	0		0	0.000
6. Contract loans		0.000	0		0	0.000
7. Derivatives		0.000	0		0	0.000
8. Receivables for securities	524,756	0.104	524,756		524,756	0.104
9. Securities Lending (Line 10, Asset Page reinvested collateral)		0.000	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	14,204,888	2.802	14,204,888	0	14,204,888	2.802
11. Other invested assets		0.000			0	0.000
12. Total invested assets	506,945,680	100.000	506,945,680	0	506,945,680	100.000

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2017
(To Be Filed by April 1)

Of The Aetna Better Health of Kentucky Insurance Company

ADDRESS (City, State and Zip Code) Louisville , KY 40202

NAIC Group Code 0001 NAIC Company Code 15761 Federal Employer's Identification Number (FEIN) 47-3279217

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 526,789,148

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	WASHINGTON STATE OF REF SER R 2018D	Bond	$ 9,581,584	1.8 %
2.02	PENNSYLVANIA ST GENERAL OBLIGA	Bond	$ 9,565,633	1.8 %
2.03	VIRGINIA ST PUB BLDG AUTH PUB SER A	Bond	$ 8,935,478	1.7 %
2.04	COLUMBIA DIST OF SER D	Bond	$ 8,796,276	1.7 %
2.05	DOUGLAS CNTY NE SCH DIST 1	Bond	$ 8,197,519	1.6 %
2.06	MARYLAND STATE OF ST AND LOCAL FACS 1ST SER B	Bond	$ 7,950,480	1.5 %
2.07	SYNCHRONY CREDIT CARD MASTER SERIES 2016-2 CLASS A	Bond	$ 6,999,630	1.3 %
2.08	FLORIDA DEPT ENVIRON PROTECTIO REF	Bond	$ 6,221,671	1.2 %
2.09	POTASH CORP CP 4(2) 144A	Cash Equivalent	$ 6,082,767	1.2 %
2.10	NEW JERSEY ST ECON DEV AUTH REF SER XX	Bond	$ 6,021,647	1.1 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 350,941,062	66.6 %	3.07	P/RP-1	$	0.0 %
3.02	NAIC-2	$ 100,591,076	19.1 %	3.08	P/RP-2	$	0.0 %
3.03	NAIC-3	$ 36,468,359	6.9 %	3.09	P/RP-3	$	0.0 %
3.04	NAIC-4	$ 6,103,546	1.2 %	3.10	P/RP-4	$	0.0 %
3.05	NAIC-5	$	0.0 %	3.11	P/RP-5	$	0.0 %
3.06	NAIC-6	$	0.0 %	3.12	P/RP-6	$	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 47,803,919	9.1 %
4.03	Foreign-currency-denominated investments	$	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 20,232,576	3.8 %
5.02	Countries designated NAIC-2	$ 13,642,007	2.6 %
5.03	Countries designated NAIC-3 or below	$ 13,929,336	2.6 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1: NETHERLANDS	$ 11,241,610	2.1 %
6.02	Country 2: GUERNSEY	$ 2,494,236	0.5 %
	Countries designated NAIC - 2:		
6.03	Country 1: INDONESIA	$ 3,473,231	0.7 %
6.04	Country 2: ITALY	$ 3,027,330	0.6 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1: BRAZIL	$ 2,934,630	0.6 %
6.06	Country 2: DOMINICAN REPUBLIC	$ 2,048,717	0.4 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$	0.0 %
8.02	Countries designated NAIC-2	$	0.0 %
8.03	Countries designated NAIC-3 or below	$	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$	0.0 %
9.02	Country 2:	$	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$	0.0 %
9.04	Country 2:	$	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$	0.0 %
9.06	Country 2:	$	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01	SHELL INTERNATIONAL FIN SR UNSECURED	1FE	$ 4,993,783	0.9 %
10.02	INTESA SANPAOLO SPA SR UNSECURED	2FE	$ 3,027,330	0.6 %
10.03	SIEMENS FINANCIERINGSMAT SR UNSECURED	1FE	$ 2,998,476	0.6 %
10.04	MYLAN NV SR UNSECURED	2FE	$ 2,497,936	0.5 %
10.05	CRED SUIS GP FUN LTD SR UNSECURED	2FE	$ 2,494,236	0.5 %
10.06	MIZUHO FINANCIAL GROUP SR UNSECURED	1FE	$ 1,500,000	0.3 %
10.07	RECKITT BENCKISER TSY SR UNSECURED	1FE	$ 1,498,481	0.3 %
10.08	SEAGATE HDD CAYMAN SR UNSECURED	2FE	$ 1,000,000	0.2 %
10.09	SOCIETE GENERALE SR UNSECURED	1FE	$ 999,714	0.2 %
10.10	LYONDELLBASELL IND NV SR UNSECURED	2FE	$ 751,415	0.1 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 6,082,767	1.2 %
11.03	Canadian-currency-denominated investments	$	0.0 %
11.04	Canadian-denominated insurance liabilities	$	0.0 %
11.05	Unhedged Canadian currency exposure	$	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$	0.0 %
12.04		$	0.0 %
12.05		$	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$	0.0 %
13.03		$	0.0 %
13.04		$	0.0 %
13.05		$	0.0 %
13.06		$	0.0 %
13.07		$	0.0 %
13.08		$	0.0 %
13.09		$	0.0 %
13.10		$	0.0 %
13.11		$	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$	0.0 %
14.04		$	0.0 %
14.05		$	0.0 %

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$	0.0 %
	Largest three investments in general partnership interests:		
15.03		$	0.0 %
15.04		$	0.0 %
15.05		$	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02		$	0.0 %
16.03		$	0.0 %
16.04		$	0.0 %
16.05		$	0.0 %
16.06		$	0.0 %
16.07		$	0.0 %
16.08		$	0.0 %
16.09		$	0.0 %
16.10		$	0.0 %
16.11		$	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$	0.0 %
16.13	Mortgage loans over 90 days past due	$	0.0 %
16.14	Mortgage loans in the process of foreclosure	$	0.0 %
16.15	Mortgage loans foreclosed	$	0.0 %
16.16	Restructured mortgage loans	$	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.02	91 to 95%	$	0.0 %	$	0.0 %	$	0.0 %
17.03	81 to 90%	$	0.0 %	$	0.0 %	$	0.0 %
17.04	71 to 80%	$	0.0 %	$	0.0 %	$	0.0 %
17.05	below 70%	$	0.0 %	$	0.0 %	$	0.0 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$	0.0 %
18.03		$	0.0 %
18.04		$	0.0 %
18.05		$	0.0 %
18.06		$	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$	0.0 %
19.04		$	0.0 %
19.05		$	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$	0.0 %	$	$	$
20.02	Repurchase agreements	$	0.0 %	$	$	$
20.03	Reverse repurchase agreements	$	0.0 %	$	$	$
20.04	Dollar repurchase agreements	$	0.0 %	$	$	$
20.05	Dollar reverse repurchase agreements	$	0.0 %	$	$	$

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$	0.0 %	$	0.0 %
21.02	Income generation	$	0.0 %	$	0.0 %
21.03	Other	$	0.0 %	$	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
22.01	Hedging	$ 0	0.0 %	$	$	$
22.02	Income generation	$ 0	0.0 %	$	$	$
22.03	Replications	$ 0	0.0 %	$	$	$
22.04	Other	$ 0	0.0 %	$	$	$

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
23.01	Hedging	$ 0	0.0 %	$	$	$
23.02	Income generation	$	0.0 %	$	$	$
23.03	Replications	$	0.0 %	$	$	$
23.04	Other	$	0.0 %	$	$	$

Aetna Better Health® of Kentucky Audited Financial Statement 2018

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Financial Statements - Statutory Basis

Aetna Better Health of Kentucky Insurance Company

Years Ended December 31, 2018 and 2017
with Report of Independent Auditors

KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Aetna Better Health of Kentucky Insurance Company

We have audited the accompanying financial statements of Aetna Better Health of Kentucky Insurance Company, which comprise the statutory statements of assets, liabilities, capital and surplus as of December 31, 2018 and 2017, and the related statutory statements of revenue and expenses, changes in capital and surplus, and cash flows for the years then ended, and the related notes to the statutory financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with statutory accounting practices prescribed or permitted by the Kentucky Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

KPMG LLP is a Delaware limited liability partnership and the U.S. member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative ("KPMG International"), a Swiss entity.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the financial statements are prepared by Aetna Better Health of Kentucky Insurance Company using statutory accounting practices prescribed or permitted by the Kentucky Department of Insurance, which is a basis of accounting other than U.S. generally accepted accounting principles. Accordingly, the financial statements are not intended to be presented in accordance with U.S. generally accepted accounting principles.

The effects on the financial statements of the variances between the statutory accounting practices described in Note 2 and U.S. generally accepted accounting principles, although not reasonably determinable, are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the variances between statutory accounting practices and U.S. generally accepted accounting principles discussed in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles paragraph, the financial statements referred to above do not present fairly, in accordance with U.S. generally accepted accounting principles, the financial position of Aetna Better Health of Kentucky Insurance Company as of December 31, 2018 and 2017, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

In our opinion, the financial statements referred to above present fairly, in all material respects, the assets, liabilities, and capital and surplus of Aetna Better Health of Kentucky Insurance Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended, in accordance with statutory accounting practices prescribed or permitted by the Kentucky Department of Insurance described in Note 2.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary information included in the supplemental schedules titled Summary Investment Schedule and Supplemental Investment Risks Interrogatories is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Kentucky Department of Insurance. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

[redacted]

Hartford, Connecticut
May 30, 2019

Statutory Statements of Assets

		Current Year			Prior Year
		Assets	Nonadmitted Assets	Net Admitted Assets	Net Admitted Assets
1	Bonds	$442,356,086	$—	$442,356,086	$479,236,865
2	Stocks:				
	2.1 Preferred stocks	—	—	—	—
	2.2 Common stocks	—	—	—	—
3	Mortgage loans on real estate:				
	3.1 First liens	13,407,858	—	13,407,858	12,979,171
	3.2 Other than first liens	—	—	—	—
4	Real estate:				
	4.1 Properties occupied by the company	—	—	—	—
	4.2 Properties held for the production of income	—	—	—	—
	4.3 Properties held for sale	—	—	—	—
5	Cash ($7,133,694 in 2018 and ($662,507) in 2017, cash equivalents ($11,486,582 in 2018 and $14,867,395 in 2017) and short-term investments ($0 in 2018 and $0 in 2017)	18,620,276	—	18,620,276	14,204,888
6	Contract loans	—	—	—	—
7	Derivatives	—	—	—	—
8	Other invested assets	—	—	—	—
9	Receivables for securities	11,415	—	11,415	524,756
10	Securities lending reinvested collateral assets	—	—	—	—
11	Aggregate write-ins for invested assets	—	—	—	—
12	Subtotals, cash and invested assets (Lines 1 to 11)	474,395,635	—	474,395,635	506,945,680
13	Title plants (for Title insurers only)	—	—	—	—
14	Investment income due and accrued	4,621,602	—	4,621,602	4,135,427
15	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection	1,931,674	—	1,931,674	1,847,707
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due	—	—	—	—
	15.3 Accrued retrospective premiums ($0 in 2018 and $0 in 2017) and contracts subject to redetermination ($0 in 2018 and $0 in 2017)	—	—	—	—
16	Reinsurance:				
	16.1 Amounts recoverable from reinsurers	—	—	—	—
	16.2 Funds held by or deposited with reinsured companies	—	—	—	—
	16.3 Other amounts receivable under reinsurance contracts	—	—	—	—
17	Amounts receivable relating to uninsured plans	—	—	—	—
18.1	Current federal and foreign income tax recoverable and interest thereon	—	—	—	—
18.2	Net deferred tax asset	5,204,425	—	5,204,425	9,836,861
19	Guaranty funds receivable or on deposit	—	—	—	—
20	Electronic data processing equipment and software	—	—	—	—
21	Furniture and equipment, including health care delivery assets	—	—	—	—
22	Net adjustment in assets and liabilities due to foreign exchange rates	—	—	—	—
23	Receivables from parent, subsidiaries and affiliates	7,789,355	—	7,789,355	2,265,089
24	Health care ($2,070,247 in 2018 and $1,758,384 in 2017) and other amounts receivable	15,448,760	13,378,513	2,070,247	1,758,384
25	Aggregate write-ins for other than invested assets	500,000	500,000	—	—
26	Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	509,891,451	13,878,513	496,012,938	526,789,148
27	From Separate Accounts, Segregated Accounts and Protected Cell Accounts	—	—	—	—
28	TOTALS (Lines 26 and 27)	$509,891,451	$13,878,513	$496,012,938	$526,789,148

	Details of Write-Ins				
2501	Deposits	$500,000	$500,000	$—	$—
2502		—	—	—	—
2599	Totals (Lines 2501 thru 2502) (Line 25 above)	$500,000	$500,000	$—	$—

See accompanying notes to statutory financial statements.

Statutory Statements of Liabilities, Capital and Surplus

		Current Year	Prior Year
		Total	Total
1	Claims unpaid (less $0 in 2018 and $0 in 2017 reinsurance ceded)	$127,259,095	$159,039,981
2	Accrued medical incentive pool and bonus amounts	1,187,135	190,629
3	Unpaid claims adjustment expenses	4,812,094	3,072,860
4	Aggregate health policy reserves ($0 in 2018 and $0 in 2017 for medical loss ratio rebate per the Public Health Service Act)	—	—
5	Aggregate life policy reserves	—	—
6	Property/casualty unearned premium reserve	—	—
7	Aggregate health claim reserves	—	—
8	Premiums received in advance	574,560	31,811,757
9	General expenses due or accrued	11,601,352	12,641,664
10.1	Current federal and foreign income tax payable and interest thereon	4,383,990	8,105,131
10.2	Net deferred tax liability	—	—
11	Ceded reinsurance premiums payable	—	—
12	Amounts withheld or retained for the account of others	3,139,799	—
13	Remittances and items not allocated	1,753,757	2,849,167
14	Borrowed money and interest thereon	—	—
15	Amounts due to parent, subsidiaries and affiliates	13,820,266	45,303,713
16	Derivatives	—	—
17	Payable for securities	—	—
18	Payable for securities lending	—	—
19	Funds held under reinsurance treaties (with $0 in 2018 and $0 in 2017 unauthorized reinsurers)	—	—
20	Reinsurance in unauthorized companies	—	—
21	Net adjustments in assets and liabilities due to foreign exchange rates	—	—
22	Liability for amounts held under uninsured plans	—	—
23	Aggregate write-ins for other liabilities	982,691	1,851,899
24	Total liabilities (Lines 1 to 23)	169,514,739	264,866,801
25	Aggregate write-ins for special surplus funds	—	22,555,000
26	Common capital stock	1,000,000	1,000,000
27	Preferred capital stock	—	—
28	Gross paid in and contributed surplus	99,010,001	99,010,001
29	Surplus notes	—	—
30	Aggregate write-ins for other than special surplus funds	—	—
31	Unassigned surplus	226,488,198	139,357,346
32	Less treasury stock at cost:		
	32.1 0.000 shares common	—	—
	32.2 0.000 shares preferred	—	—
33	Total capital and surplus (Lines 25 to 31 minus Line 32)	326,498,199	261,922,347
34	Total liabilities, capital and surplus (Lines 24 and 33)	$496,012,938	$526,789,148

	Details of Write-Ins		
2301	Escheat payable	$982,691	$1,851,899
2302		—	—
2303		—	—
2399	Totals (Lines 2301 thru 2303) (Line 23 above)	$982,691	$1,851,899
2501	Estimated health insurance fee accrual	$—	$22,555,000
2502		—	—
2503		—	—
2599	Totals (Lines 2501 thru 2503) (Line 25 above)	$—	$22,555,000

See accompanying notes to statutory financial statements.

Statutory Statements of Revenue and Expenses

		Current Year	Prior Year
		Total	Total
1	Line not used		
2	Net premium income	$1,121,827,068	$1,092,625,603
3	Change in unearned premium reserves and reserve for rate credits	—	31,898,076
4	Fee-for-service	—	—
5	Risk revenue	—	—
6	Aggregate write-ins for other health care related revenues	—	—
7	Aggregate write-ins for other non-health revenues	—	—
8	Total revenues (Lines 2 to 7)	1,121,827,068	1,124,523,679
	Hospital and Medical:		
9	Hospital/medical benefits	578,623,254	609,008,492
10	Other professional services	43,428,479	49,453,749
11	Outside referrals	8,516,577	—
12	Emergency room and out-of-area	80,128,217	89,732,481
13	Prescription drugs	218,620,756	220,118,361
14	Aggregate write-ins for other hospital and medical	—	—
15	Incentive pool, withhold adjustments and bonus amounts	1,640,478	(7,740,581)
16	Subtotal (Lines 9 to 15)	930,957,761	960,572,502
	Less:		
17	Net reinsurance recoveries	—	—
18	Total hospital and medical (Lines 16 minus 17)	930,957,761	960,572,502
19	Non-health claims (net)	—	—
20	Claims adjustment expenses (including Cost containment expenses of $26,712,514 in 2018 and $26,324,963 in 2017)	28,085,901	28,389,145
21	General administrative expenses	93,657,324	69,029,357
22	Increase in reserves for life and accident and health contracts	—	—
23	Total underwriting deductions (Lines 18 through 22)	1,052,700,986	1,057,991,004
24	Net underwriting gain (Lines 8 minus 23)	69,126,082	66,532,675
25	Net investment income earned	16,076,249	14,019,102
26	Net Realized capital gains (losses) less capital gains tax (benefit) of $(480,125) in 2018 and $216,907 in 2017	(3,331,896)	637,847
27	Net investment gains (Lines 25 plus 26)	12,744,353	14,656,949
28	Net gain or (loss) from agents' or premium balances charged off	—	—
29	Aggregate write-ins for other income or expenses	(4,224,851)	(4,535,812)
30	Net income after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	77,645,584	76,653,812
31	Federal and foreign income tax expenses incurred	18,504,307	20,912,254
32	Net income (Lines 30 minus 31)	$59,141,277	$55,741,558

	Details of Write-Ins		
2901	Regulatory penalties	($4,224,851)	($4,535,812)
2902		—	—
2903		—	—
2999	Totals (Lines 2901 thru 2903) (Line 29 above)	($4,224,851)	($4,535,812)

See accompanying notes to statutory financial statements.

Statutory Statements of Changes in Capital and Surplus

		Current Year	Prior Year
	CAPITAL AND SURPLUS ACCOUNT		
33	Capital and surplus prior reporting period	$261,922,348	$213,442,922
34	Net income from Line 32	59,141,277	55,741,558
35	Change in valuation basis of aggregate policy and claim reserves	—	—
36	Change in net unrealized capital gains and (losses) less capital gains tax of $(408,887) in 2018 and 89,227 in 2017	(1,538,193)	148,249
37	Change in net unrealized foreign exchange capital gain or (loss)	—	—
38	Change in net deferred income tax	(5,183,022)	(7,178,803)
39	Change in nonadmitted assets	12,128,036	(231,579)
40	Change in unauthorized and certified reinsurance	—	—
41	Change in treasury stock	—	—
42	Change in surplus notes	—	—
43	Cumulative effect of changes in accounting principles	—	—
44	Capital changes:		
	44.1 Paid in	—	990,000
	44.2 Transferred from surplus (Stock Dividend)	—	—
	44.3 Transferred to surplus	—	—
45	Surplus adjustments:		
	45.1 Paid in	—	(990,000)
	45.2 Transferred to capital (Stock Dividend)	—	—
	45.3 Transferred from capital	—	—
46	Dividends to stockholders	—	—
47	Aggregate write-ins for gains or (losses) in surplus	27,753	—
48	Net change in capital and surplus (Lines 34 to 47)	64,575,851	48,479,425
49	Capital and surplus end of reporting period (Line 33 plus 48)	$326,498,199	$261,922,347

	Details of Write-Ins		
4701	Other tax-related surplus adjustments	$27,753	$—
4702		—	—
4703		—	—
4799	Totals (Lines 4701 thru 4703) (Line 47 above)	$27,753	$—

See accompanying notes to statutory financial statements.

Statutory Statements of Cash Flows

		Current Year	Prior Year
	CASH FROM OPERATIONS		
1	Premiums collected net of reinsurance	$1,090,505,904	$1,125,954,663
2	Net investment income	18,140,983	17,511,807
3	Miscellaneous income	—	—
4	Total (Lines 1 through 3)	1,108,646,887	1,143,466,470
5	Benefit and loss related payments	950,102,213	1,002,057,647
6	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	—	—
7	Commissions, expenses paid and aggregate write-ins for deductions	125,269,154	103,782,491
8	Dividends paid to policyholders	—	—
9	Federal and foreign income taxes paid net of $0 tax on capital gains (losses)	21,745,323	27,025,769
10	Total (Lines 5 through 9)	1,097,116,690	1,132,865,907
11	Net cash from operations (Line 4 minus Line 10)	11,530,197	10,600,563
	CASH FROM INVESTMENTS		
12	Proceeds from investments sold, matured or repaid:		
	12.1 Bonds	197,532,407	116,787,533
	12.2 Stocks	—	—
	12.3 Mortgage loans	316,980	—
	12.4 Real estate	—	—
	12.5 Other invested assets	—	—
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	(722)	(470)
	12.7 Miscellaneous proceeds	547,760	—
	12.8 Total investment proceeds (Lines 12.1 to 12.7)	198,396,425	116,787,063
13	Cost of investments acquired (long-term only):		
	13.1 Bonds	169,085,405	69,990,769
	13.2 Stocks	—	—
	13.3 Mortgage loans	621,181	12,979,171
	13.4 Real estate	—	—
	13.5 Other invested assets	—	—
	13.6 Miscellaneous applications	—	494,470
	13.7 Total investments acquired (Lines 13.1 to 13.6)	169,706,586	83,464,410
14	Net increase (decrease) in contract loans and premium notes	—	—
15	Net cash from investments (Line 12.8 minus Lines 13.7 and 14)	28,689,839	33,322,653
	CASH FROM FINANCING AND MISCELLANEOUS SOURCES		
16	Cash provided (applied):		
	16.1 Surplus notes, capital notes	—	—
	16.2 Capital and paid in surplus, less treasury stock	—	—
	16.3 Borrowed funds	—	—
	16.4 Net deposits on deposit-type contracts and other insurance liabilities	—	—
	16.5 Dividends to stockholders	—	—
	16.6 Other cash applied	(35,804,648)	(34,496,988)
17	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(35,804,648)	(34,496,988)
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18	Net change in cash, cash equivalents and short-term investments (Line 11 plus Line 15 plus Line 17)	4,415,388	9,426,228
19	Cash, cash equivalents and short-term investments:		
	19.1 Beginning of year	14,204,888	4,778,660
	19.2 End of period (Line 18 plus Line 19.1)	$18,620,276	$14,204,888

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001	Non-cash bond transaction	$8,057,370	$12,655,315

See accompanying notes to statutory financial statements.

1. Organization and operation

Aetna Better Health of Kentucky Insurance Company (the "Company" or "ABH-KY") is a wholly-owned subsidiary of Coventry Health and Life Insurance Company, Inc. ("CH&L"), whose ultimate parent is CVS Health Corporation ("CVS Health"). On November 28, 2018, CVS Health acquired Aetna Inc. ("Aetna") and at that date became the Company's ultimate parent (the "Aetna Acquisition").

The Company contracts with the Commonwealth of Kentucky Department of Health and Human Services to provide health benefits to Medicaid and Children's Health Insurance Program ("CHIP") members. The Commonwealth of Kentucky expansion of Medicaid services on January 1, 2014 for coverage of populations including individuals, families regardless of status, up to 138% of the Federal Poverty Level. The expansion of this contract operates under the previous Medicaid contract and recipients receive the same benefits. The Company's current contract with the Commonwealth runs through June 30, 2019. The Company is currently working with the Commonwealth to finalize an extension on the contract through June 30, 2020.

The Company elected to use rounding in reporting amounts throughout the statutory financial statements and in the accompanying notes to the statutory financial statements (collectively, the "statements") and therefore summation of amounts and consistency between related amounts within the statements may be impacted by immaterial amounts.

2. Summary of significant accounting policies and going concern

Accounting practices

The accompanying statutory financial statements of the Company have been prepared in conformity with accounting practices prescribed or permitted by the Kentucky Department of Insurance ("KY DOI") (Kentucky Accounting Practices"). The KY DOI recognizes only statutory accounting practices prescribed or permitted by the Commonwealth of Kentucky for determining and reporting the financial condition and results of operations of an insurance company, which include accounting practices and procedures adopted by the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures Manual* ("NAIC SAP"). The Company's net income and capital and surplus as stated on a NAIC SAP basis and on the basis of practices prescribed or permitted by the Commonwealth of Kentucky were the same as of and for the years ended December 31, 2018 and 2017.

Kentucky Accounting Practices vary from U.S. generally accepted accounting principles ("GAAP"). The primary differences include the following:

- Certain assets, designated as nonadmitted assets (in part, uncollected premiums are nonadmitted in accordance with Statements of Statutory Accounting Principles ("SSAP") No. 6 - *Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers*) are not recorded as assets, but are charged to surplus. Thus, nonadmitting uncollected premiums eliminates the need for a separate allowance for doubtful accounts, which is utilized under GAAP;
- Certain assets, designated as nonadmitted assets (other receivables and prepaid capitation, which are nonadmitted in accordance with SSAP No. 4 - *Assets and Nonadmitted Assets*) are not recorded as assets, but are charged to surplus. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests are not recognized on the Statutory Statement of Assets, and are, therefore, considered nonadmitted;
- Bonds are recorded at amortized cost except for those with an NAIC designation of 3 through 6, which are reported at the lower of amortized cost or fair value. Therefore, changes in unrealized gains and losses for those securities held at amortized cost are not reflected in the financial statements. Under GAAP, bonds classified as available for sale are recorded at fair value, and related changes in unrealized gains and losses are recorded as a component of equity, net of deferred federal income taxes;
- Deferred tax assets and liabilities are determined and admitted in accordance with SSAP No. 101 - *Income Taxes* ("SSAP No. 101"). Changes in net deferred tax assets and liabilities are reflected as changes in surplus, whereas under GAAP, changes in such assets and liabilities are reflected in net income. In addition, statutory accounting requires consideration of a statutory allowance adjustment in the calculation of adjusted gross deferred tax assets and an admissibility test for deferred tax assets;

- In accordance with SSAP No. 2 - Revised - *Cash, Cash Equivalents, Drafts and Short-term Investments*, certain short-term borrowings are classified as a reduction of cash, cash equivalents, and short-term investments. Under GAAP, these amounts would have been classified as liabilities; and
- Cash, cash equivalents, and short-term investments in the statutory statements of cash flows represents cash balances and investments with remaining maturities of one year or less at the time of acquisition. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less. The statement does not classify cash flows consistent with GAAP and a reconciliation of net earnings to net cash provided by operations is not provided.

There were no permitted practices by the Commonwealth of Kentucky for the years ended December 31, 2018 and 2017.

Use of estimates in the preparation of the financial statements

The preparation of these financial statements in conformity with Kentucky Accounting Practices requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and revenue and expenses. Actual results could differ from those estimates.

Significant accounting policies

The Company applies the following significant accounting policies:

Cash, cash equivalents and short-term investments

Cash, cash equivalents and short-term investments, consisting primarily of money market instruments and other debt issues with an original maturity of up to one year, are carried at amortized cost. Short-term investments consist primarily of investments purchased with an original maturity date of greater than three months but less than one year. Cash equivalents consist of highly liquid instruments, which mature within three months from the date of purchase. The carrying amount of cash, cash equivalents and short-term investments approximates fair value. Cash accounts with positive balances shall not be reported separately from cash accounts with negative balances. If in the aggregate, the reporting entity has a net negative cash balance, it shall be reported as a negative asset and shall not be recorded as a liability.

Bonds

Bonds, which include special deposits as discussed more fully in Note 4, are carried at amortized cost except for those bonds with an NAIC designation of 3 through 6, which are carried at the lower of amortized cost or fair value. The amount carried at fair value is not material to the financial statements. Bond premiums and discounts are amortized using the scientific interest method. When quoted prices in active markets for identical assets are available, the Company uses these quoted market prices to determine the fair value of bonds. This is used primarily for U.S. government securities. In other cases where a quoted market price for identical assets in an active market is either not available or not observable, the Company estimates fair values using valuation methodologies based on available and observable market information or by using a matrix pricing model. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. The Company had no investments where fair value was determined using broker quotes or an internal analysis of financial performance and cash flow projections at December 31, 2018 and 2017. Bonds include all investments whose maturity is greater than one year when purchased.

The Company periodically reviews its bonds to determine whether a decline in fair value below the carrying value is other-than-temporary. For bonds, other than loan-backed and structured securities ("LB&SS"), an other-than-temporary impairment ("OTTI") shall be recorded if it is probable that the Company will be unable to collect all amounts due according to the contractual terms in effect at the date of acquisition. Declines deemed to be OTTI in the cost basis are recognized as realized capital losses. Yield-related impairments are deemed other-than-temporary when the Company intends to sell an investment at the reporting date before recovery of the cost of the investment.

For LB&SS, the Company records OTTI when the fair value of the loan-backed or structured security is less than the amortized cost basis at the balance sheet date and (1) the Company intends to sell the investment, or (2) the Company does

not have the intent and ability to retain the investment for the time sufficient to recover the amortized cost basis, or (3) the Company does not expect to recover the entire amortized cost basis of the security, even if it does not intend to sell the security and has the intent and ability to hold. If it is determined an OTTI has occurred because of (1) or (2), the amount of the OTTI is equal to the difference between the amortized cost and the fair value of the security at the balance sheet date and this difference is recorded as a realized capital loss. If it is determined an OTTI has occurred because of (3), the amount of the OTTI is equal to the difference between the amortized cost and the present value of cash flows expected to be collected, discounted at the loan-backed or structured security's effective interest rate and this difference is also accounted for as a realized capital loss.

The Company analyzes all relevant facts and circumstances for each investment when performing its analysis to determine whether an OTTI exists. Among the factors considered in evaluating whether a decline is other-than-temporary, management considers whether the decline in fair value results from a change in the quality of the investment security itself, whether the decline results from a downward movement in the market as a whole, the prospects for realizing the carrying value of the bond based on the investee's current and short-term prospects for recovery and other factors. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations and the risk that facts and circumstances factored into our assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods may result in a current period decision to sell securities that were not other-than-temporarily-impaired in prior reporting periods.

For the Company's bonds and LB&SS that provide for a prepayment penalty or acceleration fee in the event the bond or LB&SS is liquidated prior to its scheduled termination date, the Company reports such fees as investment income when earned.

Mortgage Loans on Real Estate

Mortgage loans on real estate ("Mortgage Loans") are carried at unpaid principal balances, adjusted for accrual of discounts and amortization of premiums. Mortgage loans funding and repayments are recorded on the closing date. Fair values are estimated by discounting expected mortgage loan cash flows at market rates that reflect the rates at which similar loans would be made to similar borrowers. These rates reflect management's assessment of the credit quality and the remaining duration of the loans. The fair value estimates of mortgage loans of lower credit quality, including problem and restructured loans, are based on the estimated fair value of the underlying collateral. Payment receipts on impaired loans are recorded on the cash basis. The Company recognizes interest income on impaired loans when received. The Company considers a loan impaired when it is probable that the loan will be uncollectible based on its contractual terms. The Company measures the impairment based on the fair value of the collateral less estimated costs to obtain and sell. The difference between the net value of the collateral and the recorded investment in the mortgage loan is recorded as a valuation allowance with a corresponding charge to unrealized loss. If the impairment is deemed other-than-temporary, a write-down is recognized as a realized loss, and a new cost basis is established. This new cost basis is not changed for subsequent recoveries in value. Mortgage loans for which foreclosure is probable are considered impaired.

Investment income due and accrued

Accrued investment income consists primarily of interest. Interest is recognized on an accrual basis and dividends are recorded as earned on the ex-dividend date. Due and accrued income is not recorded on: (a) bonds in default; and (b) bonds delinquent more than 90 days or where collection of interest is improbable. At December 31, 2018 and 2017, the Company did not have any nonadmitted investment income due and accrued.

Premiums and amounts due and unpaid

Premium revenue for health care products is recognized as income in the month in which enrollees are entitled to health care services. Premiums collected before the effective period are reported as premiums received in advance. Premiums related to unexpired contractual coverage periods are reported as unearned premiums in the Statutory Statements of Liabilities, Capital and Surplus (refer to discussion of aggregate health policy reserves and related expenses below).

Nonadmitted amounts consist of all premiums due and unpaid greater than 90 days past due, with the exception of amounts due under government insured plans, which may be admitted assets under certain circumstances.

Pharmaceutical rebate receivables

The Company estimates pharmaceutical rebate receivables based upon historical payment trends, actual utilization and other variables. Pharmaceutical rebates for a quarter are billed to the vendor within one month of the completion of the quarter with any adjustment to previously recorded amounts reflected at the time of billing. The Company reports pharmaceutical rebate receivables as health care receivables. Pharmacy rebate receivables not in accordance with SSAP No. 84 – *Health Care and Government Insured Plan Receivables* or are over 90 days past due are nonadmitted. All rebates are processed and settled with an affiliated entity. The pharmaceutical rebate receivables are more fully discussed in Note 8.

Hospital and medical costs and claims adjustment expenses and related reserves

Hospital and medical costs consist principally of fee-for-service medical claims and capitation costs. Claims unpaid and aggregate health claim reserves include the Company's estimate of payments to be made on claims reported but not yet paid and for health care services rendered to enrollees but not yet reported to the Company as of the Statutory Statements of Assets and Liabilities, Capital and Surplus date. Such estimates are developed using actuarial principles and assumptions, which consider, among other things, historical and projected claim submission and processing payment patterns, medical cost trends, historical utilization of health care services, claim inventory levels, medical inflation, contract requirement changes in membership and product mix, seasonality and other relevant factors. The Company reflects changes in estimates in hospital and medical costs in the Statutory Statements of Revenue and Expenses in the period they are determined. Capitation costs, which are recorded in hospital and medical expenses in the Statutory Statements of Revenue and Expenses, represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the medical services provided to the enrollee.

The Company uses the triangulation method to estimate reserves for claims incurred but not reported. The method of triangulation makes estimates of completion factors that are then applied to the total paid claims (net of coordination of benefits) to date for each incurral month. This provides an estimate of the total projected incurred claims and total amount outstanding or claims incurred but not reported (claims unpaid). For the most current dates of service where there is insufficient paid claim data to rely solely on the triangulation method, the Company examines cost and utilization trends as well as environmental factors, plan changes, provider contracts, changes in membership and/or benefits, and historical seasonal patterns to estimate the reserve required for these months.

Claims adjustment expenses, which include cost containment expenses, represent the costs incurred related to the claim settlement process such as costs to record, process and adjust claims. These expenses are included in the Company's management agreement with an affiliate described in Note 7.

Aggregate health policy reserves and related expenses

Premium deficiency reserves ("PDR") are recognized when it is probable that the expected future hospital and medical costs, including maintenance costs, will exceed anticipated future premiums and reinsurance recoveries on existing contracts. Where allowed, anticipated investment income is considered in the calculation of any PDR. For purposes of calculating a PDR, contracts are grouped in manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts. The Company had no PDR at December 31, 2018 and 2017.

As a part of the Company's Kentucky Medicaid business, a risk corridor accrual related to the Federal Affordable Care Act ("ACA") expansion members has been established. Per the Medicaid contract, the Commonwealth of Kentucky has a symmetrical risk corridor established around a targeted medical loss ratio. Based on the contractual requirements, the Company recorded no liability at December 31, 2018 and 2017 within the Aggregate Health Policy Reserve line on the Statutory Statements of Liabilities, Capital and Surplus.

Fees Paid to the Federal Government by Health Insurers

SSAP No. 106 - *Affordable Care Act Section 9010 Assessment* ("SSAP No. 106") required (1) that the health insurer fee be recognized in full on January 1 of the fee year (the calendar year in which the assessment must be paid to the federal government), in the operating expense category of insurance taxes, licenses and fees, excluding federal income taxes and

(2) that in each data year preceding a fee year a reporting entity pro-ratably accrue by reclassifying from unassigned funds (surplus) to aggregate write-ins for special surplus funds an amount equal to its estimated subsequent fee year assessment. This reclassification has no impact on total capital and surplus and is reversed in full on January 1 of the fee year. On January 22, 2018, Public Law No: 115-120 was signed into law and it imposes a moratorium on the health insurer fee for calendar year 2019. As interpreted in INT 18-02: ACA Section 9010 Assessment Moratoriums, because there is not an ACA Section 9010 fee due in September 2019, there is not an accrual of a liability on January 1, 2019 based on 2018 data year net written premiums. Accrual of a liability on January 1, 2020 for the ACA Section 9010 assessment based on 2019 data year net written premiums and the reclassification from unassigned funds (surplus) to aggregate write-ins for special surplus funds equal to the estimated 2020 fee year assessment accrued in data year 2019 will both continue as prescribed under SSAP No. 106. See Note 16 for disclosure of all amounts related to the health insurer fee for the Company.

Federal and state income taxes

The Company was included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries through November 27, 2018 pursuant to the terms of a tax sharing agreement. For the tax period from November 28, 2018 through December 31, 2018, Aetna and its wholly-owned subsidiaries are included in the consolidated federal income tax return of its parent company, CVS Health, pursuant to the terms of a tax sharing agreement (and a Supplemental Tax Sharing Agreement where applicable) between CVS Health and the Company.

In accordance with both agreements, the Company's current federal and state income tax provisions are generally computed as if the Company were filing a separate federal and state income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent realized in the consolidated return. Pursuant to these agreements, the Company has the enforceable right to recoup federal and state income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal and state income taxes.

Income taxes are accounted for under the asset and liability method. Deferred income tax assets ("DTAs") and liabilities ("DTLs") represent the expected future tax consequences of temporary differences generated by statutory accounting as defined in SSAP No. 101. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. DTAs and DTLs are computed by means of identifying temporary differences which are measured using a balance sheet approach whereby statutory and tax basis balance sheets are compared. Current income tax recoverables include all current income taxes, including interest, reasonably expected to be recovered in a subsequent accounting period.

Pursuant to SSAP No. 101, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized ("adjusted gross DTAs"). Adjusted gross DTAs are then admitted in an amount equal to the sum of paragraphs a. b. and c. below:

a. Federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse during a timeframe corresponding with Internal Revenue Service ("IRS") tax loss carryback provisions.

b. The amount of adjusted gross DTAs, after the application of paragraph a. above, expected to be realized within the applicable period and that is no greater than the applicable percentage as determined using the applicable Realization Threshold Limitation Table. The applicable period refers to the number of years in which the DTA will reverse in the Company's tax return and the applicable percentage refers to the percentage of the Company's statutory capital and surplus as required to be shown on the statutory balance sheet adjusted to exclude any net DTAs, electronic data processing equipment and operating system software and any net positive goodwill ("Stat Cap ExDTA").

   The Realization Threshold Limitation Tables allow DTAs to be admitted based upon either realization within 3 years and 15% of Stat Cap ExDTA, 1 year and 10% of Stat Cap ExDTA, or no DTA admitted pursuant to this

paragraph b. In general, the Realization Threshold Limitation Tables allow the Company to admit more DTAs if total DTAs as reported by the Company are a smaller percentage of statutory capital and surplus.

c. The amount of gross DTAs, after the application of paragraphs a. and b. above that can be offset against existing gross DTLs. In applying this offset, the Company considers the character (i.e. ordinary versus capital) of the DTAs and DTLs such that offsetting would be permitted in the tax return under existing enacted federal income tax laws and regulations and the reversal patterns of temporary differences.

Changes in DTAs and DTLs are recognized as a separate component of gains and losses in surplus ("Change in net deferred income tax") except to the extent allocated to changes in unrealized gains and losses. Changes in DTAs and DTLs allocated to unrealized gains and losses are netted against the related changes in unrealized gains and losses and are reported as "Change in net unrealized capital gains (losses)", also a separate component of gains and losses in surplus.

The Company is subject to state income taxes in the Commonwealth of Kentucky. State income tax expense is recorded in general administrative expenses in the Statutory Statements of Revenue and Expenses.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "TCJA") was enacted. Among other things, the TCJA reduced the federal corporate income tax rate to 21% effective January 1, 2018. Aside from the change in the corporate income tax rate, the TCJA did not have a material impact to the financial statements.

Going concern

As of May 30, 2019, management evaluated whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern and management has determined that it is not probable that the Company will be unable to meet its obligations as they become due within one year after the financial statements are available to be issued. Management will continuously evaluate the Company's ability to continue as a going concern and will take appropriate action and will make appropriate disclosures if there is any change in any condition or events that would raise substantial doubt about the Company's ability to continue as a going concern.

3. Accounting changes and corrections of errors

The Company did not have any accounting changes or corrections of errors in the year ended December 31, 2018 and 2017.

4. Special deposits

Special deposits, included in bonds, consist of U.S. Government obligations, at amortized cost, which approximates fair value, of $1,224,310 and $1,241,056 in 2018 and 2017, respectively. These assets are restricted in accordance with certain state requirements relating to Health Maintenance Organizations (HMOs).

5. Bonds and other financial instruments

The following is a summary of bonds and other financial instruments receiving bond treatment, which include special deposits, cash equivalents, and short-term investments, at December 31, 2018 and 2017:

December 31, 2018

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$58,648,109	$58,648,109	$803,010	($133,633)	$59,317,486
All other governments	25,937,421	25,670,462	646,661	(249,811)	26,067,312
U.S. states, territories and possessions (direct and guaranteed)	28,858,342	28,858,342	163,462	(345,124)	28,676,680
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	27,138,785	27,138,785	490,281	(82,767)	27,546,299
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	126,200,245	126,200,245	3,104,274	(288,028)	129,016,491
Industrial and miscellaneous (unaffiliated)	189,050,492	187,326,725	569,409	(1,992,514)	185,903,620
Total	$455,833,394	$453,842,668	$5,777,097	($3,091,877)	$456,527,888

December 31, 2017

	Amortized cost	Statutory carrying value	Gross unrealized gains	Gross unrealized losses	Fair value
U.S. Government	$52,347,259	$52,347,259	$20,571	($102,213)	$52,265,617
All other governments	26,042,556	26,042,548	2,026,870	(39,748)	28,029,670
U.S. states, territories and possessions (direct and guaranteed)	42,907,202	42,907,202	555,988	(148,042)	43,315,148
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	27,016,736	27,016,735	730,986	(25,943)	27,721,778
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	148,991,123	148,991,125	4,551,898	(185,569)	153,357,454
Industrial and miscellaneous (unaffiliated)	196,843,031	196,799,391	1,956,994	(1,458,839)	197,297,546
Total	$494,147,907	$494,104,260	$9,843,307	($1,960,354)	$501,987,213

Summarized below are the Company's bonds and other financial instruments receiving bond treatment, which include special deposits, with unrealized losses at December 31, 2018 and 2017, along with the related fair values, aggregated by the length of time the investments have been in an unrealized loss position:

December 31, 2018

	Less than 12 months			Greater than 12 months		
	Number of Securities	Fair value	Unrealized losses	Number of Securities	Fair value	Unrealized losses
U.S. governments	—	$—	$—	1	$2,750,896	($133,633)
U.S. all other governments	5	5,448,059	(188,167)	2	978,929	(61,644)
U.S. states, territories and possessions (direct and guaranteed)	—	—	—	2	14,767,660	(345,124)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	—	—	—	4	5,869,007	(82,767)
U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	6	10,706,589	(25,594)	12	20,507,910	(262,434)
Industrial and miscellaneous (unaffiliated)	35	50,130,673	(364,160)	28	49,353,851	(1,628,354)
Total	46	$66,285,321	($577,921)	49	$94,228,253	($2,513,956)

	Total		
	Number of Securities	Fair value	Unrealized losses
U.S. governments	1	$2,750,896	($133,633)
U.S. all other governments	7	6,426,988	(249,811)
U.S. states, territories and possessions (direct and guaranteed)	2	14,767,660	(345,124)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	4	5,869,007	(82,767)
U.S. special revenue and assessment obligations and all non–guaranteed obligations of agencies and authorities of governments and their political subdivisions	18	31,214,499	(288,028)
Industrial and miscellaneous (unaffiliated)	63	99,484,524	(1,992,514)
Total	95	$160,513,574	($3,091,877)

December 31, 2017

	Less than 12 months			Greater than 12 months		
	Number of Securities	Fair value	Unrealized losses	Number of Securities	Fair value	Unrealized losses
U.S. governments	1	$2,995,910	($182)	2	$4,680,916	($102,031)
All other Government	2	1,032,592	(9,241)	1	1,468,028	(30,507)
U.S. states, territories and possessions (direct and guaranteed)	—	—	—	1	5,650,300	(148,043)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	4	2,869,797	(25,943)	—	—	—
U.S. special revenue and assessment obligations and all non–guaranteed obligations of agencies and authorities of governments and their political subdivisions	22	31,154,282	(144,093)	3	2,283,852	(41,476)
Industrial and miscellaneous (unaffiliated)	35	40,380,736	(220,522)	29	65,081,155	(1,238,316)
Total	64	$78,433,317	($399,981)	36	$79,164,251	($1,560,373)

	Total		
	Number of Securities	Fair value	Unrealized losses
U.S. governments	3	$7,676,826	($102,213)
All other Government	3	2,500,620	(39,748)
U.S. states, territories and possessions (direct and guaranteed)	1	5,650,300	(148,043)
U.S. political subdivisions of states, territories and possessions (direct and guaranteed)	4	2,869,797	(25,943)
U.S. special revenue and assessment obligations and all non–guaranteed obligations of agencies and authorities of governments and their political subdivisions	25	33,438,134	(185,569)
Industrial and miscellaneous (unaffiliated)	64	105,461,891	(1,458,838)
Total	100	$157,597,568	($1,960,354)

The Company has reviewed the investments in the table above and has concluded that these are performing assets generating investment income to support the needs of the business. In performing this review, the Company considered factors such as the

quality of the investment security based on research performed by external rating agencies and internal credit analysts and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. Furthermore, the Company has no intention to sell the investments in the table above at December 31, 2018 and 2017 before their cost can be recovered and for loan-backed and structured securities the Company has the ability and intent to hold these securities for a period of time sufficient to recover the amortized cost; therefore, no OTTI was determined to have occurred on these investments during the years December 31, 2018 and 2017. In determining if the Company needs to sell before full recovery of value, the Company considers the forecasted recovery period, expected investment returns relative to other funding sources, projected cash flow and capital requirements, regulatory obligations, and other factors. Unrealized losses at December 31, 2018 and 2017 were generally caused by the widening of market credit spreads for these securities relative to interest rates on U.S. Treasury securities.

The contractual or expected maturities of bonds and assets receiving bond treatment (e.g., cash equivalents and short-term investments) at December 31, 2018 were as follows:

	Carrying value	Fair value
Due one year or less	$61,512,276	$61,464,332
Due after one year through five years	217,243,442	219,037,793
Due after five years through ten years	149,638,568	149,708,524
Due after ten years	25,448,382	26,317,239
Total	$453,842,668	$456,527,888

The maturity for a mortgage pass-through security, included in U.S. Government and U.S. special revenue and assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions, is not based on stated maturity, but instead is based on prepayment assumptions. Prepayment assumptions are calculated utilizing published repayment factors that estimate the prepayment rates on the mortgages in the Federal National Mortgage Association and Government National Mortgage Association pools.

Proceeds from the sales of bonds and other financial instruments were $139,812,848 and $80,611,517 in 2018 and 2017, respectively. Proceeds from the maturities of bonds were $57,719,559 and $36,176,016 in 2018 and 2017, respectively. Gross realized gains on sales of bonds were $446,315 and $1,747,772 in 2018 and 2017, respectively. Gross realized losses on sales of bonds were $2,895,203 and $693,639 in 2018 and 2017, respectively. Included in net realized capital losses for 2018 and 2017 were $1,362,411 and $198,909, respectively, of OTTI charges on bonds that were in an unrealized loss position. The Company conducts regular reviews of its bond investments to assess whether a decline in fair value below carrying value is an OTTI. The Company will also recognize an OTTI on bonds when the Company intends to sell a security that is in an unrealized loss position. The Company had no individually material realized capital losses bonds or other financial instruments receiving bond treatment that impacted its results of operations in 2018 or 2017.

The Company's unrealized loss position on loan-backed and structured securities held by the Company at December 31, 2018 and 2017 is as follows:

December 31, 2018

a. The aggregate amount of unrealized losses:		
	1. Less than 12 months	($7,737)
	2. 12 months or longer	(719,126)
b. The aggregate related fair value of securities with unrealized losses:		
	1. Less than 12 months	$1,502,474
	2. 12 months or longer	18,517,621

December 31, 2017

a. The aggregate amount of unrealized losses:

1. Less than 12 months	($34,404)
2. 12 months or longer	(433,506)

b. The aggregate related fair value of securities with unrealized losses:

1. Less than 12 months	$8,730,961
2. 12 months or longer	21,356,860

The Company has reviewed the loan-backed and structured securities in accordance with SSAP No. 43R - *Loan-Backed and Structured Securities* ("SSAP No. 43R") in the table above and have concluded that these are performing assets generating investment income to support the needs of the business. Furthermore, the Company has no intention to sell the securities at December 31, 2018 or 2017 before their cost can be recovered and does have the intent and ability to retain the securities for the time sufficient to recover the amortized cost basis; therefore, no OTTI write-down to fair value was determined to have occurred on these securities.

There was no investment income due and accrued excluded from surplus at December 31, 2018 or 2017.

The Company did not have any 5GI* securities at December 31, 2018 or 2017.

The Company did not have any assets pledged as collateral not captured in other categories at December 31, 2018 or 2017.

The Company did not have any other restricted assets at December 31, 2018 or 2017.

For securities sold, redeemed or otherwise disposed as a result of a callable feature, prepayment and acceleration fees as of December 31, 2018 and 2017 were:

	2018	2017
1. Number of CUSIPs	10	20
2. Aggregate Amount of Investment Income	$313,626	$208,756

Mortgage Loans

The Company did not have new mortgage loans in 2018.

The maximum percentage of any one loan to the value of security at the time of the loan, exclusive of insured or guaranteed or purchase money mortgages was 61%. There were no loans with a loan to value of security at the time of closing over 61% during 2018.

As of December 31, 2018 and 2017, the Company did not hold any mortgages with interest more than 180 days past due with a recorded investment excluding accrued interest. There was no interest due on mortgages with interest more than 180 days past due as of December 31, 2018 and 2017.

Payment receipts on impaired loans are recorded on the cash basis. The Company recognizes interest income on impaired loans when received. The Company had no impaired loans investment and reserves at December 31, 2018 and 2017.

The Company assesses mortgage loans on a regular basis for credit impairments, and annually assigns a credit quality indicator to each loan. The credit quality indicator is internally developed and categorizes the Company's portfolio on a scale from 1 to 7. Category 1 represents loans of superior quality, and Categories 7 represent loans where collections are potentially at risk. The vast majority of the Company's mortgage loans fall into the Level 2 - 4 ratings. These ratings represent loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes. Category 5 and 6 represents

loans where credit risk is not substantial but these loans warrant management's close attention. These indicators are based upon several factors, including current loan to value ratios, property condition, market trends, credit worthiness of the borrower and deal structure. The Company did not have any loans in Category 7. Based upon the Company's most recent assessment at December 31, 2018, the Company's mortgage loans were given the following credit rating indicators:

Credit Rating Indicator	Total
1	$—
2 - 4	13,407,858
5 & 6	—
Total	$13,407,858

As of December 31, 2018, scheduled mortgage loan principal repayments were as follows:

2021	$5,803,426
2022	7,604,432

6. Financial instruments

Financial instruments measured at fair value in the financial statements

Certain of the Company's financial instruments are measured at fair value in the financial statements. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by U.S. generally accepted accounting principles. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** – Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3** – Developed from unobservable data, reflecting the Company's own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The carrying values and estimated fair values of the Company's financial instruments at December 31, 2018 and 2017 were as follows:

December 31, 2018

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3	Not practicable (carrying value)
Bonds, Short Term, and Cash Equivalent	$456,527,887	$453,842,667	$56,565,551	$399,962,336	$—	$—
Mortgage Loans	14,062,100	13,407,858	—	—	14,062,100	—
Total	$470,589,987	$467,250,525	$56,565,551	$399,962,336	$14,062,100	$—

December 31, 2017

	Aggregate fair value	Admitted assets	Level 1	Level 2	Level 3	Not practicable (carrying value)
Bonds, Short Term, and Cash Equivalent	$501,987,213	$494,104,260	$48,822,380	$453,164,833	$—	$—
Mortgage Loans	13,845,022	12,979,171	—	—	13,845,022	—
Total	$515,832,235	$507,083,431	$48,822,380	$453,164,833	$13,845,022	$—

The valuation methods and assumptions used by the Company in estimating the fair value of bonds are discussed in Note 2.

There were no material realized and unrealized capital gains, purchases, sales, settlements, or transfers into or out of the Company's Level 3 financial assets during 2018. During 2017, mortgage loan investments of $13,845,022 were transferred at fair value from Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of Aetna, whose ultimate parent is CVS Health. There were no transfers between the Company's Level 1 or 2 financial assets during 2018 or 2017.

In evaluating the Company's management of interest rate and liquidity risk and currency exposures, the fair values of all assets and liabilities should be taken into consideration, not only those presented above.

Offsetting and netting of financial assets and liabilities

The Company did not have any offsetting and netting of financial assets or liabilities as of December 31, 2018 or 2017.

7. Information concerning parent, subsidiaries, and affiliates

As of and for the years ended December 31, 2018 and 2017, the Company had the following significant transactions with affiliates:

The Company and Aetna Medicaid Administrators LLC ("AMA") are parties to an administrative services agreement, under which AMA and certain of its affiliates provide certain administrative services, including cash management and accounting and processing of premiums and claims on the Company's Kentucky Medicaid business. Under this agreement, the Company will remit a percentage of its earned premium revenue, as applicable, to AMA as a fee. For these services, the Company was charged $86,941,598 and $86,588,034 in 2018 and 2017, respectively.

These agreements also provide for interest on all intercompany balances. There was no interest earned on amounts due from affiliates was in 2018 and 2017. There was no interest incurred on amounts due to affiliates in 2018 and 2017.

As explained in Note 2, the Company participated in a tax sharing agreement with Aetna and Aetna's other subsidiaries through November 27, 2018. Also, as explained in Note 2, the Company participates in a tax sharing agreement with CVS Health for the period from November 28, 2018 through December 31, 2018. All federal income tax receivables/payables are due from/due to Aetna for tax periods ending on or before November 27, 2018. All federal income tax receivables/payables related to the

period beginning November 28, 2018 through December 31, 2018 are due from/due to CVS Health in accordance with the tax sharing agreement with CVS Health.

At December 31, 2018 and 2017, the Company had the following amounts due to/from affiliates, which exclude amounts related to pharmacy rebate transactions as discussed more fully in Note 8:

	December 31	
	2018	2017
Amounts due from affiliates		
AMA	$7,789,355	$—
CH&L	—	2,260,618
Aetna Health Management, LLC ("AHM")	—	4,471
	$7,789,355	$2,265,089

	December	
	2018	2017
Amounts due to affiliates		
Aetna, Inc.	$13,806,924	$33,688,103
AMA	—	11,615,610
CH&L	13,316	—
Aetna Life Insurance Company	26	—
	$13,820,266	$45,303,713

The terms of settlement require that these amounts be settled within 45 days after the end of the calendar quarter.

8. Health care receivables

Pharmaceutical rebates

The Company receives pharmaceutical rebates through an agreement with AHM. AHM has contractual agreements with pharmaceutical companies for rebates, which cover the Company's membership as well as the membership of other Aetna affiliates. The Company receives those rebates from AHM that relate to the Company's membership. The Company estimates pharmaceutical rebate receivables based upon the historical payment trends, actual utilization and other variables. Actual rebates collected are applied to the collection periods below, using a first in first out methodology. At December 31, 2018 and 2017, the Company has pharmaceutical rebate receivables of $2,070,247 and $1,758,384, respectively (refer to the Company's accounting practices related to pharmaceutical rebates receivables in Note 2).

The following table discloses the quarterly revenue and subsequent cash collections relating to the pharmaceutical rebates discussed in Note 2:

Quarter	Estimated pharmacy rebates as reported on financial statements	Pharmacy rebates as invoiced/ confirmed	Actual rebates collected within 90 days of invoicing/ confirmation	Actual rebates collected within 91 to 180 days of invoicing/ confirmation	Actual rebates collected more than 180 days after invoicing/ confirmation
12/31/2018	$2,070,247	$—	$—	$—	$—
09/30/2018	2,045,290	2,070,247	—	—	—
06/30/2018	1,993,244	2,044,005	458,375	—	—
03/31/2018	1,861,812	1,993,905	524,216	1,334,843	—
12/31/2017	$1,758,384	$1,859,880	$816,711	$950,456	$29,278
09/30/2017	1,746,114	1,756,191	741,775	987,315	2,033
06/30/2017	1,656,531	1,744,103	424,719	1,163,704	59,218
03/31/2017	1,839,409	1,647,286	523,499	1,100,655	1,475
12/31/2016	$1,920,365	$1,798,304	$596,429	$1,184,747	$1,114
09/30/2016	2,143,692	2,136,477	1,185,618	942,594	842
06/30/2016	1,876,911	1,871,046	640,940	1,051,637	168,809
03/31/2016	696,424	706,184	216,827	361,714	107,152

In reference to the actual rebates collected within 90 days of invoicing/confirmation for the quarter ended December 31, 2018, the value in the table above represents a portion of the estimated rebates for that quarter, which were paid by AHM to the Company prior to December 31, 2018 and invoicing in 2019.

9. Income taxes

The components of the net DTAs recognized in the Company's Statutory Statements of Assets and Liabilities, Capital and Surplus are as follows:

	December 31, 2018		
	Ordinary	Capital	Total
Gross DTAs	$5,412,223	$951,798	$6,364,021
Statutory valuation allowance adjustment	—	(867,381)	(867,381)
Adjusted gross DTAs	5,412,223	84,417	5,496,640
DTAs nonadmitted	—	—	—
Subtotal net admitted DTAs	5,412,223	84,417	5,496,640
DTLs	(292,215)	—	(292,215)
Net admitted DTAs/(DTLs)	$5,120,008	$84,417	$5,204,425

	December 31, 2017		
	Ordinary	Capital	Total
Gross DTAs	$9,749,774	$228,786	$9,978,560
Statutory valuation allowance adjustment	—	—	—
Adjusted gross DTAs	9,749,774	228,786	9,978,560
DTAs nonadmitted	(28,286)	(113,413)	(141,699)
Subtotal net admitted DTAs	9,721,488	115,373	9,836,861
DTLs	—	—	—
Net admitted DTAs	$9,721,488	$115,373	$9,836,861

	Change		
	Ordinary	Capital	Total
Gross DTAs	($4,337,551)	$723,012	($3,614,539)
Statutory valuation allowance adjustment	—	(867,381)	(867,381)
Adjusted gross DTAs	(4,337,551)	(144,369)	(4,481,920)
DTAs nonadmitted	28,286	113,413	141,699
Subtotal net admitted DTAs	(4,309,265)	(30,956)	(4,340,221)
DTLs	(292,215)	—	(292,215)
Net admitted DTAs/(DTLs)	($4,601,480)	($30,956)	($4,632,436)

The amount of admitted gross DTAs admitted under each component of SSAP No. 101 is as follows:

	December 31, 2018		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$5,387,246	$84,417	$5,471,663
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	24,977	—	24,977
1. Adjusted gross DTAs expected to be realized following the balance sheet date	24,977	—	24,977
2. Adjusted gross DTAs allowed per limitation threshold	**N/A**	**N/A**	48,194,066
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	—	—	—
(d) DTAs admitted as the result of application of SSAP No. 101	$5,412,223	$84,417	$5,496,640

	December 31, 2017		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	$9,719,029	$115,373	$9,834,402
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	2,459	—	2,459
1. Adjusted gross DTAs expected to be realized following the balance sheet date	2,459	—	2,459
2. Adjusted gross DTAs allowed per limitation threshold	**N/A**	**N/A**	37,812,823
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	—	—	—
(d) DTAs admitted as the result of application of SSAP No. 101	$9,721,488	$115,373	$9,836,861

	Change		
	Ordinary	Capital	Total
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	($4,331,783)	($30,956)	($4,362,739)
(b) Adjusted gross DTAs expected to be realized (excluding the amount of DTAs) after application of the threshold limitations (the lesser of (b)1 and (b)2 below):	22,518	—	22,518
1. Adjusted gross DTAs expected to be realized following the balance sheet date	22,518	—	22,518
2. Adjusted gross DTAs allowed per limitation threshold	**N/A**	**N/A**	10,381,243
(c) Adjusted gross DTAs (excluding the amount of DTAs from (a) and (b) above) offset by gross DTLs	—	—	—
(d) DTAs admitted as the result of application of SSAP No. 101	($4,309,265)	($30,956)	($4,340,221)

	2018	2017
(a) Ratio percentage used to determine recovery period and threshold limitation amount	911%	676%
(b) Amount of adjusted capital and surplus used to determine recovery period threshold limitation in (b)2 above	$321,293,774	$252,085,485

The impact of tax planning strategies is as follows:

	December 31, 2018		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$5,412,223	$84,417	$5,496,640
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	—%	—%	—%
3. Net admitted adjusted gross DTAs	5,412,223	84,417	5,496,640
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	—%	—%	—%

	December 31, 2017		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	$9,749,774	$228,786	$9,978,560
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	—%	—%	—%
3. Net admitted adjusted gross DTAs	9,721,488	115,373	9,836,861
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	—%	—%	—%

	Change		
	Ordinary	Capital	Total
(a) Determination of adjusted gross DTAs and net admitted DTAs, by tax character as a percentage:			
1. Adjusted gross DTAs	($4,337,551)	($144,369)	($4,481,920)
2. Percentage of adjusted DTAs by tax character attributable to the impact of tax planning strategies	—%	—%	—%
3. Net admitted adjusted gross DTAs	(4,309,265)	(30,956)	(4,340,221)
4. Percentage of net admitted adjusted DTAs by tax character admitted because of the impact of tax planning strategies	—%	—%	—%

The Company's tax-planning strategies do not include the use of reinsurance.

There are no DTLs that were not recognized at December 31, 2018 or 2017.

The provision (benefit) for income taxes for the years ended December 31, 2018 and 2017 was as follows:

	2018	2017	Change
Federal income tax/(benefit) on operations	$18,504,307	$20,912,254	($2,407,947)
Federal income tax provision on net capital gains (losses)	(480,125)	216,907	(697,032)
Federal income tax incurred/(benefit)	$18,024,182	$21,129,161	($3,104,979)

The tax effects of temporary differences that gave rise to deferred tax assets and liabilities at December 31, 2018 and 2017 were as follows:

	2018	2017	Change
Deferred Tax Assets:			
Ordinary:			
Discounting of Unpaid Losses	$2,497,708	$2,961,004	($463,296)
Unearned Premiums	27	1,336,094	(1,336,067)
Nonadmitted Assets	2,914,488	5,424,390	(2,509,902)
Other	—	28,286	(28,286)
Gross Ordinary Deferred Tax Assets	5,412,223	9,749,774	(4,337,551)
Statutory Valuation Allowance Adjustment	—	—	—
Nonadmitted Ordinary Deferred Tax Assets	—	(28,286)	28,286
Admitted Ordinary Deferred Tax Assets	5,412,223	9,721,488	(4,309,265)
Capital:			
Investments	951,798	221,558	730,240
Other	—	7,228	(7,228)
Gross Capital Deferred Tax Assets	951,798	228,786	723,012
Statutory Valuation Allowance Adjustment	(867,381)	—	(867,381)
Nonadmitted Capital Deferred Tax Assets	—	(113,413)	113,413
Admitted Capital Deferred Tax Assets	84,417	115,373	(30,956)
Admitted Deferred Tax Assets	5,496,640	9,836,861	(4,340,221)
Deferred Tax Liabilities:			
Ordinary:			
Investments	84,332	—	84,332
Discounted Unpaid Losses - TCJA Transitional Tax Adjustment	207,883	—	207,883
Ordinary Deferred Tax Liabilities	292,215	—	292,215
Capital:			
Investments	—	—	—
Capital Deferred Tax Liabilities	—	—	—
Total Deferred tax liabilities	292,215	—	292,215
Net Deferred Tax Assets/(Liabilities)	$5,204,425	$9,836,861	($4,632,436)

The change in net deferred income taxes is comprised of the following:

	December 31		
	2018	2017	Change
Total DTAs	$5,496,640	$9,978,560	($4,481,920)
Total DTLs	(292,215)	—	(292,215)
Net DTAs/(DTLs)	$5,204,425	$9,978,560	($4,774,135)
Tax effect of unrealized gains (losses)			(408,887)
Change in net deferred income tax			($5,183,022)

The valuation allowance adjustment to gross DTAs was $867,381 and $0 for December 31, 2018 and 2017, respectively.

The provision (benefit) for federal income taxes is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The items causing this difference are as follows:

	December 31, 2018	Effective tax rate	December 31, 2017	Effective tax rate
Provision computed at statutory rate	$16,204,746	21.0 %	$26,904,752	35.0 %
Health Insurer Fee	4,732,648	6.1 %	—	— %
Transfer Pricing Adjustment	(2,217,398)	(2.9)%	(4,811,815)	(6.3)%
Tax-Exempt Interest	(945,532)	(1.2)%	(1,612,753)	(2.1)%
Change in Nonadmitted Assets	2,517,130	3.3 %	(1,170,956)	(1.5)%
Prior Year True-Up	1,161,009	1.5 %	690,147	0.9 %
Change in Valuation Allowance Adjustment	867,381	1.1 %	—	— %
Impact on Deferred Tax for Enacted Rate Change	—	— %	6,646,263	8.6 %
Other	887,220	1.1 %	1,662,326	2.2 %
Total	$23,207,204	30.1 %	$28,307,964	36.8 %
Federal and foreign income Tax expense/(benefit) incurred	$18,024,182	23.4 %	$21,129,161	27.5 %
Change in net deferred income taxes	5,183,022	6.7 %	7,178,803	9.3 %
Total statutory income taxes/(benefit)	$23,207,204	30.1 %	$28,307,964	36.8 %

The transfer pricing adjustment allows taxpayers to apply different methods to price current period intercompany services at arm's length prices as compared to what would be charged to an unrelated entity, which results in a permanent deduction for tax reporting purposes.

At December 31, 2018 and 2017, the Company had no net capital loss or net operating loss carryforwards for tax purposes.

The amount of federal income taxes incurred that is available for recoupment in the event of future net losses are:

Year	Ordinary	Capital	Total
2018	$1,439,972	$—	$1,439,972
2018	15,839,697	—	15,839,697
2017	N/A	216,907	216,907
Total	$17,279,669	$216,907	$17,496,576

The Company did not report any deposits as admitted assets under Internal Revenue Code Section 6603 at December 31, 2018 and 2017.

At December 31, 2018, the Company's Federal Income Tax Return was consolidated with the following entities:

Aetna Inc.
@ Credentials Inc.
Accordant Common, LLC
Accuscript MO, Inc.
Active Health Management, Inc.
Administrative Enterprises, Inc.
Advanced Healthcare Distributors, LLC
ADVANCERX.COM, LLC
Aetna Behavioral Health, LLC
Aetna Better Health Inc. (IL)
Aetna Better Health Inc. (NY)
Aetna Better Health Inc. (Tennessee)
Aetna Better Health of Iowa, Inc.
Aetna Better Health of Kentucky Insurance Co.
Aetna Better Health of Missouri LLC
Aetna Better Health of North Carolina, Inc.
Aetna Better Health of Texas, Inc.
Aetna Better Health, Inc. (Connecticut)
Aetna Better Health, Inc. (PA)
Aetna Card Solutions, LLC
Aetna Dental Inc. (Texas)
Aetna Financial Holdings, LLC
Aetna Health Holdings, LLC
Aetna Health Inc. (Florida)
Aetna Health Inc. (LA)
Aetna Health Inc. (Michigan)
Aetna Health Inc. (NY)
Aetna Health Inc. (Texas)
Aetna Health Insurance Company of New York
Aetna Health of California Inc.
Aetna Health of Utah, Inc.
Aetna Integrated Informatics, Inc.
Aetna Ireland Inc.
Aetna Medicaid Administrators LLC
CVS Health Corporation
Accendo Insurance Company
Accordant Health Services, LLC
ACS Acqco Corp.
Adminco, Inc.
Advanced Care Scripts, Inc.
AdvancePCS Specialty Rx, LLC
Aetna Asset Advisors, LLC
Aetna Better Health Inc. (Georgia)
Aetna Better Health Inc. (NJ)
Aetna Better Health Inc. (OH)
Aetna Better Health of California, Inc.
Aetna Better Health of Kansas Inc.
Aetna Better Health of Michigan, Inc.
Aetna Better Health of Nevada Inc.
Aetna Better Health of Oklahoma Inc.
Aetna Better Health of Washington, Inc.
Aetna Better Health, Inc. (LA)
Aetna Capital Management, LLC
Aetna Dental Inc. (New Jersey)
Aetna Dental of California, Inc.
Aetna Florida, Inc.
Aetna Health Inc. (Connecticut)
Aetna Health Inc. (Georgia)
Aetna Health Inc. (Maine)
Aetna Health Inc. (New Jersey)
Aetna Health Inc. (Pennsylvania)
Aetna Health Insurance Company
Aetna Health Management, LLC
Aetna Health of Iowa, Inc
Aetna HealthAssurance Pennsylvania, Inc.
Aetna International Inc.
Aetna Life & Casualty (Bermuda) Limited
Aetna Network Services LLC

Aetna Pharmacy Management Services, LLC
Aetna Risk Assurance Company of Connecticut
Aetna Rx Home Delivery, LLC
Aetna Specialty Pharmacy, LLC
Aetna Student Health Agency, Inc.
Aetna Workers' Comp Access, LLC
Alabama CVS Pharmacy, LLC
Alajasper Realty Services, LLC
Alaska CVS Pharmacy, LLC
Allviant Corporation
AMC - New York, Inc.
AMC - Tennessee, Inc.
American Drug Stores Delaware, LLC
American Health Holding, Inc.
Apria Finance Holdings, Inc.
APS Acquisition LLC
APS-Summit Care Pharmacy, LLC
Arizona CVS Stores, LLC
Arkansas CVS Pharmacy, LLC
ASCO Healthcare of New England Limited Partnership
ASCO HealthCare, LLC
ASI Wings, LLC
AUSHC Holdings, Inc. (CT)
Badger Acquisition LLC
Badger Acquisition of Kentucky, LLC
Badger Acquisition of Minnesota, LLC
Badger Acquisition of Ohio, LLC
Baumel Eisner Neuromedical Institute, LLC
Best Care LTC Acquisition Company, LLC
Bluegrass Pharmacy of Lexington, LLC
BPNY Acquisition Corp
Bruin Acquisition Co., Inc.
bswift, LLC
Busse CVS, LLC #3110
Campo's Medical Pharmacy, Inc.
Care Pharmaceutical Services, LP
Care4, LP
Carecenter Pharmacy, LLC
Carecenter Pharmacy, LLC
Carefree Insurance Services, Inc.
Caremark Arizona Specialty Pharmacy Holding, LLC
Caremark Arizona Specialty Pharmacy, LLC
Caremark California Specialty Pharmacy Holding, LLC
Caremark California Specialty Pharmacy, LLC
Caremark Dallas Pharmacy, LLC
Caremark Hawaii Mail Pharmacy Holding, LLC
Caremark Hawaii Mail Pharmacy, LLC
Caremark Illinois Mail Pharmacy Holding, LLC
Caremark Irving Resource Center Holding, LLC
Caremark Irving Resource Center, LLC
Caremark Ohio Specialty Pharmacy Holding, LLC
Caremark Ohio Specialty Pharmacy, LLC
Caremark PA Specialty Pharmacy Holding, LLC
Caremark PCS, LLC
Caremark Pennsylvania Specialty Pharmacy, LLC
Caremark PHC, LLC
Caremark Puerto Rico Holding, LLC
Caremark Puerto Rico Specialty Pharmacy Holding, LLC
Caremark Puerto Rico Specialty Pharmacy, LLC
Caremark Puerto Rico, LLC
Caremark Redlands Pharmacy, LLC
Caremark Rx, LLC
Caremark Texas Mail Pharmacy Holding, LLC
Caremark Texas Mail Pharmacy, LLC
Caremark Ulysses Holding Corp.
Caremark, LLC
CaremarkPCS Alabama Mail Pharmacy Holding, LLC
CaremarkPCS Alabama Mail Pharmacy, LLC
CaremarkPCS Health, LLC
CaremarkPCS Pennsylvania Mail Pharmacy Holding, LLC
CaremarkPCS Pennsylvania Mail Pharmacy, LLC
CC Advertising & Marketing, LLC
CCRx Holdings, LLC
CCRx of North Carolina Holdings, LLC
CCRx of North Carolina, LLC
Central Rx Services, LLC
Choice Source Therapeutic Of Houston, Texas, LLC
Choice Source, LLC
CHP Acquisition Corp.
Circle Tallahassee Re, LLC
Claims Administration Corporation
Cofinity, Inc.

Compass Health Services, LLC
CompScript, LLC
Connecticut CVS Pharmacy, LLC
Continuing Care RX, LLC
Coram Alternate Site Services, Inc.
Coram Clinical Trials, Inc.
Coram Healthcare Corporation of Alabama
Coram Healthcare Corporation Of Florida
Coram Healthcare Corporation Of Greater D.C.
Coram Healthcare Corporation of Greater New York
Coram Healthcare Corporation of Indiana
Coram Healthcare Corporation of Massachusetts
Coram Healthcare Corporation of Mississippi
Coram Healthcare Corporation of Nevada
Coram Healthcare Corporation of North Texas
Coram Healthcare Corporation of Northern California
Coram Healthcare Corporation of Southern California
Coram Healthcare Corporation Of Southern Florida
Coram Healthcare Corporation of Utah
Coram LLC
Coram Specialty Infusion Services, LLC
CoramRX, LLC
Corporate Benefit Strategies, Inc.
Coventry Consumer Advantage, Inc.
Coventry Health and Life Insurance Company
Coventry Health Care National Accounts, Inc.
Coventry Health Care National Network, Inc.
Coventry Health Care of Florida, Inc.
Coventry Health Care of Illinois, Inc.
Coventry Health Care of Kansas, Inc.
Coventry Health Care of Missouri, Inc.
Coventry Health Care of Nebraska, Inc.
Coventry Health Care of Virginia, Inc.
Coventry Health Care of West Virginia, Inc.
Coventry Health Care Workers Compensation, Inc.
Coventry Health Plan of Florida, Inc.
Coventry HealthCare Management Corporation
Coventry Prescription Management Services, Inc.
Coventry Rehabilitation Services, Inc.
Coventry Transplant Network, Inc.
CP Acquisition Corp.
CP Services LLC
CSR, Inc.
CVS 1001 MA, LLC
CVS 10015 MA, LLC
CVS 10019 AR, LLC
CVS 10024 VA, LLC
CVS 10049 KY, LLC
CVS 10078 FL, LLC
CVS 10099 DE, LLC
CVS 10117 VA, LLC
CVS 10125 MA, LLC
CVS 10154 GA, LLC
CVS 10170 VA, LLC
CVS 10175 OK, LLC
CVS 10196 MA, LLC
CVS 10201 MN, LLC
CVS 10206 AL, LLC
CVS 10208 AL, LLC
CVS 10238 DE, LLC
CVS 10242 NE, LLC
CVS 10251 VA, LLC
CVS 10273 OK, LLC
CVS 10275 OK, LLC
CVS 10279 KY, LLC
CVS 10286 VA, LLC
CVS 10320 VA, LLC
CVS 10326 OK, LLC
CVS 10346 FL, LLC
CVS 10374 OH, LLC
CVS 10376 DE, LLC
CVS 10396 MN, LLC
CVS 1041 MA, LLC
CVS 10410 NE, LLC
CVS 10419 WI, LLC
CVS 10422 VA, LLC
CVS 10430 AR, LLC
CVS 10432 AR, LLC
CVS 10453 VA, LLC
CVS 10454 VA, LLC
CVS 10501 MA, LLC
CVS 10504 FL, LLC
CVS 10515 TN, LLC
CVS 10518 AR, LLC
CVS 10533 WI, LLC
CVS 10534 AR, LLC
CVS 10539 AR, LLC
CVS 10560 OK, LLC

CVS 10563 VA, LLC
CVS 10586 VA, LLC
CVS 10589 GA, LLC
CVS 10644 FL, LLC
CVS 10666 AR, LLC
CVS 10683 KY, LLC
CVS 10684 VA, LLC
CVS 10746 VA, LLC
CVS 10756 MN, LLC
CVS 10768 VA, LLC
CVS 10770 VA, LLC
CVS 10779 AR, LLC
CVS 10781 CO, LLC
CVS 10782 CO, LLC
CVS 10783 CO, LLC
CVS 10784 CO, LLC
CVS 10785 CO, LLC
CVS 10787 SC, LLC
CVS 10788 KY, LLC
CVS 1079 GA, LLC
CVS 10811 AL, LLC
CVS 10812 KY, LLC
CVS 10816 AR, LLC
CVS 10830 CO, LLC
CVS 10831 CO, LLC
CVS 10836 MA, LLC
CVS 10893 OH, LLC
CVS 10898 AL, LLC
CVS 10937 VA, LLC
CVS 10949 TN, LLC
CVS 10958 CO, LLC
CVS 10967 VA, LLC
CVS 10968 VA, LLC
CVS 10975 AR, LLC
CVS 10976 OK, LLC
CVS 10990 VA, LLC
CVS 10992 VA, LLC
CVS 11000 CO, LLC
CVS 11001 CO, LLC
CVS 11002 CO, LLC
CVS 11016 AL, LLC
CVS 11017 GA, LLC
CVS 11019 KY, LLC
CVS 11024 CO, LLC
CVS 11056 VA, LLC
CVS 11070 MN, LLC
CVS 11083 VA, LLC
CVS 11086 OH, LLC
CVS 11089 KY, LLC
CVS 11092 OK, LLC
CVS 11093 AR, LLC
CVS 11104 CO, LLC
CVS 11105 CO, LLC
CVS 11115 VA, LLC
CVS 11155 OH, LLC
CVS 11158 AR, LLC
CVS 11179 VA, LLC
CVS 11233 VA, LLC
CVS 1126 FL, LLC
CVS 1131 MA, LLC
CVS 11337 CO, LLC
CVS 1194 SC, LLC
CVS 1200 SC, LLC
CVS 1383 VA, LLC
CVS 1420 GA, LLC
CVS 1427, LLC
CVS 1435 MD, LLC
CVS 1452 MD, LLC
CVS 1461 MD, LLC
CVS 1525 VA, LLC
CVS 1538 VA, LLC
CVS 1547 VA, LLC
CVS 1556 VA, LLC
CVS 1561 VA, LLC
CVS 1589 MI, LLC
CVS 1743 AZ, LLC
CVS 180 SC, LLC
CVS 1803 MA, LLC
CVS 2003 VA, LLC
CVS 2004 VA, LLC
CVS 2019 VA, LLC
CVS 2048 RI, LLC
CVS 2065 RI, LLC
CVS 2212 GA, LLC
CVS 2545 CT, LLC
CVS 264 NJ, LLC
CVS 2747 FL, LLC
CVS 2776 VA, LLC

CVS 2829 FL, LLC
CVS 301 MA, LLC
CVS 3121 FL, LLC
CVS 3227 FL, LLC
CVS 3250 FL, LLC
CVS 326 RI, LLC
CVS 3269 FL, LLC
CVS 3301 OH, LLC
CVS 3320 OH, LLC
CVS 3353 OH, LLC
CVS 3380 SC, LLC
CVS 3416 OH, LLC
CVS 3432 OH, LLC
CVS 3460 VA, LLC
CVS 3471 OH, LLC
CVS 3558 NV, LLC
CVS 3625 AZ, LLC
CVS 373 MA, LLC
CVS 3749 AZ, LLC
CVS 3818 FL, LLC
CVS 3833 NC, LLC
CVS 3965 AZ, LLC
CVS 397 RI, LLC
CVS 3987 NC, LLC
CVS 4015 FL, LLC
CVS 4073 MA, LLC
CVS 4110 TN, LLC
CVS 4225 MD, LLC
CVS 433 MA, LLC
CVS 4380 WI, LLC
CVS 4480 FL, LLC
CVS 449 MA, LLC
CVS 4523 SC, LLC
CVS 4536 MS, LLC
CVS 4639 FL, LLC
CVS 4672 GA, LLC
CVS 4738 FL, LLC (f/k/a CVS 75462 FL, LLC)
CVS 4795 AZ, LLC
CVS 4840 AL, LLC
CVS 4896 OK, LLC
CVS 4905 AL, LLC
CVS 4976 AL, LLC
CVS 4993 MS, LLC
CVS 5021 VA, LLC
CVS 2948 Henderson, LLC #2948
CVS 3042 DE, LLC
CVS 3186 WV, LLC
CVS 3232 NC, LLC
CVS 3257 FL, LLC
CVS 3268 Gilbert, LLC #3268
CVS 3271 FL, LLC
CVS 3318 FL, LLC
CVS 3343 OH, LLC
CVS 3356 OH, LLC
CVS 3407 OH, LLC
CVS 3418 FL, LLC
CVS 3452 OH, LLC
CVS 3468 OH, LLC
CVS 3537 SC, LLC
CVS 3563 NC, LLC
CVS 3667 FL, LLC
CVS 3745 Peoria, LLC #3745
CVS 3805 SC, LLC
CVS 3831 NC, LLC
CVS 3923 FL, LLC
CVS 3967 AZ, LLC
CVS 3973 NC, LLC
CVS 3988 NC, LLC
CVS 4016 MA, LLC
CVS 410 FL, LLC
CVS 4153 SC, LLC
CVS 4300 OH, LLC
CVS 4331 OH, LLC
CVS 4419 WV, LLC
CVS 4485 FL, LLC
CVS 4519 MS, LLC
CVS 4533 TN, LLC
CVS 4544 RI, LLC (f/k/a CVS 75566 RI, LLC)
CVS 4669 GA, LLC
CVS 4695 GA, LLC
CVS 4769 SC, LLC
CVS 4832 AL, LLC
CVS 4853 AL, LLC
CVS 4900 AL, LLC
CVS 4944 AL, LLC
CVS 4981 MA, LLC
CVS 5018 TN, LLC
CVS 5029 AZ, LLC

CVS 5089 NY, LLC
CVS 5111 FL, LLC
CVS 5112 FL, LLC
CVS 5113 NV, LLC
CVS 5131 AZ, LLC
CVS 516 VA, LLC
CVS 5165 FL, LLC
CVS 5168 MS, LLC
CVS 5180 FL, LLC
CVS 5271 KS, LLC
CVS 5282 LA, LLC
CVS 5354 LA, LLC
CVS 5374 LA, LLC
CVS 5375 FL, LLC
CVS 5382 IL, LLC
CVS 5419 SC, LLC
CVS 5432 LA, LLC
CVS 5448 FL, LLC
CVS 5467 VA, LLC
CVS 5469 LA, LLC
CVS 5492 MN, LLC
CVS 5523 GA, LLC
CVS 5537 NC, LLC
CVS 5542 SC, LLC
CVS 5545 NC, LLC
CVS 5552 SC, LLC
CVS 5568 NC, LLC
CVS 5577 NC, LLC
CVS 5585 NC, LLC
CVS 5589 FL, LLC
CVS 5595 NC, LLC
CVS 5616 MN, LLC
CVS 5622 GA, LLC
CVS 5625 MO, LLC
CVS 5680 GA, LLC
CVS 5683 GA, LLC
CVS 5740 MS, LLC
CVS 5779 AZ, LLC
CVS 5783 IL, LLC
CVS 5791 AZ, LLC
CVS 5793 AZ, LLC
CVS 5801 MS, LLC
CVS 5812 AZ, LLC
CVS 5815 FL, LLC
CVS 5816 FL, LLC
CVS 582 MA, LLC
CVS 5828 CA, LLC
CVS 5829 IL, LLC
CVS 5849 AZ, LLC
CVS 5850 MS, LLC
CVS 5851 IL, LLC
CVS 5856 MA, LLC
CVS 5890 AZ, LLC
CVS 5891 AZ, LLC
CVS 5892 AZ, LLC
CVS 5893 AZ, LLC
CVS 590 RI, LLC
CVS 5931 AZ, LLC
CVS 5934 AZ, LLC
CVS 6009 OK, LLC
CVS 6012 GA, LLC
CVS 6073 NJ, LLC
CVS 6089 OH, LLC
CVS 6116 KY, LLC
CVS 612 MA, LLC
CVS 6135 NJ, LLC
CVS 6142 OK, LLC
CVS 6201 MN, LLC
CVS 6233 OK, LLC
CVS 6304 TN, LLC
CVS 6305 WV, LLC
CVS 6306 WV, LLC
CVS 6342 KY, LLC
CVS 6349 OH, LLC
CVS 6363 TN, LLC
CVS 6384 KY, LLC
CVS 6395 TN, LLC
CVS 6413 TN, LLC
CVS 6423, LLC
CVS 6429 TN, LLC
CVS 6572 IN. II, LLC
CVS 6572 IN., LLC
CVS 6796 MA, LLC
CVS 6852 VA, LLC
CVS 6867 NV, LLC
CVS 6869 DE, LLC
CVS 6874 IN, LLC
CVS 6941 KY, LLC

CVS 6972 FL, LLC
CVS 7036, LLC
CVS 7047, LLC
CVS 7057 NC, LLC
CVS 7070 MS, LLC
CVS 709 FL, LLC
CVS 7109 MA, LLC
CVS 7133 FL, LLC
CVS 7148 NC, LLC
CVS 7157 NC, LLC
CVS 7173 FL, LLC
CVS 7180 AL, LLC
CVS 7200, LLC
CVS 7215 AL, LLC
CVS 7382 NC, LLC
CVS 75024 AL, LLC
CVS 75121 SC, LLC
CVS 75124 MI, LLC
CVS 75129 FL, LLC
CVS 75137 MD, LLC
CVS 75139 NJ, LLC
CVS 75144 RI, LLC
CVS 75151 OH, LLC
CVS 75156 NV, LLC
CVS 75157 MI, LLC
CVS 75160 SC, LLC
CVS 75161 AZ, LLC
CVS 75162 AZ, LLC
CVS 75163 GA, LLC
CVS 75165 GA, LLC
CVS 7519 MN, LLC
CVS 75195 FL, LLC
CVS 75235 RI, LLC
CVS 75249 FL, LLC
CVS 75257 NJ, LLC
CVS 75269 MI, LLC
CVS 75275 TN, LLC
CVS 75280 NC, LLC
CVS 75294 FL, LLC
CVS 75307 KS, LLC
CVS 75312 VA, LLC
CVS 75334 FL, LLC
CVS 75363 GA, LLC
CVS 75365 GA, LLC
CVS 75374 NJ, LLC
CVS 75377 NC, LLC
CVS 75380 GA, LLC
CVS 75393 DE, LLC
CVS 75408 FL, LLC
CVS 75416 KY, LLC
CVS 75441 GA, LLC
CVS 75444 NV, LLC
CVS 75461 AL, LLC
CVS 75485 NC, LLC
CVS 75486 KS, LLC
CVS 75503 GA, LLC
CVS 75536 GA, LLC
CVS 75558 FL, LLC
CVS 75560 NJ, LLC
CVS 75561 NJ, LLC
CVS 75562 VA, LLC
CVS 75563 MD, LLC
CVS 75569 GA, LLC
CVS 75572 NC, LLC
CVS 75583 MA, LLC
CVS 75584 MA, LLC
CVS 75590 MN, LLC
CVS 75615 FL, LLC
CVS 75619 NJ, LLC
CVS 75626 GA, LLC
CVS 75636 NV, LLC
CVS 75642 VA, LLC
CVS 75651 SC, LLC
CVS 75659 OK, LLC
CVS 75660 OK, LLC
CVS 75669 MA, LLC
CVS 75676 KY, LLC
CVS 75679 SC, LLC
CVS 75707 FL, LLC
CVS 75718 OH, LLC
CVS 75719 MN, LLC
CVS 75733 NV, LLC
CVS 75738 RI, LLC
CVS 75740 NJ, LLC
CVS 75743 NJ, LLC
CVS 75770 NC, LLC
CVS 75771 NC, LLC
CVS 75774 MA, LLC

CVS 75795 DE, LLC
CVS 75849 NC, LLC
CVS 75905 NJ, LLC
CVS 75935 NV, LLC
CVS 75947 GA, LLC
CVS 75958 MN, LLC
CVS 75961 SC, LLC
CVS 75978 FL, LLC
CVS 7648 KY, LLC
CVS 7701, LLC
CVS 7888 GA, LLC
CVS 8009 MI, LLC
CVS 8071 MI, LLC
CVS 8086 MI, LLC
CVS 8123 MI, LLC
CVS 8165 MI, LLC
CVS 8281 MD, LLC
CVS 8303 TN, LLC
CVS 8549 MI, LLC
CVS 866 FL, LLC
CVS 8776 WI, LLC
CVS 8956 MS, LLC
CVS 8993 MS, LLC
CVS 921 IL, LLC
CVS 962 GA, LLC
CVS 976 FL, LLC
CVS ALBANY, LLC
CVS ARCLIGHT, INC.
CVS Bellmore Avenue, LLC #2154
CVS Caremark Indemnity Ltd.
CVS Durham 7042, LLC
CVS EGL 571 FL, LLC
CVS ETB Holding Company, LLC
CVS Foreign, Inc. #9736
CVS Grand Bay 4782, LLC
CVS Indiana, LLC #0877
CVS Lagrange 4540, LLC
CVS Manchester NH, LLC #0200
CVS Montgomery 6094, LLC
CVS Orlando FL Distribution, LLC
CVS Pharmacy Inc.
CVS PR Center, Inc.
CVS RCI, LLC
CVS Rx Services, Inc. #0886
CVS 75799 NJ, LLC
CVS 75896 MA, LLC
CVS 75924 FL, LLC
CVS 75946 VA, LLC
CVS 75952 WI, LLC
CVS 75959 MN, LLC
CVS 75977 MN, LLC
CVS 75995 DE, LLC
CVS 770 FL, LLC
CVS 7885 GA, LLC
CVS 8003 MI, LLC
CVS 8067 MI, LLC
CVS 8078 MI, LLC
CVS 8103 MI, LLC
CVS 8133 MI, LLC
CVS 8207 MI, LLC
CVS 8302 MI, LLC
CVS 8415 NE, LLC
CVS 8615 NE, LLC
CVS 8774 WI, LLC
CVS 8909 NC, LLC
CVS 8975 SC, LLC
CVS 920 MA, LLC
CVS 932 FL, LLC
CVS 9674 CA, LLC
CVS AL Distribution, LLC
CVS AOC Services, LLC
CVS Bay City 8207 MI, LLC
CVS Caremark Advanced Technology Pharmacy, LLC
CVS Caremark Part D Services, LLC
CVS EGL 5624 MO, LLC
CVS EGL 7958 FL, LLC
CVS Falmouth KY, LLC
CVS Gilbert 3272, LLC #3272
CVS Greensboro, LLC
CVS International, LLC
CVS Logan 3454, LLC
CVS Michigan, LLC #9415
CVS NV Holding Company, LLC
CVS PA Distribution, LLC
CVS PR Center Inc.
CVS PR Holding Company, LLC
CVS RS Arizona, LLC
CVS Safir Sourcing, LLC

CVS SC Distribution, LLC
CVS State Capital, LLC #0800
CVS Transportation, LLC
CVS Vero FL Distribution, LLC
CVS Weymouth 1853, LLC
D&R Pharmaceutical Services, LLC
Delaware CVS Pharmacy, LLC
DG Danville KY, LLC
Digital Enterprise Realty, LLC
E.T.B., INC.
Eckerd Corporation Of FL, Inc.
Enloe Drugs, LLC
Escalante Solutions, Llc
Evergreen Pharmaceutical, LLC
First Health Group Corp.
First Script Network Services, Inc.
FOCUS Healthcare Management, Inc.
Generation Health, LLC
Geneva Woods LTC Pharmacy, LLC
Geneva Woods Pharmacy Alaska, LLC
Geneva Woods Pharmacy Wyoming, LLC
Geneva Woods Retail Pharmacy, LLC
German Dobson CVS, LLC #5038
Grand St. Paul CVS, LLC
Group Dental Service of Maryland, Inc.
HCP Acquisition Sub, LLC
Health Data & Managment Solutions, Inc.
Healthagen LLC
Highland Park CVS, LLC
Home Care Pharmacy, LLC
Hook-Superx, LLC
Idaho CVS Pharmacy, LLC
Interlock Pharmacy Systems, LLC
Ironbound CVS Urban Renewal, LLC
JEC Funding, Inc.
Kansas CVS Pharmacy, LLC
Langsam Health Services, LLC
LHS Acquisition Sub, LLC
Lo-Med Prescription Services, LLC
Longs Drug Stores, LLC
Managed Care Coordinators, Inc.
Martin Health Services, Inc.
Massachusetts CVS Pharmacy, Inc.
Medical Arts Health Care, Inc.
CVS SP 5897 FL, LLC
CVS TN Distribution, LLC
CVS TX Holding Company, LLC
CVS Washington 6448, LLC
CVS WWRE, INC.
D.A.W., LLC
Delaware Physicians Care, Inc.
Digital EHealth, LLC
District Of Columbia CVS Pharmacy, LLC
Echo Merger Sub, Inc
Employee Assistance Services, LLC
Enterprise Safety Organization, LLC
Evergreen Pharmaceutical of California, Inc.
Express Pharmacy Services of PA, LLC
First Health Life and Health Insurance Company
Florida Health Plan Administrators, LLC
Garfield Beach CVS, LLC
Geneva Woods Health Services, LLC
Geneva Woods Management, LLC
Geneva Woods Pharmacy Washington, LLC
Geneva Woods Pharmacy, Inc.
Georgia CVS Pharmacy, LLC
Goodyear CVS, LLC #3749
Grandview Pharmacy, LLC
Group Dental Service, Inc.
Health and Human Resource Center, Inc.
Health Re, Inc.
HealthAssurance Pennsylvania, Inc.
Holiday CVS, LLC
Home Pharmacy Services, LLC
Horizon Behavioral Services, LLC
Institutional Health Care Services, LLC
Iowa CVS Pharmacy, LLC
iTriage, LLC
JHC Acquisition, LLC
Kentucky CVS Pharmacy, LLC
LCPS Acquisition, LLC
Lobos Acquisition, LLC
Longs Drug Stores California, LLC
Louisiana CVS Pharmacy, LLC
Managed Healthcare, Inc.
Maryland CVS Pharmacy, LLC
Med World Acquisition Corp.
Melville Realty Co., Inc.

Member Health, LLC
Mental Health Network of New York IPA, Inc.
Merwin IV & Specialty Pharmacy, LLC
Merwin Rx-Compounding Pharmacy, LLC
MHHP Acquisition Company, LLC
MHNet of Florida, Inc.
Minuteclinic Diagnostic Of Alabama, LLC
Minuteclinic Diagnostic Of Florida, LLC
Minuteclinic Diagnostic Of Hawaii, LLC
Minuteclinic Diagnostic Of Kentucky, LLC
Minuteclinic Diagnostic Of Maine, LLC
Minuteclinic Diagnostic Of Massachusetts, LLC
Minuteclinic Diagnostic Of New Hampshire, LLC
Minuteclinic Diagnostic Of Ohio, LLC
Minuteclinic Diagnostic Of Oregon, LLC
Minuteclinic Diagnostic Of Rhode Island, LLC
Minuteclinic Diagnostic Of Texas, LLC
Minuteclinic Diagnostic Of Virginia, LLC
Minuteclinic Diagnostic Of Wisconsin, LLC
Minuteclinic Telehealth Services, LLC
Mississippi CVS Pharmacy, LLC
Montana CVS Pharmacy, LLC
NCS Healthcare of Illinois, LLC
NCS Healthcare of Iowa, LLC
NCS Healthcare of Kentucky, Inc.
NCS Healthcare of New Hampshire, Inc.
NCS Healthcare of Ohio, LLC
NCS Healthcare of Tennessee, Inc.
NCS Healthcare, LLC
Nebraska CVS Pharmacy, LLC
NeighborCare of Indiana, LLC
NeighborCare of Virginia, LLC
NeighborCare Pharmacy of Virginia, LLC
NeighborCare Services Corporation
Nevada CVS Pharmacy, LLC
NH Acquisition Sub, LLC
NIV Acquisition, LLC
North Shore Pharmacy Services LLC
NS Acquisition Sub, LLC
Ocean Acquisition Sub, LLC
OCR-RA Acquisition, LLC
Oklahoma CVS Pharmacy, LLC
Omnicare ESC LLC
Omnicare Headquarters LLC
Mental Health Associates, Inc.
Meritain Health, Inc.
Merwin Long Term Care, Inc.
MetraComp, Inc.
MHNet Life and Health Insurance Company
MHNet Specialty Services LLC
Minuteclinic Diagnostic Of Arizona, LLC
Minuteclinic Diagnostic Of Georgia, LLC
Minuteclinic Diagnostic Of Illinois, LLC
Minuteclinic Diagnostic Of Louisiana, LLC
Minuteclinic Diagnostic Of Maryland, LLC
Minuteclinic Diagnostic Of Nebraska, LLC
Minuteclinic Diagnostic Of New Mexico, LLC
Minuteclinic Diagnostic Of Oklahoma, LLC
Minuteclinic Diagnostic Of Pennsylvania, LLC
Minuteclinic Diagnostic Of South Carolina, LLC
Minuteclinic Diagnostic Of Utah, LLC
Minuteclinic Diagnostic Of Washington, LLC
Minuteclinic Online Diagnostic Services, LLC
Minuteclinic, LLC
Missouri CVS Pharmacy, LLC
Mountain Grove Investment Group LLC
NCS Healthcare of Indiana LLC
NCS Healthcare of Kansas, LLC
NCS Healthcare of Montana, Inc.
NCS Healthcare of New Mexico, Inc.
NCS Healthcare of South Carolina, Inc.
NCS Healthcare of Wisconsin, LLC
NCSH Acquisition Sub, LLC
NeighborCare Holdings, Inc.
NeighborCare of New Hampshire, LLC
NeighborCare Pharmacies, LLC
NeighborCare Pharmacy Services, Inc.
NeighborCare, Inc.
New Jersey CVS Pharmacy, LLC
Niagara Re, Inc.
North Carolina CVS Pharmacy, LLC
Novologix, LLC
NSPS Acquisition Sub, LLC
OCR Services Corporation
Ohio CVS Stores, LLC
Omnicare Distribution Center LLC
Omnicare Foundation
Omnicare Holding Company

Omnicare Indiana Partnership Holding Company LLC
Omnicare of Nevada, LLC
Omnicare of New York, LLC
Omnicare Pharmacies of Pennsylvania East LLC
Omnicare Pharmacies of Pennsylvania West LLC
Omnicare Pharmacies of the Great Plains Holding Company
Omnicare Pharmacy and Supply Services LLC
Omnicare Pharmacy of Florida, LP
Omnicare Pharmacy of Maine LLC
Omnicare Pharmacy of Nebraska, LLC
Omnicare Pharmacy of North Carolina, LLC
Omnicare Pharmacy of Pueblo, LLC
Omnicare Pharmacy of Tennessee, LLC
Omnicare Pharmacy of Texas 1, LP
Omnicare Pharmacy of Texas 2, LP
Omnicare Pharmacy of the Midwest, LLC
Omnicare Property Management, LLC
Omnicare, Inc.
OPGP Acquisition Sub, LLC
OPM Acquisition Sub, LLC
Oregon CVS Pharmacy, LLC
Part D Holding Co., LLC
PayFlex Holdings, Inc.
PayFlex Systems USA, Inc.
Pennsylvania CVS Pharmacy, LLC
Pennsylvania Life Insurance Company
Performax, Inc.
Pharmacare Holding Company
Pharmacare Pharmacy, LLC
Pharmacare Specialty Healthcare Distributors, LLC
Pharmacy Associates of Glens Falls, Inc.
Pharmacy Consultants, LLC
Pharmacy Holding #1, LLC
Pharmacy Holding #2, LLC
PharmaSource Healthcare, Inc.
Pharm-Corp of Maine LLC
Pharmed Holdings, Inc.
Pharmore, Inc.
Phoenix Data Solutions LLC
PMRP Acquisition Company, LLC
PP Acquisition Company, LLC
Precision Benefit Services, Inc.
PrimeNet, Inc.
PRN Pharmaceutical Services, LP
Procare 4268 Yankee, LLC
Procare Pharmacy Direct, LLC
Procare Pharmacy, LLC
Prodigy Health Group, Inc.
Professional Pharmacy Services, Inc.
Professional Risk Management, Inc.
PSI Arkansas Acquisition, LLC
Puerto Rico CVS Pharmacy, LLC
Red Oak Sourcing, LLC
Resources for Living, LLC
Retrac, Inc. #107
Rhode Island CVS Pharmacy, LLC
Richmond Heights Acquisition Corp.
Roeschen's Healthcare LLC
Rx Innovations 4439, LLC
RxAMERICA, LLC
RXC Acquisition Company
Schaller Anderson Medical Administrators Inc
Scrip World, LLC
Sheffield Avenue CVS, LLC #3690
Shore Pharmaceutical Providers, LLC
Silverscript Insurance Company
Sky Acquisition LLC
South Carolina CVS Pharmacy, LLC
South Wabash CVS, LLC #3674
Specialized Pharmacy Services, LLC
Specialty Services Holding LLC
Speedwell CVS Urban Renewal, LLC
Sterling Healthcare Services, Inc.
Strategic Resource Company
Suburban Medical Services, LLC
Superior Care Pharmacy, Inc.
T2 Medical, Inc.
TCPI Acquistion Corp.
Tennessee CVs Pharmacy, LLC
The Vasquez Group, Inc.
Thomas Phoenix CVS, LLC #3625
Three Forks Apothecary, LLC
Thundermist Services, LLC
U.S. Health Care Properties, Inc.
UAC Holding, Inc.
UC Acquisition Corp.

Uni-Care Health Services of Maine, Inc.	Utah CVS Pharmacy, LLC
Value Health Care Services LLC	VAPS Acquisition Company, LLC
Vermont CVS Pharmacy, LLC	VHCS Acquisition Sub, LLC
Virginia CVS Pharmacy, LLC	Warm Springs Road CVS, LLC #2928
Washington CVS Pharmacy, LLC	Washington Lamb CVS, LLC #3172
Weber Medical Systems LLC	Wellpartner, LLC
West Virginia CVS Pharmacy, LLC	Westhaven Services Co, LLC
Williamson Drug Company, Incorporated	Wisconsin CVS Pharmacy, LLC
Woodruff Realty Associates, LLC #2085	Woodward Detroit CVS, LLC
Work & Family Benefits, Inc.	WP Smart Holdings, LLC
ZS Acquisition Company, LLC	976 Miami RE, LLC

As explained in Note 2, the Company participates in a tax sharing agreement with its parent and affiliates.

The Company does not have any tax loss contingencies for which it is reasonably possible that the total liability will significantly increase within twelve months of the reporting date.

10. Change in claims unpaid, unpaid claims adjustment expense, and aggregate health claim reserves

The following table shows the components of the change in claims unpaid, accrued medical incentive pool and bonus amounts, unpaid claims adjustment expense and aggregate health claim reserves for the years ended December 31, 2018 and 2017:

	2018	2017
Balance, January 1	$162,303,470	$203,997,642
Health care receivable	(27,088,688)	(14,056,403)
Balance, January 1, net of health care receivable	135,214,782	189,941,239
Incurred related to:		
Current year	1,019,452,273	993,864,894
Prior years	(60,408,611)	(4,903,247)
Total incurred	959,043,662	988,961,647
Paid related to:		
Current year	883,762,047	858,774,940
Prior years	92,686,833	184,913,164
Total paid	976,448,880	1,043,688,104
Balance, December 31, net of health care receivable	117,809,564	135,214,782
Health care receivable	15,448,760	27,088,688
Balance, December 31	$133,258,324	$162,303,470

In 2018, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased by $60,408,611 from $162,303,470 in 2017 to $101,894,859 in 2018. In 2017, reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years decreased by $4,903,247 from $203,997,642 in 2016 to $199,094,395 in 2017. The lower than anticipated health care cost trend rates observed in 2018 and 2017 for claims incurred in 2017 and 2016, respectively, were due to moderating outpatient and physician trends and faster than expected claim payment speed. The Company

considers historical trend rates together with knowledge of recent events that may impact current trends when developing estimates of current trend rates. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Historical health care cost trend rates are not necessarily representative of current trends.

Net coordination of benefits are implicit in the claims incurred but not reported calculation and could not be specifically identified.

11. Capital and surplus, shareholder's dividend restrictions and quasi-reorganizations

The Company had 1,000,000 shares of common stock with a par value of $1 per share authorized, issued and outstanding at December 31, 2018 and 2017. In 2017, CH&L purchased an additional 990,000 shares of common stock in order for the Company to meet the Commonwealth of Kentucky's capital requirements. The payment of $990,000 by CH&L was satisfied by reclassifying $990,000 of paid in capital of the Company to common stock effective as of March 31, 2017.

Dividend restrictions

In accordance with Kentucky statutes, the Company shall not pay any extraordinary dividend unless the Company has notified the Kentucky Department in writing at least 30 days prior thereto or such shorter period as the Kentucky Department may permit and the Kentucky Department has not disapproved it within such period. An extraordinary dividend is any dividend or other distribution which, together with other dividends and distributions made within the preceding 12 months, exceeds the lesser of: ten percent of such insurer's surplus as regards policyholders as of the preceding December 31; or the net income of such insurer for the period covered by such statement, but shall not include pro rata distributions of any class of the insurer's own securities. The Company may not make a non-extraordinary dividend without prior notification to the Kentucky Department within five business days following the declaration thereto and at least ten days, commencing from the date of receipt by the Kentucky Department, prior to the payment thereof. Ordinary dividends are ultimately limited to earned surplus.

At December 31, 2018 and 2017, there was $32,549,820 and $26,092,235, respectively, of the Company’s profits that may be paid as ordinary dividends to its shareholder without prior approval from the Commonwealth of Kentucky.

The Company did not pay any dividends to its parent in 2018 and 2017. The Company did not receive a capital contribution from its parent in 2018 or 2017.

There were no restrictions placed on the Company’s surplus, including for whom the surplus was being held at December 31, 2018 or 2017, except as noted in Note 14.

The Company did not hold any stock for any special purposes at December 31, 2018 or 2017.

Changes in the balances of special surplus funds from the prior year are due to the accrual of estimated 2017 ACA health insurer fees reclassified from unassigned funds or surplus to aggregate write-ins for special surplus funds as discussed more fully in Note 2 and 16.

At December 31, 2018 and 2017, there was ($1,947,080) and $237,476, respectively, of unassigned surplus funds that was represented or reduced by unrealized gains and losses.

12. Contingencies

Guaranty fund assessments

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company’s assessments generally are based on a formula relating to the Company’s health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under Health Care Reform.

The Company had no assets recognized from paid and accrued premium tax offsets and policy surcharges at December 31, 2018 and 2017.

Litigation and regulatory proceedings

The following description of litigation and regulatory proceedings covers CVS Health and certain of its subsidiaries, including the Company. Certain of the proceedings described below may not impact the Company directly but may have an indirect impact on the Company as the Company is a member of the CVS Health holding company group (the "CVS Health Group").

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Provider Proceedings

The CVS Health Group is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the CVS Health Group has a contract and with whom the CVS Health Group does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the CVS Health Group paid too little to its health plan members and/or providers for these services and/or otherwise allege that the CVS Health Group failed to timely or appropriately pay or administer claims and benefits (including the CVS Health Group's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

The CVS Health Group also has received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and the CVS Health Group is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against one or more members of the CVS Health Group, including the Company, with respect to their respective out-of-network benefit payment and/or administration practices.

Other Legal and Regulatory Proceedings

The CVS Health Group is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The CVS Health Group is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in the Company's health care businesses, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's results of operations. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care and related benefits company, the CVS Health Group regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the CVS Health Group's and/or the Company's businesses, one or more of the industries in which the CVS Health Group and/or the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the CVS Health Group and/or the Company; (v) adverse developments in any pending *qui tam* lawsuit against the CVS Health Group and/or the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the CVS Health Group and/or the Company; or (vi) adverse developments in pending or future legal proceedings against the CVS Health Group and/or the Company or affecting one or more of the industries in which the CVS Health Group and/or the Company competes and/or the health care industry generally.

Litigation Insurance Coverage

The Company maintains insurance coverage for certain litigation exposures in an amount it believes is reasonable.

13. Contractual arrangements with providers

The Company generally compensates primary care physicians through prospective compensation arrangements which incorporate quality assessment standards, comprehensiveness of care, utilization and office status components. These components are used to adjust the capitation payments to individual physician offices and to determine the amount of additional periodic payments. The Company has prospective compensation arrangements for mental health, substance abuse, diagnostic laboratory, radiology and diagnostic imaging services, podiatric treatment, physical therapy and prescription drug dispensing. The Company has contracts that provide for all-inclusive per diem and per case hospitalization rates and fixed rates for ambulatory surgery, emergency room services and specialist services. The Company has also entered into quality based compensation arrangements with certain hospitals, as well as agreements with certain integrated health delivery systems under which the systems are compensated on a substantially fixed prospective basis for medical services, including primary, specialist and hospital care. The arrangements described above cover the majority of medical expenses.

14. Minimum capital and surplus

Pursuant to the laws of the states in which the Company is licensed to do business, the Company is required to maintain a minimum surplus and capital stock as defined by the statutes and regulations of those states. At both December 31, 2018 and 2017, the Company was in compliance with the minimum surplus and capital stock requirements of the states in which it is licensed to do business.

The NAIC utilizes risk-based capital ("RBC") standards for health organizations, including HMOs, that are designed to identify weakly capitalized companies by comparing each company's adjusted capital and surplus to its required capital and surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of the company. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring insurers to submit a comprehensive plan to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2018 and 2017, the Company had capital and surplus that exceeded the highest threshold specified by the RBC rules.

15. Medicaid

The Company's Medicaid products are heavily regulated by state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with regulations. The Company's Medicaid products and Children's Health Insurance Program ("CHIP") contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services the Company provides to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and the Company's Medicaid compliance efforts will continue to require significant resources. State Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid products, exclude the Company from participating in one or more Medicaid programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with state regulations or the Company's contractual requirements. The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or financial results, but the effects could be materially adverse.

For the years ended December 31, 2018 and 2017, the Company recorded premiums under the Medicaid program of $1,091,165,641 and $1,043,468,548, respectively. For the years ended December 31, 2018 and 2017, the Company also recorded premiums under the CHIP program of $30,661,427 and $49,157,055, respectively.

16. Subsequent events

Type I - Recognized subsequent events

Subsequent events have been considered through May 30, 2019.

The Company had no known reportable recognized subsequent events.

Type II - Nonrecognized subsequent events

Subsequent events have been considered through May 30, 2019.

As discussed in Note 2, in January 2018, the health insurer fee was suspended for 2019. As a result, there is no annual health insurance industry fee payable on September 30, 2019 and there are no amounts reflected in the Company's aggregate write-ins for special surplus funds related to this payable at December 31, 2018 as a result. There is also no resulting impact to the Company's RBC to assess as of December 31, 2018 as a result of this suspension. As of December 31, 2017, the Company estimated its portion of the annual health industry fee that was payable on October 1, 2018 to be $22,555,000. This was estimated based on premiums written subject to the ACA assessment of $1,092,625,603. During 2018, the Company paid $22,536,420 to the federal government for its portion of the health insurer fee due on October 1, 2018.

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings 1 Amount	2 Percentage	Admitted Assets as Reported in the Annual Statement 3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities	55,762,541	11.754	55,762,541	0	55,762,541	11.754
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies	0	0.000	0	0	0	0.000
1.22 Issued by U.S. government sponsored agencies	0	0.000	0	0	0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	25,670,460	5.411	25,670,460	0	25,670,460	5.411
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations	28,858,343	6.083	28,858,343	0	28,858,343	6.083
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	27,138,786	5.721	27,138,786	0	27,138,786	5.721
1.43 Revenue and assessment obligations	117,503,144	24.769	117,503,144	0	117,503,144	24.769
1.44 Industrial development and similar obligations	0	0.000	0	0	0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	2,884,529	0.608	2,884,529	0	2,884,529	0.608
1.512 Issued or guaranteed by FNMA and FHLMC	7,474,154	1.576	7,474,154	0	7,474,154	1.576
1.513 All other	0	0.000	0	0	0	0.000
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	0	0.000	0	0	0	0.000
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	0	0.000	0	0	0	0.000
1.523 All other	158,172,701	33.342	158,172,701	0	158,172,701	33.342
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	0	0.000	0	0	0	0.000
2.2 Unaffiliated non-U.S. securities (including Canada)	18,891,428	3.982	18,891,428	0	18,891,428	3.982
2.3 Affiliated securities	0	0.000	0	0	0	0.000
3. Equity interests:						
3.1 Investments in mutual funds	0	0.000	0	0	0	0.000
3.2 Preferred stocks:						
3.21 Affiliated	0	0.000	0	0	0	0.000
3.22 Unaffiliated	0	0.000	0	0	0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated	0	0.000	0	0	0	0.000
3.32 Unaffiliated	0	0.000	0	0	0	0.000
3.4 Other equity securities:						
3.41 Affiliated	0	0.000	0	0	0	0.000
3.42 Unaffiliated	0	0.000	0	0	0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated	0	0.000	0	0	0	0.000
3.52 Unaffiliated	0	0.000	0	0	0	0.000
4. Mortgage loans:						
4.1 Construction and land development	0	0.000	0	0	0	0.000
4.2 Agricultural	0	0.000	0	0	0	0.000
4.3 Single family residential properties	0	0.000	0	0	0	0.000
4.4 Multifamily residential properties	0	0.000	0	0	0	0.000
4.5 Commercial loans	13,407,858	2.826	13,407,858	0	13,407,858	2.826
4.6 Mezzanine real estate loans	0	0.000	0	0	0	0.000
5. Real estate investments:						
5.1 Property occupied by company	0	0.000	0	0	0	0.000
5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
6. Contract loans	0	0.000	0	0	0	0.000
7. Derivatives	0	0.000	0	0	0	0.000
8. Receivables for securities	11,415	0.002	11,415	0	11,415	0.002
9. Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.000	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	18,620,276	3.925	18,620,276	0	18,620,276	3.925
11. Other invested assets	0	0.000	0	0	0	0.000
12. Total invested assets	474,395,635	100.000	474,395,635	0	474,395,635	100.000

See accompanying independent auditors' report

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2018
(To Be Filed by April 1)

Of The Aetna Better Health of Kentucky Insurance Company

ADDRESS (City, State and Zip Code) Louisville , KY 40202

NAIC Group Code 0001 NAIC Company Code 15761 Federal Employer's Identification Number (FEIN) 47-3279217

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 496,012,938

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	WASHINGTON STATE OF	Bond	$ 9,434,246	1.9 %
2.02	DOUGLAS CNTY NE SCH DIST 1	Bond	$ 8,064,441	1.6 %
2.03	2000 BISHOPS GATE BOULEVARD	Mortgage Loan	$ 7,604,432	1.5 %
2.04	SYNCHRONY CREDIT CARD	Bond	$ 6,999,815	1.4 %
2.05	PENNSYLVANIA ST 1ST SER	Bond	$ 6,874,683	1.4 %
2.06	VIRGINIA ST PUB BLDG AUTH PUB AMT	Bond	$ 6,569,082	1.3 %
2.07	FLORIDA DEPT ENVIRON PROTECTION	Bond	$ 6,083,715	1.2 %
2.08	NEW JERSEY ST ECON DEV AUTH	Bond	$ 5,976,171	1.2 %
2.09	NEW JERSEY ST TRANSN TR FD TRANSPRTN PROGRAM	Bond	$ 5,873,064	1.2 %
2.10	QUARTERFIELD CENTER	Mortgage Loan	$ 5,803,426	1.2 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 318,735,533	64.3 %	3.07	P/RP-1	$ 0	0.0 %
3.02	NAIC-2	$ 81,339,538	16.4 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 49,057,322	9.9 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 4,709,236	0.9 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 0	0.0 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 0	0.0 %	3.12	P/RP-6	$ 0	0.0 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02 Total admitted assets held in foreign investments $ 44,561,890 9.0 %

4.03 Foreign-currency-denominated investments $ 0 0.0 %

4.04 Insurance liabilities denominated in that same foreign currency $ 0 0.0 %

See accompanying independent auditors' report

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 19,401,269	3.9 %
5.02	Countries designated NAIC-2	$ 12,122,004	2.4 %
5.03	Countries designated NAIC-3 or below	$ 13,038,617	2.6 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1: NETHERLANDS	$ 7,071,674	1.4 %
6.02	Country 2: JAPAN	$ 3,500,000	0.7 %
	Countries designated NAIC - 2:		
6.03	Country 1: INDONESIA	$ 3,454,948	0.7 %
6.04	Country 2: MEXICO	$ 2,709,738	0.5 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1: BRAZIL	$ 2,939,258	0.6 %
6.06	Country 2: DOMINICAN REPUBLIC	$ 2,022,663	0.4 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 0	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 0	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1:	$ 0	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01	SHELL INTERNATIONAL FIN	1FE	$ 3,841,397	0.8 %
10.02	MIZUHO FINANCIAL GROUP	1FE	$ 3,500,000	0.7 %
10.03	MYLAN NV	2FE	$ 2,498,504	0.5 %
10.04	NVENT FINANCE SARL	2FE	$ 1,996,774	0.4 %
10.05	DEUTSCHE BANK NY	2FE	$ 1,497,492	0.3 %
10.06	ANGLO AMERICAN CAPITAL	2FE	$ 1,450,162	0.3 %
10.07	INTESA SANPAOLO SPA	2FE	$ 1,383,828	0.3 %
10.08	BAIDU INC	1FE	$ 999,096	0.2 %
10.09	ALIBABA GROUP HOLDING	1FE	$ 992,402	0.2 %
10.10	LYONDELLBASELL IND NV	2FE	$ 731,773	0.1 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 0	0.0 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of Interrogatory 12.

	1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %
	Largest three investments with contractual sales restrictions:		
12.03		$ 0	0.0 %
12.04		$ 0	0.0 %
12.05		$ 0	0.0 %

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of Interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02	2000 BISHOPS GATE BOULEVARD	$ 7,604,432	1.5 %
16.03	QUARTERFIELD CENTER	$ 5,803,426	1.2 %
16.04		$ 0	0.0 %
16.05		$ 0	0.0 %
16.06		$ 0	0.0 %
16.07		$ 0	0.0 %
16.08		$ 0	0.0 %
16.09		$ 0	0.0 %
16.10		$ 0	0.0 %
16.11		$ 0	0.0 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 0	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential			Commercial			Agricultural		
	Loan to Value	1	2		3	4		5	6	
17.01	above 95%	$ 0	0.0	%	$ 0	0.0	%	$ 0	0.0	%
17.02	91 to 95%	$ 0	0.0	%	$ 0	0.0	%	$ 0	0.0	%
17.03	81 to 90%	$ 0	0.0	%	$ 0	0.0	%	$ 0	0.0	%
17.04	71 to 80%	$ 0	0.0	%	$ 0	0.0	%	$ 0	0.0	%
17.05	below 70%	$ 0	0.0	%	$ 13,407,858	2.7	%	$ 0	0.0	%

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 0	0.0 %	$ 0	$ 0	$ 0
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 0	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ 0	0.0 %
21.03	Other	$ 0	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
22.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

☑ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2018

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from _____ to_____
Commission file number 001-01011

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500

(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

Large accelerated filer ☑ Accelerated filer ☐

Non-accelerated filer ☐ Smaller reporting company ☐

Emerging growth company ☐

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

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $65,262,991,789 as of June 30, 2018 , based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 19, 2019 , the registrant had 1,297,082,165 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Portions of the Annual Report to Stockholders for the fiscal year ended December 31, 2018 (the "Annual Report") are incorporated by reference in response to Items 1, 1A, 2 and 3 of Part I and Items 5, 6, 7, 7A, 8 and 9A of Part II, in each case to the extent described therein.

Information contained in the definitive proxy statement for CVS Health Corporation's 2019 Annual Meeting of Stockholders, to be filed on or about April 5, 2019 (the "Proxy Statement"), is incorporated by reference in response to Items 10 through 14 of Part III to the extent described therein.

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PART I

Item 1. Business

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45.0 billion of new debt, including senior notes and term loans. For additional information, see Note 2 ''Acquisition of Aetna'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

On October 10, 2018, the Company and Aetna entered into a consent decree with the United States Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. ("WellCare") for the divestiture of Aetna's standalone Medicare Part D prescription drug plans effective December 31, 2018. On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans. Aetna's standalone Medicare Part D prescription drug plans had an aggregate of approximately 2.3 million members as of December 31, 2018 . Aetna will provide administrative services to, and will retain the financial results of, the divested plans through 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

Business Strategy

The combined company expects to transform the consumer health care experience and build healthier communities through a new innovative health care model that is local, easier to use, less expensive and puts consumers at the center of their care. The Company believes that improving the consumer's health care experience will improve consumer engagement with their health which will lead to improved health outcomes and lower total health care costs. The Company believes there are three imperatives to accomplishing this transformation: be local, make it simple and improve health. These imperatives also guide the Company's five key strategies for delivering medical cost savings for its customers: improve common chronic disease management, reduce unnecessary hospital readmissions, improve the efficiency of the sites at which medical members receive care, optimize primary care delivery and improve the Company's complex chronic disease management capabilities.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care ("Managed Medicaid") plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges ("Private Exchanges" and together with Public Exchanges, "Insurance Exchanges"), other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2018, the Company's PBM filled or managed approximately 1.9 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow a plan member to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. Beginning in 2018, clients had new capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes CVS Pharmacy locations) and 27,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the United States Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. The Company is also able to build client-specific pharmacy networks and

managed pharmacy network solutions to further drive savings for clients. These include a performance-based pharmacy network with approximately 30,000 stores that is anchored by CVS Pharmacy and Walgreens, along with up to 10,000 independent pharmacies across the United States. The performance-based network is designed to deliver unit cost savings and to improve clinical outcomes in order to help to lower overall health care costs for participating payors and their members.

Mail Order Pharmacy Services
The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies via mail, telephone, fax, e-prescribing or the Internet, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. The Company's mail order dispensing pharmacies have been awarded Mail Order Pharmacy accreditation from Utilization Review Accreditation Commission ("URAC"), a health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. These specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies also have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's mail service specialty mail order pharmacies also have been accredited by the Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care programs and organizations in the United States.

Medicare Part D Services
The Company participates in the administration of the Medicare Part D prescription drug program through the provision of PBM services to those health plan clients and other clients that have qualified as a PDP or as a Medicare Advantage prescription drug plan and by offering Medicare Part D pharmacy benefits through its SilverScript subsidiary that is a PDP that has contracted with the United States Centers for Medicare & Medicaid Services ("CMS"). The Company also assists employer, union and other health plan clients that qualify for the retiree drug subsidy made available under Medicare Part D by collecting and submitting eligibility and/or drug cost data to CMS in order for such clients to obtain the subsidy and offers Medicare Part D pharmacy benefits to such clients' retirees through Employer Group Waiver Plans ("EGWPs") sponsored by SilverScript.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes, and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address the opioid epidemic, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy; limits the daily dosage of opioids dispensed based on the strength of the opioid; and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with health care providers ("providers") and other third parties. The Company's integrated disease management programs cover diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis. The majority of these integrated programs are accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations.

Medical Benefit Management
The Company's NovoLogix ® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Pharmacy Services Information Systems

The majority of the Pharmacy Services segment's clients have migrated to a single claim adjudication platform. This platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine ® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serve an essential role in cost management and health improvement. This capability transforms pharmacy data into actionable interventions at key points of care such as mail and specialty pharmacists to help provide quality care.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on public and private health insurance exchanges, other sponsors of health benefit plans and individuals located throughout the United States. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenue is generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients. In 2018 , 2017 and 2016 , revenues from Aetna accounted for approximately 9.8% , 12.3% and 11.7% , respectively, of the Company's consolidated total revenues. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, revenues from Aetna will continue to be reported in the Pharmacy Services segment; however, these revenues are eliminated in the consolidated financial statements.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature. However, quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of PDP membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in employers or other entities that sponsor the Company's products ("plan sponsors") sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating income generally increases as the year progresses.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors (e.g., the Express Scripts business of Cigna Corporation, OptumRx, Prime Therapeutics, MedImpact and Humana) offering PBM services, including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic ® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, the Retail/LTC segment also provided commercialization services under the name RxCrossroads ® . The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, the Retail/LTC segment operated more than 9,900 retail locations, over 1,100 MinuteClinic ® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2018, the Retail/LTC segment filled approximately 1.3 billion prescriptions

on a 30-day equivalent basis. In December 2018, the Company held approximately 26% of the United States retail pharmacy market.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, beauty products, cosmetics and personal care products. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. The Company's MinuteClinics offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2018	**2017**	**2016**
Pharmacy [(1)]	76.4%	75.0%	75.0%
Front store and other [(2)]	23.6%	25.0%	25.0%
	100.0%	100.0%	100.0%

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation stores.
(2) "Other" represents less than 5% of the "Front store and other" revenue category.

Pharmacy
Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2018 , 2017 and 2016 . The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare ® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best customers by providing them with automatic sale prices, customized coupons, ExtraBucks ® rewards and other benefits. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 7,000 CVS Health and proprietary brand products, which accounted for approximately 23% of front store revenues during 2018 .

MinuteClinic
As of December 31, 2018 , the Company operated approximately 1,100 MinuteClinic ® locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. As a result, visits paid for by employers, health insurers or other third parties accounted for approximately 91% of MinuteClinic's total revenues in 2018 . MinuteClinic is collaborating with the Pharmacy Services and Health Care Benefits segments to help meet the needs of CVS Caremark's client plan members and the Company's health plan members by offering programs that can improve member health and lower costs.

MinuteClinic is now affiliated with more than 75 major health systems and continues to build a platform that supports primary care.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Onsite Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Retail Store Development

The addition of new retail locations has played, and will continue to play, a key role in the Company's continued growth and success. The Company's store development program focuses on three areas: entering new markets, adding stores within existing markets and relocating stores to more convenient sites. During 2018 , the Company opened 145 new retail locations, relocated approximately 35 stores and closed approximately 30 locations. During the last five years, the Company opened approximately 900 new and relocated locations, and acquired approximately 1,825 locations, including the pharmacies acquired from Target Corporation ("Target") in 2015. The Company believes that continuing to grow its store base appropriately and locate retail stores in more accessible markets are essential components of competing effectively in the current health care environment. As a result, the Company believes that its store development program is an integral part of its ability to meet the needs of customers and maintain its leadership position in the retail pharmacy market given the changing health care landscape.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances the customer experience, as well as providing a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. The Health Engagement Engine technology and proprietary clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview ®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Pharmacy benefit managers, managed care organizations, government funded health care programs, commercial employers and other third party payors accounted for 99.5% of the Retail/LTC segment's pharmacy revenues. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2018 , 2017 or 2016 .

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and results of operations.

Retail/LTC Competition

The retail drugstore business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the markets it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Wal-Mart), independent pharmacies, restrictive pharmacy networks, membership clubs, Internet companies, and retail health clinics (including urgent care centers), as well as mail order dispersing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018 . The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology ("HIT") products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, governmental units, government-sponsored plans, labor groups and expatriates.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical* : The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under this product, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.
- *Government Medical* : In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:
    - *Medicare Advantage and PDP:* Through annual contracts with CMS, the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 1,317 counties in 40 states and Washington, D.C. in 2018 . The Company has expanded to 1,416 counties in 45 states and Washington, D.C. for 2019 . The Company is a national provider of drug benefits under the Medicare Part D prescription drug program to both individuals and EGWPs. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive

coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. On November 30, 2018, Aetna completed the sale of all of its standalone Medicare Part D prescription drug plans to WellCare effective on December 31, 2018. Aetna will provide administrative services to, and retain the financial results of, the divested plans through 2019. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.

- *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2018 .
- *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2018 .
- *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs. During 2018 , the Company offered services on an Insured basis to Duals in four states under demonstration projects.

- *Pharmacy* : The Company offers PBM services and specialty and home delivery pharmacy services. The Company also performs various PBM services for Aetna pharmacy customers consisting of: product development, Commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs. The Pharmacy Services segment performs the administration of selected functions for retail pharmacy network contracting and claims administration; home delivery and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services. Other suppliers also provide certain PBM services.
- *Specialty* : The Health Care Benefits segment has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products and workers' compensation administrative services.
- *Consumer Health Products and Services* : The Company has a portfolio of products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and enable enhanced delivery to and experience for customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization of medical services and the provision of data to providers to enable them to improve health care quality. At December 31, 2018 , the Company's underlying nationwide provider network had approximately 1.3 million participating providers, including over 697 thousand primary care and specialist physicians and approximately 5,700 hospitals. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the NCQA. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2018 , all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company's provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company's networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner's affiliated group or organization. The Company generally requires participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end to end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. Capabilities available to members include digital wallet, provider search, cost transparency and behavioral monitoring. The Health Care Benefits segment care management solution supports the Company's clinicians with data and recommendations. The Company continues to scale its clinical platform and its local personalized care model. The Company aims to build an integrated 360 degree view of the member to ensure that it can guide them through their healthcare journey and provide them a high level of service. Through its analytics platform the Company is beginning to harness the power of data to help drive healthier outcomes and proactive care and enable consumers to take the next best action for their health.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. See Note 17 ''Segment Reporting'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein, for additional information on foreign customers. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by United States and other geographic region and funding arrangement at December 31, 2018 :

In thousands	**Insured**	**ASC**	**Total**
Northeast	1,961	3,232	5,193
Southeast	1,752	2,886	4,638
Mid-America	1,632	2,530	4,162
West	1,618	4,510	6,128
Other	587	1,393	1,980
Total medical membership	7,550	14,551	22,101

For additional information on medical membership, see the caption "Management's Discussion and Analysis of Financial Condition and Results of Operations — Health Care Benefits Segment" in the Annual Report, which section is incorporated by reference herein.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through the Company's sales personnel; through independent brokers, agents and consultants who assist in the production and servicing of business; and Private Exchanges. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The United States federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals, federal employee-related benefit programs and Medicaid products and services. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. For additional information, see Note 17 ''Segment Reporting'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future results of operations could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed capitation payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some of Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial Medical products, Medicare contracts generate higher per member per month revenues and health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released 2019

star ratings in October 2018. The 2019 star ratings will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on membership at December 31, 2018 , 79% of the Company's Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy called the Health Insurer Fee (the "HIF"). In December 2015, the Consolidated Appropriation Act was enacted, which included a one year suspension of the HIF for 2017. In January 2018, the HIF was suspended for 2019. For additional information on the ACA fees, assessments and taxes, see Note 1 ''Significant Accounting Policies'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein. The Company's goal is to collect in premiums and fees where possible, or solve for all of these ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

The majority of Health Care Benefits segment revenues are not seasonal in nature. However, the Health Care Benefits segment's quarterly operating income progression is impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses which are generally the highest during the fourth quarter due to increased marketing spending associated with Medicare annual enrollment. As a result, the Health Care Benefits segment's operating income generally is the highest in the first quarter of the year and lowest in the fourth quarter of the year.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Public and Private Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks currently faced from new entrants and disruptive actions by existing competitors compared to prior periods. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of

provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The Health Care Benefits segment's international products compete with local, global and United States based health plans and commercial health care benefit insurance companies, many of whom have a longer operating history and better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on the Company's working capital practices, see the caption "Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources" in the Annual Report, which section is incorporated by reference herein. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. With the exception of the Medicare Part D services, described further below, the remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters which impacts working capital from year to year.

Colleague Development

As of December 31, 2018 , the Company employed approximately 295,000 colleagues in 50 states, the District of Columbia, Puerto Rico and a number of countries outside the United States. To deliver the highest levels of service to customers, the Company devotes considerable time and attention to its people and service standards. The Company emphasizes attracting and training knowledgeable, friendly and helpful associates to work in the organization.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Pharmacy Services, Retail/LTC and Health Care Benefits segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company's operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices. In addition, many of the Company's PBM clients and the Company's payors in the Retail/LTC Segment, including insurers, Medicare Part D plans, Managed Medicaid plans and managed care organizations ("MCOs"), are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company's LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company's businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company's businesses creates areas of uncertainty. Further, there are numerous proposed health care laws and regulations at the federal, state and international levels, some of which could adversely affect the Company's businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or

court proceedings, including future United States Congressional appropriations, will change various aspects of the industries in which it operates or the health care industry generally or the impact those changes will have on the Company's businesses, results of operations and/or cash flows, but the effects could be materially adverse. Any failure or alleged failure to comply with applicable laws and regulations as summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's results of operations, financial condition and/or cash flows. See Item 3, "Legal Proceedings" for further information.

The Company cannot give any assurances that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that it will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in other pending or future legal proceedings against the Company or affecting one or more of the industries in which it operates and/or the health care industry generally.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims for reimbursement by Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute, state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the federal anti-kickback statute.

Both federal and state false claims laws permit private individuals to file qui tam or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The ACA made broad-based changes to the United States health care system. If the ACA is not further amended, repealed or replaced, certain of its components will continue to be phased in until 2022. While the Company anticipates continued efforts in 2019 and beyond to invalidate, modify, repeal or replace the ACA, the Company expects aspects of the ACA to continue to significantly impact its business operations and results of operations, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, regulations and guidance as well as ongoing litigation. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing federal and state budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. For example, if any elements of the ACA are invalidated or repealed at the federal level, the Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements the Company and other health plans are paid by the federal government for Medicare members, among other sources. While not all-inclusive, the following are some of the key provisions of the ACA (assuming it continues to be implemented in its current form) that become effective on or after January 1, 2019. The Company continues to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on its business operations and results of operations:

- The imposition on the Company and other health insurers, health plans and other market participants of significant fees, assessments and taxes, including an annual non-tax deductible industry-wide HIF that was $14.3 billion for 2018 and has been suspended for 2019. As currently enacted, the HIF will apply for 2020, be higher for 2020 than for 2018 and increase in 2021 and annually thereafter.
- A non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold beginning in 2022.
- Reduced funding for Medicaid expansion, which began in 2017.

The ACA also specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in Commercial benefit designs, limits Commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and significantly increases federal and state oversight of health plans, including regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of congressional and state level elections, the December 2018 U.S. District Court decision invalidating the ACA and other pending litigation challenging aspects of the law or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. The pending litigation challenging the ACA includes challenges by various states of the federal government's decision to curtail payments related to the Cost-Sharing Subsidy Program. The time frame for conclusion and final outcome and ultimate impact of this litigation are uncertain. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to the ACA. It is reasonably possible that invalidation, repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's businesses, results of operations and cash flows.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company expects to further expand its Medicare service area and products in 2019 and is seeking to substantially grow its Medicare membership, revenue and results of operations over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, since the 2014 contract year, the ACA has required minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage contract pays rebates for five consecutive years, it will be terminated by CMS.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the Office of Inspector General ("OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes

that result from enforcement or audit actions, could materially affect the fairness of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level.

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS currently conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012, CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. The Company is evaluating the potential adverse effect, which could be material, on the Company's results of operations, financial condition, and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' results of operations in 2019 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2019 star ratings in October 2018. The Company's 2019 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on the Company's membership at December 31, 2018, 79% of its Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars. CMS will release updated stars ratings in October 2019 that will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2021. CMS also gives PDPs star ratings which affect PDP's enrollment and result in contract termination if the PDP is rated less than three stars for three consecutive years. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in maintaining high star ratings and other quality measures for 2019 and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Overall, the Company projects the benchmark payment rates in CMS's April 2018 final notice detailing final Medicare Advantage benchmark payment rates for 2019 (the "Final Notice") will increase funding for the Company's Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments received and will receive in the near term are adequate to justify

the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the United States Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDP, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' role. It is not possible to predict the outcome of this Congressional or regulatory activity, any of which could adversely affect the Company.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a PBM or Health Care Benefits segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, health care providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires us and other covered entities to report any breaches of PHI to impacted individuals and to the United States Department of Health and Human Services ("HHS") and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public

personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency. States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company's businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, Public Exchanges are required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-Public Exchange entities, which include insurers offering plans through the Public Exchanges and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act, the Consumer Product Safety Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company's direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the California Consumer Privacy Act will become effective in 2020, and the Company expects additional federal and state regulation of consumer privacy protection to be enacted in 2019. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other healthcare professionals; registration of facilities with the United States Drug Enforcement Administration ("DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the United States Food and Drug Administration ("FDA"), the Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies, with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the United States Department of Justice, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular

basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to recent and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital, or "RBC", requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2018, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as the Company's parent company, CVS Health Corporation) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, Medicare Part D prescription drug plans, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's stores, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws

and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with United States Department of Labor ("DOL") regulations, the Company may have ERISA fiduciary duties with respect to PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts.

Other Legislative Initiatives and Regulatory Initiatives - The United States federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Significant uncertainty remains as to whether and how the United States Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or results of operations, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and results of operations.
- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.
- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:
    - Elimination of the payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. In January 2019, HHS proposed regulations that would exclude such rebates from the safe harbor that currently is available for such payments under the federal anti-kickback statute.
    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefits plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to configure its health plan and retail pharmacy networks; and restricting or eliminating the use of certain drug pricing methodologies.
    - Increased federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.

- Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).
- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
- Mandating coverage by the Company and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (for example, high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
- Regulating electronic connectivity.
- Mandating or regulating the disclosure of provider fee schedules and other data about the Company's payments to providers.
- Mandating or regulating disclosure of provider outcome and/or efficiency information.
- Prescribing or limiting members' financial responsibility for health care or other covered services they utilize.
- Assessing the medical device status of HIT products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.
- Imposing payment levels for services rendered to the Company's members by providers who do not have contracts with the Company.
- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
- Amending or supplementing ERISA to impose greater requirements on PBMs, the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its results of operations or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the United States Department of the Treasury and the Internal Revenue Service.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage, and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these agreements are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the

OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Disease Management Services Regulation - The Company provides disease management programs to health plan and PBM plan members for complex medical conditions and arranges for those members to receive disease management programs for common medical conditions. State laws regulate the practice of medicine, the practice of pharmacy and the practice of nursing. Clinicians engaged in a professional practice in connection with the provision of disease management services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company currently has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company is taking steps to be able to continue to serve customers in the European Economic Area following the United Kingdom's pending exit from the EU ("Brexit"). However, the impact of Brexit on the Company's international business and results of operations is uncertain.

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of the Company's operations into foreign countries increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of United States law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the United States Securities and Exchange Commission (the "SEC") and the DOJ have increased their enforcement activities with respect to the FCPA. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. The Company has internal control policies and procedures and conducts training and compliance programs for its employees to deter prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its international operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their

compliance with the regulations. The Company also may be subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by OFAC. OFAC administers and enforces economic and trade sanctions based on United States foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company may be subject to similar regulations in the non-U.S. jurisdictions in which it operates.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation seeking to regulate PBM activities in a comprehensive manner has been introduced or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to them and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and federal and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWPs") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); disclosure of data to third parties; drug utilization management practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's results of operations and/or cash flows.

PDPs and the Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in several states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a few states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits.

Pharmacy Pricing Legislation - Several states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, networks and other plan design features on behalf of its insurer, MCO and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

FDA Regulation - The FDA generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, medical devices (including mobile medical devices), cosmetics, dietary supplements and certain food items. The FDA regulates the Company's activities as a distributor of store brand products.

Retail Clinics - States regulate retail clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations governing the practice of optometry, the practice of audiology, the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses, hearing aids and alcohol.

Laws and Regulations Related to the Health Care Benefits Segment

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In

addition, some of the Company's businesses and related activities may be subject to PPO, managed care organization, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies and state boards of pharmacy have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;
- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company's ability to price for the risk it assumes, which could adversely affect its MBRs and results of operations, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company's projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing its various restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can

earn in its Insured Commercial business while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested significant increases in its premium rates in its Commercial small group Health Care Benefits business for 2019 and expects to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products, which the Company expects to continue and potentially worsen in 2019. These significant rate increases heighten the risks of adverse public and regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage. In addition, HHS' rules on rates impose additional public disclosure requirements on any rate filings that exceed the "reasonableness" threshold and require additional review of those rates.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

Since 2017, Managed Medicaid products, including those the Company offers, are subject to a minimum MLR of 85%. A Medicaid managed care quality rating system and provider network adequacy requirements also apply to Medicaid products. Because the minimum MLR is structured as a "floor", states have the latitude to enact more stringent rules governing these various restrictions. For Managed Medicaid products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

The impact of Medicaid expansion under the ACA is uncertain. The future of the ACA is uncertain, and states may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, a number of states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2019 and beyond, including the possibility of converting federal Medicaid support to block grants and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation may adversely affect Medicaid payment rates, the Company's revenues and its Medicaid membership in those states.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (for example, when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS

contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or results of operations, but the effects could be materially adverse.

State Workers' Compensation Laws - The Company's workers' compensation business includes the comparison of medical claims data against the applicable state's fee schedule pricing, including applicable regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. The Company's workers' compensation business also includes PBM and care management services, both of which are regulated at the state level. The Company's workers' compensation customers include insurance carriers and TPAs who also are regulated at the state level. The laws and regulations applicable to the Company and other participants in the workers' compensation business are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its workers' compensation compliance efforts will continue to require significant resources. The Company may be subject to significant fines, penalties and litigation if it fails to comply with those laws and regulations.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to its health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. The Company's common stock is listed on the New York Stock

Exchange under the trading symbol "CVS." General information about CVS Health is available through the Company's website at *http://www.cvshealth.com* . The Company's financial press releases and filings with the SEC are available free of charge within the Investors section of the Company's website at *http://www.cvshealth.com/investors* . In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company's website is neither a part of nor incorporated by reference in this Annual Report on Form 10-K or any of the Company's other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under Regulation FD, CVS Health Corporation (the "Registrant") hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (http://investors.cvshealth.com/) and its Twitter feed (@CVSHealthIR) to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

Item 1A. Risk Factors

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this Annual Report on Form 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this Annual Report on Form 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, these events or circumstances could have a material adverse effect on our businesses, results of operations, cash flows and/or financial condition. In that case, our stock price could decline materially, among other effects on us. You should read the following section in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" (which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section) in the Annual Report, which is incorporated by reference herein, and our consolidated financial statements and the related notes.

Overarching Risks

Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.

We expect to face significant business challenges and uncertainties in 2019. Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond. There can be no assurance regarding our ability to avoid harm to our brand and reputation, our ability to manage the risks inherent in the Aetna Acquisition or our data governance risks, our ability to manage and align our talent to our business needs or our ability to manage the risks presented by changes in public policy, laws or regulations. In addition, there can be no assurance that the Aetna Acquisition, United States government fiscal policy, changes to the United States health care system (including changes to the ACA, to drug reimbursement and/or drug pricing laws and regulations and/or to laws and regulations governing PBMs' interactions with government funded health care programs) or other unanticipated risks will not require us to revise the ways in which we conduct business, put us at risk of loss of business or materially adversely affect our businesses, cash flows, financial condition or results of operations.

Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.

Reputational risk is inherent in many of the risks we face. The industries in which we operate regularly are negatively perceived by the public and subject to negative publicity, including as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, government involvement in drug pricing and purchasing, PBMs and the future of the ACA, governmental hearings and/or investigations and actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing, insurance coverage determinations and social media and other media relations activities). This risk may be increased as the federal government continues to consider increased involvement in drug reimbursement, pricing and/or purchasing and changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, and as states seek to maintain, replace or repeal elements of the ACA such as Public Exchanges and Medicaid expansion within increasingly challenging budget constraints. This risk also may be increased as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers. Significant reductions or interruptions in funding for government health programs we serve also may lead us to reduce our exposure to these programs, which could adversely affect our brand and reputation.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our results of operations and our stock price by:

- Adversely affecting our brand and reputation;
- Adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- Requiring us to change our products and/or services;
- Reducing or restricting the compensation we can receive for our products and/or services; and/or
- Increasing or significantly changing the regulatory and legislative requirements with which we must comply.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member, customer or other constituent information, whether by us, by one of our vendors or by another third party, could require us to expend significant resources to remediate any damage, interrupt our operations and damage our brand and reputation, and could also result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, results of operations and cash flows.

Our businesses depend on our customers' and members' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our members', customers' and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and results of operations and also can and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings,

material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, cash flows, results of operations or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased salaries or other benefits. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses and results of operations.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses and results of operations. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and results of operations could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing and/or purchasing, increased regulation of PBMs, changes to Medicare, Medicaid or the regulatory environment for health care benefits, including the ACA, changes to drug reimbursement and/or pricing laws and regulations, changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changes to immigration policies and/or many other public policy initiatives. For example, in January 2019, HHS proposed regulations that would exclude from the current safe harbor under the federal anti-kickback statute manufacturer's rebates on prescription drugs paid to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of United States Presidential Executive Orders). Other significant changes to health care system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries are also possible and could adversely affect us. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not do so as effectively as our competitors, our businesses, operations and results of operations may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Potential modification to the ACA, including changes in enforcement and/or funding that further destabilize the Public Exchanges, as well as significant changes to Medicaid funding could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to federal health care laws, including the ACA, drug reimbursement and pricing laws and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care legislation, future changes to the ACA or the implementation or failure to implement the outstanding provisions of ACA, may have on our retail pharmacy, LTC pharmacy, specialty pharmacy, pharmacy services and/or Health Care Benefits operations and/or results of operations. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs.

In addition, much of the branded and generic drug product that we sell in our retail, mail and specialty pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material

adverse effect on our businesses, cash flows and results of operations. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in United States trade regulations, could adversely affect our businesses.

We cannot predict the enactment or content of new legislation and regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or results of operations, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we operate. Examples of such change include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing and/or purchasing, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence. For more information on these matters, see "Government Regulation" included in Item 1 of this Annual Report on Form 10-K.

Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.

Our strategy includes effectively investing our capital and human resources in appropriate strategic projects, current operations and acquisitions to transform our businesses in response to the changing dynamics in the industries in which we operate. Our strategic projects include, among other things: integrating the Aetna Acquisition; significant investments in human and technology resources to expand our consumer-oriented products and services; optimizing our business platforms; managing certain significant technology projects; further improving relations with manufacturers, suppliers and health care providers; negotiating contract changes with customers, manufacturers, suppliers and health care providers and implementing other business process improvements. Implementing our strategic initiatives will require significant investments of capital and human resources. Among other things, we will need to simultaneously acquire and develop new personnel, products and systems to serve existing and new customers with existing and new products and to enhance our existing customer service, information technology, control and compliance processes and systems. The future performance of our businesses will depend in large part on our ability to design and implement our strategic initiatives, some of which will occur over several years. If these initiatives do not achieve their objectives, our results of operations could be adversely affected.

Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, and we may fail to recognize and position ourselves to capitalize upon market opportunities. We may not have sufficient advance notice and resources to develop and effectively implement an alternative strategy. If our existing competitors and/or new entrants (whether vertical, horizontal or online/digital/e-commerce) into one or more of our businesses create new disruptive business models and/or develop new offerings that customers, members and/or health care providers prefer to our offerings, we may lose customers, members and/or providers, and our results of operations, cash flows and/or prospects may be adversely affected. In addition, our results of operations, cash flows and/or prospects may be adversely affected by consolidation among the participants in the industries in which we operate and/or our customer base. Our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

Risks Related to Our Businesses

Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.

The continued efforts of HMOs, MCOs, PBMs, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, as well as litigation and other legal proceedings relating to how drugs are priced, may adversely affect our profitability. In particular, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail, specialty, LTC and mail order pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Historically, the effect of this trend on generic profitability has been mitigated by the introduction of new multi-source generic drugs as well as inflation on brand name drugs and by our efforts to negotiate reduced acquisition costs of generic drugs with manufacturers. However, in recent years, there has been significant consolidation within the generic manufacturing industry and in 2019 we expect fewer new multi-source generic drugs to be introduced and lower brand name drug inflation than in recent prior years, and it is possible that these and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced acquisition costs. Any inability to offset increased brand name or

generic prescription drug costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our results of operations.

In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and audits at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are continuing at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices. For example, we anticipate that federal and state governments will continue to review and assess alternative health care delivery systems, payment methodologies and operational requirements for health care providers, including LTC facilities and pharmacies, and participants in government funded health care programs. A change in the composition of pharmacy prescription volume toward programs offering lower reimbursement rates could adversely affect our profitability. Any action taken to repeal or replace all or significant parts of ACA also could adversely affect our profitability, though it is unclear at this time what the full effects of any such changes would be.

The ACA made several significant changes to Medicaid rebates and to reimbursement rates. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for generic drugs. This change has adversely affected the reimbursements we receive when we dispense prescription drugs to Medicaid recipients. In addition, the ACA made other changes that affect the coverage and plan designs that are or will be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum MLR to avoid having to pay rebates to enrollees. These ACA changes may not affect our businesses directly, but they could indirectly impact our services, business practices and/or results of operations.

Gross margins in the industries in which we operate may decline.

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, enhanced service offerings and/or higher service levels. In that regard, we maintain contractual relationships with generic drug manufacturers and brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our businesses and results of operations could be adversely affected. Further, competitive pressures in the PBM industry have resulted in our clients sharing in a larger portion of rebates and/or discounts received from drug manufacturers. Marketplace dynamics and regulatory changes also have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could adversely affect our future profitability, and we expect these trends to continue. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs, drug pricing or purchasing, patent term extensions, purchase discount and/or rebate arrangements with drug manufacturers, or additional regulation of PBMs, formulary management or other PBM services could also reduce the discounts or rebates we receive. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, could adversely affect our profitability.

Our retail pharmacy, specialty pharmacy and LTC pharmacy operations also have been affected by the margin pressures described above, including client demands for lower prices, generic pricing and network reimbursement pressure. In addition, as competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in general pricing pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive. A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions. Finally, the margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements. These actions could also adversely affect the margins of our LTC business.

Our results of operations are affected by the health of the economy in general and in the geographies we serve.

Our businesses are affected by the United States economy and consumer confidence in general and in the geographies we serve, including various economic factors, inflation and changes in consumer purchasing power, preferences and/or spending patterns. It is possible that an unfavorable, uncertain or volatile economic environment will cause a decline in drug utilization, an increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores. Further, economic conditions including interest rate fluctuations, changes in capital market conditions and

regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms and our ability to execute sale-leaseback transactions under acceptable terms. Adverse changes in the United States economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results. This adverse effect could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

In addition, our Health Care Benefits membership remains concentrated in certain geographic areas in the United States and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits results of operations. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the United States geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenue and results of operations may be disproportionately affected by adverse changes affecting our customers.

We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.

Each of our businesses currently operates in a highly competitive and evolving business environment. We must compete successfully with existing competitors and new entrants, including strategic alliances and online, digital and e-commerce companies.

The competitive success of our retail pharmacy business, as well as our specialty pharmacy operations with third-party payors, is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. As a pharmacy retail business, we compete with other drugstore chains, supermarkets, online and other discount retailers, independent pharmacies, membership clubs, convenience stores and mass merchants, some of which are aggressively expanding into markets we serve. We also face competition from other retail health care clinics, as well as other mail order pharmacies and PBMs. Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such changes and make timely and effective changes to our strategies and business model to compete effectively. Competition may also come from other sources in the future. Changes in market dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks, could materially and adversely affect our businesses, results of operations, cash flows and prospects.

We also could be adversely affected if we fail to identify or effectively respond to changes in market dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the United States, a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy operations focus on complex and high-cost medications that serve a relatively limited universe of patients, the future growth of this business depends to a significant extent upon expanding our ability to access key drugs and successfully penetrate key treatment categories.

The competitive success of our LTC pharmacy operations is dependent upon our ability to compete in each geographic region where we have operations. In the geographic regions we serve, we compete with PharMerica, our largest LTC pharmacy competitor, as well as with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Our LTC pharmacy customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. One of our growth opportunities is to increase our penetration rate in the assisted living segment, where residents can choose which pharmacy will provide them with prescription drugs. The ability of a resident of an assisted living facility to select the pharmacy that supplies him or her with prescription drugs could adversely affect our business, financial condition and results of operations because there can be no assurance that such resident will select us.

The competitive success of our pharmacy services business is impacted by its ability to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. Competitors in the PBM industry (e.g., the Express Scripts business of Cigna Corporation,

OptumRx, Prime Therapeutics, MedImpact and Humana), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Competition also may come from other sources in the future. In addition, changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could adversely affect our claims volume and/or our competitiveness generally.

Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and results of operations. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and results of operations, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy. These actions may adversely affect our membership, revenues and results of operations

Competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. For example, strong competition in the PBM marketplace has generated greater client demand for lower pricing, increased revenue sharing and enhanced product and service offerings. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings, particularly in a rapidly changing health care industry, we may be unable to remain competitive.

We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM's client base typically is subject to renewal each year. In some cases, however, PBM clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Our clients are generally well informed and organized, can move between our competitors and often seek competing bids prior to expiration of their contracts. In addition, the reputational impact of a service-related incident could adversely affect our businesses. These factors, together with the impact of competitive pressures, could make it difficult for us to attract new clients, retain existing clients and cross-sell additional products and/or services. Further, the PBM industry has been affected by consolidation activity that may continue in the future. If one or more of our PBM clients is acquired by an entity that is not also our client, we may be unable to retain all or a portion of the acquired client's business. These circumstances, either individually or in the aggregate, could result in an adverse effect on our businesses and financial results. Therefore, we continually face challenges in competing for new PBM business and retaining or renewing our existing PBM business. With respect to our LTC pharmacy business, reimbursement from skilled nursing facilities for prescriptions we dispense is determined pursuant to our agreements with those skilled nursing facilities. The termination of these agreements generally terminates our ability to provide services to any of the residents of that facility, resulting in the loss of revenue from any source for those residents. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to us as the present terms.

Additionally, with respect to our retail and LTC pharmacy businesses, reimbursement under Medicare Part D, as well as reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their PBM representatives. The loss of those agreements, or a material change in the terms of those agreements, could adversely affect our results of operations and cash flows. In addition, restricted networks that exclude our retail or specialty pharmacies adversely affect those businesses.

The health care and related benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the marketplace. Our Health Care Benefits segment faces significant competition in all of the geographies and product areas in which it operates. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the

increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods.

Our Health Care Benefits segment competes on the basis of many factors, including perceived overall quality, quality of service, comprehensiveness of coverage, cost (including premium, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, providers available in such networks, and quality of member support and care management programs. Our Health Care Benefits segment's competitors include, among others, UnitedHealth Group Incorporated, Anthem, Inc., Humana Inc., Cigna Corporation, WellCare Health Plans, Inc., Centene Corporation, Molina Healthcare, Inc., Kaiser Permanente, health system owned health plans and new entrants into the marketplace, and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The Health Care Benefits segment's largest competitor in its Medicare products is Original Medicare. Additional competitors in this segment's businesses include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), TPAs, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefit plans, provider-owned health plans, new joint ventures (including for-profit and not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. In particular geographies, competitors may have greater capabilities, resources or membership; a more established reputation; superior supplier or health care professional pricing and contract terms; better business relationships; or other factors that give such competitors a competitive advantage. The Health Care Benefits segment competes for sales on Insurance Exchanges and is developing and expanding its Consumer Health Products and Services product and service offerings, where we face additional risks from existing and new competitors (including our vendors) who have lower cost structures, greater experience marketing to consumers and/or who target the higher margin portions of our business. Among the Health Care Benefits segment's international and HIT competitors, many have longer operating histories, better brand recognition and greater market presence in many of the areas in which the segment is seeking to expand and more experience at rapidly innovating products.

There can be no assurance that the Aetna Acquisition will not adversely affect any of our segments' respective abilities to attract new clients or retain existing clients or our ability to cross-sell additional products and/or services within any segment or between segments. If we do not compete effectively in the geographies and product areas in which we operate, our businesses, results of operations, financial condition and cash flows could be materially and adversely affected.

We are exposed to risks relating to the solvency of our customers and of other insurers.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, financial condition and results of operations. In addition, both state and federal government sponsored payers, as a result of budget deficits or reductions, may suspend payments or seek to reduce their healthcare expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us. Any delay or reduction in payments by such government sponsored payers may adversely affect our businesses, financial condition and results of operations.

We are subject to assessments under guaranty fund laws for obligations of insolvent insurance companies (such as the discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for Penn Treaty Network America Insurance Company and one of its subsidiaries that Aetna recorded in the first quarter of 2017), HMOs, ACA co-ops and other payors to policyholders and claimants.

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs that we purchase and sell.

We dispense significant volumes of brand-name and generic drugs from our retail, LTC, specialty and mail order pharmacies and through our PBM's network of retail pharmacies. When increased safety risk profiles or manufacturing or other supply issues of specific drugs or classes of drugs occur, or drugs become subject to greater restrictions as controlled substances, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced.

Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can

result in lower prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our results of operations and cash flows may decline as a result of such regulatory rulings or market changes.

Further, we acquire a substantial amount of our mail and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers are often short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the agreement and may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations. Moreover, many products distributed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our results of operations and cash flows.

In addition, our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

A disruption in our business operations could occur as a result of contamination of drugs, a failure to maintain necessary shipment and storage conditions, errors in mail order processing, the unavailability of prescription drugs provided by suppliers, labor disruptions or other unanticipated disruptions at our mail order dispensing pharmacy facilities, specialty pharmacy facilities, call centers, data centers or corporate facilities, among other factors. Such disruption could reduce our ability to process and dispense prescriptions and provide products and services to our customers.

If any products we distribute are in limited supply for significant periods of time, our financial condition and results of operations could be materially and adversely affected.

We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription drugs as well as lower-priced generic alternatives to existing brand name products because we generally earn higher gross margins on the sale of generic alternatives than on brand name equivalents. In addition, inflation in the price of brand name drugs can affect utilization, particularly given the increase in high deductible health plans. Accordingly, our businesses and results of operations could be adversely affected by a slowdown or delay in the number or magnitude of new and successful prescription drugs and/or generic alternatives, as well as inflation in the price of brand name drugs. For example, we project that the operating income of our Pharmacy Services and Retail/LTC segments may be reduced in 2019 compared to 2018 due in part to fewer new multi-source generic drugs being introduced and lower brand name drug price inflation in 2019 than 2018.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace AWP or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs ("FFS Medicaid") have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact on reimbursement practices in other commercial and government products. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our results of operations. Additionally, any future changes in drug prices could be significantly different than our projections. The effect of these possible changes on our businesses cannot be predicted at this time.

Product liability, product recall or personal injury issues could damage our reputation.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of drugs and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, that exposes us to professional liability claims. Should a product or other liability issue arise, the coverage limits under our insurance programs and the indemnification amounts available to us may not be adequate to protect us against claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. Damage to our reputation in the event of a product liability or personal injury issue or judgment against us or a product recall could have a significant adverse effect on our businesses, financial condition and results of operations.

We face challenges in growing our Medicare Advantage and Medicare Part D membership.

We are seeking to substantially grow our Medicare Advantage and Medicare Part D membership, revenue and results of operations in 2019 and over the next several years, including by significantly expanding our Medicare Advantage service area. The organic expansion of our Medicare Advantage service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations. If we are not successful in expanding our Medicare Advantage service area, we may not be able to achieve our Medicare Advantage growth goals.

We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.

We are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders. Our ability to maintain and grow membership, revenues and results of operations in our Medicaid products is dependent on our remaining competitive on price, performance and preparing successful bids. In cases where a successful bid is challenged, we incur defense costs and may incur unreimbursed implementation and other costs to meet contractual deadlines even if we ultimately lose the challenge.

If we are successful in expanding our Medicaid membership, we may increase our exposure to states that face budgetary pressures, hospitals and other providers that face revenue challenges associated with uncompensated care and pressures on our operating margins driven by the projected rapid growth in the size of and cost of care for the Medicaid eligible population.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although recently even relatively small employers have moved to ASC products. We also serve government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and regulatory requirements and have lower profit margins than the Insured Commercial products in our Health Care Benefits segment. Although our Health Care Benefits membership is projected to continue to shift towards Government products in 2019, the profitability of each of those products differs and may be less than the profitability of an Insured Commercial product. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our results of operations.

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's results of operations. There can be no assurance that the future health care and other benefit costs of our Insured Health Care Benefits products will not exceed our projections.

Premiums for our Insured Health Care Benefits products, which comprised 87% of our Health Care Benefits revenues for 2018, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and healthcare utilization patterns and require a significant degree of

judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our results of operations.

Our health care and other benefit costs can be affected by external events that we cannot forecast or anticipate and over which we have little or no control, such as emerging changes in the economy and/or public policy, additional government mandated benefits or other regulatory changes, changes in our members' behavior and healthcare utilization patterns, changes in health care practices, new technologies, increases in the cost of prescription drugs, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), direct-to-consumer marketing by drug manufacturers, clusters of high cost cases, epidemics, pandemics, terrorist attacks or other man-made disasters, natural disasters or other events that materially increase utilization of medical and/or other covered services, including prescription drugs, as well as changes in provider billing practices. Our health care and other benefit costs also can be affected by changes in our business mix, product designs, contracts with providers, medical management, underwriting, rating and/or claims processing methods and processes, and our medical management initiatives may not deliver the reduction in utilization and/or medical cost trend that we project.

It is particularly difficult to accurately anticipate, detect, price, forecast, manage and reserve for medical cost trends and utilization of medical and/or other covered services during and following periods when such utilization and/or trends are below recent historical levels, during periods of changing economic conditions and employment levels and for products with substantial membership growth and/or turnover. For example, as of December 31, 2018, we held a premium deficiency reserve of $16 million for the 2019 coverage year related to our Medicaid products. We expect utilization to increase in 2019 when compared to 2018.

If health care and other benefit costs are higher than the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our prices will not reflect the risk we assume, and our results of operations will be adversely affected. If health care and other benefit costs are lower than we predict, our prices may be higher than those of our competitors, which may cause us to lose Health Care Benefits membership.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and healthcare utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' utilization and other behavior, changes in health care practices and inflation. In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, changes in health care practices, general economic conditions (such as inflation and employment levels), new technologies, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

Our Health Care Benefits segment's results of operations and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and results of operations.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be

insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the ACA's, CMS's and OPM's minimum MLR rules and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period results of operations within benefit costs. For example, as of December 31, 2018, we held a premium deficiency reserve of $16 million for the 2019 coverage year related to our Medicaid products. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2018 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our results of operations. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the United States economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which would also be affected by the government's actions and the responsiveness of public health agencies and other insurers. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses, cash flows and results of operations, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

Changes in Public Policy and Other Legal and Regulatory Risks

Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.

Medicare Advantage payment rates to health plans have been cut over the last several years, with additional reductions to be phased in through 2019. CMS issued the Final Notice in April 2018. Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only slightly offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications), the HIF and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on the Medicare Advantage program and our Medicare Advantage results of operations. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare results of operations.

In addition, the "star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' results of operations. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below 4 for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues and results of operations may be significantly adversely affected.

Payments we receive from CMS for our Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the fairness of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.

Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; if changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; if the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if the government mandates the use of point-of-sale manufacturer's rebates or up front drug pricing discounts, makes drug manufacturer's rebates illegal, or makes changes to how pharmacy pay-for-performance is calculated; or if reinsurance thresholds are reduced below their current levels, our Medicare Part D results of operations and our ability to expand our Medicare Part D business could be adversely affected.

More generally, our Medicare results of operations and our ability to expand our Medicare membership and revenues also could be adversely affected if we fail to design and maintain programs that are attractive to Medicare Advantage or Part D participants; if CMS imposes restrictions on our Medicare business as a result of audits or other regulatory actions; if we fail to successfully implement corrective actions or other remedial measures sufficient to prevent or remove any applicable restrictions that may be imposed by CMS; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare's competitive bidding process.

Federal funding for expanded Medicaid coverage began to decrease in 2017. This reduction is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our MBRs and our results of operations.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and results of operations and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins and results of operations of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. The risk of increases in utilization of medical and/or other covered services and/or in health care and other benefit costs is particularly acute during and following periods when utilization has been below recent historical levels, during periods of changing economic conditions and/or employment levels and in products where there is significant turnover in our membership each year. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and/or CHIP premium rates is limited due, among other things, to the budgetary pressures currently facing many state governments. This could magnify the adverse impact on our operating margins and results of operations of increases in utilization of medical and other covered services, health care and other benefit costs and/or medical cost trends that exceed our projections.

Since 2013, HHS has issued determinations to health plans that their rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in a number of states also have conducted hearings on proposed premium rate increases, which can result, in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. We requested significant increases in our premium rates in our small group Commercial Health Care Benefits products for 2019 and expect to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for the applicable products (also known as "adverse selection") in our products, particularly in small group products, which we expect to continue and potentially worsen in 2019 following the expiration of the ACA's risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory reaction and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in any product line or geography. If we are unable to obtain adequate rates and/or rate increases, it could materially and adversely affect our operating margins and our ability to earn adequate returns on Insured Health Care Benefits business in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our results of operations.

The ACA requires us to pay minimum MLR rebates each year with respect to prior years. The ACA's minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and FEHB program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with the OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our results of operations.

Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently and can be inconsistent or conflicting. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors. In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. In connection with the Aetna Acquisition, we also agreed to undertakings with certain state regulators that place various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries.

Our Pharmacy Services products are subject to:

- The clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by us to adhere to the laws and regulations applicable to the dispensing of drugs could subject our Pharmacy Services businesses to civil and criminal penalties).
- Federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers.
- Compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings.
- Federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs are complex, are subject to interpretation and can expose us to penalties for non-compliance, including penalties under the False Claims Act and state false claims acts. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products that are sold on Public Exchanges or otherwise subject to the ACA. The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a health program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan and other programs, cash flows, financial condition and results of operations.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.

Our businesses are subject to extensive and complex regulations, and many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems in place to ensure that we comply with all applicable legal, regulatory and contractual requirements. These systems frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, cash flows, results of operations or financial condition.

Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.

Historically, we focused primarily on providing Retail/LTC and Pharmacy Services products and services. As a result of the Aetna Acquisition, we have significantly expanded our presence in Health Care Benefits products and services (including

products and services offered in multiple countries outside of the United States), which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core business and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Retail/LTC and Pharmacy Services products and services and increase significantly our exposure to other risks.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and results of operations.

Pharmacy services, retail pharmacy, LTC pharmacy and health care benefits are highly regulated and litigious industries. We are currently subject to various litigation matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings. Litigation, and particularly securities, collective or class action and *qui tam* litigation, is often expensive and disruptive. Certain of the lawsuits against us are or are purported to be class actions or *qui tam* actions. Litigation related to our provision of professional services in our pharmacies, specialty pharmacies, medical clinics and LTC facilities also has increased as we expand our services along the continuum of health care.

The majority of these proceedings relate to the conduct of our Retail/LTC, Pharmacy Services and Health Care Benefits operations and allege various violations of law. In addition, we operate in jurisdictions outside the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and are therefore more likely to be subject to dispute by customers, members, governmental authorities and others. We are incurring expenses to resolve these proceedings. The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur.

Litigation has been and may be brought against us by private individuals on behalf of the government through a *qui tam* or “whistleblower” suit. Under the provisions of the federal and various state false claims acts, private citizens may bring lawsuits alleging that a violation of the federal anti-kickback statute or similar laws has resulted in the submission of “false” claims to federal and/or state health care programs, including Medicare and Medicaid, and we are a defendant in a number of such proceedings. When a private individual brings a whistleblower suit, the defendant often will not be made aware of the suit for many months or even years, until the government commences its own investigation or determines whether it will intervene. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided under the Financial Reform Act increase the risk of whistleblower suits.

Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

We cannot predict the outcome of any of these matters, and the costs incurred may be substantial regardless of outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses or results of operations because of brand and reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this Annual Report on Form 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail and LTC pharmacy, pharmacy services and health care benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the United States Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the

DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. Several such audits, investigations and reviews currently are pending, some of which may be resolved in 2019, and the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our financial condition, results of operations or businesses or result in significant liabilities and negative publicity for our company. For example, since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. In addition, federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.

Premiums and/or fees for Medicare members, certain federal government employee groups and Medicaid beneficiaries are subject to retroactive adjustments and/or withholding by the federal and applicable state governments. Our business that is subject to the ACA, including amounts payable to us or payable by us under the ACA's premium stabilization programs and our risk adjustment and reinsurance data, also is subject to audit by governmental authorities. CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members.

CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes.

Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted RADV audits of a subset of Medicare Advantage plans for various contract years, including certain of our plans for various contract years, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The OIG also is auditing our risk adjustment data and that of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data. We also have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified

in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. We are evaluating the potential adverse effect, which could be material, on our results of operations, financial condition and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would require us to change our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years.

If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our financial condition, cash flows and results of operations.

CMS has issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our results of operations, financial condition and/or cash flows.

Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid results of operations and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

Any premium or fee refunds, adjustments or withholding or civil or criminal fines or penalties, or other sanctions, including restrictions on or changes in the way we do business, loss of licensure or exclusion from participation in government programs, resulting from regulatory audits or investigations, whether as a result of RADV, Public Exchange related, recovery audit program or other audits or investigations by CMS, the OIG, HHS, the DOJ or otherwise, including audits of our minimum MLR rebates, methodology and/or reports, could be material and could adversely affect our results of operations, financial condition and cash flows.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a

significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.

Programs funded in whole or in part by the United States federal government account for a significant portion of our revenue, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

Our revenues from government funded programs, including our Medicare, Medicaid, dual eligible and dual eligible special needs plan businesses and our government customers in our Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

For example, CMS is transitioning the process of calculating Medicare members' risk scores from using diagnoses data from the Risk Adjustment Processing System, or RAPS, to using diagnoses data from the Encounter Data System, or EDS. The RAPS process requires Medicare Advantage plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires Medicare Advantage plans to submit all encounter data, and CMS applies the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score will be calculated from claims data submitted through EDS, up from 15% in 2018. For 2020, the EDS percentage will increase to 50%. The transition from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues or filtering logic differences between RAPS and EDS and could have a material adverse effect on our results of operations, financial condition and/or cash flows.

In addition, while the ACA provided substantial federal funding for the expansion of the number of people who qualify to enroll in Medicaid beginning in 2014, that funding began to decrease in 2017, and the future of that funding is uncertain. As a result, in 2019, states are preparing for the adverse impact on their budgets and programs by seeking to reduce their Medicaid expenditures and/or changing the design of their Medicaid programs. These changes could have a material adverse effect on the revenues, medical benefit ratios and results operations of our Medicaid contracts and/or our ability to grow our Medicaid membership, revenues and results of operations.

Our government customers also determine the eligibility criteria, premium levels and other aspects of Medicare, Medicaid, dual eligible and dual eligible special needs plan programs that affect the number of persons enrolled in these programs, the services provided to enrollees under these programs, the conditions for participating in these programs and our administrative and health care and other benefit costs under these programs. For example, states may require participation on their Public Exchange as a condition to participating in their Medicaid or state employee health benefit programs and/or take program design actions that shift provider costs from state employee plans to Commercial and Medicare plans. In the past, determinations of this type have at times adversely affected our results of operations from and willingness to participate in such programs, and they may do so again in the future. If a government customer reduces premium levels or increases premiums by less than the increase in our costs (such as by not allowing us to recover ACA and other applicable fees, taxes and assessments), and we cannot offset the adverse impact of these actions with supplemental premiums and/or changes in benefit plans, then our businesses and results of operations could be adversely affected. In addition, if states allow certain programs to expire, reduce the number of firms with which they contract for Managed Medicaid services or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment or reduced Medicaid enrollment growth, which would adversely affect our businesses, revenues and results of operations.

The federal government's "debt ceiling", or the amount of debt the federal government is permitted to borrow to meet its legal obligations (including, among other things, interest on the national debt, Medicare and Medicaid premiums and contributions to the FEHB program), is limited by statute and can only be raised by an act of Congress.

During a federal government shutdown or if Congress does not raise the debt ceiling before the federal government's current obligations approach or exceed its cash on hand and incoming receipts, federal government spending may be subject to delay, reduction, suspension or cancellation, which may be prolonged. Over 30% of our Health Care Benefits segment's revenues are derived from health care coverage programs that are funded in whole or in part by the federal government, including the Medicare, Medicaid, dual eligible and dual eligible specials needs plan programs, CHIP and the FEHB program. When federal spending is delayed, suspended or curtailed, we continue to receive claims from providers providing services to beneficiaries of these programs, and we remain liable for, and are required to fund, such claims. A federal government shutdown or a failure to

timely raise the debt ceiling could have a material adverse effect on our businesses, results of operations, cash flows, brand and reputation and, in the case of a prolonged shutdown or failure to raise the debt ceiling, our financial condition.

If the United States defaults on its obligations due to a failure to timely raise the debt ceiling or otherwise, or its credit rating is downgraded by any of the credit rating agencies, interest rates could rise, financial markets could become volatile and/or the availability of credit (and short-term credit in particular) could be adversely affected, thereby increasing our borrowing costs, adversely affecting the value of our investment portfolio, and/or adversely affecting our ability to access the capital markets, which could have a material adverse effect on our results of operations, financial condition and cash flows and could adversely affect our liquidity.

Our results of operations may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

The federal and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave. In addition, our employee related operating costs may be increased by union organizing activity. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our results of operations will be adversely affected.

Risks Related to Customer Perceptions of our Products and Services

We must develop and maintain a relevant omni-channel experience for our retail customers.

Our business has evolved from a retail store experience to interaction with customers across numerous channels, including in-store, online, mobile and social media, among others. Omni-channel retailing is rapidly evolving and we must keep pace with changing customer expectations and new developments by our competitors. Our customers are increasingly using mobile phones, tablets, computers and other devices to comparison shop, determine product availability and complete purchases through mobile commerce applications. As a result, the portion of total consumer expenditures with all retailers occurring online and through mobile commerce applications is increasing and the pace of this increase could accelerate. We must compete by offering a consistent and convenient shopping experience for our customers regardless of the ultimate sales channel and by investing in, providing and maintaining mobile commerce applications for our customers that have the right features and are reliable and easy to use. If we are unable to make, improve or develop relevant customer-facing technology in a timely manner that keeps pace with technological developments and dynamic customer expectations, our ability to compete and our results of operations could be materially and adversely affected. In addition, if our online activities or our other customer-facing technology systems do not function as designed, we may experience a loss of customer confidence, data security breaches, lost sales, or be exposed to fraudulent purchases, any of which could materially and adversely affect our business operations, reputation and results of operations.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in our markets, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, results of operations and financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers which, consequently, could adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner,

is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our financial performance and erode customer loyalty.

Our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs), that serve a relatively limited universe of patients. As a result, the future growth of our specialty pharmacy business is dependent largely upon expanding our base of drugs or penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, results of operations and cash flows.

We operate in rapidly evolving industries. Our customers generally, and our larger customers in particular, are well-informed and organized and, along with our individual customers, can easily move between us and our competitors. These factors require us to differentiate our products and solutions, anticipate changes in customer and consumer preferences, anticipate and effectively compete with the products and solutions of new and existing competitors and innovate and deliver new and existing products and solutions that demonstrate value to our customers and members, particularly in response to marketplace changes from public policy. Any failure to do so may adversely affect our ability to retain or grow customers and/or profitable medical membership, which can adversely affect our results of operations.

In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.

Historically, employers have been the most significant customers driving purchases of our Pharmacy Services and Health Care Benefits segments. However, decisions to buy our Pharmacy Services and Health Care Benefits products and services increasingly are made or influenced by consumers, either through direct purchasing (for example, Medicare Advantage plans and PDPs) or through Insurance Exchanges that allow individual choice. Similarly, consumers increasingly seek to access health care products and services locally and through other direct channels such as mobile devices and our websites. In response to this demand, we are expanding our consumer focus. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

We also will have to respond to pricing and other actions taken by existing competitors as well as potentially disruptive new entrants. Regulatory and participation requirements for Insurance Exchange-based plans tend to emphasize price and make competitive differentiation of our Health Care Benefits products and services based on other attributes more difficult. Price competition from existing and potentially new disruptive competitors in the industries in which each of our segments compete also continues to increase. Accordingly, we face competitive pricing pressures from existing and new competitors (including our vendors and others who may have lower cost structures than we do), and these pressures may reduce our operating margins or limit sales of our products and services. Our competitors may bring their consumer-oriented products and services to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our businesses. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of Private Exchanges or encourage their employees to purchase health insurance on the Public Exchanges. We can provide no assurance that we will be able to develop or operate successful or profitable consumer-oriented products and services, or that our Health Care Benefits segment will be able to compete successfully or profitably on Public Exchanges or Private Exchanges or benefit from any opportunities presented by Public Exchanges or Private Exchanges, or that we will be able to benefit from opportunities available to any of our segments in the industries in which we operate. If we do not develop and expand competitive and profitable consumer products, are not competitive in the industries in which we operate, or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely affected.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers often are short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the

agreement and may allow the supplier to distribute through channels other than the Company. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with health care providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow membership, and our ability to profitably grow our business and/or our results of operations may be adversely affected.

While we believe joint ventures, ACOs and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our results of operations and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint venture. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our results of operations and cash flows.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to litigation against us.

These risks are particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, where third parties perform PBM, medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, cash flows, results of operations and/or financial condition.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other health care providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and results of operations.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, on October 15, 2018, an arbitrator awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Risks Related to Our Operations

Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, home delivery pharmacy prescription delivery, specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customer and other service and performance. If we misjudge the effects of such measures, customer and other service may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitable growing our customer base and/or membership, which can adversely affect our results of operations. For example, noncompliance with any privacy or security laws or regulations or any security breach involving one of our third party vendors could have a material adverse effect on our businesses, results of operations, brand and reputation.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our results of operations.

Our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and results of operations.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to the Company or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We may also be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we

have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and, as such, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, financial condition and results of operations could be adversely affected.

We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced and continue to experience a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we and our vendors have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. Although the impact of such attacks has not been material to our operations or results of operations through December 31, 2018, we can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future. As we expand our consumer-oriented products and services, increase the amount and types of data we acquire, generate and use, increase the amount of information we make available to members, consumers and providers on mobile devices, expand our use of vendors, expand internationally and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access to and/or disruption of our systems and the customer, member, provider, employee, ACO, joint venture, vendor and other third party information they contain, increases, and the cost of attempting to protect against these risks also increases.

Although we deploy a layered approach to address information security (including cybersecurity) threats and vulnerabilities that is designed to protect confidential information against data security breaches, a compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, financial condition, and results of operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our members' and customers' sensitive information. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers' and members' private information and our customers and members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our businesses, brand, reputation, cash flows and results of operations.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, results of operations and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM

claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in United States and foreign privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

Our business success and results of operations depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, ExtraCare customer loyalty program, finance and other processes. Throughout our operations, we receive, retain and transmit certain confidential information, including PII and PHI, that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report results of operations; and interact with providers, employer plan sponsors, members and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented products and services we are developing, operating and expanding and/or to meet current and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our results of operations may be adversely affected.

Our business strategy involves providing customers with differentiated, easy to use, secure products and solutions that use information to meet customer needs. The types of technology and levels of service that are acceptable to customers and members today will not necessarily be acceptable in the future, requiring us to anticipate and meet marketplace demands for technology. Our success therefore is dependent in large part on our ability, within the context of a limited budget of human resources and capital and our existing and future business relationships, to timely secure, integrate, develop, redesign and enhance our (or contract with vendors to provide) technology systems that support our business strategy initiatives and processes in a compliant, secure, and cost and resource efficient manner. Integration of our acquisitions increases these challenges, and we may not be successful in integrating various systems in a timely or cost-effective manner.

Information technology projects frequently are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of customers, providers and members, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our results of operations may be adversely affected.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately

provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our Consumer Health Products and Services products and services and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:

- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;
- Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and
- Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.

Financial Risks

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2018, we had $115.2 billion of goodwill and other intangible assets. During the year ended December 31, 2018, we took $6.1 billion of goodwill impairment charges related to our LTC reporting unit. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our results of operations, which could have a material adverse effect on our financial condition and results of operations.

We would be adversely affected if we do not effectively deploy our capital . Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, cash flows, financial condition and results of operations.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by recognized rating organizations. Credit ratings issued by nationally-recognized organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of

our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. In connection with the completion of the Aetna Acquisition, each of Standard & Poor's, Moody's and Fitch downgraded certain of our debt, financial strength and/or other credit ratings. Downgrades in our ratings could adversely affect our businesses, cash flows, financial condition and results of operations.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our results of operations and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the United States. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the United States, and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the United States credit markets, and governments' monetary policy, particularly United States monetary policy, can significantly and adversely affect the value of our investment portfolio, our results of operations and/or our financial condition by:

- Significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our results of operations and/or unrealized capital losses that reduce our shareholders' equity;
- Keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and results of operations as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- Reducing the fair values of our investments if interest rates rise;
- Causing non-performance or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our results of operations; and
- Reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

Risks Relating to Our Acquisition of Aetna

We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.

We have limited experience operating an insurance and managed health care business, and are relying in large part on the existing management of Aetna to continue to manage our Health Care Benefits business. However, there is no assurance that we will be able to continue to retain the services of such management. If we fail to retain the existing management of Aetna, our ability to realize the anticipated benefits of the transaction may be adversely affected.

The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.

Although we currently project that the Aetna Acquisition will result in a number of benefits, including that it will be accretive to our earnings per share, changes in the estimates we use for these projections and the impact of future events and conditions, some of which we do not control, could cause actual results to be lower than these projections. In addition, future events and

conditions could decrease or delay the accretion that is currently projected or could result in dilution. These events and conditions include adverse changes in market conditions, changes in the regulatory environment, additional transaction and integration-related costs and other factors such as the failure to realize some or all of the anticipated benefits of the Aetna Acquisition. Any dilution of, decrease in or delay of any accretion to, our earnings per share could cause our stock price to decline or grow at a reduced rate.

We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.

The success of the Aetna Acquisition will depend, in part, on our ability to realize the anticipated benefits and cost savings from combining the businesses of CVS Health and Aetna. Our ability to realize these anticipated benefits and cost savings is subject to certain risks, including:

- Our ability to successfully combine the businesses of CVS Health and Aetna;
- whether the combined businesses will perform as expected;
- the possibility that we paid more for Aetna than the value we will derive from the acquisition;
- the reduction of our cash available for operations and other uses and the incurrence of indebtedness to finance the acquisition; and
- the assumption of known and unknown liabilities of Aetna.

If we are not able to successfully combine the businesses of CVS Health and Aetna within the anticipated time frame, the anticipated cost savings and other benefits of the Aetna Acquisition may not be realized fully or may take longer to realize than expected, the combined businesses may not perform as expected, and our stock price may be adversely affected.

Until the completion of the Aetna Acquisition, we and Aetna operated independently, and there can be no assurances that our respective businesses can be integrated successfully. It is possible that the integration process could result in the loss of key CVS Health or Aetna employees, the disruption of either company's or both companies' ongoing businesses or in unexpected integration issues, higher than expected integration costs and an overall post-completion integration process that takes longer than originally anticipated. Specifically, issues that must be addressed in integrating the operations of CVS Health and Aetna in order to realize the anticipated benefits of the Aetna Acquisition so the combined business performs as expected include, among other things:

- combining the companies' separate operational, financial, reporting and corporate functions;
- integrating the companies' technologies, products and services;
- identifying and eliminating redundant and underperforming operations and assets;
- harmonizing the companies' operating practices, employee development, compensation and benefit programs, internal controls and other policies, procedures and processes;
- addressing possible differences in business backgrounds, corporate cultures and management philosophies;
- consolidating the companies' corporate, administrative and information technology infrastructure;
- coordinating sales, distribution and marketing efforts;
- managing the movement of certain businesses and positions to different locations;
- maintaining existing agreements with customers, providers and vendors and avoiding delays in entering into new agreements with prospective customers, providers and vendors;
- operating in industry sectors in which we and our current management may have little or no experience;
- coordinating geographically dispersed organizations;
- consolidating offices of CVS Health and Aetna that are currently in or near the same location; and
- effecting the actions that are required by regulatory approvals we obtained in connection with completing the Aetna Acquisition.

In addition, at times, the attention of certain members of our management and our resources will be focused on the integration of the businesses of the two companies and diverted from day-to-day business operations, which may adversely affect our businesses.

Our future results may be adversely impacted if we do not effectively manage our expanded operations following completion of the Aetna Acquisition.

Following completion of the Aetna Acquisition our business is significantly larger than the size of either CVS Health's or Aetna's respective pre-transaction businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to implement an effective integration of the two companies and its ability to manage a combined business with significantly larger size and scope with the associated increased costs and complexity. There can be no assurances that the management of the combined company will be successful or that the combined company will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the Aetna Acquisition. If we are not able to fully realize the expected operating efficiencies, cost savings and other benefits anticipated from the Aetna Acquisition, or such benefits take longer to realize than expected, our combined businesses may not perform as expected and our stock price may be adversely affected.

We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.

Our future success will depend in part on our ability to retain key executives and other employees of Aetna. Uncertainty about the effect of the Aetna Acquisition on CVS Health and Aetna employees may have an adverse effect on the combined company and consequently the combined business. This uncertainty may impair our ability to attract, retain and motivate key personnel. Employee retention may be particularly challenging during the integration process, as employees of CVS Health and Aetna may experience uncertainty about their future roles in the combined business.

Furthermore, if key employees of CVS Health or Aetna depart or are at risk of departing, including because of issues relating to the uncertainty and difficulty of integration, financial security or a desire not to remain as employees of the combined business, we may have to incur significant costs in retaining such individuals or in identifying, hiring and retaining replacements for departing employees and may lose significant expertise and talent relating to the business of Aetna, and our ability to realize the anticipated benefits of the Aetna Acquisition may be materially and adversely affected. Accordingly, no assurance can be given that we will be able to attract or retain key employees of Aetna to the same extent that Aetna was able to attract or retain employees in the past.

The Aetna integration process could disrupt our ongoing businesses and/or operations.

Parties with which we do business may experience uncertainty associated with the Aetna Acquisition and/or the post-closing integration process, including with respect to current or future business relationships with the combined business. Our business relationships (including business relationships of our Health Care Benefits segment) may be subject to disruption as customers, members, manufacturers, providers, vendors and others may attempt to negotiate changes in existing business relationships or consider entering into business relationships with parties other than the combined business. These disruptions could have a material adverse effect on the businesses, financial condition, results of operations or prospects of one or more of the combined company's businesses, including a material adverse effect on our ability to realize the anticipated benefits of the Aetna Acquisition.

Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.

In order to complete the Aetna Acquisition, we incurred acquisition-related debt financing of approximately $45.0 billion and assumed Aetna's existing indebtedness with a fair value of approximately $8.1 billion. Our substantially increased indebtedness and higher debt-to-equity ratio following completion of the Aetna Acquisition in comparison to that of CVS Health prior to the Aetna Acquisition has the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increases our interest expense compared to pre Aetna Acquisition periods. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources are greater than the amount of cash flows required to service the indebtedness of CVS Health or Aetna individually prior to the Aetna Acquisition. The increased levels of indebtedness could also reduce funds available to fund our efforts to combine our business with Aetna and realize expected benefits of the Aetna Acquisition and/or engage in investments in product development, capital expenditures, dividend payments, share repurchases and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.

We expect to continue to incur significant non-recurring costs associated with combining the operations of CVS Health and Aetna. We expect to continue to incur significant integration-related costs related to formulating and implementing integration plans, including facilities and systems consolidation costs and employment-related costs. We continue to assess the magnitude of these costs, and additional unanticipated costs may be incurred in the integration of the two companies' businesses. We may not achieve the net benefit of such expenditures that we project associated with the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of our businesses in the near term, or at all. If we fail to realize the expected expense and other efficiencies we project, our results of operations, cash flows and stock price may be adversely affected.

Risks Related to Our Acquisitions, Joint Ventures and International Operations

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to integration risks, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- We frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- The acquired, alliance and/or joint venture businesses may not perform as projected;
- The goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become non-recoverable;
- We may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- The acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- We may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our shareholders;
- We may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- We may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;
- We may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, material disruptions to our businesses and operations and adversely affect our brand and reputation;
- In order to complete a proposed acquisition, we may be required to divest certain portions of our business;
- We may be involved in litigation related to mergers or acquisitions, including for matters which occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- The integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

We expect joint ventures to be an important part of our business model transformation and inorganic growth strategies. Joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the customers, and member and business disruption that may occur upon joint venture termination.

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company may also be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disruption of management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and results of operations. Furthermore, acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or geographic markets, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.

We significantly expanded our international operations as a result of the closing of the Aetna Acquisition in November 2018. As a result of our expanded international operations, we face political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, privacy, data storage, location, protection and security.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and management, financial and other resources over a number of years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our businesses, results of operations, financial condition, brand, reputation and/or long-term growth.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, results of operations and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Item 1B. Unresolved Staff Comments

There are no unresolved SEC Staff Comments.

Item 2. Properties

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. In addition, the Company leases corporate offices in Arizona, Illinois, Ohio, Pennsylvania, Texas, and Brazil.

Pharmacy Services Segment

As of December 31, 2018 , the Pharmacy Services segment had the following properties:

- An owned mail service dispensing pharmacy located in Texas;
- Leased mail order dispensing pharmacies located in Hawaii, Illinois and Pennsylvania;
- Leased call centers located in California, Missouri, Pennsylvania, Tennessee and Texas;
- Approximately 40 leased on-site pharmacy stores, approximately 25 leased retail specialty pharmacy stores, approximately 20 specialty mail order pharmacies and approximately 90 branches for infusion and enteral services.

Retail/LTC Segment

As of December 31, 2018 , the Retail/LTC segment had the following properties:

- Approximately 8,200 retail stores, of which approximately 4% were owned. Net selling space for retail stores was approximately 80.5 million square feet as of December 31, 2018 . Approximately 25% of the store base was opened or significantly remodeled within the last five years;
- Approximately 1,700 retail pharmacies and approximately 80 clinics in Target stores;
- Nine owned distribution centers located in eight states and 13 leased distribution facilities located in twelve additional states and Brazil. The 22 distribution centers totaled approximately 10.4 million square feet as of December 31, 2018 ; and
- Six owned LTC pharmacies, approximately 150 leased LTC pharmacies in 46 states and one owned LTC repackaging facility.

In connection with certain business dispositions completed between 1991 and 1997, the Company continues to guarantee lease obligations for approximately 85 former stores. The Company is indemnified for these guarantee obligations by the respective purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 "Commitments and Contingencies" contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex that is approximately 1.7 million square feet in size and is located in Hartford, Connecticut. The Health Care Benefits segment also owns or leases other space in the greater Hartford area, Maryland, Pennsylvania, and various field locations in the United States and several other countries.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by

alternative space. For additional information on the amount of rental obligations for the Company's leases, see Note 6 ''Leases'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Item 3. Legal Proceedings

I. Legal Proceedings

The information contained in Note 16 ''Commitments and Contingencies'' of the "Notes to Consolidated Financial Statements" in the Annual Report is incorporated by reference herein.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of environmental legal proceedings with a governmental authority if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with LTC pharmacies in the State of New York. These proceedings are not material to the Company's business or financial condition.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market information

The Company's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Holders of common stock

The information under the heading "Holders of Common Stock" in the Annual Report is incorporated by reference herein.

Dividends

The quarterly cash dividend declared by the Company's Board of Directors (the "Board") was $0.50 per share in 2018 and 2017.

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Issuer purchases of equity securities

The following share repurchase programs were authorized by the Board:

In billions		
Authorization Date	**Authorized**	**Remaining as of December 31, 2018**
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2018 the Company did not repurchase any shares of common stock.

See Note 12 ''Shareholders' Equity'' of the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein, for additional information regarding the Company's share repurchases.

Item 6. Selected Financial Data

The selected consolidated financial data of CVS Health Corporation as of and for the periods indicated in the five-year period ended December 31, 2018 , have been derived from the consolidated financial statements of CVS Health Corporation and is incorporated herein by reference to the information contained in the Annual Report under the heading "Five-Year Financial Summary." The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated by reference elsewhere in this Annual Report on Form 10-K.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The information contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Annual Report, which includes the "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section, is incorporated by reference herein.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

The information contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations — Quantitative and Qualitative Disclosures About Market Risk" in the Annual Report is incorporated by reference herein.

Item 8. Financial Statements and Supplementary Data

The information contained in "Consolidated Statements of Operations," "Consolidated Statements of Comprehensive Income (Loss)," "Consolidated Balance Sheets," "Consolidated Statements of Shareholders' Equity," "Consolidated Statements of Cash Flows," "Notes to Consolidated Financial Statements," and "Report of Independent Registered Public Accounting Firm" in the Annual Report, is incorporated by reference herein.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2018 , have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Internal control over financial reporting

The "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm" sections of the Annual Report are incorporated by reference herein. These sections contain management's report on the Company's internal control over financial reporting and the Independent Registered Public Accounting Firm's report with respect to the effectiveness the Company's internal control over financial reporting.

Changes in internal control over financial reporting

On November 28, 2018, the Company completed its acquisition of Aetna. In conducting its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018 , management has elected to exclude Aetna from that assessment, as permitted under SEC rules. The Company is in the process of integrating the historical internal control over financial reporting of Aetna with the rest of the Company. Aetna's operations are included in the Company's 2018 consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and represented 21% of the Company's consolidated total assets as of December 31, 2018 and 3% of the Company's consolidated total revenues for the year ended December 31, 2018.

Other than the foregoing, there has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2018 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

No events have occurred during the fourth quarter ended December 31, 2018 that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The sections of the Proxy Statement under the captions "Committees of the Board," "Code of Conduct," "Audit Committee Report," "Biographies of our Incumbent Board Nominees," and "Section 16(a) Beneficial Ownership Reporting Compliance" are incorporated by reference herein.

Executive Officers of the Registrant

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 28, 2019 . In each case the officer's term of office extends to the date of the board of directors meeting following the next annual meeting of stockholders of the Company. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Lisa G. Bisaccia , age 62, Executive Vice President of CVS Health Corporation since March 2016 and Chief Human Resources Officer of CVS Health Corporation since January 2010; Senior Vice President of CVS Health Corporation from January 2010 through February 2016; Vice President, Human Resources of CVS Pharmacy, Inc. from September 2004 through December 2009. Ms. Bisaccia is also a member of the board of directors of Aramark, a leading global provider of food, facilities and uniform services.

Eva C. Boratto , age 52, Executive Vice President and Chief Financial Officer of CVS Health Corporation since November 2018; Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from March 2017 through November 2018; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017; Senior Vice President of PBM Finance from July 2010 through June 2013.

Troyen A. Brennan, M.D ., age 64, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

James D. Clark , age 54, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Joshua M. Flum , age 49, Executive Vice President, Enterprise Strategy and Digital since November 2018; Executive Vice President, Corporate Strategy and Business Development of CVS Pharmacy, Inc. from June 2016 through October 2018; Executive Vice President - Pharmacy Services of CVS Pharmacy, Inc. from March 2015 through May 2016; Senior Vice President of Retail Pharmacy of CVS Pharmacy, Inc. from December 2010 through February 2015. Mr. Flum is a member of the board of directors of CreditRiskMonitor.com, Inc., a company that facilitates the analysis of corporate financial risk, mostly in the context of the extension of trade credit from one business to another.

Kevin P. Hourican , age 45, Executive Vice President of CVS Health Corporation and President of CVS Pharmacy since April 2018; Executive Vice President - Retail Pharmacy and Supply Chain of CVS Pharmacy, Inc. from June 2016 through March 2018; Senior Vice President, Field Operations and Supply Chain of CVS Pharmacy, Inc. from June 2014 through May 2016; Senior Vice President, Field Operations of CVS Pharmacy, Inc. from June 2012 through May 2014.

Alan M. Lotvin, M.D ., age 57, Executive Vice President - Transformation of CVS Health Corporation since June 2018; Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

Karen S. Lynch , age 56, Executive Vice President of CVS Health Corporation and President of Aetna since November 2018; President of Aetna from January 2015 to the present; Executive Vice President, Local and Regional Businesses of Aetna from February 2013 through December 2014; Executive Vice President, Head of Specialty Products of Aetna from July 2012 through January 2013. Ms. Lynch is a member of the board of directors of U.S. Bancorp, a banking and financial services company.

Larry J. Merlo , age 63, President and Chief Executive Officer of CVS Health Corporation since March 2011; President and Chief Operating Officer of CVS Health Corporation from May 2010 through March 2011; President of CVS Pharmacy from January 2007 through August 2011; Executive Vice President of CVS Health Corporation from January 2007 through May 2010; also a director of CVS Health Corporation since May 2010.

Thomas M. Moriarty , age 55, Executive Vice President and General Counsel of CVS Health Corporation since October 2012 and Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Derica W. Rice , age 54, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2018; Executive Vice President of Global Services and Chief Financial Officer of Eli Lilly & Co. from May 2006 through December 2017. Mr. Rice was formerly a director of Target Corporation from September 2007 until January 2018, and is a candidate for election to the board of directors of The Walt Disney Company in March 2019.

Jonathan C. Roberts , age 63, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017; Executive Vice President of CVS Health Corporation and Chief Operating Officer of CVS Caremark from October 2010 through August 2011.

Item 11. Executive Compensation

The sections of the Proxy Statement under the captions “Non-Employee Director Compensation” and “Executive Compensation and Related Matters,” including “Compensation Discussion and Analysis,” “Letter from the Management Planning and Development Committee,” “Compensation Committee Report” and “Executive Compensation Tables” are incorporated by reference herein.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The sections of the Proxy Statement under the captions “Share Ownership of Directors and Certain Executive Officers” and “Share Ownership of Principal Stockholders” are incorporated by reference herein. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the Company’s common stock that may be issued upon the exercise of options, warrants and rights under all of equity compensation plans as of December 31, 2018 .

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1][2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	27,102	$ 77.51	25,927
Equity compensation plans not approved by stockholders [4][5]	5,136	43.01	31,633
Total	32,238	$ 75.04	57,560

(1) Shares in thousands.
(2) Consists of: (i) 18,597 shares of common stock underlying outstanding options, (ii) 1,435 shares of common stock issuable upon the exercise of outstanding stock appreciation rights (“SARs”) and (iii) 12,206 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to

outstanding SARs is the number of shares of the Company's common stock that would have been issued had the SARs been exercised based on the closing price per share of the Company's common stock on December 31, 2018, as reported on the NYSE, which was $65.52.

(3) Consists of the CVS Health 2017 Incentive Compensation Plan.

(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan").

(5) Amount in column (c) consists of the maximum number of shares of the Company's common stock available for future issuance under the Aetna Stock Plan as of December 31, 2018.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Aetna Acquisition. The Aetna Stock Plan is designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan has not been submitted to the Company's stockholders and will expire on May 21, 2020.

Under the Aetna Stock Plan, eligible participants can be granted stock options to purchase shares of the Company's common stock, SARs, time vesting and/or performance vesting incentive stock or incentive units and other stock based awards. As of December 31, 2018, the maximum number of shares of the Company's common stock that may be issued under the awards outstanding under the Aetna Stock Plan was 5.1 million shares, subject to adjustment for corporate transactions and 31.6 million shares remained available for future awards. If an award under the Aetna Stock Plan is paid solely in cash, no shares are deducted from the number of shares available for issuance under the Aetna Stock Plan.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The sections of the Proxy Statement under the captions "Independence Determinations for Directors" and "Related Person Transaction Policy" are incorporated by reference herein.

Item 14. Principal Accounting Fees and Services

The section of the Proxy Statement under the caption "Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm" is incorporated by reference herein.

PART IV

Item 15. Exhibits, Financial Statement Schedules

The following documents are filed as part of this Annual Report on Form 10-K:

1. Financial Statements. The following financial statements, related notes and report are incorporated by reference from the Annual Report in Item 8 hereof:

Consolidated Statements of Operations for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Statements of Comprehensive Income (Loss) for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Balance Sheets as of December 31, 2018 and 2017

Consolidated Statements of Cash Flows for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Statements of Shareholders' Equity for the Years Ended December 31, 2018, 2017 and 2016

Notes to Consolidated Financial Statements

Report of Independent Registered Public Accounting Firm

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed May 21, 2015; Commission File No. 001-01011).
2.2	Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011).
2.3	Master Transaction Agreement by and between Aetna Inc. and Hartford Life and Accident Insurance Company dated as of October 22, 2017.
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).
3.2	By-laws of the Registrant, as amended and restated (incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996; Commission File No. 001-01011).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006; Commission File No. 001-01011).
4.3	Form of the Registrant's 2020 Floating Rate Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.4	Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).

4.5	Form of the Registrant's 2020 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.6	Form of the Registrant's 2021 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.7	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.8	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.9	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.10	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.11	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
10	**Material Contracts**
10.1	Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2015 (Commission File No. 001-01011).
10.2	Amendment No. 1 to Credit Agreement dated as of December 15, 2017, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.5 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01-011).
10.3	Amendment No. 2 to Credit Agreement dated as of May 17, 2018, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01-011).
10.4	Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.5	Amendment No. 1 to Five Year Credit Agreement dated as of December 15, 2017, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.6	Amendment No. 2 to Five Year Credit Agreement dated as of May 17, 2018, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.7	Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as administrative agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.8	Amendment No. 1 to Term Loan Agreement dated as of May 17, 2018, to the Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.9	364-Day Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.10	Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.11	Bridge Facility Commitment Letter dated December 3, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., and Merrill Lynch, Pierce Fenner & Smith Incorporated (incorporated by reference to Exhibit 2.2 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011).

10.12	Joinder to Bridge Facility Commitment Letter dated as of December 15, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and each of the Additional Commitment Parties party thereto (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.13	364-Day Bridge Term Loan Agreement, dated October 26, 2018, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed October 26, 2018; Commission File No. 001-010011).
10.14*	The Registrant's 1996 Directors Stock Plan, as amended and restated November 5, 2002 (incorporated by reference to Exhibit 10.18 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 28, 2002; Commission File No. 001-01011).
10.15*	Caremark Rx, Inc. 2004 Incentive Stock Plan (incorporated by reference to Exhibit 99.2 of the Registrant's Registration Statement No. 333-141481 on Form S-8 filed March 22, 2007; Commission File No. 011-01011).
10.16*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011).
10.17*	The Registrant's 1997 Incentive Compensation Plan, as amended through December 31, 2008 (incorporated by reference to Exhibit 10.8 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011).
10.18*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011).
10.19*	The Registrant's 2010 Incentive Compensation Plan, as amended through January 15, 2013 (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 27, 2015; Commission File No. 001-01011).
10.20*	The Registrant's Deferred Stock Compensation Plan, as amended (incorporated by reference to Exhibit 10.17 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.21*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 10.20 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.22*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.23*	The Registrant's Deferred Compensation Plan, as amended (incorporated by reference to Exhibit 10.19 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.24*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.25*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.26*	The Registrant's 2017 Incentive Compensation Plan (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 31, 2017; Commission File No. 001-01011).
10.27*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.28*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.29*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.30*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).

10.31*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.32*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.33*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.34*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011).
10.35*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011).
10.36*	The Registrant's 2018 Management Incentive Plan.
10.37*	The Registrant's Severance Plan for Non-Store Employees amended as of November 28, 2018.
10.38*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended.
10.39*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant.
10.40*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant.
10.41*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant.
10.42*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax).
10.43*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011).
10.44*	Amended Aetna Inc. 2010 Stock Incentive Plan, as amended May 19, 2017 (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed November 30, 2018; Commission File No. 001-01011).
10.45*	Form of Aetna Inc. 2010 Stock Incentive Plan - Market Stock Unit Terms of Award.
10.46*	Form of Aetna Inc. 2010 Stock Incentive Plan - Performance Stock Unit Terms of Award (2015).
10.47*	Form of Aetna Inc. 2010 Stock Incentive Plan - Executive Restricted Stock Unit Terms of Award (2015).
10.48*	Form of Aetna Inc. 2010 Stock Incentive Plan - Stock Appreciation Right Terms of Award (2015).
10.49*	Amended and Restated Employment Agreement dated as of December 21, 2012 between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.50*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.51*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.52*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015; Commission File No. 001-01011).
10.53*	Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010; Commission File No. 001-01011).
10.54*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.55*	Confidential Separation Agreement effective as of June 25, 2018, between the Registrant and David Denton (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2018; Commission File No. 001-01011).

10.56*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.57*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.58*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan C. Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.59*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan C. Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.60*	Change in Control Agreement dated December 22, 2008 between the Registrant and Helena Foulkes (incorporated by reference to Exhibit 10.43 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.61*	Amendment dated as of December 31, 2012 to the Change in Control Agreement between the Registrant and Helena Foulkes (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.62*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarity (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
10.63*	Restrictive Covenant Agreement dated June 1, 2014 between the Registrant and Thomas Moriarity (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
13	**Annual Report to security holders, Form 10-Q or quarterly report to security holders**
13.1	Portions of the 2018 Annual Report to Stockholders of CVS Health Corporation, which are specifically designated in this Annual Report on Form 10-K as being incorporated by reference.
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.
32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2018 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income, (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements.

Item 16. Form 10-K Summary

None.

SIGNATURES

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

CVS HEALTH CORPORATION

Date: February 28, 2019

By: /s/ EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

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

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 28, 2019
/s/ MARK T. BERTOLINI **Mark T. Bertolini**	Director	February 28, 2019
/s/ RICHARD M. BRACKEN **Richard M. Bracken**	Director	February 28, 2019
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 28, 2019
/s/ EVA C. BORATTO **Eva C. Boratto**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 28, 2019
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 28, 2019
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 28, 2019
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 28, 2019
/s/ DAVID W. DORMAN **David W. Dorman**	Chair of the Board and Director	February 28, 2019
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 28, 2019
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 28, 2019
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 28, 2019
/s/ LARRY J. MERLO **Larry J. Merlo**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 28, 2019
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 28, 2019
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 28, 2019
/s/ RICHARD J. SWIFT **Richard J. Swift**	Director	February 28, 2019
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 28, 2019
/s/ TONY L. WHITE **Tony L. White**	Director	February 28, 2019

Exhibit 2.3
EXECUTION AGREEMENT

MASTER TRANSACTION AGREEMENT

by and between

AETNA INC.

and

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Dated as of October 22, 2017

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Seller Disclosure Schedule

Purchaser Disclosure Schedule

EXHIBITS

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Exhibit B	Form of Reinsurance Agreement
Exhibit C	Form of Trust Agreement
Exhibit D	Form of Administrative Services Agreement
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Exhibit N	Form of Data Processing Side Letter

MASTER TRANSACTION AGREEMENT

This Master Transaction Agreement (this " Agreement"), dated as of October 22, 2017, is entered into by and between Aetna Inc., a Pennsylvania corporation (" Seller"), and Hartford Life and Accident Insurance Company, a Connecticut insurance company (" Purchaser").

WITNESSETH:

WHEREAS, Seller owns 100% of the issued and outstanding shares of capital stock of Aetna Life Insurance Company, an insurance company organized under the laws of the State of Connecticut (the " Ceding Company");

WHEREAS, Seller and its Affiliates (as hereinafter defined), including the Ceding Company and Aetna Health and Life Insurance Company, an insurance company organized under the laws of the State of Connecticut (" AHLIC"), are engaged, among other things, in the operation of the Business (as hereinafter defined) in the United States; and

WHEREAS, the parties hereto desire to enter into this Agreement pursuant to which, on the terms and subject to the conditions set forth herein, at the Closing (as hereinafter defined), among other things:

(a) the Ceding Company will enter into a commutation agreement with AHLIC substantially in the form attached hereto as Exhibit A (the " Commutation Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the Ceding Company will recapture the portion of the Business reinsured by AHLIC effective as of immediately prior to the effectiveness of the Reinsurance Agreement (as defined below) (the " Pre-Closing Commutation");

(b) the Ceding Company will enter into a reinsurance agreement with Purchaser substantially in the form attached hereto as Exhibit B (the " Reinsurance Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the Ceding Company shall cede to Purchaser, and Purchaser shall reinsure, all "Policy Liabilities" (as such term is defined in such attached form of the Reinsurance Agreement, the " Reinsured Liabilities"), on a 100% coinsurance basis;

(c) the Ceding Company and Purchaser will enter into a trust agreement with the Trustee (as hereinafter defined) substantially in the form attached hereto as Exhibit C (the " Trust Agreement "), pursuant to which, on the terms and subject to the conditions set forth therein, Purchaser will establish and maintain a trust account (the " Trust Account") with the Trustee for the benefit of the Ceding Company to secure Purchaser's obligations to the Ceding Company under the Reinsurance Agreement;

(d) the Ceding Company will enter into an administrative services agreement with Purchaser substantially in the form attached hereto as Exhibit D (the " Administrative Services Agreement "), pursuant to which, on the terms and subject to the conditions set forth therein, Purchaser will provide to the Ceding Company administrative services with respect to the Business reinsured under the Reinsurance Agreement;

(e) the Ceding Company and Purchaser will enter into a transition services agreement substantially in the form attached hereto as Exhibit E (the " Transition Services Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the Ceding Company will, or will cause its Affiliates or third party service providers to, perform certain transition services with respect to the Business for Purchaser or its designated Affiliates;

(f) Seller and Purchaser will enter into an intellectual property assignment and license agreement substantially in the form attached hereto as Exhibit F (the " Intellectual Property Agreement"), pursuant to which Seller and the Ceding Company will, on the terms and subject to the conditions set forth therein, transfer, assign and license the Transferred Intellectual Property to Purchaser, and Purchaser will license certain Transferred Intellectual Property back to Seller;

(g) the Ceding Company, Carefree Insurance Services, Inc., a company organized under the laws of Florida and a Subsidiary of Seller, Purchaser and one or more Affiliates of Purchaser will enter into a distribution agreement substantially in the form attached hereto as Exhibit G (the " Distribution Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the parties thereto will market and sell insurance policies to each other's customers and joint customers;

(h) subject to obtaining relevant third party consents, Purchaser and Seller or their applicable Affiliates will enter into a lease assignment agreement substantially in the form attached hereto as Exhibit J (the " Portland Location Assignment Agreement"), pursuant to which Purchaser or its applicable Affiliate(s) will accept assignment of the Assigned Lease on the terms and subject to the conditions set forth herein and therein;

(i) subject to obtaining relevant third party consents, Purchaser and Seller or their applicable Affiliates will enter into sublease agreements substantially in the form attached hereto as Exhibit K , pursuant to which Seller or its applicable Affiliate(s) will sublease certain real property to Purchaser or its applicable Affiliate(s), on the terms and subject to the conditions set forth herein and therein; and

(j) Seller and its applicable Affiliates will sell to Purchaser, and Purchaser will purchase from Seller and its Affiliates, the Transferred Assets (as hereinafter defined), and Seller and its applicable Affiliates will assign to Purchaser, and Purchaser will assume from Seller and its applicable Affiliates, the Assumed Liabilities and the Assigned Contracts (as hereinafter defined).

NOW, THEREFORE, in consideration of the representations, warranties, covenants and agreements set forth herein, the parties hereto hereby agree as follows:

ARTICLE I.

DEFINITIONS

Section 1.01. Definitions. For purposes of this Agreement, the following terms have the respective meanings set forth below:

"Accounting Date" has the meaning given to such term in Section 2.06.

"Accounting Value" means, with respect to any Investment Asset as of any date of determination, the sum of: (i) the Book Value of such Investment Asset as of the applicable date of determination; plus (ii) all accrued but unpaid interest on such Investment Asset through the applicable date of determination.

"Action" means any civil, criminal, administrative or other claim, action, suit, litigation, arbitration hearing, charge, complaint, demand, notice or other similar proceeding, in each case by or before any Governmental Authority or arbitral body.

"Actuarial Report" has the meaning given to such term in Section 3.21.

"Adjusted Required Asset Value" means, as of any applicable date of determination, an amount equal to (i) the Required Asset Value as of such date, plus (if positive) or minus (if negative) (ii) the sum of all Capital Gain or Loss Adjustments required with respect to the period from the Reference Date through the applicable date of determination, plus (if positive) or minus (if negative) (iii) the sum of all Reallocated Asset Value Adjustments required with respect to the period from the Reference Date through the applicable date of determination. The Capital Gain or Loss Adjustments and Reallocated Asset Value Adjustments required with respect to the period from the Reference Date to the date hereof are required to be set forth on Section 3.19(b) of the Seller Disclosure Schedule. All Capital Gain or Loss Adjustments and Reallocated Asset Value Adjustments required with respect to the period beginning on the date hereof and ending at the Closing will be determined in accordance with Section 5.11.

"Administrative Services Agreement" has the meaning given to such term in the Recitals.

"Affiliate" means, with respect to any Person at the time in question, any other Person controlling, controlled by or under common control with such Person. For purposes of the foregoing, "control," including the terms "controlling," "controlled by" and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. Notwithstanding anything to the contrary contained in this Agreement, none of the following nor any of their respective Subsidiaries shall be deemed to be an Affiliate of Seller or any of its Subsidiaries for purposes of this Agreement: (i) bswift LLC, a Delaware limited liability company, or Prodigy Health Group, Inc., a Delaware corporation; and (ii) (x) any joint venture, accountable care organization or similar arrangement for the establishment, management or operation of a provider collaboration, network or group in which Seller and its Affiliates collectively own 50% or less of the outstanding equity securities or

economic interest and (y) any other joint venture entity formed with health systems or health care providers to the extent such joint venture entity owns or operates a health plan.

"Agreement" has the meaning given to such term in the Preamble.

"AHLIC" has the meaning given to such term in the Recitals.

"Allocable Amount" has the meaning given to such term in Section 7.01.

"Applicable Law" means all laws, common law, rules, regulations, ordinances, codes, statutes, judgments, injunctions, Governmental Orders and decrees of all Governmental Authorities applicable to the Person, place and situation in question.

"ASO Contracts" means: (i) the contracts pursuant to which the Ceding Company provides to plan sponsors of self-funded groups administrative or related services for the management of disability benefits prior to the Effective Time; and (ii) the contracts pursuant to which the Ceding Company provides to employers administrative services or software for the management of leaves of absence by employees and related rights and benefits under Applicable Law (including the Family and Medical Leave Act of 1993, as amended, the Americans with Disabilities Act of 1990, as amended, and similar U.S. state and municipal laws, and including as a result of long-term or short-term disability) and internal policies and practices of such employers, in each case of (i) and (ii) in connection with the Business.

"Asset Consideration" has the meaning given to such term in Section 2.07(a)(ii).

"Assigned Contracts" means: (i) those contracts and other agreements to which Seller or an Affiliate of Seller is a party and which are listed on Schedule I; (ii) any renewals or replacement of those contracts and other agreements to which Seller or an Affiliate of Seller is a party that are listed on Schedule I , to the extent such agreements or divisible sub-agreements thereof are entered into prior to the Closing in the ordinary course of business and in accordance with this Agreement; (iii) any vendor contracts and other vendor agreements to which Seller or an Affiliate of Seller is a party, to the extent such agreements or divisible sub-agreements thereof relate primarily or exclusively to the Business and are entered into between the date hereof and the Closing, in the ordinary course of business and in accordance with this Agreement; and (iv) each Business Employee Benefit Plan.

"Assigned Lease" has the meaning given to such term in Section 2.01.

"Assumed Liabilities" has the meaning given to such term in Section 2.04.

"Bill of Sale and Assumption and Assignment Agreement" means a bill of sale and assumption and assignment agreement, substantially in the form attached hereto as Exhibit H , to be entered into by Seller and its applicable Affiliates, on the one hand, and Purchaser, on the other hand, at the Closing.

"Board Materials" has the meaning given to such term in the definition of "Books and Records."

"Books and Records" means all records (including computer generated, recorded or stored records) relating directly and primarily to the Business that are in the possession or control of Seller, or any of its Affiliates; provided , however , that "Books and Records" excludes (the following, collectively, the " Excluded Books and Records"): (1) Tax Returns, Tax records and all other data and information with respect to Taxes of Seller and its Affiliates (other than Tax records of individual insureds under Group Contracts); (2) files, records, data and information with respect to the employees of Seller or its Affiliates, any Employee or any Employee Benefit Plan (except data and information provided pursuant to this Agreement or the Employee Leasing Agreement, in either case, with respect to any Business Employee Benefit Plan and Employee, unless prohibited by Applicable Law); (3) any materials prepared for the boards of directors or similar governing bodies of Seller or any of its Affiliates (" Board Materials"); (4) any corporate minute books, stock records or similar corporate records of Seller or any of its Affiliates; (5) any materials that are legally privileged, it being understood that Seller shall use commercially reasonable efforts to obtain waivers or make other arrangements (including redacting information or entering into joint defense agreements) that would enable such item to be transferred to or shared with Purchaser without destroying such privilege; (6) any information the disclosure or transfer of which is prohibited or restricted by Applicable Law, including antitrust, Privacy and Data Security Laws or pursuant to a contract (it being understood that Seller shall identify the records that are prohibited or restricted to be disclosed or transferred under Applicable Law and the basis for such prohibition or restriction, and shall use commercially reasonable efforts to obtain waivers or make other arrangements (including redacting information) that would enable such item to be transferred to Purchaser without so contravening any such Applicable Law or obligation under contract) (7) any internal drafts, opinions, valuations, correspondence, documents or other materials produced by, or provided between or among, Seller, its Affiliates or their respective Representatives in connection with the sale of the Business (including the negotiation, evaluation and consummation of the transactions contemplated by this Agreement and the other Transaction Agreements) or the terms of engagement of Representatives with respect thereto; and (8) consolidated financial records (including general ledgers) of Seller or its Affiliates, consolidated regulatory filings made by Seller or its Affiliates and any related correspondence with Governmental Authorities, except to the extent the information contained therein specifically or separately identifies the Business and is not otherwise included in a Book and Record. For purposes of this definition, the term " primarily" means records that relate to the Business more than any other business area of Seller or any of its Affiliates.

"Book Value" means, with respect to any Investment Asset as of any date of determination, the statutory book value thereof determined in accordance with SAP; provided that, until the Closing has occurred, the statutory book value of any asset that is transferred from AHLIC to the Ceding Company in connection with the Pre-Closing Commutation will be its statutory book value prior to such transfer.

"Burdensome Condition" has the meaning given to such term in Section 5.06(c).

"Business" means: (i) the Ceding Company's business of issuing, underwriting, reinsuring, selling, entering into, distributing, marketing, delivering, pricing, servicing, canceling, terminating and administering, as applicable, Group Contracts in the United States; and (ii) prior to the Closing, AHLIC's business of reinsuring certain Group Insurance Contracts

from the Ceding Company; provided , however , that the Business does not include any insurance business or administrative services sold by (a) the Ceding Company's "Strategic Resource Company" business unit to (x) plan sponsors seeking coverage primarily for part-time, temporary, seasonal, interim, hourly or transient employees, or (y) plan sponsors seeking coverage to meet requirements under the Davis-Bacon Act of 1931, as amended, for governmental contractors; or (b) the Ceding Company's "International" business unit to (x) plan sponsors located in Canada to cover fewer than 750 employees and beneficiaries located in the U.S., (y) plan sponsors (whether located in the United States or outside the United States) where the number of employees and beneficiaries located in the United States is fewer than (A) 25% of the total number of employees and beneficiaries on cover, or (B) 100 lives.

"Business Day" means any day other than a Saturday, Sunday or a day on which banking institutions in New York, New York or Hartford, Connecticut are permitted or obligated by Applicable Law to be closed.

"Business Employee" means each employee of Seller or any of its Affiliates who, to the Knowledge of Seller, provides, as of the Reference Date, 60 percent or more of his or her services to the Business; whose names are set forth on Section 6.01(a)(ii) of the Seller Disclosure Schedule, as such section of the Seller Disclosure Schedule may be updated in accordance with Section 6.01(a). For the avoidance of doubt, such section of the Seller Disclosure Schedule shall include such employees who as of the date hereof are actively employed as well as such employees who are on (i) a leave of absence (including temporary leave for purposes of jury or military duty, maternity or paternity leave, leave under the Family Medical Leave Act of 1993, approved personal leave or disability or medical leave) or (ii) vacation or paid time off).

"Business Employee Benefit Plan" means each plan, program or agreement set forth on Section 3.10(b) of the Seller Disclosure Schedule.

"Capital Gain or Loss Adjustment" has the meaning given to such term in Section 5.11(b)(ii).

"Ceded Reinsurance Contracts" has the meaning given to such term in Section 3.16(a).

"Ceding Commission" has the meaning given to such term in Section 2.07(a)(i).

"Ceding Company" has the meaning given to such term in the Recitals.

"Closing" has the meaning given to such term in Section 2.06.

"Closing Date" has the meaning given to such term in Section 2.06.

"Closing Required Asset Value" means the Adjusted Required Asset Value as of the Accounting Date calculated after taking into account all Capital Gain or Loss Adjustments and all Reallocated Asset Value Adjustments required pursuant to Section 5.11 or Section 3.19(b) from the Reference Date through the Closing.

"Closing Statement" means, as of any date of determination, a statement as of such date prepared in the same format as the Reference Closing Statement (assuming, for this purpose, the Closing occurred, and that the Reinsurance Agreement became effective, as of the end of the day on such date) and in accordance with the Transaction Accounting Principles.

"COBRA" means Part 6 of Subtitle B of Title I of ERISA, Section 4980B of the Code and any similar state law.

"Code" means the Internal Revenue Code of 1986.

"Commutation Agreement" has the meaning given to such term in the Recitals.

"Competing Businesses" has the meaning given to such term in Section 5.13.

"Competing Person" has the meaning given to such term in Section 5.13(e).

"Condition Satisfaction" has the meaning given to such term in Section 2.06.

"Confidentiality Agreement" has the meaning given to such term in Section 5.04(a).

"Data Input Inaccuracies" means inaccuracies or omissions to the extent arising from (i) the inputting of factual data relating to the Group Contracts or (ii) the coding, compilation or aggregation of such factual data in connection with such inputting.

"Deductible" has the meaning given to such term in Section 10.03(a).

"Discretionary Turnover Allowance" has the meaning given to such term in Section 5.11(b)(i)(B).

"Distribution Agreement" has the meaning given to such term in the Recitals.

"Effective Time" means 12:00:01 a.m. on the first calendar day of the month in which the Closing occurs.

"Employee" means each employee of Seller or any of its Affiliates whose name is set forth on Section 6.01(a)(i) of the Seller Disclosure Schedule, as such section of the Seller Disclosure Schedule may be updated in accordance with Section 6.01(a). For the avoidance of doubt, such section of the Seller Disclosure Schedule shall include such employees who as of the Closing Date are actively employed as well as such employees who are (i) on a leave of absence (including temporary leave for purposes of jury or military duty, maternity or paternity leave, leave under the Family Medical Leave Act of 1993, approved personal leave or disability or medical leave), (ii) on a vacation or paid time off or (iii) hired by Seller or any of its Affiliates in accordance with the terms and conditions of the Employee Leasing Agreement.

"Employee Benefit Plan" means each written or unwritten plan, policy, program, agreement and arrangement, other than a Business Employee Benefit Plan, whether covering a single individual or a group of individuals, that is (a) an "employee benefit plan" within the

meaning of Section 3(3) of ERISA, (b) a stock bonus, stock purchase, stock option, restricted stock, stock appreciation right, incentive stock or similar equity-based plan or (c) any other employment, severance, deferred-compensation, retention, change in control, retirement, welfare benefit, bonus, incentive or fringe benefit plan, policy, program, agreement or arrangement, in each case, which is maintained, sponsored or contributed to by Seller or any of its Affiliates and in which any Employee participates or is eligible to participate or with respect to which Seller or any of its Affiliates has any liability with respect to any Employee.

"Employee Leasing Agreement" has the meaning given to such term in Section 2.08(a)(xv).

"Employee Lease Term" has the meaning given to such term in the Employee Leasing Agreement.

"Enforceability Exceptions" has the meaning given to such term in Section 3.02.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Estimated Asset Value Statement" has the meaning given to such term in Section 2.07(d)(iii).

"Estimated Closing Required Asset Value" has the meaning given to such term in Section 2.07(d)(i).

"Estimated Closing Statement" has the meaning given to such term in Section 2.07(c)(iii).

"Estimated Required Balance" has the meaning given to such term in Section 2.07(d)(iii).

"Excluded Assets" has the meaning given to such term in Section 2.02.

"Excluded Benefits Liabilities" means any Liabilities in respect of the Employee Benefit Plans and any other benefit plans, programs, policies, arrangement or agreements maintained or contributed to by, or with respect to which Seller or its Affiliates may have any liability, other than the Business Employee Benefit Plans or as set forth in Section 6.01(i).

"Excluded Books and Records" has the meaning given to such term in the definition of "Books and Records."

"Excluded Liabilities" has the meaning given to such term in Section 2.05.

"Excluded Taxes" has the meaning given to such term in Section 2.05(c).

"Fair Market Value" means: (i) in the case of cash and cash equivalents, the face amount thereof; (ii) in the case of securities listed on an exchange or in an over-the-counter market (other than securities that constitute cash equivalents as described in clause (i) above), the final bid price on such exchange or market (provided that such bid price includes all accrued and

unpaid interest on such security through the date of determination; otherwise the amount of such accrued and unpaid interest shall be added to such bid price); and (iii) in the case of any other asset, the fair market value or valuation thereof (including accrued but unpaid interest), as determined in accordance with GAAP; provided that (a) the Fair Market Value of any Investment Asset for which a price is available through Bloomberg's "BVAL" valuation service shall be the sum of (x) the 4:00 p.m. Eastern Time bid price set for that Investment Asset by such valuation service on the applicable date of determination plus (y) all accrued and unpaid interest on such asset through the applicable date of determination, and (b) the Fair Market Value of any Investment Asset for which a price is not available through Bloomberg's "BVAL" valuation service but is available through IDC's valuation service shall be the sum of (x) the 4:00 p.m. Eastern Time bid price set for that Investment Asset by IDC's valuation service on the applicable date of determination plus (y) all accrued and unpaid interest on such asset through the applicable date of determination. Notwithstanding the foregoing, the Fair Market Value of any Investment Asset that is sold by the Ceding Company or AHLIC to a third party during the Interim Period for a price that differs from the amount determined pursuant to the prior sentence shall be the gross proceeds received by the Ceding Company or AHLIC, as applicable, in such sale, including, for the avoidance of doubt, the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset.

"Final Allocation" has the meaning given to such term in Section 7.01.

"Final Asset Value Statement" has the meaning given to such term in Section 2.09(f).

"Final Closing Required Asset Value" has the meaning given to such term in Section 2.09(f).

"Final Closing Required Asset Value Statement" has the meaning given to such term in Section 2.09(f).

"Final Closing Statement" has the meaning given to such term in Section 2.09(f).

"FMV Ex-Accrued" means, with respect to any Investment Asset as of any date of determination, the Fair Market Value thereof as of such date, excluding the amount of all accrued but unpaid interest on such Investment Asset through such date; provided that, notwithstanding the foregoing, (a) the FMV Ex-Accrued of any Investment Asset for which a price is available through Bloomberg's "BVAL" valuation service shall be the 4:00 p.m. Eastern Time bid price set for that Investment Asset by such valuation service on the applicable date of determination, and (b) the FMV Ex-Accrued of any Investment Asset for which a price is not available through Bloomberg's "BVAL" valuation service but is available through IDC's valuation service shall be the 4:00 p.m. Eastern Time bid price set for that Investment Asset by IDC's valuation service on the applicable date of determination. Notwithstanding the foregoing, the FMV Ex-Accrued of any Investment Asset that is sold by the Ceding Company or AHLIC to a third party in the period from the Reference Date through the Closing Date for a price (excluding accrued but unpaid interest) that differs from the amount determined pursuant to the prior sentence shall be the gross proceeds received by the Ceding Company or AHLIC, as

applicable, in such sale, less the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset.

"GAAP" means generally accepted accounting principles in the United States.

"Governmental Approval" has the meaning given to such term in Section 3.05.

"Governmental Authority" means any governmental, legislative, judicial, administrative or regulatory authority, agency, commission, board, body, court, self-regulatory body or entity or any instrumentality thereof, including any Tax Authority, whether United States federal, state, local or non-U.S.

"Governmental Order" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"Group Contracts" means the Group Insurance Contracts and the ASO Contracts.

"Group Insurance Contracts" means (i) the contracts, policies, certificates, binders, slips, covers or other agreements of employer and employee paid (a) group life insurance, including group term life insurance, voluntary spouse and dependent term life insurance, group universal life insurance, supplemental life insurance and accidental death and dismemberment insurance, (b) group disability insurance, including long-term and short-term disability insurance and statutory disability insurance and New York Paid Family Leave, and (c) individual or group life insurance issued or established as a result of the exercise of any conversion or other portability option or feature under any of the contracts, policies, certificates, binders, slips, covers or other agreements described in clause (i)(a) above, (ii) all funding or premium deposit agreements used to fund the group long-term disability or group life insurance contracts described in clause (i) above, (iii) all reserve buy out agreements for disability insurance and life insurance and (iv) all retained asset accounts relating to the agreements described in clause (i) above, in each case of clause (i) through (iv) that are issued or assumed by the Ceding Company prior to the Effective Time in connection with the Business and including all supplements, riders, endorsements and ancillary agreements issued or written in connection therewith and extensions thereto.

"Hannover Consent" means the consent and waiver, dated as of October 11, 2017, by Hannover Life Reassurance Company of America of Section 13.1 of that certain Yearly Renewable Term Reinsurance Agreement by and between the Ceding Company and Hannover Life Reassurance Company of America, effective January 1, 2017.

"Hartford License Agreement" has the meaning given to such term in Section 2.08(a)(xiv).

"Hartford Fire" means Hartford Fire Insurance Company, an insurance company organized under the laws of the State of Connecticut.

"HCERA" has the meaning given to such term in Section 3.10(g).

"Health Plan" has the meaning given to such term in Section 3.10(g).

"IMR" means interest maintenance reserve, calculated in accordance with SAP.

"Indemnifiable Losses" has the meaning given to such term in Section 10.04(iii).

"Indemnitee" has the meaning given to such term in Section 10.04(i).

"Indemnitor" has the meaning given to such term in Section 10.04(ii).

"Indemnity Payment" has the meaning given to such term in Section 10.04(iv).

"Independent Accountant" has the meaning given to such term in Section 2.09(e).

"Initial Asset Value Statement" has the meaning given to such term in Section 2.09(a).

"Initial Closing Required Asset Value Statement" has the meaning give to such term in Section 2.09(a).

"Initial Closing Statement" has the meaning given to such term in Section 2.09(a).

"Insurance Regulator" means, with respect to any jurisdiction, the Governmental Authority charged with the supervision of insurance companies in such jurisdiction.

"Intellectual Property" means, in any and all jurisdictions, any: (i) Trademarks; (ii) copyrights, rights in copyrightable subject matter in published and unpublished works of authorship and database rights, (iii) registrations and applications to register or renew the registration of any of the foregoing, (iv) patents and patent applications, including all reissues, divisionals, renewals, extensions, provisionals, continuations and continuations-in-part thereof, (v) rights in Trade Secrets, and (vi) intellectual property rights embodied in Software.

"Investment Assets" means any interest in any bonds, notes, debentures, mortgage loans, real estate, instruments of indebtedness, stocks, joint venture or partnership interests, and all other equity interests, certificates issued by or interests in trusts, derivatives or other assets acquired or held for investment purposes, including without limitation, any assignment instruments relating thereto.

"Investment Guidelines" means the investment policies and guidelines applicable to the investment activities of the Ceding Company (in respect of the Business) as in effect as of the date hereof, a true and complete copy of which is set forth in Section 1.01(a) of the Seller Disclosure Schedule.

"Intellectual Property Agreement" has the meaning given to such term in the Recitals.

"IT Systems" means the hardware, Software, data, databases, data communication lines, network and telecommunications equipment, Internet-related information technology infrastructure, wide area network and other information technology equipment, owned, leased or licensed by Seller or any of its Affiliates and used in the Business.

"Knowledge" means, unless otherwise expressly provided herein, the actual knowledge, after reasonable inquiry of direct reports, of those individuals listed (a) with respect to Seller, on Section 1.01(b) of the Seller Disclosure Schedule, and (b) with respect to Purchaser, on Section 1.01(b) of the Purchaser Disclosure Schedule.

"Leases" has the meaning given to such term in Section 3.15.

"Lease Consents" has the meaning given to such term in Section 5.12(b).

"Leave Recipient" has the meaning given to such term in Section 6.01(b).

"Legal Hold" means any requirement to preserve documents and records in connection with any pending or reasonably contemplated litigation or arbitration (or other form of dispute resolution), nonparty subpoena, regulatory inquiry or investigation by a Governmental Authority or other legal process or proceedings (i) for which Seller provides notice to Purchaser or (ii) arising out of, relating to or in respect of any Indemnifiable Loss for which a Purchaser Indemnified Person seeks indemnification pursuant to Article X. For purposes of this definition, the term "documents" is defined as synonymous with the term "documents or electronically stored information" in Federal Rule of Civil Procedure 34(a)(1)(A).

"Liabilities" means, with respect to any Person, any liability or obligation of such Person of any kind, character or description, whether known or unknown, absolute or contingent, accrued or unaccrued, disputed or undisputed, liquidated or unliquidated, secured or unsecured, joint or several, due or to become due, vested or unvested, executory, determined, determinable or otherwise.

"Lien" means any pledge, security interest, mortgage, lien, attachment, right of first refusal, or option, including any restriction on receipt of income or exercise of any other attribute of ownership, except such restrictions as may be contained in any Applicable Law relating to insurance.

"Listed Sales Employee" has the meaning given to such term in Section 6.01(c).

"Material Adverse Effect" means a material adverse effect on (A) the financial condition, business, assets (when compared to liabilities) or results of operations of the Business, but excluding any such effect to the extent resulting from or arising out of: (i) changes occurring after the date of this Agreement in general political, economic or securities, currency, capital, credit or financial market conditions (including changes in interest rates and changes in equity prices in general); (ii) any occurrence or condition generally affecting participants in any jurisdiction or geographic area in any segment of the industries or markets in which the Business is operated; (iii) any change or proposed change in GAAP, SAP or Applicable Law, or the interpretation or enforcement thereof; (iv) natural or man-made catastrophe events, hostilities, acts of war or terrorism, or any escalation or worsening thereof; (v) any pandemic or similar outbreak; (vi) the negotiation, execution and delivery of, or compliance with the terms of, or the taking of any action required by, this Agreement or the other Transaction Agreements, the failure to take any action prohibited by this Agreement or the other Transaction Agreements, or the public announcement of, or consummation of, any of the transactions contemplated hereby or thereby (including the effect thereof on the relationships (contractual or otherwise) of the Ceding

Company and its Affiliates with policyholders, clients, customers, employees, suppliers, vendors, service providers, members or Governmental Authorities); (vii) the identity of or facts related to Purchaser or its Affiliates or the effect of any action taken by Purchaser or its Affiliates, or taken by Seller or any of its Affiliates at the request of Purchaser or with Purchaser's prior consent (including the effect thereof on the relationships (contractual or otherwise) of the Ceding Company and its Affiliates with policyholders, clients, customers, employees, suppliers, vendors, service providers, members or Governmental Authorities); (viii) any downgrade or threatened downgrade in the rating assigned to Seller or any of its Affiliates by any rating agency (provided , that this clause (viii) shall not by itself exclude the underlying cause of any such downgrade or threatened downgrade); (ix) the fair market value of, or any change or development in the fair market value of, any of the Investment Assets of the Ceding Company or any of the Investment Assets that are to be transferred to Purchaser or the Trust Account pursuant to the terms of any Transaction Agreement; or (x) any failure of the Business to meet any financial projections or targets (provided , that this clause (x) shall not by itself exclude the underlying causes of any such failure); except, in the cases of clauses (i) through (iii), to the extent such effect disproportionately affects the Business relative to other Persons engaged in businesses similar to the Business; or (B) the ability of Seller or any of its Affiliates to perform any of their respective material obligations under this Agreement or any of the other Transaction Agreements or to consummate the material transactions contemplated by this Agreement and the other Transaction Agreements (including the ability to consummate the Closing prior to the Outside Date).

"Material Contract" has the meaning given to such term in Section 3.06(a).

"Milliman" has the meaning given to such term in Section 3.21.

"Monthly Asset Value Statement" has the meaning given to such term in Section 5.11(a)(i).

"Munich Consent" means the consent and waiver, dated as of October 21, 2017, by Munich American Reassurance Company of Section 17.4 of that certain Yearly Renewal Term Reinsurance Agreement by and between the Ceding Company and Munich American Reassurance Company, effective January 1, 2017.

"New Award" has the meaning given to such term in Section 6.01(m).

"Non-Assignable Asset" has the meaning given to such term in Section 2.03.

"Non-Assigned Leases" has the meaning given to such term in Section 3.15.

"Non-Occupied Properties" has the meaning given to such term in Section 5.12(a).

"Notice of Disagreement" has the meaning given to such term in Section 2.09(c).

"Occupied Properties" has the meaning given to such term in Section 5.12(a).

"Omaha Sublease" has the meaning given to such term in Section 2.08(a)(xiii).

"One Common Solution" means the comprehensive vendor integration Software platform for the Business.

"Open Source Software" means all Software that is distributed as "free software," "open source software," or under a similar licensing or distribution model, including the GNU General Public License, GNU Lesser General Public License, Mozilla Public License, BSD Licenses, the Artistic License, the Netscape Public License, the Sun Community Source License, the Sun Industry Standards License, the Apache License, and any license identified as an open source license by the Open Source Initiative (www.opensource.org).

"Operating Permits" has the meaning given to such term in Section 3.11.

"Outside Date" has the meaning given to such term in Section 9.01(b).

"PPACA" has the meaning given to such term in Section 3.10(g).

"Permit" means any license, permit, order, approval, consent, registration, membership, authorization or qualification under any Applicable Law or with any Governmental Authority or under any industry or non-governmental self-regulatory organization.

"Permitted Liens" means: (a) materialmen's, mechanics', construction, carriers', workmen's and repairmen's liens and other similar liens arising in the ordinary course of business; (b) Liens for Taxes, assessments and governmental charges or levies which are not yet due or delinquent, which are being contested in good faith and for which appropriate reserves are maintained in accordance with GAAP or SAP, as applicable; (c) easements, rights-of-way, encroachments, restrictions, conditions and other similar Liens which, individually or in the aggregate, do not materially impair the use or value of the applicable real property or materially interfere with the ordinary conduct of the Business; (d) statutory landlords' liens and liens granted to landlords under any lease; (e) Liens contemplated by this Agreement or any Transaction Agreement, and any custodian or similar liens contemplated or permitted thereunder; (f) in the case of the Assigned Lease, Liens affecting the interest of the lessor; (g) licenses of Intellectual Property made in the ordinary course of business (excluding any source code escrow agreements or any other agreement requiring the deposit of source code or related materials for any such Developed Software); (h) Liens incurred or pledges or deposits made in compliance with workers' compensation, unemployment insurance or other social security laws or regulations; and (i) any other Liens that do not materially impair the value of or interfere with or prohibit the current use or operation of the relevant asset in the Business.

"Person" means any individual, corporation, partnership, firm, joint venture, association, limited liability company, limited liability partnership, joint-stock company, trust, unincorporated organization, governmental, judicial or regulatory body, business unit, division or other entity.

"Personal Data" has the same meaning as the term "personal data," "personal information," or the equivalent under the applicable Privacy and Data Security Law.

"Plantation Sublease" has the meaning given to such term in Section 2.08(a)(xi).

"Portland Location" has the meaning given to such term in Section 3.15.

"Portland Location Assignment Agreement" has the meaning given to such term in the Recitals.

"Pre-Closing Commutation" has the meaning given to such term in the Recitals.

"Pre-Closing Investment Guidelines" means the investment policies and guidelines applicable to the investment activities of the Ceding Company and AHLIC with respect to the Specified Portfolio as set forth on Schedule IV.

"Pre-Closing Period" means a Tax period (or portion thereof) that ends on or before the Closing Date

"Primary Contract" has the meaning given to such term in Section 3.06(vi).

"Privacy and Data Security Law" means any Applicable Laws relating to data privacy, data security, cybersecurity, or data protection, including with respect to the collection, storage, transmission, transfer (including cross-border transfers), processing, breach notification, unauthorized access, encryption, security, safeguarding, loss, disclosure and use of Personal Data.

"Producer" means any producer, broker, agent, general agent, managing general agent, master broker agency, broker general agency, financial specialist or other Person responsible for marketing or producing Group Insurance Contracts prior to the Closing Date.

"Pro Forma Financial Statements" has the meaning given to such term in Section 3.18(b).

"Properties" has the meaning given to such term in Section 5.12.

"Purchase Price" has the meaning given to such term in Section 2.07(a).

"Purchaser" has the meaning given to such term in the Preamble.

"Purchaser 401(k) Plan" has the meaning given to such term in Section 6.01(f).

"Purchaser Disclosure Schedule" has the meaning given to such term in Article IV.

"Purchaser FSA" has the meaning given to such term in Section 6.01(k).

"Purchaser Indemnified Persons" has the meaning given to such term in Section 10.02(a).

"Purchaser Material Adverse Effect" means a material adverse effect on the ability of Purchaser or any of its Affiliates to perform its respective obligations under this Agreement or any Transaction Agreement or to consummate the material transactions contemplated by this Agreement or any of the other Transaction Agreements. For the avoidance

of doubt and without limiting the foregoing, "Purchaser Material Adverse Effect" includes a material impairment on the ability of Purchaser to obtain any Governmental Approval required to be obtained by Purchaser in connection with the consummation of the transactions contemplated by the Transaction Agreements, notwithstanding the compliance by Purchaser with the terms of this Agreement (including Section 5.06).

"Purchaser Permits" has the meaning given to such term in Section 4.08(a).

"Purchaser Specified Representations" means the representations and warranties made in Section 4.01 , Section 4.02 , Section 4.07(a) and Section 4.09.

"Reallocated Asset Value Adjustment" has the meaning given to such term in Section 5.11(c).

"Reallocated Investment Asset" means any Investment Asset or portion thereof that is designated for inclusion in the Specified Portfolio during the period from the Reference Date through the Closing Date pursuant to terms of Section 5.11 or Section 3.19(b) and was, immediately prior to such designation, held by the Ceding Company or AHLIC but not allocated to the Specified Portfolio.

"Reference Closing Statement" means the pro forma balance sheet of the Business as of the Reference Date set forth, for illustrative purposes, in Section 2.07(c)(i) of the Seller Disclosure Schedule (assuming, for this purpose, the Closing occurred, and that the Reinsurance Agreement became effective, as of the Reference Date).

"Reference Date" means June 30, 2017.

"Registered" means issued by, registered or filed with, renewed by or the subject of a pending application before, any Governmental Authority, social media service provider or Internet domain name registrar.

"Reinsurance Agreement" has the meaning given to such term in the Recitals.

"Reinsured Liabilities" has the meaning given to such term in the Recitals.

"Representative" means, with respect to any Person, such Person's Affiliates and the officers, directors, employees, agents, investment bankers, attorneys, financial advisers, accountants, actuaries or other representatives of such Person or any of its Affiliates.

"Required Asset Value" means, as of any date of determination, the amount that would be required to be set forth on the line item labeled "Investments, cash, cash equivalents & accrued inv. Income" in the column labeled "Target Unit Items to be transferred" on a Closing Statement prepared as of such date. For the avoidance of doubt, "Required Asset Value" shall not include any assets required to support any new interest maintenance reserve that will be required to be established upon the transfer of Investment Assets from AHLIC to the Ceding Company in connection with the Pre-Closing Commutation.

"Restricted Entities" has the meaning given to such term in Section 5.13.

"Restricted Period" has the meaning given to such term in Section 5.13.

"Retained Books and Records" has the meaning given to such term in Section 5.05(a).

"Review Period" has the meaning given to such term in Section 2.09(b).

"SAP" means, as to any regulated insurance company, the statutory accounting practices prescribed or permitted by the Governmental Authority responsible for the regulation of insurance companies in the jurisdiction in which such company is domiciled.

"Section 409A" has the meaning given to such term in Section 3.10(e).

"Selection Waterfall" has the meaning given to such term in Section 5.11(a)(iii).

"Seller" has the meaning given to such term in the Preamble.

"Seller 401(k) Plan" has the meaning given to such term in Section 6.01(g).

"Seller Confidentiality Agreement" has the meaning given to such term in Section 5.04(d).

"Seller Disclosure Schedule" has the meaning given to such term in Article III.

"Seller Forfeited Equity Award" has the meaning given to such term in Section 6.01(m).

"Seller FSA" has the meaning given to such term in Section 6.01(k).

"Seller Indemnified Persons" has the meaning given to such term in Section 10.02(b).

"Seller Retention Bonus Liabilities" has the meaning given to such term in Section 6.01(q).

"Seller Specified Representations" means the representations and warranties made in Section 3.01 , Section 3.02 and Section 3.20.

"Seller Trademarks" has the meaning given to such term in Section 5.10(b).

"Shared Service Functions and Assets" means the shared service functions and assets listed on Section 1.01(c) of the Seller Disclosure Schedule.

"Software" means all computer software, including but not limited to application software, system software, firmware, middleware, mobile digital applications, assemblers, applets, compilers and binary libraries, including all source code and object code versions of any and all of the foregoing, in any and all forms and media, and all related documentation.

"South Portland Sublease" has the meaning given to such term in Section 2.08(a)(xii).

"Specified Portfolio" has the meaning given to such term in Section 2.07(c)(ii).

"Statutory Statements" has the meaning given to such term in Section 3.18(a).

"Straddle Period" means a Tax period that begins on or before the Closing Date and ends after the Closing Date, provided that in the case of any Straddle Period, Taxes allocable to the Pre-Closing Period shall equal: (i) in the case of Taxes imposed on a periodic basis (such as real or personal property Taxes), the product of the amount of such Taxes for the Straddle Period and a fraction, the numerator of which is the number of calendar days in the Straddle Period that elapsed through the date hereof and the denominator of which is the number of calendar days in the entire Straddle Period, and (ii) in the case of Taxes not described in clause (i), the amount computed as if such taxable period ended as of the close of business on the date hereof.

"Subleases" means the South Portland Sublease, the Plantation Sublease and the Omaha Sublease.

"Subsidiary" of any Person at the time in question means another Person (other than a joint venture formed with health care providers) more than 50% of the total combined voting power of all classes of capital stock or other voting interests of which, or more than 50% of the equity securities of which, is at such time owned directly or indirectly by such first Person.

"Tax" or " Taxes" means any and all federal, state, provincial, foreign or local income, gross receipts, premium, capital stock, franchise, profits, withholding, social security, Medicare, unemployment, disability, real property, ad valorem/personal property, stamp, goods and services, harmonized sales, excise, occupation, sales, use, transfer, value added, alternative minimum, estimated or other tax, fee, duty, levy, custom, tariff, impost, assessment or charge of the same or of a similar nature to any of the foregoing, including any interest, penalty or addition thereto.

"Tax Authority" means, with respect to any Tax, any government or political subdivision thereof that imposes such Tax, and any agency charged with the collection, assessment, determination or administration of such Tax for such government or subdivision.

"Tax Contest" has the meaning given to such term in Section 7.03.

"Tax Return" means any return, report, declaration, claim for refund or other return or statement, including any schedule or attachment thereto, and any amendment thereof, required to be filed or furnished in connection with the determination, assessment or collection of any Tax.

"Third Party Claim" has the meaning given to such term in Section 10.04(v).

"Threshold Amount" has the meaning given to such term in Section 10.03(a).

"Trademark License Agreement" has the meaning given to such term in Section 5.10(a).

"Trademarks" means trademarks, service marks, Internet domain names, trade dress, trade names, logos, slogans, social media identifiers, handles and tags, and any other indicia of origin, registrations and applications with respect to the foregoing, and the goodwill associated therewith and symbolized thereby.

"Trade Secrets" means all confidential information deriving economic value from not being generally known or readily ascertainable, and that is the subject of reasonable efforts to maintain confidentiality, including, as applicable, inventions, processes, designs, formulae, models, tools, algorithms, Software architectures, trade secrets, know-how, ideas, research and development, data and databases and confidential information.

"Transaction Accounting Principles" means the methodologies, procedures, judgments, practices, principles and estimates used to compute and prepare the Reference Closing Statement and described in Schedule V.

"Transaction Agreements" means this Agreement, the Reinsurance Agreement, the Trust Agreement, the Administrative Services Agreement, the Transition Services Agreement, the Bill of Sale and Assignment and Assumption Agreement, the Intellectual Property Agreement, the Distribution Agreement, the Trademark License Agreement, the Commutation Agreement, the Portland Location Assignment Agreement, the Plantation Sublease, the South Portland Sublease, the Omaha Sublease, the Employee Leasing Agreement and the Data Processing Side Letter.

"Transfer Date" has the meaning given to such term in Section 6.01(c).

"Transfer Offers" has the meaning given to such term in Section 6.01(a).

"Transfer Taxes" has the meaning given to such term in Section 7.02.

"Transferred Assets" has the meaning given to such term in Section 2.01.

"Transferred Employee" has the meaning given to such term in Section 6.01(c).

"Transferred Intellectual Property" has the meaning given to such term in Section 2.01.

"Transferred Portfolio" has the meaning give to such term in Section 2.07(d)(ii).

"Transition Services Agreement" has the meaning given to such term in the Recitals.

"Triggering Event" has the meaning given to such term in the form of the Reinsurance Agreement attached hereto as Exhibit B.

"True-Up Amount" means an amount (which may be positive or negative) equal to (i) the final Accounting Value of the Transferred Portfolio as set forth in the Final Asset Value Statement minus (ii) the Final Closing Required Asset Value.

"Trust Account" has the meaning given to such term in the Recitals.

"Trust Agreement" has the meaning given to such term in the Recitals.

"Trustee" means a U.S. bank or other financial institution or another Person mutually agreed upon by Seller and Purchaser.

"WARN Act" has the meaning given to such term in Section 6.01(e).

"Workability" means the integrated leave, disability and premium life waiver administration Software platform for the Business that includes One Common Solution, as well as the following functionality: (a) absence management, (b) web portal, (c) mobile and claims payment systems, (d) tax reporting, and (e) data analytics.

ARTICLE II.

TRANSFER AND ACQUISITION OF ASSETS

Section 2.01. Purchase and Sale of the Transferred Assets. Upon the terms and subject to the conditions set forth in this Agreement, at the Closing (except with respect to the Business Employee Benefit Plans and the Assigned Lease (subject to the terms of Section 2.08(d)), at the date of termination of the Employee Lease Term), Seller shall, and shall cause its Affiliates to, sell, convey, assign, transfer and deliver to Purchaser, free and clear of all Liens other than Permitted Liens, and Purchaser shall purchase, acquire, assume and accept from Seller and its Affiliates, pursuant to agreements, notifications, or other instruments in such form, reasonably satisfactory to Purchaser, all of Seller's and each such Affiliate's right, title and interest in and to the following assets, properties, rights and contracts (other than the Excluded Assets and excluding, for the avoidance of doubt, any cash or Investment Assets that are transferred to Purchaser or to the Trust Account in connection with the transactions contemplated by the Reinsurance Agreement or pursuant to the terms of Sections 2.07 , 2.09 and 2.10), in each case that exist as of the Closing Date (such assets, properties, rights and contracts to be purchased, acquired, assumed and accepted by Purchaser being referred to herein as the " Transferred Assets"):

(a) the Assigned Contracts;

(b) (i) the Intellectual Property (other than intellectual property rights embodied in Software, and the Trademarks and domain names licensed to Purchaser pursuant to the Trademark License Agreement) owned by Seller or any of its Affiliates and primarily used in the Business, including the Intellectual Property listed on Schedule II(b);

(ii) Workability, including the Intellectual Property embodied therein, other than Software that is generally commercially available and set forth on Section 2.01(b)(ii) of the Seller Disclosure Schedule; and

(iii) all other Software that is necessary to operate Workability, in each case other than (A) Software that is generally commercially available, (B) Open Source Software, and (C) the Seller Software licensed to Purchaser pursuant to the Intellectual Property Agreement ((i), (ii) and (iii) collectively, the " Transferred Intellectual Property");

(c) all furniture, fixtures, equipment (including computer hardware), supplies and other tangible personal property of the Business, in each case to the extent listed on Schedule II(c);

(d) the Books and Records, the transfer of which shall be subject to Section 5.05;

(e) all advertising, marketing, sales and promotional materials relating directly and primarily to the Business;

(f) all rights and claims under any and all warranties extended by suppliers, vendors, contractors, manufacturers and licensors to the extent in relation to any of the Transferred Intellectual Property and hardware assets included in the Transferred Assets;

(g) subject to the terms of Section 2.08(d) , the real estate lease listed on Schedule II(g) (the " Assigned Lease") and all installations, fixtures, improvements and benefits in connection therewith;

(h) the phone numbers listed on Schedule II(h); and

(i) all other assets of the Business listed on Schedule II(i).

Section 2.02. Excluded Assets. Notwithstanding anything contained in this Agreement (including Section 2.01) to the contrary and except to the extent of rights expressly provided in certain Transaction Agreements, neither Seller nor any of its Affiliates is selling, transferring, conveying or delivering (or causing to be sold, transferred, conveyed or delivered), and Purchaser is not purchasing, assuming or accepting any assets, properties, rights and contracts of Seller or any of its Affiliates, or any interests therein, other than the Transferred Assets (all such assets, properties, rights and contracts of Seller or any of its Affiliates, or any interests therein, other than the Transferred Assets being referred to herein as the " Excluded Assets"). Without limiting the generality of the foregoing, all of the following shall constitute Excluded Assets:

(a) all cash and cash equivalents, including checking accounts, bank accounts, certificates of deposit and securities, of Seller or any of its Affiliates;

(b) all intercompany receivables and other amounts due from Seller or its Affiliates;

(c) all contracts to which Seller or any Affiliate thereof is a party or is otherwise bound other than the Assigned Contracts;

(d) any real estate leases, real estate title, or any installations, fixtures, and other improvements at Seller's or any of its Affiliates' leased real estate, whether or not used for the benefit of the Business, in each case other than the Assigned Lease or as contemplated by Section 2.01(g) ;

(e) all furniture, fixtures, equipment (including computer hardware), machinery and other tangible personal property of Seller or any of its Affiliates that are not listed on Schedule II(c);

(f) all Permits of Seller or its Affiliates;

(g) Seller's or any of its Affiliates' rights under any policies of insurance or any benefits, proceeds, or premium refunds payable or paid thereunder or with respect thereto;

(h) all rights of Seller or any of its Affiliates to file for or receive any refunds, credits or similar benefits for Taxes levied and imposed upon, or in connection with, the Transferred Assets or the conduct or operation of the Business allocable to any Pre-Closing Period or to the portion of the Straddle Period ending on the Closing Date;

(i) the Excluded Books and Records;

(j) all rights of Seller or any of its Affiliates under the Transaction Agreements;

(k) all rights of Seller or any of its Affiliates to indemnification from any Person with respect to any of the Excluded Liabilities;

(l) all prepaid Taxes allocable to taxable periods or portions thereof ending on or before the Closing Date;

(m) all Intellectual Property owned by Seller or any of its Affiliates (including all rights in and to the Seller Trademarks), other than the Transferred Intellectual Property;

(n) all Intellectual Property licensed to Seller or any of its Affiliates, other than Intellectual Property licensed pursuant to an Assigned Contract;

(o) all of Seller's or any of its Affiliates' e-mail addresses, URLs, websites, website content, and telephone numbers, other than as contemplated by Section 2.01(h);

(p) all bank accounts and lockboxes used in the Business;

(q) all assets in respect of any Employee Benefit Plan;

(r) any assets arising out of, and any associated claims arising out of, the Excluded Liabilities;

(s) any legal or beneficial interest in the capital stock and other equity interests of Seller or its Affiliates;

(t) the accounts and notes receivable not included in the Transferred Assets;

(u) any assets transferred or otherwise disposed of by Seller or any of its Affiliates (other than any intercompany transfers or sales) in compliance with Section 5.01(a) prior to the Closing;

(v) all accounting systems owned or used by Seller or any of its Affiliates, whether or not used in connection with the operation of the Business, including those that comprise the Shared Service Functions and Assets;

(w) any assets utilized by Seller or any of its Affiliates in connection with businesses other than the Business, including those that comprise the Shared Service Functions and Assets; and

(x) the Shared Service Functions and Assets.

Section 2.03. Procedures for Assets Not Transferrable.

(a) Notwithstanding anything to the contrary contained in this Agreement, if any asset, property, right or contract intended to be included in the Transferred Assets (other than with respect to the Assigned Lease, which is addressed in Section 5.12) is not assignable, transferable or able to be subleased or licensed (as applicable) (each a " Non-Assignable Asset") to Purchaser without the consent or waiver of any Person (other than Seller, Purchaser or any of their respective Affiliates or Governmental Authority), and such consent or waiver has not been obtained on or prior to the Closing Date, this Agreement and the other Transaction Agreements shall not constitute an assignment, transfer, sublease or license (as applicable) thereof unless and until such consent is obtained; provided , that this Section 2.03(a) shall not affect whether any such asset, property, right or contract will be deemed a "Transferred Asset" or "Assigned Contract" under this Agreement. In each such case, Seller shall, and shall cause its Affiliates to, use commercially reasonable efforts to obtain, prior to the Closing, any consent or waiver from any third party (other than a Governmental Authority) that is required for Seller or its applicable Affiliates to sell, transfer, assign, convey and deliver the Transferred Assets and Assigned Contracts to Purchaser or to provide the services to be provided under the Transition Services Agreement. Purchaser shall, and shall cause each of its Affiliates to, cooperate with Seller and its Affiliates at Seller's request to assist Seller and its Affiliates in obtaining such consents or waivers. Each of Seller and Purchaser shall bear its own and its Affiliates' internal costs to obtain such consents and waivers, and the costs payable to third parties for obtaining such consents and waivers (which, for the avoidance of doubt, shall not include any increased fees under the terms of any Assigned Contract from and after the Closing) shall be borne equally by Seller and Purchaser.

(b) If any such consent or waiver referred to in Section 2.03(a) cannot be obtained prior to the Closing, then, to the extent permitted by Applicable Law and the terms of any relevant contracts with third parties, Seller shall, and shall cause its applicable Affiliates to, until the earlier of (i) the time at which such consent or waiver is obtained, and (ii) the expiration or termination of the term or duration of any such Non-Assignable Asset (the length of such term or duration being as it exists as of the Closing): (A) hold the Non-Assignable Assets, from and after the Closing, in trust for the benefit of Purchaser, and all benefits and obligations existing thereunder shall be for Purchaser's account; and (B) take or cause to be taken such actions in its name or otherwise as Purchaser may reasonably request so as to provide Purchaser with the benefits of such Non-Assignable Assets, to enforce (for the benefit of Purchaser or one its Affiliates and to the extent it is commercially reasonable to do so) any of Seller's or Seller's Affiliates' respective rights relating to such Non-Assignable Assets and to effect the collection of

money or other consideration that becomes due and payable under such Non-Assignable Asset, and shall promptly pay over to Purchaser all money or other consideration received by it in respect of such Non-Assignable Asset, provided that Purchaser shall indemnify Seller and Seller's Affiliates for any Liabilities arising out of any action or omission by Purchaser relating to such Non-Assignable Asset (other than any such action or omission by Purchaser at the request or direction of Seller). Purchaser shall timely pay, perform or otherwise discharge (in accordance with the respective terms and subject to the respective conditions thereof, and in the name of Seller or its applicable Affiliate) all of the covenants and obligations of Seller or its applicable Affiliate incurred after the Closing with respect to such Non-Assignable Asset (including, for the avoidance of doubt, any increases in fees, costs or expenses required to be paid by Seller under the terms thereof), provided that Seller shall indemnify Purchaser for any Liabilities arising out of any action or omission by Seller relating to such Non-Assignable Asset (other than any such action or omission by Seller at the request or direction of Purchaser). Purchaser and Seller shall mutually cooperate to provide any other reasonable alternative arrangements as may be reasonably required to implement the purpose and intent of this Agreement and the other Transaction Agreements so that Purchaser and its Affiliates will have access to the rights and benefits contemplated by such Non-Assignable Asset from and after the Closing. Upon obtaining the requisite consent of any applicable Person, any previously Non-Assignable Asset and any Leases that were not assigned, transferred, subleased or licensed (as applicable) at the Closing (in accordance with the first sentence of this Section 2.03(a)) shall be promptly transferred, assigned, subleased or licensed (as applicable) by the Seller or its applicable Affiliate(s) to Purchaser for no additional consideration.

Section 2.04. Assumption of the Assumed Liabilities. Upon the terms and subject to the conditions set forth in this Agreement, at the Closing, Seller shall, and shall cause its Affiliates to, assign to Purchaser, and Purchaser shall assume, satisfy and discharge when due, any and all Liabilities of Seller or any of its Affiliates relating to the Transferred Assets (other than the Excluded Liabilities and excluding, for the avoidance of doubt, (i) all Reinsured Liabilities reinsured by Purchaser under and pursuant to the Reinsurance Agreement, which will be governed by the terms of the Reinsurance Agreement, to the extent arising on or after the Closing Date, (ii) any Liabilities that result from a breach by Seller or its Affiliates of any Assigned Contract arising out of an action or omission occurring prior to the Closing) (all such Liabilities to be so assumed, satisfied or discharged being referred to herein as the " Assumed Liabilities"), including the following: (a) all Liabilities arising under the Assigned Contracts; (b) all Liabilities for Taxes relating to the Transferred Assets other than Excluded Taxes; (c) all Liabilities assumed by Purchaser pursuant to Articles VI and VII; and (d) all Liabilities listed on Schedule III. Notwithstanding the foregoing, the Liabilities of Seller or any of its Affiliates relating to the Business Employee Benefit Plans and the Assigned Lease shall not be assumed or assigned to Purchaser until the termination of the Employee Lease Term, after which time Purchaser shall (with respect to the Assigned Lease, subject to the terms of Section 2.08(d)) assume, satisfy and discharge when due, any and all Liabilities of Seller or any of its Affiliates thereunder.

Section 2.05. Excluded Liabilities. Notwithstanding anything to the contrary contained in this Agreement, Purchaser will not assume or be liable for, and Seller and its applicable Affiliates will retain and remain responsible for, all of Seller's and such Affiliates' Liabilities (fixed or contingent, known or unknown) (other than the Assumed Liabilities and excluding, for

the avoidance of doubt, all Reinsured Liabilities reinsured by Purchaser under and pursuant to the Reinsurance Agreement, which will be governed by the terms of the Reinsurance Agreement), regardless of when asserted (collectively, the " Excluded Liabilities"). Without limiting the foregoing, the Excluded Liabilities include the following:

(a) all of Seller's and its Affiliates' Liabilities under the Transaction Agreements;

(b) the Excluded Benefits Liabilities;

(c) any Liability for or in respect of the payment of all Taxes of Seller or any of its Affiliates, and of any Taxes arising out of or relating to the ownership or use of the Transferred Assets or the conduct of the Business for a Pre-Closing Period, other than as provided in Section 7.02 and Taxes arising out of or relating to actions that Purchaser requests Seller to take prior to Closing (the " Excluded Taxes");

(d) all Liabilities arising out of, in connection with or under contracts to which Seller or any of its Affiliates is a party other than Liabilities relating to periods (or portions thereof) beginning from or after the Closing under the Assigned Contracts, the Assigned Lease and any other contracts included in the Transferred Assets (which such Liabilities shall be Assumed Liabilities);

(e) Seller Retention Bonus Liabilities; and

(f) Liabilities of Seller or any of its Affiliates related to any Permitted Liens on the Transferred Assets.

Section 2.06. Place and Date of Closing. Unless another date, time or place is agreed to in writing by the parties hereto, the closing of the transactions contemplated by this Agreement (the " Closing") shall take place at the offices of Willkie Farr & Gallagher LLP, 787 Seventh Avenue, New York, New York 10019, at 10:00 a.m., New York City time, on the third Business Day after the date on which the last of the conditions set forth in Article VIII to be satisfied or waived (other than those conditions that by their terms are to be satisfied at the Closing, but subject to the satisfaction or waiver of such conditions at the Closing) shall have been so satisfied or waived in accordance with this Agreement (the " Condition Satisfaction"); provided , however , that if the Condition Satisfaction occurs less than ten Business Days prior to the first Business Day of the next calendar month, then the Closing shall take place on the first Business Day of the calendar month immediately following the calendar month in which the Condition Satisfaction occurs. The Closing shall be deemed effective as of the Effective Time. For purposes of preparing the Estimated Closing Statement, Estimated Asset Value Statement, Initial Closing Statement, Initial Asset Value Statement, Final Closing Statement and Final Asset Value Statement and calculating any amounts required to be calculated therefrom, such statements shall be prepared as of the close of the last calendar day of the month immediately preceding the month in which the Closing occurs (the " Accounting Date"). The actual date and time at which the Closing occurs is referred to herein as the " Closing Date. "

Section 2.07. Consideration.

(a) The consideration with respect to the transactions contemplated by this Agreement will be an aggregate amount in cash equal to $1,450,000,000 (the " Purchase Price"), comprised of:

(i) $1,382,000,000, constituting the ceding commission to be paid to the Ceding Company in connection with the Reinsurance Agreement (the "Ceding Commission"), which amount shall constitute consideration for the reinsurance arrangements contemplated by the Reinsurance Agreement; and

(ii) $68,000,000 (the "Asset Consideration") representing the aggregate purchase price for the Transferred Assets.

(b) At the Closing, Purchaser shall pay to Seller or an Affiliate of Seller (as designated by Seller), by wire transfer of immediately available funds to such account or accounts of Seller or its Affiliates as Seller may designate in writing at least two Business Days prior to the Closing Date, an amount equal to the Asset Consideration.

(c) Reference and Estimated Closing Statement; Specified Portfolio.

(i) Section 2.07(c)(i) of the Seller Disclosure Schedule contains, for illustrative purposes, a pro forma Closing Statement assuming, for this purpose, that the Closing occurred, and the Reinsurance Agreement became effective, as of the Reference Date (the "Reference Closing Statement").

(ii) Section 2.07(c)(ii) of the Seller Disclosure Schedule contains a schedule of cash and Investment Assets held by the Ceding Company or AHLIC in respect of the Business as of the Reference Date (such portfolio, as it may have been or will be adjusted or changed between the Reference Date and the Closing Date in accordance with Sections 3.19 and 5.11 , the "Specified Portfolio"), which portfolio had an aggregate Accounting Value as of the Reference Date equal to the Required Asset Value as of the Reference Date.

(iii) Not less than five Business Days prior to the anticipated Closing Date, Seller shall prepare and deliver to Purchaser an estimated Closing Statement as of the anticipated Accounting Date (the "Estimated Closing Statement"). The Estimated Closing Statement shall be prepared in accordance with the Transaction Accounting Principles applied in a manner consistent with the preparation of the Reference Closing Statement and be in the same format as the Reference Closing Statement.

(d) Determination of Transferred Portfolio.

(i) Not less than two Business Days prior to the anticipated Closing Date, Seller shall prepare and deliver to Purchaser a calculation of the Closing Required Asset Value, which calculation will be based on the Required Asset Value reflected in the Estimated Closing Statement and will take into account all Capital Gain or Loss Adjustments and all Reallocated Asset Value Adjustments required pursuant to Section 5.11 or Section 3.19(b) through the Closing Date (the "Estimated Closing Required Asset Value").

(ii) The "Transferred Portfolio" will be determined as follows:

(A) if the Accounting Value of the Specified Portfolio as of the Closing Date equals the Closing Required Asset Value, the Transferred Portfolio will comprise all, and only, the cash and Investment Assets in the Specified Portfolio as of immediately prior to the Closing;

(B) if the Accounting Value of the Specified Portfolio as of the Closing Date is less than the Closing Required Asset Value, the Transferred Portfolio will comprise (x) all of the cash and Investment Assets in the Specified Portfolio as of immediately prior to the Closing and (y) cash or other Investment Assets selected by Seller in accordance with the Pre-Closing Investment Guidelines that have an aggregate Fair Market Value equal to the amount of such shortfall; and

(C) if the Accounting Value of the Specified Portfolio as of the Closing Date is greater than the Closing Required Asset Value, Seller will select for removal from the Specified Portfolio cash or Investment Assets that have an aggregate Accounting Value equal to such excess in accordance with the Selection Waterfall. The cash and Investment Assets remaining in the Specified Portfolio after such removal will be the Transferred Portfolio.

(iii) Concurrently with the delivery by Seller to Purchaser of the calculation of the Estimated Closing Required Asset Value pursuant to clause (i) of this Section 2.07(d) , Seller will also deliver to Purchaser (A) a schedule showing the cash and Investment Assets in the Transferred Portfolio and its estimated calculation of the aggregate Accounting Value of the cash and Investment Assets in the Transferred Portfolio as of immediately prior to the Closing (the "Estimated Asset Value Statement"), and (B) a calculation of Seller's estimate of the Required Balance (as defined in the Reinsurance Agreement) as of the Closing Date based on amounts set forth on the Estimated Closing Statement and calculated using the aggregate FMV-Ex Accrued and the aggregate Book Value of the Transferred Portfolio (the "Estimated Required Balance").

(e) Payment of Ceding Commissions and Initial Transfer Amounts. At the Closing, upon the terms set forth in this Agreement and the Reinsurance Agreement:

(i) in addition to the payment Purchaser is required to make to Seller pursuant to Section 2.07(b) above, Purchaser shall pay to Seller, by wire transfer of immediately available funds to an account or accounts designated in writing to Purchaser by Seller at least two Business Days prior to the Closing Date, an amount equal to the Ceding Commission; and

(ii) Seller shall cause the Ceding Company (or AHLIC on behalf of the Ceding Company) to deposit into the Trust Account, on behalf of Purchaser, the cash and Investment Assets in the Transferred Portfolio; provided that:

(A) if on the Closing Date the aggregate Fair Market Value of the cash and Investment Assets in the Transferred Portfolio exceeds the Estimated Required Balance, then Seller shall cause the Ceding Company (or AHLIC on behalf of the Ceding Company) to transfer to Purchaser cash or Investment Assets from the Transferred Portfolio selected by Purchaser with a Fair Market Value equal to such excess and shall cause the Ceding Company (or AHLIC on behalf of the Ceding Company) to transfer the remainder of the cash and Investment Assets in the Transferred Portfolio to the Trust Account; and

(B) if on the Closing Date the aggregate Fair Market Value of the cash and Investment Assets in the Transferred Portfolio is less than the Estimated Required Balance, Purchaser shall, at the Closing, transfer to the Trust Account Authorized Investments (as defined in the Trust Agreement) having a Fair Market Value as of the Closing Date equal to such shortfall.

Section 2.08. Closing Deliveries.

(a) Upon the terms and subject to the conditions set forth in this Agreement, at the Closing, in addition to the payments contemplated by Section 2.07 above, Seller shall, and shall cause its applicable Affiliates to, enter into and deliver to Purchaser:

(i) a copy of the Commutation Agreement duly executed by the Ceding Company and AHLIC;

(ii) a counterpart to the Reinsurance Agreement duly executed by the Ceding Company;

(iii) a counterpart to the Trust Agreement duly executed by the Ceding Company;

(iv) a counterpart to the Administrative Services Agreement duly executed by the Ceding Company;

(v) a counterpart to the Transition Services Agreement duly executed by the Ceding Company;

(vi) a counterpart to the Intellectual Property Agreement duly executed by Seller and the Ceding Company;

(vii) a counterpart to the Distribution Agreement duly executed by each of the Ceding Company and Carefree Insurance Services, Inc.;

(viii) a counterpart to the Bill of Sale and Assignment and Assumption Agreement duly executed by Seller and the Ceding Company;

(ix) a counterpart to the Trademark License Agreement duly executed by Seller and the Ceding Company;

(x) a counterpart to the Portland Location Assignment Agreement, duly executed by the Ceding Company;

(xi) a counterpart to the sublease in the form attached hereto as Exhibit K-1 (the "Plantation Sublease"), duly executed by the Ceding Company;

(xii) a counterpart to the sublease in the form attached hereto as Exhibit K-2 (the "South Portland Sublease"), duly executed by the Ceding Company;

(xiii) a counterpart to the sublease in the form attached hereto as Exhibit K-3 (the "Omaha Sublease"), duly executed by Aetna Health Management, LLC;

(xiv) a counterpart to the license agreement in the form attached hereto as Exhibit L (the "Hartford License Agreement"), duly executed by the Ceding Company;

(xv) a counterpart to the Employee Leasing Agreement in the form attached hereto as Exhibit M (the "Employee Leasing Agreement"), duly executed by Seller;

(xvi) a counterpart to the Data Processing Side Letter duly executed by the Ceding Company;

(xvii) a certificate of Seller duly executed by an authorized officer of Seller, dated as of the Closing Date, certifying as to Seller's compliance with the conditions set forth in Section 8.02(a) and Section 8.02(b); and

(xviii) such other agreements, instruments and documents as are contemplated by this Agreement or the other Transaction Agreements to be executed and delivered by Seller or any of its Affiliates on the Closing Date.

(b) Upon the terms and subject to the conditions set forth in this Agreement, at the Closing, in addition to the payments contemplated by Section 2.07 above, Purchaser shall, and shall cause its applicable Affiliates to, enter into and deliver to Seller:

(i) a counterpart to the Reinsurance Agreement duly executed by Purchaser;

(ii) a counterpart to the Trust Agreement duly executed by Purchaser;

(iii) a counterpart to the Administrative Services Agreement duly executed by Purchaser;

(iv) a counterpart to the Transition Services Agreement duly executed by Purchaser;

(v) a counterpart to the Intellectual Property Agreement duly executed by Hartford Fire;

(vi) a counterpart to the Distribution Agreement duly executed by Purchaser;

(vii) a counterpart to the Bill of Sale and Assignment and Assumption Agreement duly executed Purchaser;

(viii) a counterpart to the Trademark License Agreement duly executed by Hartford Fire;

(ix) a counterpart to a side letter in the form attached hereto as Exhibit N (the "Data Processing Side Letter"), duly executed by Purchaser, acknowledging that the Ceding Company, its Affiliates (as defined in the Transition Services Agreement) and their respective subcontractors have processed, and will continue to process, data relating to the Business in Alaska, Hawaii, India and the Philippines;

(x) a counterpart to the Portland Location Assignment Agreement, duly executed by Hartford Fire;

(xi) a counterpart to the Plantation Sublease, duly executed by Hartford Fire;

(xii) a counterpart to the South Portland Sublease, duly executed by Hartford Fire;

(xiii) a counterpart to the Omaha Sublease, duly executed by Hartford Fire;

(xiv) a counterpart to the Hartford License Agreement, duly executed by Hartford Fire;

(xv) a counterpart to the Employee Leasing Agreement, duly executed by Purchaser;

(xvi) a certificate of Purchaser duly executed by an authorized officer of Purchaser, dated as of the Closing Date, certifying as to Purchaser's compliance with the conditions set forth in Section 8.03(a) , Section 8.03(b) and 8.03(c); and

(xvii) such other agreements, instruments and documents as are contemplated by this Agreement or the other Transaction Agreements to be executed and delivered by Seller or any of its Affiliates on the Closing Date.

(c) Purchaser and Seller shall each use their reasonable best efforts to obtain, at or prior to the Closing, a counterpart to the Trust Agreement duly executed by the Trustee.

(d) Notwithstanding the delivery by Seller or Purchaser of any counterpart to the Portland Location Assignment Agreement or any Sublease pursuant to Section 2.08(a) or Section 2.08(b) , as applicable, such counterparts shall not be effective at the Closing but shall instead be held in escrow and not become effective with respect to such agreement unless and until, and shall become effective with respect to such agreement only if (i) the applicable Lease Consent is obtained on or prior to December 31, 2017 and (ii) the Employee Lease Term has expired or been terminated. If the foregoing conditions to the effectiveness of the counterparts to the Portland Location Assignment Agreement or any such Sublease are not satisfied, then, upon the expiration or termination of the Employee Lease Term, the applicable agreement to which such counterparts relate shall be deemed not to have been executed by the parties thereto and shall be void and have no force or effect. If the Portland Location Assignment Agreement is deemed not to have been executed in accordance with the prior sentence, then: (i) the Assigned Lease shall be deemed not to be a Transferred Asset or Assigned Contract hereunder; (ii) Seller shall have no Liability to any Purchaser Indemnified Person by virtue of the fact that the Assigned Lease is not a Transferred Asset or Assigned Contract hereunder; and (iii) the Liabilities of Seller and its Affiliates under the Assigned Lease shall not be Assumed Liabilities hereunder; provided , that the foregoing shall not affect either party's obligations under Article V , including Section 5.12 , or any rights to indemnification under Article X arising out of any breach by the other party of its obligations under Article V.

Section 2.09. Adjustment to Initial Transfer Amount after Closing.

(a) Within 90 days following the Closing Date, Seller shall prepare and deliver to Purchaser: (i) a Closing Statement as of the Accounting Date (the " Initial Closing Statement"), which shall be prepared in accordance with the Transaction Accounting Principles applied consistently with their application in connection with the preparation of the Reference Closing Statement and be in the same format as the Reference Closing Statement; (ii) Seller's determination of the Accounting Value of the Transferred Portfolio as of the Accounting Date (the " Initial Asset Value Statement"); and (iii) Seller's calculation of the Closing Required Asset Value based on the amounts set forth on the Initial Closing Statement and the Initial Asset Value Statement and taking into account all Capital Gain or Loss Adjustments and all Reallocated Asset Value Adjustments required from the Reference Date through the Closing Date (the

"Initial Closing Required Asset Value Statement"). Each of the Initial Closing Statement, Initial Asset Value Statement and the Initial Closing Required Asset Value Statement will be accompanied by reasonably detailed supporting documentation relating to the amounts and calculations therein. Each of the amounts set forth on the Estimated Closing Statement, the Initial Closing Statement and the Final Closing Statement shall not include any interest maintenance reserve related to the transfer of Investment Assets from AHLIC to the Ceding Company in connection with the Pre-Closing Commutation; provided , that the foregoing shall not affect the inclusion of such amounts in the calculation of the "Closing Date IMR Amount" under the Reinsurance Agreement.

(b) During the 60 days immediately following Purchaser's receipt of the Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement (the " Review Period"), Purchaser and its Representatives shall be permitted to review Sellers's working papers and any working papers of Seller's independent accountants directly relating to the preparation of the Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement, as well as all of the Books and Records and other relevant information or documents relating to the operations and finances of the Business with respect to the period up to and including the Closing Date, and Seller shall make available the individuals in its or its Affiliates' employ who are responsible for and knowledgeable about the information used in, and the preparation or calculation (as applicable) of, the Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement in order to respond to the inquiries of Purchaser; provided , however , that the independent accountants of Seller shall not be obligated to make any working papers available to Purchaser unless and until Purchaser has signed a customary confidentiality and hold harmless agreement relating to such access to working papers in form and substance reasonably acceptable to such independent accountants.

(c) If Purchaser disagrees with the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement (including any amount or computation set forth therein) in any respect and on any basis (including that the representations and warranties in Section 3.18(d) or the covenants in Section 5.11 were breached), Purchaser may, on or prior to the last day of the Review Period, deliver a notice to Seller setting forth, in reasonable detail, each disputed item or amount and the basis for Purchaser's disagreement therewith (the " Notice of Disagreement"). The Notice of Disagreement shall set forth, with respect to each disputed item, Purchaser's position as to the correct amount or computation that should have been included in the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement. If Purchaser does not deliver a Notice of Disagreement with respect to the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement to Seller by the end of the Review Period, the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement, as applicable, shall become final and binding on the parties.

(d) During the 20 Business Days immediately following the delivery of a Notice of Disagreement, Seller and Purchaser shall seek in good faith to resolve any disagreement that they may have with respect to the matters specified in the Notice of Disagreement.

(e) If, at the end of such 20 Business Day period, Seller and Purchaser have been unable to resolve all disagreements that they may have with respect to the matters specified in the Notice of Disagreement, then Seller and Purchaser shall submit all matters that remain in dispute with respect to the Notice of Disagreement (along with a copy of the applicable Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement marked to indicate those line items that are in dispute) to PricewaterhouseCoopers LLP or, if PricewaterhouseCoopers LLP is unwilling or unable to serve, another independent certified public accounting firm in the United States of international recognition mutually agreeable to Seller and Purchaser and that is not the auditor or independent accounting firm of any of the parties (the " Independent Accountant"), to make a determination with respect to all matters in dispute.

(f) Seller and Purchaser shall use commercially reasonable efforts to cause the Independent Accountant to render a determination within 30 days after the submission of such matters to the Independent Accountant or as soon as practicable thereafter. Seller, on the one hand, and Purchaser, on the other hand, shall promptly (and in any event within five Business Days) after the Independent Accountant's engagement, each submit to the Independent Accountant their respective computations of the disputed items identified in the Notice of Disagreement and information, arguments and support for their respective positions, and shall concurrently deliver a copy of such materials to the other party. Each party shall then be given an opportunity to supplement the information, arguments and support included in its initial submission with one additional submission to respond to any arguments or positions taken by the other party in such other party's initial submission, which supplemental information shall be submitted to the Independent Accountant (with a copy thereof to the other party) within 10 Business Days after the first date on which both parties have submitted their respective initial submissions to the Independent Accountant. The Independent Accountant shall thereafter be permitted to request additional or clarifying information from the parties, and each of the parties shall cooperate and shall cause their Representatives to cooperate with such requests of the Independent Accountant. The Independent Accountant shall determine, based solely on the materials so presented by the parties and upon information received in response to such requests for additional or clarifying information and not by independent review, only those issues in dispute specifically set forth in the Notice of Disagreement and shall render a written report to Seller and Purchaser in which the Independent Accountant shall, after considering all matters set forth in the Notice of Disagreement, determine what adjustments, if any, should be made to the amounts and computations set forth in the Initial Closing Statement, Initial Asset Value Statement and the Initial Closing Required Asset Value Statement solely as to the disputed items. Such written report shall set forth, in reasonable detail, the determination of the Independent Accountant with respect to each of the disputed line items specified in the Notice of Disagreement and the revisions, if any, to be made to the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement resulting therefrom, together with supporting calculations. With respect to each disputed line item, such determination shall be made in accordance with the Transaction Accounting Principles and the terms of this Agreement and, if not in accordance with the position of either Seller or Purchaser, shall not be in excess of the highest amount proposed by either party, nor less than the lowest amount proposed by either party, in the Notice of Disagreement, the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement with respect to such disputed line item. For the avoidance of doubt, the Independent Accountant shall

not review any line items or make any determination with respect to any matter other than those matters in the Notice of Disagreement that remain in dispute. The Independent Accountant's final written determination shall, absent fraud or manifest error, be conclusive and binding upon Seller and Purchaser, shall not be subject to review by a court or other tribunal and shall have the same force and effect as an arbitration award governed by the Federal Arbitration Act, 9 U.S.C. §1 et. seq. The " Final Closing Statement" means the Initial Closing Statement as made final and binding either pursuant to Section 2.09(c) or after it has been modified to reflect any revisions thereto made through the mutual agreement of Purchaser and Seller or through the determination of the Independent Accountant pursuant to this Section 2.09(f). The " Final Asset Value Statement" means the Initial Asset Value Statement as made final and binding either pursuant to Section 2.09(c) or after it has been modified to reflect any revisions thereto made through the mutual agreement of Purchaser and Seller or through the determination of the Independent Accountant pursuant to this Section 2.09(f). The " Final Closing Required Asset Value Statement" means the Initial Closing Required Asset Value Statement as made final and binding either pursuant to Section 2.09(c) or after it has been modified to reflect any revisions thereto made through mutual agreement of Purchaser and Seller or through the determination of the Independent Accountant pursuant to this Section 2.09(f) , and the " Final Closing Required Asset Value" is the Closing Required Asset Value as set forth on the Final Closing Required Asset Value Statement.

(g) The cost of the Independent Accountant's review and determination shall be shared equally by Seller and Purchaser. During the review by the Independent Accountant, Seller and Purchaser shall each make available to the Independent Accountant such individuals and such information, books, records and work papers, as may be reasonably required by the Independent Accountant to fulfill its obligations under Sections 2.09(e) and 2.09(f); provided , however , that the independent accountants of Seller or Purchaser shall not be obligated to make any working papers available to the Independent Accountant unless and until the Independent Accountant has signed a customary confidentiality and hold harmless agreement relating to such access to working papers in form and substance reasonably acceptable to such independent accountants. In acting under this Agreement, the Independent Accountant shall be entitled to the privileges and immunities of an arbitrator. Notwithstanding anything to the contrary contained in this Agreement, the provisions of this Section 2.09 represent the sole and exclusive method for determining the Final Closing Statement, the Final Asset Value Statement, the Final Closing Required Asset Value Statement and the Final Closing Required Asset Value.

(h) Seller shall, following the Closing through the date that the Final Closing Statement, the Final Asset Value Statement and the Final Closing Required Asset Value Statement become final and binding on the parties in accordance with the last three sentences of Section 2.09(f) , take all actions necessary to maintain and preserve all accounting books, records, policies and procedures on which the Initial Closing Statement, Initial Asset Value Statement and Initial Closing Required Asset Value Statement are based or on which the Final Closing Statement, Final Asset Value Statement or Final Closing Required Asset Value Statement are to be based so as not to impede or delay the final determination of the amounts set forth therein.

Section 2.10. Post-Closing Adjustments.

(a) The following adjustments will be made based on the amounts set forth on the Final Closing Statement, Final Asset Value Statement and Final Closing Required Asset Value Statement:

(i) Purchaser shall pay to the Ceding Company the True-Up Amount, if positive; or

(ii) Seller shall cause the Ceding Company to pay into the Trust Account the absolute value of the True-Up Amount, if negative.

(b) Payment of any amounts due under Section 2.10(a) shall be made within five Business Days after the date on which all three of the Final Closing Statement, the Final Asset Value Statement and Final Closing Required Asset Value Statement have become such in accordance with the last three sentences of Section 2.09(f) by wire transfer of immediately available funds.

ARTICLE III.

REPRESENTATIONS AND WARRANTIES OF SELLER

Except as set forth in the corresponding sections or subsections of the disclosure schedule delivered to Purchaser by Seller concurrently with the execution and delivery of this Agreement (the " Seller Disclosure Schedule") (it being understood and agreed by the parties hereto that disclosure of any item in any section or subsection of the Seller Disclosure Schedule shall be deemed disclosure with respect to any other section or subsection of the Seller Disclosure Schedule to which the relevance of such item is reasonably apparent, notwithstanding the omission of a reference or cross-reference thereto), Seller hereby makes the following representations and warranties to Purchaser, as of the date hereof and as of the Closing Date, as follows:

Section 3.01. Organization; Standing and Authority.

(a) Seller is a corporation duly incorporated, validly existing and in good standing under the laws of the Commonwealth of Pennsylvania. The Ceding Company is an insurance company duly organized, validly existing and in good standing under the laws of the State of Connecticut. AHLIC is an insurance company duly organized, validly existing and in good standing under the laws of the State of Connecticut.

(b) Each of Seller, the Ceding Company and AHLIC (i) have all corporate or other applicable organizational power and authority to carry on the activities it currently conducts in connection with the Business as it is now being conducted and to own, lease and operate its properties and assets and (ii) is duly qualified to do business as a foreign or alien corporation or other legal entity, as the case may be, in good standing in each jurisdiction in which the conduct of the Business makes such qualification necessary, except, in the case of clause (ii), where the failure to be so qualified, would not, individually or in the aggregate, reasonably be expected to

have a Material Adverse Effect. This Section 3.01(b) does not relate to Permits from Insurance Regulators and Operating Permits, which are addressed in Section 3.11.

Section 3.02. Authorization. Seller or the applicable Affiliate of Seller (as applicable) has all requisite corporate or other applicable organizational power to enter into, consummate the transactions contemplated by and carry out its obligations under, each of the Transaction Agreements to which it is or is contemplated to become a party. The execution and delivery by Seller or the applicable Affiliate of Seller (as applicable) of each of the Transaction Agreements to which it is or is contemplated to become a party, and the consummation by Seller or the applicable Affiliate of Seller (as applicable) of the transactions contemplated by each of the Transaction Agreements to which it is or is contemplated to become a party, have been duly authorized by all requisite corporate or other similar organizational action on the part of Seller or the applicable Affiliate of Seller (as applicable). Each of the Transaction Agreements to which Seller or the applicable Affiliate of Seller (as applicable) is or is contemplated to become a party has been, or upon execution and delivery thereof will be, duly executed and delivered by Seller or the applicable Affiliate of Seller (as applicable). Assuming due authorization, execution and delivery by the other parties hereto or thereto, each of the Transaction Agreements to which Seller or the applicable Affiliate of Seller (as applicable) is or is contemplated to become a party constitutes, or upon execution and delivery thereof will constitute, the legal, valid and binding obligation of Seller or the applicable Affiliate of Seller (as applicable), enforceable against it in accordance with its terms, subject in each case to the effect of any applicable bankruptcy, reorganization, insolvency, moratorium, rehabilitation, liquidation, fraudulent conveyance, preferential transfer or similar laws now or hereafter in effect relating to or affecting creditors' rights and remedies generally and subject, as to enforceability, to the effect of general equitable principles (regardless of whether enforcement is sought in a proceeding in equity or at law) (the " Enforceability Exceptions").

Section 3.03. Sufficiency of Assets. Except as set forth in Section 3.03 of the Seller Disclosure Schedule and subject to the receipt of all Governmental Approvals, the assets, rights, properties, Employees, Intellectual Property and services transferred or made available to Purchaser and its Affiliates pursuant to this Agreement, the other Transaction Agreements and the Assigned Contracts will, as of the Closing, comprise assets, rights, properties, Employees, Intellectual Property and services that are sufficient to permit Purchaser to operate the Business immediately following the Closing Date in substantially the same manner as the Business is being operated as of the date hereof. This Section 3.03 does not address any Permit needed for the Purchaser to write new or renewal insurance policies with respect to the Business after the Closing Date.

Section 3.04. No Conflict or Violation. Provided that all consents, approvals, authorizations and other actions described in Section 3.05 of the Seller Disclosure Schedule have been obtained or taken, the execution and delivery by Seller or the applicable Affiliate of Seller (as applicable) of, and the consummation by Seller or the applicable Affiliate of Seller (as applicable) of the transactions contemplated by, the Transaction Agreements to which Seller or the applicable Affiliate of Seller (as applicable) is or is contemplated to become a party do not and will not (a) violate or conflict with the organizational documents of Seller or the applicable Affiliate of Seller (as applicable), (b) subject to the Governmental Approvals referred to in Section 3.05 , conflict with or violate any Applicable Law or Governmental Order applicable to

Seller or the applicable Affiliate of Seller (as applicable) or by which any of them or any of their respective properties, assets or rights is bound or subject, (c) result in any breach of, or constitute a default (or event which, with the giving of notice or lapse of time or both, would constitute a default) under, or give to any Person any rights of termination, acceleration or cancellation of, or result in the creation of any Lien (other than Permitted Liens) on any of the assets, properties or rights of Seller or the applicable Affiliate of Seller (as applicable) pursuant to, any contract, or any note, bond, loan or credit agreement, mortgage or indenture to which Seller or such applicable Affiliate of Seller is a party or by which any of them or any of their respective properties, assets or rights is bound or subject or (d) result in a breach or violation of any of the terms or conditions of, result in a default under, or otherwise cause an impairment or revocation of, any material Permit used in the Business, except, in the case of clauses (b), (c) and (d) of this Section 3.04 , for any such conflicts, violations, breaches, defaults, terminations, accelerations, cancellations or creations that, individually or in the aggregate, would not reasonably be expected to have a Material Adverse Effect.

Section 3.05. Consents and Approvals. Except in connection, or in compliance, with the approvals, filings and notifications required by Applicable Laws that are set forth in Section 3.05 of the Seller Disclosure Schedule, the execution and delivery by Seller or the applicable Affiliate of Seller (as applicable) of the Transaction Agreements to which it is or is contemplated to become a party do not and will not, and the consummation by Seller or the applicable Affiliate of Seller (as applicable) of the transactions contemplated by the Transaction Agreements to which it is or is contemplated to become a party will not, require any consent, approval, license, permit, order, qualification or authorization of, or registration with or other action by, or any filing with or notification to, any Governmental Authority (each, a " Governmental Approval") to be obtained or made by or with respect to Seller or such applicable Affiliate of Seller (as applicable), except for any Governmental Approvals the failure to obtain or make which, individually or in the aggregate, would not reasonably be expected to have a Material Adverse Effect.

Section 3.06. Certain Contracts.

(a) Section 3.06(a) of the Seller Disclosure Schedule lists each Material Contract to which Seller or any of its Affiliates is a party or by which it is bound as of the date hereof. The term " Material Contract" means all of the following types of contracts (other than any Ceded Reinsurance Contract or any Group Contract) in effect on the date hereof:

(i) the Assigned Contracts;

(ii) any contract that (A) contains a restriction on the ability of the Business to solicit specified customers or prospective customers for the purchase, renewal, lapse or amendment of any Group Contract or (B) limits in any way the ability of the Business to compete or engage in the conduct of the Business or in the marketing, selling and administration of any Group Contract, in each case, that would be legally binding on Purchaser or any of its Affiliates following the consummation of the transactions contemplated hereby;

(iii) mortgages, indentures, loan or credit agreements, security agreements and other agreements and instruments relating to the borrowing of money or extension of credit directly by or to Seller or an Affiliate thereof in respect of the Business or the direct or indirect guarantee by Seller or an Affiliate thereof for the benefit of the Business of any obligation for borrowed money of any other Person, in each case other than Investment Assets held in the ordinary course of business consistent with the Investment Guidelines;

(iv) any retention agreements providing for payments to any Employee;

(v) any contract restricting or granting rights to use or practice rights under the Transferred Intellectual Property;

(vi) any contract that is primarily related to the Business but is not an Assigned Contract (each, a "Primary Contract") pursuant to which any third Person provides support, maintenance or other services for IT Systems;

(vii) any Primary Contract pursuant to which any material operational function of the Business is outsourced to or otherwise performed by a third Person;

(viii) any Primary Contract pursuant to which one or more independent contractors provides services to the Business;

(ix) any contract that relates to the acquisition or disposition of any business or operation included in the Business, or any other contract that includes an ongoing material indemnification obligation or guarantee of the Ceding Company in respect of the Business, but in either case only where any such contract contains any material obligation of Seller or any of its Affiliates that remains unperformed (other than any obligation to indemnify the buyer thereunder for breaches of provisions that have expired or which are not subject to any survival period); or

(x) any other Primary Contract.

(b) Section 3.06(b) of the Seller Disclosure Schedule lists each vendor with which, as of the date hereof, there is a direct contractual or other relationship to provide rights, services, functions or goods, as applicable, directly to the Business or which charge the Business directly for such rights, services, functions or goods, as applicable (each such vendor, a " Vendor"). For the avoidance of doubt, Section 3.06(b) of the Seller Disclosure Schedule does not list vendors for which the Business is allocated a share of the cost as part of a corporate or enterprise cost allocation.

(c) True and complete copies in all material respects of each of the Material Contracts, including in each case all amendments and addenda thereto, have been made available to Purchaser on the Project DeLorean Intralinks site or by email prior to the date hereof. Each of the Material Contracts is in full force and effect and is the valid and binding obligation of Seller and each Affiliate of Seller party thereto, and, to the Knowledge of Seller as of the date hereof,

each other party thereto, subject to the Enforceability Exceptions. None of Seller or any Affiliate of Seller that is party thereto, nor, to the Knowledge of Seller as of the date hereof, any other Person that is a party thereto, is (or, with the giving of notice or the lapse of time or both, will be), in any material respect, in violation or breach of or default under any of the Material Contracts. None of Seller or any Affiliate of Seller that is party thereto has received written or, to the Knowledge of Seller, oral notice of cancellation of any Material Contract.

Section 3.07. Title to Assets. Seller or one of its Affiliates is the record and beneficial owner of, and holder of good and valid title to, all of the Transferred Assets, free and clear of all Liens other than Permitted Liens. Purchaser will acquire good and valid title to the Transferred Assets, free and clear of Liens, except for Permitted Liens or any Liens arising from acts of Purchaser (other than entering into any Transaction Agreement), (a) in the case of Transferred Assets other than the Business Employee Benefit Plans and the Assigned Lease, at the Closing, and (b) in the case of the Business Employee Benefit Plans, upon the termination of the Employee Lease Term, and (c) in the case of the Assigned Lease, upon the termination of the Employee Lease Term and the effectiveness of the Portland Location Assignment Agreement.

Section 3.08. Absence of Litigation. Except as disclosed in Section 3.08 of the Seller Disclosure Schedule, as of the date hereof, there are no Actions relating to the Business (other than claims under or in connection with Group Contracts in the ordinary course of business) pending or, to the Knowledge of Seller, threatened in writing against (i) the Ceding Company or (ii) Seller or any of its other Affiliates with respect to the Business that, individually or in the aggregate, would reasonably be expected to have a Material Adverse Effect.

Section 3.09. Compliance With Laws.

(a) Except as disclosed in Section 3.09(a)(i) of the Seller Disclosure Schedule, Seller and its Affiliates (solely with respect to, and to the extent related to, the Business) are, and since December 31, 2014 have been, in compliance in all respects with all Applicable Laws, including Privacy and Data Security Laws, except for such instances of non-compliance that would not, individually or in the aggregate, have a material adverse impact on the Business. Except as set forth in Section 3.09(a)(ii) of the Seller Disclosure Schedule, as of the date hereof, since December 31, 2014, none of Seller or any of its Affiliates (solely with respect to, and to the extent related to, the Business) has received any written notice or other written or, to the Knowledge of Seller, oral communication from any Governmental Authority or has paid or incurred any penalty or fine imposed by a Governmental Authority, in each case, regarding any actual or alleged violation of, or failure to comply with, Applicable Law in connection with the Business (other than actual or alleged violations which have been resolved).

(b) Except as set forth in Section 3.09(b) of the Seller Disclosure Schedule, as of the date hereof, all material deficiencies or violations with respect to the Business in all reports of examinations of the affairs of the Ceding Company or AHLIC (including financial, market conduct and similar examinations) issued by any Insurance Regulator to the Ceding Company or AHLIC for any period ending on or after December 31, 2014, have been resolved to the reasonable satisfaction of the Insurance Regulator that noted such deficiencies or violations.

(c) Except as set forth in Section 3.09(c) of the Seller Disclosure Schedule, as of the date hereof, there are no Governmental Orders in effect against or involving Seller or any of its Affiliates under which Seller or any of its Affiliates has any continuing obligation relating to the Business and none of Seller or any of its Affiliates (solely with respect to, and to the extent related to, the Business) is a party to any material contract with any Governmental Authority (other than any Group Contract with respect to which a Governmental Authority is a policyholder or contractholder) in each case to the extent relating to the Business.

(d) Except as set forth in Section 3.09(d) of the Seller Disclosure Schedule, since December 31, 2014, Seller or an Affiliate thereof has filed all material reports, statements, documents, registrations, filings or submissions required to be filed with any Governmental Authority (solely with respect to, and to the extent related to, the Business). All such registrations, filings and submissions were in compliance in all material respects with Applicable Law when filed or as amended or supplemented, and, as of the date hereof, no material deficiencies have been asserted by any Governmental Authority with respect to such registrations, filings or submissions that have not been satisfied.

Section 3.10. Employee Matters.

(a) Section 3.10(a) of the Seller Disclosure Schedule sets forth a list of all material written Employee Benefit Plans as of the date hereof and a description of any material Employee Benefit Plan that is not in written form.

(b) Section 3.10(b) of the Seller Disclosure Schedule sets forth a list of all Business Employee Benefit Plans as of the date hereof. As of the date hereof, there are no material claims or disputes pending, or to the Knowledge of Seller, threatened with respect to any Business Employee Benefit Plan, other than routine claims for benefits in the ordinary course of business.

(c) No Business Employee Benefit Plan and, except as set forth on Section 3.10(c) of the Seller Disclosure Schedule, none of the Employee Benefit Plans is subject to Title IV of ERISA and no Employee participates or is eligible to participate in an Employee Benefit Plan or Business Employee Benefit Plan that is subject to Title IV of ERISA. None of the Employee Benefit Plans or Business Employee Benefit Plans is a "multiemployer plan" (as defined in section 3(37) of ERISA) and no Employee participates or is eligible to participate in an Employee Benefit Plan or Business Employee Benefit Plan that is a multiemployer plan. Purchaser shall have no Liabilities in respect of any Employee Benefit Plan, except as expressly set forth in Section 6.01(j) below.

(d) No Business Employee Benefit Plan and, except as disclosed in Section 3.10(d) of the Disclosure Schedule, no Employee Benefit Plan provides medical, dental, or life insurance coverage or any other welfare benefits after termination of employment.

(e) Each Employee Benefit Plan (i) complies in form in all material respects with all requirements of Applicable Laws and has been administered in all material respects in accordance with its terms and all Applicable Laws, and (ii) is otherwise in compliance in all material respects with all Applicable Laws. Each Business Employee Benefit Plan (i) complies in form in all material respects with all requirements of Applicable Laws and has been

administered in all material respects in accordance with its terms and all Applicable Laws, and (ii) is otherwise in compliance in all material respects with all Applicable Laws. With respect to each Employee Benefit Plan that is intended to be qualified under Section 401(a) of the Code, such plan, and its related trust, has received a determination letter (or opinion letters in the case of any prototype plans) from the IRS that it is so qualified and that its trust is exempt from tax under Section 501(a) of the Code and, to the Knowledge of the Seller, no event has occurred which will or could reasonably be expected to cause any such Employee Benefit Plan to fail to comply with such requirements. Each Employee Benefit Plan and Business Employee Benefit Plan is either (i) exempt from Section 409A of the Code (" Section 409A") or (ii) has, in all material respects, been maintained and operated in documentary and operational compliance in accordance with Section 409A and the regulations and guidance issued thereunder.

(f) Except as set forth on Section 3.10(f) of the Seller Disclosure Schedule, neither consummation of the transactions contemplated by this Agreement nor this Agreement (whether separately or together with any other action) will accelerate the time of vesting or the time of payment, or increase the amount, of compensation due to any Employee. None of the payments contemplated by the Employee Benefit Plans or any Business Employee Benefit Plan to or with respect to Employees would, in the aggregate, constitute excess parachute payments (as defined in section 280G of the Code (without regard to subsection (b)(4) thereof)). As of the date hereof, each of Seller and its Affiliates is in compliance, in all material respects, with all Applicable Laws regarding employment, labor and wage and hour matters, disability, immigration, health and safety, harassment, non-discrimination in employment, workers' compensation, and unemployment compensation (solely with respect to, and to the extent related to, the Business). To the Knowledge of the Seller, each independent contractor and consultant, in each case, providing personal services to the Seller and its Affiliates (solely with respect to, and to the extent related to, the Business) has been properly classified as an independent contractor for purposes of and consistent with good faith interpretations of, all Applicable Laws, including Applicable Laws with respect to employee benefits, and to the Knowledge of the Seller, each Employee has been properly classified consistent with good faith interpretations under the Fair Labor Standards Act (solely with respect to, and to the extent related to, the Employees). The Seller and its Affiliates are not a party to, bound by or in the process of negotiating any collective bargaining agreement or similar labor-related contract (solely with respect to, and to the extent related to, the Business). As of the date hereof, no labor organization or group of current Employees has made a pending demand (solely with respect to, and to the extent related to, the Business) for recognition or certification, and there are no representation or certification proceedings or petitions seeking a representation proceeding presently pending or, to the Knowledge of the Seller, threatened to be brought or filed with the National Labor Relations Board or any other labor relations tribunal or authority (in each case solely with respect to, and to the extent related to, the Business). To the Knowledge of the Seller, as of the date hereof, there are no material organizing activities, strikes, work stoppages, slowdowns, lockouts, arbitrations or grievances, or other material labor disputes, pending or threatened against or involving any Employees (solely with respect to, and to the extent related to, the Business).

(g) Each Employee Benefit Plan that is a "group health plan" as defined in Section 733(a)(1) of ERISA (a " Health Plan") (i) is currently in compliance in all material respects with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (" PPACA"), the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (" HCERA"), and the

regulations and guidance issued thereunder (collectively, with PPACA and HCERA, the "Healthcare Reform Laws"), and (ii) has been in compliance in all material respects with all applicable Healthcare Reform Laws since January 1, 2015.

(h) Neither Seller nor any of its Affiliates is a party to any employment agreement with any Employee, other than retention agreements that are listed in Section 3.06(a)(iv) of the Disclosure Schedule and offer letters.

(i) Section 3.10(i) of the Seller Disclosure Schedule sets forth a list of all individual independent contractors providing personal services to the Business as of the date hereof.

(j) Except as set forth on Section 3.10(j) of the Seller Disclosure Schedule, none of the Employees is a foreign national is in the United States pursuant to a United States H1-B visa or similar employer-sponsored work permit.

(k) Seller has performed a criminal background check on each Employee in a reasonable manner consistent with prudent hiring practices. Seller requires each Employee to annually complete an attestation regarding criminal conduct. To the Knowledge of Seller, none of the Employees are disqualified from performing services for the Business by reason of a criminal conviction.

Section 3.11. Permits.

(a) (i) The Ceding Company and AHLIC holds all Permits from all Insurance Regulators that are necessary for the current operation and conduct of the Business; and (ii) each of Seller and its Affiliates (solely with respect to, and to the extent related to, the Business) holds all other material Permits from all other Governmental Authorities that are necessary for the current operation and conduct of the Business and to own or use its assets and properties to the extent relating to the Business (collectively, the " Operating Permits"), except where the failure to hold an Operating Permit would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. Except as would not be reasonably likely to have a Material Adverse Effect, all such Operating Permits are valid and in full force and effect in accordance with their terms. Each of the Ceding Company and AHLIC is, and since December 31, 2014 has been, in compliance in all material respects with all such Operating Permits.

(b) As of the date hereof, since December 31, 2014, Seller and its Affiliates have not received any written notice, or, to the Knowledge of Seller, oral communication from any Governmental Authority regarding any actual, alleged, or potential material violation of, or failure to comply with, the terms or requirements of any such Operating Permit (solely with respect to, and to the extent related to, the Business). As of the date hereof, none of Seller or any of its Affiliates is the subject of any pending or, to the Knowledge of Seller, threatened action seeking the revocation, withdrawal, suspension, termination, cancellation, nonrenewal, modification or impairment of any such Operating Permit (solely with respect to, and to the extent related to, the Business).

Section 3.12. Intellectual Property.

(a) Section 3.12(a) of the Seller Disclosure Schedule sets forth, as of the date hereof, a true, complete and correct list of (i) all Transferred Intellectual Property that is Registered, indicating for each item: (A) the current owner; (B) the jurisdiction where the application or registration is located; and (C) the application or registration number, and (ii) proprietary Software and material unregistered Trademarks that are Transferred Intellectual Property.

(b) Seller or an Affiliate thereof are the exclusive owners of the Transferred Intellectual Property free and clear of all Liens other than Permitted Liens. As of the Closing Date, Purchaser or its designee will be the exclusive owners of the Transferred Intellectual Property, free and clear of all Liens other than Permitted Liens.

(c) Except as set forth in Section 3.12(c) of the Seller Disclosure Schedule (i) to the Knowledge of Seller, the operation of the Business has not been and is not infringing, violating or misappropriating the Intellectual Property of any third party, (ii) no third party has asserted in a writing received by Seller or any of its Affiliates, or to the Knowledge of Seller asserted orally, that its conduct of the Business has infringed, violated or misappropriated the Intellectual Property of any third party and there are no such claims pending or, to the Knowledge of Seller , threatened, (iii) and, to the Knowledge of Seller, as of the date hereof, no third party has infringed, violated or misappropriated or is now infringing, violating or misappropriating any Transferred Intellectual Property. Notwithstanding anything to the contrary set forth in this Agreement, this Section 3.12(c) contains all of the representations and warranties provided by Seller with respect to the non-infringement, non-violation and non-misappropriation of Intellectual Property.

(d) Seller and its Affiliates have taken commercially reasonable actions to maintain the enforceability of the Transferred Intellectual Property under all Applicable Law (including (i) making and maintaining in full force and effect all necessary filings, registrations and issuances and (ii) maintaining the secrecy of all Trade Secrets).

(e) Seller has maintained and currently maintains complete source code for all current and the immediately prior (i.e., n-1) versions and releases of all Software developed by or for Seller and included within the Transferred Intellectual Property (" Developed Software"). All Developed Software is designed and documented in a reasonable manner, consistent with accepted industry practices. Except as would not be material to the Business, no Developed Software contains any viruses, worms, back doors, spyware, adware, malware, time-bombs or key-locks (as such terms are commonly understood in the software industry).

(f) Except as set forth on Section 3.12(f) of the Seller Disclosure Schedule, no Transferred Intellectual Property that is Software contains any Open Source Software, including any software governed by an "open source" license that may (i) require, as a condition to the use of such Software, that Seller disclose, license or distribute to third parties any of the source code for such Software, (ii) requires derivative works of such Software to be licensed under the same "open source" license as the original work or otherwise requires its licensing thereof for the purpose of making derivative works, (iii) imposes any restriction on the consideration to be charged for the distribution of such Software, or (iv) creates, or purports to create, obligations for

Seller with respect to the Intellectual Property rights owned by Seller or grants, or purports to grant, to any third party any rights or immunities under Intellectual Property rights owned by Seller.

Section 3.13. Insurance Business.

(a) Except as set forth in Section 3.13 of the Seller Disclosure Schedule, since December 31, 2014 any application, form of insurance policy, certificates of insurance, riders, endorsements, advertising material, rate, rule or producer compensation utilized by the Seller and its Affiliates (solely with respect to, and to the extent related to, the Business), the use or issuance of which requires filing or approval, has been appropriately filed, and, if required, approved by the Insurance Regulator of any state in which such application forms, forms of insurance policies, advertising materials and rates and rules are required to be filed and (as applicable) approved or not objected to by such authorities within the period provided for approval or objection, except for failures to effect such filings or secure such approvals, which would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. All such application forms, forms of insurance policies, advertising materials and rates or rules are utilized in compliance in all material respects with all Applicable Laws and within the scope of the approvals (if any) received with respect thereto. No material deficiencies have been asserted by any Governmental Authority with respect to any such filings or compliance with the filings or approvals issued by the Insurance Regulators which have not been cured or otherwise resolved.

(b) The underwriting standards and ratings applied by the Ceding Company since such date with respect to Group Contracts have conformed in all material respects to those contained in the underwriting manuals utilized by the Ceding Company, as in effect at the times such Group Contracts were underwritten.

(c) Since December 31, 2014, Seller and any applicable Affiliates have timely paid in all material respects all guaranty fund assessments that have been due, claimed or asserted by, or are the subject of any voluntary contribution commitment to, any state guaranty fund or association or any Insurance Regulator in any jurisdiction in which Seller or any applicable Affiliate operates the Business arising out of or resulting from such operation of the Business by Seller and its Affiliates. Except for regular periodic assessments in the ordinary course of business or assessments based on developments that are publicly known within the insurance industry, no material claim or assessment is pending or, to the Knowledge of Seller, threatened against Seller or any Affiliate with respect to the Business by any state insurance guaranty association in connection with such association's fund relating to insolvent insurers.

(d) The Business does not include (i) any policies issued to a plan sponsor located outside the United States and its territories, or (ii) any policies issued to plan sponsors located in the United States to cover primarily employees located outside the United States.

Section 3.14. Producers; Sale Practices.

(a) Except as set forth in Section 3.14(a) of the Seller Disclosure Schedule, to the Knowledge of Seller, from December 31, 2014 to the date hereof, each Producer, at any time that

it wrote, sold or produced Group Insurance Contracts for Seller or any of its Affiliates, was duly licensed, authorized and appointed (for the Group Insurance Contract written, sold or produced by such Producer) in the particular jurisdiction in which such Producer wrote, sold or produced such Group Insurance Contract and, to the Knowledge of Seller, from December 31, 2014 to the date hereof, no such Producer violated any term or provision of Applicable Law relating to the writing, sale or production of Group Insurance Contracts, in each case except as would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

(b) Except as set forth in Section 3.14(b) of the Seller Disclosure Schedule, since December 31, 2014, none of Seller or the Ceding Company has received any written notice or communication from any Governmental Authority that a Producer is in material violation of any Applicable Law applicable to the writing, sale, production or marketing of any Group Insurance Contract.

Section 3.15. Real Property. The Transferred Assets do not include any real property other than the real property that is leased pursuant to the Assigned Lease. Section 3.15 of the Seller Disclosure Schedule lists, as of the date hereof, all real property, including the real property located at 222 SW Columbia Street, Portland, Oregon (the " Portland Location"), (a) which are owned by Seller or an Affiliate of Seller or (b) in which Seller or an Affiliate of Seller has a leasehold interest and, in each case, in which Seller intends will be occupied by Purchaser or an Affiliate thereof from and after the day immediately following the expiration or termination of the Employee Lease Term (such leases in subclause (b) of this Section 3.15 (but expressly excluding the Assigned Lease) are collectively referred to as the " Non-Assigned Leases" ; together with the Assigned Lease, collectively, the " Leases"). True and complete copies in all material respects of each of the Leases, including in each case all amendments and addenda thereto, have been made available to Purchaser on the Project DeLorean Intralinks site or by email prior to the date hereof. Seller or an Affiliate thereof has a valid and enforceable leasehold interest under the Leases, subject to Permitted Liens and to the Enforceability Exceptions and neither Seller nor any such Affiliate has received any written notice of any default under the Leases, and, to the Knowledge of Seller, no event has occurred and no condition exists that, with notice or lapse of time or both, would constitute a default by Seller or any such Affiliate under the Leases, except, in each case, for such invalidity, unenforceability or defaults that, individually or in the aggregate, would not reasonably be expected to have a Material Adverse Effect.

Section 3.16. Ceded Reinsurance Contracts.

(a) Section 3.16(a) of the Seller Disclosure Schedule lists each reinsurance agreement to which the Ceding Company or AHLIC is a party and under which the Ceding Company or AHLIC reinsured or retroceded risk under any of the Group Insurance Contracts that were in effect as of the date hereof (the " Ceded Reinsurance Contracts").

(b) Each of the Ceded Reinsurance Contracts constitutes a valid and binding obligation of the Ceding Company or AHLIC and, to the Knowledge of Seller, each other party thereto, enforceable against the Ceding Company or AHLIC and, to the Knowledge of Seller, each other party thereto in accordance with its terms, subject to the Enforceability Exceptions. Except as set forth in Section 3.16(b) of the Seller Disclosure Schedule, as of the date hereof,

neither the Ceding Company nor AHLIC has delivered notice or received written or, to the Knowledge of Seller, oral notice of early termination of any such Ceded Reinsurance Contract. There exists no material breach or event of default with respect to any Ceded Reinsurance Contract on the part of the Ceding Company or AHLIC or, to the Knowledge of Seller, as of the date hereof, any other party thereto, in each case that would, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

(c) Since December 31, 2014, there has not been any dispute with respect to any material amounts recoverable or payable by the Ceding Company pursuant to any Ceded Reinsurance Contract. All amounts owed under any Ceded Reinsurance Contracts have been timely paid in accordance with their terms.

Section 3.17. Tax.

(a) There are no outstanding audits or other administrative or judicial actions by any Governmental Authority with regard to, or related to, the Tax treatment of the Business or the Transferred Assets, nor to the Knowledge of Seller, as of the date hereof, is any such audit or other administrative or judicial action pending or threatened.

(b) Seller and its Affiliates have timely paid all material Taxes which will have been required to be paid on or prior to the date hereof in respect of the Business or the ownership of the Transferred Assets.

(c) All material Taxes required to have been withheld, collected or remitted with respect to the Business or the Transferred Assets have been withheld, collected or remitted, as applicable, to the applicable Governmental Authority in accordance with Applicable Law.

(d) Seller and its Affiliates have materially complied with all Tax reporting, withholding, and disclosure requirements applicable to the Ceded Insurance Contracts under the Code, Treasury Regulations, and forms issued by the Internal Revenue Service and under any corresponding or similar provision of state or local law.

(e) Seller and its Affiliates have duly and timely (including any applicable extensions) filed all material Tax Returns required to have been filed by them in respect of the Business or the ownership of the Transferred Assets, and all such Tax Returns are accurate and complete in all material respects as they relate to the Business or the Transferred Assets.

(f) All material deficiencies asserted in writing or assessments made in writing with respect to the Business or the ownership of the Transferred Assets by a Tax authority have been paid in full, except to the extent they are being contested in good faith through appropriate proceedings.

(g) There are no material Liens for Taxes (other than Permitted Liens) upon the Transferred Assets.

(h) Seller and each of its Affiliates are not and have not been a party to any “reportable transaction” within the meaning of Treasury Regulation Section 1.6011-4 with respect to the Business or the Transferred Assets.

(i) There is no written claim pending from any Tax authority in any jurisdiction where the Seller does not file Tax Returns in respect of the Business that the Business is or may be subject to taxation by that jurisdiction.

(j) The reserves reflected with respect to the Ceded Insurance Contracts on the consolidated federal income Tax Return filed by the affiliated group of which Seller is a member for the year ending December 31, 2014, and since such date, have been determined in all material respects in the manner required by the Code and other Applicable Law, and to the extent relevant to the determination and maintenance thereof, have been determined and maintained in all material respects in accordance with SAP.

(k) The Tax treatment of each Ceded Insurance Contract is not, and, since the time of issuance, has not been, materially less favorable to the purchaser, policyholder or intended beneficiaries thereof, than the Tax treatment and purported to qualify for at the time of issuance.

Section 3.18. Financial Statements; Books and Records.

(a) Seller has previously delivered to Purchaser true, correct and complete copies of (i) the audited annual statutory financial statements of each of the Ceding Company and AHLIC, together with the report of each such company's independent auditors thereon, as of and for the years ended December 31, 2015 and December 31, 2016 and (ii) the unaudited statutory financial statements of each of the Ceding Company and AHLIC as of and for the quarter ended June 30, 2017 (collectively, the " Statutory Statements"), in each case, as filed with the Insurance Regulator of such entity's jurisdiction of domicile. The Statutory Statements were prepared in accordance with applicable SAP consistently applied throughout all such periods and, except as set forth in Section 3.18(a) of the Seller Disclosure Schedule, fairly present in all material respects the financial position, admitted assets, liabilities, capital, and surplus of the Ceding Company and AHLIC (as applicable) at December 31, 2015, December 31, 2016 and June 30, 2017, and the results of operations, changes in surplus, and cash flows of the Ceding Company and AHLIC (as applicable) for the periods covered thereby, subject, in the case of the quarterly Statutory Statements as of and for the quarter ended June 30, 2017, to normal yearend adjustments and the absence of full footnote disclosures and other presentation items. Section 3.18(a) of the Seller Disclosure Schedule sets forth a complete list of all permitted practices used by each such company in the preparation of the Statutory Statements.

(b) The reserves, including incurred but not reported (IBNR), for payment of benefits, losses, claims, expenses, and other similar purposes (including claims litigation) with respect to the Group Contracts reflected in the Statutory Statements, the Reference Closing Statement, and the Pro Forma Financial Statements, as of their respective dates: (a) were computed in all material respects in accordance with generally accepted actuarial standards, consistently applied and developed by the Ceding Company applying consistent practices, assumptions and methodologies used as of their respective dates; (b) met the requirements of SAP and other Applicable Law; and (c) were based on actuarial information and data and inventories and policies and contracts that were accurate in all material respects; provided that this Section 3.18(b) shall not be deemed to be a representation or warranty of Seller that the reserves of the Ceding Company or AHLIC (to the extent relating to the Business) are or will be adequate or sufficient for the purposes for which they were established.

(c) Seller has previously delivered to Purchaser a true, correct and complete copy of the unaudited pro forma balance sheets of the Business as of December 31, 2015 and December 31, 2016 and an unaudited pro forma statement of profits and losses for the annual period ended December 31, 2016 (" Pro Forma Financial Statements"). The Pro Forma Financial Statements were prepared in good faith from the Books and Records using methodologies, estimates and adjustments to give effect to assumptions that provide a reasonable basis for presenting the financial position, direct profits and direct losses of the Business in accordance with GAAP, applied consistently with the historical practices of Seller, as of December 31, 2015 and December 31, 2016.

(d) The Reference Closing Statement was prepared in accordance with the Transaction Accounting Principles and fairly presents, in all material respects in accordance with the Transaction Accounting Principles, the assets and liabilities of the Business as of the Reference Date.

(e) The Books and Records (i) have been maintained in all material respects in accordance with Applicable Law and (ii) are in material compliance with any and all record keeping maintenance requirements in applicable Group Contracts. No Board Materials relating to the Business exist except those certain Board Materials identified and made available by Seller for inspection and review by Purchaser prior to the date hereof.

(f) Seller and the Ceding Company maintain a system of internal control over financial reporting sufficient to provide reasonable assurance regarding the reliability of the financial reporting of the Ceding Company with respect to the Business and the preparation of financial statements for external purposes in accordance with GAAP, applied consistently with the historical practices of Seller, or SAP, as applicable. There are no material weaknesses or significant deficiencies in the internal controls over financial reporting of Seller or the Ceding Company with respect to the Business.

Section 3.19. Specified Portfolio.

(a) During the period from the Reference Date to the date hereof, (i) no Investment Assets that were in the Specified Portfolio as of the Reference Date have been sold except: (A) sales of Investment Assets that were determined by Seller (in accordance with SAP and Seller's and its Affiliates' past practices), to have become, or to be reasonably likely to become, impaired, all of which sales are set forth on Section 3.19(a)(i)(A) of the Seller Disclosure Schedule; and (B) sales of Investment Assets set forth in Section 3.19(a)(i)(B) of the Seller Disclosure Schedule, which collectively did not exceed the Discretionary Turnover Allowance; and (ii) all additions to the Specified Portfolio were made in accordance with the Pre-Closing Investment Guidelines.

(b) Section 3.19(b)(i) of the Seller Disclosure Schedule sets forth, as of the date hereof, the Capital Gain or Loss Adjustments for each of the sales of Investment Assets set forth in Section 3.19(a)(i)(B) of the Seller Disclosure Schedule. Section 3.19(b)(ii) of the Seller Disclosure Schedule sets forth a list of each of the Reallocated Investment Assets that were added to the Specified Portfolio between the Reference Date and the date of this Agreement, and the Reallocated Asset Value Adjustments, if any, that were required with respect to such

Reallocated Investment Assets during such period. The representations and warranties in this Section 3.19 have been made assuming, for this purpose, that the terms of Section 5.11 (other than the definition of "Selection Waterfall" included therein) applied with respect to the period between the Reference Date and the date of this Agreement.

Section 3.20. No Undisclosed Liabilities. The Business has no Liabilities required to be disclosed or reserved for on a balance sheet of the Ceding Company prepared in accordance with applicable SAP, except (i) Liabilities set forth in Section 3.20 of the Seller Disclosure Schedule, (ii) Liabilities disclosed or reserved for in the Statutory Statements and (iii) Liabilities that (x) were incurred after December 31, 2016 in the ordinary course of business consistent with past practice and (y) have not had and would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

Section 3.21. Actuarial Report. Seller has delivered to Purchaser true, complete and correct copies of the actuarial report, dated as of June 7, 2017 (as adjusted by a memorandum dated August 28, 2017) prepared by Milliman Inc. (" Milliman") with respect to the Business as of December 16, 2016 (the " Actuarial Report"). The information and factual data furnished by Seller and its Affiliates in writing to Milliman with respect to the Business in connection with the preparation of the Actuarial Report (and any supplements or addenda thereto) were (a) obtained from the Books and Records, (b) generated from the same underlying sources and systems that were utilized by Seller or its applicable Affiliates to prepare the Pro Forma Statements to the extent applicable and (c) to the Knowledge of Seller, did not include any material Data Input Inaccuracies. As of the date hereof, Milliman has not issued to Seller or its Affiliates any new or revised report with respect to the Business or any errata with respect to the Actuarial Report nor has it notified Seller or any of its Affiliates that the Actuarial Report is inaccurate in any material respect.

Section 3.22. Absence of Certain Changes or Events. Except as expressly contemplated or required by this Agreement or as set forth in Section 3.22 of the Seller Disclosure Schedule, since December 31, 2016 (a) Seller and its Affiliates have operated and conducted the Business in all material respects in the ordinary course of business; (b) there has not been any event, occurrence, condition or change that has had, or would reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect; and (c) neither Seller nor any of its Affiliates has taken any action or failed to take any action that, if taken or failed to have been taken after the date hereof, would violate Section 5.01.

Section 3.23. Brokers and Finders. Except for Barclays Capital Inc. and one or more of its Affiliates, whose fees will be paid by Seller, no broker, investment banker, financial adviser or other person is entitled to any broker's, finder's, financial adviser's or other similar fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of Seller or any of its Affiliates.

Section 3.24. Data Protection and Privacy; IT Systems.

(a) Since December 31, 2014, Seller and its Affiliates with respect to the Business have been and are in compliance in all material respects with any and all contractual requirements, including applicable terms of use and privacy policies, pertaining to the protection,

privacy, security, collection, storage, use, disclosure, disposal, maintenance and transmission of Personal Data.

(b Since December 31, 2014, to the Knowledge of Seller, none of Seller and its Affiliates, or any third Person working on behalf of any of them, has experienced an incident of unauthorized access, disclosure, use, destruction or loss of any Personal Data that Seller or its Affiliates (or a third Person on behalf of any of them) collects, stores, uses or transmits in the conduct of the Business that required the delivery of notice to affected individuals pursuant to Privacy and Data Security Laws.

(c) Section 3.24(c) of the Seller Disclosure Schedule identifies (i) all IT Systems that are included in the Transferred Assets and (ii) all Vendors that provide "cloud", support, hosting, servicing, interfacing, connectivity, security, and redundancy services to the Business. All IT Systems that are included in the Transferred Assets or access to which will be provided pursuant to the Transition Services Agreement (x) are in good repair and operating condition and in all material respects adequate and suitable for the purposes for which they are being used or held for use, and (y) have not, since December 31, 2014, experienced bugs, failures, breakdowns, unauthorized access or use, or substandard performance, malfunction or failure of any unplanned downtime that caused any material disruption or interruption in or to the operation of the Business, and (z) to the Knowledge of Seller, do not contain any "malware" that would reasonably be expected to interfere with the ability of the Purchaser to conduct the Business. Seller and its Affiliates have implemented, currently maintain, and comply with commercially reasonable business continuity and backup and disaster recovery plans and procedures with respect to the IT Systems that are included in the Transferred Assets or access to which will be provided pursuant to the Transition Services Agreement.

Section 3.25. Distribution of Group Insurance Contracts.

(a) Seller hereby represents and warrants that (a) the Service Standards which are attached to the Distribution Agreement as Exhibit A are based upon and are consistent in all material respect with the Ceding Company's service standards generally applicable on an individual plan basis to specified services provided to plans in connection with large Group Insurance Contracts, except (i) as modified to reflect that the Service Standards are applicable to specified categories of Group Insurance Contracts in the aggregate, rather than on an individual plan basis; or (ii) as expressly agreed by the Parties to apply solely to Group Insurance Contracts administered on Purchaser's systems; and (b) since December 31, 2015 all Group Insurance Contracts issued by Seller or its Affiliates, in the aggregate, have been administered in material compliance with the service standards upon which such Service Standards are based.

(b) Seller hereby represents and warrants that Seller and its Affiliates calculated the compensation payable by Seller or its Affiliates to the Sales Force (as such term is defined in the Form of Distribution Agreement) in respect of the distribution of Group Insurance Contracts during the calendar year 2017 in a manner consistent with the terms of Exhibit D to the attached Form of Distribution Agreement, except in such instances as would not, individually or in the aggregate, have a material adverse impact on the Business.

Section 3.26. Administration of the Subject Contracts. The Service Standards that are attached to the form of Administrative Services Agreement as Exhibit II are based upon and are consistent in all material respects with the Ceding Company's service standards generally applicable on an individual plan basis to specified services provided to plans in connection with the Subject Contracts (as such term is defined in the form of Administrative Services Agreement attached hereto as Exhibit D). Since December 31, 2015, Seller and its Affiliates in the aggregate have administered the Subject Contracts in material compliance with the service standards upon which such Service Standards are based. In addition, since December 31, 2015, Seller and its Affiliates have administered the Subject Contracts in material compliance with all agreements with customers who purchased the Subject Contracts, including requirements to maintain the administration of the Subject Contracts in the United States.

ARTICLE IV.

REPRESENTATIONS AND WARRANTIES OF PURCHASER

Except as set forth in the corresponding sections or subsections of the disclosure schedule delivered to Seller by Purchaser concurrently with the execution and delivery of this Agreement (the " Purchaser Disclosure Schedule") (it being understood and agreed by the parties hereto that disclosure of any item in any section or subsection of the Purchaser Disclosure Schedule shall be deemed disclosure with respect to any other section or subsection of the Purchaser Disclosure Schedule to which the relevance of such item is reasonably apparent, notwithstanding the omission of a reference or cross-reference thereto), Purchaser hereby makes the following representations and warranties to Seller, as of the date hereof and as of the Closing Date as follows:

Section 4.01. Organization, Standing. Purchaser is an insurance company duly incorporated, validly existing and in good standing under the laws of Connecticut.

Section 4.02. Authorization. Purchaser or the applicable Affiliate of Purchaser (as applicable) has all requisite corporate or other applicable organizational power to enter into, consummate the transactions contemplated by and carry out its obligations under, each of the Transaction Agreements to which it is or is contemplated to become a party. The execution and delivery by Purchaser or the applicable Affiliate of Purchaser (as applicable) of each of the Transaction Agreements to which it is or is contemplated to become a party and the consummation by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the transactions contemplated by each of the Transaction Agreements to which it is or is contemplated to become a party have been duly authorized by all requisite corporate or other similar organizational action on the part of Purchaser or the applicable Affiliate of Purchaser (as applicable). Each of the Transaction Agreements to which Purchaser or the applicable Affiliate of Purchaser (as applicable) is or is contemplated to become a party has been, or upon execution and delivery thereof will be, duly executed and delivered by Purchaser or the applicable Affiliate of Purchaser (as applicable). Assuming due authorization, execution and delivery by the other parties hereto or thereto, each of the Transaction Agreements to which Purchaser or the applicable Affiliate of Purchaser (as applicable) is or is contemplated to become a party constitutes, or upon execution and delivery thereof will constitute, the legal, valid and binding

obligation of Purchaser or the applicable Affiliate of Purchaser (as applicable), enforceable against it in accordance with its terms, subject in each case to the Enforceability Exceptions.

Section 4.03. No Conflict or Violation. Provided that all consents, approvals, authorizations and other actions described in Section 4.04 have been obtained or taken, the execution and delivery by Purchaser or the applicable Affiliate of Purchaser (as applicable) of, and the consummation by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the transactions contemplated by, the Transaction Agreements to which Purchaser or the applicable Affiliate of Purchaser (as applicable) is or is contemplated to become a party do not and will not (a) violate or conflict with the organizational documents of Purchaser or the applicable Affiliate of Purchaser (as applicable), (b) subject to the Governmental Approvals referred to in Section 4.04 , conflict with or violate any Applicable Law or Governmental Order applicable to Purchaser or the applicable Affiliate of Purchaser (as applicable) or by which any of them or any of their respective properties, assets or rights is bound or subject to, (c) result in any breach of, or constitute a default (or event which, with the giving of notice or lapse of time or both, would constitute a default) under, or give to any Person any rights of termination, acceleration or cancellation of or result in the creation of any Lien (other than Permitted Liens) on any of the assets, properties or rights of Purchaser or any of its Affiliates pursuant to, any contract or any note, bond, loan or credit agreement, mortgage or indenture to which Purchaser or any of its Affiliates is a party or by which any of them or any of their respective properties or assets is bound or subject, or (d) result in a breach or violation of any of the terms or conditions of, result in a default under, or otherwise cause an impairment or revocation of, any material Permit of Purchaser or its Affiliates; except, in the case of clauses (b), (c) and (d) of this Section 4.03 , for any such conflicts, violations, breaches, defaults, terminations, accelerations, cancellations or creations that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.04. Consents and Approvals. The execution and delivery by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the Transaction Agreements to which it is or is contemplated to become a party do not, and the consummation by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the transactions contemplated by the Transaction Agreements to which it is or is contemplated to become a party will not, require any Governmental Approval to be obtained or made by or with respect to Purchaser or the applicable Affiliate of Purchaser (as applicable), except for any Governmental Approvals the failure to obtain or make which, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.05. Absence of Litigation. There are no Actions pending or, to the Knowledge of Purchaser, threatened in writing against Purchaser or any of its Affiliates or any of their respective assets, properties or businesses that (i) question the legality of the transactions contemplated by any of the Transaction Agreements or (ii) as of the date hereof, individually or in the aggregate, would reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.06. Compliance With Laws.

(a) Purchaser and its Affiliates are not in violation of any Applicable Laws (including any Applicable Laws regulating the insurance business) or Governmental Orders applicable to

them or their respective assets, properties or businesses, except for violations that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

(b) All material deficiencies or violations with respect to the respective insurance businesses of Purchaser and its Affiliates that are party to any Transaction Agreement in all reports of examinations of the affairs of Purchaser or any such Affiliate with respect to such businesses (including financial, market conduct and similar examinations) issued by any Insurance Regulator for any period ending on a date on or after December 31, 2014, have been resolved to the reasonable satisfaction of the Insurance Regulator that noted such deficiencies or violations, except as would not reasonably be expected to have a Purchaser Material Adverse Effect.

(c) Neither Purchaser nor its Affiliates, nor any of their respective properties, assets or rights, is a party to, or bound by, any Governmental Order, except for those Governmental Orders that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

(d) Purchaser and each Affiliate of Purchaser that is party to a Transaction Agreement has filed all reports, statements, documents, registrations, filings or submissions required to be filed by Purchaser or such Affiliate with any Governmental Authority to the extent they relate to their respective insurance businesses, except for any failures to file that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect. All such registrations, filings and submissions were in compliance in all material respects with Applicable Law when filed or as amended or supplemented, and no deficiencies have been asserted by any Governmental Authority with respect to such registrations, filings or submissions that have not been satisfied, except for any non-compliance or failures to file that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.07. Financial Ability.

(a) Purchaser has, and will have at the Closing, all funds necessary to: (i) pay all amounts required to be paid or deposited by Purchaser and its Affiliates pursuant to Article II; and (ii) consummate the transactions contemplated by this Agreement and the other Transaction Agreements.

(b) Purchaser has previously delivered to Seller copies of (i) the audited annual statutory financial statements of Purchaser as of and for the years ended December 31, 2015 and December 31, 2016 and (ii) the unaudited interim statutory financial statements of the Purchaser as of and for the six-month period ending June 30, 2017. The foregoing statutory financial statements were prepared in all material respects in accordance with SAP and fairly present, in all material respects in accordance therewith, the admitted assets, liabilities and capital and surplus of Purchaser at their respective dates and the results of operations, changes in surplus and cash flows of Purchaser at and for the periods indicated, subject, in the case of the financial statements referenced in clause (ii) above, to normal year-end adjustments.

Section 4.08. Permits.

(a) Purchaser and each of its Affiliates executing any Transaction Agreement holds, or as of the Closing Date will hold, all registrations, filings, licenses, permits, approvals or authorizations issued or granted by Governmental Authorities that are necessary to consummate the transactions contemplated by the Reinsurance Agreement, for the current operation and conduct of the Business and to own or use its assets and properties to the extent relating to the Business (collectively, the " Purchaser Permits") except for such failure to hold Purchaser Permits as would not reasonably be expected to have, individually or in the aggregate, a Purchaser Material Adverse Effect.

(b) Since December 31, 2014, none of Purchaser or any of its Affiliates executing any Transaction Agreement has received any written notice or communication from any Governmental Authority regarding any actual, alleged, or potential violation of, or failure to comply with, the terms or requirements of any such Purchaser Permit, except as would not reasonably be expected to have, individually or in the aggregate, a Purchaser Material Adverse Effect. As of the date hereof, none of Purchaser or any of its Affiliates executing any Transaction Agreement is the subject of any pending or, to the Knowledge of Purchaser, threatened action seeking the revocation, withdrawal, suspension, termination, cancellation, nonrenewal, modification or impairment of any such Purchaser Permit except as would not reasonably be expected to have, individually or in the aggregate, a Purchaser Material Adverse Effect.

Section 4.09. Brokers and Finders. Except for Merrill Lynch, Pierce, Fenner & Smith Inc., whose fees will be paid by Purchaser, no broker, investment banker, financial adviser or other person is entitled to any broker's, finder's, financial adviser's or other similar fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of Purchaser or any of its Affiliates.

Section 4.10. Absence of Triggering Event. As of the date hereof and assuming, for this purpose, that the Reinsurance Agreement became effective immediately prior to the date hereof, to the Knowledge of Purchaser, no Triggering Event (as defined in the Reinsurance Agreement) shall have occurred thereunder.

ARTICLE V.

COVENANTS

Section 5.01. Conduct of Business. Between the date hereof and the Closing Date, and, with respect to Section 5.01(c)-(h) , between the date hereof and the end of the Employee Lease Term, subject to the terms of the Employee Leasing Agreement, except (a) as required under any Applicable Law, (b) as otherwise contemplated by or necessary to effectuate the Transaction Agreements (including compliance with Sections 5.06(a) and 5.11), (c) for matters identified in Section 5.01 of the Seller Disclosure Schedule or (d) with the consent of Purchaser (which consent may not be unreasonably withheld, delayed or conditioned), Seller shall, and shall cause its Affiliates to, in each case solely with respect to, and to the extent relating to, the Business, use commercially reasonable efforts to (x) conduct the Business in the ordinary course of business,

(y) maintain current significant business relationships and goodwill with policyholders, customers, suppliers and service providers of and to the Business, and with the Governmental Authorities with jurisdiction over the Business, and (z) not do any of the following:

(a) other than in the ordinary course of business and other than with respect to Investment Assets, sell, voluntarily terminate, transfer, assign, lease, sublease, license or otherwise dispose of any Transferred Assets;

(b) sell, terminate, transfer or otherwise dispose of any of the cash or Investment Assets in the Specified Portfolio other than as contemplated by Section 5.11;

(c) increase the base salary (or wages), target cash incentive compensation opportunity, benefits (including severance benefits) paid or payable to any Employee, except for annual salary or wage adjustment increases in the ordinary course of business and consistent with increases applicable to similarly situated employees of the Seller and its Affiliates or as required by the terms of any Employee Benefit Plan in existence as of the date hereof;

(d) (A) establish or adopt, enter into, change, terminate, or amend in any material respect any Employee Benefit Plan or any retention or severance agreement with respect to any Employee, (B) take any action to accelerate any material rights or benefits under any Employee Benefit Plan with respect to any Employee (except to the extent required as of the date hereof by any such plan), or (C) grant any new equity or equity-based awards to any Employee;

(e) establish, adopt, enter into, change or amend any Business Employee Benefit Plan or take any action to accelerate any material rights or benefits under any Business Employee Benefit Plan;

(f) hire or engage any Employee or independent contractor providing personal services with respect to the Business, in each case, who will earn annual base salary in excess of $150,000;

(g) terminate, other than for cause, the employment or engagement of any Employee or independent contractor providing personal services with respect to the Business;

(h) transfer or reallocate, or permit the transfer or reallocation of, the employment or services of any employee or independent contractor providing personal services to Seller or its Affiliates into or out of the Business;

(i) enter into, amend in any material respect, waive any rights under, or assign or transfer any Assigned Contract or Material Contract;

(j) make any material change in the accounting, actuarial, investment, reserving, underwriting or claims administration policies, practices, or principles of (and solely to the extent relating to) the Business, except as may be required by GAAP, SAP, Applicable Law or internal accounting policies existing as at December 31, 2016;

(k) make or change any material Tax election in respect of the Business, adopt or materially change any accounting method in respect of the Business, file any material amended

Tax Return in respect of the Business, or materially modify the method by which Seller and its Affiliates determine reserves with respect to the Ceded Insurance Contracts;

(l) voluntarily grant any Lien (other than Permitted Liens) on any Transferred Assets;

(m) abandon, modify, waive, terminate or allow to lapse any material Permit of Seller or the Ceding Company to the extent relating to the Business; or

(n) enter into a binding agreement to take any of the foregoing actions.

Section 5.02. Pre-Closing Access to Information.

(a) Between the date of this Agreement and the Closing Date, subject to Applicable Law and subject to the rules applicable to visitors at Seller's offices generally, Seller shall afford to Purchaser and its Representatives reasonable access, upon reasonable advance notice and during normal business hours, to such contracts, documents and information of or relating to the assets, liabilities, business, operations and other aspects of the Business as Purchaser may reasonably request; provided , however , that Seller shall not be obligated to provide such access or information if Seller determines, in its reasonable judgment, that doing so would violate Applicable Law or a contract, agreement or obligation of confidentiality owing to a third party, jeopardize the protection of an attorney-client privilege, or expose Seller or any of its Affiliates to risk of liability for disclosure of sensitive or personal information; provided, further , that Seller shall not be obligated to provide such access to its offices if Seller determines, in its reasonable judgment, that such contracts, documents and information can be provided electronically or in another reasonably accessible location. Purchaser agrees that it will hold, and will cause its Representatives to hold, any information so obtained in confidence to the extent required by, and in accordance with, the provisions of the Confidentiality Agreement and Section 5.04. Notwithstanding anything to the contrary set forth herein, none of Seller, its Affiliates or their respective Representatives shall be required to disclose or provide access to Excluded Books and Records to Purchaser or, prior to the Closing Date, any of its Representatives or any information that Seller reasonably determines to be competitively sensitive.

(b) Without limiting the foregoing, from the date hereof until the Closing, Seller shall deliver to Purchaser complete copies of the audited or unaudited statutory financial statements of the Ceding Company, together with any notes, exhibits or schedules thereto, that are filed with the Insurance Regulator for the applicable company's jurisdiction of domicile between the date hereof and the Closing, as promptly as practicable after the filing of such statements with such Insurance Regulator.

Section 5.03. Post-Closing Access to Information.

(a) For a period of five years following the Closing Date, Seller shall: (i) allow Purchaser, upon reasonable prior notice and during normal business hours, through its Representatives, the right, at Purchaser's expense, to examine and make copies of any Excluded Books and Records which were retained by Seller or its Affiliates pursuant to this Section 5.03; and (ii) allow Purchaser to interview Seller's and its Affiliates' Representatives for any reasonable business purpose relating to the Business, including in connection with Seller's pre-

Closing employment of the Transferred Employees or Purchaser's preparation or examination of regulatory and statutory filings and financial statements and the conduct of any litigation relating to the Business (other than any litigation or dispute between Seller or its Affiliates, on the one hand, and Purchaser or its Affiliates, on the other hand), or the conduct of any regulatory authority, policyholder, reinsurer or other dispute resolution or any other Third Party Claim (whether or not such Third Party Claim is the subject of an indemnification claim by a Purchaser Indemnified Person or Seller Indemnified Person), whether pending or threatened; provided , however , that Seller shall not be obligated to provide such access to its offices if Seller determines, in its reasonable judgment, that such Excluded Books and Records can be provided electronically or in another reasonably accessible location. Access to such Representatives and Excluded Books and Records shall be at Purchaser's expense and shall not unreasonably interfere with Seller's or its Affiliates' or any of their respective successor companies' business operations.

(b) For a period of five years following the Closing Date, Purchaser shall: (i) allow Seller, upon reasonable prior notice and during normal business hours, through its Representatives, the right, at Seller's expense, to examine and make copies, at Seller's expense, of any Books and Records which were transferred to Purchaser or its Affiliates at or after the Closing and of which neither Seller nor any of its Affiliates retained a copy; and (ii) allow Seller to interview Purchaser's Representatives, upon reasonable prior notice and during normal business hours, for any reasonable business purpose relating to the Business, including in connection with Seller's preparation or examination of regulatory and statutory filings and financial statements, and the conduct of any litigation relating to the Business (other than any litigation or dispute between Seller or its Affiliates, on the one hand, and Purchaser or its Affiliates, on the other hand), or the conduct of any regulatory, contract holder, reinsurer or other dispute resolution or any other Third Party Claim (whether or not such Third Party Claim is the subject of an indemnification claim by a Purchaser Indemnified Person or Seller Indemnified Person), whether pending or threatened; provided , however , that Purchaser shall not be obligated to provide such access to its offices if Purchaser determines, in its reasonable judgment, that such Books and Records can be provided electronically or in another reasonably accessible location. Access to such Representatives and Books and Records shall be at Seller's expense and shall not unreasonably interfere with the business operations of Purchaser or its Affiliates.

(c) Except as otherwise prohibited by Applicable Law and subject to clause (d) and (e) below, Purchaser shall, with respect to the Books and Records, and Seller and its Affiliates shall, with respect to the Excluded Books and Records and the Retained Books and Records, in each case, to which the other party is entitled to access pursuant to the foregoing provisions of this Section 5.03(a) and (b) and Section 5.05 : (i) comply in all material respects with all Applicable Laws relating to the preservation and retention of records; (ii) apply preservation and retention policies that are no less stringent than those generally applied by such party; and (iii) without limitation to the foregoing, for at least five years after the Closing Date, preserve and retain all original Books and Records, Retained Books and Records, and Excluded Books and Records, as the case may be, and thereafter dispose of such originals only after it shall have given the other party 90 days' prior written notice of such disposition and the opportunity (at such other party's expense) to remove and retain such information.

(d) Notwithstanding any other provision of this Agreement, a party hereto shall not be obligated to provide such access to any Books and Records, Retained Books and Records, or Excluded Books and Records or information if such party determines, in its reasonable judgment, that doing so would violate Applicable Law (except that copies thereof shall be furnished to the requesting party or its Representatives to the extent permitted under Applicable Law) or a contract, agreement or obligation of confidentiality owing to a third party, or jeopardize the protection of an attorney-client privilege; provided, that the party contemplated to provide access shall use commercially reasonable efforts to obtain waivers or make other arrangements (including redacting information or entering into joint defense agreements) that would enable otherwise required disclosure to the other party or its Representatives to occur without so jeopardizing privilege or contravening such Applicable Law, contract or obligation of confidentiality.

(e) Notwithstanding any other provision of this Agreement to the contrary, Purchaser shall, and shall cause its Affiliates to, retain and preserve all Books and Records (in whatever form maintained) transferred to Purchaser that are subject to a Legal Hold in effect as of the Closing, until such time as Seller notifies Purchaser in writing that such Books and Records may be destroyed. Seller shall use commercially reasonable efforts to notify Purchaser within 30 days of the termination of any applicable Legal Hold. Purchaser shall provide Seller and its Affiliates with access to any Books and Records subject to this Section 5.03(e); provided that access to Books and Records subject to Legal Holds shall be limited in time only by the terms of the applicable Legal Hold; provided , however , that Purchaser shall not be obligated to provide access to its offices for such purposes if Purchaser determines, in its reasonable judgment, that such Books and Records can be provided electronically or in another reasonably accessible location.

Section 5.04. Confidentiality.

(a) The terms of the confidentiality agreement, dated June 12, 2017 (the " Confidentiality Agreement"), between Seller and The Hartford Financial Services Group Inc. shall continue in full force and effect until the Closing, at which time the confidentiality obligations under the Confidentiality Agreement shall terminate.

(b) Notwithstanding the foregoing, nothing in the Confidentiality Agreement shall restrict, prohibit or delay the ability of Seller or Purchaser to exercise its rights or perform its obligations under the Transaction Agreements. If, for any reason, the transactions contemplated by this Agreement are not consummated, the Confidentiality Agreement shall nonetheless continue in full force and effect in accordance with its terms.

(c) From and after the Closing: (i) Seller shall, and shall cause its Representatives to, maintain in confidence any written, oral or other information to the extent relating to the Business obtained by virtue of Seller's ownership of the Business prior to the Closing, including the Retained Books and Records; and (ii) Purchaser shall, and shall cause its Representatives to, maintain in confidence any written, oral or other information of or relating to Seller or its Affiliates (other than information relating to the Business) obtained by virtue of its ownership of the Business from and after the Closing, except, in each case, to the extent that the applicable party is required to disclose such information by judicial or administrative process or pursuant to

Applicable Law (provided that, except in connection with any required disclosure pursuant to any Applicable Law relating to Taxes and any filings required by the applicable securities laws, such party has given the other party written notice of such potential disclosure and, to the extent reasonably requested by such other party, cooperated with such other party in seeking an appropriate order or other remedy protecting such information from disclosure) or such information can be shown to have been in the public domain through no fault of the applicable party.

(d) Effective as of the Closing, Seller shall (i) enforce, on behalf of and at the request of Purchaser, Seller's rights, powers and privileges under any in-force confidentiality agreements with third Persons other than Purchaser regarding the potential sale of the Business executed prior to the date hereof (each, a " Seller Confidentiality Agreement") in connection with any material breach thereof by such third persons, provided that Purchaser shall reimburse Seller for its costs and expenses (including reasonable legal fees and expenses) incurred in connection with such enforcement, and (ii) submit written requests to all third Persons who executed a Seller Confidentiality Agreement that such other Persons promptly deliver to Purchaser or otherwise destroy all proprietary or confidential material furnished to such Person by or on behalf of Seller or its Affiliates in accordance with the terms of such Seller Confidentiality Agreement.

Section 5.05. Maintenance and Transfer of Books and Records.

(a) Through the Closing Date, Seller shall, and shall cause its Affiliates to, maintain the Books and Records in all material respects in the same manner and with the same care that the Books and Records have been maintained for the 12-month period prior to the execution of this Agreement. Books and Records of the type identified in Section 5.05(a) of the Seller Disclosure Schedule, including, for the avoidance of doubt, Books and Records that (i) are necessary for Seller to provide services under the Transition Services Agreement (to the extent that such Books and Records cannot reasonably be duplicated and a copy retained by Seller or its applicable Affiliate(s)); or (ii) are not permitted to be disclosed or transferred under applicable Law (such Books and Records, the " Retained Books and Records"), shall not be transferred at the Closing but will instead be made available by Seller to Purchaser, at Seller's expense, from and after the Closing in accordance with the guidelines set forth in Section 5.05(a) of the Seller Disclosure Schedule. Notwithstanding anything to the contrary in this Agreement, Seller and its Affiliates shall not be required to transfer the Retained Books and Records at the Closing or on the Closing Date, and Seller and its Affiliates shall be entitled to retain copies of any Books and Records transferred to Purchaser at the Closing or on the Closing Date. Seller shall, and shall cause its Affiliates to, provide Purchaser and its Representatives reasonable access to such Retained Books and Records, and once any Retained Books and Records are no longer necessary for the provision of services under the Transition Services Agreement or are permitted to be transferred, as applicable, Seller shall cause such Retained Books and Records to be delivered to Purchaser (or a Person designated by Purchaser) or, at Purchaser's option, to be destroyed.

(b) At the Closing, Seller shall cause all Books and Records (except the Retained Books and Records) in the possession or control of Seller or any of its Affiliates to be delivered to Purchaser (or a Person designated by Purchaser) in accordance with the requirements and guidelines set forth in Section 5.05(b) of the Seller Disclosure Schedule.

Section 5.06. Consents, Approvals and Filings.

(a) Subject to the terms and conditions hereof, Seller and Purchaser shall each use their reasonable best efforts, and shall cooperate fully with each other, (i) to comply as promptly as practicable with all requirements of Governmental Authorities applicable to the transactions contemplated by the Transaction Agreements and (ii) to obtain as promptly as practicable all Governmental Approvals necessary in connection with the consummation of the transactions contemplated by the Transaction Agreements; provided that, Purchaser shall be responsible for the costs (including any license or other fees and expenses) associated with Seller, Purchaser or any of their respective Affiliates obtaining any such Governmental Approvals. In connection therewith, Seller and Purchaser shall make and cause their respective Affiliates to make all legally required filings as promptly as practicable in order to facilitate prompt consummation of the transactions contemplated by the Transaction Agreements, shall provide and shall cause their respective Affiliates to provide such information and communications to Governmental Authorities as such Governmental Authorities may request, shall take and shall cause their respective Affiliates to take all steps that are necessary, proper, or advisable to avoid any Action by any Governmental Authority with respect to the transactions contemplated by the Transaction Agreements, shall defend or contest in good faith any Action by any third party (including any Governmental Authority), whether judicial or administrative, challenging any of the Transaction Agreements or the transactions contemplated thereby, or that could otherwise prevent, impede, interfere with, hinder, or delay in any material respect the consummation of the transactions contemplated thereby, including by using their reasonable best efforts to have vacated or reversed any stay or temporary restraining order entered with respect to the transactions contemplated by any of the Transaction Agreements by any Governmental Authority, and shall consent to and comply with any condition imposed by any Governmental Authority on its grant of any such permit, order, consent, approval, or authorization, other than any Burdensome Condition. Each of the parties shall provide to the other party copies of all applications or other communications to Governmental Authorities in connection with this Agreement in advance of the filing or submission thereof.

(b) Without limiting the generality of the foregoing, as promptly as practicable after the date hereof, each of Purchaser and Seller shall file with all applicable Insurance Regulators all required requests for approval of the transactions contemplated by the Transaction Agreements, which requests shall include all required exhibits. A reasonable time prior to furnishing any written materials to any Insurance Regulator in connection with the transactions contemplated by the Transaction Agreements, the furnishing party shall provide the other party with a copy thereof, and the other party shall have a reasonable opportunity to provide comments thereon, which comments shall be considered by the furnishing party in good faith. Each party shall give to the other party prompt written notice if it receives any notice or other communication from any Insurance Regulator or other Governmental Authority in connection with the transactions contemplated by the Transaction Agreements and, in the case of any such notice or communication that is in writing, shall promptly furnish the other party with a copy thereof. If any Governmental Authority requires that a hearing be held in connection with any such approval, each party shall use its reasonable best efforts to arrange for such hearing to be held promptly after the notice that such hearing is required has been received by such party. Each party shall give to the other party reasonable prior written notice of the time and place when any meetings, telephone calls, or other conferences may be held by it with any

Governmental Authority in connection with the transactions contemplated by the Transaction Agreements, and the other party shall have the right to have a representative or representatives attend or otherwise participate in any such meeting, telephone call, or other conference unless prohibited by Applicable Law.

(c) Notwithstanding anything herein to the contrary, neither Purchaser nor Seller shall be obligated to take or refrain from taking or to agree to it, its Affiliates or any of their respective Representatives taking or refraining from taking any action or to permit or suffer to exist any restriction, condition, limitation or requirement which, individually or together with all other such actions, restrictions, conditions, limitations or requirements, would constitute a Burdensome Condition. As used in this Agreement, " Burdensome Condition" means any arrangement, condition or restriction (i) in the case of Purchaser, (A) to sell or hold separate or agree to sell, divest or discontinue, before or after the Closing Date, any properties, assets, businesses or licenses of Purchaser or its Affiliates that are material to Purchaser and its Affiliates, taken as a whole, or to the Business, as applicable, or (B) that otherwise is reasonably likely to have a Material Adverse Effect or a material adverse effect on the business, financial condition, operations or results of operations of Purchaser and its Affiliates, taken as a whole; and (ii) in the case of Seller, would require Seller or any of its Affiliates to provide any guarantee or incur any liability with respect to the Business or the Transferred Assets after the Closing Date, or restrict the ability of Seller or any of its Affiliates to conduct their respective businesses after the Closing Date.

Section 5.07. Further Assurances.

(a) Subject to the terms and conditions herein provided, including Section 5.06 , each of the parties hereto shall, and shall cause its Affiliates to, execute such documents and other papers and perform such further acts as may be reasonably required to carry out the provisions hereof and the transactions contemplated hereby and by the other Transaction Agreements. Each such party shall, at or prior to the Closing Date, use its reasonable best efforts to fulfill or obtain the fulfillment of the conditions precedent to the consummation of the transactions contemplated hereby and by the other Transaction Agreements, including the execution and delivery of any documents, certificates, instruments or other papers and the taking of any other actions that are reasonably necessary for the consummation of the transactions contemplated hereby and by the other Transaction Agreements.

(b) Subject to the terms and conditions of this Agreement, on and after the Closing Date, Seller and Purchaser shall, and shall cause their respective Affiliates to, take all reasonable actions and execute any additional documents, instruments or conveyances of any kind which may be reasonably necessary to put Purchaser and its Affiliates in full possession and operating control of the Business and to effect fully the separation of the Business from Seller and its Affiliates.

Section 5.08. Privacy and Data Security Compliance; Use of Information. Notwithstanding any other provision of this Agreement or any Transaction Agreement to the contrary, none of Seller, Purchaser or any of their respective Affiliates shall be required to take any action that would violate or conflict with, and each such Person shall comply with, all Privacy and Data Security Laws. Notwithstanding any other provision of this Agreement, Seller

and Purchaser shall use their respective reasonable best efforts to ensure that all Personal Data about individual insureds and employees on leaves of absence under Group Contracts or other individuals is used, shared, accessed, stored, transmitted, disclosed, or otherwise processed in a manner (including the scope of information) that complies with, and facilitates each party's compliance with, Privacy and Data Security Laws. For the avoidance of doubt, any Personal Data relating to individual insureds and employees on leaves of absence under Group Contracts accessed by or disclosed to Purchaser or any of its Affiliates pursuant to this Agreement shall be subject to Purchaser's confidentiality obligations under Section 5.04 and under the Administrative Services Agreement.

Section 5.09. Non-Solicitation of Employees.

(a) For a period of 24 months following the Closing Date, without the prior written consent of Purchaser, neither Seller nor any of its Affiliates shall, whether directly or indirectly, solicit for employment or employ any Transferred Employee or any employee of the Purchaser whose name is set forth on Section 5.09(a) of the Purchaser Disclosure Schedule; provided , that nothing in this Section 5.09(a) shall prohibit Seller or any of its Affiliates from engaging in general solicitations not directed at such Persons (including general media advertisements and the use of a search firm not directed to target Transferred Employees) or from soliciting or employing any such Person whose employment with or engagement by Purchaser or any of its Affiliates has been terminated by Purchaser or its applicable Affiliate at least three months prior to the first such solicitation or employment.

(b) For a period of 24 months following the Closing Date, without the prior written consent of Seller, neither Purchaser nor any of its Affiliates shall, whether directly or indirectly, solicit for employment or employ any employee of the Seller whose name is set forth on Section 5.09(b) of the Seller Disclosure Schedule; provided , that nothing in this Section 5.09(b) shall prohibit Purchaser or any of its Affiliates from engaging in general solicitations not directed at such Persons (including general media advertisements and the use of a search firm not directed to target such Persons) or from soliciting or employing any such Person whose employment with or engagement by Seller or any of its Affiliates has been terminated by Seller or its applicable Affiliate at least three months prior to the first such solicitation or employment.

(c) For a period of 24 months following the Closing Date (including during the Employee Lease Term), without the prior written consent of Purchaser, neither Seller nor any of its Affiliates shall, whether directly or indirectly, interfere with Purchaser's obligations under Section 6.01(a) or attempt to retain for employment or rehire any Employee set forth on Section 6.01(a)(i) of the Seller Disclosure Schedule who does not become a Transferred Employee; provided , that nothing in this Section 5.09(c) shall prohibit Seller or any of its Affiliates from engaging in general solicitations not directed at such Persons (including general media advertisements and the use of a search firm not directed to target such Persons).

Section 5.10. Use of Names.

(a) At the Closing, Seller shall enter into a royalty-free license agreement with Purchaser substantially in the form attached hereto as Exhibit I (the " Trademark License Agreement"), among other things, permitting Purchaser to use the "Aetna" name and related

Trademarks on a transitional basis in connection with the operation of the Business in the United States in accordance with the terms thereof.

(b) Except as otherwise contemplated by the Administrative Services Agreement, the Distribution Agreement, the Transition Services Agreement and the Trademark License Agreement in accordance with the terms thereof: (i) following the Closing Date (including in connection with the operation of the Business and the Transferred Assets), Purchaser shall not, and shall cause its Affiliates not to, use any of the names or Trademarks set forth in Section 5.10 of the Seller Disclosure Schedule, any other Trademarks of Seller's Affiliates that include the name "Aetna," or any name, Trademark, or acronym that is confusingly similar to, or is based on or incorporates, any of such names or Trademarks (collectively, the " Seller Trademarks") whether or not in combination with other words, symbols, or other distinctive or non-distinctive elements, and all trade, corporate or business names, trademarks, tag-lines, identifying logos, trade dress, monograms, slogans, service marks, domain names, brand names, and other name or source identifiers that are derivations, translations, adaptations, combinations or variations of the Seller Trademarks or Trademarks of Seller's Affiliates, or embodying any of the foregoing, whether or not in combination with other words, symbols, or other distinctive or non-distinctive elements; and (ii) Purchaser, for itself and its Affiliates, agrees that any and all rights arising out of the Transferred Assets to the Seller Trademarks or Trademarks of Seller's Affiliates, whether written or oral, with Seller or its Affiliates, shall terminate on the Closing Date without recourse by Purchaser or any of its Affiliates. Neither Purchaser nor any of its Affiliates shall seek to register in any jurisdiction any trade, corporate, or business name, trademark, tag-line, identifying logo, trade dress, monogram, slogan, service mark, domain name, brand name, or other name or source identifier that is a derivation, translation, adaptation, combination, or variation of the Seller Trademarks or Trademarks of Seller's Affiliates.

Section 5.11. Pre-Closing Management of Specified Portfolio.

(a) Monthly Asset Value Statements and Related Adjustments.

(i) After the end of each calendar month that occurs between the date hereof and the Closing Date, Seller shall estimate in good faith the Adjusted Required Asset Value and the Accounting Value of the Specified Portfolio as of the end of such month and deliver to Purchaser a statement (each, a "Monthly Asset Value Statement") specifying such Adjusted Required Asset Value and Accounting Value as of the end of such month, provided that no such Monthly Asset Value Statement shall be so prepared or delivered with respect to the month preceding the month in which the Closing occurs.

(ii) If the Accounting Value of the Specified Portfolio set forth in a Monthly Asset Value Statement is less than the Adjusted Required Asset Value set forth in such Monthly Asset Value Statement, Seller shall (or shall cause the Ceding Company or AHLIC to), promptly following the delivery of such Monthly Asset Value Statement to Purchaser pursuant to Section 5.11(a)(i) , acquire or, subject to Section 5.11(c) below, designate for

inclusion in the Specified Portfolio additional cash or Investment Assets with an aggregate Fair Market Value equal to the amount of such shortfall.

(iii) If the Accounting Value of the Specified Portfolio set forth in a Monthly Asset Value Statement is greater than the Adjusted Required Asset Value set forth in such Monthly Asset Value Statement, Seller may, at its option and in its sole discretion, select for removal from the Specified Portfolio cash or Investment Assets that have an aggregate Accounting Value equal to such excess as follows (clauses (A) and (B) below, the "Selection Waterfall"):

(A) cash and cash equivalents in the Specified Portfolio will be selected first; and

(B) otherwise, Investment Assets will be selected in an order of shortest stated maturity to longest stated maturity, determined in each case in good faith by Seller.

(iv) Notwithstanding anything to the contrary in this Agreement, Seller may (and may cause the Ceding Company or AHLIC to) sell any Investment Asset in the Specified Portfolio if Seller determines in good faith that such Investment Asset has become, or is reasonably likely to become, impaired. In the event of any such sale of an impaired asset, Seller shall (or shall cause the Ceding Company or AHLIC to), as promptly as practicable following such sale (with a target of within one Business Day), acquire or designate for inclusion in the Specified Portfolio cash or replacement Investment Assets with an aggregate Fair Market Value equal to the Accounting Value of the Investment Asset sold in such sale, determined prior to any adjustment as a result of the impairment. For the avoidance of doubt, the Capital Gain or Loss Adjustment (as defined in clause (b) below) does not apply to sales of Investment Asset pursuant to this Section 5.11(a)(iv) , but the Reallocated Asset Value Adjustment (as defined in Section 5.11(c) below) does apply to any Reallocated Investment Asset that replaces such an Investment Asset.

(v) Any changes to the Specified Portfolio contemplated by this Section 5.11(a) will be effected in accordance with Pre-Closing Investment Guidelines.

(b) Discretionary Turnover Allowance.

(i) Between the date hereof and the Closing Date, Seller may, at its option and in its sole discretion, sell:

(A) any bond in the Specified Portfolio that has an option adjusted duration of 3.00 years or less as of the close of business on the Business Day immediately prior to the date on which it is sold, determined in accordance with the OAD model provided by

Bloomberg L.P.'s Portfolio & Risk Analytics solution (PORT); and

(B) an additional (x) 5% of the aggregate Specified Portfolio (where such percentage is determined by reference to the Accounting Value of the Specified Portfolio as of the Reference Date and sales are measured by Accounting Value of the sold Investment Assets as of the applicable sale dates) during the period between the Reference Date through December 31, 2017; and (y) if the Closing has not occurred on or prior to December 31, 2017, 1% of the Specified Portfolio (where such percentage is determined by reference to the Accounting Value of the Specified Portfolio as of the beginning of each applicable month and sales are measured by Accounting Value of the sold Investment Assets as of the applicable sale dates) during each calendar month, or portion thereof, that between December 31, 2017 and the Closing (this Section 5.11(b)(i) collectively, the "Discretionary Turnover Allowance");

provided , however , that the sales described in (A) and (B) above may not, in the aggregate, exceed 10% of the Specified Portfolio through November 30, 2017, plus 2% of the Specified Portfolio for every calendar month after November 2017.

(ii) On the date that any Investment Asset in the Specified Portfolio is sold pursuant to this Section 5.11(b) , the Adjusted Required Asset Value as of such date will, in addition to any adjustment to the Required Asset Value required under the Transaction Accounting Principles to account for any change in the interest maintenance reserve of the Ceding Company or AHLIC, as applicable, resulting from such sale, be adjusted as set forth below (each of the adjustments described in (A) and (B) below, a "Capital Gain or Loss Adjustment"):

(A) if the sale of the Investment Asset generates a (statutory basis) capital gain (calculated as the excess, if any, of the FMV Ex-Accrued of such Investment Asset as of the applicable date of sale over the Book Value of such Investment Asset as of such date), the Adjusted Required Asset Value as of such date will be increased by the amount of such capital gain, less the amount of any interest maintenance reserve of the Ceding Company or AHLIC, as applicable, generated by the sale of such asset in accordance with the Transaction Accounting Principles; and

(B) if the sale of the Investment Asset generates a (statutory basis) capital loss (calculated as the excess, if any, of the Book Value of such Investment Asset as of the applicable date of sale over the FMV Ex-Accrued of such Investment Asset as of such date), the

Adjusted Required Asset Value as of such date will be decreased by an amount equal to (A) the absolute value of such capital loss minus (B) the absolute value of any decrease in interest maintenance reserve of the Ceding Company or AHLIC, as applicable, resulting from the sale of such asset in accordance with the Transaction Accounting Principles.

(iii) In the event that Seller elects to sell any Investment Asset pursuant to this Section 5.11(b) , Seller shall, as promptly as reasonably practicable (with a target of within one Business Day) reinvest the gross proceeds it receives from such sale (less the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset) in the Specified Portfolio by either acquiring one or more new Investment Assets or, subject to Section 5.11(c) below, selecting for inclusion in the Specified Portfolio one or more Reallocated Investment Assets, in each case that have an aggregate FMV Ex-Accrued equal to the amount of such gross proceeds (less the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset).

(iv) Any changes to the Specified Portfolio contemplated by this Section 5.11(b) will be effected in accordance with the Pre-Closing Investment Guidelines.

(c) Reallocated Investment Assets. If, between the date of this Agreement and the Closing Date, any Reallocated Investment Asset is designated for inclusion in the Specified Portfolio pursuant to Section 5.11(a) or Section 5.11(b) , then the following adjustment shall be made to the Adjusted Required Asset Value as of the date of such designation (each of the adjustments described in (i) and (ii) below, a " Reallocated Asset Value Adjustment"):

(i) if the FMV Ex-Accrued of the Reallocated Investment Asset as of such date exceeds the Book Value of such Reallocated Investment Assets as of such date, the Adjusted Required Asset Value shall be decreased by the amount of such excess; and

(ii) if the FMV Ex-Accrued of the Reallocated Investment Asset as of such date is less than the Book Value of such Reallocated Investment Asset as of such date, the Adjusted Required Asset Value shall be increased by the amount of such shortfall.

Section 5.12. Properties.

(a) Schedule VI hereto sets forth all real property at which Employees of the Business use space for the current operation and conduct of the Business (collectively, the " Properties"). The Properties are separated on Schedule VI into the following two (2) categories: (1) the Properties that Seller intends, and agrees to cooperate as required in Section 5.12(b) to enable, Purchaser and such Employees to have the right to occupy or use (in the case of the Subleases, on a co-location basis with Seller, its Affiliates and their respective employees)

from and after the day immediately following the expiration or termination of the Employee Lease Term pursuant to the Portland Location Assignment Agreement, the Subleases and the Hartford License Agreement (collectively, the " Occupied Properties"); and (2) the Properties that Purchaser and such Employees will not have the right to occupy or use from and after the day immediately following the expiration of the Employee Lease Term (collectively, the " Non-Occupied Properties"). Purchaser acknowledges and agrees that all Employees at the Non-Occupied Properties shall vacate the Non-Occupied Properties from and after the day immediately following the expiration of the Employee Lease Term and Purchaser shall cause such Employees' job location to either be a home-office or an alternative real estate solution other than the Non-Occupied Properties. The Employees' job location between the Closing Date and the expiration of the Employee Lease Term shall remain at the Properties pursuant to the Employee Leasing Agreement.

(b) Seller and Purchaser shall, and shall cause their respective Affiliates to, use commercially reasonable efforts to obtain, on or prior to December 31, 2017, the required consent of (i) the landlord of the Portland Location to the assignment of the Assigned Lease pursuant to the Portland Location Assignment Agreement and (ii) the respective landlords of the other Occupied Properties to the subleasing of such locations to Purchaser pursuant to the Subleases, in each case, on the terms and subject to the conditions set forth herein and therein (collectively, the " Lease Consents"). Seller and Purchaser shall cooperate with each other as may be reasonably required to obtain the Lease Consents.

(c) If any such Lease Consent is not obtained on or prior to December 31, 2017, then, (i) the Portland Location Assignment Agreement and/or any applicable Sublease to which such Lease Consent was not obtained shall not become effective as of the expiration or termination of the Employee Lease Term and (ii) Purchaser shall, and shall cause its Affiliates to, obtain alternative office space, at its sole cost and expense, and vacate the applicable Occupied Properties for which a Lease Consent has not been obtained prior to the expiration of the Employee Lease Term for such applicable Occupied Properties as provided for in this Section 5.12(c).

Section 5.13. Non-Competition. During the period beginning on the Closing Date and ending on the date that is three years and six months after the Closing Date (the " Restricted Period"), Seller shall not, and shall cause its Affiliates (together with Seller, the " Restricted Entities") not to, directly or indirectly, issue or sell in any state or jurisdiction within the United States, any products or services of a type that comprises part of the Business as of the date hereof and that was underwritten, issued, sold, renewed or serviced as part of the Business during the two years prior to the date hereof (the " Competing Businesses"); provided , however , that this Section 5.13 shall not prohibit or in any way prevent or restrict:

(a) any Restricted Entity from operating any business other than the Business (including the business described in the proviso included in the definition of "Business") or from operating the Business from and after the time at which the Business or any portion thereof is recaptured under any coinsurance agreement;

(b) any Restricted Entity from providing (i) provider network access or network management services; (ii) medical management, case management, or cost containment services;

or (iii) administrative services for short-term disability plans that are provided in conjunction with a self-funded plan sponsor's medical benefits coverage or plan that is administered or serviced by a Restricted Entity.

(c) any Restricted Entity from performing any act or conducting any business expressly required by this Agreement or any other Transaction Agreement;

(d) any Restricted Entity from entering into a reinsurance agreement or similar arrangement primarily reinsuring the Competing Business of a ceding company that is not a Restricted Entity, so long as none of the Restricted Entities engages in the issuing, underwriting, selling, distributing, marketing, delivering, cancelling or administering of such underlying reinsured business;

(e) any Restricted Entity from (A) making any investment or providing advisory services (or activities related thereto) in a fiduciary or agency capacity and carried out on behalf of clients or other third party beneficiaries in the ordinary course of business, or (B) making passive investments for general insurance accounts or investment management, proprietary investing or trading activities in the ordinary course of its businesses; provided that in no event shall the aggregate ownership interest held by Restricted Entities in any Person engaged in a Competing Business, whether directly or indirectly, equal or exceed 20% of the aggregate voting power or issued and outstanding equity securities of such Person, subject to Sections 5.13(f) and (g) below;

(f) the ownership of, any affiliation with, or the conduct of any other activity with respect to, a Person that conducts, either directly or indirectly, a Competing Business (any such person, together with all of its Affiliates, a " Competing Person") that is the result of (A) the merger, consolidation, share exchange, sale or purchase of assets, scheme of arrangement or similar business combination involving any Restricted Entity with any Competing Person or (B) the acquisition of 20% or more of the voting power or outstanding equity interests in any Competing Person by any Restricted Entity, if, in the case of either (A) or (B), at least 66 2/3% of the total consolidated revenues of such Competing Person in the calendar year prior to such ownership or affiliation was derived from activities that do not constitute Competing Business; provided , however , that such Restricted Entity may proceed with such acquisition of a Competing Person that derived in excess of 33 1/3% of its total consolidated revenues in its most recent fiscal year from activities that constitute Competing Business only if such Restricted Entity divests, within 24 months of its acquisition, a sufficient portion of such Competing Person such that the total consolidated revenues from activities that constitute Competing Business that remain with any such Competing Person after such divestment over the last four full fiscal quarters prior to such acquisition are not greater than 33 1/3% of its consolidated revenues for such period; or

(g) subject to the foregoing clause (f), any Restricted Entity from foreclosing on collateral of or acquiring any of the outstanding capital stock or other interests in any person that has outstanding indebtedness to any Restricted Entity, or engaging in any activities otherwise prohibited by this Section 5.13 in connection with any such Person as a result of the acquisition of such capital stock or other interests in connection with a debt previously contracted.

ARTICLE VI.

EMPLOYEE MATTERS

Section 6.01. Employee Matters.

(a) Except as set forth in Section 6.01(b) , Purchaser or its Affiliate shall, not more than 30 Business Days following the Closing Date, extend offers of employment (" Transfer Offers") to all then-current Employees. Section 6.01(a)(i) of the Seller Disclosure Schedule sets forth, as of the date hereof, a list of then-current Employees, together with such Employees' (i) current base salary (or wages), (ii) current target incentive compensation opportunities by component, including (1) target annual cash bonus opportunity, (2) commission opportunity, and (3) target long-term incentive opportunity, (iii) recognized years of service, (iv) current work address, (v) remote work arrangement, if any, (vi) exempt or non-exempt status, (vii) hourly or salaried status, (viii) annual paid time off accrual rate, (ix) paid time off carryover amount, (x) current job title and career level, (xi) date of hire, (xii) valid work email address, and (xiii) status as active or on leave. Seller shall promptly update Section 6.01(a)(i) of the Seller Disclosure Schedule between the date hereof and the expiration of the Employee Lease Term to reflect any new hires, transfers, resignations and other employment additions and terminations of Employees which may have occurred subsequent to the date hereof in the ordinary course of business of the Business and shall deliver to Purchaser (A) a Closing version of Section 6.01(a)(i) of the Seller Disclosure Schedule no later than two days prior to the Closing Date, and (B) a final version of Section 6.01(a)(i) of the Seller Disclosure Schedule no later than 10 Business Days prior to the expiration of the Employee Lease Term. Notwithstanding anything to the contrary herein, to the extent an individual is hired or otherwise retained at the direction of Purchaser and added to Section 6.01(a)(i) of the Seller Disclosure Schedule after the date hereof, Purchaser or its Affiliate shall extend a Transfer Offer to such Employee as soon as reasonably practicable following such addition, but not more than the later to occur of (x) 30 Business Days following the Closing Date, and (y) ten Business Days following such addition. Section 6.01(a)(ii) of the Seller Disclosure Schedule sets forth, as of the date hereof, a list of then current Business Employees on a no-name basis by each Business Employee's current job title.

(b) With respect to any Employee identified on Section 6.01(a) of the Seller Disclosure Schedule hereto who is not actively at work upon the expiration of the Employee Lease Term as a result of a leave of absence (including temporary leave for purposes of jury or military duty, maternity or paternity leave, leave under the Family Medical Leave Act of 1993, approved personal leave or disability or medical leave) (each, a " Leave Recipient"), Purchaser shall make an offer of employment in the manner required by this Section 6.01 , contingent on such Leave Recipient's return to active status within six months following the expiration of the Employee Lease Term or such longer period as required by Applicable Law; provided that, notwithstanding anything in this Agreement to the contrary, Purchaser shall not be required to make an offer of employment to any such Employee (and shall have no obligation of any nature to hire or employ any such Employee) who is receiving long-term disability benefits. When a Leave Recipient who has accepted the offer returns to active status pursuant to the terms hereof and commences active employment with Purchaser or its Affiliates, such Leave Recipient shall be considered a Transferred Employee. Purchaser shall take, or cause its Affiliates to take, all reasonably necessary steps to sponsor or transfer sponsorship of, the work permits for all

Employees who are foreign nationals listed in Section 3.10(j) of the Seller Disclosure Schedule on or after the expiration of the Employee Lease Term. Seller shall cooperate as reasonably necessary to effect Purchaser's or its Affiliates' sponsorship or transfer of sponsorship of all such foreign national Employees, in each case, to the extent permitted by Applicable Law. Each such foreign national Employee who accepted an offer of employment from Purchaser or an Affiliate pursuant to the terms hereof shall be considered a Transferred Employee on the later of the Transfer Date or the date such Employee obtains the necessary authorization to work for Purchaser and its Affiliates and commences active employment with Purchaser and its Affiliates.

(c) Purchaser or its Affiliate shall set forth in the Transfer Offers the proposed terms of employment (or service) for the Employees and, as of the expiration of the Employee Lease Term and for a period of 12 months immediately following the expiration of the Employee Lease Term (or such earlier date on which such Employee's employment with Purchaser or its Affiliate terminates), Purchaser or its Affiliate shall provide each Transferred Employee with the following terms of employment (or service): (i) base salary (or wages) no less than the base salary (or wages) provided to such Employee by Seller or its Affiliates immediately prior to the Closing Date, or, if later, as of the Employee's date of hire; (ii) annual incentive opportunities no less than those provided by Seller or its Affiliates immediately prior to the Closing Date, or, if later, as of the Employee's date of hire, (iii) a long-term incentive compensation opportunity (whether paid in cash or equity) at a similar range and participation rate to that provided to such Employee by Seller or its Affiliates immediately prior to the Closing Date or, if later, as of the Employee's date of hire; (iv) commission opportunities that are no less than those provided to such Employee by Seller or its Affiliates immediately prior to the Closing Date or, if later, as of the Employee's date of hire, including, with respect to each individual set forth on Section 6.01(c) of the Seller Disclosure Schedule (each, a " Listed Sales Employee"), guaranteed commission opportunities consistent with the terms of the retention letter with each such Listed Sales Employee set forth on Section 3.10(a) of the Seller Disclosure Schedule, but in each case to be paid consistent with Purchaser's or its Affiliate's standard payroll cycle; (iii) employee retirement and welfare (including paid time off) benefits, in each case, substantially similar to those provided to similarly-situated employees of Purchaser or its Affiliate; and (iv) with respect to Employees whose job location is a home-office as of the Closing Date, the ability to continue to work from such home-office, and with respect to all other Employees, a job location that does not increase such Employee's commute by more than 30 miles when compared to the commute from such Employee's residence to the job location to which such Employee reports immediately prior to the expiration of the Closing Date, or if later, as of the Employee's date of hire, or provide the Employee the ability to work from a home-office. Without limiting the foregoing, Purchaser hereby acknowledges and agrees that if the Employee Lease Term extends past Lessee's regularly scheduled long-term incentive grant date in the first quarter of calendar year 2018, Purchaser shall, during the first "open window" trading period following the expiration of the Employee Lease Term, grant an award to each Transferred Employee who is eligible to earn a long-term incentive award for calendar year 2018. Employment or service, as applicable, pursuant to a Transfer Offer shall be contingent upon such Employee (i) being employed by (or providing on-going services with) Seller or any of its Subsidiaries immediately prior to the expiration of the Employee Lease Term, (ii) satisfying required professional licensure requirements (to the extent applicable), (iii) successfully completing a background check, I-9 form/eVerify process, and all applicable Purchaser new hire documentation and (iv) with respect to Employees who are foreign nationals, obtaining the necessary authorization to work for

Purchaser or its Affiliates within six (6) months of the expiration of the Employee Lease Term. All employment offers shall be for employment at-will and nothing in this Article VI shall require Purchaser or any of its Affiliates to continue to employ any Transferred Employee for any specified period of time following the expiration of the Employee Lease Term. Except as set forth in Section 6.01(b) , each Employee who accepts Purchaser's Transfer Offer shall be a " Transferred Employee" at 12:00:01 a.m. on the first day following the expiration of the Employee Lease Term. Effective as of the date they become Transferred Employees (the " Transfer Date"), such Transferred Employees shall cease to be employees of Seller and its Affiliates and shall cease any further participation in (and shall cease to accrue benefits under) Employee Benefit Plans, subject to the terms and conditions of the Employee Benefit Plans and Applicable Law.

(d) As of the expiration of the Employee Lease Term, in no event shall any Employee be entitled to accrue any benefits under the Employee Benefit Plans with respect to services rendered or compensation paid on or after the expiration of the Employee Lease Term, subject to the terms and conditions of the Employee Benefit Plans and Applicable Law.

(e) Notwithstanding anything in this Agreement to the contrary, any Transferred Employee who incurs a termination of employment during the 12-month period immediately following the expiration of the Employee Lease Term shall be entitled to receive severance payments and benefits that are no less favorable than the severance payments and benefits provided to similarly-situated employees of Purchaser or its Affiliates under the Purchaser severance plan as in effect immediately prior to the date hereof and set forth on Section 6.01(e) of the Seller Disclosure Schedule; provided , however, that in lieu of the thirty (30) day paid notice period applicable to similarly-situated employees of Purchaser, Transferred Employees will be entitled to a nine (9) week paid non-working period with benefits continuation during such period.

(f) Notwithstanding anything in this Agreement to the contrary, Purchaser or its Affiliate shall be solely responsible for all Liabilities arising from, related to or based upon the termination of any Employee who is terminated by Seller or its respective Affiliates on or after the expiration of the Employee Lease Term in the event such employee is not offered employment or service with Purchaser in accordance with the provisions of this Section 6.01. Purchaser or its Affiliate shall be solely responsible for providing all notices required under the Worker Adjustment and Retraining Notification Act, 29 U.S.C. § 2109 *et seq.* , or the regulations promulgated thereunder (the " WARN Act") (including comparable state, local or other Applicable Laws) and for taking all remedial measures, including, without limitation, the payment of all amounts, penalties, liabilities, costs and expenses if such notices are not provided, with respect to any obligations under the WARN Act (including comparable state, local or other Applicable Laws) arising out of or resulting from any termination of employment of any Transferred Employees by Purchaser and its Affiliates on or after the expiration of the Employee Lease Term.

(g) Purchaser shall cause its Affiliate to: (i) permit each Transferred Employee participating in each Employee Benefit Plan that is a defined contribution plan with a qualified cash or deferred arrangement within the meaning of Section 401(k) of the Code (the " Seller 401(k) Plan") to effect, and (ii) cause its defined contribution plan that includes a qualified cash

or deferred arrangement within the meaning of Section 401(k) of the Code (the " Purchaser 401(k) Plan") to accept, in accordance with Applicable Law, a "direct rollover" (within the meaning of Section 401(a)(31) of the Code) of his or her account balances (including earnings thereon through the date of transfer) under the Seller 401(k) Plan if such rollover to the Purchaser 401(k) Plan is elected in accordance with Applicable Law by such Transferred Employee.

(h) Subject to any reimbursement or other obligations of Purchaser or its Affiliates agreed upon pursuant to the Employee Leasing Agreement, Seller shall retain responsibility for all liabilities under and with respect to, and claims incurred under, the Employee Benefit Plans (including those relating to Transferred Employees and their covered dependents). Purchaser or its Affiliate shall be responsible for all liabilities under and with respect to, and claims incurred under, any employee benefit plans, programs, policies and arrangements maintained by Purchaser or its Affiliates (including those relating to Transferred Employees and their covered dependents).

(i) Unless Seller or one of its Affiliates is required under Applicable Law to make a payment in settlement of accrued paid time off of a Transferred Employee, (i) Purchaser or its Affiliate shall assume, recognize and provide each Transferred Employee up to forty (40) hours of the Transferred Employee's earned but unused paid time-off as of the expiration of the Employee Lease Term as determined under Seller's policy in effect as of the expiration of the Employee Lease Term and (ii) Seller or one of its Affiliates shall make a payment in settlement of accrued paid time off of any such Transferred Employee in excess of forty (40) hours in accordance with Seller's paid time off policy and Applicable Law.

(j) Purchaser or its Affiliate shall assume and pay, the accrued but unpaid annual cash bonuses with respect to performance in the calendar year ending December 31, 2017. In respect thereof, the following shall be accrued on the Initial Closing Statement: (i) accruals for ten-twelfths (10/12) of such annual cash bonuses, assuming maximum (140%) performance, and (ii) accruals representing the matching contribution that would have been made under Seller 401(k) Plan with respect to the bonus amounts accrued pursuant to Section 6.01(j)(i). In no event shall the amount of such payment by Purchaser to the Transferred Employees in the aggregate be less than the aggregate amount set forth with respect to such bonuses in the Initial Closing Statement as described in Section 6.01(j)(i).

(k) Purchaser shall, or shall cause one of its Affiliates to, make available to the Transferred Employees a flex spending account plan for medical and dependent care expenses under a new or existing plan established or maintained under Section 125 and Section 129 of the Code (the " Purchaser FSA"), effective as of the expiration of the Employee Lease Term and in accordance with this Section 6.01(k). If the Employee Lease Term ends after December 31, 2017, Purchaser, or one of its Affiliates, shall credit the applicable account under the Purchaser FSA of each Transferred Employee participating in the Seller Employee Benefit Plan maintained pursuant to Section 125 and Section 129 of the Code (the " Seller FSA") with an amount equal to the balance of such Transferred Employee's account under the Seller FSA immediately prior to the expiration of the Employee Lease Term, in accordance with the following:

(i) If the aggregate amount withheld from Transferred Employees' compensation under the Seller FSA for 2018 exceeds the aggregate amount of reimbursements paid to Transferred Employees prior to the expiration of the Employee Lease Term under the Seller FSA for claims incurred in 2018, Seller shall transfer (or cause to be transferred) to Purchaser within 30 days after the expiration of the Employee Lease Term a cash payment equal to such excess, if any.

(ii) If the aggregate amount of reimbursements paid to Transferred Employees prior to the expiration of the Employee Lease Term under the Seller FSA for claims incurred in 2018 exceeds the aggregate amount withheld from Transferred Employees' compensation under the Seller FSA for 2018 prior to the expiration of the Employee Lease Term, Purchaser shall transfer (or cause to be transferred) to Seller within 30 days after the expiration of the Employee Lease Term a cash payment equal to such excess, if any.

(iii) In each case, Purchaser shall assume and be solely responsible for all claims for reimbursement by Transferred Employees for 2018 that have not been paid in full as of the expiration of the Employee Lease Term, which claims shall be paid pursuant to and under the terms of the Purchaser FSA, and Purchaser shall indemnify and hold harmless Seller and its Affiliates from any and all claims by or with respect to Transferred Employees for reimbursement under the Seller FSA that have not been paid in full as of the expiration of the Employee Lease Term; provided, however, that the foregoing indemnification shall not apply to any claims that were adjudicated under the terms of the Seller FSA on or prior to the expiration of the Employee Lease Term. Purchaser agrees to cause the Purchaser FSA to honor through the end of the calendar year in which the Employee Lease Term expires the elections made by each Transferred Employee under the Seller FSA in respect of the flexible spending reimbursement accounts under the Purchaser FSA that are in effect immediately prior to the expiration of the Employee Lease Term, subject to each Transferred Employee's ability to adjust such elections pursuant to the terms of the Purchaser FSA. For the avoidance of doubt, except as provided herein, (A) in no event shall Seller or any of its Affiliates have any liability or obligation under the Purchaser FSA, and (B) any Transferred Employee who elects coverage under a high deductible health plan may be ineligible to make continuing elections under the Purchaser health care FSA pursuant to the terms of such plans.

For the avoidance of doubt, if the Employee Lease Term ends on December 31, 2017, Purchaser shall have no obligation to provide credits as described in this Section 6.01(k).

(l) In respect of each Employee who becomes a Transferred Employee, Seller and Purchaser shall adopt the "standard procedure" for preparing and filing IRS Forms W-2 (Wage

and Tax Statements), as described in Revenue Procedure 2004-53. Under this procedure, Purchaser, as successor employer, shall provide, as applicable, all required Forms W-2 to all Employees who become Transferred Employees reflecting only wages paid and Taxes withheld by Purchaser and its Affiliates as the successor employer. In addition, Seller and Purchaser shall adopt the "standard procedure" of Revenue Procedure 2004-53 for purposes of filing IRS Forms W-4 (Employee's Withholding Allowance Certificate) and W-5 (Earned Income Credit Advance Payment Certificate).

(m) Purchaser or one of its Affiliates shall grant during the first "open window" trading period following the expiration of the Employee Lease Term new awards, payable in cash or in stock (each, a " New Award"), vesting over two (2) years, to each Transferred Employee who, as a result of the transactions contemplated by this Agreement, forfeits restricted share units, performance share units or stock appreciation rights that were granted pursuant to any Employee Benefit Plan prior to the date hereof and are not vested as of the expiration of the Employee Lease Term (each, a " Seller Forfeited Equity Award"). The value of the New Awards will be no less than the value of the Seller Forfeited Equity Awards, both individually and in the aggregate. Seller shall provide Purchaser with a schedule of the value of each Seller Forfeited Equity Award as soon as practicable following the termination of the Employee Lease Term.

(n) Purchaser agrees to cause its Affiliate to (i) provide coverage for the Transferred Employees under its employee benefit plans as of the applicable Transfer Date, (ii) waive any preexisting conditions, waiting periods and actively at work requirements under such plans and (iii) cause such plans to honor any expenses incurred by the Transferred Employees and their beneficiaries under similar Employee Benefit Plans during the portion of the calendar year in which the Transfer Date occurs for purposes of satisfying applicable deductible, co-insurance and maximum out-of-pocket expenses. Transferred Employees shall be given credit under each employee benefit plan, program, policy or arrangement of Purchaser in which the Transferred Employees are eligible to participate for all service with Seller (to the extent such credit was given by the applicable Employee Benefit Plan) for all purposes (except that no benefit accrual will be provided under any defined benefit pension plans), except to the extent it would result in a duplication of benefits.

(o) The parties hereto shall coordinate with each other prior to the Closing Date as to the form and content of any material, broad based communication from Purchaser or any of its Affiliates to the Employees. Seller acknowledges, understands and agrees, on behalf of itself and its Affiliates, that Purchaser shall, from the date hereof, be allowed to approach and meet with all Employees. Seller and its Affiliates shall permit Purchaser reasonable access to all Employees; provided, that such access shall not interfere with the operations of the Business, and that when on Seller premises, Purchaser shall abide by any Seller security protocols. In no event shall Purchaser or any of its employees have access to the systems of Seller.

(p) Seller, Purchaser and their respective Affiliates shall promptly take all steps necessary to fulfill their obligations, and to cause their applicable employee benefit plans to fulfill the obligations that Seller and Purchaser have agreed to pursuant to this Section 6.01. All transfers of information required by this Section 6.01 shall be made at the time and in the manner (including applicable file format) as reasonably requested by Purchaser or its applicable vendor.

In furtherance thereof, Seller shall provide to Purchaser a complete employee data file, in the format and with the elements prescribed by Purchaser, no later than October 23, 2017.

(q) Seller shall be solely responsible for and shall discharge all retention bonuses under Business Employee Benefit Plans that become vested at or prior to the termination of the Employee Lease Term (" Seller Retention Bonus Liabilities").

Section 6.02. No Third Party Beneficiaries. Notwithstanding the provisions of this Article VI , this Article VI is not intended to and shall not (a) create any third party rights, (b) amend any Employee Benefit Plan or Business Employee Benefit Plan, (iii) require Purchaser or any of its Affiliates to continue any Business Employee Benefit Plan beyond the time when it otherwise lawfully could be terminated or modified, or (d) require Purchaser or any of its Affiliates to continue to employ any Transferred Employee for any specified period, or (e) provide any Transferred Employee with any rights to continued employment, severance pay or similar benefits following any termination of employment.

ARTICLE VII.

TAX MATTERS

Section 7.01. Allocation of Consideration. In addition to the allocation of the Purchase Price contemplated by Article II , Seller and Purchaser shall further allocate the Purchase Price, as finally determined pursuant to Article II , and any other applicable consideration (the " Allocable Amount") in accordance with the requirements of Section 1060 of the Code (and the regulations promulgated thereunder) for all Tax purposes; provided that such allocation for Tax purposes shall be consistent with the allocation of the Purchase Price as contemplated by Article II. As soon as practicable following the date on which the Final Closing Statement becomes final and binding on the parties pursuant to Section 2.09(f) , Seller shall prepare a schedule reflecting the allocation of the Allocable Amount and shall submit such allocation to Purchaser for review. Purchaser and Seller shall use commercially reasonable efforts to agree on the amount and proper allocation of the Allocable Amount in accordance with Section 1060 of the Code. If Seller and Purchaser have not agreed on the allocation within 90 calendar days after the date on which the Final Closing Statement become final and binding on the parties pursuant to Section 2.09(f) , then Purchaser and Seller shall each have the right to deliver notice to the other party of its intent to refer the matter for resolution to the Independent Accountant. Purchaser and Seller will each deliver to the other and to the Independent Accountant a notice setting forth in reasonable detail their proposed allocations. Within 30 days after receipt thereof, the Independent Accountant will deliver the allocation schedule and provide a written description of the basis for its determination of the allocations therein (such allocations, whether agreed to by Purchaser and Seller or determined by the Independent Accountant (the " Final Allocation") shall be final, binding and conclusive on Purchaser and Seller and the parties will report, and will cause their respective Affiliates to report, the federal, state, local and other Tax consequences of the transactions, including the filing of Internal Revenue Service Form 8594, in a manner consistent with such Final Allocation). One-half of all fees, costs and expenses of retaining the Independent Accountant shall be borne by Seller and one-half of such fees, costs and expenses of retaining the Independent Accountant shall be borne by Purchaser. Each party will bear the costs of its own counsel, witnesses (if any) and employees.

Section 7.02. Transfer Taxes. Any Transfer Taxes shall be borne fifty percent (50%) by Seller and fifty percent (50%) by Purchaser. Seller and Purchaser shall cooperate in (a) determining the amount of Transfer Taxes, (b) obtaining any relief, exemption or refund of any such Transfer Tax, (c) preparing and timely filing any and all required Tax Returns for or with respect to such Transfer Taxes with any and all appropriate Tax authorities, (d) promptly providing the other party with evidence that such Transfer Taxes have been paid, and (e) promptly reimbursing the other party for fifty percent (50%) of such Transfer Taxes, as applicable. " Transfer Taxes" means any and all sales, use, stamp, documentary, filing, recording, transfer, goods and services, provincial sales, harmonized sales, excise, real estate, stock transfer, intangible property transfer, personal property transfer, gross receipts, registration, securities transactions, conveyance and notarial Taxes, and similar fees, Taxes and governmental charges (together with any interest, penalty, addition to Tax, and additional amount imposed in respect thereof) arising out of or in connection with the transactions contemplated by this Agreement.

Section 7.03. Cooperation and Exchange of Information. Seller and Purchaser shall provide each other with such cooperation and information as either of them or their respective Affiliates may reasonably request of the other in filing any Tax Return, amended Tax Return or claim for Tax refund, determining a liability for Taxes or a right to a Tax refund, or participating in or conducting any contest in respect of Taxes (a " Tax Contest"). Such cooperation and information shall include providing copies of relevant Tax Returns or portions thereof, together with accompanying schedules, related work papers and documents relating to rulings or other determinations by Tax Authorities. Each party and its Affiliates shall make its employees available on a basis mutually convenient to both parties to provide explanations of any documents or information provided hereunder. Each of Seller and Purchaser shall retain all Tax Returns, schedules and work papers, records and other documents in its possession relating to Tax matters of the Business for each Tax period first ending after the Closing Date and for all prior Tax periods until the later of (i) the expiration of the statute of limitations of the Tax period to which such Tax Returns and other documents relate, without regard to extensions except to the extent notified in writing of such extensions for the respective Tax periods, and (ii) three years following the due date (without extension) for such Tax Returns. Any information obtained under this Section 7.03 shall be kept confidential except as otherwise may be necessary in connection with the filing of Tax Returns or claims for Tax refunds or in conducting a contest or as otherwise may be required by Applicable Law or the rules of any stock exchange. Seller shall promptly notify Purchaser if, as a result of the amendment of any Tax Return, any claim or assessment by any Tax authority or any other cause, the Tax reserves in respect of the Ceded Insurance Contracts no longer accurately reflect the reserves maintained by Seller, the Ceding Company of any of its Affiliates as of the Closing Date (immediately prior to the Closing) with respect to the Ceded Insurance Contracts, and shall provide Purchaser updated information of such reserves. Upon receipt of such information, Purchaser shall provide Seller with a revised Purchase Price allocation in accordance with the principles of Section 7.01.

Section 7.04. Miscellaneous. Seller and Purchaser agree to treat all payments (other than interest on a payment) made by either of them to or for the benefit of the other or the other's Affiliates under this Article VII and under other indemnity provisions of this Agreement as adjustments to the Purchase Price for Tax purposes and that such treatment shall govern for purposes hereof to the extent permissible under Applicable Law.

ARTICLE VIII.

CONDITIONS TO CLOSING

Section 8.01. Conditions to Obligations of Each Party.

The respective obligations of each party hereto to consummate the transactions contemplated by this Agreement shall be subject to the fulfillment or waiver, at or prior to the Closing, of each of the following conditions:

(a) Governmental Consents and Approvals. All consents, approvals, or authorizations of, declarations or filings with, or notices to, any Governmental Authority in connection with the transactions contemplated hereby that are set forth in Section 8.01(a) of the Seller Disclosure Schedule shall have been obtained or made and shall be in full force and effect, and all waiting periods required under Applicable Law with respect thereto shall have expired or been terminated, in each case without the imposition of a Burdensome Condition with respect to the party asserting the failure of this condition.

(b) No Injunction or Illegality. There shall be no law or Governmental Order in existence that prohibits the consummation of the transactions contemplated by this Agreement.

(c) Reinsurance Consents. Seller shall have received the Munich Consent and the Hannover Consent.

Section 8.02. Conditions to Obligations of Purchaser.

The obligations of Purchaser under this Agreement are subject to the satisfaction on or prior to the Closing Date of the following conditions, any one or more of which may be waived by Purchaser to the extent permitted by Applicable Law:

(a) Representations and Warranties. (i) Each of the Seller Specified Representations that are qualified by materiality or Material Adverse Effect shall be true and correct in all respects, and each of the other Seller Specified Representations that are not so qualified shall be true and correct in all material respects and (ii) each of the representations and warranties of Seller contained in Article III of this Agreement (other than those referenced in subclause (i) above) shall be true and correct in all respects (without regard to materiality or Material Adverse Effect qualifiers), in each case as of the Closing Date with the same force and effect as though made on and as of the Closing Date (except to the extent that any such representations and warranties are given as of a particular date and relate solely to a particular date or period, which representations and warranties shall be true and correct as of such date or period), except in the case of clause (ii) above where the failure to be true and correct would not have, individually or in the aggregate, a Material Adverse Effect.

(b) Covenants. Seller and its Affiliates shall have performed and complied in all material respects with all covenants and agreements required by this Agreement to be performed or complied with by Seller and its Affiliates on or prior to the Closing Date.

(c) Closing Deliverables. Seller shall have delivered or caused to be delivered to Purchaser each of the documents required to be delivered by Seller pursuant to Section 2.08(a).

Section 8.03. Conditions to Obligations of Seller. The obligations of Seller under this Agreement are subject to the satisfaction on or prior to the Closing Date of the following conditions, any one or more of which may be waived by Seller to the extent permitted by Applicable Law:

(a) Representations and Warranties. (i) Each of the Purchaser Specified Representations that are qualified by materiality or Purchaser Material Adverse Effect shall be true and correct in all respects, and each of the other Purchaser Specified Representations that are not so qualified shall be true and correct in all material respects and (ii) each of the representations and warranties of Purchaser contained in Article IV of this Agreement (other than those referenced in subclause (i) above) shall be true and correct in all respects (without regard to materiality or Purchaser Material Adverse Effect qualifiers), in each case as of the Closing Date with the same force and effect as though made on and as of the Closing Date (except to the extent that any such representations and warranties are given as of a particular date and relate solely to a particular date or period, which representations and warranties shall be true and correct as of such date or period), except in the case of clause (ii) above where the failure to be true and correct would not have, individually or in the aggregate, a Purchaser Material Adverse Effect.

(b) Covenants. Purchaser shall have performed and complied in all material respects with all covenants and agreements required by this Agreement to be performed or complied with by Purchaser on or prior to the Closing Date.

(c) Triggering Event. Assuming for the purposes of this Section 8.03(c) that the Reinsurance Agreement is in full force and effect at all applicable times prior to the Closing, there shall not have been a Triggering Event (as defined in the Reinsurance Agreement) under the Reinsurance Agreement.

(d) Closing Deliverables. Purchaser shall have delivered or caused to be delivered to Seller each of the documents required to be delivered by Purchaser pursuant to Section 2.08(b).

ARTICLE IX.

TERMINATION PRIOR TO CLOSING

Section 9.01. Termination of Agreement. This Agreement may be terminated at any time prior to the Closing:

(a) by Seller or Purchaser in writing, if there shall be any order, injunction or decree of any Governmental Authority which prohibits or restrains the parties from consummating the transactions contemplated hereby, and such order, injunction or decree shall have become final and nonappealable; provided that prior to termination under this Section 9.01(a) , the party seeking to terminate this Agreement shall have used best efforts to have such order, injunction or decree vacated;

(b) by either Seller or Purchaser in writing, if the Closing has not occurred on or before February 1, 2018 (as it may be extended as contemplated below or by Section 11.14 , the " Outside Date"), unless the failure of the Closing to occur is the result of a breach of this Agreement by the party seeking to terminate this Agreement; provided that, if on the Outside Date the condition set forth in Section 8.01(a) has not been satisfied then, upon the written notice of Seller to Purchaser, the Outside Date shall be extended to a date and time that is not later than 5:00 p.m., New York City time, on March 31, 2018;

(c) by either Seller or Purchaser (but only so long as Seller or Purchaser, as applicable, is not in material breach of its obligations under this Agreement) in writing, if a material breach of any provision of this Agreement that has been committed by the other party would cause the failure of any mutual condition to Closing or any condition to Closing for the benefit of the non-breaching party and such breach is not subsequently waived by the non-breaching party or capable of being cured or is not cured within 20 Business Days after the breaching party receives written notice from the non-breaching party that the non-breaching party intends to terminate this Agreement pursuant to this Section 9.01(c);

(d) by Seller if, (i) except for the condition in Section 8.03(c) , all of the conditions set forth in Section 8.01 , Section 8.02 and Section 8.03 have been satisfied or waived (other than those conditions that by their terms are to be satisfied at the Closing, so long as such conditions are capable of being satisfied at the Closing) and (ii) the Closing has not occurred at the then most recent date on which it was otherwise required to occur pursuant to Section 2.06 because the condition set forth in Section 8.03(c) has not been satisfied; or

(e) at any time on or prior to the Closing Date, by mutual written consent of Seller and Purchaser.

Section 9.02. Termination Procedure. In the event of termination by Purchaser or Seller pursuant to Section 9.01 , written notice thereof shall forthwith be given to the other party and the transactions contemplated by this Agreement shall be terminated, without further action by any party. If the transactions contemplated by this Agreement are terminated as provided herein:

(a) Each party shall, and shall cause its Representatives to, return all documents and other material received from the other party and its Affiliates relating to the transactions contemplated hereby, whether so obtained before or after the execution hereof, to the other party; and

(b) all information received by Purchaser or any of its Representatives with respect to the Business shall be treated in accordance with the Confidentiality Agreement and Section 5.04.

Section 9.03. Survival. In the event of the termination of this Agreement as provided in Section 9.01 , this Agreement shall thereafter become null and void as to all parties, and no party hereto shall have any liability to any other party hereto or their respective Representatives, except as set forth in Section 5.04 , this Article IX and Article XI , which shall survive the termination hereof pursuant to this Article IX; provided , however , that nothing in this Agreement shall relieve any party hereto from liability for (x) any willful and material breach of this Agreement prior to such termination or (y) fraud in the event that such party is finally

determined by a court of competent jurisdiction to have willfully and knowingly committed a fraud, with specific intent to deceive and mislead any other party, regarding such party's representations, warranties, covenants or other agreements set forth in this Agreement; provided , further , that any claim for fraud may only be brought against the party that committed such fraud. For purposes hereof, "willful and material breach" means a material breach by a party of the applicable provision of this Agreement as a result of an action or failure to act by such Person that it actually knew would result in a breach of this Agreement.

ARTICLE X.

INDEMNIFICATION

Section 10.01. Survival.

(a) The representations and warranties of Seller and Purchaser contained in this Agreement shall survive the Closing solely for purposes of this Article X and shall terminate and expire on the date that is 18 months following the Closing Date; provided , that the Seller Specified Representations and the Purchaser Specified Representations and the representations and warranties of Seller set forth in Section 3.17 shall survive until the date that is 60 days following the expiration of the applicable statute of limitations and the representations and warranties of Seller set forth in Section 3.18(d) or Section 3.19 will terminate and be of no further force and effect from and after the Closing. Any claim for indemnification in respect of any representation or warranty that is not asserted by notice given as required herein prior to the expiration of the specified period of survival shall not be valid and any right to indemnification is hereby irrevocably waived after the expiration of such period of survival. Any claim properly made for an Indemnifiable Loss in respect of such a breach asserted within such period of survival as herein provided will be timely made for purposes hereof.

(b) To the extent that it is to be performed after the Closing, each covenant in this Agreement will, for purposes of this Article X , survive and remain in effect in accordance with its terms plus a period of six months thereafter, after which no claim for indemnification with respect thereto may be brought hereunder. All covenants in this Agreement that by their terms are required to be fully performed prior to the Closing will, for purposes of this Article X , survive and remain in effect until the date that is 18 months following the Closing Date, after which time no claim for indemnification with respect thereto may be brought hereunder; provided , however , that the covenants set forth in Section 5.11 will terminate and be of no further force and effect from and after the Closing.

Section 10.02. Indemnification.

(a) Seller shall indemnify, defend and hold harmless Purchaser, its Affiliates and their respective directors, officers and employees, successors and, in connection with a sale of all or substantially all of the group benefits business of Purchaser and its Affiliates, assignees (provided , that in the case of any such sale during the 18-month period after the Closing, Seller shall have provided its consent to such assignment) (collectively, the " Purchaser Indemnified Persons") from and against any and all Indemnifiable Losses asserted against, imposed upon or incurred or suffered by any Purchaser Indemnified Person resulting from or arising out of:

(i) any inaccuracy in or breach of any representation or warranty of Seller made in this Agreement;

(ii) any breach or non-fulfillment of any agreement or covenant of Seller under this Agreement; or

(iii) any Excluded Liabilities including Excluded Taxes.

(b) Purchaser shall indemnify, defend and hold harmless Seller, its Affiliates and their respective directors, officers and employees (collectively, the " Seller Indemnified Persons") from and against any and all Indemnifiable Losses asserted against, imposed upon or incurred or suffered by any Seller Indemnified Person resulting from or arising out of:

(i) any inaccuracy in or breach of any representation or warranty of Purchaser made in this Agreement;

(ii) any breach or non-fulfillment of any agreement or covenant of Purchaser under this Agreement;

(iii) any Assumed Liability; or

(iv) the operation of the Business from and after the Closing Date (except to the extent such Indemnifiable Loss is subject to indemnification by Seller of a Purchaser Indemnified Person pursuant to Section 10.02(a)).

(c) For purposes of determining whether any representation and warranty (other than the representations and warranties set forth in Section 3.06(a) and Section 3.22) has any inaccuracy or been breached and the amount of any Indemnifiable Losses under this Article X , each representation and warranty contained in this Agreement shall be read without regard to any materiality or Material Adverse Effect qualifier contained therein.

Section 10.03. Certain Limitations.

(a) Except with respect to Indemnifiable Losses resulting from Excluded Taxes or from any inaccuracy in or breach of a representation or warranty set forth in Section 3.17 , no party shall be obligated to indemnify and hold harmless its respective Indemnitees under Section 10.02(a)(i) (in the case of Seller, and other than with respect to an inaccuracy in or breach of any Seller Specified Representation) or Section 10.02(b)(i) (in the case of Purchaser, and other than with respect to an inaccuracy in or breach of any Purchaser Specified Representation) (i) with respect to any claim or series of claims arising out of substantially similar facts and circumstances, unless such claim or series of claims involves Indemnifiable Losses in excess of $100,000 (the " Threshold Amount") (nor shall any claim that does not exceed the Threshold Amount be applied to or considered for purposes of calculating the amount of Indemnifiable Losses for which the Indemnitor is responsible under clause (ii) below) and (ii) unless and until the aggregate amount of all Indemnifiable Losses of the Indemnitees under Section 10.02(a)(i) or such Section 10.02(b)(i) , as the case may be, exceeds $14,500,000 for all Indemnifiable Losses (the " Deductible"), at which point such Indemnitor shall be liable to its respective Indemnitees for the value of the Indemnitee's claims under Section 10.02(a)(i) (other than with respect to a

breach of any Seller Specified Representation) or Section 10.02(b)(i) (other than with respect to a breach of any Purchaser Specified Representation), as the case may be, that is in excess of the Deductible, subject to the limitations set forth in this Article X; provided , however , that any Indemnifiable Losses of the Purchaser Indemnified Persons resulting from or arising out of any inaccuracy in or breach of any representation or warranty set forth in Section 3.03 shall not be subject to the Deductible, and the Threshold Amount for such Indemnifiable Losses shall be $50,000; provided further that, for the avoidance of doubt, any such Indemnifiable Losses shall be subject to the Threshold Amount and the maximum aggregate liability set forth in the following sentence prior to the proviso set forth therein. The maximum aggregate liability of Seller, on the one hand, and Purchaser on the other hand, to their respective Indemnitees for any and all Indemnifiable Losses under Section 10.02(a)(i) , in the case of Seller (other than with respect to a breach of any Seller Specified Representation), or Sections 10.02(b)(i) , in the case of Purchaser (other than with respect to a breach of any Purchaser Specified Representation), shall be $174,000,000; provided , that the maximum aggregate liability of Seller to all Purchaser Indemnified Persons for any or all Indemnifiable Losses under this Agreement shall not exceed the Purchase Price. The limitations in this Section 10.03(a) shall not apply to claims made under Section 10.02(a)(iii) , Section 10.02(b)(iii) or Section 10.02(b)(iv).

(b) Each Indemnitee shall use commercially reasonable efforts to mitigate all Indemnifiable Losses for which indemnification may be sought hereunder; provided that the costs and expenses of such mitigation shall constitute Indemnifiable Losses hereunder.

(c) Notwithstanding anything to the contrary herein, any Indemnifiable Losses resulting from or arising out of any breach of any representation or warranty of Seller made in this Agreement in respect of Taxes, including under Section 3.17 , shall be limited to Taxes attributable to Pre-Closing Periods.

Section 10.04. Definitions. As used in this Agreement:

(i) "Indemnitee" means any Person entitled to indemnification under this Agreement;

(ii) "Indemnitor" means any Person required to provide indemnification under this Agreement;

(iii) "Indemnifiable Losses" means any and all damages, losses, Liabilities, obligations, costs and expenses (including reasonable attorneys' and other professional fees and expenses); provided , that any Indemnity Payment (x) shall in no event include any amounts constituting consequential or punitive damages, or any damages calculated based on a loss of future revenue, income or profits, relating to the breach or alleged breach of this Agreement; provided , however , that notwithstanding the foregoing or anything to the contrary contained in this Agreement, Indemnifiable Losses shall include recoveries for lost profits (including diminution in value used by a trier of fact in determining lost profits) if and only if (A) such damages for lost profits are recoverable under the laws of the State of New York; (B) the Indemnitee satisfies all elements necessary for proof of

such damages for lost profits under such laws; and (C) such lost profits can be demonstrated by reference to the Actuarial Report and, with respect to the reduction or elimination of any profits contemplated by the Actuarial Report, shall in no event exceed the present value ascribed to any such remaining profits contemplated by the Actuarial Report as of the date of the Indemnifiable Loss giving rise to the related claim, calculated based on the assumptions on which the Actuarial Report was prepared and discounted using a 9% discount rate; provided , further , that the Purchaser Indemnified Persons may recover lost profits only to the extent such lost profits are attributable to the Business; and (y) shall be net of any amounts actually recovered by the Indemnitee for the Indemnifiable Losses for which such Indemnity Payment is made under any insurance policy, reinsurance agreement, warranty or indemnity or otherwise from any Person other than a party hereto (net of any actual costs, expenses or increases in premiums incurred as a result of obtaining such proceeds), and the Indemnitee shall promptly reimburse the Indemnitor for any such amount that is received by it from any such other Person with respect to an Indemnifiable Losses after any indemnification with respect thereto has actually been paid pursuant to this Agreement;

(iv) "Indemnity Payment" means any amount of Indemnifiable Losses required to be paid pursuant to this Agreement; and

(v) "Third Party Claim" means any claim, action, suit, or proceeding made or brought by any Person that is not a party to this Agreement and not an Affiliate of such party to this Agreement.

Section 10.05. Procedures for Third Party Claims.

(a) If any Indemnitee receives notice of assertion or commencement of any Third Party Claim against such Indemnitee in respect of which an Indemnitor may be obligated to provide indemnification under this Agreement, the Indemnitee shall give such Indemnitor reasonably prompt written notice (but in no event later than 30 days after becoming aware of such Third Party Claim) thereof and such notice shall include a reasonable description of the claim based on the facts known at the time and any documents relating to the claim and an estimate of the Indemnifiable Loss and shall reference the specific sections of this Agreement that form the basis of such claim to the extent reasonably ascertainable; provided , that no delay on the part of the Indemnitee in notifying any Indemnitor shall relieve the Indemnitor from any obligation hereunder unless (and then solely to the extent that) the Indemnitor is actually prejudiced by such delay (except that the Indemnitor shall not be liable for any expenses incurred during the period in which the Indemnitee failed to give such notice). Thereafter, the Indemnitee shall deliver to the Indemnitor, within five Business Days after the Indemnitee's receipt thereof, copies of all notices and documents (including court papers) received by the Indemnitee relating to the Third Party Claim.

(b) The Indemnitor shall be entitled to participate in the defense of any Third Party Claim and, if it so chooses, to assume the defense thereof with counsel selected by the

Indemnitor. Should the Indemnitor so elect to assume the defense of a Third Party Claim, the Indemnitor shall not as long as it conducts such defense be liable to the Indemnitee for legal expenses incurred by the Indemnitee in connection with the defense thereof subsequent to the Indemnitor notifying the Indemnitee in writing of its election to assume such defense. If the Indemnitor assumes such defense, the Indemnitee shall have the right to participate in the defense thereof and to employ counsel, at its own expense, separate from the counsel employed by the Indemnitor, it being understood that the Indemnitor shall control such defense. The Indemnitor shall be liable for the reasonable fees and expenses of counsel employed by the Indemnitee (A) for any period during which the Indemnitor has not assumed the defense thereof (other than during any period in which the Indemnitee shall have not yet given notice of the Third Party Claim as provided above) or (B) if the Third Party Claim involves conflicts of interest for the Indemnitee and the Indemnitor (in the reasonable opinion of counsel to the Indemnitee) that would make representation by the same counsel inappropriate, in which event the Indemnitor shall be responsible for only one counsel for the Indemnitee. If the Indemnitor chooses to defend any Third Party Claim, the other party hereto shall cooperate in the defense thereof. Such cooperation shall include the retention and (upon the Indemnitor's request) the provision to the Indemnitor of records and information that are relevant to such Third Party Claim, and making employees available on a mutually convenient basis to provide additional information and explanation of any material provided hereunder; provided , in each case, that such other party shall not be obligated to provide such records, information or access to Indemnitor if doing so would violate Applicable Law or jeopardize the protection of an attorney-client privilege. Whether or not the Indemnitor shall have assumed the defense of a Third Party Claim, the Indemnitee shall not admit any liability with respect to, or pay, settle, compromise or discharge, such Third Party Claim without the Indemnitor's prior written consent (which consent shall not be unreasonably withheld, conditioned or delayed). If the Indemnitor has assumed the defense of a Third Party Claim, the Indemnitor may only pay, settle, compromise or discharge a Third Party Claim with the Indemnitee's prior written consent (which consent shall not be unreasonably withheld, conditioned or delayed); provided , that the Indemnitor may pay, settle, compromise or discharge such a Third Party Claim without the written consent of the Indemnitee if such settlement (i) includes a release of the Indemnitee from all Liability in respect of such Third Party Claim, (ii) does not subject the Indemnitee to any injunctive relief or other equitable remedy, (iii) does not include a statement or admission of fault, culpability or failure to act by or on behalf of the Indemnitee and (iv) does not impose any financial cost on the Indemnitee (other than by application of the limitations set forth in Section 10.03(a)). If the Indemnitor submits to the Indemnitee a bona fide settlement offer with respect to a Third Party Claim that has been accepted by all Persons bringing such Third Party Claim and otherwise satisfies the requirements set forth in the proviso of the immediately preceding sentence and the Indemnitee refuses to consent to such settlement, then thereafter the Indemnitor's liability to the Indemnitee with respect to such Third Party Claim shall not exceed the Indemnitor's portion of the settlement amount included in such settlement offer.

(c) Notwithstanding anything in this Agreement to the contrary, Seller shall have the sole right to represent the interests of the Business and settle all issues in its sole discretion, and to employ counsel of its choice at its expense, in any audit or other examination or administrative or court proceeding relating to Taxes for all taxable periods (or portions thereof) ending on or before the Closing Date; provided , that Seller shall not pay, discharge, settle, compromise, litigate or otherwise dispose of any item subject to such Tax proceedings in a manner that will

adversely affect Purchaser or any of its Affiliates without obtaining the prior written consent of Purchaser, which consent shall not be unreasonably withheld, conditioned or delayed. Notwithstanding the foregoing and subject to Seller's rights set forth in the immediately preceding sentence, Purchaser shall be entitled, at its expense, to participate in the conduct of any Tax audit and any judicial or administrative proceeding relating to any such Tax audit that may adversely affect Purchaser or any of its Affiliates.

Section 10.06. Direct Claims. The Indemnitor will have a period of 30 days within which to respond in writing to any claim by an Indemnitee on account of an Indemnifiable Loss that does not result from a Third Party Claim. If the Indemnitor does not so respond within such 30 day period, the Indemnitor will be deemed to have rejected such claim, in which event the Indemnitee will be entitled to pursue such remedies as may be available to the Indemnitee.

Section 10.07. Sole Remedy. The parties hereto acknowledge and agree that, except as (a) set forth in Section 11.14 , (b) as expressly contemplated by Section 2.09 , (c) for any remedy expressly contemplated by any other Transaction Agreement with respect to a claim made under such Transaction Agreement and (d) under the circumstances described in Section 9.03(y) , if the Closing occurs, their sole and exclusive remedy following the Closing with respect to any and all claims arising out of or related to the transactions contemplated by this Agreement shall be pursuant to the provisions set forth in this Article X.

Section 10.08. Certain Other Matters.

(a) Upon making any Indemnity Payment, Indemnitor will, to the extent of such Indemnity Payment, be subrogated to all rights of Indemnitee against any third Person (other than any Tax Authority) in respect of the Indemnifiable Loss to which the Indemnity Payment related. Without limiting the generality or effect of any other provision hereof, each such Indemnitee and Indemnitor will duly execute upon request all instruments reasonably necessary to evidence and perfect the above-described subrogation rights.

(b) The rights and remedies of any party in respect of any inaccuracy or breach of any representation, warranty, covenant or agreement shall in no way be limited by the fact that the act, omission, occurrence or other state of facts or circumstances upon which any claim of any such inaccuracy or breach is based may also be the subject matter of any other representation, warranty, covenant or agreement as to which there is no inaccuracy or breach. The representations, warranties and covenants of Seller set forth herein (as such representations and warranties are qualified in accordance with the introductory paragraph of Article III), and the Purchaser Indemnified Persons' rights to indemnification with respect thereto, shall not be affected or deemed waived by reason of (and the Purchaser Indemnified Persons shall be deemed to have relied upon such representations and warranties notwithstanding) (i) any investigation made by or on behalf of any of the Purchaser Indemnified Persons (including by any of its Representatives) or by reason of the fact that any of the Purchaser Indemnified Persons or any of such Representatives knew or should have known that any such representation or warranty is, was or might be inaccurate, regardless of whether such investigation was made or such knowledge was obtained before or after the execution and delivery of this Agreement or (ii) Purchaser's waiver of any condition set forth in Article VIII. The representations, warranties and covenants of Purchaser set forth herein (as such representations and warranties are qualified

in accordance with the introductory paragraph of Article IV), and the Seller Indemnified Persons' rights to indemnification with respect thereto, shall not be affected or deemed waived by reason of (and the Seller Indemnified Persons shall be deemed to have relied upon such representations and warranties notwithstanding) (i) any investigation made by or on behalf of any of the Seller Indemnified Persons (including by any of its Representatives) or by reason of the fact that any of the Seller Indemnified Persons or any of such Representatives knew or should have known that any such representation or warranty is, was or might be inaccurate, regardless of whether such investigation was made or such knowledge was obtained before or after the execution and delivery of this Agreement or (ii) Seller's waiver of any condition set forth in Article VIII.

ARTICLE XI.

GENERAL PROVISIONS

Section 11.01. Publicity. Except as may otherwise be required by Applicable Law, regulation or obligation pursuant to any listing agreement with any national securities exchange, no press release or public announcement, including any presentation to the investment community (other than pro forma financial statements and dilution or accretion analyses included in shareholder presentations), concerning this Agreement or the transactions contemplated hereby shall be made by Seller, on the one hand, or Purchaser, on the other hand, prior to the Closing Date without advance approval thereof by the other party, such approval not to be unreasonably withheld. The parties hereto shall cooperate with each other in making any press release or public announcement concerning the Business on or prior to the Closing Date.

Section 11.02. Expenses. Regardless of whether any or all of the transactions contemplated by this Agreement are consummated, and except as otherwise expressly provided herein or in any Transaction Agreement, Purchaser and its Affiliates, on the one hand, and Seller and its Affiliates, on the other hand, shall each bear their respective direct and indirect fees, costs and expenses incurred in connection with the negotiation and preparation of this Agreement, the Transaction Agreements and the consummation of the transactions contemplated hereby or thereby, including all fees and expenses of their respective Representatives.

Section 11.03. Notices. All notices, requests, consents, claims, demands and other communications under this Agreement and the other Transaction Agreements shall be in writing and shall be given or made (and shall be deemed to have been duly given or made upon receipt) by delivery in person, by overnight courier service, by electronic mail (followed by delivery of an original via overnight courier service) or by registered or certified mail (postage prepaid, return receipt requested) to the respective parties hereto at the following respective addresses (or at such other address for a party hereto as shall be specified in a notice given in accordance with this Section 11.03):

(a) If to Purchaser:

Hartford Life and Accident Insurance Company
c/o The Hartford Financial Services Group, Inc.

One Hartford Plaza
Hartford, CT 06155
Attention: Chief Financial Officer, General Counsel
Facsimile: (855) 388-6397
Email address: beth.bombara@thehartford.com,
david.robinson@thehartford.com

With a concurrent copy (which shall not constitute notice) to:

Mayer Brown LLP
1221 Avenue of the Americas
New York, NY 10020
Attention: Stephen G. Rooney, David W. Alberts
Facsimile: (212) 849-5632; (212) 849-5611
Email address: srooney@mayerbrown.com;
dalberts@mayerbrown.com

(b) If to Seller:
Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156
Attention: General Counsel
Facsimile: (212) 457-0301

With a concurrent copy (which shall not constitute notice) to:

Willkie Farr & Gallagher LLP
787 Seventh Avenue
New York, NY 10019
Attention: Michael Groll
Rajab S. Abbassi
Facsimile: (212) 728-8111
Email address: mgroll@willkie.com
rabbassi@willkie.com

Any party may, by notice given in accordance with this Section 11.03 to the other parties, designate another address or person for receipt of notices hereunder, provided that notice of such a change shall be effective upon receipt.

Section 11.04. Entire Agreement. Except as otherwise expressly provided in the Transaction Agreements, this Agreement and the other Transaction Agreements constitute the entire agreement of the parties hereto with respect to the subject matter of the Transaction Agreements and supersede all prior agreements and undertakings, both written and oral, other than the Confidentiality Agreement to the extent not in conflict with this Agreement, between or on behalf of Seller and its Affiliates, on the one hand, and Purchaser and its Affiliates, on the other hand, with respect to the subject matter of the Transaction Agreements.

Section 11.05. Severability. If any term or other provision of this Agreement is invalid, illegal or incapable of being enforced under any Applicable Law or as a matter of public policy, all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect so long as the economic or legal substance of the transactions contemplated by this Agreement is not affected in any manner materially adverse to any party hereto. Upon such determination that any term or other provision is invalid, illegal or incapable of being enforced, the parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the parties hereto as closely as possible in a mutually acceptable manner in order that the transactions contemplated by this Agreement be consummated as originally contemplated to the greatest extent possible. If any provision of this Agreement is determined by a court of competent jurisdiction to be so broad as to be unenforceable, that provision shall be interpreted to be only so broad as it is enforceable.

Section 11.06. Assignment. This Agreement may not be assigned, in whole or in part, by operation of law or otherwise without the prior written consent of the parties hereto. Any attempted assignment in violation of this Section 11.06 shall be void. This Agreement shall be binding upon, shall inure to the benefit of, and shall be enforceable by the parties hereto and their successors and permitted assigns.

Section 11.07. Waivers and Amendments. No provision of this Agreement or any other Transaction Agreements may be amended, supplemented or modified except by a written instrument signed by all of the parties thereto. No provision of this Agreement or any other Transaction Agreements may be waived except by a written instrument signed by the party against whom the waiver is to be effective.

Section 11.08. Disclosure Schedules. Matters reflected in any Section of this Agreement, including any section or subsection of the Seller Disclosure Schedule or Purchaser Disclosure Schedule, are not necessarily limited to matters required by this Agreement to be so reflected. Such additional matters are set forth for informational purposes and do not necessarily include other matters of a similar nature. No reference to or disclosure of any item or other matter in any Section or Schedule of this Agreement, including any section or subsection of the Seller Disclosure Schedule or Purchaser Disclosure Schedule, shall be construed as an admission or indication that such item or other matter is material or that such item or other matter is required to be referred to or disclosed in this Agreement, the Seller Disclosure Schedule or Purchaser Disclosure Schedule. Without limiting the foregoing, no such reference to or disclosure of a possible breach or violation of any contract, Applicable Law or Governmental Order shall be construed as an admission or indication that breach or violation exists or has actually occurred.

Section 11.09. Governing Law; Submission to Jurisdiction; Waiver of Jury Trial.

(a) THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF NEW YORK WITHOUT REGARD TO SUCH STATE'S PRINCIPLES OF CONFLICT OF LAW THAT COULD COMPEL THE APPLICATION OF THE LAWS OF ANOTHER JURISDICTION.

(b) Each party hereto irrevocably and unconditionally submits to the exclusive jurisdiction of any federal court located in New York County in the State of New York, over any

action, suit or proceeding arising out of or relating to this Agreement or the transactions contemplated hereby; provided , however , that, if said court determines that it does not have subject matter jurisdiction, then said action, suit or proceeding may be brought in the Supreme Court of the State of New York for New York County. Each party hereto agrees that service of any process, summons, notice or document by U.S. registered mail addressed to such party shall be effective service of process for any action, suit or proceeding brought against such party in any such court. Purchaser hereby designates the individual listed in Section 11.03(a) to whom notice may be given on behalf of Purchaser as its true and lawful agent upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of Seller. Seller hereby designates the individual listed in Section 11.03(b) to whom notice may be given on behalf of Seller as its true and lawful agent upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of Purchaser. In the event either party decides to change its designation of agent, it shall provide written notice to the other party. Each party hereto irrevocably and unconditionally waives any objection to the laying of venue of any such action, suit or proceeding brought in any such court and any claim that any such action, suit or proceeding brought in any such court has been brought in an inconvenient forum. Each party hereto agrees that any final, nonappealable judgment in any such action, suit or proceeding brought in any such court shall be conclusive and binding upon such party and may be enforced in any other courts to whose jurisdiction such party may be subject, by suit upon such judgment.

(c) EACH OF THE PARTIES HERETO HEREBY WAIVES TO THE FULLEST EXTENT PERMITTED BY LAW ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY WITH RESPECT TO ANY LITIGATION DIRECTLY OR INDIRECTLY ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT. EACH OF THE PARTIES HERETO HEREBY (A) CERTIFIES THAT NO REPRESENTATIVE, AGENT OR ATTORNEY OF THE OTHER PARTY HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT SUCH OTHER PARTY WOULD NOT, IN THE EVENT OF LITIGATION, SEEK TO ENFORCE THE FOREGOING WAIVER, AND (B) ACKNOWLEDGES THAT IT HAS BEEN INDUCED TO ENTER INTO THIS AGREEMENT AND THE TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT, AS APPLICABLE, BY, AMONG OTHER THINGS, THE MUTUAL WAIVERS AND CERTIFICATIONS IN THIS SECTION 11.09.

Section 11.10. Rules of Construction. Interpretation of this Agreement and the other Transaction Agreements (except as specifically provided in any such other Transaction Agreements, in which case such specified rules of construction shall govern with respect to such other Transaction Agreements) shall be governed by the following rules of construction: (a) words in the singular shall be held to include the plural and vice versa, and words of one gender shall be held to include the other gender as the context requires; (b) references to the terms Preamble, Recitals, Article, Section, paragraph, Schedule and Exhibit are references to the Preamble, Recitals, Articles, Sections, paragraphs, Schedules and Exhibits to this Agreement unless otherwise specified; (c) references to "$" mean, and all payments required to be made under this Agreement shall be required to be made in, U.S. dollars; (d) the word "including" and words of similar import means "including without limitation," unless otherwise specified; (e) the word "or" shall not be exclusive; (f) the words "herein," "hereof," "hereunder" or "hereby" and similar terms are to be deemed to refer to this Agreement as a whole and not to any specific Section; (g) the headings are for reference purposes only and shall not affect in any way the

meaning or interpretation of the Transaction Agreements; (h) the Transaction Agreements shall be construed without regard to any presumption or rule requiring construction or interpretation against the party drafting or causing any instrument to be drafted; (i) if a word or phrase is defined, the other grammatical forms of such word or phrase have a corresponding meaning; (j) references to any statute, listing rule, rule, standard, regulation or other law include a reference to the corresponding rules and regulations; (k) references to any section of any statute, listing rule, rule, standard, regulation or other law include any successor or amendment to such section; (l) references to any Person include such Person's predecessors or successors, whether by merger, consolidation, amalgamation, reorganization or otherwise; and (m) references to any contract (including this Agreement) or organizational document are to the contract or organizational document as amended, modified, supplemented or replaced from time to time, unless otherwise stated.

Section 11.11. Certain Limitations.

(a) Notwithstanding anything to the contrary contained in this Agreement, the other Transaction Agreements, the Seller Disclosure Schedule or any of the Schedules or Exhibits hereto or thereto, Purchaser acknowledges and agrees that neither Seller nor any of its Representative makes or has made, and Purchaser has not relied on, any inducement or promise to Purchaser except as specifically made in this Agreement or any representation or warranty to Purchaser, oral or written, express or implied, other than as expressly set forth in Article III. Without limiting the generality of the foregoing, other than as expressly set forth in Article III , no Person has made any representation or warranty to Purchaser with respect to the Business, the Transferred Assets (including the Assigned Contracts), the Assumed Liabilities or any other matter, including with respect to (i) merchantability, suitability or fitness for any particular purpose, (ii) the operation of the Business by Purchaser after the Closing, (iii) the probable success or profitability of the Business after the Closing or (iv) any information, documents or material made available to Purchaser or its Representatives in any "data rooms," information memoranda, management presentations, functional "break-out" discussions or in any other form or forum in connection with the transactions contemplated by this Agreement, including any estimation, valuation, appraisal, projection or forecast with respect to the Business. With respect to any such estimation, valuation, appraisal, projection or forecast (including the confidential information memoranda prepared by or on behalf of Seller in connection with the transactions contemplated by this Agreement or the any actuarial reports provided to Purchaser), Purchaser acknowledges that: (i) there are uncertainties inherent in attempting to make such estimations, valuations, appraisals, projections and forecasts; (ii) it is familiar with such uncertainties; (iii) it is not acting and has not acted in reliance on any such estimation valuation, appraisal, projection or forecast delivered by or on behalf of Seller to Purchaser; (iv) such estimations, valuations, appraisals, projections and forecasts are not and shall not be deemed to be representations or warranties of Seller or any of its Affiliates and (v) it shall have no claim against any Person with respect to any such valuation, appraisal, projection or forecast.

(b) Seller makes no express or implied representation or warranty hereby or otherwise under this Agreement: (i) as to the future experience, success or profitability of the Business, whether or not conducted in a manner similar to the manner in which the Business was conducted prior to the Closing; (ii) that the reserves held by or on behalf of the Business or the assets supporting such reserves have been or will be adequate or sufficient for the purposes for

which they were established; (iii) that the reinsurance recoverables taken into account in determining the amount of such reserves will be collectible or whether such reserves were calculated, established or determined in accordance with any actuarial, statutory or other standard; or (iv) concerning any financial statement "line item" or asset, liability or equity amount that would be affected by any of the foregoing.

(c) Purchaser further acknowledges and agrees that it: (i) has made its own inquiry and investigation into and, based thereon, has formed an independent judgment concerning the Business, the Transferred Assets (including the Assigned Contracts) and the Assumed Liabilities; (ii) has been provided adequate access to such information as it has deemed necessary to enable it to form such independent judgment; (iii) has had such time as it deems necessary and appropriate fully and completely to review and analyze such information, documents and other materials; and (iv) has been provided an opportunity to ask questions of Seller with respect to such information, documents and other materials and has received answers to such questions that it considers satisfactory. Purchaser further acknowledges and agrees that neither Seller nor any of its Affiliates has made any representations or warranties, express or implied, as to the accuracy or completeness of, and that Purchaser and its Affiliates have made their investment decision with respect to the acquisition of the Transferred Assets without reliance upon, such information, documents and other materials other than the representations and warranties expressly set forth in this Agreement.

Section 11.12. No Third Party Beneficiaries. Nothing in this Agreement is intended or shall be construed to give any Person (including the employees of Seller or Purchaser or any Affiliate of Seller or Purchaser), other than the parties hereto, their successors and permitted assigns, any legal or equitable right, remedy or claim under or in respect of this Agreement or any provision contained herein.

Section 11.13. Execution in Counterparts. This Agreement may be executed by the parties hereto in separate counterparts, each of which when so executed and delivered shall be an original, but all such counterparts shall together constitute one and the same instrument. Delivery of an executed counterpart of a signature page to any Transaction Agreement by facsimile or other means of electronic transmission utilizing reasonable image scan technology shall be as effective as delivery of a manually executed counterpart of any such Agreement.

Section 11.14. Equitable Remedies. The parties hereto agree that irreparable damage would occur in the event that any of the provisions of this Agreement were not performed in accordance with their specific terms or were otherwise breached. It is accordingly agreed that, without the necessity of posting bond or other undertaking, the parties hereto shall be entitled to an injunction or injunctions to prevent breaches of this Agreement and to enforce specifically the terms and provisions of this Agreement in accordance with this Agreement, this being in addition (subject to the terms of this Agreement) to any other remedy to which such party is entitled at law or in equity. In the event that any Action is brought in equity to enforce the provisions of this Agreement, no party hereto shall allege, and each party hereto hereby waives any defense or counterclaim, that there is an adequate remedy at law. If, prior to the Outside Date, any party hereto brings any Action in accordance with this Section 11.14 to enforce specifically the performance of the terms and provisions hereof by the other party, the Outside Date shall be automatically extended (i) for the period during which such action is pending, plus 10 Business Days or (ii) by such other time period established by the court presiding over such action, as the case may be.

(The remainder of this page is intentionally left blank)

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

AETNA INC.

By: /s/ Bjorn Thaler

Name: Bjorn Thaler

Title: Authorized Signatory

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

By: /s/ Michael Concannon

Name: Michael Concannon

Title: Authorized Signatory

[Signature Page to Master Transaction Agreement **]**

Exhibit 10.36

2018 Management Incentive Plan

I. Objectives and Summary

CVS Health Corporation's Management Incentive Plan (the "MIP") is designed to reward incentive-eligible employees ("Eligible Participants") of CVS Health Corporation and its subsidiaries (together, "the Company") for their role in driving performance and to encourage Eligible Participants' continued employment with the Company. Funding for the payment of incentive awards will be based on actual results measured against pre-established financial goals and/or operating goals. The amount of each incentive award paid will be based on the performance of the Company and the performance of the individual Eligible Participant.

The MIP shall be administered by the Management Planning and Development Committee (the "Committee") of the Board of Directors (the "Board") under the provisions herein and of the 2017 Incentive Compensation Plan or any successor plan (the "ICP"), and the Committee may delegate to officers of CVS Health the authority to perform administrative functions of the MIP as the Committee may determine and may appoint officers and others to assist it in administering the MIP.

II. Plan Year

The MIP is a calendar year plan, which runs from January 1 to December 31, 2018 ("Plan Year"). All dates in this document occur during the current Plan Year unless otherwise stated.

III. Eligibility

A. Eligibility for Participation

The Chief Executive Officer of CVS Health Corporation ("CEO") or the CEO's designee determines those employees who are eligible to participate in the MIP except as set forth in Section III.B, below. In general, Eligible Participants include exempt employees who are not covered by any other incentive plans and who are employed on or before November 1 of the Plan Year.

The CEO may, for any reason and in his or her sole discretion, at any time during the Plan Year, determine an employee's eligibility for participation in the MIP except as set forth in Section III.B. Eligible Participants are subject to the terms and conditions relating to incentive awards set forth in the MIP.

B. Section 16 Officers

The Committee shall determine the eligibility of Section 16 Officers of CVS Health, whom will also be included in the term "Eligible Participants" unless otherwise noted. The Committee shall retain sole discretion to determine Section 16 Officer eligibility for an award, the target award, and the amount of the actual award.

C. Newly-Eligible Employees

The award, if any, to an Eligible Participant who became an Eligible Participant after the beginning of the Plan Year may be prorated based on the date of eligibility.

D. Position Change

An employee who becomes an Eligible Participant on or before November 1 of the Plan Year as a result of a position change may be eligible for a prorated incentive award. If a position change results in an employee becoming an Eligible Participant for part of the Plan Year and other incentives during other parts of the Plan Year, the employee may be eligible to receive a prorated award for the amount of time in each incentive eligible position, subject to the terms of each applicable incentive plan. A position change from one MIP-eligible

position to another MIP-eligible position during the Plan Year also may result in a prorata award as described below under Section V. (B).

E. Demotions

If a previously Eligible Participant is demoted to a non-incentive eligible position due to his or her violation of CVS Health policy or his or her performance, or if he or she voluntarily transfers to a non-incentive eligible position during the Plan Year, and is in the non-incentive eligible position on the last day of the Plan Year, he or she will not be eligible to earn an incentive award for the Plan Year under the MIP.

F. Terminations

Unless otherwise stated in Section VII of the MIP, if an Eligible Participant's employment terminates prior to March 1 following a Plan Year, he or she will not be eligible to receive an incentive award under the MIP for the most recently completed Plan Year.

G. Rehires

Employees who are rehired as Eligible Participants on or before November 1 of the Plan Year may be eligible for a prorated incentive award. For purposes of proration, credit will only be given for time worked during the Plan Year in incentive-eligible positions.

IV. MIP Funding

A. Consolidated Company Funding

MIP funding is based on consolidated Company performance, measured by Operating Profit, and modified by performance measurements set forth in Exhibit A, for a given Plan Year. Achievement of the Company's Operating Profit target and MIP modifiers will determine the total funding (the "Total Pool") as described below.

1. Operating Profit

Operating Profit may be adjusted by the financial adjustments as approved by the Committee prior to the end of the first fiscal quarter of the Plan Year (the "Financial Adjustments").

If Operating Profit is below the minimum performance threshhold, no formulaic funding will be made available for incentive awards, regardless of MIP modifier metrics performance, and there shall be no incentive awards paid under the MIP.

B. Total Pool Funding

After the minimum threshold for Operating Profit has been achieved, performance of MIP modifiers against target will be calculated for the Plan Year. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The CEO (or, as to Section 16 Eligible Participants, the Committee) may, for any reason and in his or her (or Its) sole discretion, adjust the funding of the Total Pool based on (a) input from senior Company executives regarding their assessment of the overall performance of the Company; and (b) assessment of the achievement of Plan Year performance goals. In no case, however, can the CEO or the Committee increase Total Pool funding due solely to the results of the MIP modifiers.

C. Individual Performance

The Total Pool will be available for award to Eligible Participants under the MIP, taking into account the individual contribution of each Eligible Participant. The amount, if any, of the incentive award for an Eligible Participant shall be detemined in the sole discretion of the Company, which shall be final, binding and conclusive as to all parties having an interest therein. The amount, if any, of the incentive award for a Section 16 Eligible Participant shall be determined in the sole discretion of the Committee, which shall be final, binding and conclusive as to all parties having an interest therein.

V. Earnings, Proration, and Payout

A. Timing

Incentive awards will be paid to Eligible Participants, as soon as administratively feasible following the date the Total Pool is determined and approved, but no later than March 15 of the calendar year immediately following the Plan Year. Incentive payments under the MIP may be subject to garnishments and other state or federal requirements.

B. Calculations

Calculations for full and partial awards for each Eligible Participant will be based on "Eligible Earnings" (defined below) for the Plan Year while in a MIP-eligible position. Eligible Earnings will be multiplied by the individual target opportunity of the Eligible Participant. If the Eligible Participant has been employed in multiple MIP-eligible positions during the Plan Year, then the individual opportunity will be prorated based on the number of days worked in each position.

Eligible Earnings include reoccurring items such as pay earned for hours worked, paid time off (e.g. vacation, sick, holiday, funeral, jury duty, military) but will exclude one-time payments such as annual cash incentives, commissions and similar payments, and earnings associated with equity releases and stock option exercises.

For purposes of proration under the MIP and except as otherwise provided in Section VII of the MIP, calculations will be based on the number of days that the employee was an Eligible Participant in the MIP during the Plan Year.

C. Award Opportunity

Individual target awards will be determined by position and may vary based on the Eligible Participant's level in the organization.

D. Obligation to Pay Out Percentage of Total Pool

Eligible Participants, as a group, have a right to receive an amount at least equal to the Total Pool, but no individual Eligible Participant shall be entitled to receive an award or any specific amount of the Total Pool. In no event will the aggregate of the total awards paid from the MIP be less than 92.5% of the Total Pool. To discourage unmerited litigation, any party or class asserting a challenge or claim against the Company under any provision of the MIP, including this Section V, shall bear their own costs relating to such challenge or claim, and if the challenge or claim is unsuccessful, such party or class shall reimburse the Company for all reasonable costs incurred by the Company in responding to such challenge or claim.

VI. MIP Dispute Resolution

Any questions by an Eligible Participant regarding an incentive award granted under the MIP shall first be submitted by the Eligible Participant to his or her Human Resources Business Partner ("HRBP") within 7 days of distribution of such incentive award, and the HRBP shall submit any correction that the HRBP deems appropriate to the Compensation Department by the first business day of April immediately following the distribution date.

In the event of a dispute regarding an incentive award under the MIP after the Eligible Participant has submitted his or her question to the HRBP and received a response, as provided above, the Eligible Participant may submit an appeal for resolution of such dispute to CVS Health's Advice and Counsel in writing within 30 days of the distribution of the incentive award. Failure to follow these procedures or submit a question or dispute in a timely manner may result in a waiver of the Eligible Participant's right to dispute the MIP provision or amount of the incentive award.

VII. Eligible Participant Status

A. Performance

The CEO or other designated executives have full discretion in determining the amount, if any, of an incentive awarded to an Eligible Participant, and the Participant's individual performance throughout the Plan Year will be considered by the Company in the final determination of the Eligible Participant's incentive award.

B. Leaves of Absence

An Eligible Participant on a Company-approved leave of absence at any time during the Plan Year who remains employed in an eligible position as of the last day of the Plan Year will earn a prorated incentive award based on the number of days actively worked (including time compensated as vacation, myTime or Paid Time Off ("PTO")) during the Plan Year, provided he or she meets all other eligibility criteria for an incentive award.

C. Reduction in Force, Retirement and Death

1. Reduction in Force

If an Eligible Participant is separated from employment by the Company during the Plan Year due to a reduction in force, he or she may be eligible, at the Company's discretion, to receive a prorated incentive award based on the calculation methodology described in Section V.(B) above, provided the Eligible Participant meets all other eligibility criteria for an incentive award.

2. Retirement

If an Eligible Participant is at least age 55 and has a minimum of 10 years of service with CVS Health or a predecessor company/subsidiary or is at least age 60 and has a minimum of 5 years of service with CVS Health or a predecessor company/subsidiary and the Eligible Participant retires during the Plan Year, he/she may be eligible to receive a prorated incentive award based on the calculation methodology described in Section V.(B) above, provided he/she meets all other eligibility criteria for an incentive award. Eligible Participants who do not meet the minimum retirement requirements under Section VII at the time of retirement will not be eligible for an incentive award for the Plan Year.

3. Death

In case of the death of an Eligible Participant, a prorated incentive award may be paid to the Eligible Participant's spouse, if living; otherwise, in equal shares to surviving children of the Eligible Participant. If there are no surviving children, the benefit shall be paid to the Eligible Participant's estate. The incentive award will be prorated based on the calculation methodology described in Section V.(B) above. The incentive award shall be paid as soon as administratively practicable, following the death of the Eligible Participant but no later than March 15 of the calendar year immediately following the Plan Year.

VIII. Miscellaneous

A. No Promise of Continued Employment

The MIP does not create an express or implied contract of employment between CVS Heath or and an Eligible Participant. Both CVS Health and the Eligible Participant retain the right to terminate the employment relationship at will, at any time and for any reason.

B. Rights are Non-Assignable

Neither the Eligible Participant, nor any beneficiary, nor any other person shall have any right to assign, in whole or in part, the right to receive payments under the MIP. Payments are non-assignable and non-transferable, whether voluntarily or involuntarily.

C. Compliance with Applicable Law

An Eligible Participant must comply with all applicable state and federal laws and CVS Health policies to be eligible to receive an incentive award under the MIP.

CVS Health will comply with all applicable laws concerning incentive awards; the MIP and its administration are not intended to conflict with any applicable state or federal law.

D. Change in Control

In the event of a change in control of CVS Health, as defined in the ICP, the MIP shall remain in force. Any amendments, modifications, termination or dissolution of the MIP by the acquiring entity may only occur prospectively and will not affect incentive targets or awards or eligibility in place immediately before the date of the change in control or such later date as it may be modified or dissolved by the acquiring entity.

Provisions regarding the payment of annual incentive awards that are set forth in change in control agreements with Eligible Employees shall supersede those appearing in the MIP.

E. Withholding

All required deductions will be withheld from the incentive awards prior to distribution. This includes all applicable federal, state, or local taxes, as well as any eligible 401(k) deductions and deferred compensation contributions, as defined by the applicable plans. Incentive awards that are deferred will be taxed according to applicable federal and state tax law. Each Eligible Participant shall be solely responsible for any tax consequences of his or her award hereunder.

F. MIP Amendment/Modification/Termination

CVS Health retains the right to amend, modify, or terminate the MIP at any time on or before the last day of the Plan Year for any reason, with or without notice to Eligible Participants.

G. MIP Interpretation

CVS Health retains sole, full and final authority to prescribe rules and regulations for the administration of the Plan, construe and interpret the Plan and Award agreements and correct defects, supply omissions or reconcile inconsistencies therein and to make all other decisions and determinations as it may deem necessary or advisable for the administration of the Plan.

Capitalized terms not otherwise defined herein shall have the meaning assigned to such defined term(s) in the ICP. In the event of any conflict between the ICP and the MIP, the terms of the ICP shall govern.

H. Recoupment of Incentive Awards

Each incentive award under the MIP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Eligible Employee to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the MIP.

I. Section 409A of the Internal Revenue Code

The Company intends that the MIP not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Code, as amended, and the regulations and guidance thereunder (collectively, "Section 409A"), and that to the extent any provisions of the Plan do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. Payments hereunder are intended to qualify as short-term deferral payments under Section 409A. In all events, the provisions of CVS Health Corporation's Universal 409A Definition Document are hereby incorporated by reference, and notwithstanding the any other provision of the Plan or any Award to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code (requiring certain delays for "specified employees"), payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh (7 th) month following the date of termination of employment. For purposes of any provision of the Plan providing for the payment of any amounts or

benefits in connection with a termination of employment, references to an Eligible Person's "termination of employment" (and corollary terms) shall be construed to refer to the Eligible Person's "separation from service" with the Company as determined under Section 409A.

J. Restrictive Covenant Agreement

Any award pursuant to the MIP is expressly subject to and contingent upon the requirement that the Eligible Participant shall have fully executed and delivered to the Company a restrictive covenant agreement deemed appropriate by the Company; the Company may waive such requirement in its sole discretion. Any applicable agreement containing the restrictive covenants the Company requires in connection with this award is referred to herein as the "Restrictive Covenant Agreement".

If the Company requires an Eligible Participant to execute and deliver the Restrictive Covenant Agreement in connection with any MIP award, the Company shall provide such Restrictive Covenant Agreement to the Eligible Participant. The Eligible Participant must execute and deliver such agreement by the deadline set forth by the Company. The failure of an Eligible Participant to execute and return the Restrictive Covenant Agreement by the deadline set forth by the Company, if required, shall result in the immediate and irrevocable forfeiture of any MIP award.

This Section VIII (J) of the MIP shall not constitute the Company's exclusive remedy for Eligible Participant's violation of the Restrictive Covenant Agreement. The Company reserves all rights to seek all available legal or equitable remedies in the event of Eligible Participant's violation or threatened violation of the Restrictive Covenant Agreement, including injunctive relief.

Exhibit 10.37

CVS HEALTH SEVERANCE PLAN FOR NON-STORE EMPLOYEES (Amended as of November 28, 2018)

CVS HEALTH SEVERANCE PLAN
FOR NON-STORE EMPLOYEES
(Amended as of November 28, 2018)

WHEREAS, CVS Health Corporation (the "Company") has established the CVS Health Severance Plan for Non-Store Employees (the "Plan") to provide financial assistance to employees in non- store positions who are involuntarily terminated and are eligible within the terms and conditions of the Plan;

WHEREAS, it is intended that the Plan constitute an employee welfare benefit plan within the scope of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), that the Plan constitute a separation pay plan within the scope of Department of Labor ("DOL") Regulation Section 2510.3-2(b), and that all payments made under the Plan be deductible by the Company under Section 162(a) of the Internal Revenue Code of 1986, as amended (the "Code");

WHEREAS, the benefits provided under the Plan are intended to constitute separation pay within the meaning of Treasury Regulation Section 1.409A-1(b)(9)(iii);

WHEREAS, this document is the official plan document; and

WHEREAS, the Company wishes to make certain amendments to the Plan, effective as of November 28, 2018 (the "Effective Date");

NOW, THEREFORE, as of the Effective Date, the Company does hereby amend the Plan to provide as follows:

ARTICLE 1
DEFINITIONS

For purposes of the Plan, the following terms, when used with an initial capital letter, shall have the meaning set forth below unless a different meaning is plainly required by the context.

1.1 " Affiliate " shall mean (a) any corporation which is required to be aggregated with the Company under Code Section 414(b), (c), (m), or (o) and (b) any other entity in which the Company has an ownership interest and which the Company designates as an Affiliate for purposes of the Plan.

1.2 " Cause " shall refer to a termination of an Eligible Employee's employment because of the Eligible Employee's (a) poor performance; (b) acts of unethical business activity, including but not limited to fraud, misappropriation, embezzlement, dishonesty, harassment, discrimination in violation of Employer policies, or willful or negligent destruction of property of an Employer or an Affiliate; (c) misconduct that is reasonably likely to cause material damage (monetary or otherwise) to the Employer, an Affiliate, or any personnel thereof; (d) conviction of or a plea of guilty or nolo contendere to any felony, whether or not any right to appeal has been or may be exercised; (e) negligence of duty; (f) insubordination; or (g) a violation of the Employer's policy, procedure, or practice.

1.3 " Code " shall mean the Internal Revenue Code of 1986, as amended.

1.4 " Eligible Employee " shall mean an individual who is employed by the Employer on a regular basis in a non-store position and has been employed by the Employer in any position for a minimum of twelve (12) months prior to the individual's separation of employment. For purposes of the Plan, distribution warehouse employees, field managers and employees employed by CVS ProCare, Inc. working at Company headquarters, shall be treated as working in a non-store location and therefore not subject to exclusion from eligibility. For purposes of the Plan, individuals in the following categories will not be considered Eligible Employees:

(a) individuals who are covered by a collective bargaining agreement, provided welfare benefits were the subject of good faith bargaining, unless the terms of the collective bargaining agreement provide for participation in the Plan;

(b) individuals who are seasonal employees, leased employees, independent contractors, temporary employees, or consultants;

(c) individuals who work for the Employer or an Affiliate in a store location of the Company or an Affiliate, or whose compensation is paid through or according to a store payroll, including but not limited to: pharmacists, store managers, assistant store managers, crew, and pharmacy staff;

(d) individuals employed by MinuteClinic, L.L.C. or by any practitioner-owned entity managed by MinuteClinic, L.L.C.;

(e) the President and CEO of CVS Health Corporation;

(f) individuals employed in Puerto Rico; and

(g) individuals employed outside the United States of America.

The decision of whether an individual falls into one of these categories and whether an individual is employed by an Employer on a regular basis in a non-store position for a minimum of 12 months shall be made by the Employer in its sole discretion. Any individual who is excluded from being considered an Eligible Employee under the Plan shall be excluded from the Plan regardless of the individual's reclassification by a government agency, including a reclassification by the Internal Revenue Service for tax withholding purposes.

1.5 " Employer " shall mean CVS Pharmacy, Inc. and Caremark Rx, L.L.C. and any current or future Affiliate thereof that does not maintain its own severance plan for employees of that Affiliate.

1.6 " ERISA " shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.7 " Exempt Employee " shall mean an Eligible Employee who is paid on a salaried basis for payroll purposes and classified in the sole discretion of the Employer under its normal classification procedures as an exempt employee under the Fair Labor Standards Act.

1.8 " Involuntary Termination " shall mean an Eligible Employee's termination of employment with the Employer due to the unilateral action of the Employer, including but not limited to a termination as a result of the elimination of an Eligible Employee's position due to a reorganization or changes in responsibilities, a reduction in force, or a closing of the business unit in which the Eligible Employee works; provided, however, that such Involuntary Termination constitutes a separation from service under Treasury Regulation Section 1.409A-1(h). Notwithstanding the foregoing, an Eligible Employee will not have an Involuntary Termination if the Eligible Employee: (a) is terminated for Cause, as determined by the Employer in its sole discretion; (b) voluntarily terminates employment or resigns prior to an Involuntary Termination; (c) takes a leave of absence; (d) is administratively terminated for failure to return from a leave of absence upon expiration of his or her leave; (e) terminates employment due to his or her death; (f) transfers to an Affiliate; (g) transfers to a new employer in connection with the sale of an Employer facility; or (h) fails to accept an offer for a job with the Employer that is comparable to the job that he or she is performing for the Employer at the time of the offer. For purposes of Subsection (h) of this Section 1.8, whether a job is considered "comparable" shall be determined in the sole discretion of the Employer, taking into account whether the new job is located 50 or fewer miles from the Eligible Employee's job at the time of the offer, whether the compensation offered is materially less than the Eligible Employee's compensation at the time of the offer, and whether the new job will result in a substantial change of duties from the Eligible Employee's job at the time of the offer. The determination of whether an Eligible Employee's termination of employment is an Involuntary Termination shall be made in the sole discretion of the Employer. If an Employer deems an Eligible Employee's termination of employment to be an Involuntary Termination and, Employer later learns of facts and circumstances that, had

the Employer known such facts and circumstances at the time of termination, would have resulted in a termination of employment for Cause, the Eligible Employee's termination shall be deemed as of the date of termination to not have been an Involuntary Termination.

1.9 " Non-exempt Employee " shall mean an Eligible Employee who is paid on an hourly basis for time worked and classified in the sole discretion of the Employer under its normal classification procedures as a non-exempt employee under the Fair Labor Standards Act.

1.10 " Plan Administrator " shall mean the Senior Vice President of Human Resources of CVS Pharmacy, Inc., or such other person designated to act as the Plan Administrator.

1.11 " Rehire Date " shall mean the date an Eligible Employee accepts reemployment with any Employer.

1.12 " Severance Pay " shall mean the pay an Eligible Employee is eligible to receive under Subsection (b) of Section 2.1 of the Plan upon his or her Involuntary Termination.

1.13 " Severance Period " shall mean the period of time during which an Eligible Employee is eligible to receive Severance Pay.

1.14 " Transaction-Related Termination " shall mean an Involuntary Termination, of an Eligible Employee in a Corporate/Shared Services function, that is deemed by the Plan Administrator, in his or her sole discretion, after consultation with the Employer, to have resulted from the Company's acquisition of Aetna, Inc., at any time during the period beginning with the date the acquisition closes and ending on the second anniversary of such closing date. For this purpose, a Corporate/Shared Services function shall exclude all functions in MinuteClinic, MinuteClinic IT, Omnicare, Specialty/Coram, Retail Merchandising, Retail & Pharmacy Growth, Retail Supply Chain, Retail Pharmacy Operations, Retail Stores & Field and in any other business unit that may be determined by the Plan Administrator from time to time, regardless of which Employer employs the Eligible Employee.

1.15 " Weekly Rate " shall mean, (a) with respect to an Eligible Employee paid on a salaried basis, an Eligible Employee's annual base salary (as determined by the Employer), as of the date of the Eligible Employee's Involuntary Termination, expressed on a weekly basis (as determined in the sole discretion of the Employer), and (b) with respect to an Eligible Employee paid on an hourly basis, the hourly wage rate of the Eligible Employee as of the date of the Eligible Employee's Involuntary Termination multiplied by the Eligible Employee's regularly scheduled number of hours of service per week (as determined by the Employer), not in excess of 40 hours. Weekly Rate shall exclude any overtime, incentive, and bonus payments, unless otherwise required by law.

1.16 " Year of Service " shall mean each full year of service performed by the Eligible Employee for an Employer as reflected in the records of the Employer and as determined as of the Eligible Employee's date of termination of employment, based on the Employer's policies and procedures for determining periods of service, and the applicable law.

ARTICLE 2
SEVERANCE PAY AND ELIGIBLE EMPLOYEE BENEFITS

2.1 (a) Eligibility . Upon his or her Involuntary Termination, an Eligible Employee may, in the discretion of the Plan Administrator, be granted Severance Pay and benefits provided under Subsections (b), (c), and (d) of this Section 2.1, provided the conditions of Section 2.2 are satisfied. The determination of whether Severance Pay is payable under the Plan, and the form and amount of such pay, shall be made in the sole discretion of the Plan Administrator.

(b) Severance Pay . The Severance Pay payable to an Eligible Employee in the event of Involuntary Termination shall be determined by the Plan Administrator in its sole discretion, using the following guidelines

for the applicable Eligible Employee classification:

(i) For Eligible Employees who are Non-exempt Employees:

(A) the Eligible Employee's Weekly Rate multiplied by two (2), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Non-exempt employees should not exceed the Eligible Employee's Weekly Rate multiplied by thirteen (13);

(ii) For Eligible Exempt Employees in grades 105-108, 201-203, 301, 302, 405-408:

(A) the Eligible Employee's Weekly Rate multiplied by four (4), plus,

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by twenty (20);

(iii) For Eligible Exempt Employees in grades 109-111, 204, 205, 303, 304, 409-411, the greater of

(A) the Eligible Employee's Weekly Rate multiplied by thirteen (13) or,

(B) the amount determined under the formula set forth in the immediately preceding Paragraph (ii), provided Severance Pay should not exceed the Eligible Employee's Weekly Rate multiplied by twenty (20);

(iv) For Eligible Exempt Employees in grades 112, 206, 305, 412, the Eligible Employee's Weekly Rate multiplied by twenty-six (26);

(v) For Eligible Exempt Employees in grades 36A-Z, the Eligible Employee's Weekly Rate multiplied by fifty-two (52); and

(vi) For Eligible Exempt Employees in grades 38A-Z and 39 A-Z, the Eligible Employee's Weekly Rate multiplied by fifty-two (52).

Notwithstanding the above guidelines, in the event of a Transaction-Related Termination of an Eligible Employee, Severance Pay shall be determined by the Plan Administrator in its sole discretion, using the following guidelines for the applicable Employee classification:

(1) For Eligible Employees who are Non-exempt Employees:

(A) the Eligible Employee's Weekly Rate multiplied by two (2), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the

number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Non-exempt employees should not exceed the Eligible Employee's Weekly Rate multiplied by thirty-one (31);

(2) For Eligible Exempt Employees in grades 105-108, 201-203, 301, 302, 405-408:

(A) the Eligible Employee's Weekly Rate multiplied by four (4), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by thirty-one (31);

(3) For Eligible Exempt Employees in grades 109-111, 204, 205, 303, 304, 409-411, the greater of (A) the Eligible Employee's Weekly Rate multiplied by thirteen (13) or, (B) the amount determined under the formula set forth in the immediately preceding Paragraph (2), provided Severance Pay should not exceed the Eligible Employee's Weekly Rate multiplied by forty-four (44);

(4) For Eligible Exempt Employees in grades 112, 206, 305, 412:

(A) the Eligible Employee's Weekly Rate multiplied by twenty-six (26), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by ninety-six (96);

(5) For Eligible Exempt Employees in grades 36A-Z, who have completed at least five (5) Years of Service:

(A) the Eligible Employee's Weekly Rate multiplied by fifty-two (52), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed in excess of four (4) Years of Service by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by ninety-six (96); and

(6) For Eligible Exempt Employees in grades 38A-Z and 39 A-Z:

(A) the Eligible Employee's Weekly Rate multiplied by seventy-eight (78), plus

(B) provided the Eligible Exempt Employee has completed at least five (5) Years of Service, an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed in excess of four (4) Years of Service by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by ninety-six (96).

Notwithstanding the above guidelines, the Plan Administrator may increase or decrease (including, to zero) the amount of Severance Pay with respect to any Eligible Employee for reasons it deems appropriate in its sole discretion (including, but not limited to, an increase to provide consideration for Eligible Employees who have outstanding employment agreements with an Employer or a decrease to take into account any debts owed to an Employer), at any time, whether before or after payments of Severance Pay have commenced.

(c) COBRA Assistance . In the event an Eligible Employee who has an Involuntary Termination (i) is eligible to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended ("COBRA") in accordance with the terms of the medical and prescription drug plan and/or dental plan of the Employer and (ii) properly and timely elects such continuation coverage, the Employer may pay for a portion of the cost of COBRA coverage equivalent to the contribution which the Employer makes on behalf of similarly situated active employees under such plan for the appropriate tier of coverage selected and in place immediately prior to the date of the Eligible Employee's Involuntary Termination (*e.g.* , employee-only, family coverage), for a period determined in the sole discretion of the Plan Administrator, which generally shall be the Severance Period but in any event no longer than eighteen (18) months from the date of the Involuntary Termination. Any COBRA assistance provided under this Subsection (c) shall be paid by the Employer directly to the insurance carrier, if applicable. The portion of the COBRA premium not covered by the COBRA assistance specified in this Subsection (c) must be paid by the Eligible Employee directly to the insurance carrier or service provider that administers COBRA, as applicable, based on the standard rules under the respective plan for payment of COBRA premiums. This Subsection (c) does not provide COBRA assistance in the event the Eligible Employee fails to properly and timely elect COBRA continuation coverage, regardless of whether his or her covered dependents elect COBRA continuation coverage.

(d) Outplacement Services . Upon an Involuntary Termination, the outplacement services provided to an Eligible Employee shall be provided in the sole discretion of the Plan Administrator based on the guidelines contained in this Subsection (d).

(i) If an Eligible Employee so desires, he or she may be eligible for outplacement services for assistance in obtaining new employment, provided through a vendor selected by the Employer, with the Employer directly providing payment to such vendor. The provision of outplacement services is contingent upon the Eligible Employee's cooperation with the outplacement service vendor, upon the active efforts of the Eligible Employee to locate a new position, and upon the Eligible Employee initiating outplacement services during the Severance Period.

(ii) Subject to the requirements of Paragraph (i) of this Subsection (d), outplacement services shall be offered for a period of time determined in the sole discretion of the Plan Administrator, based on guidelines that include:

(A) a virtual or group training session for Eligible Non-exempt Employees and Exempt Employees in grades 105-108, 201-203, 301, 302, 405-408;

(B) three (3) months of outplacement services for Eligible Exempt Employees in grades 109-112, 204-206, 303-305, 409-412; and

(C) six (6) months of outplacement services for Eligible Exempt Employees in grades 36A-Z, 38A-Z, and 39 A-Z;

provided, in no event shall such services extend beyond twelve (12) months following the Involuntary Termination of the Eligible Employee.

(e) Form and Timing of Payment . In the event an Eligible Employee is awarded Severance Pay

under the terms of Subsection (a) of this Section 2.1, such Severance Pay shall be paid following an Eligible Employee's Involuntary Termination (except as provided in Section 2.3, below), as follows: No Severance Pay shall commence (with respect to salary continuation payments) or be paid (with respect to a lump sum) (i) prior to the expiration of the later of a period that is identified in a separate agreement with the Eligible Employee during which he or she may consider the execution of the release of claims form (the "Consideration Period") or a period ending at least seven (7) days following the execution of the release of claims form (the "Revocation Period"), or (ii) later than sixty (60) days following the date of Eligible Employee's Involuntary Termination. Severance Pay that is paid in the form of salary continuation shall commence as soon as feasible following expiration of the later of the Consideration Period or the Revocation Period, which generally shall be the first regularly scheduled payroll date following the expiration of the Consideration Period or the Revocation Period, as the case may be, and shall thereafter be paid in substantially equal installments in accordance with the Employer's regular payroll practice, except as provided in Section 2.3 of the Plan. Further, in the Plan Administrator's sole discretion, Severance Pay may be paid to any Eligible Employees in a single lump sum, in which event Severance Pay shall be paid within the period that satisfies the 409A requirements for short-term deferrals under Section 409A of the Code.

(f) Withholding . Any payment of Severance Pay to an Eligible Employee shall be subject to normal withholding for state and federal income taxes and Social Security taxes.

(g) Death . Upon the death of the Eligible Employee who had an Involuntary Termination and who has not received all Severance Pay payable under the Plan, the Severance Pay otherwise payable under Section 2.1(b) of the Plan shall be paid in the form of a lump sum to the Eligible Employee's estate or beneficiary as soon as practicable, but in no event later than 60 days following death. Any other severance benefits provided under this Section 2.1 (COBRA assistance and outplacement services) shall cease upon the Eligible Employee's death.

2.2 Conditions on Payment of Severance Pay and Benefits . Payment of the Severance Pay and benefits provided in Section 2.1 of the Plan shall be subject to and conditioned upon the following:

(a) to the extent an Eligible Employee receives notice of a date selected by the Employer (in its sole discretion) on which the Eligible Employee's Involuntary Termination shall occur (a "Designated Termination Date"), the Eligible Employee must continue to work in a satisfactory manner until his or her Designated Termination Date;

(b) the Eligible Employee must cooperate in transitioning all of the Eligible Employee's work in consultation with the Eligible Employee's supervisor or other designated employee;

(c) the Eligible Employee must execute and deliver a release of claims form (in the form specified by the Employer from time to time which may include restrictive covenants and, if applicable, a waiver as described in Subsection (d) of this Section 2.2) within the time period specified under the terms of the applicable severance offer. Further, in no event will Severance Pay be paid with respect to an Eligible Employee in the event the release of claims form is revoked during the Revocation Period (described in Section 2.1(e) of the Plan); and

(d) the Eligible Employee must waive the right to receive any other severance payment relating to salary continuation or salary replacement the Eligible Employee may otherwise be eligible to receive upon termination of employment under any employment agreement, severance plan, practice, policy or program of the Employer or an Affiliate.

2.3 Maximum Severance Pay . Notwithstanding any other provisions to the contrary, benefits paid hereunder (a) shall not exceed two times the lesser of (i) the Eligible Employee's Compensation (as defined in this Section 2.3) during the calendar year immediately preceding the Eligible Employee's Involuntary Termination

or (ii) the maximum amount that may be taken into account under a qualified plan pursuant to Section 401(a)(17) of the Code for the calendar year in which the Eligible Employee's Involuntary Termination occurs and (b) shall be paid in full within twenty-four (24) months after the date the Eligible Employee's Involuntary Termination occurs. In the event that any Severance Pay payable to an Eligible Employee would exceed the twenty-four (24) month period provided in the foregoing sentence if the Severance Pay continued to be paid in accordance with the Employer's regular payroll practice, any Severance Pay that would otherwise exceed the twenty-four (24) month time period will be paid to the Eligible Employee in a lump sum on the last regular payroll date within the twenty-four (24) month period. For purposes of this Section 2.3, "Compensation" shall mean the Eligible Employee's total annualized compensation, based upon the annual rate of pay for services provided to the Employer for the calendar year preceding the calendar year in which the Eligible Employee's Involuntary Termination occurs, adjusted for any increase in such preceding calendar year that was expected to continue indefinitely if the Eligible Employee had not had an Involuntary Termination.

2.4 Cessation of Severance Pay Upon Reemployment . If an Eligible Employee who had an Involuntary Termination and who is receiving Severance Pay thereafter accepts reemployment with any Employer during the Severance Period, such Employee's Severance Pay shall cease on the Rehire Date and any remaining Severance Pay shall be forfeited.

2.5 Cessation of Severance Pay After Commencement of Payments . If an Eligible Employee is deemed to have an Involuntary Termination and begins to receive Severance Pay under the Plan and the Employer or the Plan Administrator becomes aware of facts and circumstances that, had the Employer known same at the time of the Eligible Employee's termination of employment, would have affected the Employer's determination as to whether such Employee's termination was an Involuntary Termination, the Plan Administrator may suspend any future Severance Pay payments to the Eligible Employee while the Employer investigates the facts and circumstances and finalizes such investigation, and, if the Employer determines that the Eligible Employee should have been terminated for Cause, such Eligible Employee's Severance Pay shall cease as of the suspension date, any remaining Severance Pay shall be forfeited and any Severance Pay that has been paid shall be subject to repayment by the Eligible Employee.

2.6 Impact of Debt on Severance Pay . In the event an Eligible Employee is indebted to the Company or Employer (determined in the sole discretion of the Company or Employer, as applicable), the Plan Administrator reserves the right to reduce, offset, withhold, and/or forfeit the Severance Pay otherwise payable under the Plan.

2.7 Employee Benefits . As of the date of an Eligible Employee's Involuntary Termination, the Eligible Employee's active participation in any benefit plan, program, or policy sponsored or subsidized by the Employer shall cease, unless otherwise continued pursuant to the terms of such plan, program or policy.

2.8 Awards . Any award or grant made to the Eligible Employee under any stock option, stock purchase, or stock appreciation rights plan of the Company or Employer shall be administered and interpreted in accordance with the terms of the applicable plan documents.

2.9 Paid Time Off . Any pay for accrued paid time off shall be determined under the terms of the Employer's applicable policies.

2.10 Benefits Not Vested . No one under any circumstance is automatically entitled to Severance Pay and benefits described in Section 2.1 of the Plan. Notwithstanding anything in the Plan to the contrary, the Plan Administrator reserves the right, at its sole discretion, to increase, decrease, or eliminate Severance Pay and benefits under the Plan.

2.11 Bonuses . Whether any bonuses are payable to an Eligible Employee shall be determined based on the terms of any applicable bonus program, plan, or policy.

ARTICLE 3
ADMINISTRATION OF THE PLAN

3.1 Control and Administration . Notwithstanding any other provision in the Plan, and to the full extent permitted under ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and final authority, in its sole and absolute discretion, to administer, apply, construe and interpret the terms of the Plan and all related plan documents and all facts surrounding claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that an Eligible Employee is entitled to benefits, and the Plan Administrator shall decide all questions regarding the form, amount and duration of benefits. The Plan Administrator may consult with attorneys, consultants and other persons for advice, counsel and reports to make determinations under the Plan, and the Plan Administrator may delegate its administrative duties and responsibilities to persons or entities of its choice, in all cases who may be employees of the Company. All determinations of the Plan Administrator shall be conclusive and binding on all parties. The Plan Administrator shall be the named fiduciary of the Plan for purposes of ERISA.

3.2 Claim Procedures .

(a) Procedure for Granting or Denying Claims . An Eligible Employee, or his or her duly authorized representative, may file a claim for payment of benefits under the Plan within 30 days after termination of employment. Such a claim must be made in writing and be delivered to the Plan Administrator, in person or by mail, postage paid. Within 90 days after receipt of such claim, the Plan Administrator shall notify the claimant of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 90 days from the end of the initial 90-day period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 90-day period. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part.

(b) Requirement for Notice of Claim Denial . The Plan Administrator shall provide to every claimant who is denied a claim for benefits a written or electronic notice setting forth in a manner calculated to be understood by the claimant:

(i) The specific reason or reasons for the denial;

(ii) Specific reference to pertinent Plan provisions on which the denial is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and

(iv) An explanation of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

(c) Right to Appeal on Claim Denial . Within 60 days after receipt by the claimant of written or electronic notification of the denial (in whole or in part) of his or her claim, the claimant or his or her duly authorized representative may make a written application to the Plan Administrator, in person or by certified mail, postage prepaid, to be afforded a full and fair review of such denial. The claimant or his or her duly authorized representative may submit written comments, documents, records, and other information relating to the claim for benefits. Moreover, the claimant or his or her duly authorized representative shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(d) Disposition of Disputed Claims . Upon receipt of a request for review, the Plan Administrator shall make a decision on the claim. The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The decision on review shall be made not later than 60 days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than 120 days after receipt of the request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial 60-day period.

The Plan Administrator shall provide the claimant or his or her duly authorized representative with written or electronic notification of the Plan's determination on review. In the case of an adverse determination, the notification shall set forth, in a manner calculated to be understood by the claimant, the specific reason or reasons for the decision as well as specific references to the Plan provisions on which the decision was based. The decision shall also include a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Moreover, the decision shall contain a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

3.3 Conditions to Legal Action. No legal action may be commenced or maintained against the Plan, the Company or any Employer prior to the claimant's exhaustion of the claims procedures set forth in Section 3.2 of the Plan. In addition, no legal action may be commenced against the Plan more than ninety (90) days after the Plan Administrator's final claim determination on review pursuant to Section 3.2(d) of the Plan. Any legal action must be conducted in the United States District Court for Rhode Island.

3.4 Named Fiduciary . The Plan Administrator of the Plan shall be the Named Fiduciary of the Plan for purposes of ERISA Section 402(a)(1).

ARTICLE 4
MISCELLANEOUS

4.1 Amendment or Termination . The Plan may be amended, terminated, withdrawn or suspended at any time in writing by the Management Planning and Development Committee of the Company or any individual designated by such Committee to take such actions.

4.2 Choice of Law . The validity, interpretation, construction and performance of the obligations created under the Plan shall be governed by ERISA, and to the extent not preempted by federal law, the laws of the State of Rhode Island without regard to its conflicts of law principles.

4.3 Validity . The invalidity or unenforceability of any provision of the Plan shall not affect the validity or enforceability of any other provision of the Plan, which shall remain in full force and effect.

4.4 Plan Exclusive Source of Rights . The Plan contains all of the terms and conditions with respect to the benefits provided hereunder, and no Eligible Employee or former Eligible Employee may rely on any other communication or representation, whether oral or written, of the Employer or any of its subsidiaries, or any officer or Eligible Employee thereof, as creating any right or obligation not expressly provided by the Plan.

4.5 Nonassignability . No benefit which shall be payable under the Plan to any Eligible Employee shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge (except as required by law), and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge a benefit shall be null and void. No benefit shall in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any Eligible Employee. No benefit shall be subject to legal attachment or legal process for, or against, the Eligible Employee and the same shall not be recognized under the Plan. Notwithstanding

the preceding sentence, the Employer retains the discretion, in accordance with federal and/or state laws, to reduce the amount of benefits payable under the Plan to any Eligible Employee to recover any amounts that the Eligible Employee owes to the Employer.

4.6 No Employment Rights . The Plan shall not give any Eligible Employee any right or claim except to the extent that the right is specifically provided under the terms of the Plan. The establishment of the Plan shall not be construed (a) to give any Eligible Employee a right to continue in the employ of the Employer or (b) to interfere with the right of the Employer to terminate the employment of any Eligible Employee at any time.

4.7 Headings. Article and section headings are for convenience only and the language of the Plan itself will be controlling.

4.8 Gender and Numbers . Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

4.9 Code Section 409A . The benefits provided under the terms of the Plan are intended to fall within the short-term deferral exception, the separation pay exception or another exception to the application of Section 409A of the Code and the applicable guidance issued thereunder. In furtherance of this intent, the Plan shall be interpreted, operated and administered in a manner consistent with this intention. To the extent the benefits provided under the Plan become subject to Code Section 409A and applicable guidance issued thereunder, the Plan shall be construed, and benefits paid hereunder, as necessary to comply with Section 409A of the Code and such guidance. Further, to the extent that an Eligible Employee becomes entitled to receive Severance Pay under the terms of the Plan, and, at the time of the Eligible Employee's Involuntary Termination, he or she is a "specified employee" within the meaning of Treasury Regulation Section 1.409A- 1(i), any portion of Severance Pay payable to such Eligible Employee that is subject to Code Section 409A and applicable guidance thereunder shall be delayed until the date that is the earlier of (i) the Eligible Employee's death or (ii) six months following the date of the Eligible Employee's Involuntary Termination, at which time the payments that were delayed for such six month period shall be paid in a lump sum on the date of the next occurring regular payroll date of the Employer, and any remaining payments shall be paid according to the original schedule provided herein. In addition, each payment of a salary continuation stream of installment payments hereunder shall be a separate payment for purposes of Section 409A of the Code.

4.10 Funding . The Plan is not funded, and Severance Pay and benefits under the Plan are paid from the general assets of the Employer.

4.11 Plan Year. The Plan's records shall be maintained on the basis of the calendar year.

IN WITNESS WHEREOF, the Management Planning and Development Committee of the Company, or its duly authorized delegate, has amended the Plan as of the Effective Date pursuant to the execution hereof on its behalf by a duly authorized officer on .

CVS HEALTH CORPORATION

By: /s/ Lisa G. Bisaccia
Title: Executive Vice President and Chief Human Resources Officer, CVS Pharmacy, Inc.

Exhibit 10.38

CVS Health Corporation
Performance-Based Restricted Stock Unit Program

I. Objectives and Summary

The objective of the CVS Health Corporation (the "Company") Performance-Based Restricted Stock Unit Plan ("PBRS Plan") is to reward eligible participants for their role in achieving the Company's Earnings before Interest and Taxes ("EBIT") target and to encourage continued employment with the Company and its subsidiaries. PBRS Awards are generally delivered as restricted stock units ("RSUs") and are based on actual results measured against pre-established targets.

II. Administration

The PBRS Plan shall be administered by the Management Planning and Development Committee (the "Committee") of the Board of Directors, or its designee, under the provisions of the 2017 Incentive Compensation Plan or any successor plan (the "ICP"). The Committee shall have full and final authority, in each case, subject to and consistent with the provisions of the ICP and the PBRS Plan, to construe and interpret rules and regulations for the administration of the PBRS Plan, correct defects, supply omissions or reconcile inconsistencies therein, and to make all other decisions and determinations as the Committee may deem necessary or advisable for the administration of the PBRS Plan. Capitalized terms not otherwise defined herein shall have the meaning assigned to such terms in the ICP. In the event of a conflict between the ICP and the PBRS Plan, the provisions of the ICP shall control.

III. PBRS Plan Year

The "PBRS Plan Year" commences on January 1 and ends on December 31 of each year, unless otherwise approved by the Committee. All dates in this document occur during the current PBRS Plan Year unless otherwise stated.

IV. Eligibility

A. Eligible Employees

The Chief Executive Officer (the "CEO") or the CEO's designee determines those employees of the Company and its subsidiaries who are eligible to participate in the PBRS Plan ("Eligible Employees"). In general, Eligible Employees are those employees who are (i) officers of CVS Pharmacy, Inc. who are Vice Presidents or above, and (ii) senior officers of other subsidiaries who have been designated as Eligible Employees by the CEO or his or her designee. Generally, Business Planning Committee ("BPC") members are not eligible to participate, unless otherwise named as an Eligible Employee by the Committee.

B. Newly-Hired Eligible Employees

A newly-hired employee satisfying the requirements set forth in Paragraph IV.A is an Eligible Employee and may receive a PBRS Award for the PBRS Plan Year in which he or she is hired provided he or she is hired on or before November 1 and remains in an Eligible Employee position through December 31 of the PBRS Plan Year.

C. Participants

Unless the Committee is required to make such determinations under applicable law or the ICP, the CEO or the CEO's designee shall determine which Eligible Employees will receive an award under the PBRS Plan (a "PBRS Award"). All such determinations, whether by the CEO, the CEO's designee, or the Committee, with respect to a PBRS ("Plan Year") shall be made no later than the last business day of February immediately

following the PBRS Plan Year (the "PBRS Award Date"). Each Eligible Employee who receives a PBRS Award is a "Participant". No Eligible Employee has any right to receive a PBRS Award, regardless of whether such Eligible Employee is employed on the last day of the PBRS Plan Year, and the determination of whether an Eligible Employee will be a Participant shall be made in the sole discretion of the CEO, the CEO's designee or the Committee, as the case may be.

D. Status Changes

(i) **Promotions** . An employee who is promoted on or before November 1 of the PBRS Plan Year to a position satisfying the requirements set forth on Paragraph IV.A is an Eligible Employee and may receive a PBRS Award for the year in which the promotion occurs.

(ii) **Demotions:** An Eligible Employee who is demoted after November 1 of the PBRS Plan Year to a position not satisfying the requirements set forth on Paragraph IV.A will remain an Eligible Employee and may receive a PBRS Award provided such demotion is not the result of voluntarily transfer to a lower level position, is not related to unsatisfactory performance, and is not as a result of a violation of a Company policy or Code of Ethics.

(iii) **Termination of Employment**

a) **In General.** Except as provided in sub-paragraph (b) below, if for any reason the employment of an Eligible Employee with the Company and any subsidiary of the Company terminates during a PBRS Plan Year, the Eligible Employee will not receive a PBRS Award for that PBRS Plan Year.

b) **Death or Disability** . If an Eligible Employee dies or commences a long-term disability (as defined in the either Company's long-term disability plan or by the Social Security Administrator, as determined by the "Committee") during a PBRS Plan Year, the Eligible Employee may receive a PBRS Award at the same time PBRS Awards are made to other Participants. Such PBRS Award will be pro-rated for the number of full months (a partial month will be counted as a full month) during which the Eligible Employee was an active employee based on a full calendar year and will (unless otherwise determined by the CEO or the Committee) be paid in cash based on the Eligible Earnings of the Eligible Employee as of the time of death or commencement of long-term disability. PBRS Awards with respect to deceased Eligible Employees shall be paid to the Eligible Employee's Beneficiary.

The decision to pay a pro rata or full award to an Eligible Employee who terminates employment with the Company and its subsidiaries prior to the PBRS Award Date for any reason other than death or long-term disability, as defined above in this section, will be at the sole discretion of the CEO or the Committee (as the case may be).

V. PBRS Funding

A. Consolidated Company Funding

PBRS funding is based on consolidated Company performance, measured by Earnings before Interest and Taxes (EBIT), and modified by customer service and client satisfaction measurements. Achievement of the Company's EBIT target and modifiers will determine the total funding (the "Total Pool").

EBIT may be adjusted by the financial adjustments as approved by the Committee prior to the end of the first fiscal quarter of the Plan Year (the "Financial Adjustments"). If EBIT is below the minimum performance threshold, no formulaic funding will be made available for awards, regardless of PBRS modifier metrics performance, and there shall be no awards paid under the PBRS.

B. Total Pool Funding

After the minimum threshold for EBIT has been achieved, performance of PBRS modifiers to target will be calculated for the Plan Year. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The CEO may, for any reason and in his or her sole discretion, adjust the funding of the Total Pool based on (a) input from senior Company executives regarding their assessment of the overall performance of the Company; and (b) assessment of the achievement of Plan Year performance goals. In no case, however, can the CEO or the Committee increase Total Pool funding due to the results of the PBRS modifiers.

C. Individual Performance

The Total Pool will be available for award to Eligible Employee's under the PBRS, taking into account the individual contribution of each Eligible Employee. The award, if any, for an Eligible Employee shall be determined in the sole discretion of the Company, which shall be final, binding and conclusive as to all parties having an interest therein.

VI. Plan Payout

A. Target PBRS Award

The target PBRS award for each Employee is 25% of "Eligible Earnings" (defined below) while in a PBRS Eligible position for the PBRS Plan Year. Eligible Earnings will be multiplied by the 25% target opportunity of the Eligible Participant.

Eligible Earnings include reoccurring items such as pay earned for hours worked, paid time off (e.g. vacation, sick, holiday, funeral, jury duty, military) but will exclude one-time payments such as annual cash incentives, commissions and similar payments, and earnings associated with equity releases and stock option exercises.

B. PBRS Award Determination and Vesting

After the achievement of at least threshold for Operating Profit has been confirmed, performance of modifiers compared to target for the Plan Year will be calculated. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The approved PBRS Award is generally payable in RSUs. The number of RSUs that the Participant will receive is equal to the PBRS Award divided by the closing price of Company common stock on the PBRS Award Date.

C. Vesting

The RSUs issued in respect of any PBRS Award will vest in accordance with and subject to the terms and conditions of the ICP and the applicable agreement for each PBRS Award. PBRS Awards unvested as of a Participant's termination of employment shall be governed by the terms and conditions of the applicable agreement for each PBRS Award and the PBRS Plan in effect at the time of grant of each award.

VII. Plan Administration

A. Employment Rights

The PBRS Plan does not create any express or implied contract of employment between the Company and an Eligible Employee or any other person. Both the Company and an Eligible Employee (whether or not a Participant) retain the right to terminate the employment relationship at any time and for any reason.

B. Rights are Non-Assignable

Neither a Participant nor any beneficiary nor any other person shall have any right to assign the right to receive payments hereunder, in whole or in part, which payments are non-assignable and non-transferable, whether voluntarily or involuntarily.

C. Change in Control

In the event of a Change in Control, the PBRS Plan shall remain in full force and effect. Any modifications to or dissolution of the PBRS Plan by the acquiring entity may only occur prospectively and will not affect entitlements, awards or eligibility before the date of the Change in Control.

D. Plan Amendment/Modification/Termination

The Company retains the right to amend, modify, or terminate the PBRS Plan for any reason and at any time on or before December 31 of the PBRS Plan Year, with or without notice to Eligible Employees or any other person. No representative of the Company or its subsidiaries has the authority to modify the terms of that PBRS Plan without written consent of the Chief Human Resources Officer or his or her designee.

E. Withholding

The Company may provide for the withholding from any benefits payable under the PBRS Plan all federal, state, city or other taxes as shall be required pursuant to any law or governmental regulation or ruling.

F. Section 409A of the Code

The Company intends that the PBRS Plan not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and the regulations and guidance thereunder (collectively, "Section 409A") and that to the extent any provisions of the PBRS Plan do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. In all events, the provisions of CVS Health Corporation's Universal 409A Definitions Document are hereby incorporated by reference and, notwithstanding any other provision of the Plan or any Award to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh month immediately following the date of termination of employment. For purposes of any provision of the PBRS Plan providing for the payment of any amounts or benefits in connection with a termination of employment, references to an Eligible Employee's "termination of employment" (and corollary terms) shall be construed to refer to the Eligible Employee's "separation from service" with the Company as determined under Section 409A.

G. Request for Plan Interpretation

Any dispute or request for interpretation of any provision in the PBRS Plan must be submitted to the appropriate Human Resources Business Partner by the Eligible Employee or his or her manager in writing.

H. Compliance with Applicable Regulations

In order to be eligible to receive a PBRS Award under the PBRS Plan, a Participant must comply with all applicable state and federal regulations and Company policies.

I. Governing Law

The validity, construction and effect of the PBRS Plan, and any rules and regulations under the Plan shall be determined in accordance with Delaware law, without giving effect to principles of conflicts of laws, and applicable federal law.

J. Recoupment

Except as may be specifically provided in the PBRS Award, each PBRS Award under the PBRS Plan shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive under the PBRS Plan.

Exhibit 10.39

CVS HEALTH CORPORATION
NONQUALIFIED STOCK OPTION AGREEMENT

GRANT DATE: [_____]

1. GRANT OF AWARD. Pursuant and subject to the provisions of the 2017 Incentive Compensation Plan of CVS Health Corporation (the " **ICP** "), on the date set forth above (the " **Grant Date** "), CVS Health Corporation (the " **Company"**) has granted and hereby evidences the Grant to the person named below (the " **Participant** "), subject to the terms and conditions set forth or incorporated in this Nonqualified Stock Option Agreement (" **Agreement** "), the right, and option, to purchase from the Company the aggregate number of shares of Common Stock ($.01 par value) of the Company (" **Shares** ") set forth below, at the purchase price indicated below (the " **Option** "), such Option to be exercised as hereinafter provided. The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. The Option is a nonqualified option as defined in the ICP.

Participant:	**[_____]**
Employee ID:	**[_____]**
Shares:	**[_____]**
Option Price:	**[_____]**

2. TERM OF OPTION. The term of this Option shall be for a period of seven (7) years from the Grant Date, subject to the earlier termination of the Option, as set forth in the ICP and in this Agreement. No portion of the Option shall be exercisable after the term of the Option.

3. EXERCISE OF OPTION. (a) The Option, subject to the provisions of the ICP, shall be exercised by submitting a request to exercise to the Company's stock option administrator, in accordance with the Company's current exercise policies and procedures, specifying the number of Shares to be purchased, which number may not be less than one hundred (100) Shares (unless the number of Shares purchased is the total balance which is then exercisable). An exercise by Participant of all or part of this Option shall be effected through the Company's "cashless exercise" procedures. Otherwise, at the time of exercise, Participant shall tender to the Company cash or cash equivalent for the aggregate option price of the Shares Participant has elected to purchase or certificates for Shares of Common Stock of the Company owned by Participant for at least six (6) months with a fair market value at least equal to the aggregate option price of the Shares Participant has elected to purchase, or a combination of the foregoing.

(b) Prior to its expiration or termination and except as otherwise provided herein, the Option will become vested in accordance with the vesting schedule set forth below, each date on which vesting occurs a " **Vesting Date** ", and any vested Option will be exercisable by Participant prior to the expiration of its term so long as Participant has maintained continuous employment with the Company or a subsidiary of the Company from the Grant Date through the exercise date:

(i) 25% of the Option shall vest on the 1st anniversary of the Grant Date.
(ii) 25% of the Option shall vest on the 2nd anniversary of the Grant Date.
(iii) 25% of the Option shall vest on the 3rd anniversary of the Grant Date.
(iv) 25% of the Option shall vest on the 4th anniversary of the Grant Date.

4. TAXES . Upon a cashless exercise of the Option the Company shall withhold from the proceeds of the exercise of the Option any required taxes. If the Option is exercised other than through a cashless exercise Company shall have the right to require Participant to pay the amount of any withholding taxes immediately, upon notification from the Company, before the proceeds from the exercise of the Option are delivered to Participant. Furthermore, the Company may elect to deduct such taxes from any other amounts then payable to Participant in cash or in Shares or from any other amounts payable any time thereafter to Participant to the extent allowed under applicable law.

5. NON-TRANSFERABILITY . The Option shall not be transferable by Participant other than by will or by the laws of descent and distribution, and during Participant's lifetime shall be exercised only by the Participant during the continuance of Participant's employment with the Company and any of its subsidiaries.

6. FORFEITURE OF OPTION UPON TERMINATION OF EMPLOYMENT . Unless otherwise provided for in the ICP or in this Agreement, as of the date on which Participant's employment with the Company and its subsidiaries terminates, the Option, to the extent unexercised as of the employment termination date, shall be forfeited immediately in its entirety, provided that, if the Participant's employment with the Company and its subsidiaries terminates without Cause, the Option, to the extent vested and unexercised, shall be exercisable at any time on or before the ninetieth (90 th) day immediately following the employment termination date and, to the extent unvested, shall be forfeited immediately.

7. TERMINATION OF PARTICIPANT'S EMPLOYMENT WITHOUT CAUSE. In the event that Participant's employment with the Company and its subsidiaries is terminated without Cause and Participant receives severance pay following Participant's employment pursuant to a written agreement, vesting of the Option shall continue through the end of the severance period set forth in the agreement providing for such severance pay. To the extent vested, the Option shall be exercisable at any time during the severance period and on or before the ninetieth (90th) day following the last day of the severance period, as long as no government regulations or rules are violated by such continued vesting or exercise period; provided, however, that in no event will the Option be exercisable beyond its original term. Any portion of the Option not vested as of the last day of the severance period shall be forfeited as of the last day of the severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting.

8. RETIREMENT OF PARTICIPANT . In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a Qualified Retirement, Participant (a) shall continue to vest in the Option, to the extent unvested as of the retirement date, for a period of three (3) years following Participant's retirement date and (b) may exercise the Option, to the extent vested, at any time within the period of three (3) years following Participant's retirement date, but not beyond the original term of the Option, in both cases as long as no government regulations or rules are violated by such continued vesting or exercise period. To the extent unvested or unexercised at the end of the three (3) year period following Participant's retirement date, the Option shall be forfeited. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 8 shall apply with respect to the vesting and exercise of the Option as of the Participant's employment termination date. " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 13 below, of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above during the severance period set forth in a severance agreement with the Company.

9. DISABILITY OF PARTICIPANT . In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the Option shall vest as of the employment termination date on a pro-rata basis as follows: the Option shall vest with respect to a total number of Shares as of the employment termination date (which is the last day that Participant is employed by the Company and any subsidiary of the Company) equal to (i) the number of Shares subject to the Option on the Grant Date *multiplied* by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the employment termination date since the Grant Date and (B) the denominator shall be forty-eight (48), *minus* (ii) the number of Shares with respect to which the Option vested prior to the employment termination date (whether or not the Option was previously exercised). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the employment termination date is eight months and five days, the numerator in sub-section (A) above shall be nine **.** The Option may be exercised to the extent vested at any time within one (1) year of Participant's employment termination date but not beyond the original term of the Option. The prorated Option shall vest on the Participant's employment termination date.

10. DEATH OF PARTICIPANT . In the event of Participant's death while Participant is employed with the Company and any subsidiary of the Company, the Option shall immediately vest in full, and the Option shall remain exercisable for a period of one (1) year after Participant's death, or until the Option expiration date, whichever occurs first, by Participant's Beneficiary. At the end of said one (1)-year time period, all rights with respect to any Option that is unexercised shall terminate and the Option shall be cancelled.

11 . TRANSFER OF EMPLOYMENT . Transfer of Participant's employment from the Company to a subsidiary of the Company, among or between subsidiaries of the Company, or from a subsidiary of the Company to the Company shall not be treated as termination of employment.

12. REQUIRED ACCEPTANCE OF AWARD. The Option may not be exercised unless and until the Company has received the Participant's acceptance of the terms and conditions set forth herein. Acceptance shall be submitted electronically as required by the Company.

13. NOTICE . Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to Participant at his or her address as shown on the records of the Company, subject to the right of either party hereafter to designate in writing to the other some other address.

14. RECOUPMENT OF OPTION AWARD . The Option subject to this Agreement under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that a copy of the Company's Recoupment Policy has been made available for the Participant's reference.

15. COMMITTEE AUTHORITY . The Committee shall have the authority, in its sole discretion, to make any interpretations, determinations, and/or take any administrative actions with respect to the ICP and this Agreement, including whether any post-termination payments to Participant shall be deemed severance pay, the duration of any severance period, and/or whether a termination was without cause.

16. GOVERNING LAW . This Nonqualified Stock Option Agreement and the Option evidenced hereby shall be governed by the laws of Delaware, without giving effect to principles of conflict of laws.

17. ACKNOWLEDGEMENT. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 10.40

CVS HEALTH CORPORATION
RESTRICTED STOCK UNIT AGREEMENT - ANNUAL GRANT

GRANT DATE : **[_____]**

1. Pursuant and subject to the provisions of the 2017 Incentive Compensation Plan of CVS Health Corporation (the " **ICP** "), on the date set forth above (the " **Grant Date** "), CVS Health Corporation (the " **Company** ") has awarded and hereby evidences the Restricted Stock Unit (" **RSU** ") award (the " **Award** ") to the person named below (the " **Participant** "), subject to the terms and conditions set forth and incorporated in this Restricted Stock Unit agreement (the " **Agreement** "). The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. On the Grant Date specified above, the Fair Market Value (the "FMV"), which is the Closing Price of the Company's common stock on the Grant Date, of each RSU equals **[_____]** .

Participant:	**[_____]**
Employee ID:	**[_____]**
RSUs (#):	**[_____]**

2. Each RSU represents a right to a future payment of one share (" **Share** ") of Common Stock ($0.01 par value) of the Company, subject to required tax withholding.

3. (a) To the extent dividends are paid on Shares while the RSUs remain outstanding, subject to Section 5(b), a cash amount equivalent to the dividends paid (such cash amount, a "Dividend Equivalent") with respect to the number of Shares covered by the RSUs shall accrue. Any accrued Dividend Equivalent shall be payable only upon vesting of the underlying RSUs. To the extent that the underlying RSUs do not vest hereunder, any related accrued Dividend Equivalent shall be forfeited.

   (b) Participant hereby agrees that the Company may withhold from the Dividend Equivalents, referred to in Paragraph 3(a) above, amounts sufficient to satisfy the applicable tax withholding in respect of such Dividend Equivalents.

4. Subject to the terms and conditions of the ICP and this Agreement and subject to Participant's continued employment, Participant shall be entitled to receive (and the Company shall deliver to Participant) (a) the Shares on the Vesting Date set forth herein, or as soon as administratively practicable, but within 30 days thereafter, unless delivery of the Shares has been deferred in accordance with Section 5 below (the date of such delivery of the Shares being hereafter referred to as the " **Settlement Date** ") and (b) the Dividend Equivalents on the Vesting Date(s) set forth herein, or as soon as administratively practicable but within 30 days thereafter. The " **Vesting Date** ," except as otherwise provided in Section 7, shall be the fourth anniversary of the Grant Date.

5. (a) In accordance with rules promulgated by the Management Planning and Development Committee of the Board of Directors (the " **Committee** "), Participant, to the extent eligible under the CVS Health Deferred Stock Compensation Plan, may elect to defer delivery of Shares in settlement of RSUs covered by this Agreement. Any such deferred delivery date elected by Participant shall become the Settlement Date for purposes of this RSU Agreement.

(b) Notwithstanding Section 3(a), to the extent dividends are paid on such deferred Shares following the Vesting Date and prior to the Settlement Date, Participant shall be entitled to receive a number of additional deferred Shares equal to: (x) the amount of dividend per Share as declared by the Company's Board of Directors on the Company's common stock multiplied by (y) the number of deferred Shares held by Participant on the record date of such dividend, divided by (z) the FMV of a Share on such dividend payment date.

6. On the Settlement Date the number of Shares to be delivered by the Company to Participant shall be reduced by the smallest number of Shares having a FMV at least equal to the dollar amount of federal, state and local tax withholding required to be withheld by the Company with respect to such RSUs on such date.

7. (a) Except as provided in Paragraphs 7 (b) - (f) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all RSUs not then vested in accordance with Section 4 above shall be immediately forfeited.

(a) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, RSUs not then vested in accordance with Section 4 will become immediately vested and the Vesting Date shall be the date of death.

(b) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a "Qualified Retirement", RSUs shall vest on a pro-rata basis as of the Participant's retirement date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company, as follows: the total number of RSUs vesting as of the retirement date shall be equal to (i) the number of RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the retirement date since the Grant Date and (B) the denominator shall be forty-eight (48). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the retirement date is eight months and five days, the numerator in sub-section (A) above shall be nine. " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 10 below, of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above during the severance period set forth in a severance agreement with the Company. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 7(c) or the terms of Section 7(e), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. Any Shares represented by the pro-rated RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(d) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the RSUs shall vest as of the employment termination date on a pro rata basis as follows: the total number of RSUs vested as of the termination date, which is the last date that the Participant is employed by the Company and any subsidiary of the Company, shall be equal to the number of RSUs granted on the Grant Date multiplied by

the following fraction: (A) the numerator shall be the whole number of months elapsed as of Participant's termination date since the Grant Date and (B) the denominator shall be forty-eight (48). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is eight months and five days, the numerator in sub-section (A) above shall be nine. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(e) In the event Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay, RSUs not vested at the time of Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall continue to vest during the severance period and settle in accordance with the original schedule set forth in Section 4 of this RSU Agreement. All RSUs not scheduled to vest during the specified severance period shall be forfeited as of the last day of the Participant's severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period specified in a severance agreement with the Company, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting. In the event Participant's termination of employment qualifies as a Qualified Retirement the terms of this Section 7(e) or the terms of Section 7(c), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. During any severance period, Participant is eligible to accrue Dividend Equivalents on outstanding RSUs as described in Paragraph 3(a) above.

(f) Notwithstanding the above, (i) the provisions of Section 10 of the ICP shall apply in the event of a Change in Control (as defined in such Section 10) and (ii) the provisions of Section 7(e)(iv) of the ICP shall apply.

(g) For purposes of this Section 7, transfer of Participant's employment from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, or transfer from a subsidiary of the Company to the Company shall not be treated as a termination of employment.

(h) Participant will be responsible for any applicable withholding or other taxes that may become due as a result of RSUs that vest as of Participant's employment termination date or thereafter.

8. An RSU does not represent an equity interest in the Company and carries no voting rights. Participant shall have no rights of a shareholder with respect to the RSUs until the Shares have been delivered to Participant.

9. Neither the execution and delivery hereof nor the granting of the Award evidenced hereby shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

10. Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

11. All decisions and interpretations made by the Board of Directors or the Committee with regard to any question arising hereunder or under the ICP shall be binding and conclusive on all persons. In the event of any inconsistency between the terms hereof and the provisions of the ICP, the ICP shall govern.

12. The award of RSUs pursuant to this Agreement is expressly subject to and contingent upon the requirement that the Participant shall have fully executed and delivered to the Company the Restrictive Covenant Agreement, that may be required and provided by the Company. The applicable agreement containing the restrictive covenants that the Company may require in connection with this award is hereafter referred to as the "Restrictive Covenant Agreement".

    If the Company intends to require Participant to execute and deliver a new Restrictive Covenant Agreement in connection with the grant hereunder, the Company shall provide such new Restrictive Covenant Agreement to Participant and Participant agrees to execute and deliver such new Restrictive Covenant Agreement by the deadline set forth by the Company. If Participant is currently subject to a Restrictive Covenant Agreement and the Company does not require Participant to execute and deliver a new Restrictive Covenant Agreement, then by accepting the award of RSUs, pursuant to this Agreement. Participant affirms his or her Restrictive Covenant Agreement and intent to be bound by the restrictions in the Restrictive Covenant Agreement and to comply with all of its provisions.

    Participant agrees that failure to execute and return the new Restrictive Covenant Agreement, if required, by the deadline set forth by the Company shall result in the immediate and irrevocable forfeiture of the RSU Award hereunder and any right to receive dividend equivalents or Shares with respect thereto. Further, if Participant violates any provision of the applicable Restrictive Covenant Agreement, any unvested RSUs will be immediately and irrevocably forfeited, and no payment of any kind, including Dividend Equivalents or Shares, shall be payable with respect thereto. This Section shall not constitute the Company's exclusive remedy for Participant's violation of the Restrictive Covenant Agreement. The Company reserves all rights to seek all available legal or equitable remedies in the event of Participant's violation or threatened violation of the Restrictive Covenant Agreement, including injunctive relief.

13. By accepting this Award, Participant acknowledges that a copy of the ICP has been made available by the Company for Participant's reference and agrees to be bound by the terms and conditions set forth in this Agreement and the ICP as in effect from time to time.

14. By accepting this Award, Participant further acknowledges that the Federal securities laws and/or Company's policies regarding trading in its securities may limit or restrict Participant's right to trade Shares, including without limitation, sales of Shares acquired in connection with RSUs. Participant agrees to comply with such Federal securities law requirements and Company policies, as such laws and policies may be amended from time to time.

15. The Company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and that to the extent any provisions of this Agreement do not comply with Code Section 409A the Company will make such changes in order to comply with Code Section 409A to the extent it considers reasonable. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A of the Code shall be delayed until the first business day of the seventh month immediately following the employment termination date. For purposes of any provision of this Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to the "termination of employment" (and corollary terms) shall be construed to refer to "separation from service" (within the meaning of Treas. Reg. Section 1.409A-1(h)). Notwithstanding the foregoing, the Company makes no representations as to the tax treatment or consequences of any payment made hereunder, and Participant, by accepting this Award, acknowledges that Participant shall be solely responsible for same.

16. The Award subject to this RSU Agreement under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay

to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for the Participant's reference.

17. This Agreement shall be governed by the laws of Delaware, without giving effect to its choice of law provisions.

18. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 10.41

CVS HEALTH CORPORATION
PERFORMANCE-BASED RESTRICTED STOCK UNIT AGREEMENT

GRANT DATE : **[_____]**

1. Pursuant and subject to the provisions of the 2017 Incentive Compensation Plan of CVS Health Corporation (the " **ICP** "), on the date set forth above (the " **Grant Date** "), the CVS Health Corporation (the " **Company** ") has awarded and hereby evidences the Performance-Based Restricted Stock (" **PBRS** ") unit award (the " **Award** ") to the person named below (the " **Participant** "), subject to the terms and conditions set forth and incorporated in this PBRS Agreement (the " **PBRS Agreement** "), the Restricted Stock Units (" **RSUs** ") set forth below. The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. On the Grant Date specified above, the Fair Market Value (the " **FMV** ") of a share of Stock equals **[_____]** , which is the closing price on such date.

Participant	**[_____]**
Employee Number	**[_____]**
RSUs (#)	**[_____]**

2. Each RSU represents a right to a future payment of one share (" **Share** ") of Common Stock ($0.01 par value) of the Company, subject to required tax withholding.

3. (a) To the extent dividends are paid on Shares while the RSUs remain outstanding, subject to Paragraph 5(b), a cash amount equivalent to the dividends paid (such cash amount, a "Dividend Equivalent") with respect to the number of Shares covered by the RSUs shall accrue. Any accrued Dividend Equivalent shall be payable only upon vesting of the underlying RSUs. To the extent that the underlying RSUs do not vest hereunder, any related accrued Dividend Equivalent shall be forfeited.

   (b) Participant hereby agrees that the Company may withhold from the Dividend Equivalents, referred to in Paragraph 3(a) above, amounts sufficient to satisfy the applicable tax withholding in respect of such Dividend Equivalents.

4. Subject to the terms and conditions of the ICP and this PBRS Agreement, and subject to Participant's continued employment, Participant shall be entitled to receive (and the Company shall deliver to Participant) (a) the Shares on the Vesting Date(s) set forth herein, or as soon as administratively practicable thereafter, but within 30 days, thereafter unless delivery of the Shares has been deferred in accordance with Paragraph 5 below (the date of such delivery of the Shares being hereafter referred to as the "Settlement Date") and (b) the Dividend Equivalents on the Vesting Date(s) set forth herein, or as soon as administratively practicable but within 30 days thereafter. Each "Vesting Date," except as otherwise provided in Paragraph 7, shall be in accordance with the schedule set forth below:

   (a) one-third (1/3) of the RSUs on the first anniversary of the Grant Date;
   (a) one-third (1/3) of the RSUs on the second anniversary of the Grant Date; and
   (b) one-third (1/3) of the RSUs on the third anniversary of the Grant Date.

5. (a) In accordance with rules promulgated by the Management Planning and Development Committee of the Board of Directors (the " **Committee** "), Participant, to the extent eligible under the CVS Health Deferred Stock Compensation Plan, may elect to defer delivery of Shares in settlement of RSUs covered by this PBRS Agreement. Any such deferred delivery date elected by Participant shall become the Settlement Date for purposes of this PBRS Agreement.

   (b) Notwithstanding Paragraph 3(a), to the extent dividends are paid on such deferred Shares following the Vesting Date and prior to the Settlement Date, Participant shall be entitled to receive a number of additional deferred Shares equal to: (x) the amount of dividend per Share as declared by the Company's Board of Directors on the Company's common stock multiplied by (y) the number of deferred Shares held by Participant on the record date of such dividend, divided by (z) the FMV of a Share on such dividend payment date.

6. On the Settlement Date the number of Shares to be delivered by the Company to Participant shall be reduced by the smallest number of Shares having a FMV at least equal to the dollar amount of Federal, state and local tax withholding required to be withheld by the Company with respect to such RSUs on such date.

7. (a) Except as provided in Paragraphs 7 (b) - (f) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all RSUs not then vested in accordance with Paragraph 4 above, shall be immediately forfeited.

   (a) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, RSUs not then vested in accordance with Paragraph 4 will become immediately vested and Vesting Date shall be the date of death.

   (c) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a "Qualified Retirement", RSUs will become immediately vested as of Participant's retirement date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company. The Vesting Date shall be the effective date of the Participant's termination of employment. " **Qualified Retirement** " shall mean a Participant's termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 9 below, of the date of his or her termination of employment or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above as of during the severance period set forth in a severance agreement with the Company. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 6(c) or the terms of Section 6(e), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this PBRS Agreement.

   (d) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the RSUs shall vest as of the employment termination date on a pro rata basis as follows: the total number of RSUs vesting as of the termination date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company shall be equal to (i) the number of RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the

termination date since the Grant Date and (B) the denominator shall be thirty-six (36) *minus* (ii) the number of RSUs that had vested prior to the termination date. For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is eight months and five days, the numerator in sub-section (A) above shall be nine. The Vesting Date shall be the effective date of the Participant's termination of employment. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this PBRS Agreement.

(e) In the event Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay, RSUs not vested at the time of Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall continue to vest during the severance period and settle in accordance with the original schedule set forth in Section 4 of this PBRS Agreement. All RSUs not scheduled to vest during the specified severance period shall be forfeited as of the last day of the Participant's severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period specified in a severance agreement with the Company, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting. In the event Participant's termination of employment qualifies as a Qualified Retirement the terms of this Section 6(e) or the terms of Section 6(c), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. During any severance period, Participant is eligible to accrue Dividend Equivalents on outstanding RSUs as described in Paragraph 3(a) above.

(f) Notwithstanding the above, (i) the provisions of Section 10 of the ICP shall apply in the event of a Change in Control (as defined in such Section 10) and (ii) the provisions of Section 7(e)(iv) of the ICP shall apply.

(g) For purposes of this Section 7, transfer of Participant's employment from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, or transfer from a subsidiary of the Company to the Company shall not be treated as termination of employment.

(h) Participant will be responsible for any applicable withholding or other taxes that become due as a result of RSUs that vest as of Participant's employment termination date or thereafter.

8. An RSU does not represent an equity interest in the Company and carries no voting rights. Participant shall have no rights of a shareholder with respect to the RSUs until the Shares have been delivered to Participant.

9. Neither the execution and delivery hereof nor the granting of the award evidenced hereby shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

10. Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

11. All decisions and interpretations made by the Board of Directors or the Committee with regard to any question arising hereunder or under the ICP shall be binding and conclusive on all persons. In the event of any inconsistency between the terms hereof and the provisions of the ICP, the ICP shall govern.

12. By accepting this Award, Participant acknowledges that a copy of the ICP has been made available for the Participant's reference, and agrees to be bound by the terms and conditions set forth in this Agreement and the ICP as in effect from time to time.

13. By accepting this Award, Participant further acknowledges that the Federal securities laws and/or Company's policies regarding trading in its securities may limit or restrict Participant's right to buy or sell Shares, including without limitation, sales of Shares acquired in connection with RSUs. Participant agrees to comply with such Federal securities law requirements and Company policies as such laws and policies may be amended from time to time.

14. The company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and the regulations and guidance thereunder (collectively, "Section 409A") and that to the extent any provisions of this PBRS Agreement do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and, notwithstanding any other provision of the Plan or this PBRS Agreement to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh month immediately following the date of termination of employment. For purposes of any provision of this PBRS Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to the "termination of employment" (and corollary terms) shall be construed to refer to "separation from service" as determined under Section 409A.

15. The Award subject to this PBRS Agreement under the Plan and ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for Participant's reference.
16. This Agreement shall be governed by the laws of Delaware, without giving effect to its choice of law provisions.

17. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 10.42

PARTNERSHIP EQUITY PROGRAM
Participant Purchased RSUs, Company Matching RSUs and Company Matching Option Agreement

AGREEMENT, by and between CVS Health Corporation, a Delaware corporation (the "Company"), and _____ ("Participant"), effective on _____ , herein after known as the "Grant Date" (this "Agreement") **.**

WHEREAS, Participant has been selected as an Eligible Participant to invest under the Company's Partnership Equity Program (the "PEP") and has elected in the Participant's Election Form to invest $ _____ in the PEP, subject to the terms and conditions set forth in the PEP and in this Agreement;

WHEREAS, the Company desires to provide Participant with written evidence acknowledging Participant's investment under the PEP through Participant Purchased RSUs and the corresponding grant of Company Matching RSUs and a Company Matching Option under the PEP.

WHEREAS, the provisions of the PEP and the Company's 2017 Incentive Compensation Plan (the "ICP") are hereby incorporated by reference and shall have the same force and effect as though fully set forth herein; Participant hereby acknowledges that a copy of the PEP and the ICP have been made available to Participant and agrees to be bound by such provisions (as presently in effect or hereafter amended); if any provision of this Agreement is inconsistent with a provision of the PEP or the ICP, the terms of the PEP and/or the ICP, or any successor thereto, shall control; capitalized terms used in this Agreement but not defined herein shall have the same meanings as in the PEP or the ICP, as the case may be; and on the Grant Date specified above, the Fair Market Value (the "FMV") of a share of CVS Health Common Stock ("Stock") equals $ ____ which is the closing price on such date.

NOW, THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the parties hereto agree as follows:

I. PARTICIPANT PURCHASED RSUs AND COMPANY MATCHING RSUs

(A) **Participant Purchased RSUs** . The Company has received from Participant a completed Participant Election Form authorizing the Company to apply designated compensation of $_____ to the purchase of _____ Participant Purchased RSUs on the Grant Date under the PEP, and the Company has accordingly credited Participant's Account under the PEP with the Participant Purchased RSUs. Except as provided under Section III of this Agreement, the Participant Purchased RSUs (including any Participant Purchased RSUs credited to Participant pursuant to Section I(C)(ii)) shall be fully vested as of the Grant Date and shall settle on the fifth (5 th) anniversary of the Grant Date.

(B) **Crediting of Company Matching RSUs** . As of the Grant Date, the Company hereby awards the Participant, subject to the terms and conditions set forth and incorporated in this Agreement and the PEP, _____ Company Matching RSUs.

(C) **Additional Transactions in Participant Accounts** .

(i) Each Participant Purchased RSU and Company Matching RSU represents a right to a future payment of one share of Stock, subject to applicable tax withholding.

(ii) To the extent that dividends are declared and paid on shares of Stock while the Participant Purchased RSUs and Company Matching RSUs remain outstanding and prior to a Settlement Date (as defined below), the Company shall credit to Participant's Purchased RSU account and Company Matching RSU account (as applicable) an additional number of Participant Purchased RSUs and Company Matching RSUs calculated by multiplying (a) the amount of dividend per share of Stock approved by the Company's Board of Directors by (b) the number of Participant Purchased RSUs and Company Matching RSUs held by Participant on the dividend record date, and dividing the product by (c) the FMV of a share of Stock on such dividend payment date.

(iii) Provided, however, that if such dividend is paid prior to the Vesting Date of Participant Purchased RSUs and/or the Company Matching RSUs, as set forth in Section I (D) below, Participant shall not be entitled to any

payment in respect of such dividend unless Participant is still employed by the Company on such dividend payment date.

(iv) Participant hereby agrees that, prior to the Settlement Date, the Company may withhold from the dividend equivalent amounts described to in Section I(C)(ii) amounts sufficient to satisfy the applicable tax withholding in respect of such dividend equivalent payments, as applicable.

(D) **Vesting of Company Matching RSUs .** Subject to the terms and conditions of the PEP and this Agreement, and to Participant's continued employment through such date, the Company Matching RSUs, and the dividend equivalent amounts attributed to same, shall vest on the fifth (5 th) anniversary of the Grant Date.

(E) **Settlement of Company Matching RSU.**

(i) A "Settlement Date" shall mean the date shares of Stock are delivered to Participant pursuant to the PEP and this Agreement.

(ii) Within fifteen (15) days following the earliest of the fifth (5 th) anniversary of the Grant Date, Participant's death, or termination of employment without Cause within the two-year period following a Change in Control, Participant shall be entitled to receive and the Company shall deliver to Participant the total number of shares of Stock (giving effect to Sections I(C)(ii) and I(C)(iv)) underlying the Company Matching RSUs on the Vesting Date set forth herein, or as soon as administratively practicable, but within 30 days thereafter, unless delivery of the Shares has been deferred in accordance with Section I(E)(iii) below (the date of such delivery of the Shares being hereafter referred to as the " **Settlement Date** "). Notwithstanding the foregoing, no shares of Stock shall be delivered upon termination of employment unless such termination of employment is considered a "separation from service" (within the meaning given of Treasury Regulation §1.409A-1(h) or successor guidance thereto).

(iii) Subject to the rules promulgated by the Committee, the terms of the CVS Health Deferred Stock Compensation Plan and Section 409A, Participant may elect to defer settlement of Participant Purchased RSUs or Company Matching RSUs covered by this Agreement.

II. COMPANY MATCHING OPTION

(A) **Grant of Option** . The Company hereby awards and evidences the grant to Participant, subject to the terms and conditions incorporated in this Agreement, the right, and option, to purchase from the Company _____ shares of Stock, with an exercise price per share of Stock equal to the FMV of a share of Stock on the Grant Date, such Company Matching Option to be exercised as hereinafter provided. The Company Matching Option is a nonqualified option as defined in the ICP.

(B) **Term of Company Matching Option .** The term of this Company Matching Option shall be for a period of ten (10) years from the Grant Date, subject to the earlier termination of the Company Matching Option, as set forth in the ICP and in this Agreement.

(C) **Vesting and Exercise of Company Matching Option**

(i) Prior to its expiration or termination, and except as otherwise provided herein, the Company Matching Option shall vest and may be exercised by Participant, provided Participant has maintained continuous employment with the Company or a subsidiary of the Company from the Grant Date until the applicable vesting date, within the following time limitations:

a. On or after three (3) years from the Grant Date, the Company Matching Option shall be vested and may be exercised as to one-third (1/3) of the shares of Stock subject to the Company Matching Option;

b. On or after four (4) years from the Grant Date, the Company Matching Option shall be vested and may be exercised as to an aggregate of two-thirds (2/3) of the shares of Stock subject to the Company Matching Option; and

c. On or after five (5) years from the Grant Date, the Company Matching Option shall be vested and may be exercised as to all of the shares of Stock subject to the Company Matching Option.

(ii) The Company Matching Option, subject to the provisions of the ICP, shall be exercised by submitting a request to exercise to the Company's stock option administrator, in accordance with the Company's current exercise policies and procedures, specifying the number of shares of Stock to be purchased, which number may not be less than one hundred (100) shares of Stock (unless the number of shares of Stock purchased is the total balance which is then exercisable). An exercise by Participant of all or part of this Company

Matching Option shall be effected through the Company's "cashless exercise" procedures. Otherwise, at the time of exercise, Participant shall tender to the Company cash or cash equivalent for the aggregate exercise price of the shares of Stock Participant has elected to purchase or certificates for shares of Stock of the Company already owned by Participant for at least six (6) months with an aggregate FMV at least equal to the aggregate exercise price of the shares of Stock Participant has elected to purchase, or a combination of the foregoing.

(D) **Company Matching Option Expiration** . The Company Matching Option shall be exercisable only as provided above and shall expire at the close of business on the tenth (10 th) anniversary of its Grant Date or such earlier expiration date as described in Section III below.

III. TERMINATION OF EMPLOYMENT AND CHANGE IN CONTROL

(A)

(i) If Participant's employment with the Company and its subsidiaries terminates within 24 months of the grant date as a result of the Participant's voluntary termination of employment or involuntary termination by the Company or any subsidiary for Cause, the Participant Purchased RSUs shall be immediately forfeited as of the termination date .

(ii) Except as provided in Section III (B)-(F) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all Company Matching RSUs and the Company Matching Option to the extent not vested as of the termination date in accordance with Sections I(D) and II(C)(i) above shall be immediately forfeited as of the termination date. To the extent vested and unexercised as of the termination date, the Company Matching Option shall be exercisable on or before the ninetieth (90 th) day following the termination date, as long as no government regulations or rules are violated by such exercise period; provided, however, that the Company Matching Option shall not be exercisable beyond its original term.

(B) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, Company Matching RSUs and the Company Matching Option not then vested in accordance with Section I(D) and Section II(C)(i), respectively, will become immediately vested and the Vesting Date will be the date of death. Participant Purchased RSUs and Company Matching RSU shall settle as of the date of death and the Company Matching Option shall be exercisable by the Participant's Beneficiary during the twelve (12) month period following the date of death, as long as no government regulations or rules are violated by such accelerated vesting or exercise period; provided, however, that no Company Matching Option will be exercisable beyond its original term.

(C) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such plan, as defined by the Social Security Administration), the Company Matching RSUs and the Company Matching Option shall vest on a pro rata basis as follows:

(i) the total number of Company Matching RSUs vested as of Participant's employment termination date (which is the last day that the Participant is employed by the Company or any subsidiary of the Company) shall be equal to the number of Company Matching RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed since the Grant Date and (B) the denominator shall be sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the Separation Date is eight months and five days, the numerator in sub-section (A) above shall be nine. Participant will be responsible for any applicable withholding taxes that may become due as of Participant's employment termination date. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section I(D) of this PEP Agreement.

(ii) the total number of Company Matching Option vested as of Participant's employment termination date with respect to the number of shares of Stock subject to the Company Matching Options, shall be equal to the number of Company Matching Options granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed since the Grant Date and (B) the denominator shall be sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed

between the Grant Date and the Separation Date is eight months and five days, the numerator in sub-section (A) above shall be nine.

(iii) the vested portion of the Company Matching Option shall be exercisable during the twelve (12) month period following Participant's employment termination date, as long as no government regulations or rules are violated by such accelerated vesting or exercise period; provided, however, that the Company Matching Option shall not be exercisable beyond its original term.

(D) **Involuntary Termination with Severance.** In the event that Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay pursuant to a written agreement in the form required by the Company, Participant's Company Matching RSUs and the Company Matching Option to the extent not vested at the time of the Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall continue to vest during the severance period and settle in accordance with the schedule set forth in Section I(D) and Section II(C)(i), respectively, of this Agreement. Participant will be responsible for any applicable withholding taxes that may become due as of Participant's employment termination date. All Company Matching RSUs and the Company Matching Option to the extent not scheduled to vest during the specified severance period shall be forfeited as of the Participant's employment termination date. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section I(D) of this PEP Agreement. During any severance period, Participant is eligible to receive dividend equivalents on outstanding RSUs as described in Paragraph I(C)(ii) above. To the extent vested, the Company Matching Option shall be exercisable on or before the ninetieth (90 th) day following the last day of the severance period, as long as no government regulations or rules are violated by such continued vesting or exercise period; provided, however, that the Company Matching Option shall not be exercisable beyond its original term.

(E) **Retirement** . " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, then such termination is without cause.

(i) In the event Participant's termination of employment qualifies as a Qualified Retirement, Participant may exercise the Company Matching Option to the extent vested as of Participant's retirement date at any time within two (2) years after Participant's retirement date, but not beyond the original term of the Company Matching Option. To the extent unvested as of the retirement date, the Company Matching Option shall be forfeited. The Committee shall have the authority in its sole discretion to make any interpretations, determinations, and/or take any administrative actions with respect to whether Participant has experienced a Qualified Retirement.

(ii) Company Matching RSUs that are unvested as of the Participant's retirement date are forfeited as of the retirement date.

(iii) In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, each portion of a Participant's Company Matching RSU or Company Matching Option under this Award shall be entitled to the more favorable treatment explicitly applicable to such portion of the Participant's Company Matching RSU or Company Matching Option under the provisions of Section XIII(F) of the PEP with respect to the vesting and settlement of the Company Matching RSUs and the Company Matching Option.

Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section I(D) of this PEP Agreement.

(F) The provisions of Section 10 of the ICP, or any successor thereto, shall apply in the event of a Change in Control.

(G) For purposes of this Section III, transfer of employment by Participant from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, transfer from a subsidiary of the Company to the Company or any other continuation of employment with the Company or a subsidiary of the Company after termination by a related entity shall not be treated as termination of employment.

IV. NON-COMPETITION. The grant of RSUs pursuant to this Agreement is expressly subject to and contingent upon the requirement that the Participant shall have fully executed and delivered to the Company the CVS Health Corporation

Restrictive Covenant Agreement provided by the Company; provided that the Company in its sole discretion may waive such requirement if Participant is currently a party to another agreement with the Company setting forth restrictive covenants, such as non-competition, non-disclosure, and/or non-solicitation obligations. The applicable agreement containing the restrictive covenants the Company requires in connection with this Award, whether previously executed or required to be executed in connection with this Award, is hereafter referred to as the "Restrictive Covenant Agreement".

If the Company intends to require Participant to execute and deliver a new Restrictive Covenant Agreement in connection with the Award hereunder, the Company shall provide such Restrictive Covenant Agreement to Participant and Participant agrees to execute and deliver such agreement by the deadline set forth by the Company, which shall be no less than ten days from the date it is provided to Participant. If Participant is currently subject to a Restrictive Covenant Agreement, Participant hereby affirms his or her agreement and intent to be bound by the restrictions in the Restrictive Covenant Agreement and to comply with all of its provisions.

Participant agrees that failure to execute and return the Restrictive Covenant Agreement by the deadline set forth by the Company, if required, shall result in the immediate and irrevocable forfeiture of the RSU Award hereunder and any right to receive dividend equivalents or Shares with respect thereto. Further, if Participant violates any provision of the applicable Restrictive Covenant Agreement, any unvested RSUs will be immediately and irrevocably forfeited, and no payment of any kind, including dividend equivalents or Shares, shall be payable with respect thereto. This Section shall not constitute the Company's exclusive remedy for Participant's violation of the Restrictive Covenant Agreement, and the Company may seek all available legal or equitable remedies in the event of Participant's violation or threatened violation of the Restrictive Covenant Agreement, including injunctive relief.

V. MISCELLANEOUS .

(A) Withholding Tax . Participant may be subject to withholding taxes as a result of the exercise of the Company Matching Option or settlement of Participant Purchased RSUs or Company Matching RSUs. The number of shares of Stock to be delivered by the Company to Participant shall be reduced by the smallest number of shares of Stock having a FMV at least equal to the dollar amount of federal, state or local tax withholding required to be withheld by the Company with respect to such exercise or settlement. Any shares of Stock so withheld or tendered will be valued as of the date they are withheld or tendered. Participant shall remit to the Company in cash, promptly when the amount of such tax obligations become determinable, all applicable federal, state, local and any foreign withholding taxes that result from each exercise of the Company Matching Option.

(B) Recoupment. This Award under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for Participant's reference.

(C) Certain Terms and Conditions of the PEP . Participant acknowledges and agrees that the terms and conditions of the PEP preclude all transfers of Participant Purchased RSUs, all Company Matching RSUs, and the Company Matching Option, except in limited circumstances in the event of Participant's death, impose a risk of forfeiture on Participant Purchased RSUs, Company Matching RSUs and the Company Matching Option, relieve the Company of certain obligations unless and until laws and regulations have been complied with, provide for adjustments to Participant Purchased RSUs, Company Matching RSUs, and the Company Matching Option upon the occurrence of certain events, and specify the state law which shall govern this Agreement, without giving effect to principles of conflict of laws.

(D) Binding Agreement . This Agreement shall be binding upon the heirs, executors, administrators, and successors of the parties. In particular, Participant's heirs, executors, administrators, and successors shall be subject to the terms and conditions of the PEP, ICP and this Agreement, and the Company may require any such person to execute an agreement or other documents acknowledging and agreeing to such terms and conditions as a condition precedent to any transfer of rights hereunder or shares of Stock issuable under the PEP, including upon exercise of the Company Matching Option, into the name of any such person.

(E) Integration Clause; Amendments to Agreement . This Agreement, together with the PEP and the ICP, constitutes the entire Agreement between the parties with respect to the PEP, and supersedes any prior agreements or documents with respect thereto. This Agreement may be amended, but no amendment or other change which may impose any additional obligation upon the Company or materially impair the rights of Participant under the PEP shall be valid unless contained in a writing signed by the party to be bound thereby.

(F) Employment . Neither the execution and delivery hereof nor the granting of the Company Matching RSUs or

the Company Matching Option evidenced hereby shall constitute or be evidence of any agreement or understanding, expressed or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

(G) **Required Acceptance of Award.** Acceptance may be submitted either electronically, if available, or in writing. The Company Matching Option may not be exercised unless and until the Company has received acceptance by the Participant of the terms and conditions set forth herein.

(H) **Company Matching RSUs.** Neither a Company Matching RSU nor a Participant Purchased RSU represents an equity interest in the Company and neither carries any voting rights. Except as otherwise specifically provided herein, Participant shall have no rights of a shareholder with respect to the RSUs until the related shares of Stock have been delivered to Participant.

(I) **Section 409A.** The Company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and that to the extent any provisions of this Agreement do not comply with Code Section 409A the Company will make such changes in order to comply with Code Section 409A to the extent it considers reasonable. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A of the Code shall be delayed until the first business day of the seventh month immediately following the employment termination date. For purposes of any provision of this Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to the "termination of employment" (and corollary terms) shall be construed to refer to "separation from service" (within the meaning of Treas. Reg. Section 1.409A-1(h)). Notwithstanding the foregoing, the Company makes no representations as to the tax treatment or consequences of any payment made hereunder, and Participant, by accepting this Award, acknowledges that Participant shall be solely responsible for same.

(J) **Notices** . Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

(K) **ACKNOWLEDGEMENT.** This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

CVS HEALTH CORPORATION

By: / **s/ Lisa G. Bisaccia**
Executive Vice President and
Chief Human Resources Officer

Accepted by: _____
PARTICIPANT NAME

_____
EMPLOYEE ID#

_____
Date

Exhibit 10.45

AETNA INC.
2010 STOCK INCENTIVE PLAN

MARKET STOCK UNIT TERMS OF AWARD

Pursuant to its 2010 Stock Incentive Plan (the "Plan"), Aetna Inc. (the "Company") hereby grants Market Stock Units on the terms and conditions hereinafter set forth. The number of Market Stock Units awarded is included in the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of the Market Stock Unit Grant Acknowledgement and Acceptance Form. All capitalized terms used herein which are not otherwise defined herein shall have the meaning specified in the Plan.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) "Change in Control" means the happening of any of the following:

(i) When any "person" as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and as used in Sections 13(d) and 14(d) thereof, including a "group" as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company's then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “Beneficial Owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means the Company's Common Shares, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date" means the date of grant of this award of Market Stock Units.

(h) “Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such date, on the next day on which the Common Stock is traded.

(i) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(j) "Grantee" means the person to whom this award has been granted.

(k) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively, of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(l) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(m) “Net Shares” means the number of shares of Common Stock which will be deposited in a brokerage account in the Grantee’s name at the Company’s designated broker after shares have been withheld to satisfy applicable tax and withholding requirements upon vesting of the Market Stock Units.

(n) “Performance Period” means the [ ] month period following the Effective Date.

(o) “Market Stock Units” means the number of units awarded that will convert to a number of shares of Common Stock based on the operation of Article II of this Agreement, or such other amount as may result by operation of Article III of this Agreement.

(p) “Plan” means the Aetna Inc. 2010 Stock Incentive Plan.

(q) "Retirement" means the termination of employment of a Grantee from active service with the Company, a Subsidiary or Affiliate provided the Grantee’s age and completed years of service total 65 or more points at termination of employment.

(r) “Section 162(m)” means Section 162(m) of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(s) “Section 409A” means Section 409A of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(t) “Shares of Stock” or “Stock” means the Common Stock.

(u) "Subsidiary" means an entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock of such entity is held by the Company and/or one or more other subsidiaries.

(v) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to the Market Stock Units by bequest or inheritance or by reason of the death of the Grantee.

(w) “Vest Date” means the date on which this award of Market Stock Units shall vest in accordance with the terms of this Agreement and in the Notice of Market Stock Unit Grant.

(x) “Vest Date Fair Market Value” means the average closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares for the 29 trading days prior to the Vest Date and the Vest Date, or, if no shares were traded on such Vest Date, for the 30 trading days prior to the Vest Date.

ARTICLE II

PERFORMANCE PERIOD & AWARD CONVERSION

Subject to the terms of this Agreement, the Market Stock Units will vest, as of the Vest Date, in accordance with the terms of the Plan and this Terms of Award Agreement, or on such earlier date as provided in Article IV. On the Vest Date the Grantee shall vest in a number of shares of Common Stock for each vested Market Stock Unit based on the formula below, net of applicable taxes and withholding. Such Net Shares will be delivered to the Company’s designated broker, in a brokerage account established in the Grantee’s name after the Vest Date. To the extent Section 162(m) is applicable to a Grantee, for shares to vest the Committee must also determine that the performance goal set forth on Exhibit A is met. If the Committee determines that the performance goal is not met at the minimum level, as applicable, no shares will vest.

The number of shares of Common Stock that each Market Stock Unit will convert and be awarded to you on the Vest Date, net of applicable taxes, shall be determined in accordance with the following formula:

(Number of Market Stock Units granted)

Multiplied by

((the Vest Date Fair Market Value) divided by (the Grant Date Fair Market Value))

Up to a maximum of 1.5 shares of Common Stock per Market Stock Unit.

Any social security calculation or other adjustments discovered after the payment of Net Shares will be settled in cash, not in Common Stock.

ARTICLE III

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this Plan, then the Committee shall, in such manner as the Committee may deem equitable, adjust the number and kind of shares subject to the award of Market Stock Units. Additionally, the Committee may make provision for cash payment to a Grantee or the Successor of the Grantee to the extent permitted under Section 409A. However, the number of Market Stock Units shall always be a whole number.

ARTICLE IV

CHANGE IN CONTROL

Notwithstanding any other provision of this Agreement to the contrary, upon the occurrence of a Change in Control, the Market Stock Units not previously forfeited pursuant to this Terms of Award Agreement shall become immediately vested and convert to a number of shares of Common Stock based on the formula in Article II but such formula shall use the Fair Market Value on the date on which the Change in Control occurs rather than the Vest Date Fair Market Value. Net Shares will be payable on the Vest Date, provided however, if within the 24 month period following the Change in Control the Company terminates Grantee's employment without cause, the Net Shares will become payable as of such termination of employment date. If an award is considered deferred compensation subject to Section 409A, the award will vest but the Change in Control will not accelerate the payment of the Market Stock Units unless the Change in Control also meets the definition of change in control set forth in Treasury Regulation Section 1.409A-3(i)(5).

ARTICLE V

TERMINATION OF EMPLOYMENT

(a) Except as provided in (c) below, if, during the Performance Period, Grantee shall cease to be employed by the Company, its Subsidiaries or Affiliates, for reason of death, Long-term Disability, Retirement or involuntary termination of employment by the Company, the portion of the Market Stock Units that may vest on the Vest Date, if any, shall be calculated in accordance with the following formula: (i) the number of completed months employed commencing on the first day of the Performance Period divided by the number of months in the Performance Period; multiplied by (ii) the number of Market Stock Units that otherwise would have vested under the term of this Agreement had the Grantee remained actively employed through the Vest Date.

(b) Except as provided in (a) above, any Market Stock Unit not vested as of the date Grantee terminates employment shall be forfeited at the time of cessation of employment; provided, however, that if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the Market Stock Unit in accordance with its terms, then upon the forfeiture of the entire Market Stock Unit, the Company will pay Grantee an amount equal to the value of a single share of Common Stock, whether or not the forfeited Market Stock Unit related to more than a single share of Common Stock, calculated as of the cessation of employment, if requested by Grantee, within 30 days of such cessation of employment.

(c) No Market Stock Unit will vest after the Company has terminated the employment of the Grantee for cause, unless the Committee, in its sole discretion, deems a payment to be warranted under the particular circumstances. In addition, the Market Stock Units will not vest if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(d) Employment for purposes of determining the vesting rights of the Grantee and the expiration of the grant under this Article V shall mean continuous active full-time salaried employment with the Company, a Subsidiary or an Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc. Notwithstanding any period during which Grantee receives salary continuation or severance shall not be considered as part of the continuous employment of the Grantee.

ARTICLE VI

EMPLOYEE COVENANTS

(a) As consideration for this grant of Market Stock Units, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related

information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company or any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement; provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of 12 months or 24 months for executive tier employees (the executive tier status determined as of the effective date of this grant) following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee to be employed or perform services elsewhere;

(iii) Grantee will not, during and for a period of 12 months or 24 months for executive tier employees (the executive tier status determined as of the effective date of this grant) following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company or any Subsidiary to cease or curtail providing services to the Company or any Subsidiary; and

(iv) Grantee will not, during and for a period of 12 months or 24 months for executive tier employees (the executive tier status determined as of the effective date of this grant) following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved.

In addition:

(v) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company or a Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(vi) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an

attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company.

(vii) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). Grantee further acknowledges that while employed by the Company, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company, and the Grantee hereby assigns all right, title, and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting therefrom.

(b) If any provision of Article VI (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the Market Stock Units is Grantee's covenants set forth in Article VI (a) and that the covenants and obligations of Grantee with respect to nondisclosure, non-solicitation and cooperation relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to vest in the Market Stock or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VI. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine.

(d) Employment Dispute Arbitration Program - <u>Mandatory Binding Arbitration of Employment Disputes.</u>

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether the Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VI (d) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VI (d) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VI (d) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VI (a) in accordance with applicable law). However, except as provided in Article VI (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement.

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org. THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the

arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VI (d) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VI (d) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(e) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VI, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

ARTICLE VII

OTHER TERMS

(a) Nothing in this Agreement shall interfere with or limit in any way the right of the Company or any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery hereof nor the granting of the Award shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ or continue the employment of the Grantee for any period.

(b) Until the Market Stock Units have become vested, Grantee shall not have any rights as a stockholder (including the right to payment of dividends) by virtue of this grant of Market Stock Units.

(c) During the Performance Period, the Market Stock Units shall be nontransferable and non-assignable except by will or the laws of descent and distribution.

(d) The award, when vested, will be settled on a net basis. Prior to issuing any Common Shares, the Company will withhold an amount sufficient to satisfy federal, state, local, social security and Medicare withholding tax requirements relating to award. Any social security calculation or other adjustments discovered after net share payment will be settled in cash, not in Shares of Common Stock. Vesting will result in taxable compensation reportable on the Grantee's W-2 in year of vesting.

(e) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connection with any such restriction.

(f) This Market Stock Unit is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(g) Anything herein to the contrary notwithstanding, a Grantee whose Market Stock Units have been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited Market Stock Units reinstated as follows: (i) if such Grantee is re-employed during the Performance Period, all forfeited Market Stock Units shall be reinstated; or (ii) if such Grantee is re-employed after the Performance Period, a cash payment will be made to the Grantee, minus applicable taxes, for the value of the forfeited Market Stock Units on the Vest Date pursuant to procedures established by the Company for this purpose.

(h) It is the intention of the Company and Grantee that this Agreement not result in unfavorable tax consequences to Grantee under Section 409A and the Agreement shall be interpreted as to so comply. Notwithstanding anything to the contrary herein, the Company and Grantee agree to the provisions set forth below in order to comply with the requirements of Section 409A.

(i) If Grantee is a "specified employee" (within the meaning of Section 409A) with respect to the Company, any non-qualified deferred compensation otherwise payable to or in respect of Grantee in connection with Grantee's termination of employment shall be delayed until the earliest date upon which such amounts may be paid without being subject to taxation under Section 409A. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

(ii) Unless deferred pursuant to this agreement, all payments shall be paid to Grantee, to the extent earned, in no event later than the last day of the "applicable 2 ½ month period," as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

(iii) The Company and Grantee agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by the Grantee due to any failure to comply with Section 409A.

(i) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(j) At such times and upon such terms and conditions as the Company shall determine, the Company may permit eligible Grantees to elect to defer the distribution of an Award otherwise payable to the Grantee under this Agreement until termination of the Grantee's Employment or such other date Company shall permit.

(k) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

Exhibit 10.46

AETNA INC.
2010 STOCK INCENTIVE PLAN

PERFORMANCE STOCK UNIT TERMS OF AWARD

Performance Period: [ ] through [ ]
Units Awarded: [ ]
Performance Metric: [ ]
Vesting Period - [ ] month period following the Effective Date (Date of Grant)

Pursuant to its 2010 Stock Incentive Plan (the "Plan"), Aetna Inc. (the "Company") hereby grants Performance Stock Units (PSUs) on the terms and conditions hereinafter set forth. The number of Performance Stock Units awarded is included in the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of the Performance Stock Unit Grant Acknowledgement and Acceptance Form. All capitalized terms used herein which are not otherwise defined herein shall have the meaning specified in the Plan.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) "Change in Control" means the happening of any of the following:

(i) When any "person" as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and as used in Sections 13(d) and 14(d) thereof, including a "group" as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company's then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “Beneficial Owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means the Company's Common Shares, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date" means the date of grant of this award of Performance Stock Units.

(h) “Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such date, on the next day on which the Common Stock is traded.

(i) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(j) "Grantee" means the person to whom this award has been granted.

(k) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively, of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(l) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(m) “Net Shares” means the number of shares of Common Stock which will be deposited in a brokerage account in the Grantee’s name at the Company’s designated broker after shares have been withheld to satisfy applicable tax and withholding requirements upon vesting of the Performance Stock Units.

(n) “Performance Period” means the [ ] month performance period ending [date]. The Performance Period shall run from [date] to [date].

(o) “Performance Stock Units” means the number of shares of Common Stock represented by the number of units awarded or such other amount as may result by operation of Article III of this Agreement.

(p) “Plan” means the Aetna Inc. 2010 Stock Incentive Plan.

(q) "Retirement" means the termination of employment of a Grantee from active service with the Company, any Subsidiary or Affiliate provided the Grantee’s age and completed years of service total 65 or more points at termination of employment.

(r) “Section 409A” means Section 409A of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(s) “Shares of Stock” or “Stock” means the Common Stock.

(t) "Subsidiary" means an entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock of such entity is held by the Company and/or one or more other subsidiaries.

(u) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to the Performance Stock Units by bequest or inheritance or by reason of the death of the Grantee.

(v) “Vest Date” means the last day of the Vesting Period and is the date on which this award of Performance Stock Units shall vest in accordance with the terms of this Agreement and in the Notice of Performance Stock Unit Grant, if at all.

(w) “Vesting Period” means the period beginning on the Effective Date and ending thirty-six months thereafter.

ARTICLE II

VESTING PERIOD

Subject to the terms of this Agreement, the Performance Stock Units will vest, as of the Vest Date, in accordance with the terms of the Plan and this Terms of Award Agreement, or on such earlier date as provided in Article IV. If the Committee determines that the performance goal set forth on Exhibit A is met, on the Vest Date, the Grantee shall vest to one share of Common Stock for each vested Performance Stock Unit net of applicable taxes and withholding (or such greater or lessor amount based on performance, as set forth on Exhibit A). Such Net Shares will be delivered to the Company's designated broker, in a brokerage account established in the Grantee's name after the Vest Date. If the Committee determines that the performance goal set forth on Exhibit A is not met at the minimum level, no shares will vest.

Any social security calculation or other adjustments discovered after the payment of Net Shares will be settled in cash not in Common Stock.

ARTICLE III

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this Plan, then the Committee shall, in such manner as the Committee may deem equitable, adjust the number and kind of shares subject to the award of Performance Stock Units. Additionally, the Committee may make provision for cash payment to a Grantee or the Successor of the Grantee. However, the number of Performance Stock Units shall always be a whole number.

ARTICLE IV

CHANGE IN CONTROL

Notwithstanding any other provision of this Agreement to the contrary, upon the occurrence of a Change in Control, the Performance Stock Units not previously forfeited pursuant to this Terms of Award Agreement shall become immediately vested at a level which equals the greater of the number of Performance Stock Units that would have vested (x) at target-level 100% vesting, or (y) based on the Company's actual year-to-date performance level using the date on which the Change in Control occurs as the end of the Vesting Period. Net Shares will be payable on the Vest Date, provided however, if within the 24 month period following the Change in Control the Company terminates Grantee's employment without cause, the Net Shares will become payable as of such termination of employment date. If an award is considered deferred compensation subject to Section 409A, the award will vest but the Change in Control will not accelerate the payment of the deferred Performance Stock Units unless the Change in Control also meets the definition of change in control set forth in Treasury Regulation Section 1.409A-3(i)(5).

ARTICLE V

TERMINATION OF EMPLOYMENT

(a) Except as provided in (c) below, if, during the Vesting Period, Grantee shall cease to be employed by the Company, any Subsidiaries or Affiliates, for reason of death, Long-term Disability, Retirement or involuntary termination of employment by the Company, the portion of the Performance Stock Units that may vest on the Vest Date, if any, shall be calculated in accordance with the following formula: (i) the number of completed months employed during the Vesting period divided by the number of months in the Vesting Period; multiplied by (ii) the number of Performance Stock Units, that otherwise would have vested. For purposes of this calculation, a month is complete on the day in the month that corresponds to the Effective Date of the grant (e.g., February 12 to March 12).

(b) Except as provided in (a) above, any Performance Stock Unit not vested as of the date Grantee terminates employment shall be forfeited at the time of cessation of employment; provided, however, that if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the Performance Stock Unit in accordance with its terms, then upon the forfeiture of the entire Performance Stock Unit, the Company will pay Grantee an amount equal to the value of a single share of Common Stock, whether or not the forfeited Performance Stock Unit related to more than a single share of Common Stock, calculated as of the cessation of employment, if requested by Grantee, within 30 days of such cessation of employment.

(c) No Performance Stock Unit will vest after the Company has terminated the employment of the Grantee for cause, unless the Committee, in its sole discretion, deems a payment to be warranted under the particular circumstances. In addition, the Performance Stock Units will not vest if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(d) Employment for purposes of determining the vesting rights of the Grantee and the expiration of the grant under this Article V shall mean continuous active full-time salaried employment with the Company, any Subsidiary or Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc. Notwithstanding any period during which Grantee receives salary continuation or severance shall not be considered as part of the continuous employment of the Grantee.

ARTICLE VI

EMPLOYEE COVENANTS

(a) As consideration for this grant of Performance Stock Units, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company, any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement ("Confidential Information"); provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of twelve (12) months following Grantee's termination of employment, directly or indirectly, (x) engage in the ownership (except less than 1% of the outstanding capital stock of any publicly traded company) of or, (y) become an employee of, or (z) act as a consultant or contractor to, any competitor of the Company ("Competitor") in any market in the United States where Company, Affiliate or Subsidiary does business.

a. For purposes of this paragraph "Competitor" shall mean any entity, organization, person or corporation that is involved in the same business as Company, Subsidiary or Affiliate, but in the case of (y) and (z), only to the extent such work, consulting or other activity on behalf of other entity, organization, person or corporation

i. is materially similar to the duties and/or functions that Grantee performed for the Company, Subsidiary or Affiliate in the last 12 months or involves duties and/or functions for Competitor about which Grantee has Confidential Information in the last 12 months. Notwithstanding

1. with respect to sales functions for the Company, Subsidiary or Affiliate that are regionally based or whose focus is geographically limited, the restriction shall only apply where such work, consulting or other activity on behalf of a Competitor overlaps in whole or in part the same geographic area in which the Grantee worked for Company, Subsidiary or Affiliate in the last 12 months;

2. with respect to corporate staff functions, the restriction shall only apply where Competitor is substantially engaged in the business of health insurance, managed health care, population health management, or related products or services.

b. Notwithstanding, if Grantee's employment is terminated by the Company, Subsidiary or Affiliate other than for cause, the length of the noncompetition covenant in this paragraph shall not exceed the length of the severance and/or salary continuation benefits paid by the Company, Subsidiary or Affiliate to Grantee.

c. Grantee acknowledges and agrees that these restrictions:

i. are necessary to protect the Confidential Information and goodwill of the Company, Subsidiary or Affiliate;

ii. are appropriately tailored and limited in time and geographic scope to do so; and

iii. do not impair or limit the Grantee's ability to earn a living.

(iii) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee of the Company, any Subsidiary or Affiliate to be employed or perform services elsewhere;

(iv) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company, any Subsidiary or Affiliate to cease or curtail providing services to the Company, any Subsidiary or Affiliate; and

(v) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved.

(vi) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, for himself or herself or on behalf of or in cooperation with any other person or entity, consult with or in any manner provide advice to, any individual or entity which is a customer of the Company or any Subsidiary or Affiliate of the Company, provided, however, that this limitation shall apply only to consultation or advice relating to any product or service of the Company, or any Subsidiary or Affiliate, or which is in competition with any product or service of the Company, or any Subsidiary or Affiliate, and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved, or about which Grantee has Confidential Information.

In addition:

(vii) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company, any Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(viii) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company.

(ix) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment and relating in any way to the business or contemplated business, products, activities, research or development of the Company, any Subsidiary or Affiliate, or resulting from any work performed by the Grantee for the Company, any Subsidiary or Affiliate (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). To the extent that the foregoing does not apply, the Grantee hereby irrevocably assigns to the Company, and its successors and assigns, for no additional consideration, the Grantee's entire right, title and interest in and to all such works of authorship. Grantee further acknowledges that while employed by the Company, any Subsidiary or Affiliate, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company, and the Grantee hereby assigns all right, title, and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting there from.

(b) If any provision of Article VI (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the Performance Stock Units is Grantee's covenants set forth in Article VI (a) and that the covenants and obligations of Grantee with respect to nondisclosure, non-solicitation and cooperation relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to vest in the Performance Stock or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VI. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine.

(d) The Restrictive Covenants set forth in this Article VI shall supplement and do not supersede the restrictions agreed to by Grantee in any other agreement or contract.

(e) Employment Dispute Arbitration Program - Mandatory Binding Arbitration of Employment Disputes.

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether the Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VI (e) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VI (e) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VI (e) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VI (a) in accordance with applicable law). However, except as provided in Article VI (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement .

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org . THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a

court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VI (e) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VI (e) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(f) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VI, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

ARTICLE VII

OTHER TERMS

(a) Nothing in this Agreement shall interfere with or limit in any way the right of the Company, any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery hereof nor the granting of the Award shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ or continue the employment of the Grantee for any period.

(b) Until the Performance Stock Units have become vested, Grantee shall not have any rights as a stockholder (including the right to payment of dividends) by virtue of this grant of Performance Stock Units.

(c) During the Vesting Period, the Performance Stock Units shall be nontransferable and non-assignable except by will or the laws of descent and distribution.

(d) The award, when vested, will be settled on a net basis. Prior to issuing any Common Shares, the Company will withhold an amount sufficient to satisfy federal, state, local, social security and Medicare withholding tax requirements relating to award. Any social security calculation or other adjustments discovered after net share payment will be settled in cash, not in Shares of Common Stock. Vesting will result in taxable compensation reportable on the Grantee's W-2 in year of vesting.

(e) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connection with any such restriction.

(f) This Performance Stock Unit is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(g) Anything herein to the contrary notwithstanding, a Grantee whose Performance Stock Units have been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited Performance Stock Units reinstated as follows: (i) if such Grantee is re-employed during the Vesting Period, all forfeited Performance Stock Units shall be reinstated; or (ii) if such Grantee is re-employed after the Vesting Period, a cash payment will be made to the Grantee, minus applicable taxes, for the value of the forfeited Performance Stock Units on the Vest Date pursuant to procedures established by the Company for this purpose.

(h) It is the intention of the Company and Grantee that this Agreement not result in unfavorable tax consequences to Grantee under Section 409A and the Agreement shall be interpreted as to so comply. Notwithstanding anything to the contrary herein, the Company and Grantee agree to the provisions set forth below in order to comply with the requirements of Section 409A.

(i) If Grantee is a "specified employee" (within the meaning of Section 409A) with respect to the Company, any non-qualified deferred compensation otherwise payable to or in respect of Grantee in connection with Grantee's termination of employment shall be delayed until the earliest date upon which such amounts may be paid without being subject to taxation under Section 409A. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

(ii) Unless deferred pursuant to this agreement, all payments shall be paid to Grantee, to the extent earned, in no event later than the last day of the "applicable 2 ½ month period," as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

(iii) The Company and Grantee agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by the Grantee due to any failure to comply with Section 409A.

(i) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(j) At such times and upon such terms and conditions as the Company shall determine, the Company may permit eligible Grantees to elect to defer the distribution of an Award otherwise payable to the Grantee under this Agreement until termination of the Grantee's Employment or such other date Company shall permit.

(k) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

Exhibit 10.47

AETNA INC.
2010 STOCK INCENTIVE PLAN

EXECUTIVE RESTRICTED STOCK UNIT TERMS OF AWARD

Pursuant to its 2010 Stock Incentive Plan (the "Plan"), Aetna Inc. (the "Company") hereby grants Restricted Stock Units on the terms and conditions hereinafter set forth. The number of Restricted Stock Units awarded and vesting information are included in the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of the Restricted Stock Unit Acknowledgement and Acceptance Form, if applicable. All capitalized terms used herein which are not otherwise defined herein shall have the meaning specified in the Plan.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) "Change in Control" means the happening of any of the following:

(i) When any "person" as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and as used in Sections 13(d) and 14(d) thereof, including a "group" as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company's then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “Beneficial Owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means the Company's Common Shares, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date" means the date of grant of this award of Restricted Stock Units.

(h) “Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such date, on the next day on which the Common Stock is traded.

(i) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(j) "Grantee" means the person to whom this award has been granted.

(k) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively, of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(l) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(m) “Net Shares” means the number of shares of Common Stock which will be deposited in a brokerage account in the Grantee’s name at the Company’s designated broker after shares have been withheld to satisfy applicable tax and withholding requirements upon vesting of the Restricted Stock Units.

(n) “Plan” means the Aetna Inc. 2010 Stock Incentive Plan.

(o) “Restricted Period” means the period during which this award of Restricted Stock Units is not vested.

(p) “Restricted Stock Units” means the number of shares of Common Stock represented by the number of units awarded or such other amount as may result by operation of Article III of this Agreement.

(q) "Retirement" means the termination of employment of a Grantee from active service with the Company, any Subsidiary or Affiliate provided the Grantee’s age and completed years of service total 65 or more points at termination of employment.

(r) “Section 409A” means Section 409A of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(s) “Shares of Stock” or “Stock” means the Common Stock.

(t) "Subsidiary" means an entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock of such entity is held by the Company and/or one or more other subsidiaries.

(u) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to the Restricted Stock Units by bequest or inheritance or by reason of the death of the Grantee.

(v) “Vest Date” means the date on which this award of Restricted Stock Units shall vest in accordance with the terms of this Agreement and as set forth on the website of the designated broker and in the Notice of Restricted Stock Unit Grant, if applicable.

ARTICLE II

RESTRICTED PERIOD

Subject to the terms of this Agreement, the Restricted Stock Units will vest in installments on the Vest Date in accordance with the terms of the Plan and this Terms of Award Agreement, or on such date as provided in Article IV or V. On the Vest Date, the Grantee shall vest to one share of Common Stock for each vested Restricted Stock Unit net of applicable taxes and withholding. Such Net Shares will be delivered to the Company’s designated broker, in a brokerage account established in the Grantee’s name.

ARTICLE III

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this Plan, then the Committee shall, in such manner as the Committee may deem equitable, adjust the number and kind of shares subject to the award of Restricted Stock Units. Additionally, the Committee may make provision for cash payment to a Grantee or the Successor of the Grantee to the extent permitted under Section 409A. However, the number of Restricted Stock Units shall always be a whole number.

ARTICLE IV

CHANGE IN CONTROL

Upon the occurrence of (i) a Change in Control, and (ii) within 24 months thereafter the Company terminates Grantee's Employment without cause, all RSUs, whether or not vested, shall become immediately vested and become payable, provided, however, that, as set forth in the Plan, to the extent the RSUs are considered deferred compensation subject to Section 409A, unless the Change in Control also satisfies the definition of "change in control" under Section 409A, payment shall not be so accelerated but shall occur upon the scheduled Vest Date(s) under Article II.

ARTICLE V

TERMINATION OF EMPLOYMENT

(a) Except as provided in (f) below, if the Grantee shall die during the Restricted Period, the unvested Restricted Stock Units shall become immediately vested and Net Shares, if any, will be deposited with the Company's designated broker in a brokerage account established in Grantee's name.

(b) Except as provided in (f) below, if the Grantee shall begin to receive Long Term Disability benefits during the Restricted Period, the unvested Restricted Stock Units shall continue to vest and Net Shares, if any, will be deposited with the Company's designated broker in a brokerage account established in Grantee's name on the scheduled Vest Date(s) under Article II.

(c) Except as provided in (f) below, if, during the restricted period, Grantee shall cease to be employed by the Company, any Subsidiaries or Affiliates during the Restricted Period, for reason of Retirement or involuntary termination of employment by the Company, a portion of the Restricted Stock Units shall vest in accordance with the following formula: (i) the number of completed months employed after the Effective Date divided by the number of full months in the restricted period; multiplied by (ii) number of Restricted Stock Units, minus any vested Restricted Stock Units. For purposes of this calculation, a month is complete on the day in the following month that corresponds to the Effective Date (e.g., February 13 to March 13). Net shares, if any, will be deposited with the Company's designated broker in a brokerage account established in Grantee's name on the next scheduled Vest Date under Article II and, applicable taxes and withholding will be applied based on the Fair Market Value on that date.

(d) Except as provided in (e) and (f) below, if the Grantee shall, for a reason other than death, Long-Term Disability, Retirement or involuntary termination of employment by the Company, cease to be employed by the Company, any Subsidiaries or Affiliates during the Restricted Period, any unvested Restricted Stock Units shall be forfeited at the time of cessation of employment.

(e) Except as provided in (a) or (b) or (c) above, any Restricted Stock Unit not vested as of the date Grantee terminates employment shall be forfeited at the time of cessation of employment; provided, however, that if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the Restricted Stock Unit in accordance with its terms, then upon the forfeiture of the entire Restricted Stock Unit, the Company will pay Grantee an amount equal to the value of a single share of Common Stock, whether or not the forfeited Restricted Stock Unit related to more than a single share of Common Stock, calculated as of the cessation of employment, if requested by Grantee, within 30 days of such cessation of employment.

(f) No Restricted Stock Unit will vest after the Company has terminated the employment of the Grantee for cause, unless the Committee, in its sole discretion, deems a payment to be warranted under the particular circumstances. In addition, the Restricted Stock Units will not vest if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(g) Employment for purposes of determining the vesting rights of the Grantee and the expiration of the grant under this Article V shall mean continuous full-time salaried employment with the Company, any Subsidiary or an Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), or in receipt of salary continuation or severance pay shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc.

ARTICLE VI

EMPLOYEE COVENANTS

(a) As consideration for this grant of Restricted Stock Units, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company, any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement ("Confidential Information"); provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is

employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of twelve (12) months following Grantee's termination of employment, directly or indirectly, (x) engage in the ownership (except less than 1% of the outstanding capital stock of any publicly traded company) of or, (y) become an employee of, or (z) act as a consultant or contractor to, any competitor of the Company ("Competitor") in any market in the United States where Company, Affiliate or Subsidiary does business.

a. For purposes of this paragraph "Competitor" shall mean any entity, organization, person or corporation that is involved in the same business as Company, Subsidiary or Affiliate, but in the case of (y) and (z), only to the extent such work, consulting or other activity on behalf of other entity, organization, person or corporation

i. is materially similar to the duties and/or functions that Grantee performed for the Company, Subsidiary or Affiliate in the last 12 months or involves duties and/or functions for Competitor about which Grantee has Confidential Information in the last 12 months. Notwithstanding

1. with respect to sales functions for the Company, Subsidiary or Affiliate that are regionally based or whose focus is geographically limited, the restriction shall only apply where such work, consulting or other activity on behalf of a Competitor overlaps in whole or in part the same geographic area in which the Grantee worked for Company, Subsidiary or Affiliate in the last 12 months;

2. with respect to corporate staff functions, the restriction shall only apply where Competitor is substantially engaged in the business of health insurance, managed health care, population health management, or related products or services.

b. Notwithstanding, if Grantee's employment is terminated by the Company, Subsidiary or Affiliate other than for cause, the length of the noncompetition covenant in this paragraph shall not exceed the length of the severance and/or salary continuation benefits paid by the Company, Subsidiary or Affiliate to Grantee.

c. Grantee acknowledges and agrees that these restrictions:

i. are necessary to protect the Confidential Information and goodwill of the Company, Subsidiary or Affiliate;

ii. are appropriately tailored and limited in time and geographic scope to do so; and

iii. do not impair or limit the Grantee's ability to earn a living.

(iii) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee of the Company, any Subsidiary or Affiliate to be employed or perform services elsewhere;

(iv) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company, any Subsidiary or Affiliate to cease or curtail providing services to the Company, any Subsidiary or Affiliate; and

(v) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved.

(vi) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, for himself or herself or on behalf of or in cooperation with any other person or entity, consult with or in any manner provide advice to, any individual or entity which is a customer of the Company or any Subsidiary or Affiliate of the Company, provided, however, that this limitation shall apply only to consultation or advice relating to any product or service of the Company, or any Subsidiary or Affiliate, or which is in competition with any product or service of the Company, or any Subsidiary or Affiliate, and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved, or about which Grantee has Confidential Information

In addition:

(vii) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company, any Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(viii) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company .

(ix) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment and relating in any way to the business or contemplated business, products, activities, research or development of the Company, any Subsidiary or Affiliate, or resulting from any work performed by the Grantee for the Company, any Subsidiary or Affiliate (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). To the extent that the foregoing does not apply, the Grantee hereby irrevocably assigns to the Company, and its successors and assigns, for no additional consideration, the Grantee's entire right, title and interest in and to all such works of authorship. Grantee further acknowledges that while employed by the Company, any Subsidiary or Affiliate, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company, and the Grantee hereby assigns all right, title, and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting therefrom.

(b) If any provision of Article VI (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the Restricted Stock Units is Grantee's covenants set forth in Article VI (a) and that the covenants and obligations of Grantee with respect to nondisclosure, non-solicitation and cooperation relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to vest in the Restricted Stock or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VI. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine.

(d) The Restrictive Covenants set forth in this Article VI shall supplement and do not supersede the restrictions agreed to by Grantee in any other agreement or contract.

(e) Employment Dispute Arbitration Program - Mandatory Binding Arbitration of Employment Disputes.

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether the Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VI (e) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VI (e) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VI (e) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VI (a) in accordance with applicable law). However, except as provided in Article VI (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement .

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org. THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VI (e) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VI (e) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(f) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VI, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

ARTICLE VII

OTHER TERMS

(a) Nothing in this Agreement shall interfere with or limit in any way the right of the Company, any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery hereof nor the granting of the Award shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ or continue the employment of the Grantee for any period.

(b) Until the Restricted Stock Units have become vested, Grantee shall not have any rights as a stockholder (including the right to payment of dividends) by virtue of this grant of Restricted Stock Units.

(c) During the Restricted Period, the Restricted Stock Units shall be nontransferable and non-assignable except by will or the laws of descent and distribution.

(d) The award will be settled on a net basis. Prior to issuing any Common Shares, the Company will withhold an amount sufficient to satisfy federal, state, local, social security and Medicare withholding tax requirements relating to award. Any social security calculation or other adjustments discovered after net share payment will be settled in cash, not in Shares of Common Stock. Vesting will result in taxable compensation reportable on the Grantee's W-2 in year of vesting.

(e) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connection with any such restriction.

(f) This Restricted Stock Unit is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(g) Anything herein to the contrary notwithstanding, a Grantee whose Restricted Stock Units have been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited Restricted Stock Units reinstated as follows: (i) if such Grantee is re-employed during the Restricted Period, all forfeited Restricted Stock Units shall be reinstated; or (ii) if such Grantee is re-employed after the Restricted Period, a cash payment will be made to the Grantee, minus applicable taxes, for the value of the forfeited Restricted Stock Units on the Vest Date pursuant to procedures established by the Company for this purpose.

(h) If any provision of this Agreement would cause Grantee to incur any additional tax or interest under Section 409A, the Company may reform such provision (including an amendment retroactive to the Effective Date to the extent permissible) to comply with Section 409A.

(i) If the Company reasonably anticipates that the Company's tax deduction with respect to the payment upon vesting of the Restricted Stock Units would be limited or eliminated by application of Section 162(m) of the Internal Revenue Code, the Company may elect, in accordance with Section 409A, to delay the payment of such Restricted Stock Units to the earliest date in which the Company anticipates that its tax deduction for such payment will not be limited or eliminated.

(j) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(k) Voluntary Deferral. At such times and upon such terms and conditions as the Company shall determine in accordance with the terms of the Plan and Section 409A, the Company may permit eligible Grantees to elect to defer the distribution of an Award otherwise payable to the Grantee under this Agreement until termination of the Grantee's Employment or such other date Company shall permit.

(l) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

I have read the Restricted Stock Unit Agreement. I accept the Restricted Stock Unit award and agree to be bound by all of its terms and conditions, including mandatory binding arbitration of employment related disputes and, if applicable, any other provisions of Article VI.

Exhibit 10.48

AETNA INC.
2010 STOCK INCENTIVE PLAN

STOCK APPRECIATION RIGHT TERMS OF AWARD

Pursuant to its 2010 Stock Incentive Plan, Aetna Inc. has granted a stock appreciation right on shares of Aetna Inc. Common Stock. The number of shares represented by this right, the Grant Price and vesting information are included on the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of Stock Appreciation Right Grant, if applicable. The Stock Appreciation Right is issued on the terms and conditions hereinafter set forth.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) “Change in Control” means the happening of any of the following:

(i) When any “person” as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”) and as used in Sections 13(d) and 14(d) thereof, including a “group” as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the “beneficial owner” (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company’s then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the “Incumbent Directors”) cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “beneficial owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means shares of the Company's Common Stock, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date” means the date of grant of this Stock Appreciation Right, as approved by the Committee.

(h) “Exercise Date” means the date the Grantee has notified the designated broker to exercise all or a portion of the Stock Appreciation Right.

(i) "Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such day, on the next day on which the Common Stock is traded.

(j) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(k) “Grantee” means the person to whom this Stock Appreciation Right has been granted.

(l) “Grant Price” means the dollar amount per share of Common Stock that is the basis for determining the appreciation in value of the Common Stock.

(m) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as

their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(n) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(o) "Plan" means the Aetna Inc. 2010 Stock Incentive Plan.

(p) "Retirement" means the termination of employment of a Grantee from active service with the Company, a Subsidiary or Affiliate provided the Grantee's age and completed years of service total 65 or more points at termination of employment.

(q) "SAR" means Stock Appreciation Right.

(r) "Shares Granted" means the number of shares of Common Stock represented by the Stock Appreciation Right, or such other amount as may result by operation of Article IV of this Agreement.

(s) "Shares of Stock" or "Stock" means the Common Stock.

(t) "Stock Appreciation Right" or "SAR" means the right granted herein to be paid the excess, as of the Exercise Date, of (i) the Fair Market Value of the shares of Common Stock associated with this Stock Appreciation Right (or the portion thereof that is surrendered on exercise) over (ii) the Grant Price of such Stock Appreciation Right.

(u) "Stock Appreciation Rights Vested" means number of Stock Appreciation Rights exercisable on any given date.

(v) "Subsidiary" means any entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock in such entity is held by the Company and/or one or more other subsidiaries.

(w) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to exercise a SAR by bequest or inheritance or by reason of the death of the Grantee.

(x) "Term" means the period during which the SAR granted hereby may be exercised.

(y) "Vest Date" means the date on which a portion of the SAR becomes exercisable pursuant to the Terms of the Award and, as set forth on the website of the designated broker and in the Notice of Stock Appreciation Right Grant, if applicable.

ARTICLE II

TERM OF SAR AND EXERCISE

(a) Subject to the terms of this Agreement, the term of the SAR shall commence on the first Vest Date and shall terminate, unless sooner terminated by the terms of the Plan or this Terms of Award Agreement, at:

(i) The close of the Company's business on the day preceding the tenth anniversary of the Effective Date, if the Company is open for business on such day; or

(ii) The close of the Company's business on the next preceding day that the Company is open for business.

(b) The SAR is exercisable in installments, each installment to become exercisable as of the Vest Date in accordance with the terms of the Plan and this Terms of Award Agreement. Once an installment is vested, it may be exercised in whole or in part only during the Term of the SAR.

ARTICLE III

METHOD OF SAR EXERCISE

In order to exercise this SAR, Grantee must comply with procedures adopted by the Company from time to time. Under current procedures, the Grantee must exercise the SAR through the Company's designated broker.

In addition, if the Grantee has been notified that he or she must consult with a member of the Company's Law and Regulatory Affairs Unit prior to engaging in transactions in Aetna stock, Grantee must consult with Law prior to exercising the SAR.

Upon exercise of the SAR, payment (net of federal, state, local, social security and medicare taxes, if applicable) shall be paid in Common Stock. The resulting shares of Common Stock will be deposited in a brokerage account established in Grantee's name at the designated broker.

ARTICLE IV

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this SAR or the Plan, then the Committee may, in such manner as the Committee may deem equitable, adjust the (i) the number and kind of shares subject to the SAR or (ii) the SAR Grant Price. Additionally, the Committee may make provision for a cash payment to a Grantee or the Successor of the Grantee to the extent permitted under Section 409A. However, the number of Shares of Stock subject to the SAR shall always be a whole number.

ARTICLE V

CHANGE IN CONTROL

Upon the occurrence of (i) a Change in Control, and (ii) within 24 months thereafter, the Company terminates Grantee's Employment without cause, all SARs, whether or not vested, shall become immediately vested and become payable in accordance with the terms of this Agreement.

ARTICLE VI
TERMINATION OF SAR

(a) Except as provided in (d) below, if the Grantee shall die or begin to receive Long Term Disability benefits after the Effective Date, the SAR shall become vested and immediately exercisable and the Grantee or Successor of the Grantee may exercise the SAR until the earlier of:

(i) The expiration of the Term of the SAR; or

(ii) A period not to exceed five years following such death or commencement of Long Term Disability benefits.

(b) Except as provided in (e) below, if Grantee shall, for reason of Retirement, cease to be employed by the Company, its Subsidiaries or Affiliates after the Effective Date, the Grantee will become immediately vested and may immediately exercise any SAR that would have otherwise become vested within one year from the Grantee's termination of employment, and the Grantee or Successor of the Grantee may exercise a vested SAR until the earlier of:

(i) The expiration of the Term of the SAR; or

(ii) A period not to exceed five years following such cessation of employment.

(c) Except as provided in (d) and (e) below, if the Grantee shall, for a reason other than death, Long Term Disability or Retirement, cease to be employed by the Company, its Subsidiaries or Affiliates during the Term of the SAR, the Grantee may exercise a vested SAR until the earlier of:

(i) The expiration of the term of the SAR; or

(ii) A period not to exceed ninety days following such cessation of employment.

(d) Except as provided in (a) or (b) above, any SAR, or portion of a SAR that has not become vested and exercisable at the time of cessation of employment shall terminate immediately upon such cessation of employment and may not be exercised thereafter. Provided, however, if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the SAR in accordance with its terms, then upon the forfeiture of the entire SAR, the Company shall pay Grantee an amount equal to the SAR value on a single share of Common Stock, whether or not the forfeited SAR related to more than a single share of Common Stock, calculated as of the date of termination of employment under the same

method as the Company calculates its SAR expense charge for purposes of its financial statement reporting, if requested by Grantee, within 30 days of such cessation of employment.

(e) No SAR may vest or be exercised after the Company has terminated the employment of the Grantee for cause, except that the Committee may, in its sole discretion, permit the exercise of a vested SAR for a period of up to ninety days in cases where the Committee shall determine such exercise period is warranted under the particular circumstances. In addition, the Company may terminate the SAR if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(f) Employment for purposes of determining the vesting rights of the Grantee and expiration date of the grant under this Article VI shall mean continuous full-time salaried employment with the Company, a Subsidiary or an Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), or in receipt of salary continuation or severance pay shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc.

(g) Except as otherwise herein provided, exercise of the SAR, whether by the Grantee or the Successor of the Grantee, shall be subject to all terms and conditions of this Agreement.

ARTICLE VII
OTHER TERMS

(a) Grantee understands that the Grantee shall not have any rights as stockholder by virtue of the grant of an SAR but only with respect to shares of Common Stock actually issued to the Grantee in accordance with the terms hereof.

(b) Anything herein to the contrary notwithstanding, the Company may postpone the exercise of the SAR or any portion thereof for such time as the Committee in its discretion may deem necessary, in order to permit the Company with reasonable diligence (i) to effect or maintain registration under the Securities Act of 1933, as amended, of the Plan or the shares of Common Stock issuable upon the exercise of the SAR or (ii) to determine that the Plan and such shares are exempt from registration; and the Company shall not be obligated by virtue of this Agreement or any provision of the Plan to recognize the exercise of the SAR or to sell or issue shares of Common Stock in violation of said Act or of the law of any government having jurisdiction thereof. Any such postponement shall not extend the Term of the SAR; and neither the Company nor its Board shall have any obligation or liability to the Grantee, or to the Grantee's Successor, with respect to any shares of Common Stock as to which the SAR shall lapse because of such postponement.

(c) The SAR shall be nontransferable and nonassignable except by will and by the laws of descent and distribution. During the Grantee's lifetime, the SAR may be exercised only by the Grantee.

(d) The SAR is not an incentive stock option as described in the Internal Revenue Code of 1986, as amended, Section 422A (b).

(e) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(f) Anything herein to the contrary notwithstanding, a Grantee whose SAR has been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited SAR reinstated for the original Term pursuant to procedures established by the Company for this purpose.

(g) Nothing in this Agreement shall interfere with a limit in anyway the right of the Company or any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery of this Agreement nor the granting of the SAR shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ Grantee for any period.

(h) This SAR is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(i) The Company shall have the power to withhold, an amount sufficient to satisfy Federal, state and local, social security and medicare withholding tax requirements, if applicable. Any social security calculation or other adjustments discovered after the net share payment will be settled in cash, not in Common Stock.

(j) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connections with any such restriction.

(k) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

ARTICLE VIII

EMPLOYEE COVENANTS

(a) As consideration for the grant of the SAR, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's Employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company, any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement ("Confidential Information"); provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of twelve (12) months following Grantee's termination of employment, directly or indirectly, (x) engage in the ownership (except less than 1% of the outstanding capital stock of any publicly traded company) of or, (y) become an employee of, or (z) act as a consultant or contractor to, any competitor of the Company ("Competitor") in any market in the United States where Company, Affiliate or Subsidiary does business.

a. For purposes of this paragraph "Competitor" shall mean any entity, organization, person or corporation that is involved in the same business as Company, Subsidiary or Affiliate, but in the case of (y) and (z), only to the extent such work, consulting or other activity on behalf of other entity, organization, person or corporation

i. is materially similar to the duties and/or functions that Grantee performed for the Company, Subsidiary or Affiliate in the last 12 months or involves duties and/or functions for Competitor about which Grantee has Confidential Information in the last 12 months. Notwithstanding

1. with respect to sales functions for the Company, Subsidiary or Affiliate that are regionally based or whose focus is geographically limited, the restriction shall only apply where such work, consulting or other activity on behalf of a Competitor overlaps in whole or in part the same geographic area in which the Grantee worked for Company, Subsidiary or Affiliate in the last 12 months;

2. with respect to corporate staff functions, the restriction shall only apply where Competitor is substantially engaged in the business of health insurance, managed health care, population health management, or related products or services.

b. Notwithstanding, if Grantee's employment is terminated by the Company, Subsidiary or Affiliate other than for cause, the length of the noncompetition covenant in this paragraph shall not exceed the length of the severance and/or salary continuation benefits paid by the Company, Subsidiary or Affiliate to Grantee.

c. Grantee acknowledges and agrees that these restrictions:

i. are necessary to protect the Confidential Information and goodwill of the Company, Subsidiary or Affiliate;

ii. are appropriately tailored and limited in time and geographic scope to do so; and

iii. do not impair or limit the Grantee's ability to earn a living.

(iii) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee of the Company, and Subsidiary or Affiliate to be employed or perform services elsewhere;

(iv) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company, any Subsidiary or Affiliate to cease or curtail providing services to the Company, any Subsidiary or Affiliate; and

(v) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved

(vi) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, for himself or herself or on behalf of or in cooperation with any other person or entity, consult with or in any manner provide advice to, any individual or entity which is a customer of the Company or any Subsidiary or Affiliate of the Company, provided, however, that this limitation shall apply only to consultation or advice relating to any product or service of the Company, or any Subsidiary or Affiliate, or which is in competition with any product or service of the Company, or any Subsidiary or Affiliate, and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved, or about which Grantee has Confidential Information.

In addition:

(vii) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company, any Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(viii) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company.

(ix) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment and relating in any way to the business or contemplated business, products, activities, research or development of the Company, any Subsidiary or Affiliate, or resulting from any work performed by the Grantee for the Company, any Subsidiary or Affiliate (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). To the extent that the foregoing does not apply, the Grantee hereby irrevocably assigns to the Company, and its successors and assigns, for no additional consideration, the Grantee's entire right, title and interest in and to all such works of authorship. Grantee further acknowledges that while employed by the Company, any Subsidiary or Affiliate, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company and the Grantee hereby assigns all right, title and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting therefrom.

(b) If any provision of Article VIII (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the SAR is Grantee's covenants set forth in Article VIII(a) and that the covenants and obligations of Grantee with respect to nondisclosure, nonsolicitation, cooperation and intellectual property rights relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to exercise the SAR or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VIII. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine..

(d) The Restrictive Covenants set forth in this Article VIII shall supplement and do not supersede the restrictions agreed to by Grantee in any other agreement or contact.

(e) Employment Dispute Arbitration Program - Mandatory Binding Arbitration of Employment Disputes.

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VIII (e) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VIII (e) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VIII (e) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VIII (a) in accordance with applicable law). However, except as provided in Article VIII (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement.

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org . THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VIII (e) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VIII (e) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(f) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VIII, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

I have read the Stock Appreciation Right Agreement. I accept the Stock Appreciation Right award and agree to be bound by all of its terms and conditions including mandatory binding arbitration of employment related disputes and, if applicable, any other provisions of Article VIII.

Exhibit 13.1

Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and Cautionary Statement Concerning Forward-Looking Statements that are included in this Annual Report.

Overview of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans (see "Liquidity and Capital Resources" later in this document). The consolidated financial statements for the year ended December 31, 2018 reflect Aetna's results subsequent to the Aetna Acquisition Date.

On October 10, 2018, the Company and Aetna entered into a consent decree with the United States Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. for the divestiture of Aetna's standalone Medicare Part D prescription drug plans effective December 31, 2018. On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans. Aetna's standalone Medicare Part D prescription drug plans had an aggregate of approximately 2.3 million members as of December 31, 2018. Aetna will provide administrative services to, and will retain the financial results of, the divested plans through 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care plans, plans offered on public health insurance exchanges and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and

branches for infusion and enteral nutrition services. During the year ended December 31, 2018, the Company's PBM filled or managed approximately 1.9 billion prescriptions on a 30-day equivalent basis.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic ® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, the Retail/LTC segment also provided commercialization services under the name RxCrossroads ® . The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, the Retail/LTC segment operated more than 9,900 retail locations, over 1,100 MinuteClinic ® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2018, the Retail/LTC segment filled approximately 1.3 billion prescriptions on a 30-day equivalent basis. In December 2018, the Company held approximately 26% of the United States retail pharmacy market.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018 . The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates.

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Results of Operations

Summary of Consolidated Financial Results

	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 183,910	$ 180,063	$ 173,377	$ 3,847	2.1 %	$ 6,686	3.9 %
Premiums	8,184	3,558	3,069	4,626	130.0 %	489	15.9 %
Services	1,825	1,144	1,080	681	59.5 %	64	5.9 %
Net investment income	660	21	20	639	3,042.9 %	1	5.0 %
Total revenues	194,579	184,786	177,546	9,793	5.3 %	7,240	4.1 %
Operating Costs:							
Cost of products sold	156,447	153,448	146,533	2,999	2.0 %	6,915	4.7 %
Benefit costs	6,594	2,810	2,179	3,784	134.7 %	631	29.0 %
Goodwill impairments	6,149	181	—	5,968	3,297.2 %	181	— %
Operating expenses	21,368	18,809	18,448	2,559	13.6 %	361	2.0 %
Total operating costs	190,558	175,248	167,160	15,310	8.7 %	8,088	4.8 %
Operating income	4,021	9,538	10,386	(5,517)	(57.8)%	(848)	(8.2)%
Interest expense	2,619	1,062	1,078	1,557	146.6 %	(16)	(1.5)%
Loss on early extinguishment of debt	—	—	643	—	— %	(643)	(100.0)%
Other expense (income)	(4)	208	28	(212)	(101.9)%	180	642.9 %
Income before income tax provision	1,406	8,268	8,637	(6,862)	(83.0)%	(369)	(4.3)%
Income tax provision	2,002	1,637	3,317	365	22.3 %	(1,680)	(50.6)%
Income (loss) from continuing operations	(596)	6,631	5,320	(7,227)	(109.0)%	1,311	24.6 %
Loss from discontinued operations, net of tax	—	(8)	(1)	8	(100.0)%	(7)	700.0 %
Net income (loss)	(596)	6,623	5,319	(7,219)	(109.0)%	1,304	24.5 %
Net (income) loss attributable to noncontrolling interest	2	(1)	(2)	3	(300.0)%	1	(50.0)%
Net income (loss) attributable to CVS Health	$ (594)	$ 6,622	$ 5,317	$ (7,216)	(109.0)%	$ 1,305	24.5 %

Commentary - 2018 compared to 2017

Revenues

- Total revenues increased $9.8 billion or 5.3% in 2018 compared to 2017 . The increase in total revenues was due to a 2.7% increase in Pharmacy Services segment revenue, a 5.8% increase in Retail/LTC segment revenue and the impact of the Aetna Acquisition (primarily reflected in the Health Care Benefits segment) which occurred in November 2018.
- Please see “Segment Analysis” later in this document for additional information about the revenues of the Company’s segments.

Operating expenses (including goodwill impairments)

- Operating expenses increased $8.5 billion or 44.9% in 2018 compared to 2017 . The increase in operating expenses was primarily due to higher operating expenses in the Retail/LTC segment including increased goodwill impairment charges in 2018, the impact of the Aetna Acquisition and an increase in acquisition-related transaction and integration costs. The increase was partially offset by a lack of charges associated with store closures in 2018.
- Operating expenses as a percentage of total revenues was 14.1% in 2018 , an increase of 380 basis points compared to 2017 . The increase in operating expenses as a percentage of total revenues in 2018 was primarily due to the goodwill impairment charges in the Retail/LTC segment in 2018.
- Please see “Segment Analysis” later in this document for additional information about the operating expenses of the Company’s segments.

Operating income

- Operating income decreased $5.5 billion or 57.8% in 2018 compared to 2017 . The decrease was primarily due to the increase in operating expenses described above, continued price compression in the Pharmacy Services segment and reimbursement pressure in the Retail/LTC segment. The decrease was partially offset by increased prescription volume, improved purchasing economics and the addition of Aetna.
- Please see "Segment Analysis" later in this document for additional information about the operating income of the Company's segments.

Interest expense

- Interest expense increased $1.6 billion during 2018 , primarily due to financing activity associated with the Aetna Acquisition. See Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements for additional information.

Other expense (income)

- Other expense decreased $212 million during 2018, primarily due to 2017 reflecting a $187 million loss on settlement of the Company's defined benefit pension plans.

Income tax provision

- The Tax Cuts and Jobs Act (the "TCJA") was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The Company completed its assessment of the TCJA's final impact in December 2018 and recorded an additional tax benefit of approximately $100 million .
- The Company's effective income tax rate was 142.4% in 2018 compared to 19.8% in 2017 . The increase in the effective income tax rate was primarily due to the goodwill impairment charges in the Retail/LTC segment in 2018, the majority of which are not deductible for income tax purposes, and an income tax benefit of $1.5 billion in 2017 which reflected the remeasurement of the Company's net deferred income tax liabilities as a result of the enactment of the TCJA. The increase was partially offset by a lower federal corporate income tax rate in 2018 compared to the prior year as a result of the enactment of the TCJA, which reduced the corporate income tax rate in 2018 to 21% from 35% in 2017.

Loss from discontinued operations

- In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things, which filed for bankruptcy in 2008, and Bob's stores, which filed for bankruptcy in 2016. The Company's loss from discontinued operations includes lease-related costs required to satisfy its Linens 'n Things and Bob's Stores lease guarantees.
- The Company incurred a loss from discontinued operations, net of tax, of $8 million in 2017 . Results from discontinued operations were immaterial in 2018.
- See "Discontinued Operations" in Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information about discontinued operations and Note 16 ''Commitments and Contingencies'' to the consolidated financial statements for additional information about the Company's lease guarantees.

Commentary - 2017 compared to 2016

Revenues

- Total revenues increased $7.2 billion or 4.1% in 2017 compared to 2016 . The increase in total revenues was due to a 8.9% increase in Pharmacy Services segment revenue, partially offset by a 2.1% decrease in Retail/LTC segment revenue.
- The increase in generic dispensing rates in 2017 negatively affected both the Pharmacy Services and Retail/LTC segment revenues in 2017 compared to 2016 .
- Please see "Segment Analysis" later in this document for additional information about the revenues of the Company's segments.

Operating expenses (including goodwill impairments)

- Operating expenses increased $542 million , or 2.9% , in 2017 compared to 2016 . The increase in operating expenses primarily relates to (i) higher operating expenses in the Retail/LTC segment including an increase of $181 million in charges associated with the closure of retail stores in connection with the Company's enterprise streamlining initiative and a $181 million goodwill impairment charge related to the RxCrossroads reporting unit; and (ii) higher operating expenses

in the Pharmacy Services segment due to 2016 reflecting the favorable impact of a reversal of an accrual of $85 million in connection with a legal settlement. The increase was partially offset by lower acquisition-related transaction and integration costs due to the bulk of the integration costs related to the acquisition of Omnicare, Inc. ("Omnicare") being incurred in 2016.

- Operating expenses as a percentage of total revenues was 10.3% in 2017 , a decline of 10 basis points compared to 2016 . The decline in operating expenses as a percentage of total revenues in 2017 was primarily due expense leverage from revenue growth.
- Please see "Segment Analysis" later in this document for additional information about the operating expenses of the Company's segments.

Operating income

- Operating income decreased $848 million or 8.2% in 2017 compared to 2016 . The decrease was primarily driven by the previously announced restricted networks that excluded CVS Pharmacy, continued price compression in the Pharmacy Services segment, reimbursement pressure in the Retail/LTC segment and the increased operating expenses described above.
- Please see "Segment Analysis" later in this document for additional information about the operating income of the Company's segments.

Interest expense

- Interest expense decreased $16 million during 2017 , primarily due to the Company's debt issuance and debt tender offers that occurred in 2016 which resulted in overall more favorable interest rates on the Company's long-term debt. See Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements for additional information.

Other expense (income)

- Other expense increased $180 million during 2017 , primarily due to 2017 reflecting a $187 million loss on settlement of the Company's defined benefit pension plans.

Loss on early extinguishment of debt

- The loss on early extinguishment of debt of $643 million in 2016 relates to the redemption of approximately $4.2 billion aggregate principal amount of certain of the Company's senior notes (see Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements). As a result of the redemption, the Company paid a premium of $583 million in excess of the debt principal, wrote off $54 million of unamortized deferred financing costs and incurred $6 million in fees.

Income tax provision

- The Company's effective income tax rate was 19.8% in 2017 compared to 38.4% in 2016 . The decrease in the effective income tax rate was primarily due to the provisional impact of the TCJA, including the revaluation of net deferred tax liabilities.
- As the result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion in 2017.

Loss from discontinued operations

- Please see the *Commentary - 2018 compared to 2017* section above for additional information about the Company's discontinued operations.
- The Company incurred losses from discontinued operations, net of tax, of $8 million and $1 million in 2017 and 2016 , respectively.

Outlook for 2019

The Company expects 2019 to be a transition year as it integrates the Aetna Acquisition and focuses on key pillars of its growth strategy. The Company believes that it is on track to exceed its 2020 target for synergies from the Aetna Acquisition. The Company also expects that the following challenges may have a disproportionate adverse impact on, and reduce, the operating income of its Pharmacy Services and Retail/LTC segments in 2019 compared to 2018:

- Ongoing pharmacy reimbursement pressure in the Pharmacy Services and Retail/LTC segments and reductions in the traditional offsets to those pressures, including a declining benefit from the introduction of new multi-source generic prescription drugs and lower benefits from generic dispensing rate increases;
- The reimbursement pressure in the Pharmacy Services segment is projected to be exacerbated by the cumulative effect on rebate guarantees of lower brand name drug price inflation and a modest 2019 selling season; and
- The Retail/LTC segment is projected to be impacted by structural and Company specific challenges in the long-term care space as well as the annualization of the Company's 2018 investment of a portion of the savings from the TCJA in wages and benefits.

The Company is taking specific actions designed to address these challenges and position it well in 2020 and beyond. These actions include new product and service initiatives in its Pharmacy Services and Retail/LTC segments, introducing a new PBM client contracting model, accelerating the action plan designed to improve the performance of the LTC business and initiating a new enterprise cost reduction effort. The Company also is continuing to evaluate its assets and the roles they play in enabling the Company's core strategies.

The Company's current expectations described above are forward-looking statements. Please see "Cautionary Statement Concerning Forward-Looking Statements" below for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company evaluates the performance of its operating segments based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The following is a reconciliation of the Company's segments total revenues and operating income (loss) to the consolidated financial statements:

In millions	Pharmacy Services [1][2]	Retail/LTC [2]	Health Care Benefits [2]	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2018						
Total revenues [3]	$ 134,128	$ 83,989	$ 5,549	$ 606	$ (29,693)	$ 194,579
Operating income (loss) [4][5]	4,699	620	276	(805)	(769)	4,021
2017						
Total revenues [7]	130,601	79,398	—	16	(25,229)	184,786
Operating income (loss) [4][5][7]	4,657	6,558	—	(936)	(741)	9,538
2016						
Total revenues [7]	119,965	81,100	—	18	(23,537)	177,546
Operating income (loss) [4][5][6][7]	4,570	7,437	—	(900)	(721)	10,386

(1) Total revenues of the Pharmacy Services segment include approximately $11.4 billion , $10.8 billion and $10.5 billion of Retail Co-Payments for 2018 , 2017 and 2016 , respectively. See Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information about Retail Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment and the Retail/LTC segment for 2018, 2017 and 2016. Effective November 28, 2018, intersegment eliminations also relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment and/or the Retail/LTC segment.

(3) Corporate/Other segment revenues for 2018 include interest income of $536 million related to the proceeds of the $40 billion principal amount of unsecured floating rate notes and unsecured fixed rate senior notes the Company issued on March 9, 2018 (collectively, the "2018 Notes"). This amount is for the period prior to the close of the Aetna Acquisition, which occurred on November 28, 2018.

(4) Retail/LTC segment operating income for 2018 , 2017 and 2016 includes $7 million , $34 million and $281 million , respectively, of acquisition-related integration costs. The integration costs in 2018 and 2017 are related to the acquisition of Omnicare. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target Corporation ("Target"). Retail/LTC segment operating income for 2018 and 2017 also includes goodwill impairment charges of $6.1 billion related to the LTC reporting unit and $181 million related to the RxCrossroads reporting unit, respectively. In addition, Retail/LTC segment operating income for 2017 and 2016 includes $215 million and $34 million , respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company's enterprise streamlining initiative. Retail/LTC segment operating income for 2018 also includes a $43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment and an $86 million loss on the divestiture of the Company's RxCrossroads subsidiary.

(5) Corporate/Other segment operating loss for 2018 , 2017 and 2016 includes $485 million , $40 million and $10 million, respectively, of divestiture and acquisition-related transaction and integration costs included in operating expenses in the consolidated statements of operations. The transaction and integration costs in 2018 are related to the acquisitions of Aetna and Omnicare. The transaction and integration costs in 2017 are related to the acquisitions of Aetna and Omnicare and the divestiture of RxCrossroads. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.

(6) Pharmacy Services segment operating income for 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

(7) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within total revenues to conform with insurance company presentation which increased total revenues and operating income by $21 million and $20 million in 2017 and 2016 , respectively.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 130,264	$ 126,770	$ 116,639	$ 3,494	2.8 %	$ 10,131	8.7%
Premiums	3,361	3,558	3,069	(197)	(5.5)%	489	15.9%
Services	490	268	255	222	82.8 %	13	5.1%
Net investment income [1]	13	5	2	8	160.0 %	3	150.0%
Total revenues	134,128	130,601	119,965	3,527	2.7 %	10,636	8.9%
Cost of products sold	125,107	121,799	111,949	3,308	2.7 %	9,850	8.8%
Benefit costs	2,805	2,810	2,179	(5)	(0.2)%	631	29.0%
Operating expenses [2]	1,517	1,335	1,267	182	13.6 %	68	5.4%
Operating expenses % of revenues	1.1%	1.0%	1.1%				
Operating income [1]	$ 4,699	$ 4,657	$ 4,570	$ 42	0.9 %	$ 87	1.9%
Operating income % of revenues	3.5%	3.6%	3.8%				
Revenues (by distribution channel): [8]							
Pharmacy network [3][4]	$ 83,261	$ 80,891	$ 73,686	$ 2,370	2.9 %	$ 7,205	9.8%
Mail choice [5]	46,934	45,709	42,783	1,225	2.7 %	2,926	6.8%
Other [4]	3,920	3,996	3,494	(76)	(1.9)%	502	14.4%
Pharmacy claims processed: [6][7]							
Total	1,889.8	1,781.9	1,639.2	107.9	6.1 %	142.7	8.7%
Pharmacy network [3]	1,601.4	1,516.7	1,387.7	84.7	5.6 %	129	9.3%
Mail choice [5]	288.4	265.2	251.5	23.2	8.7 %	13.7	5.4%
Generic dispensing rate: [6][7]							
Total	87.3%	87.0%	85.9%				
Pharmacy network [3]	87.9%	87.7%	86.7%				
Mail choice [5]	83.9%	83.1%	81.4%				
Mail choice penetration rate [6][7]	15.3%	14.9%	15.3%				

(1) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within revenues to conform with insurance company presentation which increased both net investment income and operating income by $5 million and $2 million in 2017 and 2016 , respectively.
(2) Pharmacy Services segment operating expenses in 2016 include the reversal of an accrual of $88 million in connection with a legal settlement.
(3) Pharmacy network revenues, pharmacy network claims processed and pharmacy network generic dispensing rate do not include Maintenance Choice ® activity, which is included within the mail choice category. Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice activity.
(4) Amounts revised for 2017 and 2016 to reflect the reclassification of Medicare Part D premium revenues from pharmacy network revenues to other revenues.
(5) Mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect ® claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program, which permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order..
(6) Includes the adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.
(7) The pharmacy claims processed, generic dispensing rate and mail choice penetration rate in 2016 have been revised to convert 90-day prescriptions to the equivalent of three 30-day prescriptions.
(8) Excludes net investment income.

Commentary - 2018 compared to 2017

Revenues

- Total revenues increased $3.5 billion , or 2.7% , to $134.1 billion in 2018 compared to 2017. The increase was primarily due to increased total pharmacy claims volume, partially offset by continued client pricing pressures.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 8.7% to 288.4 million claims in 2018 compared to 265.2 million claims in 2017 . The increase in mail choice claims was primarily driven by the continued adoption of Maintenance Choice offerings and an increase in specialty pharmacy claims.
  - During 2018 , the average revenue per mail choice claim, on a 30-day equivalent basis, decreased by 5.6% compared to 2017 as a result of price compression.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 5.6% to approximately 1.6 billion claims in 2018 compared to approximately 1.5 billion claims in 2017 . The increase in the pharmacy network claim volume was primarily due to net new business.
  - During 2018 , the average revenue per pharmacy network claim processed, on a 30-day equivalent basis, decreased 2.7% compared to 2017 as a result of continued price compression.
  - The Company's total generic dispensing rate increased to 87.3% in 2018 compared to 87.0% in 2017 . The continued increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate. The Company believes its generic dispensing rate will continue to increase in future periods, albeit at a slower pace. This increase will be affected by, among other things, the number of new brand and generic drug introductions and the Company's success at encouraging plan members to utilize generic drugs when they are available and clinically appropriate.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses, depreciation and amortization related to selling, general and administrative activities and administrative payroll, employee benefits and occupancy costs.
- Operating expenses increased $182 million , or 13.6% , in 2018 compared to 2017 . The year over year increase in operating expenses was primarily due to:
  - Growth in the business, including acquisitions; and
  - The reinstatement of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010' s (as amended, collectively, the "ACA's") health insurer fee ("HIF") in 2018;
  - Partially offset by the realization of partially reserved receivables in 2017 which reduced operating expenses.
- Operating expenses as a percentage of total revenues remained relatively consistent at 1.1% and 1.0% in 2018 and 2017 , respectively.

Operating income

- Operating income increased $42 million , or 0.9% , to $4.7 billion in 2018 compared to 2017 . The increase in operating income was primarily due to increased claims volume and improved purchasing economics, partially offset by continued price compression and the increased operating expenses described above.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Commentary - 2017 compared to 2016

Revenues

- Total revenues increased $10.6 billion , or 8.9% , to $130.6 billion in 2017 compared to 2016 . The increase was primarily due to growth in pharmacy network and specialty pharmacy volume as well as brand name drug price inflation, partially offset by continued price compression and increased generic dispensing.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 5.4% to 265.2 million claims in 2017 compared to 251.5 million claims in 2016 .
  - During 2017 , the Company's average revenue per mail choice claim, on a 30-day equivalent basis, increased by 1.7% compared to 2016 . The increase was primarily due to growth in specialty pharmacy and brand name drug price inflation.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 9.3% to approximately 1.5 billion claims in 2017 compared to approximately 1.4 billion claims in 2016 . The increase was primarily due to increased volume from net new business.
  - During 2017 , the average revenue per pharmacy network claim processed remained flat on a 30-day equivalent basis.
  - The Company's total generic dispensing rate increased to 87.0% in 2017 compared to 85.9% in 2016 . The increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions, and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate.

Operating expenses

- Operating expenses increased $68 million , or 5.4% , in 2017 compared to 2016 . The year over year increase in operating expenses was primarily due to an $88 million reversal of an accrual in connection with a legal settlement in 2016 and an increase in costs associated with the growth of the business. The increase was partially offset by the realization of partially reserved receivables in 2017 which reduced operating expenses.
- Operating expenses as a percentage of revenues remained relatively consistent at 1.0% and 1.1% of revenues in 2017 and 2016 , respectively.

Operating income

- Operating income increased $87 million , or 1.9% , to $4.7 billion in 2017 compared to 2016 . The increase in operating income was primarily due to growth in specialty pharmacy, higher generic dispensing and favorable purchasing economics, partially offset by price compression and the increased operating expenses described above.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Revenues							
Products	$ 83,175	$ 78,522	$ 80,275	$ 4,653	5.9 %	$ (1,753)	(2.2)%
Services	814	876	825	(62)	(7.1)%	51	6.2 %
Total revenues	83,989	79,398	81,100	4,591	5.8 %	(1,702)	(2.1)%
Cost of products sold [(1)]	59,906	56,066	57,339	3,840	6.8 %	(1,273)	(2.2)%
Operating expenses [(2)(3)(4)(5)(6)]	23,463	16,774	16,324	6,689	39.9 %	450	2.8 %
Operating expenses % of revenues	27.9%	21.1 %	20.1 %				
Operating income [(1)(2)(3)(4)(5)(6)]	$ 620	$ 6,558	$ 7,437	$ (5,938)	(90.5)%	$ (879)	(11.8)%
Operating income % of revenues	0.7%	8.3 %	9.2 %				
Revenues (by major goods/service line):							
Pharmacy	$ 64,179	$ 59,528	$ 60,838	$ 4,651	7.8 %	$ (1,310)	(2.2)%
Front Store	19,055	18,769	19,123	286	1.5 %	(354)	(1.9)%
Other	755	1,101	1,139	(346)	(31.4)%	(38)	(3.3)%
Prescriptions filled [(7)]	1,339.1	1,230.5	1,223.5	108.6	8.8 %	7.0	0.6 %
Revenue increase (decrease):							
Total	5.8%	(2.1)%	12.6 %				
Pharmacy	7.8%	(2.2)%	15.9 %				
Front Store	1.5%	(1.9)%	0.3 %				
Total prescription volume [(7)]	8.8%	0.6 %	18.6 %				
Same store sales increase (decrease): [(8)]							
Total	6.0%	(2.6)%	1.9 %				
Pharmacy	7.9%	(2.6)%	3.2 %				
Front Store	0.5%	(2.6)%	(1.5)%				
Prescription volume [(7)]	9.1%	0.4 %	3.6 %				
Generic dispensing rate	87.5%	87.3 %	85.7 %				

(1) Cost of products sold and operating income for 2017 include $2 million of acquisition-related integration costs related to the acquisition of Omnicare.
(2) Operating expenses and operating income in 2018, 2017 and 2016 include $7 million , $32 million and $235 million , respectively, of acquisition-related integration costs. In 2018 and 2017 , the integration costs related to the acquisition of Omnicare. In 2016 , the integration costs related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.
(3) Operating expenses and operating income for 2018 and 2017 include goodwill impairment charges of $6.1 billion related to the LTC reporting unit and $181 million related to the RxCrossroads reporting unit, respectively.
(4) Operating expenses and operating income for 2017 and 2016 include $215 million and $34 million , respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company's enterprise streamlining initiative.
(5) Operating expenses and operating income for 2018 include a $43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment.
(6) Operating expenses and operating income for 2018 include an $86 million loss on the divestiture of the Company's RxCrossroads subsidiary.
(7) Includes the adjustment to convert 90-day, non-specialty prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.
(8) Same store sales and prescription volume exclude revenues from MinuteClinic, and revenue and prescriptions from stores in Brazil, LTC operations and commercialization services.

Commentary - 2018 compared to 2017

Revenues

- Total revenues increased approximately $4.6 billion , or 5.8% , to $84.0 billion in 2018 compared to 2017 . The increase was primarily driven by increased prescription volume and brand name drug price inflation, partially offset by continued reimbursement pressure and the impact of recent generic introductions.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - Front store same store sales increased 0.5% in 2018 compared to 2017 . Front store sales in 2018 continued to benefit from increases in health product sales.
    - Pharmacy same store sales increased 7.9% in 2018 compared to 2017 . The increase was driven by the 9.1% increase in pharmacy same store prescription volumes on a 30-day equivalent basis due to (i) continued adoption of patient care programs, (ii) collaborations with PBMs, and (iii) the Company's preferred status in a number of Medicare Part D networks during 2018. The increase was also due to the impact of year over year brand name drug price inflation that occurred primarily in the first three months of 2018.
    - Pharmacy revenue continues to be adversely affected by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 87.5% in 2018 compared to 87.3% in 2017 . In addition, pharmacy revenue growth has also been negatively affected by continued reimbursement pressure.
    - 2017 revenues include approximately $0.4 billion related to the Company's RxCrossroads subsidiary which was sold on January 2, 2018.
    - Pharmacy revenue growth has been adversely affected by industry challenges in the LTC business, such as continuing lower occupancy rates at skilled nursing facilities, as well as the deteriorating financial health of many skilled nursing facilities which resulted in a number of customer bankruptcies in 2018.
    - Pharmacy revenue in 2018 continued to benefit from the Company's ability to attract and retain managed care customers and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

Operating expenses (including goodwill impairments)

- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $6.7 billion , or 39.9% , in 2018 compared to 2017 . The increase in operating expenses in 2018 was primarily due to:
    - A goodwill impairment charge of $6.1 billion in 2018 in the LTC reporting unit (see Note 5 ''Goodwill and Other Intangibles'' to the consolidated financial statements), as compared to a $181 million goodwill impairment charge in the RxCrossroads reporting unit recorded in 2017 in connection with the upcoming sale of RxCrossroads. See the discussion of goodwill under "Critical Accounting Policies" later in this document;
    - An $86 million pre-tax loss on the sale of the RxCrossroads subsidiary in 2018;
    - A $43 million impairment of long-lived assets in 2018; and
    - An increase in operating expenses due to (i) the investment of a portion of the savings from the TCJA in wages and benefits, (ii) increased prescription volume described previously, (iii) incremental costs associated with operating more stores and (iv) other investments in the business to drive revenue growth;
    - Partially offset by lower operating expenses as a result of a lack of charges associated with store closures in 2018, for which the Company incurred $215 million in connection with its enterprise streamlining initiative in 2017; and
    - A decrease in hurricane-related expenses of $25 million in 2018 compared to 2017 .
- Operating expenses as a percentage of total revenues were 27.9% in 2018 compared to 21.1% in 2017 . The increase in operating expenses as a percentage of total revenues was driven by the increased goodwill impairment charges in 2018.

Operating income

- Operating income decreased $5.9 billion , or 90.5% , to approximately $620 million in 2018 compared to 2017 . The decrease in operating income was driven primarily by the increased operating expenses described above.

- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - The Company's pharmacy operating income has been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC Segment. If the reimbursement pressure accelerates, the Company may not be able grow revenues, and its operating income could be adversely affected.
    - The increased use of generic drugs has positively impacted the Company's operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the Company realizes from brand to generic product conversions.

Commentary - 2017 compared to 2016

Revenues

- Total revenues decreased approximately $1.7 billion , or 2.1% , to $79.4 billion in 2017 compared to 2016 . The decrease was primarily due to a decline in same store sales as a result of the previously-announced marketplace changes that restrict CVS Pharmacy from participating in certain networks.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - Front store same store sales declined 2.6% in 2017 compared to 2016 and were negatively impacted approximately 30 basis points due to the absence of leap day in 2017 . The decrease was primarily driven by softer customer traffic and efforts to rationalize promotional strategies, partially offset by an increase in basket size.
    - Pharmacy same store sales declined 2.6% in 2017 compared to 2016 . Pharmacy same store sales were negatively impacted by approximately 390 basis points due to recent generic introductions. Same store prescription volumes increased 0.4% , despite the approximately 420 basis point negative impact from previously-discussed marketplace changes that restrict CVS Pharmacy from participating in certain networks.
    - Pharmacy revenue continues to be negatively impacted by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 87.3% in 2017 compared to 85.7% in 2016 . In addition, pharmacy revenue growth has also been negatively affected by the mix of drugs sold, continued reimbursement pressure and the lack of significant new brand name drug introductions.
    - Pharmacy revenue in 2017 continued to benefit from the Company's ability to attract and retain managed care customers, and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

Operating expenses (including goodwill impairment)

- Operating expenses increased $450 million , or 2.8% in 2017 . The increase in operating expenses in 2017 was due primarily to:
    - An increase of $181 million in charges associated with the closure of retail stores in connection with the Company's enterprise streamlining initiative;
    - A goodwill impairment charge of $181 million related to the RxCrossroads reporting unit, which was subsequently sold on January 2, 2018;
    - Hurricane related costs of $55 million; and
    - Costs associated with new store openings
- Operating expenses as a percentage of total revenues were 21.1% in 2017 compared to 20.1% in 2016 . The increase in 2017 was primarily due to a decline in expense leverage with the loss of business from the previously discussed marketplace changes that restrict CVS Pharmacy from participating in certain networks.

Operating income

- Operating income decreased $879 million , or 11.8% , to approximately $6.6 billion in 2017 compared to 2016 . The decrease in operating income was driven primarily by the increased operating expenses described above and reimbursement pressure.

Health Care Benefits Segment

On November 28, 2018, the Company completed the Aetna Acquisition. The Health Care Benefits segment is the equivalent of the former Aetna Health Care segment.

The following table summarizes the Health Care Benefits segment's performance for the period from November 28, 2018 to December 31, 2018:

In millions	
Revenues:	
Products	$ 164
Premiums	4,819
Services	521
Net investment income	45
Total revenues	5,549
Cost of products sold	147
Benefit costs	3,873
Operating expenses	1,253
Operating income	$ 276

Revenues and operating income for the Health Care Benefits segment include results for the period from November 28, 2018 to December 31, 2018 and therefore are not directly comparable to the former Aetna Health Care segment results for the fourth quarter of 2017.

Health Care Benefits segment medical membership as of December 31, 2018 was as follows:

In thousands	**Insured**	**ASC** [1]	**Total**
Medical membership:			
Commercial	3,871	13,888	17,759
Medicare Advantage	1,758	—	1,758
Medicare Supplement	793	—	793
Medicaid	1,128	663	1,791
Total medical membership	7,550	14,551	22,101

(1) Represents self-insured membership under Administrative Services Contracts.

Medical Membership
Medical membership as of December 31, 2018 remained relatively consistent compared with December 31, 2017, reflecting decreases in Commercial insured and Medicaid products, largely offset by increases in Commercial ASC and Medicare products.

Corporate/Other Segment

Commentary - 2018 compared to 2017

Revenues
- Revenues in 2018 reflect (i) revenues associated with products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, that were acquired in the Aetna Acquisition and (ii) interest income related to the $40 billion of senior notes issued on March 9, 2018 to partially fund the Aetna Acquisition.

Operating expenses

- Operating expenses within the Corporate/Other segment include executive management, corporate relations, legal, compliance, human resources, information technology, finance related costs and acquisition-related transaction and integration costs. After the Aetna Acquisition Date, such operating expenses also include operating costs to support the large case pensions and long-term care insurance products acquired in the Aetna Acquisition.
- Operating expenses increased $437 million , or 45.9% , in 2018 compared to 2017 . The increase was primarily driven by an increase in acquisition-related transaction and integration costs of $454 million in 2018.

Commentary - 2017 compared to 2016

Operating expenses

- Operating expenses within the Corporate/Other segment include executive management, corporate relations, legal, compliance, human resources, information technology, finance related costs and acquisition-related transaction and integration costs.
- Operating expenses increased $34 million , or 3.7% , in 2017 compared to 2016 . The increase was due to (i) ongoing investments in strategic initiatives, (ii) increased employee benefit costs and (iii) increased divestiture and acquisition-related costs, primarily related to $34 million of transaction costs in 2017 associated with the Aetna Acquisition.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2018 , 2017 and 2016 is as follows:

				Change			
	Year Ended December 31,			2018 vs. 2017		2017 vs. 2016	
In millions	2018	2017	2016	$	%	$	%
Net cash provided by operating activities	$ 8,865	$ 8,007	$ 10,141	$ 858	11 %	$ (2,134)	(21)%
Net cash used in investing activities	(43,285)	(2,877)	(2,470)	(40,408)	1,405 %	(407)	16 %
Net cash provided by (used in) financing activities	36,819	(6,751)	(6,761)	43,570	(645)%	10	— %
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(4)	1	2	(5)	(500)%	(1)	(50)%
Net increase (decrease) in cash, cash equivalents and restricted cash	$ 2,395	$ (1,620)	$ 912	$ 4,015	(248)%	$ (2,532)	(278)%

Commentary - 2018 compared to 2017

- *Net cash provided by operating activities* increased by $858 million in 2018 due primarily to the timing of client payments and the timing of payments for the Company's Medicare Part D operations.
- *Net cash used in investing activities* increased by $40.4 billion in 2018 largely driven by the Aetna Acquisition in November 2018. In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures remained relatively consistent at approximately $2.0 billion and $1.9 billion in 2018 and 2017 , respectively. During 2018 , approximately 21% of the Company's total capital expenditures were for new store construction, 32% were for store, fulfillment and support facilities expansion and improvements and 47% were for technology and other corporate initiatives.
    - The Company did not complete any sale-leaseback transactions in 2018 compared to $265 million in 2017 . Under the sale-leaseback transactions, the properties generally are sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The specific timing and amount of future sale-leaseback transactions will vary depending on future market conditions and other factors.
- *Net cash provided by financing activities* was $36.8 billion in 2018 compared to net cash used in financing activities of $6.8 billion in 2017 . The cash provided by financing activities in 2018 primarily related to long-term borrowings to partially fund the Aetna Acquisition.

Commentary - 2017 compared to 2016

- *Net cash provided by operating activities* decreased by $2.1 billion , in 2017 due primarily to the timing of payments for the Company's Medicare Part D operations.
- *Net cash used in investing activities* increased by $407 million in 2017 largely driven by an increase in acquisition activity as compared to 2016 . In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures in 2017 totaled approximately $1.9 billion , a decrease of $306 million compared to prior year. The decrease in 2017 capital expenditures is due to the Target integration being completed in 2016. During 2017 , approximately 25% of the Company's total capital expenditures were for new store construction, 30% were for store, fulfillment and support facilities expansion and improvements and 45% were for technology and other corporate initiatives.
    - Proceeds from sale-leaseback transactions totaled $265 million in 2017 compared to $230 million in 2016 .
- *Net cash used in financing activities* was $6.8 billion in both 2017 and 2016 as net borrowings and net payments to shareholders were relatively flat in both years.

Included in net cash used in investing activities for the years ended December 31, 2018 , 2017 and 2016 was the following store development activity [(1)] :

	2018	2017	2016
Total stores (beginning of year)	9,846	9,750	9,665
New and acquired stores [(2)]	148	179	132
Closed stores [(2)]	(27)	(83)	(47)
Total stores (end of year)	9,967	9,846	9,750
Relocated stores [(2)]	34	30	50

(1) Includes retail drugstores, certain onsite pharmacy stores, retail specialty pharmacy stores and pharmacies within Target stores.
(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company had approximately $720 million and $1.3 billion of commercial paper outstanding at weighted average interest rates of 2.8% and 2.0% as of December 31, 2018 and 2017 , respectively. In connection with its commercial paper program, the Company maintains a $1.75 billion 364-day unsecured back-up revolving credit facility, which expires on May 16, 2019, a $1.25 billion , five-year unsecured back-up revolving credit facility, which expires on July 1, 2020, a $1.0 billion , five-year

unsecured back-up revolving credit facility, which expires on May 18, 2022, and a $2.0 billion , five-year unsecured back-up revolving credit facility, which expires on May 17, 2023. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03% , regardless of usage. As of December 31, 2018 and 2017 , there were no borrowings outstanding under any of the back-up credit facilities.

Bridge Loan Facility
On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a $49.0 billion unsecured bridge loan facility commitment. The Company paid $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statements of operations.

On March 9, 2018, the Company issued unsecured senior notes with an aggregate principal amount of $40.0 billion (see "Long-term Borrowings - 2018 Notes" below). At this time, the bridge loan facility commitment was reduced to $4.0 billion , and the Company paid $8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded $173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018 , which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a $4.0 billion unsecured 364-day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the $4.0 billion unsecured 364-day bridge term loan agreement terminated.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the Federal Home Loan Bank of Boston (the "FHLBB"). As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2018 was approximately $790 million . As of December 31, 2018 , there were no outstanding advances from the FHLBB.

Long-term Borrowings

2018 Notes
On March 9, 2018, the Company issued an aggregate of $40.0 billion in principal amount of the 2018 Notes for total proceeds of approximately $39.4 billion, net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes are comprised of the following:

In millions		
3.125% senior notes due March 2020	$	2,000
Floating rate notes due March 2020		1,000
3.35% senior notes due March 2021		3,000
Floating rate notes due March 2021		1,000
3.7% senior notes due March 2023		6,000
4.1% senior notes due March 2025		5,000
4.3% senior notes due March 2028		9,000
4.78% senior notes due March 2038		5,000
5.05% senior notes due March 2048		8,000
Total debt principal	$	40,000

Term Loan Agreement
On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a $5.0 billion term loan agreement. The term loan facility under the term loan agreement consists of a $3.0 billion three-year tranche and a $2.0 billion five-year tranche. The term loan agreement allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings. In connection with the Aetna Acquisition, the Company borrowed $5.0 billion (a $3.0 billion three-year tranche

and a $2.0 billion five-year tranche) under the term loan agreement in November 2018. The Company terminated the $2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. As of December 31, 2018, the Company had $3.0 billion outstanding under the three-year tranche of the term loan agreement.

Aetna Related Debt
Upon the closing of the Aetna Acquisition, the Company assumed long-term debt with a fair value of $8.1 billion with stated interest rates ranging from 2.2% to 6.75%.

2016 Notes
On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the " 2016 Notes ") for total proceeds of approximately $3.5 billion , net of discounts and underwriting fees. The 2016 Notes may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

Early Extinguishment of Long-Term Debt
On May 16, 2016, the Company announced tender offers for (i) any and all of its 5.75% senior notes due 2017, its 6.60% senior notes due 2019 and its 4.75% senior notes due 2020 (collectively, the "Any and All Notes") and (ii) up to $1.5 billion aggregate principal amount of the 4.75% Senior Notes due 2022 issued by its wholly-owned subsidiary Omnicare, the 5.00% Senior Notes due 2024 issued by Omnicare, its 3.875% Senior Notes due 2025, its 6.25% Senior Notes due 2027, its 4.875% Senior Notes due 2035, its 6.125% Senior Notes due 2039 and its 5.75% Senior Notes due 2041 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion. The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. In connection with the purchase of the Notes, the Company paid a premium of $486 million in excess of the debt principal, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on early extinguishment of long-term debt of $542 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. In connection with that redemption, the Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of long-term debt of $101 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

See Note 8 ''Borrowings and Credit Agreements'' and Note 12 ''Shareholders' Equity'' to the consolidated financial statements for additional information about debt issuances, debt repayments, share repurchases and dividend payments.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. As of December 31, 2018 and 2017, the Company had outstanding derivative financial instruments (see Note 1 ''Significant Accounting Policies'' to the consolidated financial statements).

Debt Covenants

The Company's back-up revolving credit facilities, unsecured senior notes, unsecured floating rate notes and term loan agreement (see Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit ratings. The covenants do not materially affect the Company's financial or operating flexibility. As of December 31, 2018 , the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2018 , the Company's long-term debt was rated " Baa2 " by Moody's and " BBB " by Standard & Poor's ("S&P"), and its commercial paper program was rated " P-2 " by Moody's and " A-2 " by S&P. In December 2017, subsequent to the announcement of the proposed acquisition of Aetna, Moody's changed the outlook on the Company's long-term debt to "Under Review" from "Stable." Similarly, S&P placed the Company's long-term debt outlook on "Watch Negative" from "Stable." Upon the issuance of the 2018 Notes on March 9, 2018, S&P lowered its corporate credit rating on the Company's long-term debt to "BBB" from "BBB+" and changed the outlook from "Watch Negative" to "Stable." On November 27, 2018, S&P lowered its rating on the long-term debt of Aetna to "BBB" from "A." On November 28, 2018, upon the completion of the Aetna Acquisition, Moody's lowered its rating on CVS Health Corporation's long-term debt to " Baa2 " from "Baa1." Additionally, Moody's changed the outlook on CVS Health Corporation's long-term debt to "Negative" from "Under Review" and changed the outlook on the long-term debt of Aetna to "Negative" from "Stable." In assessing the Company's credit strength, the Company believes that both Moody's and S&P considered, among other things, the Company's capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody's and/or S&P. The Company's debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Programs

During the year ended December 31, 2018 , the Company did not repurchase any shares of common stock. See Note 12 ''Shareholders' Equity'' to the consolidated financial statements for additional information about share repurchases for the years ended December 31, 2017 and 2016.

Quarterly Cash Dividend

In December 2015, the Company's Board of Directors (the "Board") authorized a 21% increase in our quarterly common stock cash dividend to $0.425 per share effective in 2016. This increase equated to an annual dividend rate of $1.70 per share. In December 2016, the Board authorized an 18% increase in our quarterly common stock cash dividend to $0.50 per share effective in 2017. This increase equated to an annual dividend rate of $2.00 per share. During 2018, the Company maintained its quarterly dividend of $0.50 per share and expects to maintain its quarterly dividend of $0.50 per share throughout 2019.

Off-Balance Sheet Arrangements

In connection with executing operating leases, the Company provides a guarantee of the lease payments. The Company also finances a portion of its new store development through sale-leaseback transactions, which involve selling stores to unrelated parties and then leasing the stores back under leases that generally qualify and are accounted for as operating leases. The Company does not have any retained or contingent interests in the sold stores, and does not provide any guarantees, other than a guarantee of the lease payments, in connection with the transactions. In accordance with generally accepted accounting principles, the Company's operating leases are not reflected on the consolidated balance sheets.

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things (each of which subsequently filed for bankruptcy), and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy these obligations.

As of December 31, 2018 , the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things), with the maximum remaining lease term extending through 2029. Management believes the ultimate disposition of any of the remaining lease guarantees will not have a material adverse effect on the Company's consolidated financial condition or future cash flows. Please see "Results of Operations - Summary of Consolidated Financial Results - Commentary - 2018 compared to 2017 - Loss from discontinued operations" previously in this document for further information regarding the Company's guarantee of certain Linens 'n Things' store lease obligations.

Contractual Obligations

The following table summarizes certain estimated future obligations by period under the Company's various contractual obligations at December 31, 2018 . The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2018 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

	Payments Due by Period				
In millions	**Total**	**2019**	**2020 to 2021**	**2022 to 2023**	**Thereafter**
Operating leases	$ 27,980	$ 2,690	$ 4,943	$ 4,343	$ 16,004
Capital lease obligations	1,241	74	146	146	875
Contractual lease obligations with Target [(1)]	2,074	—	—	—	2,074
Lease obligations for discontinued operations	12	4	8	—	—
Long-term debt	72,903	1,242	16,150	12,699	42,812
Interest payments on long-term debt [(2)]	37,949	3,061	5,595	4,594	24,699
Other long-term liabilities on the consolidated balance sheet [(3)]					
Future policy benefits [(4)]	6,728	575	1,200	952	4,001
Unpaid claims [(4)]	2,742	816	644	413	869
Policyholders' funds [(4)(5)]	1,266	632	127	86	421
Other liabilities	1,705	455	911	100	239
Total	$ 154,600	$ 9,549	$ 29,724	$ 23,333	$ 91,994

(1) The Company leases pharmacy and clinic space from Target. See Note 6 ''Leases'' to the consolidated financial statements for additional information regarding the lease arrangements with Target. Amounts related to the operating and capital leases with Target are reflected within the operating leases and capital lease obligations above. Amounts due after the remaining estimated economic lives of the buildings are reflected herein assuming equivalent stores continue to operate through the term of the arrangements.

(2) Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2018 .

(3) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $3.9 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of the Company's business.

(4) Total payments of future policy benefits, unpaid claims and policyholders' funds include $1.2 billion , $2.7 billion and $339 million , respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.

(5) Customer funds associated with group life and health contracts of approximately $2.3 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt and equity securities supporting experience-rated products of $10 million , before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health as a holding company, since CVS Health is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2018 , the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was approximately $584 million in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and shareholder dividends. In addition, at the Company's discretion, it uses these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes considered advisable.

As of December 31, 2018 , the Company held investments of $531 million that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of the Company's business. See Note 3 ''Investments'' to the consolidated financial statements for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Solvency Regulation

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2018 , the RBC Ratio of each of the Company's primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2018 , at that date, each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Quantitative and Qualitative Disclosures About Market Risk

On November 28, 2018 the Company completed the Aetna Acquisition. As of December 31, 2018 , the Company's earnings and financial condition were exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk and commodity risk. As of December 31, 2017, the Company had outstanding interest rate derivative instruments related to its long-term debt and believed that its exposure to interest rate risk (inherent in the Company's debt securities portfolio) was not material. We refer you to Note 1 ''Significant Accounting Policies'' to the consolidated financial statements.

Evaluation of Interest Rate and Credit Quality Risk

The Company manages interest rate risk by seeking to maintain a tight match between the durations of assets and liabilities when appropriate. The Company manages credit quality risk by seeking to maintain high average credit quality ratings and diversified sector exposure within its debt securities portfolio. In connection with its investment and risk management objectives, the Company also uses derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject the Company to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, the Company expects these instruments to reduce overall risk.

Investments

The Company's investment portfolio supported the following products at December 31, 2018 :

In millions		
Experience-rated products	$	1,063
Remaining products		17,191
Total investments	$	18,254

Investment risks associated with experience-rated products generally do not impact results of operations. The risks associated with investments supporting experience-rated pension and annuity products in the large case pensions business in the Company's Corporate/Other segment are assumed by the contract holders and not by the Company (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals.

The debt securities in the Company's investment portfolio had an average credit quality rating of A at December 31, 2018 , with approximately $3.9 billion rated AAA at December 31, 2018 . The debt securities that were rated below investment grade (that

is, having a credit quality rating below BBB-/Baa3) were $1.1 billion at December 31, 2018 (of which 6% at December 31, 2018 , supported experience-rated products).

At December 31, 2018 , the Company held $373 million of municipal debt securities that were guaranteed by third parties, representing 2% of total investments at December 31, 2018 . These securities had an average credit quality rating of AA- at December 31, 2018 with the guarantee. These securities had an average credit quality rating of A- at December 31, 2018 without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At December 31, 2018 , approximately 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with accounting principles generally accepted in the United States of America). See Note 4 ''Fair Value'' to the consolidated financial statements, which is incorporated by reference herein, for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 3 ''Investments'' to the consolidated financial statements, which is incorporated by reference herein.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in net income, and the amount of the non-credit related component is included in other comprehensive income/loss, unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. Accounting for other-than-temporary impairment ("OTTI") of debt securities is considered a critical accounting estimate. The information under the heading "Critical Accounting Policies - Other-Than-Temporary Impairment of Debt Securities" contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Annual Report is incorporated by reference herein.

Evaluation of Market Valuation Risks

The Company regularly evaluates its risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. The Company also regularly evaluates the appropriateness of investments relative to management-approved investment guidelines (and operates within those guidelines) and the business objectives of its portfolios.

On a quarterly basis, the Company reviews the impact of hypothetical net losses in its investment portfolio on the Company's consolidated near-term financial condition, results of operations and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario and is approximately equal to the historical annual volatility of interest rate movements for intermediate-term available-for-sale debt securities) and an immediate decrease of 15% in prices for domestic equity securities.

Assuming an immediate 100 basis point increase in interest rates and immediate decrease of 15% in the prices for domestic equity securities, the theoretical decline in the fair values of market sensitive instruments at December 31, 2018 is as follows:

- The fair value of long-term debt would decline by $3.9 billion ($4.9 billion pretax). Changes in the fair value of long-term debt do not impact financial condition or results of operations.
- The theoretical reduction in the fair value of investment securities partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of $364 million ($461 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these securities as available for sale. The Company does not record liabilities at fair value.

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, results of operations or cash flows as of December 31, 2018 .

Evaluation of Foreign Currency and Commodity Risk

As of each of December 31, 2018 and 2017 , the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk and commodity price risk is not material.

Evaluation of Operational Risks

The Company also faces certain operational risks, including risks related to information security, including cybersecurity. The Company and its vendors have experienced a variety of cyber attacks, and the Company and its vendors expect to continue to experience cyber attacks going forward. Among other things, the Company has experienced automated attempts to gain access to public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. The Company also has seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, destroy data, disrupt or degrade service, sabotage systems or cause other damage. The impact of the cyber attacks the Company has experienced through December 31, 2018 has not been material to its operations or results of operations. The Board and the Audit Committee of the Board ("the Audit Committee") are regularly informed regarding the Company's information security policies, practices and status.

Critical Accounting Policies

The Company prepares the consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered, support the preparation of the consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Significant accounting policies are discussed in Note 1 ''Significant Accounting Policies'' to the consolidated financial statements. Management believes the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. The Company has discussed the development and selection of these critical accounting policies with the Audit Committee, and the Audit Committee has reviewed the disclosures relating to them.

Revenue Recognition

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Pharmacy Services segment, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client, (ii) the United States Centers for Medicare & Medicaid Services ("CMS") subsidized portion of prescription drugs dispensed to the Company's Silverscript PDP members, (iii) the price paid to the Pharmacy Services segment by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("Retail Co-Payments"), and (iv) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenue.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

The Company recognizes revenue using the net method for contracts under which the Company acts as an agent or does not control the prescription drug prior to transfer to the client.

The Company records revenue net of manufacturers' rebates that are earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues as identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's results of operations or financial condition.

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual performance refund amounts has not been material to the Company's results of operations or financial condition.

The Pharmacy Services segment participates in the federal government's Medicare Part D program as a PDP through the Company's SilverScript subsidiary. Revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium,

which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

In addition to these premiums, the Pharmacy Services segment receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under a risk-sharing feature of the Medicare Part D program design, referred to as the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to the third party payer for pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts have not been material to the Company's results of operations or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's results of operations or financial condition. Sales taxes are not included in revenue.

Loyalty Program

The Company's customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed rewards are reflected as a contract liability.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of the revenue from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics
For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise. A significant difference in the actual level of retroactivity compared to estimated levels would have a significant effect on the Company's results of operations.

Additionally, premium revenue subject to the ACA's minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. The Company estimates minimum MLR rebates payable by projecting MLRs for certain markets, as defined by the ACA, for each state in which each of its insurance entities operates. The claims and premiums used in estimating such rebates are modified for certain adjustments allowed by the ACA and include a statistical credibility adjustment for those states with a number of members that is not statistically credible.

Furthermore, the ACA's permanent risk adjustment program transfers funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable or payable for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue. In this analysis, the Company considers the estimate of the average risk of members of other qualified plans in comparable markets the most critical assumption. The Company estimates its ultimate risk adjustment receivable or payable using management's best estimates, which are based on various data sources, including but not limited to market risk data compiled by third party sources as well as pricing and other regulatory inputs. See Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information on the ACA's risk adjustment program.

Other-Than-Temporary Impairments of Debt Securities

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in results of operations, and the amount of the non-credit related component is included in other comprehensive income, unless the Company intends to sell the debt security or it is more likely than not that it will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

Among the factors considered in evaluating whether a decline in fair value is other-than-temporary are whether the decline results from a change in the quality of the debt security itself, whether the decline results from a downward movement in the market as a whole, and the prospects for realizing the carrying value of the debt security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, the Company determines whether it intends to sell the debt security or if it is more likely than not that it will be required to sell the debt security before recovery of its amortized cost basis. If either case is true, the Company recognizes an OTTI, and the cost basis/carrying amount of the debt security is written down to fair value.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from projections and the risk that facts and circumstances factored into the Company's assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Vendor Allowances and Purchase Discounts

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's results of operations or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract.

There have not been any material changes in the way the Company accounts for vendor allowances and purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method.

The value of ending inventory is reduced for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each store and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. The accounting for inventory contains uncertainty since management must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, a number of factors are considered which include, but are not limited to, historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

The total reserve for estimated inventory losses covered by this critical accounting policy was $328 million as of December 31, 2018 . Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $33 million as of December 31, 2018 .

Although management believes that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from such estimates, and such differences could be material.

Goodwill and Identifiable Intangible Assets

Identifiable intangible assets
Identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/relationships, covenants not to compete, technology, provider networks, value of business acquired and favorable leases. These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

Recoverability of definite-lived intangible assets
The Company evaluates the recoverability of definite-lived intangible assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. These long-lived assets are grouped and evaluated for impairment at the lowest level at which individual cash flows can be identified. When evaluating these long-lived assets for potential impairment, the Company first compares the carrying amount of the asset group to the asset group's estimated future cash flows (undiscounted and without interest charges). If the estimated future cash flows are less than that carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges).

The long-lived asset impairment loss calculation contains uncertainty since management must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, the Company considers historical results and current operating trends and consolidated sales, profitability and cash flow results and forecasts. These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

There were no material impairment losses for definite-lived intangible assets recognized in any of the three years ended December 31, 2018, 2017 or 2016.

Recoverability of indefinitely-lived intangible assets
Indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that their carrying value may not be recoverable. Indefinitely-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized and the asset is written down to its estimated fair value.

The indefinitely-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including, but not limited to, general economic conditions, availability of market information as well as the profitability of the Company.

There were no material impairment losses recognized on indefinitely-lived intangible assets recognized in any of the three years ended December 31, 2018, 2017 or 2016.

Recoverability of goodwill
Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is calculated by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include, but are not limited to, the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes;

discount rates; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends; consolidated revenues, profitability and cash flow results and forecasts; and industry trends. These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, market capitalization, efforts of customers and payers to reduce costs including their prescription drug costs and/or increase member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

2018 goodwill impairment tests
As discussed in Note 5 ''Goodwill and Other Intangibles'' to the consolidated financial statements, during 2018, the LTC reporting unit continued to experience industry wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare and when the 2017 annual goodwill impairment test was performed. These challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a projected deterioration in the financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, higher risk-free interest rates and lower market multiples of peer group companies contributed to the amount of the second quarter 2018 goodwill impairment charge.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill. The results of these impairment tests indicated that there was no impairment of goodwill. The results of the annual goodwill impairment tests showed the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair value of the LTC reporting unit exceeded its carrying value by approximately 2%.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. The updated projections continue to reflect industry wide challenges including lower occupancy rates in skilled nursing facilities, the significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, an interim goodwill impairment test was performed during the fourth quarter of 2018. The results of that impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion goodwill impairment charge in the fourth quarter of 2018. In addition to the lower financial projections, lower market multiples of peer group companies also contributed to the amount of the fourth quarter 2018 goodwill impairment charge. The fair value of the LTC reporting unit was determined using a methodology consistent with the methodology described above for the analyses performed during the second and third quarters of 2018.

As of December 31, 2018 , the remaining goodwill balance in the LTC reporting unit is approximately $431 million .

Although the Company believes the financial projections used to determine the fair value of the LTC reporting unit in the fourth quarter of 2018 are reasonable and achievable, the LTC reporting unit may continue to face challenges that may affect the Company's ability to grow its business at the rate estimated when such goodwill impairment test was performed. These challenges and some of the key assumptions included in the Company's financial projections to determine the estimated fair value of the LTC reporting unit include client retention rates, occupancy rates in skilled nursing facilities, the financial health of skilled nursing facility customers, facility reimbursement pressures, the Company's ability to execute its senior living initiative, the Company's ability to make acquisitions and integrate those businesses into its LTC operations in an orderly manner, as well as the Company's ability to extract cost savings from labor productivity and other initiatives. The Company has made a number of additions and changes to its LTC management team to better respond to these challenges. The estimated fair value of the LTC reporting unit also is dependent on earnings multiples of market participants in the pharmacy industry, as well as the risk-free interest rate environment, which impacts the discount rate used in the discounted cash flow valuation method. If the Company

does not achieve its forecasts, it is reasonably possible in the near term that the goodwill of the LTC reporting unit could be deemed to be impaired again by a material amount.

2017 and 2016 goodwill impairment tests
The Company recorded $181 million in goodwill impairment charges in 2017 related to the RxCrossroads reporting unit. During the third quarter of 2017, the Company performed its required annual impairment test of goodwill. The goodwill impairment tests showed that the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair values of the LTC and RxCrossroads reporting units exceeded their carrying values by approximately 1% and 6%, respectively. On January 2, 2018, the Company sold its RxCrossroads reporting unit to McKesson Corporation for $725 million .

The Company did not record any goodwill impairment charges during 2016 .

Health Care Costs Payable

At December 31, 2018 , 80% of health care costs payable are estimates of the ultimate cost of (i) services rendered to members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. See Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information on the Company's reserving methodology.

The Company has considered the pattern of changes in its completion factors when determining the completion factors used in its estimates of IBNR as of December 31, 2018 . However, based on historical claim experience, it is reasonably possible that the Company's estimated weighted average completion factors may vary by plus or minus 16 basis points from the Company's assumed rates, which could impact health care costs payable by approximately plus or minus $194 million pretax.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2018 , the Company increased its assumed health care cost trend rates for the most recent three months by 3.5% from health care cost trend rates recently observed. However, based on historical claim experience, it is reasonably possible that the Company's estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus $299 million pretax.

Income Taxes

Income taxes are accounted for using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain. Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company's tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although management believes that its estimates are reasonable and are based on the best available information at the time the provision is prepared, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in the consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement. Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision. Significant judgment is required in determining uncertain tax positions. The Company has established

accruals for uncertain tax positions using its judgment and adjusts these accruals, as warranted, due to changing facts and circumstances.

Business Combinations

The Company accounts for business combinations using the acquisition method of accounting which requires that the assets acquired and liabilities assumed be recorded at the date of the acquisition at their respective fair values. The excess of purchase price over the fair value of assets acquired and liabilities assumed is recorded as goodwill. Determining the fair value of identifiable assets, particularly intangible assets, and liabilities acquired also requires management to make estimates, which are based on all available information and in some cases assumptions with respect to the timing and amount of future revenues and expenses associated with an asset. The most critical assumptions used in determining the fair value of intangible assets include customer attrition, membership growth and revenue growth. In determining the estimated fair value for intangible assets, the Company typically utilizes the income approach, which discounts the projected future net cash flow using an appropriate discount rate that reflects the risks associated with such projected future cash flows. Determining the useful life of an intangible asset also requires judgment, as different types of intangible assets will have different useful lives and certain assets are considered to have indefinite useful lives.

New Accounting Pronouncements

See Note 1 ‘‘Significant Accounting Policies’’ to the consolidated financial statements for a description of new accounting pronouncements applicable to the Company.

Holders of Common Stock

As of February 19, 2019, there were 27,266 registered holders of the Company’s common stock according to the records maintained by the Company’s transfer agent.

Cautionary Statement Concerning Forward-Looking Statements

The Private Securities Litigation Reform Act of 1995 (the “Reform Act”) provides a safe harbor for forward-looking statements made by or on behalf of the Company. In addition, the Company and its representatives may, from time to time, make written or verbal forward-looking statements, including statements contained in the Company’s filings with the United States Securities and Exchange Commission (the “SEC”) and in its reports to stockholders, press releases, webcasts, conference calls, meetings and other communications. Generally, the inclusion of the words “anticipate,” “believe,” “estimate,” “expect,” “intend,” “project,” “should,” “will” and similar expressions identify statements that constitute forward-looking statements. All statements addressing operating performance of CVS Health Corporation or any subsidiary, events or developments that the Company projects, expects or anticipates will occur in the future, including statements relating to corporate strategy; revenue growth; adjusted revenue growth, earnings or earnings per common share growth; adjusted operating income or adjusted earnings per common share growth; free cash flow; debt ratings; inventory levels; inventory turn and loss rates; store development; relocations and new market entries; retail pharmacy business, sales results and/or trends and operations; PBM business, sales results and/or trends and operations; specialty pharmacy business, sales trends and operations; LTC pharmacy business, sales results and/or trends and operations; Health Care Benefits business, sales results and/or trends, medical cost trends, medical membership growth, medical benefit ratios and operations; the Company’s ability to attract or retain customers and clients; Medicare Part D competitive bidding, enrollment and operations; new product development; and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future results of operations or events, are forward-looking statements within the meaning of the Reform Act.

The forward-looking statements are and will be based upon management’s then-current views and assumptions regarding future events and operating performance, and are applicable only as of the dates of such statements. The Company undertakes no obligation to update or revise any forward-looking statements, whether as a result of new information, future events, or otherwise.

By their nature, all forward-looking statements involve risks and uncertainties. Actual results may differ materially from those contemplated by the forward-looking statements for a number of reasons as described in the Company's SEC filings, including those set forth in the Risk Factors section within the CVS Health Corporation's 2018 Annual Report on Form 10-K, and including, but not limited to:

- *Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.*
- *Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.*
- *Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.*
- *We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our future performance.*
- *We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.*
- *Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.*
- *Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.*
- *Gross margins in the industries in which we operate may decline.*
- *Our results of operations are affected by the health of the economy in general and in the geographies we serve.*
- *We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.*
- *We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.*
- *We are exposed to risks relating to the solvency of our customers and of other insurers.*
- *We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs that we purchase and sell.*
- *We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.*
- *Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.*
- *Product liability, product recall or personal injury issues could damage our reputation.*
- *We face challenges in growing our Medicare Advantage and Medicare Part D membership.*
- *We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.*
- *A change in our Health Care Benefits product mix may adversely affect our profit margins.*
- *We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's results of operations. There can be no assurance that the future health care and other benefit costs of our Insured Health Care Benefits products will not exceed our projections.*
- *A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.*
- *The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.*
- *Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.*
- *Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges.*

Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.

- *We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and results of operations and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.*
- *Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our results of operations.*
- *Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.*
- *If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.*
- *Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.*
- *We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and results of operations.*
- *We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.*
- *We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.*
- *Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.*
- *Our results of operations may be adversely affected by changes in laws and policies governing employers and by union organizing activity.*
- *We must develop and maintain a relevant omni-channel experience for our retail customers.*
- *We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.*
- *In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.*
- *Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.*
- *If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.*
- *Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.*

- *We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.*
- *Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.*
- *We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.*
- *Our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and results of operations.*
- *We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.*
- *The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, results of operations and cash flows.*
- *Our business success and results of operations depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.*
- *Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.*
- *We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:*
  - *Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;*
  - *Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and*
  - *Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.*
- *Goodwill and other intangible assets could, in the future, become impaired.*
- *We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, cash flows, financial condition and results of operations.*
- *Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our results of operations and/or our financial condition.*
- *We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.*
- *The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.*
- *We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.*
- *Our future results may be adversely impacted if we do not effectively manage our expanded operations following completion of the Aetna Acquisition.*
- *We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.*
- *The Aetna integration process could disrupt our ongoing businesses and/or operations.*
- *Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.*
- *We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.*

- *We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.*
- *We may be unable to successfully integrate companies we acquire.*
- *As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.*

The foregoing list is not exhaustive. There can be no assurance that the Company has correctly identified all the risks that affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. Should any risks or uncertainties develop into actual events, these developments could have a material adverse effect on the Company's businesses, results of operations, cash flows and/or financial condition. For these reasons, you are cautioned not to place undue reliance on the Company's forward-looking statements.

Management's Report on Internal Control Over Financial Reporting

Management is responsible for establishing and maintaining adequate internal control over financial r eporting. The Company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the Company's consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2018 .

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company ' s system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by the Company's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

On November 28, 2018, the Company completed its acquisition of Aetna Inc. ("Aetna"). Management's assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018 excludes Aetna from that assessment as permitted under SEC rules. Aetna's operations are included in the Company's consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and represented 21% of the Company's consolidated total assets as of December 31, 2018 and 3% of the Company's consolidated total revenues for the year ended December 31, 2018.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2018 .

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by the Board of Directors and ratified by the Company's shareholders. They were engaged to render an opinion regarding the fair presentation of the Company ' s consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their accompanying reports are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

February 28, 2019

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, CVS Health Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on the COSO criteria.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Aetna Inc., which is included in the 2018 consolidated financial statements of the Company and constituted 21% of total assets as of December 31, 2018 and 3% of revenues for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Aetna Inc.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes and our report dated February 28, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

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

/s/ Ernst & Young LLP
Boston, Massachusetts
February 28, 2019

Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2018	2017	2016
Revenues:			
Products	$ 183,910	$ 180,063	$ 173,377
Premiums	8,184	3,558	3,069
Services	1,825	1,144	1,080
Net investment income	660	21	20
Total revenues	194,579	184,786	177,546
Operating costs:			
Cost of products sold	156,447	153,448	146,533
Benefit costs	6,594	2,810	2,179
Goodwill impairments	6,149	181	—
Operating expenses	21,368	18,809	18,448
Total operating costs	190,558	175,248	167,160
Operating income	4,021	9,538	10,386
Interest expense	2,619	1,062	1,078
Loss on early extinguishment of debt	—	—	643
Other expense (income)	(4)	208	28
Income before income tax provision	1,406	8,268	8,637
Income tax provision	2,002	1,637	3,317
Income (loss) from continuing operations	(596)	6,631	5,320
Loss from discontinued operations, net of tax	—	(8)	(1)
Net income (loss)	(596)	6,623	5,319
Net (income) loss attributable to noncontrolling interests	2	(1)	(2)
Net income (loss) attributable to CVS Health	$ (594)	$ 6,622	$ 5,317
Basic earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.48	$ 4.93
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.47	$ 4.93
Weighted average basic shares outstanding	1,044	1,020	1,073
Diluted earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.45	$ 4.91
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.44	$ 4.90
Weighted average diluted shares outstanding	1,044	1,024	1,079
Dividends declared per share	$ 2.00	$ 2.00	$ 1.70

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income (Loss)

	For the Years Ended December 31,		
In millions	**2018**	**2017**	**2016**
Net income (loss)	$ (596)	$ 6,623	$ 5,319
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains	97	—	—
Foreign currency translation adjustments	(29)	(2)	38
Net cash flow hedges	330	(10)	2
Pension and other postretirement benefits	(124)	152	13
Other comprehensive income	274	140	53
Comprehensive income (loss)	(322)	6,763	5,372
Comprehensive (income) loss attributable to noncontrolling interests	2	(1)	(2)
Comprehensive income (loss) attributable to CVS Health	$ (320)	$ 6,762	$ 5,370

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2018	At December 31, 2017
Assets:		
Cash and cash equivalents	$ 4,059	$ 1,696
Investments	2,522	111
Accounts receivable, net	17,631	13,181
Inventories	16,450	15,296
Other current assets	4,581	945
Total current assets	45,243	31,229
Long-term investments	15,732	112
Property and equipment, net	11,349	10,292
Goodwill	78,678	38,451
Intangible assets, net	36,524	13,630
Separate accounts assets	3,884	—
Other assets	5,046	1,417
Total assets	$ 196,456	$ 95,131
Liabilities:		
Accounts payable	$ 8,925	$ 8,863
Pharmacy claims and discounts payable	12,302	10,355
Health care costs payable	5,210	5
Policyholders' funds	2,939	—
Accrued expenses	10,711	6,581
Other insurance liabilities	1,937	23
Short-term debt	720	1,276
Current portion of long-term debt	1,265	3,545
Total current liabilities	44,009	30,648
Long-term debt	71,444	22,181
Deferred income taxes	7,677	2,996
Separate accounts liabilities	3,884	—
Other long-term insurance liabilities	8,119	334
Other long-term liabilities	2,780	1,277
Total liabilities	137,913	57,436
Commitments and contingencies (Note 16)		
Shareholders' equity:		
CVS Health shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,720 shares issued and 1,295 shares outstanding at December 31, 2018 and 1,712 shares issued and 1,014 shares outstanding at December 31, 2017 and capital surplus	45,440	32,096
Treasury stock, at cost: 425 shares at December 31, 2018 and 698 shares at December 31, 2017	(28,228)	(37,796)
Retained earnings	40,911	43,556
Accumulated other comprehensive income (loss)	102	(165)
Total CVS Health shareholders' equity	58,225	37,691
Noncontrolling interests	318	4
Total shareholders' equity	58,543	37,695
Total liabilities and shareholders' equity	$ 196,456	$ 95,131

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2018	2017	2016
Cash flows from operating activities:			
Cash receipts from customers	$ 186,519	$ 176,594	$ 172,310
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(148,821)	(146,469)	(140,312)
Insurance benefits paid	(7,057)	(2,810)	(2,199)
Cash paid to other suppliers and employees	(17,234)	(15,348)	(15,478)
Interest and investment income received	644	21	20
Interest paid	(2,803)	(1,072)	(1,140)
Income taxes paid	(2,383)	(2,909)	(3,060)
Net cash provided by operating activities	8,865	8,007	10,141
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	817	61	91
Purchases of investments	(692)	(137)	(80)
Purchases of property and equipment	(2,037)	(1,918)	(2,224)
Proceeds from sale-leaseback transactions	—	265	230
Acquisitions (net of cash acquired)	(42,226)	(1,181)	(524)
Proceeds from sale of subsidiary and other assets	832	—	—
Other	21	33	37
Net cash used in investing activities	(43,285)	(2,877)	(2,470)
Cash flows from financing activities:			
Net repayments of short-term debt	(556)	(598)	1,874
Proceeds from issuance of long-term debt	44,343	—	3,455
Repayments of long-term debt	(5,522)	—	(5,943)
Purchase of noncontrolling interest in subsidiary	—	—	(39)
Payment of contingent consideration	—	—	(26)
Derivative settlements	446	—	—
Repurchase of common stock	—	(4,361)	(4,461)
Dividends paid	(2,038)	(2,049)	(1,840)
Proceeds from exercise of stock options	242	329	296
Payments for taxes related to net share settlement of equity awards	(97)	(71)	(72)
Other	1	(1)	(5)
Net cash provided by (used in) financing activities	36,819	(6,751)	(6,761)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(4)	1	2
Net increase (decrease) in cash, cash equivalents and restricted cash	2,395	(1,620)	912
Cash, cash equivalents and restricted cash at the beginning of the period	1,900	3,520	2,608
Cash, cash equivalents and restricted cash at the end of the period	$ 4,295	$ 1,900	$ 3,520

In millions	For the Years Ended December 31, 2018	2017	2016
Reconciliation of net income (loss) to net cash provided by operating activities:			
Net income (loss)	$ (596)	$ 6,623	$ 5,319
Adjustments required to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	2,718	2,479	2,475
Goodwill impairments	6,149	181	—
Losses on settlements of defined benefit pension plans	—	187	—
Stock-based compensation	280	234	222
Loss on early extinguishment of debt	—	—	643
Deferred income taxes	87	(1,334)	18
Other noncash items	339	53	135
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(1,139)	(941)	(243)
Inventories	(1,153)	(514)	(742)
Other assets	(3)	(338)	(8)
Accounts payable and pharmacy claims and discounts payable	2,489	1,710	2,189
Health care costs payable and other insurance liabilities	(471)	—	(19)
Other liabilities	165	(333)	152
Net cash provided by operating activities	$ 8,865	$ 8,007	$ 10,141

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

	Number of shares outstanding		Attributable to CVS Health						
In millions	Common Shares	Treasury Shares [1]	Common Stock and Capital Surplus [2]	Treasury Stock [1]	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total CVS Health Shareholders' Equity	Non Controlling Interests	Total Equity
Balance at December 31, 2015	**1,699**	**(598)**	**$ 30,965**	**$ (28,917)**	**$ 35,506**	**$ (358)**	**$ 37,196**	**$ 7**	**$ 37,203**
Net income [3]	—	—	—	—	5,317	—	5,317	1	5,318
Other comprehensive income (Note 13)	—	—	—	—	—	53	53	—	53
Stock option activity, stock awards, related tax benefits and other	6	—	525	—	—	—	525	—	525
Purchase of treasury shares, net of ESPP issuances	—	(46)	145	(4,566)	—	—	(4,421)	—	(4,421)
Common stock dividends	—	—	—	—	(1,840)	—	(1,840)	—	(1,840)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(4)	(4)
Balance at December 31, 2016	1,705	(644)	31,635	(33,483)	38,983	(305)	36,830	4	36,834
Net income	—	—	—	—	6,622	—	6,622	1	6,623
Other comprehensive income (Note 13)	—	—	—	—	—	140	140	—	140
Stock option activity, stock awards and other	7	—	461	—	—	—	461	—	461
Purchase of treasury shares, net of ESPP issuances	—	(54)	—	(4,313)	—	—	(4,313)	—	(4,313)
Common stock dividends	—	—	—	—	(2,049)	—	(2,049)	—	(2,049)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(1)	(1)
Balance at December 31, 2017	1,712	(698)	32,096	(37,796)	43,556	(165)	37,691	4	37,695
Adoption of new accounting standards (Note 1)	—	—	—	—	(6)	(7)	(13)	—	(13)
Net loss	—	—	—	—	(594)	—	(594)	(2)	(596)
Other comprehensive income (Note 13)	—	—	—	—	—	274	274	—	274
Common shares issued to acquire Aetna	—	274	12,923	9,561	—	—	22,484	—	22,484
Stock option activity, stock awards and other	8	—	421	—	—	—	421	—	421
Purchase of treasury shares, net of ESPP issuances	—	(1)	—	7	—	—	7	—	7
Common stock dividends	—	—	—	—	(2,045)	—	(2,045)	—	(2,045)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(13)	(13)
Acquisition of noncontrolling interests	—	—	—	—	—	—	—	329	329
Balance at December 31, 2018	**1,720**	**(425)**	**$ 45,440**	**$ (28,228)**	**$ 40,911**	**$ 102**	**$ 58,225**	**$ 318**	**$ 58,543**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2018, 2017 and 2016. Treasury stock includes $29 million related to shares held in trust for the year ended December 31, 2018 and $31 million related to shares held in trust for each of the years ended December 31, 2017 and 2016. See Note 1 ''Significant Accounting Policies'' for additional information.

(2) Common stock and capital surplus includes the par value of common stock of $17 million as of December 31, 2018, 2017 and 2016.

(3) Net income attributable to noncontrolling interests for the year ended December 31, 2016 excludes $1 million attributable to a redeemable noncontrolling interest. See Note 1 ''Significant Accounting Policies'' for additional information.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below. The consolidated financial statements for the year ended December 31, 2018 reflect Aetna's results subsequent to the Aetna Acquisition Date.

Pharmacy Services Segment ("PSS")
PSS provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. PSS' clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. PSS operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment ("RLS")
RLS sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic ® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, RLS also provided commercialization services under the name RxCrossroads ® . The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, RLS operated more than 9,900 retail locations, over 1,100 MinuteClinic ® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies.

Health Care Benefits Segment ("HCBS")
HCBS is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018 . HCBS has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. HCBS offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. HCBS' customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC."

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying consolidated financial statements of CVS Health Corporation and its subsidiaries have been prepared in accordance with accounting principles generally accepted in the United States of America (“GAAP”). The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities (“VIEs”) for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents

Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash.

Restricted cash

As of December 31, 2018 and 2017 , the Company had $230 million and $190 million , respectively, of restricted cash held in a trust in an insurance captive to satisfy collateral requirements associated with the assignment of certain insurance policies. Such amounts are included in other assets on the consolidated balance sheets. Additionally, as of December 31, 2018 and 2017 , the Company had $6 million and $14 million , respectively, of restricted cash held in escrow accounts in connection with certain recent acquisitions. Such amounts are included in other current assets on the consolidated balance sheets.

Investments

Debt Securities
Debt securities consist primarily of United States Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current within the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 ‘‘Fair Value’’ for additional information on how the Company estimates the fair value of these investments.

The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments.

Debt securities are regularly reviewed to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in the

fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in net income, and the amount of the non-credit related component is included in other comprehensive income/loss, unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

Equity Securities
Equity securities with readily available fair values are measured at fair value with changes in fair value recognized in net income.

Mortgage Loans
Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of impairment reserves. A mortgage loan may be impaired when it is a problem loan (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure), a potential problem loan (i.e., high probability of default) or a restructured loan. For impaired loans, a specific impairment reserve is established for the difference between the recorded investment in the loan and the estimated fair value of the collateral. The Company applies its loan impairment policy individually to all loans in its portfolio.

The impairment evaluation described above also considers characteristics and risk factors attributable to the aggregate portfolio. An additional allowance for loan losses is established if it is probable that there will be a credit loss on a group of similar mortgage loans. The following characteristics and risk factors are considered when evaluating if a credit loss is probable on a group of similar mortgage loans: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Full or partial impairments of loans are recorded at the time an event occurs affecting the legal status of the loan, typically at the time of foreclosure or upon a loan modification giving rise to forgiveness of debt. Interest income on a potential problem loan or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships are accounted for using the equity method of accounting. Under this method, the carrying value of the investments are based on the value of the Company's equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund managers, these investments are generally reported on up to a three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.
- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.
- Privately-placed equity securities, which are carried on the consolidated balance sheets at cost less impairments, plus or minus subsequent adjustments for observable price changes. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), a subsidiary of the Company is required to purchase and hold shares of the FHLBB. These shares are restricted and carried at cost.

Net Investment Income
Net investment income on the Company's investments is recorded when earned and is reflected in net income in the consolidated results of operations (other than net investment income on assets supporting experience-rated products). Experience-rated products are products in the large case pensions business where the contract holder, not the Company, assumes investment and other risks, subject to, among other things, minimum guarantees provided by the Company. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact the Company's net income in the consolidated results of operations (as long as the contract's minimum guarantees are not triggered). Net investment income on assets supporting large case pensions' experience-rated products is included in net investment income in the consolidated statements of operations and is credited to contract holders' accounts through a charge to benefit costs.

Realized capital gains and losses on investments (other than realized capital gains and losses on investments supporting experience-rated products) are included as a component of net investment income in the consolidated statements of operations. Realized capital gains and losses are determined on a specific identification basis. Purchases and sales of debt and equity securities and alternative investments are reflected on the trade date. Purchases and sales of mortgage loans and investment real estate are reflected on the closing date.

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Unrealized capital gains and losses on investments (other than unrealized capital gains and losses on investments supporting experience-rated products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive income. Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts, which are reflected in policyholders' funds on the consolidated balance sheets.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Accounts Receivable

Accounts receivable are stated net of allowances for doubtful accounts, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net consists of the following at December 31 :

In millions	**2018**	**2017**
Trade receivables	$ 6,896	$ 7,895
Vendor and manufacturer receivables	7,655	5,109
Premium receivables	2,259	31
Other receivables	821	146
Total accounts receivable, net	$ 17,631	$ 13,181

The activity in the allowance for doubtful accounts receivable for the years ended December 31 is as follows:

In millions	**2018**	**2017**	**2016**
Beginning balance	$ 307	$ 286	$ 161
Additions charged to bad debt expense	256	177	221
Write-offs charged to allowance	(70)	(156)	(96)
Ending balance	$ 493	$ 307	$ 286

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to reduce its required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated results of operations or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2018 , the Company's reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits and Pharmacy Services segments are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. Acquisition costs for certain long-duration insurance contracts are deferred and are recorded as other current assets or other assets on the consolidated balance sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations. At December 31, 2018 , the balance of deferred acquisition costs was $22 million , comprised primarily of commissions paid on Medicare Supplement products within the Health Care Benefits segment.

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 5 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consists of the following at December 31 :

In millions	**2018**	**2017**
Land	$ 1,872	$ 1,707
Building and improvements	3,785	3,343
Fixtures and equipment	13,028	11,963
Leashold improvements	5,384	4,793
Software	2,800	2,484
Total property and equipment	26,869	24,290
Accumulated depreciation and amortization	(15,520)	(13,998)
Property and equipment, net	$ 11,349	$ 10,292

The amount of property and equipment under capital leases at December 31 is as follows:

In millions	**2018**	**2017**
Property and equipment under capital leases	$ 582	$ 588
Accumulated amortization of property and equipment under capital leases	(163)	(140)
Property and equipment under capital leases, net	$ 419	$ 448

Depreciation expense (which includes the amortization of property and equipment under capital leases) totaled $1.7 billion in each of the years ended December 31, 2018 , 2017 and 2016 .

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded as goodwill. Goodwill is not amortized, but is subject to impairment reviews annually, or more frequently if necessary. When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess. See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill and goodwill impairments.

Intangible Assets

The Company’s definite-lived intangible assets are amortized over their estimated useful-life based upon the pattern of future cash flows attributable to the asset. Other than value of business acquired (“VOBA”), definite-lived intangible assets are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. The Company groups and evaluates definite-lived intangible assets for impairment at the lowest level at which individual cash flows can be identified whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group’s estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group’s carrying value that exceeds the asset group’s estimated future cash flows (discounted and with interest charges). There were no material impairment losses recognized on definite-lived intangible assets in any of the three years ended December 31, 2018 , 2017 or 2016 .

Indefinitely-lived intangible assets are not amortized but are tested for impairment annually, or more frequently if necessary. Indefinitely-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinitely-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinitely-lived intangible assets in any of the three years ended December 31, 2018 , 2017 or 2016 .

See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about intangible assets.

Separate Accounts

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals and net investment income (including net realized and net unrealized capital gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements primarily related to the Health Care Benefits segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the consolidated results of operations in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR from the Aetna Acquisition Date through December 31, 2018 .

The Company analyzes historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." The Company uses completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. The Company estimates completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents the Company's estimate of claims remaining to be paid as of the financial statement date and is included in the Company's health care costs payable. The completion factors the Company uses reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in Insured membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using the Company's completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, the Company uses a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. The Company applies its actuarial judgment and places a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

The Company's health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including the Company's ability to manage benefit costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of the Company's business. The health status of the Company's Insured members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and the Company's health care cost trend rate.

For each reporting period, the Company uses an extensive degree of judgment in the process of estimating its health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period the Company recognizes the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. The Company believes its estimate of health care costs payable is reasonable and adequate to cover its obligations at December 31, 2018 ; however, actual claim payments may differ from the Company's estimates. A worsening (or improvement) of the Company's health care cost trend rates or changes in completion factors from those that the Company assumed in estimating health care costs payable at December 31, 2018 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, the Company re-examines previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that the Company's estimates of health care costs payable could develop either favorably (that is, its actual benefit costs for the period were less than estimated) or unfavorably. The changes in the Company's estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For a roll forward of the Company's health care costs payable, see Note 7 "Health Care Costs Payable." The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid claims
Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the United States Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR from the Aetna Acquisition Date through December 31, 2018 . As of December 31, 2018 , unpaid claims balances of $816 million and $1.9 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

Future policy benefits
Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts, long-duration group life and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 3.5% to 11.3% from the Aetna Acquisition Date through December 31, 2018 . The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-duration long-term care contracts represent the Company's estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. The assumed interest rate on such contracts was 5.1% from the Aetna Acquisition Date through December 31, 2018 . The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2018 , future policy benefits

balances of $536 million and $6.2 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. The Company established a premium deficiency reserve of $16 million as of December 31, 2018 related to Medicaid products in the Health Care Benefits segment.

Policyholders' Funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts and customer funds associated with certain health contracts. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus credited interest thereon, net of experience-rated adjustments. From the Aetna Acquisition Date through December 31, 2018 , interest rates for pension and annuity investment contracts ranged from 3.5% to 13.4% . Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also holds funds for health savings accounts ("HSAs") on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $2.1 billion at December 31, 2018 and are reflected in other current assets with a corresponding liability in policyholder funds.

Policyholders' Funds liabilities that are expected to be paid within twelve months from the balance sheet date are classified as current on the consolidated balance sheets. Policyholders' Funds liabilities that are expected to be paid greater than twelve months from the balance sheet date are included in other long-term liabilities on the consolidated balance sheets.

Self-Insurance Liabilities

The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience. At December 31, 2018 and 2017 , self-insurance liabilities totaled $865 million and $696 million , respectively, and were recorded as accrued expenses on the consolidated balance sheets.

Facility Opening and Closing Costs

New facility opening costs, other than capital expenditures, are charged directly to expense when incurred. When the Company closes a facility, the present value of estimated unrecoverable costs, including the remaining lease obligation less estimated sublease income and the book value of abandoned property and equipment, are charged to expense.

In December 2016, the Company announced an enterprise streamlining initiative designed to reduce costs and enhance operating efficiencies to allow the Company to be more competitive in the current health care environment. During the year ended December 31, 2017 , in connection with that enterprise streamlining initiative, the Company closed 71 retail stores and recorded charges of $215 million within operating expenses in the Retail/LTC segment. The charges are primarily comprised of provisions for the present value of noncancelable lease obligations. The noncancelable lease obligations associated with stores closed during the year ended December 31, 2017 extend through the year 2039. During the year ended December 31, 2018 , the Company did not recognize any significant charges related to facility closing costs.

The long-term portion of the lease obligations associated with all outstanding facility closings was $269 million and $306 million as of December 31, 2018 and 2017 , respectively, and was recorded in other long-term liabilities on the consolidated balance sheets.

Contingent Consideration

In December 2015, the Company acquired the pharmacy and clinic businesses of Target for approximately $1.9 billion , plus contingent consideration of up to $60 million based on future prescription growth over a three year period through December 31, 2019. As of December 31, 2018, no liability for any potential contingent consideration has been recorded based on historical and projected prescription growth through 2019.

Redeemable Noncontrolling Interest

As a result of the acquisition of Omnicare, Inc. ("Omnicare") in 2015, the Company obtained a 73% ownership interest in a limited liability company ("LLC"). Due to the change in control in Omnicare, the noncontrolling member of the LLC had the contractual right to put its membership interest to the Company at fair value. Consequently, the noncontrolling interest in the LLC was recorded as a redeemable noncontrolling interest at fair value. During 2016, the noncontrolling member of the LLC exercised its option to sell its ownership interest and the Company purchased the noncontrolling interest in the LLC for approximately $39 million .

Below is a summary of the changes in redeemable noncontrolling interest for the year ended December 31, 2016 :

In millions		
Beginning balance	$	39
Net income attributable to noncontrolling interest		1
Distributions		(2)
Purchase of noncontrolling interest		(39)
Reclassification to capital surplus in connection with purchase of noncontrolling interest		1
Ending balance	$	—

Foreign Currency Translation and Transactions

For local currency functional currency, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenue and expense are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in income.

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in any of the periods presented.

Revenue Recognition

The following is a discussion of the Company's revenue recognition policies by segment under the new revenue recognition accounting standard. See "New accounting pronouncements recently adopted - Revenue from Contracts with Customers" below for further discussion regarding the adoption of the new revenue recognition accounting standard. The new revenue recognition accounting standard does not relate to contracts within the scope of *Accounting Standards Codification 944 Financial Services - Insurance* . As a result, the majority of revenues within the Health Care Benefits segment and certain revenues within the Pharmacy Services segment are not within the scope of the new accounting standard.

Pharmacy Services Segment
PSS sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each

prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to PSS, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the United States Centers for Medicare & Medicaid Services ("CMS") subsidized portion of prescription drugs dispensed to the Company's Silverscript PDP members, (iii) the price paid to PSS by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("Retail Co-Payments"), and (iv) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenue.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to in exchange for those prescription drugs. The following revenue recognition policies have been established for PSS:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which PSS acts as an agent or does not control the prescription drugs prior to transfer to the client, revenue is recognized using the net method.

Drug discounts

PSS records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. PSS estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. PSS adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues as identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's results of operations or financial condition.

Guarantees

PSS also adjusts revenues for refunds owed to the client resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's results of operations or financial condition.

Medicare Part D

PSS' revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

PSS' revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor,

and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, PSS receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to the third party payer for pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's results of operations or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's results of operations or financial condition. Sales taxes are not included in revenue.

Loyalty Program

The Company's customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed rewards are reflected as a contract liability.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of the revenue from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors are typically not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment

Premium Revenue

HCBS premiums are recognized as income in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (as amended, collectively, the "ACA's") minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services and Product Revenue

HCBS services and product revenue relates to contracts that can include various combinations of products, services, or series of services, which are generally capable of being distinct and accounted for as separate performance obligations. HCBS' services and product revenue consists of the following components:

- ASC fees are received in exchange for performing certain claim processing and member services for HCBS' ASC medical members. ASC fee revenue is recognized over the period the service is provided. Some of the administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, HCBS is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period HCBS estimates obligations under the terms of these guarantees and records its estimate as an offset to service revenues.
- Workers' compensation administrative services consist of fee-based managed care services. Workers' compensation administrative services revenue is recognized once the service is provided.
- Specialty and home delivery pharmacy product revenue is recognized when the prescription is delivered to an ASC member. Specialty and home delivery pharmacy product revenue reflects the price of the prescription on a gross basis (ASC member co-payments and plan sponsor reimbursements).

Accounting for Medicare Part D

HCBS offers Medicare Part D prescription drug insurance coverage under contracts with the CMS. HCBS' revenue recognition policy for Medicare Part D is consistent with the policy detailed in the " *Medicare Part D"* section of PSS' revenue recognition policy described above.

Disaggregation of Revenue
The following table disaggregates the Company's revenue by major source in each segment for the year ended December 31, 2018 :

In millions	Pharmacy Services	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Major goods/services lines:						
Pharmacy	$ 130,195	$ 64,179	$ 164	$ —	$ (29,693)	$ 164,845
Front Store	—	19,055	—	—	—	19,055
Premiums	3,361	—	4,819	4	—	8,184
Net investment income	13	—	45	602	—	660
Other	559	755	521	—	—	1,835
Total	$ 134,128	$ 83,989	$ 5,549	$ 606	$ (29,693)	$ 194,579

Pharmacy Services distribution channel:	
Mail choice [1]	$ 46,934
Pharmacy network [2]	83,261
Other	3,933
Total	$ 134,128

(1) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect ® claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice ® program, which permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order.
(2) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice activity, which is included within the mail choice category.

Contract Balances
Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, for example ExtraBucks ® Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31:

In millions	2018	2017
Trade receivables (included in accounts receivable, net)	$ 6,896	$ 7,895
Contract liabilities (included in accrued expenses)	67	53

During the year ended December 31, 2018 , the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	
Balance at December 31, 2017	$ 53
Adoption of ASU 2014-09	17
Loyalty program earnings and gift card issuances	332
Redemption and breakage	(335)
Balance at December 31, 2018	$ 67

Cost of products sold

The Company accounts for cost of products sold as follows:

Pharmacy Services Segment
PSS' cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through its mail service dispensing pharmacies and indirectly through its retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of its mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from PSS' mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor allowances and purchase discounts" below) and (ii) the cost of prescription drugs sold (including Retail Co-Payments) through PSS' retail pharmacy network under contracts where it is the principal, net of any volume-related or other discounts.

Retail/LTC Segment
RLS' cost of products sold includes: the cost of merchandise sold during the reporting period, including prescription drug costs, and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

Health Care Benefits Segment
HCBS' cost of products sold includes the cost of the prescription and certain administrative costs incurred for dispensing the prescription to ASC members by HCBS' specialty and home delivery pharmacy operations.

See Note 17 ''Segment Reporting'' for additional information about the cost of products sold of the Company's segments.

Vendor allowances and purchase discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment
PSS receives purchase discounts on products purchased. PSS' contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for PSS to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices, or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days after the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to PSS' results of operations. PSS accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. PSS also receives additional discounts under its wholesaler contracts if it exceeds contractually defined annual purchase volumes. In addition, PSS receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of "cost of products sold".

Retail/LTC Segment
Vendor allowances received by RLS reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments also is initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

Health Care Reform

Health Insurer Fee
Since January 1, 2014, the ACA imposes an annual premium-based health insurer fee ("HIF") for each calendar year payable in September which is not deductible for tax purposes. The Company is required to estimate a liability for the HIF at the beginning of the calendar year in which the fee is payable with a corresponding deferred asset that is amortized ratably to operating expenses over the calendar year. The Company records the liability for the health insurer fee in accrued expenses and records the deferred asset in other current assets. In 2018 and 2016, operating expenses include $157 million and $56 million , respectively, related to the Company's share of the HIF. There was no expense related to the HIF in 2017 and there will be no expense for HIF in 2019, since the HIF was suspended for each of those periods.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Advertising costs

Advertising costs are expensed when the related advertising takes place. Advertising costs, net of vendor funding (included in operating expenses), were $364 million , $230 million and $216 million in 2018 , 2017 and 2016 , respectively.

Stock-based compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as an expense over the applicable requisite service period of the stock award (generally 3 to 5 years) using the straight-line method.

Income taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.

The Tax Cuts and Jobs Act (the "TCJA") was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion for year ended December 31, 2017. The Company completed its assessment of the TCJA's final impact in December 2018 and recorded an additional tax benefit of approximately $100 million in the year ended December 31, 2018.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and recent results of operations. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit ("OPEB") Plans

The Company sponsors defined benefit pension plans ("pension plans") and OPEB plans for its employees and retirees. The Company recognizes the funded status of its pension plans and OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plans benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other long-term liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets. Nearly all of the Company's net benefit costs for the Company's defined benefit pension and postretirement plans do not contain a service cost component as most of these defined benefit plans have been frozen for an extended period of time. Non-service components of pension and postretirement benefit cost are included in other expense (income) in the consolidated statements of operations.

Earnings per common share

Earnings per share is computed using the two-class method. The Company calculates basic earnings per share based on the weighted average number of common shares outstanding for the period. See Note 14 ''Earnings Per Share'' for additional information.

Shares held in trust

The Company maintains grantor trusts, which held approximately one million shares of its common stock at December 31, 2018 and 2017 , respectively. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Variable Interest Entities

The Company has investments in (i) a generic pharmaceutical sourcing entity, (ii) certain hedge fund and private equity investments and (iii) real estate partnerships that are considered VIE's. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary
In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50% . The Red Oak arrangement has an initial term of 10 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company 39 quarterly payments beginning in October 2014. As milestones are met, the quarterly payments increase. The Company received from Cardinal approximately $183 million during each of the years ended December 31, 2018 and 2017 and $163 million during the year ended December 31, 2016 . The payments reduce the Company's carrying value of inventory and are recognized in cost of products sold when the related inventory is sold. Revenues associated with Red Oak expenses reimbursed by Cardinal for the years ended December 31, 2018 , 2017 and 2016 , as well as amounts due to or due from Cardinal at December 31, 2018 and 2017 were immaterial.

Variable Interest Entities - Other Variable Interest Holder
In November 2018, the Company completed the Aetna Acquisition. Aetna has involvement with VIEs where the Company has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.

- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these investments because the nature of the Company's involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheet and recognizes its share of each VIE's income or losses in earnings. The Company's maximum exposure to loss from these VIEs is limited to its investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which the Company does not consider significant.

The total amount of other variable interest holder VIE assets included in long-term investments on the consolidated balance sheet at December 31, 2018 was as follows:

In millions		
Hedge fund investments	$	270
Private equity investments		524
Real estate partnerships		275
Total	$	1,069

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. PSS and RLS utilize this clinical health information network in providing services to their respective client plan members and retail customers. The Company expensed fees for the use of this network of approximately $45 million , $35 million and $39 million in the years ended December 31, 2018 , 2017 and 2016 , respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company approximately $135 million , $139 million and $140 million for pharmaceutical inventory purchases during the years ended December 31, 2018 , 2017 and 2016 , respectively. Additionally, the Company performs certain collection functions for Heartland and then passes those customer cash collections back to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

Discontinued Operations

In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Bob's Stores and Linens 'n Things each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations primarily includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its lease guarantees. See "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' for more information.

Results from discontinued operations were immaterial for the year ended December 31, 2018. Below is a summary of the results of discontinued operations for the years ended December 31 , 2017 and 2016:

In millions	**2017**	**2016**
Loss from discontinued operations	$ (13)	$ (2)
Income tax benefit	5	1
Loss from discontinued operations, net of tax	$ (8)	$ (1)

New accounting pronouncements recently adopted

Revenue from Contracts with Customers
In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers* (Topic 606) ("Topic 606"). ASU 2014-09 outlines a single comprehensive model for

companies to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance. In March 2016, the FASB issued ASU 2016-08, *Principal Versus Agent Considerations (Reporting* Revenue *Gross Versus Net)* which amends the principal-versus-agent implementation guidance and in April 2016 the FASB issued ASU 2016-10, *Identifying Performance Obligations and Licensing,* which amends the guidance in those areas in the new revenue recognition standard.

The Company adopted the new standard as of January 1, 2018 using the modified retrospective method and applied the new standard to all contracts. Therefore, the comparative financial information has not been restated and continues to be reported under the accounting standards in effect for the applicable period. While the adoption of the new standard did not result in any material adjustments to the Company's revenue or net income, one difference was identified between the previous accounting guidance and the new accounting guidance in RLS related to the accounting for the Company's ExtraBucks ® Rewards customer loyalty program. This program was previously accounted for under a cost deferral method, while under the new standard this program is accounted for under a revenue deferral method. The cumulative effect of applying the new guidance to all contracts was recorded as an adjustment to retained earnings as of the adoption date.

As a result of applying the modified retrospective method to adopt the new standard, the following adjustments were made to accounts on the consolidated balance sheet as of January 1, 2018:

	Impact of Change in Accounting Policy		
	As Reported		**Adjusted**
In millions	**December 31, 2017**	**Adjustments**	**January 1, 2018**
Consolidated Balance Sheet:			
Accrued expenses	$ 6,581	$ 17	$ 6,598
Deferred income taxes	2,996	(4)	2,992
Total liabilities	57,436	13	57,449
Retained earnings	43,556	(13)	43,543
Total CVS Health shareholders' equity	37,691	(13)	37,678
Total shareholders' equity	37,695	(13)	37,682

The following tables compare the reported consolidated balance sheet, statements of operations, and statement of cash flows amounts to the pro forma amounts had the previous revenue accounting guidance remained in effect:

		Impact of Change in Accounting Policy	
In millions	**As Reported As of/For the Year Ended December 31, 2018**	**Adjustments**	**Balances Without Adoption of Topic 606**
Consolidated Statement of Operations:			
Revenues:			
Products	$ 183,910	$ 3	$ 183,913
Total revenues	194,579	3	194,582
Operating costs:			
Cost of products sold	156,447	2	156,449
Total operating costs	190,558	2	190,560
Operating income	4,021	1	4,022
Income before income tax provision	1,406	1	1,407
Income tax provision	2,002	—	2,002
Loss from continuing operations	(596)	1	(595)
Net loss	(596)	1	(595)
Net loss attributable to CVS Health	(594)	1	(593)
Consolidated Balance Sheet:			
Accrued expenses	10,711	(18)	10,693
Total current liabilities	44,009	(18)	43,991
Deferred income taxes	7,677	4	7,681
Total liabilities	137,913	(14)	137,899
Retained earnings	40,911	14	40,925
Total CVS Health shareholders' equity	58,225	14	58,239
Total shareholders' equity	58,543	14	58,557
Consolidated Statement of Cash Flow:			
Reconciliation of net loss to net cash provided by operating activities:			
Net loss	(596)	1	(595)
Other liabilities	165	(1)	164

Recognition and Measurement of Financial Assets and Financial Liabilities
In January 2016, the FASB issued ASU 2016-01, *Financial Instruments - Overall* (Subtopic 825-10): *Recognition and Measurement of Financial Assets and Financial Liabilities* . This ASU requires equity investments, except those under the equity method of accounting or those that result in the consolidation of an investee, to be measured at fair value with changes in fair value recognized in net income. However, an entity may choose to measure equity investments that do not have readily determinable fair values at cost minus impairment, if any, plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issuer. This simplifies the impairment assessment of equity investments previously held at cost. Entities are required to apply the guidance retrospectively, with the exception of the amendments related to equity investments without readily determinable fair values, which must be applied on a prospective basis. Effective January 1, 2018, the Company adopted this new accounting guidance. The adoption of this new guidance did not have a material impact on the Company's financial condition or results of operations.

Classification of Certain Cash Receipts and Cash Payments in the Consolidated Statements of Cash Flows
In August 2016, the FASB issued ASU 2016-15, *Classification of Certain Cash Receipts and Cash Payments* . This ASU is intended to add or clarify guidance on the classification of certain cash receipts and payments in the statement of cash flows and

to eliminate the diversity in practice related to such classifications. Effective January 1, 2018, the Company adopted this new accounting guidance. The adoption of this new guidance did not have a material impact on the Company's financial condition or results of operations.

Statement of Cash Flows - Restricted Cash
In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows* , which amends Accounting Standard Codification Topic 230. This ASU requires entities to show the changes in the total of cash, cash equivalents, restricted cash and restricted cash equivalents in the statement of cash flows. As a result, entities no longer are required to present transfers between cash and cash equivalents and restricted cash and restricted cash equivalents in the statement of cash flows. When cash, cash equivalents, restricted cash and restricted cash equivalents are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Entities will also have to disclose the nature of their restricted cash and restricted cash equivalent balances. The guidance is required to be applied retrospectively. Effective January 1, 2018, the Company adopted this new accounting guidance.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets as of December 31 to total cash, cash equivalents and restricted cash in the consolidated statements of cash flows:

In millions	**2018**	**2017**	**2016**
Cash and cash equivalents	$ 4,059	$ 1,696	$ 3,371
Restricted cash (included in other current assets)	6	14	—
Restricted cash (included in other assets)	230	190	149
Total cash, cash equivalents and restricted cash at the end of the period in the statement of cash flows	$ 4,295	$ 1,900	$ 3,520

See "Restricted cash" above for further discussion of the nature of the Company's restricted cash and restricted cash equivalent balances.

The following is a reconciliation of the effect on the relevant line items in the consolidated statement of cash flows for the years ended December 31, 2017 and 2016 as a result of adopting this new accounting guidance:

In millions	**As Previously Reported**	**Adjustments**	**As Revised**
Year Ended December 31, 2017			
Acquisitions (net of cash acquired)	$ (1,236)	$ 55	$ (1,181)
Net cash used in investing activities	(2,932)	55	(2,877)
Net decrease in cash, cash equivalents and restricted cash [1]	(1,675)	55	(1,620)
Cash, cash equivalents and restricted cash at the beginning of the period [1]	3,371	149	3,520
Cash, cash equivalents and restricted cash at the end of the period [1]	1,696	204	1,900
Year Ended December 31, 2016			
Acquisitions (net of cash acquired)	(524)	—	(524)
Net cash used in investing activities	(2,470)	—	(2,470)
Net decrease in cash, cash equivalents and restricted cash [1]	912	—	912
Cash, cash equivalents and restricted cash at the beginning of the period [1]	2,459	149	2,608
Cash, cash equivalents and restricted cash at the end of the period [1]	3,371	149	3,520

(1) Prior to the adoption of ASU 2016-18, these financial statement captions excluded restricted cash. The financial statement captions have been renamed to reflect the inclusion of restricted cash subsequent to the adoption of ASU 2016-18 on January 1, 2018.

Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income
In February 2018, the FASB issued ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income ("ASU 2018-02")* . This ASU permits entities to reclassify tax effects stranded in accumulated other comprehensive income as a result of the TCJA to retained

earnings. The guidance states that because the adjustment of deferred income taxes due to the reduction of the historical corporate income tax rate to the newly enacted corporate income tax rate was required to be included in income from continuing operations, the tax effects of items within accumulated other comprehensive income ("stranded tax effects") are not reflected at the appropriate tax rate. During the first quarter of 2018, the Company elected to early adopt this new standard and decreased accumulated other comprehensive income and increased retained earnings in the period of adoption by $7 million due to the change in the United States federal corporate income tax rate enacted in December 2017. See Note 13 ''Other Comprehensive Income (Loss)'' for the impact of the adoption of this guidance on accumulated other comprehensive income for the year ended December 31, 2018 .

New accounting pronouncements not yet adopted

Leases
In February 2016, the FASB issued ASU 2016-02, *Leases* (Topic 842). Lessees will be required to recognize a right-of-use asset and a lease liability for virtually all of their leases (other than leases that meet the definition of a short-term lease). The liability will be equal to the present value of future lease payments. The asset will be based on the liability, subject to adjustment, such as for initial direct costs. For income statement purposes, a dual model was retained, requiring leases to be classified as either operating or finance leases. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). Lessor accounting is similar to the current model, but updated to align with certain changes to the lessee model (e.g., certain definitions, such as initial direct costs, have been updated) and the new revenue recognition standard. The Company adopted this new accounting guidance on January 1, 2019 on a modified retrospective basis. The adoption of this new guidance resulted in an increase in both assets and liabilities of approximately $20 billion as of January 1, 2019. The adoption of this new guidance is not expected to have a material impact on the Company's results of operations or cash flows.

Accounting for Interest Associated with the Purchase of Callable Debt Securities
In March 2017, the FASB issued ASU 2017-08, *Accounting for Interest Associated with the Purchase of Callable Debt Securities (* Topic 310 *).* Under this ASU, premiums on callable debt securities are amortized to the earliest call date rather than to the contractual maturity date. Callable debt securities held at a discount will continue to be amortized to the contractual maturity date. The Company adopted this new accounting guidance on January 1, 2019 on a modified retrospective basis and recorded an immaterial cumulative effect adjustment from accumulated other comprehensive income to retained earnings on the consolidated balance sheet.

Measurement of Credit Losses on Financial Instruments
In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This ASU requires the use of a forward-looking expected loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. The ASU also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract
In August 2018, the FASB issued ASU 2018-15, *Intangibles - Goodwill and other - Internal-Use Software* (Topic 350-40): *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract.* The new standard requires a customer in a cloud computing arrangement that is a service contract to follow internal-use software guidance in Topic 350-40 to determine which implementation costs to capitalize as assets. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. Early adoption is permitted. The Company is currently evaluating the effect the implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the FASB issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Insurance Contracts* (Topic 944). The ASU requires the Company to review cash flow assumptions for its long-duration insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income. The Company is also required to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount the Company's liability for future policy benefits will be based on an estimate of the yield for an upper-medium-grade fixed-income instrument. In addition, the new guidance changes the amortization method for deferred acquisition costs and requires additional disclosures regarding the long duration insurance contract

liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2020. The Company is currently evaluating the effect the implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

2. Acquisition of Aetna

On the Aetna Acquisition Date, the Company acquired 100% of the outstanding shares and voting interests of Aetna for a combination of cash and stock. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion . Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion . The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans. Aetna is a leading health care benefits company that offers a broad range of traditional, voluntary, and consumer-directed health insurance products and related services. The majority of Aetna's operations are included in a new segment, Health Care Benefits. The Health Care Benefits segment is the equivalent of the former Aetna Health Care Segment. The remainder of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Corporate/Other segment. The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care.

The fair value of the consideration transferred on the date of acquisition consisted of the following:

In millions		
Cash	$	48,089
Common stock (274.4 million shares) [(1)]		22,117
Fair value of replacement equity awards for pre-combination services (9.9 million shares) [(2)]		367
Effective settlement of pre-existing relationship [(3)]		(807)
Total consideration transferred	$	69,766

(1) The fair value of the Company's common stock issued as consideration was calculated based on the 327.6 million Aetna common shares outstanding as of November 28, 2018 multiplied by (i) the merger agreement per share exchange ratio and (ii) the volume weighted average price of CVS Health common stock on November 28, 2018 of $80.59 .

(2) The fair value of the replacement equity awards issued by the Company was determined as of the Aetna Acquisition Date. The fair value of the awards attributed to pre-combination services of $367 million is included in the consideration transferred and the fair value of the awards attributed to post-combination services of $232 million has been, or will be, included in the Company's post-combination financial statements as compensation costs.

(3) The purchase price included $807 million of effectively settled liabilities the Company owed to Aetna from their pre-existing pharmacy services relationship.

The transaction has been accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. The following table summarizes the estimated fair values of the assets acquired and liabilities assumed at the date of acquisition:

In millions	
Cash and cash equivalents	$ 6,565
Accounts receivable [1]	4,089
Other current assets	3,896
Investments (current and long-term)	17,991
Goodwill	46,684
Intangible assets	23,746
Other long-term assets	8,282
Total assets acquired	111,253
Health care costs payable	5,359
Other current liabilities	10,026
Debt (current and long-term)	8,098
Deferred income taxes	4,574
Other long-term liabilities	13,101
Total liabilities assumed	41,158
Noncontrolling interests	329
Total consideration transferred	$ 69,766

(1) The fair value of premium receivables acquired is $2.4 billion , with the gross contractual amount being $2.8 billion . The Company expects $424 million of premium receivables to be uncollectible. The fair value of other receivables acquired is $1.7 billion , with the gross contractual amount being $1.8 billion . The Company expects $84 million of other receivables to be uncollectible.

The assessment of fair value is preliminary and is based on information that was available to management at the time the consolidated financial statements were prepared. The most significant open items included the valuation of certain intangible assets and investments, the accounting for income taxes and the accounting for contingencies as management is awaiting additional information to complete its assessment of these matters. Measurement period adjustments will be recorded in the period in which they are determined, as if they had been completed at the acquisition date. The finalization of the Company's purchase accounting assessment could result in changes in the valuation of assets acquired and liabilities assumed, which could be material.

Goodwill

Goodwill represents future economic benefits expected to arise from the Company's expanded presence in the health care industry, the assembled workforce acquired, expected purchasing, medical cost and revenue synergies, as well as operating efficiencies and cost savings. The preliminarily valuation of goodwill was allocated to the Company's business segments as follows:

In millions	
Health Care Benefits	$ 44,484
Pharmacy Services	1,500
Retail/LTC	700
Total goodwill	$ 46,684

Approximately $165 million of goodwill is deductible for income tax purposes.

Intangible Assets
The following table summarizes the preliminary fair values and weighted average useful lives for intangible assets acquired in the Aetna Acquisition, each of which is subject to change as the Company finalizes its purchase accounting:

In millions, except weighted average useful life		Gross Fair Value	Weighted Average Useful Life (years)
Customer relationships [1]	$	13,630	14.4
Standalone Medicare Part D prescription drug plan customer relationship (held for sale)		101	N/A
Technology		1,060	3.0
Provider networks [1]		4,200	20.0
Value of Business Acquired		590	20.0
Trademark (definite-lived)		65	5.0
Trademark (indefinitely-lived)		4,100	N/A
Total intangible assets	$	23,746	15.1

(1) The amortization period for the Company's customer relationships and provider networks includes an assumption of renewal or extension of these arrangements. At the acquisition date, the periods prior to the next renewal or extension for provider networks primarily ranged from one to three years, and the period prior to the next renewal or extension for customer relationships was one year. Any costs related to the renewal or extension of these contracts are expensed as incurred.

Deferred income taxes
The purchase price allocation includes net deferred tax liabilities of $4.6 billion , primarily relating to deferred tax liabilities established on the identifiable acquired intangible assets.

Consolidated results of operations
The Company's consolidated results of operations for the year ended December 31, 2018 , include $5.6 billion of revenues and $146 million of income before income tax provision associated with the results of operations of Aetna from the Aetna Acquisition Date to December 31, 2018 .

During the year ended December 31, 2018 and 2017 , the Company incurred transaction costs of $147 million and $34 million , respectively, associated with the Aetna Acquisition that were recorded within operating expenses.

Unaudited pro forma financial information
The following unaudited pro forma information presents a summary of the Company's combined results of operations for the years ended December 31, 2018 and 2017 as if the Aetna acquisition and the related financing transactions had occurred on January 1, 2017 . The following pro forma financial information is not necessarily indicative of the results of operations as they would have been had the acquisition been effected on the assumed date, nor is it necessarily an indication of trends in future results for a number of reasons, including, but not limited to, differences between the assumptions used to prepare the pro forma information, basic shares outstanding and dilutive equivalents, cost savings from operating efficiencies, potential synergies, and the impact of incremental costs incurred in integrating the businesses.

	Year Ended December 31,			
In millions, except per share data		2018		2017
Total revenues	$	243,398	$	236,000
Income from continuing operations		1,123		6,813
Basic earnings per share from continuing operations attributable to CVS Health	$	0.87	$	5.25
Diluted earnings per share from continuing operations attributable to CVS Health	$	0.86	$	5.21

The pro forma results for the years ended December 31, 2018 and 2017 include adjustments related to the following purchase accounting and acquisition-related items:

- Elimination of intercompany transactions between CVS Health and Aetna;

- Elimination of estimated foregone interest income associated with (i) cash assumed to have been used to partially fund the Aetna Acquisition and (ii) adjusting the amortized cost of Aetna's investment portfolio to fair value as of the completion of the Aetna Acquisition;
- Elimination of historical intangible asset, deferred acquisition cost and capitalized software amortization expense and addition of amortization expense based on the current preliminary values of identified intangible assets;
- Additional interest expense from (i) the long-term debt issued to partially fund the Aetna Acquisition and (ii) the amortization of the fair value adjustment to assumed long-term debt.
- Additional depreciation expense related to the adjustment of Aetna's property and equipment to fair value;
- Adjustments to align CVS Health's and Aetna's accounting policies;
- Elimination of transaction related costs; and
- Tax effects of the adjustments noted above.

3. Investments

On November 28, 2018, the Company completed the Aetna Acquisition. Prior to the Aetna Acquisition Date, the Company's short term investments balance was comprised of certificates of deposit with initial maturities of greater than three months when purchased that mature in less than one year from the balance sheet date. These investments totaled $111 million as of December 31, 2017 and were classified as available for sale. In addition, the Company had $112 million of additional long-term investments as of December 31, 2017 which primarily consisted of cost method and equity method investments. Since the total amount of investments prior to the Aetna Acquisition was not material to the consolidated financial statements, the Company will include additional disclosures for investments on a prospective basis starting from the Aetna Acquisition Date.

Total investments at December 31, 2018 were as follows:

In millions	Current	Long-term	Total
Debt securities available for sale	$ 2,359	$ 12,896	$ 15,255
Mortgage loans	145	1,216	1,361
Other investments	18	1,620	1,638
Total investments	$ 2,522	$ 15,732	$ 18,254

At December 31, 2018 , the Company held investments of $531 million related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. The conversion occurred prior to the Aetna Acquisition. These investments are included in the total investments of large case pensions supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of the Company's business and only support future policy benefits obligations under that group annuity contract.

Debt Securities

Debt securities available for sale at December 31, 2018 were as follows:

In millions	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2018				
Debt securities:				
U.S. government securities	$ 1,662	$ 26	$ —	$ 1,688
States, municipalities and political subdivisions	2,370	30	(1)	2,399
U.S. corporate securities	6,444	61	(16)	6,489
Foreign securities	2,355	31	(3)	2,383
Residential mortgage-backed securities	567	10	—	577
Commercial mortgage-backed securities	594	11	—	605
Other asset-backed securities	1,097	3	(15)	1,085
Redeemable preferred securities	30	—	(1)	29
Total debt securities [1]	$ 15,119	$ 172	$ (36)	$ 15,255

(1) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated results of operations. At December 31, 2018 , debt securities with a fair value of $916 million , gross unrealized capital gains of $12 million and gross unrealized capital losses of $2 million were included in total debt securities, but support experience-rated products.

The fair value of debt securities at December 31, 2018 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	Amortized Cost	Fair Value
Due to mature:		
Less than one year	$ 901	$ 902
One year through five years	5,489	5,521
After five years through ten years	2,973	2,999
Greater than ten years	3,498	3,566
Residential mortgage-backed securities	567	577
Commercial mortgage-backed securities	594	605
Other asset-backed securities	1,097	1,085
Total	$ 15,119	$ 15,255

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2018 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the United States Government. At December 31, 2018 , the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 4.8 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2018 , these securities had an average credit quality rating of AAA and a weighted average duration of 6.3 years.

The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2018 , these securities had an average credit quality rating of AA and a weighted average duration of 1.3 years.

Summarized below are the debt securities the Company held at December 31, 2018 that were in an unrealized capital loss position:

In millions, except number of securities	Number of Securities	Fair Value	Unrealized Losses
Debt securities:			
U.S. government securities	8	$ 26	$ —
States, municipalities and political subdivisions	54	86	1
U.S. corporate securities	1,399	1,431	16
Foreign securities	243	314	3
Residential mortgage-backed securities	45	1	—
Other asset-backed securities	516	528	15
Redeemable preferred securities	14	23	1
Total debt securities	2,279	$ 2,409	$ 36

Since Aetna's investment portfolio was measured at fair value as of the Aetna Acquisition Date, each of the securities in the table above were in an unrealized loss position for less than 12 months. The Company reviewed the securities in the table above and concluded that they are performing assets generating investment income to support the needs of the Company's businesses. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. As of December 31, 2018 , the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2018 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Due to mature:						
Less than one year	$ 21	$ —	$ 308	$ —	$ 329	$ —
One year through five years	36	2	557	5	593	7
After five years through ten years	47	—	492	9	539	9
Greater than ten years	49	—	370	5	419	5
Residential mortgage-backed securities	—	—	1	—	1	—
Other asset-backed securities	4	—	524	15	528	15
Total	$ 157	$ 2	$ 2,252	$ 34	$ 2,409	$ 36

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. From the Aetna Acquisition Date through December 31, 2018 , the Company had the following activity in its mortgage loan portfolio:

In millions	
New mortgage loans	$ 4
Mortgage loans fully-repaid	27
Mortgage loans foreclosed	—

The Company assesses mortgage loans on a regular basis for credit impairments, and annually assign a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, property condition, market trends, creditworthiness of the borrower and deal structure. The vast majority of the Company's mortgage loans fall into categories 2 to 4.

- *Category 1* - Represents loans of superior quality
- *Categories 2 to 4* - Represents loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represents loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the most recent assessments at December 31, 2018 , the Company's mortgage loans were given the following credit quality indicators:

In millions, except credit ratings indicator		
1	$	42
2 to 4		1,301
5 and 6		18
7		—
Total	$	1,361

At December 31, 2018 scheduled mortgage loan principal repayments were as follows:

In millions		
2019	$	145
2020		109
2021		269
2022		228
2023		83
Thereafter		527
Total	$	1,361

Net Investment Income

Sources of net investment income for the year ended December 31, 2018 were as follows:

In millions		
Debt securities	$	637
Mortgage loans		6
Other investments		17
Gross investment income		660
Investment expenses		(3)
Net investment income (excluding net realized capital gains or losses)		657
Net realized capital gains		3
Net investment income [1]	$	660

(1) Net investment income in 2018 includes $4 million related to investments supporting experience-rated products.

The Company's net investment income was $21 million and $20 million in 2017 and 2016 , respectively, relating to interest income on debt securities. The Company did not have any material realized capital gains or losses during 2017 or 2016.

The portion of unrealized capital gains and losses recognized during the year ended December 31, 2018 related to investments in equity securities held as of December 31, 2018 was not material.

Excluding amounts related to experience-rated products, proceeds from the sale of available for sale debt securities and the related gross realized capital gains and losses from the Aetna Acquisition Date through December 31, 2018 were as follows: (1)

In millions		
Proceeds from sales	$	389
Gross realized capital gains		2
Gross realized capital losses		(2)

(1) The proceeds from sales and gross realized capital gains and losses exclude the impact of the sales of short-term debt securities which primarily relate to the Company's investments in mutual funds. These investments were excluded from the disclosed amounts because they represent an immaterial amount of aggregate gross realized capital gains or losses and have a high volume of sales activity.

4. Fair Value

The preparation of the Company's consolidated financial statements in accordance with GAAP requires certain assets and liabilities to be reflected at their fair value, and others on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income (loss) attributable to CVS Health or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of United States Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The Company reviews these prices to ensure they are based on observable market inputs that include, but are not limited to, quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable but not prices (for example, interest rates and credit risks). The Company also reviews the

methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of these prices at December 31, 2018 . The Company's Level 2 debt securities were not material as of December 31, 2017 .

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company obtained one non-binding broker quote for each of these Level 3 debt securities and did not adjust any of these quotes at December 31, 2018 . The total fair value of broker quoted debt securities was $50 million at December 31, 2018 . The Company did not have any Level 3 debt securities as of December 31, 2017. Examples of these broker quoted Level 3 debt securities include certain United States and foreign corporate securities and certain of the Company's commercial mortgage-backed securities as well as other asset-backed securities. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain United States and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would result in a change in the fair value measurement, which may be significant. The Company did not have any Level 3 equity securities as of December 31, 2017.

Derivative Financial Instruments - The fair values of derivative financial instruments are determined using quoted prices in markets that are not active or inputs that are observable for the asset or liability and therefore they are classified as Level 2 in the fair value hierarchy. The fair value of these instruments are recorded in other current assets or accrued expenses, as applicable. The Company did not have any material outstanding derivative financial instruments as of December 31, 2018.

Financial assets and liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2018 and 2017 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2018				
Assets:				
Debt securities:				
U.S. government securities	$ 1,597	$ 91	$ —	$ 1,688
States, municipalities and political subdivisions	—	2,399	—	2,399
U.S. corporate securities	—	6,422	67	6,489
Foreign securities	—	2,380	3	2,383
Residential mortgage-backed securities	—	577	—	577
Commercial mortgage-backed securities	—	605	—	605
Other asset-backed securities	—	1,085	—	1,085
Redeemable preferred securities	—	22	7	29
Total debt securities	1,597	13,581	77	15,255
Equity securities	19	—	54	73
Total	$ 1,616	$ 13,581	$ 131	$ 15,328
December 31, 2017				
Assets:				
Debt securities:				
U.S. corporate securities	$ —	$ 1	$ —	$ 1
Foreign securities	—	110	—	110
Total debt securities	—	111	—	111
Equity securities	—	—	—	—
Derivative financial instruments	—	5	—	5
Total assets	$ —	$ 116	$ —	$ 116
Liabilities:				
Derivative financial instruments	$ —	$ 23	$ —	$ 23

There were no transfers between Levels 1 and 2 during the years ended December 31, 2018 and 2017 . The change in the balance of Level 3 financial assets during 2018 relates to investments acquired in the Aetna Acquisition, which occurred on November 28, 2018. There were no transfers into or out of Level 3 from November 28, 2018 to December 31, 2018.

Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2018 and 2017 were as follows:

	Carrying	Estimated Fair Value			
In millions	**Value**	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2018					
Assets:					
Mortgage loans	$ 1,361	$ —	$ —	$ 1,366	$ 1,366
Equity securities [1]	140	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	382	—	—	357	357
Long-term debt	72,709	71,252	—	—	71,252

	Carrying	Estimated Fair Value			
In millions	**Value**	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2017					
Assets:					
Equity securities [1]	$ 47	N/A	N/A	N/A	N/A
Liabilities:					
Long-term debt	25,726	26,756	—	—	26,756

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies. See Note 1 ‘‘Significant Accounting Policies’’ for additional information regarding the valuation of cost-method investments.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

As part of the Aetna Acquisition, the Company acquired Separate Accounts assets related to large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders’ equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 4 “Fair Value.” Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts’ interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value (“NAV”) per share/unit on the valuation date.

Separate Accounts financial assets as of December 31, 2018 were as follows:

In millions	Level 1	Level 2	Level 3	Total
Debt securities	$ 782	$ 2,500	$ 4	$ 3,286
Equity securities	—	3	—	3
Common/collective trusts	—	404	—	404
Total [1]	$ 782	$ 2,907	$ 4	$ 3,693

(1) Excludes $191 million of cash and cash equivalents and accounts receivable at December 31, 2018 .

During 2018 , the Company had an immaterial amount of Level 3 Separate Accounts financial assets and an immaterial amount of gross transfers of Separate Accounts financial assets into or out of Level 3. During 2018 , there were no transfers of Separate Accounts financial assets between Levels 1 and 2. The Company held no Separate Accounts financial assets as of December 31, 2017 .

Offsetting Financial Assets and Liabilities

Subsequent to the Aetna Acquisition Date, certain financial assets and liabilities are offset in the Company's consolidated balance sheets or are subject to master netting arrangements or similar agreements with the applicable counterparty. Financial assets, including derivative assets, subject to offsetting and enforceable master netting arrangements were $13 million as of December 31, 2018.

5. Goodwill and Other Intangibles

Goodwill

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2018 and 2017 :

In millions	Pharmacy Services	Retail/LTC	Health Care Benefits	Total
Balance at December 31, 2016	$ 21,637	$ 16,612	$ —	$ 38,249
Acquisitions	182	203	—	385
Foreign currency translation adjustments	—	(2)	—	(2)
Impairments	—	(181)	—	(181)
Balance at December 31, 2017	21,819	16,632	—	38,451
Acquisitions	1,569	735	44,484	46,788
Foreign currency translation adjustments	—	(14)	—	(14)
Divestiture of RxCrossroads subsidiary	—	(398)	—	(398)
Impairments	—	(6,149)	—	(6,149)
Balance at December 31, 2018	$ 23,388	$ 10,806	$ 44,484	$ 78,678

Cumulative goodwill impairments as of December 31, 2018 and 2017 were $6.1 billion and $181 million , respectively.

The changes in the carrying amount of goodwill during the years ended December 31, 2018 and 2017 reflect the following activity:

Aetna Acquisition
On November 28, 2018, the Company completed the Aetna Acquisition. The majority of the preliminary valuation of goodwill associated with the Aetna Acquisition was recorded in the Health Care Benefits segment. The Company also allocated a portion of such goodwill to the Retail/LTC and Pharmacy Services segments related to the fair value of identified synergies that are expected to directly benefit those segments. See Note 2 ''Acquisition of Aetna'' for further discussion regarding the Aetna Acquisition.

LTC
During 2018, the LTC reporting unit continued to experience industry wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare and when the 2017 annual goodwill impairment test was performed. These challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a projected deterioration in the financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, higher risk-free interest rates and lower market multiples of peer group companies contributed to the amount of the second quarter 2018 goodwill impairment charge.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill or trade names.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. The updated projections continue to reflect industry wide challenges including lower occupancy rates in skilled nursing facilities, significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, an interim goodwill impairment test was performed during the fourth quarter of 2018. The results of that impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion goodwill impairment charge in the fourth quarter of 2018. In addition to the lower financial projections, lower market multiples of peer group companies also contributed to the amount of the fourth quarter 2018 goodwill impairment charge. The fair value of the LTC reporting unit was determined using a methodology consistent with the methodology described above for the analyses performed during the second and third quarters of 2018.

As of December 31, 2018 , the remaining goodwill balance in the LTC reporting unit is approximately $431 million .

RxCrossroads
During 2017, the Company began pursuing various strategic alternatives for its RxCrossroads reporting unit. In connection with this effort, the Company performed an interim goodwill impairment test in the second quarter of 2017. The results of that impairment test showed that the fair value of the RxCrossroads reporting unit was lower than the carrying value, resulting in a $135 million pre-tax goodwill impairment charge in the second quarter of 2017.

The TCJA was enacted on December 22, 2017 and reduced the United States federal corporate income tax rate from 35% to 21% effective January 1, 2018 (see Note 10 ''Income Taxes''). As a result, the RxCrossroads deferred income tax liabilities were reduced by $47 million and an income tax benefit of $47 million was recorded in the 2017 statement of operations. The reduction in the deferred income tax liabilities increased the carrying value of the RxCrossroads reporting unit by $47 million which triggered an additional goodwill impairment charge in the RxCrossroads reporting unit of $46 million during the fourth quarter of 2017.

On January 2, 2018, the Company sold its RxCrossroads subsidiary to McKesson Corporation for $725 million , at which time the remaining goodwill of this reporting unit was removed from the consolidated balance sheet.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31 :

In millions, except weighted average life	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Life (years)
2018				
Trademarks (indefinitely-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	26,213	(6,349)	19,864	14.8
Technology	1,060	(31)	1,029	3.0
Provider networks	4,200	(19)	4,181	20.0
Value of Business Acquired	590	(7)	583	20.0
Favorable leases and other	1,177	(808)	369	17.1
Total	$ 43,738	$ (7,214)	$ 36,524	15.3
2017				
Trademark (indefinitely-lived)	$ 6,398	$ —	$ 6,398	N/A
Customer contracts/relationships and covenants not to compete	12,341	(5,536)	6,805	15.3
Favorable leases and other	1,190	(763)	427	16.2
Total	$ 19,929	$ (6,299)	$ 13,630	15.4

Amortization expense for intangible assets totaled $1.0 billion , $817 million and $795 million for the years ended December 31, 2018 , 2017 and 2016 , respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2019	$ 2,563
2020	2,350
2021	2,253
2022	1,879
2023	1,844

6. Leases

The Company leases most of its retail and mail order dispensing pharmacy locations, and certain distribution centers and corporate offices under noncancelable operating leases, typically with initial terms of 15 to 25 years and with options that permit renewals for additional periods. The Company also leases certain equipment and other assets under noncancelable operating leases, typically with initial terms of 3 to 10 years.

In December 2015, in connection with the acquisition of the pharmacy and clinic businesses of Target, the Company entered into lease agreements with Target for the pharmacy and clinic space within Target stores. Given that the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings being leased, the Company concluded for accounting purposes that the lease term was the remaining economic life of the buildings. Consequently, most of the individual Target pharmacy and clinic leases are capital leases.

Minimum rent on operating leases is expensed on a straight-line basis over the term of the lease. In addition to minimum rental payments, certain leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred.

The following table is a summary of the Company's net rental expense for operating leases for the years ended December 31:

In millions	2018	2017	2016
Minimum rentals	$ 2,528	$ 2,455	$ 2,418
Contingent rentals	28	29	35
Rental expense	2,556	2,484	2,453
Less: sublease income	(21)	(24)	(24)
Total rental expense, net	$ 2,535	$ 2,460	$ 2,429

The following table is a summary of the future minimum lease payments under capital and operating leases as of December 31, 2018 :

In millions	Capital Leases	Operating Leases [1]
2019	$ 74	$ 2,690
2020	73	2,544
2021	73	2,399
2022	73	2,233
2023	73	2,110
Thereafter	875	16,004
Total future lease payments [2]	1,241	$ 27,980
Less: imputed interest	(599)	
Present value of capital lease obligations	$ 642	

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $164 million due in the future under noncancelable subleases.
(2) The Company leases pharmacy and clinic space from Target. Amounts related to such capital and operating leases are reflected above. Amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.1 billion are not reflected herein since the estimated economic life of the buildings is shorter than the contractual term of the lease arrangement.

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the above table. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. There were no sale-leaseback transactions in 2018. Proceeds from sale-leaseback transactions totaled $265 million and $230 million in 2017 and 2016 , respectively.

7. Health Care Costs Payable

On November 28, 2018 , the Company completed the Aetna Acquisition. Prior to the Aetna Acquisition, the Company's health care costs payable balance was immaterial and related to unpaid pharmacy claims for its stand-alone Medicare Part D PDPs within the Pharmacy Services segment. Accordingly, the Company will include disclosures for health care costs payable for the year ended December 31, 2018. Since the health care costs payable liability related to the Pharmacy Services segment is immaterial, the Company's disclosures will be presented on a consolidated basis and will not be disaggregated between the Pharmacy Services and Health Care Benefits segments.

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements and accruals for state assessments within the Health Care Benefits segment. See Note 1 ''Significant Accounting Policies'' for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company's estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company's liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company's inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company's different claim processing systems and would not

be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency was not included in the disclosures included below.

The following table shows the components of the change in health care costs payable during 2018:

In millions		
Health care costs payable, beginning of the period	$	5
Less: Reinsurance recoverables		—
Health care costs payable, beginning of the period, net		5
Acquisitions, net		5,357
Add: Components of incurred health care costs		
Current year		6,594
Prior years		(42)
Total incurred health care costs [(1)]		6,552
Less: Claims paid		
Current year		6,464
Prior years		260
Total claims paid		6,724
Add: Premium deficiency reserve		16
Health care costs payable, end of period, net		5,206
Add: Reinsurance recoverables		4
Health care costs payable, end of period	$	5,210

(1) Total incurred health care costs for the year ended December 31, 2018 in the table above exclude (i) $16 million related to a premium deficiency reserve for the 2019 coverage year related to Medicaid products, (ii) $4 million of benefit costs recorded in the Health Care Benefits segment that are included in Other Insurance Liabilities on the consolidated balance sheet and (iii) $22 million of benefit costs recorded in the Corporate/Other segment that are included in Other Insurance Liabilities on the consolidated balance sheet.

At December 31, 2018 , the Company's liabilities for IBNR plus expected development on reported claims totaled approximately $ 4.1 billion . Substantially all of the Company's liabilities for IBNR plus expected development on reported claims at December 31, 2018 related to the current calendar year.

Due to the proximity of the Aetna Acquisition Date to December 31, 2018 , the Company did not include disclosures related to incurred and paid claim development from November 28, 2018 to December 31, 2018 . The Company will begin including disclosures related to incurred and paid claim development for the year ended December 31, 2019.

8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31 :

In millions	2018	2017
Short-term debt		
Commercial paper	$ 720	$ 1,276
Long-term debt		
1.9% senior notes due July 2018	—	2,250
2.25% senior notes due December 2018	—	1,250
2.2% senior notes due March 2019	375	—
2.25% senior notes due August 2019	850	850
3.125% senior notes due March 2020	2,000	—
Floating rate notes due March 2020	1,000	—
2.8% senior notes due July 2020	2,750	2,750
3.35% senior notes due March 2021	3,000	—
Floating rate notes due March 2021	1,000	—
4.125% senior notes due May 2021	550	550
2.125% senior notes due June 2021	1,750	1,750
4.125% senior notes due June 2021	500	—
5.45% senior notes due June 2021	600	—
3-Year tranche loan due November 2021	3,000	—
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	—
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	6,000	—
2.8% senior notes due June 2023	1,300	—
4% senior notes due December 2023	1,250	1,250
3.375% senior notes due August 2024	650	650
3.5% senior notes due November 2024	750	—
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	5,000	—
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
6.25% senior notes due June 2027	372	372
4.3% senior notes due March 2028	9,000	—
4.875% senior notes due July 2035	652	652
3.25% senior exchange debentures due December 2035	—	1
6.625% senior notes due June 2036	771	—
6.75% senior notes due December 2037	533	—
4.78% senior notes due March 2038	5,000	—
6.125% senior notes due September 2039	447	447
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	—
4.125% senior notes due November 2042	500	—
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	—
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	—
5.05% senior notes due March 2048	8,000	—
Capital lease obligations	642	670
Other	19	43
Total debt principal	74,265	27,170

Debt premiums	302	28
Debt discounts and deferred financing costs	(1,138)	(196)
	73,429	27,002
Less:		
Short-term debt (commercial paper)	(720)	(1,276)
Current portion of long-term debt	(1,265)	(3,545)
Long-term debt	$ 71,444	$ 22,181

The following is a summary of the Company's required principal debt repayments due during each of the next five years and thereafter, as of December 31, 2018 :

In millions		
2019	$	1,985
2020		5,775
2021		10,427
2022		4,178
2023		8,581
Thereafter		43,319
Total	$	74,265

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company had approximately $720 million and $1.3 billion of commercial paper outstanding at weighted average interest rates of 2.8% and 2.0% as of December 31, 2018 and 2017 , respectively. In connection with its commercial paper program, the Company maintains a $1.75 billion 364 -day unsecured back-up revolving credit facility, which expires on May 16, 2019, a $1.25 billion , five -year unsecured back-up revolving credit facility, which expires on July 1, 2020, a $1.0 billion , five -year unsecured back-up revolving credit facility, which expires on May 18, 2022, and a $2.0 billion , five -year unsecured back-up revolving credit facility, which expires on May 17, 2023. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03% , regardless of usage. As of December 31, 2018 and 2017 , there were no borrowings outstanding under any of the back-up credit facilities.

Bridge Loan Facility
On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a $49.0 billion unsecured bridge loan facility commitment. The Company paid $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statements of operations.

On March 9, 2018, the Company issued an aggregate of $40.0 billion principal amount of unsecured floating rate notes and unsecured fixed rate senior notes, collectively the "2018 Notes". At this time, the bridge loan facility commitment was reduced to $4.0 billion , and the Company paid $8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded $173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018 , which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a $4.0 billion unsecured 364 -day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the $4.0 billion unsecured 364 -day bridge term loan agreement terminated.

Terminated Revolving Credit Facility
On January 3, 2017, the Company entered into a $2.5 billion revolving credit facility. The credit facility allowed for borrowings at various rates that were dependent, in part, on the Company's debt ratings and required the Company to pay a weighted average quarterly facility fee of approximately 0.03% , regardless of usage. The Company terminated this credit facility in May 2017.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2018 was approximately $790 million . As of December 31, 2018 , there were no outstanding advances from the FHLBB.

Long-term Borrowings

2018 Notes
On March 9, 2018, the Company issued the 2018 Notes with an aggregate principal amount of $40.0 billion , for total proceeds of approximately $39.4 billion , net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes are comprised of the following:

In millions		
3.125% senior notes due March 2020	$	2,000
Floating rate notes due March 2020		1,000
3.35% senior notes due March 2021		3,000
Floating rate notes due March 2021		1,000
3.7% senior notes due March 2023		6,000
4.1% senior notes due March 2025		5,000
4.3% senior notes due March 2028		9,000
4.78% senior notes due March 2038		5,000
5.05% senior notes due March 2048		8,000
Total debt principal	$	40,000

Beginning in December 2017 through March 31, 2018, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of long-term debt to fund the Aetna Acquisition.

In connection with the issuance of the 2018 Notes, the Company terminated all outstanding cash flow hedges. In connection with the hedge transactions, the Company received a net amount of $446 million from the hedge counterparties upon termination, which was recorded as a gain, net of tax, of $331 million in accumulated other comprehensive income and will be reclassified as a reduction of interest expense over the life of the 2018 Notes. See Note 13 ‘‘Other Comprehensive Income (Loss)’’ for additional information. The Company expects to reclassify approximately $18 million , net of tax, in gains associated with these cash flow hedges into net income within the next 12 months.

Term Loan Agreement
On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a $5.0 billion term loan agreement. The term loan facility under the term loan agreement consists of a $3.0 billion three -year tranche and a $2.0 billion five -year tranche. The term loan agreement allows for borrowings at various rates that are dependent, in part, on the Company’s debt ratings. In connection with the Aetna Acquisition, the Company borrowed $5.0 billion (a $3.0 billion three -year tranche and a $2.0 billion five -year tranche) under term loan agreement in November 2018. The Company terminated the $2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. As of December 31, 2018, the Company had $3.0 billion outstanding under the three -year tranche of the term loan agreement.

Aetna Related Debt
On the Aetna Acquisition Date, the Company assumed long-term debt with a fair value of $8.1 billion , with stated interest rates ranging from 2.2% to 6.75% . The long-term debt assumed is included in the summary of borrowings table above.

2016 Notes
On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the “ 2016 Notes ”) for total proceeds of approximately $3.5 billion , net of discounts and underwriting fees. The 2016 Notes may be redeemed, in whole at any time, or in part from time to time, at the Company’s option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

Early Extinguishment of Long-Term Debt
On May 16, 2016, the Company announced tender offers for (i) any and all of its 5.75% senior notes due 2017, its 6.60% senior notes due 2019 and its 4.75% senior notes due 2020 (collectively, the “Any and All Notes”) and (ii) up to $1.5 billion aggregate

principal amount of the 4.75% Senior Notes due 2022 issued by its wholly-owned subsidiary Omnicare, the 5.00% Senior Notes due 2024 issued by Omnicare, its 3.875% Senior Notes due 2025, its 6.25% Senior Notes due 2027, its 4.875% Senior Notes due 2035, its 6.125% Senior Notes due 2039 and its 5.75% Senior Notes due 2041 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion . The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. In connection with the purchase of the Notes, the Company paid a premium of $486 million in excess of the debt principal, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on early extinguishment of long-term debt of $542 million , which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. In connection with that redemption, the Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of long-term debt of $101 million , which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

Debt Covenants

The back-up revolving credit facilities, unsecured senior notes, unsecured floating rate notes and term loan agreement contain customary restrictive financial and operating covenants. These covenants do not include a requirement for the acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit rating. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2018 , the Company was in compliance with all of its debt covenants.

9. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2018 , the Company sponsors several active 401(k) savings plans that cover all employees who meet plan eligibility requirements. The Company makes matching contributions consistent with the provisions of the respective plans.

At the participant's option, account balances, including the Company's matching contribution, can be invested without restriction among various investment options under each plan. Two of the defined contribution plans offer the Company's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health 401(k) Plan or Aetna 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under the above defined contribution plans were $334 million , $314 million and $295 million in 2018, 2017 and 2016, respectively. The Company's contributions for the year ended December 31, 2018 include contributions to the Aetna Inc. 401(k) plan subsequent to the Aetna Acquisition Date.

Defined Benefit Pension Plans

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna sponsors a tax-qualified pension plan that was frozen in 2010. Aetna also sponsors a non-qualified supplemental pension plan that was frozen in 2007. Aetna's pension plan benefit obligations and the fair value of plan assets were remeasured as of the Aetna Acquisition Date.

Prior to the Aetna Acquisition, during the year ended December 31, 2017 , the Company settled the pension obligations of its existing two tax-qualified defined benefit pension plans by irrevocably transferring pension liabilities to an insurance company through the purchase of group annuity contracts and through lump sum distributions. These purchases, funded with pension plan assets, resulted in pre-tax settlement losses of $187 million in the year ended December 31, 2017 , related to the recognition of accumulated deferred actuarial losses. The settlement losses were recorded in other expense in the consolidated statement of operations. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans as described in the "Other Postretirement Benefits" section below.

Pension Benefit Obligations and Plan Assets
The following tables outline the change in benefit obligations and plan assets over the specified periods:

In millions	2018	2017
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 131	$ 844
Acquired benefit obligations	5,685	—
Interest cost	25	20
Actuarial loss (gain)	41	(31)
Benefit payments	(41)	(35)
Settlements	—	(667)
Benefit obligation, end of year	$ 5,841	$ 131

In millions	2018	2017
Change in plan assets:		
Fair value of plan assets, beginning of year	$ —	$ 624
Fair value of plan assets acquired	5,709	—
Actual return on plan assets	(17)	32
Employer contributions	12	46
Benefit payments	(41)	(35)
Settlements	—	(667)
Fair value of plan assets, end of year	5,663	—
Funded status	$ (178)	$ (131)

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2018 and 2017 for the pension plans consisted of the following:

In millions	2018	2017
Accrued benefit assets reflected in other assets	$ 147	$ —
Accrued benefit liabilities reflected in accrued expenses	(25)	(21)
Accrued benefit liabilities reflected in other long-term liabilities	(300)	(110)
Net liabilities	$ (178)	$ (131)

Net Periodic Benefit Costs
The components of net periodic benefit cost for the years ended December 31 are shown below:

In millions	2018	2017	2016
Components of net periodic benefit cost:			
Interest cost	$ 25	$ 20	$ 27
Expected return on plan assets	(33)	(20)	(32)
Amortization of net actuarial loss	2	21	32
Settlement losses	—	187	—
Net periodic benefit cost	$ (6)	$ 208	$ 27

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligations and net benefit costs as further detailed below.

Discount Rates - The discount rate for the acquired Aetna plans is determined using a yield curve as of the annual measurement date. Each yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve. The weighted average discount rate for the Aetna pension plans was 4.4% in 2018 .

The Company settled the pension obligations of its existing tax-qualified plans during 2017. The discount rates for determining plan benefit obligations (excluding the terminated qualified plan) were approximately 4.0% , 3.5% and 4.0% in 2018 , 2017 and 2016 , respectively. The discount rate for the terminated qualified plan was 3.1% in 2016.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan by plan basis. The expected long-term rate of return for the acquired Aetna plans was 6.6% in 2018. See "Pension Plan Assets" below for additional details regarding the Aetna pension plan assets as of December 31, 2018.

The Company settled the pension obligations of its existing tax-qualified plans during 2017. The expected long-term rate of return for these plans ranged from 4.0% to 5.5% in both 2017 and 2016 .

Net Actuarial Losses/Gains - Based on the mortality experience of the acquired Aetna pension plans, in 2018 the Company utilized the RP-2014WC Mortality Table with a generation projection of future mortality improvements using Scale MP-2018 for the acquired Aetna plans.

Pension Plan Assets
As of December 31, 2017, the assets in the Company's prior qualified defined benefit pension plans had been fully liquidated to settle all plan obligations through the purchase of group annuity contracts and through lump sum distributions. On November 28, 2018, the Company completed the Aetna Acquisition. At December 31, 2018, the assets of the Aetna pension plan (the "Aetna Pension Plan") primarily include debt and equity securities held in separate accounts, as well as common/collective trusts and real estate investments. The valuation methodologies used to price these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Assets of the Aetna pension plan also include investments in other assets that are carried at fair value. The following is a description of the valuation methodology used to price real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which includes, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Aetna Pension Plan assets with changes in fair value measured on a recurring basis at December 31, 2018 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
Debt securities:				
U.S. government securities	$ 511	$ 38	$ —	$ 549
States, municipalities and political subdivisions	—	147	—	147
U.S. corporate securities	—	1,671	5	1,676
Foreign securities	—	177	—	177
Residential mortgage-backed securities	—	339	—	339
Commercial mortgage-backed securities	—	70	—	70
Other asset-backed securities	—	162	—	162
Redeemable preferred securities	—	6	—	6
Total debt securities	511	2,610	5	3,126
Equity securities:				
U.S. Domestic	744	—	—	744
International	356	—	—	356
Domestic real estate	30	—	—	30
Total equity securities	1,130	—	—	1,130
Other investments:				
Real estate	—	—	425	425
Common/collective trusts [(1)]	—	253	—	253
Derivatives	—	2	—	2
Total other investments	—	255	425	680
Total pension investments [(2)]	$ 1,641	$ 2,865	$ 430	$ 4,936

(1) The assets in the underlying funds of common/collective trusts consist of $109 million of equity securities and $144 million of debt securities.
(2) Excludes $98 million of cash and cash equivalents, $465 million of private equity limited partnership investments and $164 million of hedge fund limited partnership investments as the amounts are carried at fair value.

The change in the balance of pension plan assets during 2018 relates to investments acquired in the Aetna Acquisition, which occurred on November 28, 2018. There was an immaterial amount of transfers into or out of Level 3 from November 28, 2018 to December 31, 2018.

The Aetna Pension Plan invests in a diversified mix of assets intended to maximize long-term returns while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing Aetna Pension Plan's liability characteristics. Complementary investment styles and techniques are utilized by multiple professional investment firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2018 , target investment allocations for the Aetna Pension Plan were: 31% in equity securities, 57% in debt securities, 6% in real estate, 3% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the Aetna Pension Plan's Benefit Finance Committee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows
The Company generally contributes to its tax-qualified pension plans based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the non-qualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed $12 million , $46 million and $25 million to the pension plans during 2018 , 2017 and 2016 , respectively. No contributions are required for the Aetna Pension Plan in 2019. The Company expects to make an immaterial amount of contributions for all other pension plans in 2019. The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension plan benefit obligation as of December 31, 2018 :

In millions		
2019	$	375
2020		387
2021		411
2022		387
2023		391
2024-2028		1,916

Multiemployer Pension Plans
The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following aspects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. Total Company contributions to multiemployer pension plans were $18 million , $17 million and $15 million in 2018 , 2017 and 2016 , respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. On November 28, 2018, the Company completed the Aetna Acquisition. Aetna also sponsors OPEB plans that provide certain health care and life insurance benefits for retired employees. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2018 and 2017 , the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $228 million and $25 million , respectively. Net periodic benefit costs related to these other postretirement benefits were $2 million in 2018 , and $1 million in both 2017 and 2016 .

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the other postretirement benefit obligation as of December 31, 2018 :

In millions		
2019	$	17
2020		17
2021		17
2022		16
2023		16
2024-2028		76

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to

certain employees who meet eligibility requirements. Total Company contributions to multiemployer health and welfare plans were $58 million , $58 million and $52 million in 2018 , 2017 and 2016 , respectively.

10. Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31:

In millions	**2018**	**2017**	**2016**
Current:			
Federal	$ 1,480	$ 2,594	$ 2,803
State	499	464	511
	1,979	3,058	3,314
Deferred:			
Federal	22	(1,435)	5
State	1	14	(2)
	23	(1,421)	3
Total	$ 2,002	$ 1,637	$ 3,317

The TCJA was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective on January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion for year ended December 31, 2017. The Company completed its assessment of the TCJA's final impact in December 2018 and recorded an additional tax benefit of approximately $100 million in the year ended December 31, 2018.

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31:

	2018	**2017**	**2016**
Statutory income tax rate	21.0 %	35.0 %	35.0 %
State income taxes, net of federal tax benefit	27.7	4.1	4.1
Effect of the Tax Cuts and Jobs Act	(7.1)	(18.3)	—
Health insurer fee	2.2	—	0.2
Goodwill impairments	89.5	0.8	—
Sale of subsidiary	5.0	—	—
Other	4.1	(1.8)	(0.9)
Effective income tax rate	142.4 %	19.8 %	38.4 %

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31:

In millions	**2018**	**2017**
Deferred income tax assets:		
Lease and rents	$ 277	$ 291
Inventory	28	31
Employee benefits	243	246
Allowance for doubtful accounts	243	187
Retirement benefits	130	40
Net operating loss and capital loss carryforwards	529	101
Deferred income	104	93
Insurance reserves	467	—
Investments	11	—
Other	242	18
Valuation allowance	(520)	(77)
Total deferred income tax assets	1,754	930
Deferred income tax liabilities:		
Depreciation and amortization	(9,431)	(3,926)
Total deferred income tax liabilities	(9,431)	(3,926)
Net deferred income tax liabilities	$ (7,677)	$ (2,996)

The increase in net deferred income tax liabilities is mainly due to the Aetna Acquisition. As of December 31, 2018, the Company has net operating and capital loss carryovers of approximately $529 million . The Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and recent results of operations. The Company established a valuation allowance of $520 million because it does not consider it more likely than not that these deferred tax assets will be recovered.

A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows:

In millions	**2018**	**2017**	**2016**
Beginning balance	$ 344	$ 307	$ 338
Additions based on tax positions related to the current year	1	62	68
Additions based on tax positions related to prior years	324	32	70
Reductions for tax positions of prior years	(5)	(28)	(100)
Expiration of statutes of limitation	(2)	(10)	(22)
Settlements	(1)	(19)	(47)
Ending balance	$ 661	$ 344	$ 307

The increase in the balance of unrecognized tax benefits in 2018 compared to 2017 and 2016 is mainly due to the Aetna Acquisition.

The Company and most of its subsidiaries are subject to United States federal income tax as well as income tax of numerous state and local jurisdictions. The Company is a participant in the Compliance Assurance Process, which is a program made available by the Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax return. The IRS has substantially completed its examinations of the Company's 2015, 2016 and 2017 consolidated United States federal income tax returns. The IRS is currently examining the Company's 2018 consolidated United States federal income tax return.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2018 , no examination has resulted in any proposed adjustments that would result in a material change to the Company's results of operations, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2012. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2019, but the change in the balance of the Company's uncertain tax positions is projected to be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in the income tax provision. The Company accrued interest expense of approximately $19 million , $11 million and $10 million in 2018 , 2017 and 2016 , respectively. The Company had approximately $80 million and $34 million accrued for interest and penalties as of December 31, 2018 and 2017 , respectively.

As of December 31, 2018 , the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $597 million , after considering the federal benefit of state income taxes.

11. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of the Company's Board of Directors (the "Board"). The ICP allows for a maximum of 32 million shares of CVS Health common stock to be reserved and available for grants. Prior to the acquisition of Aetna in 2018, the ICP was the only compensation plan under which the Company granted stock options, restricted stock and other stock-based awards to its employees, with the exception of the Company's Employee Stock Purchase Plan ("ESPP"). As of December 31, 2018 , there were approximately 26 million shares of CVS Health common stock available for future grants under the ICP.

As of the Aetna Acquisition Date, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health common stock reserved and available for issuance pursuant to future awards. As of December 31, 2018 , there were approximately 32 million shares of CVS Health common stock available for future grants under the SIP.

Stock-based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for each of the respective periods:

In millions	2018	2017	2016
Stock options and stock appreciation rights ("SARs") (1)(2)	$ 70	$ 65	$ 79
Restricted stock units and performance stock units (2)	210	169	143
Total stock-based compensation	$ 280	$ 234	$ 222

(1) Includes the ESPP.
(2) Stock-based compensation for the year ended December 31, 2018 includes $14 million and $27 million associated with accelerated vesting of SARs and restricted stock replacement awards, respectively, issued to Aetna employees who were terminated subsequent to the acquisition.

ESPP

The ESPP provides for the purchase of up to 30 million shares of common stock. Under the ESPP, beginning in 2016, eligible employees could purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. Prior to 2016, the purchase price was equal

to 85% of the lower of the fair market value on the first day or the last day of the offering period. During 2018 , approximately two million shares of common stock were purchased under the provisions of the ESPP at an average price of $61.40 per share. As of December 31, 2018 , approximately 9 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for each of the respective periods:

	2018	2017	2016
Dividend yield (1)	1.45%	1.24%	0.88%
Expected volatility (2)	28.02%	22.70%	20.64%
Risk-free interest rate (3)	1.87%	0.86%	0.45%
Expected life (in years) (4)	0.5	0.5	0.5
Weighted-average grant date fair value	$ 12.26	$ 13.01	$ 14.98

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is based on the historical volatility of the Company's daily stock market prices over the previous six month period.
(3) The risk-free interest rate is based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).
(4) The expected life is based on the semi-annual purchase period.

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are set at the time of grant by the MP&D Committee. For each restricted stock unit and performance share stock granted, employees receive one share of common stock, net of taxes, at the end of the vesting period. Compensation cost is recorded based on the market price of the Company's common stock on the grant date and is recognized on a straight-line basis over the requisite service period. On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna performance stock unit and restricted stock unit awards as of the Aetna Acquisition Date were converted into replacement CVS Health restricted stock awards.

As of December 31, 2018 , there was $491 million of total unrecognized compensation cost related to Company restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.01 years. The total fair value of restricted shares vested during 2018 , 2017 and 2016 was $262 million , $175 million and $218 million , respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2018 :

Units in thousands	Units	Weighted Average Grant Date Fair Value
Unvested at beginning of year	5,014	$ 86.92
Granted	10,185	$ 73.18
Vested	(3,757)	$ 68.85
Forfeited	(437)	$ 76.92
Unvested at end of year	11,005	$ 76.18

Stock Options and SARs

All stock option grants are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model and stock-based compensation is recognized on a straight-line basis over the requisite

service period. Stock options granted generally become exercisable over a four -year period from the grant date. Stock options generally expire seven years after the grant date.

On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna SARs outstanding as of the Aetna Acquisition Date were converted into replacement CVS Health SARs. The replacement SARs granted will be settled in CVS Health common stock, net of taxes, based on the appreciation of the stock price on the exercise date over the market price on the date of grant. The fair value of SARs is estimated using the Black-Scholes option pricing model and stock-based compensation is recognized on a straight-line basis over the requisite service period. SARs generally become exercisable over a three -year period from the grant date. SARs generally expire ten years after the grant date.

The following table is a summary of stock option and SAR activity that occurred for the years ended December 31, 2018 , 2017 and 2016 :

In millions	**2018**	**2017**	**2016**
Cash received from stock options exercised (including ESPP)	$ 242	$ 329	$ 296
Payments for taxes for net share settlement of equity awards	97	71	72
Intrinsic value of stock options and SARs exercised	79	176	244
Fair value of stock options and SARs vested	324	341	298

The fair value of each stock option and SAR is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2018	**2017**	**2016**
Dividend yield (1)	2.76%	2.56%	1.62%
Expected volatility (2)	21.27%	18.39%	17.22%
Risk-free interest rate (3)	2.77%	1.77%	1.24%
Expected life (in years) (4)	4.8	4.1	4.2
Weighted-average grant date fair value	$ 24.55	$ 9.43	$ 13.00

(1) The dividend yield is based on annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is estimated using the Company's historical volatility over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.
(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.
(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option holder exercise experience.

As of December 31, 2018 , unrecognized compensation expense related to unvested stock options and SARs totaled $58 million , which the Company expects to be recognized over a weighted-average period of 1.2 years. After considering anticipated forfeitures, the Company expects approximately 11 million of the unvested stock options and SARs to vest over the requisite service period.

The following table is a summary of the Company's stock option and SAR activity for the year ended December 31, 2018

In thousands, except weighted average exercise price and remaining contractual term	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at December 31, 2017	20,530	$ 75.32		
Granted	7,144	$ 51.06		
Exercised	(2,993)	$ 44.62		
Forfeited	(908)	$ 86.97		
Expired	(864)	$ 81.79		
Outstanding at December 31, 2018	22,909	$ 71.15	4.08	$ 165,245
Exercisable at December 31, 2018	11,436	$ 72.69	2.23	$ 73,784
Vested at December 31, 2018 and expected to vest in the future	22,532	$ 71.18	4.05	$ 163,596

12. Shareholders' Equity

Share Repurchases

The following share repurchase programs have been authorized by the Board:

In billions Authorization Date	Authorized	Remaining as of December 31, 2018
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2014 Repurchase Program was completed during the second quarter of 2017. The 2016 Repurchase Program can be modified or terminated by the Board at any time.

2018 Activity
During the year ended December 31, 2018 , the Company did not repurchase any shares of common stock pursuant to the 2016 Repurchase Program.

2017 Activity
Pursuant to the authorization under the 2014 Repurchase Program, in August 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion . Upon payment of the $3.6 billion purchase price in January 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares, which were placed into treasury stock in January 2017. The ASRs were accounted for as an initial treasury stock transaction for $2.9 billion and a forward contract for $0.7 billion . In April 2017, the Company received an additional 9.9 million shares of common stock, representing the remaining 20% of the $3.6 billion notional amount of the ASRs, thereby concluding the ASRs. The additional 9.9 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in April 2017.

During the year ended December 31, 2017, the Company repurchased an aggregate of 55.4 million shares of common stock for approximately $4.4 billion under the 2014 and 2016 Repurchase Programs.

2016 Activity
Pursuant to the authorization under the 2014 Repurchase Program, in December 2015, the Company entered into a $725 million fixed dollar ASR with Barclays. Upon payment of the $725 million purchase price in December 2015, the Company received a number of shares of its common stock equal to 80% of the $725 million notional amount of the ASR or approximately 6.2

million shares, which were placed into treasury stock in December 2015. The ASR was accounted for as an initial treasury stock transaction for $580 million and a forward contract for $145 million . The forward contract was classified as an equity instrument and was recorded within capital surplus on the consolidated balance sheet. In January 2016, the Company received an additional 1.4 million shares of common stock, representing the remaining 20% of the $725 million notional amount of the ASR, thereby concluding the ASR. The additional 1.4 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in January 2016.

During the year ended December 31, 2016, the Company repurchased an aggregate of 47.5 million shares of common stock for approximately $4.5 billion under the 2014 Repurchase Program.

Dividends

The quarterly cash dividend declared by the Board was $0.50 per share in 2018 and 2017. CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna's insurance business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. The Company's HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP.

The combined statutory net income for the year ended December 31, 2018 (which includes Aetna and its subsidiaries from November 28, 2018 to December 2018) was not material. The combined statutory capital and surplus at December 31, 2018 of the Company's insurance and HMO subsidiaries was approximately $11.1 billion . From November 28, 2018 to December 31, 2018 , the Company's insurance and HMO subsidiaries paid $909 million of gross dividends to the Company.

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2018 , these amounts were as follows:

In millions		
Estimated minimum statutory surplus required by regulators	$	5,358
Investments on deposit with regulatory bodies		630
Estimated maximum dividend distributions permitted in 2019 without prior regulatory approval		584

Noncontrolling Interests

At December 31, 2018 , noncontrolling interests were $318 million primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders ' equity.

13. Other Comprehensive Income (Loss)

Shareholders' equity included the following activity in accumulated other comprehensive income (loss) in 2018 , 2017 and 2016 :

	At December 31,		
In millions	**2018**	**2017**	**2016**
Net unrealized investment gains (losses):			
Beginning of year balance	$ —	$ —	$ —
Other comprehensive income before reclassifications *($132 pretax)*	97	—	—
Amounts reclassified from accumulated other comprehensive income *($1 pretax)* (1)	—	—	—
Other comprehensive income	97	—	—
End of year balance	97	—	—
Foreign currency translation adjustments:			
Beginning of year balance	(129)	(127)	(165)
Other comprehensive income (loss)	(29)	(2)	38
Other comprehensive income (loss)	(29)	(2)	38
End of year balance	(158)	(129)	(127)
Net cash flow hedges:			
Beginning of year balance	(15)	(5)	(7)
Adoption of new accounting standard (4)	(3)	—	—
Other comprehensive income (loss) before reclassifications *($465, $(18) and $0 pretax)*	344	(11)	—
Amounts reclassified from accumulated other comprehensive loss *($(19), $2 and $3 pretax)* (2)	(14)	1	2
Other comprehensive income (loss)	330	(10)	2
End of year balance	312	(15)	(5)
Pension and OPEB plans:			
Beginning of year balance	(21)	(173)	(186)
Adoption of new accounting standard (4)	(4)	—	—
Other comprehensive loss before reclassifications *($(178), $0 and $0 pretax)*	(132)	—	—
Amounts reclassified from accumulated other comprehensive loss *($11, $249 and $21 pretax)* (3)	8	152	13
Other comprehensive income (loss)	(124)	152	13
End of year balance	(149)	(21)	(173)
Total beginning of year accumulated other comprehensive loss	(165)	(305)	(358)
Adoption of new accounting standard (4)	(7)	—	—
Total other comprehensive income	274	140	53
Total end of year accumulated other comprehensive income (loss)	$ 102	$ (165)	$ (305)

(1) Amounts reclassified from accumulated other comprehensive income for debt securities are included in net investment income within the consolidated statements of operations.
(2) Amounts reclassified from accumulated other comprehensive loss for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations.
(3) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other (income) expense in the consolidated statements of operations.
(4) See Note 1 ''Significant Accounting Policies'' for additional information on the adoption of ASU 2018-02 during the first quarter of 2018.

14. Earnings Per Share

Earnings (loss) per share is computed using the two-class method. For periods in which the Company reports net income, diluted earnings per share is determined by using the weighted average number of common and dilutive common equivalent shares outstanding during the period, unless the effect is antidilutive. Due to the loss from continuing operations attributable to CVS Health in the year ended December 31, 2018 , 3 million potentially dilutive common equivalent shares were excluded from

the calculation of diluted earnings per share, as the impact of these shares was antidilutive. In addition, options to purchase 13.2 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the year ended December 31, 2018 because the exercise prices of the options were greater than the average market price of the common shares and, therefore, the effect would be antidilutive. For the same reason, options to purchase 10.4 million and 6.7 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the years ended December 31, 2017 and 2016 , respectively.

The following is a reconciliation of basic and diluted earnings (loss) per share from continuing operations for the years ended December 31:

In millions, except per share amounts	**2018**	**2017**	**2016**
Numerator for earnings per share calculation:			
Income (loss) from continuing operations	$ (596)	$ 6,631	$ 5,320
Income allocated to participating securities	(3)	(24)	(27)
Net (income) loss attributable to noncontrolling interests	2	(1)	(2)
Income (loss) from continuing operations attributable to CVS Health	$ (597)	$ 6,606	$ 5,291
Denominator for earnings per share calculation:			
Weighted average shares, basic	1,044	1,020	1,073
Effect of dilutive securities	—	4	6
Weighted average shares, diluted	1,044	1,024	1,079
Earnings (loss) per share from continuing operations:			
Basic	$ (0.57)	$ 6.48	$ 4.93
Diluted	$ (0.57)	$ 6.45	$ 4.91

15. Reinsurance

The Company utilizes reinsurance agreements primarily to reduce required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans to a subsidiary of WellCare, effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare has ceded to Aetna 100% of the insurance risk related to the divested standalone Medicare Part D prescription drug plans for the 2019 PDP plan year.

In January 2019, the Company entered into two four -year reinsurance agreements with an unrelated reinsurer that allowed it to reduce required capital and provided collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2018 were as follows:

In millions	
Reinsurer	
Hartford Life and Accident Insurance Company	$ 3,470
Lincoln Life & Annuity Company of New York	424
Constitution Life	320
VOYA Retirement Insurance and Annuity Company	186
All Other	141
Total	$ 4,541

Direct, assumed and ceded premiums earned for the year ended December 31, 2018 were as follows:

In millions		
Direct	$	8,365
Assumed		38
Ceded		(219)
Net premiums	$	8,184

The impact of reinsurance on benefit costs for the year ended December 31, 2018 was as follows:

In millions		
Direct	$	6,773
Assumed		32
Ceded		(211)
Net benefit costs	$	6,594

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. These contracts were entered into to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements for certain portions of its group term life insurance and group accidental death and dismemberment insurance businesses and certain portions of the Health Care Benefits segment's Medicare Advantage and group Commercial Insured businesses. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2018 .

16. Commitments and Contingencies

Guarantees

The Company has the following significant guarantee arrangements at December 31, 2018 :

- ASC Claim Funding Accounts - The Company has arrangements with certain banks for the processing of claim payments for its ASC customers. The banks maintain accounts to fund claims of the Company's ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, the Company guarantees that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million . The Company can limit its exposure to these guarantees by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.
- Separate Accounts Assets - Certain Separate Accounts assets associated with the large case pensions business in the Corporate/Other segment represent funds maintained as a contractual requirement to fund specific pension annuities that the Company has guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $1.4 billion at December 31, 2018 . See Note 1 ''Significant Accounting Policies'' for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2018 exceeded the value of the guaranteed benefit obligation. As a result, the Company was not required to maintain any additional liability for its related guarantees at December 31, 2018 .

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed

to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of December 31, 2018, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens ‘n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company’s assessments generally are based on a formula relating to the Company’s health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, “Penn Treaty”) in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, Aetna recorded a discounted estimated liability and expense of $231 million pretax for its estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The Company did not record an asset for expected premium tax offsets for its in force business at December 31, 2018, as the amount was not material. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company’s results of operations, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company’s experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The total guaranty fund assessments liability as of December 31, 2018 was $90 million and was recorded in accrued expenses on the consolidated balance sheet.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company’s accruals for outstanding legal matters are material individually or in the aggregate to the Company’s financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company’s retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. The Company is defending itself against these claims.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The *Corcoran* plaintiffs have appealed the District Court's decision to the Ninth Circuit. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, moved for judgment on the pleadings, filed a counterclaim and moved the case to Mississippi Circuit Court. The Company's motion for judgment on the pleadings remains pending. The Company is defending itself against these claims.

Manufacturer's Rebate Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning manufacturer's rebates that the Company has negotiated.

Bewley, et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants' motions. The Company is defending itself against these claims.

Klein , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation* . The Company is defending itself against these claims.

In April 2017, the Company received a CID from the Attorney General of Washington requesting documents and information regarding pricing and rebates for insulin products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin pricing. The Office of the Attorney General of Washington has notified the Company that information provided in response to the Washington Attorney General's CID will be shared with the Attorneys General of California, Florida, Minnesota, New Mexico, the District of Columbia and Mississippi. In July 2017, the Company received a CID from the Attorney General of Minnesota requesting documents and information regarding pricing and rebates for insulin and epinephrine products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin and epinephrine pricing. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. Fewer than 100 similar cases that name the Company as a defendant in some capacity are pending in state courts. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). For several of these audits, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served Omnicare with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Company pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Company pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, Omnicare received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, Omnicare also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the arbitrator awarded the claimant hospitals approximately $150 million . The Company is defending itself against the claimant hospitals' claims and has appealed the arbitrator's decision.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's results of operations, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's results of operations, cash flows or financial condition.

Other Legal and Regulatory Proceedings .

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in the Company's Commercial Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's results of operations. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the

Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company currently has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information for which results of operations are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services, Retail/LTC and Health Care Benefits segments' performance based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The chief operating decision maker does not use total assets by segment to make decisions regarding resources. Therefore the total asset disclosure by segment has not been included. See Note 1 ''Significant Accounting Policies'' for a description of the Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other segments and related significant accounting policies.

In 2018 , 2017 and 2016 , approximately 9.8% , 12.3% and 11.7% , respectively, of the Company's consolidated revenues were from Aetna, a Pharmacy Services segment client. On November 28, 2018, the Company completed the Aetna Acquisition. Subsequent to the Aetna Acquisition, transactions with Aetna will continue to be reported within the Pharmacy Services segment, but are eliminated in the Company's consolidated financial statements.

Effective for the first quarter of 2019, the Company will realign the composition of its segments to correspond with changes to its operating model. As a result of this realignment, the Company's Silverscript PDP will move from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company will move Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment.

In millions	Pharmacy Services [1][2]	Retail/ LTC [2]	Health Care Benefits [2]	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2018:						
Revenues from customers	$ 134,115	$ 83,989	$ 5,504	$ 4	$ (29,693)	$ 193,919
Net investment income [3]	13	—	45	602	—	660
Total revenues	134,128	83,989	5,549	606	(29,693)	194,579
Operating income (loss) [4][5]	4,699	620	276	(805)	(769)	4,021
Depreciation and amortization	712	1,698	170	138	—	2,718
Additions to property and equipment	326	1,350	46	401	—	2,123
2017:						
Revenues from customers	130,596	79,398	—	—	(25,229)	184,765
Net investment income	5	—	—	16	—	21
Total revenues [7]	130,601	79,398	—	16	(25,229)	184,786
Operating income (loss) [4][5][7]	4,657	6,558	—	(936)	(741)	9,538
Depreciation and amortization	712	1,651	—	116	—	2,479
Additions to property and equipment	311	1,398	—	340	—	2,049
2016:						
Revenues from customers	119,963	81,100	—	—	(23,537)	177,526
Net investment income	2	—	—	18	—	20
Total revenues [7]	119,965	81,100	—	18	(23,537)	177,546
Operating income (loss) [4][5][6][7]	4,570	7,437	—	(900)	(721)	10,386
Depreciation and amortization	714	1,642	—	119	—	2,475
Additions to property and equipment	295	1,732	—	252	—	2,279

(1) Total revenues of PSS include approximately $11.4 billion , $10.8 billion and $10.5 billion of Retail Co-Payments for 2018 , 2017 and 2016 , respectively. See Note 1 ‘‘Significant Accounting Policies’’ for additional information about Retail Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between PSS and RLS for 2018, 2017 and 2016. Effective November 28, 2018, intersegment eliminations also relate to intersegment revenue generating activities that occur between HCBS, PSS and/or RLS.

(3) Corporate/Other segment net investment income for 2018 includes interest income of $536 million related to the proceeds of the $40 billion 2018 Notes. This amount is for the period prior to the close of the Aetna Acquisition, which occurred on November 28, 2018.

(4) RLS operating income for 2018 , 2017 and 2016 includes $7 million , $34 million and $281 million , respectively, of acquisition-related integration costs. The integration costs in 2018 and 2017 are related to the acquisition of Omnicare. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target. RLS operating income for 2018 and 2017 also includes goodwill impairment charges of $6.1 billion related to the LTC reporting unit and $181 million related to the RxCrossroads reporting unit, respectively. In addition, RLS operating income for 2017 and 2016 includes $215 million and $34 million , respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company’s enterprise streamlining initiative. RLS operating income for 2018 also includes a $43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment and an $86 million loss on the divestiture of the Company’s RxCrossroads subsidiary.

(5) Corporate/Other segment operating loss for 2018 , 2017 and 2016 includes $485 million , $40 million and $10 million , respectively, of divestiture and acquisition-related transaction and integration costs included in operating expenses in the consolidated statements of operations. The transaction and integration costs in 2018 are related to the acquisitions of Aetna and Omnicare. The transaction and integration costs in 2017 are related to the acquisitions of Aetna and Omnicare and the divestiture of RxCrossroads. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.

(6) PSS operating income for 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

(7) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within total revenues to conform with insurance company presentation which increased total revenues and operating income by $21 million and $20 million in 2017 and 2016, respectively.

In conjunction with the Company's implementation of a new enterprise resource planning system in the first quarter of 2018, the Company changed the manner in which certain shared functional costs are allocated to its reportable segments.

Additionally, in connection with the Aetna Acquisition on November 28, 2018, the Company reclassified interest income from interest expense, net to net investment income within revenues to conform with insurance company presentation. Segment financial information for the years ended December 31, 2017 and 2016 , have been retrospectively adjusted to reflect this change to the Company's cost allocation methodology and net investment income presentation as shown below:

	Year Ended December 31, 2017				
In millions	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Revenues, as previously reported	$ 130,596	$ 79,398	$ —	$ (25,229)	$ 184,765
Adjustments	5	—	16	—	21
Revenues, as adjusted	$ 130,601	$ 79,398	$ 16	$ (25,229)	$ 184,786
Cost of products sold [1]	$ 121,746	$ 56,081	$ —	$ (24,417)	$ 153,410
Adjustments	53	(15)	—	—	38
Cost of products sold	$ 121,799	$ 56,066	$ —	$ (24,417)	$ 153,448
Benefit costs [1]	$ 2,810	$ —	$ —	$ —	$ 2,810
Adjustments	—	—	—	—	—
Benefit costs	$ 2,810	$ —	$ —	$ —	$ 2,810
Operating expenses, as previously reported	$ 1,285	$ 16,848	$ 966	$ (71)	$ 19,028
Adjustments	50	(74)	(14)	—	(38)
Operating expenses, as adjusted	$ 1,335	$ 16,774	$ 952	$ (71)	$ 18,990
Operating income (loss), as previously reported	$ 4,755	$ 6,469	$ (966)	$ (741)	$ 9,517
Adjustments	(98)	89	30	—	21
Operating income (loss), as adjusted	$ 4,657	$ 6,558	$ (936)	$ (741)	$ 9,538

(1) The total of cost of products sold and benefit costs previously was reported as cost of revenues.

	Year Ended December 31, 2016				
In millions	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Revenues, as previously reported	$ 119,963	$ 81,100	$ —	$ (23,537)	$ 177,526
Adjustments	2	—	18	—	20
Revenues, as adjusted	$ 119,965	$ 81,100	$ 18	$ (23,537)	$ 177,546
Cost of products sold [1]	$ 111,883	$ 57,362	$ —	$ (22,755)	$ 146,490
Adjustments	66	(23)	—	—	43
Cost of products sold	$ 111,949	$ 57,339	$ —	$ (22,755)	$ 146,533
Benefit costs [1]	$ 2,179	$ —	$ —	$ —	$ 2,179
Adjustments	—	—	—	—	—
Benefit costs	$ 2,179	$ —	$ —	$ —	$ 2,179
Operating expenses, as previously reported	$ 1,225	$ 16,436	$ 891	$ (61)	$ 18,491
Adjustments	42	(112)	27	—	(43)
Operating expenses, as adjusted	$ 1,267	$ 16,324	$ 918	$ (61)	$ 18,448
Operating income (loss), as previously reported	$ 4,676	$ 7,302	$ (891)	$ (721)	$ 10,366
Adjustments	(106)	135	(9)	—	20
Operating income (loss), as adjusted	$ 4,570	$ 7,437	$ (900)	$ (721)	$ 10,386

(1) The total of cost of products sold and benefit costs previously was reported as cost of revenues.

18. Quarterly Financial Information (Unaudited)

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2018:					
Total revenues [1]	$ 45,743	$ 46,922	$ 47,490	$ 54,424	$ 194,579
Operating income (loss) [1]	1,996	(1,373)	2,574	824	4,021
Income (loss) from continuing operations	998	(2,562)	1,390	(422)	(596)
Net income (loss) attributable to CVS Health	998	(2,563)	1,390	(419)	(594)
Per common share data:					
Basic earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Diluted earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Dividends per common share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of $50 million , $214 million and $221 million was made for the first, second and third quarters of 2018, respectively, to increase revenues and increase interest expense.

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2017:					
Total revenues [1]	$ 44,520	$ 45,689	$ 46,186	$ 48,391	$ 184,786
Operating income [1]	1,799	2,121	2,504	3,114	9,538
Income from continuing operations	962	1,097	1,285	3,287	6,631
Net income attributable to CVS Health	952	1,098	1,285	3,287	6,622
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 0.93	$ 1.07	$ 1.26	$ 3.23	$ 6.48
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.23	$ 6.47
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.22	$ 6.45
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.22	$ 6.44
Dividends per common share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of $6 million , $4 million , $5 million and $6 million was made for the first, second, third and fourth quarters of 2017, respectively, to increase revenues and increase interest expense.

Five-Year Financial Summary

In millions, except per share amounts	2018 [2]	2017	2016	2015	2014
Statement of operations data:					
Total revenues [1]	$ 194,579	$ 184,786	$ 177,546	$ 153,311	$ 139,382
Operating income [1]	4,021	9,538	10,386	9,496	8,837
Income (loss) from continuing operations	(596)	6,631	5,320	5,230	4,645
Net income (loss) attributable to CVS Health	(594)	6,622	5,317	5,237	4,644
Per common share data:					
Basic earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.48	$ 4.93	$ 4.65	$ 3.98
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —	$ 0.01	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.47	$ 4.93	$ 4.66	$ 3.98
Diluted earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.45	$ 4.91	$ 4.62	$ 3.96
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —	$ 0.01	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.44	$ 4.90	$ 4.63	$ 3.96
Dividends per common share	$ 2.00	$ 2.00	$ 1.70	$ 1.40	$ 1.10
Balance sheet and other data:					
Total assets	$ 196,456	$ 95,131	$ 94,462	$ 92,437	$ 73,202
Long-term debt	$ 71,444	$ 22,181	$ 25,615	$ 26,267	$ 11,630
Total shareholders' equity	$ 58,543	$ 37,695	$ 36,834	$ 37,203	$ 37,963
Number of stores (at end of year)	9,967	9,846	9,750	9,681	7,866

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of $21 million, $20 million, $21 million and $15 million was made for years ended December 31, 2017, 2016, 2015 and 2014, respectively, to increase revenues and increase interest expense.

(2) On November 28, 2018, the Company acquired Aetna. Aetna's operations are included in the Company's consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and the period then ended. See Note 2 ''Acquisition of Aetna'' of Notes to Consolidated Financial Statements for additional information.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 28, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2007.

Boston, Massachusetts
February 28, 2019

Exhibit 21.1

Subsidiaries of CVS Health Corporation

Listed below are subsidiaries under CVS Health Corporation at December 31, 2018 with their jurisdictions of organization shown in parentheses. Subsidiaries excluded from the list below are not insurance companies and would not, in the aggregate, constitute a "significant subsidiary" of CVS Health Corporation, as that term is defined in Rule 1-02(w) of Regulation S-X.

- **CVS Foreign, Inc. (New York)**
    - CVS Caremark Indemnity Ltd. (Bermuda)
    - CVS International, L.L.C. (Delaware)

- **CVS Pharmacy, Inc. (Rhode Island)**
    - Aetna Inc. (Pennsylvania)
        - Aetna Health Holdings, LLC (Delaware)
            - Aetna Health of California Inc. (California)
            - Aetna Health Inc. (Connecticut)
            - Aetna Health Inc. (Florida)
            - Aetna Health Inc. (Georgia)
            - Aetna Health Inc. (Maine)
            - Aetna Health Inc. (Michigan)
            - Aetna Health Inc. (New Jersey)
            - Aetna Health Inc. (New York)
                - Aetna Better Health Inc. (New York)
            - Aetna Health Inc. (Pennsylvania)
            - Aetna Health Inc. (Texas)
            - Aetna Better Health of California Inc. (California)
            - Aetna Better Health of Iowa Inc. (Iowa)
            - Aetna Better Health of Texas Inc. (Texas)
            - Aetna Better Health of Washington, Inc. (Washington)
            - Aetna Better Health Inc. (Georgia)
            - Aetna HealthAssurance Pennsylvania, Inc. (Pennsylvania)
            - Aetna Dental of California Inc. (California)
            - Aetna Dental Inc. (New Jersey)
            - Aetna Dental Inc. (Texas)
            - Aetna Rx Home Delivery, LLC (Delaware)
            - Aetna Health Management, LLC (Delaware)
            - Aetna Ireland Inc. (Delaware)
            - Aetna Specialty Pharmacy, LLC (Delaware)
            - Cofinity, Inc. (Delaware)
            - @Credentials Inc. (Delaware)
            - Aetna Better Health Inc. (Pennsylvania)
            - Aetna Better Health Inc. (Connecticut)
            - Aetna Better Health Inc. (Illinois)
            - Aetna Better Health of Kansas Inc. (Kansas)
            - Aetna Better Health, Inc. (Louisiana)
            - Aetna Florida Inc. (Florida)
            - Aetna Better Health Inc. (Ohio)
            - Aetna Better Health of Oklahoma Inc. (Oklahoma)
            - Aetna Better Health of Nevada Inc. (Nevada)
            - Aetna Better Health Inc. (New Jersey)
            - Aetna Better Health of North Carolina Inc. (North Carolina)
            - Aetna Network Services LLC (Connecticut)

- Aetna Risk Assurance Company of Connecticut Inc. (Connecticut)
- Aetna Student Health Agency Inc. (Massachusetts)
- Delaware Physicians Care, Incorporated (Delaware)
- Schaller Anderson Medical Administrators, Incorporated (Delaware)
- Aetna Medicaid Administrators LLC (Arizona)
- iTriage, LLC (Delaware)
- bswift LLC (Illinois)
- Prodigy Health Group, Inc. (Delaware)
    - Niagara Re, Inc. (New York)
    - Performax, Inc. (Delaware)
    - Scrip World, LLC (Utah)
    - Precision Benefit Services, Inc. (Delaware)
    - American Health Holding, Inc. (Ohio)
    - Meritain Health, Inc. (New York)
        - Administrative Enterprises, Inc. (Arizona)
        - U.S Healthcare Holdings, LLC (Ohio)
        - Prime Net, Inc. (Ohio)
        - Professional Risk Management, Inc. (Ohio)
- ADMINCO, Inc. (Arizona)
- Aetna Pharmacy Management Services, LLC (Delaware)
- Coventry Transplant Network, Inc. (Delaware)
- Aetna Health of Iowa Inc. (Iowa)
- Coventry Health Care of Nebraska, Inc. (Nebraska)
- Aetna Health Inc. (Louisiana)
- HealthAssuance Pennsylvania, Inc. (Pennsylvania)
- Coventry Prescription Management Services Inc. (Nevada)
- Coventry Health and Life Insurance Company (Missouri)
    - Aetna Better Health of Kentucky Insurance Company (Kentucky)
- Coventry Health Care of Virginia, Inc. (Virginia)
- Coventry Health Care of Missouri, Inc. (Missouri)
- Aetna Better Health of Missouri LLC (Missouri)
- Coventry Health Care of Illinois, Inc. (Illinois)
- Coventry Health Care of West Virginia, Inc. (West Virginia)
- Coventry HealthCare Management Corporation (Delaware)
- Coventry Health Care of Kansas, Inc. (Kansas)
- Coventry Health Care National Accounts, Inc. (Delaware)
- Aetna Better Health of Michigan Inc. (Michigan)
- Aetna Health of Utah Inc. (Utah)
- Aetna Better Health Inc. (Tennessee)
- Coventry Health Care National Network, Inc. (Delaware)
- Coventry Consumer Advantage, Inc. (Delaware)
- MHNet Specialty Services, LLC (Maryland)
    - Mental Health Network of New York IPA, Inc. (New York)
    - Mental Health Associates, Inc. (Louisiana)
    - MHNet of Florida, Inc. (Florida)
    - MHNet Life and Health Insurance Company (Texas)
- Group Dental Service, Inc. (Maryland)
    - Group Dental Service of Maryland, Inc. (Maryland)
- Florida Health Plan Administrators, LLC (Florida)
    - Coventry Health Care of Florida, Inc. (Florida)
    - Carefree Insurance Services, Inc. (Florida)
    - Coventry Health Plan of Florida, Inc. (Florida)

- First Health Group Corp. (Delaware)
    - First Health Life & Health Insurance Company (Texas)
    - Claims Administration Corp. (Maryland)
- Coventry Health Care Workers' Compensation, Inc. (Delaware)
    - Coventry Rehabilitation Services, Inc. (Delaware)
    - First Script Network Services, Inc. (Nevada)
    - FOCUS HealthCare Management, Inc. (Tennessee)
    - Medical Examinations of New York, P.C. (New York)
    - MetraComp, Inc. (Connecticut)
- Continental Life Insurance Company of Brentwood, Tennessee (Tennessee)
    - American Continental Insurance Company (Tennessee)
- Aetna Life Insurance Company (Connecticut)
    - AHP Holdings, Inc. (Connecticut)
        - Aetna Insurance Company of Connecticut (Connecticut)
        - AE Fourteen, Incorporated (Connecticut)
        - Aetna Life Assignment Company (Connecticut)
    - Aetna ACO Holdings Inc. (Delaware)
        - Innovation Health Holdings, LLC (Delaware)
            - Innovation Health Insurance Company (Virginia)
                - Innovation Health Plan, Inc. (Virginia)
        - Texas Health + Aetna Health Insurance Holding Company LLC (Texas)
            - Texas Health + Aetna Health Insurance Company (Texas)
                - Texas Health + Aetna Health Plan Inc. (Texas)
    - Banner Health and Aetna Health Insurance Holding Company LLC (Delaware)
- Banner Health and Aetna Health Insurance Company (Arizona)
- Banner Health and Aetna Health Plan Inc. (Arizona)
    - Sutter Health and Aetna Insurance Holding Company LLC (Delaware)
        - Sutter Health and Aetna Administrative Services LLC (Delaware)
        - Sutter Health and Aetna Insurance Company (California)
    - Allina Health and Aetna Insurance Holding Company LLC (Delaware)
        - Allina Health and Aetna Insurance Company (Minnesota)
    - PE Holdings, LLC (Connecticut)
    - Aetna Resources LLC (Delaware)
    - Canal Place, LLC (Delaware)
    - Aetna Ventures, LLC (Delaware)
    - Broadspire National Services, Inc. (Florida)
    - Aetna Multi-Strategy 1099 Fund, LLC (Delaware)
- Phoenix Data Solutions LLC (Delaware)
- Aetna Financial Holdings, LLC (Delaware)
    - Aetna Asset Advisors, LLC (Delaware)
    - U.S. Healthcare Properties, Inc. (Pennsylvania)
    - Aetna Capital Management, LLC (Delaware)
        - Aetna Partners Diversified Fund, LLC (Delaware)
    - Aetna Workers' Comp Access, LLC (Delaware)
    - Aetna Behavioral Health, LLC (Delaware)
    - Managed Care Coordinators, Inc. (Delaware)
    - Horizon Behavioral Services, LLC (Delaware)
        - Employee Assistance Services, LLC (Kentucky)
        - Health and Human Resource Center, Inc. (California)
        - Resources for Living, LLC (Texas)
        - The Vasquez Group Inc. (Illinois)
        - Work and Family Benefits, Inc. (New Jersey)

- Aetna Card Solutions, LLC (Connecticut)
- PayFlex Holdings, Inc. (Delaware)
    - PayFlex Systems USA, Inc. (Nebraska)
- Aetna Health and Life lnsurance Company (Connecticut)
- Aetna Health Insurance Company (Pennsylvania)
- Aetna Health Insurance Company of New York (New York)
- AUSHC Holdings, Inc. (Connecticut)
    - PHPSNE Parent Corporation (Delaware)
- Active Health Management, Inc. (Delaware)
    - Health Data & Management Solutions, Inc. (Delaware)
        - Futrix Limited (New Zealand)
    - Aetna Integrated Informatics, Inc. (Pennsylvania)
- Health Re, Inc. (Vermont)
- ASI Wings, LLC (Delaware)
- Healthagen LLC
- Aetna Corporate Services LLC (Delaware)
- Echo Merger Sub, Inc. (Delaware)
- Aetna International Inc. (Connecticut)
    - Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
    - Aetna Global Holdings Limited (England & Wales)
        - Aetna Insurance (Hong Kong) Limited(Hong Kong)
        - Virtual Home Healthcare LLC (Dubai)
        - Aetna Korea Ltd. (South Korea)
        - Minor Health Entreprise Co, Ltd.
        - Health Care Management Co. Ltd.
            - Aetna Services (Thailand) Limited
        - Aetna Health Insurance (Thailand) Public Company Limited
        - Aetna Holdings (Thailand) Limited
            - Health Care Management Co. Ltd.
            - Minor Health Entreprise Co, Ltd.
                - Aetna Health Insurance (Thailand) Public Company Limited
    - Aetna Global Benefits (Bermuda) Limited (Bermuda)
        - Goodhealth Worldwide (Global) Limited (Bermuda)
        - Aetna Global Benefits (Europe) Limited (England & Wales)
        - Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)
        - Goodhealth Worldwide (Asia) Limited (Hong Kong)
        - Aetna Global Benefits Limited (DIFC, UAE)
        - Aetna Global Benefits (Middle East) LLC (UAE)
        - Pt. Aetna Global Benefits Indonesia (Indonesia)
        - Aetna Global Benefits (Bahamas) Limited (Bahamas)
        - Spinnaker Topco Limited (Bermuda)
            - Spinnaker Bidco Limited (England and Wales)
                - Aetna Holdco (UK) Limited (England and Wales)
                - Aetna Global Benefits (UK) Limited (England and Wales)
                - Aetna Insurance Company Limited (England and Wales)
    - Aetna Insurance (Singapore) Pte. Ltd. (Singapore)
    - Aetna Health Insurance Company of Europe DAC (Ireland)
    - Aetna (Shanghai) Enterprise Services Co. Ltd. (China)
        - Aetna (Beijing) Enterprise Management Services Co., Ltd. (China)
    - Aetna Global Benefits (Singapore) PTE. LTD. (Singapore)
        - Indian Health Organisation Private Limited (India)
    - PT Aetna Management Consulting

- Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd (China)

- CVS Pharmacy, Inc. (continued)

  - Alabama CVS Pharmacy, L.L.C. (Alabama)
  - Alaska CVS Pharmacy, L.L.C. (Alaska)
  - American Drug Stores Delaware, L.L.C. (Delaware)
  - Arkansas CVS Pharmacy, L.L.C. (Arkansas)
  - CareCenter Pharmacy, L.L.C. (Delaware)
  - Caremark Rx, L.L.C. (Delaware)
    - CaremarkPCS, L.L.C. (Delaware)
    - Accordant Health Services, L.L.C. (Delaware)
    - AdvancePCS SpecialtyRx, LLC (Delaware)
    - AdvanceRx.com, L.L.C. (Delaware)
    - CaremarkPCS Health, L.L.C. (Delaware)
      - Caremark IPA, L.L.C. (New York)
    - Caremark PhC, L.L.C. (Delaware)
    - Caremark Ulysses Holding Corp. (New York)
      - MemberHealth LLC (Delaware)
      - UAC Holding, Inc. (Delaware)
        - Pennsylvania Life Insurance Company (Pennsylvania)
    - Caremark, L.L.C. (California)
      - Caremark Arizona Mail Pharmacy, LLC (Arizona)
      - Caremark Arizona Specialty Pharmacy, L.L.C. (Arizona)
      - Caremark California Specialty Pharmacy, L.L.C. (California)
      - Caremark Florida Mail Pharmacy, LLC (Florida)
      - Caremark Florida Specialty Pharmacy, LLC (Florida)
      - Caremark Hawaii Mail Pharmacy, L.L.C. (Hawaii)
      - Caremark Hawaii Specialty Pharmacy, LLC (Hawaii)
      - Caremark Illinois Mail Pharmacy, LLC (Illinois)
      - CVS Caremark Advanced Technology Pharmacy, L.L.C. (Illinois)
      - Caremark Illinois Specialty Pharmacy, LLC (Illinois)
      - Caremark Irving Resource Center, LLC (Texas)
      - Caremark Kansas Specialty Pharmacy, LLC (Kansas)
      - Caremark Logistics, LLC (Delaware)
      - Caremark Louisiana Specialty Pharmacy, LLC (Louisiana)
      - Caremark Maryland Specialty Pharmacy, LLC (Maryland)
      - Caremark Massachusetts Specialty Pharmacy, L.L.C. (Massachusetts)
      - Caremark Michigan Specialty Pharmacy, LLC (Michigan)
      - Caremark Minnesota Specialty Pharmacy, LLC (Minnesota)
      - Caremark New Jersey Specialty Pharmacy, LLC (New Jersey)
      - Caremark North Carolina Specialty Pharmacy, LLC (North Carolina)
      - Caremark Ohio Specialty Pharmacy, L.L.C. (Ohio)
      - Caremark Pennsylvania Specialty Pharmacy, LLC (Pennsylvania)
      - Caremark Redlands Pharmacy, L.L.C. (California)
      - Caremark Repack, LLC (Illinois)
      - Caremark Tennessee Specialty Pharmacy, LLC (Tennessee)
      - Caremark Texas Mail Pharmacy, LLC (Texas)
      - Caremark Texas Specialty Pharmacy, LLC (Texas)
      - Caremark Washington Specialty Pharmacy, LLC (Washington)
      - Central Rx Services, LLC (Nevada)
      - Generation Health, L.L.C. (Delaware)

        - NovoLogix, LLC (Delaware)
    - CaremarkPCS Alabama Mail Pharmacy, LLC (Alabama)
    - CaremarkPCS, L.L.C. (Delaware)
    - CVS Caremark Part D Services, L.L.C. (Delaware)
    - Eckerd Corporation of Florida, Inc. (Florida)
    - Express Pharmacy Services of PA, L.L.C. (Delaware)
    - Ocean Acquisition Sub, L.L.C. (Delaware)
        - Coram LLC (Delaware)
        - Coram Clinical Trials, Inc. (Delaware)
        - T2 Medical, Inc. (Delaware)
            - Coram Healthcare Corporation of Alabama (Delaware)
            - Coram Healthcare Corporation of Florida (Delaware)
            - Coram Healthcare Corporation of Greater D.C. (Delaware)
            - Coram Healthcare Corporation of Greater New York (New York)
            - Coram Healthcare Corporation of Indiana (Delaware)
            - Coram Healthcare Corporation of Mississippi (Delaware)
            - Coram Healthcare Corporation of Nevada (Delaware)
            - Coram Healthcare Corporation of Northern California (Delaware)
            - Coram Healthcare Corporation of Southern California (Delaware)
            - Coram Healthcare Corporation of Southern Florida (Delaware)
            - Coram Specialty Infusion Services, L.L.C. (Delaware)
                - Coram Rx, LLC (Delaware)
                - Coram Healthcare Corporation of North Texas (Delaware)
                - Coram Healthcare Corporation of Utah (Delaware)
                - Coram Healthcare Corporation of Massachusetts (Delaware)
            - Coram Alternate Site Services, Inc. (Delaware)
                - Geneva Woods Management, LLC (Delaware)
    - Part D Holding Company, L.L.C. (Delaware)
        - Accendo Insurance Company (Utah)
        - Silverscript Insurance Company (Tennessee)
- Connecticut CVS Pharmacy, L.L.C. (Connecticut)
- CVS 2948 Henderson, L.L.C. (Nevada)
- CVS AL Distribution, L.L.C. (Alabama)
- CVS Albany, L.L.C. (New York)
- CVS AOC Services, L.L.C. (Delaware)
- CVS Indiana, L.L.C. (Indiana)
- CVS International, L.L.C. (Delaware)
    - CCI Foreign, S'arl (R.C.S. Luxembourg)
        - Beauty Holdings, L.L.C. (Delaware)
            - Drogaria Onofre Ltda. (Brazil)
            - Pamplona Saúde e Beleza LTDA (Brazil)
- CVS Kidney Care, LLC (Delaware)
- CVS Manchester NH, L.L.C. (New Hampshire)
- CVS Michigan, L.L.C. (Michigan)
- CVS Orlando FL Distribution, L.L.C. (Florida)
- CVS PA Distribution, L.L.C. (Pennsylvania)
- CVS PR Center, Inc. (Delaware)
    - Puerto Rico CVS Pharmacy, L.L.C. (Puerto Rico)
    - Caremark Puerto Rico, L.L.C. (Puerto Rico)
    - Caremark Puerto Rico Specialty Pharmacy, L.L.C. (Puerto Rico)
- CVS RS Arizona, L.L.C. (Arizona)
    - Arizona CVS Stores, L.L.C. (Arizona)

    - CVS 3268 Gilbert, L.L.C. (Arizona)
    - CVS 3745 Peoria, L.L.C. (Arizona)
    - CVS Gilbert 3272, L.L.C. (Arizona)
- CVS Rx Services, Inc. (New York)
    - Busse CVS, L.L.C. (Illinois)
    - Goodyear CVS, L.L.C. (Arizona)
    - Sheffield Avenue CVS, L.L.C. (Illinois)
    - South Wabash CVS, L.L.C. (Illinois)
    - Thomas Phoenix CVS, L.L.C. (Arizona)
    - Washington Lamb CVS, L.L.C. (Nevada)
- CVS SC Distribution, L.L.C. (South Carolina)
- CVS State Capital, L.L.C. (Maine)
- CVS TN Distribution, L.L.C. (Tennessee)
- CVS Transportation, L.L.C. (Indiana)
- CVS Vero FL Distribution, L.L.C. (Florida)
- D.A.W., LLC (Massachusetts)
- Delaware CVS Pharmacy, L.L.C. (Delaware)
- Digital eHealth, LLC (Rhode Island)
- District of Columbia CVS Pharmacy, L.L.C. (District of Columbia)
- Enterprise Patient Safety Organization, LLC (Rhode Island)
- E.T.B., INC. (Texas)
- Garfield Beach CVS, L.L.C. (California)
- Georgia CVS Pharmacy, L.L.C. (Georgia)
- German Dobson CVS, L.L.C. (Arizona)
- Grand St. Paul CVS, L.L.C. (Minnesota)
- Highland Park CVS, L.L.C. (Illinois)
- Holiday CVS, L.L.C. (Florida)
- Hook-SupeRx, L.L.C. (Delaware)
- Idaho CVS Pharmacy, L.L.C. (Idaho)
- Iowa CVS Pharmacy, L.L.C. (Iowa)
- Kansas CVS Pharmacy, L.L.C. (Kansas)
- Kentucky CVS Pharmacy, L.L.C. (Kentucky)
- Longs Drug Stores California, L.L.C. (California)
- Louisiana CVS Pharmacy, L.L.C. (Louisiana)
- Maryland CVS Pharmacy, L.L.C. (Maryland)
- Melville Realty Company, Inc. (New York)
- CVS Bellmore Avenue, L.L.C. (New York)
- MinuteClinic, L.L.C. (Delaware)
    - MinuteClinic Diagnostic of Alabama, L.L.C. (Alabama)
    - MinuteClinic Diagnostic of Arizona, LLC (Minnesota)
    - MinuteClinic Diagnostic of Florida, LLC (Minnesota)
    - MinuteClinic Diagnostic of Georgia, LLC (Minnesota)
    - MinuteClinic Diagnostic of Hawaii, L.L.C. (Hawaii)
    - MinuteClinic Diagnostic of Illinois, LLC (Delaware)
    - MinuteClinic Diagnostic of Kentucky, L.L.C. (Kentucky)
    - MinuteClinic Diagnostic of Louisiana, L.L.C. (Louisiana)
    - MinuteClinic Diagnostic of Maine, L.L.C. (Maine)
    - MinuteClinic Diagnostic of Maryland, LLC (Minnesota)
    - MinuteClinic Diagnostic of Massachusetts, LLC (Massachusetts)
    - MinuteClinic Diagnostic of Nebraska, L.L.C. (Nebraska)
    - MinuteClinic Diagnostic of New Hampshire, L.L.C. (New Hampshire)
    - MinuteClinic Diagnostic of New Mexico, L.L.C. (New Mexico)

- MinuteClinic Diagnostic of Ohio, LLC (Ohio)
- MinuteClinic Diagnostic of Oklahoma, LLC (Oklahoma)
- MinuteClinic Diagnostic of Oregon, LLC (Oregon)
- MinuteClinic Diagnostic of Pennsylvania, LLC (Minnesota)
- MinuteClinic Diagnostic of Rhode Island, LLC (Minnesota)
- MinuteClinic Diagnostic of South Carolina, L.L.C. (South Carolina)
- MinuteClinic Diagnostic of Texas, LLC (Minnesota)
- MinuteClinic Diagnostic of Utah, L.L.C. (Utah)
- MinuteClinic Diagnostic of Virginia, LLC (Virginia)
- MinuteClinic Diagnostic of Washington, LLC (Oregon)
- MinuteClinic Diagnostic of Wisconsin, L.L.C. (Wisconsin)
- MinuteClinic Online Diagnostic Services, LLC (Delaware)
- MinuteClinic Telehealth Services, LLC (Delaware)

- Mississippi CVS Pharmacy, L.L.C. (Mississippi)
- Missouri CVS Pharmacy, L.L.C. (Missouri)
- Montana CVS Pharmacy, L.L.C. (Montana)
- Nebraska CVS Pharmacy, L.L.C. (Nebraska)
- New Jersey CVS Pharmacy, L.L.C. (New Jersey)
- North Carolina CVS Pharmacy, L.L.C. (North Carolina)
- Ohio CVS Stores, L.L.C. (Ohio)
- Oklahoma CVS Pharmacy, L.L.C. (Oklahoma)
- Omnicare, Inc. (Delaware)
  - ACS ACQCO CORP. (Delaware)
    - Advanced Care Scripts, Inc. (Florida)
  - Omnicare Holding Company (Delaware)
    - Evergreen Pharmaceutical of California, Inc. (California)
    - JHC Acquisition, LLC (Delaware)
      - Geneva Woods Pharmacy, LLC (Alaska)
        - Geneva Woods Health Services, LLC (Delaware)
          - Geneva Woods Retail Pharmacy LLC (Delaware)
          - Geneva Woods LTC Pharmacy, LLC
            - Geneva Woods Pharmacy Wyoming, LLC (Delaware)
            - Geneva Woods Pharmacy Washington, LLC (Delaware)
            - Geneva Woods Pharmacy Alaska, LLC (Delaware)
    - AMC - Tennessee, LLC (Delaware)
    - CHP Acquisition, LLC (Delaware)
      - Home Pharmacy Services, LLC (Missouri)
    - CP Acquisition, LLC (Oklahoma)
    - Managed Healthcare, LLC (Delaware)
    - Med World Acquisition Corp. (Delaware)
    - Medical Arts Health Care, LLC (Georgia)
    - MHHP Acquisition Company, LLC (Delaware)
    - NCS Healthcare, LLC (Delaware)
      - NCS Healthcare of South Carolina, LLC (Ohio)
      - NCS Healthcare of Tennessee, LLC (Ohio)
      - NCS Healthcare of Kentucky, Inc. (Oh
      - NCS Healthcare of Montana, LLC (Ohio)
      - NCS Healthcare of New Mexico, LLC (Ohio)
      - UNI-Care Health Services of Maine, LLC (New Hampshire)
    - NeighborCare, Inc. (Pennsylvania)
      - Three Forks Apothecary, LLC (Kentucky)
      - NeighborCare Holdings, Inc. (Delaware)

- Badger Acquisition of Kentucky LLC (Delaware)
- NeighborCare Services Corporation (Delaware)
    - D & R Pharmaceutical Services LLC (Kentucky)
    - NeighborCare Pharmacy Services, Inc. (Delaware)
        - APS Acquisition LLC (Delaware)
        - ASCO HealthCare, LLC (Maryland)
        - Badger Acquisition LLC (Delaware)
            - Badger Acquisition of Minnesota LLC (Delaware)
                - Merwin Long Term Care, LLC (Minnesota)
            - Badger Acquisition of Ohio LLC (Delaware)
        - Best Care LTC Acquisition Company, LLC (Delaware)
        - Care Pharmaceutical Services, LP (Delaware)
        - CCRx Holdings, LLC (Delaware)
            - Continuing Care Rx, LLC (Pennsylvania)
            - CCRx of North Carolina LLC (Delaware)
        - Compscript, LLC (Florida)
            - Campo's Medical Pharmacy, LLC (Louisiana)
        - Enloe Drugs, LLC (Delaware)
        - Evergreen Pharmaceutical, LLC (Washington)
        - Home Care Pharmacy, LLC (Delaware)
        - Interlock Pharmacy Systems, LLC (Missouri)
        - Langsam Health Services, LLC (Delaware)
            - LCPS Acquisition, LLC (Delaware)
                - Omnicare Pharmacy of Tennessee LLC (Delaware)
        - Lobos Acquisition, LLC (Delaware)
        - Lo-Med Prescription Services, LLC (Ohio)
            - ZS Acquisition Company, LLC (Delaware)
        - NCS Healthcare of Illinois, LLC (Ohio)
        - NCS Healthcare of Iowa, LLC (Ohio)
            - Martin Health Services, LLC (Delaware)
        - NCS Healthcare of Kansas, LLC (Ohio)
        - NCS Healthcare of Ohio, LLC (Ohio)
        - NCS Healthcare of Wisconsin, LLC (Ohio)
        - North Shore Pharmacy Services LLC (Delaware)
        - Omnicare Indiana Partnership Holding Company LLC (Delaware)
        - Omnicare of New York, LLC (Delaware)
            - NeighborCare of Indiana, LLC (Indiana)
                - Grandview Pharmacy, LLC (Indiana)
            - NeighborCare of Virginia, LLC (Virginia)
        - Omnicare Pharmacies of Pennsylvania West LLC (Pennsylvania)
            - Omnicare Pharmacies of Pennsylvania East LLC (Delaware)
        - Omnicare Pharmacy and Supply Services LLC (South Dakota)
        - Omnicare Pharmacy of the Midwest, LLC (Delaware)
        - Omnicare Property Management, LLC (Delaware)
        - Pharmacy Consultants, LLC (South Carolina)
        - PRN Pharmaceutical Services, LP (Delaware)
        - Roeschen's Healthcare LLC (Wisconsin)
            - PP Acquisition Company LLC (Delaware)
        - Specialized Pharmacy Services, LLC (Michigan)

        - Value Health Care Services LLC (Delaware)
        - VAPS Acquisition Company, LLC (Delaware)
        - Westhaven Services Co, LLC (Ohio)
    - NIV Acquisition, LLC (Delaware)
    - OCR Services, LLC (Delaware)
        - Shore Pharmaceutical Providers, LLC (Delaware)
    - Omnicare of Nevada, LLC (Delaware)
    - Omnicare Pharmacies of the Great Plains Holding, LLC (Delaware)
        - Omnicare of Nebraska LLC (Delaware)
    - Pharmacy Associates of Glenn Falls, LLC (New York)
    - Sterling Healthcare Services, LLC (Delaware)
    - Superior Care Pharmacy, LLC (Delaware)
    - TCPI Acquisition, LLC (Delaware)
    - UC Acquisition, LLC (Delaware)
    - Weber Medical Systems LLC (Delaware)
    - Williamson Drug Company, LLC (Virginia)

- CVS Pharmacy, Inc. (continued)

    - Oregon CVS Pharmacy, L.L.C. (Oregon)
    - Pennsylvania CVS Pharmacy, L.L.C. (Pennsylvania)
    - ProCare Pharmacy Direct, L.L.C. (Ohio)
    - ProCare Pharmacy, L.L.C. (Rhode Island)
    - Red Oak Sourcing, LLC (Delaware)
    - Rhode Island CVS Pharmacy, L.L.C. (Rhode Island)
    - South Carolina CVS Pharmacy, L.L.C. (South Carolina)
    - Tennessee CVS Pharmacy, L.L.C. (Tennessee)
    - Utah CVS Pharmacy, L.L.C. (Utah)
    - Vermont CVS Pharmacy, L.L.C. (Vermont)
    - Virginia CVS Pharmacy, L.L.C. (Virginia)
    - Warm Springs Road CVS, L.L.C. (Nevada)
    - Washington CVS Pharmacy, L.L.C. (Washington)
    - Wellpartner, LLC (Delaware)
    - West Virginia CVS Pharmacy, L.L.C. (West Virginia)
    - Wisconsin CVS Pharmacy, L.L.C. (Wisconsin)
    - Woodward Detroit CVS, L.L.C. (Michigan)

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3ASR No. 333-217596) of CVS Health Corporation, and
(2) Registration Statements (Form S-8 Nos. 333-228622, 333-167746, 333-217853, 333-208805, 333-141481, 333-139470, 333-63664, 333-91253, 333-49407, 333-34927, and 333-28043) of CVS Health Corporation;

of our reports dated February 28, 2019, with respect to the consolidated financial statements of CVS Health Corporation and the effectiveness of internal control over financial reporting of CVS Health Corporation incorporated by reference in this Annual Report (Form 10-K) of CVS Health Corporation for the year ended December 31, 2018.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 28, 2019

Exhibit 31.1

Certification

I, Larry J. Merlo, President and Chief Executive Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;

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

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

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

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

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

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

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

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

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

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

Date: February 28, 2019

By: /s/ LARRY J. MERLO

Larry J. Merlo

President and Chief Executive Officer

Exhibit 31.2

Certification

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;

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

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

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

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

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

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

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

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

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

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

Date: February 28, 2019

By: / s / EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2018 (the “Report”) solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the “Exchange Act”) and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Larry J. Merlo, President and Chief Executive Officer of the Company, certify that, to the best of my knowledge:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 28, 2019

/ s / LARRY J. MERLO

Larry J. Merlo

President and Chief Executive Officer

Exhibit 32.2

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2018 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of the Company, certify that, to the best of my knowledge:

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

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 28, 2019

/ s / EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Advanced Medical Reviews, Inc.

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Aetna Health Management

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Aetna Health Management, LLC

Financial Statements
December 31, 2018 and 2017
(With Independent Auditors' Report Thereon)

AETNA HEALTH MANAGEMENT, LLC

Financial Statements
December 31, 2018 and 2017

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Aetna Health Management, LLC:

We have audited the accompanying financial statements of Aetna Health Management, LLC, which comprise the balance sheets as of December 31, 2018 and 2017, and the related statements of income, comprehensive income, changes in member's equity, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Aetna Health Management, LLC as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

[redacted]

Hartford, Connecticut
April 26, 2019

KPMG LLP is a Delaware limited liability partnership and the U.S. member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative ("KPMG International"), a Swiss entity.

AETNA HEALTH MANAGEMENT, LLC

Balance Sheets
As of December 31, 2018 and 2017
(in thousands)

	2018	2017
Assets:		
Cash and cash equivalents	$ 62,244	$ 80,397
Debt securities available for sale (amortized cost $128,663 in 2018 and $303,298 in 2017)	129,263	309,832
Other investments	48,503	102,460
Amounts due from affiliates	805,405	1,012,886
Pharmaceutical rebate receivable	1,247,071	1,022,880
Pharmaceutical claims receivable	331,384	226,884
Preferred network rebate receivable	339,969	66,622
Accrued investment income	1,707	4,406
Deferred tax asset, net	14,630	15,400
Other assets	13,203	14,614
Goodwill	3,439	3,439
Property and equipment, net	19,062	26,122
Total assets	$ 3,015,880	$ 2,885,942
Liabilities and Member's Equity:		
Liabilities		
Drafts outstanding	$ 144,960	$ 112,264
Amounts due to affiliates	1,648,242	1,740,008
Accrued taxes and licenses	—	70
Cash received in advance	22,900	11,131
Accrued salaries and incentives	—	2,564
Accrued commissions	13,502	25,738
Income taxes payable	24,301	36,365
Pharmaceutical claims payable	464,947	390,941
Other accrued expenses	54,858	115,054
Total liabilities	$ 2,373,710	$ 2,434,135
Member's equity		
Additional paid-in capital	2,166,930	2,166,930
Accumulated other comprehensive income	1,258	5,031
Retained deficit	(1,526,018)	(1,720,154)
Total member's equity	642,170	451,807
Total liabilities and member's equity	$ 3,015,880	$ 2,885,942

See accompanying notes to the financial statements.

AETNA HEALTH MANAGEMENT, LLC

Statements of Income
For the Years Ended December 31, 2018 and 2017
(in thousands)

	2018	2017
Revenue:		
Management fee income	$ 1,644,920	$ 1,926,672
Pharmacy rebate income	394,198	276,302
Investment income	3,626	9,155
Net realized capital gains	5,979	1,304
Other revenue	28,561	20,572
Total revenue	2,077,284	2,234,005
Expenses:		
Operating expenses	1,640,881	1,970,620
Total expenses	1,640,881	1,970,620
Income before income tax expense	436,403	263,385
Income tax expense	111,353	178,339
Net income	$ 325,050	$ 85,046

See accompanying notes to the financial statements.

AETNA HEALTH MANAGEMENT, LLC

Statements of Comprehensive Income
For the Years Ended December 31, 2018 and 2017
(in thousands)

	2018	2017
Net income	$ 325,050	$ 85,046
Other comprehensive income (loss):		
Unrealized gains (losses) on securities	(4,687)	4,062
Other comprehensive income (loss)	(4,687)	4,062
Total comprehensive income	$ 320,363	$ 89,108

See accompanying notes to the financial statements, including Note 6 for further information about other comprehensive income.

AETNA HEALTH MANAGEMENT, LLC

Statement of Changes in Member's Equity
For the Years Ended December 31, 2018 and 2017
(in thousands)

	Additional paid in-capital	Accumulated other comprehensive income	Retained deficit	Total member's equity
Balance at December 31, 2016	**$ 2,072,930**	**$ 969**	**$ (1,805,379)**	**$ 268,520**
Net income	**—**	**—**	**85,046**	**85,046**
Capital contribution	**94,000**	**—**	**—**	**94,000**
Non-controlling interest	**—**	**—**	**179**	**179**
Other comprehensive income	**—**	**4,062**	**—**	**4,062**
Balance at December 31, 2017	**2,166,930**	**5,031**	**(1,720,154)**	**451,807**
Net income	**—**	**—**	**325,050**	**325,050**
Adoption of new accounting standards (Note 2)	**—**	**914**	**(914)**	**—**
Dividend to stockholder (intercompany)	**—**	**—**	**(130,000)**	**(130,000)**
Other comprehensive income (loss)	**—**	**(4,687)**	**—**	**(4,687)**
Balance at December 31, 2018	**$ 2,166,930**	**$ 1,258**	**$ (1,526,018)**	**$ 642,170**

See accompanying notes to financial statements.

AETNA HEALTH MANAGEMENT, LLC

Statements of Cash Flows
For the Years Ended December 31, 2018 and 2017
(in thousands)

	2018	2017
Cash flows from operating activities:		
Net income	**$ 325,050**	$ 85,046
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Depreciation and amortization	**14,238**	26,660
Net realized capital gains	**(5,979)**	(1,304)
Equity in earnings of affiliates, net	**(1)**	(2,645)
Deferred tax provision	**2,015**	23,964
Accretion of net investment premium	**1,669**	4,552
Changes in assets and liabilities:		
Pharmaceutical rebate receivables	**(224,191)**	(158,563)
Amounts due to/from affiliates	**115,715**	140,609
Income taxes	**(12,064)**	(22,306)
Accrued investment income	**2,699**	1,108
Other receivables and other assets	**1,412**	6,024
Drafts outstanding	**32,696**	4,535
Pharmaceutical claims receivable	**(104,500)**	(14,979)
Preferred network rebate receivable	**(273,347)**	(49,630)
Accrued expenses	**(74,996)**	(301,764)
Pharmaceutical claims payable	**74,006**	45,582
Accrued taxes and licenses	**(70)**	(12,174)
Cash received in advance	**11,769**	(4,620)
Net cash used in operating activities	**(113,879)**	(229,905)
Cash flows from investing activities:		
Proceeds from sales and maturities of investments	**252,013**	243,771
Cost of investments purchased	**(19,109)**	(109,516)
Additions to property and equipment	**(7,178)**	(3,736)
Non-controlling interest	**—**	179
Net cash provided by investing activities	**225,726**	130,698
Cash flows from financing activities:		
Dividends paid to shareholder	**(130,000)**	—
Capital contribution received	**—**	94,000
Net cash provided by financing activities	**(130,000)**	94,000
Net increase (decrease) in cash and cash equivalents	**(18,153)**	(5,207)
Cash and cash equivalents, beginning of period	**80,397**	85,604
Cash and cash equivalents, end of period	**$ 62,244**	$ 80,397
Supplemental cash flow information:		
Income taxes paid	$ 121,402	$ 176,681

See accompanying notes to the financial statements.

Notes to Financial Statements
December 31, 2018 and 2017

1. Organization

Aetna Health Management, LLC (the "Company"), a Delaware limited liability company, is a wholly-owned subsidiary of Aetna Health Holdings, LLC ("AHH, LLC"), a Delaware limited liability company. AHH, LLC is a wholly-owned subsidiary of Aetna Inc. ("Aetna"), a Pennsylvania corporation. The Company was formed as a corporation on June 19, 1992 and was converted to a limited liability company on December 1, 2002. The Company is primarily a health plan management company, performing administrative, operational, legal, financial, risk management, and data processing services. The Company also functions as a network administrator and a pharmacy benefit manager.

The Company generates approximately 98% of its revenue from agreements with its affiliated Health Plan Legal Entities ("Health Plan Legal Entities"), see Note 8 for further discussion of this relationship. A loss of this revenue would significantly impact the results of operations of the Company.

On November 28, 2018, CVS Health acquired 100% of the outstanding shares and voting interests of Aetna Inc. for a combination of cash and stock.

2. Summary of Significant Accounting Policies

Basis of Presentation
The accompanying financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP"). The Company has evaluated subsequent events from the financial statement date through the date the financial statements were issued and determined there were no subsequent events to disclose.

Use of Estimates
The preparation of the accompanying financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the amounts reported in these financial statements and notes. The Company considers the following accounting estimates critical in the preparation of the accompanying consolidated financial statements: fair value of investments and other-than-temporary impairment ("OTTI") of debt securities. The Company uses information available to management at the time estimates are made; however, these estimates could change materially if different information or assumptions were used. Additionally, these estimates may not ultimately reflect the actual amounts of the final transactions that occur.

Reclassifications
Certain reclassifications have been made to the 2017 audited financial statements to conform with the classifications used in 2018, including a reclassification of certain investments from debt and equity securities available for sale to other investments.

Cash and Cash Equivalents
Cash and cash equivalents include cash on-hand and debt securities with an original maturity of three months or less when purchased. The carrying value of cash equivalents approximates fair value due to the short-term nature of these investments.

Investments
Debt Securities
Debt securities consist primarily of U.S. Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt and equity securities. The Company has classified its debt securities as available for

sale and carries them at fair value. Refer to Note 4 for additional information on how the Company estimates the fair value of these investments.

The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments.

The Company regularly reviews its debt securities to determine whether a decline in fair value below the carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in the fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in the Company's operating results, and the amount of the non-credit related component is included in other comprehensive income, unless the Company intends to sell the debt security or it is more likely than not that it will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. The Company does not accrue interest on debt securities when it believes the collection of interest is unlikely.

Other Investments
Other investments consist primarily of alternative investments, which are comprised of a hedge fund limited partnership, privately placed warrant and a preferred stock investment in HealthEdge.

The Company does not have a controlling ownership in the Company's hedge fund limited partnership. Hedge fund limited partnerships are carried at fair value which is estimated using the net asset value ("NAV") per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. The Company reviews its investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the balance sheet date, the Company will recognize an impairment by recording a reduction in the carrying value of the limited partnership with a corresponding charge to realized capital losses.

The Company currently holds a privately placed warrant which is classified as an equity security and carried at fair value. There was no activity related to the equity security for the years ended December 31, 2017 and December 31, 2018.

The Company's investment in HealthEdge is recorded at cost less impairments, plus or minus subsequent adjustments for observable price changes. During the year ended December 31, 2018, the Company identified observable price changes related to the HealthEdge investment and increased the carrying value of the investment by $5 million and recorded a corresponding realized capital gain as a result of the adoption of *Recognition and Measurement of Financial Assets and Financial Liabilities* accounting standard described further in the New Accounting Standards section below.

Net Investment Income and Realized Capital Gains and Losses
Net investment income and realized capital gains and losses on investments are reflected in the Company's results of operations. Realized capital gains and losses on investments are determined on a specific identification basis. The Company reflects purchases and sales of debt securities on the trade date. Unrealized capital gains and losses on investments are reflected in total member's equity, net of tax, as a component of accumulated other comprehensive income.

Property and Equipment
The Company capitalizes internally developed software which is included in property and equipment. The Company calculates depreciation and amortization primarily using the straight-line method over the estimated useful lives of the respective assets ranging from three to ten years. Depreciation expense for the years ended

December 31, 2018 and 2017 was $11 million and $26 million, respectively. Included in the depreciation expense for the years ended December 31, 2018 and 2017 was $11 million and $25 million, respectively, of amortization expense for internal use software. Refer to Note 7 for additional information on property and equipment.

Pharmaceutical Rebate Receivables
The Company estimates pharmaceutical rebates receivable from drug manufacturers based upon historical payment trends, actual utilization and other variables. Pharmaceutical rebates for a quarter are billed to the vendor within one month of the completion of the quarter with any adjustment to previously recorded amounts reflected at the time of billing.

Pharmaceutical Claims Receivable and Payable
Pharmacy claims are paid by the Company to the pharmacy providers on behalf of the Health Plan Legal Entities. The Health Plan Legal Entities reimburse the Company approximately two weeks after the Company pays the providers.

Preferred Network Rebate Receivable
Effective January 1, 2015, the Company instituted a Preferred Pharmacy Network Rebate. The Company estimates pharmacy rebates due from the contracted pharmacy based upon the pharmacy's preferred status and utilization.

Goodwill
The Company evaluates goodwill for impairment annually, or more frequently if circumstances indicate a possible impairment, by comparing an estimate of the fair value of the Company to its carrying value, including goodwill. If the carrying value exceeds fair value, the Company compares the implied fair value of the applicable goodwill with the carrying amount of that goodwill to measure the amount of the goodwill impairment, if any. During 2018, the Company performed an annual impairment test based on an evaluation of future discounted cash flows in conjunction with its annual planning process, and determined that there was no impairment of goodwill in the year ended December 31, 2018.

Other Assets
Other assets primarily consist of pre-paid expenses, and other miscellaneous receivables. Certain expense items which will benefit future periods are recorded as prepaid expenses and expensed over the actual periods benefited.

Revenue Recognition
The Company earns plan management fees by providing managerial, operating, processing, and accounting support to various Commercial, Medicaid and Medicaid/Medicare Duals plans, some of which are related parties. Refer to Note 8 for further details. Management fee income relates to contracts that can include various combinations of products, services, or series of services, which are generally capable of being distinct and accounted for as separate performance obligations. Plan management fees are recognized as revenue over the period the service is provided and are calculated as a percentage of revenue or are based on expenses incurred by the Company on behalf of the health plan as outlined by each plan's master agreement. Additional revenue may also be earned when certain quality and performance metrics are achieved. The Company earns administrative fees, which are based on contracted service rates by providing administrative support services to related Aetna Medicaid entities that do not have a management agreement directly with the Company.

At December 31, 2018, there were no material contract assets or contract liabilities. For the twelve months ended December 31, 2018, the Company had no material bad debt expense.

Income Taxes

The Company recognizes deferred income tax assets and liabilities for the differences between the financial and income tax reporting basis of assets and liabilities based on enacted tax rates and laws. Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. Deferred income tax expense or benefit primarily reflects the net change in deferred income tax assets and liabilities during the year. The current income tax provision reflects the tax results of revenues and expenses currently taxable or deductible. Penalties and interest on the Company's tax positions are classified as a component of the Company's income tax provision.

The Company was included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries through November 27, 2018 pursuant to the terms of a tax sharing agreement. For the tax period from November 28, 2018 through December 31, 2018, Aetna and its wholly-owned subsidiaries are included in the consolidated federal income tax return of its parent company, CVS Health, pursuant to the terms of a tax sharing agreement (and a Supplemental Tax Sharing Agreement where applicable) between CVS Health and the Company.

In accordance with both tax sharing agreements, the Company's current federal income tax provision is generally computed as if the Company were filing a separate federal income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent realized in the consolidated return. Pursuant to these agreements, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. For state tax filing purposes, the Company files primarily unitary returns which results in a state tax liability that is based on an apportionment of Aetna federal taxable income.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "TCJA") was enacted. Among other items, the TCJA reduced the federal corporate income tax rate to 21 percent effective January 1, 2018. Accordingly, the Company remeasured its deferred tax assets and liabilities as of the enactment date to reflect the lower tax rate and recognized an incremental tax expense of $8 million related to the change in its net deferred tax assets and liabilities.

New Accounting Standards

Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income

In February 2018, the FASB issued ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*. This ASU permits entities to reclassify tax effects stranded in accumulated other comprehensive income as a result of the TCJA to retained earnings. The guidance states that because the adjustment of deferred income taxes due to the reduction of the historical corporate income tax rate to the newly enacted corporate income tax rate was required to be included in net income, the tax effects of items within accumulated other comprehensive income ("stranded tax effects") are not reflected at the appropriate tax rate. The Company elected to early adopt this new standard and reclassified the stranded tax effects of $914 thousand during the year ended December 31, 2018, from accumulated other comprehensive income to retained earnings in the Balance Sheet.

Revenue from Contracts with Customers

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers* (Topic 606) ("Topic 606"). ASU 2014-09 outlines a single comprehensive model for companies to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance. In March 2016, the FASB issued ASU 2016-08, Principal Versus *Agent Considerations (Reporting* Revenue Gross Versus Net) which amends the principal-versus-agent implementation guidance and in April 2016 the FASB issued ASU 2016-10, Identifying Performance Obligations and Licensing, which amends the guidance in those areas in the new revenue recognition standard. The ASU requires that an entity recognize revenue for the transfer of goods or services to a customer at an amount that reflects the consideration to which an entity expects to be entitled in exchange for those goods or services. The ASU also requires additional disclosures regarding the nature, amount, timing and

uncertainty of revenue and cash flows arising from customer contracts. The Company adopted the new standards as of January 1, 2018 using the modified retrospective method and applied the new standard to all contracts. The Company included additional disclosures required by the new accounting guidance under "Revenue Recognition" above. There were no material changes in the timing of its recognition of revenue or net income, as a result of the adoption.

Recognition and Measurement of Financial Assets and Financial Liabilities
In January 2016, the FASB issued ASU 2016-01, *Financial Instruments - Overall* (Subtopic 825-10): *Recognition and Measurement of Financial Assets and Financial Liabilities*. This ASU requires equity investments, except those under the equity method of accounting or those that result in the consolidation of an investee, to be measured at fair value with changes in fair value recognized in net income. The Company adopted this provision on a modified retrospective basis as of January 1, 2018. The Company also elected, on a prospective basis, to report equity investments without a readily determinable fair value at cost less impairments, plus or minus subsequent adjustments for observable price changes. The adoption of this new guidance resulted in an increase to the carrying value of the HealthEdge investment by $5 million and the recognition of a corresponding realized capital gain.

Future Accounting Standards
Accounting for Interest Associated with the Purchase of Callable Debt Securities
In March 2017, the FASB issued ASU 2017-08, *Accounting for Interest Associated with the Purchase of Callable Debt Securities (*Topic 310*)*. Under this ASU, premiums on callable debt securities are amortized to the earliest call date rather than to the contractual maturity date. Callable debt securities held at a discount will continue to be amortized to the contractual maturity date. The adoption of this new guidance on January 1, 2019 did not have a material impact on the Company's financial position and operating results.

Measurement of Credit Losses on Financial Instruments
In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This ASU requires the use of a forward-looking expected loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. The ASU also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. The standard is effective for private companies for fiscal years beginning after December 15, 2020. The Company is currently evaluating the impact of implementation of this standard.

3. Investments

Debt securities available for sale at December 31, 2018 and 2017 were as follows:

(Thousands)	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2018				
Debt securities:				
U.S. government securities	**$ 3,925**	**$ 19**	**$ —**	**$ 3,944**
States, municipalities and political subdivisions	**96,447**	**681**	**(397)**	**96,731**
U.S. corporate securities	**15,887**	**144**	**(137)**	**15,893**
Foreign securities	**8,717**	**273**	**(27)**	**8,964**
Other asset-backed securities	**3,687**	**60**	**(16)**	**3,731**
Total debt securities	**$ 128,663**	**$ 1,177**	**$ (577)**	**$ 129,263**
December 31, 2017				
Debt securities:				
U.S. government securities	$ 6,595	$ 172	$ —	$ 6,767
States, municipalities and political subdivisions	194,026	3,141	(1,444)	195,723
U.S. corporate securities	25,475	853	(13)	26,315
Foreign securities	51,720	3,949	(37)	55,632
Residential mortgage-backed securities	18,338	98	(173)	18,263
Commercial mortgage-backed securities	5,332	—	(112)	5,220
Other asset-backed securities	1,812	100	—	1,912
Total debt securities	$ 303,298	$ 8,313	$ (1,779)	$ 309,832

The fair value of debt securities at December 31, 2018 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid.

(Thousands)	Amortized Cost	Fair Value
Due to mature:		
Less than one year	**$ 17,335**	**$ 17,415**
One year through five years	**60,857**	**61,229**
After five years through ten years	**22,915**	**23,036**
Greater than ten years	**23,869**	**23,852**
Other loan backed securities	**3,687**	**3,731**
Total	**$ 128,663**	**$ 129,263**

Mortgage-Backed and Other Asset-Backed Securities
The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2018, these securities had an average credit quality rating of AA and a weighted average duration of 3.4 years.

Non-controlling (Minority) Interests
At December 31, 2017, continuing business non-controlling interests were $59 million primarily related to third party interests in our investment holdings. During 2018 the Company sold all third party interests in our investment holdings. For the year ended December 31, 2017, the non-controlling entities' share was included in total Member's equity on the Balance Sheets and was reflected within net investment income on the Statements of Income. Net income attributable to non-controlling interests was $179 thousand in 2017.

Unrealized Capital Losses and Net Realized Capital Gains (Losses)

When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. The Company recognizes an other-than-temporary impairment ("OTTI") when it intends to sell a debt security that is in an unrealized capital loss position or if the Company determines a credit-related loss on a debt security has occurred.

Summarized below are the debt securities the Company held at December 31, 2018 and 2017 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total		
(Thousands)	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses
December 31, 2018									
States, municipalities and political subdivisions	**9**	**$ 27,320**	**$ 155**	**5**	**$ 9,050**	**$ 242**	**14**	**$ 36,370**	**$ 397**
U.S. corporate securities	**5**	**2,995**	**39**	**5**	**3,054**	**98**	**10**	**6,049**	**137**
Foreign securities	**2**	**2,746**	**27**	**—**	**—**	**—**	**2**	**2,746**	**27**
Other asset-backed securities	**1**	**1,229**	**16**	**—**	**—**	**—**	**1**	**1,229**	**16**
Total debt securities	**17**	**$ 34,290**	**$ 237**	**10**	**$ 12,104**	**$ 340**	**27**	**$ 46,394**	**$ 577**
December 31, 2017									
States, municipalities and political subdivisions	21	$ 44,876	$ 421	8	$ 49,624	$ 1,023	29	$ 94,500	$ 1,444
U.S. corporate securities	2	2,228	12	1	1,000	1	3	3,228	13
Foreign securities	3	2,080	31	1	189	6	4	2,269	37
Residential mortgage-backed securities	2	8,198	42	1	2,766	131	3	10,964	173
Commercial mortgage-backed securities	—	—	—	1	5,219	112	1	5,219	112
Total debt securities	28	$ 57,382	$ 506	12	$ 58,798	$ 1,273	40	$ 116,180	$ 1,779

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2018 were as follows:

(Thousands)	Fair Value	Unrealized Losses
Due to mature:		
Less than one year	**$ 6,965**	**$ 38**
One year through five years	**10,232**	**170**
After five years through ten years	**13,157**	**85**
Greater than ten years	**14,811**	**268**
Other asset-backed securities	**1,229**	**16**
Total	**$ 46,394**	**$ 577**

The Company reviewed the securities in the tables above and concluded that these are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. At December 31, 2018 and 2017, the Company did not intend to sell these securities, and the Company did not believe it was more likely than not that it would be required to sell these securities prior to anticipated recovery of their amortized cost basis.

Net Investment Income

Sources of net investment income for 2018 and 2017 were as follows:

(Thousands)		2018		2017
Debt securities	$	5,386	$	12,249
Other investments		7,698		5,899
Gross investment income		13,084		18,148
Investment expenses		(9,458)		(8,993)
Net investment income	$	3,626	$	9,155

Realized Capital Gains/Losses

Net realized capital (losses) gains for 2018 and 2017 were as follows:

(Thousands)		2018		2017
Other-than-temporary impairment ("OTTI") losses on debt securities recognized in earnings	$	(760)	$	(345)
Other net realized capital gains		6,739		1,649
Net realized capital gains	$	5,979	$	1,304

Yield-related impairments are recognized in other comprehensive income unless we have the intention to sell the security in an unrealized capital loss position, in which case the yield-related OTTI is recognized in earnings. In 2018 and 2017, we recognized yield-related OTTI losses of $760 thousand and $345 thousand, respectively, related to our debt securities. We recognized a realized capital gain of $4.7 million related to observable price changes in the Company's investment in HealthEdge during the year ended December 31, 2018, We had no other individually material capital losses on debt or equity securities that impacted our operating results during 2018 or 2017.

Proceeds from the sale of available for sale debt securities and the related gross realized capital gains and losses for 2018 and 2017 were as follows:

(Thousands)		2018		2017
Proceeds on sales	$	166,359	$	193,874
Gross realized capital gains		3,949		2,851
Gross realized capital losses		1,940		1,202

4. Fair Value

The preparation of the Company's financial statements in accordance with GAAP requires certain of the Company's assets and liabilities to be reflected at their fair value, and others on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how the Company determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value in the Company's Balance Sheet

Certain of the Company's financial instruments are measured at fair value in the Company's balance sheet. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1** - Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2** - Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are

observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.

- **Level 3** - Developed from unobservable data, reflecting the Company's own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified as Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Debt Securities – Where quoted prices are available in an active market, the Company's debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities are comprised primarily of U.S. Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models such as matrix pricing, which use quoted market prices of debt securities with similar characteristics, or discounted cash flows to estimate fair value. The Company reviews these prices to ensure they are based on observable market inputs that include, but are not limited to, quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable but not prices (for example, interest rates and credit risks). The Company also reviews the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of these prices at December 31, 2018 and 2017.

Equity Securities – The Company currently holds a privately placed warrant which is classified as an equity security. For privately placed equity securities, there is no active market; therefore, the Company classifies the security in Level 3 because the Company prices the security through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would result in a change in the fair value measurement, which may be significant. There was no activity related to the equity security for the year ended December 31, 2017 and December 31, 2018.

Hedge fund limited partnerships: Hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. At December 31, 2017, the value of the hedge fund limited partnerships was $59 million. During the fourth quarter of 2017, the Company sold all third party interests in our investment holdings. These investments have been excluded from the fair value tables below.

Investments in all hedge fund limited partnerships can be redeemed at the current net asset value based on the fair value of the underlying assets. The Company may withdraw all or any part of its capital account quarterly, as of the last day of the period with 90 days written notice of such withdrawal. Withdrawals in the period could be subject to a total fund level withdrawal limit. There were no unfunded commitments for these investments as of December 31, 2018 or 2017.

Financial assets measured at fair value on a recurring basis in the Company's Balance Sheets at December 31, 2018 and 2017 were as follows:

(Thousands)	Level 1	Level 2	Level 3	Total
December 31, 2018				
Debt securities:				
U.S. government securities	**$ 3,944**	**$ —**	**$ —**	**$ 3,944**
States, municipalities and political subdivisions	**—**	**96,731**	**—**	**96,731**
U.S. corporate securities	**—**	**15,893**	**—**	**15,893**
Foreign securities	**—**	**8,964**	**—**	**8,964**
Other asset-backed securities	**—**	**3,731**	**—**	**3,731**
Total debt securities	**3,944**	**125,319**	**—**	**129,263**
Equity securities	**—**	**—**	**3,772**	**3,772**
Total	**$ 3,944**	**$ 125,319**	**$ 3,772**	**$ 133,035**
December 31, 2017				
Debt securities:				
U.S. government securities	$ 6,767	$ —	$ —	$ 6,767
States, municipalities and political subdivisions	—	195,723	—	195,723
U.S. corporate securities	—	26,315	—	26,315
Foreign securities	—	55,632	—	55,632
Residential mortgage-backed securities	—	18,263	—	18,263
Commercial mortgage-backed securities	—	5,220	—	5,220
Other asset-backed securities	—	1,912	—	1,912
Total debt securities	6,767	303,065	—	309,832
Equity securities	—	—	3,772	3,772
Total	$ 6,767	$ 303,065	$ 3,772	$ 313,604

There were no transfers between Levels 1 and 2 during the years ended December 31, 2018 and 2017. There were no transfers into or out of Level 3 during the years ended December 31, 2018 and 2017.

Financial Instruments Not Measured at Fair Value in our Balance Sheets

The following is a description of the valuation methodologies used for estimating the fair value of our financial assets and liabilities that are carried on the Company's Balance Sheets at adjusted cost or contract value.

The carrying value and estimated fair value classified by level of fair value hierarchy for certain of our financial instruments at December 31, 2018 and 2017 were as follows:

(Thousands)	Carrying	Estimated fair value			
December 31, 2018	Value	Level 1	Level 2	Level 3	Total
Assets:					
Equity securities [1]	**$ 44,731**	**N/A**	**N/A**	**N/A**	**N/A**
December 31, 2017					
Assets:					
Equity securities [1]	$ 40,000	N/A	N/A	N/A	N/A

[1] It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies.

5. Income Taxes

The components of the income tax expense for the years ended December 31, 2018 and 2017 were as follows:

(Thousands)	2018	2017
Current income taxes:		
Federal	**$ 113,023**	$ 149,105
State	**(3,685)**	5,270
Total current income taxes	**109,338**	154,375
Deferred income taxes:		
Federal	**1,938**	23,158
State	**77**	806
Total deferred income taxes	**2,015**	23,964
Total income taxes	**$ 111,353**	$ 178,339

Income taxes are different from the amount computed by applying the federal income tax rate to income before income taxes for the years ended December 31, 2018 and 2017 as follows:

(Thousands)	2018	2017
Income before income taxes	**436,403**	$ 263,385
Tax rate	**21%**	35%
Total federal tax provision	**91,645**	92,185
Tax effect of:		
State income tax provision, net of federal income tax	**(2,834)**	4,729
Permanent items, including Section 482 adjustment	**38,070**	89,526
Impact on deferred tax for enacted rate change	**—**	7,891
Prior year estimate to actual and other[1]	**(15,528)**	(15,992)
Income taxes	**$ 111,353**	$ 178,339

[1] The prior year estimate to actual income tax benefit is primarily driven by a change in estimate of the annual Internal Revenue Code (IRC) Section 482 management fee adjustment.

The components of the deferred tax assets at December 31, 2018 and 2017 were as follows:

(Thousands)	2018	2017
Deferred tax assets:		
Restructure reserves	**$ 1,528**	$ 77
Capitalized supplies	**340**	332
Deferred compensation	**2,051**	—
Intangibles	**299**	419
Investments	**213**	199
Software	**17,816**	24,353
Net operating loss - federal and state	**1,209**	1,591
Other	**239**	360
Gross deferred tax assets	**23,695**	27,331
Deferred tax liabilities:		
Investments	**$ 2,027**	$ 3,701
Intangibles	**824**	744
Software	**4,629**	6,157
Other liabilities	**1,585**	1,329
Gross deferred tax liabilities	**9,065**	11,931
Net total deferred tax assets	**$ 14,630**	$ 15,400

In assessing the realizability of the deferred tax asset, management considers whether it is more likely than not that some portion or all of the deferred tax asset will not be realized. The ultimate realization of a deferred tax asset is dependent upon generation of future taxable income during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities and tax planning strategies in making this assessment. Based upon the level of historical taxable income, management believes that all other deferred tax assets will be realized.

The Company participates in the Compliance Assurance Process ("CAP") with the Internal Revenue Service ("IRS"). Under the CAP, the IRS undertakes audit procedures during the tax year and as the return is being prepared for filing. The IRS has concluded its CAP audit of the Company's tax returns for 2016 and prior years. The CAP audits for the 2017 and 2018 tax years are in process.

At December 31, 2018 and 2017, the Company did not have material uncertain tax positions ("UTPs") reflected in its balance sheet.

On December 22, 2017, the TCJA was enacted. Refer to Note 2 for additional information related to the TCJA.

6. Other Comprehensive Income (Loss)

Member's equity included the following activity in accumulated other comprehensive income (loss) in 2018 and 2017:

	At December 31,	
(Thousands)	**2018**	**2017**
Unrealized gains (losses) on securities		
Beginning of period balance	**$ 5,031**	**$ 969**
Adoption of new accounting standard (Note 2)	**914**	**—**
Unrealized gains (losses)	**(5,933)**	**5,547**
Tax (expense) benefit	**1,246**	**(1,485)**
Other comprehensive income (loss)	**(4,687)**	**4,062**
End of period balance	**$ 1,258**	**$ 5,031**

7. Property and Equipment

Property and equipment at December 31, 2018 and 2017 consist of the following:

(Thousands)	**2018**	**2017**
Furniture and equipment	**$ 12,354**	$ 62,739
Internal use software	**43,416**	82,329
Gross property and equipment	**55,770**	145,068
Less accumulated depreciation	**(36,708)**	(118,946)
Net property and equipment	**$ 19,062**	$ 26,122

The decrease in gross property and equipment and accumulated depreciation during the year ended December 31, 2018 is primarily due to the retirement of fully depreciated assets.

8. Related Party Transactions

The Company and certain Health Plan Legal Entities are parties to administrative services agreements, under which the Company provides certain administrative services, including accounting and processing of premiums and claims. Under these agreements, these Health Plan Legal Entities remit a percentage of their earned Commercial, Medicaid and Medicare premium revenue, as applicable, to the Company as a fee, subject to an annual true-up mechanism as defined in the agreements. The Company reported $1.6 billion and $1.9 billion, respectively, as management fee income pursuant to these agreements for the years ended December 31, 2018 and 2017. A portion of the management fee income represents commission expense of $225 million and $294 million for the years ended December 31, 2018 and 2017, respectively.

These agreements also provide for interest on all intercompany balances. Interest earned on amounts due from affiliates was $7.6 million and $5.9 million for the years ended December 31, 2018 and 2017, respectively, and is classified as management fee income in the Statement of Income.

The Company is party to agreements with the Health Plan Legal Entities which enables the Health Plan Legal Entities to receive manufacturers' pharmacy rebates from the Company under which the Health Plan Legal Entities remit 10% of its earned pharmaceutical rebates to the Company as a fee. The Company earned pharmaceutical rebate administrative income of $394 million and $276 million in 2018 and 2017, respectively, and is classified as pharmacy rebate income in the Statements of Income.

The Company manages, administers and performs various prescription drug and pharmacy benefit management functions and services for and on behalf of its members. In July 2010, the Company entered into a Pharmacy Benefit Management Subcontract Agreement with CVS (the "PBM Agreement"). Under the PBM Agreement, Aetna continues to maintain and manage the pharmacy benefit management ("PBM") organization and retain and operate its mail order

and specialty pharmacies. CVS provides the administration of selected functions for the retail pharmacy network contracting and claims administration; mail order pharmacy and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services.

At December 31, 2018 and 2017, the Company did not have any intercompany loans.

The Company and Aetna also entered into an expense allocation agreement. The agreement obligates the Company to reimburse Aetna the cost of providing services to the Company, as well as interest on outstanding monthly intercompany balances. Charges under this agreement reflect actual costs when practicable and estimated costs. Estimated costs, whenever used, are adjusted periodically to bring them into alignment with actual costs. For 2018 and 2017, the Company incurred costs of $1.3 billion and $1.8 billion, respectively, related to this agreement. At December 31, 2018 and 2017, the Company had $57 million and $309 million due to Aetna Inc., respectively, related to this agreement. The terms of this agreement require that all intercompany balances be settled within 45 days after the end of the calendar quarter.

No contributions were made to the Company from Aetna Health Holding during the year ended December 31, 2018. Contributions of $94 million were made to the Company from Aetna Health Holdings during the years ended December 31, 2017.

There were no dividends paid to during the year ended December 31, 2017. Dividends paid from the Company to Aetna Health Holdings during the year ended December 31, 2018 were $130 million and consisted of the following transactions:

(Thousands)

Dividends:

Date of payment	Amount
March 28, 2018	$ 105,000
September 27, 2018	25,000

9. Commitments and Contingencies

Litigation and Regulatory Proceedings

The following description of litigation and regulatory proceedings covers Aetna and certain of its subsidiaries, including the Company (collectively, “we”, “our” or “us”). Certain of the proceedings described below may impact the Company and/or may lead to claim payments under the Company’s policies that name the Company’s affiliates as insureds. Certain of the proceedings described below also may impact the Company indirectly as the Company is a member of the Aetna holding company group.

The Company’s affiliates are involved in numerous lawsuits arising, for the most part, in the ordinary course of their business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, the Centers for Medicare &

Medicaid Services, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the Office of Inspector General, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice (the "DOJ"), the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our proposed transaction with CVS Health Corporation, our withdrawal from certain states' public health insurance exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses. We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. We are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Aetna Medicaid Administrators LLC

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Aetna Medicaid Administrators, LLC

Financial Statements
December 31, 2018 and 2017
(With Independent Auditors' Report Thereon)

AETNA MEDICAID ADMINISTRATORS, LLC

Financial Statements
December 31, 2018 and 2017

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KPMG LLP
One Financial Plaza
755 Main Street
Hartford, CT 06103

Independent Auditors' Report

The Board of Directors
Aetna Medicaid Administrators, LLC:

We have audited the accompanying financial statements of Aetna Medicaid Administrators, LLC, which comprise the balance sheets as of December 31, 2018 and 2017, and the related statements of operations, comprehensive income, member's equity, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Aetna Medicaid Administrators, LLC as of December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

[redacted]

Hartford, Connecticut
May 30, 2019

KPMG LLP is a Delaware limited liability partnership and the U.S. member firm of the KPMG network of independent member firms affiliated with KPMG International Cooperative ("KPMG International"), a Swiss entity.

AETNA MEDICAID ADMINISTRATORS, LLC

Balance Sheets
December 31, 2018 and 2017

	2018	2017
Assets:		
Current assets:		
Cash and cash equivalents	**$ 79,852,738**	$ 32,898,380
Investments	**16,115,632**	13,189,650
Accounts receivable, net	**117,446,909**	285,712,795
Prepaid expenses	**3,311,768**	2,128,421
Restricted cash	**651,208**	315,591
Total current assets	**217,378,255**	334,244,837
Property and equipment, net	**55,808**	135,416
Long-term investments	**38,624,733**	74,131,417
Internal-use software	**44,316,974**	35,408,753
Total assets	**$ 300,375,770**	$ 443,920,423
Liabilities:		
Current liabilities:		
Accounts payable and accrued liabilities	**$ 109,009,526**	$ 196,534,052
Income taxes payable	**2,469,644**	11,667,316
Total current liabilities	**111,479,170**	208,201,368
Deferred income taxes	**3,499,087**	7,812,026
Total liabilities	**114,978,257**	216,013,394
Commitments and contingencies (Note 8)		
Member's equity:		
Common shares (75,000,000 shares authorized and 11,519,636 shares issued and outstanding, and additional paid-in capital)	**28,216,455**	28,216,455
Retained earnings	**157,263,874**	199,266,113
Accumulated other comprehensive income	**(82,816)**	424,461
Total member's equity	**185,397,513**	227,907,029
Total liabilities and member's equity	**$ 300,375,770**	$ 443,920,423

See accompanying notes to the financial statements.

Statements of Operations
Years ended December 31, 2018 and 2017

	2018	2017
Revenue:		
Plan management fees	**$ 959,814,480**	$ 996,500,104
Net investment income and realized capital gains	**1,866,806**	1,391,015
Total revenue	**961,681,286**	997,891,119
Expenses:		
Salaries and benefits	**497,136,215**	561,896,484
General and administrative	**159,207,130**	121,935,421
Purchased services	**219,986,793**	168,314,678
Depreciation and amortization	**8,450,654**	7,030,200
Loss on disposal of assets	**23,560**	99,369
Total expenses	**884,804,352**	859,276,152
Income before income tax expense	**76,876,934**	138,614,967
Income tax expense	**18,787,751**	82,848,117
Net income	**$ 58,089,183**	$ 55,766,850

See accompanying notes to the financial statements.

Statements of Comprehensive Income
Years ended December 31, 2018 and 2017

	2018	2017
Net income	**$ 58,089,183**	$ 55,766,850
Other comprehensive income:		
Unrealized (loss) gain on securities, net of tax	**(598,699)**	86,081
Other comprehensive (loss) income	**(598,699)**	86,081
Total comprehensive income	**$ 57,490,484**	$ 55,852,931

See accompanying notes to the financial statements, including Note 6 for further information about other comprehensive income.

Statements of Member's Equity
Years ended December 31, 2018 and 2017

	Member's equity & additional paid-in capital	Retained earnings	Accumulated other comprehensive income (loss)	Total member's equity
Balance at December 31, 2016	**$ 28,216,455**	**$ 143,499,263**	**$ 338,380**	**$ 172,054,098**
Net income	—	55,766,850	—	55,766,850
Other comprehensive income	—	—	86,081	86,081
Balance at December 31, 2017	**28,216,455**	**199,266,113**	**424,461**	**227,907,029**
Net income	—	**58,089,183**	—	**58,089,183**
Adoption of new accounting standards (Note 2)	—	**(91,422)**	**91,422**	—
Dividend to stockholder (intercompany)	—	**(100,000,000)**	—	**(100,000,000)**
Other comprehensive loss	—	—	**(598,699)**	**(598,699)**
Balance at December 31, 2018	**$ 28,216,455**	**$ 157,263,874**	**$ (82,816)**	**$ 185,397,513**

See accompanying notes to the financial statements.

Statements of Cash Flows
Years ended December 31, 2018 and 2017

	2018	2017
Cash flows from operating activities:		
Net income	**$ 58,089,183**	$ 55,766,850
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	**8,450,654**	7,030,200
Loss on disposal of assets	**23,560**	99,369
Net realized losses (gain) on investments	**1,531,834**	(125,860)
Amortization of premiums	**481,575**	475,800
Deferred taxes	**(4,153,790)**	301,130
Changes in assets and liabilities:		
Accounts receivable	**168,265,886**	(51,239,736)
Prepaid expenses	**(1,183,347)**	(1,017,106)
Accounts payable and accrued liabilities	**(87,502,999)**	54,254,457
Income taxes payable	**(9,197,672)**	(16,287,064)
Restricted cash	**(335,617)**	317,993
Net cash provided by operating activities	**134,469,267**	49,576,033
Cash flows from investing activities:		
Additions to property, equipment, and software, net	**(17,324,354)**	(12,500,979)
Cost of investments	**(14,415,580)**	(70,507,881)
Proceeds from sales and maturities of investments	**44,225,025**	28,646,706
Net cash provided by (used for) investing activities	**12,485,091**	(54,362,154)
Cash flows from financing activities:		
Capital distributions	**(100,000,000)**	—
Net cash used for financing activities	**(100,000,000)**	—
Net increase (decrease) in cash and cash equivalents	**46,954,358**	(4,786,121)
Cash and cash equivalents, beginning of period	**32,898,380**	37,684,501
Cash and cash equivalents, end of period	**$ 79,852,738**	$ 32,898,380
Supplemental cash flow information:		
Income taxes paid	**$ 32,160,740**	$ 98,834,051

See accompanying notes to the financial statements.

1. Organization

Aetna Medicaid Administrators, LLC ("the Company"), formerly Schaller Anderson, LLC, is a wholly owned subsidiary of Aetna Health Holdings, LLC. The Company's ultimate parent is Aetna Inc., a Pennsylvania corporation ("Aetna").

The Company provides administrative, management, and support services to Medicaid and Medicare insurance plans, including health plans owned by affiliated companies. The Company provides all services necessary for the day-to-day operations of the health plans it administers and provides limited services, such as medical management oversight for health plans administered by affiliated entities.

On November 28, 2018, CVS Health acquired 100% of the outstanding shares and voting interests of Aetna Inc. for a combination of cash and stock.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP"). The Company has evaluated subsequent events from the financial statement date through May 30, 2019 noting that a dividend was paid from the Company to Aetna Health Holdings of $15 million during March of 2019.

Use of Estimates

The preparation of the accompanying consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the amounts reported in these consolidated financial statements and notes. The Company considers the following accounting estimates critical in the preparation of the accompanying consolidated financial statements: fair value of investments, other-than-temporary impairment ("OTTI") of debt securities, revenue recognition and allowance for estimated terminations and uncollectable accounts. The Company uses information available to management at the time estimates are made; however, these estimates could change materially if different information or assumptions were used. Additionally, these estimates may not ultimately reflect the actual amounts of the final transactions that occur.

Cash and Cash Equivalents

Cash and cash equivalents include cash on-hand and debt securities with an original maturity of three months or less when purchased. The carrying value of cash equivalents approximates fair value due to the short-term nature of these investments.

Accounts Receivable

At December 31, 2018 and 2017, accounts receivable includes management fees receivable and reimbursable expenses from unrelated entities, investment receivables, and intercompany receivables as follows:

	2018	2017
Accounts receivable, unrelated entities	**$ 22,588,331**	$ 2,010,988
Investment receivables	**728,202**	418,249
Intercompany receivables	**94,130,376**	283,283,558
Total accounts receivable	**$ 117,446,909**	$ 285,712,795

See Note 7 for more information on the Company's business concentrations and affiliated parties.

Investments

Debt securities consist primarily of U.S. Treasury and agency securities, state and local securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless we intend to sell an investment within the next 12 months, in which case it is classified as current in the Company's Balance Sheets. The Company has classified its debt securities as available-for-sale and carries them at fair value. Refer to Note 4 for additional information on how we estimate the fair value of these investments.

The Company regularly reviews its debt securities to determine whether a decline in fair value below the carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in the fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in the Company's operating results, and the amount of the non-credit related component is included in other comprehensive income, unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. The Company does not accrue interest on debt securities when management believes the collection of interest is unlikely.

Net Investment Income and Realized Capital Gains and Losses

Net investment income and realized capital gains and losses on investments are reflected in the Company's Statements of Operations. Realized capital gains and losses on investments are determined on a specific identification basis. The Company reflects purchases and sales of debt securities on the trade date. Unrealized capital gains and losses on investments are reflected in total shareholder's equity, net of tax, as a component of accumulated other comprehensive income.

Property and Equipment, Net

Property and equipment are reported at historical cost, net of accumulated depreciation. Depreciation is calculated primarily using the straight-line method over the following estimated useful lives:

Computer hardware	**3-5 years**
Furniture and fixtures	**10 years**
Building improvements	**5-10 years**
Capitalized software	**5 years**

Property and equipment at December 31, 2018 and 2017 consist of the following:

	2018	2017
Furniture and fixtures	**$ 2,228,473**	$ 4,773,736
Computer hardware	**270,423**	348,987
Auto	**54,505**	4,910
Building improvements	**4,579,308**	4,579,308
Gross property and equipment	**7,132,709**	9,706,941
Less accumulated depreciation	**7,076,901**	9,571,525
Net property and equipment	**$ 55,808**	$ 135,416

Property and equipment values are reviewed for impairment whenever events or changes in circumstances indicate that the carrying value of property and equipment may not be recoverable. Recoverability of an asset is measured by a comparison of the carrying amount of the asset to the future undiscounted cash flows expected to result from future use of the asset and its eventual disposition. If the sum of the undiscounted future cash flows is less than the

carrying value of the asset, impairment is recognized to the extent the carrying value of the asset exceeds its fair value. There were no impairment losses for the years ended December 31, 2018 and 2017.

The Company realized a loss on disposal of assets of $23,560 and $99,369 for the years ended December 31, 2018 and 2017, respectively.

Accounts Payable and Accrued Liabilities
Accounts payable and accrued liabilities at December 31, 2018 and 2017 consist of the following:

	2018	2017
Accounts payable	**$ 66,281,476**	$ 81,687,939
Accrued payroll	**10,726,931**	20,170,146
Intercompany liabilities	**32,001,119**	94,675,967
Total accounts payable and accrued liabilities	**$ 109,009,526**	$ 196,534,052

Internal-use Software
Internal-use software consists of capitalized costs associated with development of software applications used in the processing of medical claims. For the years ended December 31, 2018 and 2017, $13,828,939 and $12,492,120 of internal-use software was placed in service, respectively. The costs are amortized over a five year period. The ending balances as of December 31, 2018 and 2017, were $44,316,974 and $35,408,753, respectively.

Internal-use software values are reviewed for impairment whenever events or changes in circumstances indicate that the carrying value of internal-use software may not be recoverable. Internal-use computer software is not expected to provide substantive service potential. Impairment exists when a significant change occurs in the extent or manner in which the software is used or is expected to be used, a significant change is made or will be made to the software program, costs of developing or modifying internal-use computer software significantly exceeded the amount originally expected to develop or modify the software.

Revenue Recognition
The Company earns plan management fee revenue by providing managerial, operative, processing, and accounting support to various Medicaid and Medicaid/Medicare Dual plans, some of which are related parties (Note 7). Plan management fee income relates to contracts that can include various combinations of services or series of services which are generally capable of being distinct and accounted for as separate performance obligations. Plan management fees are calculated as a percentage of revenue or are based on expenses incurred by the Company on behalf of the health plan as outlined by each plan's master agreement. Additional revenue may also be earned when certain quality and performance metrics are achieved. The Company recognizes plan management fees as services are rendered.

For the twelve months ended December 31, 2018, the Company had no material bad debt expense.

Income Taxes
The Company recognizes deferred income tax assets and liabilities for the differences between the financial and income tax reporting basis of assets and liabilities based on enacted tax rates and laws. Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. Deferred income tax expense or benefit primarily reflects the net change in deferred income tax assets and liabilities during the year. The current income tax provision reflects the tax results of revenues and expenses currently taxable or deductible. Penalties and interest on the Company's tax positions are classified as a component of the Company's income tax provision.

The Company was included in the consolidated federal income tax return of its parent company, Aetna and Aetna's other wholly-owned subsidiaries through November 27, 2018 pursuant to the terms of a tax sharing agreement. For the tax period from November 28, 2018 through December 31, 2018, Aetna and its wholly-owned subsidiaries are

included in the consolidated federal income tax return of its parent company, CVS Health, pursuant to the terms of a tax sharing agreement (and a Supplemental Tax Sharing Agreement where applicable) between CVS Health and the Company.

In accordance with both tax sharing agreements, the Company's current federal income tax provision is generally computed as if the Company were filing a separate federal income tax return; current income tax benefits, including those resulting from net operating losses, are recognized to the extent realized in the consolidated return. Pursuant to these agreements, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. For state tax filing purposes, the Company files primarily unitary returns which results in a state tax liability that is based on an apportionment of Aetna federal taxable income.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "TCJA") was enacted. Among other things, the TCJA reduced the federal corporate income tax rate to 21 percent effective January 1, 2018. Accordingly, the Company remeasured its deferred tax assets and liabilities as of the enactment date to reflect the lower tax rate and in 2017 recognized an incremental tax benefit of $3,815,782 related to the change in its net deferred tax assets and liabilities.

New Accounting Standards

Revenue from Contracts with Customers

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers* (Topic 606) ("Topic 606"). ASU 2014-09 outlines a single comprehensive model for companies to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance. In March 2016, the FASB issued ASU 2016-08, *Principal Versus Agent Considerations (Reporting* Revenue Gross Versus Net) which amends the principal-versus-agent implementation guidance and in April 2016 the FASB issued ASU 2016-10, Identifying Performance Obligations and Licensing, which amends the guidance in those areas in the new revenue recognition standard. The ASU requires that an entity recognize revenue for the transfer of goods or services to a customer at an amount that reflects the consideration to which an entity expects to be entitled in exchange for those goods or services. The ASU also requires additional disclosures regarding the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts. The Company adopted the new standards as of January 1, 2018 using the modified retrospective method and applied the new standard to all contracts. The Company included additional disclosures required by the new accounting guidance under "Revenue Recognition" above. There were no material changes in the timing of its recognition of revenue or net income, as a result of the adoption.

Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income

In February 2018, the FASB issued ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*. This ASU permits entities to reclassify tax effects stranded in accumulated other comprehensive income as a result of the TCJA to retained earnings. The guidance states that because the adjustment of deferred income taxes due to the reduction of the historical corporate income tax rate to the newly enacted corporate income tax rate was required to be included in net income, the tax effects of items within accumulated other comprehensive income ("stranded tax effects") are not reflected at the appropriate tax rate. The Company elected to early adopt this new standard and reclassified the stranded tax effects of $91,422 during the year ended December 31, 2018, from accumulated other comprehensive income to retained earnings in the Balance Sheet.

Future Accounting Standards

Accounting for Interest Associated with the Purchase of Callable Debt Securities

In March 2017, the FASB issued ASU 2017-08, *Accounting for Interest Associated with the Purchase of Callable*

*Debt Securities (*Topic 310*)*. Under this ASU, premiums on callable debt securities are amortized to the earliest call date rather than to the contractual maturity date. Callable debt securities held at a discount will continue to be amortized to the contractual maturity date. The adoption of this new guidance on January 1, 2019 did not have a material impact on the Company's financial position and operating results.

Measurement of Credit Losses on Financial Instruments
In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This ASU requires the use of a forward-looking expected loss impairment model for trade and other receivables, held-to maturity debt securities, loans and other instruments. The ASU also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. The standard is effective for private companies for fiscal years beginning after December 15, 2020. The Company is currently evaluating the impact of implementation of this standard.

3. Investments

Debt securities available for sale at December 31, 2018 and 2017 were as follows:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2018				
Debt securities:				
U.S. government securities	**$ 9,531,358**	**$ 231,450**	**$ —**	**$ 9,762,808**
States, municipalities and political subdivisions	**41,100,638**	**393,307**	**(694,751)**	**40,799,194**
U.S. corporate securities	**3,713,200**	**29,043**	**(13,485)**	**3,728,758**
Foreign securities	**500,000**	**—**	**(50,395)**	**449,605**
Total	**$ 54,845,196**	**$ 653,800**	**$ (758,631)**	**$ 54,740,365**
December 31, 2017				
Debt securities:				
U.S. government securities	$ 12,114,592	$ 75,284	$ —	$ 12,189,876
States, municipalities and political subdivisions	68,842,539	807,135	(310,691)	69,338,983
U.S. corporate securities	5,710,919	81,379	(90)	5,792,208
Total	$ 86,668,050	$ 963,798	$ (310,781)	$ 87,321,067

The fair value of debt securities at December 31, 2018 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid.

	Amortized Cost	Fair Value
Due to mature:		
Less than one year	**$ 4,176,874**	**$ 4,145,418**
One year through five years	**7,346,476**	**7,333,953**
After five years through ten years	**18,509,419**	**18,616,995**
Greater than ten years	**24,812,427**	**24,643,999**
Total	**$ 54,845,196**	**$ 54,740,365**

Unrealized Capital Losses and Net Realized Capital Gains (Losses)
When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. The Company recognizes an OTTI when it intends to sell a debt security that is in an unrealized capital loss position or if the Company determines a credit-related loss on a debt security has occurred.

Summarized below are the debt securities the Company held at December 31, 2018 and 2017 that were in an unrealized capital loss position, aggregated by the length of time the investments have been in that position:

	Less than 12 months			Greater than 12 months			Total		
	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses	Number of Securities	Fair Value	Unrealized Losses
December 31, 2018									
Debt securities:									
States, municipalities and political subdivisions	**4**	**$ 6,235,725**	**$ 214,040**	**19**	**$26,693,913**	**$ 480,711**	**23**	**$32,929,638**	**$ 694,751**
U.S. corporate securities	**—**	**—**	**—**	**1**	**1,985,692**	**13,485**	**1**	**1,985,692**	**13,485**
Foreign securities	**1**	**449,605**	**50,395**	**—**	**—**	**—**	**1**	**$ 449,605**	**$ 50,395**
Total debt securities	**5**	**$ 6,685,330**	**$ 264,435**	**20**	**$28,679,605**	**$ 494,196**	**25**	**$35,364,935**	**$ 758,631**
December 31, 2017									
Debt securities:									
States, municipalities and political subdivisions	13	$19,384,945	$ 51,027	2	$ 2,248,506	$ 259,664	15	$21,633,451	$ 310,691
U.S. corporate securities	1	999,774	90	—	—	—	1	999,774	90
Total debt securities	14	$20,384,719	$ 51,117	2	$ 2,248,506	$ 259,664	16	$22,633,225	$ 310,781

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2018 were as follows:

	Fair Value	Unrealized Losses
Due to mature:		
Less than one year	**$ 4,145,418**	**$ 31,456**
One year through five years	**3,383,482**	**44,344**
After five years through ten years	**8,854,188**	**123,874**
Greater than ten years	**18,981,847**	**558,957**
Total	**$ 35,364,935**	**$ 758,631**

The Company reviewed the securities in the tables above and concluded that these are performing assets generating investment income to support the needs of the Company's business. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. At December 31, 2018, the Company did not intend to sell these securities, and the Company did not believe it was more likely than not that it would be required to sell these securities prior to anticipated recovery of their amortized cost basis.

Net Investment Income

Sources of net investment income for 2018 and 2017 were as follows:

	2018	2017
Debt securities	**$ 2,522,719**	$ 887,790
Other investments	**875,921**	377,365
Net investment income	**$ 3,398,640**	$ 1,265,155

Realized Capital Gains/Losses

Net realized capital (losses) gains for the years ended December 31, 2018 and 2017 were as follows:

	2018	2017
Net realized capital (losses) gains	**$ (789,574)**	$ 157,388
Other-than-temporary impairment ("OTTI") losses on debt securities recognized in earnings	**(742,260)**	(31,528)
Net realized capital (losses) gains	**$ (1,531,834)**	$ 125,860

Yield-related impairments are recognized in other comprehensive income unless we have the intention to sell the security in an unrealized capital loss position, in which case the yield-related OTTI is recognized in earnings. We recognized yield-related OTTI losses of $742,260 and $31,528 related to debt securities for the years 2018 and 2017, respectively. The company had no other individually material realized capital losses on its debt securities that impacted its operating results during 2018 or 2017.

Proceeds from the sale of available for sale debt securities and the related gross realized capital gains for 2018 and 2017 were as follows:

	2018	2017
Proceeds on sales	**$ 39,725,025**	$ 18,622,640
Gross realized capital gains	**200,011**	157,416
Gross realized capital losses	**989,585**	—

4. Fair Value

The preparation of the Company's financial statements in accordance with GAAP requires certain of the Company's assets and liabilities to be reflected at their fair value, and others on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how the Company determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value
Certain of the Company's financial instruments are measured at fair value in the Company's balance sheet. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- **Level 1 -** Unadjusted quoted prices for identical assets or liabilities in active markets.
- **Level 2 -** Inputs other than Level 1 that are based on observable market data. These include quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- **Level 3 -** Developed from unobservable data, reflecting the Company's own assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities as Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets

and liabilities would then be classified as Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Debt Securities – Where quoted prices are available in an active market, the Company's debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities are comprised primarily of U.S. Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models such as matrix pricing, which use quoted market prices of debt securities with similar characteristics, or discounted cash flows to estimate fair value. The Company reviews these prices to ensure they are based on observable market inputs that include, but are not limited to, quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable but not prices (for example, interest rates and credit risks). The Company also reviews the methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of these prices at December 31, 2018 and 2017.

Financial assets measured at fair value on a recurring basis in the Company's Balance Sheets at December 31, 2018 and 2017 were as follows:

	Level 1	Level 2	Level 3	Total
December 31, 2018				
Debt securities:				
U.S. government securities	**$ 9,762,808**	**$ —**	**$ —**	**$ 9,762,808**
States, municipalities and political subdivisions	**—**	**40,799,194**	**—**	**40,799,194**
U.S. corporate securities	**—**	**3,728,758**	**—**	**3,728,758**
Foreign securities	**—**	**449,605**	**—**	**449,605**
Total debt securities	**$ 9,762,808**	**$ 44,977,557**	**$ —**	**$ 54,740,365**
December 31, 2017				
Debt securities:				
U.S. government securities	$ 12,189,876	$ —	$ —	$ 12,189,876
States, municipalities and political subdivisions	—	69,338,983	—	69,338,983
U.S. corporate securities	—	5,792,208	—	5,792,208
Total debt securities	$ 12,189,876	$ 75,131,191	$ —	$ 87,321,067

There were no transfers between Levels 1 and 2 during the years ended December 31, 2018 and 2017. There were no transfers into or out of Level 3 during the years ended December 31, 2018 and 2017.

5. Income Taxes

The components of the income tax expense (benefit) for the years ended December 31, 2018 and 2017 were as follows:

	2018	2017
Current income taxes:		
Federal	$ 29,861,088	$ 71,145,005
State	(6,919,547)	11,401,982
Total current income taxes	22,941,541	82,546,987
Deferred income taxes (benefit):		
Federal	(3,731,657)	(476,885)
State	(422,133)	778,015
Total deferred income taxes	(4,153,790)	301,130
Total income taxes	$ 18,787,751	$ 82,848,117

Income taxes are different from the amount computed by applying the federal income tax rate to income before income taxes for the two years ended December 31, 2018 and 2017 as follows:

	2018	2017
Income before income taxes	$ 76,876,934	$ 138,614,967
Tax rate	21%	35%
Total federal tax provision	16,144,156	48,515,238
Tax effect of:		
State	(5,888,575)	7,916,133
Impact on deferred tax for enacted rate change	—	(3,815,782)
Prior year provision to return adjustment	(6,786,892)	(4,709,977)
Permanent items, including Section 482 adjustment	15,319,062	34,942,505
Income taxes	$ 18,787,751	$ 82,848,117

The components of the deferred tax liability at December 31, 2018 and 2017 were as follows:

	2018	2017
Deferred tax assets (liabilities):		
Contingent risk share liability	$ 170,785	$ 78,914
Software	(6,638,851)	(8,623,413)
Investments, net	(36,557)	(7,911)
Depreciation	381,262	302,313
Bonus and compensation	305,463	—
Unrealized gain on investments	22,015	(137,134)
Other	2,296,796	575,205
Gross deferred tax liabilities	$ (3,499,087)	$ (7,812,026)

In assessing the realizability of the deferred tax asset, management considers whether it is more likely than not that some portion or all of the deferred tax asset will not be realized. The ultimate realization of a deferred tax asset is dependent upon generation of future taxable income during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities and tax planning strategies in making this assessment. Based upon the level of historical taxable income, management believes it is more likely than not that the Company will realize the entire benefits of the deferred tax assets. Accordingly, no valuation allowance has been provided for at December 31, 2018 and 2017.

The Company participates in the Compliance Assurance Process ("CAP") with the Internal Revenue Service ("IRS"). Under the CAP, the IRS undertakes audit procedures during the tax year and as the return is being prepared for filing. The IRS has concluded its CAP audit of the Company's tax returns for 2016 and prior years. The CAP audits for the 2017 and 2018 tax years are in process.

The Company is also subject to audits by state taxing authorities for tax years from 2008 through 2017.

At December 31, 2018, the Company did not have material uncertain tax positions reflected in the balance sheets.

On December 22, 2017, the TCJA was enacted. Refer to Note 2 for additional information related to the TCJA.

6. Other Comprehensive Income (Loss)

Member's equity included the following activity in accumulated other comprehensive income (loss) in 2018 and 2017 :

	At December 31,	
	2018	**2017**
Securities:		
Beginning of period balance	**$ 424,461**	$ 338,380
Adoption of new accounting standard (Note 2)	**91,422**	—
Less: Net unrealized (losses) gains ($757,847) and $100,252) pretax)	**(598,699)**	86,081
Other comprehensive income	**(598,699)**	86,081
End of period balance	**$ (82,816)**	$ 424,461

7. Related Party Transactions

Dividends paid from the Company to Aetna Health Holdings during the year ended December 31, 2018 were $100 million. There were no dividend payments during the year ended December 31, 2017.

In 2018 and 2017, the Company's plan management fees were derived from contracts with both unrelated entities as well as from Aetna owned entities. Plan management fee concentrations greater than 5% are as follows:

	2018	**2017**
Unrelated entities:		
Mercy Care (MC)	**23%**	17%
Regional Behavioral Health Authority (RBHA)	**6**	10
Maryland Physician's Care Inc	**—**	5
Aetna owned entities:		
Aetna Better Health Inc. of Illinois (ABHI IL)	**—%**	11%
Aetna Better Health Inc. of Pennsylvania (ABHI PA)	**9**	8
Aetna Better Health Inc. of Ohio (ABHI OH)	**8**	8
Aetna Better Health Inc. of Kentucky (ABHI KY)	**9**	9
Aetna Better Health Inc. of Florida (ABHI FL)	**5**	—
Aetna Better Health Inc. of Virginia (ABHI VA)	**8**	—

The contract between the Company and Mercy Care expires on September 30, 2021, and unless either party gives the other party written notice of at least 365 days prior to the termination date, this agreement will automatically renew for a second five year term. Mercy Care has contracted with the Arizona Health Care Cost Containment System (AHCCCS) to provide managed care services to several covered populations. The terms of the agreement shall be automatically extended for periods of one year unless either party notifies the other party in writing at least

180 days prior to the expiration of the term currently in effect. There is no guarantee that AHCCCS will continue to renew the contract with Mercy Care.

The contract with the Regional Behavioral Health Authority (RBHA) expires on June 30, 2022 and unless either party gives the other party written notice of at least 365 days prior to the expiration date, this agreement will automatically renew for a third five year term. However, RBHA merged into Mercy Care on July 1, 2018. RBHA has a contract with AHCCCS, which renews annually. This contract will remain with the merged entity. There is no guarantee that AHCCCS will continue to renew the contract.

The contract between Maryland Physician's Care and the Company ended June 30, 2017.

There were two Medicaid entities in 2018 and three Medicaid entities in 2017, which were owned by Aetna that had a management contract with AHM. The Company provides certain administrative and management services to these entities for which the Company is reimbursed by AHM at cost. These entities have agreements with various states and there are no guarantees that they will continue to renew their contract with the states in the future.

Aetna Better Health of Illinois has a contract for the joint state Centers for Medicare and Medicaid Services (CMS) Medicare Medicaid Duals program through December 31, 2018. During February, 2019, the State of Illinois Department of Healthcare and Family Services has made a formal request to CMS to extend the Illinois Medicare Medicaid Duals program through December 31, 2020, with a possible contract extension through December 31, 2022. ABHI IL has also contracted with the state of Illinois, acting through its Department on Aging, to furnish transition and care coordination services to certain Colbert class nursing facility residents through June 30, 2019.

Aetna Better Health of Illinois had a contract with the state of Illinois, acting through its Department of Healthcare and Family Services, to serve as a managed care organization for the state's Integrated Care Program (ICP), Family Health Plan Population - Affordable Care Act Adult program (FHP-ACA) and Managed Long Term Supports and Services (MLTSS) program through December 31, 2017.

ABHI PA currently operates its HealthChoices Medicaid managed care plan statewide under contract with the Commonwealth of Pennsylvania acting through its Department of Human Services. The contract currently extends through December 31, 2020. There is no guarantee that the state will renew the contract.

Aetna Better Health of Ohio operates a Medicare-Medicaid Plan ("MMP") administered by the Center for Medicare and Medicare Services ("CMS") in partnership through its contract with the State of Ohio Department of Medicaid (ODM) (the three-way contract). The three-way contract is effective through December 31, 2019, and an extension through December 31, 2022 was requested by ODM and has been approved by CMS. The Company also has contracted with ODM to provide services to dual recipients who have elected not to receive Medicare services through the Company. That contract was effective July 1, 2018 and incorporates, runs concurrently with, and is subordinate to the three-way contract. There is no guarantee that the state and CMS will continue to renew the contract.

The contract between Commonwealth of Kentucky Cabinet for Health and Family Services Department for Medicaid Services was assigned by Coventry Health and Life Insurance Company to Aetna Better Health of Kentucky, Inc on February 1, 2016. This contract expires on June 30, 2019, leaving one year of renewal options on the contract. There is no guarantee that Commonwealth of Kentucky will renew the contract.

Aetna Better Health Florida has contracted with the state of Florida to serve as a managed-care organization for the Temporary Aid to Needy Families, Aged Blind & Disabled and Long Term Care populations through December 31, 2023. There is no guarantee that the state of Florida will renew the contract.

Aetna Better Health Virginia has a dual eligible special needs contract with CMS and the State of Virginia's Department of Medical Assistance Services (DMAS) through December 31, 2019. There is no guarantee that CMS

and DMAS will renew the contract. ABHI VA has a contract with DMAS for its Commonwealth Coordinated Care program which is a 5 year award that began August 1, 2017 and there will be the possibility of five 12-month extensions. ABH VA has a contract with DMAS for its Medallion 4.0 program. That contract may be renewed or extended annually by the Department of Medical Assistance Services for up to six successive 12-month periods under the terms and conditions of the contract which began on August 1, 2018. There is no guarantee that DMAS will renew the contracts.

Included in accounts payable and accrued liabilities and purchased services are amounts owed or paid to related parties for administrative support services; included in accounts receivable and plan management fees are amounts due or received from related parties for services provided by the Company.

The following summarizes the Company's related party balances:

December 31, 2018

	Accounts Payable and Accrued Liabilities	Accounts Receivable	Plan Management Fees
ActiveHealth Mgt. Parent Company	$ 36,854	$ —	$ —
Aetna Health Inc. - PA	—	11,722	—
Aetna Health Inc. - PA CHP	—	—	11,537,558
Aetna Behavioral Health, LLC	—	130	—
Health and Human Resource Center, Inc.	—	226	—
Goodhealth Worldwide Global Limited	—	98	—
Aetna Corporate Services LLC	—	57,479	—
American Health Holding, Inc.	700	—	—
ASI - Wings, LLC	15,005	—	—
bSwift, LLC	6,634	—	—
Chickering Claims Administrator Inc	349	—	—
Claims Administration Corp	41	—	—
Cofinity, Inc.	1,094	—	—
Corporate Benefit Strategies, Inc.	959	—	—
Coventry Management Services, Inc	101,529	—	—
First Script Network Services, Inc	49	—	—
Health Data & Management Solutions, Inc.	9,398	—	—
Healthcare USA of Missouri, LLC	19,053	—	—
Meritain Health Inc.	14,198		
PayFlex Systems USA, Inc.	700	—	—
Prodigy Health Group, Inc.	121	—	—
Aetna Better Health Inc (IL)	—	7,018,110	22,699,371
Aetna Better Health Inc. (PA)	—	24,602,275	90,107,765
Aetna Better Health Inc. (NY)	—	3,372,900	35,983,450
Aetna Better Health Inc (OH)	2,047,029	—	72,275,190
Aetna Better Health Inc (NE)	—	—	72,532
Aetna Better Health Inc (NJ)	—	1,823,978	32,814,143
Aetna Better Health Inc (LA)	12,647,745	—	41,325,766
Aetna Better Health Inc (MD)	—	45,231	—
Aetna Better Health Inc (MO)	—	—	71,509
Aetna Better Health Inc (MI)	—	11,478,888	40,202,068
Aetna Better Health Inc (TX)	—	1,784,495	28,339,705
Aetna Better Health Inc. (KY)	7,789,356	—	85,901,269
Aetna Better Health Inc. (VA)	—	6,083,682	77,680,403
Aetna Better Health Inc. (CA)	—	238,940	1,639,167

Aetna Inc.	4,027,043	—	—
Aetna Life Insurance Company	922,733	28,968,254	—
AHM – Parent Operations	—	1,890,425	—
Delaware Physicians Care, Incorporated	43	—	—
Horizon Behavioral Services, LLC	—	50	—
Missouri Care, Incorporated	135,403	—	—
Aetna Better Health Inc. (NV)	—	8,108	6,467
Aetna Global Holdings Limited	2	—	—
Aetna Resources, LLC	4,224,809	—	(200)
Coventry Health Care of Florida, Inc.	—	3,062,813	43,475,034
Coventry Health Care of West Virginia, Inc.	—	3,612,822	31,156,559
Coventry Health Care Workers Compensation	—	67,269	—
Aetna International Inc.	—	2,481	—
Aetna Life & Casualty Bermuda Limited	272	—	—
Total	**$ 32,001,119**	**$ 94,130,376**	**$ 615,287,756**

December 31, 2017

	Accounts Payable and Accrued Liabilities	Accounts Receivable	Plan Management Fees
ActiveHealth Mgt. Parent Company	$ 43,633	$ —	$ —
Aetna Better Health Inc (IL)	—	10,312,084	113,786,518
Aetna Better Health Inc. (PA)	—	66,804,477	83,573,033
Aetna Better Health Inc. (NY)	—	2,608,275	26,999,095
Aetna Better Health Inc (OH)	—	16,501,810	76,927,430
Aetna Better Health Inc (NE)	—	700	174,491
Aetna Better Health Inc (NJ)	—	8,471,292	21,089,699
Aetna Better Health Inc (LA)	—	10,522,578	38,930,292
Coventry ABH – KY, Coventry ABH – MI, & Coventry ABH – WV	—	6,546,153	13,450,040
Aetna Better Health Inc (MO)	—	2,799	19,416,388
Aetna Better Health Inc (MI)	—	2,836,716	42,030,341
Aetna Better Health Inc (TX)	—	2,064,103	24,935,941
Aetna Better Health Inc. (KY)	—	11,615,610	87,150,585
Aetna Better Health Inc. (VA)	—	3,308,097	24,974,774
Aetna Inc.	89,374,709	—	—
Aetna Life Insurance Company	3,567	107,976,406	—
AHM – Parent Operations	—	26,767,397	—
Delaware Physicians Care, Incorporated	1,998	—	—
Missouri Care, Incorporated	237,829	—	—
Aetna Better Health Inc. (NV)	20,191	—	254,365
AHM - Parent Operations	4,940,131	1,187,152	
Aetna Better Health Inc. (CT)	50	—	
Aetna Resources, LLC	47,935	—	
First Health Group Corp.	5,924	—	
Coventry Health Care of Florida, Inc.	—	3,510,120	35,391,036
Coventry Health Care of West Virginia, Inc.	—	2,247,329	29,833,788
Coventry Health Care Workers Compensation	—	406	—
Aetna International Inc.	—	10	—
Aetna Life & Casualty Bermuda Limited	—	44	—
Total	**$ 94,675,967**	**$ 283,283,558**	**$ 638,917,816**

The Company's cash receipts and disbursements were processed by Aetna as part of a centralized cash management program. Aetna processes activity daily and settles due to/from affiliate accounts on or before the last day of the following quarter. The amounts due to/from affiliate accounts at December 31, 2018 and 2017 were settled in January 2019 and 2018, respectively.

The Company's administrative services agreement with Aetna Health Management ("AHM") permits AHM to perform certain cash management transactions on behalf of the Company utilizing the bank account or lockbox of Aetna Health Holdings, LLC.

8. Commitments and Contingencies

The Company did not have contingent assessments or gain contingencies at December 31, 2018 or 2017. Additionally, the Company did not have claims related to extra contractual obligation and bad faith losses stemming from lawsuits at December 31, 2018 or 2017.

Litigation and Regulatory Proceedings
The following description of litigation and regulatory proceedings covers Aetna and certain of its subsidiaries, including the Company (collectively, "we", "our" or "us"). Certain of the proceedings described below may impact the Company. Certain of the proceedings described below also may impact the Company indirectly as the Company is a member of the Aetna holding company group.

The Company's affiliates are involved in numerous lawsuits arising, for the most part, in the ordinary course of their business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, the Centers for Medicare & Medicaid Services, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the Office of Inspector General, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice (the "DOJ"), the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our proposed transaction with CVS Health Corporation, our withdrawal from certain states' public health insurance exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses. We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. We are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Akorbi

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Akorbi
Akorbi Consolidated (Consolidated)
Income Statement - Akorbi
From Jan 2017 to Dec 2019

Financial Row	FY 2017	FY 2018	FY 2019
Ordinary Income/Expense			
Income	**35,331,135**	**39,066,400**	**50,655,333**
Cost Of Sales	**26,326,722**	**31,121,625**	**39,491,189**
Gross Profit	**9,004,414**	**7,944,775**	**11,164,144**
Expense			
60000 - Personnel Expenses	4,254,299	3,537,586	3,591,397
61000 - Travel	231,694	136,154	134,620
62000 - General and Administrative	163,774	176,648	342,028
64000 - Professional Fees	674,153	426,651	303,880
65000 - Marketing and Branding	62,100	155,151	316,106
66000 - Finance Fees and Taxes	32,120	64,580	100,335
69000 - Allocation	3,269,672	3,050,022	3,226,951
Total - Expense	**8,687,811**	**7,546,791**	**8,015,316**
Net Ordinary Income	**316,603**	**397,984**	**3,148,827**
Other Income and Expenses			
Other Expense	**255,249**	**210,466**	**611,768**
Net Other Income	**(255,249)**	**(210,466)**	**(611,768)**
Net Income	**61,353**	**187,518**	**2,537,059**

The Guardian Life Insurance Company of America (Avesis)

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Bluegrass Care Navigators

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BLUEGRASS CARE NAVIGATORS
a dba of Hospice of the Bluegrass, Inc.
Lexington, Kentucky

CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2018 and 2017

BLUEGRASS CARE NAVIGATORS
a dba of Hospice of the Bluegrass, Inc.
Lexington, Kentucky

CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2018 and 2017

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Crowe LLP
Independent Member Crowe Global

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Bluegrass Care Navigators
Lexington, Kentucky

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Bluegrass Care Navigators which comprise the consolidated statements of financial position as of December 31, 2018 and 2017, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

(Continued)

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Bluegrass Care Navigators as of December 31, 2018 and 2017, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 1 to the consolidated financial statements, Bluegrass Care Navigators has adopted ASU 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. Our opinion is not modified with respect to this matter.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating statements of financial position, consolidating statements of activities, consolidated schedules of other patient service expenses, and consolidated schedules of other administrative and general expenses are presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position and changes in net assets of the individual entities, and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Crowe LLP

Crowe LLP

Lexington, Kentucky
March 22, 2019

BLUEGRASS CARE NAVIGATORS
CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
December 31, 2018 and 2017

	2018	2017
ASSETS		
Current assets		
Cash and cash equivalents	$ 4,805,312	$ 5,172,787
Patient accounts receivable, net	7,723,117	9,071,163
Pledges receivable - current	22,427	21,093
Bequests receivable	119,780	-
Miscellaneous receivables	1,442,132	1,535,693
Prepaid expenses and other current assets	1,153,880	1,253,993
Total current assets	15,266,648	17,054,729
Investments	51,345,978	54,383,712
Investments held by others	385,287	422,931
Pledges receivable - long-term	4,121	8,757
Property, building, and equipment, net	29,607,016	24,156,706
Other assets	452,438	455,059
Total assets	$ 97,061,488	$ 96,481,894
LIABILITIES AND NET ASSETS		
Current liabilities		
Current portion of long-term debt	$ 445,666	$ 445,667
Accounts payable	4,546,093	4,503,070
Accrued liabilities	4,350,615	3,509,035
Annuities payable - current	11,486	14,091
Total current liabilities	9,353,860	8,471,863
Annuities payable - long-term	109,033	132,278
Long-term debt	1,939,165	2,452,679
Funds held for others	597,973	691,422
Total liabilities	12,000,031	11,748,242
Net assets		
Without donor restrictions	82,905,250	82,469,047
With donor restrictions	2,156,207	2,264,605
Total net assets	85,061,457	84,733,652
Total liabilities and net assets	$ 97,061,488	$ 96,481,894

See accompanying notes to consolidated financial statements.

BLUEGRASS CARE NAVIGATORS
CONSOLIDATED STATEMENTS OF ACTIVITIES
Years ended December 31, 2018 and 2017

	2018	2017
NET ASSETS WITHOUT DONOR RESTRICTIONS		
Revenues, gains, and other support		
Net patient service revenue	$ 63,596,528	$ 54,765,181
Contributions	2,633,615	1,191,438
Income from fundraising events, net of direct fundraising expenses of $81,181 and $83,780 in 2018 and 2017, respectively	114,324	163,267
Other gains and support	1,190,060	927,610
Total revenues, gains, and other support	67,534,527	57,047,496
Net assets released from restrictions	50,249	35,777
Expenses		
Patient service expenses -		
Contract services	2,723,831	2,467,113
Durable medical equipment	353,042	231,054
Employee compensation, including benefits	34,771,528	31,866,598
Outpatient expenses	246,912	247,840
Medicaid room and board	6,792,566	6,140,556
Pharmacy and chemotherapy	1,827,783	1,710,474
Provision for bad debts	219,084	160,083
Supplies	632,631	532,356
Other	7,468,577	6,394,934
	55,035,954	49,751,008
Administrative and general expenses -		
Employee compensation, including benefits	5,340,190	4,626,442
Office and equipment rentals, including cleaning and maintenance	572,531	483,353
Other	2,740,727	2,524,834
	8,653,448	7,634,629
Fundraising expenses not directly related to fundraising events -		
Employee compensation, including benefits	470,337	453,510
Other	156,478	135,630
	626,815	589,140
Total expenses	64,316,217	57,974,777
Excess (deficiency) of revenues over expenses before investment income	3,268,559	(891,504)

(Continued)

BLUEGRASS CARE NAVIGATORS
CONSOLIDATED STATEMENTS OF ACTIVITIES
Years ended December 31, 2018 and 2017

	2018	2017
Investment income		
Investment income, net of expenses of $209,118 and $174,230 in 2018 and 2017, respectively	$ 2,824,534	$ 1,718,056
Net realized gains on investments	14,100	305,398
Net unrealized gains (losses) on investments	(5,670,990)	4,386,294
Total investment income	(2,832,356)	6,409,748
Change in net assets without donor restrictions	436,203	5,518,244
NET ASSETS WITH DONOR RESTRICTIONS		
Contributions and grants	76,829	52,727
Investment income	107,097	70,700
Net realized gains on investments	469	11,506
Net unrealized gains (losses) on investments	(242,544)	194,917
Net assets released from restrictions	(50,249)	(35,777)
Change in net assets with donor restrictions	(108,398)	294,073
Total change in net assets	327,805	5,812,317
Net assets, beginning of year	84,733,652	78,921,335
Net assets, end of year	$ 85,061,457	$ 84,733,652

See accompanying notes to consolidated financial statements.

BLUEGRASS CARE NAVIGATORS
CONSOLIDATED STATEMENTS OF CASH FLOWS
Years ended December 31, 2018 and 2017

	2018	2017
Cash flows from operating activities		
Change in net assets	$ 327,805	$ 5,812,317
Adjustments to reconcile change in net assets to net cash from operating activities		
Depreciation	1,105,208	1,069,326
Amortization	2,619	2,735
Provision for bad debts	219,084	160,083
Net unrealized and realized (gains) losses on investments	5,898,965	(4,898,115)
Donated investments	(1,020)	(98,026)
Donated property	(1,250,000)	-
Contributions restricted for capital asset	(63,370)	(84,955)
Losses (gains) on disposal of property and equipment	(4,260)	3,506
Changes in:		
Patient accounts receivable	1,128,962	(1,175,327)
Pledges receivable	3,302	25,874
Bequests receivable	(119,780)	-
Miscellaneous receivables	93,562	107,136
Prepaid expenses and other current assets	100,113	(278,332)
Accounts payable	37,501	182,189
Accrued liabilities	841,580	(4,031)
Funds held for others	(93,449)	67,040
Net cash from operating activities	8,226,822	891,420
Cash flows from investing activities		
Capital expenditures	(5,311,050)	(1,002,191)
Proceeds from sale of property and equipment	15,314	18,300
Notes receivable relating to investments	-	8,827,056
Purchase of investments	(3,052,046)	(34,650,217)
Proceeds from sale of investments	229,479	23,933,875
Net cash from investing activities	(8,118,303)	(2,873,177)
Cash flows from financing activities		
Principal payments on debt	(513,514)	(536,241)
Change in annuities payable	(25,850)	(3,143)
Proceeds from contributions restricted for capital asset	63,370	84,955
Net cash from financing activities	(475,994)	(454,429)
Change in cash and cash equivalents	(367,475)	(2,436,186)
Cash and cash equivalents at beginning of year	5,172,787	7,608,973
Cash and cash equivalents at end of year	$ 4,805,312	$ 5,172,787
Supplemental disclosure of cash flow information		
Cash paid during the year for interest	$ 80,974	$ 81,221
Acquisitions of property, building and equipment included in accounts payable	5,522	26,897
In-kind contribution of building	1,250,000	-

See accompanying notes to consolidated financial statements.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Consolidation: The consolidated financial statements include the accounts of Bluegrass Care Navigators, a dba of Hospice of the Bluegrass, Inc., its wholly-owned not-for-profit affiliates, Bluegrass Palliative Care and Hospice of the Bluegrass Foundation, Inc. ("Foundation"), and its wholly-owned for-profit subsidiary Hospice Management Services, LLC ("HMS"). Collectively the entities are referred to as the "Organization". All material intercompany transactions and accounts have been eliminated upon consolidation. HMS had no activity for the years ended December 31, 2018 and 2017.

Nature of Operations: Bluegrass Care Navigators is a not-for-profit organization incorporated under the laws of the Commonwealth of Kentucky. It was established to provide a coordinated program of palliative and supportive care for terminally ill persons and their families which is provided by an interdisciplinary team of paid and volunteer professionals and lay persons, to investigate the effectiveness of modalities used to ease the final stages of death, to study and develop improved skills in all areas dealing with the management of grief and anxiety in the bereaved, and to provide an environment for the consideration of the best ways of caring for the dying as sensitive and sensible human beings. Bluegrass Palliative Care was founded to provide holistic patient and family-centered palliative care. The Foundation was established as a supporting organization of Bluegrass Care Navigators and provides support to Bluegrass Care Navigators by soliciting and investing funds on behalf of Bluegrass Care Navigators. HMS was formed to provide management services to other hospice organizations.

Basis of Accounting: The consolidated financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America ("U.S. GAAP").

Financial Statement Presentation: The consolidated financial statements report the changes in and totals of each net asset class based on the existence of donor restrictions, as applicable. Net assets are classified as without donor restrictions and with donor restrictions and are detailed as follows:

> Net assets without donor restrictions are not restricted by donor-imposed stipulations and may be expended for any purpose in performing the primary objectives of the organization. Board-designated assets are quasi-endowed by the Board in the amount of approximately $124,000 and $131,000 as of December 31, 2018 and 2017, respectively. This designation may be removed at the Board's discretion. In 2018, the Board also designated approximately $1,007,000 for general expenditure to support new programs including pediatric palliative care, behavior health support, and complementary alternative medicine.
>
> Net assets with donor restrictions are subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature and expire by the passage of time or by actions of the Organization. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Functional Expenses: The costs of program and supporting services activities have been summarized on a functional basis in the consolidated statements of activities. Accordingly, certain costs have been allocated among the programs and supporting services benefited. The expenses that are allocated include depreciation, computer support and education, which are allocated on the basis of time and effort.

(Continued)

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Use of Estimates: The preparation of consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash and cash equivalents consist of bank deposits in accounts that are federally insured up to $250,000. Additionally, for purposes of the consolidated statements of cash flows, the Organization considers all highly liquid investments of operating cash purchased with an original maturity of three months or less to be cash equivalents.

Patient Accounts Receivable: The patient accounts receivable balance represents the unpaid amounts billed to patients and third-party payors. Contractual adjustments, discounts, and an allowance for doubtful accounts are recorded to report receivables for services at net realizable value. Past due receivables are determined based on contractual terms. The Organization does not accrue interest on any of its accounts receivables.

Allowance for Doubtful Accounts: The allowance for doubtful accounts is determined by management based on the Organization's historical losses, specific patient circumstances, and general economic conditions. Periodically, management reviews accounts receivable and adjusts the allowance based on current circumstances and charges off uncollectible receivables when all attempts to collect have failed. Management believes the allowance of $341,657 and $293,638 as of December 31, 2018 and 2017, respectively, is adequate to cover potential losses from doubtful accounts.

Pledges Receivable: Pledges receivable represent the remaining balance of unconditional promises to give that have not yet been paid. Pledges that are expected to be collected within one year or less are recorded at net realizable value. Pledges that are expected to be collected beyond one year are recorded at the present value of their estimated future cash flows. The pledges have been discounted using an interest rate commensurate with risk applicable during the time the pledge was made. Amortization of the pledge discounts are recognized as contribution revenue each year until the pledge is paid in full. Conditional promises to give are recognized only when the conditions on which they depend are substantially met and the promises become unconditional.

Bequests Receivable: Bequests receivable represent amounts designated to the Organization in a will or trust, whereby the value can be reasonably estimated and measurable.

Investments: All investments are valued at their fair values in the consolidated statements of financial position. Unrealized gains and losses are included in the change in net assets. See Notes 2 and 11 for additional information on the nature of the Organization's investments.

Investments Held by Others: Investments held by others represent funds held by the Bluegrass Community Foundation and the Foundation for Appalachian Kentucky. Annual distributions from the funds, in addition to interest and dividend earnings, and net realized and unrealized gains (losses) are reported as a component of the change in unrealized gains on the consolidated statements of activities.

(Continued)

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Property, Building, and Equipment: Property, building, and equipment are stated at cost or, if donated to the Organization, at fair value on the date of acquisition. Additions and improvements over $5,000 are capitalized; expenditures for routine maintenance are charged to operations. Depreciation is provided over the estimated useful lives of the various classes of assets on the straight-line method.

Gifts of long-lived assets such as land, buildings, and equipment are reported as net assets without donor restrictions unless explicit donor stipulations specify how the donated assets are to be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used, and gifts of cash and other assets that must be used to acquire long-lived assets are reported as net assets with donor restrictions. Absent explicit donor stipulations about how long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Impairment of Long-Lived Assets: On an ongoing basis, the Organization reviews long-lived assets for impairment whenever events or circumstances indicate that the carrying amounts may be overstated. The Organization recognizes impairment losses if the undiscounted cash flows expected to be generated by the asset are less than the carrying value of the related asset. The impairment loss adjusts the assets to fair value. As of December 31, 2018 and 2017, management believes that no impairment existed.

Other Assets: Other assets primarily consist of goodwill and other intangibles. Goodwill represents the excess of the purchase price over the fair value of net assets of various acquisitions. Other intangibles include amounts paid to obtain Certificates of Need to operate in certain counties within the state of Kentucky. The carrying value of goodwill and intangible assets is reviewed annually to determine if facts and circumstances suggest that the assets may be impaired. Certificates of Need have an indefinite useful life and will not be amortized but will be subject to impairment testing based on their estimated fair value. For the years ended December 31, 2018 and 2017, management has determined that the remaining unamortized goodwill and Certificates of Need balances were not impaired.

Net Patient Service Revenue: The Organization has agreements with third-party payors that provide for payments to the Organization at its established rates. Payment arrangements include prospectively determined rates on admission and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered.

The Medicare and Medicaid programs constituted approximately 77% and 18%, respectively, of net patient service revenue for the year ended December 31, 2018 and approximately 76% and 17%, respectively, for the year ended December 31, 2017. Services rendered to Medicare beneficiaries are paid on a nationally-based prospective per diem reimbursement subject to certain aggregate limits. In the opinion of management, retroactive adjustments, if any, would not be material to the financial position or results of operations of the Organization. Services rendered to Medicaid beneficiaries are reimbursed at approximately the Medicare rate, and there are no aggregate limits.

(Continued)

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

The Organization, like other health care providers, may be subject to investigations, regulatory action, lawsuits, and claims arising out of the conduct of its business, including the interpretation of laws and regulations governing the Medicare and Medicaid programs and other third-party payor agreements. Management intends to fully cooperate with any governmental agencies in requests for information. Noncompliance with laws and regulations can make the Organization subject to regulatory action, including fines, penalties, and exclusion from the Medicare and Medicaid programs. Although not required, the Organization has a comprehensive compliance program in place. The Organization currently has select Medicaid claims under a post-pay review by a Medicaid Integrity Contractor. The Organization received notice from the Medicaid Integrity Contractor that several of the selected claims were denied. The Organization has consulted with legal counsel and believes that all claims selected for review are valid and defensible. As of the report date, no conclusive results regarding such additional communications have been received. Based on the status of the claims review, management has not recorded a liability since a probable outcome is uncertain and a liability cannot be reasonably estimated as of the report date.

The Organization is subject to two specific payment limit caps under the Medicare program. One limit relates to inpatient care days that exceed 20% of the total days of hospice care provided for the year. The Organization did not exceed the 20% cap related to inpatient days in 2018 and 2017. The second limit relates to an aggregate Medicare reimbursement cap calculated by the Organization. The Organization did not exceed the Medicare cap for the years ended December 31, 2018 and 2017.

Charity Care: The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The criteria for charity care takes into consideration current and potential insurance resources. The cost of charity care provided was approximately $459,000 and $1,782,000 for the years ended December 31, 2018 and 2017, respectively. This cost estimate was based upon the Organization's average cost of care per patient day. The Organization has not received restricted donations for charity care in 2018 or 2017.

Business and Credit Concentrations: The Organization grants credit to patients and generally does not require collateral or other security in extending credit; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans or policies (e.g., Medicare, Medicaid, Blue Cross, health maintenance organizations, and commercial insurance policies). The percentage of patient service revenue attributable to these programs exceeded 96% for 2018 and 2017.

The cycle for patient reimbursement is approximately two months. While the majority of claims are paid timely, outliers representing special account reimbursement circumstances may vary the cycle significantly from account to account. The Organization establishes an allowance for doubtful accounts based on historical collection experience. The major categories of patient accounts receivable as of December 31, 2018 and 2017 were:

	2018	2017
Medicare	$ 5,345,585	$ 6,423,000
Medicaid	1,637,974	1,936,147
Commercial	576,674	710,412
Other	504,541	295,242
Total	8,064,774	9,364,801
Allowance for doubtful accounts	(341,657)	(293,638)
Patient accounts receivable, net	$ 7,723,117	$ 9,071,163

(Continued)

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Contributions: Contributions received and unconditional promises to give are recorded as net assets without donor restrictions or net assets with donor restrictions depending on the existence of donor restrictions and the nature of such restrictions, if they exist.

When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the consolidated statements of activities as net assets released from restrictions.

Donor-restricted contributions whose restrictions are met in the same reporting period are reported as net assets without donor restrictions.

Donated Services: The Organization receives donated services from a variety of unpaid volunteers. The value of donated services is not reflected in the accompanying consolidated financial statements since the recognition criteria have not been met. The value of volunteer hours not recognized approximated $706,000 and $623,000 for the years ended December 31, 2018 and 2017, respectively. Volunteer services provided by individuals possessing specialized skills, which if not donated would have been purchased by the Organization, are included in the accompanying consolidated financial statements. These amounts totaled approximately $10,000 and $7,500 for the years ended December 31, 2018 and 2017, respectively.

Income Taxes: The Organization is exempt from income taxes on income from related activities under Section 501(c) (3) of the U.S. Internal Revenue Code and corresponding state tax law. Accordingly, no provision has been made for federal and state income taxes.

A tax position is recognized as a benefit only if it is “more likely than not” that the tax position would be sustained in a tax examination, with a tax examination being presumed to occur. The amount recognized is the largest amount of tax benefit that is greater than 50% likely of being realized on examination. For tax positions not meeting the “more likely than not” test, no tax benefit is recorded.

The Organization’s Form 990 has not been subject to examination by the Internal Revenue Service or the Commonwealth of Kentucky for the last three years. The Organization does not expect the total of unrecognized tax benefits to significantly change in the next 12 months. The Organization did not have any amounts accrued or recognized for interest and penalties at December 31, 2018 and 2017.

Litigation: From time to time, the Organization is involved in litigation arising in the normal course of business. After consultation with legal counsel, it is management’s opinion that these matters will be resolved without material adverse effect on the consolidated statements of financial position or the consolidated statements of activities.

Recently Adopted Accounting Pronouncements: In August 2016, FASB issued ASU 2016-14, *Not-for-Profit Entities (Topic 958) – Presentation of Financial Statements of Not-for-Profit Entities*. The update addresses the complexity and understandability of net asset classification, deficiencies in information about liquidity and availability of resources, and the lack of consistency in the type of information provided about expenses and investment return. The Organization has adopted ASU 2016-14 as of and for the year ended December 31, 2018 and adjusted the presentation of these consolidated financial statements accordingly. The ASU has been applied retrospectively to all periods presented.

(Continued)

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Subsequent Events: Management has performed an analysis of the activities and transactions subsequent to December 31, 2018 to determine the need for any adjustments to and/or disclosures within the consolidated financial statements for the year ended December 31, 2018. Management has evaluated subsequent events for recognition and disclosure through March 22, 2019, which is the date the consolidated financial statements were available to be issued.

Reclassifications: Certain prior year amounts have been reclassified to conform to the current year presentation with no effect on net assets, change in net assets or net change in cash and cash equivalents.

NOTE 2 – INVESTMENTS

Investments consisted of the following at December 31:

	2018	2017
Money market funds	$ 77,236	$ 203,444
Equity mutual funds	26,469,646	29,681,533
Fixed income mutual funds	14,220,017	14,423,469
Certificates of deposits	244,533	242,453
Alternative investments	10,029,396	9,487,927
Interest in perpetual trusts	305,150	344,886
	$ 51,345,978	$ 54,383,712

The following summarizes the investment return for the years ended December 31:

	2018	2017
Interest and dividend income	$ 3,140,749	$ 1,962,986
Investment expenses	(209,118)	(174,230)
	2,931,631	1,788,756
Net realized gains	14,569	316,904
Net unrealized gains (losses)	(5,913,534)	4,581,211
	$ (2,967,334)	$ 6,686,871

(Continued)

NOTE 3 – PLEDGES RECEIVABLE

The Organization recognizes unconditional promises of contributions at fair value in the period the promise is made. Pledges receivable are scheduled to be received over the following periods:

	2018	2017
Less than one year	$ 22,427	$ 21,093
One to five years	4,511	9,411
Greater than five years	1,000	1,000
Total contributions	27,938	31,504
Unamortized discount and allowance	(1,390)	(1,654)
	$ 26,548	$ 29,850

Pledges receivable expected to be paid over periods greater than one year have been discounted at rates of .83% - 2.51% for the years ended December 31, 2018 and 2017, which has been determined by management to be commensurate with the risk of not collecting the related pledges.

NOTE 4 – PROPERTY, BUILDING, AND EQUIPMENT

The Organization's property, building, and equipment, and the related accumulated depreciation at December 31 are as follows:

	2018	2017
Land and improvements	$ 7,362,957	$ 5,521,557
Building	25,354,756	24,895,456
Office and computer equipment, including software	5,575,906	5,379,887
Medical equipment	1,166,150	1,112,110
Construction in progress	4,173,591	743,476
	43,633,360	37,652,486
Accumulated depreciation	(14,026,344)	(13,495,780)
	$ 29,607,016	$ 24,156,706

Depreciation expense for the years ended December 31, 2018 and 2017 was $1,105,208 and $1,069,326, respectively.

Construction in progress as of December 31, 2018 relates to renovations on a facility in Lexington, Kentucky, with an expected total project cost of $15,000,000. Administrative and clinical offices will be located within the facility. The Organization plans to occupy the facility in the 1st quarter of 2020.

Construction in progress as of December 31, 2017 related to renovations on a facility in Frankfort, Kentucky, housing administrative offices and an Adult Day Health program which began operations in the 2nd quarter of 2018.

(Continued)

NOTE 5 – DEBT

Tax Exempt Bonds:

Long-term debt consists of the following at December 31:

	2018	2017
The City of Hazard, Kentucky Industrial Building Revenue Bond, Series 2009; monthly principal and interest payments beginning December 1, 2009 with original maturity November 1, 2016; collateralized by all real estate relating to the issue. This long-term debt was modified on April 8, 2015 resulting in an extended maturity of March 1, 2025 and a fixed interest rate of 3.04% at December 31, 2018. The interest rate at December 31, 2017 was 2.50% and changed during 2018 due to the new federal tax law. The bonds are now held by Branch Banking and Trust Company.	$ 2,384,831	$ 2,898,346
Current maturities	(445,666)	(445,667)
	$ 1,939,165	$ 2,452,679

The Series 2009 Bonds contain various covenants including debt service coverage ratio, unrestricted asset balances, and various other reporting and deposit requirements. The Organization is in compliance with all financial covenants at December 31, 2018.

Scheduled principal repayments for the next five years and thereafter under the terms of the agreement for the Series 2009 Bonds are as follows:

2019	$ 445,666
2020	445,666
2021	445,666
2022	445,666
2023	445,666
Thereafter	156,501
	$ 2,384,831

Total interest incurred on bonds amounted to $80,973 and $80,067 for the years ended December 31, 2018 and 2017, respectively.

Revolving Line of Credit:

In 2018, the Organization entered into a revolving line of credit with Branch Banking and Trust Company for $5,000,000 to be used for working capital and secured by pledging a portion of the Organization's investment portfolio. The pledged investment amount as of December 31, 2018 was $27,246,748. The line of credit bears interest at the one-month LIBOR rate plus 1.10% (3.56% at December 31, 2018), with an expiration date of August 23, 2019. There were no borrowings or interest expense incurred on this line in 2018.

(Continued)

NOTE 5 – DEBT (Continued)

Non-revolving Line of Credit:

In 2018, the Organization entered into a non-revolving line of credit with Branch Banking and Trust Company for $15,000,000 secured by pledging a portion of the Organization's investment portfolio. The pledged investment amount as of December 31, 2018 was $27,246,748. The line of credit bears interest at the one-month LIBOR rate plus 1.10% (3.56% at December 31, 2018), with an expiration date of August 23, 2021. The Organization plans to use this line to fund construction costs on a building purchased in 2018 which is planned to go into operation in the first quarter of 2020. There were no borrowings or interest expense incurred on this line in 2018.

NOTE 6 – RETIREMENT PLANS

The Organization maintains a 401(k) savings plan in which employees may contribute eligible compensation up to the maximum amount allowed by law. The Organization matches 100% of employee deferrals that do not exceed 3% of compensation, plus 66 2/3% of deferrals that exceed 3% but do not exceed 6% of compensation for each employee who meets certain service and age requirements, and pays the administrative costs of this Plan up to a maximum contribution of 5% of compensation. In 2018 and 2017, the Organization's contributions to the Plan totaled $1,029,169 and $949,845, respectively.

NOTE 7 – OPERATING LEASES

The Organization leases office space for its branch locations under operating leases. These include month-to-month leases and leases for terms of up to 120 months, which expire at various dates through 2028. Rent expense under these leases was $555,759 and $406,715 in 2018 and 2017, respectively.

The following is a schedule by year of the future minimum rental payments required under operating leases as of December 31, 2018:

2019	$ 466,598
2020	397,701
2021	266,405
2022	151,169
2023	108,175
Thereafter	570,122
	$ 1,960,170

NOTE 8 – DEFERRED COMPENSATION

The Organization maintains a Deferred Compensation Plan for certain key executives. Under the terms of the Plan, the Organization is to defer a percentage of the executives' salaries each year as stipulated in the agreement. The amounts contributed to the Plan are invested in mutual funds as specified by each executive. The amount of deferred compensation expense was $18,500 for 2018 and $18,000 for 2017.

(Continued)

NOTE 9 – RELATED PARTY TRANSACTIONS

The Organization had pledges receivable from various employees. The Organization also entered into transactions for goods and services with various vendors at which board members are employed.

NOTE 10 – SELF-FUNDED HEALTH INSURANCE

The Organization maintains a self-funded health insurance plan for all full-time employees, certain part-time employees, and their eligible dependents. The amounts funded by the Organization are based on claims processed and submitted for payment on a weekly basis by a third-party plan administrator. The Organization purchased a stop-loss liability insurance policy (reinsurance) that reimburses the Organization for individual participant claims paid in excess of $150,000. The expense under this plan for the years ended December 31, 2018 and 2017 was $3,260,652 and $3,257,122, respectively. The Organization has estimated and accrued for incurred but not reported expenses of $275,446 and $218,375 as of December 31, 2018 and 2017, respectively.

NOTE 11 – FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS

U.S. GAAP defines fair value as the price that would be received for an asset or paid to transfer a liability (an exit price) in the Organization's principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date.

Certain investments are valued using the net asset value (NAV) (or its equivalent) provided by the fund as a practical expedient. Those investments are private equity funds and other alternative assets, and are excluded from the valuation hierarchy, pursuant to the adoption of ASU 2015-07, *Fair Value Measurement*.

A fair value hierarchy requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. There are three levels of inputs that may be used to measure fair value:

Level 1: Quoted prices for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant other observable inputs other than Level 1 prices such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect a reporting entity’s own assumptions about the assumptions that market participants would use in pricing an asset or liability.

In many cases, a valuation technique used to measure fair value includes inputs from multiple levels of the fair value hierarchy. The lowest level of significant input determines the placement of the entire fair value measurement in the hierarchy.

(Continued)

NOTE 11 – FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS (Continued)

Assets Measured on a Recurring Basis

Investments measured at fair value on a recurring basis are summarized below:

	Fair Value Measurements at December 31, 2018				
	Level 1	Level 2	Level 3	Valued Using NAV Expedient	Total
Investments:					
Money market funds	$ 77,236	$ -	$ -	$ -	$ 77,236
Equity mutual funds	26,469,646	-	-	-	26,469,646
Fixed income mutual funds	14,220,017	-	-	-	14,220,017
Certificates of deposit	-	244,533	-	-	244,533
Core Property Fund	-	-	-	2,098,635	2,098,635
Energy Debt Fund	-	-	-	1,426,352	1,426,352
Special Situations Fund	-	-	-	4,053,551	4,053,551
Structured Credit Fund	-	-	-	1,639,176	1,639,176
Private capital funds	-	-	-	811,682	811,682
Interest in perpetual trusts	-	-	305,150	-	305,150
Total Investments	40,766,899	244,533	305,150	10,029,396	51,345,978
Investments held by others	-	-	385,287	-	385,287
Total assets	$ 40,766,899	$ 244,533	$ 690,437	$ 10,029,396	$ 51,731,265

	Fair Value Measurements at December 31, 2017				
	Level 1	Level 2	Level 3	Valued Using NAV Expedient	Total
Investments:					
Money market funds	$ 203,444	$ -	$ -	$ -	$ 203,444
Equity mutual funds	29,681,533	-	-	-	29,681,533
Fixed income mutual funds	14,423,469	-	-	-	14,423,469
Certificates of deposit	-	242,453	-	-	242,453
Core Property Fund	-	-	-	1,925,977	1,925,977
Energy Debt Fund	-	-	-	1,407,006	1,407,006
Special Situations Fund	-	-	-	3,837,070	3,837,070
Structured Credit Fund	-	-	-	1,519,172	1,519,172
Private capital funds	-	-	-	798,702	798,702
Interest in perpetual trusts	-	-	344,886	-	344,886
Total Investments	44,308,446	242,453	344,886	9,487,927	54,383,712
Investments held by others	-	-	422,931	-	422,931
Total assets	$ 44,308,446	$ 242,453	$ 767,817	$ 9,487,927	$ 54,806,643

(Continued)

NOTE 11 – FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS (Continued)

Reconciliations of beginning and ending balances for the Organization's fair value measurements using Level 3 inputs for the years ended December 31, 2018 and 2017 are as follows:

	2018		
	Perpetual Trusts	Investments Held By Others	Total
Assets at beginning of year	$ 344,886	$ 422,931	$ 767,817
Unrealized losses on investments	(39,736)	(49,650)	(89,386)
Purchases and contributions	-	12,006	12,006
Assets at end of year	$ 305,150	$ 385,287	$ 690,437

	2017		
	Perpetual Trusts	Investments Held By Others	Total
Assets at beginning of year	$ 310,253	$ 378,905	$ 689,158
Unrealized gains on investments	34,633	38,853	73,486
Purchases and contributions	-	5,173	5,173
Assets at end of year	$ 344,886	$ 422,931	$ 767,817

Inputs and Valuation Techniques

In determining fair value, management uses various valuation approaches. With respect to investments for which quoted prices in active markets are observable (Level 1 inputs), management determines fair value based on the quoted prices at the measurement date.

With respect to investments using significant observable inputs other than Level 1 prices (Level 2) or significant unobservable inputs (Level 3) management determines fair value using investment manager input incorporating information such as historical and current performance of underlying assets, cash flow projections, levels of subscription and redemption, liquidity, and financial trend analysis of individual investment managers. Investment managers utilize standard valuation procedures and policies to assess the fair value of the underlying investment holdings to derive fair values. For holdings in marketable securities listed on national securities exchanges, the values represent the publicly traded values, and holdings in private securities are generally valued using the mark-to-market method, which attempts to apply a fair value standard by referring to meaningful third-party transactions, comparable public market valuations, appraisals, and/or the income approach.

In most instances, the Organization possesses the ability to redeem its investment at the fair value measurement date (Level 2 inputs), and in some instances additional restrictions are in place such that investment redemption at fair value is not possible at the measurement date (Level 3 inputs).

(Continued)

NOTE 11 – FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS (Continued)

Money Market Funds

The fair values of money market funds are determined by obtaining quoted prices on nationally recognized securities exchanges (Level 1 inputs).

Equity Mutual Funds

Equity mutual funds consist of mutual funds which are primarily invested in equity securities. The fair values of mutual funds, which are readily marketable, are determined by obtaining quoted prices on nationally recognized securities exchanges (Level 1 inputs).

Fixed Income Mutual Funds

Fixed income mutual funds consist of mutual funds which are primarily invested in fixed income securities. The fair values of mutual funds, which are readily marketable, are determined by obtaining quoted prices on nationally recognized securities exchanges (Level 1 inputs).

Certificates of Deposit

The fair values of certificates of deposit are estimated to approximate deposit account balances, payable on demand or due at maturity, as no discounts for credit quality or liquidity were determined to be applicable (Level 2 inputs).

Alternative Investments (Core Property Fund, Energy Debt Fund, Special Situations Fund, and Structured Credit Fund)

The fair value of alternative investments is based on several valuation techniques including NAV reported by fund managers, which is determined by managers based on the value of underlying holdings of the funds.

Private Capital Funds

Private capital funds are investments in a limited liability partnership. The investment managers have developed an internal model for pricing these investments. Information such as historical and current performance of the underlying assets, cash flow projections, liquidity and credit premiums required by a market participant, and financial trend analysis with respect to the individual fund manager, are utilized in determining valuations. Due to current market conditions as well as the limited trading activity of these investments, the market value of the investments is highly sensitive to assumptions and market volatility.

Interest in Perpetual Trusts

The fair value of the beneficial interests in perpetual trust assets is based upon the net asset values of the trusts at December 31st. The Organization is able to compare the valuations to widely available published data for reasonableness but due to the illiquidity of the assets, they have been considered to be valued using Level 3 inputs.

(Continued)

NOTE 11 – FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS (Continued)

Investments Held by Others

The fair value of beneficial interests in assets held by the Bluegrass Community Foundation and the Foundation for Appalachian Kentucky (the "Community Foundations") is based upon Bluegrass Care Navigators' proportionate share of the Community Foundations' pooled investment portfolio. The Organization's management reviews the valuations and returns in comparison to industry benchmarks and other information provided by the Community Foundations, but there is currently no visibility provided by the Community Foundations to the specific listing of underlying investment holdings, nor is there an ability to redeem the amount in its entirety with current notice as redemption requires approval from the Community Foundations' Boards (Level 3 inputs).

Private Capital Funds: The Organization has a limited partnership interest in a private capital fund. The fund's objective is to generate a premium fund level return relative to opportunities available in the public markets. This fund invests primarily across three broad sectors: global private equity, special situations, and real assets, within defined ranges over a multi-year investment period. As of December 31, 2018, the fund has committed capital to 28 underlying investment funds. This fund does not allow for withdrawals until the LLP is dissolved, unless special approval is awarded by the general partner. There are special provisions that allow for the life of the LLP to be extended beyond the original dissolution date in 2023 by up to three years.

At December 31, 2018, the Organization's unfunded commitments for private capital funds total approximately $51,500. A portion of the current unfunded commitments will be funded by distributions generated by the Organization's existing investment holdings. The Organization's investment policy targets an allocation of 10% to private capital funds. The actual percentage is expected to vary within a range of +/- 10%.

Core Property Fund: The Fund seeks both current income and long-term capital appreciation through investing in pooled investment vehicles that invest in commercial real estate properties and are managed by underlying investment managers. At December 31, 2018, redemptions are allowed on March 31st, June 30th, September 30th and December 31st provided there is a 95-day written notice provided to the administrator.

Energy Debt Fund: The Fund's objective is to generate high total returns by investing directly and indirectly in below investment grade bonds and loans (and other debt and equity instruments) of U.S. and international energy companies. At December 31, 2018, redemptions are allowed on June 30th and December 31st, after the first withdrawal date following the three- year anniversary of the initial investment, provided there is a 95-day written notice provided to the administrator. The Organization entered into a new agreement with the Fund in January 2019 which extends the first anniversary date to April 1, 2022 with the first withdrawal date being June 30, 2022.

Special Situations Fund: The Fund's objective is to seek to achieve high returns balanced against an appropriate level of volatility and direct market exposure over a full market cycle by investing in private equity funds, hybrid funds and other alternative investment funds. At December 31, 2018, redemptions are allowed on June 30th and December 31st, after the first withdrawal date following the two- year anniversary of the initial investment, provided there is a 95-day written notice provided to the administrator. The anniversary date is April 28, 2019 with the first withdrawal date being June 30, 2019.

(Continued)

NOTE 11 – FAIR VALUE MEASUREMENTS OF FINANCIAL INSTRUMENTS (Continued)

Structured Credit Fund: The Fund's objective is to generate high total returns by investing in a portfolio comprised of collateralized debt obligations and other structured credit investments. At December 31, 2018, redemptions are allowed on March 31st, June 30th, September 30th and December 31st if the fund approves a quarterly repurchase, provided shares were acquired more than two years prior to the effective date of the proposed repurchase. The anniversary date is March 30, 2019 with the first withdrawal date being March 31, 2019.

NOTE 12 – ENDOWMENT FUNDS

Overview: The Organization's endowment funds consist of pooled investment funds and liquid assets pooled with the Organization's main operating account. As required by U.S. GAAP, net assets associated with the endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of UPMIFA: The Organization's Board of Directors has determined the requirements of Kentucky's version of the Uniform Prudent Management of Institutional Funds Act ("UPMIFA") to center around the preservation of the fair value of the original investment as of the date of the asset transfer. The investments resulting from donations directing that they be invested in perpetuity and the earnings or losses from these investments are classified as net assets with donor restrictions. The net assets with donor restrictions are reclassified as net assets without donor restrictions when used as directed by the donor or otherwise appropriated for expenditure by the Organization in a manner consistent with the standard prudence described by Kentucky's version of UPMIFA. Funds designated by the Organization's Board of Directors as a quasi-endowment and related earnings are classified as net assets without donor restrictions. The Organization considers the following factors in making a determination to appropriate or accumulate its endowment funds:

(1) The duration and preservation of the fund
(2) The purposes of the Organization and the donor-restricted endowment fund
(3) General economic conditions
(4) The possible effect of inflation and deflation
(5) The expected total return from income and the appreciation of investments
(6) Other resources of the Organization
(7) The investment policies of the Organization

Return Objectives and Risk Parameters: The Organization has adopted investment and spending policies for endowment assets that attempt to provide a perpetual source of support to programs supported by its endowments while seeking to preserve the purchasing power of the endowment assets. Endowment assets include assets of donor-restricted funds that the Organization must hold in perpetuity.

Strategies Employed for Achieving Objectives: To satisfy its long-term rate-of-return objectives, the Organization relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Organization targets a broadly diversified portfolio to achieve its long-term return objectives within prudent risk constraints.

Fund with Deficiencies: From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Organization to retain as a fund of perpetual duration. Cumulative deficiencies of this nature that are in excess of related net assets with donor restriction amounts are reported in net assets with donor restrictions. There were no funds with deficiencies as of December 31, 2018 and 2017.

(Continued)

NOTE 12 – ENDOWMENT FUNDS (Continued)

Spending Policy and How the Investment Objectives Relate to Spending Policy: The spending policy determined by the Board of Directors will be based on the total return of the assets invested in the endowment (income plus capital appreciation) and will be determined as a percentage of the total fair market value of the endowment based on twelve quarter rolling average of total endowment fund fair market value. The draw of funds will be based on the total market value rolling average balance at the end of each year and available for distribution the following fiscal year. The percentage is set at a maximum of 5% of the value of the funds based on the previous twelve quarter rolling average of the market value of that fund. The income will be used for the Organization's grant making programs.

Endowment Net Asset Composition by Type of Fund: The Organization's composition of endowment assets for the years ended December 31 is as follows:

	Without Donor Restrictions	With Donor Restrictions		
	Board Designated	Accumulated Earnings	Original Gift	Total
2018:				
Board designated	$ 123,572	$ -	$ -	$ 123,572
Donor-restricted		902,980	765,539	1,668,519
	$ 123,572	$ 902,980	$ 765,539	$ 1,792,091

Below is a reconciliation of endowment assets with the total net assets with donor restrictions reported in the consolidated statement of financial position:

	2018
Endowment assets	$ 1,668,519
Assets held in perpetual trusts	305,150
Assets with time or purpose donor restrictions	182,538
	$ 2,156,207

	Without Donor Restrictions	With Donor Restrictions		
	Board Designated	Accumulated Earnings	Original Gift	Total
2017:				
Board designated	$ 130,626	$ -	$ -	$ 130,626
Donor-restricted		998,223	765,539	1,763,762
	$ 130,626	$ 998,223	$ 765,539	$ 1,894,388

(Continued)

NOTE 12 – ENDOWMENT FUNDS (Continued)

Below is a reconciliation of endowment assets with the total net assets with donor restrictions reported in the consolidated statement of financial position:

	2017
Endowment assets	$ 1,763,762
Assets held in perpetual trusts	344,886
Assets with time or purpose donor restrictions	155,957
	$ 2,264,605

Changes in endowment net assets for years ended December 31 were as follows:

	Without Donor Restrictions	With Donor Restrictions		
	Board Designated	Accumulated Earnings	Original Gift	Total
2018:				
Beginning balance	$ 130,626	$ 998,223	$ 765,539	$ 1,894,388
Total investment loss	(7,054)	(95,243)	-	(102,297)
Ending balance	$ 123,572	$ 902,980	$ 765,539	$ 1,792,091
2017:				
Beginning balance	$ 104,042	$ 755,732	$ 765,539	$ 1,625,313
Contributions	10,000	-	-	10,000
Total investment gain	16,584	242,491	-	259,075
Ending balance	$ 130,626	$ 998,223	$ 765,539	$ 1,894,388

(Continued)

NOTE 13 – LIQUIDITY AND AVAILABILITY

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of the statement of financial position date, comprise the following:

	2018	2017
Cash and cash equivalents	$ 4,805,312	$ 5,172,787
Patient accounts receivable, net	7,723,117	9,071,163
Pledges receivable, current portion	22,427	21,093
Bequests receivable	119,780	-
Miscellaneous receivables, less worker's comp insurance receivable of $1,125,644 and $1,248,894 as of December 31, 2018 and 2017, respectively	316,488	286,799
Investments not pledged as collateral for long-term borrowing or subject to long-term lock-up provisions	20,222,020	46,821,762
Less: Net assets with donor-imposed restrictions	(2,156,207)	(2,264,605)
	$ 31,052,937	$ 59,108,999

As part of the Organization's liquidity management plan, management invests cash in excess of daily requirements in interest bearing accounts, CDs, money market funds, equity mutual funds and fixed income mutual funds. The Organization has a goal to maintain liquid financial assets, which consist of cash and unrestricted investments, on hand to be available as its general expenditures, liabilities, and other obligations come due. The Organization typically collects patient accounts receivable within one year of the date of service. Collections by payor type may vary based on payor source liquidity and timeliness of claims processing. A portion of the investment portfolio is pledged as collateral (Note 5) securing debt and a portion is invested in alternative vehicles some of which have lock-up provisions. These amounts have been excluded from this disclosure.

Board designated funds represent the Board designated endowment (Note 12) plus Board designated funds of $1,007,412 in 2018 appropriated for general expenditure as part of the annual budget to support new programs including pediatric palliative care, behavioral health support and complementary alternative medicine. The Organization's endowment investments are subject to an annual spending rate of 5 percent as described in Note 12. Although the Organization does not intend to spend from the investments (other than amounts Board designated for general expenditure as part of the annual budget approval equal to $1,007,412), the total 5 percent could be made available if necessary. In the event of an unanticipated liquidity need, the Organization's investment portfolio could be converted to cash on a short-term basis and be available to support cash flow needs and operations. Additionally, the Organization maintains a line of credit available in the amount of $5,000,000 which could be drawn upon as necessary (as further discussed in Note 5). As of December 31, 2018, $5,000,000 remained available on the line of credit.

ADDITIONAL INFORMATION

BLUEGRASS CARE NAVIGATORS
CONSOLIDATING STATEMENTS OF FINANCIAL POSITION
December 31, 2018

	Bluegrass Care Navigators	Bluegrass Palliative Care	Hospice of the Bluegrass Foundation, Inc.	Eliminations	Consolidated
ASSETS					
Current assets					
Cash and cash equivalents	$ 4,254,163	$ 462,916	$ 88,233	$ -	$ 4,805,312
Patient accounts receivable, net	7,524,876	198,241	-	-	7,723,117
Pledges receivable - current	22,427	-	-	-	22,427
Bequests receivable	119,780	-	-	-	119,780
Miscellaneous receivables	1,902,198	267,013	-	(727,079)	1,442,132
Prepaid expenses and other current assets	1,153,724	156	-	-	1,153,880
Total current assets	14,977,168	928,326	88,233	(727,079)	15,266,648
Investments	51,108,806	-	237,172	-	51,345,978
Investments held by others	385,287	-	-	-	385,287
Pledges receivable - long-term	4,121	-	-	-	4,121
Property, plant, and equipment, net	29,607,016	-	-	-	29,607,016
Other assets	452,438	-	-	-	452,438
Total assets	$ 96,534,836	$ 928,326	$ 325,405	$ (727,079)	$ 97,061,488
LIABILITIES AND NET ASSETS					
Current liabilities					
Current portion of long-term debt	$ 445,666	$ -	$ -	$ -	$ 445,666
Accounts payable	4,548,586	724,151	435	(727,079)	4,546,093
Accrued liabilities	4,350,615	-	-	-	4,350,615
Annuities payable – current	11,486	-	-	-	11,486
Total current liabilities	9,356,353	724,151	435	(727,079)	9,353,860
Annuities payable - long-term	109,033	-	-	-	109,033
Long-term debt	1,939,165	-	-	-	1,939,165
Funds held for others	597,973	-	-	-	597,973
Total liabilities	12,002,524	724,151	435	(727,079)	12,000,031
Net assets					
Without donor restrictions	82,376,105	204,175	324,970	-	82,905,250
With donor restrictions	2,156,207	-	-	-	2,156,207
Total net assets	84,532,312	204,175	324,970	-	85,061,457
Total liabilities and net assets	$ 96,534,836	$ 928,326	$ 325,405	$ (727,079)	$ 97,061,488

See accompanying independent auditor's report.

BLUEGRASS CARE NAVIGATORS
CONSOLIDATING STATEMENTS OF FINANCIAL POSITION
December 31, 2017

	Hospice of the Bluegrass Care Navigators	Bluegrass Palliative Care	Bluegrass Foundation, Inc.	Eliminations	Consolidated
ASSETS					
Current assets					
Cash and cash equivalents	$ 4,848,568	$ 236,679	$ 87,540	$ -	$ 5,172,787
Patient accounts receivable, net	8,932,007	139,156	-	-	9,071,163
Pledges receivable - current	21,093	-	-	-	21,093
Miscellaneous receivables	2,034,631	253,361	-	(752,299)	1,535,693
Prepaid expenses and other current assets	1,253,812	181	-	-	1,253,993
Total current assets	17,090,111	629,377	87,540	(752,299)	17,054,729
Investments	54,114,723	-	268,989	-	54,383,712
Investments held by others	422,931	-	-	-	422,931
Pledges receivable - long-term	8,757	-	-	-	8,757
Property, plant, and equipment, net	24,156,706		-	-	24,156,706
Other assets	455,059	-	-	-	455,059
Total assets	$ 96,248,287	$ 629,377	$ 356,529	$ (752,299)	$ 96,481,894
LIABILITIES AND NET ASSETS					
Current liabilities					
Current portion of long-term debt	$ 445,666	$ -	$ -	$ -	$ 445,666
Accounts payable	4,500,357	754,509	504	(752,299)	4,503,071
Accrued liabilities	3,509,035	-	-	-	3,509,035
Annuities payable – current	12,416	-	1,675	-	14,091
Total current liabilities	8,467,474	754,509	2,179	(752,299)	8,471,863
Annuities payable - long-term	123,598	-	8,680	-	132,278
Long-term debt	2,452,679	-	-	-	2,452,679
Funds held for others	691,422	-	-	-	691,422
Total liabilities	11,735,173	754,509	10,859	(752,299)	11,748,242
Net assets (deficit)					
Without donor restrictions	82,248,509	(125,132)	345,670	-	82,469,047
With donor restrictions	2,264,605	-	-	-	2,264,605
Total net assets	84,513,114	(125,132)	345,670	-	84,733,652
Total liabilities and net assets	$ 96,248,287	$ 629,377	$ 356,529	$ (752,299)	$ 96,481,894

See accompanying independent auditor's report.

BLUEGRASS CARE NAVIGATORS
CONSOLIDATING STATEMENT OF ACTIVITIES
Year ended December 31, 2018

	Bluegrass Care Navigators	Bluegrass Palliative Care	Hospice of the Bluegrass Foundation, Inc.	Eliminations	Consolidated
NET ASSETS WITHOUT DONOR RESTRICTIONS					
Revenues, gains, and other support					
Net patient service revenue	$ 62,770,055	$ 826,473	$ -	$ -	$63,596,528
Contributions	2,629,361	1,768	2,486	-	2,633,615
Income from fundraising events, net of direct fundraising expenses of $81,181	114,324	-	-	-	114,324
Other gains and support	353,177	836,872	10,355	(10,344)	1,190,060
Total revenues, gains, and other support	65,866,917	1,665,113	12,841	(10,344)	67,534,527
Net assets released from restrictions	50,249	-	-	-	50,249
Expenses					
Patient service expenses –					
Contract services	2,723,831	-	-	-	2,723,831
Durable medical equipment	352,242	800	-	-	353,042
Employee compensation, including benefits	33,104,707	1,666,821	-	-	34,771,528
Outpatient expenses	246,912	-	-	-	246,912
Medicaid room and board	6,792,566	-	-	-	6,792,566
Pharmacy and chemotherapy	1,825,810	1,973	-	-	1,827,783
Provision for bad debts	152,878	66,206	-	-	219,084
Supplies	632,597	34	-	-	632,631
Other	7,452,421	16,156	10,344	(10,344)	7,468,577
	53,283,964	1,751,990	10,344	(10,344)	55,035,954
Administrative and general expenses –					
Employee compensation including benefits	5,065,482	274,708	-	-	5,340,190
Office and equipment rentals, including cleaning and maintenance	572,531	-	-	-	572,531
Other	2,682,010	58,717	-	-	2,740,727
	8,320,023	333,425	-	-	8,653,448
Fundraising expenses not directly related to fundraising events –					
Employee compensation, including benefits	470,337	-	-	-	470,337
Other	154,641	-	1,837	-	156,478
	624,978	-	1,837	-	626,815
Total expenses	62,228,965	2,085,415	12,181	(10,344)	64,316,217
Excess (deficiency) of revenues over expenses before investment income	3,688,201	(420,302)	660	-	3,268,559

(Continued)

BLUEGRASS CARE NAVIGATORS
CONSOLIDATING STATEMENT OF ACTIVITIES
Year ended December 31, 2018

	Bluegrass Care Navigators	Bluegrass Palliative Care	Hospice of the Bluegrass Foundation, Inc.	Eliminations	Consolidated
Investment income					
Investment income, net of expenses of $209,118	$ 2,802,622	$ 15	$ 21,897	$ -	$ 2,824,534
Net realized gains on investments	13,275	-	825	-	14,100
Net unrealized losses on investments	(5,626,907)	-	(44,082)	-	(5,670,989)
Total investment income	(2,811,010)	15	(21,360)	-	(2,832,355)
Change in net assets without donor restrictions	877,191	(420,287)	(20,700)	-	436,204
Forgiveness of accounts payable to Bluegrass Palliative Care from Bluegrass Care Navigators	(749,594)	749,594	-	-	-
NET ASSETS WITH DONOR RESTRICTIONS					
Contributions and grants	76,829	-	-	-	76,829
Investment income	107,097	-	-	-	107,097
Net realized gains on investments	469	-	-	-	469
Net unrealized losses on investments	(242,545)	-	-	-	(242,545)
Net assets released from restrictions	(50,249)	-	-	-	(50,249)
Change in net assets with donor restrictions	(108,399)	-	-	-	(108,399)
Total change in net assets	19,198	329,307	(20,700)	-	327,805
Net assets, beginning of year	84,513,114	(125,132)	345,670	-	84,733,652
Net assets, end of year	$ 84,532,312	$ 204,175	$ 324,970	$ -	$ 85,061,457

See accompanying independent auditor's report.

BLUEGRASS CARE NAVIGATORS
CONSOLIDATING STATEMENT OF ACTIVITIES
Year ended December 31, 2017

	Bluegrass Care Navigators	Bluegrass Palliative Care	Hospice of the Bluegrass Foundation, Inc.	Eliminations	Consolidated
NET ASSETS WITHOUT DONOR RESTRICTIONS					
Revenues, gains, and other support					
Net patient service revenue	$ 54,167,599	$ 597,582	$ -	$ -	$ 54,765,181
Contributions	1,188,991	788	1,659	-	1,191,438
Income from fundraising events, net of direct fundraising expenses of $83,780	163,267	-	-	-	163,267
Other gains and support	160,131	777,522	-	(10,043)	927,610
Total revenues, gains, and other support	55,679,988	1,375,892	1,659	(10,043)	57,047,496
Net assets released from restrictions	35,777	-	-	-	35,777
Expenses					
Patient service expenses –					
Contract services	2,467,113	-	-	-	2,467,113
Durable medical equipment	231,054	-	-	-	231,054
Employee compensation, including benefits	30,419,416	1,447,182	-	-	31,866,598
Outpatient expenses	247,840	-	-	-	247,840
Medicaid room and board	6,140,556	-	-	-	6,140,556
Pharmacy and chemotherapy	1,710,474	-	-	-	1,710,474
Provision for bad debts	128,617	31,466	-	-	160,083
Supplies	532,348	8	-	-	532,356
Other	6,380,974	13,960	10,043	(10,043)	6,394,934
	48,258,392	1,492,616	10,043	(10,043)	49,751,008
Administrative and general expenses –					
Employee compensation including benefits	4,497,947	128,495	-	-	4,626,442
Office and equipment rentals, including cleaning and maintenance	480,850	2,503	-	-	483,353
Other	2,477,992	46,842	-	-	2,524,834
	7,456,789	177,840	-	-	7,634,629
Fundraising expenses not directly related to fundraising events –					
Employee compensation, including benefits	453,510	-	-	-	453,510
Other	132,610	-	3,020	-	135,630
	586,120	-	3,020	-	589,140
Total expenses	56,301,301	1,670,456	13,063	(10,043)	57,974,777
Deficiency of revenues over expenses before investment income	(585,536)	(294,564)	(11,404)	-	(891,504)

(Continued)

BLUEGRASS CARE NAVIGATORS
CONSOLIDATING STATEMENT OF ACTIVITIES
Year ended December 31, 2017

	Hospice of the Bluegrass Care Navigators	Bluegrass Palliative Care	Bluegrass Foundation, Inc.	Eliminations	Consolidated
Investment income					
Investment income, net of expenses of $174,230	$ 1,705,510	$ 12	$ 12,534	$ -	$ 1,718,056
Net realized gains on investments	303,286	-	2,112	-	305,398
Net unrealized gains on investments	4,361,164	-	25,130	-	4,386,294
Total investment income	6,369,960	12	39,776	-	6,409,748
Change in net assets without donor restrictions	5,784,424	(294,552)	28,372	-	5,518,244
NET ASSETS WITH DONOR RESTRICTIONS					
Contributions and grants	52,727	-	-	-	52,727
Investment income	70,700	-	-	-	70,700
Net realized gains on investments	11,506	-	-	-	11,506
Net unrealized gains on investments	194,917	-	-	-	194,917
Net assets released from restrictions	(35,777)	-	-	-	(35,777)
Change in net assets with donor restrictions	294,073	-	-	-	294,073
Total change in net assets	6,078,497	(294,552)	28,372	-	5,812,317
Net assets, beginning of year	78,434,617	169,420	317,298	-	78,921,335
Net assets (deficit), end of year	$ 84,513,114	$ (125,132)	$ 345,670	$ -	$ 84,733,652

See accompanying independent auditor's report.

BLUEGRASS CARE NAVIGATORS
CONSOLIDATED SCHEDULES OF OTHER PATIENT SERVICE EXPENSES
Years ended December 31, 2018 and 2017

	2018	2017
Ambulance	$ 479,459	$ 407,888
Answering service	34,147	28,947
Computer support and equipment	1,480,982	1,599,755
Inpatient units	148,421	115,456
Depreciation	963,042	927,604
Education	92,225	85,627
Facilities	1,042,376	787,051
Insurance	140,051	135,803
Miscellaneous	232,297	124,118
Patient care phone	209,438	194,313
Patient service contract labor	514,989	119,917
Patient service travel	1,112,965	1,038,427
Physician services	226,728	161,570
Postage	224,559	189,806
Printing and duplication	64,529	46,488
Program support	466,984	415,286
Therapies	35,385	16,878
	$ 7,468,577	$ 6,394,934

See accompanying independent auditor's report.

BLUEGRASS CARE NAVIGATORS
CONSOLIDATED SCHEDULES OF OTHER ADMINISTRATIVE AND GENERAL EXPENSES
Years ended December 31, 2018 and 2017

	2018	2017
Administrative travel	$ 449,802	$ 392,902
Computer support and equipment	228,438	227,337
Depreciation and amortization	132,706	131,501
Education	14,112	12,661
Employment advertising	35,369	21,724
Facilities	233,524	192,208
Insurance	171,390	176,495
Interest	80,973	80,067
Loss on disposal of fixed assets	4,016	3,506
Membership and licensing fees	187,183	120,893
Miscellaneous	216,727	178,812
Postage	27,342	27,772
Printing and duplicating	32,793	81,595
Professional fees	599,622	568,620
Supplies and materials	98,238	87,455
Telephone	228,492	221,286
	$ 2,740,727	$ 2,524,834

See accompanying independent auditor's report.

Care Innovations

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Center for the Study of Services

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Central Kentucky Interpreter Referral, Inc.

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Central Kentucky Interpreter Referral, Inc.
Profit & Loss
January through December 2019

		Jan - Dec 19
Ordinary Income/Expense		
Income		
ASL Sub-Con Income		792,437.25
Interpreter Travel Time		195.00
Phone Translation Income		2,780.00
Spanish Income		126,566.25
Written Translation Income		2,740.26
Total Income		924,718.76
Gross Profit		924,718.76
Expense		
Accountant		11,490.00
Advertising		955.19
Auto Expenses		3,674.70
Background Check		320.00
Bank Charges		481.98
Community Dues		225.00
Continuing Education		7,411.27
Depreciation Expense		8,108.00
Employee Benefits		75.00
Health Insurance		10,024.73
Insurance		6,525.40
Interest		2,324.41
Interpreters Sub-Con Expense		428,444.30
License Renewal		1,002.38
Meals for Interpreter Meetings		416.07
Memberships		2,630.14
Miscellaneous		479.68
Office Cleaner		1,080.00
Office Space		19,200.00
Office Supplies		6,337.80
Parking fee		691.61
Payroll Expenses		
Coordinator Salary	135,859.33	
Bonus	7,250.00	
Hourly Wage	274,633.69	
Payroll Taxes	31,475.59	
SIMPLE Match Expense	10,286.03	
Total Payroll Expenses		459,504.64
Postage		767.65
Post Office Box		76.00
Repairs & Maint		5,456.05
Tax costs		15.00
Telephone, internet, webhosting		11,563.04
Travel		3,333.81
Utilities		3,571.13
Written Translation		1,765.65
Total Expense		997,950.63
Net Ordinary Income		-73,231.87

Central Kentucky Interpreter Referral, Inc.
Profit & Loss
January through December 2019

	Jan - Dec 19	
Other Income/Expense		
Other Expense		
Nonprofit mission		
Donation	55.00	
Total Nonprofit mission		55.00
Total Other Expense		55.00
Net Other Income		-55.00
Net Income		-73,286.87

Central Kentucky Interpreter Referral, Inc.
Profit & Loss
January through December 2018

		Jan - Dec 18
Ordinary Income/Expense		
Income		
Uncategorized Income		0.00
ASL Sub-Con Income		733,466.44
Interpreter Travel Time		812.50
Mileage Reimbursement		6.72
Phone Translation Income		1,330.00
Spanish Income		73,823.75
Written Translation Income		31.05
Total Income		809,470.46
Gross Profit		809,470.46
Expense		
Accountant		9,235.00
Advertising		223.88
Amortization Expense		3,834.00
Auto Expenses		4,968.32
Background Check		890.00
Bank Charges		379.25
Community Dues		225.00
Continuing Education		990.00
Depreciation Expense		9,987.00
Employee Benefits		20.00
Health Insurance		6,787.23
Insurance		4,909.47
Interest		1,125.09
Interpreters Sub-Con Expense		349,557.99
Legal Expense		265.00
License Renewal		1,573.51
Meals for Interpreter Meetings		190.28
Memberships		670.08
Office Cleaner		1,080.00
Office Space		19,200.00
Office Supplies		8,634.65
Other Services		230.00
Parking fee		756.00
Payroll Expenses		
Coordinator Salary	112,423.04	
Bonus	26,919.53	
Hourly Wage	258,500.81	
Payroll Taxes	30,811.29	
SIMPLE Match Expense	10,036.01	
Total Payroll Expenses		438,690.68
Postage		723.74
Post Office Box		72.00
Repairs & Maint		7,583.24
Small Equipment <$2500		2,493.10
Tax costs		15.00
Telephone, internet, webhosting		12,325.07
Travel		3,997.81
Utilities		3,448.04
Written Translation		20.25
Total Expense		895,100.68
Net Ordinary Income		-85,630.22

Central Kentucky Interpreter Referral, Inc.
Profit & Loss
January through December 2018

		Jan - Dec 18
Other Income/Expense		
Other Expense		
Nonprofit mission		
Donation	1,100.00	
Total Nonprofit mission		1,100.00
Total Other Expense		1,100.00
Net Other Income		-1,100.00
Net Income		**-86,730.22**

Central Kentucky Interpreter Referral, Inc.
Profit & Loss
January through December 2017

		Jan - Dec 17
Ordinary Income/Expense		
Income		
ASL Sub-Con Income		857,012.80
Interpreter Travel Time		4,500.00
Mileage Reimbursement		1,564.00
Phone Translation Income		1,980.00
Spanish Income		71,932.50
Written Translation Income		426.29
Total Income		937,415.59
Gross Profit		937,415.59
Expense		
Accountant		6,770.00
Advertising		736.97
Amortization Expense		3,833.00
Auto Expenses		4,867.23
Background Check		380.00
Bank Charges		535.04
Community Dues		225.00
Continuing Education		9,188.33
Depreciation Expense		16,251.00
Employee Benefits		90.00
Entertainment		133.90
Finance Charges		0.00
Health Insurance		9,008.99
Insurance		5,333.96
Interest		1,023.13
Interpreter Mileage		1,233.46
Interpreters Sub-Con Expense		384,539.60
Legal Expense		100.00
License Renewal		643.45
Meals for Interpreter Meetings		343.91
Memberships		1,666.85
Miscellaneous		0.00
Office Cleaner		1,108.00
Office Space		19,200.00
Office Supplies		7,582.37
Parking fee		795.00
Payroll Expenses		
Coordinator Salary	51,000.04	
Bonus	45,550.00	
Hourly Wage	307,754.81	
Payroll Taxes	31,509.27	
SIMPLE Match Expense	10,121.70	
Total Payroll Expenses		445,935.82
Postage		1,093.73
Post Office Box		70.00
Repairs & Maint		7,175.54
Tax costs		1,711.49
Telephone, internet, webhosting		11,557.07
Travel		2,045.14
Utilities		2,834.98
Written Translation		274.05
Total Expense		948,287.01
Net Ordinary Income		-10,871.42

Central Kentucky Interpreter Referral, Inc.
Profit & Loss
January through December 2017

	Jan - Dec 17	
Other Income/Expense		
Other Expense		
Nonprofit mission		
Donation	50.00	
Total Nonprofit mission		50.00
Total Other Expense		50.00
Net Other Income		-50.00
Net Income		-10,921.42

Change Healthcare Holdings, LLC

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

FORM 10-Q

(Mark One)

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

For the quarterly period ended September 30, 2019

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

For the transition period from_____to_____

Commission file number 001-38961

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware **(State or Other Jurisdiction of Incorporation or Organization)**	**82-2152098** **(I.R.S. Employer Identification No.)**
3055 Lebanon Pike, Suite 1000 **Nashville, TN** **(Address of Principal Executive Offices)**	**37214** **(Zip Code)**

(615) 932-3000
(Registrant's Telephone Number, Including Area Code)

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $.001 per share	**CHNG**	**The Nasdaq Stock Market LLC**
6.00% Tangible Equity Units	**CHNGU**	**The Nasdaq Stock Market LLC**

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

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

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

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

Emerging growth company ☒

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

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

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

Class	Outstanding as of November 11, 2019
Common Stock, $0.001 par value	**124,948,388**

Change Healthcare Inc.

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Change Healthcare Inc.
Condensed Statements of Operations
(unaudited and amounts in thousands, except share and per share amounts)

	Three Months Ended September 30,		Six Months Ended September 30,	
	2019	2018	2019	2018
Revenue	$ —	$ —	$ —	$ —
Operating expenses				
General and administrative	1,138	31	1,389	62
Accretion Expense	48,363	—	48,363	—
Total operating expenses	49,501	31	49,752	62
Operating income (loss)	(49,501)	(31)	(49,752)	(62)
Non-operating (income) expense				
Loss from Equity Method Investment in the Joint Venture	56,179	25,571	95,732	48,337
(Gain) Loss on Sale of Interests in the Joint Venture	—	(197)	—	(661)
Management fee income	(772)	(31)	(876)	(62)
Interest expense	644	—	644	—
Interest income	(644)	—	(644)	—
Amortization of debt discount and issuance costs	212	—	212	—
Unrealized gain (loss) on forward purchase contract	2,435	—	2,435	—
Total non-operating (income) expense	58,054	25,343	97,503	47,614
Income (loss) before income tax provision (benefit)	(107,555)	(25,374)	(147,255)	(47,676)
Income tax provision (benefit)	(13,620)	(6,783)	(15,804)	(11,584)
Net income (loss)	$ (93,935)	$ (18,591)	$ (131,451)	$ (36,092)
Net income (loss) per share:				
Basic	$ (0.66)	$ (0.25)	$ (1.20)	$ (0.48)
Diluted	$ (0.66)	$ (0.25)	$ (1.20)	$ (0.48)
Weighted average shares (see Note 5):				
Basic	142,223,836	75,506,552	109,111,853	75,555,700
Diluted	142,223,836	75,506,552	109,111,853	75,555,700

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Condensed Statements of Comprehensive Income (Loss)
(unaudited and amounts in thousands)

	Three Months Ended September 30,		Six Months Ended September 30,	
	2019	2018	2019	2018
Net income (loss)	$(93,935)	$(18,591)	$(131,451)	$(36,092)
Other comprehensive income (loss):				
Unrealized gain (loss) on available for sale debt securities of the Joint Venture, net of taxes	1,173	—	1,173	—
Changes in fair value of interest rate swap of the Joint Venture, net of taxes	(1,310)	1,478	(6,741)	2,260
Foreign currency translation adjustment of the Joint Venture	1,583	566	1,809	(2,027)
Other comprehensive income (loss)	1,446	2,044	(3,759)	233
Total comprehensive income (loss)	$(92,489)	$(16,547)	$(135,210)	$(35,859)

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Condensed Balance Sheets
(unaudited and amounts in thousands, except share and per share amounts)

	September 30, 2019	March 31, 2019
Assets		
Current Assets:		
Cash	$ 3,409	$ 3,409
Prepaid expenses	2,315	—
Due from the Joint Venture	1,345	373
Investment in Joint Venture tangible equity units, current	15,154	—
Income taxes receivable	1,602	1,781
Total current assets	23,825	5,563
Dividend receivable	34,547	81,264
Investment in the Joint Venture	1,826,887	1,211,996
Investment in Joint Venture tangible equity units	259,237	—
Total assets	$ 2,144,496	$1,298,823
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable and accrued expenses	$ 453	$ 176
Due to the Joint Venture	9,513	6,167
Current portion of long-term debt	15,154	—
Total current liabilities	25,120	6,343
Long-term debt	27,384	—
Due to McKesson	48,363	—
Deferred income tax liabilities	156,770	159,993
Other liabilities	752	—
Commitments and contingencies (see Note 4)		
Stockholders' Equity:		
Common Stock (par value, $.001), 9,000,000,000 and 252,800,000 shares authorized and 124,935,806 and 75,474,654 shares issued and outstanding at September 30, 2019 and March 31, 2019, respectively	124	75
Class X common stock (par value, $.001), 1 and 1 share authorized and no shares issued and outstanding at September 30, 2019 and March 31, 2019, respectively	—	—
Preferred stock (par value, $.001), 900,000,000 and 0 shares authorized and no shares issued and outstanding at September 30, 2019 and March 31, 2019, respectively	—	—
Additional paid-in capital	2,006,494	1,153,509
Accumulated other comprehensive income (loss)	(6,593)	(3,256)
Retained earnings (deficit)	(113,918)	(17,841)
Total stockholders' equity	1,886,107	1,132,487
Total liabilities and stockholders' equity	$ 2,144,496	$1,298,823

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Condensed Statements of Stockholders' Equity
(unaudited and amounts in thousands, except share and per share amounts)

	Common Stock Shares	Amount	Additional Paid-in Capital	Retained Earnings (Deficit)	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
Balance at March 31, 2018	75,749,118	$ 75	$1,139,300	$ 34,661	$ 2,536	$ 1,176,572
Cumulative effect of accounting change of the Joint Venture-ASU 2017-12	—	—		(490)	490	—
Equity compensation expense	—	—	5,300	—	—	5,300
Repurchase of Change Healthcare Inc. common stock	(251,789)	—	(4,782)	—	—	(4,782)
Issuance of Change Healthcare Inc. common stock upon exercise of equity awards	4,045	—	—	—	—	—
Net income (loss)	—	—	—	(17,501)	—	(17,501)
Foreign currency translation adjustment of the Joint Venture	—	—	—	—	(2,593)	(2,593)
Change in fair value of interest rate cap, net of taxes of the Joint Venture	—	—	—	—	782	782
Balance at June 30, 2018	75,501,374	$ 75	$1,139,818	$ 16,670	$ 1,215	$ 1,157,778
Equity compensation expense	—	—	2,969	—	—	2,969
Repurchase of Change Healthcare Inc. common stock	(90,629)	—	(1,720)	—	—	(1,720)
Issuance of Change Healthcare Inc. common stock upon exercise of equity awards	35,139	—	—	—	—	—
Net income (loss)	—	—	—	(18,591)	—	(18,591)
Foreign currency translation adjustment of the Joint Venture	—	—	—	—	566	566
Change in fair value of interest rate cap, net of taxes of the Joint Venture	—	—	—	—	1,478	1,478
Balance at September 30, 2018	75,445,885	$ 75	$1,141,067	$ (1,921)	$ 3,259	$ 1,142,480
Balance at March 31, 2019	75,474,654	$ 75	$1,153,509	$ (17,841)	$ (3,256)	$ 1,132,487
Cumulative effect of accounting change of the Joint Venture-ASC 606	—	—	—	35,797	—	35,797
Cumulative effect of accounting change of the Joint Venture-ASU 2018-02	—	—	—	(422)	422	—
Equity compensation expense	—	—	5,862	—	—	5,862
Net income (loss)	—	—	—	(37,517)	—	(37,517)
Foreign currency translation adjustment of the Joint Venture	—	—	—	—	226	226
Change in fair value of interest rate cap, net of taxes of the Joint Venture	—	—	—	—	(5,431)	(5,431)
Balance at June 30, 2019	75,474,654	$ 75	$1,159,371	$ (19,983)	$ (8,039)	$ 1,131,424
Issuance of Change Healthcare Inc. common stock upon initial public offering	49,285,713	49	608,630	—	—	608,679
Effect of initial public offering issuance costs on Joint Venture equity	—	—	(4,160)	—	—	(4,160)
Issuance of tangible equity units	—	—	232,929	—	—	232,929
Equity compensation expense	—	—	8,585	—	—	8,585
Issuance of Change Healthcare Inc. common stock upon exercise of equity awards	175,439	—	1,139	—	—	1,139
Net income (loss)	—	—	—	(93,935)	—	(93,935)
Unrealized gain (loss) on available for sale debt securities of the Joint Venture	—	—	—	—	1,173	1,173
Foreign currency translation adjustment of the Joint Venture	—	—	—	—	1,583	1,583
Change in fair value of interest rate cap, net of taxes of the Joint Venture	—	—	—	—	(1,310)	(1,310)
Balance at September 30, 2019	124,935,806	$ 124	$2,006,494	$(113,918)	$ (6,593)	$ 1,886,107

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Condensed Statements of Cash Flows
(unaudited and amounts in thousands)

	Six Months Ended September 30,	
	2019	2018
Cash flows from operating activities:		
Net income (loss)	$(131,451)	$(36,092)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:		
Loss from Equity Method Investment in the Joint Venture	95,732	48,337
Deferred income tax expense (benefit)	(15,806)	(11,584)
(Gain) loss on Sale of Interests in the Joint Venture	—	(661)
(Gain) loss on available for sale debt securities	2,435	—
Amortization of debt discount and issuance costs	212	—
Changes in operating assets and liabilities:		
Prepaid expenses	(2,315)	—
Due from the Joint Venture	(972)	(62)
Income taxes receivable	179	13,292
Accounts payable and accrued expenses	277	64
Due to McKesson	48,363	—
Due to the Joint Venture	3,346	(9,663)
Net cash provided by (used in) operating activities	—	3,631
Cash flows from investing activities:		
Proceeds from sale of interests in Joint Venture	—	4,782
Investment in debt and equity securities of the Joint Venture	(278,875)	—
Proceeds from investment in debt and equity securities of the Joint Venture	3,621	—
Investment in the Joint Venture	(609,818)	—
Net cash provided by (used in) investing activities	(885,072)	4,782
Cash flows from financing activities:		
Proceeds from initial public offering, net of issuance costs	608,679	—
Proceeds from issuance of equity component of tangible equity units, net of issuance costs	232,929	—
Proceeds from issuance of debt component of tangible equity units	47,367	—
Payment of loan costs	(1,421)	—
Repayment of senior amortizing notes	(3,621)	—
Proceeds from exercise of equity awards	1,139	—
Payments to acquire common stock	—	(4,782)
Net cash provided by (used in) financing activities	885,072	(4,782)
Net increase (decrease) in cash, cash equivalents and restricted cash	—	3,631
Cash, cash equivalents and restricted cash at beginning of period	3,409	—
Cash, cash equivalents and restricted cash at end of period	$ 3,409	$ 3,631

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

1. Nature of Business and Organization

Organization

Change Healthcare Inc. (the "Company"), a Delaware corporation, was formed on June 22, 2016 to hold an equity investment in Change Healthcare LLC (the "Joint Venture"), a joint venture between the Company and McKesson Corporation ("McKesson"). As of September 30, 2019, the Company and McKesson each owned approximately 41% and 59%, respectively, of the membership interest in the Joint Venture, subject to adjustment based on exercise of equity-based awards or other changes in the number of the Joint Venture's membership units outstanding.

The Transactions

In June 2016, the Company, the Joint Venture, Change Healthcare Holdings, LLC, Change Healthcare Intermediate Holdings, LLC, Change Healthcare Performance, Inc. ("Legacy CHC") and its stockholders—including affiliates of The Blackstone Group, Inc. (formerly known as the Blackstone Group L.P.) ("Blackstone") and Hellman & Friedman LLC entered into an Agreement of Contribution and Sale (the "Contribution Agreement") with McKesson (together with the Company, the "Members"). Under the terms of the Contribution Agreement, the parties agreed to form the Joint Venture, a joint venture that combined the majority of the McKesson Technology Solutions businesses, excluding McKesson's Enterprise Information Solutions business and RelayHealth Pharmacy Network (such contributed businesses, "Core MTS"), with substantially all of the assets and operations of Legacy CHC, but excluding Legacy CHC's pharmacy claims switching and prescription routing businesses (such excluded business, the "eRx Network" and the businesses contributed by Legacy CHC, together with Core MTS, the "Contributed Businesses"). The creation of the Joint Venture, including the contribution of the Contributed Businesses and related transactions, is collectively referred to as the "Transactions". The Transactions closed on March 1, 2017.

Amendment of Certificate of Incorporation

Effective June 26, 2019 and in contemplation of its initial public offering of common stock, the Company amended its certificate of incorporation to effect a 126.4 for 1 stock split for all previously issued shares of common stock, to increase the authorized number of common stock, and to authorize shares of preferred stock. Following this amendment, the authorized shares include 9,000,000,000 shares of common stock (par value $.001 per share), 1 share of Class X stock (par value $.001 per share), and 900,000,000 shares of preferred stock (par value $.001 per share). All issued or outstanding shares or related share-based payment arrangement disclosures included herein have been retrospectively adjusted for the stock split.

Initial Public Offering

Effective July 1, 2019, the Company completed its initial public offering of 49,285,713 shares of common stock and a concurrent offering of 5,750,000 of tangible equity units ("TEUs") for net proceeds of $608,679 and $278,875, respectively. The proceeds of the offering of common stock were subsequently contributed to the Joint Venture in exchange for 49,285,713 additional units of the Joint Venture, which together with the Company's existing holdings represents an approximately 41% interest in the Joint Venture. The proceeds of the offering of TEUs were used to acquire TEUs of the Joint Venture that substantially mirror the terms of the TEUs included in the offering. The Joint Venture, in turn, used the proceeds received from the Company to repay $805,000 of its indebtedness under the Term Loan Facility without penalty in July 2019. The Joint Venture repaid an additional $85,000 of its indebtedness under the Term Loan Facility without penalty during the three months ended September 30, 2019 for a total paydown of $890,000.

2. Basis of Presentation

Principles of Consolidation

The accompanying unaudited condensed financial statements have been prepared in accordance with United States generally accepted accounting principles ("GAAP") for interim financial information and with the instructions to Form 10-Q and Rule 10-01 of Regulation S-X of the Securities and Exchange Commission ("SEC") Guidelines, Rules and Regulations and, in the opinion of management, reflect all normal recurring adjustments necessary for a fair presentation of results for the unaudited interim periods presented. Certain information and footnote disclosures normally included in

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

annual financial statements prepared in accordance with GAAP have been condensed or omitted. The results of operations for the interim period are not necessarily indicative of the results to be obtained for the full fiscal year. All intercompany accounts and transactions have been eliminated in the unaudited condensed financial statements.

Accounting Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. The Company bases its estimates on historical experience, current business factors and various other assumptions that the Company believes are necessary to consider in order to form a basis for making judgments about the carrying values of assets and liabilities, the recorded amounts of expenses and disclosure of contingent assets and liabilities. The Company is subject to uncertainties such as the impact of future events, economic, environmental and political factors and changes in the Company's business environment; therefore, actual results could differ from these estimates. Accordingly, the accounting estimates used in the preparation of the Company's financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the Company's operating environment changes. Changes in estimates are made when circumstances warrant. Such changes in estimates and refinements in estimation methodologies are reflected in the reported results of operations; and if material, the effects of changes in estimates are disclosed in the notes to the financial statements. Estimates and assumptions by management affect: the carrying value of the Company's investments; the provision and benefit for income taxes and related deferred tax accounts; contingencies; and the value attributed to equity awards. Additionally, the Company's financial statements are impacted by estimates and assumptions made by management that affect the financial statements of the Joint Venture, including: the allowance for doubtful accounts; the fair value assigned to assets acquired and liabilities assumed in business combinations; tax receivable agreement obligations; the fair value of interest rate cap agreement obligations; measurement of the components of tangible equity units; contingent consideration; loss accruals; the carrying value of long-lived assets (including goodwill and intangible assets); the classification and measurement of assets held for sale; the amortization period of long-lived assets (excluding goodwill); the carrying value, capitalization and amortization of software development costs; the provision and benefit for income taxes and related deferred tax accounts; certain accrued expenses; revenue recognition; contingencies; and the value attributed to equity awards.

Tangible Equity Units

In connection with the initial public offering, the Company completed an offering of tangible equity units (TEUs). Each TEU comprises an amortizing note and purchase contract, both of which are freestanding instruments and separate units of account. The amortizing notes were issued at par and are classified as debt on the accompanying condensed consolidated balance sheet, with scheduled principal payments over the next twelve months reflected in current maturities of long-term debt. The purchase contracts are accounted for as prepaid forward contracts and classified as equity. The TEU proceeds and issuance costs were allocated to the amortizing notes and purchase contracts on a relative fair value basis. See Note 10 for further discussion.

Other Investments

The Company holds investments in tangible equity units issued by the Joint Venture with terms that substantially mirror the TEUs issued by the Company. Each TEU comprises an amortizing note and forward purchase contract, both of which are freestanding instruments and separate units of account. The Company accounts for its investment in each component at fair value. Unrealized gains and losses resulting from changes in the fair value of the investment in debt securities are included as a component of other comprehensive income. Unrealized gains and losses resulting from changes in the fair value of the investment in the equity purchase contracts are recorded in current period earnings, in accordance with ASU 2016-01. See Note 11 for further discussion.

Recently Adopted Accounting Pronouncements

In April 2019, the Company adopted Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU")No. 2018-07 on a modified retrospective basis, which expands the scope of Topic 718 to include share-based payment transactions for acquiring goods and services from nonemployees. Among other provisions, the measurement date for awards to nonemployees was changed from the earlier of the date at which a commitment for performance by the counterparty was reached or the date at which performance was complete under the previous guidance to the grant date under this update. Because the Company's equity-based compensation was previously subject to remeasurement at fair value each quarter under previous authoritative literature, the adoption of this update had no material direct effect on the Company's consolidated financial statements. As described in Note 7, however, the adoption of this update changed the relationship between the equity-based compensation and the accounting for the freestanding option (i.e. the Dividend receivable).

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In April 2019, the Joint Venture adopted Accounting Standards Codification ("ASC") 606,*Revenue from Contracts with Customers*, which replaces most prior general and industry specific revenue recognition guidance with a principles-based comprehensive revenue recognition framework on a modified retrospective basis. Under this revised framework, a company will recognize revenue to depict the transfer of promised goods and services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods and services. As the Company's operations consist principally of an investment in the Joint Venture, its financial statements reflect no revenue and, accordingly, the Company recognized no direct impact on its financial statements from the adoption of this update. However, upon adoption, the Joint Venture recognized a cumulative effect adjustment to its Members' deficit. As a result of the impact of the adoption of ASC 606 to the Joint Venture's Members' equity (deficit), the Company was required to recognize a proportionate amount of this cumulative effect adjustment to its April 1, 2019 retained earnings as well. The effect is disclosed within a separate caption of the accompanying condensed statement of stockholders' equity.

Accounting Pronouncements Not Yet Adopted

In June 2016, the FASB issued ASUNo. 2016-13, as amended by ASU No. 2018-19, which requires that a financial asset (or group of financial assets) measured at amortized cost be presented at the net amount expected to be collected based on relevant information about past events, including historical experience, current conditions and reasonable and supportable forecasts that affect the collectability of the reported amount. This update is scheduled to be effective for the Company beginning April 1, 2021, with early adoption permitted beginning April 1, 2019. The Company is currently assessing the potential effects this update may have on its condensed consolidated financial statements.

In August 2018, the FASB issued ASU2018-13, which modifies the disclosure requirements for fair value measurements. ASU2018-13 is effective for public companies for annual and interim periods beginning after December 15, 2019. Early adoption is permitted for either the entire standard or only the provisions that eliminate or modify requirements. The Company is currently assessing the potential effects this update may have on its financial statement disclosures.

3. Equity Method Investment in Change Healthcare LLC

Exchange of Equity Method Investments

In connection with the Transactions, the Company exchanged its 45.615% investment in Legacy CHC for 30% of the membership units of the Joint Venture. The Joint Venture used proceeds from the issuance of debt to acquire the remaining 54.385% of Legacy CHC. The Company accounted for this exchange of investments as a non-monetary transaction at their respective carrying values. Prior to the Transactions, the investors of Legacy CHC accounted for their investments at fair value. As a result, the book basis and fair value of the Company's investment in Legacy CHC were generally the same such that no gain was recognized as a result of the Transactions.

The fair value of the Joint Venture was determined at March 1, 2017 using a combination of the income and the market valuation approaches. Under the income approach, a discounted cash flow model ("DCF") was used in which cash flows anticipated over several periods, plus a terminal value at the end of that time horizon, are discounted to their present value using an appropriate expected rate of return. The discount rate used for cash flows reflects capital market conditions and the specific risks associated with the business. Under the market approach, valuation multiples of reasonably similar publicly traded companies or guideline companies are applied to the operating data of the subject business to derive the estimated fair value. These valuation approaches are considered a Level 3 fair value measurement. Fair value determination requires complex assumptions and judgment by management in projecting future operating results, selecting guideline companies for comparisons, determining appropriate market value multiples, selecting the discount rate to measure the risks inherent in the future cash flows and assessing the business's life cycle and the competitive trends impacting the business, including considering technical, legal, regulatory, or economic barriers to entry. Any material changes in key assumptions, including failure to meet business plans, deterioration in the financial market, an increase in interest rate or an increase in the cost of equity financing by market participants within the industry or other unanticipated events and circumstances, may affect such estimates.

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Additional Ownership Interest

Following the initial public offering, the Company contributed the proceeds of the offering of common stock to the Joint Venture in exchange for 49,285,713 additional units of the Joint Venture, which represented approximately 11% of additional ownership interest. Resulting from the additional ownership interest acquired, the Company measured additional basis differences at July 1, 2019 based on the fair value of the Joint Venture's assets and liabilities as of the date of the initial public offering, and using valuation approaches substantially similar to those used as of the date of the Transactions.

Equity Method Investment in Change Healthcare LLC

The Company accounts for its investment in the Joint Venture using the equity method of accounting. During the three and six months ended September 30, 2019 and 2018, the Company recorded a proportionate share of the earnings from this investment based on its ownership percentage during each respective period, which included transaction and integration related expenses incurred by the Joint Venture and the Company's portion of basis adjustments including amortization expenses associated with equity method intangible assets. These amounts are aggregated and recorded under the caption, "Loss from Equity Method Investment in the Joint Venture" in the accompanying condensed statements of operations.

Summarized financial information of the Joint Venture is as follows:

	Three Months Ended September 30,		Six Months Ended September 30,	
	2019	2018	2019	2018
Statement of Operations Data:				
Total revenue	$ 795,811	$ 800,190	$ 1,651,367	$ 1,623,453
Cost of operations (exclusive of depreciation and amortization)	$ 331,234	$ 327,563	$ 658,181	$ 664,993
Customer postage	$ 57,110	$ 62,404	$ 115,594	$ 127,962
Net income (loss)	$ (130)	$ 113,440	$ 71,785	$ 125,946

Subsequent to the Company's initial public offering of common stock, the Company now has a publicly available indication of the value of its investment in the Joint Venture. The fair value that was derived from trading prices of the Company's common stock at September 30, 2019 indicated a potential impairment to the carrying value of its investment in the Joint Venture. Accordingly, the Company evaluated its equity method investment for an other-than-temporary impairment ("OTTI"). The Company considered various factors in determining whether an OTTI has occurred, including the Company's ability and intent to hold the investment, the trading history available, the implied EBITDA valuation multiples compared to public guideline companies, the Joint Venture's ability to achieve milestones and any notable operational and strategic changes by the Joint Venture. After the evaluation, the Company determined that an OTTI had not occurred as of September 30, 2019 nor as of the date of this quarterly report on Form 10-Q. However, the Company may experience declines in the fair value of its investment in the Joint Venture, and it may determine an impairment loss will be required to be recognized in a future reporting period. Such determination will be based on the prevailing facts and circumstances, including those related to the reported results and disclosures of the Joint Venture as well as from changes in the market price of the Company's common stock.

In the event the Company obtains a controlling interest in the Joint Venture, the Company will evaluate its investment under the guidance in ASC 805 for a business combination achieved in stages. Upon such a change in control, the Company will remeasure its investment in the Joint Venture to fair value as of the date that control is obtained and will recognize a gain or loss in its statement of operations for the difference between the carrying value and fair value of its investment.

4. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

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5. Net Income (Loss) Per Share

The following table sets forth the computation of basic net income (loss) per share of common stock for the periods indicated:

	Three Months Ended September 30,		Six Months Ended September 30,	
	2019	2018	2019	2018
Basic net income (loss) per share:				
Numerator:				
Net income (loss)	$ (93,935)	$ (18,591)	$ (131,451)	$ (36,092)
Denominator:				
Weighted average common shares outstanding	123,794,511	75,506,552	99,897,191	75,555,700
Minimum shares issuable under purchase contracts	18,429,325	—	9,214,662	—
	142,223,836	75,506,552	109,111,853	75,555,700
Basic net income (loss) per share	$ (0.66)	$ (0.25)	$ (1.20)	$ (0.48)

The calculation of diluted net income (loss) per share has not been presented due to the presence of a net loss for each period.

Due to their antidilutive effect, the following securities have been excluded from diluted net income (loss) per share for the periods indicated:

	Three Months Ended September 30,		Six Months Ended September 30,	
	2019	2018	2019	2018
Incremental shares issuable under purchase contracts	3,685,750	—	1,842,875	—
Time-Vesting Options	1,156,510	1,832,196	1,405,556	1,839,878
Restricted Stock Units	908,745	—	454,373	—

6. Income Taxes

The income tax benefit for the three months ended September 30, 2019 and 2018 was $13,620 and $6,783, respectively, which represents an effective tax rate of 12.7% and 26.7%, respectively. The income tax benefit for the six months ended September 30, 2019 and 2018 was $15,804 and $11,584, respectively, which represents an effective tax rate of 10.7% and 24.3%, respectively.

Fluctuations in our reported income tax rates from the statutory rate are primarily due to benefits recognized as a result of certain incentive tax credits resulting from research and experimental expenditures and discrete items recognized in the quarters.

McKesson Tax Receivable Agreement

In connection with the closing of the Transactions, the Joint Venture, subsidiaries of McKesson that serve as members of the Joint Venture (the "McK Members"), McKesson and the Company entered into a tax receivable agreement (the "McKesson Tax Receivable Agreement"). The McKesson Tax Receivable Agreement generally provides for the payment by the Joint Venture to the McK Members and it assigns 85% of the net cash tax savings realized (or, in certain circumstances, deemed to be realized) by the Company in periods ending on or after the date on which McKesson ceases to own at least 20% of the outstanding units of the Joint Venture (the "LLC Units") as a result of (i) certain amortizable tax basis in assets transferred to the Joint Venture at the closing of the Transactions and (ii) imputed interest deductions and certain other tax attributes arising from payments under the McKesson Tax Receivable Agreement. Additionally, upon the occurrence of the first exchange of LLC Units by McKesson (or its permitted

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transferees), if any, the Company has agreed to enter into an additional tax receivable agreement with the McK Members, pursuant to which the Company would be required to pay to the relevant McK Member 85% of the net cash tax savings, if any, arising from the Company's utilization of (i) certain tax basis increases resulting from the relevant exchange and payments under such additional tax receivable agreement and (ii) imputed interest deductions. The Company may also be required to enter into and make payments under an additional tax receivable agreement with McKesson in certain circumstances.

Because payments under the McKesson Tax Receivable Agreement are contingent upon McKesson's ceasing to own at least 20% of the Joint Venture and such an event was not probable at the inception of the McKesson Tax Receivable Agreement or as of September 30, 2019, no related obligation has been reflected on the accompanying condensed balance sheet.

Letter Agreement

The Company, the Joint Venture, McKesson and certain of McKesson's affiliates have entered into a letter agreement relating to the Contribution Agreement (the "Letter Agreement"). The Letter Agreement addresses miscellaneous tax-related matters, including (i) technical clarifications and modifications to the manner in which the Joint Venture allocates certain items of taxable income, loss and deduction among, and calculates and makes required tax distributions to, its members, (ii) the sharing of certain contingent tax benefits and expenses not addressed by the McKesson Tax Receivable Agreement or the tax matters agreement that the Company will enter into with McKesson in connection with a spin-off or split-off transaction (or a combination of the foregoing) that McKesson may, at its election, initiate and complete that would result, among other things, in the acquisition by the Company of all of McKesson's LLC Units and the issuance by the Company to McKesson and/or McKesson's securityholders of an equal number of shares of its common stock and (iii) procedures applicable in the case of certain tax proceedings. In particular, pursuant to the terms of the Letter Agreement, McKesson may adjust the manner in which depreciation or amortization deductions in respect of assets transferred to the Joint Venture at the closing of the Transactions are allocated among the Company, McKesson and certain of McKesson's affiliates beyond minimum amounts provided in the LLC Agreement. If an amount of deductions is allocated to the Company in excess of a specified minimum threshold, the Company will be required to make cash payments to McKesson equal to 100% of the tax savings of the Company attributable to such excess deductions for any tax period ending prior to the date on which McKesson ceases to own at least 20% of the outstanding LLC Units of the Joint Venture, after which the terms of the McKesson Tax Receivable Agreement will control. At September 30, 2019, the Company has recorded a liability to McKesson equal to $48,363, which reflects the amount payable for future tax savings the Company anticipates receiving as a result of deductions that are probable to be allocated by McKesson to the Company for the year ended March 31, 2019 and is reflected as Due to McKesson on the consolidated balance sheet.

7. Fair Value Measurements

The Company's assets and liabilities that are measured at fair value on a recurring basis consist of the Company's Dividend Receivable and Other Investments. The debt component of the tangible equity units issued by the Company is a Level 2 liability measured at fair value on a nonrecurring basis based on available market data and a discounted cash flow analysis (see Note 10). The tables below summarize the Dividend Receivable and Other Investments as of September 30, 2019 and March 31, 2019, aggregated by the level in the fair value hierarchy within which those measurements fall.

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Description	Balance at September 30, 2019	Quoted in Markets Identical (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Other Investments (see Note 11)	$ 274,391	$ —	$ 274,391	$ —
Dividend Receivable	34,547	—	—	34,547
Total	$ 308,938	$ —	$ 274,391	$ 34,547

Description	Balance at March 31, 2019	Quoted in Markets Identical (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Other Investments (see Note 11)	$ —	$ —	$ —	$ —
Dividend Receivable	81,264	—	—	81,264
Total	$ 81,264	$ —	$ —	$ 81,264

The Company is entitled to receive an additional unit of the Joint Venture for each share of stock issued by the Company. In the case of equity-based awards, the requirement to receive an additional unit of the Joint Venture upon exercise of such awards represents a freestanding derivative. Because the fair value measurement of this derivative involves significant unobservable inputs, the most significant of which is the use of a levered volatility calculation of a peer group of companies, the Company has determined that it represents a Level 3 fair value measurement.

Because the freestanding derivative is directly related to the Company's equity-based compensation awards, the valuation of the derivative is determined to be consistent with the valuation of the underlying equity-based awards (although we use a current period measurement date). As with the equity-based awards, changes in the value of the derivative are generally expected to fluctuate with changes in the value of the Company's common stock.

The following table summarizes the fair value of the freestanding derivative at September 30, 2019 and March 31, 2019, respectively:

		Fair Values of Derivative Financial Instruments Asset (Liability)	
Derivative financial instruments not designated as hedging instruments:	Balance Sheet Location	September 30, 2019	March 31, 2019
Freestanding Option	Dividend receivable	$ 34,547	$ 81,264

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The following table presents a reconciliation of the fair value of the derivative for which the Company uses significant unobservable inputs:

	Three Months Ended September 30,		Six Months Ended September 30,	
	2019	2018	2019	2018
Balance at beginning of period	$ 48,807	$64,338	$ 81,264	$59,116
Increase in fair value based on ASC 505 equity-based compensation	—	2,969	—	8,269
Settlements due to exercise of awards	(1,324)	(666)	(1,324)	(744)
Change in fair value of equity-based awards	(12,936)	—	(45,393)	—
Balance at end of period	$ 34,547	$66,641	$ 34,547	$66,641

Other Investments

The Company invested in a unit purchase contract and a debt instrument of the Joint Venture on terms that substantially mirror the economics of the TEUs (see Note 10). At September 30, 2019 and March 31, 2019, the Company's investment in the Joint Venture's debt securities were classified as "available-for-sale" and its investment in the Joint Venture's purchase contracts were accounted for as equity securities measured at fair value. Changes in unrealized gains and losses for the Company's investment in the Joint Venture's debt securities are recognized as adjustments to other comprehensive income (loss) while changes in unrealized gains and losses for the Company's investment in the Joint Venture's purchase contracts are recognized as adjustments to pretax income (loss). The fair value measurement of the investments is based on available market data and a discounted cash flow analysis of the Joint Venture's debt and equity securities for which the Company is investing.

Dividend Receivable

As the dividend receivable was initially received in connection with the contribution of assets to the Joint Venture, the initial fair value was treated as a component of the Company's contribution of assets and receipt of its Investment in the Joint Venture. During the three and six months ended September 30, 2019 and 2018, the Company recognized a decrease in the Dividend Receivable which was recorded as a component of Loss from Equity Method Investment in the Joint Venture. The result was that no net equity-based compensation related to employees of the Joint Venture was recognized in the financial statements of the Company for the three and six months ended September 30, 2019 and 2018.

Following the adoption of FASB ASUNo. 2018-07, however, the measurement of equity-based compensation generally becomes fixed at the date of grant such that the fair value of the dividend receivable is no longer correlated with the amount of equity compensation recognized. As a result, following the adoption of FASB ASU No. 2018-07, the Loss from Equity Method Investment in the Joint Venture is subject to variability associated with changes in the fair value of the equity-based awards.

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8. Accumulated Other Comprehensive Income (Loss)

The following is a summary of the Company's proportionate share of the Joint Venture's accumulated other comprehensive income (loss) balances, net of taxes, as of and for the three and six months ended September 30, 2019 and 2018.

	Available For Sale Debt Security	Foreign Currency Translation Adjustment	Cash Flow Hedge	Accumulated Other Comprehensive Income (Loss)
Balance at March 31, 2018	$ —	$ 1,268	$ 1,268	$ 2,536
Cumulative effect of accounting change of the Joint Venture-ASU 2017-12	—	—	490	490
Change associated with foreign currency translation	—	(2,593)	—	(2,593)
Change associated with current period hedging	—	—	1,206	1,206
Reclassification into earnings	—	—	(424)	(424)
Balance at June 30, 2018	$ —	$ (1,325)	$ 2,540	$ 1,215
Change associated with foreign currency translation	—	566	—	566
Change associated with current period hedging	—	—	1,866	1,866
Reclassification into earnings	—	—	(388)	(388)
Balance at September 30, 2018	$ —	$ (759)	$ 4,018	$ 3,259
Balance at March 31, 2019	$ —	$ (1,565)	$ (1,691)	$ (3,256)
Cumulative effect of accounting change of the Joint Venture-ASU 2018-02	—	—	422	422
Change associated with foreign currency translation	—	226	—	226
Change associated with current period hedging	—	—	(5,117)	(5,117)
Reclassification into earnings	—	—	(314)	(314)
Balance at June 30, 2019	$ —	$ (1,339)	$ (6,700)	$ (8,039)
Unrealized gain (loss) on available for sale debt securities of the Joint Venture	1,173	—	—	1,173
Change associated with foreign currency translation	—	1,583	—	1,583
Change associated with current period hedging	—	—	(1,509)	(1,509)
Reclassification into earnings	—	—	199	199
Balance at September 30, 2019	$ 1,173	$ 244	$ (8,010)	$ (6,593)

Effective April 1, 2018, the Joint Venture adopted FASB ASUNo. 2017-12, which significantly changed the framework by which hedge accounting is recognized, presented and disclosed in the Joint Venture's financial statements. The adoption of this update by the Joint Venture resulted in a reclassification between its accumulated other comprehensive income (loss) and accumulated earnings (deficit).

Effective April 1, 2019, the Joint Venture adopted FASB ASUNo. 2018-02, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017. The adoption of this update resulted in a reclassification between accumulative other comprehensive income (loss) and accumulated earnings (deficit).

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As an investor in the Joint Venture, the Company has recognized its proportionate amount of these reclassifications as presented in the table above.

9. Equity Based Compensation

Effective as of the Company's initial public offering, the Company adopted the Change Healthcare Inc. 2019 Omnibus Incentive Plan (the "Omnibus Incentive Plan") pursuant to which 25.0 million shares of the Company's common stock have been reserved for issuance to employees, directors and consultants of the Company, the Joint Venture and its affiliates.

In connection with the Omnibus Incentive Plan, the Company, during the three and six months ended September 30, 2019, granted to the Joint Venture's employees and directors one or a combination of time-vesting restricted stock units (RSUs), time-vesting deferred stock units, performance stock units, and cash settled restricted stock units under vesting terms that generally vary from one to four years from the date of grant. Each of these instruments is described below.

Restricted Stock Units ("RSUs")—The Company granted 4,436,758 RSUs during the three and six months ended September 30, 2019. The RSUs are subject to either a graded vesting schedule over four years, or a one or four year cliff vesting schedule, depending on the terms of the specific award. Upon vesting, the RSUs are exchanged for shares of the Company's common stock.

Performance Stock Units ("PSUs")— The Company granted 1,079,621 PSUs during the three and six months ended September 30, 2019.The PSUs consist of two tranches, one for which the quantity of awards expected to vest varies based on the Joint Venture's compound annual revenue growth rate over a three year period in comparison to a target percentage and one for which the quantity of awards expected to vest varies based on the Joint Venture's compound annual Adjusted EBITDA growth rate over a three year period in comparison to a target percentage. The awards earned upon satisfaction of the performance conditions become vested on the fourth anniversary of the vesting commencement date of the award (i.e. continued service is required beyond the satisfaction of the performance condition prior to vesting). The Joint Venture recognizes compensation expense for the PSUs based on the number of awards that are considered probable to vest. Recognition of expense is based on the probability of achievement of performance targets and is periodically reevaluated.

Cash Settled Restricted Stock Units ("CSRSUs")— The Company granted 597,006 CSRSUs during the three and six months ended September 30, 2019.The CSRSUs are expected to vest ratably over three years. Upon vesting, however, the Company is required to pay cash in settlement of such CSRSUs based on their fair value at the date such CSRSUs vest.

Deferred Stock Units ("DSUs")—The Company granted 45,704 DSUs during the three and six months ended September 30, 2019. The DSUs vest 100% upon the one-year anniversary of the date of grant. Unlike the RSUs, however, the DSUs are exchanged for shares of the Company's common stock only following the participant's separation from service.

During the three and six months ended September 30, 2019, the Joint Venture recognized compensation expense of $6,096 related to awards granted under the Omnibus Incentive Plan. At September 30, 2019, aggregate unrecognized compensation expense of the Joint Venture related to the awards granted under the Omnibus Incentive Plan was $87,211.

10. Tangible Equity Units

In July 2019, the Company completed its offering of 5,750,000 TEUs. Total proceeds, net of underwriting discounts, were $278,875. Each TEU, which has a stated amount of $50, is comprised of a stock purchase contract and a senior amortizing note due June 30, 2022. The Company allocated the proceeds from the issuance of the TEUs to equity and debt based on the relative fair values of the respective components of each TEU. The value allocated to the stock purchase contracts is reflected net of issuance costs in additional paid in capital. The value allocated to the senior amortizing notes is reflected in debt on the accompanying balance sheet, with payments expected in the next twelve months reflected in current maturities of long-term debt. Issuance costs, reflected as a reduction of the face amount of the amortizing notes, are being accreted to the face amount of the debt under the effective interest method.

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The aggregate values assigned upon issuance of the TEUs, based on the relative fair value of the respective components of each TEU, were as follows:

	Equity Component	Debt Component	Total
Price per TEU	$ 41.7622	$ 8.2378	$ 50.00
Gross proceeds	240,133	47,367	287,500
Issuance costs	(7,204)	(1,421)	(8,625)
Net proceeds	$ 232,929	$ 45,946	$278,875

Each senior amortizing note has an initial principal amount of $8.2378 and bears interest at 5.5% per year. On each March 30, June 30, September 30 and December 30, the Company pays equal quarterly cash installments of $0.7500 per amortizing note (except for the September 30, 2019 installment payment, which was $0.7417 per amortizing note). Each installment constitutes a payment of interest and partial payment of principal. The carrying value and fair value of the senior amortizing notes as of September 30, 2019 was $42,537 and $43,896, respectively. Unless settled earlier, each purchase contract will automatically settle on June 30, 2022. The Company will deliver between a minimum of 18,429,325 shares and a maximum of 22,115,075 shares of the Company's common stock, subject to adjustment, based on the Applicable Market Value (as defined below) of the Company's common stock as described below:

- If the Applicable Market Value is greater than $15.60 per share, holders will receive 3.2051 shares of common stock per purchase contract.
- If the Applicable Market Value is less than or equal to $15.60 per share but greater than or equal to $13.00 per share, the holder will receive a number of shares of the Company's common stock per purchase contract equal to $50, divided by the Applicable Market Value; and
- If the Applicable Market Value is less than $13.00 per share, the holder will receive 3.8461 shares of common stock per purchase contract.

The Applicable Market Value is defined as the arithmetic average of the volume weighted average price per share of the Company's common stock over the twenty consecutive trading day period immediately preceding the balance sheet date, or June 30, 2022, for settlement of the stock purchase contracts.

The TEUs have a dilutive effect on the Company's net income (loss) per share. The 18,429,325 minimum shares to be issued are included in the calculation of basic net income (loss) per share. The difference between the minimum shares and the maximum shares are potentially dilutive securities, and accordingly, are included in the Company's diluted net income (loss) per share on a pro rata basis to the extent the Applicable Market Value is higher than $13.00 but is less than $15.60 at period end.

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(unaudited and amounts in thousands, except share and per share amounts)

11. Other Investments

The proceeds of the offering of TEUs were used to acquire TEUs of the Joint Venture that substantially mirror the terms of the TEUs included in the offering. Under these mirrored arrangements, the Joint Venture is required to make cash payments or to transfer LLC Units to the Company concurrent with any cash payments or issuance of shares by the Company pursuant to the terms of its TEUs. The Company accounts for these mirror arrangements as investments in debt and equity securities.

At September 30, 2019 and March 31, 2019, the Company's investment in debt securities are classified as"available-for-sale" and its investment in forward purchase contracts are considered equity securities measured at fair value. Changes in unrealized gains and losses for the Company's debt securities are recognized as adjustments to other comprehensive income (loss) while changes in unrealized gains and losses for the Company's investment in forward purchase contracts are recognized as adjustments to pretax income (loss).

A summary of the Company's other investments at September 30, 2019 and March 31, 2019 is summarized in the tables that follow.

	September 30, 2019			
		Unrealized Amounts		
	Amortized Costs	Gains	Losses	Fair Value
Debt Securities (Level 2)	$ 42,326	$ 1,571	$ —	$ 43,897
Forward Purchase Contracts (Level 2)	$232,929	$ —	$ (2,435)	230,494
				$274,391
Amounts classified within current assets				15,154
Amounts classified within Other investments				$259,237

	March 31, 2019			
		Unrealized Amounts		
	Amortized Costs	Gains	Losses	Fair Value
Debt Securities	$ —	$ —	$ —	$ —
Forward Purchase Contracts	$ —	$ —	$ —	—
				—
Amounts classified within current assets				—
Amounts classified within Other investments				$ —

Scheduled maturities of investments in debt securities at September 30, 2019 were as follows:

	Amortized Cost	Fair Value
Due in one year or less	$ 15,154	$ 15,154
Due after one year through five years	27,172	28,742
Due after five years through ten years	—	—
Due after ten years	—	—
	$ 42,326	$ 43,896

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

The portion of unrealized gains and losses for each period related to equity securities still held at each reporting date is calculated as follows:

	Three Months Ended September 30,		Six Months Ended September 30,	
	2019	2018	2019	2018
Net gains and losses recognized during the period on equity securities	$ (2,435)	$ —	$(2,435)	$ —
Less: Net gains and losses recognized during the period on equity securities sold during the period	—	—	—	—
Unrealized gains and losses recognized during the reporting period on equity securities still held at the reporting date	$ (2,435)	$ —	$(2,435)	$ —

12. Subsequent Events

Agreement to Sell Office Property

In October 2019, the Joint Venture executed an agreement for the sale of its Alpharetta, GA office property for gross proceeds of approximately $31,500. The sale is expected to be completed during the third quarter of the Joint Venture's fiscal year. While the Joint Venture expects to recognize a gain of an immaterial amount as a result of this transaction, the Company expects, as a result of the write-off of basis differences associated with this office property, to recognize a loss within its Loss from equity method investment in the Joint Venture of approximately $14,000.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion and analysis of the financial condition and results of operations of Change Healthcare Inc. and Change Healthcare LLC is provided as a supplement to, and should be read in conjunction with, Change Healthcare Inc.'s and Change Healthcare LLC's audited financial statements and the accompanying notes as well as the "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Change Healthcare Inc.'s Registration Statement on Form S-1 (File No. 333-230345), as well as the unaudited consolidated financial statements and the related notes presented in Part I, Item 1 of this Quarterly Report for the quarter ended September 30, 2019 ("Quarterly Report").

In addition to historical data, this discussion contains forward-looking statements about the business, operations and financial performance of Change Healthcare Inc. and Change Healthcare LLC based on current expectations that involve risks, uncertainties and assumptions. Actual results may differ materially from those discussed in the forward-looking statements as a result of various factors, including but not limited to those discussed below in "Cautionary Notice Regarding Forward-Looking Statements," and Part II, Item 1A, "Risk Factors."

References in this discussion and analysis to "Change Healthcare Inc." refer to Change Healthcare Inc. and not to any of its subsidiaries. References in this discussion and analysis to the Joint Venture refer to Change Healthcare LLC and its direct and indirect subsidiaries.

Recent Developments

Effective June 26, 2019, Change Healthcare Inc.'s Registration Statement on FormS-1 for the initial public offering of 49.3 million shares of common stock and the concurrent offering of 5.75 million tangible equity units ("TEUs") was declared effective by the Securities and Exchange Commission ("SEC") and Change Healthcare Inc. subsequently amended its charter to authorize 9 billion shares of common stock and effected a 126.4 for 1 split of its common stock. Change Healthcare Inc.'s common stock and TEUs began trading the next day on the NASDAQ under the CHNG and CHNGU ticker symbols, respectively.

The offerings of common stock and TEUs were consummated on July 1, 2019 and resulted in Change Healthcare Inc. receiving net proceeds of $608.7 million and $278.9 million respectively, before consideration of offering costs paid subsequent to the offering from available cash. The proceeds of the offering of common stock were subsequently contributed to the Joint Venture in exchange for 49.3 million additional units of the Joint Venture, thereby resulting in an additional ownership in the Joint Venture of approximately 11%. The proceeds of the offering of TEUs were used to acquire TEUs of the Joint Venture that substantially mirror the terms of the TEUs issued by Change Healthcare Inc. in the offering. The Joint Venture, in turn, used the proceeds received from Change Healthcare Inc. to repay $805.0 million of its indebtedness under the Term Loan Facility (as defined herein) without penalty in July 2019.

In July 2019, the Joint Venture amended its Revolving Credit Facility (as defined herein), the primary effects of which were to increase the maximum amount that can be borrowed from $500.0 million to $785.0 million and to extend the maturity date until March 1, 2024. In the event that the outstanding balance under the Term Loan Facility exceeds $1.1 billion on December 1, 2023, however, amounts due, if any, under the Revolving Facility become due and payable on December 1, 2023.

Change Healthcare Inc.

Overview

Change Healthcare Inc. (formerly HCIT Holdings, Inc.), a Delaware corporation, was formed on June 22, 2016 to hold an equity investment in Change Healthcare LLC, a joint venture between Change Healthcare Inc. and McKesson Corporation ("McKesson"), which we refer to as the Joint Venture. Each of Change Healthcare Inc. and McKesson holds a 50% voting interest in the Joint Venture, with equal representation on the Joint Venture's board of directors and with all major operating, investing and financial activities requiring the consent of both members. As a result, Change Healthcare Inc. accounts for this investment using the equity method of accounting.

Change Healthcare Inc. has no substantive assets apart from its investment in the Joint Venture. As a result, Change Healthcare Inc. believes the financial statements of the Joint Venture are more relevant to an investor than Change Healthcare Inc.'s financial statements as they include greater detail regarding the financial condition and results of operations of the business.

Key Components of Change Healthcare Inc.'s Results of Operations

Loss from Equity Method Investment in the Joint Venture

Loss from equity method investment in the Joint Venture generally represents Change Healthcare Inc.'s proportionate share of the income or loss from this investment, including basis adjustments related to amortization expense associated with equity method intangible assets, property and equipment, deferred revenue and other items.

Loss from equity method investment in the Joint Venture was $56.2 million and $25.6 million for the three months ended September 30, 2019 and 2018, respectively. The loss from equity method investment in the Joint Venture increased as a result of incremental basis difference amortization due to the additional units of the Joint Venture that were acquired using the proceeds of the initial public offering, combined with lower operating profits at the Joint Venture in the current quarter when compared to the same quarter in the prior year, primarily due to the gain recognized from the sale of the Joint Venture's extended care business during the three months ended September 30, 2018.

Loss from equity method investment in the Joint Venture was $95.7 million and $48.3 million for the six months ended September 30, 2019 and 2018, respectively. The loss from equity method investment in the Joint Venture for the six months ended September 30, 2019 was discretely affected by the Joint Venture's adoption of Financial Accounting Standards Board ("FASB") Accounting Standards Codification No. 606 ("ASC 606") and Change Healthcare Inc.'s adoption of FASB Accounting Standards Update No. 2018-07 ("ASU 2018-07"). The loss from equity method investment in the Joint Venture was decreased by approximately $17.0 million as a result of the continuing effect of the adoption of ASC 606 and was increased by approximately $45.4 million as a result of changes in the fair value of its dividend receivable following the adoption of ASU 2018-07.

General and Administrative Expense and Management Fees

In addition to its income (loss) from its equity method investment in the Joint Venture, Change Healthcare Inc. may also periodically incur certain other operating expenses, including professional service fees, general liability insurance, and other fees associated with being an SEC registrant.

To the extent any such fees Change Healthcare Inc. incurs are required to facilitate or maintain its status as a public company, however, the limited liability company agreement of the Joint Venture (the "LLC Agreement") contemplates that Change Healthcare Inc. be reimbursed for such costs by the Joint Venture. Such reimbursements are classified as management fees within Change Healthcare Inc.'s statements of operations.

Gain (Loss) on Sale of Interests in the Joint Venture

Under the terms of the LLC Agreement, Change Healthcare Inc. and the Joint Venture agreed to cooperate to ensure a 1:1 ratio of outstanding shares of common stock of Change Healthcare Inc. to the units of the Joint Venture ("LLC Units") held by Change Healthcare Inc. as long as the subsidiaries of McKesson that serve as members of the Joint Venture (the "McK Members") hold LLC Units. This provision requires that Change Healthcare Inc. be issued an additional LLC Unit for each share of common stock that Change Healthcare Inc. issues. Similarly, for any share that Change Healthcare Inc. repurchases, the Joint Venture is likewise required to repurchase a respective LLC Unit from Change Healthcare Inc. In this latter case, the repurchase by the Joint Venture of LLC Unit(s) from Change Healthcare Inc. results in a gain or loss to Change Healthcare Inc. equal to the difference in the fair value of such LLC Units and the proportionate carrying value of Change Healthcare Inc.'s investment in the Joint Venture associated with such repurchased LLC Units.

Income Taxes

As the Joint Venture is treated as a partnership for income tax purposes, Change Healthcare Inc. is subject to income taxes for its allocable portion of the Joint Venture's taxable income. The income tax benefit was $13.6 million and $6.8 million (which resulted in effective income tax rates of 12.7% and 26.7%) for the three months ended September 30, 2019 and 2018, respectively. The income tax benefit was $15.8 million and $11.6 million (which resulted in effective income tax rates of 10.7% and 24.3%) for the six months ended September 30, 2019 and 2018, respectively.

In connection with the closing of the Transactions, the Joint Venture, subsidiaries of McKesson that serve as members of the Joint Venture (the "McK Members"), McKesson and the Company entered into a tax receivable agreement (the "McKesson Tax Receivable Agreement"). Additionally, the Company, the Joint Venture, McKesson and certain of McKesson's affiliates have entered into a letter agreement relating to the Contribution Agreement (the "Letter Agreement"). The McKesson Tax Receivable Agreement and the Letter Agreement contemplate payments from the Company to the McK Members or to McKesson based upon certain criteria

as outlined in Note 6, *Income Taxes.* In the three months ended September 30, 2019 the Company has recorded a liability to McKesson equal to $48.4 million, which reflects the amount payable for future tax savings the Company anticipates receiving as a result of deductions that are probable to be allocated by McKesson to the Company for the year ended March 31, 2019.

Liquidity and Capital Resources

Overview

Change Healthcare Inc.'s principal source of liquidity consists of distributions or advances from the Joint Venture. To the extent that Change Healthcare Inc. requires additional funds, Change Healthcare Inc. may need to raise funds through subsequent debt or equity financing.

Change Healthcare Inc. has not incurred, nor does it expect to incur, significant capital expenditures in the normal course of business or to pursue acquisition opportunities other than through the Joint Venture.

Off-Balance Sheet Arrangements

As of September 30, 2019, Change Healthcare Inc. had no off-balance sheet arrangements.

Recent Accounting Pronouncements

See Note 2, *Basis of Presentation*, within Change Healthcare Inc.'s financial statements appearing elsewhere in this Quarterly Report for information about recent accounting pronouncements and the potential impact on Change Healthcare Inc.'s financial statements.

Critical Accounting Estimates

The preparation of financial statements in accordance with United States generally accepted accounting principles ("GAAP") requires Change Healthcare Inc. to make estimates and assumptions that affect reported amounts and related disclosures. Change Healthcare Inc. considers an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on Change Healthcare Inc.'s results of operations and financial condition.

As disclosed in Note 2, *Summary of Significant Accounting Policies,* in Change Healthcare Inc.'s Registration Statement on Form S-1 (333-230345), Change Healthcare Inc. evaluates its equity method investment for impairment review whenever an event or change in circumstances occurs that may have a significant adverse impact on the carrying value of the investment. If a loss in value occurs that is deemed to be other than temporary, an impairment loss would be recognized.

Subsequent to the IPO, Change Healthcare Inc. now has a publicly available indication of the value of its investment in the Joint Venture. Accordingly, Change Healthcare Inc. evaluated its equity method investment for an other-than-temporary impairment ("OTTI"). Change Healthcare Inc. considered various factors in determining whether an OTTI had occurred, including Change Healthcare Inc.'s ability and intent to hold the investment, the trading history available, the implied EBITDA valuation multiples compared to public guideline companies, and the Joint Venture's ability to achieve milestones and any operational and strategic changes by the Joint Venture that might have negatively impacted the fair value. After the evaluation, Change Healthcare Inc. determined that an OTTI had not occurred as of September 30, 2019 or as of the date of this quarterly report on Form 10-Q. However, the Joint Venture may experience declines in its fair value, and Change Healthcare Inc. may determine an impairment loss will be required to be recognized in a future reporting period. Such determination will be based on the prevailing facts and circumstances, including those related to the reported results and disclosures of the Joint Venture, as well as from changes in the market price of Change Healthcare Inc.'s common stock.

Change Healthcare Inc.'s investments in the debt and equity securities of the Joint Venture are reported at fair value. The measurement of these investments is impacted by changes in market interest rates, as well as factors that impact the underlying value of the Joint Venture's equity. See Note 11 for further discussion.

Change Healthcare Inc. believes the current assumptions and other considerations used to estimate amounts reflected in Change Healthcare Inc.'s financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in Change Healthcare Inc.'s financial statements, the resulting changes could have a material adverse effect on Change Healthcare Inc.'s results of operations and financial condition.

See Note 2, *Summary of Significant Accounting Policies*, within Change Healthcare Inc.'s financial statements appearing in the Registration Statement on Form S-1 (333-230345) for information about Change Healthcare Inc.'s other critical accounting policies.

Quantitative and Qualitative Disclosure of Market Risk

As Change Healthcare Inc. has no substantive assets or operations apart from its investment in the Joint Venture, Change Healthcare Inc. does not believe that it has significant market risk.

Summary Disclosures about Contractual Obligations and Commercial Commitments

During the three months ended September 30, 2019, Change Healthcare Inc. issued TEUs comprised of a stock purchase contract and a senior amortizing note due June 30, 2022. See Note 10, *Tangible Equity Units.* Change Healthcare Inc. has no other ongoing contractual obligations or commercial commitments as of September 30, 2019.

Change Healthcare LLC

Overview

The Joint Venture is a leading independent healthcare technology company, formed through the combination of substantially all of the businesses of Change Healthcare Performance, Inc. (formerly Change Healthcare, Inc.) ("Legacy CHC") and a majority of the McKesson Technology Solutions business ("Core MTS"), which was completed on March 1, 2017. The Joint Venture offers a comprehensive suite of software, analytics, technology enabled services and network solutions that drive improved results in the complex workflows of healthcare system payers and providers. The Joint Venture's solutions are designed to improve clinical decision making, simplify billing, collection and payment processes and enable a better patient experience.

The Joint Venture offers comprehensive end-to-end solutions with modular capabilities to address its customers' needs. Working with its customers to analyze workflows before, during and after care has been delivered to patients, the Joint Venture designs and commercializes innovative solutions for various points in the healthcare delivery timeline. The Joint Venture's offerings range from discrete data and analytics solutions to broad enterprise-wide solutions, which include workflow software and technology-enabled services that help its customers achieve their operational objectives.

The Joint Venture's Intelligent Healthcare Network was created to facilitate the transfer of data among participants and is one of the largest clinical and financial healthcare networks in the United States. In the fiscal year ended March 31, 2018, Change Healthcare facilitated nearly 14 billion healthcare transactions and approximately $1 trillion in adjudicated claims or approximately one-third of all U.S. healthcare expenditures. The Joint Venture serves the vast majority of U.S. payers and providers. The Joint Venture's customer base includes approximately 2,200 government and commercial payer connections, 900,000 physicians, 118,000 dentists, 33,000 pharmacies, 5,500 hospitals and 600 laboratories. This network transacts clinical records for over 112 million unique patients, more than one-third of the estimated total U.S. population. With insights gained from its pervasive network, extensive applications and analytics portfolio and its services operations, the Joint Venture has designed analytics solutions that include industry-leading and trusted franchises supported by extensive intellectual property and regularly updated content.

In addition to the advantages of scale, the Joint Venture believes it offers the collaborative benefits of a mission-critical partner. The Joint Venture seeks enduring relationships with each customer through solutions embedded in their complex daily workflows that deliver measurable results. The Joint Venture's customer retention rate for its top 50 provider and top 50 payer customers for the fiscal year ended March 31, 2019 was 100%. The Joint Venture believes its size, scale, thought leadership and prevalence across the healthcare ecosystem help make it a preferred partner for innovative technology companies and industry associations focused on driving standardization and efficiencies in the healthcare industry.

Segments

The Joint Venture reports its financial results in the following three reportable segments: Software and Analytics, Network Solutions and Technology-Enabled Services.

- Software and Analytics provides software and analytics solutions for financial performance, payment accuracy, clinical decision management, value-based payment, provider and consumer engagement and imaging and clinical workflow.
- Network Solutions enables financial, administrative and clinical transactions, electronicbusiness-to-business and consumer-to-business payments and aggregation and analytics of clinical and financial data.
- Technology-Enabled Services provides solutions for financial and administrative management, value-based care, communication and payment, pharmacy benefits administration and healthcare consulting.

In April 2019, the Joint Venture made certain changes in the way that it manages its business and allocates costs. Specifically, the Joint Venture made the following changes:

- Moved its consumer payments solution from the Network Solutions reportable segment to the Technology-enabled Services reportable segment.
- Moved its consumer engagement solutions from the Software and Analytics reportable segment to the Network Solutions reportable segment.
- Made certain changes in the way that costs are assigned to reportable segments.

The presentation of revenue and Adjusted EBITDA included within this management's discussion and analysis of financial condition and results of operations has been retrospectively adjusted for all periods presented to reflect the above described changes.

Factors Affecting Change Healthcare's Results of Operations

The following are certain key factors that affect, will affect, or have recently affected, the Joint Venture's results of operations:

Post-Contribution Cost Synergies

In connection with the Transactions, the Joint Venture identified opportunities to implement certain cost synergies based on its analyses of existing operating structures, estimated spend by category, its resource requirements and industry benchmarks for similar activities. The Joint Venture expects such cost synergies to include, among others, (i) product integration, network efficiencies and combining common products; (ii) procurement savings from the elimination of duplicate orders, leveraging scale and optimization of providers; (iii) utilization of global talent; and (iv) reduction of management redundancies and duplicative roles.

By the end of the fourth year following the combination of Legacy CHC and Core MTS, the Joint Venture expects to have implemented operational initiatives to fully realize these synergies, which are expected to result in significant annual run-rate cost savings and efficiencies. The Joint Venture has incurred significant non-recurring expenses and expects to continue to incur such expenses in order to achieve these cost synergies.

Macroeconomic and Industry Trends

The healthcare industry is highly regulated and subject to frequently changing complex regulatory and other requirements. For example, ongoing healthcare reform has significantly affected the healthcare regulatory environment by changing how healthcare services are covered, delivered and reimbursed through coverage expansion, reduced federal healthcare program spending, increased efforts to link federal healthcare program payments to quality and efficiency and insurance market reforms. The number of states that will ultimately participate in some form of Medicaid expansion and the future of mandated coverage for individuals is not yet clear. If the Patient Protection and Affordable Care Act (collectively, the "ACA") is repealed or significantly modified, such repeal or modification, any alternative reforms adopted in its place or the failure to adopt alternative reforms may have a material impact on the Joint Venture's business. For example, since many of the Joint Venture's products and services include solutions designed to assist customers in effectively navigating the shift to value-based healthcare, the elimination of, or significant reductions to, the ACA's various value-based healthcare initiatives may adversely impact the Joint Venture's business. While the specific regulatory instruments and tactics used to implement reform may change in the future, the Joint Venture expects that the pervasive focus on improving coverage, efficiency and quality and related needs for payers and providers to optimize performance and reduce costs will continue.

Revenue Convergence

In April 2019, the Joint Venture adopted Accounting Standards Codification ("ASC") 606,*Revenue from Contracts with Customers*, which replaces most prior general and industry specific revenue recognition guidance with a principles-based comprehensive revenue recognition framework.

The Joint Venture adopted ASC 606 using the modified retrospective transition method applied only to contracts that were not completed as of the date of initial application. The adoption of ASC 606 resulted in a cumulative effect adjustment to reduce members' equity (deficit) as of April 1, 2019 by $159.9 million. After assessing all potential impacts of adopting the new standard on its consolidated financial statements, related disclosures, and necessary control and process changes, the Joint Venture noted the following to be the most notable impacts of adopting the new standard:

- Revenue for certain contingent fee service arrangements will be accelerated as revenue for these arrangements is recognized as the services are performed.
- Revenue related to certain time-based software and content license agreements will be accelerated. The license component for certain time-based software will be recognized upon delivery to the customer ("point in time"), or in the case of software that requires significant production, modification or customization, recognized as the implementation work is performed. A non-license component (e.g., technical support) will be recognized over the respective contract terms ("over time").
- Incremental costs to obtain contracts and qualifying costs to fulfill will be capitalized and amortized over the period of benefit. The net result of this change was an increase to capitalized contract costs on the balance sheet; these capitalized costs will be amortized and recognized as expense over an incrementally longer period of time.

Refer to Note 2, *Basis of Presentation*, in the unaudited condensed financial statements of the Joint Venture included as Exhibit 99.1 to this Quarterly Report for a full description of the impact of the adoption of ASC 606 on the Joint Venture's financial statements.

Equity-based Compensation

Change Healthcare Inc. grants equity-based awards of Change Healthcare Inc. common stock to certain employees, officers and directors of Change Healthcare Inc. and the Joint Venture. For grants to employees, equity-based awards are generally measured at the date of grant and recognized as expense over each employee's service period. Because the Joint Venture's employees are not considered employees of Change Healthcare Inc., however, prior to the adoption of FASB ASU No. 2018-07 on April 1, 2019, the Joint Venture was generally required tore-measure these equity-based awards at fair value each quarter until the earlier of the completion of required service or the performance commitment date. As a result, the Joint Venture's results of operations have historically reflected volatility from the periodic re-measurement of its equity-based awards.

In April 2019, the Joint Venture adopted FASB ASUNo. 2018-07, the effect of which is to require that equity awards tonon-employees be treated similarly to awards to employees. As a result, the Joint Venture expects to significantly lessen the volatility on equity-based compensation that has historically resulted from changes in the fair value of the underlying stock of Change Healthcare Inc., stock price volatility among its peer companies, changes in interest rates and the passage of time.

In connection with the initial public offering, the Board of Directors adopted, and the stockholders approved, the Change Healthcare Inc. 2019 Omnibus Incentive Plan (the "Omnibus Incentive Plan"), which became effective as of the date of the IPO. The purpose of our Omnibus Incentive Plan is to provide a means through which to attract and retain key personnel and to provide a means whereby our directors, officers, employees, consultants and advisors (and those of the Joint Venture and its subsidiaries) can acquire and maintain an equity interest in us or be paid incentive compensation. The Omnibus Incentive Plan allows us to implement a new market-based long-term incentive program to align our executive compensation package with similarly situated public companies.

As part of the 2019 Omnibus Incentive Plan, the Board of Directors may, from time to time, grant awards to one or more eligible persons. All awards granted under the Plan shall vest and become exercisable in such manner and on such dates or upon such events as determined by the Board of Directors, including attainment of performance conditions. Each award granted under the Omnibus Incentive Plan shall be evidenced by an award agreement, which agreement need not be the same for each participant.

Refer to Note 11, *Equity Based Compensation*, in the unaudited condensed financial statements of the Joint Venture included as Exhibit 99.1 to this Quarterly Report for a full description of the new awards included in the long-term incentive program.

Acquisitions and Divestitures

The Joint Venture actively evaluates opportunities to improve and expand its business through targeted acquisitions that are consistent with its strategy. On occasion, the Joint Venture also may dispose of certain components of its business that no longer fit within its overall strategy. Because of the Joint Venture's acquisition and divestiture activity, as well as the shifting revenue mix of its business due to this activity, the Joint Venture's results of operations may not be directly comparable among periods.

In July 2018, certain of the Joint Venture's affiliates sold all of the membership interests in the Joint Venture's extended care business (a component of the software and analytics reportable segment) for net cash proceeds of $159.9 million.

Income Taxes

The Joint Venture's effective income tax rate is affected by several factors. The following table and subsequent commentary reconciles the Joint Venture's federal statutory rate to its effective income tax rate and the subsequent commentary describes the more significant of the reconciling factors:

	Six Months Ended September 30, 2019	Six Months Ended September 30, 2018
Statutory U.S. federal tax rate	21.00%	21.00%
State income taxes (net of federal benefit)	0.13	(0.04)
Income passed through to Members	(16.39)	(21.15)
Change in valuation allowance	(4.58)	0.05
Research and development credits (net of uncertain tax positions)	(2.29)	(2.83)
Return to provision adjustments	1.29	0.14
Other	4.29	1.03
Effective income tax rate	3.45%	(1.80)%

State Income Taxes—The Joint Venture's effective tax rate for state income taxes is generally impacted by changes in its apportionment.

Income Passed through to Members—Certain of the Joint Venture's subsidiaries are organized as limited liability corporations and report income that is distributed to the Members where it is subject to income taxes.

Change in tax liability on outside basis difference of foreign subsidiary—The Joint Venture records tax expense or benefit related to undistributed earnings in a foreign subsidiary for the change in the amount of excess of book basis over tax basis in the subsidiary.

Change in Valuation Allowance—The Joint Venture records valuation allowances or reverses existing valuation allowances related to assumed future income tax benefits depending on circumstances and factors related to its business. During the six months ended September 30, 2019, the Joint Venture released a valuation allowance related to prior deferred tax assets as a result of its change in judgment resulting from forecasted earnings and tax planning strategies that provide for future taxable income in the relevant jurisdictions.

Research and development credits (net of uncertain tax position liability)—The Joint Venture records credits against income taxes for certain research and development expenditures in the U.S. and Canada net of the portion that is estimated to be included in Change Healthcare Inc.'s unrecognized tax benefits.

Qualified McKesson Exit

In connection with a Qualified McKesson Exit, we anticipate that Change Healthcare Inc. will acquire the interest in the Joint Venture that it did not own prior to such transaction. As a result, in periods following the Qualified McKesson Exit, Change Healthcare LLC is expected to be a wholly-owned subsidiary of Change Healthcare Inc., and Change Healthcare Inc. will consolidate the financial position and results of Change Healthcare LLC in its financial statements.

Change Healthcare Inc. expects to account for the Qualified McKesson Exit and related transactions as a business combination achieved in stages in accordance with the FASB Accounting Standards Codification Business Combinations Topic, resulting in a new basis of accounting. As a result, Change Healthcare Inc. will be required to remeasure its investment in the Joint Venture to fair value as of the date that control is obtained and will recognize a gain or loss in its statement of operations for the difference in the carrying value and fair value of this investment. Further, Change Healthcare Inc. expects to recognize the consideration transferred, as well as the acquired business's identifiable assets, liabilities and noncontrolling interests at their acquisition date fair value. The excess of the consideration transferred over the fair value of the identifiable assets, liabilities and noncontrolling interest, if any, is anticipated to be recorded as goodwill. Any excess of the fair value of the identifiable assets acquired and liabilities assumed over the consideration transferred, if any, would generally be recognized within earnings as of the acquisition date.

As a result of the accounting for these transactions and the anticipated change in basis of accounting, the consolidated results of Change Healthcare Inc. in periods following the Qualified McKesson Exit will not be comparable to the consolidated results of the Joint Venture in periods prior to the Qualified McKesson Exit. The following are certain of the more significant changes resulting from the Qualified McKesson Exit that are expected to affect the comparability of financial results and operations:

- Gain or loss upon remeasuring Change Healthcare Inc.'s investment in the Joint Venture at its fair value.
- Increased tangible and intangible assets resulting from adjusting the basis of tangible and intangible assets to their fair value which is expected to result in increased depreciation and amortization expense.
- Potential increase or decrease in long-term debt as a result of adjustments to state the long-term debt at its fair value. Resulting differences in the historical carrying value and fair value of the long-term debt are expected to result in either additional discount or premium which, in turn, may materially increase or decrease future interest expense.
- Decreased deferred revenue as a result of recognizing deferred revenue in the business combination only to the extent that contractual obligations remain to be fulfilled at that time. Decreases in deferred revenue are expected to result in decreased solutions revenue in the near term.
- Income currently attributable to the Joint Venture and not subject to U.S. federal income taxes and most state and local income taxes will become subject to such taxes, resulting in an expected increase in Change Healthcare Inc.'s effective tax rate compared with the historical effective tax rate of the Joint Venture.

Results of Operations

The Joint Venture adopted the new revenue recognition accounting standard, ASC 606, effective April 1, 2019 on a modified retrospective basis. Its results of operations as presented within the following discussion and analysis includes financial results for reporting periods during fiscal 2020, which are disclosed in compliance with the new revenue recognition standard. Historical financial results for reporting periods prior to fiscal 2020 have not been retroactively restated and are presented in conformity with amounts previously disclosed under the prior revenue recognition standard, ASC 605. The Joint Venture has included additional information regarding the impacts from the adoption of the new revenue recognition standard for the three and six months ended September 30, 2019 and included financial results during fiscal 2020 under ASC 605 for comparison to the prior year.

The following table summarizes our consolidated results of operations for the three months ended September 30, 2019 and 2018, respectively:

(in millions)	Three Months Ended September 30, 2019 As Reported	Impacts from Adoption	Without Adoption (ASC 605)	2018 As Reported (ASC 605)	$ Change	% Change	Six Months Ended September 30, 2019 As Reported	Impacts from Adoption	Without Adoption (ASC 605)	2018 As Reported (ASC 605)	$ Change	% Change
Revenue												
Solutions revenue	$ 738.7	$ 9.9	$ 748.6	$ 737.8	$ 10.8	1.5%	$1,535.8	$ (31.6)	$ 1,504.2	$ 1,495.5	$ 8.7	0.6%
Postage revenue	57.1	—	57.1	62.4	(5.3)	(8.5)	115.6	—	115.6	128.0	(12.4)	(9.7)
Total revenue	795.8	9.9	805.7	800.2	5.5	0.7	1,651.4	(31.6)	1,619.8	1,623.5	(3.7)	(0.2)
Operating expenses												
Costs of operations (exclusive of depreciation and amortization below)	331.2	1.0	332.2	327.6	4.6	1.4	658.2	1.8	660.0	665.0	(5.0)	(0.8)
Research and development	51.8	—	51.8	51.2	0.6	1.2	101.1	—	101.1	106.6	(5.5)	(5.2)
Sales, marketing, general and administrative	190.0	4.6	194.6	207.1	(12.5)	(6.0)	383.3	9.8	393.1	414.0	(20.9)	(5.0)
Customer postage	57.1	—	57.1	62.4	(5.3)	(8.5)	115.6	—	115.6	128.0	(12.4)	(9.7)
Depreciation and amortization	77.4	—	77.4	69.3	8.1	11.7	148.8	—	148.8	137.8	11.0	8.0
Accretion and changes in estimate with related parties, net	3.2	—	3.2	5.9	(2.7)	(45.8)	7.1	—	7.1	9.8	(2.7)	(27.6)
Gain on sale of the Extended Care Business	—	—	—	(111.4)	111.4	(100.0)	—	—	—	(111.4)	111.4	(100.0)
Total operating expenses	710.7	5.6	716.3	612.1	104.2	17.0	1,414.1	11.6	1,425.7	1,349.8	75.9	5.6
Operating income	85.1	4.3	89.4	188.1	(98.7)	(52.5)	237.3	(43.2)	194.1	273.7	(79.6)	(29.1)
Non-operating (income) and expense												
Interest expense	69.9	—	69.9	80.7	(10.8)	(13.4)	153.3	—	153.3	159.2	(5.9)	(3.7)
Loss on extinguishment of debt	16.9	—	16.9	—	16.9		16.9	—	16.9	—	16.9	
Contingent consideration	1.7	—	1.7	(0.1)	1.8	(1,800.0)	0.9	—	0.9	0.2	0.7	350.0
Other, net	(4.4)	—	(4.4)	(3.8)	(0.6)	15.8	(8.2)	—	(8.2)	(9.4)	1.2	(12.8)
Non-operating (income) and expense	84.1	—	84.1	76.8	7.3	9.5	162.9	—	162.9	150.0	12.9	8.6
Income (loss) before income tax provision (benefit)	1.0	4.3	5.3	111.3	(106.0)	(95.2)	74.4	(43.2)	31.2	123.7	(92.5)	(74.8)
Income tax provision (benefit)	1.0	—	1.0	(2.1)	3.1	(147.6)	2.6	(2.3)	0.3	(2.2)	2.5	(113.6)
Net income (loss)	$ 0.0	$ 4.3	$ 4.3	$ 113.4	$(109.1)	(96.2)%	$ 71.8	$ (40.9)	$ 30.9	$ 125.9	$ (95.0)	(75.5)%

As a result of displaying amounts in millions, rounding differences may exist in the table above.

Three Months Ended September 30, 2019 (ASC 605 Basis) Compared to Three Months Ended September 30, 2018

Solutions Revenue

Solutions revenue increased $10.8 million for the three months ended September 30, 2019, compared with the same period in the prior year. Factors affecting the Joint Venture's solutions revenue are described in the various segment discussions below.

Expenses

Costs of Operations (Exclusive of Depreciation and Amortization)

Costs of operations (exclusive of depreciation and amortization) increased $4.6 million for the three months ended September 30, 2019, compared with the same period in the prior year. The increase in the Joint Venture's costs of operations is primarily attributable to an increase in information technology maintenance and data and communications costs.

Research and Development

Research and development expenses increased $0.6 million for the three months ended September 30, 2019, compared with the same period in the prior year. The increase is primarily attributable to increases in investments, offset by synergies associated with reduction or elimination of duplicative roles.

Sales, Marketing, General and Administrative

Sales, marketing, general and administrative expenses decreased $12.5 million for the three months ended September 30, 2019, compared with the same period in the prior year. Sales, marketing, general and administrative expense for each of the three months ended September 30, 2019 and 2018 reflects significant integration related costs, including professional and consulting fees related to rationalizations of information technology, business process re-engineering, implementation of human resource and finance information technology systems, severance and other costs. The amount of such costs, however, decreased by $8.5 million in the three months ended September 30, 2019 as compared to the same period in the prior year.

Customer Postage

Customer postage decreased $5.3 million for the three months ended September 30, 2019, compared with the same period in the prior year. Customer postage is affected by the declines in print volumes within communication and payment solutions, which were partially offset by the effect of a USPS postage rate increase in January 2019 (e.g. an increase in first-class postage of 10%). Because customer postage is a pass-through cost to the Joint Venture's customers, however, changes in volume of customer postage generally have no effect on operating income.

Depreciation and Amortization

Depreciation and amortization increased $8.1 million for the three months ended September 30, 2019, compared with the same period in the prior year. Depreciation and amortization were generally affected by routine amortization of tangible and intangible assets existing at March 31, 2019 as well as the routine amortization and depreciation of additions to property, equipment, and software since that date.

Accretion and changes in estimate with related parties, net

Accretion and changes in estimate with related parties, net decreased $2.7 million for the three months ended September 30, 2019, compared with the same period in the prior year. Accretion is routinely affected by changes in the expected timing or amount of cash flows which may result from various factors, including changes in tax rates and McKesson's discretionary allocation of deductions under the terms of the Letter Agreement.

Interest expense

Interest expense decreased $10.8 million for the three months ended September 30, 2019, compared with the same period in the prior year. This decrease is primarily attributable to the repayment of approximately $805.0 million of variable interest rate debt in July 2019 from the proceeds of the initial public offering and an additional repayment of $85.0 million during the three months ended September 30, 2019. The Joint Venture has interest rate cap agreements in place to limit its exposure to rising interest rates, and such agreements together with the Joint Venture's fixed rate notes effectively fixed interest rates for approximately 59% of the Joint Venture's total indebtedness at September 30, 2019.

Loss on Extinguishment of Debt

Loss on extinguishment of debt for the three months ended September 30, 2019 of $16.9 million includes a loss of $15.8 million related to the unamortized discounts and debt issuance costs associated with the total repayment of $890.0 million on the Term Loan Facility, as well as a loss of $1.1 million due to the deemed extinguishment associated with the amendment of the Revolving Credit Facility.

Contingent consideration

Contingent consideration reflects changes in the fair value of the Joint Venture's earnout obligation to the former owners of an acquired business. Such amounts may increase or decrease in the future based on changes in the expected amount, timing, and probability of making such payments in the future.

Other, net

Other, net primarily represents income the Joint Venture receives from McKesson and eRx Network related to transitional and other services that we provide them following the closing of the Transactions in March 2017.

Income Tax Provision (Benefit)

The income tax provision was $1.0 million (effective tax rate of 115.0%) for the three months ended September 30, 2019 as compared to an income tax benefit of $2.1 million (effective tax rate of -1.9%) for the three months ended September 30, 2018. The Joint Venture's income taxes and related effective tax rate are routinely affected by it and its subsidiaries' legal organization. Certain of the Joint Venture's subsidiaries are organized as limited liability corporations and report income that is distributed to the Members where it is subject to income taxes. Other subsidiaries are organized as corporations, for which the tax effects are directly reflected in the Joint Venture's financial statements.

Solutions Revenue and Adjusted EBITDA

	Three Months Ended September 30,					
	2019			2018		
(in millions)	As Reported	Impacts from Adoption	Without Adoption (ASC 605)	As Reported (ASC 605)	$ Change	% Change
Solutions revenue (1)						
Software and Analytics	$ 376.1	$ 13.2	$ 389.3	$ 383.5	$ 5.8	1.5%
Network Solutions	$ 144.3	$ —	$ 144.3	$ 136.3	$ 8.0	5.9%
Technology-enabled Services	$ 244.1	$ (3.2)	$ 240.9	$ 243.3	$ (2.4)	(1.0)%
Adjusted EBITDA						
Software and Analytics	$ 140.1	$ 8.8	$ 148.9	$ 139.4	$ 9.5	6.8%
Network Solutions	$ 86.5	$ (0.4)	$ 86.1	$ 83.6	$ 2.5	3.0%
Technology-enabled Services	$ 44.8	$ (3.8)	$ 41.0	$ 39.2	$ 1.8	4.6%

(1) Includes inter-segment revenue

As a result of displaying amounts in millions, rounding differences may exist in the tables above.

Software and Analytics

Software and Analytics revenue increased $5.8 million for the three months ended September 30, 2019 compared with the same period in the prior year. Software and Analytics revenue reflects core revenue growth and timing, partially offset by ongoing efforts to rationalize the connected analytics solution and the effect of prior year one-time nonrecurring revenue of $6.0 million in the enterprise imaging business.

Software and Analytics Adjusted EBITDA increased $9.5 million for the three months ended September 30, 2019, compared to the same period in the prior year. This increase in Adjusted EBITDA was attributable to core revenue growth and timing, operational synergies, and cost initiatives related to the connected analytics solution, partially offset by the decline in the enterprise imaging business.

Network Solutions

Network Solutions revenue increased $8.0 million for the three months ended September 30, 2019 compared with the same period in the prior year, which primarily reflects increased revenues resulting from the sale of new contracts in the data solutions, dental and medical network businesses and stronger volume.

Network Solutions Adjusted EBITDA increased by $2.5 million for the three months ended September 30, 2019 compared to the same period in the prior year. As described above, Network Solutions revenue was positively affected by increased revenues resulting from the sale of new contacts in the data solutions, dental and medical network businesses and stronger volumes. Adjusted EBITDA similarly increased as a result of these factors partially offset by investments to support the data solutions new market expansion efforts and continued investment in network capabilities.

Technology-enabled Services

Technology-enabled Services revenue decreased $2.4 million for the three months ended September 30, 2019, compared with the same period in the prior year. Technology-enabled Services revenue for the three months ended September 30, 2019 was primarily impacted by new sales and same store organic growth of $24 million, which was more than offset by $30 million of customer attrition (including the company's decision to exit certain contracts). Customer attrition for the three months ended September 30, 2019 reflects the full current period impact of attrition that occurred throughout fiscal year 2019 in the Joint Venture's physician revenue cycle management and communication and payment services solutions, driven by industry consolidation. While the Joint Venture expects that such consolidation will continue in the future, as part of its strategy, the Joint Venture is repositioning certain of its solutions to better address end market dynamics, enhance efficiency and to improve the long-term growth potential of these solutions.

Technology-enabled Services Adjusted EBITDA increased $1.8 million for the three months ended September 30, 2019, compared to the same period in the prior year. Technology-enabled Services Adjusted EBITDA for the three months ended September 30, 2019 reflects the decrease in Technology-enabled Services revenue which was more than offset by cost savings from the Joint Venture's post-contribution cost synergy initiatives.

Six Months Ended September 30, 2019 (ASC 605 Basis) Compared to Six Months Ended September 30, 2018

Solutions Revenue

Solutions revenue increased $8.7 million for the six months ended September 30, 2019, compared with the same period in the prior year. Solutions revenue for the six months ended September 30, 2019 was generally affected the continuation of trends described in the discussion of results of operations for the three months ended September 30, 2019. In addition, the comparison to the prior year period was discretely affected by the sale of the Joint Venture's extended care business in July 2018.

Expenses

Expenses were affected by similar items outlined in the discussion of results for the three months ended September 30, 2019.

Solutions Revenue and Adjusted EBITDA

	Six Months Ended September 30,					
	2019			2018		
(in millions)	As Reported	Impacts from Adoption	Without Adoption (ASC 605)	As Reported (ASC 605)	$ Change	% Change
Solutions revenue (1)						
Software and Analytics	$ 813.5	(28.5)	785.0	$ 779.9	$ 5.1	0.7%
Network Solutions	$ 285.9	—	285.9	$ 272.9	$ 13.0	4.8%
Technology-enabled Services	$ 488.1	(3.1)	485.0	$ 493.3	$ (8.3)	(1.7)%
Adjusted EBITDA						
Software and Analytics	$ 342.4	(37.1)	305.3	$ 282.1	$ 23.2	8.2%
Network Solutions	$ 171.5	(0.9)	170.6	$ 165.8	$ 4.8	2.9%
Technology-enabled Services	$ 90.0	(4.5)	85.5	$ 89.2	$ (3.7)	(4.1)%

(1) Includes inter-segment revenue

Revenue and Adjusted EBITDA for the six months ended September 30, 2019 for all three segments were affected by similar trends outlined in the discussion of results for the three months ended September 30, 2019. The increases in revenue and Adjusted EBITDA for Software and Analytics were partially offset by the divestiture of the extended care business, which contributed revenue of $9.2 million and Adjusted EBITDA of $1.5 million in the six months ended September 30, 2018.

Significant Changes in Assets and Liabilities

Within the Joint Venture's network solutions business, the Joint Venture regularly receives funds from certain pharmaceutical industry participants in advance of its obligation to remit these funds to participating retail pharmacies. Such funds are not restricted; however, these funds are generally paid out in satisfaction of the processing obligations within three business days of their receipt. At the time of receipt, the Joint Venture records a corresponding liability within accrued expenses on its consolidated balance sheets. At September 30, 2019, the Joint Venture reported $20.3 million of such pass-through payment obligations which were subsequently paid in the first week of October 2019. At March 31, 2019, the Joint Venture reported $7.4 million of such pass-through payment obligations.

Liquidity and Capital Resources

Overview

The Joint Venture's principal sources of liquidity are cash flows provided by operating activities, cash and cash equivalents on hand, and potential funds available under its Revolving Credit Facility. The Joint Venture's principal uses of liquidity are working capital, capital expenditures, debt service, business acquisitions and other general corporate purposes. The Joint Venture anticipates its cash on hand, cash generated from operations, and funds available under the Revolving Credit Facility will be sufficient to fund its planned capital expenditures, debt service obligations, business acquisitions and operating needs. The Joint Venture may, however, elect to raise funds through debt or equity financing in the future to fund significant investments or acquisitions that are consistent with its growth strategy.

Cash, cash equivalents and restricted cash totaled $73.0 million and $48.9 million at September 30, 2019 and March 31, 2019, respectively, of which $23.7 million and $28.1 million was held outside the United States. As of September 30, 2019, no amounts had been drawn under the senior secured revolving line of credit and the Joint Venture could have borrowed up to the additional $779.9 million available. The Joint Venture also has the ability to borrow up to an additional $1,080.0 million, or such amount that the senior secured net leverage ratio does not exceed 4.9 to 1.0, whichever is greater, under the Senior Secured Credit Facilities, subject to certain additional conditions and commitments by existing or new lenders to fund any additional borrowings.

The balance retained in cash and cash equivalents is consistent with the Joint Venture's short-term cash needs and investment objectives. The Joint Venture may be required to make additional principal payments on the Term Loan Facility based on excess cash flows of the prior year, as defined in the credit agreement governing the Term Loan Facility.

	Six Months Ended September 30,			
(in millions)	2019	2018	$ Change	% Change
Cash provided by (used in) operating activities	$ 223.9	$ 227.9	$ (4.0)	(1.8)%
Cash provided by (used in) investing activities	(148.8)	35.6	(184.4)	(518.0)
Cash provided by (used in) financing activities	(51.3)	(104.8)	53.5	(51.0)
Effects of exchange rate changes on cash, cash equivalents and restricted cash	0.3	(0.7)	1.0	(142.9)
Net change in cash, cash equivalents and restricted cash	$ 24.1	$ 158.0	(133.9)	(84.7)%

Operating Activities

Cash provided by operating activities is primarily affected by operating income, including the impact of debt service payments, integration related costs and the timing of collections and related disbursements. Cash provided by operating activities includes $12.9 million and $156.1 million as a source of cash related to pass-through funds for the six months ended September 30, 2019 and 2018, respectively.

Investing Activities

Cash used in investing activities primarily reflects routine capital expenditures related to purchase of property and equipment and the development of software, as well as expenditures related to significant software development efforts necessary to integrate the contributed businesses in both periods. Cash provided by investing activities in the six months ended September 30, 2018 was primarily impacted by the proceeds from the sale of the extended care business.

Financing Activities

Cash used in financing activities reflects cash payments under the Term Loan Facility, receipts under the Joint Venture's interest rate cap agreements, and payments for deferred financing obligations. Cash used in financing activities was primarily impacted by the proceeds from the initial public offering and resulting increased payments under the Term Loan Facility in the six months ended September 30, 2019.

Capital Expenditures

The Joint Venture incurs capital expenditures to grow its business by developing new and enhanced capabilities, to increase the effectiveness and efficiency of the organization and to reduce risks. The Joint Venture incurs capital expenditures for product development, disaster recovery, security enhancements, regulatory compliance and the replacement and upgrade of existing equipment at the end of its useful life.

Debt

Senior Credit Facilities and Senior Notes

In March 2017, the Joint Venture entered into the $5,100 million term loan facility (the "Term Loan Facility"), and a $500 million revolving credit facility (as amended in July 2019 to increase the maximum amount that can be borrowed to $785 million, the "Revolving Credit Facility" and, together with the Term Loan Facility, the "Senior Secured Credit Facilities"). Additionally, the Joint Venture issued $1,000 million of 5.75% senior notes due 2025 (the "Senior Notes"). No amounts have been drawn against the Revolving Credit Facility as of September 30, 2019.

The Joint Venture used the initial public offering proceeds received from Change Healthcare Inc. to repay $805,000 of its indebtedness under the Term Loan Facility without penalty in July 2019. The Joint Venture repaid an additional $85,000 of its indebtedness under the Term Loan Facility without penalty during the three months ended September 30, 2019 for a total paydown of $890,000.

In July 2019, the Joint Venture amended the Revolving Credit Facility, the primary effects of which were to increase the maximum amount that can be borrowed from $500 million to $785 million and to extend the maturity date until July 3, 2024. In the event that the outstanding balance under the Term Loan Facility exceeds $1,100 million on December 1, 2023, however, amounts due, if any, under the Revolving Facility become due and payable on December 1, 2023.

Tangible Equity Units

In July 2019, the Joint Venture issued a debt arrangement to Change Healthcare Inc. on terms that substantially mirror the economics of the amortizing note component of the Change Healthcare Inc. TEUs. The Joint Venture agreed to pay Change Healthcare Inc. an aggregate principal amount of $47,367 in quarterly installments of principal and interest (5.5% per year) on March 30, June 30, September 30, and December 30 of each year through June 30, 2022.

Hedges

From time to time, the Joint Venture executes interest rate cap agreements with various counterparties that effectively cap its LIBOR exposure on a portion of its existing Term Loan Facility or similar replacement debt. The following table summarizes the terms of the Joint Venture's interest rate cap agreements at September 30, 2019.

Effective Date	Expiration Date	Notional Amount	Receive LIBOR Exceeding (1)	Pay Fixed Rate
March 31, 2017	March 31, 2020	$ 650,000	1.25%	0.56%
March 31, 2017	March 31, 2020	$ 750,000	1.00%	0.82%
August 31, 2018	March 31, 2020	$ 500,000	1.00%	1.82%
March 31, 2020	December 31, 2021	$ 1,500,000	1.00%	1.82%

(1) All based on 1-month LIBOR, except the $650,000 tranche which receives based on 3-month LIBOR.

The interest rate caps are recorded on the balance sheet at fair value. Changes in the fair value of the interest rate cap agreements are recorded in other comprehensive income.

In accordance with ASC 815, the fair value of the interest rate caps at inception is reclassified from other comprehensive income to interest expense in the same period the interest expense on the underlying hedged debt impacts earnings. Any payments the Joint Venture receives to the extent LIBOR exceeds the specified cap rate is also reclassified from other comprehensive income to interest expense in the period received.

In July 2017, the Financial Conduct Authority (the authority that regulates LIBOR) announced it intends to stop compelling banks to submit rates for the calculation of LIBOR after 2021. The Alternative Reference Rates Committee ("ARRC") has proposed that the Secured Overnight Financing Rate ("SOFR") is the rate that represents best practice as the alternative to USD-LIBOR for use in derivatives and other financial contracts that are currently indexed to USD-LIBOR. ARRC has proposed a paced market transition plan to SOFR fromUSD-LIBOR and organizations are currently working on industry wide and company specific transition plans as it relates to derivatives and cash markets exposed to USD-LIBOR. The Joint Venture has material contracts that are indexed to USD-LIBOR and is monitoring this activity and evaluating the related risks.

Effect of Certain Debt Covenants

A breach of any of the covenants under the agreements governing the Joint Venture's debt could limit its ability to borrow funds under the Term Loan Facility and could result in a default under the Term Loan Facility. Upon the occurrence of an event of default under the Term Loan Facility, the lenders could elect to declare all amounts then outstanding to be immediately due and payable, and the lenders could terminate all commitments to extend further credit. If the Joint Venture were unable to repay the amounts declared due, the lenders could proceed against any collateral granted to them to secure that indebtedness.

With certain exceptions, the Term Loan Facility obligations are secured by a first-priority security interest in substantially all of the assets of the Joint Venture, including its investment in subsidiaries. The Term Loan Facility contains various restrictions and nonfinancial covenants, along with a senior secured net leverage ratio test. The nonfinancial covenants include restrictions on dividends, investments, dispositions, future borrowings and other specified payments, as well as additional reporting and disclosure requirements. The senior secured net leverage test must be met as a condition to incur additional indebtedness, but otherwise is applicable only to the extent that amounts drawn exceed 35% of the Revolving Credit Facility at the end of any fiscal quarter. As of September 30, 2019, the Joint Venture was in compliance with all debt covenants.

The Joint Venture's ability to meet its liquidity needs depends on its subsidiaries' earnings and cash flows, the terms of the Joint Venture and its subsidiaries' indebtedness, and other contractual restrictions. Except for certain permitted distributions, the Joint Venture generally is not permitted to make any distribution to its members.

Off-Balance Sheet Arrangements

As of September 30, 2019, the Joint Venture had nooff-balance sheet arrangements.

Recent Accounting Pronouncements

See Exhibit 99.1, "Notes to Consolidated Financial Statements," Note 2, "Summary of Significant Accounting Policies," for information about recent accounting pronouncements and the potential impact on the Joint Venture's consolidated financial statements.

Critical Accounting Estimates

The preparation of financial statements in accordance with GAAP requires us to make estimates and assumptions that affect reported amounts and related disclosures. The Joint Venture considers an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on our consolidated results of operations and financial condition.

The Joint Venture believes the current assumptions and other considerations used to estimate amounts reflected in its consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on the Joint Venture's consolidated results of operations and financial condition.

Revenue Recognition

In April 2019, the Joint Venture adopted Accounting Standards Codification ASC 606, Revenue from Contracts with Customers, which replaced most prior general and industry specific revenue recognition guidance with a principles-based comprehensive revenue recognition framework. Under this revised framework, a company recognizes revenue to depict the transfer of promised goods and services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods and services.

The Joint Venture generates most of its solutions revenue by using technology solutions (generally Software as a Service ("SaaS")) to provide services to its customers that automate and simplify business and administrative functions for payers, providers, pharmacies, and channel partners and through the licensing of software, software systems (consisting of software, hardware and maintenance support) and content.

The Joint Venture recognizes revenue when the customer obtains control of the good or service through the Joint Venture satisfying a performance obligation by transferring the promised good or service to the customer.

Principal Revenue Generating Products and Services

Content license subscriptions and time-based software—The Joint Venture's content license subscriptions and time-based software arrangements provide a license to use a software for a specified period of time. At the end of the contractual period, the customer either renews the license for an additional term or ceases to use the software. Software licenses are typically delivered to the customer with functionality that the customer can benefit from the software on its own or together with readily available resources. As contracts for these solutions generally do not price individual components separately, the Joint Venture allocates the transaction price to the license and ongoing support performance obligations based on standalone selling price ("SSP"), primarily determined by historical value relationships between licenses and ongoing support and updates. Revenue allocated to content license subscriptions and time-based software license agreements is generally recognized at the point-in-time of delivery of the license or the content update upon transfer of control of the underlying license to the customer. Generally, software implementation fees are recognized over the implementation period through an input measure of progress method. Revenue allocated to maintenance and support is recognized ratably over the period covered by the agreements, as passage of time represents a faithful depiction of the transfer of these services. In some cases, software arrangements provide licenses to several software applications that are highly integrated with the implementation services and software updates and cannot function separately. The bundle is a single performance obligation since the individually promised goods and services are not distinct in the context of the contract because the related implementation services significantly modify and customize the software and the updates provided to the integrated software solution are critical to the software's utility. The related revenue is recognized on a straight-line basis, ratably over the contractual term due to the frequency and criticality of the updates throughout the license period.

Contingent fee services—The Joint Venture provides services to customers in which the transaction price is contingent on future occurrences, such as savings generated or amounts collected on behalf of its customers through the delivery of its services. In some cases, the Joint Venture performs services in advance of invoicing the customer, thereby creating a contract asset. Revenue in these arrangements is estimated and constrained until the Joint Venture determines that it is probable that a significant revenue reversal will not occur, and variable consideration is allocated to the performance obligation for which the Joint Venture earns a contingent fee.

Perpetual software licenses—The Joint Venture's perpetual software arrangements provide a license for a customer to use software in perpetuity. Software licenses are typically delivered to the customer with functionality from which the customer can benefit from the license on its own or together with readily available resources. Perpetual software arrangements are recognized at the time of delivery or through an input measure of progress method over the installation period if the arrangements require significant production or modification or customization of the software. Contracts accounted for through an input measure of progress method are generally measured based on the ratio of labor hours incurred to date to total estimated labor hours to be incurred. Software implementation fees are recognized as the work is performed or under the input method for perpetual software. Hardware revenues are generally recognized upon delivery. Maintenance is recognized ratably over the term of the agreement as passage of time represents a faithful depiction of the transfer of these services.

Professional services—The Joint Venture provides training and consulting services to its customers, and the services may be fixed fee or time and materials based. Consulting services that fall outside of the standard implementation services vary depending on the scope and complexity of the service requested by the customer. Consulting services are deemed to be capable of being distinct from other products and services, and the services are satisfied either at a point of time or over time based on delivery. Training services are usually provided as an optional service to enhance the customer's experience with a software product or provides additional education surrounding the general topic of the solution. Training services are capable of being distinct from other products and services. The Joint Venture treats training services as a distinct performance obligation, and they are satisfied at a point of time.

Transaction processing services—The Joint Venture provides transaction processing (such as claims processing) services to hospitals, pharmacies and health systems via a cloud-based (SaaS) platform. The promised service is to stand ready to process transactions for our customers over the contractual period on an as needed basis. The revenue related to these services is recognized over time as the transactions are processed, and the revenue is recognized over the individual days in which the services are performed. Any fixed annual fees and implementation fees are recognized ratably over the contract period.

Hosted solutions and software as a service ("SaaS")—The Joint Venture enters into arrangements whereby the Joint Venture provides the customer access to a Joint Venture-owned software solution, which are generally marketed under annual and multi-year arrangements. The customer is only provided "access" (not a license) to the software application. In these arrangements, the customer does not purchase equipment nor does the customer take physical possession of the software. The related revenue is recognized ratably over the contracted term. For fixed fee arrangements, revenue recognition begins after set-up and implementation are complete. For per-transaction fee arrangements, revenue is recognized as transactions are processed beginning on the service start date.

Contract Balances

The Joint Venture's payment terms vary by customer and product type. For certain products or services, the Joint Venture requires upfront payments before control of the product or service has transferred to the customer. For other products and services, the Joint Venture invoices the customer in arrears after providing the products or services. In addition, for certain contingent fee services, customers are billed in arrears, typically based upon a percentage of collections the Joint Venture makes on the customer's behalf.

Under the new revenue standard, the Joint Venture generally recognizes a contract asset when revenue is recognized in advance of invoicing on a customer contract, unless the right to payment for that revenue is unconditional (i.e. requiring no further performance and only the passage of time). If a right to payment is determined to meet the criteria to be considered 'unconditional', then the Joint Venture will recognize a receivable.

There were no impairment losses recognized on accounts receivable or contract assets in the three and six months ended September 30, 2019.

The Joint Venture records deferred revenues when billings or payments are received from customers in advance of its performance. Deferred revenue is generally recognized when transfer of control to customers occurs. The deferred revenue balance is driven by multiple factors, including the frequency of renewals, invoice timing, and invoice duration. As of September 30, 2019, the Joint Venture expects 94% of the deferred revenue balance to be recognized in one year or less, and approximately $328 million of the beginning period balance was recognized during the three months ended September 30, 2019.

Costs to Obtain or Fulfill a Contract

Sales commissions and certain other incentive payments (e.g., bonuses that are contingent solely on obtaining a contract or a pool of contracts) earned by the Joint Venture's sales organization are capitalized as incremental costs to obtain a contract. The Joint Venture typically does not offer commissions on contract renewals. Decremented commissions upon renewal (i.e., non-commensurate with initial commissions) are offered to the Joint Venture's sales associates for certain customers and are not material. Under ASC 606, all commissions and other qualifying incentive payments capitalized are amortized over an expected period of benefit defined as the initial contract term plus anticipated renewals. In contrast, under ASC 605 these capitalized costs were amortized over the specific

revenue contract terms, which are typically 12 to 60 months. In making the significant judgment in determining the appropriate period of benefit, the Joint Venture evaluated both qualitative and quantitative factors such as the expected customer relationship period and technology obsolescence. In addition, prior to solution go-live, the Joint Venture incurs certain contract fulfillment costs primarily related to SaaS setup for our clients. These costs are capitalized to the extent they are directly related to a contract, are recoverable, and create a resource used to deliver the Joint Venture's SaaS services. Capitalized costs to fulfill a contract are amortized over the expected period of benefit.

At September 30, 2019, the Joint Venture had capitalized costs to obtain a contract of $12.4 million in prepaid and other current assets and $67.4 million in other noncurrent assets. During the three and six months ended September 30, 2019, the Joint Venture recognized $5.1 million and $9.2 million, respectively, of amortization expense related to such capitalized costs, which is included in the total operating expenses. At September 30, 2019, the Joint Venture had capitalized costs to fulfill a contract of $1.4 million in prepaid and other current assets and $8.6 million in other noncurrent assets. During the three and six months ended September 30, 2019, the Joint Venture recognized $0.3 million and $0.6 million, respectively, of amortization expense related to such capitalized costs, which is included in cost of operations.

Postage Revenues

Postage revenues are the result of providing delivery services to customers in the Joint Venture's payment and communication solutions. Postage revenues are generally billed as a pass-through cost to the Joint Venture's customers. The service is part of a combined performance obligation with the printing and handling services provided to the customer because the postage services are not distinct within the context of the contract. The Joint Venture presents Postage Revenue separately from Solutions Revenue on the consolidated statements of operation as it makes the financial statements more informative for the users. The revenue related to the combined performance obligation of the postage, printing, and handling service is recognized as the transactions are processed, and the revenue is recognized over the individual days in which the services are performed.

Arrangements with Multiple Performance Obligations

The Joint Venture engages in customer arrangements which may include multiple performance obligations, such as any combination of software, hardware, implementation, SaaS-based offerings, consulting services, or maintenance services. For such arrangements, the Joint Venture allocates revenues to each performance obligation on a relative standalone selling price basis. A performance obligation's standalone selling price is determined based on the directly observable prices charged to customers when available or estimated using other methods such as the adjusted market assessment approach, the expected cost plus a margin approach, or other approaches in cases where distinct performance obligations are not sold separately but instead sold at a bundled price. For performance obligations with historical pricing that is highly variable, the residual approach is used. Such instances primarily relate to the Joint Venture's perpetual software arrangements in which the Joint Venture sells the same products to different customers for a broad range of amounts.

Remaining Performance Obligations

The aggregate amount of transaction price allocated to performance obligations that are unsatisfied (or partially unsatisfied) for executed contracts includes deferred revenue and other revenue yet to be recognized from non-cancellable contracts. As of September 30, 2019, the Joint Venture's total remaining performance obligations approximated $1.4 billion, of which approximately 52% is expected to be recognized over the next twelve months, and the remaining 48% thereafter.

In this balance, the Joint Venture does not include the value of unsatisfied performance obligations related to those contracts for which it recognizes revenue at the amount for which it has the right to invoice for services performed. Additionally, this balance does not include revenue related to performance obligations that are part of a contract with an original expected duration of one year or less. Lastly, this balance does not include variable consideration allocated to the individual goods or services in a series of distinct goods or services that are substantially the same and that have the same pattern of transfer to the customer. Examples includes variable fees associated with transaction processing and contingent fee services.

Disaggregated Revenue

The Joint Venture disaggregates the revenue from contracts with customers by operating segment as it believes doing so best depicts how the nature, amount, timing and uncertainty of the Joint Venture's revenue are affected by economic factors. See Note 9 in the Joint Venture unaudited financial statements included in Exhibit 99.1, "Segment Reporting" for the total revenue disaggregated by operating segment for the six months ended September 30, 2019 and 2018.

The Joint Venture's total revenue by disaggregated revenue source was generally consistent for each reportable segment for the three and six months ended September 30, 2019 compared with the corresponding periods in 2018.

Customer Incentives

Certain customers, which include the Joint Venture's channel partners, may receive cash-based incentives or rebates based on actual sales and achievement of a cumulative level of sales, which are accounted for as variable consideration. The Joint Venture considers these amounts to be consideration payable to the customer, and therefore, the Joint Venture estimates these amounts based on the expected amount to be provided to customers and reduces the transaction price accordingly.

Practical Expedients and Exemptions

The Joint Venture has elected to utilize either the right to invoice practical expedient or the series-based variable consideration allocation framework for most transaction processing services not subject to contingencies. The Joint Venture also has elected to exclude sales taxes and other similar taxes from the measurement of the transaction price in contracts with customers. Therefore, revenue is recognized net of such taxes.

In certain customer arrangements with customers, the Joint Venture determined there are certain promised goods or services which are immaterial in the context of the contract from both a quantitative and qualitative perspective, and therefore, the goods and services are disregarded when assessing the performance obligations in the customer arrangement.

The Joint Venture has elected to apply the significant financing practical expedient, and as a result, the Joint Venture will not adjust the promised amount of consideration in a customer contract for the effects of a significant financing component when the period of time between when the Joint Venture transfers a promised good or service to a customer and when the customer pays for the good or service will be one year or less.

Apart from the adoption of ASC 606, the Joint Venture believes there have been no other significant changes during the six months ended September 30, 2019 to the items we previously disclosed as our critical accounting estimates in "Management's Discussion and Analysis of Financial Condition and Results of Operations".

Cautionary Notice Regarding Forward-Looking Statements

This Quarterly Report contains "forward-looking statements" within the meaning of federal securities laws. Any statements made in this quarterly report that are not statements of historical fact, including statements about our beliefs and expectations, are forward-looking statements. Forward-looking statements include information concerning possible or assumed future results of operations, including descriptions of our business plans and strategies. These statements often include words such as "anticipate," "expect," "suggest," "plan," "believe," "intend," "estimate," "target," "project," "should," "could," "would," "may," "will," "forecast," "outlook," "potential," "continues," "seeks," "predicts," and the negatives of these words and other similar expressions.

Although we believe that these forward-looking statements are based on reasonable assumptions, you should be aware that factors affecting our actual financial results could cause actual results to differ materially from those expressed in the forward-looking statements. Factors that could materially affect our financial results or such forward-looking statements include, among others, the following factors:

- macroeconomic and industry trends and adverse developments in the debt, consumer credit and financial services markets;
- our ability to provide competitive services and prices while maintaining our margins;
- our ability to retain or renew existing customers and attract new customers;
- our ability to maintain the security and integrity of our data;
- our ability to deliver services timely without interruption;
- our ability to maintain our access to data sources;
- government regulation and changes in the regulatory environment;
- litigation or regulatory proceedings;
- our ability to effectively manage our costs;
- economic and political instability in the United States and international markets where we operate;
- our ability to effectively develop and maintain strategic alliances and joint ventures;
- our ability to timely develop new services and the market's willingness to adopt our new services;
- our ability to manage and expand our operations and keep up with rapidly changing technologies;
- our ability to make acquisitions and integrate the operations of acquired businesses;
- our ability to protect and enforce our intellectual property, trade secrets and other forms of unpatented intellectual property;
- our ability to defend our intellectual property from infringement claims by third parties;
- the ability of our outside service providers and key vendors to fulfill their obligations to us;
- further consolidation in our end-customer markets;
- losses against which we do not insure;
- our ability to make timely payments of principal and interest on our indebtedness;
- our ability to satisfy covenants in the agreements governing our indebtedness;
- our ability to maintain our liquidity;
- our reliance on key management personnel; and
- our controlling stockholders.

There may be other factors, many of which are beyond our control, that may cause our actual results to differ materially from the forward-looking statements, including factors disclosed in the Registration Statement on Form S-1 (No. 333-230345) in the section entitled "Risk Factors" and in the section entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations" in this report. You should evaluate all forward-looking statements made in this report and the other public statements we may make from time to time in the context of these risks and uncertainties.

Our forward-looking statements made herein speak only as of the date on which made. We expressly disclaim any intent, obligation or undertaking to update or revise any forward-looking statements made herein to reflect any change in our expectations with regard thereto or any change in events, conditions or circumstances on which any such statements are based. All subsequent written and oral forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by the cautionary statements contained in this report.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Change Healthcare Inc.

Change Healthcare Inc. holds an equity method investment in the LLC Units of the Joint Venture as well as, following the consummation of the offering of TEUs on July 1, 2019, investments in the amortizing notes and prepaid forward purchase contracts components of the TEUs issued by the Joint Venture. In the case of the equity method investment in the Joint Venture, Change Healthcare Inc. is only exposed to changes in the fair value of the investment to the extent that the changes in fair value are so significant and long-lasting that they represented an other than temporary impairment of the investment. In the case of the investments in the amortizing note and prepaid forward purchase contracts components of the TEUs, however, such investments are required to be remeasured to their respective fair value each quarter with the changes in those values affecting earnings and other comprehensive income of Change Healthcare Inc.

Change Healthcare LLC

The Joint Venture has interest rate risk primarily related to borrowings under the Senior Secured Credit Facilities. Borrowings under the Senior Secured Credit Facilities bear interest at a rate equal to, at the Joint Venture's option, either (i) LIBOR for the relevant interest period, adjusted for statutory reserve requirements (which is subject, in the case of the Term Loan Facility, to a floor of 1.00% per annum and, in the case of the Revolving Credit Facility, to a floor of 0.00% per annum), plus an applicable margin or (ii) a base rate equal to the highest of (a) the rate of interest in effect as publicly announced by the administrative agent as its prime rate, (b) the federal funds effective rate plus 0.50% and (c) adjusted LIBOR for an interest period of one month plus 1.00% (which may be subject, solely in the case of the Term Loan Facility, to a floor of 2.00% per annum), in each case, plus an applicable margin.

As of September 30, 2019, the Joint Venture had borrowings of $3,993.3 million (before unamortized debt discount) under the Senior Secured Credit Facilities. As of September 30, 2019, the LIBOR-based interest rate on the Term Loan Facility and Revolving Credit Facility were each LIBOR plus 2.5%.

The Joint Venture manages economic risks, including interest rate, liquidity and credit risk, primarily by managing the amount, sources and duration of our debt funding and the use of derivative financial instruments. Specifically, the Joint Venture enters into interest rate cap agreements to manage exposures that arise from business activities that result in the receipt or payment of future known and uncertain cash amounts, the value of which are determined by interest rates. The Joint Venture's interest rate cap agreements are used to manage differences in the amount, timing and duration of our known or expected cash receipts and our known or expected cash payments principally related to our borrowings. As of September 30, 2019, the Joint Venture's outstanding interest rate cap agreements were each designated as cash flow hedges of interest rate risk and were determined to be highly effective.

A change in interest rates on variable rate debt may impact the Joint Venture's pretax earnings and cash flows. Based on the Joint Venture's outstanding debt as of September 30, 2019, and assuming that its mix of debt instruments, derivative financial instruments and other variables remain the same, the annualized effect of a one percentage point change in variable interest rates would have an annualized pretax impact on the Joint Venture's earnings and cash flows of approximately $20.9 million.

In the future, in order to manage the Joint Venture's interest rate risk, it may refinance its existing debt, enter into additional interest rate cap agreements, modify its existing interest rate cap agreements or make changes that may impact its ability to treat its interest rate cap agreements as a cash flow hedge. However, the Joint Venture does not intend or expect to enter into derivative or interest rate cap agreement transactions for speculative purposes.

ITEM 4. CONTROLS AND PROCEDURES

Disclosure Controls and Procedures

Change Healthcare Inc.'s management, with the participation of its Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of its disclosure controls and procedures as of the end of the period covered by this report. The term "disclosure controls and procedures" as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act") means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms and that such information is accumulated and communicated to management including the Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely discussions regarding required disclosures.

Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable, not absolute, assurance of achieving their desired control objectives. Based on the evaluation of Change Healthcare Inc.'s disclosure controls and procedures as of the end of the period covered by this report, its Chief Executive Officer and Chief Financial Officer concluded that, as of such date, its disclosure controls and procedures were effective at a reasonable assurance level.

Changes in Internal Control Over Financial Reporting

During the quarter covered by this report, there have been no changes in Change Healthcare Inc.'s internal controls over financial reporting that have materially affected, or are reasonably likely to materially affect, its internal controls over financial reporting.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

Change Healthcare Inc.

In the normal course of business, Change Healthcare Inc. may become subject to various claims and legal proceedings. As of September 30, 2019, Change Healthcare Inc. was not involved in any material pending legal proceedings.

Change Healthcare LLC

The Joint Venture is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

From time to time, the Joint Venture receives subpoenas or requests for information from various government agencies. The Joint Venture generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by the Joint Venture. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Joint Venture and other members of the health care industry, as well as to settlements.

Additionally, in the normal course of business, the Joint Venture is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Joint Venture does not believe that it is reasonably possible that their outcomes will have a material adverse effect on the Joint Venture's consolidated financial position, results of operations or liquidity.

To reduce their exposure to an unexpected significant monetary award resulting from an adverse judicial decision, both Change Healthcare Inc. and Change Healthcare LLC maintain insurance that they believe is appropriate and adequate based on historical experience. Both Change Healthcare Inc. and Change Healthcare LLC advise their insurance carriers of any claims, threatened or pending, against them in the course of litigation and generally receives a reservation of rights letter from the carriers when such claims exceed applicable deductibles.

ITEM 1A. RISK FACTORS

In addition to the other information included in this report, you should carefully consider the factors discussed in "Risk Factors" included in the Registration Statement on Form S-1 (No. 333-230345), as well as the factors identified under "Cautionary Notice Regarding Forward-Looking Statements" at the end of Part I, Item 2 of this Quarterly Report, which could materially affect the Change Healthcare Inc.'s or the Joint Venture's business, financial condition or future results. The risks described in the Registration Statement on Form S-1 and this Quarterly Report are not the only risks Change Healthcare Inc. or the Joint Venture face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition or operating results.

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

None

ITEM 3. DEFAULTS UPON SENIOR SECURITIES

None

ITEM 4. MINE SAFETY DISCLOSURES

None

ITEM 5. OTHER INFORMATION

None

ITEM 6.EXHIBITS

The exhibits listed on the accompanying Exhibit Index are filed, furnished or incorporated by reference (as stated therein) as part of this Quarterly Report.

Exhibit Index

3.1	Amended and Restated Certificate of Incorporation of Change Healthcare Inc., dated as of June 26, 2019 (incorporated by reference to Exhibit 3.1 to the Company's Form 8-K filed on July 2, 2019).
3.2	Amended and Restated Bylaws of Change Healthcare Inc., dated as of June 26, 2019 (incorporated by reference to Exhibit 3.2 to the Company's Form 8-K filed on July 2, 2019).
4.1	Purchase Contract Agreement, dated as of July 1, 2019, between Change Healthcare Inc. and U.S. Bank N.A., as purchase contract agent, as attorney-in-fact for the Holders from time to time as provided therein and as trustee under the indenture referred to therein (incorporated by reference to Exhibit 4.1 to the Company's Form 8-K filed on July 2, 2019).
4.2	Form of Unit (included in Exhibit 4.1).
4.3	Form of Purchase Contract (included in Exhibit 4.1).
4.4	Indenture, dated as of July 1, 2019, between Change Healthcare Inc. and U.S. Bank N.A., as trustee (incorporated by reference to Exhibit 4.4 to the Company's Form 8-K filed on July 2, 2019).
4.5	First Supplemental Indenture, dated as of July 1, 2019, between Change Healthcare Inc. and U.S. Bank N.A., as trustee (incorporated by reference to Exhibit 4.5 to the Company's Form 8-K filed on July 2, 2019).
10.1	Change Healthcare LLC Annual Incentive Plan (AIP) Amended and Restated as of September 18, 2019.
10.2	Change Healthcare LLC U.S. Executive Severance Benefit Guidelines (Amended and Restated September 18, 2019).
31.1	Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended (filed herewith).
31.2	Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended (filed herewith).
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (furnished herewith).
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (furnished herewith).
99.1	Condensed financial information of Change Healthcare LLC as of September 30, 2019 and March 31, 2019, and for the six months ended September 30, 2019 and 2018.
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

Certain agreements and other documents filed as exhibits to this Form10-Q contain representations and warranties that the parties thereto made to each other. These representations and warranties have been made solely for the benefit of the other parties to such agreements and may have been qualified by certain information that has been disclosed to the other parties to such agreements and other documents and that may not be reflected in such agreements and other documents. In addition, these representations and warranties may be intended as a way of allocating risks among parties if the statements contained therein prove to be incorrect, rather than as actual statements of fact. Accordingly, there can be no reliance on any such representations and warranties as characterizations of the actual state of facts. Moreover, information concerning the subject matter of any such representations and warranties may have changed since the date of such agreements and other documents.

SIGNATURES

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

Change Healthcare Inc.

November 14, 2019

By /s/ Neil E. de Crescenzo
Neil E. de Crescenzo
Chief Executive Officer and Director
(Principal Executive Officer)

November 14, 2019

By /s/ Fredrik Eliasson
Fredrik Eliasson
Executive Vice President, Chief Financial Officer
(Principal Financial Officer)

Exhibit 10.1

Change Healthcare LLC
Annual Incentive Plan (AIP)
Amended and Restated as of September 18, 2019

1. **Purpose**. The purpose of the Change Healthcare LLC Annual Incentive Plan (the "Plan") is to provide an incentive to eligible employees of Change Healthcare LLC and its participating subsidiaries (collectively, the "Company") who contribute to the success of the enterprise. The Plan offers eligible employees an opportunity to earn compensation in addition to their base salaries, based upon the performance of the Company (including its Business Units) and their individual performance.

2. **Plan Administration**. The Compensation Committee of the Board of Directors (the "Board") of the Company (the "Committee"), in consultation with the Chief Executive Officer of the Company (the "CEO"), shall administer the Plan. The CEO shall oversee and interpret any and all aspects of the Plan (including the amount payable to any individual participant) and may delegate any responsibilities under the Plan to the Chief People Officer ("CPO") of the Company. The CEO (other than with respect to himself) shall make final recommendations to the Committee regarding both the amount and the timing of any bonus payments pursuant to the Plan. The Committee shall review and approve the CEO's recommendations. If an employee believes that he/she has been paid incorrectly or denied payment incorrectly under the Plan, the employee must provide written notice to the CPO (the "appeal") within thirty (30) days of the date of the incorrect payment or payment refusal. The CEO has the sole unilateral discretion and authority to accept or reject an appeal, whether to modify or make a payment in response to an appeal, to interpret and apply the Plan and any and all language contained in the Plan, and to determine the amount of payment. Any and all decisions made by the CEO are final.

3. **Plan Year**. The Plan shall be effective from April 1 of each fiscal year of the Company through March 31 of such fiscal year (each, a "Plan Year").

4. **Participant Eligibility**. Employees eligible to participate in the Plan generally include regular full-time employees, unless state, local, province, or territorial laws requires additional employee participation, and an eligible employee selected to participate in the Plan is referred to as a "Participant". A Participant must be employed and meet the eligibility criteria before the Participation Deadline to be eligible to participate in the Plan for that year.

Generally, individuals who are ineligible to participate in the Plan include the following:

- Temporary employees, independent contractors and consultants
- Employees located in the United States who do not have a signed Company Protection Agreement on file with the Company
- Anyone not actively employed on the date the Actual Awards are distributed (except as described in this Plan summary)
- Any other employee that does not meet the eligibility criteria above

5. **Annual Incentive Potential**. The target bonus potential ("Annual Incentive Plan or AIP Target Percentage") is calculated as a percentage of the Participant's Annual Base Salary as of the last day of the Plan Year to which the bonus relates. If a Participant no longer participates in the Plan due to a change in job during the Plan Year, the AIP Target Percentage is calculated as a percentage of the Participant's Annual Base Salary as of the last day of the Plan Year on which the individual was a Participant in the Plan. If a Participant changes from full-time to part-time or vice versa during the Plan year, then the AIP Target Percentage is calculated based on the different employment percentages applicable during the Plan Year. The guidelines for determining AIP Target Percentage are based on the level of the job the employee is assigned. These guidelines, however, may be adjusted to reflect the significance, scope and level of accountability for a given job. Adjustments (increases or reductions) to the AIP Target Percentage levels may be made at the discretion of the CEO or the CPO of the Company. Additionally, certain AIP Target Percentage levels are set forth in written employment agreements. As such, these written agreements shall be controlling.

6. **Performance Targets**. The funding and payment of bonuses is based upon performance metrics established by the Committee. Unless and until otherwise specified by the Committee, the three Plan components are the Company Performance Targets, Business Unit Performance Targets and Individual Performance Measures. Calculation of Actual Awards shall be based on the achievement of multiple objectives. Each objective has a threshold, target and a maximum level of performance. For each objective, the bonus payment shall range from zero to a maximum percentage based on the level of performance for that objective.

   a. Company Performance Targets. Payments are contingent upon the Company achieving the Company Performance Targets as shall be set by the Committee within the first ninety days of a Plan Year. If, and when, bonuses are declared, financial calculations shall be made to determine the funding level for Participants based upon the Company Performance Targets.

   b. Business Unit Performance Targets. For those eligible employees whose job responsibilities are primarily related to a particular Business Unit, payments for a portion of the Participant's bonus amount are contingent upon the Business Unit, achieving the applicable Performance Targets as shall be set by the Committee with respect to each Plan Year. If, and when, bonuses are declared, financial calculations shall be made to determine a funding level for each Business Unit.

c. Individual Performance Measures. Each Participant shall have one or more Individual Performance Measures. Individual Performance Measures may be quantitative, qualitative or both. Once the Company and/or the Business Unit have achieved their performance goals, a Participant's Individual Performance Measures, taken as a whole with the Company and/or Business Unit performance, shall determine the amount of the Participant's Actual Award. Individual bonus potential can be greatly impacted by the level of achievement of Individual Performance Measures as determined by each Participant's manager. Actual Awards shall be adjusted, at each Participant's manager's discretion, to reflect the Participant's individual contribution to the achievement of Company Performance Targets and Business Unit Performance Targets and the Participant's Individual Performance Measures. A Participant's manager shall review and approve, modify or disapprove the Actual Award, if any, to be paid to a Participant for the Plan Year, and reserves the right to reduce or increase or eliminate the individual payments determined according to the above method.

7. **Prorations**. If an employee, not previously eligible for participation in the Plan, moves to a job and becomes eligible for participation in the Plan, the employee's Actual Award shall be calculated as a prorated portion of the annual bonus relevant to that Plan Year based upon the employee's first date of eligibility. If a person otherwise eligible for participation in the Plan becomes an employee of the Company during the Plan Year, the employee's Actual Award shall be calculated as a prorated portion of the annual bonus for that Plan Year based upon the employee's first date of employment. If a Participant is transferred to a new job during the Plan Year with a higher or lower AIP Target Percentage, the determination of the Participant's Actual Award shall be calculated based on the two different AIP Target Percentages, prorated for each AIP Target Percentage based on the date of the change in job. If a Participant is transferred to a new job during the Plan Year with a higher or lower Business Unit Performance Target, the determination of the Participant's Actual Award shall be calculated based on the different Performance Targets, prorated for each Business Unit Performance Target, based on the date of the change in job within that Plan Year. If a Participant no longer participates in the Plan due to a change in job during the Plan Year, the employee shall be eligible to receive a prorated award based on the period of participation in the Plan; provided, that the employee must continue to meet the "Conditions For Receiving Payment" set forth below. Such prorated award shall be paid at the same time as awards are made to other Participants under the Plan.

8. **Payout and Taxation**. The Company anticipates any bonus amounts earned under the Plan for each Plan Year shall be paid in a lump sum around June of the year following that Plan Year after completion of audited financial statements for the Plan Year and final executive and Committee approval but in any event, bonus amounts earned under the Plan, if any, shall be paid prior to March 15 of the calendar year following the end of the Plan Year to which such bonus amounts relate. Specific provisions regarding distribution

are outlined below under the "Conditions for Receiving Payment" section of the Plan. Payroll taxes shall be withheld from the bonus award, or remitted to tax authorities, subject to and in accordance with law. Actual Awards that Participants receive shall be reported as income in the year in which they are paid, in accordance with applicable law.

9. **Conditions for Receiving Payment**. No Actual Awards under this Plan shall be paid to any Participant if employment is terminated, whether voluntary or involuntary, prior to the actual payment distribution date, except as described in Section 10 of this Plan summary or to the extent required by applicable law. However, the Company retains the authority to make exceptions to the foregoing policy in unusual or meritorious cases including, but not limited to, the death of a Participant during the Plan Year, termination of employment due to total or partial disability, call to active military service or retirement with the written consent of the Company. For clarity, a Participant **is** considered an active employee of the Company during any notice period, whether based on a written employment agreement, the applicable local employment or labor laws, or the common or civil law ("Notice Period") if the Participant continues working during the Notice Period, regardless of why that Participant's employment is terminated. However, if a Participant receives a payment in lieu of notice, instead of working during the Notice Period, the employee will not be considered an active employee during the Notice Period and the last day worked is considered the termination date for purposes of the Plan.

10. **Effect of Termination of Employment**. Except as expressly set forth in this section, a Participant must be an active employee of the Company on the date the Actual Awards are distributed to Participants to be eligible to receive any payment under the Plan.

    a. **Death or Long-Term Disability**. If a Participant's employment is terminated by the Company due to death or Long-Term Disability during the Plan Year, the Participant shall be entitled to receive a prorated portion of the Actual Award, with proration based on the date of termination of employment within the Plan Year.

    b. **Retirement**. If a Participant's employment is terminated due to Retirement on or after the Participation Deadline, the Participant shall be entitled to receive a prorated portion of the Actual Award, with proration based on the date of termination of employment within the Plan Year.

    c. **Other Qualifying Terminations**. If a Participant's employment is terminated due to a Qualifying Termination on or after the Participation Deadline, the Participant shall be entitled to receive a prorated portion of the Actual Award, with proration based on the date of termination of employment within the Plan Year.

11. **Limitations and/or Adjustments**. Payment of an Actual Award under the Plan is not an integral part of a Participant's compensation package. A Participant's base salary compensates them for the expected results of any given job role within the Company. Payment of an Actual Award is at the discretion of the Company. For the avoidance of doubt, the Plan is discretionary by nature, and unless the provincial labor/employment standards legislation applicable in the province of employment where the Participant works requires otherwise in the specific circumstance, awards made under the Plan shall not be deemed a portion of a Participant's compensation for any purpose whatsoever, including without limitation, when calculating a Participant's entitlements to termination pay, severance pay or other amounts payable upon termination of employment. Participation in a Plan Year does not guarantee payment of an award under the Plan for that Plan Year and Participation in one Plan Year does not guarantee participation in any subsequent Plan Year. The Company reserves the right to review, amend, suspend and/or terminate the Plan, the incentive calculation formulas and all other aspects of the Plan at any time. Plan changes shall be based on a determination of the Company's business needs and do not require prior notification or explanation to Participants. A Participant's participation in the Plan shall not be construed as an employment contract or as a promise of continuing employment between the Company and the Participant. Employment with the Company is terminable at will, unless an employment contract or state, local, province, or territorial laws requires otherwise.

12. **Active Employment Eligibility**. If a Participant takes any type of approved leave of absence for less than (12) consecutive weeks during the Plan Year, this period of time will be included in the calculation of the award. If a Participant takes any type of approved leave of absence for (12) consecutive weeks during the Plan Year or more, the period of time in excess of (12) weeks will not be considered in the Participant's Actual Award calculation, unless an employment contract or state, local, province, or territorial laws requires otherwise.

13. **Section 409A**. The payments made under this Plan to Participants subject to U.S. taxes are intended be exempt from with Section 409A of the Internal Revenue Code of 1986, as amended, and applicable guidance issued thereunder ("Section 409A"). Payments made under this Plan shall be interpreted and construed to be distributed in the short-term deferral period, as defined under Treasury Regulation section 1.409A-1(b)(4). Notwithstanding any provision of this Plan to the contrary, this Plan shall be interpreted and construed consistent with the terms set forth in this Section 13, provided that the Company shall not be required to assume any increased economic burden in connection therewith. Although the Company intends to administer this Plan so that it shall be exempt from the requirements of Section 409A, the Company does not represent or warrant that this Plan shall be exempt from Section 409A or any other provision of federal, state, local, or non-United States law. The Company, or either of its directors, officers, employees or advisers shall not be liable to the Participant (or any other individual claiming a benefit through the Participant) for any tax, interest, or penalties the Participant may owe as a result of compensation paid under this Plan, and shall have no obligation to indemnify or otherwise protect the Participant from the obligation to pay any taxes pursuant to Section 409A.

14. **Clawback**. Any payment made under this Plan shall be subject to reduction, cancellation, forfeiture or recoupment to the extent necessary to comply with (i) any clawback, forfeiture or similar policy adopted by the Company, whether in existence as of the effective date of the Plan or later adopted by the Company) and (ii) any applicable law or government regulation. Further, unless otherwise determined by the Committee, to the extent that the Participant receives any amount in excess of the amount that the Participant should otherwise have received under the terms of the Plan for any reason (including, without limitation, by reason of a financial restatement, mistake in calculations or other administrative error), the Participant shall be required to repay any such excess amount to the Company. The Company will make any determination for clawback, forfeiture or recovery in its sole discretion and in accordance with any applicable law, government regulation or Company policy, as applicable. By participating in this Plan the Participant consents to such deductions being made by the Company.

15. **Change in Control**. In connection with a Change in Control, the Committee shall have the discretion to make changes to the Plan and awards hereunder as the Committee, in its sole discretion, deems to be equitable and appropriate.

16. **Definitions**.

    a. "Actual Award" means the finally determined amount payable to a Participant under the Plan for a Plan Year.

    b. "Affiliate" means any Person that directly or indirectly controls, is controlled by, or is under common control with Change Healthcare Inc. The term "control" (including, with correlative meaning, the terms "controlled by" and "under common control with"), as applied to any Person, means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting or other securities, by contract, or otherwise.

    c. "Annual Base Salary" means annual rate of pay as of the last day of the Plan year for exempt Participants. Fornon-exempt Participants, this is the hourly rate of pay annualized for the number of hours worked during the Plan Year.

    d. "Change in Control" means (i) the acquisition (whether by purchase, merger, consolidation, combination, or other similar transaction) by any Person of beneficial ownership (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of more than 50% (on a fully diluted basis) of either (A) the then-outstanding

shares of Common Stock, taking into account as outstanding for this purpose such Common Stock issuable upon the exercise of options or warrants, the conversion of convertible stock or debt, the exchange of exchangeable stock or units, and the exercise of any similar right to acquire such Common Stock; or (B) the combined voting power of the then-outstanding voting securities of Change Healthcare Inc. entitled to vote generally in the election of directors, in the case of each of the foregoing clauses (A) and (B) assuming that all Units (as defined in the Company LLC Agreement) held by MCK Members (as defined in the Company LLC Agreement) had been exchanged for an equal number of shares of Common Stock; provided, however, that for purposes of the Plan, the following acquisitions shall not constitute a Change in Control: (I) any acquisition by Change Healthcare Inc. or any Affiliate; (II) any acquisition by any employee benefit plan sponsored or maintained by Change Healthcare Inc. or any Affiliate; or (III) any acquisition in connection with a Qualified MCK Exit (as defined in the Company LLC Agreement); (ii) during any period of 12 months, individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason to constitute at least a majority of the Board; provided, that any Person becoming a director subsequent to the effective date of the Plan, whose election or nomination for election was approved by a vote of at least two-thirds of the Incumbent Directors then on the Board (either by a specific vote or by approval of the proxy statement of Change Healthcare Inc. in which such Person is named as a nominee for director, without written objection to such nomination) shall be an Incumbent Director; provided, however, that no individual initially elected or nominated as a director of the Company as a result of an actual or threatened election contest, as such terms are used in Rule 14a-12 of Regulation 14A promulgated under the Exchange Act, with respect to directors or as a result of any other actual or threatened solicitation of proxies or consents by or on behalf of any Person other than the Board shall be deemed to be an Incumbent Director; or (iii) the sale, transfer, or other disposition of all or substantially all of the assets of Change Healthcare Inc. and the Company (taken as a whole) to any Person that is not an Affiliate of Change Healthcare Inc. or the Company.

e. "Common Stock" means the common stock of Change Healthcare Inc., par value $0.001 per share (and any stock or other securities into which such Common Stock may be converted or into which it may be exchanged).

f. "Company LLC Agreement" means the Third Amended and Restated Limited Liability Company Agreement of Change Healthcare LLC, dated as of March 1, 2017.

g. "Exchange Act" means the Securities Exchange Act of 1934, as amended, and any successor thereto. Reference in the Plan to any section of (or rule promulgated under) the Exchange Act shall be deemed to include any rules, regulations, or other interpretative guidance under such section or rule, and any amendments or successor provisions to such section, rules, regulations, or guidance.

h. "Long-Term Disability" shall mean the Company or its affiliates having cause to terminate a Participant's employment or service on account of "disability," as defined in any written employment agreement then in effect between the Participant and the Company or an affiliate, or in the absence of such an agreement, a condition entitling the Participant to receive benefits under a long-term disability plan of the Company or an affiliate or, in the absence of such a plan, the complete and permanent inability by reason of illness or accident to perform the duties of the occupation at which a Participant was employed or served when such disability commenced or, as determined by the Company based upon medical evidence acceptable to it.

i. "Participation Deadline" with respect to a Plan Year shall mean January 1 of the Plan Year.

j. "Person" means any individual, entity, or group (within the meaning of Section 13(d)(3) or 14(d)(2) of the Exchange Act).

k. "Qualifying Termination" means a termination of employment eligible to receive benefits under the Company's Severance Guidelines or Executive Severance Guidelines in accordance with the terms and conditions of such guidelines as may be amended from time to time.

l. "Retirement" means, unless otherwise set forth in an employment agreement with a Participant or specifically defined under local law for the purposes of payment of compensation for services, termination from the Company with age of at least 65.

17. **Governing Law**. For employees on U.S. payroll, the laws of the state of Tennessee shall govern all questions concerning the construction, validity and interpretation of the Plan, without regard to the state of Tennessee's conflict of laws rules.

For International employees, the laws of the country where the Participant permanently resides shall govern all questions concerning the construction, validity and interpretation of the Plan, without regard to the Country of Residence's conflict of laws rules.

Exhibit 10.2

CHANGE HEALTHCARE LLC
U.S. EXECUTIVE SEVERANCE BENEFIT GUIDELINES

(AMENDED AND RESTATED SEPTEMBER 18, 2019)

1. INTRODUCTION.

The terms of the Change Healthcare LLC Executive Severance Benefit Guidelines (the "***Guidelines***") are set forth below. The purpose of the Guidelines is to provide a framework to be used in the event that any of the Change Healthcare LLC, Participating Companies (collectively, the "***Company***") decides to award severance to Eligible Executives who have a Qualifying Termination and who do not have a contractual entitlement to Severance Benefits. The determination as to which Executive is eligible to receive Severance Benefits in the event of a Qualifying Termination is within the Company's sole discretion. The Company may amend, modify or terminate these Guidelines at any time with or without notice to Executives, including without limitation the right to establish Severance Benefits on an action by action basis in its sole discretion.

2. EFFECTIVE DATE.

These Guidelines are effective as of February 1, 2018. These Guidelines supersede any plan, program, guidelines, policy or arrangements previously in effect for the Executives by which Severance Benefits would be provided by the Company, with the exception of Executives who have entered into an individual employment agreement with the Company that provides for Severance Benefits.

3. ELIGIBILITY FOR SEVERANCE BENEFITS.

(a) **General Rules**. An executive of the Company in the executive career band "E", who is a U.S. Eligible Paid Executive is entitled to receive Severance Benefits, subject to the conditions and requirements set forth in these Guidelines. These guidelines do not apply to the Chief Executive Officer.

(b) **Definitions.** The following definitions shall apply to these Guidelines:

(i) **"Affiliate"** means any Person that directly or indirectly controls, is controlled by, or is under common control with Change Healthcare Inc. The term "control" (including, with correlative meaning, the terms "controlled by" and "under common control with"), as applied to any Person, means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting or other securities, by contract, or otherwise.

(ii) **"Cause"** means the following: (A) the Executive's violation of any federal or state law or regulation applicable to the business of the Company or its affiliates; (B) the Executive being convicted of, or entering a plea of nolo contendere to any crime or committing any act of moral turpitude; (C) the Executive engaging in any act of dishonesty, fraud or misrepresentation; (D) the breach of any agreement between the Executive and the Company (or any affiliate of the Company), including but not limited to a breach of a restrictive covenant agreement; (E) the Executive's habitual or willful neglect of duties; (F) the Executive's breach of any duties owed to the Company, including but not limited to fiduciary duty and duty of care; or (G) the Executive's failure to perform his or her assigned duties or responsibilities (other than a failure resulting from the Executive's disability) after notice thereof from the Company describing the Executive's failure to perform such duties or responsibilities. Notwithstanding the foregoing, if "Cause" is defined in an employment agreement between the Company and Executive then the meaning of "Cause" in the employment agreement shall apply.

(iii) **"Change in Control**" means (i) the acquisition (whether by purchase, merger, consolidation, combination, or other similar transaction) by any Person of beneficial ownership (within the meaning of Rule 13d-3 promulgated under the Exchange Act) of more than 50% (on a fully diluted basis) of either (A) the then-outstanding shares of Common Stock, taking into account as outstanding for this purpose such Common Stock issuable upon the exercise of options or warrants, the conversion of convertible stock or debt, the exchange of exchangeable stock or units, and the exercise of any similar right to acquire such Common Stock; or (B) the combined voting power of the then outstanding voting securities of Change Healthcare Inc. entitled to vote generally in the election of directors, in the case of each of the foregoing clauses (A) and (B) assuming that all Units (as defined in the Company LLC Agreement) held by MCK Members (as defined in the Company LLC Agreement) had been exchanged for an equal number of shares of Common Stock; provided, however, that for purposes of the Plan, the following acquisitions shall not constitute a Change in Control: (I) any acquisition by Change Healthcare Inc. or any Affiliate; (II) any acquisition by any employee benefit plan sponsored or maintained by Change Healthcare Inc. or any Affiliate; or (III) any acquisition in connection with a Qualified MCK Exit (as defined in the Joint Venture LLC Agreement); (ii) during any period of 12 months, individuals who, at the beginning of such period, constitute the Board of Directors of Change Healthcare Inc. (the "***Board***," the "***Incumbent Directors***") cease for any reason to constitute at least a majority of the Board; provided, that any Person becoming a director subsequent to the Effective Date, whose election or nomination for election was approved by a vote of at least two-thirds of the Incumbent Directors then on the Board (either by a

specific vote or by approval of the proxy statement of Change Healthcare Inc. in which such Person is named as a nominee for director, without written objection to such nomination) shall be an Incumbent Director; provided, however, that no individual initially elected or nominated as a director of the Company as a result of an actual or threatened election contest, as such terms are used in Rule 14a-12 of Regulation 14A promulgated under the Exchange Act, with respect to directors or as a result of any other actual or threatened solicitation of proxies or consents by or on behalf of any Person other than the Board shall be deemed to be an Incumbent Director; or (iii) the sale, transfer, or other disposition of all or substantially all of the assets of Change Healthcare Inc. and the Company (taken as a whole) to any Person that is not an Affiliate of Change Healthcare Inc. or the Company.

(iv) **"COBRA Continuation"** means the continuation of medical, dental and/or vision benefits under the Company-sponsored group health plan that an Executive who is enrolled in such group health plan may elect pursuant to the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly known as COBRA).

(v) **"COBRA Subsidy"** means, subject to the Eligible Executive being eligible to elect COBRA Continuation coverage, the Company's payment, in lump sum, of the amount equal to the cost of such Eligible Executive's COBRA Continuation premiums that the Company and Eligible Executive would pay if he or she elects COBRA Continuation for the number of months specified in Schedule A, as attached to these Guidelines.

(vi) **"Code"** means the Internal Revenue Code, as amended from time to time.

(vii) "**Common Stock**" means the common stock of Change Healthcare Inc., par value $0.001 per share (and any stock or other securities into which such Common Stock may be converted or into which it may be exchanged).

(viii) **"Company"** means Change Healthcare LLC.

(ix) "**Company LLC Agreement**" means the Third Amended and Restated Limited Liability Company Agreement of Change Healthcare LLC, dated as of March 1, 2017.

(x) "**Comparable Employment**" means a position with the Company that is similar in job authority, duties, reporting structure, responsibilities, and is located within 50 miles of the Executive's current worksite or with a relocation package; and with a salary equal to or greater than the Executive's current salary.

(xi) **"Eligible Executive"** means an Executive of the Company who has a Qualifying Termination. It is within the sole discretion of the Company to determine whether an Executive is an Eligible Executive.

(xii) **"Exchange Act"** means the Securities Exchange Act of 1934, as amended, and any successor thereto. Reference in the Guidelines to any section of (or rule promulgated under) the Exchange Act shall be deemed to include any rules, regulations, or other interpretative guidance under such section or rule, and any amendments or successor provisions to such section, rules, regulations, or guidance.

(xiii) **"Executive"** means an employee of the Company it the E Compensation Grade.

(xiv) **"Guidelines**" means these Change Healthcare LLC Executive Severance Benefits Guidelines, as amended from time to time.

(xv) "**Participating Companies"** means any subsidiary or affiliate of Change Healthcare LLC, that is owned by no less than an 80% interest by Change Healthcare LLC, or any of its subsidiaries.

(xvi) **"Person"** means any individual, entity, or group (within the meaning of Section 13(d)(3) or 14(d)(2) of the Exchange Act).

(xvii) **"Qualifying Termination"** means that the Company involuntarily terminates without Cause the employment of an Executive, or any other constructive termination that the Executive and the Company have agreed constitutes a Qualifying Termination. It is within the sole discretion of the Company to determine whether a termination is a Qualifying Termination.

(xviii) **"Release"** means a waiver and release in favor of the Company and on the form provided by the Company. The waiver and release will apply to all claims, known and unknown, relating to the Executive's employment with the Company through and including the date of execution. The contents of the general release will vary, depending on the state in which the affected Executive resides, the age of the Executive, and whether two or more employees are affected by the same action.

(xix) **"Severance Benefits"** means the amount of payments that an Eligible Executive may receive under these Guidelines.

(c) **Eligibility.** In order to be eligible to receive Severance Benefits under these Guidelines, an Eligible Executive must not fall under one of the exceptions, as set forth in Section 3(d) of these Guidelines, and fulfill the following:

(i) be actively employed until his or her date of termination as scheduled by the Company unless otherwise indicated by the Company.

(ii) must execute and return a Release in accordance with the time periods set forth in the release agreement.

(d) **Exceptions**. An Executive who otherwise is an Eligible Executive will not receive Severance Benefits in any of the following circumstances:

(i) The Executive has executed an individually negotiated employment contract or agreement with the Company, which includes the provision of Severance Benefits upon his or her termination. Such Executive's Severance Benefits, if any, shall be governed by the terms of such individually negotiated employment contract or agreement. If these Guidelines would provide the Executive more benefits than the Executive's individual agreement, the Company may, at its sole discretion, offer the Executive the amount set forth herein;

(ii) The Executive voluntarily terminates employment with the Company. Voluntary terminations include, but are not limited to, resignation and retirement;

(iii) The Executive rejects an offer of Comparable Employment with the Company;

(iv) In connection with a Change in Control between the Company and another entity, the surviving entity (a "***Successor Employer***") employs Executive for the period of time outlined in Schedule A as attached to these Guidelines, after the Change in Control in the same position as he or she held immediately prior to the Change in Control or offers Comparable Employment to Executive.

If, during any period, the Company has not regarded an individual as an employee of the Company and, for that reason, has not withheld employment taxes with respect to that individual, then that individual shall not be an Eligible Executive for that period, even in the event that the individual is determined, retroactively, to have been an employee of the Company during all or any portion of that period.

4. AMOUNT OF SEVERANCE BENEFITS.

Schedule A, attached to these Guidelines, sets forth the amount of the Severance Benefits that an Eligible Executive may receive pursuant to these Guidelines.

5. EQUITY.

When the Eligible Executive terminates employment, any outstanding stock options, restricted stock units or other equity grants will be treated as set forth in the applicable equity incentive plan and award agreements and/or any other related documents.

6. OTHER EMPLOYMENT BENEFITS.

(a) **COBRA Continuation**. Each Eligible Executive who is enrolled in a Company-sponsored health, dental or vision plan will be eligible for COBRA Continuation coverage. The Company will notify the individual of any such right to continue health coverage.

(b) **Other Employee Benefits**. All non-health benefits (such as life insurance and disability coverage) will terminate as of the Executive's last day of being physically present on the job, the last day of active employment with the Company, or the date of termination, as determined by the applicable plan documents and/or the Company in its sole discretion (except to the extent that the Executive elects and pays for any conversion privilege available). The Executive's right to benefits under the Company's 401(k) plan shall be determined exclusively by the plan and any of its related agreements.

(c) **Coordination with Other Plans.** Any Severance Benefits payable to the Eligible Executive under these Guidelines will not be counted as compensation for purposes of determining benefits under any other benefit policies or plans of the Company, except to the extent expressly provided therein.

7. TIME AND FORM OF PAYMENT.

Subject to the terms and conditions set forth in these Guidelines, Severance Benefits will be paid in a single lump sum on the first payroll date following the effective date of the Release, except as otherwise provided in Schedule A, as attached to these Guidelines. No Severance Benefits will be paid or provided until the expiration of any applicable revocation period. In no event will any Severance Benefits be paid or provided under these Guidelines if the Release does not become effective by fifteen (15) days prior to (i) the end of the short-term deferral period as defined in Treasury Regulation § 1.409A-1(b)(4) or (ii) the end of the second calendar year following the year in which the separation occurs, if the Severance Benefits are less than the maximum amount provided under Treasury Regulation § 1.409A-1(b)(9)(iii)(A).

8. NON-DUPLICATION OF BENEFITS.

There will be no duplication of severance benefits that the Company or any of its affiliates pay or provide to the Eligible Executive, and that the Severance Benefits provided under these Guidelines are in lieu of any severance benefits for which the Eligible Executive might otherwise have been eligible under any plan, program, guidelines, policy or arrangement of the Company or any of its affiliates. To the extent necessary to avoid duplication of benefits, Severance Benefits paid or provided under these Guidelines will be reduced to offset severance benefits paid or provided to the Eligible Executive under any other plan, program, guidelines, policy or arrangement of the Company or any of its affiliates. Notwithstanding the foregoing, an Executive who has an employment agreement, in effect with the Company at the time of his or her termination of employment, that provides for severance payments and/or benefits shall not be eligible to be an Eligible Executive and shall not receive any Severance Benefits under these Guidelines.

9. NOTICE.

The Company may give at least two (2) weeks'non-working notice in advance of termination at the Company's sole discretion. If the effective date of the termination is immediate, then the Company may pay the Eligible Executive(s) an amount equal to two (2) weeks' salary in lieu of notice. However, the provision of notice and/or notice pay is at the Company's sole discretion, unless notice and/or notice pay is required by applicable law.

10. NO IMPLIED EMPLOYMENT CONTRACT.

Nothing in these Guidelines shall be deemed (a) to give any Executive any right to be retained in the employ of the Company, or (b) to interfere with the right of the Company to discharge any Executive at any time and for any reason, which right is hereby reserved. Nothing contained in these Guidelines alters or amends an Executive's status as an at-will employee. As an at-will employee, either the Executive or the Company may terminate the employment relationship with or without cause, with or without advance notice.

11. REEMPLOYMENT.

If an Eligible Executive receives Severance Benefits pursuant to these Guidelines and is subsequently reemployed by the Company in reasonably Comparable Employment, such Eligible Executive shall be obligated to repay the Company any portion of Severance Benefits received that is in excess of the time the he or she was separated from the Company. For purposes of determining the repayment obligation, the Severance Benefits shall be converted to a "***Weekly Benefit Amount***," which shall be calculated by dividing the Severance Benefits paid by the number of weeks of base salary payments that the Eligible Executive received as set forth in Schedule A, as attached to these Guidelines. The Weekly Benefit Amount multiplied by the number of whole weeks the Eligible Executive was separated from the Company shall be deducted from the total amount of Severance Benefits paid, and such Eligible Executive shall repay to the Company the difference between the two amounts.

12. Section 280G of the Code.

(a) Notwithstanding any other provision of these Guidelines or any other plan, arrangement or agreement to the contrary, if any of the payments or benefits provided or to be provided by the Company or its affiliates to the Eligible Executive or for the Eligible Executive's benefit pursuant to the terms of these Guidelines or otherwise ("***Covered Payments***") constitute parachute payments ("***Parachute Payments***") within the meaning of Section 280G of the Code and would, but for this Section 12 be subject to the excise tax imposed under Section 4999 of the Code (or any successor provision thereto) or any similar tax imposed by state or local law or any interest or penalties with respect to such taxes (collectively, the "***Excise Tax***"), then prior to making the Covered Payments, a calculation shall be made comparing (i) the Net Benefit (as defined below) to the Eligible Executive of the Covered Payments after payment of the Excise Tax to (ii) the Net Benefit to the Executive if the Covered Payments are limited to the extent necessary to avoid being subject to the Excise Tax. Only if the amount calculated under (i) above is less than the amount under (ii) above will the Covered Payments be reduced to the minimum extent necessary to ensure that no portion of the Covered Payments is subject to the Excise Tax (that amount, the "***Reduced Amount***"). "***Net Benefit***" shall mean the present value of the Covered Payments net of all federal, state, local, foreign income, employment and excise taxes.

(b) Any such reduction shall be made in accordance with Section 409A of the Code and the following:

(i) the Covered Payments which do not constitute nonqualified deferred compensation subject to Section 409A of the Code shall be reduced first; and

(ii) all other Covered Payments shall then be reduced as follows: (A) cash payments shall be reduced beforenon-cash payments; and (B) payments to be made on a later payment date shall be reduced before payments to be made on an earlier payment date.

(c) Any determination required under this Section 12, including whether any payments or benefits are parachute payments, shall be made by the Company (or an accounting firm that the Company selects) in its sole discretion. The Eligible Executive shall provide the Company with such information and documents as the Company may reasonably request in order to make a determination under this Section 12. The Company's determination shall be final and binding on the Eligible Executive.

(d) It is possible that after the determinations and selections made pursuant to this Section 12 the Eligible Executive will receive Covered Payments that are in the aggregate more than the amount provided under this Section 12 ("***Overpayment***") or less than the amount provided under this Section 12 ("***Underpayment***").

(i) In the event that: (A) the Company determines, based upon the assertion of a deficiency by the Internal Revenue Service against either the Company or the Eligible Executive which the Company believes has a high probability of success, that an Overpayment has been made or (B) it is established pursuant to a final determination of a court or an Internal Revenue Service proceeding that has been finally and conclusively resolved that an Overpayment has been made, then the Eligible Executive shall pay any such Overpayment to the Company together with interest at the applicable federal rate (as defined in Section 7872(f)(2)(A) of the Code) from the date of the Eligible Executive's receipt of the Overpayment until the date of repayment.

(ii) In the event that: (A) the Company, based upon controlling precedent or substantial authority, determine that an Underpayment has occurred or (B) a court of competent jurisdiction determines that an Underpayment has occurred, any such Underpayment will be paid promptly by the Company to or for the benefit of the Eligible Executive together with interest at the applicable federal rate (as defined in Section 7872(f)(2)(A) of the Code) from the date the amount would have otherwise been paid to the Eligible Executive until the payment date.

(e) Notwithstanding the foregoing, the Company in its sole discretion may choose to put the Parachute Payments to a shareholder vote in accordance with Section 280G(b)(5)(B) and the regulations promulgated thereunder.

13. GENERAL PROVISIONS.

(a) **Severability.** The invalidity or unenforceability of any provision of these Guidelines shall not affect the validity or enforceability of any other provision of the Guidelines. If any provision of these Guidelines is held by a court of competent jurisdiction to be illegal, invalid, void or unenforceable, such provision shall be deemed modified, amended and narrowed to the extent necessary to render such provision legal, valid, and enforceable, and the other remaining provisions of these Guidelines shall not be affected but shall remain in full force and effect.

(b) **Headings and Subheadings.** Headings and subheadings contained in these Guidelines are intended solely for convenience and no provision of these Guidelines is to be construed by reference to the heading or subheading of any section or paragraph.

(c) **Unfunded Obligations.** The amounts to be paid to Eligible Executives under these Guidelines are unfunded obligations of the Company. The Company is not required to segregate any monies or other assets from its general funds with respect to these obligations. Eligible Executives shall not have any preference or security interest in any assets of the Company other than as a general unsecured creditor.

(d) **Successors.** These Guidelines will be binding upon any successor to the Company, its assets, its businesses or its interest, in the same manner and to the same extent that the Company would be obligated under the Guidelines if no succession had taken place. In the case of any transaction in which a successor would not by the foregoing provision or by operation of law be bound by these Guidelines, the Company shall require any successor to the Company to expressly and unconditionally assume these Guidelines in writing and honor the obligations of the Company hereunder, in the same manner and to the same extent that the Company would be required to perform if no succession had taken place. All payments and benefits that become due to an Eligible Executive under these Guidelines will inure to the benefit of his or her heirs, assigns, designees, or legal representatives.

(e) **Transfer and Assignment.** Neither an Eligible Executive nor any other person shall have any right to sell, assign, transfer, pledge, anticipate or otherwise encumber, transfer, hypothecate or convey any amounts payable under these Guidelines prior to the date that such amounts are paid, except that, in the case of an Eligible Executive's death, such amounts shall be paid to his or her estate.

(f) **Waiver.** Any party's failure to enforce any provision or provisions of these Guidelines will not in any way be construed as a waiver of any such provision or provisions, nor prevent any party from thereafter enforcing each and every other provision of the Guidelines.

(g) **Governing Law.** To the extent not pre-empted by federal law, these Guidelines shall be construed in accordance with and governed by the laws of Tennessee without regard to conflicts of law principles.

(h) **Clawback.** Any payment made under the Guidelines shall be subject to reduction, cancellation, forfeiture or recoupment to the extent necessary to comply with (i) any clawback, forfeiture or similar policy adopted by Change Healthcare Inc., whether in existence as of the Effective Date or later adopted by Change Healthcare Inc.) and (ii) any applicable law or government regulation. Further, unless otherwise determined by the Compensation Committee of Change Healthcare Inc., to the extent that the Participant receives any amount in excess of the amount that the Participant should otherwise have received under the terms of the Guidelines for any reason (including, without limitation, by reason of a financial restatement, mistake in calculations or other administrative error), the Participant shall be required to repay any such excess amount to Change Healthcare Inc. Change Healthcare Inc. will make any determination for clawback, forfeiture or recovery in its sole discretion and in accordance with any applicable law, government regulation or Change Healthcare Inc. policy, as applicable. By participating in these Guidelines the Participant consents to such deductions being made by Change Healthcare Inc.

(i) **Withholding.** The Company shall have the right to withhold from any amount payable hereunder any Federal, state, and local taxes in order for the Company to satisfy any withholding tax obligation it may have under any applicable law or regulation.

(j) **Section 409A of the Code.**

(i) These Guidelines are intended to comply with Section 409A of the Code or an exemption thereunder and shall be construed and administered in accordance with Section 409A of the Code. Notwithstanding any other provision of the Guidelines, payments provided under the Guidelines may only be made upon an event and in a manner that complies with Section 409A of the Code or an applicable exemption. Any payments under the Guidelines that may be excluded from Section 409A of the Code either as separation pay due to an involuntary separation from service or as a short-term deferral shall be excluded from Section 409A of the Code to the maximum extent possible. For purposes of Section 409A of the Code, each installment payment or benefit provided under the Guidelines shall be treated as a separate payment. Any payments subject to and not exempt from Section 409A is to be made under the Guidelines upon a termination of employment shall only be made upon a “separation from service” under Section 409A of the Code. Although the Company intends to administer these Guidelines so that they shall comply with the requirements of 409A, the

Company does not represent or warrant that these Guidelines shall comply with Section 409A or any other provision of federal, state, local or non-United States law. The Company, or either of its directors, officers, employees or advisers shall not be liable for all or any portion of any taxes, penalties, interest, or other expenses that may be incurred by a Eligible Executive as a result of compensation paid under the Guidelines, and shall have no obligation to indemnify or otherwise protect an Eligible Executive from the obligation to pay any taxes pursuant to Section 409A.

(ii) Notwithstanding any other provision of the Guidelines, if any payment or benefit provided to an Eligible Executive in connection with his or her Qualifying Termination is determined to constitute "nonqualified deferred compensation" within the meaning of Section 409A of the Code and the Eligible Executive is determined to be a "specified employee" as defined in Section 409A(a)(2)(b)(i) of the Code, then such payment or benefit shall not be paid until the first payroll date to occur following the six-month anniversary of the Qualifying Termination or, if earlier, on the Eligible Executive 's death (the "***Specified Employee Payment Date***"). The aggregate of any payments that would otherwise have been paid before the Specified Employee Payment Date shall be paid to the Eligible Executive in a lump sum on the Specified Employee Payment Date and thereafter, any remaining payments shall be paid without delay in accordance with their original schedule. Notwithstanding any other provision of the Guidelines, if any payment or benefit is conditioned on the Eligible Executive's execution of a Release, the first payment shall include all amounts that would otherwise have been paid to the Eligible Executive during the period beginning on the date of the Qualifying Termination and ending on the payment date if no delay had been imposed. If the consideration and revocation period of the Release crosses over two (2) calendar years, then the Severance Benefits shall be paid or begin being paid (taking the preceding sentence into effect), on the later of (A) the first payroll date in the second calendar year, or (B) the first payroll date following the effective date of the Release.

(iii) To the extent required by Section 409A of the Code, each reimbursement orin-kind benefit provided under the Guidelines shall be provided in accordance with the following: (A) the amount of expenses eligible for reimbursement, or in-kind benefits provided, during each calendar year cannot affect the expenses eligible for reimbursement, or in-kind benefits to be provided, in any other calendar year; and (B) any right to reimbursements or in-kind benefits under the Guidelines shall not be subject to liquidation or exchange for another benefit.

SCHEDULE A

Severance Benefits Schedule

U.S Executives (excluding the Chief Executive Officer) in the Executive "E"Career Band

Qualifying Termination Not in Connection with a Change in Control

Base: Eligible Executive shall be eligible to receive a lump sum payment equivalent to twelve (12) months of base salary in effect on the date of the Qualifying Termination.

COBRA Subsidy: Eligible Executive shall be eligible to receive payment of, in lump sum, an amount equivalent to the COBRA health insurance premiums that the Company and Eligible Executive would pay for employees with similar coverage during the twelve (12) month period following Eligible Executive's termination.

Qualifying Termination in Connection with a Change in Control

If Eligible Executive's Qualifying Termination occurs upon a Change in Control, or within twelve (12) months after a Change in Control, Eligible Executive shall be eligible to receive a lump sum payment equivalent to the sum of:

- Twelve (12) months of base salary in effect on the date of the Qualifying Termination;
- The bonus Eligible Executive would have received under the Annual Incentive Plan ("AIP") in effect at the time of such Qualifying Termination, at one times the Eligible Executive's full target payout rate for the year in which the Qualifying Termination occurs; and
- The COBRA health insurance premiums that the Company and Eligible Executive would pay for employees with similar coverage during the twelve (12) month period following Eligible Executive's termination;

provided, however, that (i) the sum of the above-described benefits payable to Eligible Executive in connection with a Change in Control may be subject to reduction as described in Section 12 of the Guidelines and/or (ii) in connection with a Change in Control, the Compensation Committee of Change Healthcare Inc. shall have the discretion to make changes to the Guidelines and benefits payable hereunder as the Compensation Committee of Change Healthcare Inc., in its sole discretion, deems to be equitable and appropriate.

Eligibility Exception: In accordance with section 3(d)(iv), twelve (12) months.

Exhibit 31.1

SARBANES-OXLEY SECTION 302(a) CERTIFICATION

I, Neil E. de Crescenzo, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Change Healthcare Inc.;

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

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

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

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

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

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

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

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

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

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

Date: November 14, 2019

By: /s/ Neil E. de Crescenzo
Name: Neil E. de Crescenzo
Title: President and Chief Executive Officer of Change Healthcare Inc.

Exhibit 31.S

ARBNR- EAOXLYEC AETI 0X- 32S(a) TEBI 0F0TRI 0X-

I, Fredrik Eliasson, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Change Healthcare Inc.;

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

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

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

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

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

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

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

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

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

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

Date: November 14, 2019

By: /s/ Fredrik Eliasson
Name: Fredrik Eliasson
Title: Executive Vice President and Chief Financial Officer of Change Healthcare Inc.

Exhibit 32.1

CERTIFICATION PURSUANT TO

18 U.S.C. SECTION 1350,

AS ADOPTED PURSUANT TO

SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report of Change Healthcare Inc. (the "Company") on Form10-Q for the period ended September 30, 2019, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Neil E. de Crescenzo, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, in my capacity as an officer of the Company, that, to my knowledge:

1. The Report fully complies with the requirements of section 13(a) or 15(d), as applicable, of the Securities Exchange Act of 1934; and
2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: November 14, 2019

By: /s/ Neil E. de Crescenzo
Name: Neil E. de Crescenzo
Title: President and Chief Executive Officer of Change Healthcare Inc.

Exhibit 32.2

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In connection with the Quarterly Report of Change Healthcare Inc. (the "Company") on Form10-Q for the period ended September 30, 2019, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Fredrik Eliasson, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, in my capacity as an officer of the Company, that, to my knowledge:

1. The Report fully complies with the requirements of section 13(a) or 15(d), as applicable, of the Securities Exchange Act of 1934; and
2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: November 14, 2019

By: /s/ Fredrik Eliasson
Name: Fredrik Eliasson
Title: Executive Vice President and
Chief Financial Officer of Change Healthcare Inc.

Exhibit 99.1

Financial Information of Significant Equity Method Investee
Change Healthcare LLC

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EXPLANATORY NOTE

Unconsolidated Significant Subsidiary

Change Healthcare Inc.'s ("the Company") primary asset is its interest in the Joint Venture which is accounted for using the equity method. As the Company's investment in the Joint Venture is considered to be significant, the Joint Venture's annual financial statements are required to be included as an exhibit to each Company Annual Report on Form 10-K in accordance with SEC Rule 3-09 of Regulation S-X. Given the significance of this investment to the financial position and results of operations of the Company, however, we have elected to include financial information of the Joint Venture in this Quarterly Report on Form 10-Q.

Change Healthcare LLC
Condensed Consolidated Statements of Operations
(unaudited and amounts in thousands, except unit and per unit data)

	Three Months Ended September 30,		Six Months Ended September 30,	
	2019	2018	2019	2018
Revenue:				
Solutions revenue	$ 738,701	$ 737,786	$ 1,535,773	$ 1,495,491
Postage revenue	57,110	62,404	115,594	127,962
Total revenue	795,811	800,190	1,651,367	1,623,453
Operating expenses:				
Cost of operations (exclusive of depreciation and amortization below)	331,234	327,563	658,181	664,993
Research and development	51,783	51,243	101,122	106,567
Sales, marketing, general and administrative	190,039	207,105	383,312	414,019
Customer postage	57,110	62,404	115,594	127,962
Depreciation and amortization	77,448	69,258	148,764	137,785
Accretion and changes in estimate with related parties, net	3,214	5,932	7,094	9,756
Gain on Sale of the Extended Care Business	—	(111,392)	—	(111,392)
Total operating expenses	710,828	612,113	1,414,067	1,349,690
Operating income (loss)	84,983	188,077	237,300	273,763
Non-operating (income) and expense				
Interest expense, net	69,901	80,677	153,307	159,226
Loss on extinguishment of debt	16,900	—	16,900	—
Contingent consideration	1,700	(72)	909	200
Other, net	(4,386)	(3,849)	(8,164)	(9,381)
Total non-operating (income) and expense	84,115	76,756	162,952	150,045
Income (loss) before income tax provision (benefit)	868	111,321	74,348	123,718
Income tax provision (benefit)	998	(2,119)	2,563	(2,228)
Net income (loss)	$ (130)	$ 113,440	$ 71,785	$ 125,946
Net income (loss) per common unit:				
Basic	$ —	$ 0.45	$ 0.25	$ 0.50
Diluted	$ —	$ 0.45	$ 0.25	$ 0.50
Weighted average common units outstanding:				
Basic	318,219,028	251,501,744	285,107,046	251,550,892
Diluted	323,970,033	253,333,940	288,809,850	253,390,770

See accompanying notes to condensed consolidated financial statements.

Change Healthcare LLC
Condensed Consolidated Statements of Comprehensive Income (Loss)
(unaudited and amounts in thousands)

	Three Months Ended		Six Months Ended	
	September 30, 2019	September 30, 2018	September 30, 2019	September 30, 2018
Net income (loss)	$ (130)	$ 113,440	$ 71,785	$ 125,946
Other comprehensive income (loss):				
Foreign currency translation adjustment	3,812	1,886	4,568	(6,752)
Changes in fair value of interest rate cap, net of taxes	(3,156)	4,925	(21,254)	7,529
Other comprehensive income (loss)	656	6,811	(16,686)	777
Total comprehensive income (loss)	$ 526	$ 120,251	$ 55,099	$ 126,723

See accompanying notes to condensed consolidated financial statements.

Change Healthcare LLC
Condensed Consolidated Balance Sheets
(unaudited and amounts in thousands)

	September 30, 2019	March 31, 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 72,992	$ 47,718
Restricted cash	—	1,176
Accounts receivable, net of allowance for doubtful accounts	675,306	759,502
Contract assets	139,111	—
Prepaid expenses and other current assets	155,019	172,067
Assets held for sale (see Note 14)	29,562	—
Total current assets	1,071,990	980,463
Property and equipment, net	160,305	197,263
Goodwill	3,295,381	3,284,266
Intangible assets, net	1,261,290	1,320,161
Other noncurrent assets, net	500,627	421,985
Total assets	$ 6,289,593	$ 6,204,138
Liabilities and members' equity		
Current liabilities:		
Drafts and accounts payable	$ 64,010	$ 98,550
Accrued expenses	315,419	316,179
Deferred revenues	337,371	437,636
Due to related parties, net	23,230	34,629
Current portion of long-term debt	26,644	2,789
Total current liabilities	766,674	889,783
Long-term debt, excluding current portion	4,944,395	5,787,150
Deferred income tax liabilities	110,016	106,099
Tax receivable agreement obligations to related parties	199,876	212,698
Other long-term liabilities	112,812	113,194
Commitments and contingencies (see Note 6)		
Members' equity (deficit)	155,820	(904,786)
Total liabilities and members' equity	$ 6,289,593	$ 6,204,138

See accompanying notes to condensed consolidated financial statements.

Change Healthcare LLC
Condensed Consolidated Statements of Members' Equity (Deficit)
(unaudited and amounts in thousands)

	2019	2018
Balance at March 31	$ (904,786)	$ (1,066,180)
Cumulative effect of a change in accounting principle-revenue recognition	159,877	—
Advances to Member	—	(208)
Repurchase of equity awards	—	(4,838)
Capital contribution from Member from exercise of equity awards	—	205
Equity compensation expense	5,862	5,300
Net income (loss)	71,915	12,506
Foreign currency translation adjustment	756	(8,638)
Change in fair value of interest rate cap agreements, net of taxes	(18,098)	2,604
Other	(409)	456
Balance at June 30	$ (684,883)	$ (1,058,793)
Advances to Members, net	—	2,844
Repurchase of equity awards	—	(2,249)
Capital contribution from Member from exercise of equity awards	1,139	—
Issuance of LLC units for IPO proceeds	601,429	—
Issuance of tangible equity units	230,154	—
Equity compensation expense	8,565	2,969
Net income (loss)	(130)	113,440
Foreign currency translation adjustment	3,812	1,886
Change in fair value of interest rate cap agreements, net of taxes	(3,156)	4,925
Other	(1,110)	(192)
Balance at September 30	$ 155,820	$ (935,170)

See accompanying notes to condensed consolidated financial statements.

Change Healthcare LLC
Condensed Consolidated Statements of Cash Flows
(unaudited and amounts in thousands)

	Six Months Ended September 30,	
	2019	**2018**
Cash flows from operating activities:		
Net income (loss)	$ 71,785	$ 125,946
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:		
Depreciation and amortization	148,764	137,785
Amortization of capitalized software developed for sale	6,698	7,378
Accretion and changes in estimate, net	7,094	9,756
Equity compensation	15,207	8,269
Deferred income tax expense (benefit)	1,473	(3,013)
Amortization of debt discount and issuance costs	9,941	10,964
Contingent consideration	909	200
Gain on Sale of the Extended Care Business	—	(111,392)
Loss on extinguishment of debt	16,900	—
Other	(111)	538
Changes in operating assets and liabilities:		
Accounts receivable	54,240	6,730
Contract assets	12,688	—
Prepaid expenses and other	(8,583)	(16,373)
Accounts payable	(15,209)	(32,035)
Accrued expenses and other liabilities	(16,311)	142,707
Deferred revenue	(69,471)	(75,074)
Due to related party, net	(12,150)	15,482
Net cash provided by (used in) operating activities	223,864	227,868
Cash flows from investing activities:		
Capitalized expenditures	(129,847)	(124,631)
Proceeds from Sale of the Extended Care Business	—	160,244
Investments in businesses	(18,946)	—
Net cash provided by (used in) investing activities	(148,793)	35,613
Cash flows from financing activities:		
Payments of third party initial public offering and loan costs	(8,554)	—
Payments under tax receivable agreements with related parties	(27,227)	(25,096)
Payments on Term Loan Facility	(902,750)	(76,500)
Receipts (payments) on derivative instruments	3,109	2,090
Payments of deferred financing obligations	—	(3,432)
Capital contribution from Members from exercise of equity awards	1,139	205
Repurchase of equity awards	—	(5,305)
Proceeds from Change Healthcare Inc. initial public offering	608,679	—
Proceeds from debt issued to Change Healthcare Inc.	47,367	—
Proceeds from forward purchase contract with Change Healthcare Inc.	232,929	—
Advances to and refunds from Change Healthcare Inc.	(2,590)	2,636
Payment of debt issued to Change Healthcare Inc.	(3,621)	—
Other	247	598
Net cash provided by (used in) financing activities	(51,272)	(104,804)
Effect of exchange rate changes on cash and cash equivalents	299	(672)
Net increase (decrease) in cash, cash equivalents and restricted cash	24,098	158,005
Cash, cash equivalents and restricted cash at beginning of period	48,894	50,011
Cash, cash equivalents and restricted cash at end of period	$ 72,992	$ 208,016

See accompanying notes to condensed consolidated financial statements.

1. Nature of Business and Organization

Nature of Business

Change Healthcare LLC (the "Joint Venture"), is a leading independent healthcare technology platform that provides data and analytics-driven solutions to improve clinical, financial and patient engagement outcomes in the U.S. healthcare system. The Joint Venture offers a comprehensive suite of software, analytics, technology enabled solutions that drive improved results in the complex workflows of healthcare system payers and providers.

Organization

In June 2016, Change Healthcare Inc., the Joint Venture, Change Healthcare Holdings, LLC, Change Healthcare Intermediate Holdings, LLC, Change Healthcare Performance, Inc. ("Legacy CHC") and its stockholders—including affiliates of The Blackstone Group, L.P. ("Blackstone") and Hellman & Friedman LLC ("Hellman & Friedman")—entered into an Agreement of Contribution and Sale (the "Contribution Agreement") with McKesson Corporation ("McKesson", together with Change Healthcare Inc., the "Members"). Under the terms of the Contribution Agreement, the parties agreed to form the Joint Venture, a joint venture that combined the majority of the McKesson Technology Solutions businesses, excluding McKesson's Enterprise Information Solutions business and RelayHealth Pharmacy Network (such contributed businesses, "Core MTS") with substantially all of the assets and operations of Legacy CHC, but excluding Legacy CHC's pharmacy claims switching and prescription routing businesses (such excluded businesses, the "eRx Network" and the businesses contributed by Legacy CHC, together with Core MTS, the "Contributed Businesses"). The creation of the Joint Venture, including the contribution of the Contributed Businesses and related transactions, is collectively referred to as the "Transactions". The Transactions closed on March 1, 2017.

Basis of Accounting

Due to the existence of shared control among the Members over all major financial and operating decisions of the Joint Venture and its consolidated subsidiaries, the assets and liabilities contributed to the Joint Venture were recognized in the accompanying condensed consolidated financial statements at their historical carrying values (i.e., joint venture accounting).

Change Healthcare Inc. Initial Public Offering

Effective July 1, 2019, Change Healthcare Inc. completed its initial public offering of 49,285,713 of common stock and a concurrent offering of 5,750,000 of tangible equity units ("TEUs"). The proceeds of the offering of common stock were subsequently contributed to the Joint Venture in exchange for an additional 49,285,713 units of the Joint Venture ("LLC Units"), which together with the Company's existing holdings represents an approximately 41% interest in the Joint Venture. The proceeds of the offering of TEUs were used to acquire instruments of the Joint Venture that, in economic terms, substantially mirror the terms of the TEUs included in Change Healthcare Inc.'s offering. The net proceeds received from Change Healthcare Inc. from the offering of common stock and the offering of TEUs were $603,787 and $276,633, respectively, and the Joint Venture, in turn, used the proceeds to repay $805,000 of its indebtedness under the Term Loan Facility without penalty in July 2019. The Joint Venture repaid an additional $85,000 of its indebtedness under the Term Loan Facility without penalty during the three months ended September 30, 2019 for a total paydown of $890,000. However, due to the presence of unamortized discounts and debt issuance costs, the Joint Venture recognized a loss on extinguishment of debt of approximately $15,791 during the three and six months ended September 30, 2019.

Amendment of Revolving Credit Facility

Additionally, in July 2019, the Joint Venture amended its Revolving Credit Facility, the primary effects of which were to increase the maximum amount that can be borrowed from $500,000 to $785,000 and to extend the maturity date until July 3, 2024. In the event that the outstanding balance under the Term Loan Facility exceeds $1,100,000 on December 1, 2023, however, amounts due, if any, under the Revolving Facility become due and payable on December 1, 2023. In connection with this amendment, a portion of the debt was deemed extinguished, and the Joint Venture recognized a loss on extinguishment of $1,109 during the three and six months ended September 30, 2019.

2. Basis of Presentation

Principles of Consolidation

The accompanying unaudited condensed consolidated financial statements have been prepared in accordance with United States generally accepted accounting principles ("GAAP") for interim financial information and with the instructions to Form 10-Q and Rule 10-01 of Regulation S-X of the Securities and Exchange Commission ("SEC") Guidelines, Rules and Regulations ("Regulation S-X") and, in the opinion of management, reflect all normal recurring adjustments necessary for a fair presentation of results for the unaudited interim periods presented. Certain information and footnote disclosures normally included in annual financial statements prepared in accordance with GAAP have been condensed or omitted. The results of operations for the interim period are not necessarily indicative of the results to be obtained for the full fiscal year. All intercompany accounts and transactions have been eliminated in the unaudited condensed consolidated financial statements.

Tangible Equity Units

In connection with the initial public offering of Change Healthcare Inc., the Joint Venture completed an offering of TEUs that were issued to Change Healthcare Inc. Each TEU comprises an amortizing note and purchase contract, both of which are freestanding instruments and separate units of account. The amortizing notes were issued at par and are classified as debt on the accompanying condensed consolidated balance sheet, with scheduled principal payments over the next twelve months reflected in current maturities of long-term debt. The purchase contracts are accounted for as prepaid forward contracts and classified as equity. The TEU proceeds and issuance costs were allocated to the amortizing notes and purchase contracts on a relative fair value basis, consistent with the methodology utilized by Change Healthcare Inc. See Note 12 for further discussion.

Accounting Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. The Joint Venture bases its estimates on historical experience, current business factors and various other assumptions that the Joint Venture believes are necessary to consider in order to form a basis for making judgments about the carrying values of assets and liabilities, the recorded amounts of revenue and expenses and disclosure of contingent assets and liabilities. The Joint Venture is subject to uncertainties such as the impact of future events, economic, environmental and political factors and changes in the Joint Venture's business environment; therefore, actual results could differ from these estimates. Accordingly, the accounting estimates used in the preparation of the Joint Venture's financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the Joint Venture's operating environment changes. Such changes in estimates and refinements in estimation methodologies are reflected in the reported results of operations, and, if material, the effects of changes in estimates are disclosed in the notes to the condensed consolidated financial statements. Estimates and assumptions by management affect: the allowance for doubtful accounts; the fair value assigned to assets acquired and liabilities assumed in business combinations; tax receivable agreement obligations; the fair value of interest rate cap agreement obligations; contingent consideration; loss accruals; the carrying value of long-lived assets (including goodwill and intangible assets); the classification and measurement of assets held for sale; the measurement of the components of tangible equity units; the amortization period of long-lived assets (excluding goodwill); the carrying value, capitalization and amortization of software development costs; the provision and benefit for income taxes and related deferred tax accounts; certain accrued expenses; revenue recognition; contingencies; and the value attributed to equity awards.

Allowance for Doubtful Accounts

The allowance for doubtful accounts of $21,796 and $20,438 at September 30, 2019 and March 31, 2019, respectively, reflects the Joint Venture's best estimate of losses inherent in the Joint Venture's receivables portfolio determined on the basis of historical experience, specific allowances for known troubled accounts and other currently available evidence.

Accounting Pronouncements Not Yet Adopted

In February 2016, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU")No. 2016-02, which generally requires that all lease obligations be recognized on the balance sheet at the present value of the remaining lease payments with a corresponding lease asset. As originally issued, the standard required that companies adopt the standard using the modified retrospective transition method and report a cumulative effect adjustment to the opening balance of retained earnings in the earliest comparative period presented. In July 2018, the FASB issued ASU No. 2018-11 which provides companies with the

option to apply this cumulative effect adjustment to the opening balance of retained earnings in the period of adoption instead of the earliest comparative period presented. This update is scheduled to be effective for the Joint Venture beginning April 1, 2020, with early adoption permitted. The Joint Venture is currently assessing both the method of adoption and the potential effects this update may have on its condensed consolidated financial statements.

In June 2016, the FASB issued ASUNo. 2016-13, as amended by ASU No. 2018-19, which requires that a financial asset (or group of financial assets) measured at amortized cost be presented at the net amount expected to be collected based on relevant information about past events, including historical experience, current conditions and reasonable and supportable forecasts that affect the collectability of the reported amount. This update is scheduled to be effective for the Joint Venture beginning April 1, 2021, with early adoption permitted beginning April 1, 2019. The Joint Venture is currently assessing the potential effects this update may have on its condensed consolidated financial statements.

In August 2018, the FASB issued ASUNo. 2018-13, which modifies the disclosure requirements related to fair value measurements based on the FASB Concepts Statements. This update eliminates certain disclosures, modifies others and, in certain cases, requires additional disclosures. This update is effective for the Joint Venture beginning April 1, 2020, with earlier adoption permitted. The Joint Venture is currently assessing the potential effects this update may have on its condensed consolidated financial statements.

In August 2018, the FASB issued ASUNo. 2018-15, which aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. This update also requires that the effects of such capitalized costs be classified in the same respective caption of the statement of operations, balance sheet and cash flows as the underlying hosting arrangement. Upon adoption, a company may elect to either retrospectively restate each prior reporting period or apply the update prospectively to all implementation costs incurred after the effective date. This update is scheduled to be effective for the Joint Venture beginning April 1, 2020, with early adoption permitted. The Joint Venture is currently assessing both the method of adoption and the potential effects this update may have on its condensed consolidated financial statements.

Recently Adopted Accounting Pronouncements

In April 2019, the Joint Venture adopted FASB ASUNo. 2018-16, which adds the Overnight Index Swap rate based on the Secured Overnight Financing Rate as a benchmark interest rate for hedging purposes. As the adoption of this update applies only to qualifying new or redesignated hedging relationships entered into following the date of adoption, its adoption has no immediate effect on the Joint Venture's condensed consolidated financial statements.

In April 2019, the Joint Venture adopted FASB ASUNo. 2018-02, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017 ("Tax Legislation"). Because the Joint Venture's financial statements do not separately classify the components of members' deficit, the effect of the adoption of this update was limited to the separate disclosure in Note 10 related to the reclassification of such stranded costs from accumulated comprehensive income (loss) to accumulated deficit.

In April 2019, the Joint Venture adopted FASB ASUNo. 2018-07, which expands the scope of Topic 718 to include share-based payment transactions for acquiring goods and services from nonemployees. Among other provisions, the measurement date for awards to nonemployees changed from the earlier of the date at which a commitment for performance by the counterparty is reached or the date at which performance is complete under the previous guidance to the grant date under this update. Because the Joint Venture's equity-based compensation was previously subject to remeasurement at fair value each quarter under the previous authoritative literature, the effect of the adoption of this update had no material effect on the Joint Venture's condensed consolidated financial statements.

In April 2019, the Joint Venture adopted Accounting Standards Codification ("ASC") 606, Revenue from Contracts with Customers, which replaced most prior general and industry specific revenue recognition guidance with a principles-based comprehensive revenue recognition framework. Under this revised framework, a company recognizes revenue to depict the transfer of promised goods and services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods and services. All of the Joint Venture's revenue is accounted for under ASC 606.

The Joint Venture adopted ASC 606 using the modified retrospective transition method applied only to contracts that were not completed as of the date of initial application. The Joint Venture has also elected the contract modification transition practical expedient, and as a result, will treat all contract modifications entered into prior to adoption date as if they were part of the original

contract. The adoption of the new revenue standard utilizing these transition methods resulted in a cumulative effect adjustment that reduced members' equity (deficit) as of April 1, 2019 by $159,877. After assessing all potential impacts of adopting the new standard on its consolidated financial statements, related disclosures, and necessary control and process changes, the Joint Venture has noted the following to be the most notable impacts of adopting the new standard:

• Revenue for certain contingent fee service arrangements will be accelerated as revenue for these arrangements is recognized as the services are performed.

• Revenue related to certain time-based software and content license agreements will be accelerated. The license component for certain time-based software will be recognized upon delivery to the customer ("point in time"), or in the case of software that requires significant production, modification or customization, recognized as the implementation work is performed. A non-license component (e.g., technical support) will be recognized over the respective contract terms ("over time").

• Incremental costs to obtain contracts and qualifying costs to fulfill will be capitalized and amortized over the period of benefit. The net result of this change was an increase to capitalized contract costs on the balance sheet; these capitalized costs will be amortized and recognized as expense over an incrementally longer period of time.

The following tables represent the impact of the new standard on the Joint Venture's unaudited financial statements as of and for the three and six months ended September 30, 2019:

	Three Months Ended September 30,				Six Months Ended September 30,			
	2019			2018	2019			2018
	As Reported	Impacts from Adoption	Without Adoption (ASC 605)	As Reported (ASC 605)	As Reported	Impacts from Adoption	Without Adoption (ASC 605)	As Reported (ASC 605)
Revenue:								
Solutions revenue	$ 738,701	$ 9,945	$ 748,646	$ 737,786	$ 1,535,773	$ (31,586)	$ 1,504,187	$ 1,495,491
Postage revenue	57,110	—	57,110	62,404	115,594	—	115,594	127,962
Total revenue	795,811	9,945	805,756	800,190	1,651,367	(31,586)	1,619,781	1,623,453
Operating expenses:								
Cost of operations (exclusive of depreciation and amortization below)	331,234	996	332,230	327,563	658,181	1,804	659,985	664,993
Research and development	51,783	—	51,783	51,243	101,122	—	101,122	106,567
Sales, marketing, general and administrative	190,039	4,595	194,634	207,105	383,312	9,764	393,076	414,019
Customer postage	57,110	—	57,110	62,404	115,594	—	115,594	127,962
Depreciation and amortization	77,448	—	77,448	69,258	148,764	—	148,764	137,785
Accretion and changes in estimate with related parties, net	3,214	—	3,214	5,932	7,094	—	7,094	9,756
Gain on Sale of the Extended Care Business	—	—	—	(111,392)	—	—	—	(111,392)
Impairment of long-lived assets and related costs	—	—	—	—	—	—	—	—
Total operating expenses	710,828	5,591	716,419	612,113	1,414,067	11,568	1,425,635	1,349,690
Operating income (loss)	84,983	4,354	89,337	188,077	237,300	(43,154)	194,146	273,763
Non-operating (income) and expense								
Interest expense, net	69,901	—	69,901	80,677	153,307	—	153,307	159,226
Loss on extinguishment of debt	16,900	—	16,900	—	16,900	—	16,900	—
Contingent consideration	1,700	—	1,700	(72)	909	—	909	200
Other, net	(4,386)	—	(4,386)	(3,849)	(8,164)	—	(8,164)	(9,381)
Total non-operating (income) and expense	84,115	—	84,115	76,756	162,952	—	162,952	150,045
Income (loss) before income tax provision (benefit)	868	4,354	5,222	111,321	74,348	(43,154)	31,194	123,718
Income tax provision (benefit)	998	(32)	966	(2,119)	2,563	(2,283)	280	(2,228)
Net income (loss)	$ (130)	$ 4,386	$ 4,256	$ 113,440	$ 71,785	$ (40,871)	$ 30,914	$ 125,946
Net income (loss) per common unit:								
Basic	$ —	$ 0.01	$ 0.01	$ 0.45	$ 0.25	$ (0.14)	$ 0.11	$ 0.50
Diluted	$ —	$ 0.01	$ 0.01	$ 0.45	$ 0.25	$ (0.14)	$ 0.11	$ 0.50

	September 30, 2019			March 31, 2019
	As Reported	Impacts from Adoption	Without Adoption (ASC 605)	As Reported (ASC 605)
Assets				
Current assets:				
Cash and cash equivalents	$ 72,992	$ —	$ 72,992	$ 47,718
Restricted cash	—	—	—	1,176
Accounts receivable, net of allowance for doubtful accounts	675,306	15,814	691,120	759,502
Contract assets	139,111	(139,111)	—	—
Prepaid expenses and other current assets	155,019	20,914	175,933	172,067
Assets held for sale	29,562	—	29,562	—
Total current assets	1,071,990	(102,383)	969,607	980,463
Property and equipment, net	160,305	—	160,305	197,263
Goodwill	3,295,381	—	3,295,381	3,284,266
Intangible assets, net	1,261,290	—	1,261,290	1,320,161
Other noncurrent assets, net	500,627	(40,520)	460,107	421,985
Total assets	$6,289,593	$(142,903)	$6,146,690	$ 6,204,138
Liabilities and members' equity				
Current liabilities:				
Drafts and accounts payable	$ 64,010	$ —	$ 64,010	$ 98,550
Accrued expenses	315,419	—	315,419	316,179
Deferred revenues	337,371	57,881	395,252	437,636
Due to related parties, net	23,230	—	23,230	34,629
Current portion of long-term debt	26,644	—	26,644	2,789
Total current liabilities	766,674	57,881	824,555	889,783
Long-term debt, excluding current portion	4,944,395	—	4,944,395	5,787,150
Deferred income tax liabilities	110,016	—	110,016	106,099
Tax receivable agreement obligations to related parties	199,876	—	199,876	212,698
Other long-term liabilities	112,812	—	112,812	113,194
Commitments and contingencies				
Members' equity (deficit)	155,820	(200,784)	(44,964)	(904,786)
Total liabilities and members' equity	$6,289,593	$(142,903)	$6,146,690	$ 6,204,138

The adoption of the new standard had an immaterial impact on the Joint Venture's unaudited statement of cash flows for the three and six months ended September 30, 2019. See Note 3, *Revenue Recognition* for more information.

3. Revenue Recognition

The Joint Venture generates most of its solutions revenue by using technology solutions (generally Software as a Service ("SaaS")) to provide services to its customers that automate and simplify business and administrative functions for payers, providers, pharmacies, and channel partners and through the licensing of software, software systems (consisting of software, hardware and maintenance support) and content.

The Joint Venture recognizes revenue when the customer obtains control of the good or service through the Joint Venture satisfying a performance obligation by transferring the promised good or service to the customer.

Principal Revenue Generating Products and Services

Content license subscriptions and time-based software—The Joint Venture's content license subscriptions and time-based software arrangements provide a license to use a software for a specified period of time. At the end of the contractual period, the customer either renews the license for an additional term or ceases to use the software. Software licenses are typically delivered to the customer with functionality that the customer can benefit from the software on its own or together with readily available resources. As contracts for these solutions generally do not price individual components separately, the Joint Venture allocates the transaction price to the license and ongoing support performance obligations based on standalone selling price ("SSP"), primarily determined by historical value relationships between licenses and ongoing support and updates. Revenue allocated to content license subscriptions and time-based software license agreements is generally recognized at the point-in-time of delivery of the license or the content update upon transfer of control of the underlying license to the customer. Generally, software implementation fees are recognized over the implementation period through an input measure of progress method. Revenue allocated to maintenance and support is recognized ratably over the period covered by the agreements, as passage of time represents a faithful depiction of the transfer of these services. In some cases, software arrangements provide licenses to several software applications that are highly integrated with the implementation services and software updates and cannot function separately. The bundle is a single performance obligation since the individually promised goods and services are not distinct in the context of the contract because the related implementation services significantly modify and customize the software and the updates provided to the integrated software solution are critical to the software's utility. The related revenue is recognized on a straight-line basis, ratably over the contractual term due to the frequency and criticality of the updates throughout the license period.

Contingent fee services—The Joint Venture provides services to customers in which the transaction price is contingent on future occurrences, such as savings generated or amounts collected on behalf of its customers through the delivery of its services. In some cases, the Joint Venture performs services in advance of invoicing the customer, thereby creating a contract asset. Revenue in these arrangements is estimated and constrained until the Joint Venture determines that it is probable a significant revenue reversal will not occur, and variable consideration is allocated to the performance obligation for which the Joint Venture earns a contingent fee.

Perpetual software licenses—The Joint Venture's perpetual software arrangements provide a license for a customer to use software in perpetuity. Software licenses are typically delivered to the customer with functionality from which the customer can benefit from the license on its own or together with readily available resources. Perpetual software arrangements are recognized at the time of delivery or through an input measure of progress method over the installation period if the arrangements require significant production or modification or customization of the software. Contracts accounted for through an input measure of progress method are generally measured based on the ratio of labor hours incurred to date to total estimated labor hours to be incurred. Software implementation fees are recognized as the work is performed or under the input method for perpetual software. Hardware revenues are generally recognized upon delivery. Maintenance is recognized ratably over the term of the agreement as passage of time represents a faithful depiction of the transfer of these services.

Professional services—The Joint Venture provides training and consulting services to its customers, and the services may be fixed fee or time and materials based. Consulting services that fall outside of the standard implementation services vary depending on the scope and complexity of the service requested by the customer. Consulting services are deemed to be capable of being distinct from other products and services, and the services are satisfied either at a point of time or over time based on delivery. Training services are usually provided as an optional service to enhance the customer's experience with a software product or provides additional education surrounding the general topic of the solution. Training services are capable of being distinct from other products and services. The Joint Venture treats training services as a distinct performance obligation, and they are satisfied at a point of time.

Transaction processing services—The Joint Venture provides transaction processing (such as claims processing) services to hospitals, pharmacies and health systems via a cloud-based (SaaS) platform. The promised service is to stand ready to process transactions for our customers over the contractual period on an as needed basis. The revenue related to these services is recognized over time as the transactions are processed, and the revenue is recognized over the individual days in which the services are performed. Any fixed annual fees and implementation fees are recognized ratably over the contract period.

Hosted solutions and software as a service ("SaaS")—The Joint Venture enters into arrangements whereby the Joint Venture provides the customer access to a Joint Venture-owned software solution, which are generally marketed under annual and multi-year arrangements. The customer is only provided "access" (not a license) to the software application. In these arrangements, the customer does not purchase equipment nor does the customer take physical possession of the software. The related revenue is recognized ratably over the contracted term. For fixed fee arrangements, revenue recognition begins after set-up and implementation are complete. For per-transaction fee arrangements, revenue is recognized as transactions are processed beginning on the service start date.

Contract Balances

The Joint Venture's payment terms vary by customer and product type. For certain products or services, the Joint Venture requires upfront payments before control of the product or service has transferred to the customer. For other products and services, the Joint Venture invoices the customer in arrears after providing the products or services. In addition, for certain contingent fee services, customers are billed in arrears, typically based upon a percentage of collections the Joint Venture makes on the customer's behalf.

Under the new revenue standard, the Joint Venture generally recognizes a contract asset when revenue is recognized in advance of invoicing on a customer contract, unless the right to payment for that revenue is unconditional (i.e. requiring no further performance and only the passage of time). If a right to payment is determined to meet the criteria to be considered 'unconditional', then the Joint Venture will recognize a receivable.

There were no impairment losses recognized on accounts receivable or contract assets during the three and six months ended September 30, 2019.

The Joint Venture records deferred revenues when billings or payments are received from customers in advance of its performance. Deferred revenue is generally recognized when transfer of control to customers occurs. The deferred revenue balance is driven by multiple factors, including the frequency of renewals, invoice timing, and invoice duration. As of September 30, 2019, the Joint Venture expects 94% of the deferred revenue balance to be recognized in one year or less, and approximately $328,000 of the beginning period balance was recognized during the first six months of fiscal 2020.

Costs to Obtain or Fulfill a Contract

Sales commissions and certain other incentive payments (e.g., bonuses that are contingent solely on obtaining a contract or a pool of contracts) earned by the Joint Venture's sales organization are capitalized as incremental costs to obtain a contract. The Joint Venture typically does not offer commissions on contract renewals. Decremented commissions upon renewal (i.e., non-commensurate with initial commissions) are offered to the Joint Venture's sales associates for certain customers and are not material. Under ASC 606, all commissions and other qualifying incentive payments capitalized are amortized over an expected period of benefit defined as the initial contract term plus anticipated renewals. In contrast, under ASC 605 these capitalized costs were amortized over the specific revenue contract terms, which are typically 12 to 60 months. In making the significant judgment in determining the appropriate period of benefit, the Joint Venture evaluated both qualitative and quantitative factors such as the expected customer relationship period and technology obsolescence. In addition, prior to solution go-live, the Joint Venture incurs certain contract fulfillment costs primarily related to SaaS setup for our clients. These costs are capitalized to the extent they are directly related to a contract, are recoverable, and create a resource used to deliver the Joint Venture's SaaS services. Capitalized costs to fulfill a contract are amortized over the expected period of benefit.

At September 30, 2019, the Joint Venture had capitalized costs to obtain a contract of $12,407 in prepaid and other current assets and $67,426 in other noncurrent assets. During the three and six months ended September 30, 2019, the Joint Venture recognized $5,098 and $9,207 of amortization expense related to such capitalized costs, respectively, which is included in the total operating expenses. At September 30, 2019, the Joint Venture had capitalized costs to fulfill a contract of $1,383 in prepaid and other current assets and $8,571 in other noncurrent assets. During the three and six months ended September 30, 2019, the Joint Venture recognized $313 and $609 of amortization expense, respectively, related to such capitalized costs, which is included in cost of operations.

Postage Revenues

Postage revenues are the result of providing delivery services to customers in the Joint Venture's payment and communication solutions. Postage revenues are generally billed as a pass-through cost to the Joint Venture's customers. The service is part of a combined performance obligation with the printing and handling services provided to the customer because the postage services are not distinct within the context of the contract. The Joint Venture presents Postage Revenue separately from Solutions Revenue on the consolidated statements of operation as it makes the financial statements more informative for the users. The revenue related to the combined performance obligation of the postage, printing, and handling service is recognized as the transactions are processed, and the revenue is recognized over the individual days in which the services are performed.

Arrangements with Multiple Performance Obligations

The Joint Venture engages in customer arrangements which may include multiple performance obligations, such as any combination of software, hardware, implementation, SaaS-based offerings, consulting services, or maintenance services. For such arrangements, the Joint Venture allocates revenues to each performance obligation on a relative standalone selling price basis. A performance obligation's standalone selling price is determined based on the directly observable prices charged to customers, when available or estimated using other methods such as the adjusted market assessment approach, the expected cost plus a margin approach, or other approaches in cases where distinct performance obligations are not sold separately but instead sold at a bundled price. For performance obligations with historical pricing that is highly variable, the residual approach is used. Such instances primarily relate to the Joint Venture's perpetual software arrangements in which the Joint Venture sells the same products to different customers for a broad range of amounts.

Remaining Performance Obligations

The aggregate amount of transaction price allocated to performance obligations that are unsatisfied (or partially unsatisfied) for executed contracts includes deferred revenue and other revenue yet to be recognized from non-cancellable contracts. As of September 30, 2019, the Joint Venture's total remaining performance obligations approximated $1,347,000, of which approximately 52% is expected to be recognized over the next twelve months, and the remaining 48% thereafter.

In this balance, the Joint Venture does not include the value of unsatisfied performance obligations related to those contracts for which it recognizes revenue at the amount for which it has the right to invoice for services performed. Additionally, this balance does not include revenue related to performance obligations that are part of a contract with an original expected duration of one year or less. Lastly, this balance does not include variable consideration allocated to the individual goods or services in a series of distinct goods or services that are substantially the same and that have the same pattern of transfer to the customer. Examples includes variable fees associated with transaction processing and contingent fee services.

Disaggregated Revenue

The Joint Venture disaggregates the revenue from contracts with customers by operating segment as it believes doing so best depicts how the nature, amount, timing and uncertainty of the Joint Venture's revenue are affected by economic factors. See Note 9, *Segment Reporting* for the total revenue disaggregated by operating segment for the three and six months ended September 30, 2019 and 2018.

The Joint Venture's total revenue by disaggregated revenue source was generally consistent for each reportable segment for the three and six months ended September 30, 2019 and 2018.

Customer Incentives

Certain customers, which include the Joint Venture's channel partners, may receive cash-based incentives or rebates based on actual sales and achievement of a cumulative level of sales, which are accounted for as variable consideration. The Joint Venture considers these amounts to be consideration payable to the customer, and therefore, the Joint Venture estimates these amounts based on the expected amount to be provided to customers and reduces the transaction price accordingly.

Practical Expedients and Exemptions

The Joint Venture has elected to utilize either the right to invoice practical expedient or the series-based variable consideration allocation framework for most transaction processing services not subject to contingencies. The Joint Venture also has elected to exclude sales taxes and other similar taxes from the measurement of the transaction price in contracts with customers. Therefore, revenue is recognized net of such taxes.

In certain customer arrangements with customers, the Joint Venture determined there are certain promised goods or services which are immaterial in the context of the contract from both a quantitative and qualitative perspective, and therefore, the goods and services are disregarded when assessing the performance obligations in the customer arrangement.

The Joint Venture has elected to apply the significant financing practical expedient, and as a result, the Joint Venture will not adjust the promised amount of consideration in a customer contract for the effects of a significant financing component when the period of time between when the Joint Venture transfers a promised good or service to a customer and when the customer pays for the good or service will be one year or less.

4. Interest Rate Cap Agreements

Risk Management Objective of Using Derivatives

The Joint Venture is exposed to certain risks arising from both its business operations and economic conditions. The Joint Venture principally manages its exposures to a wide variety of business and operational risks through management of its core business activities. The Joint Venture manages economic risks, including interest rate, liquidity and credit risk, primarily by managing the amount, sources and duration of its debt funding and the use of derivative financial instruments. Specifically, the Joint Venture enters into derivative financial instruments to manage differences in the amount, timing and duration of the Joint Venture's known or expected cash receipts and its known or expected cash payments principally related to the Joint Venture's borrowings.

Cash Flow Hedges of Interest Rate Risk

The Joint Venture's objectives in using interest rate derivatives are to add stability to interest expense and to manage its exposure to interest rate movements. To accomplish these objectives, the Joint Venture primarily uses interest rate cap agreements as part of its interest rate risk management strategy.

In March 2016 and 2017, Legacy CHC and the Joint Venture, respectively, executed annuitized interest rate cap agreements with a combined notional amount of $650,000 and $750,000, respectively, to limit the exposure of the variable component of interest rates under the then existing term loan facility or future variable rate indebtedness, each beginning in March 2017 and expiring in March 2020.

In August 2018, the Joint Venture executed additional annuitized interest rate cap agreements with notional amounts of $500,000 and $1,500,000, respectively, to limit the exposure of the variable component of interest rates under the term loan facility or future variable rate indebtedness to a maximum of 1.0%. The $500,000 interest rate cap agreement began effective August 31, 2018 and expires March 31, 2020. The $1,500,000 interest rate cap agreement begins effective March 31, 2020 and expires December 31, 2021.

As of September 30, 2019, each of the Joint Venture's outstanding interest rate cap agreements was designated as a cash flow hedge of interest rate risk and was determined to be highly effective.

Following the adoption of ASU 2017-12, all changes in the fair value of derivatives designated and that qualify as cash flow hedges are recorded in accumulated other comprehensive income and are subsequently reclassified into earnings in the period that the hedged forecasted transaction affects earnings. Amounts reported in accumulated other comprehensive income related to derivatives will be reclassified to interest expense as interest payments are made on the Joint Venture's variable-rate debt. During the twelve months subsequent to September 30, 2019, the Joint Venture estimates that $16,009 will be reclassified as an increase to interest expense.

The following table summarizes the fair value of the Joint Venture's derivative instruments at September 30, 2019 and March 31, 2019:

	Fair Values of Derivative Financial Instruments Asset (Liability)		
Derivative financial instruments designated as hedging instruments:	**Balance Sheet Location**	**September 30, 2019**	**March 31, 2019**
Interest rate cap agreements	Prepaid and other current assets	$ 731	$ 8,766
Interest rate cap agreements	Accrued expenses	(11,629)	(2,160)
Interest rate cap agreements	Other long-term liabilities	(23,066)	(16,846)
		$ (33,964)	$ (10,240)

Tabular Disclosure of the Effect of Derivative Instruments on the Statement of Operations

The effect of the derivative instruments on the accompanying condensed consolidated statements of operations for the three and six months ended September 30, 2019 and 2018 is summarized in the following table:

	Three Months Ended September 30, 2019	Three Months Ended September 30, 2018	Six Months Ended September 30, 2019	Six Months Ended September 30, 2018
Derivative financial instruments in cash flow hedging relationships:				
Gain/ (loss) related to effective portion of derivative financial instruments recognized in other comprehensive income (loss)	$ (3,635)	$ 6,218	$ (20,686)	$ 11,868
Gain/ (loss) related to portion of derivative financial instruments reclassified from accumulated other comprehensive income (loss) to interest expense	$ 479	$ 1,293	$ (568)	$ 2,705

Credit Risk-related Contingent Features

The Joint Venture has agreements with each of its derivative counterparties providing that if the Joint Venture defaults on any of its indebtedness, including a default where repayment of the indebtedness has not been accelerated by the lender, then the Joint Venture also could be declared in default on its derivative obligations.

As of September 30, 2019, the termination value of derivative financial instruments in a net liability position, which includes accrued interest but excludes any adjustment for nonperformance risk, was $35,207. If the Joint Venture had breached any of these provisions at September 30, 2019, the Joint Venture could have been required to settle its obligations under the agreements at this termination value. The Joint Venture does not offset any derivative financial instruments, and the derivative financial instruments are not subject to collateral posting requirements.

5. Fair Value Measurements

Assets and Liabilities Measured at Fair Value on a Recurring Basis

The Joint Venture's assets and liabilities that are measured at fair value on a recurring basis consist of the Joint Venture's derivative financial instruments and contingent consideration obligations. The tables below summarize these items as of September 30, 2019 and March 31, 2019, aggregated by the level in the fair value hierarchy within which those measurements fall.

Description	Balance at September 30, 2019	Quoted in Markets Identical (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Interest rate cap agreements	$ (33,964)	$ —	$ (33,964)	$ —
Contingent consideration obligations	(4,000)	—	—	(4,000)
Total	$ (37,964)	$ —	$ (33,964)	$ (4,000)

Description	Balance at March 31, 2019	Quoted in Markets Identical (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Interest rate cap agreements	$ (10,240)	$ —	$ (10,240)	$ —
Contingent consideration obligations	(3,091)	—	—	(3,091)
Total	$ (13,331)	$ —	$ (10,240)	$ (3,091)

The valuation of the Joint Venture's derivative financial instruments is determined using widely accepted valuation techniques, including discounted cash flow analysis on the expected cash flows of each derivative. This analysis reflects the contractual terms of the derivative, including the period to maturity, and uses observable market-based inputs, including interest rate curves. The fair value of the interest rate cap agreements is determined using the market standard methodology of netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments) using the overnight index swap rate as the discount rate.

The Joint Venture incorporates credit valuation adjustments to appropriately reflect both its own nonperformance risk and the respective counterparty's nonperformance risk in the fair value measurements. In adjusting the fair value of its derivative contracts for the effect of nonperformance risk, the Joint Venture has considered the impact of netting and any applicable credit enhancements and measures the credit risk of its derivative financial instruments that are subject to master netting agreements on a net basis by counterparty portfolio.

Although the Joint Venture has determined that the majority of the inputs used to value its derivatives fall within Level 2 of the fair value hierarchy, the credit valuation adjustments associated with its derivatives utilize Level 3 inputs to evaluate the likelihood of default by itself and by its counterparties. As of September 30, 2019, the Joint Venture determined that the credit valuation adjustments are not significant to the overall valuation of its derivatives. As a result, the Joint Venture determined that its derivative valuations in their entirety are classified in Level 2 of the fair value hierarchy.

The valuation of the Joint Venture's contingent consideration obligations was determined using a discounted cash flow method as applied to cash flows determined through a Monte Carlo Simulation. This analysis reflects the contractual terms of the purchase agreements (e.g., minimum and maximum payments, length of earn-out periods, manner of calculating any amounts due, etc.) and utilizes assumptions with regard to future cash flows, probabilities of achieving such future cash flows and a discount rate. Significant increases with respect to assumptions as to future revenue and probabilities of achieving such future revenue would have resulted in a higher fair value measurement while an increase in the discount rate would have resulted in a lower fair value measurement.

The table below presents a reconciliation of the fair value of the liabilities that use significant unobservable inputs (Level 3):

	Three Months Ended September 30, 2019	Three Months Ended September 30, 2018	Six Months Ended September 30, 2019	Six Months Ended September 30, 2018
Balance at beginning of period	$ (2,300)	$ (4,172)	$ (3,091)	$ (4,000)
Adjustment of provisional amounts	—	—	—	100
Gain/ (loss) included in contingent consideration	(1,700)	72	(909)	(200)
Balance at end of period	$ (4,000)	$ (4,100)	$ (4,000)	$ (4,100)

Assets and Liabilities Measured at Fair Value upon Initial Recognition

The carrying amount and the estimated fair value of financial instruments held by the Joint Venture at September 30, 2019 and March 31, 2019 were:

	September 30, 2019		March 31, 2019	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Cash and cash equivalents	$ 72,992	$ 72,992	$ 47,718	$ 47,718
Accounts receivable	$ 675,306	$ 675,306	$ 759,502	$ 759,502
Senior Credit Facilities (Level 2)	$3,925,509	$3,973,284	$4,804,905	$4,834,800
Senior Notes (Level 2)	$ 981,335	$1,015,000	$ 979,905	$ 990,000
Debt component of tangible equity units (Level 2)	$ 42,069	$ 43,896	$ —	$ —

The carrying amounts of cash equivalents and accounts receivable approximate fair value because of their short-term maturities. The fair value of the Senior Credit Facilities and Senior Notes is based upon market quotes and trades by investors in partial interests of these instruments. The fair value of the debt component of tangible equity units is based on a discounted cash flow analysis.

Investments in Businesses

In December 2018, the Joint Venture purchased $15,000 of preferred shares of a health care company and $500 shares in a related company holding certain intellectual property, each of which is classified within Other noncurrent assets, net on the accompanying condensed consolidated balance sheets. Because this investment has no readily determinable fair value, the Joint Venture measures this investment at cost minus impairment, if any, plus or minus changes resulting from observable price changes in orderly transactions for the identical or a similar investment of the same issuer. The Joint Venture recognized no changes in the value of this investment during the three and six months ended September 30, 2019.

6. Legal Proceedings

The Joint Venture is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

Government Subpoenas and Investigations

From time to time, the Joint Venture receives subpoenas or requests for information from various government agencies. The Joint Venture generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by the Joint Venture. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Joint Venture and other members of the health care industry, as well as to settlements.

Other Matters

Additionally, in the normal course of business, the Joint Venture is involved in various claims and legal proceedings. While the ultimate resolution of ongoing matters has yet to be determined, the Joint Venture does not believe that their outcomes will have a material adverse effect on the Joint Venture's consolidated financial position, results of operations or liquidity.

7. Income Taxes

The Joint Venture is treated as a partnership for income tax purposes and is therefore not subject to U.S. federal income taxes and not subject to most state and local income taxes. Legacy CHC and Change Healthcare Practice Management Solutions, Inc., both wholly owned subsidiaries of the Joint Venture, are subject to U.S. federal, state and local, and non-U.S. corporate income taxes.

The income tax expense for the three months ended September 30, 2019 and income tax benefit for the three months ended September 30, 2018 was $998 and $2,119, respectively, which represents an effective tax rate of 115.0% and (1.9%), respectively. The income tax expense for the six months ended September 30, 2019 and income tax benefit for the six months ended September 30, 2018 was $2,563 and $2,228, respectively, which represents an effective tax rate of 3.4% and (1.8%), respectively.

Fluctuations in the Joint Venture's reported income tax rates are primarily due to the earnings from partnerships that are passed through to the Members for which the Joint Venture is not subject to tax and benefits recognized as a result of certain incentive tax credits resulting from research and experimental expenditures in both the US and Canada.

8. Tax Receivable Agreement Obligations to Related Parties

Upon the consummation of the Transactions, the Joint Venture assumed obligations related to certain tax receivable agreements (collectively, the "Tax Receivable Agreements") with its current and former owners. Because the assets and obligations of the predecessor businesses were contributed to the Joint Venture at their historical carrying values, these Tax Receivable Agreements are subject to differing accounting models as explained below.

2009—2011 Tax Receivable Agreements

Under the 2009—2011 Tax Receivable Agreements assumed by the Joint Venture in connection with the Transactions, the Joint Venture is obligated to make payments to certain of the former Legacy CHC stockholders, equal to 85% of the applicable cash savings that the Joint Venture expects to realize as a result of tax attributes arising from certain previous transactions. As a result of the covered change of control with respect to the Tax Receivable Agreements that occurred in connection with the Transactions, payments the Joint Venture makes under the 2009—2011 Tax Receivable Agreements are required to be calculated using certain valuation assumptions, including that the Joint Venture will have sufficient taxable income to use the applicable tax attributes and that certain of such tax attributes will be used by the Joint Venture on a pro rata basis from the date of the Transactions (or in certain cases from the date of certain previous transactions) through the expiration of the applicable tax attribute. Because the 2009—2011 Tax Receivable Agreements were previously subject to fair value measurement in connection with a prior business combination transaction, it is recognized at its initial fair value plus recognized accretion to date.

2017 Tax Receivable Agreement

The 2017 Tax Receivable Agreement generally provides for the payment by Change Healthcare Performance, Inc. (a wholly owned subsidiary of the Joint Venture) to affiliates of Blackstone, Hellman & Friedman of 85% of the net cash tax savings realized (or, in certain circumstances, deemed to be realized) in periods ending on or after the Transactions as a result of certain net operating losses and certain other tax attributes of Change Healthcare Performance, Inc. as of the date of the Transactions. The 2017 Tax Receivable Agreement is considered a loss contingency under FASB ASC Topic 450 and is reflected on the accompanying condensed consolidated balance sheet at the amount that is both probable and reasonably estimable with future changes in this value being reflected within pretax income or loss.

McKesson Tax Receivable Agreement

The McKesson Tax Receivable Agreement generally requires payment to affiliates of McKesson (the "McKesson TRA Parties") of 85% of certain cash tax savings realized (or, in certain circumstances, deemed to be realized) by Change Healthcare Performance, Inc. in periods ending on or after the date on which McKesson ceases to own at least 20% of the Joint Venture as a result of (i) certain amortizable tax basis in assets transferred to Joint Venture at the closing of the Transactions and (ii) imputed interest deductions and certain other tax attributes arising from payments under the McKesson Tax Receivable Agreement. Because payments under the McKesson Tax Receivable Agreement are contingent upon McKesson's ceasing to own at least 20% of the Joint Venture and such an event was not probable at inception of the McKesson Tax Receivable Agreement or as of September 30, 2019, no related obligation has been reflected on the accompanying condensed consolidated balance sheet.

Based on facts and circumstances at September 30, 2019, the Joint Venture estimates the aggregate payments due under these Tax Receivable Agreements to be as follows:

	2009 - 2011 Tax Receivable Agreements	2017 Tax Receivable Agreement	Total
2020 (remainder)	$ —	$ —	$ —
2021	18,703	1,179	19,882
2022	19,756	1,179	20,935
2023	19,826	41,330	61,156
2024	19,096	19,650	38,746
Thereafter	119,498	52,393	171,891
Gross expected payments	196,879	115,731	312,610
Less: Amounts representing discount	(92,852)	—	(92,852)
Total tax receivable agreement obligations due to related parties	104,027	115,731	219,758
Less: Current portion due (included in due to related parties, net)	(18,703)	(1,179)	(19,882)
Tax receivable agreement long-term obligations due to related parties	$ 85,324	$114,552	$199,876

The timing and/or amount of aggregate payments due may vary based on a number of factors, including the amount of net operating losses and income tax rates.

9. Segment Reporting

Management views the Joint Venture's operating results based on three reportable segments: (a) Software and Analytics, (b) Network Solutions and (c) Technology-enabled Services. The accounting policies of the reportable segments are the same as those described in the summary of significant accounting policies in Note 2 to the Joint Venture's audited consolidated financial statements for the year ended March 31, 2019.

In April 2019, the Joint Venture made certain changes in the way that it manages its business and allocates costs. Specifically, the Joint Venture made the following changes during the period:

- Moved its consumer payments solution from the Network Solutions reportable segment to the Technology-enabled Services reportable segment.
- Moved its consumer engagement solutions from the Software and Analytics reportable segment to the Network Solutions reportable segment.
- Made certain changes in the way that costs are assigned to the reportable segments.

The presentation in the tables that follow has been retrospectively adjusted to reflect the above described changes. The retrospective reclassifications resulted in an impact to revenue and Adjusted EBITDA of less than 2% for each reportable segment.

Software and Analytics

The Software and Analytics segment provides solutions for revenue cycle management, provider network management, payment accuracy, value-based payments, clinical decision support, consumer engagement, risk adjustment and quality performance, and imaging and clinical workflow.

Network Solutions

The Network Solutions segment provides solutions for financial, administrative and clinical transactions, electronic payments and aggregation and analytics of clinical and financial data.

Technology-enabled Services

The Technology-enabled Services segment provides solutions for revenue cycle and practice management, value-based care enablement, communications and payments, pharmacy benefits administration and consulting.

Corporate and Eliminations

Inter-segment revenue and expenses primarily represent claims management and payment and communication solutions provided between segments.

Corporate and eliminations includes pass-through postage costs, management, administrative and certain other shared corporate services costs that are not allocated to the respective reportable segments, as well as eliminations to remove inter-segment revenue and expenses and consolidating adjustments to classify certain rebates paid to channel partners as a reduction of revenue. These administrative costs are excluded from the adjusted EBITDA measure for each respective reportable segment.

Listed below are the revenue and adjusted EBITDA for each of the reportable segments for the three and six months ended September 30, 2019 and 2018. This information is reflected in the manner utilized by management to make operating decisions, assess performance and allocate resources. Such amounts include allocations of corporate shared services functions that are essential to the core operations of the reportable segments such as information technology, operations and product development functions. Segment assets and related depreciation expenses are not presented to management for purposes of operational decision making, and therefore are not included in the accompanying tables.

	Three Months Ended September 30, 2019				
	Software and Analytics	Network Solutions	Technology-enabled Services	Corporate and Eliminations	Consolidated
Revenue from external customers:					
Solutions revenue	$ 375,789	$ 124,368	$ 243,685	$ (5,141)	$ 738,701
Postage revenue	—	—	—	57,110	57,110
Inter-segment revenue	339	19,908	439	(20,686)	—
Net revenue	$ 376,128	$ 144,276	$ 244,124	$ 31,283	$ 795,811
Adjusted EBITDA	$ 140,078	$ 86,500	$ 44,841	$ (53,726)	$ 217,693
Equity compensation					9,345
Acquisition accounting adjustments					553
Acquisition and divestiture-related costs					414
Integration and related costs					19,781
Management fees and related costs					2,413
Strategic initiatives, duplicative and transition costs					6,120
Severance costs					2,929
Accretion and changes in estimate with related parties, net					3,214
Impairment of long-lived assets and other exit related costs					—
Contingent consideration					1,700
Loss on Extinguishment of Debt					16,900
Other non-routine, net					2,858
EBITDA Adjustments					66,227
EBITDA					151,466
Interest expense					69,901
Depreciation and amortization					77,448
Amortization of capitalized software developed for sale					3,249
Income (loss) before income tax provision (benefit)					$ 868

	Six Months Ended September 30, 2019				
	Software and Analytics	Network Solutions	Technology-enabled Services	Corporate and Eliminations	Consolidated
Revenue from external customers:					
Solutions revenue	$ 812,904	$ 246,121	$ 487,293	$ (10,545)	$ 1,535,773
Postage revenue	—	—	—	115,594	115,594
Inter-segment revenue	568	39,767	821	(41,156)	—
Net revenue	$ 813,472	$ 285,888	$ 488,114	$ 63,893	$ 1,651,367
Adjusted EBITDA	$ 342,393	$ 171,472	$ 89,992	$ (105,108)	$ 498,749
Equity compensation					15,207
Acquisition accounting adjustments					927
Acquisition and divestiture-related costs					1,073
Integration and related costs					45,507
Management fees and related costs					5,060
Strategic initiatives, duplicative and transition costs					9,688
Severance costs					10,099
Accretion and changes in estimate with related parties, net					7,094
Impairment of long-lived assets and other exit related costs					(840)
Contingent consideration					909
Loss on Extinguishment of Debt					16,900
Other non-routine, net					4,008
EBITDA Adjustments					115,632
EBITDA					383,117
Interest expense					153,307
Depreciation and amortization					148,764
Amortization of capitalized software developed for sale					6,698
Income (loss) before income tax provision (benefit)					$ 74,348

	Three Months Ended September 30, 2018				
	Software and Analytics	Network Solutions	Technology-enabled Services	Corporate and Eliminations	Consolidated
Revenue from external customers:					
Solutions revenue	$ 379,998	$ 121,302	$ 242,408	$ (5,922)	$ 737,786
Postage revenue	—	—	—	62,404	62,404
Inter-segment revenue	3,512	15,020	935	(19,467)	—
Net revenue	$ 383,510	$ 136,322	$ 243,343	$ 37,015	$ 800,190
Adjusted EBITDA	$ 139,419	$ 83,612	$ 39,181	$ (46,261)	$ 215,951
Equity compensation					2,959
Acquisition accounting adjustments					555
Acquisition and divestiture-related costs					3,319
Integration and related costs					26,291
Strategic initiatives, duplicative and transition costs					8,348
Severance costs					2,339
Costs related to recently issued accounting standards					1,772
Accretion and changes in estimate with related parties, net					5,932
Management fees and related costs					2,607
Impairment of long-lived assets and other exit related costs					2,343
Gain on Sale of extended care business					(111,392)
Contingent consideration					—
Other non-routine, net					6,004
EBITDA Adjustments					(48,923)
EBITDA					264,874
Interest expense					80,677
Depreciation and amortization					69,258
Amortization of capitalized software developed for sale					3,618
Income (loss) before income tax provision (benefit)					$ 111,321

	Six Months Ended September 30, 2018				
	Software and Analytics	Network Solutions	Technology-enabled Services	Corporate and Eliminations	Consolidated
Revenue from external customers:					
Solutions revenue	$ 772,826	$ 241,892	$ 491,436	$ (10,663)	$ 1,495,491
Postage revenue	—	—	—	127,962	127,962
Inter-segment revenue	7,086	31,033	1,902	(40,021)	—
Net revenue	$ 779,912	$ 272,925	$ 493,338	$ 77,278	$ 1,623,453
Adjusted EBITDA	$ 282,056	$ 165,849	$ 89,154	$ (93,318)	$ 443,741
Equity compensation					8,259
Acquisition accounting adjustments					2,540
Acquisition and divestiture-related costs					7,507
Integration and related costs					47,242
Strategic initiatives, duplicative and transition costs					19,122
Severance costs					10,015
Costs related to recently issued accounting standards					5,513
Accretion and changes in estimate with related parties, net					9,756
Management fees and related costs					5,284
Impairment of long-lived assets and other exit related costs					3,360
Gain on Sale of extended care business					(111,392)
Contingent consideration					272
Other non-routine, net					8,156
EBITDA Adjustments					15,634
EBITDA					428,107
Interest expense					159,226
Depreciation and amortization					137,785
Amortization of capitalized software developed for sale					7,378
Income (loss) before income tax provision (benefit)					$ 123,718

10. Accumulated Other Comprehensive Income (Loss)

The following is a summary of the accumulated other comprehensive income (loss) balances, net of taxes, and related changes for each of the quarterly periods in the three and six months ended September 30, 2019 and 2018.

	Foreign Currency Translation Adjustment	Cash Flow Hedge	Accumulated Other Comprehensive Income (Loss)
Balance at March 31, 2018	$ (14,823)	$ 6,218	$ (8,605)
Cumulative effect of accounting change	—	1,633	1,633
Change associated with foreign currency translation	(8,638)	—	(8,638)
Change associated with current period hedging	—	4,016	4,016
Reclassification into earnings	—	(1,412)	(1,412)
Balance at June 30, 2018	$ (23,461)	$ 10,455	$ (13,006)
Cumulative effect of accounting change	—	—	—
Change associated with foreign currency translation	1,886	—	1,886
Change associated with current period hedging	—	6,218	6,218
Reclassification into earnings	—	(1,293)	(1,293)
Balance at September 30, 2018	$ (21,575)	$ 15,380	$ (6,195)
Balance at March 31, 2019	$ (24,263)	$ (10,769)	$ (35,032)
Reclassification of stranded tax effects as a result of the Tax Legislation	—	(1,406)	(1,406)
Change associated with foreign currency translation	756	—	756
Change associated with current period hedging	—	(17,051)	(17,051)
Reclassification into earnings	—	(1,047)	(1,047)
Balance at June 30, 2019	$ (23,507)	$ (30,273)	$ (53,780)
Change associated with foreign currency translation	3,812	—	3,812
Change associated with current period hedging	—	(3,635)	(3,635)
Reclassification into earnings	—	479	479
Balance at September 30, 2019	$ (19,695)	$ (33,429)	$ (53,124)

11. Equity Based Compensation

Following Change Healthcare Inc.'s initial public offering, Change Healthcare Inc. adopted the Change Healthcare Inc. 2019 Omnibus Incentive Plan (the "Omnibus Incentive Plan") pursuant to which 25.0 million shares of the Change Healthcare Inc.'s stock have been reserved for issuance to employees, directors and consultants of Change Healthcare Inc., the Joint Venture and its affiliates.

In connection with the Omnibus Incentive Plan, Change Healthcare Inc., during the three months ended September 30, 2019, granted to the Joint Venture's employees and directors one or a combination of time-vesting restricted stock units (RSUs), time-vesting deferred stock units, performance stock units, and cash settled restricted stock units under vesting terms that generally vary from one to four years from the date of grant. Each of these instruments are described below.

Restricted Stock Units ("RSUs")—Change Healthcare Inc. granted 4,436,758 RSUs during the three months ended September 30, 2019. The RSUs are subject to either a graded vesting schedule over four years or a one or four year cliff vesting schedule, depending on the terms of the specific award. Upon vesting, the RSUs are exchanged for shares of the Change Healthcare Inc.'s common stock.

Performance Stock Units ("PSUs")—Change Healthcare Inc. granted 1,079,621 PSUs during the three months ended September 30, 2019. The PSUs consist of two tranches, one for which the quantity of awards expected to vest varies based on the Joint Venture's compound annual Revenue growth rate over a three year period in comparison to a target percentage and one for which the quantity of awards expected to vest varies based on the Joint Venture's compound annual Adjusted EBITDA growth rate over a three year period in comparison to a target percentage. The awards earned upon satisfaction of the performance conditions become vested on the fourth anniversary of the vesting commencement date of the award (i.e. continued service is required beyond the satisfaction of the performance condition prior to vesting). The Joint Venture recognizes compensation expense for the PSUs based on the number of awards that are considered probable to vest. Recognition of expense is based on the probability of achievement of performance targets and is periodically reevaluated.

Cash Settled Restricted Stock Units ("CSRSUs")— Change Healthcare Inc. granted 597,006 CSRSUs during the three months ended September 30, 2019. The CSRSUs are expected to vest ratably over three years. Upon vesting, however, Change Healthcare Inc. is required to pay cash in settlement of such CSRSUs based on their fair value at the date such CSRSUs vest.

Deferred Stock Units ("DSUs")—Change Healthcare Inc. granted 45,704 DSUs during the three months ended September 30, 2019. The DSUs vest 100% upon the one-year anniversary of the date of grant. Unlike the RSUs, however, the DSUs are exchanged for shares of the Change Healthcare Inc.'s common stock only following the participant's separation from service.

During the three and six months ended September 30, the Joint Venture recognized compensation expense of $6,096 related to awards granted under the 2019 Plan. At September 30, 2019, aggregate unrecognized compensation expense of the Joint Venture related to awards granted under the 2019 Plan was $87,211.

12. Tangible Equity Units

In July 2019, Change Healthcare Inc. completed its offering of 5,750,000 TEUs. Each TEU, which had a stated amount of $50, was comprised of a prepaid stock purchase contract and a senior amortizing note due June 30, 2022. Change Healthcare Inc. allocated the proceeds from the issuance of the TEUs to equity and debt based on the relative fair values of the respective components of each TEU. Change Healthcare Inc. invested the net proceeds of each in a unit purchase contract and a debt instrument of the Joint Venture on terms that substantially mirror the economics of the TEUs, resulting in net proceeds to the Joint Venture of $276,633 after consideration of underwriting discounts and third party costs that were allocated between the unit purchase contract and debt instrument consistent with the allocation utilized by Change Healthcare Inc. Under these mirrored arrangements, the Joint Venture is required to make cash payments or to transfer LLC Units to Change Healthcare Inc. concurrent with any cash payments or issuance of shares by Change Healthcare Inc. pursuant to the terms of its TEUs.

With respect to the mirrored debt arrangement, the Joint Venture agreed to pay Change Healthcare Inc. an aggregate principal amount of $47,367 in quarterly installments of principal and interest (5.5% per year) on March 30, June 30, September 30, and December 30 of each year through June 30, 2022. Such amounts have been classified with debt on the accompanying consolidated balance sheets.

With respect to the mirrored unit purchase contract, the Joint Venture agreed to issue LLC Units to Change Healthcare Inc. in an amount equal to the number of shares of common stock issued by Change Healthcare Inc. to holders of its purchase contract and at the time of delivery of such common stock to such holders. Such amounts have been classified within Member's deficit on the accompanying consolidated balance sheets.

Because the economics of the unit purchase contract are intended to mirror the purchase contracts issued by Change Healthcare Inc., the Joint Venture expects to deliver between 18,429,325 LLC Units and 22,115,075 LLC Units, subject to adjustment, based on the Applicable Market Value (as defined below) of Change Healthcare Inc.'s common stock as described below:

- If the Applicable Market Value of Change Healthcare Inc.'s common stock is greater than $15.60 per share, holders will receive 3.2051 shares of common stock per purchase contract and the Joint Venture will issue an identical number of LLC units to Change Healthcare Inc.
- If the Applicable Market Value is less than or equal to $15.60 per share but greater than or equal to $13.00 per share, the holder will receive a number of shares of the Company's common stock per purchase contract equal to $50, divided by the Applicable Market Value and the Joint Venture will issue an identical number of LLC units to Change Healthcare Inc.; and
- If the Applicable Market Value is less than $13.00 per share, the holder will receive 3.8461 shares of common stock per purchase contract and the Joint Venture will issue an identical number of LLC units to Change Healthcare Inc.

The Applicable Market Value is defined as the arithmetic average of the volume weighted average price per share of the Company's common stock over the twenty consecutive trading day period immediately preceding the balance sheet date, or June 30, 2022, for settlement of the stock purchase contracts.

The unit purchase contract has a dilutive effect on the Change Healthcare Inc.'s net income (loss) per unit. The 18,429,325 minimum LLC Units to be issued are included in the calculation of basic net income (loss) per unit. The difference between the minimum LLC Units and the maximum LLC Units are potentially dilutive securities, and accordingly, will be included in the Joint Venture's diluted net income (loss) per unit on a pro rata basis to the extent the Applicable Market Value is higher than $13.00 but is less than $15.60 at period end.

13. Net Income (Loss) per Common Unit

The following table sets forth the computation of basic and diluted net income (loss) per common unit:

	Three Months Ended September 30,		Six Months Ended September 30,	
	2019	2018	2019	2018
Basic net income per common unit:				
Numerator:				
Net income (loss)	$ (130)	$ 113,440	$ $ 71,785	$ 125,946
Denominator:				
Weighted average common units outstanding	299,789,703	251,501,744	275,892,383	251,550,892
Minimum units issuable under purchase contracts	18,429,325	—	9,214,663	—
	318,219,028	251,501,744	285,107,046	251,550,892
Basic net income (loss) per common unit	$ —	$ 0.45	$ 0.25	$ 0.50
Diluted net income per common unit:				
Numerator:				
Net income (loss)	$ (130)	$ 113,440	$ 71,785	$ 125,946
Denominator:				
Number of shares used in basic computation	318,219,028	251,501,744	285,107,046	251,550,892
Weighted average effect of dilutive securities				
Add:				
Dilutive units issuable under unit purchase contracts	3,685,750	—	1,842,875	—
Reimbursement units issuable to Change Healthcare Inc.	2,065,255	1,832,196	1,859,929	1,839,878
	323,970,033	253,333,940	288,809,850	253,390,770
Diluted net income (loss) per common unit	$ —	$ 0.45	$ 0.25	$ 0.50

14. Asset Held for Sale

During the three months ended September 30, 2019, the Joint Venture committed to a plan to sell its Alpharetta, GA office property in an effort to reduce its real estate footprint. The Joint Venture expects to complete a sale of the property during its fiscal third quarter and recognize an immaterial gain on sale. As of September 30, 2019, the property had a carrying value of $29,562. As a result of this contemplated sale transaction, the Joint Venture has classified the property as an asset held for sale on the accompanying condensed consolidated balance sheet at September 30, 2019.

15. Subsequent Events

Agreement to Sell Office Building

In October 2019, the Joint Venture executed an agreement for the sale of its Alpharetta, GA office property for proceeds of approximately $31,500. The sale is expected to be completed during the third quarter of the Joint Venture's fiscal year. The Joint Venture expects to recognize a gain of an immaterial amount as a result of this sale.

The Joint Venture has evaluated subsequent events through November 14, 2019, the date the financial statements were available to be issued.

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

FORM 10-Q

(Mark One)

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

For the quarterly period ended June 30, 2019

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

For the transition period from_____to_____

Commission file number 001-38961

Change Healthcare Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware (State or Other Jurisdiction of Incorporation or Organization)	**82-2152098** (I.R.S. Employer Identification No.)
3055 Lebanon Pike, Suite 1000 **Nashville, TN** (Address of Principal Executive Offices)	**37214** (Zip Code)

(615) 932-3000
(Registrant's Telephone Number, Including Area Code)

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $.001 per share	**CHNG**	**The Nasdaq Stock Market LLC**
6.00% Tangible Equity Units	**CHNGU**	**The Nasdaq Stock Market LLC**

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

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

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

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

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

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

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

Class	Outstanding as of August 12, 2019
Common Stock, $0.001 par value	124,850,450

Change Healthcare Inc.

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Change Healthcare Inc.
Condensed Statements of Operations
(unaudited and amounts in thousands, except share and per share amounts)

	Three Months Ended June 30,	
	2019	2018
Revenue	$ —	$ —
Operating expenses		
General and administrative	251	31
Total operating expenses	251	31
Operating income (loss)	(251)	(31)
Non-operating (income) expense		
Loss from Equity Method Investment in the Joint Venture	39,554	22,766
(Gain) Loss on Sale of Interests in the Joint Venture	—	(464)
Management fee income	(104)	(31)
Total non-operating (income) expense	39,450	22,271
Income (loss) before income tax provision (benefit)	(39,701)	(22,302)
Income tax provision (benefit)	(2,184)	(4,801)
Net income (loss)	$ (37,517)	$ (17,501)
Net income (loss) per share:		
Basic	$ (0.50)	$ (0.23)
Diluted	$ (0.50)	$ (0.23)
Weighted average common shares outstanding:		
Basic	75,474,654	75,604,775
Diluted	75,474,654	75,604,775

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Condensed Statements of Comprehensive Income (Loss)
(unaudited and amounts in thousands)

	Three Months Ended June 30,	
	2019	2018
Net income (loss)	$ (37,517)	$ (17,501)
Other comprehensive income (loss):		
Changes in fair value of interest rate swap of the Joint Venture, net of taxes	(5,431)	782
Foreign currency translation adjustment of the Joint Venture	226	(2,593)
Other comprehensive income (loss)	(5,205)	(1,811)
Total comprehensive income (loss)	$ (42,722)	$ (19,312)

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Condensed Balance Sheets
(unaudited and amounts in thousands, except share and per share amounts)

	June 30, 2019	March 31, 2019
Assets		
Current Assets:		
Cash	$ 3,409	$ 3,409
Due from the Joint Venture	574	373
Income taxes receivable	1,601	1,781
Total current assets	5,584	5,563
Dividend receivable	48,807	81,264
Investment in the Joint Venture	1,253,535	1,211,996
Total assets	$ 1,307,926	$ 1,298,823
Liabilities and stockholders' equity		
Current liabilities:		
Accrued expenses	$ 343	$ 176
Due to the Joint Venture	6,167	6,167
Total current liabilities	6,510	6,343
Deferred income tax liabilities	169,992	159,993
Commitments and contingencies (see Note 4)		
Stockholders' Equity:		
Common Stock (par value, $.001), 9,000,000,000 and 252,800,000 shares authorized and 75,474,654 and 75,474,654 shares issued and outstanding at June 30, 2019 and March 31, 2019, respectively	75	75
Class X common stock (par value, $.001), 1 and 1 share authorized and no shares issued and outstanding at June 30, 2019 and March 31, 2019, respectively	—	—
Preferred stock (par value, $.001), 900,000,000 and 0 shares authorized and no shares issued and outstanding at June 30, 2019 and March 31, 2019, respectively	—	—
Additional paid-in capital	1,159,371	1,153,509
Accumulated other comprehensive income (loss)	(8,039)	(3,256)
Retained earnings (deficit)	(19,983)	(17,841)
Total stockholders' equity	1,131,424	1,132,487
Total liabilities and stockholders' equity	$ 1,307,926	$ 1,298,823

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Condensed Statements of Stockholders' Equity
(unaudited and amounts in thousands, except share and per share amounts)

	Common Stock Shares	Common Stock Amount	Additional Paid-in Capital	Retained Earnings (Deficit)	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
Balance at March 31, 2018	75,749,118	$ 75	$ 1,139,300	$ 34,661	$ 2,536	$ 1,176,572
Cumulative effect of accounting change of the Joint Venture-ASU 2017-12	—	—		(490)	490	—
Equity compensation expense	—	—	5,300	—	—	5,300
Repurchase of Change Healthcare Inc. common stock	(251,789)	—	(4,782)	—	—	(4,782)
Issuance of Change Healthcare Inc. common stock upon exercise of equity awards	4,045	—	—	—	—	—
Net income (loss)	—	—	—	(17,501)	—	(17,501)
Foreign currency translation adjustment of the Joint Venture	—	—	—	—	(2,593)	(2,593)
Change in fair value of interest rate cap, net of taxes of the Joint Venture	—	—	—	—	782	782
Balance at June 30, 2018	75,501,374	$ 75	$ 1,139,818	$ 16,670	$ 1,215	$ 1,157,778
Balance at March 31, 2019	75,474,654	$ 75	$ 1,153,509	$ (17,841)	$ (3,256)	$ 1,132,487
Cumulative effect of accounting change of the Joint Venture-ASC 606	—	—	—	35,797	—	35,797
Cumulative effect of accounting change of the Joint Venture-ASU 2018-02	—	—	—	(422)	422	—
Equity compensation expense	—	—	5,862	—	—	5,862
Net income (loss)	—	—	—	(37,517)	—	(37,517)
Foreign currency translation adjustment of the Joint Venture	—	—	—	—	226	226
Change in fair value of interest rate cap, net of taxes of the Joint Venture	—	—	—	—	(5,431)	(5,431)
Balance at June 30, 2019	75,474,654	$ 75	$ 1,159,371	$ (19,983)	$ (8,039)	$ 1,131,424

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Condensed Statements of Cash Flows
(unaudited and amounts in thousands)

	Three Months Ended June 30,	
	2019	2018
Cash flows from operating activities:		
Net income (loss)	$ (37,517)	$ (17,501)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:		
Loss from Equity Method Investment in the Joint Venture	39,554	22,766
Deferred income tax expense (benefit)	(2,184)	(4,801)
(Gain) Loss on Sale of Interests in the Joint Venture	—	(464)
Changes in operating assets and liabilities:		
Due from the Joint Venture	(201)	(31)
Income taxes receivable	180	(208)
Accrued expenses	168	31
Due to the Joint Venture	—	208
Net cash provided by (used in) operating activities	—	—
Cash flows from investing activities:		
Proceeds from sale of interests in Joint Venture	—	4,782
Net cash provided by (used in) investing activities	—	4,782
Cash flows from financing activities:		
Payments to acquire common stock	—	(4,782)
Net cash provided by (used in) financing activities	—	(4,782)
Net increase (decrease) in cash, cash equivalents and restricted cash	—	—
Cash, cash equivalents and restricted cash at beginning of period	3,409	—
Cash, cash equivalents and restricted cash at end of period	$ 3,409	$ —

See accompanying notes to condensed financial statements.

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

1. Nature of Business and Organization

Organization

Change Healthcare Inc. (the "Company"), a Delaware corporation, was formed on June 22, 2016 to hold an equity investment in Change Healthcare LLC (the "Joint Venture"), a joint venture between the Company and McKesson Corporation ("McKesson"). As of June 30, 2019, the Company and McKesson each owned approximately 30% and 70%, respectively, of the membership interest in the Joint Venture, subject to adjustment based on exercise of equity-based awards or other changes in the number of the Joint Venture's membership units outstanding.

The Transactions

In June 2016, the Company, the Joint Venture, Change Healthcare Holdings, LLC, Change Healthcare Intermediate Holdings, LLC, Change Healthcare Performance, Inc. ("Legacy CHC") and its stockholders—including affiliates of The Blackstone Group, Inc. (formerly known as the Blackstone Group L.P.) ("Blackstone") and Hellman & Friedman LLC entered into an Agreement of Contribution and Sale (the "Contribution Agreement") with McKesson (together with the Company, the "Members"). Under the terms of the Contribution Agreement, the parties agreed to form the Joint Venture, a joint venture that combined the majority of the McKesson Technology Solutions businesses, excluding McKesson's Enterprise Information Solutions business and RelayHealth Pharmacy Network (such contributed businesses, "Core MTS"), with substantially all of the assets and operations of Legacy CHC, but excluding Legacy CHC's pharmacy claims switching and prescription routing businesses (such excluded business, the "eRx Network" and the businesses contributed by Legacy CHC, together with Core MTS, the "Contributed Businesses"). The creation of the Joint Venture, including the contribution of the Contributed Businesses and related transactions, is collectively referred to as the "Transactions". The Transactions closed on March 1, 2017.

Amendment of Certificate of Incorporation

Effective June 26, 2019 and in contemplation of its initial public offering of common stock, the Company amended its certificate of incorporation to effect a 126.4 for 1 stock split for all previously issued shares of common stock, to increase the authorized number of common stock, and to authorize shares of preferred stock. Following this amendment, the authorized shares include 9,000,000,000 shares of common stock (par value $.001 per share), 1 share of Class X stock (par value $.001 per share), and 900,000,000 shares of preferred stock (par value $.001 per share). All issued or outstanding shares or related share-based payment arrangement disclosures included herein have been retrospectively adjusted for the stock split.

2. Basis of Presentation

Principles of Consolidation

The accompanying unaudited condensed financial statements have been prepared in accordance with United States generally accepted accounting principles ("GAAP") for interim financial information and with the instructions to Form 10-Q and Rule 10-01 of Regulation S-X of the Securities and Exchange Commission ("SEC") Guidelines, Rules and Regulations and, in the opinion of management, reflect all normal recurring adjustments necessary for a fair presentation of results for the unaudited interim periods presented. Certain information and footnote disclosures normally included in annual financial statements prepared in accordance with GAAP have been condensed or omitted. The results of operations for the interim period are not necessarily indicative of the results to be obtained for the full fiscal year. All intercompany accounts and transactions have been eliminated in the unaudited condensed financial statements.

Accounting Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. The Company bases its estimates on historical experience, current business factors and various other assumptions that the Company believes are necessary to consider in order to form a basis for making judgments about the carrying values of assets and liabilities, the recorded amounts of expenses and disclosure of contingent assets and liabilities. The Company is subject to uncertainties such as the impact of future events, economic, environmental and political factors and changes in the Company's business environment; therefore, actual results could differ from

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

these estimates. Accordingly, the accounting estimates used in the preparation of the Company's financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the Company's operating environment changes. Changes in estimates are made when circumstances warrant. Such changes in estimates and refinements in estimation methodologies are reflected in the reported results of operations; and if material, the effects of changes in estimates are disclosed in the notes to the financial statements. Estimates and assumptions by management affect: the carrying value of the Company's investment; the provision and benefit for income taxes and related deferred tax accounts; contingencies; and the value attributed to equity awards.

Recently Adopted Accounting Pronouncements

In April 2019, the Company adopted Financial Accounting Standards Board ("FASB") Accounting Standards Update ("ASU") No. 2018-07 on a modified retrospective basis, which expands the scope of Topic 718 to include share-based payment transactions for acquiring goods and services from nonemployees. Among other provisions, the measurement date for awards to nonemployees was changed from the earlier of the date at which a commitment for performance by the counterparty was reached or the date at which performance was complete under the previous guidance to the grant date under this update. Because the Company's equity-based compensation was previously subject to remeasurement at fair value each quarter under previous authoritative literature, the adoption of this update had no material direct effect on the Company's consolidated financial statements. As described in Note 7, however, the adoption of this update changed the relationship between the equity-based compensation and the accounting for the freestanding option (i.e. the Dividend receivable).

In April 2019, the Joint Venture adopted Accounting Standards Codification ("ASC") 606, *Revenue from Contracts with Customers*, which replaces most prior general and industry specific revenue recognition guidance with a principles-based comprehensive revenue recognition framework on a modified retrospective basis. Under this revised framework, a company will recognize revenue to depict the transfer of promised goods and services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods and services. As the Company's operations consists principally of an investment in the Joint Venture, its financial statements reflect no revenue and, accordingly, the Company recognized no direct impact on its financial statements from the adoption of this update. However, upon adoption, the Joint Venture recognized a cumulative effect adjustment to its Members' deficit. As a result of the impact of the adoption of ASC 606 to the Joint Venture's Members' deficit, the Company was required to recognize a proportionate amount of this cumulative effect adjustment to its April 1, 2019 retained earnings as well. The effect is disclosed within a separate caption of the accompanying condensed statement of stockholders' equity.

3. Equity Method Investment in Change Healthcare LLC

Exchange of Equity Method Investments

In connection with the Transactions, the Company exchanged its 45.615% investment in Legacy CHC for 30% of the membership units of the Joint Venture. The Joint Venture used proceeds from the issuance of debt to acquire the remaining 54.385% of Legacy CHC. The Company accounted for this exchange of investments as a non-monetary transaction at their respective carrying values. Prior to the Transactions, the investors of Legacy CHC accounted for their investments at fair value. As a result, the book basis and fair value of the Company's investment in Legacy CHC were generally the same such that no gain was recognized as a result of the Transactions.

The fair value of the Joint Venture was determined at March 1, 2017 using a combination of the income and the market valuation approaches. Under the income approach, a discounted cash flow model ("DCF") was used in which cash flows anticipated over several periods, plus a terminal value at the end of that time horizon, are discounted to their present value using an appropriate expected rate of return. The discount rate used for cash flows reflects capital market conditions and the specific risks associated with the business. Under the market approach, valuation multiples of reasonably similar publicly traded companies or guideline companies are applied to the operating data of the subject business to derive the estimated fair value. These valuation approaches are considered a Level 3 fair value measurement. Fair value determination requires complex assumptions and judgment by management in projecting future operating results, selecting guideline companies for comparisons, determining appropriate market value multiples, selecting the discount rate to measure the risks inherent in the future cash flows and assessing the business's life cycle and the competitive trends impacting the business, including considering technical, legal, regulatory, or economic barriers to entry. Any material changes in key assumptions, including failure to meet business plans, deterioration in the financial market, an increase in interest rate or an increase in the cost of equity financing by market participants within the industry or other unanticipated events and circumstances, may affect such estimates.

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

Equity Method Investment in Change Healthcare LLC

The Company accounts for its investment in the Joint Venture using the equity method of accounting. During the three months ended June 30, 2019 and 2018, the Company recorded a proportionate share of the earnings from this investment, which included transaction and integration related expenses incurred by the joint venture and the Company's portion of basis adjustments including amortization expenses associated with equity method intangible assets. These amounts are aggregated and recorded under the caption, "Loss from Equity Method Investment in the Joint Venture" in the accompanying condensed statements of operations.

Summarized financial information of the Joint Venture is as follows:

	Three Months Ended June 30,	
	2019	2018
Statement of Operations Data:		
Total revenue	$ 855,556	$ 823,263
Cost of operations (exclusive of depreciation and amortization)	$ 326,947	$ 337,430
Customer postage	$ 58,484	$ 65,558
Net income (loss)	$ 71,915	$ 12,506

Subsequent to the Company's initial public offering of common stock, it now has a publicly available indication of the value of its investment in the Joint Venture. The fair value that was derived from trading prices of the Company's common stock indicated a potential impairment to the carrying value of its investment in the Joint Venture. Accordingly, the Company evaluated its equity method investment for an other-than-temporary impairment ("OTTI"). The Company considered various factors in determining whether an OTTI has occurred, including the limited trading history available, the Company's ability and intent to hold the investment until its fair value recovers, the implied EBITDA valuation multiples compared to public guideline companies, the Joint Venture's ability to achieve milestones and any notable operational and strategic changes by the Joint Venture. After the evaluation, the Company determined that an OTTI had not occurred as of June 30, 2019 nor as of the date of this quarterly report on Form 10-Q. However, the Company may experience declines in the fair value of its investment in the Joint Venture, and it may determine an impairment loss will be required to be recognized in a future reporting period. Such determination will be based on the prevailing facts and circumstances, including those related to the reported results and disclosures of the Joint Venture as well as from changes in the market price of the Company's common stock.

4. Legal Proceedings

In the ordinary course of business, the Company may become subject to various claims and legal proceedings. The Company is not currently a defendant in any pending litigation.

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

5. Net Income (Loss) Per Share

The following table sets forth the computation of basic net income (loss) per share of common stock:

	Three Months Ended June 30,	
	2019	2018
Basic net income (loss) per share:		
Numerator:		
Net income (loss)	$ (37,517)	$ (17,501)
Denominator:		
Weighted average common shares outstanding	75,474,654	75,604,775
Basic net income (loss) per share	$ (0.50)	$ (0.23)

The calculation of diluted net income (loss) per share has not been presented due to the presence of a net loss for each period.

Due to their antidilutive effect, the following securities have been excluded from diluted net income (loss) per share:

	Three Months Ended June 30,	
	2019	2018
Replacement Time-Vesting Options	1,654,632	1,847,560

6. Income Taxes

The income tax benefit for the three months ended June 30, 2019 and 2018 was $2,184 and $4,801, respectively, which represents an effective tax rate of 5.5% and 21.5%, respectively.

Fluctuations in our reported income tax rates from the statutory rate are primarily due to benefits recognized as a result of certain incentive tax credits resulting from research and experimental expenditures and discrete items recognized in the quarters.

McKesson Tax Receivable Agreement

In connection with the closing of the Transactions, the Joint Venture, subsidiaries of McKesson that serve as members of the Joint Venture (the "McK Members"), McKesson and the Company entered into a tax receivable agreement (the "McKesson Tax Receivable Agreement"). The McKesson Tax Receivable Agreement generally provides for the payment by the Joint Venture to the McK Members and it assigns of 85% of the net cash tax savings realized (or, in certain circumstances, deemed to be realized) by the Company in periods ending on or after the date on which McKesson ceases to own at least 20% of the outstanding units of the Joint Venture (the "LLC Units") as a result of (i) certain amortizable tax basis in assets transferred to the Joint Venture at the closing of the Transactions and (ii) imputed interest deductions and certain other tax attributes arising from payments under the McKesson Tax Receivable Agreement. Additionally, upon the occurrence of the first exchange of LLC Units by McKesson (or its permitted transferees), if any, the Company has agreed to enter into an additional tax receivable agreement with the McK Members, pursuant to which the Company would be required to pay to the relevant McK Member 85% of the net cash tax savings, if any, arising from the Company's utilization of (i) certain tax basis increases resulting from the relevant exchange and payments under such additional tax receivable agreement and (ii) imputed interest deductions. We may also be required to enter into and make payments under an additional tax receivable agreement with McKesson in certain circumstances.

Because payments under the McKesson Tax Receivable Agreement are contingent upon McKesson's ceasing to own at least 20% of the Company and such an event was not probable at the inception of the McKesson Tax Receivable Agreement or as of June 30, 2019, no related obligation has been reflected on the accompanying condensed balance sheet.

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

Letter Agreement

The Company, the Joint Venture, McKesson and certain of McKesson's affiliates have entered into a letter agreement relating to the Contribution Agreement (the "Letter Agreement"). The Letter Agreement addresses miscellaneous tax-related matters, including (i) technical clarifications and modifications to the manner in which the Joint Venture allocates certain items of taxable income, loss and deduction among, and calculates and makes required tax distributions to, its members, (ii) the sharing of certain contingent tax benefits and expenses not addressed by the McKesson Tax Receivable Agreement or the tax matters agreement that the Company will enter into with McKesson in connection with a spin-off or split-off transaction (or a combination of the foregoing) that McKesson may, at its election, initiate and complete that would result, among other things, in the acquisition by the Company of all of McKesson's LLC Units and the issuance by the Company to McKesson and/or McKesson's securityholders of an equal number of shares of its common stock and (iii) procedures applicable in the case of certain tax proceedings. In particular, pursuant to the terms of the Letter Agreement, McKesson may adjust the manner in which depreciation or amortization deductions in respect of assets transferred to the Joint Venture at the closing of the Transactions are allocated among the Company, McKesson and certain of McKesson's affiliates beyond minimum amounts provided in the LLC Agreement. If an amount of deductions is allocated to the Company in excess of a specified minimum threshold, the Company will be required to make cash payments to McKesson equal to 100% of the tax savings of the Company attributable to such excess deductions for any tax period ending prior to the date on which McKesson ceases to own at least 20% of the outstanding LLC Units of the Joint Venture, after which the terms of the McKesson Tax Receivable Agreement will control. The determination of whether any amount of deductions will be allocated to the Company is, in part, dependent on a future initial public offering. No obligation has been reflected on the accompanying condensed consolidated balance sheet.

7. Fair Value Measurements

The Company is entitled to receive an additional unit of the Joint Venture for each share of stock issued by the Company. In the case of equity-based awards, the requirement to receive an additional unit of the Joint Venture upon exercise of such awards represents a freestanding derivative. Because the fair value measurement of this derivative involves significant unobservable inputs, the most significant of which is the use of a levered volatility calculation of a peer group of companies, the Company has determined that it represents a Level 3 fair value measurement.

Because the freestanding derivative is directly related to the Company's equity-based compensation awards, the valuation of the derivative is determined to be consistent with the valuation of the underlying equity-based awards (although we use a current period measurement date). As with the equity-based awards, changes in the value of the derivative are generally expected to fluctuate with changes in the value of the Company's stock.

The following table summarizes the fair value of the freestanding derivative at June 30, 2019 and March 31, 2019, respectively:

	Fair Values of Derivative Financial Instruments Asset (Liability)		
Derivative financial instruments not designated as hedging instruments:	**Balance Sheet Location**	**June 30, 2019**	**March 31, 2019**
Freestanding Option	Dividend receivable	$ 48,807	$ 81,264

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

The following table presents a reconciliation of the fair value of the derivative for which the Company uses significant unobservable inputs:

	Three Months Ended June 30,	
	2019	2018
Balance at beginning of period	$ 81,264	$ 59,116
Increase in fair value based on ASC 505 equity-based compensation	—	5,300
Settlements due to exercise of awards	—	(78)
Change in fair value of equity-based awards	(32,457)	—
Balance at end of period	$ 48,807	$ 64,338

As the dividend receivable was initially received in connection with the contribution of assets to the Joint Venture, the initial fair value was treated as a component of the Company's contribution of assets and receipt of its Investment in Change Healthcare. During the three months ended June 30, 2018, the Company recognized an increase in the Dividend Receivable, which was equal to the amount of equity-based compensation recognized and was recorded as a component of Loss from Equity Method Investment in the Joint Venture. The result was that no net equity-based compensation related to employees of the Joint Venture was recognized in the financial statements of the Company for the three months ended June 30, 2018.

Following the adoption of FASB ASU No. 2018-07, however, the measurement of equity-based compensation generally becomes fixed at the date of grant such that the fair value of the dividend receivable is no longer correlated with the amount of equity compensation recognized. As a result, following the adoption of FASB ASU No. 2018-07, the Loss from Equity Method Investment in the Joint Venture is subject to variability associated with changes in the fair value of the equity-based awards.

8. Accumulated Other Comprehensive Income (Loss)

The following is a summary of the Company's proportionate share of the Joint Venture's accumulated other comprehensive income (loss) balances, net of taxes, as of and for the three months ended June 30, 2019 and 2018.

	Foreign Currency Translation Adjustment	Cash Flow Hedge	Accumulated Other Comprehensive Income (Loss)
Balance at March 31, 2018	$ 1,268	$ 1,268	$ 2,536
Cumulative effect of accounting change of the Joint Venture-ASU 2017-12	—	490	490
Change associated with foreign currency translation	(2,593)	—	(2,593)
Change associated with current period hedging	—	1,206	1,206
Reclassification into earnings	—	(424)	(424)
Balance at June 30, 2018	$ (1,325)	$ 2,540	$ 1,215
Balance at March 31, 2019	$ (1,565)	$ (1,691)	$ (3,256)
Cumulative effect of accounting change of the Joint Venture-ASU 2018-02	—	422	422
Change associated with foreign currency translation	226	—	226
Change associated with current period hedging	—	(5,117)	(5,117)
Reclassification into earnings	—	(314)	(314)
Balance at June 30, 2019	$ (1,339)	$ (6,700)	$ (8,039)

Change Healthcare Inc.
Notes to Condensed Financial Statements
(unaudited and amounts in thousands, except share and per share amounts)

Effective April 1, 2018, the Joint Venture adopted FASB ASU No. 2017-12, which significantly changed the framework by which hedge accounting is recognized, presented and disclosed in the Joint Venture's financial statements. The adoption of this update by the Joint Venture resulted in a reclassification between its accumulated other comprehensive income (loss) and accumulated earnings (deficit).

Effective April 1, 2019, the Joint Venture adopted FASB ASU No. 2018-02, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017. The adoption of this update resulted in a reclassification between accumulative other comprehensive income (loss) and accumulated earnings (deficit).

As an investor in the Joint Venture, the Company has recognized its proportionate amount of these reclassifications as presented in the table above.

9. Subsequent Events

In July 2019, the Company completed its initial offering of 49,285,713 of common stock and the concurrent offering of 5,750,000 of tangible equity units ("TEUs") for net proceeds of $608,679 and $278,875 respectively, before consideration of offering costs paid subsequent to the offerings from available cash. The proceeds of the offering of common stock were subsequently contributed to the Joint Venture in exchange for 49,285,713 additional units of the Joint Venture, which together with the Company's existing holdings represents an approximately 41% interest in the Joint Venture. The proceeds of the offering of TEUs were used to acquire TEUs of the Joint Venture that substantially mirror the terms of the TEUs included in the offering. The Joint Venture, in turn, used the proceeds received from Change Healthcare Inc. to repay $805,000 of its indebtedness under the Term Loan Facility without penalty. However, due to the presence of unamortized discounts, the Joint Venture expects to recognize a loss on extinguishment of debt of approximately $14,300 for which the Company will recognize a proportionate amount within its loss from equity method investment in the Joint Venture.

In addition to the effects of the Joint Venture's partial extinguishment of debt on the Company's loss from equity method investment in the Joint Venture, the Company also expects other direct and indirect effects of the offerings. Some of the more significant expected effects include the following:

- As a direct result of the additional ownership interest acquired in the Joint Venture, the Company expects to recognize a greater proportion of the earnings or loss of the Joint Venture when measuring its loss from equity method investment in the Joint Venture each period.
- The purchase of additional interests in the Joint Venture results in a difference in the cost of the Company's investment in the Joint Venture and the amount of the underlying equity in the Joint Venture (i.e. "basis difference"). In accordance with GAAP, such basis differences must be accounted for as if the investee were a consolidated subsidiary. As a result, the Company is required to prepare a valuation of the Joint Venture's assets and liabilities as of the purchase date and perform an allocation of the purchase price among the underlying assets and liabilities of the Joint Venture as if the Company had gained control of the Joint Venture. The effect is that the Company will be required to recognize the effect of these additional basis differences on its periodic measurement of the loss from equity method investment in the Joint Venture. Due to the recent timing of the acquisition of this interest and the time necessary to complete such a valuation exercise, the Company cannot yet quantify the effects of these basis differences on the loss from equity method investment in the Joint Venture.
- The investment in the mirror TEUs (which include both an amortizing debt component and a prepaid equity forward purchase contract) of the Joint Venture is expected to result in the Company recognizing separate investments in a debt security and a prepaid equity forward purchase contract. In each case, the Company expects these investments to be subject to periodic measurement to their respective fair values.
- As a result of the offering of TEUs, the Company expects to recognize interest expense associated with the amortizing note component of the TEUs as well as interest income associated with the amounts expected to be received from the mirror TEUs issued by the Joint Venture to the Company.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion and analysis of the financial condition and results of operations of Change Healthcare Inc. and Change Healthcare LLC is provided as a supplement to, and should be read in conjunction with, Change Healthcare Inc.'s and Change Healthcare LLC's audited financial statements and the accompanying notes as well as the "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Change Healthcare Inc.'s Registration Statement on Form S-1 (File No. 333-230345), as well as the unaudited consolidated financial statements and the related notes presented in Part I, Item 1 of this Quarterly Report for the quarter ended June 30, 2019 ("Quarterly Report").

In addition to historical data, this discussion contains forward-looking statements about the business, operations and financial performance of Change Healthcare Inc. and Change Healthcare LLC based on current expectations that involve risks, uncertainties and assumptions. Actual results may differ materially from those discussed in the forward-looking statements as a result of various factors, including but not limited to those discussed below in "Cautionary Notice Regarding Forward-Looking Statements," and Part II, Item 1A, "Risk Factors."

References in this discussion and analysis to "Change Healthcare Inc." refer to Change Healthcare Inc. and not to any of its subsidiaries. References in this discussion and analysis to the Joint Venture refer to Change Healthcare LLC and its direct and indirect subsidiaries.

Recent Developments

Effective June 26, 2019, Change Healthcare Inc.'s Registration Statement on Form S-1 for the initial public offering of 49.3 million shares of common stock and the concurrent offering of 5.75 million tangible equity units ("TEUs") was declared effective by the Securities & Exchange Commission and Change Healthcare Inc. subsequently amended its charter to authorize $9 billion shares of common stock and effected a 126.4 for 1 split of its common stock. Change Healthcare Inc.'s stock and TEUs began trading the next day on the NASDAQ under the CHNG and CHNGU ticker symbols, respectively.

The offerings of common stock and TEUs were consummated on July 1, 2019 and resulted in Change Healthcare Inc. receiving net proceeds of $608.7 million and $278.9 million respectively, before consideration of offering costs paid subsequent to the offering from available cash. The proceeds of the offering of common stock were subsequently contributed to the Joint Venture in exchange for 49.3 million additional units of the Joint Venture. The proceeds of the offering of TEUs were used to acquire TEUs of the Joint Venture that substantially mirror the terms of the TEUs issued by Change Healthcare Inc. in the offering. The Joint Venture, in turn, used the proceeds received from Change Healthcare Inc. to repay $805 million of its indebtedness under the Term Loan Facility without penalty and expects to use the remaining proceeds to repay additional amounts outstanding under the Term Loan Facility.

In July 2019, the Joint Venture amended its Revolving Facility, the primary effects of which were to increase the maximum amount that can be borrowed from $500.0 million to $785.0 million and to extend the maturity date until March 1, 2024. In the event that the outstanding balance under the Term Loan Facility exceeds $1.1 billion on December 1, 2023, however, amounts due, if any, under the Revolving Facility become due and payable on December 31, 2023.

Change Healthcare Inc.

Overview

Change Healthcare Inc. (formerly HCIT Holdings, Inc.), a Delaware corporation, was formed on June 22, 2016 to hold an equity investment in Change Healthcare LLC, a joint venture between Change Healthcare Inc. and McKesson Corporation ("McKesson"), which we refer to as the Joint Venture. Each of Change Healthcare Inc. and McKesson holds a 50% voting interest in the Joint Venture, with equal representation on the Joint Venture's board of directors and with all major operating, investing and financial activities requiring the consent of both members. As a result, Change Healthcare Inc. accounts for this investment using the equity method of accounting.

Change Healthcare Inc. has no substantive assets apart from its investment in the Joint Venture. As a result, Change Healthcare Inc. believes the financial statements of the Joint Venture are more relevant to an investor than Change Healthcare Inc.'s financial statements as they include greater detail regarding the financial condition and results of operations of the business.

Key Components of Change Healthcare Inc.'s Results of Operations

Loss from Equity Method Investment in the Joint Venture

Loss from equity method investment in the Joint Venture generally represents Change Healthcare Inc.'s proportionate share of the income or loss from this investment, including basis adjustments related to amortization expense associated with equity method intangible assets, property and equipment, deferred revenue and other items.

Loss from equity method investment in the Joint Venture was $39.6 million and $22.8 million for the three months ended June 30, 2019 and 2018, respectively. The loss from equity method investment in the Joint Venture for the three months ended June 30, 2019 was discretely affected by the Joint Venture's adoption of Financial Accounting Standards Board ("FASB") Accounting Standards Codification No. 606 ("ASC 606") and Change Healthcare Inc.'s adoption of FASB Accounting Standards Update No. 2018-07 ("ASU 2018-07"). The loss from equity method investment in the Joint Venture was decreased by approximately $13.6 million as a result of the continuing effect of the adoption of ASC 606 and was increased by approximately $32.5 million as a result of changes in the fair value of its dividend receivable following the adoption of ASU 2018-07.

General and Administrative Expense and Management Fees

In addition to its income (loss) from its equity method investment in the Joint Venture, Change Healthcare Inc. may also periodically incur certain other operating expenses, including professional service fees, general liability insurance, and other fees associated with being an SEC registrant.

To the extent any such fees Change Healthcare Inc. incurs are required to facilitate or maintain its status as a public company, however, the limited liability company agreement of the Joint Venture (the "LLC Agreement") contemplates that Change Healthcare Inc. be reimbursed for such costs by the Joint Venture. Such reimbursements are classified as management fees within Change Healthcare Inc.'s statements of operations.

Gain (Loss) on Sale of Interests in the Joint Venture

Under the terms of the LLC Agreement, Change Healthcare Inc. and the Joint Venture agreed to cooperate to ensure a 1:1 ratio of outstanding shares of common stock of Change Healthcare Inc. to the units of the Joint Venture ("LLC Units") held by Change Healthcare Inc. as long as the subsidiaries of McKesson that serve as members of the Joint Venture (the "McK Members") hold LLC Units. This provision requires that Change Healthcare Inc. be issued an additional LLC Unit for each share of common stock that Change Healthcare Inc. issues. Similarly, for any share that Change Healthcare Inc. repurchases, the Joint Venture is likewise required to repurchase a respective LLC Unit from Change Healthcare Inc. In this latter case, the repurchase by the Joint Venture of LLC Unit(s) from Change Healthcare Inc. results in a gain or loss to Change Healthcare Inc. equal to the difference in the fair value of such LLC Units and the proportionate carrying value of Change Healthcare Inc.'s investment in the Joint Venture associated with such repurchased LLC Units.

Income Taxes

As the Joint Venture is treated as a partnership for income tax purposes, Change Healthcare Inc. is subject to income taxes for its allocable portion of the Joint Venture's taxable income. The income tax benefit was $2.2 million and $4.8 million (which resulted in effective income tax rates of 5.5% and 21.5%) for the three months ended June 30, 2019 and 2018, respectively.

Liquidity and Capital Resources

Overview

Change Healthcare Inc.'s principal source of liquidity consists of distributions or advances from the Joint Venture. To the extent that Change Healthcare Inc. requires additional funds, Change Healthcare Inc. may need to raise funds through subsequent debt or equity financing.

Change Healthcare Inc. has not incurred, nor does it expect to incur, significant capital expenditures in the normal course of business or to pursue acquisition opportunities other than through the Joint Venture.

Off-Balance Sheet Arrangements

As of June 30, 2019, Change Healthcare Inc. had no off-balance sheet arrangements.

Recent Accounting Pronouncements

See Note 2, *Basis of Presentation*, within Change Healthcare Inc.'s financial statements appearing elsewhere in this Quarterly Report for information about recent accounting pronouncements and the potential impact on Change Healthcare Inc.'s financial statements.

Critical Accounting Estimates

The preparation of financial statements in accordance with United States generally accepted accounting principles ("GAAP") requires Change Healthcare Inc. to make estimates and assumptions that affect reported amounts and related disclosures. Change Healthcare Inc. considers an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on Change Healthcare Inc.'s results of operations and financial condition.

As disclosed in Note 2, *Summary of Significant Accounting Policies,* in Change Healthcare Inc.'s Registration Statement on Form S-1 (333-230345), Change Healthcare Inc. evaluates its equity method investment for impairment review whenever an event or change in circumstances occurs that may have a significant adverse impact on the carrying value of the investment. If a loss in value occurs that is deemed to be other than temporary, an impairment loss would be recognized.

Subsequent to the IPO, Change Healthcare Inc. now has a publicly available indication of the value of its investment in the Joint Venture. The fair value that was derived from trading prices of Change Healthcare Inc.'s common stock during the two-day trading period in June 2019 indicated a potential impairment to Change Healthcare Inc.'s carrying value. Accordingly, Change Healthcare Inc. evaluated its equity method investment for an other-than-temporary impairment ("OTTI"). Change Healthcare Inc. considered various factors in determining whether an OTTI had occurred, including the limited trading history available, the implied EBITDA valuation multiples compared to public guideline companies, the Joint Venture's ability to achieve milestones and any operational and strategic changes by the Joint Venture that might have negatively impacted the fair value. After the evaluation, Change Healthcare Inc. determined that an OTTI had not occurred as of June 30, 2019 or as of the date of this quarterly report on Form 10-Q. However, the Joint Venture may experience declines in its fair value and Change Healthcare Inc. may determine an impairment loss will be required to be recognized in a future reporting period. Such determination will be based on the prevailing facts and circumstances, including those related to the reported results and disclosures of the Joint Venture as well as from changes in the market price of Change Healthcare Inc.'s common stock.

Change Healthcare Inc. believes the current assumptions and other considerations used to estimate amounts reflected in Change Healthcare Inc.'s financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in Change Healthcare Inc.'s financial statements, the resulting changes could have a material adverse effect on Change Healthcare Inc.'s results of operations and financial condition.

See Note 2, *Summary of Significant Accounting Policies*, within Change Healthcare Inc.'s financial statements appearing in Registration Statement on Form S-1 (333-230345) for information about Change Healthcare Inc.'s other critical accounting policies.

Quantitative and Qualitative Disclosure of Market Risk

As Change Healthcare Inc. has no substantive assets or operations apart from its investment in the Joint Venture, Change Healthcare Inc. does not believe that it has significant market risk.

Summary Disclosures about Contractual Obligations and Commercial Commitments

Change Healthcare Inc. has no ongoing contractual obligations or commercial commitments as of June 30, 2019. As indicated in Recent Developments above, Change Healthcare Inc. consummated an offering of TEUs on July 1, 2019. Such TEUs include aggregate amortizing notes of $47.4 million which are due in quarterly installments of principal and interest through June 30, 2022.

Change Healthcare LLC

Overview

The Joint Venture is a leading independent healthcare technology company, formed through the combination of substantially all of the businesses of Change Healthcare Performance, Inc. (formerly Change Healthcare, Inc.) ("Legacy CHC") and a majority of the McKesson Technology Solutions business (the "Core MTS"), which was completed on March 1, 2017. The Joint Venture offers a comprehensive suite of software, analytics, technology enabled services and network solutions that drive improved results in the complex workflows of healthcare system payers and providers. The Joint Venture's solutions are designed to improve clinical decision making, simplify billing, collection and payment processes and enable a better patient experience.

The Joint Venture offers comprehensive end-to-end solutions with modular capabilities to address its customers' needs. Working with its customers to analyze workflows before, during and after care has been delivered to patients, the Joint Venture designs and commercializes innovative solutions for various points in the healthcare delivery timeline. The Joint Venture's offerings range from discrete data and analytics solutions to broad enterprise-wide solutions, which include workflow software and technology-enabled services that help its customers achieve their operational objectives. As payers and providers become larger and more sophisticated and manage increasingly complex workflows, the Joint Venture believes it will increasingly seek strategic partners with scale and comprehensive, high value solutions.

The Joint Venture's Intelligent Healthcare Network was created to facilitate the transfer of data among participants and is one of the largest clinical and financial healthcare networks in the United States. In the fiscal year ended March 31, 2018, Change Healthcare facilitated nearly 14 billion healthcare transactions and approximately $1 trillion in adjudicated claims or approximately one-third of all U.S. healthcare expenditures. The Joint Venture serves the vast majority of U.S. payers and providers. The Joint Venture's customer base includes approximately 2,200 government and commercial payer connections, 900,000 physicians, 118,000 dentists, 33,000 pharmacies, 5,500 hospitals and 600 laboratories. This network transacts clinical records for over 112 million unique patients, more than one-third of the estimated total U.S. population. With insights gained from its pervasive network, extensive applications and analytics portfolio and its services operations, the Joint Venture has designed analytics solutions that include industry-leading and trusted franchises supported by extensive intellectual property and regularly updated content.

In addition to the advantages of scale, the Joint Venture believes it offers the collaborative benefits of a mission-critical partner. The Joint Venture seeks enduring relationships with each customer through solutions embedded in their complex daily workflows that deliver measurable results. The Joint Venture's customer retention rate for its top 50 provider and top 50 payer customers for the fiscal year ended March 31, 2019 was 100%. The Joint Venture believes its size, scale, thought leadership and prevalence across the healthcare ecosystem help make it a preferred partner for innovative technology companies and industry associations focused on driving standardization and efficiencies in the healthcare industry.

Segments

The Joint Venture reports its financial results in the following three reportable segments: Software and Analytics, Network Solutions and Technology-Enabled Services.

- Software and Analytics provides software and analytics solutions for financial performance, payment accuracy, clinical decision management, value-based payment, provider and consumer engagement and imaging and clinical workflow.
- Network Solutions enables financial, administrative and clinical transactions, electronic business-to-business and consumer-to-business payments and aggregation and analytics of clinical and financial data.
- Technology-Enabled Services provides solutions for financial and administrative management, value-based care, communication and payment, pharmacy benefits administration and healthcare consulting.

In April 2019, the Joint Venture made certain changes in the way that it manages its business and allocates costs. Specifically, the Joint Venture made the following changes:

- Moved its consumer payments solution from the Network Solutions reportable segment to the Technology-enabled Services reportable segment.
- Moved its consumer engagement solutions from the Software and Analytics reportable segment to the Network Solutions reportable segment.
- Made certain changes in the way that costs are assigned to reportable segments.

The presentation of revenue and Adjusted EBITDA included within this management's discussion and analysis of financial condition and results of operations has been retrospectively adjusted for all periods presented to reflect the above described changes.

Factors Affecting Change Healthcare's Results of Operations

The following are certain key factors that affect, will affect, or have recently affected, the Joint Venture's results of operations:

Post-Contribution Cost Synergies

In connection with the Transactions, the Joint Venture identified opportunities to implement certain cost synergies based on its analyses of existing operating structures, estimated spend by category, its resource requirements and industry benchmarks for similar activities. The Joint Venture expects such cost synergies to include, among others, (i) product integration, network efficiencies and combining common products; (ii) procurement savings from the elimination of duplicate orders, leveraging scale and optimization of providers; (iii) utilization of global talent; and (iv) reduction of management redundancies and duplicative roles.

By the end of the fourth year following the combination of the Legacy CHC and Core MTS, the Joint Venture expects to have implemented operational initiatives to fully realize these synergies, which are expected to result in significant annual run-rate cost savings and efficiencies. The Joint Venture has incurred significant non-recurring expenses and expects to continue to incur such expenses in order to achieve these cost synergies.

Macroeconomic and Industry Trends

The healthcare industry is highly regulated and subject to frequently changing complex regulatory and other requirements. For example, ongoing healthcare reform has significantly affected the healthcare regulatory environment by changing how healthcare services are covered, delivered and reimbursed through coverage expansion, reduced federal healthcare program spending, increased efforts to link federal healthcare program payments to quality and efficiency and insurance market reforms. The number of states that will ultimately participate in some form of Medicaid expansion and the future of mandated coverage for individuals is not yet clear. If the Patient Protection and Affordable Care Act (collectively, the "ACA") is repealed or significantly modified, such repeal or modification, any alternative reforms adopted in its place or the failure to adopt alternative reforms may have a material impact on the Joint Venture's business. For example, since many of the Joint Venture's products and services include solutions designed to assist customers in effectively navigating the shift to value-based healthcare, the elimination of, or significant reductions to, the ACA's various value-based healthcare initiatives may adversely impact the Joint Venture's business. While the specific regulatory instruments and tactics used to implement reform may change in the future, the Joint Venture expects that the pervasive focus on improving coverage, efficiency and quality and related needs for payers and providers to optimize performance and reduce costs will continue.

Revenue Convergence

In April 2019, the Joint Venture adopted Accounting Standards Codification ("ASC") 606, *Revenue from Contracts with Customers*, which replaces most prior general and industry specific revenue recognition guidance with a principles-based comprehensive revenue recognition framework.

The Joint Venture adopted ASC 606 using the modified retrospective transition method applied only to contracts that were not completed as of the date of initial application. The adoption of ASC 606 resulted in a cumulative effect adjustment to reduce members' deficit as of April 1, 2019 by $159.9 million. After assessing all potential impacts of adopting the new standard on its consolidated financial statements, related disclosures, and necessary control and process changes, the Joint Venture noted the following to be the most notable impacts of adopting the new standard:

- Revenue for certain contingent fee service arrangements will be accelerated as revenue for these arrangements is recognized as the services are performed.
- Revenue related to certain time-based software and content license agreements will be accelerated. The license component for certain time-based software will be recognized upon delivery to the customer ("point in time"), or in the case of software that requires significant production, modification or customization, recognized as the implementation work is performed. A non-license component (e.g., technical support) will be recognized over the respective contract terms ("over time").
- Incremental costs to obtain contracts and qualifying costs to fulfill will be capitalized and amortized over the period of benefit. The net result of this change was an increase to capitalized contract costs on the balance sheet; these capitalized costs will be amortized and recognized as expense over an incrementally longer period of time.

Refer to Note 2, *Basis of Presentation*, in the unaudited condensed financial statements of the Joint Venture included as Exhibit 99.1 to this Quarterly Report for a full description of the impact of the adoption of ASC 606 on the Joint Venture's financial statements.

Equity-based Compensation

Change Healthcare Inc. grants equity-based awards of Change Healthcare Inc. common stock to certain employees, officers and directors of Change Healthcare Inc., eRx Network, and the Joint Venture. For grants to employees, equity-based awards are generally measured at the date of grant and recognized as expense over each employee's service period. Because the Joint Venture's employees are not considered employees of Change Healthcare Inc., however, prior to the adoption of FASB ASU No. 2018-07 on April 1, 2019, the Joint Venture was generally required to re-measure these equity-based awards at fair value each quarter until the earlier of the completion of required service or the performance commitment date. As a result, the Joint Venture's results of operations have historically reflected volatility from the periodic re-measurement of its equity-based awards.

In April 2019, the Joint Venture adopted FASB ASU No. 2018-07, the effect of which is to require that equity awards to non-employees be treated similarly to awards to employees. As a result, the Joint Venture expects to significantly lessen the volatility on equity-based compensation that has historically resulted from changes in the fair value of the underlying stock of Change Healthcare Inc., stock price volatility among its peer companies, changes in interest rates and the passage of time.

Acquisitions and Divestitures

The Joint Venture actively evaluates opportunities to improve and expand its business through targeted acquisitions that are consistent with its strategy. On occasion, the Joint Venture also may dispose of certain components of its business that no longer fit within its overall strategy. Because of the Joint Venture's acquisition and divestiture activity as well as the shifting revenue mix of its business due to this activity, the Joint Venture's results of operations may not be directly comparable among periods.

In July 2018, certain of the Joint Venture's affiliates sold all of the membership interests in the Joint Venture's extended care business (a component of the software and analytics reportable segment) for net cash proceeds of $159.9 million, subject to certain post-closing adjustments including for working capital.

Income Taxes

The Joint Venture's effective income tax rate is affected by several factors. The following table and subsequent commentary reconciles the Joint Venture's federal statutory rate to its effective income tax rate and the subsequent commentary describes the more significant of the reconciling factors:

	Three Months Ended June 30, 2019	Three Months Ended June 30, 2018
Statutory U.S. federal tax rate	21.00%	21.00%
State income taxes (net of federal benefit)	1.42	(1.51)
Income passed through to Members	(14.84)	(25.23)
Global intangible low taxed income (GLTI)	0.70	2.89
Change in tax liability on outside basis difference of foreign subsidiary	0.51	1.19
Change in valuation allowance	(4.60)	0.43
Accretion and changes in estimate, net	0.39	1.71
Research and development credits (net of uncertain tax positions)	(2.85)	(3.02)
Other	0.39	1.67
Effective income tax rate	2.12%	(0.87)%

State Income Taxes--The Joint Venture's effective tax rate for state income taxes is generally impacted by changes in its apportionment.

Income Passed through to Members—Certain of the Joint Venture's subsidiaries are organized as limited liability corporations and report income that is distributed to the Members where it is subject to income taxes.

Global intangible low taxed income—The Tax Cuts and Jobs Act introduced a tax on U.S. based corporations with foreign earnings that exceed an allowable percentage of invested foreign assets.

Change in tax liability on outside basis difference of foreign subsidiary—The Joint Venture records tax expense or benefit related to undistributed earnings in a foreign subsidiary for the change in the amount of excess of book basis over tax basis in the subsidiary.

Change in Valuation Allowance—The Joint Venture records valuation allowances or reverse existing valuation allowances related to assumed future income tax benefits depending on circumstances and factors related to its business. During the three months ended June 30, 2019, the Joint Venture released a valuation allowance related to prior deferred tax assets as a result of its change in judgment resulting from forecasted earnings and tax planning strategies that provide for future taxable income in the relevant jurisdictions.

Accretion and changes in estimate, net—As a result of a prior business combination, the Joint Venture was required to record its 2009-2011 Tax Receivable Agreements at their then fair value which results in subsequent periodic accretion to adjust this initial fair value to the gross amount of payments due under such agreements. The Joint Venture generally is unable to deduct such accretion when determining its taxable income.

Research and development credits (net of uncertain tax position liability)—The Joint Venture records credits against income taxes for certain research and development expenditures in the U.S. and Canada net of the portion that is estimated to be included in the Company's unrecognized tax benefits.

Public Company Costs

Following the completion of Change Healthcare Inc.'s offering, the Joint Venture expects to incur additional costs associated with Change Healthcare Inc.'s operating as a public company. The Joint Venture expects that these costs will include additional personnel, legal, consulting, regulatory, insurance, accounting, investor relations and other expenses that it did not incur as a private company. The Sarbanes-Oxley Act, as well as rules adopted by the SEC and national securities exchanges, requires public companies to implement specified corporate governance practices that historically have been inapplicable to Change Healthcare Inc. and the Joint Venture. These additional rules and regulations will increase the Joint Venture's legal, regulatory and financial compliance costs and will make some activities more time-consuming and costly.

Qualified McKesson Exit

In connection with a Qualified McKesson Exit, we anticipate that Change Healthcare Inc. will acquire the interest in the Joint Venture that it did not own prior to such transaction. As a result, in periods following the Qualified McKesson Exit, Change Healthcare LLC is expected to be a wholly-owned subsidiary of Change Healthcare Inc. and Change Healthcare Inc. will consolidate the financial position and results of Change Healthcare LLC in its financial statements.

Change Healthcare Inc. expects to account for the Qualified McKesson Exit and related transactions as a business combination achieved in stages in accordance with the FASB Accounting Standards Codification Business Combinations Topic, resulting in a new basis of accounting. As a result, Change Healthcare Inc. will be required to remeasure its investment in the Joint Venture to fair value as of the date that control is obtained and will recognize a gain or loss in its statement of operations for the difference in the carrying value and fair value of this investment. Further, Change Healthcare Inc. expects to recognize the consideration transferred, as well as the acquired business's identifiable assets, liabilities and noncontrolling interests at their acquisition date fair value. The excess of the consideration transferred over the fair value of the identifiable assets, liabilities and noncontrolling interest, if any, is anticipated to be recorded as goodwill. Any excess of the fair value of the identifiable assets acquired and liabilities assumed over the consideration transferred, if any, would generally be recognized within earnings as of the acquisition date.

As a result of the accounting for these transactions and the anticipated change in basis of accounting, the consolidated results of Change Healthcare Inc. in periods following the Qualified McKesson Exit will not be comparable to the consolidated results of the Joint Venture in periods prior to the Qualified McKesson Exit. The following are certain of the more significant changes resulting from the Qualified McKesson Exit that are expected to affect the comparability of financial results and operations:

- Gain or loss upon remeasuring Change Healthcare Inc.'s investment in the Joint Venture at its fair value.
- Increased tangible and intangible assets resulting from adjusting the basis of tangible and intangible assets to their fair value which is expected to result in increased depreciation and amortization expense.
- Potential increase or decrease in long-term debt as a result of adjustments to state the long-term debt at its fair value. Resulting differences in the historical carrying value and fair value of the long-term debt are expected to result in either additional discount or premium which, in turn, may materially increase or decrease future interest expense.
- Decreased deferred revenue as a result of recognizing deferred revenue in the business combination only to the extent that contractual obligations remain to be fulfilled at that time. Decreases in deferred revenue are expected to result in decreased solutions revenue in the near term.
- Income currently attributable to the Joint Venture and not subject to U.S. federal income taxes and most state and local income taxes will become subject to such taxes, resulting in an expected increase in Change Healthcare Inc.'s effective tax rate compared with the historical effective tax rate of the Joint Venture.

Results of Operations

The Joint Venture adopted the new revenue recognition accounting standard Accounting Standards Codification ("ASC") 606 effective April 1, 2019 on a modified retrospective basis. Its results of operations as presented within the following discussion and analysis includes financial results for reporting periods during fiscal 2020, which are disclosed in compliance with the new revenue recognition standard. Historical financial results for reporting periods prior to fiscal 2020 have not been retroactively restated and are presented in conformity with amounts previously disclosed under the prior revenue recognition standard ASC 605. The Joint Venture has included additional information regarding the impacts from the adoption of the new revenue recognition standard for the three months ended June 30, 2019 and included financial results during fiscal 2020 under ASC 605 for comparison to the prior year.

The following table summarizes our consolidated results of operations for the three months ended June 30, 2019 and 2018, respectively:

	Three Months Ended June 30,					
	2019			2018	$	%
(in millions)	As Reported	Impacts from Adoption	Without Adoption (ASC 605)	2018	Change	Change
Revenue						
Solutions revenue	$ 797.1	$ (41.5)	$ 755.6	$ 757.7	$ (2.1)	(0.3)%
Postage revenue	58.5	—	58.5	65.6	(7.1)	(10.8)
Total revenue	855.6	(41.5)	814.1	823.3	(9.2)	(1.1)
Operating expenses						
Costs of operations (exclusive of depreciation and amortization below)	$ 326.9	$ 0.8	$ 327.7	$ 337.4	$ (9.7)	(2.9)
Research and development	49.3	—	49.3	55.3	(6.0)	(10.8)
Sales, marketing, general and administrative	193.3	5.2	198.5	206.9	(8.4)	(4.1)
Customer postage	58.5	—	58.5	65.6	(7.1)	(10.8)
Depreciation and amortization	71.3	—	71.3	68.5	2.8	4.1
Accretion and changes in estimate with related parties, net	3.9	—	3.9	3.8	0.1	2.6
Total operating expenses	$ 703.2	$ 6.0	$ 709.2	$ 737.5	$ (28.3)	(3.8)
Operating income	152.4	(47.5)	104.9	85.8	19.1	22.3
Non-operating (income) and expense						
Interest expense	83.4	—	83.4	78.5	4.9	6.2
Contingent consideration	(0.8)	—	(0.8)	0.3	(1.1)	(366.7)
Other, net	(3.8)	—	(3.8)	(5.5)	1.7	(30.9)
Non-operating (income) and expense	78.8	—	78.8	73.3	5.5	7.5
Income (loss) before income tax provision (benefit)	73.6	(47.5)	26.1	12.5	13.6	108.8
Income tax provision (benefit)	1.6	(2.3)	(0.7)	(0.1)	(0.6)	600.0
Net income (loss)	$ 72.0	$ (45.2)	$ 26.8	$ 12.6	$ 14.2	112.7%

As a result of displaying amounts in millions, rounding differences may exist in the table above.

Three Months Ended June 30, 2019 (ASC 605 Basis) Compared to Three Months Ended June 30, 2018

Solutions Revenue

Solutions revenue decreased $2.1 million for the three months ended June 30, 2019, compared with the same period in the prior year. Factors affecting the Joint Venture's solutions revenue are described in the various segment discussions below.

Expenses

Costs of Operations

Costs of operations decreased $9.7 million for the three months ended June 30, 2019, compared with the same period in the prior year. The decrease in the Joint Venture's costs of operations is primarily attributable to cost synergies associated with network efficiencies and reduction or elimination of duplicative roles, among other factors.

Research and Development

Research and development expenses decreased $6.0 million for the three months ended June 30, 2019, compared with the same period in the prior year. As with cost of operations, the reduction in research and development expense reflects continued synergies associated with reduction or elimination of duplicative roles.

Sales, Marketing, General and Administrative Expense

Sales, marketing, general and administrative expenses decreased $8.4 million for the three months ended June 30, 2019, compared with the same period in the prior year. Sales, marketing, general and administrative expense for each of the three months ended June 30, 2019 and 2018 reflects significant integration related costs, including professional and consulting fees related to rationalizations of information technology, business process re-engineering, implementation of human resource and finance information technology systems, severance and other costs. The amount of such costs, however, decreased by $2.9 million in the three months ended June 30, 2019 as compared to the same period in the prior year.

In addition to recognizing a decrease in integration related costs during the quarter, the decrease in sales, marketing, general and administrative expense can be attributed to the prior year period including costs to implement ASC 606 ($3.7 million) that did not recur in the three-month period ended June 30, 2019.

Customer Postage

Customer postage decreased $7.1 million for the three months ended June 30, 2019, compared with the same period in the prior year. Customer postage is affected by the declines in print volumes within communication and payment solutions, which were partially offset by the effect of a USPS postage rate increase in January 2019 (e.g. an increase in first-class postage of 10%). Because customer postage is a pass-through cost to the Joint Venture's customers, however, changes in volume of customer postage generally have no effect on operating income.

Depreciation and Amortization

Depreciation and amortization increased $2.8 million for the three months ended June 30, 2019, compared with the same period in the prior year. Depreciation and amortization were generally affected by routine amortization of tangible and intangible assets existing at March 31, 2019 as well as the routine amortization and depreciation of additions to property, equipment, and software since that date.

Accretion and changes in estimate with related parties, net

Accretion and changes in estimate with related parties, net increased $0.1 million for the three months ended June 30, 2019, compared with the same period in the prior year. Accretion is routinely affected by changes in the expected timing or amount of cash flows which may result from various factors, including changes in tax rates.

Interest expense

Interest expense increased $4.9 million for the three months ended June 30, 2019, compared with the same period in the prior year. This increase is primarily attributable to increased interest rates during the period. While the Joint Venture has interest rate cap agreements in place to limit its exposure to such rising interest rates, such agreements together with the Joint Venture's fixed rate notes, effectively fixed interest rates for approximately 49% of its total indebtedness at June 30, 2019.

As discussed in *Recent Developments*, the Joint Venture used proceeds from the initial public offering to repay approximately $805 million of its variable interest rate debt in July 2019. As a result, the Joint Venture expects to recognize reduced interest expense in future periods and reduced variability to fluctuations in market interest rates.

Contingent consideration

Contingent consideration reflects changes in the fair value of the Joint Venture's earnout obligation to the former owners of an acquired business. Such amounts may increase or decrease in the future based on changes in the expected amount, timing, and probability of making such payments in the future.

Other, net

Other, net primarily represents income the Joint Venture receives from McKesson and eRx Network related to transitional and other services that we provide them following the closing of the Transactions in March 2017.

Income Tax Provision (Benefit)

The income tax provision was $1.6 million (effective tax rate of 2.1%) for the three months ended June 30, 2019 as compared to an income tax benefit of $0.1 million (effective tax rate of -0.9%) for the three months ended June 30, 2018. The Joint Venture's income taxes and related effective tax rate are routinely affected by it and its subsidiaries' legal organization. Certain of the Joint Venture's subsidiaries are organized as limited liability corporations and report income that is distributed to the Members where it is subject to income taxes. Other subsidiaries are organized as corporations, for which the tax effects are directly reflected in the Joint Venture's financial statements.

Solutions Revenue and Adjusted EBITDA

	Three Months Ended June 30,					
	2019			2018		
(in millions)	As Reported	Impacts from Adoption	Without Adoption (ASC 605)	As Reported (ASC 605)	$ Change	% Change
Solutions revenue (1)						
Software and Analytics	$ 437.3	$ (41.6)	$ 395.7	$ 396.4	$ (0.7)	(0.2)%
Network Solutions	$ 141.6	$ —	$ 141.6	$ 136.6	$ 5.0	3.7%
Technology-enabled Services	$ 244.0	$ 0.1	$ 244.1	$ 250.0	$ (5.9)	(2.4)%
Adjusted EBITDA						
Software and Analytics	$ 202.3	$ (46.0)	$ 156.3	$ 142.6	$ 13.7	9.6%
Network Solutions	$ 85.0	$ (0.5)	$ 84.5	$ 82.2	$ 2.3	2.8%
Technology-enabled Services	$ 45.2	$ (0.8)	$ 44.4	$ 50.0	$ (5.6)	(11.2)%

(1) Includes inter-segment revenue

As a result of displaying amounts in millions, rounding differences may exist in the tables above.

Software and Analytics

Software and Analytics revenue decreased $0.7 million for the three months ended June 30, 2019, compared with the same period in the prior year. Software and Analytics revenue reflects core revenue growth and timing, more than offset by ongoing efforts to rationalize the connected analytics solution and the effect on revenue of the sale of the Joint Venture's extended care business in July 2018. Specifically, the Joint Venture recognized revenue of $0 million and $9.2 million in the three months ended June 30, 2019 and 2018 related to this extended care business.

Software and Analytics Adjusted EBITDA increased $13.7 million for the three months ended June 30, 2019, compared to the same period in the prior year. This increase in Adjusted EBITDA was attributable to core revenue growth and timing, operational synergies, and cost initiatives related to the connected analytics solution. This increase was partially offset by a $1.5 million decrease in Adjusted EBITDA that resulted from the divestiture of the extended care business.

Network Solutions

Network Solutions revenue increased $5.0 million for the three months ended June 30, 2019, compared with the same period in the prior year. Network solutions revenue for the quarter ended June 30, 2019 primarily reflects the implementation of new customers among the business to business payments ($1.7 million) and increased revenues resulting from the sale of new data solutions contracts ($1.4 million).

Network Solutions Adjusted EBITDA increased by $2.3 million for the three months ended June 30, 2019, compared to the same period in the prior year. As described above, Network Solutions revenue was positively affected by the implementation of new customers among the business to business payments, and increased revenues resulting from the sale of new data contracts, growth in dental network revenue resulting from a contract renewal, price increases, and stronger volumes. Adjusted EBITDA similarly increased as a result of these factors.

Technology-enabled Services

Technology-enabled Services revenue decreased $5.9 million for the three months ended June 30, 2019, compared with the same period in the prior year. Technology-enabled Services revenue for the three months ended June 30, 2019 reflects new sales and same store organic growth of $21 million which was more than offset by $27 million of customer attrition (including the company's decision to exit certain contracts). Customer attrition for the three months ended June 30, 2019 reflects the full current period impact of attrition that occurred throughout Fiscal 2019 in the Joint Venture's physician revenue cycle management and communication and payment services solutions, driven by industry consolidation. While the Joint Venture expects that such consolidation will continue in the future, as part of its strategy, the Joint Venture is repositioning certain of its solutions to better address end market dynamics, enhance efficiency and to improve the long-term growth potential of these solutions.

Technology-enabled Services Adjusted EBITDA decreased $5.6 million for the three months ended June 30, 2019, compared to the same period in the prior year. Technology-enabled Services Adjusted EBITDA for the three months ended June 30, 2019 reflects the decrease in Technology-enabled Services revenue and increased costs associated with repositioning certain of our physician revenue cycle management and communication and payment solutions, which were partially offset by cost savings from the Joint Venture's post-contribution cost synergy initiatives.

Significant Changes in Assets and Liabilities

Within the Joint Venture's network solutions business, the Joint Venture regularly receives funds from certain pharmaceutical industry participants in advance of its obligation to remit these funds to participating retail pharmacies. Such funds are not restricted; however, these funds are generally paid out in satisfaction of the processing obligations within three business days of their receipt. At the time of receipt, the Joint Venture records a corresponding liability within accrued expenses on its consolidated balance sheets. At June 30, 2019, the Joint Venture reported $19.8 million of such pass-through payment obligations which were subsequently paid in the first week of July 2019. At March 31, 2019, the Joint Venture reported $7.4 million of such pass-through payment obligations.

Liquidity and Capital Resources

Overview

The Joint Venture's principal sources of liquidity are cash flows provided by operating activities, cash and cash equivalents on hand, and its Revolving Credit Facility. The Joint Venture's principal uses of liquidity are working capital, capital expenditures, debt service, business acquisitions and other general corporate purposes. The Joint Venture anticipates its cash on hand, cash generated from operations, and funds available under the Revolving Credit Facility will be sufficient to fund its planned capital expenditures, debt service obligations, business acquisitions and operating needs. The Joint Venture may, however, elect to raise funds through debt or equity financing in the future to fund significant investments or acquisitions that are consistent with its growth strategy.

Cash, cash equivalents and restricted cash totaled $27.4 million and $48.9 million at June 30, 2019 and March 31, 2019, respectively, of which $12.3 million and $28.1 million was held outside the United States. As of June 30, 2019, no amounts had been drawn under the senior secured revolving line of credit and the Joint Venture could have borrowed up to the additional $495.1 million available. The Joint Venture also has the ability to borrow up to an additional $1,080.0 million, or such amount that the senior secured net leverage ratio does not exceed 4.9 to 1.0, whichever is greater, under the Senior Secured Credit Facilities, subject to certain additional conditions and commitments by existing or new lenders to fund any additional borrowings.

The balance retained in cash and cash equivalents is consistent with the Joint Venture's short-term cash needs and investment objectives. The Joint Venture may be required to make additional principal payments on the Term Loan Facility based on excess cash flows of the prior year, as defined in the credit agreement governing the Term Loan Facility.

(in millions)	Three Months Ended June 30, 2019	Three Months Ended June 30, 2018	$ Change	% Change
Cash provided by (used in) operating activities	$ 84.5	$ 190.9	$(106.4)	-56%
Cash provided by (used in) investing activities	(67.4)	(65.2)	(2.2)	3%
Cash provided by (used in) financing activities	(38.6)	(43.1)	4.5	-10%
Effects of exchange rate changes on cash, cash equivalents and restricted cash	0.1	(0.8)	0.9	-113%
Net change in cash, cash equivalents and restricted cash	$ (21.4)	$ 81.8	$(103.2)	-126%

Operating Activities

Cash provided by operating activities is primarily affected by operating income, including the impact of debt service payments, integration related costs and the timing of collections and related disbursements. Cash provided by operating activities includes $12.3 million and $154.6 million as a source of cash related to pass-through funds for the three months ended June 30, 2019 and 2018, respectively.

Investing Activities

Cash used in investing activities reflects routine capital expenditures related to purchase of property and equipment and the development of software as well as expenditures related to significant software development efforts necessary to integrate the contributed businesses.

Financing Activities

Cash used in financing activities reflects cash payments under the Term Loan Facility, receipts under the Joint Venture's interest rate cap agreements, and payments for deferred financing obligations.

Capital Expenditures

The Joint Venture incurs capital expenditures to grow its business by developing new and enhanced capabilities, to increase the effectiveness and efficiency of the organization and to reduce risks. The Joint Venture incurs capital expenditures for product development, disaster recovery, security enhancements, regulatory compliance and the replacement and upgrade of existing equipment at the end of its useful life.

Debt

Senior Credit Facilities and Senior Notes

In March 2017, the Joint Venture entered into the $5,100.0 million Term Loan Facility, and a $500.0 million Revolving Credit Facility. Additionally, the Joint Venture issued $1,000.0 million of 5.75% senior notes due 2025 (the "Senior Notes"). No amounts have been drawn against the Revolving Facility as of June 30, 2019.

Hedge

From time to time, the Joint Venture executes interest rate cap agreements with various counterparties that effectively cap its LIBOR exposure on a portion of its existing Term Loan Facility or similar replacement debt. The following table summarizes the terms of the Joint Venture's interest rate cap agreements at June 30, 2019.

Effective Date	Expiration Date	Notional Amount	Receive LIBOR Exceeding (1)	Pay Fixed Rate
March 31, 2017	March 31, 2020	$ 650,000	1.25%	0.56%
March 31, 2017	March 31, 2020	$ 750,000	1.00%	0.82%
August 31, 2018	March 31, 2020	$ 500,000	1.00%	1.82%
March 31, 2020	December 31, 2021	$ 1,500,000	1.00%	1.82%

(1) All based on 1-month LIBOR, except the $650,000 tranche which receives based on 3-month LIBOR.

The interest rate caps are recorded on the balance sheet at fair value. Changes in the fair value of the interest rate cap agreements are recorded in other comprehensive income.

In accordance with ASC 815, the fair value of the interest rate caps at inception is reclassified from other comprehensive income to interest expense in the same period the interest expense on the underlying hedged debt impacts earnings. Any payments the Joint Venture receives to the extent LIBOR exceeds the specified cap rate is also reclassified from other comprehensive income to interest expense in the period received.

In July 2017, the Financial Conduct Authority (the authority that regulates LIBOR) announced it intends to stop compelling banks to submit rates for the calculation of LIBOR after 2021. The Alternative Reference Rates Committee ("ARRC") has proposed that the Secured Overnight Financing Rate ("SOFR") is the rate that represents best practice as the alternative to USD-LIBOR for use in derivatives and other financial contracts that are currently indexed to USD-LIBOR. ARRC has proposed a paced market transition plan to SOFR from USD-LIBOR and organizations are currently working on industry wide and company specific transition plans as it relates to derivatives and cash markets exposed to USD-LIBOR. The Joint Venture has material contracts that are indexed to USD-LIBOR and is monitoring this activity and evaluating the related risks.

Effect of Certain Debt Covenants

A breach of any of the covenants under the agreements governing the Joint Venture's debt could limit its ability to borrow funds under the Term Loan Facility and could result in a default under the Term Loan Facility. Upon the occurrence of an event of default under the Term Loan Facility, the lenders could elect to declare all amounts then outstanding to be immediately due and payable, and the lenders could terminate all commitments to extend further credit. If the Joint Venture were unable to repay the amounts declared due, the lenders could proceed against any collateral granted to them to secure that indebtedness.

With certain exceptions, the Term Loan Facility obligations are secured by a first-priority security interest in substantially all of the assets of the Joint Venture, including its investment in subsidiaries. The Term Loan Facility contains various restrictions and nonfinancial covenants, along with a senior secured net leverage ratio test. The nonfinancial covenants include restrictions on dividends, investments, dispositions, future borrowings and other specified payments, as well as additional reporting and disclosure requirements. The senior secured net leverage test must be met as a condition to incur additional indebtedness, but otherwise is applicable only to the extent that amounts drawn on the Revolving Credit Facility exceed $175.0 million at the end of the fiscal quarter. As of June 30, 2019, the Joint Venture was in compliance with all debt covenants.

The Joint Venture's ability to meet its liquidity needs depends on its subsidiaries' earnings and cash flows, the terms of the Joint Venture and its subsidiaries' indebtedness, and other contractual restrictions. Except for certain permitted distributions, the Joint Venture generally is not permitted to make any distribution to its members.

Off-Balance Sheet Arrangements

As of June 30, 2019, the Joint Venture had no off-balance sheet arrangements.

Recent Accounting Pronouncements

See Exhibit 99.1, "Notes to Consolidated Financial Statements," Note 2, "Summary of Significant Accounting Policies," for information about recent accounting pronouncements and the potential impact on the Joint Venture's consolidated financial statements.

Critical Accounting Estimates

The preparation of financial statements in accordance with GAAP requires us to make estimates and assumptions that affect reported amounts and related disclosures. The Joint Venture considers an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on our consolidated results of operations and financial condition.

The Joint Venture believes the current assumptions and other considerations used to estimate amounts reflected in its consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on the Joint Venture's consolidated results of operations and financial condition.

Revenue Recognition

In April 2019, the Joint Venture adopted Accounting Standards Codification ASC 606, Revenue from Contracts with Customers, which replaced most prior general and industry specific revenue recognition guidance with a principles-based comprehensive revenue recognition framework. Under this revised framework, a company recognizes revenue to depict the transfer of promised goods and services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods and services.

The Joint Venture generates most of its solutions revenue by using technology solutions (generally Software as a Service ("SaaS")) to provide services to its customers that automate and simplify business and administrative functions for payers, providers, pharmacies, and channel partners and through the licensing of software, software systems (consisting of software, hardware and maintenance support) and content.

The Joint Venture recognizes revenue when the customer obtains control of the good or service through the Joint Venture satisfying a performance obligation by transferring the promised good or service to the customer.

Principal Revenue Generating Products and Services

Content license subscriptions and time-based software—The Joint Venture's content license subscriptions and time-based software arrangements provide a license to use a software for a specified period of time. At the end of the contractual period, the customer either renews the license for an additional term or ceases to use the software. Software licenses are typically delivered to the customer with functionality that the customer can benefit from the software on its own or together with readily available resources. As contracts for these solutions generally do not price individual components separately, the Joint Venture allocates the transaction price to the license and ongoing support performance obligations based on standalone selling price ("SSP"), primarily determined by historical value relationships between licenses and ongoing support and updates. Revenue allocated to content license subscriptions and time-based software license agreements is generally recognized at the point-in-time of delivery of the license or the content update upon transfer of control of the underlying license to the customer. Generally, software implementation fees are recognized over the implementation period through an input measure of progress method. Revenue allocated to maintenance and support is recognized ratably over the period covered by the agreements, as passage of time represents a faithful depiction of the transfer of these services. In some cases, software arrangements provide licenses to several software applications that are highly integrated with the implementation services and software updates and cannot function separately. The bundle is a single performance obligation since the individually promised goods and services are not distinct in the context of the contract because the related implementation services significantly modify and customize the software and the updates provided to the integrated software solution are critical to the software's utility. The related revenue is recognized on a straight-line basis, ratably over the contractual term due to the frequency and criticality of the updates throughout the license period.

Contingent fee services—The Joint Venture provides services to customers in which the transaction price is contingent on future occurrences, such as savings generated or amounts collected on behalf of its customers through the delivery of its services. In some cases, the Joint Venture performs services in advance of invoicing the customer, thereby creating a contract asset. Revenue in these arrangements is estimated and constrained until the Joint Venture determines that it is probable that a significant revenue reversal will not occur, and variable consideration is allocated to the performance obligation for which the Joint Venture earns a contingent fee.

Perpetual software licenses — The Joint Venture's perpetual software arrangements provide a license for a customer to use software in perpetuity. Software licenses are typically delivered to the customer with functionality from which the customer can benefit from the license on its own or together with readily available resources. Perpetual software arrangements are recognized at the time of delivery or through an input measure of progress method over the installation period if the arrangements require significant production or modification or customization of the software. Contracts accounted for through an input measure of progress method are generally measured based on the ratio of labor hours incurred to date to total estimated labor hours to be incurred. Software implementation fees are recognized as the work is performed or under the input method for perpetual software. Hardware revenues are generally recognized upon delivery. Maintenance is recognized ratably over the term of the agreement as passage of time represents a faithful depiction of the transfer of these services.

Professional services — The Joint Venture provides training and consulting services to its customers, and the services may be fixed fee or time and materials based. Consulting services that fall outside of the standard implementation services vary depending on the scope and complexity of the service requested by the customer. Consulting services are deemed to be capable of being distinct from other products and services, and the services are satisfied either at a point of time or over time based on delivery. Training services are usually provided as an optional service to enhance the customer's experience with a software product or provides additional education surrounding the general topic of the solution. Training services are capable of being distinct from other products and services. The Joint Venture treats training services as a distinct performance obligation, and they are satisfied at a point of time.

Transaction processing services — The Joint Venture provides transaction processing (such as claims processing) services to hospitals, pharmacies and health systems via a cloud-based (SaaS) platform. The promised service is to stand ready to process transactions for our customers over the contractual period on an as needed basis. The revenue related to these services is recognized over time as the transactions are processed, and the revenue is recognized over the individual days in which the services are performed. Any fixed annual fees and implementation fees are recognized ratably over the contract period.

Hosted solutions and software as a service ("SaaS") — The Joint Venture enters into arrangements whereby the Joint Venture provides the customer access to a Joint Venture-owned software solution, which are generally marketed under annual and multi-year arrangements. The customer is only provided "access" (not a license) to the software application. In these arrangements, the customer does not purchase equipment nor does the customer take physical possession of the software. The related revenue is recognized ratably over the contracted term. For fixed fee arrangements, revenue recognition begins after set-up and implementation are complete. For per-transaction fee arrangements, revenue is recognized as transactions are processed beginning on the service start date.

Contract Balances

The Joint Venture's payment terms vary by customer and product type. For certain products or services, the Joint Venture requires upfront payments before control of the product or service has transferred to the customer. For other products and services, the Joint Venture invoices the customer in arrears after providing the products or services. In addition, for certain contingent fee services, customers are billed in arrears, typically based upon a percentage of collections the Joint Venture makes on the customer's behalf.

Under the new revenue standard, the Joint Venture generally recognizes a contract asset when revenue is recognized in advance of invoicing on a customer contract, unless the right to payment for that revenue is unconditional (i.e. requiring no further performance and only the passage of time). If a right to payment is determined to meet the criteria to be considered 'unconditional', then the Joint Venture will recognize a receivable.

There were no impairment losses recognized on accounts receivable or contract assets in the quarter ended June 30, 2019.

The Joint Venture records deferred revenues when billings or payments are received from customers in advance of its performance. Deferred revenue is generally recognized when transfer of control to customers occurs. The deferred revenue balance is driven by multiple factors, including the frequency of renewals, invoice timing, and invoice duration. As of June 30, 2019, the Joint Venture expects 93% of the deferred revenue balance to be recognized in one year or less, and approximately $180 million of the beginning period balance was recognized during the first quarter of fiscal 2020.

Costs to Obtain or Fulfill a Contract

Sales commissions and certain other incentive payments (e.g., bonuses that are contingent solely on obtaining a contract or a pool of contracts) earned by the Joint Venture's sales organization are capitalized as incremental costs to obtain a contract. The Joint Venture typically does not offer commissions on contract renewals. Decremented commissions upon renewal (i.e., non-commensurate with initial commissions) are offered to the Joint Venture's sales associates for certain customers and are not material. Under ASC 606, all commissions and other qualifying incentive payments capitalized are amortized over an expected period of benefit defined as the initial contract term plus anticipated renewals. In contrast, under ASC 605 these capitalized costs were amortized over the specific revenue contract terms, which are typically 12 to 60 months. In making the significant judgment in determining the appropriate period

of benefit, the Joint Venture evaluated both qualitative and quantitative factors such as the expected customer relationship period and technology obsolescence. In addition, prior to solution go-live, the Joint Venture incurs certain contract fulfillment costs primarily related to SaaS setup for our clients. These costs are capitalized to the extent they are directly related to a contract, are recoverable, and create a resource used to deliver the Joint Venture's SaaS services. Capitalized costs to fulfill a contract are amortized over the expected period of benefit.

At June 30, 2019, the Joint Venture had capitalized costs to obtain a contract of $14.2 million in prepaid and other current assets and $62.0 million in other noncurrent assets. During the three months ended June 30, 2019, the Joint Venture recognized $4.1 million of amortization expense related to such capitalized costs, which is included in the total operating expenses. At June 30, 2019, the Joint Venture had capitalized costs to fulfill a contract of $1.3 million in prepaid and other current assets and $8.3 million in other noncurrent assets. During the three months ended June 30, 2019, the Joint Venture recognized $0.3 million of amortization expense related to such capitalized costs, which is included in total operating expenses.

Postage Revenues

Postage revenues are the result of providing delivery services to customers in the Joint Venture's payment and communication solutions. Postage revenues are generally billed as a pass-through cost to the Joint Venture's customers. The service is part of a combined performance obligation with the printing and handling services provided to the customer because the postage services are not distinct within the context of the contract. The Joint Venture presents Postage Revenue separately from Solutions Revenue on the consolidated statements of operation as it makes the financial statements more informative for the users. The revenue related to the combined performance obligation of the postage, printing, and handling service is recognized as the transactions are processed, and the revenue is recognized over the individual days in which the services are performed.

Arrangements with Multiple Performance Obligations

The Joint Venture engages in customer arrangements which may include multiple performance obligations, such as any combination of software, hardware, implementation, SaaS-based offerings, consulting services, or maintenance services. For such arrangements, the Joint Venture allocates revenues to each performance obligation on a relative standalone selling price basis. A performance obligation's standalone selling price is determined based on the directly observable prices charged to customers when available or estimated using other methods such as the adjusted market assessment approach, the expected cost plus a margin approach, or other approaches in cases where distinct performance obligations are not sold separately but instead sold at a bundled price. For performance obligations with historical pricing that is highly variable, the residual approach is used. Such instances primarily relate to the Joint Venture's perpetual software arrangements in which the Joint Venture sells the same products to different customers for a broad range of amounts.

Remaining Performance Obligations

The aggregate amount of transaction price allocated to performance obligations that are unsatisfied (or partially unsatisfied) for executed contracts includes deferred revenue and other revenue yet to be recognized from non-cancellable contracts. As of June 30, 2019, the Joint Venture's total remaining performance obligations approximated $1.3 billion, of which approximately 53% is expected to be recognized over the next twelve months, and the remaining 47% thereafter.

In this balance, the Joint Venture does not include the value of unsatisfied performance obligations related to those contracts for which it recognizes revenue at the amount for which it has the right to invoice for services performed. Additionally, this balance does not include revenue related to performance obligations that are part of a contract with an original expected duration of one year or less. Lastly, this balance does not include variable consideration allocated to the individual goods or services in a series of distinct goods or services that are substantially the same and that have the same pattern of transfer to the customer. Examples includes variable fees associated with transaction processing and contingent fee services.

Disaggregated Revenue

The Joint Venture disaggregates the revenue from contracts with customers by operating segment as it believes doing so best depicts how the nature, amount, timing and uncertainty of the Joint Venture's revenue are affected by economic factors. See Note 9 in the Joint Venture's unaudited financial statements included in Exhibit 99.1, "Segment Reporting" for the total revenue disaggregated by operating segment for the three months ended June 30, 2019 and June 30, 2018.

The Joint Venture's total revenue by disaggregated revenue source was generally consistent for each reportable segment for the three months ended June 30, 2019 and June 30, 2018.

Customer Incentives

Certain customers, which include the Joint Venture's channel partners, may receive cash-based incentives or rebates based on actual sales and achievement of a cumulative level of sales, which are accounted for as variable consideration. The Joint Venture considers these amounts to be consideration payable to the customer, and therefore, the Joint Venture estimates these amounts based on the expected amount to be provided to customers and reduces the transaction price accordingly.

Practical Expedients and Exemptions

The Joint Venture has elected to utilize either the right to invoice practical expedient or the series-based variable consideration allocation framework for most transaction processing services not subject to contingencies. The Joint Venture also has elected to exclude sales taxes and other similar taxes from the measurement of the transaction price in contracts with customers. Therefore, revenue is recognized net of such taxes.

In certain customer arrangements with customers, the Joint Venture determined there are certain promised goods or services which are immaterial in the context of the contract from both a quantitative and qualitative perspective, and therefore, the goods and services are disregarded when assessing the performance obligations in the customer arrangement.

The Joint Venture has elected to apply the significant financing practical expedient, and as a result, the Joint Venture will not adjust the promised amount of consideration in a customer contract for the effects of a significant financing component when the period of time between when the Joint Venture transfers a promised good or service to a customer and when the customer pays for the good or service will be one year or less.

Apart from the adoption of FASB ASU No. 2014-09, the Joint Venture believes there have been no other significant changes during the three months ended June 30, 2019 to the items we previously disclosed as our critical accounting estimates in “Management’s Discussion and Analysis of Financial Condition and Results of Operations”.

Cautionary Notice Regarding Forward-Looking Statements

This Quarterly Report contains “forward-looking statements” within the meaning of federal securities laws. Any statements made in this quarterly report that are not statements of historical fact, including statements about our beliefs and expectations, are forward-looking statements. Forward-looking statements include information concerning possible or assumed future results of operations, including descriptions of our business plans and strategies. These statements often include words such as “anticipate,” “expect,” “suggest,” “plan,” “believe,” “intend,” “estimate,” “target,” “project,” “should,” “could,” “would,” “may,” “will,” “forecast,” “outlook,” “potential,” “continues,” “seeks,” “predicts,” and the negatives of these words and other similar expressions.

Although we believe that these forward-looking statements are based on reasonable assumptions, you should be aware that factors affecting our actual financial results could cause actual results to differ materially from those expressed in the forward-looking statements. Factors that could materially affect our financial results or such forward-looking statements include, among others, the following factors:

- macroeconomic and industry trends and adverse developments in the debt, consumer credit and financial services markets;
- our ability to provide competitive services and prices while maintaining our margins;
- our ability to retain or renew existing customers and attract new customers;
- our ability to maintain the security and integrity of our data;
- our ability to deliver services timely without interruption;
- our ability to maintain our access to data sources;
- government regulation and changes in the regulatory environment;
- litigation or regulatory proceedings;
- our ability to effectively manage our costs;
- economic and political instability in the United States and international markets where we operate;
- our ability to effectively develop and maintain strategic alliances and joint ventures;
- our ability to timely develop new services and the market's willingness to adopt our new services;
- our ability to manage and expand our operations and keep up with rapidly changing technologies;
- our ability to make acquisitions and integrate the operations of acquired businesses;
- our ability to protect and enforce our intellectual property, trade secrets and other forms of unpatented intellectual property;
- our ability to defend our intellectual property from infringement claims by third parties;
- the ability of our outside service providers and key vendors to fulfill their obligations to us;
- further consolidation in our end-customer markets;
- losses against which we do not insure;
- our ability to make timely payments of principal and interest on our indebtedness;
- our ability to satisfy covenants in the agreements governing our indebtedness;
- our ability to maintain our liquidity;
- our reliance on key management personnel; and
- our controlling stockholders.

There may be other factors, many of which are beyond our control, that may cause our actual results to differ materially from the forward-looking statements, including factors disclosed in the Registration Statement on Form S-1 (No. 333-230345) in the section entitled "Risk Factors" and in the section entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations" in this report. You should evaluate all forward-looking statements made in this report and the other public statements we may make from time to time in the context of these risks and uncertainties.

Our forward-looking statements made herein speak only as of the date on which made. We expressly disclaim any intent, obligation or undertaking to update or revise any forward-looking statements made herein to reflect any change in our expectations with regard thereto or any change in events, conditions or circumstances on which any such statements are based. All subsequent written and oral forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by the cautionary statements contained in this report.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Change Healthcare Inc.

Change Healthcare Inc. holds an equity method investment in the LLC Units of the Joint Venture as well as, following the consummation of the offering of TEUs on July 1, 2019, investments in the amortizing notes and prepaid forward purchase contracts components of the TEUs issued by the Joint Venture. In the case of the equity method investment in the Joint Venture, Change Healthcare Inc. is only exposed to changes in the fair value of the investment to the extent that the changes in fair value are so significant and long-lasting that they represented an other than temporary impairment of the investment. In the case of the investments in the amortizing note and prepaid forward purchase contracts components of the TEUs, however, such investments are required to be remeasured to their respective fair value each quarter with the changes in those values affecting the pretax income of Change Healthcare Inc.

Change Healthcare LLC

The Joint Venture has interest rate risk primarily related to borrowings under the Senior Secured Credit Facilities. Borrowings under the Senior Secured Credit Facilities bear interest at a rate equal to, at the Company's option, either (i) LIBOR for the relevant interest period, adjusted for statutory reserve requirements (which is subject, solely in the case of the Term Loan Facility, to a floor of 1.00% per annum and, solely in the case of the Revolving Credit Facility, to a floor of 0.00% per annum), plus an applicable margin or (ii) a base rate equal to the highest of (a) the rate of interest in effect as publicly announced by the administrative agent as its prime rate, (b) the federal funds effective rate plus 0.50% and (c) adjusted LIBOR for an interest period of one month plus 1.00% (which may be subject, solely in the case of the Term Loan Facility, to a floor of 2.00% per annum), in each case, plus an applicable margin. The applicable margin for loans under the Term Loan Facility and Revolving Credit Facility are each subject to a reduction from and after a Qualified IPO.

As of June 30, 2019, the Joint Venture had borrowings of $4,883.3 million (before unamortized debt discount) under the Senior Secured Credit Facilities. As of June 30, 2019, the LIBOR-based interest rate on the Term Loan Facility and Revolving Credit Facility were each LIBOR plus 2.75% (but subject to a .25% reduction following the Qualified IPO in July 2019).

The Joint Venture manages economic risks, including interest rate, liquidity and credit risk, primarily by managing the amount, sources and duration of our debt funding and the use of derivative financial instruments. Specifically, the Joint Venture enters into interest rate cap agreements to manage exposures that arise from business activities that result in the receipt or payment of future known and uncertain cash amounts, the value of which are determined by interest rates. The Joint Venture's interest rate cap agreements are used to manage differences in the amount, timing and duration of our known or expected cash receipts and our known or expected cash payments principally related to our borrowings. As of June 30, 2019, the Joint Venture's outstanding interest rate cap agreements were each designated as cash flow hedges of interest rate risk and were determined to be highly effective.

A change in interest rates on variable rate debt may impact the Joint Venture's pretax earnings and cash flows. Based on the Joint Venture's outstanding debt as of June 30, 2019, and assuming that its mix of debt instruments, derivative financial instruments and other variables remain the same, the annualized effect of a one percentage point change in variable interest rates would have an annualized pretax impact on the Joint Venture's earnings and cash flows of approximately $29.8 million. This variability is expected to decrease in future periods following the repayment of approximately $805 million of variable rate indebtedness in July 2019.

In the future, in order to manage the Joint Venture's interest rate risk, it may refinance its existing debt, enter into additional interest rate cap agreements, modify its existing interest rate cap agreements or make changes that may impact its ability to treat its interest rate cap agreements as a cash flow hedge. However, the Joint Venture does not intend or expect to enter into derivative or interest rate cap agreement transactions for speculative purposes.

ITEM 4. CONTROLS AND PROCEDURES

Disclosure Controls and Procedures

Change Healthcare Inc.'s management, with the participation of its Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of its disclosure controls and procedures as of the end of the period covered by this report. The term "disclosure controls and procedures" as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act") means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms and that such information is accumulated and communicated to management including the Chief Executive Officer and Chief Financial Officer, as appropriate, to allow timely discussions regarding required disclosures.

Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable, not absolute, assurance of achieving their desired control objectives. Based on the evaluation of Change Healthcare Inc.'s disclosure controls and procedures as of the end of the period covered by this report, its Chief Executive Officer and Chief Financial Officer concluded that, as of such date, its disclosure controls and procedures were effective at a reasonable assurance level.

Changes in Internal Control Over Financial Reporting

During the quarter covered by this report, there have been no changes in Change Healthcare Inc.'s internal controls over financial reporting that have materially affected, or are reasonably likely to materially affect, its internal controls over financial reporting.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

Change Healthcare Inc.

In the normal course of business, Change Healthcare Inc. may become subject to various claims and legal proceedings. As of June 30, 2019, Change Healthcare Inc. was not involved in any material pending legal proceedings.

Change Healthcare LLC

The Joint Venture is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

From time to time, the Joint Venture receives subpoenas or requests for information from various government agencies. The Joint Venture generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by the Joint Venture. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Joint Venture and other members of the health care industry, as well as to settlements.

Additionally, in the normal course of business, the Joint Venture is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Joint Venture does not believe that it is reasonably possible that their outcomes will have a material adverse effect on the Joint Venture's consolidated financial position, results of operations or liquidity.

To reduce their exposure to an unexpected significant monetary award resulting from an adverse judicial decision, both Change Healthcare Inc. and Change Healthcare LLC maintain insurance that they believe is appropriate and adequate based on historical experience. Both Change Healthcare Inc. and Change Healthcare LLC advise their insurance carriers of any claims, threatened or pending, against them in the course of litigation and generally receives a reservation of rights letter from the carriers when such claims exceed applicable deductibles.

ITEM 1A. RISK FACTORS

In addition to the other information included in this report, you should carefully consider the factors discussed in "Risk Factors" included in the Registration Statement on Form S-1 (No. 333-230345), as well as the factors identified under "Cautionary Statement Regarding Forward-Looking Statements" at the end of Part I, Item 2 of this Quarterly Report, which could materially affect the Change Healthcare Inc.'s or the Joint Venture's business, financial condition or future results. The risks described in the Registration Statement on Form S-1 and this Quarterly Report are not the only risks Change Healthcare Inc. or the Joint Venture face. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition or operating results.

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

Use of Proceeds from Registered Securities

On July 1, 2019, Change Healthcare Inc. completed an initial public offering (the "Common Stock Offering") of its common stock, par value $0.001 per share ("Common Stock"), and the concurrent public offering (the "TEU Offering" and, together with the Common Stock Offering, the "Offerings") of its 6.00% tangible equity units ("TEUs"), described in Change Healthcare Inc.'s prospectus relating to the Common Stock Offering (the "Common Stock Prospectus") and Change Healthcare Inc.'s prospectus relating to the TEUs Offering, in each case dated June 26, 2019 (collectively, the "Prospectuses"), filed with the Securities and Exchange Commission (the "Commission") on June 28, 2019 pursuant to Rule 424(b) of the Securities Act of 1933, as amended, which is deemed to be part of Change Healthcare Inc.'s Registration Statement on Form S-1 (File No. 333-230345), as amended (the "Registration Statement"), declared effective by the Commission on June 26, 2019. The underwriters of the Offerings were led by Barclays Capital Inc., Goldman Sachs & Co. LLC and J.P. Morgan Securities LLC.

With respect to the Common Stock Offering, Change Healthcare Inc. sold 49,285,713 shares of Common Stock at a public offering price of $13.00 per share, including 6,428,571 shares of Common Stock pursuant to the full exercise of the underwriters' option to purchase additional shares. With respect to the TEU Offering, Change Healthcare Inc. issued and sold 5,750,000 TEUs in the TEU Offering with a stated amount of $50.00 per TEU, including 750,000 TEUs pursuant to the full exercise of the underwriters' option to purchase additional TEUs. Change Healthcare Inc. received net proceeds of $609 million from the Common Stock Offering and $279 million from the TEU Offering, in each case after underwriting discounts and commissions of $40.7 million, but before offering costs paid subsequent to the offering from available cash.

The proceeds of the Common Stock Offering were subsequently contributed to the Joint Venture in exchange for 49.3 million additional units of the Joint Venture. The proceeds of the TEU Offering were used to acquire interests in the Joint Venture that substantially mirror the terms of the TEUs issued by Change Healthcare Inc. in the offering. The Joint Venture, in turn, used the proceeds received from Change Healthcare Inc. to repay $805 million of its indebtedness under the Term Loan Facility without penalty and expects to use the remaining proceeds to repay additional amounts outstanding under the Term Loan Facility.

ITEM 3. DEFAULTS UPON SENIOR SECURITIES

None

ITEM 4. MINE SAFETY DISCLOSURES

None

ITEM 5. OTHER INFORMATION

None

ITEM 6. EXHIBITS

The exhibits listed on the accompanying Exhibit Index are filed, furnished or incorporated by reference (as stated therein) as part of this Quarterly Report.

Exhibit Index

3.1	Amended and Restated Certificate of Incorporation of Change Healthcare Inc., dated as of June 26, 2019 (incorporated by reference to Exhibit 3.1 to the Company's Form 8-K filed on July 2, 2019).
3.2	Amended and Restated Bylaws of Change Healthcare Inc., dated as of June 26, 2019 (incorporated by reference to Exhibit 3.2 to the Company's Form 8-K filed on July 2, 2019).
4.1	Purchase Contract Agreement, dated as of July 1, 2019, between Change Healthcare Inc. and U.S. Bank N.A., as purchase contract agent, as attorney-in-fact for the Holders from time to time as provided therein and as trustee under the indenture referred to therein (incorporated by reference to Exhibit 4.1 to the Company's Form 8-K filed on July 2, 2019).
4.2	Form of Unit (included in Exhibit 4.1).
4.3	Form of Purchase Contract (included in Exhibit 4.1).
4.4	Indenture, dated as of July 1, 2019, between Change Healthcare Inc. and U.S. Bank N.A., as trustee (incorporated by reference to Exhibit 4.4 to the Company's Form 8-K filed on July 2, 2019).
4.5	First Supplemental Indenture, dated as of July 1, 2019, between Change Healthcare Inc. and U.S. Bank N.A., as trustee (incorporated by reference to Exhibit 4.5 to the Company's Form 8-K filed on July 2, 2019).
4.6	Form of Amortizing Note (included in Exhibit 4.5).
10.1	Change Healthcare Inc. 2019 Omnibus Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Form 8-K filed on July 2, 2019).
10.2	Change Healthcare Inc. 2019 Employee Stock Purchase Plan (incorporated by reference to Exhibit 10.2 to the Company's Form 8-K filed on July 2, 2019).
31.1	Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended (filed herewith).
31.2	Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended (filed herewith).
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (furnished herewith).
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (furnished herewith).
99.1	Condensed financial information of Change Healthcare LLC as of June 30, 2019 and March 31, 2019, and for the three months ended June 30, 2019 and 2018.
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

Certain agreements and other documents filed as exhibits to this Form 10-Q contain representations and warranties that the parties thereto made to each other. These representations and warranties have been made solely for the benefit of the other parties to such agreements and may have been qualified by certain information that has been disclosed to the other parties to such agreements and other documents and that may not be reflected in such agreements and other documents. In addition, these representations and warranties may be intended as a way of allocating risks among parties if the statements contained therein prove to be incorrect, rather than as actual statements of fact. Accordingly, there can be no reliance on any such representations and warranties as characterizations of the actual state of facts. Moreover, information concerning the subject matter of any such representations and warranties may have changed since the date of such agreements and other documents.

SIGNATURES

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

Change Healthcare Inc.

August 14, 2019

By /s/ Neil E. de Crescenzo
Neil E. de Crescenzo
Chief Executive Officer and Director
(Principal Executive Officer)

August 14, 2019

By /s/ Fredrik Eliasson
Fredrik Eliasson
Executive Vice President, Chief Financial Officer
(Principal Financial Officer)

Exhibit 31.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER

I, Neil E. de Crescenzo, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q for the quarter ended June 30, 2019 of Change Healthcare Inc. (the "registrant");

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

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

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

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

   (b) [Reserved]

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

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

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

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

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

Date: August 14, 2019

/s/ Neil E. de Crescenzo

Neil E. de Crescenzo
Chief Executive Officer
(Principal Executive Officer)

Exhibit 31.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER

I, Fredrik Eliasson, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q for the quarter ended June 30, 2019 of Change Healthcare Inc. (the "registrant");

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

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

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

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

   (b) [Reserved]

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

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

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

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

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

Date: August 14, 2019

/s/ Fredrik Eliasson

Fredrik Eliasson
Executive Vice President, Chief Financial Officer
(Principal Financial Officer)

Exhibit 32.1

Certification pursuant to

18 U.S.C. Section 1350,

as adopted pursuant to

Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report on Form 10-Q of Change Healthcare Inc. (the "Company") for the period ended June 30, 2019, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned certifies, in his capacity as an officer of the Company and pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ Neil E. de Crescenzo
Neil E. de Crescenzo
Chief Executive Officer
(Principal Executive Officer)
Date: August 14, 2019

A signed original of this certification required by Section 906, or other document authenticating, acknowledging, or otherwise adopting the signatures that appear in typed form within the electronic version of this written statement required by Section 906, has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request. The foregoing certification is being furnished solely pursuant to 18 U.S.C. Section 1350 and is not being filed as part of the Report or as a separate disclosure document.

Exhibit 32.2

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In connection with the Quarterly Report on Form 10-Q of Change Healthcare Inc. (the "Company") for the period ended June 30, 2019, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned certifies, in his capacity as an officer of the Company and pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

/s/ Fredrik Eliasson
Fredrik Eliasson
Executive Vice President, Chief Financial Officer
(Principal Financial Officer)
Date: August 14, 2019

A signed original of this certification required by Section 906, or other document authenticating, acknowledging, or otherwise adopting the signatures that appear in typed form within the electronic version of this written statement required by Section 906, has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request. The foregoing certification is being furnished solely pursuant to 18 U.S.C. Section 1350 and is not being filed as part of the Report or as a separate disclosure document.

Exhibit 99.1

Financial Information of Significant Equity Method Investee
Change Healthcare LLC

Index to Condensed Consolidated Financial Statements

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EXPLANATORY NOTE

Unconsolidated Significant Subsidiary

Change Healthcare Inc.'s ("the Company") primary asset is its interest in the Joint Venture which is accounted for using the equity method. As the Company's investment in the Joint Venture is considered to be significant, the Joint Venture's annual financial statements are required to be included as an exhibit to each Company Annual Report on Form 10-K in accordance with SEC Rule 3-09 of Regulation S-X. Given the significance of this investment to the financial position and results of operations of the Company, however, we have elected to include financial information of the Joint Venture in this Quarterly Report on Form 10-Q.

Change Healthcare LLC
Condensed Consolidated Statements of Operations
(unaudited and amounts in thousands, except unit and per unit data)

	Three Months Ended June 30,	
	2019	2018
Revenue:		
Solutions revenue	$ 797,072	$ 757,705
Postage revenue	58,484	65,558
Total revenue	855,556	823,263
Operating expenses:		
Cost of operations (exclusive of depreciation and amortization below)	326,947	337,430
Research and development	49,339	55,324
Sales, marketing, general and administrative	193,273	206,914
Customer postage	58,484	65,558
Depreciation and amortization	71,316	68,527
Accretion and changes in estimate with related parties, net	3,880	3,824
Total operating expenses	703,239	737,577
Operating income (loss)	152,317	85,686
Non-operating (income) and expense		
Interest expense, net	83,406	78,549
Contingent consideration	(791)	272
Other, net	(3,778)	(5,532)
Total non-operating (income) and expense	78,837	73,289
Income (loss) before income tax provision (benefit)	73,480	12,397
Income tax provision (benefit)	1,565	(109)
Net income (loss)	$ 71,915	$ 12,506
Net income (loss) per common unit:		
Basic	$ 0.29	$ 0.05
Diluted	$ 0.28	$ 0.05
Weighted average common units outstanding:		
Basic	251,469,846	251,599,967
Diluted	253,124,478	253,447,527

See accompanying notes to condensed consolidated financial statements.

Change Healthcare LLC
Condensed Consolidated Statements of Comprehensive Income (Loss)
(unaudited and amounts in thousands)

	Three Months Ended	
	June 30, 2019	June 30, 2018
Net income (loss)	$ 71,915	$12,506
Other comprehensive income (loss):		
Foreign currency translation adjustment	756	(8,638)
Changes in fair value of interest rate cap, net of taxes	(18,098)	2,604
Other comprehensive income (loss)	(17,342)	(6,034)
Total comprehensive income (loss)	$ 54,573	$ 6,472

See accompanying notes to condensed consolidated financial statements.

Change Healthcare LLC
Condensed Consolidated Balance Sheets
(unaudited and amounts in thousands)

	June 30, 2019	March 31, 2019
Assets		
Current assets:		
Cash and cash equivalents	$ 27,122	$ 47,718
Restricted cash	264	1,176
Accounts receivable, net of allowance for doubtful accounts	727,205	759,502
Contract assets	145,054	—
Prepaid expenses and other current assets	159,489	172,067
Total current assets	1,059,134	980,463
Property and equipment, net	194,027	197,263
Goodwill	3,284,979	3,284,266
Intangible assets, net	1,284,369	1,320,161
Other noncurrent assets, net	480,463	421,985
Total assets	$ 6,302,972	$ 6,204,138
Liabilities and members' deficit		
Current liabilities:		
Drafts and accounts payable	$ 48,855	$ 98,550
Accrued expenses	332,750	316,179
Deferred revenues	361,663	437,636
Due to related parties, net	28,359	34,629
Current portion of long-term debt	7,085	2,789
Total current liabilities	778,712	889,783
Long-term debt, excluding current portion	5,783,537	5,787,150
Deferred income tax liabilities	107,255	106,099
Tax receivable agreement obligations to related parties	196,696	212,698
Other long-term liabilities	121,655	113,194
Commitments and contingencies (see Note 6)		
Members' deficit	(684,883)	(904,786)
Total liabilities and members' deficit	$ 6,302,972	$ 6,204,138

See accompanying notes to condensed consolidated financial statements.

Change Healthcare LLC
Condensed Consolidated Statements of Members' Deficit
(unaudited and amounts in thousands)

	2019	2018
Balance at March 31	$(904,786)	$(1,066,180)
Cumulative effect of a change in accounting principle-revenue recognition	159,877	—
Advances to Member	—	(208)
Repurchase of equity awards	—	(4,838)
Capital contribution from Member from exercise of equity awards	—	205
Equity compensation expense	5,862	5,300
Net income (loss)	71,915	12,506
Foreign currency translation adjustment	756	(8,638)
Change in fair value of interest rate cap agreements, net of taxes	(18,098)	2,604
Other	(409)	456
Balance at June 30	$(684,883)	$(1,058,793)

See accompanying notes to condensed consolidated financial statements.

Change Healthcare LLC
Condensed Consolidated Statements of Cash Flows
(unaudited and amounts in thousands)

	Three Months Ended June 30,	
	2019	2018
Cash flows from operating activities:		
Net income (loss)	$ 71,915	$ 12,506
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:		
Depreciation and amortization	71,316	68,527
Amortization of capitalized software developed for sale	3,452	3,760
Accretion and changes in estimate, net	3,880	3,824
Equity compensation	5,862	5,300
Deferred income tax expense (benefit)	1,158	(613)
Amortization of debt discount and issuance costs	5,524	5,470
Contingent consideration	(791)	272
Other	(460)	(215)
Changes in operating assets and liabilities:		
Accounts receivable	7,748	16,996
Contract assets	(3,049)	—
Prepaid expenses and other	(16,338)	(28,733)
Accounts payable	(33,954)	(7,647)
Accrued expenses, deferred revenue and other liabilities	(25,524)	115,602
Due to related party, net	(6,269)	(4,196)
Net cash provided by (used in) operating activities	84,470	190,853
Cash flows from investing activities:		
Capitalized expenditures	(67,414)	(65,166)
Net cash provided by (used in) investing activities	(67,414)	(65,166)
Cash flows from financing activities:		
Payments under tax receivable agreements with related parties	(27,227)	(25,096)
Payments on Term Loan Facility	(12,750)	(12,750)
Receipts (payments) on derivative instruments	2,112	1,013
Payments of deferred financing obligations	—	(2,035)
Capital contribution from Members from exercise of equity awards	—	205
Repurchase of equity awards	—	(4,838)
Advances to Member and Other	—	(208)
Other	(759)	598
Net cash provided by (used in) financing activities	(38,624)	(43,111)
Effect of exchange rate changes on cash and cash equivalents	60	(812)
Net increase (decrease) in cash, cash equivalents and restricted cash	(21,508)	81,764
Cash, cash equivalents and restricted cash at beginning of period	48,894	50,011
Cash, cash equivalents and restricted cash at end of period	$ 27,386	$131,775

See accompanying notes to condensed consolidated financial statements.

1. Nature of Business and Organization

Nature of Business

Change Healthcare LLC (the "Joint Venture"), is a leading independent healthcare technology platform that provides data and analytics-driven solutions to improve clinical, financial and patient engagement outcomes in the U.S. healthcare system. The Joint Venture offers a comprehensive suite of software, analytics, technology enabled solutions that drive improved results in the complex workflows of healthcare system payers and providers.

Organization

In June 2016, Change Healthcare Inc., the Joint Venture, Change Healthcare Holdings, LLC, Change Healthcare Intermediate Holdings, LLC, Change Healthcare Performance, Inc. ("Legacy CHC") and its stockholders—including affiliates of The Blackstone Group, L.P. ("Blackstone") and Hellman & Friedman LLC ("Hellman & Friedman")—entered into an Agreement of Contribution and Sale (the "Contribution Agreement") with McKesson Corporation ("McKesson", together with Change Healthcare Inc., the "Members"). Under the terms of the Contribution Agreement, the parties agreed to form the Joint Venture, a joint venture that combined the majority of the McKesson Technology Solutions businesses, excluding McKesson's Enterprise Information Solutions business and RelayHealth Pharmacy Network (such contributed businesses, "Core MTS") with substantially all of the assets and operations of Legacy CHC, but excluding Legacy CHC's pharmacy claims switching and prescription routing businesses (such excluded businesses, the "eRx Network" and the businesses contributed by Legacy CHC, together with Core MTS, the "Contributed Businesses"). The creation of the Joint Venture, including the contribution of the Contributed Businesses and related transactions, is collectively referred to as the "Transactions". The Transactions closed on March 1, 2017.

Basis of Accounting

Due to the existence of shared control among the Members over all major financial and operating decisions of the Joint Venture and its consolidated subsidiaries, the assets and liabilities contributed to the Joint Venture were recognized in the accompanying condensed consolidated financial statements at their historical carrying values (i.e., joint venture accounting).

2. Basis of Presentation

Principles of Consolidation

The accompanying unaudited condensed consolidated financial statements have been prepared in accordance with United States generally accepted accounting principles ("GAAP") for interim financial information and with the instructions to Form 10-Q and Rule 10-01 of Regulation S-X of the Securities and Exchange Commission ("SEC") Guidelines, Rules and Regulations ("Regulation S-X") and, in the opinion of management, reflect all normal recurring adjustments necessary for a fair presentation of results for the unaudited interim periods presented. Certain information and footnote disclosures normally included in annual financial statements prepared in accordance with GAAP have been condensed or omitted. The results of operations for the interim period are not necessarily indicative of the results to be obtained for the full fiscal year. All intercompany accounts and transactions have been eliminated in the unaudited condensed consolidated financial statements.

Reclassifications

Certain reclassifications have been made to the prior period financial statements to conform to the current period presentation.

Accounting Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. The Joint Venture bases its estimates on historical experience, current business factors and various other assumptions that the Joint Venture believes are necessary to consider in order to form a basis for making judgments about the carrying values of assets and liabilities, the recorded amounts of revenue and expenses and disclosure of contingent assets and liabilities. The Joint Venture is subject to uncertainties such as the impact of future events, economic, environmental and political factors and changes in the Joint Venture's business environment;

therefore, actual results could differ from these estimates. Accordingly, the accounting estimates used in the preparation of the Joint Venture's financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the Joint Venture's operating environment changes. Such changes in estimates and refinements in estimation methodologies are reflected in the reported results of operations, and, if material, the effects of changes in estimates are disclosed in the notes to the condensed consolidated financial statements. Estimates and assumptions by management affect: the allowance for doubtful accounts; the fair value assigned to assets acquired and liabilities assumed in business combinations; tax receivable agreement obligations; the fair value of interest rate cap agreement obligations; contingent consideration; loss accruals; the carrying value of long-lived assets (including goodwill and intangible assets); the amortization period of long-lived assets (excluding goodwill); the carrying value, capitalization and amortization of software development costs; the provision and benefit for income taxes and related deferred tax accounts; certain accrued expenses; revenue recognition; contingencies; and the value attributed to equity awards.

Allowance for Doubtful Accounts

The allowance for doubtful accounts of $21,260 and $20,438 at June 30, 2019 and March 31, 2019, respectively, reflects the Joint Venture's best estimate of losses inherent in the Joint Venture's receivables portfolio determined on the basis of historical experience, specific allowances for known troubled accounts and other currently available evidence.

Accounting Pronouncements Not Yet Adopted

In February 2016, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2016-02, which generally requires that all lease obligations be recognized on the balance sheet at the present value of the remaining lease payments with a corresponding lease asset. As originally issued, the standard required that companies adopt the standard using the modified retrospective transition method and report a cumulative effect adjustment to the opening balance of retained earnings in the earliest comparative period presented. In July 2018, the FASB issued ASU No. 2018-11 which provides companies with the option to apply this cumulative effect adjustment to the opening balance of retained earnings in the period of adoption instead of the earliest comparative period presented. This update is scheduled to be effective for the Joint Venture beginning April 1, 2020, with early adoption permitted. The Joint Venture is currently assessing both the method of adoption and the potential effects this update may have on its condensed consolidated financial statements.

In June 2016, the FASB issued ASU No. 2016-13, as amended by ASU No. 2018-19, which requires that a financial asset (or group of financial assets) measured at amortized cost be presented at the net amount expected to be collected based on relevant information about past events, including historical experience, current conditions and reasonable and supportable forecasts that affect the collectability of the reported amount. This update is scheduled to be effective for the Joint Venture beginning April 1, 2021, with early adoption permitted beginning April 1, 2019. The Joint Venture is currently assessing the potential effects this update may have on its condensed consolidated financial statements.

In August 2018, the FASB issued ASU No. 2018-13, which modifies the disclosure requirements related to fair value measurements based on the FASB Concepts Statements. This update eliminates certain disclosures, modifies others and, in certain cases, requires additional disclosures. This update is effective for the Joint Venture beginning April 1, 2020, with earlier adoption permitted. The Joint Venture is currently assessing the potential effects this update may have on its condensed consolidated financial statements.

In August 2018, the FASB issued ASU No. 2018-15, which aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. This update also requires that the effects of such capitalized costs be classified in the same respective caption of the statement of operations, balance sheet and cash flows as the underlying hosting arrangement. Upon adoption, a company may elect to either retrospectively restate each prior reporting period or apply the update prospectively to all implementation costs incurred after the effective date. This update is scheduled to be effective for the Joint Venture beginning April 1, 2020, with early adoption permitted. The Joint Venture is currently assessing both the method of adoption and the potential effects this update may have on its condensed consolidated financial statements.

Recently Adopted Accounting Pronouncements

In April 2019, the Joint Venture adopted FASB ASU No. 2018-16, which adds the Overnight Index Swap rate based on the Secured Overnight Financing Rate as a benchmark interest rate for hedging purposes. As the adoption of this update applies only to qualifying new or redesignated hedging relationships entered into following the date of adoption, its adoption has no immediate effect on the Joint Venture's condensed consolidated financial statements.

In April 2019, the Joint Venture adopted FASB ASU No. 2018-02, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017 ("Tax Legislation"). Because the Joint Venture's financial statements do not separately classify the components of members' deficit, the effect of the adoption of this update was limited to the separate disclosure in Note 10 related to the reclassification of such stranded costs from accumulated comprehensive income (loss) to accumulated deficit.

In April 2019, the Joint Venture adopted FASB ASU No. 2018-07, which expands the scope of Topic 718 to include share-based payment transactions for acquiring goods and services from nonemployees. Among other provisions, the measurement date for awards to nonemployees changed from the earlier of the date at which a commitment for performance by the counterparty is reached or the date at which performance is complete under the previous guidance to the grant date under this update. Because the Joint Venture's equity-based compensation was previously subject to remeasurement at fair value each quarter under the previous authoritative literature, the effect of the adoption of this update had no material effect on the Joint Venture's condensed consolidated financial statements.

In April 2019, the Joint Venture adopted Accounting Standards Codification ("ASC") 606, Revenue from Contracts with Customers, which replaced most prior general and industry specific revenue recognition guidance with a principles-based comprehensive revenue recognition framework. Under this revised framework, a company recognizes revenue to depict the transfer of promised goods and services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods and services. All of the Joint Venture's revenue is accounted for under ASC 606.

The Joint Venture adopted ASC 606 using the modified retrospective transition method applied only to contracts that were not completed as of the date of initial application. The Joint Venture has also elected the contract modification transition practical expedient, and as a result, will treat all contract modifications entered into prior to adoption date as if they were part of the original contract. The adoption of the new revenue standard utilizing these transition methods resulted in a cumulative effect adjustment that reduced members' deficit as of April 1, 2019 by $159,877. After assessing all potential impacts of adopting the new standard on its consolidated financial statements, related disclosures, and necessary control and process changes, the Joint Venture has noted the following to be the most notable impacts of adopting the new standard:

- Revenue for certain contingent fee service arrangements will be accelerated as revenue for these arrangements is recognized as the services are performed.
- Revenue related to certain time-based software and content license agreements will be accelerated. The license component for certain time-based software will be recognized upon delivery to the customer ("point in time"), or in the case of software that requires significant production, modification or customization, recognized as the implementation work is performed. A non-license component (e.g., technical support) will be recognized over the respective contract terms ("over time").
- Incremental costs to obtain contracts and qualifying costs to fulfill will be capitalized and amortized over the period of benefit. The net result of this change was an increase to capitalized contract costs on the balance sheet; these capitalized costs will be amortized and recognized as expense over an incrementally longer period of time.

The following tables represent the impact of the new standard on the Joint Venture's unaudited financial statements for the three months ended June 30, 2019:

	Three months ended June 30,			
	2019			2018
	As Reported	Impacts from Adoption	Without Adoption (ASC 605)	As Reported (ASC 605)
Revenue:				
Solutions revenue	$ 797,072	$(41,531)	$755,541	$ 757,705
Postage revenue	58,484	—	58,484	65,558
Total revenue	855,556	(41,531)	814,025	823,263
Operating expenses:				
Cost of operations (exclusive of depreciation and amortization below)	326,947	808	327,755	337,430
Research and development	49,339	—	49,339	55,324
Sales, marketing, general and administrative	193,273	5,169	198,442	206,914
Customer postage	58,484	—	58,484	65,558
Depreciation and amortization	71,316	—	71,316	68,527
Accretion and changes in estimate with related parties, net	3,880	—	3,880	3,824
Total operating expenses	703,239	5,977	709,216	737,577
Operating income (loss)	152,317	(47,508)	104,809	85,686
Non-operating (income) and expense				
Interest expense, net	83,406	—	83,406	78,549
Contingent consideration	(791)	—	(791)	272
Other, net	(3,778)	—	(3,778)	(5,532)
Total non-operating (income) and expense	78,837	—	78,837	73,289
Income (loss) before income tax provision (benefit)	73,480	(47,508)	25,972	12,397
Income tax provision (benefit)	1,565	(2,251)	(686)	(109)
Net income (loss)	$ 71,915	$(45,257)	$ 26,658	$ 12,506
Net income (loss) per common unit:				
Basic	$ 0.29		$ 0.11	$ 0.05
Diluted	$ 0.28		$ 0.11	$ 0.05

	June 30, 2019			March 31, 2019
	As Reported	Impacts from Adoption	Without Adoption (ASC 605)	As Reported (ASC 605)
Assets				
Current assets:				
Cash and cash equivalents	$ 27,122	$ —	$ 27,122	$ 47,718
Restricted cash	264	—	264	1,176
Accounts receivable, net of allowance for doubtful accounts	727,205	24,428	751,633	759,502
Contract assets	145,054	(145,054)	—	—
Prepaid expenses and other current assets	159,489	20,084	179,573	172,067
Total current assets	1,059,134	(100,542)	958,592	980,463
Property and equipment, net	194,027	—	194,027	197,263
Goodwill	3,284,979	—	3,284,979	3,284,266
Intangible assets, net	1,284,369	—	1,284,369	1,320,161
Other noncurrent assets, net	480,463	(40,335)	440,128	421,985
Total assets	$6,302,972	$(140,877)	$6,162,095	$6,204,138
Liabilities and members' deficit				
Current liabilities:				
Drafts and accounts payable	$ 48,855	$ (62)	$ 48,793	$ 98,550
Accrued expenses	332,750	—	332,750	316,179
Deferred revenues	361,663	66,023	427,686	437,636
Due to related parties, net	28,359	—	28,359	34,629
Current portion of long-term debt	7,085	—	7,085	2,789
Total current liabilities	778,712	65,961	844,673	889,783
Long-term debt, excluding current portion	5,783,537	—	5,783,537	5,787,150
Deferred income tax liabilities	107,255	—	107,255	106,099
Tax receivable agreement obligations to related parties	196,696	—	196,696	212,698
Other long-term liabilities	121,655	566	122,221	113,194
Commitments and contingencies				
Members' deficit	(684,883)	(207,404)	(892,287)	(904,786)
Total liabilities and members' deficit	$6,302,972	$(140,877)	$6,162,095	$6,204,138

The adoption of the new standard had an immaterial impact on the Joint Venture's unaudited statement of cash flows for the three-months ended June 30, 2019. See Note 3, *Revenue Recognition* for more information.

3. Revenue Recognition

The Joint Venture generates most of its solutions revenue by using technology solutions (generally Software as a Service ("SaaS")) to provide services to its customers that automate and simplify business and administrative functions for payers, providers, pharmacies, and channel partners and through the licensing of software, software systems (consisting of software, hardware and maintenance support) and content.

The Joint Venture recognizes revenue when the customer obtains control of the good or service through the Joint Venture satisfying a performance obligation by transferring the promised good or service to the customer.

Principal Revenue Generating Products and Services

Content license subscriptions and time-based software - The Joint Venture's content license subscriptions and time-based software arrangements provide a license to use a software for a specified period of time. At the end of the contractual period, the customer either renews the license for an additional term or ceases to use the software. Software licenses are typically delivered to the customer with functionality that the customer can benefit from the software on its own or together with readily available resources. As contracts for these solutions generally do not price individual components separately, the Joint Venture allocates the transaction price to the license and ongoing support performance obligations based on standalone selling price ("SSP"), primarily determined by historical value relationships between licenses and ongoing support and updates. Revenue allocated to content license subscriptions and time-based software license agreements is generally recognized at the point-in-time of delivery of the license or the content update upon transfer of control of the underlying license to the customer. Generally, software implementation fees are recognized over the implementation period through an input measure of progress method. Revenue allocated to maintenance and support is recognized ratably over the period covered by the agreements, as passage of time represents a faithful depiction of the transfer of these services. In some cases, software arrangements provide licenses to several software applications that are highly integrated with the implementation services and software updates and cannot function separately. The bundle is a single performance obligation since the individually promised goods and services are not distinct in the context of the contract because the related implementation services significantly modify and customize the software and the updates provided to the integrated software solution are critical to the software's utility. The related revenue is recognized on a straight-line basis, ratably over the contractual term due to the frequency and criticality of the updates throughout the license period.

Contingent fee services - The Joint Venture provides services to customers in which the transaction price is contingent on future occurrences, such as savings generated or amounts collected on behalf of its customers through the delivery of its services. In some cases, the Joint Venture performs services in advance of invoicing the customer, thereby creating a contract asset. Revenue in these arrangements is estimated and constrained until the Joint Venture determines that it is probable a significant revenue reversal will not occur, and variable consideration is allocated to the performance obligation for which the Joint Venture earns a contingent fee.

Perpetual software licenses - The Joint Venture's perpetual software arrangements provide a license for a customer to use software in perpetuity. Software licenses are typically delivered to the customer with functionality from which the customer can benefit from the license on its own or together with readily available resources. Perpetual software arrangements are recognized at the time of delivery or through an input measure of progress method over the installation period if the arrangements require significant production or modification or customization of the software. Contracts accounted for through an input measure of progress method are generally measured based on the ratio of labor hours incurred to date to total estimated labor hours to be incurred. Software implementation fees are recognized as the work is performed or under the input method for perpetual software. Hardware revenues are generally recognized upon delivery. Maintenance is recognized ratably over the term of the agreement as passage of time represents a faithful depiction of the transfer of these services.

Professional services - The Joint Venture provides training and consulting services to its customers, and the services may be fixed fee or time and materials based. Consulting services that fall outside of the standard implementation services vary depending on the scope and complexity of the service requested by the customer. Consulting services are deemed to be capable of being distinct from other products and services, and the services are satisfied either at a point of time or over time based on delivery. Training services are usually provided as an optional service to enhance the customer's experience with a software product or provides additional education surrounding the general topic of the solution. Training services are capable of being distinct from other products and services. The Joint Venture treats training services as a distinct performance obligation, and they are satisfied at a point of time.

Transaction processing services - The Joint Venture provides transaction processing (such as claims processing) services to hospitals, pharmacies and health systems via a cloud-based (SaaS) platform. The promised service is to stand ready to process transactions for our customers over the contractual period on an as needed basis. The revenue related to these services is recognized over time as the transactions are processed, and the revenue is recognized over the individual days in which the services are performed. Any fixed annual fees and implementation fees are recognized ratably over the contract period.

Hosted solutions and software as a service ("SaaS") - The Joint Venture enters into arrangements whereby the Joint Venture provides the customer access to a Joint Venture-owned software solution, which are generally marketed under annual and multi-year arrangements. The customer is only provided "access" (not a license) to the software application. In these arrangements, the customer does not purchase equipment nor does the customer take physical possession of the software. The related revenue is recognized ratably over the contracted term. For fixed fee arrangements, revenue recognition begins after set-up and implementation are complete. For per-transaction fee arrangements, revenue is recognized as transactions are processed beginning on the service start date.

Contract Balances

The Joint Venture's payment terms vary by customer and product type. For certain products or services, the Joint Venture requires upfront payments before control of the product or service has transferred to the customer. For other products and services, the Joint Venture invoices the customer in arrears after providing the products or services. In addition, for certain contingent fee services, customers are billed in arrears, typically based upon a percentage of collections the Joint Venture makes on the customer's behalf.

Under the new revenue standard, the Joint Venture generally recognizes a contract asset when revenue is recognized in advance of invoicing on a customer contract, unless the right to payment for that revenue is unconditional (i.e. requiring no further performance and only the passage of time). If a right to payment is determined to meet the criteria to be considered 'unconditional', then the Joint Venture will recognize a receivable.

There were no impairment losses recognized on accounts receivable or contract assets in the quarter ended June 30, 2019.

The Joint Venture records deferred revenues when billings or payments are received from customers in advance of its performance. Deferred revenue is generally recognized when transfer of control to customers occurs. The deferred revenue balance is driven by multiple factors, including the frequency of renewals, invoice timing, and invoice duration. As of June 30, 2019, the Joint Venture expects 93% of the deferred revenue balance to be recognized in one year or less, and approximately $180,000 of the beginning period balance was recognized during the first quarter of fiscal 2020.

Costs to Obtain or Fulfill a Contract

Sales commissions and certain other incentive payments (e.g., bonuses that are contingent solely on obtaining a contract or a pool of contracts) earned by the Joint Venture's sales organization are capitalized as incremental costs to obtain a contract. The Joint Venture typically does not offer commissions on contract renewals. Decremented commissions upon renewal (i.e., non-commensurate with initial commissions) are offered to the Joint Venture's sales associates for certain customers and are not material. Under ASC 606, all commissions and other qualifying incentive payments capitalized are amortized over an expected period of benefit defined as the initial contract term plus anticipated renewals. In contrast, under ASC 605 these capitalized costs were amortized over the specific revenue contract terms, which are typically 12 to 60 months. In making the significant judgment in determining the appropriate period of benefit, the Joint Venture evaluated both qualitative and quantitative factors such as the expected customer relationship period and technology obsolescence. In addition, prior to solution go-live, the Joint Venture incurs certain contract fulfillment costs primarily related to SaaS setup for our clients. These costs are capitalized to the extent they are directly related to a contract, are recoverable, and create a resource used to deliver the Joint Venture's SaaS services. Capitalized costs to fulfill a contract are amortized over the expected period of benefit.

At June 30, 2019, the Joint Venture had capitalized costs to obtain a contract of $14,236 in prepaid and other current assets and $62,001 in other noncurrent assets. During the three months ended June 30, 2019, the Joint Venture recognized $4,109 of amortization expense related to such capitalized costs, which is included in the total operating expenses. At June 30, 2019, the Joint Venture had capitalized costs to fulfill a contract of $1,306 in prepaid and other current assets and $8,281 in other noncurrent assets. During the three months ended June 30, 2019, the Joint Venture recognized $296 of amortization expense related to such capitalized costs, which is included in total operating expenses.

Postage Revenues

Postage revenues are the result of providing delivery services to customers in the Joint Venture's payment and communication solutions. Postage revenues are generally billed as a pass-through cost to the Joint Venture's customers. The service is part of a combined performance obligation with the printing and handling services provided to the customer because the postage services are not distinct within the context of the contract. The Joint Venture presents Postage Revenue separately from Solutions Revenue on the consolidated statements of operation as it makes the financial statements more informative for the users. The revenue related to the combined performance obligation of the postage, printing, and handling service is recognized as the transactions are processed, and the revenue is recognized over the individual days in which the services are performed.

Arrangements with Multiple Performance Obligations

The Joint Venture engages in customer arrangements which may include multiple performance obligations, such as any combination of software, hardware, implementation, SaaS-based offerings, consulting services, or maintenance services. For such arrangements, the Joint Venture allocates revenues to each performance obligation on a relative standalone selling price basis. A performance obligation's standalone selling price is determined based on the directly observable prices charged to customers, when available or estimated using other methods such as the adjusted market assessment approach, the expected cost plus a margin

approach, or other approaches in cases where distinct performance obligations are not sold separately but instead sold at a bundled price. For performance obligations with historical pricing that is highly variable, the residual approach is used. Such instances primarily relate to the Joint Venture's perpetual software arrangements in which the Joint Venture sells the same products to different customers for a broad range of amounts.

Remaining Performance Obligations

The aggregate amount of transaction price allocated to performance obligations that are unsatisfied (or partially unsatisfied) for executed contracts includes deferred revenue and other revenue yet to be recognized from non-cancellable contracts. As of June 30, 2019, the Joint Venture's total remaining performance obligations approximated $1,274,000, of which approximately 53% is expected to be recognized over the next twelve months, and the remaining 47% thereafter.

In this balance, the Joint Venture does not include the value of unsatisfied performance obligations related to those contracts for which it recognizes revenue at the amount for which it has the right to invoice for services performed. Additionally, this balance does not include revenue related to performance obligations that are part of a contract with an original expected duration of one year or less. Lastly, this balance does not include variable consideration allocated to the individual goods or services in a series of distinct goods or services that are substantially the same and that have the same pattern of transfer to the customer. Examples includes variable fees associated with transaction processing and contingent fee services.

Disaggregated Revenue

The Joint Venture disaggregates the revenue from contracts with customers by operating segment as it believes doing so best depicts how the nature, amount, timing and uncertainty of the Joint Venture's revenue are affected by economic factors. See note 9, "Segment Reporting" for the total revenue disaggregated by operating segment for the three months ended June 30, 2019 and June 30, 2018.

The Joint Venture's total revenue by disaggregated revenue source was generally consistent for each reportable segment for the three months ended June 30, 2019 and June 30, 2018.

Customer Incentives

Certain customers, which include the Joint Venture's channel partners, may receive cash-based incentives or rebates based on actual sales and achievement of a cumulative level of sales, which are accounted for as variable consideration. The Joint Venture considers these amounts to be consideration payable to the customer, and therefore, the Joint Venture estimates these amounts based on the expected amount to be provided to customers and reduces the transaction price accordingly.

Practical Expedients and Exemptions

The Joint Venture has elected to utilize either the right to invoice practical expedient or the series-based variable consideration allocation framework for most transaction processing services not subject to contingencies. The Joint Venture also has elected to exclude sales taxes and other similar taxes from the measurement of the transaction price in contracts with customers. Therefore, revenue is recognized net of such taxes.

In certain customer arrangements with customers, the Joint Venture determined there are certain promised goods or services which are immaterial in the context of the contract from both a quantitative and qualitative perspective, and therefore, the goods and services are disregarded when assessing the performance obligations in the customer arrangement.

The Joint Venture has elected to apply the significant financing practical expedient, and as a result, the Joint Venture will not adjust the promised amount of consideration in a customer contract for the effects of a significant financing component when the period of time between when the Joint Venture transfers a promised good or service to a customer and when the customer pays for the good or service will be one year or less.

4. Interest Rate Cap Agreements

Risk Management Objective of Using Derivatives

The Joint Venture is exposed to certain risks arising from both its business operations and economic conditions. The Joint Venture principally manages its exposures to a wide variety of business and operational risks through management of its core business activities. The Joint Venture manages economic risks, including interest rate, liquidity and credit risk, primarily by managing the amount, sources and duration of its debt funding and the use of derivative financial instruments. Specifically, the Joint Venture enters into derivative financial instruments to manage differences in the amount, timing and duration of the Joint Venture's known or expected cash receipts and its known or expected cash payments principally related to the Joint Venture's borrowings.

Cash Flow Hedges of Interest Rate Risk

The Joint Venture's objectives in using interest rate derivatives are to add stability to interest expense and to manage its exposure to interest rate movements. To accomplish these objectives, the Joint Venture primarily uses interest rate cap agreements as part of its interest rate risk management strategy.

In March 2016 and 2017, Legacy CHC and the Joint Venture, respectively, executed annuitized interest rate cap agreements with a combined notional amount of $650,000 and $750,000, respectively, to limit the exposure of the variable component of interest rates under the then existing term loan facility or future variable rate indebtedness, each beginning in March 2017 and expiring in March 2020.

In August 2018, the Joint Venture executed additional annuitized interest rate cap agreements with notional amounts of $500,000 and $1,500,000, respectively, to limit the exposure of the variable component of interest rates under the term loan facility or future variable rate indebtedness to a maximum of 1.0%. The $500,000 interest rate cap agreement began effective August 31, 2018 and expires March 31, 2020. The $1,500,000 interest rate cap agreement begins effective March 31, 2020 and expires December 31, 2021.

As of June 30, 2019, each of the Joint Venture's outstanding interest rate cap agreements was designated as a cash flow hedge of interest rate risk and was determined to be highly effective.

Following the adoption of ASU 2017-12, all changes in the fair value of derivatives designated and that qualify as cash flow hedges are recorded in accumulated other comprehensive income and are subsequently reclassified into earnings in the period that the hedged forecasted transaction affects earnings. Amounts reported in accumulated other comprehensive income related to derivatives will be reclassified to interest expense as interest payments are made on the Joint Venture's variable-rate debt. During the twelve months subsequent to June 30, 2019, the Joint Venture estimates that $11,315 will be reclassified as an increase to interest expense.

The following table summarizes the fair value of the Joint Venture's derivative instruments at June 30, 2019 and March 31, 2019:

	Fair Values of Derivative Financial Instruments Asset (Liability)		
Derivative financial instruments designated as hedging instruments:	**Balance Sheet Location**	**June 30, 2019**	**March 31, 2019**
Interest rate cap agreements	Prepaid and other current assets	$ 2,202	$ 8,766
Interest rate cap agreements	Accrued expenses	(7,262)	(2,160)
Interest rate cap agreements	Other long-term liabilities	(24,319)	(16,846)
		$ (29,379)	$(10,240)

Tabular Disclosure of the Effect of Derivative Instruments on the Statement of Operations

The effect of the derivative instruments on the accompanying condensed consolidated statements of operations for the three months ended June 30, 2019 and 2018, is summarized in the following table:

	Three Months Ended June 30, 2019	Three Months Ended June 30, 2018
Derivative financial instruments in cash flow hedging relationships:		
Gain/ (loss) related to effective portion of derivative financial instruments recognized in other comprehensive income (loss)	$ (17,051)	$ 5,649
Gain/ (loss) related to portion of derivative financial instruments reclassified from accumulated other comprehensive income (loss) to interest expense	$ (1,047)	$ (1,412)

Credit Risk-related Contingent Features

The Joint Venture has agreements with each of its derivative counterparties providing that if the Joint Venture defaults on any of its indebtedness, including a default where repayment of the indebtedness has not been accelerated by the lender, then the Joint Venture also could be declared in default on its derivative obligations.

As of June 30, 2019, the termination value of derivative financial instruments in a net liability position, which includes accrued interest but excludes any adjustment for nonperformance risk, was $30,805. If the Joint Venture had breached any of these provisions at June 30, 2019, the Joint Venture could have been required to settle its obligations under the agreements at this termination value. The Joint Venture does not offset any derivative financial instruments, and the derivative financial instruments are not subject to collateral posting requirements.

5. Fair Value Measurements

Assets and Liabilities Measured at Fair Value on a Recurring Basis

The Joint Venture's assets and liabilities that are measured at fair value on a recurring basis consist of the Joint Venture's derivative financial instruments and contingent consideration obligations. The tables below summarize these items as of June 30, 2019 and March 31, 2019, aggregated by the level in the fair value hierarchy within which those measurements fall.

Description	Balance at June 30, 2019	Quoted in Markets Identical (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Interest rate cap agreements	$ (29,379)	$ —	$ (29,379)	$ —
Contingent consideration obligations	(2,300)	—	—	(2,300)
Total	$ (31,679)	$ —	$ (29,379)	$ (2,300)

Description	Balance at March 31, 2019	Quoted in Markets Identical (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Interest rate cap agreements	$ (10,240)	$ —	$ (10,240)	$ —
Contingent consideration obligations	(3,091)	—	—	(3,091)
Total	$ (13,331)	$ —	$ (10,240)	$ (3,091)

The valuation of the Joint Venture's derivative financial instruments is determined using widely accepted valuation techniques, including discounted cash flow analysis on the expected cash flows of each derivative. This analysis reflects the contractual terms of the derivative, including the period to maturity, and uses observable market-based inputs, including interest rate curves. The fair value of the interest rate cap agreements is determined using the market standard methodology of netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments) using the overnight index swap rate as the discount rate.

The Joint Venture incorporates credit valuation adjustments to appropriately reflect both its own nonperformance risk and the respective counterparty's nonperformance risk in the fair value measurements. In adjusting the fair value of its derivative contracts for the effect of nonperformance risk, the Joint Venture has considered the impact of netting and any applicable credit enhancements and measures the credit risk of its derivative financial instruments that are subject to master netting agreements on a net basis by counterparty portfolio.

Although the Joint Venture has determined that the majority of the inputs used to value its derivatives fall within Level 2 of the fair value hierarchy, the credit valuation adjustments associated with its derivatives utilize Level 3 inputs to evaluate the likelihood of default by itself and by its counterparties. As of June 30, 2019, the Joint Venture determined that the credit valuation adjustments are not significant to the overall valuation of its derivatives. As a result, the Joint Venture determined that its derivative valuations in their entirety are classified in Level 2 of the fair value hierarchy.

The valuation of the Joint Venture's contingent consideration obligations was determined using a discounted cash flow method as applied to cash flows determined through a Monte Carlo Simulation. This analysis reflects the contractual terms of the purchase agreements (e.g., minimum and maximum payments, length of earn-out periods, manner of calculating any amounts due, etc.) and utilizes assumptions with regard to future cash flows, probabilities of achieving such future cash flows and a discount rate. Significant increases with respect to assumptions as to future revenue and probabilities of achieving such future revenue would have resulted in a higher fair value measurement while an increase in the discount rate would have resulted in a lower fair value measurement.

The table below presents a reconciliation of the fair value of the liabilities that use significant unobservable inputs (Level 3):

	Three Months Ended June 30, 2019	Three Months Ended June 30, 2018
Balance at beginning of period	$ (3,091)	$ (4,000)
Adjustment of provisional amounts	—	100
Gain/ (loss) included in contingent consideration	791	(272)
Balance at end of period	$ (2,300)	$ (4,172)

Assets and Liabilities Measured at Fair Value upon Initial Recognition

The carrying amount and the estimated fair value of financial instruments held by the Joint Venture at June 30, 2019 and March 31, 2019 were:

	June 30, 2019		March 31, 2019	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Cash and cash equivalents	$ 27,122	$ 27,122	$ 47,718	$ 47,718
Accounts receivable	$ 727,205	$ 727,205	$ 759,502	$ 759,502
Senior Credit Facilities (Level 2)	$4,796,345	$4,834,418	$4,804,905	$4,834,800
Senior Notes (Level 2)	$ 980,615	$1,005,000	$ 979,905	$ 990,000

The carrying amounts of cash equivalents and accounts receivable approximate fair value because of their short-term maturities. The fair value of long-term debt is based upon market quotes and trades by investors in partial interests of these instruments.

Investments in Businesses

In December 2018, the Joint Venture purchased $15,000 of preferred shares of a health care company and $500 shares in a related company holding certain intellectual property, each of which is classified within Other noncurrent assets, net on the accompanying condensed consolidated balance sheets. Because this investment has no readily determinable fair value, the Joint Venture measures this investment at cost minus impairment, if any, plus or minus changes resulting from observable price changes in orderly transactions for the identical or a similar investment of the same issuer. The Joint Venture recognized no changes in the value of this investment during the three months ended June 30, 2019.

6. Legal Proceedings

The Joint Venture is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

Government Subpoenas and Investigations

From time to time, the Joint Venture receives subpoenas or requests for information from various government agencies. The Joint Venture generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses sometimes require time and effort and can result in considerable costs being incurred by the Joint Venture. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Joint Venture and other members of the health care industry, as well as to settlements.

Other Matters

Additionally, in the normal course of business, the Joint Venture is involved in various claims and legal proceedings. While the ultimate resolution of ongoing matters has yet to be determined, the Joint Venture does not believe that their outcomes will have a material adverse effect on the Joint Venture's consolidated financial position, results of operations or liquidity.

7. Income Taxes

The Joint Venture is treated as a partnership for income tax purposes and is therefore not subject to U.S. federal income taxes and not subject to most state and local income taxes. Legacy CHC and Change Healthcare Practice Management Solutions, Inc., both wholly owned subsidiaries of the Joint Venture, are subject to U.S. federal, state and local, and non-U.S. corporate income taxes.

The income tax expense for the three months ended June 30, 2019 and benefit for the three months ended June 30, 2018 was $1,565 and $109, respectively, which represents an effective tax rate of 2.1% and (0.9%), respectively.

Fluctuations in the Joint Venture's reported income tax rates are primarily due to the earnings from partnerships that are passed through to the Members for which the Joint Venture is not subject to tax and benefits recognized as a result of certain incentive tax credits resulting from research and experimental expenditures in both the US and Canada.

8. Tax Receivable Agreement Obligations to Related Parties

Upon the consummation of the Transactions, the Joint Venture assumed obligations related to certain tax receivable agreements (collectively, the "Tax Receivable Agreements") with its current and former owners. Because the assets and obligations of the predecessor businesses were contributed to the Joint Venture at their historical carrying values, these Tax Receivable Agreements are subject to differing accounting models as explained below.

2009 - 2011 Tax Receivable Agreements

Under the 2009 - 2011 Tax Receivable Agreements assumed by the Joint Venture in connection with the Transactions, the Joint Venture is obligated to make payments to certain of the former Legacy CHC stockholders, equal to 85% of the applicable cash savings that the Joint Venture expects to realize as a result of tax attributes arising from certain previous transactions. As a result of the covered change of control with respect to the Tax Receivable Agreements that occurred in connection with the Transactions, payments the Joint Venture makes under the 2009—2011 Tax Receivable Agreements are required to be calculated using certain valuation assumptions, including that the Joint Venture will have sufficient taxable income to use the applicable tax attributes and that certain of such tax attributes will be used by the Joint Venture on a pro rata basis from the date of the Transactions (or in certain cases from the date of certain previous transactions) through the expiration of the applicable tax attribute. Because the 2009—2011 Tax Receivable Agreements were previously subject to fair value measurement in connection with a prior business combination transaction, it is recognized at its initial fair value plus recognized accretion to date.

2017 Tax Receivable Agreement

The 2017 Tax Receivable Agreement generally provides for the payment by Change Healthcare Performance, Inc. (a subsidiary of the Joint Venture) to affiliates of Blackstone, Hellman & Friedman of 85% of the net cash tax savings realized (or, in certain circumstances, deemed to be realized) in periods ending on or after the Transactions as a result of certain net operating losses and certain other tax attributes of Change Healthcare Performance, Inc. as of the date of the Transactions. The 2017 Tax Receivable Agreement is considered a loss contingency under FASB ASC Topic 450 and is reflected on the accompanying condensed consolidated balance sheet at the amount that is both probable and reasonably estimable with future changes in this value being reflected within pretax income or loss.

McKesson Tax Receivable Agreement

The McKesson Tax Receivable Agreement generally requires payment to affiliates of McKesson (the "McKesson TRA Parties") of 85% of certain cash tax savings realized (or, in certain circumstances, deemed to be realized) by Change Healthcare Performance, Inc. in periods ending on or after the date on which McKesson ceases to own at least 20% of the Joint Venture as a result of (i) certain amortizable tax basis in assets transferred to Joint Venture at the closing of the Transactions and (ii) imputed interest deductions and certain other tax attributes arising from payments under the McKesson Tax Receivable Agreement. Because payments under the McKesson Tax Receivable Agreement are contingent upon McKesson's ceasing to own at least 20% of the Joint Venture and such an event was not probable at inception of the McKesson Tax Receivable Agreement or as of June 30, 2019, no related obligation has been reflected on the accompanying condensed consolidated balance sheet.

Based on facts and circumstances at June 30, 2019, the Joint Venture estimates the aggregate payments due under these Tax Receivable Agreements to be as follows:

	2009 - 2011 Tax Receivable Agreements	2017 Tax Receivable Agreement	Total
2020 (remainder)	$ —	$ —	$ —
2021	18,669	1,179	19,848
2022	19,756	1,179	20,935
2023	19,826	41,330	61,156
2024	19,096	19,650	38,746
Thereafter	119,498	52,393	171,891
Gross expected payments	196,845	115,731	312,576
Less: Amounts representing discount	(96,032)	—	(96,032)
Total tax receivable agreement obligations due to related parties	100,813	115,731	216,544
Less: Current portion due (included in due to related parties, net)	(18,669)	(1,179)	(19,848)
Tax receivable agreement obligations due to related parties	$ 82,144	$114,552	$196,696

The timing and/or amount of aggregate payments due may vary based on a number of factors, including the amount of net operating losses and income tax rates.

9. Segment Reporting

Management views the Joint Venture's operating results based on three reportable segments: (a) software and analytics, (b) network solutions and (c) technology-enabled services. The accounting policies of the reportable segments are the same as those described in the summary of significant accounting policies in Note 2 to the Joint Venture's audited consolidated financial statements for the year ended March 31, 2019.

In April 2019, the Joint Venture made certain changes in the way that it manages its business and allocates costs. Specifically, the Joint Venture made the following changes during the period:

- Moved its consumer payments solution from the Network Solutions reportable segment to the Technology-enabled Services reportable segment.
- Moved its consumer engagement solutions from the Software and Analytics reportable segment to the Network Solutions reportable segment.
- Made certain changes in the way that costs are assigned to the reportable segments.

The presentation in the tables that follow has been retrospectively adjusted to reflect the above described changes.

Software and Analytics

The software and analytics segment provides solutions for revenue cycle management, provider network management, payment accuracy, value-based payments, clinical decision support, consumer engagement, risk adjustment and quality performance, and imaging and clinical workflow.

Network Solutions

The network solutions segment provides solutions for financial, administrative and clinical transactions, electronic payments and aggregation and analytics of clinical and financial data.

Technology-enabled Services

The technology-enabled services segment provides solutions for revenue cycle and practice management, value-based care enablement, communications and payments, pharmacy benefits administration and consulting.

Corporate and Eliminations

Inter-segment revenue and expenses primarily represent claims management and payment and communication solutions provided between segments.

Corporate and eliminations includes pass-through postage costs, management, administrative and certain other shared corporate services costs that are not allocated to the respective reportable segments, as well as eliminations to remove inter-segment revenue and expenses and consolidating adjustments to classify certain rebates paid to channel partners as a reduction of revenue. These administrative costs are excluded from the adjusted EBITDA measure for each respective reportable segment.

Listed below are the revenue and adjusted EBITDA for each of the reportable segments for the three months ended June 30, 2019 and 2018. This information is reflected in the manner utilized by management to make operating decisions, assess performance and allocate resources. Such amounts include allocations of corporate shared services functions that are essential to the core operations of the reportable segments such as information technology, operations and product development functions. Segment assets and related depreciation expenses are not presented to management for purposes of operational decision making, and therefore are not included in the accompanying tables.

	Three Months Ended June 30, 2019				
	Software and Analytics	Network Solutions	Technology-enabled Services	Corporate and Eliminations	Consolidated
Revenue from external customers:					
Solutions revenue	$432,522	$126,305	$ 243,649	$ (5,404)	$ 797,072
Postage revenue	—	—	—	58,484	58,484
Inter-segment revenue	4,822	15,307	341	(20,470)	—
Net revenue	$437,344	$141,612	$ 243,990	$ 32,610	$ 855,556
Adjusted EBITDA	$202,314	$ 84,973	$ 45,151	$ (51,382)	$ 281,056
Equity compensation					5,862
Acquisition accounting adjustments					373
Acquisition and divestiture-related costs					658
Integration and related costs					25,725
Strategic initiatives, duplicative and transition costs					3,569
Severance costs					7,170
Accretion and changes in estimate with related parties, net					3,880
Management fees and related costs					2,648
Impairment of long-lived assets and other					(840)
Contingent consideration					(791)
Other non-routine, net					1,148
EBITDA Adjustments					49,402
EBITDA					231,654
Interest expense					83,406
Depreciation and amortization					71,316
Amortization of capitalized software developed for sale					3,452
Income (loss) before income tax provision (benefit)					$ 73,480

	Three Months Ended June 30, 2018				
	Software and Analytics	Network Solutions	Technology-enabled Services	Corporate and Eliminations	Consolidated
Revenue from external customers:					
Solutions revenue	$392,829	$120,589	$ 249,028	$ (4,741)	$ 757,705
Postage revenue	—	—	—	65,558	65,558
Inter-segment revenue	3,573	16,014	967	(20,554)	—
Net revenue	$396,402	$136,603	$ 249,995	$ 40,263	$ 823,263
Adjusted EBITDA	$142,637	$ 82,237	$ 49,972	$ (47,059)	$ 227,787
Equity compensation					5,300
Acquisition accounting adjustments					1,985
Acquisition and divestiture-related costs					4,188
Integration and related costs					20,951
Strategic initiatives, duplicative and transition costs					10,774
Severance costs					7,676
Costs related to recently issued accounting standards					3,741
Accretion and changes in estimate with related parties, net					3,824
Management fees and related costs					2,677
Impairment of long-lived assets and other					1,017
Contingent consideration					272
Other non-routine, net					2,149
EBITDA Adjustments					64,554
Interest expense					78,549
Depreciation and amortization					68,527
Amortization of capitalized software developed for sale					3,760
Income (loss) before income tax provision (benefit)					$ 12,397

10. Accumulated Other Comprehensive Income (Loss)

The following is a summary of the accumulated other comprehensive income (loss) balances, net of taxes, and related changes for each of the quarterly periods in the three months ended June 30, 2019 and 2018.

	Foreign Currency Translation Adjustment	Cash Flow Hedge	Accumulated Other Comprehensive Income (Loss)
Balance at March 31, 2018	$ (14,823)	$ 6,218	$ (8,605)
Cumulative effect of accounting change	—	1,633	1,633
Change associated with foreign currency translation	(8,638)	—	(8,638)
Change associated with current period hedging	—	4,016	4,016
Reclassification into earnings	—	(1,412)	(1,412)
Balance at June 30, 2018	$ (23,461)	$ 10,455	$ (13,006)
Balance at March 31, 2019	$ (24,263)	$ (10,769)	$ (35,032)
Reclassification of stranded tax effects as a result of the Tax Legislation	—	(1,406)	(1,406)
Change associated with foreign currency translation	756	—	756
Change associated with current period hedging	—	(17,051)	(17,051)
Reclassification into earnings	—	(1,047)	(1,047)
Balance at June 30, 2019	$ (23,507)	$ (30,273)	$ (53,780)

11. Net Income (Loss) per Common Unit

The following table sets forth the computation of basic and diluted net income (loss) per common unit:

	Three Months Ended June 30,	
	2019	2018
Basic net income per common unit:		
Numerator:		
Net income (loss)	$ 71,915	$ 12,506
Denominator:		
Weighted average common units outstanding	251,469,846	251,599,967
Basic net income (loss) per common unit	$ 0.29	$ 0.05
Diluted net income per common unit:		
Numerator:		
Net income (loss)	$ 71,915	$ 12,506
Denominator:		
Number of shares used in basic computation	251,469,846	251,599,967
Weighted average effect of dilutive securities		
Add:		
Reimbursement units issuable to Change Healthcare Inc.	1,654,632	1,847,560
	253,124,478	253,447,527
Diluted net income (loss) per common unit	$ 0.28	$ 0.05

12. Subsequent Events

Initial Offering of Common Stock and Concurrent Offering of Tangible Equity Units

In July 2019, Change Healthcare Inc. completed its initial offering of 49,285,713 shares of common stock and the concurrent offering of 5,750,000 tangible equity units ("TEUs") for net proceeds of $608,679 and $278,875 respectively, before consideration of offering costs paid subsequent to the offerings from available cash. The proceeds of the offering of common stock were subsequently contributed to the Joint Venture in exchange for 49,285,713 additional units of the Joint Venture. The proceeds of the offering of TEUs were used to acquire TEUs of the Joint Venture that substantially mirror the terms of the TEUs included in the offering. The Joint Venture, in turn, used certain of the proceeds received from Change Healthcare Inc. to repay $805,000 of its indebtedness under the Term Loan Facility without penalty. However, due to the presence of unamortized discounts, the Joint Venture expects to recognize a loss on extinguishment of debt of approximately $14,300.

Amendment of Revolving Facility

In July 2019, the Joint Venture amended its Revolving Facility, the primary effects of which were to increase the maximum amount that can be borrowed from $500,000 to $785,000 and to extend the maturity date until July 2, 2024. In the event that the outstanding balance under the Term Loan Facility exceeds $1,100,000 on December 1, 2023, however, amounts due, if any, under the Revolving Facility become due and payable on December 1, 2023.

The Joint Venture has evaluated subsequent events through August 14, 2019, the date the financial statements were available to be issued.

CHANGE HEALTHCARE HOLDINGS, LLC

ANNUAL REPORT FOR THE FISCAL YEAR ENDED

MARCH 31, 2018

CHANGE HEALTHCARE HOLDINGS, LLC
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FORWARD-LOOKING STATEMENTS

This Annual Report for the fiscal year ended March 31, 2018 ("Annual Report") contains statements that express Change Healthcare's or management's intentions, plans, beliefs, expectations or predictions of future events, which are considered forward-looking statements. You should not place undue reliance on those statements because they are subject to numerous uncertainties and factors relating to our operations and business environment, all of which are difficult to predict and many of which are beyond our control. Forward-looking statements include information concerning our possible or assumed future results of operations, including descriptions of our business strategy. These statements often include words such as "may," "will," "should," "believe," "expect," "anticipate," "intend," "plan," "estimate" or similar expressions. These statements are based upon assumptions that we have made in light of our experience in the industry, as well as our perceptions of historical trends, current conditions, expected future developments and other factors that we believe are appropriate under the circumstances. As you read this Annual Report, you should understand that these statements are not guarantees of performance or results. They involve known and unknown risks, uncertainties and assumptions, including those described under the heading "Risk Factors" in Item 3 and elsewhere in this Annual Report. Although we believe that these forward-looking statements are based upon reasonable assumptions, you should be aware that many factors, including those described under the heading "Risk Factors" in Item 3 and elsewhere in this Annual Report, could affect our actual financial results or results of operations and could cause actual results to differ materially from those in the forward-looking statements.

Our forward-looking statements made herein speak only as of the date on which made. We expressly disclaim any intent, obligation or undertaking to update or revise any forward-looking statements made herein to reflect any change in our expectations with regard thereto or any change in events, conditions or circumstances on which any such statements are based. All subsequent written and oral forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by the cautionary statements contained in this Annual Report.

ITEM 1. FINANCIAL STATEMENTS

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INDEPENDENT AUDITORS' REPORT

To the Member

Change Healthcare Holdings, LLC

We have audited the accompanying consolidated financial statements of Change Healthcare Holdings, LLC and subsidiaries (the "Company"), which comprise the consolidated balance sheet as of March 31, 2018 and 2017, and the related consolidated statement of operations, comprehensive income (loss), member's deficit, and cash flows for year ended March 31, 2018 and the period June 17, 2016 to March 31, 2017 and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Change Healthcare Holdings, LLC as of March 31, 2018 and 2017, and the results of its operations and its cash flows for the year ended March 31, 2018 and the period from June 17, 2016 to March 31, 2017 in accordance with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP

Atlanta, Georgia

July 27, 2018

Change Healthcare Holdings, LLC
Consolidated Statements of Operations
(amounts in thousands)

	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Revenue:		
Solutions revenue	$ 3,024,446	$ 283,455
Postage revenue	274,397	26,132
Total revenue	3,298,843	309,587
Operating expenses:		
Cost of operations (exclusive of depreciation and amortization below)	1,407,893	133,688
Research and development	221,662	22,582
Sales, marketing, general and administrative	749,871	109,898
Customer postage	274,397	26,132
Depreciation and amortization	278,363	26,548
Accretion and changes in estimate with related parties, net	(49,991)	(24,507)
Impairment of long-lived assets and related costs	839	48,700
Total operating expenses	2,883,034	343,041
Operating income (loss)	415,809	(33,454)
Non-operating (income) and expense		
Interest expense, net	292,463	22,361
Loss on extinguishment of debt	—	70,122
Other, net	(17,202)	(1,339)
Total non-operating (income) and expense	275,261	91,144
Income (loss) before income tax provision (benefit)	140,548	(124,598)
Income tax provision (benefit)	(52,458)	(41,006)
Net income (loss)	$ 193,006	$ (83,592)

See accompanying notes to consolidated financial statements.

Change Healthcare Holdings, LLC
Consolidated Balance Sheets
(amounts in thousands)

	March 31, 2018	March 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 48,899	$ 185,670
Restricted cash	1,112	2,443
Accounts receivable, net of allowance for doubtful accounts of $18,015 and $14,227 at March 31, 2018 and March 31, 2017, respectively	705,544	696,780
Prepaid expenses and other current assets	146,157	140,350
Total current assets	901,712	1,025,243
Property and equipment, net	167,500	179,044
Goodwill	3,344,833	3,248,719
Intangible assets, net	1,454,842	1,609,723
Other noncurrent assets, net	332,040	220,725
Total assets	$ 6,200,927	$ 6,283,454
Liabilities and members' deficit		
Current liabilities:		
Drafts and accounts payable	$ 84,128	$ 93,462
Accrued expenses	329,332	296,055
Deferred revenues	493,947	516,065
Due to related party, net	8,695	156,644
Current portion of long-term debt	53,393	57,149
Total current liabilities	969,495	1,119,375
Long-term debt, excluding current portion	5,867,487	5,901,946
Deferred income tax liabilities	114,904	145,470
Tax receivable agreement obligations to related parties	223,163	298,149
Other long-term liabilities	94,228	94,607
Commitments and contingencies (see Note 13)		
Members' deficit	(1,068,350)	(1,276,093)
Total liabilities and members' deficit	$ 6,200,927	$ 6,283,454

See accompanying notes to consolidated financial statements.

Change Healthcare Holdings, LLC
Consolidated Statements of Comprehensive Income (Loss)
(amounts in thousands)

	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Net income (loss)	$ 193,006	$ (83,592)
Other comprehensive income (loss):		
Foreign currency translation adjustment	4,146	86
Changes in fair value of interest rate cap, net of taxes	7,398	(1,772)
Other comprehensive income (loss)	11,544	(1,686)
Total comprehensive income (loss)	$ 204,550	$ (85,278)

See accompanying notes to consolidated financial statements.

Change Healthcare Holdings, LLC
Consolidated Statements of Members' Deficit
(amounts in thousands)

	Members' Deficit
Balance at June 17, 2016 (inception)	$ —
Capital contribution from Members	100
Contribution of net assets of MTS and CHC from Members	2,096,605
Distribution to Members	(3,099,376)
Establishment of tax receivable obligation to related parties, net of taxes	(119,464)
Settlement of CHC equity awards	(69,420)
Equity compensation expense	715
Net income (loss)	(83,592)
Foreign currency translation adjustment	86
Change in fair value of interest rate cap agreements, net of taxes	(1,772)
Other	25
Balance at March 31, 2017	$ (1,276,093)
Advances to Member	(15,828)
Settlement of CHC equity awards	545
Repurchase of equity awards	(4,799)
Capital contribution from Member from exercise of equity awards	346
Equity compensation expense	24,700
Net income (loss)	193,006
Foreign currency translation adjustment	4,146
Change in fair value of interest rate cap agreements, net of taxes	7,398
Other	(1,771)
Balance at March 31, 2018	(1,068,350)

See accompanying notes to consolidated financial statements.

Change Healthcare Holdings, LLC
Consolidated Statements of Cash Flow
(amounts in thousands)

	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Cash flows from operating activities:		
Net income (loss)	$ 193,006	$ (83,592)
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:		
Depreciation and amortization	278,363	26,548
Amortization of capitalized software developed for sale	18,303	1,505
Accretion and changes in estimate with related parties, net	(49,991)	(24,507)
Equity compensation	24,700	715
Deferred income tax expense (benefit)	(60,532)	(42,033)
Amortization of debt discount and issuance costs	21,434	1,734
Loss on extinguishment of debt	—	32,720
Impairment of long-lived assets and related costs	839	48,700
Other	2,723	87
Changes in operating assets and liabilities:		
Accounts receivable	(4,526)	(12,813)
Prepaid expenses and other	(19,957)	(11,508)
Accounts payable	(9,105)	10,250
Accrued expenses, deferred revenue and other liabilities	(16,806)	(35,924)
Due to related party, net	(52,654)	47,468
Tax receivable agreement obligations to related parties	(971)	—
Net cash provided by (used in) operating activities	324,826	(40,650)
Cash flows from investing activities:		
Purchases of property and equipment	(38,046)	(6,425)
Capitalized software expenditures	(128,547)	(5,192)
Payments for acquisitions, net of cash acquired	(94,520)	—
Other	384	432
Net cash provided by (used in) investing activities	(260,729)	(11,185)
Cash flows from financing activities:		
Proceeds from contributed businesses	—	169,361
Proceeds from Term Loan Facility and Senior Notes Due 2025	—	6,087,250
Payments on contributed Term Loan Facility and Senior Notes	—	(2,784,972)
Payment of premium to extinguish Senior Notes	—	(37,402)
Payment of loan costs	—	(138,222)
Payments on Term Loan Facility	(51,000)	—
Payments on derivative instruments	(6,799)	—
Payment of data sublicense obligation	(3,074)	—
Payments of deferred financing obligations	(3,147)	(81)
Settlement of CHC equity awards	(3,155)	(65,720)
Capital contribution from Members	346	100
Repurchase of equity awards	(4,799)	—
Payment of working capital settlement to related party	(109,176)	—
Distribution to Members	—	(2,990,200)
Advances to Member and Other	(16,685)	—
Net cash provided by (used in) financing activities	(197,489)	240,114
Effect of exchange rate changes on cash and cash equivalents	(4,710)	(166)
Net increase (decrease) in cash, cash equivalents and restricted cash	(138,102)	188,113
Cash, cash equivalents and restricted cash at beginning of period	188,113	—
Cash, cash equivalents and restricted cash at end of period	$ 50,011	$ 188,113

Supplemental disclosures of cash flow information		
Cash paid for interest	$ 267,604	$ 15,936
Cash paid for income taxes	$ 9,968	$ 23
Supplemental disclosures of noncash transactions		
Working capital settlement liability:		
Due to related party, net	$ —	(109,176)
Members' deficit	$ —	109,176
Contributed assets and liabilities:		
Current assets	$ —	$ 822,400
Property and Equipment	$ —	$ 177,998
Goodwill	$ —	$ 3,248,719
Intangible assets, net	$ —	$ 1,628,711
Other noncurrent assets, net	$ —	$ 243,435
Current liabilities	$ —	$ (1,005,742)
Long-term debt	$ —	(2,737,776)
Deferred income tax liabilities	$ —	$ (213,239)
Tax receivable agreement obligations to related parties	$ —	$ (183,342)
Other long-term liabilities	$ —	(52,075)
Business Combination:		
Prepaid expenses and other current assets	$ 226	$ —
Other assets	$ (6,000)	$ —
Goodwill	$ 9,774	$ —
Accrued expenses	$ (341)	$ —
Other long-term liabilities	$ (3,659)	$ —

See accompanying notes to consolidated financial statements.

1. Nature of Business and Organization

Nature of Business

Change Healthcare Holdings, LLC (the "Company"), an indirect wholly-owned subsidiary of Change Healthcare LLC ("Parent"), is one of the largest, independent healthcare technology companies in the United States. The Company provides software and analytics, network solutions and technology-enabled services that help our customers obtain actionable insights, exchange mission-critical information, control costs, optimize revenue opportunities, increase cash flow and effectively navigate the shift to value-based healthcare.

Organization

In June 2016, HCIT Holdings, Inc. ("HCIT"), the Company, Parent, Change Healthcare Intermediate Holdings, LLC, Change Healthcare, Inc. ("CHC") and its stockholders—including affiliates of The Blackstone Group, L.P. ("Blackstone") and Hellman & Friedman LLC ("Hellman & Friedman")—entered into an Agreement of Contribution and Sale (the "Contribution Agreement") with McKesson Corporation ("McKesson", together with HCIT, the "Members"). Under the terms of the Contribution Agreement, HCIT, the CHC stockholders and McKesson agreed to form Parent through a joint venture that combined the majority of the McKesson Technology Solutions businesses ("MTS") with CHC's businesses (the "Transactions"), including substantially all of the assets and operations of CHC, but excluding CHC's pharmacy claims switching and prescription routing businesses ("eRx Network"). McKesson retained its Enterprise Information Solutions business and its RelayHealth Pharmacy Network. eRx Network was retained by CHC's stockholders. The Transactions closed on March 1, 2017. While formed in June 2016, the Company had no substantive assets or operations prior to the consummation of the Transactions.

The Transactions

Pursuant to the terms of the Contribution Agreement, (i) the CHC stockholders, directly and indirectly, transferred ownership of CHC to the Company in consideration of (a) the payment at the closing of the Transactions by the Company to CHC's stockholders and certain participants in the Change Healthcare, Inc. Amended and Restated 2009 Equity Incentive Plan (the "CHC Equity Plan") of approximately $1.8 billion and (b) the issuance to CHC's stockholders of membership interests representing approximately 30% of Parent's equity interests with such interests being held by CHC's stockholders indirectly through HCIT; and (ii) McKesson caused MTS to be transferred to the Company in consideration of (a) the assumption and subsequent payment at the closing of the Transactions by the Company to McKesson of a promissory note in the amount of approximately $1.3 billion, (b) the issuance of membership interests in Parent representing approximately 70% of Parent's equity interests and (c) a tax receivable agreement from Parent. These payments to McKesson and the former CHC stockholders have been reflected as distributions in the accompanying consolidated statement of members' deficit.

In connection with the Transactions, the Company entered into a new senior secured credit facility, consisting of a term loan facility in the amount of $5.1 billion and a revolving credit facility in an aggregate principal amount of $500 million, and issued $1.0 billion of 5.75% senior notes due 2025. The proceeds were used to make all payments to the CHC stockholders, certain participants in the CHC Equity Plan and McKesson described above, to refinance certain of CHC's existing indebtedness and to pay fees and expenses incurred in connection with the Transactions.

The Company provides certain transition services to eRx Network, and McKesson provides certain transition services to the Company, in each case in exchange for specified fees. Fees received related to these agreements are reflected within "Other, net" in the accompanying consolidated statement of operations. The related balance sheet effect of these agreements is reflected within "Due to related party, net" on the accompanying consolidated balance sheets.

2. Summary of Significant Accounting Policies

Basis of Accounting

Due to the existence of shared control among the Members over all major financial and operating decisions of Parent, the Company, and its consolidated subsidiaries, the assets and liabilities contributed to the Company were recognized in the accompanying consolidated financial statements at their historical carrying values (i.e., joint venture accounting). Adjustments to conform accounting policies of the contributed businesses have been reflected as adjustments to members' deficit.

Principles of Consolidation

The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("GAAP") and include all subsidiaries and entities that are controlled by the Company. The results of operations for companies acquired are included in the consolidated financial statements from the effective date of acquisition. All intercompany accounts and transactions have been eliminated in the consolidated financial statements.

Reclassifications

Certain reclassifications have been made to the prior period financial statements to conform to the current period presentation.

Accounting Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The Company bases its estimates on historical experience, current business factors and various other assumptions that the Company believes are necessary to consider in order to form a basis for making judgments about the carrying values of assets and liabilities, the recorded amounts of revenue and expenses and disclosure of contingent assets and liabilities. The Company is subject to uncertainties such as the impact of future events, economic, environmental and political factors and changes in the Company's business environment; therefore, actual results could differ from these estimates. Accordingly, the accounting estimates used in the preparation of the Company's financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the Company's operating environment changes. Changes in estimates are made when circumstances warrant. Such changes in estimates and refinements in estimation methodologies are reflected in the reported results of operations; and if material, the effects of changes in estimates are disclosed in the notes to the consolidated financial statements. Estimates and assumptions by management affect: the allowance for doubtful accounts; the fair value assigned to assets acquired and liabilities assumed in business combinations; tax receivable agreement obligations; the fair value of interest rate cap agreement obligations; contingent consideration; loss accruals; the carrying value of long-lived assets (including goodwill and intangible assets); the amortization period of long-lived assets (excluding goodwill); the carrying value, capitalization and amortization of software development costs; the provision and benefit for income taxes and related deferred tax accounts; certain accrued expenses; revenue recognition; contingencies; and the value attributed to equity awards.

Business Combinations

The Company recognizes the consideration transferred (i.e., purchase price) in a business combination, as well as the acquired business' identifiable assets, liabilities and noncontrolling interests at their acquisition date fair value. The excess of the consideration transferred over the fair value of the identifiable assets, liabilities and noncontrolling interest, if any, is recorded as goodwill. Any excess of the fair value of the identifiable assets acquired and liabilities assumed over the consideration transferred, if any, is generally recognized within earnings as of the acquisition date.

The fair value of the consideration transferred, assets, liabilities and noncontrolling interests is estimated based on one or a combination of income, costs or market approaches as determined based on the nature of the asset or liability and the level of inputs available to the Company (i.e., quoted prices in an active market, other observable inputs or unobservable inputs). To the extent that

the Company's initial accounting for a business combination is incomplete at the end of a reporting period, provisional amounts are reported for those items which are incomplete.

Cash and Cash Equivalents

The Company considers all highly liquid investments with an original maturity from the date of purchase of three months or less to be cash equivalents.

The Company's cash and cash equivalents are deposited with several financial institutions. Deposits may exceed the amounts insured by the Federal Deposit Insurance Corporation in the U.S. and similar deposit insurance programs in other jurisdictions. The Company mitigates the risk of our short-term investment portfolio by depositing funds with reputable financial institutions and monitoring risk profiles.

Our cash balances from time to time include funds we manage for customers, the most significant of which relates to funds remitted to retail pharmacies. Such funds are not restricted; however, these funds are generally paid out in satisfaction of the processing obligations pursuant to the management contracts. At the time of receipt, we record a corresponding liability within accrued expenses on the accompanying consolidated balance sheets. Such liabilities are summarized as "Pass-through payments" within Note 9 to these consolidated financial statements.

Restricted Cash

Cash that is subject to legal restrictions or is unavailable for general operating purposes is classified as restricted cash in the accompanying consolidated balance sheets. At March 31, 2018 and 2017, our restricted cash balances represent cash received to support refund payments to patients of certain customers. The balance of restricted cash of $2,443 at March 31, 2017 was previously classified within the Prepaid expenses and other current assets caption and has been reclassified to conform to the current period presentation.

Allowance for Doubtful Accounts

The allowance for doubtful accounts reflects the Company's best estimate of losses inherent in the Company's receivables portfolio determined on the basis of historical experience, specific allowances for known troubled accounts and other currently available evidence.

Capitalized Software Developed for Internal Use

The Company provides services to many of its customers using software developed for internal use. The costs that are incurred to develop such software are expensed as incurred during the preliminary project stage and classified within research and development on the accompanying consolidated statements of operations. Once certain criteria have been met, direct costs incurred in developing or obtaining computer software are capitalized. Training and maintenance costs are expensed as incurred. Capitalized software costs are included in Other noncurrent assets, net in the accompanying consolidated balance sheet and are generally amortized over the estimated useful life of three years.

Capitalized Software Developed for Sale

Development costs for software developed for sale to external customers are capitalized once a project has reached the point of technological feasibility. Completed projects are amortized after reaching the point of general availability using the straight-line method based on an estimated useful life of approximately three years. At each balance sheet date, or earlier if an indicator of an impairment exists, the Company evaluates the recoverability of unamortized capitalized software costs based on estimated future undiscounted revenues net of estimated related costs over the remaining amortization period.

Property and Equipment

Property and equipment are stated at cost, net of accumulated depreciation. Depreciation, including that related to assets under capital lease, is computed using the straight-line method over the estimated useful lives of the related assets. Expenditures for

maintenance, repair and renewals of minor items are expensed as incurred. Expenditures for maintenance repair and renewals that extend the useful life of an asset are capitalized.

Goodwill and Intangible Assets

Goodwill and intangible assets resulting from the Company's and its predecessors' acquisitions are accounted for using the acquisition method of accounting. Intangible assets with definite lives are amortized on a straight-line basis, at their inception, over the estimated useful lives of the related assets generally as follows:

Customer relationships	3-20 years
Tradenames	5-20 years
Non-compete agreements	3-5 years
Technology-based intangible assets	5-10 years

The Company assesses its goodwill for impairment annually (as of January 1 of each year) or whenever significant indicators of impairment are present. The Company first assesses whether it can reach a more likely than not conclusion that goodwill is not impaired via qualitative analysis alone. To the extent such a conclusion cannot be reached based on a qualitative assessment alone, the Company, using the assistance of a valuation specialist as appropriate, compares the fair value of each reporting unit to its associated carrying value. The Company will generally recognize an impairment charge for the amount, if any, by which the carrying amount of the reporting unit exceeds its fair value. The Company recognized no impairment in conjunction with its most recent goodwill impairment analysis.

Long-Lived Assets

Long-lived assets used in operations are reviewed for impairment whenever events or changes in circumstances indicate that carrying amounts may not be recoverable. For long-lived assets to be held and used, the Company recognizes an impairment loss only if its carrying amount is not recoverable through its undiscounted cash flows and measures the impairment loss based on the difference between the carrying amount and fair value. Long-lived assets held for sale are reported at the lower of cost or fair value less costs to sell.

Derivatives

Derivative financial instruments are used to manage the Company's interest rate exposure. The Company does not enter into financial instruments for speculative purposes. Derivative financial instruments are accounted for and measured at fair value and recorded on the balance sheet. For derivative instruments that are designated and qualify as a cash flow hedge, the effective portion of the gain or loss on the derivative instrument is reported as a component of other comprehensive income and reclassified into earnings in the same line item associated with the forecasted transaction in the same period or periods during which the hedged transaction affects earnings (for example, in "interest expense" when the hedged transactions are interest cash flows associated with floating-rate debt). The ineffective portion of the hedge attributed to the remaining gain or loss on the derivative instrument in excess of the cumulative change in the present value of future cash flows of the hedged item, if any, is recognized in interest expense in current earnings during the period of change.

Equity Compensation

HCIT grants certain equity awards to employees and directors of the Company under the HCIT Holdings, Inc. 2009 Equity Incentive Plan. Because these equity awards have been granted to employees of HCIT's equity method investee, they are subject to the accounting framework for awards granted to non-employees. Under this framework, the Company ultimately measures the compensation for equity awards based on the fair value of such awards at the earlier of the performance commitment date or the date at which the Company employee's performance is complete. Such awards are generally re-measured at fair value on a quarterly basis from the date of grant through the final measurement date. The fair value of such awards are recognized as assets or expense in the same period and in the same manner as if the Company had paid cash for the goods or services. The Company recognizes forfeitures as they occur.

Revenue Recognition

The Company generates most of its solutions revenue by using technology solutions (generally Software as a Service ("SaaS")) to provide services to our customers that automate and simplify business and administrative functions for payers, providers and pharmacies and through the licensing of software, software systems (consisting of software, hardware and maintenance support) and content.

SaaS-based subscription, content licenses and transaction processing fees are generally marketed under annual and multi-year agreements and are recognized ratably over the contracted terms. Revenue recognition begins on the service start date for fixed fee arrangements, on delivery for content licenses, and recognized as transactions are performed beginning on the service start date for per-transaction fee arrangements. Remote processing service fees are recognized monthly as the service is performed. Outsourcing service revenues are recognized as the service is performed. Revenue for certain services are subject to customer acceptance or collection by the Company's customer and revenue in such circumstances is recognized upon such customer acceptance or resolution of collection contingencies.

Software systems are marketed under information systems agreements as well as service agreements. Perpetual software arrangements are recognized at the time of delivery, under the percentage-of-completion method if the arrangements require significant production, modification or customization of the software, or in certain instances under the completed contract method if reasonable estimates cannot be made. Contracts accounted for under the percentage-of-completion method are generally measured based on the ratio of labor hours incurred to date to total estimated labor hours to be incurred. Changes in estimates to complete and revisions in overall profit estimates on these contracts are charged to earnings in the period in which they are determined. The Company accrues for contract losses if and when the current estimate of total contract costs exceeds total contract revenue. Software implementation fees are recognized as the work is performed or under the percentage-of-completion method for perpetual software. Hardware revenues are generally recognized upon delivery.

Revenue from time-based software license agreements is recognized ratably over the term of the agreement. Software implementation fees for time-based software licenses are recognized ratably over the software license term. Maintenance and support agreements are marketed under annual or multi-year agreements and are recognized ratably over the period covered by the agreements.

Postage fees related to the Company's payment and communication solutions volumes are recorded on a gross basis.

The Company excludes sales and use tax from revenue in the accompanying consolidated statements of operations.

The Company engages in multiple-element arrangements, which may contain any combination of software, hardware, implementation, SaaS-based offerings, consulting services or maintenance services. For multiple-element arrangements that do not include software, revenue is allocated to the separate elements based on their relative selling price and recognized in accordance with the revenue recognition criteria applicable to each element. Relative selling price is determined based on vendor specific objective evidence ("VSOE") of selling price if available, third-party evidence ("TPE"), if VSOE of selling price is not available, or estimated selling price, if neither VSOE of selling price nor TPE is available. For multiple-element arrangements accounted for in accordance with specific software accounting guidance when some elements are delivered prior to others in an arrangement and VSOE of fair value exists for the undelivered elements, revenue for the delivered elements is recognized upon delivery of such items. The Company establishes VSOE for hardware and implementation and consulting services based on the price charged when sold separately, and for maintenance services based on substantive renewal rates offered to customers. Revenue for the software element is recognized under the residual method only when fair value has been established for all of the undelivered elements in an arrangement. If fair value cannot be established for any undelivered element, all of the arrangement's revenue is deferred until the delivery of the last element commences or until the fair value of the undelivered element is determinable. For multiple-element arrangements with both software elements and nonsoftware elements, arrangement consideration is allocated between the software elements as a whole and nonsoftware elements. The Company then further allocates consideration to the individual elements within the software group, and revenue is recognized for all elements under the applicable accounting guidance and our policies described above.

Cash receipts or billings in advance of revenue recognition are recorded as deferred revenues in the accompanying consolidated balance sheets.

Foreign Currency Translation

The reporting currency of the Company and its subsidiaries is the U.S. dollar. The Company's foreign subsidiaries generally consider their local currency to be their functional currency. Foreign currency-denominated assets and liabilities of these foreign subsidiaries are translated into U.S. dollars at year-end exchange rates and revenues and expenses are translated at average exchange rates during the corresponding period, and equity accounts are primarily translated at historical exchange rates. Foreign currency translation adjustments are included in Other comprehensive income (loss) in the accompanying consolidated statements of comprehensive income (loss), and the cumulative effect is included within members' deficit in the accompanying consolidated balance sheets. Realized gains and losses from currency exchange transactions are recorded in sales, marketing, general and administrative expenses in the accompanying consolidated statements of operations. The Company releases cumulative translation adjustment from equity into net income as a gain or loss only upon complete or substantially complete liquidation of a controlling interest in a subsidiary or a group of assets within a foreign entity.

Income Taxes

The Company records deferred income taxes for the tax effect of differences between book and tax bases of its assets and liabilities, as well as differences relating to the timing of recognition of income and expenses.

Deferred income taxes reflect the available net operating losses and the net tax effect of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Realization of the future tax benefits related to deferred tax assets is dependent on many factors, including the Company's past earnings history, expected future earnings, the character and jurisdiction of such earnings, reversing taxable temporary differences, unsettled circumstances that, if unfavorably resolved, would adversely affect utilization of its deferred tax assets, carryback and carryforward periods and tax strategies that could potentially enhance the likelihood of realization of a deferred tax asset.

The Company recognizes tax benefits for uncertain tax positions at the time the Company concludes that the tax position, based solely on its technical merits, is more likely than not to be sustained upon examination. The benefit, if any, is measured as the largest amount of benefit, determined on a cumulative probability basis that is more likely than not to be realized upon ultimate settlement. Tax positions failing to qualify for initial recognition are recognized in the first subsequent interim period that they meet the more likely than not standard, upon resolution through negotiation or litigation with the taxing authority or on expiration of the statute of limitations.

Warranties

In the normal course of business, the Company provides warranties regarding the performance of software and products it sells. The Company's liability under these warranties is to bring the product into compliance with previously agreed upon specifications. For software products, this may result in additional project costs, which are reflected in our estimates used for the percentage of completion method of accounting for software installations services within these contracts. In addition, most of the Company's customers who purchase software and automation products also purchase annual maintenance agreements. Revenues from these maintenance agreements are recognized on a straight-line basis over the contract period and the cost of servicing product warranties is charged to expense when claims become estimable. Accrued warranty costs were not material to the accompanying consolidated balance sheets.

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-09, which replaces most prior general and industry specific revenue recognition guidance with a principles-based comprehensive revenue recognition framework. Under this revised framework, a company will recognize revenue to depict the transfer of promised goods and services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods and services. This update is expected to be effective for the Company beginning April 1, 2019. Upon adoption, a company may elect to either retrospectively restate each prior reporting period or reflect the cumulative effect of initially applying the update with an adjustment to retained earnings at the date of adoption. While the Company cannot yet determine the effect the adoption of this update will have on its financial statements, the Company believes that significant changes to its accounting policies, disclosures, estimation

processes, internal controls and information systems, as well as significant implementation costs prior to adoption, will be necessary to comply with this update. Such changes are expected to be necessary to accumulate information and data required to estimate the transaction prices in our contracts, and to allocate such transaction prices to the specific performance obligations in our contracts, as a result of variability from volume-based pricing, price increases, contingent fees, service level agreements and other arrangements. Due to the extent of the expected data that will need to be accumulated, the Company expects to adopt using the modified retrospective transition method.

In February 2016, the FASB issued ASU No. 2016-02, which generally requires that all lease obligations be recognized on the balance sheet at the present value of the remaining lease payments with a corresponding lease asset. This update is scheduled to be effective for the Company beginning April 1, 2020, with early adoption permitted. The Company is currently assessing the potential effects this update may have on its consolidated financial statements.

In June 2016, the FASB issued ASU No. 2016-13, which requires that a financial asset (or group of financial assets) measured at amortized cost be presented at the net amount expected to be collected based on relevant information about past events, including historical experience, current conditions and reasonable and supportable forecasts that affect the collectability of the reported amount. This update is scheduled to be effective for the Company beginning April 1, 2021, with early adoption permitted beginning April 1, 2019. The Company is currently assessing the potential effects this update may have on its consolidated financial statements.

In October 2016, the FASB issued ASU No. 2016-16, which eliminates the requirement to defer income tax accounting on intra-entity transfers other than inventory. This update is scheduled to be effective for the Company beginning April 1, 2019, with early adoption permitted as of the beginning of an annual period. The Company is currently assessing the potential effects this update may have on its consolidated financial statements.

In January 2017, the FASB issued ASU 2017-01, which provides a screen to determine when an integrated set of assets and activities represents a business. Specifically, this update requires that when substantially all of the fair value of the gross assets acquired (or disposed of) is concentrated in a single identifiable asset or a group of similar identifiable assets, the set of assets and activities is not a business. This update is scheduled to be effective for the Company beginning April 1, 2019. The Company is currently assessing the potential effects this update may have on its consolidated financial statements.

In August 2017, the FASB issued ASU No. 2017-12, which significantly changes the framework by which hedge accounting is recognized, presented, and disclosed in the financial statements. Specifically, this update aligns risk management with the related financial reporting by permitting hedging of the contractually specified component or interest rate in the arrangement and requiring that an entity present the earnings effect of the hedging instrument in the same income statement caption in which the earnings effect of the hedged item is reported. Additionally, this update includes other simplifications of the hedge accounting guidance. These additional simplifications include the ability to continually evaluate hedge effectiveness using a qualitative approach as well as permitting certain simplifying assumptions when evaluating a “critical terms match” method of effectiveness. This update is scheduled to be effective for the Company beginning April 1, 2020, with early application permitted. The Company adopted this update effective April 1, 2018 using the modified retrospective transition method. This transition method requires the Company to recognize the cumulative effect of the change on the opening balance of each affected component of equity in the statement of financial position as of the date of adoption. Upon adoption, this update had no material effect on the Company’s consolidated financial statements.

In February 2018, the FASB issued ASU No. 2018-02, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017 (“Tax Legislation”). The update is scheduled to be effective for the Company beginning April 1, 2019, with early adoption permitted. The Company is currently assessing the potential effects this update may have on its consolidated financial statements.

In March 2017, the Company adopted FASB ASU No. 2017-04, which generally provided that an entity should recognize an impairment charge for the amount by which the carrying amount of a reporting unit exceeds its fair value, subject to a restriction that the impairment charge cannot exceed the value of the total goodwill of the reporting unit. Upon adoption, this update had no effect on the Company’s consolidated financial statements.

In April 2017, the Company adopted FASB ASU No. 2016-18, which specifies that amounts generally described as restricted cash should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. As a result of the adoption of this update, the accompanying statement of cash flows has been

adjusted to combine cash and cash equivalents and restricted cash when presenting both the beginning and ending balances. Additionally, restricted cash has been presented as a separate caption on the accompanying consolidated balance sheets.

In December 2017, the Company adopted the provisions of Securities & Exchange Commission ("SEC") Staff Accounting Bulletin ("SAB") 118, which was subsequently codified as FASB ASU No. 2018-05. This update provides guidance on accounting for the effects of the Tax Legislation and provides a measurement period that should not extend beyond one year from the Tax Legislation enactment date for companies to complete the accounting under ASC 740. Under this update, a company must reflect the income tax effects of those aspects of the Tax Legislation for which the accounting under ASC 740 is complete. To the extent that a company's accounting for certain income tax effects of the Tax Legislation is incomplete but the company is able to determine a reasonable estimate, it must record a provisional estimate in the financial statements. If a company cannot determine a provisional estimate to be included in the financial statements, it should continue to apply ASC 740 on the basis of the provisions of the tax laws that were in effect immediately before the enactment of the Tax Legislation. The Company (together with its consolidated subsidiaries) estimates, based on currently available information, that the enactment of the Tax Legislation resulted in an increase in income tax benefit of approximately $33,024 and an increase to operating income of $88,741 for the year ended March 31, 2018. A majority of the effects of the Tax Legislation are the result of the change in the enacted rate causing a remeasurement of the U.S. federal deferred tax liabilities and tax receivable agreements at the lower enacted corporate tax rate.

3. Concentration of Credit Risk

The Company's revenue and accounts receivable are primarily generated by customers in the healthcare provider sector in the United States. Changes in economic conditions, government regulations or demographic trends, among other matters, in the United States could adversely affect the Company's revenue and results of operations.

The Company maintains its cash and cash equivalent balances in either insured depository accounts or money market mutual funds. The money market mutual funds are limited to investments in low-risk securities such as United States or government agency obligations, or repurchase agreements secured by such securities.

4. Business Combinations

In January 2018, the Company acquired all of the equity interests of National Decision Support Company, LLC ("NDSC"), a provider of cloud-based solutions that deliver medical guidelines to the point-of-care directly through electronic health record systems.

Prior to the acquisition, the Company had prepaid royalties related to the use of an NDSC product. In connection with the acquisition, this pre-existing relationship was effectively settled by increasing the amount of the consideration transferred by the amount of the prepaid royalty asset.

The following table summarizes information related to this acquisition. The preliminary values of the consideration transferred, assets acquired and liabilities assumed in the NDSC acquisition, including the related tax effects, are subject to change upon the receipt of a final valuation, resolution of any pre-acquisition contingencies and working capital settlement.

	NDSC
Total Consideration Fair Value at Acquisition Date:	
Cash paid at closing	$ 101,237
Settlement of preexisting relationship	6,000
Contingent consideration	4,000
Other	(226)
	$ 111,011
Allocation of the Consideration Transferred:	
Cash	$ 6,717
Accounts receivable	3,732
Prepaid expenses and other current assets	198
Property and equipment	166
Identifiable intangible assets:	
Tradename	4,100
Non-compete agreements	2,200
Customer relationships	3,400
Technology	7,185
Other assets	568
Goodwill	88,924
Accounts payable	(298)
Accrued expenses and other current liabilities	(5,881)
Total consideration transferred	$ 111,011
Acquisition costs in sales, marketing, general and administrative expense:	
For the year ended March 31, 2018	$ 731

	NDSC
Other Information:	
Gross contractual accounts receivable	$ 3,732
Amount not expected to be collected	$ —
Goodwill expected to be deductible for tax purposes	$ 88,924
Contingent Consideration Information:	
Contingent consideration range	$0 to $20,000
Measurement period	January 1, 2018 to December 31, 2020
Basis of measurement	Revenue performance, subject to minimum margin
Type of measurement	Level 3
Key assumptions at the acquisition date:	
Range of annual revenue performance	$22,500-$66,100
Expected payment date(s)	2018-2020
Discount rate(s)	10%
Increase (decrease) to net income (loss):	
For the year ended March 31, 2018	$ —

The Company generally recognizes goodwill attributable to the assembled workforce and expected synergies among the operations of the acquired entities and the Company's existing operations. In the case of the Company's acquisitions of operating companies, synergies generally have resulted from the elimination of duplicative facilities and personnel costs and cross selling opportunities among the Company's existing customer base. Goodwill is generally deductible for federal income tax purposes when a business combination is treated as an asset purchase. Goodwill is generally not deductible for federal income tax purposes when the business combination is treated as a stock purchase.

5. Prepaid Expenses and Other

Prepaid expenses and other generally includes items for which the Company has paid the related vendor or supplier in advance of receiving the related service. Prepaid expenses and other at March 31, 2018 and 2017, consisted of the following:

	March 31, 2018	March 31, 2017
Prepaid expenses	$ 108,519	$ 112,667
Inventory	9,474	7,062
Notes and other receivables	13,219	12,762
Other current assets	14,945	7,859
Total prepaid expenses and other	$ 146,157	$ 140,350

6. Property and Equipment

Property and equipment as of March 31, 2018 and 2017, consisted of the following:

	March 31, 2018	March 31, 2017
Land	$ 7,638	7,638
Buildings and leasehold improvements	138,005	142,147
Computer equipment	209,593	196,785
Production equipment	33,740	26,253
Office equipment, furniture and fixtures	59,923	57,244
Construction in process	26,474	16,992
	475,373	447,059
Less accumulated depreciation	(307,873)	(268,015)
Property and equipment, net	$ 167,500	179,044

Depreciation expense was $39,855 and $4,280 for the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively.

7. Goodwill and Intangible Assets

The following table presents the changes in the carrying amount of goodwill for the indicated periods:

	Software and Analytics	Network Solutions	Technology-enabled Services	Total
Balance at June 17, 2016 (inception)	$ —	$ —	$ —	$ —
Carrying value of contributed goodwill	1,818,957	907,517	522,245	3,248,719
Balance at March 31, 2017	$ 1,818,957	$ 907,517	$ 522,245	$ 3,248,719
Acquisitions	88,924	—	—	88,924
Effects of foreign currency	6,515	—	—	6,515
Other	—	675	—	675
Balance at March 31, 2018	$ 1,914,396	$ 908,192	$ 522,245	$ 3,344,833

Intangible assets subject to amortization at March 31, 2018 consisted of the following:

	Weighted Average Remaining Life	Gross Carrying Amount	Accumulated Amortization	Net
Customer relationships	11.0	$ 2,242,210	$ (861,017)	$ 1,381,193
Tradenames	4.2	34,998	(17,920)	17,078
Non-compete agreements	0.6	24,190	(19,539)	4,651
Data sublicense agreement	—	—	—	—
Technology-based intangible assets	4.4	344,660	(295,022)	49,638
Other	0.3	6,413	(4,131)	2,282
Total		$ 2,652,471	$ (1,197,629)	$ 1,454,842

Intangible assets subject to amortization as of March 31, 2017 consisted of the following:

	Weighted Average Remaining Life	Gross Carrying Amount	Accumulated Amortization	Net
Customer relationships	12.9	$ 2,240,943	$ (739,056)	$ 1,501,887
Tradenames	4.1	31,799	(14,738)	17,061
Non-compete agreements	0.8	43,982	(30,167)	13,815
Data sublicense agreement	0.5	31,000	(28,367)	2,633
Technology-based intangible assets	3.9	340,170	(266,251)	73,919
Other	3.0	841	(433)	408
Total		$ 2,688,735	$ (1,079,012)	$ 1,609,723

Amortization expense was $174,119 and $16,582 for the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively.

Aggregate future amortization expense for intangible assets is estimated to be:

2019	$ 145,294
2020	135,268
2021	130,567
2022	120,288
2023	111,728
Thereafter	811,697
	$ 1,454,842

8. Other Noncurrent Assets, Net

Other noncurrent assets as of March 31, 2018 and 2017 consisted of the following:

	March 31, 2018	March 31, 2017
Deferred tax asset- noncurrent	$ 34,738	$ 8,931
Capitalized software developed for sale, net	48,826	45,272
Capitalized software developed for internal use, net	166,616	104,325
Deferred loan costs	9,792	12,292
Interest rate cap agreements	11,127	5,291
Other noncurrent assets	60,941	44,614
Total other noncurrent assets	$ 332,040	$ 220,725

Amortization expense for capitalized software developed for internal use was $64,389 and $5,686 for the year ended March 31, 2018 and for the period from June 17, 2016 (inception) to March 31, 2017, respectively.

Changes in the carrying amount of capitalized software developed for sale, net, which is included in Other noncurrent assets in the accompanying consolidated balance sheet, were as follows:

	March 31, 2018	March 31, 2017
Balance at beginning of period	$ 45,272	$ —
Amounts contributed	—	45,416
Amounts capitalized	21,096	1,330
Amortization expense	(18,303)	(1,505)
Other	761	31
Balance at end of year	$ 48,826	$ 45,272

9. Accrued Expenses

Accrued expenses generally represent items for which the Company has received a service from a vendor in advance of being invoiced for that service. Accrued expenses as of March 31, 2018 and 2017 consisted of the following:

	March 31, 2018	March 31, 2017
Customer deposits	$ 35,911	$ 27,986
Accrued compensation	113,903	134,770
Accrued outside services	28,614	25,848
Accrued insurance	12,688	13,616
Accrued income, sales and other taxes	13,936	10,751
Accrued interest	6,877	5,530
Interest rate cap agreements	—	6,520
Current portion of tax receivable agreement obligations to related parties	25,003	980
Pass-through payments	6,498	8,285
Other accrued liabilities	85,902	61,769
	$ 329,332	$ 296,055

10. Long-Term Debt

The Company's long-term indebtedness is comprised of a senior secured term loan facility (the "Term Loan Facility"), a revolving credit facility (the "Revolving Facility"; together with the Term Loan Facility, the "Senior Credit Facilities"), and 5.75% senior notes due 2025 (the "Senior Notes"),

Long-term debt as of March 31, 2018 and 2017, consisted of the following:

	March 31, 2018	March 31, 2017
Senior Credit Facilities		
$5,100 million Term Loan Facility, due March 1, 2024, net of unamortized discount of $107,670 and $124,047 at March 31, 2018 and March 31, 2017, respectively (effective interest rate of 4.16%)	$ 4,941,330	$ 4,975,953
$500 million Revolving Facility, expiring March 1, 2022, and bearing interest at a variable interest rate	—	—
Senior Notes		
$1,000 million 5.75% Senior Notes due March 1, 2025, net of unamortized discount of $22,843 and $25,400 at March 31, 2018 and March 31, 2017, respectively (effective interest rate of 6.15%)	977,157	974,600
Obligation under data sublicense agreement	—	3,074
Other	2,393	5,468
Less current portion	(53,393)	(57,149)
Long-term debt	$ 5,867,487	$ 5,901,946

Senior Credit Facilities

The Senior Credit Facilities provide the Company with the right at any time to request additional term loan tranches and/or term loan increases, increases in the revolving commitments and/or additional revolving credit facilities up to the sum of (i) (a) the greater of (I) $1,080.0 million and (II) an amount equal to 100.0% of EBITDA for the most recently ended four consecutive fiscal quarter period in respect of which financial statements are available, plus (b) certain voluntary prepayments, repurchases, redemptions and other retirements of indebtedness and commitments under our Senior Credit Facilities, incremental equivalent debt, and refinancings thereof, plus (ii) an additional aggregate amount such that, after giving pro forma effect to such incurrence, (x) if such additional

amounts are secured on a pari passu basis with the first lien obligations under our Senior Credit Facilities, our consolidated first lien net leverage ratio does not exceed 4.90 to 1.00, (y) if such additional amounts are secured on a junior lien basis to the first lien obligations under our Senior Credit Facilities, our consolidated secured net leverage ratio does not exceed 5.75 to 1.00 and (z) if such additional amounts are unsecured, either (I) our consolidated total net leverage ratio does not exceed 6.00 to 1.00 or (II) the Company could incur at least $1.00 of additional indebtedness under a consolidated interest coverage ratio test under our Senior Credit Facilities of 2.00 to 1.00. The lenders under the Senior Credit Facilities will not be under any obligation to provide any such incremental commitments or loans, which are uncommitted, and any such addition of or increase in commitments or loans will be subject to obtaining commitments and certain customary conditions precedent set forth in the Company's Senior Credit Facilities. The applicable margin for loans under the Term Loan Facility is subject to reduction from and after a Qualified IPO (as defined in the Senior Credit Facilities).

Borrowings under the Senior Credit Facilities bear interest at a rate equal to, at the Company's option, either (i) LIBOR for the relevant interest period, adjusted for statutory reserve requirements (which is subject, solely in the case of the Term Loan Facility, to a floor of 1.00% per annum and, solely in the case of the Revolving Facility, to a floor of 0.00% per annum), plus an applicable margin or (ii) a base rate equal to the highest of (a) the rate of interest in effect as publicly announced by the administrative agent as its prime rate, (b) the federal funds effective rate plus 0.50% and (c) adjusted LIBOR for an interest period of one month plus 1.00% (which may be subject, solely in the case of the Term Loan Facility, to a floor of 2.00% per annum), in each case, plus an applicable margin. The applicable margin for loans under the Revolving Facility is subject to reduction after the completion of the Company's first full fiscal quarter after the closing of its Senior Credit Facilities based upon its consolidated first lien net leverage ratio as well as following a Qualified IPO.

In addition to paying interest on outstanding principal under the Senior Credit Facilities, the Company will be required to pay a commitment fee of 0.50% per annum (which is subject to a decrease to 0.375% per annum after the completion of its first full fiscal quarter after the closing of its Senior Credit Facilities based upon its consolidated first lien net leverage ratio) to the lenders under the Revolving Facility in respect of the unutilized commitments thereunder. The Company must also pay customary letter of credit fees and an annual administrative agency fee.

The Senior Credit Facilities requires the Company to prepay outstanding term loans, subject to certain exceptions, with:

- 50% of the Parent Borrower's (as defined in the Senior Credit Facilities) annual Excess Cash Flow (as defined in the Senior Credit Facilities) commencing with the first full fiscal year completed after the closing of the Senior Credit Facilities (which percentage will be reduced to 25% and 0% if the Company achieves and maintain (as of the end of the applicable fiscal year) specified consolidated first lien net leverage ratios), subject to certain credits and exceptions;

- 100% of the net cash proceeds of non-ordinary course asset sales or other dispositions of property, including insurance condemnation proceeds (which percentage will be reduced to 50%, 25% and 0% if the Company achieves and maintain specified consolidated first lien net leverage ratios), subject to certain exceptions, in excess of a minimum amount threshold set forth in the Senior Credit Facilities and subject to our right to reinvest the proceeds within a time period set forth in the Senior Credit Facilities; and

- 100% of the net cash proceeds of any incurrence of debt by the borrowers or their restricted subsidiaries, other than proceeds from debt permitted to be incurred by the terms of the Senior Credit Facilities.

The foregoing mandatory prepayments will be applied, subject to certain exceptions, to the term loans outstanding under the Senior Credit Facilities then outstanding as directed by the Parent Borrower.

The Company may voluntarily, in minimum amounts set forth in the Senior Credit Facilities, repay outstanding loans or reduce outstanding commitments under the Senior Credit Facilities at any time without premium or penalty (other than, subject to certain exceptions, a 1.00% premium payable on the amount of loans under the Term Loan Facility repaid or refinanced with the primary purpose of reducing the all-in yield of the Term Loan Facility (or any amendment with the same effect) on or prior to the six-month anniversary of closing of the Senior Credit Facilities), subject to reimbursements of the lenders' redeployment costs actually incurred in the case of a prepayment of LIBOR borrowings prior to the last day of the relevant interest period. The foregoing voluntary prepayments may be applied to the scheduled installments of principal of the Term Loan Facility in such order as the Parent Borrower shall direct and applied to any class of loans under the Senior Credit Facilities as the Parent Borrower shall direct.

The Term Loan Facility amortizes in equal quarterly installments in aggregate annual amounts equal to 1.00% of the principal amount of the Term Loan Facility outstanding as of the date of the closing of the Senior Credit Facilities, with the balance being payable at maturity. Principal amounts outstanding under the Revolving Facility are due and payable in full at maturity.

All obligations of the borrowers under the Senior Credit Facilities and under any swap agreements and cash management arrangements that are entered into by the borrowers or any of their restricted subsidiaries and that, in either case, are provided by any agent or lender party to the Senior Credit Facilities or any of their respective affiliates, are unconditionally guaranteed by all material wholly owned direct and indirect domestic restricted subsidiaries of the borrowers and by the direct parent of the Parent Borrower, with customary exceptions including, among other things, where providing such guarantees is not permitted by law, regulation or contract or would result in adverse tax consequences.

All obligations of the borrowers under the Senior Credit Facilities and under any swap agreements and cash management arrangements that are entered into by the borrowers or any of their restricted subsidiaries and that, in either case, are provided by any lender or agent party to the Senior Credit Facilities or any of their respective affiliates, and the guarantees of such obligations, are secured, subject to permitted liens and other exceptions, by substantially all of the assets of the borrowers and each guarantor, including but not limited to: (i) a perfected pledge of all of the capital stock issued by the parent borrower and each direct wholly owned domestic restricted subsidiary of the borrowers or any subsidiary guarantor (subject to certain exceptions) and up to 65% of the capital stock issued and outstanding by each direct wholly owned foreign restricted subsidiary of the borrowers or any subsidiary guarantor (subject to certain exceptions) and (ii) perfected security interests in and mortgages on substantially all tangible and intangible personal property and material owned real property of the borrowers and the subsidiary guarantors (subject to certain exceptions and exclusions).

The Senior Credit Facilities contain a number of covenants that, among other things, restrict, subject to certain exceptions, the Company's ability to:

- incur additional indebtedness and guarantee indebtedness;
- create or incur liens;
- engage in mergers or consolidations;
- sell, transfer or otherwise dispose of assets;
- make investments, acquisitions, loans or advances;
- pay dividends and distributions or repurchase our capital stock;
- prepay redeem, or repurchase any subordinated indebtedness;
- enter into agreements which limit the Company's ability to incur liens on our assets for the benefit of the Senior Credit Facilities or that restrict the ability of non-guarantor restricted subsidiaries to pay dividends or make other payments to the Company;
- enter into certain transactions with our affiliates; and
- change the passive holding company status of the direct parent of the Parent Borrower.

In addition, with respect to the Revolving Facility, the documentation governing the Senior Credit Facilities requires the Company to maintain, as of the last day of each four fiscal quarter period, a maximum consolidated first lien net leverage ratio only if, as of the last day of any fiscal quarter, revolving loans under the Revolving Facility (including swing-line loans, but excluding undrawn letters of credit up to $100.0 million and other letters of credit that have been cash-collateralized or otherwise backstopped) are outstanding in an aggregate amount greater than 35% of the total commitments under the Revolving Facility at such time. The financial maintenance covenant is subject to customary equity cure rights and may be amended or waived with the consent of the lenders holding a majority of the commitments under the Revolving Facility. The Senior Credit Facilities will also contain, in addition

to the negative covenants described above, certain customary affirmative covenants and events of default, including upon a change of control.

As of March 31, 2018, the Company was in compliance with all of the applicable covenants under the Senior Credit Facilities.

Senior Notes

The Senior Notes bear interest at an annual rate of 5.75% with interest payable semi-annually on March 1 and September 1 of each year and mature on March 1, 2025.

The Company may redeem the Senior Notes, in whole or in part, at any time on or after March 1, 2020 at the applicable redemption price, plus accrued and unpaid interest.

At any time prior to March 1, 2020, the Company may, at its option and on one or more occasions, redeem up to 40% of the aggregate principal amount of the Senior Notes at a redemption price equal to 105.75% of the aggregate principal amount, plus accrued and unpaid interest, with the net cash proceeds of certain equity offerings. At any time prior to March 1, 2020, the Company may redeem the Senior Notes, in whole or in part, at its option and on one or more occasions, at a redemption price equal to 100% of the principal amount, plus an “applicable premium”, as defined in the governing Senior Credit Facilities, and accrued and unpaid interest.

If the Company experiences specific kinds of changes in control, it must offer to purchase the Senior Notes at a purchase price equal to 101% of the principal amount, plus accrued and unpaid interest.

The Senior Notes are senior unsecured obligations and rank equally in right of payment with all of the Company’s existing and future indebtedness and senior in right of payment to all of its existing and future subordinated indebtedness. The Company’s obligations under the Senior Notes are guaranteed on a senior basis by all of its existing and subsequently acquired or organized wholly-owned United States restricted subsidiaries that guarantee the Senior Credit Facilities. The Senior Notes and the related guarantees are effectively subordinated to the Company’s existing and future secured obligations and that of its affiliate guarantors to the extent of the value of the collateral securing such obligations, and are structurally subordinated to all existing and future indebtedness and other liabilities of any of the Company’s subsidiaries that do not guarantee the Senior Notes.

The indenture governing the Senior Notes (the “Indenture”) contains customary covenants that restrict the ability of the Company and its restricted subsidiaries, subject to certain exceptions, to:

- pay dividends on capital stock or redeem, repurchase or retire capital stock of the Company;
- incur additional indebtedness or issue certain capital stock;
- incur certain liens;
- make investments, loans, advances and acquisitions;
- consolidate, merge or transfer all or substantially all of their assets and the assets of their subsidiaries;
- prepay subordinated debt;
- engage in certain transactions with affiliates; and
- enter into agreements restricting the subsidiaries’ ability to pay dividends.

The Indenture also contains certain customary affirmative covenants and events of default.

As of March 31, 2018, the Company was in compliance with all of the applicable covenants under the Senior Notes.

Obligation Under Data Sublicense Agreement

In 2009 and 2010, CHC acquired certain additional rights to specified uses of its data from the former owner of a portion of its business in order to broaden its ability to pursue business intelligence and data analytics solutions for payers and providers. CHC previously licensed exclusive rights to this data to the former owner of a portion of its business. In connection with these data rights acquisitions, CHC recorded amortizable intangible assets and corresponding obligations at inception based on the present value of the

scheduled annual payments through 2018, which totaled $65,000 in the aggregate (approximately $3,500 remained payable at March 31, 2017). In connection with a prior business combination, CHC was required to adjust this obligation to its fair value. The Company assumed the obligation of this agreement in connection with the Transactions.

Other

From time to time, the Company enters into deferred financing arrangements with certain vendors. The obligations under such arrangements are recorded at the present value of the scheduled payments. Such future payments totaled approximately $2,393 at March 31, 2018.

Aggregate Future Maturities

The aggregate amounts of future maturities under long-term debt arrangements are as follows:

2019	$ 53,393
2020	51,000
2021	51,000
2022	51,000
2023	51,000
Thereafter	5,794,000
	$ 6,051,393

11. Interest Rate Cap Agreements

Risk Management Objective of Using Derivatives

The Company is exposed to certain risks arising from both its business operations and economic conditions. The Company principally manages its exposures to a wide variety of business and operational risks through management of its core business activities. The Company manages economic risks, including interest rate, liquidity and credit risk, primarily by managing the amount, sources and duration of its debt funding and the use of derivative financial instruments. Specifically, the Company enters into derivative financial instruments to manage exposures that arise from business activities that result in the receipt or payment of future known and uncertain cash amounts, the value of which are determined by interest rates. The Company's derivative financial instruments are used to manage differences in the amount, timing and duration of the Company's known or expected cash receipts and its known or expected cash payments principally related to the Company's borrowings.

Cash Flow Hedges of Interest Rate Risk

The Company's objectives in using interest rate derivatives are to add stability to interest expense and to manage its exposure to interest rate movements. To accomplish this objective, the Company primarily uses interest rate cap agreements as part of its interest rate risk management strategy.

In March 2016 and 2017, CHC and the Company, respectively, executed annuitized interest rate cap agreements with a combined notional amount of $650,000 and $750,000, respectively to limit the exposure of the variable component of interest rates under the then existing term loan facility or future variable rate indebtedness to a maximum of 1.25% and 1.0%, respectively, beginning in March 2017 and expiring in March 2020. As of March 31, 2018, the Company's outstanding interest rate cap agreements were designated as cash flow hedges of interest rate risk and were determined to be highly effective.

The effective portion of changes in the fair value of derivatives designated and that qualify as cash flow hedges is recorded in accumulated other comprehensive income and is subsequently reclassified into earnings in the period that the hedged forecasted transaction affects earnings. The ineffective portion of the change in fair value of the derivatives is recognized directly in earnings. Amounts reported in accumulated other comprehensive income related to derivatives will be reclassified to interest expense as interest payments are made on the Company's variable-rate debt. During the twelve months subsequent to March 31, 2018, the Company estimates that an additional $4,559 will be reclassified as a reduction to interest expense.

The following table summarizes the fair value of the Company's derivative instruments at March 31, 2018 and 2017:

		Fair Values of Derivative Financial Instruments Asset (Liability)	
Derivative financial instruments designated as hedging instruments:	**Balance Sheet Location**	**March 31, 2018**	**March 31, 2017**
Interest rate cap agreements	Prepaid and other current assets	$ 6,062	$ —
Interest rate cap agreements	Other noncurrent assets, net	$ 11,127	$ 5,291
Interest rate cap agreements	Accrued expenses	$ —	$ (6,520)
		$ 17,189	$ (1,229)

Tabular Disclosure of the Effect of Derivative Instruments on the Statement of Operations

The effect of the derivative instruments on the accompanying consolidated statements of operations for the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, is summarized in the following table:

	Year Ended March 31, 2018	**Period from June 17, 2016 (inception) to March 31, 2017**
Derivative financial instruments in cash flow hedging relationships:		
Gain/ (loss) related to effective portion of derivative financial instruments recognized in other comprehensive loss	$ 10,604	$ (3,015)
Gain/ (loss) related to effective portion of derivative financial instruments reclassified from accumulated other comprehensive loss to interest expense	$ 1,110	$ (3)
Gain/ (loss) related to ineffective portion of derivative financial instruments recognized in interest expense	$ 1,073	$ 554

Credit Risk-related Contingent Features

The Company has agreements with each of its derivative counterparties that contain a provision where if the Company defaults on any of its indebtedness, including default where repayment of the indebtedness has not been accelerated by the lender, then the Company also could be declared in default on its derivative obligations.

The Company does not offset any derivative financial instruments, and the derivative financial instruments are not subject to collateral posting requirements.

12. Fair Value Measurements

Assets and Liabilities Measured at Fair Value on a Recurring Basis

The Company's assets and liabilities that are measured at fair value on a recurring basis consist of the Company's derivative financial instruments and contingent consideration obligations. The tables below summarize these items as of March 31, 2018 and 2017, aggregated by the level in the fair value hierarchy within which those measurements fall.

Description	Balance at March 31, 2018	Quoted in Markets Identical (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Interest rate cap agreements	$ 17,189	$ —	$ 17,189	$ —
Contingent consideration obligations	(4,000)	—	—	(4,000)
Total	$ 13,189	$ —	$ 17,189	$ (4,000)

Description	Balance at March 31, 2017	Quoted in Markets Identical (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Interest rate cap agreements	$ (1,229)	$ —	$ (1,229)	$ —
Total	$ (1,229)	$ —	$ (1,229)	$ —

The valuation of the Company's derivative financial instruments is determined using widely accepted valuation techniques, including discounted cash flow analysis on the expected cash flows of each derivative. This analysis reflects the contractual terms of the derivative, including the period to maturity, and uses observable market-based inputs, including interest rate curves. The fair value of the interest rate cap agreements are determined using the market standard methodology of netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments) using the overnight index swap rate as the discount rate.

The Company incorporates credit valuation adjustments to appropriately reflect both its own nonperformance risk and the respective counterparty's nonperformance risk in the fair value measurements. In adjusting the fair value of its derivative contracts for the effect of nonperformance risk, the Company has considered the impact of netting and any applicable credit enhancements and measures the credit risk of its derivative financial instruments that are subject to master netting agreements on a net basis by counterparty portfolio.

Although the Company has determined that the majority of the inputs used to value its derivatives fall within Level 2 of the fair value hierarchy, the credit valuation adjustments associated with its derivatives utilize Level 3 inputs to evaluate the likelihood of default by itself and by its counterparties. As of March 31, 2018, the Company determined that the credit valuation adjustments are not significant to the overall valuation of its derivatives. As a result, the Company determined that its derivative valuations in their entirety are classified in Level 2 of the fair value hierarchy.

The valuation of the Company's contingent consideration obligations was provisionally (subject to receipt of a final valuation) determined using a probability weighted discounted cash flow method. This analysis reflects the contractual terms of the purchase agreements (e.g., minimum and maximum payments, length of earn-out periods, manner of calculating any amounts due, etc.) and utilizes assumptions with regard to future cash flows, probabilities of achieving such future cash flows and a discount rate. Significant increases with respect to assumptions as to future revenue and probabilities of achieving such future revenue would have resulted in a

higher fair value measurement while an increase in the discount rate would have resulted in a lower fair value measurement.

The table below presents a reconciliation of the fair value of the liabilities that use significant unobservable inputs (Level 3):

	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Balance at beginning of period	$ —	$ —
Issuance of contingent consideration	(4,000)	—
Balance at end of period	$ (4,000)	$ —

Assets and Liabilities Measured at Fair Value on a Non-recurring Basis

In connection with the combining of the businesses in connection with the Transactions, the Company identified certain redundancies among the combined software and analytics segment product portfolio. In one such instance, one of the contributed businesses' software products had been fully developed and in the other further development would be required. As a result, the Company determined to cease future development of this redundant internal use software product and recognized an impairment charge to reduce the carrying value of the asset, previously classified within Other noncurrent assets on the accompanying consolidated balance sheet, to zero in March 2017. Additionally, because this abandoned software project included a license that required annual maintenance expenditures for future years for which the Company does not expect to derive any economic benefit, the Company recognized a liability for this exit cost with a fair value of $19,137 at March 1, 2017 (total expected remaining payments of $22,913). This fair value (a Level 3 measurement) was determined by use of a discounted cash flow model and an assumed discount rate of 7.75% which was based upon a spread above the rate underlying the Company's senior notes. The related losses have been included with the Impairment of long-lived assets and related costs caption within the accompanying consolidated statement of operations.

Assets and Liabilities Measured at Fair Value upon Initial Recognition

The carrying amount and the estimated fair value of financial instruments held by the Company as of March 31, 2018 and 2017, were:

	March 31, 2018		March 31, 2017	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Cash and cash equivalents	$ 48,899	$ 48,899	$ 185,670	$ 185,670
Accounts receivable	$ 705,544	$ 705,544	$ 696,780	$ 696,780
Senior Credit Facilities (Level 2)	$ 4,941,330	$ 5,010,495	$ 4,975,953	$ 5,093,625
Senior Notes (Level 2)	$ 977,157	$ 985,000	$ 974,600	$ 1,008,750

The carrying amounts of cash equivalents and accounts receivable approximate fair value because of their short-term maturities. The fair value of long-term debt is based upon market quotes and trades by investors in partial interests of these instruments.

13. Commitments

Lease Commitments

The Company recognizes lease expense on a straight-line basis, including predetermined fixed escalations, over the initial lease term including reasonably assured renewal periods from the time that the Company controls the leased property.

The Company leases its offices and other facilities under operating lease agreements that expire at various dates through 2027. Future minimum lease commitments under these non-cancellable lease agreements as of March 31, 2018 were as follows:

2019	$ 39,844
2020	32,681
2021	24,704
2022	21,559
2023	14,165
Thereafter	14,168
Total minimum lease payments	$ 147,121

The Company expects to receive $5,600 of minimum rentals in the future under noncancelable subleases as of March 31, 2018. Total rent expense for all operating leases was $54,367 and $4,267 for the year ended March 31, 2018 and for the period from June 17, 2016 (inception) to March 31, 2017.

Other Commitments

In February 2018, the Company, through one of its wholly-owned subsidiaries, entered into an Amended and Restated Master Services Agreement (the "Agreement") with Wipro, LLC and Wipro Limited (jointly, "Wipro"). The term of the Agreement is ten years, with the Company having three one-year renewal options. The Company has committed to purchase services from Wipro through the initial ten-year term of the Agreement (the "Minimum Commitment") in an aggregate amount of $1 billion. Under the Agreement, Wipro will globally provide the Company with professional services for information technology (including infrastructure, application development and maintenance), business process outsourcing, call center services and similar services. As the Company orders specific services under the Agreement the parties will execute Statements of Work describing the specific scope of the services to be performed by Wipro. The amount of the Minimum Commitment may be reduced on the occurrence of certain events, some of which also provide the Company the right to terminate the Agreement. If the Company has not fully satisfied the Minimum Commitment (as reduced) by the end of the initial ten-year term, it is required to pay Wipro 25% of the shortfall.

In connection with the Agreement, the Company expects to incur significant severance costs related to the transition of services currently performed by the Company to Wipro. However, pending execution of future Statements of Work, the Company cannot reliably estimate the timing or amount of such future severance costs. Accordingly, the Company's balance sheet reflects no accrual for such costs associated with the Agreement.

14. Legal Proceedings

In addition to commitments and obligations in the ordinary course of business, the Company is subject to various claims with customers and vendors, pending and potential legal actions for damages, investigations relating to governmental laws and regulations and other matters arising out of the normal conduct of its business.

Government Subpoenas and Investigations

From time to time, the Company receives subpoenas or requests for information from various government agencies. The Company generally responds to such subpoenas and requests in a cooperative, thorough and timely manner. These responses

sometimes require time and effort and can result in considerable costs being incurred by the Company. Such subpoenas and requests also can lead to the assertion of claims or the commencement of civil or criminal legal proceedings against the Company and other members of the health care industry, as well as to settlements.

Other Matters

Additionally, in the normal course of business, the Company is involved in various claims and legal proceedings. While the ultimate resolution of these matters has yet to be determined, the Company does not believe that it is reasonably possible that their outcomes will have a material adverse effect on the Company's consolidated financial position, results of operations or liquidity.

15. Members' Deficit

The Third Amended and Restated Limited Liability Company Agreement of Parent entered into at the time of the Transactions among the McKesson Members (as defined in the LLC Agreement), Parent, certain subsidiaries of Parent and HCIT (the "LLC Agreement") governs the rights and obligations of the McKesson Members and HCIT in their roles as members of Parent and owners of the Units (as defined in the LLC Agreement). The Company is an indirect, wholly-owned subsidiary of Parent.

Parent Board

Except as expressly provided in the LLC Agreement, the management of the business and affairs of the Parent are vested in a board of directors (the "Parent Board") comprised of not more than ten members. Each of the McKesson Members, on the one hand, and HCIT, on the other hand, is entitled to designate up to four directors of the Parent Board, of whom three directors may be employees or affiliates of the designating member, and one director may not be an employee or affiliate of the designating member and must otherwise be independent of Parent. The ninth director on the Parent Board will be Parent's chief executive officer and the tenth director on the Parent Board will be an independent director that is mutually designated by the McKesson Members and HCIT. The number of Parent Board designees of the McKesson Members and HCIT is subject to reduction based on the Units ownership level of the corresponding Parent member. Neither the McKesson Members nor HCIT shall have the right to designate any directors to the Parent Board once their respective ownership of Units drops below 10% of the Units then outstanding.

Approval Rights of the Members

Pursuant to the LLC Agreement, certain actions by Parent will require the prior written consent of both the McKesson Members and HCIT. These matters include, without limitation: (i) materially changing the line of business of Parent; (ii) the appointment, removal or replacement of Parent's chief executive officer or chairman of the Parent Board; (iii) approving Parent's annual operating plan and budget; (iv) entering into certain material agreements, including affiliate transactions (subject to certain exceptions); (v) declaring or paying any dividend, redeeming or repurchasing equity securities or issuing or authorizing the issuance of equity securities of Parent; (vi) incurring indebtedness (subject to certain exceptions); (vii) a change of control of Parent, or the sale, lease or disposal of assets of the Company outside the ordinary course of business (other than expressly permitted by the LLC Agreement including pursuant to drag along rights set forth therein); (viii) any initial public offering, other than a Qualified IPO (as defined below); (ix) terminating, liquidating or dissolving Parent; and (x) any amendment to, modification of, or waiver under the Contribution Agreement or the Transaction Documents (as defined in the LLC Agreement) by Parent. The foregoing approval rights of the members of Parent will terminate, as to each of the McKesson Members and HCIT, at such time as the McKesson Members (together with their permitted transferees) no longer own, directly or indirectly, 10% or more of the Units initially held by the McKesson Members (directly or indirectly through ownership of common stock of HCIT).

Special Allocations

Generally, pursuant to the LLC Agreement, the profits and losses of Parent will be allocated among the members of Parent in proportion to the number of Units held by them. However, depreciation and amortization expenses related to certain assets transferred to Parent by one of the McKesson Members at the time of the Transactions, as well as associated income tax deductions, will be allocated solely to the McKesson Member that transferred the applicable asset to Parent at the time of the Transactions.

Qualified Initial Public Offering

Pursuant to the LLC Agreement, the parties agreed to cooperate in good faith and use their reasonable best efforts to consummate, as promptly as practicable following the Contribution Agreement closing, but in any event within 18 months of the Contribution Agreement closing (provided that the deadline may be extended by a committee of the Parent Board to 24 months from the Contribution Agreement closing), (i) a firm commitment underwritten public offering registered under the Securities Act of 1933, as amended, of HCIT common stock representing at least 10% of the beneficial ownership of Parent's outstanding equity interests (after giving effect to such offering) and (ii) pursuant to which HCIT would be listed for trading on The New York Stock Exchange, the NASDAQ Stock Market, or any other securities exchange or quotation system agreed to by the McKesson Members and HCIT (a "Qualified IPO") (HCIT, following such Qualified IPO, the "PubCo"). In March 2018, the parties agreed to extend the time period for consummating a Qualified IPO from 18 months to 24 months from the Contribution Agreement closing.

In addition, if a Qualified IPO has not been consummated within 24 months of the Contribution Agreement Closing (the "Initial Period"), then either the McKesson Members or HCIT may cause Parent and the other members to consummate a Qualified IPO (an "IPO Demand") within a period of up to six months following the expiration of the Initial Period (the "IPO Preference Period").

Liability

Pursuant to the LLC Agreement, the debts, obligations and liabilities of Parent, whether arising in contract, tort or otherwise, shall be solely the debts, obligations and liabilities of Parent, and no Member, director or Company officer shall be obligated personally for any such debt, obligation or liability of Parent or for any losses of Parent solely by reason of being a Member or acting as a director or Parent officer.

16. Incentive Compensation Plans

Equity Compensation Plans

In connection with the Transactions, HCIT assumed the CHC Equity Plan and amended it as the HCIT Holdings, Inc. Amended and Restated 2009 Equity Incentive Plan (the "Equity Plan"). Pursuant to the Equity Plan, 300,000 shares of HCIT's common stock have been reserved for the issuance of equity awards to employees, directors and consultants of the Company (i.e., HCIT's equity method investee) and its affiliates.

HCIT grants equity-based awards of HCIT common stock to certain employees, officers and directors of HCIT, eRx Network and the Company (collectively, the "Company Group") under terms of awards that are described below. Grants under the Equity Plan consist of one or a combination of time-vested and/or performance-based awards. In most circumstances, the shares issued upon exercise of the equity awards are subject to certain call rights by HCIT in the event of termination of service of an award holder and put rights by the award holder or his/her beneficiary in the event of death or disability. HCIT, through the Company, expects to repurchase shares of common stock held by former employees no earlier than six months following the issuance of such shares of HCIT common stock. As of March 31, 2018, HCIT expects to repurchase approximately 1,900 such shares of HCIT common stock.

Replacement Awards

In connection with the Transactions, HCIT was obligated to either assume obligations under CHC's prior equity award plans or to issue substantially equivalent equity awards. HCIT elected to issue replacement awards with vesting and exercisability terms generally identical to the awards which were replaced. Because the stock of eRx Network and the 2017 Tax Receivable Agreement (as described in Note 19) were distributed to CHC stockholders immediately prior to the Transactions, certain participants in the CHC Equity Plan also received equity awards in eRx Network and the right to receive a cash payment related to a proportionate value of the 2017 Tax Receivable Agreement in connection with the Transactions.

These replacement awards granted under the Equity Plan consisted of one, or a combination of, the following time-vested awards and/or exit-vesting awards.

Vested Awards: Vested awards consist of the following:

(i) Tier I Time-Vesting Awards became immediately vested in connection with the Transactions, 54.4% of which were liquidated for cash upon the closing of the Transactions. The remaining 45.6% of such options were exchanged for vested options of HCIT with exercise prices and expiration terms that correspond with those of the original grant to CHC Equity Plan participants ("Replacement Time-Vesting Options"). These CHC Equity Plan participants also received vested options in eRx Network with exercise prices equal to 25% of the fair value of the eRx Network stock and a cash payment related to the proportionate value of the 2017 Tax Receivable Agreement at the time of the Transactions.

(ii) Tier II Time-Vesting Awards became immediately vested in connection with the Transactions but because the original exercise price of these awards was greater than the fair value of the stock at the time of the Transactions, none of the awards were liquidated and they were replaced with vested Replacement Time-Vesting Options with an exercise price equal to the original exercise price as reduced by the fair value of one share of eRx Network stock.

(iii) 2.0x Exit-Vesting Awards became immediately vested in connection with the Transactions as a result of meeting the specified performance and market conditions outlined in the original award terms. As with the Tier I Time-Vesting Awards, 54.4% were liquidated for cash upon the closing of the Transactions. The remaining 45.6% of such options were exchanged for vested Replacement Time-Vesting Options with exercise prices and expiration terms that correspond with those of the original grant to the CHC Equity Plan participants. The CHC Equity Plan participants also received vested options in eRx Network with exercise prices equal to 25% of the fair value of the eRx Network stock and a cash payment related to the proportionate value of the 2017 Tax Receivable Agreement at the time of the Transactions.

Unvested Awards: Certain awards granted by CHC contained conditions that were not satisfied at the time of the Transactions. These awards generally consisted of awards that vest subject to the employee's continued employment through the date when Blackstone has sold at least 25% of the maximum number of CHC's shares held by it (i.e., a liquidity event) and achieved specified rates of return that vary by award. In connection with the Transactions, these unvested equity awards were replaced with unvested restricted stock of HCIT ("Replacement Exit-Vesting Restricted Stock") with an aggregate intrinsic value and vesting conditions which were identical to the original CHC awards. CHC Equity Plan participants also received unvested restricted stock of eRx Network and a right, contingent upon vesting of the awards, to receive a future cash payment related to the proportionate value of the 2017 Tax Receivable Agreement at the time of the Transactions.

Restricted Share Units: Vesting of CHC restricted share units was not affected by the Transactions. 54.4% of the vested portion of such restricted share units were liquidated in connection with the Transactions and the remainder of the vested and unvested restricted share units were replaced with vested and unvested HCIT restricted share units ("Replacement Restricted Share Units") with terms identical to the original awards. CHC Equity Plan participants also received vested and unvested restricted share units of eRx Network and a right to receive a future cash payment upon vesting related to the proportionate value of the 2017 Tax Receivable Agreement at the time of the Transactions.

The following table summarized Replacement Award option activity for the year ended March 31, 2018:

	Replacement Time-Vesting Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at April 1, 2017	45,809	$ 1,492	6.5	$ 41,597
Granted	—	—	—	—
Exercised	(4,582)	1,383	—	4,588
Expired	—	—	—	—
Forfeited	(2,720)	1,739	—	1,873
Outstanding at March 31, 2018	38,507	$ 1,488	5.4	$ 35,137
Exercisable at March 31, 2018	38,507	$ 1,488	5.4	$ 35,137

McKesson Awards

McKesson has historically granted equity awards to its employees in the ordinary course of business. In connection with the Transactions, certain of these employees with McKesson equity awards became employees of the Company. Under the terms of the original awards, the awards would expire following the affected employees' termination. In connection with the Transactions, McKesson modified certain of the awards to permit continued vesting of the current tranche of awards through May 2017 such that following the Transactions they are considered awards to non-employees. All other McKesson equity awards were immediately cancelled. Because these employees were required to render service to the Company in order to continue the vesting through May 2017, the related compensation expense has been included in the accompanying condensed consolidated statement of operations. No incremental compensation was recognized in connection with the modification of the affected awards.

Time-Vesting Options

Time-vesting options were granted with an exercise price equal to the fair value of HCIT common stock on the date of grant and generally vest in equal 25% installments on the first through fourth anniversary of the designated vesting start date, subject to the award holders continued employment through such vesting date. The Company estimates the fair value of the time-vesting options using the Black-Scholes option pricing model. As of March 31, 2018, unrecognized expense related to the time-vesting options was $44,330. This expense is expected to be recognized over a weighted average period of 3.0 years.

Exit-Vesting Options

Exit-vesting options were granted with an exercise price equal to the fair value of HCIT common stock on the date of grant and vest, subject to the award holder's continued employment through the vesting date, on the earlier to occur of the date that (i) affiliates of Blackstone sell 25% of the equity interests of Parent held by it on March 1, 2017 (the "Transaction Date") at a specified weighted average price per share and McKesson distributes more than 50% of the equity interests of Parent held by it on the Transaction Date or (ii) McKesson and affiliates of Blackstone collectively sell more than 25% of the aggregate equity interests held by McKesson and Blackstone on the Transaction Date at a specified weighted average price per share.

The following table summarizes time-vesting and exit-vesting option activity for the year ended March 31, 2018:

	Awards		Weighted Average Exercise Price		Weighted Average Remaining Contractual Term		Aggregate Intrinsic Value	
	Time-Vesting Options	Exit-Vesting Options	Time-Vesting Options	Exit-Vesting Options	Time-Vesting Options	Exit-Vesting Options	Time-Vesting Options	Exit-Vesting Options
Outstanding at April 1, 2017	—	—	$ —	$ —	—	—	$ —	$ —
Granted	63,610	63,610	2,400	2,400	9.6	9.6	—	—
Exercised	—	—	—	—	—	—	—	—
Expired	—	—	—	—	—	—	—	—
Forfeited	(11,021)	(11,084)	2,400	2,400	—	—	—	—
Outstanding at March 31, 2018	52,589	52,526	2,400	2,400	8.9	8.9	—	—
Exercisable at March 31, 2018	12,765	—	$ 2,400	$ —	8.9	—	$ —	$ —

Restricted Share Units

During the year ended March 31, 2018, HCIT granted 2,500 restricted share units ("RSUs") which were scheduled to vest, subject to the employee's continued employment, on March 31, 2019. In the event the employee was terminated by the Company without cause, by the employee for good reason or on account of the employee's death or disability, the RSUs would immediately vest and become nonforfeitable. Settlement of these RSUs upon vesting could have occurred in HCIT common stock, cash in an amount equal to the fair market value of the number of shares that would otherwise be delivered upon the vesting date or any combination of HCIT common stock or cash. In the event the HCIT common stock were not publicly traded at the time of settlement, the employee could have elected to require HCIT to settle such RSUs in cash. Because settlement of the RSUs in common stock was outside the control of HCIT, the RSUs were historically classified as liabilities in the consolidated balance sheets. Such awards were cancelled during 2018 following the resignation of the employee without good reason.

The following table summarizes the restricted share unit activity for the year ended March 31, 2018:

	Replacement Exit-Vesting Restricted Stock	Replacement Restricted Share Units	Restricted Share Units
Unvested at April 1, 2017	16,067	600	—
Granted	—	—	2,500
Canceled	(5,364)	—	(2,500)
Vested	—	(600)	—
Unvested at March 31, 2018	10,703	—	—

The total fair value of shares vested during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017 was $1,440 and $0, respectively.

Valuation Assumptions

The following table summarizes the weighted average fair value of awards using the Black-Scholes and Monte Carlo Simulation option pricing models, as appropriate, and the weighted average assumptions used to develop the fair value estimates under each of the valuation models for the year ended March 31, 2018.

Year Ended March 31, 2018:	Time-Vesting Options	Exit-Vesting Options	Replacement Exit-Vesting Restricted Stock
Weighted average fair value	$ 1,194	$ 826	$ 1,509
Expected dividend yield	— %	— %	— %
Expected volatility	52.15 %	52.08 %	57.61 %
Risk-free interest rate	2.67 %	2.72 %	2.40 %
Expected term (years)	5.47	6.22	3.00

Expected dividend yield—The Company is subject to limitations on the payment of dividends under its Senior Credit Facilities as further discussed in Note 10 to these consolidated financial statements. An increase in the dividend yield will decrease compensation expense.

Expected volatility—This is a measure of the amount by which the price of the equity instrument has fluctuated or is expected to fluctuate. The expected volatility was based on the levered median historical volatility of a group of guideline companies. An increase in the expected volatility will increase compensation expense.

Risk-free interest rate—This is the U.S. Treasury rate as of the measurement date having a term approximating the expected life of the award. An increase in the risk-free interest rate will increase compensation expense.

Expected term—This is the period of time over which the awards are expected to remain outstanding. The Company estimates the expected term as the mid-point between the actual or expected vesting date and the contractual term. An increase in the expected term will increase compensation expense.

Summary of Equity Compensation Expense

The Company recognized expense of $24,700 and $715 during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. The Company recognized a deferred tax benefit of $5,520 for the year ended March 31, 2018. The Company recognized actual tax benefits of $2,174 from options exercised during the year ended March 31, 2018.

17. Retirement Plans and Other Postretirement Benefits

Defined Contribution Plans

Employees of the Company may participate in one of its 401k plans, which provide for matching contributions from the Company. Expenses related to these 401k plans were $16,828 and $1,379, for the year ended March 31, 2018 and for the period from June 17, 2016 (inception) to March 31, 2017.

Deferred Compensation Plans

Certain of the Company’s employees are eligible to participate in deferred compensation plans previously administered and sponsored by McKesson. Pursuant to these deferred compensation plans, certain executives and other highly compensated employees may defer a portion of their salaries and incentive compensation at their discretion.

The following table summarizes the liabilities related to this plan at March 31, 2018 and 2017:

Balance Sheet Location	March 31, 2018	March 31, 2017
Accrued expenses	$ 707	$ 998
Other long-term liabilities	13,790	11,129
	$ 14,497	$ 12,127

Post-employment Benefits

The Company generally offers post-employment benefits to its employees in the case of certain employee termination events consisting of severance and outplacement services. The extent of such benefits varies based on employee title and accumulates based on the respective employee's years of service to the Company. Due to the episodic nature of the Company's severance benefit history and the inability to reasonably predict future termination events, no accrual for accumulating severance benefits is accrued until the point that the payment of a severance benefit is probable and can be reasonably estimated. As of March 31, 2018 and 2017, the Company recognized liabilities related to these benefits in the amount of $9,336 and $8,553, respectively.

18. Income Taxes

	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Income (loss) before income tax provision (benefit)		
Domestic	$ 125,902	$ (125,884)
Foreign	14,646	1,286
Total income (loss) before income tax provision (benefit)	140,548	(124,598)

The Company is treated as a partnership for income tax purposes and is therefore not subject to U.S. federal income taxes and most state and local income taxes. Change Healthcare, Inc. and Change Healthcare Practice Management Solutions, Inc., both wholly-owned subsidiaries of the Company, are subject to U.S. federal, state and local, and non-U.S. corporate income taxes.

The income tax provision (benefit) for the year ended March 31, 2018 and for the period from June 17, 2016 (inception) to March 31, 2017 was as follows:

	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Current:		
Federal	$ 4,617	$ 537
State	1,178	296
Foreign	2,279	194
Current income tax provision (benefit)	8,074	1,027
Deferred:		
Federal	(28,172)	(35,674)
State	(32,715)	(6,259)
Foreign	355	(100)
Deferred income tax provision (benefit)	(60,532)	(42,033)
Total income tax provision (benefit)	$ (52,458)	$ (41,006)

The reconciliation between the federal statutory rate and the effective income tax rate is as follows:

	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Statutory U.S. federal tax rate	31.50 %	35.00 %
State income taxes (net of federal benefit)	(1.72)	3.49
Income passed through to Members	(8.78)	(10.64)
Remeasurement of deferred tax assets and liabilities arising from the Tax Legislation	(42.95)	—
Transition tax arising from the Tax Legislation	1.68	—
Fees and expenses related to the Transactions	—	1.97
Change in valuation allowance	(11.97)	(2.38)
Accretion and changes in estimate, net	(5.47)	5.01
Other	0.39	0.46
Effective income tax rate	(37.32) %	32.91 %

On December 22, 2017, H.R.1, also known as the Tax Legislation, was signed into law. The Tax Legislation significantly revises the U.S. corporate income tax by, among other things, lowering corporate income tax rates, placing limits on the utilization of net operating loss carryovers, implementing the territorial tax system and imposing a repatriation tax on deemed repatriated earnings of foreign subsidiaries.

The Company has recognized a tax benefit for the impact of the revaluation of U.S. deferred tax assets and liabilities due to the federal corporate income tax rate reduction from 35% to 21%. In order to properly account for the blended tax rate in place for fiscal year 2018, the Company estimated the deferred tax assets and liabilities expected to reverse during the current fiscal year and applied a tax rate of 31.5%. All other deferred tax assets and liabilities are expected to reverse in fiscal year 2019 or later and were revalued at 21%.

Additionally, the Company has estimated its liability and included provisional amounts for the one-time transition tax as tax expense.

The enactment of the Tax Legislation resulted in an increase in income tax benefit of approximately $33,024 for the year ended March 31, 2018. A majority of the tax effects are the result of the change in the enacted rate causing a remeasurement of the U.S. federal deferred tax liabilities at the lower enacted corporate tax rate.

Tax benefits recognized during the year ended March 31, 2018 primarily related to the transition tax and rate change on net deferred tax assets and liabilities are considered provisional under SAB 118. The impact of the Tax Legislation may differ from this estimate, possibly materially, due to, among other things, changes in interpretations and assumptions the Company has made, guidance that may be issued, and actions the Company may take as a result of the Tax Legislation.

The Company will continue to refine its accumulated earnings and profit pools and the allocation of cash and non-cash earnings for purposes of calculating the transition tax liability. Additionally, net deferred tax assets were reevaluated as of the enactment date using estimated fiscal year 2018 utilization amounts and blended tax rates. The Company has not accounted for the tax impacts related to the Global Intangible Low Tax Income, Base Erosion Anti Abuse Tax or Foreign Derived Intangible Income regimes or any of the other provisions of the Tax Legislation that are not effective until fiscal year 2019.

The Company will update the impact of the Tax Legislation throughout the measurement period until the matters above are finalized.

In addition to the Tax Legislation, the Company recognized a change in estimate of deferred tax assets during the year ended March 31, 2018 as a result of the finalization of a valuation of the 2017 Tax Receivable Agreement and other matters. These changes in estimate resulted in an income tax benefit of $8,790, for the year ended March 31, 2018. In addition, the Company recognized changes in its valuation allowances related to prior deferred tax assets as a result of the Company's change in judgment resulting from transactions and tax planning strategies that provide for future taxable income in the relevant jurisdictions. This resulted in an income tax benefit of $16,819 for the year ended March 31, 2018. Together, these changes in estimate resulted in an income tax benefit of $25,609 for the year ended March 31, 2018.

At March 31, 2018, the Company had net operating loss carryforwards (tax effected) for federal, state and foreign income tax purposes of $104,068, $81,618 and $4,905, respectively, which expire from 2026 through 2037, 2019 through 2038 and 2028 through 2038, respectively. A portion of net operating loss carryforwards may be subject to an annual limitation regarding their utilization against taxable income in future periods due to the "change of ownership related to a legal entity simplification" provisions of the Internal Revenue Code and similar state provisions.

The Company believes that it is more likely than not that the benefit from certain state and foreign net operating loss carryforwards will not be realized. In recognition of this risk, the Company has provided a valuation allowance of $21,365 on the deferred tax assets related to these state and foreign net operating loss carryforwards. If or when recognized, the tax benefits related to any reversal of the valuation allowance on deferred tax assets as of March 31, 2018, will be accounted for as a reduction of income tax expense of $18,825.

The federal, state and foreign net operating loss carryforwards within the income tax returns filed included unrecognized tax benefits. The deferred tax assets recognized for those net operating losses are presented net of these unrecognized tax benefits.

Significant components of the Company's deferred tax assets (liabilities) as of March 31, 2018 and 2017 were as follows:

	March 31, 2018	March 31, 2017
Deferred tax assets and (liabilities):		
Depreciation and amortization	$ (317,585)	$ (485,426)
Accounts receivable	1,460	1,236
Fair value of interest rate cap agreements	(3,207)	531
Accruals and reserves	19,225	28,019
Capital and net operating losses	193,133	285,011
Debt discount and interest	242	51
Equity compensation	12,616	17,520
Valuation allowance	(21,365)	(48,531)
Tax receivable agreements obligations to related parties	32,864	60,780
Other	2,451	4,270
Net deferred tax assets and (liabilities)	$ (80,166)	$ (136,539)
Reported as:		
Non-current deferred tax assets	34,738	8,931
Non-current deferred tax liabilities	(114,904)	(145,470)
Net deferred tax liabilities	$ (80,166)	$ (136,539)

A reconciliation of the beginning and ending amount of unrecognized tax benefit is as follows:

	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Beginning unrecognized benefit	$ 60,079	$ 60,079
Decreases from prior period tax positions	(8,984)	—
Increases from prior period tax positions	—	—
Increases from current period tax positions	—	—
Decreases from settlements with taxing authorities	—	—
Ending unrecognized benefit	$ 51,095	$ 60,079

The Company had unrecognized tax benefits of $51,095 and $60,079 as of March 31, 2018 and 2017, respectively, which if recognized, $41,347 would affect the effective income tax rate.

The Company recognizes interest income and expense (if any) related to income taxes as a component of income tax expense. The Company recognized no interest and penalties for the year ended March 31, 2018 and for the period from June 17, 2016 (inception) to March 31, 2017.

The Company and its subsidiaries file income tax returns in the U.S. federal jurisdiction and various states and foreign jurisdictions. The U.S. federal and state income tax returns for certain subsidiaries of the Company remain subject to examination by the Internal Revenue Service for the tax years 2006 and beyond, i.e., periods prior to their ownership by the Company. With respect to state and local jurisdictions and countries outside of the United States, the Company and its subsidiaries are typically subject to examination for a number of years after the income tax returns have been filed. Although the outcome of tax audits is always uncertain, the Company believes that adequate amounts of tax, interest and penalties have been provided for in the accompanying consolidated financial statements for any adjustments that may be incurred due to state, local or foreign audits.

19. Tax Receivable Agreement Obligations to Related Parties

Upon the consummation of the Transactions, the Company assumed obligations related to certain tax receivable agreements (collectively, the "tax receivable agreements") with our current and former owners. Because the assets and obligations of the predecessor businesses were contributed to the Company at their historical carrying values, these tax receivable agreements are subject to differing accounting models as explained below.

2009 - 2011 Tax Receivable Agreements

Under the 2009 - 2011 Tax Receivable Agreements assumed by the Company in connection with the Transactions, the Company is obligated to make payments to certain of the former CHC stockholders, equal to 85% of the applicable cash savings that the Company expects to realize as a result of tax attributes arising from certain previous transactions. As a result of the covered change of control with respect to the tax receivable agreements that occurred in connection with the Transactions, payments the Company makes under the 2009 - 2011 Tax Receivable Agreements are required to be calculated using certain valuation assumptions, including that the Company will have sufficient taxable income to use the applicable tax attributes and that certain of such tax attributes will be used by the Company on a pro rata basis from the date of the Transactions (or in certain cases from the date of certain previous transactions) through the expiration of the applicable tax attribute. Because the 2009 - 2011 Tax Receivable Agreements were previously subject to fair value measurement in connection with a prior business combination transaction, it is recognized at its initial fair value plus recognized accretion to date. In connection with the covered change in control, the change in assumed valuation assumptions resulted in a change in estimate (decrease to the pretax loss) of $26,475 for the period from June 17, 2016 (inception) to March 31, 2017, which is included in the accretion and changes in estimate, net caption within the accompanying statement of operations.

2017 Tax Receivable Agreement

The 2017 Receivable Agreement generally provides for the payment by Change Healthcare, Inc. (a subsidiary of the Company) to affiliates of Blackstone and Hellman & Friedman of 85% of the net cash tax savings realized (or, in certain circumstances, deemed to be realized) in periods ending on or after the Transactions as a result of certain net operating losses and certain other tax attributes of Change Healthcare, Inc. as of the date of the Transactions. The 2017 Tax Receivable Agreement is considered a loss contingency under FASB ASC Topic 450 and is reflected on the accompanying consolidated balance sheet at the amount that is both probable and reasonably estimable with future changes in this value being reflected within pretax income or loss.

McKesson Tax Receivable Agreement

The McKesson Tax Receivable Agreement generally requires payment to affiliates of McKesson (the "McKesson TRA Parties") of 85% of certain cash tax savings realized (or, in certain circumstances, deemed to be realized) by HCIT in periods ending on or after the date on which McKesson ceases to own at least 20% of Parent as a result of (i) certain amortizable tax basis in assets transferred to Parent at the Contribution Agreement Closing and (ii) imputed interest deductions and certain other tax attributes arising from payments under the McKesson Tax Receivable Agreement. Because payments under the McKesson Tax Receivable Agreement are contingent upon McKesson's ceasing to own at least 20% of Parent and such an event was not probable at inception of the McKesson Tax Receivable Agreement or as of March 31, 2018, no related obligation has been reflected on the accompanying consolidated balance sheet.

Based on facts and circumstances at March 31, 2018, the Company estimates the aggregate payments due under these tax receivable agreements to be as follows:

	2009 - 2011 Tax Receivable Agreements	2017 Tax Receivable Agreement	Total
2019	$ 13,400	$ 11,603	$ 25,003
2020	25,416	1,190	26,606
2021	18,989	1,477	20,466
2022	19,027	3,019	22,046
2023	19,505	53,761	73,266
Thereafter	130,221	58,753	188,974
Gross expected payments	226,558	129,803	356,361
Less: Amounts representing discount	(108,195)	—	(108,195)
Total tax receivable agreement obligations due to related parties	118,363	129,803	248,166
Less: Current portion due (included in accrued expenses)	(13,400)	(11,603)	(25,003)
Tax receivable agreement obligations due to related parties	$ 104,963	$ 118,200	$ 223,163

The timing and/or amount of aggregate payments due may vary based on a number of factors, including the amount of net operating losses and income tax rates.

As a result of the finalization of a valuation of the 2017 Tax Receivable Agreement and other matters, for federal and state income tax return purposes, the Company recognized a change in estimate of $19,928 (decrease to operating income) during the year ended March 31, 2018 ($11,138 decrease to net income).

In addition, as discussed in Note 18, as a result of the Tax Legislation, the federal corporate income tax rate was reduced effective January 1, 2018. Because amounts due under the tax receivable agreements fluctuate with changes in tax rates, among other factors, the decrease in the federal corporate income tax rate resulted in a corresponding decrease in the tax receivable agreements obligations. During the year ended March 31, 2018, the Company recognized a change in estimate (increase to operating income) of $88,741 as a result of this change in the federal corporate tax rate, which resulted in a $63,755 increase to net income. The change in estimate is a provisional estimate under SAB 118 due to the impact of the Tax Legislation.

20. Other Related Party Transactions

Advances to Members

Under the terms of the LLC Agreement, Parent, using funds from the Company, is required to periodically advance to its members amounts necessary to fund their respective tax obligations on an interim basis, subject to recoupment in the event that such advances exceed the final tax obligations of the respective Members for such year. Once the final tax obligations of each of the Members is determined for such year, Parent is obligated to formally distribute such amounts to the respective Members. To the extent that the amounts to be distributed were subject to interim advances, additional cash will be distributed only to the extent that the interim

advances were insufficient to fund the respective Member's final tax obligation. Distributions up to the amount of interim advances result in full settlement of any advances to the respective Member.

Advances to Members totaled $15,828 and $0 during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. Such amounts are classified as a component of Members' deficit in the accompanying consolidated balance sheets.

Dilution

Under the terms of the LLC Agreement, Parent and HCIT agreed to cooperate to ensure a 1:1 ratio of HCIT shares outstanding to units of Parent held by HCIT for as long as the McKesson members hold units of Parent. Specifically, the parties agreed that:

- In the event that HCIT issues additional shares, Parent is required to issue a corresponding number of units to HCIT.
- Any net proceeds received by HCIT with respect to an HCIT share must be concurrently contributed to Parent.
- Any stock split or combination of other equity restructuring involving HCIT shares must be concurrent with an equivalent unit split or other equity restructuring of Parent.
- HCIT may not redeem, repurchase or otherwise acquire any HCIT shares unless substantially simultaneously Parent redeems, repurchases, or otherwise acquires from HCIT an equal number of units for the same price per security.
- Parent may not redeem, repurchase or otherwise acquire any units held by HCIT unless substantially simultaneously HCIT redeems, repurchases, or otherwise acquires an equal number of HCIT shares for the same price per security.

During the year ended March 31, 2018, Parent issued 2,200 units to HCIT and repurchased 71 units from HCIT. Because Parent has no independent assets or operations apart from its investment in the Company, activities of the Parent described above have been pushed down to the Company.

eRx Network Option Agreement

Prior to the Transactions, the equity interests for entities representing the eRx Network were distributed to the former CHC stockholders, and in connection therewith a CHC subsidiary and the CHC Stockholders entered into an option agreement for a subsidiary of Parent to acquire the eRx Network (the "Option Agreement"). Under the terms of the Option Agreement, the option to acquire the eRx Network will only become exercisable at any such time that McKesson owns (directly or indirectly), in the aggregate, less than 5% of the outstanding Units of Parent. Such option will expire, unexercised or unexercisable, on the fifth anniversary of the Transactions. Under the Option Agreement, upon exercise of the option, a CHC subsidiary will be required to pay an exercise price of $1.00 plus a fixed multiple of the incremental increase (if any) in the EBITDA (as defined in the Option Agreement) of the eRx Network for the trailing 12 months preceding the exercise of the option over a baseline level of such EBITDA.

Management Services Agreement

Parent, certain subsidiaries of Parent, McKesson and affiliates of Blackstone and Hellman & Friedman (such affiliates of Blackstone and Hellman & Friedman referred to herein collectively as "the Sponsors"), entered into a Management Services Agreement, whereby McKesson and the Sponsors will be retained to provide certain management, consulting, financial and other advisory services to the Company for certain periods following the consummation of the Transactions for an annual fee not to exceed 1% of our EBITDA (as defined in the Senior Credit Facilities) in the applicable fiscal year, subject to proration as applicable. Under the Management Services Agreement, McKesson and the Sponsors may also receive certain fees in connection with certain specific transactions involving the Company, including a Qualified IPO.

The Company recognized $10,488 ($2,281 for Blackstone, $865 for Hellman & Friedman and $7,342 for McKesson) and $888 ($193 for Blackstone, $73 for Hellman & Friedman and $622 for McKesson) in management fees during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. The management fees are reflected within sales, marketing, general and administrative expense in the accompanying consolidated statements of operations.

Transition Services Agreements

In connection with the consummation of the Transactions, Parent, certain subsidiaries of Parent, McKesson and the eRx Network entered into transition services agreements pursuant to which (i) the Company will provide certain transition services to

McKesson and to the eRx Network and (ii) McKesson will provide certain transition services to the Company, in each case in exchange for specified fees and subject to the terms and conditions therein.

The Company recognized transition service fee expense of $92,053 and $8,658 for services received from McKesson during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. In addition, the Company recognized $11,834 and $817 in transition fee income from eRx Network in these same periods. The transition service fees paid or to be paid to McKesson are reflected net within sales, marketing, general and administrative expense in the accompanying consolidated statements of operations. The amounts received or to be received from eRx Network are reflected in other income in the accompanying statement of operations. The related balance sheet effect of these agreements is reflected within due to related party, net on the accompanying consolidated balance sheets. Cash flows related to these agreements are reflected in operating activities in the accompanying consolidated statements of cash flows.

eRx Network Line of Credit

In addition, the Company provided eRx Network at the closing of the Transactions with a $3,000 line of credit due November 30, 2017 of which $300 had been drawn at March 31, 2017. This amount was subsequently repaid during the twelve months ended March 31, 2018.

Services Provided to HCIT by the Company

HCIT generally has no substantive independent assets or operations apart from its investment in the Company. As a result, the Company provides certain services for which it is not reimbursed. These services include the utilization of office space and a portion of the salaries of HCIT's officers who are considered employees of the Company.

Employer Healthcare Program Agreement with Equity Healthcare

Effective as of January 1, 2014, CHC entered into an employer health program agreement with Equity Healthcare LLC ("Equity Healthcare"), an affiliate of Blackstone, pursuant to which Equity Healthcare provides to the Company certain negotiating, monitoring and other services in connection with the Company health benefit plans. In consideration for Equity Healthcare's services, the Company paid Equity Healthcare a fee of $3.00 per participating employee per month for plans through December 31, 2017. Beginning January 1, 2018, the Company began paying Equity Healthcare a fee of $1.00 per participating employee per month.

Term Loans Held by Related Party

During the period from June 17, 2016 (inception) to March 31, 2017, certain investment funds managed by GSO Capital Partners LP (the "GSO-managed funds") held a portion of the term loans under the Senior Credit Facilities. GSO Advisor Holdings LLC ("GSO Advisor") is the general partner of GSO Capital Partners LP. Blackstone, indirectly through its subsidiaries, holds all of the issued and outstanding equity interests of GSO Advisor. As of March 31, 2018 and 2017, respectively, the GSO-managed funds held $29,838 and $200,000 in principal amount of the Senior Credit Facilities ($298 and $2,000 of which is classified within current portion of long-term debt at March 31, 2018 and 2017, respectively).

Transactions with Blackstone Portfolio Companies

The Company both provides various services to, and purchases services from, certain Blackstone portfolio companies under contracts that were executed in the normal course of business. The Company recognized revenue of approximately $4,366 and $400 related to services provided to Blackstone portfolio companies during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. The Company paid Blackstone portfolio companies approximately $16,251 and $100 related to services provided to the Company during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively.

Transactions with Hellman & Friedman Portfolio Companies

The Company both provides various services to, and purchases services from, certain Hellman & Friedman portfolio companies under contracts that were executed in the normal course of business. The Company recognized revenue of approximately $4,955 and $400 related to services provided to Hellman & Friedman portfolio companies during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. The Company paid Hellman & Friedman portfolio companies approximately $2,509 and $10 related to services provided to the Company during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively.

Other Transactions with McKesson

The Company both provides various services to, and purchases services from, McKesson, and its affiliates. Services are provided to McKesson and its affiliates through customer arrangements and through subleasing of certain office space. The Company recognized revenue of approximately $13,354 and $1,511 related to services provided to McKesson and its affiliates during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. The Company recognized sublease income of $3,806 and $394 from McKesson and its affiliates during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively and the Company incurred rent and other expense of $918 and $102 with McKesson and affiliates during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively.

Other

The Company has executed agreements with a vendor and its affiliate in which a director of the Company is the president and chief executive officer to provide certain software related services. Under these agreements, the Company paid the vendor approximately $30 in the aggregate during the period from June 17, 2016 (inception) to March 31, 2017.

Additionally, the Company has an agreement with a customer in which a former officer of the Company is a member of the board of directors of the customer. Under this agreement, the Company recognized revenue of approximately $7,482 and $76 in the aggregate during the year ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively.

21. Segment Reporting

Management views the Company's operating results based in three reportable segments: (a) software and analytics (which represents the aggregation of two operating segments), (b) network solutions and (c) technology-enabled services. Listed below are the revenue and Adjusted EBITDA for each of the reportable segments. This information is reflected in the manner utilized by management to make operating decisions, assess performance and allocate resources. Such amounts include allocations of corporate shared services functions that are essential to the core operations of the reportable segments such as information technology, operations and product development functions. Segment assets and related depreciation expenses are not presented to management for purposes of operational decision making, and therefore are not included in the accompanying tables. The accounting policies of the reportable segments are the same as those described in the summary of significant accounting policies in Note 2 to these consolidated financial statements.

Software and Analytics

The software and analytics segment provides software and analytics solutions for financial performance, payment accuracy, clinical decision management, value-based payment, provider and consumer engagement and imaging and clinical workflow.

Network Solutions

The network solutions segment enables financial, administrative and clinical transactions, electronic business to business and consumer to business payments and aggregation and analytics of clinical and financial data.

Technology-enabled Services

The technology-enabled services segment provides solutions for financial and administrative management, value-based care, communication and payment, pharmacy benefits administration and healthcare consulting.

Corporate and Eliminations

Inter-segment revenue and expenses primarily represent claims management and payment and communication solutions provided between segments.

Corporate and eliminations includes pass-through postage costs, management, administrative and certain other shared corporate services functions such as legal, finance, human resources and marketing, eliminations to remove inter-segment revenue and expenses, and consolidating adjustments to classify certain rebates paid to channel partners as a reduction of revenue. These administrative costs are excluded from the adjusted EBITDA measure for each respective operating segment.

The revenue and adjusted EBITDA for the operating segments are as follows:

Change Healthcare Holdings, LLC
Notes to Consolidated Financial Statements
(In Thousands, Except Per Share, Unit and Per Unit Amounts)

	Year Ended March 31, 2018				
	Software Analytics	Network Solutions	Technology-enabled Services	Corporate Eliminations	Consolidated
Revenue from external customers:					
Solutions revenue	$ 1,442,843	$ 611,287	$ 994,722	$ (24,406)	$ 3,024,446
Postage revenue	—	—	—	274,397	274,397
Inter-segment revenue	1,773	8,866	12,226	(22,865)	—
Net revenue	$ 1,444,616	$ 620,153	$ 1,006,948	$ 227,126	$ 3,298,843
Adjusted EBITDA	$ 598,273	$ 304,150	$ 198,876	$ (157,461)	$ 943,838
Equity compensation					24,700
Acquisition accounting adjustments					2,581
Acquisition and divestiture-related costs					1,801
Transactions-related costs					4,626
Integration and related costs					107,194
Management fees and related costs					11,472
Costs related to recently issued accounting standards					26,594
Strategic initiatives, duplicative and transition costs					12,313
Severance costs					38,277
Accretion and changes in estimate, net					(49,991)
Impairment of long-lived assets					839
Loss on extinguishment of debt					—
Other non-routine, net					33,755
EBITDA Adjustments					214,161
Interest expense					292,463
Depreciation and amortization					278,363
Amortization of capitalized software developed for sale					18,303
Income (loss) before income tax provision (benefit)					$ 140,548

	Period from June 17, 2016 to March 31, 2017				
	Software Analytics	Network Solutions	Technology-enabled Services	Corporate Eliminations	Consolidated
Revenue from external customers:					
Solutions revenue	$ 138,481	$ 57,077	$ 90,231	$ (2,334)	$ 283,455
Postage revenue	—	—	—	26,132	26,132
Inter-segment revenue	306	152	1,424	(1,882)	—
Net revenue	$ 138,787	$ 57,229	$ 91,655	$ 21,916	$ 309,587
Adjusted EBITDA	$ 53,010	$ 21,397	$ 18,302	$ (10,528)	$ 82,181
Equity compensation					715
Acquisition accounting adjustments					46
Acquisition and divestiture-related costs					25
Transactions-related costs					43,297
Integration and related costs					8,775
Management fees and related costs					893
Costs related to recently issued accounting standards					1,611
Strategic initiatives, duplicative and transition costs					921
Severance costs					2,227
Accretion and changes in estimate, net					(24,507)
Impairment of long-lived assets					48,700
Loss on extinguishment of debt					70,122
Other non-routine, net					3,540
EBITDA Adjustments					156,365
Interest expense					22,361
Depreciation and amortization					26,548
Amortization of capitalized software developed for sale					1,505
Income (loss) before income tax provision (benefit)					$ (124,598)

22. Accumulated Other Comprehensive Income (Loss)

The following is a summary of the accumulated other comprehensive income (loss) balances, net of taxes, as of and for the year ended March 31, 2018 and for the period from June 17, 2016 (inception) to March 31, 2017.

	Foreign Currency Translation Adjustment	Cash Flow Hedge	Accumulated Other Comprehensive Income (Loss)
Balance at June 17, 2016 (inception)	$ —	$ —	$ —
Contribution of accumulated other comprehensive income (loss)	(19,055)	592	(18,463)
Change associated with foreign currency translation	86	—	86
Change associated with current period hedging (net of taxes of $1,246)	—	(1,769)	(1,769)
Reclassification into earnings	—	(3)	(3)
Balance at March 31, 2017	$ (18,969)	$ (1,180)	$ (20,149)
Change associated with foreign currency translation	4,146	—	4,146
Change associated with current period hedging (net of taxes of $4,316)	—	6,288	6,288
Reclassification into earnings	—	1,110	1,110
Balance at March 31, 2018	$ (14,823)	$ 6,218	$ (8,605)

23. Subsequent Events

Sale of Barista Operations, LLC

In July 2018, an affiliate of the Company sold all of the membership interests of Barista Operations, LLC, which was comprised of the Company's extended care solutions business (a component of the software and analytics reportable segment) to ECS Acquisition Co. LLC, for cash of $167,500, subject to certain post-closing adjustments.

Change in Segment Presentation

In April 2018, the Company moved its clinical network solution and certain of its institutional provider customers from the Network Solutions reportable segment to the Software & Analytics reportable segment. The Company expects to present this change retrospectively beginning with its financial statements for the first quarter of fiscal 2019.

The Company has evaluated subsequent events through July 27, 2018, the date the financial statements were available to be issued.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

References in this discussion and analysis to the "Company", "Change Healthcare", "we", "us" and "our" refer to Change Healthcare Holdings, LLC and its direct and indirect subsidiaries.

In addition to historical data, this discussion contains forward-looking statements about our business, operations and financial performance based on current expectations that involve risks, uncertainties and assumptions. Our actual results may differ materially from those discussed in the forward-looking statements as a result of various factors, including but not limited to those discussed in "Cautionary Notice Regarding Forward-Looking Statements" elsewhere in this Annual Report.

Overview

Change Healthcare is one of the largest independent healthcare technology companies in the United States, formed through the combination of substantially all of the businesses of Change Healthcare, Inc. ("CHC") and a majority of the McKesson Technology Solutions business (the "MTS Business"), which was completed on March 1, 2017 (the "Transactions"). We provide software and analytics, network solutions and technology-enabled services that help our customers obtain actionable insights, exchange mission-critical information, control costs, optimize revenue opportunities, increase cash flow and effectively navigate the shift to value-based healthcare. We believe that we are well positioned to enable improved efficiencies and insights before, during and after patient encounters for all major stakeholders across the healthcare system, including commercial and governmental payers, employers, hospitals, physicians and other providers, laboratories and consumers. We believe that our solutions deliver significant value to our customers and other stakeholders, including:

• *Payers:* Solutions to address payment accuracy, consumer and member engagement, network management and the transition to value-based payments;

• *Providers:* Capabilities to help our customers manage revenue and financial risk, optimize patient access, ensure clinically appropriate care and manage claims and payments across the revenue cycle; and

• *Consumers:* Digital tools to access personal health information, engage with providers, enable electronic payment and make smart healthcare choices based on quality, cost and convenience.

The foundation of our business is a pervasive, industry-leading healthcare transaction network. Our Intelligent Healthcare Network™ is one of the largest healthcare financial and administrative networks in the United States, reaching nearly all government and commercial payers (approximately 2,100 connections), approximately 800,000 physicians, 117,000 dentists, 60,000 pharmacies, 5,500 hospitals, nearly 400 vendors and 600 laboratories. Our combined predecessor networks processed over 12 billion healthcare-related transactions, covering over $2 trillion in claims and touching one in five United States patient records. We have developed our network of payers and providers over 35 years and connect to the vast majority of private and government payers and claim-submitting providers in a hybrid cloud-based, user-centric and secure infrastructure environment.

In addition to our foundational healthcare transaction network, we believe that the breadth of our software and analytic products and technology-enabled services enhances our value proposition and bolsters our position as a preferred strategic partner to help customers address increasing demands for efficiency, administrative simplification and value-based care.

Segments

We report our financial results in the following three reportable segments: Software and Analytics, Network Solutions and Technology-Enabled Services.

- Software and Analytics provides software and analytics solutions for financial performance, payment accuracy, clinical decision management, value-based payment, provider and consumer engagement and imaging and clinical workflow.

- Network Solutions enables financial, administrative and clinical transactions, electronic business-to-business and consumer-to-business payments and aggregation and analytics of clinical and financial data.

- Technology-Enabled Services provides solutions for financial and administrative management, value-based care, communication and payment, pharmacy benefits administration and healthcare consulting.

Factors Affecting our Financial Condition and Results of Operations

The following are certain key factors that affect, will affect, or have recently affected, our financial condition and results of operations:

Recent Developments

In connection with the combination of CHC and the MTS Business, we were obligated to pay McKesson for working capital contributed to us in excess of previously estimated values along with reimbursement of certain transaction expenses. During the twelve months ended March 31, 2018, we paid McKesson $126.0 million in final settlement of these matters.

On December 22, 2017, H.R.1, also known as the Tax Cuts and Jobs Act of 2017 ("Tax Legislation"), was signed into law. The Tax Legislation significantly revises the U.S. corporate income tax by, among other things, lowering corporate income tax rates, placing limits on the utilization of net operating loss carryovers, implementing the territorial tax system and imposing a repatriation tax on deemed repatriated earnings of foreign subsidiaries. We estimate that the enactment of the Tax Legislation resulted in an increase in net income of approximately $121.8 million for the twelve months ended March 31, 2018, which included $33.0 million related to income tax benefit and $88.7 million related to the resulting reduction of our tax receivable agreements obligations.

In January 2018, we acquired all of the equity interests of National Decision Support Company, LLC, a provider of cloud-based solutions which deliver medical guidelines to the point-of-care directly through bi-directional integrations with the electronic medical records. The consideration transferred consisted of cash paid at the closing of $94.5 million (net of cash acquired of $6.7 million and subject to a subsequent working capital adjustment), settlement of a pre-existing relationship of $6.0 million and possible future consideration of a maximum of $20.0 million that varies contingent upon the attainment of certain future revenue and contribution margin objectives.

In February 2018, the Company, through one of its wholly-owned subsidiaries, entered into an Amended and Restated Master Services Agreement (the "Agreement") with Wipro, LLC and Wipro Limited (jointly, "Wipro"). The term of the Agreement is ten years, with the Company having three one-year renewal options. The Company has committed to purchase services from Wipro through the initial ten-year term of the Agreement (the "Minimum Commitment") in the amount of $1.0 billion. Under the Agreement, Wipro will globally provide the Company with professional services for information technology (including infrastructure, application development and maintenance), business process outsourcing, call center services and similar services. As the Company orders specific services under the Agreement the parties will execute Statements of Work describing the specific scope of the services to be performed by Wipro. The amount of the Minimum Commitment may be reduced on the occurrence of certain events, some of which also provide the Company the right to terminate the Agreement. If the Company has not fully satisfied the Minimum Commitment (as reduced) by the end of the initial ten-year term, it is required to pay Wipro 25% of the shortfall.

The Transactions

Pursuant to the terms of the Contribution Agreement, (i) the CHC stockholders, directly and indirectly, transferred ownership of CHC to us in consideration of (a) the payment at the closing of the Transactions by us to CHC's stockholders and certain participants in the Change Healthcare, Inc. Amended and Restated 2009 Equity Incentive Plan (the "CHC Equity Plan") of approximately $1.8 billion and (b) the issuance to CHC's stockholders of membership interests representing approximately 30% of Parent's equity interests with such interests being held by CHC's stockholders indirectly through HCIT; and (ii) McKesson caused MTS to be transferred to us in consideration of (a) the assumption and subsequent payment at the closing of the Transactions by us to McKesson of a promissory note in the amount of approximately $1.3 billion, (b) the issuance of membership interests in Parent representing approximately 70% of Parent's equity interests and (c) a tax receivable agreement from Parent. These payments to McKesson and the former CHC stockholders have been reflected as distributions in the consolidated statement of members' deficit.

In connection with the Transactions, we entered into a new senior secured credit facility, consisting of a term loan facility in the amount of $5.1 billion and a revolving credit facility in an aggregate principal amount of $500 million, and issued $1.0 billion of 5.75% senior notes due 2025. The proceeds were used to make all payments to the CHC stockholders, certain participants in the CHC Equity Plan and McKesson described above, to refinance certain of CHC's existing indebtedness and to pay fees and expenses incurred in connection with the Transactions. In connection with the Transactions, we recognized certain fees and expenses in fiscal 2017 that have been classified within sales, marketing, general and administrative on the consolidated statements of operations and during this same period, we recognized a loss on extinguishment of debt of approximately $70.1 million.

Macroeconomic and Industry Trends

The healthcare industry is highly regulated and subject to frequently changing complex regulatory and other requirements. For example, ongoing healthcare reform has significantly affected the healthcare regulatory environment by changing how healthcare services are covered, delivered and reimbursed through coverage expansion, reduced federal healthcare program spending, increased efforts to link federal healthcare program payments to quality and efficiency and insurance market reforms. The number of states that will ultimately participate in some form of Medicaid expansion and the future of mandated coverage for individuals is not yet clear. If the Patient Protection and Affordable Care Act (collectively, the "ACA") is repealed or significantly modified, such repeal or modification, any alternative reforms adopted in its place or the failure to adopt alternative reforms may have a material impact on our business. For example, since many of our products and services include solutions designed to assist customers in effectively navigating the shift to value-based healthcare, the elimination of, or significant reductions to, the ACA's various value-based healthcare initiatives may adversely impact our business. While the specific regulatory instruments and tactics used to implement reform may change in the future, we expect that the pervasive focus on improving coverage, efficiency and quality and related needs for payers and providers to optimize performance and reduce costs will continue.

Post-Contribution Cost Synergies

In connection with the Transactions, we have identified opportunities to implement certain cost synergies based on our analyses of existing operating structures, estimated spend by category, our resource requirements and industry benchmarks for similar activities. We expect such cost synergies to include, among others, (i) product integration, network efficiencies and combining common products; (ii) procurement savings from the elimination of duplicate orders, leveraging scale and optimization of providers; (iii) utilization of global talent; and (iv) reduction of management redundancies and duplicative roles.

By the end of the third year following the combination of the CHC and the MTS Business, we expect to have implemented operational initiatives to achieve approximately $150.0 million in annual run-rate synergies, which are expected to be fully realized by the end of the fourth year following such closing. We expect to incur significant non-recurring costs in order to achieve these cost synergies.

Equity-based Compensation

HCIT grants equity-based awards of HCIT common stock to certain employees, officers and directors of HCIT, eRx Network, and the Company (collectively, the "Company Group"). For grants to employees, equity-based awards are generally measured at the date of grant and recognized as expense over each employee's service period. Because the Company's employees are not considered employees of HCIT, however, the Company is generally required to re-measure these equity-based awards at fair value each quarter until the earlier of the completion of required service or the performance commitment date. As a result, management expects that its results of operations may reflect volatility from the periodic re-measurement of its equity based awards. Such volatility can result from changes in the fair value of the underlying stock of HCIT, stock price volatility among its peer companies, changes in interest rates and the passage of time.

Acquisitions and Divestitures

We actively evaluate opportunities to improve and expand our business through targeted acquisitions that are consistent with our strategy. On occasion, we also may dispose of certain components of our business that no longer fit within our overall strategy. Because of our acquisition and divestiture activity as well as the shifting revenue mix of our business due to this activity, our results of operations may not be directly comparable among periods. The following summarizes our significant acquisition transactions since March 1, 2017 and affected segments:

Date	Business	Description	Affected Segment
January 2018	National Decision Support Company, LLC ("NDSC")	Provider of cloud-based solutions which deliver medical guidelines to the point-of-care through bi-directional integrations with the electronic medical records.	Software and Analytics

In certain cases, we agree to transfer additional consideration to the sellers of the acquired businesses in the event that specified performance measures are achieved, including with NDSC. United States generally accepted accounting principles generally require us to recognize the initial fair value of the expected amount to be paid under such contingent consideration arrangements as a component of the total consideration transferred. Subsequent changes in the fair value of the amounts expected to be paid, however,

are generally required to be recognized as a component of net income. Such changes in fair value may occur based on changes in the expected timing or amount of payments or the effect of discounting the liability for the time value of money.

Income Taxes

Our effective income tax rate is affected by several factors. The following table and subsequent commentary reconciles our federal statutory rate to our effective income tax rate and the subsequent commentary describes the more significant of the reconciling factors:

	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Statutory U.S. federal tax rate	31.50 %	35.00 %
State income taxes (net of federal benefit)	(1.72)	3.49
Income passed through to Members	(8.78)	(10.64)
Remeasurement of deferred tax assets and liabilities arising from the Tax Legislation	(42.95)	—
Transition tax arising from the Tax Legislation	1.68	—
Fees and expenses related to the Transactions	—	1.97
Change in valuation allowance	(11.97)	(2.38)
Accretion and changes in estimate, net	(5.47)	5.01
Other	0.39	0.46
Effective income tax rate	(37.32) %	32.91 %

State Income Taxes—Our effective tax rate for state income taxes is generally impacted by changes in our apportionment.

Income Passed through to Members—Certain of our subsidiaries are organized as limited liability corporations and report income that is distributed to the Members where it is subject to income taxes.

Remeasurement of deferred tax assets and liabilities—As a result of the lowering of enacted tax rates under the Tax Legislation, we were required to revalue our deferred tax assets and liabilities using the tax rates in effect at the time the temporary differences are expected to reverse.

Transition tax arising from the Tax Legislation--Following the enactment of the Tax Legislation, companies must now pay a transition tax on deemed repatriated earnings of foreign subsidiaries.

Fees and expenses related to the Transactions—In connection with the Transactions, we incurred certain fees and expenses that are not considered deductible for tax purposes.

Change in Valuation Allowance--We record valuation allowances or reverse existing valuation allowances related to assumed future income tax benefits depending on circumstances and factors related to our business. During the year ended March 31, 2018, we released a valuation allowance related to prior deferred tax assets as a result of our change in judgment resulting from transactions and tax planning strategies that provide for future taxable income in the relevant jurisdictions.

Accretion and changes in estimate, net—As a result of a prior business combination, we were required to record our 2009-2011 Tax Receivable Agreements at their then fair value which results in subsequent periodic accretion to adjust this initial fair value to the gross amount of payments due under such agreements. We generally are unable to deduct such accretion when determining our taxable income.

Impairment of Long-lived Assets and Related Costs

In connection with the combining of the businesses in connection with the Transactions, we identified certain redundancies among the combined software and analytics segment product portfolio. In one such instance, one of the contributed businesses' software products had been fully developed and in the other further development would be required. As a result, we determined to cease future development of this redundant internal use software product and recognized an impairment charge of $26.0 million to reduce the carrying value of the asset to zero in March 2017. Additionally, because this abandoned software project included a license that required annual maintenance expenditures for future years for which we do not expect to derive any economic benefit, we recognized a liability for this exit cost with a fair value of $19,137 at March 1, 2017 (total expected remaining payments of $22,913).

The related losses have been included with the Impairment of long-lived assets and related costs caption within the consolidated statement of operations.

Key Components of Our Results of Operations

Revenue

We generate most of our solutions revenue by using technology solutions to provide services to our customers that automate and simplify business and administrative functions for payers, providers and pharmacies and through the licensing of software, software systems (consisting of software, hardware and maintenance support) and content.

Cost of Operations

Cost of operations consists primarily of compensation expense related to personnel providing services to our customers and costs associated with the maintenance of our business operations. These costs primarily include materials, hardware costs, and costs for software maintenance. Cost of operations also includes royalties, rebates paid to channel partners (net of rebates to certain customers that offset revenue), data communication costs, facility rent expenses as well as amortization costs associated with capitalized software developed for sale.

Research and Development

Research and development costs consist primarily of personnel costs and professional service fees for outside service providers that are not otherwise capitalized as software.

Sales, Marketing, General and Administrative Expense

Sales, marketing, general and administrative expense consists primarily of personnel costs associated with our sales, account management and marketing functions, as well as management, administrative and other shared corporate services related to the operations of our reportable segments and overall business operations.

Customer Postage

Customer postage, which is generally billed as a pass-through cost to our customers, is the most significant cost incurred in the delivery of our communication and payment solutions. Our postage costs and related revenues increase as our communication and payment solutions volumes increase and are also impacted when the United States Postal Service ("USPS") changes postage rates. Effective January 21, 2018, the USPS increased the cost of first class postage by approximately 2%.

Depreciation and Amortization

Depreciation and amortization expense is related to depreciation of our property and equipment, acquired intangible assets, including technology assets, as well as the amortization of capitalized software developed for internal use.

Accretion and Changes in Estimate, Net

Accretion and changes in estimate, net reflects the accretion of the carrying value of our 2009-2011 Tax Receivable Agreements to the full amount of the expected payments using the interest method as well as the effects of periodic changes in estimate related to this agreement and the 2017 and McKesson Tax Receivable Agreements.

Non-Operating Income and Expense

Non-operating income and expense includes loss on extinguishment of debt, interest expense, interest income, transition service agreement fee income and other non-operating income and expenses.

Results of Operations

As discussed in the accompanying notes to the condensed consolidated financial statements, no substantive assets or operations were contributed to the Company until March 2017. As a result, no comparative financial information is available for any periods prior to March 2017.

Key Performance Measures

Management, including our chief operating decision maker, evaluates the financial performance of our businesses based on a variety of key indicators. These indicators include the non-GAAP measure Adjusted EBITDA and the GAAP measures revenue, cash provided by operating activities and cash paid for capital expenditures. For the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, these key indicators were as follows:

(in millions)	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017	$ Change	% Change
Revenue	$ 3,298.8	$ 309.6	$ 2,989.2	965.5%
Reconciliation of net income (loss) to Adjusted EBITDA [1]:				
Net income (loss)	$ 193.0	$ (83.6)	$ 276.6	-330.9%
Net interest expense	292.5	22.4	270.1	1205.8%
Income tax provision (benefit)	(52.5)	(41.0)	(11.5)	28.0%
Depreciation and amortization	278.4	26.5	251.9	950.6%
Amortization of software developed for sale	18.3	1.5	16.8	1120.0%
EBITDA	729.7	(74.2)	803.9	-1083.4%
Adjustments to EBITDA:				
Equity compensation [2]	24.7	0.7	24.0	3428.6%
Acquisition accounting adjustments [3]	2.6	—	2.6	—
Acquisition and divestiture-related costs [4]	1.8	—	1.8	—
Transactions-related costs [5]	4.6	43.3	(38.7)	-89.4%
Integration and related costs [6]	107.2	8.8	98.4	1118.2%
Management fees and related costs [7]	11.5	0.9	10.6	1177.8%
Costs related to recently issued accounting standards [8]	26.6	1.6	25.0	1562.5%
Strategic initiatives, duplicative and transition costs [9]	12.3	0.9	11.4	1266.7%
Severance costs [10]	38.3	2.2	36.1	1640.9%
Accretion and changes in estimate, net [11]	(50.0)	(24.5)	(25.5)	104.1%
Impairment of long-lived assets [12]	0.8	48.7	(47.9)	-98.4%
Loss on extinguishment of debt [13]	—	70.1	(70.1)	-100.0%
Other non-routine, net [14]	33.8	3.5	30.3	865.7%
Total Adjustments to EBITDA	214.2	156.2	58.0	37.1%
Adjusted EBITDA	$ 943.9	$ 82.0	$ 861.9	1051.1%
Other Metrics:				
Cash provided by (used in) operating activities	$ 324.8	$ (40.7)	$ 365.5	-898.0%
Capital expenditures	$ 166.6	$ 11.6	$ 155.0	1336.2%

As a result of displaying amounts in millions, rounding differences may exist in the table above.

(1) Adjusted EBITDA is defined as net income (loss) before net interest expense, income tax provision (benefit), depreciation and amortization and other adjustments noted in the table above. We present Adjusted EBITDA as a supplemental measure of our operating performance because it eliminates the impact of certain items that we do not consider indicative of our ongoing operating performance. Also, we believe Adjusted EBITDA is a measure frequently used by securities analysts, investors and other interested parties in their evaluation of the operating performance of companies similar to ours. In addition, our board of directors and executive management team use Adjusted EBITDA as a compensation measure under our incentive compensation plan. Furthermore, under the credit agreement governing our senior secured credit facility, our ability to engage in activities such as incurring additional indebtedness, making investments and paying dividends is tied to a ratio based on Adjusted EBITDA. See "Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources - Debt." Adjusted EBITDA does not reflect our capital expenditures, interest, income tax, depreciation, amortization, stock-based compensation and certain other income and expense items. Other companies in our industry may calculate Adjusted EBITDA differently than we do, limiting its usefulness as a comparative measure. Because of these limitations, Adjusted EBITDA should not be considered in isolation or as a substitute for performance measures calculated in accordance with GAAP. Adjusted EBITDA is not a measure of financial condition or profitability under GAAP and should not be considered as an alternative to cash flows from operating activities, as a measure of liquidity or as an alternative to operating income or net income as indicators of operating performance. The most directly comparable GAAP measure to Adjusted EBITDA is net income. The table above provides a reconciliation from our net income (loss) to Adjusted EBITDA for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively.

(2) Represents non-cash equity-based compensation of HCIT to employees and directors of the Company. We believe excluding this non-cash expense allows us to compare operating performance without regard to the impact of equity-based compensation expense, which varies from period to period based on the timing of grants and value of the options.

(3) Represents adjustments that arose from acquisition method accounting following a business combination. These adjustments principally relate to the revaluation of deferred revenue to fair value and the subsequent reduction to recognized revenue. As the related revenue stream is an ongoing component of our business, we believe it is appropriate to consider these items in earnings in the period in which they would have been recognized absent the application of acquisition method accounting.

(4) Represents acquisition, divestiture and related costs charged to operations.

(5) Represents costs associated with the Transactions following the close of the Transactions and unrelated to integration efforts.

(6) Represents incremental costs incurred in connection with the integration of CHC and the MTS Business. Such costs include professional fees for consultants engaged in project management, process design, human resource policy harmonization, etc.

(7) Represents management and advisory fees paid to the Members pursuant to a management services agreement. Such fees will cease upon a qualified initial public offering of HCIT. As a result, we do not believe these costs represent an on-going cost of operating the business.

(8) Represents external costs related to upcoming changes in accounting standards regarding the recognition of revenue.

(9) Represents adjustments for advisory and consulting fees incurred in connection with strategic initiatives and significant operations efficiency measures including the rebranding of the Company and other costs.

(10) Represents severance costs which primarily relate to operational efficiency measures.

(11) Represents accretion of certain of our tax receivable agreement obligations from their initial fair value to the total expected payments due under the agreement as well as changes in estimate related to other tax receivable agreements. Because the amortized costs of these agreements are directly attributable to the Members and their affiliates, we do not believe they represent a routine ongoing cost of operations of a typical business.

(12) Represents impairment charges generally incurred in connection with the retirement of products or the abandonment of property and equipment or product development initiatives.

(13) Represents the loss on extinguishment of debt that resulted from the Transactions.

(14) Represents other non-cash or non-routine adjustments that management believes are not indicative of our ongoing operations.

Revenue

The below table summarizes revenue for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017 by segment and in total.

(in millions)	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017	$ Change	% Change
Software & Analytics	$ 1,444.6	$ 138.8	$ 1,305.8	940.8%
Network Solutions	620.2	57.2	563.0	984.3%
Technology-enabled Services	1,006.9	91.7	915.2	998.0%
Postage	274.4	26.1	248.3	951.3%
Total revenue, gross	$ 3,346.1	$ 313.8	$ 3,032.3	966.3%
Consolidating Adjustments and Intersegment Eliminations:				
Software & Analytics	$ (1.8)	$ (0.3)	$ (1.5)	500.0%
Network Solutions	(8.9)	(0.2)	(8.7)	4350.0%
Technology-enabled Services	(12.2)	(1.4)	(10.8)	773.3%
Consolidating Adjustments	(24.4)	(2.3)	(22.1)	960.9%
Total revenue, as reported	$ 3,298.8	$ 309.6	$ 2,989.2	965.5%

As a result of displaying amounts in millions, rounding differences may exist in the tables above.

Software and Analytics

Software and Analytics revenue for the twelve months ended March 31, 2018 was driven by strong volumes among the network and financial management, chart retrieval and clinical review and member engagement solutions, partially offset by lengthened sales cycles in the imaging, workflow and care solutions business as customers awaited further clarity regarding reimbursement models under the Patient Protection and Affordable Care Act ("ACA"). Other solutions in this portfolio remained relatively stable.

Network Solutions

Network Solutions revenue for the twelve months ended March 31, 2018 reflects a shift from one-time perpetual analytics software to SaaS-based solutions and the sunset of certain products. These revenue challenges were partially offset by new sales and implementations among the data solutions business which were facilitated by the expiration of the HLTH data sublicense agreement during the twelve months ended March 31, 2018. Following the termination of this HLTH data sublicense agreement, customers that previously received our services indirectly through HLTH, and for which we were only entitled to a royalty from HLTH, are being transitioned to direct customer relationships with us for which we are entitled to the full amount of revenue.

Technology-enabled Services

Technology-enabled Services revenue reflects the one-time write-off of a deferred sales incentive following a customer's early termination of its contract. Apart from this one-time write off, revenues reflect decreased volumes in our physician revenue cycle management and communication and payment services solutions which are each partially attributable to customer attrition resulting from industry consolidation.

Operating Expenses

Operating expenses for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017 were as follows:

(in millions)	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017	$ Change	% Change
Costs of operations	$ 1,407.9	$ 133.7	$ 1,274.2	953%
Research and development	221.7	22.6	199.1	881%
Selling, general, and administrative expense	749.9	109.9	640.0	582%
Customer postage	274.4	26.1	248.3	951%
Depreciation and amortization	278.4	26.5	251.9	951%
Accretion and changes in estimate, net	(50.0)	(24.5)	(25.5)	104%
Impairment of long-lived assets and related costs	0.8	48.7	(47.9)	-98%
Total operating expenses	$ 2,883.1	$ 343.0	$ 2,540.1	

As a result of displaying amounts in millions, rounding differences may exist in the table above.

Costs of Operations

Costs of operations were $1,407.9 million and $133.7 million, or 46.6% and 47.2% of solutions revenue for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. Cost of operations for the twelve months ended March 31, 2018 reflect severance costs associated with a May 2017 reduction in force. Cost of operations for the period from June 17, 2016 (inception) to March 31, 2017 reflects one month of routine operations.

Research and Development

Research and development expenses were $221.7 million and $22.6 million for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. Research and development expense for the twelve months ended March 31, 2018 reflects the absence of software maintenance costs associated with a software license that was abandoned in March 2017. Additionally, as with cost of operations, research and development expenses for the twelve months ended March 31, 2018 reflect severance costs associated with a May 2017 reduction in force, the benefit of which was reflected in the financial statements for the remainder of the twelve months ended March 31, 2018.

Selling, General and Administrative Expense

Selling, general and administrative expenses were $749.9 million and $109.9 million for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. Selling, general and administrative expense for the twelve months ended March 31, 2018 reflect significant integration related costs, including professional and consulting fees related to rationalizations of information technology, business process re-engineering, implementation of human resource and finance information technology systems, severance and other costs. In addition to these integration related costs, we are incurring significant costs related to efforts to design, plan for and implement new business processes associated with the upcoming adoption of ASU 2014-09, which we expect to adopt effective April 1, 2019. Selling, general and administrative expenses for the period from January 17, 2016 (inception) to March 31, 2017 was affected by non-recurring costs related to the Transactions.

Customer Postage

Customer postage was $274.4 million and $26.1 million for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. Customer postage is affected by the changes in volume in the communication and payment solutions. Because customer postage is a pass-through cost to our customers, however, changes in volume of customer postage generally have no effect on operating income.

Depreciation and Amortization

Depreciation and amortization was $278.4 million and $26.5 million for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. Depreciation and amortization for the twelve months ended

March 31, 2018 were generally affected by the effect of the NDSC acquisition, the routine amortization of tangible and intangible assets existing at March 31, 2017, as well as the routine amortization and depreciation of additions to property, equipment, and software since that date, partially offset by the effect of certain intangible assets becoming fully amortized during the period. Depreciation and amortization for the period from June 17, 2016 (inception) to March 31, 2017 reflects only routine depreciation and amortization.

Accretion and changes in estimate, net

Accretion and changes in estimate, net was a benefit of $50.0 million and $24.5 million for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. Accretion is routinely affected by changes in the expected timing or amount of cash flows which may result from various factors, including changes in tax rates.

Accretion and changes in estimate, net for the twelve months ended March 31, 2018 was affected by the Tax Legislation, the finalization of the valuation of the 2017 Tax Receivable Agreement and other matters. As a result of the Tax Legislation, the federal corporate income tax rate was reduced effective January 1, 2018. Because amounts due under the tax receivable agreements fluctuate with such changes in tax rates, among other factors, the decrease in the federal corporate income tax rate resulted in a corresponding decrease in the tax receivable agreements obligations. As a result, we recognized a change in estimate (increase to operating income) of $88.8 million as a result of this change in the federal corporate income tax rate.

With respect to the finalization of the valuation of the 2017 Tax Receivable Agreement and other matters, we recognized a change in estimate (decrease to operating income) of $19.9 million during the twelve months ended March 31, 2018.

Accretion and changes in estimate, net for the period from June 17, 2016 (inception) to March 31, 2017 was affected by the covered change in control provisions of the 2009-2011 Tax Receivable Agreements that were triggered by the Transactions. As a result of this covered change of control, payments we make under the 2009 - 2011 Tax Receivable Agreements are required to be calculated using certain valuation assumptions, including that we will have sufficient taxable income to use the applicable tax attributes and that certain of such tax attributes will be used on a pro rata basis from the date of the Transactions (or in certain cases from the date of certain previous transactions) through the expiration of the applicable tax attribute. As a result of the change in assumed valuation assumptions, we recognized a change in estimate (decrease to the pretax loss) of $26,475 for the period from June 17, 2016 (inception) to March 31, 2017.

Non-Operating Income and Expense

(in millions)	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017	$ Change	% Change
Interest expense	$ 292.5	$ 22.4	$ 270.1	1206%
Other (income) and expense, net	(17.2)	(1.3)	(15.9)	1223%
Loss on extinguishment of debt	—	70.1	(70.1)	-100%
Non-operating (income) and expense	$ 275.3	$ 91.2	$ 184.1	

As a result of displaying amounts in millions, rounding differences may exist in the table above.

Interest expense was $292.5 million and $22.4 million for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. Interest expense for the twelve months ended March 31, 2018 was impacted by the quarterly principal amortization of $12.8 million and changes in LIBOR, partially offset by the effect of our interest rate cap agreements.

Other income and expense, net primarily represents income we receive from McKesson and eRx Network related to transitional services that we provide them following the closing of the Transactions in March 2017.

The loss on extinguishment of debt resulted from the refinancing of prior debt in connection with the Transactions.

Income Tax Provision (Benefit)

The income tax benefit was $52.5 million and $41.0 million (which resulted in effective income tax rates of -37.3% and 32.9% for the twelve months ended March 31, 2018 and the period from June 17, 2016 (inception) to March 31, 2017, respectively. Our income taxes and related effective tax rate are routinely affected by our and our subsidiaries' legal organization. Certain of our subsidiaries are organized as limited liability corporations and report income that is distributed to the Members where it is subject to income taxes. Other subsidiaries are organized as corporations and report losses for which the tax effects are directly reflected in our financial statements.

In addition to these routine factors, however, income taxes for the twelve months ended March 31, 2018 were affected by the Tax Legislation, which was primarily associated with the re-measurement of deferred tax balances using the recently enacted tax rates. Income taxes for the twelve months ended March 31, 2018 were further affected by the finalization of a valuation of the 2017 Tax Receivable Agreement, changes in state apportionment and the release of state valuation allowances following implementation of certain tax planning strategies.

Significant Changes in Assets and Liabilities

In July 2017, the Company paid $126.0 million in settlement of its working capital and related obligations to McKesson in connection with the Transactions.

Adjusted EBITDA and Adjusted EBITDA Margins

(in millions)	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017	$ Change	% Change
Adjusted EBITDA by segment:				
Software & Analytics	$ 598.3	$ 53.0	$ 545.3	1028.9%
Network Solutions	$ 304.2	$ 21.4	$ 282.8	1321.5%
Technology-enabled Services	$ 198.9	$ 18.3	$ 180.6	986.9%
Adjusted EBITDA Margin by segment:				
Software & Analytics	41.4%	38.2%	—	3.2%
Network Solutions	49.0%	37.4%	—	11.6%
Technology-enabled Services	19.8%	20.0%	—	-0.2%

As a result of displaying amounts in millions, rounding differences may exist in the table above. Segment Adjusted EBITDA margins are calculated as the quotient of adjusted EBITDA and solutions revenue.

Software and Analytics

Software and Analytics adjusted EBITDA reflects a combination of the impact of financial management solutions and organic revenue growth across other solutions as well as the impact of cost reduction initiatives.

Network Solutions

As described above, Network Solutions revenue was affected by a shift from on-premise analytics software to SaaS-based solutions as well as the sunset of certain products within its clinical network solutions. The related effects on adjusted EBITDA, however, were largely mitigated by new revenue in the data solutions business as well as cost reductions resulting from headcount rationalization, rebate savings and other operational efficiency initiatives.

Technology-enabled Services

As described above, Technology-enabled Services revenue was affected by decreased volumes in the physician revenue cycle management and communication and payment services solutions. Adjusted EBITDA was similarly affected by these factors and further impacted by costs incurred to modernize our technology, make processes more efficient, and improve the customer experience.

Liquidity and Capital Resources

Overview

Our principal sources of liquidity are cash flows provided by operating activities, cash and cash equivalents on hand, and our senior secured revolving line of credit. Our principal uses of liquidity are working capital, capital expenditures, debt service, business acquisitions and other general corporate purposes. We anticipate our cash on hand, cash generated from operations, and funds available under the senior secured revolving line of credit will be sufficient to fund our planned capital expenditures, debt service obligations, business acquisitions and operating needs. We may, however, elect to raise funds through debt or equity financing in the future to fund significant investments or acquisitions that are consistent with our growth strategy.

Cash, cash equivalents and restricted cash totaled $50.0 million and $188.1 million at March 31, 2018 and 2017, respectively, of which $23.9 million and $28.3 million was held outside the United States. As of March 31, 2018, no amounts had been drawn under the senior secured revolving line of credit and we could have borrowed up to the additional $494.8 million available. We also have the ability to borrow up to an additional $1,080.0 million, or such amount that the Senior Secured Net Leverage ratio does not exceed 4.9 to 1.0, whichever is greater, under the senior secured credit facility, subject to certain additional conditions and commitments by existing or new lenders to fund any additional borrowings.

The balance retained in cash and cash equivalents is consistent with our short-term cash needs and investment objectives. We may be required to make additional principal payments on our senior secured term loan facility (the "Term Loan Facility") based on excess cash flows of the prior year, as defined in the credit agreement.

(in millions)	Year Ended March 31, 2018	Period from June 17, 2016 (inception) to March 31, 2017
Cash provided by (used in) operating activities	$ 324.8	$ (40.7)
Cash used in investing activities	(260.7)	(11.2)
Cash provided by (used in) financing activities	(197.5)	240.1
Effects of exchange rate changes on cash, cash equivalents and restricted cash	(4.7)	(0.2)
Net change in cash, cash equivalents and restricted cash	$ (138.1)	$ 188.1

Operating Activities

Cash provided by operating activities is primarily affected by operating income, including the impact of debt service payments, integration related costs and the timing of collections and related disbursements.

Investing Activities

Cash used in investing activities reflects routine capital expenditures related to purchase of property and equipment and the development of software as well as the acquisition of NDSC in January 2018.

Financing Activities

Cash used in financing activities reflects cash payments under the Term Loan Facility, distributions to the Members to fund their respective income tax obligations, payment of a working capital settlement to McKesson, payments under our interest rate cap agreements, and payments for deferred financing obligations.

Capital Expenditures

We incur capital expenditures to grow our business by developing new and enhanced capabilities, to increase the effectiveness and efficiency of the organization and to reduce risks. We incur capital expenditures for product development, disaster recovery, security enhancements, regulatory compliance and the replacement and upgrade of existing equipment at the end of its useful life.

Debt

Senior Credit Facilities and Senior Notes

In March 2017, we entered into the $5,100.0 million Term Loan Facility, and a $500.0 million revolving credit facility (the "Revolving Facility"; together with the Term Loan Facility, the "Senior Credit Facilities"). Additionally, we issued $1,000.0 million of 5.75% senior notes due 2025 (the "Senior Notes"). No amounts have been drawn against the Revolving Facility as of March 31, 2018.

Hedge

In March 2016 and 2017, CHC and we, respectively, entered into annuitized interest rate cap agreements with various counter parties that effectively cap our LIBOR exposure on a portion of our existing Term Loan Facility or similar replacement debt at 1.25% and 1.0%, respectively, beginning March 31, 2017. We have designated these cap agreements as cash flow hedges. The current notional amount under these agreements is $650.0 million and $750.0 million, respectively (an aggregate of $1,400.0 million). In March 2017, we began to pay the various counterparties a fixed rate on the outstanding notional amounts of 0.556% and 0.819% and receive payments to the extent LIBOR exceeds 1.25% or 1.0%, respectively, depending on the specific interest rate cap agreement.

The interest rate caps are recorded on the balance sheet at fair value. The effective portion of changes in the fair value of the interest rate cap agreements is recorded in other comprehensive income. The ineffective portion of changes in the fair value of the caps, which is due to, and will continue to result from, the cost of financing the cap premium, is recorded in interest expense. The effective portion of the change in the fair value of the caps resulted in an unrealized gain of $6.3 million, recorded in other comprehensive income for twelve months ended March 31, 2018. The ineffective portion of the change in the fair value of the caps resulted in a gain of $1.1 million recorded in interest expense for twelve months ended March 31, 2018.

In accordance with ASC 815, the fair value of the interest rate caps at inception is reclassified from other comprehensive income to interest expense in the same period the interest expense on the underlying hedged debt impacts earnings. Any payments we receive to the extent LIBOR exceeds 1.25% or 1.0%, respectively, is also reclassified from other comprehensive income to interest expense in the period received. Interest expense reclassified from other comprehensive income to a reduction of interest expense related to the fair value of the portion of the caps expiring in the months ended was $1.1 million. We expect to reclassify approximately $4.6 million from other comprehensive income to a reduction of interest expense in the next twelve months related to the fair value of the portion of the caps expiring and payments received to the extent LIBOR exceeds the applicable strike price.

Effect of Certain Debt Covenants

A breach of any of the covenants under the agreements governing our debt could limit our ability to borrow funds under the Term Loan Facility and could result in a default under the Term Loan Facility. Upon the occurrence of an event of default under the Term Loan Facility, the lenders could elect to declare all amounts then outstanding to be immediately due and payable, and the lenders could terminate all commitments to extend further credit. If we were unable to repay the amounts declared due, the lenders could proceed against any collateral granted to them to secure that indebtedness.

With certain exceptions, the Term Loan Facility obligations are secured by a first-priority security interest in substantially all of the assets of Change Healthcare Holdings, LLC, including its investment in subsidiaries. The Term Loan Facility contains various restrictions and nonfinancial covenants, along with a senior secured net leverage ratio test. The nonfinancial covenants include restrictions on dividends, investments, dispositions, future borrowings and other specified payments, as well as additional reporting and disclosure requirements. The senior secured net leverage test must be met as a condition to incur additional indebtedness, but

otherwise is applicable only to the extent that amounts drawn on the Revolving Facility exceed $175.0 million at the end of the fiscal quarter. As of March 31, 2018, we were in compliance with all debt covenants.

Our ability to meet our liquidity needs depends on our subsidiaries' earnings and cash flows, the terms of our and our subsidiaries' indebtedness, and other contractual restrictions. Except for certain permitted distributions, we generally are not permitted to make any distribution to the Members.

For additional information about our debt and hedge, see Part I, Item 1, "Notes to Consolidated Financial Statements," Note 10, "Long-term Debt."

Recent Accounting Pronouncements

See Part I, Item 1, "Notes to Consolidated Financial Statements," Note 2, "Summary of Significant Accounting Policies," for information about recent accounting pronouncements and the potential impact on our consolidated financial statements.

Critical Accounting Estimates

The preparation of financial statements in accordance with United States generally accepted accounting principles requires us to make estimates and assumptions that affect reported amounts and related disclosures. We consider an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been made could have a material impact on our consolidated results of operations and financial condition.

The following discussion of critical accounting estimates is not intended to be a comprehensive list of all of our accounting policies that require estimates and highlights only those policies that involve estimates that we believe entail a higher degree of judgment and complexity. We believe the current assumptions and other considerations used to estimate amounts reflected in our consolidated financial statements are appropriate. However, if actual experience differs from the assumptions and other considerations used in estimating amounts reflected in our consolidated financial statements, the resulting changes could have a material adverse effect on our consolidated results of operations and financial condition.

The discussion that follows presents information about our critical accounting estimates, as well as the effects of hypothetical changes in the material assumptions used to develop each estimate:

Revenue Recognition

We generate most of our solutions revenue by using technology solutions to provide services to our customers that automate and simplify business and administrative functions for payers, providers and pharmacies and through the licensing of software, software systems (consisting of software, hardware and maintenance support) and content.

Postage fees related to our payment and communication solutions volumes are recorded on a gross basis.

We exclude sales and use tax from revenue in the accompanying consolidated statements of operations.

We engage in multiple-element arrangements, which may contain any combination of software, hardware, implementation, SaaS-based offerings, consulting services or maintenance services. For multiple-element arrangements that do not include software, revenue is allocated to the separate elements based on their relative selling price and recognized in accordance with the revenue recognition criteria applicable to each element. Relative selling price is determined based on vendor specific objective evidence ("VSOE") of selling price if available, third-party evidence ("TPE"), if VSOE of selling price is not available, or estimated selling price, if neither VSOE of selling price nor TPE is available. For multiple-element arrangements accounted for in accordance with specific software accounting guidance when some elements are delivered prior to others in an arrangement and VSOE of fair value exists for the undelivered elements, revenue for the delivered elements is recognized upon delivery of such items. We establish VSOE for hardware and implementation and consulting services based on the price charged when sold separately, and for maintenance services based on substantive renewal rates offered to customers. Revenue for the software element is recognized under the residual method only when fair value has been established for all of the undelivered elements in an arrangement. If fair value cannot be established for any undelivered element, all of the arrangement's revenue is deferred until the delivery of the last element commences or until the fair value of the undelivered element is determinable. For multiple-element arrangements with both software elements and non-software elements, arrangement consideration is allocated between the software elements as a whole and non-software elements. We then further allocate consideration to the individual elements within the software group, and revenue is recognized for all elements under the applicable accounting guidance and our policies described above.

Cash receipts or billings in advance of revenue recognition are recorded as deferred revenues in the accompanying consolidated balance sheets.

Business Combinations

We recognize the consideration transferred (i.e. purchase price) in a business combination as well as the acquired business' identifiable assets, liabilities and noncontrolling interests at their acquisition date fair value. The excess of the consideration transferred

over the fair value of the identifiable assets, liabilities and noncontrolling interest, if any, is recorded as goodwill. Any excess of the fair value of the identifiable assets acquired and liabilities assumed over the consideration transferred, if any, is generally recognized within earnings as of the acquisition date. To the extent that our initial accounting for a business combination is incomplete at the end of a reporting period, provisional amounts are reported for those items which are incomplete. We adjust such provisional amounts in the reporting period in which the adjustment amounts are determined.

The fair value of the consideration transferred, assets, liabilities and noncontrolling interests is estimated based on one or a combination of income, cost or market approaches as determined based on the nature of the asset or liability and the level of inputs available to us (i.e., quoted prices in an active market, other observable inputs or unobservable inputs). With respect to assets, liabilities and noncontrolling interest, the determination of fair value requires management to make subjective judgments as to projections of future operating performance, the appropriate discount rate to apply, long-term growth rates, etc. The effect of these judgments then impacts the amount of the goodwill that is recorded and the amount of depreciation and amortization expense to be recognized in future periods related to tangible and intangible assets acquired.

With respect to the consideration transferred, certain of our acquisitions may include contingent consideration, the fair value of which is generally required to be measured each quarter until resolution of the contingency. In addition to the judgments applicable to valuing tangible and intangible assets, the determination of the fair value of the attainment of certain specified financial performance measures requires management to make subjective judgments as to the probability and timing of the attainment of certain specified financial performance measures. The determination of the fair value of the contingent consideration is particularly sensitive to judgments relative to the probability of achieving the specified financial performance measures.

Goodwill and Intangible Assets

Goodwill and intangible assets from our acquisitions are accounted for using the acquisition method of accounting. Intangible assets with definite lives are amortized on a straight-line basis over the estimated useful lives of the related assets generally as follows:

Customer relationships	3-20 years
Tradenames	5-20 years
Non-compete agreements	3-5 years
Technology-based intangible assets	5-10 years

With respect to intangible assets (excluding goodwill), we review for impairment whenever events or changes in circumstances indicate that carrying amounts may not be recoverable. For those assets that are held and used, we recognize an impairment loss only if its carrying amount is not recoverable through its undiscounted cash flows and measure the impairment loss based on the difference between the carrying amount and fair value. Assets held for sale are reported at the lower of cost or fair value less costs to sell.

We assess our goodwill for impairment annually (as of January 1 of each year) or whenever significant indicators of impairment are present. We first assess whether we can reach a more likely than not conclusion that goodwill is not impaired via qualitative analysis alone. To the extent such a conclusion cannot be reached based solely on a qualitative assessment, we (using the assistance of a valuation specialist as appropriate) compare the fair value of each reporting unit to its associated carrying value. We will generally recognize an impairment charge for the amount, if any, by which the carrying amount of the reporting unit exceeds its fair value.

We have identified software and analytics, imaging, workflow and care solutions, network solutions and technology-enabled services as our reporting units. For reporting purposes, software and analytics and imaging, workflow and care solutions are aggregated into a single reportable segment.

When necessary, we estimate the fair value of our reporting units using a methodology that considers both income and market approaches. Each approach requires the use of certain assumptions. The income approach requires management to exercise judgment in making assumptions regarding the reporting unit's future income stream, a discount rate and a constant rate of growth after the initial forecast period utilized. These assumptions are subject to change based on business and economic conditions and could materially affect the indicated values of our reporting units.

The market approach requires management to exercise judgment in its selection of guideline companies, as well in its selection of the most relevant transaction multiple. Guideline companies selected are comparable to us in terms of product or service offerings, markets and/or customers, among other characteristics.

For fiscal 2018, we used a qualitative approach to conclude that there was no impairment of the goodwill of any of our reporting units.

Income Taxes

We record deferred income taxes for the tax effect of differences between book and tax bases of our assets and liabilities, as well as differences related to the timing of recognition of income and expenses.

Deferred income taxes reflect the available net operating losses and the net tax effect of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes. Realization of the future tax benefits related to deferred tax assets is dependent on many factors, including our past earnings history, expected future earnings, the character and jurisdiction of such earnings, reversing taxable temporary differences, unsettled circumstances that, if unfavorably resolved would adversely affect utilization of our deferred tax assets, carryback and carryforward periods and tax strategies that could potentially enhance the likelihood of realization of a deferred tax asset.

We recognize tax benefits for uncertain tax positions at the time that we conclude the tax position, based solely on its technical merits, is more likely than not to be sustained upon examination. The benefit, if any, is measured as the largest amount of benefit, determined on a cumulative probability basis that is more likely than not to be realized upon ultimate settlement. Tax positions failing to qualify for initial recognition are recognized in the first subsequent interim period that they meet the more likely than not standard, are resolved through negotiation or litigation with the taxing authority or on expiration of the statute of limitations.

Tax Receivable Agreement Obligations

The Company is a party to certain Tax Receivable Agreements which generally obligate us to make payments to one or a combination of Blackstone, Hellman & Friedman, McKesson, and current or former members of management, equal to 85% of the applicable cash savings that the Company realizes as a result of tax attributes arising from, in certain cases, from the Transactions and in other cases from prior transactions.

For the tax receivable agreements originally executed at or immediately prior to the Transactions, our balance sheet reflects these obligations at the amount that is both probable and reasonably estimable without discount for the time value of money. Such amounts are subject to change upon finalization of the 2017 tax return as well as upon future changes in tax rates.

For the tax receivable agreements that were executed in connection with prior transactions, CHC's balance sheet historically reflected these obligations at the amount that was both probable and reasonably estimable. In connection with a prior business combination, these prior tax receivable agreement obligations were adjusted to their fair value at that time. In March 2017, we assumed these obligations and initially recognized them at their historical carrying values which we are accreting to the total value of expected payments over the terms of these agreements. As a result of the change in control that resulted from the Transactions, payments under these agreements are now required to be calculated using certain valuation assumptions, including that we will have sufficient taxable income to use the applicable tax attributes and that certain of such tax attributes will be used by us on a pro rata basis from the date of the Transactions (or in certain cases, from the date of certain previous transactions) through the expiration of the applicable tax attribute. The effect of this change in control is that future changes in estimate related to these obligations are expected to result only from changes in the underlying tax rates.

Accretion and changes in estimates related to these obligations are classified as a separate caption on our consolidated statement of operations.

Summary Disclosure about Contractual Obligations and Commercial Commitments

Contractual Obligations

The following table presents certain minimum payments due under contractual obligations with minimum firm commitments as of March 31, 2018:

		Payments by Period				
		Total	Less than 1 year	1-3 years	3-5 years	After 5 years
		(in millions)				
Senior Credit Facilities and other long-term obligations	(1)	$ 5,051.3	$ 53.3	$ 102.0	$ 102.0	$ 4,794.0
Senior Notes	(2)	1,000.0	—	—	—	1,000.0
Expected interest	(3)	1,506.0	246.0	487.0	479.0	294.0
2009 - 2011 Tax Receivable Agreements	(4)	226.5	13.4	44.4	38.5	130.2
2017 Tax Receivable Agreement	(5)	129.8	11.6	2.7	56.8	58.7
Operating lease obligations	(6)	147.1	39.8	57.4	35.7	14.2
Contingent consideration obligation	(7)	4.0	0.3	3.7	—	—
Purchase obligations and other	(8)	1,199.0	235.0	244.0	228.0	492.0
Total contractual obligations	(9)	$ 9,263.7	$ 599.4	$ 941.2	$ 940.0	$ 6,783.1

(1) Represents the principal amount of indebtedness under the Senior Credit Facilities and our deferred financing obligations.
(2) Represents the principal amount of indebtedness under the Senior Notes without reduction for any original issue discount.
(3) Consists of interest payable under the Senior Credit Facilities and Senior Notes. Interest related to the Senior Credit Facilities is based on our interest rates in effect as of March 31, 2018 and assumes that we make no optional or mandatory prepayments of principal prior to their maturity. Because the interest rates under the Senior Secured Credit Facilities are variable, actual payments may differ.
(4) Represents expected amounts due without reduction for any fair value adjustments recognized in prior acquisition method accounting.
(5) Represents expected amounts due. The timing and/or amount of the aggregate payments due, however, may vary based on a number of factors, including differences in the expected and actual utilization of prior net operating losses and changes in the tax rate then applicable, whether due to statutory changes or changes in apportionment.
(6) Represents amounts due under existing operating leases related to our offices and other facilities.
(7) Contingent consideration transferred in connection with acquisitions includes a contingent obligation to make additional payments based on the achievement of certain future performance objectives. Because the ultimate timing and amount of payments are dependent on the outcome of future events, the timing and/or amount of these additional payments may vary from this estimate.
(8) Represents contractual commitments under the Agreement, the management services agreement we entered into with affiliates of the Members in connection with the Transactions, certain telecommunication and other supply contracts and certain other obligations. Where our purchase commitments are cumulative over a period of time (i.e. no specified annual commitment), the table above assumes such commitments will be fulfilled on a ratable basis over the commitment period.
(9) Total contractual obligations exclude liabilities for the McKesson Tax Receivable Agreement due to the high degree of uncertainty regarding the ultimate amount, if any, and timing of future cash payments. Payments under this agreement will not begin unless or until McKesson ceases to own at least 20% of Parent.

See the notes to our consolidated financial statements included elsewhere in this Annual Report for additional information related to our operating leases and other commitments and contingencies.

ITEM 3. RISK FACTORS

Overview

You should carefully consider the risks and uncertainties described below, and all information contained in these financial statements and Management's Discussion and Analysis of Financial Condition and Results of Operations, when evaluating our company and business. We believe that the following information identifies the material risks and uncertainties affecting the Company, but it is possible that other risks and uncertainties might significantly impact us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also materially and adversely affect our business operations. The occurrence of any of the following risks or uncertainties could significantly and adversely affect our business, prospects, financial condition and operating results.

Risks Related to our Business

Our business faces significant competition, which may harm our business, results of operations or financial condition.

We face substantial competition from many healthcare information systems companies and other technology companies within the healthcare IT and services markets. We also compete with certain of our customers that provide internally some of the same solutions that we offer. The vigorous competition we face requires us to provide high quality, innovative products at a competitive price. These competitive threats will likely remain or expand in the future. Our key competitors include:

- healthcare transaction processing companies, including those providing electronic data interchange ("EDI") services and/or internet-based services and those providing services through other means, such as paper and fax;
- healthcare information system vendors that support providers or payers with their revenue and payment cycle management, imaging usage, retrieval and management, capacity and resource management, and clinical information exchange processes, including physician and dental practice management, hospital information, imaging and workflow solutions, homecare and electronic medical record system vendors;
- IT and healthcare consulting service providers;
- health insurance companies, pharmacy benefit management companies, hospital management companies and pharmacies that provide or are developing electronic transaction and payment distribution services for use by providers and/or by their members and customers;
- healthcare payments and communication solutions providers, including financial institutions and payment processors that have invested in healthcare data management assets, and print and mail vendors;
- healthcare eligibility and enrollment services companies;
- healthcare payment accuracy companies;
- healthcare engagement and transparency companies;
- healthcare billing and coding services; and
- providers of healthcare risk adjustment, quality and other data and analytics solutions.

In addition, the increasing standardization of certain healthcare IT products and services has made it easier for companies to enter these markets with competitive products and services. Software, hardware, information systems and business process outsourcing companies, both with and without healthcare companies as their partners, offer or have announced their intention to offer products or services that are competitive with solutions that we offer. There have been a number of recent entrants that have successfully marketed competitive solutions and they may expand these offerings in the future. We cannot fully anticipate whether or when companies in adjacent or other product, service or technology areas may launch competitive products, and any such entry may lead to obsolescence of our products or loss of market share or erosion of the prices for our solutions, or both. The extent of this competition varies by the size of companies, geographical coverage and scope and breadth of products and services offered. Within certain of the markets in which we operate, our competitors are significantly larger and have greater financial or other resources than we do and have established reputations for success.

Additionally, the pace of change in the healthcare information systems market is rapid, and there are frequent new solution introductions, solution enhancements and evolving industry standards and requirements. We cannot guarantee that we will be able to upgrade our existing solutions or services, or introduce new solutions or services at the same rate as our competitors, or at all, nor can we guarantee that such upgrades or new solutions or services will achieve market acceptance over or among competitive offerings, or at all. Our competitors may also commercialize products, services or technologies that render our solutions obsolete or less marketable.

These competitive pressures could have a material adverse impact on our business, results of operation or financial condition.

Competition between us and some of our customers, or decisions by our customers to perform internally some of the same solutions or services that we offer, could harm our business, results of operations or financial condition.

Some of our existing customers compete with us, or may do so in the future, and some of our existing customers belong to alliances that compete with us, or may do so in the future, either with respect to the solutions or services we provide to them or with respect to some of our other lines of business. For example, some of our payer customers currently offer—through affiliated clearinghouses, web portals and other means—electronic data transmission services to providers that allow the provider to bypass third-party EDI service providers such as us, and additional payers may do so in the future. The ability of payers to replicate our solutions and the ability of providers to connect directly with payers may adversely affect the terms and conditions we are able to negotiate in our agreements with payers and our transaction volume with them, which directly relates to our revenues. In addition, to the extent that our customers determine to perform internally any of the business processes our solutions address, either because they believe they can provide such processes more efficiently internally or otherwise, we may lose such customers, or the volume of our business with such customers may be reduced, which could harm our business, results of operations or financial condition.

In recent years, the healthcare industry has also been subject to increasing consolidation. Many healthcare organizations, including a number of our customers, have consolidated to create larger enterprises with greater market power. If this consolidation trend continues among our customers, it could give the resulting enterprises greater bargaining power, which may lead to downward price pressure on our solutions or services, or less demand for them, or both. In addition, when our customers combine, they often consolidate infrastructure including IT systems, which in turn may erode the diversity of our customer and revenue base. Any of these effects could harm our business, results of operations or financial condition.

If we are unable to retain our existing customers or attract new customers, our business, financial condition or results of operations could suffer.

Our success depends substantially upon the retention of our existing customers and attracting new customers. We may not be able to retain our existing customers or attract new customers if we are unable to provide solutions or services that our existing or prospective payer customers believe enable them to achieve improved efficiencies and cost-effectiveness, and that our existing or prospective provider customers believe allow them to more effectively manage their revenue cycle, increase reimbursement rates and improve cash flows.

Our success in retaining and attracting customers will also depend, in part, on our ability to innovate successfully and be responsive to technological developments, pricing pressures and changing business models. To remain competitive in the evolving healthcare IT markets, we must continuously upgrade our existing solutions, and develop and introduce new solutions on a timely basis. Future advances in healthcare IT could lead to new technologies, products or services that are competitive with our solutions, resulting in pricing pressure or rendering our solutions obsolete or not competitive. In addition, because we deliver enterprise-wide and single entity clinical, patient care, financial, imaging, supply chain and strategic management software solutions to hospitals, physicians and other providers, and payers, our ability to integrate these software solutions could be challenged, which may impair our ability to retain customers and harm our reputation with prospective new customers. We also may not be able to retain or attract customers if our solutions contain errors or otherwise fail to perform properly, if our pricing structure is not competitive or if we are unable to renegotiate our customer contracts upon expiration.

Our revenues depend in part upon maintaining high customer retention rates and our future growth depends on attracting new customers. If we are unable to maintain our customer retention rates, or if we are unable to attract new customers, our business, results of operations or financial condition could be adversely impacted.

If we are unable to connect to a large number of payers and providers, our solutions would be limited and less desirable to our customers.

Our business largely depends upon our ability to connect electronically to a substantial number of payers, such as insurance companies, Medicare and Medicaid agencies and pharmacy benefit managers, and providers, such as hospitals, physicians, clinics, dentists, laboratories and pharmacies. The attractiveness of some of the solutions we offer to providers, such as our claims management and submission services, depends in part on our ability to connect to a large number of payers, which allows us to streamline and simplify workflows for providers. These connections may be made either directly or through a clearinghouse. We may not be able to maintain our connections with a large number of payers on satisfactory terms and we may not be able to develop new connections, either directly or through other clearinghouses, on satisfactory terms. The failure to maintain these connections could cause our solutions to be less attractive to our provider customers. In addition, our payer customers view our relationships with providers as desirable in allowing them to receive a high volume of transactions electronically and realize the resulting cost efficiencies through the use of our solutions. Competing EDI service providers can easily establish connections with payers and providers and thereby may replicate the solution we provide. Our failure to maintain existing connections with payers, providers and other clearinghouses or to develop new connections as circumstances warrant, or an increase in the utilization of direct links between payers and providers, could cause our electronic transaction processing systems to be less desirable to healthcare constituents, which would reduce the number of transactions that we process, which would reduce our revenues and could have a material adverse impact on our business, results of operation or financial condition.

Failure to maintain our relationships with our channel partners or significant changes in the terms of the agreements we have with them may have an adverse effect on our ability to successfully market our solutions.

We have entered into contracts with our channel partners to market and sell some of our solutions. Most of these contracts are on a non-exclusive basis. However, under contracts with some of our channel partners, we may be bound by provisions that restrict our ability to market and sell our solutions to potential customers. Our arrangements with some of these channel partners involve negotiated payments to them based on percentages of revenues they generate. If the payments prove to be too high, we may be unable to realize acceptable margins, but if the payments prove to be too low, the channel partners may not be motivated to produce a sufficient volume of revenues. The success of these contractual arrangements will depend in part upon the channel partners' own competitive, marketing and strategic considerations, including the relative advantages of using alternative solutions being developed and marketed by them or our competitors. If any of these channel partners is unsuccessful in marketing our solutions or seeks to amend the financial or other terms of the contracts we have with them, we may need to broaden our marketing efforts to increase focus on the solutions they sell and alter our distribution strategy, which may divert our planned efforts and resources from other projects and increase our costs generally. In addition, as part of the packages these channel partners sell, they may offer a choice to their customers between solutions that we supply and similar solutions offered by our competitors or by the channel partners directly. If our solutions are not chosen for inclusion in these packages, the revenues we earn from our channel partner relationships will decrease. Lastly, we could be subject to claims and liability as a result of the activities, products or services of these channel partners or other resellers of our solutions. Even if these claims do not result in liability to us, investigating and defending these claims could be expensive, time-consuming and result in adverse publicity that could have a material adverse impact on our business, results of operation or financial condition.

Our business strategy and future success depend on our ability to cross-sell our solutions.

Our ability to generate revenue and growth partly depends on our ability to cross-sell our solutions to our existing customers and new customers. We have identified our ability to successfully cross-sell our solutions as a key part of our business strategy and therefore one of the most significant factors influencing our growth. We may not be successful in cross-selling our solutions because our customers may find our additional solutions unnecessary, unattractive or cost-ineffective. Our failure to sell additional solutions to our existing and new customers could negatively affect our ability to grow our business.

We have faced and will continue to face pressure to reduce our prices, which may reduce our margins, profitability and competitive position.

As electronic transaction processing has further penetrated the healthcare market and has become highly standardized, competition among revenue cycle management software and EDI providers is increasingly focused on providing value added services and capabilities to customers. This competition has placed pressure, and could place further pressure, on us to add functionality and keep our prices competitive in order to retain market share. Likewise, as a result of Medicare payment reductions and other reimbursement changes, our provider customers have sought, and may attempt in the future to seek, price concessions from us. If we are unable to reduce our costs sufficiently to offset declines in our prices, or if we are unable to introduce new, innovative offerings with higher margins, it could have a material adverse impact on our business, results of operation or financial condition.

In addition, many healthcare industry constituents are consolidating to create integrated healthcare delivery systems with greater market power. As provider networks, such as hospitals, and payer organizations, such as private insurance companies, consolidate, competition to provide the types of solutions we provide may become more intense and the importance of establishing and maintaining relationships with key healthcare industry constituents could increase. These healthcare industry constituents have used in the past, and likely will try to use in the future, their market power—particularly where it has been increased following mergers and consolidations—to negotiate price reductions for our solutions. If we are forced to further reduce prices, our margins will decrease and our results of operations could deteriorate, unless we are able to achieve corresponding reductions in expenses.

An economic downturn or volatility could have a material adverse impact on our business, results of operation or financial condition.

The United States and world economies have experienced significant economic uncertainty and volatility during recent years. A weakening of economic conditions could lead to reductions in demand for our solutions. For example, in the United States our revenues can be adversely affected by the impact of lower healthcare utilization trends driven by high unemployment and other economic factors. Further, weakened economic conditions or a recession could reduce the amounts that patients are willing or able to spend on healthcare services. As a result, patients may elect to delay or forgo seeking healthcare services, which could further reduce healthcare utilization and our transaction volumes or decrease payer and provider demand for our solutions. Also, high unemployment rates could cause commercial payer membership to decline which also could lessen healthcare utilization and decrease our transaction volumes. In addition, as a result of volatile or uncertain economic conditions, we may experience the negative effects of increased financial pressures on our payer and provider customers. For instance, our business could be negatively impacted by increased competitive pricing pressure and a decline in our customers' creditworthiness, which could result in us incurring increased bad debt expense. Additionally, volatile or uncertain economic conditions in the United States and other parts of world could lead our government customers to terminate, or elect not to renew, existing contracts with us, or not enter into new contracts with us. If we are not able to timely and appropriately adapt to changes resulting from a weak economic environment, it could have a material adverse impact on our business, results of operation or financial condition.

We are subject to risks associated with our international operations.

We market, sell and support our solutions internationally. We plan to continue to expand our non-U.S. operations and continue to focus on developing successful direct and indirect non-U.S. sales and support channels. Non-U.S. operations are subject to inherent risks, and our business, results of operations and financial condition, including our revenue growth and profitability, could be adversely affected by a variety of uncontrollable and changing factors. These include, but are not limited to:

- greater difficulty in collecting accounts receivable and longer collection periods;
- difficulties and costs of staffing and managing non-U.S. operations;
- the impact of global economic and political market conditions;
- effects of sovereign debt conditions, including budgetary constraints;
- unfavorable or volatile foreign currency exchange rates;
- legal compliance costs or business risks associated with our global operations where: i) local laws and customs differ from, or are more stringent than those in the U.S., such as those relating to data protection and data security, or ii) risk is heightened with the U.S. Foreign Corrupt Practices Act of 1977 (the "FCPA"), the U.K. Anti-Bribery Act and similar laws and regulations in foreign jurisdictions;
- certification, licensing, or regulatory requirements and unexpected changes to those requirements;
- changes to or reduced protection of intellectual property rights in some countries;
- potentially adverse tax consequences as a result of changes in tax laws or otherwise, and difficulties associated with repatriating cash generated or held abroad in a tax-efficient manner;
- different or additional functionality requirements or preferences;
- trade protection measures;
- trade protection measures;
- export control regulations;
- health service provider or government spending patterns or government-imposed austerity measures;
- natural disasters, war or terrorist acts; or
- labor disruptions that may occur in a country.

Our ability to generate revenue could suffer if we do not continue to update and improve our existing solutions and develop new ones.

We must continually improve the functionality of our existing solutions in a timely manner and introduce new and valuable healthcare IT and service solutions in order to respond to technological and regulatory developments and customer demands and, thereby, retain existing customers and attract new ones. For example, from time to time, government agencies may alter format and data code requirements applicable to electronic transactions. In addition, our customers sometimes request that our solutions be customized to satisfy particular security protocols, modifications and other contractual terms in excess of industry norms and our standard configurations. We may not be successful in responding to technological and regulatory developments or changing customer needs. In addition, these regulatory or customer-imposed requirements may impact the profitability of particular solutions and customer engagements. The pace of change in the markets we serve is rapid, and there are frequent new product and service introductions by our competitors and channel partners who use our solutions in their offerings. If we do not respond successfully to technological and regulatory changes, as well as evolving industry standards and customer demands, our solutions may become obsolete. Technological changes also may result in the offering of competitive solutions at lower prices than we are charging for our solutions, which could result in our losing sales unless we lower the prices we charge or provide additional efficiencies or capabilities to the customer. If we do lower our prices on some of our solutions, we will need to increase our margins on these solutions in order to maintain our overall profitability.

Achieving market acceptance of new or updated solutions is necessary in order for them to become profitable and will likely require significant efforts and expenditures.

Our future financial results will depend in part on whether our new or updated solutions receive sufficient customer acceptance. Achieving market acceptance for new or updated solutions is likely to require substantial marketing efforts and expenditure of significant funds to create awareness and demand by constituents in the healthcare industry. In addition, deployment of new or updated solutions may require the use of additional resources for training our existing sales force and customer service personnel and for hiring and training additional salespersons and customer service personnel. Failure to achieve broad penetration in target markets with respect to new or updated solutions could have a material adverse impact on our business, results of operation or financial condition.

There are increased risks of performance problems during times when we are making significant changes to our solutions or to systems we use to provide our solutions. In addition, changes to our solutions or systems, including cost savings initiatives, may cost more than anticipated, may not provide the benefits expected, may take longer than anticipated to develop and implement or may increase the risk of performance problems.

In order to respond to technological and regulatory changes and evolving industry standards, our solutions and the software and systems we use to provide our solutions must be continually updated and enhanced. Because some of the software and systems that we use to provide solutions to customers are inherently complex, changing, updating, enhancing and creating new versions of our solutions or the software or systems we use to provide our solutions create a risk of errors or performance problems, despite testing and quality control. We cannot be certain that errors will not arise in connection with any such changes, updates, enhancements or new versions, especially when first introduced. Even if new or modified solutions do not have performance problems, our technical and customer service personnel may have difficulties in installing them or in providing any necessary training and support to customers, and our customers may not follow our guidance on appropriate training, support and implementation for such new or modified solutions. In addition, changes in our technology and systems may not provide the additional functionality or other benefits that were expected.

Implementation of changes in our technology and systems also may cost more or take longer than originally expected and may require more testing than initially anticipated. While new solutions will be tested before they are used in production, we cannot be sure that the testing will uncover all problems that may occur in actual use.

We also periodically implement efficiency measures and other cost-saving initiatives to improve our operating performance. These efficiency measures and other cost saving initiatives may not provide the benefits anticipated or do so in the time frame expected. Implementation of these measures also may increase the risk of performance problems due to unforeseen impacts on our organization, systems and processes.

If significant problems occur as a result of these changes, we may fail to meet our contractual obligations to customers, which could result in claims being made against us or in the loss of customer relationships.

Our business will suffer if we fail to successfully integrate acquired businesses and technologies or to appropriately assess the risks in particular transactions.

We historically have acquired, and in the future may acquire, businesses, technologies, services, product lines and other assets. The successful integration of any businesses and assets we acquire into our operations, on a cost-effective basis, can be critical to our future performance. The amount and timing of the expected benefits of any acquisition, including potential synergies, are subject to risks and uncertainties. These risks and uncertainties include, but are not limited to, those relating to:

- our ability to maintain relationships with the customers and suppliers of the acquired business;
- our ability to cross-sell solutions to customers with which we have established relationships and those with which the acquired businesses have established relationships;
- our ability to retain or replace key personnel of the acquired business;
- potential conflicts in payer, provider, vendor or marketing relationships;
- our ability to coordinate organizations that are geographically diverse and may have different business cultures;
- the diversion of management's attention to the integration of the operations of businesses or other assets we have acquired;
- difficulties in the integration or migration of IT systems; and
- compliance with regulatory and other requirements, including internal control over financial reporting.

We cannot guarantee that any acquired businesses, technologies, services, product lines or other assets will be successfully integrated with our operations in a timely or cost-effective manner, or at all. Failure to successfully integrate acquired businesses or to achieve anticipated operating synergies, revenue enhancements or cost savings could have a material adverse impact on our business, results of operation or financial condition.

Although our management attempts to evaluate the risks inherent in each transaction and to evaluate acquisition candidates appropriately, we may not properly ascertain all such risks and the acquired businesses or other assets may not perform as we expect or enhance the value of the Company as a whole. Acquired companies or businesses also may have larger than expected liabilities that are not covered by the indemnification, if any, that we are able to obtain from the sellers. Furthermore, the historical financial statements of the companies we have acquired or may acquire in the future are prepared by management of such companies and are not independently verified by our management. In addition, any pro forma financial statements prepared by us to give effect to such acquisitions may not accurately reflect the results of operations of such companies that would have been achieved had the acquisition of such entities been completed at the beginning of the applicable periods. There are also no assurances that we will continue to acquire businesses at valuations consistent with our prior acquisitions or that we will complete acquisitions at all. If we are unable to successfully complete and integrate strategic acquisitions in a timely manner, our business and growth strategies could be negatively affected.

Poor service, system errors or failures of our solutions to conform to specifications could cause unforeseen liabilities or injury, harm our reputation and have a material adverse impact on our business, results of operation or financial condition.

We must meet our customers' service level expectations and our contractual obligations with respect to our solutions. Failure to do so could subject us to liability, as well as cause us to lose customers. In some cases, we rely upon third-party contractors (which, along with suppliers and other third-party vendors, we also refer to as "vendors") to assist us in providing our solutions. Our ability to meet our contractual obligations and customer expectations thus may be impacted by the performance of our vendors and their ability to comply with applicable laws and regulations. For example, our electronic payment and remittance solutions depend in part on the ability of our vendors to comply with applicable banking, financial service and payment card industry requirements and their failure to do so could cause an interruption in the solutions we provide or require us to seek alternative solutions or relationships. Moreover, some of our solutions are intended to provide information to healthcare professionals in the course of delivering patient care. If use of or inability to use our solutions leads to faulty clinical decisions or injury to patients, although our contracts disclaim liability for medical decisions and responsibility for patient care, such disclaimers may be unenforceable and we could be subject to claims or litigation by healthcare professionals, their patients or our customers.

Some of the software and systems that we use to provide our solutions are inherently complex. Errors or downtime in the software and systems we use to provide our solutions could cause serious problems for our customers. For example, because of the

large amount of data we collect and manage, it is possible that hardware failures and errors in our systems would result in data loss or corruption or cause the information that we collect to be incomplete or contain inaccuracies that our customers could regard as significant. In addition, errors in our transaction processing systems could result in payers paying the wrong amount, making payments to the wrong payee or delaying payments. If problems occur, our customers may seek compensation from us or may seek to terminate their agreements with us, withhold payments to us, seek refunds from us of part or all of the fees charged under our agreements, ask us to reconstruct lost or corrupted data at our expense, request a loan or advancement of funds or initiate litigation or other dispute resolution procedures. We also may be subject to claims against us by others affected by any such problems.

We attempt to limit, by contract, our liability for damages arising from our negligence, errors, mistakes or security breaches. However, contractual limitations on liability may not be accepted by our customers, may not be enforceable or may otherwise not provide sufficient protection to us from liability for damages. We maintain liability insurance coverage, including coverage for errors and omissions and cyber-liability. It is possible, however, that claims could exceed the amount of our applicable insurance coverage, if any, or that this coverage may not continue to be available on acceptable terms or in sufficient amounts. Even if these claims do not result in liability to us, investigating and defending against them could be expensive and time consuming and could divert management's attention away from our operations. In addition, negative publicity caused by these events may negatively impact our customer relationships, market acceptance of our solutions, including unrelated solutions, or may harm our reputation and our business.

Disruptions in service or damages to our data or other operation centers, or other software or systems failures, could have a material adverse impact on our business, results of operation or financial condition.

Our data and network operations centers are essential to our business. Our business operations depend on our ability to maintain and protect our network and computer systems, many of which are located in our primary data and operations centers that we own and operate and some of which are outsourced to certain third-party hosting providers. We have consolidated several satellite data centers and plan to continue such consolidation. We also provide remote hosting services that involve operating both our software and the software of vendors for our customers. The ability to access on demand the systems, applications, and data that we host and support is important to our customers.

Our operations and facilities are vulnerable to interruption and/or damage from a number of sources, many of which are beyond our control, including, without limitation: (1) power loss and telecommunications failures; (2) fire, flood, hurricane and other natural disasters; (3) software and hardware errors, failures or crashes; and (4) cyber and ransomware attacks, computer viruses, hacking and other similar disruptive problems. The occurrence of any of these events could result in interruptions, delays or cessations in service to users of our solutions, which could impair or prohibit our ability to provide our solutions, reduce the attractiveness of our solutions to our customers and could have a material adverse impact on our business, results of operation or financial condition. If customers' access to our solutions is interrupted because of problems in the operation of our or their facilities, we could be in breach of our agreements with customers and/or exposed to significant claims, particularly if the access interruption is associated with problems in the timely delivery of medical care.

We attempt to mitigate these risks through various means including disaster recovery and business continuity plans, penetration testing, vulnerability scans, patching and other information security procedures and cybersecurity and ransomware measures, insurance against fires, floods, other natural disasters, cyber-liability and general business interruptions, and customer and employee training and awareness, but our precautions cannot protect against all risks. Any significant instances of system downtime could negatively affect our reputation and ability to provide our solutions or remote hosting services, which could have a material adverse impact on our business, results of operation or financial condition.

We also rely on a number of vendors to provide us with a variety of solutions and services, including cloud-based data hosting, telecommunications and data processing services necessary for our transaction services and processing functions and software developers for the development and maintenance of certain software products we use to provide our solutions. As a result, our disaster recovery and business continuity plans may rely, in part, upon vendors of related services. If these vendors do not fulfill their contractual obligations, have system failures or choose to discontinue their products or services, our business and operations could be disrupted, our brand and reputation could be harmed and our financial condition or operating results could be adversely affected.

If the security measures protecting our IT systems are breached or fail, we could be subject to liability, and customers may curtail or stop using our solutions.

Our business relies to a significant degree upon the secure electronic transmission, use and storage of sensitive information, including protected health information and other personally identifiable information, financial information and other confidential

information and data. To protect this information, we implement security measures and maintain information security policies and procedures based on guidance from the National Institute of Standards and Technology Cybersecurity Framework, ISO/IEC 27001, the Payment Card Industry Data Security Standard, HITRUST, Health Insurance Portability and Accountability Act ("HIPAA") and other requirements under applicable law, in each case as applicable to the data collected, hosted and processed. Despite the implementation of security measures, our infrastructure, data or other operation centers and systems used in connection with our business operations, including the internet and related systems of our vendors, including vendors to which we outsource data hosting, storage and processing functions, may be vulnerable to physical break-ins, hackers, improper employee or contractor access, computer viruses, programming errors, denial-of-service attacks, ransomware events, phishing schemes, fraud, terrorist attacks or other breaches by third parties or similar disruptive problems. We cannot predict whether our security measures will be adequate to prevent all possible security threats or adequate protect our systems in the event of third-party security threats, breaches or events. Any of these events, including the unauthorized access, misappropriation, disclosure or loss of sensitive information, including financial or personal health information, or a significant disruption of our network, could adversely affect our ability to provide our solutions and fulfill contractual demands, could require us to devote significant financial and other resources to mitigate such problems and could increase our future information security costs, including through organizational changes, deploying additional personnel and protection technologies, further training of employees and engaging third party experts and consultants. Moreover, unauthorized access, use or disclosure of certain sensitive information in our possession could result in civil or criminal liability or regulatory action, including potential fines and penalties, as well as costs relating to investigation of the breach, required notifications, credit monitoring services and other necessary expenses. In addition, any actual or perceived breach of our security measures may cause existing customers to terminate their relationship with us or deter customers from using or purchasing our solutions in the future. The occurrence of any of these events could have a material adverse impact on our business, results of operation or financial condition.

Recently, there have been a number of high profile security breaches involving the improper dissemination of personal information of individuals both within and outside of the healthcare industry. Lawsuits and governmental fines and penalties resulting from these security breaches have sought significant monetary damages. While we maintain liability insurance coverage, claims could exceed the amount of our applicable insurance coverage, if any, or this coverage may not continue to be available on acceptable terms or in sufficient amounts.

We rely on Internet infrastructure, bandwidth providers, data center providers, other third parties and our own systems for providing certain of our solutions to our customers, and any failure or interruption in the services provided by these third parties or our own systems could expose us to litigation and negatively impact our relationships with partners, adversely affecting our brand and our business.

Our ability to deliver our solutions is dependent on the development and maintenance of the infrastructure of the Internet and other telecommunications services by third parties. This includes maintenance of a reliable network connection with the necessary speed, data capacity and security for providing reliable Internet access and services and reliable telephone and facsimile services. As a result, our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information technology, emerging cybersecurity risks and threats, evolving industry and regulatory standards and changing preferences of our partners.

Our solutions are designed to operate without interruption in accordance with our service level commitments. However, we have experienced limited interruptions in these systems in the past, including server failures that temporarily slow down the performance of our solutions, and we may experience more significant interruptions in the future. We rely on internal systems as well as third-party suppliers, including bandwidth and telecommunications equipment providers, to provide our solutions. We do not maintain redundant systems or facilities for some of these services. Interruptions in these systems, whether due to system failures, computer viruses, physical or electronic break-ins or other catastrophic events, could affect the security or availability of our solutions and prevent or inhibit the ability of our partners to access our solutions.

In the event of a catastrophic event with respect to one or more of these systems or facilities, we may experience an extended period of system unavailability, which could result in substantial costs to remedy those problems or negatively impact our relationship with our partners, our business, results of operations and financial condition. To operate without interruption, both we and our service providers must guard against:

- damage from fire, power loss and other natural disasters;
- telecommunications failures;
- software and hardware errors, failures and crashes;
- security breaches, computer viruses and similar disruptive problems; and
- other potential interruptions.

Any disruption in the network access, telecommunications or co-location services provided by third-party providers or any failure of or by third-party providers' systems or our own systems to handle current or higher volume of use could significantly harm our business. We exercise limited control over our third-party suppliers, which increases our vulnerability to problems with services they provide. Any errors, failures, interruptions or delays experienced in connection with these third-party technologies and information services or our own systems could negatively impact our relationships with partners and adversely affect our business and could expose us to third-party liabilities. Although we maintain insurance for our business, the coverage under our policies may not be adequate to compensate us for all losses that may occur. In addition, we cannot provide assurance that we will continue to be able to obtain adequate insurance coverage at an acceptable cost.

The reliability and performance of our Internet connection may be harmed by increased usage or by denial-of-service attacks. The Internet has experienced a variety of outages and other delays as a result of damages to portions of its infrastructure, and it could face outages and delays in the future. These outages and delays could reduce the level of Internet usage as well as the availability of the Internet to us for delivery of our Internet-based solutions.

Recent and future developments in the healthcare industry could have a material adverse impact on our business, results of operation or financial condition.

Almost all of our revenue is derived from the healthcare industry, which is highly regulated and subject to changing political, legislative, regulatory and other influences. For example, the ACA, changes how healthcare services are covered, delivered and reimbursed. As currently structured, the ACA mandates that substantially all U.S. citizens maintain health insurance coverage, expands health insurance coverage through a combination of public program expansion and private sector reforms, reduces Medicare program spending and promotes value-based purchasing. However, efforts by the current presidential administration and certain members of Congress to repeal or make significant changes to the ACA, its implementation and/or its interpretation have cast uncertainty onto the future of the law. For example, in December 2017, tax reform legislation was enacted that eliminates the financial penalty for individuals that fail to maintain health insurance coverage, effective January 2019, a change that may result in fewer individuals electing to purchase health insurance. Further, the Centers for Medicare & Medicaid Services ("CMS") has indicated that it intends to increase flexibility in state Medicaid programs, including by expanding the scope of waivers under which states may implement Medicaid expansion provisions, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. We are unable to predict the full impact of the ACA and other health reform initiatives on our operations in light of the uncertainty regarding whether, when, and how the ACA will be further changed, what alternative reforms, if any, may be enacted, the timing of enactment and implementation of alternative provisions, and the impact of alternative provisions on various healthcare industry participants. In particular, because many of our products and services include solutions designed to assist customers in effectively navigating the shift to value-based healthcare, the elimination of, or significant revisions to, the ACA's various value-based healthcare initiatives may adversely impact our business.

While many of the provisions of the ACA are not directly applicable to us, the ACA affects the businesses of our customers and the Medicaid programs of the states with which we have contracts. For example, as a result of the Medicare payment reductions and other reimbursement changes, especially if provisions expanding coverage are repealed without eliminating the payment reductions or other reimbursement changes, our customers may attempt to seek price concessions from us or reduce their use of our solutions. Thus, the ACA may result in a reduction of expenditures by customers or potential customers in the healthcare industry, which could have a material adverse impact on our business, results of operation or financial condition. Further, the general uncertainty of healthcare

reform efforts, particularly if Congress repeals provisions of the ACA but delays the implementation date of repeal or fails to enact replacement provisions at the time of repeal, may negatively impact purchase decisions or demand for our solutions.

Moreover, there are currently numerous federal, state and private initiatives seeking to increase the use of IT in healthcare as a means of improving care and reducing costs. For example, the Health Information Technology for Economic and Clinical Health ("HITECH") Act, which was enacted in 2009, and the 21st Century Cures Act (the "Cures Act"), which was enacted in 2016, contain incentives and penalties to promote the use of Electronic Health Records ("EHR" technology and the efficient exchange of health information electronically. Further, the Cures Act provides for penalties to be imposed on IT developers, health information exchanges or networks and health providers that are found to improperly block the exchange of health information. These and other initiatives may result in additional or costly legal or regulatory requirements that are applicable to us and our customers, may encourage more companies to enter our markets, may provide advantages to our competitors and may result in the development of technology solutions that compete with ours. Any such initiatives also may result in a reduction of expenditures by existing or potential customers, which could have a material adverse impact on our business, results of operations or financial condition.

In addition, other general reductions in expenditures by healthcare industry constituents could result from, among other things, government regulation or private initiatives that affect the manner in which providers interact with patients, payers or other healthcare industry constituents, including changes in pricing or means of delivery of healthcare solutions. In addition, cost containment efforts at the federal and state levels may affect industry expenditures. For example, the Budget Control Act of 2011 requires automatic spending reductions to reduce the federal deficit. CMS began imposing a 2% reduction on Medicare claims in 2013. These reductions have been extended through 2027.

Even if general expenditures by healthcare industry constituents remain the same or increase, other developments in the healthcare industry may result in reduced spending on healthcare IT and services or in some or all of the specific markets we serve or are planning to serve. In addition, our customers' expectations regarding pending or potential healthcare industry developments also may affect their budgeting processes and spending plans with respect to the types of solutions we provide. For example, use of our solutions could be affected by:

- changes in the billing patterns of providers;
- changes in the design of health insurance plans;
- changes in the contracting methods payers use in their relationships with providers;
- decreases in marketing expenditures by pharmaceutical companies or medical device manufacturers, as a result of governmental regulation or private initiatives that discourage or prohibit promotional activities by pharmaceutical or medical device companies; and
- implementation of government programs that streamline and standardize eligibility enrollment processes that could result in decreased pricing or demand for our eligibility and enrollment solutions.

The healthcare industry has changed significantly in recent years, and we expect that significant changes will continue to occur. The timing and impact of developments in the healthcare industry are difficult to predict. We cannot be sure that the markets for our solutions will continue to exist at their current levels, will not change in ways that adversely affect us or that we will have adequate technical, financial and marketing resources to react to changes in those markets.

Government regulation, industry standards and other requirements create risks and challenges with respect to our compliance efforts and our business strategies.

The healthcare industry is highly regulated and subject to frequently changing laws, regulations, industry standards and other requirements. Many healthcare laws and regulations are complex, and their application to specific solutions, services and relationships may not be clear. Because our customers are subject to various requirements, we may be impacted as a result of our contractual obligations even when we are not directly subject to such requirements. For many of these requirements, there is little history of legal or regulatory interpretation upon which to rely. In particular, many existing healthcare laws and regulations, when enacted, did not anticipate the healthcare IT solutions and services that we provide, and these laws and regulations may be applied to our solutions and services in ways that we do not anticipate. The ACA, efforts to repeal or materially change the ACA, and other federal and state efforts to reform or revise aspects of the healthcare industry or to revise or create additional legal or and regulatory requirements could impact our operations, the use of our solutions and services and our ability to market new solutions and services, or could create unexpected liabilities for us. We also may be impacted by non-healthcare laws, industry standards and other requirements. For example, laws, regulations and industry standards regulating the banking and financial services industry may impact our operations as

a result of the payment and remittance services we offer directly or through vendors. Additionally, laws and regulations governing how we communicate with our customers and our customers' patients, such as the Telephone Consumer Protection Act of 1991 ("TCPA"), Controlling the Assault of Non-Solicited Pornography and Marketing Act of 2003 ("CAN-SPAM Act"), and the Junk Fax Prevention Act of 2005 ("Junk Fax Act"), place certain restrictions on companies that place telephone calls and send email, text and/or fax communications, which may impact our operations and if not followed, would result in fines, penalties and other liabilities and adverse publicity and injury to our reputation.

We are unable to predict what changes to laws, regulations and other requirements might be made in the future or how those changes could affect our business or the costs of compliance.

We have attempted to structure our operations to comply with laws, regulations and other requirements applicable to us directly and to our customers and contractors, but there can be no assurance that our operations will not be challenged or impacted by enforcement initiatives. We have been and may in the future become involved in governmental investigations, audits, reviews and assessments. Certain of our businesses have been reviewed or are currently under review, including for compliance with various legal, regulatory or other requirements. Any determination by a court or agency that our solutions or services violate, or cause our customers to violate, applicable laws, regulations or other requirements could subject us or our customers to civil or criminal penalties. Such a determination also could require us to change or terminate portions of our business, disqualify us from serving customers who are or do business with government entities or cause us to refund some or all of our service fees or otherwise compensate our customers. In addition, failure to satisfy laws, regulations or other requirements could adversely affect demand for our solutions and services and could force us to expend significant capital, research and development and other resources to address the failure. Even an unsuccessful challenge by regulatory and other authorities or private whistleblowers could be expensive and time-consuming, could result in loss of business, exposure to adverse publicity and injury to our reputation and could adversely affect our ability to retain and attract customers. Laws, regulations and other requirements impacting our operations include the following:

HIPAA Privacy and Security Requirements. There are numerous federal and state laws and regulations related to the privacy and security of personal health information. In particular, regulations promulgated pursuant to HIPAA establish privacy and security standards that limit the use and disclosure of individually identifiable health information (known as "protected health information") and require the implementation of administrative, physical and technological safeguards to protect the privacy of protected health information and ensure the confidentiality, integrity and availability of electronic protected health information. The privacy regulations established under HIPAA also provide patients with rights related to understanding and controlling how their protected health information is used and disclosed. We are directly subject to certain provisions of the regulations as a "Business Associate" through our relationships with customers. We are also directly subject to the HIPAA privacy and security regulations as a "Covered Entity" with respect to our operations as a healthcare clearinghouse and with respect to our clinical care visit services.

To the extent permitted by applicable privacy regulations and our contracts with our customers, we may use and disclose protected health information to perform our services and for other limited purposes, such as creating de-identified information, but other uses and disclosures, such as marketing communications, require written authorization from the individual or must meet an exception specified under the privacy regulations. Determining whether protected health information has been sufficiently de-identified to comply with the HIPAA privacy standards and our contractual obligations may require complex factual and statistical analyses and may be subject to interpretation.

If we are unable to properly protect the privacy and security of protected health information entrusted to us, we could be found to have breached our contracts with our customers. Further, if we fail to comply with applicable HIPAA privacy and security standards, we could face civil and criminal penalties. HHS performs compliance audits of Covered Entities and Business Associates and enforces the HIPAA privacy and security standards. HHS has become an increasingly active regulator and has signaled its intention to continue this trend. HHS has the discretion to impose penalties without being required to attempt to resolve violations through informal means, such as implementing a corrective action plan. HHS enforcement activity can result in financial liability and reputational harm, and responses to such enforcement activity can consume significant internal resources. In addition to enforcement by HHS, state attorneys general are authorized to bring civil actions seeking either injunctions or damages in response to violations that threaten the privacy of state residents. Although we have implemented and maintain policies and processes to assist us in complying with these regulations and our contractual obligations, we cannot provide assurance regarding how these regulations will be interpreted, enforced or applied to our operations. In addition to the risks associated with enforcement activities and potential contractual liabilities, our ongoing efforts to comply with evolving laws and regulations at the federal and state levels might also require us to make costly system purchases and/or modifications from time to time.

Other Privacy and Security Requirements. In addition to HIPAA, numerous other federal and state laws govern the collection, dissemination, use, access to and confidentiality of personal information and some states are considering new laws and regulations that further protect this information. In many cases, these state laws are more restrictive than, and not preempted by, HIPAA. They may allow personal rights of action with respect to privacy or security breaches, as well as fines. State laws are contributing to increased enforcement activity and may also be subject to interpretation by various courts and other governmental authorities. Further, Congress and a number of states have considered prohibitions or limitations on the disclosure of personal and other information to individuals or entities located outside of the United States.

There also are numerous international privacy and security laws that govern the collection, dissemination, use, access, retention, protection, transfer and confidentiality of personal information. For example, the General Data Protection Regulation, which became effective in the European Union on May 25, 2018 is more stringent than laws and regulations governing personal data in the United States. These laws and regulations are rapidly evolving and changing, and could have an adverse effect on our operations. Companies' obligations and requirements under these laws and regulations are subject to uncertainty in how they may be interpreted and enforced by government authorities and regulators. The costs of compliance with, and the other burdens imposed by, these and other laws or regulatory actions may increase our operational costs, prevent us from selling our products or services, and/or affect our ability to invest in or jointly develop products. We may also face audits or investigations by one or more domestic or foreign government agencies relating to our compliance with these regulations. An adverse outcome under any such investigation or audit could result in liability, result in adverse publicity, and adversely affect our business.

Data Protection and Breaches. In recent years, there have been a number of well-publicized data breaches involving the improper dissemination of personal information of individuals both within and outside of the healthcare industry. Most states require holders of personal information to maintain safeguards and take certain actions in response to a data breach, such as providing prompt notification of the breach to affected individuals. In some states, these laws are limited to electronic data, but states increasingly are enacting or considering stricter and broader requirements. Additionally, under HIPAA, Covered Entities must report breaches of unsecured protected health information to affected individuals without unreasonable delay, not to exceed 60 days following discovery of the breach by a Covered Entity or its agents. Notification also must be made to the U.S. Department of Health and Human Services (the "HHS") and, in certain circumstances involving large breaches, to the media. Business Associates must report breaches of unsecured protected health information to Covered Entities within 60 days of discovery of the breach by the Business Associate or its agents. A non-permitted use or disclosure of protected health information is presumed to be a breach under HIPAA unless the Covered Entity or Business Associate establishes that there is a low probability the information has been compromised-consistent with requirements enumerated in HIPAA.

In addition, the Federal Trade Commission (the "FTC") has prosecuted certain data breach cases as unfair and deceptive acts or practices under the Federal Trade Commission Act. By regulation, the FTC requires creditors, which may include some of our customers, to implement identity theft prevention programs to detect, prevent and mitigate identity theft in connection with customer accounts. Although Congress passed legislation that restricts the definition of "creditor" and exempts many healthcare providers from complying with this identity theft prevention rule, we may be required to apply additional resources to our existing processes to assist our affected customers in complying with this rule.

We have implemented and maintain physical, technical and administrative safeguards intended to protect all personal information and have processes in place to assist us in complying with applicable laws and regulations regarding the protection of this information and properly responding to any security breaches or incidents; however, we cannot be sure that these safeguards are adequate to protect all personal information or assist us in complying with all applicable laws and regulations regarding the protection of personal information and responding to any security breaches or incidents.

HIPAA Transaction and Identifier Standards. HIPAA and its implementing regulations mandate format and data content standards and provider identifier standards (known as the National Provider Identifier) that must be used in certain electronic transactions, such as claims, payment advice and eligibility inquiries. As required by the ACA, HHS has established standards that health plans must use for electronic fund transfers with providers, has established operating rules for certain transactions, is in the process of establishing operating rules to promote uniformity in the implementation of the remaining types of covered transactions. The ACA also requires HHS to establish standards for health claims attachment transactions. HHS has modified the standards for electronic healthcare transactions (e.g., eligibility, claims submission and payment and electronic remittance) from Version 4010/4010A to Version 5010. Further, as of 2015, HHS requires the use of updated standard code sets for diagnoses and procedures known as the ICD-10 code sets.

In the event of new requirements, we will be required to modify our systems to accommodate these changes. We will continue to modify our systems and processes as needed to prepare for and implement changes to the transaction standards, code sets operating rules and identifier requirements; however, we may not be successful in responding to these changes, and any responsive changes we make to our systems and software may result in errors or otherwise negatively impact our service levels. In addition, the compliance dates for new or modified transaction standards, operating rules and identifiers may overlap, which may further burden our resources.

We also may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance or enforcement date. Some payers and healthcare clearinghouses with which we conduct business interpret HIPAA transaction requirements differently than we do or may require us to use legacy formats or include legacy identifiers as they transition to full compliance. For example, we continue to process transactions using legacy identifiers for non-Medicare claims that are sent to us to the extent that the intended recipients have not instructed us to suppress those legacy identifiers. Where payers or healthcare clearinghouses require conformity with their interpretations or require us to accommodate legacy transactions or identifiers as a condition of successful transactions, we seek to comply with their requirements, but may be subject to enforcement actions as a result. We continue to work with payers, providers, practice management system vendors and other healthcare industry constituents to implement the transaction standards and identifier standards. However, we cannot provide assurance regarding how CMS will enforce the transaction and identifier standards or how CMS will view our practice of accommodating requests to process transactions that include legacy formats or identifiers for non-Medicare claims. Any regulatory change, clarification or enforcement action by CMS that prohibited the processing by healthcare clearinghouses or private payers of transactions containing legacy formats or identifiers could have a material adverse impact on our business, results of operation or financial condition.

Anti-Kickback Laws. A number of federal and state laws govern patient referrals, financial relationships with physicians and other referral sources and inducements to providers and patients, including restrictions contained in amendments to the Social Security Act, commonly known as the “federal Anti-Kickback Law.” The federal Anti-Kickback Law prohibits any person or entity from offering, paying, soliciting or receiving, directly or indirectly, anything of value with the intent of generating referrals of patients covered by Medicare, Medicaid or other federal healthcare programs. Violation of the federal Anti-Kickback Law is a felony. The federal Anti-Kickback Law contains a limited number of exceptions, and the Office of the Inspector General of HHS has created regulatory safe harbors to the federal Anti-Kickback Law. Activities that comply with a safe harbor are deemed protected from prosecution under the federal Anti-Kickback Law. Failure to meet a safe harbor does not automatically render an arrangement illegal under the Anti-Kickback Law. The arrangement, however, does risk increased scrutiny by government enforcement authorities, based on its particular facts and circumstances. Our contracts and other arrangements may not meet an exception or a safe harbor. Additionally, many states have similar anti-kickback laws that are not necessarily limited to items or services for which payment is made by a federal healthcare program.

The laws and regulations in this area are both broad and vague and generally are not subject to frequent regulatory or judicial interpretation. We review our practices with regulatory experts in an effort to comply with all applicable laws and regulatory requirements. However, we are unable to predict how these laws and regulations will be interpreted or the full extent of their application, particularly to services that are not directly reimbursed by federal healthcare programs, such as transaction processing services. Any determination by a federal or state regulatory authority that any of our activities or those of our customers or vendors violate any of these laws or regulations could subject us to civil or criminal penalties, could require us to change or terminate some portions of our business, could require us to refund a portion of our service fees, could disqualify us from providing services to customers that are, or do business with, government programs and could have a material adverse impact on our business, results of operation or financial condition. Even an unsuccessful challenge by a regulatory authority of our activities could result in adverse publicity and could require a costly response from us.

False or Fraudulent Claim Laws; Medical Billing and Coding. Medical billing, coding and collection activities are governed by numerous federal and state civil and criminal laws. We provide billing and coding services, claims processing and other solutions to providers that relate to, or directly involve, the reimbursement of health services covered by Medicare, Medicaid, other federal healthcare programs and private payers. In addition, as part of our data transmission and claims submission services, we may employ certain edits, using logic, mapping and defaults, when submitting claims to third-party payers. Such edits are utilized when the information received from providers is insufficient to complete individual data elements requested by payers. We also provide solutions including risk analytics, chart reviews, clinical care visits, payment accuracy, audit functions and enrollment and eligibility, to Medicaid and Medicare managed care plans, commercial plans and other entities. These solutions, which include identifying diagnosis codes with respect to hierarchical condition categories, impact the amounts paid by Medicare and Medicaid to managed care plans. We rely on our customers to provide us with accurate and complete information and to appropriately use analytics, codes, reports and other information in connection with the solutions we provide to them, but they may not always do so.

As a result of these aspects of our business, we may be subject to, or contractually required to comply with, numerous federal and state laws that prohibit false or fraudulent claims. For example, errors or the unintended consequences of data manipulations by us or our systems with respect to the entry, formatting, preparation or transmission of claims, coding, audit, eligibility and other information, may result in allegations of false or fraudulent claims. False or fraudulent claims include, but are not limited to, billing for services not rendered, making or causing to be made or used a false record or statement that is material to a false claim, failing to refund known overpayments, misrepresenting actual services rendered, improper coding and billing for medically unnecessary items or services. Some of these laws, including restrictions contained in amendments to the Social Security Act, commonly known as the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud, waste and abuse laws. Federal and state authorities increasingly assert liability under the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the various criminal healthcare fraud provisions. Current penalties under the federal Civil Monetary Penalty Law are significant, up to $74,792 per prohibited kickback and assessments of up to three times the amount claimed or received. Further, violations of the federal False Claims Act (the "FCA") are punishable by treble damages and penalties of up to $22,363 per false claim, and whistleblowers may receive a share of amounts recovered. Civil monetary penalties, including those imposed under the federal Anti-Kickback Law and the FCA, are updated annually based on changes to the consumer price index.

In addition, the federal FCA prohibits the knowing submission of false claims or statements to the federal government, including to the Medicare and Medicaid programs. Whistleblower provisions allow private individuals to sue on behalf of the federal government alleging that the defendant has defrauded the federal government. Although simple negligence will not give rise to liability under the FCA, "knowingly" is defined broadly by the FCA and submitting a claim with reckless disregard to its truth or falsity can constitute "knowingly" submitting a false claim and may result in liability. Civil penalties also may be imposed for the failure to report and return an overpayment made by the federal government within 60 days of identifying the overpayment and also may result in liability under the FCA. The ACA provides that submission of a claim for an item or service generated in violation of the Anti-Kickback Law constitutes a false or fraudulent claim under the FCA. Whistleblowers and federal authorities have taken the position, and some courts have held, that providers who allegedly violated other statutes, such as the U.S. federal laws that prohibit certain physician self-referrals (also known as the "Stark Law"), have thereby submitted false claims under the FCA. Several states, including states in which we operate, have adopted their own false claims provisions and their own whistleblower provisions whereby a private party may file a civil lawsuit in state court. Although we believe our processes are consistent with applicable reimbursement rules and industry practice, a court, government authority or whistleblower could challenge these processes. In addition, we cannot guarantee that federal and state authorities will regard any billing and coding errors we process or make as inadvertent or will not hold us responsible for any compliance issues related to claims, reports and other information we handle on behalf of providers and payers. We cannot predict the impact of any enforcement actions under the various false claims and fraud, waste and abuse laws applicable to our operations. Even an unsuccessful challenge of our practices could cause us to incur adverse publicity and significant legal and related costs.

We also are subject to the exclusion rules of the Office of Inspector General ("OIG") of HHS whereby OIG may exclude individuals and entities convicted of program-related crimes from participation in the Medicare and Medicaid programs. A company that employs an OIG-excluded individual and submits a claim for reimbursement to a federal healthcare program, or causes such a claim to be submitted, may be subject to significant penalties under the federal Civil Monetary Penalty Law, plus treble damages, for each item or service furnished during the period in which the individual was excluded. A company contracting with providers has an affirmative duty to check the OIG's exclusion website regarding the exclusion status of individuals prior to entering into employment or contractual relationships and periodically re-check the OIG's exclusion website, or run the risk of liability under the federal Civil Monetary Penalty Law if it fails to do so. We regularly check the OIG exclusion website for excluded individuals as part of our initial hiring and continued employment and contractor practices, but we may not always identify all excluded individuals.

FDA Regulation of Medical Software. Certain of our products are classified as medical devices and are subject to regulation by the Food and Drug Administration (the "FDA") and numerous other federal, state and foreign governmental authorities. In general, the FDA permits commercial distribution of a new medical device after the device has received clearance under Section 510(k) of the Federal Food, Drug and Cosmetic Act (the "FDCA"), or is the subject of an approved premarket approval application, unless the device is specifically exempt from those requirements. Moreover, the FDA has increasingly focused on the regulation of medical software and health information technology products as medical devices under the FDCA. For example, in February 2015, the FDA issued guidance to inform manufacturers and distributors of medical device data systems that it did not intend to enforce compliance with regulatory controls that apply to medical device data systems, medical image storage devices, and medical image communication devices. Cures Act builds on the FDA's efforts to limit the regulation of low-risk medical devices by exempting certain categories of software functions from the definition of "medical device" under the FDCA, including software functions intended for administrative support of a healthcare facility and certain functions related to the exchange and use of electronic medical records. However, a software function may not be excluded from the device

definition if the FDA determines that use of the software function would be reasonably likely to have serious adverse health consequences. If the FDA chooses to regulate more of our solutions as medical devices, or subsequently changes or reverses its guidance regarding not enforcing certain regulatory controls, then it can impose extensive requirements upon us. Any additional FDA regulations governing healthcare software products may increase the cost and time-to-market of new or existing solutions or may prevent us from marketing our solutions. If we fail to maintain regulatory approvals and clearances, or are unable to obtain, or experience significant delays in obtaining, FDA clearances or approvals for our future products or product enhancements, our ability to commercially distribute and market these products could suffer.

Modifications to our medical device products may require new regulatory approvals or clearances, including 510(k) or de novo clearances or premarket approvals, or require us to recall or cease marketing the modified devices until these clearances or approvals are obtained.

Once a device is on the market, we must comply with numerous additional regulations which may require us to file adverse event reports and recalls as well as manufacture the software in accordance with a quality management system. Compliance with applicable regulatory requirements is subject to continual review and is monitored through periodic inspections by the FDA. If we fail to comply with regulatory requirements in the United States or experience delays in obtaining necessary regulatory approvals or clearances, this could delay production of our medical device products and lead to fines, difficulties in obtaining regulatory approvals or clearances, recalls, enforcement actions, including injunctive relief or consent decrees, or other consequences, which could, in turn, have an adverse effect on our financial condition or results of operations.

Foreign governmental authorities that regulate the manufacture and sale of medical devices have become increasingly stringent and, to the extent we market and sell our products internationally, we may be subject to international regulation in the future.

Interoperability Requirements. There is increasing demand among customers, industry groups and government authorities that healthcare IT products provided by various vendors be compatible with each other and allow for the efficient exchange of EHR information. In 2013, in order to address this demand for interoperability, McKesson and a number of other healthcare IT companies co-founded the CommonWell Health Alliance with the aim of developing a standard for data sharing among physicians, hospitals, clinics and pharmacies. Certain federal and state agencies also are developing standards that could eventually become mandatory for software and systems purchased by these agencies, or used by our customers. For example, under the Cures Act, the Office of the National Coordinator for Health Information Technology ("ONC") within HHS will be required to develop a "trusted exchange framework" and common agreement for the secure exchange of health information between networks. Although the Cures Act does not make implementation of the trusted exchange framework mandatory, the Cures Act encourages its adoption through the establishment of a publicly available directory of networks that are capable of trusted exchange and by permitting federal agencies to require implementation of the trusted exchange framework by network contractors as the contractors update their health IT or operational practices.

The Cures Act also encourages interoperability through changes to EHR certification standards implemented as part of HHS's programs to promote interoperability. In particular, the amended EHR certification standards will require developers (i) to publish application programming interfaces that permit exchange of EHR and other health information among different health IT systems, (ii) to successfully test the "real world use" of interoperability technology, and (iii) to attest that they will not engage in "information blocking" or otherwise inhibit the appropriate exchange, access, and use of electronic health information. Health IT developers, exchanges, or networks that do engage in such information blocking, by knowingly adopting practices that are likely to interfere with, prevent, or materially discourage the access, exchange, or use of electronic health information, may be subject to civil monetary penalties of up to $1 million per violation.

Although several of our healthcare IT solutions have received certification, rules regarding interoperability and certification standards are subject to regular revision and updates. In October 2016, HHS published rules establishing processes to facilitate ONC's direct review and evaluation of the performance of certified health IT in certain circumstances, including in response to problems or issues that could pose serious risks to public health or safety. As a result of changing requirements, we may incur increased development costs and delays in receiving certification for our solutions, and changing or supplementing rules also may lengthen our sales and implementation cycle. We also may incur costs in periods prior to the corresponding recognition of revenue. To the extent these requirements subsequently are changed or supplemented, or our prior certifications are no longer valid, or we are delayed in receiving new certifications for our solutions, customers may postpone or cancel their decisions to purchase or implement these solutions.

Restrictions on Communications. Communications with our customers and our customers' patients increasingly are scrutinized under laws and regulations governing communications, including significant increases in class action litigation brought under the TCPA. For example, the TCPA subjects us and our vendors to various rules regarding contacting our customers and our

customers' patients via telephone, fax or text message and may impact our operations. In the last few years, TCPA lawsuits have increased, largely due to a more expansive interpretation of the statute by some courts and by the Federal Communications Commission ("FCC"), as well as statutory damages that are available to successful plaintiffs. Because our solutions need and rely upon various messaging components to achieve successful outcomes for us and our customers, our ability to communicate with our customers and their patients may be affected by the TCPA and its regulations. In addition, because of lack of clarity regarding several aspects of TCPA and its regulations, we inadvertently could fail to comply with the TCPA, and consequently be subject to significant statutory damages and negative publicity associated with class action litigation and/or costs associated with modifying our solutions and business strategies. Furthering the compliance challenges posed by the TCPA is the fact that the FCC continues to review dozens of petitions from parties in various industries that seek interpretation of the TCPA's various regulations. To the extent the FCC issues an order that alters current understanding and accepted interpretation of the TCPA's regulations, we may be required to modify our solutions in ways that may make them less attractive to our customers and/or require us to alter our business strategies and incur increased costs. In addition, we also may be subject to claims alleging failure to comply with email regulations under the CAN-SPAM Act, and additional fax regulations under the Junk Fax Act~~.~~, as well as potentially under non-U.S. laws that regulate communications and messaging and that affect our operations, such as Canada's Anti-Spam Law (CASL) and the European Union's e-Privacy Directive and implementing member state laws (and any subsequent changes to such laws).

Financial Services Related Laws, Regulations and Industry Standards. Financial services and electronic payment processing services are subject to numerous laws, regulations and industry standards. These laws may subject us, our vendors and our customers to liability as a result of our communication and payment solutions. Although we do not act as a bank, we offer solutions that involve banks, or vendors who contract with banks and other regulated providers of financial services. The various payment modalities that we offer our customers directly and through third-party providers may be deemed regulated activity at the federal or state level, and, as a result, we may be affected by banking and financial services industry laws, regulations and standards, such as licensing requirements, solvency standards, reporting and disclosure obligations and requirements to maintain the privacy and security of nonpublic personal financial information. In addition, our communication and payment solutions may be affected by payment card industry operating rules and security standards, certification requirements, state prompt payment laws and other rules governing electronic funds transfers. If we fail to comply with any applicable communication and payment rules or requirements, we may be subject to fines and changes in transaction fees and may lose our ability to process payment transactions or facilitate other types of billing and payment solutions. Moreover, in addition to regulatory requirements related to electronic funds transfers, payment transactions processed using the Automated Clearing House Network are subject to network operating rules promulgated by the National Automated Clearing House Association, and these rules may affect our payment practices. Further, our communication and payment solutions may impact the ability of our payer customers to comply with state prompt payment laws. These laws require payers to pay healthcare claims meeting the statutory or regulatory definition of a "clean claim" within a specified time frame. Finally, as we expand our financial services offerings we may be subject to additional laws and regulations, including certain consumer protection laws such as the Fair Debt Collections Practices Act (the "FDCPA"), the Fair Credit Reporting Act (the "FCRA") and various other state laws implicated by such financial services.

Foreign Corrupt Practices Act and Bribery Laws. The FCPA and similar international bribery laws make it unlawful for entities to make payments to foreign government officials to assist in obtaining and maintaining business. Specifically, the anti-bribery provisions of the FCPA prohibit any offer, payment, promise to pay, or authorizing the payment of money or anything of value to any person, while knowing that all or a portion of such money or thing of value will be offered, given or promised, directly or indirectly, to a foreign official to do or omit to do an act in violation of his or her duty, or to secure any improper advantage in order to assist in obtaining or retaining business for or with, or directing business, to any person. In addition to the anti-bribery provisions of the FCPA, the statute also contains accounting requirements designed to operate in tandem with the anti-bribery provisions. Covered companies are required to make and keep books and records that accurately and fairly reflect the transactions of the company and devise and maintain an adequate system of internal accounting controls. With our international businesses, we could incur significant fines and penalties, as well as criminal liability, if we fail to comply with either the anti-bribery or accounting requirements of the FCPA, or similar international bribery laws. Even an unsuccessful challenge of our compliance with these laws could cause us to incur adverse publicity and significant legal and related costs.

Physician Payments Sunshine Act. The Physician Payments Sunshine Act of 2010 (the "Sunshine Act") requires manufacturers of medical devices covered by Medicare, Medicaid, and the Children's Health Insurance Program to collect and track all financial relationships with physicians and teaching hospitals and to report annually such data to CMS. Medical device manufacturers must report to CMS payments or "transfers of value" made to physicians, including meals, travel reimbursement, consulting fees and research payments. In addition, several states and the District of Columbia have passed laws requiring that medical device manufacturers report various details of their financial relationships with physicians. The Sunshine Act authorizes

significant civil monetary penalties for each payment or transfer of value not accurately or completely reported. Although we have processes in place to track and timely report such financial relationships, we inadvertently may fail to track and report all such financial relationships and thus may be subject to significant penalties for such non-compliance.

United States Postal Service Laws and Regulations. Our communication and payment solutions provide mailing services primarily delivered through the USPS. Although we generally pass these costs through to our customers, postage is the most significant cost incurred in the delivery of our communication and payment solutions. Postage rates are dependent on the operating efficiencies of the USPS and legislative and regulatory mandates imposed on the USPS as a result of various fiscal and political factors. Accordingly, new USPS laws or regulations, including changes in the interpretation of existing regulations, changes in the operations of USPS and recent or future rate increases, may negatively impact our business, results of operations or financial condition. For example, if measures taken by the USPS to reduce its operating costs are not effective, additional postage rate increases or other operational changes may occur. We also rely on significant discounts from the basic USPS postage rate structure, which could be changed or discontinued at any time. While we cannot predict the timing or magnitude of such changes, the current economic and political environment is likely to lead to further rate increases and/or changes in the operations, policies and regulatory interpretations of the USPS. Because we may be unable to implement changes mandated by the USPS in our operations or pass future rate increases through to our customers, any failure or alleged failure to comply with applicable laws and regulations, or any adverse applications of, or changes in, the USPS laws and regulations affecting our business, could have a material adverse impact on our business, results of operation or financial condition.

Other State Laws. Most states have a variety of laws that may potentially impact our operations and business practices. For example, many states in which we provide clinical care in-home assessment services prohibit corporations and other non-licensed entities from practicing medicine by employing physicians and certain non-physician practitioners. These prohibitions on the corporate practice of medicine impact how we structure our relationships with physicians and other affected non-physician practitioners. If our arrangements with physicians or other practitioners were found to violate a corporate practice of medicine prohibition, our contractual arrangements with practitioners in such states could be adversely affected, which, in turn, may adversely affect both our operations and profitability. Further, we could face sanctions for aiding and abetting the violation of the state's professional licensure statutes. We continually monitor legislative, regulatory and judicial developments related to licensure and engagement arrangements with professionals; however, new agency interpretations, federal or state legislation or regulations, or judicial decisions could require us to change how we operate, may increase our costs of services and could have a material adverse impact on our business, results of operation or financial condition.

Legislative changes and contractual limitations may impede our ability to utilize our offshore service capabilities.

In our operations, we have contractors and employees located outside of the United States who may have access to personal information, including protected health information in order to assist us in performing services for our customers. From time to time, Congress considers legislation that would restrict the transmission of personal information regarding a United States resident to any foreign affiliate, subcontractor or unaffiliated third party without adequate privacy protections or without providing notice to the identifiable individual of the transmission and an opportunity to opt out. Some of the proposals considered would have required patient consent and imposed liability on healthcare businesses arising from the improper sharing or other misuse of personal information. Congress also has considered creating a private civil cause of action that would allow an injured party to recover damages sustained as a result of a violation of these proposed restrictions. Furthermore, a number of states have considered prohibitions or limitations on the disclosure of personal information to individuals or entities located outside of the United States. If legislation of this type is enacted, our ability to utilize offshore resources may be impeded, and we may be subject to sanctions for failure to comply with the new mandates of the legislation. In addition, the enactment of such legislation could result in such work being performed at a lower margin of profitability, or even at a loss. Further, as a result of concerns regarding the possible misuse of personal information, some of our customers have contractually limited or may seek to limit our ability to use our offshore resources which may increase our costs. Use of offshore resources may increase our risk of violating our contractual obligations to our customers to protect the privacy and security of personal information provided to us, which could adversely impact our reputation and our business. In addition, depending on the location of contractors and employees accessing personal information outside of the United States, we may have additional compliance obligations under non-U.S. laws applicable to accessing, using, or otherwise processing personal information and transmitting that information back to the U.S.

We rely on third parties, including third parties outside the U.S., for some of our information technology infrastructure, development and maintenance, quality assurance, operations, and customer support.

We currently depend on various third parties for substantial business functions, including with respect to our information technology (including infrastructure, application development and maintenance), business process outsourcing, call center services, customer support and similar services. Specifically, we outsource some of our software development and design, quality assurance,

and operations activities to third-party contractors that have employees and consultants located outside the United States. In February 2018, we entered into a ten-year agreement with Wipro in which we committed to purchase from Wipro at least $1.0 billion in outsourced professional services over the ten-year term of the agreement. If we fail to meet this minimum commitment, we may be forced to pay to Wipro 25% of the shortfall relative to the minimum commitment at the end of the term, thus increasing our costs without a commensurate increase in services provided to our business. In addition, our dependence on Wipro and other third-party contractors creates a number of business risks—in particular, the risk that we may not maintain service quality, control or effective management with respect to these outsourcing arrangements of our business operations. Moreover, because certain of our third-party contractors conduct operations for us outside the United States, the political and military events in foreign jurisdictions could have an adverse impact on our outsourced operations. If we experience problems with our third-party contractors, the costs charged by our third-party contractors increase or our agreements with our third-party contractors are terminated, we may not be able to develop new solutions, enhance or operate existing solutions, or provide customer support in an alternate manner that is equally or more efficient and cost-effective.

We anticipate that we will continue to depend on these and other third-party relationships in order to grow our business for the foreseeable future. If we are unsuccessful in maintaining existing and, if needed, establishing new relationships with third parties, our ability to efficiently operate existing services or develop new services and provide adequate customer support could be impaired, and, as a result, our competitive position or our results of operations could suffer.

Failure by our customers to obtain proper permissions or provide us with accurate and appropriate information may result in claims against us or may limit or prevent our use of information, which could harm our business.

We require our customers to provide necessary notices and obtain necessary permissions for the use and disclosure of the information that we receive. If they do not provide necessary notices or obtain necessary permissions, then our use and disclosure of information that we receive from them or on their behalf may be limited or prohibited by state or federal privacy or other laws. Such failures by our customers could impair our functions, processes and databases that reflect, contain or are based upon such information. For example, as part of our claims submission services, we rely on our customers to provide us with accurate and appropriate information and directives for our actions. While we have implemented features and safeguards relating to the accuracy and completeness of claims content, these features and safeguards may not be sufficient to prevent inaccurate claims data from being submitted to payers. In addition, such failures by our customers could interfere with or prevent creation or use of rules, analyses or other data-driven activities that benefit us, or make our solutions less useful. Accordingly, we may be subject to claims or liability for inaccurate claims data submitted to payers or for use or disclosure of information by reason of lack of valid notice or permission. As another example, we rely on our customers to provide us with accurate and appropriate billing and coding information, including provider enrollment information and medical necessity information. While we have implemented features and safeguards relating to provider enrollment and medical necessity requirements, these features and safeguards may not be sufficient to prevent inaccurate or incomplete billing and coding claims from being submitted to payers. Accordingly, we may be subject to claims or liability for inaccurate or incomplete billing and coding claims. These claims or liabilities could damage our reputation, subject us to unexpected costs and could have a material adverse impact on our business, results of operation or financial condition.

Certain of our solutions present the potential for embezzlement, identity theft or other similar illegal behavior by our employees or vendors with respect to third parties.

Among other things, our solutions include printing and mailing checks and/or facilitating electronic funds transfers for our payer customers and handling mail and payments from payers and from patients for many of our provider customers. These services frequently include handling original checks, payment card information, banking account information and may include currency. Even in those cases in which we do not facilitate payments or handle original documents or mail, our services also involve the use and disclosure of personal and business information that could be used to impersonate third parties or otherwise gain access to their data or funds. If any of our employees or vendors or other bad actors takes, converts or misuses such funds, documents or information, or we experience a data breach creating a risk of identity theft, we could be liable for damages, and our reputation could be damaged or destroyed. In addition, we could be perceived to have facilitated or participated in illegal misappropriation of funds, documents or data and, therefore, be subject to civil or criminal liability. Federal and state regulators may take the position that a data breach or misdirection of data constitutes an unfair or deceptive act or trade practice. We also may be required to notify individuals affected by any data breaches. Further, a data breach or similar incident could impact the ability of our customers that are creditors to comply with the federal “red flags” rules, which require the implementation of identity theft prevention programs to detect, prevent and mitigate identity theft in connection with customer accounts.

Contractual relationships with customers that are governmental agencies or are funded by government programs may impose special burdens on us and provide special benefits to those customers.

A portion of our revenues comes from customers that are governmental agencies or are funded by government programs. Our contracts and subcontracts may be subject to some or all of the following:

- termination when appropriated funding for the current fiscal year is exhausted;
- termination for the governmental customer's convenience, subject to a negotiated settlement for costs incurred and profit on work completed, along with the right to place contracts out for bid before completion of the full contract term, as well as the right to make unilateral changes in contract requirements, subject to negotiated price adjustments;
- compliance and reporting requirements related to, among other things, agency-specific policies and regulations, information security, subcontracting requirements, equal employment opportunity, affirmative action for veterans and workers with disabilities and accessibility for the disabled;
- broad audit rights; and
- specialized remedies for breach and default, including setoff rights, risk allocation, retroactive price adjustments and civil or criminal fraud penalties, as well as mandatory administrative dispute resolution procedures instead of state contract law remedies.

In addition, certain violations of federal and state law may result in termination of our contracts and subcontracts, and under certain circumstances, suspension and/or debarment from future government contracts. We also are subject to conflict-of-interest rules that may affect our eligibility for some federal, state and local government contracts and subcontracts, including rules applicable to all United States government contracts and subcontracts, as well as rules applicable to the specific agencies with which we have contracts or with which we may seek to enter into contracts.

The protection of our intellectual property requires substantial resources and protections of our proprietary rights may not be adequate.

We rely upon a combination of trade secret, copyright and trademark laws, patents, license agreements, confidentiality procedures, nondisclosure agreements and technical measures to protect the intellectual property used in our business. The steps we have taken to protect and enforce our proprietary rights and intellectual property may not be adequate. For instance, we may not be able to secure trademark or service mark registrations for marks in the United States or in foreign countries or take similar steps to secure patents for our proprietary processes, methods and technologies. Even if we are successful in obtaining patent and/or trademark registrations, these registrations may be opposed or invalidated by a third party. In addition, our agreements with employees, consultants and others who develop intellectual property for or on behalf of the Company could be breached and could result in our trade secrets and confidential information being publicly disclosed. We may not have adequate remedies for any such breach. Third parties also may infringe upon or misappropriate our copyrights, trademarks, service marks, patents and other intellectual property rights. If we believe a third party has misappropriated our intellectual property, litigation may be necessary to enforce and protect those rights, which would divert management resources, would be expensive and may not effectively protect our intellectual property. As a result, if a third party infringes or misappropriates our intellectual property, it may have a material adverse impact on our business, results of operation or financial condition. In addition, there can be no assurance that our competitors will not independently develop products or services that are equivalent or superior to our solutions.

Third parties may claim that we are infringing their intellectual property, and we could suffer significant litigation or licensing expenses or be prevented from selling certain solutions.

We could be subject to claims that we are misappropriating or infringing intellectual property or other proprietary rights of others. These claims, even if not meritorious, could be expensive to defend and divert management's attention from our operations. If we become liable to third parties for infringing these rights, we could be required to pay a substantial damage award, including treble damages in some cases, and to develop non-infringing technology, obtain a license or cease selling the solutions or services that use or contain the infringing intellectual property. We may be unable to develop non-infringing solutions or obtain a license on commercially reasonable terms, or at all. We also may be required to indemnify our customers if they become subject to third party claims relating to intellectual property that we license or otherwise provide to them, which could be costly.

Our products and services depend, in part, on intellectual property and technology licensed from third parties.

Much of our business and many of our products rely on key technologies developed or licensed by third parties. For example, many of our software offerings are developed using software components or other intellectual property licensed from third parties, including through both proprietary and open source licenses. These third-party software components may become obsolete, defective or incompatible with future versions of our products, or our relationship with the third party licensor may deteriorate, or our agreements with the third party licensor may expire or be terminated. We may face legal or business disputes with licensors that may threaten or lead to the disruption of inbound licensing relationships. In order to remain in compliance with the terms of our licenses, we must carefully monitor and manage our use of third-party software components, including both proprietary and open source license terms that may require the licensing or public disclosure of our intellectual property without compensation or on undesirable terms. Because the availability and cost of licenses from third parties depends upon the willingness of third parties to deal with us on the terms we request, there is a risk that third parties who license to our competitors will either refuse to license us at all, or refuse to license us on terms equally favorable to those granted to our competitors. Consequently, we may lose a competitive advantage with respect to these intellectual property rights or we may be required to enter into costly arrangements in order to terminate or limit these rights. Additionally, some of these licenses may not be available to us in the future on terms that are acceptable or that allow our product offerings to remain competitive. Our inability to obtain licenses or rights on favorable terms could have a material effect on our business, including our financial condition and results of operations. In addition, it is possible that as a consequence of a merger or acquisition, third parties may obtain licenses to some of our intellectual property rights or our business may be subject to certain restrictions that were not in place prior to such transaction. Because the availability and cost of licenses from third parties depends upon the willingness of third parties to deal with us on the terms we request, there is a risk that third parties who license to our competitors will either refuse to license us at all, or refuse to license us on terms equally favorable to those granted to our competitors. Consequently, we may lose a competitive advantage with respect to these intellectual property rights or we may be required to enter into costly arrangements in order to terminate or limit these rights.

A write-off or acceleration of amortization of all or a part of our long-lived assets (including identifiable intangible assets and goodwill) would adversely affect our operating results and reduce our net worth.

We have significant long-lived assets which include property and equipment, identifiable intangible assets, other noncurrent assets and goodwill. As of March 31, 2018, we had $167.5 million of property and equipment, $1,454.8 million of identifiable intangible assets, $332.0 million of other noncurrent assets and $3,344.8 million of goodwill on our balance sheet, which collectively represented in excess of 85% of our total assets. We amortize property and equipment, identifiable intangible assets and relevant other noncurrent assets over their estimated useful lives. Though we are not permitted to amortize goodwill under United States generally accepted accounting principles, we evaluate our goodwill for impairment at least annually. In the event of anticipated obsolescence or impairment of our long-lived assets, we may write-off all or part of the affected assets or accelerate the related amortization of these assets. A write-off or acceleration of amortization in the future would result in an immediate one-time charge to earnings in the event of an impairment of assets and, in the event of anticipated obsolescence of assets that do not reach the level of an impairment, regular reductions to earnings over the remaining lives of the affected assets. Although it would not affect our cash flow, a write-off or acceleration of amortization in future periods of all or a part of these long-lived assets would adversely affect our financial condition and operating results. See “Management’s Discussion and Analysis of Financial Condition and Results of Operations—Critical Accounting Estimates—Goodwill and Intangible Assets” of this Annual Report.

Our success depends in part on our ability to identify, recruit and retain skilled management and technical personnel. If we fail to recruit and retain suitable candidates or if our relationship with our employees changes or deteriorates, there could be a material adverse impact on our business, results of operation or financial condition.

Our future success depends upon our continuing ability to identify, attract, hire and retain highly qualified personnel, including skilled management, product, technology, sales and marketing personnel, all of whom are in high demand and are often subject to competing offers. Competition for qualified personnel in the healthcare IT industry is intense, and we may not be able to hire or retain a sufficient number of qualified personnel to meet our requirements, or be able to do so at salary, benefit and other compensation costs that are acceptable to us. A loss of a substantial number of qualified employees, or an inability to attract, retain and motivate additional highly skilled employees required for expansion of our business, could have a material adverse impact on our business, results of operation or financial condition. In addition, while none of our employees currently are unionized, unionization of our employees is possible in the future. Such unionizing activities could be costly to address and, if successful, likely would adversely impact our operations.

Lengthy sales, installation and implementation cycles for some of our solutions may result in delays or an inability to generate revenues from these solutions.

Some of our solutions have long sales, installation and implementation cycles, which could range from a few months to two years or more from initial contact with the customer to completion of implementation and resultant generation of revenue. How and when to implement, replace, or expand an information system, or modify or add business processes, are important decisions for healthcare organizations, and some customers may be reluctant to change or modify existing procedures. Some of the solutions we provide require significant capital expenditures and time commitments by the customer. Sales may be subject to delays due to customers' internal procedures for deploying new technologies and processes, and implementation may be subject to delays based on the availability of the internal customer resources needed. We may be unable to control many of the factors that will influence the timing of the buying decisions of potential customers or the pace at which installation and training may occur, including any decision by our customers to delay or cancel implementation. If we experience longer sales, installation and implementation cycles for our solutions, we may experience delays in generating, or a decreased ability to generate, revenue from these solutions, which could have a material adverse impact on our business, results of operation or financial condition. Furthermore, significant delays or failures to meet milestones established in our agreements with customers may result in a breach of contract, termination of the agreement, damages and/or penalties as well as a reduction in our margins or a delay in our ability to recognize revenue.

We may be a party to legal, regulatory and other proceedings that could result in unexpected adverse outcomes.

From time to time, we have been, are and may in the future be, a party to legal and regulatory proceedings and investigations, including matters involving governmental agencies and entities with whom we do business and other proceedings and investigations arising in the ordinary course of business. In addition, there are an increasing number of, and we may be subject to, investigations and proceedings in the healthcare industry generally that seek recovery under HIPAA, the federal Anti-Kickback Law, the FCA, the Stark Law, the Sunshine Act, state laws and other statutes and regulations applicable to our business. We also may be subject to legal proceedings under non-healthcare federal, state and international laws affecting our business, such as the TCPA, FDCPA, FCRA, CAN-SPAM Act, Junk Fax Act, FCPA, employment, banking and financial services and USPS laws and regulations. Such proceedings are inherently unpredictable, and the outcome can result in verdicts and/or injunctive relief that may affect how we operate our business or we may enter into settlements of claims for monetary payments. In some cases, substantial non-economic remedies or punitive damages may be sought. Governmental investigations, audits and other reviews could also result in criminal penalties or other sanctions, including restrictions, changes in the way we conduct business or exclusion from participation in government programs. We evaluate our exposure to these legal and regulatory proceedings and establish reserves for the estimated liabilities in accordance with GAAP. Assessing and predicting the outcome of these matters involves substantial uncertainties. Unexpected outcomes in these legal proceedings, or changes in management's evaluations or predictions and accompanying changes in established reserves, could have a material adverse impact on our business, results of operation or financial condition.

Litigation is costly, time-consuming and disruptive to normal business operations. The defense of these matters could also result in continued diversion of our management's time and attention away from business operations, which could also harm our business. Even if these matters are not resolved against us, the uncertainty and expense associated with unresolved legal proceedings could harm our business and reputation.

If we fail to develop or maintain an effective system of internal controls, we may not be able to report our financial results accurately or prevent fraud, which would likely have a negative impact on our business.

Effective internal controls are necessary for us to provide timely, reliable financial reports, prevent fraud and to operate our business successfully. Our efforts to develop and maintain our system of internal controls—particularly in light of significant complexities in implementation of internal controls that relate to our integration of the contributed businesses as a result of the Transactions—may be costly and/or unsuccessful, and we may be unable to maintain effective controls over our financial processes and reporting as a result. Any failure to develop, implement or maintain effective internal controls, in a cost-effective manner or at all, could harm our operating results or cause us to fail to meet our reporting obligations to the holders of the Notes and otherwise. Given the difficulties inherent in the design and operation of internal controls over financial reporting, we can provide no assurance as to the effectiveness of our internal controls, and we may incur significant costs in our efforts to implement effective internal controls for the combined company resulting from the contribution of the contributed businesses in the Transactions.

In addition, we are in a multi-year process of implementing a new Enterprise Resource Planning ("ERP") business solution to create a system of integrated applications to manage our businesses and automate many functions related to financial reporting, human

resources and other services. It is our intent through this ERP to integrate the major facets of our organization in order to improve planning, development, processes, sales, human resources management and other applications as they affect our evolving business model. Any failure(s) during this continued implementation process to develop, implement or maintain effective internal controls or to improve our internal controls could harm our operating results or cause us to fail to meet our reporting obligations.

Changes in accounting standards issued by the Financial Accounting Standards Board ("FASB") or other standard-setting bodies may adversely affect our financial statements.

Our financial statements are subject to the application of GAAP, which is periodically revised and/or expanded. From time to time, we are required to adopt new or revised accounting standards issued by recognized authoritative bodies. It is possible that future accounting standards we are required to adopt, such as the amended guidance for revenue recognition and leases, may require changes to the current accounting treatment that we apply to our consolidated financial statements and may require us to make significant changes to our systems. Such changes could result in a material adverse impact on our financial position and results of operations.

Risks Related to Our Organizational Structure

We are a holding company and our principal asset is our ownership of equity interests in our subsidiaries; accordingly, we are dependent upon distributions from our subsidiaries to pay any debt service, taxes and any other expenses.

We are a holding company and our principal asset is our ownership of equity interests in our subsidiaries. We have limited direct operations and no independent means of generating revenue. As a result, we are dependent upon dividends, distributions and other payments from our subsidiaries to generate the funds necessary to meet our outstanding debt service and other obligations. Our subsidiaries may not generate sufficient cash from operations to enable us to make principal and interest payments on our indebtedness. In addition, our subsidiaries are separate and distinct legal entities and any payments on dividends, distributions, loans or advances to us by our subsidiaries could be subject to legal and contractual restrictions on dividends. In addition, payments to us by our subsidiaries will be contingent upon our subsidiaries' earnings and generation of positive cash flow. Subject to certain qualifications and limitations in our Senior Credit Facilities, our subsidiaries are permitted to incur additional indebtedness that may restrict payments from those subsidiaries to us. There can be no assurance that agreements governing the current and future indebtedness of our subsidiaries will permit those subsidiaries to provide us with sufficient cash to fund payments of principal, premiums, if any, and interest on our indebtedness when due. In addition, any guarantee will be effectively subordinated to any senior secured indebtedness of a subsidiary guarantor to the extent of the assets securing such indebtedness. To the extent that we need funds and our subsidiaries are unable or otherwise restricted from making distributions under applicable law or regulation, contractual obligations or are otherwise unable to provide funds to us, our liquidity and financial condition could be adversely affected.

We may be unable to integrate recent and future acquisitions successfully or realize the anticipated synergies and other benefits of such acquisitions within the anticipated time frame, or at all.

Integrating businesses that we have recently acquired or plan to acquire in the future will require significant management time, attention and resources. The combined business may fail to realize some or all of the anticipated benefits of the transactions, including anticipated synergies, if the integration process is not successful, takes longer than expected or is more costly than expected. Potential difficulties we may encounter in the integration process include the following:

- the inability to successfully integrate the acquired businesses in a manner that permits us, following completion of the relevant transactions, to achieve the benefits anticipated to result from such transactions;
- the risk of not realizing all of the anticipated operational efficiencies or other anticipated strategic and financial benefits of the acquisitions within the expected time frame or at all;
- potential unknown liabilities and unforeseen increased expenses, including pending litigation, delays or regulatory conditions associated with the transactions; and
- performance shortfalls as a result of the diversion of management's attention caused by completing the transactions and integrating the businesses' operations.

You should be aware that the integration process following certain transactions could result in the distraction of our management, disruption of our ongoing business or inconsistencies in our operations, services, standards, controls, procedures or policies, any of which could adversely affect our ability to maintain relationships with customers, vendors and employees or to achieve the anticipated benefits of the transactions, or could otherwise have a material adverse impact on our business, results of operation or financial condition.

We may be unable to integrate the contributed businesses successfully or realize the anticipated synergies and other benefits of the Transactions within the anticipated time frame, or at all.

The Transactions involved the combination of the contributed businesses that previously operated independently. Integrating these businesses continues to require significant management time, attention and resources. The combined business may fail to realize some or all of the anticipated benefits of the Transactions, including anticipated synergies, if the integration process is not successful, takes longer than expected or is more costly than expected. On a combined basis, we expect to benefit from operational synergies resulting from the consolidation of capabilities and elimination of redundancies, as well as greater efficiencies from our increased scale. However, this process may preclude or impede realization of the benefits expected from the Transactions and could adversely affect revenues and investments in future growth, which could have a material adverse impact on our business, results of operation or financial condition. We cannot be certain that we will not be required to implement further realignment activities, make additions or other changes to our workforce based on other cost reduction measures or changes in the markets and industry in which we compete. In addition, future business conditions and events may impact our ability to continue to realize any benefits of these initiatives. Moreover, disagreements could arise between our controlling members, or between our controlling members and our management, which could cause disruptions to our operations or the implementation of our strategies or result in significant distractions to our management. If we are not able to successfully achieve our objectives for one or more of these reasons, or for other reasons, the anticipated benefits of the Transactions may not be realized fully or at all or may take longer to realize than expected.

We are jointly controlled by McKesson and the Sponsors, and disagreements that may arise between our controlling members, or between our controlling members and our management, that could cause disruptions to our operations, the development or implementation of our strategies or our ability to raise future financing, any of which could have a material adverse impact on our business, results of operation or financial condition.

Disagreements with respect to important strategic or operational decisions relating to our business may arise between our controlling members, McKesson and the Sponsors, who through their affiliates have the right to appoint all of the members of Change Healthcare's board of directors and have joint approval rights over many important aspects of our business, including over operating matters, governance matters and finance and strategic matters. Operating a business under the joint control of unaffiliated, controlling members could lead to conflicts of interest or deadlocks on important and time-sensitive operational, financial or strategic decisions, and will require additional organizational formalities as well as time-consuming procedures for sharing information and making decisions. Disagreements may also arise between our controlling members and our management. Any disagreements between our controlling members, or between our controlling members and our management, could cause disruptions to our operations, the development or implementation of our strategies or our ability to raise future financing, and could result in significant distraction to our management, which could have a material adverse impact on our business, results of operation or financial condition.

Our directors and executive officers have potential conflicts of interest with us.

Our controlling members will be entitled to designate all of the members of Change Healthcare's board of directors, and a majority of such designees may be affiliated with McKesson or the Sponsors. Our controlling members also have joint approval rights over many important aspects of our business, including over operating, governance, finance and strategic matters. In particular, our controlling members have approval rights over the appointment and compensation of our chief executive officer, and Change Healthcare's board of directors will oversee and supervise the selection of and compensation decisions with respect to our other officers. Our officers and the members of Change Healthcare's board of directors may own significant equity interests in, or, in the case of our directors, may be employees or executive officers of, our controlling members. Moreover, the ownership interests of our directors or officers in our controlling members may be of greater value than their ownership of their equity interests in us. Ownership of equity interests by, and other affiliations of our directors and officers in, our controlling members, could create, or appear to create, potential conflicts of interest when directors and officers are faced with decisions that could have different implications for the controlling members or their affiliates than they do for the Company.

The Company relies on McKesson and its subsidiaries for certain transition services. The inability or unwillingness of McKesson or its subsidiaries to provide such services in a timely or effective manner could materially adversely affect our business, results of operation or financial condition.

We rely on McKesson and its subsidiaries to provide the Company with certain services for our business and customers pursuant to the terms of a transition services agreement (the "McKesson Transition Services Agreement") for a specified transition period. Certain of these services are essential to the efficient operation of the Company. Once the transition period specified in the McKesson Transition Services Agreement has expired, we will be required to provide these services ourselves or to obtain substitute arrangements with third parties. After the transition period, we may be unable to provide these services internally because of financial or other constraints, and we may be unable to implement substitute arrangements on a timely and cost-effective basis on terms that are favorable to us, or at all. In addition, McKesson may fail to perform such transition services in a timely or effective manner, or at all, during the term of the McKesson Transition Services Agreement, either due to its inability or unwillingness to continue such services or for other reasons. If there is an interruption in such services prior to expiration of the McKesson Transition Services Agreement, or if such services are inadequate, we will be required to provide these services ourselves or to obtain substitute arrangements with third parties on a faster timeline than anticipated, which may be challenging without significant effort or expense. Any failure by McKesson to perform such transition services, or any failure by us to replace such transition services with acceptable arrangements when necessary, could have a material adverse impact on our business, results of operation or financial condition.

We are obligated to provide certain transition services to McKesson and its affiliates, and to the eRx Network. Our inability or unwillingness to provide such services in a timely or effective manner, including at a reasonable cost, could materially adversely impact our business, results of operation or financial condition.

We are obligated to provide certain services to (i) McKesson and its affiliates, pursuant to the McKesson Transition Services Agreement, and (ii) the eRx Network, pursuant to the terms of a separate transition services agreement (the "CHC Transition Services Agreement" and, collectively with the McKesson Transition Services Agreement, the "Transition Services Agreements"), for a specified transition period. Once the transition period specified in each of the Transition Services Agreements has expired, McKesson and its affiliates, and the eRx Network, as applicable, will be required to provide these services themselves or to obtain substitute arrangements with third parties. We may fail to perform such transition services in a timely or effective manner, or at all, during the term of each respective Transition Services Agreement, either due to our inability or unwillingness to continue such services, our inability to provide such services at reasonable costs or for other reasons. Any such inability or other reasons could lead to unforeseen liabilities under the terms of the Transition Services Agreements or otherwise, including liabilities resulting from the inability of McKesson or its affiliates or the eRx Network to provide these services themselves or to obtain substitute arrangements with third parties. Any such financial consequences or liabilities could have a material adverse impact on our business, results of operation or financial condition.

The amounts we will be required to pay under our tax receivable agreements could be significant and, in certain circumstances, could differ significantly (in both timing and amount) from the underlying tax benefits we actually realize.

Parent and CHC (collectively, our "TRA Affiliates") are parties to certain tax receivable agreements (collectively, the "tax receivable agreements") with our current and former owners. The McKesson Tax Receivable Agreement generally provides for the payment by Parent the McKesson TRA Parties of 85% of certain cash tax savings realized (or, in certain circumstances, deemed to be realized) by HCIT and its subsidiaries in certain periods ending on or after the date on which McKesson ceases to own at least 20% of Parent as a result of (i) certain amortizable tax basis in assets transferred to Parent at the Contribution Agreement Closing and (ii) imputed interest deductions and certain other tax attributes arising from payments under the McKesson Tax Receivable Agreement.

The 2017 Tax Receivable Agreement generally provides for the payment by CHC to affiliates of the Sponsors (the "New CHC TRA Parties") of 85% of the net cash tax savings realized (or, in certain circumstances, deemed to be realized) by CHC in periods ending on or after the Transaction Date as a result of certain net operating losses and certain other tax attributes of CHC as of the Transaction Date.

CHC Holdings is party to the 2009-2011 Tax Receivable Agreements (together with the 2017 Tax Receivable Agreement, the "CHC Tax Receivable Agreements") which obligate CHC Holdings to make payments to certain of its current and former owners, including affiliates of the Sponsors and certain current and former members of CHC Holdings management (the "Existing CHC TRA Parties," and collectively, with the McKesson TRA Parties and the New CHC TRA Parties, the "TRA Parties"), equal to 85% of the

applicable cash savings that CHC Holdings realizes (or is deemed to realize) as a result of tax attributes arising from certain previous transactions. Because covered changes of control with respect to the Existing CHC Tax Receivable Agreements previously occurred or occurred as a result of the Transactions, payments that CHC Holdings makes under these tax receivable agreements will be calculated using certain valuation assumptions, including that CHC Holdings will have sufficient taxable income to use the applicable tax attributes and that certain of such tax attributes will be used by CHC Holdings on a pro rata basis from the Transaction Date (or in certain cases from the date of certain previous transactions) through the expiration of the applicable tax attribute.

The payments our TRA Affiliates may be required to make under these tax receivable agreements could be substantial. The amount and timing of any payments under the tax receivable agreements will vary depending upon a number of factors, including the amount and timing of the taxable income we generate in the future, the tax rate then applicable and whether McKesson then owns at least 20% of Parent. We expect that, assuming no material changes in tax law and that we earn sufficient taxable income to realize the full potential tax benefit, future payments under the CHC Tax Receivable Agreements will range from $13 million to $73 million per year over the next 11 years and from $0.1 million to $8 million per year over the following 10 years. As of the date hereof, we expect total remaining payments under the CHC Tax Receivable Agreements of approximately $356 million. Because payments under the McKesson Tax Receivable Agreement would not begin until after McKesson ceases to own at least 20% of Parent, the amount of any such payments cannot be reliably estimated at this time.

There may be circumstances in which the payments under the tax receivable agreements may differ significantly (in both timing and amount) from the underlying tax benefits our TRA Affiliates actually realize. Pursuant to the tax receivable agreements, upon a covered change of control, our TRA Affiliates could be required to make payments that significantly exceed the actual cash tax savings from the tax benefits giving rise to such payments. As noted above, with respect to the 2009-2011 Tax Receivable Agreements, covered changes of control previously occurred or occurred as a result of the Transactions. Moreover, in certain circumstances, our TRA Affiliates will have the option to terminate the tax receivable agreements in exchange for a lump-sum payment (based on an assumption that all expected potential tax benefits actually will be realized). In addition, under the tax receivable agreements, none of the TRA Parties will reimburse our TRA Affiliates for any payments previously made if such tax benefits are subsequently disallowed, except that excess payments made to a TRA Party will be netted against payments otherwise to be made, if any, after the determination of such excess. As a result, in such circumstances, our TRA Affiliates could make payments under the tax receivable agreements that are greater than the actual cash tax savings and may not be able to recoup those payments. Any difference between the payments our TRA Affiliates are required to make under the tax receivable agreements and the underlying tax benefits actually realized could adversely affect our business. Furthermore, because certain of our TRA Affiliates are holding companies with no operations of their own, their ability to make payments under each relevant tax receivable agreement is substantially dependent on the ability of their subsidiaries to make distributions to them. To the extent that our TRA Affiliates are unable to make payments under the tax receivable agreements for any reason, such payments will be deferred and will accrue interest until paid.

If certain transactions in connection with a Qualified McKesson Exit (as defined in the LLC Agreement) do not qualify as tax-free transactions under Sections 368(a)(1)(D) and 355 of the Internal Revenue Code of 1986, as amended (the "Code"), including as a result of actions taken in connection with the Qualified McKesson Exit or as a result of subsequent acquisitions of shares of HCIT common stock, then McKesson may be required to pay substantial U.S. federal income taxes, and, in certain circumstances and subject to certain conditions, we may be required to indemnify McKesson for all or part of any such tax liability.

It is intended that the distribution contemplated under the Separation and Distribution Agreement to be entered into between a newly-formed Delaware corporation ("SpinCo") and McKesson at the time of a Qualified McKesson Exit (the "Distribution") will qualify as a tax-free transaction to McKesson under Sections 368(a)(1)(D) and 355 of the Code, but there can be no assurance that the Distribution will so qualify. Even if the Distribution were otherwise to qualify as a tax-free transaction under Sections 368(a)(1)(D) and 355 of the Code, it would be taxable to McKesson pursuant to Section 355(e) of the Code if there were a 50% or greater change in ownership of either McKesson or SpinCo (including stock of HCIT after the merger of SpinCo into HCIT following a Qualified IPO), directly or indirectly, as part of a plan or series of related transactions involving the Distribution. For this purpose, any acquisitions of McKesson, SpinCo or HCIT stock within a certain period are presumed to be part of such a plan, although McKesson may be able to rebut that presumption in certain circumstances. If the Internal Revenue Service were to determine that other acquisitions of McKesson, SpinCo or HCIT stock were part of a plan or series of related transactions, that determination could result in significant tax to McKesson. In certain circumstances and subject to certain limitations, under the Tax Matters Agreement, HCIT and we will be required to indemnify McKesson if the Distribution becomes taxable as a result of certain actions by HCIT or SpinCo or as a result of certain changes in ownership of the stock of HCIT or SpinCo after the Distribution or certain acquisitions of stock of McKesson prior

to the Distribution. If we are required to indemnify McKesson, this indemnification obligation could be substantial and could have a material adverse effect on us, including with respect to our financial condition or results of operations.

We are subject to certain restriction in order to avoid significant tax-related liabilities.

The Contribution Agreement, the LLC Agreement and the Tax Matters Agreement prohibit us from taking certain actions that could cause the Distribution to fail to qualify for tax-free treatment. In particular, prior to the Distribution and for a two-year period thereafter, our ability to restructure or discontinue certain aspects of the MTS business will be subject to significant restrictions, which may adversely affect our ability to timely and efficiently integrate the Contributed Businesses. In addition, these agreements impose significant restrictions during that two-year period on the issuance and redemption by HCIT of its stock, as well as on our and HCIT's ability to engage in certain mergers, consolidations, or other strategic transactions, or to enter into agreements with respect to any of the foregoing matters. Furthermore, any failure to comply with any of these restrictions could require us and HCIT to make substantial indemnification payments to McKesson for tax-related losses. Due to these restrictions and indemnification obligations, we may be limited in our ability to pursue strategic transactions, equity or convertible debt financings or other transactions that may otherwise be in our best interests.

Risks Related to Our Indebtedness

Our substantial leverage could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of our variable rate debt and prevent us from meeting our obligations under our debt agreements.

If we cannot generate sufficient cash flow from operations to service our debt, we may need to refinance our debt, dispose of assets or issue equity to obtain necessary funds. We do not know whether we will be able to take any of such actions on a timely basis or on terms satisfactory to us or at all.

Our high degree of leverage could have important consequences, including:

- making it more difficult for us to make payments on our indebtedness;
- increasing our vulnerability to general economic and industry conditions;
- requiring a substantial portion of cash flow from operations to be dedicated to the payment of principal and interest on our indebtedness, thereby reducing our ability to use our cash flow to fund our operations, capital expenditures and future business opportunities;
- exposing us to the risk of increased interest rates because our borrowings under the Senior Credit Facilities are at variable rates of interest;
- restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, debt service requirements, acquisitions and general corporate or other purposes;
- limiting our ability to adjust to changing market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged; and
- increasing our cost of borrowing.

Borrowings under our Senior Credit Facilities are at variable rates of interest and expose us to interest rate risk. If interest rates increase, our debt service obligations on the variable rate indebtedness may increase even though the amount borrowed remains the same, and our net income and cash flows, including cash available for servicing our indebtedness, will correspondingly decrease. Assuming all revolving loans are drawn under the Senior Credit Facilities, a 0.125% change in the floating rate would result in an additional $5.2 million increase in our annual cash interest expense.

Despite our substantial indebtedness, we may still be able to incur significantly more debt. The incurrence of additional debt could increase the risks associated with our substantial leverage, including our ability to service our indebtedness.

We and our subsidiaries may be able to incur significant additional indebtedness in the future, including additional tranches of term loans and/or term loan increases, increases in the revolving commitments and/or additional revolving credit facilities. Although we are currently subject to certain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the additional indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. If we incur additional indebtedness or other obligations, the current risks related to our substantial leverage would increase and could have a negative impact on us or our credit ratings.

The Senior Credit Facilities provide that we have the right at any time to request additional term loan tranches and/or term loan increases, increases in the revolving commitments and/or additional revolving credit facilities up to the sum of (i) (a) the greater of (I) $1,080.0 million and (II) an amount equal to 100.0% of EBITDA for the last four fiscal quarters plus (b) certain voluntary prepayments, repurchases, redemptions and other retirements of existing and future indebtedness and commitments under our Senior Credit Facilities, incremental equivalent debt and refinancings thereof, plus (ii) an additional aggregate amount such that, after giving pro forma effect to such incurrence (x) if such additional amounts are secured on a pari passu basis with first lien obligations under the Senior Credit Facilities, our consolidated first lien net leverage ratio for the last four fiscal quarters does not exceed 4.90 to 1.00, (y) if such additional amounts are secured on a junior lien basis to first lien obligations under the Senior Credit Facilities, our consolidated secured net leverage ratio for the last four fiscal quarters does not exceed 5.75 to 1.00 and (z) if such additional amounts are unsecured, either (I) our consolidated total net leverage ratio for the last four fiscal quarters does not exceed 6.00 to 1.00 or (II) our consolidated interest coverage ratio for the last four fiscal quarters does not exceed 2.00 to 1.0. The lenders under the Senior Credit Facilities will not be under any obligation to provide any such incremental commitments or loans, which are uncommitted, and any such addition of or increase in commitments or loans will be subject to obtaining commitments and certain customary conditions precedent to be set forth in the Senior Credit Facilities.

Our current debt agreements restrict our ability and the ability of most of our subsidiaries to engage in some business and financial transactions.

The Senior Credit Facilities and the Indenture contain a number of covenants that, among other things, restrict, subject to certain exceptions, our ability to:

- incur additional indebtedness and guarantee indebtedness;
- create and incur liens;
- engage in mergers and consolidations;
- sell, transfer and otherwise dispose of assets;
- make investments, acquisitions, loans and advances;
- pay dividends and distributions and repurchase our capital stock;
- prepay, redeem and repurchase subordinated indebtedness and make modifications to the terms of subordinated indebtedness;
- enter into agreements which limit our ability to incur liens on our assets for the benefit of the Senior Credit Facilities, or that restrict the ability of non-guarantor restricted subsidiaries to pay dividends or make other payments to us;
- enter into certain transactions with our affiliates; and
- change the passive holding company status of Intermediate Holdings, the direct parent of the Company.

In addition, with respect to the Revolving Facility, the Senior Credit Facilities require us to maintain, as of the last day of each four fiscal quarter period, a maximum consolidated first lien net leverage ratio of 7.50 to 1.0 only if, as of the last day of any fiscal quarter, revolving loans under the Revolving Facility (including swing-line loans, but excluding undrawn letters of credit up to $100.0 million and other letters of credit that have been cash-collateralized or otherwise backstopped) are outstanding in an aggregate amount greater than 35% of the total commitments under the Revolving Facility at such time. The financial maintenance covenant is subject to

customary equity cure rights and may be amended or waived with the consent of the lenders holding a majority of the commitments under the Revolving Facility. The Senior Credit Facilities also contain certain customary affirmative covenants, negative covenants and events of default, including upon a change of control.

The Indenture also contains a number of restrictive covenants that impose significant operating and financial restrictions on us and may limit our ability to engage in acts that may be in our long-term best interest, including restrictions on our ability and the ability of our restricted subsidiaries to:

- pay dividends on our capital stock or redeem, repurchase or retire our capital stock, subject to customary exceptions, including compliance with a fixed charge coverage ratio and subject to limitation based on net income generated during the term of the indenture;
- incur additional indebtedness or issue certain capital stock;
- incur certain liens;
- make investments, loans, advances and acquisitions;
- consolidate, merge or transfer all or substantially all of our assets and the assets of our subsidiaries;
- prepay subordinated debt;
- engage in certain transactions with our affiliates; and
- enter into agreements restricting our restricted subsidiaries' ability to pay dividends.

If we or our restricted subsidiaries engage in certain asset sales, we generally must either invest the net proceeds from such sales in our business within a period of time, prepay certain debt (including indebtedness outstanding under our Senior Credit Facilities) or make an offer to purchase a principal amount of the Notes equal to the excess net proceeds, subject to certain exceptions. If a change of control occurs, we must make an offer to purchase the Notes at a purchase price of 101%. The Indenture also contains certain customary reporting requirements, negative covenants and events of default.

We will be required to make tax distributions to Parent's equity holders for their tax liabilities in respect of our taxable income, which distributions may significantly exceed the equity holders' actual tax liabilities in respect of such income. The restricted payment provisions of the Indenture and our Senior Credit Facilities will permit us to make distributions to Parent to make all such required payments by Parent.

Change Healthcare and its parent companies (Parent and Change Healthcare Intermediate Holdings, LLC ("Intermediate Holdings")) are pass-through entities for U.S. federal income tax purposes. Accordingly, U.S. federal and applicable state and local income taxes in respect of the taxable income of Parent (and of the Company) are not payable by Parent (or the Company), but instead, each Parent equity holder is subject to such taxes in respect of its allocable share of Parent's net taxable income (which includes the Company's net taxable income). The LLC Agreement requires Parent to make quarterly distributions ("tax distributions") to its equity holders in respect of the taxable income of Change Healthcare.

The LLC Agreement requires that tax distributions be made in amounts sufficient for each Parent equity holder to receive distributions at least equal to its tax liability in respect of Change Healthcare's income. In addition, tax distributions are required to be made to Parent's equity holders pro rata based on their percentage equity ownership, even though some items of Change Healthcare's income, gain, deduction and loss will not be allocated to equity holders pro rata. The effect of this provision will be to "top up" tax distributions to any equity holder that receives disproportionately lower allocations of income and gain, so that the aggregate tax distributions payable by Parent to all equity holders may significantly exceed the equity holders' aggregate tax liability in respect of Change Healthcare's income.

The restricted payment provisions of the Indenture and our Senior Credit Facilities will permit us to make distributions to Parent (and to Intermediate Holdings) to make required tax distributions under the LLC Agreement.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which are subject to prevailing economic and competitive conditions and to certain financial, business and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness. If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, seek additional capital, restructure or refinance our indebtedness, or sell assets. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. The Indenture and our Senior Credit Facilities allow us to reinvest the proceeds of asset sales, subject to certain limitations and exceptions. We may not be able to consummate those asset sales to raise capital or sell assets at prices that we believe are fair and proceeds that we do receive may not be adequate to meet any debt service obligations then due. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit ratings, which could harm our ability to incur additional indebtedness.

Conduent Credit Balance Solutions, LLC (parent Conduent Inc.)

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FORM 10-K

CONDUENT Inc - CNDT

Filed: February 28, 2019 (period: December 31, 2018)

Annual report with a comprehensive overview of the company

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

FORM 10-K

(Mark One)

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

For the fiscal year ended: December 31, 2018

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

For the transition period from: _____ to: _____

Commission File Number 001-37817

CONDUENT INCORPORATED
(Exact Name of Registrant as specified in its charter)

New York	**81-2983623**
(State of incorporation)	(IRS Employer Identification No.)
100 Campus Drive, Suite 200 **Florham Park, New Jersey 07932**	**(844) 663-2638**
(Address of principal executive offices)	**(Registrants telephone number, including area code)**

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

Title of each class	Name of each exchange on which registered
Common Stock, $0.01 par value	**New York Stock Exchange**

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

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

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

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

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

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

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

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

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

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

The aggregate market value of the voting and non-voting common stock of the registrant held by non-affiliates as of June 30, 2018 was $3,809,514,932.

Indicate the number of shares outstanding of each of the Registrant's classes of common stock, as of the latest practicable date:

Class	Outstanding at January 31, 2019
Common Stock, $0.01 par value	211,601,559

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Form 10-K incorporates by reference the Registrant's Notice of 2019 Annual Meeting of Shareholders and Proxy Statement (to be filed with the Securities and Exchange Commission pursuant to Regulation 14A no later than 120 days after the close of the fiscal year covered by this report on Form 10-K).

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FORWARD-LOOKING STATEMENTS

From time to time, we and our representatives may provide information, whether orally or in writing, including certain statements in this Annual Report on Form 10-K, which are deemed to be "forward-looking" within the meaning of the Private Securities Litigation Reform Act of 1995 (the "Litigation Reform Act"). These forward-looking statements and other information are based on our beliefs as well as assumptions made by us using information currently available.

The words “anticipate,” “believe,” “estimate,” “expect,” “intend,” “will,” “should” and similar expressions, as they relate to us, are intended to identify forward-looking statements. These statements reflect our current views with respect to future events and are subject to certain risks, uncertainties and assumptions. Should one or more of these risks or uncertainties materialize, or should underlying assumptions prove incorrect, actual results may vary materially from those expressed or implied herein as anticipated, believed, estimated, expected or intended or using other similar expressions.

In accordance with the provisions of the Litigation Reform Act, we are making investors aware that such forward-looking statements, because they relate to future events, are by their very nature subject to many important factors and uncertainties that could cause actual results to differ materially from those contemplated by the forward-looking statements contained in this Annual Report on Form 10-K, any exhibits to this Form 10-K and other public statements we make.

Such factors include, but are not limited to: government appropriations and termination rights contained in our government contracts; our ability to renew commercial and government contracts awarded through competitive bidding processes; our ability to recover capital and other investments in connection with our contracts; our ability to attract and retain necessary technical personnel and qualified subcontractors; our ability to deliver on our contractual obligations properly and on time; competitive pressures; our significant indebtedness; changes in interest in outsourced business process services; our ability to obtain adequate pricing for our services and to improve our cost structure; claims of infringement of third-party intellectual property rights; the failure to comply with laws relating to individually identifiable information, and personal health information and laws relating to processing certain financial transactions, including payment card transactions and debit or credit card transactions; breaches of our information systems or security systems or any service interruptions; our ability to estimate the scope of work or the costs of performance in our contracts; our continuing emphasis on and shift toward technology-led digital transactions; customer decision-making cycles and lead time for customer commitments; our ability to collect our receivables for unbilled services; a decline in revenues from or a loss or failure of significant clients; fluctuations in our non-recurring revenue; our failure to maintain a satisfactory credit rating; our ability to attract and retain key employees; increases in the cost of telephone and data services or significant interruptions in such services; our failure to develop new service offerings; our ability to modernize our information technology infrastructure and consolidate data centers; our ability to comply with data security standards; our ability to receive dividends or other payments from our subsidiaries; changes in tax and other laws and regulations; changes in government regulation and economic, strategic, political and social conditions; changes in U.S. GAAP or other applicable accounting policies; and other factors that are set forth in the “Risk Factors” section, the “Legal Proceedings” section, the “Management's Discussion and Analysis of Financial Condition and Results of Operations” section and other sections of this Annual Report on Form 10-K, as well as in our Quarterly Reports on Form 10-Q and Current Reports on Form 8-K. We do not intend to update these forward-looking statements, except as required by law.

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CONDUENT INCORPORATED
FORM 10-K
December 31, 2018

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PART I

ITEM 1. BUSINESS

In this Annual Report on Form 10-K, unless the content otherwise dictates, "Conduent", the "Company", "we" or "our" mean Conduent Inc. and its consolidated subsidiaries.

Our Business

Conduent is a leading provider of business process services with expertise in managing operations involving high volume, repeatable and individualized interactions. The Company's portfolio covers both front office and back office operations; however, the majority of its revenue and differentiation derives from engagements where it serves on behalf of its clients to manage end-user interactions across a wide-range of domains. Examples include payments, collections, benefit administration and end-user communication services. The Company creates value for its clients through more efficient service delivery combined with a personalized and seamless experience for the end-user. The Company applies its expertise, technology and innovation to continually modernize its offerings for improved customer and constituent satisfaction and loyalty, increase process efficiency and respond rapidly to changing market dynamics.

On December 31, 2016, Conduent Incorporated (formerly known as the BPO business) spun-off from Xerox Corporation, pursuant to the Separation and Distribution Agreement between the Company and Xerox Corporation (Separation). As a result of the spin-off, we now operate as an independent, publicly traded company on the New York Stock Exchange, under the ticker "CNDT".

With approximately 82,000 employees globally as of December 31, 2018, we provide differentiated services to clients spanning small, medium and large businesses and to governments around the world.

Our Transformation

We have a portfolio of businesses that we are optimizing and effectively targeting attractive growth areas in a rapidly evolving business process services industry. We have taken significant actions to improve our profitability and drive growth with a more focused portfolio of services.

Key initiatives include:

- ***Realigned Delivery.*** During 2018, we reorganized the business to better align to our vertical go-to-market strategy and to our global delivery capabilities. We believe this operating structure will allow us to better integrate and tailor business solutions for our customers.

- ***Divested Non-Core Assets.*** We divested four businesses in 2018 for aggregate proceeds of $703 million in cash. These divestitures enabled us to increase our focus on areas where we have a competitive advantage.

- ***Increased Use of Automation.*** We have developed and deployed a set of advanced software-based automation tools as part of our service delivery operations. These tools reduce the amount of repetitive, manual labor required to deliver many of our services and improve service quality through lower error rates and faster processing times.

- ***Real Estate, Infrastructure and Selling, General and Administrative (SG&A).*** We have significantly reduced the number of our leased and owned properties from 339 to 266 and reduced our information technology infrastructure spending. We have also reduced our SG&A costs from $611 million in 2017 to $560 million in 2018.

We continue to execute on our strategic transformation program to deliver cost savings through infrastructure optimization, labor productivity and automation initiatives, restructuring of unprofitable contracts and other efficiencies. This transformation program has and will enable us to better capitalize on our differentiated service offerings, industry expertise and global delivery excellence and position us for long-term shareholder value creation.

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Our Market Opportunity

We estimate our addressable market size in the global business process service industry at approximately $201 billion in 2018, according to third party industry reports, and we are a leader across several segments of this large, diverse and growing market. Providing business process services is complex and multi-faceted with services that span many industries.

Ongoing competitive pressures and increasing demand for further productivity gains have motivated businesses to outsource elements of their day-to-day operations to accelerate performance and innovation. As a result, our clients have become more focused on their core businesses and the range of outsourced activities has expanded greatly. Increasing globalization has also required many companies to optimize cost structures to retain competitiveness and business process services have become a key component of this strategy.

The ongoing shift to next-generation software and automation technologies is driving greater demand for, and expectation of, efficiency and personalization by the constituents and customers of the businesses and governments we serve. Addressing these business and operational challenges is necessary for business process services companies to capitalize on these trends. In addition, business process services have the potential to meaningfully enhance productivity for businesses and governments and satisfaction for their constituents and customers.

Segments

During 2018, in an effort to better reflect how we manage our business, we segregated our Public Sector segment into Government Services (including Health Enterprise, which was previously reported in Other segment) and Transportation segments. In addition, the Company also reclassified the operating results of our divestitures from the reportable segments to Other segment and separately reflected Shared IT/Infrastructure & Corporate Costs. All prior periods presented have been revised to reflect these changes.

- Our *Commercial Industries* segment provides business process services and customized solutions to clients in a variety of industries. Across the Commercial Industries segment, we deliver end-to-end business-to-business and business-to-customer services that enable our clients to optimize their key processes. Our multi-industry competencies include omni-channel communications, human resource management and finance and accounting services.

- Our *Government Services* segment provides government-centric business process services and subject matter experts to U.S. federal, state and local and foreign governments.

- Our *Transportation* segment provides systems and support to transportation departments and agencies globally. Primary offerings include support for electronic toll collection, public transit, parking and photo enforcement.

Other represents our divestitures and our Student Loan business, which the Company exited in the third quarter of 2018.

We present segment financial information in Note 2 – Segment Reporting to our Consolidated Financial Statements included in Part II, Item 8 of this Form 10-K, which is incorporated herein by reference. The discussion below highlights our segment revenues for the year ended December 31, 2018.

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Commercial Industries

Our Commercial Industries segment is our largest segment, with $2.5 billion in revenues in 2018, representing 47.2% of total revenues. Across the Commercial Industries segment, we deliver end-to-end business-to-business and business-to-customer services that enable our clients to optimize their key processes. Our multi-industry competencies include omni-channel communications, human resource management and finance and accounting services. These services are complemented by innovative industry-specific services such as payment integrity solutions to clients in the healthcare payer space, care and quality analytics, workflow solutions and software adoption services to healthcare provider clients, personalized product information for clients in the automotive industry, source-to-pay solutions for clients in the manufacturing industry, revenue generation and clinical services for clients in the pharmaceutical and life sciences industries, end-user engagement and marketing services for clients in the Retail industry, and mortgage and consumer loan processing for clients in the Financial Services industry.

Government Services

Our Government Services segment generated revenues of $1.4 billion in 2018, representing 25.1% of our total revenues. This segment provides government-centric business process services to U.S. federal, state and local governments for public assistance program administration, transaction processing and payment services. In order to provide targeted support to our government clients, our Government Services segment is organized into several primary businesses:

- ***Federal, State and Local Government:*** We support our government clients with services targeting key civilian agencies within federal, state and local governments, as well as government administrative offices. Our depth of agency-specific expertise combined with our scale allows us to deliver and manage programs at all levels of government. Our broad set of services includes public assistance program administration such as child support, pension administration, records management, electronic benefits, eligibility and payment cards, unclaimed property, disease management and software offerings in support of federal, state and local government agencies.

- ***Payments:*** With more than $75 billion disbursed annually, we are a leader in government payment disbursements for federally sponsored programs like Supplemental Nutritional Assistance Program (SNAP, commonly known as food stamps) and Women, Infant and Children (WIC) as well as government initiated cash disbursements such as child support, unemployment and federal social security. We provide our payment card services which include branded prepaid debit card (Visa and Mastercard), Electronic Benefit Transfer (EBT for SNAP and WIC) and Electronic Child Care to 35 states and the U.S. Treasury with a diversified portfolio consisting of 165 different payment programs nationwide.

- ***Government Healthcare:*** We provide medical management and fiscal agent care management services to Medicaid programs and federally-funded U.S. government healthcare programs in 24 states, Puerto Rico and the District of Columbia. Our services include a range of innovative solutions such as Medicaid management fiscal agent, pharmacy benefits management and clinical program management. These services help states optimize their costs by streamlining access to care and improve patient health outcomes through population health management and help families in need by improving beneficiary support.

Transportation

Our Transportation segment generated revenues of $0.7 billion in 2018, representing 13.5% of our total revenues. This segment provides revenue-generating transportation services to government clients in 24 countries. Our services include support for electronic toll collection, public transit, parking and photo enforcement. Across these offerings, we manage key processes on behalf of our clients including fee collection, compliance and violation management, notifications, statements and reporting. These innovative services significantly improve individual travel experiences, optimize how vehicles and goods move efficiently within cities, digitize integrated modes of transportation and help our government clients to better serve their constituents.

Other

Other includes our divestitures and our Student Loan business, which the Company exited in the third quarter of 2018. In 2018, Other accounted for $0.8 billion of revenues, representing 14.2% of total revenues.

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Our Service Offerings

Our portfolio of business process services includes a combination of industry-specific and multi-industry services. We have subject matter experts who are responsible for implementing each of these services, delivering service excellence to clients, ensuring best practices to improve cost competitiveness, innovating our next generation offerings and supporting worldwide sales.

Industry-Specific Services

Commercial Industry-Specific Services

Examples of the services we offer include personalized product information for automotive clients, source to pay solutions for manufacturing clients, care integration and coordination, member health risk assessments and payment integrity (such as recovering claims from the appropriate payers) for healthcare clients, mortgage and consumer loan processing for financial institution clients and customized workforce learning solutions for aerospace clients.

Transportation Services

The transportation services we offer include support for electronic toll collection, public transit, parking and photo enforcement. Across these offerings, we manage key processes on behalf of our clients including fee collection, compliance and violation management, notifications, statements and reporting.

Government Services

Our broad set of public sector services includes public assistance program administration, pension administration, records management, disease management and software offerings in support of federal, state and local government agencies. It also includes fiscal agent administrative services and providing management information systems in support of Medicaid programs or pharmacy benefits management for Government Healthcare clients.

Multi-Industry Services

Transaction Processing Services

We help our clients to improve communications with their customers and constituents, whether it is on paper, on-line or through other communication channels. By supporting our clients' customer communication processes, we help our clients deliver a better experience to their customers and operate with improved efficiency and greater effectiveness.

We offer a broad array of flexible transaction processing services that include data entry, scanning, image processing, enrollment processing, claims processing, high volume offsite print and mail services and file indexing. Our multi-channel communication capabilities (including secure print, email, text and web) enable the delivery of personalized and targeted communications that are designed to elicit the desired response from customers or other end-users (*e.g.*, on-time bill payment and increased marketing response rates). Our service offerings utilize both proprietary and commercially available third-party technologies, combined with our expertise to ensure continued quality and innovation for our clients.

Payment Services

Prepaid Cards: We are an extensive provider of VISA and MasterCard prepaid debit cards, as well as other electronic payment cards in support of U.S. government benefit programs such as Social Security, the Supplemental Nutrition Assistance Program (formerly known as food stamps), the Special Supplemental Nutrition Program for Women, Infants and Children and other specialized Electronic Benefits Transfer programs. Our secure payment services reduce fraud and eliminate paper checks by disbursing electronic payments directly to end-users, even those without bank accounts. Our proprietary processing platform, significant operational expertise, advanced fraud analytics and adoption of Europay, MasterCard and Visa chip-enabled technology put us in the forefront of the Prepaid Card industry.

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Health Savings Accounts (HSA): We provide clients with a simplified approach to help their employees manage their health care costs and accumulate wealth with tax-advantaged accounts. We consolidate administration of all health spending accounts onto one common platform, including HSA, Health Reimbursement Arrangements, Flexible Spending Accounts and Health Incentive Accounts. By consolidating and integrating the management of health spending accounts, we help our clients improve benefit enrollment and account opening, consolidate customer service, simplify communications and streamline account funding and management. As of December 31, 2018, we had approximately 1 million active HSA accounts and $2.5 billion of assets under management within our HSA offering.

Child Support Payments: We are an industry leader of State Government Disbursement Units in the U.S. for child support payments. We collect payments from non-custodial parents via check, credit card and transfers from employee payroll systems and disburse payments to the beneficiaries.

End-User Engagement

We offer a range of services that help our clients support their end-users. This includes in-bound and out-bound call support for both simple and complex transactions, technical support and patient assistance. We also provide multi-channel communication support (both print and digital) across a range of industries.

Human Resources Services

We help our clients support their employees at all stages of employment from initial on-boarding through retirement, as well as HSA administration. We offer clients a range of customized advisory, technology and administrative services that improve the ability of employees to manage their benefits, professional development and retirement planning. Also, we assist our clients with workers' compensation claims management.

Finance and Accounting Services

We serve clients by managing their critical finance, accounting and procurement processes. Our services include general accounting and reporting, billing and accounts receivable and purchasing, accounts payable and expense management services. We also offer wholesale and retail lockbox services and process auto and mortgage loans in the United States. With a global, dedicated team, we manage the core, end-to-end process areas of finance, accounting and procurement for some of the world's most recognized brands.

Legal Business Services

We have been providing client support to law firms and corporate legal departments for over 20 years. We work across the litigation lifecycle, with particular focus on the legal discovery and review process. Our offerings include litigation support services, compliance and risk review and managed services support.

Workforce Learning Services

We are a provider of end-to-end learning services, designed to accelerate the productivity and development of our clients' employees and extended work forces. Our global presence, superior innovation and expertise allow us to deliver performance-based learning services tailored to our clients' unique strategic business goals. Our offerings include learning strategy and assessment, instructor management and learning administration.

Applied Automation and Analytics Solutions

Many of our service offerings described above incorporate our applied automation and analytics solutions to increase their value and effectiveness to clients across all industries. We deploy these solutions to personalize millions of interactions, optimize service delivery and simplify complex processes. For example, our customer care services harness the power of applied analytics and automation to help our customer service agents work more efficiently across different communication channels. Our applied automation solutions track and learn the most efficient means to address common customer service needs as they occur in real time so that we can solve the same problem faster the next time around. The combination of applied automation and analytics allows us to identify new service demand patterns and opportunities quickly so that we can proactively address them on behalf of our clients.

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Our Competitive Strengths

We possess a number of competitive strengths that distinguish us from our competitors, including:

Leadership in attractive growth markets. We are a leader in business process services. Our clients continue to outsource key business processes to accelerate performance and innovation. Additionally, clients are moving beyond services for back-office functions in order to drive customer satisfaction and loyalty, as well as productivity and efficiency. The increase in globalization and cost competition continues to accelerate, forcing companies to seek ways to stay ahead of the competition. These factors, along with clients and their customers demanding more personalized, seamless and secure solutions, are collectively driving the ongoing shift to next-generation software and automation technologies.

- ***Healthcare.*** U.S. healthcare spending was estimated to have represented 17.9% of GDP in 2017 and is projected to grow at an average rate of 5.5% per year for 2017-2026. As one of the most regulated industries, healthcare providers must balance increased utilization with heightened complexity and new financial pressures such as government budget challenges to significantly reduce reimbursements, reimbursement penalties for hospital readmissions and a shift from fee-for-service to “value-based” population health management. We are widely recognized by industry analysts as a leader in healthcare payer operations, serving 19 of the top 20 U.S. managed healthcare plans and providing administrative and care management solutions to Medicaid programs and federally funded U.S. government healthcare programs in 24 states, Puerto Rico and the District of Columbia.

- ***Transportation.*** Traffic congestion continues to increase as urbanization and changing demographics take hold globally. As a result, optimized transportation systems are becoming critical to increase efficiency while maintaining strict safety requirements. Electronic toll collection, public transit and parking all represent key growth drivers as governments at all levels increasingly focus on transportation infrastructure. We are an award-winning innovator in parking management.

- ***Transaction Processing.*** We provide high volume print and mail services, enrollment processing and personalized and targeted marketing and communications, to large corporations and we believe we are a leading provider in this market.

- ***Prepaid Cards***: We are the leading provider of prepaid payment card services in support of the U.S. government prepaid card services market.

Global delivery expertise. Our scale and global delivery network enables us to deliver our proprietary technology, differentiated service offerings and service capabilities expertly to clients around the world. We have operations in India, Philippines, Jamaica, Guatemala, Mexico, Romania, Dominican Republic and several locations within the United States, giving our customers the option for "onshore" or "offshore" outsourced business process services. This global delivery model enables us to leverage lower-cost production locations, consistent methodologies and processes, time zone advantages and business continuity plans. As of December 31, 2018, 49% of our employees were located in high cost countries and 51% were located in low cost countries.

Differentiated suite of multi-industry service offerings at scale. We manage transaction-intensive processes and work directly with end-users to meet their needs often in real-time. We are unique in our ability to offer our clients these business process services on a large scale and with high quality. Additionally, we are able to leverage our multi-industry services to bring the same scale and quality to our portfolio of industry-specific service offerings, such as healthcare claims management, employee benefits management and public transit fare collection.

Innovation and development. We innovate by developing and acquiring new technologies and capabilities that improve business processes. We are constantly creating the next generation of simple, automated and touchless business processes to drive lower costs, higher quality and increased end-user satisfaction. Analytics allow us to transform big data into useful information that helps identify operational improvements and constituent insights. Additionally, we leverage robotic process automation and predictive analytics and combine this with our deep subject matter expertise to create intelligent services that improve security, increase speed and improve accuracy, quality and regulatory compliance, and uncover insights that support better decision making and outcomes for our clients.

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Stable recurring revenue model supported by a loyal, diverse client base. We have a broad and diverse base of clients in 26 countries across geographies and industries, including Fortune 1000 companies, small and midsize businesses and governmental entities. Our close client relationships and successful client execution support our stable recurring revenue model and high renewal rates. Excluding our strategic decision not to renew certain contracts, renewal rates for 2018 and 2017 were 95% and 94%, respectively.

Our Strategies

Our strategy is to drive leadership in attractive markets by leveraging and building on our competitive strengths. We intend to execute our strategy through increased business portfolio focus and operating discipline, enhanced sales and delivery capabilities and tightly aligned investments. Our strategy is designed to deliver value by delivering profitable growth, expanding operating margins and deploying a disciplined capital allocation strategy.

Specific elements of our strategy include the following:

Expand within attractive industries. The industries in which we operate have attractive revenue growth rates, generally in the mid-single digits. We intend to sharpen our focus and expand our business in industries with strong growth and profitability characteristics. We will employ a disciplined approach to portfolio management to complement our competitive strengths and build depth and breadth in our core businesses. Within the Healthcare industry, we intend to leverage our data analytics, differentiated service offerings and industry know-how to continue to service payer, provider and core government healthcare clients. Within the Transportation industry, we will leverage our global, end-to-end platforms to continue to deliver seamless travel experiences while providing back-end Transaction Processing and Call Center services for government clients globally.

Optimize and strengthen our services capabilities. We plan to optimize our services capabilities and strengthen several core areas, including Transaction Processing, Finance and Accounting and Prepaid Card services by building out our services offerings and continuing to improve our competitive strengths. We have divested non-core assets, refocused our business towards higher margin growing segments and consolidated delivery operations to enable greater productivity. Within Transaction Processing, we intend to continue to build industry-specific service offerings and advance inbound and outbound processing capabilities. Within End-User Engagement, we intend to capitalize on our global scale, cost efficiencies and our ability to provide seamless communications between our clients and their end-users through traditional (e.g., voice) and digital (e.g., web, mobile and Internet of Things) channels. In Prepaid Cards, we plan to continue to leverage our scalable platform to help our clients simplify their payment disbursement processes.

Continue to advance next-generation platforms and capabilities. We intend to maintain our focus on innovation to create next-generation solutions aligned with our clients' future needs and our growth strategies. We plan to advance our current platforms, further automate and personalize business processes and enhance data analytics capabilities to deliver value-added services for our clients.

Engage, develop and support our people. We intend to increasingly develop our employees by investing in training, processes and systems to equip them with modern tools that enable them to perform their jobs more efficiently. Furthermore, we plan to strengthen our sales teams throughout improved and optimized coverage and effective talent management.

Competition

Although we encounter competition in all areas of our portfolio, we lead across many areas of our principal businesses. We compete on the basis of technology, performance, price, quality, reliability and customer service and support. In the current political environment in the U.S. and other territories, we also consider our "onshore" delivery capacity to be a competitive advantage. We participate in a highly competitive and rapidly evolving market, driven by changes in industry standards and demands of customers to become more efficient. Our competitors range from large international companies to relatively small firms. Our competitors include:

- Large multinational service providers such as CGI Group, Accenture, Aon Hewitt, Cognizant, Hewlett-Packard Enterprise, IBM, Teletech and Teleperformance;
- Traditional Business Process Outsourcing companies such as Genpact, ELX Services, Exela Technologies and WNS Global Services;
- Payroll processing and human capital management providers such as ADP and Paychex;

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- Healthcare-focused IT and service solutions providers such as Cerner and Maximus;
- U.S. Federal focused government services such as CACI International and DXC Technology;
- Transportation multi-nationals such as Roper/TransCore, Cubic and Kapsch; and
- Smaller niche business processing service providers and in-house departments that perform functions that could be outsourced to us.

Sales and Marketing

We market our business process services to both potential and existing clients through our worldwide sales force and our business development team. Additionally, we have dedicated "solution architects" who work with clients to better understand their situation and develop a custom-tailored solution to meet their unique needs.

Our sales and marketing strategy is to go to market by industry to deliver key industry-specific and multi-industry service offerings to our clients. We focus on developing new prospects through market research and analysis, renewing expiring contracts and leveraging existing client relationships to offer additional services. We leverage our broad, multi-industry service offerings to package solutions through enterprise selling, while maintaining a disciplined approach to pricing and contracting. Our sales efforts typically involve extended selling cycles and our expertise in specific industries is critical to winning new business.

Our Geographies

We provide services globally and we have a diversified geographic delivery network, including a significant presence within the U.S. In 2018, approximately 12% of our revenues were generated by clients outside the United States. In 2018, our revenues by geography were as follows: $4,748 million in the United States (88% of total revenues), $497 million in Europe (9% of total revenues) and $148 million from the rest of the world (3% of total revenues). We present geographical information in Note 2 – Segment Reporting to our Consolidated Financial Statements included in Part II, Item 8 of this Form 10-K, which is incorporated herein by reference.

Innovation and Research and Development

Our innovation and research and development (R&D) capabilities are critical to our client value proposition and competitive positioning. Our investments in innovation align with our growth strategies and are driven by a view of future needs and required competencies developed in close partnership with our clients and R&D partners. We are investing in attractive markets, such as healthcare and transportation, and building on proven platforms to create services that distinguish us from our competitors.

Our innovation and R&D are focused on three key areas: automation, personalization and analytics.

Automation—Create simple, automated and touchless business processes to drive lower costs, higher quality and increased agility. Businesses require agility to quickly respond to market changes and new customer requirements. To enable greater business process agility, our R&D goals are to simplify, automate and enable business processes via flexible platforms that run on robust and scalable infrastructures. Automation of business processes benefits from our strong image, video and robotic processing, as well as our machine learning capabilities. Application of these methods to business processes enables technology to perform tasks that today are performed manually. Examples include providing automation solutions in transportation by aggregating and automatically applying business rules to simplify toll payments, using our state-of-the-art video and image analytics to reduce the need for manual review of license plates in tolling and toll adjustment scenarios, analyzing data on eligibility claims and checking for correctness on applications. The scope of automation is applied across our portfolio of services and is a key element of our ongoing strategy of modern, efficient services.

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Personalization—Augment humans by providing secure, real-time and context-aware personalized products and services. Whether business correspondence, personal communication, manufactured items or information service, personalization increases the value to the recipient. Our R&D investments lead to technologies that improve the efficiency, economics and relevance of business services, such as customer care and health and welfare services. For example, in our current customer care service offerings, the human touch is seamlessly added as our software automatically takes telephony data and merges it with customer records pulled from multiple sources to seamlessly create targeted scripts and flows. This allows the agent to have the caller's data readily available and provide a more personal experience to the customer—whether on the phone or online. In toll systems, our systems automatically pull up a customer's name, verify their information and prompt them for unpaid tolls. In transit systems, our mobile app aggregates and calculates the time, cost, carbon footprint and health benefits from walking, biking, driving, parking and taking public transit. For health and welfare, our systems provide state-of-the-art personalized delivery to ensure the best utilization of funds for the neediest populations.

Analytics—Transform big data into useful information to support better decision making. Competitive advantage can be achieved by better utilizing available and real-time information. Today, information resides in an ever increasing universe of servers, repositories and formats. The vast majority of information is unstructured, including text, images, voice and videos. We seek to better manage large data systems in order to extract business insights to provide our clients with actionable recommendations and new services. Tailoring these methods to various industry applications leads to new customer value propositions. In hospitals, we mine usage and clinical indicators to improve patient experiences. We also help our healthcare clients identify waste and fraud by identifying networks of providers and patients with suspicious behavior, such as sudden and dramatic increases in a provider's level of business or unusual or illogical patient treatment sequences. In transportation, we enable transport and parking operators to better understand and predict commuter needs, including adherence to schedules, passenger loading levels, car park utilization rates and the impact of varying factors, such as weather and schedule variations. In our card payment services business, we perform geo location analytics to predict potential fraud behaviors to assure monies are being distributed to the intended recipients.

Intellectual Property

Our general policy is to seek patent protection for those inventions likely to be incorporated into our products and services or where obtaining such proprietary rights will improve our competitive position. We own approximately 1,011 patents and pending applications. Our patent portfolio evolves as new patents are awarded to us and as older patents expire. These patents expire at various dates, generally 20 years from their original filing dates. While we believe that our portfolio of patents and applications has value, in general, no single patent is essential to our business or any individual segment. In addition, any of our proprietary rights could be challenged, invalidated or circumvented, or may not provide significant competitive advantages.

Our business relies on software provided to an approximately equal extent, by both internal development and external sourcing to deliver our services. With respect to internally developed software, we claim copyright on all such software, registering works which may be accessible to third parties. In addition, we rely on maintaining source code confidentiality to assure our market competitiveness. With respect to externally sourced software, we rely on contracts assuring our continued access for our business usage.

In the United States, we own 87 trademarks, which are either registered or applied for, reflecting the many businesses we participate in. These trademarks may have a perpetual life, subject to renewal every 10 years and may be subject to cancellation or invalidation based on certain use requirements and third party challenges, or on other grounds. We vigorously enforce and protect our trademarks.

People and Culture

We draw on the business and technical expertise of our talented and diverse global workforce to provide our clients with high-quality services. Our business leaders bring a strong diversity of experience in our industry and a track record of successful performance and execution.

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Conduent established its own diversity and inclusion program post-separation, which is overseen by Conduent's human resources department. Conduent promotes understanding and inclusion through a comprehensive set of diversity initiatives and strategies, including addressing under-representation by identifying shortfalls and developing action plans to close those gaps and through work-life programs that assist employees in certain aspects of their personal lives. Additionally, Conduent informs and educates all employees on diversity programs, policies and achievements. As an independent company, we intend to continue our commitment to diversity and inclusion and implement similar policies and programs.

In the United States, Conduent complies with Equal Employment Opportunity guidelines and all applicable federal, state and local laws that govern the hiring and treatment of our employees.

As of December 31, 2018, we had approximately 82,000 employees globally, with 43% located in the United States and the remainder located primarily in India, Philippines, Jamaica, Guatemala and Mexico.

Training and Talent Development

We believe our people are our most important asset, which is why we invest in employee growth and development programs. We are focused on building a workplace where our people can do their best work and have access to the tools and resources they need to perform their jobs more effectively. We are building a culture of learning and have shifted from delivering training to incorporating learning into day-to-day work.

We have a strong performance management system in place that requires all employees to engage with their managers on goal-setting and performance feedback, enabling personal and professional development. There is a strong emphasis on mentorship and coaching, both formal and informal, to help employees get to the next level in their careers. We enable this by developing management capability for our frontline leaders to ensure they are able to coach and mentor their teams and engage in constructive and continuous two-way dialogue.

Corporate Ethics

Our commitment to business ethics represents more than a declaration to do the right thing. It has become an integral part of the way we do business. We operate according to our ethics and compliance program, which is designed to meet general governance and specific industry and regulatory requirements with a focus on values, culture and performance with integrity. Conduent has a business ethics program, which is overseen by the business ethics office, and a code of business conduct (Code), which serves as the foundation of our business ethics program. The Code sets forth our expectations for ethical leadership, performance with integrity and compliance with company policies and the law. In addition, the Code embodies and reinforces Conduent's commitment to integrity and helps employees resolve ethics and compliance concerns consistent with operating principles and legal and policy controls. In addition, our employees are required to complete business ethics training annually and we periodically solicit their input to gauge the state of Conduent's ethical culture and help identify areas for improvement.

Our directors must act in accordance with our Code of Business Conduct and Ethics for Members of the Board; our principal executive officer, principal financial officer and principal accounting officer, among others, must act in accordance with our Finance Code of Conduct; and all of our executives and employees must act in accordance with our Code of Business Conduct. Each of these codes of conduct can be accessed through our website at www.conduent.com/corporate-governance. They are also available to any shareholder who requests them in writing addressed to Conduent Incorporated, 100 Campus Drive Suite 200, Florham Park, NJ 07932, Attention: Corporate Secretary. We will disclose any future amendments to, or waivers from, provisions of our Code of Business Conduct and Ethics for members of the Board and, our Code of Business Conduct and our Finance Code of Conduct for our officers on our website as promptly as practicable, and consistent with the requirements of applicable U.S. Securities and Exchange Commission (SEC) and New York Stock Exchange rules.

Seasonality

Our revenues can be affected by various factors such as our clients' demand pattern for our services. These factors have historically resulted in higher revenues and profits in the fourth quarter.

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Other

Conduent Incorporated is a New York corporation, organized in 2016. Our principal executive offices are located at 100 Campus Drive, Florham Park, New Jersey 07932. Our telephone number is (844) 663-2638.

In the Investor Information section of our Internet website, you will find our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and any amendments to these reports. We make these documents available as soon as we can after we have filed them with, or furnished them to, the SEC.

Our Internet address is www.conduent.com.

ITEM 1A. RISK FACTORS

Our government contracts are subject to appropriation of funds, termination rights, audits and investigations, which, if exercised, could negatively impact our reputation and reduce our ability to compete for new contracts.

A significant portion of our revenues is derived from contracts with U.S. federal, state and local governments and their agencies, and some of our revenues are derived from contracts with foreign governments and their agencies. Government entities typically finance projects through appropriated funds. While these projects are often planned and executed as multi-year projects, government entities usually reserve the right to change the scope of or terminate these projects for lack of approved funding and/or at their convenience. Changes in government or political developments, including budget deficits, shortfalls or uncertainties, failures to enact appropriation legislation (e.g., a government "shut-down"), government spending reductions (e.g., Congressional sequestration of funds under the Budget Control Act of 2011) or other debt or funding constraints, could result in lower governmental sales and in our projects being reduced in price or scope or terminated altogether, which also could limit our recovery of incurred costs, reimbursable expenses and profits on work completed prior to the termination. Additionally, if the government discovers improper or illegal activities or contractual non-compliance (including improper billing), we may be subject to various civil and criminal penalties and administrative sanctions, which may include termination of contracts, forfeiture of profits, suspension of payments, fines and suspensions or debarment from doing business with the government. Any resulting penalties or sanctions could materially adversely affect our results of operations and financial condition. Moreover, government contracts are generally subject to audits and investigations by government agencies. If the government finds that we inappropriately charged any costs to a contract, the costs are not reimbursable or, if already reimbursed, the cost must be refunded to the government. Further, the negative publicity that could arise from any such penalties, sanctions or findings in such audits or investigations could have an adverse effect on our reputation in the industry and reduce our ability to compete for new contracts and could materially adversely affect our results of operations and financial condition.

We derive significant revenue and profit from commercial and government contracts awarded through competitive bidding processes, including renewals, which can impose substantial costs on us, and we will not achieve revenue and profit objectives if we fail to accurately and effectively bid on such projects.

Many of these contracts are extremely complex and require the investment of significant resources in order to prepare accurate bids and proposals. Competitive bidding imposes substantial costs and presents a number of risks, including: (i) the substantial cost and managerial time and effort that we spend to prepare bids and proposals for contracts that may or may not be awarded to us; (ii) the need to estimate accurately the resources and costs that will be required to implement and service any contracts we are awarded, sometimes in advance of the final determination of their full scope and design; (iii) the expense and delay that may arise if our competitors protest or challenge awards made to us pursuant to competitive bidding and the risk that such protests or challenges could result in the requirement to resubmit bids and in the termination, reduction or modification of the awarded contracts; and (iv) the opportunity cost of not bidding on and winning other contracts we might otherwise pursue. If our competitors protest or challenge an award made to us on a government contract, the costs to defend such an award may be significant and could involve subsequent litigation that could take years to resolve.

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Our ability to recover capital and other investments in connection with our contracts is subject to risk.

In order to attract and retain large outsourcing contracts, we sometimes make significant capital and other investments to enable us to perform our services under those contracts, such as purchases of information technology equipment, facility costs, labor resources and costs incurred to develop and implement software. The net book value of certain assets recorded, including a portion of our intangible assets, could be impaired, and our results of operations and financial condition could be materially adversely affected in the event of the early termination of all or a part of such a contract or a reduction in volumes and services thereunder for reasons such as a customer's or client's merger or acquisition, divestiture of assets or businesses, business failure or deterioration or a customer's or client's exercise of contract termination rights.

We rely to a significant extent on third-party providers, such as subcontractors, a relatively small number of primary software vendors, utility providers and network providers; if they cannot deliver or perform as expected or if our relationships with them are terminated or otherwise change, our results of operations and financial condition could be materially adversely affected.

Our ability to service our customers and clients and deliver and implement solutions depends to a large extent on third-party providers such as subcontractors, a relatively small number of primary software vendors, software application developers, utility providers and network providers meeting their obligations to us and our expectations in a timely, quality manner. Recently, we have experienced suboptimal performance from an inherited legacy technology vendor, which has caused certain operational challenges and customer delivery performance issues that we have been aggressively addressing. Our results of operations and financial condition could be materially adversely affected and we might incur significant additional liabilities (a) if we are unable to adequately renegotiate these legacy contracts, or (b) if any of our third-party providers (1) do not meet their service level obligations, (2) do not meet our or our clients' expectations, (3) terminate or refuse to renew their relationships with us, or (4) offer their products to us with less advantageous prices and other terms than previously offered.

Failure to deliver on our contractual obligations properly and on time could materially adversely affect our results of operations and financial condition.

Our business model depends in large part on our ability to retain existing and attract new work from our base of existing clients, as well as on relationships we develop with our clients so that we can understand our clients' needs and deliver solutions and services that are tailored to meet those needs. In order for our business to grow, we must successfully manage the provision of services under our contracts. If a client is not satisfied with the quality of work performed by us or a subcontractor, or with the type of services or solutions delivered, then we could incur additional costs to address the situation, the profitability of that work might be impaired and the client's dissatisfaction with our services could damage our ability to obtain additional work from that client or obtain new work from other potential clients. In particular, many of our contracts with non-government clients may be terminated by the client, without cause, upon specified advance notice. Accordingly, clients who are not satisfied might seek to terminate existing contracts prior to their scheduled expiration date, which may result in our inability to fully recover our up-front investments. In addition, clients could direct future business to our competitors. We could also trigger contractual credits to clients or a contractual default. Failure to properly transition new clients to our systems, properly budget transition costs or accurately estimate contract operational costs could result in delays in our contract performance, trigger service level penalties, impair fixed or intangible assets or result in contract profit margins that do not meet our expectations or our historical profit margins.

In addition, we incur significant expenditures for the development and construction of system software platforms needed to support our clients' needs. Our failure to fully understand client requirements or implement the appropriate operating systems or databases or solutions which enable the use of other supporting software may delay the project and result in cost overruns or potential impairment of the related software platforms, which could materially adversely affect our results of operations and financial condition.

We face significant competition and our failure to compete successfully could materially adversely affect our results of operations and financial condition.

To remain competitive, we must develop services and applications; periodically enhance our existing offerings; remain cost efficient; and attract and retain key personnel and management. If we are unable to compete successfully, we could lose market share and important customers to our competitors and that could materially adversely affect our results of operations and financial condition.

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Our significant indebtedness could materially adversely affect our results of operations and financial condition.

We have and will continue to have a significant amount of debt and other obligations. Our substantial debt and other obligations could have important consequences. For example, it could (i) increase our vulnerability to general adverse economic and industry conditions; (ii) limit our ability to obtain additional financing for future working capital, capital expenditures, acquisitions and other general corporate requirements; (iii) require us to dedicate a substantial portion of our cash flows from operations to service debt and other obligations thereby reducing the availability of our cash flows from operations for other purposes; (iv) limit our flexibility in planning for, or reacting to, changes in our businesses and the industries in which we operate; (v) place us at a competitive disadvantage compared to our competitors that have less debt; and (vi) become due and payable upon a change in control. If new debt is added to our current debt levels, these related risks could increase.

Our ability to make payments on and to refinance our indebtedness, as well as any future debt that we may incur, will depend on our ability to generate cash in the future from operations, financings or asset sales. Our ability to generate cash is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control.

The terms of our indebtedness may restrict our current and future operations, particularly our ability to incur debt that we may need to fund initiatives in response to changes in our business, the industries in which we operate, the economy and governmental regulations.

The terms of our indebtedness include a number of restrictive covenants that impose significant operating and financial restrictions on us and our subsidiaries and limit our ability to engage in actions that may be in our long-term best interests. These may restrict our and our subsidiaries' ability to take some or all of the following actions:

- incur or guarantee additional indebtedness or sell disqualified or preferred stock;
- pay dividends on, make distributions in respect of, repurchase or redeem, capital stock;
- make investments or acquisitions;
- sell, transfer or otherwise dispose of certain assets, including accounts receivable;
- create liens;
- enter into sale/leaseback transactions;
- enter into agreements restricting the ability to pay dividends or make other intercompany transfers;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our or our subsidiaries' assets;
- enter into transactions with affiliates;
- prepay, repurchase or redeem certain kinds of indebtedness;
- issue or sell stock of our subsidiaries; and/or
- significantly change the nature of our business.

As a result of all of these restrictions, we may be:

- limited in how we conduct our business and pursue our strategy;
- unable to raise additional debt financing to operate during general economic or business downturns; or
- unable to compete effectively or to take advantage of new business opportunities.

A breach of any of the restrictive covenants, if applicable, could result in an event of default under the terms of this indebtedness. If an event of default occurs, the lenders would have the right to accelerate the repayment of such debt and the event of default or acceleration may result in the acceleration of the repayment of any other of our debt to which a cross-default or cross-acceleration provision applies. Furthermore, the lenders of this indebtedness may require that we pledge our assets as collateral as security for our repayment obligations. If we were unable to repay any amount of this indebtedness when due and payable, the lenders could proceed against the collateral that secures this indebtedness. In the event our creditors accelerate the repayment of our borrowings, we may not have sufficient assets to repay such indebtedness, which could materially adversely affect our results of operations and financial condition.

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Our business is dependent on continued interest in outsourcing.

Our business and growth depend in large part on continued interest in outsourced business process services. Outsourcing means that an entity contracts with a third-party, such as us, to provide business process services rather than perform such services in-house. There can be no assurance that this interest will continue, as organizations may elect to perform such services themselves and/or the business process outsourcing industry could move to an as-a-Service model, thereby eliminating traditional business process outsourcing tasks. A significant change in this interest in outsourcing could materially adversely affect our results of operations and financial condition. Additionally, there can be no assurance that our cross-selling efforts will cause clients to purchase additional services from us or adopt a single-source outsourcing approach.

Our profitability is dependent upon our ability to obtain adequate pricing for our services and to improve our cost structure.

Our success depends on our ability to obtain adequate pricing for our services that will provide a reasonable return to our shareholders. Depending on competitive market factors, future prices we obtain for our services may decline from previous levels. If we are unable to obtain adequate pricing for our services, it could materially adversely affect our results of operations and financial condition. In addition, our contracts are increasingly requiring tighter timelines for implementation as well as more stringent service level metrics. This makes the bidding process for new contracts much more difficult and requires us to adequately consider these requirements in the pricing of our services.

In order to meet the service requirements of our customers, which often includes 24/7 service, and to optimize our employee cost base, including our back-office support, we often locate our delivery service and back-office support centers in lower-cost locations, including several developing countries. Concentrating our centers in these locations presents a number of operational risks, many of which are beyond our control, including the risks of political instability, natural disasters, safety and security risks, labor disruptions, excessive employee turnover and rising labor rates. Additionally, a change in the political environment in the United States or the adoption and enforcement of legislation and regulations curbing the use of such centers outside of the United States could materially adversely affect our results of operations and financial condition. These risks could impair our ability to effectively provide services to our customers and keep our costs aligned to our associated revenues and market requirements.

Our ability to sustain and improve profit margins is dependent on a number of factors, including our ability to continue to improve the cost efficiency of our operations through such programs as robotic process automation, to absorb the level of pricing pressures on our services through cost improvements and to successfully complete information technology initiatives. If any of these factors adversely materialize or if we are unable to achieve and maintain productivity improvements through restructuring actions or information technology initiatives, our ability to offset labor cost inflation and competitive price pressures would be impaired, each of which could materially adversely affect our results of operations and financial condition.

We may be subject to claims of infringement of third-party intellectual property rights which could adversely affect our results of operation and financial condition.

We rely heavily on the use of intellectual property. We do not own all of the software that we use to run our business; instead we license this software from a small number of primary vendors. If these vendors assert claims that we or our clients are infringing on their software or related intellectual property, we could incur substantial costs to defend these claims, which could materially adversely affect our results of operations and financial condition. In addition, if any of our vendors' infringement claims are ultimately successful, our vendors could require us to (i) cease selling or using products or services that incorporate the challenged software or technology, (ii) obtain a license or additional licenses from our vendors or (iii) redesign our services which rely on the challenged software or technology. In addition, we may be exposed to claims for monetary damages. If we are unsuccessful in defending an infringement claim and our vendors require us to initiate any of the above actions, or we are required to pay monetary damages, then such actions could materially adversely affect our results of operations and financial condition.

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We are subject to laws of the United States and foreign jurisdictions relating to individually identifiable information and personal health information, and failure to comply with those laws, whether or not inadvertent, could subject us to legal actions and negatively impact our operations.

We receive, process, transmit and store information relating to identifiable individuals, both in our role as a service provider and as an employer. As a result, we are subject to numerous United States (both federal and state) and foreign jurisdiction laws and regulations designed to protect both individually identifiable information as well as personal health information, including the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the HIPAA regulations governing, among other things, the privacy, security and electronic transmission of individually identifiable health information, and the European Union Directive on Data Protection (Directive 95/46/EC). The EU General Data Protection Regulation (GDPR) replaced the Data Protection Directive 95/46/EC (with an enforcement date of May 25, 2018) and is designed to harmonize data privacy laws across Europe, to protect and empower all EU citizens data privacy, to reshape the way organizations across the region approach data privacy and will have a significant impact on how we process and handle certain data. Other United States (both federal and state) and foreign jurisdiction laws apply to our processing of individually identifiable information. These laws have been subject to frequent changes, and new legislation in this area may be enacted at any time. For example, the invalidation of the U.S.-EU Safe Harbor regime and the GDPR have required us to implement alternative mechanisms in order for some of our data flows from Europe to the United States to comply with applicable law. Changes to existing laws, the introduction of new laws in this area or failure to comply with existing laws that are applicable to us may subject us to, among other things, additional costs or changes to our business practices, liability for monetary damages, fines and/or criminal prosecution, unfavorable publicity, restrictions on our ability to obtain and process information and allegations by our customers and clients that we have not performed our contractual obligations, any of which could materially adversely affect our results of operations and financial condition.

We are subject to laws of the United States and foreign jurisdictions relating to processing certain financial transactions, including payment card transactions and debit or credit card transactions, and failure to comply with those laws, whether or not inadvertent, could subject us to legal actions and materially adversely affect our results of operations and financial condition.

We process, support and execute financial transactions, and disburse funds, on behalf of both government and commercial customers, often in partnership with financial institutions. This activity includes receiving debit and credit card information, processing payments for and due to our customers and disbursing funds on payment or debit cards to payees of our customers. As a result, we are subject to numerous United States (both federal and state) and foreign jurisdiction laws and regulations, including the Electronic Fund Transfer Act, as amended, the Currency and Foreign Transactions Reporting Act of 1970 (commonly known as the Bank Secrecy Act), as amended, the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (including the so-called Durbin Amendment), as amended, the Gramm-Leach-Bliley Act (also known as the Financial Modernization Act of 1999), as amended, and the Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT ACT) Act of 2001, as amended. Other United States (both federal and state) and foreign jurisdiction laws apply to our processing of certain financial transactions and related support services. These laws are subject to frequent changes, and new statutes and regulations in this area may be enacted at any time. Changes to existing laws, the introduction of new laws in this area or failure to comply with existing laws that are applicable to us may subject us to, among other things, additional costs or changes to our business practices, liability for monetary damages, fines and/or criminal prosecution, unfavorable publicity, restrictions on our ability to process and support financial transactions and allegations by our customers, partners and clients that we have not performed our contractual obligations. Any of these could materially adversely affect our results of operations and financial condition.

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Our data systems, information systems and network infrastructure may be subject to hacking or other cybersecurity threats and other service interruptions, which could expose us to liability, impair our reputation or temporarily render us unable to fulfill our service obligations under our contracts.

We are a leading provider of business processing services concentrated in transaction-intensive processing, analytics and automation. We act as a trusted business partner in both front office and back office platforms, providing interactions on a substantial scale with our customers and other third-parties. Our customers include global commercial clients and government clients who depend upon our operational efficiency, non-interruption of service, and accuracy and security of information. We also use third-party providers such as subcontractors, software vendors, utility providers and network providers, upon whom we rely for our business processing services, to deliver uninterrupted, secure service. As part of our business processing services we also develop system software platforms necessary to support our customers' needs, with significant ongoing investment in developing and operating customer-appropriate operating systems, data bases and system software solutions. We also receive, process, transmit and store substantial volumes of information relating to identifiable individuals, both in our role as a service provider and as an employer, and we are subject to numerous laws, rules and regulations in the United States (both federal and state) and foreign jurisdictions designed to protect both individually identifiable information as well as personal health information. We also receive, process and implement financial transactions, and disburse funds, on behalf of both commercial and government customers, which activity includes receiving debit and credit card information to process payments due to our customers as well as disbursing funds to payees of our customers. As a result of these and other business processing services, the integrity, security, accuracy and non-interruption of our systems and information technology and that of our third-party providers and our interfaces with our customers are extremely important to our business, operating results, growth, prospects and reputation.

We have implemented security systems and controls, both directly and with third-party subcontractors and service providers, with the intent of maintaining both the physical security of our facilities and the data security of our customers', clients' and suppliers' confidential information and information related to identifiable individuals (including payment card and debit and credit card information and health information) against unauthorized access through our information systems or by other electronic transmission or through the misdirection, theft or loss of physical media. These include, for example, the appropriate encryption of information. Despite such efforts, we are susceptible to breach of security systems which may result in unauthorized access to our facilities and those of our customers and/or the information we and our customers are trying to protect. Cybersecurity failure might be caused by computer hacking, malware, computer viruses, worms and other destructive software, "cyber-attacks" and other malicious activity, as well as natural disasters, power outages, terrorist attacks and similar events. Operational or business delays may also result from the disruption of network or information systems and subsequent remediation activities.

Because the techniques used to obtain unauthorized access are constantly changing and becoming increasingly more sophisticated and often are not recognized until launched against a target, we or our third-party service providers may be unable to anticipate these techniques or implement sufficient preventative measures. Hacking, malware, phishing, viruses and other "cyber-attacks" have become more prevalent, have occurred in our systems in the past, and may occur in our systems in the future. Although we have implemented and intend to continue to implement what we believe to be appropriate cyber practices and cybersecurity systems, these systems may prove to be inadequate and result in the disruption, failure, misappropriation or corruption of our network and information systems. Notwithstanding the preventative and protective measures we have in place, it may not be possible for us to fully or timely know if or when such incidents arise, or the full business impact of any cybersecurity breach.

Additionally, with advances in computer capabilities and data protection requirements to address ongoing threats, we may be required to expend significant capital and other resources to protect against potential security breaches or to alleviate problems caused by security breaches. Moreover, employee error or malfeasance, faulty password management or other irregularities may result in a defeat of our or our third-party service providers' security measures and a breach of our or our third-party service providers' information systems (whether digital, cloud-based or otherwise).

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If unauthorized parties gain physical access to one of our or one of our third-party service providers' facilities or electronic access to our or one of our third-party service providers' information systems or such sensitive or confidential information is misdirected, lost or stolen during transmission or transport, any theft or misuse of such information could result in, among other things, unfavorable publicity and significant damage to our brand, governmental inquiry, oversight and possible regulatory action, difficulty in marketing our services, loss of existing and potential customers, allegations by our customers that we have not performed our contractual obligations, litigation by affected parties and possible financial obligations for substantial damages related to the theft or misuse of such information, any of which could materially adversely affect our results of operations and financial condition. Moreover, a security breach could require us to devote significant management resources to address the problems created by the security breach and to expend significant additional resources to upgrade further the security measures that we employ to guard such personal information against "cyber-attacks" and to maintain various systems and data centers for our customers. Often these systems and data centers must be maintained worldwide and on a 24/7 basis. Although we endeavor to ensure that there is adequate backup and maintenance of these systems and centers, we could experience service interruptions that could result in curtailed operations and loss of existing and potential customers, which could significantly reduce our revenues and profits in addition to significantly impairing our reputation. If our information systems and our back-up systems are damaged, breached or cease to function properly, we may have to make a significant investment to repair or replace them, and we may suffer interruptions in our operations in the interim, each of which could materially adversely affect our results of operations and financial condition and diminish the value of our shares.

In addition, our and our customers' systems and networks are subject to continued threats of terrorism, which could disrupt our operations as well as disrupt the utilities and telecommunications infrastructure on which our business depends. To the extent any such disruptions were to occur, our business, operating results and financial condition could be materially adversely affected.

If we underestimate the scope of work or the costs of performance in our contracts, or we mis-perform our contracts, our results of operations and financial condition could be materially adversely affected.

In order to stay competitive in our industry, we must keep pace with changing technologies and customer preferences. Many of our contracts require us to design, develop and implement new technological and operating systems for our customers. Many of these systems involve detailed and complex computer source code which must be created and integrated into a working system that meets contract specifications. The accounting for these contracts requires judgment relative to assessing risks, estimating contract revenues and costs and making assumptions for schedule and technical issues. To varying degrees, each contract type involves some risk that we could underestimate the costs and resources necessary to fulfill the contract. In each case, our failure to accurately estimate costs or the resources and technology needed to perform our contracts or to effectively manage and control our costs during the performance of our work could result, and in some instances has resulted, in reduced profits or in losses. In addition, many of our contracts contain complicated performance obligations, including, without limitation, designing and building new integrated computer systems. These contracts carry potential financial penalties or could result in financial damages or exposures if we fail to properly perform those obligations and could result in our results of operations and financial condition being materially adversely affected.

Our continuing emphasis and shift toward technology-led digital transactions, rather than more labor intensive commoditized services, could impact our type and timing of the customer contracts that we enter into, particularly in the short-term.

We have made the strategic decision to increase our focus on technology-led digital transactions and focus less on historic labor-intensive commoditized services and customer contracts. We believe technology-led digital transactions are becoming, and will become, the type of services required by many of our customers and those in the industry. We believe that our continuing focus on digital transactions will better create long-term value and increased profitability. However, this increased emphasis on technology-led digital transactions has resulted in and will continue to result in our exiting certain services and contracts, and could adversely impact our revenues and our results of operations, particularly in the short-term.

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Our customers' decision-making cycles are changing and the lead time for customers to commit to contracts with us has been lengthening.

As our services industry and our service offerings change and evolve, particularly with our customers increasing their focus on digital offerings, our customers are spending increased time and resources evaluating technology and other investments needed to obtain optimal results and performance, including from their outsourcing providers including the Company. This has led to longer sales lead time cycles for contract commitments from our customers, which can adversely affect the timing of customer commitments and our revenues and results of operations.

If we are unable to collect our receivables for unbilled services, our results of operations and financial condition could be materially adversely affected.

The profitability of certain of our large contracts depends on our ability to successfully obtain payment from our clients of the amounts they owe us for work performed. Actual losses on client balances could differ from current estimates and, as a result, may require adjustment of our receivables for unbilled services. Our receivables include long-term contracts. Over the course of a long-term contract, our customers' financial condition may change such that their ability to pay their obligations, and our ability to collect our fees for services rendered, is adversely affected. Additionally, we may perform work for the federal, state and local governments, with respect to which we must file requests for equitable adjustment or claims with the proper agency to seek recovery in whole or in part, for out-of-scope work directed or caused by the government customer in support of its project, and the amounts of such recoveries may not meet our expectations or cover our costs. Timely collection of client balances also depends on our ability to complete our contractual commitments (such as, our ability to achieve specified milestones in percentage-of-completion contracts) and bill and collect our contracted revenues. If we are unable to meet our contractual requirements, we might experience delays in collection of and/or be unable to collect our client balances, and if this occurs, our results of operations and cash flows could be adversely affected. In addition, if we experience an increase in the time to bill and collect for our services, our results of operations and financial condition could be materially adversely affected.

A decline in revenues from or a loss or failure of significant clients could materially adversely affect our results of operations and financial condition.

Our results of operations and financial condition could be materially adversely affected by the loss or failure of significant clients. Some of our clients are in business sectors which have experienced significant financial difficulties or consolidation, and/or the reduction of volumes or their inability to make payments to us, as a result of, among other things, their merger or acquisition, divestiture of assets or businesses, contract expiration, nonrenewal or early termination (including termination for convenience) or business or financial failure or deterioration. Economic and political conditions could affect our clients' businesses and the markets they serve.

We have non-recurring revenue, which subjects us to a risk that our revenues and cash flows from operations may fluctuate from period to period.

Revenue generated from our non-recurring services may fluctuate due to factors both within and outside of our control. Our mix of non-recurring and recurring revenues is impacted by acquisitions as well as growth in our non-recurring lines of business, as well as our strategic decisions to exit or reduce our services in particular service areas. There is less predictability and certainty in the timing and amount of revenues generated by our non-recurring services and, accordingly, our results of operations and financial condition could be materially adversely affected by the timing and amount of revenues generated from our non-recurring services.

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The failure to obtain or maintain a satisfactory credit rating could adversely affect our liquidity, capital position, borrowing costs, access to capital markets and ability to post surety or performance bonds to support clients' contracts.

Any future downgrades to our credit rating could negatively impact our ability to renew contracts with our existing clients, limit our ability to compete for new clients, result in increased premiums for surety or performance bonds to support our clients' contracts and/or result in a requirement that we provide collateral to secure our surety or performance bonds. Further, certain of our commercial outsourcing contracts provide that, in the event our credit ratings are downgraded to specified levels, the client may elect to terminate its contract with us and either pay a reduced termination fee or, in some limited instances, no termination fee. Such a credit rating downgrade could adversely affect these client relationships.

There can be no assurance that we will be able to maintain our credit ratings. Any additional actual or anticipated downgrades of our credit ratings, including any announcement that our ratings are under review for a downgrade, may have a negative impact on our liquidity, capital position and access to capital markets.

A failure to attract and retain necessary technical personnel and qualified subcontractors could materially adversely affect our results of operations and financial condition.

Because we operate in intensely competitive markets, our success depends to a significant extent upon our ability to attract, retain and motivate highly skilled and qualified technical personnel and to subcontract with qualified, competent subcontractors. If we fail to attract, train and retain sufficient numbers of qualified engineers, technical staff and sales and marketing representatives or are unable to contract with qualified, competent subcontractors, our results of operations and financial condition could be materially adversely affected. Experienced and capable personnel in the services industry remain in high demand, and there is continual competition for their talents. Our ability to renegotiate certain of our legacy third-party contracts which we view as unfavorable, or to improve the service levels we expect from these contracts and third-party providers, is key to our ability to timely, efficiently and profitably deliver our services to our customers. Additionally, we may be required to increase our hiring in geographic areas outside of the United States, which could subject us to increased geopolitical and exchange rate risk. The loss of any key technical employee, the loss of a key subcontractor relationship or our inability to renegotiate or obtain required service levels from legacy and other third-party providers, could materially adversely affect our results of operations and financial condition.

Increases in the cost of telephone and data services or significant interruptions in such services could materially adversely affect our results of operations and financial condition.

Our business is significantly dependent on telephone and data service provided by various local and long distance telephone and data service providers around the world. Accordingly, any disruption of these services could materially adversely affect our results of operations and financial condition. We have taken steps to mitigate our exposure to service disruptions by investing in redundant circuits, although there is no assurance that the redundant circuits would not also suffer disruption. Any inability to obtain telephone or data services at favorable rates could materially adversely affect our results of operations and financial condition. Where possible, we have entered into long-term contracts with various providers to mitigate short-term rate increases and fluctuations. There is no obligation, however, for the vendors to renew their contracts with us, or to offer the same or lower rates in the future, and such contracts are subject to termination or modification for various reasons outside of our control. A significant increase in the cost of telephone or data services that is not recoverable through an increase in the price of our services could materially adversely affect our results of operations and financial condition. In addition, a number of our facilities are located in jurisdictions outside of the United States where the provision of utility services, including electricity and water, may not be consistently reliable, and while there are backup systems in many of our operating facilities, an extended outage of utility or network services could materially adversely affect our results of operations and financial condition.

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If we fail to successfully develop new service offerings, including new technology components, and protect our intellectual property rights, we may be unable to retain current customers and gain new customers and our revenues would decline.

The process of developing new service offerings, including new technology components, is inherently complex and uncertain. It requires accurate anticipation of customers' changing needs and emerging technological trends. We must make long-term investments and commit significant resources before knowing whether these investments will eventually result in service offerings that achieve customer acceptance and generate the revenues required to provide desired returns. For example, establishing internal automation processes to help us develop new service offerings will require significant up-front costs and resources, which, if not monetized effectively, could materially adversely affect our revenues. In addition, some of our service offerings rely on technologies developed by and licensed from third-parties. We may not be able to obtain or continue to obtain licenses and technologies from these third-parties at all or on reasonable terms, or such third-parties may demand cross-licenses to our intellectual property. It is also possible that our intellectual property rights could be challenged, invalidated or circumvented, allowing others to use our intellectual property to our competitive detriment. We also must ensure that all of our service offerings comply with both existing and newly enacted regulatory requirements in the countries in which they are sold. If we fail to accurately anticipate and meet our customers' needs through the development of new service offerings (including technology components) or if we fail to adequately protect our intellectual property rights or if our new service offerings are not widely accepted or if our current or future service offerings fail to meet applicable worldwide regulatory requirements, we could lose market share and customers to our competitors and that could materially adversely affect our results of operations and financial condition.

The Company's business, operating results and reputation may be negatively impacted by failures or delays in our efforts to modernize our information technology infrastructure and to consolidate to fewer data centers.

We have experienced certain disruptions in our operations and service delivery performance issues as a result of some of our information technology infrastructure that is outdated and needs to be enhanced and updated, which disruptions have adversely impacted client and delivery performance. As a result we are investing in modernizing a significant portion of our information technology infrastructure with new systems and processes and consolidating our data centers as part of our transformation initiatives. This also includes investments in our data center and networks, enhancement, modernization and consolidation of our IT infrastructure and customer-facing technologies, enhanced cybersecurity and movement to cloud-based technology. We expect that these changes will provide greater strategic and operational flexibility and efficiency and better control of our systems and processes. There is a risk, however, that our modernization efforts and data center consolidations could materially and adversely disrupt our operations and our service delivery to customers, could result in contractual penalties or damage claims from customers, could occur over a period longer than planned, and could require greater than expected investment and other internal and external resources. It may also take longer to realize the intended favorable benefits from an enhanced technology infrastructure than we expected, or that disruptions may continue to occur while we enhance this infrastructure.

The process of consolidating our data center involves inherent risks and may cause disruptions to our operations. In October 2018, we suffered a significant outage as a result of a data center migration, which resulted in unplanned system unavailability and disruption for our customers. We plan to undertake several data center migrations in the future and, in the course of these data migrations, could potentially experience significant service outages. Future service disruptions could hinder our ability to attract new customers, cause us to incur legal liability, contractual penalties or issue service credits to our customers and cause us to lose current customers, each of which could have a material adverse effect on our business, financial condition and results of operations.

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If we fail to meet industry data security standards, our ability to meet contractual obligations may be impaired and result in contractual damage or contract breach claims.

In some of our services lines, we are contractually subject to industry data security standards. These industry data security standards include Card Brand (Visa, Mastercard, American Express, Discover and JCB) operating rules, certification requirements and rules governing electronic funds transfers, including Payment Card Industry Data Security Standard (PCI DSS), a data security standard applicable to companies that collect, store or transmit payment card data. These standards also include the Health Information Trust Alliance (HITRUST) which applies to aspects of the healthcare industry and components of which is being used in other industries as well. While we are taking steps to achieve future compliance and/or certification for our systems, we may not be compliant now, and in the future we may not be able to maintain compliance with PCI DSS, HITRUST and other applicable industry standards. We are taking steps to achieve compliance and/or certification for our systems, but we cannot assure that these efforts will be successful in the time period required or at all. Any failure to comply fully or materially with PCI DSS, HITRUST and other applicable industry standards now or at any point in the future may provide customers the right to terminate contracts with us or to enforce provisions obligating us to reimburse them for any penalties or costs incurred by them as a result of our non-compliance, or subject us to other fines, penalties, damages or civil liability, each of which could have a material adverse effect on our business, financial condition and results of operations. In addition, failure to meet PCI DSS standards could result in the loss of our ability to accept credit card payments and the failure to meet HITRUST standards could impact our ability to service customers in the healthcare and other industries, both of which could have a material adverse impact on our business, financial condition and results of operations.

We are a holding company and, therefore, may not be able to receive dividends or other payments in needed amounts from our subsidiaries.

Our principal assets are the shares of capital stock and indebtedness of our subsidiaries. We rely on dividends, interest and other payments from these subsidiaries to meet our obligations for paying principal and interest on outstanding debt obligations, paying corporate expenses and, if determined by our Board, paying dividends to shareholders and repurchasing common shares. Certain of our subsidiaries are subject to regulatory requirements of the jurisdictions in which they operate or other restrictions that may limit the amounts that these subsidiaries can pay in dividends or other payments to us. No assurance can be given that there will not be further changes in law, regulatory actions or other circumstances that could restrict the ability of our subsidiaries to pay dividends to us. In addition, due to differences in tax rates, repatriation of funds from certain countries into the United States could have unfavorable tax ramifications for us.

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Our results of operations and financial condition could be materially adversely affected by legal and regulatory matters.

We are potentially subject to various contingent liabilities that are not reflected on our balance sheet, including those arising as a result of being involved in a variety of claims, lawsuits, investigations and proceedings concerning: securities law; governmental and non-governmental entity contracting, servicing and governmental entity procurement law; intellectual property law; environmental law; employment law; the Employee Retirement Income Security Act of 1974 (ERISA); and other laws, regulations and contractual undertakings, as discussed under Note 14 – Contingencies and Litigation in our Consolidated Financial Statements. If developments in any of these matters cause a change in our determination as to an unfavorable outcome and result in the need to recognize a material accrual or materially increase an existing accrual, or if any of these matters result in an adverse judgment or are settled for significant amounts above any existing accruals, it could materially adversely affect our results of operations and financial condition in the period or periods in which such change in determination, judgment or settlement occurs. There can be no assurances as to the favorable outcome of any claim, lawsuit, investigation or proceeding. It is possible that a resolution of one or more such proceedings, through judgment, settlement or otherwise, could require us to make substantial payments to satisfy judgments, fines or penalties or settlement amounts, any of which could materially adversely affect our results of operations and financial condition. Additionally, the terms of dismissal, settlement, release or other resolution may permit certain claims to be reopened under certain conditions. For example, we entered into an agreement with the State of Texas and the Texas Health and Human Services Commission to settle all claims resulting from alleged failures by Conduent State Healthcare LLC and Texas Medicaid & Healthcare Partnership to properly perform obligations under two contracts entered into with the Texas Health and Human Services Commission in 2003 and 2010. The settlement amount is $236 million, which is payable in installments in 2019, 2020 and 2021; however, the settlement agreement does not prevent the Company from prepaying the entire amount. Pursuant to that agreement, the release of the State of Texas's claims is not effective until the Company pays the settlement amount in full. Accordingly, if the Company fails to make any of the required installment payments, the State of Texas has the right to reopen the claims and move forward with the litigation. Claims, lawsuits investigations and proceedings involving the Company could also result in reputational harm, criminal sanctions, consent decrees or orders preventing us from offering certain services, requiring a change in our business practices in costly ways or requiring development of non-infringing or otherwise altered products or technologies. In addition, it can be very costly to defend litigation and these costs could materially adversely affect our results of operations and financial condition. See Note 14 – Contingencies and Litigation to our Consolidated Financial Statements.

Our results of operations and financial condition may be materially adversely affected by conditions abroad, including local economics, political environments, fluctuating foreign currencies and shifting regulatory schemes.

A portion of our revenues is generated from operations outside the United States. In addition, we maintain significant operations outside the United States. Our results of operations and financial condition could be materially adversely affected by changes in foreign currency exchange rates, as well as by a number of other factors, including, without limitation, changes in economic conditions from country to country, changes in a country's political conditions, trade controls and protection measures, financial sanctions, licensing requirements, local tax issues, capitalization and other related legal matters. The ultimate manner in which Great Britain withdraws from the European Union, and the resulting impact on cross-border transactions and operations between Great Britain and the European Union member states, could materially and adversely affect our operations and financial condition. We generally hedge foreign currency denominated assets, liabilities and anticipated transactions primarily through the use of currency derivative contracts. The use of derivative contracts is intended to mitigate or reduce transactional level volatility in the results of foreign operations, but does not completely eliminate volatility. We do not hedge the translation effect of international revenues and expenses, which are denominated in currencies other than our U.S. parent functional currency, within our Consolidated Financial Statements. If we are unable to effectively hedge these risks, our results of operations and financial condition could be materially adversely affected.

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Risks related to the spin-off:

We may be unable to achieve some or all of the benefits that we expect to achieve from the spin-off.

We believe that, as an independent, publicly traded company, we will be able to, among other things, design and implement corporate strategies and policies that are targeted to our business, better focus our financial and operational resources on our specific business, create effective incentives for our management and employees that are more closely tied to our business performance, provide investors more flexibility and enable us to achieve alignment with a more natural shareholder base and implement and maintain a capital structure designed to meet our specific needs. However, as a result of separating from Xerox, we may be more susceptible to market fluctuations and other adverse events. As an independent entity, we have an arm's-length relationship with Xerox and we may not be able to obtain supplies from Xerox on terms as favorable to us as those we had as a wholly owned subsidiary of Xerox prior to the spin-off. As a smaller, independent company, Conduent has a narrower business focus and may be more vulnerable to changing market conditions as well as the risk of takeover by third parties. In addition, we may be unable to achieve some or all of the benefits that we expected to achieve as an independent company in the time we expect, if at all. Furthermore, Xerox used to guarantee our and our subsidiaries' performance under certain services contracts and real estate leases. Following the spin-off, we expect that Conduent will provide such performance guarantees, and we may be unable to retain or renew contracts or real estate leases or a failure to renew such contracts or leases on favorable terms and conditions could materially adversely affect our results of operations and financial condition. If we fail to achieve some or all of the benefits that we expected to achieve as an independent company, or do not achieve them in the time we expect, our results of operations and financial condition could be materially adversely affected.

We may be unable to make, on a timely or cost-effective basis, the changes necessary to operate as an independent, publicly traded company, and we may experience increased costs after the spin-off.

We had historically operated as part of Xerox's corporate organization, and Xerox had provided us with various corporate functions. Following the spin-off, Xerox has no obligation to provide us with assistance other than the transition services described under "Certain Relationships and Related Party Transactions -Transition Services Agreement." These services do not include every service that we have received from Xerox in the past, and Xerox is only obligated to provide these services for limited periods following completion of the spin-off. Accordingly, following the spin-off, we have needed to provide internally or obtain from unaffiliated third parties the services we had received from Xerox. These services include senior management, legal, human resources, finance and accounting, treasury, information technology, marketing and communications, internal audit and other shared services, the effective and appropriate performance of which are critical to our operations. We may be unable to replace these services on terms and conditions as favorable as those we received from Xerox. Because our business had operated as part of the wider Xerox organization, we may incur additional costs that could adversely affect our business. If we fail to obtain the quality of services necessary to operate effectively or incur greater costs in obtaining these services, our results of operations and financial condition could be materially adversely affected.

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We have no recent operating history as an independent, publicly traded company, and our historical and pro forma financial data are not necessarily representative of the results we would have achieved as an independent, publicly traded company and may not be a reliable indicator of our future results.

We derived certain of the historical financial data included in this Annual Report from Xerox's consolidated financial statements, and this data does not necessarily reflect the results of operations and financial condition we would have achieved as an independent, publicly traded company during the periods presented, or those that we will achieve in the future. This is primarily because of the following factors:

- Prior to the spin-off, we operated as part of Xerox's broader corporate organization and Xerox performed various corporate functions for us, including, but not limited to, senior management, legal, human resources, finance and accounting, treasury, information technology, marketing and communications, internal audit and other shared services. Our historical financial data reflect allocations of corporate expenses from Xerox for these and similar functions. These allocations may not reflect the costs we have incurred and in the future will incur for similar services as an independent, publicly traded company.
- We entered into transactions with Xerox that did not exist prior to the spin-off, such as Xerox's provision of transition services, which will cause us to incur new costs.
- Such historical financial data does not and in the future may not reflect changes that we have experienced and expect to experience in the future as a result of our separation from Xerox. As part of Xerox, we enjoyed certain benefits from Xerox's operating diversity, size, purchasing power, credit rating, borrowing leverage and available capital for investments. Many of our services contracts, particularly those for our transportation service offerings in our Public Sector business, require significant capital investments, and after the spin-off, we may not have access to the capital (from both internal and external sources) necessary to fund these services contracts. As an independent entity, we may be unable to purchase goods, services and technologies, such as insurance and health care benefits and computer software licenses, or access capital markets on terms as favorable to us as those we obtained as part of Xerox prior to the spin-off

Following the spin-off, we are now responsible for the additional costs associated with being an independent, publicly traded company, including costs related to corporate governance, investor and public relations and public reporting. For additional information about our past financial performance and the basis of presentation of our financial statements, see "Selected Historical Financial Data," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our historical financial statements and the notes thereto included in this annual report on Form 10-K.

We may have been able to receive better terms from unaffiliated third parties than the terms we receive in our agreements with Xerox.

We entered into agreements with Xerox related to our separation from Xerox, including the Separation and Distribution Agreement, Transition Services Agreement, Tax Matters Agreement, Employee Matters Agreement and any other agreements, while we were still part of Xerox. Accordingly, these agreements may not reflect terms that would have resulted from arm's-length negotiations among unaffiliated third parties. The terms of these agreements relate to, among other things, allocations of assets, liabilities, rights, indemnifications and other obligations between Xerox and us. We may have received better terms from third parties. See "Certain Relationships and Related Party Transactions-Agreements with Xerox."

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The spin-off could result in significant tax liability to Xerox and its shareholders.

Completion of the spin-off required Xerox's receipt of a written opinion of Cravath, Swaine & Moore LLP to the effect that the Distribution should qualify for non-recognition of gain and loss under Section 355 of the Internal Revenue Code (the "Code") and the receipt and continuing effectiveness and validity of the IRS Ruling.

The opinion of counsel did not address any U.S. state or local or foreign tax consequences of the spin-off. The opinion assumed that the spin-off was completed according to the terms of the Separation and Distribution Agreement and relied on the facts as stated in the Separation and Distribution Agreement, the Tax Matters Agreement, the other ancillary agreements, the Information Statement included in our registration statement on Form 10 and a number of other documents. In addition, the opinion was based on certain representations as to factual matters from, and certain covenants by, Xerox and us. The opinion cannot be relied on if any of the assumptions, representations or covenants are incorrect, incomplete or inaccurate or are violated in any material respect.

Xerox received an IRS ruling in connection with the spin-off (the "IRS Ruling"). The IRS Ruling relies on certain facts, assumptions, representations and undertakings from Xerox and us regarding the past and future conduct of Xerox's and our businesses and other matters. If any of these facts, assumptions, representations or undertakings is incorrect or not otherwise satisfied, Xerox may not be able to rely on the IRS Ruling. In addition, the IRS Ruling is not a comprehensive ruling from the IRS regarding all aspects of the U.S. federal income tax consequences of the transactions.

Accordingly, notwithstanding the opinion of counsel and the IRS Ruling, there can be no assurance that the IRS will not assert, or that a court would not sustain, a contrary position.

If the distribution in connection with the spin-off were determined not to qualify for non-recognition of gain and loss for U.S. federal income tax purposes, U.S. holders who received our common stock could be subject to tax. In this case, each U.S. holder who received our common stock in the distribution would generally, for U.S. federal income tax purposes, be treated as having received a distribution in an amount equal to the fair market value of our common stock received, which would generally result in (i) a taxable dividend to the U.S. holder to the extent of that U.S. holder's pro rata share of Xerox's current and accumulated earnings and profits; (ii) a reduction in the U.S. holder's basis (but not below zero) in Xerox common stock to the extent the amount received exceeds the shareholder's share of Xerox's earnings and profits; and (iii) a taxable gain from the exchange of Xerox common stock to the extent the amount received exceeds the sum of the U.S. holder's share of Xerox's earnings and profits and the U.S. holder's basis in its Xerox common stock.

We could have an indemnification obligation to Xerox if the Distribution were determined not to qualify for non-recognition treatment, which could materially adversely affect our results of operations and financial condition.

If it were determined that the distribution in connection with the spin-off did not qualify for non-recognition of gain and loss under Section 355 of the Code, we could, under certain circumstances, be required to indemnify Xerox for the resulting taxes and related expenses. Any such indemnification obligation could materially adversely affect our results of operations and financial condition.

In addition, Section 355(e) of the Code generally creates a presumption that the distribution would be taxable to Xerox, but not to shareholders, if we or our shareholders were to engage in transactions that result in a 50% or greater change by vote or value in the ownership of our stock during the four-year period beginning on the date that begins two years before the date of the distribution, unless it were established that such transactions and the distribution were not part of a plan or series of related transactions giving effect to such a change in ownership. If the distribution were taxable to Xerox due to such a 50% or greater change in ownership of our stock, Xerox would recognize gain equal to the excess of the fair market value of our common stock distributed to Xerox shareholders over Xerox's tax basis in our common stock and we generally would be required to indemnify Xerox for the tax on such gain and related expenses. Any such indemnification obligation could materially adversely affect our results of operations and financial condition.

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We agreed to numerous restrictions to preserve the non-recognition treatment of the Distribution, which may reduce our strategic and operating flexibility.

We agreed in the Tax Matters Agreement to covenants and indemnification obligations that address compliance with Section 355 of the Code. These covenants and indemnification obligations may limit our ability to pursue strategic transactions or engage in new businesses or other transactions that may otherwise maximize the value of our business, and might discourage or delay a strategic transaction that our shareholders may consider favorable.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None

ITEM 2. PROPERTIES

We lease and own numerous facilities worldwide with larger concentrations of space in Kentucky, New Jersey, California, Mexico, Guatemala, the Philippines, Jamaica, Romania and India. Our owned and leased facilities house general offices, sales offices, service locations, call centers and distribution centers. The size of our property portfolio as of December 31, 2018 was approximately 8.2 million square feet at an annual operating cost (lease costs and expenses) of approximately $217 million and comprised 260 leased properties and 6 owned properties. We believe that our current facilities are suitable and adequate for our current businesses. Because of the interrelation of our business segments, each of the segments uses substantially all of these properties at least in part.

In addition to the 8.2 million square feet of our real estate property portfolio, we also had 1.4 million square feet of our leased and owned properties that became surplus in 2018 due to the implementation of our strategic transformation program as well as various productivity initiatives to consolidate our real estate footprint. We aggressively managed our surplus properties through early terminations and subleasing of leased properties and the sale of owned properties. As a result, approximately 1.0 million square feet of the surplus property portfolio were resolved as of December 31, 2018. Additional leased and owned properties may become surplus over the next three years as we continue the strategic transformation program. We are obligated to maintain our leased surplus properties through required contractual lease periods and plan to dispose of or sublease these properties.

ITEM 3. LEGAL PROCEEDINGS

The information set forth under Note 14 – Contingencies and Litigation in the Consolidated Financial Statements in Part II, Item 8 is incorporated herein by reference.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

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Aetna Better Health® of Kentucky Att E-1101

Part II

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

Stock Exchange Information

The common stock of Conduent Incorporated is listed on the New York Stock Exchange under the ticker symbol "CNDT." Our common stock began trading January 3, 2017.

Conduent Common Stock Prices for 2018

New York Stock Exchange composite prices*	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
High	$ 20.32	$ 21.06	$ 23.39	$ 22.66
Low	$ 15.06	$ 17.40	$ 17.79	$ 9.68

** Price as of close of business.*

Common Shareholders of Record

Refer to Item 6. Selected Financial Data—Five Years in Review for common shareholders of record at year-end, which is incorporated here by reference.

Conduent Common Stock Dividends

We did not pay any dividends on our common stock in 2018. We intend to retain future earnings for use in the operation of our business and to fund future growth. We do not anticipate paying any dividends on our common stock for the foreseeable future.

Performance Graph

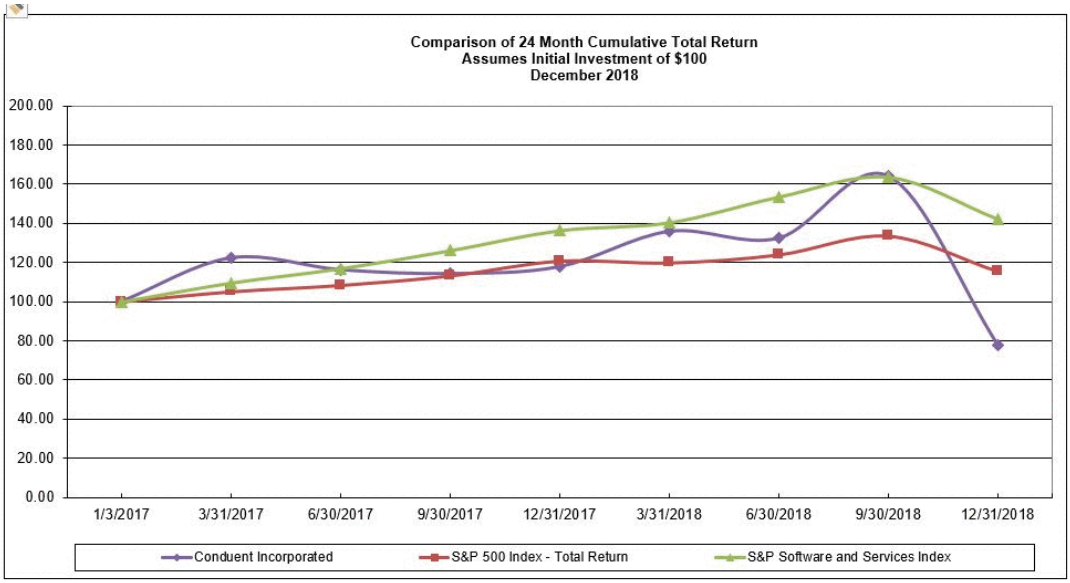

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Sales of Unregistered Securities During the Quarter Ended December 31, 2018

None

ITEM 6. SELECTED FINANCIAL DATA

FIVE YEARS IN REVIEW[1]

(in millions, except per-share and common shareholders of record data)

	2018	2017	2016	2015	2014
Operations					
Revenues	$ 5,393	$ 6,022	$ 6,408	$ 6,662	$ 6,938
Income (loss) income from continuing operations	(416)	177	(983)	(336)	34
Net income (loss)	(416)	181	(983)	(414)	(81)
Per-Share Data					
Income (loss) from continuing operations					
Basic	$ (2.06)	$ 0.82	$ (4.85)	$ (1.65)	$ 0.17
Diluted	(2.06)	0.81	(4.85)	(1.65)	0.17
Net income (loss) attributable to Conduent					
Basic	(2.06)	0.84	(4.85)	(2.04)	(0.40)
Diluted	(2.06)	0.83	(4.85)	(2.04)	(0.40)
Financial Position					
Working capital	$ 767	$ 1,342	$ 515	$ (867)	$ (887)
Total Assets	6,680	7,548	7,709	9,058	10,954
Consolidated Capitalization					
Current portion of long-term debt	$ 55	$ 82	$ 28	$ 24	$ 268
Long-term debt	1,512	1,979	1,913	37	43
Total Debt[2]	1,567	2,061	1,941	61	311
Series A preferred stock	142	142	142	n/a	n/a
Conduent shareholders' equity/former parent investment	3,222	3,529	3,288	5,162	5,411
Total Consolidated Capitalization	$ 4,931	$ 5,732	$ 5,371	$ 5,223	$ 5,722
Selected Data and Ratios[3]					
Common shareholders of record at year-end[3]	26,226	26,936	n/a	n/a	n/a
Book value per common share[3]	$ 15.68	$ 16.77	n/a	n/a	n/a
Year-end common stock market price[3]	$ 10.63	$ 16.16	n/a	n/a	n/a

_____

(1) On December 31, 2016, Conduent spun-off from Xerox Corporation. See Note 1 – Basis of Presentation and Summary of Significant Accounting Policies to the Consolidated Financial Statements included in Item 8 of this 2018 Form 10-K for a discussion concerning the historical financial statements.

(2) Includes capital lease obligations.

(3) Common stock of Conduent Incorporated did not begin trading on the NYSE until January 3, 2017; therefore, selected data and ratios are not available for years prior to 2017.

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

The following Management's Discussion and Analysis (MD&A) is intended to help the reader understand the results of operations and financial condition of Conduent Incorporated. This MD&A is provided as a supplement to, and should be read in conjunction with, our Consolidated Financial Statements and the accompanying notes. This MD&A provides additional information about our operations, current developments, financial condition, cash flows and results of operations.

Throughout the MD&A, we refer to various notes to our Consolidated Financial Statements which appear in Item 8 of this 2018 Form 10-K, and the information contained in such notes is incorporated by reference into the MD&A in the places where such references are made.

Overview

With revenues of $5.4 billion, we are a leading provider of business process services with expertise in transaction-intensive processing, analytics and automation. We serve as a trusted business partner in both the front office and back office, enabling personalized, seamless interactions on a massive scale that improve end-user experience.

Headquartered in Florham Park, New Jersey, we have a team of approximately 82,000 people as of December 31, 2018, servicing customers in 26 countries. In 2018, 12% of our revenue was generated outside the U.S.

Our reportable segments correspond to how we organize and manage the business and are aligned to the industries in which our clients operate.

During 2018, in an effort to better reflect how we manage our business, we segregated our Public Sector segment into Government Services (including Health Enterprise, which was previously reported in Other segment) and Transportation segments. In addition, the Company also reclassified the operating results of our divestitures from the reportable segments to Other segment and separately reflected Shared IT/Infrastructure & Corporate Costs. All prior periods presented have been revised to reflect these changes.

- **Commercial Industries -** Our Commercial Industries segment provides business process services and customized solutions to clients in a variety of industries. Across the Commercial Industries segment, we deliver end-to-end business-to-business and business-to-customer services that enable our clients to optimize their key processes. Our multi-industry competencies include transaction processing, end-user engagement, human resource management, omni-channel communications and finance and accounting services.
- **Government Services -** Our Government Services sector provides government-centric business process services to U.S. federal, state and local and foreign governments for transportation, public assistance, program administration, transaction processing and payment services.
- **Transportation -** Our Transportation segment provides systems and support services to transportation departments and agencies globally. Offerings include electronic toll collection, public transit, parking and photo enforcement.

Other includes our divestitures and our Student Loan business, which the Company exited in the third quarter of 2018.

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Significant 2018 Actions

Dispositions

In 2018, we completed divestitures of: (1) our Commercial Vehicle Operations business; (2) our off-street parking business; (3) our U.S. human resource consulting and actuarial business and the human resource consulting and outsourcing business located in Canada and the United Kingdom; and (4) our local and municipal constituent government software solutions business. The aggregate proceeds for these divestitures was $703 million in cash. The businesses sold represented $304 million and $500 million of 2018 and 2017 revenue, respectively. We recorded a pre-tax gain of $78 million on these divestitures for the year ended December 31, 2018.

Significant 2017 Actions

Dispositions

In 2017, we completed divestitures of: (1) our Firehouse business and suite of emergency records management products used by fire departments across the country for their incident reporting and Emergency Management System information and records management; (2) our healthcare provider consulting services business, which advises healthcare organizations on IT application optimization; (3) the Breakaway Group business, which provides advisory project services to assist healthcare organizations optimize their health IT applications; (4) the mobile device management business of Wireless Data Services Limited; and (5) the Global Mobility business. The aggregate proceeds for these divestitures was $56 million in cash. The businesses sold represented $60 million and $82 million of 2017 and 2016 revenue, respectively. We recorded a pre-tax gain of $16 million on these divestitures for the year ended December 31, 2017.

In addition, in 2017, we sold a property located in Dallas, Texas, which was formerly the Affiliated Computer Services (ACS) headquarters, for a pre-tax gain of $24 million. This was part of our effort to consolidate our real estate footprint.

Health Enterprise Settlement

On November 28, 2017, we entered into a definitive settlement agreement with the State of New York regarding resolution of the HE platform project. Under the terms of the settlement: (1) our contract with the State of New York terminated effective December 15, 2017 and we were released from all liabilities and obligations in connection with the contract at such time; and (2) paid or incurred costs on behalf of, the State of New York in the amount of approximately $20 million. As we have previously reserved this amount, we incurred no additional charges as a result of the settlement.

Significant 2016 Actions

Separation

On December 31, 2016, Conduent Incorporated spun-off from Xerox Corporation, pursuant to the Separation and Distribution Agreement. The separation was completed by way of a pro rata distribution of Conduent Incorporated shares held by Xerox to Xerox's shareholders. As a result of the spin-off we operate as an independent, publicly traded company on the New York Stock Exchange under the ticker "CNDT".

Goodwill Impairment Charge

Our Commercial Industries reporting units operating results declined in 2016 versus our expectations, including a weak fourth quarter 2016. In performing our annual impairment test during the fourth quarter of 2016, we determined that the carrying value of the Commercial Industries reporting unit exceeded its fair value by 53%, which resulted in a goodwill impairment of $935 million. This has been presented as Goodwill impairment, a separate line item in the Consolidated Statements of Income (Loss). Refer to Note 6 – Goodwill and Intangible Assets, Net, in the Consolidated Financial Statements for additional information.

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Health Enterprise Charge

In February 2017, we determined that it was not probable that the New York Medicaid Management Information System (NY MMIS) project would be completed. As a result of this determination, we recorded a pre-tax charge (NY MMIS charge) of $161 million ($98 million after-tax) in the fourth quarter of 2016. The charge included $83 million for the write-off of contract receivables which were recorded as a reduction of revenue and $78 million recorded in Cost of services including $36 million for wind-down costs, $28 million related to the non-cash charge for the impairment of software and $14 million for the write-off of deferred contract set-up and transition costs and other related assets and liabilities.

Critical Accounting Policies

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires us to make estimates and assumptions in certain circumstances that affect amounts reported in the accompanying Consolidated Financial Statements and notes thereto. In preparing our Consolidated Financial Statements, we have made our best estimates and judgments of certain amounts included in the Consolidated Financial Statements giving due consideration to materiality. However, application of these accounting policies involves the exercise of judgment and use of assumptions as to future uncertainties and, as a result, actual results could differ from these estimates. Senior management has discussed the development and selection of the critical accounting policies, estimates and related disclosures included herein with the Audit Committee of the Board of Directors. We consider these as critical to understanding our Consolidated Financial Statements, as their application places the most significant demands on management's judgment, since financial reporting results rely on estimates of the effects of matters that are inherently uncertain. In instances where different estimates could have reasonably been used, we disclose the impact of these different estimates on our operations. In certain instances, the accounting rules are prescriptive; therefore, it would not have been possible to reasonably use different estimates. Changes in assumptions and estimates are reflected in the period in which they occur. The impact of such changes could be material to our results of operations and financial condition in any quarterly or annual period.

Specific risks associated with these critical accounting policies are discussed throughout the MD&A, where such policies affect our reported and expected financial results. For a detailed discussion of the application of these and other accounting policies, refer to Note 1 – Basis of Presentation and Summary of Significant Accounting Policies in the Consolidated Financial Statements.

Revenue Recognition

Application of the accounting principles in U.S. GAAP related to the measurement and recognition of revenue requires us to make judgments and estimates. Complex arrangements with nonstandard terms and conditions may require significant contract interpretation to determine the appropriate accounting. Refer to Note 1 – Basis of Presentation and Summary of Significant Accounting Policies — Revenue Recognition in the Consolidated Financial Statements for additional information regarding our revenue recognition policies.

Held for Sale

We classify assets as held for sale in the period when the following conditions are met: (i) management, having the authority to approve the action, commits to a plan to sell the asset (disposal group); (ii) the asset (disposal group) is available for immediate sale in its present condition subject only to terms that are usual and customary for sales of such assets (disposal group); (iii) an active program to locate a buyer and other actions required to complete the plan to sell the asset (disposal group) have been initiated; (iv) the sale of the asset (disposal group) is probable, and transfer of the asset (disposal group) is expected to qualify for recognition as a completed sale within one year, except if events or circumstances beyond our control extend the period of time required to sell the asset (disposal group) beyond one year; (v) the asset (disposal group) is being actively marketed for sale at a price that is reasonable in relation to its current fair value; and (vi) actions required to complete the plan indicate that it is unlikely that significant changes to the plan will be made or that the plan will be withdrawn.

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A long-lived asset (disposal group) that is classified as held for sale is initially measured at the lower of its carrying value or fair value less any costs to sell. Any loss resulting from this measurement is recognized in the period in which the held for sale criteria are met. Conversely, gains are not recognized on the sale of a long-lived asset (disposal group) until the date of sale.

The fair value of a long-lived asset (disposal group) less any costs to sell is assessed each reporting period it remains classified as held for sale and any subsequent changes are reported as an adjustment to the carrying value of the asset (disposal group), as long as the new carrying value does not exceed the carrying value of the asset at the time it was initially classified as held for sale. Upon determining that a long-lived asset (disposal group) meets the criteria to be classified as held for sale, the Company reports the assets and liabilities of the disposal group in the line items Assets held for sale and Liabilities held for sale, respectively, in the Consolidated Balance Sheets.

In 2018, management approved the disposal through sale of certain assets and businesses, which were a mix of both Commercial Industries, Government Services and Transportation. This action was taken as a result of our evaluation of these businesses as they represent businesses in markets or with services that we did not see as strategic or core. As of December 31, 2018, most of these businesses have been sold. At December 31, 2018, we reclassified $15 million to assets held for sale and $40 million to liabilities held for sale relating to a portfolio of select standalone customer care contracts that was not yet sold. See Note 3 – Assets/Liabilities Held for Sale and Divestitures for additional information.

Intangible Assets

The fair values of identifiable intangible assets are primarily estimated using an income approach. These estimates include market participant assumptions and require projected financial information, including assumptions about future revenue growth and costs necessary to facilitate the projected growth. Other key inputs include assumptions about technological obsolescence, customer attrition rates, brand recognition, the allocation of projected cash flows to identifiable intangible assets and discount rates. We regularly review intangible assets with finite lives for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. Factors we consider important which could trigger an impairment review include the following:

- significant underperformance relative to historical or projected future operating results;
- significant changes in the manner of our use of the acquired assets or the strategy for our overall business; and
- significant negative industry or economic trends.

When we determine that the carrying value of intangibles and long-lived assets may not be recoverable based upon the existence of one or more of the above indicators of potential impairment, we assess whether an impairment has occurred based on whether net book value of the assets exceeds the related projected undiscounted cash flows from these assets. We consider a number of factors, including past operating results, budgets, economic projections, market trends and product development cycles in estimating future cash flows. Differing estimates and assumptions as to any of the factors described above could result in a materially different impairment charge, if any, and thus materially different results of operations.

Goodwill

Goodwill is not amortized but rather tested for impairment annually, or more frequently if an event or circumstance indicates that impairment may have been incurred. Events or circumstances that might indicate an interim evaluation is warranted include, among other things, unexpected adverse business conditions, macro and reporting unit specific economic factors, supply costs, unanticipated competitive activities and acts by governments and courts.

Application of the annual goodwill impairment test requires judgment, including the identification of reporting units, assignment of assets and liabilities to reporting units, assignment of goodwill to reporting units and the assessment of the fair value of each reporting unit. We determined that our reporting units were the same as our operating segments and, therefore, our business is comprised of three reporting units. Our annual quantitative impairment test of goodwill was performed in the fourth quarter of 2018.

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In our quantitative test, we estimate the fair value of each reporting unit by weighting the results from the income approach (discounted cash flow methodology) and market approach. These valuation approaches require significant judgment and consider a number of factors that include, but are not limited to, expected future cash flows, growth rates and discount rates and comparable multiples from publicly traded companies in our industry. In addition, we are required to make certain assumptions and estimates regarding the current economic environment, industry factors and the future profitability of our businesses.

When performing our discounted cash flow analysis for each reporting unit, we incorporate the use of projected financial information and discount rates that are developed using market participant-based assumptions. The cash-flow projections are based on three-year financial forecasts developed by management that include revenue and expense projections, restructuring and strategic transformation activities, capital spending trends and investment in working capital to support anticipated revenue growth or other changes in the business. The selected discount rates consider the risk and nature of the respective reporting units' cash flows, appropriate capital structure and rates of return that market participants would require to invest their capital in our reporting units.

We believe these assumptions are appropriate and reflect our forecasted long-term business model and give appropriate consideration to our historical results as well as the current economic environment and markets that we serve.

Based on our quantitative assessments, we concluded that the fair value of our reporting units (which are the Financial Services & Healthcare, Consumer & Industrial and Europe operating segments, together comprising Commercial Industries, Government Services operating segment and the Transportation operating segment) exceeded their respective carrying values by approximately $600 million (for all Commercial Industries), $285 million for Government Services and $120 million for Transportation, respectively. The most significant assumption used in the goodwill analysis relates to the long-term organic growth rate for the operating segments comprising Commercial Industries, Government Services and Transportation segments. For example, the EBITDA long term growth rates for the Commercial Industries operating segments, Government Services and Transportation segments were 3%, 2.5% and 4%, respectively. The growth rates are consistent with industry long term growth rates and contemplate that Conduent will grow, on a long term basis, at least consistent with its peers. To the extent that Conduent losses a significant contract or multiple significant contracts, such that its growth rates are negatively impacted, its goodwill could be impaired. Specifically, if Conduent's EBITDA long term growth rates were zero for the Commercial and Government operating segments and 3% for the Transportation operating segment, the fair values of the operating segments would approximate the book values of the operating segments.

Refer to Note 6 – Goodwill and Intangible Assets, Net in the Consolidated Financial Statements for additional information regarding goodwill by reportable segment.

Income Taxes

We are subject to income taxes in the United States and numerous foreign jurisdictions. The determination of our provision for income taxes requires significant judgment, the use of estimates and the interpretation and application of complex tax laws. Our provision is based on nonrecurring events as well as recurring factors, including the taxation of foreign income. In addition, our provision will change based on discrete or other nonrecurring events such as audit settlements, tax law changes, changes in valuation allowances and other factors, that may not be predictable. In the event that there is a significant unusual or one-time item recognized in our operating results, the taxes attributable to that item would be separately calculated and recorded at the same time as an unusual or one-time item.

We record the estimated future tax effects of temporary differences between the tax bases of assets and liabilities and amounts reported in our Consolidated Balance Sheets, as well as operating loss and tax credit carryforwards. We follow very specific and detailed guidelines in each tax jurisdiction regarding the recoverability of any tax assets recorded in our Consolidated Balance Sheets and provide valuation allowances as required. We regularly review our deferred tax assets for recoverability considering historical profitability, projected future taxable income, the expected timing of the reversals of existing temporary differences and tax planning strategies. Gross deferred tax assets of $210 million and $245 million had valuation allowances of $44 million and $35 million at December 31, 2018 and 2017, respectively.

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On December 22, 2017, the U.S. enacted the Tax Cuts and Jobs Act (Tax Reform). The Tax Reform includes a tax on global intangible low-taxed income ("GILTI"), which imposes a U.S. tax on certain income earned by the Company's foreign subsidiaries. In January 2018, the FASB released guidance on the accounting for tax on GILTI. The guidance indicates that either accounting for deferred taxes on GILTI or treating GILTI as a period cost are both acceptable accounting elections. The Company elected to treat the tax on GILTI as a period cost when incurred and therefore, no deferred taxes for GILTI have been recognized for the year ended December 31, 2018.

We are subject to ongoing tax examinations and assessments in various jurisdictions. Accordingly, we may incur additional tax expense based upon our assessment of the more-likely-than-not outcomes of such matters. In addition, when applicable, we adjust previously recorded tax expense to reflect examination results. Our ongoing assessments of the more-likely-than-not outcomes of examinations and related tax positions require judgment and can materially increase or decrease our effective tax rate, as well as impact our operating results. Unrecognized tax benefits were $20 million, $15 million and $14 million at December 31, 2018, 2017 and 2016, respectively.

Refer to Note 13 – Income Taxes in the Consolidated Financial Statements for additional information regarding deferred income taxes and unrecognized tax benefits.

Loss Contingencies

We are currently involved in various claims and legal proceedings. At least quarterly, we review the status of each significant matter and assess its potential financial exposure considering all available information including, but not limited to, the impact of negotiations, settlements, rulings, advice of legal counsel and other updated information and events pertaining to a particular matter. If the potential loss from any claim or legal proceeding is considered probable and the amount can be reasonably estimated, we accrue a liability for the estimated loss. Significant judgment is required in both the determination of probability and the determination as to whether an exposure is reasonably estimable. Because of uncertainties related to these matters, accruals are based only on the best information available at the time. As additional information becomes available, we reassess the potential liability related to pending claims and litigation, and may revise estimates. These revisions in the estimates of the potential liabilities could have a material impact on the results of operations and financial position.

Refer to Note 14 – Contingencies and Litigation in the Consolidated Financial Statements for additional information regarding loss contingencies.

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Financial Information

Financial information for the three years ended December 31, 2018 was as follows:

(in millions)	Year Ended December 31, 2018	2017	2016	2018 vs. 2017 $ Change	% Change	2017 vs. 2016 $ Change	% Change
Revenue	$ 5,393	$ 6,022	$ 6,408	$ (629)	(10)%	$ (386)	(6)%
Operating Costs and Expenses							
Cost of Services (excluding depreciation and amortization)	4,182	4,730	5,174	$ (548)	(12)%	$ (444)	(9)%
Selling, general and administrative (excluding depreciation and amortization)	560	611	679	$ (51)	(8)%	(68)	(10)%
Research and development (excluding depreciation and amortization)	11	12	31	(1)	(8)%	(19)	(61)%
Depreciation and amortization	460	495	611	(35)	(7)%	(116)	(19)%
Restructuring and related costs	81	101	101	(20)	(20)%	—	— %
Interest expense	112	137	40	(25)	(18)%	97	243 %
(Gain) loss on divestitures and transaction costs	42	(42)	2	84	(200)%	(44)	
Litigation costs (recoveries), net	227	(11)	40	238		(51)	(128)%
(Gain) loss on extinguishment of debt	108	—	—	108	100 %	—	— %
Goodwill impairment	—	—	935	—	— %	(935)	(100)%
Separation costs	—	12	44	(12)	(100)%	(32)	(73)%
Other (income) expenses, net	5	(7)	(22)	12	(171)%	15	(68)%
Total Operating Costs and Expenses	**$ 5,788**	**$ 6,038**	**$ 7,635**	**$ (250)**		**$ (1,597)**	
Income (Loss) Before Income Taxes	$ (395)	$ (16)	$ (1,227)	$ (379)		$ 1,211	
Income tax expense (benefit)	21	(193)	(244)	214	(111)%	51	(21)%
Income (Loss) From Continuing Operations	**$ (416)**	**$ 177**	**$ (983)**	**$ (593)**		**$ 1,160**	

Revenue

Revenue for 2018 decreased, compared to the prior year period, mainly due to the impact from adopting the accounting guidance related to revenue recognition, which is also referred to herein as the "new revenue standard", divestitures completed in 2017 and 2018, strategic decisions by management as part of our portfolio rationalization, including exiting certain unprofitable contracts and contract losses. Partially offsetting these declines were increases from the ramp of new business. Excluding the impact of the new revenue standard and divestitures, the 2018 revenue decreased by 3.8% mainly due to strategic decisions by management as part of our portfolio rationalization, including exiting certain unprofitable contracts and contract losses, partially offset by the ramp of new business.

Revenue for 2017 decreased, compared to the prior year period, mainly due to the impact from strategic decisions by management as part of our portfolio rationalization, including exiting certain unprofitable contracts, the run-off of our Student Loan business and contract losses. Partially offsetting these declines were new contracts in the Government Services and the Transportation segments.

Cost of Services (excluding depreciation and amortization)

Cost of services for 2018 decreased, compared to the prior year period, mainly driven by the impact from adopting the new revenue standard, reductions in real estate, information technology and labor costs from our strategic transformation initiatives, lost business, strategic contract actions taken by management as part of portfolio management, lower volumes and divestitures completed in 2017 and 2018.

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Cost of services for 2017 decreased, compared to the prior year period, primarily due to cost transformation, lost business, wind-down of the NY MMIS contract, run-off of our Student Loan business, strategic contract actions taken by management as part of portfolio management and lower volumes.

Selling, General and Administrative (SG&A) (excluding depreciation and amortization)

Lower SG&A for 2018, compared to the prior year period, was reflective of the impact of our strategic transformation initiatives, primarily due to reductions in labor costs.

Lower SG&A for 2017, compared to the prior year period, was reflective of the impact of our strategic transformation initiatives driving lower wages and benefits, partially offset by the expansion and investment in our sales force.

Depreciation and Amortization

Depreciation and amortization decreased in 2018, compared to the prior year period, primarily due to the divestitures in 2018. The decrease in Depreciation and amortization for 2017, compared to the prior year period, was primarily due to the acceleration of amortization of certain trade-names in 2016. Refer to Note 6 – Goodwill and Intangible Assets, Net in the Consolidated Financial Statements for additional information regarding our intangible assets.

Restructuring and Related Costs

Restructuring and related costs for the year ended December 31, 2018, include $34 million of severance costs due to headcount reductions of approximately 3,000 employees worldwide, $40 million of lease cancellation and other costs as part of our effort to consolidate our real estate footprint as well as $7 million of costs primarily related to data center migration and professional support services associated with the implementation of the strategic transformation program.

Restructuring and related costs for the year ended December 31, 2017 include $41 million of severance costs due to headcount reductions of approximately 3,200 employees worldwide, $51 million of lease cancellation costs as part of our effort to consolidate our real estate footprint and $9 million of costs primarily related to professional support services associated with the implementation of the strategic transformation program.

Restructuring and related costs for the year ended December 31, 2016 include $54 million of severance costs due to headcount reductions of approximately 3,600 employees worldwide, $28 million of costs primarily related to professional support services associated with the implementation of the strategic transformation program and $19 million of lease cancellation costs as part of our effort to consolidate our real estate footprint.

Refer to Note 7 – Restructuring Programs and Related Costs in the Consolidated Financial Statements for additional information regarding our restructuring programs.

Interest Expense

The decrease in Interest expense for 2018, compared to the prior year period, was driven primarily by the repayment of the Senior Notes and repricing of the term loans in 2018, partially offset by the write-off of debt issuance costs for certain loans that were refinanced in June 2018, amortization of debt issuance costs associated with the repricing of the loans and interest rate increases in 2018. Refer to Note 9 – Debt in the Consolidated Financial Statements for additional information.

Increase in interest expense for 2017, compared to the prior year period, was primarily due to the issuance of debt with the capitalization of the Company during the spin-off in December 2016 and subsequent borrowing under Term Loan B in January 2017, as well as amounts outstanding at various times throughout the year and interest rate increases.

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(Gain) Loss on Divestitures and Transaction Costs

The loss for 2018, compared to the prior year period gain, was driven primarily by an impairment charge related to the anticipated sale of a portfolio of select standalone customer care contracts that was completed in February 2019, partially offset by net gains from divestitures and transaction costs. The gain for 2017, compared to the prior year period loss, was due to gains from the sale of property located in Dallas and from divestitures. See Note 3 – Assets/Liabilities Held for Sale and Divestitures for additional information on 2018 divestitures.

Litigation Costs (Recoveries), Net

Increase in net litigation costs for 2018, compared to the prior year period, was primarily due to increases in reserves related to the litigation settlement pursuant to the Texas Agreement ("Texas Agreement"), Student Loan Service exposures and a reserve for certain terminated contracts that are subject to litigation.

Decrease in net litigation costs for 2017, compared to the prior year period, was primarily due to income received from certain customer dispute settlements and adjustment to contingent consideration on a previous acquisition.

Refer to Note 14 – Contingencies and Litigation to the Consolidated Financial Statements for additional information.

(Gain) Loss on Extinguishment of Debt

The loss on extinguishment of debt for 2018, related to the premium paid for the substantial buyback of the 10.5% Senior Notes due 2024.

Refer to Note 9 – Debt to the Consolidated Financial Statements for additional information regarding the debt redemption.

Goodwill Impairment

Our Commercial Industries reporting unit experienced declining operating results in 2016 versus expectations. As a result, we recorded a goodwill impairment of $935 million in 2016. Refer to Note 6 – Goodwill and Intangible Assets, Net in the Consolidated Financial Statements for additional information regarding the Goodwill impairment charge.

Separation Costs

Separation costs are primarily for third-party investment banking, accounting, legal, consulting and other similar types of services related to the separation transaction as well as costs associated with the operational separation of the two companies, such as those related to human resources, brand management, real estate and information management to the extent not capitalized. Separation costs also include the costs associated with bonuses and restricted stock grants awarded to employees for retention through the separation.

Other (Income) Expenses, Net

Other (income) expenses, net primarily includes foreign currency transaction losses (gains) and other deferred compensation investment results.

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Income Taxes

On December 22, 2017, the Tax Cuts and Jobs Act (Tax Reform) was enacted. The effects of changes in tax rates and laws were recognized in 2017, the period in which the new legislation was enacted. The income tax effects of the Tax Reform were initially accounted for on a provisional basis pursuant to the SEC staff guidance on income taxes. Reasonable estimates for all material tax effects of the Tax Reform were provided. A provisional benefit was recorded for $210 million resulting from a reduction in the tax rate from 35% to 21%. This was partially offset by a $12 million charge from one time tax on undistributed and previously untaxed post-1986 foreign earnings and profits (Transition Tax). The Company finalized its accounting for this matter in the fourth quarter of 2018 and recognized a $2 million additional benefit year to date, included as a component of income tax expense from continuing operations. The 2018 effective tax rate was (5.3)% and was lower than the U.S. statutory rate of 21%, primarily due to pre-tax loss and tax from the impacts of business divestitures, partially offset by U.S. foreign tax credits. As a result of higher U.S. Federal taxable income caused by the divestitures, the Company is not subject to Base Erosion Anti-Abuse Tax (BEAT) in 2018.

Excluding the impact of divestitures, the State of Texas litigation reserve, the loss on extinguishment of debt, charges for amortization of intangible assets, restructuring and divestiture related costs, the normalized effective tax rate without a BEAT tax for 2018 was 25.1%.

The 2017 rate was higher than the U.S. statutory rate of 35% primarily due to the impact of the Tax Reform, which included the reduction of the U.S. statutory rate from 35% to 21% and the Transition Tax.

Excluding primarily the tax impact of the Tax Reform, the termination of the COLI, amortization of intangible assets and gains on U.S divestitures, the adjusted effective tax rate for 2017 was 33.8%.

Operations Review of Segments

Our reportable segments correspond to how we organize and manage the business and are aligned to the industries in which our clients operate.

During 2018, in an effort to better reflect how we manage our business, we segregated our Public Sector segment into Government Services (including Health Enterprise, which was previously reported in Other segment) and Transportation segments. In addition, the Company also reclassified the operating results of our divestitures from the reportable segments to Other segment and separately reflected Shared IT/Infrastructure & Corporate Costs. All prior periods presented have been revised to reflect these changes.

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The following are our results of financial performance by segment for the three years ended December 31, 2018:

(in millions)	Commercial Industries	Government Services	Transportation	Other		Shared IT / Infrastructure & Corporate Costs	Total
Year Ended December 31, 2018				Divestitures	Other		
Total Revenue	$ 2,547	$ 1,351	$ 729	$ 752	$ 14	$ —	$ 5,393
Profit (Loss)	$ 500	$ 424	$ 113	$ 98	$ (18)	$ (695)	$ 422
Adjusted EBITDA	$ 597	$ 451	$ 149	$ 105	$ (15)	$ (647)	$ 640
% of Total Revenue	47.2%	25.1%	13.5%	13.9%	0.3 %	—%	100.0%
Adjusted EBITDA Margin	23.4%	33.4%	20.4%	14.0%	(107.1)%	—%	11.9%
Year Ended December 31, 2017							
Total Revenue	$ 2,685	$ 1,433	$ 767	$ 1,062	$ 75	$ —	$ 6,022
Profit (Loss)	$ 563	$ 398	$ 114	$ 128	$ 16	$ (802)	$ 417
Adjusted EBITDA	$ 661	$ 440	$ 157	$ 141	$ 18	$ (745)	$ 672
% of Total Revenue	44.7%	23.8%	12.7%	17.6%	1.2 %	—%	100.0%
Adjusted EBITDA Margin	24.6%	30.7%	20.5%	13.3%	24.0 %	—%	11.2%
Year Ended December 31, 2016							
Total Revenue	$ 2,827	$ 1,575	$ 766	$ 1,109	$ 131	$ —	$ 6,408
Profit (Loss)	$ 520	$ 421	$ 88	$ 166	$ (149)	$ (850)	$ 196
Adjusted EBITDA	$ 623	$ 464	$ 129	$ 190	$ 9	$ (780)	$ 635
% of Total Revenue	44.1%	24.6%	12.0%	17.3%	2.0 %	—%	100.0%
Adjusted EBITDA Margin	22.0%	29.5%	16.8%	17.1%	6.9 %	—%	9.9%

Commercial Industries Segment

Revenue

Commercial Industries revenue for 2018 decreased, compared to the prior year period, primarily driven by strategic contract actions and contract losses, businesses divested in 2018 and the impact of the new revenue standard, partially offset by revenue from new contracts and price increases from existing accounts.

Commercial Industries revenue 2017 decreased, compared to the prior year period, primarily driven by strategic contract actions and contract losses, lower volumes in our customer care offerings and lost business, partially offset by revenue from new contracts and price increases with existing clients.

Segment Profit and Adjusted EBITDA

Decrease in the Commercial Industries segment profit and adjusted EBITDA margin for 2018, compared to the prior year period, was mainly driven by the overall revenue decline from strategic actions and investments in technology platforms, partially offset by reductions in real estate, information technology and labor costs from our strategic transformation initiatives and from increases in new business.

Increase in the Commercial Industries segment profit and adjusted EBITDA margin for 2017, compared to the prior year period, was primarily driven by reduced costs as a result of reductions in real estate, information technology and labor costs from our strategic transformation initiatives, as well as contract remediation and strategic contract actions, partially offset by the overall revenue decline and investments in technology platforms.

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Government Services Segment

Revenue

Government Services revenue for 2018 decreased, compared to the prior year period, primarily driven by strategic contract actions and the impact of the new revenue standard, contract losses and lower volumes, partially offset by certain price increases from contract remediation and ramp of new business.

Government Services revenue for 2017 decreased, compared to the prior year period, primarily driven by strategic contract actions, contract losses and lower volumes, partially offset by certain price increases from contract remediation and ramp of new business.

Segment Profit and Adjusted EBITDA

Increase in the Government Services segment profit and adjusted EBITDA margin for 2018, compared to the prior year period, was mainly driven by reductions in real estate, information technology and labor costs from our strategic transformation initiatives and contract remediation, as well as price increases on certain accounts, partially offset by investments in technology platforms.

Decrease in the Government Services segment profit and adjusted EBITDA for 2017, compared to the prior year period, was primarily driven by strategic contract actions, contract losses in healthcare and payment services businesses, partially offset by our strategic transformation initiative.

Transportation Segment

Revenue

Transportation revenue for 2018 decreased, compared to the prior year period, primarily driven by the impact of the new revenue standard, contract losses, service level penalties and lower volumes, partially offset by certain price increases from contract remediation and ramp of new business.

Transportation revenue for 2017 was flat, compared to the prior year period, primarily driven by ramp of new business, offset by strategic decisions and contract losses.

Segment Profit and Adjusted EBITDA

Transportation segment profit and adjusted EBITDA margin for 2018, compared to the prior year period, was flat. This was mainly driven by reductions in real estate, information technology and labor costs from our strategic transformation initiatives, offset by investments in technology platforms.

Increase in the Transportation segment profit and adjusted EBITDA for 2017, compared to the prior year period, was mainly due to our strategic transformation initiative, partially offset by strategic decisions and contract losses.

Other

Revenue

Other revenue for 2018 decreased, compared to the prior year period, driven mainly by the divestitures completed in 2017 and 2018 and the run-off of our Student Loan Services business.

Other revenue for 2017 decreased, compared to the prior year period, driven mainly by the divestitures completed in 2017 and the run-off of our Student Loan Services business.

Segment Profit (Loss) and Adjusted EBITDA

Decrease in Other segment profit and adjusted EBITDA for 2018 were primarily due to divestitures completed in 2017 and 2018 and the run-off of our Student Loan Services business.

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Increase in Other segment profit for 2017 was primarily due to nonrecurring NY MMIS and HE charges in 2016. Decrease in Other segment adjusted EBITDA for 2017 was primarily due to divestitures completed in 2017 and the run-off of our Student Loan Services business.

Shared IT / Infrastructure & Corporate Costs

Improvements in Shared IT/Infrastructure and Corporate costs for both 2018 and 2017, compared to the prior year periods, were primarily driven by reduced costs as a result of reductions in real estate, information technology and labor costs from our strategic transformation initiatives.

Metrics

Signings

Signings are defined as estimated future revenues from contracts signed during the period, including renewals of existing contracts. Total Contract Value (TCV) is the estimated total contractual revenue related to signed contracts. The amounts in the following table reflect the impact of our adoption of the new revenue recognition standard on January 1, 2018 and also excludes divestitures. Refer to Note 1 – Basis of Presentation and Summary of Significant Accounting Policies for further discussion of the estimated impact of the adoption of this standard.

	Year Ended December 31,		2018 vs. 2017	
(in millions)	2018	2017	$ Change	% Change
New business TCV	$ 1,598	$ 2,031	$ (433)	(21)%
Renewals TCV	3,847	2,297	1,550	67 %
Total Signings	$ 5,445	$ 4,328	$ 1,117	26 %
Annual recurring revenue signings[1]	$ 365	$ 471	$ (106)	(23)%
Non-recurring revenue signings[2]	$ 234	$ 326	$ (92)	(28)%

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(1) Recurring revenue signings are for new business contracts longer than one year.

(2) Non-recurring revenue signings are for contracts shorter than one year.

Signings for the 2018 increased, compared to the prior year, mainly due to increased renewal activities, partially offset by new business signings decline due to a continued focus on strategic wins with acceptable margins.

Renewal Rate

Renewal rate is defined as the annual recurring revenue (ARR) on contracts that are renewed during the period as a percentage of ARR on all contracts for which a renewal decision was made during the period, excluding any contracts that were not renewed and where a strategic action to improve the risk or profitability had been initiated.

Excluding our strategic decision not to renew certain contracts, renewal rates for 2018 and 2017 were 95% and 94%, respectively.

Capital Resources and Liquidity

As of December 31, 2018 and 2017, total cash and cash equivalents were $756 million (of which approximately $100 million was cash in foreign locations) and $658 million, respectively. Subsequent to December 31, 2018, the Company purchased the HSP business for approximately $90 million and entered into an agreement to settle the Texas litigation, $20 million of which is payable in the first quarter of 2019. Also, it is anticipated that our working capital in the first quarter of 2019 will be a net use of cash. Regarding the Texas litigation, the Settlement Agreement does not prevent the Company from prepaying the foregoing amounts and the Company is currently considering whether to do so. The Company also has a $750 million revolving line of credit for its various cash needs, of which $12 million has been utilized for letters of credit.

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As of December 31, 2018, there were $1.5 billion outstanding borrowings under our Credit Agreement of which $55 million was due within one year. Refer to Note 9 – Debt in the Consolidated Financial Statements for additional debt information.

Refer to the *Capital Market Activity* section below for additional information regarding our capital activity.

Cash Flow Analysis

The following summarizes our cash flows for the three years ended December 31, 2018, as reported in our Consolidated Statements of Cash Flows in the accompanying Consolidated Financial Statements:

	Year Ended December 31,			Change	
(in millions)	2018	2017	2016	2018	2017
Net cash provided by operating activities	$ 283	$ 300	$ 95	$ (17)	$ 205
Net cash provided by investing activities	460	74	16	386	58
Net cash provided by (used in) financing activities	(637)	(124)	150	(513)	(274)

Operating Activities

The decrease in cash generated from operating activities for 2018, compared to the prior year period, was primarily attributable to increased tax payments and increased deferred compensation payments, partially offset by other working capital amounts.

The increase in cash generated from operating activities for 2017, compared to the prior year period, was primarily attributable to improvements in working capital and reduced wind-down payments associated with implementations in California, Montana and New York, partially offset by higher interest payments on our outstanding debt.

Investing Activities

The increase in cash generated from investing activities for 2018, compared to the prior year period, was primarily due to the proceeds from the divestitures, partially offset by increased spending for capital expenditures related to modernizing our information technology infrastructure.

The increase in cash provided by investing activities for 2017, compared to the prior year period, was primarily related to proceeds received on the liquidation of investments related to the termination of the deferred compensation plan, proceeds from the sale of business and assets and lower net additions to land, buildings and equipment, partially offset by non-recurring proceeds from related party notes receivable in 2016.

Financing Activities

The increase in cash used from financing activities for 2018, compared to the prior year period, was related to net debt repayments, premium on debt redemption and repayments of capital leases, partially offset by payments to former parent company in 2017.

The decrease in cash used in financing activities for 2017, compared to the prior year period, was primarily related to a decrease in proceeds from long term debt and an increase in debt payments, partially offset by a reduction in payments to former parent.

Capital Market Activity

On June 28, 2018, the Company entered into Amendment No. 3 (Amendment) to the December 7, 2016 Credit Agreement and in July 2018, the Company redeemed $476 million of its $510 million 10.5% Senior Notes due 2024.

Refer to Note 9 – Debt in the Consolidated Financial Statements for additional information on both Amendment No. 3 and the partial redemption of the Senior Notes.

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Financial Instruments

Refer to Note 10 – Financial Instruments in the Consolidated Financial Statements for additional information.

Contractual Cash Obligations and Other Commercial Commitments and Contingencies

At December 31, 2018, we had the following contractual cash obligations and other commercial commitments and contingencies:

(in millions)	2019	2020	2021	2022	2023	Thereafter
Total debt, including capital lease obligations[1]	$ 55	$ 50	$ 84	$ 576	$ 800	$ 33
Interest on debt[2]	90	89	86	56	4	3
Minimum operating lease commitments[3]	153	113	78	53	33	76
Defined benefit pension plans	2	—	—	—	—	—
Estimated Purchase Commitments[4]	87	58	34	3	—	1
Total	$ 387	$ 310	$ 282	$ 688	$ 837	$ 113

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(1) Total debt represents principal debt and capital leases. Refer to Note 9 – Debt in the Consolidated Financial Statements for additional information regarding debt.
(2) Represents interest on debt. Refer to Note 9 – Debt in the Consolidated Financial Statements for additional information.
(3) Refer to Note 5 – Land, Buildings, Equipment and Software, Net in the Consolidated Financial Statements for additional information.
(4) Other purchase commitments: We enter into other purchase commitments with vendors in the ordinary course of business. Our policy with respect to all purchase commitments is to record losses, if any, when they are probable and reasonably estimable. We currently do not have, nor do we anticipate, material loss contracts.

The table above does not include the amounts payable under the Texas Agreement. Refer to Note 14 – Contingencies and Litigation for additional information.

Other Contingencies and Commitments

As more fully discussed in Note 14 – Contingencies and Litigation in the Consolidated Financial Statements, we are involved in a variety of claims, lawsuits, investigations and proceedings concerning: securities law; governmental entity contracting, servicing and procurement law; intellectual property law; environmental law; employment law; the Employee Retirement Income Security Act (ERISA); and other laws and regulations. In addition, guarantees, indemnifications and claims may arise during the ordinary course of business from relationships with suppliers, customers and non-consolidated affiliates. Nonperformance under a contract including a guarantee, indemnification or claim could trigger an obligation of the Company.

We determine whether an estimated loss from a contingency should be accrued by assessing whether a loss is deemed probable and can be reasonably estimated. Should developments in any of these areas cause a change in our determination as to an unfavorable outcome and result in the need to recognize a material accrual, or should any of these matters result in a final adverse judgment or be settled for significant amounts, they could have a material adverse effect on our results of operations, cash flows and financial position in the period or periods in which such change in determination, judgment or settlement occurs.

Off-Balance Sheet Arrangements

As of December 31, 2018, we do not believe we have any off-balance sheet arrangements that have, or are reasonably likely to have, a material current or future effect on financial condition, changes in financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources.

In addition, refer to the preceding table for the Company's contractual cash obligations and other commercial commitments and Note 14 – Contingencies and Litigation in the Consolidated Financial Statements for additional information regarding contingencies, guarantees and indemnifications.

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ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Market Risk

We are exposed to market risk from foreign currency exchange rates, which could affect operating results, financial position and cash flows. We manage our exposure to this market risk through our regular operating and financing activities and, when appropriate, through the use of derivative financial instruments. We utilized derivative financial instruments to hedge economic exposures, as well as reduce earnings and cash flow volatility resulting from shifts in market rates. We also hedge the cost to fund material non-dollar entities by buying currencies periodically in advance of the funding date. This is accounted for using derivative accounting.

Recent market events have not caused us to materially modify or change our financial risk management strategies with respect to our exposures to foreign currency risk. Refer to Note 10 – Financial Instruments in the Consolidated Financial Statements for additional discussion on our financial risk management.

Foreign Exchange Risk Management

Assuming a 10% appreciation or depreciation in foreign currency exchange rates from the quoted foreign currency exchange rates at December 31, 2018, the potential change in the fair value of foreign currency-denominated assets and liabilities in each entity would not be significant because all material currency asset and liability exposures were economically hedged as of December 31, 2018. A 10% appreciation or depreciation of the U.S. Dollar against all currencies from the quoted foreign currency exchange rates at December 31, 2018 would have an impact on our cumulative translation adjustment portion of equity of approximately $50 million. The net amount invested in foreign subsidiaries and affiliates, primarily in the U.K. and Europe, and translated into U.S. Dollars using the year-end exchange rates, was approximately $504 million at December 31, 2018.

Interest Rate Risk Management

The consolidated weighted-average interest rates related to our total debt for 2018 approximated 3.42% for Term A Loan due 2021, 5.44% for Term B Loan due 2023, 7.71% for Senior Notes due 2024 and 2.08% for capital lease obligations. As of December 31, 2018, $1,564 million of our total debt of $1,598 million carried variable interest rates. The fair values of our fixed rate financial instruments are sensitive to changes in interest rates and at December 31, 2018, a 10% increase in market interest rates would decrease the fair values of such financial instruments by approximately $1.5 million. A 10% decrease in market interest rates would increase the fair values of such financial instruments by approximately $4 million.

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ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of Conduent Incorporated

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Conduent Incorporated and its subsidiaries (the "Company") as of December 31, 2018 and 2017, and the related consolidated statements of income (loss), comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, including the related notes and schedule of valuation and qualifying accounts for each of the three years in the period ended December 31, 2018 appearing under Item 15(a)(2) (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by the COSO.

Change in Accounting Principle

As discussed in Note 1 to the consolidated financial statements, the Company changed the manner in which it accounts for revenues from contracts with customers in 2018.

Basis for Opinions

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

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

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

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Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

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

/s/ PricewaterhouseCoopers LLP

Florham Park, New Jersey

February 28, 2019

We have served as the Company's auditor since 2016.

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REPORTS OF MANAGEMENT

Management's Responsibility for Financial Statements

Our management is responsible for the integrity and objectivity of all information presented in this annual report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States of America and include amounts based on management's best estimates and judgments. Management believes the consolidated financial statements fairly reflect the form and substance of transactions and that the financial statements fairly represent the Company's financial position and results of operations.

The Audit Committee of the Board of Directors, which is composed solely of independent directors, meets regularly with the independent registered public accountants, PricewaterhouseCoopers LLP, the internal auditors and representatives of management to review accounting, financial reporting, internal control and audit matters, as well as the nature and extent of the audit effort. The Audit Committee is responsible for the engagement of the independent registered public accountants. The independent registered public accountants and internal auditors have free access to the Audit Committee.

/s/ ASHOK VEMURI	/s/ BRIAN WEBB-WALSH	/s/ ALLAN COHEN
Chief Executive Officer	**Chief Financial Officer**	**Chief Accounting Officer**

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CONDUENT INCORPORATED
CONSOLIDATED STATEMENTS OF INCOME (LOSS)

(in millions, except per-share data)	Year Ended December 31, 2018	2017	2016
Revenue	$ 5,393	$ 6,022	$ 6,408
Operating Costs and Expenses			
Cost of Services (excluding depreciation and amortization)	4,182	4,730	5,174
Selling, general and administrative (excluding depreciation and amortization)	560	611	679
Research and development (excluding depreciation and amortization)	11	12	31
Depreciation and amortization	460	495	611
Restructuring and related costs	81	101	101
Interest expense	112	137	40
(Gain) loss on divestitures and transaction costs	42	(42)	2
Litigation costs (recoveries), net	227	(11)	40
(Gain) loss on extinguishment of debt	108	—	—
Goodwill impairment	—	—	935
Separation costs	—	12	44
Other (income) expenses, net	5	(7)	(22)
Total Operating Costs and Expenses	5,788	6,038	7,635
Income (Loss) Before Income Taxes	(395)	(16)	(1,227)
Income tax expense (benefit)	21	(193)	(244)
Income (Loss) From Continuing Operations	(416)	177	(983)
Income (loss) from discontinued operations, net of tax	—	4	—
Net Income (Loss)	$ (416)	$ 181	$ (983)
Basic Earnings (Loss) per Share:			
Continuing operations	$ (2.06)	$ 0.82	$ (4.85)
Discontinued operations	—	0.02	—
Total Basic Earnings (Loss) per Share	$ (2.06)	$ 0.84	$ (4.85)
Diluted Earnings (Loss) per Share:			
Continuing operations	$ (2.06)	$ 0.81	$ (4.85)
Discontinued operations	—	0.02	—
Total Diluted Earnings (Loss) per Share	$ (2.06)	$ 0.83	$ (4.85)

The accompanying notes are an integral part of these Consolidated Financial Statements.

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CONDUENT INCORPORATED
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)

(in millions)	Year Ended December 31, 2018	2017	2016
Net Income (Loss)	$ (416)	$ 181	$ (983)
Other Comprehensive Income (Loss), Net[1]			
Currency translation adjustments, net	(31)	35	(135)
Reclassification of currency translation adjustments on divestitures	42	—	—
Reclassification of divested benefit plans and other	62	—	—
Unrecognized gains (loss), net	1	2	—
Changes in benefit plans, net	—	(5)	(20)
Other Comprehensive Income (Loss), Net	74	32	(155)
Comprehensive Income (Loss), Net	$ (342)	$ 213	$ (1,138)

(1) All amounts are net of tax. Tax effects were immaterial. See Note 17 – Other Comprehensive Income (Loss) for information about pre-tax amounts.

The accompanying notes are an integral part of these Consolidated Financial Statements.

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CONDUENT INCORPORATED
CONSOLIDATED BALANCE SHEETS

(in millions, except share data in thousands)	December 31, 2018	December 31, 2017
Assets		
Cash and cash equivalents	$ 756	$ 658
Accounts receivable, net	782	1,114
Assets held for sale	15	757
Contract assets	177	—
Other current assets	234	181
Total current assets	1,964	2,710
Land, buildings and equipment, net	328	257
Intangible assets, net	651	891
Goodwill	3,408	3,366
Other long-term assets	329	324
Total Assets	$ 6,680	$ 7,548
Liabilities and Equity		
Current portion of long-term debt	$ 55	$ 82
Accounts payable	230	118
Accrued compensation and benefits costs	193	355
Unearned income	112	151
Liabilities held for sale	40	169
Other current liabilities	567	493
Total current liabilities	1,197	1,368
Long-term debt	1,512	1,979
Deferred taxes	327	384
Other long-term liabilities	280	146
Total Liabilities	3,316	3,877
Contingencies (See Note 14)		
Series A convertible preferred stock	142	142
Common stock	2	2
Additional paid-in capital	3,878	3,850
Retained earnings (deficit)	(233)	171
Accumulated other comprehensive loss	(425)	(494)
Total Equity	3,222	3,529
Total Liabilities and Equity	$ 6,680	$ 7,548
Shares of common stock issued and outstanding	211,306	210,440
Shares of series A convertible preferred stock issued and outstanding	120	120

The accompanying notes are an integral part of these Consolidated Financial Statements.

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CONDUENT INCORPORATED
CONSOLIDATED STATEMENTS OF CASH FLOWS

(in millions)	Year Ended December 31, 2018	2017	2016
Cash Flows from Operating Activities:			
Net income (loss)	$ (416)	$ 181	$ (983)
Adjustments required to reconcile net income to cash flows from operating activities:			
Depreciation and amortization	460	495	611
Contract inducement amortization	3	2	2
Goodwill impairment	—	—	935
Deferred income taxes	(75)	(230)	(160)
(Gain) loss from investments	(2)	(10)	(7)
Amortization of debt financing costs	11	9	—
(Gain) loss on extinguishment of debt	108	—	—
(Gain) loss on divestitures and transaction costs	42	(42)	2
Stock-based compensation	38	40	23
Changes in operating assets and liabilities:			
(Increase) decrease in accounts receivable	133	31	(23)
(Increase) decrease in other current and long-term assets	(111)	(32)	(96)
Increase (decrease) in accounts payable and accrued compensation	(56)	(49)	(60)
Increase (decrease) in restructuring liabilities	8	34	27
Increase (decrease) in other current and long-term liabilities	161	(125)	(210)
Net change in income tax assets and liabilities	(17)	11	39
Other operating, net	(4)	(15)	(5)
Net cash provided by (used in) operating activities	283	300	95
Cash Flows from Investing Activities:			
Cost of additions to land, buildings and equipment	(179)	(96)	(149)
Proceeds from sale of land, buildings and equipment	13	33	—
Cost of additions to internal use software	(45)	(36)	(39)
Proceeds from investments	1	117	11
Proceeds from divestitures and sale of assets, net of cash	675	56	(54)
Net proceeds on notes receivable	—	—	248
Other investing, net	(5)	—	(1)
Net cash provided by (used in) investing activities	460	74	16
Cash Flows from Financing Activities:			
Proceeds on long-term debt	—	306	1,969
Debt issuance fee payments	(3)	(8)	(67)
Payments on debt	(519)	(241)	(32)
Premium on debt redemption	(95)	—	—
Net payments to former parent company	—	(161)	(1,720)
Taxes paid for settlement of stock based compensation	(10)	(5)	—
Dividends paid on preferred stock	(10)	(10)	—
Other financing	—	(5)	—
Net cash provided by (used in) financing activities	(637)	(124)	150
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(8)	1	(6)
Increase (decrease) in cash, cash equivalents and restricted cash	98	251	255
Cash, Cash Equivalents and Restricted Cash at Beginning of Period	667	416	161
Cash, Cash Equivalents and Restricted Cash at End of period[1]	$ 765	$ 667	$ 416

(1) *Includes $9 million, $9 million and $26 million of restricted cash as of December 31, 2018, 2017 and 2016, respectively, that were included in Other current assets on the Consolidated Balance Sheets.*

The accompanying notes are an integral part of these Consolidated Financial Statements.

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CONDUENT INCORPORATED
CONSOLIDATED STATEMENTS OF SHAREHOLDERS' EQUITY

(in millions)	Common Stock	Additional Paid-in Capital	Retained Earnings	AOCL[1]	Former Parent Company Investment	Conduent Shareholders' Equity
Balance at December 31, 2015	$ —	$ —	$ —	$ (181)	$ 5,343	$ 5,162
Series A preferred stock transfer	—	—	—	—	(142)	(142)
Capitalization of Company	2	3,812	—	—	(3,814)	—
Net transfers from former parent company	—	—	—	(190)	(404)	(594)
Comprehensive Income (Loss):						
Net Income (Loss)	—	—	—	—	(983)	(983)
Other comprehensive income (loss), net	—	—	—	(155)	—	(155)
Total Comprehensive Income (Loss), Net	—	—	—	(155)	(983)	(1,138)
Balance at December 31, 2016	$ 2	$ 3,812	$ —	$ (526)	$ —	$ 3,288
Cash dividends paid - preferred stock[2]	—	—	(10)	—	—	(10)
Stock option and incentive plans, net	—	38	—	—	—	38
Comprehensive Income (Loss):						
Net Income (Loss)	—	—	181	—	—	181
Other comprehensive income (loss), net	—	—	—	32	—	32
Total Comprehensive Income (Loss), Net	—	—	181	32	—	213
Balance at December 31, 2017	$ 2	$ 3,850	$ 171	$ (494)	$ —	$ 3,529
Cash dividends paid - preferred stock[2]	—	—	(10)	—	—	(10)
Cumulative impact of adopting the new revenue standard	—	—	17	—	—	17
Reclassification of amounts impacted by Tax Reform	—	—	5	(5)	—	—
Stock option and incentive plans, net	—	28	—	—	—	28
Comprehensive Income (Loss):						
Net Income (Loss)	—	—	(416)	—	—	(416)
Other comprehensive income (loss), net	—	—	—	74	—	74
Total Comprehensive Income (Loss), Net	—	—	(416)	74	—	(342)
Balance at December 31, 2018	$ 2	$ 3,878	$ (233)	$ (425)	$ —	$ 3,222

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(1) AOCL - Accumulated other comprehensive loss.

(2) Cash dividend on preferred stock of $80.00 per share for 2018 and 2017.

The accompanying notes are an integral part of these Consolidated Financial Statements.

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CONDUENT INCORPORATED
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note 1 – Basis of Presentation and Summary of Significant Accounting Policies

References herein to “we,” “us,” “our,” the “Company” and “Conduent” refer to Conduent Incorporated and its consolidated subsidiaries unless the context suggests otherwise.

Description of Business

We are a global enterprise and leading provider of business process services with expertise in transaction-intensive processing, analytics and automation. We serve as a trusted business partner in both the front office and back office, enabling personalized, seamless interactions on a massive scale that improve end-user experience. We create value for our commercial and government clients by applying our expertise, technology and innovation to help them drive customer and constituent satisfaction and loyalty, increase process efficiency and respond rapidly to changing market dynamics. Our portfolio includes industry-focused service offerings in attractive growth markets such as healthcare and transportation, as well as multi-industry service offerings such as transaction processing, customer care and payment services.

Basis of Presentation

Our Consolidated Financial Statements included the historical basis of assets, liabilities, revenues and expenses of the individual businesses of the Company, including joint ventures and partnerships over which the Company has a controlling financial interest. We have prepared the Consolidated Financial Statements pursuant to the rules and regulations of the SEC. Certain reclassifications have been made to prior years' amounts to conform to the current year presentation. All intercompany transactions and balances have been eliminated.

We have also considered the impact of subsequent events on these consolidated financial statements.

Separation from Xerox Corporation

On December 31, 2016, Conduent spun-off from Xerox Corporation (Xerox), pursuant to the Separation and Distribution Agreement (Separation). The Separation was completed by way of a pro rata distribution of Conduent shares held by Xerox to Xerox’s shareholders. As a result, we operate as an independent, publicly traded company on the New York Stock Exchange, under the ticker "CNDT".

Prior to December 31, 2016, the Financial Statements of the Company were derived from the financial statements and accounting records of Xerox as if Conduent operated on a standalone basis. Historically, the Company consisted of the Business Process Outsourcing Operating segment within Xerox’s reportable Services segment and did not operate as a separate, standalone company. Accordingly, Xerox performed certain corporate overhead functions for the Company. Therefore, certain corporate costs, including compensation costs for corporate employees supporting the Company, were allocated from Xerox. It is not practicable to estimate actual costs that would have been incurred had the Company been a separate standalone company. Allocations for management costs and corporate support services provided to the Company totaled $165 million for year ended December 31, 2016. Management of the Company believes the assumptions regarding the allocated expenses reasonably reflect the utilization of services provided to or the benefit received by the Company during the period prior to the Separation. The Consolidated Financial Statements for the period prior to the Separation does not necessarily include all the expenses that would have been incurred or held by the Company had it been a separate, standalone company.

Use of Estimates

We prepared the Consolidated Financial Statements using financial information available at the time of preparation, which requires us to make estimates and assumptions that affect the amounts reported. Our most significant estimates pertain to the intangible and long-lived assets, valuation of goodwill, contingencies and litigation, income taxes and corporate allocations (for year ended December 31, 2016). Our estimates are based on management's best knowledge of current events, historical experience, and on various other assumptions that are believed to be reasonable under the circumstances. As a result, actual results may be different from these estimates.

New Accounting Standards

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Leases: In February 2016, the FASB updated the accounting guidance related to leases requiring lessees to recognize a right-of-use asset and a lease liability on the balance sheet for all leases with a lease term greater than 12 months. The accounting for lessors is largely unchanged. This updated guidance is effective for the Company beginning January 1, 2019. The Company adopted this updated accounting guidance beginning January 1, 2019 using the optional transition approach, which allows entities to initially apply the new leases standard at the adoption date and recognize a cumulative-effect adjustment to the opening balance of retained earnings in the period of adoption. Comparative periods will continue to be presented under existing lease guidance. This updated standard will have a significant impact on its Consolidated Balance Sheets by increasing its assets and liabilities. The Company does not expect the adoption to have a material impact on its Consolidated Statements of Income (Loss) and Consolidated Statements of Cash Flows.

Credit Losses: In June 2016, the FASB updated the accounting guidance related to measurement of credit losses on financial instruments, which requires financial assets measured at amortized cost to be presented at the net amount expected to be collected. This updated guidance is effective for fiscal years beginning after December 15, 2019, including interim periods within those fiscal years. Early adoption is permitted. We are currently evaluating the impact on the Company's Consolidated Financial Statements.

Recently Adopted Accounting Standards

Cloud Computing Arrangements: In August 2018, the Financial Accounting Standards Board (FASB) issued an accounting update which aligns the requirements for capitalizing implementation costs incurred in a hosting cloud computing arrangement that is a service contract with the existing capitalization requirements for implementation costs incurred to develop or obtain internal-use software (and hosting cloud computing arrangements that include an internal-use software license). The Company elected to early adopt this standard on July 1, 2018 on a prospective basis. The adoption of this guidance did not have a material impact on the Company’s Consolidated Financial Statements.

Reclassifying Certain Tax Effects From Accumulated Other Comprehensive Income: On December 22, 2017, the Tax Cuts and Jobs Act (Tax Reform) was enacted, lowering the U.S. corporate tax rate from 35% to 21%. The U.S. deferred tax assets and liabilities, including the balances originally recorded to Accumulated Other Comprehensive Income (AOCI), were adjusted to the new tax rate through net income from continuing operations in December 2017. In February 2018, the FASB issued guidance permitting companies, on an elective basis, to reclassify the disproportionate income tax effects of Tax Reform on items within AOCI to retained earnings. The only disproportionate income tax effects in the Company’s AOCI balance in December 2017 related to the U.S. pension plan. The plan was transferred to H.I.G. Capital as part of the U.S. human resource consulting and actuarial business divestiture completed in August 2018. In light of this, the Company adopted this accounting policy effective July 1, 2018 and has reclassified $5 million from AOCI to retained earnings as of September 30, 2018. Refer to the Consolidated Statements of Shareholders' Equity for additional information regarding this reclassification.

Cash Flows: In November 2016, the FASB issued updated accounting guidance regarding the presentation of restricted cash in the Consolidated Statements of Cash Flows. Specifically, this update requires that restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the Consolidated Statements of Cash Flows. The Company adopted this updated accounting guidance on January 1, 2018 using the retrospective method. The adoption of this guidance resulted in a reclassification of restricted cash of $9 million and $26 million for the years ended December 31, 2017 and 2016, respectively, in the Consolidated Statements of Cash Flows.

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Revenue Recognition: In May 2014, the FASB updated the accounting guidance related to revenue recognition, which is also referred to herein as "the new revenue standard" to clarify the principles for recognizing revenue and replaced all existing revenue recognition guidance in U.S. GAAP with one accounting model. The core principle of the guidance is that an entity should recognize revenue when the promised goods or services are transferred to customers in an amount that reflects the consideration that is expected to be received for those goods or services. The updated guidance also requires additional qualitative and quantitative disclosures relating to the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers largely on a disaggregated basis. The Company adopted the new revenue standard as of January 1, 2018, using the modified retrospective method. The Company has applied the new revenue standard only to contracts not completed as of the date of initial application. The adoption has primarily impacted the following: (1) revenue associated with postage recognized on a net basis versus previously being recognized on a gross basis; (2) the timing of revenue recognition associated with fixed fees for certain contracts with more than one performance obligation; and (3) the timing of recognition of certain pricing discounts and credits.

The Company recorded a net increase to opening retained earnings of $17 million, a decrease to current and long-term unearned income of $9 million and $6 million, respectively, and increase to contract assets of $7 million and an increase to deferred taxes of $5 million as of January 1, 2018, due to the cumulative impact of adopting this new guidance. The comparative information has not been restated and continues to be reported under the accounting standards in effect for the periods presented.

The impact of the new revenue standard for the year ended December 31, 2018, was a decrease in Revenue of approximately $150 million, primarily as a result of recognizing postage receipts on a net basis, in the Company's Consolidated Statements of Income (Loss). The impact of the new revenue standard, as of and for the period ended December 31, 2018, on the Company's pre-tax income (loss), Consolidated Balance Sheets and Statements of Cash Flows was not material.

Summary of Accounting Policies

Revenue recognition

The Company recognizes revenue when control of the promised goods or services is transferred to its customers, in an amount that reflects the consideration that the Company expects to receive in exchange for those goods or services.

The Company's contracts with customers often include promises to transfer multiple products and services to a customer. Determining whether products and services are considered distinct performance obligations that should be accounted for separately, versus together, may require judgment. Typically, the Company's contracts include performance obligation(s) to stand-ready on a daily or monthly basis to provide services to the customers. Under a stand-ready obligation, the evaluation of the nature of our performance obligation is focused on each time increment rather than the underlying activities. Accordingly, the promise to stand-ready is accounted for as a single-series performance obligation.

Once the Company determines the performance obligations, the Company estimates the amount of variable consideration, if any, to be included in determining the transaction price. Typical forms of variable consideration include variable pricing based on the number of transactions processed or usage-based pricing arrangements. Variable consideration is also present in the form of volume discounts, tiered and declining pricing, penalties for service level agreements, performance bonuses and credits. In circumstances where we meet certain requirements to allocate variable consideration to a distinct service within a series of related services, we allocate variable consideration to each distinct period of service within the series. If we do not meet those requirements, we include an estimate of variable consideration in the transaction price to the extent it is probable that a significant reversal of cumulative revenue recognized will not occur when the uncertainty is resolved. For contracts with multiple performance obligations, the transaction price is allocated to the separate performance obligations on a relative standalone selling price basis. The Company generally determines standalone selling prices based on the prices charged to customers or by using expected cost plus margin.

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The Company typically satisfies its performance obligations over time as the services are provided. A time-elapsed output method is used to measure progress because the nature of the Company's promise is a stand-ready service and efforts are expended evenly throughout the period. In limited circumstances, such as contracts for implementation or development projects, the Company also uses a cost-to-cost based input method. The Company has determined that the above methods provide a faithful depiction of the transfer of services to the customer.

Estimates of revenue expected to be recognized in future periods exclude unexercised customer options to purchase additional services that do not represent material rights to the customer. Customer options that do not represent a material right are only accounted for when the customer exercises its option to purchase additional goods or services. The Company recognizes revenue for non-refundable upfront implementation fees on a straight-line basis over the period between the initiation of the services through the end of the contract term.

When more than one party is involved in providing services to a customer, the Company evaluates whether it is the principal, and reports revenue on a gross basis, or an agent, and reports revenue on a net basis. In this assessment, the Company considers the following: if it obtains control of the specified services before they are transferred to the customer; is primarily responsible for fulfillment and inventory risk; and has discretion in establishing price.

The Company reports revenue net of any revenue-based taxes assessed by governmental authorities that are imposed on and concurrent with specific revenue-producing transactions. The primary revenue-based taxes are sales tax and value-added tax (VAT).

The Company's payment terms vary by type of services offered. The time between invoicing and when payment is due is not significant. For certain services and customer types, the Company requires payment before services are rendered.

From time to time, the Company's contracts are modified to account for additions or changes to existing performance obligations. The Company's contract modifications related to stand-ready performance obligations are generally accounted for prospectively.

Disaggregation of Revenue

During the second quarter of 2018, the Company changed how it presents the disaggregated revenue by major service line to reflect the core businesses separate from the non-core businesses. This change had no impact on disaggregated revenue by reportable segment or the timing of revenue recognition.

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The following table provides information about disaggregated revenue by major service line, the timing of revenue recognition and a reconciliation of the disaggregated revenue by reportable segments. Refer to Note 2 – Segment Reporting for additional information on the Company's reportable segments.

(in millions)	Year Ended December 31, 2018
Commercial Industries:	
Omni-channel communications	$ 852
Human resource services	754
Industry services	941
Total Commercial Industries	2,547
Government Services	1,351
Transportation	729
Other:	
Divestitures	752
Education	14
Total Other	766
Total Consolidated Revenue	$ 5,393
Timing of Revenue Recognition:	
Point in time	$ 142
Over time	5,251
Total Revenue	$ 5,393

The Company's contracts with customers are broadly similar in nature throughout the Company's major service lines. The following is a description of the major service lines:

- **Omni-Channel Communications:** The Company offers a range of services that help its clients support their end-users. This includes in-bound and out-bound call support for both simple and complex transactions, technical support and patient assistance. The Company also provides multi-channel communication support (both print and digital) across a range of industries.

- **Human Resource Services:** The Company helps its clients support their employees at all stages of employment from initial on-boarding through retirement as well as health savings account (HSA) administration. The Company offers clients a range of customized advisory, technology and administrative services that improve the ability of employees to manage their benefits, professional development and retirement planning. Also, the Company assists its clients with workers' compensation claims management.

- **Industry Services:** The Company leverages technology to assist its clients with transaction processing as well as providing platform solutions. This includes offerings such as finance and accounting, transaction processing, learning, legal and payment integrity services, among others.

- **Government Services:** The Company's services include public assistance program administration such as child support, pension administration, records management, electronic benefits, eligibility and payment cards, unclaimed property, disease management and software offerings in support of federal, state and local government agencies. The Company also provides payment services, which include prepaid cards, child support disbursements and other government support programs, disbursement of electronic payments directly to end-users, collections and transfer of payments.

- **Transportation:** The Company provides systems and support services to transportation departments and agencies globally. Offerings include support for electronic toll collection, public transit, parking and photo enforcement.

- **Divestitures:** This represents divestitures that were previously reported as Commercial Industries Non-core and Public Sector Non-core.

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Contract Balances

The Company receives payments from customers based upon contractual billing schedules. Accounts receivable are recorded when the right to consideration becomes unconditional. Contract assets are the Company's rights to consideration for services provided when the right is conditioned on something other than passage of time (for example, meeting a milestone for the right to bill under the cost-to-cost measure of progress). Contract assets are transferred to Accounts receivable when the rights become unconditional. Unearned income includes payments received in advance of performance under the contract, which are realized when the associated revenue is recognized under the contract.

The following table provides information about the balances of the Company's contract assets, unearned income and receivables from contracts with customers:

(in millions)	December 31, 2018	January 1, 2018
Contract Assets (Unearned Income)		
Current contract assets[1]	$ 177	$ 191
Long-term contract assets[2]	7	2
Current unearned income	(112)	(128)
Long-term unearned income[3]	(32)	(46)
Net Contract Assets (Unearned Income)	$ 40	$ 19
Accounts receivable, net	$ 782	$ 908

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(1) Prior to the adoption of the new revenue standard, these amounts were recorded in Accounts receivable, net and represented unbilled amounts.

(2) Presented in Other long-term assets in the Consolidated Balance Sheets

(3) Presented in Other long-term liabilities in the Consolidated Balance Sheets

Revenue of $134 million was recognized during the year ended December 31, 2018 related to the Company's unearned income at January 1, 2018. The Company had no asset impairment charges related to contract assets for the year ended December 31, 2018.

Transaction Price Allocated to the Remaining Performance Obligations

Estimated revenue expected to be recognized in the future related to performance obligations that are unsatisfied or partially satisfied at December 31, 2018, was approximately $2 billion. The Company expects to recognize approximately 67% of the revenues over the next two years and the remainder thereafter.

Costs to Obtain and Fulfill a Contract

The Company capitalizes commission expenses paid to internal sales personnel that are incremental to obtaining customer contracts. The net book value of these costs, which was $24 million as of December 31, 2018, are included in Other long-term assets. The judgments made in determining the amount of costs incurred include whether the commissions are incremental and directly related to a successful acquisition of a customer contract. These costs are amortized in Depreciation and amortization over the term of the contract or the estimated life of the customer relationship, if renewals are expected and the renewal commission is not commensurate with the initial commission. These costs are periodically reviewed for impairment. The Company expenses sales commissions when incurred if the amortization period of the sales commission is one year or less.

In addition, the Company may provide inducement payments to secure customer contracts. These inducement payments are capitalized and amortized to expense over the term of the customer contract. The net book value of these costs totaled $23 million as of December 31, 2018 and are included in Other long-term assets.

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Also, the Company capitalizes costs incurred to fulfill its contracts that (i) relate directly to the contract, (ii) are expected to generate resources that will be used to satisfy the Company's performance obligation under the contract and (iii) are expected to be recovered through revenue generated under the contract. The net book value of these costs, which comprise set-up/transition activities, was $53 million as of December 31, 2018, and are classified in Other long-term assets on the Consolidated Balance Sheets. Contract fulfillment costs are expensed to Cost of services as the Company satisfies its performance obligations by transferring the service to the customer. These costs are amortized on a systematic basis over the expected period of benefit.

The amortization of costs incurred to obtain and fulfill a contract for the year ended December 31, 2018, was approximately $50 million.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash on hand, including money market funds and investments with original maturities of three months or less.

Receivable Sales

In 2018, 2017 and 2016, the Company sold certain accounts receivable and derecognized the corresponding receivable balance. Refer to Note 4 – Accounts Receivable, Net for more details on our receivable sales.

Assets/Liabilities Held for Sale

We classify assets as held for sale in the period when the following conditions are met: (i) management, having the authority to approve the action, commits to a plan to sell the asset (disposal group); (ii) the asset (disposal group) is available for immediate sale in its present condition subject only to terms that are usual and customary for sales of such assets (disposal group); (iii) an active program to locate a buyer and other actions required to complete the plan to sell the asset (disposal group) have been initiated; (iv) the sale of the asset (disposal group) is probable, and transfer of the asset (disposal group) is expected to qualify for recognition as a completed sale within one year, except if events or circumstances beyond our control extend the period of time required to sell the asset (disposal group) beyond one year; (v) the asset (disposal group) is being actively marketed for sale at a price that is reasonable in relation to its current fair value; and (vi) actions required to complete the plan indicate that it is unlikely that significant changes to the plan will be made or that the plan will be withdrawn.

A long-lived asset (disposal group) that is classified as held for sale is initially measured at the lower of its carrying value or fair value less any costs to sell. Any loss resulting from this measurement is recognized in the period in which the held for sale criteria are met. Conversely, gains are not recognized on the sale of a long-lived asset (disposal group) until the date of sale.

The fair value of a long-lived asset (disposal group) less any costs to sell is assessed each reporting period it remains classified as held for sale and any subsequent changes are reported as an adjustment to the carrying value of the asset (disposal group), as long as the new carrying value does not exceed the carrying value of the asset at the time it was initially classified as held for sale.

In both 2018 and 2017, management approved the disposal through sale of certain assets and businesses. This action was taken as a result of our strategic evaluation of these businesses. As of December 31, 2018 and 2017, these businesses qualified as assets held for sale and we reclassified $15 million and $757 million to assets held for sale for 2018 and 2017, respectively, and $40 million and $169 million to liabilities held for sale for 2018 and 2017, respectively.

Refer to Note 3 – Assets/Liabilities Held for Sale and Divestitures for further discussion.

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Land, Buildings and Equipment

Land, buildings and equipment are recorded at cost. Buildings and equipment are depreciated over their estimated useful lives. Leasehold improvements are depreciated over the shorter of the lease term or the estimated useful life. Significant improvements are capitalized and maintenance and repairs are expensed when incurred.

Refer to Note 5 – Land, Buildings, Equipment and Software, Net for further discussion.

Software - Internal Use and Product

Internal Use: We capitalize direct costs associated with developing, purchasing or otherwise acquiring software for internal use and amortize these costs on a straight-line basis over the expected useful life of the software, beginning when the software is implemented. Costs for upgrades and enhancements that will not result in additional functionality are expensed as incurred. Amounts incurred for Internal Use Software are included in Cash Flows from Investing.

Refer to Note 5 – Land, Buildings, Equipment and Software, Net for further information.

Goodwill

For acquired businesses, the Company records the acquired assets and assumed liabilities based on their relative fair values at the date of acquisitions (commonly referred to as the purchase price allocation). Goodwill represents the excess of the purchase price paid in excess of the fair value of net tangible and intangible assets acquired. For the Company's business acquisitions, the purchase price is allocated to identifiable intangible assets separate from goodwill if they are from contractual or other legal rights, or if they could be separated from the acquired business and sold, transferred, licensed, rented or exchanged.

We test goodwill for impairment annually or more frequently if an event or change in circumstances indicate the asset may be impaired. Impairment testing for goodwill is done at the reporting unit level. We determined the fair value of our reporting units utilizing a combination of both an Income Approach and a Market Approach. The Income Approach utilizes a discounted cash flow analysis based upon the forecasted future business results of our reporting units. The Market Approach utilizes the guideline public company method. If the fair value of a reporting unit is less than its carrying amount, an impairment charge would be recognized for amount by which the carrying amount exceeds the reporting unit's fair value, not to exceed the total amount of goodwill allocated to the reporting unit.

Refer to Note 6 – Goodwill and Intangible Assets, Net for further information.

Other Intangible Assets

Other intangible assets primarily consist of assets acquired through business combinations, including installed customer base and distribution network relationships, patents and trademarks. Other intangible assets are amortized on a straight-line basis over their estimated economic lives unless impairment is identified.

Refer to Note 6 – Goodwill and Intangible Assets, Net for further information.

Impairment of Long-Lived Assets

We review the recoverability of our long-lived assets, including buildings, equipment, internal use software, product software and other intangible assets, when events or changes in circumstances occur that indicate that the carrying value of the asset may not be recoverable. The assessment of possible impairment is based on our ability to recover the carrying value of the asset from the expected future pre-tax cash flows (undiscounted and without interest charges) of the related operations. If these cash flows are less than the carrying value of such asset, an impairment loss is recognized for the difference between estimated fair value and carrying value. Our primary measure of fair value is based on forecasted cash flows.

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Income Taxes

We account for income taxes under the asset and liability method. Deferred tax assets and liabilities are based on differences between U.S. GAAP reporting and tax bases of assets or liabilities and based on current tax laws, regulations and rates.

The recognition of deferred tax assets requires an assessment to determine the realization of such assets. Management establishes valuation allowances on deferred tax assets when it is determined “more-likely-than-not” that some portion or all of the deferred tax assets may not be realized. Management considers positive and negative evidence in evaluating the ability of the Company to realize its deferred tax assets, including its historical results and forecasts of future ability to realize its deferred tax assets, including projected future taxable income, the expected timing of the reversals of existing temporary differences and tax planning strategies.

We are subject to ongoing tax examinations and assessments in various jurisdictions. We have unrecognized tax benefits for uncertain tax positions. We follow U.S. GAAP which prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. Our ongoing assessments of the more-likely-than-not outcomes of the examinations and related tax positions require judgment and can materially increase or decrease our effective tax rate, as well as impact our operating results.

On December 22, 2017, the US enacted the Tax Cuts and Jobs Act (Tax Reform). The Tax Reform includes a tax on global intangible low-taxed income (“GILTI”), which imposes a U.S. tax on certain income earned by the Company’s foreign subsidiaries. In January 2018, the FASB released guidance on the accounting for tax on GILTI. The guidance indicates that either accounting for deferred taxes on GILTI or treating GILTI as a period cost are both acceptable accounting elections. The Company elected to treat the tax on GILTI as a period cost when incurred and therefore, no deferred taxes for GILTI have been recognized for the year ended December 31, 2018.

Refer to Note 13 – Income Taxes for further discussion.

Foreign Currency Translation and Re-measurement

The functional currency for most foreign operations is the local currency. Net assets are translated at current rates of exchange and income, expense and cash flow items are translated at average exchange rates for the applicable period. The translation adjustments are recorded in Accumulated other comprehensive loss.

The U.S. Dollar is used as the functional currency for certain foreign subsidiaries that conduct their business in U.S. Dollars. A combination of current and historical exchange rates is used in re-measuring the local currency transactions of these subsidiaries and the resulting exchange adjustments are recorded in Currency (gains) and losses within other expenses, net together with other foreign currency re-measurements.

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Note 2 – Segment Reporting

Our reportable segments correspond to how we organize and manage the business, as defined by our CEO who is also our Chief Operating Decision Maker, and are aligned to the industries in which our clients operate. Our segments involve the delivery of business process services and include service arrangements where we manage a customer's business activity or process.

During 2018, in an effort to better reflect how we manage our business, we segregated our Public Sector segment into Government Services (including Health Enterprise, which was previously reported in Other segment) and Transportation segments. In addition, the Company also reclassified the operating results of our divestitures from the reportable segments to Other segment and separately reflected Shared IT/Infrastructure & Corporate Costs. All prior periods presented have been revised to reflect these changes.

We report our financial performance based on the three reportable segments: Commercial Industries, Government Services and Transportation.

- **Commercial Industries:** Our Commercial Industries segment provides business process services and customized solutions to clients in a variety of industries. Across the Commercial Industries segment, we deliver end-to-end business-to-business and business-to-customer services that enable our clients to optimize their key processes. Our multi-industry competencies include omni-channel communications, human resource management and finance and accounting services.

- **Government Services:** Our Government Services segment provides government-centric business process services to U.S. federal, state and local and foreign governments for, public assistance, program administration, transaction processing and payment services.

- **Transportation:** Our Transportation segment provides systems and support services to transportation departments and agencies globally. Offerings include support for electronic toll collection, public transit, parking and photo enforcement.

Other includes our divestitures and our Student Loan business, which the Company exited in the third quarter of 2018.

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Selected financial information for our reportable segments was as follows:

(in millions)	Year Ended December 31,						
	Commercial Industries	Government Services	Transportation	Other		Shared IT / Infrastructure & Corporate Costs	Total
2018				Divestitures	Other		
Revenue	$ 2,547	$ 1,351	$ 729	$ 752	$ 14	$ —	$ 5,393
Segment profit (loss)	$ 500	$ 424	$ 113	$ 98	$ (18)	$ (695)	$ 422
Segment depreciation and amortization	$ 97	$ 30	$ 36	$ 7	$ 3	$ 48	$ 221
Adjusted EBITDA	$ 597	$ 451	$ 149	$ 105	$ (15)	$ (647)	$ 640
2017							
Revenue	$ 2,685	$ 1,433	$ 767	$ 1,062	$ 75	$ —	$ 6,022
Segment profit (loss)	$ 563	$ 398	$ 114	$ 128	$ 16	$ (802)	$ 417
Segment depreciation and amortization	$ 98	$ 41	$ 43	$ 13	$ 2	$ 57	$ 254
Adjusted EBITDA	$ 661	$ 440	$ 157	$ 141	$ 18	$ (745)	$ 672
2016							
Revenue	$ 2,827	$ 1,575	$ 766	$ 1,109	$ 131	$ —	$ 6,408
Segment profit (loss)	$ 520	$ 421	$ 88	$ 166	$ (149)	$ (850)	$ 196
Segment depreciation and amortization	$ 103	$ 43	$ 41	$ 24	$ 52	$ 70	$ 333
Adjusted EBITDA	$ 623	$ 464	$ 129	$ 190	$ 9	$ (780)	$ 635

The following is a reconciliation of segment profit (loss) profit to pre-tax (loss) income:

(in millions)	Year Ended December 31,		
Segment Profit (Loss) Reconciliation to Pre-tax Income (Loss)	2018	2017	2016
Income (Loss) Before Income Taxes	$ (395)	$ (16)	$ (1,227)
Reconciling items:			
Restructuring and related costs	81	101	101
Amortization of acquired intangible assets	242	243	280
Goodwill impairment	—	—	935
Interest expense	112	137	40
Separation costs	—	12	44
(Gain) loss on divestitures and transaction costs	42	(42)	2
Litigation costs (recoveries), net	227	(11)	40
(Gain) loss on extinguishment of debt	108	—	—
Other (income) expenses, net	5	(7)	(22)
Business transformation costs	—	—	3
Segment Pre-Tax Income (Loss)	$ 422	$ 417	$ 196
Segment depreciation and amortization	221	254	333
NY MMIS depreciation	—	—	(52)
Business transformation costs	—	—	(3)
NY MMIS charge (credit)	(2)	9	161
HE charge (credit)	(1)	(8)	—
Adjusted EBITDA	$ 640	$ 672	$ 635

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Geographic area data is based upon the location of the subsidiary reporting the revenue or long-lived assets and is as follows for each of the years ended December 31:

	Revenues			Long-Lived Assets [1]	
(in millions)	2018	2017	2016	2018	2017
United States	$ 4,748	$ 5,303	$ 5,686	$ 375	$ 289
Europe	497	538	547	28	42
Other areas	148	181	175	62	54
Total Revenues and Long-Lived Assets	$ 5,393	$ 6,022	$ 6,408	$ 465	$ 385

(1) Long-lived assets are comprised of (i) Land, buildings and equipment, net, (ii) Internal use software, net and (iii) Product software, net.

In 2016, our methodology to disclose revenue on a geographic basis changed to reflect where the work is contracted.

Note 3 – Assets/Liabilities Held for Sale and Divestitures

In September 2018, the Company entered into an agreement (subject to regulatory approval) to sell a portfolio of select standalone customer care contracts to Skyview Capital LLC. The assets and liabilities related to this portfolio, collectively referred to as the Disposal Group, have been reclassified to held for sale and measured at the lower of carrying value or fair value less cost to sell. The fair value less estimated cost to sell, as measured by the terms of the sale's agreement, was less than the carrying amount by $66 million. Accordingly, the Company recorded a $66 million impairment charge, which included a write-off of goodwill of $11 million and long-lived assets of $11 million. This impairment charge was included in the (Gain) loss on divestitures and transaction costs line in the Consolidated Statements of Income (Loss). This Disposal Group is reported in Other segment. The revenues generated from this business were $439 million and $483 million for the years ended December 31, 2018 and 2017, respectively.

Following is a summary of the major categories of assets and liabilities that have been reclassified to held for sale.

(in millions)	December 31, 2018
Accounts Receivable, net	$ 15
Total Assets held for sale	$ 15
Accounts payable	$ 1
Accrued compensation	16
Unearned revenue	8
Other	15
Total Liabilities held for sale	$ 40

In September 2018, the Company completed the sale of its local and municipal constituent government software solutions business to Avenu Insights & Analytics. The proceeds from this divestiture were $106 million in cash and the transaction generated a pre-tax gain of $0 million. The revenues generated from this business were $81 million and $113 million for the nine months ended September 30, 2018 and for the year ended December 31, 2017, respectively.

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In August 2018, the Company completed the sale of its U.S. human resource consulting and actuarial business and the human resource consulting and outsourcing business located in Canada and the United Kingdom (U.K.) to H.I.G. Capital. The proceeds from this divestiture include $168 million in cash paid at closing, $20 million to be collected in installments over four years and a contingent consideration of $6 million. The transaction generated a pre-tax loss of $7 million. The revenues generated from this business were $172 million, which includes $6 million of intercompany revenue and $279 million for the nine months ended September 30, 2018 and for the year ended December 31, 2017, respectively.

In July 2018, the Company completed the sale of its off-street parking business, including the Multipark System in France and the U.K., along with its U.S. Airport Parking business to Andera Partners. The proceeds from this divestiture were $26 million in cash and the transaction generated a pre-tax gain of $8 million. The revenues generated from this business were $18 million and $42 million for the nine months ended September 30, 2018 and for the year ended December 31, 2017, respectively.

In June 2018, the Company completed the sale of its Commercial Vehicle Operations (CVO) business to Alinda Capital Partners. During the third quarter of 2018, the Company recorded a final working capital adjustment for the sale of the CVO business in the amount of $3 million, increasing the total cash proceeds received and pre-tax gain recorded to $403 million and $77 million, respectively. The revenue generated from this business was $33 million and $66 million for the six months ended June 30, 2018 and for the year ended December 31, 2017, respectively.

Note 4 – Accounts Receivable, Net

The Accounts receivable, net balance of $782 million and $1,114 million at December 31, 2018 and 2017, respectively, included allowance for doubtful accounts of $1 million and $2 million at December 31, 2018 and 2017, respectively.

The Company enters into supply chain financing programs from time to time to sell certain accounts receivable without recourse to third-party financial institutions. Sales of accounts receivable are reflected as a reduction of accounts receivable on the Consolidated Balance Sheets and the proceeds are included in cash flow from operating activities in the Consolidated Statements of Cash Flows.

Accounts receivable sales were as follows:

	Year Ended December 31,		
(in millions)	2018	2017	2016
Accounts receivable sales	$ 119	$ 94	$ 259

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Note 5 - Land, Buildings, Equipment and Software, Net

Land, buildings and equipment, net were as follows:

(in millions except as noted)	Estimated Useful Lives (Years)	December 31, 2018	December 31, 2017
Land		$ 2	$ 3
Building and building equipment	25 to 50	7	17
Leasehold improvements	Varies	246	247
Office furniture and equipment	3 to 15	901	784
Other	4 to 20	2	1
Construction in progress		64	24
Subtotal		1,222	1,076
Accumulated depreciation		(894)	(819)
Land, Buildings and Equipment, Net		$ 328	$ 257

Depreciation expense and operating lease rent expense were as follows:

(in millions)	Year Ended December 31, 2018	2017	2016
Depreciation expense	$ 121	$ 125	$ 130
Operating lease rent expense	$ 208	$ 267	$ 299

We lease buildings and equipment, substantially all of which are accounted for as operating leases. Certain leases were accounted for as capital leases and the remaining net book value of those assets, included in Land, Buildings and Equipment, net were approximately $24 million and $32 million at December 31, 2018 and 2017, respectively.

Future minimum operating lease commitments that have initial or remaining non-cancelable lease terms in excess of one year at December 31, 2018 were as follows (in millions):

2019	2020	2021	2022	2023	Thereafter
$ 153	$ 113	$ 78	$ 53	$ 33	$ 76

Internal Use and Product Software

Internal use and product software are included in Other long-term assets on the Company's Consolidated Balance Sheets. Additions to Internal Use and Product Software as well as year-end balances for these assets were as follows:

(in millions)	Year Ended December 31, 2018	2017	2016
Additions to:			
Internal use software	$ 47	$ 36	$ 39
Product software	8	10	10

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(in millions)	December 31,	
Capitalized Costs, Net	2018	2017
Internal use software[1]	$ 123	$ 106
Product software[1]	18	22

(1) See Note 8 – Supplementary Financial Information for additional information.

Useful lives of our internal use and product software generally vary from one to seven years.

During 2016 we determined that it was probable that we would not fully complete our NY MMIS project in its current form. As a result of this decision an impairment charge of approximately $28 million was recorded in Cost of services. We also recorded an additional impairment charge in 2016 related to the 2015 HE charge of approximately $9 million in Restructuring and asset impairment.

Note 6 - Goodwill and Intangible Assets, Net

Goodwill

The following table presents the changes in the carrying amount of goodwill, by reportable segments:

(in millions)	Commercial Industries	Government Services	Transportation	Total
Balance at December 31, 2016	$ 1,504	$ 1,738	$ 647	$ 3,889
Foreign currency translation	19	—	28	47
Disposition	(19)	(14)	—	(33)
Assets held-for-sale	(105)	(414)	(18)	(537)
Balance at December 31, 2017	**$ 1,399**	**$ 1,310**	**$ 657**	**$ 3,366**
Foreign currency translation	(10)	—	(16)	(26)
Assets held-for-sale	(12)	—	—	(12)
Other[1]	14	66	—	80
Balance at December 31, 2018	**$ 1,391**	**$ 1,376**	**$ 641**	**$ 3,408**

(1) Represents 2018 true-up to the 2017 Assets held for sale.

Impairment Charge

There was no impairment identified for the years ended December 31, 2018 and 2017. In 2016, due to the declining trends and projections in the Commercial Industries reporting unit, we concluded that the fair value of our Commercial Industries reporting unit was less than its carrying value. Accordingly, we recorded a pre-tax goodwill impairment charge of $935 million during the fourth quarter of 2016, which is separately presented in the Consolidated Statements of Income (Loss). There was no impairment identified for the Public Sector in 2016.

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Intangible Assets, Net

Net intangible assets were $651 million at December 31, 2018 of which $417 million, $160 million and $74 million relate to our Commercial Industries, Government Services and Transportation segments, respectively. Intangible assets were comprised of the following:

		December 31, 2018			December 31, 2017		
(in millions except years)	Weighted Average Amortization	Gross Carrying Amount	Accumulated Amortization	Net Amount	Gross Carrying Amount	Accumulated Amortization	Net Amount
Customer relationships	11 years	$ 2,914	$ 2,264	$ 650	$ 2,907	$ 2,022	$ 885
Technology, patents and non-compete	4 years	6	5	1	11	5	6
Total Intangible Assets		$ 2,920	$ 2,269	$ 651	$ 2,918	$ 2,027	$ 891

Amortization expense related to intangible assets was $242 million, $243 million and $280 million for the years ended December 31, 2018, 2017 and 2016, respectively. Amortization expense is expected to approximate $241 million in 2019, $238 million in 2020, $134 million in 2021, $12 million in 2022 and $6 million in 2023.

Note 7 – Restructuring Programs and Related Costs

The Company engages in a series of restructuring programs related to downsizing its employee base, exiting certain activities, outsourcing certain internal functions and engaging in other actions designed to reduce its cost structure and improve productivity. The implementation of the Company's strategic transformation program and various productivity initiatives have reduced the Company's real estate footprint across all geographies and segments resulting in increased lease cancellation and other related costs. Also included in Restructuring and Related Costs are incremental, non-recurring costs related to the consolidation of our data centers. Management continues to evaluate the Company's business and in the future, there may be additional provisions for new plan initiatives and/or changes in previously recorded estimates as payments are made or actions are completed.

Costs associated with restructuring, including employee severance and lease termination costs, are generally recognized when it has been determined that a liability has been incurred, which is generally upon communication to the affected employees or exit from the leased facility. In those geographies where we have either a formal severance plan or a history of consistently providing severance benefits representing a substantive plan, we recognize employee severance costs when they are both probable and reasonably estimable.

A summary of our restructuring program activity during the two years ended December 31, 2018 is as follows:

(in millions)	Severance and Related Costs	Lease Cancellation and Other Costs	Total
Balance at December 31, 2016	$ 15	$ 6	$ 21
Restructuring provision	49	54	103
Adjustments to prior accruals	(8)	(3)	(11)
Total Net Current Period Charges	41	51	92
Payments against reserve and currency	(42)	(23)	(65)
Other	—	(4)	(4)
Balance at December 31, 2017	$ 14	$ 30	$ 44
Restructuring provision	39	39	78
Adjustments to prior accruals	(5)	5	—
Total Net Current Period Charges	34	44	78
Payments against reserve and currency	(35)	(40)	(75)
Other	—	2	2
Balance at Balance at December 31, 2018	$ 13	$ 36	$ 49

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We also recorded costs related to professional support services associated with the implementation of the strategic transformation program of $3 million, $9 million and $28 million during the years ended December 31, 2018, 2017 and 2016, respectively.

The following table summarizes the total amount of costs incurred in connection with these restructuring programs by reportable and non-reportable segments:

	Year Ended December 31,		
(in millions)	2018	2017	2016
Commercial Industries	$ 26	$ 15	$ 27
Government Services	1	2	3
Transportation	3	1	2
Other	6	4	17
Corporate	42	70	24
Total Net Restructuring Charges	$ 78	$ 92	$ 73

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Note 8 – Supplementary Financial Information

The components of Other assets and liabilities were as follows:

(in millions)	December 31, 2018	December 31, 2017
Other Current Assets		
Prepaid expenses	$ 87	$ 73
Income taxes receivable	40	13
Value-added tax (VAT) receivable	22	18
Restricted cash	9	9
Other	76	68
Total Other Current Assets	$ 234	$ 181
Other Current Liabilities		
Accrued liabilities	$ 307	$ 320
Legal settlements	147	62
Software accruals	23	17
Restructure reserves	36	32
Income tax payable	3	6
Other taxes payable	15	7
Other	36	49
Total Other Current Liabilities	$ 567	$ 493
Other Long-term Assets		
Internal use software, net	$ 123	$ 106
Deferred contract costs, net[1]	100	126
Product software, net	18	22
Other	88	70
Total Other Long-term Assets	$ 329	$ 324
Other Long-term Liabilities		
Legal settlements	$ 144	$ —
Income tax liabilities	29	20
Unearned income	32	54
Restructuring reserves	13	12
Other	62	60
Total Other Long-term Liabilities	$ 280	$ 146

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(1) The balances at December 31, 2018 and 2017 are expected to be amortized over a weighted average remaining life of approximately 10 and 9 years, respectively.

Amortization expense for the next five years and thereafter for deferred contract costs is expected as follows:

2019	2020	2021	2022	2023	Thereafter
$ 41	$ 13	$ 8	$ 6	$ 2	$ 30

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Note 9 – Debt

We classify our debt based on the contractual maturity dates of the underlying debt instruments or as of the earliest put date available to the debt holders. We defer costs associated with debt issuance over the applicable term. These costs are amortized as interest expense in our Consolidated Statements of Income (Loss).

Long-term debt was as follows:

(in millions)	Weighted Average Interest Rates at December 31, 2018[1]	December 31, 2018	December 31, 2017
Term loan A due 2022	3.42%	$ 705	$ 732
Term loan B due 2023	5.44%	833	842
Senior notes due 2024	7.71%	34	510
Capital lease obligations	2.08%	26	33
Principal Debt Balance		$ 1,598	$ 2,117
Debt issuance costs and unamortized discounts		(31)	(56)
Less: current maturities		(55)	(82)
Total Long-term Debt		$ 1,512	$ 1,979

(1) Represents weighted average effective interest rate which includes the effect of discounts and premiums on issued debt.

Scheduled principal payments due on our long-term debt for the next five years and thereafter are as follows:

2019	2020	2021	2022	2023	Thereafter	Total
$ 55	$ 50	$ 84	$ 576	$ 800	$ 33	$ 1,598

Credit Facility

On December 7, 2016, we entered into a senior secured credit agreement (Credit Agreement) among the Company, its subsidiaries: Conduent Business Services, LLC (CBS), Affiliated Computer Services International B.V. and Conduent Finance, Inc. (CFI), the lenders party and JP Morgan Chase Bank, N.A., as the administrative agent. The Credit Agreement contains senior secured credit facilities (Senior Credit Facilities) consisting of:

(i) Senior Secured Term Loan A (Term Loan A) with an aggregate principal amount of $700 million;
(ii) Senior Secured Term Loan B (Term Loan B) with an aggregate principal amount of $850 million;
(iii) Senior Revolving Credit Facility (Revolving Credit Facility) with an aggregate available amount of $750 million including a sub-limit for up to $300 million million available for the issuance of letters of credit.

As of December 31, 2018, we have utilized $12 million of our revolving credit facility capacity to issue letters of credit.

The Credit Agreement permits us to incur incremental term loan borrowings and /or increase commitments under the revolving credit facility, subject to certain limitations and satisfaction of certain conditions, in an aggregate amount not to exceed (i) $300 million plus, (ii) if the senior secured net leverage ratio of Conduent Business Services (CBS) and its subsidiaries does not exceed 2.25 to 1.00 on a pro forma basis (without giving effect to any incurrence under clause (i) that is incurred substantially simultaneously with amounts incurred under clause (ii)), an unlimited amount.

All obligations under the Credit Agreement are unconditionally guaranteed by the Company, CBS, Conduent Finance, Inc. (CFI) and the existing and future direct and indirect wholly owned domestic subsidiaries of CBS (subject to certain exceptions). All obligations under the Credit Agreement, and the guarantees of those obligations, are secured, subject to certain exceptions, by substantially all of the assets of CBS and the guarantors under the Credit Agreement (other than the Company and CFI), including a first-priority pledge of all the capital stock of CBS and the subsidiaries of CBS directly held by CBS or the guarantors (other than the Company and CFI) under the

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Credit Agreement (which pledges, in the case of any foreign subsidiary, will be limited to 65% of the capital stock of any first-tier foreign subsidiary).

The Credit Agreement contains certain customary affirmative and negative covenants, restrictions and events of default. The Credit Agreement requires total net leverage ratio for December 31, 2018 and thereafter not to exceed 3.75 to 1.00.

Senior Notes

The Senior Notes are jointly and severally guaranteed on a senior unsecured basis by the Company and each of the existing and future domestic subsidiaries of CFI or CBS that guarantee the obligations under the Senior Credit Facilities.

Interest is payable semi-annually. At the option of the Issuers, the Senior Notes are redeemable in whole or in part, at any time prior to December 15, 2020, at a price equal to 100% of the aggregate principal amount of the Senior Notes plus accrued and unpaid interest, if any, to, but excluding, the redemption date plus a “make-whole” premium. The Issuers may also redeem the Senior Notes, in whole or in part, at any time on or after December 15, 2020, at the redemption prices specified in the Indenture, plus accrued and unpaid interest, if any, to but excluding the redemption date. Additionally, at any time prior to December 15, 2019, the Issuers may redeem up to 35% of the aggregate principal amount of the Senior Notes, subject to certain conditions, with the net cash proceeds from certain equity offerings at a price equal to 110.50% of the principal amount of the Senior Notes, plus accrued and unpaid interest, if any, to, but excluding, the redemption date.

Loans Repricing and Redemption

On June 28, 2018, the Company entered into Amendment No. 3 (Amendment) to the December 7, 2016 Credit Agreement, which (i) extended the revolving credit maturity from December 7, 2021 to December 7, 2022 and reduced the interest rate on the revolving credit by 0.5% from 2.25% over LIBOR to 1.75% over LIBOR; (ii) extended the maturity date of the Term A Loans from December 7, 2021 to December 7, 2022 and reduced the interest rate by 0.5% from 2.25% over LIBOR to 1.75% over LIBOR, and (iii) reduced the interest rate on the Term B Loans by 0.5% from 3.0% over LIBOR to 2.5% over LIBOR. These transactions resulted in a write-off of unamortized discount and issuance costs of $3 million.

In July 2018, the Company redeemed $476 million of its $510 million 10.50% Senior Notes due 2024. As part of the redemption, the Company paid a premium of $95 million and wrote off the associated unamortized discount and issuance costs of $13 million.

Interest

Interest paid on our short-term and long-term debt amounted to $100 million, $129 million, $5 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Interest expense and interest income was as follows:

	Year Ended December 31,		
(in millions)	2018	2017	2016
Interest expense	$ 112	$ 137	$ 40
Interest income	7	3	3

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Note 10 – Financial Instruments

We are exposed to market risk from changes in foreign currency exchange rates and interest rates, which could affect operating results, financial position and cash flows. We manage our exposure to these market risks through our regular operating and financing activities and, when appropriate, through the use of derivative financial instruments. These derivative financial instruments are utilized to hedge economic exposures, as well as to reduce earnings and cash flow volatility resulting from shifts in market rates. We enter into limited types of derivative contracts to manage foreign currency exposures that we hedge. Our primary foreign currency market exposures include the Philippine Peso, Indian Rupee and Mexican Peso. The fair market values of all our derivative contracts change with fluctuations in interest rates or currency exchange rates and are designed so that any changes in their values are offset by changes in the values of the underlying exposures. Derivative financial instruments are held solely as risk management tools and not for trading or speculative purposes. The related cash flow impacts of all of our derivative activities are reflected as cash flows from operating activities.

We do not believe there is significant risk of loss in the event of non-performance by the counterparty associated with our derivative instruments because these transactions are executed with a major financial institution. Further, our policy is to deal only with counterparties having a minimum investment grade or better credit rating. Credit risk is managed through the continuous monitoring of exposures to such counterparties.

Summary of Foreign Exchange Hedging Positions

At December 31, 2018 and 2017, we had outstanding forward exchange with gross notional values of $167 million and $160 million, respectively. At December 31, 2018, approximately 65% of these contracts mature within three months, 14% in three to six months, 17% in six to twelve months and 4% in greater than 12 months.

The following is a summary of the primary hedging positions and corresponding fair values:

	December 31, 2018		December 31, 2017	
(in millions)	Gross Notional Value	Fair Value Asset (Liability)[1]	Gross Notional Value	Fair Value Asset (Liability)[1]
Currencies Hedged (Buy/Sell)				
Philippine Peso/U.S. Dollar	$ 53	$ —	$ 62	$ —
Indian Rupee/U.S. Dollar	69	2	68	1
Mexican Peso/U.S. Dollar	8	—	9	—
All Other	37	—	21	—
Total Foreign Exchange Hedging	$ 167	$ 2	$ 160	$ 1

(1) Represents the net receivable (payable) amount included in the Consolidated Balance Sheet.

Note 11 – Fair Value of Financial Assets and Liabilities

Fair value represents the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. U.S. GAAP established a hierarchy framework to classify the fair value based on the observability of significant inputs to the measurement. The levels of the fair value hierarchy are as follows:

Level 1: Fair value is determined using an unadjusted quoted price in an active market for identical assets or liabilities.

Level 2: Fair value is estimated using inputs other than quoted prices included within Level 1 that are observable, either directly or indirectly.

Level 3: Fair value is estimated using unobservable inputs that are significant to the fair value of the assets or liabilities.

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Summary of Financial Assets and Liabilities Accounted for at Fair Value on a Recurring Basis

The following table represents assets and liabilities measured at fair value on a recurring basis. The basis for the measurement at fair value in all cases was Level 2.

(in millions)	December 31, 2018	December 31, 2017
Assets:		
Foreign exchange contract - forward	$ 3	$ 2
Total Assets	$ 3	$ 2
Liabilities:		
Foreign exchange contracts - forwards	$ 1	$ 1
Deferred compensation plan liabilities[1]	—	99
Total Liabilities	$ 1	$ 100

(1) In September 2017, the Company terminated the legacy deferred compensation plans (Plans) and the Company Owned Life Insurance (COLI), which held the Plans' investments. The Company made the payments to Plan participants in 2018.

Summary of Other Financial Assets and Liabilities

The estimated fair values of our other financial assets and liabilities were as follows:

	December 31, 2018		December 31, 2017	
(in millions)	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Assets:				
Assets held for sale	$ 15	$ 15	$ 757	$ 757
Liabilities:				
Long-term debt	$ 1,512	$ 1,463	$ 1,979	$ 2,070
Liabilities held for sale	$ 40	$ 40	$ 169	$ 169

The fair value amounts for Cash and cash equivalents, Restricted cash, Accounts receivable, net and Short-term debt approximate carrying amounts due to the short-term maturities of these instruments.

The fair value of the Assets held for sale and the Liabilities held for sale were measured based on the sale's price less estimated transactions costs (Level 3). Refer to Note 3 – Assets/Liabilities Held for Sale and Divestitures to the Consolidated Financial Statements for additional information.

The fair value of Long-term debt was estimated based on the current rates offered to the Company for debt of similar maturities (Level 2).

Note 12 – Employee Benefit Plans

Defined Benefit Plans

In 2018, all of the U.S. and the majority of the international plan assets and obligations were part of the divestiture of the U.S. human resource consulting and actuarial business and the human resource consulting and outsourcing business located in Canada and the U.K. The company's remaining benefit obligations and plan assets in 2018 were $12 million and $3 million, respectively.

As of December 31, 2017 the Company had a pension benefit obligation of $280 million ($102 million in the US and $178 million from non-US plans). The plans also had assets of approximately $222 million ($62 million in the US and $160 million from non-US plans), in which the assets were invested primarily in equity and fixed income securities (level 1 and level 2).

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Defined Contribution Plans

We have post-retirement savings and investment plans in several countries, including the U.S., U.K. and Canada. In many instances, employees from those defined benefit pension plans that have been amended to freeze future service accruals were transitioned to an enhanced defined contribution plan. In these plans employees are allowed to contribute a portion of their salaries and bonuses to the plans, and we match a portion of the employee contributions. We recorded charges related to our defined contribution plans of $28 million in 2018, $35 million in 2017 and $35 million in 2016.

Note 13 - Income Taxes

Prior to the Separation, Conduent's operating results were included in Xerox Corporation's various consolidated U.S. federal and state income tax returns, as well as non-U.S. tax filings. For the purposes of the Company's Consolidated Financial Statements for periods prior to the Separation, income tax expense and deferred tax balances have been recorded as if the Company filed tax returns on a standalone basis separate from Xerox. The Separate Return Method applies the accounting guidance for income taxes to the standalone financial statements as if the Company was a separate taxpayer and a standalone enterprise for fiscal 2016.

On December 22, 2017, the U.S. enacted the Tax Cuts and Jobs Act (Tax Reform). The Tax Reform significantly changes the U.S. corporate income tax laws by, among other things, reducing the corporate income tax rate to 21% starting in 2018 and creating a territorial tax system with a one-time mandatory tax on previous deferred foreign earnings of U.S. subsidiaries. With respect to this legislation, the Company recorded a provisional tax benefit of $198 million in the fourth quarter of 2017, which included a $210 million tax benefit due to the re-measurement of deferred tax assets and liabilities resulting from the decrease in the corporate U.S. federal income tax rate from 35% to 21% and $12 million as a one-time-charge on the transition tax for Post-1986 undistributed and not previously taxed foreign earnings and profits. The Company finalized its accounting for this legislation in the fourth quarter of 2018 and recognized a $2 million additional benefit year to date, included as a component of income tax expense from continuing operations. The true-up of the provisional benefit includes $5 million additional benefit due to re-measurement of deferred tax assets and liabilities resulting from the decrease in the U.S. corporate federal income tax rate, a $1 million reduction in the one-time charge on the transition tax and a $4 million charge due to change in recognition of deferred tax assets related to deductibility of certain expenses.

Income (loss) before income taxes (pre-tax income (loss)) was as follows:

	Year Ended December 31,		
(in millions)	2018	2017	2016
Domestic loss	$ (411)	$ (91)	$ (1,329)
Foreign income	16	75	102
Loss Before Income Taxes	$ (395)	$ (16)	$ (1,227)

Provision (benefit) for income taxes were as follows:

	Year Ended December 31,		
(in millions)	2018	2017	2016
Federal Income Taxes			
Current	$ 35	$ 4	$ (116)
Deferred	(62)	(233)	(132)
Foreign Income Taxes			
Current	41	25	31
Deferred	(6)	(3)	(3)
State Income Taxes			
Current	20	8	1
Deferred	(7)	6	(25)
Total Benefit	$ 21	$ (193)	$ (244)

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A reconciliation of the U.S. federal statutory income tax rate to the consolidated effective income tax rate was as follows:

	Year Ended December 31,		
	2018	2017	2016
U.S. federal statutory income tax rate	21.0 %	35.0 %	35.0 %
Nondeductible expenses[1]	(3.7)%	(104.0)%	(19.0)%
Effect of tax law changes	0.5 %	1,282.4 %	— %
Change in valuation allowance for deferred tax assets	(1.7)%	(39.5)%	0.1 %
State taxes, net of federal benefit	(2.3)%	1.2 %	1.8 %
Audit and other tax return adjustments	— %	— %	1.4 %
Tax-exempt income, credits and incentives	2.2 %	38.9 %	0.7 %
Foreign rate differential adjusted for U.S. taxation of foreign profits[2]	1.9 %	47.7 %	0.7 %
Divestitures[3]	(20.3)%	(51.9)%	— %
Unrecognized tax benefits and other	(2.9)%	(3.5)%	(0.8)%
Effective Income Tax Rate	(5.3)%	1,206.3 %	19.9 %

(1) In 2017, nondeductible expenses primarily related to officers life insurance.
(2) The "U.S. taxation of foreign profits" represents the U.S. tax, net of foreign tax credits, associated with actual and deemed repatriations of earnings from our non-U.S. subsidiaries.
(3) 2018 and 2017 divestitures include nondeductible goodwill allocated to divested businesses.

On a consolidated basis, we paid/(received) a total of $108 million, $29 million and $(123) million in income taxes to federal, foreign and state jurisdictions during the three years ended December 31, 2018, 2017 and 2016, respectively.

Total income tax expense (benefit) was allocated as follows:

	Year Ended December 31,		
(in millions)	2018	2017	2016
Pre-tax income	$ 21	$ (193)	$ (244)
Discontinued operations	—	3	—
Common shareholders' equity:			
Changes in defined benefit plans	—	—	8
Stock option and incentive plans, net	—	—	—
Total Income Tax Expense (Benefit)	$ 21	$ (190)	$ (236)

Unrecognized Tax Benefits and Audit Resolutions

We recognize tax liabilities when, despite our belief that our tax return positions are supportable, we believe that certain positions may not be fully sustained upon review by tax authorities. Each period we assess uncertain tax positions for recognition, measurement and effective settlement. Benefits from uncertain tax positions are measured at the largest amount of benefit that is greater than 50 percent likely of being realized upon settlement. Where we have determined that our tax return filing position does not satisfy the more-likely-than-not recognition threshold, we have recorded no tax benefits.

We are also subject to ongoing tax examinations in numerous jurisdictions due to the extensive geographical scope of our operations. Our ongoing assessments of the more-likely-than-not outcomes of the examinations and related tax positions require judgment and can increase or decrease our effective tax rate, as well as impact our operating results. The specific timing of when the resolution of each tax position will be reached is uncertain. As of December 31, 2018, we do not believe that there are any positions for which it is reasonably possible that the total amount of unrecognized tax benefits will significantly increase or decrease within the next 12 months.

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A reconciliation of the beginning and ending amount of unrecognized tax benefits was as follows:

(in millions)	2018	2017	2016
Balance at January 1	$ 15	$ 14	$ 24
Additions related to current year	3	—	1
Additions related to prior years positions	5	—	—
Reductions related to prior years positions	—	—	(5)
Settlements with taxing authorities[1]	(1)	—	(5)
Currency	(2)	1	(1)
Balance at December 31	$ 20	$ 15	$ 14

(1) 2018 and 2016 settlement resulted in $1 million and $5 million cash paid, respectively.

We maintain offsetting benefits from other jurisdictions of $15 million, $16 million and $16 million, at December 31, 2018, 2017 and 2016, respectively. We recognized interest and penalties accrued on unrecognized tax benefits, as well as interest received from favorable settlements within income tax expense. We had $10 million, $6 million and $4 million accrued for the payment of interest and penalties associated with unrecognized tax benefits at December 31, 2018, 2017 and 2016, respectively. In the U.S., we are no longer subject to U.S. federal income tax examinations for years before 2012. With respect to our major foreign jurisdictions, the years generally remain open back to 2006.

Deferred Income Taxes

The Company is indefinitely reinvested in the undistributed earnings of its foreign subsidiaries with respect to the U.S. These foreign subsidiaries have aggregate cumulative undistributed earnings of $164 million as of December 31, 2018. For years after 2017, the Tax Reform does allow for certain earnings to be repatriated free from U.S. Federal taxes. However, the repatriation of earnings could give rise to additional tax liabilities. We have also not provided for deferred taxes on outside basis differences in our investments in our foreign subsidiaries that are unrelated to unremitted earnings. These other basis differences will also be indefinitely reinvested. A determination of the unrecognized deferred taxes related to these other components of our outside basis differences is not practicable. We have provided for deferred taxes with respect to certain unremitted earnings of foreign subsidiaries that are not indefinitely reinvested between foreign subsidiaries outside of the U.S.

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The tax effects of temporary differences that give rise to significant portions of the deferred taxes were as follows:

(in millions)	December 31, 2018	December 31, 2017
Deferred Tax Assets		
Net operating losses	$ 46	$ 41
Operating reserves, accruals and deferrals	68	85
Deferred compensation	16	59
Pension	2	15
Settlement reserves	67	18
Other	11	27
Subtotal	210	245
Valuation allowance	(44)	(35)
Total	$ 166	$ 210
Deferred Tax Liabilities		
Unearned income	$ 86	$ 134
Intangibles and goodwill	341	413
Depreciation	30	5
Other	24	25
Total	$ 481	$ 577
Total Deferred Taxes, Net	$ (315)	$ (367)

The deferred tax assets for the respective periods were assessed for recoverability and, where applicable, a valuation allowance was recorded to reduce the total deferred tax asset to an amount that will, more-likely-than-not, be realized in the future. The net change in the total valuation allowance for the years ended December 31, 2018 and 2017 was an increase of $9 million and $11 million, respectively. The valuation allowance relates primarily to certain net operating loss carryforwards, tax credit carryforwards and deductible temporary differences for which we have concluded it is more-likely-than-not that these items will not be realized in the ordinary course of operations.

Although realization is not assured, we have concluded that it is more-likely-than-not that the deferred tax assets, for which a valuation allowance was determined to be unnecessary, will be realized in the ordinary course of operations based on the available positive and negative evidence, including scheduling of deferred tax liabilities and projected income from operating activities. The amount of the net deferred tax assets considered realizable, however, could be reduced in the near term if actual future income or income tax rates are lower than estimated, or if there are differences in the timing or amount of future reversals of existing taxable or deductible temporary differences.

At December 31, 2018, we had tax credit carryforwards of $9 million available to offset future income taxes which will expire between 2019 and 2038 if not utilized. We also had net operating loss carryforwards for income tax purposes of $417 million that will expire between 2019 and 2038, if not utilized; and $54 million available to offset future taxable income indefinitely.

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Note 14 – Contingencies and Litigation

As more fully discussed below, the Company is involved in a variety of claims, lawsuits, investigations and proceedings concerning: governmental entity contracting, servicing and procurement law; intellectual property law; employment law; commercial and contracts law; the Employee Retirement Income Security Act (ERISA); and other laws and regulations. The Company determines whether an estimated loss from a contingency should be accrued by assessing whether a loss is deemed probable and can be reasonably estimated. The Company assesses its potential liability by analyzing its litigation and regulatory matters using available information. The Company develops its view on estimated losses in consultation with outside counsel handling its defense in these matters, which involves an analysis of potential results, assuming a combination of litigation and settlement strategies. Should developments in any of these matters cause a change in the Company's determination as to an unfavorable outcome and result in the need to recognize a material accrual, or should any of these matters result in a final adverse judgment or be settled for significant amounts in excess of any accrual for such matter or matters, this could have a material adverse effect on the Company's results of operations, cash flows and financial position in the period or periods in which such change in determination, judgment or settlement occurs. The Company believes it has recorded adequate provisions for any such matters as of December 31, 2018. Litigation is inherently unpredictable, and it is not possible to predict the ultimate outcome of these matters and such outcome in any such matters could be in excess of any amounts accrued and could be material to the Company's results of operations, cash flows or financial position in any reporting period.

Additionally, guarantees, indemnifications and claims arise during the ordinary course of business from relationships with suppliers, customers and non-consolidated affiliates when the Company undertakes an obligation to guarantee the performance of others if specified triggering events occur. Nonperformance under a contract could trigger an obligation of the Company. These potential claims include actions based upon alleged exposures to products, real estate, intellectual property such as patents, environmental matters and other indemnifications. The ultimate effect on future financial results is not subject to reasonable estimation because considerable uncertainty exists as to the final outcome of these claims. However, while the ultimate liabilities resulting from such claims may be significant to results of operations in the period recognized, management does not anticipate they will have a material adverse effect on the consolidated financial position or liquidity. As of December 31, 2018, the Company had accrued its estimate of liability incurred under its indemnification arrangements and guarantees.

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Litigation Against the Company

State of Texas v. Xerox Corporation, Conduent Business Services, LLC (f/k/a Xerox Business Services, LLC), Conduent State Healthcare, LLC (f/k/a Xerox State Healthcare, LLC, f/k/a ACS State Healthcare, LLC) and Conduent Incorporated: On May 9, 2014, the State of Texas, via the Texas Office of Attorney General (the "State"), filed a lawsuit in the 53rd Judicial District Court of Travis County, Texas. The lawsuit alleges that Xerox Corporation, Xerox State Healthcare, LLC and ACS State Healthcare (collectively, the "Xerox Defendants") violated the Texas Medicaid Fraud Prevention Act in the administration of its contract with the Texas Department of Health and Human Services ("HHSC"). The State alleges that the Xerox Defendants made false representations of material facts regarding the processes, procedures, implementation and results regarding the prior authorization of orthodontic claims. The State seeks recovery of amounts paid for orthodontic treatment under the Texas Medicaid program for the period from approximately 2004 to 2012, three times the amount of the payments made as a result of the alleged unlawful acts, civil penalties, pre- and post-judgment interest and all costs and attorneys' fees. The Xerox Defendants filed their Answer in June, 2014 denying all allegations. A trial date was originally scheduled for November, 2018. During the first quarter of 2018, the State notified the Xerox Defendants in the litigation discovery process that its claim is in excess of two billion dollars based primarily on the assertion of treble damages and civil penalties per illegal act for almost two hundred thousand purported illegal acts. During the second quarter of 2018, the trial date was rescheduled for May, 2019. During October of 2018, discussions with the State were undertaken to determine if a mutually acceptable settlement might be reached. Those discussions were not productive. In the wake of those discussions, we recorded an additional $72 million reserve during the third quarter of 2018, increasing our aggregate reserve for this matter as of September 30, 2018, to $110 million. During December 2018, we re-engaged with the State in discussions to settle the matter. In February 2019, those discussions culminated in a settlement agreement and release among the Xerox Defendants, the State and HHSC. Pursuant to the terms of the Texas Agreement ("Texas Agreement"), the Company will pay the State of Texas $236 million in full settlement of the claims asserted against the Xerox Defendants. This amount is payable in installments of: (1) $20 million within 10 days of execution of the settlement agreement; (2) $20 million by April 15, 2019; (3) $38 million by July 31, 2019; (4) $79 million by July 31, 2020; and (5) $79 million by July 31, 2021. The Agreement does not prevent the Company from prepaying the foregoing amounts and the Company is currently considering whether to do so. The Company does not intend to make further disclosure regarding a possible prepayment unless it actually prepays such amounts in whole or in part. As part of the settlement, all proceedings in the lawsuit are suspended and the State and the HHSC will dismiss the lawsuit with prejudice and release the Xerox Defendants from all of the State's claims after all settlement payments are made. As a result of entering into the Texas Agreement, the Company recorded an additional reserve of $113 million in the quarter ended December 31, 2018 which is net of a $13 million discount to reflect the fair value of the liability. The Defendants' have not made any admission of liability or wrongdoing in entering into the Texas Agreement.

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Dennis Nasrawi v. Buck Consultants et al.: On October 8, 2009, plaintiffs filed a lawsuit in the Superior Court of California, Stanislaus County, and on November 24, 2009, the case was removed to the U.S. Court for the Eastern District of California, Fresno Division. Plaintiffs allege actuarial negligence against Buck Consultants, LLC ("Buck"), which was a wholly-owned subsidiary of Conduent, for the use of faulty actuarial assumptions in connection with the 2007 actuarial valuation for the Stanislaus County Employees Retirement Association ("StanCERA"). Plaintiffs allege that the employer contribution rate adopted by StanCERA based on Buck's valuation was insufficient to fund the benefits promised by the County. On July 13, 2012, the Court entered its ruling that the plaintiffs lacked standing to sue in a representative capacity on behalf of all plan participants. The Court also ruled that plaintiffs had adequately pleaded their claim that Buck allegedly aided and abetted StanCERA in breaching its fiduciary duty. Plaintiffs then filed their Fifth Amended Complaint and added StanCERA to the litigation. Buck and StanCERA filed demurrers to the amended complaint. On September 13, 2012, the Court sustained both demurrers with prejudice, completely dismissing the matter and barring plaintiffs from refiling their claims. Plaintiffs appealed, and ultimately the California Court of Appeals (Sixth District) reversed the trial court's ruling and remanded the case back to the trial court as to Buck only, and only with respect to Plaintiff's claim of aiding and abetting StanCERA in breaching its fiduciary duty. This case has been stayed pending the outcome of parallel litigation the plaintiffs are pursuing against StanCERA. The parallel litigation was tried before the bench in June 2018, and on January 24, 2019, the court found in favor of StanCERA, holding that it had not breached its fiduciary duty to plaintiffs. Plaintiffs in the parallel litigation have the right to file an appeal, which we expect. Nasrawi remains stayed until the parallel litigation is finally concluded. Absent the court finding that StanCERA breached its fiduciary duty, plaintiffs' claim against Buck for aiding and abetting said breach would not appear viable. Buck will continue to aggressively defend these lawsuits. In August 2018, Conduent sold Buck Consultants, LLC; however, the Company retained this liability after the sale. The Company is not able to determine or predict the ultimate outcome of this proceeding or reasonably provide an estimate or range of estimate of the possible outcome or loss, if any.

Conduent Business Services, LLC v. Cognizant Business Services, LLC: On April 12, 2017, Conduent Business Services LLC ("Conduent") filed a lawsuit against Cognizant Business Services Corporation ("Cognizant") in the Supreme Court of New York County, New York. The lawsuit relates to the Amended and Restated Master Outsourcing Services Agreement effective as of October 24, 2012, and the service delivery contracts and work orders thereunder, between Conduent and Cognizant, as amended and supplemented (the "Contract"). The Contract contains certain minimum purchase obligations by Conduent through the date of expiration. The lawsuit alleges that Cognizant committed multiple breaches of the Contract, including Cognizant's failure to properly perform its obligations as subcontractor to Conduent under Conduent's contract with the New York Department of Health to provide a Medicaid Management Information Systems (the "NY MMIS Contract"). In the lawsuit, Conduent seeks damages in excess of one hundred fifty million dollars. During the first quarter of 2018, Conduent provided notice to Cognizant that it was terminating the Contract for cause and recorded in the same period certain charges associated with the termination. Cognizant asserted two counterclaims for breach of contract seeking recovery of damages in excess of forty-seven million dollars, which includes amounts alleged not paid to Cognizant under the contract and an alleged twenty-five million dollars of termination fee. Conduent has responded to Cognizant's counterclaims by denying the allegations. Conduent will continue to vigorously defend itself against the counterclaims but the Company is not able to determine or predict the ultimate outcome of this proceeding or reasonably provide an estimate or range of estimate of the possible outcome.

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Other Matters:

On January 5, 2016, the Consumer Financial Protection Bureau (the "CFPB") notified Xerox Education Services, Inc. (XES) that, in accordance with the CFPB's discretionary Notice and Opportunity to Respond and Advise (NORA) process, the CFPB's Office of Enforcement is considering recommending that the CFPB take legal action against XES, alleging that XES violated the Consumer Financial Protection Act's prohibition of unfair practices. Should the CFPB commence an action, it may seek restitution, civil monetary penalties, injunctive relief, or other corrective action. The purpose of a NORA letter is to provide a party being investigated an opportunity to present its position to the CFPB before an enforcement action is recommended or commenced. XES submitted its response to the NORA. The CFPB's NORA stems from an inquiry that commenced in 2014 when XES received and responded to a CFPB Civil Investigative Demand containing a broad request for information. During this process, XES self-disclosed to the U.S. Department of Education (the "Department") and the CFPB certain adjustments of which it had become aware that had not been timely made relating to its servicing of a small percentage of third-party student loans under outsourcing arrangements for various financial institutions. The CFPB, the U.S. Department of Education, the U.S. Department of Justice, the New York Office of the Attorney General, the New York Department of Financial Services and the Massachusetts Office of the Attorney General began similar reviews. XES has cooperated and continues to fully cooperate with all regulatory agencies. It resolved the Massachusetts Office of the Attorney General investigation in November 2016 and the investigations by both the New York agencies in January 2019. Both as a result of these inquiries, its own reviews of operations and work performed by external auditors, XES has identified certain other operational issues requiring remediation, and this remediation work has commenced. XES disclosed these additional operational projects to the Department at the end of the second quarter of 2018 and is working to complete these projects. In the third quarter of 2018, the Company exited the Student Loan Services business. The Company cannot provide assurance that the CFPB, another regulator, a financial institution on behalf of which the Company serviced third-party student loans, or another party will not ultimately commence a legal action against XES in which fines, penalties or other liabilities are sought from XES. Nor is the Company able to predict the likely outcome of these matters, should any such matter be commenced, or reasonably provide an estimate or range of estimates of any loss in excess of current reserves. The Company could in future periods incur judgments or enter into settlements to resolve these potential matters for amounts in excess of current reserves and there could be a material adverse effect on the Company's results of operations, cash flows and financial position in the period in which such change in judgment or settlement occurs.

Guarantees and Indemnifications

Indemnifications Provided as Part of Contracts and Agreements

Acquisitions/Divestitures:

We have indemnified, subject to certain deductibles and limits, the purchasers of businesses or divested assets for the occurrence of specified events under certain of our divestiture agreements. In addition, we customarily agree to hold the other party harmless against losses arising from a breach of representations and covenants, including such matters as adequate title to assets sold, intellectual property rights and certain income taxes arising prior to the date of acquisition. Where appropriate, an obligation for such indemnifications is recorded as a liability at the time of the acquisition or divestiture. Since the obligated amounts of these types of indemnifications are often not explicitly stated or are contingent on the occurrence of future events, the overall maximum amount, or range of amount of the obligation under such indemnifications cannot be reasonably estimated. Other than obligations recorded as liabilities at the time of divestiture, we have not historically made significant payments for these indemnifications. Additionally, under certain of our acquisition agreements, we have provided for additional consideration to be paid to the sellers if established financial targets are achieved within specific timeframes post-closing. We have recognized liabilities for these contingent obligations based on an estimate of the fair value of these contingencies at the time of acquisition. Contingent obligations related to indemnifications arising from our divestitures and contingent consideration provided for by our acquisitions are not expected to be material to our financial position, results of operations or cash flows.

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Other Agreements:

We are also party to the following types of agreements pursuant to which we may be obligated to indemnify the other party with respect to certain matters:

- Guarantees on behalf of our subsidiaries with respect to real estate leases. These lease guarantees may remain in effect subsequent to the sale of the subsidiary.
- Agreements to indemnify various service providers, trustees and bank agents from any third-party claims related to their performance on our behalf, with the exception of claims that result from the third-party's own willful misconduct or gross negligence.
- Guarantees of our performance in certain services contracts to our customers and indirectly the performance of third parties with whom we have subcontracted for their services. This includes indemnifications to customers for losses that may be sustained as a result of our performance of services at a customer's location.

In each of these circumstances, our payment is conditioned on the other party making a claim pursuant to the procedures specified in the particular contract and such procedures also typically allow us to challenge the other party's claims. In the case of lease guarantees, we may contest the liabilities asserted under the lease. Further, our obligations under these agreements and guarantees may be limited in terms of time and/or amount, and in some instances, we may have recourse against third parties for certain payments we made.

Intellectual Property Indemnifications

We do not own most of the software that we use to run our business. Instead, we license this software from a small number of primary vendors. We indemnify certain software providers against claims that may arise as a result of our use or our subsidiaries', customers' or resellers' use of their software in our services and solutions. These indemnities usually do not include limits on the claims, provided the claim is made pursuant to the procedures required in the services contract.

Indemnification of Officers and Directors

Our corporate by-laws require that, except to the extent expressly prohibited by law, we must indemnify our officers and directors against judgments, fines, penalties and amounts paid in settlement and reasonable expenses, including attorneys' fees, incurred in connection with civil or criminal action or proceedings or any appeal, as it relates to their services to our Company and our subsidiaries. Although the by-laws provide no limit on the amount of indemnification, we may have recourse against our insurance carriers for certain payments made by us. However, certain indemnification payments (such as those related to "clawback" provisions in certain compensation arrangements) may not be covered under our directors' and officers' insurance coverage. We also indemnify certain fiduciaries of our employee benefit plans for liabilities incurred in their service as fiduciary whether or not they are officers of the Company. Finally, in connection with our acquisition of businesses, we may become contractually obligated to indemnify certain former and current directors, officers and employees of those businesses in accordance with pre-acquisition by-laws or indemnification agreements or applicable state law.

Other Contingencies

Certain contracts, primarily in the Company's Public Sector segment, require the Company to provide a surety bond or a letter of credit as a guarantee of performance. As of December 31, 2018, the Company had $646 million of outstanding surety bonds used to secure its performance of contractual obligations with its clients and $344 million of outstanding letters of credit issued to secure the Company's performance of contractual obligations to its clients as well as other corporate obligations. In general, the Company would only be liable for the amount of these guarantees in the event of default in the Company's performance of its obligations under each contract. The Company believes it has sufficient capacity in the surety markets and liquidity from its cash flow and its various credit arrangements (including its Credit Facility) to allow it to respond to future requests for proposals that require such credit support.

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Note 15 - Preferred Stock

Series A Preferred Stock

In connection with the December 31, 2016 spin-off from Xerox Corporation, we issued 120 thousand shares of Series A convertible perpetual preferred stock with an aggregate liquidation preference of $120 million and an initial fair value of $142 million. The Series A convertible preferred stock pays quarterly cash dividends at a rate of 8% per year ($9.6 million per year). Each share of the Series A convertible preferred stock is convertible at any time, at the option of the holder, into 44.9438 shares of common stock for a total of 5,393 thousand shares (reflecting an initial conversion price of approximately $22.250 per share of common stock), subject to customary anti-dilution adjustments.

If the closing price of our common stock exceeds 137% of the initial conversion price for 20 out of 30 trading days, we have the right to cause any or all of the Series A convertible preferred stock to be converted into shares of common stock at the then applicable conversion rate. The Series A convertible preferred stock is also convertible, at the option of the holder, upon a change in control, at the applicable conversion rate plus an additional number of shares determined by reference to the price paid for our common stock upon such change in control. In addition, upon the occurrence of certain fundamental change events, including a change in control or the delisting of Conduent's common stock, the holder of Series A convertible preferred stock has the right to require us to redeem any or all of the Series A convertible preferred stock in cash at a redemption price per share equal to the liquidation preference and any accrued and unpaid dividends to, but not including, the redemption date. As a result of the contingent redemption feature, the Series A convertible preferred stock is classified as temporary equity and reflected separately from permanent equity in the Consolidated Balance Sheets.

Note 16 – Shareholders' Equity

Preferred Stock

As of December 31, 2018, we had one class of preferred stock outstanding. See Note 15 – Preferred Stock for further information. We are authorized to issue approximately 100 million shares of cumulative preferred stock at $0.01 par value per share.

Common Stock

We have 1 billion authorized shares of common stock at $0.01 par value per share. At December 31, 2018, 15 million shares were reserved for issuance under our incentive compensation plans and 5.4 million shares were reserved for conversion of the Series A convertible preferred stock.

Stock Compensation Plans

Certain of our employees participate in a long-term incentive plan. Our long-term incentive plan authorizes the issuance of restricted stock units / shares (RSU), performance stock units / share (PSU) and non-qualified stock options to employees. All awards for these plans prior to 2017 were made in Xerox stock and therefore converted into Conduent stock effective upon the Separation. Using a formula designed to preserve the value of the award immediately prior to the Separation, all of these awards will be settled and are reflected in the Company's Consolidated Statements of Shareholders' Equity. Stock-based compensation expense includes expense based on the awards and terms previously granted to the employees.

Stock-based compensation expense was as follows:

	Year Ended December 31,		
(in millions)	2018	2017	2016
Stock-based compensation expense, pre-tax	$ 38	$ 42	$ 23
Income tax benefit recognized in earnings	7	17	9

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Restricted Stock Units / Shares Compensation expense is based upon the grant date market price. The compensation expense is recorded over the vesting period, which is normally three years from the date of grant, based on management's estimate of the number of shares expected to vest.

Performance Stock Units / Shares: The Company granted PSUs that vest contingent upon its achievement of certain specified financial performance criteria over a three-year period. If the three-year actual results exceed the stated targets, then the plan participants have the potential to earn additional shares of common stock, which cannot exceed 100% of the original grant.

The fair value of PSUs is based upon the market price of Conduent's common stock on the date of the grant. Compensation expense is recognized over the vesting period, which is normally three years from the date of grant, based on management's estimate of the number of shares expected to vest. If the stated targets are not met, any recognized compensation cost would be reversed.

Employee Stock Options: Stock options were issued by a former parent company and were converted to Conduent's common stock upon the Separation. These options generally expire within the next one year. Other than these options, Conduent has not issued any new stock options.

Summary of Stock-based Compensation Activity

	2018		2017		2016	
(shares in thousands)	Shares	Weighted Average Grant Date Fair Value	Shares	Weighted Average Grant Date Fair Value	Shares	Weighted Average Grant Date Fair Value
Restricted Stock Units / Shares						
Outstanding at January 1	3,125	$ 16.29	1,961	$ 13.99	782	$ 11.70
Granted	1,246	18.82	1,988	16.75	2,602	9.61
Vested	(1,501)	17.30	(215)	19.98	(119)	9.43
Canceled	(471)	16.62	(609)	15.88	(121)	10.55
Impact of spin-off[1]	—	n/a	—	n/a	(1,183)	n/a
Outstanding at December 31	2,399	16.90	3,125	16.29	1,961	13.99
Performance Stock Units / Shares						
Outstanding at January 1	5,429	$ 16.55	4,926	$ 13.99	7,522	$ 11.57
Granted	730	18.64	3,933	16.76	1,850	9.35
Vested	(980)	17.12	(1,696)	19.67	—	—
Canceled	(622)	16.59	(1,734)	17.46	(1,478)	11.96
Impact of spin-off[1]	—	n/a	—	n/a	(2,968)	n/a
Outstanding at December 31	4,557	16.76	5,429	16.55	4,926	13.99

(1) Stock-based compensation was converted from former parent stock into Conduent common stock at spin-off.

The Company issued 96 thousand Deferred Stock Units (DSU) to non-employee members of the Board of Directors. These DSUs are fully vested and will be issued when the directors leave the Board.

The Company has 119 thousand stock options outstanding as of December 31, 2018 at a strike price of $10.15. These stock options are fully vested and exercisable.

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The total unrecognized compensation cost related to non-vested stock-based awards at December 31, 2018 was as follows (in millions):

Awards	Unrecognized Compensation	Remaining Weighted-Average Vesting Period (Years)
Restricted Stock Units / Shares	$ 21	0.9
Performance Stock Units / Shares	15	0.8
Total	$ 36	

The aggregate intrinsic value of outstanding RSUs and PSUs awards were as follows (in millions):

Awards	December 31, 2018
Restricted Stock Units / Shares	$ 26
Performance Stock Units / Shares	48

Information related to stock options outstanding and exercisable at December 31, 2018 was as follows

(in millions)	Options	
	Outstanding	Exercisable
Aggregate intrinsic value	$ 1	$ 1
Weighted-average remaining contractual life (years)	0.6	0.6

The total intrinsic value and actual tax benefit realized for vested and exercised stock-based awards were as follows:

(in millions)	December 31, 2018			December 31, 2017			December 31, 2016		
Awards	Total Intrinsic Value	Cash Received	Tax Benefit	Total Intrinsic Value	Cash Received	Tax Benefit	Total Intrinsic Value	Cash Received	Tax Benefit
Restricted Stock Units / Shares	$ 20	$ —	$ 4	$ 3	$ —	$ 1	$ 1	$ —	$ —
Performance Stock Units / Shares	18	—	4	25	—	10	—	—	—
Stock Options	2	2	—	3	6	1	3	9	1

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Note 17 – Other Comprehensive Income (Loss)

Other Comprehensive Loss is comprised of the following:

	Year Ended December 31,					
	2018		2017		2016	
(in millions)	Pre-tax	Net of Tax	Pre-tax	Net of Tax	Pre-tax	Net of Tax
Currency Translation						
Currency translation adjustments, net	$ (31)	$ (31)	$ 35	$ 35	$ (135)	$ (135)
Reclassification of currency translation adjustments on divestitures	42	42	—	—	—	—
Translation adjustments gains(losses)	$ 11	$ 11	$ 35	$ 35	$ (135)	$ (135)
Unrealized Gains (Losses)						
Changes in fair value of cash flow hedges gains (losses)	$ 2	$ 1	$ 1	$ 1	$ (2)	$ (1)
Changes in cash flow hedges reclassed to earnings[1]	(1)	—	2	1	2	1
Net Unrealized Gains (Losses)	$ 1	$ 1	$ 3	$ 2	$ —	$ —
Defined Benefit Plans Gains (Losses)						
Reclassification of divested benefit plans and other	$ 65	$ 62	$ —	$ —	$ —	$ —
Net actuarial/prior service gains (losses)	—	—	(5)	(4)	(31)	(23)
Actuarial loss amortization/settlement[2]	—	—	2	2	1	1
Other gains (losses)[3]	—	—	(4)	(3)	3	2
Changes in Defined Benefit Plans Gains (Losses)	$ 65	$ 62	$ (7)	$ (5)	$ (27)	$ (20)
Other Comprehensive Income (Loss)	$ 77	$ 74	$ 31	$ 32	$ (162)	$ (155)

(1) Reclassified to Cost of sales - refer to Note 10 – Financial Instruments for additional information regarding our cash flow hedges.
(2) Reclassified to total net periodic benefit cost.
(3) Primarily represents currency impact on cumulative amount of benefit plan net actuarial losses and prior service credits in AOCL.

Accumulated Other Comprehensive Loss (AOCL)

Below are the balances and changes in AOCL[1]:

(in millions)	Currency Translation Adjustments	Gains (Losses) on Cash Flow Hedges	Defined Benefit Pension Items	Total
Balance at December 31, 2017	$ (437)	$ 1	$ (58)	$ (494)
Reclassification of amounts impacted by Tax Reform	—	—	(5)	(5)
Other comprehensive income (loss) before reclassifications	(31)	1	—	(30)
Amounts reclassified from accumulated other comprehensive loss	42	—	62	104
Net current period other comprehensive income (loss)	11	1	62	74
Balance at December 31, 2018	$ (426)	$ 2	$ (1)	$ (425)

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(in millions)	Currency Translation Adjustments	Gains (Losses) on Cash Flow Hedges	Defined Benefit Pension Items	Total
Balance at December 31, 2016	$ (472)	$ (1)	$ (53)	$ (526)
Other comprehensive income (loss) before reclassifications	35	2	(5)	32
Amounts reclassified from accumulated other comprehensive loss	—	—	—	—
Net current period other comprehensive income (loss)	35	2	(5)	32
Balance at December 31, 2017	$ (437)	$ 1	$ (58)	$ (494)

(in millions)	Currency Translation Adjustments	Gains (Losses) on Cash Flow Hedges	Defined Benefit Pension Items	Total
Balance at December 31, 2015	$ (147)	$ (1)	$ (33)	$ (181)
Net transfers from former parent company	(190)	—	—	(190)
Other comprehensive income (loss) before reclassifications	(135)	—	(20)	(155)
Amounts reclassified from accumulated other comprehensive loss	—	—	—	—
Net current period other comprehensive income (loss)	(135)	—	(20)	(155)
Balance at December 31, 2016	$ (472)	$ (1)	$ (53)	$ (526)

(1) All amounts are net of tax. Tax effects were immaterial.

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Note 18 – Earnings per Share

We did not declare any common stock dividends in the periods presented.

The following table sets forth the computation of basic and diluted earnings per share of common stock:

(in millions, except per share data. Shares in thousands)	Year Ended December 31, 2018	2017	2016
Basic Earnings (Loss) per Share:			
Net income (loss) from continuing operations	$ (416)	$ 177	$ (983)
Accrued dividends on preferred stock	(10)	(10)	—
Adjusted Net Income (Loss) From Continuing Operations Available to Common Shareholders	(426)	167	(983)
Net income (loss) from discontinued operations	—	4	—
Adjusted Net Income (Loss) Available to Common Shareholders	$ (426)	$ 171	$ (983)
Weighted average common shares outstanding	206,056	204,007	202,875
Basic Earnings (Loss) per Share:			
Continuing operations	$ (2.06)	$ 0.82	$ (4.85)
Discontinued operations	—	0.02	—
Basic Earnings (Loss) per Share	$ (2.06)	$ 0.84	$ (4.85)
Diluted Earnings (Loss) per Share:			
Net income (loss) from continuing operations	$ (416)	$ 177	$ (983)
Accrued dividends on preferred stock	(10)	(10)	—
Adjusted Net Income (Loss) From Continuing Operations Available to Common Shareholders	(426)	167	(983)
Net income (loss) from discontinued operations	—	4	—
Adjusted Net Income (Loss) Available to Common Shareholders	$ (426)	$ 171	$ (983)
Weighted average common shares outstanding	206,056	204,007	202,875
Common shares issuable with respect to:			
Stock options	—	195	—
Restricted stock and performance units / shares	—	2,591	—
8% Convertible preferred stock	—	—	—
Adjusted Weighted Average Common Shares Outstanding	206,056	206,793	202,875
Diluted Earnings (Loss) per Share:			
Continuing operations	$ (2.06)	$ 0.81	$ (4.85)
Discontinued operations	—	0.02	—
Diluted Earnings (Loss) per Share	$ (2.06)	$ 0.83	$ (4.85)
The following securities were not included in the computation of diluted earnings per share as they were either contingently issuable shares or shares that if included would have been anti-dilutive (shares in thousands):			
Stock Options	119	—	857
Restricted stock and performance shares/units	5,242	2,568	5,719
Convertible preferred stock	5,393	5,393	5,393
Total Anti-Dilutive Securities	10,754	7,961	11,969

Note 19 – Subsequent Events

In January 2019, the Company completed the acquisition of Health Solutions Plus (HSP), a software provider of healthcare payer administration solutions for $90 million and a maximum contingent consideration payment of $7.8 million over two years.

In February 2019, the Company completed the sale of a portfolio of select standalone customer care contracts to Skyview Capital LLC for $25 million, subject to delayed transfer of certain assets in some countries pending fulfillment of legal requirements.

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QUARTERLY RESULTS OF OPERATIONS (Unaudited)

(in millions, except per-share data)	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Full Year
2018					
Revenues	$ 1,420	$ 1,387	$ 1,304	$ 1,282	$ 5,393
Costs and Expenses	1,474	1,333	1,556	1,425	5,788
(Loss) Income before Income Taxes	(54)	54	(252)	(143)	(395)
Income tax (benefit) expense	(4)	43	(15)	(3)	21
(Loss) Income from Continuing Operations	(50)	11	(237)	(140)	(416)
Income from discontinued operations, net of tax	—	—	—	—	—
Net (Loss) Income	$ (50)	$ 11	$ (237)	$ (140)	$ (416)
Basic Earnings (Loss) per Share[1]:					
Continuing operations	$ (0.26)	$ 0.05	$ (1.16)	$ (0.69)	$ (2.06)
Discontinued operations	—	—	—	—	—
Total Basic (Loss) Earnings per Share:	$ (0.26)	$ 0.05	$ (1.16)	$ (0.69)	$ (2.06)
Diluted Earnings (Loss) per Share[1]:					
Continuing operations	$ (0.26)	$ 0.04	$ (1.16)	$ (0.69)	$ (2.06)
Discontinued operations	—	—	—	—	—
Total Diluted (Loss) Earnings per Share	$ (0.26)	$ 0.04	$ (1.16)	$ (0.69)	$ (2.06)
2017					
Revenues	$ 1,553	$ 1,496	$ 1,480	$ 1,493	$ 6,022
Costs and Expenses	1,575	1,507	1,467	1,489	6,038
(Loss) Income before Income Taxes	(22)	(11)	13	4	(16)
Income tax (benefit) expense	(12)	(7)	30	(204)	(193)
(Loss) Income from Continuing Operations	(10)	(4)	(17)	208	177
Income (loss) from discontinued operations, net of tax	4	—	—	—	4
Net (Loss) Income	$ (6)	$ (4)	$ (17)	$ 208	$ 181
Basic Earnings (Loss) per Share[1]:					
Continuing operations	$ (0.06)	$ (0.03)	$ (0.09)	$ 1.00	$ 0.82
Discontinued operations	$ 0.02	$ —	$ —	$ —	$ 0.02
Total Basic (Loss) Earnings per Share:	$ (0.04)	$ (0.03)	$ (0.09)	$ 1.00	$ 0.84
Diluted Earnings (Loss) per Share[1]:					
Continuing operations	$ (0.06)	$ (0.03)	$ (0.09)	$ 0.98	$ 0.81
Discontinued operations	$ 0.02	$ —	$ —	$ —	$ 0.02
Total Diluted (Loss) Earnings per Share	$ (0.04)	$ (0.03)	$ (0.09)	$ 0.98	$ 0.83

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(1) The sum of quarterly earnings per share may differ from the full-year amounts due to rounding, or in the case of diluted earnings per share, because securities that are anti-dilutive in certain quarters may not be anti-dilutive on a full-year basis.

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

None

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ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements

Management is responsible for the integrity and objectivity of all information presented in this Annual Report on Form 10-K. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States of America and include amounts based on management's best estimates and judgments. Management believes the consolidated financial statements fairly reflect the form and substance of transactions and that the financial statements fairly represent the Company's financial position and results of operations.

The Audit Committee of the Board of Directors, which is composed solely of independent directors, meets regularly with the independent registered public accountants, PricewaterhouseCoopers LLP, the internal auditors and representatives of management to review accounting, financial reporting, internal control and audit matters, as well as the nature and extent of the audit effort. The Audit Committee is responsible for the engagement of the independent registered public accountants. The independent registered public accountants and internal auditors have access to the Audit Committee.

Disclosure Controls and Procedures

The Company's management evaluated, with the participation of our principal executive officer and principal financial officer, the effectiveness of our disclosure controls and procedures, as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended, as of December 31, 2018, the end of the period covered by this Annual Report on Form 10-K. Based on this evaluation, our principal executive officer and principal financial officer have concluded that, as of the end of the period covered by this Annual Report on Form 10-K, our disclosure controls and procedures were effective to ensure that information we are required to disclose in the reports that we file or submit under the Securities Exchange Act of 1934, as amended, is recorded, processed, summarized and reported within the time periods specified in the Securities and Exchange Commission's rules and forms relating to Conduent Incorporated, including our consolidated subsidiaries, and was accumulated and communicated to the Company's management, including the principal executive officer and principal financial officer, or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure.

Management's Report on Internal Control over Financial Reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) promulgated under the Securities Exchange Act of 1934, as amended. Under the supervision and with the participation of our management, including our principal executive officer, principal financial officer and principal accounting officer, we have conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in "Internal Control - Integrated Framework" (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

Based on the above evaluation, management concluded that our internal control over financial reporting was effective as of December 31, 2018.

The effectiveness of our internal control over financial reporting as of December 31, 2018 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which appears in Part II, Item 8 of this Annual Report on Form 10-K.

Changes in Internal Control over Financial Reporting

In connection with the evaluation required by paragraph (d) of Rule 13a-15 under the Exchange Act, there was no change identified in our internal control over financial reporting that occurred during the last fiscal quarter ended December 31, 2018 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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ITEM 9B. OTHER INFORMATION

None

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PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information regarding directors is incorporated herein by reference to the section entitled “Proposal 1 - Election of Directors” in our definitive Proxy Statement (2019 Proxy Statement) to be filed pursuant to Regulation 14A of the Securities Exchange Act of 1934, as amended, for our 2019 Annual Meeting of Stockholders. The Proxy Statement is expected to be filed within 120 days after the end of our fiscal year ended December 31, 2018.

The information regarding compliance with Section 16(a) of the Securities and Exchange Act of 1934 is incorporated herein by reference to the section entitled “Section 16(a) Beneficial Ownership Reporting Compliance” of our 2019 Proxy Statement.

The information required by this Item regarding the Audit Committee, its members and the Audit Committee financial experts is incorporated by reference herein from the subsection entitled “Committee Functions, Membership and Meetings” in the section entitled “Proposal 1 - Election of Directors” in our 2019 Proxy Statement.

We have adopted a code of ethics applicable to our principal executive officer, principal financial officer and principal accounting officer. The Finance Code of Conduct can be found on our website at: https://www.conduent.com/corporate-governance/ethics-and-compliance/. Information concerning our Finance Code of Conduct can be found under "Corporate Governance" in our 2019 Proxy Statement and is incorporated here by reference.

Executive Officers of Conduent

The following is a list of the executive officers of Conduent, their current ages, their present positions and the year appointed to their present positions.

Each officer is elected to hold office until the meeting of the Board of Directors held on the day of the next annual meeting of shareholders, subject to the provisions of the by-laws.

Name	Age	Present Position	Year Appointed to Present Position	Conduent Officer Since
Ashok Vemuri*	50	Chief Executive Officer	2017	2017
Allan Cohen	49	Vice President & Chief Accounting Officer	2017	2017
Jeffrey Friedel	54	Executive Vice President & Chief People Officer	2017	2017
James Michael Peffer	57	Executive Vice President, General Counsel & Secretary	2017	2017
Brian J. Webb-Walsh	43	Executive Vice President & Chief Financial Officer	2017	2017

* Member of Conduent Board of Directors

Each of the officers named above has been an officer or an executive of Conduent or its subsidiaries for less than five years.

Mr. Vemuri served as Chief Executive Officer of Xerox Business Services, LLC and an Executive Vice President of Xerox Corporation since July 2016. Mr. Vemuri previously was President, Chief Executive Officer and a member of the Board of Directors of IGATE Corporation. Prior to IGATE, Mr. Vemuri spent 14 years at Infosys Limited, a multinational consulting and IT services company, in a variety of leadership and business development roles.

Prior to joining Conduent, Mr. Cohen served as Senior Vice President and Controller of NBC Universal since 2011. Mr. Cohen also previously served as Vice President, Assistant Controller at Time Warner, Professional Accounting Fellow in the Division of Corporate Finance at the SEC and Senior Manager at PriceWaterhouseCoopers.

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Prior to joining Conduent, Mr. Friedel served as Vice President and Head of the Office of Integrity and Compliance at Infosys Limited from January 2016 to September 2016, a global leader in technology services and consulting, where he oversaw SEC compliance, internal investigations, code of conduct, whistleblower, and anti-bribery and export regulations. Mr. Friedel has also previously served as Senior Vice President and General Counsel at IGATE Corporation from June 2014 to December 2015, an IT services and business process outsourcing company which was acquired by CapGemini. Prior to June 2014, Mr. Friedel held a variety of leadership roles at Infosys Limited.

Mr. Peffer served as Vice President, General Counsel and Secretary for Xerox Corporation from August 2016 to December 2016. Prior to this, Mr. Peffer served as Associate General Counsel of Xerox Corporation and Executive Vice President of Xerox Business Services, LLC since 2010. Prior to 2010, Mr. Peffer was Senior Vice President and Deputy General Counsel of ACS from May 2009.

Mr. Webb-Walsh served as the Chief Financial Officer of Xerox Services since January 2016. Prior to this, Mr. Webb-Walsh was Senior Vice President of Finance for the Government Healthcare Group and the Platform Development and Systems Integration Group of Xerox Services. Mr. Webb-Walsh joined Xerox Corporation in 1997 and has held a variety of leadership positions.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this Item included under the following captions under “Proposal 1 - Election of Directors” in our 2019 Proxy Statement is incorporated herein by reference: “Compensation Discussion and Analysis”, “Summary Compensation Table”, “Grants of Plan-Based Awards in 2018”, “Outstanding Equity Awards at 2018 Fiscal Year-End”, “Option Exercises and Stock Vested in 2018”, “Pension Benefits for the 2018 Fiscal Year”, “Nonqualified Deferred Compensation for the 2018 Fiscal Year”, “Potential Payments upon Termination or Change in Control”, “Summary of Annual Director Annual Compensation, "Compensation Committee Interlocks and Insider Participation” and “Compensation Committee”. The information included under the heading “Compensation Committee Report” in our 2019 Proxy Statement is incorporated herein by reference; however, this information shall not be deemed to be “soliciting material” or to be “filed” with the SEC or subject to Regulation 14A or 14C, or to the liabilities of Section 18 of the Exchange Act.

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

Information required by this Item regarding security ownership of certain beneficial owners and management and securities authorized for issuance under equity compensation plans is incorporated herein by reference to the subsections entitled “Ownership of Company Securities,” and “Equity Compensation Plan Information” under “Proposal 1 - Election of Directors” in our 2019 Proxy Statement.

ITEM 13. CERTAIN RELATIONSHIPS, RELATED TRANSACTIONS AND DIRECTOR INDEPENDENCE

Information required by this Item regarding certain relationships and related transactions is incorporated herein by reference to the subsection entitled “Certain Relationships and Related Person Transactions” under “Proposal 1 - Election of Directors” in our 2019 Proxy Statement. The information regarding director independence is incorporated herein by reference to the subsections entitled “Corporate Governance” and “Director Independence” in the section entitled “Proposal 1 - Election of Directors” in our 2019 Proxy Statement.

ITEM 14. PRINCIPAL AUDITOR FEES AND SERVICES

The information required by this Item regarding principal auditor fees and services is incorporated herein by reference to the section entitled “Proposal 2 - Ratification of Election of Independent Registered Public Accounting Firm” in our 2019 Proxy Statement.

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PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) (1) Index to Financial Statements and Financial Statement Schedule, incorporated by reference or filed as part of this report:

- Report of Independent Registered Public Accounting Firm including Report on Financial Statement Schedule;
- Consolidated Statements of Income (Loss) for each of the years in the three-year period ended December 31, 2018;
- Consolidated Statements of Comprehensive Income (Loss) for each of the years in the three-year period ended December 31, 2018;
- Consolidated Balance Sheets as of December 31, 2018 and 2017;
- Consolidated Statements of Cash Flows for each of the years in the three-year period ended December 31, 2018;
- Consolidated Statements of Shareholders' Equity for each of the years in the three-year period ended December 31, 2018;
- Notes to the Consolidated Financial Statements;
- Schedule II - Valuation and Qualifying Accounts for the three years ended December 31, 2018; and
- All other schedules are omitted as they are not applicable, or the information required is included in the financial statements or notes thereto.

(2) Supplementary Data:

- Quarterly Results of Operations (unaudited).
- SCHEDULE II

VALUATION AND QUALIFYING ACCOUNTS

For the three years ended December 31, 2018

(in millions)	Balance at beginning of period	Additions charged to expense[1]	Amounts (credited) charged to other income statement accounts [2]	Deductions and other, net of recoveries [3][4]	Balance at end of period
Allowance for Losses:					
2018 Accounts Receivable	$ 2	$ —	$ —	$ (1)	$ 1
2017 Accounts Receivable	7	(1)	—	(4)	2
2016 Accounts Receivable	6	4	—	(3)	7
Tax Valuation Allowance:					
2018 Tax Valuation	35	9	—	—	44
2017 Tax Valuation	24	11	—	—	35
2016 Tax Valuation	38	—	—	(14)	24

(1) Account Receivables: additions charged to expense represent bad debt provisions relate to estimated losses due to credit and similar collectibility issues.
(2) Account Receivables: Other charges (credits) relate to adjustments to reserves necessary to reflect events of non-payment such as customer accommodations and contract terminations.

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(3) Account Receivables: Deductions and other, net of recoveries primarily relates to receivable write-offs, but also includes the impact of foreign currency translation adjustments and recoveries of previously written off receivables.

(4) Tax Valuation: Reductions to tax valuation allowance are primarily related to certain net operating loss carryforwards, tax credit carryforwards and deductible temporary differences for which we have concluded it is more-likely-than-not that these items will not be realized in the ordinary course of operations.

(3) The exhibits listed below are filed or incorporated by reference are part of this Form 10-K.

Management contracts or compensatory plans or arrangements listed that are applicable to the executive officers named in the Summary Compensation Table which appears in Registrant's 2019 Proxy Statement or to our directors are preceded by an asterisk (*).

Exhibit No.	
2.1	Separation and Distribution Agreement, dated as of December 30, 2016, by and between Xerox Corporation and Conduent Incorporated.
	Incorporated by reference to Exhibit 2.1 to Registrant's Current Report on Form 8-K dated January 3, 2017. (See SEC File Number 001-37817).
3.1	Restated Certificate of Incorporation of Registrant as of December 23, 2016.
	Incorporated by reference to Exhibit 3.1 to Registrant's Current Report on Form 8-K dated December 23, 2016. (See SEC File Number 001-37817).
3.2	Amended and Restated By-Laws of Registrant as amended through December 31, 2016.
	Incorporated by reference to Exhibit 3.2 to Registrant's Current Report on Form 8-K dated December 23, 2016. (See SEC File Number 001-37817).
4.1(a)	Indenture, dated as of December 7, 2016, among Conduent Finance, Inc., Xerox Business Services, LLC, the Guarantors named therein and U.S. Bank National Association, as trustee.
	Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K dated December 9, 2016. (See SEC File Number 001-37817).
4.1(b)	First Supplemental Indenture, dated as of January 9, 2018, among Conduent Finance, Inc., Xerox Business Services, LLC, the Guarantors named therein and U.S. Bank National Association, as trustee.
	Incorporated by reference to Exhibit 4.1(a) to the Registrant's Quarterly Report on Form 10-Q dated August 8, 2018. (See SEC File Number 001-37817).
4.1(c)	Second Supplemental Indenture, dated as of June 1, 2018, among Conduent Finance, Inc., Xerox Business Services, LLC, the Guarantors named therein and U.S. Bank National Association, as trustee.
	Incorporated by reference to Exhibit 4.1(b) to the Registrant's Quarterly Report on Form 10-Q dated August 8, 2018. (See SEC File Number 001-37817).
4.1(d)	Third Supplemental Indenture, dated as of June 1, 2018, among Conduent Finance, Inc., Xerox Business Services, LLC, the Guarantors named therein and U.S. Bank National Association, as trustee.
	Incorporated by reference to Exhibit 4.1(c) to the Registrant's Quarterly Report on Form 10-Q dated August 8, 2018. (See SEC File Number 001-37817).
4.1(e)	Fourth Supplemental Indenture, dated as of June 1, 2018, among Conduent Finance, Inc., Xerox Business Services, LLC, the Guarantors named therein and U.S. Bank National Association, as trustee.
	Incorporated by reference to Exhibit 4.1(d) to the Registrant's Quarterly Report on Form 10-Q dated August 8, 2018. (See SEC File Number 001-37817).
4.1(f)	Fifth Supplemental Indenture, dated as of July 12, 2018, among Conduent Finance, Inc., Xerox Business Services, LLC, the Guarantors named therein and U.S. Bank National Association, as trustee.
	Incorporated by reference to Exhibit 4.1 to Registrant's Current Report on Form 8-K dated July 12, 2018. (See SEC File Number 001-37817).
10.1(a)	Credit Agreement, dated as of December 7, 2016, among Conduent Incorporated, Xerox Business Services, LLC, Affiliated Computer Services International B.V., Conduent Finance, Inc., the Lenders from time to time party thereto and JPMorgan Chase Bank, N.A., as Administrative Agent.
	Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K dated December 9, 2016. (See SEC File Number 001-37817).

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10.1(b)	Amendment No. 1 to Credit Agreement, dated as of April 1, 2017, among Conduent Incorporated, Conduent Business Services, LLC (f/k/a Xerox Business Services, LLC), Affiliated Computer Services International B.V., Conduent Finance, Inc., the Lenders from time to time party thereto and JPMorgan Chase Bank, N.A. as Administrative Agent.
	Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K dated April 11, 2017. (See SEC File Number 001-37817).
10.1(c)	Amendment No. 2 to Credit Agreement, dated as of October 10, 2017, among Conduent Incorporated, Conduent Business Services, LLC (f/k/a Xerox Business Services, LLC), Affiliated Computer Services International B.V., Conduent Finance, Inc., the Lenders from time to time party thereto and JPMorgan Chase Bank, N.A. as Administrative Agent.
	Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K dated October 10, 2017. (See SEC File Number 001-37817).
10.1(d)	Amendment No. 3 to Credit Agreement, dated as of June 28, 2018, among Conduent Incorporated, Conduent Business Services, LLC (f/k/a Xerox Business Services, LLC), Affiliated Computer Services International B.V., Conduent Finance, Inc., the Lenders from time to time party thereto and JPMorgan Chase Bank, N.A. as Administrative Agent.
	Incorporated by reference to Exhibit 10.1 to Registrant’s Current Report on Form 8-K dated June 28, 2018. (See SEC File Number 001-37817).
10.1(d)	First Incremental Agreement, dated as of January 3, 2017, among JPMorgan Chase Bank, N.A., as Administrative Agent and Xerox Business Services, LLC.
	Incorporated by reference to Exhibit 10.1(b) to the Registrant's Annual Report on Form 10-K dated March 10, 2017, (See SEC File Number 001-37817).
10.3(a)	Transition Services Agreement, dated as of December 30, 2016, by and between Xerox Corporation and Conduent Incorporated.
	Incorporated by reference to Exhibit 10.1 to Registrant’s Current Report on Form 8-K dated January 3, 2017. (See SEC File Number 001-37817).
10.3(b)	Tax Matters Agreement, dated as of December 30, 2016, by and between Xerox Corporation and Conduent Incorporated.
	Incorporated by reference to Exhibit 10.2 to Registrant’s Current Report on Form 8-K dated January 3, 2017. (See SEC File Number 001-37817).
10.3(c)	Employee Matters Agreement, dated as of December 30, 2016, by and between Xerox Corporation and Conduent Incorporated.
	Incorporated by reference to Exhibit 10.3 to Registrant’s Current Report on Form 8-K dated January 3, 2017. (See SEC File Number 001-37817).
10.3(d)	Intellectual Property Agreement, dated as of December 30, 2016, by and between Xerox Corporation and Conduent Incorporated.
	Incorporated by reference to Exhibit 10.4 to Registrant’s Current Report on Form 8-K dated January 3, 2017. (See SEC File Number 001-37817).
10.3(e)	Trademark License Agreement, dated as of December 30, 2016, by and between Xerox Corporation and Conduent Incorporated.
	Incorporated by reference to Exhibit 10.5 to Registrant’s Current Report on Form 8-K dated January 3, 2017. (See SEC File Number 001-37817).
10.4(a)	Joinder Agreement to Agreement, dated December 31, 2016, among Conduent Incorporated, Xerox Corporation, Icahn Partners Master Fund LP, Icahn Partners LP, Icahn Onshore LP, Icahn Offshore LP, Icahn Capital LP, IPH GP LLC, Icahn Enterprises Holdings L.P., Icahn Enterprises G.P. Inc., Beckton Corp., High River Limited Partnership, Hopper Investments LLC, Barberry Corp., Jonathan Christodoro and Carl C. Icahn.
	Incorporated by reference to Exhibit 10.6 to Registrant’s Current Report on Form 8-K dated January 3, 2017. (See SEC File Number 001-37817).
10.4(b)	Agreement, dated January 28, 2016, among Xerox Corporation, Icahn Partners Master Fund LP, Icahn Partners LP, Icahn Onshore LP, Icahn Offshore LP, Icahn Capital LP, IPH GP LLC, Icahn Enterprises Holdings L.P., Icahn Enterprises G.P. Inc., Beckton Corp., High River Limited Partnership, Hopper Investments LLC, Barberry Corp., Jonathan Christodoro and Carl C. Icahn.
	Incorporated by reference to Exhibit 10.6 to Registrant’s Amendment No. 1 to Form 10 dated August 15, 2016. (See SEC File Number 001-37817).
10.5(a)	Exchange Agreement dated October 27, 2016 by and among Darwin A. Deason, Conduent Incorporated and Xerox Corporation.

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	Incorporated by reference to Exhibit 10.14 to Registrant's Amendment No. 5 to Form 10 dated October 28, 2016. (See SEC File Number 001-37817).
10.5(b)	Shareholders Agreement dated December 18, 2018 by and between Darwin Deason and Conduent Incorporated.
	Incorporated by reference to Exhibit 10.1 to Registrant's Current Report on Form 8-K dated December 18, 2018. (See SEC File Number 001-37817).
The management contracts or compensatory plans or arrangements listed below that are applicable to the executive officers named in the Summary Compensation Table which will appear in the Registrant's 2019 Proxy Statement or to our directors are preceded by an asterisk (*).	
*10.6(a)(i)	Registrant's Performance Incentive Plan dated as of December 15, 2016 ("PIP").
	Incorporated by reference to Exhibit 4.3 to Registrant's Registration Statement No. 333-215361 dated December 29, 2016. (See SEC File Number 001-37817).
*10.6(a)(ii)	Form of Restricted Stock Award Agreement under the PIP.
	Incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated March 29, 2017. (See SEC File Number 001-37817).
*10.6(a)(iii)	Form of Performance Share Award Agreement (ELTIP) under the PIP.
	Incorporated by reference to Exhibit 10.2 to the Registrant's Current Report on Form 8-K dated March 29, 2017. (See SEC File Number 001-37817).
*10.6(a)(iv)	Form of Performance Share Award Agreement (SIG) under the PIP.
	Incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K dated March 29, 2017. (See SEC File Number 001-37817).
*10.6(a)(v)	Forms of Performance Stock Unit Award Agreement 2017 under the PIP
	Incorporated by reference to Exhibit 10.6(a)(v) to the Registrant's Annual Report on Form 10-K dated March 1, 2018. (See SEC File Number 001-37817).
*10.6(a)(vi)	Forms of Restricted Stock Unit Award Agreement 2017 under the PIP.
	Incorporated by reference to Exhibit 10.6(a)(vi) to the Registrant's Annual Report on Form 10-K dated March 1, 2018. (See SEC File Number 001-37817)
*10.6(a)(vii)	Form of Restricted Stock Unit Award Agreement 2018 under the PIP Severance Plan, dated as of October 1, 2017.
	Incorporated by reference to Exhibit 10.6(a)(vii) to the Registrant's Quarterly Report on Form 10-Q dated May 9, 2018. (See SEC File Number 001-37817).
*10.6(a)(viii)	Form of Performance Stock Unit Award Agreement 2018 under the PIP Severance Plan, dated as of October 1, 2017.
	Incorporated by reference to Exhibit 10.6(a)(viii) to the Registrant's Quarterly Report on Form 10-Q dated May 9, 2018. (See SEC File Number 001-37817).
*10.6(a)(ix)	Form of Restricted Stock Unit Award Agreement 2019 under the PIP Severance Plan.
*10.6(a)(x)	Form of Performance Stock Unit Award Agreement 2019 under the PIP Severance Plan.
*10.6(b)(i)	Registrant's Equity Compensation Plan for Non-Employee Directors dated as of December 15, 2016 ("ECPNED").
	Incorporated by reference to Exhibit 4.4 to Registrant's Registration Statement No. 333-215361 dated December 29, 2016. (See SEC File Number 001-37817).
*10.6(b)(ii)	Form of Agreement under the ECPNED.
	Incorporated by reference to Exhibit 10.6(b)(ii) to the Registrant's Annual Report on From 10-K dated March 10, 2017. (See SEC File Number 001-37817).
*10.6.(c)	Registrant's Executive Change in Control Severance Plan dated as of April 25, 2017.
	Incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K dated August 28, 2017. (See SEC File Number 001-37817).
*10.6(d)	Letter Agreement dated June 10, 2016 between Xerox Corporation and Ashok Vemuri regarding compensation arrangements.
	Incorporated by reference to Exhibit 99.2 to Xerox Corporation's Current Report on Form 8-K dated June 14, 2016. (See SEC File Number 001-04471).
*10.6(e)	Letter Agreement dated July 22, 2016 between Xerox Corporation and J. Michael Peffer regarding compensation arrangements.

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	Incorporated by reference to Exhibit 10.12 to Registrant's Amendment No. 4 to Form 10 dated October 21, 2016. (See SEC File Number 001-37817).
*10.6(f)	Letter Agreement dated September 6, 2016 between Xerox Corporation and Brian Webb-Walsh regarding compensation arrangements.
	Incorporated by reference to Exhibit 10.13 to Registrant's Amendment No. 4 to Form 10 dated October 21, 2016. (See SEC File Number 001-37817).
*10.6(g)	Letter Agreement dated September 28, 2017 between Conduent Incorporated and Allan Cohen regarding compensation arrangements.
	Incorporated by reference to Exhibit 10.6(g) to the Registrant's Annual Report on Form 10-K dated March 1, 2018. (See SEC File Number 001-37817).
10.7(a)	Settlement Agreement and Release between the State of Texas, the Texas Health and Human Services Commission, Xerox Corporation, Conduent Incorporated, Conduent Business Services, LLC and Conduent State Healthcare, LLC dated February 18, 2019.
	Incorporated by reference to the Registrant's Current Report on Form 8-K dated February 19, 2019. (See SEC File Number 001-37817).
21.1	List of subsidiaries of Registrant.
23	Consent of PricewaterhouseCoopers LLP.
31(a)	Certification of CEO pursuant to Rule 13a-14(a) or Rule 15d-14(a).
31(b)	Certification of CFO pursuant to Rule 13a-14(a) or Rule 15d-14(a).
32	Certification of CEO and CFO pursuant to 18 U.S.C. §1350 as adopted pursuant to §906 of the Sarbanes-Oxley Act of 2002.
101.CAL	XBRL Taxonomy Extension Calculation Linkbase.
101.DEF	XBRL Taxonomy Extension Definition Linkbase.
101.INS	XBRL Instance Document.
101.LAB	XBRL Taxonomy Extension Label Linkbase.
101.PRE	XBRL Taxonomy Extension Presentation Linkbase.
101.SCH	XBRL Taxonomy Extension Schema Linkbase.

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

CONDUENT INCORPORATED

/s/ ASHOK VEMURI

Ashok Vemuri
Chief Executive Officer

February 28, 2019

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

February 28, 2019

Signature	Title
Principal Executive Officer:	
/S/ ASHOK VEMURI	Chief Executive Officer and Director
Ashok Vemuri	
Principal Financial Officer:	
/S/ BRIAN WEBB-WALSH	Executive Vice President and Chief Financial Officer
Brian Webb-Walsh	
Principal Accounting Officer:	
/S/ ALLAN COHEN	Vice President and Chief Accounting Officer
Allan Cohen	
/S/ NICHOLAS GRAZIANO	Director
Nicholas Graziano	
/S/ JOIE A. GREGOR	Director
Joie A. Gregor	
/s/ SCOTT LETIER	Director
Scott Letier	
/S/ COURTNEY MATHER	Director
Courtney Mather	
/S/ MICHAEL NEVIN	Director
Michael Nevin	
/S/ MICHAEL A. NUTTER	Director
Michael A. Nutter	
/s/ WILLIAM G. PARRETT	Director and Chairman of the Board
William G. Parrett	
/S/ VIRGINIA M. WILSON	Director
Virginia M. Wilson	

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RESTRICTED STOCK UNIT AWARD AGREEMENT PURSUANT TO CONDUENT INCORPORATED PERFORMANCE INCENTIVE PLAN

AGREEMENT, by Conduent Incorporated, a New York corporation (the "Company"), dated as of the date that appears in the award summary that provides the number of Restricted Stock Units and vesting provisions of the award (the "Award Summary"), in favor of the individual whose name appears on the Award Summary (the "Employee"), who is an employee of the Company, one of the Company's subsidiaries or one of its affiliates (the Company, or such subsidiary or affiliate, the "Employer").

In accordance with the provisions of the Conduent Performance Incentive Plan (the "Plan"), the Compensation Committee of the Board of Directors of the Company (the "Committee") or the Chief Executive Officer of the Company (the "CEO") has authorized the execution and delivery of this Agreement.

Terms used herein that are defined in the Plan or in this Agreement shall have the meanings assigned to them in the Plan or this Agreement, respectively.

The Award Summary contains the details of the awards covered by this Agreement and is incorporated herein in its entirety.

NOW, THEREFORE, in consideration of the premises and for other good and valuable consideration the Company agrees as follows:

AWARDS

1. Award of Restricted Stock Units. Subject to all terms and conditions of the Plan and this Agreement, the Company has awarded to the Employee on the date indicated on the Award Summary the number of Restricted Stock Units (individually, a "RSU") as shown on the Award Summary. Notwithstanding anything herein to the contrary, only active employees and those employees on Short Term Disability Leave, Social Service Leave, Family Medical Leave or Paid Uniform Services Leave (pursuant to the Company's Human Resources Policies or similar policies of the Company's subsidiaries or affiliates) on the effective date of the award as shown on the Award Summary shall be eligible to receive the award.

TERMS OF THE RESTRICTED STOCK UNITS

2. Entitlement to Shares. As soon as practicable on or after each applicable Vesting Date (as defined below) (or such earlier date provided in Section 9), the Company shall deliver to the Employee, in such manner as the Company shall determine, a number of shares of Common Stock equal to the number of vested RSUs (subject to reduction for withholding of the Employee's taxes in relation to the award as described in Section 11) within 60 days following each applicable Vesting Date (or, if earlier, a distribution event set forth in Section 9 that satisfies the requirements of Section 409A(a)(2) of the Code).

No fractional shares shall be issued as a result of such tax withholding. Instead, the Company shall apply the equivalent of any fractional share amount to amounts withheld for taxes. Notwithstanding the foregoing, the Company shall be entitled to delay delivery of such shares of Common Stock (or cash payment in lieu thereof, as applicable) until it shall have received from the Employee a duly executed Form W-8 or W-9, as applicable, and any other information or completed forms the Company may reasonably require.

3. Vesting. Except as otherwise determined by the Committee in its sole discretion (subject to Section 23 of the Plan) or as otherwise provided in this Section 3 or Section 9, the vesting of RSUs covered hereby shall be subject to the Employee's continued employment with the Company or a subsidiary or affiliate through the applicable Vesting Date. The Employee shall be eligible to vest in one-third of the shares of Common Stock covered by this Agreement as set forth in the Award Summary on each of December 31, 2019, December 31, 2020 and December 31, 2021 (each, a "Vesting Date").

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Upon the occurrence of an event constituting a Change in Control, notwithstanding anything to the contrary in Section 22(b) of the Plan, the RSUs outstanding on the date of such Change in Control, and any dividend equivalents with respect thereto, shall remain outstanding and thereafter the vesting of such RSUs, and any dividend equivalents with respect thereto, shall be subject to Employee's continued employment with the Company or a subsidiary or an affiliate through each applicable Vesting Date as provided in this Section 3, at which time such RSUs shall vest and shall be paid in cash in accordance with Section 22(f) of the Plan at the earliest time set forth in Section 22(c) of the Plan that will not trigger a tax or penalty under Section 409A of the Code, as determined by the Committee; provided that the RSUs, and any dividend equivalents with respect thereto, shall vest and shall be paid to the extent provided in Section 9 in the event of the Employee's termination of employment following such Change in Control and prior to a Vesting Date. Upon payment pursuant to the terms of the Plan, such awards shall be cancelled.

4. Dividend Equivalents. The Employee shall become entitled to receive from the Company on each applicable Vesting Date (or such earlier date provided in Section 9) a cash payment equaling the same amount(s) that the holder of record of a number of shares of Common Stock equal to the number of vested RSUs (if any) would have been entitled to receive as dividends on such Common Stock during the period commencing on the effective date hereof and ending on each applicable Vesting Date (or such earlier date provided in Section 9) as provided under Section 3. Payments under this Section shall be net of any required withholding taxes.

OTHER TERMS

5. Ownership Guidelines. Guidelines pertaining to the Employee's required ownership of Common Stock (the "Stock Ownership Guidelines") shall be determined by the Committee or its authorized delegate, as applicable, in its sole discretion from time to time as communicated to the Employee in writing.

6. Holding Requirements. In the event of non-compliance with the Stock Ownership Guidelines under Section 5 hereof, following a five-year noncompliance period as described in the Stock Ownership Guidelines, the Employee must retain fifty percent (50%) of the net shares of Common Stock acquired in connection with the vesting of RSUs (net of withholding tax and any applicable fees) until the threshold set forth in the Stock Ownership Guidelines is satisfied. Such shares shall be held in the Employee's Morgan Stanley account or in another account acceptable to the Company. In addition, shares used to maintain the Employee's ownership level pursuant to this award should be held with Morgan Stanley or in another account acceptable to the Company.

7. Voting Rights/Dividends. Except as otherwise provided herein, the Employee shall have no rights as a shareholder with respect to the RSUs until the date of issuance of a stock certificate to him for such RSUs and no adjustment shall be made for dividends or other rights for which the record date is prior to the date the RSUs become vested.

8. Non-Assignability. Unless otherwise provided by the Committee in its discretion, RSUs may not be sold, assigned, alienated, transferred, pledged, attached or otherwise encumbered except as provided in Section 11 of the Plan. Any purported sale, assignment, alienation, transfer, pledge, attachment or other encumbrance of a RSU in violation of the provisions of this Section 8 and Section 11 of the Plan shall be void.

9. Effect of Termination of Employment or Death.

(a) Effect on RSUs. In the event the Employee

(i) voluntarily ceases to be an employee of the Employer for any reason other than Termination For Good Reason following a Change in Control, the RSUs that have not vested in accordance with Section 3 shall be canceled and forfeited on the date of such voluntary termination of employment;

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(ii) involuntarily ceases to be an employee of the Employer on or after the nine-month anniversary of the grant date of the RSUs and prior to a Change in Control for any reason other than due to death, Disability or a termination for Cause, the number of RSUs scheduled to vest on the Vesting Date immediately following such termination, and any dividend equivalents with respect thereto, shall be prorated based on a fraction, the numerator of which is the number of full months elapsed since the most recent Vesting Date immediately preceding such date of termination (or since January 1, 2018, in the case of a termination of employment prior to the first Vesting Date) and the denominator of which is 12, and any remaining RSUs shall be forfeited. Such prorated number of RSUs, and any dividend equivalents with respect thereto, shall immediately vest and shall be settled in accordance with Section 2 within 60 days following the Vesting Date immediately following such termination; provided that such vesting shall be contingent, at the discretion of the Company, upon the Employee executing a general release (which may include an agreement with respect to engagement in detrimental activity in a form acceptable to the Company) and such release becoming effective and irrevocable within the 60-day period following such termination;

(iii) involuntarily ceases to be an employee of the Employer following a Change in Control for any reason other than due to death, Disability or termination for Cause, then the RSUs covered by this Agreement, and any dividend equivalents with respect thereto, shall immediately vest (without proration based on the portion of the vesting period elapsed prior to such termination) and shall be paid in cash in accordance with Section 22(f) of the Plan within 60 days following the earliest time set forth in Section 22(c) of the Plan that will not trigger a tax or penalty under Section 409A of the Code, as determined by the Committee. Such vesting shall be contingent, at the discretion of the Company, upon the Employee executing a general release (which may include an agreement with respect to engagement in detrimental activity, in a form acceptable to the Company) and such release becoming effective and irrevocable within the 60-day period following such termination;

(iv) involuntarily ceases to be an employee of the Employer by reason of death or Disability, (1) the RSUs covered by this Agreement, and any dividend equivalents with respect thereto, shall immediately vest if such termination of employment occurs prior to a Change in Control and shall be settled within 60 days following the Vesting Date immediately following such termination] in accordance with Section 2, and (2) if such termination of employment occurs following a Change in Control, then the number of RSUs covered by this Agreement, and any dividend equivalents with respect thereto, shall immediately vest and shall be paid in cash in accordance with Section 22(f) of the Plan at the earliest time set forth in Section 22(c) of the Plan that will not trigger a tax or penalty under Section 409A of the Code, as determined by the Committee, in either case without proration based on the portion of the vesting period elapsed prior to such termination;

(v) involuntarily ceases to be an employee of the Employer (A) due to termination for Cause or (B) prior to the nine-month anniversary of the grant date of the RSUs and prior to a Change in Control for any reason other than due to death or Disability, the RSUs shall be cancelled and forfeited on the date of such termination of employment; and

(vi) voluntarily ceases to be an employee due to a Termination for Good Reason following a Change in Control, the number of RSUs covered by this Agreement, and any dividend equivalents with respect thereto, shall immediately vest (without proration based on the portion of the vesting period elapsed prior to such termination) and shall be paid in cash in accordance with Section 22(f) of the Plan within 60 days following the earliest time set forth in Section 22(c) of the Plan that will not trigger a tax or penalty under Section 409A of the Code, as determined by the Committee. Such vesting shall be contingent, at the discretion of the Company, upon the Employee executing a general release (which may include an agreement with respect to engagement in detrimental activity, in a form acceptable to the Company) and such release becoming effective and irrevocable within the 60-day period following such termination.

(b) Definitions. "Cause" means (i) a violation of any of the rules, policies, procedures or guidelines of the Employer, including but not limited to the Company's Business Ethics Policy and the Proprietary Information and Conflict of Interest Agreement (ii) any conduct which qualifies for "immediate discharge" under the Employer's Human Resource Policies as in effect from time to time (iii) rendering services to a firm which engages, or engaging directly or indirectly, in any business that is competitive with the Employer, or represents a conflict of interest with the interests of the Employer; (iv) conviction of, or entering a guilty plea with respect to, a crime whether or not connected with the Employer; or (v) any other conduct determined to be injurious, detrimental or prejudicial to any interest of the Employer.

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"Termination For Good Reason" has the meaning set forth in Section 22(a)(vi) of the Plan.

"Disability" shall include cessation of active employment due to commencement of long-term disability under the Employer's long-term disability plan or under a disability policy of any subsidiary or Affiliate, as applicable; provided that a Disability shall not be deemed to have occurred for such purposes unless the circumstances would also result in a "disability" within the meaning of Section 409A of the Code.

(c) Divestiture. Notwithstanding the above, the termination of Employee's employment with Employer in connection with the Employer's sale (whether by sale of assets or a subsidiary, or both) of a line of business within which the Employee was employed immediately prior to such sale as determined by the Committee in its sole discretion, that does not constitute a Change in Control, shall be treated as an involuntary termination of employment for purposes of this Agreement and the RSUs shall vest and be paid as provided in Section 9(a)(ii) above, whether or not such termination occurs after the nine-month anniversary of the grant date of the RSUs; provided, however, that, in the event the Employee is offered a comparable position (as determined by the Committee in accordance with the Company's severance policy) with the acquirer of such line of business and does not accept such offer, the RSUs shall be cancelled and forfeited on the date of termination of employment.

10. General Restrictions. If at any time the Committee or its authorized delegate, as applicable, shall determine, in its discretion, that the listing, registration or qualification of any shares of Common Stock subject to this Agreement upon any securities exchange or under any state or Federal law, or the consent or approval of any government regulatory body, is necessary or desirable as a condition of, or in connection with, the awarding of the RSUs or the issue or purchase of shares of Common Stock hereunder, the certificates for shares of Common Stock may not be issued in respect of RSUs in whole or in part unless such listing, registration, qualification, consent or approval shall have been effected or obtained free of any conditions not acceptable to the Committee or its authorized delegate, as applicable, and any delay caused thereby shall in no way affect the date of termination of the RSUs.

11. Responsibility for Taxes. The Employee acknowledges that the ultimate responsibility for the Employee's Federal, state and municipal individual income taxes, the Employee's portion of social security and other payroll taxes, and any other taxes related to the Employee's participation in the Plan and legally applicable to the Employee, is and remains his or her responsibility and may exceed the amount actually withheld by the Company or the Employer. In the event that there is withholding tax liability in connection with the vesting or settlement of RSUs, the Employee may satisfy, in whole or in part, any withholding tax liability: (a) by cash payment of an amount equal to such withholding liability; or (b) by having the Company withhold from the number of RSUs in which the Employee would be entitled to vest a number of shares of Common Stock having a fair value equal to such withholding tax liability in accordance with the Company's share withholding procedures.

12. Nature of Award. In accepting the award, the Employee acknowledges that:

(a) the Plan is established voluntarily by the Company, it is discretionary in nature and it may be modified, amended, suspended or terminated by the Company at any time in a manner consistent with Section 13 of the Plan regarding Plan amendment and termination and, in addition, the RSUs are subject to modification and adjustment under Section 6 of the Plan.

(a) the award of the RSUs is voluntary and occasional and does not create any contractual or other right to receive future grants of RSUs, or benefits in lieu of RSUs, even if RSUs have been granted repeatedly in the past;

(b) all decisions with respect to future RSU awards, if any, will be at the sole discretion of the Committee or its authorized delegate, as applicable;

(c) The Employee's participation in the Plan shall not create a right to further employment with the Employer and shall not interfere with the ability of the Employer to terminate Employee's employment relationship at any time; further, the RSU award and Employee's participation in the Plan will not be interpreted to form an employment contract or relationship with the Employer;

(d) The Employee is voluntarily participating in the Plan;

(e) the RSUs and the shares of Common Stock subject to the RSUs are an extraordinary item that does not constitute compensation of any kind for services of any kind rendered to the Employer, and which is outside the scope of the Employee's employment contract, if any;

(f) the RSUs and the shares of Common Stock subject to the RSUs are not intended to replace any pension rights or compensation;

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(g) the RSUs and the shares of Common Stock subject to the RSUs are not part of normal or expected compensation or salary for any purposes, including, but not limited to, calculating any severance, resignation, termination, redundancy, dismissal, end of service payments, bonuses, long-service awards, pension or retirement or welfare benefits or similar payments and in no event should be considered as compensation for, or relating in any way to, past services for the Employer;

(h) the future value of the underlying shares of Common Stock is unknown and cannot be predicted with certainty;

(i) in consideration of the award of the RSUs, no claim or entitlement to compensation or damages shall arise from forfeiture of the RSUs, including, but not limited to, forfeiture resulting from termination of the Employee's employment with the Employer (for any reason whatsoever and whether or not in breach of local labor laws) and the Employee irrevocably releases the Company and the Employer from any such claim that may arise; if, notwithstanding the foregoing, any such claim is found by a court of competent jurisdiction to have arisen, the Employee shall be deemed irrevocably to have waived the Employee's entitlement to pursue such claim; and

(j) subject to the provisions in the Plan regarding Change in Control, RSUs and the benefits under the Plan, if any, will not auto-matically transfer to another company in the case of a merger, take-over or transfer of liability.

13. No Advice Regarding Award. Neither the Company nor the Employer is providing any tax, legal or financial advice, nor is the Company or Employer making any recommendations regarding the Employee's participation in the Plan, or his or her acquisition or sale of the underlying shares of Common Stock. The Employee is hereby advised to consult with his or her own personal tax, legal and financial advisors regarding his or her partici-pation in the Plan before taking any action related to the Plan.

14. Amendment of This Agreement. With the consent of the Em-ployee, the Committee or its authorized delegate, as applicable, may amend this Agree-ment in a manner not inconsistent with the Plan.

15. Subsidiary. As used herein the term "subsidiary" shall mean any present or future corporation which would be a "subsidiary corpora-tion" of the Com-pany as the term is defined in Section 425 of the Internal Revenue Code (the "Code") of 1986 on the date of award.

16. Affiliate. As used herein the term "affiliate" shall mean any entity in which the Company has a significant equity interest, as deter-mined by the Committee.

17. Recoupments.

(a) If an employee or former employee of the Employer is reasonably deemed by the Committee or its authorized delegate, as applicable, to have engaged in detrimental activity against the Employer, any awards granted to such employee or former employee shall be cancelled and be of no further force or effect and any payment or delivery of an award from six months prior to such detrimental activity may be rescinded. In the event of any such rescission, the Employee shall pay to the Company the amount of any gain realized or payment received as a result of the rescinded exercise, payment or delivery, in such manner and on such terms and conditions as may be required by the Committee or its authorized delegate, as applicable. Detrimental activity may include:

(i) violating terms of a non-compete agreement with the Employer, if any;

(ii) disclosing confidential or proprietary business information of the Employer to any person or entity including but not limited to a competitor, vendor or customer without appropriate authorization from the Employer;

(iii) violating any rules, policies, procedures or guidelines of the Employer;

(iv) directly or indirectly soliciting any employee of the Employer to terminate employment with the Employer;

(v) directly or indirectly soliciting or accepting business from any customer or potential customer or encouraging any customer, potential customer or supplier of the Employer, to reduce the level of business it does with the Employer; or

(vi) engaging in any other conduct or act that is determined to be injurious, detrimental or prejudicial to any interest of the Employer.

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(b) If an accounting restatement by the Company is required in order to correct any material noncompliance with financial reporting requirements under relevant securities laws, the Company will have the authority to recover from executive officers or former executive officers, whether or not still employed by the Employer, any excess incentive-based compensation (in excess of what would have been paid under the accounting restatement), including entitlement to shares, provided under this Agreement to executive officers of the Employer, that was based on such erroneous data and paid during the three-year period preceding the date on which the Company is required to prepare the accounting restatement. Notwithstanding anything herein to the contrary, the Company may implement any policy or take any action with respect to the recovery of excess incentive-based compensation, including entitlement to shares of Common Stock that the Company determines to be necessary or advisable in order to comply with the requirements of the Dodd-Frank Wall Street Financial Reform and Consumer Protection Act.

18. Cancellation and Rescission of Award. Without limiting the foregoing Section regarding non-engagement in detrimental activity against the Employer, the Company may cancel any award provided hereunder if the Employee is not in compliance with all of the following conditions:

(a) The Employee shall not render services for any organization or engage directly or indirectly in any business which would cause the Employee to breach any of the post-employment prohibitions contained in any agreement between the Employer and the Employee.

(b) The Employee shall not, without prior written authorization from the Employer, disclose to anyone outside the Employer, or use in other than the Employer's business, any confidential information or material, as specified in any agreement between the Employer and the Employee which contains post-employment prohibitions, relating to the business of the Employer acquired by the Employee either during or after employment with the Employer.

Notwithstanding the above, this Agreement does not in any manner restrict the Employee from reporting possible violations of federal, state or local laws or regulations to any governmental agency or entity, and shall not, and not be interpreted to, impair the participant from exercising any legally protected whistleblower rights (including under Rule 21F under the Exchange Act). Similarly, the Employer does not in any manner restrict the Employee from participating in any proceeding or investigation by a federal, state or local government agency or entity responsible for enforcing such laws. The Employee is not required to notify the Employer that he or she has made such report or disclosure, or of his or her participation in an agency investigation or proceeding.

(c) The Employee, pursuant to any agreement between the Employer and the Employee which contains post-employment prohibitions, shall disclose promptly and assign to the Employer all right, title and interest in any invention or idea, patentable or not, made or conceived by the Employee during employment with the Employer, relating in any manner to the actual or anticipated busi-ness, research or development work of the Employer, and shall do anything reasonably necessary to enable the Employer to secure a patent where appropriate in the United States and in foreign countries.

(d) Failure to comply with the provision of subparagraphs (a), (b) or (c) of this Section 18 prior to, or during the six months after, any payment or delivery shall cause such payment or delivery to be rescinded. The Company shall notify the Employee in writing of any such rescission within two years after such payment or delivery. Within ten days after receiving such a notice from the Company, the Employee shall pay to the Company the amount of any payment received as a result of the rescinded payment or delivery pursuant to an award. Such payment to the Company by the Employee shall be made either in cash or by returning to the Company the number of shares of Common Stock that the Employee received in connection with the rescinded payment or delivery.

19. Notices. Notices hereunder shall be in writing and if to the Company shall be mailed to the Company at 100 Campus Dr. Suite 200 Florham Park, NJ 07932 USA, addressed to the attention of Stock Plan Administrator, and if to the Employee shall be delivered personally or mailed to the Employee at his address as the same appears on the records of the Company.

20. Language. If the Employee has received this Agreement or any other document related to the Plan translated into a language other than English and if the meaning of the translated version is different than the English version, the English version will control.

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21. Electronic Delivery and Acceptance. The Company will deliver any documents related to current or future participation in the Plan by electronic means. The Employee hereby consents to receive such documents by electronic delivery, and agrees to participate in the Plan and be bound by the terms and conditions of this Agreement, through an on-line or electronic system established and maintained by the Company or a third party designated by the Company. Electronic acceptance by the Employee is required and the award will be cancelled for any employee who fails to comply with the Company's acceptance requirement within six months of the effective date of the award.

22. Interpretation of This Agreement. The Committee or its authorized delegate, as applicable, shall have the authority to interpret the Plan and this Agreement and to take whatever administrative actions, including correction of administrative errors in the awards subject to this Agreement and in this Agreement, as the Committee or its authorized delegate, as applicable, in its sole good faith judgment shall determine to be advisable. All decisions, interpretations and administrative actions made by the Committee or its authorized delegate, as applicable, hereunder or under the Plan shall be binding and conclusive on the Company and the Employee. In the event there is inconsistency between the provisions of this Agreement and of the Plan, the provisions of the Plan shall govern.

23. Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the parties hereto and the successors and assigns of the Company and to the extent provided in Section 11 of the Plan to the personal representatives, legatees and heirs of the Employee.

24. Governing Law and Venue. The validity, construction and effect of the Agreement and any actions taken under or relating to this Agreement shall be determined in accordance with the laws of the state of New York and applicable Federal law.

This grant is made and/or administered in the United States. For purposes of litigating any dispute that arises under this grant or the Agreement the parties hereby submit to and consent to the jurisdiction of the state of New York, agree that such litigation shall be conducted in the state or federal courts located in New York.

25. Section 409A. It is intended that the provisions of this Agreement comply with, or are exempt from, Section 409A, and all provisions of this Agreement shall be construed and interpreted in a manner consistent with the requirements for avoiding taxes or penalties under Section 409A.

Neither the Employee nor any of the Employee's creditors or beneficiaries shall have the right to subject any deferred compensation (within the meaning of Section 409A) payable under this Agreement to any anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, attachment or garnishment. Except as permitted under Section 409A, any deferred compensation (within the meaning of Section 409A) payable to the Employee or for the Employee's benefit under this Agreement may not be reduced by, or offset against, any amount owing by the Employee to the Company or any of its Affiliates. In the event that any 60-day period described in Section 9 of this Agreement straddles two calendar years, then any RSUs, and any dividends with respect thereto, that are settled within such 60-day period in accordance with this Agreement shall be settled in the second calendar year.

If, at the time of the Employee's separation from service (within the meaning of Section 409A), (a) the Employee shall be a specified employee (within the meaning of Section 409A and using the identification methodology selected by the Company from time to time) and (b) the Company shall make a good faith determination that an amount payable hereunder constitutes deferred compensation (within the meaning of Section 409A) the payment of which is required to be delayed pursuant to the six-month delay rule set forth in Section 409A in order to avoid taxes or penalties under Section 409A, then the Company shall not pay such amount on the otherwise scheduled payment date but shall instead pay it, without interest, on the first business day after such six-month period.

Notwithstanding any provision of this Agreement to the contrary, in light of the uncertainty with respect to the proper application of Section 409A, the Company reserves the right to make amendments to this Agreement as the Company deems necessary or desirable to avoid the imposition of taxes or penalties under Section 409A. In any case, the Employee shall be solely responsible and liable for the satisfaction of all taxes and penalties that may be imposed on the Employee or for the Employee's account in connection with this Agreement (including any taxes and penalties under Section 409A), and neither the Company nor any of its Affiliates shall have any obligation to indemnify or otherwise hold the Employee harmless from any or all of such taxes or penalties.

26. Separability. In case any provision in the Agreement, or in any other instrument referred to herein, shall become invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions in the Agreement, or in any other instrument referred to herein, shall not in any way be affected or impaired thereby.

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27. Integration of Terms. Except as otherwise provided in this Agreement, this Agreement contains the entire agreement between the parties relating to the subject matter hereof and supersedes any and all oral statements and prior writings with respect thereto.

28. Appendix for Non-U.S. Countries. Notwithstanding any provisions in this Agreement, the RSU award shall be subject to any special terms and conditions set forth in any appendix to this Agreement for the Employee's country (the "Appendix"). Moreover, if the Employee relocates to one of the countries included in the Appendix, the special terms and conditions for such country will apply to the Employee, to the extent the Company determines that the application of such terms and conditions is necessary or advisable in order to comply with local law or facilitate the administration of the Plan. The Appendix constitutes part of this Agreement.

2 9 . Imposition of Other Requirements. The Committee or its authorized delegate, as applicable, reserves the right to impose other requirements on the Employee's participation in the Plan, on the RSUs and on any shares of Common Stock acquired under the Plan, to the extent the Committee or its authorized delegate, as applicable, determines it is nec-essary or advisable in order to comply with local law or facilitate the administration of the Plan, and to require the Employee to sign any additional agreements or undertakings that may be necessary to accomplish the foregoing.

IN WITNESS WHEREOF, the Company has executed this Agreement as of the day and year set forth on the Award Summary.

CONDUENT INCORPORATED

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Signature

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PERFORMANCE STOCK UNIT AWARD AGREEMENT PURSUANT TO CONDUENT INCORPORATED PERFORMANCE INCENTIVE PLAN

AGREEMENT, by Conduent Incorporated, a New York corporation (the "Company"), dated as of the date that appears in the award summary that provides the number of Performance Stock Units and vesting provisions of the award (the "Award Summary"), in favor of the individual whose name appears on the Award Summary (the "Employee"), who is an employee of the Company, one of the Company's subsidiaries or one of its affiliates (the Company, or such subsidiary or affiliate, the "Employer").

In accordance with the provisions of the Conduent Performance Incentive Plan (the "Plan"), the Compensation Committee of the Board of Directors of the Company (the "Committee") or the Chief Executive Officer of the Company (the "CEO") has authorized the execution and delivery of this Agreement.

Terms used herein that are defined in the Plan or in this Agreement shall have the meanings assigned to them in the Plan or this Agreement, respectively.

The Award Summary contains the details of the awards covered by this Agreement and is incorporated herein in its entirety.

NOW, THEREFORE, in consideration of the premises and for other good and valuable consideration, the Company agrees as follows:

AWARDS

1. Award of Performance Stock Units. Subject to all terms and conditions of the Plan and this Agreement, the Company has awarded to the Employee on the date indicated on the Award Summary Performance Stock Units (individually, a "PS") as shown on the Award Summary, representing the target number of shares of Common Stock covered by this Agreement (the "Target PSs"). Notwithstanding anything herein to the contrary, only active employees and those employees on Short Term Disability Leave, Social Service Leave, Family Medical Leave or Paid Uniform Services Leave (pursuant to the Company's Human Resources Policies or similar policies of the Company's subsidiaries or affiliates) on the effective date of the award as shown on the Award Summary shall be eligible to receive the award.

TERMS OF THE PERFORMANCE STOCK UNITS

2. Entitlement to Shares. As soon as practicable on or after the Vesting Date (as defined below) (or such earlier date provided in Section 9) in connection with the PSs, the Company shall deliver to the Employee, in such manner as the Company shall determine, a number of shares of Common Stock equal to the number of vested PSs (subject to reduction for withholding of the Employee's taxes in relation to the award as described in Section 11) within 60 days following the Vesting Date (or, if earlier, a distribution event set forth in Section 9 that satisfies the requirements of Section 409A(a)(2) of the Code).

No fractional shares shall be issued pursuant to this Agreement. Instead, the Company shall apply the equivalent of any fractional share amount to amounts withheld for taxes. Notwithstanding the foregoing, the Company shall be entitled to delay delivery of such shares of Common Stock (or cash payment in lieu thereof, as applicable) until it shall have received from the Employee a duly executed Form W-8 or W-9, as applicable, and any other information or completed forms the Company may reasonably require.

3. Vesting. Except as otherwise determined by the Committee in its sole discretion (subject to Section 23 of the Plan) or as otherwise provided in this Section 3 or Section 9, the vesting of the PSs covered hereby shall be subject to (i) the achievement of the performance goals as set forth in the Award Summary (the "Performance Goals") as determined by the Committee and (ii) the Employee's continued employment with the Company or a subsidiary or affiliate through December 31, 2021 (the "Vesting Date"). In the event the achievement of the Performance Goals is "below threshold" level, then all of the PSs will be forfeited; in the event that achievement of the Performance Goals is between "threshold" and "target" level, then no less than 50% and no more than 100% of the Target PSs will vest; and in the event achievement of the Performance Goals is between "target" and "maximum" level, then no less than 100% and no more than 200% of the Target PSs will vest, in each case as set forth in the Award Summary and subject to the Employee's continued employment through the Vesting Date as described in clause (ii) of the immediately preceding sentence.

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Upon the occurrence of an event constituting a Change in Control prior to the Vesting Date, notwithstanding anything to the contrary in Section 22(b) of the Plan, the Performance Goals shall be deemed achieved at target level, but thereafter the PSs, and any dividend equivalents with respect thereto, shall remain outstanding and thereafter the vesting of such PSs, and any dividend equivalents with respect thereto, shall be subject to the Employee's continued employment with the Company or a subsidiary or an affiliate through the Vesting Date, at which time such PSs shall be paid in cash in accordance with Section 22(f) of the Plan at the earliest time set forth in Section 22(c) of the Plan that will not trigger tax or penalty under Section 409A of the Code, as determined by the Committee; provided that such PSs, and any dividend equivalents with respect thereto, shall vest and shall be paid to the extent provided in Section 9 in the event of the Employee's termination of employment following such Change in Control and prior to the Vesting Date or in the event such Change in Control occurs following a termination of the Employee's employment. Upon payment pursuant to the terms of the Plan, such awards shall be cancelled.

4. Dividend Equivalents. The Employee shall become entitled to receive from the Company on the Vesting Date (or such earlier date provided in Section 9) a cash payment equaling the same amount(s) that the holder of record of a number of shares of Common Stock equal to the number of vested PSs (if any) would have been entitled to receive as dividends on such Common Stock during the period commencing on the effective date hereof and ending on the Vesting Date (or such earlier date provided in Section 9) as provided under Section 3. Payments under this Section shall be net of any required withholding taxes.

OTHER TERMS

5 . Ownership Guidelines. Guidelines pertaining to the Employee's required ownership of Common Stock (the "Stock Ownership Guidelines") shall be determined by the Committee or its authorized delegate, as applicable, in its sole discretion from time to time as communicated to the Employee in writing.

6 . Holding Requirements. In the event of non-compliance with the Stock Ownership Guidelines under Section 5 hereof, following a five-year noncompliance period as described in the Stock Ownership Guidelines, the Employee must retain fifty percent (50%) of the net shares of Common Stock acquired in connection with the vesting of PSs (net of withholding tax and any applicable fees) until the threshold set forth in the Stock Ownership Guidelines is satisfied. Such shares shall be held in the Employee's Morgan Stanley account or in another account acceptable to the Company. In addition, shares used to maintain the Employee's ownership level pursuant to this award should be held with Morgan Stanley or in another account acceptable to the Company.

7. Voting Rights/ Dividends. Except as otherwise provided herein, the Employee shall have no rights as a shareholder with respect to the PSs until the date of issuance of a stock certificate to him for such PSs and no adjustment shall be made for dividends or other rights for which the record date is prior to the date the PSs become vested.

8. Non-Assignability. Unless otherwise provided by the Committee in its discretion, PSs may not be sold, assigned, alienated, transferred, pledged, attached or otherwise encumbered except as provided in Section 11 of the Plan. Any purported sale, assignment, alienation, transfer, pledge, attachment or other encumbrance of a PS in violation of the provisions of this Section 8 and Section 11 of the Plan shall be void.

9. Effect of Termination of Employment or Death.

(a) Effect on PSs. In the event the Employee

(i) voluntarily ceases to be an employee of the Employer for any reason other than Termination For Good Reason following a Change in Control, the PSs that have not vested in accordance with Section 3 shall be canceled and forfeited on the date of such voluntary termination of employment;

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(ii) involuntarily ceases to be an employee of the Employer on or after the nine-month anniversary of the grant date of PSs and prior to a Change in Control for any reason other than due to death, Disability or a termination for Cause, the number of PSs covered by this Agreement, and any dividend equivalents with respect thereto, shall be prorated based on a fraction, the numerator of which is the number of full months elapsed during the three-year performance period prior to such termination of employment and the denominator of which is 36, and any remaining PSs shall be forfeited. The vesting of such prorated number of PSs, and any dividend equivalents with respect thereto, shall remain subject to the achievement of the Performance Goals in accordance with Section 3 and shall be settled within 60 days following the Vesting Date in accordance with Section 2. Such vesting shall be contingent, at the discretion of the Company, upon the Employee executing a general release (which may include an agreement with respect to engagement in detrimental activity, in a form acceptable to the Company) and such release becoming effective and irrevocable within the 60-day period following such termination;

(iii) involuntarily ceases to be an employee of the Employer following a Change in Control for any reason other than due to death, Disability or termination for Cause, then the PSs (the Performance Goals for which shall have been deemed achieved at target level, pursuant to Section 3), and any dividend equivalents with respect thereto, shall immediately vest (without proration based on the portion of the three-year performance period elapsed prior to such termination) and shall be paid in cash in accordance with Section 22(f) of the Plan within 60 days following the earliest time set forth in Section 22(c) of the Plan that will not trigger a tax or penalty under Section 409A of the Code, as determined by the Committee. Such vesting shall be contingent, at the discretion of the Company, upon the Employee executing a general release (which may include an agreement with respect to engagement in detrimental activity, in a form acceptable to the Company) and such release becoming effective and irrevocable within the 60-day period following such termination;

(iv) involuntarily ceases to be an employee of the Employer by reason of death or Disability, (1) the vesting of the PSs shall remain subject to the achievement of the Performance Goals in accordance with Section 3, if such termination of employment occurs prior to a Change in Control and shall be settled on the Vesting Date in accordance with Section 2, and (2) if such termination of employment occurs following a Change in Control, then the PSs (the Performance Goals for which shall have been deemed achieved at target level, pursuant to Section 3), and any dividend equivalents with respect thereto, shall immediately vest and shall be paid in cash in accordance with Section 22(f) of the Plan at the earliest time set forth in Section 22(c) of the Plan that will not trigger a tax or penalty under Section 409A of the Code, as determined by the Committee, in either case without proration based on the portion of the three-year performance period elapsed prior to such termination;

(v) involuntarily ceases to be an employee of the Employer (A) due to termination for Cause or (B) prior to the nine-month anniversary of the grant date of the PSs and prior to a Change in Control for any reason other than due to death or Disability, the PSs shall be cancelled and forfeited on the date of such termination of employment; and

(vi) voluntarily ceases to be an employee due to a Termination for Good Reason following a Change in Control, the PSs (the Performance Goals for which shall have been deemed achieved at target level, pursuant to Section 3), and any dividend equivalents with respect thereto, shall immediately vest and shall be paid in cash in accordance with Section 22(f) of the Plan within 60 days following the earliest time set forth in Section 22(c) of the Plan that will not trigger a tax or penalty under Section 409A of the Code, as determined by the Committee, without proration based on the portion of the three-year performance period elapsed prior to such termination. Such vesting shall be contingent, at the discretion of the Company, upon the Employee executing a general release (which may include an agreement with respect to engagement in detrimental activity, in a form acceptable to the Company) and such release becoming effective and irrevocable within the 60-day period following such termination.

(b) Definitions. "Cause" means (i) a violation of any of the rules, policies, procedures or guidelines of the Employer, including but not limited to the Company's Business Ethics Policy and the Proprietary Information and Conflict of Interest Agreement (ii) any conduct which qualifies for "immediate discharge" under the Employer's Human Resource Policies as in effect from time to time (iii) rendering services to a firm which engages, or engaging directly or indirectly, in any business that is competitive with the Employer, or represents a conflict of interest with the interests of the Employer; (iv) conviction of, or entering a guilty plea with respect to, a crime whether or not connected with the Employer; or (v) any other conduct determined to be injurious, detrimental or prejudicial to any interest of the Employer.

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"Termination For Good Reason" has the meaning set forth in Section 22(a)(vi) of the Plan.

"Disability" shall include cessation of active employment due to commencement of long-term disability under the Employer's long-term disability plan or under a disability policy of any subsidiary or Affiliate, as applicable; provided that a Disability shall not be deemed to have occurred for such purposes unless the circumstances would also result in a "disability" within the meaning of Section 409A of the Code.

(c) Divestiture. Notwithstanding the above, the termination of Employee's employment with Employer in connection with the Employer's sale (whether by sale of assets or a subsidiary, or both) of a line of business within which the Employee was employed immediately prior to such sale as determined by the Committee in its sole discretion, that does not constitute a Change in Control, shall be treated as an involuntary termination of employment for purposes of this Agreement and the PSs shall vest and be paid as provided in Section 9(a)(ii) above, whether or not such termination occurs after the nine-month anniversary of the grant date of the PSs; provided, however, that, in the event the Employee is offered a comparable position (as determined by the Committee in accordance with the Company's severance policy) with the acquirer of such line of business and does not accept such offer, the PSs shall be cancelled and forfeited on the date of termination of employment.

10. General Restrictions. If at any time the Committee or its authorized delegate, as applicable, shall determine, in its discretion, that the listing, registration or qualification of any shares of Common Stock subject to this Agreement upon any securities exchange or under any state or Federal law, or the consent or approval of any government regulatory body, is necessary or desirable as a condition of, or in connection with, the awarding of the PSs or the issue or purchase of shares of Common Stock hereunder, the certificates for shares of Common Stock may not be issued in respect of PSs in whole or in part unless such listing, registration, qualification, consent or approval shall have been effected or obtained free of any conditions not acceptable to the Committee or its authorized delegate, as applicable, and any delay caused thereby shall in no way affect the date of termination of the PSs.

11. Responsibility for Taxes. The Employee acknowledges that the ultimate responsibility for the Employee's Federal, state and municipal individual income taxes, the Employee's portion of social security and other payroll taxes, and any other taxes related to the Employee's participation in the Plan and legally applicable to the Employee, is and remains his or her responsibility and may exceed the amount actually withheld by the Company or the Employer. In the event that there is withholding tax liability in connection with the vesting or settlement of the PSs, the Employee may satisfy, in whole or in part, any withholding tax liability: (a) by cash payment of an amount equal to such withholding liability; or (b) by having the Company withhold from the number of PSs in which the Employee would be entitled to vest a number of shares of Common Stock having a fair value equal to such withholding tax liability in accordance with the Company's share withholding procedures.

12. Nature of Award. In accepting the award, the Employee acknowledges that:

(a) the Plan is established voluntarily by the Company, it is discretionary in nature and it may be modified, amended, suspended or terminated by the Company at any time in a manner consistent with Section 13 of the Plan regarding Plan amendment and termination and, in addition, the PSs are subject to modification and adjustment under Section 6 of the Plan.

(a) the award of the PSs is voluntary and occasional and does not create any contractual or other right to receive future grants of PSs, or benefits in lieu of PSs, even if PSs have been granted repeatedly in the past;

(b) all decisions with respect to future PS awards, if any, will be at the sole discretion of the Committee or its authorized delegate, as applicable;

(c) The Employee's participation in the Plan shall not create a right to further employment with the Employer and shall not interfere with the ability of the Employer to terminate Employee's employment relationship at any time; further, the PS award and Employee's participation in the Plan will not be interpreted to form an employment contract or relationship with the Employer;

(d) The Employee is voluntarily participating in the Plan;

(e) the PSs and the shares of Common Stock subject to the PSs are an extraordinary item that does not constitute compensa-tion of any kind for services of any kind rendered to the Employer, and which is outside the scope of the Employee's employment contract, if any;

(f) the PSs and the shares of Common Stock subject to the PSs are not intended to replace any pension rights or compensation;

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(g) the PSs and the shares of Common Stock subject to the PSs are not part of normal or expected compensation or salary for any purposes, including, but not limited to, calculating any severance, resignation, termination, redundancy, dismissal, end of service payments, bonuses, long-service awards, pension or retirement or welfare benefits or similar payments and in no event should be considered as compensation for, or relating in any way to, past services for the Employer;

(h) the future value of the underlying shares of Common Stock is unknown and cannot be predicted with certainty;

(i) in consideration of the award of the PSs, no claim or entitlement to compensation or damages shall arise from forfeiture of the PSs, including, but not limited to, forfeiture resulting from termination of the Employee's employment with the Employer (for any reason whatsoever and whether or not in breach of local labor laws) and the Employee irrevocably releases the Company and the Employer from any such claim that may arise; if, notwithstanding the foregoing, any such claim is found by a court of competent jurisdiction to have arisen, the Employee shall be deemed irrevocably to have waived the Employee's entitlement to pursue such claim; and

(j) subject to the provisions in the Plan regarding Change in Control, PSs and the benefits under the Plan, if any, will not auto-matically transfer to another company in the case of a merger, take-over or transfer of liability.

13. No Advice Regarding Award. Neither the Company nor the Employer is providing any tax, legal or financial advice, nor is the Company or Employer making any recommendations regarding the Employee's participation in the Plan, or his or her acquisition or sale of the underlying shares of Common Stock. The Employee is hereby advised to consult with his or her own personal tax, legal and financial advisors regarding his or her partici-pation in the Plan before taking any action related to the Plan.

14. Amendment of This Agreement. With the consent of the Em-ployee, the Committee or its authorized delegate, as applicable, may amend this Agree-ment in a manner not inconsistent with the Plan.

15. Subsidiary. As used herein the term "subsidiary" shall mean any present or future corporation which would be a "subsidiary corpora-tion" of the Com-pany as the term is defined in Section 425 of the Internal Revenue Code (the "Code") of 1986 on the date of award.

16. Affiliate. As used herein the term "affiliate" shall mean any entity in which the Company has a significant equity interest, as deter-mined by the Committee.

17. Recoupments.

(a) If an employee or former employee of the Employer is reasonably deemed by the Committee or its authorized delegate, as applicable, to have engaged in detrimental activity against the Employer, any awards granted to such employee or former employee shall be cancelled and be of no further force or effect and any payment or delivery of an award from six months prior to such detrimental activity may be rescinded. In the event of any such rescission, the Employee shall pay to the Company the amount of any gain realized or payment received as a result of the rescinded exercise, payment or delivery, in such manner and on such terms and conditions as may be required by the Committee or its authorized delegate, as applicable. Detrimental activity may include:

(i) violating terms of a non-compete agreement with the Employer, if any;

(ii) disclosing confidential or proprietary business information of the Employer to any person or entity including but not limited to a competitor, vendor or customer without appropriate authorization from the Employer;

(iii) violating any rules, policies, procedures or guidelines of the Employer;

(iv) directly or indirectly soliciting any employee of the Employer to terminate employment with the Employer;

(v) directly or indirectly soliciting or accepting business from any customer or potential customer or encouraging any customer, potential customer or supplier of the Employer, to reduce the level of business it does with the Employer; or

(vi) engaging in any other conduct or act that is determined to be injurious, detrimental or prejudicial to any interest of the Employer.

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(b) If an accounting restatement by the Company is required in order to correct any material noncompliance with financial reporting requirements under relevant securities laws, the Company will have the authority to recover from executive officers or former executive officers, whether or not still employed by the Employer, any excess incentive-based compensation (in excess of what would have been paid under the accounting restatement), including entitlement to shares, provided under this Agreement to executive officers of the Employer, that was based on such erroneous data and paid during the three-year period preceding the date on which the Company is required to prepare the accounting restatement. Notwithstanding anything herein to the contrary, the Company may implement any policy or take any action with respect to the recovery of excess incentive-based compensation, including entitlement to shares of Common Stock that the Company determines to be necessary or advisable in order to comply with the requirements of the Dodd-Frank Wall Street Financial Reform and Consumer Protection Act.

18. Cancellation and Rescission of Award. Without limiting the foregoing Section regarding non-engagement in detrimental activity against the Employer, the Company may cancel any award provided hereunder if the Employee is not in compliance with all of the following conditions:

(a) The Employee shall not render services for any organization or engage directly or indirectly in any business which would cause the Employee to breach any of the post-employment prohibitions contained in any agreement between the Employer and the Employee.

(b) The Employee shall not, without prior written authorization from the Employer, disclose to anyone outside the Employer, or use in other than the Employer's business, any confidential information or material, as specified in any agreement between the Employer and the Employee which contains post-employment prohibitions, relating to the business of the Employer acquired by the Employee either during or after employment with the Employer.

Notwithstanding the above, this Agreement does not in any manner restrict the Employee from reporting possible violations of federal, state or local laws or regulations to any governmental agency or entity, and shall not, and not be interpreted to, impair the participant from exercising any legally protected whistleblower rights (including under Rule 21F under the Exchange Act). Similarly, the Employer does not in any manner restrict the Employee from participating in any proceeding or investigation by a federal, state or local government agency or entity responsible for enforcing such laws. The Employee is not required to notify the Employer that he or she has made such report or disclosure, or of his or her participation in an agency investigation or proceeding.

(c) The Employee, pursuant to any agreement between the Employer and the Employee which contains post-employment prohibitions, shall disclose promptly and assign to the Employer all right, title and interest in any invention or idea, patentable or not, made or conceived by the Employee during employment with the Employer, relating in any manner to the actual or anticipated busi-ness, research or development work of the Employer, and shall do anything reasonably necessary to enable the Employer to secure a patent where appropriate in the United States and in foreign countries.

(d) Failure to comply with the provision of subparagraphs (a), (b) or (c) of this Section 18 prior to, or during the six months after, any payment or delivery shall cause such payment or delivery to be rescinded. The Company shall notify the Employee in writing of any such rescission within two years after such payment or delivery. Within ten days after receiving such a notice from the Company, the Employee shall pay to the Company the amount of any payment received as a result of the rescinded payment or delivery pursuant to an award. Such payment to the Company by the Employee shall be made either in cash or by returning to the Company the number of shares of Common Stock that the Employee received in connection with the rescinded payment or delivery.

19. Notices. Notices hereunder shall be in writing and if to the Company shall be mailed to the Company at 100 Campus Dr. Suite 200 Florham Park, NJ 07932 USA, addressed to the attention of Stock Plan Administrator, and if to the Employee shall be delivered personally or mailed to the Employee at his address as the same appears on the records of the Company.

20. Language. If the Employee has received this Agreement or any other document related to the Plan translated into a language other than English and if the meaning of the translated version is different than the English version, the English version will control.

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21. Electronic Delivery and Acceptance. The Company will deliver any documents related to current or future participation in the Plan by electronic means. The Employee hereby consents to receive such documents by electronic delivery, and agrees to participate in the Plan and be bound by the terms and conditions of this Agreement, through an on-line or electronic system established and maintained by the Company or a third party designated by the Company. Electronic acceptance by the Employee is required and the award will be cancelled for any employee who fails to comply with the Company's acceptance requirement within six months of the effective date of the award.

22. Interpretation of This Agreement. The Committee or its authorized delegate, as applicable, shall have the authority to interpret the Plan and this Agreement and to take whatever administrative actions, including correction of administrative errors in the awards subject to this Agreement and in this Agreement, as the Committee or its authorized delegate, as applicable, in its sole good faith judgment shall determine to be advisable. All decisions, interpretations and administrative actions made by the Committee or its authorized delegate, as applicable, hereunder or under the Plan shall be binding and conclusive on the Company and the Employee. In the event there is inconsistency between the provisions of this Agreement and of the Plan, the provisions of the Plan shall govern.

23. Successors and Assigns. This Agreement shall be binding upon and inure to the benefit of the parties hereto and the successors and assigns of the Company and to the extent provided in Section 11 of the Plan to the personal representatives, legatees and heirs of the Employee.

24. Governing Law and Venue. The validity, construction and effect of the Agreement and any actions taken under or relating to this Agreement shall be determined in accordance with the laws of the state of New York and applicable Federal law.

This grant is made and/or administered in the United States. For purposes of litigating any dispute that arises under this grant or the Agreement the parties hereby submit to and consent to the jurisdiction of the state of New York, agree that such litigation shall be conducted in the state or federal courts located in New York.

25. Section 409A. It is intended that the provisions of this Agreement comply with, or are exempt from, Section 409A, and all provisions of this Agreement shall be construed and interpreted in a manner consistent with the requirements for avoiding taxes or penalties under Section 409A.

Neither the Employee nor any of the Employee's creditors or beneficiaries shall have the right to subject any deferred compensation (within the meaning of Section 409A) payable under this Agreement to any anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, attachment or garnishment. Except as permitted under Section 409A, any deferred compensation (within the meaning of Section 409A) payable to the Employee or for the Employee's benefit under this Agreement may not be reduced by, or offset against, any amount owing by the Employee to the Company or any of its Affiliates. In the event that any 60-day period described in Section 9 of this Agreement straddles two calendar years, then any PSs, and any dividends with respect thereto, that are settled within such 60-day period in accordance with this Agreement shall be settled in the second calendar year

If, at the time of the Employee's separation from service (within the meaning of Section 409A), (a) the Employee shall be a specified employee (within the meaning of Section 409A and using the identification methodology selected by the Company from time to time) and (b) the Company shall make a good faith determination that an amount payable hereunder constitutes deferred compensation (within the meaning of Section 409A) the payment of which is required to be delayed pursuant to the six-month delay rule set forth in Section 409A in order to avoid taxes or penalties under Section 409A, then the Company shall not pay such amount on the otherwise scheduled payment date but shall instead pay it, without interest, on the first business day after such six-month period.

Notwithstanding any provision of this Agreement to the contrary, in light of the uncertainty with respect to the proper application of Section 409A, the Company reserves the right to make amendments to this Agreement as the Company deems necessary or desirable to avoid the imposition of taxes or penalties under Section 409A. In any case, the Employee shall be solely responsible and liable for the satisfaction of all taxes and penalties that may be imposed on the Employee or for the Employee's account in connection with this Agreement (including any taxes and penalties under Section 409A), and neither the Company nor any of its Affiliates shall have any obligation to indemnify or otherwise hold the Employee harmless from any or all of such taxes or penalties.

26. Separability. In case any provision in the Agreement, or in any other instrument referred to herein, shall become invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions in the Agreement, or in any other instrument referred to herein, shall not in any way be affected or impaired thereby.

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27. Integration of Terms. Except as otherwise provided in this Agreement, this Agreement contains the entire agreement between the parties relating to the subject matter hereof and supersedes any and all oral statements and prior writings with respect thereto.

28. Appendix for Non-U.S. Countries. Notwithstanding any provisions in this Agreement, the PS award shall be subject to any special terms and conditions set forth in any appendix to this Agreement for the Employee's country (the "Appendix"). Moreover, if the Employee relocates to one of the countries included in the Appendix, the special terms and conditions for such country will apply to the Employee, to the extent the Company determines that the application of such terms and conditions is necessary or advisable in order to comply with local law or facilitate the administration of the Plan. The Appendix constitutes part of this Agreement.

29. Imposition of Other Requirements. The Committee or its authorized delegate, as applicable, reserves the right to impose other requirements on the Employee's participation in the Plan, on the PSs and on any shares of Common Stock acquired under the Plan, to the extent the Committee or its authorized delegate, as applicable, determines it is nec-essary or advisable in order to comply with local law or facilitate the administration of the Plan, and to require the Employee to sign any additional agreements or undertakings that may be necessary to accomplish the foregoing.

IN WITNESS WHEREOF, the Company has executed this Agreement as of the day and year set forth on the Award Summary.

CONDUENT INCORPORATED

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Signature

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SUBSIDIARIES OF CONDUENT INCORORATED

The following companies are subsidiaries of Conduent Incorporated as of December 31, 2018. Unless otherwise noted, a subsidiary is a company in which Conduent Incorporated or a subsidiary of Conduent Incorporated holds 50% or more of the voting stock. The names of other subsidiaries have been omitted as they would not, if considered in the aggregate as a single subsidiary, constitute a significant subsidiary:

Name of Subsidiary	Jurisdiction of Incorporation or Organization
Conduent Care Management, Inc.	Arizona
Conduent Healthy Communities Corporation	California
Conduent Asset Management Group, LLC	Delaware
Conduent BPO Services, Inc.	Delaware
Conduent Workers Compensation Holdings, Inc.	Delaware
Conduent Defense, LLC	Delaware
Conduent EDI Solutions, Inc.	Delaware
Conduent Education Loan Services LLC	Delaware
Conduent Global, Inc.	Delaware
Conduent Health Administration, Inc.	Delaware
Conduent Human Resources Services, LLC	Delaware
Conduent Lending, Inc.	Delaware
Conduent Middle East, Inc.	Delaware
Conduent TradeOne Marketing, Inc.	Delaware
Conduent Securities LLC	Delaware
Conduent Care Solutions, LLC	Delaware
Conduent Card Service LLC	Delaware
Conduent Finance, Inc.	Delaware
Conduent Education Industry Services, LLC	Delaware
Conduent Payment Integrity Solutions, Inc	Delaware
Conduent Public Health Solutions, Inc.	Delaware
Conduent ParkIndy, LLC	Delaware
Conduent Health Assessments, LLC	Delaware
The National Abandoned Property Processing Corporation	Delaware
Conduent Business Services, LLC	Delaware
Conduent Education Services, LLC	Delaware
Conduent Education Solutions, LLC	Delaware
Conduent European Funding LLC	Delaware
Conduent Export LLC	Delaware
Conduent Federal Solutions, LLC	Delaware
Conduent Helpline LLC	Delaware
Conduent Helpline Holdings, LLC	Delaware
Conduent Mortgage Services, Inc.	Delaware
Conduent Public Health Solutions, Inc.	Delaware
Conduent Credit Balance Solutions, LLC.	Delaware
Conduent Workers Compensation, LLC	Delaware
Conduent State Healthcare, LLC	Delaware
Integrated Call Center Solutions LLC	Delaware
United Call Center Solutions LLC	Delaware

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Conduent Healthcare Knowledge Solutions LLC	Florida
Conduent Transport Solutions, Inc.	Georgia
Conduent Wireless Data Services (Operations) Inc.	Idaho
Conduent Human Services, LLC	Indiana
Conduent Healthcare Information Services, Inc.	Indiana
Conduent Image Solutions, Inc.	Louisiana
Conduent Bill Review Corporation	Nevada
Conduent Commercial Solutions, LLC	Nevada
Conduent Patient Access Solutions, LLC	New Jersey
Conduent Compliance & Risk Consulting Corporation	New York
Conduent State & Local Solutions, Inc.	New York
Conduent Performance Improvement Solutions, Inc.	Oregon
Conduent Customer Care Solutions, Inc.	Oregon
Conduent HR Services, LLC	Pennsylvania
Conduent Healthcare Data Management, Inc.	Tennessee
Conduent Securities Services, Inc.	Texas
ACS Welfare Benefit Trust	Texas
Conduent Legal & Compliance Solutions, LLC	Texas
Mercury Fund II, Ltd.	Texas
Conduent Business Process Optimization Services, Inc.	Texas
Conduent WDS Global—Texas, Inc.	Texas
Conduent Heritage, LLC	Virginia
Conduent Learning Services, Inc.	Washington
Conduent Wireless Data Services North America Inc.	Washington
Conduent Care and Quality Solutions, Inc.	Wisconsin
Eagle Connect Sh.p.k.	Albania
Voice Star Sh.p.k.	Albania
Market Line S.A.	Argentina
Consilience Software Australasia Pty Ltd	Australia
Conduent Business Services (Australasia) PTY. LTD.	Australia
Wireless Data Services PTY Limited	Australia
Affiliated Computer Services Austria GmbH	Austria
Affiliated Computer Services International (Barbados) Limited	Barbados
Conduent (Belgium)	Belgium
ACS Transportation Services Participacoes Ltda	Brazil
Conduent Servicos de Terceirizacao de Processos de Negocios Ltda.	Brazil
Conduent Consultoria e Servicos de Recursos Humanos Ltda	Brazil
Conduent do Brasil Servicos de Call Center Ltda.	Brazil
Conduent Business Services Canada, Inc./Services D'affaires Conduent Canada Inc.	Canada
Conduent Solutions Chile SA	Chile

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ACS Road Technology Services (Beijing) Co. Ltd.	China
Affiliated Computer Services (Tianjin) Co., Ltd.	China
Customer Helpline Colombia S.A.S.	Colombia
ML Colombia S.A.	Colombia
Conduent Czech Republic s.r.o.	Czech Republic
Customer Helpline (Czech Republic), s.r.o.	Czech Republic
Conduent Solutions Dominican Republic, S.A.S.	Dominican Republic
Affiliated Computer Services (Fiji) Limited	Fiji
Conduent Business Process (France) Solutions (France) SAS	France
Conduent Business Solutions (France) SAS	France
Affiliated Computer Services of Germany GmbH	Germany
ACS Holdings (Germany) GmbH	Germany
Invoco Holding GmbH	Germany
Invoco Business Solutions GmbH	Germany
Invoco Communication Center GmbH	Germany
Invoco Customer Service GmbH	Germany
Invoco Helpline Communication GmbH	Germany
Invoco Helpline GmbH	Germany
Invoco Marketing & Vetrieb GmbH	Germany
Invoco Media Sales GmbH	Germany
Invoco Multimeida GmbH	Germany
Invoco Sales GmbH	Germany
Invoco Service Center GmbH	Germany
Invoco Services & Sales GmbH	Germany
Invoco Technical Service GmbH	Germany
ACS-BPS (Ghana) Limited	Ghana
Conduent Business Services de Guatemala, Sociedad Anonima	Guatemala
Customer Helpline (Guatemala), Sociedad Anonima	Guatemala
ACS China Solutions Hong Kong Limited	Hong Kong
Conduent Business Solutions (Hong Kong) Limited	Hong Kong
Bereichem Helpline India Private Limited	India
Conduent Business Services India LLP	India
Conduent Ireland Limited	Ireland
Conduent Business Services Italy S.r.l.	Italy
Nuova Karel Soluzioni S.r.l. unipersonale	Italy
Conduent Business Solutions Italia, S.p.A.	Italy
Conduent Solutions (Jamaica) Limited	Jamaica
Conduent Jamaica Limited	Jamaica
United Call Solutions (Jamaica) Limited	Jamaica
Sia Rigas Karte	Latvia
Affiliated Computer Services Holdings (Luxembourg) S.A.R.L.	Luxembourg
Conduent Business Services Malaysia Sdn. Bhd.	Malaysia
ACS Malta Limited	Malta

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Conduent de Mexico, S.A. de C.V.	Mexico
Conduent Helpline Mexico, S. de R.L. de C.V.	Mexico
Conduent Solutions de Mexico, S. de R.L. de C.V.	Mexico
Affiliated Computer Services International B.V.	Netherlands
Continuum Global Solutions Holdings B.V.	Netherlands
Customer Helpline (Netherland) B.V.	Netherlands
Customer Helpline Holdings (Netherlands) B.V.	Netherlands
Wilhaave Groep BV	Netherlands
Unamic Holding BV	Netherlands
Unamic/HCN BV	Netherlands
Conduent Business Services (Netherlands) B.V.	Netherlands
Market Line Peru S.A.C.	Peru
ACS Solutions Peru S.A.	Peru
Conduent Business Services Philippines, Inc.	Philippines
Conduent Solutions Philippines, Inc.	Philippines
Integrated Call Center Solutions (Philippines), Inc.	Philippines
ACS Solutions Poland Sp. Z.o.o.	Poland
Affiliated Computer Services of Poland Sp. z.o.o.	Poland
ACS Puerto Rico, LLC	Puerto Rico
Conduent Business Solutions of Puerto Rico, Inc.	Puerto Rico
Conduent Business Services Romania S.r.l.	Romania
Continuum Global Solutions Limited	Scotland
Conduent Europe Finance Limited Partnership	Scotland
Wireless Data Services (Asia Pacific) PTE Ltd.	Singapore
Conduent (PTY) LTD	South Africa
Affiliated Computer Services of Spain, S.L., Sociedad Unipersonal	Spain
Xerox Business Solutions Spain, S.L.	Spain
Conduent Holdings (St. Lucia) Ltd.	St. Lucia
Affiliated Computer Services GmbH	Switzerland
Conduent Business Solutions AG	Switzerland
Comtinuum Global Musteri Hizmetleri Limited Sirketi	Turkey
Unamic HCN Musteri Hizmetleri Limited Sirketi	Turkey
Conduent Business Process Solutions Limited	United Kingdom
Conduent Parking Enforcement Solutions Limited	United Kingdom
Wireless Data Services Limited	United Kingdom

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CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We hereby consent to the incorporation by reference in the Registration Statement on Form S-8 (No. 333-215361) of Conduent Incorporated of our report dated February 28, 2019, relating to the financial statements, financial statement schedule, and the effectiveness of internal control over financial reporting, which appears in this Form 10-K.

/S/ PRICEWATERHOUSECOOPERS LLP

PricewaterhouseCoopers LLP
Florham Park, New Jersey
February 28, 2019

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CEO CERTIFICATIONS

I, Ashok Vemuri, certify that:

1. I have reviewed this Annual Report on Form 10-K of Conduent Incorporated;

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

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

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

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

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

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

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

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

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

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

February 28, 2019

/s/ ASHOK VEMURI

Ashok Vemuri
Principal Executive Officer

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CFO CERTIFICATIONS

I, Brian Webb-Walsh, certify that:

1. I have reviewed this Annual Report on Form 10-K of Conduent Incorporated;

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

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

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

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

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

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

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

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

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

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

February 28, 2019

/s/ BRIAN WEBB-WALSH

Brian Webb-Walsh
Principal Financial Officer

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

In connection with the Form 10-K of Conduent Incorporated, a New York corporation (the "Company"), for the year ended December 31, 2017, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), Ashok Vemuri, Chief Executive Officer of the Company, and Brian Webb-Walsh, Chief Financial Officer of the Company, each hereby certifies, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, to the best of his/her knowledge, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ ASHOK VEMURI

Ashok Vemuri
Chief Executive Officer

February 28, 2019

/s/ BRIAN WEBB-WALSH

Brian Webb-Walsh
Chief Financial Officer

February 28, 2019

This certification accompanies this Report pursuant to § 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of § 18 of the Securities Exchange Act of 1934, as amended.

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

The information contained herein may not be copied, adapted or distributed and is not warranted to be accurate, complete or timely. The user assumes all risks for any damages or losses arising from any use of this information, except to the extent such damages or losses cannot be limited or excluded by applicable law. Past financial performance is no guarantee of future results.

Cotiviti Holdings, Inc.

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2017

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

For the transition period from to

Commission file number: 001-37787

Cotiviti Holdings, Inc.

(Exact name of registrant as specified in its charter)

Delaware **(State or other jurisdiction of incorporation or organization)**	**46-0595918** **(I.R.S. Employer Identification No.)**
115 Perimeter Center Place **Suite 700 Atlanta, GA** **(Address of principal executive offices)**	**30346** **(Zip Code)**

(770) 379-2800
(Registrant's telephone number, including area code)

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

Title of each class	Name of each exchange on which registered
Common Stock, $0.001 par value per share	**The New York Stock Exchange**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers in response to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K ☐

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

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐
Emerging growth company	☐		

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2017, the last business day of the Registrant's most recently completed fiscal year, the aggregate market value of the shares of voting and non-voting common stock of the Registrant held by non-affiliates was $979.0 million based on the last sales price of the Registrant's common stock as reported by the New York Stock Exchange on that day.

The number of issued and outstanding shares of the registrant's common stock, $0.001 par value, as of January 31, 2018, was 92,421,924.

DOCUMENTS INCORPORATED BY REFERENCE

Designated portions of the Registrant's Proxy Statement for its 2018 Annual Meeting of Stockholders, which is to be filed subsequent to the date hereof, are incorporated by reference into Part III of this Annual Report on Form 10-K, to the extent described therein.

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Definitions

*As used in this Annual Report on Form 10-K for the year ended December 31, 2017 (this "**Annual Report on Form 10−K**" or this "**Annual Report**"), the following abbreviations and terms have the meanings as listed below. Additionally, the terms "**Cotiviti**," "**we**," "**us**" and "**our**" refer to Cotiviti Holdings, Inc. and its consolidated subsidiaries, unless the context clearly indicates otherwise. The term "**Cotiviti Holdings**" refers only to Cotiviti Holdings, Inc. and not to any of its subsidiaries. Unless and as otherwise stated, any references in this Annual Report to any agreement means such agreement and all schedules, exhibits and attachments in each case as amended, restated, supplemented or otherwise modified to the date of filing this Annual Report.*

2012 Plan: refers to the Cotiviti Holdings, Inc. 2012 Equity Incentive Plan.

2016 Plan: refers to the Cotiviti Holdings, Inc. 2016 Equity Incentive Plan.

2018 Proxy Statement: refers to our definitive proxy statement for our 2018 Annual Meeting of Stockholders to be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our 2017 fiscal year.

ABR: refers to Alternate Base Rate as defined under the Restated Credit Agreement (with respect to borrowings under the First Lien Credit Facilities) or the Initial Secured Credit Facilities (with respect to borrowings under the Initial First Lien Credit Facilities and the Initial Second Lien Credit Facility).

Adjusted EBITDA: refers to net income (loss) before depreciation and amortization, impairment of intangible assets, interest expense, other non-operating (income) expense, income tax (benefit) expense, gain on discontinued operations, transaction-related expenses and other, stock-based compensation and loss on extinguishment of debt.

Advent: refers to Advent International Corporation, which controls funds that hold an aggregate of 44.9% of the combined voting power of our outstanding common stock as of December 31, 2017.

Affordable Care Act: refers to the Patient Protection and Affordable Care Act of 2010.

AROs: refers to asset retirement obligations.

ASC: refers to the FASB Accounting Standards Codification.

ASU: refers to Accounting Standards Update issued by the FASB.

Board: refers to the Board of Directors of Cotiviti Holdings, Inc.

Connolly: refers to Connolly Superholdings, Inc.

Connolly iHealth Merger: refers to the May 2014 merger of Connolly and iHealth Technologies.

CMS: refers to the Centers for Medicare and Medicaid Services, the United States federal agency which administers Medicare and Medicaid.

DGCL: refers to the Delaware General Corporation Law.

Equity Plans: refers, collectively, to the 2012 Plan and the 2016 Plan.

EPS: refers to earnings per share.

Exchange Act: refers to the United States Securities Exchange Act of 1934, as amended.

ESPP: refers, collectively, to our U.S. and Non-U.S. employee stock purchase plans, which became effective January 1, 2017, and were approved by our stockholders on May 25, 2017.

FASB: refers to the Financial Accounting Standards Board.

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FCPA: refers to the United States Foreign Corrupt Practices Act of 1977.

First Lien Credit Facilities: refers to the First Lien Term A Loans in the original principal amount of $250.0 million, the First Lien Term B Loans in the original principal amount of $550.0 million and the $100.0 million Revolver under the Restated Credit Agreement.

First Lien Term A Loans: refers to the First Lien Term A Loans in the original principal amount of $250.0 million under our Restated Credit Agreement.

First Lien Term B Loans: refers to the First Lien Term B Loans in the original principal amount of $550.0 million under our Restated Credit Agreement.

First Lien Term Loans: refers, collectively, to the First Lien Term A Loans and the First Lien Term B Loans under our Restated Credit Agreement.

GAAP: refers to generally accepted accounting principles in the United States.

HHS: refers to the United States Department of Health and Human Services.

HIPAA: we collectively refer to the United States Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH Act, together with their implementing regulations including the Omnibus Final Rule, as "HIPAA".

HITECH: refers to the United States Health Information Technology for Economic and Clinical Health Act of 2009, enacted as part of the American Recovery and Reinvestment Act of 2009, which amended HIPAA.

ICD-10: refers to the 10th revision of the International Statistical Classification of Diseases and Related Health Problems, a medical classification list adopted by the World Health Organization containing codes for, among other things, diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases.

iHealth Technologies: refers to iHealth Technologies, Inc.

Initial First Lien Credit Facilities: refers to the Initial First Lien Term Loan and the Initial First Lien Revolver.

Initial First Lien Term Loan: refers to the first lien term loan in the original principal amount of $810.0 million under our Initial Secured Credit Facilities.

Initial First Lien Revolver: refers to the $75.0 million first lien revolving facility under our Initial Secured Credit Facilities.

Initial Second Lien Credit Facility: refers to the second lien term loan in the original principal amount of $265.0 million under our Initial Secured Credit Facilities.

Initial Secured Credit Facilities: refers to the loans provided pursuant to the First Lien Credit Agreement, dated as of May 14, 2014, entered into by our subsidiary Cotiviti Corporation and certain of our other subsidiaries, as borrowers and/or guarantors, the lenders named therein, as lenders, and the agents named therein, pursuant to which the lenders agreed to provide the Initial First Lien Credit Facilities, comprising the $810.0 million Initial First Lien Term Loan and the $75.0 million Initial First Lien Revolver, and the $265.0 million Initial Second Lien Credit Facility. The Initial Secured Credit Facilities were refinanced in September 2016 with the First Lien Credit Facilities pursuant to the Restated Credit Agreement.

IPO: refers to an initial public offering of common equity.

IT: refers to information technology.

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LIBOR: refers to the London inter-bank offered rate.

Medicaid: refers to the means-tested United States government health care insurance program for people of all ages, jointly funded by state and federal governments and managed by the states. The Social Security Amendments of 1965 created Medicaid by adding Title XIX to the Social Security Act of 1935.

Medicare: refers to the United States government health care insurance program providing health insurance to people age 65 and older, regardless of income or medical history, as well as people of all ages with disabilities and certain medical conditions. The Social Security Amendments of 1965 created Medicare by adding Title XVIII to the Social Security Act of 1935.

Medicare Advantage: refers to a type of health insurance program within Part C of Medicare. Medicare Advantage plans generally provide a managed health care plan that is paid based on a monthly capitated fee.

Medicare RAC: refers to a Medicare Recovery Audit Contractor. We are one of the Medicare RACs for CMS under the Medicare Recovery Audit Program.

NYSE: refers to the New York Stock Exchange, on which our shares are listed under the symbol "COTV."

Omnibus Final Rule: refers to the Final Omnibus Privacy, Security, Breach Notification and Enforcement Rules, implemented in 2013, which amended the original Privacy, Security, Breach Notification and Enforcement Rules under HIPAA, as directed pursuant to the HITECH Act.

PHI: refers to protected health information as defined under HIPAA as an individual's health information that is created or received by a health care provider, health plan, employer, or health care clearinghouse and is related to the individual's health condition, provision of health care, or payment for the provision of health care and that identifies, or could reasonably identify, the individual.

PII: refers to personally identifiable information, which is information that permits the identity of an individual to whom the information applies to be reasonably inferred by either direct or indirect means.

Restated Credit Agreement: refers to the Amended and Restated First Lien Credit Agreement, dated as of September 28, 2016, entered into by our subsidiary Cotiviti Corporation and certain other of our subsidiaries, as borrowers and/or guarantors, the lenders named therein, as lenders, and the agents named therein, pursuant to which the lenders agreed to provide the First Lien Credit Facilities comprising the First Lien Term A Loans in the original principal amount of $250.0 million, the First Lien Term B Loans in the original principal amount of $550.0 million and the $100.0 million Revolver.

Revolver: refers to the $100.0 million first lien revolving credit facility under our Restated Credit Agreement.

Regulation FD: refers to Regulation Fair Disclosure promulgated by the SEC under the Exchange Act.

RowdMap: refers to RowdMap, Inc., which we acquired on July 14, 2017.

RowdMap Acquisition: refers to the July 14, 2017 acquisition of all of the outstanding shares of RowdMap.

RSUs: refers to restricted stock units.

Sarbanes-Oxley Act: refers to the United States Sarbanes-Oxley Act of 2002.

SEC: refers to the United States Securities and Exchange Commission.

SG&A: refers to selling, general and administrative expenses.

Special Cash Dividend: On May 26, 2016 we paid a Special Cash Dividend of $150.0 million, or $1.94 per share of common stock outstanding prior to the IPO, to holders of record of our common stock on the dividend record date. In

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connection with the Special Cash Dividend we lowered the exercise price of then outstanding stock options by $1.94 per share in order to preserve the intrinsic value of the options giving effect to the Special Cash Dividend.

Tax Act: refers to the Tax Cuts and Jobs Act enacted on December 22, 2017, which among other things, reduces the federal tax rate on U.S. earnings to 21%, effective January 1, 2018, and moves from a global taxation regime to a modified territorial regime.

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Cautionary note regarding forward-looking statements

This Annual Report on Form 10-K contains forward-looking statements within the meaning of the U.S. Private Securities Litigation Reform Act of 1995, Section 27A of the Securities Act and Section 21E of the Exchange Act. Forward-looking statements can be identified by words such as “anticipate,” estimate,” “expect,” “project,” “seek,” “plan,” “intend,” “believe,” “will,” “may,” “could,” “continue,” “likely,” “should” and similar references to future periods, or by the inclusion of forecasts or projections. Examples of forward-looking statements include, but are not limited to, statements we make regarding the outlook for our future business and financial performance.

Forward-looking statements are based on our current expectations and assumptions regarding our business, the economy and other future conditions. Because forward-looking statements relate to the future, by their nature, they are subject to inherent uncertainties, risks and changes in circumstances that are difficult to predict. As a result, our actual results may differ materially from those contemplated by the forward-looking statements. Important factors that could cause actual results to differ materially from those in the forward-looking statements include regional, national or global political, economic, business, competitive, market and regulatory conditions and the following:

- system interruptions or failures, including cyber-security breaches, identity theft or other disruptions that could compromise our information;
- our inability to successfully leverage our existing client base by expanding the volume of claims reviewed and cross-selling additional solutions;
- our clients declining to renew their agreements with us or renewing at lower performance fee levels;
- our failure to innovate and develop new solutions for our clients;
- delays in implementing our solutions;
- our failure to maintain or upgrade our operational platforms;
- inability to develop new clients;
- improvements to healthcare claims and retail billing processes reducing the demand for our solutions or rendering our solutions unnecessary;
- loss of a large client;
- early termination provisions in our contracts;
- our failure to accurately estimate the factors upon which we base our contract pricing;
- our inability to manage our relationships with information suppliers, software vendors or utility providers;
- our inability to protect our intellectual property rights, proprietary technology, information, processes and know-how;
- our inability to execute our business plans including our inability to manage our growth;
- our inability to successfully integrate and realize synergies from any future acquisitions or strategic partnerships;
- our inability to realize the book value of intangible assets;
-

our being required to pay significant refunds to CMS under our Medicare RAC contracts or significant changes to the Medicare RAC program;

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- declines in contracts awarded through competitive bidding or our inability to re-procure contracts through the competitive bidding process;
- our success in attracting and retaining qualified employees and key personnel;
- our inability to expand our retail business;
- fluctuations in our results of operations;
- our failure to maintain effective internal controls;
- litigation, regulatory or dispute resolution proceedings, including claims or proceedings related to intellectual property infringements or claims not covered by insurance;
- healthcare spending fluctuations;
- consolidation among healthcare payers or retailers;
- slow development of the healthcare payment accuracy market;
- negative publicity concerning the healthcare payment industry or patient confidentiality and privacy;
- significant competition for our solutions;
- risks associated with international operations;
- general economic, political and market forces and dislocations beyond our control;
- variations in our revenue between reporting periods due to timing issues;
- our failure to comply with applicable federal, state, local and international privacy, security and data laws, regulations and standards;
- changes in regulations governing healthcare administration and policies, including governmental restrictions on the outsourcing of functions such as those that we provide;
- changes in tax laws and rules or in their interpretation or enforcement;
- the timing and magnitude of shares purchased under our share repurchase program;
- risks related to our substantial indebtedness and holding company structure;
- volatility in bank and capital markets; and
- provisions in our amended and restated certificate of incorporation.

See -Item 1A, "Risk Factors" for a further description of these and other factors. For the reasons described above, we caution you against relying on any forward-looking statements, which should also be read in conjunction with the other cautionary statements that are included elsewhere in this Annual Report. Any forward-looking statement made by us in this Annual Report speaks only as of the date on which it is made. Factors or events that could cause our actual results to differ may emerge from time to time, and it is not possible for us to predict all of them. We undertake no obligation to publicly update or revise any forward-looking statement, whether as a result of new information, future developments or otherwise, except as may be required by law.

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Available information

Our website address is www.cotiviti.com. Information that we furnish to or file with the SEC, including our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and any amendments to, or exhibits included in, those reports or statements are available for download, free of charge, on our website as soon as reasonably practicable after such materials are filed with or furnished to the SEC. From time to time, in addition to copies of all recent press releases, we also post announcements, updates, events, investor information and presentations on our website at http://investors.cotiviti.com as means of disclosing material non-public information and for complying with our disclosure obligations under Regulation FD.

Reports and statements that we file with or furnish to the SEC, including related exhibits, are also available on the SEC's website at www.sec.gov. In addition, you may obtain and copy materials we furnish to or file with the SEC at the SEC's public reference room at 100 F Street, NE, Room 1580, Washington, D.C. 20549. Information on the operation of the SEC's public reference facilities may be obtained by calling the SEC at 1-800-SEC-0330. You may request copies of these documents, upon payment of a duplicating fee, by writing to the SEC at its principal office at 100 F Street, NE, Room 1580, Washington, D.C. 20549.

The contents of the websites referred to above are not incorporated into this filing. References to the URLs for these websites are intended to be inactive textual references only.

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PART I

Item 1. Business

Overview

Cotiviti is a leading provider of analytics-driven payment accuracy and spend management solutions, focused primarily on the healthcare sector (89% of 2017 revenue). Our integrated solutions help clients enhance payment accuracy in an increasingly complex healthcare environment. We leverage our robust technology platform, configurable analytics, proprietary information assets and expertise in healthcare reimbursement to help our clients enhance their claims payment accuracy. We help our healthcare clients identify and correct payment inaccuracies, which resulted in approximately $3.4 billion in savings in 2017. We work with over 60 healthcare organizations, including a majority of the 25 largest U.S. commercial, Medicare and Medicaid managed health plans, as well as CMS. We are also a leading provider of payment accuracy solutions to approximately 30 retail clients (11% of 2017 revenue), including a majority of the ten largest retailers in the United States.

Cotiviti was formed in May 2014 through the merger of Connolly, a leader in retrospective payment accuracy solutions for the healthcare and retail sectors and iHealth Technologies, a leader in prospective payment accuracy solutions for the healthcare sector. Through the Connolly iHealth Merger, we significantly broadened our suite of payment accuracy solutions, expanded our client base, enhanced our subject matter expertise and positioned ourselves for significant growth opportunities.

Timely and accurate healthcare claims processing is critical to the U.S. healthcare system. The administration of healthcare claims is complex and payment inaccuracies can occur for many reasons. We expect changes in the healthcare industry, such as increasingly complex reimbursement models, increased coding complexity, changing demographics and potential changes to the Affordable Care Act to further increase the need for our solutions. We support healthcare payers in managing the complexities in the claims payment process. Our analytics-

driven solutions review claims for accuracy with respect to billing, contract compliance, payment responsibility and clinical appropriateness before and after claims are paid. In July 2017, we acquired RowdMap, a payer-provider, value-based analytics company. The RowdMap Acquisition broadens our data analytics capabilities and provides adjacent solutions to address additional drivers of medical spend and support the overall healthcare market shift from volume to value.

Our growth strategy for healthcare includes:

- expand within our existing client base by increasing the volume of claims we review with our solutions; expanding utilization across the depth and breadth of our solutions; and cross-selling our prospective and retrospective solutions;
- expand our client base;
- innovate to improve and develop new solutions to expand the scope of our services; and
- pursue opportunistic acquisitions and strategic partnerships in payment accuracy and adjacent markets.

As a result of the meaningful savings we deliver to our clients, we have increased our client base and strengthened our long-standing relationships over time with many of the leading healthcare payers in the United States. In 2017, we generated revenue from four new clients and five cross-sell clients which we believe will drive revenue growth in 2018 and beyond. The average length of our relationships with our ten largest healthcare clients is over ten years. Additionally, we have substantially increased the annual savings captured by our healthcare clients over time.

We are also a leading provider of payment accuracy solutions to the retail market. Retailers process and validate extremely high volumes of transactions with disparate suppliers on varying terms. We work with retail clients in the United States, Canada and the United Kingdom to realize their negotiated allowances, concessions, rebates and other incentives associated with merchandise procurement, logistics and other service transactions. In 2017, we generated over $550 million in savings for our retail clients.

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For a further discussion of our two operating segments: (i) Healthcare and (ii) Global Retail and Other, refer to Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations—Our Segments” and Note 15 to the Consolidated Financial Statements.

Our track record of consistently delivering value for our clients has enabled strong growth in our revenue and profitability, especially within our core healthcare payer client base. For the years ended December 31, 2017, 2016 and 2015, our total revenue was $678.7 million, $625.2 million and $541.3 million, respectively. In these same periods, we generated net income of $138.2 million, $48.9 million and $13.9 million, respectively, representing 20.4%, 7.8% and 2.6% of revenue, respectively. Net income for the year ended December 31, 2017 was impacted by a $45.0 million net tax benefit related to the enactment of the Tax Act. Adjusted EBITDA was $267.9 million, $239.7 million and $203.4 million, respectively, representing 39.5%, 38.3% and 37.6% of revenue, respectively. For a reconciliation of net income to Adjusted EBITDA, a measure not calculated in accordance with GAAP, see Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations—How we Assess Our Performance—Adjusted EBITDA.”

The Healthcare Payment Process

Timely and accurate healthcare claims processing is critical to the U.S. healthcare system. This process is complicated and involves applying specific codes, policies and contracts, cross-referencing disparate data sources and, in many cases, adhering to regulatory requirements. To ensure prompt and accurate claims reimbursement, payers utilize internal processes and systems and third party solutions to review claims and apply analytics throughout the claims payment process. The following graphic represents the healthcare claims payment process and where Cotiviti provides payment accuracy solutions.

After delivering care, a provider initiates the claims payment process by submitting a claim for reimbursement to the patient's health insurance carrier (Step 1). The insurance carrier (payer) uses internal and external tools to conform the claim to its claims processing system: it validates that the patient is a member; that the services provided were eligible under the member's benefits; and that appropriate prior authorizations were in place. The payer then adjudicates the claim by applying the provider's contract and fee schedule to the claim along with any claim system edits (Step 2). During this adjudication process, the payer uses payment accuracy solutions to perform claim reviews for information discrepancies between the provider's submission and the payer's payment policies. These reviews range in complexity and can be executed by the payer or by third party solutions. After the claim has been adjudicated but before the claim is paid, the payer may utilize the advanced, automated analytical solutions that Cotiviti provides to review the claim to identify additional discrepancies (Step 3). If the prepayment review identifies a claim inaccuracy, the payer makes the correction and pays the corrected claim (Step 4).

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After payment is made and additional information becomes available, the payer and third party solutions such as Cotiviti's continue to identify, select and evaluate claims for payment accuracy (Step 5). If this retrospective payment review identifies a payment inaccuracy, the payer makes the correction and recovers overpayments through offsets against future claims or by seeking reimbursement from the provider.

Our Solutions

We apply our analytics-driven payment accuracy solutions at multiple points across the client's claims processing cycle. Our extensive library of complex payment analytics is designed to identify, select and make recommendations for correct application of contracts and coding to meet client payment policies. Following is a description of our solutions:

Prospective Claims Accuracy Solutions. Our prospective claims accuracy solutions help our healthcare clients identify and address claim discrepancies immediately following claim adjudication and before a claim is paid to a healthcare provider. We help our clients ensure that claims payments meet regulatory, compliance, industry and health plan requirements based on correct coding and clinical guidelines. We customize, configure and integrate our payment policy algorithms to enhance our clients' claims payment systems and automatically and efficiently review our clients' adjudicated claims. By directly interfacing with our clients' systems, our solutions analyze claims either in real-time or in batch processes. Our algorithms apply our proprietary library of current payment policies including industry, regulatory and medical specialty coding requirements as well as customized health plan rules. We review claims on a transactional as well as longitudinal basis, evaluating against our accumulated

claims data, to make accurate payment policy recommendations. We believe that our differentiated content library, configurable algorithms and other post-adjudication software tools provide our clients with a more thorough and client-specific analysis of claims than other claim adjudication systems, creating more value for our clients. In 2017, we received approximately $84 billion in claims to analyze for prospective claims accuracy.

Retrospective Claims Accuracy Solutions. Our retrospective claims accuracy solutions help health insurers identify and resolve payment inaccuracies after a claim has been paid to a healthcare provider. These solutions utilize sophisticated analytics and data mining tools to identify potential inaccuracies. Our claim analytics include longitudinal reviews of data to identify discrepancies that may span multiple claims and time periods. Our analytics are configurable to our clients' claims payment processes and enable us to prioritize areas of review based on our clients' operational and financial objectives. If expert validation is required, our claims analysts conduct a deeper review of more complex reimbursement issues. In analyzing claims retrospectively, we leverage additional information sources and broader data sets beyond the claims files, many of which only become accessible post-payment. These data and retrospective analytics enable reviews of a variety of payment accuracy categories, including issues relating to coordination of benefits, member eligibility and provider adherence to complex contract conditions. We also can provide clinical chart validation for our clients, in which our certified clinical and coding specialists review the clinical documentation associated with a claim. Clinical chart validation provides our clients with broader payment accuracy reviews beyond claims files analysis, including more complex clinical appropriateness and payment policies. We believe that our combination of retrospective analytics and clinical and coding expertise provides our clients with more thorough and configurable solutions than they are able to develop on their own, leading to increased savings for our clients. In 2017, we received approximately $563 billion in claims to analyze for retrospective claims accuracy.

Other Services. Beyond our prospective and retrospective claims accuracy solutions, we provide analytics and support to our clients in optimizing their operations and enterprise-wide claims payments and trends. These offerings include selective anti-fraud, waste and abuse analytics to identify abnormal patterns in coding and billing practices. We also provide our clients with ongoing surveillance and longitudinal analytics, by reviewing claims submissions and payments across multiple dimensions, including provider, plan-type, procedure and others. In addition, clients engage us for comprehensive claims history analytics to identify necessary areas for direct interaction, as well as to identify policy and program changes that can improve future payment accuracy.

With our RowdMap Risk-Readiness® Platform, we help clients identify and reduce waste associated with low-value care from inefficient and unnecessary services. This platform develops benchmarks on physicians and hospitals within most zip codes in the United States. The Risk-Readiness solution applies proprietary analytics against data sources including comprehensive CMS information, clinical policies, health guidelines and value-based analytics to evaluate provider performance across multiple dimensions. Based on these benchmarks, RowdMap develops a Risk-Readiness Network Efficiency Score to measure the efficiency of a provider network. Clients may use these insights in

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many ways including network sculpting, contracting and payment differentiation.

The examples below are simplified representations from our extensive library of complex payment analytics.

Solution Area	Example #1	Example #2
Billing Accuracy Was the claim coded correctly? Are the code reimbursements consistent with the payer's payment policy?	• Under ICD−10 coding guidelines, asthma and bronchitis have different codes. However, there is a single code for patients diagnosed with both asthma and bronchitis • Our solutions identify situations where a provider submitted separate claims for simultaneous asthma and bronchitis diagnoses and recommends	• Reimbursement for many episodes of care is evolving from separate payments for each service to a bundled payment for the full episode and relevant services • For example, bundled payments for surgical procedures should include the surgical procedure and post-operative follow-up visits

	claim modification and reimbursement to reflect use of a single code	• Our solutions perform longitudinal claim reviews to determine if an office visit is related to a previous surgical procedure and should be bundled according to our client's policy
Contract Compliance Is the claim submitted and calculated in accordance with payer / provider contract terms? Is this payment calculated appropriately based on bundles, quality or value-based care?	• Tests and procedures may be conducted under the supervision both of a general practitioner and a specialist (e.g. a radiologist) • Depending on the provider's contract, reimbursement may be covered either under a global payment or separate payments to each provider • Our solutions cross-reference claims from multiple providers to identify circumstances where a combined reimbursement should be applied	• Increasingly, payers participate in value-based reimbursement arrangements with strategic provider networks • These contractual arrangements are complex and it can be difficult to determine coverage and capitated or fee-for-service reimbursement terms • Our solutions assess claims submissions and support our clients in administering the appropriate contracted liability, coverage and payments terms with the provider network
Payment Responsibility Does the client have responsibility for this claim? Does any other party share in the liability?	• Many employer-sponsored benefit plans stipulate that Medicare is the primary payer for beneficiaries who are at least 65 years of age • In such instances, our solutions identify the appropriate payer and we support our clients in working with the provider to bill Medicare	• If both of the dependent's parents are insured by separate health plans, the health plan of the parent whose birthday comes first in the calendar year is designated as the primary insurer • Our solutions determine the health plan liable for dependent claims and support our clients in remedying the inaccurate billing

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Solution Area	Example #1	Example #2
Clinical Appropriateness Was care delivered in accordance with industry association and payer guidelines? Does chart documentation support treatment and claim submission?	• The initial symptoms for Acute Renal Failure and Dehydration are very similar and may result in incorrect coding • The level of care, tests and procedures required to treat Acute Renal Failure are significantly higher than for Dehydration • Our solutions and clinical experts identify claims in which treatment details in the medical chart do not support a diagnosis of Acute Renal Failure and, where appropriate, recommend chart edits and revised payment levels to reflect a Dehydration diagnosis	• Many of our health plan clients elect to administer the ABIM Foundation's Choosing Wisely® guidelines to reduce unnecessary tests and procedures • For example, electrocardiograms are measurements of heart activity that are recommended for patients with heart disease but have minimal usefulness for healthy patients • When our clients elect to follow the Choosing Wisely® guidelines in setting policy, we support them in identifying claims that are not deemed clinically appropriate

Healthcare Industry Overview

The market for payment accuracy solutions is large and growing, driven by increasing healthcare costs and payment complexities. From 2006 to 2016, healthcare costs in the United States grew at a 4.5% compounded annual growth rate to $3.3 trillion and increased 4.6% in 2017 to $3.5 trillion. According to CMS, healthcare costs are expected to continue to grow at an average annual growth rate of 5.6% through 2026 reaching $5.7 trillion. The introduction of new reimbursement models, the increase in coding complexity and the shift to managed care plans within government healthcare are expected to further increase the complexity of healthcare payments.

We believe that there is substantial opportunity for continued growth in the payment accuracy solutions market. We estimate that there was over $1 trillion in unnecessary or wasteful spending in the U.S. healthcare system in 2017. We provide Healthcare payers with payment accuracy solutions in an effort to identify and resolve these inaccurate billings. We believe payers will continue to make investments in payment accuracy solutions. With the RowdMap Acquisition and their Risk-Readiness® platform, we can address the unnecessary and inefficient care estimated to be delivered. We estimate that our combined solutions address approximately $600 billion of the total wasteful spending in the U.S. healthcare system.

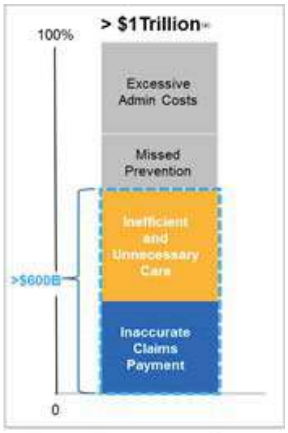

Total Healthcare Waste

(a) Source: U.S. National Academy of Sciences' Institute of Medicine and CMS and company estimates

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We believe we are well positioned to benefit from the below principal drivers of growth in the payment accuracy solutions market:

- ***Increasingly complex reimbursement models***. We believe that reimbursement models will continue to become more complex as healthcare payers accommodate new markets and new lines of business. A broader focus on value-based reimbursement and consumer engagement programs, which are designed to reduce costs and improve patient outcomes, adds an additional layer of complexity as payments are migrated from a fee-for-service basis to value-based and risk sharing models. As a result, healthcare payers must reconcile additional data sources, contracts with multiple provider networks and longitudinal episodes of care over time, driving demand for payment accuracy and risk-readiness solutions.

- ***Increased coding complexity.*** Advancements in medical technology, procedures and medications have resulted in an increasing number of testing and treatment options for providers to utilize. Scientific advancements also have led to an increase in the discovery of treatable or curable diseases. As the acceleration of medical science continues, the way in which health claims are processed is evolving to keep pace.

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Changing demographics. An aging and sicker population is driving rising healthcare costs, increased utilization of prescription drugs and increased co-morbidities within patient populations. As the population ages, the number of higher-cost Medicare beneficiaries has increased from 41.5 million in 2005 to 55.9 million in 2016 and is estimated to grow to 72.0 million in 2025. As a result of both high and growing costs, healthcare insurers, the federal government and each of the state governments are under pressure to reduce costs while improving access to care and the quality of patient outcomes, creating a greater demand for highly efficient payment review solutions.

- ***Shift to managed care plans within government healthcare.*** Individuals who receive government sponsored healthcare are transitioning from direct fee-for-service coverage to managed care network models through Medicare Advantage and managed Medicaid plans. The percentage of Medicare eligible patients enrolled in a Medicare Advantage plan has steadily increased from 22% in 2008 to 35% as of December 2017. Additionally, many state-administered Medicaid programs are alleviating budget constraints by contracting with private health insurers to manage a growing number of Medicaid eligible enrollees. The shift to managed care networks and increase in individuals covered by private health insurers increases the opportunity for commercially focused payment accuracy solutions such as ours.

- ***Consolidation of managed care companies.*** Managed care providers are going through a period of consolidation driven by regulatory and competitive dynamics. Larger plans have historically been strong adopters of payment accuracy solutions. With a client base including over 60 healthcare organizations, including a majority of the 25 largest U.S. commercial, Medicare and Medicaid managed health plans, we believe we are well positioned to benefit from managed care consolidation.

Our Strengths

Our operational and financial success is based on the following key strengths:

- ***Broad suite of specialized solutions.*** We offer a broad suite of analytics-driven payment accuracy solutions that deliver measurable value to our clients and are highly configurable across provider settings and claim types. Our suite of solutions includes prospective and retrospective analytics that review billing accuracy, contract compliance, payment responsibility, clinical appropriateness and network risk-readiness assessments. We believe that the breadth of our solutions across multiple points in the claims payment process and the depth of our expertise and capabilities are difficult for any single healthcare payer to replicate.

- ***Large and expanding library of information and knowledge assets.*** Our robust library of information assets includes proprietary algorithms and concepts developed by our research teams over more than 15 years. We believe that our library of accumulated information and unique knowledge assets, including those acquired with RowdMap, is a differentiator that is difficult to replicate by current or potential competitors and provides a competitive advantage. We continuously expand and improve the quality of our library by regularly incorporating new claims data and up-to-date algorithms and concepts. We also have a team of full-time, dedicated, doctors, nurses, claims coders, auditors and other experts focused on developing new proprietary

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algorithms and analytics assets for our payment accuracy solutions. Additionally, our team of specialists monitors hundreds of content sources on medical and payment policy to ensure our algorithms and concepts incorporate the latest standards.

- ***Advanced and proprietary technology platform and analytics capabilities.*** Our advanced proprietary platform and analytics capabilities are the result of significant investment in our technology infrastructure and applications. We are continually developing and improving our scalable technology platform to deliver the speed, integrity and quality necessary for client-specific business solutions. In addition, our focus on analytics, automation and knowledge-sharing allows us to quickly and accurately implement existing algorithms and concepts as well as solutions for newly identified reimbursement discrepancies. We believe that our proprietary technology platform is a key driver of our leading market position.

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Aligned financial model that delivers measureable return. Our financial performance is directly tied to the savings we deliver to our clients. The majority of our contracts are structured such that we receive a percentage of the savings that we help our clients achieve. We have consistently generated a high return on investment for our clients as a result of our aligned financial model. The savings we deliver are incremental to our clients' internal payment accuracy capabilities. As a result, we can provide a substantial contribution to our clients' earnings and create strong alignment and durability in our client relationships. In 2017, 2016 and 2015, our commercial healthcare clients realized approximately $3.4 billion, $3.3 billion and $2.7 billion, respectively, in savings using our solutions.

- ***Long-standing and expanding client relationships.*** Our client base includes the largest and most recognized healthcare plan organizations in the United States, including a majority of the 25 largest U.S. commercial, Medicaid and Medicare managed health plans, as well as CMS. The average length of our relationships with our top ten healthcare clients is over ten years. We also have strong, long-standing relationships with approximately 30 retail clients, including a majority of the ten largest U.S. retailers. We believe our robust client relationships and strong client retention rates reflect a high level of satisfaction with our solutions. Our clients' satisfaction results from how we deliver solutions by configuring our algorithms and analyses to align with their operational, financial and network management priorities.

- ***Attractive operating model.*** We believe we have an attractive operating model due to the recurring nature of our revenue, the scalability of our solutions and the low capital intensity/high free cash flow conversion of our business. Our information asset and technology platform is highly scalable, which allows us to accommodate significant additional transaction volumes with limited incremental costs. We have low capital needs that allow us to generate strong cash flow. Our capital expenditures as a percentage of revenue were 5.5%, 5.6% and 4.2% during the years ended December 31, 2017, 2016 and 2015, respectively. We believe our recurring revenue, combined with our scalable solutions and low capital needs, will continue to contribute to our long-term growth, strong operating margins and flexibility in allocating capital.

- ***History of innovation.*** We have a long history of developing innovative solutions which we continuously incorporate into our suite of offerings. Many of our solutions have been generated as a response to complex client issues. This development process has continually enhanced our solutions, thereby optimizing the value we deliver to our clients over time and allowing us to thrive in an ever-changing and increasingly complex healthcare environment. Our track record of innovation is strengthened by the diverse backgrounds of our clinical and coding specialists who continually and consistently update and develop our content library and analytical algorithms as we identify new ways to accelerate value creation for our clients.

- ***Experienced management team with a track record of performance.*** Our leadership team has extensive and relevant expertise in the payment accuracy market. Our management has a proven track record in adapting to clients' needs and developing innovative analytical solutions to drive growth and profitability.

Our Growth Strategies

We believe we are well positioned to benefit from the expected growth in claims processing complexity and healthcare spend, which we expect will drive continued demand for payment accuracy solutions among healthcare payers. Our strategies for achieving growth include:

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Expand within our existing client base. We have significant opportunities to expand our business within our existing client base through the following strategies:

- ***Increase the volume of claims reviewed by our solutions.*** When our clients initially implement our solutions, they typically start by having us review a subset of their claims. As we demonstrate success and deliver value, our clients often increase the volume of claims we review. We have significant opportunities to evaluate additional claim types, plan types, geographic regions and/or provider settings.

- ***Expand the utilization of our solutions.*** When our clients initially implement our solutions, they typically start with a subset of our algorithms and analytical tools. As we demonstrate success and deliver value, our clients often expand the utilization of our algorithms and analytical tools. The opportunity to expand the utilization of our solutions is significant.

- ***Cross-sell our portfolio of solutions.*** We believe we have a significant opportunity to further cross-sell our prospective and retrospective solutions to existing clients as we have cross-sell opportunities across approximately half of our healthcare client base. We continue to actively engage with existing clients to cross-sell our solutions. In 2017, we generated revenue from five successful cross-sells with existing clients.

Expand our client base. There is an opportunity to increase our client base of healthcare payers by targeting new relationships. The top 100 healthcare payers that are not our existing clients made approximately $180 billion in payments in 2017. We are pursuing these healthcare payers as potential new clients by leveraging our proven value proposition, leadership position, track record of performance and the strong references provided by our diversified client base of leading health plans. The addition of new clients creates revenue growth opportunities for future periods. In 2017, we generated revenue from four new healthcare clients.

Continue to innovate. We plan to enhance our existing solutions by utilizing the most current digital technologies to develop new concepts and analytical algorithms and improve our information assets to allow us to expand our value creation for clients. We also plan to continue to improve our processes and upgrade our technology infrastructure to improve the efficiency with which we deliver our solutions. Additionally, we will continue to monitor the evolution of the healthcare environment and develop new solutions in anticipation of increasing complexity in reimbursement models to supplement our core payment accuracy solutions.

Selectively pursue acquisitions and strategic partnerships. We plan to selectively pursue acquisitions and strategic partnerships to (i) accelerate the pace of innovation and expansion of our core solutions, (ii) provide cross-sell opportunities, (iii) offer complementary data, technologies or industry expertise to our existing analytics-driven payment accuracy solutions or (iv) expand our market opportunity beyond payment accuracy to other dimensions of healthcare waste, potentially including missed prevention opportunities, inefficiently delivered services, excessive administrative costs and unnecessary services. We have a successful track record of identifying, acquiring and integrating high-quality solutions providers that complement and enhance the value of our existing solutions, as demonstrated by the RowdMap Acquisition.

Retail Payment Accuracy Solutions

We are a leading provider of payment accuracy solutions to retailers in the United States, with additional clients in Canada and the United Kingdom, with over 35 years of experience. We serve approximately 30 retail clients, including a majority of the ten largest retailers in the United States. Our relationships with these clients tend to be long-term, with an average tenure of more than ten years.

The retail industry faces significant cost containment challenges as retailers process and validate extremely high volumes of transactions with disparate suppliers on varying terms. The retail payment accuracy market continues to grow in complexity due to shifts in consumer spending habits, such as the increasing adoption of internet-based shopping, as well as newer pricing strategies, such as dynamic pricing and promotional activities.

We provide value to retailers by helping them identify and recover payments to suppliers of goods and services that are inconsistent with contractual or agreed upon terms. We use automated analytics capabilities and experienced teams to review supplier agreements, invoices, purchase orders, promotions and other transactions and identify

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discrepancies in merchandise procurement, logistics and other services transactions. In 2017, we generated over $550 million in savings for our retail clients.

Seasonality

Historically, there has been a seasonal pattern to our healthcare revenue with the revenues in the first quarter generally lower than the other quarters and revenues in the fourth

quarter generally being higher than the other quarters. Accordingly, the comparison of revenue from quarter-to-quarter may fluctuate and is dependent on various factors, including, but not limited to: a reset of member liability; timing of special projects; implementation delays; timing of inaccurate payments being prevented or recovered; industry utilization trends; and the aforementioned seasonal considerations. Consequently, you should not rely on our revenue for any one quarter as an indication of our future performance.

Sales and Marketing

Our sales and marketing activities are focused on increasing the scope of claims reviewed by our solutions, cross-selling our solutions to our existing clients and generating new clients. Our sales and client services professionals sell our solutions directly to clients and manage the ongoing client relationships. Marketing activities for our healthcare and retail solutions include: targeted, direct marketing; advertising; tradeshow participation; workshops; web-based marketing activities; e-newsletters; and customer and industry conferences.

Competition

The payment accuracy solutions business is highly competitive. Competitive factors in the payment accuracy industry include the amount of savings identified, quality of the technology-based solution or service, application features and functions, ease of delivery and integration, ability of the payment accuracy partner to maintain, enhance and support the applications or services, industry experience and expertise, sensitivity to maintaining provider and supplier relationships and pricing.

In the healthcare payment accuracy market, we compete primarily with other payment accuracy vendors, fraud, waste and abuse claim editors and predictive analytics companies, Medicare RACs, healthcare consulting firms and other third party liability services providers. Competitors for our healthcare solutions include Optum, Inc., Verscend Technologies, Inc. (f/k/a Verisk Health, Inc.), Change Healthcare Corporation, HMS Holdings Corp., The Rawlings Group, Equian, LLC, Zelis Healthcare Corporation and other, smaller companies. In addition, most healthcare payers, including a number of our clients, also have the ability to perform some or all payment accuracy functions in-house.

In the retail payment accuracy market, we compete primarily with PRGX Global, Inc. as well as a number of smaller companies that do not have a material share of the retail payment accuracy market.

Intellectual Property

We rely on a combination of confidentiality agreements with our clients, employees, consultants, subcontractors and other parties as well as other security measures, such as information access and distribution controls, to establish and protect our proprietary technology, information, processes and know-how that comprise our solutions. We also have brands that have goodwill in the markets that we serve, and we rely on trademarks to protect our related rights.

Research & Development

Our research and development activities relate primarily to the design, development and enhancement of our payment accuracy solutions. We expect to continue investing significant resources to maintain, enhance and extend the functionality of our proprietary systems and existing solutions, to develop new solutions in response to the needs of our clients, and to enhance the capabilities surrounding our infrastructure.

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Government Regulation

A majority of our business is directly or indirectly related to the healthcare industry and is affected by changes in the healthcare industry, including political, legislative and regulatory changes and fluctuations in healthcare spending. Participants in the healthcare industry, including our clients, are required to comply with extensive and complex federal and state laws and regulations including fraud and abuse, false claims, anti-kickback and privacy and security laws and regulations. Although many of the regulatory and governmental requirements do not directly apply to our operations, many of our clients are required to comply with these

requirements, which may impact our business and the demand for our services and solutions. Many of the laws and regulations, including federal and state false claims laws that affect us as a result of some of our services and solutions, are complex and may be subject to varying interpretations by courts and other governmental authorities. Our failure to comply with any applicable laws and regulations could result in restrictions on our ability to provide certain services and solutions, as well as the possible imposition of civil and criminal penalties, damages, fines and exclusion from participation in federal and state healthcare programs.

The Patient Protection and Affordable Care Act

In the United States, federal and state legislatures and agencies periodically consider healthcare reform measures that may contain proposals to increase governmental involvement in healthcare, lower reimbursement rates or otherwise change the environment in which healthcare industry participants operate. Our business could be affected by changes in healthcare laws including the Affordable Care Act, which was signed into law in March 2010 and has been under consideration for repeal or restructuring by the current administration. The Affordable Care Act has changed how healthcare services are covered, delivered and reimbursed through expanded coverage of uninsured individuals, reduced Medicare program spending and insurance market reforms. The Affordable Care Act has created major changes in how healthcare is delivered and reimbursed and generally increased access to health insurance benefits to the uninsured and underinsured population of the United States. Among other things, the Affordable Care Act has increased the number of individuals with Medicaid and private insurance coverage, implemented reimbursement policies that tie payment to quality, facilitated the creation of accountable care organizations that may use capitation and other alternative payment methodologies, strengthened enforcement of fraud and abuse laws and encouraged the use of information technology. Many of these provisions could be modified or eliminated by Congress or the executive branch. Congress has considered several bills to repeal all, or certain parts, of the Affordable Care Act. For example, the Tax Act enacted in December 2017 eliminated the tax penalty, beginning in 2019, for individuals who fail to enroll in a qualified medical plan, as mandated by the Affordable Care Act. The change to this provision could result in a significant number of individuals deciding to forgo health insurance, which could have an impact on premiums and healthcare spending overall.

While many of the provisions of Affordable Care Act will not be directly applicable to us, the Affordable Care Act, as enacted, affects the business of our healthcare clients as well as the Medicaid programs of the states with which we have contracts, which may in turn affect our business. Many of the changes promulgated by the Affordable Care Act require implementing regulations which have not yet been drafted or have been released only as proposed rules. Until the Affordable Care Act is fully implemented, and because there is uncertainty concerning the future of the Affordable Care Act, it will be difficult to predict its full impact and influence on the healthcare industry. As a result, it is difficult to predict the impact the Affordable Care Act will have on our business given the threats to and uncertainty surrounding the Affordable Care Act.

HIPAA and other Health Information Laws

A significant portion of our business is regulated by HIPAA. Among other things, HIPAA requires business associates and covered entities to comply with certain privacy and security requirements relating to PHI and PII and mandates the way certain types of healthcare services are coded and processed. We frequently act as a business associate to our covered entity clients and, as a result, collect, use, disclose and maintain PHI and PII of individuals, as well as other financial, confidential and proprietary information belonging to our clients and certain third parties from whom we obtain information (e.g., private insurance companies, financial institutions). HIPAA and other state, industry and international laws and regulations require us to establish and maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity, confidentiality and availability of electronic protected health information, which also includes information about the payment for healthcare services. The laws and rules promulgated by these acts are changed frequently by legislation, regulatory issuances and/or administrative interpretation. For instance, in January 2013, HHS issued the Omnibus Final Rule modifying and supplementing many of the standards and regulations under HIPAA. The Omnibus Final Rule significantly lowered the disclosure standards required for

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notifications of breaches in patient privacy and expanded the universe of available liability under certain of HIPAA's requirements, including expanding direct liability for HIPAA's requirements to companies such as ours, which act as business associates to covered entities.

HIPAA establishes privacy and security standards that limit the use and disclosure of PHI and require the implementation of administrative, physical and technical safeguards to ensure the confidentiality, integrity and availability of individually identifiable health information in electronic form, as well as breach notification procedures for breaches of PHI and penalties for violation of HIPAA's requirements for entities subject to its regulation. Violations of HIPAA's requirements may result in civil and criminal penalties. Civil penalties may be up to $55,500 per violation with a maximum civil penalty of $1.65 million in a calendar year for violations of the same requirement. These amounts may be adjusted periodically for inflation. Moreover, a single breach incident can result in violations of multiple requirements, resulting in possible penalties well in excess of $1.65 million. Recent enforcement actions by HHS for HIPAA violations have imposed penalties of up to $5.6 million. State attorneys general also have the right to prosecute HIPAA violations committed against residents of their states. While HIPAA does not create a private right of action that would allow individuals to sue in civil court for HIPAA violations, its standards have been used as the basis for the duty of care in state civil suits, such as those for negligence or recklessness in misusing individuals' health information. HHS is currently conducting audits to assess HIPAA compliance efforts by covered entities and business associates and is authorized to establish a permanent program for the future.

In addition to HIPAA, numerous other federal and state laws govern the collection, maintenance, protection, use, transmission, disclosure and disposal of PHI and PII and these laws can be more restrictive than HIPAA, which means that entities subject to them must comply with the more restrictive state law in addition to complying with HIPAA. Not only may some of these state laws impose fines and penalties upon violators, but some, unlike HIPAA, may also afford private rights of action to individuals who believe their personal information has been misused. State laws are changing rapidly, and there is discussion of a new federal privacy law or federal breach notification law. Further, the United States Congress and a number of states have considered or are considering additional prohibitions or limitations on the disclosure of medical or other information to individuals or entities located outside of the United States.

Healthcare Administrative Simplification

HIPAA mandates a package of interlocking administrative simplification rules to establish standards and requirements for the electronic transmission of certain healthcare claims and payment transactions, to encourage electronic commerce in the healthcare industry. The standard transaction regulations established under HIPAA mandate certain format and data content standards for the most common electronic healthcare transactions, using technical standards promulgated by recognized standards publishing organizations. We have adapted our solutions to ICD-10, the current coding system effective for all Medicare claims with a date of service after October 1, 2015.

Reductions in Government Healthcare Spending

In recent years, legislative and regulatory changes have limited, and in some cases reduced, the levels of payment that healthcare payers receive for various services under the Medicare, Medicaid and other federal healthcare programs. In some cases, healthcare payers base their payment rates on Medicare policy, and therefore, adjustments that negatively impact Medicare payments also may negatively impact payments received by healthcare providers from other payers. The Affordable Care Act provides for significant federal healthcare program spending reductions, including reductions in Medicare payments to most healthcare providers and Medicare Advantage plans. In addition to reductions required by the Affordable Care Act, the Budget Control Act of 2011 requires automatic spending reductions of $1.2 trillion for federal fiscal years 2013 through 2021, minus any deficit reductions enacted by Congress and debt service costs. Under the Budget Control Act, the percentage reduction for most Medicare programs may not be more than 2% for a fiscal year, with a uniform percentage reduction across those Medicare programs. Due to subsequent legislation, the reductions have been extended through 2025. The Medicaid program, however, is not included in the reductions. Federal healthcare program spending continues to be a “hot-button” issue in the United States and the federal government continues to consider deficit reduction measures and other changes to government healthcare programs, including a possible repeal or restructuring of the Affordable Care Act.

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Employees

As of the year ended December 31, 2017, we had approximately 3,300 employees including approximately 2,300 domestic employees and approximately 1,000 international employees. None of our employees are represented by labor unions. We have not experienced any work stoppages and we consider our relationship with our employees to be good.

Item 1A. Risk Factors

Our business, financial condition, operating results and stock price can be materially and adversely affected by a number of factors, whether currently known or unknown, including those described below. Any one or more of such factors, some of which are outside of our control, could directly or indirectly cause our financial condition and operating results to vary materially from our past or anticipated future financial condition or operating results. These risk factors may be important to understanding any statement made by us in this Annual Report or elsewhere. The following information should be read in conjunction with Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" and the consolidated financial statements and related notes in Part II, Item 8, "Financial Statements and Supplementary Data" of this Annual Report.

Risks Relating to Our Business

Our business and future growth depend on our ability to successfully expand the scope of claims reviewed for, and cross-sell additional solutions to, our existing client base. Additionally, if our existing clients do not renew their agreements with us, renew at reduced performance fee or service levels, or prematurely terminate their agreements with us, it could have a material adverse effect on our business, financial condition and results of operations.

We historically have derived, and expect in the future to derive, a significant portion of our revenue from our existing clients and, accordingly, we are reliant on ongoing renewals of our agreements with existing clients. As a result, maintaining a high renewal rate and selling additional solutions to our existing clients is critical to our future growth and our business, financial condition and results of operations. We may experience significantly more difficulty than we anticipate in renewing our existing client agreements or selling additional solutions to them. Factors that may affect the renewal rate for our services and our ability to sell additional solutions include:

- the price, performance and functionality of our solutions;
- the availability, price, performance and functionality of competing solutions;
- our clients' perceived ability to review claims accurately using their internal resources;
- our ability to evolve our solutions to meet our clients' needs;
- our ability to develop complementary solutions;
- our continued ability to access the data necessary to enable us to effectively develop and deliver new solutions to clients;
- the stability and security of our platform;
- changes in healthcare laws, regulations or trends; and
- the business environment of our clients.

Contracts with our clients generally have stated terms of one to five years. Our clients have no obligation to renew their contracts for our services after the term expires. In addition, our clients may negotiate terms less advantageous to us upon renewal, may renew with a reduced scope of services, may choose to discontinue one or more services under an existing contract, may exercise flexibilities within their contracts to adjust service volumes, or may terminate the agreement prior to its contracted completion date, if any, which could reduce our revenue from these

clients. If our clients fail to renew their agreements, renew their agreements upon less favorable terms, at lower performance fee levels or for fewer services, fail to purchase additional solutions from us, or terminate their agreements with us, and we are unsuccessful in generating significant revenue from new or other existing clients to replace any lost revenue, our growth may be constrained and our revenue may decline which could have a material adverse effect on our business, financial condition and results of operations.

If we fail to innovate and develop new solutions, or if these new solutions are not adopted by existing and potential clients, it could have a material adverse effect on our business, financial condition and results of operations.

Our results of operations and continued growth will depend on our ability to successfully develop and market new solutions that our existing and potential clients are willing to adopt. We must continue to invest significant resources in research and development to enhance our existing solutions and develop new solutions. We cannot provide assurance that our new or enhanced solutions will be responsive to client preferences or industry changes, or that the product and solutions development initiatives we prioritize will yield the gains that we anticipate, if any.

If we are unable to predict market preferences or if our industry changes, or if we are unable to modify our current solutions or develop new solutions on a timely basis, we may lose clients or fail to attract new clients. If existing clients are not willing to adopt new solutions, or if potential clients do not value such new solutions, it could have a material adverse effect on our business, financial condition and results of operations.

We have long sales and implementation cycles for many of our solutions and if we fail to close sales after expending time and resources on the sales process, or if we experience delays in implementing the solutions we sell, it could have a material adverse effect on our business, financial condition and results of operations.

Potential clients generally perform a thorough evaluation of available payment accuracy solutions and require us to expend time, effort and money educating them as to the value of our solutions prior to entering into a contract with them. We may expend significant funds and management resources during the sales cycle and ultimately fail to close the sale. Our sales cycle may be extended due to our clients' budgetary constraints or for other reasons. In addition, following a successful sale, the implementation of our systems frequently involves a lengthy process, as we integrate our technology with the new client's technology and learn the new client's business, operations and billing processes and preferences. If we are unsuccessful in closing sales after expending funds and management resources or if we experience delays in such sales, it could have a material adverse effect on our business, financial condition and results of operations. In addition, during implementation cycles, we expend significant time and resources and we do not recognize any revenue and, even if implementation has begun, there can be no assurance that we will recognize revenue on a timely basis or at all from our efforts. Implementation for a given client may be canceled, as our contracts typically provide that they can be terminated for any reason or no reason on notice. In addition, implementation may be delayed, or the target dates for completion may be extended into the future, for a variety of reasons, including the needs and requirements of the client. If implementation periods are extended, our provision of our solutions will be delayed, and our financial condition may be adversely affected. In addition, delay or cancellation in implementing our solutions could result in delays in recognizing revenue or fluctuations in our results of operations as well as loss of time, effort and expenses invested in the implementation process, adversely affecting our future operating results.

Because most of our revenue each quarter is derived from agreements entered into with our clients during previous quarters, the negative impacts resulting from a decline in new or renewed agreements in any one quarter may not be fully reflected in our revenue or results of operations for that quarter. Such declines, however, could negatively affect our revenue and results of operations in future periods. Our sales and implementation cycles also make it difficult for us to rapidly increase our total revenue through additional sales in any single period and may contribute to fluctuations in our quarterly operating results. As a result, in future quarters our operating results could fall below the expectations of securities analysts or investors.

If we fail to maintain or upgrade our operational platforms, it could have a material adverse effect on our business, financial condition and results of operation.

We expect to make substantial investments in and changes to our operational platforms, systems and applications to compete effectively and keep up with technological advances. We may face difficulties in integrating any upgraded platforms into our current technology infrastructure. In addition, significant technological changes could render our existing solutions obsolete. Although we have invested, and will continue to invest, significant resources in

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developing and enhancing our solutions and platforms, any failure to keep up with technological advances or to integrate upgraded operational platforms and solutions into our existing technology infrastructure could have a material adverse effect on our business, financial condition and results of operations.

If our applications and solutions do not function reliably or fail to achieve client expectations, clients could assert claims against us and/or attempt to cancel their agreements with us. In addition, performance problems, defects or errors in our solutions may arise in the future and may discourage existing or potential clients from purchasing new or additional solutions from us. Corrections of defects or errors could be time consuming, costly, impossible or impracticable. The existence of errors or defects in our applications or solutions could divert our resources from other business matters, damage our reputation, harm investor confidence, increase our costs, and have a material adverse effect on our business, financial condition and results of operations,

If we are unable to develop new client relationships, it could have a material adverse effect on our business, financial condition and results of operations.

As part of our strategy, we seek to develop new client relationships, principally among healthcare payers. Our ability to develop new relationships depends on a variety of factors, including the quality and performance of our solutions, as well as the ability to market and sell our solutions effectively and differentiate ourselves from our competitors. We may not be successful in developing new client relationships. If we are unable to develop new client relationships, it could have a material adverse effect on our business, financial condition and results of operations.

Internal improvements to healthcare claims and retail billing processes by our clients could reduce the need for, and revenue generated by, our solutions, which could have a material adverse effect on our business, financial condition and results of operations.

We provide solutions that help our clients enhance payment accuracy in an increasingly complex environment. If our clients improve their healthcare claims and retail billing processes, demand for our solutions could be reduced. Since most of our contracts are performance fee-based, enhancement of client internal billing processes could reduce the revenue generated by our solutions. With enough time and investment, many of our clients may be able to reduce or resolve recurring payment process complexities and resulting payment inaccuracies. In addition, many of our clients also utilize third party or internal technology, systems and personnel that review transactions before we do, all of which are constantly updated and improved. As the skills, experience and resources of such technology, systems and personnel improve, they may be able to identify payment inaccuracies before using our solutions, which would reduce the payment inaccuracies identified by our solutions and our ability to generate related revenue, which could have a material adverse effect on our business, financial condition and results of operations.

A significant portion of our revenue comes from a limited number of clients, and the loss of one or more of these clients could have a material adverse effect on our business, financial condition and results of operations.

We generate a significant portion of our revenue from a limited number of large clients. Our first-, second- and third-largest clients accounted for approximately 13%, 11% and 10% of our revenue for the year ended December 31, 2017. In addition, our ten largest clients, in the aggregate, accounted for approximately 59% of our revenue for the year ended December 31, 2017. The engagement between these clients and us generally is covered through a master services agreement with multiple separate statements of work, each with different and/or staggered terms, generally ranging from one to three years. In addition, we rely on our reputation and recommendations from key clients to promote our solutions to potential new clients. Accordingly, if any of these clients fail to renew or terminate their existing contracts or their statements of work with us, or cease to provide us with statements of work under existing master services agreements, it could have a material adverse effect on our business, financial condition and results of operations.

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Our client contracts generally contain provisions under which the client may terminate the use of our solutions prior to the completion of the agreement.

Many of our client contracts provide that the client may terminate the contract without cause prior to the end of the term of the agreement by providing us with relatively short prior written notice of the termination. As a result, the existence of contractual relationships with our clients is not an assurance that we will continue to provide our solutions to any of our clients through the entire term of their respective agreements. If clients representing a significant portion of our revenue terminated their agreements unexpectedly, we may not, in the short-term, be able to replace the revenue and income from such contracts and this could have a material adverse effect on our business, financial condition and results of operations. In addition, client contract terminations also could harm our reputation within the industry which could negatively impact our ability to obtain new clients.

If we fail to accurately estimate the factors upon which we base our contract pricing, we may generate less profit than expected or incur losses on those contracts, which could have a material adverse effect on our business, financial condition and results of operations.

Our client contracts are generally performance fee-based. We receive a fee for such contracts based on the payment inaccuracies that we prevent for our prospective solutions clients, or the recoveries received by our retrospective solutions and retail clients. Our ability to earn a profit on a performance fee contract requires that we accurately estimate the costs involved and outcomes likely to be achieved and assess the probability of completing multiple tasks and transactions within the contracted time period.

We derive a relatively small portion of our revenue on a “fee-for-service” basis whereby billing is based upon a subscription basis, flat fee or a fee per hour. To earn a profit on these contracts, we must accurately estimate costs involved and assess the probability of achieving certain milestones within the contracted time period. If we do not accurately estimate the costs and timing for completing projects, or if we encounter increased or unexpected costs, delays, failures, liabilities or risks, including those outside of our control, our contracts could prove unprofitable for us or yield lower profit margins than anticipated. Although we believe that we have recorded adequate provisions in our financial statements for losses on our fee-for-service and subscription contracts where applicable, as required under GAAP, we cannot provide assurance that our contract provisions will be adequate to cover all actual future losses. The inability to accurately estimate the factors upon which we base our contract pricing could have a material adverse effect on our business, financial condition and results of operations.

In addition, some of our client contracts guarantee that we will achieve certain performance levels. If we are unsuccessful in reaching these performance levels, we may have to provide the client with service credits or reduce our fees, which could have a material adverse effect on our business, financial condition and results of operations.

We depend on many different entities to supply information. If we are unable to successfully manage our relationships with any of these suppliers, it may harm the quality and availability of our solutions, which could have a material adverse effect on our business, financial condition and results of operations.

We obtain data used in our solutions from many sources, including commercial insurance plans, financial institutions, managed care organizations, government entities and non-government entities. From time to time, challenges arise in managing and maintaining our relationships with entities that are not our clients and that furnish information to us pursuant to a combination of voluntary cooperation and legal obligation under laws and regulations that are often subject to differing interpretation. Our data suppliers may determine that some uses of data for our clients are not permitted by our agreements and seek to limit or end our access and use of certain data for particular purposes or clients. They may also make errors in compiling, transmitting or accurately characterizing data, or may have technological limitations that interfere with our receipt or use of the data we are relying upon them to provide. If a number of information sources or suppliers become unable or unwilling to provide us with certain data under terms of use that are acceptable to us and our clients, or if the applicable regulatory and law enforcement regime for use and protection of this data changes in a way that imposes unacceptable or unreasonable conditions or risks on us or disincentivizes our suppliers to continue to provide us with data, we cannot provide assurance that we will be able to obtain new agreements with alternative data suppliers on terms favorable to us, or at all. If we lose our data sources or access to certain data; are unable to identify and reach the requisite agreements with suitable alternative suppliers and integrate these data sources into our service offerings; or there is a lack of integrity of data that our suppliers provide, we could experience service disruptions, increased costs, reduced quality of our solutions and/or performance penalties

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under our client contracts, which could have a material adverse effect on our business, financial condition and results of operations.

Our success depends on our ability to protect our intellectual property rights.

Our success depends in part on our ability to protect our proprietary software, confidential information and know-how, technology and other intellectual property and intellectual property rights. To do so, we rely generally on copyright, trademark and trade secret laws, confidentiality and invention assignment agreements with employees and third parties, and license and other agreements with consultants, vendors and clients. There can be no assurance that all of our employees, consultants, vendors and clients have executed such agreements or have not breached or will not breach their agreements with us, that we will have adequate remedies for any breach, or that our trade secrets will not otherwise become known or independently developed by competitors. Additionally, we monitor our use of open source software to avoid uses that would require us to disclose our proprietary source code or violate applicable open source licenses, but if we engaged in such uses inadvertently, we could be required to take remedial action or release certain of our proprietary source code. These scenarios could have a material adverse effect on our business, financial condition and results of operations. In addition, despite the protections we place on our intellectual property, a third party could, without authorization, copy or otherwise obtain and use our products or technology, or develop similar technology. In addition, agreement terms that address non-competition are difficult to enforce in many jurisdictions and might not be enforceable in certain cases.

Pursuant to our initial strategy regarding intellectual property protection, we currently hold one patent that does not apply to our current solutions and we have filed a limited number of provisional and non-provisional patent applications, which may or may not result in an issued patent or patents. In addition, the examination process with respect to our applications may require us to narrow our claims. To the extent that any patents are issued from our patent applications, which is not certain, they may be contested, circumvented or invalidated in the future. Moreover, the rights granted under any issued patents may not provide us with proprietary protection or competitive advantages or may be successfully challenged by third parties, and competitors may be able to independently develop similar or superior technologies, reducing or eliminating the value of any patent that we may be granted.

We rely on our trademarks, service marks, trade names and brand names to distinguish our services and solutions from those of our competitors and have registered or applied to register many of these trademarks. We cannot assure you that our trademark applications will be approved. Third parties may also oppose our trademark applications, or otherwise challenge our use of the trademarks. In the event that our trademarks were successfully challenged, we could be forced to rebrand our services or solutions, which could result in loss of brand recognition and could require us to devote resources advertising and marketing new brands. Further, we cannot assure you that competitors will not infringe our trademarks or that we will have adequate resources to enforce our trademarks. Additionally, if we expand our focus to the international payment accuracy market, there is no guarantee that our trademarks, service marks, trade names and brand names will be adequately protected.

If we are unable to protect our proprietary technology, information, processes and know-how, the value of our solutions may be diminished, which could have a material adverse effect on our business, financial condition and results of operations.

We rely significantly on proprietary technology, information, processes and know-how that are not subject to patent or copyright protection. We seek to protect this information through trade secret or confidentiality agreements with our employees, consultants, subcontractors or other parties, as well as through other security measures. These agreements and security measures may be inadequate to protect our intellectual property or other proprietary information. It is possible that others will independently develop the same or similar technology or otherwise obtain access to our unpatented technology. Misappropriation of our intellectual property or other proprietary information by third parties, disclosure or dissemination of our business intelligence, queries, algorithms and other proprietary information by any means, or independent development of technologies or solutions the same as or similar to ours could reduce the differentiation of our solutions, undermining competitive advantages we currently derive or may derive therefrom and harming our business, reducing the value of our investment in development or business acquisitions or resulting in third parties making claims against us related to losses of their confidential or proprietary information. Any of these situations could result in our expending significant time and incurring expense to enforce our intellectual property rights. Although we have taken measures to protect our proprietary rights, others may compete with our

business by offering solutions or services that are substantially similar to ours. If the protection of our proprietary rights

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is inadequate to prevent unauthorized use or misappropriation by third parties or our employees, the value of our solutions, brand and other intangible assets may be diminished and competitors may be able to more effectively offer solutions that have the same or similar functionality as our solutions, which could have a material adverse effect on our business, financial condition and results of operations.

Our ability to obtain, protect and enforce our intellectual property rights is subject to uncertainty as to the scope of protection, registerability, patentability, validity and enforceability of our intellectual property rights in each applicable jurisdiction, as well as the risk of general litigation or third party oppositions.

Existing U.S. federal and state intellectual property laws offer only limited protection. Moreover, if we expand our business into markets outside of the United States, our intellectual property rights may not receive the same degree of protection as they would in the United States because of the differences in foreign trademark and other laws concerning proprietary rights. Governments may adopt regulations, and government agencies or courts may render decisions, requiring compulsory licensing of intellectual property rights. When we seek to enforce our intellectual property rights we may be subject to claims that the intellectual property rights are invalid or unenforceable. Litigation may be necessary in the future to enforce our intellectual property rights and to protect our trade secrets. Litigation brought to protect and enforce our intellectual property rights could be costly, time consuming and distracting to management and could result in the impairment or loss of portions of our intellectual property rights. Furthermore, our efforts to enforce our intellectual property rights may be met with defenses, counterclaims and countersuits attacking the validity and enforceability of our intellectual property rights. Our inability to protect our proprietary technology against unauthorized copying or use, as well as any costly litigation or diversion of our management's attention and resources, could delay further sales or the implementation of our solutions, impair the functionality of our solutions, delay introductions of new solutions, result in our substituting inferior or more costly technologies into our solutions, or have a material adverse effect on our business, financial condition and results of operations.

Third parties may claim that we are infringing their intellectual property, and we could suffer significant litigation or licensing expenses or be prevented from selling certain solutions, which could have a material adverse effect on our business, financial condition and results of operations.

We could be subject to claims that we are misappropriating or infringing intellectual property or other proprietary rights of others. These claims, even if not meritorious, could be expensive to defend and divert management's attention from our operations. If we become liable to third parties for infringing these rights, we could be required to pay a substantial damage award and develop non-infringing technology, cease using the solutions or providing the services that use or contain the infringing intellectual property or obtain a license. We may be unable to develop non-infringing solutions or obtain a license on commercially reasonable terms, or at all. We may also be required to indemnify our clients if they become subject to third party claims relating to intellectual property that we license or otherwise provide to them, which could be costly. If we are subject to claims of misappropriating or infringing the intellectual property or other proprietary rights of others, it could have a material adverse effect on our business, financial condition and results of operations.

Our ability to execute on our business plans will be negatively impacted if we fail to meet objectives under our business initiatives including to properly manage our growth, which could have a material adverse effect on our business, financial condition and results of operations.

We are continually pursuing business initiatives to update our technology, increase innovation and obtain operating efficiencies. As part of these initiatives, we seek to improve our productivity, flexibility, quality, functionality and cost savings by investing in the development and implementation of global platforms and integration of our business processes and functions to achieve economies of scale. These various initiatives may not yield their intended gains, which may impact our competitiveness and our ability to meet our growth objectives. In particular, in recent years, the size and the scope of our business operations have expanded

rapidly, particularly as a result of the Connolly iHealth Merger, and we expect that we will continue to grow and expand into new areas within the healthcare industry. However, such growth and expansion carry costs and risks that, if not effectively managed, could have a material adverse effect on our business, financial condition and results of operations. To effectively manage our business plans, we must continue to improve our operations, while remaining competitive. We must also be flexible and responsive to our clients' needs and to changes in the political, economic and regulatory environment in which we operate. The greater size and complexity of our expanding business puts additional strain on our administrative, operational and financial resources and makes the determination of optimal resource allocation more difficult. A failure to anticipate or properly

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address the demands that our growth and diversification may have on our resources and existing infrastructure may result in unanticipated costs and inefficiencies and could negatively impact our ability to execute on our business plans and growth goals, which could have a material adverse effect on our business, financial condition and results of operations.

If we do not successfully integrate future acquisitions or strategic partnerships that we may enter into, we may not realize the anticipated benefits of any such acquisitions or partnerships, which could have a material adverse effect on our business, financial condition and results of operations.

We have previously and expect in the future to pursue acquisitions to expand and diversify our business, solutions or technology. For example, on July 14, 2017, we acquired RowdMap. We may also form strategic partnerships with third parties that we believe will complement or augment our existing business. We cannot, however, provide assurance that we will be able to identify any potential acquisition or strategic partnership candidates, consummate any additional acquisitions or enter into any strategic partnerships or that any future acquisitions or strategic partnerships will be successfully integrated or will be advantageous to us. Entities we acquire may not achieve the revenue and earnings we anticipate or their liabilities may exceed our expectations. We could face integration issues pertaining to the internal controls and operational functions of the acquired companies and we also could fail to realize cost efficiencies or synergies that we anticipated when selecting our acquisition candidates. The pursuit of potential acquisitions or the integration of consummated acquisition could divert management attention and cause us to incur expenses for identifying, investigating and pursuing suitable acquisitions, whether or not they are consummated. Client dissatisfaction or performance problems with a particular acquired entity or resulting from a strategic partnership could have a material adverse effect on our reputation as a whole. We may be unable to profitably manage any acquired entities, or we may fail to integrate them successfully without incurring substantial expenses, delays or other problems. We may not achieve the anticipated benefits from any acquisitions or strategic partnerships including the RowdMap Acquisition, due to a number of factors, including:

- inability or difficulty integrating and benefiting from acquired technologies, solutions or clients in a profitable manner, including as a result of reductions in operating income, increases in expenses, failure to achieve synergies, or otherwise;
- unanticipated costs or liabilities associated with the acquisition or strategic partnership;
- difficulty integrating the accounting systems, operations, and personnel of the acquired business;
- adverse effects to our existing business relationships and clients or to the acquisition's business relationships and clients as a result of the acquisition or strategic partnership;
- loss of key employees, particularly those of the acquired business;
- assumption of potential liabilities of the acquired business, including regulatory noncompliance or acquired litigation, and expenses from the acquired business for contractual disputes, infringement of intellectual property rights, data privacy violations or other claims;
- difficulty in acquiring suitable businesses, including challenges in predicting the value an acquisition will ultimately contribute to our business; and

- use of substantial portions of our available cash or assumption of additional indebtedness to consummate an acquisition.

If we fail to successfully integrate the businesses that we acquire or strategic partnerships that we enter into, we may not realize any of the benefits we anticipate in connection with the acquisitions or partnerships, which could have a material adverse effect on our business, financial condition and results of operations.

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We may not be able to realize the entire book value of goodwill and other intangible assets from the Connolly iHealth Merger or from other acquisitions.

As of December 31, 2017, we have $1,251.4 million of goodwill and $492.0 million of net intangible assets, primarily related to the Connolly iHealth Merger and from other acquisitions. We assess goodwill and other intangible assets for impairment at least annually and more frequently if certain events or circumstances warrant. In the event that the book value of goodwill or other intangible assets is impaired, any such impairment would be charged to earnings in the period of impairment. In the event that we determine that goodwill and other intangible assets are impaired in the future, it could have a material adverse effect on our business, financial condition and results of operations.

Our business, financial condition and results of operations could be adversely affected if the terms of our current Medicare RAC program contracts are substantially changed or if CMS seeks significant refunds under our original Medicare RAC program contract.

During 2017, we had three effective Medicare RAC contracts: our original Medicare RAC contract and two new Region 2 (Central U.S.) and Region 3 (Southeast U.S.) Medicare RAC contracts. Active recovery auditing under our original Medicare RAC contract ended in July 2016, and the contract terminated in accordance with its terms on January 31, 2018. We began reviewing medical charts under the new Region 2 and Region 3 Medicare RAC contracts, which have one year initial terms, with multiple one year renewal options at the election of CMS, in the first quarter of 2017.

CMS has discretion with respect to the number of claims and types of concepts that Medicare RAC contractors may audit. For example, CMS has suspended the review of certain types of claims, and, effective October 1, 2015, shifted the responsibility for initial medical reviews for certain claims, many of which were profitable to us, to Quality Improvement Organizations. There can be no assurance that CMS will lift its suspension of such reviews and CMS may determine to restrict the types of claims its payment accuracy providers review even further. The continued suspension of these reviews, changes to review strategies and any other changes to the Medicare RAC program could have a material impact on our future revenue under our new Medicare RAC contracts.

In addition, on August 29, 2014, CMS announced that it would settle with hospitals willing to withdraw inpatient status claims currently pending in the Medicare RAC appeals process by offering to pay hospitals 68% for all eligible claims under appeal. CMS then indicated to us and the other Medicare RACs that we will only be entitled to the contracted contingency fee on the settled amounts of the claims, or 32% of the original claim amounts. Based on the initial lists of finalized settlements provided by CMS, if CMS were successful in adjusting the contracted contingency fee, we would be required to refund CMS approximately $22.3 million in Medicare RAC contingency fees due to these adjustments, which is in excess of the amount we have accrued for these settlements. In 2016, CMS announced a second settlement process to allow eligible providers to settle their inpatient status claims currently under appeal beginning on December 1, 2016. These additional settlements could result in CMS claims that it is entitled to additional refunds, however, CMS has not asserted any such claims since the initial communication and the amount of additional claims, if any, cannot be determined at this time. Although we accrue an estimated liability for appeals based on the amount of fees subject to appeals, closures, or other adjustments, and we similarly accrue an allowance against accounts receivables related to fees yet to be collected, the impact of CMS' settlement offer to hospitals remains uncertain. We have and continue to vigorously dispute any obligation to repay contingency fees related to claims settled as part of CMS's hospital settlement initiative. Our original Medicare RAC contract with CMS expired on January 31, 2018. As a result of the contract expiration, we believe our obligation under the settlement processes described above expired. See Note 20 to our consolidated financial statements for further information.

We believe that our Medicare RAC contracts with CMS represent a significant future business opportunity for us. If the types of claims subject to recovery audits under our new Medicare RAC contracts is significantly reduced or subject to suspension or delay, if CMS fails to renew the new contracts at the end of any term, if CMS seeks significant refunds from us in connection with its settlement process, or if CMS imposes or implements other changes to the Medicare RAC program that materially reduce our revenue or profitability associated with the Medicare RAC program, any such change, action or delay could have a material adverse effect on our business, financial condition and results of operations.

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If we fail to maintain and enhance awareness of our brand, our future growth rate might be impacted and our business might suffer.

Maintaining and enhancing awareness of our brand in a cost-effective manner is critical to continuing the widespread acceptance of our existing solutions and is an important element in attracting new clients and in attracting and retaining qualified employees. The promotion of our brands may require us to make substantial investments which may become not only increasingly important, but also increasingly difficult or expensive as competition in our market increases. Successful promotion of our brand will depend largely on the effectiveness of our marketing efforts and on our ability to provide value to clients through our solutions. Our efforts to build and maintain our brand have involved and will continue to involve significant expense, and may not yield increased revenue. In addition, third parties' use of trademarks and branding similar to ours could materially harm our business or result in litigation or other expenses. If we fail to successfully maintain our brand, or incur substantial expenses in attempts to maintain our brand, it could have a material adverse effect on our business, financial condition and results of operations.

We obtain a portion of our business through submitting responses to requests for proposals, or "RFPs." Future contracts may not be awarded through this process on the same level and we may not re-procure certain contracts.

In order to market our solutions to clients, we sometimes are required to respond to RFPs to compete for a contract. This requires that we accurately estimate our cost structure for servicing a proposed contract, the time required to establish operations and the likely terms of any proposals submitted by our competitors. We also must assemble and submit a large volume of information within a RFP's rigid timetable. Our ability to provide timely and complete responses to RFPs will greatly impact our business. Should any part of our business suffer a negative event, for example, a client dispute or a government inquiry, we may be required to disclose the occurrence of that event in a RFP, which could impact our ability to win the contract at issue. We cannot provide assurance that we will continue to obtain contracts in response to RFPs, that we will be successful in reentering into contracts after they expire or that our proposals will result in profitable contracts. In addition, if we are unable to win particular contracts, we may be precluded from entering certain markets for a number of years. If we are unable to consistently win new contract awards or renew expiring contracts over any extended period, it could have a material adverse effect on our business, financial condition and results of operations.

We may be precluded from bidding on and/or performing certain work due to other work that we perform, which could have a material adverse effect on our business, financial condition and results of operations.

Various laws, regulations and administrative policies prohibit companies from performing work for government agencies in capacities that might be viewed as creating an actual or perceived conflict of interest. In particular, CMS has stringent conflict of interest rules, which limit our bidding for work that might conflict, or be perceived by CMS to conflict, with contractual work for CMS. State governments and managed care organizations also have conflict of interest restrictions that could limit our ability to bid for certain work. Conflict of interest rules and standards change frequently and are subject to varying interpretations and varying degrees and consistency of enforcement at the federal, state and municipal levels, and we cannot provide assurance that we will be successful in navigating these restrictions.

The expansion and diversification of our business operations increases the possibility that clients or potential clients will perceive conflicts of interest between our various subsidiaries, products, services, activities and client relationships. Such conflicts, whether real or perceived, could result in loss of contracts or require us to divest ourselves of certain existing

business in order to qualify for new contract awards. We may be required to adjust our current management and personnel structure, as well as our corporate organization and entity structure, in order to appropriately mitigate conflicts and otherwise accommodate our needs as a company that is expanding in size and complexity. Our failure to devote sufficient care, attention and resources to managing these adjustments may result in technical or administrative errors that could expose us to potential liability or adverse regulatory action. If we are prevented from expanding our business due to real or perceived conflicts of interest, it could have a material adverse effect on our business, financial condition and results of operations.

Our success depends, in part, on the continued service and availability of key personnel.

Our success and future growth is dependent upon the ability of our executive officers, senior managers and other key personnel to operate and manage our business and execute on our business and growth strategies successfully. We cannot provide assurance that we will be able to continue to retain our executive officers, senior managers or other

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key personnel or attract additional key personnel. We may incur increased expenses in connection with the hiring, promotion, retention or replacement of any of these individuals. The loss of the services of any of our key personnel could have a material adverse effect on our business, financial condition and results of operations.

Our business is dependent on our ability to attract and retain qualified employees.

Our ability to operate our business and provide our solutions is dependent on our ability to recruit, employ, train and retain the skilled personnel who have relevant experience in the healthcare and retail industries as well as information technology professionals who can design, implement, operate and maintain complex information technology systems. For example, certain of our employees in our healthcare division must either have or rapidly develop a significant amount of technical knowledge with regard to medical insurance coding and procedures. In addition, certain of our retrospective claims accuracy solutions rely on a team of trained registered nurses or medical coding professionals to review medical information and provide feedback with respect to the medical appropriateness of care provided. Innovative, experienced and technologically proficient professionals, qualified nurses and experienced medical coding professionals are in great demand and are likely to remain a limited resource. Our ability to recruit and retain such individuals depends on a number of factors, including the competitive demands for employees having, or able to rapidly develop, the specialized skills we need and the level and structure of compensation required to hire and retain such employees. We may not be able to recruit or retain the personnel necessary to efficiently operate and support our business. Even if our recruitment and retention strategies are successful, our labor costs may increase significantly. In addition, our internal training programs may not be successful in providing inexperienced personnel with the specialized skills required to perform their duties. If we are unable to hire, train, motivate and retain sufficient personnel with the requisite skills without significantly increasing our labor costs, it could have a material adverse effect on our business, financial condition and results of operations.

If we are not able to expand our retail business or reduce costs of implementing our retail solutions, revenue and profitability for our retail business could remain flat or decline, which could have a material adverse effect on our business, financial condition and results of operations.

The domestic retail payment accuracy market is a highly developed market with limited potential for growth. We have payment accuracy solution contracts with eight of the ten largest U.S. retailers and longer than ten year relationships with many of our top retail clients, which represents a significant share of the retail payment accuracy market and, therefore, the opportunity to grow our share of the existing domestic retail market is limited. In addition, some of our clients have an internal staff that reviews the transactions before we do. As the skills, experience and resources of our retail clients' internal recovery staff improve, they will identify many overpayments themselves and reduce some of our opportunities to identify payment inaccuracies and generate related revenue. If we are not able to reduce the costs of implementing our payment accuracy solutions, our domestic retail business revenue may remain flat or decline, which could have a material adverse effect on our business, financial condition and results of operations.

Our results of operations are subject to significant fluctuations due to a variety of factors, some of which are outside of our control. As a result, you will not be able to rely on our results of operations in any particular period as an indication of our future performance.

Our results of operations may fluctuate and may fail to match our past or projected performance. Because we generally provide solutions under contracts that contain performance fee arrangements and generally recognize revenue only when our clients have received the economic value of the payment inaccuracies discovered using our solutions, we have experienced significant variations in our revenue between reporting periods due to the timing and delays in resolving these inaccuracies. We also occasionally face challenges in obtaining full payments for our properly provided solutions from clients and parties to whom we provide solutions, despite our right to prompt and full payment under the terms of our contracts.

Our revenue and results of operations also have been impacted from period to period as a result of a number of factors, including:

- number of payments reviewed and changes in scope of payments reviewed;
- amount of inaccurate payments identified using our solutions and the amount of related recoveries;

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- the success of our cross-selling efforts;
- fluctuations in sales activity given our lengthy sales cycle;
- the commencement, completion or termination of contracts during any particular period;
- expenses related to contracts that are incurred in periods prior to revenue being recognized;
- the timing of government contract awards;
- the time required to resolve bid protests related to government contract awards;
- contract renewal discussions, which may result in delayed payments for previously provided services;
- the intermittent timing of periodic revenue recovery projects, particularly for our retail clients;
- non-recurring retail recovery projects;
- technological and operational issues affecting our clients, including delays in payment receipt for previously recognized revenue due to delays in certain clients processing our findings through their systems;
- adjustments to age/quality of receivables and accruals as a result of delays involving contract limitations and changes, subcontractor performance deficiencies or internal managerial decisions not to pursue identified claim revenue from clients;
- seasonality in our business; and
- regulatory changes or general economic conditions as they affect healthcare providers and payers and retailers.

In addition, as we seek to expand the scope of solutions used by our existing clients, cross-sell our solutions to existing clients and introduce enhancements to our existing solutions or new solutions, we may not be able to accurately estimate the timing for implementing and completing contracts, making it difficult to reliably forecast revenue under those contracts. We cannot predict the extent to which future revenue variations could occur due to these or other

factors. Consequently, our results of operations are subject to significant fluctuation and our results of operations for any particular quarter or fiscal year may not be indicative of results of operations for future periods.

Our use of accounting estimates involves judgment and actual results could differ, and ineffective internal controls could adversely impact our business and operating results.

The methods, estimates, and judgments that we use in applying accounting policies have a significant impact on our results of operations. For more information on our critical accounting policies and estimates, see Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Note 2, "Summary of Significant Accounting Policies", of the notes to our consolidated financial statements, each included elsewhere in this Annual Report on Form 10-K. These methods, estimates, and judgments are subject to significant risks, uncertainties, and assumptions, and changes could affect our results of operations.

In addition, our internal control over financial reporting may not prevent or detect misstatements because of the inherent limitations, including the possibility of human error, the circumvention or overriding of controls, or fraud. Even effective internal controls can provide only reasonable assurance with respect to the preparation and fair presentation of our consolidated financial statements. If we are unable to maintain adequate internal control over financial reporting, we may be unable to report our financial information accurately on a timely basis, may suffer adverse regulatory consequences or violations of applicable stock exchange listing rules, may not be in compliance with the covenants under our credit facilities and incur additional costs. There could also be a negative reaction in the financial markets due to a loss of investor confidence in us and the reliability of our financial statements, which could have a material adverse effect on our business, financial condition and results of operations, further harm investor confidence, and negatively impact the trading price of our common stock.

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We may be a party to litigation, regulatory actions or other dispute resolution proceedings. Adverse judgments or settlements in any of these proceedings could have a material adverse effect on our business, financial condition and results of operations.

We are subject and may be a party to lawsuits and other claims that arise from time to time in the ordinary course of our business. These may include lawsuits and claims related to, for example, contracts, subcontracts, protection of confidential information or trade secrets, wage and benefits, employment of our workforce or compliance with any of a wide array of state and federal statutes, rules and regulations that pertain to different aspects of our business. We also may be required to initiate expensive litigation or other proceedings to protect our business interests. In addition, because of the payments we receive from government clients, we may be subject to unexpected inquiries, investigations, legal actions or enforcement proceedings pursuant to the Federal False Claims Act, healthcare fraud, waste and abuse laws or similar legislation. Any investigations, settlements or adverse judgments stemming from such legal disputes or other claims may result in significant monetary damages or injunctive relief against us, as well as reputational injury that could adversely affect us. In addition, litigation and other legal claims are subject to inherent uncertainties and management's view of currently pending legal matters may change in the future. Those uncertainties include, but are not limited to, costs of litigation, unpredictable judicial or jury decisions and the differing laws and judicial proclivities regarding damage awards among the states in which we operate. Unexpected outcomes in such legal proceedings, or changes in management's evaluation or predictions of the likely outcomes of such proceedings, could have a material adverse effect on our business, financial condition and results of operations.

We could experience losses or incur liabilities not covered by insurance.

Our business exposes us to risks that are inherent in the provision of analytics. If clients or individuals assert liability claims against us, any ensuing litigation, regardless of outcome, could result in a substantial cost to us, divert management's attention from operations, and decrease market acceptance of our toolsets. We attempt to limit our liability to clients by contract; however, the limitations of liability set forth in the contracts may not be enforceable or may not otherwise protect us from liability for damages. Additionally, we may be subject to claims that are not explicitly covered by contract. We also maintain general liability coverage; however, this coverage may not continue to be available on acceptable terms, may not be

available in sufficient amounts to cover one or more large claims against us, and may include larger self-insured retentions or exclusions for certain products. In addition, the insurer might disclaim coverage as to any future claim. A successful claim not fully covered by our insurance could have a material adverse impact on our business, financial condition and results of operations.

Risks Relating to Information Technology

We obtain and process a large amount of sensitive data. Our systems and networks may be subject to cyber-security breaches and other disruptions that could compromise our information. Any real or perceived improper use of, disclosure of, or access to such data could harm our reputation as a trusted brand, as well as have a material adverse effect on our business, financial condition and results of operations.

We use, obtain and process large amounts of confidential, sensitive and proprietary data, including PHI subject to regulation under HIPAA and PII subject to state and federal privacy, security and breach notification laws. The secure processing and maintenance of this information is critical to our operations and business strategy and we use various proprietary and third-party information and security technology, software applications and other technology systems to do so. Our third-party applications include enterprise cloud storage and cloud computing application services provided and maintained by third-party vendors. We are dependent on the continuity and effectiveness of our information and cyber security infrastructure, polices, procedures and capabilities to protect our systems and the data that reside on or are transmitted through them and contracted third-party systems. Any disruptions, inaccuracies, delays, systems failures, data or privacy breaches, or other security breaches (including any cyber security breaches) in these and other processes could subject us to client dissatisfaction and losses and damage our reputation.

Our databases and systems, as well as those of our third party vendors, have been, and likely will continue to be, subject to computer viruses or other malicious codes, unauthorized access attempts, denial of service attacks, phishing and other cyber attacks. We also face risks associated with new personnel, as well as with new processes and technologies which are implemented from time to time to augment our security and privacy management programs. To date, we have seen no material impact on our business or operations from these attacks, however, we cannot guarantee that our security efforts or the security efforts of our third party vendors will prevent breaches or breakdowns to our or

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their databases or systems. If our security measures or those of the third party vendors we use who have access to this information are inadequate or are breached as a result of third party action, employee error, malfeasance, malware, phishing, hacking attacks, system error, trickery or otherwise, and, as a result, someone obtains unauthorized access to sensitive information, including PHI and PII, on our systems or our providers' systems, our reputation and business could be damaged. We cannot guarantee that our security efforts will prevent breaches or breakdowns to our or our third party vendors' databases or systems. The occurrence of any of these events could cause our solutions to be perceived as vulnerable, cause our clients to lose confidence in our solutions, negatively affect our ability to attract new clients and cause existing clients to terminate or not renew their use of our services and solutions and severely damage our reputation and/or investor confidence in us. If the information is lost, improperly disclosed or threatened to be disclosed, we could incur significant liability and be subject to regulatory scrutiny and penalties. Furthermore, we could be forced to expend significant resources in identifying and responding to any evolving threats or vulnerabilities, or a security breach, including investigating the cause of the breach, repairing system damage, increasing cyber-security protection costs by deploying additional personnel and protection technologies, notifying and providing credit monitoring to affected individuals, paying regulatory fines and litigating and resolving legal claims and regulatory actions, all of which could increase our expenses and divert the attention of our management and key personnel away from our business operations. Techniques used in infiltrating or sabotaging systems change frequently and generally are not recognized until after they are launched. We may experience security or other breach incidents that remain undetected for a period of time. In addition, we continuously receive data feeds from our clients, so any infiltration of our clients' systems may be transmitted to us.

In addition, if our own confidential business information were improperly disclosed, our business could be materially adversely affected. A core aspect of our business is the

reliability and security of our technology platform. Any perceived or actual breach of security could have a significant impact on our reputation as a trusted brand, cause us to lose existing clients, prevent us from obtaining new clients, require us to expend significant funds to remedy problems caused by breaches and to implement measures to prevent further breaches, and expose us to legal risk and potential liability. Any security breach at a third party vendor providing services to us could have similar effects. Any breach or disruption of any systems or networks on which we rely could have a material adverse effect on our business, financial condition and results of operations.

Certain of our activities present the potential for identity theft or similar illegal behavior by our employees or contractors with respect to third parties, which could have a material adverse effect on our business, financial condition and results of operations.

Our solutions involve the use and disclosure of personal information that in some cases could be used to impersonate third parties or otherwise improperly gain access to their data or funds. If any of our employees or contractors take, convert or misuse such information, or we experience a data breach creating a risk of identity theft, we could be liable for damages and our business reputation could be damaged. In addition, we could be perceived to have facilitated or participated in illegal misappropriation of documents or data and, therefore, be subject to civil or criminal liability. Federal and state regulators may take the position that a data breach or misdirection of data constitutes an unfair or deceptive act or trade practice. We also may be required to notify individuals affected by any data breaches. Further, a data breach or similar incident could impact the ability of our clients that are "creditors" under the federal "red flags" rules to comply with those rules, which require the implementation of identity theft prevention programs to detect, prevent and mitigate identity theft in connection with client accounts, which could be costly to our clients and to us. If data utilized in our solutions are misappropriated for the purposes of identity theft or similar illegal behavior, it could have a material adverse effect on our reputation, business, financial condition and results of operations.

Our business depends on effective information processing systems that are compliant with current HIPAA transaction and code set standards and the integrity of the data in, and operations of, our information systems, as well as those of other entities that provide us with data or receive data from us.

Our ability to conduct our operations and accurately report our financial results depends on the integrity of the data in our information systems and the integrity of the processes performed by those systems. These information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs, satisfy client requests and handle and enable our expansion and growth. Despite our testing and quality control measures, we cannot be certain that errors or system deficiencies will not be found and that any necessary remediation can be done in a timeframe that is acceptable to our clients or that client relationships will not be impaired by the occurrence of errors or the need for remediation. In addition, implementation of upgrades and enhancements may cost more, take longer or

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require more testing than originally expected. Given the large amount of data we collect and manage, it is possible that hardware failures, errors or technical deficiencies in our systems could result in data loss or corruption or cause the information that we collect, utilize or disseminate to be incomplete or contain inaccuracies that our clients regard as significant.

Moreover, because many of the services we furnish to clients involve submitting high volumes of monetary claims to third parties and processing payments from them, the efficiency and effectiveness of our own operations are to some degree dependent on the claims processing systems of these third parties and their compliance on a timely basis with any new transaction and code set standards. Claims processing systems failures, incapacities or deficiencies internal to these third parties could significantly delay or obstruct our ability to recover money for our clients, and thereby interfere with our performance under our contracts and our ability to generate revenue from those contracts in the timeframe we anticipate, which in turn could have a material adverse effect on our business, financial condition and results of operations.

System interruptions or failures could expose us to liability and have a material adverse effect on our business, financial condition and results of operations.

Our data and operations centers are essential to our business, which depends on our ability to maintain and protect our information systems. In addition, our operations are spread

across the United States, Canada, the United Kingdom and India and we rely heavily on technology to communicate internally and efficiently perform our services. We have implemented measures that are designed to mitigate the potential adverse effects of a disruption, relocation or change in operating environment; however, we cannot provide assurance that the situations we plan for and the amount of insurance coverage that we maintain will be adequate in any particular case. In addition, despite system redundancy and security measures, our systems and operations are vulnerable to damage or interruption from, among other sources:

- power loss, transmission cable cuts and telecommunications failures;
- damage or interruption caused by fire, earthquake and other natural disasters;
- attacks by hackers or nefarious actors;
- human error;
- computer viruses and other malware, or software defects; and
- physical break-ins, sabotage, intentional acts of vandalism, terrorist attacks and other events beyond our control.

If we encounter a business interruption, if we fail to effectively maintain our information systems, if it takes longer than we anticipate to complete required upgrades, enhancements or integrations or if our business continuity plans and business interruption insurance do not effectively compensate on a timely basis, we could suffer operational disruptions, disputes with clients, civil or criminal penalties, regulatory problems, increases in administrative expenses, loss of our ability to produce timely and accurate financial and other reports or other adverse consequences, any of which could have a material adverse effect on our business, financial condition and results of operations.

We use software vendors, utility providers and network providers in our business and if they cannot deliver or perform as expected or if our relationships with them are terminated or otherwise change it could have a material adverse effect on our business, financial condition and results of operations.

Our ability to service our clients and deliver and implement solutions requires that we work with certain third party providers, including software vendors, utility providers and network providers, and depends on such third parties meeting our expectations in both timeliness and quality. We might incur significant additional liabilities if the services provided by these third parties do not meet our expectations, if they terminate or refuse to renew their relationships with us or if they were to offer their services to us on less advantageous terms, which could have a material adverse effect on our business, financial condition and results of operations. In addition, while there are backup systems in many of our operating facilities, an extended outage of utility or network services supplied by these vendors or providers could

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impair our ability to deliver our solutions, which could have a material adverse effect on our business, financial condition and results of operations.

Our use of "open source" software could adversely affect our ability to offer our solutions and subject us to possible litigation.

The products or technologies acquired, licensed or developed by us may incorporate "open source" software, and we may use open source software in connection with our solutions. Companies that incorporate open source software into their products have, from time to time, faced claims challenging the use of open source software and/or compliance with open source license terms. As a result, we could be subject to suits by parties claiming ownership of what we believe to be open source software or claiming noncompliance with open source licensing terms. Some open source software licenses require users who distribute software containing open source software to publicly disclose all or part of the source code to such software and/or make available any derivative works of the open source code, which could include valuable proprietary code of the user, on unfavorable terms or at no cost. While we monitor the use of open source software and try to ensure that none is used in a manner that would require us to disclose our proprietary source code or that would otherwise breach the terms of an open source

agreement, such use could inadvertently occur, in part because open source license terms are often ambiguous. Any requirement to disclose our proprietary source code or pay damages for breach of contract could have a material adverse effect on our business, financial condition and results of operations and could help our competitors develop products and solutions that are similar to or better than ours.

Risks Relating to Our Industry

Healthcare spending fluctuations, simplification of the healthcare delivery and reimbursement system, programmatic changes to the scope of benefits and limitations to payment integrity initiatives could reduce the need for and the price of our solutions, which could have a material adverse effect on our business, financial condition and results of operations.

Our solutions improve our healthcare clients' ability to accurately pay healthcare claims and prevent or recover inaccurate payments, which often are a result of complexities in the healthcare claims payment system. Although the healthcare benefit and payment system continues to grow in complexity due to factors such as increased regulation and increased healthcare enrollment, the need for our solutions, the price clients are willing to pay for them and/or the scope and profitability of the solutions that we provide to our clients could be negatively affected by, among other things:

- simplification of the U.S. healthcare delivery and reimbursement systems, either through shifts in the commercial healthcare marketplace or through legislative or regulatory changes at the federal or state level;
- reductions in the scope of private sector or government healthcare benefits (for example, decisions to eliminate coverage of certain services or the possible repeal or restructuring of the Affordable Care Act);
- the transition of healthcare beneficiaries from fee-for-service plans to value-based plans;
- the adoption of healthcare plans with significantly higher deductibles;
- limits placed on payment integrity initiatives, including the Medicare RAC program; and
- lower than projected growth in private health insurance or the various Medicare and Medicaid programs, including Medicare Advantage.

Any of these developments could have a material adverse effect on our business, financial condition and results of operations.

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Consolidation among healthcare payers or retailers could have a material adverse effect on our business, financial condition and results of operations.

The healthcare and retail industries have recently undergone significant consolidation and further consolidation could occur in the future. When companies consolidate, services provided by more than one provider may be consolidated and purchased from a single provider or they may renegotiate or not renew their existing contractual arrangements, which could lead to the loss of a client. Overlapping services that were previously purchased separately typically are purchased only once by the combined entity, resulting in loss of revenue for the service provider. If our clients merge with or are acquired by other entities that are not our clients, they may discontinue their use of our solutions or renegotiate the terms of our agreements. If an existing client of ours merges with or is acquired by a company that does not use payment accuracy solutions, we could lose our existing client. Finally, consolidation may also result in the acquisition or future development by our clients of products and services that compete with our products and services. Any of these potential results of consolidation could have a material adverse effect on our business, financial condition and results of operations.

The healthcare payment accuracy market is relatively new and unpenetrated, and if it does not develop or if it develops more slowly than we expect, it could have a material adverse effect on our business, financial condition and results of operations.

The healthcare payment accuracy market is relatively new and the overall market opportunity remains relatively unpenetrated. It is uncertain whether the healthcare payment accuracy market will achieve and sustain high levels of demand, client acceptance and market adoption. Our success will depend to a substantial extent on the willingness of our clients to use, and to increase the frequency and extent of their utilization of, our solutions, as well as on our ability to demonstrate the value of payment accuracy solutions to healthcare payers and government agencies. If our current and future clients do not perceive the benefits of our solutions, then our market may not continue to develop, or it may develop more slowly than we expect. If any of these events occurs, it could have a material adverse effect on our business, financial condition and results of operations.

Negative publicity concerning the healthcare payment accuracy industry or patient confidentiality and privacy could limit the future growth of the healthcare payment accuracy market.

Our payment accuracy solutions help prevent and recover improper payments made to healthcare providers. As a result, healthcare providers and others have criticized the healthcare payment accuracy industry and have hired lobbyists to discredit the reported success that payment accuracy solutions have had in improving the accuracy of payments. Further, negative publicity regarding patient confidentiality and privacy could limit market acceptance of our healthcare solutions. Many consumer advocates, privacy advocates and government regulators believe that the existing laws and regulations do not adequately protect privacy. They have become increasingly concerned with the use of personal information. As a result, they are lobbying for further restrictions on the dissemination or commercial use of personal information to the public and private sectors. If healthcare providers, privacy advocates and others are successful in creating negative publicity for the healthcare payment accuracy industry, government and private healthcare payers could hesitate to contract with payment accuracy providers, such as us, which could have a material adverse effect on our reputation, business, financial condition and results of operations.

We face significant competition for our solutions and we expect competition to increase.

Competition among providers of healthcare payment accuracy solutions to U.S. healthcare insurance companies is strong and we may encounter additional competition as new competitors enter this area.

Our current healthcare solutions competitors include:

- other payment accuracy vendors, including vendors focused on discrete aspects of the healthcare payment accuracy process;
- fraud, waste and abuse claim edit and predictive analysis companies;
- primary claims processors;

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- numerous regional utilization management companies;
- in-house payment accuracy capabilities;
- other Medicare RACs; and
- healthcare consulting firms and other third party liability service providers.

In addition, our competition for retail solutions consists of one main competitor, PRGX Global, Inc. and a number of smaller companies that do not have a material market share of the retail payment accuracy market.

Many of the payment accuracy solutions we provide may potentially be provided by competitors, and their success in attracting business or winning contract bids could adversely affect our business. In certain cases, our competitors and potential competitors have significantly greater resources and market recognition than we have and may be in a position to bundle services that compete with our product and services offerings, or may be able to devote greater

resources to the sale of their services and to developing and implementing new and improved systems and solutions for the clients that we serve.

We cannot provide assurance that we will be able to compete successfully against existing or new competitors. In addition, we may be forced to lower our pricing or the demand for our solutions may decrease as a result of increased competition. Further, a failure to be responsive to our existing and potential clients' needs could hinder our ability to maintain or expand our client base, hire and retain new employees, pursue new business opportunities, complete future acquisitions and operate our business effectively. Any inability to compete effectively could have a material adverse effect on our business, financial condition and results of operations.

Because we sell our solutions to retail clients located outside of the United States, our business is susceptible to risks associated with international operations.

We maintain operations outside of the United States which we may expand in the future. Conducting and expanding international operations subjects us to risks that we have not generally faced in the United States. These include:

- exposure to foreign currency exchange rate risk;
- difficulties in collecting payments internationally and managing and staffing international operations;
- establishing relationships with subcontractors and suppliers in international locations;
- increased travel, infrastructure and legal compliance costs associated with international locations;
- burdens of complying with a wide variety of laws associated with international operations, including data privacy and security, taxes and customs, labor and employment, and intellectual property;
- significant fines, penalties and collateral consequences if we fail to comply with anti-bribery laws;
- heightened risk of improper, unfair or corrupt business practices in certain geographies;
- potentially adverse tax consequences, including repatriation of earnings;
- increased financial accounting and reporting burdens and complexities;
- political, social and economic instability abroad, terrorist attacks and security concerns in general; and
- reduced or varied protection for intellectual property rights in some countries.

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The occurrence of any one of these risks could negatively affect our international operations and, consequently, have a material adverse effect on our business, financial condition and results of operations.

General economic, political and market forces and dislocations beyond our control could reduce demand for our solutions, which could have a material adverse effect on our business, financial condition and results of operations.

The demand for our solutions may be impacted by factors that are beyond our control, including macroeconomic, political and market conditions, the availability of short-term and long-term funding and capital, the level and volatility of interest rates, currency exchange rates and inflation. For example, the United States economy has, at times, experienced periods of contraction and both the future domestic and global economic environments may continue to be

less favorable than those of prior years. In addition, the United Kingdom electorate voted on June 23, 2016, to exit the European Union (which has popularly been referred to as "Brexit"), resulting in market volatility that may continue during the Brexit negotiation process. Any one or more of these factors may contribute to reduced activity and prices in the securities markets generally and could result in a reduction in demand for our solutions, which could have a material adverse effect on our business, results of operations and financial condition.

Risks Relating to Government Regulation

We are subject to extensive government regulation and our contracts with our clients are subject to governmental audit and investigation. Any violation of the laws and regulations applicable to us or a negative audit or investigation finding could have a material adverse effect on our business, financial condition and results of operations.

Much of our business is regulated by the federal government and the states in which we operate. The laws and regulations governing our operations generally are intended to benefit and protect individual citizens, including government program beneficiaries, health plan members and healthcare providers, rather than stockholders. The government agencies administering these laws and regulations have broad latitude to enforce them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer and how we interact with our clients, providers, other healthcare payers and the public. We are subject, on an ongoing basis, to various governmental reviews, audits and investigations to verify our compliance with our contracts and with applicable laws and regulations. Increased involvement by us in analytic or audit work that can have an impact on the eligibility of individuals for medical coverage or specific benefits could increase the likelihood and incidence of our being subjected to scrutiny or legal actions by parties other than our clients, based on alleged mistakes or deficiencies in our work, with significant resulting costs and strain on our resources.

In addition, because we receive payments from federal and state governmental agencies, we are subject to various laws, including the Federal False Claims Act and similar state statutes, which permit government law enforcement agencies to institute suits against us for violations and, in some cases, to seek double or treble damages, penalties and assessments. In addition, private citizens, acting as whistleblowers, can sue on behalf of the government under the "qui tam" provisions of the Federal False Claims Act and similar statutory provisions in many states.

The expansion of our operations into new products and services may further expose us to requirements and potential liabilities under additional statutes and legislative schemes that previously have not been relevant to our business, such as banking statutes, that may both increase demands on our resources for compliance activities and subject us to potential penalties for noncompliance with statutory and regulatory standards.

If the government discovers improper or illegal activities in the course of audits or investigations, we may be subject to various civil and criminal penalties and administrative sanctions, which may include termination of contracts, forfeiture of profits, suspension of payments, fines and suspensions and debarment from doing business with the government. Such risks, particularly under the Federal False Claims Act and similar state fraud statutes, have increased in recent years due to legislative changes that have (among other impacts) expanded the definition of a false claim to include, potentially, any unreimbursed overpayment received from, or other monetary debt owed to, a government agency. If we are found to be in violation of any applicable law or regulation, or if we receive an adverse review, audit or investigation, any resulting negative publicity, penalties or sanctions could have an adverse effect on our reputation in the industry, cause clients to terminate their contracts with us or impair our ability to compete for new contracts and have a material adverse effect on our business, financial condition and results of operations.

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If we fail to comply with applicable privacy, security and data laws, regulations and standards, including with respect to third party service providers that utilize sensitive personal information on our behalf, it could have a material adverse effect on our reputation, business, financial condition and results of operations.

In order to provide our services and solutions, we often receive, process, transmit and store PHI and PII of individuals, as well as other financial, confidential and proprietary information belonging to our clients and third parties (e.g., private insurance companies, financial institutions, etc.). The receipt, maintenance, protection, use, transmission, disclosure and disposal of this information is regulated at the federal, state, international and industry levels. We are also obligated under our contractual requirements with clients, who are themselves subject to extensive regulatory obligations and oversight. These laws, rules and requirements are subject to frequent change. Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs and may constrain or require us to alter our business model or operations. For example, as a result of the Omnibus Final Rule promulgated in 2013 pursuant to the HITECH Act, we became subject to direct federal regulation under HIPAA, which provides for governmental investigations, audits, enforcement actions and penalties.

HIPAA establishes privacy and security standards that limit our use and disclosure of PHI and requires us to implement administrative, physical and technical safeguards to ensure the confidentiality, integrity and availability of PHI, as well as notify our covered entity clients of breaches of unsecured PHI and security incidents. HIPAA also imposes direct penalties on us for violations of its requirements. In addition to HIPAA, we are subject to varying state laws governing the use and disclosure of PII, including medical record information, as well as state laws requiring notification in case of a breach of such information. The Omnibus Final Rule significantly increased the risk of liability to us and our business associate subcontractors both by making us directly subject to many of HIPAA's requirements and by broadening the breach notification standard to make more incidents of inadvertent disclosure reportable and subject to penalties.

We act as a HIPAA "business associate" to our covered entity clients because we collect, use, disclose and maintain PHI to provide services to these clients. HIPAA requires us to enter into satisfactory written business associate agreements with our covered entity clients, which contain specified written assurances that we will safeguard PHI that we create or access and will fulfill other material obligations. Under the Omnibus Final Rule, we may be held directly liable under our business associate agreements and HIPAA for any violations of HIPAA. Therefore, we could face liability to our clients under our contracts with them as well as liability to the government under HIPAA if we do not comply with our business associate obligations and those provisions of HIPAA that are applicable to us. While we take measures to comply with applicable laws and regulations as well as our own internally disseminated privacy and security policies, such laws, regulations and related legal standards for privacy and security continue to evolve and any failure or perceived failure to comply with applicable laws, regulations and standards may result in threatened or actual proceedings, actions and public statements against us by government entities, private parties, consumer advocacy groups or others, or could cause us to lose clients, which could have a material adverse effect on our business, financial condition and results of operations. The penalties for a violation of HIPAA are significant and, if imposed, could have a material adverse effect on our business, financial condition and results of operations. While we have included protections in our contracts with our third party service providers as required by the Omnibus Final Rule, we have limited oversight or control over their actions and practices. In addition, we could also be exposed to data breach risk if there is unauthorized access to one of our or our subcontractors' facilities or servers, to third-party enterprise cloud storage and cloud computing application services we use, or from lost or stolen laptops or other portable media, current or former employee theft of data containing PHI, misdirected mailings containing PHI, or other forms of administrative or operational error. HHS has the authority to conduct audits to assess HIPAA compliance efforts by covered entities and business associates, but it is unclear the extent to which HHS is currently conducting or plans to conduct audits in the future. As a result, we could be subject to an audit. An audit of us or our business associate subcontractors resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third party service providers, could have a material adverse effect on our reputation and business, including, among other consequences, mandatory disclosure to the media, public and regulators, loss of existing or new clients, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards, indemnification costs and liability to third parties, if we breach any confidentiality obligations regarding client data, any of which could have a material

adverse effect on our results of operations, financial position and cash flows. Further, if such laws and regulations are not enforced equally against other competitors in a particular market, our compliance with such laws may put us at a competitive disadvantage vis-à-vis competitors who do not comply with such requirements.

We are also subject to extensive and complex state privacy, security and data laws, regulations and standards, which may impose more restrictive requirements on us than under United States federal laws and regulations. Failure to comply with these enhanced standards could have a material adverse effect on our reputation, business, financial condition and results of operations.

We have clients in most of the 50 states and our solutions may contain healthcare information of patients located across most of the 50 states. Therefore, we may be subject to state privacy laws, which vary from state to state and, in some cases, can impose more restrictive requirements than federal law. Where state laws are more protective, we have to comply with the stricter provisions. In addition to fines and penalties imposed upon violators, some of these state laws also afford private rights of action to individuals who believe their personal information has been misused. California's patient privacy laws, for example, provide for penalties of up to $250,000 per violation and permit injured parties to sue for damages. The interplay of federal and state laws may be subject to varying interpretations by courts and government agencies, creating complex compliance issues for us and our clients and potentially exposing us to additional expense, adverse publicity and liability. Further, as regulatory focus on privacy issues continues to increase and laws and regulations concerning the protection of personal information expand and become more complex, these potential risks to our business could intensify. Changes in laws or regulations associated with the enhanced protection of certain types of sensitive data, such as PHI or PII, along with increased client demands for enhanced data security infrastructure, could greatly increase our cost of providing our services and solutions, decrease demand for our services or solutions, reduce our revenue and/or subject us to additional liabilities.

Because we have international operations, we are also subject to government regulation in foreign jurisdictions, certain of which impose additional privacy requirements and restrictions on us, increasing our cost of doing business in those jurisdictions.

In addition, several foreign governments have regulations dealing with the collection and use of personal information obtained from their citizens. For example, the European Union, or EU, adopted the Data Protection Directive, or DPD, imposing strict regulations and establishing a series of requirements regarding the collection and use of personally identifiable information online. The DPD provides for specific regulations requiring all non-EU countries doing business with EU member states to provide adequate data privacy protection when receiving personal data from any of the EU member states. Similarly, Canada's Personal Information and Protection of Electronic Documents Act provides Canadian residents with privacy protections in regard to transactions with businesses and organizations in the private sector and sets out ground rules for how private sector organizations may collect, use, and disclose personal information in the course of commercial activities. Foreign governments may attempt to apply such laws extraterritorially or through treaties or other arrangements with U.S. governmental entities, and our practice management services for practices along the Canadian border and our market research services could each involve the personal information of foreign residents. Failure to comply with these laws could increase our cost of providing our services and solutions, decrease demand for or restriction our ability to provide our services or solutions, reduce our revenue and/or subject us to additional liabilities in those jurisdictions.

Changes in the United States healthcare environment, or in laws relating to healthcare programs and policies, and steps we take in anticipation of such changes, particularly as they relate to the Affordable Care Act and Medicare and Medicaid programs, could have a material adverse effect on our business, financial condition and results of operations.

The healthcare industry in the United States is subject to a multitude of changing political, economic and regulatory influences that affect every aspect of our healthcare system. The Affordable Care Act made major changes in how healthcare is delivered and reimbursed, and generally increased access to health insurance benefits to the uninsured and underinsured population of the United States. Among other things, the Affordable Care Act increased the number of individuals with Medicaid and private insurance coverage, implemented reimbursement policies that tie payment to quality, facilitated the creation of accountable care organizations that may use capitation and other alternative payment methodologies, strengthened enforcement of fraud and abuse laws and encouraged the use of information technology. However, many of these changes require implementing regulations which have not yet been drafted or have been released only as proposed rules.

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Since January 2017, legislation has repealed and regulation has altered provisions of the Affordable Care Act impacting its core provisions, and a desire has been expressed by certain Administration officials and congressional leaders to continue to dismantle all or portions of the Affordable Care Act. For example, the Tax Act enacted in December 2017 eliminated the tax penalty, beginning in 2019, for individuals who fail to enroll in a qualified medical plan, as mandated by the Affordable Care Act. The change to this provision could result in a significant number of individuals deciding to forgo health insurance, which could have an impact on premiums and healthcare spending overall. There have also been judicial challenges to the Affordable Care Act and its component provisions, and we expect there will be additional challenges and amendments to, or possibly repeal or restructure of the Affordable Care Act in the future. As such, it is and will be difficult to predict this law's full impact and influence on the healthcare industry.

In addition, we expect that there will be legislative and regulatory efforts to contain healthcare costs, reduce federal and state government spending on healthcare products and services and limit or restrict the scope of the Medicare RAC program and other program integrity initiatives. Healthcare stakeholders may react to changed circumstances and financial pressures, including those surrounding the implementation of the Affordable Care Act and uncertainty regarding its future structure or potential repeal, by taking actions such as curtailing or deferring their retention of service providers like us, which could reduce the demand for our solutions and, in turn, have a material adverse effect on our business, financial condition and results of operations.

We have made and intend to continue to make investments in personnel, infrastructure and product development, as well as in the overall expansion of the services and solutions that we offer to support existing and new clients as they implement the requirements of the Affordable Care Act and other federal and state healthcare programs. However, future changes to the Affordable Care Act or other federal or state healthcare reform measures may lower reimbursement rates, establish new payment models, increase or decrease government involvement in healthcare, decrease the Medicare RAC program's scope, or otherwise change the operating environment for us and our clients. If we are unable to adapt our solutions to meet changing requirements or expand service delivery into new areas, or the demand for our solutions is reduced as a result of healthcare organizations' reactions to changed circumstances and financial pressures in the healthcare marketplace, it could have a material adverse effect on our business, financial condition and results of operations.

Federal or state governments may limit or prohibit the outsourcing of certain services or functions, or may refuse to grant consents and/or waivers necessary to permit private entities, such as us, to perform certain elements of government programs or functions, such as healthcare claim auditing, or there may be state or federal limitations placed on the ability of the government to award contracts to private companies that use non-U.S. personnel, such as us, which could have a material adverse effect on our business, financial condition and results of operations.

Federal or state governments could limit or prohibit private contractors like us from operating or performing elements of certain government functions or programs. State or local governments could be required to operate such programs with government employees as a condition of receiving federal funding. Moreover, under current law, in order to privatize certain functions of government programs, the federal government must grant a consent and/or waiver to the petitioning state or local agency. If the federal government does not grant a necessary consent or waiver, the state or local agency will be unable to outsource that function to a private entity. Such a situation could eliminate a contracting opportunity or reduce the value of an existing contract.

In addition, the federal government and a number of states have considered laws and/or issued rules and orders that would limit, restrict or wholly prohibit the use of non-U.S. labor in performance of government contracts, or impose sanctions for the use of such resources. In particular, federal or state governmental authorities may impose additional data security standards or additional privacy or other restrictions on the use or other disclosure of health information outside of the United States, and legislation has been proposed at various times at both the federal and the state level that would limit, forbid, or regulate the use or transmission of medical information outside of the United States. Some of our clients have chosen to contractually limit or restrict our ability to use non-U.S. resources. We employ personnel and occasionally engage vendors located outside of the United States, and while we endeavor to only employ non-U.S. personnel and vendors where appropriate and permissible, any such limitations or restrictions could require us to repatriate work currently being done outside the U.S. or prevent us from having additional work done outside the United States, raise our costs of doing business, expose us to unexpected fines or penalties, increase the prices we must charge to clients to realize a profit and eliminate or significantly reduce the value of existing contracts or potential contract

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opportunities, any of which could have a material adverse effect on our business, financial condition and results of operations.

Our services could become subject to new, revised or enhanced regulatory requirements in the future, which could result in increased costs, could delay or prevent our introduction of new solutions or could impair the function or value of our existing solutions, which could have a material adverse effect on our business, financial condition and results of operations.

The healthcare industry is highly regulated on the federal, state and local levels, and is subject to changing legislative, regulatory, political and other influences. Changes to existing laws and regulations, or the enactment of new federal and state laws and regulations affecting the healthcare industry, could create unexpected liabilities for us, could cause us or our clients to incur additional costs and could restrict our or our clients' operations. Many healthcare laws are complex, subject to frequent change and dependent on interpretation and enforcement decisions from government agencies with broad discretion. The application of these laws to us or our clients, or to the specific services and relationships we have with our clients, is not always clear. In addition, federal and state legislatures periodically have considered or passed legislation to reform or amend the U.S. healthcare system at both the federal and state level, such as the enactment of the Affordable Care Act and the efforts to amend, repeal or revise the Affordable Care Act, which have created ongoing uncertainty and potential costs for us and our clients. Our failure to anticipate accurately the application of these laws and similar or future laws and regulations, or our failure to comply with them, could create liability for us, result in adverse publicity and have a material adverse effect on our business, financial condition and results of operations.

Our services may become subject to new or enhanced regulatory requirements and we may be required to change or adapt our services in order to comply with these regulations. For example, the introduction of the ICD−10 coding framework in 2015 presented challenges for our business, including requiring us to allocate resources to training and upgrading our systems. If we failed to successfully implement new coding frameworks or other new regulatory requirements, it could adversely affect our ability to offer services deemed critical by our clients, which could have a material adverse effect on our business, financial condition and results of operations. New or enhanced regulatory requirements may render our solutions obsolete or prevent us from performing certain services. Further, new or enhanced regulatory requirements could impose additional costs on us, thereby making existing solutions unprofitable, and could make the introduction of new solutions more costly or time consuming than we anticipate, which could have a material adverse effect on our business, financial condition and results of operations.

The following legal and regulatory developments also could have a material adverse effect on our business, financial condition and results of operations:

- amendment, enactment, or interpretation of laws and regulations that restrict the access and use of personal information and reduce the supply of data available to clients;
- changes in cultural and consumer attitudes to favor further restrictions on information collection and sharing, which may lead to regulations that prevent full utilization of our solutions;
- failure of our solutions to comply with current laws and regulations; and
- failure of our solutions to adapt to changes in the regulatory environment in an efficient, cost-effective manner.

Changes in our level of taxes, or changes in tax laws or in their interpretation or enforcement, could have a material adverse effect on our effective tax rate, results of operations, cash flows and financial condition.

We have operations in most states within the United States as well as in Canada, the United Kingdom and India. Accordingly, we are subject to taxation in many jurisdictions with increasingly complex tax laws, the application of which can be uncertain and which are subject to amendment and changes in interpretation or enforcement. Changes in tax laws, treaties or regulations, or their interpretation or enforcement, have become more unpredictable and may become more stringent, which could materially adversely affect our tax position.

Our future effective tax rates could be unfavorably affected by changes in the tax rates in jurisdictions where our income is earned and taxed, by changes in, or our interpretation of, tax rules and regulations in the jurisdictions in

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which we do business, by increases in expenses not deductible for tax purposes including impairments of goodwill, by changes in GAAP or other applicable accounting standards or by changes in the valuation of our deferred tax assets and liabilities. Tax rates in the jurisdictions in which we operate may change as a result of macroeconomic or other factors outside of our control.

In particular, on December 22, 2017, the Tax Act was signed into law. The Tax Act contains significant changes to corporate taxation, including reduction of the corporate tax rate, limitation of the tax deduction for interest expense, limitation of the deduction for net operating losses and elimination of net operating loss carrybacks, one time taxation of offshore earnings at reduced rates regardless of whether they are repatriated, elimination of U.S. tax on foreign earnings (subject to certain important exceptions), immediate deductions for certain new investments instead of deductions for depreciation expense over time, and modifying or repealing many business deductions and credits. It is not clear how the Tax Act will be interpreted and implemented and, notwithstanding the reduction in the corporate income tax rate, the overall impact of the Tax Act is uncertain, and our business and financial condition could ultimately be adversely affected.

In addition, we are subject to periodic examination of our income tax returns by the U.S. Internal Revenue Service and other domestic and international tax authorities. Tax authorities in various jurisdictions may disagree with and subsequently challenge the amount of profits taxed or taxes paid in their state or country, which may result in increased tax liability, including accrued interest and penalties, which would cause our tax expense to increase. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our provision for income taxes and have reserved for potential adjustments that may result. There can be no assurance that the final determination of any of these examinations will not have a material adverse effect on our financial condition and results of operations.

We have operations and client relationships outside of the United States and we could be materially adversely affected by violations of the FCPA and similar anti-bribery laws in non-U.S. jurisdictions.

The FCPA and similar anti-bribery laws in non-U.S. jurisdictions generally prohibit companies and their intermediaries from making improper payments to non-U.S. officials for the purpose of obtaining or retaining business. As we expand our international presence, we may operate in many parts of the world that have experienced governmental corruption and, in certain circumstances, strict compliance with anti-bribery laws may be at variance with local customs and practices. While our policies mandate compliance with these anti-bribery laws and we have training and compliance programs related to such laws, such policies, programs and our internal control policies and procedures may not protect us from reckless or criminal acts committed by our employees, subcontractors or agents. Violations of the FCPA or other anti-bribery laws, or allegations of such violations, could have a material adverse impact on our business, financial condition and results of operations.

Risks Relating to Our Indebtedness

We are a holding company and rely on dividends, distributions and other payments, advances and transfers of funds from our subsidiaries to meet our obligations.

We are a holding company that does not conduct any business operations of our own. As a result, we are largely dependent upon cash dividends and distributions and other transfers from our subsidiaries to meet our obligations. The agreements governing the indebtedness of our subsidiaries impose restrictions on our subsidiaries' ability to pay dividends or other distributions to us. The deterioration of the earnings from, or other available assets of, our subsidiaries for any reason also could limit or impair their ability to pay dividends or other distributions to us.

Our outstanding indebtedness could adversely affect our financial condition and our ability to operate our business, and we may not be able to generate sufficient cash flows to meet our debt service obligations.

On September 28, 2016, our subsidiary Cotiviti Corporation and certain other of our subsidiaries entered into the Restated Credit Agreement, pursuant to which the lenders party thereto agreed to provide the First Lien Credit Facilities consisting of the (a) First Lien Term A Loans in the original principal amount of $250.0 million, (b) the First Lien Term B Loans in the original principal amount of $550.0 million and (c) the $100.0 million Revolver, of which $25.0 million may, at our option, be made available for letters of credit and $20.0 million may, at our option, be made available for swingline loans. In connection with entering into the Restated Credit Agreement, we refinanced our

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previously outstanding Initial Secured Credit Facilities, comprising the Initial First Lien Credit Facilities and the Initial Second Lien Credit Facility.

As of December 31, 2017, we had $777.5 million outstanding principal amount under our First Lien Term Loans and availability under the Revolver of $99.5 million. Our outstanding indebtedness and any additional indebtedness we incur may have important consequences for us, including, without limitation, that:

- we may be required to use a substantial portion of our cash flow to pay the principal of and interest on our indebtedness;
- our indebtedness and leverage may increase our vulnerability to adverse changes in general economic and industry conditions, as well as to competitive pressures;
- our ability to obtain additional financing for working capital, capital expenditures, acquisitions and for general corporate and other purposes may be limited;
- expose us to the risk of increased interest rates because certain of our borrowings, including and most significantly our borrowings under our First Lien Credit Facilities, are at variable rates of interest;
- prevent us from taking advantage of business opportunities as they arise or successfully carrying out our plans to expand our business; and
- our flexibility in planning for, or reacting to, changes in our business and our industry may be limited.

Under the terms of the agreements governing our First Lien Credit Facilities, we are required to comply with specified financial and operating covenants, which may limit our ability to operate our business as we otherwise might operate it. For example, the obligations under the First Lien Credit Facilities may be accelerated upon the occurrence of an event of default, which includes customary events of default including, without limitation, payment defaults, cross-defaults to certain material indebtedness, covenant defaults, material inaccuracy of representations and warranties, bankruptcy events, material judgments, certain ERISA-related events, material defects with respect to guarantees and collateral, invalidity of subordination provisions and change of control. If not cured, an event of default could result in any amounts outstanding, including any accrued interest and unpaid fees, becoming immediately due and payable, which would require us to, among other things, seek additional financing in the debt or equity markets, refinance or restructure all or a portion of our indebtedness, sell selected assets and/or reduce or delay planned capital or operating expenditures. Such measures might not be sufficient to enable us to service our debt and any such financing or refinancing might not be available on economically favorable terms or at all. If we are not able to generate sufficient cash flows to meet our debt service obligations or are forced to take additional measures to be able to service our indebtedness, it could have a material adverse effect on our business, financial condition and results of operations.

Despite our substantial indebtedness, we and our subsidiaries may still be able to incur substantially more debt. This could further exacerbate the risks associated with our substantial leverage.

We may incur substantial additional indebtedness in the future. Although the agreements governing our First Lien Credit Facilities contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions and the indebtedness we can incur in compliance with these restrictions could be

substantial. For example, pursuant to incremental facilities under the First Lien Credit Facilities, we may incur up to (i) an aggregate amount of the greater of $230.0 million and 75.0% of Consolidated Adjusted EBITDA (as defined in the First Lien Credit Facilities) of additional secured or unsecured debt plus (ii) an unlimited additional amount of secured debt, subject to compliance with certain leverage-based tests, as described in the agreements governing our First Lien Credit Facilities. If we incur additional debt, the risks associated with our substantial leverage would increase.

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Restrictive covenants in the agreements governing our First Lien Credit Facilities impose significant operating and financial restrictions on us that may restrict our ability to pursue our business strategies.

The agreements governing our First Lien Credit Facilities contain a number of restrictive covenants that impose significant operating and financial restrictions on us and may limit our ability to engage in acts that may be in our long-term best interests. These include covenants restricting, among other things, our ability to:

- incur additional indebtedness or other contingent obligations;
- grant liens;
- enter into certain agreements with negative pledge clauses or restrictions on subsidiary distributions;
- pay dividends or other distributions from our subsidiaries to us;
- make payments in respect of junior liens or subordinated debt;
- make investments, acquisitions, loans and advances;
- consolidate, merge, liquidate or dissolve;
- sell, transfer or otherwise dispose of assets;
- engage in sale-leaseback transactions;
- engage in transactions with affiliates;
- materially alter the business that we conduct;
- modify organizational documents in a manner that is materially adverse to the lenders under the agreements governing our First Lien Credit Facilities; and
- amend or otherwise change the terms of the documentation governing certain restricted debt.

The Restated Credit Agreement contains a financial covenant that requires compliance with a secured leverage ratio test set at 5.50:1.00, with stepdowns to 5.25:1.00 and 5.00:1.00 after September 30, 2018 and September 30, 2019, respectively, as of the period of four consecutive fiscal quarters recently ended, on the last day of any fiscal quarter, commencing with the fiscal quarter ending December 31, 2016. Our ability to meet that financial ratio can be affected by events beyond our control and we cannot assure you that we will be able to meet that ratio. We were in compliance with this covenant as of December 31, 2017, but there can be no assurance that we will be in compliance with such covenant in the future.

A breach of any covenant or restriction contained in the agreements governing our First Lien Credit Facilities could result in a default under those agreements. If any such default occurs, the lenders under the First Lien Term Loans or Revolver may elect (after the expiration of any applicable notice or grace periods) to declare all outstanding borrowings, together with accrued and unpaid interest and other amounts payable thereunder, to be immediately due and payable, but in the case of a breach of the financial covenant, the holders of the First Lien Term B Loans may only exercise such rights after a majority of the lenders under the Revolver have

terminated the commitments under the Revolver and accelerated the revolving loans thereunder, and the lenders holding a majority of the First Lien Term A Loans have accelerated the First Lien Term A Loans. The lenders under the First Lien Term Loans and Revolver also have the right upon an event of default thereunder to terminate any commitments they have to provide further borrowings. Further, following an event of default under the agreements governing our First Lien Credit Facilities, the lenders under the First Lien Term Loans and Revolver will have the right to proceed against the collateral granted to them to secure that debt. If the debt under the First Lien Term Loans or the Revolver was to be accelerated, our assets may not be sufficient to repay in full that debt or any other debt that may become due as a result of that acceleration.

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We are dependent upon our lenders for financing to execute our business strategy and meet our liquidity needs. If our lenders are unable to fund borrowings under their credit commitments or we are unable to borrow, it could have a material adverse effect on our business, financial condition and results of operations.

During periods of volatile credit markets, there is risk that lenders, even those with strong balance sheets and sound lending practices, could fail or refuse to honor their legal commitments and obligations under existing credit commitments, including but not limited to extending credit up to the maximum permitted by the Revolver. If our lenders are unable to fund borrowings under their revolving credit commitments or we are unable to borrow, it could be difficult to obtain sufficient funding to execute our business strategy or meet our liquidity needs, which could have a material adverse effect on our business, financial condition and results of operations.

Our debt may be downgraded, which could adversely affect our ability to manage our operations and respond to changes in our business.

A decrease in the ratings that rating agencies assign to our short and long-term debt may negatively impact our access to the debt capital markets and increase our cost of borrowing, which could have a material adverse effect on our business, financial condition and results of operations.

Volatility and weakness in bank and capital markets may adversely affect credit availability and related financing costs for us.

Bank and capital markets can experience periods of volatility and disruption. If the disruption in these markets is prolonged, our ability to refinance, and the related cost of refinancing, some or all of our debt could be adversely affected. Although we currently can access the bank and capital markets, there is no assurance that such markets will continue to be a reliable source of financing for us. These factors, including the tightening of credit markets, could adversely affect our ability to obtain cost-effective financing. Increased volatility and disruptions in the financial markets also could make it more difficult and more expensive for us to refinance outstanding indebtedness and obtain financing. In addition, the adoption of new statutes and regulations, the implementation of recently enacted laws or new interpretations or the enforcement of older laws and regulations applicable to the financial markets or the financial services industry could result in a reduction in the amount of available credit or an increase in the cost of credit. Disruptions in the financial markets can also adversely affect our lenders, insurers, clients and other counterparties. Any of these could result in a material adverse effect to our business, financial condition and results of operations.

Risks Relating to Ownership of Our Common Stock

The price of our common stock may be volatile and you could lose all or part of your investment.

Securities markets worldwide have experienced in the past, and are likely to experience in the future, significant price and volume fluctuations. This market volatility, as well as general economic, market or political conditions could reduce the market price of our common stock regardless of our results of operations. The trading price of our common stock may become highly volatile and could be subject to wide price fluctuations in response to various factors, including, among other things, the risk factors described herein and other factors beyond our control. Factors affecting the trading price of our common stock could include:

- market conditions in the broader stock market;
- actual or anticipated variations in our quarterly financial and operating results;
- developments in the healthcare industry in general or in the healthcare payment or claims processing markets in particular;
- variations in operating results of similar companies;
- introduction of new services and solutions by us, our competitors or our clients;
- issuance of new, negative or changed securities analysts' reports, recommendations or estimates;

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- investor perceptions of us and the industries in which we or our clients operate;
- sales, or anticipated sales, of our stock, including sales by our officers, directors and significant stockholders;
- additions or departures of key personnel;
- regulatory or political developments;
- the public's response to press releases or other public announcements by us or third parties, including our filings with the SEC;
- announcements, media reports or other public forum comments related to litigation, claims or reputational charges against us;
- guidance, if any, that we provide to the public, any changes in this guidance or our failure to meet this guidance;
- the sustainability of an active trading market for our common stock;
- investor perceptions of the investment opportunity associated with our common stock relative to other investment alternatives;
- other events or factors, including those resulting from system failures and disruptions, outages, breaches, earthquakes, hurricanes, war, acts of terrorism, other natural disasters or responses to these events;
- changes in accounting principles;
- stock-based compensation expense under GAAP or other applicable accounting standards;
- litigation and governmental investigations; and
- changing economic conditions.

These and other factors may cause the market price and demand for shares of our common stock to fluctuate substantially, which may limit or prevent investors from readily selling their shares of common stock and may otherwise negatively affect the liquidity of our common stock. In addition, in the past, when the market price of a stock has been volatile, holders of that stock sometimes have instituted securities class action litigation against the company that issued the stock. Securities litigation against us, regardless of the merits or outcome, could result in substantial costs and divert the time and attention of our management from our business, which could significantly harm our business, profitability and reputation.

Although we no longer are controlled by Advent, Advent is a significant investor whose interests may differ from those of our public stockholders.

Although we no longer are controlled by Advent, Advent continues to beneficially own in the aggregate 44.9% of the combined voting power of our outstanding common stock as of December 31, 2017. As a result of this ownership, Advent retains significant influence over the outcome of votes on all matters requiring approval by our stockholders, including the election of directors, the adoption of amendments to our charter and bylaws, mergers, consolidations, acquisitions and other significant corporate transactions, and our winding up and dissolution.

In addition, persons associated with Advent currently serve on our Board. The interests of Advent may not always coincide with the interests of our other stockholders and the concentration of ownership in Advent will limit other stockholders' ability to influence corporate matters. The concentration of ownership and voting power of Advent also may delay, defer or even prevent an acquisition by a third party or other change of control and may make some transactions more difficult or impossible without their support, even if such events are in the best interests of our other stockholders.

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Further, Advent may have an interest in having us pursue acquisitions, divestitures, financing or other transactions, including, but not limited to, the issuance of additional debt or equity and the declaration and payment of dividends, that, in its judgment, could enhance Advent's equity investments, even though such transactions may involve risk to us or to our creditors. Additionally, Advent may make investments in businesses that directly or indirectly compete with us, or may pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us.

Advent may take actions that our other stockholders do not view as beneficial, which may adversely affect our business, financial condition and results of operations and cause the value of your investment to decline.

Our directors and stockholders, with certain exceptions, do not have obligations to present business opportunities to us and may compete with us.

Our amended and restated certificate of incorporation provides that our directors and stockholders do not have any obligation to offer us an opportunity to participate in business opportunities presented to them even if the opportunity is one that we might reasonably have pursued (and therefore may be free to compete with us in the same business or similar businesses), and that, to the extent permitted by law, such directors and stockholders will not be liable to us or our stockholders for breach of any duty by reason of any such activities.

As a result, our directors and stockholders and their respective affiliates will not be prohibited from investing in competing businesses or doing business with our clients. Therefore, we may be in competition with our directors and stockholders or their respective affiliates, and we may not have knowledge of, or be able to pursue, transactions that could potentially be beneficial to us. Accordingly, we may lose certain corporate opportunities or suffer competitive harm, which could have a material adverse effect on our business, financial condition, results of operation or prospects.

Anti-takeover protections in our amended and restated certificate of incorporation, our amended and restated bylaws or our contractual obligations may discourage or prevent a takeover of our company, even if an acquisition would be beneficial to our stockholders.

Provisions contained in our amended and restated certificate of incorporation and amended and restated bylaws, as amended, as well as provisions of the DGCL, could delay or make it more difficult to remove incumbent directors or could impede a merger, takeover or other business combination involving us or the replacement of our management or discourage a potential investor from making a tender offer for our common stock, which, under certain circumstances, could reduce the market value of our common stock, even if it would benefit our stockholders.

In addition, our Board has the authority to cause us to issue, without any further vote or action by the stockholders, up to 50,000,000 shares of preferred stock, par value $0.001 per share, in one or more series, to designate the number of shares constituting any series, and to fix the rights, preferences, privileges and restrictions thereof, including dividend rights, voting rights, rights and terms of redemption, redemption price or prices and liquidation preferences of such series. The issuance of shares of preferred stock or the adoption of a stockholder rights plan may have the effect of delaying, deferring or preventing a change in control of our company

without further action by the stockholders, even where stockholders are offered a premium for their shares.

In addition, under the Restated Credit Agreement, a "change of control" (as defined in the Restated Credit Agreement) would cause us to be in default and the lenders would have the right to terminate the commitments to provide loans under the Revolver and accelerate all outstanding loans, and if so accelerated, we would be required to repay all of our outstanding obligations under our First Lien Credit Facilities. From time to time we may enter into other contracts that contain change of control provisions that limit the value of, or even terminate, the contract upon a change of control. These change of control provisions may discourage a takeover of our company, even if an acquisition would be beneficial to our stockholders.

We have and will continue to incur increased costs and obligations as a result of being a public company.

As a publicly traded company, we have incurred and will continue to incur additional legal, accounting and other expenses that we were not required to incur in the past, and in the future will incur additional expenses as we have ceased to be an emerging growth company as of December 31, 2017. We are required to file with the SEC annual and quarterly information and other reports that are specified in Section 13 of the Exchange Act. We are also subject to other

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reporting and corporate governance requirements, including the requirements of the NYSE and certain provisions of the Sarbanes-Oxley Act and the regulations promulgated thereunder, which impose additional compliance obligations upon us. Among other things, as a public company:

- we prepare and distribute periodic public reports and other stockholder communications in compliance with our obligations under the federal securities laws and applicable NYSE rules;
- the roles and duties of our Board and committees of the Board are expanded;
- we comply with more comprehensive financial reporting and disclosure compliance functions;
- we are subject to the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act;
- we manage enhanced investor relations functions; and
- we involve and retain to a greater degree outside counsel and accountants in the activities listed above.

These changes require a commitment of additional resources and many of our competitors also comply with these obligations. We may not be successful in complying with these obligations in the future and the commitment of resources required for complying with them could adversely affect our business, financial condition and results of operations.

The changes necessitated by becoming a public company require a significant commitment of resources and management supervision that has increased and may continue to increase our costs and might place a strain on our systems and resources. As a result, our management's attention might be diverted from other business concerns. If we fail to maintain an effective internal control environment or to comply with the numerous legal and regulatory requirements imposed on public companies, we could make material errors in, and be required to restate, our financial statements. Any such restatement could result in a loss of public confidence in the reliability of our financial statements and sanctions imposed on us by the SEC. If we are unable to satisfy our obligations as a public company, we could be subject to delisting of our common stock, fines, sanctions and other regulatory action and potentially civil litigation.

Our management team historically managed a private company and the transition to managing a public company presents new challenges.

Since our IPO in May 2016 we have been subject to various regulatory requirements, including those of the SEC and the NYSE. These requirements include record keeping, financial

reporting and corporate governance rules and regulations. We have not historically had the resources typically found in a public company. Our internal infrastructure may not be adequate to support our increased reporting obligations, and we may be unable to hire, train or retain necessary staff and may be reliant on engaging outside consultants or professionals to overcome our lack of experience or employees. If our internal infrastructure is inadequate, we are unable to engage outside consultants or are otherwise unable to fulfill our public company obligations, it could have a material adverse effect on our business, financial condition and results of operations.

We no longer are an "emerging growth company".

As of December 31, 2017, we no longer qualify as an emerging growth company and, as a result, we no longer are able to take advantage of certain exemptions from various reporting requirements that are applicable to other public companies. Accordingly, we must, among other things, comply with the auditor attestation requirements of Section 404 of the Sarbanes-Oxley Act, provide additional disclosure regarding executive compensation in our periodic reports and proxy statements and hold a nonbinding advisory vote on executive compensation and stockholder approval of any golden parachute payments not previously approved in our proxy statement. The rules governing the standards that must be met to comply with these various reporting requirements are complex and require significant documentation, testing and possible remediation and the incurrence of significant additional expenditures as well as the time and attention of our management and finance teams. If we are unable to comply with these requirements, it could have a material adverse effect on our stock price.

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Because we do not intend to pay cash dividends in the foreseeable future, stockholders may not receive any return on investment unless they are able to sell their common stock for a price greater than their purchase price.

We do not intend in the foreseeable future to pay any dividends to holders of our common stock. We currently intend to retain our future earnings, if any, for the foreseeable future, to repay indebtedness and to support our general corporate purposes. Therefore, holders of our common stock are not likely to receive any dividends on their common stock for the foreseeable future and the success of any investment in shares of our common stock will depend upon any future appreciation in their value. There is no guarantee that shares of our common stock will appreciate in value or even maintain the price at which investors have purchased their shares. The payment of future dividends, if any, will be at the discretion of our Board, subject to applicable law, and will depend on, among other things, our earnings, financial condition, capital requirements, level of indebtedness, statutory and contractual restrictions that apply to the payment of dividends and other considerations that our Board deems relevant. The agreements governing our First Lien Credit Facilities limit the amounts available to us to pay cash dividends, and, to the extent that we require additional funding, financing sources may prohibit the payment of a dividend. As a consequence of these limitations and restrictions, we may not be able to make the payment of dividends on our common stock.

If securities or industry analysts publish unfavorable research about our business, the price of our common stock and our trading volume could decline.

The trading market for our common stock depends in part on the research and reports that securities or industry analysts publish about us or our business and industry. If one or more of the analysts who cover us downgrade our common stock or publish unfavorable research about our business, the price of our common stock likely would decline. If one or more of these analysts cease coverage of our company or fail to publish reports on us regularly, demand for our common stock could decrease, which might cause the price of our common stock and trading volume to decline.

Claims for indemnification by our directors and officers may reduce our available funds to satisfy successful third party claims against us and may reduce the amount of money available to us.

Our amended and restated certificate of incorporation and bylaws provide that we will indemnify our directors and officers, in each case, to the fullest extent permitted by Delaware law. Pursuant to our charter, our directors will not be liable to us or any stockholders for monetary damages for any breach of fiduciary duty, except (i) acts that breach his or her duty of loyalty to us or our stockholders, (ii) acts or omissions without good faith or involving

intentional misconduct or knowing violation of the law, (iii) pursuant to Section 174 of the DGCL or (iv) for any transaction from which the director derived an improper personal benefit. The bylaws also require us, if so requested, to advance expenses that such director or officer incurred in defending or investigating a threatened or pending action, suit or proceeding, provided that such person will return any such advance if it is ultimately determined that such person is not entitled to indemnification by us. Any claims for indemnification by our directors and officers may reduce our available funds to satisfy successful third party claims against us and may reduce the amount of money available to us.

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Our amended and restated certificate of incorporation provides, subject to certain exceptions, that the Court of Chancery of the State of Delaware will be the sole and exclusive forum for certain stockholder litigation matters, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our directors, officers, employees or stockholders.

Our amended and restated certificate of incorporation provides, subject to limited exceptions, that the Court of Chancery of the State of Delaware will, to the fullest extent permitted by law, be the sole and exclusive forum for (i) any derivative action or proceeding brought on our behalf; (ii) any action asserting a claim of breach of a fiduciary duty owed by any of our directors, officers or other employees to us or our stockholders; (iii) any action asserting a claim against us, any director or our officers or employees arising pursuant to any provision of the DGCL, our certificate or our amended and restated by-laws; or (iv) any action asserting a claim against us, any director or our officers or employees that is governed by the internal affairs doctrine. Any person or entity purchasing or otherwise acquiring any interest in shares of our capital stock shall be deemed to have notice of and to have consented to the provisions of our certificate described above. This choice of forum provision may limit a stockholder's ability to bring a claim in a judicial forum that it finds favorable for disputes with us or any of our directors, officers, other employees or stockholders which may discourage lawsuits with respect to such claims. Alternatively, if a court were to find the choice of forum provision that will be contained in our certificate to be inapplicable or unenforceable in an action, we may incur additional costs associated with resolving such action in other jurisdictions, which could materially adversely affect our business, financial condition and results of operations.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters is located at The Terraces South, 115 Perimeter Center Place, Suite 700, Atlanta, GA 30346. We do not own any of our facilities. As of the fiscal year ended December 31, 2017, we had the following leased facilities:

Location	Number of Facilities:
Pennsylvania	4
Georgia	3
Kentucky	3
Connecticut	2
Arkansas	1
Illinois	1
Maine	1
Massachusetts	1
Minnesota	1
North Carolina	1
Texas	1
Utah	1
Washington, DC	1
Non-U.S. Locations[(a)]	5

(a) We lease one facility in Canada, two facilities in the United Kingdom and two facilities in India.

Item 3. Legal Proceedings

We are subject to various legal proceedings and claims arising in the ordinary course of business. Our management currently does not expect that the results of any of these legal proceedings, either individually or in the aggregate, would have a material adverse effect on our financial position, results of operations or cash flows.

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Item 4. Mine Safety Disclosures

Not applicable.

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EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth the names and ages, as of December 31, 2017, of the individuals who serve as our executive officers. There are no family relationships between or among our executive officers and there is no arrangement or understanding between any executive officer and any other person pursuant to which the executive officer was selected. At the annual meeting of the Board of Directors, the executive officers are elected by the Board to hold office for one year and until their respective successors are elected and qualified, or until earlier resignation or removal.

Information with regard to our directors is incorporated herein by reference to our 2018 Proxy Statement as provided in Part III, Item 10 of this Annual Report.

Name	Age	Position
J. Douglas (Doug) Williams	56	Chief Executive Officer and Director
Bradley Ferguson	47	Senior Vice President and Chief Financial Officer
David Beaulieu	61	Senior Vice President and Chief Operations Officer
Jonathan Olefson	42	Senior Vice President, General Counsel and Secretary
Nord Samuelson	53	Senior Vice President and Chief Digital Officer

J. Douglas (Doug) Williams

Mr. Williams is our Chief Executive Officer, a position he has held since May 2014. He has served as a member of our Board since May 2014. Prior to the Connolly iHealth Merger, Mr. Williams served as President and Chief Executive Officer of iHealth Technologies since its inception in May 2001. Prior to his position with iHealth Technologies, Mr. Williams served as Chief Executive Officer of Magellan Specialty Health from April 2000 to May 2001. Mr. Williams has also served in various executive and managerial roles with Vivra Specialty Partners and CIGNA Healthcare. Mr. Williams holds a B.S. in Business Administration from Appalachian State University. We believe that Mr. Williams' extensive leadership experience, institutional knowledge of our Company and broad familiarity with the payment accuracy market qualify him to serve as one of our directors.

Bradley Ferguson

Mr. Ferguson joined us as our Senior Vice President and Chief Financial Officer in November 2017. He most recently served as Executive Vice President, Corporate Development and Managing Director, Consumer & Small Business for EarthLink, Inc. (prior to its acquisition by Windstream in February 2017), where he led all merger and acquisition efforts. Prior to that, Mr. Ferguson served as EarthLink's Executive Vice President, Chief Financial Officer for six years, and in various other senior financial positions. He began his career as an accountant with Arthur Andersen, LLP and holds a degree in Accounting from the University of Georgia, an MBA from Emory University and is a Certified Public Accountant.

David Beaulieu

Mr. Beaulieu is our Senior Vice President and Chief Operations Officer, a position he has held since April 2015. Mr. Beaulieu previously served as our Senior Vice President, Technology and Innovation, from May 2014 to April 2015. Prior to the Connolly iHealth Merger, Mr. Beaulieu served as Chief Operating Officer of iHealth Technologies since July 2010. Mr. Beaulieu previously served as Executive Vice President of Marketing, Sales & Business Solutions at DST Health Solutions from October 2008 to June 2010, and as Chief Operating Officer at Amisys Synertech from 2004 to 2008 prior to its acquisition by DST Health Solutions. Prior to this, Mr. Beaulieu was the Managing Partner for Government Business Services at First Consulting Group and held various operational and executive positions at CIGNA Healthcare. Mr. Beaulieu holds a B.A. in Government from Bates College.

Jonathan Olefson

Mr. Olefson is our Senior Vice President, General Counsel and Secretary, a position he has held since October 2013. Prior to joining us, Mr. Olefson spent nine years in senior legal and compliance roles at Cognizant Technology Solutions, most recently as Vice President and General Counsel (Corporate, M&A and Intellectual Property) from 2012 to 2013. Prior to this, he was an Associate at Fulbright & Jaworski, L.L.P from 2000 to 2004. Mr. Olefson holds a J.D. from the George Washington University and a B.A. in Political Science from Emory University.

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Nord Samuelson

Mr. Samuelson has been our Chief Digital Officer since October 2017. Mr. Samuelson previously served as Managing Director, Digital Community Lead for AlixPartners, LLP from 2011 through 2017. From 2010 to 2011, Mr. Samuelson served as Managing Partner of North Main LLC and Managing Director of The Palladium Group following its merger with North Main LLC. Prior to this, Mr. Samuelson served with 170 Systems as the Vice President of Business Development from 2003 to 2008, prior to which he was the Vice President of Professional Services. Mr. Samuelson previously held various roles with the Monitor Company. Mr. Samuelson holds a B.A. in Economics and Mathematics from Bowdoin College.

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PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Our common stock has traded on the NYSE under the symbol "COTV" since May 26, 2016. Prior to that time, there was no public market for our shares. As of December 31, 2017, there were 26 holders of record of our common stock. The actual number of stockholders is considerably greater than this number of record holders, and includes stockholders who are beneficial owners but whose shares are held in street name by brokers and other nominees. The

following table sets forth for the periods indicated the high and low sales prices of our common stock on the NYSE.

Fiscal Year 2017:	High	Low
First Quarter (January 1, 2017 through March 31, 2017)	$42.50	$32.97
Second Quarter (April 1, 2017 through June 30, 2017)	$42.99	$36.10
Third Quarter (July 1, 2017 through September 30, 2017)	$45.97	$34.23
Fourth Quarter (October 1, 2017 through December 31, 2017)	$36.15	$30.84
Fiscal Year 2016:		
Second Quarter (May 26, 2016 (first trading date after IPO) through June 30, 2016)	$21.47	$17.00
Third Quarter (July 1, 2016 through September 30, 2016)	$34.36	$20.65
Fourth Quarter (October 1, 2016 through December 31, 2016)	$36.44	$29.19

On February 20, 2018, the closing price of our common stock on the NYSE was $33.64 per share.

Dividends

Prior to the consummation of our IPO, we paid a Special Cash Dividend of $150.0 million or $1.94 per share of common stock outstanding, to holders of record of our common stock on May 24, 2016. We do not currently intend to declare or pay any similar special dividends in the future and do not intend to pay cash dividends on our common stock in the foreseeable future. However, in the future we may change this policy and choose to pay dividends.

We are a holding company that does not conduct any business operations of our own. As a result, our ability to pay cash dividends on our common stock is dependent upon cash dividends and distributions and other transfers from our subsidiaries. The ability of our subsidiaries to pay dividends is currently restricted by the terms of our Restated Credit Agreement and may be further restricted by any future indebtedness we or our subsidiaries incur.

In addition, Delaware law may restrict our Board's ability to declare dividends.

Recent Sales of Unregistered Securities

The following sets forth information regarding all unregistered securities sold by us in transactions that were exempt from the requirements of the Securities Act in the last three years:

- In June 2015, we granted options to purchase an aggregate of 24,584 shares of common stock at a strike price of $11.33 per share (as adjusted for stock split and Special Cash Dividend) to a member of our Board pursuant to the 2012 Plan.

- In November 2015, we granted options to purchase an aggregate of 1,948,844 shares of common stock at a strike price of $13.79 per share (as adjusted for stock split and Special Cash Dividend) to certain members of management and certain employees pursuant to the 2012 Plan.

- In December 2015, we granted options to purchase an aggregate of 24,584 shares of common stock at a strike price of $13.79 per share (as adjusted for stock split and Special Cash Dividend) to a member of our Board pursuant to the 2012 Plan.

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The shares of common stock in all of the transactions listed above were issued or will be issued in reliance upon Section 4(a)(2) of the Securities Act or Rule 701 promulgated under Section 3(b) of the Securities Act as the sale of such securities did not or will not involve a public offering. The recipients of the securities in each of these transactions represented their intentions to acquire the securities for investment only and not with a view to or for sale in connection with any distribution thereof, and appropriate legends were placed upon the stock certificates issued in these transactions. All recipients had adequate access, through their relationships with us, to information about us.

- In July 2017, in connection with the RowdMap Acquisition, we issued an aggregate of 768,021 shares of common stock to certain employees of RowdMap in connection with their continued employment with us. Half of these shares are subject to continued employment and performance-based vesting requirements. The other half are subject to continued employment, with one-third vesting on each of the first three anniversaries of the closing of the acquisition. These issuances were made in reliance on an exemption or exclusion from the registration requirements of Regulation D promulgated under the Securities Act.

Securities Authorized for Issuance Under Equity Compensation Plans

The information required is set forth in Item 12 of Part III of this Annual Report on Form 10-K.

Purchases of Equity Securities

On October 31, 2017, we announced that our Board approved a stock purchase program under which we may repurchase up to $100.0 million of our common stock through October 31, 2018. Any stock repurchases may be made through open market transactions, block trades, privately negotiated transactions (including accelerated share repurchase transactions) or other means, subject to market conditions.

Any repurchase activity will depend on many factors such as our working capital needs, cash requirements for investments, debt repayment obligations, economic and market conditions at the time, including the price of our common stock, and other factors that we consider relevant. Our stock repurchase program may be accelerated, suspended, delayed or discontinued at any time.

During 2017, we purchased 317,900 shares of our common stock under the stock repurchase program for a total of $10.0 million. The following table summarizes the stock repurchase activity for the three months ended December 31, 2017, and the approximate remaining dollar value of shares that may be purchased pursuant to our stock repurchase program:

(In thousands, except per share amounts) Period (Based on Trade Date)	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased As Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares That May Yet Be Purchased Under the Plans or Programs
October 2017	-	$ -	-	$ 100,000
November 2017	317,900	31.43	317,900	90,010
December 2017	-	-	-	90,010
Total:	317,900	$ 31.43	317,900	$ 90,010

Item 6. Selected Financial Data

The following financial information for each of the five years ended on December 31 has been derived from our consolidated financial statements. Our historical results are not necessarily indicative of future operating results. This information should be read in conjunction with the audited consolidated financial statements and related footnotes thereto and Item 7, “Management's Discussion and Analysis of Financial Condition and Results of Operations” included elsewhere in this Annual Report on Form 10-K.

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On May 14, 2014, we acquired the stock of iHealth Technologies, resulting in the Connolly iHealth Merger. The results of operations of iHealth Technologies have been included in our consolidated financial statements as of and since the date of the Connolly iHealth Merger. As a result, the consolidated financial statements for periods prior to such date are not comparable to subsequent periods.

(in thousands, except share and per share amounts)	For the Years Ended December 31, 2017	2016	2015	2014	2013
Consolidated Statement of Operations Data:					
Net revenue	$ 678,661	$ 625,162	$ 541,343	$ 441,372	$ 319,399
Cost of revenue	251,127	251,768	204,617	179,088	161,521
Selling, general and administrative expenses	176,512	156,684	136,745	92,537	52,656
Depreciation and amortization	85,183	80,969	74,162	59,771	30,856
Transaction-related expenses	2,219	1,788	1,469	5,745	2,109
Impairment of intangible assets	1,322	—	27,826	74,034	—
Operating income	162,298	133,953	96,524	30,197	72,257
Other expense (income)	35,868	64,131	68,819	72,826	31,688
Income tax (benefit) expense	(11,773)	20,970	14,401	(16,804)	16,926
Gain on discontinued operations, net of tax	—	—	(559)	—	—
Net income (loss)	$ 138,203	$ 48,852	$ 13,863	$ (25,825)	$ 23,643
Total earnings (loss) per share:					
Basic	$ 1.50	$ 0.57	$ 0.18	$ (0.40)	$ 0.53
Diluted	$ 1.45	$ 0.55	$ 0.18	$ (0.40)	$ 0.53
Weighted average shares outstanding:					
Basic	91,928,364	85,053,890	77,216,133	65,253,954	44,408,008
Diluted	95,096,090	88,578,192	77,641,388	65,253,954	44,408,008

(in thousands)	December 31, 2017	2016	2015	2014	2013
Consolidated balance sheet data:					
Cash and cash equivalents	$ 165,518	$ 110,635	$ 149,365	$ 118,612	$ 89,062
Total assets	2,099,229	2,002,263	2,114,088	2,188,318	819,967
Total long-term debt[(a)]	767,618	780,202	1,034,070	1,061,165	359,894
Total liabilities	997,761	1,062,927	1,326,492	1,415,185	456,744
Working capital	116,350	31,037	90,968	61,296	18,733
Total stockholders' equity	1,101,468	939,336	787,596	773,133	363,223

(a) Includes the current portion of our long-term debt and is net of debt issuance costs.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following is a discussion and analysis of our financial condition and results of operations as of, and for, the periods presented. You should read the following discussion and analysis of our financial condition and results of operations together with the sections entitled Item 1A, "Risk Factors," "Cautionary Note Regarding Forward-Looking Statements," Item 6, "Selected Historical Consolidated Financial Data" and our Consolidated Financial Statements and related Notes thereto included elsewhere in this Annual Report. This discussion and analysis contains forward-looking statements regarding the industry outlook, our expectations for the performance of our business, our liquidity and capital resources and the other non-historical statements. These forward-looking statements are subject to numerous risks and uncertainties, including but not limited to the risks and uncertainties described in Item 1A, "Risk Factors" and "Cautionary Note Regarding Forward-Looking Statements." Our actual results may differ materially from those contained in or implied by these forward-looking statements.

Overview

We are a leading provider of analytics-driven payment accuracy and spend management solutions, focused primarily on the healthcare sector. Our integrated solutions help clients enhance payment accuracy in an increasingly complex healthcare environment. We leverage our robust technology platform, configurable analytics, proprietary information assets and expertise in healthcare reimbursement to help our clients enhance their claims payment accuracy. We help our healthcare clients identify and correct payment inaccuracies, which resulted in approximately $3.4 billion in savings in 2017. We work with over 60 healthcare

organizations, including a majority of the 25 largest U.S. commercial, Medicare and Medicaid managed health plans, as well as CMS. We are also a leading provider of payment accuracy solutions to approximately 30 retail clients, including a majority of the ten largest retailers in the United States. We operate in two segments, Healthcare and Global Retail and Other.

Our growth strategy for healthcare includes:

- expand within our existing client base by increasing the volume of claims we review with our solutions; expanding the utilization across the depth and breadth of solutions; and cross-selling our prospective and retrospective solutions;
- expand our client base;
- innovate to improve and develop new solutions to expand the scope of our services; and
- pursue opportunistic acquisitions and strategic partnerships in payment accuracy and adjacent markets.

As a result of the meaningful savings we deliver to our clients, we have increased our client base and strengthened our long-standing relationships with many of the leading healthcare payers in the United States. In 2017, we generated revenue from four new clients and five cross-sell clients which we believe will drive revenue growth in 2018 and beyond. The average length of our relationships with our ten largest healthcare clients is over ten years. We have also substantially increased the annual savings captured by our healthcare clients over time.

We are also a leading provider of payment accuracy solutions to the retail market. Retailers process and validate extremely high volumes of transactions with disparate suppliers on varying terms. We work with retail clients in the United States, Canada and the United Kingdom to realize their negotiated allowances, concessions, rebates and other incentives associated with merchandise procurement, logistics and other service transactions. In 2017, we generated over $550 million in savings for our retail clients.

For a further discussion of our two operating segments, (i) Healthcare and (ii) Global Retail and Other, refer to "—Our Segments" and Note 15 to the Consolidated Financial Statements.

Our History

We were founded as Connolly in 1979 as a provider of payment accuracy solutions to the retail industry and launched our retrospective claims accuracy solutions to the healthcare industry in 1998. Connolly was acquired by the funds managed by Advent in 2012. In May 2014, Connolly merged with iHealth Technologies, which was founded in

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2001. At the time of the merger, Connolly was a leading provider of retrospective claims accuracy solutions to U.S. healthcare payors and retailers and iHealth Technologies was a leading provider of prospective claims accuracy solutions to U.S. healthcare payors. We rebranded our company as Cotiviti in September 2015 and completed our IPO in May 2016. In July 2017, we acquired RowdMap, a healthcare payer-provider, value-based analytics company.

Recent Developments

- We continued to execute on our strategy, increasing volume, expanding the adoption of our solutions within our existing healthcare clients and expanding the solutions we provide to create value for our clients, all of which contributed to healthcare revenue growth of 10% during the year ended December 31, 2017.
- Growth in our healthcare business also continues to benefit from the addition of new clients and our successful cross-sell efforts. During the year ended December 31, 2017, we generated $35.9 million in revenue from eight new clients and from an additional seven existing clients who have adopted either prospective or retrospective solutions, all of which were added in 2016 and 2017 as well as the RowdMap Acquisition.
- Our original Medicare RAC contract with CMS expired on January 31, 2018. As a result of the expiration of the contract, we expect to release at least $32 million of the

total $56 million liability for refunds and appeals during the first quarter 2018. This will increase first quarter 2018 revenue by an amount equal to the total liability released upon contract expiration. We continue to assess the remaining estimated liability for refunds and appeals to determine management's best estimate of any appeals overturned prior to the expiration of the contract term.

- On December 22, 2017, the U.S. government enacted the Tax Act, reducing the federal tax rate on U.S. earnings to 21%, effective January 1, 2018, and moving from a global taxation regime to a modified territorial regime. Given the significant complexity of the Tax Act, anticipated guidance from the U.S. Treasury about implementing the Tax Act, and the potential for additional guidance from the SEC or the FASB related to the Tax Act, we have not completed our accounting for the tax effects related to the enactment of the Tax Act. However, in certain cases, we have made a reasonable estimate of the effects on our existing deferred tax balances and the one-time transition tax.

  We recorded a net income tax benefit of $45.0 million in the year ended December 31, 2017 associated with the items we could reasonably estimate primarily related to the revaluation of our net deferred tax liabilities based on a U.S. federal tax rate of 21%, partially offset by a $1.6 million one-time transition tax on our unremitted foreign earnings and profits which we have elected to pay in the current year. Although we believe this represents a reasonable estimate of the impact of the income tax effects of the Tax Act as of December 31, 2017, it should be considered provisional. Upon completion of our 2017 U.S. tax return, we will be able to conclude whether any further adjustments are required to our deferred tax liabilities, as well as the liability associated with the one-time mandatory tax. Any adjustments to these provisional amounts will be reported as a component of tax expense (benefit) in the reporting period in which any such adjustments are determined, which will be no later than the fourth quarter of 2018.

- During the year ended December 31, 2017, approximately 1.8 million shares of common stock were issued upon the exercise of stock options. The stock option exercises resulted in a $16.2 million tax benefit and contributed to a lower effective tax rate for the year ended December 31, 2017.

- In October 2017, the Board of Directors approved a share repurchase program under which we may repurchase up to $100 million of common stock. This authorization permits us to repurchase shares from time to time until October 31, 2018 through a variety of methods, including open market repurchases and in privately negotiated transactions subject to debt covenants and other customary legal, contractual, regulatory and market considerations and may be discontinued at any time. In November 2017, we purchased 317,900 shares of common stock for $10.0 million under this share repurchase program.

- In July 2017, we completed our acquisition of RowdMap, a payer-provider, value-based analytics company that helps health plans and providers identify and reduce low-value care from inefficient and unnecessary services. We paid approximately $74.0 million in cash, subject to certain adjustments and funded entirely with available liquidity. We also issued an aggregate of 768,021 shares of restricted common stock to certain employees of

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RowdMap as a material inducement to their employment with us. Half of these shares are subject to performance-based vesting requirements. The other half are subject to continued employment with us, with one-third vesting on each of the first three anniversaries of the closing of the acquisition.

- In April 2017, we entered into and executed the First Amendment Agreement to the then outstanding Restated Credit Agreement, which, among other things, provided for a 25 basis point reduction in applicable interest rate spread over LIBOR associated with the First Lien Term B Loans. As a result, we recognized a loss on extinguishment of debt of $3.2 million during the year ended December 31, 2017.

Factors Affecting Our Results of Operations

Dollar Amount of Claims Reviewed

Revenue in our Healthcare segment in a given period is impacted by the dollar amount of claims we review for our clients, which impacts inaccurate payments that we identify for our clients and the amount of revenue we receive under our performance fee-based contracts. The dollar amount of claims that we review is driven by the scope of claims submitted to us by our clients. The dollar amount of inaccurate payments we identify is also dependent upon the type and number of our solutions used by our clients. As a result of our long-standing relationships with our clients, we have a steady, recurring revenue base.

The following table presents the dollar amount of claims received for review in our Healthcare segment for the periods presented (in thousands):

	Year Ended December 31,		
	2017	2016	2015
Amount of claims/payments reviewed by our retrospective claims accuracy solutions[(a)]	$563,194,157	$490,092,730	$451,287,783
Amount of claims/payments reviewed by our prospective claims accuracy solutions	$ 83,768,390	$ 76,079,350	$ 65,605,716

(a) Excludes our Medicare RAC contracts, for which we do not track the dollar amount of claims reviewed.

In our Global Retail and Other segment, our revenue is dependent on (i) the amount of payments that we review for our retail clients and (ii) the timing of our payment reviews, which typically are completed on a batch processing basis following the lapse of a period of time after payment. We do not track the dollar amount of claims reviewed in our Global Retail and Other segment.

Healthcare Industry and General Economic Conditions

A majority of our business is directly related to the healthcare industry and is affected by healthcare spending and complexity in the healthcare industry, as follows:

- *Healthcare Spending by Payers.* Changing demographics, the shift to managed care plans within government healthcare and increased healthcare coverage may lead to an increase in healthcare spending by our payer clients. From 2006 to 2016, healthcare costs in the United States grew at a 4.5% CAGR to $3.3 trillion. According to CMS, healthcare costs are expected to continue to grow at an average annual rate of 5.6% through 2025. Our revenue is impacted by the expansion or contraction of healthcare coverage, spending and utilization, which directly affects the number of payments available for our review.

- *Complexity in the Healthcare Industry.* We believe that reimbursement models will continue to become more complex as healthcare payers accommodate new markets and lines of business and as advancements in medical care increase the number of testing and treatment options available. As reimbursement models grow more complex and healthcare coverage increases, the complexity and number of claims may also increase, which could impact the demand for our payment accuracy solutions. Also, many of the changes promulgated by the Affordable Care Act, which may be repealed or restructured under the current administration, require implementing regulations that have not yet been drafted or have been released only as proposed rules. Such

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changes could have a further impact on our results of operations.

In addition, our Global Retail and Other segment is impacted by general economic conditions. For example, in a difficult economy, consumers may be willing to spend less and retailers may reduce their purchasing accordingly, thereby reducing their overall payments available for review. Alternatively, in an expanding economy, retailers may increase their purchasing to meet expected increasing demand resulting in increased payments subject to review using our solutions.

Components of Results of Operations

Net revenue

Our net revenue is generated from contracts with our clients. Our client contracts generally provide for performance fees that are based on a percentage of the inaccurate payments that we prevent through our prospective claims accuracy solutions or the payment recoveries received by our clients that use our retrospective claims accuracy solutions. We derive approximately 3% of our revenue on a "fee-for-service" basis whereby billing is based upon a flat fee or a fee per hour. Our clients may request a refund or offset if their providers or vendors ultimately reject the payment inaccuracies we find or if our clients determine not to pursue reimbursement from their providers or vendors even though we may have collected fees. We record an estimate for refund liabilities at any given time based on actual historical refund data by client type. In such cases, we record any such refund as a reduction of revenue. See "—Critical Accounting Policies—Revenue Recognition, Unbilled Receivables and Estimated Liability for Refunds and Appeals."

Historically, there has been a seasonal pattern to our healthcare revenue with the revenues in the first quarter generally lower than the other quarters and revenues in the fourth quarter generally being higher than the other quarters. Accordingly, the comparison of revenue from quarter-to-quarter may fluctuate and is dependent on various factors, including, but not limited to: a reset of member liability; timing of special projects; implementation delays; timing of inaccurate payments being prevented or recovered; industry utilization trends; and the aforementioned seasonal considerations. Consequently, you should not rely on our revenue for any one quarter as an indication of our future performance. Additionally, we record an estimated liability for refunds and appeals which is subject to management's assumptions. These assumptions may change from time to time and result in adjustments to revenue. Historically, our adjustments of these estimates on a quarterly basis, to reflect actual results or updated expectations, have not been material to our overall business, and have resulted in either a net increase or a net decrease in revenue. During the fourth quarter of 2017, changes in these estimates resulted in a reduction to our healthcare revenue of approximately $7.0 million.

Cost of revenue

Our cost of revenue is comprised of:

- *Compensation*, which includes the total compensation and benefit-related expenses, including stock-based compensation expense, for employees who provide direct revenue generating services to clients; and

- *Other costs of revenue*, which primarily include expenses related to the use of subcontractors and professional services firms, costs associated with the retrieval of medical records and facilities-related costs associated with locations that are used strictly for revenue generating activities. Cost of revenue does not include depreciation and amortization, which is stated separately in our Consolidated Statements of Comprehensive Income.

Selling, general and administrative expenses

Our selling, general and administrative expenses are comprised of:

- *Compensation*, which includes total compensation and benefit-related expenses, including stock-based compensation expense, for our employees who are not directly involved in revenue generating activities including those involved with developing new service offerings; and

- *Other selling, general and administrative expenses*, which include all of our general operating costs. These costs include, but are not limited to, rent and occupancy costs for facilities associated with locations that are

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used for employees not serving in revenue generating roles, telecommunications costs, information technology infrastructure costs, software licensing costs, advertising and marketing expenses, costs associated with developing new service offerings and expenses related to the use of certain subcontractors and professional services firms. Selling, general and administrative expenses do not include depreciation and amortization, which is stated separately in our Consolidated Statements of Comprehensive Income.

Depreciation and amortization of property and equipment

Depreciation and amortization of property and equipment consists of depreciation related to our investments in property and equipment, including claims accuracy solutions software, as well as amortization of capitalized internal-use software and software development costs.

Amortization of intangible assets

Amortization of intangible assets includes amortization of customer relationships, acquired software and certain trademarks.

Transaction-related expenses

Transaction-related expenses consist primarily of professional services and other expenses associated with our IPO and other offerings as well as certain expenses associated with corporate development activity, including the RowdMap Acquisition.

Impairment of intangible assets

Impairment of intangible assets results from when the carrying value of certain intangible assets exceeds their fair value. We incurred an impairment of a customer relationships asset in 2017 and certain trademarks in 2015.

Interest expense

Interest expense consists of accrued interest and related payments on our outstanding long-term debt as well as the amortization of debt issuance costs. Additionally, interest expense includes any effective portion of realized interest rate hedging derivative gains and losses previously recorded in accumulated other comprehensive income (loss) when the actual interest payments are made on our variable rate debt and the related derivate contract settles. See "—Credit Facilities."

Loss on extinguishment of debt

Loss on extinguishment of debt consists of fees paid and write-offs of unamortized debt issuance costs and original issue discount in connection with the 2017 repricing of our First Lien Term B Loans, the 2016 early repayment of a portion of our long-term debt, the 2016 refinancing of our long-term debt and the 2015 repricing of our long-term debt.

Other non-operating (income) expense

Other non-operating (income) expense primarily consists of foreign exchange gains and losses. In addition, income received for certain sub-leases, interest income and realized gains and losses are included in other non-operating (income) expense.

Income tax (benefit) expense

Income tax (benefit) expense consists of federal, state, local and foreign taxes based on earnings in multiple jurisdictions. Our income tax expense is impacted by the pre-tax earnings in jurisdictions with varying tax rates and any related foreign tax credits or deductions that may be available to us. Our current and future provision for income taxes will vary from statutory rates due to the impact of changes resulting from the enactment of the Tax Act, income tax incentives and holidays, certain non-deductible expenses, valuation allowances in certain countries, withholding taxes, excess tax benefits on the exercise of stock options and other discrete items.

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Stock-based compensation expense

We grant equity incentive awards to certain employees, officers and non-employee directors as long-term incentive compensation. As part of the RowdMap Acquisition, we issued restricted stock to certain employees. We recognize the related expense for these awards ratably over the applicable vesting period or as achievement of performance criteria become probable. Such expense is recognized in either cost of revenue or selling, general and administrative expenses based upon the function of the optionee. The following table shows the allocation of

stock-based compensation expense among our expense line items for the periods presented (in thousands):

	Year Ended December 31,		
	2017	2016	2015
Cost of revenue	$ 2,050	$ 5,026	$ 963
Selling, general and administrative expenses	14,823	17,928	2,436
Total	$16,873	$22,954	$3,399

As of December 31, 2017, we had total unrecognized stock-based compensation expense related to unvested service-based awards of $43.3 million, which we expect to recognize over the next 2.4 years. Stock-based compensation expense for the year ended December 31, 2017 includes approximately $6.1 million, of which approximately $5.9 million is included in selling, general and administrative expenses and $0.2 million is included in cost of revenue, related to the performance-based restricted stock issued in connection with the RowdMap Acquisition that we estimate is probable of achieving the performance criteria. Stock-based compensation expense for the year ended December 31, 2016 includes approximately $15.9 million as a result of the vesting of performance-based awards, of which approximately $3.9 million is included in cost of revenue above and the remaining $12.0 million is included in selling, general and administrative expenses above. Additionally, for the year ended December 31, 2016, stock-based compensation expense included in selling, general and administrative expenses includes approximately $2.3 million related to the accelerated vesting of certain stock options as the result of our IPO.

Foreign currency translation adjustments

The assets and liabilities of our foreign subsidiaries with a functional currency other than the U.S. Dollar are translated into U.S. Dollars using applicable exchange rates at the balance sheet date. Revenue and expenses are translated at average exchange rates effective during the year. The resulting foreign currency translation gains and losses are included as a component of other comprehensive income (loss). We had upward foreign currency translation adjustments of $0.9 million for the year ended December 31, 2017 as a result of the weakening of the U.S. dollar against the Canadian Dollar and British Pound. We had downward foreign currency translation adjustments of $0.9 million and $0.7 million for the years ended December 31, 2016 and 2015, respectively, as the result of the strengthening of the U.S. Dollar against the Canadian Dollar and British Pound.

Change in fair value of derivative instruments, net of related taxes

We are a party to interest rate cap agreements that hedge the potential impact fluctuations in interest rates may have on payments we make pursuant to our long-term debt. We had an upward net change in fair value of derivative instruments, net of related taxes, or approximately $0.8 million for the year ended December 31, 2017 and a downward net change in fair value of derivative instruments, net of related taxes of approximately $0.4 million and $2.3 million for the years ended December 31, 2016 and 2015, respectively. The changes were the result of fluctuations in three-month LIBOR.

How We Assess Our Performance

Adjusted EBITDA

We believe Adjusted EBITDA (a non-GAAP measure) is useful to investors as a supplemental measure to evaluate our overall operating performance. Management uses Adjusted EBITDA as a measurement to compare our operating performance to our peers and competitors. We define Adjusted EBITDA as net income before depreciation and amortization, impairment of intangible assets, interest expense, other non-operating (income) expense such as

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foreign currency transaction gains and losses, income tax (benefit) expense, gain on discontinued operations, transaction-related expenses and other, stock-based compensation and loss on extinguishment of debt. See the notes to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for additional information regarding these adjustments. Management believes Adjusted EBITDA is useful because it provides meaningful supplemental information about our operating performance and facilitates period-to-period comparisons without regard to our financing methods, capital structure or other items that we

believe are not indicative of our ongoing operating performance. By providing this non-GAAP financial measure, management believes we are enhancing investors' understanding of our business and our results of operations, as well as assisting investors in evaluating how well we are executing our strategic initiatives. Management believes that Adjusted EBITDA is frequently used by securities analysts, investors and other interested parties as a supplemental measure of financial performance within our industry. In addition, the determination of Adjusted EBITDA is consistent with the definition of a similar measure in our First Lien Credit Facilities.

Adjusted EBITDA has important limitations as an analytical tool and you should not consider it in isolation or as a substitute for analysis of our results as reported under GAAP. Some of these limitations are:

- Adjusted EBITDA does not reflect our cash expenditures or future requirements for capital expenditures or contractual commitments;
- Adjusted EBITDA does not reflect changes in, or cash requirements for, our working capital needs;
- Although depreciation is a non-cash charge, the assets being depreciated will often have to be replaced in the future, and Adjusted EBITDA does not reflect any cash requirements for such replacements;
- Adjusted EBITDA does not reflect the impact of stock-based compensation upon our results of operations;
- Adjusted EBITDA does not reflect the significant interest expense, or the cash requirements necessary to service interest or principal payments on our debt;
- Adjusted EBITDA does not reflect our income tax (benefit) expense or the cash requirements to pay our income taxes; and
- Other companies in our industry may calculate Adjusted EBITDA differently than we do, limiting its usefulness as a comparative measure.

In evaluating Adjusted EBITDA, you should be aware that in the future we may incur expenses similar to those eliminated in this presentation.

The following table presents a reconciliation of Adjusted EBITDA to net income, the most directly comparable GAAP measure, for the periods presented:

	Year Ended December 31,		
	2017	2016	2015
(in thousands)			
Net income	$138,203	$ 48,852	$ 13,863
Depreciation and amortization	85,183	80,969	74,162
Impairment of intangible assets[a]	1,322	—	27,826
Interest expense	34,876	48,653	65,561
Other non-operating (income) expense[b]	(2,191)	(939)	(826)
Income tax (benefit) expense	(11,773)	20,970	14,401
Gain on discontinued operations, net of tax[c]	—	—	(559)
Transaction-related expenses and other[d]	2,219	1,788	1,469
Stock-based compensation[e]	16,873	22,954	3,399
Loss on extinguishment of debt[f]	3,183	16,417	4,084
Adjusted EBITDA	$267,895	$239,664	$203,380

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(a) Represents an impairment related to our customer relationships intangible asset during the year ended December 31, 2017 as a result of the loss of a retail client in the United Kingdom. Also represents a $27,826 impairment charge during the year ended December 31, 2015 as a result of our rebranding and the related impact to our trademarks.

(b) Represents other non−operating (income) expense that consists primarily of interest income and gains and losses on transactions settled in foreign currencies. Income received for certain sub−leases is included herein.

(c) Represents payment on a $900 note receivable ($559 net of taxes) related to a business that was disposed of in 2012. This note receivable had been reported in the loss on discontinued operations in 2012 upon the sale of that business. Since the date of sale, we had elected to fully reserve the note receivable as the collectability was determined to be uncertain.
(d) Represents transaction−related expenses that consist primarily of certain expenses associated with our secondary offerings and our IPO and other offering costs in 2016 as well as certain corporate development activity, including the RowdMap Acquisition.
(e) Represents expense related to equity incentive awards granted to certain employees, officers and non−employee directors as long−term incentive compensation and restricted stock issued in connection with the RowdMap Acquisition. We recognize the related expense for these awards ratably over the vesting period or as achievement of performance criteria become probable.
(f) Represents loss on extinguishment of debt that consists primarily of fees paid and write−offs of unamortized debt issuance costs and original issue discount in connection with the 2017 repricing of our First Lien Term B Loans, the 2016 early repayment of a portion of our long-term debt, the 2016 refinancing of our long-term debt and the repricing of our long−term debt in 2015.

Dollar Amount of Inaccurate Payments Prevented or Recovered

The majority of our net revenue consists of performance fees earned under our client contracts. A small portion (approximately 3%) of our revenue is derived on a "fee-for-service" basis whereby billing is based upon a subscription basis, flat fee or a fee per hour. Our performance fees generally represent a specified percentage of inaccurate payments that are either prevented prior to payment using our prospective claims accuracy solutions or recovered by our clients after they are identified using our retrospective claims accuracy solutions. For those clients where we identify any payment inaccuracies in advance of payment to the providers, the clients reduce the amount paid to the providers based upon the inaccuracies that we have identified. For those clients where we identify payment inaccuracies using our retrospective claims accuracy solutions after the client has made payment, clients generally recover claims either by taking credits against outstanding payables to healthcare providers or retail vendors, or future purchases from the related retail vendors, or receiving refund checks directly from those healthcare providers or retail vendors.

The dollar amount of inaccurate payments prevented or recovered in a given period is impacted by the dollar amount of claims or payments reviewed, the scope of claims or payments that we review, the success of our cross-selling efforts, our ability to retain existing clients and obtain new clients and our ability to enhance our existing solutions or create new solutions.

We believe the dollar amount of inaccurate payments prevented or recovered is useful to measure our overall operating performance and how well we are executing on our client contracts.

The following table presents the combined dollar amount of inaccurate payments prevented or recovered in our Healthcare and Global Retail and Other segments for the periods presented (in thousands):

	Year Ended December 31,		
	2017	2016	2015
Amount of inaccurate payments prevented or recovered[a]	$3,979,601	$3,853,505	$3,272,565
Amount of inaccurate payments prevented or recovered, excluding our Medicare RAC contract[a]	$3,960,032	$3,742,217	$3,064,061

(a) Inaccurate payments prevented or recovered for prior periods are reported to us on a rolling basis. Accordingly, amounts reflected for prior periods are subject to change.

Factors Affecting the Comparability of our Results of Operations

As a result of a number of factors, our historical results of operations may not be comparable to our results of

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operations in future periods and our results of operations may not be directly comparable from period to period. Set forth below is a brief discussion of the key factors impacting the comparability of our results of operations.

Debt Refinancings, Repayments and Repricing

In connection with our various debt refinancings, we incurred significant debt issuance costs, primarily associated with the new indebtedness. These debt issuance costs are amortized utilizing the effective interest method over the associated life of the related indebtedness and recorded as interest expense. Unamortized debt issuance costs were $7.2 million, $10.8 million and $21.0 million as of December 31, 2017, 2016 and 2015, respectively.

In May 2015, we repriced our Initial First Lien Credit Facilities, which reduced the related interest rates. We incurred $4.1 million in debt extinguishment costs for the year ended December 31, 2015 in connection with the repricing primarily related to accelerated recognition of the unamortized portion of debt issuance costs and original issue discount related to indebtedness that was repaid to certain lenders.

In June 2016, we repaid $223.0 million in outstanding principal under our then outstanding Initial Second Lien Credit Facility using proceeds from our IPO. We also made a voluntary prepayment of $13.1 million of outstanding principal under the Initial Second Lien Credit Facility. As a result of these repayments, we recognized a loss on extinguishment of debt totaling $7.1 million for the year ended December 31, 2016 primarily related to the accelerated recognition of the unamortized portion of debt issuance costs and original issue discount. See "—Liquidity and Capital Resources—First Lien Credit Facilities."

In September 2016, we completed a refinancing of our Initial First and Second Lien Credit Facilities and entered into the Restated Credit Agreement, which provides for the First Lien Credit Facilities consisting of (a) the First Lien Term A Loans in the original principal amount of $250.0 million, (b) the First Lien Term B Loans in the original principal amount of $550.0 million and (c) the $100.0 million Revolver, reducing our total debt principal outstanding by $22.7 million and reducing the interest rates we pay on our outstanding debt. As a result of this refinancing, we recognized a loss on extinguishment of debt of $9.3 million for the year ended December 31, 2016, primarily related to the payment of certain fees and the accelerated recognition of the unamortized portion of debt issuance costs and original issue discount related to indebtedness that was repaid to certain lenders.

In April 2017, we entered into the First Amendment Agreement to the then outstanding Restated Credit Agreement, which, among other things, provided for lower applicable interest rates associated with the First Lien Term B Loans. As a result, we recognized a loss on extinguishment of $3.2 million during the year ended December 31, 2017.

Medicare RAC Contract

Historically, one of our largest clients was CMS under our original Medicare RAC contract. However, net revenue under our Medicare RAC contracts has declined over the past several years as a result of a number of factors, including the cessation of the submission of claims for review by CMS for a period of two months in 2014, the reduction of the scope of claims that we review (in particular the ongoing suspension of review of certain of inpatient hospital claims), cessation of active auditing under the original Medicare RAC contract ending on July 29, 2016 and subsequent delays with the contract renewal process with reviews under our new Medicare RAC contracts not commencing until the first quarter of 2017 as discussed further below. Net revenue under our Medicare RAC contracts was $6.5 million, $14.0 million and $18.5 million for the years ended December 31, 2017, 2016 and 2015, respectively.

In October 2016, CMS announced that we were awarded two new Medicare RAC contracts to provide retrospective payment accuracy services for Medicare Parts A and B (other than durable medical equipment, prosthetics, orthotics, and supplies claims and home health and hospice claims). Pursuant to these awards, we are the Medicare RAC for Region 2 (Central U.S.) and Region 3 (Southeast U.S.). The new Medicare RAC program contracts have a one year initial term, with multiple one year renewal options at the election of CMS. In March 2017, we began auditing under our two new Medicare RAC contracts awarded in October 2016. These contracts have been ramping slower than anticipated and contributed minimal revenue in 2017. We do not anticipate our Medicare RAC contract will represent a significant portion of our business going forward.

Our original Medicare RAC contract with CMS expired on January 31, 2018. In connection with the expiration of the contract, we determined that we have no obligation to CMS with respect to any appeals resolved in the providers

favor after the expiration date and, in addition, we believe that we have no obligation to CMS in connection with the hospital settlement processes described in Note 7 to our consolidated financial statements. See Note 20 to our consolidated financial statements for further information.

Impairment of Intangible Assets

Due to the loss of a retail client in the United Kingdom, we recorded an impairment of intangible assets of $1.3 million related to our customer relationships during the year ended December 31, 2017.

As a result of our Cotiviti rebranding, we recorded an impairment of intangible assets of $27.8 million related to our Connolly and iHealth trademarks during the year ended December 31, 2015. The remaining trademark value of $4.2 million as of December 31, 2016 is related to our retail business that continues to operate as Connolly, a division of Cotiviti.

Stock-based compensation

Stock-based compensation expense for the year ended December 31, 2017 includes approximately $6.1 million related to the performance-based restricted stock issued in connection with the RowdMap Acquisition that we estimate is probable of achieving the performance criteria. Stock-based compensation expense for the year ended December 31, 2016 includes approximately $15.9 million as a result of the vesting of performance-based awards. Additionally, for the year ended December 31, 2016, stock-based compensation expense includes approximately $2.3 million related to the accelerated vesting of certain stock options as the result of our IPO.

Our Segments

We report our results of operations in two segments, (i) Healthcare and (ii) Global Retail and Other. Through our Healthcare segment, we offer prospective and retrospective claims accuracy solutions to healthcare payers in the United States. We also provide a network efficiency solution to payers and providers as well as, on a limited basis, certain analytics-based solutions unrelated to our healthcare payment accuracy solutions in the United States. Through our Global Retail and Other segment, we provide retrospective claims accuracy solutions to retailers primarily in the United States with additional clients in Canada and the United Kingdom, as well as solutions that improve efficiency and effectiveness of payment networks for a limited number of clients.

We evaluate the performance of each segment based on segment net revenue and segment operating income. The cost of revenue for each segment is based on direct expenses associated with revenue generating activities of each segment. We allocate selling, general and administrative expenses and depreciation and amortization to each segment based on the segments' proportionate share of revenue and expenses directly related to the operation of the segment as determined by management. The following table sets forth the net revenue and operating income for our Healthcare and Global Retail and Other segments for the periods presented (in thousands):

	Year Ended December 31,		
	2017	2016	2015
Net Revenue			
Healthcare	$605,228	$552,041	$467,044
Global Retail and Other	73,433	73,121	74,299
Consolidated net revenue	$678,661	$625,162	$541,343
Operating Income			
Healthcare	$151,340	$123,917	$ 84,240
Global Retail and Other	10,958	10,036	12,284
Consolidated operating income	$162,298	$133,953	$ 96,524

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The following table sets forth our segment net revenue and percentage of consolidated net revenue by product type for the periods presented (in thousands):

	Year Ended December 31,					
	2017	%	2016	%	2015	%
Healthcare						
Retrospective claims accuracy	$351,662	51.8	$310,496	49.7	$251,288	46.4
Prospective claims accuracy	236,192	34.8	229,491	36.7	201,899	37.3
Other	17,374	2.6	12,054	1.9	13,857	2.6
Total Healthcare	605,228	89.2	552,041	88.3	467,044	86.3
Global Retail and Other						
Retrospective claims accuracy	71,437	10.5	70,656	11.3	72,060	13.3
Other	1,996	0.3	2,465	0.4	2,239	0.4
Total Global Retail and Other	73,433	10.8	73,121	11.7	74,299	13.7
Consolidated net revenue	$678,661	100.0	$625,162	100.0	$541,343	100.0

Results of Operations

Year Ended December 31, 2017 Compared to Year Ended December 31, 2016

The following table sets forth our consolidated statement of operations for the periods presented (in thousands):

	Year Ended December 31,				Percentage Change
	2017	Percentage of Net Revenue (%)	2016	Percentage of Net Revenue (%)	Period to Period (%)
Net revenue	$678,661	100.0	$625,162	100.0	8.6
Cost of revenue (exclusive of depreciation and amortization, stated separately below):					
Compensation	226,439	33.4	229,601	36.7	(1.4)
Other costs of revenue	24,688	3.6	22,167	3.5	11.4
Total cost of revenue	251,127	37.0	251,768	40.2	(0.3)
Selling, general and administrative expenses (exclusive of depreciation and amortization, stated separately below):					
Compensation	108,151	15.9	97,123	15.6	11.4
Other selling, general and administrative expenses	68,361	10.1	59,561	9.5	14.8
Total selling, general and administrative expenses	176,512	26.0	156,684	25.1	12.7
Depreciation and amortization of property and equipment	25,577	3.8	20,151	3.2	26.9
Amortization of intangible assets	59,606	8.8	60,818	9.7	(2.0)
Transaction-related expenses	2,219	0.3	1,788	0.3	24.1
Impairment of intangible assets	1,322	0.2	—	—	—
Total operating expenses	516,363	76.1	491,209	78.5	5.1
Operating income	162,298	23.9	133,953	21.5	21.2
Other expense (income):					
Interest expense	34,876	5.1	48,653	7.8	(28.3)
Loss on extinguishment of debt	3,183	0.5	16,417	2.6	(80.6)
Other non-operating (income) expense	(2,191)	(0.3)	(939)	(0.1)	133.3
Total other expense (income)	35,868	5.3	64,131	10.3	(44.1)
Income before income taxes	126,430	18.6	69,822	11.2	81.1
Income tax (benefit) expense	(11,773)	(1.8)	20,970	3.3	(156.1)
Net income	$138,203	20.4	$ 48,852	7.9	182.9

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Net revenue

Net revenue was $678.7 million for the year ended December 31, 2017 as compared to $625.2 million for the year ended December 31, 2016. The increase of $53.5 million was the result of increased Healthcare segment revenue of $53.2 million and increased Global Retail and Other segment revenue of $0.3 million. See "—Segment net revenue and operating income."

Cost of revenue

Cost of revenue related to compensation was $226.4 million for the year ended December 31, 2017 as compared to $229.6 million for the year ended December 31, 2016. The decrease of $3.2 million was primarily the result of a decrease of approximately $3.0 million in stock-based compensation due to the vesting of performance-based stock options during the year ended December 31, 2016 partially offset by additional equity grants. Payroll related expenses decreased $2.4 million primarily due to changes in some of our variable compensation programs in late 2016 in order to better align our compensation structure with our business strategy offset by increased headcount to support the growth of our Healthcare segment. These decreases were partially offset by a $2.2 million increase to employee benefit costs due to rising healthcare coverage costs and the increase in the number of our employees.

Other costs of revenue were $24.7 million for the year ended December 31, 2017 as compared to $22.2 million for the year ended December 31, 2016. The increase of $2.5 million was primarily the result of an increase of approximately $1.8 million in professional and consulting fees as we have leveraged external resources and expertise. Personnel-related costs increased approximately $1.1 million due to an increase in the number of employees. Rent and occupancy increased approximately $0.3 million as a result of new and expanded locations. These increases were partially offset by a $0.7 million decrease in other variable costs.

Selling, general and administrative expenses

Selling, general and administrative expenses related to compensation were $108.2 million for the year ended December 31, 2017 as compared to $97.1 million for the year ended December 31, 2016. The increase of $11.1 million was primarily related to a $12.8 million increase in payroll related expenses due to an increase in the number of employees to support our growing operations, particularly as we continue to invest in technology, analytics and go-to-market. Employee benefit costs increased approximately $1.4 million due to rising healthcare coverage costs and the increase in number of employees. This was partially offset by a decrease in stock-based compensation of $3.1 million due to the vesting of performance-based stock options and the accelerated vesting of certain stock options as a result of our IPO during the year ended December 31, 2016 partially offset by additional equity grants including restricted stock issued in connection with the RowdMap Acquisition.

Other selling, general and administrative expenses were $68.4 million for the year ended December 31, 2017 as compared to $59.6 million for the year ended December 31, 2016. The increase of $8.8 million was primarily due an increase of $4.7 million in IT infrastructure and telecommunication expenses. Professional and consulting fees increased $2.4 million as we have leveraged external resources and expertise. Personnel-related expenses increased approximately $1.9 million due to an increased number of employees. These increases were partially offset by a $0.2 million decrease in other variable costs

Depreciation and amortization of property and equipment

Depreciation and amortization of property and equipment was $25.6 million for the year ended December 31, 2017 as compared to $20.2 million for the year ended December 31, 2016. The increase of $5.4 million was due to continued investments in capital expenditures primarily related to enhancing our IT platform.

Amortization of intangible assets

Amortization of intangible assets was $59.6 million for the year ended December 31, 2017 as compared to $60.8 million for the year ended December 31, 2016. The decrease of $1.2 million was due to the addition of $19.5 million in intangible assets in connection with the RowdMap Acquisition which was partially offset by certain acquired software becoming fully amortized in 2017.

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Transaction-related expenses

Transaction-related expenses were $2.2 million for the year ended December 31, 2017 primarily related to expenses incurred in connection with our secondary offering costs as well as certain expenses related to corporate development activity, including the RowdMap Acquisition. Transaction-related expenses were $1.8 million for the year ended December 31, 2016 primarily related to expenses incurred in connection with our IPO and other offering costs as well as certain expenses related to corporate development activity.

Impairment of Intangible Assets

Impairment of intangible assets was $1.3 million for the year ended December 31, 2017 related to our customer relationships as a result of the loss of a retail client in the United Kingdom.

Interest expense

Interest expense was $34.9 million for the year ended December 31, 2017 as compared to $48.7 million for the year ended December 31, 2016. The decrease of $13.8 million was primarily due to the significant decline in outstanding principal over the past year in connection with the use of our IPO proceeds and the September 2016 refinancing, which resulted in a $6.1 million decrease in interest expense. Additionally, interest rate reductions in connection with the September 2016 refinancing and the April 2017 repricing of our First Lien Term B Loans resulted in an $8.6 million decrease in interest expense. This decrease was partially offset by a $1.5 million increase in interest expense related to our interest rate cap agreements.

Loss on extinguishment of debt

Loss on extinguishment of debt was $3.2 million for the year ended December 31, 2017 related to the payment of fees and write-off of unamortized debt issuance costs and original issue discount as a result of the repricing of our First Lien Term B Loans. Loss on extinguishment of debt was $16.4 million for the year ended December 31, 2016 related to the payment of fees and write-off of unamortized debt issuance costs and original issue discount as a result of the refinancing of our long-term debt in September 2016 and the early payment on our outstanding borrowings under our then outstanding second lien credit facility in June 2016.

Other non-operating (income) expense

Other non-operating (income) expense was $2.2 million for the year ended December 31, 2017 as compared to $0.9 million for the year ended December 31, 2016. The increase of $1.3 million was primarily the result of additional interest income as a result of our growing cash balance and foreign exchange gains related to our operations in India.

Income tax (benefit) expense

Income tax benefit was $11.8 million for the year ended December 31, 2017 as compared to income tax expense of $21.0 million for the year ended December 31, 2016. The effective tax rate for the year ended December 31, 2017 was (9.3%) compared to 30.0% for the year ended December 31, 2016. The decrease in the effective tax rate is primarily due to a $45.0 million net tax benefit as a result of the enactment of the Tax Act in December 2017. In addition, we recorded $12.0 million and $4.0 million during the year ending December 31, 2017 and 2016, respectively, of net tax benefits related to stock-based compensation. The net tax benefit of $12.0 million in 2017 consists of $15.0 million of tax benefits associated with excess tax benefits upon exercise of stock options offset by $3.0 million of nondeductible restricted stock issued in connection with the RowdMap acquisition.

Segment net revenue and operating income

Healthcare segment net revenue was $605.2 million for the year ended December 31, 2017 as compared to $552.0 million for the year ended December 31, 2016. The increase of $53.2 million was primarily the result of an increase of $35.9 million due to the addition of new clients and the success of our cross-sell efforts as well as the addition related to the RowdMap Acquisition and a net increase of $17.3 million due to further penetration and extended scope of services provided to our existing client base, which is net of a reduction of approximately $7.0 million related to an increase in our estimated liability for refunds and appeals.

Global Retail and Other segment net revenue was $73.4 million for the year ended December 31, 2017 as compared to $73.1 million for the year ended December 31, 2016. The increase of $0.3 million was primarily the result of the timing, nature and size of claims reviewed.

Healthcare segment operating income was $151.3 million for the year ended December 31, 2017 as compared to $123.9 million for the year ended December 31, 2016. The increase in operating income of $27.4 million was the result of an increase in net revenue noted above. Stock-based compensation expense decreased $5.0 million due to the vesting of performance-based stock options and the accelerated vesting of certain stock options due to the IPO during 2016 partially offset by additional equity grants including the issuance of restricted stock in connection with the RowdMap Acquisition. Additionally, there was a $2.1 million decrease in other variable costs. These increases in operating income were partially offset by an increase in compensation expense of $14.9 million related to an increase in the number of employees in our growing Healthcare segment. Professional and consulting fees increased $4.7 million as we have leveraged external resources and expertise. Our ongoing investment in strategic initiatives contributed an additional $4.3 million in expense primarily related to an increase in IT infrastructure costs. Depreciation and amortization expenses increased by $4.2 million due to our continued investments in capital expenditures. Personnel-related expenses increased $3.6 million due to an increase in the number of employees. Rent and occupancy related costs increased $0.8 million as a result of new and expanded locations. Transaction-related expenses increased $0.4 million primarily related to our secondary offerings and the RowdMap Acquisition.

Global Retail and Other segment operating income was $11.0 million for the year ended December 31, 2017 as compared to $10.0 million for the year ended December 31, 2016. The increase in operating income of $1.0 million was the result of the increase in revenue noted above, a decrease of $1.0 million in stock-based compensation expense primarily due to the vesting of performance-based stock options in 2016 and a decrease of approximately $1.0 million in compensation related expenses as a result of changes in our variable compensation plans and as a result of the retail segment becoming a smaller portion of our overall business resulting in a lower allocation of corporate expenses. These increases to operating income were offset by a $1.3 million impairment of intangible assets related to our customer relationships in the United Kingdom.

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Year Ended December 31, 2016 Compared to Year Ended December 31, 2015

The following table sets forth our consolidated statement of operations for the periods presented (in thousands):

	Year Ended December 31,				Percentage Change Period to Period
	2016	Percentage of Net Revenue (%)	2015	Percentage of Net Revenue (%)	(%)
Net revenue	$625,162	100.0	$541,343	100.0	15.5
Cost of revenue (exclusive of depreciation and amortization, stated separately below):					
Compensation	229,601	36.7	183,817	34.0	24.9
Other costs of revenue	22,167	3.5	20,800	3.8	6.6
Total cost of revenue	251,768	40.2	204,617	37.8	23.0
Selling, general and administrative expenses (exclusive of depreciation and amortization, stated separately below):					
Compensation	97,123	15.6	70,802	13.1	37.2
Other selling, general and administrative expenses	59,561	9.5	65,943	12.2	(9.7)
Total selling, general and administrative expenses	156,684	25.1	136,745	25.3	14.6
	20,151	3.2	12,695	2.3	58.7

Depreciation and amortization of property and equipment					
Amortization of intangible assets	60,818	9.7	61,467	11.4	(1.1)
Transaction-related expenses	1,788	0.3	1,469	0.3	21.7
Impairment of intangible assets	—	—	27,826	5.1	(100.0)
Total operating expenses	491,209	78.5	444,819	82.2	10.4
Operating income	133,953	21.5	96,524	17.8	38.8
Other expense (income):					
Interest expense	48,653	7.8	65,561	12.1	(25.8)
Loss on extinguishment of debt	16,417	2.6	4,084	0.8	302.0
Other non-operating (income) expense	(939)	(0.1)	(826)	(0.2)	13.7
Total other expense (income)	64,131	10.3	68,819	12.7	(6.8)
Income from continuing operations before income taxes	69,822	11.2	27,705	5.1	152.0
Income tax expense	20,970	3.3	14,401	2.6	45.6
Income from continuing operations	48,852	7.9	13,304	2.5	(267.2)
Gain on discontinued operations, net of tax	—	—	559	0.1	(100.0)
Net income	$ 48,852	7.9	$ 13,863	2.6	252.4

Net revenue

Net revenue was $625.2 million for the year ended December 31, 2016 as compared to $541.3 million for the year ended December 31, 2015. The increase of $83.9 million was the result of increased Healthcare segment revenue of $85.0 million and decreased Global Retail and Other segment revenue of $1.2 million. See "—Segment net revenue and operating income."

Cost of revenue

Cost of revenue related to compensation was $229.6 million for the year ended December 31, 2016 as compared to $183.8 million for the year ended December 31, 2015. The increase of $45.8 million was primarily the result of approximately $34.8 million in additional payroll related expenses due to increased headcount and growth of our Healthcare segment. Stock-based compensation increased by approximately $4.1 million due to the vesting of performance-based stock options during the year ended December 31, 2016 as well as additional stock option grants. Employee benefit costs increased approximately $3.7 million due to rising healthcare coverage costs and the increase in the number of our employees. Additionally, we made changes to some of our variable compensation programs in 2016 in order to better align our compensation structure with our business strategy which resulted in additional expense of approximately $3.2 million.

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Other costs of revenue were $22.2 million for the year ended December 31, 2016 as compared to $20.8 million for the year ended December 31, 2015. The increase of $1.4 million was primarily the result of a $2.1 million increase in facilities related costs and a $1.9 million increase in variable costs to support our growing operations partially offset by a $2.6 million decrease in the cost to retrieve medical records due to reduced volume.

Selling, general and administrative expenses

Selling, general and administrative expenses related to compensation were $97.1 million for the year ended December 31, 2016 as compared to $70.8 million for the year ended December 31, 2015. The increase of $26.3 million was primarily related to a $15.5 million increase in stock-based compensation due to the vesting of performance-based stock options and the accelerated vesting of certain stock options as a result of the IPO during the year ended December 31, 2016 as well as additional stock option grants. Compensation related expenses increased $8.9 million primarily due to an increase in the number of employees to support our growing operations, including the enhancement of key corporate functions in connection with being a public company. Employee benefit costs increased approximately $1.9 million due to rising healthcare coverage costs and the increase in number of employees.

Other selling, general and administrative expenses were $59.6 million for the year ended December 31, 2016 as compared to $65.9 million for the year ended December 31, 2015.

The decrease of $6.3 million was primarily due to a decrease of $9.1 million in other costs including professional and consulting fees as our current need to leverage external resources in support of our strategic initiatives has been reduced. This decrease was partially offset by a $2.8 million increase in IT infrastructure and telecommunications costs to support our growing operations.

Depreciation and amortization of property and equipment

Depreciation and amortization of property and equipment was $20.2 million for the year ended December 31, 2016 as compared to $12.7 million for the year ended December 31, 2015. The increase of $7.5 million was due to continued investments in capital expenditures over the prior year.

Amortization of intangible assets

Amortization of intangible assets was $60.8 million for the year ended December 31, 2016 as compared to $61.5 million for the year ended December 31, 2015. The decrease of $0.7 million was the result of the impairment of our legacy trademarks related to the Cotiviti rebranding in September 2015.

Transaction-related expenses

Transaction-related expenses were $1.8 million for the year ended December 31, 2016 primarily related to expenses incurred in connection with our IPO and other offering costs as well as certain expenses related to corporate development activity. Transaction-related expenses were $1.5 million for the year ended December 31, 2015 primarily related to expenses incurred in connection with our IPO.

Impairment of intangible assets

Impairment of intangible assets was $27.8 million for the year ended December 31, 2015 related to our Connolly and iHealth trademarks as a result of our Cotiviti rebranding in September 2015. We had no impairment of intangible assets for the year ended December 31, 2016.

Interest expense

Interest expense was $48.7 million for the year ended December 31, 2016 as compared to $65.6 million for the year ended December 31, 2015. In May 2015 we repriced our then outstanding Initial First Lien Term Loans, lowering the interest rate by 50 basis points. In June 2016, we repaid $236.1 million of outstanding borrowings under our then outstanding Initial Second Lien Credit Facility. In September 2016, we entered into the Restated Credit Agreement pursuant to which we refinanced our long-term debt under our Initial Secured Credit Facilities, reducing our outstanding principal by $22.7 million and reducing our overall interest rates. The total decrease in interest expense of $16.9 million

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was the result of the reduction in principal, which contributed approximately $8.2 million of the interest expense decrease, and the lower interest rates, which contributed the remaining $8.7 million interest expense decrease.

Loss on extinguishment of debt

Loss on extinguishment of debt was $16.4 million for the year ended December 31, 2016 related to the payment of fees and write-off of unamortized debt issuance costs and original issue discount as a result of the refinancing of our long-term debt in September 2016 pursuant to the Restated Credit Agreement and the early payment on our outstanding borrowings under our then outstanding Initial Second Lien Credit Facility in June 2016. During the year ended December 31, 2015 we recognized a loss on extinguishment of $4.1 million related to the write-off of unamortized debt issuance costs and original issue discount as a result of the repricing of our then outstanding Initial First Lien Term Loan.

Other non-operating (income) expense

Other non-operating (income) expense was $0.9 million for the year ended December 31, 2016 as compared to $0.8 million for the year ended December 31, 2015. The increase of

$0.1 million was primarily the result of foreign exchange gains related to our operations in India.

Income tax expense

Income tax expense was $21.0 million for the year ended December 31, 2016 as compared to $14.4 million for the year ended December 31, 2015. The increase in income tax expense for the year ended December 31, 2016 as compared to the year ended December 31, 2015 was primarily a result of the increase in pre-tax income. The effective tax rate for the year ended December 31, 2016 was 30.0% compared to 52.0% for the year ended December 31, 2015. The decrease in the effective tax rate is primarily due to a $1.3 million tax benefit related to the settlement of an uncertain tax position recorded in a prior period, a $4.0 million excess tax benefit related to stock option exercises due to the early adoption of ASU 2016-09, Improvements to Employee Share-Based Payment Accounting, and a $1.1 million tax benefit related to the impact of certain tax planning.

Segment net revenue and operating income

Healthcare segment net revenue was $552.0 million for the year ended December 31, 2016 as compared to $467.0 million for the year ended December 31, 2015. The increase of $85.0 million was primarily the result of a net increase of $66.8 million due to increased penetration and extended scope of services provided to our existing client base which includes approximately $5.0 million relating to special projects that we do not expect to reoccur and a $18.2 million increase due to the addition of new clients and the success of our cross-sell efforts.

Global Retail and Other segment net revenue was $73.1 million for the year ended December 31, 2016 as compared to $74.3 million for the year ended December 31, 2015. The decrease of $1.2 million was primarily related to foreign currency fluctuations due to the strengthening U.S. dollar and the negative impact of certain regulatory changes in the U.K.

Healthcare segment operating income was $123.9 million for the year ended December 31, 2016 as compared to $84.2 million for the year ended December 31, 2015. The increase in operating income of $39.7 million was the result of an increase in net revenue noted above. This was partially offset by an increase in compensation expense of $50.8 million related to an increase in the number of employees in our growing Healthcare segment. Additionally, stock-based compensation expense increased approximately $18.1 million due to the vesting of performance-based stock options and the accelerated vesting of certain stock options upon our IPO. Our ongoing investment in strategic initiatives contributed an additional $2.9 million in expense primarily related to an increase in IT infrastructure costs. Rent and occupancy related costs increased $2.1 million as a result of additional leased office space needed to support our growing operations. Depreciation and amortization expenses increased by $6.7 million due to our continued investments in capital expenditures. Transaction-related expenses increased $0.3 million primarily related to the costs associated with the IPO and other offerings. These increased expenses were offset by an impairment of intangible assets of $26.3 million for the year ended December 31, 2015 related to our Connolly and iHealth trademarks as a result of our Cotiviti rebranding in September 2015, a $5.6 million decrease in professional and consulting fees as our current need to leverage external resources in support of our strategic initiatives has been reduced and a $2.6 million decrease in the

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costs to retrieve medical records due to reduced volume. Additionally, certain variable costs decreased approximately $1.1 million.

Global Retail and Other segment operating income was $10.0 million for the year ended December 31, 2016 as compared to $12.3 million for the year ended December 31, 2015. The decrease in operating income of $2.3 million was the result of the decrease in net revenue noted above, a $1.5 million increase in stock-based compensation primarily related to the vesting of performance-based stock options and a $1.7 million increase in compensation related expenses. Additionally there was a $0.2 million increase in expenses related to the ongoing costs associated with our IT infrastructure initiatives. Depreciation and amortization expenses increased $0.1 million due to our continued investments in capital expenditures. These increased expenses were partially offset by a $1.5 million impairment of intangible assets for the year ended December 31, 2015 related to our Connolly trademark as a result of our Cotiviti rebranding in September 2015 and a decrease of $0.9 million in certain variable costs.

Quarterly Results of Operations

The following table sets forth statement of operations data for each of the quarters presented. We have prepared the quarterly statement of operations data on a basis consistent with the consolidated financial statements included elsewhere in this Annual Report on Form 10-K. In the opinion of management, the financial information reflects all adjustments, consisting of normal recurring adjustments, which we consider necessary for a fair presentation of this data. This information should be read in conjunction with the consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K. The results of historical periods are not necessarily indicative of the results for any future period. See Note 19 to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for further details.

	Three Months Ended							
	December 31, 2017	September 30, 2017	June 30, 2017	March 31, 2017	December 31, 2016	September 30, 2016	June 30, 2016	March 31, 2016
(unaudited)								
(in thousands)								
Net revenue	$ 176,729	$ 174,188	$167,611	$ 160,133	$ 167,912	$ 156,241	$158,291	$ 142,718
Cost of revenue (exclusive of depreciation and amortization, stated separately below):								
Compensation	52,876	58,405	58,870	56,288	62,338	58,517	55,285	53,461
Other costs of revenue	5,203	6,676	6,123	6,686	4,836	6,658	5,275	5,398
Total cost of revenue	58,079	65,081	64,993	62,974	67,174	65,175	60,560	58,859
Selling, general and administrative expenses (exclusive of depreciation and amortization, stated separately below):								
Compensation	28,732	29,162	25,564	24,693	22,341	32,496	23,176	19,110
Other selling, general and administrative expenses	18,869	17,313	15,300	16,879	15,409	13,978	14,945	15,229
Total selling, general and administrative expenses	47,601	46,475	40,864	41,572	37,750	46,474	38,121	34,339
Depreciation and amortization of property and equipment	8,036	6,070	5,896	5,575	5,287	5,218	4,811	4,835
Amortization of intangible assets	14,459	14,747	15,201	15,199	15,200	15,203	15,208	15,207
Transaction-related expenses	54	773	661	731	879	16	653	240
Impairment of intangible assets	1,322	—	—	—	—	—	—	—
Total operating expenses	129,551	133,146	127,615	126,051	126,290	132,086	119,353	113,480
Operating income	47,178	41,042	39,996	34,082	41,622	24,155	38,938	29,238
Other expense (income):								
Interest expense	8,816	9,101	8,538	8,421	8,308	9,625	14,660	16,060
Loss on extinguishment of debt	—	—	3,183	—	—	9,349	7,068	—
Other non-operating (income) expense	(733)	(449)	(556)	(453)	(168)	(113)	(359)	(299)
Total other expense (income)	8,083	8,652	11,165	7,968	8,140	18,861	21,369	15,761
Income from continuing operations before income taxes	39,095	32,390	28,831	26,114	33,482	5,294	17,569	13,477
Income tax (benefit) expense	(31,573)	12,918	7,743	(861)	8,190	711	6,676	5,393
Net income	$ 70,668	$ 19,472	$ 21,088	$ 26,975	$ 25,292	$ 4,583	$ 10,893	$ 8,084

Liquidity and Capital Resources

Our primary sources of liquidity are our existing cash and cash equivalents, cash provided by operating activities and borrowings under credit facilities. As of December 31, 2017, we had cash and cash equivalents of $165.5 million and availability under the Revolver of $99.5 million. Our total indebtedness was $777.5 million as of December 31, 2017. See "—Credit Facilities."

On September 28, 2016, our subsidiary Cotiviti Corporation and certain other of our subsidiaries entered into the Restated Credit Agreement pursuant to which the lenders party thereto agreed to provide the First Lien Credit Facilities consisting of (a) the First Lien Term A Loans in the original principal amount of $250.0 million, (b) the First Lien Term B Loans in the original principal amount of $550.0 million and (c) the $100.0 million Revolver. In

connection with entering into the Restated Credit Agreement, we refinanced the Initial Secured Credit Facilities. In April 2017, we repriced our First Lien Term B Loans, reducing the interest rate by 25 basis points.

Our principal liquidity needs have been, and we expect them to continue to be, debt service, capital expenditures, working capital and potential mergers and acquisitions. Our capital expenditures support investments in our underlying infrastructure to enhance our solutions and technology for future growth. Our capital expenditures were $37.3 million, $35.2 million and $23.0 million for the years ended December 31, 2017, 2016 and 2015, respectively. The increase is primarily due to expenditures associated with enhancing our IT platform. Our strategy includes the expansion of our existing solutions and the development of new solutions, which will require cash expenditures over the next few years and will be funded primarily with cash provided by operating activities. During the year ended December 31, 2017, we paid approximately $74.0 million in connection with the RowdMap Acquisition. We believe this network efficiency solution is a complement to our payment accuracy solutions.

We believe that our cash flow from operations, availability under our First Lien Credit Facilities and available cash and cash equivalents will be sufficient to meet our liquidity needs for at least the foreseeable future. We anticipate that to the extent that we require additional liquidity, it will be funded through the incurrence of additional indebtedness, the issuance of equity financings, or a combination thereof. We cannot assure you that we will be able to obtain this additional liquidity on reasonable terms, or at all. Additionally, our liquidity and our ability to meet our obligations and fund our capital requirements are also dependent on our future financial performance, which is subject to general economic, financial and other factors that are beyond our control. Accordingly, we cannot assure that our business will generate sufficient cash flow from operations or that future borrowings will be available from additional indebtedness or otherwise to meet our liquidity needs. If we decide to pursue one or more significant acquisitions, we may incur additional debt or sell additional equity to finance such acquisitions, which could possibly result in additional expenses or dilution.

Cash Flows

The following table provides a summary of cash flows from operating, investing and financing activities for the periods presented (in thousands):

	Year Ended December 31,		
	2017	2016	2015
Net cash provided by operating activities	$ 175,103	$ 189,171	$ 63,154
Net cash used in investing activities	(107,266)	(34,032)	(22,581)
Net cash used in financing activities	(13,321)	(193,275)	(8,976)

Operating Activities

Net cash provided by operating activities was $175.1 million and $189.2 million for the years ended December 31, 2017 and 2016, respectively. The decrease in cash provided by operating activities for the year ended December 31, 2017, as compared to the year ended December 31, 2016 primarily was due to a $41.3 million increase in net income adjusted for the exclusion of non-cash expenses, offset by approximately a $55.4 million decrease related to the effect of changes in operating assets and liabilities.

Net income adjusted for the exclusion of non-cash expenses was approximately $206.4 million for the year ended December 31, 2017, as compared to $165.1 million for the year ended December 31, 2016. The increase was primarily due to the growth in our Healthcare operations and the reduction in interest expense.

The effect of changes in operating assets and liabilities was a cash decrease of $31.3 million for the year ended December 31, 2017, compared to an increase of $24.1 million for the year ended December 31, 2016. The most significant drivers contributing to this decrease relate to the following:

- changes in accounts receivable primarily driven by increased revenue and timing of collections. Accounts receivable, net of the allowance for doubtful accounts, increased $10.4 million during the year ended December 31, 2017 as compared to a decrease of $3.5 million during the year ended December 31, 2016; and

- changes in accrued compensation primarily driven by timing of payments and lower discretionary bonus funding in 2017 partially offset by an increase in the number of employees. Accrued compensation decreased $15.9 million during the year ended December 31, 2017 as compared to an increase of $15.7 million during the year ended December 31, 2016.

Net cash provided by operating activities was $189.2 million and $63.2 million for the years ended December 31, 2016 and December 31, 2015, respectively. The increase in cash provided by operating activities for the year ended December 31, 2016 as compared to the year ended December 31, 2015 primarily was due to a $48.4 million increase in net income adjusted for the exclusion of non-cash expenses, a $0.9 million gain on discontinued operations in 2015 and approximately a $76.7 million cash increase related to the effect of changes in operating assets and liabilities.

Net income adjusted for the exclusion of non-cash expenses was approximately $165.1 million for the year ended December 31, 2016 as compared to $116.7 million for the year ended December 31, 2015. The increase was primarily due to the growth in our Healthcare operations.

The effect of changes in operating assets and liabilities was an increase of $24.1 million for the year ended December 31, 2016 as compared to a decrease of $52.7 million for the year ended December 31, 2015. The most significant drivers contributing to this increase relate to the following:

- prior year tax payments of approximately $10.0 million were applied to our tax liabilities for the year ended December 31, 2016;

- a payment of $22.3 million to the former stockholders of iHealth Technologies during the year ended December 31, 2015 which had been recorded as a liability in accounts payable and accrued other expenses;

- changes in accounts receivable primarily driven by increased revenue and timing of collections. Accounts receivable, net of the allowance for doubtful accounts, decreased $3.5 million during the year ended December 31, 2016 as compared to an increase of $28.8 million during the year ended December 31, 2015; and

- changes in accrued compensation primarily driven by an increase in the number of employees and timing of payments. Accrued compensation increased $15.7 million during the year ended December 31, 2016 as compared to an increase of $0.3 million during the year ended December 31, 2015.

Investing Activities

Net cash used in investing activities was $107.3 million and $34.0 million for the years ended December 31, 2017 and 2016, respectively. The increase in cash used in investing activities during the year ended December 31, 2017 as compared to the year ended December 31, 2016 was due to the RowdMap Acquisition for approximately $70.0 million, net of cash acquired. Additionally, capital expenditures increased $2.1 million due to our ongoing investments, particularly as it relates to enhancing our information technology infrastructure and platforms to support our growing operations.

Net cash used in investing activities was $34.0 million and $22.6 million for the years ended December 31, 2016 and December 31, 2015, respectively. The increase in cash used in investing activities during the year ended December 31, 2016 as compared to the year ended December 31, 2015 primarily was due to an increase in capital expenditures due to our ongoing investments, particularly as it relates to enhancing our information technology infrastructure and platforms to support our growing operations.

Financing Activities

Net cash used in financing activities was $13.3 million for the year ended December 31, 2017 compared to $193.3 million for the year ended December 31, 2016. The use of cash for financing activities during the year ended December 31, 2017 was primarily due to scheduled debt principal payments of $18.0 million and the repurchase of common stock of $10.0 million partially offset by proceeds from the issuance of common stock under our equity plans of $15.3 million. The use of cash for financing activities during the year ended December 31, 2016 was primarily due to the repayment of $236.1 million of outstanding borrowings under our Second Lien Credit Facility, the net payment of $22.7 million of outstanding indebtedness as a result of the September 2016 refinancing of our long-term debt and the

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payment of the Special Cash Dividend of $150.0 million. These cash outflows during the year ended December 31, 2016 were partially offset by net cash proceeds from our IPO of $227.0 million.

Net cash used in financing activities was $193.3 million for the year ended December 31, 2016 compared to $9.0 million for the year ended December 31, 2015. The increase in cash used in financing activities during the year ended December 31, 2016 as compared to the year ended December 31, 2015 was primarily due to (a) the payment of the Special Cash Dividend of $150.0 million on May 26, 2016; (b) the repayment of $236.1 million of outstanding borrowings under our then outstanding Initial Second Lien Credit Facility in June 2016; (c) the net payment of $22.7 million of outstanding indebtedness as a result of the September 2016 refinancing of our long-term debt; (d) scheduled debt principal payments of $8.6 million; and (e) payment of $7.1 million in financing fees related to the September 2016 refinancing partially offset by net cash proceeds from our IPO of $227.0 million and proceeds of $4.2 million related to stock option exercises.

Credit Facilities

Initial Secured Credit Facilities

On May 14, 2014, in connection with the Connolly iHealth Merger, we entered into the Initial Secured Credit Facilities, consisting of the Initial First Lien Credit Facilities and the Initial Second Lien Credit Facility. The Initial First Lien Credit Facilities consisted of an Initial First Lien Term Loan in the original principal amount of $810.0 million and a $75.0 million Initial First Lien Revolver, of which $25.0 million could, at our option, be made available for letters of credit and $20.0 million could, at our option, be made available for swingline loans. The Initial Second Lien Credit Facility consisted of an Initial Second Lien Term Loan in the original principal amount of $265.0 million.

The Initial First Lien Term Loan was set to mature on May 14, 2021 and the Initial First Lien Revolver was set to mature on May 14, 2019. We were required to make annual amortization payments in respect of the Initial First Lien Term Loan in an amount equal to 1.00% of the original principal amount thereof, payable in equal quarterly installments of 0.25% of the original principal amount of the Initial First Lien Term Loan. Such quarterly amortization payments would have been reduced ratably by any mandatory or voluntary prepayments. The Initial Second Lien Credit Facility was set to mature on May 14, 2022 and did not require amortization payments.

The obligations under the Initial First Lien Credit Facilities were secured by first priority security interests in substantially all of the assets of the borrowers and the guarantors party thereto, subject to permitted liens and other exceptions. The obligations under the Initial Second Lien Credit Facility were secured by second priority security interests in substantially all of the assets of the borrowers and the guarantors party thereto, subject to permitted liens and other exceptions. All of our subsidiaries were guarantors under the Initial Secured Credit Facilities. The Initial Secured Credit Facilities contained financial covenants and certain business covenants, including restrictions on dividend payments, which we were required to comply with during the term of the agreement.

Borrowings under the Initial Secured Credit Facilities bore interest at a rate per annum equal to the applicable margin, plus, at our election, either (a) a base rate determined by reference to the highest of (i) the federal funds effective rate in effect on such date plus 0.50%, (ii) LIBOR plus 1.00%, (iii) the prime commercial lending rate of the administrative agent as in effect on the relevant day and (iv) with respect to the Initial First Lien Term Loan and the Initial Second Lien Credit Facility only, 2.00% or (b) LIBOR determined by reference to the applicable Reuters screen page two business days prior to the commencement of the interest period relevant to the subject borrowing, adjusted for certain additional costs, which could not, in the case of borrowings of Initial First Lien Term Loans and loans under the Initial Second Lien Credit Facility, be less than 1.00%.

The applicable margin for the Initial First Lien Term Loan was originally 3.00% for base rate borrowings and 4.00% for LIBOR borrowings. On May 27, 2015, the credit agreement governing our Initial First Lien Credit Facilities was amended to reduce the applicable margin for the Initial First Lien Term Loan to 2.50% for base rate borrowings and 3.50% for LIBOR borrowings. We were also required to pay a customary annual administration fee to the administrative agent under the Initial First Lien Credit Facilities.

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Prior to our IPO, the applicable margin for loans under the Initial First Lien Revolver was determined in accordance with the table set forth below, with the first lien leverage ratio determined in accordance with the terms of the documentation governing the Initial First Lien Credit Facilities:

First Lien Leverage Ratio	Applicable Margin for Base Rate Loans	Applicable Margin for LIBOR Loans
Greater than 4.00:1.00	2.25 %	3.25 %
Less than or equal to 4.00:1.00 and greater than 3.50:1.00	2.00 %	3.00 %
Less than or equal to 3.50:1.00	1.75 %	2.75 %

Following our IPO, the applicable margin for loans under the Initial First Lien Revolver was determined in accordance with the table set forth below:

First Lien Leverage Ratio	Applicable Margin for Base Rate Loans	Applicable Margin for LIBOR Loans
Greater than 4.00:1.00	2.00 %	3.00 %
Less than or equal to 4.00:1.00 and greater than 3.50:1.00	1.75 %	2.75 %
Less than or equal to 3.50:1.00	1.50 %	2.50 %

The applicable margin for the term loan under the Initial Second Lien Credit Facility was 5.75% for base rate loans and 6.75% for LIBOR loans. We were also required to pay a customary annual administration fee to the administrative agent under the Initial Second Lien Credit Facility.

First Lien Credit Facilities

On September 28, 2016, we entered into the Restated Credit Agreement, pursuant to which the lenders party thereto agreed to provide the First Lien Credit Facilities, consisting of First Lien Term A Loans in the original principal amount of $250.0 million, First Lien Term B Loans in the original principal amount of $550.0 million and the $100.0 million Revolver, of which $25.0 million may, at our option, be made available for letters of credit and $20.0 million may, at our option, be made available for swingline loans.

In connection with entering into the Restated Credit Agreement, we refinanced the Initial Secured Credit Facilities.

The First Lien Term A Loans will mature on September 28, 2021. We are required to make annual amortization payments in respect of the First Lien Term A Loans in an amount equal to 5.00% of the original principal amount thereof, with step-ups to 7.50%, 10.00% and 15.00% of the original principal amount of the First Lien Term A Loans after December 2018, December 2019 and December 2020, respectively, payable in equal quarterly installments of 1.25%, 1.875%, 2.50% and 3.75%, respectively, of the original principal amount of the First Lien Term A Loans. Such quarterly amortization payments are reduced by any mandatory or voluntary prepayments in a manner determined by our subsidiary, Cotiviti Corporation.

The First Lien Term B Loans will mature on September 28, 2023. We are required to make annual amortization payments in respect of the First Lien Term B Loans in an amount equal to 1.00% of the original principal amount thereof, payable in equal quarterly installments of 0.25% of the original principal amount of the First Lien Term B Loans. Such quarterly amortization payments are reduced ratably by any mandatory or voluntary prepayments.

The Revolver will mature on September 28, 2021 and does not require amortization payments.

The obligations under the First Lien Credit Facilities are secured by first priority security interests in substantially all of the assets of the borrowers and the guarantors thereto, subject to permitted liens and other exceptions. Certain of our subsidiaries are guarantors under the First Lien Credit Facilities. The Restated Credit Agreement contains financial covenants (for the benefit of the holders of the First Lien Term A Loans and the lenders under the Revolver) and certain business covenants, including restrictions on dividend payments, with which we must comply during the term of the agreement. As of December 31, 2017, we were in compliance with the Restated Credit Agreement.

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Borrowings under the First Lien Credit Facilities bear interest at a rate per annum equal to the applicable margin, plus, at our election, either (a) a base rate determined by reference to the highest of (i) the New York Federal Reserve Bank effective rate in effect on such date plus 0.50%, (ii) LIBOR plus 1.00%, (iii) the prime commercial lending rate of the administrative agent as in effect on the relevant day and (iv) with respect to the First Lien Term B Loans only, 1.75% or (b) LIBOR determined by reference to the applicable Reuters screen page two business days prior to the commencement of the interest period relevant to the subject borrowing, adjusted for certain additional costs, which may not, (i) with respect to the First Lien Term B Loans only, be less than 0.75% and (ii) with respect to the First Lien Term A Loans and Revolver only, be less than 0.00%.

The applicable margin for the First Lien Term B Loans is 1.75% for base rate borrowings and 2.75% for LIBOR borrowings. If Cotiviti Corporation's corporate credit rating from Moody's is Ba3 or better and its corporate family rating from S&P is BB– or better, the applicable margins for the First Lien Term B Loans will be reduced by 0.25% for so long as such ratings are maintained. As of December 31, 2017, Cotiviti Corporation's corporate credit rating from Moody's was B1 and its corporate family rating from S&P was BB–.

The applicable margin for the First Lien Term A Loans and Revolver is determined in accordance with the table set forth below:

	Secured Leverage Ratio	Applicable Margin for Base Rate Loans of First Lien Term A Loans and Revolver	Applicable Margin for LIBOR Loans of First Lien Term A Loans and Revolver
Category 1	Greater than 4.00:1.00	2.00%	3.00%
Category 2	Less than or equal to 4.00:1.00 and greater than 3.50:1.00	1.75%	2.75%
Category 3	Less than or equal to 3.50:1.00 and greater than 3.00:1.00	1.50%	2.50%
Category 4	Less than or equal to 3.00:1.00	1.25%	2.25%

Contractual Obligations

As of December 31, 2017, our contractual obligations and other commitments were as follows:

	Payments due by period				
	Less than 1 Year	1 - 3 Years	3 - 5 Years	Thereafter	Total
			(in millions)		
Principal payments of debt	$ 18.0	$ 54.8	$ 189.1	$ 515.6	$ 777.5
Interest on long-term debt[a]	32.6	62.4	49.7	16.3	161.0
Asset retirement obligations[b]	0.8	2.2	0.1	—	3.1
Operating lease payments[c]	8.6	18.5	16.5	44.3	87.9
Purchase obligations[d]	14.9	0.5	—	—	15.4
Interest rate cap agreements[e]	1.3	1.1	—	—	2.4
Transition tax[f]	1.6	—	—	—	1.6
Total	$ 77.8	$ 139.5	$ 255.4	$ 576.2	$1,048.9

(a) Represents the expected cash payments for interest on our long-term debt based on interest rates in place and the amounts outstanding as of December 31, 2017. Because the interest rates under the Initial Secured Credit Facilities are variable, actual payments may differ.
(b) Represents asset retirement obligations arising from contractual requirements to perform specified activities at the time of disposition of certain leasehold improvements and equipment at certain of our facilities.
(c) Represents amounts due under existing operating leases related to our offices and other facilities.
(d) Represents noncancelable commitments for the purchase of software, goods and services.
(e) Represents amounts due under our existing interest rate cap agreements.
(f) Represents estimated amounts due as a result of the Tax Act. See Note 11 to our consolidated financial statements.

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Critical Accounting Policies

Our discussion and analysis of our financial condition and results of operations is based upon our financial statements, which have been prepared in accordance with GAAP. The preparation of these financial statements requires us to make estimates and judgments that affect the reported amounts of assets, liabilities, revenue and expenses. Certain of our accounting policies require the application of significant judgment by management in selecting the appropriate assumptions for calculating financial estimates. By their nature, these judgments are subject to an inherent degree of uncertainty. These judgments are based on our historical experience, terms of existing contracts, our evaluation of trends in the industry, information provided by our clients and information available from other outside sources, as appropriate. Our actual results may differ from these estimates. The accounting policies that we believe to be the most critical to an understanding of our financial condition and results of operations and that require the most complex and subjective management judgments are discussed below.

Revenue Recognition, Unbilled Receivables and Estimated Liability for Refunds and Appeals

We base our net revenue on specific contracts with our clients. These contracts generally specify: (a) time periods covered by the work to be performed; (b) nature and extent of services we are to provide; (c) the client's duties in assisting and cooperating with us; and (d) fees payable to us. Our fees earned are most often expressed as a specified percentage of our findings and, in certain cases, as a flat fee. For those clients where we identify any payment errors in advance of payment to the providers, the clients reduce the amount paid to the providers based upon the savings we have identified. For those clients where we identify payment errors after the client has made payment, clients generally recover claims either by taking credits against outstanding payables or future purchases from the related providers or vendors or receiving refund checks directly from those vendors. The manner in which a claim is recovered by a client often is dictated by industry practice. In addition, many clients establish specific procedural guidelines that we must satisfy prior to submitting claims for client approval, and these guidelines are unique to each client.

We generally recognize revenue for performance fee-based contracts when we have determined our clients have received economic value. This is determined generally through credits taken against existing accounts payable due to the providers or vendors, refund checks received from those vendors, or evidence of reduced payments to providers based upon savings identified by us. Additionally, the following criteria must be met: (a) persuasive evidence of an arrangement exists; (b) services have been rendered; (c) the fee billed to the client is fixed or determinable and (d) collectability is reasonably assured.

We derive a relatively small portion of revenue on a “fee-for-service” basis whereby billing is based upon a subscription basis, flat fee or a fee per hour. We recognize revenue for these types of services ratably over the contract term, and when criteria (a) through (d) as set forth above are met.

Historically, there has been a certain amount of revenue with respect to which, even though we had met the requirements of our revenue recognition policy, the claim is ultimately rejected. In such cases, our clients may request a refund or offset if their providers or vendors ultimately reject the payment inaccuracies we find or if our clients determine not to pursue reimbursement from their providers or vendors even though we may have collected fees. We record any such refunds as a reduction of revenue. We record an estimate for refund liabilities at any given time based on actual historical refund data by client type. We satisfy such refund liabilities either by offsets to accounts receivable or by cash payments to clients. In addition to these estimated refund liabilities, we calculate client specific reserves when we determine an additional reserve may be necessary.

The appeal process established by CMS by which providers can dispute claims generated under our Medicare RAC contracts includes five levels of appeals and can extend in excess of two years. Healthcare providers have the right to appeal a claim and may pursue additional appeals if the initial appeal is found in favor of CMS. If an appeal is successful, we may be required to return all or a portion of the fee we earned with respect to the appealed claim. We accrue an estimated liability for appeals based on the amount of fees that are subject to appeals, closures or other adjustments and those which we estimate are probable of being returned to CMS following a successful appeal by the providers. Our estimates are based on our historical experience with the Medicare RAC appeal process. Our original Medicare RAC contract with CMS expired on January 31, 2018. As a result of the contract expiration, we expect to release at least $32 million of the total $56 million liability during the first quarter 2018. We continue to assess the remaining estimated liability for refunds and appeals to determine management’s best estimate of any appeals overturned prior to the expiration of the contract term. See Note 20 to our consolidated financial statements for further detail.

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At December 31, 2017 and December 31, 2016, a total of $35.4 million and $41.0 million, respectively, was presented as an estimated allowance for refunds and appeals, representing our estimate of claims that may be overturned related to amounts in accounts receivable. At December 31, 2017 and December 31, 2016, a total of $61.6 million and $62.5 million, respectively, was presented as an estimated liability for refunds and appeals, representing our estimate of claims that may be overturned related to revenue which had already been collected.

Our assumptions are based on historical refund data by our clients. We do not believe that we face a risk of significant loss in excess of the amounts accrued, other than a contingent liability of up to $13.0 million for refunds and appeals under our original Medicare RAC contract. Any future changes to our customer contracts, including further modifications to our original and/or new Medicare RAC contract, may require us to apply different estimates and assumptions, which in turn could impact both our revenue and our estimated liability for refunds and appeals in future periods. See Note 7 and Note 20 to our consolidated financial statements for further details.

Unbilled receivables represent revenue recognized related to claims for which clients have received economic value that were not invoiced at the balance sheet date. As of December 31, 2017 and December 31, 2016, approximately $62.3 million and $51.6 million, respectively, related to unbilled receivables were included in accounts receivable on our Consolidated Balance Sheets.

Certain unbilled receivables arise when a portion of our earned fee is deferred at the time of the initial invoice. At a later date (which can be up to a year after original invoice, and at other times, a year after completion of the audit period based on contractual terms or as agreed with our client), we invoice the unbilled receivable amount. Notwithstanding the deferred due date, our clients acknowledge we have earned this unbilled receivable at the time of the original invoice, but we have agreed to defer billing the client for the related services. As of December 31, 2017 and December 31, 2016, approximately $5.0 million and $6.1 million, respectively, related to unbilled receivables of this nature were included in accounts receivable on our Consolidated Balance Sheets.

We record periodic changes in unbilled receivables and refund liabilities as adjustments to revenue.

Business Combinations

We have recorded goodwill and acquired intangible assets through acquisitions accounted for as business combinations. When identifiable intangible assets, including technology platforms are acquired, we determine the fair values of these assets as of the acquisition date. Discounted cash flow models are typically used in these valuations if quoted market prices are not available, and the models require the use of significant estimates and assumptions including but not limited to:

- estimating future revenue and cash flows expected to be collected; and
- developing appropriate discount rates, long-term growth rates and probability rates.

The determination of the above inputs involves significant estimates and assumptions about several highly subjective variables. Our estimates and assumptions may be based, in part, on the availability of market data. We base our fair value estimates on assumptions we believe are reasonable, but recognize that the assumptions are inherently uncertain.

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination which are not individually identified and separately recognized. We do not amortize goodwill. We review goodwill for impairment at least annually by assessing qualitative factors or performing a quantitative analysis in determining whether it is more likely than not that the fair value of net assets are below their carrying amounts.

Intangible assets with definite lives are initially recorded at fair value and are amortized on a basis consistent with the timing and pattern of expected cash flows used to value the intangible assets, generally on a straight-line basis over the estimated useful life. Intangible assets with definite lives are reviewed for impairment whenever events or changes in circumstances indicate the carrying amount of the asset may not be recoverable. If required, the

impairment test for intangible assets with definite lives is completed by comparing an updated undiscounted cash flow model to the carrying value of the intangible asset.

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Goodwill and Indefinite — Lived Intangible Assets

Goodwill has resulted from business acquisitions including the RowdMap Acquisition in 2017 as described in Note 3 to our audited consolidated financial statements included elsewhere in this Annual Report on Form 10-K. As of December 31, 2017, we had goodwill of approximately $1.3 billion, which represented approximately 60% of our consolidated total assets.

We review goodwill for impairment at least annually. An entity is permitted to make a qualitative assessment of whether it is more likely than not that a reporting unit's fair value is less than its carrying amount before applying the goodwill impairment test. If an entity concludes it is not more likely than not that the fair value of a reporting unit is less than its carrying amount, it need not perform the quantitative impairment test as required in FASB ASC Topic 350, *Intangibles—Goodwill and Other*. Otherwise, the entity must perform the quantitative impairment test. Under the quantitative impairment test, the fair value of the reporting unit is compared with its carrying value (including goodwill) and recognize an impairment charge for the amount by which the carrying amount exceeds the reporting unit’s fair value. Fair value of the reporting unit is determined using a discounted cash flow analysis. If the fair value of the reporting unit exceeds its carrying value, there is no goodwill impairment loss.

Application of the goodwill impairment test requires judgment, including: the identification of reporting units; assignment of assets and liabilities to reporting units; assignment of goodwill to reporting units; determination of the fair value of each reporting unit; and an assumption as to the form of the transaction in which the reporting unit would be acquired by a market participant (either a taxable or nontaxable transaction).

We estimate reporting unit fair value using the income approach. We perform discounted cash flow analyses which utilize projected cash flows as well as a residual value, which is discounted to the present value in order to arrive at reporting unit fair value. While we continue to review and analyze many factors that can impact our business prospects in the future, our analyses are subjective and are based on conditions existing at and trends leading up to the time the assumptions are made. Actual results could differ from management's estimates, and such differences could be material to our consolidated financial position and results of operations. We rely on the following key assumptions, which require significant judgment and estimates, in our discounted cash flows analysis:

- reporting unit projected revenues based on our best estimates;
- discount rate applied to forecasted future cash flows to calculate the present value of those cash flows; and
- long-term growth rate applied to our last year forecasted cash flows to calculate the residual value of our future cash flows.

Our annual impairment analysis is completed as of October 1 of each year. In our October 1, 2017 analysis, we performed the qualitative assessment for our Healthcare reporting unit and concluded it was not more likely than not that the reporting unit’s fair value was less than its carrying amount. For our Global Retail and Other reporting unit, the results of the quantitative test indicated the excess of the estimated fair value of the reporting unit was greater than its carrying value. Furthermore, we conducted an additional quantitative test as of December 31, 2017 due to anticipated changes to our operations in the United Kingdom, and the estimated fair value of the reporting unit was greater than its carrying value by approximately 25%. Our analysis included the use of a discount rate for our Global Retail and Other reporting unit of 12.0%. The long-term growth rate used for our Global Retail and Other reporting unit was 0.0%. Unfavorable changes in these key assumptions could impact testing results and could lead to a potential failure in the qualitative step of the goodwill impairment testing process. Given the excess of the fair value over the carrying value for our Global Retail and Other reporting unit, we do not believe an inconsequential change in the discount rate or long-term growth rate assumption would have a significant impact.

Intangible assets with indefinite lives which are not being amortized, including certain trademarks, are tested for impairment at least annually. An entity is allowed to first assess qualitative factors to determine whether the existence of events and circumstances indicates it is more likely than not that an indefinite-lived intangible asset is impaired. If it is determined a quantitative assessment is necessary, then the fair value of the intangible asset is compared to its carrying value. If the carrying value is greater than the implied fair value of the intangible asset, an impairment is recognized for the excess amount.

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We perform our annual impairment review of indefinite-lived intangible assets at October 1, or when a triggering event occurs between annual impairment tests.

No impairment charges for goodwill and indefinite-lived intangible assets were recorded for the years ended December 31, 2017 and December 31, 2016. A $27.8 million impairment related to our legacy trademarks was recorded during the year ended December 31, 2015 as a result of our Cotiviti rebranding in September 2015. See Notes 5 and 6 to our audited consolidated financial statements included elsewhere in this Annual Report on Form 10-K for additional information on impairment testing results.

Impairment of Long-Lived Assets

We review long-lived assets, including property and equipment and intangible assets with definite lives, for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. If circumstances require the asset or asset group be tested for possible impairment, we first compare undiscounted cash flows expected to be generated by the asset or asset group to its carrying value. If the carrying value of the asset or asset group is not recoverable on an undiscounted cash flow basis, an impairment loss is recognized to the extent the carrying value exceeds its fair value. We determine fair value through various valuation techniques including discounted cash flow models, quoted market values and third party independent appraisals, as considered necessary. See Note 2 to our audited consolidated financial statements included elsewhere in this Annual Report on Form 10-K for additional information on impairment testing results.

We estimate the fair value of long-lived intangible assets using the excess earnings approach. The excess earnings approach considers factors such as the wasting nature of intangible assets and the allowance of a fair return on the net tangible assets and other intangible assets employed in determining an appropriate fair value. This approach also includes performing discounted cash flow analyses which utilize projected cash flows as well as a residual value, which is discounted to the present value in order to arrive at fair value. We rely on the following key assumptions in our discounted cash flows analysis:

- projected revenues based on our estimates;
- discount rate applied to forecasted future cash flows to calculate the present value of those cash flows; and
- long-term growth rate applied to our last year forecasted cash flows to calculate the residual value of our future cash flows.

The determination of the above inputs involves significant estimates and assumptions about several highly subjective variables. Our estimates and assumptions may be based, in part, on the availability of market data. We base our fair value estimates on assumptions we believe are reasonable, but recognize that the assumptions are inherently uncertain.

Income Taxes

We account for income taxes using the asset and liability method. We recognize deferred tax assets and liabilities for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases, as well as for tax attributes such as operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

We recognize net deferred tax assets to the extent that we believe these assets are more likely than not to be realized. In making such a determination, we consider all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax-planning strategies and results of recent operations. In the event we determine that we would be able to realize our deferred tax assets in the future in excess of their net recorded amount, we reduce the deferred tax asset valuation allowance and record a benefit in our provision for income taxes in the Consolidated Statements of Comprehensive Income.

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We record liabilities related to uncertain tax positions in accordance with ASC 740, *Income Taxes*, on the basis of a two-step process whereby (1) we determine whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more likely than not recognition threshold, we recognize the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority. We recognize interest and penalties related to unrecognized tax benefits within the income tax provision in the accompanying Consolidated Statements of Comprehensive Income. Accrued interest and penalties are included within accounts payable and accrued other expenses in the Consolidated Balance Sheets.

The Tax Act, which was enacted on December 22, 2017, resulted in a substantial income tax benefit for the year ended December 31, 2017. See Note 11 to our audited consolidated financial statements included elsewhere in this Annual Report on Form 10-K for additional information.

Stock-Based Compensation

Equity Incentive Plans

In 2012, we adopted the 2012 Plan pursuant to which our Board of Directors (or committee as designated by the Board of Directors) may grant options to purchase shares of our stock, restricted stock and certain other equity awards to directors, officers and key employees. We only granted stock options that can be settled in shares of our common stock under the 2012 Plan. The 2012 Plan had a total of 7,243,330 shares authorized for issuance. Upon completion of the IPO in May 2016, we adopted the 2016 Plan, and issuances under the 2012 Plan were suspended. Awards granted under the 2012 Plan will remain outstanding until the earlier of exercise, forfeiture, cancellation or expiration. There are no shares available for future issuance under the 2012 Plan as it was discontinued upon adoption of the 2016 Plan. Under the 2016 Plan, our Board of Directors (or a committee or sub-committee designated by the Board of Directors) may grant options to purchase shares of our stock, restricted stock and certain other equity awards to directors, officers and key employees. The 2016 Plan was established with the authorization for grants of up to 5,490,000 shares of authorized but unissued shares of common stock. As of December 31, 2017 the total number of shares available for future issuance under the 2016 Plan is 4,313,279.

Stock Options

Under the terms of the 2016 Plan, we may issue options to purchase shares of our common stock at a price equal to 100% of the market price on the date of grant. Issuances under the 2012 Plan, prior to its suspension, were under terms similar to issuances under the 2016 Plan. Stock options granted are subject to either time of service (service-based awards) or performance (performance-based awards) criteria. Service-based awards typically vest ratably over a five year service period from the date of grant under the 2012 Plan and typically vest ratably over a four year service period from the date of grant under the 2016 Plan. In the event of a change in control, any outstanding, unvested service-based awards will vest immediately. Performance-based awards vest in accordance with the specific performance criteria espoused in the executed award agreements. The term of any stock option shall not exceed ten years from the date of grant. However, an incentive stock option granted to an employee who, at the time of grant, owns stock possessing more than 10% of the total combined voting power of all classes of our stock may not have a term exceeding five years from the date of grant.

The following table sets forth the options granted, exercised, forfeited or expired under the Equity Plans for the periods presented:

	Weighted average	Weighted average remaining	Aggregate

	Outstanding Options	exercise price per share	contractual life (Years)	Intrinsic Value (in thousands)
Outstanding at December 31, 2016	5,997,372	$ 10.18	7.30	$ 145,270
Granted	599,153	34.70		
Forfeited	(240,845)	19.48		
Exercised	(1,778,104)	7.61		
Expired	(2,969)	13.92		
Outstanding at December 31, 2017	4,574,607	$ 13.89	6.65	$ 85,138

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Aggregate intrinsic value represents the difference between our estimated fair value of common stock and the exercise price of outstanding in-the-money options. The fair value per share of common stock was $32.21 as of December 31, 2017 based upon the closing price of our common stock on the NYSE. The total intrinsic value of options exercised was $52.8 million and $15.5 million for the years ended December 31, 2017 and 2016 and was insignificant for the year ended December 31, 2015. The total fair value of stock options vested was $4.1 million, $22.5 million and $2.5 million during the years ended December 31, 2017, 2016 and 2015, respectively.

Restricted Stock Units

We may also issue RSUs, which provide participants the right to receive shares of our common stock on the vesting date of the underlying RSUs. RSUs may be subject to vesting requirements, restrictions and conditions to payment. Such requirements may be based on the continued service for a specified time period or on the attainment of specified performance goals as specified in the award agreements. RSUs are payable in cash or in shares or a combination of both. We began issuing RSUs upon adoption of the 2016 Plan; no RSUs were issued under the 2012 Plan. Under the terms of the 2016 Plan, RSUs have a grant date fair value equal to the closing price of our stock on the grant date. The units typically vest ratably over a four year service period.

The following is a summary of RSU activity under the 2016 Plan:

	Number of Awards	Weighted average grant date fair value per share
Nonvested at December 31, 2016	67,295	$ 25.88
Granted	398,728	34.30
Forfeited	(48,447)	31.91
Vested and converted to shares	(38,302)	29.88
Nonvested at December 31, 2017	379,274	$ 33.56

Restricted Stock

We issued an aggregate of 768,021 shares of restricted common stock to certain employees of RowdMap at a fair market value of $43.27 per share. Half of these shares are subject to continued employment and performance-based vesting requirements and, if achieved, will vest on the one year anniversary of the closing date of the RowdMap Acquisition. The other half are subject to continued employment with us, with one-third vesting on each of the first three anniversaries of the closing of the RowdMap Acquisition.

Stock-Based Compensation Expense

The fair value of each stock option award is estimated on the date of grant using a Black-Scholes-Merton option pricing model. The expected term of the option represents the period the stock-based awards are expected to be outstanding. We use the simplified method under the provisions of ASC 718, *Compensation – Stock Compensation*, for estimating the expected term of the options. Since our shares were not publicly traded until May 2016 and were rarely traded privately, at the time of each grant, there is insufficient volatility data available. Accordingly, we calculate expected volatility using comparable peer companies with publicly

traded shares over a term similar to the expected term of the options issued. We do not intend to pay dividends on our common shares, and therefore, the dividend yield percentage is zero. The risk free interest rate is based on the U.S. Treasury constant maturity interest rate whose term is consistent with the expected life of our stock options.

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We used the following weighted average assumptions to estimate the fair value of stock options granted for the periods presented:

	Year Ended December 31,		
	2017	2016	2015
Expected term (years)	6.25	6.25	6.25
Expected volatility	40.00 %	50.00 %	50.00 %
Expected dividend yield	0.00 %	0.00 %	0.00 %
Weighted average risk-free interest rate	1.93 %	1.36 %	1.70 %
Weighted average grant date fair value	$14.57	$ 9.53	$ 7.77

Total fair market value related to the restricted stock issued in connection with the RowdMap Acquisition was $33.2 million based on the closing price of our common stock on the date of grant. For the time-based shares, stock-based compensation expense is being recorded ratably over the three year vesting period. For the performance-based shares, stock-based compensation expense will be recorded over the one year vesting period to the extent it is probable the performance criteria will be achieved. For the year ended December 31, 2017, we recorded approximately $6.1 million in stock-based compensation expense related to the performance-based awards that we estimate are probable of achieving the performance criteria.

We recorded total stock-based compensation expense of $16.9 million, $23.0 million and $3.4 million for the years ended December 31, 2017, 2016 and 2015, respectively. Stock-based compensation expense during the year ended December 31, 2016 includes $15.9 million related to the vesting of all outstanding performance-based stock options. Stock-based compensation expense during the year ended December 31, 2016 also includes $2.3 million related to the accelerated vesting of certain stock options as the result of our IPO. We account for forfeitures as they occur. As of December 31, 2017, we had total unrecognized compensation cost related to 2,526,406 unvested service-based stock options, RSUs and restricted stock of $43.3 million which we expect to recognize over the next 2.4 years.

Prior to our IPO, the valuation of our common stock was determined in accordance with the guidelines set forth in the AICPA Practice Aid, *Valuation of Privately-Held Company Equity Securities Issued as Compensation*. Since our shares were not publicly traded until May 2016, we considered numerous objective and subjective factors to determine our best estimate of the fair value of our common stock, including but not limited to:

- our historical financial results and estimated trends and prospects for future financial performance; and
- third party valuations in connection with our annual goodwill impairment testing.

In 2015, we issued options to purchase shares of our common stock at the following exercise prices (as adjusted to reflect stock split and Special Cash Dividend). We did not issue any stock options in 2016 prior to our IPO in May:

Option Grant Date	Options Granted	Exercise Price	Grant Date Fair Value Common Stock
June 2, 2015	24,584	$11.33	$ 11.83
November 23, 2015	1,948,844	$13.79	$ 15.73
December 1, 2015	24,584	$13.79	$ 15.73

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We estimated the fair value of our common stock prior to our IPO using the market approach and income approach, in order to assist our Board in assigning an exercise price to future stock grants. We believe both of these approaches were appropriate methodologies given our stage of development at that time. For the market approach, we utilized the guideline company method by analyzing a population of comparable companies and selected those companies that we considered to be the most comparable to us in terms of size, growth, profitability, risk and return on investment, among others. We then used these guideline companies to develop relevant market multiples and ratios, which were applied to our corresponding financial projections to estimate our total enterprise value. We also included a lack of marketability discount given we were not publicly traded and there was not an active market for our common stock. We relied on the following key assumptions for the market approach:

- our projected revenue determined as of the valuation date based on our estimates; and
- multiples of market value to expected future revenue, determined as of the valuation date, based on a group of comparable companies.

For the income approach, we performed discounted cash flow analyses which utilized projected cash flows as well as a residual value, which were discounted to the present value in order to arrive at an enterprise value. We relied on the following key assumptions for the income approach in addition to management projections discussed above:

- discount rate applied to forecasted future cash flows to calculate the present value of those cash flows; and
- terminal value multiple applied to our last year forecasted cash flows to calculate the residual value of our future cash flows.

The fair value of options, RSUs and restricted stock issued subsequent to our IPO is based on the closing price of our common stock on the NYSE on the grant date.

Off-Balance Sheet Arrangements

Except for operating leases and certain letters of credit entered into in the normal course of business, we do not have any off-balance sheet arrangements that have or are reasonably likely to have a current or future effect on our financial condition, changes in financial condition, revenue or expenses, results of operations, liquidity, capital expenditures or capital resources that is material to investors.

Recently Issued Accounting Pronouncements

See “Recently Issued Accounting Pronouncements” in Note 2 to our audited consolidated financial statements included elsewhere in this Annual Report on Form 10-K for additional information.

Item 7A. Quantitative and Qualitative Disclosures About Market Risks

We are exposed to market risks relating to interest rate fluctuations and inflation.

Interest Rate Risk

We are exposed to interest rate risk on our First Lien Credit Facilities, which bear interest at variable rates. As of December 31, 2017, we had $777.5 million outstanding principal amount under our First Lien Term Loans. Borrowings under the First Lien Credit Facilities bear interest at a rate per annum equal to the applicable margin, plus, at our election, either (a) a base rate determined by reference to the highest of (i) the New York Federal Reserve Bank effective rate in effect on such date plus 0.50%, (ii) LIBOR plus 1.00%, (iii) the prime commercial lending rate of the administrative agent as in effect on the relevant day and (iv) with respect to the First Lien Term B Loans only, 1.75% or (b) LIBOR determined by reference to the applicable Reuters screen page two business days prior to the commencement of the interest period relevant to the subject borrowing, adjusted for certain additional costs.

We manage our interest rate risk through the use of derivative financial instruments. Specifically, we enter into interest rate cap agreements to manage our exposure to potential interest rate increases that may result from fluctuations in the three month LIBOR. Interest rate cap agreements designated as cash flow hedges involve the receipt of variable

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amounts from a counterparty if interest rates rise above the strike rate on the contract in exchange for a deferred premium.

As of December 31, 2017 and December 31, 2016, we had $435.0 million and $540.0 million, respectively, in notional debt outstanding related to interest rate cap agreements, which cover interest payments through September 2019. The interest rate cap agreements outstanding as of December 31, 2017 and 2016 effectively guarantee a ceiling to the interest rate we would otherwise pay on our floating rate debt. This interest rate ceiling on all outstanding hedges is 3.00%. As of December 31, 2017, our interest rate cap agreements were designated as cash flow hedges so that changes in the fair market value of the interest rate cap agreements were included within other comprehensive income (loss).

Based on our outstanding debt as of December 31, 2017, and assuming that our mix of debt instruments, interest rate caps and other variables remain the same, the annualized effect of a one percentage point change in variable interest rates would have an annualized pretax impact on our earnings and cash flows of approximately $7.4 million.

In the future, in order to manage our interest rate risk, we may refinance our existing debt, enter into additional interest rate cap agreements, modify our existing interest rate cap agreement or make changes that may impact our ability to treat our interest rate caps as cash flow hedges. However, we do not intend or expect to enter into derivative or interest rate cap transactions for speculative purposes.

Inflation Risk

We do not believe that the effects of inflation have had a material effect on our business, financial condition or results of operations. If our costs become subject to significant inflationary pressures, we may not be able to offset such increased costs through price increases. Our inability or failure to offset any such cost increases in the future could have a material adverse effect on our business, financial condition and results of operations. We cannot assure you, however, that our results of operations and financial condition will not be materially impacted by inflation in the future.

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ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

COTIVITI HOLDINGS, INC.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and Board of Directors
Cotiviti Holdings, Inc.:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of Cotiviti Holdings, Inc. and subsidiaries (the "Company") as of December 31, 2017 and 2016, the related consolidated statements of comprehensive income, stockholders' equity, and cash flows for each of the years in the three−year period ended December 31, 2017, the related notes and financial statement schedules I and II (collectively, the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for each of the years in the three−year period ended December 31, 2017, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 22, 2018 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ KPMG LLP

We have served as the Company's auditor since 2013.

New York, New York
February 22, 2018

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Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
Cotiviti Holdings, Inc.:

Opinion on Internal Control Over Financial Reporting

We have audited Cotiviti Holdings, Inc. and subsidiaries' (the "Company") internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the consolidated balance sheets of the Company as of December 31, 2017 and 2016, and the related consolidated statements of comprehensive income, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2017, and related notes and financial statement schedules I and II, and our report dated February 22, 2018 expressed an unqualified opinion on those consolidated financial statements.

The Company acquired RowdMap, Inc. (the "Acquired Business") during 2017, and management excluded from its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2017, the Acquired Business's internal control over financial reporting associated with total revenues representing approximately 1.0% of consolidated revenues and total assets representing approximately 1.0% of consolidated assets included in the consolidated financial statements of the Company as of and for the year ended December 31, 2017. Our audit of internal control over financial reporting of the Company also excluded an evaluation of the internal control over financial reporting of the Acquired Business.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report On Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over

financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

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

/s/ KPMG LLP

New York, New York
February 22, 2018

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Cotiviti Holdings, Inc.
Consolidated Balance Sheets
(In thousands, except share and per share amounts)

	2017	2016
ASSETS		
Current assets:		
Cash and cash equivalents	$ 165,518	$ 110,635
Restricted cash	11,383	9,103
Accounts receivable, net of allowance for doubtful accounts of $176 and $851 at December 31, 2017 and 2016, respectively; and net of estimated allowance for refunds and appeals of $35,434 and $41,020 at December 31, 2017 and 2016, respectively	83,756	67,735
Prepaid expenses and other current assets	15,314	14,957
Total current assets	275,971	202,430
Property and equipment, net	77,340	67,640
Goodwill	1,251,364	1,196,024
Intangible assets, net	492,040	533,305
Other long-term assets	2,514	2,864
TOTAL ASSETS	**$ 2,099,229**	**$ 2,002,263**
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		

Current maturities of long-term debt	$ 18,000	$ 18,000
Customer deposits	11,383	9,103
Accounts payable and accrued other expenses	25,906	23,162
Accrued compensation costs	42,725	58,589
Estimated liability for refunds and appeals	61,607	62,539
Total current liabilities	159,621	171,393
Long-term liabilities:		
Long-term debt	749,618	762,202
Other long-term liabilities	5,474	8,799
Deferred tax liabilities	83,048	120,533
Total long-term liabilities	838,140	891,534
Total liabilities	997,761	1,062,927
Commitments and contingencies (Note 7)		
Stockholders' equity:		
Common stock ($0.001 par value; 600,000,000 shares authorized, 92,299,294 and 90,748,740 issued, and 92,299,294 and 90,741,340 outstanding at December 31, 2017 and 2016, respectively)	92	91
Additional paid-in capital	933,710	911,582
Retained earnings	172,120	33,917
Accumulated other comprehensive loss	(4,454)	(6,156)
Treasury stock, at cost (7,400 shares at December 31, 2016)	—	(98)
Total stockholders' equity	1,101,468	939,336
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	**$ 2,099,229**	**$ 2,002,263**

See accompanying notes to consolidated financial statements.

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Cotiviti Holdings, Inc.
Consolidated Statements of Comprehensive Income
(In thousands, except share and per share amounts)

	Year Ended December 31,		
	2017	2016	2015
Net revenue	$678,661	$625,162	$541,343
Cost of revenue (exclusive of depreciation and amortization, stated separately below):			
Compensation	226,439	229,601	183,817
Other costs of revenue	24,688	22,167	20,800
Total cost of revenue	251,127	251,768	204,617
Selling, general and administrative expenses (exclusive of depreciation and amortization, stated separately below):			
Compensation	108,151	97,123	70,802
Other selling, general and administrative expenses	68,361	59,561	65,943
Total selling, general and administrative expenses	176,512	156,684	136,745
Depreciation and amortization of property and equipment	25,577	20,151	12,695
Amortization of intangible assets	59,606	60,818	61,467
Transaction-related expenses	2,219	1,788	1,469
Impairment of intangible assets	1,322	—	27,826
Total operating expenses	516,363	491,209	444,819
Operating income	162,298	133,953	96,524
Other expense (income):			
Interest expense	34,876	48,653	65,561
Loss on extinguishment of debt	3,183	16,417	4,084
Other non-operating (income) expense	(2,191)	(939)	(826)
Total other expense (income)	35,868	64,131	68,819
Income before income taxes	126,430	69,822	27,705
Income tax (benefit) expense	(11,773)	20,970	14,401
Income from continuing operations	138,203	48,852	13,304
Gain on discontinued operations, net of tax	—	—	559
Net income	**$138,203**	**$ 48,852**	**$ 13,863**
Other comprehensive income, net of tax:			
Foreign currency translation adjustments	924	(923)	(664)
Change in fair value of derivative instruments	778	(366)	(2,345)
Total other comprehensive income (loss)	1,702	(1,289)	(3,009)

Comprehensive income	**$139,905**	**$ 47,563**	**$ 10,854**
Earnings per share from continuing operations:			
Basic	$ 1.50	$ 0.57	$ 0.17
Diluted	$ 1.45	$ 0.55	$ 0.17
Earnings per share from discontinued operations:			
Basic	$ —	$ —	$ 0.01
Diluted	$ —	$ —	$ 0.01
Earnings per share:			
Basic	$ 1.50	$ 0.57	$ 0.18
Diluted	$ 1.45	$ 0.55	$ 0.18

See accompanying notes to consolidated financial statements.

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Cotiviti Holdings, Inc.
Consolidated Statements of Stockholders' Equity
(In thousands, except shares)

	Common Stock		Additional	Retained	Accumulated Other	Treasury Stock		Total
	Shares	Amount	Paid-in Capital	Earnings (Deficit)	Comprehensive Income / (Loss)	Shares	Amount	Stockholders' Equity
Balance, January 1, 2015	**77,204,691**	**$ 77**	**$ 803,810**	**$ (28,798)**	**$ (1,858)**	**7,400**	**$ (98)**	**$ 773,133**
Net income	—	—	—	13,863	—	—	—	13,863
Stock-based compensation expense	—	—	3,399	—	—	—	—	3,399
Exercise of stock options	25,620	—	210	—	—	—	—	210
Other comprehensive loss, net	—	—	—	—	(3,009)	—	—	(3,009)
Balance, December 31, 2015	**77,230,311**	**$ 77**	**$ 807,419**	**$ (14,935)**	**$ (4,867)**	**7,400**	**$ (98)**	**$ 787,596**
Net income	—	—	—	48,852	—	—	—	48,852
Proceeds from issuance of common stock	12,936,038	13	226,950	—	—	—	—	226,963
Dividends paid	—	—	(150,000)	—	—	—	—	(150,000)
Stock-based compensation expense	—	—	22,954	—	—	—	—	22,954
Exercise of stock options	574,991	1	4,259	—	—	—	—	4,260
Other comprehensive loss, net	—	—	—	—	(1,289)	—	—	(1,289)
Balance, December 31, 2016	**90,741,340**	**$ 91**	**$ 911,582**	**$ 33,917**	**$ (6,156)**	**7,400**	**$ (98)**	**$ 939,336**
Net income	—	—	—	138,203	—	—	—	138,203
Stock-based compensation expense	—	—	16,873	—	—	—	—	16,873
Exercise of stock options	1,778,104	2	13,530	—	—	—	—	13,532
Release of RSUs	35,056	—	(124)	—	—	77	(3)	(127)
Retirement of treasury shares	—	—	(101)	—	—	(7,477)	101	—
Stock issued under ESPP	62,694	—	1,949	—	—	—	—	1,949
Repurchase of common stock	(317,900)	(1)	(9,999)	—	—	—	—	(10,000)
Other comprehensive gain, net	—	—	—	—	1,702	—	—	1,702
Balance, December 31, 2017	**92,299,294**	**$ 92**	**$ 933,710**	**$172,120**	**$ (4,454)**	**—**	**$ —**	**$ 1,101,468**

See accompanying notes to consolidated financial statements.

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Cotiviti Holdings, Inc.

Consolidated Statements of Cash Flows
(In thousands)

	Year Ended December 31,		
	2017	2016	2015
Cash flows from operating activities:			
Net income	$ 138,203	$ 48,852	$ 13,863
Adjustments to reconcile net income to net cash provided by operating activities:			
Deferred income taxes	(41,641)	(7,735)	(11,832)
Depreciation and amortization	85,183	80,969	74,162
Stock-based compensation expense	16,873	22,954	3,399
Amortization of debt issuance costs	2,893	4,278	5,565
Accretion of asset retirement obligations	194	186	166
Loss on impairment of intangible assets	1,322	—	27,826
Loss on extinguishment of debt	3,183	16,417	4,084
Gain on discontinued operations	—	—	(900)
Changes in operating assets and liabilities:			
Restricted cash	(2,280)	1,638	9,486
Accounts receivable	(13,494)	11,121	(18,641)
Other assets	1,232	7,217	(12,167)
Customer deposits	2,280	(1,638)	(9,486)
Accrued compensation	(16,072)	15,687	263
Accounts payable and accrued other expenses	(2,402)	(4,821)	(14,831)
Estimated liability for refunds and appeals	(932)	(5,236)	(7,166)
Other long-term liabilities	413	109	(115)
Other	148	(827)	(522)
Net cash provided by operating activities	**175,103**	**189,171**	**63,154**
Cash flows from investing activities:			
Expenditures for property and equipment	(37,274)	(35,213)	(22,982)
Business combinations, net of cash acquired	(69,992)	—	—
Other investing activities	—	1,181	401
Net cash used in investing activities	**(107,266)**	**(34,032)**	**(22,581)**
Cash flows from financing activities:			
Net proceeds from issuance of common stock	—	226,963	—
Proceeds from issuance of common stock under equity plans	15,340	4,243	210
Proceeds from issuance of debt	—	800,000	—
Dividends paid	—	(150,000)	—
Repurchase of common stock	(10,000)	—	—
Payment of debt issuance costs	(661)	(7,131)	(1,086)
Repayment of debt	(18,000)	(1,067,350)	(8,100)
Net cash used in financing activities	**(13,321)**	**(193,275)**	**(8,976)**
Effect of foreign exchanges on cash and cash equivalents	367	(594)	(844)
Net increase (decrease) in cash and cash equivalents	**54,883**	**(38,730)**	**30,753**
Cash and cash equivalents at beginning of period	**110,635**	**149,365**	**118,612**
Cash and cash equivalents at end of the period	**$ 165,518**	**$ 110,635**	**$149,365**
Supplemental disclosures of cash flow information:			
Cash paid for income taxes	$ 28,452	$ 25,359	$ 41,119
Cash paid for interest	29,601	43,227	60,238
Noncash investing activities (accrued property and equipment purchases)	5,912	8,163	12,949

See accompanying notes to consolidated financial statements

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Cotiviti Holdings, Inc.
Notes to the Financial Statements
(In thousands, except shares and per share amounts)

Note 1. Description of Business

Cotiviti Holdings, Inc. (collectively with its subsidiaries, "we," "our," "Cotiviti" or the "Company") is a leading provider of analytics−driven payment accuracy and spend management solutions, focused primarily on the healthcare sector. Our integrated solutions help clients enhance payment accuracy in an increasingly complex healthcare environment. We leverage our robust technology platform, configurable analytics, proprietary information assets and expertise in healthcare reimbursement to help our clients enhance their claims payment accuracy. We help our healthcare clients identify and correct payment inaccuracies. We work with over 60 healthcare organizations, including a majority of the 25 largest U.S. commercial, Medicaid and Medicare managed health plans, as well as CMS. We are also a leading provider of payment accuracy solutions to approximately 30 retail clients, including a majority of the ten largest retailers in the United States.

We have adopted a holding company structure and our primary domestic operations are performed through our wholly-owned operating subsidiaries. We have international operations in Canada, the United Kingdom and India.

Note 2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements include our accounts and our wholly owned subsidiaries. All significant intercompany balances and transactions have been eliminated in consolidation. Certain prior year amounts have been reclassified to conform to the current year presentation.

Use of Estimates

The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions affecting the reported amounts in our consolidated financial statements and accompanying notes. These estimates are based on information available as of the date of the Consolidated Financial Statements; therefore, actual results could differ from those estimates.

Foreign Currency Translation

Assets and liabilities of our foreign subsidiaries with a functional currency other than the U.S. Dollar are translated into U.S. Dollars using applicable exchange rates at the balance sheet date. Revenue and expenses are translated at average exchange rates effective during the year. The resulting foreign currency translation gains and losses are included as a component of accumulated other comprehensive income (loss) within stockholders' equity on our Consolidated Balance Sheets.

Assets and liabilities of our foreign subsidiaries for which the functional currency is the U.S. Dollar are re-measured into U.S. Dollars using applicable exchange rates at the balance sheet date, except nonmonetary assets and liabilities, which are re-measured at the historical exchange rates prevailing when acquired. Revenue and expenses are re-measured at average exchange rates effective during the year.

Foreign currency translation gains and losses from re-measurement are included in other non-operating (income) expense in the accompanying Consolidated Statements of Comprehensive Income. The amounts of net gain (loss) on foreign currency re-measurement recognized were immaterial for all periods presented.

Revenue Recognition, Unbilled Receivables and Estimated Liability for Refunds and Appeals

We provide services under contracts that contain various fee structures, including performance fee−based contracts and fixed fee arrangements. Revenue is recognized when a contract exists, services have been provided to the client, the fee is fixed and determinable and collectability is reasonably assured.

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We recognize revenue on performance fee-based contracts based upon the specific terms of the underlying contract. The contract terms generally specify: (a) time periods covered by the work to be performed; (b) nature and extent of services we are to provide; (c) the client's duties in assisting and cooperating with us; and (d) fees payable to us. Our fees are most often expressed as a percentage of our findings. Generally, our services are rendered when our clients realize the economic benefits from our services. Our clients realize economic benefits when they take credits against their existing accounts payable based on when we identify cost savings, when they receive refund checks based on overpayments, or when they acknowledge payment reductions based on cost savings.

We derive a relatively small portion of revenue on contracts with fixed fee arrangements. We recognize revenue on these contracts ratably over the contract term and once all of the above criteria have been satisfied.

As discussed below under Recently Issued Accounting Standards, we will adopt the updated FASB revenue recognition guidance ASC 606 on January 1, 2018. ASC 606 is an update to ASC 605, which was the revenue recognition standard in effect for each of the three years in the period ended December 31, 2017.

Historically, there has been a certain amount of revenue with respect to which, even though we had met the requirements of our revenue recognition policy, the claim is ultimately rejected. In such cases, our clients may request a refund or offset if their providers or vendors ultimately reject the payment inaccuracies we find or if our clients determine not to pursue reimbursement from their providers or vendors even though we may have collected fees. We record any such refund as a reduction of revenue. We record an estimate for refund liabilities at any given time based on actual historical refund data by client type. We satisfy such refund liabilities either by offsets to accounts receivable or by cash payments to clients. In addition to these estimated refund liabilities, we calculate client specific reserves when we determine an additional reserve may be necessary.

The estimated liability for refunds and appeals representing our estimate of claims that may be overturned related to revenue which had already been received was $61,607 and $62,539 at December 31, 2017 and December 31, 2016, respectively. The estimated allowance for refunds and appeals representing our estimate of claims that may be overturned related to amounts in accounts receivable was $35,434 and $41,020 at December 31, 2017 and December 31, 2016, respectively.

Under the Medicare Recovery Audit Program, in which we are one of the Medicare RACs for CMS, healthcare providers have the right to appeal a claim and may pursue additional appeals if the initial appeal is found in favor of CMS. We accrue an estimated liability for appeals based on the amount of fees that are subject to appeals, closures or other adjustments and those which we estimate are probable of being returned to CMS following a successful appeal by the providers. Our estimates are based on our historical experience with the Medicare RAC appeal process. This estimated liability for Medicare RAC appeals is an offset to revenue in our Consolidated Statements of Comprehensive Income. The liability is included in the estimated liability for refunds and appeals on our Consolidated Balance Sheets. See Note 7 and Note 20 for further information regarding the estimated liability for appeals related to the Medicare RAC program.

Unbilled receivables represent revenue recognized related to claims for which clients have received economic value that were not invoiced at the balance sheet date. Unbilled receivables were approximately $62,294 and $51,643 as of December 31, 2017 and December 31, 2016, respectively and are included in accounts receivable on our Consolidated Balance Sheets.

Certain unbilled receivables arise when a portion of our earned fee is deferred at the time of the initial invoice. At a later date (which can be up to a year after original invoice, and at other times during the year after completion of the audit period based on contractual terms or as agreed with our client), we invoice the unbilled receivable amount. Notwithstanding the deferred due date, our clients acknowledge we have earned this unbilled receivable at the time of the original invoice, but we have agreed to defer billing the client for the related services. Unbilled receivables of this nature were approximately $4,958 and $6,137 as of December 31, 2017 and December 31, 2016, respectively, and are included in accounts receivable on our Consolidated Balance Sheets.

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Cotiviti Holdings, Inc.
Notes to the Financial Statements (continued)
(In thousands, except shares and per share amounts)

We record periodic changes in unbilled receivables and refund liabilities as adjustments to revenue.

Cost of Revenue

Cost of revenue is a direct cost associated with generating revenue. Cost of revenue related to compensation includes the total cost of payroll, related benefits and stock-based compensation expense for employees in roles that serve to provide direct revenue generating services to clients. Other cost of revenue primarily includes expenses related to the use of certain subcontractors and professional service firms, costs associated with the retrieval of medical records and facilities related costs associated with locations that are used strictly for revenue generating activities. Cost of revenue does not include depreciation and amortization, which is stated separately in our Consolidated Statements of Comprehensive Income.

Selling, General and Administrative

Compensation within SG&A includes the total cost of payroll, related benefits and stock-based compensation expense for employees who do not have a direct role associated with revenue generation including those involved with developing new service offerings. Other SG&A expenses include all general operating costs. These costs include, but are not limited to, rent and occupancy costs for facilities associated with locations that are used for employees not serving in revenue generating roles, telecommunications costs, information technology infrastructure costs, software licensing costs, advertising and marketing expenses, costs associated with developing new service offerings and expenses related to the use of certain subcontractors and professional services firms. SG&A expenses do not include depreciation and amortization, which is stated separately in our Consolidated Statements of Comprehensive Income.

Advertising Costs

Advertising costs are expensed as incurred and included in other SG&A expenses on our Consolidated Statements of Comprehensive Income. Advertising expense was $1,439, $1,345 and $1,241 for the years ended December 31, 2017, 2016 and 2015, respectively.

Cash and Cash Equivalents

Cash and cash equivalents include all cash balances and highly liquid investments with an original maturity of 90 days or less from the date of purchase.

Restricted Cash

In connection with providing services to certain clients, we maintain a series of lockbox accounts with certain financial institutions. These lockbox accounts exist to receive funds we collect on behalf of our clients resulting from services provided. When client funds are received and deposited into the lockbox accounts, we record a corresponding customer deposit liability. These funds are included as both restricted cash in current assets and customer deposits in current liabilities on our Consolidated Balance Sheets.

Accounts Receivable

Trade accounts receivable are recorded at the invoiced amount and do not bear interest. We accrue an allowance against accounts receivable related to fees yet to be collected, based on historical losses adjusted for current market conditions, our clients' financial condition, the amount of any receivables in dispute, the current receivables aging and current payment patterns. We record changes in our estimate to the allowance for doubtful accounts through bad debt expense and relieve the allowance after all means of collection have been exhausted and the potential for recovery is considered remote. Write-offs for all periods presented have not been significant. We do not have any off balance sheet credit exposure related to our clients.

Cotiviti Holdings, Inc.
Notes to the Financial Statements (continued)
(In thousands, except shares and per share amounts)

Property and Equipment

Property and equipment is stated at cost, net of accumulated depreciation. Depreciation on property and equipment is calculated using the straight-line method over the estimated useful lives of the assets and is included in depreciation and amortization of property and equipment in our Consolidated Statements of Comprehensive Income. The estimated useful lives of our property and equipment are as follows:

Computer equipment	3 - 5 years
Software	2 - 5 years
Furniture and fixtures	7 years
Leasehold improvements	Lesser of remaining lease term or expected service life of improvement

We have AROs arising from contractual requirements to perform specified activities at the time of disposition of certain leasehold improvements and equipment at some of our facilities. We record a liability for the estimated costs of these AROs. The liabilities are included in other long-term liabilities on our Consolidated Balance Sheets and are initially measured at fair value and subsequently are adjusted for accretion expense and any changes in the amount or timing of the estimated cash flows.

Internally Developed Software Costs

Capitalization of costs incurred in connection with software developed for internal use commences when both the preliminary project stage is completed and management has authorized further funding for the project, based on a determination that it is probable the project will be completed and used to perform the function intended. Capitalized costs are limited to (i) external direct costs of materials and services consumed in developing or obtaining internal use software and (ii) payroll and payroll related costs for employees who are directly associated with and devote time to the internal use software project. Capitalization of such costs ceases no later than the point at which the project is substantially complete and ready for its intended use. All other costs to develop software for internal use are expensed as incurred.

We capitalized approximately $14,765, $21,580 and $7,239 for the years ended December 31, 2017, 2016 and 2015 respectively. Amortization of software and software development costs is calculated on a straight-line basis over the expected economic life of the software, generally estimated to be five years and is included in depreciation and amortization of property and equipment on our Consolidated Statements of Comprehensive Income. Amortization expense for internal use software was $7,745, $2,992 and $2,287 for the years ended December 31, 2017, 2016 and 2015, respectively. Amortization expense for the year ended December 31, 2015 includes the write off of approximately $975 related to software that is no longer being used.

Goodwill

Goodwill is an asset representing the future economic benefits arising from other assets acquired in a business combination which are not individually identified and separately recognized. We do not amortize goodwill. Goodwill is reviewed for impairment on an annual basis as of October 1, of each year or more frequently if events or circumstances indicate the carrying amount may not be recoverable. These tests are performed at the reporting unit level. We have two reporting units, Healthcare and Global Retail and Other. Application of the goodwill impairment test requires judgment, including: the identification of reporting units; assignment of assets and liabilities to reporting units; determination of the fair value of each reporting unit; and an assumption as to the form of the transaction in which the reporting unit would be acquired by a market participant (either a taxable or nontaxable transaction).

Under ASC 350, *Intangibles—Goodwill and Other*, we are permitted to make a qualitative assessment of whether it is more likely than not that a reporting unit's fair value is less than its carrying amount. If we can support the conclusion that it is more likely than not that the fair value of a reporting unit is greater than its carrying amount, then we would not need to perform the quantitative impairment test. If we cannot support such a conclusion, or we do not elect to

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perform the qualitative assessment, then a quantitative test for goodwill is used to identify potential impairment by comparing the fair value of a reporting unit with its carrying amount, including goodwill. The fair value of a reporting unit is determined using a discounted cash flow analysis based on assumptions regarding our future business outlook. While we continue to review and analyze many factors that can impact our business prospects in the future, our analyses are subjective and are based on conditions existing at and trends leading up to the time the assumptions are made. Actual results could differ materially from these assumptions.

Intangible Assets

Our intangible assets with definite lives include customer relationships and acquired software. Intangible assets with indefinite lives include a trademark, which is not being amortized, and is tested for impairment on an annual basis as of October 1 of each year or when events or changes in circumstances necessitate an evaluation for impairment. Recoverability of these assets is measured by a comparison of the carrying amounts to the future discounted cash flows the assets are expected to generate. Intangible assets with definite lives are initially recorded at fair value and are amortized on a basis consistent with the timing and pattern of expected cash flows used to value the intangibles, generally on a straight-line basis over useful lives ranging from 5 to 14 years. Amortization expense is included in amortization of intangible assets in our Consolidated Statements of Comprehensive Income. Intangible assets with definite lives are reviewed for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. See Note 5 for further detail.

Long-Lived Assets

Long-lived assets, including property and equipment, with definite lives, are reviewed for impairment whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable. If circumstances require the asset or asset group be tested for possible impairment, we first compare undiscounted cash flows expected to be generated by the asset or asset group to its carrying value. If the carrying value of the asset or asset group is not recoverable on an undiscounted cash flow basis, an impairment loss is recognized to the extent the carrying value exceeds its fair value. Fair value is determined through various valuation techniques including discounted cash flow models, quoted market values and third party independent appraisals, as necessary.

Business Combinations

We account for acquisitions of businesses using the acquisition method of accounting. The purchase price is allocated to the identifiable net assets acquired, including intangible assets and liabilities assumed, based on estimated fair values at the date of the acquisition. The excess of the purchase price over the amount allocated to the identifiable assets and liabilities, if any, is recorded as goodwill.

Determining the fair value of assets acquired and liabilities assumed requires significant judgment, including the selection of valuation methodologies, estimates of future revenue and cash flows and discount rates.

Under the acquisition method of accounting for business combinations, any changes to acquired balances in tax accounts, including adjustments to deferred tax asset valuation allowances or liabilities related to uncertain tax positions, which are recorded during the measurement period, and are determined to be attributable to facts and circumstances that existed as of the acquisition date, are considered a measurement period adjustment and will result in an offsetting increase or decrease to goodwill. All other changes to deferred tax asset valuation allowances and liabilities related to uncertain tax positions will result in an increase or decrease to income tax expense.

Income Taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases, as well as for tax attributes such as operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable

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income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

We recognize net deferred tax assets to the extent that we believe these assets are more likely than not to be realized. In making such a determination, we consider all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and results of recent operations. In the event we determine that we would be able to realize our deferred tax assets in the future in excess of their net recorded amount, we reduce the deferred tax asset valuation allowance and record a benefit in our provision for income taxes in our Consolidated Statements of Comprehensive Income.

We record liabilities related to uncertain tax positions in accordance with ASC 740, *Income Taxes*, on the basis of a two step process whereby (1) we determine whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more likely than not recognition threshold, we recognize the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority. We recognize interest and penalties related to unrecognized tax benefits within the income tax provision in the accompanying Consolidated Statements of Comprehensive Income. Accrued interest and penalties are included within accounts payable and accrued other expenses in the Consolidated Balance Sheets.

The Tax Act, which was enacted on December 22, 2017, resulted in a substantial impact on our income tax benefit for the year ended December 31, 2017. See Note 11 for additional information.

Derivative Instruments

Our derivative instruments consist entirely of interest rate cap agreements, are stated at fair value and are included in accounts payable and accrued other expenses and other long-term liabilities on our Consolidated Balance Sheets. Changes in the fair value of derivatives that are designated as cash flow hedges are deferred in accumulated other comprehensive loss on our Consolidated Balance Sheets until the underlying hedged transactions are recognized in earnings, at which time any deferred hedging gains or losses are also recorded in earnings. See Note 9 for more information.

Stock-Based Compensation

Our policy is to issue new shares for purchases under our equity incentive plans as described in Note 14. Stock-based compensation expense is estimated at the grant date based on an award's fair value. The determination of the stock-based compensation expense related to stock options is calculated using a Black-Scholes-Merton option pricing model and is affected by our stock price, expected stock price volatility over the term of the awards, expected term, risk free interest rate and expected dividends. The determination of the stock-based compensation expense related to RSUs is calculated based on the closing price of our stock on the grant date. We record forfeitures as they occur.

We recognize stock-based compensation expense for service-based equity awards using the straight-line attribution method over the requisite service period.

We have awarded performance-based equity awards to certain employees and directors. Performance-based awards vest in accordance with the specific performance criteria outlined in the executed award agreements. The vesting of performance-based equity awards is also dependent upon the participant's continued employment. The criteria associated with our outstanding performance-based stock options as defined in the terms of the award agreements, was satisfied as of September 30, 2016 and therefore these stock options all became vested and exercisable. As such, we recorded stock-based compensation expense during the year ended December 31, 2016 based on the grant date fair value of the performance-based awards.

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As part of the RowdMap Acquisition, we issued restricted stock to certain employees. We recognized the related expense for these awards ratably over the applicable vesting period or as achievement of performance criteria become probable. See Note 14 for additional information.

Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines and penalties and other sources are recorded when it is probable a liability has been incurred and the amount can be reasonably estimated. Legal costs incurred in connection with loss contingencies are expensed as incurred. See Note 7 for further detail on loss contingency related to the Medicare RAC.

Fair Value of Financial Instruments

The carrying values for cash and cash equivalents, restricted cash, accounts receivable, accounts payable, and other accrued liabilities reasonably approximate fair market value due to their nature and the short term maturity of these financial instruments. We measure assets and liabilities at fair value based on assumptions that market participants would use in pricing an asset or liability in the principal or most advantageous market. When considering market participant assumptions in fair value measurements, we use a consistent fair value hierarchy framework as defined in ASC 820, *Fair Value Measurement*. See Note 10 for more information regarding management's fair value estimates.

Recently Issued Accounting Standards

New accounting rules and disclosure requirements can impact our financial results and the comparability of our financial statements. The authoritative literature which has recently been issued and that we believe will most impact our consolidated financial statements is described below. There are also several new proposals under development. If and when enacted, these proposals may have a significant impact on our financial statements.

In February 2016, the FASB issued ASU 2016-02, *Leases* ("ASU 2016-02"), which changes the accounting recognition, measurement and disclosure for leases in order to increase transparency. ASU 2016-02 requires lease assets and liabilities to be recognized on the balance sheet and key information about leasing arrangements to be disclosed. The guidance is effective for public companies with annual reporting periods beginning after December 15, 2018, including interim periods within that reporting period. Early adoption is permitted. We are evaluating this new guidance and its impact on our consolidated financial statements and related disclosures.

In May 2014, the FASB issued ASU 2014−09, *Revenue from Contracts with Customers* (Topic 606) ("ASU 2014−09"), which supersedes existing revenue recognition guidance and provides clarification of principles for recognizing revenue from contracts with customers. ASU 2014-09 sets forth a five-step model for determining when and how revenue is recognized. The core principle of the new standard is that a company should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. Additional disclosures will be required to describe the nature, amount, timing and uncertainty of revenue and cash flows arising from customer contracts. The two permitted transition methods under ASU 2014-09 are the full retrospective method, in which case the new guidance would be applied to each prior reporting period presented and the cumulative effect of applying the standard would be recognized at the earliest period shown, or the modified retrospective method, in which case the cumulative effect of applying the standard would be recognized at the date of the initial application. The guidance is effective for public companies with annual periods beginning after December 15, 2017 and interim periods within that reporting period.

In 2016, we formed an internal team to evaluate and quantify the potential impact of this new revenue guidance. As of the date of this filing, we have completed our contract review and policy drafting. Based on our review, we believe the timing of revenue recognition will not materially change from current practice. We will adopt as of January 1, 2018 using the modified retrospective method. Adoption of this standard will require changes to our business processes, systems and controls to support the additional required disclosures. Our identification and design of such changes is

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ongoing. We will provide additional information about the impact of this new guidance, including enhanced disclosure requirements, in future filings.

Note 3. Acquisition

On July 14, 2017, we acquired all of the outstanding equity of RowdMap. Based in Louisville, Kentucky, RowdMap is a payer-provider, value-based analytics company that helps health plans and providers identify and reduce low-value care from inefficient and unnecessary services. We paid approximately $74,000 in cash, subject to certain adjustments and funded entirely with available liquidity. We also issued an aggregate of 768,021 shares of restricted common stock to certain employees of RowdMap in connection with their continued employment with us. Half of these shares are subject to continued employment and performance-based vesting requirements. The other half are subject to continued employment, with one-third vesting on each of the first three anniversaries of the closing of the acquisition. We record stock-based compensation expense related to this restricted stock ratably over the vesting period or to the extent it is probable the performance criteria will be achieved. This stock-based compensation expense is not deductible for income tax purposes.

As part of the RowdMap Acquisition, we allocated the purchase price to the identifiable net assets acquired, including intangible assets and liabilities assumed, based on the estimated fair values at the date of acquisition. The excess of the purchase price over the amount allocated to the identifiable assets and liabilities was recorded as goodwill.

Goodwill represents the value of acquired assembled workforce, specialized processes and procedures and operating synergies, none of which qualify as separate intangible assets. We believe these specialized processes and procedures will enhance our long history of innovation and help expand our solution offerings. We determined the estimated fair values of intangible assets acquired using estimates of future discounted cash flows to be generated by the business over the estimated duration of those cash flows. We based the estimated cash flows on our projections of future revenue, operating expenses, capital expenditures, working capital needs and tax rates. We estimated the duration of the cash flows based on the projected useful lives of the assets acquired. The discount rate was determined based on specific business risk, cost of capital and other factors.

The purchase price allocation is preliminary and subject to change up to one year after the date of acquisition and could result in changes to the amounts recorded below. The preliminary allocation of the purchase price to the fair values of the assets acquired and liabilities assumed at the date of the acquisition was as follows:

	July 14, 2017
Cash	$ 4,107
Accounts receivable	2,526
Prepaid expenses and other assets	1,212
Other long-term assets	12
Property and equipment	263
Intangible assets	19,510
Total identifiable assets acquired	27,630
Accounts payable and accrued liabilities	4,491
Deferred tax liabilities	3,688
Total liabilities assumed	8,179
Net identifiable assets acquired	19,451
Goodwill	54,673
Net assets acquired	$ 74,124

The $19,510 of acquired intangible assets include acquired software of $6,310 (5 year useful life) and customer relationships of $13,200 (5 year useful life).

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For federal income tax purposes, the RowdMap Acquisition was treated as a stock acquisition. The goodwill and the intangible assets recognized are not deductible for income tax purposes.

In connection with the RowdMap Acquisition, a preliminary liability of $1,068 was recorded in accounts payable and accrued other expenses on the Consolidated Balance Sheets as of December 31, 2017, for payments due to the former stockholders of RowdMap, some of whom are now our employees.

We recorded approximately $700 of transaction costs primarily related to professional services associated with the acquisition as transaction-related expenses within our Consolidated Statements of Comprehensive Income during the year ended December 31, 2017.

The acquisition was not significant to our consolidated financial statements, therefore, pro forma results of operations related to this business acquisition have not been presented. The financial results of RowdMap have been included in our consolidated financial statements since the date of the acquisition.

Note 4. Property and Equipment

Property and equipment by major asset class for the periods presented consisted of the following:

	December 31,	
	2017	2016
Computer equipment	$ 46,731	$ 40,349
Software	67,511	42,614
Furniture and fixtures	9,199	8,652
Leasehold improvements	5,256	4,392
Projects in progress	10,295	12,001
Property and equipment, gross	$138,992	$108,008
Less: accumulated depreciation and amortization	61,652	40,368
Property and equipment, net	$ 77,340	$ 67,640

In December 2015, we purchased a perpetual software license, which is included in the software total above. We are paying for this software over a two year period ending in January 2018. As such, there is approximately $3,351 included in accounts payable and accrued other expenses on our Consolidated Balance Sheets as of December 31, 2017 and 2016 and $3,225 included in other long-term liabilities on our Consolidated Balance Sheets as of December 31, 2016. The amount included in other long-term liabilities as of December 31, 2016 represented the then present value of payments that will ultimately be made.

Total depreciation and amortization expense related to property and equipment, including capitalized software costs, was $25,577, $20,151 and $12,695 for the years ended December 31, 2017, 2016 and 2015, respectively.

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Note 5. Intangible Assets

Intangible asset balances by major asset class for the periods presented were as follows:

	Gross Carrying Amount	Accumulated Amortization	Impairment	Net Carrying Amount	Weighted Average Amortization Period
December 31, 2017:					

Customer relationships	$650,954	$ 190,572	$ 1,322	$459,060	13.5 years
Acquired software	54,210	25,430	—	28,780	6.8 years
Connolly trademark	4,200	—	—	4,200	indefinite-lived
Total	$709,364	$ 216,002	$ 1,322	$492,040	13.0 years
December 31, 2016:					
Customer relationships	$640,052	$ 144,768	$ —	$495,284	13.7 years
Acquired software	82,400	48,579	—	33,821	6.2 years
Connolly trademark	4,200	—	—	4,200	indefinite-lived
Total	$726,652	$ 193,347	$ —	$533,305	12.8 years

As of December 31, 2017, $34,500 of the acquired software intangible asset that became fully amortized during 2017 has been removed from the gross carrying amount and accumulated amortization.

Amortization expense was $59,606, $60,818 and $61,467 for the years ended December 31, 2017, 2016 and 2015, respectively.

As a result of the loss of a retail client in the United Kingdom, we recorded an impairment of intangible assets of $1,322 related to our customer relationships during the year ended December 31, 2017.

As a result of our rebranding in September 2015, we recorded an impairment of intangible assets of $27,826 related to our legacy trademarks during the year ended December 31, 2015. The remaining trademark value as of December 31, 2017 of $4,200 is related to our retail business that continues to operate as Connolly, a division of Cotiviti.

As of December 31, 2017 amortization expense for the next 5 years is expected to be:

2018	$57,588
2019	57,588
2020	57,588
2021	53,264
2022	48,956

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Note 6. Goodwill

Total goodwill in our Consolidated Balance Sheets was $1,251,364 and $1,196,024 as of December 31, 2017 and December 31, 2016, respectively.

Changes in the carrying amount of goodwill for the years ended December 31, 2017 and 2016 as allocated to each of our Healthcare and Global Retail and Other segments was as follows:

	December 31, 2017		December 31, 2016	
	Healthcare	Global Retail and Other	Healthcare	Global Retail and Other
Beginning balance	$1,147,771	$ 48,253	$1,147,771	$ 49,273
RowdMap Acquisition	54,673	—	—	—
Foreign currency translation	—	667	—	(1,020)
Ending balance	$1,202,444	$ 48,920	$1,147,771	$ 48,253

There was no impairment related to goodwill for any period presented.

Note 7. Commitments and Contingencies

Operating Leases

We are obligated under non-cancellable lease agreements for certain facilities and equipment, which frequently include renewal options and escalation clauses. For leases that contain predetermined fixed escalations, we recognize the related rent expense on a straight-line basis and record the difference between the recognized rent expense and amounts payable under the lease as lease obligations. Lease obligations due within one year are included in accounts payable and accrued other expenses on our Consolidated Balance Sheets. These leases expire at various points through 2029. Rent expense related to these leases was $10,719, $10,529 and $8,826 for the years ended December 31, 2017, 2016 and 2015, respectively.

Future minimum payments under non cancelable operating lease agreements as of December 31, 2017 were as follows:

Year ending December 31:	
2018	$ 8,640
2019	9,588
2020	8,882
2021	8,173
2022	8,363
2023 - 2029	44,308
Total minimum lease payments	$87,954

Legal and Other Matters

We may be involved in various legal proceedings and litigation arising in the ordinary course of business. While any legal proceeding or litigation has an element of uncertainty, management believes the ultimate disposition of these matters will not have a material adverse effect on our consolidated financial position, results of operations, or liquidity.

Medicare RAC Contract Contingency

In August 2014, CMS announced it would allow providers to remove all eligible claims currently pending in the appeals process by offering to pay hospitals 68% of the original claim amount. This settlement was offered to the

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providers and it was unknown what, if any, impact there would be for the Medicare RACs. On July 1, 2015, CMS issued a Technical Direction Letter to the Medicare RACs, including us, indicating that Medicare RACs will only be entitled to the contract contingency fee on the settled amounts of the claims, or 32% of the original inpatient claim amounts. Based on the initial lists of finalized settlements provided by CMS, we would be required to refund CMS approximately $22,308 due to the related adjustments in Medicare RAC contingency fees. In 2016, CMS announced a second settlement process to allow eligible providers to settle their inpatient status claims currently under appeal beginning on December 1, 2016. These additional settlements could result in CMS claims that it is entitled to additional refunds, however, CMS has not asserted any such claims since its initial communication and the amount of additional claims, if any, cannot be determined at this time. While there are uncertainties in any dispute resolution and results are uncertain, we have disputed CMS's findings based on our interpretation of the terms of the Medicare RAC contract and our belief that the backup data provided by CMS is inaccurate and/or incomplete. Our liability for estimated refunds and appeals includes amounts for these settled claims based on our best estimates of the amount we believe will be ultimately payable to CMS based on our interpretation of the terms of the Medicare RAC contract. As of December 31, 2017, we believed that it was possible that we could be required to pay an additional amount up to approximately $13,000 in excess of the amount we accrued as of December 31, 2017 based on the claims data we have received from CMS to date. As CMS completes its settlement process with the providers and updated files are provided to us, the potential amount owed by us may change.

Our original Medicare RAC contract with CMS expired on January 31, 2018. In connection with the expiration of the contract, we determined that we have no obligation to CMS with respect to any appeals resolved in the providers favor after the expiration date and, in

addition, we believe that we have no obligation to CMS in connection with the hospital settlement processes described above. See Note 20 for further information.

Asset Retirement Obligations

We have AROs arising from contractual requirements to perform specified activities at the time of disposition of certain leasehold improvements and equipment at some of our facilities. Changes in the carrying amount of AROs were as follows:

	Year ended December 31,	
	2017	2016
Balance beginning of period	$2,725	$2,415
Additional ARO liability	—	133
Accretion expense	183	177
Settled ARO liability	(64)	—
Balance at end of period	$2,844	$2,725

Note 8. Long−term Debt

In April 2017, we entered into and executed the First Amendment Agreement to the Restated Credit Agreement, which, among other things, provided for a 25 basis point reduction in applicable interest rate spread over LIBOR associated with the First Lien Term B Loans. As a result, we recognized a loss on extinguishment of $3,183 during the year ended December 31, 2017, which is included in our Consolidated Statements of Comprehensive Income.

In September 2016, we entered into and executed the Restated Credit Agreement, which replaced our then outstanding Initial Secured Credit Facilities, lowered total debt outstanding by $22,700 and provided for lower applicable interest rates. The Restated Credit Agreement consists of (a) the First Lien Term A Loans in the amount of $250,000, (b) the First Lien Term B Loans in the amount of $550,000 and (c) the Revolver in the amount of up to $100,000. As a result of this refinancing, we recognized a loss on extinguishment of debt of $9,349 during the year ended December 31, 2016, which is included in our Consolidated Statements of Comprehensive Income.

In June 2016, we repaid $223,000 in outstanding principal under our then outstanding Initial Second Lien Credit Facility using proceeds from our IPO. We also made a voluntary prepayment of $13,100 of outstanding principal

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under the Initial Second Lien Credit Facility. As a result of these repayments, we recognized a loss on extinguishment of debt of $7,068 during the year ended December 31, 2016, which is included in our Consolidated Statements of Comprehensive Income.

In May 2015, we entered into and executed the First and Second Amendments to the then outstanding Initial First Lien Credit Facilities, which, among other things, provided for lower applicable interest rates associated with the Initial First Lien Credit Facilities by 50 basis points. As a result, we recognized a loss on extinguishment of debt of $4,084 during the year ended December 31, 2015, which is included in our Consolidated Statements of Comprehensive Income.

Long−term debt for the periods presented was as follows:

	December 31,	
	2017	2016
First Lien Term A Loans[a]	$234,237	$246,694
First Lien Term B Loans[b]	540,585	544,345
Revolver[c]	—	—
Total debt	774,822	791,039
Less: debt issuance costs	7,204	10,837
Less: current portion	18,000	18,000
Total long-term debt	$749,618	$762,202

(a) The First Lien Term A Loans mature on September 28, 2021 and requires quarterly principal payments of $3,125 per quarter in 2018, $4,688 per quarter in 2019, $6,250 per quarter in 2020 and $9,375 per quarter for the first two quarters of 2021. The remainder of the outstanding First Lien Term A Loans borrowings are due on September 28, 2021. Any mandatory or voluntary prepayment will be applied against the remaining scheduled installments of principal payments in direct order of maturity, unless other direction of application is provided by us. Based on our periodic election, borrowings under the First Lien Term A Loans bear interest at either (a) the ABR plus, based on our Secured Leverage Ratio (as defined in the Restated Credit Agreement), 1.25% - 2.00% for ABR loans or (b) LIBOR plus, based on our Secured Leverage Ratio, 2.25% to 3.00% for LIBOR loans. The ABR is equal to the highest of (i) the New York Federal Reserve Bank rate in effect on such date plus 0.50%, (ii) the LIBOR plus 1.00% and (iii) the prime commercial lending rate of the administrative agent as in effect on the relevant day. The interest period applicable to any LIBOR borrowing is one, two, three or six months, at the election of the borrower. Interest on LIBOR loans is payable the last day of the applicable interest period and, in the case of an interest period of more than three months' duration, each day on which interest would have been payable had successive interest periods of three months's duration been applicable to such borrowing. The interest rate in effect was 3.95% and 3.75% at December 31, 2017 and 2016, respectively.

(b) The First Lien Term B Loans mature on September 28, 2023 and requires quarterly principal payments of $1,375 with all remaining borrowings due on September 28, 2023. Based on our periodic election, borrowings under the First Lien Term B Loans bear interest at either (a) the ABR plus 1.75% for ABR loans or (b) LIBOR plus 2.50% for LIBOR loans. The ABR is equal to the highest of (i) the New York Federal Reserve Bank rate in effect on such date plus 0.50%, (ii) LIBOR plus 1.00%, (iii) the prime commercial lending rate of the administrative agent as in effect on the relevant day and (iv) 1.75%. LIBOR is equal to the higher of (a) the published LIBOR or (b) 0.75%. If our corporate credit rating from Moody's Investor Service, Inc. is Ba3 or better and our corporate family rating from Standard & Poor's Financial Services, LLC is BB- or better, the margin will be reduced by 0.25% per annum for as long as such ratings are maintained. The interest period applicable to any LIBOR borrowing is one, two, three or six months, at the election of the borrower. Interest on LIBOR loans is payable the last day of the applicable interest period and, in the case of an interest period of more than three months' duration, each day on which interest would have been payable had successive interest periods of three months' duration been applicable to such borrowing. The interest rate in effect was 4.20% and 3.75% at December 31, 2017 and 2016, respectively.

(c) The Revolver expires on September 28, 2021. Interest for any borrowings under the Revolver is payable over one, two, three or six months at our election. A commitment fee is payable quarterly based on the unused portion of the Revolver commitment which ranges from 0.30% to 0.50% per annum based on certain financial tests. Based on our periodic election, borrowings under the Revolver bear interest at either (a) ABR plus, based on our Secured Leverage Ratio, 1.25% - 2.00% for ABR loans or (b) LIBOR plus, based on our Secured Leverage Ratio, 2.25% to 3.00% for LIBOR loans. The ABR is equal to the highest of (i) the New York Federal Reserve Bank rate in effect on such date plus 0.50%, (ii) LIBOR plus 1.00% and (iii) the prime commercial lending rate of the administrative agent as in effect on the relevant day. There were no borrowings outstanding under the

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Revolver as of December 31, 2017 and 2016. The interest rate in effect was 3.95% and 3.75% at December 31, 2017 and 2016, respectively.

The Restated Credit Agreement includes certain binding affirmative and negative covenants, including delivery of financial statements and other reports, maintenance of existence and transactions with affiliates. The negative covenants restrict our ability, among other things, to incur indebtedness, grant liens, make investments, sell or otherwise dispose of assets or enter into a merger, pay dividends or repurchase stock. As a result of these restrictions, approximately 64% of the subsidiary net assets are deemed restricted as of December 31, 2017. Refer to Schedule I Condensed Financial Information of Parent. There is a required financial covenant applicable only to the Revolver and the First Lien Term A Loans, pursuant to which we agree not to permit our Secured Leverage Ratio (as defined in the Restated Credit Agreement) to exceed 5.50:1.00 through September 2018, 5.25:1.00 through September 2019 and 5.00:1.00 through June 2021. In addition, the Restated Credit Agreement includes certain events of default including payment defaults, failure to perform affirmative covenants, failure to refrain from actions or omissions prohibited by negative covenants, the inaccuracy of representations or warranties, bankruptcy and insolvency related defaults and a change of control default. We were in compliance with all such covenants as of December 31, 2017 and December 31, 2016.

The Restated Credit Agreement requires mandatory prepayments based upon our leverage ratio at the time payment is required and an annual excess cash flows commencing with

the year ended December 31, 2017. The mandatory prepayment is contingently payable in the second quarter of each year based on an annual excess cash flow calculation for the preceding year as defined within the Restated Credit Agreement. As of December 31, 2017 we do not expect to be required to make a mandatory prepayment during 2018.

As of December 31, 2017, the expected aggregate maturities of long−term debt for each of the next five years are as follows:

	December 31, 2017
2018	$ 18,000
2019	24,250
2020	30,500
2021	183,625
2022	5,500
Thereafter	515,625
Total	$ 777,500

Note 9. Derivative Instruments

We are exposed to fluctuations in interest rates on our long−term debt. We manage our exposure to fluctuations in the 3−month LIBOR through the use of interest rate cap agreements designated as cash flow hedges. We are meeting our objective by hedging the risk of changes in cash flows related to changes in LIBOR by capping the interest on our floating rate debt linked to LIBOR to approximately 3%. We do not utilize derivatives for speculative or trading purposes.

As of December 31, 2017 and December 31, 2016, we had $435,000 and $540,000, respectively, in notional debt outstanding related to these interest rate caps, which cover quarterly interest payments through September 2019. The notional amount decreases over time. See Note 8 for more information regarding the debt outstanding related to these agreements.

All of our outstanding interest rate cap contracts qualify for cash flow hedge accounting treatment in accordance with ASC 815, *Derivatives and Hedging*. Cash flow hedge accounting treatment allows for gains and losses on the effective portion of qualifying hedges to be deferred in accumulated other comprehensive income (loss) until the underlying transaction occurs, rather than recognizing the gains and losses on these instruments in earnings during each period they are outstanding. When the actual interest payments are made on our variable rate debt as described in Note 8

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and the related derivative contract settles, any effective portion of realized interest rate hedging derivative gains and losses previously recorded in accumulated other comprehensive income (loss) is recognized in interest expense. We recognized interest expense of $1,789, $283 and $105 during the years ended December 31, 2017, 2016 and 2015, respectively, associated with the interest rate cap agreements.

Ineffectiveness results, in certain circumstances, when the change in total fair value of the derivative instrument differs from the change in the fair value of our expected future cash outlays for the related interest payment and is recognized immediately in interest expense. There was no ineffectiveness recorded during the years ended December 31, 2017, 2016, and 2015, respectively. Likewise, if the hedge does not qualify for hedge accounting, the periodic changes in its fair value are recognized in the period of the change in interest expense. All cash flows related to our interest rate cap agreements are classified as operating cash flows.

Any outstanding derivative instruments expose us to credit loss in the event of nonperformance by the counterparties to the agreements, but we do not expect that the counterparty will fail to meet their obligations. The amount of such credit exposure is generally the positive fair value of our outstanding contracts. To manage credit risks, we select counterparties based on credit assessments, limit our overall exposure to any single counterparty and monitor the market position of any counterparty.

The table below reflects quantitative information related to the fair value of our derivative instruments and where these amounts are recorded in our consolidated financial statements as of the period presented:

	December 31,	
	2017	2016
Liability fair value recorded in other long-term liabilities	$ 951	$ 1,729
Liability fair value recorded in accounts payable and accrued other expenses	979	1,065
Estimated amount of existing losses expected to be reclassified into earnings in the next 12 months	(2,440)	(1,783)

We record deferred hedge premiums which are being paid over the life of the hedge in accumulated other comprehensive income (loss) until the related hedge ultimately settles and interest payments are made on the underlying debt. As of December 31, 2017, we have made payments of $4,021 related to these deferred premiums. We expect to pay an additional $2,374 in deferred premiums through 2019 related to our outstanding interest rate cap agreements which is reflected in the fair value of these derivatives in the table above.

Comprehensive income includes changes in the fair value of our interest rate cap agreements which qualify for hedge accounting. Changes in other comprehensive income (loss) for the periods presented related to derivative instruments classified as cash flow hedges were as follows:

Balance, January 1, 2015	$ (623)
Reclassifications in earnings, net of tax benefit of $40	65
Change in fair value of derivative instrument, net of tax of $1,360	(2,410)
Balance, December 31, 2015	(2,968)
Reclassifications in earnings, net of tax benefit of $107	176
Change in fair value of derivative instrument, net of tax of $319	(542)
Balance, December 31, 2016	(3,334)
Reclassifications in earnings, net of tax benefit of $675	1,114
Change in fair value of derivative instrument, net of tax of $215	(336)
Balance, December 31, 2017	$ (2,556)

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Note 10. Fair Value Measurements

We measure assets and liabilities at fair value based on assumptions market participants would use in pricing an asset or liability in the principal or most advantageous market. Authoritative guidance on fair value measurements establishes a consistent framework for measuring fair value whereby inputs are assigned a hierarchical level. The hierarchical levels are:

Level 1: Unadjusted quoted prices in active markets for identical assets or liabilities accessible to the reporting entity at the measurement date.

Level 2: Observable prices, other than quoted prices included in Level 1 inputs for the asset or liability, either directly or indirectly, for substantially the full term of the asset or liability.

Level 3: Unobservable inputs for the asset or liability used to measure fair value to the extent observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at measurement date.

The following table summarizes our financial instruments measured at fair value within the Consolidated Balance Sheets:

	December 31, 2017			December 31, 2016		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Liabilities:						
Long-term debt	$ —	$ —	$774,822	$ —	$ —	$791,039
Interest rate cap agreements	—	1,930	—	—	2,794	—
Total	$ —	$1,930	$774,822	$ —	$2,794	$791,039

The fair value of our private debt is determined based on fluctuations in current interest rates, the trends in market yields of debt instruments with similar credit ratings, general economic conditions and other quantitative and qualitative factors. The carrying value of our debt approximates its fair value.

The fair value of the interest rate cap agreements is determined using the market standard methodology of discounting the future expected variable cash receipts that would occur if interest rates rose above the strike rate of the caps. The analysis reflects the contractual terms of the derivatives, including period to maturity and remaining deferred premium payments, and uses observable market−based inputs, including interest rates and implied volatilities. The variable cash receipts are based on an expectation of future interest rates (forward curves) derived from observable market interest rates. As such, the estimated fair values of these liabilities are classified as Level 2 in the fair value hierarchy.

Note 11. Income Taxes

On December 22, 2017, the U.S. government enacted the Tax Act, reducing the federal tax rate on U.S. earnings to 21%, effective January 1, 2018, and moves from a global taxation regime to a modified territorial regime. Given the significant complexity of the Tax Act, anticipated guidance from the U.S. Treasury about implementing the Tax Act, and the potential for additional guidance from the Securities and Exchange Commission or the Financial Accounting Standards Board related to the Tax Act, we will continue to evaluate the accounting for the tax effects related to the enactment of the Tax Act. As of December 31, 2017, we have made a reasonable estimate of the effects of the Tax Act on our existing deferred tax balances and the one-time transition tax as described below.

We recognized a net income tax benefit of $45,019 in the year ended December 31, 2017 associated with the revaluation of our net deferred tax liabilities based on a U.S. federal tax rate of 21% of $46,600 offset by the one-time transition tax expense of $1,581 on our unremitted foreign earnings and profits which we have elected to pay in the current year. As part of our analysis, a tax credit carryforward of $1,174 was identified and a full valuation allowance

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was established. Although we believe this represents a reasonable estimate of the impact of the income tax effects of the Tax Act, it should be considered provisional as of December 31, 2017. Upon completion of our 2017 U.S. tax return, we will be able to conclude whether any further adjustments are required to our deferred tax liabilities, as well as the liability associated with the one-time mandatory tax. Any adjustments to these provisional amounts will be reported as a component of tax (benefit) expense in the reporting period in which any such adjustments are determined, which will be no later than the fourth quarter of 2018.

While the Tax Act provides for a modified territorial regime, effective January 1, 2018, it includes a new U.S. tax base erosion provision, the global intangible low-taxed income ("GILTI") tax. Although we do not expect that we will be subject to any material incremental U.S. tax on GILTI income in 2018, we have elected to account for any potential GILTI tax in the period in which it is incurred, and therefore have not provided any deferred income tax impacts of GILTI for the year ended December 31, 2017.

Total income tax (benefit) expense for the years ended December 31, 2017, 2016, and 2015 was as follows:

Year ended December 31,		
2017	2016	2015

Income tax (benefit) expense from continuing operations	$(11,773)	$20,970	$14,401
Income tax expense from discontinued operations	—	—	341
Total income tax (benefit) expense	$(11,773)	$20,970	$14,742

For the years ended December 31, 2017, 2016, and 2015, income from continuing operations before income taxes includes the following components:

	Year ended December 31,		
	2017	2016	2015
U.S. operations	$122,952	$66,838	$27,605
Foreign operations	3,478	2,984	100
Income before income taxes	$126,430	$69,822	$27,705

The income tax (benefit) expense that is attributable to income from continuing operations before income taxes included in our Consolidated Statements of Comprehensive Income for the years ended December 31, 2017, 2016, and 2015 consisted of the following:

	Year ended December 31,		
	2017	2016	2015
Current:			
U.S. federal	$ 26,509	$26,734	$ 20,382
State and local	1,679	613	4,822
Foreign	1,680	1,358	1,029
Current income tax expense	29,868	28,705	26,233
Deferred			
U.S. federal	(42,430)	(5,858)	(12,584)
State and local	(304)	(1,825)	798
Foreign	1,093	(52)	(46)
Deferred income tax benefit	(41,641)	(7,735)	(11,832)
Total income tax (benefit) expense	$(11,773)	$20,970	$ 14,401

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The factors accounting for the variation in our overall effective tax rates from continuing operations compared to U.S. statutory income tax rates for the years ended December 31, 2017, 2016, and 2015 were as follows:

	Year ended December 31,		
	2017	2016	2015
Federal income tax expense at the statutory rate	$ 44,250	$24,438	$ 9,697
State and local taxes, net of federal benefit	1,657	556	3,922
Non-deductible costs	1,197	779	1,070
Stock-based compensation	(11,985)	(4,000)	—
Unrecognized tax positions	(532)	(1,397)	508
U.S. Tax Act benefit, net	(45,019)	—	—
Other	(1,341)	594	(796)
Total income tax (benefit) expense	$(11,773)	$20,970	$14,401

Our effective income tax rate from continuing operations was (9.3%), 30.0% and 52.0% for the years ended December 31, 2017, 2016, and 2015, respectively. The decrease in the effective tax rate for the year ended December 31, 2017 compared to December 31, 2016 is primarily due to a $45,019 tax benefit as a result of the remeasurement of deferred tax liabilities of $46,600, offset by a $1,581 estimated repatriation tax charge. In addition, for the year ended December 31, 2017, we recorded a $11,985 net tax benefit consisting of $15,017 of federal excess tax benefits associated with the exercise of stock options offset by $3,032 of income tax

expense associated with the nondeductible restricted stock issued in connection with the RowdMap Acquisition. The decrease in the effective tax rate for the year ended December 31, 2016 compared to December 31, 2015 is primarily due to a $1,300 state tax benefit related to the settlement of an uncertain tax position that was recorded in a prior period, a $4,000 excess tax benefit related to stock option exercises resulting from the early adoption of ASU 2016-09 and a $1,122 state tax benefit from the implementation of certain tax planning.

In general, it is our practice and intention to reinvest the earnings of our non branch foreign subsidiaries in those operations on an indefinite basis. For the years ended December 31, 2016 and 2015, the amounts considered indefinitely reinvested were $8,065 and $5,910, respectively. If the earnings were not considered indefinitely reinvested under prior law, the tax on such earnings would be approximately $1,891 and $1,386 for the years ended December 31, 2016, and 2015, respectively. In light of the Tax Act, companies are required to pay tax on historical earnings that have not been repatriated to the U.S. For year ended December 31, 2017, the amount considered indefinitely reinvested was provisionally estimated at $8,739, and the foreign taxes on such earnings is provisionally estimated at $1,581.

The net deferred taxes below are included on our Consolidated Balance Sheets as a long-term net deferred tax liability of $83,048 at December 31, 2017 and a long-term net deferred tax liability of $120,533 at December 31, 2016.

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The components of our deferred tax assets and liabilities as of December 31, 2017 and 2016 are as follows:

	Year ended December 31,	
	2017	2016
Deferred tax assets:		
Allowance for doubtful accounts and estimated allowance for refunds and appeals	$ 21,829	$ 34,794
Accrued compensation	929	2,185
Deferred rent	194	149
Stock-based compensation	6,045	10,381
Tax credit and net operating loss carryforward	3,420	652
Other deductible temporary differences	2,333	5,077
Gross deferred tax assets	34,750	53,238
Less: valuation allowance	(1,847)	(199)
Total deferred tax assets	32,903	53,039
Deferred tax liabilities:		
Unbilled receivables and other liabilities	(1,206)	(2,307)
Intangibles and goodwill	(103,203)	(154,528)
Property and equipment	(4,738)	(10,795)
Software development costs	(5,868)	(2,603)
Other taxable temporary differences	(936)	(3,339)
Total gross deferred tax liabilities	(115,951)	(173,572)
Net deferred tax liability	$ (83,048)	$(120,533)

We have federal net operating loss carryforwards of $1,197 which will expire in 2029. In addition, we have a foreign net operating loss of $3,695 with an unlimited carryforward. All state net operating losses were utilized in the prior year. Additionally, we generated state tax credit carryforwards of $1,322, which are anticipated to be fully utilized before expiration.

As of December 31, 2017 and 2016, a valuation allowance of $1,847 and $199, respectively, has been recorded to reflect the portion of the deferred tax asset that is not more likely than not to be realized. The increase in the valuation allowance relates to cumulative foreign net operating losses for 2017, as well as foreign tax credit carryforwards relating to the Tax Act. The amount of the deferred tax asset considered realizable, however, could be adjusted if estimates of future taxable income during the carryforward period are reduced or increased or if objective negative evidence in the form of cumulative losses is no longer present and additional weight may be given to subjective evidence such as our projections for growth.

Due to change of ownership provisions in the Internal Revenue Code, use of a portion of our domestic net operating loss and tax credit carryforwards will be limited in future periods. Further, a portion of the carryforwards may expire before being applied to reduce future income tax liabilities.

ASC 740 clarifies the accounting and reporting for uncertainties in income tax law. This interpretation prescribes a comprehensive model for financial statement recognition measurement, presentation and disclosure of uncertain tax positions taken or expected to be taken in income tax returns. ASC 740 requires that the tax effects of an uncertain tax position be recognized only if it is "more likely than not" to be sustained by the taxing authority as of the reporting date.

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A reconciliation of the beginning and ending amount of unrecognized tax benefits at December 31, 2017 and 2016 is as follows:

	Year ended December 31,	
	2017	2016
Unrecognized tax benefits — January 1	$ 2,571	$ 4,937
Increase for tax positions taken in prior period	1,186	67
Increase for tax positions taken in current period	385	203
Decrease for tax positions taken in prior period	—	(508)
Decrease for tax positions taken in current period	—	(43)
Decrease related to lapse in statute of limitations	(1,836)	(96)
Decrease related to settlement of positions taken in prior periods	(308)	(1,989)
Unrecognized tax benefits — December 31	$ 1,998	$ 2,571

The majority of the balance of unrecognized tax benefits as of December 31, 2017 and 2016, would affect the effective tax rate if recognized.

The total uncertain tax positions expected to reverse in the next 12 months is approximately $81 and $2,301 as of December 31, 2017 and 2016, respectively, due to lapse of statute of limitations. The current year change in uncertain tax positions is primarily the result of the settlement of an uncertain tax position recorded during a prior period as well as lapses in statute of limitations, offset by increases of tax positions taken in a prior period.

The total penalty and interest incurred, relating to uncertain tax positions, for years ended December 31, 2017, 2016, and 2015, was $103, $424 and $920, respectively. We include interest and penalties as tax expense in the Consolidated Statements of Comprehensive Income.

We file income taxes with the U.S. federal government and various states and foreign jurisdictions. We operate in a number of state and local jurisdictions and as such are subject to state and local income tax examinations based upon various statutes of limitations in each jurisdiction. We are currently under audit by the State of New York for the tax year ended December 31, 2014 and for iHealth Technologies for the tax years ended December 31, 2012, December 31, 2013, May 13, 2014 and December 31, 2014.

Note 12. Stockholders' Equity

Share Repurchase Program

On October 31, 2017, the Board of Directors approved a share repurchase program under which we may repurchase up to $100,000 of common stock. This authorization permits us to repurchase shares from time to time until October 31, 2018 through a variety of methods, including open market repurchases and in privately negotiated transactions subject to debt covenants and other customary legal, contractual, regulatory and market considerations and may be discontinued at any time. All share repurchases will be implemented in accordance with Rule 10b-18 of the Exchange Act with respect to the timing, pricing and volume of such transactions. There can be no assurance as to the amount, timing or prices of repurchases, which may vary based on market conditions and other factors.

During the year ended December 31, 2017, we repurchased 317,900 shares of our common stock under this share repurchase program for $10,000, at a weighted average share price of $31.43 per share. Shares repurchased are immediately retired.

Secondary Offerings

On August 7, 2017, we completed a secondary offering of 10,000,000 shares of our common stock by certain of our stockholders at an offering price of $37.00 per share. All of the shares offered were sold by selling stockholders. Accordingly, we did not receive any proceeds from the sale of shares. In connection with this offering, we incurred

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approximately $700 in professional services expenses, which are included in transaction-related expenses on our Consolidated Statements of Comprehensive Income for the year ended December 31, 2017.

On March 7, 2017, we completed a secondary offering of 9,683,000 shares of our common stock by certain of our stockholders, including 1,263,000 shares sold to the underwriters pursuant to their option to purchase additional shares, at an offering price of $36.00 per share. All of the shares offered were sold by selling stockholders. Accordingly, we did not receive any proceeds from the sale of the shares. In connection with this offering, we incurred approximately $600 in professional services expenses, which are included in transaction-related expenses on our Consolidated Statements of Comprehensive Income for the year ended December 31, 2017.

Issuance of Common Stock

On May 25, 2016 we consummated our IPO in which we issued and sold a total of 12,936,038 shares of common stock, including a portion of the underwriter overallotment, at a public offering price of $19.00 per share. We received net proceeds of approximately $226,963 after deducting underwriting discounts and commissions and other offering expenses of approximately $18,822.

A summary of the current rights and preferences of holders of our common stock are as follows:

Voting

Common stockholders are entitled to one vote per share of common stock held on all matters on which such common stockholders are entitled to vote.

Dividends

Common stockholders are eligible to receive dividends on common stock held when funds are available and as approved by the Board. The Restated Credit Agreement contains certain negative covenants that may restrict our ability to pay dividends. In addition, Delaware law may restrict the Board's ability to declare dividends.

Liquidation Rights

In the event of liquidation or dissolution, common stockholders are entitled to receive all assets available for distribution to stockholders.

Registration Rights

The Second Amended and Restated Stockholders Agreement entered into as of June 1, 2016 in connection with our IPO contains (i) demand registration rights for Advent, subject to a cap of two requests in any 12 month period; (ii) piggy-back registration rights for any stockholder holding at least $500 worth of shares (each, a "Holder"), subject to a pro rata reduction if the total amount of shares requested to be included exceeds the amount of securities which in the opinion of the underwriters can be sold; and (iii) shelf registration rights for

Holders, subject to a required anticipated aggregate offering price, net of selling expenses, of $5,000 subject to a cap of two requests for shelf registrations, for all Holders in the aggregate, in any 12 month period. Holders that are capable of selling all of their registrable securities pursuant to Rule 144 under the Securities Act in a single transaction without timing or volume limitations do not have piggy-back registration rights. We will be responsible for fees and expenses in connection with the registration rights, other than underwriters' discounts and brokers' commissions, if any, relating to any such registration and offering.

Common Stock Split

On May 13, 2016 we effected a 6.1-for-1 stock split of all outstanding shares of our common stock. All share, option and per share information presented in the accompanying consolidated financial statements and notes thereto have

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been adjusted to reflect the stock split on a retroactive basis for all periods presented and all share information is rounded up to the nearest whole share after reflecting the stock split.

Common Stock Dividends

On May 26, 2016 we paid a Special Cash Dividend of $150,000, or $1.94 per share of common stock outstanding prior to the IPO, to holders of record of our common stock on the dividend record date. In connection with the Special Cash Dividend we lowered the exercise price of then outstanding stock options by $1.94 per share in order to preserve the intrinsic value of the options giving effect to the Special Cash Dividend.

Note 13. Earnings per Share

Basic EPS is computed based on the weighted average number of shares of common stock outstanding during the period. Diluted EPS is computed based on the weighted average number of shares of common stock plus the effect of dilutive potential common shares outstanding during the period. For all periods presented, potentially dilutive outstanding shares consisted of equity incentive awards. Restricted stock issued in connection with RowdMap was also included in the calculation of dilutive potential common shares for the year ended December 31, 2017. Our potential common shares consist of the incremental common shares issuable upon the exercise of the options or vesting of RSUs and restricted stock. The dilutive effect of outstanding equity incentive awards is reflected in diluted earnings per share by application of the treasury stock method. For all periods presented, all outstanding common stock consisted of a single−class.

Basic and diluted earnings per share are computed as follows:

	Year Ended December 31,		
	2017	2016	2015
Net income available to common stockholders	$ 138,203	$ 48,852	$ 13,863
Weighted average outstanding shares of common stock	91,928,364	85,053,890	77,216,133
Dilutive effect of stock-based awards and restricted stock	3,167,726	3,524,302	425,255
Adjusted weighted average outstanding and assumed conversions for diluted EPS	95,096,090	88,578,192	77,641,388
Earnings per share from continuing operations:			
Basic	$ 1.50	$ 0.57	$ 0.17
Diluted	1.45	0.55	0.17
Earnings per share from discontinued operations:			
Basic	$ —	$ —	$ 0.01
Diluted	—	—	0.01

Earnings per share:			
Basic	$ 1.50	$ 0.57	$ 0.18
Diluted	1.45	0.55	0.18

Employee stock options, RSUs and restricted stock that were excluded from the calculation of diluted earnings per share because their effect is anti−dilutive for the periods presented were as follows:

	Years Ended December 31,		
	2017	2016	2015
Employee stock options, RSUs and restricted stock	833,670	341,054	2,035,332

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The criteria associated with all of our outstanding performance-based stock options as defined in the terms of the applicable award agreements, were satisfied as of September 30, 2016 and, as a result, outstanding performance-based stock options were included in the calculation of diluted earnings per share for the year ended December 31, 2016. Performance-based stock options of 2,794,910 as of December 31, 2015, were not included in the calculation of diluted earnings per share as the vesting conditions were not probable of occurring. Performance-based restricted stock of 76,546 shares as of December 31, 2017 were not included in the calculation of diluted earnings per share as the vesting conditions were not probable of occurring.

Note 14. Stock−Based Compensation

Equity Incentive Plans

In 2012, we adopted the 2012 Plan pursuant to which our Board of Directors (or committee as designated by the Board of Directors) may grant options to purchase shares of our stock, restricted stock and certain other equity awards to directors, officers and key employees. We only granted stock options that can be settled in shares of our common stock under the 2012 Plan. The 2012 Plan had a total of 7,243,330 shares authorized for issuance. Upon completion of the IPO in May 2016, we adopted the 2016 Plan, and issuances under the 2012 Plan were suspended. Awards granted under the 2012 Plan will remain outstanding until the earlier of exercise, forfeiture, cancellation or expiration. There are no shares available for future issuance under the 2012 Plan as it was discontinued upon adoption of the 2016 Plan. Under the 2016 Plan, our Board of Directors (or a committee or sub-committee designated by the Board of Directors) may grant options to purchase shares of our stock, restricted stock and certain other equity awards to directors, officers and key employees. The 2016 Plan was established with the authorization for grants of up to 5,490,000 shares of authorized but unissued shares of common stock. As of December 31, 2017 the total number of shares available for future issuance under the 2016 Plan is 4,313,279.

Stock Options

Under the terms of the 2016 Plan, we may issue options to purchase shares of our common stock at a price equal to 100% of the market price on the date of grant. Issuances under the 2012 Plan, prior to its suspension, were under terms similar to issuances under the 2016 Plan. Stock options granted are subject to either time of service (service-based awards) or performance (performance-based awards) criteria. Service-based awards typically vest ratably over a five year service period from the date of grant under the 2012 Plan and typically vest ratably over a four year service period from the date of grant under the 2016 Plan. In the event of a change in control, any outstanding, unvested service-based awards will vest immediately. Performance-based awards vest in accordance with the specific performance criteria espoused in the executed award agreements. The term of any stock option shall not exceed ten years from the date of grant. However, an incentive stock option granted to an employee who, at the time of grant, owns stock possessing more than 10% of the total combined voting power of all classes of our stock may not have a term exceeding five years from the date of grant.

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The following is a summary of stock option activity under the Equity Plans:

	Outstanding Options	Weighted average exercise price per share	Weighted average remaining contractual life (Years)	Aggregate Intrinsic Value (in thousands)
Outstanding at December 31, 2016	5,997,372	$ 10.18	7.30	$ 145,270
Granted	599,153	34.70		
Forfeited	(240,845)	19.48		
Exercised	(1,778,104)	7.61		
Expired	(2,969)	13.92		
Outstanding at December 31, 2017	4,574,607	$ 13.89	6.65	$ 85,138
Vested and exercisable at December 31, 2017	3,117,670	$ 10.38	5.95	$ 68,061

Aggregate intrinsic value represents the difference between the fair value of common stock and the exercise price of outstanding in-the-money options. The fair value per share of common stock was $32.21 as of December 31, 2017 based upon the closing price of our common stock on the NYSE. The total intrinsic value of options exercised was $52,828 and $15,521 for the years ended December 31, 2017 and 2016, respectively, and was insignificant for the year ended December 31, 2015. The total fair value of stock options vested was $4,066, $22,453 and $2,450 during the years ended December 31, 2017, 2016 and 2015, respectively.

Restricted Stock Units

RSUs provide participants the right to receive a payment based on the value of a share of common stock. RSUs may be subject to vesting requirements, restrictions and conditions to payment. Such requirements may be based on the continued service for a specified time period or on the attainment of specified performance goals as specified in the award agreements. RSUs are payable in cash or in shares or a combination of both. Under the terms of the Equity Plans, RSUs have a grant date fair value equal to the closing price of our stock on the grant date. The units typically vest ratably over a four year service period other than those issued to members of our Board of Directors. Director RSU grants vest over their one-year annual service period. We began issuing RSUs upon adoption of the 2016 Plan; no RSUs were issued under the 2012 Plan.

The following is a summary of RSU activity under the 2016 Plan:

	Number of Awards	Weighted average grant date fair value per share
Nonvested at December 31, 2016	67,295	$ 25.88
Granted	398,728	34.30
Forfeited	(48,447)	31.91
Vested and converted to shares	(38,302)	29.88
Nonvested at December 31, 2017	379,274	$ 33.56
Expected to vest at December 31, 2017	379,274	$ 33.56

Restricted Stock

We issued an aggregate of 768,021 shares of restricted common stock to certain employees of RowdMap at a fair market value of $43.27 per share. Half of these shares are

subject to continued employment and performance-based vesting requirements and, if achieved, will vest on the one year anniversary of the closing date of the RowdMap

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Cotiviti Holdings, Inc.
Notes to the Financial Statements (continued)
(In thousands, except shares and per share amounts)

Acquisition. The other half are subject to continued employment with us, with one-third vesting on each of the first three anniversaries of the closing of the RowdMap Acquisition.

Employee Stock Purchase Plan

We have an ESPP, which became effective January 1, 2017, for US and non-US employees, both of which have a series of six month offering periods, with a new offering period beginning on the first day of January and July each year. The ESPP was adopted by our Board of Directors in August 2016 and approved by shareholders in May 2017. Employees may contribute up to 10% of their pay towards the purchase of common stock via payroll deductions to a maximum of $10 per year, or $5 per offering period. Purchase dates occur on the last business day of June and December of each year and shares are purchased at a 10% discount off the closing price on the NYSE on the date of purchase. Employees must hold the shares purchased for a minimum of 90 days.

The ESPP had 1,260,000 shares of our common stock initially reserved for issuance upon its inception. The reserve automatically increases each January by an amount equal to the lesser of 1,260,000 or approximately 1.5% of total common shares outstanding on the first day of January. A summary of ESPP share reserve activity for the year ended December 31, 2017 is as follows:

	Shares	Weighted average price
Available for future purchases, beginning of year	1,260,000	
Shares reserved for issuance[(a)]	—	
Common stock purchased	(62,694)	$ 31.09
Available for future purchases, end of year	1,197,306	

(a) On January 1, 2018, the number of shares reserved for issuance was increased by 1,260,000.

Stock-Based Compensation Expense

The fair value of each stock option award is estimated on the date of grant using a Black-Scholes-Merton option pricing model. The expected term of the option represents the period the stock-based awards are expected to be outstanding. We use the simplified method under the provisions of ASC 718, *Compensation – Stock Compensation*, for estimating the expected term of the options. Since our shares were not publicly traded until May 2016 and were rarely traded privately, at the time of each grant, there has been insufficient volatility data available. Accordingly, we calculate expected volatility using comparable peer companies with publicly traded shares over a term similar to the expected term of the options issued. We do not intend to pay dividends on our common shares, therefore, the dividend yield percentage is zero. The risk-free interest rate is based on the U.S. Treasury constant maturity interest rate whose term is consistent with the expected life of our stock options.

We used the following weighted average assumptions to estimate the fair value of stock options granted for the periods presented as follows:

	Year Ended December 31,		
	2017	2016	2015
Expected term (years)	6.25	6.25	6.25
Expected volatility	40.00 %	50.00 %	50.00 %
Expected dividend yield	0.00 %	0.00 %	0.00 %
Weighted average risk-free interest rate	1.93 %	1.36 %	1.70 %
Weighted average grant date fair value	$14.57	$ 9.53	$ 7.77

Total fair market value related to the restricted stock issued in connection with the RowdMap Acquisition was $33,232 based on the closing price of our common stock on the date of grant. For the time-based shares, stock-based compensation expense is being recorded ratably

over the three year vesting period. For the performance-based shares, stock-based compensation expense will be recorded over the one year vesting period to the extent it is probable the

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Cotiviti Holdings, Inc.
Notes to the Financial Statements (continued)
(In thousands, except shares and per share amounts)

performance criteria will be achieved. For the year ended December 31, 2017, we recorded approximately $6,072 in stock-based compensation expense related to the performance-based awards that we estimate are probable of achieving the performance criteria.

We recorded total stock-based compensation expense of $16,873, $22,954 and $3,399 for the years ended December 31, 2017, 2016 and 2015. Stock-based compensation expense during the year ended December 31, 2016 includes $15,898 related to the vesting of all outstanding performance-based stock options. Stock-based compensation expense during the year ended December 31, 2016 also includes $2,257 related to the accelerated vesting of certain stock options as the result of our IPO. We account for forfeitures as they occur. As of December 31, 2017, we had total unrecognized compensation cost of $43,342 related to 2,526,406 unvested service-based stock options, RSUs and restricted stock which we expect to recognize over the next 2.4 years.

Note 15. Segment and Geographic Information

Operating segments are components of an enterprise for which separate financial information is available that is evaluated regularly by our Chief Operating Decision Maker in deciding how to allocate resources and in assessing financial performance. We conduct our business through two reportable business segments: Healthcare and Global Retail and Other.

Through our Healthcare segment, we offer prospective and retrospective claims accuracy solutions to healthcare payers in the United States. We also provide a network efficiency solution to payers and providers as well as, on a limited basis, certain analytics-based solutions unrelated to our healthcare payment accuracy solutions in the United States. Through our Global Retail and Other segment, we provide retrospective claims accuracy solutions to retailers primarily in the United States, with additional clients in Canada and the United Kingdom, as well as solutions that improve efficiency and effectiveness of payment networks for a limited number of clients.

We evaluate the performance of each segment based on segment net revenue and segment operating income. Operating income is calculated as net revenue less operating expenses and is not affected by other expense (income) or by income taxes. Indirect costs are generally allocated to the segments based on the segments' proportionate share of revenue and expenses directly related to the operation of the segment. We do not allocate interest expense, other non−operating (income) expense or the provision for income taxes, since these items are not considered in evaluating the segment's overall operating performance. Our Chief Operating Decision Maker does not receive or utilize asset information to evaluate performance of operating segments. Accordingly, asset−related information has not been presented.

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Cotiviti Holdings, Inc.
Notes to the Financial Statements (continued)
(In thousands, except shares and per share amounts)

Our operating segment results for the periods presented were as follows:

Year Ended

	December 31,		
	2017	2016	2015
Net Revenue			
Healthcare	$605,228	$552,041	$467,044
Global Retail and Other	73,433	73,121	74,299
Consolidated net revenue	$678,661	$625,162	$541,343
Depreciation and amortization			
Healthcare	$ 81,388	$ 77,178	$ 70,479
Global Retail and Other	3,795	3,791	3,683
Consolidated depreciation and amortization	$ 85,183	$ 80,969	$ 74,162
Transaction-related expenses			
Healthcare	$ 2,087	$ 1,673	$ 1,332
Global Retail and Other	132	115	137
Consolidated transaction-related expenses	$ 2,219	$ 1,788	$ 1,469
Impairment of intangible assets			
Healthcare	$ —	$ —	$ 26,326
Global Retail and Other	1,322	—	1,500
Consolidated impairment of intangible assets	$ 1,322	$ —	$ 27,826
Operating Income			
Healthcare	$151,340	$123,917	$ 84,240
Global Retail and Other	10,958	10,036	12,284
Consolidated operating income	$162,298	$133,953	$ 96,524

Operating segment net revenue by product type for the periods presented was as follows:

	Year Ended December 31,					
	2017	%	2016	%	2015	%
Healthcare						
Retrospective claims accuracy	$351,662	51.8	$310,496	49.7	$251,288	46.4
Prospective claims accuracy	236,192	34.8	229,491	36.7	201,899	37.3
Other	17,374	2.6	12,054	1.9	13,857	2.6
Total Healthcare	605,228	89.2	552,041	88.3	467,044	86.3
Global Retail and Other						
Retrospective claims accuracy	71,437	10.5	70,656	11.3	72,060	13.3
Other	1,996	0.3	2,465	0.4	2,239	0.4
Total Global Retail and Other	73,433	10.8	73,121	11.7	74,299	13.7
Consolidated net revenue	$678,661	100.0	$625,162	100.0	$541,343	100.0

Geographic Information

Geographic net revenue and long-lived assets are attributed to the geographic regions based on the geographic location of each of our subsidiaries/locations. Our operations are primarily within the continental United States. We also operate in Canada and the United Kingdom.

Net revenue generated in the United States accounted for approximately 99%, 98% and 98% of total net revenue for the years ended December 31, 2017, 2016 and 2015, respectively. Remaining net revenue was generated in the rest of the world.

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Long-lived assets are primarily based in the United States with over 99% of total consolidated long-lived assets. Less than 1% of total consolidated long-lived assets are foreign.

Note 16. Client Concentration

The list of our largest clients changes periodically. Our largest clients, all of which are in our Healthcare segment, accounted for the following percentages of total net revenue:

	Year Ended December 31,		
	2017	2016	2015
Customer A	13 %	15 %	14 %
Customer B	11 %	11 %	10 %
Customer C	10 %	7 %	8 %

In many instances, we provide our services pursuant to agreements which have auto renewal clauses and may be periodically subject to a competitive reprocurement process.

Note 17. Employee Benefit Plans

Contributions expensed and included in compensation on our Consolidated Statements of Comprehensive Income for employee benefit plans are detailed below:

	Year Ended December 31,		
	2017	2016	2015
401(k) Plan [(a)]	$5,101	$3,860	$3,053
Profit Share Plan [(b)]	—	220	539
Provident Plan [(c)]	712	528	427
Total	$5,813	$4,608	$4,019

(a) We sponsor a defined contribution retirement plan in accordance with Section 401(k) of the Internal Revenue Code, which cover substantially all U.S. employees, subject to certain minimum age and service requirements. The plans provide for a contribution based on a percentage of eligible employee contributions.

(b) We had a nonqualified profit sharing incentive compensation plan for certain eligible employees. Contributions were made within 90 days following the last day of the plan to a brokerage account in an amount determined at our discretion for employees who had completed 1,000 hours of service and were employed at the time of the contribution. This plan was discontinued after the 2014 plan year, with the final payout occurring in June 2016.

(c) Eligible employees of our subsidiary located in India are covered by the Provident Fund, contributions which are based on a percentage of eligible employees' salaries, and the Indian Payment of Gratuity Act, which provides for benefits to be paid to eligible employees upon termination of employment (collectively, the "India Plan"). Benefits under the India Plan are administered by the Indian Government. As of December 31, 2017 and 2016 we had an accrued benefit obligation relating to the India Plan of $1,008 and $763, respectively.

Note 18. Discontinued Operations

In February 2015, we received payment on a $900 note receivable related to a business that was disposed of in 2012. Since the date of sale, we had elected to fully reserve the note receivable as the collectability was determined to be uncertain. This gain from the collection of the note receivable, net of tax, is reflected as a gain on discontinued operations on our Consolidated Statements of Comprehensive Income. The estimated impact to diluted EPS as a result of this gain on discontinued operations was $0.01 per diluted share for the year ended December 31, 2015.

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Note 19. Selected Quarterly Financial Data (Unaudited)

Historically, there has been a seasonal pattern to our healthcare revenue with the revenues in the first quarter generally lower than the other quarters and revenues in the fourth quarter generally being higher than the other quarters. Accordingly, the comparison of revenue from quarter to quarter may fluctuate and is dependent on various factors, including, but not limited to, reset of member liability, timing of special projects and timing of inaccurate payments being prevented or recovered as well as the aforementioned seasonal considerations. Consequently, you should not rely on our revenue for any one quarter as an indication of our future performance.

The following table summarizes our unaudited quarterly operating results for the last two years:

Year Ended December 31, 2017	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Revenue[a]	$160,133	$167,611	$174,188	$176,729
Operating income[b]	34,082	39,996	41,042	47,178
Net income[b][c]	26,975	21,088	19,472	70,668
Total earnings per share—Basic[c]	$ 0.30	$ 0.23	$ 0.21	$ 0.77
Total earnings per share—Diluted[c]	$ 0.28	$ 0.22	$ 0.20	$ 0.74

Year Ended December 31, 2016	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Revenue[d]	$142,718	$158,291	$156,241	$167,912
Operating income[d][e]	29,238	38,938	24,155	41,622
Net income[d][e][f]	8,084	10,893	4,583	25,292
Total earnings per share—Basic[d][e][f]	$ 0.10	$ 0.13	$ 0.05	$ 0.28
Total earnings per share—Diluted[d][e][f]	$ 0.10	$ 0.13	$ 0.05	$ 0.27

(a) During the fourth quarter 2017, healthcare revenue was reduced by approximately $7,000 as a result of an increase in our estimated liability for refunds and appeals.

(b) During the second quarter 2017, as a result of the repricing our Term Loan B, we recorded a loss on extinguishment of $3,183 (see Note 8).

(c) During the fourth quarter 2017, we recognized a net income tax benefit of $45,019 associated with the impact of the Tax Act enacted on December 22, 2017 (see Note 11).

(d) During the second quarter 2016, we generated approximately $5,000 in healthcare revenue from special projects that did not reoccur in the second half of the year.

(e) During the second quarter 2016, stock-based compensation expense includes $2,257 related to the accelerated vesting of certain stock options as the result of our IPO. During the third quarter 2016, stock-based compensation expense includes $15,898 related to the vesting of all outstanding performance-based stock options (see Note 14).

(f) During the second quarter 2016, we made a voluntary prepayment on our Initial Second Lien Credit Facility which resulted in a $7,068 loss on extinguishment of debt. During the third quarter 2016, as a result of refinancing our long-term debt, we recorded a loss on extinguishment of $9,349 (see Note 8).
.

Note 20. Subsequent Event

Our original Medicare RAC contract with CMS expired on January 31, 2018. As discussed in Note 2, healthcare providers have the right to appeal a claim and may pursue additional appeals if the initial appeal is found in favor of CMS. We accrue an estimated liability for appeals based on the amount of fees that are subject to appeals, closures or other adjustments and those which we estimate are probable of being returned to CMS following a successful appeal by the providers. Our estimates are based on our historical experience with the Medicare RAC appeal process. In

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connection with the expiration of the contract, we determined that we have no obligation to CMS with respect to any appeals resolved in the providers favor after the expiration date and, in addition, we believe that we have no obligation to CMS in connection with the hospital

settlement processes as described in Note 7. Accordingly, we expect to release at least $32,000 of the total $56,000 liability during the first quarter 2018. This will increase first quarter 2018 revenue by an amount equal to the total liability released upon contract expiration. We continue to assess the remaining estimated liability for refunds and appeals to determine management's best estimate of any appeals overturned prior to the expiration of the contract term.

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Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

Our management has evaluated, with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of our disclosure controls and procedures, as defined in Rule 13(a)-15(e) of the Exchange Act, as of the end of the period covered by this Annual Report on Form 10−K pursuant to Rule 13a-15(b) of the Exchange Act. In accordance with guidance issued by the Securities and Exchange Commission, registrants are permitted to exclude business combinations from their final assessment of internal control over financial reporting for the first fiscal year in which the acquisition occurred. Our management's evaluation over internal controls over financial reporting excluded the evaluation of internal control activities specific to RowdMap, which we acquired in July 2017 as discussed in Note 3 to our consolidated financial statements. We have included the financial results of RowdMap in our consolidated financial statements from the date of acquisition. Total revenues excluded from our assessment of internal controls over financial reporting represented approximately 1% of total 2017 revenue and total assets excluded represented approximately 1% of total assets as of December 31, 2017. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer have concluded that our disclosure controls and procedures as of the end of the period covered by this Annual Report on Form 10−K are effective at a reasonable assurance level in ensuring that information required to be disclosed in our Exchange Act reports is (1) recorded, processed, summarized and reported in a timely manner and (2) accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure. While our disclosure controls and procedures are designed to provide reasonable assurance of their effectiveness, because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, within the Company have been detected.

Management's Annual Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting (as defined in Rule 13a-15(f) or Rule 15d-15(f) under the Exchange Act). Under the supervision and with the participation of our management, including our CEO and CFO, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework).

Based on that evaluation, our management concluded that our internal control over financial reporting was effective as of December 31, 2017 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of consolidated financial statements for external reporting purposes in accordance with U.S. GAAP.

KPMG LLP, the independent registered public accounting firm that audited our Consolidated Financial Statements included in this Annual Report on Form 10-K, audited the effectiveness of our internal control over financial reporting as of December 31, 2017. KPMG LLP has issued their report which is included elsewhere herein.

Changes in Internal Control over Financial Reporting

There were no changes in our internal control over financial reporting that occurred during the year ended December 31, 2017 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

None.

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PART III

Item 10. Directors, Executive Officers and Corporate Governance

The information required by this Item will be included in and is incorporated herein by reference to our 2018 Proxy Statement and to the material under the caption "Executive Officers of the Registrant" in Part I of this Annual Report.

Item 11. Executive Compensation

The information required by this Item will be included in and is incorporated herein by reference to our 2018 Proxy Statement.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Securities Authorized for Issuance Under Equity Compensation Plans

Equity Compensation Plans Table

The following table shows information relating to the number of shares authorized for issuance under our equity compensation plans as of December 31, 2017.

Plan Category	Securities to be issued upon exercise of outstanding options, warrants and rights	Weighted average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans
Equity compensation plans			
Approved by shareholders	4,574,607	$ 13.89	5,510,585
Not approved by shareholders	—	$ —	—

Other information required by this Item will be included in and is incorporated herein by reference to our 2018 Proxy Statement.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by this Item will be included in and is incorporated herein by reference to our 2018 Proxy Statement.

Item 14. Principal Accounting Fees and Services

The information required by this Item will be included in and is incorporated herein by reference to our 2018 Proxy Statement.

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PART IV

Item 15. Exhibits and Financial Statement Schedules

Financial Statements and Financial Statement Schedules

See "—Index to Consolidated Financial Statements" in Item 8 of this Annual Report on Form 10-K.

Schedule I – Condensed Financial Information of Cotiviti Holdings, Inc.

Schedule II – Valuation and Qualifying Accounts of Cotiviti Holdings, Inc.

Exhibits

The exhibits listed in the accompanying index to exhibits are filed or incorporated by reference as part of this Annual Report on Form 10-K.

Exhibit No.	Description of Exhibits
3.1	Amended and Restated Certificate of Incorporation of Cotiviti Holdings, Inc. (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K (File No. 001-37787) filed on June 3, 2016).
3.2	Amended and Restated Bylaws of Cotiviti Holdings, Inc. (incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K (File No. 001-37787) filed on June 3, 2016).
4.1	Specimen Certificate of Common Stock (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-1 (File No. 333-211022) filed on April 29, 2016).
4.2	Second Amended and Restated Stockholders Agreement, by and among Cotiviti Holdings, Inc. and certain stockholders named therein (incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K (File No. 001-37787) filed on June 3, 2016).
10.1	Restatement Agreement No. 1, dated September 28, 2016, to the First Lien Credit Agreement, dated May 14, 2014, among Cotiviti Corporation, Cotiviti Domestic Holdings, Inc., Cotiviti Intermediate Holdings, Inc., the other Loan Parties party thereto, the Lenders party thereto and JPMorgan Chase Bank, N.A., as Successor Agent, and Goldman Sachs Bank USA, as Resigning Agent (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 001-37787) filed on November 10, 2016).
10.2	Director Indemnification Agreement (incorporated by reference to Exhibit 10.7 to the Company's Quarterly Report on Form 10-Q (File No. 001-37787) filed on August 10, 2016).
10.3†	Executive Employment Agreement, dated May 15, 2015, by and between John D. Williams and Connolly iHealth Technologies, LLC (incorporated by reference to Exhibit 10.8 to the Company's Registration Statement on Form S-1 (File No. 333-211022) filed on April 29, 2016).
10.4†	Executive Employment Agreement, dated May 15, 2015, by and between Steve Senneff and Connolly iHealth Technologies, LLC (incorporated by reference to Exhibit 10.9 to the Company's Registration Statement on Form S-1 (File No. 333-211022) filed on April 29, 2016).
10.5†	Executive Employment Agreement, dated May 15, 2015, by and between David Beaulieu and Connolly iHealth Technologies, LLC (incorporated by reference to Exhibit 10.10 to the Company's Registration Statement on Form S-1 (File No. 333-211022) filed on April 29, 2016).
10.6*†	Executive Employment Agreement, dated October 27, 2017, by and between Bradley Ferguson and Cotiviti USA, LLC.

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Exhibit No.	Description of Exhibits
10.7*†	Executive Employment Agreement, dated October 23, 2017, by and between Nord Samuelson and Cotiviti USA, LLC.
10.8*†	Executive Employment Agreement, dated May 15, 2015, by and between Jonathan Olefson and Connolly iHealth Technologies, LLC.
10.9†	Cotiviti Holdings, Inc. 2012 Equity Incentive Plan (incorporated by reference to Exhibit 4.2 to the Company's Registration Statement on Form S-8 (File No. 333-211618) filed on May 25, 2016).
10.10†	Form of Stock Option Agreement under Cotiviti Holdings, Inc. 2012 Equity Incentive Plan (incorporated by reference to Exhibit 10.12 to the Company's Registration Statement on Form S-1 (File No. 333−211022) filed on April 29, 2016).
10.11†	Cotiviti Holdings, Inc. 2016 Equity Incentive Plan (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (File No. 333-211618) filed on May 25, 2016).
10.12†	Form of Stock Option Award Agreement under Cotiviti Holdings, Inc. 2016 Equity Incentive Plan (incorporated by reference to Exhibit 10.14 to the Company's Registration Statement on Form S-1 (File No. 333-211022) filed on April 29, 2016).
10.13†	Form of Restricted Stock Unit Award Agreement under Cotiviti Holdings, Inc. 2016 Equity Incentive Plan (incorporated by reference to Exhibit 10.15 to the Company's Registration Statement on Form S-1 (File No. 333-211022) filed on April 29, 2016).
10.14†	Cotiviti Holdings, Inc. Employee Stock Purchase Plan for U.S. Employees (incorporated by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (File No. 333-214568) filed on November 10, 2016).
10.15†	Cotiviti Holdings, Inc. Employee Stock Purchase Plan for Non-U.S. Employees (incorporated by reference to Exhibit 4.2 to the Company's Registration Statement on Form S-8 (File No. 333-214568) filed on November 10, 2016).
21.1*	List of subsidiaries of the Company.
23.1*	Consent of KPMG LLP
24.1*	Power of Attorney (included on the signature pages herein).
31.1*	Certification of Chief Executive Officer pursuant to Rule 13a-14(a) or 15d-14(a) of the Securities Exchange Act of 1934, as amended, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2*	Certification of Chief Financial Officer pursuant to Rule 13a-14(a) or 15d-14(a) of the Securities Exchange Act of 1934, as amended, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1*	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2*	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS*	XBRL Instance Document.
101.SCH*	XBRL Taxonomy Extension Schema Document.
101.CAL*	XBRL Taxonomy Extension Calculation Linkbase Document.

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Exhibit No.	Description of Exhibits
101.DEF*	XBRL Taxonomy Extension Definition Linkbase Document.
101.LAB*	XBRL Taxonomy Extension Label Linkbase Document.
101.PRE*	XBRL Taxonomy Extension Presentation Linkbase Document.

* Filed herewith.
† Management contract or compensatory plan, contract or arrangement.

Item 16. Form 10-K Summary

Not applicable.

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SIGNATURES

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

COTIVITI HOLDINGS, INC.

Date: February 22, 2018

By: /s/ J. DOUGLAS WILLIAMS
Name: J. Douglas Williams
Title: Chief Executive Officer
(Principal Executive Officer)

POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, that each person whose signature appears below constitutes and appoints J. Douglas Williams, Bradley Ferguson and Jonathan Olefson, each or any one of them, his true and lawful attorney-in-fact and agent, with full power of substitution and resubstitution, for him and in his name, place and stead, in any and all capacities, to sign any and all amendments to this Annual Report on Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the United States Securities and Exchange Commission, granting unto said attorneys-in-fact and agents, and each of them, full power and authority to do and perform each and every act and thing requisite and necessary to be done in connection therewith, as fully to all intents and purposes as he might or could do in person, hereby ratifying and confirming all that said attorneys-in-fact and agents, or any of them, or their or his substitutes or substitute, may lawfully do or cause to be done by virtue hereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this Annual Report on Form 10-K has been signed below by the following persons on behalf of the Registrant in the capacities and on the dates indicated.

Signature	Title	Date
/s/ J. DOUGLAS WILLIAMS J. Douglas Williams	Chief Executive Officer and Director (Principal Executive Officer)	February 22, 2018
/s/ BRADLEY FERGUSON	Senior Vice President and Chief Financial Officer	

Bradley Ferguson	(Principal Financial Officer and Principal Accounting Officer)	February 22, 2018
/s/ DAVID SWIFT David Swift	Chairman and Director	February 22, 2018
/s/ ELIZABETH CONNOLLY ALEXANDER Elizabeth Connolly Alexander	Director	February 22, 2018
/s/ MALA ANAND Mala Anand	Director	February 22, 2018
/s/ KENNETH GOULET Kenneth Goulet	Director	February 22, 2018
/s/ RUBEN J. KING-SHAW, JR. Ruben Jose King-Shaw, Jr.	Director	February 22, 2018
/s/ JOHN MALDONADO John Maldonado	Director	February 22, 2018
/s/ JAMES PARISI James Parisi	Director	February 22, 2018
/s/ CHRISTOPHER PIKE Christopher Pike	Director	February 22, 2018
/s/ R. HALSEY WISE R. Halsey Wise	Director	February 22, 2018

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Cotiviti Holdings, Inc.
Schedule I - Condensed Financial Information of Registrant
Parent Company Balance Sheets
(In thousands, except share amounts)

	December 31, 2017	December 31, 2016
ASSETS		
Non current assets:		
Investment in subsidiaries	1,101,468	939,336
TOTAL ASSETS	$ 1,101,468	$ 939,336
LIABILITIES AND STOCKHOLDERS' EQUITY		
Total liabilities	$ —	$ —
Stockholders' equity:		
Common stock ($0.001 par value; 600,000,000 shares authorized, 92,299,294 and 90,748,740 issued, and 92,299,294 and 90,741,340 outstanding at December 31, 2017 and 2016, respectively)	92	91
Additional paid-in capital	933,710	911,582
Retained earnings	172,120	33,917
Accumulated other comprehensive loss	(4,454)	(6,156)
Treasury stock, at cost (7,400 shares at December 31, 2016)	—	(98)
Total stockholders' equity	1,101,468	939,336
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 1,101,468	$ 939,336

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Cotiviti Holdings, Inc.
Schedule I - Condensed Financial Information
Parent Company Statements of Comprehensive Income
(In thousands)

	Years ended December 31,		
	2017	2016	2015
Equity in income of subsidiaries	$ 138,203	$ 48,852	$ 13,863
Net income	138,203	48,852	13,863
Equity in other comprehensive income (loss) of subsidiaries	1,702	(1,289)	(3,009)
Total comprehensive income	$ 139,905	$ 47,563	$ 10,854

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Cotiviti Holdings, Inc.
Schedule I—Condensed Financial Information of Registrant
Parent Company Statements of Cash Flows
(In thousands)

	Year Ended December 31,		
	2017	2016	2015
Cash flows from operating activities:			
Net income	$ 138,203	$ 48,852	$ 13,863
Adjustments to reconcile net income to net cash provided by operating activities:			
Equity in income of subsidiaries	(138,203)	(48,852)	(13,863)
Net cash provided by operating activities	—	—	—
Cash flows from investing activities:			
Investment in subsidiaries	(5,340)	(81,206)	(210)
Net cash used in investing activities	**(5,340)**	**(81,206)**	**(210)**
Cash flows from financing activities:			
Proceeds from issuance of common stock	—	226,963	—
Proceeds from issuance of common stock under equity plans	15,340	4,243	210
Dividends paid	—	(150,000)	—
Repurchase of common stock	(10,000)	—	—
Net cash provided by financing activities	**5,340**	**81,206**	**210**
Net increase in cash and cash equivalents	—	—	—
Cash and cash equivalents at beginning of period	—	—	—
Cash and cash equivalents at end of the period	**$ —**	**$ —**	**$ —**
Supplemental disclosures of cash flow information:			
Noncash operating activities (stock-based compensation)	$ 16,873	$ 22,954	$ 3,399

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Cotiviti Holdings, Inc.
Schedule I—Condensed Financial Information of Registrant
Notes to Parent Company Financial Statements
(In thousands, except share amounts)

Note 1. Basis of Presentation

Cotiviti Holdings, Inc. (collectively with its subsidiaries, "we," "our," or "the Company") is incorporated in the state of Delaware and has adopted a holding company structure. With effect from September 2015, the name of our Company was changed from Connolly Superholdings, Inc. to Cotiviti Holdings, Inc. Our primary domestic operations are performed through Cotiviti, LLC and Cotiviti USA, LLC, both of which are our wholly-owned operating subsidiaries. We have international operations in Canada, the United Kingdom and India.

Pursuant to the terms of the Restated Credit Agreement discussed in Note 8 of the Notes to the Cotiviti Holdings, Inc. Consolidated Financial Statements, Cotiviti Corporation and certain of its subsidiaries have restrictions on their ability to, among other things, incur additional indebtedness, pay dividends or make certain intercompany loans and advances. As a result of these restrictions, these parent company financial statements have been prepared in accordance with Rule 12-04 of Regulation S-X, as restricted net assets of the Company's subsidiaries (as defined in Rule 4-08(e)(3) of Regulation S-X) exceed 25% of the Company's consolidated net assets as of December 31, 2017. The Company is a holding company without any operations of its own. These condensed financial statements have been prepared on a "parent-only" basis. Under a parent-only presentation, the Parent Company's investments in subsidiaries are presented under the equity method of accounting. Certain information and footnote disclosures normally included in financial statements prepared in accordance with U.S. GAAP have been condensed or omitted. Stock-based compensation expense associated with equity incentive awards issued by the Parent Company and the related tax effects are recorded at the subsidiary level where the employees provide the services. The accompanying condensed financial information should be read in conjunction with the Cotiviti Holdings, Inc. Consolidated Financial Statements and related Notes thereto.

Note 2. Stockholders' Equity

Share Repurchase Program

On October 31, 2017, the Board of Directors approved a share repurchase program under which we may repurchase up to $100,000 of common stock. This authorization permits us to repurchase shares from time to time until October 31, 2018 through a variety of methods, including open market repurchases and in privately negotiated transactions subject to debt covenants and other customary legal, contractual, regulatory and market considerations and may be discontinued at any time. All share repurchases will be implemented in accordance with Rule 10b-18 of the Exchange Act with respect to the timing, pricing and volume of such transactions. There can be no assurance as to the amount, timing or prices of repurchases, which may vary based on market conditions and other factors.

During the year ended December 31, 2017, we repurchased 317,900 shares of our common stock under this share repurchase program for $10,000, at a weighted average share price of $31.43 per share.

Secondary Offerings

On August 7, 2017, we completed a secondary offering of 10,000,000 shares of our common stock by certain of our stockholders at an offering price of $37.00 per share. All of the shares offered were sold by selling stockholders. Accordingly, we did not receive any proceeds from the sale of shares. In connection with this offering, we incurred approximately $700 in professional services expenses, which are included in transaction-related expenses on our Consolidated Statements of Comprehensive Income for the year ended December 31, 2017.

On March 7, 2017, we completed a secondary offering of 9,683,000 shares of our common stock by certain of our stockholders, including 1,263,000 shares sold to the underwriters pursuant to their option to purchase additional shares, at an offering price of $36.00 per share. All of the shares offered were sold by selling stockholders. Accordingly, we did not receive any proceeds from the sale of the shares. In connection with this offering, we incurred approximately $600 in professional services expenses, which are included in transaction-related expenses on our Consolidated Statements of Comprehensive Income for the year ended December 31, 2017.

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Issuance of Common Stock

On May 25, 2016 we consummated our IPO in which we issued and sold a total of 12,936,038 shares of common stock, including a portion of the underwriter overallotment, at a public offering price of $19.00 per share. We received net proceeds of approximately $226,963 after deducting underwriting discounts and commissions and other offering expenses of approximately $18,822.

Common Stock Split

On May 13, 2016 we effected a 6.1-for-1 stock split of all outstanding shares of our common stock. All share, option and per share information presented in the accompanying consolidated financial statements and notes thereto have been adjusted to reflect the stock split on a retroactive basis for all periods presented and all share information is rounded up to the nearest whole share after reflecting the stock split.

Common Stock Dividends

On May 26, 2016 we paid a Special Cash Dividend of $150,000, or $1.94 per share of common stock outstanding prior to the IPO, to holders of record of our common stock on the dividend record date. In connection with the Special Cash Dividend we lowered the exercise price of then outstanding stock options by $1.94 per share in order to preserve the intrinsic value of the options giving effect to the Special Cash Dividend.

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Cotiviti Holdings, Inc.
Schedule II—Valuation and Qualifying Accounts
(in thousands)

Description	Balance at Beginning of Period	Additions: Charged to Operating Expenses	Additions: Provision Charged Against Revenue[a]	Deductions[b]	Balance at End of Period
Year Ended December 31, 2017					
Allowance and estimated liability for refunds and appeals[c]	$ 103,559	$ —	$ 88,874	$ (95,392)	$ 97,041
Allowance for doubtful accounts	851	(295)	—	(380)	176
Year Ended December 31, 2016					
Allowance and estimated liability for refunds and appeals[c]	$ 101,181	$ —	$ 99,472	$ (97,094)	$103,559
Allowance for doubtful accounts	1,053	(147)	—	(55)	851
Year Ended December 31, 2015					
Allowance and estimated liability for refunds and appeals[c]	$ 98,157	$ —	$ 67,702	$ (64,678)	$101,181
Allowance for doubtful accounts	655	804	—	(406)	1,053

(a)

Provision charged against revenue include estimates for refund and appeals liabilities based on actual historical refunds and appeals data by client type, net of any changes to previously estimated amounts.

(b) Deductions related to the allowance and estimated liability for refunds and appeals represent credits or payments provided to our clients to settle the liability. Deductions related to the allowance for doubtful accounts represent write-offs of bad debt expense.

(c) The balance at end of period consists of the estimated allowance for refunds and appeals netted against accounts receivable of $35,434, $41,020 and $33,406 and the estimated liability for refunds and appeals of $61,607, $62,539 and $67,775 as of December 31, 2017, 2016 and 2015, respectively. Refer to the Notes to our Consolidated Financial Statements.

CQ Fluency, Inc.

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CVS Health Corporation (Caremark PCS)

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

☑ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2018

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from _____ to_____
Commission file number 001-01011

CVSHealth

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500

(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

Large accelerated filer ☑ Accelerated filer ☐

Non-accelerated filer ☐ Smaller reporting company ☐

Emerging growth company ☐

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

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $65,262,991,789 as of June 30, 2018 , based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 19, 2019 , the registrant had 1,297,082,165 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Portions of the Annual Report to Stockholders for the fiscal year ended December 31, 2018 (the "Annual Report") are incorporated by reference in response to Items 1, 1A, 2 and 3 of Part I and Items 5, 6, 7, 7A, 8 and 9A of Part II, in each case to the extent described therein.

Information contained in the definitive proxy statement for CVS Health Corporation's 2019 Annual Meeting of Stockholders, to be filed on or about April 5, 2019 (the "Proxy Statement"), is incorporated by reference in response to Items 10 through 14 of Part III to the extent described therein.

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PART I

Item 1. Business

Overview

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45.0 billion of new debt, including senior notes and term loans. For additional information, see Note 2 ''Acquisition of Aetna'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

On October 10, 2018, the Company and Aetna entered into a consent decree with the United States Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. ("WellCare") for the divestiture of Aetna's standalone Medicare Part D prescription drug plans effective December 31, 2018. On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans. Aetna's standalone Medicare Part D prescription drug plans had an aggregate of approximately 2.3 million members as of December 31, 2018 . Aetna will provide administrative services to, and will retain the financial results of, the divested plans through 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

Business Strategy

The combined company expects to transform the consumer health care experience and build healthier communities through a new innovative health care model that is local, easier to use, less expensive and puts consumers at the center of their care. The Company believes that improving the consumer's health care experience will improve consumer engagement with their health which will lead to improved health outcomes and lower total health care costs. The Company believes there are three imperatives to accomplishing this transformation: be local, make it simple and improve health. These imperatives also guide the Company's five key strategies for delivering medical cost savings for its customers: improve common chronic disease management, reduce unnecessary hospital readmissions, improve the efficiency of the sites at which medical members receive care, optimize primary care delivery and improve the Company's complex chronic disease management capabilities.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care ("Managed Medicaid") plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges ("Private Exchanges" and together with Public Exchanges, "Insurance Exchanges"), other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services. During the year ended December 31, 2018, the Company's PBM filled or managed approximately 1.9 billion prescriptions on a 30-day equivalent basis.

PBM Services

The Company dispenses prescription drugs directly through its mail order dispensing and specialty mail order pharmacies and through pharmacies in its retail network. All prescriptions processed by the Company are analyzed, processed and documented by the Company's proprietary prescription management systems. These systems provide essential features and functionality to allow a plan member to utilize their prescription drug benefits. These systems also streamline the process by which prescriptions are processed by staff and network pharmacists by enhancing review of various items through automation, including plan eligibility, early refills, duplicate dispensing, appropriateness of dosage, drug interactions or allergies, over-utilization and potential fraud.

Plan Design Offerings and Administration
The Company administers pharmacy benefit plans for clients who contract with it to facilitate prescription drug coverage and claims processing for their eligible plan members. The Company assists its PBM clients in designing pharmacy benefit plans that help improve health outcomes while minimizing the costs to the client. The Company also assists PBM clients in monitoring the effectiveness of their plans through frequent, informal communications, the use of proprietary software, as well as through formal annual, quarterly and sometimes monthly performance reviews.

The Company makes recommendations to help PBM clients design benefit plans that promote the use of lower cost, clinically appropriate drugs and helps its PBM clients control costs by recommending plan designs that encourage the use of generic equivalents of brand name drugs when such equivalents are available. Clients also have the option, through plan design, to further lower their pharmacy benefit plan costs by setting different member payment levels for different products on their drug lists or "formularies," which helps guide members to choose lower cost alternatives through appropriate financial incentives.

Formulary Management
The Company utilizes an independent panel of doctors, pharmacists and other medical experts, referred to as the CVS Caremark National Pharmacy and Therapeutics Committee, to review and approve the selection of drugs that meet the Company's standards of safety and efficacy for inclusion on one of the Company's template formularies. The Company's formularies provide recommended products in numerous drug classes to help ensure member access to clinically appropriate drugs with alternatives within a class under the client's pharmacy benefit plan, while helping to drive the lowest net cost for clients that select one of the Company's formularies. To help improve clinical outcomes for members and clients, the Company conducts ongoing, independent reviews of all drugs, including, but not limited to, those appearing on the formularies and generic equivalent products. Many of the Company's clients choose to adopt a template formulary offering as part of their plan design. Beginning in 2018, clients had new capabilities to offer real time benefits information for a member's specific plan design, provided digitally at the point of prescribing, at the pharmacy and directly to members.

Retail Pharmacy Network Management Services
The Company maintains a national network of more than 68,000 retail pharmacies, consisting of approximately 41,000 chain pharmacies (which includes CVS Pharmacy locations) and 27,000 independent pharmacies, in the United States, including Puerto Rico, the District of Columbia, Guam and the United States Virgin Islands. When a customer fills a prescription in a retail pharmacy, the pharmacy sends prescription data electronically to the Company from the point-of-sale. This data interfaces with the Company's proprietary prescription management systems, which verify relevant plan member data and eligibility, while also performing a drug utilization review to help evaluate clinical appropriateness and safety and confirming that the pharmacy will receive payment for the prescription. The Company is also able to build client-specific pharmacy networks and

managed pharmacy network solutions to further drive savings for clients. These include a performance-based pharmacy network with approximately 30,000 stores that is anchored by CVS Pharmacy and Walgreens, along with up to 10,000 independent pharmacies across the United States. The performance-based network is designed to deliver unit cost savings and to improve clinical outcomes in order to help to lower overall health care costs for participating payors and their members.

Mail Order Pharmacy Services
The Pharmacy Services segment operates mail order dispensing pharmacies in the United States. Plan members or their prescribers submit prescriptions or refill requests, primarily for maintenance medications, to these pharmacies via mail, telephone, fax, e-prescribing or the Internet, and staff pharmacists review these prescriptions and refill requests with the assistance of the Company's prescription management systems. This review may involve communications with the prescriber and, with the prescriber's approval when required, can result in generic substitution, therapeutic interchange or other actions designed to help reduce cost and/or improve quality of treatment. The Company's mail order dispensing pharmacies have been awarded Mail Order Pharmacy accreditation from Utilization Review Accreditation Commission ("URAC"), a health care accrediting organization that establishes quality standards for the health care industry.

Specialty Pharmacy and Infusion Services
The Pharmacy Services segment operates specialty mail order pharmacies, retail specialty pharmacy stores and branches for infusion and enteral nutrition services in the United States. These specialty mail order pharmacies are used for delivery of advanced medications to individuals with chronic or genetic diseases and disorders. The Company's specialty mail order pharmacies also have been awarded Specialty Pharmacy accreditation from URAC. Substantially all of the Company's mail service specialty mail order pharmacies also have been accredited by the Joint Commission, which is an independent, not-for-profit organization that accredits and certifies health care programs and organizations in the United States.

Medicare Part D Services
The Company participates in the administration of the Medicare Part D prescription drug program through the provision of PBM services to those health plan clients and other clients that have qualified as a PDP or as a Medicare Advantage prescription drug plan and by offering Medicare Part D pharmacy benefits through its SilverScript subsidiary that is a PDP that has contracted with the United States Centers for Medicare & Medicaid Services ("CMS"). The Company also assists employer, union and other health plan clients that qualify for the retiree drug subsidy made available under Medicare Part D by collecting and submitting eligibility and/or drug cost data to CMS in order for such clients to obtain the subsidy and offers Medicare Part D pharmacy benefits to such clients' retirees through Employer Group Waiver Plans ("EGWPs") sponsored by SilverScript.

Clinical Services
The Company offers multiple clinical programs and services to help clients manage overall pharmacy and health care costs in a clinically appropriate manner. These programs are primarily designed to promote better health outcomes, and to help target inappropriate medication utilization and non-adherence to medication, each of which may result in adverse medical events that negatively affect member health and client pharmacy and medical spend. These programs include utilization management ("UM"), medication management, quality assurance, adherence and counseling programs to complement the client's plan design and clinical strategies. To help address the opioid epidemic, the Company introduced an industry-leading UM approach that limits to seven days the supply of opioids dispensed for certain acute prescriptions for patients who are new to therapy; limits the daily dosage of opioids dispensed based on the strength of the opioid; and requires the use of immediate-release formulations of opioids before extended-release opioids are dispensed. The Company's Pharmacy Advisor program facilitates pharmacist counseling, both face-to-face and over the telephone, to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions. The Company also has digital connectivity that helps to lower drug costs for patients by providing expanded visibility to lower cost alternatives through enhanced analytics and data sharing.

Disease Management Programs
The Company's clinical programs and services utilize advanced protocols and offer clients convenience in working with health care providers ("providers") and other third parties. The Company's integrated disease management programs cover diseases such as rheumatoid arthritis, Parkinson's disease, seizure disorders and multiple sclerosis. The majority of these integrated programs are accredited by the National Committee for Quality Assurance ("NCQA"), a private, not-for-profit organization that evaluates, accredits and certifies a wide range of health care organizations.

Medical Benefit Management
The Company's NovoLogix ® online preauthorization tool helps identify and capture cost savings opportunities for specialty drugs billed under the medical benefit by identifying outliers to appropriate dosages and costs, and helps to ensure clinically appropriate use of specialty drugs.

Pharmacy Services Information Systems

The majority of the Pharmacy Services segment's clients have migrated to a single claim adjudication platform. This platform incorporates architecture that centralizes the data generated from filling mail order prescriptions, adjudicating retail pharmacy claims and delivering other solutions to PBM clients. The Health Engagement Engine ® technology and proprietary clinical algorithms help connect the various parts of the enterprise and serve an essential role in cost management and health improvement. This capability transforms pharmacy data into actionable interventions at key points of care such as mail and specialty pharmacists to help provide quality care.

Pharmacy Services Clients

The Company's Pharmacy Services clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans and plans offered on public and private health insurance exchanges, other sponsors of health benefit plans and individuals located throughout the United States. Pharmaceuticals are provided to eligible members in benefit plans maintained by clients and utilize the Company's information systems, among other things, to help perform safety checks, drug interaction screening and identify opportunities for generic substitution. Substantially all of the Pharmacy Services segment's revenue is generated from dispensing and managing prescription drugs to eligible members in benefit plans maintained by clients. In 2018 , 2017 and 2016 , revenues from Aetna accounted for approximately 9.8% , 12.3% and 11.7% , respectively, of the Company's consolidated total revenues. On the Aetna Acquisition Date, Aetna became a wholly-owned subsidiary of CVS Health. Subsequent to the Aetna Acquisition Date, revenues from Aetna will continue to be reported in the Pharmacy Services segment; however, these revenues are eliminated in the consolidated financial statements.

Pharmacy Services Seasonality

The majority of Pharmacy Services segment revenues are not seasonal in nature. However, quarterly earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of PDP membership. The Medicare Part D standard benefit design results in coverage that varies with a member's cumulative annual out-of-pocket costs. The benefit design generally results in employers or other entities that sponsor the Company's products ("plan sponsors") sharing a greater portion of the responsibility for total prescription drug costs in the early part of the year. As a result, the PDP pay percentage or benefit ratio generally decreases and operating income generally increases as the year progresses.

Pharmacy Services Competition

The Company believes the primary competitive factors in the pharmacy services industry include: (i) the ability to negotiate favorable discounts from drug manufacturers as well as to negotiate favorable discounts from, and access to, retail pharmacy networks; (ii) the ability to identify and apply effective cost management programs utilizing clinical strategies, including the development and utilization of preferred formularies; (iii) the ability to market PBM products and services; (iv) the commitment to provide flexible, clinically-oriented services to clients and be responsive to clients' needs; (v) the quality, scope and costs of products and services offered to clients and their members; and (vi) operational excellence in delivering services. The Pharmacy Services segment has a significant number of competitors (e.g., the Express Scripts business of Cigna Corporation, OptumRx, Prime Therapeutics, MedImpact and Humana) offering PBM services, including large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic ® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, the Retail/LTC segment also provided commercialization services under the name RxCrossroads ® . The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, the Retail/LTC segment operated more than 9,900 retail locations, over 1,100 MinuteClinic ® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2018, the Retail/LTC segment filled approximately 1.3 billion prescriptions

on a 30-day equivalent basis. In December 2018, the Company held approximately 26% of the United States retail pharmacy market.

Retail/LTC Products and Services

A typical retail store sells prescription drugs and a wide assortment of high-quality, nationally advertised brand name and proprietary brand merchandise. Front store categories include over-the-counter drugs, beauty products, cosmetics and personal care products. LTC operations include distribution of prescription drugs and related consulting and ancillary services. The Company purchases merchandise from numerous manufacturers and distributors. The Company believes that competitive sources are readily available for substantially all of the products carried in its retail stores and the loss of any one supplier would not likely have a material effect on the Retail/LTC segment. The Company's MinuteClinics offer a variety of health care services.

Retail/LTC revenues by major product group are as follows:

	Percentage of Revenues		
	2018	**2017**	**2016**
Pharmacy [(1)]	76.4%	75.0%	75.0%
Front store and other [(2)]	23.6%	25.0%	25.0%
	100.0%	100.0%	100.0%

(1) Pharmacy includes LTC sales and sales in pharmacies within Target Corporation stores.
(2) "Other" represents less than 5% of the "Front store and other" revenue category.

Pharmacy
Pharmacy revenues represented approximately three-fourths of Retail/LTC segment revenues in each of 2018 , 2017 and 2016 . The Company believes that retail pharmacy operations will continue to represent a critical part of the Company's business due to industry demographics, e.g., an aging American population consuming a greater number of prescription drugs, prescription drugs being used more often as the first line of defense for managing illness, the introduction of new pharmaceutical products, and Medicare Part D growth. The Company believes the retail pharmacy business benefits from investment in both people and technology, as well as innovative collaborations with health plans, PBMs and providers. Given the nature of prescriptions, consumers want their prescriptions filled accurately by professional pharmacists using the latest tools and technology, and ready when promised. Consumers also need medication management programs and better information to help them get the most out of their health care dollars. To assist consumers with these needs, the Company has introduced integrated pharmacy health care services that provide an earlier, easier and more effective approach to engaging consumers in behaviors that can help lower costs, improve health and save lives.

Front Store
Front store revenues reflect the Company's strategy of innovating with new and unique products and services, using innovative personalized marketing and adjusting the mix of merchandise to match customers' needs and preferences. A key component of the front store strategy is the ExtraCare ® card program, which is one of the largest and most successful retail loyalty programs in the United States. The ExtraCare program allows the Company to balance marketing efforts so it can reward its best customers by providing them with automatic sale prices, customized coupons, ExtraBucks ® rewards and other benefits. The Company continues to launch and enhance new and exclusive brands to create unmatched offerings in beauty products and deliver other unique product offerings, including a full range of high-quality CVS Health and other proprietary brand products that are only available through CVS stores. The Company currently carries approximately 7,000 CVS Health and proprietary brand products, which accounted for approximately 23% of front store revenues during 2018 .

MinuteClinic
As of December 31, 2018 , the Company operated approximately 1,100 MinuteClinic ® locations in the United States. The clinics are staffed by nurse practitioners and physician assistants who utilize nationally established guidelines to deliver a variety of health care services. Payors value these clinics because they provide convenient, high-quality, cost-effective care, in many cases offering an attractive alternative to more expensive sites of care. As a result, visits paid for by employers, health insurers or other third parties accounted for approximately 91% of MinuteClinic's total revenues in 2018 . MinuteClinic is collaborating with the Pharmacy Services and Health Care Benefits segments to help meet the needs of CVS Caremark's client plan members and the Company's health plan members by offering programs that can improve member health and lower costs.

MinuteClinic is now affiliated with more than 75 major health systems and continues to build a platform that supports primary care.

Long-term Care Pharmacy Operations
The Retail/LTC segment provides LTC pharmacy services through the Omnicare business. Omnicare's customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. The Company provides pharmacy consulting, including monthly patient drug therapy evaluations, to assist in compliance with state and federal regulations and provide proprietary clinical and health management programs. It also provides pharmaceutical case management services for retirees, employees and dependents who have drug benefits under corporate-sponsored health care programs.

Onsite Pharmacies
The Company also operates a limited number of pharmacies located at client sites, which provide certain health plan members and customers with a convenient alternative for filling their prescriptions.

Retail Store Development

The addition of new retail locations has played, and will continue to play, a key role in the Company's continued growth and success. The Company's store development program focuses on three areas: entering new markets, adding stores within existing markets and relocating stores to more convenient sites. During 2018 , the Company opened 145 new retail locations, relocated approximately 35 stores and closed approximately 30 locations. During the last five years, the Company opened approximately 900 new and relocated locations, and acquired approximately 1,825 locations, including the pharmacies acquired from Target Corporation ("Target") in 2015. The Company believes that continuing to grow its store base appropriately and locate retail stores in more accessible markets are essential components of competing effectively in the current health care environment. As a result, the Company believes that its store development program is an integral part of its ability to meet the needs of customers and maintain its leadership position in the retail pharmacy market given the changing health care landscape.

Retail/LTC Information Systems

The Company has continued to invest in information systems to enable it to deliver exceptional customer service, enhance safety and quality, and expand patient care services while lowering operating costs. The proprietary WeCARE Workflow supports pharmacy teams by prioritizing work to meet customer expectations, facilitating prescriber outreach, and seamlessly integrating clinical programs. This solution delivers improved efficiency and enhances the customer experience, as well as providing a framework to accommodate the evolution of pharmacy practice and the expansion of clinical programs. The Health Engagement Engine technology and proprietary clinical algorithms enable the Company to help identify opportunities for pharmacists to deliver face-to-face counseling regarding patient health and safety matters, including adherence issues, gaps in care and management of certain chronic health conditions. The Company's digital strategy is to empower the consumer to navigate their pharmacy experience and manage their condition through integrated online and mobile solutions that offer utility and convenience. The Company's LTC digital technology suite, Omniview ®, improves the efficiency of customers' operations with tools that include executive dashboards, pre-admission pricing, electronic ordering of prescription refills, proof-of-delivery tracking, access to patient profiles, receipt and management of facility bills, and real-time validation of Medicare Part D coverage, among other capabilities.

Retail/LTC Customers

The success of the Retail/LTC segment's businesses is dependent upon the Company's ability to establish and maintain contractual relationships with pharmacy benefit managers and other payors on acceptable terms. Pharmacy benefit managers, managed care organizations, government funded health care programs, commercial employers and other third party payors accounted for 99.5% of the Retail/LTC segment's pharmacy revenues. No single Retail/LTC payor accounted for 10% or more of the Company's consolidated total revenues in 2018 , 2017 or 2016 .

Retail/LTC Seasonality

The majority of Retail/LTC segment revenues, particularly pharmacy revenues, generally are not seasonal in nature. However, front store revenues tend to be higher during the December holiday season. In addition, both pharmacy and front store revenues are affected by the timing and severity of the cough, cold and flu season. Uncharacteristic or extreme weather conditions also can adversely affect consumer shopping patterns and Retail/LTC revenues, expenses and results of operations.

Retail/LTC Competition

The retail drugstore business is highly competitive. The Company believes that it competes principally on the basis of: (i) store location and convenience, (ii) customer service and satisfaction, (iii) product selection and variety, and (iv) price. In the markets it serves, the Company competes with other drugstore chains (e.g., Walgreens and Rite Aid), supermarkets, discount retailers (e.g., Wal-Mart), independent pharmacies, restrictive pharmacy networks, membership clubs, Internet companies, and retail health clinics (including urgent care centers), as well as mail order dispersing pharmacies.

LTC pharmacy services are highly regional or local in nature, and within a given geographic area of operation, highly competitive. The Company's largest LTC pharmacy competitor nationally is PharMerica. The Company also competes with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Some states have enacted "freedom of choice" or "any willing provider" requirements as part of their state Medicaid programs or in separate legislation, which may increase the competition that the Company faces in providing services to long-term care facility residents in these states.

References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018 . The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology ("HIT") products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers, governmental units, government-sponsored plans, labor groups and expatriates.

Health Care Benefits Products and Services

The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC." Health Care Benefits products and services consist of the following:

- *Commercial Medical* : The Health Care Benefits segment offers point-of-service ("POS"), preferred provider organization ("PPO"), health maintenance organization ("HMO") and indemnity benefit ("Indemnity") plans. Commercial medical products also include health savings accounts ("HSAs") and consumer-directed health plans that combine traditional POS or PPO and/or dental coverage, subject to a deductible, with an accumulating benefit account (which may be funded by the plan sponsor and/or the member in the case of HSAs). Principal products and services are targeted specifically to large multi-site national, mid-sized and small employers, individual insureds and expatriates. The Company offers medical stop loss insurance coverage for certain employers who elect to self-insure their health benefits. Under this product, the Company assumes risk for costs associated with large individual claims and/or aggregate loss experience within an employer's plan above a pre-set annual threshold.
- *Government Medical* : In select geographies, the Health Care Benefits segment offers Medicare Advantage plans, Medicare Supplement plans and prescription drug coverage for Medicare beneficiaries; participates in Medicaid and subsidized Children's Health Insurance Programs ("CHIP"); and participates in demonstration projects for members who are eligible for both Medicare and Medicaid ("Duals"). These Government Medical products are further described below:
    - *Medicare Advantage and PDP:* Through annual contracts with CMS, the Company offers HMO and PPO products for eligible individuals in certain geographic areas through the Medicare Advantage program. Members typically receive enhanced benefits over traditional fee-for-service Medicare coverage ("Original Medicare"), including reduced cost-sharing for preventive care, vision and other services. The Company offered network-based HMO and/or PPO plans in 1,317 counties in 40 states and Washington, D.C. in 2018 . The Company has expanded to 1,416 counties in 45 states and Washington, D.C. for 2019 . The Company is a national provider of drug benefits under the Medicare Part D prescription drug program to both individuals and EGWPs. All Medicare eligible individuals are eligible to participate in this voluntary prescription drug plan. Members typically receive

coverage for certain prescription drugs, usually subject to a deductible, co-insurance and/or co-payment. On November 30, 2018, Aetna completed the sale of all of its standalone Medicare Part D prescription drug plans to WellCare effective on December 31, 2018. Aetna will provide administrative services to, and retain the financial results of, the divested plans through 2019. For certain qualifying employer groups, the Company offers Medicare PPO products nationally. When combined with the Company's PDP product, these national PPO plans form an integrated national Insured Medicare product for employers that provides medical and pharmacy benefits.

- *Medicare Supplement:* For certain Medicare eligible members, the Company offers supplemental coverage for certain health care costs not covered by Original Medicare. The products included in the Medicare Supplement portfolio help to cover some of the gaps in Original Medicare, and include coverage for Medicare deductibles and coinsurance amounts. The Company offered a wide selection of Medicare Supplement products in 49 states and Washington, D.C. in 2018 .
- *Medicaid and CHIP:* The Company offers health care management services to individuals eligible for Medicaid and CHIP under multi-year contracts with government agencies in various states that are subject to annual appropriations. CHIP are state-subsidized insurance programs that provide benefits for families with uninsured children. The Company offered these services on an Insured or ASC basis in 16 states in 2018 .
- *Duals:* The Company provides health coverage to beneficiaries who are dually eligible for both Medicare and Medicaid coverage. These members must meet certain income and resource requirements in order to qualify for this coverage. The Company coordinates 100% of the care for these members and may provide them with additional services in order to manage their health care costs. During 2018 , the Company offered services on an Insured basis to Duals in four states under demonstration projects.

- *Pharmacy* : The Company offers PBM services and specialty and home delivery pharmacy services. The Company also performs various PBM services for Aetna pharmacy customers consisting of: product development, Commercial formulary management, pharmacy rebate contracting and administration, sales and account management and precertification programs. The Pharmacy Services segment performs the administration of selected functions for retail pharmacy network contracting and claims administration; home delivery and specialty pharmacy order fulfillment and inventory purchasing and management; and certain administrative services. Other suppliers also provide certain PBM services.
- *Specialty* : The Health Care Benefits segment has a portfolio of additional health products and services that complement its medical products such as dental plans, behavioral health and employee assistance products, provider network access and vision products and workers' compensation administrative services.
- *Consumer Health Products and Services* : The Company has a portfolio of products and services aimed at creating a holistic and integrated approach to individual health and wellness. These products and services complement the Commercial Medical and Government Medical products and enable enhanced delivery to and experience for customers.

Health Care Benefits Provider Networks

The Company contracts with physicians, hospitals and other providers for services they provide to members. The Company uses a variety of techniques designed to help encourage appropriate utilization of medical services ("utilization") and maintain affordability of quality coverage. In addition to contracts with providers for negotiated rates of reimbursement, these techniques include creating risk sharing arrangements that align economic incentives with providers, the development and implementation of guidelines for the appropriate utilization of medical services and the provision of data to providers to enable them to improve health care quality. At December 31, 2018 , the Company's underlying nationwide provider network had approximately 1.3 million participating providers, including over 697 thousand primary care and specialist physicians and approximately 5,700 hospitals. Other providers in the Company's provider networks also include laboratory, imaging, urgent care and other freestanding health facilities.

Health Care Benefits Quality Assessment

CMS uses a 5-star rating system to monitor Medicare health care and drug plans and ensure that they meet CMS's quality standards. CMS uses this rating system to provide Medicare beneficiaries with a tool that they can use to compare the overall quality of care and level of customer service of companies that provide Medicare health care and drug plans. The rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management and overall customer satisfaction. See "Health Care Benefits Pricing" below in this Item 1 for further discussion of star ratings. The Company seeks Health Plan accreditation for Aetna HMO plans from the NCQA. Health care plans seeking accreditation must pass a rigorous, comprehensive review and must annually report on their performance.

Aetna Life Insurance Company ("ALIC"), a wholly-owned subsidiary of the Company, has received nationwide NCQA PPO Health Plan accreditation. As of December 31, 2018 , all of the Company's Commercial HMO and all of ALIC's PPO members who were eligible participated in HMOs or PPOs that are accredited by the NCQA.

The Company's provider selection and credentialing/re-credentialing policies and procedures are consistent with NCQA and URAC, as well as state and federal, requirements. In addition, the Company is certified under the NCQA Credentials Verification Organization ("CVO") certification program for all certification options and has URAC CVO accreditation.

Quality assessment programs for contracted providers who participate in the Company's networks begin with the initial review of health care practitioners. Practitioners' licenses and education are verified, and their work history is collected by the Company or in some cases by the practitioner's affiliated group or organization. The Company generally requires participating hospitals to be certified by CMS or accredited by the Joint Commission, the American Osteopathic Association, or Det Norske Veritas Healthcare.

The Company also offers quality and outcome measurement programs, quality improvement programs, and health care data analysis systems to providers and purchasers of health care services.

Health Care Benefits Information Systems

The Health Care Benefits segment currently operates and supports an end to end suite of information technology platforms to support member engagement, enrollment, health benefit administration, care management, service operations, financial reporting and analytics. The multiple platforms are supported by an integration layer to facilitate the transfer of real-time data. There is continued focus and investment in digital products to offer innovative solutions and a seamless experience to the Company's members through mobile and web channels. Capabilities available to members include digital wallet, provider search, cost transparency and behavioral monitoring. The Health Care Benefits segment care management solution supports the Company's clinicians with data and recommendations. The Company continues to scale its clinical platform and its local personalized care model. The Company aims to build an integrated 360 degree view of the member to ensure that it can guide them through their healthcare journey and provide them a high level of service. Through its analytics platform the Company is beginning to harness the power of data to help drive healthier outcomes and proactive care and enable consumers to take the next best action for their health.

Health Care Benefits Customers

Medical membership is dispersed throughout the United States, and the Company also serves medical members in certain countries outside the United States. See Note 17 ''Segment Reporting'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein, for additional information on foreign customers. The Company offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, many of which are available nationwide. Depending on the product, the Company markets to a range of customers including employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans, labor groups and expatriates.

The following table presents total medical membership by United States and other geographic region and funding arrangement at December 31, 2018 :

In thousands	**Insured**	**ASC**	**Total**
Northeast	1,961	3,232	5,193
Southeast	1,752	2,886	4,638
Mid-America	1,632	2,530	4,162
West	1,618	4,510	6,128
Other	587	1,393	1,980
Total medical membership	7,550	14,551	22,101

For additional information on medical membership, see the caption "Management's Discussion and Analysis of Financial Condition and Results of Operations — Health Care Benefits Segment" in the Annual Report, which section is incorporated by reference herein.

The Company markets both Commercial Insured and ASC products and services primarily to employers that sponsor the Company's products for the benefit of their employees and their employees' dependents. Frequently, larger employers offer employees a choice among coverage options, from which the employee makes his or her selection during a designated annual open enrollment period. Typically, employers pay all of the monthly premiums to the Company and, through payroll deductions, obtain reimbursement from employees for a percentage of the premiums that is determined by each employer. Some Health Care Benefits products are sold directly to employees of employer groups on a fully employee-funded basis. In some cases, the Company bills the covered individual directly.

The Company offers Insured Medicare coverage on an individual basis as well as through employer groups to their retirees. Medicaid and CHIP members are enrolled on an individual basis. The Company also offers Insured health care coverage to members who are dually-eligible for both Medicare and Medicaid.

Health Care Benefits products are sold through the Company's sales personnel; through independent brokers, agents and consultants who assist in the production and servicing of business; and Private Exchanges. For large plan sponsors, independent consultants and brokers are frequently involved in employer health plan selection decisions and sales. In some instances, the Company may pay commissions, fees and other amounts to brokers, agents, consultants and sales representatives who place business with the Company. In certain cases, the customer pays the broker for services rendered, and the Company may facilitate that arrangement by collecting the funds from the customer and transmitting them to the broker. The Company supports marketing and sales efforts with an advertising program that may include television, radio, billboards, print media and social media, supplemented by market research and direct marketing efforts.

The United States federal government is a significant customer of the Health Care Benefits segment through contracts with CMS for coverage of Medicare-eligible individuals, federal employee-related benefit programs and Medicaid products and services. Other than the contracts with CMS, the Health Care Benefits segment is not dependent upon a single customer or a few customers the loss of which would have a significant effect on the earnings of the segment. The loss of business from any one, or a few, independent brokers or agents would not have a material adverse effect on the earnings of the Health Care Benefits segment. For additional information, see Note 17 ''Segment Reporting'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Health Care Benefits Pricing

For Commercial Insured plans, contracts containing the pricing and other terms of the relationship are generally established in advance of the policy period and typically have a duration of one year. Fees under ASC plans are generally fixed for a period of one year.

Generally, a fixed premium rate is determined at the beginning of the policy period for Commercial Insured plans. The Company typically cannot recover unanticipated increases in health care and other benefit costs in the current policy period; however, it may consider prior experience for a product in the aggregate or for a specific customer, among other factors, in determining premium rates for future policy periods. Where required by state laws, premium rates are filed and approved by state regulators prior to contract inception. Future results of operations could be adversely affected if the premium rates requested are not approved or are adjusted downward or their approval is delayed by state or federal regulators.

The Company has Medicare Advantage and PDP contracts with CMS to provide HMO, PPO and prescription drug coverage to Medicare beneficiaries in certain geographic areas. Under these annual contracts, CMS pays the Company a fixed capitation payment and/or a portion of the premium, both of which are based on membership and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed capitation payment or premium. PDP contracts also provide a risk-sharing arrangement with CMS to limit the Company's exposure to unfavorable expenses or benefit from favorable expenses. Amounts payable to the Company under the Medicare arrangements are subject to annual revision by CMS, and the Company elects to participate in each Medicare service area or region on an annual basis. Premiums paid to the Company for Medicare products are subject to federal government reviews and audits, which can result, and have resulted, in retroactive and prospective premium adjustments and refunds to the government and/or members. In addition to payments received from CMS, some of Medicare Advantage products and all PDP products require a supplemental premium to be paid by the member or sponsoring employer. In some cases these supplemental premiums are adjusted based on the member's income and asset levels. Compared to Commercial Medical products, Medicare contracts generate higher per member per month revenues and health care and other benefit costs.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the "ACA") ties a portion of each Medicare Advantage plan's reimbursement to the plan's "star ratings." Since 2015, plans must have a star rating of four or higher (out of five) to qualify for a quality bonus in their basic premium rates. CMS released 2019

star ratings in October 2018. The 2019 star ratings will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on membership at December 31, 2018 , 79% of the Company's Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars.

Rates for Medicare Supplement products are regulated at the state level and vary by state and plan.

Under Insured Medicaid contracts, state government agencies pay the Company fixed monthly rates per member that vary by state, line of business and demographics; and the Company arranges, pays for and manages the health care services provided to Medicaid beneficiaries. These rates are subject to change by each state, and, in some instances, provide for adjustment for health risk factors. CMS requires these rates to be actuarially sound. The Company also receives fees from customers where it provides services under ASC Medicaid contracts. ASC Medicaid contracts generally are for periods of more than one year, and certain of them contain performance incentives and limited financial risk sharing with respect to certain medical, financial and operational metrics. Under these arrangements, performance is evaluated annually, with associated financial incentive opportunities, and financial risk share obligations are typically limited to a percentage of the fees otherwise payable to the Company. Payments to the Company under Medicaid contracts are subject to the annual appropriation process in the applicable state.

Under Duals contracts, the rate setting process is generally established by CMS in partnership with the state government agency participating in the demonstration project. Both CMS and the state government agency may seek premium and other refunds under certain circumstances, including if the Company fails to comply with CMS regulations or other contractual requirements.

The Company offers HMO and consumer-directed medical and dental plans to federal employees under the Federal Employees Health Benefits ("FEHB") Program and the Federal Employees Dental and Vision Insurance Program. Premium rates and fees for those plans are subject to federal government review and audit, which can result, and have resulted, in retroactive and prospective premium and fee adjustments and refunds to the government and/or members.

Beginning in 2014, the ACA imposed significant new industry-wide fees, assessments and taxes, including an annual levy called the Health Insurer Fee (the "HIF"). In December 2015, the Consolidated Appropriation Act was enacted, which included a one year suspension of the HIF for 2017. In January 2018, the HIF was suspended for 2019. For additional information on the ACA fees, assessments and taxes, see Note 1 ''Significant Accounting Policies'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein. The Company's goal is to collect in premiums and fees where possible, or solve for all of these ACA-related fees, assessments and taxes.

Health Care Benefits Seasonality

The majority of Health Care Benefits segment revenues are not seasonal in nature. However, the Health Care Benefits segment's quarterly operating income progression is impacted by (i) the seasonality of benefit costs which generally increase during the year as Insured members progress through their annual deductibles and out-of-pocket expense limits and (ii) the seasonality of operating expenses which are generally the highest during the fourth quarter due to increased marketing spending associated with Medicare annual enrollment. As a result, the Health Care Benefits segment's operating income generally is the highest in the first quarter of the year and lowest in the fourth quarter of the year.

Health Care Benefits Competition

The health care benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, competitors' marketing and pricing and a proliferation of competing products, including new products that are continually being introduced into the marketplace. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Public and Private Exchanges, and the increased use of technology to interact with members, providers and customers, increase the risks currently faced from new entrants and disruptive actions by existing competitors compared to prior periods. References to competitors and other companies throughout this Annual Report on Form 10-K, including the information incorporated by reference herein, are for illustrative or comparison purposes only and do not indicate that these companies are the Company's or any segment's only competitors or closest competitors.

The Company believes that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), quality of service, comprehensiveness of coverage, cost (including premium rates, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of

provider networks, ability to offer different provider network options, providers available in such networks, and quality of member support and care management programs. The Company believes that it is competitive on each of these factors. The Company's ability to increase the number of persons covered by its health plans or to increase Health Care Benefits segment revenues is affected by its ability to differentiate itself from its competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Insured products compete with local and regional health care benefits plans, health care benefits and other plans sponsored by other large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The largest competitor in Medicare products is Original Medicare. Additional Health Care Benefits segment competitors include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), third party administrators ("TPAs"), HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefits plans, technology companies, provider-owned health plans, new joint ventures (including not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, and consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. The Company's ability to increase the number of persons enrolled in Insured Commercial Medical products also is affected by the desire and ability of employers to self-fund their health coverage.

The Health Care Benefits segment's ASC plans compete primarily with other large commercial health care benefit companies, numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association and TPAs.

The Health Care Benefits segment's international products compete with local, global and United States based health plans and commercial health care benefit insurance companies, many of whom have a longer operating history and better brand recognition and greater marketplace presence in one or more geographies.

The provider solutions and HIT marketplaces and products are evolving rapidly. The Company competes for provider solutions and HIT business with other large health plans and commercial health care benefit insurance companies as well as information technology companies and companies that specialize in provider solutions and HIT. Many information technology product competitors have longer operating histories, better brand recognition, greater marketplace presence and more experience in developing innovative products.

In addition to competitive pressures affecting the Company's ability to obtain new customers or retain existing customers, the Health Care Benefits segment's medical membership has been and may continue to be adversely affected by adverse and/or uncertain economic conditions and reductions in workforce by existing customers due to adverse and/or uncertain general economic conditions, especially in the United States and industries where such membership is concentrated.

Health Care Benefits Reinsurance

The Company currently has several reinsurance agreements with non-affiliated insurers that relate to Health Care Benefits insurance policies. The Company entered into these contracts to reduce the risk of catastrophic losses which in turn reduces capital and surplus requirements. The Company frequently evaluates reinsurance opportunities and refines its reinsurance and risk management strategies on a regular basis.

Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Generic Sourcing Venture

The Company and Cardinal Health, Inc. ("Cardinal") each have a 50% ownership in Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak. Red Oak does not own or hold inventory on behalf of either company.

Working Capital Practices

The Company funds the growth of its businesses through a combination of cash flow from operations, commercial paper and other short-term borrowings, proceeds from sale-leaseback transactions and long-term borrowings. For additional information on the Company's working capital practices, see the caption "Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources" in the Annual Report, which section is incorporated by reference herein. The majority of the Retail/LTC segment non-pharmacy revenues are paid in cash, or with debit or credit cards. Managed care organizations, pharmacy benefit managers, government funded health care programs, commercial employers and other third party insurance programs, which represent the vast majority of the Company's consolidated pharmacy revenues, typically settle in less than 30 days. With the exception of the Medicare Part D services, described further below, the remainder of the Company's consolidated pharmacy revenues are paid in cash, or with debit or credit cards. Employer groups, individuals, college students, part-time and hourly workers, health plans, providers, governmental units, government-sponsored plans (with the exception of Medicare Part D services, which are described below), labor groups and expatriates, which represent the vast majority of Health Care Benefits segment revenues, typically settle in less than 30 days. As a provider of Medicare Part D services, the Company contracts annually with CMS. Utilization of services each plan year results in the accumulation of either a receivable from or a payable to CMS. The timing of settlement of the receivable or payable with CMS takes several quarters which impacts working capital from year to year.

Colleague Development

As of December 31, 2018 , the Company employed approximately 295,000 colleagues in 50 states, the District of Columbia, Puerto Rico and a number of countries outside the United States. To deliver the highest levels of service to customers, the Company devotes considerable time and attention to its people and service standards. The Company emphasizes attracting and training knowledgeable, friendly and helpful associates to work in the organization.

Intellectual Property

The Company has registered and/or applied to register a variety of trademarks and service marks used throughout its businesses, as well as domain names, and relies on a combination of copyright, patent, trademark and trade secret laws, in addition to contractual restrictions, to establish and protect the Company's proprietary rights. The Company regards its intellectual property as having significant value in the Pharmacy Services, Retail/LTC and Health Care Benefits segments. The Company is not aware of any facts that could materially impact the continuing use of any of its intellectual property.

Government Regulation

Overview

The Company's operations are subject to comprehensive federal, state and local laws and regulations and comparable multiple levels of international regulation in the jurisdictions in which it does business. There also continues to be a heightened level of review and/or audit by federal, state and international regulators of the health and related benefits industry's business and reporting practices. In addition, many of the Company's PBM clients and the Company's payors in the Retail/LTC Segment, including insurers, Medicare Part D plans, Managed Medicaid plans and managed care organizations ("MCOs"), are themselves subject to extensive regulations that affect the design and implementation of prescription drug benefit plans that they sponsor. Similarly, the Company's LTC clients, such as skilled nursing facilities, are subject to government regulations, including many of the same government regulations to which the Company is subject.

The laws and rules governing the Company's businesses and interpretations of those laws and rules continue to expand and become more restrictive each year and are subject to frequent change. The application of these complex legal and regulatory requirements to the detailed operation of the Company's businesses creates areas of uncertainty. Further, there are numerous proposed health care laws and regulations at the federal, state and international levels, some of which could adversely affect the Company's businesses if they are enacted. The Company cannot predict whether pending or future federal or state legislation or

court proceedings, including future United States Congressional appropriations, will change various aspects of the industries in which it operates or the health care industry generally or the impact those changes will have on the Company's businesses, results of operations and/or cash flows, but the effects could be materially adverse. Any failure or alleged failure to comply with applicable laws and regulations as summarized below, or any adverse applications or interpretations of, or changes in, the laws and regulations affecting the Company and/or its businesses, could have a material adverse effect on the Company's results of operations, financial condition and/or cash flows. See Item 3, "Legal Proceedings" for further information.

The Company cannot give any assurances that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that it will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in this Government Regulation section, as they may relate to one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which it operates and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in other pending or future legal proceedings against the Company or affecting one or more of the industries in which it operates and/or the health care industry generally.

Laws and Regulations Related to Multiple Segments of the Company's Business

Laws Related to Reimbursement by Government Programs - The Company is subject to various federal and state laws concerning its submission of claims for reimbursement by Medicare, Medicaid and other federal and state government-sponsored health care programs. Potential sanctions for violating these laws include recoupment or reduction of government reimbursement amounts, civil penalties, treble damages, and exclusion from participation in government health care programs. Such laws include the federal False Claims Act (the "False Claims Act"), the federal anti-kickback statute, state false claims acts and anti-kickback statutes in most states, the federal "Stark Law" and related state laws. In particular, the False Claims Act prohibits intentionally submitting, conspiring to submit, or causing to be submitted, false claims, records, or statements to the federal government, or intentionally failing to return overpayments, in connection with reimbursement by federal government programs. In addition, any claim for government reimbursement also violates the False Claims Act where it results from a violation of the federal anti-kickback statute.

Both federal and state false claims laws permit private individuals to file qui tam or "whistleblower" lawsuits on behalf of the federal or state government. Participants in the health and related benefits industry, including the Company, frequently are subject to actions under the False Claims Act or similar state laws. The federal Stark Law generally prohibits physicians from referring Medicare or Medicaid beneficiaries for certain services, including outpatient prescription drugs, to any entity with which the physician, or an immediate family member of the physician, has a financial relationship. The Stark Law further prohibits the entity receiving a prohibited referral from presenting a claim for reimbursement by Medicare or Medicaid for services furnished pursuant to the prohibited referral. Various states have enacted similar laws.

The ACA - The ACA made broad-based changes to the United States health care system. If the ACA is not further amended, repealed or replaced, certain of its components will continue to be phased in until 2022. While the Company anticipates continued efforts in 2019 and beyond to invalidate, modify, repeal or replace the ACA, the Company expects aspects of the ACA to continue to significantly impact its business operations and results of operations, including pricing, medical benefit ratios ("MBRs") and the geographies in which the Company's products are available.

While most of the significant aspects of the ACA became effective during or prior to 2014, parts of the ACA continue to evolve through the promulgation of executive orders, regulations and guidance as well as ongoing litigation. Additional changes to the ACA and those regulations and guidance at the federal and/or state level are likely, and those changes are likely to be significant. Growing federal and state budgetary pressures make it more likely that any changes, including changes at the state level in response to changes to, or invalidation, repeal or replacement of, the ACA and/or changes in the funding levels and/or payment mechanisms of federally supported benefit programs, will be adverse to us. For example, if any elements of the ACA are invalidated or repealed at the federal level, the Company expects that some states would seek to enact similar requirements, such as prohibiting pre-existing condition exclusions, prohibiting rescission of insurance coverage, requiring coverage for dependents up to age 26, requiring guaranteed renewability of insurance coverage and prohibiting lifetime limits on insurance coverage.

The expansion of health care coverage contemplated by the ACA is being funded in part by reductions to the reimbursements the Company and other health plans are paid by the federal government for Medicare members, among other sources. While not all-inclusive, the following are some of the key provisions of the ACA (assuming it continues to be implemented in its current form) that become effective on or after January 1, 2019. The Company continues to evaluate these provisions and the related regulations and regulatory guidance to determine the impact that they will have on its business operations and results of operations:

- The imposition on the Company and other health insurers, health plans and other market participants of significant fees, assessments and taxes, including an annual non-tax deductible industry-wide HIF that was $14.3 billion for 2018 and has been suspended for 2019. As currently enacted, the HIF will apply for 2020, be higher for 2020 than for 2018 and increase in 2021 and annually thereafter.
- A non-tax deductible 40% excise tax on employer-sponsored health care benefits above a certain threshold beginning in 2022.
- Reduced funding for Medicaid expansion, which began in 2017.

The ACA also specifies minimum medical loss ratios ("MLRs") for Commercial and Medicare Insured products, specifies features required to be included in Commercial benefit designs, limits Commercial individual and small group rating and pricing practices, encourages additional competition (including potential incentives for new market entrants) and significantly increases federal and state oversight of health plans, including regulations and processes that could delay or limit the Company's ability to appropriately increase its health plan premium rates. This in turn could adversely affect the Company's ability to continue to participate in certain product lines and/or geographies that it serves today.

Potential repeal of the ACA, ongoing legislative, regulatory and administrative policy changes to the ACA, the results of congressional and state level elections, the December 2018 U.S. District Court decision invalidating the ACA and other pending litigation challenging aspects of the law or funding for the law and federal budget negotiations continue to create uncertainty about the ultimate impact of the ACA. The pending litigation challenging the ACA includes challenges by various states of the federal government's decision to curtail payments related to the Cost-Sharing Subsidy Program. The time frame for conclusion and final outcome and ultimate impact of this litigation are uncertain. Given the inherent difficulty of foreseeing the nature and scope of future changes to the ACA and how states, businesses and individuals will respond to those changes, the Company cannot predict the impact on it of future changes to the ACA. It is reasonably possible that invalidation, repeal or replacement of or other changes to the ACA and/or states' responses to such changes, in the aggregate, could have a significant adverse effect on the Company's businesses, results of operations and cash flows.

Medicare Regulation - The Company's Medicare Advantage products compete directly with Original Medicare and Medicare Advantage products offered by other Medicare Advantage organizations and Medicare Supplement products offered by other insurers. The Company's Medicare PDP and Medicare Supplement products are products that Medicare beneficiaries who are enrolled in Original Medicare purchase to enhance their Original Medicare coverage.

The Company continues to expand the number of counties in which it offers Medicare products. The Company expects to further expand its Medicare service area and products in 2019 and is seeking to substantially grow its Medicare membership, revenue and results of operations over the next several years, including through growth in Medicare Supplement products. The anticipated organic expansion of the Medicare service area and Medicare products offered and the Medicare-related provisions of the ACA significantly increase the Company's exposure to funding and regulation of, and changes in government policy with respect to and/or funding or regulation of, the various Medicare programs in which the Company participates, including changes in the amounts payable to us under those programs and/or new reforms or surcharges on existing programs. For example, since the 2014 contract year, the ACA has required minimum MLRs for Medicare Advantage and Medicare Part D plans of 85%. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage contract pays rebates for five consecutive years, it will be terminated by CMS.

The Company's Medicare Advantage and PDP products are heavily regulated by CMS. The regulations and contractual requirements applicable to the Company and other private participants in Medicare programs are complex, expensive to comply with and subject to change. For example, in the second quarter of 2014, CMS issued a final rule implementing the ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. The precise interpretation, impact and legality of this rule are not clear and are subject to pending litigation. Payments the Company receives from CMS for its Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals enrolled. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the Office of Inspector General ("OIG") and CMS itself. Substantial changes in the risk adjustment mechanism, including changes

that result from enforcement or audit actions, could materially affect the fairness of the Company's Medicare reimbursement, require the Company to raise prices or reduce the benefits offered to Medicare beneficiaries, and potentially limit the Company's (and the industry's) participation in the Medicare program.

The Company has invested significant resources to comply with Medicare standards, and its Medicare compliance efforts will continue to require significant resources. CMS may seek premium and other refunds, prohibit the Company from continuing to market and/or enroll members in or refuse to passively enroll members in one or more of the Company's Medicare or Medicare-Medicaid demonstration (historically known as "dual eligible") plans, exclude us from participating in one or more Medicare, dual eligible or dual eligible special needs plan programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS regulations or its Medicare contractual requirements. The Company's Medicare Supplement products are regulated at the state level.

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare Advantage and PDP beneficiaries. For example, CMS currently conducts risk adjustment data validation ("RADV") audits of a subset of Medicare Advantage contracts for each contract year. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. The OIG also is auditing the Company's risk adjustment data and that of other companies, and the Company expects CMS and the OIG to continue auditing risk adjustment data. The Company also has received Civil Investigative Demands ("CIDs") from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of its patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012, CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. The Company is evaluating the potential adverse effect, which could be material, on the Company's results of operations, financial condition, and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year.

A portion of each Medicare Advantage plan's reimbursement is tied to the plan's "star ratings." The star rating system considers a variety of measures adopted by CMS, including quality of preventative services, chronic illness management, compliance and overall customer satisfaction. Only Medicare Advantage plans with an overall star rating of four or more stars (out of five stars) are eligible for a quality bonus in their basic premium rates. As a result, the Company's Medicare Advantage plans' results of operations in 2019 and going forward will be significantly affected by their star ratings. The Company's star ratings and past performance scores are adversely affected by the compliance issues that arise each year in its Medicare operations. CMS released the Company's 2019 star ratings in October 2018. The Company's 2019 star ratings will be used to determine which of its Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2020. Based on the Company's membership at December 31, 2018, 79% of its Medicare Advantage members were in plans with 2019 star ratings of at least 4.0 stars. CMS will release updated stars ratings in October 2019 that will be used to determine which Medicare Advantage plans have ratings of four stars or higher and qualify for bonus payments in 2021. CMS also gives PDPs star ratings which affect PDP's enrollment and result in contract termination if the PDP is rated less than three stars for three consecutive years. CMS continues to revise its star ratings system to make it harder to achieve four stars or more. Despite the Company's success in maintaining high star ratings and other quality measures for 2019 and the continuation of its improvement efforts, there can be no assurances that it will be successful in maintaining or improving its star ratings in future years. Accordingly, the Company's Medicare Advantage plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

Overall, the Company projects the benchmark payment rates in CMS's April 2018 final notice detailing final Medicare Advantage benchmark payment rates for 2019 (the "Final Notice") will increase funding for the Company's Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only partially offsets the challenge the Company faces from the impact of the increasing cost of medical care (including prescription medications) and CMS local and national coverage decisions that require the Company to pay for services and supplies that are not factored into the Company's bids. The federal government may seek to impose restrictions on the configuration of pharmacy or other provider networks for Medicare Advantage and/or PDP plans, or otherwise restrict the ability of these plans to alter benefits, negotiate prices or establish other terms to improve affordability or maintain viability of products. The Company currently believes that the payments received and will receive in the near term are adequate to justify

the Company's continued participation in the Medicare Advantage and PDP programs, although there are economic and political pressures to continue to reduce spending on the program, and this outlook could change.

Going forward, the Company expects CMS, the OIG, the DOJ, other federal agencies and the United States Congress to continue to scrutinize closely each component of the Medicare program (including Medicare Advantage, PDP, demonstration projects such as Medicare-Medicaid plans and provider network access and adequacy), modify the terms and requirements of the program and possibly seek to recast or limit private insurers' role. It is not possible to predict the outcome of this Congressional or regulatory activity, any of which could adversely affect the Company.

Anti-Remuneration Laws - Federal law prohibits, among other things, an entity from knowingly and willfully offering, paying, soliciting or receiving, subject to certain exceptions and "safe harbors," any remuneration to induce the referral of individuals or the purchase, lease or order of items or services for which payment may be made under Medicare, Medicaid or certain other federal and state health care programs. A number of states have similar laws, some of which are not limited to services paid for with government funds. Sanctions for violating these federal and state anti-remuneration laws may include imprisonment, criminal and civil fines, and exclusion from participation in Medicare, Medicaid and other federal and state government-sponsored health care programs. Companies involved in public health care programs such as Medicare and/or Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The Company has invested significant resources to comply with Medicare and Medicaid program standards. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that the Company's compliance efforts in this area will continue to require significant resources.

Antitrust and Unfair Competition - The Federal Trade Commission ("FTC") investigates and prosecutes practices that are "unfair trade practices" or "unfair methods of competition." Numerous lawsuits have been filed throughout the United States against pharmaceutical manufacturers, retail pharmacies and/or PBMs under various federal and state antitrust and unfair competition laws challenging, among other things: (i) brand name drug pricing and rebate practices of pharmaceutical manufacturers, (ii) the maintenance of retail or specialty pharmacy networks by PBMs, and (iii) various other business practices of PBMs and retail pharmacies. To the extent that the Company appears to have actual or potential market power in a relevant market or CVS Pharmacy, CVS Specialty or MinuteClinic plays a unique or expanded role in a PBM or Health Care Benefits segment product offering, the Company's business arrangements and uses of confidential information may be subject to heightened scrutiny from an anti-competitive perspective and possible challenge by state or federal regulators or private parties.

Privacy and Confidentiality Requirements - Many of the Company's activities involve the receipt, use and disclosure by the Company of personally identifiable information ("PII") as permitted in accordance with applicable federal and state privacy and data security laws, which require organizations to provide appropriate privacy and security safeguards for such information. In addition to PII, the Company uses and discloses de-identified data for analytical and other purposes when permitted. Additionally, there are industry standards for handling credit card data known as the Payment Card Industry Data Security Standard, which are a set of requirements designed to help ensure that entities that process, store or transmit credit card information maintain a secure environment. Certain states have incorporated these requirements into state laws or enacted other requirements relating to the use and/or disclosure of PII.

The federal Health Insurance Portability and Accountability Act of 1996 and the regulations issued thereunder (collectively, "HIPAA"), as further modified by the American Recovery and Reinvestment Act of 2009 ("ARRA") impose extensive requirements on the way in which health plans, health care providers, health care clearinghouses (known as "covered entities") and their business associates use, disclose and safeguard protected health information ("PHI"). Further, ARRA requires us and other covered entities to report any breaches of PHI to impacted individuals and to the United States Department of Health and Human Services ("HHS") and to notify the media in any states where 500 or more people are impacted by the unauthorized release or use of or access to PHI. Criminal penalties and civil sanctions may be imposed for failing to comply with HIPAA standards. The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of ARRA, amended HIPAA to impose additional restrictions on third-party funded communications using PHI and the receipt of remuneration in exchange for PHI. The HITECH Act also extended HIPAA privacy and security requirements and penalties directly to business associates. HHS has begun to audit health plans, providers and other parties to enforce HIPAA compliance, including with respect to data security.

In addition to HIPAA, state health privacy laws apply to the extent they are more protective of individual privacy than is HIPAA, including laws that place stricter controls on the release of information relating to specific diseases or conditions and requirements to notify members of unauthorized release or use of or access to PHI. States also have adopted regulations to implement provisions of the Financial Modernization Act of 1999 (also known as the Gramm-Leach-Bliley Act ("GLBA")) which generally require insurers, including health insurers, to provide customers with notice regarding how their non-public

personal health and financial information is used and the opportunity to "opt out" of certain disclosures before the insurer shares such information with a non-affiliated third party. Like HIPAA, GLBA sets a "floor" standard, allowing states to adopt more stringent requirements governing privacy protection. Complying with additional state requirements requires us to make additional investments beyond those the Company has made to comply with HIPAA and GLBA.

The Cybersecurity Information Sharing Act of 2015 encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. In addition, states have begun to enact more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency. States also are starting to issue regulations and proposed regulations specifically related to cybersecurity, such as the regulations issued by the New York Department of Financial Services. Complying with conflicting cybersecurity regulations, which may differ from state to state, requires significant resources. In addition, differing approaches to state privacy and/or cyber-security regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its products and services across state lines. Widely-reported large scale commercial data breaches in the United States and abroad increase the likelihood that additional data security legislation will be considered by additional states. These legislative and regulatory developments will impact the design and operation of the Company's businesses, its privacy and security strategy and its web-based and mobile assets.

Finally, Public Exchanges are required to adhere to privacy and security standards with respect to PII, and to impose privacy and security standards that are at least as protective of PII as those the Public Exchange has implemented for itself or non-Public Exchange entities, which include insurers offering plans through the Public Exchanges and their designated downstream entities, including PBMs and other business associates. These standards may differ from, and be more stringent than, HIPAA.

Consumer Protection Laws - The federal government has many consumer protection laws, such as the Federal Trade Commission Act, the Federal Postal Service Act, the Consumer Product Safety Act and the FTC's Telemarketing Sales Rule. Most states also have similar consumer protection laws. In addition, the federal government and most states have adopted laws and/or regulations requiring places of public accommodation, health care services and other goods and services to be accessible to people with disabilities. These consumer protection and accessibility laws and regulations have been the basis for investigations, lawsuits and multistate settlements relating to, among other matters, the marketing of loyalty programs, and health care products and services, pricing accuracy, expired front store products, financial incentives provided by drug manufacturers to pharmacies in connection with therapeutic interchange programs, disclosures related to how personal data is used and protected and the accessibility of goods and services to people with disabilities. As a result of the Company's direct-to-consumer activities, including mobile and web-based solutions offered to members and to other consumers, the Company also is subject to federal and state regulations applicable to electronic communications and to other general consumer protection laws and regulations. For example, the California Consumer Privacy Act will become effective in 2020, and the Company expects additional federal and state regulation of consumer privacy protection to be enacted in 2019. The Company expects these new laws and regulations to impact the design of its products and services and the management and operation of its businesses and to increase its compliance costs.

Telemarketing and Other Outbound Contacts - Certain federal and state laws, such as the Telephone Consumer Protection Act, give the FTC, Federal Communications Commission and state attorneys general the ability to regulate, and bring enforcement actions relating to, telemarketing practices and certain automated outbound contacts such as phone calls, texts or emails. Under certain circumstances, these laws provide consumers with a private right of action. Violations of these laws could result in substantial statutory penalties and other sanctions.

Pharmacy and Professional Licensure and Regulation - The Company is subject to a variety of intersecting federal and state statutes and regulations that govern the wholesale distribution of drugs; operation of retail, specialty, infusion, LTC and mail order pharmacies; licensure of facilities and professionals, including pharmacists, technicians, nurses and other healthcare professionals; registration of facilities with the United States Drug Enforcement Administration ("DEA") and analogous state agencies that regulate controlled substances; packaging, storing, shipping and tracking of pharmaceuticals; repackaging of drug products; labeling, medication guides and other consumer disclosures; interactions with prescribers and health care professionals; compounding of prescription medications; dispensing of controlled and non-controlled substances; counseling of patients; transfers of prescriptions; advertisement of prescription products and pharmacy services; security; inventory control; recordkeeping; reporting to Boards of Pharmacy, the United States Food and Drug Administration ("FDA"), the Consumer Product Safety Commission, the DEA and related state agencies; and other elements of pharmacy practice. Pharmacies are highly regulated and have contact with a wide variety of federal, state and local agencies, with various powers to investigate, inspect, audit or solicit information, including Boards of Pharmacy and Nursing, the DEA, the FDA, the United States Department of Justice, HHS and others. Many of these agencies have broad enforcement powers, conduct audits on a regular

basis, can impose substantial fines and penalties, and may revoke the license, registration or program enrollment of a facility or professional.

State Insurance, HMO and Insurance Holding Company Regulation - A number of states regulate affiliated groups of insurers and HMOs such as the Company under holding company statutes. These laws may, among other things, require prior regulatory approval of dividends and material intercompany transfers of assets and transactions between the regulated companies and their affiliates, including their parent holding companies. The Company expects the states in which its insurance and HMO subsidiaries are licensed to continue to expand their regulation of the corporate governance and internal control activities of its insurance companies and HMOs. Changes to state insurance, HMO and/or insurance holding company laws or regulations or changes to the interpretation of those laws or regulations, including due to regulators' increasing concerns regarding insurance company and/or HMO solvency due, among other things, to recent and expected payor insolvencies, could negatively affect the Company's businesses in various ways, including through increases in solvency fund assessments, requirements that the Company hold greater levels of capital and/or delays in approving dividends from regulated subsidiaries.

PBM offerings of prescription drug coverage under certain risk arrangements may be subject to laws and regulations in various states. Such laws may require that the party at risk become licensed as an insurer, establish reserves or otherwise demonstrate financial viability. Laws that may apply in such cases include insurance laws and laws governing MCOs and limited prepaid health service plans.

The states of domicile of the Company's regulated subsidiaries have statutory risk-based capital, or "RBC", requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. The RBC Model Act sets forth the formula for calculating RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual company's business. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. At December 31, 2018, the RBC level of each of the Company's insurance and HMO subsidiaries was above the level that would require regulatory action.

For information regarding restrictions on certain payments of dividends or other distributions by the Company's HMO and insurance company subsidiaries, see Note 12 ''Shareholders' Equity'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

The holding company laws for the states of domicile of certain of the Company's subsidiaries also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company (such as the Company's parent company, CVS Health Corporation) that controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would control the insurance holding company. Control is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

Certain states have laws that prohibit submitting a false claim or making a false record or statement in order to secure reimbursement from an insurance company. These state laws vary, and violation of them may lead to the imposition of civil or criminal penalties.

Government Agreements and Mandates - The Company and/or its various affiliates are subject to certain consent decrees, settlement and other agreements, corrective action plans and corporate integrity agreements with various federal, state and local authorities relating to such matters as privacy practices, controlled substances, Medicare Part D prescription drug plans, expired products, environmental and safety matters, marketing and advertising practices, PBM, LTC and other pharmacy operations and various other business practices. Certain of these agreements contain ongoing reporting, monitoring and/or other compliance requirements for the Company. Failure to meet the Company's obligations under these agreements could result in civil or criminal remedies, financial penalties, administrative remedies, and/or exclusion from participation in federal health care programs.

Environmental and Safety Regulation - The Company's businesses are subject to various federal, state and local laws, regulations and other requirements pertaining to protection of the environment, public health and employee safety, including, for example, regulations governing the management of hazardous substances, the cleaning up of contaminated sites, and the maintenance of safe working conditions in the Company's stores, distribution centers and other facilities. Governmental agencies at the federal, state and local levels continue to focus on the retail and health care sectors' compliance with such laws

and regulations, and have at times pursued enforcement activities. Any failure to comply with these regulations could result in fines or other sanctions by government authorities.

ERISA Regulation - The Employee Retirement Income Security Act of 1974 ("ERISA"), provides for comprehensive federal regulation of certain employee pension and benefit plans, including private employer and union sponsored health plans and certain other plans that contract with us to provide PBM services. In general, the Company assists plan sponsors in the administration of their health benefit plans, including the prescription drug benefit portion of those plans, in accordance with the plan designs adopted by the plan sponsors. In addition, the Company may have fiduciary duties where it has specifically contracted with a plan sponsor to accept limited fiduciary responsibility, such as for the adjudication of initial prescription drug benefit claims and/or the appeals of denied claims under a plan. In addition to its fiduciary provisions, ERISA imposes civil and criminal liability on service providers to health plans and certain other persons if certain forms of illegal remuneration are made or received. These provisions of ERISA are broadly written and their application to specific business practices is often uncertain.

Some of the Company's health and related benefits and large case pensions products and services and related fees also are subject to potential issues raised by judicial interpretations relating to ERISA. Under those interpretations, together with United States Department of Labor ("DOL") regulations, the Company may have ERISA fiduciary duties with respect to PBM members and/or certain general account assets held under contracts that are not guaranteed benefit policies. As a result, certain transactions related to those general account assets are subject to conflict of interest and other restrictions, and the Company must provide certain disclosures to policyholders annually. The Company must comply with these restrictions or face substantial penalties.

In addition, ERISA generally preempts all state and local laws that relate to employee benefit plans, but the extent of the pre-emption continues to be reviewed by courts.

Other Legislative Initiatives and Regulatory Initiatives - The United States federal and state governments, as well as governments in other countries where the Company does business, continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the health care and related benefits system and the Company's businesses. For example:

- Under the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 significant, automatic across-the-board budget cuts (known as sequestration) began in March 2013, including Medicare spending cuts of not more than 2% of total program costs per year through 2024. Significant uncertainty remains as to whether and how the United States Congress will proceed with actions that create additional federal revenue and/or with entitlement reform. The Company cannot predict future federal Medicare or federal or state Medicaid funding levels or the impact that future federal or state budget actions or entitlement program reform, if it occurs, will have on the Company's businesses, operations or results of operations, but the effects could be materially adverse, particularly on the Company's Medicare and/or Medicaid revenues, MBRs and results of operations.
- The European Union's ("EU's") General Data Protection Regulation ("GDPR") began to apply across the EU during 2018.
- Other significant legislative and/or regulatory measures which are or recently have been under consideration include the following:
    - Elimination of the payment of manufacturer's rebates on prescription drugs to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. In January 2019, HHS proposed regulations that would exclude such rebates from the safe harbor that currently is available for such payments under the federal anti-kickback statute.
    - Imposing requirements and restrictions on the design and/or administration of pharmacy benefits plans offered by the Company's and its clients' health plans and/or its PBM clients and/or the services the Company provides to those clients, including restricting or eliminating the use of formularies for prescription drugs; restricting the Company's ability to require members to obtain drugs through a home delivery or specialty pharmacy; restricting the Company's ability to place certain specialty or other drugs in the higher cost tiers of its pharmacy formularies; restricting the Company's ability to make changes to drug formularies and/or clinical programs; limiting or eliminating rebates on pharmaceuticals; requiring the use of up front purchase price discounts on pharmaceuticals in lieu of rebates; restricting the Company's ability to configure its health plan and retail pharmacy networks; and restricting or eliminating the use of certain drug pricing methodologies.
    - Increased federal or state government regulation of, or involvement in, the pricing and/or purchasing of drugs.

- Restricting the Company's ability to limit providers' participation in its networks and/or remove providers from its networks by imposing network adequacy requirements or otherwise (including in its Medicare and Commercial Health Care Benefits products).
- Imposing assessments on (or to be collected by) health plans or health carriers, which may or may not be passed onto their customers. These assessments may include assessments for insolvency, the uninsured, uncompensated care, Medicaid funding or defraying health care provider medical malpractice insurance costs.
- Mandating coverage by the Company and its clients' health plans for additional conditions and/or specified procedures, drugs or devices (for example, high cost pharmaceuticals, experimental pharmaceuticals and oral chemotherapy regimens).
- Regulating electronic connectivity.
- Mandating or regulating the disclosure of provider fee schedules and other data about the Company's payments to providers.
- Mandating or regulating disclosure of provider outcome and/or efficiency information.
- Prescribing or limiting members' financial responsibility for health care or other covered services they utilize.
- Assessing the medical device status of HIT products and/or solutions, mobile consumer wellness tools and clinical decision support tools, which may require compliance with FDA requirements in relation to some of these products, solutions and/or tools.
- Imposing payment levels for services rendered to the Company's members by providers who do not have contracts with the Company.
- Restricting the ability of employers and/or health plans to establish or impose member financial responsibility.
- Amending or supplementing ERISA to impose greater requirements on PBMs, the administration of employer-funded benefit plans or limit the scope of current ERISA pre-emption, which would among other things expose us and other health plans to expanded liability for punitive and other extra-contractual damages and additional state regulation.

It is uncertain whether the Company can counter the potential adverse effects of such potential legislation or regulation on its results of operations or cash flows, including whether it can recoup, through higher premium rates, expanded membership or other measures, the increased costs of mandated coverage or benefits, assessments, fees, taxes or other increased costs, including the cost of modifying its systems to implement any enacted legislation or regulations.

The Company's businesses also may be affected by other legislation and regulations. The Dodd-Frank Wall Street Reform and Consumer Protection Act (the "Financial Reform Act") creates incentives for whistleblowers to speak directly to the government rather than utilizing internal compliance programs and reduces the burden of proof under the Foreign Corrupt Practices Act of 1977 (the "FCPA"). There also are laws and regulations that set standards for the escheatment of funds to states.

Health savings accounts, health reimbursement arrangements and flexible spending accounts and certain of the tax, fee and subsidy provisions of the ACA also are regulated by the United States Department of the Treasury and the Internal Revenue Service.

The Company also may be adversely affected by court and regulatory decisions that expand or revise the interpretations of existing statutes and regulations or impose medical malpractice or bad faith liability. Federal and state courts continue to consider cases, and federal and state regulators continue to issue regulations and interpretations, addressing bad faith liability for denial of medical claims, the scope of ERISA's fiduciary duty requirements, the scope of the False Claims Act and the pre-emptive effect of ERISA on state laws.

Contract Audits - The Company is subject to audits of many of its contracts, including its PBM client contracts, its PBM rebate contracts, its PBM network contracts, its contracts relating to Medicare Advantage, and/or Medicare Part D, the agreements the Company's pharmacies enter into with other payors, its Medicaid contracts and its customer contracts. Because some of the Company's contracts are with state or federal governments or with entities contracted with state or federal agencies, audits of these agreements are often regulated by the federal or state agencies responsible for administering federal or state benefits programs, including those which operate Medicaid fee for service plans, Managed Medicaid plans, Medicare Part D plans or Medicare Advantage organizations.

Federal Employee Health Benefits Program - The Company's subsidiaries contract with the Office of Personnel Management (the "OPM") to provide managed health care services under the FEHB program in their service areas. These contracts with the

OPM and applicable government regulations establish premium rating arrangements for this program. OPM regulations require that community-rated FEHB plans meet a FEHB program-specific MLR by plan code and market. Managing to these rules is complicated by the simultaneous application of the minimum MLR standards and associated premium rebate requirements of the ACA. The Company also has a contractual arrangement with carriers for the FEHB program, such as the BlueCross BlueShield Association, to provide pharmacy services to federal employees, postal workers, annuitants, and their dependents under the Government-wide Service Benefit Plan, as authorized by the FEHB Act and as part of the FEHB program. Additionally, the Company manages certain FEHB plans on a "cost-plus" basis. These arrangements subject the Company to certain aspects of FEHB Act, and other federal regulations, such as the FEHB Acquisition Regulation, that otherwise would not be applicable to the Company. The OPM also is auditing the Company and its other contractors to, among other things, verify that plans meet their applicable FEHB program-specific MLR and the premiums established under the OPM's Insured contracts and costs allocated pursuant to the OPM's cost-based contracts are in compliance with the requirements of the applicable FEHB program. The OPM may seek premium refunds or institute other sanctions against the Company if it fails to comply with the FEHB program requirements.

Disease Management Services Regulation - The Company provides disease management programs to health plan and PBM plan members for complex medical conditions and arranges for those members to receive disease management programs for common medical conditions. State laws regulate the practice of medicine, the practice of pharmacy and the practice of nursing. Clinicians engaged in a professional practice in connection with the provision of disease management services must satisfy applicable state licensing requirements and must act within their scope of practice.

Third Party Administration and Other State Licensure Laws - Many states have licensure or registration laws governing certain types of administrative organizations, such as PPOs, TPAs and companies that provide utilization review services. Several states also have licensure or registration laws governing the organizations that provide or administer consumer card programs (also known as cash card or discount card programs).

International Regulation - The Company currently has insurance licenses in several foreign jurisdictions and does business directly or through local affiliations in numerous countries around the world. The Company is taking steps to be able to continue to serve customers in the European Economic Area following the United Kingdom's pending exit from the EU ("Brexit"). However, the impact of Brexit on the Company's international business and results of operations is uncertain.

The Company's international operations are subject to different, and sometimes more stringent, legal and regulatory requirements, which vary widely by jurisdiction, including anti-corruption laws; economic sanctions laws; various privacy, insurance, tax, tariff and trade laws and regulations; corporate governance, privacy, data protection (including the EU's General Data Protection Regulation which began to apply across the EU during 2018), data mining, data transfer, labor and employment, intellectual property, consumer protection and investment laws and regulations; discriminatory licensing procedures; compulsory cessions of reinsurance; required localization of records and funds; higher premium and income taxes; limitations on dividends and repatriation of capital; and requirements for local participation in an insurer's ownership. In addition, the expansion of the Company's operations into foreign countries increases the Company's exposure to the anti-bribery, anti-corruption and anti-money laundering provisions of United States law, including the FCPA, and corresponding foreign laws, including the U.K. Bribery Act 2010 (the "UK Bribery Act").

Anti-Corruption Laws - The FCPA prohibits offering, promising or authorizing others to give anything of value to a foreign government official to obtain or retain business or otherwise secure a business advantage. The Company also is subject to applicable anti-corruption laws of the jurisdictions in which it operates. In many countries outside the United States, health care professionals are employed by the government. Therefore, the Company's dealings with them are subject to regulation under the FCPA. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the United States Securities and Exchange Commission (the "SEC") and the DOJ have increased their enforcement activities with respect to the FCPA. The UK Bribery Act is an anti-corruption law that is broader in scope than the FCPA and applies to all companies with a nexus to the United Kingdom. Disclosures of FCPA violations may be shared with the UK authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions. The Company has internal control policies and procedures and conducts training and compliance programs for its employees to deter prohibited practices. However, if the Company's employees or agents fail to comply with applicable laws governing its international operations, it may face investigations, prosecutions and other legal proceedings and actions which could result in civil penalties, administrative remedies and criminal sanctions.

Anti-Money Laundering Regulations - Certain lines of the Company's businesses are subject to Treasury anti-money laundering regulations. Those lines of business have implemented anti-money laundering policies designed to insure their

compliance with the regulations. The Company also may be subject to anti-money laundering laws in non-U.S. jurisdictions where it operates.

Office of Foreign Assets Control - The Company also is subject to regulation by OFAC. OFAC administers and enforces economic and trade sanctions based on United States foreign policy and national security goals against targeted foreign countries and regimes, terrorists, international narcotics traffickers, those engaged in activities related to the proliferation of weapons of mass destruction, and other threats to the national security, foreign policy or economy of the United States. In addition, the Company may be subject to similar regulations in the non-U.S. jurisdictions in which it operates.

Laws and Regulations Related to the Pharmacy Services Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Pharmacy Services segment specifically. Among these are the following:

PBM Laws and Regulation - Legislation seeking to regulate PBM activities in a comprehensive manner has been introduced or enacted in a number of states. This legislation could adversely affect the Company's ability to conduct business on commercially reasonable terms in states where the legislation is in effect. In addition, certain quasi-regulatory organizations, including the National Association of Boards of Pharmacy and the National Association of Insurance Commissioners ("NAIC") and the National Council of Insurance Legislators, have issued model regulations or may propose future regulations concerning PBMs and/or PBM activities. Similarly, credentialing organizations such as NCQA and URAC may establish voluntary standards regarding PBM, mail or specialty pharmacy activities. While the actions of these quasi-regulatory or standard-setting organizations do not have the force of law, they may influence states to adopt their requirements or recommendations and influence client requirements for PBM or specialty pharmacy services. Moreover, any standards established by these organizations could also impact the Company's health plan clients and/or the services provided to them and/or the Company's health plans.

The Company's PBM activities also are regulated directly and indirectly at the federal and state levels, including being subject to the False Claims Act and state false claims acts and federal and state anti-kickback laws. These laws and regulations govern, and proposed legislation and regulations may govern and/or further restrict, critical PBM practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; use of, administration of and/or changes to drug formularies, maximum allowable cost ("MAC") list pricing, average wholesale prices ("AWPs") and/or clinical programs; the offering to plan sponsors of pricing that includes retail network "differential" or "spread" (i.e., a difference between the drug price charged to the plan sponsor by a PBM and the price paid by the PBM to the dispensing provider); disclosure of data to third parties; drug utilization management practices; the level of duty a PBM owes its customers; configuration of pharmacy networks; the operations of the Company's pharmacies (including audits of its pharmacies); disclosure of negotiated provider reimbursement rates; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to members' drug utilization; and registration or licensing of PBMs. Failure by the Company or one of its PBM services suppliers to comply with these laws or regulations could result in material fines and/or sanctions and could have a material adverse effect on the Company's results of operations and/or cash flows.

PDPs and the Company's PBM service contracts, including those in which the Company assumes certain risks under performance guarantees or similar arrangements, are generally not subject to insurance regulation by the states. However, state departments of insurance are increasing their oversight of PBM activities due to legislation passing in several states requiring PBMs to register or obtain a license with the department. Rulemaking is either underway or has already taken place in a few states with the areas of focus on licensure requirements, pharmacy reimbursement for generics (MAC reimbursement) and pharmacy audits - most of which fall under the state insurance code.

Pharmacy Network Access Legislation - Medicare Part D and a majority of states now have some form of legislation affecting the Company's (and its health plans' and its health plan clients') ability to limit access to a pharmacy provider network or remove network providers. For example, certain "any willing provider" legislation may require the Company or its clients to admit a nonparticipating pharmacy if such pharmacy is willing and able to meet the plan's price and other applicable terms and conditions for network participation. These laws could negatively affect the services and economic benefits achievable through a limited pharmacy provider network. Also, a majority of states now have some form of legislation affecting the Company's ability (and the Company's and its client health plans' ability) to conduct audits of network pharmacies regarding claims submitted to the Company for payment. These laws could negatively affect the Company's ability to recover overpayments of claims submitted by network pharmacies that the Company identifies through pharmacy audits.

Pharmacy Pricing Legislation - Several states have passed legislation regulating the Company's ability to manage and establish MACs for generic prescription drugs. MAC methodology is a common cost management practice used by private and public payors (including CMS) to pay pharmacies for dispensing generic prescription drugs. MAC prices specify the allowable reimbursement by a PBM for a particular strength and dosage of a generic drug that is available from multiple manufacturers but sold at different prices. State legislation can regulate the disclosure of MAC prices and MAC price methodologies, the kinds of drugs that a PBM can pay for at a MAC price, and the rights of pharmacies to appeal a MAC price established by a PBM. These laws could negatively affect the Company's ability to establish MAC prices for generic drugs.

Formulary and Plan Design Regulation - A number of government entities regulate the administration of prescription drug benefits. HHS regulates how Medicare Part D formularies are developed and administered, including requiring the inclusion of all drugs in certain classes and categories, subject to limited exceptions. Under the ACA, CMS imposes drug coverage requirements for health plans required to cover essential health benefits, including plans offered through federal or state Public Exchanges. Additionally, the NAIC and health care accreditation agencies like NCQA and URAC have developed model acts and standards for formulary development that are often incorporated into government requirements. Many states regulate the scope of prescription drug coverage, as well as the delivery channels to receive prescriptions, for insurers, MCOs and Medicaid managed care plans. The increasing government regulation of formularies could significantly affect the Company's ability to develop and administer formularies, networks and other plan design features on behalf of its insurer, MCO and other clients. Similarly, some states prohibit health plan sponsors from implementing certain restrictive design features. This regulation could limit or preclude (i) limited networks, (ii) a requirement to use particular providers, (iii) copayment differentials among providers and (iv) formulary tiering practices.

FDA Regulation - The FDA regulates the Company's compounding pharmacy and clinical research operations.

Laws and Regulations Related to the Retail/LTC Segment

In addition to the laws and regulations discussed above that may affect multiple segments of the Company's business, the Company is subject to federal, state and local statutes and regulations governing the operation of its Retail/LTC segment specifically. Among these are the following:

FDA Regulation - The FDA generally has authority to, among other things, regulate the manufacture, distribution, sale and labeling of many products sold through retail pharmacies, including prescription drugs, over-the-counter medications, medical devices (including mobile medical devices), cosmetics, dietary supplements and certain food items. The FDA regulates the Company's activities as a distributor of store brand products.

Retail Clinics - States regulate retail clinics operated by nurse practitioners or physician assistants through physician oversight, clinic and lab licensure requirements and the prohibition of the corporate practice of medicine. A number of states have implemented or proposed laws or regulations that impact certain components of retail clinic operations such as physician oversight, signage, third party contracting requirements, bathroom facilities, and scope of services. These laws and regulations may affect the operation and expansion of the Company's owned and managed retail clinics.

Other Laws - Other federal, state and local laws and regulations also impact the Company's retail operations, including laws and regulations governing the practice of optometry, the practice of audiology, the provision of dietician services and the sale of durable medical equipment, contact lenses, eyeglasses, hearing aids and alcohol.

Laws and Regulations Related to the Health Care Benefits Segment

Overview - Differing approaches to state insurance regulation and varying enforcement philosophies may materially and adversely affect the Company's ability to standardize its Health Care Benefits products and services across state lines. These laws and regulations, including the ACA, restrict how the Company conducts its business and result in additional burdens and costs to the Company. Significant areas of governmental regulation include premium rates and rating methodologies, underwriting rules and procedures, required benefits, sales and marketing activities, provider rates of payment, restrictions on health plans' ability to limit providers' participation in their networks and/or remove providers from their networks and financial condition (including reserves and minimum capital or risk based capital requirements). These laws and regulations are different in each jurisdiction and vary from product to product.

Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. Applicable laws also restrict the ability of the Company's regulated subsidiaries to pay dividends, and certain dividends require prior regulatory approval. In

addition, some of the Company's businesses and related activities may be subject to PPO, managed care organization, utilization review or TPA-related licensure requirements and regulations. These licensure requirements and regulations differ from state to state, but may contain provider network, contracting, product and rate, financial and reporting requirements. There also are laws and regulations that set specific standards for the Company's delivery of services, payment of claims, fraud prevention, protection of consumer health information, and payment for covered benefits and services.

Required Regulatory Approvals - The Company must obtain and maintain regulatory approvals to price, market and administer many of its Health Care Benefits products. Supervisory agencies, including CMS, the Center for Consumer Information and Insurance Oversight and the DOL, as well as state health, insurance, managed care and Medicaid agencies and state boards of pharmacy have broad authority to take one or more of the following actions:

- Grant, suspend and revoke the Company's licenses to transact business;
- Suspend or exclude the Company from participation in government programs;
- Suspend or limit the Company's authority to market products;
- Regulate many aspects of the products and services the Company offers, including the pricing and underwriting of many of its products and services;
- Assess damages, fines and/or penalties;
- Terminate the Company's contract with the government agency and/or withhold payments from the government agency to the Company;
- Impose retroactive adjustments to premiums and require the Company to pay refunds to the government, customers and/or members;
- Restrict the Company's ability to conduct acquisitions or dispositions;
- Require the Company to maintain minimum capital levels in its subsidiaries and monitor its solvency and reserve adequacy;
- Regulate the Company's investment activities on the basis of quality, diversification and other quantitative criteria; and/or
- Exclude the Company's plans from participating in Public Exchanges if they are deemed to have a history of "unreasonable" premium rate increases or fail to meet other criteria set by HHS or the applicable state.

The Company's operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time the Company receives subpoenas and other requests for information from, federal, state and international supervisory and enforcement agencies, attorneys general and other state, federal and international governmental authorities and legislators.

Commercial Product Pricing and Underwriting Restrictions - Pricing and underwriting regulation by states limits the Company's underwriting and rating practices and those of other health insurers, particularly for small employer groups, and varies by state. In general, these limitations apply to certain customer segments and limit the Company's ability to set prices for new or renewing groups, or both, based on specific characteristics of the group or the group's prior claim experience. In some states, these laws and regulations restrict the Company's ability to price for the risk it assumes and/or reflect reasonable costs in the Company's pricing.

The ACA expanded the premium rate review process by, among other things, requiring the Company's Commercial Insured rates to be reviewed for "reasonableness" at either the state or the federal level. HHS established a federal premium rate review process that generally applies to proposed premium rate increases equal to or exceeding a federally (or lower state) specified threshold. HHS's rate review process imposes additional public disclosure requirements as well as additional review on filings requesting premium rate increases equal to or exceeding this "reasonableness" threshold. These combined state and federal review requirements may prevent, further delay or otherwise affect the Company's ability to price for the risk it assumes, which could adversely affect its MBRs and results of operations, particularly during periods of increased utilization of medical services and/or medical cost trend or when such utilization and/or trend exceeds the Company's projections.

The ACA also specifies minimum MLRs of 85% for large group Commercial products and 80% for individual and small group Commercial products. Because the ACA minimum MLRs are structured as "floors" for many of their requirements, states have the latitude to enact more stringent rules governing its various restrictions. For Commercial products, states have and may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio," incorporate minimum MLR requirements into prospective premium rate filings, require prior approval of premium rates or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can

earn in its Insured Commercial business while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

In addition, the Company requested significant increases in its premium rates in its Commercial small group Health Care Benefits business for 2019 and expects to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. The Company's rates also must be adequate to reflect adverse selection in its products, particularly in small group Commercial products, which the Company expects to continue and potentially worsen in 2019. These significant rate increases heighten the risks of adverse public and regulatory action and adverse selection and the likelihood that the Company's requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

Many of the laws and regulations governing the Company's pricing and underwriting practices also limit the differentials in premium rates insurers and other carriers may charge between new and renewal business, and/or between groups based on differing characteristics. They may also require that carriers disclose to customers the basis on which the carrier establishes new business and renewal premium rates and limit the ability of a carrier to terminate customers' coverage. In addition, HHS' rules on rates impose additional public disclosure requirements on any rate filings that exceed the "reasonableness" threshold and require additional review of those rates.

Medicaid Regulation - The Company is seeking to substantially grow its Medicaid, dual eligible and dual eligible special needs plan businesses over the next several years. As a result, the Company also is increasing its exposure to changes in government policy with respect to and/or regulation of the various Medicaid, dual eligible and dual eligible special needs plan programs in which the Company participates, including changes in the amounts payable to the Company under those programs.

Since 2017, Managed Medicaid products, including those the Company offers, are subject to a minimum MLR of 85%. A Medicaid managed care quality rating system and provider network adequacy requirements also apply to Medicaid products. Because the minimum MLR is structured as a "floor", states have the latitude to enact more stringent rules governing these various restrictions. For Managed Medicaid products, states may adopt higher minimum MLR requirements, use more stringent definitions of "medical loss ratio" or impose other requirements related to minimum MLR. Minimum MLR requirements and similar actions further limit the level of margin the Company can earn in its Insured Medicaid products while leaving the Company exposed to medical costs that are higher than those reflected in its pricing. The Company also may be subject to significant fines, penalties, premium refunds and litigation if it fails to comply with minimum MLR laws and regulations.

The impact of Medicaid expansion under the ACA is uncertain. The future of the ACA is uncertain, and states may opt out of the elements of the ACA requiring expansion of Medicaid coverage without losing their current federal Medicaid funding. To date, a number of states and the District of Columbia have expanded Medicaid coverage to the higher eligibility levels contemplated by the ACA. In addition, the election of new governors and/or state legislatures may impact states' previous decisions regarding Medicaid expansion. Proposals for substantial changes to federal funding of state Medicaid programs are likely to be considered in 2019 and beyond, including the possibility of converting federal Medicaid support to block grants and per capita caps on federal funding. Uncertainty regarding federal funding is causing and will continue to cause states to re-evaluate their Medicaid expansions and consider new assessments, fees and/or taxes on health plans. That re-evaluation may adversely affect Medicaid payment rates, the Company's revenues and its Medicaid membership in those states.

The economic aspects of the Medicaid, dual eligible and dual eligible special needs plan business vary from state to state and are subject to frequent change. Medicaid premiums are paid by each state and differ from state to state. The federal government and certain states also are considering proposals and legislation for Medicaid and dual eligible program reforms or redesigns, including restrictions on the collection of manufacturer's rebates on pharmaceuticals by Medicaid MCOs and their contracted PBMs, further program, population and/or geographic expansions of risk-based managed care, increasing beneficiary cost-sharing or payment levels, and changes to benefits, reimbursement, eligibility criteria, provider network adequacy requirements (including requiring the inclusion of specified high cost providers in the Company's networks) and program structure. In some states, current Medicaid and dual eligible funding and premium revenue may not be adequate for the Company to continue program participation. The Company's Medicaid and dual eligible contracts with states (or sponsors of Medicaid managed care plans) are subject to cancellation by the state (or the sponsors of the managed care plans) after a short notice period without cause (for example, when a state discontinues a managed care program) or in the event of insufficient state funding.

The Company's Medicaid, dual eligible and dual eligible special needs plan products also are heavily regulated by CMS and state Medicaid agencies, which have the right to audit the Company's performance to determine compliance with CMS

contracts and regulations. The Company's Medicaid products, dual eligible products and CHIP contracts also are subject to complex federal and state regulations and oversight by state Medicaid agencies regarding the services provided to Medicaid enrollees, payment for those services, network requirements (including mandatory inclusion of specified high-cost providers), and other aspects of these programs, and by external review organizations which audit Medicaid plans on behalf of the state Medicaid agencies. The laws, regulations and contractual requirements applicable to the Company and other participants in Medicaid and dual eligible programs, including requirements that the Company submit encounter data to the applicable state agency, are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its Medicaid and dual eligible program compliance efforts will continue to require significant resources. CMS and/or state Medicaid agencies may fine the Company, withhold payments to the Company, seek premium and other refunds, terminate the Company's existing contracts, elect not to award the Company new contracts or not to renew the Company's existing contracts, prohibit the Company from continuing to market and/or enroll members in or refuse to automatically assign members to one or more of the Company's Medicaid or dual eligible products, exclude the Company from participating in one or more Medicaid or dual eligible programs and/or institute other sanctions and/or civil monetary penalties against the Company if it fails to comply with CMS or state regulations or contractual requirements.

The Company cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid program, nor can it predict the impact those changes will have on its business operations or results of operations, but the effects could be materially adverse.

State Workers' Compensation Laws - The Company's workers' compensation business includes the comparison of medical claims data against the applicable state's fee schedule pricing, including applicable regulations and clinical guidelines. State fee schedules, which typically represent the maximum reimbursement for medical services provided to the injured worker, differ by state and change as state laws and regulations are passed and/or amended. The Company's workers' compensation business also includes PBM and care management services, both of which are regulated at the state level. The Company's workers' compensation customers include insurance carriers and TPAs who also are regulated at the state level. The laws and regulations applicable to the Company and other participants in the workers' compensation business are extensive, complex and subject to change. The Company has invested significant resources to comply with these standards, and its workers' compensation compliance efforts will continue to require significant resources. The Company may be subject to significant fines, penalties and litigation if it fails to comply with those laws and regulations.

Federal and State Reporting - The Company is subject to extensive financial and business reporting requirements, including penalties for inaccuracies and/or omissions, at both the federal and state level. The Company's ability to comply with certain of these requirements depends on receipt of information from third parties that may not be readily available or reliably provided in all instances. The Company is and will continue to be required to modify its information systems, dedicate significant resources and incur significant expenses to comply with these requirements. However, the Company cannot eliminate the risks of unavailability of or errors in its reports.

Product Design and Administration and Sales Practices - State and/or federal regulatory scrutiny of health care benefit product design and administration and marketing and advertising practices, including the filing of insurance policy forms, the adequacy of provider networks, the accuracy of provider directories, and the adequacy of disclosure regarding products and their administration, is increasing as are the penalties being imposed for inappropriate practices. Medicare, Medicaid and dual eligible products and products offering more limited benefits in particular continue to attract increased regulatory scrutiny.

Guaranty Fund Assessments/Solvency Protection - Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to its health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer governed health plans established under the ACA. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

Available Information

CVS Health Corporation was incorporated in Delaware in 1996. The corporate office is located at One CVS Drive, Woonsocket, Rhode Island 02895, telephone (401) 765-1500. The Company's common stock is listed on the New York Stock

Exchange under the trading symbol "CVS." General information about CVS Health is available through the Company's website at *http://www.cvshealth.com* . The Company's financial press releases and filings with the SEC are available free of charge within the Investors section of the Company's website at *http://www.cvshealth.com/investors* . In addition, the SEC maintains an internet site that contains reports, proxy and information statements and other information regarding issuers, such as the Company, that file electronically with the SEC. The address of that website is *http://www.sec.gov.* The information on or linked to the Company's website is neither a part of nor incorporated by reference in this Annual Report on Form 10-K or any of the Company's other SEC filings.

In accordance with guidance provided by the SEC regarding use by a company of its websites and social media channels as a means to disclose material information to investors and to comply with its disclosure obligations under Regulation FD, CVS Health Corporation (the "Registrant") hereby notifies investors, the media and other interested parties that it intends to continue to use its media and investor relations website (http://investors.cvshealth.com/) and its Twitter feed (@CVSHealthIR) to publish important information about the Registrant, including information that may be deemed material to investors. The list of social media channels that the Registrant uses may be updated on its media and investor relations website from time to time. The Registrant encourages investors, the media, and other interested parties to review the information the Registrant posts on its website and social media channels as described above, in addition to information announced by the Registrant through its SEC filings, press releases and public conference calls and webcasts.

Item 1A. Risk Factors

You should carefully consider each of the following risks and uncertainties and all of the other information set forth in this Annual Report on Form 10-K. These risks and uncertainties and other factors may affect forward-looking statements, including those we make in this Annual Report on Form 10-K or elsewhere, such as in news releases or investor or analyst calls, meetings or presentations. The risks and uncertainties described below are not the only ones we face. There can be no assurance that we have identified all the risks that affect us. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial also may adversely affect our businesses. Any of these risks or uncertainties could cause our actual results to differ materially from our expectations and the expected results discussed in our forward-looking statements. You should not consider past results to be an indication of future performance.

If any of the following risks or uncertainties develops into actual events or if the circumstances described in the risks or uncertainties occur or continue to occur, these events or circumstances could have a material adverse effect on our businesses, results of operations, cash flows and/or financial condition. In that case, our stock price could decline materially, among other effects on us. You should read the following section in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" (which includes our "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section) in the Annual Report, which is incorporated by reference herein, and our consolidated financial statements and the related notes.

Overarching Risks

Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.

We expect to face significant business challenges and uncertainties in 2019. Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond. There can be no assurance regarding our ability to avoid harm to our brand and reputation, our ability to manage the risks inherent in the Aetna Acquisition or our data governance risks, our ability to manage and align our talent to our business needs or our ability to manage the risks presented by changes in public policy, laws or regulations. In addition, there can be no assurance that the Aetna Acquisition, United States government fiscal policy, changes to the United States health care system (including changes to the ACA, to drug reimbursement and/or drug pricing laws and regulations and/or to laws and regulations governing PBMs' interactions with government funded health care programs) or other unanticipated risks will not require us to revise the ways in which we conduct business, put us at risk of loss of business or materially adversely affect our businesses, cash flows, financial condition or results of operations.

Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.

Reputational risk is inherent in many of the risks we face. The industries in which we operate regularly are negatively perceived by the public and subject to negative publicity, including as a result of adverse media coverage, litigation against us and other industry participants, the ongoing public debates over drug pricing, government involvement in drug pricing and purchasing, PBMs and the future of the ACA, governmental hearings and/or investigations and actual or perceived shortfalls regarding our industries' or our own products and/or business practices (including PBM operations, drug pricing, insurance coverage determinations and social media and other media relations activities). This risk may be increased as the federal government continues to consider increased involvement in drug reimbursement, pricing and/or purchasing and changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, and as states seek to maintain, replace or repeal elements of the ACA such as Public Exchanges and Medicaid expansion within increasingly challenging budget constraints. This risk also may be increased as we continue to offer products and services that make greater use of data and as our business model becomes more focused on delivering health care to consumers. Significant reductions or interruptions in funding for government health programs we serve also may lead us to reduce our exposure to these programs, which could adversely affect our brand and reputation.

Negative public perception and/or publicity of our industries in general, or of us or our key vendors, brokers or product distribution networks in particular, can further increase our costs of doing business and adversely affect our results of operations and our stock price by:

- Adversely affecting our brand and reputation;
- Adversely affecting our ability to market and sell our products and/or services and/or retain our existing customers and members;
- Requiring us to change our products and/or services;
- Reducing or restricting the compensation we can receive for our products and/or services; and/or
- Increasing or significantly changing the regulatory and legislative requirements with which we must comply.

Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.

Our information systems are critical to the operation of our businesses. We collect, process, maintain, retain, evaluate, utilize and distribute large amounts of personal health and financial information and other confidential and sensitive data about our customers, members and other constituents in the ordinary course of our businesses. Some of our information systems rely upon third party systems to accomplish these tasks. The use and disclosure of such information is regulated at the federal, state and international levels, and these laws, rules and regulations are subject to change and increased enforcement activity, such as the EU's GDPR which began to apply across the EU during 2018 and the audit program implemented by HHS under HIPAA. In some cases, such laws, rules and regulations also apply to our vendors and/or may hold us liable for any violations by our vendors. International laws, rules and regulations governing the use and disclosure of such information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction. Noncompliance with any privacy or security laws or regulations, or any security breach, cyber-attack or cybersecurity breach, and any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member, customer or other constituent information, whether by us, by one of our vendors or by another third party, could require us to expend significant resources to remediate any damage, interrupt our operations and damage our brand and reputation, and could also result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our brand, reputation, businesses, results of operations and cash flows.

Our businesses depend on our customers' and members' willingness to entrust us with their health related and other sensitive personal information. Events that adversely affect that trust, including inadequate disclosure to our members or customers of our uses of their information, failing to keep our information technology systems and our members', customers' and other constituents' sensitive information secure from significant attack, theft, damage, loss or unauthorized disclosure or access, whether as a result of our action or inaction or that of our business associates, vendors or other third parties, could adversely affect our brand and reputation, membership and results of operations and also can and/or has exposed us to mandatory disclosure to the media, litigation (including class action litigation), governmental investigations and enforcement proceedings,

material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders, adverse actions against our licenses to do business and/or injunctive relief, any of which could adversely affect our businesses, cash flows, results of operations or financial condition. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and of our customers', members' and other constituents' sensitive information. There can be no assurance that additional such failures will not occur, or if any do occur, that we will detect them or that they can be sufficiently remediated.

We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our future performance.

Our ability to attract and retain qualified and experienced employees is essential to meet our current and future goals and objectives. There is no guarantee we will be able to attract and retain such employees or that competition among potential employers will not result in increased salaries or other benefits. If we are unable to retain existing employees or attract additional employees, or we experience an unexpected loss of leadership, we could experience a material adverse effect on our businesses and results of operations.

In addition, our failure to adequately plan for succession of senior management and other key management roles or the failure of key employees to successfully transition into new roles could have a material adverse effect on our businesses and results of operations. The succession plans we have in place and our employment arrangements with certain key executives do not guarantee the services of these executives will continue to be available to us.

We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.

The political environment in which we operate remains uncertain. It is reasonably possible that our business operations and results of operations could be materially adversely affected by legislative, regulatory and public policy changes at the federal or state level, increased government involvement in drug reimbursement, pricing and/or purchasing, increased regulation of PBMs, changes to Medicare, Medicaid or the regulatory environment for health care benefits, including the ACA, changes to drug reimbursement and/or pricing laws and regulations, changes to the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changes to immigration policies and/or many other public policy initiatives. For example, in January 2019, HHS proposed regulations that would exclude from the current safe harbor under the federal anti-kickback statute manufacturer's rebates on prescription drugs paid to PBMs, PDPs and Managed Medicaid organizations in connection with federally funded health care programs. It is not possible to predict whether or when any such changes will occur or what form any such changes may take (including through the use of United States Presidential Executive Orders). Other significant changes to health care system legislation or regulation as well as changes with respect to tax and trade policies, tariffs and other government regulations affecting trade between the United States and other countries are also possible and could adversely affect us. If we fail to respond adequately to such changes, including by implementing strategic and operational initiatives, or do not do so as effectively as our competitors, our businesses, operations and results of operations may be materially adversely affected.

In addition to efforts to amend, repeal or replace the ACA and related regulations, we expect the federal and state governments to continue to enact and seriously consider many broad-based legislative and regulatory proposals that will or could materially impact various aspects of the health care and related benefits system and our businesses. Potential modification to the ACA, including changes in enforcement and/or funding that further destabilize the Public Exchanges, as well as significant changes to Medicaid funding could impact the number of Americans with health insurance and, consequently, prescription drug coverage. Further changes to federal health care laws, including the ACA, drug reimbursement and pricing laws and/or laws governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, are probable. We cannot predict the effect, if any, that new health care legislation, future changes to the ACA or the implementation or failure to implement the outstanding provisions of ACA, may have on our retail pharmacy, LTC pharmacy, specialty pharmacy, pharmacy services and/or Health Care Benefits operations and/or results of operations. The federal and many state governments also are considering changes in the interpretation, enforcement and/or application of existing programs, laws and regulations, including changes to payments under and funding of Medicare and Medicaid programs.

In addition, much of the branded and generic drug product that we sell in our retail, mail and specialty pharmacies, and much of the other merchandise we sell, is manufactured in whole or in substantial part outside of the United States. In most cases, the products or merchandise are imported by others and sold to us. As a result, significant changes in tax or trade policies, tariffs or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material

adverse effect on our businesses, cash flows and results of operations. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in United States trade regulations, could adversely affect our businesses.

We cannot predict the enactment or content of new legislation and regulations or changes to existing laws or regulations or their enforcement, interpretation or application, or the effect they will have on our business operations or results of operations, which could be materially adverse. Even if we could predict such matters, it is not possible to eliminate the adverse impact of public policy changes that would fundamentally change the dynamics of one or more of the industries in which we operate. Examples of such change include: the federal or one or more state governments fundamentally restructuring or reducing the funding available for Medicare, Medicaid, dual eligible or dual eligible special needs plan programs, increasing its involvement in drug reimbursement, pricing and/or purchasing, changing the laws and regulations governing PBMs', PDPs' and/or Managed Medicaid organizations' interactions with government funded health care programs, changing the tax treatment of health or related benefits, or repealing or otherwise significantly altering the ACA. The likelihood of adverse changes remains high due to state and federal budgetary pressures, and our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence. For more information on these matters, see "Government Regulation" included in Item 1 of this Annual Report on Form 10-K.

Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.

Our strategy includes effectively investing our capital and human resources in appropriate strategic projects, current operations and acquisitions to transform our businesses in response to the changing dynamics in the industries in which we operate. Our strategic projects include, among other things: integrating the Aetna Acquisition; significant investments in human and technology resources to expand our consumer-oriented products and services; optimizing our business platforms; managing certain significant technology projects; further improving relations with manufacturers, suppliers and health care providers; negotiating contract changes with customers, manufacturers, suppliers and health care providers and implementing other business process improvements. Implementing our strategic initiatives will require significant investments of capital and human resources. Among other things, we will need to simultaneously acquire and develop new personnel, products and systems to serve existing and new customers with existing and new products and to enhance our existing customer service, information technology, control and compliance processes and systems. The future performance of our businesses will depend in large part on our ability to design and implement our strategic initiatives, some of which will occur over several years. If these initiatives do not achieve their objectives, our results of operations could be adversely affected.

Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, and we may fail to recognize and position ourselves to capitalize upon market opportunities. We may not have sufficient advance notice and resources to develop and effectively implement an alternative strategy. If our existing competitors and/or new entrants (whether vertical, horizontal or online/digital/e-commerce) into one or more of our businesses create new disruptive business models and/or develop new offerings that customers, members and/or health care providers prefer to our offerings, we may lose customers, members and/or providers, and our results of operations, cash flows and/or prospects may be adversely affected. In addition, our results of operations, cash flows and/or prospects may be adversely affected by consolidation among the participants in the industries in which we operate and/or our customer base. Our businesses and results of operations could be materially and adversely affected by such changes, even if we correctly predict their occurrence.

Risks Related to Our Businesses

Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.

The continued efforts of HMOs, MCOs, PBMs, government entities, and other third party payors to reduce prescription drug costs and pharmacy reimbursement rates, as well as litigation and other legal proceedings relating to how drugs are priced, may adversely affect our profitability. In particular, increased utilization of generic drugs (which normally yield a higher gross profit rate than equivalent brand named drugs) has resulted in pressure to decrease reimbursement payments to retail, specialty, LTC and mail order pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Historically, the effect of this trend on generic profitability has been mitigated by the introduction of new multi-source generic drugs as well as inflation on brand name drugs and by our efforts to negotiate reduced acquisition costs of generic drugs with manufacturers. However, in recent years, there has been significant consolidation within the generic manufacturing industry and in 2019 we expect fewer new multi-source generic drugs to be introduced and lower brand name drug inflation than in recent prior years, and it is possible that these and other external factors may enhance the ability of manufacturers to sustain or increase pricing of generic drugs and diminish our ability to negotiate reduced acquisition costs. Any inability to offset increased brand name or

generic prescription drug costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our results of operations.

In addition, during the past several years, the United States health care industry has been subject to an increase in governmental regulation and audits at both the federal and state levels. Efforts to control health care costs, including prescription drug costs, are continuing at the federal and state government levels. Changing political, economic and regulatory influences may significantly affect health care financing and reimbursement practices. For example, we anticipate that federal and state governments will continue to review and assess alternative health care delivery systems, payment methodologies and operational requirements for health care providers, including LTC facilities and pharmacies, and participants in government funded health care programs. A change in the composition of pharmacy prescription volume toward programs offering lower reimbursement rates could adversely affect our profitability. Any action taken to repeal or replace all or significant parts of ACA also could adversely affect our profitability, though it is unclear at this time what the full effects of any such changes would be.

The ACA made several significant changes to Medicaid rebates and to reimbursement rates. One of these changes was to revise the definition of the Average Manufacturer Price, a pricing element common to most payment formulas, and the reimbursement formula for generic drugs. This change has adversely affected the reimbursements we receive when we dispense prescription drugs to Medicaid recipients. In addition, the ACA made other changes that affect the coverage and plan designs that are or will be provided by many of our health plan clients, including the requirement for health insurers to meet a minimum MLR to avoid having to pay rebates to enrollees. These ACA changes may not affect our businesses directly, but they could indirectly impact our services, business practices and/or results of operations.

Gross margins in the industries in which we operate may decline.

The PBM industry has been experiencing margin pressure as a result of competitive pressures and increased client demands for lower prices, increased revenue sharing, enhanced service offerings and/or higher service levels. In that regard, we maintain contractual relationships with generic drug manufacturers and brand name drug manufacturers that provide for purchase discounts and/or rebates on drugs dispensed by pharmacies in our retail network and by our specialty and mail order pharmacies (all or a portion of which may be passed on to clients). Manufacturer's rebates often depend on a PBM's ability to meet contractual market share or other requirements, including in some cases the placement of a manufacturer's products on the PBM's formularies. If we lose our relationship with one or more drug manufacturers, or if the discounts or rebates provided by drug manufacturers decline, our businesses and results of operations could be adversely affected. Further, competitive pressures in the PBM industry have resulted in our clients sharing in a larger portion of rebates and/or discounts received from drug manufacturers. Marketplace dynamics and regulatory changes also have impacted our ability to offer plan sponsors pricing that includes the use of retail "differential" or "spread", which could adversely affect our future profitability, and we expect these trends to continue. Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to additional regulation of PBMs, drug pricing or purchasing, patent term extensions, purchase discount and/or rebate arrangements with drug manufacturers, or additional regulation of PBMs, formulary management or other PBM services could also reduce the discounts or rebates we receive. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, including our ability to use MAC lists and collect transmission fees, could adversely affect our profitability.

Our retail pharmacy, specialty pharmacy and LTC pharmacy operations also have been affected by the margin pressures described above, including client demands for lower prices, generic pricing and network reimbursement pressure. In addition, as competition increases in the geographies in which we operate, including competition from new entrants, a significant increase in general pricing pressures could occur, and this could require us to reevaluate our pricing structures to remain competitive. A shift in the mix of our pharmacy prescription volume towards programs offering lower reimbursement rates could adversely affect our margins, including the ongoing shift in pharmacy mix towards 90-day prescriptions at retail and the ongoing shift in pharmacy mix towards Medicare Part D prescriptions. Finally, the margins of our LTC business are further affected by the increased efforts of health care payors to negotiate reduced or capitated pricing arrangements. These actions could also adversely affect the margins of our LTC business.

Our results of operations are affected by the health of the economy in general and in the geographies we serve.

Our businesses are affected by the United States economy and consumer confidence in general and in the geographies we serve, including various economic factors, inflation and changes in consumer purchasing power, preferences and/or spending patterns. It is possible that an unfavorable, uncertain or volatile economic environment will cause a decline in drug utilization, an increase in health care utilization and dampen demand for PBM services as well as consumer demand for products sold in our retail stores. Further, economic conditions including interest rate fluctuations, changes in capital market conditions and

regulatory changes may affect our ability to obtain necessary financing on acceptable terms, our ability to secure suitable store locations under acceptable terms and our ability to execute sale-leaseback transactions under acceptable terms. Adverse changes in the United States economy, consumer confidence and economic conditions could have an adverse effect on our businesses and financial results. This adverse effect could be further exacerbated by the increasing prevalence of high deductible health plans and health plan designs favoring co-insurance over co-payments as members and other consumers may decide to postpone, or not to seek, medical treatment which may lead them to incur more expensive medical treatment in the future and/or decrease our prescription volumes.

In addition, our Health Care Benefits membership remains concentrated in certain geographic areas in the United States and in certain industries. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in those geographic areas where our membership is concentrated could therefore have a disproportionately adverse effect on our Health Care Benefits results of operations. Our Health Care Benefits membership has been and may continue to be affected by workforce reductions by our customers due to adverse and/or uncertain general economic conditions, especially in the United States geographies and industries where our membership is concentrated. As a result, we may not be able to profitably grow and diversify our Health Care Benefits membership geographically, by product type or by customer industry, and our revenue and results of operations may be disproportionately affected by adverse changes affecting our customers.

We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.

Each of our businesses currently operates in a highly competitive and evolving business environment. We must compete successfully with existing competitors and new entrants, including strategic alliances and online, digital and e-commerce companies.

The competitive success of our retail pharmacy business, as well as our specialty pharmacy operations with third-party payors, is dependent on our ability to establish and maintain contractual relationships with PBMs and other payors on acceptable terms in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. As a pharmacy retail business, we compete with other drugstore chains, supermarkets, online and other discount retailers, independent pharmacies, membership clubs, convenience stores and mass merchants, some of which are aggressively expanding into markets we serve. We also face competition from other retail health care clinics, as well as other mail order pharmacies and PBMs. Disruptive innovation by existing or new competitors could alter the competitive landscape in the future and require us to accurately identify and assess such changes and make timely and effective changes to our strategies and business model to compete effectively. Competition may also come from other sources in the future. Changes in market dynamics or the actions of competitors or manufacturers, including industry consolidation, the emergence of new competitors and strategic alliances, and decisions to exclude us from new narrow or restricted retail pharmacy networks, could materially and adversely affect our businesses, results of operations, cash flows and prospects.

We also could be adversely affected if we fail to identify or effectively respond to changes in market dynamics. For example, specialty pharmacy represents a significant and growing proportion of prescription drug spending in the United States, a significant portion of which is dispensed outside of traditional retail pharmacies. Because our specialty pharmacy operations focus on complex and high-cost medications that serve a relatively limited universe of patients, the future growth of this business depends to a significant extent upon expanding our ability to access key drugs and successfully penetrate key treatment categories.

The competitive success of our LTC pharmacy operations is dependent upon our ability to compete in each geographic region where we have operations. In the geographic regions we serve, we compete with PharMerica, our largest LTC pharmacy competitor, as well as with numerous local and regional institutional pharmacies, pharmacies owned by long-term care facilities and local retail pharmacies. Our LTC pharmacy customers consist of skilled nursing facilities, assisted living facilities, independent living communities, hospitals, correctional facilities, and other health care service providers. One of our growth opportunities is to increase our penetration rate in the assisted living segment, where residents can choose which pharmacy will provide them with prescription drugs. The ability of a resident of an assisted living facility to select the pharmacy that supplies him or her with prescription drugs could adversely affect our business, financial condition and results of operations because there can be no assurance that such resident will select us.

The competitive success of our pharmacy services business is impacted by its ability to establish and maintain contractual relationships with network pharmacies in an environment where some PBM clients are considering adopting narrow or restricted retail pharmacy networks. Competitors in the PBM industry (e.g., the Express Scripts business of Cigna Corporation,

OptumRx, Prime Therapeutics, MedImpact and Humana), include large, national PBM companies, PBMs owned by large national health plans and smaller standalone PBMs. Competition also may come from other sources in the future. In addition, changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could adversely affect our claims volume and/or our competitiveness generally.

Customer contracts in our Health Care Benefits segment are generally for a period of one year, and our customers have considerable flexibility in moving between us and our competitors. One of the key factors on which we compete for customers, especially in uncertain economic environments, is overall cost. We are therefore under pressure to contain premium price increases despite being faced with increasing health care and other benefit costs and increasing operating costs. If we are unable to increase our prices to reflect increasing costs, our profitability will be adversely affected. If we are unable to limit our price increases, we may lose members to competitors with more favorable pricing, adversely affecting our revenues and results of operations. In response to rising prices, our customers may elect to self-insure or to reduce benefits in order to limit increases in their benefit costs. Alternatively, our customers may purchase different types of products from us that are less profitable. Such elections may result in reduced membership in our more profitable Insured products and/or lower premiums for our Insured products, which may adversely affect our revenues and results of operations, although such elections also may reduce our health care and other benefit costs. In addition, our Medicare, Medicaid and CHIP products are subject to termination without cause, periodic re-bid, rate adjustment and program redesign, as customers seek to contain their benefit costs, particularly in an uncertain economy. These actions may adversely affect our membership, revenues and results of operations

Competitors in each of our businesses may offer services and pricing terms that we may not be willing or able to offer. For example, strong competition in the PBM marketplace has generated greater client demand for lower pricing, increased revenue sharing and enhanced product and service offerings. Unless we can demonstrate enhanced value to our clients through innovative product and service offerings, particularly in a rapidly changing health care industry, we may be unable to remain competitive.

We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. PBM client contracts often have terms of approximately three years in duration, so approximately one third of a PBM's client base typically is subject to renewal each year. In some cases, however, PBM clients may negotiate a shorter or longer contract term or may require early or periodic renegotiation of pricing prior to expiration of a contract. Our clients are generally well informed and organized, can move between our competitors and often seek competing bids prior to expiration of their contracts. In addition, the reputational impact of a service-related incident could adversely affect our businesses. These factors, together with the impact of competitive pressures, could make it difficult for us to attract new clients, retain existing clients and cross-sell additional products and/or services. Further, the PBM industry has been affected by consolidation activity that may continue in the future. If one or more of our PBM clients is acquired by an entity that is not also our client, we may be unable to retain all or a portion of the acquired client's business. These circumstances, either individually or in the aggregate, could result in an adverse effect on our businesses and financial results. Therefore, we continually face challenges in competing for new PBM business and retaining or renewing our existing PBM business. With respect to our LTC pharmacy business, reimbursement from skilled nursing facilities for prescriptions we dispense is determined pursuant to our agreements with those skilled nursing facilities. The termination of these agreements generally terminates our ability to provide services to any of the residents of that facility, resulting in the loss of revenue from any source for those residents. There can be no assurance that we will be able to win new business or secure renewal business on terms as favorable to us as the present terms.

Additionally, with respect to our retail and LTC pharmacy businesses, reimbursement under Medicare Part D, as well as reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their PBM representatives. The loss of those agreements, or a material change in the terms of those agreements, could adversely affect our results of operations and cash flows. In addition, restricted networks that exclude our retail or specialty pharmacies adversely affect those businesses.

The health care and related benefits industry is highly competitive, primarily due to a large number of for-profit and not-for-profit competitors, our competitors' marketing and pricing, and a proliferation of competing products, including new products that are continually being introduced into the marketplace. Our Health Care Benefits segment faces significant competition in all of the geographies and product areas in which it operates. New entrants into the marketplace, as well as consolidation within the industry, have contributed to and are expected to intensify the competitive environment. In addition, the rapid pace of change as the industry evolves towards a consumer-focused retail marketplace, including Insurance Exchanges, and the

increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared to prior periods.

Our Health Care Benefits segment competes on the basis of many factors, including perceived overall quality, quality of service, comprehensiveness of coverage, cost (including premium, provider discounts and member out-of-pocket costs), product design, financial stability and ratings, breadth and quality of provider networks, providers available in such networks, and quality of member support and care management programs. Our Health Care Benefits segment's competitors include, among others, UnitedHealth Group Incorporated, Anthem, Inc., Humana Inc., Cigna Corporation, WellCare Health Plans, Inc., Centene Corporation, Molina Healthcare, Inc., Kaiser Permanente, health system owned health plans and new entrants into the marketplace, and numerous for-profit and not-for-profit organizations operating under licenses from the Blue Cross and Blue Shield Association. The Health Care Benefits segment's largest competitor in its Medicare products is Original Medicare. Additional competitors in this segment's businesses include other types of medical and dental provider organizations, various specialty service providers (including PBM services providers), health care consultants, financial services companies, integrated health care delivery organizations (networks of providers who also coordinate administrative services for and assume insurance risk of their members), TPAs, HIT companies and, for certain plans, programs sponsored by the federal or state governments. Emerging competitors include start up health care benefit plans, provider-owned health plans, new joint ventures (including for-profit and not-for-profit joint ventures among firms from multiple industries), technology firms, financial services firms that are distributing competing products on their proprietary Private Exchanges, consulting firms that are distributing competing products on their proprietary Private Exchanges, as well as non-traditional distributors such as retail companies. In particular geographies, competitors may have greater capabilities, resources or membership; a more established reputation; superior supplier or health care professional pricing and contract terms; better business relationships; or other factors that give such competitors a competitive advantage. The Health Care Benefits segment competes for sales on Insurance Exchanges and is developing and expanding its Consumer Health Products and Services product and service offerings, where we face additional risks from existing and new competitors (including our vendors) who have lower cost structures, greater experience marketing to consumers and/or who target the higher margin portions of our business. Among the Health Care Benefits segment's international and HIT competitors, many have longer operating histories, better brand recognition and greater market presence in many of the areas in which the segment is seeking to expand and more experience at rapidly innovating products.

There can be no assurance that the Aetna Acquisition will not adversely affect any of our segments' respective abilities to attract new clients or retain existing clients or our ability to cross-sell additional products and/or services within any segment or between segments. If we do not compete effectively in the geographies and product areas in which we operate, our businesses, results of operations, financial condition and cash flows could be materially and adversely affected.

We are exposed to risks relating to the solvency of our customers and of other insurers.

If our customers' operating and financial performance deteriorates, or they are unable to make scheduled payments or obtain adequate financing, our customers may not be able to pay timely, or may delay payment of, amounts owed to us. Any inability of our customers to pay us for our products and services may adversely affect our businesses, financial condition and results of operations. In addition, both state and federal government sponsored payers, as a result of budget deficits or reductions, may suspend payments or seek to reduce their healthcare expenditures resulting in our customers delaying payments to us or renegotiating their contracts with us. Any delay or reduction in payments by such government sponsored payers may adversely affect our businesses, financial condition and results of operations.

We are subject to assessments under guaranty fund laws for obligations of insolvent insurance companies (such as the discounted estimated liability expense of $231 million pretax for our estimated share of future assessments for Penn Treaty Network America Insurance Company and one of its subsidiaries that Aetna recorded in the first quarter of 2017), HMOs, ACA co-ops and other payors to policyholders and claimants.

We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs that we purchase and sell.

We dispense significant volumes of brand-name and generic drugs from our retail, LTC, specialty and mail order pharmacies and through our PBM's network of retail pharmacies. When increased safety risk profiles or manufacturing or other supply issues of specific drugs or classes of drugs occur, or drugs become subject to greater restrictions as controlled substances, physicians may cease writing prescriptions for these drugs or the utilization of these drugs may be otherwise reduced.

Additionally, adverse publicity regarding drugs with higher safety risk profiles may result in reduced consumer demand for such drugs. On occasion, products are withdrawn by their manufacturers or transition to over-the-counter products, which can

result in lower prescription utilization. In addition, future FDA rulings could restrict the supply or increase the cost of products sold to our customers. Our results of operations and cash flows may decline as a result of such regulatory rulings or market changes.

Further, we acquire a substantial amount of our mail and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers are often short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the agreement and may allow the supplier to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations. Moreover, many products distributed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages. In some cases, we depend upon a single source of supply. Any such supply shortages or loss of any such single source of supply could adversely affect our results of operations and cash flows.

In addition, our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling prescription drugs to us or delay delivery, including as a result of supply shortages, supplier production disruptions, supplier quality issues, closing or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner and on acceptable terms, or at all.

A disruption in our business operations could occur as a result of contamination of drugs, a failure to maintain necessary shipment and storage conditions, errors in mail order processing, the unavailability of prescription drugs provided by suppliers, labor disruptions or other unanticipated disruptions at our mail order dispensing pharmacy facilities, specialty pharmacy facilities, call centers, data centers or corporate facilities, among other factors. Such disruption could reduce our ability to process and dispense prescriptions and provide products and services to our customers.

If any products we distribute are in limited supply for significant periods of time, our financial condition and results of operations could be materially and adversely affected.

We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.

The profitability of our Retail/LTC and Pharmacy Services segments is dependent upon the utilization of prescription drug products. Utilization trends are affected by, among other factors, the introduction of new and successful prescription drugs as well as lower-priced generic alternatives to existing brand name products because we generally earn higher gross margins on the sale of generic alternatives than on brand name equivalents. In addition, inflation in the price of brand name drugs can affect utilization, particularly given the increase in high deductible health plans. Accordingly, our businesses and results of operations could be adversely affected by a slowdown or delay in the number or magnitude of new and successful prescription drugs and/or generic alternatives, as well as inflation in the price of brand name drugs. For example, we project that the operating income of our Pharmacy Services and Retail/LTC segments may be reduced in 2019 compared to 2018 due in part to fewer new multi-source generic drugs being introduced and lower brand name drug price inflation in 2019 than 2018.

Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.

It is possible that the pharmaceutical industry or regulators may evaluate and/or develop an alternative pricing reference to replace AWP or Wholesale Acquisition Cost ("WAC"), which are the pricing references used for many of our PBM and LTC client contracts, drug purchase agreements, retail network contracts, specialty payor agreements and other contracts with third party payors in connection with the reimbursement of drug payments. In addition, many state Medicaid fee-for-service programs ("FFS Medicaid") have established pharmacy network payments on the basis of Actual Acquisition Cost ("AAC"). The use of an AAC basis in FFS Medicaid could have an impact on reimbursement practices in other commercial and government products. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state health programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM clients and other payors and/or our ability to negotiate rebates and/or discounts with drug manufacturers, wholesalers, PBMs and retail pharmacies. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our results of operations. Additionally, any future changes in drug prices could be significantly different than our projections. The effect of these possible changes on our businesses cannot be predicted at this time.

Product liability, product recall or personal injury issues could damage our reputation.

The products that we sell could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the dispensing and packaging of drugs and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Product liability or personal injury claims may be asserted against us with respect to any of the drugs or other products we sell or services we provide. For example, we are a defendant in litigation proceedings relating to opioids and the sale of products containing talc. Our businesses involve the provision of professional services, including by pharmacists, physician assistants, nurses and nurse practitioners, that exposes us to professional liability claims. Should a product or other liability issue arise, the coverage limits under our insurance programs and the indemnification amounts available to us may not be adequate to protect us against claims. We also may not be able to maintain our existing levels of insurance on acceptable terms in the future. Damage to our reputation in the event of a product liability or personal injury issue or judgment against us or a product recall could have a significant adverse effect on our businesses, financial condition and results of operations.

We face challenges in growing our Medicare Advantage and Medicare Part D membership.

We are seeking to substantially grow our Medicare Advantage and Medicare Part D membership, revenue and results of operations in 2019 and over the next several years, including by significantly expanding our Medicare Advantage service area. The organic expansion of our Medicare Advantage service area is subject to the ability of CMS to process our requests for service area expansions and our ability to build cost competitive provider networks in the expanded service areas that meet applicable network adequacy requirements. CMS' decisions on our requests for service area expansions also may be affected adversely by compliance issues that arise each year in our Medicare operations. If we are not successful in expanding our Medicare Advantage service area, we may not be able to achieve our Medicare Advantage growth goals.

We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.

We are seeking to substantially grow our Medicaid, dual eligible and dual eligible special needs plan membership over the next several years. In many instances, to acquire and retain our government customers' business, we must bid against our competitors in a highly competitive environment. Winning bids often are challenged successfully by unsuccessful bidders. Our ability to maintain and grow membership, revenues and results of operations in our Medicaid products is dependent on our remaining competitive on price, performance and preparing successful bids. In cases where a successful bid is challenged, we incur defense costs and may incur unreimbursed implementation and other costs to meet contractual deadlines even if we ultimately lose the challenge.

If we are successful in expanding our Medicaid membership, we may increase our exposure to states that face budgetary pressures, hospitals and other providers that face revenue challenges associated with uncompensated care and pressures on our operating margins driven by the projected rapid growth in the size of and cost of care for the Medicaid eligible population.

A change in our Health Care Benefits product mix may adversely affect our profit margins.

Our Insured Health Care Benefits products that involve greater potential risk generally tend to be more profitable than our ASC products. Historically, smaller employer groups have been more likely to purchase Insured Health Care Benefits products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures, although recently even relatively small employers have moved to ASC products. We also serve government-sponsored programs, including Medicare and Medicaid, that are subject to competitive bids and regulatory requirements and have lower profit margins than the Insured Commercial products in our Health Care Benefits segment. Although our Health Care Benefits membership is projected to continue to shift towards Government products in 2019, the profitability of each of those products differs and may be less than the profitability of an Insured Commercial product. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our results of operations.

We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's results of operations. There can be no assurance that the future health care and other benefit costs of our Insured Health Care Benefits products will not exceed our projections.

Premiums for our Insured Health Care Benefits products, which comprised 87% of our Health Care Benefits revenues for 2018, are priced in advance based on our forecasts of health care and other benefit costs during a fixed premium period, which is generally one year. These forecasts are typically developed several months before the fixed premium period begins, are influenced by historical data (and recent historical data in particular), are dependent on our ability to anticipate and detect medical cost trends and changes in our members' behavior and healthcare utilization patterns and require a significant degree of

judgment. For example, our revenue on Medicare policies is based on bids submitted in June of the year before the contract year. Cost increases in excess of our projections cannot be recovered in the fixed premium period through higher premiums. As a result, our profits are particularly sensitive to the accuracy of our forecasts and our ability to anticipate and detect medical cost trends. Even relatively small differences between predicted and actual health care and other benefit costs as a percentage of premium revenues can result in significant adverse changes in our results of operations.

Our health care and other benefit costs can be affected by external events that we cannot forecast or anticipate and over which we have little or no control, such as emerging changes in the economy and/or public policy, additional government mandated benefits or other regulatory changes, changes in our members' behavior and healthcare utilization patterns, changes in health care practices, new technologies, increases in the cost of prescription drugs, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), direct-to-consumer marketing by drug manufacturers, clusters of high cost cases, epidemics, pandemics, terrorist attacks or other man-made disasters, natural disasters or other events that materially increase utilization of medical and/or other covered services, including prescription drugs, as well as changes in provider billing practices. Our health care and other benefit costs also can be affected by changes in our business mix, product designs, contracts with providers, medical management, underwriting, rating and/or claims processing methods and processes, and our medical management initiatives may not deliver the reduction in utilization and/or medical cost trend that we project.

It is particularly difficult to accurately anticipate, detect, price, forecast, manage and reserve for medical cost trends and utilization of medical and/or other covered services during and following periods when such utilization and/or trends are below recent historical levels, during periods of changing economic conditions and employment levels and for products with substantial membership growth and/or turnover. For example, as of December 31, 2018, we held a premium deficiency reserve of $16 million for the 2019 coverage year related to our Medicaid products. We expect utilization to increase in 2019 when compared to 2018.

If health care and other benefit costs are higher than the levels reflected in our pricing or if we are not able to obtain appropriate pricing on new or renewal business, our prices will not reflect the risk we assume, and our results of operations will be adversely affected. If health care and other benefit costs are lower than we predict, our prices may be higher than those of our competitors, which may cause us to lose Health Care Benefits membership.

A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.

A number of factors contribute to rising health care and other benefit costs, including previously uninsured members entering the health care system, changes in members' behavior and healthcare utilization patterns, turnover in our membership, additional government mandated benefits or other regulatory changes, changes in the health status of our members, the aging of the population and other changing demographic characteristics, advances in medical technology, increases in the number and cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by drug manufacturers, the increasing influence of social media on our members' utilization and other behavior, changes in health care practices and inflation. In addition, government-imposed limitations on Medicare and Medicaid reimbursements to health plans and providers have caused the private sector to bear a greater share of increasing health care and other benefits costs over time, and future amendments or repeal or replacement of the ACA that increase the uninsured population may exacerbate this problem. Other factors that affect our health care and other benefit costs include changes as a result of the ACA, changes to the ACA and other changes in the regulatory environment, the evolution toward a consumer driven business model, changes in health care practices, general economic conditions (such as inflation and employment levels), new technologies, influenza related health care costs (which may be substantial and were higher than Aetna projected in 2017-2018), clusters of high-cost cases, epidemics or pandemics, health care provider and member fraud, and numerous other factors that are or may be beyond our control.

Our Health Care Benefits segment's results of operations and competitiveness depend in large part on our ability to appropriately manage future health care and other benefit costs through underwriting criteria, product design, provider network configuration, negotiation of favorable provider contracts and medical management programs. Our medical cost management programs may not be successful and may have a smaller impact on health care and benefit costs than we expect. The factors described above may adversely affect our ability to predict and manage health care and other benefit costs, which can adversely affect our competitiveness and results of operations.

The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be

insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.

A large portion of health care claims are not submitted to us until after the end of the quarter in which services are rendered by providers to our members. Our reported health care costs payable for any particular period reflect our estimates of the ultimate cost of such claims as well as claims that have been reported to us but not yet paid. We also must estimate the amount of rebates payable under the ACA's, CMS's and OPM's minimum MLR rules and the amounts payable by us to, and receivable by us from, the United States federal government under the ACA's remaining premium stabilization program.

Our estimates of health care costs payable are based on a number of factors, including those derived from historical claim experience, but this estimation process also makes use of extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, turnover and other changes in membership, changes in product mix, changes in the utilization of medical and/or other covered services, including prescription drugs, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. We estimate health care costs payable periodically, and any resulting adjustments, including premium deficiency reserves, are reflected in current-period results of operations within benefit costs. For example, as of December 31, 2018, we held a premium deficiency reserve of $16 million for the 2019 coverage year related to our Medicaid products. A worsening (or improvement) of health care cost trend rates or changes in claim payment patterns from those that we assumed in estimating health care costs payable as of December 31, 2018 would cause these estimates to change in the near term, and such a change could be material.

Furthermore, if we are not able to accurately and promptly anticipate and detect medical cost trends or accurately estimate the cost of incurred but not yet reported claims or reported claims that have not been paid, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited, which would further exacerbate the extent of any adverse impact on our results of operations. These risks are particularly acute during and following periods when utilization of medical and/or other covered services and/or medical cost trends are below recent historical levels and in products where there is significant turnover in our membership each year, and such risks are further magnified by the ACA and other legislation and regulations that limit our ability to price for our projected and/or experienced increases in utilization and/or medical cost trends.

Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.

Nuclear, biological or other attacks, whether as a result of war or terrorism, other man-made disasters, natural disasters, epidemics, pandemics and other extreme events can affect the United States economy in general, our industries and us specifically. In particular, such extreme events or the threat of such extreme events could result in significant health care (including behavioral health) costs, which would also be affected by the government's actions and the responsiveness of public health agencies and other insurers. In addition, our employees and those of our vendors are concentrated in certain large, metropolitan areas which may be particularly exposed to these events. Such events could adversely affect our businesses, cash flows and results of operations, and, in the event of extreme circumstances, our financial condition or viability, particularly if our responses to such events are less adequate than those of our competitors.

Changes in Public Policy and Other Legal and Regulatory Risks

Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges. Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.

Medicare Advantage payment rates to health plans have been cut over the last several years, with additional reductions to be phased in through 2019. CMS issued the Final Notice in April 2018. Overall, we project the benchmark rates in the Final Notice will increase funding for our Medicare Advantage business, excluding the impact of coding trend, by approximately 2.5 percent in 2019 compared to 2018. This 2019 rate increase only slightly offsets the challenge we face from the impact of the increasing cost of medical care (including prescription medications), the HIF and CMS local and national coverage decisions that require us to pay for services and supplies that are not factored into our bids and creates continued pressure on the Medicare Advantage program and our Medicare Advantage results of operations. We cannot predict future Medicare funding levels, the impact of future federal budget actions or ensure that such changes or actions will not have an adverse effect on our Medicare results of operations.

In addition, the "star ratings" from CMS for our Medicare Advantage plans will continue to have a significant effect on our plans' results of operations. Since 2015, only Medicare Advantage plans with a star rating of four or higher (out of five) are eligible for a quality bonus in their basic premium rates. CMS continues to change its rating system to make achieving and maintaining a four or higher star rating more difficult. Our star ratings and past performance scores are adversely affected by the compliance issues that arise each year in our Medicare operations. If our star ratings fall below 4 for a significant portion of our Medicare Advantage membership or do not match the performance of our competitors or the star rating quality bonuses are reduced or eliminated, our revenues and results of operations may be significantly adversely affected.

Payments we receive from CMS for our Medicare Advantage and Part D businesses also are subject to risk adjustment based on the health status of the individuals we enroll. Elements of that risk adjustment mechanism continue to be challenged by the DOJ, the OIG and CMS itself. Substantial changes in the risk adjustment mechanism, including changes that result from enforcement or audit actions, could materially affect the fairness of our Medicare reimbursement, require us to raise prices or reduce the benefits we offer to Medicare beneficiaries, and potentially limit our (and the industry's) participation in the Medicare program.

Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our pharmacy gross margin rates due to regulatory and competitive pressures. Further, as a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this phenomenon occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D business. In addition, if the cost and complexity of Medicare Part D exceed management's expectations or prevent effective program implementation or administration; if changes to the regulations regarding how drug costs are reported for Medicare Part D are implemented in a manner that adversely affects the profitability of our Medicare Part D business; if changes to the applicable regulations impact our ability to retain fees from third parties including network pharmacies; if the government alters Medicare Part D program requirements or reduces funding because of the higher-than-anticipated cost to taxpayers of Medicare Part D or for other reasons; if the government mandates the use of point-of-sale manufacturer's rebates or up front drug pricing discounts, makes drug manufacturer's rebates illegal, or makes changes to how pharmacy pay-for-performance is calculated; or if reinsurance thresholds are reduced below their current levels, our Medicare Part D results of operations and our ability to expand our Medicare Part D business could be adversely affected.

More generally, our Medicare results of operations and our ability to expand our Medicare membership and revenues also could be adversely affected if we fail to design and maintain programs that are attractive to Medicare Advantage or Part D participants; if CMS imposes restrictions on our Medicare business as a result of audits or other regulatory actions; if we fail to successfully implement corrective actions or other remedial measures sufficient to prevent or remove any applicable restrictions that may be imposed by CMS; or if we are not successful in retaining enrollees, or winning contract renewals or new contracts under Medicare's competitive bidding process.

Federal funding for expanded Medicaid coverage began to decrease in 2017. This reduction is causing states to re-evaluate funding for their Medicaid expansions. That re-evaluation may adversely affect Medicaid payment rates, our Medicaid membership in those states, our revenues, our MBRs and our results of operations.

We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and results of operations and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.

Premium rates for our Insured Health Care Benefits products generally must be filed with state insurance regulators and are subject to their approval, which creates risk for us in the current political and regulatory environment. The ACA generally requires a review by HHS in conjunction with state regulators of premium rate increases that exceed a federally specified threshold (or lower state-specific thresholds set by states determined by HHS to have adequate processes). Rate reviews can magnify the adverse impact on our operating margins and results of operations of increases in health care and other benefit costs, increased utilization of covered services, and ACA assessments, fees and taxes, by restricting our ability to reflect these increases and/or these assessments, fees and taxes in our pricing. The risk of increases in utilization of medical and/or other covered services and/or in health care and other benefit costs is particularly acute during and following periods when utilization has been below recent historical levels, during periods of changing economic conditions and/or employment levels and in products where there is significant turnover in our membership each year. Further, our ability to reflect ACA assessments, fees and taxes in our Medicare rates is limited. Similarly, our ability to reflect them in our Medicaid and/or CHIP premium rates is limited due, among other things, to the budgetary pressures currently facing many state governments. This could magnify the adverse impact on our operating margins and results of operations of increases in utilization of medical and other covered services, health care and other benefit costs and/or medical cost trends that exceed our projections.

Since 2013, HHS has issued determinations to health plans that their rate increases were "unreasonable," and we continue to experience challenges to appropriate premium rate increases in certain states. Regulators or legislatures in a number of states have implemented or are considering limits on premium rate increases, either by enforcing existing legal requirements more stringently or proposing different regulatory standards. Regulators or legislatures in a number of states also have conducted hearings on proposed premium rate increases, which can result, in some instances have resulted, in substantial delays in implementing proposed rate increases even if they ultimately are approved. Our plans can be excluded from participating in small group Public Exchanges if they are deemed to have a history of "unreasonable" rate increases. We requested significant increases in our premium rates in our small group Commercial Health Care Benefits products for 2019 and expect to continue to request significant increases in those rates for 2020 and beyond in order to adequately price for projected medical cost trends, required expansions of coverage and significant assessments, fees and taxes imposed by the federal and state governments, including the ACA. Our rates also must be adequate to reflect the risk that our products will be selected by people with a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for the applicable products (also known as "adverse selection") in our products, particularly in small group products, which we expect to continue and potentially worsen in 2019 following the expiration of the ACA's risk corridor and reinsurance programs at the end of 2016. These significant rate increases heighten the risks of adverse public and regulatory reaction and adverse selection and the likelihood that our requested premium rate increases will be denied, reduced or delayed, which could lead to operating margin compression.

We anticipate continued regulatory and legislative action to increase regulation of premium rates in our Insured Health Care Benefits products. We may not be able to obtain rates that are actuarially justified or that are sufficient to make our policies profitable in any product line or geography. If we are unable to obtain adequate rates and/or rate increases, it could materially and adversely affect our operating margins and our ability to earn adequate returns on Insured Health Care Benefits business in one or more states or cause us to withdraw from certain geographies and/or products.

Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our results of operations.

The ACA requires us to pay minimum MLR rebates each year with respect to prior years. The ACA's minimum MLR rebate requirements limit the level of margin we can earn in our Commercial Insured and Medicare Insured businesses. CMS minimum MLR rebate regulations limit the level of margin we can earn in our Medicaid Insured business. Certain portions of our Health Care Benefits Medicaid and FEHB program business also are subject to minimum MLR rebate requirements in addition to but separate from those imposed by the ACA. Minimum MLR rebate requirements leave us exposed to medical costs that are higher than those reflected in our pricing. The process supporting the management and determination of the amount of MLR rebates payable is complex and requires judgment, and the minimum MLR reporting requirements are detailed. Federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with the OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS. Additional challenges to our methodology and/or reports relating to minimum MLR and related rebates by federal and state regulators and private litigants are reasonably possible. The outcome of these audits and additional challenges could adversely affect our results of operations.

Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.

Our businesses are subject to extensive regulation and oversight by state, federal and international governmental authorities. The laws and regulations governing our operations and interpretations of those laws and regulations are increasing in number and complexity, change frequently and can be inconsistent or conflicting. In general, these laws and regulations are designed to benefit and protect customers, members and providers rather than us or our investors. In addition, the governmental authorities that regulate our businesses have broad latitude to make, interpret and enforce the laws and regulations that govern us and continue to interpret and enforce those laws and regulations more strictly and more aggressively each year. In connection with the Aetna Acquisition, we also agreed to undertakings with certain state regulators that place various restrictions on certain of our businesses and the payment of dividends by certain of our subsidiaries.

Our Pharmacy Services products are subject to:

- The clinical quality, patient safety and other risks inherent in the dispensing, packaging and distribution of drugs and other health care products and services, including claims related to purported dispensing and other operational errors (any failure by us to adhere to the laws and regulations applicable to the dispensing of drugs could subject our Pharmacy Services businesses to civil and criminal penalties).
- Federal and state anti-kickback and other laws that govern our relationship with drug manufacturers, customers and consumers.
- Compliance requirements under ERISA, including fiduciary obligations in connection with the development and implementation of items such as drug formularies and preferred drug listings.
- Federal and state legislative proposals and/or regulatory activity that could adversely affect pharmacy benefit industry practices.

Our Health Care Benefits products are highly regulated, particularly those that serve Medicare, Medicaid, dual eligible, dual eligible special needs and small group Commercial customers and members. The laws and regulations governing participation in Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs are complex, are subject to interpretation and can expose us to penalties for non-compliance, including penalties under the False Claims Act and state false claims acts. In addition, the ACA may have expanded the jurisdiction of, and our exposure to, the False Claims Act to products that are sold on Public Exchanges or otherwise subject to the ACA. The scope of the practices and activities that are prohibited by federal and state false claims acts is the subject of pending litigation. Claims under federal and state false claims acts can be brought by the government or by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit, and we are a defendant in a number of such proceedings. If we are convicted of fraud or other criminal conduct in the performance of a health program or if there is an adverse decision against us under the False Claims Act, we may be temporarily or permanently suspended from participating in government health care programs, including Medicare Advantage, Medicare Part D, Medicaid, dual eligible and dual eligible special needs plan programs, and we also may be required to pay significant fines and/or other monetary penalties.

If we fail to comply with laws and regulations that apply to government programs, we could be subject to criminal fines, civil penalties, premium refunds, prohibitions on marketing or active or passive enrollment of members, corrective actions, termination of our contracts or other sanctions which could have a material adverse effect on our ability to participate in Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan and other programs, cash flows, financial condition and results of operations.

Our businesses, profitability and growth also may be adversely affected by (i) judicial and regulatory decisions that change and/or expand the interpretations of existing statutes and regulations, impose medical or bad faith liability, increase our responsibilities under ERISA or the remedies available under ERISA, or reduce the scope of ERISA pre-emption of state law claims or (ii) other legislation and regulations.

If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.

Our businesses are subject to extensive and complex regulations, and many of our contracts with customers include detailed requirements. In order to be eligible to offer certain products or bid on certain contracts, we must demonstrate that we have robust systems in place to ensure that we comply with all applicable legal, regulatory and contractual requirements. These systems frequently are reviewed and audited by our customers and regulators. If our systems and processes designed to maintain compliance with applicable legal and contractual requirements, and to prevent and detect instances of, or the potential for, non-compliance fail or are deemed inadequate, we may suffer brand and reputational harm and be subject to regulatory actions, litigation and other proceedings which may result in damages, fines, suspension or loss of licensure, suspension or exclusion from participation in government programs and/or other penalties, any of which could adversely affect our businesses, cash flows, results of operations or financial condition.

Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.

Historically, we focused primarily on providing Retail/LTC and Pharmacy Services products and services. As a result of the Aetna Acquisition, we have significantly expanded our presence in Health Care Benefits products and services (including

products and services offered in multiple countries outside of the United States), which present a different litigation and regulatory risk profile than the products and services that we historically have offered.

The increased volume of business in areas beyond our historical core business and new products and services subject us to litigation and regulatory risks that are different from the risks of providing Retail/LTC and Pharmacy Services products and services and increase significantly our exposure to other risks.

We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and results of operations.

Pharmacy services, retail pharmacy, LTC pharmacy and health care benefits are highly regulated and litigious industries. We are currently subject to various litigation matters, investigations, regulatory audits, inspections, government inquiries, and regulatory and other legal proceedings. Litigation, and particularly securities, collective or class action and *qui tam* litigation, is often expensive and disruptive. Certain of the lawsuits against us are or are purported to be class actions or *qui tam* actions. Litigation related to our provision of professional services in our pharmacies, specialty pharmacies, medical clinics and LTC facilities also has increased as we expand our services along the continuum of health care.

The majority of these proceedings relate to the conduct of our Retail/LTC, Pharmacy Services and Health Care Benefits operations and allege various violations of law. In addition, we operate in jurisdictions outside the United States, where contractual rights, tax positions and applicable regulations may be subject to interpretation or uncertainty to a greater degree than in the United States, and are therefore more likely to be subject to dispute by customers, members, governmental authorities and others. We are incurring expenses to resolve these proceedings. The outcome of litigation and other adverse legal proceedings is always uncertain, and outcomes that are not justifiable by the evidence or existing law or regulation can and do occur.

Litigation has been and may be brought against us by private individuals on behalf of the government through a *qui tam* or "whistleblower" suit. Under the provisions of the federal and various state false claims acts, private citizens may bring lawsuits alleging that a violation of the federal anti-kickback statute or similar laws has resulted in the submission of "false" claims to federal and/or state health care programs, including Medicare and Medicaid, and we are a defendant in a number of such proceedings. When a private individual brings a whistleblower suit, the defendant often will not be made aware of the suit for many months or even years, until the government commences its own investigation or determines whether it will intervene. Whistleblower suits have resulted in significant settlements between governmental agencies and health care companies. The significant incentives and protections provided under the Financial Reform Act increase the risk of whistleblower suits.

Many of the legal proceedings against us seek substantial damages (including non-economic or punitive damages and treble damages), and certain of these proceedings also seek changes in our business practices. While we currently have insurance coverage for some potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded or costs incurred. In addition, some types of damages, like punitive damages, may not be covered by insurance, and in some jurisdictions the coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

We cannot predict the outcome of any of these matters, and the costs incurred may be substantial regardless of outcome. Litigation and other adverse legal proceedings could materially adversely affect our businesses or results of operations because of brand and reputational harm to us caused by such proceedings, the costs of defending such proceedings, the costs of settlement or judgments against us, or the changes in our operations that could result from such proceedings. See Item 3 of this Annual Report on Form 10-K for additional information.

We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.

As one of the largest national retail and LTC pharmacy, pharmacy services and health care benefits providers, we frequently are subject to regular and special governmental market conduct and other audits, investigations and reviews by, and we receive subpoenas and other requests for information from, various federal and state agencies, regulatory authorities, attorneys general, committees, subcommittees and members of the United States Congress and other state, federal and international governmental authorities. For example, we have received CIDs from, and provided documents and information to, the Civil Division of the

DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. Several such audits, investigations and reviews currently are pending, some of which may be resolved in 2019, and the results of which may be adverse to us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical and/or other covered services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us and other industry participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources. In addition, our medical costs and the medical expenses of our Health Care Benefits ASC customers may be adversely affected if we do not prevent or detect fraudulent activity by providers and/or members.

Regular and special governmental audits, investigations and reviews by federal, state and international regulators could result in changes to our business practices, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities or other sanctions, including suspension or exclusion from participation in government programs and suspension or loss of licensure. Any of these audits, investigations or reviews could have a material adverse effect on our financial condition, results of operations or businesses or result in significant liabilities and negative publicity for our company. For example, since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various years for RADV audit. In addition, federal and state auditors are challenging our Commercial Health Care Benefits business' compliance with the ACA's minimum MLR requirements as well as our FEHB plans' compliance with OPM's FEHB program-specific minimum MLR requirements. Our Medicare and Medicaid contracts also are subject to minimum MLR audits. If a Medicare Advantage or Medicare Part D contract pays minimum MLR rebates for three consecutive years, it will become ineligible to enroll new members. If a Medicare Advantage or Medicare Part D contract pays such rebates for five consecutive years, it will be terminated by CMS.

We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.

Premiums and/or fees for Medicare members, certain federal government employee groups and Medicaid beneficiaries are subject to retroactive adjustments and/or withholding by the federal and applicable state governments. Our business that is subject to the ACA, including amounts payable to us or payable by us under the ACA's premium stabilization programs and our risk adjustment and reinsurance data, also is subject to audit by governmental authorities. CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of the services we provide to our Medicare members.

CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes.

Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted RADV audits of a subset of Medicare Advantage plans for various contract years, including certain of our plans for various contract years, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The OIG also is auditing our risk adjustment data and that of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data. We also have received CIDs from, and provided documents and information to, the Civil Division of the DOJ in connection with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified

in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. On October 26, 2018, CMS issued proposed rules related to, among other things, changes to the RADV audit methodology established by CMS in 2012. CMS projects that the changes to the RADV audit methodology would increase its recoveries from Medicare Advantage plans as a result of RADV audits. CMS has requested comments on the proposed rules, including whether the proposed RADV rule change should apply retroactively to audits of Medicare Advantage plans for contract year 2011 and forward. We are evaluating the potential adverse effect, which could be material, on our results of operations, financial condition and cash flows if the proposed RADV rule change were adopted as proposed. CMS also has announced its intent to use third party auditors to attain its ultimate goal of subjecting all Medicare Advantage contracts to either a comprehensive or a targeted RADV audit for each contract year. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would require us to change our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years.

If we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil monetary penalties or other sanctions, including fines and penalties under the False Claims Act, which could have a material adverse effect on our ability to participate in Medicare Advantage, Part D or other government programs, and on our financial condition, cash flows and results of operations.

CMS has issued a final rule implementing ACA requirements that Medicare Advantage and PDP plans report and refund to CMS overpayments that those plans receive from CMS. However, CMS's statements in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS's prior RADV audit guidance. These statements appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the fee for service adjustment comparison contemplated by CMS's RADV audit methodology. The precise interpretation, impact and legality of the final rule are not clear and are subject to pending litigation. If Medicare Advantage plans were not paid based on payment model principles that align with the requirements of the Social Security Act or such payments were not implemented correctly, it could have a material adverse effect on our results of operations, financial condition and/or cash flows.

Certain of our Medicaid contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our Medicaid programs because more states are using encounter data to determine compliance with performance standards and, in part, to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect accurate, or to correct inaccurate or incomplete, encounter data and have been and could be exposed to premium withholding, operating sanctions and financial fines and penalties for noncompliance. We have experienced challenges in obtaining complete and accurate encounter data due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could affect the Medicaid premium rates we receive and how Medicaid membership is assigned to us, which could have a material adverse effect on our Medicaid results of operations and cash flows and/or our ability to bid for, and continue to participate in, certain Medicaid programs.

Any premium or fee refunds, adjustments or withholding or civil or criminal fines or penalties, or other sanctions, including restrictions on or changes in the way we do business, loss of licensure or exclusion from participation in government programs, resulting from regulatory audits or investigations, whether as a result of RADV, Public Exchange related, recovery audit program or other audits or investigations by CMS, the OIG, HHS, the DOJ or otherwise, including audits of our minimum MLR rebates, methodology and/or reports, could be material and could adversely affect our results of operations, financial condition and cash flows.

Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a

significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.

Programs funded in whole or in part by the United States federal government account for a significant portion of our revenue, and we expect that percentage to increase. As our government funded businesses grow, our exposure to changes in federal and state government policy with respect to and/or regulation of the various government funded programs in which we participate also increases.

Our revenues from government funded programs, including our Medicare, Medicaid, dual eligible and dual eligible special needs plan businesses and our government customers in our Commercial business, are dependent on annual funding by the federal government and/or applicable state or local governments. Federal, state and local governments have the right to cancel or not to renew their contracts with us on short notice without cause or if funds are not available. Funding for these programs is dependent on many factors outside our control, including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities.

For example, CMS is transitioning the process of calculating Medicare members' risk scores from using diagnoses data from the Risk Adjustment Processing System, or RAPS, to using diagnoses data from the Encounter Data System, or EDS. The RAPS process requires Medicare Advantage plans to apply a filter logic based on CMS guidelines and only submit claims that satisfy those guidelines. For submissions through EDS, CMS requires Medicare Advantage plans to submit all encounter data, and CMS applies the risk adjustment filtering logic to determine the risk scores. For 2019, 25% of the risk score will be calculated from claims data submitted through EDS, up from 15% in 2018. For 2020, the EDS percentage will increase to 50%. The transition from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues or filtering logic differences between RAPS and EDS and could have a material adverse effect on our results of operations, financial condition and/or cash flows.

In addition, while the ACA provided substantial federal funding for the expansion of the number of people who qualify to enroll in Medicaid beginning in 2014, that funding began to decrease in 2017, and the future of that funding is uncertain. As a result, in 2019, states are preparing for the adverse impact on their budgets and programs by seeking to reduce their Medicaid expenditures and/or changing the design of their Medicaid programs. These changes could have a material adverse effect on the revenues, medical benefit ratios and results operations of our Medicaid contracts and/or our ability to grow our Medicaid membership, revenues and results of operations.

Our government customers also determine the eligibility criteria, premium levels and other aspects of Medicare, Medicaid, dual eligible and dual eligible special needs plan programs that affect the number of persons enrolled in these programs, the services provided to enrollees under these programs, the conditions for participating in these programs and our administrative and health care and other benefit costs under these programs. For example, states may require participation on their Public Exchange as a condition to participating in their Medicaid or state employee health benefit programs and/or take program design actions that shift provider costs from state employee plans to Commercial and Medicare plans. In the past, determinations of this type have at times adversely affected our results of operations from and willingness to participate in such programs, and they may do so again in the future. If a government customer reduces premium levels or increases premiums by less than the increase in our costs (such as by not allowing us to recover ACA and other applicable fees, taxes and assessments), and we cannot offset the adverse impact of these actions with supplemental premiums and/or changes in benefit plans, then our businesses and results of operations could be adversely affected. In addition, if states allow certain programs to expire, reduce the number of firms with which they contract for Managed Medicaid services or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment or reduced Medicaid enrollment growth, which would adversely affect our businesses, revenues and results of operations.

The federal government's "debt ceiling", or the amount of debt the federal government is permitted to borrow to meet its legal obligations (including, among other things, interest on the national debt, Medicare and Medicaid premiums and contributions to the FEHB program), is limited by statute and can only be raised by an act of Congress.

During a federal government shutdown or if Congress does not raise the debt ceiling before the federal government's current obligations approach or exceed its cash on hand and incoming receipts, federal government spending may be subject to delay, reduction, suspension or cancellation, which may be prolonged. Over 30% of our Health Care Benefits segment's revenues are derived from health care coverage programs that are funded in whole or in part by the federal government, including the Medicare, Medicaid, dual eligible and dual eligible specials needs plan programs, CHIP and the FEHB program. When federal spending is delayed, suspended or curtailed, we continue to receive claims from providers providing services to beneficiaries of these programs, and we remain liable for, and are required to fund, such claims. A federal government shutdown or a failure to

timely raise the debt ceiling could have a material adverse effect on our businesses, results of operations, cash flows, brand and reputation and, in the case of a prolonged shutdown or failure to raise the debt ceiling, our financial condition.

If the United States defaults on its obligations due to a failure to timely raise the debt ceiling or otherwise, or its credit rating is downgraded by any of the credit rating agencies, interest rates could rise, financial markets could become volatile and/or the availability of credit (and short-term credit in particular) could be adversely affected, thereby increasing our borrowing costs, adversely affecting the value of our investment portfolio, and/or adversely affecting our ability to access the capital markets, which could have a material adverse effect on our results of operations, financial condition and cash flows and could adversely affect our liquidity.

Our results of operations may be adversely affected by changes in laws and policies governing employers and by union organizing activity.

The federal and certain state legislatures continue to consider and pass legislation that increases our costs of doing business, including increased minimum wages and requiring employers to provide paid sick leave. In addition, our employee related operating costs may be increased by union organizing activity. If we are unable to reflect these increased expenses in our pricing or otherwise modify our operations to mitigate the effects of such increases, our results of operations will be adversely affected.

Risks Related to Customer Perceptions of our Products and Services

We must develop and maintain a relevant omni-channel experience for our retail customers.

Our business has evolved from a retail store experience to interaction with customers across numerous channels, including in-store, online, mobile and social media, among others. Omni-channel retailing is rapidly evolving and we must keep pace with changing customer expectations and new developments by our competitors. Our customers are increasingly using mobile phones, tablets, computers and other devices to comparison shop, determine product availability and complete purchases through mobile commerce applications. As a result, the portion of total consumer expenditures with all retailers occurring online and through mobile commerce applications is increasing and the pace of this increase could accelerate. We must compete by offering a consistent and convenient shopping experience for our customers regardless of the ultimate sales channel and by investing in, providing and maintaining mobile commerce applications for our customers that have the right features and are reliable and easy to use. If we are unable to make, improve or develop relevant customer-facing technology in a timely manner that keeps pace with technological developments and dynamic customer expectations, our ability to compete and our results of operations could be materially and adversely affected. In addition, if our online activities or our other customer-facing technology systems do not function as designed, we may experience a loss of customer confidence, data security breaches, lost sales, or be exposed to fraudulent purchases, any of which could materially and adversely affect our business operations, reputation and results of operations.

We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.

The success of our businesses depends in part on customer loyalty, superior customer service and our ability to persuade customers to frequent our retail stores and online sites and to purchase products in additional categories and our proprietary brands. Failure to timely identify or effectively respond to changing consumer preferences and spending patterns, and evolving demographic mixes in our markets, an inability to expand the products being purchased by our clients and customers, or the failure or inability to obtain or offer particular categories of products could adversely affect our relationship with our customers and clients and the demand for our products and services and could result in excess inventories of products.

We offer our retail customers proprietary brand products that are available exclusively at our retail stores and through our online retail sites. The sale of proprietary products subjects us to unique risks including potential product liability risks, mandatory or voluntary product recalls, potential supply chain and distribution chain disruptions for raw materials and finished products, our ability to successfully protect our intellectual property rights and the rights of applicable third parties, and other risks generally encountered by entities that source, market and sell private-label products. Any failure to adequately address some or all of these risks could have an adverse effect on our retail business, results of operations and financial condition. Additionally, an increase in the sales of our proprietary brands may adversely affect our sales of products owned by our suppliers which, consequently, could adversely impact certain of our supplier relationships. Our ability to locate qualified, economically stable suppliers who satisfy our requirements, and to acquire sufficient products in a timely and effective manner,

is critical to ensuring, among other things, that customer confidence is not diminished. Any failure to develop sourcing relationships with a broad and deep supplier base could adversely affect our financial performance and erode customer loyalty.

Our specialty pharmacy business focuses on complex and high-cost medications, many of which are made available by manufacturers to a limited number of pharmacies (so-called limited distribution drugs), that serve a relatively limited universe of patients. As a result, the future growth of our specialty pharmacy business is dependent largely upon expanding our base of drugs or penetration in certain treatment categories. Any contraction of our base of patients or reduction in demand for the prescriptions we currently dispense could have an adverse effect on our specialty pharmacy business, results of operations and cash flows.

We operate in rapidly evolving industries. Our customers generally, and our larger customers in particular, are well-informed and organized and, along with our individual customers, can easily move between us and our competitors. These factors require us to differentiate our products and solutions, anticipate changes in customer and consumer preferences, anticipate and effectively compete with the products and solutions of new and existing competitors and innovate and deliver new and existing products and solutions that demonstrate value to our customers and members, particularly in response to marketplace changes from public policy. Any failure to do so may adversely affect our ability to retain or grow customers and/or profitable medical membership, which can adversely affect our results of operations.

In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.

Historically, employers have been the most significant customers driving purchases of our Pharmacy Services and Health Care Benefits segments. However, decisions to buy our Pharmacy Services and Health Care Benefits products and services increasingly are made or influenced by consumers, either through direct purchasing (for example, Medicare Advantage plans and PDPs) or through Insurance Exchanges that allow individual choice. Similarly, consumers increasingly seek to access health care products and services locally and through other direct channels such as mobile devices and our websites. In response to this demand, we are expanding our consumer focus. To compete effectively in the consumer-driven marketplace, we will be required to develop or acquire new capabilities, attract new talent and develop new service and distribution relationships that respond to consumer needs and preferences.

We also will have to respond to pricing and other actions taken by existing competitors as well as potentially disruptive new entrants. Regulatory and participation requirements for Insurance Exchange-based plans tend to emphasize price and make competitive differentiation of our Health Care Benefits products and services based on other attributes more difficult. Price competition from existing and potentially new disruptive competitors in the industries in which each of our segments compete also continues to increase. Accordingly, we face competitive pricing pressures from existing and new competitors (including our vendors and others who may have lower cost structures than we do), and these pressures may reduce our operating margins or limit sales of our products and services. Our competitors may bring their consumer-oriented products and services to market more quickly, have greater experience marketing to consumers and/or may be targeting the higher margin portions of our businesses. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of Private Exchanges or encourage their employees to purchase health insurance on the Public Exchanges. We can provide no assurance that we will be able to develop or operate successful or profitable consumer-oriented products and services, or that our Health Care Benefits segment will be able to compete successfully or profitably on Public Exchanges or Private Exchanges or benefit from any opportunities presented by Public Exchanges or Private Exchanges, or that we will be able to benefit from opportunities available to any of our segments in the industries in which we operate. If we do not develop and expand competitive and profitable consumer products, are not competitive in the industries in which we operate, or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely affected.

Risks Related to Our Relationships with Manufacturers, Providers, Suppliers and Vendors

Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.

Our PBM business generates revenues primarily by contracting with clients to provide prescription drugs and related health care services to plan members. As a result, we are dependent on our relationships with prescription drug manufacturers and suppliers. We acquire a substantial amount of our mail order and specialty pharmacies' prescription drug supply from a limited number of suppliers. Our agreements with these suppliers often are short-term and easily cancelable by either party without cause. In addition, these agreements may limit our ability to provide services for competing drugs during the term of the

agreement and may allow the supplier to distribute through channels other than the Company. A termination or modification to any of these relationships could have a material adverse effect on our businesses, financial condition and results of operations.

We are seeking to enhance our health care provider networks by entering into joint ventures and other collaborative risk-sharing arrangements with health care providers. Providers' willingness to enter these arrangements with us depends upon, among other things, our ability to provide them with up to date quality of care data to support these value-based contracts. These arrangements are designed to give providers incentives to engage in population health management and optimize delivery of health care to our members. These arrangements also may allow us to expand into new geographies, target new customer groups, increase membership and reduce medical costs and, if we provide technology or other services to the relevant health system or provider organization, may contribute to our revenue and earnings from alternative sources. If such arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our medical costs may not be competitive and may be higher than we project, our attractiveness to customers may be reduced, we may lose or be unable to grow membership, and our ability to profitably grow our business and/or our results of operations may be adversely affected.

While we believe joint ventures, ACOs and other non-traditional health care provider organizational structures present opportunities for us, the implementation of our joint ventures and other non-traditional structure strategies may not achieve the intended results, which could adversely affect our results of operations and cash flows. Among other things, joint ventures require us to maintain collaborative relationships with our counterparties, continue to gain access to provider rates that make the joint ventures economically sustainable and devote significant management time to the operation and management of the joint venture. We may not be able to achieve these objectives in one or more of our joint ventures, which could adversely affect our results of operations and cash flows.

If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Our arrangements with these third parties may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us or to comply with applicable laws or regulations. For example, certain of our vendors have been responsible for releases of sensitive information of our members and employees, which has caused us to incur additional expenses and given rise to litigation against us.

These risks are particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs, where third parties perform PBM, medical management and other member related services for us. Any failure of our or these third parties' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members', customers' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our businesses, cash flows, results of operations and/or financial condition.

Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.

Hospitals and other providers and health systems continue to consolidate across the health care industry. While this consolidation could increase efficiency and has the potential to improve the delivery of health care services, it also reduces competition and the number of potential contracting parties in certain geographies. These health systems also are increasingly forming and considering forming health plans to directly offer health insurance in competition with us, a process that has been accelerated by the ACA. In addition, ACOs (including commercial and Medicaid-only ACOs developed as a result of state Medicaid laws), practice management companies, consolidation among and by integrated health systems and other changes in the organizational structures that physicians, hospitals and other health care providers adopt continues to change the way these providers interact with us and the competitive landscape in which we operate. These changes may increase our medical and other covered benefits costs, may affect the way we price our products and services and estimate our medical and other covered benefits costs and may require us to change our operations, including by withdrawing from certain geographies where we do not have a significant presence across our businesses or are unable to collaborate or contract with providers on acceptable terms. Each of these changes may adversely affect our businesses and results of operations.

We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.

Some providers that render services to our Health Care Benefits members do not have contracts with us. In those cases, we do not have a pre-established understanding with these providers as to the amount of compensation that is due to them for services rendered to our members. In some states, the amount of compensation due to these nonparticipating providers is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances providers may believe that they are underpaid for their services and may either litigate or arbitrate their dispute with us or try to recover the difference between what we have paid them and the amount they charged us from our members, which may result in customer and member dissatisfaction. For example, on October 15, 2018, an arbitrator awarded certain claimant hospitals approximately $150 million in a proceeding relating to Aetna's out-of-network benefit payment and administration practices. Such disputes may cause us to pay higher medical or other benefit costs than we projected.

Risks Related to Our Operations

Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.

Our ability to attract and retain customers and members is dependent upon providing cost effective, quality customer service operations (such as call center operations, PBM functions, retail pharmacy and LTC services, home delivery pharmacy prescription delivery, specialty pharmacy prescription delivery, claims processing, customer case installation and online access and tools) that meet or exceed our customers' and members' expectations. As we seek to reduce general and administrative expenses, we must balance the potential impact of cost-saving measures on our customer and other service and performance. If we misjudge the effects of such measures, customer and other service may be adversely affected. We depend on third parties for certain of our customer service, PBM and prescription delivery operations. If we or our vendors fail to provide service that meets our customers' and members' expectations, we may have difficulty retaining or profitable growing our customer base and/or membership, which can adversely affect our results of operations. For example, noncompliance with any privacy or security laws or regulations or any security breach involving one of our third party vendors could have a material adverse effect on our businesses, results of operations, brand and reputation.

We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.

We accept payments using a variety of methods, including cash, checks, credit cards, debit cards, gift cards, mobile payments and potentially other technologies in the future. Acceptance of these payment methods subjects us to rules, regulations, contractual obligations and compliance requirements, including payment network rules and operating guidelines, data security standards and certification requirements, and rules governing electronic funds transfers. These requirements may change in the future, which could make compliance more difficult or costly. For certain payment options, including credit and debit cards, we pay interchange and other fees, which could increase periodically thereby raising our operating costs. We rely on third parties to provide payment processing services, including the processing of credit cards, debit cards, and various other forms of electronic payment. If these vendors are unable to provide these services to us, or if their systems are compromised, our operations could be disrupted. The payment methods that we offer also expose us to potential fraud and theft by persons seeking to obtain unauthorized access to, or exploit any weaknesses in, the payment systems we use. If we fail to abide by applicable rules or requirements, or if data relating to our payment systems is compromised due to a breach or misuse, we may be responsible for any costs incurred by payment card issuing banks and other third parties or subject to fines and higher transaction fees. In addition, our reputation and ability to accept certain types of payments could each be harmed resulting in reduced sales and adverse effects on our results of operations.

Our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and results of operations.

We and our vendors are subject to business continuity hazards and other risks, including natural disasters, utility and other mechanical failures, acts of war or terrorism, disruption of communications, data security and preservation, disruption of supply or distribution, safety regulation and labor difficulties. The occurrence of any of these or other events to the Company or our vendors might disrupt or shut down our operations or otherwise adversely affect our operations. We may also be subject to certain liability claims in the event of an injury or loss of life, or damage to property, resulting from such events. Although we

have developed procedures for crisis management and disaster recovery and business continuity plans and maintain insurance policies that we believe are customary and adequate for our size and industry, our insurance policies include limits and, as such, our coverage may be insufficient to protect against all potential hazards and risks incident to our businesses. In addition, our crisis management and disaster recovery procedures and business continuity plans may not be effective. Should any such hazards or risks occur, or should our insurance coverage be inadequate or unavailable, our businesses, financial condition and results of operations could be adversely affected.

We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.

We and our vendors have experienced and continue to experience a variety of cyber attacks, and we and our vendors expect to continue to experience cyber attacks going forward. Among other things, we and our vendors have experienced automated attempts to gain access to our public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. We also have seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. Although the impact of such attacks has not been material to our operations or results of operations through December 31, 2018, we can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future. As we expand our consumer-oriented products and services, increase the amount and types of data we acquire, generate and use, increase the amount of information we make available to members, consumers and providers on mobile devices, expand our use of vendors, expand internationally and expand our use of social media, our exposure to these data security and related cybersecurity risks, including the risk of undetected attacks, damage, loss or unauthorized disclosure or access to and/or disruption of our systems and the customer, member, provider, employee, ACO, joint venture, vendor and other third party information they contain, increases, and the cost of attempting to protect against these risks also increases.

Although we deploy a layered approach to address information security (including cybersecurity) threats and vulnerabilities that is designed to protect confidential information against data security breaches, a compromise of our information security controls or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged, or used by unauthorized or improper persons, could harm our reputation and expose us to regulatory actions and claims from customers and clients, financial institutions, payment card associations and other persons, any of which could adversely affect our businesses, financial condition, and results of operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may not immediately produce signs of intrusion, we may be unable to anticipate these techniques or to implement adequate preventative measures. Moreover, a data security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. We also could be adversely affected by any significant disruption in the systems of third parties we interact with, including key payors and vendors.

The costs of attempting to protect against the foregoing risks and the costs of responding to a cyber-incident are significant. Large scale data breaches at other entities increase the challenge we and our vendors face in maintaining the security of our information technology systems and proprietary information and of our members' and customers' sensitive information. Following a cyber-incident, our and/or our vendors' remediation efforts may not be successful, and a cyber-incident could result in interruptions, delays or cessation of service, and loss of existing or potential customers and members. In addition, breaches of our and/or our vendors' security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers, our members or other third-parties, could expose our customers' and members' private information and our customers and members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, and result in investigations, regulatory enforcement actions, material fines and penalties, loss of customers, litigation or other actions which could have a material adverse effect on our businesses, brand, reputation, cash flows and results of operations.

The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, results of operations and cash flows.

Our information systems are subject to damage or interruption from power outages, facility damage, computer and telecommunications failures, computer viruses, security breaches (including credit card or personally identifiable information breaches), cyber attacks, vandalism, catastrophic events and human error. If our information systems are damaged, fail to work properly or otherwise become unavailable, or if we are unable to successfully complete our planned consolidation of our PBM

claims adjudication platforms, we may incur substantial costs to repair or replace them, and may experience reputational damage, loss of critical information, customer disruption and interruptions or delays in our ability to perform essential functions and implement new and innovative services. In addition, compliance with changes in United States and foreign privacy and information security laws and standards may result in considerable expense due to increased investment in technology and the development of new operational processes.

Our business success and results of operations depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.

Many aspects of our operations are dependent on our information systems and the information collected, processed, stored, and handled by these systems. We rely heavily on our computer systems to manage our ordering, pricing, point-of-sale, pharmacy fulfillment, inventory replenishment, claims processing, ExtraCare customer loyalty program, finance and other processes. Throughout our operations, we receive, retain and transmit certain confidential information, including PII and PHI, that our customers and clients provide to purchase products or services, enroll in programs or services, register on our websites, interact with our personnel, or otherwise communicate with us. In addition, for these operations, we depend in part on the secure transmission of confidential information over public networks.

We have many different information and other technology systems supporting our businesses (including as a result of our acquisitions). Our businesses depend in large part on these systems to adequately price our products and services; accurately establish reserves, process claims and report results of operations; and interact with providers, employer plan sponsors, members and vendors in an efficient and uninterrupted fashion. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Certain of our technology systems (including software) are older, legacy systems that are less flexible, less efficient and require a significant ongoing commitment of capital and human resources to maintain, protect and enhance them and to integrate them with our other systems. We must re-engineer and reduce the number of these systems to meet changing consumer and vendor preferences and needs, improve our productivity and reduce our operating expenses. We also need to develop or acquire new technology systems, contract with new vendors or modify certain of our existing systems to support the consumer-oriented products and services we are developing, operating and expanding and/or to meet current and developing industry and regulatory standards, including to keep pace with continuing changes in information processing technology and emerging cybersecurity risks and threats. If we fail to achieve these objectives, our ability to profitably grow our business and/or our results of operations may be adversely affected.

Our business strategy involves providing customers with differentiated, easy to use, secure products and solutions that use information to meet customer needs. The types of technology and levels of service that are acceptable to customers and members today will not necessarily be acceptable in the future, requiring us to anticipate and meet marketplace demands for technology. Our success therefore is dependent in large part on our ability, within the context of a limited budget of human resources and capital and our existing and future business relationships, to timely secure, integrate, develop, redesign and enhance our (or contract with vendors to provide) technology systems that support our business strategy initiatives and processes in a compliant, secure, and cost and resource efficient manner. Integration of our acquisitions increases these challenges, and we may not be successful in integrating various systems in a timely or cost-effective manner.

Information technology projects frequently are long-term in nature and may take longer to complete and cost more than we expect and may not deliver the benefits we project once they are complete. If we do not effectively and efficiently secure, manage, integrate and enhance our technology portfolio (including vendor sourced systems), we could, among other things, have problems determining health care and other benefit cost estimates and/or establishing appropriate pricing, meeting the needs of customers, providers and members, developing and expanding our consumer-oriented products and services or keeping pace with industry and regulatory standards, and our results of operations may be adversely affected.

Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.

Our products are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may frequently recommend and/or market health care benefits products of our competitors. Accordingly, we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract, retain or motivate sales personnel and third-party brokers, consultants and agents, or if we do not adequately

provide support, training and education to this sales network regarding our complex product portfolio, or if our sales strategy is not appropriately aligned across distribution channels. This risk is heightened as we develop, operate and expand our Consumer Health Products and Services products and services and our business model evolves to include a greater focus on consumers and direct-to-consumer sales, such as competing for sales on Insurance Exchanges.

New distribution channels for our products and services continue to emerge, including Private Exchanges operated by health care consultants and technology companies. These channels may make it more difficult for us to directly engage consumers and other customers in the selection and management of their health care benefits, in health care utilization and in the effective navigation of the health care system. We also may be challenged by new technologies and marketplace entrants that could interfere with our existing relationships with customers and health plan members in these areas.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These investigations have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:

- Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;
- Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and
- Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.

Financial Risks

Goodwill and other intangible assets could, in the future, become impaired.

As of December 31, 2018, we had $115.2 billion of goodwill and other intangible assets. During the year ended December 31, 2018, we took $6.1 billion of goodwill impairment charges related to our LTC reporting unit. Goodwill and indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. When evaluating goodwill for potential impairment, we compare the fair value of our reporting units to their respective carrying amounts. We estimate the fair value of our reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, a goodwill impairment loss is recognized in an amount equal to the excess to the extent of the goodwill balance. Estimated fair values could change if, for example, there are changes in the business climate, changes in the competitive environment, adverse legal or regulatory actions or developments, changes in capital structure, cost of debt, interest rates, capital expenditure levels, operating cash flows or market capitalization. Because of the significance of our goodwill and intangible assets, any future impairment of these assets could require material noncash charges to our results of operations, which could have a material adverse effect on our financial condition and results of operations.

We would be adversely affected if we do not effectively deploy our capital . Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, cash flows, financial condition and results of operations.

Our operations generate significant capital, and we have the ability to raise additional capital. The manner in which we deploy our capital, including investments in our businesses, our operations (such as information technology and other strategic and capital projects), dividends, acquisitions, share and/or debt repurchases, repayment of debt, reinsurance or other capital uses, impacts our financial strength, claims paying ability and credit ratings issued by recognized rating organizations. Credit ratings issued by nationally-recognized organizations are broadly distributed and generally used throughout our industries. Our ratings reflect each rating organization's opinion of our financial strength, operating performance and ability to meet our debt obligations or obligations to our insureds. We believe our credit ratings and the financial strength and claims paying ability of

our principal insurance and HMO subsidiaries are important factors in marketing our Health Care Benefits products to certain of our customers.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. In connection with the completion of the Aetna Acquisition, each of Standard & Poor's, Moody's and Fitch downgraded certain of our debt, financial strength and/or other credit ratings. Downgrades in our ratings could adversely affect our businesses, cash flows, financial condition and results of operations.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our results of operations and/or our financial condition.

The global capital markets, including credit markets, continue to experience volatility and uncertainty. As an insurer, we have a substantial investment portfolio that supports our policy liabilities and surplus and is comprised largely of debt securities of issuers located in the United States. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the United States, and to a lesser extent the international financial markets; and volatility, uncertainty and/or disruptions in the global capital markets, particularly the United States credit markets, and governments' monetary policy, particularly United States monetary policy, can significantly and adversely affect the value of our investment portfolio, our results of operations and/or our financial condition by:

- Significantly reducing the value and/or liquidity of the debt securities we hold in our investment portfolio and creating realized capital losses that reduce our results of operations and/or unrealized capital losses that reduce our shareholders' equity;
- Keeping interest rates low on high-quality short-term or medium-term debt securities (such as we have experienced during recent years) and thereby materially reducing our net investment income and results of operations as the proceeds from securities in our investment portfolio that mature or are otherwise disposed of continue to be reinvested in lower yielding securities;
- Reducing the fair values of our investments if interest rates rise;
- Causing non-performance or defaults on their obligations to us by third parties, including customers, issuers of securities in our investment portfolio, mortgage borrowers and/or reinsurance and/or derivatives counterparties;
- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our net income and shareholders' equity;
- Reducing our ability to issue short-term debt securities at attractive interest rates, thereby increasing our interest expense and decreasing our results of operations; and
- Reducing our ability to issue other securities.

Although we seek, within guidelines we deem appropriate, to match the duration of our assets and liabilities and to manage our credit and counterparty exposures, a failure adequately to do so could adversely affect our net income and our financial condition and, in extreme circumstances, our cash flows.

Risks Relating to Our Acquisition of Aetna

We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.

We have limited experience operating an insurance and managed health care business, and are relying in large part on the existing management of Aetna to continue to manage our Health Care Benefits business. However, there is no assurance that we will be able to continue to retain the services of such management. If we fail to retain the existing management of Aetna, our ability to realize the anticipated benefits of the transaction may be adversely affected.

The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.

Although we currently project that the Aetna Acquisition will result in a number of benefits, including that it will be accretive to our earnings per share, changes in the estimates we use for these projections and the impact of future events and conditions, some of which we do not control, could cause actual results to be lower than these projections. In addition, future events and

conditions could decrease or delay the accretion that is currently projected or could result in dilution. These events and conditions include adverse changes in market conditions, changes in the regulatory environment, additional transaction and integration-related costs and other factors such as the failure to realize some or all of the anticipated benefits of the Aetna Acquisition. Any dilution of, decrease in or delay of any accretion to, our earnings per share could cause our stock price to decline or grow at a reduced rate.

We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.

The success of the Aetna Acquisition will depend, in part, on our ability to realize the anticipated benefits and cost savings from combining the businesses of CVS Health and Aetna. Our ability to realize these anticipated benefits and cost savings is subject to certain risks, including:

- Our ability to successfully combine the businesses of CVS Health and Aetna;
- whether the combined businesses will perform as expected;
- the possibility that we paid more for Aetna than the value we will derive from the acquisition;
- the reduction of our cash available for operations and other uses and the incurrence of indebtedness to finance the acquisition; and
- the assumption of known and unknown liabilities of Aetna.

If we are not able to successfully combine the businesses of CVS Health and Aetna within the anticipated time frame, the anticipated cost savings and other benefits of the Aetna Acquisition may not be realized fully or may take longer to realize than expected, the combined businesses may not perform as expected, and our stock price may be adversely affected.

Until the completion of the Aetna Acquisition, we and Aetna operated independently, and there can be no assurances that our respective businesses can be integrated successfully. It is possible that the integration process could result in the loss of key CVS Health or Aetna employees, the disruption of either company's or both companies' ongoing businesses or in unexpected integration issues, higher than expected integration costs and an overall post-completion integration process that takes longer than originally anticipated. Specifically, issues that must be addressed in integrating the operations of CVS Health and Aetna in order to realize the anticipated benefits of the Aetna Acquisition so the combined business performs as expected include, among other things:

- combining the companies' separate operational, financial, reporting and corporate functions;
- integrating the companies' technologies, products and services;
- identifying and eliminating redundant and underperforming operations and assets;
- harmonizing the companies' operating practices, employee development, compensation and benefit programs, internal controls and other policies, procedures and processes;
- addressing possible differences in business backgrounds, corporate cultures and management philosophies;
- consolidating the companies' corporate, administrative and information technology infrastructure;
- coordinating sales, distribution and marketing efforts;
- managing the movement of certain businesses and positions to different locations;
- maintaining existing agreements with customers, providers and vendors and avoiding delays in entering into new agreements with prospective customers, providers and vendors;
- operating in industry sectors in which we and our current management may have little or no experience;
- coordinating geographically dispersed organizations;
- consolidating offices of CVS Health and Aetna that are currently in or near the same location; and
- effecting the actions that are required by regulatory approvals we obtained in connection with completing the Aetna Acquisition.

In addition, at times, the attention of certain members of our management and our resources will be focused on the integration of the businesses of the two companies and diverted from day-to-day business operations, which may adversely affect our businesses.

Our future results may be adversely impacted if we do not effectively manage our expanded operations following completion of the Aetna Acquisition.

Following completion of the Aetna Acquisition our business is significantly larger than the size of either CVS Health's or Aetna's respective pre-transaction businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to implement an effective integration of the two companies and its ability to manage a combined business with significantly larger size and scope with the associated increased costs and complexity. There can be no assurances that the management of the combined company will be successful or that the combined company will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the Aetna Acquisition. If we are not able to fully realize the expected operating efficiencies, cost savings and other benefits anticipated from the Aetna Acquisition, or such benefits take longer to realize than expected, our combined businesses may not perform as expected and our stock price may be adversely affected.

We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.

Our future success will depend in part on our ability to retain key executives and other employees of Aetna. Uncertainty about the effect of the Aetna Acquisition on CVS Health and Aetna employees may have an adverse effect on the combined company and consequently the combined business. This uncertainty may impair our ability to attract, retain and motivate key personnel. Employee retention may be particularly challenging during the integration process, as employees of CVS Health and Aetna may experience uncertainty about their future roles in the combined business.

Furthermore, if key employees of CVS Health or Aetna depart or are at risk of departing, including because of issues relating to the uncertainty and difficulty of integration, financial security or a desire not to remain as employees of the combined business, we may have to incur significant costs in retaining such individuals or in identifying, hiring and retaining replacements for departing employees and may lose significant expertise and talent relating to the business of Aetna, and our ability to realize the anticipated benefits of the Aetna Acquisition may be materially and adversely affected. Accordingly, no assurance can be given that we will be able to attract or retain key employees of Aetna to the same extent that Aetna was able to attract or retain employees in the past.

The Aetna integration process could disrupt our ongoing businesses and/or operations.

Parties with which we do business may experience uncertainty associated with the Aetna Acquisition and/or the post-closing integration process, including with respect to current or future business relationships with the combined business. Our business relationships (including business relationships of our Health Care Benefits segment) may be subject to disruption as customers, members, manufacturers, providers, vendors and others may attempt to negotiate changes in existing business relationships or consider entering into business relationships with parties other than the combined business. These disruptions could have a material adverse effect on the businesses, financial condition, results of operations or prospects of one or more of the combined company's businesses, including a material adverse effect on our ability to realize the anticipated benefits of the Aetna Acquisition.

Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.

In order to complete the Aetna Acquisition, we incurred acquisition-related debt financing of approximately $45.0 billion and assumed Aetna's existing indebtedness with a fair value of approximately $8.1 billion. Our substantially increased indebtedness and higher debt-to-equity ratio following completion of the Aetna Acquisition in comparison to that of CVS Health prior to the Aetna Acquisition has the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increases our interest expense compared to pre Aetna Acquisition periods. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources are greater than the amount of cash flows required to service the indebtedness of CVS Health or Aetna individually prior to the Aetna Acquisition. The increased levels of indebtedness could also reduce funds available to fund our efforts to combine our business with Aetna and realize expected benefits of the Aetna Acquisition and/or engage in investments in product development, capital expenditures, dividend payments, share repurchases and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.

We expect to continue to incur significant non-recurring costs associated with combining the operations of CVS Health and Aetna. We expect to continue to incur significant integration-related costs related to formulating and implementing integration plans, including facilities and systems consolidation costs and employment-related costs. We continue to assess the magnitude of these costs, and additional unanticipated costs may be incurred in the integration of the two companies' businesses. We may not achieve the net benefit of such expenditures that we project associated with the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of our businesses in the near term, or at all. If we fail to realize the expected expense and other efficiencies we project, our results of operations, cash flows and stock price may be adversely affected.

Risks Related to Our Acquisitions, Joint Ventures and International Operations

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.

We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities as part of our growth strategy. In addition to integration risks, some other risks we face with respect to acquisitions and other inorganic growth strategies include:

- We frequently compete with other firms, some of which may have greater financial and other resources and a greater tolerance for risk, to acquire attractive companies;
- The acquired, alliance and/or joint venture businesses may not perform as projected;
- The goodwill or other intangible assets established as a result of our acquisitions may be incorrectly valued or may become non-recoverable;
- We may assume unanticipated liabilities, including those that were not disclosed to us or which we underestimated;
- The acquired businesses, or the pursuit of other inorganic growth strategies, could disrupt or compete with our existing businesses, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies, procedures and performance;
- We may finance future acquisitions and other inorganic growth strategies by issuing common stock for some or all of the purchase price, which would dilute the ownership interests of our shareholders;
- We may incur significant debt in connection with acquisitions (whether to finance acquisitions or by assuming debt from the businesses we acquire);
- We may not have the expertise to manage and profitably grow the businesses we acquire, and we may need to rely on the retention of key personnel and other suppliers of businesses we acquire, which may be difficult or impossible to accomplish;
- We may enter into merger or purchase agreements but, due to reasons within or outside our control, fail to complete the related transactions, which could result in termination fees or other penalties that could be material, material disruptions to our businesses and operations and adversely affect our brand and reputation;
- In order to complete a proposed acquisition, we may be required to divest certain portions of our business;
- We may be involved in litigation related to mergers or acquisitions, including for matters which occurred prior to the applicable closing, which may be costly to defend and may result in adverse rulings against us that could be material; and
- The integration into our businesses of the businesses and entities we acquire may affect the way in which existing laws and regulations apply to us, including subjecting us to laws and regulations that did not previously apply to us.

We expect joint ventures to be an important part of our business model transformation and inorganic growth strategies. Joint ventures present risks that are different from acquisitions, including selection of appropriate joint venture parties, initial and ongoing governance of the joint venture, joint venture compliance activities (including compliance with applicable CMS requirements), growing the joint venture's business in a manner acceptable to all the parties, including other providers in the networks that include joint ventures, maintaining positive relationships among the joint venture parties and the customers, and member and business disruption that may occur upon joint venture termination.

We may be unable to successfully integrate companies we acquire.

Upon the closing of any acquisition we complete, we will need to successfully integrate the products, services and related assets, as well as internal controls into our business operations. If an acquisition is consummated, the integration of the acquired business, its products, services and related assets into our company may also be complex and time-consuming and, if the integration is not fully successful, we may not achieve the anticipated benefits, operating and cost synergies or growth opportunities of an acquisition. Potential difficulties that may be encountered in the integration process include the following:

- Integrating personnel, operations and systems (including internal control environments and compliance policies), while maintaining focus on producing and delivering consistent, high quality products and services;
- Coordinating geographically dispersed organizations;
- Disruption of management's attention from our ongoing business operations;
- Retaining existing customers and attracting new customers; and
- Managing inefficiencies associated with integrating our operations.

An inability to realize the full extent of the anticipated benefits, operating and cost synergies, innovations and operations efficiencies or growth opportunities of an acquisition, as well as any delays or additional expenses encountered in the integration process, could have a material adverse effect on our businesses and results of operations. Furthermore, acquisitions, even if successfully integrated, may fail to further our business strategy as anticipated, expose us to increased competition or challenges with respect to our products, services or geographic markets, and expose us to additional liabilities associated with an acquired business including risks and liabilities associated with litigation involving the acquired business. Any one of these challenges or risks could impair our ability to realize any benefit from our acquisitions after we have expended resources on them.

As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.

We significantly expanded our international operations as a result of the closing of the Aetna Acquisition in November 2018. As a result of our expanded international operations, we face political, legal, compliance, operational, regulatory, economic and other risks that we do not face or that are more significant than in our domestic operations. These risks vary widely by country and include varying regional and geopolitical business conditions and demands, government intervention and censorship, discriminatory regulation, nationalization or expropriation of assets and pricing constraints. Our international products need to meet country-specific customer and member preferences as well as country-specific legal requirements, including those related to licensing, privacy, data storage, location, protection and security.

Our international operations increase our exposure to, and require us to devote significant management resources to implement controls and systems to comply with, the privacy and data protection laws of non-U.S. jurisdictions and the anti-bribery, anti-corruption and anti-money laundering laws of the United States (including the FCPA) and the United Kingdom (including the UK Bribery Act) and similar laws in other jurisdictions. Implementing our compliance policies, internal controls and other systems upon our expansion into new countries and geographies may require the investment of considerable management time and management, financial and other resources over a number of years before any significant revenues or profits are generated. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business, and significant brand and reputational harm. We must regularly reassess the size, capability and location of our global infrastructure and make appropriate changes, and must have effective change management processes and internal controls in place to address changes in our businesses and operations. Our success depends, in part, on our ability to anticipate these risks and manage these difficulties, and the failure to do so could have a material adverse effect on our businesses, results of operations, financial condition, brand, reputation and/or long-term growth.

Our international operations require us to overcome logistical and other challenges based on differing languages, cultures, legal and regulatory schemes and time zones. Our international operations encounter labor laws, standards and customs that can be difficult and make employee relationships less flexible than in our domestic operations and expensive to modify or terminate. In some countries we are required to, or choose to, operate with local business associates, which requires us to manage our relationships with these third parties and may reduce our operational flexibility and ability to quickly respond to business challenges.

In some countries we may be exposed to currency exchange controls or other restrictions that prevent us from transferring funds internationally or converting local currencies into U.S. dollars or other currencies. Fluctuations in foreign currency exchange rates may adversely affect our revenues, results of operations and cash flows from our international operations. Some of our operations are, and are increasingly likely to be, in emerging markets where these risks are heightened. Any measures we may implement to reduce the effect of volatile currencies and other risks on our international operations may not be effective.

Item 1B. Unresolved Staff Comments

There are no unresolved SEC Staff Comments.

Item 2. Properties

The Company's principal office is an owned building complex located in Woonsocket, Rhode Island, which totals approximately one million square feet. In addition, the Company leases corporate offices in Arizona, Illinois, Ohio, Pennsylvania, Texas, and Brazil.

Pharmacy Services Segment

As of December 31, 2018 , the Pharmacy Services segment had the following properties:

- An owned mail service dispensing pharmacy located in Texas;
- Leased mail order dispensing pharmacies located in Hawaii, Illinois and Pennsylvania;
- Leased call centers located in California, Missouri, Pennsylvania, Tennessee and Texas;
- Approximately 40 leased on-site pharmacy stores, approximately 25 leased retail specialty pharmacy stores, approximately 20 specialty mail order pharmacies and approximately 90 branches for infusion and enteral services.

Retail/LTC Segment

As of December 31, 2018 , the Retail/LTC segment had the following properties:

- Approximately 8,200 retail stores, of which approximately 4% were owned. Net selling space for retail stores was approximately 80.5 million square feet as of December 31, 2018 . Approximately 25% of the store base was opened or significantly remodeled within the last five years;
- Approximately 1,700 retail pharmacies and approximately 80 clinics in Target stores;
- Nine owned distribution centers located in eight states and 13 leased distribution facilities located in twelve additional states and Brazil. The 22 distribution centers totaled approximately 10.4 million square feet as of December 31, 2018 ; and
- Six owned LTC pharmacies, approximately 150 leased LTC pharmacies in 46 states and one owned LTC repackaging facility.

In connection with certain business dispositions completed between 1991 and 1997, the Company continues to guarantee lease obligations for approximately 85 former stores. The Company is indemnified for these guarantee obligations by the respective purchasers. These guarantees generally remain in effect for the initial lease term and any extension thereof pursuant to a renewal option provided for in the lease prior to the time of the disposition. For additional information on these guarantees, see "Lease Guarantees" in Note 16 "Commitments and Contingencies" contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Health Care Benefits Segment

The Health Care Benefits segment's principal office is an owned building complex that is approximately 1.7 million square feet in size and is located in Hartford, Connecticut. The Health Care Benefits segment also owns or leases other space in the greater Hartford area, Maryland, Pennsylvania, and various field locations in the United States and several other countries.

Management believes that the Company's owned and leased facilities are suitable and adequate to meet the Company's anticipated needs. At the end of the existing lease terms, management believes the leases can be renewed or replaced by

alternative space. For additional information on the amount of rental obligations for the Company's leases, see Note 6 ''Leases'' contained in the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein.

Item 3. Legal Proceedings

I. Legal Proceedings

The information contained in Note 16 ''Commitments and Contingencies'' of the "Notes to Consolidated Financial Statements" in the Annual Report is incorporated by reference herein.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of environmental legal proceedings with a governmental authority if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. The Company is in the process of negotiating with the New York State Department of Environmental Conservation to resolve claims of alleged historical noncompliance with hazardous waste regulations in connection with LTC pharmacies in the State of New York. These proceedings are not material to the Company's business or financial condition.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market information

The Company's common stock is listed on the New York Stock Exchange under the symbol "CVS."

Holders of common stock

The information under the heading "Holders of Common Stock" in the Annual Report is incorporated by reference herein.

Dividends

The quarterly cash dividend declared by the Company's Board of Directors (the "Board") was $0.50 per share in 2018 and 2017.

CVS Health has paid cash dividends every quarter since becoming a public company. Future dividends will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Issuer purchases of equity securities

The following share repurchase programs were authorized by the Board:

In billions		
Authorization Date	**Authorized**	**Remaining as of December 31, 2018**
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase transactions, and/or other derivative transactions. The 2016 Repurchase Program can be modified or terminated by the Board at any time. During the three months ended December 31, 2018 the Company did not repurchase any shares of common stock.

See Note 12 ''Shareholders' Equity'' of the "Notes to Consolidated Financial Statements" in the Annual Report, which is incorporated by reference herein, for additional information regarding the Company's share repurchases.

Item 6. Selected Financial Data

The selected consolidated financial data of CVS Health Corporation as of and for the periods indicated in the five-year period ended December 31, 2018 , have been derived from the consolidated financial statements of CVS Health Corporation and is incorporated herein by reference to the information contained in the Annual Report under the heading "Five-Year Financial Summary." The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated by reference elsewhere in this Annual Report on Form 10-K.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The information contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Annual Report, which includes the "Cautionary Statement Concerning Forward-Looking Statements" at the end of such section, is incorporated by reference herein.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

The information contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations — Quantitative and Qualitative Disclosures About Market Risk" in the Annual Report is incorporated by reference herein.

Item 8. Financial Statements and Supplementary Data

The information contained in "Consolidated Statements of Operations," "Consolidated Statements of Comprehensive Income (Loss)," "Consolidated Balance Sheets," "Consolidated Statements of Shareholders' Equity," "Consolidated Statements of Cash Flows," "Notes to Consolidated Financial Statements," and "Report of Independent Registered Public Accounting Firm" in the Annual Report, is incorporated by reference herein.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of disclosure controls and procedures

The Company's Chief Executive Officer and Chief Financial Officer, after evaluating the effectiveness of the design and operation of the Company's disclosure controls and procedures (as defined in Rules 13a-15 (f) and 15d-15(f) under the Securities Exchange Act of 1934) as of December 31, 2018 , have concluded that as of such date the Company's disclosure controls and procedures were adequate and effective at a reasonable assurance level and designed to ensure that material information relating to the Company and its consolidated subsidiaries would be made known to such officers on a timely basis.

Internal control over financial reporting

The "Management's Report on Internal Control Over Financial Reporting" and "Report of Independent Registered Public Accounting Firm" sections of the Annual Report are incorporated by reference herein. These sections contain management's report on the Company's internal control over financial reporting and the Independent Registered Public Accounting Firm's report with respect to the effectiveness the Company's internal control over financial reporting.

Changes in internal control over financial reporting

On November 28, 2018, the Company completed its acquisition of Aetna. In conducting its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018 , management has elected to exclude Aetna from that assessment, as permitted under SEC rules. The Company is in the process of integrating the historical internal control over financial reporting of Aetna with the rest of the Company. Aetna's operations are included in the Company's 2018 consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and represented 21% of the Company's consolidated total assets as of December 31, 2018 and 3% of the Company's consolidated total revenues for the year ended December 31, 2018.

Other than the foregoing, there has been no change in the Company's internal control over financial reporting identified in connection with the evaluation required by paragraph (d) of Rule 13a-15 or Rule 15d-15 that occurred during the fourth quarter ended December 31, 2018 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

No events have occurred during the fourth quarter ended December 31, 2018 that would require disclosure under this item.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The sections of the Proxy Statement under the captions "Committees of the Board," "Code of Conduct," "Audit Committee Report," "Biographies of our Incumbent Board Nominees," and "Section 16(a) Beneficial Ownership Reporting Compliance" are incorporated by reference herein.

Executive Officers of the Registrant

The following sets forth the name, age and biographical information for each of the Registrant's executive officers as of February 28, 2019 . In each case the officer's term of office extends to the date of the board of directors meeting following the next annual meeting of stockholders of the Company. Previous positions and responsibilities held by each of the executive officers over the past five years or more are indicated below:

Lisa G. Bisaccia , age 62, Executive Vice President of CVS Health Corporation since March 2016 and Chief Human Resources Officer of CVS Health Corporation since January 2010; Senior Vice President of CVS Health Corporation from January 2010 through February 2016; Vice President, Human Resources of CVS Pharmacy, Inc. from September 2004 through December 2009. Ms. Bisaccia is also a member of the board of directors of Aramark, a leading global provider of food, facilities and uniform services.

Eva C. Boratto , age 52, Executive Vice President and Chief Financial Officer of CVS Health Corporation since November 2018; Executive Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from March 2017 through November 2018; Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation from July 2013 through February 2017; Senior Vice President of PBM Finance from July 2010 through June 2013.

Troyen A. Brennan, M.D ., age 64, Executive Vice President and Chief Medical Officer of CVS Health Corporation since November 2008; Executive Vice President and Chief Medical Officer of Aetna Inc. from February 2006 through November 2008.

James D. Clark , age 54, Senior Vice President - Controller and Chief Accounting Officer of CVS Health Corporation since November 2018; Vice President - Finance and Accounting of CVS Pharmacy, Inc. from September 2009 through October 2018.

Joshua M. Flum , age 49, Executive Vice President, Enterprise Strategy and Digital since November 2018; Executive Vice President, Corporate Strategy and Business Development of CVS Pharmacy, Inc. from June 2016 through October 2018; Executive Vice President - Pharmacy Services of CVS Pharmacy, Inc. from March 2015 through May 2016; Senior Vice President of Retail Pharmacy of CVS Pharmacy, Inc. from December 2010 through February 2015. Mr. Flum is a member of the board of directors of CreditRiskMonitor.com, Inc., a company that facilitates the analysis of corporate financial risk, mostly in the context of the extension of trade credit from one business to another.

Kevin P. Hourican , age 45, Executive Vice President of CVS Health Corporation and President of CVS Pharmacy since April 2018; Executive Vice President - Retail Pharmacy and Supply Chain of CVS Pharmacy, Inc. from June 2016 through March 2018; Senior Vice President, Field Operations and Supply Chain of CVS Pharmacy, Inc. from June 2014 through May 2016; Senior Vice President, Field Operations of CVS Pharmacy, Inc. from June 2012 through May 2014.

Alan M. Lotvin, M.D ., age 57, Executive Vice President - Transformation of CVS Health Corporation since June 2018; Executive Vice President - Specialty Pharmacy, CVS Caremark from November 2012 through May 2018.

Karen S. Lynch , age 56, Executive Vice President of CVS Health Corporation and President of Aetna since November 2018; President of Aetna from January 2015 to the present; Executive Vice President, Local and Regional Businesses of Aetna from February 2013 through December 2014; Executive Vice President, Head of Specialty Products of Aetna from July 2012 through January 2013. Ms. Lynch is a member of the board of directors of U.S. Bancorp, a banking and financial services company.

Larry J. Merlo , age 63, President and Chief Executive Officer of CVS Health Corporation since March 2011; President and Chief Operating Officer of CVS Health Corporation from May 2010 through March 2011; President of CVS Pharmacy from January 2007 through August 2011; Executive Vice President of CVS Health Corporation from January 2007 through May 2010; also a director of CVS Health Corporation since May 2010.

Thomas M. Moriarty , age 55, Executive Vice President and General Counsel of CVS Health Corporation since October 2012 and Chief Policy and External Affairs Officer since March 2017; Chief Strategy Officer from March 2014 through February 2017.

Derica W. Rice , age 54, Executive Vice President of CVS Health Corporation and President of CVS Caremark since March 2018; Executive Vice President of Global Services and Chief Financial Officer of Eli Lilly & Co. from May 2006 through December 2017. Mr. Rice was formerly a director of Target Corporation from September 2007 until January 2018, and is a candidate for election to the board of directors of The Walt Disney Company in March 2019.

Jonathan C. Roberts , age 63, Executive Vice President and Chief Operating Officer of CVS Health Corporation since March 2017; Executive Vice President of CVS Health Corporation and President of CVS Caremark from September 2012 through February 2017; Executive Vice President of CVS Health Corporation and Chief Operating Officer of CVS Caremark from October 2010 through August 2011.

Item 11. Executive Compensation

The sections of the Proxy Statement under the captions “Non-Employee Director Compensation” and “Executive Compensation and Related Matters,” including “Compensation Discussion and Analysis,” “Letter from the Management Planning and Development Committee,” “Compensation Committee Report” and “Executive Compensation Tables” are incorporated by reference herein.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The sections of the Proxy Statement under the captions “Share Ownership of Directors and Certain Executive Officers” and “Share Ownership of Principal Stockholders” are incorporated by reference herein. Those sections contain information concerning security ownership of certain beneficial owners and management and related stockholder matters.

The following table summarizes information about the Company’s common stock that may be issued upon the exercise of options, warrants and rights under all of equity compensation plans as of December 31, 2018 .

	Number of securities to be issued upon exercise of outstanding options, warrants and rights [1][2] (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in first column) [1] (c)
Equity compensation plans approved by stockholders [3]	27,102	$ 77.51	25,927
Equity compensation plans not approved by stockholders [4][5]	5,136	43.01	31,633
Total	32,238	$ 75.04	57,560

(1) Shares in thousands.
(2) Consists of: (i) 18,597 shares of common stock underlying outstanding options, (ii) 1,435 shares of common stock issuable upon the exercise of outstanding stock appreciation rights (“SARs”) and (iii) 12,206 shares of common stock issuable on the vesting of outstanding restricted stock units, deferred stock units and performance stock units, assuming target level performance in the case of performance stock units. The number of shares included with respect to

outstanding SARs is the number of shares of the Company's common stock that would have been issued had the SARs been exercised based on the closing price per share of the Company's common stock on December 31, 2018, as reported on the NYSE, which was $65.52.

(3) Consists of the CVS Health 2017 Incentive Compensation Plan.

(4) Consists of the Amended Aetna Inc. 2010 Stock Incentive Plan (the "Aetna Stock Plan").

(5) Amount in column (c) consists of the maximum number of shares of the Company's common stock available for future issuance under the Aetna Stock Plan as of December 31, 2018.

The Aetna Stock Plan was last approved by Aetna's shareholders at Aetna's 2017 Annual Meeting on May 19, 2017. The Company elected to continue to grant awards under the Aetna Stock Plan to employees of Aetna and its subsidiaries following the completion of the Aetna Acquisition. The Aetna Stock Plan is designed to promote the Company's interests and those of its stockholders and to further align the interests of stockholders and employees by tying awards to total return to stockholders, enabling plan participants to acquire additional equity interests in the Company and providing compensation opportunities dependent upon the Company's performance. The Aetna Stock Plan has not been submitted to the Company's stockholders and will expire on May 21, 2020.

Under the Aetna Stock Plan, eligible participants can be granted stock options to purchase shares of the Company's common stock, SARs, time vesting and/or performance vesting incentive stock or incentive units and other stock based awards. As of December 31, 2018, the maximum number of shares of the Company's common stock that may be issued under the awards outstanding under the Aetna Stock Plan was 5.1 million shares, subject to adjustment for corporate transactions and 31.6 million shares remained available for future awards. If an award under the Aetna Stock Plan is paid solely in cash, no shares are deducted from the number of shares available for issuance under the Aetna Stock Plan.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The sections of the Proxy Statement under the captions "Independence Determinations for Directors" and "Related Person Transaction Policy" are incorporated by reference herein.

Item 14. Principal Accounting Fees and Services

The section of the Proxy Statement under the caption "Item 2: Ratification of Appointment of Independent Registered Public Accounting Firm" is incorporated by reference herein.

PART IV

Item 15. Exhibits, Financial Statement Schedules

The following documents are filed as part of this Annual Report on Form 10-K:

1. Financial Statements. The following financial statements, related notes and report are incorporated by reference from the Annual Report in Item 8 hereof:

Consolidated Statements of Operations for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Statements of Comprehensive Income (Loss) for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Balance Sheets as of December 31, 2018 and 2017

Consolidated Statements of Cash Flows for the Years Ended December 31, 2018, 2017 and 2016

Consolidated Statements of Shareholders' Equity for the Years Ended December 31, 2018, 2017 and 2016

Notes to Consolidated Financial Statements

Report of Independent Registered Public Accounting Firm

2. Financial Statement Schedules. All financial statement schedules are omitted because they are not applicable, not required under the instructions, or the information is included in the consolidated financial statements or related notes.

3. Exhibits. The exhibits listed in the "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K. Exhibits marked with an asterisk (*) are management contracts or compensatory plans or arrangements. Exhibits other than those listed are omitted because they are not required to be listed or are not applicable. Pursuant to Item 601(b)(4)(iii) of Regulation S-K, the Registrant hereby agrees to furnish to the Securities and Exchange Commission a copy of any omitted instrument that is not required to be listed.

INDEX TO EXHIBITS

Exhibit	Description
2	**Plan of acquisition, reorganization, arrangement, liquidation or succession**
2.1	Agreement and Plan of Merger, dated as of May 20, 2015, among CVS Pharmacy, Inc., Tree Merger Sub, Inc. and Omnicare, Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed May 21, 2015; Commission File No. 001-01011).
2.2	Agreement and Plan of Merger, dated as of December 3, 2017, among CVS Health Corporation, Hudson Merger Sub Corp. and Aetna Inc. (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011).
2.3	Master Transaction Agreement by and between Aetna Inc. and Hartford Life and Accident Insurance Company dated as of October 22, 2017.
3	**Articles of Incorporation and Bylaws**
3.1	Restated Certificate of Incorporation of the Registrant (incorporated by reference to Exhibit 3.1C of Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).
3.2	By-laws of the Registrant, as amended and restated (incorporated by reference to Exhibit 3.2 to the Registrant's Current Report on Form 8-K filed June 5, 2018; Commission File No. 001-01011).
4	**Instruments defining the rights of security holders, including indentures**
4.1	Specimen common stock certificate (incorporated by reference to Exhibit 4.1 to the Registration Statement of the Registrant ((then known as CVS Corporation) as successor to Melville Corporation) on Form 8-B filed November 4, 1996; Commission File No. 001-01011).
4.2	Senior Indenture dated August 15, 2006, between the Registrant and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed August 15, 2006; Commission File No. 001-01011).
4.3	Form of the Registrant's 2020 Floating Rate Note (incorporated by reference to Exhibit 4.1 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.4	Form of the Registrant's 2021 Floating Rate Note (incorporated by reference to Exhibit 4.2 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).

4.5	Form of the Registrant's 2020 Note (incorporated by reference to Exhibit 4.3 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.6	Form of the Registrant's 2021 Note (incorporated by reference to Exhibit 4.4 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.7	Form of the Registrant's 2023 Note (incorporated by reference to Exhibit 4.5 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.8	Form of the Registrant's 2025 Note (incorporated by reference to Exhibit 4.6 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.9	Form of the Registrant's 2028 Note (incorporated by reference to Exhibit 4.7 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.10	Form of the Registrant's 2038 Note (incorporated by reference to Exhibit 4.8 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
4.11	Form of the Registrant's 2048 Note (incorporated by reference to Exhibit 4.9 to the Registrant's Current Report on Form 8-K filed March 12, 2018; Commission File No. 001-01011).
10	**Material Contracts**
10.1	Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2015 (Commission File No. 001-01011).
10.2	Amendment No. 1 to Credit Agreement dated as of December 15, 2017, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.5 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01-011).
10.3	Amendment No. 2 to Credit Agreement dated as of May 17, 2018, to the Credit Agreement dated as of July 1, 2015, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01-011).
10.4	Five Year Credit Agreement, dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.5	Amendment No. 1 to Five Year Credit Agreement dated as of December 15, 2017, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.3 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.6	Amendment No. 2 to Five Year Credit Agreement dated as of May 17, 2018, to the Five Year Credit Agreement dated as of May 18, 2017, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.7	Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as administrative agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.8	Amendment No. 1 to Term Loan Agreement dated as of May 17, 2018, to the Term Loan Agreement dated as of December 15, 2017, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.9	364-Day Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.10	Five Year Credit Agreement dated as of May 17, 2018, by and among the Registrant, the lenders party thereto and The Bank of New York Mellon, as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2018; Commission File No. 001-01011).
10.11	Bridge Facility Commitment Letter dated December 3, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., and Merrill Lynch, Pierce Fenner & Smith Incorporated (incorporated by reference to Exhibit 2.2 to the Registrant's Current Report on Form 8-K filed December 5, 2017; Commission File No. 001-01011).

10.12	Joinder to Bridge Facility Commitment Letter dated as of December 15, 2017, by and among the Registrant, Barclays Bank PLC, Goldman Sachs Bank USA, Goldman Sachs Lending Partners LLC, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and each of the Additional Commitment Parties party thereto (incorporated by reference to Exhibit 2.1 to the Registrant's Current Report on Form 8-K filed December 19, 2017; Commission File No. 001-01011).
10.13	364-Day Bridge Term Loan Agreement, dated October 26, 2018, by and among the Registrant, the lenders party thereto and Barclays Bank PLC, as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed October 26, 2018; Commission File No. 001-010011).
10.14*	The Registrant's 1996 Directors Stock Plan, as amended and restated November 5, 2002 (incorporated by reference to Exhibit 10.18 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 28, 2002; Commission File No. 001-01011).
10.15*	Caremark Rx, Inc. 2004 Incentive Stock Plan (incorporated by reference to Exhibit 99.2 of the Registrant's Registration Statement No. 333-141481 on Form S-8 filed March 22, 2007; Commission File No. 011-01011).
10.16*	The Registrant's Supplemental Retirement Plan I for Select Senior Management, as amended and restated as of December 31, 2008 (incorporated by reference to Exhibit 10.6 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011).
10.17*	The Registrant's 1997 Incentive Compensation Plan, as amended through December 31, 2008 (incorporated by reference to Exhibit 10.8 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2009; Commission File No. 011-01011).
10.18*	Form of Enterprise Non-Competition, Non-Disclosure and Developments Agreement between the Registrant and certain of the Registrant's executive officers (incorporated by reference to Exhibit 10.25 of the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011).
10.19*	The Registrant's 2010 Incentive Compensation Plan, as amended through January 15, 2013 (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 27, 2015; Commission File No. 001-01011).
10.20*	The Registrant's Deferred Stock Compensation Plan, as amended (incorporated by reference to Exhibit 10.17 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.21*	The Registrant's 2007 Employee Stock Purchase Plan, as amended (incorporated by reference to Exhibit 10.20 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.22*	Universal 409A Definition Document, as amended (incorporated by reference to Exhibit 10.28 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2015; Commission File No. 001-01011).
10.23*	The Registrant's Deferred Compensation Plan, as amended (incorporated by reference to Exhibit 10.19 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.24*	The Registrant's Partnership Equity Program, as amended (incorporated by reference to Exhibit 10.25 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.25*	The Registrant's Performance-Based Restricted Stock Unit Plan, as amended (incorporated by reference to Exhibit 10.27 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.26*	The Registrant's 2017 Incentive Compensation Plan (incorporated by reference to Exhibit A to the Registrant's Definitive Proxy Statement on Form 14A filed March 31, 2017; Commission File No. 001-01011).
10.27*	The Registrant's Executive Incentive Plan, as amended (incorporated by reference to Exhibit 10.4 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.28*	The Registrant's Long-Term Incentive Plan, as amended (incorporated by reference to Exhibit 10.5 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended June 30, 2017; Commission File No. 001-01011).
10.29*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.29 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.30*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.30 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).

10.31*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.32*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax) (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.33*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.34*	Form of Performance Stock Unit Agreement - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011).
10.35*	Form of Performance Stock Unit Agreement (LTIP) - Annual Grant between the Registrant and selected employees of the Registrant (incorporated by reference to Exhibit 10.2 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2018; Commission File No. 001-01011).
10.36*	The Registrant's 2018 Management Incentive Plan.
10.37*	The Registrant's Severance Plan for Non-Store Employees amended as of November 28, 2018.
10.38*	The Registrant's Performance-Based Restricted Stock Unit Program, as amended.
10.39*	Form of Non-Qualified Stock Option Agreement between the Registrant and selected employees of the Registrant.
10.40*	Form of Restricted Stock Unit Agreement - Annual Grant - between the Registrant and selected employees of the Registrant.
10.41*	Form of Performance-Based Restricted Stock Unit Agreement between the Registrant and selected employees of the Registrant.
10.42*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Pre-Tax).
10.43*	Form of Partnership Equity Program Participant Purchased RSUs, Company Matching RSUs and Company Matching Options Agreement (Post-Tax) (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2013; Commission File No. 001-01011).
10.44*	Amended Aetna Inc. 2010 Stock Incentive Plan, as amended May 19, 2017 (incorporated by reference to Exhibit 99.1 to the Registrant's Registration Statement on Form S-8 filed November 30, 2018; Commission File No. 001-01011).
10.45*	Form of Aetna Inc. 2010 Stock Incentive Plan - Market Stock Unit Terms of Award.
10.46*	Form of Aetna Inc. 2010 Stock Incentive Plan - Performance Stock Unit Terms of Award (2015).
10.47*	Form of Aetna Inc. 2010 Stock Incentive Plan - Executive Restricted Stock Unit Terms of Award (2015).
10.48*	Form of Aetna Inc. 2010 Stock Incentive Plan - Stock Appreciation Right Terms of Award (2015).
10.49*	Amended and Restated Employment Agreement dated as of December 21, 2012 between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.31 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.50*	Form of Non-Qualified Stock Option Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.37 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.51*	Form of Restricted Stock Unit Agreement - Annual Grant between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.38 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.52*	Amendment dated January 22, 2015 to Nonqualified Stock Option Agreements between the Registrant and Larry Merlo (incorporated by reference to Exhibit 10.1 to the Registrant's Current Report on Form 8-K filed January 23, 2015; Commission File No. 001-01011).
10.53*	Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton (incorporated by reference to Exhibit 10.39 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2010; Commission File No. 001-01011).
10.54*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and David Denton (incorporated by reference to Exhibit 10.32 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.55*	Confidential Separation Agreement effective as of June 25, 2018, between the Registrant and David Denton (incorporated by reference to Exhibit 10.1 to the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended September 30, 2018; Commission File No. 001-01011).

10.56*	Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.33 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.57*	Amendment dated as of December 31, 2012 to the Change in Control Agreement dated December 22, 2008 between the Registrant and Jonathan Roberts (incorporated by reference to Exhibit 10.34 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2012; Commission File No. 001-01011).
10.58*	Restricted Stock Unit Agreement - Annual Grant dated April 1, 2016 between the Registrant and Jonathan C. Roberts (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.59*	Restrictive Covenant Agreement dated May 20, 2016 between the Registrant and Jonathan C. Roberts (incorporated by reference to Exhibit 10.45 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2016; Commission File No. 001-01011).
10.60*	Change in Control Agreement dated December 22, 2008 between the Registrant and Helena Foulkes (incorporated by reference to Exhibit 10.43 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.61*	Amendment dated as of December 31, 2012 to the Change in Control Agreement between the Registrant and Helena Foulkes (incorporated by reference to Exhibit 10.44 to the Registrant's Annual Report on Form 10-K for the fiscal year ended December 31, 2014; Commission File No. 001-01011).
10.62*	Change in Control Agreement dated October 1, 2012 between the Registrant and Thomas Moriarity (incorporated by reference to Exhibit 10.1 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
10.63*	Restrictive Covenant Agreement dated June 1, 2014 between the Registrant and Thomas Moriarity (incorporated by reference to Exhibit 10.2 of the Registrant's Quarterly Report on Form 10-Q for the fiscal quarter ended March 31, 2015; Commission File No. 001-01011).
13	**Annual Report to security holders, Form 10-Q or quarterly report to security holders**
13.1	Portions of the 2018 Annual Report to Stockholders of CVS Health Corporation, which are specifically designated in this Annual Report on Form 10-K as being incorporated by reference.
21	**Subsidiaries of the registrant**
21.1	Subsidiaries of CVS Health Corporation.
23	**Consents of experts and counsel**
23.1	Consent of Ernst & Young LLP.
31	**Rule 13a-14(a)/15d-14(a) Certifications**
31.1	Certification by the Chief Executive Officer.
31.2	Certification by the Chief Financial Officer.
32	**Section 1350 Certifications**
32.1	Certification by the Chief Executive Officer.
32.2	Certification by the Chief Financial Officer.
101	**Interactive Data File**
101	The following materials from the CVS Health Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2018 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Operations, (ii) the Consolidated Statements of Comprehensive Income, (iii) the Consolidated Balance Sheets, (iv) the Consolidated Statements of Cash Flows, (v) the Consolidated Statements of Shareholders' Equity and (vi) the related Notes to Consolidated Financial Statements.

Item 16. Form 10-K Summary

None.

SIGNATURES

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

CVS HEALTH CORPORATION

Date: February 28, 2019

By: /s/ EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

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

Signature	Title(s)	Date
/s/ FERNANDO AGUIRRE **Fernando Aguirre**	Director	February 28, 2019
/s/ MARK T. BERTOLINI **Mark T. Bertolini**	Director	February 28, 2019
/s/ RICHARD M. BRACKEN **Richard M. Bracken**	Director	February 28, 2019
/s/ C. DAVID BROWN II **C. David Brown II**	Director	February 28, 2019
/s/ EVA C. BORATTO **Eva C. Boratto**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 28, 2019
/s/ JAMES D. CLARK **James D. Clark**	Senior Vice President - Controller and Chief Accounting Officer (Principal Accounting Officer)	February 28, 2019
/s/ ALECIA A. DECOUDREAUX **Alecia A. DeCoudreaux**	Director	February 28, 2019
/s/ NANCY-ANN M. DEPARLE **Nancy-Ann M. DeParle**	Director	February 28, 2019
/s/ DAVID W. DORMAN **David W. Dorman**	Chair of the Board and Director	February 28, 2019
/s/ ROGER N. FARAH **Roger N. Farah**	Director	February 28, 2019
/s/ ANNE M. FINUCANE **Anne M. Finucane**	Director	February 28, 2019
/s/ EDWARD J. LUDWIG **Edward J. Ludwig**	Director	February 28, 2019
/s/ LARRY J. MERLO **Larry J. Merlo**	President and Chief Executive Officer (Principal Executive Officer) and Director	February 28, 2019
/s/ JEAN-PIERRE MILLON **Jean-Pierre Millon**	Director	February 28, 2019
/s/ MARY L. SCHAPIRO **Mary L. Schapiro**	Director	February 28, 2019
/s/ RICHARD J. SWIFT **Richard J. Swift**	Director	February 28, 2019
/s/ WILLIAM C. WELDON **William C. Weldon**	Director	February 28, 2019
/s/ TONY L. WHITE **Tony L. White**	Director	February 28, 2019

Exhibit 2.3
EXECUTION AGREEMENT

MASTER TRANSACTION AGREEMENT

by and between

AETNA INC.

and

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Dated as of October 22, 2017

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Seller Disclosure Schedule

Purchaser Disclosure Schedule

EXHIBITS

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Exhibit B	Form of Reinsurance Agreement
Exhibit C	Form of Trust Agreement
Exhibit D	Form of Administrative Services Agreement
Exhibit E	Form of Transition Services Agreement
Exhibit F	Form of Intellectual Property Agreement
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Exhibit L	Form of Hartford License Agreement
Exhibit M	Form of Employee Leasing Agreement
Exhibit N	Form of Data Processing Side Letter

MASTER TRANSACTION AGREEMENT

This Master Transaction Agreement (this " Agreement"), dated as of October 22, 2017, is entered into by and between Aetna Inc., a Pennsylvania corporation (" Seller"), and Hartford Life and Accident Insurance Company, a Connecticut insurance company (" Purchaser").

WITNESSETH:

WHEREAS, Seller owns 100% of the issued and outstanding shares of capital stock of Aetna Life Insurance Company, an insurance company organized under the laws of the State of Connecticut (the " Ceding Company");

WHEREAS, Seller and its Affiliates (as hereinafter defined), including the Ceding Company and Aetna Health and Life Insurance Company, an insurance company organized under the laws of the State of Connecticut (" AHLIC"), are engaged, among other things, in the operation of the Business (as hereinafter defined) in the United States; and

WHEREAS, the parties hereto desire to enter into this Agreement pursuant to which, on the terms and subject to the conditions set forth herein, at the Closing (as hereinafter defined), among other things:

(a) the Ceding Company will enter into a commutation agreement with AHLIC substantially in the form attached hereto as Exhibit A (the " Commutation Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the Ceding Company will recapture the portion of the Business reinsured by AHLIC effective as of immediately prior to the effectiveness of the Reinsurance Agreement (as defined below) (the " Pre-Closing Commutation");

(b) the Ceding Company will enter into a reinsurance agreement with Purchaser substantially in the form attached hereto as Exhibit B (the " Reinsurance Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the Ceding Company shall cede to Purchaser, and Purchaser shall reinsure, all "Policy Liabilities" (as such term is defined in such attached form of the Reinsurance Agreement, the " Reinsured Liabilities"), on a 100% coinsurance basis;

(c) the Ceding Company and Purchaser will enter into a trust agreement with the Trustee (as hereinafter defined) substantially in the form attached hereto as Exhibit C (the " Trust Agreement "), pursuant to which, on the terms and subject to the conditions set forth therein, Purchaser will establish and maintain a trust account (the " Trust Account") with the Trustee for the benefit of the Ceding Company to secure Purchaser's obligations to the Ceding Company under the Reinsurance Agreement;

(d) the Ceding Company will enter into an administrative services agreement with Purchaser substantially in the form attached hereto as Exhibit D (the " Administrative Services Agreement "), pursuant to which, on the terms and subject to the conditions set forth therein, Purchaser will provide to the Ceding Company administrative services with respect to the Business reinsured under the Reinsurance Agreement;

(e) the Ceding Company and Purchaser will enter into a transition services agreement substantially in the form attached hereto as Exhibit E (the " Transition Services Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the Ceding Company will, or will cause its Affiliates or third party service providers to, perform certain transition services with respect to the Business for Purchaser or its designated Affiliates;

(f) Seller and Purchaser will enter into an intellectual property assignment and license agreement substantially in the form attached hereto as Exhibit F (the " Intellectual Property Agreement"), pursuant to which Seller and the Ceding Company will, on the terms and subject to the conditions set forth therein, transfer, assign and license the Transferred Intellectual Property to Purchaser, and Purchaser will license certain Transferred Intellectual Property back to Seller;

(g) the Ceding Company, Carefree Insurance Services, Inc., a company organized under the laws of Florida and a Subsidiary of Seller, Purchaser and one or more Affiliates of Purchaser will enter into a distribution agreement substantially in the form attached hereto as Exhibit G (the " Distribution Agreement"), pursuant to which, on the terms and subject to the conditions set forth therein, the parties thereto will market and sell insurance policies to each other's customers and joint customers;

(h) subject to obtaining relevant third party consents, Purchaser and Seller or their applicable Affiliates will enter into a lease assignment agreement substantially in the form attached hereto as Exhibit J (the " Portland Location Assignment Agreement"), pursuant to which Purchaser or its applicable Affiliate(s) will accept assignment of the Assigned Lease on the terms and subject to the conditions set forth herein and therein;

(i) subject to obtaining relevant third party consents, Purchaser and Seller or their applicable Affiliates will enter into sublease agreements substantially in the form attached hereto as Exhibit K , pursuant to which Seller or its applicable Affiliate(s) will sublease certain real property to Purchaser or its applicable Affiliate(s), on the terms and subject to the conditions set forth herein and therein; and

(j) Seller and its applicable Affiliates will sell to Purchaser, and Purchaser will purchase from Seller and its Affiliates, the Transferred Assets (as hereinafter defined), and Seller and its applicable Affiliates will assign to Purchaser, and Purchaser will assume from Seller and its applicable Affiliates, the Assumed Liabilities and the Assigned Contracts (as hereinafter defined).

NOW, THEREFORE, in consideration of the representations, warranties, covenants and agreements set forth herein, the parties hereto hereby agree as follows:

ARTICLE I.

DEFINITIONS

Section 1.01. Definitions. For purposes of this Agreement, the following terms have the respective meanings set forth below:

"Accounting Date" has the meaning given to such term in Section 2.06.

"Accounting Value" means, with respect to any Investment Asset as of any date of determination, the sum of: (i) the Book Value of such Investment Asset as of the applicable date of determination; plus (ii) all accrued but unpaid interest on such Investment Asset through the applicable date of determination.

"Action" means any civil, criminal, administrative or other claim, action, suit, litigation, arbitration hearing, charge, complaint, demand, notice or other similar proceeding, in each case by or before any Governmental Authority or arbitral body.

"Actuarial Report" has the meaning given to such term in Section 3.21.

"Adjusted Required Asset Value" means, as of any applicable date of determination, an amount equal to (i) the Required Asset Value as of such date, plus (if positive) or minus (if negative) (ii) the sum of all Capital Gain or Loss Adjustments required with respect to the period from the Reference Date through the applicable date of determination, plus (if positive) or minus (if negative) (iii) the sum of all Reallocated Asset Value Adjustments required with respect to the period from the Reference Date through the applicable date of determination. The Capital Gain or Loss Adjustments and Reallocated Asset Value Adjustments required with respect to the period from the Reference Date to the date hereof are required to be set forth on Section 3.19(b) of the Seller Disclosure Schedule. All Capital Gain or Loss Adjustments and Reallocated Asset Value Adjustments required with respect to the period beginning on the date hereof and ending at the Closing will be determined in accordance with Section 5.11.

"Administrative Services Agreement" has the meaning given to such term in the Recitals.

"Affiliate" means, with respect to any Person at the time in question, any other Person controlling, controlled by or under common control with such Person. For purposes of the foregoing, "control," including the terms "controlling," "controlled by" and "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a Person, whether through the ownership of voting securities, by contract or otherwise. Notwithstanding anything to the contrary contained in this Agreement, none of the following nor any of their respective Subsidiaries shall be deemed to be an Affiliate of Seller or any of its Subsidiaries for purposes of this Agreement: (i) bswift LLC, a Delaware limited liability company, or Prodigy Health Group, Inc., a Delaware corporation; and (ii) (x) any joint venture, accountable care organization or similar arrangement for the establishment, management or operation of a provider collaboration, network or group in which Seller and its Affiliates collectively own 50% or less of the outstanding equity securities or

economic interest and (y) any other joint venture entity formed with health systems or health care providers to the extent such joint venture entity owns or operates a health plan.

"Agreement" has the meaning given to such term in the Preamble.

"AHLIC" has the meaning given to such term in the Recitals.

"Allocable Amount" has the meaning given to such term in Section 7.01.

"Applicable Law" means all laws, common law, rules, regulations, ordinances, codes, statutes, judgments, injunctions, Governmental Orders and decrees of all Governmental Authorities applicable to the Person, place and situation in question.

"ASO Contracts" means: (i) the contracts pursuant to which the Ceding Company provides to plan sponsors of self-funded groups administrative or related services for the management of disability benefits prior to the Effective Time; and (ii) the contracts pursuant to which the Ceding Company provides to employers administrative services or software for the management of leaves of absence by employees and related rights and benefits under Applicable Law (including the Family and Medical Leave Act of 1993, as amended, the Americans with Disabilities Act of 1990, as amended, and similar U.S. state and municipal laws, and including as a result of long-term or short-term disability) and internal policies and practices of such employers, in each case of (i) and (ii) in connection with the Business.

"Asset Consideration" has the meaning given to such term in Section 2.07(a)(ii).

"Assigned Contracts" means: (i) those contracts and other agreements to which Seller or an Affiliate of Seller is a party and which are listed on Schedule I; (ii) any renewals or replacement of those contracts and other agreements to which Seller or an Affiliate of Seller is a party that are listed on Schedule I , to the extent such agreements or divisible sub-agreements thereof are entered into prior to the Closing in the ordinary course of business and in accordance with this Agreement; (iii) any vendor contracts and other vendor agreements to which Seller or an Affiliate of Seller is a party, to the extent such agreements or divisible sub-agreements thereof relate primarily or exclusively to the Business and are entered into between the date hereof and the Closing, in the ordinary course of business and in accordance with this Agreement; and (iv) each Business Employee Benefit Plan.

"Assigned Lease" has the meaning given to such term in Section 2.01.

"Assumed Liabilities" has the meaning given to such term in Section 2.04.

"Bill of Sale and Assumption and Assignment Agreement" means a bill of sale and assumption and assignment agreement, substantially in the form attached hereto as Exhibit H , to be entered into by Seller and its applicable Affiliates, on the one hand, and Purchaser, on the other hand, at the Closing.

"Board Materials" has the meaning given to such term in the definition of "Books and Records."

"Books and Records" means all records (including computer generated, recorded or stored records) relating directly and primarily to the Business that are in the possession or control of Seller, or any of its Affiliates; provided , however , that "Books and Records" excludes (the following, collectively, the " Excluded Books and Records"): (1) Tax Returns, Tax records and all other data and information with respect to Taxes of Seller and its Affiliates (other than Tax records of individual insureds under Group Contracts); (2) files, records, data and information with respect to the employees of Seller or its Affiliates, any Employee or any Employee Benefit Plan (except data and information provided pursuant to this Agreement or the Employee Leasing Agreement, in either case, with respect to any Business Employee Benefit Plan and Employee, unless prohibited by Applicable Law); (3) any materials prepared for the boards of directors or similar governing bodies of Seller or any of its Affiliates (" Board Materials"); (4) any corporate minute books, stock records or similar corporate records of Seller or any of its Affiliates; (5) any materials that are legally privileged, it being understood that Seller shall use commercially reasonable efforts to obtain waivers or make other arrangements (including redacting information or entering into joint defense agreements) that would enable such item to be transferred to or shared with Purchaser without destroying such privilege; (6) any information the disclosure or transfer of which is prohibited or restricted by Applicable Law, including antitrust, Privacy and Data Security Laws or pursuant to a contract (it being understood that Seller shall identify the records that are prohibited or restricted to be disclosed or transferred under Applicable Law and the basis for such prohibition or restriction, and shall use commercially reasonable efforts to obtain waivers or make other arrangements (including redacting information) that would enable such item to be transferred to Purchaser without so contravening any such Applicable Law or obligation under contract) (7) any internal drafts, opinions, valuations, correspondence, documents or other materials produced by, or provided between or among, Seller, its Affiliates or their respective Representatives in connection with the sale of the Business (including the negotiation, evaluation and consummation of the transactions contemplated by this Agreement and the other Transaction Agreements) or the terms of engagement of Representatives with respect thereto; and (8) consolidated financial records (including general ledgers) of Seller or its Affiliates, consolidated regulatory filings made by Seller or its Affiliates and any related correspondence with Governmental Authorities, except to the extent the information contained therein specifically or separately identifies the Business and is not otherwise included in a Book and Record. For purposes of this definition, the term " primarily" means records that relate to the Business more than any other business area of Seller or any of its Affiliates.

"Book Value" means, with respect to any Investment Asset as of any date of determination, the statutory book value thereof determined in accordance with SAP; provided that, until the Closing has occurred, the statutory book value of any asset that is transferred from AHLIC to the Ceding Company in connection with the Pre-Closing Commutation will be its statutory book value prior to such transfer.

"Burdensome Condition" has the meaning given to such term in Section 5.06(c).

"Business" means: (i) the Ceding Company's business of issuing, underwriting, reinsuring, selling, entering into, distributing, marketing, delivering, pricing, servicing, canceling, terminating and administering, as applicable, Group Contracts in the United States; and (ii) prior to the Closing, AHLIC's business of reinsuring certain Group Insurance Contracts

from the Ceding Company; provided , however , that the Business does not include any insurance business or administrative services sold by (a) the Ceding Company's "Strategic Resource Company" business unit to (x) plan sponsors seeking coverage primarily for part-time, temporary, seasonal, interim, hourly or transient employees, or (y) plan sponsors seeking coverage to meet requirements under the Davis-Bacon Act of 1931, as amended, for governmental contractors; or (b) the Ceding Company's "International" business unit to (x) plan sponsors located in Canada to cover fewer than 750 employees and beneficiaries located in the U.S., (y) plan sponsors (whether located in the United States or outside the United States) where the number of employees and beneficiaries located in the United States is fewer than (A) 25% of the total number of employees and beneficiaries on cover, or (B) 100 lives.

"Business Day" means any day other than a Saturday, Sunday or a day on which banking institutions in New York, New York or Hartford, Connecticut are permitted or obligated by Applicable Law to be closed.

"Business Employee" means each employee of Seller or any of its Affiliates who, to the Knowledge of Seller, provides, as of the Reference Date, 60 percent or more of his or her services to the Business; whose names are set forth on Section 6.01(a)(ii) of the Seller Disclosure Schedule, as such section of the Seller Disclosure Schedule may be updated in accordance with Section 6.01(a). For the avoidance of doubt, such section of the Seller Disclosure Schedule shall include such employees who as of the date hereof are actively employed as well as such employees who are on (i) a leave of absence (including temporary leave for purposes of jury or military duty, maternity or paternity leave, leave under the Family Medical Leave Act of 1993, approved personal leave or disability or medical leave) or (ii) vacation or paid time off).

"Business Employee Benefit Plan" means each plan, program or agreement set forth on Section 3.10(b) of the Seller Disclosure Schedule.

"Capital Gain or Loss Adjustment" has the meaning given to such term in Section 5.11(b)(ii).

"Ceded Reinsurance Contracts" has the meaning given to such term in Section 3.16(a).

"Ceding Commission" has the meaning given to such term in Section 2.07(a)(i).

"Ceding Company" has the meaning given to such term in the Recitals.

"Closing" has the meaning given to such term in Section 2.06.

"Closing Date" has the meaning given to such term in Section 2.06.

"Closing Required Asset Value" means the Adjusted Required Asset Value as of the Accounting Date calculated after taking into account all Capital Gain or Loss Adjustments and all Reallocated Asset Value Adjustments required pursuant to Section 5.11 or Section 3.19(b) from the Reference Date through the Closing.

"Closing Statement" means, as of any date of determination, a statement as of such date prepared in the same format as the Reference Closing Statement (assuming, for this purpose, the Closing occurred, and that the Reinsurance Agreement became effective, as of the end of the day on such date) and in accordance with the Transaction Accounting Principles.

"COBRA" means Part 6 of Subtitle B of Title I of ERISA, Section 4980B of the Code and any similar state law.

"Code" means the Internal Revenue Code of 1986.

"Commutation Agreement" has the meaning given to such term in the Recitals.

"Competing Businesses" has the meaning given to such term in Section 5.13.

"Competing Person" has the meaning given to such term in Section 5.13(e).

"Condition Satisfaction" has the meaning given to such term in Section 2.06.

"Confidentiality Agreement" has the meaning given to such term in Section 5.04(a).

"Data Input Inaccuracies" means inaccuracies or omissions to the extent arising from (i) the inputting of factual data relating to the Group Contracts or (ii) the coding, compilation or aggregation of such factual data in connection with such inputting.

"Deductible" has the meaning given to such term in Section 10.03(a).

"Discretionary Turnover Allowance" has the meaning given to such term in Section 5.11(b)(i)(B).

"Distribution Agreement" has the meaning given to such term in the Recitals.

"Effective Time" means 12:00:01 a.m. on the first calendar day of the month in which the Closing occurs.

"Employee" means each employee of Seller or any of its Affiliates whose name is set forth on Section 6.01(a)(i) of the Seller Disclosure Schedule, as such section of the Seller Disclosure Schedule may be updated in accordance with Section 6.01(a). For the avoidance of doubt, such section of the Seller Disclosure Schedule shall include such employees who as of the Closing Date are actively employed as well as such employees who are (i) on a leave of absence (including temporary leave for purposes of jury or military duty, maternity or paternity leave, leave under the Family Medical Leave Act of 1993, approved personal leave or disability or medical leave), (ii) on a vacation or paid time off or (iii) hired by Seller or any of its Affiliates in accordance with the terms and conditions of the Employee Leasing Agreement.

"Employee Benefit Plan" means each written or unwritten plan, policy, program, agreement and arrangement, other than a Business Employee Benefit Plan, whether covering a single individual or a group of individuals, that is (a) an "employee benefit plan" within the

meaning of Section 3(3) of ERISA, (b) a stock bonus, stock purchase, stock option, restricted stock, stock appreciation right, incentive stock or similar equity-based plan or (c) any other employment, severance, deferred-compensation, retention, change in control, retirement, welfare benefit, bonus, incentive or fringe benefit plan, policy, program, agreement or arrangement, in each case, which is maintained, sponsored or contributed to by Seller or any of its Affiliates and in which any Employee participates or is eligible to participate or with respect to which Seller or any of its Affiliates has any liability with respect to any Employee.

"Employee Leasing Agreement" has the meaning given to such term in Section 2.08(a)(xv).

"Employee Lease Term" has the meaning given to such term in the Employee Leasing Agreement.

"Enforceability Exceptions" has the meaning given to such term in Section 3.02.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Estimated Asset Value Statement" has the meaning given to such term in Section 2.07(d)(iii).

"Estimated Closing Required Asset Value" has the meaning given to such term in Section 2.07(d)(i).

"Estimated Closing Statement" has the meaning given to such term in Section 2.07(c)(iii).

"Estimated Required Balance" has the meaning given to such term in Section 2.07(d)(iii).

"Excluded Assets" has the meaning given to such term in Section 2.02.

"Excluded Benefits Liabilities" means any Liabilities in respect of the Employee Benefit Plans and any other benefit plans, programs, policies, arrangement or agreements maintained or contributed to by, or with respect to which Seller or its Affiliates may have any liability, other than the Business Employee Benefit Plans or as set forth in Section 6.01(i).

"Excluded Books and Records" has the meaning given to such term in the definition of "Books and Records."

"Excluded Liabilities" has the meaning given to such term in Section 2.05.

"Excluded Taxes" has the meaning given to such term in Section 2.05(c).

"Fair Market Value" means: (i) in the case of cash and cash equivalents, the face amount thereof; (ii) in the case of securities listed on an exchange or in an over-the-counter market (other than securities that constitute cash equivalents as described in clause (i) above), the final bid price on such exchange or market (provided that such bid price includes all accrued and

unpaid interest on such security through the date of determination; otherwise the amount of such accrued and unpaid interest shall be added to such bid price); and (iii) in the case of any other asset, the fair market value or valuation thereof (including accrued but unpaid interest), as determined in accordance with GAAP; provided that (a) the Fair Market Value of any Investment Asset for which a price is available through Bloomberg's "BVAL" valuation service shall be the sum of (x) the 4:00 p.m. Eastern Time bid price set for that Investment Asset by such valuation service on the applicable date of determination plus (y) all accrued and unpaid interest on such asset through the applicable date of determination, and (b) the Fair Market Value of any Investment Asset for which a price is not available through Bloomberg's "BVAL" valuation service but is available through IDC's valuation service shall be the sum of (x) the 4:00 p.m. Eastern Time bid price set for that Investment Asset by IDC's valuation service on the applicable date of determination plus (y) all accrued and unpaid interest on such asset through the applicable date of determination. Notwithstanding the foregoing, the Fair Market Value of any Investment Asset that is sold by the Ceding Company or AHLIC to a third party during the Interim Period for a price that differs from the amount determined pursuant to the prior sentence shall be the gross proceeds received by the Ceding Company or AHLIC, as applicable, in such sale, including, for the avoidance of doubt, the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset.

"Final Allocation" has the meaning given to such term in Section 7.01.

"Final Asset Value Statement" has the meaning given to such term in Section 2.09(f).

"Final Closing Required Asset Value" has the meaning given to such term in Section 2.09(f).

"Final Closing Required Asset Value Statement" has the meaning given to such term in Section 2.09(f).

"Final Closing Statement" has the meaning given to such term in Section 2.09(f).

"FMV Ex-Accrued" means, with respect to any Investment Asset as of any date of determination, the Fair Market Value thereof as of such date, excluding the amount of all accrued but unpaid interest on such Investment Asset through such date; provided that, notwithstanding the foregoing, (a) the FMV Ex-Accrued of any Investment Asset for which a price is available through Bloomberg's "BVAL" valuation service shall be the 4:00 p.m. Eastern Time bid price set for that Investment Asset by such valuation service on the applicable date of determination, and (b) the FMV Ex-Accrued of any Investment Asset for which a price is not available through Bloomberg's "BVAL" valuation service but is available through IDC's valuation service shall be the 4:00 p.m. Eastern Time bid price set for that Investment Asset by IDC's valuation service on the applicable date of determination. Notwithstanding the foregoing, the FMV Ex-Accrued of any Investment Asset that is sold by the Ceding Company or AHLIC to a third party in the period from the Reference Date through the Closing Date for a price (excluding accrued but unpaid interest) that differs from the amount determined pursuant to the prior sentence shall be the gross proceeds received by the Ceding Company or AHLIC, as

applicable, in such sale, less the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset.

"GAAP" means generally accepted accounting principles in the United States.

"Governmental Approval" has the meaning given to such term in Section 3.05.

"Governmental Authority" means any governmental, legislative, judicial, administrative or regulatory authority, agency, commission, board, body, court, self-regulatory body or entity or any instrumentality thereof, including any Tax Authority, whether United States federal, state, local or non-U.S.

"Governmental Order" means any order, writ, judgment, injunction, decree, stipulation, determination or award entered by or with any Governmental Authority.

"Group Contracts" means the Group Insurance Contracts and the ASO Contracts.

"Group Insurance Contracts" means (i) the contracts, policies, certificates, binders, slips, covers or other agreements of employer and employee paid (a) group life insurance, including group term life insurance, voluntary spouse and dependent term life insurance, group universal life insurance, supplemental life insurance and accidental death and dismemberment insurance, (b) group disability insurance, including long-term and short-term disability insurance and statutory disability insurance and New York Paid Family Leave, and (c) individual or group life insurance issued or established as a result of the exercise of any conversion or other portability option or feature under any of the contracts, policies, certificates, binders, slips, covers or other agreements described in clause (i)(a) above, (ii) all funding or premium deposit agreements used to fund the group long-term disability or group life insurance contracts described in clause (i) above, (iii) all reserve buy out agreements for disability insurance and life insurance and (iv) all retained asset accounts relating to the agreements described in clause (i) above, in each case of clause (i) through (iv) that are issued or assumed by the Ceding Company prior to the Effective Time in connection with the Business and including all supplements, riders, endorsements and ancillary agreements issued or written in connection therewith and extensions thereto.

"Hannover Consent" means the consent and waiver, dated as of October 11, 2017, by Hannover Life Reassurance Company of America of Section 13.1 of that certain Yearly Renewable Term Reinsurance Agreement by and between the Ceding Company and Hannover Life Reassurance Company of America, effective January 1, 2017.

"Hartford License Agreement" has the meaning given to such term in Section 2.08(a)(xiv).

"Hartford Fire" means Hartford Fire Insurance Company, an insurance company organized under the laws of the State of Connecticut.

"HCERA" has the meaning given to such term in Section 3.10(g).

"Health Plan" has the meaning given to such term in Section 3.10(g).

"IMR" means interest maintenance reserve, calculated in accordance with SAP.

"Indemnifiable Losses" has the meaning given to such term in Section 10.04(iii).

"Indemnitee" has the meaning given to such term in Section 10.04(i).

"Indemnitor" has the meaning given to such term in Section 10.04(ii).

"Indemnity Payment" has the meaning given to such term in Section 10.04(iv).

"Independent Accountant" has the meaning given to such term in Section 2.09(e).

"Initial Asset Value Statement" has the meaning given to such term in Section 2.09(a).

"Initial Closing Required Asset Value Statement" has the meaning give to such term in Section 2.09(a).

"Initial Closing Statement" has the meaning given to such term in Section 2.09(a).

"Insurance Regulator" means, with respect to any jurisdiction, the Governmental Authority charged with the supervision of insurance companies in such jurisdiction.

"Intellectual Property" means, in any and all jurisdictions, any: (i) Trademarks; (ii) copyrights, rights in copyrightable subject matter in published and unpublished works of authorship and database rights, (iii) registrations and applications to register or renew the registration of any of the foregoing, (iv) patents and patent applications, including all reissues, divisionals, renewals, extensions, provisionals, continuations and continuations-in-part thereof, (v) rights in Trade Secrets, and (vi) intellectual property rights embodied in Software.

"Investment Assets" means any interest in any bonds, notes, debentures, mortgage loans, real estate, instruments of indebtedness, stocks, joint venture or partnership interests, and all other equity interests, certificates issued by or interests in trusts, derivatives or other assets acquired or held for investment purposes, including without limitation, any assignment instruments relating thereto.

"Investment Guidelines" means the investment policies and guidelines applicable to the investment activities of the Ceding Company (in respect of the Business) as in effect as of the date hereof, a true and complete copy of which is set forth in Section 1.01(a) of the Seller Disclosure Schedule.

"Intellectual Property Agreement" has the meaning given to such term in the Recitals.

"IT Systems" means the hardware, Software, data, databases, data communication lines, network and telecommunications equipment, Internet-related information technology infrastructure, wide area network and other information technology equipment, owned, leased or licensed by Seller or any of its Affiliates and used in the Business.

"Knowledge" means, unless otherwise expressly provided herein, the actual knowledge, after reasonable inquiry of direct reports, of those individuals listed (a) with respect to Seller, on Section 1.01(b) of the Seller Disclosure Schedule, and (b) with respect to Purchaser, on Section 1.01(b) of the Purchaser Disclosure Schedule.

"Leases" has the meaning given to such term in Section 3.15.

"Lease Consents" has the meaning given to such term in Section 5.12(b).

"Leave Recipient" has the meaning given to such term in Section 6.01(b).

"Legal Hold" means any requirement to preserve documents and records in connection with any pending or reasonably contemplated litigation or arbitration (or other form of dispute resolution), nonparty subpoena, regulatory inquiry or investigation by a Governmental Authority or other legal process or proceedings (i) for which Seller provides notice to Purchaser or (ii) arising out of, relating to or in respect of any Indemnifiable Loss for which a Purchaser Indemnified Person seeks indemnification pursuant to Article X. For purposes of this definition, the term "documents" is defined as synonymous with the term "documents or electronically stored information" in Federal Rule of Civil Procedure 34(a)(1)(A).

"Liabilities" means, with respect to any Person, any liability or obligation of such Person of any kind, character or description, whether known or unknown, absolute or contingent, accrued or unaccrued, disputed or undisputed, liquidated or unliquidated, secured or unsecured, joint or several, due or to become due, vested or unvested, executory, determined, determinable or otherwise.

"Lien" means any pledge, security interest, mortgage, lien, attachment, right of first refusal, or option, including any restriction on receipt of income or exercise of any other attribute of ownership, except such restrictions as may be contained in any Applicable Law relating to insurance.

"Listed Sales Employee" has the meaning given to such term in Section 6.01(c).

"Material Adverse Effect" means a material adverse effect on (A) the financial condition, business, assets (when compared to liabilities) or results of operations of the Business, but excluding any such effect to the extent resulting from or arising out of: (i) changes occurring after the date of this Agreement in general political, economic or securities, currency, capital, credit or financial market conditions (including changes in interest rates and changes in equity prices in general); (ii) any occurrence or condition generally affecting participants in any jurisdiction or geographic area in any segment of the industries or markets in which the Business is operated; (iii) any change or proposed change in GAAP, SAP or Applicable Law, or the interpretation or enforcement thereof; (iv) natural or man-made catastrophe events, hostilities, acts of war or terrorism, or any escalation or worsening thereof; (v) any pandemic or similar outbreak; (vi) the negotiation, execution and delivery of, or compliance with the terms of, or the taking of any action required by, this Agreement or the other Transaction Agreements, the failure to take any action prohibited by this Agreement or the other Transaction Agreements, or the public announcement of, or consummation of, any of the transactions contemplated hereby or thereby (including the effect thereof on the relationships (contractual or otherwise) of the Ceding

Company and its Affiliates with policyholders, clients, customers, employees, suppliers, vendors, service providers, members or Governmental Authorities); (vii) the identity of or facts related to Purchaser or its Affiliates or the effect of any action taken by Purchaser or its Affiliates, or taken by Seller or any of its Affiliates at the request of Purchaser or with Purchaser's prior consent (including the effect thereof on the relationships (contractual or otherwise) of the Ceding Company and its Affiliates with policyholders, clients, customers, employees, suppliers, vendors, service providers, members or Governmental Authorities); (viii) any downgrade or threatened downgrade in the rating assigned to Seller or any of its Affiliates by any rating agency (provided , that this clause (viii) shall not by itself exclude the underlying cause of any such downgrade or threatened downgrade); (ix) the fair market value of, or any change or development in the fair market value of, any of the Investment Assets of the Ceding Company or any of the Investment Assets that are to be transferred to Purchaser or the Trust Account pursuant to the terms of any Transaction Agreement; or (x) any failure of the Business to meet any financial projections or targets (provided , that this clause (x) shall not by itself exclude the underlying causes of any such failure); except, in the cases of clauses (i) through (iii), to the extent such effect disproportionately affects the Business relative to other Persons engaged in businesses similar to the Business; or (B) the ability of Seller or any of its Affiliates to perform any of their respective material obligations under this Agreement or any of the other Transaction Agreements or to consummate the material transactions contemplated by this Agreement and the other Transaction Agreements (including the ability to consummate the Closing prior to the Outside Date).

"Material Contract" has the meaning given to such term in Section 3.06(a).

"Milliman" has the meaning given to such term in Section 3.21.

"Monthly Asset Value Statement" has the meaning given to such term in Section 5.11(a)(i).

"Munich Consent" means the consent and waiver, dated as of October 21, 2017, by Munich American Reassurance Company of Section 17.4 of that certain Yearly Renewal Term Reinsurance Agreement by and between the Ceding Company and Munich American Reassurance Company, effective January 1, 2017.

"New Award" has the meaning given to such term in Section 6.01(m).

"Non-Assignable Asset" has the meaning given to such term in Section 2.03.

"Non-Assigned Leases" has the meaning given to such term in Section 3.15.

"Non-Occupied Properties" has the meaning given to such term in Section 5.12(a).

"Notice of Disagreement" has the meaning given to such term in Section 2.09(c).

"Occupied Properties" has the meaning given to such term in Section 5.12(a).

"Omaha Sublease" has the meaning given to such term in Section 2.08(a)(xiii).

"One Common Solution" means the comprehensive vendor integration Software platform for the Business.

"Open Source Software" means all Software that is distributed as "free software," "open source software," or under a similar licensing or distribution model, including the GNU General Public License, GNU Lesser General Public License, Mozilla Public License, BSD Licenses, the Artistic License, the Netscape Public License, the Sun Community Source License, the Sun Industry Standards License, the Apache License, and any license identified as an open source license by the Open Source Initiative (www.opensource.org).

"Operating Permits" has the meaning given to such term in Section 3.11.

"Outside Date" has the meaning given to such term in Section 9.01(b).

"PPACA" has the meaning given to such term in Section 3.10(g).

"Permit" means any license, permit, order, approval, consent, registration, membership, authorization or qualification under any Applicable Law or with any Governmental Authority or under any industry or non-governmental self-regulatory organization.

"Permitted Liens" means: (a) materialmen's, mechanics', construction, carriers', workmen's and repairmen's liens and other similar liens arising in the ordinary course of business; (b) Liens for Taxes, assessments and governmental charges or levies which are not yet due or delinquent, which are being contested in good faith and for which appropriate reserves are maintained in accordance with GAAP or SAP, as applicable; (c) easements, rights-of-way, encroachments, restrictions, conditions and other similar Liens which, individually or in the aggregate, do not materially impair the use or value of the applicable real property or materially interfere with the ordinary conduct of the Business; (d) statutory landlords' liens and liens granted to landlords under any lease; (e) Liens contemplated by this Agreement or any Transaction Agreement, and any custodian or similar liens contemplated or permitted thereunder; (f) in the case of the Assigned Lease, Liens affecting the interest of the lessor; (g) licenses of Intellectual Property made in the ordinary course of business (excluding any source code escrow agreements or any other agreement requiring the deposit of source code or related materials for any such Developed Software); (h) Liens incurred or pledges or deposits made in compliance with workers' compensation, unemployment insurance or other social security laws or regulations; and (i) any other Liens that do not materially impair the value of or interfere with or prohibit the current use or operation of the relevant asset in the Business.

"Person" means any individual, corporation, partnership, firm, joint venture, association, limited liability company, limited liability partnership, joint-stock company, trust, unincorporated organization, governmental, judicial or regulatory body, business unit, division or other entity.

"Personal Data" has the same meaning as the term "personal data," "personal information," or the equivalent under the applicable Privacy and Data Security Law.

"Plantation Sublease" has the meaning given to such term in Section 2.08(a)(xi).

"Portland Location" has the meaning given to such term in Section 3.15.

"Portland Location Assignment Agreement" has the meaning given to such term in the Recitals.

"Pre-Closing Commutation" has the meaning given to such term in the Recitals.

"Pre-Closing Investment Guidelines" means the investment policies and guidelines applicable to the investment activities of the Ceding Company and AHLIC with respect to the Specified Portfolio as set forth on Schedule IV.

"Pre-Closing Period" means a Tax period (or portion thereof) that ends on or before the Closing Date

"Primary Contract" has the meaning given to such term in Section 3.06(vi).

"Privacy and Data Security Law" means any Applicable Laws relating to data privacy, data security, cybersecurity, or data protection, including with respect to the collection, storage, transmission, transfer (including cross-border transfers), processing, breach notification, unauthorized access, encryption, security, safeguarding, loss, disclosure and use of Personal Data.

"Producer" means any producer, broker, agent, general agent, managing general agent, master broker agency, broker general agency, financial specialist or other Person responsible for marketing or producing Group Insurance Contracts prior to the Closing Date.

"Pro Forma Financial Statements" has the meaning given to such term in Section 3.18(b).

"Properties" has the meaning given to such term in Section 5.12.

"Purchase Price" has the meaning given to such term in Section 2.07(a).

"Purchaser" has the meaning given to such term in the Preamble.

"Purchaser 401(k) Plan" has the meaning given to such term in Section 6.01(f).

"Purchaser Disclosure Schedule" has the meaning given to such term in Article IV.

"Purchaser FSA" has the meaning given to such term in Section 6.01(k).

"Purchaser Indemnified Persons" has the meaning given to such term in Section 10.02(a).

"Purchaser Material Adverse Effect" means a material adverse effect on the ability of Purchaser or any of its Affiliates to perform its respective obligations under this Agreement or any Transaction Agreement or to consummate the material transactions contemplated by this Agreement or any of the other Transaction Agreements. For the avoidance

of doubt and without limiting the foregoing, "Purchaser Material Adverse Effect" includes a material impairment on the ability of Purchaser to obtain any Governmental Approval required to be obtained by Purchaser in connection with the consummation of the transactions contemplated by the Transaction Agreements, notwithstanding the compliance by Purchaser with the terms of this Agreement (including Section 5.06).

"Purchaser Permits" has the meaning given to such term in Section 4.08(a).

"Purchaser Specified Representations" means the representations and warranties made in Section 4.01 , Section 4.02 , Section 4.07(a) and Section 4.09.

"Reallocated Asset Value Adjustment" has the meaning given to such term in Section 5.11(c).

"Reallocated Investment Asset" means any Investment Asset or portion thereof that is designated for inclusion in the Specified Portfolio during the period from the Reference Date through the Closing Date pursuant to terms of Section 5.11 or Section 3.19(b) and was, immediately prior to such designation, held by the Ceding Company or AHLIC but not allocated to the Specified Portfolio.

"Reference Closing Statement" means the pro forma balance sheet of the Business as of the Reference Date set forth, for illustrative purposes, in Section 2.07(c)(i) of the Seller Disclosure Schedule (assuming, for this purpose, the Closing occurred, and that the Reinsurance Agreement became effective, as of the Reference Date).

"Reference Date" means June 30, 2017.

"Registered" means issued by, registered or filed with, renewed by or the subject of a pending application before, any Governmental Authority, social media service provider or Internet domain name registrar.

"Reinsurance Agreement" has the meaning given to such term in the Recitals.

"Reinsured Liabilities" has the meaning given to such term in the Recitals.

"Representative" means, with respect to any Person, such Person's Affiliates and the officers, directors, employees, agents, investment bankers, attorneys, financial advisers, accountants, actuaries or other representatives of such Person or any of its Affiliates.

"Required Asset Value" means, as of any date of determination, the amount that would be required to be set forth on the line item labeled "Investments, cash, cash equivalents & accrued inv. Income" in the column labeled "Target Unit Items to be transferred" on a Closing Statement prepared as of such date. For the avoidance of doubt, "Required Asset Value" shall not include any assets required to support any new interest maintenance reserve that will be required to be established upon the transfer of Investment Assets from AHLIC to the Ceding Company in connection with the Pre-Closing Commutation.

"Restricted Entities" has the meaning given to such term in Section 5.13.

"Restricted Period" has the meaning given to such term in Section 5.13.

"Retained Books and Records" has the meaning given to such term in Section 5.05(a).

"Review Period" has the meaning given to such term in Section 2.09(b).

"SAP" means, as to any regulated insurance company, the statutory accounting practices prescribed or permitted by the Governmental Authority responsible for the regulation of insurance companies in the jurisdiction in which such company is domiciled.

"Section 409A" has the meaning given to such term in Section 3.10(e).

"Selection Waterfall" has the meaning given to such term in Section 5.11(a)(iii).

"Seller" has the meaning given to such term in the Preamble.

"Seller 401(k) Plan" has the meaning given to such term in Section 6.01(g).

"Seller Confidentiality Agreement" has the meaning given to such term in Section 5.04(d).

"Seller Disclosure Schedule" has the meaning given to such term in Article III.

"Seller Forfeited Equity Award" has the meaning given to such term in Section 6.01(m).

"Seller FSA" has the meaning given to such term in Section 6.01(k).

"Seller Indemnified Persons" has the meaning given to such term in Section 10.02(b).

"Seller Retention Bonus Liabilities" has the meaning given to such term in Section 6.01(q).

"Seller Specified Representations" means the representations and warranties made in Section 3.01 , Section 3.02 and Section 3.20.

"Seller Trademarks" has the meaning given to such term in Section 5.10(b).

"Shared Service Functions and Assets" means the shared service functions and assets listed on Section 1.01(c) of the Seller Disclosure Schedule.

"Software" means all computer software, including but not limited to application software, system software, firmware, middleware, mobile digital applications, assemblers, applets, compilers and binary libraries, including all source code and object code versions of any and all of the foregoing, in any and all forms and media, and all related documentation.

"South Portland Sublease" has the meaning given to such term in Section 2.08(a)(xii).

"Specified Portfolio" has the meaning given to such term in Section 2.07(c)(ii).

"Statutory Statements" has the meaning given to such term in Section 3.18(a).

"Straddle Period" means a Tax period that begins on or before the Closing Date and ends after the Closing Date, provided that in the case of any Straddle Period, Taxes allocable to the Pre-Closing Period shall equal: (i) in the case of Taxes imposed on a periodic basis (such as real or personal property Taxes), the product of the amount of such Taxes for the Straddle Period and a fraction, the numerator of which is the number of calendar days in the Straddle Period that elapsed through the date hereof and the denominator of which is the number of calendar days in the entire Straddle Period, and (ii) in the case of Taxes not described in clause (i), the amount computed as if such taxable period ended as of the close of business on the date hereof.

"Subleases" means the South Portland Sublease, the Plantation Sublease and the Omaha Sublease.

"Subsidiary" of any Person at the time in question means another Person (other than a joint venture formed with health care providers) more than 50% of the total combined voting power of all classes of capital stock or other voting interests of which, or more than 50% of the equity securities of which, is at such time owned directly or indirectly by such first Person.

"Tax" or " Taxes" means any and all federal, state, provincial, foreign or local income, gross receipts, premium, capital stock, franchise, profits, withholding, social security, Medicare, unemployment, disability, real property, ad valorem/personal property, stamp, goods and services, harmonized sales, excise, occupation, sales, use, transfer, value added, alternative minimum, estimated or other tax, fee, duty, levy, custom, tariff, impost, assessment or charge of the same or of a similar nature to any of the foregoing, including any interest, penalty or addition thereto.

"Tax Authority" means, with respect to any Tax, any government or political subdivision thereof that imposes such Tax, and any agency charged with the collection, assessment, determination or administration of such Tax for such government or subdivision.

"Tax Contest" has the meaning given to such term in Section 7.03.

"Tax Return" means any return, report, declaration, claim for refund or other return or statement, including any schedule or attachment thereto, and any amendment thereof, required to be filed or furnished in connection with the determination, assessment or collection of any Tax.

"Third Party Claim" has the meaning given to such term in Section 10.04(v).

"Threshold Amount" has the meaning given to such term in Section 10.03(a).

"Trademark License Agreement" has the meaning given to such term in Section 5.10(a).

"Trademarks" means trademarks, service marks, Internet domain names, trade dress, trade names, logos, slogans, social media identifiers, handles and tags, and any other indicia of origin, registrations and applications with respect to the foregoing, and the goodwill associated therewith and symbolized thereby.

"Trade Secrets" means all confidential information deriving economic value from not being generally known or readily ascertainable, and that is the subject of reasonable efforts to maintain confidentiality, including, as applicable, inventions, processes, designs, formulae, models, tools, algorithms, Software architectures, trade secrets, know-how, ideas, research and development, data and databases and confidential information.

"Transaction Accounting Principles" means the methodologies, procedures, judgments, practices, principles and estimates used to compute and prepare the Reference Closing Statement and described in Schedule V.

"Transaction Agreements" means this Agreement, the Reinsurance Agreement, the Trust Agreement, the Administrative Services Agreement, the Transition Services Agreement, the Bill of Sale and Assignment and Assumption Agreement, the Intellectual Property Agreement, the Distribution Agreement, the Trademark License Agreement, the Commutation Agreement, the Portland Location Assignment Agreement, the Plantation Sublease, the South Portland Sublease, the Omaha Sublease, the Employee Leasing Agreement and the Data Processing Side Letter.

"Transfer Date" has the meaning given to such term in Section 6.01(c).

"Transfer Offers" has the meaning given to such term in Section 6.01(a).

"Transfer Taxes" has the meaning given to such term in Section 7.02.

"Transferred Assets" has the meaning given to such term in Section 2.01.

"Transferred Employee" has the meaning given to such term in Section 6.01(c).

"Transferred Intellectual Property" has the meaning given to such term in Section 2.01.

"Transferred Portfolio" has the meaning give to such term in Section 2.07(d)(ii).

"Transition Services Agreement" has the meaning given to such term in the Recitals.

"Triggering Event" has the meaning given to such term in the form of the Reinsurance Agreement attached hereto as Exhibit B.

"True-Up Amount" means an amount (which may be positive or negative) equal to (i) the final Accounting Value of the Transferred Portfolio as set forth in the Final Asset Value Statement minus (ii) the Final Closing Required Asset Value.

"Trust Account" has the meaning given to such term in the Recitals.

"Trust Agreement" has the meaning given to such term in the Recitals.

"Trustee" means a U.S. bank or other financial institution or another Person mutually agreed upon by Seller and Purchaser.

"WARN Act" has the meaning given to such term in Section 6.01(e).

"Workability" means the integrated leave, disability and premium life waiver administration Software platform for the Business that includes One Common Solution, as well as the following functionality: (a) absence management, (b) web portal, (c) mobile and claims payment systems, (d) tax reporting, and (e) data analytics.

ARTICLE II.

TRANSFER AND ACQUISITION OF ASSETS

Section 2.01. Purchase and Sale of the Transferred Assets. Upon the terms and subject to the conditions set forth in this Agreement, at the Closing (except with respect to the Business Employee Benefit Plans and the Assigned Lease (subject to the terms of Section 2.08(d)), at the date of termination of the Employee Lease Term), Seller shall, and shall cause its Affiliates to, sell, convey, assign, transfer and deliver to Purchaser, free and clear of all Liens other than Permitted Liens, and Purchaser shall purchase, acquire, assume and accept from Seller and its Affiliates, pursuant to agreements, notifications, or other instruments in such form, reasonably satisfactory to Purchaser, all of Seller's and each such Affiliate's right, title and interest in and to the following assets, properties, rights and contracts (other than the Excluded Assets and excluding, for the avoidance of doubt, any cash or Investment Assets that are transferred to Purchaser or to the Trust Account in connection with the transactions contemplated by the Reinsurance Agreement or pursuant to the terms of Sections 2.07 , 2.09 and 2.10), in each case that exist as of the Closing Date (such assets, properties, rights and contracts to be purchased, acquired, assumed and accepted by Purchaser being referred to herein as the " Transferred Assets"):

(a) the Assigned Contracts;

(b) (i) the Intellectual Property (other than intellectual property rights embodied in Software, and the Trademarks and domain names licensed to Purchaser pursuant to the Trademark License Agreement) owned by Seller or any of its Affiliates and primarily used in the Business, including the Intellectual Property listed on Schedule II(b);

(ii) Workability, including the Intellectual Property embodied therein, other than Software that is generally commercially available and set forth on Section 2.01(b)(ii) of the Seller Disclosure Schedule; and

(iii) all other Software that is necessary to operate Workability, in each case other than (A) Software that is generally commercially available, (B) Open Source Software, and (C) the Seller Software licensed to Purchaser pursuant to the Intellectual Property Agreement ((i), (ii) and (iii) collectively, the " Transferred Intellectual Property");

(c) all furniture, fixtures, equipment (including computer hardware), supplies and other tangible personal property of the Business, in each case to the extent listed on Schedule II(c);

(d) the Books and Records, the transfer of which shall be subject to Section 5.05;

(e) all advertising, marketing, sales and promotional materials relating directly and primarily to the Business;

(f) all rights and claims under any and all warranties extended by suppliers, vendors, contractors, manufacturers and licensors to the extent in relation to any of the Transferred Intellectual Property and hardware assets included in the Transferred Assets;

(g) subject to the terms of Section 2.08(d) , the real estate lease listed on Schedule II(g) (the " Assigned Lease") and all installations, fixtures, improvements and benefits in connection therewith;

(h) the phone numbers listed on Schedule II(h); and

(i) all other assets of the Business listed on Schedule II(i).

Section 2.02. Excluded Assets. Notwithstanding anything contained in this Agreement (including Section 2.01) to the contrary and except to the extent of rights expressly provided in certain Transaction Agreements, neither Seller nor any of its Affiliates is selling, transferring, conveying or delivering (or causing to be sold, transferred, conveyed or delivered), and Purchaser is not purchasing, assuming or accepting any assets, properties, rights and contracts of Seller or any of its Affiliates, or any interests therein, other than the Transferred Assets (all such assets, properties, rights and contracts of Seller or any of its Affiliates, or any interests therein, other than the Transferred Assets being referred to herein as the " Excluded Assets"). Without limiting the generality of the foregoing, all of the following shall constitute Excluded Assets:

(a) all cash and cash equivalents, including checking accounts, bank accounts, certificates of deposit and securities, of Seller or any of its Affiliates;

(b) all intercompany receivables and other amounts due from Seller or its Affiliates;

(c) all contracts to which Seller or any Affiliate thereof is a party or is otherwise bound other than the Assigned Contracts;

(d) any real estate leases, real estate title, or any installations, fixtures, and other improvements at Seller's or any of its Affiliates' leased real estate, whether or not used for the benefit of the Business, in each case other than the Assigned Lease or as contemplated by Section 2.01(g) ;

(e) all furniture, fixtures, equipment (including computer hardware), machinery and other tangible personal property of Seller or any of its Affiliates that are not listed on Schedule II(c);

(f) all Permits of Seller or its Affiliates;

(g) Seller's or any of its Affiliates' rights under any policies of insurance or any benefits, proceeds, or premium refunds payable or paid thereunder or with respect thereto;

(h) all rights of Seller or any of its Affiliates to file for or receive any refunds, credits or similar benefits for Taxes levied and imposed upon, or in connection with, the Transferred Assets or the conduct or operation of the Business allocable to any Pre-Closing Period or to the portion of the Straddle Period ending on the Closing Date;

(i) the Excluded Books and Records;

(j) all rights of Seller or any of its Affiliates under the Transaction Agreements;

(k) all rights of Seller or any of its Affiliates to indemnification from any Person with respect to any of the Excluded Liabilities;

(l) all prepaid Taxes allocable to taxable periods or portions thereof ending on or before the Closing Date;

(m) all Intellectual Property owned by Seller or any of its Affiliates (including all rights in and to the Seller Trademarks), other than the Transferred Intellectual Property;

(n) all Intellectual Property licensed to Seller or any of its Affiliates, other than Intellectual Property licensed pursuant to an Assigned Contract;

(o) all of Seller's or any of its Affiliates' e-mail addresses, URLs, websites, website content, and telephone numbers, other than as contemplated by Section 2.01(h);

(p) all bank accounts and lockboxes used in the Business;

(q) all assets in respect of any Employee Benefit Plan;

(r) any assets arising out of, and any associated claims arising out of, the Excluded Liabilities;

(s) any legal or beneficial interest in the capital stock and other equity interests of Seller or its Affiliates;

(t) the accounts and notes receivable not included in the Transferred Assets;

(u) any assets transferred or otherwise disposed of by Seller or any of its Affiliates (other than any intercompany transfers or sales) in compliance with Section 5.01(a) prior to the Closing;

(v) all accounting systems owned or used by Seller or any of its Affiliates, whether or not used in connection with the operation of the Business, including those that comprise the Shared Service Functions and Assets;

(w) any assets utilized by Seller or any of its Affiliates in connection with businesses other than the Business, including those that comprise the Shared Service Functions and Assets; and

(x) the Shared Service Functions and Assets.

Section 2.03. Procedures for Assets Not Transferrable.

(a) Notwithstanding anything to the contrary contained in this Agreement, if any asset, property, right or contract intended to be included in the Transferred Assets (other than with respect to the Assigned Lease, which is addressed in Section 5.12) is not assignable, transferable or able to be subleased or licensed (as applicable) (each a " Non-Assignable Asset") to Purchaser without the consent or waiver of any Person (other than Seller, Purchaser or any of their respective Affiliates or Governmental Authority), and such consent or waiver has not been obtained on or prior to the Closing Date, this Agreement and the other Transaction Agreements shall not constitute an assignment, transfer, sublease or license (as applicable) thereof unless and until such consent is obtained; provided , that this Section 2.03(a) shall not affect whether any such asset, property, right or contract will be deemed a "Transferred Asset" or "Assigned Contract" under this Agreement. In each such case, Seller shall, and shall cause its Affiliates to, use commercially reasonable efforts to obtain, prior to the Closing, any consent or waiver from any third party (other than a Governmental Authority) that is required for Seller or its applicable Affiliates to sell, transfer, assign, convey and deliver the Transferred Assets and Assigned Contracts to Purchaser or to provide the services to be provided under the Transition Services Agreement. Purchaser shall, and shall cause each of its Affiliates to, cooperate with Seller and its Affiliates at Seller's request to assist Seller and its Affiliates in obtaining such consents or waivers. Each of Seller and Purchaser shall bear its own and its Affiliates' internal costs to obtain such consents and waivers, and the costs payable to third parties for obtaining such consents and waivers (which, for the avoidance of doubt, shall not include any increased fees under the terms of any Assigned Contract from and after the Closing) shall be borne equally by Seller and Purchaser.

(b) If any such consent or waiver referred to in Section 2.03(a) cannot be obtained prior to the Closing, then, to the extent permitted by Applicable Law and the terms of any relevant contracts with third parties, Seller shall, and shall cause its applicable Affiliates to, until the earlier of (i) the time at which such consent or waiver is obtained, and (ii) the expiration or termination of the term or duration of any such Non-Assignable Asset (the length of such term or duration being as it exists as of the Closing): (A) hold the Non-Assignable Assets, from and after the Closing, in trust for the benefit of Purchaser, and all benefits and obligations existing thereunder shall be for Purchaser's account; and (B) take or cause to be taken such actions in its name or otherwise as Purchaser may reasonably request so as to provide Purchaser with the benefits of such Non-Assignable Assets, to enforce (for the benefit of Purchaser or one its Affiliates and to the extent it is commercially reasonable to do so) any of Seller's or Seller's Affiliates' respective rights relating to such Non-Assignable Assets and to effect the collection of

money or other consideration that becomes due and payable under such Non-Assignable Asset, and shall promptly pay over to Purchaser all money or other consideration received by it in respect of such Non-Assignable Asset, provided that Purchaser shall indemnify Seller and Seller's Affiliates for any Liabilities arising out of any action or omission by Purchaser relating to such Non-Assignable Asset (other than any such action or omission by Purchaser at the request or direction of Seller). Purchaser shall timely pay, perform or otherwise discharge (in accordance with the respective terms and subject to the respective conditions thereof, and in the name of Seller or its applicable Affiliate) all of the covenants and obligations of Seller or its applicable Affiliate incurred after the Closing with respect to such Non-Assignable Asset (including, for the avoidance of doubt, any increases in fees, costs or expenses required to be paid by Seller under the terms thereof), provided that Seller shall indemnify Purchaser for any Liabilities arising out of any action or omission by Seller relating to such Non-Assignable Asset (other than any such action or omission by Seller at the request or direction of Purchaser). Purchaser and Seller shall mutually cooperate to provide any other reasonable alternative arrangements as may be reasonably required to implement the purpose and intent of this Agreement and the other Transaction Agreements so that Purchaser and its Affiliates will have access to the rights and benefits contemplated by such Non-Assignable Asset from and after the Closing. Upon obtaining the requisite consent of any applicable Person, any previously Non-Assignable Asset and any Leases that were not assigned, transferred, subleased or licensed (as applicable) at the Closing (in accordance with the first sentence of this Section 2.03(a)) shall be promptly transferred, assigned, subleased or licensed (as applicable) by the Seller or its applicable Affiliate(s) to Purchaser for no additional consideration.

Section 2.04. Assumption of the Assumed Liabilities. Upon the terms and subject to the conditions set forth in this Agreement, at the Closing, Seller shall, and shall cause its Affiliates to, assign to Purchaser, and Purchaser shall assume, satisfy and discharge when due, any and all Liabilities of Seller or any of its Affiliates relating to the Transferred Assets (other than the Excluded Liabilities and excluding, for the avoidance of doubt, (i) all Reinsured Liabilities reinsured by Purchaser under and pursuant to the Reinsurance Agreement, which will be governed by the terms of the Reinsurance Agreement, to the extent arising on or after the Closing Date, (ii) any Liabilities that result from a breach by Seller or its Affiliates of any Assigned Contract arising out of an action or omission occurring prior to the Closing) (all such Liabilities to be so assumed, satisfied or discharged being referred to herein as the " Assumed Liabilities"), including the following: (a) all Liabilities arising under the Assigned Contracts; (b) all Liabilities for Taxes relating to the Transferred Assets other than Excluded Taxes; (c) all Liabilities assumed by Purchaser pursuant to Articles VI and VII; and (d) all Liabilities listed on Schedule III. Notwithstanding the foregoing, the Liabilities of Seller or any of its Affiliates relating to the Business Employee Benefit Plans and the Assigned Lease shall not be assumed or assigned to Purchaser until the termination of the Employee Lease Term, after which time Purchaser shall (with respect to the Assigned Lease, subject to the terms of Section 2.08(d)) assume, satisfy and discharge when due, any and all Liabilities of Seller or any of its Affiliates thereunder.

Section 2.05. Excluded Liabilities. Notwithstanding anything to the contrary contained in this Agreement, Purchaser will not assume or be liable for, and Seller and its applicable Affiliates will retain and remain responsible for, all of Seller's and such Affiliates' Liabilities (fixed or contingent, known or unknown) (other than the Assumed Liabilities and excluding, for

the avoidance of doubt, all Reinsured Liabilities reinsured by Purchaser under and pursuant to the Reinsurance Agreement, which will be governed by the terms of the Reinsurance Agreement), regardless of when asserted (collectively, the " Excluded Liabilities"). Without limiting the foregoing, the Excluded Liabilities include the following:

(a) all of Seller's and its Affiliates' Liabilities under the Transaction Agreements;

(b) the Excluded Benefits Liabilities;

(c) any Liability for or in respect of the payment of all Taxes of Seller or any of its Affiliates, and of any Taxes arising out of or relating to the ownership or use of the Transferred Assets or the conduct of the Business for a Pre-Closing Period, other than as provided in Section 7.02 and Taxes arising out of or relating to actions that Purchaser requests Seller to take prior to Closing (the " Excluded Taxes");

(d) all Liabilities arising out of, in connection with or under contracts to which Seller or any of its Affiliates is a party other than Liabilities relating to periods (or portions thereof) beginning from or after the Closing under the Assigned Contracts, the Assigned Lease and any other contracts included in the Transferred Assets (which such Liabilities shall be Assumed Liabilities);

(e) Seller Retention Bonus Liabilities; and

(f) Liabilities of Seller or any of its Affiliates related to any Permitted Liens on the Transferred Assets.

Section 2.06. Place and Date of Closing. Unless another date, time or place is agreed to in writing by the parties hereto, the closing of the transactions contemplated by this Agreement (the " Closing") shall take place at the offices of Willkie Farr & Gallagher LLP, 787 Seventh Avenue, New York, New York 10019, at 10:00 a.m., New York City time, on the third Business Day after the date on which the last of the conditions set forth in Article VIII to be satisfied or waived (other than those conditions that by their terms are to be satisfied at the Closing, but subject to the satisfaction or waiver of such conditions at the Closing) shall have been so satisfied or waived in accordance with this Agreement (the " Condition Satisfaction"); provided , however , that if the Condition Satisfaction occurs less than ten Business Days prior to the first Business Day of the next calendar month, then the Closing shall take place on the first Business Day of the calendar month immediately following the calendar month in which the Condition Satisfaction occurs. The Closing shall be deemed effective as of the Effective Time. For purposes of preparing the Estimated Closing Statement, Estimated Asset Value Statement, Initial Closing Statement, Initial Asset Value Statement, Final Closing Statement and Final Asset Value Statement and calculating any amounts required to be calculated therefrom, such statements shall be prepared as of the close of the last calendar day of the month immediately preceding the month in which the Closing occurs (the " Accounting Date"). The actual date and time at which the Closing occurs is referred to herein as the " Closing Date. "

Section 2.07. Consideration.

(a) The consideration with respect to the transactions contemplated by this Agreement will be an aggregate amount in cash equal to $1,450,000,000 (the " Purchase Price"), comprised of:

(i) $1,382,000,000, constituting the ceding commission to be paid to the Ceding Company in connection with the Reinsurance Agreement (the "Ceding Commission"), which amount shall constitute consideration for the reinsurance arrangements contemplated by the Reinsurance Agreement; and

(ii) $68,000,000 (the "Asset Consideration") representing the aggregate purchase price for the Transferred Assets.

(b) At the Closing, Purchaser shall pay to Seller or an Affiliate of Seller (as designated by Seller), by wire transfer of immediately available funds to such account or accounts of Seller or its Affiliates as Seller may designate in writing at least two Business Days prior to the Closing Date, an amount equal to the Asset Consideration.

(c) Reference and Estimated Closing Statement; Specified Portfolio.

(i) Section 2.07(c)(i) of the Seller Disclosure Schedule contains, for illustrative purposes, a pro forma Closing Statement assuming, for this purpose, that the Closing occurred, and the Reinsurance Agreement became effective, as of the Reference Date (the "Reference Closing Statement").

(ii) Section 2.07(c)(ii) of the Seller Disclosure Schedule contains a schedule of cash and Investment Assets held by the Ceding Company or AHLIC in respect of the Business as of the Reference Date (such portfolio, as it may have been or will be adjusted or changed between the Reference Date and the Closing Date in accordance with Sections 3.19 and 5.11 , the "Specified Portfolio"), which portfolio had an aggregate Accounting Value as of the Reference Date equal to the Required Asset Value as of the Reference Date.

(iii) Not less than five Business Days prior to the anticipated Closing Date, Seller shall prepare and deliver to Purchaser an estimated Closing Statement as of the anticipated Accounting Date (the "Estimated Closing Statement"). The Estimated Closing Statement shall be prepared in accordance with the Transaction Accounting Principles applied in a manner consistent with the preparation of the Reference Closing Statement and be in the same format as the Reference Closing Statement.

(d) Determination of Transferred Portfolio.

(i) Not less than two Business Days prior to the anticipated Closing Date, Seller shall prepare and deliver to Purchaser a calculation of the Closing Required Asset Value, which calculation will be based on the Required Asset Value reflected in the Estimated Closing Statement and will take into account all Capital Gain or Loss Adjustments and all Reallocated Asset Value Adjustments required pursuant to Section 5.11 or Section 3.19(b) through the Closing Date (the "Estimated Closing Required Asset Value").

(ii) The "Transferred Portfolio" will be determined as follows:

(A) if the Accounting Value of the Specified Portfolio as of the Closing Date equals the Closing Required Asset Value, the Transferred Portfolio will comprise all, and only, the cash and Investment Assets in the Specified Portfolio as of immediately prior to the Closing;

(B) if the Accounting Value of the Specified Portfolio as of the Closing Date is less than the Closing Required Asset Value, the Transferred Portfolio will comprise (x) all of the cash and Investment Assets in the Specified Portfolio as of immediately prior to the Closing and (y) cash or other Investment Assets selected by Seller in accordance with the Pre-Closing Investment Guidelines that have an aggregate Fair Market Value equal to the amount of such shortfall; and

(C) if the Accounting Value of the Specified Portfolio as of the Closing Date is greater than the Closing Required Asset Value, Seller will select for removal from the Specified Portfolio cash or Investment Assets that have an aggregate Accounting Value equal to such excess in accordance with the Selection Waterfall. The cash and Investment Assets remaining in the Specified Portfolio after such removal will be the Transferred Portfolio.

(iii) Concurrently with the delivery by Seller to Purchaser of the calculation of the Estimated Closing Required Asset Value pursuant to clause (i) of this Section 2.07(d) , Seller will also deliver to Purchaser (A) a schedule showing the cash and Investment Assets in the Transferred Portfolio and its estimated calculation of the aggregate Accounting Value of the cash and Investment Assets in the Transferred Portfolio as of immediately prior to the Closing (the "Estimated Asset Value Statement"), and (B) a calculation of Seller's estimate of the Required Balance (as defined in the Reinsurance Agreement) as of the Closing Date based on amounts set forth on the Estimated Closing Statement and calculated using the aggregate FMV-Ex Accrued and the aggregate Book Value of the Transferred Portfolio (the "Estimated Required Balance").

(e) Payment of Ceding Commissions and Initial Transfer Amounts. At the Closing, upon the terms set forth in this Agreement and the Reinsurance Agreement:

(i) in addition to the payment Purchaser is required to make to Seller pursuant to Section 2.07(b) above, Purchaser shall pay to Seller, by wire transfer of immediately available funds to an account or accounts designated in writing to Purchaser by Seller at least two Business Days prior to the Closing Date, an amount equal to the Ceding Commission; and

(ii) Seller shall cause the Ceding Company (or AHLIC on behalf of the Ceding Company) to deposit into the Trust Account, on behalf of Purchaser, the cash and Investment Assets in the Transferred Portfolio; provided that:

(A) if on the Closing Date the aggregate Fair Market Value of the cash and Investment Assets in the Transferred Portfolio exceeds the Estimated Required Balance, then Seller shall cause the Ceding Company (or AHLIC on behalf of the Ceding Company) to transfer to Purchaser cash or Investment Assets from the Transferred Portfolio selected by Purchaser with a Fair Market Value equal to such excess and shall cause the Ceding Company (or AHLIC on behalf of the Ceding Company) to transfer the remainder of the cash and Investment Assets in the Transferred Portfolio to the Trust Account; and

(B) if on the Closing Date the aggregate Fair Market Value of the cash and Investment Assets in the Transferred Portfolio is less than the Estimated Required Balance, Purchaser shall, at the Closing, transfer to the Trust Account Authorized Investments (as defined in the Trust Agreement) having a Fair Market Value as of the Closing Date equal to such shortfall.

Section 2.08. Closing Deliveries.

(a) Upon the terms and subject to the conditions set forth in this Agreement, at the Closing, in addition to the payments contemplated by Section 2.07 above, Seller shall, and shall cause its applicable Affiliates to, enter into and deliver to Purchaser:

(i) a copy of the Commutation Agreement duly executed by the Ceding Company and AHLIC;

(ii) a counterpart to the Reinsurance Agreement duly executed by the Ceding Company;

(iii) a counterpart to the Trust Agreement duly executed by the Ceding Company;

(iv) a counterpart to the Administrative Services Agreement duly executed by the Ceding Company;

(v) a counterpart to the Transition Services Agreement duly executed by the Ceding Company;

(vi) a counterpart to the Intellectual Property Agreement duly executed by Seller and the Ceding Company;

(vii) a counterpart to the Distribution Agreement duly executed by each of the Ceding Company and Carefree Insurance Services, Inc.;

(viii) a counterpart to the Bill of Sale and Assignment and Assumption Agreement duly executed by Seller and the Ceding Company;

(ix) a counterpart to the Trademark License Agreement duly executed by Seller and the Ceding Company;

(x) a counterpart to the Portland Location Assignment Agreement, duly executed by the Ceding Company;

(xi) a counterpart to the sublease in the form attached hereto as Exhibit K-1 (the "Plantation Sublease"), duly executed by the Ceding Company;

(xii) a counterpart to the sublease in the form attached hereto as Exhibit K-2 (the "South Portland Sublease"), duly executed by the Ceding Company;

(xiii) a counterpart to the sublease in the form attached hereto as Exhibit K-3 (the "Omaha Sublease"), duly executed by Aetna Health Management, LLC;

(xiv) a counterpart to the license agreement in the form attached hereto as Exhibit L (the "Hartford License Agreement"), duly executed by the Ceding Company;

(xv) a counterpart to the Employee Leasing Agreement in the form attached hereto as Exhibit M (the "Employee Leasing Agreement"), duly executed by Seller;

(xvi) a counterpart to the Data Processing Side Letter duly executed by the Ceding Company;

(xvii) a certificate of Seller duly executed by an authorized officer of Seller, dated as of the Closing Date, certifying as to Seller's compliance with the conditions set forth in Section 8.02(a) and Section 8.02(b); and

(xviii) such other agreements, instruments and documents as are contemplated by this Agreement or the other Transaction Agreements to be executed and delivered by Seller or any of its Affiliates on the Closing Date.

(b) Upon the terms and subject to the conditions set forth in this Agreement, at the Closing, in addition to the payments contemplated by Section 2.07 above, Purchaser shall, and shall cause its applicable Affiliates to, enter into and deliver to Seller:

(i) a counterpart to the Reinsurance Agreement duly executed by Purchaser;

(ii) a counterpart to the Trust Agreement duly executed by Purchaser;

(iii) a counterpart to the Administrative Services Agreement duly executed by Purchaser;

(iv) a counterpart to the Transition Services Agreement duly executed by Purchaser;

(v) a counterpart to the Intellectual Property Agreement duly executed by Hartford Fire;

(vi) a counterpart to the Distribution Agreement duly executed by Purchaser;

(vii) a counterpart to the Bill of Sale and Assignment and Assumption Agreement duly executed Purchaser;

(viii) a counterpart to the Trademark License Agreement duly executed by Hartford Fire;

(ix) a counterpart to a side letter in the form attached hereto as Exhibit N (the "Data Processing Side Letter"), duly executed by Purchaser, acknowledging that the Ceding Company, its Affiliates (as defined in the Transition Services Agreement) and their respective subcontractors have processed, and will continue to process, data relating to the Business in Alaska, Hawaii, India and the Philippines;

(x) a counterpart to the Portland Location Assignment Agreement, duly executed by Hartford Fire;

(xi) a counterpart to the Plantation Sublease, duly executed by Hartford Fire;

(xii) a counterpart to the South Portland Sublease, duly executed by Hartford Fire;

(xiii) a counterpart to the Omaha Sublease, duly executed by Hartford Fire;

(xiv) a counterpart to the Hartford License Agreement, duly executed by Hartford Fire;

(xv) a counterpart to the Employee Leasing Agreement, duly executed by Purchaser;

(xvi) a certificate of Purchaser duly executed by an authorized officer of Purchaser, dated as of the Closing Date, certifying as to Purchaser's compliance with the conditions set forth in Section 8.03(a) , Section 8.03(b) and 8.03(c); and

(xvii) such other agreements, instruments and documents as are contemplated by this Agreement or the other Transaction Agreements to be executed and delivered by Seller or any of its Affiliates on the Closing Date.

(c) Purchaser and Seller shall each use their reasonable best efforts to obtain, at or prior to the Closing, a counterpart to the Trust Agreement duly executed by the Trustee.

(d) Notwithstanding the delivery by Seller or Purchaser of any counterpart to the Portland Location Assignment Agreement or any Sublease pursuant to Section 2.08(a) or Section 2.08(b) , as applicable, such counterparts shall not be effective at the Closing but shall instead be held in escrow and not become effective with respect to such agreement unless and until, and shall become effective with respect to such agreement only if (i) the applicable Lease Consent is obtained on or prior to December 31, 2017 and (ii) the Employee Lease Term has expired or been terminated. If the foregoing conditions to the effectiveness of the counterparts to the Portland Location Assignment Agreement or any such Sublease are not satisfied, then, upon the expiration or termination of the Employee Lease Term, the applicable agreement to which such counterparts relate shall be deemed not to have been executed by the parties thereto and shall be void and have no force or effect. If the Portland Location Assignment Agreement is deemed not to have been executed in accordance with the prior sentence, then: (i) the Assigned Lease shall be deemed not to be a Transferred Asset or Assigned Contract hereunder; (ii) Seller shall have no Liability to any Purchaser Indemnified Person by virtue of the fact that the Assigned Lease is not a Transferred Asset or Assigned Contract hereunder; and (iii) the Liabilities of Seller and its Affiliates under the Assigned Lease shall not be Assumed Liabilities hereunder; provided , that the foregoing shall not affect either party's obligations under Article V , including Section 5.12 , or any rights to indemnification under Article X arising out of any breach by the other party of its obligations under Article V.

Section 2.09. Adjustment to Initial Transfer Amount after Closing.

(a) Within 90 days following the Closing Date, Seller shall prepare and deliver to Purchaser: (i) a Closing Statement as of the Accounting Date (the " Initial Closing Statement"), which shall be prepared in accordance with the Transaction Accounting Principles applied consistently with their application in connection with the preparation of the Reference Closing Statement and be in the same format as the Reference Closing Statement; (ii) Seller's determination of the Accounting Value of the Transferred Portfolio as of the Accounting Date (the " Initial Asset Value Statement"); and (iii) Seller's calculation of the Closing Required Asset Value based on the amounts set forth on the Initial Closing Statement and the Initial Asset Value Statement and taking into account all Capital Gain or Loss Adjustments and all Reallocated Asset Value Adjustments required from the Reference Date through the Closing Date (the

"Initial Closing Required Asset Value Statement"). Each of the Initial Closing Statement, Initial Asset Value Statement and the Initial Closing Required Asset Value Statement will be accompanied by reasonably detailed supporting documentation relating to the amounts and calculations therein. Each of the amounts set forth on the Estimated Closing Statement, the Initial Closing Statement and the Final Closing Statement shall not include any interest maintenance reserve related to the transfer of Investment Assets from AHLIC to the Ceding Company in connection with the Pre-Closing Commutation; provided , that the foregoing shall not affect the inclusion of such amounts in the calculation of the "Closing Date IMR Amount" under the Reinsurance Agreement.

(b) During the 60 days immediately following Purchaser's receipt of the Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement (the " Review Period"), Purchaser and its Representatives shall be permitted to review Sellers's working papers and any working papers of Seller's independent accountants directly relating to the preparation of the Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement, as well as all of the Books and Records and other relevant information or documents relating to the operations and finances of the Business with respect to the period up to and including the Closing Date, and Seller shall make available the individuals in its or its Affiliates' employ who are responsible for and knowledgeable about the information used in, and the preparation or calculation (as applicable) of, the Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement in order to respond to the inquiries of Purchaser; provided , however , that the independent accountants of Seller shall not be obligated to make any working papers available to Purchaser unless and until Purchaser has signed a customary confidentiality and hold harmless agreement relating to such access to working papers in form and substance reasonably acceptable to such independent accountants.

(c) If Purchaser disagrees with the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement (including any amount or computation set forth therein) in any respect and on any basis (including that the representations and warranties in Section 3.18(d) or the covenants in Section 5.11 were breached), Purchaser may, on or prior to the last day of the Review Period, deliver a notice to Seller setting forth, in reasonable detail, each disputed item or amount and the basis for Purchaser's disagreement therewith (the " Notice of Disagreement"). The Notice of Disagreement shall set forth, with respect to each disputed item, Purchaser's position as to the correct amount or computation that should have been included in the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement. If Purchaser does not deliver a Notice of Disagreement with respect to the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement to Seller by the end of the Review Period, the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement, as applicable, shall become final and binding on the parties.

(d) During the 20 Business Days immediately following the delivery of a Notice of Disagreement, Seller and Purchaser shall seek in good faith to resolve any disagreement that they may have with respect to the matters specified in the Notice of Disagreement.

(e) If, at the end of such 20 Business Day period, Seller and Purchaser have been unable to resolve all disagreements that they may have with respect to the matters specified in the Notice of Disagreement, then Seller and Purchaser shall submit all matters that remain in dispute with respect to the Notice of Disagreement (along with a copy of the applicable Initial Closing Statement, the Initial Asset Value Statement and the Initial Closing Required Asset Value Statement marked to indicate those line items that are in dispute) to PricewaterhouseCoopers LLP or, if PricewaterhouseCoopers LLP is unwilling or unable to serve, another independent certified public accounting firm in the United States of international recognition mutually agreeable to Seller and Purchaser and that is not the auditor or independent accounting firm of any of the parties (the " Independent Accountant"), to make a determination with respect to all matters in dispute.

(f) Seller and Purchaser shall use commercially reasonable efforts to cause the Independent Accountant to render a determination within 30 days after the submission of such matters to the Independent Accountant or as soon as practicable thereafter. Seller, on the one hand, and Purchaser, on the other hand, shall promptly (and in any event within five Business Days) after the Independent Accountant's engagement, each submit to the Independent Accountant their respective computations of the disputed items identified in the Notice of Disagreement and information, arguments and support for their respective positions, and shall concurrently deliver a copy of such materials to the other party. Each party shall then be given an opportunity to supplement the information, arguments and support included in its initial submission with one additional submission to respond to any arguments or positions taken by the other party in such other party's initial submission, which supplemental information shall be submitted to the Independent Accountant (with a copy thereof to the other party) within 10 Business Days after the first date on which both parties have submitted their respective initial submissions to the Independent Accountant. The Independent Accountant shall thereafter be permitted to request additional or clarifying information from the parties, and each of the parties shall cooperate and shall cause their Representatives to cooperate with such requests of the Independent Accountant. The Independent Accountant shall determine, based solely on the materials so presented by the parties and upon information received in response to such requests for additional or clarifying information and not by independent review, only those issues in dispute specifically set forth in the Notice of Disagreement and shall render a written report to Seller and Purchaser in which the Independent Accountant shall, after considering all matters set forth in the Notice of Disagreement, determine what adjustments, if any, should be made to the amounts and computations set forth in the Initial Closing Statement, Initial Asset Value Statement and the Initial Closing Required Asset Value Statement solely as to the disputed items. Such written report shall set forth, in reasonable detail, the determination of the Independent Accountant with respect to each of the disputed line items specified in the Notice of Disagreement and the revisions, if any, to be made to the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement resulting therefrom, together with supporting calculations. With respect to each disputed line item, such determination shall be made in accordance with the Transaction Accounting Principles and the terms of this Agreement and, if not in accordance with the position of either Seller or Purchaser, shall not be in excess of the highest amount proposed by either party, nor less than the lowest amount proposed by either party, in the Notice of Disagreement, the Initial Closing Statement, the Initial Asset Value Statement or the Initial Closing Required Asset Value Statement with respect to such disputed line item. For the avoidance of doubt, the Independent Accountant shall

not review any line items or make any determination with respect to any matter other than those matters in the Notice of Disagreement that remain in dispute. The Independent Accountant's final written determination shall, absent fraud or manifest error, be conclusive and binding upon Seller and Purchaser, shall not be subject to review by a court or other tribunal and shall have the same force and effect as an arbitration award governed by the Federal Arbitration Act, 9 U.S.C. §1 et. seq. The " Final Closing Statement" means the Initial Closing Statement as made final and binding either pursuant to Section 2.09(c) or after it has been modified to reflect any revisions thereto made through the mutual agreement of Purchaser and Seller or through the determination of the Independent Accountant pursuant to this Section 2.09(f). The " Final Asset Value Statement" means the Initial Asset Value Statement as made final and binding either pursuant to Section 2.09(c) or after it has been modified to reflect any revisions thereto made through the mutual agreement of Purchaser and Seller or through the determination of the Independent Accountant pursuant to this Section 2.09(f). The " Final Closing Required Asset Value Statement" means the Initial Closing Required Asset Value Statement as made final and binding either pursuant to Section 2.09(c) or after it has been modified to reflect any revisions thereto made through mutual agreement of Purchaser and Seller or through the determination of the Independent Accountant pursuant to this Section 2.09(f) , and the " Final Closing Required Asset Value" is the Closing Required Asset Value as set forth on the Final Closing Required Asset Value Statement.

(g) The cost of the Independent Accountant's review and determination shall be shared equally by Seller and Purchaser. During the review by the Independent Accountant, Seller and Purchaser shall each make available to the Independent Accountant such individuals and such information, books, records and work papers, as may be reasonably required by the Independent Accountant to fulfill its obligations under Sections 2.09(e) and 2.09(f); provided , however , that the independent accountants of Seller or Purchaser shall not be obligated to make any working papers available to the Independent Accountant unless and until the Independent Accountant has signed a customary confidentiality and hold harmless agreement relating to such access to working papers in form and substance reasonably acceptable to such independent accountants. In acting under this Agreement, the Independent Accountant shall be entitled to the privileges and immunities of an arbitrator. Notwithstanding anything to the contrary contained in this Agreement, the provisions of this Section 2.09 represent the sole and exclusive method for determining the Final Closing Statement, the Final Asset Value Statement, the Final Closing Required Asset Value Statement and the Final Closing Required Asset Value.

(h) Seller shall, following the Closing through the date that the Final Closing Statement, the Final Asset Value Statement and the Final Closing Required Asset Value Statement become final and binding on the parties in accordance with the last three sentences of Section 2.09(f) , take all actions necessary to maintain and preserve all accounting books, records, policies and procedures on which the Initial Closing Statement, Initial Asset Value Statement and Initial Closing Required Asset Value Statement are based or on which the Final Closing Statement, Final Asset Value Statement or Final Closing Required Asset Value Statement are to be based so as not to impede or delay the final determination of the amounts set forth therein.

Section 2.10. Post-Closing Adjustments.

(a) The following adjustments will be made based on the amounts set forth on the Final Closing Statement, Final Asset Value Statement and Final Closing Required Asset Value Statement:

(i) Purchaser shall pay to the Ceding Company the True-Up Amount, if positive; or

(ii) Seller shall cause the Ceding Company to pay into the Trust Account the absolute value of the True-Up Amount, if negative.

(b) Payment of any amounts due under Section 2.10(a) shall be made within five Business Days after the date on which all three of the Final Closing Statement, the Final Asset Value Statement and Final Closing Required Asset Value Statement have become such in accordance with the last three sentences of Section 2.09(f) by wire transfer of immediately available funds.

ARTICLE III.

REPRESENTATIONS AND WARRANTIES OF SELLER

Except as set forth in the corresponding sections or subsections of the disclosure schedule delivered to Purchaser by Seller concurrently with the execution and delivery of this Agreement (the " Seller Disclosure Schedule") (it being understood and agreed by the parties hereto that disclosure of any item in any section or subsection of the Seller Disclosure Schedule shall be deemed disclosure with respect to any other section or subsection of the Seller Disclosure Schedule to which the relevance of such item is reasonably apparent, notwithstanding the omission of a reference or cross-reference thereto), Seller hereby makes the following representations and warranties to Purchaser, as of the date hereof and as of the Closing Date, as follows:

Section 3.01. Organization; Standing and Authority.

(a) Seller is a corporation duly incorporated, validly existing and in good standing under the laws of the Commonwealth of Pennsylvania. The Ceding Company is an insurance company duly organized, validly existing and in good standing under the laws of the State of Connecticut. AHLIC is an insurance company duly organized, validly existing and in good standing under the laws of the State of Connecticut.

(b) Each of Seller, the Ceding Company and AHLIC (i) have all corporate or other applicable organizational power and authority to carry on the activities it currently conducts in connection with the Business as it is now being conducted and to own, lease and operate its properties and assets and (ii) is duly qualified to do business as a foreign or alien corporation or other legal entity, as the case may be, in good standing in each jurisdiction in which the conduct of the Business makes such qualification necessary, except, in the case of clause (ii), where the failure to be so qualified, would not, individually or in the aggregate, reasonably be expected to

have a Material Adverse Effect. This Section 3.01(b) does not relate to Permits from Insurance Regulators and Operating Permits, which are addressed in Section 3.11.

Section 3.02. Authorization. Seller or the applicable Affiliate of Seller (as applicable) has all requisite corporate or other applicable organizational power to enter into, consummate the transactions contemplated by and carry out its obligations under, each of the Transaction Agreements to which it is or is contemplated to become a party. The execution and delivery by Seller or the applicable Affiliate of Seller (as applicable) of each of the Transaction Agreements to which it is or is contemplated to become a party, and the consummation by Seller or the applicable Affiliate of Seller (as applicable) of the transactions contemplated by each of the Transaction Agreements to which it is or is contemplated to become a party, have been duly authorized by all requisite corporate or other similar organizational action on the part of Seller or the applicable Affiliate of Seller (as applicable). Each of the Transaction Agreements to which Seller or the applicable Affiliate of Seller (as applicable) is or is contemplated to become a party has been, or upon execution and delivery thereof will be, duly executed and delivered by Seller or the applicable Affiliate of Seller (as applicable). Assuming due authorization, execution and delivery by the other parties hereto or thereto, each of the Transaction Agreements to which Seller or the applicable Affiliate of Seller (as applicable) is or is contemplated to become a party constitutes, or upon execution and delivery thereof will constitute, the legal, valid and binding obligation of Seller or the applicable Affiliate of Seller (as applicable), enforceable against it in accordance with its terms, subject in each case to the effect of any applicable bankruptcy, reorganization, insolvency, moratorium, rehabilitation, liquidation, fraudulent conveyance, preferential transfer or similar laws now or hereafter in effect relating to or affecting creditors' rights and remedies generally and subject, as to enforceability, to the effect of general equitable principles (regardless of whether enforcement is sought in a proceeding in equity or at law) (the " Enforceability Exceptions").

Section 3.03. Sufficiency of Assets. Except as set forth in Section 3.03 of the Seller Disclosure Schedule and subject to the receipt of all Governmental Approvals, the assets, rights, properties, Employees, Intellectual Property and services transferred or made available to Purchaser and its Affiliates pursuant to this Agreement, the other Transaction Agreements and the Assigned Contracts will, as of the Closing, comprise assets, rights, properties, Employees, Intellectual Property and services that are sufficient to permit Purchaser to operate the Business immediately following the Closing Date in substantially the same manner as the Business is being operated as of the date hereof. This Section 3.03 does not address any Permit needed for the Purchaser to write new or renewal insurance policies with respect to the Business after the Closing Date.

Section 3.04. No Conflict or Violation. Provided that all consents, approvals, authorizations and other actions described in Section 3.05 of the Seller Disclosure Schedule have been obtained or taken, the execution and delivery by Seller or the applicable Affiliate of Seller (as applicable) of, and the consummation by Seller or the applicable Affiliate of Seller (as applicable) of the transactions contemplated by, the Transaction Agreements to which Seller or the applicable Affiliate of Seller (as applicable) is or is contemplated to become a party do not and will not (a) violate or conflict with the organizational documents of Seller or the applicable Affiliate of Seller (as applicable), (b) subject to the Governmental Approvals referred to in Section 3.05 , conflict with or violate any Applicable Law or Governmental Order applicable to

Seller or the applicable Affiliate of Seller (as applicable) or by which any of them or any of their respective properties, assets or rights is bound or subject, (c) result in any breach of, or constitute a default (or event which, with the giving of notice or lapse of time or both, would constitute a default) under, or give to any Person any rights of termination, acceleration or cancellation of, or result in the creation of any Lien (other than Permitted Liens) on any of the assets, properties or rights of Seller or the applicable Affiliate of Seller (as applicable) pursuant to, any contract, or any note, bond, loan or credit agreement, mortgage or indenture to which Seller or such applicable Affiliate of Seller is a party or by which any of them or any of their respective properties, assets or rights is bound or subject or (d) result in a breach or violation of any of the terms or conditions of, result in a default under, or otherwise cause an impairment or revocation of, any material Permit used in the Business, except, in the case of clauses (b), (c) and (d) of this Section 3.04 , for any such conflicts, violations, breaches, defaults, terminations, accelerations, cancellations or creations that, individually or in the aggregate, would not reasonably be expected to have a Material Adverse Effect.

Section 3.05. Consents and Approvals. Except in connection, or in compliance, with the approvals, filings and notifications required by Applicable Laws that are set forth in Section 3.05 of the Seller Disclosure Schedule, the execution and delivery by Seller or the applicable Affiliate of Seller (as applicable) of the Transaction Agreements to which it is or is contemplated to become a party do not and will not, and the consummation by Seller or the applicable Affiliate of Seller (as applicable) of the transactions contemplated by the Transaction Agreements to which it is or is contemplated to become a party will not, require any consent, approval, license, permit, order, qualification or authorization of, or registration with or other action by, or any filing with or notification to, any Governmental Authority (each, a " Governmental Approval") to be obtained or made by or with respect to Seller or such applicable Affiliate of Seller (as applicable), except for any Governmental Approvals the failure to obtain or make which, individually or in the aggregate, would not reasonably be expected to have a Material Adverse Effect.

Section 3.06. Certain Contracts.

(a) Section 3.06(a) of the Seller Disclosure Schedule lists each Material Contract to which Seller or any of its Affiliates is a party or by which it is bound as of the date hereof. The term " Material Contract" means all of the following types of contracts (other than any Ceded Reinsurance Contract or any Group Contract) in effect on the date hereof:

(i) the Assigned Contracts;

(ii) any contract that (A) contains a restriction on the ability of the Business to solicit specified customers or prospective customers for the purchase, renewal, lapse or amendment of any Group Contract or (B) limits in any way the ability of the Business to compete or engage in the conduct of the Business or in the marketing, selling and administration of any Group Contract, in each case, that would be legally binding on Purchaser or any of its Affiliates following the consummation of the transactions contemplated hereby;

(iii) mortgages, indentures, loan or credit agreements, security agreements and other agreements and instruments relating to the borrowing of money or extension of credit directly by or to Seller or an Affiliate thereof in respect of the Business or the direct or indirect guarantee by Seller or an Affiliate thereof for the benefit of the Business of any obligation for borrowed money of any other Person, in each case other than Investment Assets held in the ordinary course of business consistent with the Investment Guidelines;

(iv) any retention agreements providing for payments to any Employee;

(v) any contract restricting or granting rights to use or practice rights under the Transferred Intellectual Property;

(vi) any contract that is primarily related to the Business but is not an Assigned Contract (each, a "Primary Contract") pursuant to which any third Person provides support, maintenance or other services for IT Systems;

(vii) any Primary Contract pursuant to which any material operational function of the Business is outsourced to or otherwise performed by a third Person;

(viii) any Primary Contract pursuant to which one or more independent contractors provides services to the Business;

(ix) any contract that relates to the acquisition or disposition of any business or operation included in the Business, or any other contract that includes an ongoing material indemnification obligation or guarantee of the Ceding Company in respect of the Business, but in either case only where any such contract contains any material obligation of Seller or any of its Affiliates that remains unperformed (other than any obligation to indemnify the buyer thereunder for breaches of provisions that have expired or which are not subject to any survival period); or

(x) any other Primary Contract.

(b) Section 3.06(b) of the Seller Disclosure Schedule lists each vendor with which, as of the date hereof, there is a direct contractual or other relationship to provide rights, services, functions or goods, as applicable, directly to the Business or which charge the Business directly for such rights, services, functions or goods, as applicable (each such vendor, a " Vendor"). For the avoidance of doubt, Section 3.06(b) of the Seller Disclosure Schedule does not list vendors for which the Business is allocated a share of the cost as part of a corporate or enterprise cost allocation.

(c) True and complete copies in all material respects of each of the Material Contracts, including in each case all amendments and addenda thereto, have been made available to Purchaser on the Project DeLorean Intralinks site or by email prior to the date hereof. Each of the Material Contracts is in full force and effect and is the valid and binding obligation of Seller and each Affiliate of Seller party thereto, and, to the Knowledge of Seller as of the date hereof,

each other party thereto, subject to the Enforceability Exceptions. None of Seller or any Affiliate of Seller that is party thereto, nor, to the Knowledge of Seller as of the date hereof, any other Person that is a party thereto, is (or, with the giving of notice or the lapse of time or both, will be), in any material respect, in violation or breach of or default under any of the Material Contracts. None of Seller or any Affiliate of Seller that is party thereto has received written or, to the Knowledge of Seller, oral notice of cancellation of any Material Contract.

Section 3.07. Title to Assets. Seller or one of its Affiliates is the record and beneficial owner of, and holder of good and valid title to, all of the Transferred Assets, free and clear of all Liens other than Permitted Liens. Purchaser will acquire good and valid title to the Transferred Assets, free and clear of Liens, except for Permitted Liens or any Liens arising from acts of Purchaser (other than entering into any Transaction Agreement), (a) in the case of Transferred Assets other than the Business Employee Benefit Plans and the Assigned Lease, at the Closing, and (b) in the case of the Business Employee Benefit Plans, upon the termination of the Employee Lease Term, and (c) in the case of the Assigned Lease, upon the termination of the Employee Lease Term and the effectiveness of the Portland Location Assignment Agreement.

Section 3.08. Absence of Litigation. Except as disclosed in Section 3.08 of the Seller Disclosure Schedule, as of the date hereof, there are no Actions relating to the Business (other than claims under or in connection with Group Contracts in the ordinary course of business) pending or, to the Knowledge of Seller, threatened in writing against (i) the Ceding Company or (ii) Seller or any of its other Affiliates with respect to the Business that, individually or in the aggregate, would reasonably be expected to have a Material Adverse Effect.

Section 3.09. Compliance With Laws.

(a) Except as disclosed in Section 3.09(a)(i) of the Seller Disclosure Schedule, Seller and its Affiliates (solely with respect to, and to the extent related to, the Business) are, and since December 31, 2014 have been, in compliance in all respects with all Applicable Laws, including Privacy and Data Security Laws, except for such instances of non-compliance that would not, individually or in the aggregate, have a material adverse impact on the Business. Except as set forth in Section 3.09(a)(ii) of the Seller Disclosure Schedule, as of the date hereof, since December 31, 2014, none of Seller or any of its Affiliates (solely with respect to, and to the extent related to, the Business) has received any written notice or other written or, to the Knowledge of Seller, oral communication from any Governmental Authority or has paid or incurred any penalty or fine imposed by a Governmental Authority, in each case, regarding any actual or alleged violation of, or failure to comply with, Applicable Law in connection with the Business (other than actual or alleged violations which have been resolved).

(b) Except as set forth in Section 3.09(b) of the Seller Disclosure Schedule, as of the date hereof, all material deficiencies or violations with respect to the Business in all reports of examinations of the affairs of the Ceding Company or AHLIC (including financial, market conduct and similar examinations) issued by any Insurance Regulator to the Ceding Company or AHLIC for any period ending on or after December 31, 2014, have been resolved to the reasonable satisfaction of the Insurance Regulator that noted such deficiencies or violations.

(c) Except as set forth in Section 3.09(c) of the Seller Disclosure Schedule, as of the date hereof, there are no Governmental Orders in effect against or involving Seller or any of its Affiliates under which Seller or any of its Affiliates has any continuing obligation relating to the Business and none of Seller or any of its Affiliates (solely with respect to, and to the extent related to, the Business) is a party to any material contract with any Governmental Authority (other than any Group Contract with respect to which a Governmental Authority is a policyholder or contractholder) in each case to the extent relating to the Business.

(d) Except as set forth in Section 3.09(d) of the Seller Disclosure Schedule, since December 31, 2014, Seller or an Affiliate thereof has filed all material reports, statements, documents, registrations, filings or submissions required to be filed with any Governmental Authority (solely with respect to, and to the extent related to, the Business). All such registrations, filings and submissions were in compliance in all material respects with Applicable Law when filed or as amended or supplemented, and, as of the date hereof, no material deficiencies have been asserted by any Governmental Authority with respect to such registrations, filings or submissions that have not been satisfied.

Section 3.10. Employee Matters.

(a) Section 3.10(a) of the Seller Disclosure Schedule sets forth a list of all material written Employee Benefit Plans as of the date hereof and a description of any material Employee Benefit Plan that is not in written form.

(b) Section 3.10(b) of the Seller Disclosure Schedule sets forth a list of all Business Employee Benefit Plans as of the date hereof. As of the date hereof, there are no material claims or disputes pending, or to the Knowledge of Seller, threatened with respect to any Business Employee Benefit Plan, other than routine claims for benefits in the ordinary course of business.

(c) No Business Employee Benefit Plan and, except as set forth on Section 3.10(c) of the Seller Disclosure Schedule, none of the Employee Benefit Plans is subject to Title IV of ERISA and no Employee participates or is eligible to participate in an Employee Benefit Plan or Business Employee Benefit Plan that is subject to Title IV of ERISA. None of the Employee Benefit Plans or Business Employee Benefit Plans is a "multiemployer plan" (as defined in section 3(37) of ERISA) and no Employee participates or is eligible to participate in an Employee Benefit Plan or Business Employee Benefit Plan that is a multiemployer plan. Purchaser shall have no Liabilities in respect of any Employee Benefit Plan, except as expressly set forth in Section 6.01(j) below.

(d) No Business Employee Benefit Plan and, except as disclosed in Section 3.10(d) of the Disclosure Schedule, no Employee Benefit Plan provides medical, dental, or life insurance coverage or any other welfare benefits after termination of employment.

(e) Each Employee Benefit Plan (i) complies in form in all material respects with all requirements of Applicable Laws and has been administered in all material respects in accordance with its terms and all Applicable Laws, and (ii) is otherwise in compliance in all material respects with all Applicable Laws. Each Business Employee Benefit Plan (i) complies in form in all material respects with all requirements of Applicable Laws and has been

administered in all material respects in accordance with its terms and all Applicable Laws, and (ii) is otherwise in compliance in all material respects with all Applicable Laws. With respect to each Employee Benefit Plan that is intended to be qualified under Section 401(a) of the Code, such plan, and its related trust, has received a determination letter (or opinion letters in the case of any prototype plans) from the IRS that it is so qualified and that its trust is exempt from tax under Section 501(a) of the Code and, to the Knowledge of the Seller, no event has occurred which will or could reasonably be expected to cause any such Employee Benefit Plan to fail to comply with such requirements. Each Employee Benefit Plan and Business Employee Benefit Plan is either (i) exempt from Section 409A of the Code (" Section 409A") or (ii) has, in all material respects, been maintained and operated in documentary and operational compliance in accordance with Section 409A and the regulations and guidance issued thereunder.

(f) Except as set forth on Section 3.10(f) of the Seller Disclosure Schedule, neither consummation of the transactions contemplated by this Agreement nor this Agreement (whether separately or together with any other action) will accelerate the time of vesting or the time of payment, or increase the amount, of compensation due to any Employee. None of the payments contemplated by the Employee Benefit Plans or any Business Employee Benefit Plan to or with respect to Employees would, in the aggregate, constitute excess parachute payments (as defined in section 280G of the Code (without regard to subsection (b)(4) thereof)). As of the date hereof, each of Seller and its Affiliates is in compliance, in all material respects, with all Applicable Laws regarding employment, labor and wage and hour matters, disability, immigration, health and safety, harassment, non-discrimination in employment, workers' compensation, and unemployment compensation (solely with respect to, and to the extent related to, the Business). To the Knowledge of the Seller, each independent contractor and consultant, in each case, providing personal services to the Seller and its Affiliates (solely with respect to, and to the extent related to, the Business) has been properly classified as an independent contractor for purposes of and consistent with good faith interpretations of, all Applicable Laws, including Applicable Laws with respect to employee benefits, and to the Knowledge of the Seller, each Employee has been properly classified consistent with good faith interpretations under the Fair Labor Standards Act (solely with respect to, and to the extent related to, the Employees). The Seller and its Affiliates are not a party to, bound by or in the process of negotiating any collective bargaining agreement or similar labor-related contract (solely with respect to, and to the extent related to, the Business). As of the date hereof, no labor organization or group of current Employees has made a pending demand (solely with respect to, and to the extent related to, the Business) for recognition or certification, and there are no representation or certification proceedings or petitions seeking a representation proceeding presently pending or, to the Knowledge of the Seller, threatened to be brought or filed with the National Labor Relations Board or any other labor relations tribunal or authority (in each case solely with respect to, and to the extent related to, the Business). To the Knowledge of the Seller, as of the date hereof, there are no material organizing activities, strikes, work stoppages, slowdowns, lockouts, arbitrations or grievances, or other material labor disputes, pending or threatened against or involving any Employees (solely with respect to, and to the extent related to, the Business).

(g) Each Employee Benefit Plan that is a "group health plan" as defined in Section 733(a)(1) of ERISA (a " Health Plan") (i) is currently in compliance in all material respects with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (" PPACA"), the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (" HCERA"), and the

regulations and guidance issued thereunder (collectively, with PPACA and HCERA, the "Healthcare Reform Laws"), and (ii) has been in compliance in all material respects with all applicable Healthcare Reform Laws since January 1, 2015.

(h) Neither Seller nor any of its Affiliates is a party to any employment agreement with any Employee, other than retention agreements that are listed in Section 3.06(a)(iv) of the Disclosure Schedule and offer letters.

(i) Section 3.10(i) of the Seller Disclosure Schedule sets forth a list of all individual independent contractors providing personal services to the Business as of the date hereof.

(j) Except as set forth on Section 3.10(j) of the Seller Disclosure Schedule, none of the Employees is a foreign national is in the United States pursuant to a United States H1-B visa or similar employer-sponsored work permit.

(k) Seller has performed a criminal background check on each Employee in a reasonable manner consistent with prudent hiring practices. Seller requires each Employee to annually complete an attestation regarding criminal conduct. To the Knowledge of Seller, none of the Employees are disqualified from performing services for the Business by reason of a criminal conviction.

Section 3.11. Permits.

(a) (i) The Ceding Company and AHLIC holds all Permits from all Insurance Regulators that are necessary for the current operation and conduct of the Business; and (ii) each of Seller and its Affiliates (solely with respect to, and to the extent related to, the Business) holds all other material Permits from all other Governmental Authorities that are necessary for the current operation and conduct of the Business and to own or use its assets and properties to the extent relating to the Business (collectively, the " Operating Permits"), except where the failure to hold an Operating Permit would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. Except as would not be reasonably likely to have a Material Adverse Effect, all such Operating Permits are valid and in full force and effect in accordance with their terms. Each of the Ceding Company and AHLIC is, and since December 31, 2014 has been, in compliance in all material respects with all such Operating Permits.

(b) As of the date hereof, since December 31, 2014, Seller and its Affiliates have not received any written notice, or, to the Knowledge of Seller, oral communication from any Governmental Authority regarding any actual, alleged, or potential material violation of, or failure to comply with, the terms or requirements of any such Operating Permit (solely with respect to, and to the extent related to, the Business). As of the date hereof, none of Seller or any of its Affiliates is the subject of any pending or, to the Knowledge of Seller, threatened action seeking the revocation, withdrawal, suspension, termination, cancellation, nonrenewal, modification or impairment of any such Operating Permit (solely with respect to, and to the extent related to, the Business).

Section 3.12. Intellectual Property.

(a) Section 3.12(a) of the Seller Disclosure Schedule sets forth, as of the date hereof, a true, complete and correct list of (i) all Transferred Intellectual Property that is Registered, indicating for each item: (A) the current owner; (B) the jurisdiction where the application or registration is located; and (C) the application or registration number, and (ii) proprietary Software and material unregistered Trademarks that are Transferred Intellectual Property.

(b) Seller or an Affiliate thereof are the exclusive owners of the Transferred Intellectual Property free and clear of all Liens other than Permitted Liens. As of the Closing Date, Purchaser or its designee will be the exclusive owners of the Transferred Intellectual Property, free and clear of all Liens other than Permitted Liens.

(c) Except as set forth in Section 3.12(c) of the Seller Disclosure Schedule (i) to the Knowledge of Seller, the operation of the Business has not been and is not infringing, violating or misappropriating the Intellectual Property of any third party, (ii) no third party has asserted in a writing received by Seller or any of its Affiliates, or to the Knowledge of Seller asserted orally, that its conduct of the Business has infringed, violated or misappropriated the Intellectual Property of any third party and there are no such claims pending or, to the Knowledge of Seller , threatened, (iii) and, to the Knowledge of Seller, as of the date hereof, no third party has infringed, violated or misappropriated or is now infringing, violating or misappropriating any Transferred Intellectual Property. Notwithstanding anything to the contrary set forth in this Agreement, this Section 3.12(c) contains all of the representations and warranties provided by Seller with respect to the non-infringement, non-violation and non-misappropriation of Intellectual Property.

(d) Seller and its Affiliates have taken commercially reasonable actions to maintain the enforceability of the Transferred Intellectual Property under all Applicable Law (including (i) making and maintaining in full force and effect all necessary filings, registrations and issuances and (ii) maintaining the secrecy of all Trade Secrets).

(e) Seller has maintained and currently maintains complete source code for all current and the immediately prior (i.e., n-1) versions and releases of all Software developed by or for Seller and included within the Transferred Intellectual Property (" Developed Software"). All Developed Software is designed and documented in a reasonable manner, consistent with accepted industry practices. Except as would not be material to the Business, no Developed Software contains any viruses, worms, back doors, spyware, adware, malware, time-bombs or key-locks (as such terms are commonly understood in the software industry).

(f) Except as set forth on Section 3.12(f) of the Seller Disclosure Schedule, no Transferred Intellectual Property that is Software contains any Open Source Software, including any software governed by an "open source" license that may (i) require, as a condition to the use of such Software, that Seller disclose, license or distribute to third parties any of the source code for such Software, (ii) requires derivative works of such Software to be licensed under the same "open source" license as the original work or otherwise requires its licensing thereof for the purpose of making derivative works, (iii) imposes any restriction on the consideration to be charged for the distribution of such Software, or (iv) creates, or purports to create, obligations for

Seller with respect to the Intellectual Property rights owned by Seller or grants, or purports to grant, to any third party any rights or immunities under Intellectual Property rights owned by Seller.

Section 3.13. Insurance Business.

(a) Except as set forth in Section 3.13 of the Seller Disclosure Schedule, since December 31, 2014 any application, form of insurance policy, certificates of insurance, riders, endorsements, advertising material, rate, rule or producer compensation utilized by the Seller and its Affiliates (solely with respect to, and to the extent related to, the Business), the use or issuance of which requires filing or approval, has been appropriately filed, and, if required, approved by the Insurance Regulator of any state in which such application forms, forms of insurance policies, advertising materials and rates and rules are required to be filed and (as applicable) approved or not objected to by such authorities within the period provided for approval or objection, except for failures to effect such filings or secure such approvals, which would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect. All such application forms, forms of insurance policies, advertising materials and rates or rules are utilized in compliance in all material respects with all Applicable Laws and within the scope of the approvals (if any) received with respect thereto. No material deficiencies have been asserted by any Governmental Authority with respect to any such filings or compliance with the filings or approvals issued by the Insurance Regulators which have not been cured or otherwise resolved.

(b) The underwriting standards and ratings applied by the Ceding Company since such date with respect to Group Contracts have conformed in all material respects to those contained in the underwriting manuals utilized by the Ceding Company, as in effect at the times such Group Contracts were underwritten.

(c) Since December 31, 2014, Seller and any applicable Affiliates have timely paid in all material respects all guaranty fund assessments that have been due, claimed or asserted by, or are the subject of any voluntary contribution commitment to, any state guaranty fund or association or any Insurance Regulator in any jurisdiction in which Seller or any applicable Affiliate operates the Business arising out of or resulting from such operation of the Business by Seller and its Affiliates. Except for regular periodic assessments in the ordinary course of business or assessments based on developments that are publicly known within the insurance industry, no material claim or assessment is pending or, to the Knowledge of Seller, threatened against Seller or any Affiliate with respect to the Business by any state insurance guaranty association in connection with such association's fund relating to insolvent insurers.

(d) The Business does not include (i) any policies issued to a plan sponsor located outside the United States and its territories, or (ii) any policies issued to plan sponsors located in the United States to cover primarily employees located outside the United States.

Section 3.14. Producers; Sale Practices.

(a) Except as set forth in Section 3.14(a) of the Seller Disclosure Schedule, to the Knowledge of Seller, from December 31, 2014 to the date hereof, each Producer, at any time that

it wrote, sold or produced Group Insurance Contracts for Seller or any of its Affiliates, was duly licensed, authorized and appointed (for the Group Insurance Contract written, sold or produced by such Producer) in the particular jurisdiction in which such Producer wrote, sold or produced such Group Insurance Contract and, to the Knowledge of Seller, from December 31, 2014 to the date hereof, no such Producer violated any term or provision of Applicable Law relating to the writing, sale or production of Group Insurance Contracts, in each case except as would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

(b) Except as set forth in Section 3.14(b) of the Seller Disclosure Schedule, since December 31, 2014, none of Seller or the Ceding Company has received any written notice or communication from any Governmental Authority that a Producer is in material violation of any Applicable Law applicable to the writing, sale, production or marketing of any Group Insurance Contract.

Section 3.15. Real Property. The Transferred Assets do not include any real property other than the real property that is leased pursuant to the Assigned Lease. Section 3.15 of the Seller Disclosure Schedule lists, as of the date hereof, all real property, including the real property located at 222 SW Columbia Street, Portland, Oregon (the " Portland Location"), (a) which are owned by Seller or an Affiliate of Seller or (b) in which Seller or an Affiliate of Seller has a leasehold interest and, in each case, in which Seller intends will be occupied by Purchaser or an Affiliate thereof from and after the day immediately following the expiration or termination of the Employee Lease Term (such leases in subclause (b) of this Section 3.15 (but expressly excluding the Assigned Lease) are collectively referred to as the " Non-Assigned Leases" ; together with the Assigned Lease, collectively, the " Leases"). True and complete copies in all material respects of each of the Leases, including in each case all amendments and addenda thereto, have been made available to Purchaser on the Project DeLorean Intralinks site or by email prior to the date hereof. Seller or an Affiliate thereof has a valid and enforceable leasehold interest under the Leases, subject to Permitted Liens and to the Enforceability Exceptions and neither Seller nor any such Affiliate has received any written notice of any default under the Leases, and, to the Knowledge of Seller, no event has occurred and no condition exists that, with notice or lapse of time or both, would constitute a default by Seller or any such Affiliate under the Leases, except, in each case, for such invalidity, unenforceability or defaults that, individually or in the aggregate, would not reasonably be expected to have a Material Adverse Effect.

Section 3.16. Ceded Reinsurance Contracts.

(a) Section 3.16(a) of the Seller Disclosure Schedule lists each reinsurance agreement to which the Ceding Company or AHLIC is a party and under which the Ceding Company or AHLIC reinsured or retroceded risk under any of the Group Insurance Contracts that were in effect as of the date hereof (the " Ceded Reinsurance Contracts").

(b) Each of the Ceded Reinsurance Contracts constitutes a valid and binding obligation of the Ceding Company or AHLIC and, to the Knowledge of Seller, each other party thereto, enforceable against the Ceding Company or AHLIC and, to the Knowledge of Seller, each other party thereto in accordance with its terms, subject to the Enforceability Exceptions. Except as set forth in Section 3.16(b) of the Seller Disclosure Schedule, as of the date hereof,

neither the Ceding Company nor AHLIC has delivered notice or received written or, to the Knowledge of Seller, oral notice of early termination of any such Ceded Reinsurance Contract. There exists no material breach or event of default with respect to any Ceded Reinsurance Contract on the part of the Ceding Company or AHLIC or, to the Knowledge of Seller, as of the date hereof, any other party thereto, in each case that would, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

(c) Since December 31, 2014, there has not been any dispute with respect to any material amounts recoverable or payable by the Ceding Company pursuant to any Ceded Reinsurance Contract. All amounts owed under any Ceded Reinsurance Contracts have been timely paid in accordance with their terms.

Section 3.17. Tax.

(a) There are no outstanding audits or other administrative or judicial actions by any Governmental Authority with regard to, or related to, the Tax treatment of the Business or the Transferred Assets, nor to the Knowledge of Seller, as of the date hereof, is any such audit or other administrative or judicial action pending or threatened.

(b) Seller and its Affiliates have timely paid all material Taxes which will have been required to be paid on or prior to the date hereof in respect of the Business or the ownership of the Transferred Assets.

(c) All material Taxes required to have been withheld, collected or remitted with respect to the Business or the Transferred Assets have been withheld, collected or remitted, as applicable, to the applicable Governmental Authority in accordance with Applicable Law.

(d) Seller and its Affiliates have materially complied with all Tax reporting, withholding, and disclosure requirements applicable to the Ceded Insurance Contracts under the Code, Treasury Regulations, and forms issued by the Internal Revenue Service and under any corresponding or similar provision of state or local law.

(e) Seller and its Affiliates have duly and timely (including any applicable extensions) filed all material Tax Returns required to have been filed by them in respect of the Business or the ownership of the Transferred Assets, and all such Tax Returns are accurate and complete in all material respects as they relate to the Business or the Transferred Assets.

(f) All material deficiencies asserted in writing or assessments made in writing with respect to the Business or the ownership of the Transferred Assets by a Tax authority have been paid in full, except to the extent they are being contested in good faith through appropriate proceedings.

(g) There are no material Liens for Taxes (other than Permitted Liens) upon the Transferred Assets.

(h) Seller and each of its Affiliates are not and have not been a party to any “reportable transaction” within the meaning of Treasury Regulation Section 1.6011-4 with respect to the Business or the Transferred Assets.

(i) There is no written claim pending from any Tax authority in any jurisdiction where the Seller does not file Tax Returns in respect of the Business that the Business is or may be subject to taxation by that jurisdiction.

(j) The reserves reflected with respect to the Ceded Insurance Contracts on the consolidated federal income Tax Return filed by the affiliated group of which Seller is a member for the year ending December 31, 2014, and since such date, have been determined in all material respects in the manner required by the Code and other Applicable Law, and to the extent relevant to the determination and maintenance thereof, have been determined and maintained in all material respects in accordance with SAP.

(k) The Tax treatment of each Ceded Insurance Contract is not, and, since the time of issuance, has not been, materially less favorable to the purchaser, policyholder or intended beneficiaries thereof, than the Tax treatment and purported to qualify for at the time of issuance.

Section 3.18. Financial Statements; Books and Records.

(a) Seller has previously delivered to Purchaser true, correct and complete copies of (i) the audited annual statutory financial statements of each of the Ceding Company and AHLIC, together with the report of each such company's independent auditors thereon, as of and for the years ended December 31, 2015 and December 31, 2016 and (ii) the unaudited statutory financial statements of each of the Ceding Company and AHLIC as of and for the quarter ended June 30, 2017 (collectively, the " Statutory Statements"), in each case, as filed with the Insurance Regulator of such entity's jurisdiction of domicile. The Statutory Statements were prepared in accordance with applicable SAP consistently applied throughout all such periods and, except as set forth in Section 3.18(a) of the Seller Disclosure Schedule, fairly present in all material respects the financial position, admitted assets, liabilities, capital, and surplus of the Ceding Company and AHLIC (as applicable) at December 31, 2015, December 31, 2016 and June 30, 2017, and the results of operations, changes in surplus, and cash flows of the Ceding Company and AHLIC (as applicable) for the periods covered thereby, subject, in the case of the quarterly Statutory Statements as of and for the quarter ended June 30, 2017, to normal yearend adjustments and the absence of full footnote disclosures and other presentation items. Section 3.18(a) of the Seller Disclosure Schedule sets forth a complete list of all permitted practices used by each such company in the preparation of the Statutory Statements.

(b) The reserves, including incurred but not reported (IBNR), for payment of benefits, losses, claims, expenses, and other similar purposes (including claims litigation) with respect to the Group Contracts reflected in the Statutory Statements, the Reference Closing Statement, and the Pro Forma Financial Statements, as of their respective dates: (a) were computed in all material respects in accordance with generally accepted actuarial standards, consistently applied and developed by the Ceding Company applying consistent practices, assumptions and methodologies used as of their respective dates; (b) met the requirements of SAP and other Applicable Law; and (c) were based on actuarial information and data and inventories and policies and contracts that were accurate in all material respects; provided that this Section 3.18(b) shall not be deemed to be a representation or warranty of Seller that the reserves of the Ceding Company or AHLIC (to the extent relating to the Business) are or will be adequate or sufficient for the purposes for which they were established.

(c) Seller has previously delivered to Purchaser a true, correct and complete copy of the unaudited pro forma balance sheets of the Business as of December 31, 2015 and December 31, 2016 and an unaudited pro forma statement of profits and losses for the annual period ended December 31, 2016 (" Pro Forma Financial Statements"). The Pro Forma Financial Statements were prepared in good faith from the Books and Records using methodologies, estimates and adjustments to give effect to assumptions that provide a reasonable basis for presenting the financial position, direct profits and direct losses of the Business in accordance with GAAP, applied consistently with the historical practices of Seller, as of December 31, 2015 and December 31, 2016.

(d) The Reference Closing Statement was prepared in accordance with the Transaction Accounting Principles and fairly presents, in all material respects in accordance with the Transaction Accounting Principles, the assets and liabilities of the Business as of the Reference Date.

(e) The Books and Records (i) have been maintained in all material respects in accordance with Applicable Law and (ii) are in material compliance with any and all record keeping maintenance requirements in applicable Group Contracts. No Board Materials relating to the Business exist except those certain Board Materials identified and made available by Seller for inspection and review by Purchaser prior to the date hereof.

(f) Seller and the Ceding Company maintain a system of internal control over financial reporting sufficient to provide reasonable assurance regarding the reliability of the financial reporting of the Ceding Company with respect to the Business and the preparation of financial statements for external purposes in accordance with GAAP, applied consistently with the historical practices of Seller, or SAP, as applicable. There are no material weaknesses or significant deficiencies in the internal controls over financial reporting of Seller or the Ceding Company with respect to the Business.

Section 3.19. Specified Portfolio.

(a) During the period from the Reference Date to the date hereof, (i) no Investment Assets that were in the Specified Portfolio as of the Reference Date have been sold except: (A) sales of Investment Assets that were determined by Seller (in accordance with SAP and Seller's and its Affiliates' past practices), to have become, or to be reasonably likely to become, impaired, all of which sales are set forth on Section 3.19(a)(i)(A) of the Seller Disclosure Schedule; and (B) sales of Investment Assets set forth in Section 3.19(a)(i)(B) of the Seller Disclosure Schedule, which collectively did not exceed the Discretionary Turnover Allowance; and (ii) all additions to the Specified Portfolio were made in accordance with the Pre-Closing Investment Guidelines.

(b) Section 3.19(b)(i) of the Seller Disclosure Schedule sets forth, as of the date hereof, the Capital Gain or Loss Adjustments for each of the sales of Investment Assets set forth in Section 3.19(a)(i)(B) of the Seller Disclosure Schedule. Section 3.19(b)(ii) of the Seller Disclosure Schedule sets forth a list of each of the Reallocated Investment Assets that were added to the Specified Portfolio between the Reference Date and the date of this Agreement, and the Reallocated Asset Value Adjustments, if any, that were required with respect to such

Reallocated Investment Assets during such period. The representations and warranties in this Section 3.19 have been made assuming, for this purpose, that the terms of Section 5.11 (other than the definition of "Selection Waterfall" included therein) applied with respect to the period between the Reference Date and the date of this Agreement.

Section 3.20. No Undisclosed Liabilities. The Business has no Liabilities required to be disclosed or reserved for on a balance sheet of the Ceding Company prepared in accordance with applicable SAP, except (i) Liabilities set forth in Section 3.20 of the Seller Disclosure Schedule, (ii) Liabilities disclosed or reserved for in the Statutory Statements and (iii) Liabilities that (x) were incurred after December 31, 2016 in the ordinary course of business consistent with past practice and (y) have not had and would not, individually or in the aggregate, reasonably be expected to have a Material Adverse Effect.

Section 3.21. Actuarial Report. Seller has delivered to Purchaser true, complete and correct copies of the actuarial report, dated as of June 7, 2017 (as adjusted by a memorandum dated August 28, 2017) prepared by Milliman Inc. (" Milliman") with respect to the Business as of December 16, 2016 (the " Actuarial Report"). The information and factual data furnished by Seller and its Affiliates in writing to Milliman with respect to the Business in connection with the preparation of the Actuarial Report (and any supplements or addenda thereto) were (a) obtained from the Books and Records, (b) generated from the same underlying sources and systems that were utilized by Seller or its applicable Affiliates to prepare the Pro Forma Statements to the extent applicable and (c) to the Knowledge of Seller, did not include any material Data Input Inaccuracies. As of the date hereof, Milliman has not issued to Seller or its Affiliates any new or revised report with respect to the Business or any errata with respect to the Actuarial Report nor has it notified Seller or any of its Affiliates that the Actuarial Report is inaccurate in any material respect.

Section 3.22. Absence of Certain Changes or Events. Except as expressly contemplated or required by this Agreement or as set forth in Section 3.22 of the Seller Disclosure Schedule, since December 31, 2016 (a) Seller and its Affiliates have operated and conducted the Business in all material respects in the ordinary course of business; (b) there has not been any event, occurrence, condition or change that has had, or would reasonably be expected to have, individually or in the aggregate, a Material Adverse Effect; and (c) neither Seller nor any of its Affiliates has taken any action or failed to take any action that, if taken or failed to have been taken after the date hereof, would violate Section 5.01.

Section 3.23. Brokers and Finders. Except for Barclays Capital Inc. and one or more of its Affiliates, whose fees will be paid by Seller, no broker, investment banker, financial adviser or other person is entitled to any broker's, finder's, financial adviser's or other similar fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of Seller or any of its Affiliates.

Section 3.24. Data Protection and Privacy; IT Systems.

(a) Since December 31, 2014, Seller and its Affiliates with respect to the Business have been and are in compliance in all material respects with any and all contractual requirements, including applicable terms of use and privacy policies, pertaining to the protection,

privacy, security, collection, storage, use, disclosure, disposal, maintenance and transmission of Personal Data.

(b Since December 31, 2014, to the Knowledge of Seller, none of Seller and its Affiliates, or any third Person working on behalf of any of them, has experienced an incident of unauthorized access, disclosure, use, destruction or loss of any Personal Data that Seller or its Affiliates (or a third Person on behalf of any of them) collects, stores, uses or transmits in the conduct of the Business that required the delivery of notice to affected individuals pursuant to Privacy and Data Security Laws.

(c) Section 3.24(c) of the Seller Disclosure Schedule identifies (i) all IT Systems that are included in the Transferred Assets and (ii) all Vendors that provide "cloud", support, hosting, servicing, interfacing, connectivity, security, and redundancy services to the Business. All IT Systems that are included in the Transferred Assets or access to which will be provided pursuant to the Transition Services Agreement (x) are in good repair and operating condition and in all material respects adequate and suitable for the purposes for which they are being used or held for use, and (y) have not, since December 31, 2014, experienced bugs, failures, breakdowns, unauthorized access or use, or substandard performance, malfunction or failure of any unplanned downtime that caused any material disruption or interruption in or to the operation of the Business, and (z) to the Knowledge of Seller, do not contain any "malware" that would reasonably be expected to interfere with the ability of the Purchaser to conduct the Business. Seller and its Affiliates have implemented, currently maintain, and comply with commercially reasonable business continuity and backup and disaster recovery plans and procedures with respect to the IT Systems that are included in the Transferred Assets or access to which will be provided pursuant to the Transition Services Agreement.

Section 3.25. Distribution of Group Insurance Contracts.

(a) Seller hereby represents and warrants that (a) the Service Standards which are attached to the Distribution Agreement as Exhibit A are based upon and are consistent in all material respect with the Ceding Company's service standards generally applicable on an individual plan basis to specified services provided to plans in connection with large Group Insurance Contracts, except (i) as modified to reflect that the Service Standards are applicable to specified categories of Group Insurance Contracts in the aggregate, rather than on an individual plan basis; or (ii) as expressly agreed by the Parties to apply solely to Group Insurance Contracts administered on Purchaser's systems; and (b) since December 31, 2015 all Group Insurance Contracts issued by Seller or its Affiliates, in the aggregate, have been administered in material compliance with the service standards upon which such Service Standards are based.

(b) Seller hereby represents and warrants that Seller and its Affiliates calculated the compensation payable by Seller or its Affiliates to the Sales Force (as such term is defined in the Form of Distribution Agreement) in respect of the distribution of Group Insurance Contracts during the calendar year 2017 in a manner consistent with the terms of Exhibit D to the attached Form of Distribution Agreement, except in such instances as would not, individually or in the aggregate, have a material adverse impact on the Business.

Section 3.26. Administration of the Subject Contracts. The Service Standards that are attached to the form of Administrative Services Agreement as Exhibit II are based upon and are consistent in all material respects with the Ceding Company's service standards generally applicable on an individual plan basis to specified services provided to plans in connection with the Subject Contracts (as such term is defined in the form of Administrative Services Agreement attached hereto as Exhibit D). Since December 31, 2015, Seller and its Affiliates in the aggregate have administered the Subject Contracts in material compliance with the service standards upon which such Service Standards are based. In addition, since December 31, 2015, Seller and its Affiliates have administered the Subject Contracts in material compliance with all agreements with customers who purchased the Subject Contracts, including requirements to maintain the administration of the Subject Contracts in the United States.

ARTICLE IV.

REPRESENTATIONS AND WARRANTIES OF PURCHASER

Except as set forth in the corresponding sections or subsections of the disclosure schedule delivered to Seller by Purchaser concurrently with the execution and delivery of this Agreement (the " Purchaser Disclosure Schedule") (it being understood and agreed by the parties hereto that disclosure of any item in any section or subsection of the Purchaser Disclosure Schedule shall be deemed disclosure with respect to any other section or subsection of the Purchaser Disclosure Schedule to which the relevance of such item is reasonably apparent, notwithstanding the omission of a reference or cross-reference thereto), Purchaser hereby makes the following representations and warranties to Seller, as of the date hereof and as of the Closing Date as follows:

Section 4.01. Organization, Standing. Purchaser is an insurance company duly incorporated, validly existing and in good standing under the laws of Connecticut.

Section 4.02. Authorization. Purchaser or the applicable Affiliate of Purchaser (as applicable) has all requisite corporate or other applicable organizational power to enter into, consummate the transactions contemplated by and carry out its obligations under, each of the Transaction Agreements to which it is or is contemplated to become a party. The execution and delivery by Purchaser or the applicable Affiliate of Purchaser (as applicable) of each of the Transaction Agreements to which it is or is contemplated to become a party and the consummation by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the transactions contemplated by each of the Transaction Agreements to which it is or is contemplated to become a party have been duly authorized by all requisite corporate or other similar organizational action on the part of Purchaser or the applicable Affiliate of Purchaser (as applicable). Each of the Transaction Agreements to which Purchaser or the applicable Affiliate of Purchaser (as applicable) is or is contemplated to become a party has been, or upon execution and delivery thereof will be, duly executed and delivered by Purchaser or the applicable Affiliate of Purchaser (as applicable). Assuming due authorization, execution and delivery by the other parties hereto or thereto, each of the Transaction Agreements to which Purchaser or the applicable Affiliate of Purchaser (as applicable) is or is contemplated to become a party constitutes, or upon execution and delivery thereof will constitute, the legal, valid and binding

obligation of Purchaser or the applicable Affiliate of Purchaser (as applicable), enforceable against it in accordance with its terms, subject in each case to the Enforceability Exceptions.

Section 4.03. No Conflict or Violation. Provided that all consents, approvals, authorizations and other actions described in Section 4.04 have been obtained or taken, the execution and delivery by Purchaser or the applicable Affiliate of Purchaser (as applicable) of, and the consummation by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the transactions contemplated by, the Transaction Agreements to which Purchaser or the applicable Affiliate of Purchaser (as applicable) is or is contemplated to become a party do not and will not (a) violate or conflict with the organizational documents of Purchaser or the applicable Affiliate of Purchaser (as applicable), (b) subject to the Governmental Approvals referred to in Section 4.04 , conflict with or violate any Applicable Law or Governmental Order applicable to Purchaser or the applicable Affiliate of Purchaser (as applicable) or by which any of them or any of their respective properties, assets or rights is bound or subject to, (c) result in any breach of, or constitute a default (or event which, with the giving of notice or lapse of time or both, would constitute a default) under, or give to any Person any rights of termination, acceleration or cancellation of or result in the creation of any Lien (other than Permitted Liens) on any of the assets, properties or rights of Purchaser or any of its Affiliates pursuant to, any contract or any note, bond, loan or credit agreement, mortgage or indenture to which Purchaser or any of its Affiliates is a party or by which any of them or any of their respective properties or assets is bound or subject, or (d) result in a breach or violation of any of the terms or conditions of, result in a default under, or otherwise cause an impairment or revocation of, any material Permit of Purchaser or its Affiliates; except, in the case of clauses (b), (c) and (d) of this Section 4.03 , for any such conflicts, violations, breaches, defaults, terminations, accelerations, cancellations or creations that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.04. Consents and Approvals. The execution and delivery by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the Transaction Agreements to which it is or is contemplated to become a party do not, and the consummation by Purchaser or the applicable Affiliate of Purchaser (as applicable) of the transactions contemplated by the Transaction Agreements to which it is or is contemplated to become a party will not, require any Governmental Approval to be obtained or made by or with respect to Purchaser or the applicable Affiliate of Purchaser (as applicable), except for any Governmental Approvals the failure to obtain or make which, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.05. Absence of Litigation. There are no Actions pending or, to the Knowledge of Purchaser, threatened in writing against Purchaser or any of its Affiliates or any of their respective assets, properties or businesses that (i) question the legality of the transactions contemplated by any of the Transaction Agreements or (ii) as of the date hereof, individually or in the aggregate, would reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.06. Compliance With Laws.

(a) Purchaser and its Affiliates are not in violation of any Applicable Laws (including any Applicable Laws regulating the insurance business) or Governmental Orders applicable to

them or their respective assets, properties or businesses, except for violations that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

(b) All material deficiencies or violations with respect to the respective insurance businesses of Purchaser and its Affiliates that are party to any Transaction Agreement in all reports of examinations of the affairs of Purchaser or any such Affiliate with respect to such businesses (including financial, market conduct and similar examinations) issued by any Insurance Regulator for any period ending on a date on or after December 31, 2014, have been resolved to the reasonable satisfaction of the Insurance Regulator that noted such deficiencies or violations, except as would not reasonably be expected to have a Purchaser Material Adverse Effect.

(c) Neither Purchaser nor its Affiliates, nor any of their respective properties, assets or rights, is a party to, or bound by, any Governmental Order, except for those Governmental Orders that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

(d) Purchaser and each Affiliate of Purchaser that is party to a Transaction Agreement has filed all reports, statements, documents, registrations, filings or submissions required to be filed by Purchaser or such Affiliate with any Governmental Authority to the extent they relate to their respective insurance businesses, except for any failures to file that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect. All such registrations, filings and submissions were in compliance in all material respects with Applicable Law when filed or as amended or supplemented, and no deficiencies have been asserted by any Governmental Authority with respect to such registrations, filings or submissions that have not been satisfied, except for any non-compliance or failures to file that, individually or in the aggregate, would not reasonably be expected to have a Purchaser Material Adverse Effect.

Section 4.07. Financial Ability.

(a) Purchaser has, and will have at the Closing, all funds necessary to: (i) pay all amounts required to be paid or deposited by Purchaser and its Affiliates pursuant to Article II; and (ii) consummate the transactions contemplated by this Agreement and the other Transaction Agreements.

(b) Purchaser has previously delivered to Seller copies of (i) the audited annual statutory financial statements of Purchaser as of and for the years ended December 31, 2015 and December 31, 2016 and (ii) the unaudited interim statutory financial statements of the Purchaser as of and for the six-month period ending June 30, 2017. The foregoing statutory financial statements were prepared in all material respects in accordance with SAP and fairly present, in all material respects in accordance therewith, the admitted assets, liabilities and capital and surplus of Purchaser at their respective dates and the results of operations, changes in surplus and cash flows of Purchaser at and for the periods indicated, subject, in the case of the financial statements referenced in clause (ii) above, to normal year-end adjustments.

Section 4.08. Permits.

(a) Purchaser and each of its Affiliates executing any Transaction Agreement holds, or as of the Closing Date will hold, all registrations, filings, licenses, permits, approvals or authorizations issued or granted by Governmental Authorities that are necessary to consummate the transactions contemplated by the Reinsurance Agreement, for the current operation and conduct of the Business and to own or use its assets and properties to the extent relating to the Business (collectively, the " Purchaser Permits") except for such failure to hold Purchaser Permits as would not reasonably be expected to have, individually or in the aggregate, a Purchaser Material Adverse Effect.

(b) Since December 31, 2014, none of Purchaser or any of its Affiliates executing any Transaction Agreement has received any written notice or communication from any Governmental Authority regarding any actual, alleged, or potential violation of, or failure to comply with, the terms or requirements of any such Purchaser Permit, except as would not reasonably be expected to have, individually or in the aggregate, a Purchaser Material Adverse Effect. As of the date hereof, none of Purchaser or any of its Affiliates executing any Transaction Agreement is the subject of any pending or, to the Knowledge of Purchaser, threatened action seeking the revocation, withdrawal, suspension, termination, cancellation, nonrenewal, modification or impairment of any such Purchaser Permit except as would not reasonably be expected to have, individually or in the aggregate, a Purchaser Material Adverse Effect.

Section 4.09. Brokers and Finders. Except for Merrill Lynch, Pierce, Fenner & Smith Inc., whose fees will be paid by Purchaser, no broker, investment banker, financial adviser or other person is entitled to any broker's, finder's, financial adviser's or other similar fee or commission in connection with the transactions contemplated by this Agreement based upon arrangements made by or on behalf of Purchaser or any of its Affiliates.

Section 4.10. Absence of Triggering Event. As of the date hereof and assuming, for this purpose, that the Reinsurance Agreement became effective immediately prior to the date hereof, to the Knowledge of Purchaser, no Triggering Event (as defined in the Reinsurance Agreement) shall have occurred thereunder.

ARTICLE V.

COVENANTS

Section 5.01. Conduct of Business. Between the date hereof and the Closing Date, and, with respect to Section 5.01(c)-(h) , between the date hereof and the end of the Employee Lease Term, subject to the terms of the Employee Leasing Agreement, except (a) as required under any Applicable Law, (b) as otherwise contemplated by or necessary to effectuate the Transaction Agreements (including compliance with Sections 5.06(a) and 5.11), (c) for matters identified in Section 5.01 of the Seller Disclosure Schedule or (d) with the consent of Purchaser (which consent may not be unreasonably withheld, delayed or conditioned), Seller shall, and shall cause its Affiliates to, in each case solely with respect to, and to the extent relating to, the Business, use commercially reasonable efforts to (x) conduct the Business in the ordinary course of business,

(y) maintain current significant business relationships and goodwill with policyholders, customers, suppliers and service providers of and to the Business, and with the Governmental Authorities with jurisdiction over the Business, and (z) not do any of the following:

(a) other than in the ordinary course of business and other than with respect to Investment Assets, sell, voluntarily terminate, transfer, assign, lease, sublease, license or otherwise dispose of any Transferred Assets;

(b) sell, terminate, transfer or otherwise dispose of any of the cash or Investment Assets in the Specified Portfolio other than as contemplated by Section 5.11;

(c) increase the base salary (or wages), target cash incentive compensation opportunity, benefits (including severance benefits) paid or payable to any Employee, except for annual salary or wage adjustment increases in the ordinary course of business and consistent with increases applicable to similarly situated employees of the Seller and its Affiliates or as required by the terms of any Employee Benefit Plan in existence as of the date hereof;

(d) (A) establish or adopt, enter into, change, terminate, or amend in any material respect any Employee Benefit Plan or any retention or severance agreement with respect to any Employee, (B) take any action to accelerate any material rights or benefits under any Employee Benefit Plan with respect to any Employee (except to the extent required as of the date hereof by any such plan), or (C) grant any new equity or equity-based awards to any Employee;

(e) establish, adopt, enter into, change or amend any Business Employee Benefit Plan or take any action to accelerate any material rights or benefits under any Business Employee Benefit Plan;

(f) hire or engage any Employee or independent contractor providing personal services with respect to the Business, in each case, who will earn annual base salary in excess of $150,000;

(g) terminate, other than for cause, the employment or engagement of any Employee or independent contractor providing personal services with respect to the Business;

(h) transfer or reallocate, or permit the transfer or reallocation of, the employment or services of any employee or independent contractor providing personal services to Seller or its Affiliates into or out of the Business;

(i) enter into, amend in any material respect, waive any rights under, or assign or transfer any Assigned Contract or Material Contract;

(j) make any material change in the accounting, actuarial, investment, reserving, underwriting or claims administration policies, practices, or principles of (and solely to the extent relating to) the Business, except as may be required by GAAP, SAP, Applicable Law or internal accounting policies existing as at December 31, 2016;

(k) make or change any material Tax election in respect of the Business, adopt or materially change any accounting method in respect of the Business, file any material amended

Tax Return in respect of the Business, or materially modify the method by which Seller and its Affiliates determine reserves with respect to the Ceded Insurance Contracts;

(l) voluntarily grant any Lien (other than Permitted Liens) on any Transferred Assets;

(m) abandon, modify, waive, terminate or allow to lapse any material Permit of Seller or the Ceding Company to the extent relating to the Business; or

(n) enter into a binding agreement to take any of the foregoing actions.

Section 5.02. Pre-Closing Access to Information.

(a) Between the date of this Agreement and the Closing Date, subject to Applicable Law and subject to the rules applicable to visitors at Seller's offices generally, Seller shall afford to Purchaser and its Representatives reasonable access, upon reasonable advance notice and during normal business hours, to such contracts, documents and information of or relating to the assets, liabilities, business, operations and other aspects of the Business as Purchaser may reasonably request; provided , however , that Seller shall not be obligated to provide such access or information if Seller determines, in its reasonable judgment, that doing so would violate Applicable Law or a contract, agreement or obligation of confidentiality owing to a third party, jeopardize the protection of an attorney-client privilege, or expose Seller or any of its Affiliates to risk of liability for disclosure of sensitive or personal information; provided, further , that Seller shall not be obligated to provide such access to its offices if Seller determines, in its reasonable judgment, that such contracts, documents and information can be provided electronically or in another reasonably accessible location. Purchaser agrees that it will hold, and will cause its Representatives to hold, any information so obtained in confidence to the extent required by, and in accordance with, the provisions of the Confidentiality Agreement and Section 5.04. Notwithstanding anything to the contrary set forth herein, none of Seller, its Affiliates or their respective Representatives shall be required to disclose or provide access to Excluded Books and Records to Purchaser or, prior to the Closing Date, any of its Representatives or any information that Seller reasonably determines to be competitively sensitive.

(b) Without limiting the foregoing, from the date hereof until the Closing, Seller shall deliver to Purchaser complete copies of the audited or unaudited statutory financial statements of the Ceding Company, together with any notes, exhibits or schedules thereto, that are filed with the Insurance Regulator for the applicable company's jurisdiction of domicile between the date hereof and the Closing, as promptly as practicable after the filing of such statements with such Insurance Regulator.

Section 5.03. Post-Closing Access to Information.

(a) For a period of five years following the Closing Date, Seller shall: (i) allow Purchaser, upon reasonable prior notice and during normal business hours, through its Representatives, the right, at Purchaser's expense, to examine and make copies of any Excluded Books and Records which were retained by Seller or its Affiliates pursuant to this Section 5.03; and (ii) allow Purchaser to interview Seller's and its Affiliates' Representatives for any reasonable business purpose relating to the Business, including in connection with Seller's pre-

Closing employment of the Transferred Employees or Purchaser's preparation or examination of regulatory and statutory filings and financial statements and the conduct of any litigation relating to the Business (other than any litigation or dispute between Seller or its Affiliates, on the one hand, and Purchaser or its Affiliates, on the other hand), or the conduct of any regulatory authority, policyholder, reinsurer or other dispute resolution or any other Third Party Claim (whether or not such Third Party Claim is the subject of an indemnification claim by a Purchaser Indemnified Person or Seller Indemnified Person), whether pending or threatened; provided , however , that Seller shall not be obligated to provide such access to its offices if Seller determines, in its reasonable judgment, that such Excluded Books and Records can be provided electronically or in another reasonably accessible location. Access to such Representatives and Excluded Books and Records shall be at Purchaser's expense and shall not unreasonably interfere with Seller's or its Affiliates' or any of their respective successor companies' business operations.

(b) For a period of five years following the Closing Date, Purchaser shall: (i) allow Seller, upon reasonable prior notice and during normal business hours, through its Representatives, the right, at Seller's expense, to examine and make copies, at Seller's expense, of any Books and Records which were transferred to Purchaser or its Affiliates at or after the Closing and of which neither Seller nor any of its Affiliates retained a copy; and (ii) allow Seller to interview Purchaser's Representatives, upon reasonable prior notice and during normal business hours, for any reasonable business purpose relating to the Business, including in connection with Seller's preparation or examination of regulatory and statutory filings and financial statements, and the conduct of any litigation relating to the Business (other than any litigation or dispute between Seller or its Affiliates, on the one hand, and Purchaser or its Affiliates, on the other hand), or the conduct of any regulatory, contract holder, reinsurer or other dispute resolution or any other Third Party Claim (whether or not such Third Party Claim is the subject of an indemnification claim by a Purchaser Indemnified Person or Seller Indemnified Person), whether pending or threatened; provided , however , that Purchaser shall not be obligated to provide such access to its offices if Purchaser determines, in its reasonable judgment, that such Books and Records can be provided electronically or in another reasonably accessible location. Access to such Representatives and Books and Records shall be at Seller's expense and shall not unreasonably interfere with the business operations of Purchaser or its Affiliates.

(c) Except as otherwise prohibited by Applicable Law and subject to clause (d) and (e) below, Purchaser shall, with respect to the Books and Records, and Seller and its Affiliates shall, with respect to the Excluded Books and Records and the Retained Books and Records, in each case, to which the other party is entitled to access pursuant to the foregoing provisions of this Section 5.03(a) and (b) and Section 5.05 : (i) comply in all material respects with all Applicable Laws relating to the preservation and retention of records; (ii) apply preservation and retention policies that are no less stringent than those generally applied by such party; and (iii) without limitation to the foregoing, for at least five years after the Closing Date, preserve and retain all original Books and Records, Retained Books and Records, and Excluded Books and Records, as the case may be, and thereafter dispose of such originals only after it shall have given the other party 90 days' prior written notice of such disposition and the opportunity (at such other party's expense) to remove and retain such information.

(d) Notwithstanding any other provision of this Agreement, a party hereto shall not be obligated to provide such access to any Books and Records, Retained Books and Records, or Excluded Books and Records or information if such party determines, in its reasonable judgment, that doing so would violate Applicable Law (except that copies thereof shall be furnished to the requesting party or its Representatives to the extent permitted under Applicable Law) or a contract, agreement or obligation of confidentiality owing to a third party, or jeopardize the protection of an attorney-client privilege; provided, that the party contemplated to provide access shall use commercially reasonable efforts to obtain waivers or make other arrangements (including redacting information or entering into joint defense agreements) that would enable otherwise required disclosure to the other party or its Representatives to occur without so jeopardizing privilege or contravening such Applicable Law, contract or obligation of confidentiality.

(e) Notwithstanding any other provision of this Agreement to the contrary, Purchaser shall, and shall cause its Affiliates to, retain and preserve all Books and Records (in whatever form maintained) transferred to Purchaser that are subject to a Legal Hold in effect as of the Closing, until such time as Seller notifies Purchaser in writing that such Books and Records may be destroyed. Seller shall use commercially reasonable efforts to notify Purchaser within 30 days of the termination of any applicable Legal Hold. Purchaser shall provide Seller and its Affiliates with access to any Books and Records subject to this Section 5.03(e); provided that access to Books and Records subject to Legal Holds shall be limited in time only by the terms of the applicable Legal Hold; provided , however , that Purchaser shall not be obligated to provide access to its offices for such purposes if Purchaser determines, in its reasonable judgment, that such Books and Records can be provided electronically or in another reasonably accessible location.

Section 5.04. Confidentiality.

(a) The terms of the confidentiality agreement, dated June 12, 2017 (the " Confidentiality Agreement"), between Seller and The Hartford Financial Services Group Inc. shall continue in full force and effect until the Closing, at which time the confidentiality obligations under the Confidentiality Agreement shall terminate.

(b) Notwithstanding the foregoing, nothing in the Confidentiality Agreement shall restrict, prohibit or delay the ability of Seller or Purchaser to exercise its rights or perform its obligations under the Transaction Agreements. If, for any reason, the transactions contemplated by this Agreement are not consummated, the Confidentiality Agreement shall nonetheless continue in full force and effect in accordance with its terms.

(c) From and after the Closing: (i) Seller shall, and shall cause its Representatives to, maintain in confidence any written, oral or other information to the extent relating to the Business obtained by virtue of Seller's ownership of the Business prior to the Closing, including the Retained Books and Records; and (ii) Purchaser shall, and shall cause its Representatives to, maintain in confidence any written, oral or other information of or relating to Seller or its Affiliates (other than information relating to the Business) obtained by virtue of its ownership of the Business from and after the Closing, except, in each case, to the extent that the applicable party is required to disclose such information by judicial or administrative process or pursuant to

Applicable Law (provided that, except in connection with any required disclosure pursuant to any Applicable Law relating to Taxes and any filings required by the applicable securities laws, such party has given the other party written notice of such potential disclosure and, to the extent reasonably requested by such other party, cooperated with such other party in seeking an appropriate order or other remedy protecting such information from disclosure) or such information can be shown to have been in the public domain through no fault of the applicable party.

(d) Effective as of the Closing, Seller shall (i) enforce, on behalf of and at the request of Purchaser, Seller's rights, powers and privileges under any in-force confidentiality agreements with third Persons other than Purchaser regarding the potential sale of the Business executed prior to the date hereof (each, a " Seller Confidentiality Agreement") in connection with any material breach thereof by such third persons, provided that Purchaser shall reimburse Seller for its costs and expenses (including reasonable legal fees and expenses) incurred in connection with such enforcement, and (ii) submit written requests to all third Persons who executed a Seller Confidentiality Agreement that such other Persons promptly deliver to Purchaser or otherwise destroy all proprietary or confidential material furnished to such Person by or on behalf of Seller or its Affiliates in accordance with the terms of such Seller Confidentiality Agreement.

Section 5.05. Maintenance and Transfer of Books and Records.

(a) Through the Closing Date, Seller shall, and shall cause its Affiliates to, maintain the Books and Records in all material respects in the same manner and with the same care that the Books and Records have been maintained for the 12-month period prior to the execution of this Agreement. Books and Records of the type identified in Section 5.05(a) of the Seller Disclosure Schedule, including, for the avoidance of doubt, Books and Records that (i) are necessary for Seller to provide services under the Transition Services Agreement (to the extent that such Books and Records cannot reasonably be duplicated and a copy retained by Seller or its applicable Affiliate(s)); or (ii) are not permitted to be disclosed or transferred under applicable Law (such Books and Records, the " Retained Books and Records"), shall not be transferred at the Closing but will instead be made available by Seller to Purchaser, at Seller's expense, from and after the Closing in accordance with the guidelines set forth in Section 5.05(a) of the Seller Disclosure Schedule. Notwithstanding anything to the contrary in this Agreement, Seller and its Affiliates shall not be required to transfer the Retained Books and Records at the Closing or on the Closing Date, and Seller and its Affiliates shall be entitled to retain copies of any Books and Records transferred to Purchaser at the Closing or on the Closing Date. Seller shall, and shall cause its Affiliates to, provide Purchaser and its Representatives reasonable access to such Retained Books and Records, and once any Retained Books and Records are no longer necessary for the provision of services under the Transition Services Agreement or are permitted to be transferred, as applicable, Seller shall cause such Retained Books and Records to be delivered to Purchaser (or a Person designated by Purchaser) or, at Purchaser's option, to be destroyed.

(b) At the Closing, Seller shall cause all Books and Records (except the Retained Books and Records) in the possession or control of Seller or any of its Affiliates to be delivered to Purchaser (or a Person designated by Purchaser) in accordance with the requirements and guidelines set forth in Section 5.05(b) of the Seller Disclosure Schedule.

Section 5.06. Consents, Approvals and Filings.

(a) Subject to the terms and conditions hereof, Seller and Purchaser shall each use their reasonable best efforts, and shall cooperate fully with each other, (i) to comply as promptly as practicable with all requirements of Governmental Authorities applicable to the transactions contemplated by the Transaction Agreements and (ii) to obtain as promptly as practicable all Governmental Approvals necessary in connection with the consummation of the transactions contemplated by the Transaction Agreements; provided that, Purchaser shall be responsible for the costs (including any license or other fees and expenses) associated with Seller, Purchaser or any of their respective Affiliates obtaining any such Governmental Approvals. In connection therewith, Seller and Purchaser shall make and cause their respective Affiliates to make all legally required filings as promptly as practicable in order to facilitate prompt consummation of the transactions contemplated by the Transaction Agreements, shall provide and shall cause their respective Affiliates to provide such information and communications to Governmental Authorities as such Governmental Authorities may request, shall take and shall cause their respective Affiliates to take all steps that are necessary, proper, or advisable to avoid any Action by any Governmental Authority with respect to the transactions contemplated by the Transaction Agreements, shall defend or contest in good faith any Action by any third party (including any Governmental Authority), whether judicial or administrative, challenging any of the Transaction Agreements or the transactions contemplated thereby, or that could otherwise prevent, impede, interfere with, hinder, or delay in any material respect the consummation of the transactions contemplated thereby, including by using their reasonable best efforts to have vacated or reversed any stay or temporary restraining order entered with respect to the transactions contemplated by any of the Transaction Agreements by any Governmental Authority, and shall consent to and comply with any condition imposed by any Governmental Authority on its grant of any such permit, order, consent, approval, or authorization, other than any Burdensome Condition. Each of the parties shall provide to the other party copies of all applications or other communications to Governmental Authorities in connection with this Agreement in advance of the filing or submission thereof.

(b) Without limiting the generality of the foregoing, as promptly as practicable after the date hereof, each of Purchaser and Seller shall file with all applicable Insurance Regulators all required requests for approval of the transactions contemplated by the Transaction Agreements, which requests shall include all required exhibits. A reasonable time prior to furnishing any written materials to any Insurance Regulator in connection with the transactions contemplated by the Transaction Agreements, the furnishing party shall provide the other party with a copy thereof, and the other party shall have a reasonable opportunity to provide comments thereon, which comments shall be considered by the furnishing party in good faith. Each party shall give to the other party prompt written notice if it receives any notice or other communication from any Insurance Regulator or other Governmental Authority in connection with the transactions contemplated by the Transaction Agreements and, in the case of any such notice or communication that is in writing, shall promptly furnish the other party with a copy thereof. If any Governmental Authority requires that a hearing be held in connection with any such approval, each party shall use its reasonable best efforts to arrange for such hearing to be held promptly after the notice that such hearing is required has been received by such party. Each party shall give to the other party reasonable prior written notice of the time and place when any meetings, telephone calls, or other conferences may be held by it with any

Governmental Authority in connection with the transactions contemplated by the Transaction Agreements, and the other party shall have the right to have a representative or representatives attend or otherwise participate in any such meeting, telephone call, or other conference unless prohibited by Applicable Law.

(c) Notwithstanding anything herein to the contrary, neither Purchaser nor Seller shall be obligated to take or refrain from taking or to agree to it, its Affiliates or any of their respective Representatives taking or refraining from taking any action or to permit or suffer to exist any restriction, condition, limitation or requirement which, individually or together with all other such actions, restrictions, conditions, limitations or requirements, would constitute a Burdensome Condition. As used in this Agreement, " Burdensome Condition" means any arrangement, condition or restriction (i) in the case of Purchaser, (A) to sell or hold separate or agree to sell, divest or discontinue, before or after the Closing Date, any properties, assets, businesses or licenses of Purchaser or its Affiliates that are material to Purchaser and its Affiliates, taken as a whole, or to the Business, as applicable, or (B) that otherwise is reasonably likely to have a Material Adverse Effect or a material adverse effect on the business, financial condition, operations or results of operations of Purchaser and its Affiliates, taken as a whole; and (ii) in the case of Seller, would require Seller or any of its Affiliates to provide any guarantee or incur any liability with respect to the Business or the Transferred Assets after the Closing Date, or restrict the ability of Seller or any of its Affiliates to conduct their respective businesses after the Closing Date.

Section 5.07. Further Assurances.

(a) Subject to the terms and conditions herein provided, including Section 5.06 , each of the parties hereto shall, and shall cause its Affiliates to, execute such documents and other papers and perform such further acts as may be reasonably required to carry out the provisions hereof and the transactions contemplated hereby and by the other Transaction Agreements. Each such party shall, at or prior to the Closing Date, use its reasonable best efforts to fulfill or obtain the fulfillment of the conditions precedent to the consummation of the transactions contemplated hereby and by the other Transaction Agreements, including the execution and delivery of any documents, certificates, instruments or other papers and the taking of any other actions that are reasonably necessary for the consummation of the transactions contemplated hereby and by the other Transaction Agreements.

(b) Subject to the terms and conditions of this Agreement, on and after the Closing Date, Seller and Purchaser shall, and shall cause their respective Affiliates to, take all reasonable actions and execute any additional documents, instruments or conveyances of any kind which may be reasonably necessary to put Purchaser and its Affiliates in full possession and operating control of the Business and to effect fully the separation of the Business from Seller and its Affiliates.

Section 5.08. Privacy and Data Security Compliance; Use of Information. Notwithstanding any other provision of this Agreement or any Transaction Agreement to the contrary, none of Seller, Purchaser or any of their respective Affiliates shall be required to take any action that would violate or conflict with, and each such Person shall comply with, all Privacy and Data Security Laws. Notwithstanding any other provision of this Agreement, Seller

and Purchaser shall use their respective reasonable best efforts to ensure that all Personal Data about individual insureds and employees on leaves of absence under Group Contracts or other individuals is used, shared, accessed, stored, transmitted, disclosed, or otherwise processed in a manner (including the scope of information) that complies with, and facilitates each party's compliance with, Privacy and Data Security Laws. For the avoidance of doubt, any Personal Data relating to individual insureds and employees on leaves of absence under Group Contracts accessed by or disclosed to Purchaser or any of its Affiliates pursuant to this Agreement shall be subject to Purchaser's confidentiality obligations under Section 5.04 and under the Administrative Services Agreement.

Section 5.09. Non-Solicitation of Employees.

(a) For a period of 24 months following the Closing Date, without the prior written consent of Purchaser, neither Seller nor any of its Affiliates shall, whether directly or indirectly, solicit for employment or employ any Transferred Employee or any employee of the Purchaser whose name is set forth on Section 5.09(a) of the Purchaser Disclosure Schedule; provided , that nothing in this Section 5.09(a) shall prohibit Seller or any of its Affiliates from engaging in general solicitations not directed at such Persons (including general media advertisements and the use of a search firm not directed to target Transferred Employees) or from soliciting or employing any such Person whose employment with or engagement by Purchaser or any of its Affiliates has been terminated by Purchaser or its applicable Affiliate at least three months prior to the first such solicitation or employment.

(b) For a period of 24 months following the Closing Date, without the prior written consent of Seller, neither Purchaser nor any of its Affiliates shall, whether directly or indirectly, solicit for employment or employ any employee of the Seller whose name is set forth on Section 5.09(b) of the Seller Disclosure Schedule; provided , that nothing in this Section 5.09(b) shall prohibit Purchaser or any of its Affiliates from engaging in general solicitations not directed at such Persons (including general media advertisements and the use of a search firm not directed to target such Persons) or from soliciting or employing any such Person whose employment with or engagement by Seller or any of its Affiliates has been terminated by Seller or its applicable Affiliate at least three months prior to the first such solicitation or employment.

(c) For a period of 24 months following the Closing Date (including during the Employee Lease Term), without the prior written consent of Purchaser, neither Seller nor any of its Affiliates shall, whether directly or indirectly, interfere with Purchaser's obligations under Section 6.01(a) or attempt to retain for employment or rehire any Employee set forth on Section 6.01(a)(i) of the Seller Disclosure Schedule who does not become a Transferred Employee; provided , that nothing in this Section 5.09(c) shall prohibit Seller or any of its Affiliates from engaging in general solicitations not directed at such Persons (including general media advertisements and the use of a search firm not directed to target such Persons).

Section 5.10. Use of Names.

(a) At the Closing, Seller shall enter into a royalty-free license agreement with Purchaser substantially in the form attached hereto as Exhibit I (the " Trademark License Agreement"), among other things, permitting Purchaser to use the "Aetna" name and related

Trademarks on a transitional basis in connection with the operation of the Business in the United States in accordance with the terms thereof.

(b) Except as otherwise contemplated by the Administrative Services Agreement, the Distribution Agreement, the Transition Services Agreement and the Trademark License Agreement in accordance with the terms thereof: (i) following the Closing Date (including in connection with the operation of the Business and the Transferred Assets), Purchaser shall not, and shall cause its Affiliates not to, use any of the names or Trademarks set forth in Section 5.10 of the Seller Disclosure Schedule, any other Trademarks of Seller's Affiliates that include the name "Aetna," or any name, Trademark, or acronym that is confusingly similar to, or is based on or incorporates, any of such names or Trademarks (collectively, the " Seller Trademarks") whether or not in combination with other words, symbols, or other distinctive or non-distinctive elements, and all trade, corporate or business names, trademarks, tag-lines, identifying logos, trade dress, monograms, slogans, service marks, domain names, brand names, and other name or source identifiers that are derivations, translations, adaptations, combinations or variations of the Seller Trademarks or Trademarks of Seller's Affiliates, or embodying any of the foregoing, whether or not in combination with other words, symbols, or other distinctive or non-distinctive elements; and (ii) Purchaser, for itself and its Affiliates, agrees that any and all rights arising out of the Transferred Assets to the Seller Trademarks or Trademarks of Seller's Affiliates, whether written or oral, with Seller or its Affiliates, shall terminate on the Closing Date without recourse by Purchaser or any of its Affiliates. Neither Purchaser nor any of its Affiliates shall seek to register in any jurisdiction any trade, corporate, or business name, trademark, tag-line, identifying logo, trade dress, monogram, slogan, service mark, domain name, brand name, or other name or source identifier that is a derivation, translation, adaptation, combination, or variation of the Seller Trademarks or Trademarks of Seller's Affiliates.

Section 5.11. Pre-Closing Management of Specified Portfolio.

(a) Monthly Asset Value Statements and Related Adjustments.

(i) After the end of each calendar month that occurs between the date hereof and the Closing Date, Seller shall estimate in good faith the Adjusted Required Asset Value and the Accounting Value of the Specified Portfolio as of the end of such month and deliver to Purchaser a statement (each, a "Monthly Asset Value Statement") specifying such Adjusted Required Asset Value and Accounting Value as of the end of such month, provided that no such Monthly Asset Value Statement shall be so prepared or delivered with respect to the month preceding the month in which the Closing occurs.

(ii) If the Accounting Value of the Specified Portfolio set forth in a Monthly Asset Value Statement is less than the Adjusted Required Asset Value set forth in such Monthly Asset Value Statement, Seller shall (or shall cause the Ceding Company or AHLIC to), promptly following the delivery of such Monthly Asset Value Statement to Purchaser pursuant to Section 5.11(a)(i) , acquire or, subject to Section 5.11(c) below, designate for

inclusion in the Specified Portfolio additional cash or Investment Assets with an aggregate Fair Market Value equal to the amount of such shortfall.

(iii) If the Accounting Value of the Specified Portfolio set forth in a Monthly Asset Value Statement is greater than the Adjusted Required Asset Value set forth in such Monthly Asset Value Statement, Seller may, at its option and in its sole discretion, select for removal from the Specified Portfolio cash or Investment Assets that have an aggregate Accounting Value equal to such excess as follows (clauses (A) and (B) below, the "Selection Waterfall"):

(A) cash and cash equivalents in the Specified Portfolio will be selected first; and

(B) otherwise, Investment Assets will be selected in an order of shortest stated maturity to longest stated maturity, determined in each case in good faith by Seller.

(iv) Notwithstanding anything to the contrary in this Agreement, Seller may (and may cause the Ceding Company or AHLIC to) sell any Investment Asset in the Specified Portfolio if Seller determines in good faith that such Investment Asset has become, or is reasonably likely to become, impaired. In the event of any such sale of an impaired asset, Seller shall (or shall cause the Ceding Company or AHLIC to), as promptly as practicable following such sale (with a target of within one Business Day), acquire or designate for inclusion in the Specified Portfolio cash or replacement Investment Assets with an aggregate Fair Market Value equal to the Accounting Value of the Investment Asset sold in such sale, determined prior to any adjustment as a result of the impairment. For the avoidance of doubt, the Capital Gain or Loss Adjustment (as defined in clause (b) below) does not apply to sales of Investment Asset pursuant to this Section 5.11(a)(iv) , but the Reallocated Asset Value Adjustment (as defined in Section 5.11(c) below) does apply to any Reallocated Investment Asset that replaces such an Investment Asset.

(v) Any changes to the Specified Portfolio contemplated by this Section 5.11(a) will be effected in accordance with Pre-Closing Investment Guidelines.

(b) Discretionary Turnover Allowance.

(i) Between the date hereof and the Closing Date, Seller may, at its option and in its sole discretion, sell:

(A) any bond in the Specified Portfolio that has an option adjusted duration of 3.00 years or less as of the close of business on the Business Day immediately prior to the date on which it is sold, determined in accordance with the OAD model provided by

Bloomberg L.P.'s Portfolio & Risk Analytics solution (PORT); and

(B) an additional (x) 5% of the aggregate Specified Portfolio (where such percentage is determined by reference to the Accounting Value of the Specified Portfolio as of the Reference Date and sales are measured by Accounting Value of the sold Investment Assets as of the applicable sale dates) during the period between the Reference Date through December 31, 2017; and (y) if the Closing has not occurred on or prior to December 31, 2017, 1% of the Specified Portfolio (where such percentage is determined by reference to the Accounting Value of the Specified Portfolio as of the beginning of each applicable month and sales are measured by Accounting Value of the sold Investment Assets as of the applicable sale dates) during each calendar month, or portion thereof, that between December 31, 2017 and the Closing (this Section 5.11(b)(i) collectively, the "Discretionary Turnover Allowance");

provided , however , that the sales described in (A) and (B) above may not, in the aggregate, exceed 10% of the Specified Portfolio through November 30, 2017, plus 2% of the Specified Portfolio for every calendar month after November 2017.

(ii) On the date that any Investment Asset in the Specified Portfolio is sold pursuant to this Section 5.11(b) , the Adjusted Required Asset Value as of such date will, in addition to any adjustment to the Required Asset Value required under the Transaction Accounting Principles to account for any change in the interest maintenance reserve of the Ceding Company or AHLIC, as applicable, resulting from such sale, be adjusted as set forth below (each of the adjustments described in (A) and (B) below, a "Capital Gain or Loss Adjustment"):

(A) if the sale of the Investment Asset generates a (statutory basis) capital gain (calculated as the excess, if any, of the FMV Ex-Accrued of such Investment Asset as of the applicable date of sale over the Book Value of such Investment Asset as of such date), the Adjusted Required Asset Value as of such date will be increased by the amount of such capital gain, less the amount of any interest maintenance reserve of the Ceding Company or AHLIC, as applicable, generated by the sale of such asset in accordance with the Transaction Accounting Principles; and

(B) if the sale of the Investment Asset generates a (statutory basis) capital loss (calculated as the excess, if any, of the Book Value of such Investment Asset as of the applicable date of sale over the FMV Ex-Accrued of such Investment Asset as of such date), the

Adjusted Required Asset Value as of such date will be decreased by an amount equal to (A) the absolute value of such capital loss minus (B) the absolute value of any decrease in interest maintenance reserve of the Ceding Company or AHLIC, as applicable, resulting from the sale of such asset in accordance with the Transaction Accounting Principles.

(iii) In the event that Seller elects to sell any Investment Asset pursuant to this Section 5.11(b) , Seller shall, as promptly as reasonably practicable (with a target of within one Business Day) reinvest the gross proceeds it receives from such sale (less the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset) in the Specified Portfolio by either acquiring one or more new Investment Assets or, subject to Section 5.11(c) below, selecting for inclusion in the Specified Portfolio one or more Reallocated Investment Assets, in each case that have an aggregate FMV Ex-Accrued equal to the amount of such gross proceeds (less the amount of such gross proceeds that is attributable to accrued but unpaid interest on such Investment Asset).

(iv) Any changes to the Specified Portfolio contemplated by this Section 5.11(b) will be effected in accordance with the Pre-Closing Investment Guidelines.

(c) Reallocated Investment Assets. If, between the date of this Agreement and the Closing Date, any Reallocated Investment Asset is designated for inclusion in the Specified Portfolio pursuant to Section 5.11(a) or Section 5.11(b) , then the following adjustment shall be made to the Adjusted Required Asset Value as of the date of such designation (each of the adjustments described in (i) and (ii) below, a " Reallocated Asset Value Adjustment"):

(i) if the FMV Ex-Accrued of the Reallocated Investment Asset as of such date exceeds the Book Value of such Reallocated Investment Assets as of such date, the Adjusted Required Asset Value shall be decreased by the amount of such excess; and

(ii) if the FMV Ex-Accrued of the Reallocated Investment Asset as of such date is less than the Book Value of such Reallocated Investment Asset as of such date, the Adjusted Required Asset Value shall be increased by the amount of such shortfall.

Section 5.12. Properties.

(a) Schedule VI hereto sets forth all real property at which Employees of the Business use space for the current operation and conduct of the Business (collectively, the " Properties"). The Properties are separated on Schedule VI into the following two (2) categories: (1) the Properties that Seller intends, and agrees to cooperate as required in Section 5.12(b) to enable, Purchaser and such Employees to have the right to occupy or use (in the case of the Subleases, on a co-location basis with Seller, its Affiliates and their respective employees)

from and after the day immediately following the expiration or termination of the Employee Lease Term pursuant to the Portland Location Assignment Agreement, the Subleases and the Hartford License Agreement (collectively, the " Occupied Properties"); and (2) the Properties that Purchaser and such Employees will not have the right to occupy or use from and after the day immediately following the expiration of the Employee Lease Term (collectively, the " Non-Occupied Properties"). Purchaser acknowledges and agrees that all Employees at the Non-Occupied Properties shall vacate the Non-Occupied Properties from and after the day immediately following the expiration of the Employee Lease Term and Purchaser shall cause such Employees' job location to either be a home-office or an alternative real estate solution other than the Non-Occupied Properties. The Employees' job location between the Closing Date and the expiration of the Employee Lease Term shall remain at the Properties pursuant to the Employee Leasing Agreement.

(b) Seller and Purchaser shall, and shall cause their respective Affiliates to, use commercially reasonable efforts to obtain, on or prior to December 31, 2017, the required consent of (i) the landlord of the Portland Location to the assignment of the Assigned Lease pursuant to the Portland Location Assignment Agreement and (ii) the respective landlords of the other Occupied Properties to the subleasing of such locations to Purchaser pursuant to the Subleases, in each case, on the terms and subject to the conditions set forth herein and therein (collectively, the " Lease Consents"). Seller and Purchaser shall cooperate with each other as may be reasonably required to obtain the Lease Consents.

(c) If any such Lease Consent is not obtained on or prior to December 31, 2017, then, (i) the Portland Location Assignment Agreement and/or any applicable Sublease to which such Lease Consent was not obtained shall not become effective as of the expiration or termination of the Employee Lease Term and (ii) Purchaser shall, and shall cause its Affiliates to, obtain alternative office space, at its sole cost and expense, and vacate the applicable Occupied Properties for which a Lease Consent has not been obtained prior to the expiration of the Employee Lease Term for such applicable Occupied Properties as provided for in this Section 5.12(c).

Section 5.13. Non-Competition. During the period beginning on the Closing Date and ending on the date that is three years and six months after the Closing Date (the " Restricted Period"), Seller shall not, and shall cause its Affiliates (together with Seller, the " Restricted Entities") not to, directly or indirectly, issue or sell in any state or jurisdiction within the United States, any products or services of a type that comprises part of the Business as of the date hereof and that was underwritten, issued, sold, renewed or serviced as part of the Business during the two years prior to the date hereof (the " Competing Businesses"); provided , however , that this Section 5.13 shall not prohibit or in any way prevent or restrict:

(a) any Restricted Entity from operating any business other than the Business (including the business described in the proviso included in the definition of "Business") or from operating the Business from and after the time at which the Business or any portion thereof is recaptured under any coinsurance agreement;

(b) any Restricted Entity from providing (i) provider network access or network management services; (ii) medical management, case management, or cost containment services;

or (iii) administrative services for short-term disability plans that are provided in conjunction with a self-funded plan sponsor's medical benefits coverage or plan that is administered or serviced by a Restricted Entity.

(c) any Restricted Entity from performing any act or conducting any business expressly required by this Agreement or any other Transaction Agreement;

(d) any Restricted Entity from entering into a reinsurance agreement or similar arrangement primarily reinsuring the Competing Business of a ceding company that is not a Restricted Entity, so long as none of the Restricted Entities engages in the issuing, underwriting, selling, distributing, marketing, delivering, cancelling or administering of such underlying reinsured business;

(e) any Restricted Entity from (A) making any investment or providing advisory services (or activities related thereto) in a fiduciary or agency capacity and carried out on behalf of clients or other third party beneficiaries in the ordinary course of business, or (B) making passive investments for general insurance accounts or investment management, proprietary investing or trading activities in the ordinary course of its businesses; provided that in no event shall the aggregate ownership interest held by Restricted Entities in any Person engaged in a Competing Business, whether directly or indirectly, equal or exceed 20% of the aggregate voting power or issued and outstanding equity securities of such Person, subject to Sections 5.13(f) and (g) below;

(f) the ownership of, any affiliation with, or the conduct of any other activity with respect to, a Person that conducts, either directly or indirectly, a Competing Business (any such person, together with all of its Affiliates, a " Competing Person") that is the result of (A) the merger, consolidation, share exchange, sale or purchase of assets, scheme of arrangement or similar business combination involving any Restricted Entity with any Competing Person or (B) the acquisition of 20% or more of the voting power or outstanding equity interests in any Competing Person by any Restricted Entity, if, in the case of either (A) or (B), at least 66 2/3% of the total consolidated revenues of such Competing Person in the calendar year prior to such ownership or affiliation was derived from activities that do not constitute Competing Business; provided , however , that such Restricted Entity may proceed with such acquisition of a Competing Person that derived in excess of 33 1/3% of its total consolidated revenues in its most recent fiscal year from activities that constitute Competing Business only if such Restricted Entity divests, within 24 months of its acquisition, a sufficient portion of such Competing Person such that the total consolidated revenues from activities that constitute Competing Business that remain with any such Competing Person after such divestment over the last four full fiscal quarters prior to such acquisition are not greater than 33 1/3% of its consolidated revenues for such period; or

(g) subject to the foregoing clause (f), any Restricted Entity from foreclosing on collateral of or acquiring any of the outstanding capital stock or other interests in any person that has outstanding indebtedness to any Restricted Entity, or engaging in any activities otherwise prohibited by this Section 5.13 in connection with any such Person as a result of the acquisition of such capital stock or other interests in connection with a debt previously contracted.

ARTICLE VI.

EMPLOYEE MATTERS

Section 6.01. Employee Matters.

(a) Except as set forth in Section 6.01(b) , Purchaser or its Affiliate shall, not more than 30 Business Days following the Closing Date, extend offers of employment (" Transfer Offers") to all then-current Employees. Section 6.01(a)(i) of the Seller Disclosure Schedule sets forth, as of the date hereof, a list of then-current Employees, together with such Employees' (i) current base salary (or wages), (ii) current target incentive compensation opportunities by component, including (1) target annual cash bonus opportunity, (2) commission opportunity, and (3) target long-term incentive opportunity, (iii) recognized years of service, (iv) current work address, (v) remote work arrangement, if any, (vi) exempt or non-exempt status, (vii) hourly or salaried status, (viii) annual paid time off accrual rate, (ix) paid time off carryover amount, (x) current job title and career level, (xi) date of hire, (xii) valid work email address, and (xiii) status as active or on leave. Seller shall promptly update Section 6.01(a)(i) of the Seller Disclosure Schedule between the date hereof and the expiration of the Employee Lease Term to reflect any new hires, transfers, resignations and other employment additions and terminations of Employees which may have occurred subsequent to the date hereof in the ordinary course of business of the Business and shall deliver to Purchaser (A) a Closing version of Section 6.01(a)(i) of the Seller Disclosure Schedule no later than two days prior to the Closing Date, and (B) a final version of Section 6.01(a)(i) of the Seller Disclosure Schedule no later than 10 Business Days prior to the expiration of the Employee Lease Term. Notwithstanding anything to the contrary herein, to the extent an individual is hired or otherwise retained at the direction of Purchaser and added to Section 6.01(a)(i) of the Seller Disclosure Schedule after the date hereof, Purchaser or its Affiliate shall extend a Transfer Offer to such Employee as soon as reasonably practicable following such addition, but not more than the later to occur of (x) 30 Business Days following the Closing Date, and (y) ten Business Days following such addition. Section 6.01(a)(ii) of the Seller Disclosure Schedule sets forth, as of the date hereof, a list of then current Business Employees on a no-name basis by each Business Employee's current job title.

(b) With respect to any Employee identified on Section 6.01(a) of the Seller Disclosure Schedule hereto who is not actively at work upon the expiration of the Employee Lease Term as a result of a leave of absence (including temporary leave for purposes of jury or military duty, maternity or paternity leave, leave under the Family Medical Leave Act of 1993, approved personal leave or disability or medical leave) (each, a " Leave Recipient"), Purchaser shall make an offer of employment in the manner required by this Section 6.01 , contingent on such Leave Recipient's return to active status within six months following the expiration of the Employee Lease Term or such longer period as required by Applicable Law; provided that, notwithstanding anything in this Agreement to the contrary, Purchaser shall not be required to make an offer of employment to any such Employee (and shall have no obligation of any nature to hire or employ any such Employee) who is receiving long-term disability benefits. When a Leave Recipient who has accepted the offer returns to active status pursuant to the terms hereof and commences active employment with Purchaser or its Affiliates, such Leave Recipient shall be considered a Transferred Employee. Purchaser shall take, or cause its Affiliates to take, all reasonably necessary steps to sponsor or transfer sponsorship of, the work permits for all

Employees who are foreign nationals listed in Section 3.10(j) of the Seller Disclosure Schedule on or after the expiration of the Employee Lease Term. Seller shall cooperate as reasonably necessary to effect Purchaser's or its Affiliates' sponsorship or transfer of sponsorship of all such foreign national Employees, in each case, to the extent permitted by Applicable Law. Each such foreign national Employee who accepted an offer of employment from Purchaser or an Affiliate pursuant to the terms hereof shall be considered a Transferred Employee on the later of the Transfer Date or the date such Employee obtains the necessary authorization to work for Purchaser and its Affiliates and commences active employment with Purchaser and its Affiliates.

(c) Purchaser or its Affiliate shall set forth in the Transfer Offers the proposed terms of employment (or service) for the Employees and, as of the expiration of the Employee Lease Term and for a period of 12 months immediately following the expiration of the Employee Lease Term (or such earlier date on which such Employee's employment with Purchaser or its Affiliate terminates), Purchaser or its Affiliate shall provide each Transferred Employee with the following terms of employment (or service): (i) base salary (or wages) no less than the base salary (or wages) provided to such Employee by Seller or its Affiliates immediately prior to the Closing Date, or, if later, as of the Employee's date of hire; (ii) annual incentive opportunities no less than those provided by Seller or its Affiliates immediately prior to the Closing Date, or, if later, as of the Employee's date of hire, (iii) a long-term incentive compensation opportunity (whether paid in cash or equity) at a similar range and participation rate to that provided to such Employee by Seller or its Affiliates immediately prior to the Closing Date or, if later, as of the Employee's date of hire; (iv) commission opportunities that are no less than those provided to such Employee by Seller or its Affiliates immediately prior to the Closing Date or, if later, as of the Employee's date of hire, including, with respect to each individual set forth on Section 6.01(c) of the Seller Disclosure Schedule (each, a " Listed Sales Employee"), guaranteed commission opportunities consistent with the terms of the retention letter with each such Listed Sales Employee set forth on Section 3.10(a) of the Seller Disclosure Schedule, but in each case to be paid consistent with Purchaser's or its Affiliate's standard payroll cycle; (iii) employee retirement and welfare (including paid time off) benefits, in each case, substantially similar to those provided to similarly-situated employees of Purchaser or its Affiliate; and (iv) with respect to Employees whose job location is a home-office as of the Closing Date, the ability to continue to work from such home-office, and with respect to all other Employees, a job location that does not increase such Employee's commute by more than 30 miles when compared to the commute from such Employee's residence to the job location to which such Employee reports immediately prior to the expiration of the Closing Date, or if later, as of the Employee's date of hire, or provide the Employee the ability to work from a home-office. Without limiting the foregoing, Purchaser hereby acknowledges and agrees that if the Employee Lease Term extends past Lessee's regularly scheduled long-term incentive grant date in the first quarter of calendar year 2018, Purchaser shall, during the first "open window" trading period following the expiration of the Employee Lease Term, grant an award to each Transferred Employee who is eligible to earn a long-term incentive award for calendar year 2018. Employment or service, as applicable, pursuant to a Transfer Offer shall be contingent upon such Employee (i) being employed by (or providing on-going services with) Seller or any of its Subsidiaries immediately prior to the expiration of the Employee Lease Term, (ii) satisfying required professional licensure requirements (to the extent applicable), (iii) successfully completing a background check, I-9 form/eVerify process, and all applicable Purchaser new hire documentation and (iv) with respect to Employees who are foreign nationals, obtaining the necessary authorization to work for

Purchaser or its Affiliates within six (6) months of the expiration of the Employee Lease Term. All employment offers shall be for employment at-will and nothing in this Article VI shall require Purchaser or any of its Affiliates to continue to employ any Transferred Employee for any specified period of time following the expiration of the Employee Lease Term. Except as set forth in Section 6.01(b) , each Employee who accepts Purchaser's Transfer Offer shall be a " Transferred Employee" at 12:00:01 a.m. on the first day following the expiration of the Employee Lease Term. Effective as of the date they become Transferred Employees (the " Transfer Date"), such Transferred Employees shall cease to be employees of Seller and its Affiliates and shall cease any further participation in (and shall cease to accrue benefits under) Employee Benefit Plans, subject to the terms and conditions of the Employee Benefit Plans and Applicable Law.

(d) As of the expiration of the Employee Lease Term, in no event shall any Employee be entitled to accrue any benefits under the Employee Benefit Plans with respect to services rendered or compensation paid on or after the expiration of the Employee Lease Term, subject to the terms and conditions of the Employee Benefit Plans and Applicable Law.

(e) Notwithstanding anything in this Agreement to the contrary, any Transferred Employee who incurs a termination of employment during the 12-month period immediately following the expiration of the Employee Lease Term shall be entitled to receive severance payments and benefits that are no less favorable than the severance payments and benefits provided to similarly-situated employees of Purchaser or its Affiliates under the Purchaser severance plan as in effect immediately prior to the date hereof and set forth on Section 6.01(e) of the Seller Disclosure Schedule; provided , however, that in lieu of the thirty (30) day paid notice period applicable to similarly-situated employees of Purchaser, Transferred Employees will be entitled to a nine (9) week paid non-working period with benefits continuation during such period.

(f) Notwithstanding anything in this Agreement to the contrary, Purchaser or its Affiliate shall be solely responsible for all Liabilities arising from, related to or based upon the termination of any Employee who is terminated by Seller or its respective Affiliates on or after the expiration of the Employee Lease Term in the event such employee is not offered employment or service with Purchaser in accordance with the provisions of this Section 6.01. Purchaser or its Affiliate shall be solely responsible for providing all notices required under the Worker Adjustment and Retraining Notification Act, 29 U.S.C. § 2109 *et seq.* , or the regulations promulgated thereunder (the " WARN Act") (including comparable state, local or other Applicable Laws) and for taking all remedial measures, including, without limitation, the payment of all amounts, penalties, liabilities, costs and expenses if such notices are not provided, with respect to any obligations under the WARN Act (including comparable state, local or other Applicable Laws) arising out of or resulting from any termination of employment of any Transferred Employees by Purchaser and its Affiliates on or after the expiration of the Employee Lease Term.

(g) Purchaser shall cause its Affiliate to: (i) permit each Transferred Employee participating in each Employee Benefit Plan that is a defined contribution plan with a qualified cash or deferred arrangement within the meaning of Section 401(k) of the Code (the " Seller 401(k) Plan") to effect, and (ii) cause its defined contribution plan that includes a qualified cash

or deferred arrangement within the meaning of Section 401(k) of the Code (the " Purchaser 401(k) Plan") to accept, in accordance with Applicable Law, a "direct rollover" (within the meaning of Section 401(a)(31) of the Code) of his or her account balances (including earnings thereon through the date of transfer) under the Seller 401(k) Plan if such rollover to the Purchaser 401(k) Plan is elected in accordance with Applicable Law by such Transferred Employee.

(h) Subject to any reimbursement or other obligations of Purchaser or its Affiliates agreed upon pursuant to the Employee Leasing Agreement, Seller shall retain responsibility for all liabilities under and with respect to, and claims incurred under, the Employee Benefit Plans (including those relating to Transferred Employees and their covered dependents). Purchaser or its Affiliate shall be responsible for all liabilities under and with respect to, and claims incurred under, any employee benefit plans, programs, policies and arrangements maintained by Purchaser or its Affiliates (including those relating to Transferred Employees and their covered dependents).

(i) Unless Seller or one of its Affiliates is required under Applicable Law to make a payment in settlement of accrued paid time off of a Transferred Employee, (i) Purchaser or its Affiliate shall assume, recognize and provide each Transferred Employee up to forty (40) hours of the Transferred Employee's earned but unused paid time-off as of the expiration of the Employee Lease Term as determined under Seller's policy in effect as of the expiration of the Employee Lease Term and (ii) Seller or one of its Affiliates shall make a payment in settlement of accrued paid time off of any such Transferred Employee in excess of forty (40) hours in accordance with Seller's paid time off policy and Applicable Law.

(j) Purchaser or its Affiliate shall assume and pay, the accrued but unpaid annual cash bonuses with respect to performance in the calendar year ending December 31, 2017. In respect thereof, the following shall be accrued on the Initial Closing Statement: (i) accruals for ten-twelfths (10/12) of such annual cash bonuses, assuming maximum (140%) performance, and (ii) accruals representing the matching contribution that would have been made under Seller 401(k) Plan with respect to the bonus amounts accrued pursuant to Section 6.01(j)(i). In no event shall the amount of such payment by Purchaser to the Transferred Employees in the aggregate be less than the aggregate amount set forth with respect to such bonuses in the Initial Closing Statement as described in Section 6.01(j)(i).

(k) Purchaser shall, or shall cause one of its Affiliates to, make available to the Transferred Employees a flex spending account plan for medical and dependent care expenses under a new or existing plan established or maintained under Section 125 and Section 129 of the Code (the " Purchaser FSA"), effective as of the expiration of the Employee Lease Term and in accordance with this Section 6.01(k). If the Employee Lease Term ends after December 31, 2017, Purchaser, or one of its Affiliates, shall credit the applicable account under the Purchaser FSA of each Transferred Employee participating in the Seller Employee Benefit Plan maintained pursuant to Section 125 and Section 129 of the Code (the " Seller FSA") with an amount equal to the balance of such Transferred Employee's account under the Seller FSA immediately prior to the expiration of the Employee Lease Term, in accordance with the following:

(i) If the aggregate amount withheld from Transferred Employees' compensation under the Seller FSA for 2018 exceeds the aggregate amount of reimbursements paid to Transferred Employees prior to the expiration of the Employee Lease Term under the Seller FSA for claims incurred in 2018, Seller shall transfer (or cause to be transferred) to Purchaser within 30 days after the expiration of the Employee Lease Term a cash payment equal to such excess, if any.

(ii) If the aggregate amount of reimbursements paid to Transferred Employees prior to the expiration of the Employee Lease Term under the Seller FSA for claims incurred in 2018 exceeds the aggregate amount withheld from Transferred Employees' compensation under the Seller FSA for 2018 prior to the expiration of the Employee Lease Term, Purchaser shall transfer (or cause to be transferred) to Seller within 30 days after the expiration of the Employee Lease Term a cash payment equal to such excess, if any.

(iii) In each case, Purchaser shall assume and be solely responsible for all claims for reimbursement by Transferred Employees for 2018 that have not been paid in full as of the expiration of the Employee Lease Term, which claims shall be paid pursuant to and under the terms of the Purchaser FSA, and Purchaser shall indemnify and hold harmless Seller and its Affiliates from any and all claims by or with respect to Transferred Employees for reimbursement under the Seller FSA that have not been paid in full as of the expiration of the Employee Lease Term; provided, however, that the foregoing indemnification shall not apply to any claims that were adjudicated under the terms of the Seller FSA on or prior to the expiration of the Employee Lease Term. Purchaser agrees to cause the Purchaser FSA to honor through the end of the calendar year in which the Employee Lease Term expires the elections made by each Transferred Employee under the Seller FSA in respect of the flexible spending reimbursement accounts under the Purchaser FSA that are in effect immediately prior to the expiration of the Employee Lease Term, subject to each Transferred Employee's ability to adjust such elections pursuant to the terms of the Purchaser FSA. For the avoidance of doubt, except as provided herein, (A) in no event shall Seller or any of its Affiliates have any liability or obligation under the Purchaser FSA, and (B) any Transferred Employee who elects coverage under a high deductible health plan may be ineligible to make continuing elections under the Purchaser health care FSA pursuant to the terms of such plans.

For the avoidance of doubt, if the Employee Lease Term ends on December 31, 2017, Purchaser shall have no obligation to provide credits as described in this Section 6.01(k).

(l) In respect of each Employee who becomes a Transferred Employee, Seller and Purchaser shall adopt the "standard procedure" for preparing and filing IRS Forms W-2 (Wage

and Tax Statements), as described in Revenue Procedure 2004-53. Under this procedure, Purchaser, as successor employer, shall provide, as applicable, all required Forms W-2 to all Employees who become Transferred Employees reflecting only wages paid and Taxes withheld by Purchaser and its Affiliates as the successor employer. In addition, Seller and Purchaser shall adopt the "standard procedure" of Revenue Procedure 2004-53 for purposes of filing IRS Forms W-4 (Employee's Withholding Allowance Certificate) and W-5 (Earned Income Credit Advance Payment Certificate).

(m) Purchaser or one of its Affiliates shall grant during the first "open window" trading period following the expiration of the Employee Lease Term new awards, payable in cash or in stock (each, a " New Award"), vesting over two (2) years, to each Transferred Employee who, as a result of the transactions contemplated by this Agreement, forfeits restricted share units, performance share units or stock appreciation rights that were granted pursuant to any Employee Benefit Plan prior to the date hereof and are not vested as of the expiration of the Employee Lease Term (each, a " Seller Forfeited Equity Award"). The value of the New Awards will be no less than the value of the Seller Forfeited Equity Awards, both individually and in the aggregate. Seller shall provide Purchaser with a schedule of the value of each Seller Forfeited Equity Award as soon as practicable following the termination of the Employee Lease Term.

(n) Purchaser agrees to cause its Affiliate to (i) provide coverage for the Transferred Employees under its employee benefit plans as of the applicable Transfer Date, (ii) waive any preexisting conditions, waiting periods and actively at work requirements under such plans and (iii) cause such plans to honor any expenses incurred by the Transferred Employees and their beneficiaries under similar Employee Benefit Plans during the portion of the calendar year in which the Transfer Date occurs for purposes of satisfying applicable deductible, co-insurance and maximum out-of-pocket expenses. Transferred Employees shall be given credit under each employee benefit plan, program, policy or arrangement of Purchaser in which the Transferred Employees are eligible to participate for all service with Seller (to the extent such credit was given by the applicable Employee Benefit Plan) for all purposes (except that no benefit accrual will be provided under any defined benefit pension plans), except to the extent it would result in a duplication of benefits.

(o) The parties hereto shall coordinate with each other prior to the Closing Date as to the form and content of any material, broad based communication from Purchaser or any of its Affiliates to the Employees. Seller acknowledges, understands and agrees, on behalf of itself and its Affiliates, that Purchaser shall, from the date hereof, be allowed to approach and meet with all Employees. Seller and its Affiliates shall permit Purchaser reasonable access to all Employees; provided, that such access shall not interfere with the operations of the Business, and that when on Seller premises, Purchaser shall abide by any Seller security protocols. In no event shall Purchaser or any of its employees have access to the systems of Seller.

(p) Seller, Purchaser and their respective Affiliates shall promptly take all steps necessary to fulfill their obligations, and to cause their applicable employee benefit plans to fulfill the obligations that Seller and Purchaser have agreed to pursuant to this Section 6.01. All transfers of information required by this Section 6.01 shall be made at the time and in the manner (including applicable file format) as reasonably requested by Purchaser or its applicable vendor.

In furtherance thereof, Seller shall provide to Purchaser a complete employee data file, in the format and with the elements prescribed by Purchaser, no later than October 23, 2017.

(q) Seller shall be solely responsible for and shall discharge all retention bonuses under Business Employee Benefit Plans that become vested at or prior to the termination of the Employee Lease Term (" Seller Retention Bonus Liabilities").

Section 6.02. No Third Party Beneficiaries. Notwithstanding the provisions of this Article VI , this Article VI is not intended to and shall not (a) create any third party rights, (b) amend any Employee Benefit Plan or Business Employee Benefit Plan, (iii) require Purchaser or any of its Affiliates to continue any Business Employee Benefit Plan beyond the time when it otherwise lawfully could be terminated or modified, or (d) require Purchaser or any of its Affiliates to continue to employ any Transferred Employee for any specified period, or (e) provide any Transferred Employee with any rights to continued employment, severance pay or similar benefits following any termination of employment.

ARTICLE VII.

TAX MATTERS

Section 7.01. Allocation of Consideration. In addition to the allocation of the Purchase Price contemplated by Article II , Seller and Purchaser shall further allocate the Purchase Price, as finally determined pursuant to Article II , and any other applicable consideration (the " Allocable Amount") in accordance with the requirements of Section 1060 of the Code (and the regulations promulgated thereunder) for all Tax purposes; provided that such allocation for Tax purposes shall be consistent with the allocation of the Purchase Price as contemplated by Article II. As soon as practicable following the date on which the Final Closing Statement becomes final and binding on the parties pursuant to Section 2.09(f) , Seller shall prepare a schedule reflecting the allocation of the Allocable Amount and shall submit such allocation to Purchaser for review. Purchaser and Seller shall use commercially reasonable efforts to agree on the amount and proper allocation of the Allocable Amount in accordance with Section 1060 of the Code. If Seller and Purchaser have not agreed on the allocation within 90 calendar days after the date on which the Final Closing Statement become final and binding on the parties pursuant to Section 2.09(f) , then Purchaser and Seller shall each have the right to deliver notice to the other party of its intent to refer the matter for resolution to the Independent Accountant. Purchaser and Seller will each deliver to the other and to the Independent Accountant a notice setting forth in reasonable detail their proposed allocations. Within 30 days after receipt thereof, the Independent Accountant will deliver the allocation schedule and provide a written description of the basis for its determination of the allocations therein (such allocations, whether agreed to by Purchaser and Seller or determined by the Independent Accountant (the " Final Allocation") shall be final, binding and conclusive on Purchaser and Seller and the parties will report, and will cause their respective Affiliates to report, the federal, state, local and other Tax consequences of the transactions, including the filing of Internal Revenue Service Form 8594, in a manner consistent with such Final Allocation). One-half of all fees, costs and expenses of retaining the Independent Accountant shall be borne by Seller and one-half of such fees, costs and expenses of retaining the Independent Accountant shall be borne by Purchaser. Each party will bear the costs of its own counsel, witnesses (if any) and employees.

Section 7.02. Transfer Taxes. Any Transfer Taxes shall be borne fifty percent (50%) by Seller and fifty percent (50%) by Purchaser. Seller and Purchaser shall cooperate in (a) determining the amount of Transfer Taxes, (b) obtaining any relief, exemption or refund of any such Transfer Tax, (c) preparing and timely filing any and all required Tax Returns for or with respect to such Transfer Taxes with any and all appropriate Tax authorities, (d) promptly providing the other party with evidence that such Transfer Taxes have been paid, and (e) promptly reimbursing the other party for fifty percent (50%) of such Transfer Taxes, as applicable. " Transfer Taxes" means any and all sales, use, stamp, documentary, filing, recording, transfer, goods and services, provincial sales, harmonized sales, excise, real estate, stock transfer, intangible property transfer, personal property transfer, gross receipts, registration, securities transactions, conveyance and notarial Taxes, and similar fees, Taxes and governmental charges (together with any interest, penalty, addition to Tax, and additional amount imposed in respect thereof) arising out of or in connection with the transactions contemplated by this Agreement.

Section 7.03. Cooperation and Exchange of Information. Seller and Purchaser shall provide each other with such cooperation and information as either of them or their respective Affiliates may reasonably request of the other in filing any Tax Return, amended Tax Return or claim for Tax refund, determining a liability for Taxes or a right to a Tax refund, or participating in or conducting any contest in respect of Taxes (a " Tax Contest"). Such cooperation and information shall include providing copies of relevant Tax Returns or portions thereof, together with accompanying schedules, related work papers and documents relating to rulings or other determinations by Tax Authorities. Each party and its Affiliates shall make its employees available on a basis mutually convenient to both parties to provide explanations of any documents or information provided hereunder. Each of Seller and Purchaser shall retain all Tax Returns, schedules and work papers, records and other documents in its possession relating to Tax matters of the Business for each Tax period first ending after the Closing Date and for all prior Tax periods until the later of (i) the expiration of the statute of limitations of the Tax period to which such Tax Returns and other documents relate, without regard to extensions except to the extent notified in writing of such extensions for the respective Tax periods, and (ii) three years following the due date (without extension) for such Tax Returns. Any information obtained under this Section 7.03 shall be kept confidential except as otherwise may be necessary in connection with the filing of Tax Returns or claims for Tax refunds or in conducting a contest or as otherwise may be required by Applicable Law or the rules of any stock exchange. Seller shall promptly notify Purchaser if, as a result of the amendment of any Tax Return, any claim or assessment by any Tax authority or any other cause, the Tax reserves in respect of the Ceded Insurance Contracts no longer accurately reflect the reserves maintained by Seller, the Ceding Company of any of its Affiliates as of the Closing Date (immediately prior to the Closing) with respect to the Ceded Insurance Contracts, and shall provide Purchaser updated information of such reserves. Upon receipt of such information, Purchaser shall provide Seller with a revised Purchase Price allocation in accordance with the principles of Section 7.01.

Section 7.04. Miscellaneous. Seller and Purchaser agree to treat all payments (other than interest on a payment) made by either of them to or for the benefit of the other or the other's Affiliates under this Article VII and under other indemnity provisions of this Agreement as adjustments to the Purchase Price for Tax purposes and that such treatment shall govern for purposes hereof to the extent permissible under Applicable Law.

ARTICLE VIII.

CONDITIONS TO CLOSING

Section 8.01. Conditions to Obligations of Each Party.

The respective obligations of each party hereto to consummate the transactions contemplated by this Agreement shall be subject to the fulfillment or waiver, at or prior to the Closing, of each of the following conditions:

(a) Governmental Consents and Approvals. All consents, approvals, or authorizations of, declarations or filings with, or notices to, any Governmental Authority in connection with the transactions contemplated hereby that are set forth in Section 8.01(a) of the Seller Disclosure Schedule shall have been obtained or made and shall be in full force and effect, and all waiting periods required under Applicable Law with respect thereto shall have expired or been terminated, in each case without the imposition of a Burdensome Condition with respect to the party asserting the failure of this condition.

(b) No Injunction or Illegality. There shall be no law or Governmental Order in existence that prohibits the consummation of the transactions contemplated by this Agreement.

(c) Reinsurance Consents. Seller shall have received the Munich Consent and the Hannover Consent.

Section 8.02. Conditions to Obligations of Purchaser.

The obligations of Purchaser under this Agreement are subject to the satisfaction on or prior to the Closing Date of the following conditions, any one or more of which may be waived by Purchaser to the extent permitted by Applicable Law:

(a) Representations and Warranties. (i) Each of the Seller Specified Representations that are qualified by materiality or Material Adverse Effect shall be true and correct in all respects, and each of the other Seller Specified Representations that are not so qualified shall be true and correct in all material respects and (ii) each of the representations and warranties of Seller contained in Article III of this Agreement (other than those referenced in subclause (i) above) shall be true and correct in all respects (without regard to materiality or Material Adverse Effect qualifiers), in each case as of the Closing Date with the same force and effect as though made on and as of the Closing Date (except to the extent that any such representations and warranties are given as of a particular date and relate solely to a particular date or period, which representations and warranties shall be true and correct as of such date or period), except in the case of clause (ii) above where the failure to be true and correct would not have, individually or in the aggregate, a Material Adverse Effect.

(b) Covenants. Seller and its Affiliates shall have performed and complied in all material respects with all covenants and agreements required by this Agreement to be performed or complied with by Seller and its Affiliates on or prior to the Closing Date.

(c) Closing Deliverables. Seller shall have delivered or caused to be delivered to Purchaser each of the documents required to be delivered by Seller pursuant to Section 2.08(a).

Section 8.03. Conditions to Obligations of Seller. The obligations of Seller under this Agreement are subject to the satisfaction on or prior to the Closing Date of the following conditions, any one or more of which may be waived by Seller to the extent permitted by Applicable Law:

(a) Representations and Warranties. (i) Each of the Purchaser Specified Representations that are qualified by materiality or Purchaser Material Adverse Effect shall be true and correct in all respects, and each of the other Purchaser Specified Representations that are not so qualified shall be true and correct in all material respects and (ii) each of the representations and warranties of Purchaser contained in Article IV of this Agreement (other than those referenced in subclause (i) above) shall be true and correct in all respects (without regard to materiality or Purchaser Material Adverse Effect qualifiers), in each case as of the Closing Date with the same force and effect as though made on and as of the Closing Date (except to the extent that any such representations and warranties are given as of a particular date and relate solely to a particular date or period, which representations and warranties shall be true and correct as of such date or period), except in the case of clause (ii) above where the failure to be true and correct would not have, individually or in the aggregate, a Purchaser Material Adverse Effect.

(b) Covenants. Purchaser shall have performed and complied in all material respects with all covenants and agreements required by this Agreement to be performed or complied with by Purchaser on or prior to the Closing Date.

(c) Triggering Event. Assuming for the purposes of this Section 8.03(c) that the Reinsurance Agreement is in full force and effect at all applicable times prior to the Closing, there shall not have been a Triggering Event (as defined in the Reinsurance Agreement) under the Reinsurance Agreement.

(d) Closing Deliverables. Purchaser shall have delivered or caused to be delivered to Seller each of the documents required to be delivered by Purchaser pursuant to Section 2.08(b).

ARTICLE IX.

TERMINATION PRIOR TO CLOSING

Section 9.01. Termination of Agreement. This Agreement may be terminated at any time prior to the Closing:

(a) by Seller or Purchaser in writing, if there shall be any order, injunction or decree of any Governmental Authority which prohibits or restrains the parties from consummating the transactions contemplated hereby, and such order, injunction or decree shall have become final and nonappealable; provided that prior to termination under this Section 9.01(a) , the party seeking to terminate this Agreement shall have used best efforts to have such order, injunction or decree vacated;

(b) by either Seller or Purchaser in writing, if the Closing has not occurred on or before February 1, 2018 (as it may be extended as contemplated below or by Section 11.14 , the " Outside Date"), unless the failure of the Closing to occur is the result of a breach of this Agreement by the party seeking to terminate this Agreement; provided that, if on the Outside Date the condition set forth in Section 8.01(a) has not been satisfied then, upon the written notice of Seller to Purchaser, the Outside Date shall be extended to a date and time that is not later than 5:00 p.m., New York City time, on March 31, 2018;

(c) by either Seller or Purchaser (but only so long as Seller or Purchaser, as applicable, is not in material breach of its obligations under this Agreement) in writing, if a material breach of any provision of this Agreement that has been committed by the other party would cause the failure of any mutual condition to Closing or any condition to Closing for the benefit of the non-breaching party and such breach is not subsequently waived by the non-breaching party or capable of being cured or is not cured within 20 Business Days after the breaching party receives written notice from the non-breaching party that the non-breaching party intends to terminate this Agreement pursuant to this Section 9.01(c);

(d) by Seller if, (i) except for the condition in Section 8.03(c) , all of the conditions set forth in Section 8.01 , Section 8.02 and Section 8.03 have been satisfied or waived (other than those conditions that by their terms are to be satisfied at the Closing, so long as such conditions are capable of being satisfied at the Closing) and (ii) the Closing has not occurred at the then most recent date on which it was otherwise required to occur pursuant to Section 2.06 because the condition set forth in Section 8.03(c) has not been satisfied; or

(e) at any time on or prior to the Closing Date, by mutual written consent of Seller and Purchaser.

Section 9.02. Termination Procedure. In the event of termination by Purchaser or Seller pursuant to Section 9.01 , written notice thereof shall forthwith be given to the other party and the transactions contemplated by this Agreement shall be terminated, without further action by any party. If the transactions contemplated by this Agreement are terminated as provided herein:

(a) Each party shall, and shall cause its Representatives to, return all documents and other material received from the other party and its Affiliates relating to the transactions contemplated hereby, whether so obtained before or after the execution hereof, to the other party; and

(b) all information received by Purchaser or any of its Representatives with respect to the Business shall be treated in accordance with the Confidentiality Agreement and Section 5.04.

Section 9.03. Survival. In the event of the termination of this Agreement as provided in Section 9.01 , this Agreement shall thereafter become null and void as to all parties, and no party hereto shall have any liability to any other party hereto or their respective Representatives, except as set forth in Section 5.04 , this Article IX and Article XI , which shall survive the termination hereof pursuant to this Article IX; provided , however , that nothing in this Agreement shall relieve any party hereto from liability for (x) any willful and material breach of this Agreement prior to such termination or (y) fraud in the event that such party is finally

determined by a court of competent jurisdiction to have willfully and knowingly committed a fraud, with specific intent to deceive and mislead any other party, regarding such party's representations, warranties, covenants or other agreements set forth in this Agreement; provided , further , that any claim for fraud may only be brought against the party that committed such fraud. For purposes hereof, "willful and material breach" means a material breach by a party of the applicable provision of this Agreement as a result of an action or failure to act by such Person that it actually knew would result in a breach of this Agreement.

ARTICLE X.

INDEMNIFICATION

Section 10.01. Survival.

(a) The representations and warranties of Seller and Purchaser contained in this Agreement shall survive the Closing solely for purposes of this Article X and shall terminate and expire on the date that is 18 months following the Closing Date; provided , that the Seller Specified Representations and the Purchaser Specified Representations and the representations and warranties of Seller set forth in Section 3.17 shall survive until the date that is 60 days following the expiration of the applicable statute of limitations and the representations and warranties of Seller set forth in Section 3.18(d) or Section 3.19 will terminate and be of no further force and effect from and after the Closing. Any claim for indemnification in respect of any representation or warranty that is not asserted by notice given as required herein prior to the expiration of the specified period of survival shall not be valid and any right to indemnification is hereby irrevocably waived after the expiration of such period of survival. Any claim properly made for an Indemnifiable Loss in respect of such a breach asserted within such period of survival as herein provided will be timely made for purposes hereof.

(b) To the extent that it is to be performed after the Closing, each covenant in this Agreement will, for purposes of this Article X , survive and remain in effect in accordance with its terms plus a period of six months thereafter, after which no claim for indemnification with respect thereto may be brought hereunder. All covenants in this Agreement that by their terms are required to be fully performed prior to the Closing will, for purposes of this Article X , survive and remain in effect until the date that is 18 months following the Closing Date, after which time no claim for indemnification with respect thereto may be brought hereunder; provided , however , that the covenants set forth in Section 5.11 will terminate and be of no further force and effect from and after the Closing.

Section 10.02. Indemnification.

(a) Seller shall indemnify, defend and hold harmless Purchaser, its Affiliates and their respective directors, officers and employees, successors and, in connection with a sale of all or substantially all of the group benefits business of Purchaser and its Affiliates, assignees (provided , that in the case of any such sale during the 18-month period after the Closing, Seller shall have provided its consent to such assignment) (collectively, the " Purchaser Indemnified Persons") from and against any and all Indemnifiable Losses asserted against, imposed upon or incurred or suffered by any Purchaser Indemnified Person resulting from or arising out of:

(i) any inaccuracy in or breach of any representation or warranty of Seller made in this Agreement;

(ii) any breach or non-fulfillment of any agreement or covenant of Seller under this Agreement; or

(iii) any Excluded Liabilities including Excluded Taxes.

(b) Purchaser shall indemnify, defend and hold harmless Seller, its Affiliates and their respective directors, officers and employees (collectively, the " Seller Indemnified Persons") from and against any and all Indemnifiable Losses asserted against, imposed upon or incurred or suffered by any Seller Indemnified Person resulting from or arising out of:

(i) any inaccuracy in or breach of any representation or warranty of Purchaser made in this Agreement;

(ii) any breach or non-fulfillment of any agreement or covenant of Purchaser under this Agreement;

(iii) any Assumed Liability; or

(iv) the operation of the Business from and after the Closing Date (except to the extent such Indemnifiable Loss is subject to indemnification by Seller of a Purchaser Indemnified Person pursuant to Section 10.02(a)).

(c) For purposes of determining whether any representation and warranty (other than the representations and warranties set forth in Section 3.06(a) and Section 3.22) has any inaccuracy or been breached and the amount of any Indemnifiable Losses under this Article X , each representation and warranty contained in this Agreement shall be read without regard to any materiality or Material Adverse Effect qualifier contained therein.

Section 10.03. Certain Limitations.

(a) Except with respect to Indemnifiable Losses resulting from Excluded Taxes or from any inaccuracy in or breach of a representation or warranty set forth in Section 3.17 , no party shall be obligated to indemnify and hold harmless its respective Indemnitees under Section 10.02(a)(i) (in the case of Seller, and other than with respect to an inaccuracy in or breach of any Seller Specified Representation) or Section 10.02(b)(i) (in the case of Purchaser, and other than with respect to an inaccuracy in or breach of any Purchaser Specified Representation) (i) with respect to any claim or series of claims arising out of substantially similar facts and circumstances, unless such claim or series of claims involves Indemnifiable Losses in excess of $100,000 (the " Threshold Amount") (nor shall any claim that does not exceed the Threshold Amount be applied to or considered for purposes of calculating the amount of Indemnifiable Losses for which the Indemnitor is responsible under clause (ii) below) and (ii) unless and until the aggregate amount of all Indemnifiable Losses of the Indemnitees under Section 10.02(a)(i) or such Section 10.02(b)(i) , as the case may be, exceeds $14,500,000 for all Indemnifiable Losses (the " Deductible"), at which point such Indemnitor shall be liable to its respective Indemnitees for the value of the Indemnitee's claims under Section 10.02(a)(i) (other than with respect to a

breach of any Seller Specified Representation) or Section 10.02(b)(i) (other than with respect to a breach of any Purchaser Specified Representation), as the case may be, that is in excess of the Deductible, subject to the limitations set forth in this Article X; provided , however , that any Indemnifiable Losses of the Purchaser Indemnified Persons resulting from or arising out of any inaccuracy in or breach of any representation or warranty set forth in Section 3.03 shall not be subject to the Deductible, and the Threshold Amount for such Indemnifiable Losses shall be $50,000; provided further that, for the avoidance of doubt, any such Indemnifiable Losses shall be subject to the Threshold Amount and the maximum aggregate liability set forth in the following sentence prior to the proviso set forth therein. The maximum aggregate liability of Seller, on the one hand, and Purchaser on the other hand, to their respective Indemnitees for any and all Indemnifiable Losses under Section 10.02(a)(i) , in the case of Seller (other than with respect to a breach of any Seller Specified Representation), or Sections 10.02(b)(i) , in the case of Purchaser (other than with respect to a breach of any Purchaser Specified Representation), shall be $174,000,000; provided , that the maximum aggregate liability of Seller to all Purchaser Indemnified Persons for any or all Indemnifiable Losses under this Agreement shall not exceed the Purchase Price. The limitations in this Section 10.03(a) shall not apply to claims made under Section 10.02(a)(iii) , Section 10.02(b)(iii) or Section 10.02(b)(iv).

(b) Each Indemnitee shall use commercially reasonable efforts to mitigate all Indemnifiable Losses for which indemnification may be sought hereunder; provided that the costs and expenses of such mitigation shall constitute Indemnifiable Losses hereunder.

(c) Notwithstanding anything to the contrary herein, any Indemnifiable Losses resulting from or arising out of any breach of any representation or warranty of Seller made in this Agreement in respect of Taxes, including under Section 3.17 , shall be limited to Taxes attributable to Pre-Closing Periods.

Section 10.04. Definitions. As used in this Agreement:

(i) "Indemnitee" means any Person entitled to indemnification under this Agreement;

(ii) "Indemnitor" means any Person required to provide indemnification under this Agreement;

(iii) "Indemnifiable Losses" means any and all damages, losses, Liabilities, obligations, costs and expenses (including reasonable attorneys' and other professional fees and expenses); provided , that any Indemnity Payment (x) shall in no event include any amounts constituting consequential or punitive damages, or any damages calculated based on a loss of future revenue, income or profits, relating to the breach or alleged breach of this Agreement; provided , however , that notwithstanding the foregoing or anything to the contrary contained in this Agreement, Indemnifiable Losses shall include recoveries for lost profits (including diminution in value used by a trier of fact in determining lost profits) if and only if (A) such damages for lost profits are recoverable under the laws of the State of New York; (B) the Indemnitee satisfies all elements necessary for proof of

such damages for lost profits under such laws; and (C) such lost profits can be demonstrated by reference to the Actuarial Report and, with respect to the reduction or elimination of any profits contemplated by the Actuarial Report, shall in no event exceed the present value ascribed to any such remaining profits contemplated by the Actuarial Report as of the date of the Indemnifiable Loss giving rise to the related claim, calculated based on the assumptions on which the Actuarial Report was prepared and discounted using a 9% discount rate; provided , further , that the Purchaser Indemnified Persons may recover lost profits only to the extent such lost profits are attributable to the Business; and (y) shall be net of any amounts actually recovered by the Indemnitee for the Indemnifiable Losses for which such Indemnity Payment is made under any insurance policy, reinsurance agreement, warranty or indemnity or otherwise from any Person other than a party hereto (net of any actual costs, expenses or increases in premiums incurred as a result of obtaining such proceeds), and the Indemnitee shall promptly reimburse the Indemnitor for any such amount that is received by it from any such other Person with respect to an Indemnifiable Losses after any indemnification with respect thereto has actually been paid pursuant to this Agreement;

(iv) "Indemnity Payment" means any amount of Indemnifiable Losses required to be paid pursuant to this Agreement; and

(v) "Third Party Claim" means any claim, action, suit, or proceeding made or brought by any Person that is not a party to this Agreement and not an Affiliate of such party to this Agreement.

Section 10.05. Procedures for Third Party Claims.

(a) If any Indemnitee receives notice of assertion or commencement of any Third Party Claim against such Indemnitee in respect of which an Indemnitor may be obligated to provide indemnification under this Agreement, the Indemnitee shall give such Indemnitor reasonably prompt written notice (but in no event later than 30 days after becoming aware of such Third Party Claim) thereof and such notice shall include a reasonable description of the claim based on the facts known at the time and any documents relating to the claim and an estimate of the Indemnifiable Loss and shall reference the specific sections of this Agreement that form the basis of such claim to the extent reasonably ascertainable; provided , that no delay on the part of the Indemnitee in notifying any Indemnitor shall relieve the Indemnitor from any obligation hereunder unless (and then solely to the extent that) the Indemnitor is actually prejudiced by such delay (except that the Indemnitor shall not be liable for any expenses incurred during the period in which the Indemnitee failed to give such notice). Thereafter, the Indemnitee shall deliver to the Indemnitor, within five Business Days after the Indemnitee's receipt thereof, copies of all notices and documents (including court papers) received by the Indemnitee relating to the Third Party Claim.

(b) The Indemnitor shall be entitled to participate in the defense of any Third Party Claim and, if it so chooses, to assume the defense thereof with counsel selected by the

Indemnitor. Should the Indemnitor so elect to assume the defense of a Third Party Claim, the Indemnitor shall not as long as it conducts such defense be liable to the Indemnitee for legal expenses incurred by the Indemnitee in connection with the defense thereof subsequent to the Indemnitor notifying the Indemnitee in writing of its election to assume such defense. If the Indemnitor assumes such defense, the Indemnitee shall have the right to participate in the defense thereof and to employ counsel, at its own expense, separate from the counsel employed by the Indemnitor, it being understood that the Indemnitor shall control such defense. The Indemnitor shall be liable for the reasonable fees and expenses of counsel employed by the Indemnitee (A) for any period during which the Indemnitor has not assumed the defense thereof (other than during any period in which the Indemnitee shall have not yet given notice of the Third Party Claim as provided above) or (B) if the Third Party Claim involves conflicts of interest for the Indemnitee and the Indemnitor (in the reasonable opinion of counsel to the Indemnitee) that would make representation by the same counsel inappropriate, in which event the Indemnitor shall be responsible for only one counsel for the Indemnitee. If the Indemnitor chooses to defend any Third Party Claim, the other party hereto shall cooperate in the defense thereof. Such cooperation shall include the retention and (upon the Indemnitor's request) the provision to the Indemnitor of records and information that are relevant to such Third Party Claim, and making employees available on a mutually convenient basis to provide additional information and explanation of any material provided hereunder; provided , in each case, that such other party shall not be obligated to provide such records, information or access to Indemnitor if doing so would violate Applicable Law or jeopardize the protection of an attorney-client privilege. Whether or not the Indemnitor shall have assumed the defense of a Third Party Claim, the Indemnitee shall not admit any liability with respect to, or pay, settle, compromise or discharge, such Third Party Claim without the Indemnitor's prior written consent (which consent shall not be unreasonably withheld, conditioned or delayed). If the Indemnitor has assumed the defense of a Third Party Claim, the Indemnitor may only pay, settle, compromise or discharge a Third Party Claim with the Indemnitee's prior written consent (which consent shall not be unreasonably withheld, conditioned or delayed); provided , that the Indemnitor may pay, settle, compromise or discharge such a Third Party Claim without the written consent of the Indemnitee if such settlement (i) includes a release of the Indemnitee from all Liability in respect of such Third Party Claim, (ii) does not subject the Indemnitee to any injunctive relief or other equitable remedy, (iii) does not include a statement or admission of fault, culpability or failure to act by or on behalf of the Indemnitee and (iv) does not impose any financial cost on the Indemnitee (other than by application of the limitations set forth in Section 10.03(a)). If the Indemnitor submits to the Indemnitee a bona fide settlement offer with respect to a Third Party Claim that has been accepted by all Persons bringing such Third Party Claim and otherwise satisfies the requirements set forth in the proviso of the immediately preceding sentence and the Indemnitee refuses to consent to such settlement, then thereafter the Indemnitor's liability to the Indemnitee with respect to such Third Party Claim shall not exceed the Indemnitor's portion of the settlement amount included in such settlement offer.

(c) Notwithstanding anything in this Agreement to the contrary, Seller shall have the sole right to represent the interests of the Business and settle all issues in its sole discretion, and to employ counsel of its choice at its expense, in any audit or other examination or administrative or court proceeding relating to Taxes for all taxable periods (or portions thereof) ending on or before the Closing Date; provided , that Seller shall not pay, discharge, settle, compromise, litigate or otherwise dispose of any item subject to such Tax proceedings in a manner that will

adversely affect Purchaser or any of its Affiliates without obtaining the prior written consent of Purchaser, which consent shall not be unreasonably withheld, conditioned or delayed. Notwithstanding the foregoing and subject to Seller's rights set forth in the immediately preceding sentence, Purchaser shall be entitled, at its expense, to participate in the conduct of any Tax audit and any judicial or administrative proceeding relating to any such Tax audit that may adversely affect Purchaser or any of its Affiliates.

Section 10.06. Direct Claims. The Indemnitor will have a period of 30 days within which to respond in writing to any claim by an Indemnitee on account of an Indemnifiable Loss that does not result from a Third Party Claim. If the Indemnitor does not so respond within such 30 day period, the Indemnitor will be deemed to have rejected such claim, in which event the Indemnitee will be entitled to pursue such remedies as may be available to the Indemnitee.

Section 10.07. Sole Remedy. The parties hereto acknowledge and agree that, except as (a) set forth in Section 11.14 , (b) as expressly contemplated by Section 2.09 , (c) for any remedy expressly contemplated by any other Transaction Agreement with respect to a claim made under such Transaction Agreement and (d) under the circumstances described in Section 9.03(y) , if the Closing occurs, their sole and exclusive remedy following the Closing with respect to any and all claims arising out of or related to the transactions contemplated by this Agreement shall be pursuant to the provisions set forth in this Article X.

Section 10.08. Certain Other Matters.

(a) Upon making any Indemnity Payment, Indemnitor will, to the extent of such Indemnity Payment, be subrogated to all rights of Indemnitee against any third Person (other than any Tax Authority) in respect of the Indemnifiable Loss to which the Indemnity Payment related. Without limiting the generality or effect of any other provision hereof, each such Indemnitee and Indemnitor will duly execute upon request all instruments reasonably necessary to evidence and perfect the above-described subrogation rights.

(b) The rights and remedies of any party in respect of any inaccuracy or breach of any representation, warranty, covenant or agreement shall in no way be limited by the fact that the act, omission, occurrence or other state of facts or circumstances upon which any claim of any such inaccuracy or breach is based may also be the subject matter of any other representation, warranty, covenant or agreement as to which there is no inaccuracy or breach. The representations, warranties and covenants of Seller set forth herein (as such representations and warranties are qualified in accordance with the introductory paragraph of Article III), and the Purchaser Indemnified Persons' rights to indemnification with respect thereto, shall not be affected or deemed waived by reason of (and the Purchaser Indemnified Persons shall be deemed to have relied upon such representations and warranties notwithstanding) (i) any investigation made by or on behalf of any of the Purchaser Indemnified Persons (including by any of its Representatives) or by reason of the fact that any of the Purchaser Indemnified Persons or any of such Representatives knew or should have known that any such representation or warranty is, was or might be inaccurate, regardless of whether such investigation was made or such knowledge was obtained before or after the execution and delivery of this Agreement or (ii) Purchaser's waiver of any condition set forth in Article VIII. The representations, warranties and covenants of Purchaser set forth herein (as such representations and warranties are qualified

in accordance with the introductory paragraph of Article IV), and the Seller Indemnified Persons' rights to indemnification with respect thereto, shall not be affected or deemed waived by reason of (and the Seller Indemnified Persons shall be deemed to have relied upon such representations and warranties notwithstanding) (i) any investigation made by or on behalf of any of the Seller Indemnified Persons (including by any of its Representatives) or by reason of the fact that any of the Seller Indemnified Persons or any of such Representatives knew or should have known that any such representation or warranty is, was or might be inaccurate, regardless of whether such investigation was made or such knowledge was obtained before or after the execution and delivery of this Agreement or (ii) Seller's waiver of any condition set forth in Article VIII.

ARTICLE XI.

GENERAL PROVISIONS

Section 11.01. Publicity. Except as may otherwise be required by Applicable Law, regulation or obligation pursuant to any listing agreement with any national securities exchange, no press release or public announcement, including any presentation to the investment community (other than pro forma financial statements and dilution or accretion analyses included in shareholder presentations), concerning this Agreement or the transactions contemplated hereby shall be made by Seller, on the one hand, or Purchaser, on the other hand, prior to the Closing Date without advance approval thereof by the other party, such approval not to be unreasonably withheld. The parties hereto shall cooperate with each other in making any press release or public announcement concerning the Business on or prior to the Closing Date.

Section 11.02. Expenses. Regardless of whether any or all of the transactions contemplated by this Agreement are consummated, and except as otherwise expressly provided herein or in any Transaction Agreement, Purchaser and its Affiliates, on the one hand, and Seller and its Affiliates, on the other hand, shall each bear their respective direct and indirect fees, costs and expenses incurred in connection with the negotiation and preparation of this Agreement, the Transaction Agreements and the consummation of the transactions contemplated hereby or thereby, including all fees and expenses of their respective Representatives.

Section 11.03. Notices. All notices, requests, consents, claims, demands and other communications under this Agreement and the other Transaction Agreements shall be in writing and shall be given or made (and shall be deemed to have been duly given or made upon receipt) by delivery in person, by overnight courier service, by electronic mail (followed by delivery of an original via overnight courier service) or by registered or certified mail (postage prepaid, return receipt requested) to the respective parties hereto at the following respective addresses (or at such other address for a party hereto as shall be specified in a notice given in accordance with this Section 11.03):

(a) If to Purchaser:

Hartford Life and Accident Insurance Company
c/o The Hartford Financial Services Group, Inc.

One Hartford Plaza
Hartford, CT 06155
Attention: Chief Financial Officer, General Counsel
Facsimile: (855) 388-6397
Email address: beth.bombara@thehartford.com,
david.robinson@thehartford.com

With a concurrent copy (which shall not constitute notice) to:

Mayer Brown LLP
1221 Avenue of the Americas
New York, NY 10020
Attention: Stephen G. Rooney, David W. Alberts
Facsimile: (212) 849-5632; (212) 849-5611
Email address: srooney@mayerbrown.com;
dalberts@mayerbrown.com

(b) If to Seller:
Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156
Attention: General Counsel
Facsimile: (212) 457-0301

With a concurrent copy (which shall not constitute notice) to:

Willkie Farr & Gallagher LLP
787 Seventh Avenue
New York, NY 10019
Attention: Michael Groll
Rajab S. Abbassi
Facsimile: (212) 728-8111
Email address: mgroll@willkie.com
rabbassi@willkie.com

Any party may, by notice given in accordance with this Section 11.03 to the other parties, designate another address or person for receipt of notices hereunder, provided that notice of such a change shall be effective upon receipt.

Section 11.04. Entire Agreement. Except as otherwise expressly provided in the Transaction Agreements, this Agreement and the other Transaction Agreements constitute the entire agreement of the parties hereto with respect to the subject matter of the Transaction Agreements and supersede all prior agreements and undertakings, both written and oral, other than the Confidentiality Agreement to the extent not in conflict with this Agreement, between or on behalf of Seller and its Affiliates, on the one hand, and Purchaser and its Affiliates, on the other hand, with respect to the subject matter of the Transaction Agreements.

Section 11.05. Severability. If any term or other provision of this Agreement is invalid, illegal or incapable of being enforced under any Applicable Law or as a matter of public policy, all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect so long as the economic or legal substance of the transactions contemplated by this Agreement is not affected in any manner materially adverse to any party hereto. Upon such determination that any term or other provision is invalid, illegal or incapable of being enforced, the parties hereto shall negotiate in good faith to modify this Agreement so as to effect the original intent of the parties hereto as closely as possible in a mutually acceptable manner in order that the transactions contemplated by this Agreement be consummated as originally contemplated to the greatest extent possible. If any provision of this Agreement is determined by a court of competent jurisdiction to be so broad as to be unenforceable, that provision shall be interpreted to be only so broad as it is enforceable.

Section 11.06. Assignment. This Agreement may not be assigned, in whole or in part, by operation of law or otherwise without the prior written consent of the parties hereto. Any attempted assignment in violation of this Section 11.06 shall be void. This Agreement shall be binding upon, shall inure to the benefit of, and shall be enforceable by the parties hereto and their successors and permitted assigns.

Section 11.07. Waivers and Amendments. No provision of this Agreement or any other Transaction Agreements may be amended, supplemented or modified except by a written instrument signed by all of the parties thereto. No provision of this Agreement or any other Transaction Agreements may be waived except by a written instrument signed by the party against whom the waiver is to be effective.

Section 11.08. Disclosure Schedules. Matters reflected in any Section of this Agreement, including any section or subsection of the Seller Disclosure Schedule or Purchaser Disclosure Schedule, are not necessarily limited to matters required by this Agreement to be so reflected. Such additional matters are set forth for informational purposes and do not necessarily include other matters of a similar nature. No reference to or disclosure of any item or other matter in any Section or Schedule of this Agreement, including any section or subsection of the Seller Disclosure Schedule or Purchaser Disclosure Schedule, shall be construed as an admission or indication that such item or other matter is material or that such item or other matter is required to be referred to or disclosed in this Agreement, the Seller Disclosure Schedule or Purchaser Disclosure Schedule. Without limiting the foregoing, no such reference to or disclosure of a possible breach or violation of any contract, Applicable Law or Governmental Order shall be construed as an admission or indication that breach or violation exists or has actually occurred.

Section 11.09. Governing Law; Submission to Jurisdiction; Waiver of Jury Trial.

(a) THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF NEW YORK WITHOUT REGARD TO SUCH STATE'S PRINCIPLES OF CONFLICT OF LAW THAT COULD COMPEL THE APPLICATION OF THE LAWS OF ANOTHER JURISDICTION.

(b) Each party hereto irrevocably and unconditionally submits to the exclusive jurisdiction of any federal court located in New York County in the State of New York, over any

action, suit or proceeding arising out of or relating to this Agreement or the transactions contemplated hereby; provided , however , that, if said court determines that it does not have subject matter jurisdiction, then said action, suit or proceeding may be brought in the Supreme Court of the State of New York for New York County. Each party hereto agrees that service of any process, summons, notice or document by U.S. registered mail addressed to such party shall be effective service of process for any action, suit or proceeding brought against such party in any such court. Purchaser hereby designates the individual listed in Section 11.03(a) to whom notice may be given on behalf of Purchaser as its true and lawful agent upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of Seller. Seller hereby designates the individual listed in Section 11.03(b) to whom notice may be given on behalf of Seller as its true and lawful agent upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of Purchaser. In the event either party decides to change its designation of agent, it shall provide written notice to the other party. Each party hereto irrevocably and unconditionally waives any objection to the laying of venue of any such action, suit or proceeding brought in any such court and any claim that any such action, suit or proceeding brought in any such court has been brought in an inconvenient forum. Each party hereto agrees that any final, nonappealable judgment in any such action, suit or proceeding brought in any such court shall be conclusive and binding upon such party and may be enforced in any other courts to whose jurisdiction such party may be subject, by suit upon such judgment.

(c) EACH OF THE PARTIES HERETO HEREBY WAIVES TO THE FULLEST EXTENT PERMITTED BY LAW ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY WITH RESPECT TO ANY LITIGATION DIRECTLY OR INDIRECTLY ARISING OUT OF, UNDER OR IN CONNECTION WITH THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT. EACH OF THE PARTIES HERETO HEREBY (A) CERTIFIES THAT NO REPRESENTATIVE, AGENT OR ATTORNEY OF THE OTHER PARTY HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT SUCH OTHER PARTY WOULD NOT, IN THE EVENT OF LITIGATION, SEEK TO ENFORCE THE FOREGOING WAIVER, AND (B) ACKNOWLEDGES THAT IT HAS BEEN INDUCED TO ENTER INTO THIS AGREEMENT AND THE TRANSACTIONS CONTEMPLATED BY THIS AGREEMENT, AS APPLICABLE, BY, AMONG OTHER THINGS, THE MUTUAL WAIVERS AND CERTIFICATIONS IN THIS SECTION 11.09.

Section 11.10. Rules of Construction. Interpretation of this Agreement and the other Transaction Agreements (except as specifically provided in any such other Transaction Agreements, in which case such specified rules of construction shall govern with respect to such other Transaction Agreements) shall be governed by the following rules of construction: (a) words in the singular shall be held to include the plural and vice versa, and words of one gender shall be held to include the other gender as the context requires; (b) references to the terms Preamble, Recitals, Article, Section, paragraph, Schedule and Exhibit are references to the Preamble, Recitals, Articles, Sections, paragraphs, Schedules and Exhibits to this Agreement unless otherwise specified; (c) references to "$" mean, and all payments required to be made under this Agreement shall be required to be made in, U.S. dollars; (d) the word "including" and words of similar import means "including without limitation," unless otherwise specified; (e) the word "or" shall not be exclusive; (f) the words "herein," "hereof," "hereunder" or "hereby" and similar terms are to be deemed to refer to this Agreement as a whole and not to any specific Section; (g) the headings are for reference purposes only and shall not affect in any way the

meaning or interpretation of the Transaction Agreements; (h) the Transaction Agreements shall be construed without regard to any presumption or rule requiring construction or interpretation against the party drafting or causing any instrument to be drafted; (i) if a word or phrase is defined, the other grammatical forms of such word or phrase have a corresponding meaning; (j) references to any statute, listing rule, rule, standard, regulation or other law include a reference to the corresponding rules and regulations; (k) references to any section of any statute, listing rule, rule, standard, regulation or other law include any successor or amendment to such section; (l) references to any Person include such Person's predecessors or successors, whether by merger, consolidation, amalgamation, reorganization or otherwise; and (m) references to any contract (including this Agreement) or organizational document are to the contract or organizational document as amended, modified, supplemented or replaced from time to time, unless otherwise stated.

Section 11.11. Certain Limitations.

(a) Notwithstanding anything to the contrary contained in this Agreement, the other Transaction Agreements, the Seller Disclosure Schedule or any of the Schedules or Exhibits hereto or thereto, Purchaser acknowledges and agrees that neither Seller nor any of its Representative makes or has made, and Purchaser has not relied on, any inducement or promise to Purchaser except as specifically made in this Agreement or any representation or warranty to Purchaser, oral or written, express or implied, other than as expressly set forth in Article III. Without limiting the generality of the foregoing, other than as expressly set forth in Article III , no Person has made any representation or warranty to Purchaser with respect to the Business, the Transferred Assets (including the Assigned Contracts), the Assumed Liabilities or any other matter, including with respect to (i) merchantability, suitability or fitness for any particular purpose, (ii) the operation of the Business by Purchaser after the Closing, (iii) the probable success or profitability of the Business after the Closing or (iv) any information, documents or material made available to Purchaser or its Representatives in any "data rooms," information memoranda, management presentations, functional "break-out" discussions or in any other form or forum in connection with the transactions contemplated by this Agreement, including any estimation, valuation, appraisal, projection or forecast with respect to the Business. With respect to any such estimation, valuation, appraisal, projection or forecast (including the confidential information memoranda prepared by or on behalf of Seller in connection with the transactions contemplated by this Agreement or the any actuarial reports provided to Purchaser), Purchaser acknowledges that: (i) there are uncertainties inherent in attempting to make such estimations, valuations, appraisals, projections and forecasts; (ii) it is familiar with such uncertainties; (iii) it is not acting and has not acted in reliance on any such estimation valuation, appraisal, projection or forecast delivered by or on behalf of Seller to Purchaser; (iv) such estimations, valuations, appraisals, projections and forecasts are not and shall not be deemed to be representations or warranties of Seller or any of its Affiliates and (v) it shall have no claim against any Person with respect to any such valuation, appraisal, projection or forecast.

(b) Seller makes no express or implied representation or warranty hereby or otherwise under this Agreement: (i) as to the future experience, success or profitability of the Business, whether or not conducted in a manner similar to the manner in which the Business was conducted prior to the Closing; (ii) that the reserves held by or on behalf of the Business or the assets supporting such reserves have been or will be adequate or sufficient for the purposes for

which they were established; (iii) that the reinsurance recoverables taken into account in determining the amount of such reserves will be collectible or whether such reserves were calculated, established or determined in accordance with any actuarial, statutory or other standard; or (iv) concerning any financial statement "line item" or asset, liability or equity amount that would be affected by any of the foregoing.

(c) Purchaser further acknowledges and agrees that it: (i) has made its own inquiry and investigation into and, based thereon, has formed an independent judgment concerning the Business, the Transferred Assets (including the Assigned Contracts) and the Assumed Liabilities; (ii) has been provided adequate access to such information as it has deemed necessary to enable it to form such independent judgment; (iii) has had such time as it deems necessary and appropriate fully and completely to review and analyze such information, documents and other materials; and (iv) has been provided an opportunity to ask questions of Seller with respect to such information, documents and other materials and has received answers to such questions that it considers satisfactory. Purchaser further acknowledges and agrees that neither Seller nor any of its Affiliates has made any representations or warranties, express or implied, as to the accuracy or completeness of, and that Purchaser and its Affiliates have made their investment decision with respect to the acquisition of the Transferred Assets without reliance upon, such information, documents and other materials other than the representations and warranties expressly set forth in this Agreement.

Section 11.12. No Third Party Beneficiaries. Nothing in this Agreement is intended or shall be construed to give any Person (including the employees of Seller or Purchaser or any Affiliate of Seller or Purchaser), other than the parties hereto, their successors and permitted assigns, any legal or equitable right, remedy or claim under or in respect of this Agreement or any provision contained herein.

Section 11.13. Execution in Counterparts. This Agreement may be executed by the parties hereto in separate counterparts, each of which when so executed and delivered shall be an original, but all such counterparts shall together constitute one and the same instrument. Delivery of an executed counterpart of a signature page to any Transaction Agreement by facsimile or other means of electronic transmission utilizing reasonable image scan technology shall be as effective as delivery of a manually executed counterpart of any such Agreement.

Section 11.14. Equitable Remedies. The parties hereto agree that irreparable damage would occur in the event that any of the provisions of this Agreement were not performed in accordance with their specific terms or were otherwise breached. It is accordingly agreed that, without the necessity of posting bond or other undertaking, the parties hereto shall be entitled to an injunction or injunctions to prevent breaches of this Agreement and to enforce specifically the terms and provisions of this Agreement in accordance with this Agreement, this being in addition (subject to the terms of this Agreement) to any other remedy to which such party is entitled at law or in equity. In the event that any Action is brought in equity to enforce the provisions of this Agreement, no party hereto shall allege, and each party hereto hereby waives any defense or counterclaim, that there is an adequate remedy at law. If, prior to the Outside Date, any party hereto brings any Action in accordance with this Section 11.14 to enforce specifically the performance of the terms and provisions hereof by the other party, the Outside Date shall be automatically extended (i) for the period during which such action is pending, plus 10 Business Days or (ii) by such other time period established by the court presiding over such action, as the case may be.

(The remainder of this page is intentionally left blank)

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

AETNA INC.

By: /s/ Bjorn Thaler

Name: Bjorn Thaler

Title: Authorized Signatory

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

By: /s/ Michael Concannon

Name: Michael Concannon

Title: Authorized Signatory

[Signature Page to Master Transaction Agreement **]**

Exhibit 10.36

2018 Management Incentive Plan

I. Objectives and Summary

CVS Health Corporation's Management Incentive Plan (the "MIP") is designed to reward incentive-eligible employees ("Eligible Participants") of CVS Health Corporation and its subsidiaries (together, "the Company") for their role in driving performance and to encourage Eligible Participants' continued employment with the Company. Funding for the payment of incentive awards will be based on actual results measured against pre-established financial goals and/or operating goals. The amount of each incentive award paid will be based on the performance of the Company and the performance of the individual Eligible Participant.

The MIP shall be administered by the Management Planning and Development Committee (the "Committee") of the Board of Directors (the "Board") under the provisions herein and of the 2017 Incentive Compensation Plan or any successor plan (the "ICP"), and the Committee may delegate to officers of CVS Health the authority to perform administrative functions of the MIP as the Committee may determine and may appoint officers and others to assist it in administering the MIP.

II. Plan Year

The MIP is a calendar year plan, which runs from January 1 to December 31, 2018 ("Plan Year"). All dates in this document occur during the current Plan Year unless otherwise stated.

III. Eligibility

A. Eligibility for Participation

The Chief Executive Officer of CVS Health Corporation ("CEO") or the CEO's designee determines those employees who are eligible to participate in the MIP except as set forth in Section III.B, below. In general, Eligible Participants include exempt employees who are not covered by any other incentive plans and who are employed on or before November 1 of the Plan Year.

The CEO may, for any reason and in his or her sole discretion, at any time during the Plan Year, determine an employee's eligibility for participation in the MIP except as set forth in Section III.B. Eligible Participants are subject to the terms and conditions relating to incentive awards set forth in the MIP.

B. Section 16 Officers

The Committee shall determine the eligibility of Section 16 Officers of CVS Health, whom will also be included in the term "Eligible Participants" unless otherwise noted. The Committee shall retain sole discretion to determine Section 16 Officer eligibility for an award, the target award, and the amount of the actual award.

C. Newly-Eligible Employees

The award, if any, to an Eligible Participant who became an Eligible Participant after the beginning of the Plan Year may be prorated based on the date of eligibility.

D. Position Change

An employee who becomes an Eligible Participant on or before November 1 of the Plan Year as a result of a position change may be eligible for a prorated incentive award. If a position change results in an employee becoming an Eligible Participant for part of the Plan Year and other incentives during other parts of the Plan Year, the employee may be eligible to receive a prorated award for the amount of time in each incentive eligible position, subject to the terms of each applicable incentive plan. A position change from one MIP-eligible

position to another MIP-eligible position during the Plan Year also may result in a prorata award as described below under Section V. (B).

E. Demotions

If a previously Eligible Participant is demoted to a non-incentive eligible position due to his or her violation of CVS Health policy or his or her performance, or if he or she voluntarily transfers to a non-incentive eligible position during the Plan Year, and is in the non-incentive eligible position on the last day of the Plan Year, he or she will not be eligible to earn an incentive award for the Plan Year under the MIP.

F. Terminations

Unless otherwise stated in Section VII of the MIP, if an Eligible Participant's employment terminates prior to March 1 following a Plan Year, he or she will not be eligible to receive an incentive award under the MIP for the most recently completed Plan Year.

G. Rehires

Employees who are rehired as Eligible Participants on or before November 1 of the Plan Year may be eligible for a prorated incentive award. For purposes of proration, credit will only be given for time worked during the Plan Year in incentive-eligible positions.

IV. MIP Funding

A. Consolidated Company Funding

MIP funding is based on consolidated Company performance, measured by Operating Profit, and modified by performance measurements set forth in Exhibit A, for a given Plan Year. Achievement of the Company's Operating Profit target and MIP modifiers will determine the total funding (the "Total Pool") as described below.

1. Operating Profit

Operating Profit may be adjusted by the financial adjustments as approved by the Committee prior to the end of the first fiscal quarter of the Plan Year (the "Financial Adjustments").

If Operating Profit is below the minimum performance threshhold, no formulaic funding will be made available for incentive awards, regardless of MIP modifier metrics performance, and there shall be no incentive awards paid under the MIP.

B. Total Pool Funding

After the minimum threshold for Operating Profit has been achieved, performance of MIP modifiers against target will be calculated for the Plan Year. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The CEO (or, as to Section 16 Eligible Participants, the Committee) may, for any reason and in his or her (or Its) sole discretion, adjust the funding of the Total Pool based on (a) input from senior Company executives regarding their assessment of the overall performance of the Company; and (b) assessment of the achievement of Plan Year performance goals. In no case, however, can the CEO or the Committee increase Total Pool funding due solely to the results of the MIP modifiers.

C. Individual Performance

The Total Pool will be available for award to Eligible Participants under the MIP, taking into account the individual contribution of each Eligible Participant. The amount, if any, of the incentive award for an Eligible Participant shall be detemined in the sole discretion of the Company, which shall be final, binding and conclusive as to all parties having an interest therein. The amount, if any, of the incentive award for a Section 16 Eligible Participant shall be determined in the sole discretion of the Committee, which shall be final, binding and conclusive as to all parties having an interest therein.

V. Earnings, Proration, and Payout

A. Timing

Incentive awards will be paid to Eligible Participants, as soon as administratively feasible following the date the Total Pool is determined and approved, but no later than March 15 of the calendar year immediately following the Plan Year. Incentive payments under the MIP may be subject to garnishments and other state or federal requirements.

B. Calculations

Calculations for full and partial awards for each Eligible Participant will be based on "Eligible Earnings" (defined below) for the Plan Year while in a MIP-eligible position. Eligible Earnings will be multiplied by the individual target opportunity of the Eligible Participant. If the Eligible Participant has been employed in multiple MIP-eligible positions during the Plan Year, then the individual opportunity will be prorated based on the number of days worked in each position.

Eligible Earnings include reoccurring items such as pay earned for hours worked, paid time off (e.g. vacation, sick, holiday, funeral, jury duty, military) but will exclude one-time payments such as annual cash incentives, commissions and similar payments, and earnings associated with equity releases and stock option exercises.

For purposes of proration under the MIP and except as otherwise provided in Section VII of the MIP, calculations will be based on the number of days that the employee was an Eligible Participant in the MIP during the Plan Year.

C. Award Opportunity

Individual target awards will be determined by position and may vary based on the Eligible Participant's level in the organization.

D. Obligation to Pay Out Percentage of Total Pool

Eligible Participants, as a group, have a right to receive an amount at least equal to the Total Pool, but no individual Eligible Participant shall be entitled to receive an award or any specific amount of the Total Pool. In no event will the aggregate of the total awards paid from the MIP be less than 92.5% of the Total Pool. To discourage unmerited litigation, any party or class asserting a challenge or claim against the Company under any provision of the MIP, including this Section V, shall bear their own costs relating to such challenge or claim, and if the challenge or claim is unsuccessful, such party or class shall reimburse the Company for all reasonable costs incurred by the Company in responding to such challenge or claim.

VI. MIP Dispute Resolution

Any questions by an Eligible Participant regarding an incentive award granted under the MIP shall first be submitted by the Eligible Participant to his or her Human Resources Business Partner ("HRBP") within 7 days of distribution of such incentive award, and the HRBP shall submit any correction that the HRBP deems appropriate to the Compensation Department by the first business day of April immediately following the distribution date.

In the event of a dispute regarding an incentive award under the MIP after the Eligible Participant has submitted his or her question to the HRBP and received a response, as provided above, the Eligible Participant may submit an appeal for resolution of such dispute to CVS Health's Advice and Counsel in writing within 30 days of the distribution of the incentive award. Failure to follow these procedures or submit a question or dispute in a timely manner may result in a waiver of the Eligible Participant's right to dispute the MIP provision or amount of the incentive award.

VII. Eligible Participant Status

A. Performance

The CEO or other designated executives have full discretion in determining the amount, if any, of an incentive awarded to an Eligible Participant, and the Participant's individual performance throughout the Plan Year will be considered by the Company in the final determination of the Eligible Participant's incentive award.

B. Leaves of Absence

An Eligible Participant on a Company-approved leave of absence at any time during the Plan Year who remains employed in an eligible position as of the last day of the Plan Year will earn a prorated incentive award based on the number of days actively worked (including time compensated as vacation, myTime or Paid Time Off ("PTO")) during the Plan Year, provided he or she meets all other eligibility criteria for an incentive award.

C. Reduction in Force, Retirement and Death

1. Reduction in Force

If an Eligible Participant is separated from employment by the Company during the Plan Year due to a reduction in force, he or she may be eligible, at the Company's discretion, to receive a prorated incentive award based on the calculation methodology described in Section V.(B) above, provided the Eligible Participant meets all other eligibility criteria for an incentive award.

2. Retirement

If an Eligible Participant is at least age 55 and has a minimum of 10 years of service with CVS Health or a predecessor company/subsidiary or is at least age 60 and has a minimum of 5 years of service with CVS Health or a predecessor company/subsidiary and the Eligible Participant retires during the Plan Year, he/she may be eligible to receive a prorated incentive award based on the calculation methodology described in Section V.(B) above, provided he/she meets all other eligibility criteria for an incentive award. Eligible Participants who do not meet the minimum retirement requirements under Section VII at the time of retirement will not be eligible for an incentive award for the Plan Year.

3. Death

In case of the death of an Eligible Participant, a prorated incentive award may be paid to the Eligible Participant's spouse, if living; otherwise, in equal shares to surviving children of the Eligible Participant. If there are no surviving children, the benefit shall be paid to the Eligible Participant's estate. The incentive award will be prorated based on the calculation methodology described in Section V.(B) above. The incentive award shall be paid as soon as administratively practicable, following the death of the Eligible Participant but no later than March 15 of the calendar year immediately following the Plan Year.

VIII. Miscellaneous

A. No Promise of Continued Employment

The MIP does not create an express or implied contract of employment between CVS Heath or and an Eligible Participant. Both CVS Health and the Eligible Participant retain the right to terminate the employment relationship at will, at any time and for any reason.

B. Rights are Non-Assignable

Neither the Eligible Participant, nor any beneficiary, nor any other person shall have any right to assign, in whole or in part, the right to receive payments under the MIP. Payments are non-assignable and non-transferable, whether voluntarily or involuntarily.

C. Compliance with Applicable Law

An Eligible Participant must comply with all applicable state and federal laws and CVS Health policies to be eligible to receive an incentive award under the MIP.

CVS Health will comply with all applicable laws concerning incentive awards; the MIP and its administration are not intended to conflict with any applicable state or federal law.

D. Change in Control

In the event of a change in control of CVS Health, as defined in the ICP, the MIP shall remain in force. Any amendments, modifications, termination or dissolution of the MIP by the acquiring entity may only occur prospectively and will not affect incentive targets or awards or eligibility in place immediately before the date of the change in control or such later date as it may be modified or dissolved by the acquiring entity.

Provisions regarding the payment of annual incentive awards that are set forth in change in control agreements with Eligible Employees shall supersede those appearing in the MIP.

E. Withholding

All required deductions will be withheld from the incentive awards prior to distribution. This includes all applicable federal, state, or local taxes, as well as any eligible 401(k) deductions and deferred compensation contributions, as defined by the applicable plans. Incentive awards that are deferred will be taxed according to applicable federal and state tax law. Each Eligible Participant shall be solely responsible for any tax consequences of his or her award hereunder.

F. MIP Amendment/Modification/Termination

CVS Health retains the right to amend, modify, or terminate the MIP at any time on or before the last day of the Plan Year for any reason, with or without notice to Eligible Participants.

G. MIP Interpretation

CVS Health retains sole, full and final authority to prescribe rules and regulations for the administration of the Plan, construe and interpret the Plan and Award agreements and correct defects, supply omissions or reconcile inconsistencies therein and to make all other decisions and determinations as it may deem necessary or advisable for the administration of the Plan.

Capitalized terms not otherwise defined herein shall have the meaning assigned to such defined term(s) in the ICP. In the event of any conflict between the ICP and the MIP, the terms of the ICP shall govern.

H. Recoupment of Incentive Awards

Each incentive award under the MIP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Eligible Employee to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the MIP.

I. Section 409A of the Internal Revenue Code

The Company intends that the MIP not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Code, as amended, and the regulations and guidance thereunder (collectively, "Section 409A"), and that to the extent any provisions of the Plan do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. Payments hereunder are intended to qualify as short-term deferral payments under Section 409A. In all events, the provisions of CVS Health Corporation's Universal 409A Definition Document are hereby incorporated by reference, and notwithstanding the any other provision of the Plan or any Award to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code (requiring certain delays for "specified employees"), payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh (7 th) month following the date of termination of employment. For purposes of any provision of the Plan providing for the payment of any amounts or

benefits in connection with a termination of employment, references to an Eligible Person's "termination of employment" (and corollary terms) shall be construed to refer to the Eligible Person's "separation from service" with the Company as determined under Section 409A.

J. Restrictive Covenant Agreement

Any award pursuant to the MIP is expressly subject to and contingent upon the requirement that the Eligible Participant shall have fully executed and delivered to the Company a restrictive covenant agreement deemed appropriate by the Company; the Company may waive such requirement in its sole discretion. Any applicable agreement containing the restrictive covenants the Company requires in connection with this award is referred to herein as the "Restrictive Covenant Agreement".

If the Company requires an Eligible Participant to execute and deliver the Restrictive Covenant Agreement in connection with any MIP award, the Company shall provide such Restrictive Covenant Agreement to the Eligible Participant. The Eligible Participant must execute and deliver such agreement by the deadline set forth by the Company. The failure of an Eligible Participant to execute and return the Restrictive Covenant Agreement by the deadline set forth by the Company, if required, shall result in the immediate and irrevocable forfeiture of any MIP award.

This Section VIII (J) of the MIP shall not constitute the Company's exclusive remedy for Eligible Participant's violation of the Restrictive Covenant Agreement. The Company reserves all rights to seek all available legal or equitable remedies in the event of Eligible Participant's violation or threatened violation of the Restrictive Covenant Agreement, including injunctive relief.

Exhibit 10.37

CVS HEALTH SEVERANCE PLAN FOR NON-STORE EMPLOYEES (Amended as of November 28, 2018)

CVS HEALTH SEVERANCE PLAN
FOR NON-STORE EMPLOYEES
(Amended as of November 28, 2018)

WHEREAS, CVS Health Corporation (the "Company") has established the CVS Health Severance Plan for Non-Store Employees (the "Plan") to provide financial assistance to employees in non- store positions who are involuntarily terminated and are eligible within the terms and conditions of the Plan;

WHEREAS, it is intended that the Plan constitute an employee welfare benefit plan within the scope of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), that the Plan constitute a separation pay plan within the scope of Department of Labor ("DOL") Regulation Section 2510.3-2(b), and that all payments made under the Plan be deductible by the Company under Section 162(a) of the Internal Revenue Code of 1986, as amended (the "Code");

WHEREAS, the benefits provided under the Plan are intended to constitute separation pay within the meaning of Treasury Regulation Section 1.409A-1(b)(9)(iii);

WHEREAS, this document is the official plan document; and

WHEREAS, the Company wishes to make certain amendments to the Plan, effective as of November 28, 2018 (the "Effective Date");

NOW, THEREFORE, as of the Effective Date, the Company does hereby amend the Plan to provide as follows:

ARTICLE 1
DEFINITIONS

For purposes of the Plan, the following terms, when used with an initial capital letter, shall have the meaning set forth below unless a different meaning is plainly required by the context.

1.1 " Affiliate " shall mean (a) any corporation which is required to be aggregated with the Company under Code Section 414(b), (c), (m), or (o) and (b) any other entity in which the Company has an ownership interest and which the Company designates as an Affiliate for purposes of the Plan.

1.2 " Cause " shall refer to a termination of an Eligible Employee's employment because of the Eligible Employee's (a) poor performance; (b) acts of unethical business activity, including but not limited to fraud, misappropriation, embezzlement, dishonesty, harassment, discrimination in violation of Employer policies, or willful or negligent destruction of property of an Employer or an Affiliate; (c) misconduct that is reasonably likely to cause material damage (monetary or otherwise) to the Employer, an Affiliate, or any personnel thereof; (d) conviction of or a plea of guilty or nolo contendere to any felony, whether or not any right to appeal has been or may be exercised; (e) negligence of duty; (f) insubordination; or (g) a violation of the Employer's policy, procedure, or practice.

1.3 " Code " shall mean the Internal Revenue Code of 1986, as amended.

1.4 " Eligible Employee " shall mean an individual who is employed by the Employer on a regular basis in a non-store position and has been employed by the Employer in any position for a minimum of twelve (12) months prior to the individual's separation of employment. For purposes of the Plan, distribution warehouse employees, field managers and employees employed by CVS ProCare, Inc. working at Company headquarters, shall be treated as working in a non-store location and therefore not subject to exclusion from eligibility. For purposes of the Plan, individuals in the following categories will not be considered Eligible Employees:

(a) individuals who are covered by a collective bargaining agreement, provided welfare benefits were the subject of good faith bargaining, unless the terms of the collective bargaining agreement provide for participation in the Plan;

(b) individuals who are seasonal employees, leased employees, independent contractors, temporary employees, or consultants;

(c) individuals who work for the Employer or an Affiliate in a store location of the Company or an Affiliate, or whose compensation is paid through or according to a store payroll, including but not limited to: pharmacists, store managers, assistant store managers, crew, and pharmacy staff;

(d) individuals employed by MinuteClinic, L.L.C. or by any practitioner-owned entity managed by MinuteClinic, L.L.C.;

(e) the President and CEO of CVS Health Corporation;

(f) individuals employed in Puerto Rico; and

(g) individuals employed outside the United States of America.

The decision of whether an individual falls into one of these categories and whether an individual is employed by an Employer on a regular basis in a non-store position for a minimum of 12 months shall be made by the Employer in its sole discretion. Any individual who is excluded from being considered an Eligible Employee under the Plan shall be excluded from the Plan regardless of the individual's reclassification by a government agency, including a reclassification by the Internal Revenue Service for tax withholding purposes.

1.5 " Employer " shall mean CVS Pharmacy, Inc. and Caremark Rx, L.L.C. and any current or future Affiliate thereof that does not maintain its own severance plan for employees of that Affiliate.

1.6 " ERISA " shall mean the Employee Retirement Income Security Act of 1974, as amended.

1.7 " Exempt Employee " shall mean an Eligible Employee who is paid on a salaried basis for payroll purposes and classified in the sole discretion of the Employer under its normal classification procedures as an exempt employee under the Fair Labor Standards Act.

1.8 " Involuntary Termination " shall mean an Eligible Employee's termination of employment with the Employer due to the unilateral action of the Employer, including but not limited to a termination as a result of the elimination of an Eligible Employee's position due to a reorganization or changes in responsibilities, a reduction in force, or a closing of the business unit in which the Eligible Employee works; provided, however, that such Involuntary Termination constitutes a separation from service under Treasury Regulation Section 1.409A-1(h). Notwithstanding the foregoing, an Eligible Employee will not have an Involuntary Termination if the Eligible Employee: (a) is terminated for Cause, as determined by the Employer in its sole discretion; (b) voluntarily terminates employment or resigns prior to an Involuntary Termination; (c) takes a leave of absence; (d) is administratively terminated for failure to return from a leave of absence upon expiration of his or her leave; (e) terminates employment due to his or her death; (f) transfers to an Affiliate; (g) transfers to a new employer in connection with the sale of an Employer facility; or (h) fails to accept an offer for a job with the Employer that is comparable to the job that he or she is performing for the Employer at the time of the offer. For purposes of Subsection (h) of this Section 1.8, whether a job is considered "comparable" shall be determined in the sole discretion of the Employer, taking into account whether the new job is located 50 or fewer miles from the Eligible Employee's job at the time of the offer, whether the compensation offered is materially less than the Eligible Employee's compensation at the time of the offer, and whether the new job will result in a substantial change of duties from the Eligible Employee's job at the time of the offer. The determination of whether an Eligible Employee's termination of employment is an Involuntary Termination shall be made in the sole discretion of the Employer. If an Employer deems an Eligible Employee's termination of employment to be an Involuntary Termination and, Employer later learns of facts and circumstances that, had

the Employer known such facts and circumstances at the time of termination, would have resulted in a termination of employment for Cause, the Eligible Employee's termination shall be deemed as of the date of termination to not have been an Involuntary Termination.

1.9 " Non-exempt Employee " shall mean an Eligible Employee who is paid on an hourly basis for time worked and classified in the sole discretion of the Employer under its normal classification procedures as a non-exempt employee under the Fair Labor Standards Act.

1.10 " Plan Administrator " shall mean the Senior Vice President of Human Resources of CVS Pharmacy, Inc., or such other person designated to act as the Plan Administrator.

1.11 " Rehire Date " shall mean the date an Eligible Employee accepts reemployment with any Employer.

1.12 " Severance Pay " shall mean the pay an Eligible Employee is eligible to receive under Subsection (b) of Section 2.1 of the Plan upon his or her Involuntary Termination.

1.13 " Severance Period " shall mean the period of time during which an Eligible Employee is eligible to receive Severance Pay.

1.14 " Transaction-Related Termination " shall mean an Involuntary Termination, of an Eligible Employee in a Corporate/Shared Services function, that is deemed by the Plan Administrator, in his or her sole discretion, after consultation with the Employer, to have resulted from the Company's acquisition of Aetna, Inc., at any time during the period beginning with the date the acquisition closes and ending on the second anniversary of such closing date. For this purpose, a Corporate/Shared Services function shall exclude all functions in MinuteClinic, MinuteClinic IT, Omnicare, Specialty/Coram, Retail Merchandising, Retail & Pharmacy Growth, Retail Supply Chain, Retail Pharmacy Operations, Retail Stores & Field and in any other business unit that may be determined by the Plan Administrator from time to time, regardless of which Employer employs the Eligible Employee.

1.15 " Weekly Rate " shall mean, (a) with respect to an Eligible Employee paid on a salaried basis, an Eligible Employee's annual base salary (as determined by the Employer), as of the date of the Eligible Employee's Involuntary Termination, expressed on a weekly basis (as determined in the sole discretion of the Employer), and (b) with respect to an Eligible Employee paid on an hourly basis, the hourly wage rate of the Eligible Employee as of the date of the Eligible Employee's Involuntary Termination multiplied by the Eligible Employee's regularly scheduled number of hours of service per week (as determined by the Employer), not in excess of 40 hours. Weekly Rate shall exclude any overtime, incentive, and bonus payments, unless otherwise required by law.

1.16 " Year of Service " shall mean each full year of service performed by the Eligible Employee for an Employer as reflected in the records of the Employer and as determined as of the Eligible Employee's date of termination of employment, based on the Employer's policies and procedures for determining periods of service, and the applicable law.

ARTICLE 2
SEVERANCE PAY AND ELIGIBLE EMPLOYEE BENEFITS

2.1 (a) Eligibility . Upon his or her Involuntary Termination, an Eligible Employee may, in the discretion of the Plan Administrator, be granted Severance Pay and benefits provided under Subsections (b), (c), and (d) of this Section 2.1, provided the conditions of Section 2.2 are satisfied. The determination of whether Severance Pay is payable under the Plan, and the form and amount of such pay, shall be made in the sole discretion of the Plan Administrator.

(b) Severance Pay . The Severance Pay payable to an Eligible Employee in the event of Involuntary Termination shall be determined by the Plan Administrator in its sole discretion, using the following guidelines

for the applicable Eligible Employee classification:

(i) For Eligible Employees who are Non-exempt Employees:

(A) the Eligible Employee's Weekly Rate multiplied by two (2), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Non-exempt employees should not exceed the Eligible Employee's Weekly Rate multiplied by thirteen (13);

(ii) For Eligible Exempt Employees in grades 105-108, 201-203, 301, 302, 405-408:

(A) the Eligible Employee's Weekly Rate multiplied by four (4), plus,

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by twenty (20);

(iii) For Eligible Exempt Employees in grades 109-111, 204, 205, 303, 304, 409-411, the greater of

(A) the Eligible Employee's Weekly Rate multiplied by thirteen (13) or,

(B) the amount determined under the formula set forth in the immediately preceding Paragraph (ii), provided Severance Pay should not exceed the Eligible Employee's Weekly Rate multiplied by twenty (20);

(iv) For Eligible Exempt Employees in grades 112, 206, 305, 412, the Eligible Employee's Weekly Rate multiplied by twenty-six (26);

(v) For Eligible Exempt Employees in grades 36A-Z, the Eligible Employee's Weekly Rate multiplied by fifty-two (52); and

(vi) For Eligible Exempt Employees in grades 38A-Z and 39 A-Z, the Eligible Employee's Weekly Rate multiplied by fifty-two (52).

Notwithstanding the above guidelines, in the event of a Transaction-Related Termination of an Eligible Employee, Severance Pay shall be determined by the Plan Administrator in its sole discretion, using the following guidelines for the applicable Employee classification:

(1) For Eligible Employees who are Non-exempt Employees:

(A) the Eligible Employee's Weekly Rate multiplied by two (2), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the

number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Non-exempt employees should not exceed the Eligible Employee's Weekly Rate multiplied by thirty-one (31);

(2) For Eligible Exempt Employees in grades 105-108, 201-203, 301, 302, 405-408:

(A) the Eligible Employee's Weekly Rate multiplied by four (4), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by thirty-one (31);

(3) For Eligible Exempt Employees in grades 109-111, 204, 205, 303, 304, 409-411, the greater of (A) the Eligible Employee's Weekly Rate multiplied by thirteen (13) or, (B) the amount determined under the formula set forth in the immediately preceding Paragraph (2), provided Severance Pay should not exceed the Eligible Employee's Weekly Rate multiplied by forty-four (44);

(4) For Eligible Exempt Employees in grades 112, 206, 305, 412:

(A) the Eligible Employee's Weekly Rate multiplied by twenty-six (26), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by ninety-six (96);

(5) For Eligible Exempt Employees in grades 36A-Z, who have completed at least five (5) Years of Service:

(A) the Eligible Employee's Weekly Rate multiplied by fifty-two (52), plus

(B) an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed in excess of four (4) Years of Service by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by ninety-six (96); and

(6) For Eligible Exempt Employees in grades 38A-Z and 39 A-Z:

(A) the Eligible Employee's Weekly Rate multiplied by seventy-eight (78), plus

(B) provided the Eligible Exempt Employee has completed at least five (5) Years of Service, an amount equal to the Eligible Employee's Weekly Rate multiplied by the number of Years of Service completed in excess of four (4) Years of Service by the Eligible Employee multiplied by two (2),

provided Severance Pay for Exempt Employees should not exceed the Eligible Employee's Weekly Rate multiplied by ninety-six (96).

Notwithstanding the above guidelines, the Plan Administrator may increase or decrease (including, to zero) the amount of Severance Pay with respect to any Eligible Employee for reasons it deems appropriate in its sole discretion (including, but not limited to, an increase to provide consideration for Eligible Employees who have outstanding employment agreements with an Employer or a decrease to take into account any debts owed to an Employer), at any time, whether before or after payments of Severance Pay have commenced.

(c) COBRA Assistance . In the event an Eligible Employee who has an Involuntary Termination (i) is eligible to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended ("COBRA") in accordance with the terms of the medical and prescription drug plan and/or dental plan of the Employer and (ii) properly and timely elects such continuation coverage, the Employer may pay for a portion of the cost of COBRA coverage equivalent to the contribution which the Employer makes on behalf of similarly situated active employees under such plan for the appropriate tier of coverage selected and in place immediately prior to the date of the Eligible Employee's Involuntary Termination (*e.g.* , employee-only, family coverage), for a period determined in the sole discretion of the Plan Administrator, which generally shall be the Severance Period but in any event no longer than eighteen (18) months from the date of the Involuntary Termination. Any COBRA assistance provided under this Subsection (c) shall be paid by the Employer directly to the insurance carrier, if applicable. The portion of the COBRA premium not covered by the COBRA assistance specified in this Subsection (c) must be paid by the Eligible Employee directly to the insurance carrier or service provider that administers COBRA, as applicable, based on the standard rules under the respective plan for payment of COBRA premiums. This Subsection (c) does not provide COBRA assistance in the event the Eligible Employee fails to properly and timely elect COBRA continuation coverage, regardless of whether his or her covered dependents elect COBRA continuation coverage.

(d) Outplacement Services . Upon an Involuntary Termination, the outplacement services provided to an Eligible Employee shall be provided in the sole discretion of the Plan Administrator based on the guidelines contained in this Subsection (d).

(i) If an Eligible Employee so desires, he or she may be eligible for outplacement services for assistance in obtaining new employment, provided through a vendor selected by the Employer, with the Employer directly providing payment to such vendor. The provision of outplacement services is contingent upon the Eligible Employee's cooperation with the outplacement service vendor, upon the active efforts of the Eligible Employee to locate a new position, and upon the Eligible Employee initiating outplacement services during the Severance Period.

(ii) Subject to the requirements of Paragraph (i) of this Subsection (d), outplacement services shall be offered for a period of time determined in the sole discretion of the Plan Administrator, based on guidelines that include:

(A) a virtual or group training session for Eligible Non-exempt Employees and Exempt Employees in grades 105-108, 201-203, 301, 302, 405-408;

(B) three (3) months of outplacement services for Eligible Exempt Employees in grades 109-112, 204-206, 303-305, 409-412; and

(C) six (6) months of outplacement services for Eligible Exempt Employees in grades 36A-Z, 38A-Z, and 39 A-Z;

provided, in no event shall such services extend beyond twelve (12) months following the Involuntary Termination of the Eligible Employee.

(e) Form and Timing of Payment . In the event an Eligible Employee is awarded Severance Pay

under the terms of Subsection (a) of this Section 2.1, such Severance Pay shall be paid following an Eligible Employee's Involuntary Termination (except as provided in Section 2.3, below), as follows: No Severance Pay shall commence (with respect to salary continuation payments) or be paid (with respect to a lump sum) (i) prior to the expiration of the later of a period that is identified in a separate agreement with the Eligible Employee during which he or she may consider the execution of the release of claims form (the "Consideration Period") or a period ending at least seven (7) days following the execution of the release of claims form (the "Revocation Period"), or (ii) later than sixty (60) days following the date of Eligible Employee's Involuntary Termination. Severance Pay that is paid in the form of salary continuation shall commence as soon as feasible following expiration of the later of the Consideration Period or the Revocation Period, which generally shall be the first regularly scheduled payroll date following the expiration of the Consideration Period or the Revocation Period, as the case may be, and shall thereafter be paid in substantially equal installments in accordance with the Employer's regular payroll practice, except as provided in Section 2.3 of the Plan. Further, in the Plan Administrator's sole discretion, Severance Pay may be paid to any Eligible Employees in a single lump sum, in which event Severance Pay shall be paid within the period that satisfies the 409A requirements for short-term deferrals under Section 409A of the Code.

(f) Withholding . Any payment of Severance Pay to an Eligible Employee shall be subject to normal withholding for state and federal income taxes and Social Security taxes.

(g) Death . Upon the death of the Eligible Employee who had an Involuntary Termination and who has not received all Severance Pay payable under the Plan, the Severance Pay otherwise payable under Section 2.1(b) of the Plan shall be paid in the form of a lump sum to the Eligible Employee's estate or beneficiary as soon as practicable, but in no event later than 60 days following death. Any other severance benefits provided under this Section 2.1 (COBRA assistance and outplacement services) shall cease upon the Eligible Employee's death.

2.2 Conditions on Payment of Severance Pay and Benefits . Payment of the Severance Pay and benefits provided in Section 2.1 of the Plan shall be subject to and conditioned upon the following:

(a) to the extent an Eligible Employee receives notice of a date selected by the Employer (in its sole discretion) on which the Eligible Employee's Involuntary Termination shall occur (a "Designated Termination Date"), the Eligible Employee must continue to work in a satisfactory manner until his or her Designated Termination Date;

(b) the Eligible Employee must cooperate in transitioning all of the Eligible Employee's work in consultation with the Eligible Employee's supervisor or other designated employee;

(c) the Eligible Employee must execute and deliver a release of claims form (in the form specified by the Employer from time to time which may include restrictive covenants and, if applicable, a waiver as described in Subsection (d) of this Section 2.2) within the time period specified under the terms of the applicable severance offer. Further, in no event will Severance Pay be paid with respect to an Eligible Employee in the event the release of claims form is revoked during the Revocation Period (described in Section 2.1(e) of the Plan); and

(d) the Eligible Employee must waive the right to receive any other severance payment relating to salary continuation or salary replacement the Eligible Employee may otherwise be eligible to receive upon termination of employment under any employment agreement, severance plan, practice, policy or program of the Employer or an Affiliate.

2.3 Maximum Severance Pay . Notwithstanding any other provisions to the contrary, benefits paid hereunder (a) shall not exceed two times the lesser of (i) the Eligible Employee's Compensation (as defined in this Section 2.3) during the calendar year immediately preceding the Eligible Employee's Involuntary Termination

or (ii) the maximum amount that may be taken into account under a qualified plan pursuant to Section 401(a)(17) of the Code for the calendar year in which the Eligible Employee's Involuntary Termination occurs and (b) shall be paid in full within twenty-four (24) months after the date the Eligible Employee's Involuntary Termination occurs. In the event that any Severance Pay payable to an Eligible Employee would exceed the twenty-four (24) month period provided in the foregoing sentence if the Severance Pay continued to be paid in accordance with the Employer's regular payroll practice, any Severance Pay that would otherwise exceed the twenty-four (24) month time period will be paid to the Eligible Employee in a lump sum on the last regular payroll date within the twenty-four (24) month period. For purposes of this Section 2.3, "Compensation" shall mean the Eligible Employee's total annualized compensation, based upon the annual rate of pay for services provided to the Employer for the calendar year preceding the calendar year in which the Eligible Employee's Involuntary Termination occurs, adjusted for any increase in such preceding calendar year that was expected to continue indefinitely if the Eligible Employee had not had an Involuntary Termination.

2.4 Cessation of Severance Pay Upon Reemployment . If an Eligible Employee who had an Involuntary Termination and who is receiving Severance Pay thereafter accepts reemployment with any Employer during the Severance Period, such Employee's Severance Pay shall cease on the Rehire Date and any remaining Severance Pay shall be forfeited.

2.5 Cessation of Severance Pay After Commencement of Payments . If an Eligible Employee is deemed to have an Involuntary Termination and begins to receive Severance Pay under the Plan and the Employer or the Plan Administrator becomes aware of facts and circumstances that, had the Employer known same at the time of the Eligible Employee's termination of employment, would have affected the Employer's determination as to whether such Employee's termination was an Involuntary Termination, the Plan Administrator may suspend any future Severance Pay payments to the Eligible Employee while the Employer investigates the facts and circumstances and finalizes such investigation, and, if the Employer determines that the Eligible Employee should have been terminated for Cause, such Eligible Employee's Severance Pay shall cease as of the suspension date, any remaining Severance Pay shall be forfeited and any Severance Pay that has been paid shall be subject to repayment by the Eligible Employee.

2.6 Impact of Debt on Severance Pay . In the event an Eligible Employee is indebted to the Company or Employer (determined in the sole discretion of the Company or Employer, as applicable), the Plan Administrator reserves the right to reduce, offset, withhold, and/or forfeit the Severance Pay otherwise payable under the Plan.

2.7 Employee Benefits . As of the date of an Eligible Employee's Involuntary Termination, the Eligible Employee's active participation in any benefit plan, program, or policy sponsored or subsidized by the Employer shall cease, unless otherwise continued pursuant to the terms of such plan, program or policy.

2.8 Awards . Any award or grant made to the Eligible Employee under any stock option, stock purchase, or stock appreciation rights plan of the Company or Employer shall be administered and interpreted in accordance with the terms of the applicable plan documents.

2.9 Paid Time Off . Any pay for accrued paid time off shall be determined under the terms of the Employer's applicable policies.

2.10 Benefits Not Vested . No one under any circumstance is automatically entitled to Severance Pay and benefits described in Section 2.1 of the Plan. Notwithstanding anything in the Plan to the contrary, the Plan Administrator reserves the right, at its sole discretion, to increase, decrease, or eliminate Severance Pay and benefits under the Plan.

2.11 Bonuses . Whether any bonuses are payable to an Eligible Employee shall be determined based on the terms of any applicable bonus program, plan, or policy.

ARTICLE 3
ADMINISTRATION OF THE PLAN

3.1 Control and Administration . Notwithstanding any other provision in the Plan, and to the full extent permitted under ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and final authority, in its sole and absolute discretion, to administer, apply, construe and interpret the terms of the Plan and all related plan documents and all facts surrounding claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under the Plan shall be paid only if the Plan Administrator decides in its discretion that an Eligible Employee is entitled to benefits, and the Plan Administrator shall decide all questions regarding the form, amount and duration of benefits. The Plan Administrator may consult with attorneys, consultants and other persons for advice, counsel and reports to make determinations under the Plan, and the Plan Administrator may delegate its administrative duties and responsibilities to persons or entities of its choice, in all cases who may be employees of the Company. All determinations of the Plan Administrator shall be conclusive and binding on all parties. The Plan Administrator shall be the named fiduciary of the Plan for purposes of ERISA.

3.2 Claim Procedures .

(a) Procedure for Granting or Denying Claims . An Eligible Employee, or his or her duly authorized representative, may file a claim for payment of benefits under the Plan within 30 days after termination of employment. Such a claim must be made in writing and be delivered to the Plan Administrator, in person or by mail, postage paid. Within 90 days after receipt of such claim, the Plan Administrator shall notify the claimant of the granting or denying, in whole or in part, of such claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 90 days from the end of the initial 90-day period. If such extension is necessary, the claimant will be given a written notice to this effect prior to the expiration of the initial 90-day period. The Plan Administrator shall have full discretion to deny or grant a claim in whole or in part.

(b) Requirement for Notice of Claim Denial . The Plan Administrator shall provide to every claimant who is denied a claim for benefits a written or electronic notice setting forth in a manner calculated to be understood by the claimant:

(i) The specific reason or reasons for the denial;

(ii) Specific reference to pertinent Plan provisions on which the denial is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and

(iv) An explanation of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

(c) Right to Appeal on Claim Denial . Within 60 days after receipt by the claimant of written or electronic notification of the denial (in whole or in part) of his or her claim, the claimant or his or her duly authorized representative may make a written application to the Plan Administrator, in person or by certified mail, postage prepaid, to be afforded a full and fair review of such denial. The claimant or his or her duly authorized representative may submit written comments, documents, records, and other information relating to the claim for benefits. Moreover, the claimant or his or her duly authorized representative shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(d) Disposition of Disputed Claims . Upon receipt of a request for review, the Plan Administrator shall make a decision on the claim. The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The decision on review shall be made not later than 60 days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than 120 days after receipt of the request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial 60-day period.

The Plan Administrator shall provide the claimant or his or her duly authorized representative with written or electronic notification of the Plan's determination on review. In the case of an adverse determination, the notification shall set forth, in a manner calculated to be understood by the claimant, the specific reason or reasons for the decision as well as specific references to the Plan provisions on which the decision was based. The decision shall also include a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Moreover, the decision shall contain a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

3.3 Conditions to Legal Action. No legal action may be commenced or maintained against the Plan, the Company or any Employer prior to the claimant's exhaustion of the claims procedures set forth in Section 3.2 of the Plan. In addition, no legal action may be commenced against the Plan more than ninety (90) days after the Plan Administrator's final claim determination on review pursuant to Section 3.2(d) of the Plan. Any legal action must be conducted in the United States District Court for Rhode Island.

3.4 Named Fiduciary . The Plan Administrator of the Plan shall be the Named Fiduciary of the Plan for purposes of ERISA Section 402(a)(1).

ARTICLE 4
MISCELLANEOUS

4.1 Amendment or Termination . The Plan may be amended, terminated, withdrawn or suspended at any time in writing by the Management Planning and Development Committee of the Company or any individual designated by such Committee to take such actions.

4.2 Choice of Law . The validity, interpretation, construction and performance of the obligations created under the Plan shall be governed by ERISA, and to the extent not preempted by federal law, the laws of the State of Rhode Island without regard to its conflicts of law principles.

4.3 Validity . The invalidity or unenforceability of any provision of the Plan shall not affect the validity or enforceability of any other provision of the Plan, which shall remain in full force and effect.

4.4 Plan Exclusive Source of Rights . The Plan contains all of the terms and conditions with respect to the benefits provided hereunder, and no Eligible Employee or former Eligible Employee may rely on any other communication or representation, whether oral or written, of the Employer or any of its subsidiaries, or any officer or Eligible Employee thereof, as creating any right or obligation not expressly provided by the Plan.

4.5 Nonassignability . No benefit which shall be payable under the Plan to any Eligible Employee shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge (except as required by law), and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge a benefit shall be null and void. No benefit shall in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any Eligible Employee. No benefit shall be subject to legal attachment or legal process for, or against, the Eligible Employee and the same shall not be recognized under the Plan. Notwithstanding

the preceding sentence, the Employer retains the discretion, in accordance with federal and/or state laws, to reduce the amount of benefits payable under the Plan to any Eligible Employee to recover any amounts that the Eligible Employee owes to the Employer.

4.6 No Employment Rights . The Plan shall not give any Eligible Employee any right or claim except to the extent that the right is specifically provided under the terms of the Plan. The establishment of the Plan shall not be construed (a) to give any Eligible Employee a right to continue in the employ of the Employer or (b) to interfere with the right of the Employer to terminate the employment of any Eligible Employee at any time.

4.7 Headings. Article and section headings are for convenience only and the language of the Plan itself will be controlling.

4.8 Gender and Numbers . Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

4.9 Code Section 409A . The benefits provided under the terms of the Plan are intended to fall within the short-term deferral exception, the separation pay exception or another exception to the application of Section 409A of the Code and the applicable guidance issued thereunder. In furtherance of this intent, the Plan shall be interpreted, operated and administered in a manner consistent with this intention. To the extent the benefits provided under the Plan become subject to Code Section 409A and applicable guidance issued thereunder, the Plan shall be construed, and benefits paid hereunder, as necessary to comply with Section 409A of the Code and such guidance. Further, to the extent that an Eligible Employee becomes entitled to receive Severance Pay under the terms of the Plan, and, at the time of the Eligible Employee's Involuntary Termination, he or she is a "specified employee" within the meaning of Treasury Regulation Section 1.409A- 1(i), any portion of Severance Pay payable to such Eligible Employee that is subject to Code Section 409A and applicable guidance thereunder shall be delayed until the date that is the earlier of (i) the Eligible Employee's death or (ii) six months following the date of the Eligible Employee's Involuntary Termination, at which time the payments that were delayed for such six month period shall be paid in a lump sum on the date of the next occurring regular payroll date of the Employer, and any remaining payments shall be paid according to the original schedule provided herein. In addition, each payment of a salary continuation stream of installment payments hereunder shall be a separate payment for purposes of Section 409A of the Code.

4.10 Funding . The Plan is not funded, and Severance Pay and benefits under the Plan are paid from the general assets of the Employer.

4.11 Plan Year. The Plan's records shall be maintained on the basis of the calendar year.

IN WITNESS WHEREOF, the Management Planning and Development Committee of the Company, or its duly authorized delegate, has amended the Plan as of the Effective Date pursuant to the execution hereof on its behalf by a duly authorized officer on .

CVS HEALTH CORPORATION

By: /s/ Lisa G. Bisaccia
Title: Executive Vice President and Chief Human Resources Officer, CVS Pharmacy, Inc.

Exhibit 10.38

CVS Health Corporation
Performance-Based Restricted Stock Unit Program

I. Objectives and Summary

The objective of the CVS Health Corporation (the "Company") Performance-Based Restricted Stock Unit Plan ("PBRS Plan") is to reward eligible participants for their role in achieving the Company's Earnings before Interest and Taxes ("EBIT") target and to encourage continued employment with the Company and its subsidiaries. PBRS Awards are generally delivered as restricted stock units ("RSUs") and are based on actual results measured against pre-established targets.

II. Administration

The PBRS Plan shall be administered by the Management Planning and Development Committee (the "Committee") of the Board of Directors, or its designee, under the provisions of the 2017 Incentive Compensation Plan or any successor plan (the "ICP"). The Committee shall have full and final authority, in each case, subject to and consistent with the provisions of the ICP and the PBRS Plan, to construe and interpret rules and regulations for the administration of the PBRS Plan, correct defects, supply omissions or reconcile inconsistencies therein, and to make all other decisions and determinations as the Committee may deem necessary or advisable for the administration of the PBRS Plan. Capitalized terms not otherwise defined herein shall have the meaning assigned to such terms in the ICP. In the event of a conflict between the ICP and the PBRS Plan, the provisions of the ICP shall control.

III. PBRS Plan Year

The "PBRS Plan Year" commences on January 1 and ends on December 31 of each year, unless otherwise approved by the Committee. All dates in this document occur during the current PBRS Plan Year unless otherwise stated.

IV. Eligibility

A. Eligible Employees

The Chief Executive Officer (the "CEO") or the CEO's designee determines those employees of the Company and its subsidiaries who are eligible to participate in the PBRS Plan ("Eligible Employees"). In general, Eligible Employees are those employees who are (i) officers of CVS Pharmacy, Inc. who are Vice Presidents or above, and (ii) senior officers of other subsidiaries who have been designated as Eligible Employees by the CEO or his or her designee. Generally, Business Planning Committee ("BPC") members are not eligible to participate, unless otherwise named as an Eligible Employee by the Committee.

B. Newly-Hired Eligible Employees

A newly-hired employee satisfying the requirements set forth in Paragraph IV.A is an Eligible Employee and may receive a PBRS Award for the PBRS Plan Year in which he or she is hired provided he or she is hired on or before November 1 and remains in an Eligible Employee position through December 31 of the PBRS Plan Year.

C. Participants

Unless the Committee is required to make such determinations under applicable law or the ICP, the CEO or the CEO's designee shall determine which Eligible Employees will receive an award under the PBRS Plan (a "PBRS Award"). All such determinations, whether by the CEO, the CEO's designee, or the Committee, with respect to a PBRS ("Plan Year") shall be made no later than the last business day of February immediately

following the PBRS Plan Year (the "PBRS Award Date"). Each Eligible Employee who receives a PBRS Award is a "Participant". No Eligible Employee has any right to receive a PBRS Award, regardless of whether such Eligible Employee is employed on the last day of the PBRS Plan Year, and the determination of whether an Eligible Employee will be a Participant shall be made in the sole discretion of the CEO, the CEO's designee or the Committee, as the case may be.

D. Status Changes

(i) **Promotions** . An employee who is promoted on or before November 1 of the PBRS Plan Year to a position satisfying the requirements set forth on Paragraph IV.A is an Eligible Employee and may receive a PBRS Award for the year in which the promotion occurs.

(ii) **Demotions:** An Eligible Employee who is demoted after November 1 of the PBRS Plan Year to a position not satisfying the requirements set forth on Paragraph IV.A will remain an Eligible Employee and may receive a PBRS Award provided such demotion is not the result of voluntarily transfer to a lower level position, is not related to unsatisfactory performance, and is not as a result of a violation of a Company policy or Code of Ethics.

(iii) **Termination of Employment**

a) **In General.** Except as provided in sub-paragraph (b) below, if for any reason the employment of an Eligible Employee with the Company and any subsidiary of the Company terminates during a PBRS Plan Year, the Eligible Employee will not receive a PBRS Award for that PBRS Plan Year.

b) **Death or Disability** . If an Eligible Employee dies or commences a long-term disability (as defined in the either Company's long-term disability plan or by the Social Security Administrator, as determined by the "Committee") during a PBRS Plan Year, the Eligible Employee may receive a PBRS Award at the same time PBRS Awards are made to other Participants. Such PBRS Award will be pro-rated for the number of full months (a partial month will be counted as a full month) during which the Eligible Employee was an active employee based on a full calendar year and will (unless otherwise determined by the CEO or the Committee) be paid in cash based on the Eligible Earnings of the Eligible Employee as of the time of death or commencement of long-term disability. PBRS Awards with respect to deceased Eligible Employees shall be paid to the Eligible Employee's Beneficiary.

The decision to pay a pro rata or full award to an Eligible Employee who terminates employment with the Company and its subsidiaries prior to the PBRS Award Date for any reason other than death or long-term disability, as defined above in this section, will be at the sole discretion of the CEO or the Committee (as the case may be).

V. PBRS Funding

A. Consolidated Company Funding

PBRS funding is based on consolidated Company performance, measured by Earnings before Interest and Taxes (EBIT), and modified by customer service and client satisfaction measurements. Achievement of the Company's EBIT target and modifiers will determine the total funding (the "Total Pool").

EBIT may be adjusted by the financial adjustments as approved by the Committee prior to the end of the first fiscal quarter of the Plan Year (the "Financial Adjustments"). If EBIT is below the minimum performance threshold, no formulaic funding will be made available for awards, regardless of PBRS modifier metrics performance, and there shall be no awards paid under the PBRS.

B. Total Pool Funding

After the minimum threshold for EBIT has been achieved, performance of PBRS modifiers to target will be calculated for the Plan Year. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The CEO may, for any reason and in his or her sole discretion, adjust the funding of the Total Pool based on (a) input from senior Company executives regarding their assessment of the overall performance of the Company; and (b) assessment of the achievement of Plan Year performance goals. In no case, however, can the CEO or the Committee increase Total Pool funding due to the results of the PBRS modifiers.

C. Individual Performance

The Total Pool will be available for award to Eligible Employee's under the PBRS, taking into account the individual contribution of each Eligible Employee. The award, if any, for an Eligible Employee shall be determined in the sole discretion of the Company, which shall be final, binding and conclusive as to all parties having an interest therein.

VI. Plan Payout

A. Target PBRS Award

The target PBRS award for each Employee is 25% of "Eligible Earnings" (defined below) while in a PBRS Eligible position for the PBRS Plan Year. Eligible Earnings will be multiplied by the 25% target opportunity of the Eligible Participant.

Eligible Earnings include reoccurring items such as pay earned for hours worked, paid time off (e.g. vacation, sick, holiday, funeral, jury duty, military) but will exclude one-time payments such as annual cash incentives, commissions and similar payments, and earnings associated with equity releases and stock option exercises.

B. PBRS Award Determination and Vesting

After the achievement of at least threshold for Operating Profit has been confirmed, performance of modifiers compared to target for the Plan Year will be calculated. The Total Pool for all business units will be fully based (100%) on consolidated Company performance.

The approved PBRS Award is generally payable in RSUs. The number of RSUs that the Participant will receive is equal to the PBRS Award divided by the closing price of Company common stock on the PBRS Award Date.

C. Vesting

The RSUs issued in respect of any PBRS Award will vest in accordance with and subject to the terms and conditions of the ICP and the applicable agreement for each PBRS Award. PBRS Awards unvested as of a Participant's termination of employment shall be governed by the terms and conditions of the applicable agreement for each PBRS Award and the PBRS Plan in effect at the time of grant of each award.

VII. Plan Administration

A. Employment Rights

The PBRS Plan does not create any express or implied contract of employment between the Company and an Eligible Employee or any other person. Both the Company and an Eligible Employee (whether or not a Participant) retain the right to terminate the employment relationship at any time and for any reason.

B. Rights are Non-Assignable

Neither a Participant nor any beneficiary nor any other person shall have any right to assign the right to receive payments hereunder, in whole or in part, which payments are non-assignable and non-transferable, whether voluntarily or involuntarily.

C. Change in Control

In the event of a Change in Control, the PBRS Plan shall remain in full force and effect. Any modifications to or dissolution of the PBRS Plan by the acquiring entity may only occur prospectively and will not affect entitlements, awards or eligibility before the date of the Change in Control.

D. Plan Amendment/Modification/Termination

The Company retains the right to amend, modify, or terminate the PBRS Plan for any reason and at any time on or before December 31 of the PBRS Plan Year, with or without notice to Eligible Employees or any other person. No representative of the Company or its subsidiaries has the authority to modify the terms of that PBRS Plan without written consent of the Chief Human Resources Officer or his or her designee.

E. Withholding

The Company may provide for the withholding from any benefits payable under the PBRS Plan all federal, state, city or other taxes as shall be required pursuant to any law or governmental regulation or ruling.

F. Section 409A of the Code

The Company intends that the PBRS Plan not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and the regulations and guidance thereunder (collectively, "Section 409A") and that to the extent any provisions of the PBRS Plan do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. In all events, the provisions of CVS Health Corporation's Universal 409A Definitions Document are hereby incorporated by reference and, notwithstanding any other provision of the Plan or any Award to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh month immediately following the date of termination of employment. For purposes of any provision of the PBRS Plan providing for the payment of any amounts or benefits in connection with a termination of employment, references to an Eligible Employee's "termination of employment" (and corollary terms) shall be construed to refer to the Eligible Employee's "separation from service" with the Company as determined under Section 409A.

G. Request for Plan Interpretation

Any dispute or request for interpretation of any provision in the PBRS Plan must be submitted to the appropriate Human Resources Business Partner by the Eligible Employee or his or her manager in writing.

H. Compliance with Applicable Regulations

In order to be eligible to receive a PBRS Award under the PBRS Plan, a Participant must comply with all applicable state and federal regulations and Company policies.

I. Governing Law

The validity, construction and effect of the PBRS Plan, and any rules and regulations under the Plan shall be determined in accordance with Delaware law, without giving effect to principles of conflicts of laws, and applicable federal law.

J. Recoupment

Except as may be specifically provided in the PBRS Award, each PBRS Award under the PBRS Plan shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive under the PBRS Plan.

Exhibit 10.39

CVS HEALTH CORPORATION
NONQUALIFIED STOCK OPTION AGREEMENT

GRANT DATE: [_____]

1. GRANT OF AWARD . Pursuant and subject to the provisions of the 2017 Incentive Compensation Plan of CVS Health Corporation (the " **ICP** "), on the date set forth above (the " **Grant Date** "), CVS Health Corporation (the " **Company"**) has granted and hereby evidences the Grant to the person named below (the " **Participant** "), subject to the terms and conditions set forth or incorporated in this Nonqualified Stock Option Agreement (" **Agreement** "), the right, and option, to purchase from the Company the aggregate number of shares of Common Stock ($.01 par value) of the Company (" **Shares** ") set forth below, at the purchase price indicated below (the " **Option** "), such Option to be exercised as hereinafter provided. The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. The Option is a nonqualified option as defined in the ICP.

Participant:	**[_____]**
Employee ID:	**[_____]**
Shares:	**[_____]**
Option Price:	**[_____]**

2. TERM OF OPTION . The term of this Option shall be for a period of seven (7) years from the Grant Date, subject to the earlier termination of the Option, as set forth in the ICP and in this Agreement. No portion of the Option shall be exercisable after the term of the Option.

3. EXERCISE OF OPTION . (a) The Option, subject to the provisions of the ICP, shall be exercised by submitting a request to exercise to the Company's stock option administrator, in accordance with the Company's current exercise policies and procedures, specifying the number of Shares to be purchased, which number may not be less than one hundred (100) Shares (unless the number of Shares purchased is the total balance which is then exercisable). An exercise by Participant of all or part of this Option shall be effected through the Company's "cashless exercise" procedures. Otherwise, at the time of exercise, Participant shall tender to the Company cash or cash equivalent for the aggregate option price of the Shares Participant has elected to purchase or certificates for Shares of Common Stock of the Company owned by Participant for at least six (6) months with a fair market value at least equal to the aggregate option price of the Shares Participant has elected to purchase, or a combination of the foregoing.

(b) Prior to its expiration or termination and except as otherwise provided herein, the Option will become vested in accordance with the vesting schedule set forth below, each date on which vesting occurs a " **Vesting Date** ", and any vested Option will be exercisable by Participant prior to the expiration of its term so long as Participant has maintained continuous employment with the Company or a subsidiary of the Company from the Grant Date through the exercise date:

(i) 25% of the Option shall vest on the 1st anniversary of the Grant Date.
(ii) 25% of the Option shall vest on the 2nd anniversary of the Grant Date.
(iii) 25% of the Option shall vest on the 3rd anniversary of the Grant Date.
(iv) 25% of the Option shall vest on the 4th anniversary of the Grant Date.

4. TAXES . Upon a cashless exercise of the Option the Company shall withhold from the proceeds of the exercise of the Option any required taxes. If the Option is exercised other than through a cashless exercise Company shall have the right to require Participant to pay the amount of any withholding taxes immediately, upon notification from the Company, before the proceeds from the exercise of the Option are delivered to Participant. Furthermore, the Company may elect to deduct such taxes from any other amounts then payable to Participant in cash or in Shares or from any other amounts payable any time thereafter to Participant to the extent allowed under applicable law.

5. NON-TRANSFERABILITY . The Option shall not be transferable by Participant other than by will or by the laws of descent and distribution, and during Participant's lifetime shall be exercised only by the Participant during the continuance of Participant's employment with the Company and any of its subsidiaries.

6. FORFEITURE OF OPTION UPON TERMINATION OF EMPLOYMENT . Unless otherwise provided for in the ICP or in this Agreement, as of the date on which Participant's employment with the Company and its subsidiaries terminates, the Option, to the extent unexercised as of the employment termination date, shall be forfeited immediately in its entirety, provided that, if the Participant's employment with the Company and its subsidiaries terminates without Cause, the Option, to the extent vested and unexercised, shall be exercisable at any time on or before the ninetieth (90 th) day immediately following the employment termination date and, to the extent unvested, shall be forfeited immediately.

7. TERMINATION OF PARTICIPANT'S EMPLOYMENT WITHOUT CAUSE. In the event that Participant's employment with the Company and its subsidiaries is terminated without Cause and Participant receives severance pay following Participant's employment pursuant to a written agreement, vesting of the Option shall continue through the end of the severance period set forth in the agreement providing for such severance pay. To the extent vested, the Option shall be exercisable at any time during the severance period and on or before the ninetieth (90th) day following the last day of the severance period, as long as no government regulations or rules are violated by such continued vesting or exercise period; provided, however, that in no event will the Option be exercisable beyond its original term. Any portion of the Option not vested as of the last day of the severance period shall be forfeited as of the last day of the severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting.

8. RETIREMENT OF PARTICIPANT . In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a Qualified Retirement, Participant (a) shall continue to vest in the Option, to the extent unvested as of the retirement date, for a period of three (3) years following Participant's retirement date and (b) may exercise the Option, to the extent vested, at any time within the period of three (3) years following Participant's retirement date, but not beyond the original term of the Option, in both cases as long as no government regulations or rules are violated by such continued vesting or exercise period. To the extent unvested or unexercised at the end of the three (3) year period following Participant's retirement date, the Option shall be forfeited. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 8 shall apply with respect to the vesting and exercise of the Option as of the Participant's employment termination date. " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 13 below, of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above during the severance period set forth in a severance agreement with the Company.

9. DISABILITY OF PARTICIPANT . In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the Option shall vest as of the employment termination date on a pro-rata basis as follows: the Option shall vest with respect to a total number of Shares as of the employment termination date (which is the last day that Participant is employed by the Company and any subsidiary of the Company) equal to (i) the number of Shares subject to the Option on the Grant Date *multiplied* by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the employment termination date since the Grant Date and (B) the denominator shall be forty-eight (48), *minus* (ii) the number of Shares with respect to which the Option vested prior to the employment termination date (whether or not the Option was previously exercised). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the employment termination date is eight months and five days, the numerator in sub-section (A) above shall be nine **.** The Option may be exercised to the extent vested at any time within one (1) year of Participant's employment termination date but not beyond the original term of the Option. The prorated Option shall vest on the Participant's employment termination date.

10. DEATH OF PARTICIPANT . In the event of Participant's death while Participant is employed with the Company and any subsidiary of the Company, the Option shall immediately vest in full, and the Option shall remain exercisable for a period of one (1) year after Participant's death, or until the Option expiration date, whichever occurs first, by Participant's Beneficiary. At the end of said one (1)-year time period, all rights with respect to any Option that is unexercised shall terminate and the Option shall be cancelled.

11 . TRANSFER OF EMPLOYMENT . Transfer of Participant's employment from the Company to a subsidiary of the Company, among or between subsidiaries of the Company, or from a subsidiary of the Company to the Company shall not be treated as termination of employment.

12. REQUIRED ACCEPTANCE OF AWARD. The Option may not be exercised unless and until the Company has received the Participant's acceptance of the terms and conditions set forth herein. Acceptance shall be submitted electronically as required by the Company.

13. NOTICE . Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to Participant at his or her address as shown on the records of the Company, subject to the right of either party hereafter to designate in writing to the other some other address.

14. RECOUPMENT OF OPTION AWARD . The Option subject to this Agreement under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that a copy of the Company's Recoupment Policy has been made available for the Participant's reference.

15. COMMITTEE AUTHORITY . The Committee shall have the authority, in its sole discretion, to make any interpretations, determinations, and/or take any administrative actions with respect to the ICP and this Agreement, including whether any post-termination payments to Participant shall be deemed severance pay, the duration of any severance period, and/or whether a termination was without cause.

16. GOVERNING LAW . This Nonqualified Stock Option Agreement and the Option evidenced hereby shall be governed by the laws of Delaware, without giving effect to principles of conflict of laws.

17. ACKNOWLEDGEMENT. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 10.40

CVS HEALTH CORPORATION
RESTRICTED STOCK UNIT AGREEMENT - ANNUAL GRANT

GRANT DATE : **[_____]**

1. Pursuant and subject to the provisions of the 2017 Incentive Compensation Plan of CVS Health Corporation (the " **ICP** "), on the date set forth above (the " **Grant Date** "), CVS Health Corporation (the " **Company** ") has awarded and hereby evidences the Restricted Stock Unit (" **RSU** ") award (the " **Award** ") to the person named below (the " **Participant** "), subject to the terms and conditions set forth and incorporated in this Restricted Stock Unit agreement (the " **Agreement** "). The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. On the Grant Date specified above, the Fair Market Value (the "FMV"), which is the Closing Price of the Company's common stock on the Grant Date, of each RSU equals **[_____]** .

Participant:	**[_____]**
Employee ID:	**[_____]**
RSUs (#):	**[_____]**

2. Each RSU represents a right to a future payment of one share (" **Share** ") of Common Stock ($0.01 par value) of the Company, subject to required tax withholding.

3. (a) To the extent dividends are paid on Shares while the RSUs remain outstanding, subject to Section 5(b), a cash amount equivalent to the dividends paid (such cash amount, a "Dividend Equivalent") with respect to the number of Shares covered by the RSUs shall accrue. Any accrued Dividend Equivalent shall be payable only upon vesting of the underlying RSUs. To the extent that the underlying RSUs do not vest hereunder, any related accrued Dividend Equivalent shall be forfeited.

   (b) Participant hereby agrees that the Company may withhold from the Dividend Equivalents, referred to in Paragraph 3(a) above, amounts sufficient to satisfy the applicable tax withholding in respect of such Dividend Equivalents.

4. Subject to the terms and conditions of the ICP and this Agreement and subject to Participant's continued employment, Participant shall be entitled to receive (and the Company shall deliver to Participant) (a) the Shares on the Vesting Date set forth herein, or as soon as administratively practicable, but within 30 days thereafter, unless delivery of the Shares has been deferred in accordance with Section 5 below (the date of such delivery of the Shares being hereafter referred to as the " **Settlement Date** ") and (b) the Dividend Equivalents on the Vesting Date(s) set forth herein, or as soon as administratively practicable but within 30 days thereafter. The " **Vesting Date** ," except as otherwise provided in Section 7, shall be the fourth anniversary of the Grant Date.

5. (a) In accordance with rules promulgated by the Management Planning and Development Committee of the Board of Directors (the " **Committee** "), Participant, to the extent eligible under the CVS Health Deferred Stock Compensation Plan, may elect to defer delivery of Shares in settlement of RSUs covered by this Agreement. Any such deferred delivery date elected by Participant shall become the Settlement Date for purposes of this RSU Agreement.

(b) Notwithstanding Section 3(a), to the extent dividends are paid on such deferred Shares following the Vesting Date and prior to the Settlement Date, Participant shall be entitled to receive a number of additional deferred Shares equal to: (x) the amount of dividend per Share as declared by the Company's Board of Directors on the Company's common stock multiplied by (y) the number of deferred Shares held by Participant on the record date of such dividend, divided by (z) the FMV of a Share on such dividend payment date.

6. On the Settlement Date the number of Shares to be delivered by the Company to Participant shall be reduced by the smallest number of Shares having a FMV at least equal to the dollar amount of federal, state and local tax withholding required to be withheld by the Company with respect to such RSUs on such date.

7. (a) Except as provided in Paragraphs 7 (b) - (f) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all RSUs not then vested in accordance with Section 4 above shall be immediately forfeited.

(a) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, RSUs not then vested in accordance with Section 4 will become immediately vested and the Vesting Date shall be the date of death.

(b) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a "Qualified Retirement", RSUs shall vest on a pro-rata basis as of the Participant's retirement date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company, as follows: the total number of RSUs vesting as of the retirement date shall be equal to (i) the number of RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the retirement date since the Grant Date and (B) the denominator shall be forty-eight (48). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the retirement date is eight months and five days, the numerator in sub-section (A) above shall be nine. " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 10 below, of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above during the severance period set forth in a severance agreement with the Company. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 7(c) or the terms of Section 7(e), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. Any Shares represented by the pro-rated RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(d) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the RSUs shall vest as of the employment termination date on a pro rata basis as follows: the total number of RSUs vested as of the termination date, which is the last date that the Participant is employed by the Company and any subsidiary of the Company, shall be equal to the number of RSUs granted on the Grant Date multiplied by

the following fraction: (A) the numerator shall be the whole number of months elapsed as of Participant's termination date since the Grant Date and (B) the denominator shall be forty-eight (48). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is eight months and five days, the numerator in sub-section (A) above shall be nine. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this RSU Agreement.

(e) In the event Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay, RSUs not vested at the time of Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall continue to vest during the severance period and settle in accordance with the original schedule set forth in Section 4 of this RSU Agreement. All RSUs not scheduled to vest during the specified severance period shall be forfeited as of the last day of the Participant's severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period specified in a severance agreement with the Company, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting. In the event Participant's termination of employment qualifies as a Qualified Retirement the terms of this Section 7(e) or the terms of Section 7(c), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. During any severance period, Participant is eligible to accrue Dividend Equivalents on outstanding RSUs as described in Paragraph 3(a) above.

(f) Notwithstanding the above, (i) the provisions of Section 10 of the ICP shall apply in the event of a Change in Control (as defined in such Section 10) and (ii) the provisions of Section 7(e)(iv) of the ICP shall apply.

(g) For purposes of this Section 7, transfer of Participant's employment from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, or transfer from a subsidiary of the Company to the Company shall not be treated as a termination of employment.

(h) Participant will be responsible for any applicable withholding or other taxes that may become due as a result of RSUs that vest as of Participant's employment termination date or thereafter.

8. An RSU does not represent an equity interest in the Company and carries no voting rights. Participant shall have no rights of a shareholder with respect to the RSUs until the Shares have been delivered to Participant.

9. Neither the execution and delivery hereof nor the granting of the Award evidenced hereby shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

10. Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

11. All decisions and interpretations made by the Board of Directors or the Committee with regard to any question arising hereunder or under the ICP shall be binding and conclusive on all persons. In the event of any inconsistency between the terms hereof and the provisions of the ICP, the ICP shall govern.

12. The award of RSUs pursuant to this Agreement is expressly subject to and contingent upon the requirement that the Participant shall have fully executed and delivered to the Company the Restrictive Covenant Agreement, that may be required and provided by the Company. The applicable agreement containing the restrictive covenants that the Company may require in connection with this award is hereafter referred to as the "Restrictive Covenant Agreement".

    If the Company intends to require Participant to execute and deliver a new Restrictive Covenant Agreement in connection with the grant hereunder, the Company shall provide such new Restrictive Covenant Agreement to Participant and Participant agrees to execute and deliver such new Restrictive Covenant Agreement by the deadline set forth by the Company. If Participant is currently subject to a Restrictive Covenant Agreement and the Company does not require Participant to execute and deliver a new Restrictive Covenant Agreement, then by accepting the award of RSUs, pursuant to this Agreement. Participant affirms his or her Restrictive Covenant Agreement and intent to be bound by the restrictions in the Restrictive Covenant Agreement and to comply with all of its provisions.

    Participant agrees that failure to execute and return the new Restrictive Covenant Agreement, if required, by the deadline set forth by the Company shall result in the immediate and irrevocable forfeiture of the RSU Award hereunder and any right to receive dividend equivalents or Shares with respect thereto. Further, if Participant violates any provision of the applicable Restrictive Covenant Agreement, any unvested RSUs will be immediately and irrevocably forfeited, and no payment of any kind, including Dividend Equivalents or Shares, shall be payable with respect thereto. This Section shall not constitute the Company's exclusive remedy for Participant's violation of the Restrictive Covenant Agreement. The Company reserves all rights to seek all available legal or equitable remedies in the event of Participant's violation or threatened violation of the Restrictive Covenant Agreement, including injunctive relief.

13. By accepting this Award, Participant acknowledges that a copy of the ICP has been made available by the Company for Participant's reference and agrees to be bound by the terms and conditions set forth in this Agreement and the ICP as in effect from time to time.

14. By accepting this Award, Participant further acknowledges that the Federal securities laws and/or Company's policies regarding trading in its securities may limit or restrict Participant's right to trade Shares, including without limitation, sales of Shares acquired in connection with RSUs. Participant agrees to comply with such Federal securities law requirements and Company policies, as such laws and policies may be amended from time to time.

15. The Company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and that to the extent any provisions of this Agreement do not comply with Code Section 409A the Company will make such changes in order to comply with Code Section 409A to the extent it considers reasonable. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A of the Code shall be delayed until the first business day of the seventh month immediately following the employment termination date. For purposes of any provision of this Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to the "termination of employment" (and corollary terms) shall be construed to refer to "separation from service" (within the meaning of Treas. Reg. Section 1.409A-1(h)). Notwithstanding the foregoing, the Company makes no representations as to the tax treatment or consequences of any payment made hereunder, and Participant, by accepting this Award, acknowledges that Participant shall be solely responsible for same.

16. The Award subject to this RSU Agreement under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay

to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for the Participant's reference.

17. This Agreement shall be governed by the laws of Delaware, without giving effect to its choice of law provisions.

18. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 10.41

CVS HEALTH CORPORATION
PERFORMANCE-BASED RESTRICTED STOCK UNIT AGREEMENT

GRANT DATE : **[_____]**

1. Pursuant and subject to the provisions of the 2017 Incentive Compensation Plan of CVS Health Corporation (the " **ICP** "), on the date set forth above (the " **Grant Date** "), the CVS Health Corporation (the " **Company** ") has awarded and hereby evidences the Performance-Based Restricted Stock (" **PBRS** ") unit award (the " **Award** ") to the person named below (the " **Participant** "), subject to the terms and conditions set forth and incorporated in this PBRS Agreement (the " **PBRS Agreement** "), the Restricted Stock Units (" **RSUs** ") set forth below. The ICP is hereby made a part hereof and Participant agrees to be bound by all the provisions of the ICP. Capitalized terms not otherwise defined herein shall have the meaning assigned to such term(s) in the ICP. On the Grant Date specified above, the Fair Market Value (the " **FMV** ") of a share of Stock equals **[_____]** , which is the closing price on such date.

Participant	**[_____]**
Employee Number	**[_____]**
RSUs (#)	**[_____]**

2. Each RSU represents a right to a future payment of one share (" **Share** ") of Common Stock ($0.01 par value) of the Company, subject to required tax withholding.

3. (a) To the extent dividends are paid on Shares while the RSUs remain outstanding, subject to Paragraph 5(b), a cash amount equivalent to the dividends paid (such cash amount, a "Dividend Equivalent") with respect to the number of Shares covered by the RSUs shall accrue. Any accrued Dividend Equivalent shall be payable only upon vesting of the underlying RSUs. To the extent that the underlying RSUs do not vest hereunder, any related accrued Dividend Equivalent shall be forfeited.

   (b) Participant hereby agrees that the Company may withhold from the Dividend Equivalents, referred to in Paragraph 3(a) above, amounts sufficient to satisfy the applicable tax withholding in respect of such Dividend Equivalents.

4. Subject to the terms and conditions of the ICP and this PBRS Agreement, and subject to Participant's continued employment, Participant shall be entitled to receive (and the Company shall deliver to Participant) (a) the Shares on the Vesting Date(s) set forth herein, or as soon as administratively practicable thereafter, but within 30 days, thereafter unless delivery of the Shares has been deferred in accordance with Paragraph 5 below (the date of such delivery of the Shares being hereafter referred to as the "Settlement Date") and (b) the Dividend Equivalents on the Vesting Date(s) set forth herein, or as soon as administratively practicable but within 30 days thereafter. Each "Vesting Date," except as otherwise provided in Paragraph 7, shall be in accordance with the schedule set forth below:

   (a) one-third (1/3) of the RSUs on the first anniversary of the Grant Date;
   (a) one-third (1/3) of the RSUs on the second anniversary of the Grant Date; and
   (b) one-third (1/3) of the RSUs on the third anniversary of the Grant Date.

5. (a) In accordance with rules promulgated by the Management Planning and Development Committee of the Board of Directors (the " **Committee** "), Participant, to the extent eligible under the CVS Health Deferred Stock Compensation Plan, may elect to defer delivery of Shares in settlement of RSUs covered by this PBRS Agreement. Any such deferred delivery date elected by Participant shall become the Settlement Date for purposes of this PBRS Agreement.

   (b) Notwithstanding Paragraph 3(a), to the extent dividends are paid on such deferred Shares following the Vesting Date and prior to the Settlement Date, Participant shall be entitled to receive a number of additional deferred Shares equal to: (x) the amount of dividend per Share as declared by the Company's Board of Directors on the Company's common stock multiplied by (y) the number of deferred Shares held by Participant on the record date of such dividend, divided by (z) the FMV of a Share on such dividend payment date.

6. On the Settlement Date the number of Shares to be delivered by the Company to Participant shall be reduced by the smallest number of Shares having a FMV at least equal to the dollar amount of Federal, state and local tax withholding required to be withheld by the Company with respect to such RSUs on such date.

7. (a) Except as provided in Paragraphs 7 (b) - (f) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all RSUs not then vested in accordance with Paragraph 4 above, shall be immediately forfeited.

   (a) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, RSUs not then vested in accordance with Paragraph 4 will become immediately vested and Vesting Date shall be the date of death.

   (c) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of a "Qualified Retirement", RSUs will become immediately vested as of Participant's retirement date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company. The Vesting Date shall be the effective date of the Participant's termination of employment. " **Qualified Retirement** " shall mean a Participant's termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice, in accordance with the provisions of Section 9 below, of the date of his or her termination of employment or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, such termination is without cause. A Participant shall also be deemed to have experienced a Qualified Retirement if the Company elects to terminate Participant's employment without Cause and Participant shall meet the age and service requirement set forth above as of during the severance period set forth in a severance agreement with the Company. In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, the terms of this Section 6(c) or the terms of Section 6(e), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this PBRS Agreement.

   (d) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such Plan, as defined by the Social Security Administration), the RSUs shall vest as of the employment termination date on a pro rata basis as follows: the total number of RSUs vesting as of the termination date, which is the last day that the Participant is employed by the Company and any subsidiary of the Company shall be equal to (i) the number of RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed as of the

termination date since the Grant Date and (B) the denominator shall be thirty-six (36) *minus* (ii) the number of RSUs that had vested prior to the termination date. For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the termination date is eight months and five days, the numerator in sub-section (A) above shall be nine. The Vesting Date shall be the effective date of the Participant's termination of employment. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section 4 of this PBRS Agreement.

(e) In the event Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay, RSUs not vested at the time of Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall continue to vest during the severance period and settle in accordance with the original schedule set forth in Section 4 of this PBRS Agreement. All RSUs not scheduled to vest during the specified severance period shall be forfeited as of the last day of the Participant's severance period. In the event that Participant returns to employment with the Company or any subsidiary prior to the expiration of the severance period specified in a severance agreement with the Company, Participant shall be treated as if his or her employment with the Company or any subsidiary of the Company had continued through the severance period for purposes of determining eligibility for continued vesting. In the event Participant's termination of employment qualifies as a Qualified Retirement the terms of this Section 6(e) or the terms of Section 6(c), whichever provides for greater benefits to Participant, shall be applied with respect to the vesting of RSUs that are unvested as of the employment termination date. During any severance period, Participant is eligible to accrue Dividend Equivalents on outstanding RSUs as described in Paragraph 3(a) above.

(f) Notwithstanding the above, (i) the provisions of Section 10 of the ICP shall apply in the event of a Change in Control (as defined in such Section 10) and (ii) the provisions of Section 7(e)(iv) of the ICP shall apply.

(g) For purposes of this Section 7, transfer of Participant's employment from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, or transfer from a subsidiary of the Company to the Company shall not be treated as termination of employment.

(h) Participant will be responsible for any applicable withholding or other taxes that become due as a result of RSUs that vest as of Participant's employment termination date or thereafter.

8. An RSU does not represent an equity interest in the Company and carries no voting rights. Participant shall have no rights of a shareholder with respect to the RSUs until the Shares have been delivered to Participant.

9. Neither the execution and delivery hereof nor the granting of the award evidenced hereby shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

10. Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

11. All decisions and interpretations made by the Board of Directors or the Committee with regard to any question arising hereunder or under the ICP shall be binding and conclusive on all persons. In the event of any inconsistency between the terms hereof and the provisions of the ICP, the ICP shall govern.

12. By accepting this Award, Participant acknowledges that a copy of the ICP has been made available for the Participant's reference, and agrees to be bound by the terms and conditions set forth in this Agreement and the ICP as in effect from time to time.

13. By accepting this Award, Participant further acknowledges that the Federal securities laws and/or Company's policies regarding trading in its securities may limit or restrict Participant's right to buy or sell Shares, including without limitation, sales of Shares acquired in connection with RSUs. Participant agrees to comply with such Federal securities law requirements and Company policies as such laws and policies may be amended from time to time.

14. The company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and the regulations and guidance thereunder (collectively, "Section 409A") and that to the extent any provisions of this PBRS Agreement do not comply with Section 409A the Company will make such changes as it deems reasonable in order to comply with Section 409A. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and, notwithstanding any other provision of the Plan or this PBRS Agreement to the contrary, to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A shall be delayed until the first business day of the seventh month immediately following the date of termination of employment. For purposes of any provision of this PBRS Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to the "termination of employment" (and corollary terms) shall be construed to refer to "separation from service" as determined under Section 409A.

15. The Award subject to this PBRS Agreement under the Plan and ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require the Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for Participant's reference.
16. This Agreement shall be governed by the laws of Delaware, without giving effect to its choice of law provisions.

17. This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

By: /s/ Lisa G. Bisaccia
Executive Vice President, Chief Human Resources Officer
CVS Health Corporation

Exhibit 10.42

PARTNERSHIP EQUITY PROGRAM
Participant Purchased RSUs, Company Matching RSUs and Company Matching Option Agreement

AGREEMENT, by and between CVS Health Corporation, a Delaware corporation (the "Company"), and _____ ("Participant"), effective on _____ , herein after known as the "Grant Date" (this "Agreement") **.**

WHEREAS, Participant has been selected as an Eligible Participant to invest under the Company's Partnership Equity Program (the "PEP") and has elected in the Participant's Election Form to invest $ _____ in the PEP, subject to the terms and conditions set forth in the PEP and in this Agreement;

WHEREAS, the Company desires to provide Participant with written evidence acknowledging Participant's investment under the PEP through Participant Purchased RSUs and the corresponding grant of Company Matching RSUs and a Company Matching Option under the PEP.

WHEREAS, the provisions of the PEP and the Company's 2017 Incentive Compensation Plan (the "ICP") are hereby incorporated by reference and shall have the same force and effect as though fully set forth herein; Participant hereby acknowledges that a copy of the PEP and the ICP have been made available to Participant and agrees to be bound by such provisions (as presently in effect or hereafter amended); if any provision of this Agreement is inconsistent with a provision of the PEP or the ICP, the terms of the PEP and/or the ICP, or any successor thereto, shall control; capitalized terms used in this Agreement but not defined herein shall have the same meanings as in the PEP or the ICP, as the case may be; and on the Grant Date specified above, the Fair Market Value (the "FMV") of a share of CVS Health Common Stock ("Stock") equals $ ____ which is the closing price on such date.

NOW, THEREFORE, in consideration of the mutual covenants contained herein and other good and valuable consideration, the parties hereto agree as follows:

I. PARTICIPANT PURCHASED RSUs AND COMPANY MATCHING RSUs

(A) **Participant Purchased RSUs** . The Company has received from Participant a completed Participant Election Form authorizing the Company to apply designated compensation of $_____ to the purchase of _____ Participant Purchased RSUs on the Grant Date under the PEP, and the Company has accordingly credited Participant's Account under the PEP with the Participant Purchased RSUs. Except as provided under Section III of this Agreement, the Participant Purchased RSUs (including any Participant Purchased RSUs credited to Participant pursuant to Section I(C)(ii)) shall be fully vested as of the Grant Date and shall settle on the fifth (5 th) anniversary of the Grant Date.

(B) **Crediting of Company Matching RSUs** . As of the Grant Date, the Company hereby awards the Participant, subject to the terms and conditions set forth and incorporated in this Agreement and the PEP, _____ Company Matching RSUs.

(C) **Additional Transactions in Participant Accounts** .

(i) Each Participant Purchased RSU and Company Matching RSU represents a right to a future payment of one share of Stock, subject to applicable tax withholding.

(ii) To the extent that dividends are declared and paid on shares of Stock while the Participant Purchased RSUs and Company Matching RSUs remain outstanding and prior to a Settlement Date (as defined below), the Company shall credit to Participant's Purchased RSU account and Company Matching RSU account (as applicable) an additional number of Participant Purchased RSUs and Company Matching RSUs calculated by multiplying (a) the amount of dividend per share of Stock approved by the Company's Board of Directors by (b) the number of Participant Purchased RSUs and Company Matching RSUs held by Participant on the dividend record date, and dividing the product by (c) the FMV of a share of Stock on such dividend payment date.

(iii) Provided, however, that if such dividend is paid prior to the Vesting Date of Participant Purchased RSUs and/or the Company Matching RSUs, as set forth in Section I (D) below, Participant shall not be entitled to any

payment in respect of such dividend unless Participant is still employed by the Company on such dividend payment date.

(iv) Participant hereby agrees that, prior to the Settlement Date, the Company may withhold from the dividend equivalent amounts described to in Section I(C)(ii) amounts sufficient to satisfy the applicable tax withholding in respect of such dividend equivalent payments, as applicable.

(D) **Vesting of Company Matching RSUs .** Subject to the terms and conditions of the PEP and this Agreement, and to Participant's continued employment through such date, the Company Matching RSUs, and the dividend equivalent amounts attributed to same, shall vest on the fifth (5 th) anniversary of the Grant Date.

(E) **Settlement of Company Matching RSU.**

(i) A "Settlement Date" shall mean the date shares of Stock are delivered to Participant pursuant to the PEP and this Agreement.

(ii) Within fifteen (15) days following the earliest of the fifth (5 th) anniversary of the Grant Date, Participant's death, or termination of employment without Cause within the two-year period following a Change in Control, Participant shall be entitled to receive and the Company shall deliver to Participant the total number of shares of Stock (giving effect to Sections I(C)(ii) and I(C)(iv)) underlying the Company Matching RSUs on the Vesting Date set forth herein, or as soon as administratively practicable, but within 30 days thereafter, unless delivery of the Shares has been deferred in accordance with Section I(E)(iii) below (the date of such delivery of the Shares being hereafter referred to as the " **Settlement Date** "). Notwithstanding the foregoing, no shares of Stock shall be delivered upon termination of employment unless such termination of employment is considered a "separation from service" (within the meaning given of Treasury Regulation §1.409A-1(h) or successor guidance thereto).

(iii) Subject to the rules promulgated by the Committee, the terms of the CVS Health Deferred Stock Compensation Plan and Section 409A, Participant may elect to defer settlement of Participant Purchased RSUs or Company Matching RSUs covered by this Agreement.

II. COMPANY MATCHING OPTION

(A) **Grant of Option** . The Company hereby awards and evidences the grant to Participant, subject to the terms and conditions incorporated in this Agreement, the right, and option, to purchase from the Company _____ shares of Stock, with an exercise price per share of Stock equal to the FMV of a share of Stock on the Grant Date, such Company Matching Option to be exercised as hereinafter provided. The Company Matching Option is a nonqualified option as defined in the ICP.

(B) **Term of Company Matching Option .** The term of this Company Matching Option shall be for a period of ten (10) years from the Grant Date, subject to the earlier termination of the Company Matching Option, as set forth in the ICP and in this Agreement.

(C) **Vesting and Exercise of Company Matching Option**

(i) Prior to its expiration or termination, and except as otherwise provided herein, the Company Matching Option shall vest and may be exercised by Participant, provided Participant has maintained continuous employment with the Company or a subsidiary of the Company from the Grant Date until the applicable vesting date, within the following time limitations:

a. On or after three (3) years from the Grant Date, the Company Matching Option shall be vested and may be exercised as to one-third (1/3) of the shares of Stock subject to the Company Matching Option;

b. On or after four (4) years from the Grant Date, the Company Matching Option shall be vested and may be exercised as to an aggregate of two-thirds (2/3) of the shares of Stock subject to the Company Matching Option; and

c. On or after five (5) years from the Grant Date, the Company Matching Option shall be vested and may be exercised as to all of the shares of Stock subject to the Company Matching Option.

(ii) The Company Matching Option, subject to the provisions of the ICP, shall be exercised by submitting a request to exercise to the Company's stock option administrator, in accordance with the Company's current exercise policies and procedures, specifying the number of shares of Stock to be purchased, which number may not be less than one hundred (100) shares of Stock (unless the number of shares of Stock purchased is the total balance which is then exercisable). An exercise by Participant of all or part of this Company

Matching Option shall be effected through the Company's "cashless exercise" procedures. Otherwise, at the time of exercise, Participant shall tender to the Company cash or cash equivalent for the aggregate exercise price of the shares of Stock Participant has elected to purchase or certificates for shares of Stock of the Company already owned by Participant for at least six (6) months with an aggregate FMV at least equal to the aggregate exercise price of the shares of Stock Participant has elected to purchase, or a combination of the foregoing.

(D) **Company Matching Option Expiration** . The Company Matching Option shall be exercisable only as provided above and shall expire at the close of business on the tenth (10 th) anniversary of its Grant Date or such earlier expiration date as described in Section III below.

III. TERMINATION OF EMPLOYMENT AND CHANGE IN CONTROL

(A)

(i) If Participant's employment with the Company and its subsidiaries terminates within 24 months of the grant date as a result of the Participant's voluntary termination of employment or involuntary termination by the Company or any subsidiary for Cause, the Participant Purchased RSUs shall be immediately forfeited as of the termination date .

(ii) Except as provided in Section III (B)-(F) below, if, for any reason, Participant's employment with the Company and any subsidiary of the Company terminates, all Company Matching RSUs and the Company Matching Option to the extent not vested as of the termination date in accordance with Sections I(D) and II(C)(i) above shall be immediately forfeited as of the termination date. To the extent vested and unexercised as of the termination date, the Company Matching Option shall be exercisable on or before the ninetieth (90 th) day following the termination date, as long as no government regulations or rules are violated by such exercise period; provided, however, that the Company Matching Option shall not be exercisable beyond its original term.

(B) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of death, Company Matching RSUs and the Company Matching Option not then vested in accordance with Section I(D) and Section II(C)(i), respectively, will become immediately vested and the Vesting Date will be the date of death. Participant Purchased RSUs and Company Matching RSU shall settle as of the date of death and the Company Matching Option shall be exercisable by the Participant's Beneficiary during the twelve (12) month period following the date of death, as long as no government regulations or rules are violated by such accelerated vesting or exercise period; provided, however, that no Company Matching Option will be exercisable beyond its original term.

(C) In the event Participant's employment with the Company and any subsidiary of the Company terminates by reason of total and permanent disability (as defined in the Company's Long-Term Disability Plan, or, if not defined in such plan, as defined by the Social Security Administration), the Company Matching RSUs and the Company Matching Option shall vest on a pro rata basis as follows:

(i) the total number of Company Matching RSUs vested as of Participant's employment termination date (which is the last day that the Participant is employed by the Company or any subsidiary of the Company) shall be equal to the number of Company Matching RSUs granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed since the Grant Date and (B) the denominator shall be sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed between the Grant Date and the Separation Date is eight months and five days, the numerator in sub-section (A) above shall be nine. Participant will be responsible for any applicable withholding taxes that may become due as of Participant's employment termination date. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section I(D) of this PEP Agreement.

(ii) the total number of Company Matching Option vested as of Participant's employment termination date with respect to the number of shares of Stock subject to the Company Matching Options, shall be equal to the number of Company Matching Options granted on the Grant Date multiplied by the following fraction: (A) the numerator shall be the whole number of months elapsed since the Grant Date and (B) the denominator shall be sixty (60). For purposes of this calculation, the number of months in the numerator in sub-section (A) above shall include any partial month in which Participant has worked. For example, if the time elapsed

between the Grant Date and the Separation Date is eight months and five days, the numerator in sub-section (A) above shall be nine.

(iii) the vested portion of the Company Matching Option shall be exercisable during the twelve (12) month period following Participant's employment termination date, as long as no government regulations or rules are violated by such accelerated vesting or exercise period; provided, however, that the Company Matching Option shall not be exercisable beyond its original term.

(D) **Involuntary Termination with Severance.** In the event that Participant's employment with the Company and any subsidiary of the Company terminates and Participant receives severance pay pursuant to a written agreement in the form required by the Company, Participant's Company Matching RSUs and the Company Matching Option to the extent not vested at the time of the Participant's employment termination date but scheduled to vest during the severance period specified in the agreement providing for severance pay shall continue to vest during the severance period and settle in accordance with the schedule set forth in Section I(D) and Section II(C)(i), respectively, of this Agreement. Participant will be responsible for any applicable withholding taxes that may become due as of Participant's employment termination date. All Company Matching RSUs and the Company Matching Option to the extent not scheduled to vest during the specified severance period shall be forfeited as of the Participant's employment termination date. Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section I(D) of this PEP Agreement. During any severance period, Participant is eligible to receive dividend equivalents on outstanding RSUs as described in Paragraph I(C)(ii) above. To the extent vested, the Company Matching Option shall be exercisable on or before the ninetieth (90 th) day following the last day of the severance period, as long as no government regulations or rules are violated by such continued vesting or exercise period; provided, however, that the Company Matching Option shall not be exercisable beyond its original term.

(E) **Retirement** . " **Qualified Retirement** " shall mean termination of employment on or after attainment of age fifty-five (55) with at least ten (10) years of continuous service, or attainment of age sixty (60) with at least five (5) years of continuous service, provided that: (i) if Participant elects to terminate his or her employment voluntarily, Participant has provided the Company with at least twelve (12) months advance notice of his or her retirement date or such other term of advance notice as is determined by the Chief Human Resources Officer of the Company; or (ii) if the Company elects to terminate Participant's employment, then such termination is without cause.

(i) In the event Participant's termination of employment qualifies as a Qualified Retirement, Participant may exercise the Company Matching Option to the extent vested as of Participant's retirement date at any time within two (2) years after Participant's retirement date, but not beyond the original term of the Company Matching Option. To the extent unvested as of the retirement date, the Company Matching Option shall be forfeited. The Committee shall have the authority in its sole discretion to make any interpretations, determinations, and/or take any administrative actions with respect to whether Participant has experienced a Qualified Retirement.

(ii) Company Matching RSUs that are unvested as of the Participant's retirement date are forfeited as of the retirement date.

(iii) In the event Participant's termination of employment qualifies as a Qualified Retirement and Participant also enters into a severance agreement with the Company, each portion of a Participant's Company Matching RSU or Company Matching Option under this Award shall be entitled to the more favorable treatment explicitly applicable to such portion of the Participant's Company Matching RSU or Company Matching Option under the provisions of Section XIII(F) of the PEP with respect to the vesting and settlement of the Company Matching RSUs and the Company Matching Option.

Any Shares represented by RSUs that vest under this section shall settle on the Settlement Date that would have applied under the original schedule set forth in Section I(D) of this PEP Agreement.

(F) The provisions of Section 10 of the ICP, or any successor thereto, shall apply in the event of a Change in Control.

(G) For purposes of this Section III, transfer of employment by Participant from the Company to a subsidiary of the Company, transfer among or between subsidiaries of the Company, transfer from a subsidiary of the Company to the Company or any other continuation of employment with the Company or a subsidiary of the Company after termination by a related entity shall not be treated as termination of employment.

IV. NON-COMPETITION. The grant of RSUs pursuant to this Agreement is expressly subject to and contingent upon the requirement that the Participant shall have fully executed and delivered to the Company the CVS Health Corporation

Restrictive Covenant Agreement provided by the Company; provided that the Company in its sole discretion may waive such requirement if Participant is currently a party to another agreement with the Company setting forth restrictive covenants, such as non-competition, non-disclosure, and/or non-solicitation obligations. The applicable agreement containing the restrictive covenants the Company requires in connection with this Award, whether previously executed or required to be executed in connection with this Award, is hereafter referred to as the "Restrictive Covenant Agreement".

If the Company intends to require Participant to execute and deliver a new Restrictive Covenant Agreement in connection with the Award hereunder, the Company shall provide such Restrictive Covenant Agreement to Participant and Participant agrees to execute and deliver such agreement by the deadline set forth by the Company, which shall be no less than ten days from the date it is provided to Participant. If Participant is currently subject to a Restrictive Covenant Agreement, Participant hereby affirms his or her agreement and intent to be bound by the restrictions in the Restrictive Covenant Agreement and to comply with all of its provisions.

Participant agrees that failure to execute and return the Restrictive Covenant Agreement by the deadline set forth by the Company, if required, shall result in the immediate and irrevocable forfeiture of the RSU Award hereunder and any right to receive dividend equivalents or Shares with respect thereto. Further, if Participant violates any provision of the applicable Restrictive Covenant Agreement, any unvested RSUs will be immediately and irrevocably forfeited, and no payment of any kind, including dividend equivalents or Shares, shall be payable with respect thereto. This Section shall not constitute the Company's exclusive remedy for Participant's violation of the Restrictive Covenant Agreement, and the Company may seek all available legal or equitable remedies in the event of Participant's violation or threatened violation of the Restrictive Covenant Agreement, including injunctive relief.

V. MISCELLANEOUS .

(A) Withholding Tax . Participant may be subject to withholding taxes as a result of the exercise of the Company Matching Option or settlement of Participant Purchased RSUs or Company Matching RSUs. The number of shares of Stock to be delivered by the Company to Participant shall be reduced by the smallest number of shares of Stock having a FMV at least equal to the dollar amount of federal, state or local tax withholding required to be withheld by the Company with respect to such exercise or settlement. Any shares of Stock so withheld or tendered will be valued as of the date they are withheld or tendered. Participant shall remit to the Company in cash, promptly when the amount of such tax obligations become determinable, all applicable federal, state, local and any foreign withholding taxes that result from each exercise of the Company Matching Option.

(B) Recoupment. This Award under the ICP shall be subject to the terms of the Company's Recoupment Policy as it exists from time to time, which may require Participant to immediately repay to the Company the value of any pre-tax economic benefit that he or she may derive from the Award. By accepting this Award, Participant acknowledges that the Company's Recoupment Policy has been made available for Participant's reference.

(C) Certain Terms and Conditions of the PEP . Participant acknowledges and agrees that the terms and conditions of the PEP preclude all transfers of Participant Purchased RSUs, all Company Matching RSUs, and the Company Matching Option, except in limited circumstances in the event of Participant's death, impose a risk of forfeiture on Participant Purchased RSUs, Company Matching RSUs and the Company Matching Option, relieve the Company of certain obligations unless and until laws and regulations have been complied with, provide for adjustments to Participant Purchased RSUs, Company Matching RSUs, and the Company Matching Option upon the occurrence of certain events, and specify the state law which shall govern this Agreement, without giving effect to principles of conflict of laws.

(D) Binding Agreement . This Agreement shall be binding upon the heirs, executors, administrators, and successors of the parties. In particular, Participant's heirs, executors, administrators, and successors shall be subject to the terms and conditions of the PEP, ICP and this Agreement, and the Company may require any such person to execute an agreement or other documents acknowledging and agreeing to such terms and conditions as a condition precedent to any transfer of rights hereunder or shares of Stock issuable under the PEP, including upon exercise of the Company Matching Option, into the name of any such person.

(E) Integration Clause; Amendments to Agreement . This Agreement, together with the PEP and the ICP, constitutes the entire Agreement between the parties with respect to the PEP, and supersedes any prior agreements or documents with respect thereto. This Agreement may be amended, but no amendment or other change which may impose any additional obligation upon the Company or materially impair the rights of Participant under the PEP shall be valid unless contained in a writing signed by the party to be bound thereby.

(F) Employment . Neither the execution and delivery hereof nor the granting of the Company Matching RSUs or

the Company Matching Option evidenced hereby shall constitute or be evidence of any agreement or understanding, expressed or implied, on the part of the Company or its subsidiaries to employ Participant for any specific period.

(G) **Required Acceptance of Award.** Acceptance may be submitted either electronically, if available, or in writing. The Company Matching Option may not be exercised unless and until the Company has received acceptance by the Participant of the terms and conditions set forth herein.

(H) **Company Matching RSUs.** Neither a Company Matching RSU nor a Participant Purchased RSU represents an equity interest in the Company and neither carries any voting rights. Except as otherwise specifically provided herein, Participant shall have no rights of a shareholder with respect to the RSUs until the related shares of Stock have been delivered to Participant.

(I) **Section 409A.** The Company intends that this Agreement not violate any applicable provision of, or result in any additional tax or penalty under, Section 409A of the Internal Revenue Code of 1986 (the "Code"), as amended, and that to the extent any provisions of this Agreement do not comply with Code Section 409A the Company will make such changes in order to comply with Code Section 409A to the extent it considers reasonable. In all events, the provisions of CVS Health Corporation's 409A Universal Definitions Document are hereby incorporated by reference and to the extent required to avoid a violation of the applicable rules under Section 409A by reason of Section 409A(a)(2)(B)(i) of the Code, payment of any amounts subject to Section 409A of the Code shall be delayed until the first business day of the seventh month immediately following the employment termination date. For purposes of any provision of this Agreement providing for the payment of any amounts or benefits upon or following a termination of employment, references to the "termination of employment" (and corollary terms) shall be construed to refer to "separation from service" (within the meaning of Treas. Reg. Section 1.409A-1(h)). Notwithstanding the foregoing, the Company makes no representations as to the tax treatment or consequences of any payment made hereunder, and Participant, by accepting this Award, acknowledges that Participant shall be solely responsible for same.

(J) **Notices** . Any notice required to be given hereunder to the Company shall be in writing. If by regular mail, any required notice shall be addressed to: CVS Health Corporation, Attention: Senior Director, Executive Compensation, One CVS Drive, Woonsocket, RI 02895. If by electronic mail, any notice required shall be sent to: equityadministration@cvshealth.com, with "Retirement Notice" in the subject line. Any notice required to be given hereunder to Participant shall be addressed to such Participant at the address shown on the records of the Company, subject to the right of either party hereafter to designate, in writing, to the other, some other address.

(K) **ACKNOWLEDGEMENT.** This Agreement shall be fully effective only upon the Participant's formal acceptance of the terms and conditions set forth above as required by the Company.

CVS HEALTH CORPORATION

By: / **s/ Lisa G. Bisaccia**
Executive Vice President and
Chief Human Resources Officer

Accepted by: _____
PARTICIPANT NAME

_____
EMPLOYEE ID#

_____
Date

Exhibit 10.45

AETNA INC.
2010 STOCK INCENTIVE PLAN

MARKET STOCK UNIT TERMS OF AWARD

Pursuant to its 2010 Stock Incentive Plan (the "Plan"), Aetna Inc. (the "Company") hereby grants Market Stock Units on the terms and conditions hereinafter set forth. The number of Market Stock Units awarded is included in the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of the Market Stock Unit Grant Acknowledgement and Acceptance Form. All capitalized terms used herein which are not otherwise defined herein shall have the meaning specified in the Plan.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) "Change in Control" means the happening of any of the following:

(i) When any "person" as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and as used in Sections 13(d) and 14(d) thereof, including a "group" as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company's then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “Beneficial Owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means the Company's Common Shares, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date" means the date of grant of this award of Market Stock Units.

(h) “Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such date, on the next day on which the Common Stock is traded.

(i) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(j) "Grantee" means the person to whom this award has been granted.

(k) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively, of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(l) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(m) “Net Shares” means the number of shares of Common Stock which will be deposited in a brokerage account in the Grantee’s name at the Company’s designated broker after shares have been withheld to satisfy applicable tax and withholding requirements upon vesting of the Market Stock Units.

(n) “Performance Period” means the [ ] month period following the Effective Date.

(o) “Market Stock Units” means the number of units awarded that will convert to a number of shares of Common Stock based on the operation of Article II of this Agreement, or such other amount as may result by operation of Article III of this Agreement.

(p) “Plan” means the Aetna Inc. 2010 Stock Incentive Plan.

(q) "Retirement" means the termination of employment of a Grantee from active service with the Company, a Subsidiary or Affiliate provided the Grantee’s age and completed years of service total 65 or more points at termination of employment.

(r) “Section 162(m)” means Section 162(m) of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(s) “Section 409A” means Section 409A of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(t) “Shares of Stock” or “Stock” means the Common Stock.

(u) "Subsidiary" means an entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock of such entity is held by the Company and/or one or more other subsidiaries.

(v) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to the Market Stock Units by bequest or inheritance or by reason of the death of the Grantee.

(w) “Vest Date” means the date on which this award of Market Stock Units shall vest in accordance with the terms of this Agreement and in the Notice of Market Stock Unit Grant.

(x) “Vest Date Fair Market Value” means the average closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares for the 29 trading days prior to the Vest Date and the Vest Date, or, if no shares were traded on such Vest Date, for the 30 trading days prior to the Vest Date.

ARTICLE II

PERFORMANCE PERIOD & AWARD CONVERSION

Subject to the terms of this Agreement, the Market Stock Units will vest, as of the Vest Date, in accordance with the terms of the Plan and this Terms of Award Agreement, or on such earlier date as provided in Article IV. On the Vest Date the Grantee shall vest in a number of shares of Common Stock for each vested Market Stock Unit based on the formula below, net of applicable taxes and withholding. Such Net Shares will be delivered to the Company’s designated broker, in a brokerage account established in the Grantee’s name after the Vest Date. To the extent Section 162(m) is applicable to a Grantee, for shares to vest the Committee must also determine that the performance goal set forth on Exhibit A is met. If the Committee determines that the performance goal is not met at the minimum level, as applicable, no shares will vest.

The number of shares of Common Stock that each Market Stock Unit will convert and be awarded to you on the Vest Date, net of applicable taxes, shall be determined in accordance with the following formula:

(Number of Market Stock Units granted)

Multiplied by

((the Vest Date Fair Market Value) divided by (the Grant Date Fair Market Value))

Up to a maximum of 1.5 shares of Common Stock per Market Stock Unit.

Any social security calculation or other adjustments discovered after the payment of Net Shares will be settled in cash, not in Common Stock.

ARTICLE III

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this Plan, then the Committee shall, in such manner as the Committee may deem equitable, adjust the number and kind of shares subject to the award of Market Stock Units. Additionally, the Committee may make provision for cash payment to a Grantee or the Successor of the Grantee to the extent permitted under Section 409A. However, the number of Market Stock Units shall always be a whole number.

ARTICLE IV

CHANGE IN CONTROL

Notwithstanding any other provision of this Agreement to the contrary, upon the occurrence of a Change in Control, the Market Stock Units not previously forfeited pursuant to this Terms of Award Agreement shall become immediately vested and convert to a number of shares of Common Stock based on the formula in Article II but such formula shall use the Fair Market Value on the date on which the Change in Control occurs rather than the Vest Date Fair Market Value. Net Shares will be payable on the Vest Date, provided however, if within the 24 month period following the Change in Control the Company terminates Grantee's employment without cause, the Net Shares will become payable as of such termination of employment date. If an award is considered deferred compensation subject to Section 409A, the award will vest but the Change in Control will not accelerate the payment of the Market Stock Units unless the Change in Control also meets the definition of change in control set forth in Treasury Regulation Section 1.409A-3(i)(5).

ARTICLE V

TERMINATION OF EMPLOYMENT

(a) Except as provided in (c) below, if, during the Performance Period, Grantee shall cease to be employed by the Company, its Subsidiaries or Affiliates, for reason of death, Long-term Disability, Retirement or involuntary termination of employment by the Company, the portion of the Market Stock Units that may vest on the Vest Date, if any, shall be calculated in accordance with the following formula: (i) the number of completed months employed commencing on the first day of the Performance Period divided by the number of months in the Performance Period; multiplied by (ii) the number of Market Stock Units that otherwise would have vested under the term of this Agreement had the Grantee remained actively employed through the Vest Date.

(b) Except as provided in (a) above, any Market Stock Unit not vested as of the date Grantee terminates employment shall be forfeited at the time of cessation of employment; provided, however, that if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the Market Stock Unit in accordance with its terms, then upon the forfeiture of the entire Market Stock Unit, the Company will pay Grantee an amount equal to the value of a single share of Common Stock, whether or not the forfeited Market Stock Unit related to more than a single share of Common Stock, calculated as of the cessation of employment, if requested by Grantee, within 30 days of such cessation of employment.

(c) No Market Stock Unit will vest after the Company has terminated the employment of the Grantee for cause, unless the Committee, in its sole discretion, deems a payment to be warranted under the particular circumstances. In addition, the Market Stock Units will not vest if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(d) Employment for purposes of determining the vesting rights of the Grantee and the expiration of the grant under this Article V shall mean continuous active full-time salaried employment with the Company, a Subsidiary or an Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc. Notwithstanding any period during which Grantee receives salary continuation or severance shall not be considered as part of the continuous employment of the Grantee.

ARTICLE VI

EMPLOYEE COVENANTS

(a) As consideration for this grant of Market Stock Units, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related

information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company or any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement; provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of 12 months or 24 months for executive tier employees (the executive tier status determined as of the effective date of this grant) following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee to be employed or perform services elsewhere;

(iii) Grantee will not, during and for a period of 12 months or 24 months for executive tier employees (the executive tier status determined as of the effective date of this grant) following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company or any Subsidiary to cease or curtail providing services to the Company or any Subsidiary; and

(iv) Grantee will not, during and for a period of 12 months or 24 months for executive tier employees (the executive tier status determined as of the effective date of this grant) following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved.

In addition:

(v) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company or a Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(vi) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an

attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company.

(vii) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). Grantee further acknowledges that while employed by the Company, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company, and the Grantee hereby assigns all right, title, and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting therefrom.

(b) If any provision of Article VI (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the Market Stock Units is Grantee's covenants set forth in Article VI (a) and that the covenants and obligations of Grantee with respect to nondisclosure, non-solicitation and cooperation relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to vest in the Market Stock or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VI. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine.

(d) Employment Dispute Arbitration Program - <u>Mandatory Binding Arbitration of Employment Disputes.</u>

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether the Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VI (d) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VI (d) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VI (d) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VI (a) in accordance with applicable law). However, except as provided in Article VI (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement.

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org. THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the

arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VI (d) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VI (d) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(e) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VI, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

ARTICLE VII

OTHER TERMS

(a) Nothing in this Agreement shall interfere with or limit in any way the right of the Company or any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery hereof nor the granting of the Award shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ or continue the employment of the Grantee for any period.

(b) Until the Market Stock Units have become vested, Grantee shall not have any rights as a stockholder (including the right to payment of dividends) by virtue of this grant of Market Stock Units.

(c) During the Performance Period, the Market Stock Units shall be nontransferable and non-assignable except by will or the laws of descent and distribution.

(d) The award, when vested, will be settled on a net basis. Prior to issuing any Common Shares, the Company will withhold an amount sufficient to satisfy federal, state, local, social security and Medicare withholding tax requirements relating to award. Any social security calculation or other adjustments discovered after net share payment will be settled in cash, not in Shares of Common Stock. Vesting will result in taxable compensation reportable on the Grantee's W-2 in year of vesting.

(e) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connection with any such restriction.

(f) This Market Stock Unit is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(g) Anything herein to the contrary notwithstanding, a Grantee whose Market Stock Units have been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited Market Stock Units reinstated as follows: (i) if such Grantee is re-employed during the Performance Period, all forfeited Market Stock Units shall be reinstated; or (ii) if such Grantee is re-employed after the Performance Period, a cash payment will be made to the Grantee, minus applicable taxes, for the value of the forfeited Market Stock Units on the Vest Date pursuant to procedures established by the Company for this purpose.

(h) It is the intention of the Company and Grantee that this Agreement not result in unfavorable tax consequences to Grantee under Section 409A and the Agreement shall be interpreted as to so comply. Notwithstanding anything to the contrary herein, the Company and Grantee agree to the provisions set forth below in order to comply with the requirements of Section 409A.

(i) If Grantee is a "specified employee" (within the meaning of Section 409A) with respect to the Company, any non-qualified deferred compensation otherwise payable to or in respect of Grantee in connection with Grantee's termination of employment shall be delayed until the earliest date upon which such amounts may be paid without being subject to taxation under Section 409A. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

(ii) Unless deferred pursuant to this agreement, all payments shall be paid to Grantee, to the extent earned, in no event later than the last day of the "applicable 2 ½ month period," as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

(iii) The Company and Grantee agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by the Grantee due to any failure to comply with Section 409A.

(i) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(j) At such times and upon such terms and conditions as the Company shall determine, the Company may permit eligible Grantees to elect to defer the distribution of an Award otherwise payable to the Grantee under this Agreement until termination of the Grantee's Employment or such other date Company shall permit.

(k) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

Exhibit 10.46

AETNA INC.
2010 STOCK INCENTIVE PLAN

PERFORMANCE STOCK UNIT TERMS OF AWARD

Performance Period: [ ] through [ ]
Units Awarded: [ ]
Performance Metric: [ ]
Vesting Period - [ ] month period following the Effective Date (Date of Grant)

Pursuant to its 2010 Stock Incentive Plan (the "Plan"), Aetna Inc. (the "Company") hereby grants Performance Stock Units (PSUs) on the terms and conditions hereinafter set forth. The number of Performance Stock Units awarded is included in the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of the Performance Stock Unit Grant Acknowledgement and Acceptance Form. All capitalized terms used herein which are not otherwise defined herein shall have the meaning specified in the Plan.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) "Change in Control" means the happening of any of the following:

(i) When any "person" as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and as used in Sections 13(d) and 14(d) thereof, including a "group" as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company's then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “Beneficial Owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means the Company's Common Shares, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date" means the date of grant of this award of Performance Stock Units.

(h) “Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such date, on the next day on which the Common Stock is traded.

(i) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(j) "Grantee" means the person to whom this award has been granted.

(k) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively, of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(l) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(m) “Net Shares” means the number of shares of Common Stock which will be deposited in a brokerage account in the Grantee’s name at the Company’s designated broker after shares have been withheld to satisfy applicable tax and withholding requirements upon vesting of the Performance Stock Units.

(n) “Performance Period” means the [ ] month performance period ending [date]. The Performance Period shall run from [date] to [date].

(o) “Performance Stock Units” means the number of shares of Common Stock represented by the number of units awarded or such other amount as may result by operation of Article III of this Agreement.

(p) “Plan” means the Aetna Inc. 2010 Stock Incentive Plan.

(q) "Retirement" means the termination of employment of a Grantee from active service with the Company, any Subsidiary or Affiliate provided the Grantee’s age and completed years of service total 65 or more points at termination of employment.

(r) “Section 409A” means Section 409A of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(s) “Shares of Stock” or “Stock” means the Common Stock.

(t) "Subsidiary" means an entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock of such entity is held by the Company and/or one or more other subsidiaries.

(u) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to the Performance Stock Units by bequest or inheritance or by reason of the death of the Grantee.

(v) “Vest Date” means the last day of the Vesting Period and is the date on which this award of Performance Stock Units shall vest in accordance with the terms of this Agreement and in the Notice of Performance Stock Unit Grant, if at all.

(w) “Vesting Period” means the period beginning on the Effective Date and ending thirty-six months thereafter.

ARTICLE II

VESTING PERIOD

Subject to the terms of this Agreement, the Performance Stock Units will vest, as of the Vest Date, in accordance with the terms of the Plan and this Terms of Award Agreement, or on such earlier date as provided in Article IV. If the Committee determines that the performance goal set forth on Exhibit A is met, on the Vest Date, the Grantee shall vest to one share of Common Stock for each vested Performance Stock Unit net of applicable taxes and withholding (or such greater or lessor amount based on performance, as set forth on Exhibit A). Such Net Shares will be delivered to the Company's designated broker, in a brokerage account established in the Grantee's name after the Vest Date. If the Committee determines that the performance goal set forth on Exhibit A is not met at the minimum level, no shares will vest.

Any social security calculation or other adjustments discovered after the payment of Net Shares will be settled in cash not in Common Stock.

ARTICLE III

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this Plan, then the Committee shall, in such manner as the Committee may deem equitable, adjust the number and kind of shares subject to the award of Performance Stock Units. Additionally, the Committee may make provision for cash payment to a Grantee or the Successor of the Grantee. However, the number of Performance Stock Units shall always be a whole number.

ARTICLE IV

CHANGE IN CONTROL

Notwithstanding any other provision of this Agreement to the contrary, upon the occurrence of a Change in Control, the Performance Stock Units not previously forfeited pursuant to this Terms of Award Agreement shall become immediately vested at a level which equals the greater of the number of Performance Stock Units that would have vested (x) at target-level 100% vesting, or (y) based on the Company's actual year-to-date performance level using the date on which the Change in Control occurs as the end of the Vesting Period. Net Shares will be payable on the Vest Date, provided however, if within the 24 month period following the Change in Control the Company terminates Grantee's employment without cause, the Net Shares will become payable as of such termination of employment date. If an award is considered deferred compensation subject to Section 409A, the award will vest but the Change in Control will not accelerate the payment of the deferred Performance Stock Units unless the Change in Control also meets the definition of change in control set forth in Treasury Regulation Section 1.409A-3(i)(5).

ARTICLE V

TERMINATION OF EMPLOYMENT

(a) Except as provided in (c) below, if, during the Vesting Period, Grantee shall cease to be employed by the Company, any Subsidiaries or Affiliates, for reason of death, Long-term Disability, Retirement or involuntary termination of employment by the Company, the portion of the Performance Stock Units that may vest on the Vest Date, if any, shall be calculated in accordance with the following formula: (i) the number of completed months employed during the Vesting period divided by the number of months in the Vesting Period; multiplied by (ii) the number of Performance Stock Units, that otherwise would have vested. For purposes of this calculation, a month is complete on the day in the month that corresponds to the Effective Date of the grant (e.g., February 12 to March 12).

(b) Except as provided in (a) above, any Performance Stock Unit not vested as of the date Grantee terminates employment shall be forfeited at the time of cessation of employment; provided, however, that if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the Performance Stock Unit in accordance with its terms, then upon the forfeiture of the entire Performance Stock Unit, the Company will pay Grantee an amount equal to the value of a single share of Common Stock, whether or not the forfeited Performance Stock Unit related to more than a single share of Common Stock, calculated as of the cessation of employment, if requested by Grantee, within 30 days of such cessation of employment.

(c) No Performance Stock Unit will vest after the Company has terminated the employment of the Grantee for cause, unless the Committee, in its sole discretion, deems a payment to be warranted under the particular circumstances. In addition, the Performance Stock Units will not vest if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(d) Employment for purposes of determining the vesting rights of the Grantee and the expiration of the grant under this Article V shall mean continuous active full-time salaried employment with the Company, any Subsidiary or Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc. Notwithstanding any period during which Grantee receives salary continuation or severance shall not be considered as part of the continuous employment of the Grantee.

ARTICLE VI

EMPLOYEE COVENANTS

(a) As consideration for this grant of Performance Stock Units, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company, any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement ("Confidential Information"); provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of twelve (12) months following Grantee's termination of employment, directly or indirectly, (x) engage in the ownership (except less than 1% of the outstanding capital stock of any publicly traded company) of or, (y) become an employee of, or (z) act as a consultant or contractor to, any competitor of the Company ("Competitor") in any market in the United States where Company, Affiliate or Subsidiary does business.

a. For purposes of this paragraph "Competitor" shall mean any entity, organization, person or corporation that is involved in the same business as Company, Subsidiary or Affiliate, but in the case of (y) and (z), only to the extent such work, consulting or other activity on behalf of other entity, organization, person or corporation

i. is materially similar to the duties and/or functions that Grantee performed for the Company, Subsidiary or Affiliate in the last 12 months or involves duties and/or functions for Competitor about which Grantee has Confidential Information in the last 12 months. Notwithstanding

1. with respect to sales functions for the Company, Subsidiary or Affiliate that are regionally based or whose focus is geographically limited, the restriction shall only apply where such work, consulting or other activity on behalf of a Competitor overlaps in whole or in part the same geographic area in which the Grantee worked for Company, Subsidiary or Affiliate in the last 12 months;

2. with respect to corporate staff functions, the restriction shall only apply where Competitor is substantially engaged in the business of health insurance, managed health care, population health management, or related products or services.

b. Notwithstanding, if Grantee's employment is terminated by the Company, Subsidiary or Affiliate other than for cause, the length of the noncompetition covenant in this paragraph shall not exceed the length of the severance and/or salary continuation benefits paid by the Company, Subsidiary or Affiliate to Grantee.

c. Grantee acknowledges and agrees that these restrictions:

i. are necessary to protect the Confidential Information and goodwill of the Company, Subsidiary or Affiliate;

ii. are appropriately tailored and limited in time and geographic scope to do so; and

iii. do not impair or limit the Grantee's ability to earn a living.

(iii) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee of the Company, any Subsidiary or Affiliate to be employed or perform services elsewhere;

(iv) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company, any Subsidiary or Affiliate to cease or curtail providing services to the Company, any Subsidiary or Affiliate; and

(v) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved.

(vi) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, for himself or herself or on behalf of or in cooperation with any other person or entity, consult with or in any manner provide advice to, any individual or entity which is a customer of the Company or any Subsidiary or Affiliate of the Company, provided, however, that this limitation shall apply only to consultation or advice relating to any product or service of the Company, or any Subsidiary or Affiliate, or which is in competition with any product or service of the Company, or any Subsidiary or Affiliate, and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved, or about which Grantee has Confidential Information.

In addition:

(vii) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company, any Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(viii) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company.

(ix) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment and relating in any way to the business or contemplated business, products, activities, research or development of the Company, any Subsidiary or Affiliate, or resulting from any work performed by the Grantee for the Company, any Subsidiary or Affiliate (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). To the extent that the foregoing does not apply, the Grantee hereby irrevocably assigns to the Company, and its successors and assigns, for no additional consideration, the Grantee's entire right, title and interest in and to all such works of authorship. Grantee further acknowledges that while employed by the Company, any Subsidiary or Affiliate, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company, and the Grantee hereby assigns all right, title, and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting there from.

(b) If any provision of Article VI (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the Performance Stock Units is Grantee's covenants set forth in Article VI (a) and that the covenants and obligations of Grantee with respect to nondisclosure, non-solicitation and cooperation relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to vest in the Performance Stock or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VI. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine.

(d) The Restrictive Covenants set forth in this Article VI shall supplement and do not supersede the restrictions agreed to by Grantee in any other agreement or contract.

(e) Employment Dispute Arbitration Program - Mandatory Binding Arbitration of Employment Disputes.

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether the Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VI (e) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VI (e) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VI (e) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VI (a) in accordance with applicable law). However, except as provided in Article VI (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement .

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org . THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a

court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VI (e) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VI (e) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(f) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VI, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

ARTICLE VII

OTHER TERMS

(a) Nothing in this Agreement shall interfere with or limit in any way the right of the Company, any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery hereof nor the granting of the Award shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ or continue the employment of the Grantee for any period.

(b) Until the Performance Stock Units have become vested, Grantee shall not have any rights as a stockholder (including the right to payment of dividends) by virtue of this grant of Performance Stock Units.

(c) During the Vesting Period, the Performance Stock Units shall be nontransferable and non-assignable except by will or the laws of descent and distribution.

(d) The award, when vested, will be settled on a net basis. Prior to issuing any Common Shares, the Company will withhold an amount sufficient to satisfy federal, state, local, social security and Medicare withholding tax requirements relating to award. Any social security calculation or other adjustments discovered after net share payment will be settled in cash, not in Shares of Common Stock. Vesting will result in taxable compensation reportable on the Grantee's W-2 in year of vesting.

(e) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connection with any such restriction.

(f) This Performance Stock Unit is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(g) Anything herein to the contrary notwithstanding, a Grantee whose Performance Stock Units have been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited Performance Stock Units reinstated as follows: (i) if such Grantee is re-employed during the Vesting Period, all forfeited Performance Stock Units shall be reinstated; or (ii) if such Grantee is re-employed after the Vesting Period, a cash payment will be made to the Grantee, minus applicable taxes, for the value of the forfeited Performance Stock Units on the Vest Date pursuant to procedures established by the Company for this purpose.

(h) It is the intention of the Company and Grantee that this Agreement not result in unfavorable tax consequences to Grantee under Section 409A and the Agreement shall be interpreted as to so comply. Notwithstanding anything to the contrary herein, the Company and Grantee agree to the provisions set forth below in order to comply with the requirements of Section 409A.

(i) If Grantee is a "specified employee" (within the meaning of Section 409A) with respect to the Company, any non-qualified deferred compensation otherwise payable to or in respect of Grantee in connection with Grantee's termination of employment shall be delayed until the earliest date upon which such amounts may be paid without being subject to taxation under Section 409A. Any amount, the payment or benefit of which is delayed by application of the preceding sentence, shall be paid as soon as possible following the expiration of such period.

(ii) Unless deferred pursuant to this agreement, all payments shall be paid to Grantee, to the extent earned, in no event later than the last day of the "applicable 2 ½ month period," as such term is defined in Treasury Regulation Section 1.409A-1(b)(4)(i)(A) with respect to such payment's treatment as a "short-term deferral" for purposes of Section 409A.

(iii) The Company and Grantee agree to cooperate in good faith in an effort to comply with Section 409A. Under no circumstances shall the Company be responsible for any taxes, penalties, interest or other losses or expenses incurred by the Grantee due to any failure to comply with Section 409A.

(i) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(j) At such times and upon such terms and conditions as the Company shall determine, the Company may permit eligible Grantees to elect to defer the distribution of an Award otherwise payable to the Grantee under this Agreement until termination of the Grantee's Employment or such other date Company shall permit.

(k) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

Exhibit 10.47

AETNA INC.
2010 STOCK INCENTIVE PLAN

EXECUTIVE RESTRICTED STOCK UNIT TERMS OF AWARD

Pursuant to its 2010 Stock Incentive Plan (the "Plan"), Aetna Inc. (the "Company") hereby grants Restricted Stock Units on the terms and conditions hereinafter set forth. The number of Restricted Stock Units awarded and vesting information are included in the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of the Restricted Stock Unit Acknowledgement and Acceptance Form, if applicable. All capitalized terms used herein which are not otherwise defined herein shall have the meaning specified in the Plan.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) "Change in Control" means the happening of any of the following:

(i) When any "person" as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act") and as used in Sections 13(d) and 14(d) thereof, including a "group" as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the "beneficial owner" (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company's then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the "Incumbent Directors") cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “Beneficial Owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means the Company's Common Shares, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date" means the date of grant of this award of Restricted Stock Units.

(h) “Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such date, on the next day on which the Common Stock is traded.

(i) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(j) "Grantee" means the person to whom this award has been granted.

(k) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively, of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(l) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(m) “Net Shares” means the number of shares of Common Stock which will be deposited in a brokerage account in the Grantee’s name at the Company’s designated broker after shares have been withheld to satisfy applicable tax and withholding requirements upon vesting of the Restricted Stock Units.

(n) “Plan” means the Aetna Inc. 2010 Stock Incentive Plan.

(o) “Restricted Period” means the period during which this award of Restricted Stock Units is not vested.

(p) “Restricted Stock Units” means the number of shares of Common Stock represented by the number of units awarded or such other amount as may result by operation of Article III of this Agreement.

(q) "Retirement" means the termination of employment of a Grantee from active service with the Company, any Subsidiary or Affiliate provided the Grantee’s age and completed years of service total 65 or more points at termination of employment.

(r) “Section 409A” means Section 409A of the Internal Revenue Code of 1986, as amended, and the regulation issued thereunder, as may be amended from time to time.

(s) “Shares of Stock” or “Stock” means the Common Stock.

(t) "Subsidiary" means an entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock of such entity is held by the Company and/or one or more other subsidiaries.

(u) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to the Restricted Stock Units by bequest or inheritance or by reason of the death of the Grantee.

(v) “Vest Date” means the date on which this award of Restricted Stock Units shall vest in accordance with the terms of this Agreement and as set forth on the website of the designated broker and in the Notice of Restricted Stock Unit Grant, if applicable.

ARTICLE II

RESTRICTED PERIOD

Subject to the terms of this Agreement, the Restricted Stock Units will vest in installments on the Vest Date in accordance with the terms of the Plan and this Terms of Award Agreement, or on such date as provided in Article IV or V. On the Vest Date, the Grantee shall vest to one share of Common Stock for each vested Restricted Stock Unit net of applicable taxes and withholding. Such Net Shares will be delivered to the Company’s designated broker, in a brokerage account established in the Grantee’s name.

ARTICLE III

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this Plan, then the Committee shall, in such manner as the Committee may deem equitable, adjust the number and kind of shares subject to the award of Restricted Stock Units. Additionally, the Committee may make provision for cash payment to a Grantee or the Successor of the Grantee to the extent permitted under Section 409A. However, the number of Restricted Stock Units shall always be a whole number.

ARTICLE IV

CHANGE IN CONTROL

Upon the occurrence of (i) a Change in Control, and (ii) within 24 months thereafter the Company terminates Grantee's Employment without cause, all RSUs, whether or not vested, shall become immediately vested and become payable, provided, however, that, as set forth in the Plan, to the extent the RSUs are considered deferred compensation subject to Section 409A, unless the Change in Control also satisfies the definition of "change in control" under Section 409A, payment shall not be so accelerated but shall occur upon the scheduled Vest Date(s) under Article II.

ARTICLE V

TERMINATION OF EMPLOYMENT

(a) Except as provided in (f) below, if the Grantee shall die during the Restricted Period, the unvested Restricted Stock Units shall become immediately vested and Net Shares, if any, will be deposited with the Company's designated broker in a brokerage account established in Grantee's name.

(b) Except as provided in (f) below, if the Grantee shall begin to receive Long Term Disability benefits during the Restricted Period, the unvested Restricted Stock Units shall continue to vest and Net Shares, if any, will be deposited with the Company's designated broker in a brokerage account established in Grantee's name on the scheduled Vest Date(s) under Article II.

(c) Except as provided in (f) below, if, during the restricted period, Grantee shall cease to be employed by the Company, any Subsidiaries or Affiliates during the Restricted Period, for reason of Retirement or involuntary termination of employment by the Company, a portion of the Restricted Stock Units shall vest in accordance with the following formula: (i) the number of completed months employed after the Effective Date divided by the number of full months in the restricted period; multiplied by (ii) number of Restricted Stock Units, minus any vested Restricted Stock Units. For purposes of this calculation, a month is complete on the day in the following month that corresponds to the Effective Date (e.g., February 13 to March 13). Net shares, if any, will be deposited with the Company's designated broker in a brokerage account established in Grantee's name on the next scheduled Vest Date under Article II and, applicable taxes and withholding will be applied based on the Fair Market Value on that date.

(d) Except as provided in (e) and (f) below, if the Grantee shall, for a reason other than death, Long-Term Disability, Retirement or involuntary termination of employment by the Company, cease to be employed by the Company, any Subsidiaries or Affiliates during the Restricted Period, any unvested Restricted Stock Units shall be forfeited at the time of cessation of employment.

(e) Except as provided in (a) or (b) or (c) above, any Restricted Stock Unit not vested as of the date Grantee terminates employment shall be forfeited at the time of cessation of employment; provided, however, that if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the Restricted Stock Unit in accordance with its terms, then upon the forfeiture of the entire Restricted Stock Unit, the Company will pay Grantee an amount equal to the value of a single share of Common Stock, whether or not the forfeited Restricted Stock Unit related to more than a single share of Common Stock, calculated as of the cessation of employment, if requested by Grantee, within 30 days of such cessation of employment.

(f) No Restricted Stock Unit will vest after the Company has terminated the employment of the Grantee for cause, unless the Committee, in its sole discretion, deems a payment to be warranted under the particular circumstances. In addition, the Restricted Stock Units will not vest if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(g) Employment for purposes of determining the vesting rights of the Grantee and the expiration of the grant under this Article V shall mean continuous full-time salaried employment with the Company, any Subsidiary or an Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), or in receipt of salary continuation or severance pay shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc.

ARTICLE VI

EMPLOYEE COVENANTS

(a) As consideration for this grant of Restricted Stock Units, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company, any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement ("Confidential Information"); provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is

employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of twelve (12) months following Grantee's termination of employment, directly or indirectly, (x) engage in the ownership (except less than 1% of the outstanding capital stock of any publicly traded company) of or, (y) become an employee of, or (z) act as a consultant or contractor to, any competitor of the Company ("Competitor") in any market in the United States where Company, Affiliate or Subsidiary does business.

a. For purposes of this paragraph "Competitor" shall mean any entity, organization, person or corporation that is involved in the same business as Company, Subsidiary or Affiliate, but in the case of (y) and (z), only to the extent such work, consulting or other activity on behalf of other entity, organization, person or corporation

i. is materially similar to the duties and/or functions that Grantee performed for the Company, Subsidiary or Affiliate in the last 12 months or involves duties and/or functions for Competitor about which Grantee has Confidential Information in the last 12 months. Notwithstanding

1. with respect to sales functions for the Company, Subsidiary or Affiliate that are regionally based or whose focus is geographically limited, the restriction shall only apply where such work, consulting or other activity on behalf of a Competitor overlaps in whole or in part the same geographic area in which the Grantee worked for Company, Subsidiary or Affiliate in the last 12 months;

2. with respect to corporate staff functions, the restriction shall only apply where Competitor is substantially engaged in the business of health insurance, managed health care, population health management, or related products or services.

b. Notwithstanding, if Grantee's employment is terminated by the Company, Subsidiary or Affiliate other than for cause, the length of the noncompetition covenant in this paragraph shall not exceed the length of the severance and/or salary continuation benefits paid by the Company, Subsidiary or Affiliate to Grantee.

c. Grantee acknowledges and agrees that these restrictions:

i. are necessary to protect the Confidential Information and goodwill of the Company, Subsidiary or Affiliate;

ii. are appropriately tailored and limited in time and geographic scope to do so; and

iii. do not impair or limit the Grantee's ability to earn a living.

(iii) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee of the Company, any Subsidiary or Affiliate to be employed or perform services elsewhere;

(iv) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company, any Subsidiary or Affiliate to cease or curtail providing services to the Company, any Subsidiary or Affiliate; and

(v) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved.

(vi) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, for himself or herself or on behalf of or in cooperation with any other person or entity, consult with or in any manner provide advice to, any individual or entity which is a customer of the Company or any Subsidiary or Affiliate of the Company, provided, however, that this limitation shall apply only to consultation or advice relating to any product or service of the Company, or any Subsidiary or Affiliate, or which is in competition with any product or service of the Company, or any Subsidiary or Affiliate, and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved, or about which Grantee has Confidential Information

In addition:

(vii) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company, any Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(viii) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company .

(ix) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment and relating in any way to the business or contemplated business, products, activities, research or development of the Company, any Subsidiary or Affiliate, or resulting from any work performed by the Grantee for the Company, any Subsidiary or Affiliate (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). To the extent that the foregoing does not apply, the Grantee hereby irrevocably assigns to the Company, and its successors and assigns, for no additional consideration, the Grantee's entire right, title and interest in and to all such works of authorship. Grantee further acknowledges that while employed by the Company, any Subsidiary or Affiliate, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company, and the Grantee hereby assigns all right, title, and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting therefrom.

(b) If any provision of Article VI (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the Restricted Stock Units is Grantee's covenants set forth in Article VI (a) and that the covenants and obligations of Grantee with respect to nondisclosure, non-solicitation and cooperation relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to vest in the Restricted Stock or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VI. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine.

(d) The Restrictive Covenants set forth in this Article VI shall supplement and do not supersede the restrictions agreed to by Grantee in any other agreement or contract.

(e) Employment Dispute Arbitration Program - Mandatory Binding Arbitration of Employment Disputes.

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether the Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VI (e) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VI (e) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VI (e) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VI (a) in accordance with applicable law). However, except as provided in Article VI (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement .

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org. THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VI (e) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VI (e) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(f) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VI, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

ARTICLE VII

OTHER TERMS

(a) Nothing in this Agreement shall interfere with or limit in any way the right of the Company, any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery hereof nor the granting of the Award shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ or continue the employment of the Grantee for any period.

(b) Until the Restricted Stock Units have become vested, Grantee shall not have any rights as a stockholder (including the right to payment of dividends) by virtue of this grant of Restricted Stock Units.

(c) During the Restricted Period, the Restricted Stock Units shall be nontransferable and non-assignable except by will or the laws of descent and distribution.

(d) The award will be settled on a net basis. Prior to issuing any Common Shares, the Company will withhold an amount sufficient to satisfy federal, state, local, social security and Medicare withholding tax requirements relating to award. Any social security calculation or other adjustments discovered after net share payment will be settled in cash, not in Shares of Common Stock. Vesting will result in taxable compensation reportable on the Grantee's W-2 in year of vesting.

(e) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connection with any such restriction.

(f) This Restricted Stock Unit is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(g) Anything herein to the contrary notwithstanding, a Grantee whose Restricted Stock Units have been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited Restricted Stock Units reinstated as follows: (i) if such Grantee is re-employed during the Restricted Period, all forfeited Restricted Stock Units shall be reinstated; or (ii) if such Grantee is re-employed after the Restricted Period, a cash payment will be made to the Grantee, minus applicable taxes, for the value of the forfeited Restricted Stock Units on the Vest Date pursuant to procedures established by the Company for this purpose.

(h) If any provision of this Agreement would cause Grantee to incur any additional tax or interest under Section 409A, the Company may reform such provision (including an amendment retroactive to the Effective Date to the extent permissible) to comply with Section 409A.

(i) If the Company reasonably anticipates that the Company's tax deduction with respect to the payment upon vesting of the Restricted Stock Units would be limited or eliminated by application of Section 162(m) of the Internal Revenue Code, the Company may elect, in accordance with Section 409A, to delay the payment of such Restricted Stock Units to the earliest date in which the Company anticipates that its tax deduction for such payment will not be limited or eliminated.

(j) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(k) Voluntary Deferral. At such times and upon such terms and conditions as the Company shall determine in accordance with the terms of the Plan and Section 409A, the Company may permit eligible Grantees to elect to defer the distribution of an Award otherwise payable to the Grantee under this Agreement until termination of the Grantee's Employment or such other date Company shall permit.

(l) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

I have read the Restricted Stock Unit Agreement. I accept the Restricted Stock Unit award and agree to be bound by all of its terms and conditions, including mandatory binding arbitration of employment related disputes and, if applicable, any other provisions of Article VI.

Exhibit 10.48

AETNA INC.
2010 STOCK INCENTIVE PLAN

STOCK APPRECIATION RIGHT TERMS OF AWARD

Pursuant to its 2010 Stock Incentive Plan, Aetna Inc. has granted a stock appreciation right on shares of Aetna Inc. Common Stock. The number of shares represented by this right, the Grant Price and vesting information are included on the website of the designated broker, currently UBS Financial Services, Inc., and in the Notice of Stock Appreciation Right Grant, if applicable. The Stock Appreciation Right is issued on the terms and conditions hereinafter set forth.

ARTICLE I

DEFINITIONS

(a) "Affiliate" means an entity at least a majority of the total voting power of the then-outstanding voting securities of which is held, directly or indirectly, by the Company and/or one or more other Affiliates.

(b) "Board" means the Board of Directors of Aetna Inc.

(c) “Change in Control” means the happening of any of the following:

(i) When any “person” as defined in Section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”) and as used in Sections 13(d) and 14(d) thereof, including a “group” as defined in Section 13(d) of the Exchange Act but excluding the Company and any Subsidiary thereof and any employee benefit plan sponsored or maintained by the Company or any Subsidiary (including any trustee of such plan acting as trustee), directly or indirectly, becomes the “beneficial owner” (as defined in Rule 13d-3 under the Exchange Act, as amended from time to time), of securities of the Company representing 20 percent or more of the combined voting power of the Company’s then outstanding securities;

(ii) When, during any period of 24 consecutive months, the individuals who, at the beginning of such period, constitute the Board (the “Incumbent Directors”) cease for any reason other than death to constitute at least a majority thereof, provided that a director who was not a director at the beginning of such 24-month period shall be deemed to have satisfied such 24-month requirement (and be an Incumbent Director) if such director was elected by, or on the recommendation of or with the approval of, at least two-thirds of the directors who then qualified as Incumbent Directors either actually (because they were directors at the beginning of such 24-month period) or by prior operation of this paragraph (ii); or

(iii) The occurrence of a transaction requiring stockholder approval for the acquisition of the Company by an entity other than the Company or a Subsidiary through purchase of assets, or by merger, or otherwise.

Notwithstanding the foregoing, in no event shall a “Change in Control” be deemed to have occurred (i) as a result of the formation of a Holding Company, or (ii) with respect to Grantee, if Grantee is part of a “group,” within the meaning of Section 13(d)(3) of the Exchange Act as in effect on the effective date, which consummates the Change in Control transaction. In addition, for purposes of the definition of “Change in Control” a person engaged in business as an underwriter of securities shall not be deemed to be the “beneficial owner” of, or to “beneficially own,” any securities acquired through such person’s participation in good faith in a firm commitment underwriting until the expiration of forty days after the date of such acquisition.

(d) "Committee" means the Board's Committee on Compensation and Organization or any successor thereto.

(e) "Common Stock" means shares of the Company's Common Stock, $.01 par value per share.

(f) "Company" means Aetna Inc.

(g) "Effective Date” means the date of grant of this Stock Appreciation Right, as approved by the Committee.

(h) “Exercise Date” means the date the Grantee has notified the designated broker to exercise all or a portion of the Stock Appreciation Right.

(i) "Fair Market Value" means the closing price of the Common Stock as reported by the Consolidated Tape of the New York Stock Exchange Listed Shares on the date such value is to be determined, or, if no shares were traded on such day, on the next day on which the Common Stock is traded.

(j) “Fundamental Corporate Event” shall mean any stock dividend, extraordinary cash dividend, recapitalization, reorganization, merger, consolidation, split-up, spin-off, combination, exchange of shares, warrants or rights offering to purchase Common Stock at a price substantially below fair market value, or similar event.

(k) “Grantee” means the person to whom this Stock Appreciation Right has been granted.

(l) “Grant Price” means the dollar amount per share of Common Stock that is the basis for determining the appreciation in value of the Common Stock.

(m) “Holding Company” means an entity that becomes a holding company for the Company or its businesses as a part of any reorganization, merger, consolidation or other transaction, provided that the outstanding shares of common stock of such entity and the combined voting power of the then outstanding voting securities of such entity entitled to vote generally in the election of directors is, immediately after such reorganization, merger, consolidation or other transaction, beneficially owned, directly or indirectly, by all or substantially all of the individuals and entities who were the beneficial owners, respectively of the voting stock outstanding immediately prior to such reorganization, merger, consolidation or other transaction in substantially the same proportions as

their ownership, immediately prior to such reorganization, merger, consolidation or other transaction, of such outstanding voting stock.

(n) "Long Term Disability" means long-term disability as defined under the terms of the Company's applicable long-term disability plans or policies.

(o) "Plan" means the Aetna Inc. 2010 Stock Incentive Plan.

(p) "Retirement" means the termination of employment of a Grantee from active service with the Company, a Subsidiary or Affiliate provided the Grantee's age and completed years of service total 65 or more points at termination of employment.

(q) "SAR" means Stock Appreciation Right.

(r) "Shares Granted" means the number of shares of Common Stock represented by the Stock Appreciation Right, or such other amount as may result by operation of Article IV of this Agreement.

(s) "Shares of Stock" or "Stock" means the Common Stock.

(t) "Stock Appreciation Right" or "SAR" means the right granted herein to be paid the excess, as of the Exercise Date, of (i) the Fair Market Value of the shares of Common Stock associated with this Stock Appreciation Right (or the portion thereof that is surrendered on exercise) over (ii) the Grant Price of such Stock Appreciation Right.

(u) "Stock Appreciation Rights Vested" means number of Stock Appreciation Rights exercisable on any given date.

(v) "Subsidiary" means any entity of which, at the time such subsidiary status is to be determined, at least 50% of the total combined voting power of all classes of stock in such entity is held by the Company and/or one or more other subsidiaries.

(w) "Successor" means the legal representative of the estate of a deceased Grantee or the person or persons who shall acquire the right to exercise a SAR by bequest or inheritance or by reason of the death of the Grantee.

(x) "Term" means the period during which the SAR granted hereby may be exercised.

(y) "Vest Date" means the date on which a portion of the SAR becomes exercisable pursuant to the Terms of the Award and, as set forth on the website of the designated broker and in the Notice of Stock Appreciation Right Grant, if applicable.

ARTICLE II

TERM OF SAR AND EXERCISE

(a) Subject to the terms of this Agreement, the term of the SAR shall commence on the first Vest Date and shall terminate, unless sooner terminated by the terms of the Plan or this Terms of Award Agreement, at:

(i) The close of the Company's business on the day preceding the tenth anniversary of the Effective Date, if the Company is open for business on such day; or

(ii) The close of the Company's business on the next preceding day that the Company is open for business.

(b) The SAR is exercisable in installments, each installment to become exercisable as of the Vest Date in accordance with the terms of the Plan and this Terms of Award Agreement. Once an installment is vested, it may be exercised in whole or in part only during the Term of the SAR.

ARTICLE III

METHOD OF SAR EXERCISE

In order to exercise this SAR, Grantee must comply with procedures adopted by the Company from time to time. Under current procedures, the Grantee must exercise the SAR through the Company's designated broker.

In addition, if the Grantee has been notified that he or she must consult with a member of the Company's Law and Regulatory Affairs Unit prior to engaging in transactions in Aetna stock, Grantee must consult with Law prior to exercising the SAR.

Upon exercise of the SAR, payment (net of federal, state, local, social security and medicare taxes, if applicable) shall be paid in Common Stock. The resulting shares of Common Stock will be deposited in a brokerage account established in Grantee's name at the designated broker.

ARTICLE IV

CAPITAL CHANGES

In the event that the Committee shall determine that any Fundamental Corporate Event affects the Common Stock such that an adjustment is required to preserve, or to prevent enlargement of, the benefits or potential benefits made available under this SAR or the Plan, then the Committee may, in such manner as the Committee may deem equitable, adjust the (i) the number and kind of shares subject to the SAR or (ii) the SAR Grant Price. Additionally, the Committee may make provision for a cash payment to a Grantee or the Successor of the Grantee to the extent permitted under Section 409A. However, the number of Shares of Stock subject to the SAR shall always be a whole number.

ARTICLE V

CHANGE IN CONTROL

Upon the occurrence of (i) a Change in Control, and (ii) within 24 months thereafter, the Company terminates Grantee's Employment without cause, all SARs, whether or not vested, shall become immediately vested and become payable in accordance with the terms of this Agreement.

ARTICLE VI
TERMINATION OF SAR

(a) Except as provided in (d) below, if the Grantee shall die or begin to receive Long Term Disability benefits after the Effective Date, the SAR shall become vested and immediately exercisable and the Grantee or Successor of the Grantee may exercise the SAR until the earlier of:

(i) The expiration of the Term of the SAR; or

(ii) A period not to exceed five years following such death or commencement of Long Term Disability benefits.

(b) Except as provided in (e) below, if Grantee shall, for reason of Retirement, cease to be employed by the Company, its Subsidiaries or Affiliates after the Effective Date, the Grantee will become immediately vested and may immediately exercise any SAR that would have otherwise become vested within one year from the Grantee's termination of employment, and the Grantee or Successor of the Grantee may exercise a vested SAR until the earlier of:

(i) The expiration of the Term of the SAR; or

(ii) A period not to exceed five years following such cessation of employment.

(c) Except as provided in (d) and (e) below, if the Grantee shall, for a reason other than death, Long Term Disability or Retirement, cease to be employed by the Company, its Subsidiaries or Affiliates during the Term of the SAR, the Grantee may exercise a vested SAR until the earlier of:

(i) The expiration of the term of the SAR; or

(ii) A period not to exceed ninety days following such cessation of employment.

(d) Except as provided in (a) or (b) above, any SAR, or portion of a SAR that has not become vested and exercisable at the time of cessation of employment shall terminate immediately upon such cessation of employment and may not be exercised thereafter. Provided, however, if Grantee's employment is terminated by the Company other than for cause and Grantee has not previously, or does not subsequently, vest to any portion of the SAR in accordance with its terms, then upon the forfeiture of the entire SAR, the Company shall pay Grantee an amount equal to the SAR value on a single share of Common Stock, whether or not the forfeited SAR related to more than a single share of Common Stock, calculated as of the date of termination of employment under the same

method as the Company calculates its SAR expense charge for purposes of its financial statement reporting, if requested by Grantee, within 30 days of such cessation of employment.

(e) No SAR may vest or be exercised after the Company has terminated the employment of the Grantee for cause, except that the Committee may, in its sole discretion, permit the exercise of a vested SAR for a period of up to ninety days in cases where the Committee shall determine such exercise period is warranted under the particular circumstances. In addition, the Company may terminate the SAR if Grantee has willfully engaged in gross misconduct or other serious impropriety which the Company determines is likely to be damaging or detrimental to the Company, any Subsidiary or Affiliate.

(f) Employment for purposes of determining the vesting rights of the Grantee and expiration date of the grant under this Article VI shall mean continuous full-time salaried employment with the Company, a Subsidiary or an Affiliate, except that the period during which the Grantee is on vacation, sick leave, or other pre-approved leave of absence (provided there is no actual termination of employment), or in receipt of salary continuation or severance pay shall not interrupt the continuous employment of the Grantee. Employment shall also include service with Aetna Foundation, Inc.

(g) Except as otherwise herein provided, exercise of the SAR, whether by the Grantee or the Successor of the Grantee, shall be subject to all terms and conditions of this Agreement.

ARTICLE VII
OTHER TERMS

(a) Grantee understands that the Grantee shall not have any rights as stockholder by virtue of the grant of an SAR but only with respect to shares of Common Stock actually issued to the Grantee in accordance with the terms hereof.

(b) Anything herein to the contrary notwithstanding, the Company may postpone the exercise of the SAR or any portion thereof for such time as the Committee in its discretion may deem necessary, in order to permit the Company with reasonable diligence (i) to effect or maintain registration under the Securities Act of 1933, as amended, of the Plan or the shares of Common Stock issuable upon the exercise of the SAR or (ii) to determine that the Plan and such shares are exempt from registration; and the Company shall not be obligated by virtue of this Agreement or any provision of the Plan to recognize the exercise of the SAR or to sell or issue shares of Common Stock in violation of said Act or of the law of any government having jurisdiction thereof. Any such postponement shall not extend the Term of the SAR; and neither the Company nor its Board shall have any obligation or liability to the Grantee, or to the Grantee's Successor, with respect to any shares of Common Stock as to which the SAR shall lapse because of such postponement.

(c) The SAR shall be nontransferable and nonassignable except by will and by the laws of descent and distribution. During the Grantee's lifetime, the SAR may be exercised only by the Grantee.

(d) The SAR is not an incentive stock option as described in the Internal Revenue Code of 1986, as amended, Section 422A (b).

(e) This Agreement is subject to the 2010 Stock Incentive Plan heretofore adopted by the Company and approved by its shareholders. The terms and provisions of the Plan (including any subsequent amendments thereto) are hereby incorporated herein by reference. In the event of a conflict between any term or provision contained herein and a term or provision of the Plan, the applicable terms and provisions of the Plan will govern and prevail.

(f) Anything herein to the contrary notwithstanding, a Grantee whose SAR has been forfeited as a result of termination of employment due to U.S. Military Service and who is later re-employed (in a full-time active status) after discharge within the time period set in 38 U.S.C. Section 4312 will be eligible to have the forfeited SAR reinstated for the original Term pursuant to procedures established by the Company for this purpose.

(g) Nothing in this Agreement shall interfere with a limit in anyway the right of the Company or any Subsidiary or Affiliate to terminate the Grantee's employment at any time. Neither the execution and delivery of this Agreement nor the granting of the SAR shall constitute or be evidence of any agreement or understanding, express or implied, on the part of the Company or any of its Subsidiaries to employ Grantee for any period.

(h) This SAR is an unfunded obligation of the Company and nothing in this Agreement shall be construed to create any claim against particular assets or require the Company to segregate or otherwise set aside any assets or create any fund to meet its obligations hereunder.

(i) The Company shall have the power to withhold, an amount sufficient to satisfy Federal, state and local, social security and medicare withholding tax requirements, if applicable. Any social security calculation or other adjustments discovered after the net share payment will be settled in cash, not in Common Stock.

(j) The Company may from time to time adopt stock ownership requirements applicable to Grantees who are senior managers of the Company. In connection with and for the purpose of implementing those ownership requirements, the Company may adopt certain restrictions on the ability of a Grantee to sell shares issued under this Agreement when such ownership requirements have not been satisfied. Any such restriction on sale will be communicated generally to affected Grantees and the restriction may be modified by the Company from time to time, at its discretion. Neither the Company nor its Board of Directors shall have any obligation or liability to a Grantee in connections with any such restriction.

(k) This Agreement is made under and shall be governed by and construed in accordance with the laws of the State of Connecticut, without giving effect to its choice of law provisions.

ARTICLE VIII

EMPLOYEE COVENANTS

(a) As consideration for the grant of the SAR, without prior written consent of the Company:

(i) Grantee will not (except to the extent required by an order of a court having competent jurisdiction or under subpoena from an appropriate government agency) use or disclose to any third person, whether during or subsequent to Grantee's Employment, any trade secrets, confidential information and proprietary materials, which may include, but are not limited to, the following categories of information and materials: customer lists and identities; provider lists and identities; employee lists and identities; product development and related information; marketing plans and related information; sales plans and related information; premium or other pricing information; operating policies and manuals; research; payment rates; methodologies; procedures; contractual forms; business plans; financial records; computer programs; database; or other financial, commercial, business or technical information related to the Company, any Subsidiary or Affiliate unless such information has been previously disclosed to the public by the Company or has become public knowledge other than by a breach of this Agreement ("Confidential Information"); provided, however, that this limitation shall not apply to any such use or disclosure made while Grantee is employed by the Company, any Subsidiary or Affiliate if such disclosure occurred in connection with the performance of Grantee's job as an employee of the Company, any Subsidiary or Affiliate;

(ii) Grantee will not, during and for a period of twelve (12) months following Grantee's termination of employment, directly or indirectly, (x) engage in the ownership (except less than 1% of the outstanding capital stock of any publicly traded company) of or, (y) become an employee of, or (z) act as a consultant or contractor to, any competitor of the Company ("Competitor") in any market in the United States where Company, Affiliate or Subsidiary does business.

a. For purposes of this paragraph "Competitor" shall mean any entity, organization, person or corporation that is involved in the same business as Company, Subsidiary or Affiliate, but in the case of (y) and (z), only to the extent such work, consulting or other activity on behalf of other entity, organization, person or corporation

i. is materially similar to the duties and/or functions that Grantee performed for the Company, Subsidiary or Affiliate in the last 12 months or involves duties and/or functions for Competitor about which Grantee has Confidential Information in the last 12 months. Notwithstanding

1. with respect to sales functions for the Company, Subsidiary or Affiliate that are regionally based or whose focus is geographically limited, the restriction shall only apply where such work, consulting or other activity on behalf of a Competitor overlaps in whole or in part the same geographic area in which the Grantee worked for Company, Subsidiary or Affiliate in the last 12 months;

2. with respect to corporate staff functions, the restriction shall only apply where Competitor is substantially engaged in the business of health insurance, managed health care, population health management, or related products or services.

b. Notwithstanding, if Grantee's employment is terminated by the Company, Subsidiary or Affiliate other than for cause, the length of the noncompetition covenant in this paragraph shall not exceed the length of the severance and/or salary continuation benefits paid by the Company, Subsidiary or Affiliate to Grantee.

c. Grantee acknowledges and agrees that these restrictions:

i. are necessary to protect the Confidential Information and goodwill of the Company, Subsidiary or Affiliate;

ii. are appropriately tailored and limited in time and geographic scope to do so; and

iii. do not impair or limit the Grantee's ability to earn a living.

(iii) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly induce or attempt to induce any employee of the Company, and Subsidiary or Affiliate to be employed or perform services elsewhere;

(iv) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly, induce or attempt to induce any agent or agency, broker, supplier or health care provider of the Company, any Subsidiary or Affiliate to cease or curtail providing services to the Company, any Subsidiary or Affiliate; and

(v) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, directly or indirectly solicit or attempt to solicit the trade of any individual or entity which, at the time of such solicitation, is a customer of the Company, any Subsidiary or Affiliate, or which the Company, any Subsidiary or Affiliate is undertaking reasonable steps to procure as a customer at the time of or immediately preceding termination of Employment; provided, however, that this limitation shall only apply to any product or service which is in competition with a product or service of the Company, any Subsidiary or Affiliate and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved

(vi) Grantee will not, during and for a period of 24 months following Grantee's termination of Employment, for himself or herself or on behalf of or in cooperation with any other person or entity, consult with or in any manner provide advice to, any individual or entity which is a customer of the Company or any Subsidiary or Affiliate of the Company, provided, however, that this limitation shall apply only to consultation or advice relating to any product or service of the Company, or any Subsidiary or Affiliate, or which is in competition with any product or service of the Company, or any Subsidiary or Affiliate, and shall apply only with respect to a customer or prospective customer with whom the Grantee has been directly or indirectly involved, or about which Grantee has Confidential Information.

In addition:

(vii) Following the termination of Grantee's Employment, Grantee shall provide assistance to and shall cooperate with the Company, any Subsidiary or Affiliate, upon its reasonable request and without additional compensation, with respect to matters within the scope of Grantee's duties and responsibilities during Employment, provided that any reasonable out-of-pocket expenses Grantee incurs in connection with any assistance Grantee has been requested to provide under this provision for items including, but not limited to, transportation, meals, lodging and telephone, shall be reimbursed by the Company. The Company agrees and acknowledges that it shall, to the maximum extent possible under the then prevailing circumstances, coordinate, or cause a Subsidiary or Affiliate to coordinate, any such request with Grantee's other commitments and responsibilities to minimize the degree to which such request interferes with such commitments and responsibilities; and

(viii) Grantee shall promptly notify the Company's General Counsel if Grantee is contacted by a regulatory or self-regulatory agency with respect to matters pertaining to the Company or by an attorney or other individual who informs the Grantee that he/she has filed, intends to file, or is considering filing a claim or complaint against the Company.

(ix) Grantee acknowledges that all original works of authorship that are created by Grantee (solely or jointly with others) within the scope of Grantee's employment and relating in any way to the business or contemplated business, products, activities, research or development of the Company, any Subsidiary or Affiliate, or resulting from any work performed by the Grantee for the Company, any Subsidiary or Affiliate (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) which are protectable by copyright are "works made for hire" as that term is defined in the United States Copyright Act (17 U.S.C., Section 101). To the extent that the foregoing does not apply, the Grantee hereby irrevocably assigns to the Company, and its successors and assigns, for no additional consideration, the Grantee's entire right, title and interest in and to all such works of authorship. Grantee further acknowledges that while employed by the Company, any Subsidiary or Affiliate, Grantee may develop ideas, inventions, discoveries, innovations, procedures, methods, know-how or other works which relate to the Company's current or are reasonably expected to relate to the Company's future business (in each case, regardless of when or where the work product is prepared or whose equipment or other resources is used in preparing the same) that may be patentable or subject to trade secret protection. Grantee agrees that all such works of authorship, ideas, inventions, discoveries, innovations, procedures, methods, know-how and other works shall belong exclusively to the Company and the Grantee hereby assigns all right, title and interest therein to the Company.

To the extent any of the foregoing works may be patentable, Grantee agrees that the Company may file and prosecute any application for patents for such works and that the Grantee will, on request, execute assignments to the Company relating to (and take all such further steps as may be reasonably necessary to perfect the Company's sole and exclusive ownership of) any such application and any patents resulting therefrom.

(b) If any provision of Article VIII (a) is determined by a court of competent jurisdiction not to be enforceable in the manner set forth herein, the Company and Grantee agree that it is the intention of the parties that such provision should be enforceable to the maximum extent possible under applicable law and that such court shall reform such provision to make it enforceable in accordance with the intent of the parties.

(c) Grantee acknowledges that a material part of the inducement for the Company to grant the SAR is Grantee's covenants set forth in Article VIII(a) and that the covenants and obligations of Grantee with respect to nondisclosure, nonsolicitation, cooperation and intellectual property rights relate to special, unique and extraordinary matters and that a violation of any of the terms of such covenants and obligations will cause the Company irreparable injury for which adequate remedies are not available at law. Therefore, Grantee agrees that, if Grantee shall breach any of those covenants or obligations, Grantee shall not be entitled to exercise the SAR or be entitled to retain any income therefrom and the Company shall be entitled to an injunction, restraining order or such other equitable relief (without the requirement to post bond) restraining Grantee from committing any violation of the covenants and obligations contained in Article VIII. The Company also shall be entitled to recover any attorneys' fees, costs, and expenses it incurs in connection with any judicial proceeding arising out of Grantee's breach of this Agreement. The remedies in the preceding sentences are cumulative and are in addition to any other rights and remedies the Company may have at law or in equity as a court or arbitrator shall reasonably determine..

(d) The Restrictive Covenants set forth in this Article VIII shall supplement and do not supersede the restrictions agreed to by Grantee in any other agreement or contact.

(e) Employment Dispute Arbitration Program - Mandatory Binding Arbitration of Employment Disputes.

(i) Except as otherwise specified in this Agreement, the Grantee and the Company agree that all employment-related legal disputes between them will be submitted to and resolved by binding arbitration, and neither the Grantee nor the Company will file or participate as an individual party or member of a class in a lawsuit in any court against the other with respect to such matters. This shall apply to claims brought on or after the date the Grantee accepts this Agreement, even if the facts and circumstances relating to the claim occurred prior to that date and regardless of whether Grantee or the Company previously filed a complaint/charge with a government agency concerning the claim.

For purposes of Article VIII (e) of this Agreement, "the Company" includes Aetna Inc., its Subsidiaries and Affiliates, their predecessors, successors and assigns, and those acting as representatives or agents of those entities. THE GRANTEE UNDERSTANDS THAT, WITH RESPECT TO CLAIMS SUBJECT TO THE ARBITRATION REQUIREMENT, ARBITRATION REPLACES THE RIGHT OF THE GRANTEE AND THE COMPANY TO SUE OR PARTICIPATE IN A LAWSUIT. THE GRANTEE ALSO UNDERSTANDS THAT IN ARBITRATION, A DISPUTE IS RESOLVED BY AN ARBITRATOR INSTEAD OF A JUDGE OR JURY, AND THE DECISION OF THE ARBITRATOR IS FINAL AND BINDING.

(ii) THE GRANTEE UNDERSTANDS THAT THE ARBITRATION PROVISIONS OF THIS AGREEMENT AFFECT THE LEGAL RIGHTS OF THE GRANTEE AND THE COMPANY AND ACKNOWLEDGES THAT THE GRANTEE HAS BEEN ADVISED TO, AND HAS BEEN GIVEN THE OPPORTUNITY TO, OBTAIN LEGAL ADVICE BEFORE SIGNING THIS AGREEMENT.

(iii) Article VIII (e) of this Agreement does not apply to workers' compensation claims, unemployment compensation claims, and claims under the Employee Retirement Income Security Act of 1974 ("ERISA") for employee benefits. A dispute as to whether Article VIII (e) of this Agreement applies must be submitted to the binding arbitration process set forth in this Agreement.

(iv) The Grantee and/or the Company may seek emergency or temporary injunctive relief from a court (including with respect to claims arising out of Article VIII (a) in accordance with applicable law). However, except as provided in Article VIII (c) of this Agreement, after the court has issued a ruling concerning the emergency or temporary injunctive relief, the Grantee and the Company shall be required to submit the dispute to binding arbitration pursuant to this Agreement.

(v) Unless otherwise agreed, the arbitration will be administered by the American Arbitration Association (the "AAA") and will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures (the "Rules"), as modified in this Agreement, in effect at the time the request for arbitration is filed. The AAA's Rules are available on the AAA's website at www.adr.org . THE GRANTEE ACKNOWLEDGES THAT THE COMPANY HAS ENCOURAGED THE GRANTEE TO READ THESE RULES PROMPTLY AND CAREFULLY AND THAT THE GRANTEE HAS BEEN AFFORDED SUFFICIENT OPPORTUNITY TO DO SO.

(vi) If the Company initiates a request for arbitration, the Company will pay all of the administrative fees and costs charged by the AAA, including the arbitrator's compensation and charges for hearing room rentals, etc. If the Grantee initiates a request for arbitration or submits a counterclaim to the Company's request for arbitration, the Grantee shall be required to contribute One Hundred Dollars ($100.00) to those administrative fees and costs, payable to the AAA at the time the Grantee's request for arbitration or counterclaim is submitted. The Company may increase the contribution amount in the future without amending this Agreement, but not to exceed the maximum permitted under the AAA rules then in effect. In all cases, the Grantee and the Company shall be responsible for payment of any fees assessed by the arbitrator as a result of that party's delay, request for postponement, failure to comply with the arbitrator's rulings and for other similar reasons.

(vii) The Grantee and the Company may choose to be represented by legal counsel in the arbitration process and shall be responsible for their own legal fees, expenses and costs. However, the arbitrator shall have the same authority as a court to order the Grantee or the Company to pay some or all of the other's legal fees, expenses and costs, in accordance with applicable law.

(viii) Unless otherwise agreed, there shall be a single arbitrator, selected by the Grantee and the Company from a list of qualified neutrals furnished by the AAA. If the Grantee and the Company cannot agree on an arbitrator, one will be selected by the AAA.

(ix) Unless otherwise agreed, the arbitration hearing will take place in the city where the Grantee works or last worked for the Company. If the Grantee and the Company disagree as to the proper locale, the AAA will decide.

(x) The Grantee and the Company shall be entitled to conduct limited pre-hearing discovery. Each may take the deposition of one person and anyone designated by the other as an expert witness. The party taking the deposition shall be responsible for all associated costs, such as the cost of a court reporter and the cost of an original transcript. Each party also has the right to submit one set of ten written questions (including subparts) to the other party, which must be answered under oath, and to request and obtain all documents on which the other party relies in support of its answers to the written questions. Additional discovery may be permitted by the arbitrator upon a showing that it is necessary for that party to have a fair opportunity to present a claim or defense.

(xi) The arbitrator shall apply the same substantive law that would apply if the matter were heard by a court and shall have the authority to order the same remedies (but no others) as would be available in a court proceeding. The time limits for requesting arbitration or submitting a counterclaim and the administrative prerequisites for filing an arbitration claim or counterclaim are the same as they would be in a court proceeding. The arbitrator shall consider and decide any dispositive motions (motions seeking a decision on some or all of the claims or counterclaims without an arbitration hearing) filed by any party.

(xii) All proceedings, including the arbitration hearing and decision, are private and confidential, unless otherwise required by law. Arbitration decisions may not be published or publicized without the consent of both the Grantee and the Company.

(xiii) Unless otherwise agreed, the arbitrator's decision will be in writing with a brief summary of the arbitrator's opinion.

(xiv) The arbitrator's decision is final and binding on the Grantee and the Company. After the arbitrator's decision is issued, the Grantee or the Company may obtain an order of judgment from a court and may obtain a court order enforcing the decision. The arbitrator's decision may be appealed to the courts only under the limited circumstances provided by law.

(xv) If the Grantee previously signed an agreement, including but not limited to an employment agreement, containing arbitration provisions, those provisions are superseded by the arbitration provisions of this Agreement.

(xvi) If any provision of Article VIII (e) is found to be void or otherwise unenforceable, in whole or in part, this shall not affect the validity of the remainder of Article VIII (e) and the remainder of the Agreement. All other provisions shall remain in full force and effect.

(f) Except as provided in connection with mandatory binding arbitration of employment disputes, Grantee hereby submits to the exclusive jurisdiction of the courts of the State of Connecticut and the United States District Court for the District of Connecticut with respect to any action relating to this Agreement, and agrees that (i) the sole and exclusive appropriate venue for any suit or proceeding relating to this Agreement shall be in such court, and (ii) hereby waives any and all objections and defenses based on forum, venue or personal or subject matter jurisdiction as they may relate to a suit or proceeding brought before such court in accordance with the Agreement.

For purposes of this Article VIII, the term "Employment" shall refer to active employment with the Company, any Subsidiary or Affiliate, and shall not include salary continuation or severance periods.

I have read the Stock Appreciation Right Agreement. I accept the Stock Appreciation Right award and agree to be bound by all of its terms and conditions including mandatory binding arbitration of employment related disputes and, if applicable, any other provisions of Article VIII.

Exhibit 13.1

Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis should be read in conjunction with the audited consolidated financial statements and Cautionary Statement Concerning Forward-Looking Statements that are included in this Annual Report.

Overview of Business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna") for a combination of cash and CVS Health stock (the "Aetna Acquisition"). The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion. Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion. The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans (see "Liquidity and Capital Resources" later in this document). The consolidated financial statements for the year ended December 31, 2018 reflect Aetna's results subsequent to the Aetna Acquisition Date.

On October 10, 2018, the Company and Aetna entered into a consent decree with the United States Department of Justice (the "DOJ") that allowed the Company's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As part of the agreement reached with the DOJ, Aetna entered into a purchase agreement with a subsidiary of WellCare Health Plans, Inc. for the divestiture of Aetna's standalone Medicare Part D prescription drug plans effective December 31, 2018. On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans. Aetna's standalone Medicare Part D prescription drug plans had an aggregate of approximately 2.3 million members as of December 31, 2018. Aetna will provide administrative services to, and will retain the financial results of, the divested plans through 2019.

As a result of the Aetna Acquisition, the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. Certain aspects of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Company's Corporate/Other segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other.

Overview of the Pharmacy Services Segment

The Pharmacy Services segment provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. The Pharmacy Services segment's clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care plans, plans offered on public health insurance exchanges and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. The Pharmacy Services segment operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and

branches for infusion and enteral nutrition services. During the year ended December 31, 2018, the Company's PBM filled or managed approximately 1.9 billion prescriptions on a 30-day equivalent basis.

Overview of the Retail/LTC Segment

The Retail/LTC segment sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic ® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, the Retail/LTC segment also provided commercialization services under the name RxCrossroads ® . The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, the Retail/LTC segment operated more than 9,900 retail locations, over 1,100 MinuteClinic ® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies. During the year ended December 31, 2018, the Retail/LTC segment filled approximately 1.3 billion prescriptions on a 30-day equivalent basis. In December 2018, the Company held approximately 26% of the United States retail pharmacy market.

Overview of the Health Care Benefits Segment

The Health Care Benefits segment is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018 . The Health Care Benefits segment has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. The Health Care Benefits segment offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. The Health Care Benefits segment's customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates.

Overview of the Corporate/Other Segment

The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as large case pensions and long-term care insurance products.

Results of Operations

Summary of Consolidated Financial Results

	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 183,910	$ 180,063	$ 173,377	$ 3,847	2.1 %	$ 6,686	3.9 %
Premiums	8,184	3,558	3,069	4,626	130.0 %	489	15.9 %
Services	1,825	1,144	1,080	681	59.5 %	64	5.9 %
Net investment income	660	21	20	639	3,042.9 %	1	5.0 %
Total revenues	194,579	184,786	177,546	9,793	5.3 %	7,240	4.1 %
Operating Costs:							
Cost of products sold	156,447	153,448	146,533	2,999	2.0 %	6,915	4.7 %
Benefit costs	6,594	2,810	2,179	3,784	134.7 %	631	29.0 %
Goodwill impairments	6,149	181	—	5,968	3,297.2 %	181	— %
Operating expenses	21,368	18,809	18,448	2,559	13.6 %	361	2.0 %
Total operating costs	190,558	175,248	167,160	15,310	8.7 %	8,088	4.8 %
Operating income	4,021	9,538	10,386	(5,517)	(57.8)%	(848)	(8.2)%
Interest expense	2,619	1,062	1,078	1,557	146.6 %	(16)	(1.5)%
Loss on early extinguishment of debt	—	—	643	—	— %	(643)	(100.0)%
Other expense (income)	(4)	208	28	(212)	(101.9)%	180	642.9 %
Income before income tax provision	1,406	8,268	8,637	(6,862)	(83.0)%	(369)	(4.3)%
Income tax provision	2,002	1,637	3,317	365	22.3 %	(1,680)	(50.6)%
Income (loss) from continuing operations	(596)	6,631	5,320	(7,227)	(109.0)%	1,311	24.6 %
Loss from discontinued operations, net of tax	—	(8)	(1)	8	(100.0)%	(7)	700.0 %
Net income (loss)	(596)	6,623	5,319	(7,219)	(109.0)%	1,304	24.5 %
Net (income) loss attributable to noncontrolling interest	2	(1)	(2)	3	(300.0)%	1	(50.0)%
Net income (loss) attributable to CVS Health	$ (594)	$ 6,622	$ 5,317	$ (7,216)	(109.0)%	$ 1,305	24.5 %

Commentary - 2018 compared to 2017

Revenues

- Total revenues increased $9.8 billion or 5.3% in 2018 compared to 2017 . The increase in total revenues was due to a 2.7% increase in Pharmacy Services segment revenue, a 5.8% increase in Retail/LTC segment revenue and the impact of the Aetna Acquisition (primarily reflected in the Health Care Benefits segment) which occurred in November 2018.
- Please see “Segment Analysis” later in this document for additional information about the revenues of the Company’s segments.

Operating expenses (including goodwill impairments)

- Operating expenses increased $8.5 billion or 44.9% in 2018 compared to 2017 . The increase in operating expenses was primarily due to higher operating expenses in the Retail/LTC segment including increased goodwill impairment charges in 2018, the impact of the Aetna Acquisition and an increase in acquisition-related transaction and integration costs. The increase was partially offset by a lack of charges associated with store closures in 2018.
- Operating expenses as a percentage of total revenues was 14.1% in 2018 , an increase of 380 basis points compared to 2017 . The increase in operating expenses as a percentage of total revenues in 2018 was primarily due to the goodwill impairment charges in the Retail/LTC segment in 2018.
- Please see “Segment Analysis” later in this document for additional information about the operating expenses of the Company’s segments.

Operating income

- Operating income decreased $5.5 billion or 57.8% in 2018 compared to 2017 . The decrease was primarily due to the increase in operating expenses described above, continued price compression in the Pharmacy Services segment and reimbursement pressure in the Retail/LTC segment. The decrease was partially offset by increased prescription volume, improved purchasing economics and the addition of Aetna.
- Please see "Segment Analysis" later in this document for additional information about the operating income of the Company's segments.

Interest expense

- Interest expense increased $1.6 billion during 2018 , primarily due to financing activity associated with the Aetna Acquisition. See Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements for additional information.

Other expense (income)

- Other expense decreased $212 million during 2018, primarily due to 2017 reflecting a $187 million loss on settlement of the Company's defined benefit pension plans.

Income tax provision

- The Tax Cuts and Jobs Act (the "TCJA") was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The Company completed its assessment of the TCJA's final impact in December 2018 and recorded an additional tax benefit of approximately $100 million .
- The Company's effective income tax rate was 142.4% in 2018 compared to 19.8% in 2017 . The increase in the effective income tax rate was primarily due to the goodwill impairment charges in the Retail/LTC segment in 2018, the majority of which are not deductible for income tax purposes, and an income tax benefit of $1.5 billion in 2017 which reflected the remeasurement of the Company's net deferred income tax liabilities as a result of the enactment of the TCJA. The increase was partially offset by a lower federal corporate income tax rate in 2018 compared to the prior year as a result of the enactment of the TCJA, which reduced the corporate income tax rate in 2018 to 21% from 35% in 2017.

Loss from discontinued operations

- In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Linens 'n Things, which filed for bankruptcy in 2008, and Bob's stores, which filed for bankruptcy in 2016. The Company's loss from discontinued operations includes lease-related costs required to satisfy its Linens 'n Things and Bob's Stores lease guarantees.
- The Company incurred a loss from discontinued operations, net of tax, of $8 million in 2017 . Results from discontinued operations were immaterial in 2018.
- See "Discontinued Operations" in Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information about discontinued operations and Note 16 ''Commitments and Contingencies'' to the consolidated financial statements for additional information about the Company's lease guarantees.

Commentary - 2017 compared to 2016

Revenues

- Total revenues increased $7.2 billion or 4.1% in 2017 compared to 2016 . The increase in total revenues was due to a 8.9% increase in Pharmacy Services segment revenue, partially offset by a 2.1% decrease in Retail/LTC segment revenue.
- The increase in generic dispensing rates in 2017 negatively affected both the Pharmacy Services and Retail/LTC segment revenues in 2017 compared to 2016 .
- Please see "Segment Analysis" later in this document for additional information about the revenues of the Company's segments.

Operating expenses (including goodwill impairments)

- Operating expenses increased $542 million , or 2.9% , in 2017 compared to 2016 . The increase in operating expenses primarily relates to (i) higher operating expenses in the Retail/LTC segment including an increase of $181 million in charges associated with the closure of retail stores in connection with the Company's enterprise streamlining initiative and a $181 million goodwill impairment charge related to the RxCrossroads reporting unit; and (ii) higher operating expenses

in the Pharmacy Services segment due to 2016 reflecting the favorable impact of a reversal of an accrual of $85 million in connection with a legal settlement. The increase was partially offset by lower acquisition-related transaction and integration costs due to the bulk of the integration costs related to the acquisition of Omnicare, Inc. ("Omnicare") being incurred in 2016.

- Operating expenses as a percentage of total revenues was 10.3% in 2017 , a decline of 10 basis points compared to 2016 . The decline in operating expenses as a percentage of total revenues in 2017 was primarily due expense leverage from revenue growth.
- Please see "Segment Analysis" later in this document for additional information about the operating expenses of the Company's segments.

Operating income

- Operating income decreased $848 million or 8.2% in 2017 compared to 2016 . The decrease was primarily driven by the previously announced restricted networks that excluded CVS Pharmacy, continued price compression in the Pharmacy Services segment, reimbursement pressure in the Retail/LTC segment and the increased operating expenses described above.
- Please see "Segment Analysis" later in this document for additional information about the operating income of the Company's segments.

Interest expense

- Interest expense decreased $16 million during 2017 , primarily due to the Company's debt issuance and debt tender offers that occurred in 2016 which resulted in overall more favorable interest rates on the Company's long-term debt. See Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements for additional information.

Other expense (income)

- Other expense increased $180 million during 2017 , primarily due to 2017 reflecting a $187 million loss on settlement of the Company's defined benefit pension plans.

Loss on early extinguishment of debt

- The loss on early extinguishment of debt of $643 million in 2016 relates to the redemption of approximately $4.2 billion aggregate principal amount of certain of the Company's senior notes (see Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements). As a result of the redemption, the Company paid a premium of $583 million in excess of the debt principal, wrote off $54 million of unamortized deferred financing costs and incurred $6 million in fees.

Income tax provision

- The Company's effective income tax rate was 19.8% in 2017 compared to 38.4% in 2016 . The decrease in the effective income tax rate was primarily due to the provisional impact of the TCJA, including the revaluation of net deferred tax liabilities.
- As the result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion in 2017.

Loss from discontinued operations

- Please see the *Commentary - 2018 compared to 2017* section above for additional information about the Company's discontinued operations.
- The Company incurred losses from discontinued operations, net of tax, of $8 million and $1 million in 2017 and 2016 , respectively.

Outlook for 2019

The Company expects 2019 to be a transition year as it integrates the Aetna Acquisition and focuses on key pillars of its growth strategy. The Company believes that it is on track to exceed its 2020 target for synergies from the Aetna Acquisition. The Company also expects that the following challenges may have a disproportionate adverse impact on, and reduce, the operating income of its Pharmacy Services and Retail/LTC segments in 2019 compared to 2018:

- Ongoing pharmacy reimbursement pressure in the Pharmacy Services and Retail/LTC segments and reductions in the traditional offsets to those pressures, including a declining benefit from the introduction of new multi-source generic prescription drugs and lower benefits from generic dispensing rate increases;
- The reimbursement pressure in the Pharmacy Services segment is projected to be exacerbated by the cumulative effect on rebate guarantees of lower brand name drug price inflation and a modest 2019 selling season; and
- The Retail/LTC segment is projected to be impacted by structural and Company specific challenges in the long-term care space as well as the annualization of the Company's 2018 investment of a portion of the savings from the TCJA in wages and benefits.

The Company is taking specific actions designed to address these challenges and position it well in 2020 and beyond. These actions include new product and service initiatives in its Pharmacy Services and Retail/LTC segments, introducing a new PBM client contracting model, accelerating the action plan designed to improve the performance of the LTC business and initiating a new enterprise cost reduction effort. The Company also is continuing to evaluate its assets and the roles they play in enabling the Company's core strategies.

The Company's current expectations described above are forward-looking statements. Please see "Cautionary Statement Concerning Forward-Looking Statements" below for information regarding important factors that may cause the Company's actual results to differ from those currently projected and/or otherwise materially affect the Company.

Segment Analysis

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company evaluates the performance of its operating segments based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The following is a reconciliation of the Company's segments total revenues and operating income (loss) to the consolidated financial statements:

In millions	Pharmacy Services [1][2]	Retail/LTC [2]	Health Care Benefits [2]	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2018						
Total revenues [3]	$ 134,128	$ 83,989	$ 5,549	$ 606	$ (29,693)	$ 194,579
Operating income (loss) [4][5]	4,699	620	276	(805)	(769)	4,021
2017						
Total revenues [7]	130,601	79,398	—	16	(25,229)	184,786
Operating income (loss) [4][5][7]	4,657	6,558	—	(936)	(741)	9,538
2016						
Total revenues [7]	119,965	81,100	—	18	(23,537)	177,546
Operating income (loss) [4][5][6][7]	4,570	7,437	—	(900)	(721)	10,386

(1) Total revenues of the Pharmacy Services segment include approximately $11.4 billion , $10.8 billion and $10.5 billion of Retail Co-Payments for 2018 , 2017 and 2016 , respectively. See Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information about Retail Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services segment and the Retail/LTC segment for 2018, 2017 and 2016. Effective November 28, 2018, intersegment eliminations also relate to intersegment revenue generating activities that occur between the Health Care Benefits segment, the Pharmacy Services segment and/or the Retail/LTC segment.

(3) Corporate/Other segment revenues for 2018 include interest income of $536 million related to the proceeds of the $40 billion principal amount of unsecured floating rate notes and unsecured fixed rate senior notes the Company issued on March 9, 2018 (collectively, the "2018 Notes"). This amount is for the period prior to the close of the Aetna Acquisition, which occurred on November 28, 2018.

(4) Retail/LTC segment operating income for 2018 , 2017 and 2016 includes $7 million , $34 million and $281 million , respectively, of acquisition-related integration costs. The integration costs in 2018 and 2017 are related to the acquisition of Omnicare. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target Corporation ("Target"). Retail/LTC segment operating income for 2018 and 2017 also includes goodwill impairment charges of $6.1 billion related to the LTC reporting unit and $181 million related to the RxCrossroads reporting unit, respectively. In addition, Retail/LTC segment operating income for 2017 and 2016 includes $215 million and $34 million , respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company's enterprise streamlining initiative. Retail/LTC segment operating income for 2018 also includes a $43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment and an $86 million loss on the divestiture of the Company's RxCrossroads subsidiary.

(5) Corporate/Other segment operating loss for 2018 , 2017 and 2016 includes $485 million , $40 million and $10 million, respectively, of divestiture and acquisition-related transaction and integration costs included in operating expenses in the consolidated statements of operations. The transaction and integration costs in 2018 are related to the acquisitions of Aetna and Omnicare. The transaction and integration costs in 2017 are related to the acquisitions of Aetna and Omnicare and the divestiture of RxCrossroads. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.

(6) Pharmacy Services segment operating income for 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

(7) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within total revenues to conform with insurance company presentation which increased total revenues and operating income by $21 million and $20 million in 2017 and 2016 , respectively.

Pharmacy Services Segment

The following table summarizes the Pharmacy Services segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Revenues:							
Products	$ 130,264	$ 126,770	$ 116,639	$ 3,494	2.8 %	$ 10,131	8.7%
Premiums	3,361	3,558	3,069	(197)	(5.5)%	489	15.9%
Services	490	268	255	222	82.8 %	13	5.1%
Net investment income [1]	13	5	2	8	160.0 %	3	150.0%
Total revenues	134,128	130,601	119,965	3,527	2.7 %	10,636	8.9%
Cost of products sold	125,107	121,799	111,949	3,308	2.7 %	9,850	8.8%
Benefit costs	2,805	2,810	2,179	(5)	(0.2)%	631	29.0%
Operating expenses [2]	1,517	1,335	1,267	182	13.6 %	68	5.4%
Operating expenses % of revenues	1.1%	1.0%	1.1%				
Operating income [1]	$ 4,699	$ 4,657	$ 4,570	$ 42	0.9 %	$ 87	1.9%
Operating income % of revenues	3.5%	3.6%	3.8%				
Revenues (by distribution channel): [8]							
Pharmacy network [3][4]	$ 83,261	$ 80,891	$ 73,686	$ 2,370	2.9 %	$ 7,205	9.8%
Mail choice [5]	46,934	45,709	42,783	1,225	2.7 %	2,926	6.8%
Other [4]	3,920	3,996	3,494	(76)	(1.9)%	502	14.4%
Pharmacy claims processed: [6][7]							
Total	1,889.8	1,781.9	1,639.2	107.9	6.1 %	142.7	8.7%
Pharmacy network [3]	1,601.4	1,516.7	1,387.7	84.7	5.6 %	129	9.3%
Mail choice [5]	288.4	265.2	251.5	23.2	8.7 %	13.7	5.4%
Generic dispensing rate: [6][7]							
Total	87.3%	87.0%	85.9%				
Pharmacy network [3]	87.9%	87.7%	86.7%				
Mail choice [5]	83.9%	83.1%	81.4%				
Mail choice penetration rate [6][7]	15.3%	14.9%	15.3%				

(1) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within revenues to conform with insurance company presentation which increased both net investment income and operating income by $5 million and $2 million in 2017 and 2016 , respectively.
(2) Pharmacy Services segment operating expenses in 2016 include the reversal of an accrual of $88 million in connection with a legal settlement.
(3) Pharmacy network revenues, pharmacy network claims processed and pharmacy network generic dispensing rate do not include Maintenance Choice ® activity, which is included within the mail choice category. Pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice activity.
(4) Amounts revised for 2017 and 2016 to reflect the reclassification of Medicare Part D premium revenues from pharmacy network revenues to other revenues.
(5) Mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect ® claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice program, which permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order..
(6) Includes the adjustment to convert 90-day prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.
(7) The pharmacy claims processed, generic dispensing rate and mail choice penetration rate in 2016 have been revised to convert 90-day prescriptions to the equivalent of three 30-day prescriptions.
(8) Excludes net investment income.

Commentary - 2018 compared to 2017

Revenues

- Total revenues increased $3.5 billion , or 2.7% , to $134.1 billion in 2018 compared to 2017. The increase was primarily due to increased total pharmacy claims volume, partially offset by continued client pricing pressures.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 8.7% to 288.4 million claims in 2018 compared to 265.2 million claims in 2017 . The increase in mail choice claims was primarily driven by the continued adoption of Maintenance Choice offerings and an increase in specialty pharmacy claims.
  - During 2018 , the average revenue per mail choice claim, on a 30-day equivalent basis, decreased by 5.6% compared to 2017 as a result of price compression.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 5.6% to approximately 1.6 billion claims in 2018 compared to approximately 1.5 billion claims in 2017 . The increase in the pharmacy network claim volume was primarily due to net new business.
  - During 2018 , the average revenue per pharmacy network claim processed, on a 30-day equivalent basis, decreased 2.7% compared to 2017 as a result of continued price compression.
  - The Company's total generic dispensing rate increased to 87.3% in 2018 compared to 87.0% in 2017 . The continued increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate. The Company believes its generic dispensing rate will continue to increase in future periods, albeit at a slower pace. This increase will be affected by, among other things, the number of new brand and generic drug introductions and the Company's success at encouraging plan members to utilize generic drugs when they are available and clinically appropriate.

Operating expenses

- Operating expenses in the Pharmacy Services segment include selling, general and administrative expenses, depreciation and amortization related to selling, general and administrative activities and administrative payroll, employee benefits and occupancy costs.
- Operating expenses increased $182 million , or 13.6% , in 2018 compared to 2017 . The year over year increase in operating expenses was primarily due to:
  - Growth in the business, including acquisitions; and
  - The reinstatement of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010' s (as amended, collectively, the "ACA's") health insurer fee ("HIF") in 2018;
  - Partially offset by the realization of partially reserved receivables in 2017 which reduced operating expenses.
- Operating expenses as a percentage of total revenues remained relatively consistent at 1.1% and 1.0% in 2018 and 2017 , respectively.

Operating income

- Operating income increased $42 million , or 0.9% , to $4.7 billion in 2018 compared to 2017 . The increase in operating income was primarily due to increased claims volume and improved purchasing economics, partially offset by continued price compression and the increased operating expenses described above.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's efforts to (i) retain existing clients, (ii) obtain new business and (iii) maintain or improve the rebates and/or discounts the Company receives from manufacturers, wholesalers and retail pharmacies continue to have an impact on operating income. In particular, competitive pressures in the PBM industry have caused the Company and other PBMs to continue to share with clients a larger portion of rebates and/or discounts received from pharmaceutical manufacturers. In addition, marketplace dynamics and regulatory changes have limited the Company's ability to offer plan sponsors pricing that includes retail network "differential" or "spread," and the Company expects these trends to continue. The "differential" or "spread" is any difference between the drug price charged to plan sponsors, including Medicare Part D plan sponsors, by a PBM and the price paid for the drug by the PBM to the dispensing provider.

Commentary - 2017 compared to 2016

Revenues

- Total revenues increased $10.6 billion , or 8.9% , to $130.6 billion in 2017 compared to 2016 . The increase was primarily due to growth in pharmacy network and specialty pharmacy volume as well as brand name drug price inflation, partially offset by continued price compression and increased generic dispensing.
- As you review the Pharmacy Services segment's performance in this area, you should consider the following important information about the business:
  - The Company's mail choice claims processed, on a 30-day equivalent basis, increased 5.4% to 265.2 million claims in 2017 compared to 251.5 million claims in 2016 .
  - During 2017 , the Company's average revenue per mail choice claim, on a 30-day equivalent basis, increased by 1.7% compared to 2016 . The increase was primarily due to growth in specialty pharmacy and brand name drug price inflation.
  - The Company's pharmacy network claims processed, on a 30-day equivalent basis, increased 9.3% to approximately 1.5 billion claims in 2017 compared to approximately 1.4 billion claims in 2016 . The increase was primarily due to increased volume from net new business.
  - During 2017 , the average revenue per pharmacy network claim processed remained flat on a 30-day equivalent basis.
  - The Company's total generic dispensing rate increased to 87.0% in 2017 compared to 85.9% in 2016 . The increase in the Company's generic dispensing rate was primarily due to the impact of new generic drug introductions, and the Company's ongoing efforts to encourage plan members to use generic drugs when they are available and clinically appropriate.

Operating expenses

- Operating expenses increased $68 million , or 5.4% , in 2017 compared to 2016 . The year over year increase in operating expenses was primarily due to an $88 million reversal of an accrual in connection with a legal settlement in 2016 and an increase in costs associated with the growth of the business. The increase was partially offset by the realization of partially reserved receivables in 2017 which reduced operating expenses.
- Operating expenses as a percentage of revenues remained relatively consistent at 1.0% and 1.1% of revenues in 2017 and 2016 , respectively.

Operating income

- Operating income increased $87 million , or 1.9% , to $4.7 billion in 2017 compared to 2016 . The increase in operating income was primarily due to growth in specialty pharmacy, higher generic dispensing and favorable purchasing economics, partially offset by price compression and the increased operating expenses described above.

Retail/LTC Segment

The following table summarizes the Retail/LTC segment's performance for the respective periods:

	Year Ended December 31,			Change			
				2018 vs. 2017		2017 vs. 2016	
In millions	**2018**	**2017**	**2016**	**$**	**%**	**$**	**%**
Revenues							
Products	$ 83,175	$ 78,522	$ 80,275	$ 4,653	5.9 %	$ (1,753)	(2.2)%
Services	814	876	825	(62)	(7.1)%	51	6.2 %
Total revenues	83,989	79,398	81,100	4,591	5.8 %	(1,702)	(2.1)%
Cost of products sold [1]	59,906	56,066	57,339	3,840	6.8 %	(1,273)	(2.2)%
Operating expenses [2][3][4][5][6]	23,463	16,774	16,324	6,689	39.9 %	450	2.8 %
Operating expenses % of revenues	27.9%	21.1 %	20.1 %				
Operating income [1][2][3][4][5][6]	$ 620	$ 6,558	$ 7,437	$ (5,938)	(90.5)%	$ (879)	(11.8)%
Operating income % of revenues	0.7%	8.3 %	9.2 %				
Revenues (by major goods/service line):							
Pharmacy	$ 64,179	$ 59,528	$ 60,838	$ 4,651	7.8 %	$ (1,310)	(2.2)%
Front Store	19,055	18,769	19,123	286	1.5 %	(354)	(1.9)%
Other	755	1,101	1,139	(346)	(31.4)%	(38)	(3.3)%
Prescriptions filled [7]	1,339.1	1,230.5	1,223.5	108.6	8.8 %	7.0	0.6 %
Revenue increase (decrease):							
Total	5.8%	(2.1)%	12.6 %				
Pharmacy	7.8%	(2.2)%	15.9 %				
Front Store	1.5%	(1.9)%	0.3 %				
Total prescription volume [7]	8.8%	0.6 %	18.6 %				
Same store sales increase (decrease): [8]							
Total	6.0%	(2.6)%	1.9 %				
Pharmacy	7.9%	(2.6)%	3.2 %				
Front Store	0.5%	(2.6)%	(1.5)%				
Prescription volume [7]	9.1%	0.4 %	3.6 %				
Generic dispensing rate	87.5%	87.3 %	85.7 %				

(1) Cost of products sold and operating income for 2017 include $2 million of acquisition-related integration costs related to the acquisition of Omnicare.
(2) Operating expenses and operating income in 2018, 2017 and 2016 include $7 million , $32 million and $235 million , respectively, of acquisition-related integration costs. In 2018 and 2017 , the integration costs related to the acquisition of Omnicare. In 2016 , the integration costs related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.
(3) Operating expenses and operating income for 2018 and 2017 include goodwill impairment charges of $6.1 billion related to the LTC reporting unit and $181 million related to the RxCrossroads reporting unit, respectively.
(4) Operating expenses and operating income for 2017 and 2016 include $215 million and $34 million , respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company's enterprise streamlining initiative.
(5) Operating expenses and operating income for 2018 include a $43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment.
(6) Operating expenses and operating income for 2018 include an $86 million loss on the divestiture of the Company's RxCrossroads subsidiary.
(7) Includes the adjustment to convert 90-day, non-specialty prescriptions to the equivalent of three 30-day prescriptions. This adjustment reflects the fact that these prescriptions include approximately three times the amount of product days supplied compared to a normal prescription.
(8) Same store sales and prescription volume exclude revenues from MinuteClinic, and revenue and prescriptions from stores in Brazil, LTC operations and commercialization services.

Commentary - 2018 compared to 2017

Revenues

- Total revenues increased approximately $4.6 billion , or 5.8% , to $84.0 billion in 2018 compared to 2017 . The increase was primarily driven by increased prescription volume and brand name drug price inflation, partially offset by continued reimbursement pressure and the impact of recent generic introductions.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - Front store same store sales increased 0.5% in 2018 compared to 2017 . Front store sales in 2018 continued to benefit from increases in health product sales.
    - Pharmacy same store sales increased 7.9% in 2018 compared to 2017 . The increase was driven by the 9.1% increase in pharmacy same store prescription volumes on a 30-day equivalent basis due to (i) continued adoption of patient care programs, (ii) collaborations with PBMs, and (iii) the Company's preferred status in a number of Medicare Part D networks during 2018. The increase was also due to the impact of year over year brand name drug price inflation that occurred primarily in the first three months of 2018.
    - Pharmacy revenue continues to be adversely affected by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 87.5% in 2018 compared to 87.3% in 2017 . In addition, pharmacy revenue growth has also been negatively affected by continued reimbursement pressure.
    - 2017 revenues include approximately $0.4 billion related to the Company's RxCrossroads subsidiary which was sold on January 2, 2018.
    - Pharmacy revenue growth has been adversely affected by industry challenges in the LTC business, such as continuing lower occupancy rates at skilled nursing facilities, as well as the deteriorating financial health of many skilled nursing facilities which resulted in a number of customer bankruptcies in 2018.
    - Pharmacy revenue in 2018 continued to benefit from the Company's ability to attract and retain managed care customers and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

Operating expenses (including goodwill impairments)

- Operating expenses in the Retail/LTC segment include store payroll, store employee benefits, store occupancy costs, selling expenses, advertising expenses, depreciation and amortization expense and certain administrative expenses.
- Operating expenses increased $6.7 billion , or 39.9% , in 2018 compared to 2017 . The increase in operating expenses in 2018 was primarily due to:
    - A goodwill impairment charge of $6.1 billion in 2018 in the LTC reporting unit (see Note 5 ''Goodwill and Other Intangibles'' to the consolidated financial statements), as compared to a $181 million goodwill impairment charge in the RxCrossroads reporting unit recorded in 2017 in connection with the upcoming sale of RxCrossroads. See the discussion of goodwill under "Critical Accounting Policies" later in this document;
    - An $86 million pre-tax loss on the sale of the RxCrossroads subsidiary in 2018;
    - A $43 million impairment of long-lived assets in 2018; and
    - An increase in operating expenses due to (i) the investment of a portion of the savings from the TCJA in wages and benefits, (ii) increased prescription volume described previously, (iii) incremental costs associated with operating more stores and (iv) other investments in the business to drive revenue growth;
    - Partially offset by lower operating expenses as a result of a lack of charges associated with store closures in 2018, for which the Company incurred $215 million in connection with its enterprise streamlining initiative in 2017; and
    - A decrease in hurricane-related expenses of $25 million in 2018 compared to 2017 .
- Operating expenses as a percentage of total revenues were 27.9% in 2018 compared to 21.1% in 2017 . The increase in operating expenses as a percentage of total revenues was driven by the increased goodwill impairment charges in 2018.

Operating income

- Operating income decreased $5.9 billion , or 90.5% , to approximately $620 million in 2018 compared to 2017 . The decrease in operating income was driven primarily by the increased operating expenses described above.

- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - The Company's pharmacy operating income has been adversely affected by the efforts of managed care organizations, PBMs and governmental and other third-party payors to reduce their prescription drug costs, including the use of restrictive networks, as well as changes in the mix of business within the pharmacy portion of the Retail/LTC Segment. If the reimbursement pressure accelerates, the Company may not be able grow revenues, and its operating income could be adversely affected.
    - The increased use of generic drugs has positively impacted the Company's operating income but has resulted in third-party payors augmenting their efforts to reduce reimbursement payments to retail pharmacies for prescriptions. This trend, which the Company expects to continue, reduces the benefit the Company realizes from brand to generic product conversions.

Commentary - 2017 compared to 2016

Revenues

- Total revenues decreased approximately $1.7 billion , or 2.1% , to $79.4 billion in 2017 compared to 2016 . The decrease was primarily due to a decline in same store sales as a result of the previously-announced marketplace changes that restrict CVS Pharmacy from participating in certain networks.
- As you review the Retail/LTC segment's performance in this area, you should consider the following important information about the business:
    - Front store same store sales declined 2.6% in 2017 compared to 2016 and were negatively impacted approximately 30 basis points due to the absence of leap day in 2017 . The decrease was primarily driven by softer customer traffic and efforts to rationalize promotional strategies, partially offset by an increase in basket size.
    - Pharmacy same store sales declined 2.6% in 2017 compared to 2016 . Pharmacy same store sales were negatively impacted by approximately 390 basis points due to recent generic introductions. Same store prescription volumes increased 0.4% , despite the approximately 420 basis point negative impact from previously-discussed marketplace changes that restrict CVS Pharmacy from participating in certain networks.
    - Pharmacy revenue continues to be negatively impacted by the conversion of brand name drugs to equivalent generic drugs, which typically have a lower selling price. The generic dispensing rate grew to 87.3% in 2017 compared to 85.7% in 2016 . In addition, pharmacy revenue growth has also been negatively affected by the mix of drugs sold, continued reimbursement pressure and the lack of significant new brand name drug introductions.
    - Pharmacy revenue in 2017 continued to benefit from the Company's ability to attract and retain managed care customers, and the increased use of pharmaceuticals by an aging population as the first line of defense for health care.

Operating expenses (including goodwill impairment)

- Operating expenses increased $450 million , or 2.8% in 2017 . The increase in operating expenses in 2017 was due primarily to:
    - An increase of $181 million in charges associated with the closure of retail stores in connection with the Company's enterprise streamlining initiative;
    - A goodwill impairment charge of $181 million related to the RxCrossroads reporting unit, which was subsequently sold on January 2, 2018;
    - Hurricane related costs of $55 million; and
    - Costs associated with new store openings
- Operating expenses as a percentage of total revenues were 21.1% in 2017 compared to 20.1% in 2016 . The increase in 2017 was primarily due to a decline in expense leverage with the loss of business from the previously discussed marketplace changes that restrict CVS Pharmacy from participating in certain networks.

Operating income

- Operating income decreased $879 million , or 11.8% , to approximately $6.6 billion in 2017 compared to 2016 . The decrease in operating income was driven primarily by the increased operating expenses described above and reimbursement pressure.

Health Care Benefits Segment

On November 28, 2018, the Company completed the Aetna Acquisition. The Health Care Benefits segment is the equivalent of the former Aetna Health Care segment.

The following table summarizes the Health Care Benefits segment's performance for the period from November 28, 2018 to December 31, 2018:

In millions	
Revenues:	
Products	$ 164
Premiums	4,819
Services	521
Net investment income	45
Total revenues	5,549
Cost of products sold	147
Benefit costs	3,873
Operating expenses	1,253
Operating income	$ 276

Revenues and operating income for the Health Care Benefits segment include results for the period from November 28, 2018 to December 31, 2018 and therefore are not directly comparable to the former Aetna Health Care segment results for the fourth quarter of 2017.

Health Care Benefits segment medical membership as of December 31, 2018 was as follows:

In thousands	**Insured**	**ASC** [1]	**Total**
Medical membership:			
Commercial	3,871	13,888	17,759
Medicare Advantage	1,758	—	1,758
Medicare Supplement	793	—	793
Medicaid	1,128	663	1,791
Total medical membership	7,550	14,551	22,101

(1) Represents self-insured membership under Administrative Services Contracts.

Medical Membership
Medical membership as of December 31, 2018 remained relatively consistent compared with December 31, 2017, reflecting decreases in Commercial insured and Medicaid products, largely offset by increases in Commercial ASC and Medicare products.

Corporate/Other Segment

Commentary - 2018 compared to 2017

Revenues
- Revenues in 2018 reflect (i) revenues associated with products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, that were acquired in the Aetna Acquisition and (ii) interest income related to the $40 billion of senior notes issued on March 9, 2018 to partially fund the Aetna Acquisition.

Operating expenses

- Operating expenses within the Corporate/Other segment include executive management, corporate relations, legal, compliance, human resources, information technology, finance related costs and acquisition-related transaction and integration costs. After the Aetna Acquisition Date, such operating expenses also include operating costs to support the large case pensions and long-term care insurance products acquired in the Aetna Acquisition.
- Operating expenses increased $437 million , or 45.9% , in 2018 compared to 2017 . The increase was primarily driven by an increase in acquisition-related transaction and integration costs of $454 million in 2018.

Commentary - 2017 compared to 2016

Operating expenses

- Operating expenses within the Corporate/Other segment include executive management, corporate relations, legal, compliance, human resources, information technology, finance related costs and acquisition-related transaction and integration costs.
- Operating expenses increased $34 million , or 3.7% , in 2017 compared to 2016 . The increase was due to (i) ongoing investments in strategic initiatives, (ii) increased employee benefit costs and (iii) increased divestiture and acquisition-related costs, primarily related to $34 million of transaction costs in 2017 associated with the Aetna Acquisition.

Liquidity and Capital Resources

Cash Flows

The Company maintains a level of liquidity sufficient to allow it to meet its cash needs in the short-term. Over the long term, the Company manages its cash and capital structure to maximize shareholder return, maintain its financial condition and maintain flexibility for future strategic initiatives. The Company continuously assesses its regulatory capital requirements, working capital needs, debt and leverage levels, debt maturity schedule, capital expenditure requirements, dividend payouts, potential share repurchases and future investments or acquisitions. The Company believes its operating cash flows, commercial paper program, credit facilities, sale-leaseback program, as well as any potential future borrowings, will be sufficient to fund these future payments and long-term initiatives.

The net change in cash, cash equivalents and restricted cash for the years ended December 31, 2018 , 2017 and 2016 is as follows:

				Change			
	Year Ended December 31,			2018 vs. 2017		2017 vs. 2016	
In millions	2018	2017	2016	$	%	$	%
Net cash provided by operating activities	$ 8,865	$ 8,007	$ 10,141	$ 858	11 %	$ (2,134)	(21)%
Net cash used in investing activities	(43,285)	(2,877)	(2,470)	(40,408)	1,405 %	(407)	16 %
Net cash provided by (used in) financing activities	36,819	(6,751)	(6,761)	43,570	(645)%	10	— %
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(4)	1	2	(5)	(500)%	(1)	(50)%
Net increase (decrease) in cash, cash equivalents and restricted cash	$ 2,395	$ (1,620)	$ 912	$ 4,015	(248)%	$ (2,532)	(278)%

Commentary - 2018 compared to 2017

- *Net cash provided by operating activities* increased by $858 million in 2018 due primarily to the timing of client payments and the timing of payments for the Company's Medicare Part D operations.
- *Net cash used in investing activities* increased by $40.4 billion in 2018 largely driven by the Aetna Acquisition in November 2018. In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures remained relatively consistent at approximately $2.0 billion and $1.9 billion in 2018 and 2017 , respectively. During 2018 , approximately 21% of the Company's total capital expenditures were for new store construction, 32% were for store, fulfillment and support facilities expansion and improvements and 47% were for technology and other corporate initiatives.
    - The Company did not complete any sale-leaseback transactions in 2018 compared to $265 million in 2017 . Under the sale-leaseback transactions, the properties generally are sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The specific timing and amount of future sale-leaseback transactions will vary depending on future market conditions and other factors.
- *Net cash provided by financing activities* was $36.8 billion in 2018 compared to net cash used in financing activities of $6.8 billion in 2017 . The cash provided by financing activities in 2018 primarily related to long-term borrowings to partially fund the Aetna Acquisition.

Commentary - 2017 compared to 2016

- *Net cash provided by operating activities* decreased by $2.1 billion , in 2017 due primarily to the timing of payments for the Company's Medicare Part D operations.
- *Net cash used in investing activities* increased by $407 million in 2017 largely driven by an increase in acquisition activity as compared to 2016 . In addition, cash used in investing activities reflected the following activity:
    - Gross capital expenditures in 2017 totaled approximately $1.9 billion , a decrease of $306 million compared to prior year. The decrease in 2017 capital expenditures is due to the Target integration being completed in 2016. During 2017 , approximately 25% of the Company's total capital expenditures were for new store construction, 30% were for store, fulfillment and support facilities expansion and improvements and 45% were for technology and other corporate initiatives.
    - Proceeds from sale-leaseback transactions totaled $265 million in 2017 compared to $230 million in 2016 .
- *Net cash used in financing activities* was $6.8 billion in both 2017 and 2016 as net borrowings and net payments to shareholders were relatively flat in both years.

Included in net cash used in investing activities for the years ended December 31, 2018 , 2017 and 2016 was the following store development activity [(1)] :

	2018	2017	2016
Total stores (beginning of year)	9,846	9,750	9,665
New and acquired stores [(2)]	148	179	132
Closed stores [(2)]	(27)	(83)	(47)
Total stores (end of year)	9,967	9,846	9,750
Relocated stores [(2)]	34	30	50

(1) Includes retail drugstores, certain onsite pharmacy stores, retail specialty pharmacy stores and pharmacies within Target stores.
(2) Relocated stores are not included in new and acquired stores or closed stores totals.

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company had approximately $720 million and $1.3 billion of commercial paper outstanding at weighted average interest rates of 2.8% and 2.0% as of December 31, 2018 and 2017 , respectively. In connection with its commercial paper program, the Company maintains a $1.75 billion 364-day unsecured back-up revolving credit facility, which expires on May 16, 2019, a $1.25 billion , five-year unsecured back-up revolving credit facility, which expires on July 1, 2020, a $1.0 billion , five-year

unsecured back-up revolving credit facility, which expires on May 18, 2022, and a $2.0 billion , five-year unsecured back-up revolving credit facility, which expires on May 17, 2023. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03% , regardless of usage. As of December 31, 2018 and 2017 , there were no borrowings outstanding under any of the back-up credit facilities.

Bridge Loan Facility
On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a $49.0 billion unsecured bridge loan facility commitment. The Company paid $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statements of operations.

On March 9, 2018, the Company issued unsecured senior notes with an aggregate principal amount of $40.0 billion (see "Long-term Borrowings - 2018 Notes" below). At this time, the bridge loan facility commitment was reduced to $4.0 billion , and the Company paid $8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded $173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018 , which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a $4.0 billion unsecured 364-day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the $4.0 billion unsecured 364-day bridge term loan agreement terminated.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the Federal Home Loan Bank of Boston (the "FHLBB"). As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2018 was approximately $790 million . As of December 31, 2018 , there were no outstanding advances from the FHLBB.

Long-term Borrowings

2018 Notes
On March 9, 2018, the Company issued an aggregate of $40.0 billion in principal amount of the 2018 Notes for total proceeds of approximately $39.4 billion, net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes are comprised of the following:

In millions		
3.125% senior notes due March 2020	$	2,000
Floating rate notes due March 2020		1,000
3.35% senior notes due March 2021		3,000
Floating rate notes due March 2021		1,000
3.7% senior notes due March 2023		6,000
4.1% senior notes due March 2025		5,000
4.3% senior notes due March 2028		9,000
4.78% senior notes due March 2038		5,000
5.05% senior notes due March 2048		8,000
Total debt principal	$	40,000

Term Loan Agreement
On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a $5.0 billion term loan agreement. The term loan facility under the term loan agreement consists of a $3.0 billion three-year tranche and a $2.0 billion five-year tranche. The term loan agreement allows for borrowings at various rates that are dependent, in part, on the Company's debt ratings. In connection with the Aetna Acquisition, the Company borrowed $5.0 billion (a $3.0 billion three-year tranche

and a $2.0 billion five-year tranche) under the term loan agreement in November 2018. The Company terminated the $2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. As of December 31, 2018, the Company had $3.0 billion outstanding under the three-year tranche of the term loan agreement.

Aetna Related Debt
Upon the closing of the Aetna Acquisition, the Company assumed long-term debt with a fair value of $8.1 billion with stated interest rates ranging from 2.2% to 6.75%.

2016 Notes
On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the " 2016 Notes ") for total proceeds of approximately $3.5 billion , net of discounts and underwriting fees. The 2016 Notes may be redeemed, in whole at any time, or in part from time to time, at the Company's option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

Early Extinguishment of Long-Term Debt
On May 16, 2016, the Company announced tender offers for (i) any and all of its 5.75% senior notes due 2017, its 6.60% senior notes due 2019 and its 4.75% senior notes due 2020 (collectively, the "Any and All Notes") and (ii) up to $1.5 billion aggregate principal amount of the 4.75% Senior Notes due 2022 issued by its wholly-owned subsidiary Omnicare, the 5.00% Senior Notes due 2024 issued by Omnicare, its 3.875% Senior Notes due 2025, its 6.25% Senior Notes due 2027, its 4.875% Senior Notes due 2035, its 6.125% Senior Notes due 2039 and its 5.75% Senior Notes due 2041 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion. The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. In connection with the purchase of the Notes, the Company paid a premium of $486 million in excess of the debt principal, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on early extinguishment of long-term debt of $542 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. In connection with that redemption, the Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of long-term debt of $101 million, which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

See Note 8 ''Borrowings and Credit Agreements'' and Note 12 ''Shareholders' Equity'' to the consolidated financial statements for additional information about debt issuances, debt repayments, share repurchases and dividend payments.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. As of December 31, 2018 and 2017, the Company had outstanding derivative financial instruments (see Note 1 ''Significant Accounting Policies'' to the consolidated financial statements).

Debt Covenants

The Company's back-up revolving credit facilities, unsecured senior notes, unsecured floating rate notes and term loan agreement (see Note 8 ''Borrowings and Credit Agreements'' to the consolidated financial statements) contain customary restrictive financial and operating covenants. These covenants do not include an acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit ratings. The covenants do not materially affect the Company's financial or operating flexibility. As of December 31, 2018 , the Company was in compliance with all of its debt covenants.

Debt Ratings

As of December 31, 2018 , the Company's long-term debt was rated " Baa2 " by Moody's and " BBB " by Standard & Poor's ("S&P"), and its commercial paper program was rated " P-2 " by Moody's and " A-2 " by S&P. In December 2017, subsequent to the announcement of the proposed acquisition of Aetna, Moody's changed the outlook on the Company's long-term debt to "Under Review" from "Stable." Similarly, S&P placed the Company's long-term debt outlook on "Watch Negative" from "Stable." Upon the issuance of the 2018 Notes on March 9, 2018, S&P lowered its corporate credit rating on the Company's long-term debt to "BBB" from "BBB+" and changed the outlook from "Watch Negative" to "Stable." On November 27, 2018, S&P lowered its rating on the long-term debt of Aetna to "BBB" from "A." On November 28, 2018, upon the completion of the Aetna Acquisition, Moody's lowered its rating on CVS Health Corporation's long-term debt to " Baa2 " from "Baa1." Additionally, Moody's changed the outlook on CVS Health Corporation's long-term debt to "Negative" from "Under Review" and changed the outlook on the long-term debt of Aetna to "Negative" from "Stable." In assessing the Company's credit strength, the Company believes that both Moody's and S&P considered, among other things, the Company's capital structure and financial policies as well as its consolidated balance sheet, its historical acquisition activity and other financial information. Although the Company currently believes its long-term debt ratings will remain investment grade, it cannot guarantee the future actions of Moody's and/or S&P. The Company's debt ratings have a direct impact on its future borrowing costs, access to capital markets and new store operating lease costs.

Share Repurchase Programs

During the year ended December 31, 2018 , the Company did not repurchase any shares of common stock. See Note 12 ''Shareholders' Equity'' to the consolidated financial statements for additional information about share repurchases for the years ended December 31, 2017 and 2016.

Quarterly Cash Dividend

In December 2015, the Company's Board of Directors (the "Board") authorized a 21% increase in our quarterly common stock cash dividend to $0.425 per share effective in 2016. This increase equated to an annual dividend rate of $1.70 per share. In December 2016, the Board authorized an 18% increase in our quarterly common stock cash dividend to $0.50 per share effective in 2017. This increase equated to an annual dividend rate of $2.00 per share. During 2018, the Company maintained its quarterly dividend of $0.50 per share and expects to maintain its quarterly dividend of $0.50 per share throughout 2019.

Off-Balance Sheet Arrangements

In connection with executing operating leases, the Company provides a guarantee of the lease payments. The Company also finances a portion of its new store development through sale-leaseback transactions, which involve selling stores to unrelated parties and then leasing the stores back under leases that generally qualify and are accounted for as operating leases. The Company does not have any retained or contingent interests in the sold stores, and does not provide any guarantees, other than a guarantee of the lease payments, in connection with the transactions. In accordance with generally accepted accounting principles, the Company's operating leases are not reflected on the consolidated balance sheets.

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things (each of which subsequently filed for bankruptcy), and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy these obligations.

As of December 31, 2018 , the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things), with the maximum remaining lease term extending through 2029. Management believes the ultimate disposition of any of the remaining lease guarantees will not have a material adverse effect on the Company's consolidated financial condition or future cash flows. Please see "Results of Operations - Summary of Consolidated Financial Results - Commentary - 2018 compared to 2017 - Loss from discontinued operations" previously in this document for further information regarding the Company's guarantee of certain Linens 'n Things' store lease obligations.

Contractual Obligations

The following table summarizes certain estimated future obligations by period under the Company's various contractual obligations at December 31, 2018 . The table below does not include future payments of claims to health care providers or pharmacies because certain terms of these payments are not determinable at December 31, 2018 (for example, the timing and volume of future services provided under fee-for-service arrangements and future membership levels for capitated arrangements).

	Payments Due by Period				
In millions	**Total**	**2019**	**2020 to 2021**	**2022 to 2023**	**Thereafter**
Operating leases	$ 27,980	$ 2,690	$ 4,943	$ 4,343	$ 16,004
Capital lease obligations	1,241	74	146	146	875
Contractual lease obligations with Target [(1)]	2,074	—	—	—	2,074
Lease obligations for discontinued operations	12	4	8	—	—
Long-term debt	72,903	1,242	16,150	12,699	42,812
Interest payments on long-term debt [(2)]	37,949	3,061	5,595	4,594	24,699
Other long-term liabilities on the consolidated balance sheet [(3)]					
Future policy benefits [(4)]	6,728	575	1,200	952	4,001
Unpaid claims [(4)]	2,742	816	644	413	869
Policyholders' funds [(4)(5)]	1,266	632	127	86	421
Other liabilities	1,705	455	911	100	239
Total	$ 154,600	$ 9,549	$ 29,724	$ 23,333	$ 91,994

(1) The Company leases pharmacy and clinic space from Target. See Note 6 ''Leases'' to the consolidated financial statements for additional information regarding the lease arrangements with Target. Amounts related to the operating and capital leases with Target are reflected within the operating leases and capital lease obligations above. Amounts due after the remaining estimated economic lives of the buildings are reflected herein assuming equivalent stores continue to operate through the term of the arrangements.
(2) Interest payments on long-term debt are calculated using outstanding balances and interest rates in effect on December 31, 2018 .
(3) Payments of other long-term liabilities exclude Separate Accounts liabilities of approximately $3.9 billion because these liabilities are supported by assets that are legally segregated and are not subject to claims that arise out of the Company's business.
(4) Total payments of future policy benefits, unpaid claims and policyholders' funds include $1.2 billion , $2.7 billion and $339 million , respectively, of reserves for contracts subject to reinsurance. The Company expects the assuming reinsurance carrier to fund these obligations and has reflected these amounts as reinsurance recoverable assets on the consolidated balance sheets.
(5) Customer funds associated with group life and health contracts of approximately $2.3 billion have been excluded from the table above because such funds may be used primarily at the customer's discretion to offset future premiums and/or for refunds, and the timing of the related cash flows cannot be determined. Additionally, net unrealized capital gains on debt and equity securities supporting experience-rated products of $10 million , before tax, have been excluded from the table above.

Restrictions on Certain Payments

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, health maintenance organizations ("HMOs") and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity (referred to as surplus) and restrict the amount of dividends and other distributions that may be paid to their equity holders. These regulations are not directly applicable to CVS Health as a holding company, since CVS Health is not an HMO or an insurance company. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. The additional regulations and undertakings applicable to the Company's HMO and insurance company subsidiaries are not expected to affect the Company's ability to service the Company's debt, meet other financing obligations or pay dividends, or the ability of any of the Company's subsidiaries to service their debt or other financing obligations. Under applicable regulatory requirements and undertakings, at December 31, 2018 , the maximum amount of dividends that may be paid by the Company's insurance and HMO subsidiaries without prior approval by regulatory authorities was approximately $584 million in the aggregate.

The Company maintains capital levels in its operating subsidiaries at or above targeted and/or required capital levels and dividends amounts in excess of these levels to meet liquidity requirements, including the payment of interest on debt and shareholder dividends. In addition, at the Company's discretion, it uses these funds for other purposes such as funding share and debt repurchase programs, investments in new businesses and other purposes considered advisable.

As of December 31, 2018 , the Company held investments of $531 million that are not accounted for as Separate Accounts assets but are legally segregated and are not subject to claims that arise out of the Company's business. See Note 3 ''Investments'' to the consolidated financial statements for additional information on investments related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract.

Solvency Regulation

The National Association of Insurance Commissioners (the "NAIC") utilizes risk-based capital ("RBC") standards for insurance companies that are designed to identify weakly-capitalized companies by comparing each company's adjusted surplus to its required surplus (the "RBC Ratio"). The RBC Ratio is designed to reflect the risk profile of insurance companies. Within certain ratio ranges, regulators have increasing authority to take action as the RBC Ratio decreases. There are four levels of regulatory action, ranging from requiring an insurer to submit a comprehensive financial plan for increasing its RBC to the state insurance commissioner to requiring the state insurance commissioner to place the insurer under regulatory control. At December 31, 2018 , the RBC Ratio of each of the Company's primary insurance subsidiaries was above the level that would require regulatory action. The RBC framework described above for insurers has been extended by the NAIC to health organizations, including HMOs. Although not all states had adopted these rules at December 31, 2018 , at that date, each of the Company's active HMOs had a surplus that exceeded either the applicable state net worth requirements or, where adopted, the levels that would require regulatory action under the NAIC's RBC rules. External rating agencies use their own capital models and/or RBC standards when they determine a company's rating.

Quantitative and Qualitative Disclosures About Market Risk

On November 28, 2018 the Company completed the Aetna Acquisition. As of December 31, 2018 , the Company's earnings and financial condition were exposed to interest rate risk, credit quality risk, market valuation risk, foreign currency risk and commodity risk. As of December 31, 2017, the Company had outstanding interest rate derivative instruments related to its long-term debt and believed that its exposure to interest rate risk (inherent in the Company's debt securities portfolio) was not material. We refer you to Note 1 ''Significant Accounting Policies'' to the consolidated financial statements.

Evaluation of Interest Rate and Credit Quality Risk

The Company manages interest rate risk by seeking to maintain a tight match between the durations of assets and liabilities when appropriate. The Company manages credit quality risk by seeking to maintain high average credit quality ratings and diversified sector exposure within its debt securities portfolio. In connection with its investment and risk management objectives, the Company also uses derivative financial instruments whose market value is at least partially determined by, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets or credit ratings/spreads. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps. These instruments, viewed separately, subject the Company to varying degrees of interest rate, equity price and credit risk. However, when used for hedging, the Company expects these instruments to reduce overall risk.

Investments

The Company's investment portfolio supported the following products at December 31, 2018 :

In millions		
Experience-rated products	$	1,063
Remaining products		17,191
Total investments	$	18,254

Investment risks associated with experience-rated products generally do not impact results of operations. The risks associated with investments supporting experience-rated pension and annuity products in the large case pensions business in the Company's Corporate/Other segment are assumed by the contract holders and not by the Company (subject to, among other things, certain minimum guarantees). Assets supporting experience-rated products may be subject to contract holder or participant withdrawals.

The debt securities in the Company's investment portfolio had an average credit quality rating of A at December 31, 2018 , with approximately $3.9 billion rated AAA at December 31, 2018 . The debt securities that were rated below investment grade (that

is, having a credit quality rating below BBB-/Baa3) were $1.1 billion at December 31, 2018 (of which 6% at December 31, 2018 , supported experience-rated products).

At December 31, 2018 , the Company held $373 million of municipal debt securities that were guaranteed by third parties, representing 2% of total investments at December 31, 2018 . These securities had an average credit quality rating of AA- at December 31, 2018 with the guarantee. These securities had an average credit quality rating of A- at December 31, 2018 without the guarantee. The Company does not have any significant concentration of investments with third party guarantors (either direct or indirect).

The Company generally classifies debt securities as available for sale, and carries them at fair value on the consolidated balance sheets. At December 31, 2018 , approximately 1% of debt securities were valued using inputs that reflect the Company's assumptions (categorized as Level 3 inputs in accordance with accounting principles generally accepted in the United States of America). See Note 4 ''Fair Value'' to the consolidated financial statements, which is incorporated by reference herein, for additional information on the methodologies and key assumptions used to determine the fair value of investments. For additional information related to investments, see Note 3 ''Investments'' to the consolidated financial statements, which is incorporated by reference herein.

The Company regularly reviews debt securities in its portfolio to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in net income, and the amount of the non-credit related component is included in other comprehensive income/loss, unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. Accounting for other-than-temporary impairment ("OTTI") of debt securities is considered a critical accounting estimate. The information under the heading "Critical Accounting Policies - Other-Than-Temporary Impairment of Debt Securities" contained in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in the Annual Report is incorporated by reference herein.

Evaluation of Market Valuation Risks

The Company regularly evaluates its risk from market-sensitive instruments by examining, among other things, levels of or changes in interest rates (short-term or long-term), duration, prepayment rates, equity markets and/or credit ratings/spreads. The Company also regularly evaluates the appropriateness of investments relative to management-approved investment guidelines (and operates within those guidelines) and the business objectives of its portfolios.

On a quarterly basis, the Company reviews the impact of hypothetical net losses in its investment portfolio on the Company's consolidated near-term financial condition, results of operations and cash flows assuming the occurrence of certain reasonably possible changes in near-term market rates and prices. Interest rate changes (whether resulting from changes in treasury yields or credit spreads or other factors) represent the most material risk exposure category for the Company. The Company has estimated the impact on the fair value of market sensitive instruments based on the net present value of cash flows using a representative set of likely future interest rate scenarios. The assumptions used were as follows: an immediate increase of 100 basis points in interest rates (which the Company believes represents a moderately adverse scenario and is approximately equal to the historical annual volatility of interest rate movements for intermediate-term available-for-sale debt securities) and an immediate decrease of 15% in prices for domestic equity securities.

Assuming an immediate 100 basis point increase in interest rates and immediate decrease of 15% in the prices for domestic equity securities, the theoretical decline in the fair values of market sensitive instruments at December 31, 2018 is as follows:

- The fair value of long-term debt would decline by $3.9 billion ($4.9 billion pretax). Changes in the fair value of long-term debt do not impact financial condition or results of operations.
- The theoretical reduction in the fair value of investment securities partially offset by the theoretical reduction in the fair value of interest rate sensitive liabilities would result in a net decline in fair value of $364 million ($461 million pretax) related to continuing non-experience-rated products. Reductions in the fair value of investment securities would be reflected as an unrealized loss in equity, as the Company classifies these securities as available for sale. The Company does not record liabilities at fair value.

Based on overall exposure to interest rate risk and equity price risk, the Company believes that these changes in market rates and prices would not materially affect consolidated near-term financial condition, results of operations or cash flows as of December 31, 2018 .

Evaluation of Foreign Currency and Commodity Risk

As of each of December 31, 2018 and 2017 , the Company did not have any material foreign currency exchange rate or commodity derivative instruments in place and believes its exposure to foreign currency exchange rate risk and commodity price risk is not material.

Evaluation of Operational Risks

The Company also faces certain operational risks, including risks related to information security, including cybersecurity. The Company and its vendors have experienced a variety of cyber attacks, and the Company and its vendors expect to continue to experience cyber attacks going forward. Among other things, the Company has experienced automated attempts to gain access to public facing networks, brute force, SYN flood and distributed denial of service attacks, attempted malware infections, vulnerability scanning, ransomware attacks, spear-phishing campaigns, mass reconnaissance attempts, injection attempts, phishing, PHP injection and cross-site scripting. The Company also has seen an increase in attacks designed to obtain access to consumers' accounts using illegally obtained demographic information. The Company is dedicating and will continue to dedicate significant resources and incur significant expenses to maintain and update on an ongoing basis the systems and processes that are designed to mitigate the information security risks it faces and protect the security of its computer systems, software, networks and other technology assets against attempts by unauthorized parties to obtain access to confidential information, destroy data, disrupt or degrade service, sabotage systems or cause other damage. The impact of the cyber attacks the Company has experienced through December 31, 2018 has not been material to its operations or results of operations. The Board and the Audit Committee of the Board ("the Audit Committee") are regularly informed regarding the Company's information security policies, practices and status.

Critical Accounting Policies

The Company prepares the consolidated financial statements in conformity with generally accepted accounting principles, which require management to make certain estimates and apply judgment. Estimates and judgments are based on historical experience, current trends and other factors that management believes to be important at the time the consolidated financial statements are prepared. On a regular basis, the Company reviews its accounting policies and how they are applied and disclosed in the consolidated financial statements. While the Company believes the historical experience, current trends and other factors considered, support the preparation of the consolidated financial statements in conformity with generally accepted accounting principles, actual results could differ from estimates, and such differences could be material.

Significant accounting policies are discussed in Note 1 ''Significant Accounting Policies'' to the consolidated financial statements. Management believes the following accounting policies include a higher degree of judgment and/or complexity and, thus, are considered to be critical accounting policies. The Company has discussed the development and selection of these critical accounting policies with the Audit Committee, and the Audit Committee has reviewed the disclosures relating to them.

Revenue Recognition

Pharmacy Services Segment
The Pharmacy Services segment sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to the Pharmacy Services segment, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client, (ii) the United States Centers for Medicare & Medicaid Services ("CMS") subsidized portion of prescription drugs dispensed to the Company's Silverscript PDP members, (iii) the price paid to the Pharmacy Services segment by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("Retail Co-Payments"), and (iv) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenue.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to in exchange for those prescription drugs. The Company has established the following revenue recognition policies for the Pharmacy Services segment:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

The Company recognizes revenue using the net method for contracts under which the Company acts as an agent or does not control the prescription drug prior to transfer to the client.

The Company records revenue net of manufacturers' rebates that are earned by its clients based on their plan members' utilization of brand-name formulary drugs. The Company estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. The Company adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues as identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's results of operations or financial condition.

The Company also adjusts revenues for refunds owed to clients resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual performance refund amounts has not been material to the Company's results of operations or financial condition.

The Pharmacy Services segment participates in the federal government's Medicare Part D program as a PDP through the Company's SilverScript subsidiary. Revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium,

which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

In addition to these premiums, the Pharmacy Services segment receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under a risk-sharing feature of the Medicare Part D program design, referred to as the risk corridor, and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to the third party payer for pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts have not been material to the Company's results of operations or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's results of operations or financial condition. Sales taxes are not included in revenue.

Loyalty Program

The Company's customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed rewards are reflected as a contract liability.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of the revenue from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors typically are not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics
For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment
Health Care Benefits revenue is principally derived from insurance premiums and fees billed to customers. Revenue is recognized based on customer billings, which reflect contracted rates per employee and the number of covered employees recorded in the Company's records at the time the billings are prepared. Billings are generally sent monthly for coverage during the following month.

The Company's billings may be subsequently adjusted to reflect enrollment changes due to member terminations or other factors. These adjustments are known as retroactivity adjustments. In each period, the Company estimates the amount of future retroactivity and adjusts the recorded revenue accordingly. As information regarding actual retroactivity amounts becomes known, the Company refines its estimates and records any required adjustments to revenues in the period in which they arise. A significant difference in the actual level of retroactivity compared to estimated levels would have a significant effect on the Company's results of operations.

Additionally, premium revenue subject to the ACA's minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. The Company estimates minimum MLR rebates payable by projecting MLRs for certain markets, as defined by the ACA, for each state in which each of its insurance entities operates. The claims and premiums used in estimating such rebates are modified for certain adjustments allowed by the ACA and include a statistical credibility adjustment for those states with a number of members that is not statistically credible.

Furthermore, the ACA's permanent risk adjustment program transfers funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable or payable for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue. In this analysis, the Company considers the estimate of the average risk of members of other qualified plans in comparable markets the most critical assumption. The Company estimates its ultimate risk adjustment receivable or payable using management's best estimates, which are based on various data sources, including but not limited to market risk data compiled by third party sources as well as pricing and other regulatory inputs. See Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information on the ACA's risk adjustment program.

Other-Than-Temporary Impairments of Debt Securities

The Company regularly reviews its debt securities to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. If a decline in fair value is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in results of operations, and the amount of the non-credit related component is included in other comprehensive income, unless the Company intends to sell the debt security or it is more likely than not that it will be required to sell the debt security prior to its anticipated recovery of its amortized cost basis. The Company analyzes all facts and circumstances believed to be relevant for each investment when performing this analysis, in accordance with applicable accounting guidance.

Among the factors considered in evaluating whether a decline in fair value is other-than-temporary are whether the decline results from a change in the quality of the debt security itself, whether the decline results from a downward movement in the market as a whole, and the prospects for realizing the carrying value of the debt security based on the investment's current and short-term prospects for recovery. For unrealized losses determined to be the result of market conditions (for example, increasing interest rates and volatility due to conditions in the overall market) or industry-related events, the Company determines whether it intends to sell the debt security or if it is more likely than not that it will be required to sell the debt security before recovery of its amortized cost basis. If either case is true, the Company recognizes an OTTI, and the cost basis/carrying amount of the debt security is written down to fair value.

The risks inherent in assessing the impairment of a debt security include the risk that market factors may differ from projections and the risk that facts and circumstances factored into the Company's assessment may change with the passage of time. Unexpected changes to market factors and circumstances that were not present in past reporting periods are among the factors that may result in a current period decision to sell debt securities that were not impaired in prior reporting periods.

Vendor Allowances and Purchase Discounts

Pharmacy Services Segment
The Pharmacy Services segment receives purchase discounts on products purchased. Contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for the Pharmacy Services segment to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days of the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to the Company's results of operations or financial condition. The Company accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. The Pharmacy Services segment also receives additional discounts under its wholesaler contracts if it exceeds contractually defined purchase volumes. In addition, the Pharmacy Services segment receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of cost of products sold.

Retail/LTC Segment
Vendor allowances received by the Retail/LTC segment reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments is also initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract.

There have not been any material changes in the way the Company accounts for vendor allowances and purchase discounts during the past three years.

Inventory

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method.

The value of ending inventory is reduced for estimated inventory losses that have occurred during the interim period between physical inventory counts. Physical inventory counts are taken on a regular basis in each store and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. The accounting for inventory contains uncertainty since management must use judgment to estimate the inventory losses that have occurred during the interim period between physical inventory counts. When estimating these losses, a number of factors are considered which include, but are not limited to, historical physical inventory results on a location-by-location basis and current physical inventory loss trends.

The total reserve for estimated inventory losses covered by this critical accounting policy was $328 million as of December 31, 2018 . Although management believes there is sufficient current and historical information available to record reasonable estimates for estimated inventory losses, it is possible that actual results could differ. In order to help investors assess the aggregate risk, if any, associated with the inventory-related uncertainties discussed above, a ten percent (10%) pre-tax change in estimated inventory losses, which is a reasonably likely change, would increase or decrease the total reserve for estimated inventory losses by approximately $33 million as of December 31, 2018 .

Although management believes that the estimates discussed above are reasonable and the related calculations conform to generally accepted accounting principles, actual results could differ from such estimates, and such differences could be material.

Goodwill and Identifiable Intangible Assets

Identifiable intangible assets
Identifiable intangible assets consist primarily of trademarks, trade names, customer contracts/relationships, covenants not to compete, technology, provider networks, value of business acquired and favorable leases. These intangible assets arise primarily from the determination of their respective fair market values at the date of acquisition. Amounts assigned to identifiable intangible assets, and their related useful lives, are derived from established valuation techniques and management estimates.

Recoverability of definite-lived intangible assets
The Company evaluates the recoverability of definite-lived intangible assets whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. These long-lived assets are grouped and evaluated for impairment at the lowest level at which individual cash flows can be identified. When evaluating these long-lived assets for potential impairment, the Company first compares the carrying amount of the asset group to the asset group's estimated future cash flows (undiscounted and without interest charges). If the estimated future cash flows are less than that carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group's estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group's carrying value that exceeds the asset group's estimated future cash flows (discounted and with interest charges).

The long-lived asset impairment loss calculation contains uncertainty since management must use judgment to estimate each asset group's future sales, profitability and cash flows. When preparing these estimates, the Company considers historical results and current operating trends and consolidated sales, profitability and cash flow results and forecasts. These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, efforts of third party organizations to reduce their prescription drug costs and/or increased member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

There were no material impairment losses for definite-lived intangible assets recognized in any of the three years ended December 31, 2018, 2017 or 2016.

Recoverability of indefinitely-lived intangible assets
Indefinitely-lived intangible assets are subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that their carrying value may not be recoverable. Indefinitely-lived intangible assets are tested by comparing the estimated fair value of the asset to its carrying value. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized and the asset is written down to its estimated fair value.

The indefinitely-lived intangible asset impairment loss calculation contains uncertainty since management must use judgment to estimate fair value based on the assumption that, in lieu of ownership of an intangible asset, the Company would be willing to pay a royalty in order to utilize the benefits of the asset. Fair value is estimated by discounting the hypothetical royalty payments to their present value over the estimated economic life of the asset. These estimates can be affected by a number of factors including, but not limited to, general economic conditions, availability of market information as well as the profitability of the Company.

There were no material impairment losses recognized on indefinitely-lived intangible assets recognized in any of the three years ended December 31, 2018, 2017 or 2016.

Recoverability of goodwill
Goodwill represents the excess of amounts paid for acquisitions over the fair value of the net identifiable assets acquired. Goodwill is subject to annual impairment reviews, or more frequent reviews if events or circumstances indicate that the carrying value may not be recoverable. Goodwill is tested for impairment on a reporting unit basis. The impairment test is calculated by comparing the reporting unit's fair value with its net book value (or carrying amount), including goodwill. The fair value of the reporting units is estimated using a combination of a discounted cash flow method and a market multiple method. If the net book value (carrying amount) of the reporting unit exceeds its fair value, the reporting unit's goodwill is considered to be impaired and an impairment is recognized in an amount equal to the excess.

The determination of the fair value of the reporting units requires the Company to make significant assumptions and estimates. These assumptions and estimates primarily include, but are not limited to, the selection of appropriate peer group companies; control premiums and valuation multiples appropriate for acquisitions in the industries in which the Company competes;

discount rates; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, capital expenditures and future working capital requirements. When determining these assumptions and preparing these estimates, the Company considers each reporting unit's historical results and current operating trends; consolidated revenues, profitability and cash flow results and forecasts; and industry trends. These estimates can be affected by a number of factors including, but not limited to, general economic and regulatory conditions, market capitalization, efforts of customers and payers to reduce costs including their prescription drug costs and/or increase member co-payments, the continued efforts of competitors to gain market share and consumer spending patterns.

2018 goodwill impairment tests
As discussed in Note 5 ''Goodwill and Other Intangibles'' to the consolidated financial statements, during 2018, the LTC reporting unit continued to experience industry wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare and when the 2017 annual goodwill impairment test was performed. These challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a projected deterioration in the financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, higher risk-free interest rates and lower market multiples of peer group companies contributed to the amount of the second quarter 2018 goodwill impairment charge.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill. The results of these impairment tests indicated that there was no impairment of goodwill. The results of the annual goodwill impairment tests showed the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair value of the LTC reporting unit exceeded its carrying value by approximately 2%.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. The updated projections continue to reflect industry wide challenges including lower occupancy rates in skilled nursing facilities, the significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, an interim goodwill impairment test was performed during the fourth quarter of 2018. The results of that impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion goodwill impairment charge in the fourth quarter of 2018. In addition to the lower financial projections, lower market multiples of peer group companies also contributed to the amount of the fourth quarter 2018 goodwill impairment charge. The fair value of the LTC reporting unit was determined using a methodology consistent with the methodology described above for the analyses performed during the second and third quarters of 2018.

As of December 31, 2018 , the remaining goodwill balance in the LTC reporting unit is approximately $431 million .

Although the Company believes the financial projections used to determine the fair value of the LTC reporting unit in the fourth quarter of 2018 are reasonable and achievable, the LTC reporting unit may continue to face challenges that may affect the Company's ability to grow its business at the rate estimated when such goodwill impairment test was performed. These challenges and some of the key assumptions included in the Company's financial projections to determine the estimated fair value of the LTC reporting unit include client retention rates, occupancy rates in skilled nursing facilities, the financial health of skilled nursing facility customers, facility reimbursement pressures, the Company's ability to execute its senior living initiative, the Company's ability to make acquisitions and integrate those businesses into its LTC operations in an orderly manner, as well as the Company's ability to extract cost savings from labor productivity and other initiatives. The Company has made a number of additions and changes to its LTC management team to better respond to these challenges. The estimated fair value of the LTC reporting unit also is dependent on earnings multiples of market participants in the pharmacy industry, as well as the risk-free interest rate environment, which impacts the discount rate used in the discounted cash flow valuation method. If the Company

does not achieve its forecasts, it is reasonably possible in the near term that the goodwill of the LTC reporting unit could be deemed to be impaired again by a material amount.

2017 and 2016 goodwill impairment tests
The Company recorded $181 million in goodwill impairment charges in 2017 related to the RxCrossroads reporting unit. During the third quarter of 2017, the Company performed its required annual impairment test of goodwill. The goodwill impairment tests showed that the fair values of the Pharmacy Services and Retail Pharmacy reporting units exceeded their carrying values by significant margins and the fair values of the LTC and RxCrossroads reporting units exceeded their carrying values by approximately 1% and 6%, respectively. On January 2, 2018, the Company sold its RxCrossroads reporting unit to McKesson Corporation for $725 million .

The Company did not record any goodwill impairment charges during 2016 .

Health Care Costs Payable

At December 31, 2018 , 80% of health care costs payable are estimates of the ultimate cost of (i) services rendered to members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. The remainder of health care costs payable is primarily comprised of pharmacy and capitation payables, other amounts due to providers pursuant to risk sharing agreements and accruals for state assessments. The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. See Note 1 ''Significant Accounting Policies'' to the consolidated financial statements for additional information on the Company's reserving methodology.

The Company has considered the pattern of changes in its completion factors when determining the completion factors used in its estimates of IBNR as of December 31, 2018 . However, based on historical claim experience, it is reasonably possible that the Company's estimated weighted average completion factors may vary by plus or minus 16 basis points from the Company's assumed rates, which could impact health care costs payable by approximately plus or minus $194 million pretax.

Management considers historical health care cost trend rates together with its knowledge of recent events that may impact current trends when developing estimates of current health care cost trend rates. When establishing reserves as of December 31, 2018 , the Company increased its assumed health care cost trend rates for the most recent three months by 3.5% from health care cost trend rates recently observed. However, based on historical claim experience, it is reasonably possible that the Company's estimated health care cost trend rates may vary by plus or minus 3.5% from the assumed rates, which could impact health care costs payable by plus or minus $299 million pretax.

Income Taxes

Income taxes are accounted for using the asset and liability method. Deferred tax assets and liabilities are established for any temporary differences between financial and tax reporting bases and are adjusted as needed to reflect changes in the enacted tax rates expected to be in effect when the temporary differences reverse. Such adjustments are recorded in the period in which changes in tax laws are enacted, regardless of when they are effective. Deferred tax assets are reduced, if necessary, by a valuation allowance to the extent future realization of those losses, deductions or other tax benefits is sufficiently uncertain. Significant judgment is required in determining the provision for income taxes and the related taxes payable and deferred tax assets and liabilities since, in the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company's tax returns are subject to audit by various domestic and foreign tax authorities that could result in material adjustments based on differing interpretations of the tax laws. Although management believes that its estimates are reasonable and are based on the best available information at the time the provision is prepared, actual results could differ from these estimates resulting in a final tax outcome that may be materially different from that which is reflected in the consolidated financial statements.

The tax benefit from an uncertain tax position is recognized only if it is more likely than not that the tax position will be sustained on examination by the taxing authorities, based on the technical merits of the position. The tax benefits recognized in the consolidated financial statements from such positions are then measured based on the largest benefit that has a greater than 50% likelihood of being realized upon settlement. Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision. Significant judgment is required in determining uncertain tax positions. The Company has established

accruals for uncertain tax positions using its judgment and adjusts these accruals, as warranted, due to changing facts and circumstances.

Business Combinations

The Company accounts for business combinations using the acquisition method of accounting which requires that the assets acquired and liabilities assumed be recorded at the date of the acquisition at their respective fair values. The excess of purchase price over the fair value of assets acquired and liabilities assumed is recorded as goodwill. Determining the fair value of identifiable assets, particularly intangible assets, and liabilities acquired also requires management to make estimates, which are based on all available information and in some cases assumptions with respect to the timing and amount of future revenues and expenses associated with an asset. The most critical assumptions used in determining the fair value of intangible assets include customer attrition, membership growth and revenue growth. In determining the estimated fair value for intangible assets, the Company typically utilizes the income approach, which discounts the projected future net cash flow using an appropriate discount rate that reflects the risks associated with such projected future cash flows. Determining the useful life of an intangible asset also requires judgment, as different types of intangible assets will have different useful lives and certain assets are considered to have indefinite useful lives.

New Accounting Pronouncements

See Note 1 ‘‘Significant Accounting Policies’’ to the consolidated financial statements for a description of new accounting pronouncements applicable to the Company.

Holders of Common Stock

As of February 19, 2019, there were 27,266 registered holders of the Company’s common stock according to the records maintained by the Company’s transfer agent.

Cautionary Statement Concerning Forward-Looking Statements

The Private Securities Litigation Reform Act of 1995 (the “Reform Act”) provides a safe harbor for forward-looking statements made by or on behalf of the Company. In addition, the Company and its representatives may, from time to time, make written or verbal forward-looking statements, including statements contained in the Company’s filings with the United States Securities and Exchange Commission (the “SEC”) and in its reports to stockholders, press releases, webcasts, conference calls, meetings and other communications. Generally, the inclusion of the words “anticipate,” “believe,” “estimate,” “expect,” “intend,” “project,” “should,” “will” and similar expressions identify statements that constitute forward-looking statements. All statements addressing operating performance of CVS Health Corporation or any subsidiary, events or developments that the Company projects, expects or anticipates will occur in the future, including statements relating to corporate strategy; revenue growth; adjusted revenue growth, earnings or earnings per common share growth; adjusted operating income or adjusted earnings per common share growth; free cash flow; debt ratings; inventory levels; inventory turn and loss rates; store development; relocations and new market entries; retail pharmacy business, sales results and/or trends and operations; PBM business, sales results and/or trends and operations; specialty pharmacy business, sales trends and operations; LTC pharmacy business, sales results and/or trends and operations; Health Care Benefits business, sales results and/or trends, medical cost trends, medical membership growth, medical benefit ratios and operations; the Company’s ability to attract or retain customers and clients; Medicare Part D competitive bidding, enrollment and operations; new product development; and the impact of industry and regulatory developments, as well as statements expressing optimism or pessimism about future results of operations or events, are forward-looking statements within the meaning of the Reform Act.

The forward-looking statements are and will be based upon management’s then-current views and assumptions regarding future events and operating performance, and are applicable only as of the dates of such statements. The Company undertakes no obligation to update or revise any forward-looking statements, whether as a result of new information, future events, or otherwise.

By their nature, all forward-looking statements involve risks and uncertainties. Actual results may differ materially from those contemplated by the forward-looking statements for a number of reasons as described in the Company's SEC filings, including those set forth in the Risk Factors section within the CVS Health Corporation's 2018 Annual Report on Form 10-K, and including, but not limited to:

- *Risks to our brand and reputation, the Aetna Acquisition, data governance risks, effectiveness of our talent management and alignment of talent to our business needs, and potential changes in public policy, laws and regulations present overarching risks to our enterprise in 2019 and beyond.*
- *Our brand and reputation are two of our most important assets; negative public perception of the industries in which we operate, or of our industries' or our practices, can adversely affect our businesses, results of operations, cash flows and prospects.*
- *Data governance failures can adversely affect our reputation, businesses and prospects. Our use and disclosure of members', customers' and other constituents' sensitive information is subject to complex regulations at multiple levels. We would be adversely affected if we or our business associates or other vendors fail to adequately protect members', customers' or other constituents' sensitive information.*
- *We face significant competition in attracting and retaining talented employees. Further, managing succession for, and retention of, key executives is critical to our success, and our failure to do so could adversely affect our future performance.*
- *We are subject to potential changes in public policy, laws and regulations, including reform of the United States health care system, that can adversely affect the markets for our products and services and our businesses, operations, results of operations, cash flows and prospects.*
- *Our enterprise strategy may not be an effective response to the changing dynamics in the industries in which we operate, or we may not be able to implement our strategy and related strategic projects.*
- *Efforts to reduce reimbursement levels and alter health care financing practices could adversely affect our businesses.*
- *Gross margins in the industries in which we operate may decline.*
- *Our results of operations are affected by the health of the economy in general and in the geographies we serve.*
- *We operate in a highly competitive business environment. Competitive and economic pressures may limit our ability to increase pricing to reflect higher costs or may force us to accept lower margins. If customers elect to self-insure, reduce benefits or adversely renegotiate or amend their agreements with us, our revenues and results of operations will be adversely affected. We may not be able to obtain appropriate pricing on new or renewal business.*
- *We may lose clients and/or fail to win new business. If we fail to compete effectively in the geographies and product areas in which we operate, including maintaining or increasing membership in our Health Care Benefits segment, our results of operations, financial condition and cash flows could be materially and adversely affected.*
- *We are exposed to risks relating to the solvency of our customers and of other insurers.*
- *We face risks relating to the market availability, pricing, suppliers and safety profiles of prescription drugs that we purchase and sell.*
- *We face risks related to the frequency and rate of the introduction and pricing of generic drugs and brand name prescription drug products.*
- *Possible changes in industry pricing benchmarks and drug pricing generally can adversely affect our PBM business.*
- *Product liability, product recall or personal injury issues could damage our reputation.*
- *We face challenges in growing our Medicare Advantage and Medicare Part D membership.*
- *We face challenges in growing our Medicaid membership, and expanding our Medicaid membership exposes us to additional risks.*
- *A change in our Health Care Benefits product mix may adversely affect our profit margins.*
- *We may not be able to accurately forecast health care and other benefit costs, which could adversely affect our Health Care Benefits segment's results of operations. There can be no assurance that the future health care and other benefit costs of our Insured Health Care Benefits products will not exceed our projections.*
- *A number of factors, many of which are beyond our control, contribute to rising health care and other benefit costs. If we are unable to satisfactorily manage our health care and other benefit costs, our Health Care Benefits segment's results of operations and competitiveness will be adversely affected.*
- *The reserves we hold for expected claims in our Insured Health Care Benefits products are based on estimates that involve an extensive degree of judgment and are inherently variable. Any reserve, including a premium deficiency reserve, may be insufficient. If actual claims exceed our estimates, our results of operations could be materially adversely affected, and our ability to take timely corrective actions to limit future costs may be limited.*
- *Extreme events, or the threat of extreme events, could materially increase our health care (including behavioral health) costs. We cannot predict whether or when any such events will occur.*
- *Legislative and regulatory changes could create significant challenges to our Medicare Advantage and Medicare Part D revenues and results of operations, and proposed changes to these programs could create significant additional challenges.*

Entitlement program reform, if it occurs, could have a material adverse effect on our businesses, operations and/or results of operations.

- *We may not be able to obtain adequate premium rate increases in our Insured Health Care Benefits products, which would have an adverse effect on our revenues, MBRs and results of operations and could magnify the adverse impact of increases in health care and other benefit costs and of ACA assessments, fees and taxes.*
- *Minimum MLR rebate requirements limit the level of margin we can earn in our Insured Health Care Benefits products while leaving us exposed to higher than expected medical costs. Challenges to our minimum MLR rebate methodology and/or reports could adversely affect our results of operations.*
- *Our business activities are highly regulated. Our Pharmacy Services, Medicare Advantage, Medicare Part D, Medicaid, dual eligible, dual eligible special needs plan, small group and certain other products are subject to particularly extensive and complex regulations. If we fail to comply with applicable laws and regulations, we could be subject to significant adverse regulatory actions or suffer brand and reputational harm which may have a material adverse effect on our businesses. Compliance with existing and future laws, regulations and/or judicial decisions may reduce our profitability and limit our growth.*
- *If our compliance or other systems and processes fail or are deemed inadequate, we may suffer brand and reputational harm and become subject to regulatory actions or litigation which could adversely affect our businesses, results of operations, cash flows and/or financial condition.*
- *Our litigation and regulatory risk profile are changing as a result of the Aetna Acquisition and as we offer new products and services and expand in business areas beyond our historical core businesses of Retail/LTC and Pharmacy Services.*
- *We routinely are subject to litigation and other adverse legal proceedings, including class actions and qui tam actions. Many of these proceedings seek substantial damages which may not be covered by insurance. These proceedings may be costly to defend, result in changes in our business practices, harm our brand and reputation and adversely affect our businesses and results of operations.*
- *We frequently are subject to regular and special governmental audits, investigations and reviews that could result in changes to our business practices and also could result in material refunds, fines, penalties, civil liabilities, criminal liabilities and other sanctions.*
- *We are subject to retroactive adjustments to and/or withholding of certain premiums and fees, including as a result of CMS RADV audits. We generally rely on health care providers to appropriately code claim submissions and document their medical records. If these records do not appropriately support our risk adjusted premiums, we may be required to refund premium payments to CMS and/or pay fines and penalties under the False Claims Act.*
- *Programs funded in whole or in part by the U.S. federal government account for a significant portion of our revenues. The U.S. federal government and our other government customers may reduce funding for health care or other programs, cancel or decline to renew contracts with us, or make changes that adversely affect the number of persons eligible for certain programs, the services provided to enrollees in such programs, our premiums and our administrative and health care and other benefit costs, any of which could have a material adverse effect on our businesses, results of operations and cash flows. In addition, an extended federal government shutdown or a delay by Congress in raising the federal government's debt ceiling could lead to a delay, reduction, suspension or cancellation of federal government spending and a significant increase in interest rates that could, in turn, have a material adverse effect on our businesses, results of operations and cash flows.*
- *Our results of operations may be adversely affected by changes in laws and policies governing employers and by union organizing activity.*
- *We must develop and maintain a relevant omni-channel experience for our retail customers.*
- *We must maintain and improve our relationships with our retail and specialty pharmacy customers and increase the demand for our products and services, including proprietary brands. If we fail to develop new products, differentiate our products from those of our competitors or demonstrate the value of our products to our customers and members, our ability to retain or grow our customer base may be adversely affected.*
- *In order to be competitive in the increasingly consumer-oriented marketplace for our health care products and services, we will need to develop and deploy consumer-friendly products and services and make investments in consumer engagement, reduce our cost structure and compete successfully with new entrants into our businesses. If we are unsuccessful, our future growth and profitability may be adversely affected.*
- *Our results of operations may be adversely affected if we are unable to contract with manufacturers, providers, suppliers and vendors on competitive terms and develop and maintain attractive networks with high quality providers.*
- *If our service providers fail to meet their contractual obligations to us or to comply with applicable laws or regulations, we may be exposed to brand and reputational harm, litigation or regulatory action. This risk is particularly high in our Medicare, Medicaid, dual eligible and dual eligible special needs plan programs.*
- *Continuing consolidation and integration among providers and other suppliers may increase our medical and other covered benefits costs, make it difficult for us to compete in certain geographies and create new competitors.*

- *We may experience increased medical and other benefit costs, litigation risk and customer and member dissatisfaction when providers that do not have contracts with us render services to our Health Care Benefits members.*
- *Customers, particularly large sophisticated customers, expect us to implement their contracts and onboard their employees and members efficiently and effectively. Failure to do so could adversely affect our reputation, businesses, results of operations, cash flows and prospects. If we or our vendors fail to provide our customers with quality service that meets their expectations, our ability to retain and grow our membership and customer base will be adversely affected.*
- *We are subject to payment-related risks that could increase our operating costs, expose us to fraud or theft, subject us to potential liability and disrupt our business operations.*
- *Our and our vendors' operations are subject to a variety of business continuity hazards and risks, any of which could interrupt our operations or otherwise adversely affect our performance and results of operations.*
- *We and our vendors have experienced cyber attacks. We can provide no assurance that we or our vendors will be able to detect, prevent or contain the effects of such attacks or other information security (including cybersecurity) risks or threats in the future.*
- *The failure or disruption of our information technology systems or the failure of our information technology infrastructure to support our businesses could adversely affect our reputation, businesses, results of operations and cash flows.*
- *Our business success and results of operations depend in part on effective information technology systems and on continuing to develop and implement improvements in technology. Pursuing multiple initiatives simultaneously could make this continued development and implementation significantly more challenging.*
- *Sales of our products and services are dependent on our ability to attract and motivate internal sales personnel and independent third-party brokers, consultants and agents. New distribution channels create new disintermediation risk. We may be subject to penalties or other regulatory actions as a result of the marketing practices of brokers and agents selling our products.*
- *We also face other risks that could adversely affect our businesses, results of operations, financial condition and/or cash flows, which include:*
  - *Failure of our corporate governance policies or procedures, for example significant financial decisions being made at an inappropriate level in our organization;*
  - *Inappropriate application of accounting principles or a significant failure of internal control over financial reporting, which could lead to a restatement of our results of operations and/or a deterioration in the soundness and accuracy of our reported results of operations; and*
  - *Failure to adequately manage our run-off businesses and/or our regulatory and financial exposure to businesses we have sold, including Aetna's divested standalone Medicare Part D, domestic group life insurance, group disability insurance and absence management businesses.*
- *Goodwill and other intangible assets could, in the future, become impaired.*
- *We would be adversely affected if we do not effectively deploy our capital. Downgrades or potential downgrades in our credit ratings, should they occur, could adversely affect our brand and reputation, businesses, cash flows, financial condition and results of operations.*
- *Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, mortgage loans, alternative investments and other investments, our results of operations and/or our financial condition.*
- *We have limited experience in the insurance and managed health care industry, which may hinder our ability to achieve our objectives as a combined company.*
- *The Aetna Acquisition may not be accretive, and may be dilutive, to our earnings per share, which may adversely affect our stock price.*
- *We may fail to successfully combine the businesses and operations of CVS Health and Aetna to realize the anticipated benefits and cost savings of the Aetna Acquisition within the anticipated timeframe or at all, which could adversely affect our stock price.*
- *Our future results may be adversely impacted if we do not effectively manage our expanded operations following completion of the Aetna Acquisition.*
- *We may have difficulty attracting, motivating and retaining executives and other key employees following completion of the Aetna Acquisition.*
- *The Aetna integration process could disrupt our ongoing businesses and/or operations.*
- *Our indebtedness following completion of the Aetna Acquisition is substantially greater than our indebtedness on a stand-alone basis and greater than the combined indebtedness of CVS Health and Aetna existing prior to the announcement of the transaction. This increased level of indebtedness could adversely affect our business flexibility and increase our borrowing costs.*
- *We will continue to incur significant integration-related costs in connection with the Aetna Acquisition.*

- *We expect to continue to pursue acquisitions, joint ventures, strategic alliances and other inorganic growth opportunities, which may be unsuccessful, cause us to assume unanticipated liabilities, disrupt our existing businesses, be dilutive or lead us to assume significant debt, among other things.*
- *We may be unable to successfully integrate companies we acquire.*
- *As a result of our expanded international operations, we face political, legal and compliance, operational, regulatory, economic and other risks that we do not face or are more significant than in our domestic operations.*

The foregoing list is not exhaustive. There can be no assurance that the Company has correctly identified all the risks that affect it. Additional risks and uncertainties not presently known to the Company or that the Company currently believes to be immaterial also may adversely affect the Company's businesses. Should any risks or uncertainties develop into actual events, these developments could have a material adverse effect on the Company's businesses, results of operations, cash flows and/or financial condition. For these reasons, you are cautioned not to place undue reliance on the Company's forward-looking statements.

Management's Report on Internal Control Over Financial Reporting

Management is responsible for establishing and maintaining adequate internal control over financial r eporting. The Company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the Company's consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on the Company's consolidated financial statements. In order to ensure the Company's internal control over financial reporting is effective, management regularly assesses such control and did so most recently for its financial reporting as of December 31, 2018 .

Management conducted an assessment of the effectiveness of the Company's internal control over financial reporting based on the criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 Framework). This evaluation included review of the documentation, evaluation of the design effectiveness and testing of the operating effectiveness of controls. The Company ' s system of internal control over financial reporting is enhanced by periodic reviews by the Company's internal auditors, written policies and procedures and a written Code of Conduct adopted by the Company's Board of Directors, applicable to all employees of the Company. In addition, the Company has an internal Disclosure Committee, comprised of management from each functional area within the Company, which performs a separate review of disclosure controls and procedures. There are inherent limitations in the effectiveness of any system of internal control over financial reporting.

On November 28, 2018, the Company completed its acquisition of Aetna Inc. ("Aetna"). Management's assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018 excludes Aetna from that assessment as permitted under SEC rules. Aetna's operations are included in the Company's consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and represented 21% of the Company's consolidated total assets as of December 31, 2018 and 3% of the Company's consolidated total revenues for the year ended December 31, 2018.

Based on management's assessment, management concluded that the Company's internal control over financial reporting is effective and provides reasonable assurance that assets are safeguarded and that the financial records are reliable for preparing financial statements as of December 31, 2018 .

Ernst & Young LLP, the Company's independent registered public accounting firm, is appointed by the Board of Directors and ratified by the Company's shareholders. They were engaged to render an opinion regarding the fair presentation of the Company ' s consolidated financial statements as well as conducting an audit of internal control over financial reporting. Their accompanying reports are based upon audits conducted in accordance with the standards of the Public Company Accounting Oversight Board (United States).

February 28, 2019

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on Internal Control over Financial Reporting

We have audited CVS Health Corporation's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, CVS Health Corporation (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on the COSO criteria.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Aetna Inc., which is included in the 2018 consolidated financial statements of the Company and constituted 21% of total assets as of December 31, 2018 and 3% of revenues for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Aetna Inc.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes and our report dated February 28, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

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

/s/ Ernst & Young LLP
Boston, Massachusetts
February 28, 2019

Consolidated Statements of Operations

In millions, except per share amounts	For the Years Ended December 31, 2018	2017	2016
Revenues:			
Products	$ 183,910	$ 180,063	$ 173,377
Premiums	8,184	3,558	3,069
Services	1,825	1,144	1,080
Net investment income	660	21	20
Total revenues	194,579	184,786	177,546
Operating costs:			
Cost of products sold	156,447	153,448	146,533
Benefit costs	6,594	2,810	2,179
Goodwill impairments	6,149	181	—
Operating expenses	21,368	18,809	18,448
Total operating costs	190,558	175,248	167,160
Operating income	4,021	9,538	10,386
Interest expense	2,619	1,062	1,078
Loss on early extinguishment of debt	—	—	643
Other expense (income)	(4)	208	28
Income before income tax provision	1,406	8,268	8,637
Income tax provision	2,002	1,637	3,317
Income (loss) from continuing operations	(596)	6,631	5,320
Loss from discontinued operations, net of tax	—	(8)	(1)
Net income (loss)	(596)	6,623	5,319
Net (income) loss attributable to noncontrolling interests	2	(1)	(2)
Net income (loss) attributable to CVS Health	$ (594)	$ 6,622	$ 5,317
Basic earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.48	$ 4.93
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.47	$ 4.93
Weighted average basic shares outstanding	1,044	1,020	1,073
Diluted earnings (loss) per share:			
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.45	$ 4.91
Loss from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.44	$ 4.90
Weighted average diluted shares outstanding	1,044	1,024	1,079
Dividends declared per share	$ 2.00	$ 2.00	$ 1.70

See accompanying notes to consolidated financial statements.

Consolidated Statements of Comprehensive Income (Loss)

	For the Years Ended December 31,		
In millions	**2018**	**2017**	**2016**
Net income (loss)	$ (596)	$ 6,623	$ 5,319
Other comprehensive income (loss), net of tax:			
Net unrealized investment gains	97	—	—
Foreign currency translation adjustments	(29)	(2)	38
Net cash flow hedges	330	(10)	2
Pension and other postretirement benefits	(124)	152	13
Other comprehensive income	274	140	53
Comprehensive income (loss)	(322)	6,763	5,372
Comprehensive (income) loss attributable to noncontrolling interests	2	(1)	(2)
Comprehensive income (loss) attributable to CVS Health	$ (320)	$ 6,762	$ 5,370

See accompanying notes to consolidated financial statements.

Consolidated Balance Sheets

In millions, except per share amounts	At December 31, 2018	At December 31, 2017
Assets:		
Cash and cash equivalents	$ 4,059	$ 1,696
Investments	2,522	111
Accounts receivable, net	17,631	13,181
Inventories	16,450	15,296
Other current assets	4,581	945
Total current assets	45,243	31,229
Long-term investments	15,732	112
Property and equipment, net	11,349	10,292
Goodwill	78,678	38,451
Intangible assets, net	36,524	13,630
Separate accounts assets	3,884	—
Other assets	5,046	1,417
Total assets	$ 196,456	$ 95,131
Liabilities:		
Accounts payable	$ 8,925	$ 8,863
Pharmacy claims and discounts payable	12,302	10,355
Health care costs payable	5,210	5
Policyholders' funds	2,939	—
Accrued expenses	10,711	6,581
Other insurance liabilities	1,937	23
Short-term debt	720	1,276
Current portion of long-term debt	1,265	3,545
Total current liabilities	44,009	30,648
Long-term debt	71,444	22,181
Deferred income taxes	7,677	2,996
Separate accounts liabilities	3,884	—
Other long-term insurance liabilities	8,119	334
Other long-term liabilities	2,780	1,277
Total liabilities	137,913	57,436
Commitments and contingencies (Note 16)		
Shareholders' equity:		
CVS Health shareholders' equity:		
Preferred stock, par value $0.01: 0.1 shares authorized; none issued or outstanding	—	—
Common stock, par value $0.01: 3,200 shares authorized; 1,720 shares issued and 1,295 shares outstanding at December 31, 2018 and 1,712 shares issued and 1,014 shares outstanding at December 31, 2017 and capital surplus	45,440	32,096
Treasury stock, at cost: 425 shares at December 31, 2018 and 698 shares at December 31, 2017	(28,228)	(37,796)
Retained earnings	40,911	43,556
Accumulated other comprehensive income (loss)	102	(165)
Total CVS Health shareholders' equity	58,225	37,691
Noncontrolling interests	318	4
Total shareholders' equity	58,543	37,695
Total liabilities and shareholders' equity	$ 196,456	$ 95,131

See accompanying notes to consolidated financial statements.

Consolidated Statements of Cash Flows

In millions	For the Years Ended December 31, 2018	2017	2016
Cash flows from operating activities:			
Cash receipts from customers	$ 186,519	$ 176,594	$ 172,310
Cash paid for inventory and prescriptions dispensed by retail network pharmacies	(148,821)	(146,469)	(140,312)
Insurance benefits paid	(7,057)	(2,810)	(2,199)
Cash paid to other suppliers and employees	(17,234)	(15,348)	(15,478)
Interest and investment income received	644	21	20
Interest paid	(2,803)	(1,072)	(1,140)
Income taxes paid	(2,383)	(2,909)	(3,060)
Net cash provided by operating activities	8,865	8,007	10,141
Cash flows from investing activities:			
Proceeds from sales and maturities of investments	817	61	91
Purchases of investments	(692)	(137)	(80)
Purchases of property and equipment	(2,037)	(1,918)	(2,224)
Proceeds from sale-leaseback transactions	—	265	230
Acquisitions (net of cash acquired)	(42,226)	(1,181)	(524)
Proceeds from sale of subsidiary and other assets	832	—	—
Other	21	33	37
Net cash used in investing activities	(43,285)	(2,877)	(2,470)
Cash flows from financing activities:			
Net repayments of short-term debt	(556)	(598)	1,874
Proceeds from issuance of long-term debt	44,343	—	3,455
Repayments of long-term debt	(5,522)	—	(5,943)
Purchase of noncontrolling interest in subsidiary	—	—	(39)
Payment of contingent consideration	—	—	(26)
Derivative settlements	446	—	—
Repurchase of common stock	—	(4,361)	(4,461)
Dividends paid	(2,038)	(2,049)	(1,840)
Proceeds from exercise of stock options	242	329	296
Payments for taxes related to net share settlement of equity awards	(97)	(71)	(72)
Other	1	(1)	(5)
Net cash provided by (used in) financing activities	36,819	(6,751)	(6,761)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(4)	1	2
Net increase (decrease) in cash, cash equivalents and restricted cash	2,395	(1,620)	912
Cash, cash equivalents and restricted cash at the beginning of the period	1,900	3,520	2,608
Cash, cash equivalents and restricted cash at the end of the period	$ 4,295	$ 1,900	$ 3,520

In millions	For the Years Ended December 31, 2018	2017	2016
Reconciliation of net income (loss) to net cash provided by operating activities:			
Net income (loss)	$ (596)	$ 6,623	$ 5,319
Adjustments required to reconcile net income (loss) to net cash provided by operating activities:			
Depreciation and amortization	2,718	2,479	2,475
Goodwill impairments	6,149	181	—
Losses on settlements of defined benefit pension plans	—	187	—
Stock-based compensation	280	234	222
Loss on early extinguishment of debt	—	—	643
Deferred income taxes	87	(1,334)	18
Other noncash items	339	53	135
Change in operating assets and liabilities, net of effects from acquisitions:			
Accounts receivable, net	(1,139)	(941)	(243)
Inventories	(1,153)	(514)	(742)
Other assets	(3)	(338)	(8)
Accounts payable and pharmacy claims and discounts payable	2,489	1,710	2,189
Health care costs payable and other insurance liabilities	(471)	—	(19)
Other liabilities	165	(333)	152
Net cash provided by operating activities	$ 8,865	$ 8,007	$ 10,141

See accompanying notes to consolidated financial statements.

Consolidated Statements of Shareholders' Equity

	Number of shares outstanding		Attributable to CVS Health						
In millions	Common Shares	Treasury Shares [1]	Common Stock and Capital Surplus [2]	Treasury Stock [1]	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total CVS Health Shareholders' Equity	Non Controlling Interests	Total Equity
Balance at December 31, 2015	**1,699**	**(598)**	**$ 30,965**	**$ (28,917)**	**$ 35,506**	**$ (358)**	**$ 37,196**	**$ 7**	**$ 37,203**
Net income [3]	—	—	—	—	5,317	—	5,317	1	5,318
Other comprehensive income (Note 13)	—	—	—	—	—	53	53	—	53
Stock option activity, stock awards, related tax benefits and other	6	—	525	—	—	—	525	—	525
Purchase of treasury shares, net of ESPP issuances	—	(46)	145	(4,566)	—	—	(4,421)	—	(4,421)
Common stock dividends	—	—	—	—	(1,840)	—	(1,840)	—	(1,840)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(4)	(4)
Balance at December 31, 2016	1,705	(644)	31,635	(33,483)	38,983	(305)	36,830	4	36,834
Net income	—	—	—	—	6,622	—	6,622	1	6,623
Other comprehensive income (Note 13)	—	—	—	—	—	140	140	—	140
Stock option activity, stock awards and other	7	—	461	—	—	—	461	—	461
Purchase of treasury shares, net of ESPP issuances	—	(54)	—	(4,313)	—	—	(4,313)	—	(4,313)
Common stock dividends	—	—	—	—	(2,049)	—	(2,049)	—	(2,049)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(1)	(1)
Balance at December 31, 2017	1,712	(698)	32,096	(37,796)	43,556	(165)	37,691	4	37,695
Adoption of new accounting standards (Note 1)	—	—	—	—	(6)	(7)	(13)	—	(13)
Net loss	—	—	—	—	(594)	—	(594)	(2)	(596)
Other comprehensive income (Note 13)	—	—	—	—	—	274	274	—	274
Common shares issued to acquire Aetna	—	274	12,923	9,561	—	—	22,484	—	22,484
Stock option activity, stock awards and other	8	—	421	—	—	—	421	—	421
Purchase of treasury shares, net of ESPP issuances	—	(1)	—	7	—	—	7	—	7
Common stock dividends	—	—	—	—	(2,045)	—	(2,045)	—	(2,045)
Other decreases in noncontrolling interests	—	—	—	—	—	—	—	(13)	(13)
Acquisition of noncontrolling interests	—	—	—	—	—	—	—	329	329
Balance at December 31, 2018	**1,720**	**(425)**	**$ 45,440**	**$ (28,228)**	**$ 40,911**	**$ 102**	**$ 58,225**	**$ 318**	**$ 58,543**

(1) Treasury shares include 1 million shares held in trust for each of the years ended December 31, 2018, 2017 and 2016. Treasury stock includes $29 million related to shares held in trust for the year ended December 31, 2018 and $31 million related to shares held in trust for each of the years ended December 31, 2017 and 2016. See Note 1 ''Significant Accounting Policies'' for additional information.

(2) Common stock and capital surplus includes the par value of common stock of $17 million as of December 31, 2018, 2017 and 2016.

(3) Net income attributable to noncontrolling interests for the year ended December 31, 2016 excludes $1 million attributable to a redeemable noncontrolling interest. See Note 1 ''Significant Accounting Policies'' for additional information.

See accompanying notes to consolidated financial statements.

Notes to Consolidated Financial Statements

1. Significant Accounting Policies

Description of business

CVS Health Corporation, together with its subsidiaries (collectively, "CVS Health," the "Company," "we," "our" or "us"), is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,900 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 92 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 38 million people through traditional, voluntary and consumer-directed health insurance products and related services, including rapidly expanding Medicare Advantage offerings. The Company believes its innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

On November 28, 2018 (the "Aetna Acquisition Date"), the Company acquired Aetna Inc. ("Aetna"). As a result of the acquisition of Aetna (the "Aetna Acquisition"), the Company added the Health Care Benefits segment, which is the equivalent of the former Aetna Health Care segment. The Company now has four reportable segments: Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other, which are described below. The consolidated financial statements for the year ended December 31, 2018 reflect Aetna's results subsequent to the Aetna Acquisition Date.

Pharmacy Services Segment ("PSS")
PSS provides a full range of pharmacy benefit management ("PBM") solutions, including plan design offerings and administration, formulary management, retail pharmacy network management services, mail order pharmacy, specialty pharmacy and infusion services, Medicare Part D services, clinical services, disease management services and medical spend management. PSS' clients are primarily employers, insurance companies, unions, government employee groups, health plans, Medicare Part D prescription drug plans ("PDPs"), Medicaid managed care plans, plans offered on public health insurance exchanges ("Public Exchanges") and private health insurance exchanges, other sponsors of health benefit plans and individuals throughout the United States. In addition, the Company is a national provider of drug benefits to eligible beneficiaries under the Medicare Part D prescription drug program. PSS operates retail specialty pharmacy stores, specialty mail order pharmacies, mail order dispensing pharmacies, compounding pharmacies and branches for infusion and enteral nutrition services.

Retail/LTC Segment ("RLS")
RLS sells prescription drugs and a wide assortment of general merchandise, including over-the-counter drugs, beauty products, cosmetics and personal care products, provides health care services through its MinuteClinic ® walk-in medical clinics and conducts long-term care ("LTC") pharmacy operations, which distribute prescription drugs and provide related pharmacy consulting and other ancillary services to chronic care facilities and other care settings. Prior to January 2, 2018, RLS also provided commercialization services under the name RxCrossroads ® . The Company divested its RxCrossroads subsidiary on January 2, 2018. As of December 31, 2018, RLS operated more than 9,900 retail locations, over 1,100 MinuteClinic ® locations as well as online retail pharmacy websites, LTC pharmacies and onsite pharmacies.

Health Care Benefits Segment ("HCBS")
HCBS is one of the nation's leading diversified health care benefits providers, serving an estimated 38 million people as of December 31, 2018 . HCBS has the information and resources to help members, in consultation with their health care professionals, make better informed decisions about their health care. HCBS offers a broad range of traditional, voluntary and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, medical management capabilities, Medicare Advantage and Medicare Supplement plans, PDPs, Medicaid health care management services, workers' compensation administrative services and health information technology products and services. HCBS' customers include employer groups, individuals, college students, part-time and hourly workers, health plans, health care providers ("providers"), governmental units, government-sponsored plans, labor groups and expatriates. The Company refers to insurance products (where it assumes all or a majority of the risk for medical and dental care costs) as "Insured" and administrative services contract products (where the plan sponsor assumes all or a majority of the risk of medical and dental care costs) as "ASC."

Corporate/Other Segment
The Company presents the remainder of its financial results in the Corporate/Other segment, which consists of:

- Management and administrative expenses to support the overall operations of the Company, which include certain aspects of executive management and the corporate relations, legal, compliance, human resources, information technology and finance departments; and
- Products for which the Company no longer solicits or accepts new customers such as its large case pensions and long-term care insurance products.

Basis of Presentation

The accompanying consolidated financial statements of CVS Health Corporation and its subsidiaries have been prepared in accordance with accounting principles generally accepted in the United States of America (“GAAP”). The consolidated financial statements include the accounts of the Company and its majority-owned subsidiaries and variable interest entities (“VIEs”) for which the Company is the primary beneficiary. All material intercompany balances and transactions have been eliminated.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents

Cash and cash equivalents consist of cash and temporary investments with maturities of three months or less when purchased. The Company invests in short-term money market funds, commercial paper and time deposits, as well as other debt securities that are classified as cash equivalents within the accompanying consolidated balance sheets, as these funds are highly liquid and readily convertible to known amounts of cash.

Restricted cash

As of December 31, 2018 and 2017 , the Company had $230 million and $190 million , respectively, of restricted cash held in a trust in an insurance captive to satisfy collateral requirements associated with the assignment of certain insurance policies. Such amounts are included in other assets on the consolidated balance sheets. Additionally, as of December 31, 2018 and 2017 , the Company had $6 million and $14 million , respectively, of restricted cash held in escrow accounts in connection with certain recent acquisitions. Such amounts are included in other current assets on the consolidated balance sheets.

Investments

Debt Securities
Debt securities consist primarily of United States Treasury and agency securities, mortgage-backed securities, corporate and foreign bonds and other debt securities. Debt securities are classified as either current or long-term investments based on their contractual maturities unless the Company intends to sell an investment within the next twelve months, in which case it is classified as current within the consolidated balance sheets. Debt securities are classified as available for sale and are carried at fair value. See Note 4 ‘‘Fair Value’’ for additional information on how the Company estimates the fair value of these investments.

The cost for mortgage-backed and other asset-backed securities is adjusted for unamortized premiums and discounts, which are amortized using the interest method over the estimated remaining term of the securities, adjusted for anticipated prepayments.

Debt securities are regularly reviewed to determine whether a decline in fair value below the cost basis or carrying value is other-than-temporary. When a debt security is in an unrealized capital loss position, the Company monitors the duration and severity of the loss to determine if sufficient market recovery can occur within a reasonable period of time. If a decline in the

fair value of a debt security is considered other-than-temporary, the cost basis or carrying value of the debt security is written down. The write-down is then bifurcated into its credit and non-credit related components. The amount of the credit-related component is included in net income, and the amount of the non-credit related component is included in other comprehensive income/loss, unless the Company intends to sell the debt security or it is more likely than not that the Company will be required to sell the debt security prior to its anticipated recovery of the debt security's amortized cost basis. Interest is not accrued on debt securities when management believes the collection of interest is unlikely.

Equity Securities
Equity securities with readily available fair values are measured at fair value with changes in fair value recognized in net income.

Mortgage Loans
Mortgage loan investments on the consolidated balance sheets are valued at the unpaid principal balance, net of impairment reserves. A mortgage loan may be impaired when it is a problem loan (i.e., more than 60 days delinquent, in bankruptcy or in process of foreclosure), a potential problem loan (i.e., high probability of default) or a restructured loan. For impaired loans, a specific impairment reserve is established for the difference between the recorded investment in the loan and the estimated fair value of the collateral. The Company applies its loan impairment policy individually to all loans in its portfolio.

The impairment evaluation described above also considers characteristics and risk factors attributable to the aggregate portfolio. An additional allowance for loan losses is established if it is probable that there will be a credit loss on a group of similar mortgage loans. The following characteristics and risk factors are considered when evaluating if a credit loss is probable on a group of similar mortgage loans: loan-to-value ratios, property type (e.g., office, retail, apartment, industrial), geographic location, vacancy rates and property condition.

Full or partial impairments of loans are recorded at the time an event occurs affecting the legal status of the loan, typically at the time of foreclosure or upon a loan modification giving rise to forgiveness of debt. Interest income on a potential problem loan or restructured loan is accrued to the extent it is deemed to be collectible and the loan continues to perform under its original or restructured terms. Interest income on problem loans is recognized on a cash basis. Cash payments on loans in the process of foreclosure are treated as a return of principal. Mortgage loans with a maturity date or a committed prepayment date within twelve months are classified as current on the consolidated balance sheets.

Other Investments
Other investments consist primarily of the following:

- Private equity and hedge fund limited partnerships are accounted for using the equity method of accounting. Under this method, the carrying value of the investments are based on the value of the Company's equity ownership of the underlying investment funds provided by the general partner or manager of the investments, the financial statements of which generally are audited. As a result of the timing of the receipt of the valuation information provided by the fund managers, these investments are generally reported on up to a three month lag. The Company reviews investments for impairment at least quarterly and monitors their performance throughout the year through discussions with the administrators, managers and/or general partners. If the Company becomes aware of an impairment of a limited partnership's investments through its review or prior to receiving the limited partnership's financial statements at the financial statement date, an impairment will be recognized by recording a reduction in the carrying value of the limited partnership with a corresponding charge to net investment income.
- Investment real estate, which is carried on the consolidated balance sheets at depreciated cost, including capital additions, net of write-downs for other-than-temporary declines in fair value. Depreciation is calculated using the straight-line method based on the estimated useful life of each asset. If any real estate investment is considered held-for-sale, it is carried at the lower of its carrying value or fair value less estimated selling costs. The Company generally estimates fair value using a discounted future cash flow analysis in conjunction with comparable sales information. At the time of the sale, the difference between the sales price and the carrying value is recorded as a realized capital gain or loss.
- Privately-placed equity securities, which are carried on the consolidated balance sheets at cost less impairments, plus or minus subsequent adjustments for observable price changes. Additionally, as a member of the Federal Home Loan Bank of Boston ("FHLBB"), a subsidiary of the Company is required to purchase and hold shares of the FHLBB. These shares are restricted and carried at cost.

Net Investment Income
Net investment income on the Company's investments is recorded when earned and is reflected in net income in the consolidated results of operations (other than net investment income on assets supporting experience-rated products). Experience-rated products are products in the large case pensions business where the contract holder, not the Company, assumes investment and other risks, subject to, among other things, minimum guarantees provided by the Company. The effect of investment performance on experience-rated products is allocated to contract holders' accounts daily, based on the underlying investment experience and, therefore, does not impact the Company's net income in the consolidated results of operations (as long as the contract's minimum guarantees are not triggered). Net investment income on assets supporting large case pensions' experience-rated products is included in net investment income in the consolidated statements of operations and is credited to contract holders' accounts through a charge to benefit costs.

Realized capital gains and losses on investments (other than realized capital gains and losses on investments supporting experience-rated products) are included as a component of net investment income in the consolidated statements of operations. Realized capital gains and losses are determined on a specific identification basis. Purchases and sales of debt and equity securities and alternative investments are reflected on the trade date. Purchases and sales of mortgage loans and investment real estate are reflected on the closing date.

Realized capital gains and losses on investments supporting large case pensions' experience-rated products are not included in realized capital gains and losses in the consolidated statements of operations and instead are credited directly to contract holders' accounts. The contract holders' accounts are reflected in policyholders' funds on the consolidated balance sheets.

Unrealized capital gains and losses on investments (other than unrealized capital gains and losses on investments supporting experience-rated products) are reflected in shareholders' equity, net of tax, as a component of accumulated other comprehensive income. Unrealized capital gains and losses on investments supporting large case pensions' experience-rated products are credited directly to contract holders' accounts, which are reflected in policyholders' funds on the consolidated balance sheets.

Derivative Financial Instruments

The Company uses derivative financial instruments in order to manage interest rate and foreign exchange risk and credit exposure. The Company's use of these derivatives is generally limited to hedging risk and has principally consisted of using interest rate swaps, treasury rate locks, forward contracts, futures contracts, warrants, put options and credit default swaps.

Accounts Receivable

Accounts receivable are stated net of allowances for doubtful accounts, customer credit allowances, contractual allowances and estimated terminations. Accounts receivable, net consists of the following at December 31 :

In millions	**2018**	**2017**
Trade receivables	$ 6,896	$ 7,895
Vendor and manufacturer receivables	7,655	5,109
Premium receivables	2,259	31
Other receivables	821	146
Total accounts receivable, net	$ 17,631	$ 13,181

The activity in the allowance for doubtful accounts receivable for the years ended December 31 is as follows:

In millions	**2018**	**2017**	**2016**
Beginning balance	$ 307	$ 286	$ 161
Additions charged to bad debt expense	256	177	221
Write-offs charged to allowance	(70)	(156)	(96)
Ending balance	$ 493	$ 307	$ 286

Inventories

Inventories are valued at the lower of cost or net realizable value using the weighted average cost method. Physical inventory counts are taken on a regular basis in each retail store and LTC pharmacy and a continuous cycle count process is the primary procedure used to validate the inventory balances on hand in each distribution center and mail facility to ensure that the amounts reflected in the accompanying consolidated financial statements are properly stated. During the interim period between physical inventory counts, the Company accrues for anticipated physical inventory losses on a location-by-location basis based on historical results and current trends.

Reinsurance Recoverables

The Company utilizes reinsurance agreements primarily to reduce its required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Company could result in losses; however, the Company does not expect charges for unrecoverable reinsurance to have a material effect on its consolidated results of operations or financial condition. The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from similar geographic regions, activities or economic characteristics of its reinsurers. At December 31, 2018 , the Company's reinsurance recoverables consisted primarily of amounts due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Reinsurance recoverables are recorded as other current assets or other assets on the consolidated balance sheets.

Health Care Contract Acquisition Costs

Insurance products included in the Health Care Benefits and Pharmacy Services segments are cancelable by either the customer or the member monthly upon written notice. Acquisition costs related to prepaid health care and health indemnity contracts are generally expensed as incurred. Acquisition costs for certain long-duration insurance contracts are deferred and are recorded as other current assets or other assets on the consolidated balance sheets and are amortized over the estimated life of the contracts. The amortization of deferred acquisition costs is recorded in operating expenses in the consolidated statements of operations. At December 31, 2018 , the balance of deferred acquisition costs was $22 million , comprised primarily of commissions paid on Medicare Supplement products within the Health Care Benefits segment.

Property and Equipment

Property and equipment is reported at historical cost, net of accumulated depreciation. Property, equipment and improvements to leased premises are depreciated using the straight-line method over the estimated useful lives of the assets, or when applicable, the term of the lease, whichever is shorter. Estimated useful lives generally range from 5 to 40 years for buildings, building improvements and leasehold improvements and 3 to 10 years for fixtures, equipment and internally developed software. Repair and maintenance costs are charged directly to expense as incurred. Major renewals or replacements that substantially extend the useful life of an asset are capitalized and depreciated. Application development stage costs for significant internally developed software projects are capitalized and depreciated.

Property and equipment consists of the following at December 31 :

In millions	**2018**	**2017**
Land	$ 1,872	$ 1,707
Building and improvements	3,785	3,343
Fixtures and equipment	13,028	11,963
Leashold improvements	5,384	4,793
Software	2,800	2,484
Total property and equipment	26,869	24,290
Accumulated depreciation and amortization	(15,520)	(13,998)
Property and equipment, net	$ 11,349	$ 10,292

The amount of property and equipment under capital leases at December 31 is as follows:

In millions	**2018**	**2017**
Property and equipment under capital leases	$ 582	$ 588
Accumulated amortization of property and equipment under capital leases	(163)	(140)
Property and equipment under capital leases, net	$ 419	$ 448

Depreciation expense (which includes the amortization of property and equipment under capital leases) totaled $1.7 billion in each of the years ended December 31, 2018 , 2017 and 2016 .

Goodwill

The Company accounts for business combinations using the acquisition method of accounting, which requires the excess cost of an acquisition over the fair value of net assets acquired and identifiable intangible assets to be recorded as goodwill. Goodwill is not amortized, but is subject to impairment reviews annually, or more frequently if necessary. When evaluating goodwill for potential impairment, the Company compares the fair value of its reporting units to their respective carrying amounts. The Company estimates the fair value of its reporting units using a combination of a discounted cash flow method and a market multiple method. If the carrying amount of a reporting unit exceeds its estimated fair value, an impairment loss is recognized in an amount equal to that excess. See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about goodwill and goodwill impairments.

Intangible Assets

The Company’s definite-lived intangible assets are amortized over their estimated useful-life based upon the pattern of future cash flows attributable to the asset. Other than value of business acquired (“VOBA”), definite-lived intangible assets are amortized using the straight-line method. VOBA is amortized over the expected life of the acquired contracts in proportion to estimated premiums. The Company groups and evaluates definite-lived intangible assets for impairment at the lowest level at which individual cash flows can be identified whenever events or changes in circumstances indicate that the carrying value of an asset may not be recoverable. If indicators of impairment are present, the Company first compares the carrying amount of the asset group to the estimated future cash flows associated with the asset group (undiscounted and without interest charges). If the estimated future cash flows used in this analysis are less than the carrying amount of the asset group, an impairment loss calculation is prepared. The impairment loss calculation compares the carrying amount of the asset group to the asset group’s estimated future cash flows (discounted and with interest charges). If required, an impairment loss is recorded for the portion of the asset group’s carrying value that exceeds the asset group’s estimated future cash flows (discounted and with interest charges). There were no material impairment losses recognized on definite-lived intangible assets in any of the three years ended December 31, 2018 , 2017 or 2016 .

Indefinitely-lived intangible assets are not amortized but are tested for impairment annually, or more frequently if necessary. Indefinitely-lived intangible assets are tested for impairment by comparing the estimated fair value of the asset to its carrying value. The Company estimates the fair value of its indefinitely-lived trademarks using the relief from royalty method under the income approach. If the carrying value of the asset exceeds its estimated fair value, an impairment loss is recognized, and the asset is written down to its estimated fair value. There were no impairment losses recognized on indefinitely-lived intangible assets in any of the three years ended December 31, 2018 , 2017 or 2016 .

See Note 5 ‘‘Goodwill and Other Intangibles’’ for additional information about intangible assets.

Separate Accounts

Separate Accounts assets and liabilities related to large case pensions products represent funds maintained to meet specific objectives of contract holders who bear the investment risk. These assets and liabilities are carried at fair value. Net investment income (including net realized capital gains and losses) accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals and net investment income (including net realized and net unrealized capital gains and losses) on Separate Accounts assets are not reflected in the consolidated statements of operations or cash flows. Management fees charged to contract holders are included in services revenue and recognized over the period earned.

Health Care Costs Payable

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements primarily related to the Health Care Benefits segment's Insured Commercial, Medicare and Medicaid products and accruals for state assessments. Unpaid health care claims include an estimate of payments the Company will make for (i) services rendered to the Company's Insured members but not yet reported to the Company and (ii) claims which have been reported to the Company but not yet paid, each as of the financial statement date (collectively, "IBNR"). Health care costs payable also include an estimate of the cost of services that will continue to be rendered after the financial statement date if the Company is obligated to pay for such services in accordance with contractual or regulatory requirements. Such estimates are developed using actuarial principles and assumptions which consider, among other things, historical and projected claim submission and processing patterns, assumed and historical medical cost trends, historical utilization of medical services, claim inventory levels, changes in Insured membership and product mix, seasonality and other relevant factors. The Company reflects changes in these estimates in benefit costs in the consolidated results of operations in the period they are determined. Capitation costs represent contractual monthly fees paid to participating physicians and other medical providers for providing medical care, regardless of the volume of medical services provided to the Insured member. Amounts due under risk-sharing arrangements are based on the terms of the underlying contracts with the providers and consider claims experience under the contracts through the financial statement date.

The Company develops its estimate of IBNR using actuarial principles and assumptions that consider numerous factors. Of those factors, the Company considers the analysis of historical and projected claim payment patterns (including claims submission and processing patterns) and the assumed health care cost trend rate (the year-over-year change in per member per month health care costs) to be the most critical assumptions. In developing its IBNR estimate, the Company consistently applies these actuarial principles and assumptions each period, with consideration to the variability of related factors. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR from the Aetna Acquisition Date through December 31, 2018 .

The Company analyzes historical claim payment patterns by comparing claim incurred dates (i.e., the date services were provided) to claim payment dates to estimate "completion factors." The Company uses completion factors predominantly to estimate the ultimate cost of claims incurred more than three months before the financial statement date. The Company estimates completion factors by aggregating claim data based on the month of service and month of claim payment and estimating the percentage of claims incurred for a given month that are complete by each month thereafter. For any given month, substantially all claims are paid within six months of the date of service, but it can take up to 48 months or longer after the date of service before all of the claims are completely resolved and paid. These historically-derived completion factors are then applied to claims paid through the financial statement date to estimate the ultimate claim cost for a given month's incurred claim activity. The difference between the estimated ultimate claim cost and the claims paid through the financial statement date represents the Company's estimate of claims remaining to be paid as of the financial statement date and is included in the Company's health care costs payable. The completion factors the Company uses reflect judgments and possible adjustments based on data such as claim inventory levels, claim submission and processing patterns and, to a lesser extent, other factors such as changes in health care cost trend rates, changes in Insured membership and changes in product mix. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claims may be more (less) complete than originally estimated using the Company's completion factors, which may result in reserves that are higher (lower) than the ultimate cost of claims.

Because claims incurred within three months before the financial statement date are less mature, the Company uses a combination of historically-derived completion factors and the assumed health care cost trend rate to estimate the ultimate cost of claims incurred for these months. The Company applies its actuarial judgment and places a greater emphasis on the assumed health care cost trend rate for the most recent claim incurred dates as these months may be influenced by seasonal patterns and changes in membership and product mix.

The Company's health care cost trend rate is affected by changes in per member utilization of medical services as well as changes in the unit cost of such services. Many factors influence the health care cost trend rate, including the Company's ability to manage benefit costs through product design, negotiation of favorable provider contracts and medical management programs, as well as the mix of the Company's business. The health status of the Company's Insured members, aging of the population and other demographic characteristics, advances in medical technology and other factors continue to contribute to rising per member utilization and unit costs. Changes in health care practices, inflation, new technologies, increases in the cost of prescription drugs (including specialty pharmacy drugs), direct-to-consumer marketing by pharmaceutical companies, clusters of high-cost cases, claim intensity, changes in the regulatory environment, health care provider or member fraud and numerous other factors also contribute to the cost of health care and the Company's health care cost trend rate.

For each reporting period, the Company uses an extensive degree of judgment in the process of estimating its health care costs payable. As a result, considerable variability and uncertainty is inherent in such estimates, particularly with respect to claims with claim incurred dates of three months or less before the financial statement date; and the adequacy of such estimates is highly sensitive to changes in assumed completion factors and the assumed health care cost trend rates. For each reporting period the Company recognizes the actuarial best estimate of health care costs payable considering the potential volatility in assumed completion factors and health care cost trend rates, as well as other factors. The Company believes its estimate of health care costs payable is reasonable and adequate to cover its obligations at December 31, 2018 ; however, actual claim payments may differ from the Company's estimates. A worsening (or improvement) of the Company's health care cost trend rates or changes in completion factors from those that the Company assumed in estimating health care costs payable at December 31, 2018 would cause these estimates to change in the near term, and such a change could be material.

Each quarter, the Company re-examines previously established health care costs payable estimates based on actual claim payments for prior periods and other changes in facts and circumstances. Given the extensive degree of judgment in this estimate, it is possible that the Company's estimates of health care costs payable could develop either favorably (that is, its actual benefit costs for the period were less than estimated) or unfavorably. The changes in the Company's estimate of health care costs payable may relate to a prior quarter, prior year or earlier periods. For a roll forward of the Company's health care costs payable, see Note 7 "Health Care Costs Payable." The Company's reserving practice is to consistently recognize the actuarial best estimate of its ultimate liability for health care costs payable.

Other Insurance Liabilities

Unpaid claims
Unpaid claims consist primarily of reserves associated with certain short-duration group disability and term life insurance contracts, including an estimate for IBNR as of the financial statement date. Reserves associated with certain short-duration group disability and term life insurance contracts are based upon the Company's estimate of the present value of future benefits, which is based on assumed investment yields and assumptions regarding mortality, morbidity and recoveries from the United States Social Security Administration. The Company develops its estimate of IBNR using actuarial principles and assumptions which consider, among other things, contractual requirements, claim incidence rates, claim recovery rates, seasonality and other relevant factors. The Company discounts certain claim liabilities related to group long-term disability and life insurance waiver of premium contracts. The discount rates generally reflect the Company's expected investment returns for the investments supporting all incurral years of these liabilities. The discount rates for retrospectively-rated contracts are set at contractually specified levels. The Company's estimates of unpaid claims are subject to change due to changes in the underlying experience of the insurance contracts, changes in investment yields or other factors, and these changes are recorded in current and future benefits in the consolidated statements of operations in the period they are determined. The Company estimates its reserve for claims IBNR for life products largely based on completion factors. The completion factors used are based on the Company's historical experience and reflect judgments and possible adjustments based on data such as claim inventory levels, claim payment patterns, changes in business volume and other factors. If claims are submitted or processed on a faster (slower) pace than historical periods, the actual claims may be more (less) complete than originally estimated using completion factors, which may result in reserves that are higher (lower) than required to cover future life benefit payments. There have been no significant changes to the methodologies or assumptions used to develop the Company's estimate of IBNR from the Aetna Acquisition Date through December 31, 2018 . As of December 31, 2018 , unpaid claims balances of $816 million and $1.9 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Substantially all life and disability insurance liabilities have been fully ceded to unrelated third parties through indemnity reinsurance agreements; however, the Company remains directly obligated to the policyholders.

Future policy benefits
Future policy benefits consist primarily of reserves for limited payment pension and annuity contracts, long-duration group life and long-term care insurance contracts. Reserves for limited payment pension and annuity contracts are computed using actuarial principles that consider, among other things, assumptions reflecting anticipated mortality, retirement, expense and interest rate experience. Such assumptions generally vary by plan, year of issue and policy duration. Assumed interest rates on such contracts ranged from 3.5% to 11.3% from the Aetna Acquisition Date through December 31, 2018 . The Company periodically reviews mortality assumptions against both industry standards and its experience. Reserves for long-duration long-term care contracts represent the Company's estimate of the present value of future benefits to be paid to or on behalf of policyholders less the present value of future net premiums. The assumed interest rate on such contracts was 5.1% from the Aetna Acquisition Date through December 31, 2018 . The Company's estimate of the present value of future benefits under such contracts is based upon mortality, morbidity and interest rate assumptions. As of December 31, 2018 , future policy benefits

balances of $536 million and $6.2 billion were recorded in other insurance liabilities and other long-term insurance liabilities, respectively.

Premium Deficiency Reserves

The Company evaluates its insurance contracts to determine if it is probable that a loss will be incurred. A premium deficiency loss is recognized when it is probable that expected future claims, including maintenance costs (for example, direct costs such as claim processing costs), will exceed existing reserves plus anticipated future premiums and reinsurance recoveries. Anticipated investment income is considered in the calculation of premium deficiency losses for short-duration contracts. For purposes of determining premium deficiency losses, contracts are grouped consistent with the Company's method of acquiring, servicing and measuring the profitability of such contracts. The Company established a premium deficiency reserve of $16 million as of December 31, 2018 related to Medicaid products in the Health Care Benefits segment.

Policyholders' Funds

Policyholders' funds consist primarily of reserves for pension and annuity investment contracts and customer funds associated with certain health contracts. Reserves for such contracts are equal to cumulative deposits less withdrawals and charges plus credited interest thereon, net of experience-rated adjustments. From the Aetna Acquisition Date through December 31, 2018 , interest rates for pension and annuity investment contracts ranged from 3.5% to 13.4% . Reserves for contracts subject to experience rating reflect the Company's rights as well as the rights of policyholders and plan participants. The Company also holds funds for health savings accounts ("HSAs") on behalf of members associated with high deductible health plans. These amounts are held to pay for qualified health care expenses incurred by these members. The HSA balances were approximately $2.1 billion at December 31, 2018 and are reflected in other current assets with a corresponding liability in policyholder funds.

Policyholders' Funds liabilities that are expected to be paid within twelve months from the balance sheet date are classified as current on the consolidated balance sheets. Policyholders' Funds liabilities that are expected to be paid greater than twelve months from the balance sheet date are included in other long-term liabilities on the consolidated balance sheets.

Self-Insurance Liabilities

The Company is self-insured for certain losses related to general liability, workers' compensation and auto liability. The Company obtains third party insurance coverage to limit exposure from these claims. The Company is also self-insured for certain losses related to health and medical liabilities. The Company's self-insurance accruals, which include reported claims and claims incurred but not reported, are calculated using standard insurance industry actuarial assumptions and the Company's historical claims experience. At December 31, 2018 and 2017 , self-insurance liabilities totaled $865 million and $696 million , respectively, and were recorded as accrued expenses on the consolidated balance sheets.

Facility Opening and Closing Costs

New facility opening costs, other than capital expenditures, are charged directly to expense when incurred. When the Company closes a facility, the present value of estimated unrecoverable costs, including the remaining lease obligation less estimated sublease income and the book value of abandoned property and equipment, are charged to expense.

In December 2016, the Company announced an enterprise streamlining initiative designed to reduce costs and enhance operating efficiencies to allow the Company to be more competitive in the current health care environment. During the year ended December 31, 2017 , in connection with that enterprise streamlining initiative, the Company closed 71 retail stores and recorded charges of $215 million within operating expenses in the Retail/LTC segment. The charges are primarily comprised of provisions for the present value of noncancelable lease obligations. The noncancelable lease obligations associated with stores closed during the year ended December 31, 2017 extend through the year 2039. During the year ended December 31, 2018 , the Company did not recognize any significant charges related to facility closing costs.

The long-term portion of the lease obligations associated with all outstanding facility closings was $269 million and $306 million as of December 31, 2018 and 2017 , respectively, and was recorded in other long-term liabilities on the consolidated balance sheets.

Contingent Consideration

In December 2015, the Company acquired the pharmacy and clinic businesses of Target for approximately $1.9 billion , plus contingent consideration of up to $60 million based on future prescription growth over a three year period through December 31, 2019. As of December 31, 2018, no liability for any potential contingent consideration has been recorded based on historical and projected prescription growth through 2019.

Redeemable Noncontrolling Interest

As a result of the acquisition of Omnicare, Inc. ("Omnicare") in 2015, the Company obtained a 73% ownership interest in a limited liability company ("LLC"). Due to the change in control in Omnicare, the noncontrolling member of the LLC had the contractual right to put its membership interest to the Company at fair value. Consequently, the noncontrolling interest in the LLC was recorded as a redeemable noncontrolling interest at fair value. During 2016, the noncontrolling member of the LLC exercised its option to sell its ownership interest and the Company purchased the noncontrolling interest in the LLC for approximately $39 million .

Below is a summary of the changes in redeemable noncontrolling interest for the year ended December 31, 2016 :

In millions		
Beginning balance	$	39
Net income attributable to noncontrolling interest		1
Distributions		(2)
Purchase of noncontrolling interest		(39)
Reclassification to capital surplus in connection with purchase of noncontrolling interest		1
Ending balance	$	—

Foreign Currency Translation and Transactions

For local currency functional currency, (i) assets and liabilities are translated at end-of-period exchange rates, (ii) revenues and expenses are translated at average exchange rates in effect during the period and (iii) equity is translated at historical exchange rates. The resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income (loss).

For U.S. dollar functional currency locations, foreign currency assets and liabilities are remeasured into U.S. dollars at end-of-period exchange rates, except for nonmonetary balance sheet accounts which are remeasured at historical exchange rates. Revenue and expense are remeasured at average exchange rates in effect during each period, except for those expenses related to the nonmonetary balance sheet amounts which are remeasured at historical exchange rates. Gains or losses from foreign currency remeasurement are included in income.

Gains and losses from foreign currency transactions and the effects of foreign currency remeasurements were not material in any of the periods presented.

Revenue Recognition

The following is a discussion of the Company's revenue recognition policies by segment under the new revenue recognition accounting standard. See "New accounting pronouncements recently adopted - Revenue from Contracts with Customers" below for further discussion regarding the adoption of the new revenue recognition accounting standard. The new revenue recognition accounting standard does not relate to contracts within the scope of *Accounting Standards Codification 944 Financial Services - Insurance* . As a result, the majority of revenues within the Health Care Benefits segment and certain revenues within the Pharmacy Services segment are not within the scope of the new accounting standard.

Pharmacy Services Segment
PSS sells prescription drugs directly through its mail service dispensing pharmacies and indirectly through the Company's retail pharmacy network. The Company's pharmacy benefit arrangements are accounted for in a manner consistent with a master supply arrangement as there are no contractual minimum volumes and each prescription is considered a separate purchasing decision and distinct performance obligation transferred at a point in time. PBM services performed in connection with each

prescription claim are considered part of a single performance obligation which culminates in the dispensing of prescription drugs.

The Company recognizes revenue using the gross method at the contract price negotiated with its clients when the Company has concluded it controls the prescription drug before it is transferred to the client plan members. The Company controls prescriptions dispensed indirectly through its retail pharmacy network because it has separate contractual arrangements with those pharmacies, has discretion in setting the price for the transaction and assumes primary responsibility for fulfilling the promise to provide prescription drugs to its client plan members while also performing the related PBM services.

Revenues include (i) the portion of the price the client pays directly to PSS, net of any discounts earned on brand name drugs or other discounts and refunds paid back to the client (see "Drug Discounts" and "Guarantees" below), (ii) the United States Centers for Medicare & Medicaid Services ("CMS") subsidized portion of prescription drugs dispensed to the Company's Silverscript PDP members, (iii) the price paid to PSS by client plan members for mail order prescriptions and the price paid to retail network pharmacies by client plan members for retail prescriptions ("Retail Co-Payments"), and (iv) claims based administrative fees for retail pharmacy network contracts. Sales taxes are not included in revenue.

The Company recognizes revenue when control of the prescription drugs is transferred to customers, in an amount that reflects the consideration the Company expects to be entitled to in exchange for those prescription drugs. The following revenue recognition policies have been established for PSS:

- Revenues generated from prescription drugs sold by mail service dispensing pharmacies are recognized when the prescription drug is delivered to the client plan member. At the time of delivery, the Company has performed substantially all of its performance obligations under its client contracts and does not experience a significant level of returns or reshipments.
- Revenues generated from prescription drugs sold by third party pharmacies in the Company's retail pharmacy network and associated administrative fees are recognized at the Company's point-of-sale, which is when the claim is adjudicated by the Company's online claims processing system and the Company has transferred control of the prescription drug and performed all of its performance obligations.

For contracts under which PSS acts as an agent or does not control the prescription drugs prior to transfer to the client, revenue is recognized using the net method.

Drug discounts

PSS records revenue net of manufacturers' rebates earned by its clients based on their plan members' utilization of brand-name formulary drugs. PSS estimates these rebates at period-end based on actual and estimated claims data and its estimates of the manufacturers' rebates earned by its clients. The estimates are based on the best available data at period-end and recent history for the various factors that can affect the amount of rebates due to the client. PSS adjusts its rebates payable to clients to the actual amounts paid when these rebates are paid or as significant events occur. Any cumulative effect of these adjustments is recorded against revenues as identified. Adjustments generally result from contract changes with clients or manufacturers that have retroactive rebate adjustments, differences between the estimated and actual product mix subject to rebates, or whether the brand name drug was included in the applicable formulary. The effect of adjustments between estimated and actual manufacturers' rebate amounts has not been material to the Company's results of operations or financial condition.

Guarantees

PSS also adjusts revenues for refunds owed to the client resulting from pricing guarantees and performance against defined service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's results of operations or financial condition.

Medicare Part D

PSS' revenues include insurance premiums earned by the PDP, which are determined based on the PDP's annual bid and related contractual arrangements with CMS. The insurance premiums include a beneficiary premium, which is the responsibility of the PDP member, and can be subsidized by CMS in the case of low-income members, and a direct premium paid by CMS. Premiums collected in advance are initially recorded within other insurance liabilities and are then recognized ratably as revenue over the period in which members are entitled to receive benefits.

PSS' revenues also include a risk-sharing feature of the Medicare Part D program design referred to as the risk corridor. The Company estimates variable consideration in the form of amounts payable to, or receivable from, CMS under the risk corridor,

and adjusts revenue based on calculations of additional subsidies to be received from or owed to CMS at the end of the reporting year.

In addition to Medicare Part D premiums, PSS receives additional payments each month from CMS related to catastrophic reinsurance, low-income cost sharing subsidies and coverage gap benefits. If the subsidies received differ from the amounts earned from actual prescriptions transferred, the difference is recorded in either accounts receivable, net or accrued expenses.

Retail/LTC Segment

Retail Pharmacy

The Company's retail drugstores recognize revenue at the time the customer takes possession of the merchandise. For pharmacy sales, each prescription claim is its own arrangement with the customer and is a performance obligation, separate and distinct from other prescription claims under other retail network arrangements. Revenues are adjusted for refunds owed to the third party payer for pricing guarantees and performance against defined value-based service and performance metrics. The inputs to these estimates are not subject to a high degree of subjectivity or volatility. The effect of adjustments between estimated and actual pricing and performance refund amounts has not been material to the Company's results of operations or financial condition.

Revenue from Company gift cards purchased by customers is deferred as a contract liability until goods or services are transferred. Any amounts not expected to be redeemed by customers (i.e., breakage) are recognized based on historical redemption patterns.

Customer returns are not material to the Company's results of operations or financial condition. Sales taxes are not included in revenue.

Loyalty Program

The Company's customer loyalty program, ExtraCare ®, is comprised of two components, ExtraSavings ™ and ExtraBucks ® Rewards. ExtraSavings are coupons that are recorded as a reduction of revenue when redeemed as the Company concluded that they do not represent a promise to the customer to deliver additional goods or services at the time of issuance because they are not tied to a specific transaction or spending level.

ExtraBucks Rewards are accumulated by customers based on their historical spending levels. Thus, the Company has determined that there is an additional performance obligation to those customers at the time of the initial transaction. The Company allocates the transaction price to the initial transaction and the ExtraBucks Rewards transaction based upon the relative standalone selling price, which considers historical redemption patterns for the rewards. Revenue allocated to ExtraBucks Rewards is recognized as those rewards are redeemed. At the end of each period, unredeemed rewards are reflected as a contract liability.

Long-term Care

Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration the Company expects to be entitled to in exchange for those goods or services. Each prescription claim represents a separate performance obligation of the Company, separate and distinct from other prescription claims under customer arrangements. A significant portion of the revenue from sales of pharmaceutical and medical products are reimbursed by the federal Medicare Part D program and, to a lesser extent, state Medicaid programs. The Company monitors its revenues and receivables from these reimbursement sources, as well as other third party insurance payors, and reduces revenue at the revenue recognition date to properly account for the variable consideration due to anticipated differences between billed and reimbursed amounts. Accordingly, the total revenues and receivables reported in the Company's consolidated financial statements are recorded at the amount expected to be ultimately received from these payors.

Patient co-payments associated with Medicare Part D, certain state Medicaid programs, Medicare Part B and certain third party payors are typically not collected at the time products are delivered or services are rendered, but are billed to the individuals as part of normal billing procedures and subject to normal accounts receivable collections procedures.

Walk-In Medical Clinics

For services provided by the Company's walk-in medical clinics, revenue recognition occurs for completed services provided to patients, with adjustments taken for third party payor contractual obligations and patient direct bill historical collection rates.

Health Care Benefits Segment

Premium Revenue

HCBS premiums are recognized as income in the month in which the enrollee is entitled to receive health care services. Premiums are reported net of an allowance for estimated terminations and uncollectible amounts. Additionally, premium revenue subject to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010's (as amended, collectively, the "ACA's") minimum medical loss ratio ("MLR") rebate requirements is recorded net of the estimated minimum MLR rebates for the current calendar year. Premiums related to unexpired contractual coverage periods (unearned premiums) are reported as other insurance liabilities on the consolidated balance sheets and recognized as revenue when earned.

Some of the Company's contracts allow for premiums to be adjusted to reflect actual experience or the relative health status of Insured members. Such adjustments are reasonably estimable at the outset of the contract, and adjustments to those estimates are made based on actual experience of the customer emerging under the contract and the terms of the underlying contract.

Services and Product Revenue

HCBS services and product revenue relates to contracts that can include various combinations of products, services, or series of services, which are generally capable of being distinct and accounted for as separate performance obligations. HCBS' services and product revenue consists of the following components:

- ASC fees are received in exchange for performing certain claim processing and member services for HCBS' ASC medical members. ASC fee revenue is recognized over the period the service is provided. Some of the administrative services contracts include guarantees with respect to certain functions, such as customer service response time, claim processing accuracy and claim processing turnaround time, as well as certain guarantees that a plan sponsor's benefit claim experience will fall within a certain range. With any of these guarantees, HCBS is financially at risk if the conditions of the arrangements are not met, although the maximum amount at risk is typically limited to a percentage of the fees otherwise payable to the Company by the customer involved. Each period HCBS estimates obligations under the terms of these guarantees and records its estimate as an offset to service revenues.
- Workers' compensation administrative services consist of fee-based managed care services. Workers' compensation administrative services revenue is recognized once the service is provided.
- Specialty and home delivery pharmacy product revenue is recognized when the prescription is delivered to an ASC member. Specialty and home delivery pharmacy product revenue reflects the price of the prescription on a gross basis (ASC member co-payments and plan sponsor reimbursements).

Accounting for Medicare Part D

HCBS offers Medicare Part D prescription drug insurance coverage under contracts with the CMS. HCBS' revenue recognition policy for Medicare Part D is consistent with the policy detailed in the " *Medicare Part D"* section of PSS' revenue recognition policy described above.

Disaggregation of Revenue
The following table disaggregates the Company's revenue by major source in each segment for the year ended December 31, 2018 :

In millions	Pharmacy Services	Retail/ LTC	Health Care Benefits	Corporate/ Other	Intersegment Eliminations	Consolidated Totals
Major goods/services lines:						
Pharmacy	$ 130,195	$ 64,179	$ 164	$ —	$ (29,693)	$ 164,845
Front Store	—	19,055	—	—	—	19,055
Premiums	3,361	—	4,819	4	—	8,184
Net investment income	13	—	45	602	—	660
Other	559	755	521	—	—	1,835
Total	$ 134,128	$ 83,989	$ 5,549	$ 606	$ (29,693)	$ 194,579

Pharmacy Services distribution channel:	
Mail choice (1)	$ 46,934
Pharmacy network (2)	83,261
Other	3,933
Total	$ 134,128

(1) Pharmacy Services mail choice is defined as claims filled at a Pharmacy Services mail facility, which includes specialty mail claims inclusive of Specialty Connect ® claims picked up at a CVS Pharmacy retail store, as well as prescriptions filled at the Company's retail pharmacies under the Maintenance Choice ® program, which permits eligible client plan members to fill their maintenance prescriptions through mail order delivery or at a CVS Pharmacy retail store for the same price as mail order.
(2) Pharmacy Services pharmacy network is defined as claims filled at retail and specialty retail pharmacies, including the Company's retail pharmacies and LTC pharmacies, but excluding Maintenance Choice activity, which is included within the mail choice category.

Contract Balances
Contract liabilities primarily represent the Company's obligation to transfer additional goods or services to a customer for which the Company has received consideration, for example ExtraBucks ® Rewards and unredeemed Company gift cards. The consideration received remains a contract liability until goods or services have been provided to the customer. In addition, the Company recognizes breakage on Company gift cards based on historical redemption patterns.

The following table provides information about receivables and contract liabilities from contracts with customers as of December 31:

In millions	2018	2017
Trade receivables (included in accounts receivable, net)	$ 6,896	$ 7,895
Contract liabilities (included in accrued expenses)	67	53

During the year ended December 31, 2018 , the contract liabilities balance includes increases related to customers' earnings in ExtraBucks Rewards or issuances of Company gift cards and decreases for revenues recognized during the period as a result of the redemption of ExtraBucks Rewards or Company gift cards and breakage of Company gift cards. Below is a summary of such changes:

In millions	
Balance at December 31, 2017	$ 53
Adoption of ASU 2014-09	17
Loyalty program earnings and gift card issuances	332
Redemption and breakage	(335)
Balance at December 31, 2018	$ 67

Cost of products sold

The Company accounts for cost of products sold as follows:

Pharmacy Services Segment
PSS' cost of products sold includes: (i) the cost of prescription drugs sold during the reporting period directly through its mail service dispensing pharmacies and indirectly through its retail pharmacy network, (ii) shipping and handling costs, and (iii) the operating costs of its mail service dispensing pharmacies and client service operations and related information technology support costs including depreciation and amortization. The cost of prescription drugs sold component of cost of products sold includes: (i) the cost of the prescription drugs purchased from manufacturers or distributors and shipped to members in clients' benefit plans from PSS' mail service dispensing pharmacies, net of any volume-related or other discounts (see "Vendor allowances and purchase discounts" below) and (ii) the cost of prescription drugs sold (including Retail Co-Payments) through PSS' retail pharmacy network under contracts where it is the principal, net of any volume-related or other discounts.

Retail/LTC Segment
RLS' cost of products sold includes: the cost of merchandise sold during the reporting period, including prescription drug costs, and the related purchasing costs, warehousing and delivery costs (including depreciation and amortization) and actual and estimated inventory losses.

Health Care Benefits Segment
HCBS' cost of products sold includes the cost of the prescription and certain administrative costs incurred for dispensing the prescription to ASC members by HCBS' specialty and home delivery pharmacy operations.

See Note 17 ''Segment Reporting'' for additional information about the cost of products sold of the Company's segments.

Vendor allowances and purchase discounts

The Company accounts for vendor allowances and purchase discounts as follows:

Pharmacy Services Segment
PSS receives purchase discounts on products purchased. PSS' contractual arrangements with vendors, including manufacturers, wholesalers and retail pharmacies, normally provide for PSS to receive purchase discounts from established list prices in one, or a combination, of the following forms: (i) a direct discount at the time of purchase, (ii) a discount for the prompt payment of invoices, or (iii) when products are purchased indirectly from a manufacturer (e.g., through a wholesaler or retail pharmacy), a discount (or rebate) paid subsequent to dispensing. These rebates are recognized when prescriptions are dispensed and are generally calculated and billed to manufacturers within 30 days after the end of each completed quarter. Historically, the effect of adjustments resulting from the reconciliation of rebates recognized to the amounts billed and collected has not been material to PSS' results of operations. PSS accounts for the effect of any such differences as a change in accounting estimate in the period the reconciliation is completed. PSS also receives additional discounts under its wholesaler contracts if it exceeds contractually defined annual purchase volumes. In addition, PSS receives fees from pharmaceutical manufacturers for administrative services. Purchase discounts and administrative service fees are recorded as a reduction of "cost of products sold".

Retail/LTC Segment
Vendor allowances received by RLS reduce the carrying cost of inventory and are recognized in cost of products sold when the related inventory is sold, unless they are specifically identified as a reimbursement of incremental costs for promotional programs and/or other services provided. Amounts that are directly linked to advertising commitments are recognized as a reduction of advertising expense (included in operating expenses) when the related advertising commitment is satisfied. Any such allowances received in excess of the actual cost incurred also reduce the carrying cost of inventory. The total value of any upfront payments received from vendors that are linked to purchase commitments is initially deferred. The deferred amounts are then amortized to reduce cost of products sold over the life of the contract based upon purchase volume. The total value of any upfront payments received from vendors that are not linked to purchase commitments also is initially deferred. The deferred amounts are then amortized to reduce cost of products sold on a straight-line basis over the life of the related contract. The total amortization of these upfront payments was not material to the Company's consolidated financial statements in any of the periods presented.

Health Care Reform

Health Insurer Fee
Since January 1, 2014, the ACA imposes an annual premium-based health insurer fee ("HIF") for each calendar year payable in September which is not deductible for tax purposes. The Company is required to estimate a liability for the HIF at the beginning of the calendar year in which the fee is payable with a corresponding deferred asset that is amortized ratably to operating expenses over the calendar year. The Company records the liability for the health insurer fee in accrued expenses and records the deferred asset in other current assets. In 2018 and 2016, operating expenses include $157 million and $56 million , respectively, related to the Company's share of the HIF. There was no expense related to the HIF in 2017 and there will be no expense for HIF in 2019, since the HIF was suspended for each of those periods.

Risk Adjustment
The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable (recorded in accounts receivable) or payable (recorded in accrued expenses) for the current calendar year and reflects the pro-rata year-to-date impact as an adjustment to premium revenue.

Advertising costs

Advertising costs are expensed when the related advertising takes place. Advertising costs, net of vendor funding (included in operating expenses), were $364 million , $230 million and $216 million in 2018 , 2017 and 2016 , respectively.

Stock-based compensation

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as an expense over the applicable requisite service period of the stock award (generally 3 to 5 years) using the straight-line method.

Income taxes

The Company accounts for income taxes under the asset and liability method, which requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been included in the consolidated financial statements. Under this method, deferred tax assets and liabilities are determined on the basis of the differences between the consolidated financial statements and tax basis of assets and liabilities using enacted tax rates in effect for the year or years in which the differences are expected to reverse. The effect of a change in the tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date of such change.

The Tax Cuts and Jobs Act (the "TCJA") was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion for year ended December 31, 2017. The Company completed its assessment of the TCJA's final impact in December 2018 and recorded an additional tax benefit of approximately $100 million in the year ended December 31, 2018.

The Company recognizes deferred tax assets to the extent that it believes these assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies, and recent results of operations. The Company establishes a valuation allowance when it does not consider it more likely than not that a deferred tax asset will be recovered.

The Company records uncertain tax positions on the basis of a two-step process whereby (1) the Company determines whether it is more likely than not that the tax positions will be sustained on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes the largest amount of tax benefit that is more than 50% likely to be realized upon ultimate settlement with the related tax authority.

Interest and/or penalties related to uncertain tax positions are recognized in the income tax provision.

Measurement of Defined Benefit Pension and Other Postretirement Employee Benefit ("OPEB") Plans

The Company sponsors defined benefit pension plans ("pension plans") and OPEB plans for its employees and retirees. The Company recognizes the funded status of its pension plans and OPEB plans on the consolidated balance sheets based on the year-end measurements of plan assets and benefit obligations. When the fair value of plan assets are in excess of the plans benefit obligations, the amounts are reported in other current assets and other assets. When the fair value of benefit obligations are in excess of plan assets, the amounts are reported in accrued expenses and other long-term liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets. Nearly all of the Company's net benefit costs for the Company's defined benefit pension and postretirement plans do not contain a service cost component as most of these defined benefit plans have been frozen for an extended period of time. Non-service components of pension and postretirement benefit cost are included in other expense (income) in the consolidated statements of operations.

Earnings per common share

Earnings per share is computed using the two-class method. The Company calculates basic earnings per share based on the weighted average number of common shares outstanding for the period. See Note 14 ''Earnings Per Share'' for additional information.

Shares held in trust

The Company maintains grantor trusts, which held approximately one million shares of its common stock at December 31, 2018 and 2017 , respectively. These shares are designated for use under various employee compensation plans. Since the Company holds these shares, they are excluded from the computation of basic and diluted shares outstanding.

Variable Interest Entities

The Company has investments in (i) a generic pharmaceutical sourcing entity, (ii) certain hedge fund and private equity investments and (iii) real estate partnerships that are considered VIE's. The Company does not have a future obligation to fund losses or debts on behalf of these investments; however, it may voluntarily contribute funds. In evaluating whether the Company is the primary beneficiary of a VIE, the Company considers several factors, including whether the Company has (a) the power to direct the activities that most significantly impact the VIE's economic performance and (b) the obligation to absorb losses and the right to receive benefits that could potentially be significant to the VIE.

Variable Interest Entities - Primary Beneficiary
In 2014, the Company and Cardinal Health, Inc. ("Cardinal") established Red Oak Sourcing, LLC ("Red Oak"), a generic pharmaceutical sourcing entity in which the Company and Cardinal each own 50% . The Red Oak arrangement has an initial term of 10 years. Under this arrangement, the Company and Cardinal contributed their sourcing and supply chain expertise to Red Oak and agreed to source and negotiate generic pharmaceutical supply contracts for both companies through Red Oak; however, Red Oak does not own or hold inventory on behalf of either company. No physical assets (e.g., property and equipment) were contributed to Red Oak by either company, and minimal funding was provided to capitalize Red Oak. The Company has determined that it is the primary beneficiary of this VIE because it has the ability to direct the activities of Red Oak. Consequently, the Company consolidates Red Oak in its consolidated financial statements within the Retail/LTC segment.

Cardinal is required to pay the Company 39 quarterly payments beginning in October 2014. As milestones are met, the quarterly payments increase. The Company received from Cardinal approximately $183 million during each of the years ended December 31, 2018 and 2017 and $163 million during the year ended December 31, 2016 . The payments reduce the Company's carrying value of inventory and are recognized in cost of products sold when the related inventory is sold. Revenues associated with Red Oak expenses reimbursed by Cardinal for the years ended December 31, 2018 , 2017 and 2016 , as well as amounts due to or due from Cardinal at December 31, 2018 and 2017 were immaterial.

Variable Interest Entities - Other Variable Interest Holder
In November 2018, the Company completed the Aetna Acquisition. Aetna has involvement with VIEs where the Company has determined that it is not the primary beneficiary, consisting of the following:

- *Hedge fund and private equity investments* - The Company invests in hedge fund and private equity investments in order to generate investment returns for its investment portfolio supporting its insurance businesses.

- *Real estate partnerships* - The Company invests in various real estate partnerships, including those that construct, own and manage low-income housing developments. For the low income housing development investments, substantially all of the projected benefits to the Company are from tax credits and other tax benefits.

The Company is not the primary beneficiary of these investments because the nature of the Company's involvement with the activities of these VIEs does not give the Company the power to direct the activities that most significantly impact their economic performance. The Company records the amount of its investment in these VIEs as long-term investments on the consolidated balance sheet and recognizes its share of each VIE's income or losses in earnings. The Company's maximum exposure to loss from these VIEs is limited to its investment balances as disclosed below and the risk of recapture of previously recognized tax credits related to the real estate partnerships, which the Company does not consider significant.

The total amount of other variable interest holder VIE assets included in long-term investments on the consolidated balance sheet at December 31, 2018 was as follows:

In millions		
Hedge fund investments	$	270
Private equity investments		524
Real estate partnerships		275
Total	$	1,069

Related Party Transactions

The Company has an equity method investment in SureScripts, LLC ("SureScripts"), which operates a clinical health information network. PSS and RLS utilize this clinical health information network in providing services to their respective client plan members and retail customers. The Company expensed fees for the use of this network of approximately $45 million , $35 million and $39 million in the years ended December 31, 2018 , 2017 and 2016 , respectively. The Company's investment in and equity in the earnings of SureScripts for all periods presented is immaterial.

The Company has an equity method investment in Heartland Healthcare Services ("Heartland"). Heartland operates several LTC pharmacies in four states. Heartland paid the Company approximately $135 million , $139 million and $140 million for pharmaceutical inventory purchases during the years ended December 31, 2018 , 2017 and 2016 , respectively. Additionally, the Company performs certain collection functions for Heartland and then passes those customer cash collections back to Heartland. The Company's investment in and equity in the earnings of Heartland for all periods presented is immaterial.

Discontinued Operations

In connection with certain business dispositions completed between 1991 and 1997, the Company retained guarantees on store lease obligations for a number of former subsidiaries, including Bob's Stores and Linens 'n Things each of which subsequently filed for bankruptcy. The Company's loss from discontinued operations primarily includes lease-related costs which the Company believes it will likely be required to satisfy pursuant to its lease guarantees. See "Lease Guarantees" in Note 16 ''Commitments and Contingencies'' for more information.

Results from discontinued operations were immaterial for the year ended December 31, 2018. Below is a summary of the results of discontinued operations for the years ended December 31 , 2017 and 2016:

In millions		**2017**		**2016**
Loss from discontinued operations	$	(13)	$	(2)
Income tax benefit		5		1
Loss from discontinued operations, net of tax	$	(8)	$	(1)

New accounting pronouncements recently adopted

Revenue from Contracts with Customers
In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers* (Topic 606) ("Topic 606"). ASU 2014-09 outlines a single comprehensive model for

companies to use in accounting for revenue arising from contracts with customers and supersedes most current revenue recognition guidance, including industry-specific guidance. In March 2016, the FASB issued ASU 2016-08, *Principal Versus Agent Considerations (Reporting* Revenue *Gross Versus Net)* which amends the principal-versus-agent implementation guidance and in April 2016 the FASB issued ASU 2016-10, *Identifying Performance Obligations and Licensing,* which amends the guidance in those areas in the new revenue recognition standard.

The Company adopted the new standard as of January 1, 2018 using the modified retrospective method and applied the new standard to all contracts. Therefore, the comparative financial information has not been restated and continues to be reported under the accounting standards in effect for the applicable period. While the adoption of the new standard did not result in any material adjustments to the Company's revenue or net income, one difference was identified between the previous accounting guidance and the new accounting guidance in RLS related to the accounting for the Company's ExtraBucks ® Rewards customer loyalty program. This program was previously accounted for under a cost deferral method, while under the new standard this program is accounted for under a revenue deferral method. The cumulative effect of applying the new guidance to all contracts was recorded as an adjustment to retained earnings as of the adoption date.

As a result of applying the modified retrospective method to adopt the new standard, the following adjustments were made to accounts on the consolidated balance sheet as of January 1, 2018:

	Impact of Change in Accounting Policy		
	As Reported		**Adjusted**
In millions	**December 31, 2017**	**Adjustments**	**January 1, 2018**
Consolidated Balance Sheet:			
Accrued expenses	$ 6,581	$ 17	$ 6,598
Deferred income taxes	2,996	(4)	2,992
Total liabilities	57,436	13	57,449
Retained earnings	43,556	(13)	43,543
Total CVS Health shareholders' equity	37,691	(13)	37,678
Total shareholders' equity	37,695	(13)	37,682

The following tables compare the reported consolidated balance sheet, statements of operations, and statement of cash flows amounts to the pro forma amounts had the previous revenue accounting guidance remained in effect:

		Impact of Change in Accounting Policy	
In millions	**As Reported As of/For the Year Ended December 31, 2018**	**Adjustments**	**Balances Without Adoption of Topic 606**
Consolidated Statement of Operations:			
Revenues:			
Products	$ 183,910	$ 3	$ 183,913
Total revenues	194,579	3	194,582
Operating costs:			
Cost of products sold	156,447	2	156,449
Total operating costs	190,558	2	190,560
Operating income	4,021	1	4,022
Income before income tax provision	1,406	1	1,407
Income tax provision	2,002	—	2,002
Loss from continuing operations	(596)	1	(595)
Net loss	(596)	1	(595)
Net loss attributable to CVS Health	(594)	1	(593)
Consolidated Balance Sheet:			
Accrued expenses	10,711	(18)	10,693
Total current liabilities	44,009	(18)	43,991
Deferred income taxes	7,677	4	7,681
Total liabilities	137,913	(14)	137,899
Retained earnings	40,911	14	40,925
Total CVS Health shareholders' equity	58,225	14	58,239
Total shareholders' equity	58,543	14	58,557
Consolidated Statement of Cash Flow:			
Reconciliation of net loss to net cash provided by operating activities:			
Net loss	(596)	1	(595)
Other liabilities	165	(1)	164

Recognition and Measurement of Financial Assets and Financial Liabilities
In January 2016, the FASB issued ASU 2016-01, *Financial Instruments - Overall* (Subtopic 825-10): *Recognition and Measurement of Financial Assets and Financial Liabilities* . This ASU requires equity investments, except those under the equity method of accounting or those that result in the consolidation of an investee, to be measured at fair value with changes in fair value recognized in net income. However, an entity may choose to measure equity investments that do not have readily determinable fair values at cost minus impairment, if any, plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issuer. This simplifies the impairment assessment of equity investments previously held at cost. Entities are required to apply the guidance retrospectively, with the exception of the amendments related to equity investments without readily determinable fair values, which must be applied on a prospective basis. Effective January 1, 2018, the Company adopted this new accounting guidance. The adoption of this new guidance did not have a material impact on the Company's financial condition or results of operations.

Classification of Certain Cash Receipts and Cash Payments in the Consolidated Statements of Cash Flows
In August 2016, the FASB issued ASU 2016-15, *Classification of Certain Cash Receipts and Cash Payments* . This ASU is intended to add or clarify guidance on the classification of certain cash receipts and payments in the statement of cash flows and

to eliminate the diversity in practice related to such classifications. Effective January 1, 2018, the Company adopted this new accounting guidance. The adoption of this new guidance did not have a material impact on the Company's financial condition or results of operations.

Statement of Cash Flows - Restricted Cash
In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows* , which amends Accounting Standard Codification Topic 230. This ASU requires entities to show the changes in the total of cash, cash equivalents, restricted cash and restricted cash equivalents in the statement of cash flows. As a result, entities no longer are required to present transfers between cash and cash equivalents and restricted cash and restricted cash equivalents in the statement of cash flows. When cash, cash equivalents, restricted cash and restricted cash equivalents are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Entities will also have to disclose the nature of their restricted cash and restricted cash equivalent balances. The guidance is required to be applied retrospectively. Effective January 1, 2018, the Company adopted this new accounting guidance.

The following is a reconciliation of cash and cash equivalents on the consolidated balance sheets as of December 31 to total cash, cash equivalents and restricted cash in the consolidated statements of cash flows:

In millions	**2018**	**2017**	**2016**
Cash and cash equivalents	$ 4,059	$ 1,696	$ 3,371
Restricted cash (included in other current assets)	6	14	—
Restricted cash (included in other assets)	230	190	149
Total cash, cash equivalents and restricted cash at the end of the period in the statement of cash flows	$ 4,295	$ 1,900	$ 3,520

See "Restricted cash" above for further discussion of the nature of the Company's restricted cash and restricted cash equivalent balances.

The following is a reconciliation of the effect on the relevant line items in the consolidated statement of cash flows for the years ended December 31, 2017 and 2016 as a result of adopting this new accounting guidance:

In millions	**As Previously Reported**	**Adjustments**	**As Revised**
Year Ended December 31, 2017			
Acquisitions (net of cash acquired)	$ (1,236)	$ 55	$ (1,181)
Net cash used in investing activities	(2,932)	55	(2,877)
Net decrease in cash, cash equivalents and restricted cash [1]	(1,675)	55	(1,620)
Cash, cash equivalents and restricted cash at the beginning of the period [1]	3,371	149	3,520
Cash, cash equivalents and restricted cash at the end of the period [1]	1,696	204	1,900
Year Ended December 31, 2016			
Acquisitions (net of cash acquired)	(524)	—	(524)
Net cash used in investing activities	(2,470)	—	(2,470)
Net decrease in cash, cash equivalents and restricted cash [1]	912	—	912
Cash, cash equivalents and restricted cash at the beginning of the period [1]	2,459	149	2,608
Cash, cash equivalents and restricted cash at the end of the period [1]	3,371	149	3,520

(1) Prior to the adoption of ASU 2016-18, these financial statement captions excluded restricted cash. The financial statement captions have been renamed to reflect the inclusion of restricted cash subsequent to the adoption of ASU 2016-18 on January 1, 2018.

Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income
In February 2018, the FASB issued ASU 2018-02, *Income Statement - Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income ("ASU 2018-02")* . This ASU permits entities to reclassify tax effects stranded in accumulated other comprehensive income as a result of the TCJA to retained

earnings. The guidance states that because the adjustment of deferred income taxes due to the reduction of the historical corporate income tax rate to the newly enacted corporate income tax rate was required to be included in income from continuing operations, the tax effects of items within accumulated other comprehensive income ("stranded tax effects") are not reflected at the appropriate tax rate. During the first quarter of 2018, the Company elected to early adopt this new standard and decreased accumulated other comprehensive income and increased retained earnings in the period of adoption by $7 million due to the change in the United States federal corporate income tax rate enacted in December 2017. See Note 13 ''Other Comprehensive Income (Loss)'' for the impact of the adoption of this guidance on accumulated other comprehensive income for the year ended December 31, 2018 .

New accounting pronouncements not yet adopted

Leases
In February 2016, the FASB issued ASU 2016-02, *Leases* (Topic 842). Lessees will be required to recognize a right-of-use asset and a lease liability for virtually all of their leases (other than leases that meet the definition of a short-term lease). The liability will be equal to the present value of future lease payments. The asset will be based on the liability, subject to adjustment, such as for initial direct costs. For income statement purposes, a dual model was retained, requiring leases to be classified as either operating or finance leases. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). Lessor accounting is similar to the current model, but updated to align with certain changes to the lessee model (e.g., certain definitions, such as initial direct costs, have been updated) and the new revenue recognition standard. The Company adopted this new accounting guidance on January 1, 2019 on a modified retrospective basis. The adoption of this new guidance resulted in an increase in both assets and liabilities of approximately $20 billion as of January 1, 2019. The adoption of this new guidance is not expected to have a material impact on the Company's results of operations or cash flows.

Accounting for Interest Associated with the Purchase of Callable Debt Securities
In March 2017, the FASB issued ASU 2017-08, *Accounting for Interest Associated with the Purchase of Callable Debt Securities (* Topic 310 *).* Under this ASU, premiums on callable debt securities are amortized to the earliest call date rather than to the contractual maturity date. Callable debt securities held at a discount will continue to be amortized to the contractual maturity date. The Company adopted this new accounting guidance on January 1, 2019 on a modified retrospective basis and recorded an immaterial cumulative effect adjustment from accumulated other comprehensive income to retained earnings on the consolidated balance sheet.

Measurement of Credit Losses on Financial Instruments
In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses* (Topic 326). This ASU requires the use of a forward-looking expected loss impairment model for trade and other receivables, held-to-maturity debt securities, loans and other instruments. The ASU also requires impairments and recoveries for available-for-sale debt securities to be recorded through an allowance account and revises certain disclosure requirements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. The Company is currently evaluating the effect that implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract
In August 2018, the FASB issued ASU 2018-15, *Intangibles - Goodwill and other - Internal-Use Software* (Topic 350-40): *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract.* The new standard requires a customer in a cloud computing arrangement that is a service contract to follow internal-use software guidance in Topic 350-40 to determine which implementation costs to capitalize as assets. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. Early adoption is permitted. The Company is currently evaluating the effect the implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

Targeted Improvements to the Accounting for Long-Duration Insurance Contracts
In August 2018, the FASB issued ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Insurance Contracts* (Topic 944). The ASU requires the Company to review cash flow assumptions for its long-duration insurance contracts at least annually and recognize the effect of changes in future cash flow assumptions in net income. The Company is also required to update discount rate assumptions quarterly and recognize the effect of changes in these assumptions in other comprehensive income. The rate used to discount the Company's liability for future policy benefits will be based on an estimate of the yield for an upper-medium-grade fixed-income instrument. In addition, the new guidance changes the amortization method for deferred acquisition costs and requires additional disclosures regarding the long duration insurance contract

liabilities in the Company's interim and annual financial statements. The standard is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2020. The Company is currently evaluating the effect the implementation of this standard will have on the Company's consolidated results of operations, cash flows, financial condition and related disclosures.

2. Acquisition of Aetna

On the Aetna Acquisition Date, the Company acquired 100% of the outstanding shares and voting interests of Aetna for a combination of cash and stock. Under the terms of the merger agreement, Aetna shareholders received $145.00 in cash and 0.8378 CVS Health shares for each Aetna share. The transaction valued Aetna at approximately $212 per share or approximately $70 billion . Including the assumption of Aetna's debt, the total value of the transaction was approximately $78 billion . The Company financed the cash portion of the purchase price through a combination of cash on hand and by issuing approximately $45 billion of new debt, including senior notes and term loans. Aetna is a leading health care benefits company that offers a broad range of traditional, voluntary, and consumer-directed health insurance products and related services. The majority of Aetna's operations are included in a new segment, Health Care Benefits. The Health Care Benefits segment is the equivalent of the former Aetna Health Care Segment. The remainder of Aetna's operations, including products for which the Company no longer solicits or accepts new customers, such as large case pensions and long-term care insurance products, are included in the Corporate/Other segment. The Company acquired Aetna to help improve the consumer health care experience by combining Aetna's health care benefits products and services with CVS Health's more than 9,900 retail locations, approximately 1,100 walk-in medical clinics and integrated pharmacy capabilities with the goal of becoming the new, trusted front door to health care.

The fair value of the consideration transferred on the date of acquisition consisted of the following:

In millions		
Cash	$	48,089
Common stock (274.4 million shares) [(1)]		22,117
Fair value of replacement equity awards for pre-combination services (9.9 million shares) [(2)]		367
Effective settlement of pre-existing relationship [(3)]		(807)
Total consideration transferred	$	69,766

(1) The fair value of the Company's common stock issued as consideration was calculated based on the 327.6 million Aetna common shares outstanding as of November 28, 2018 multiplied by (i) the merger agreement per share exchange ratio and (ii) the volume weighted average price of CVS Health common stock on November 28, 2018 of $80.59 .

(2) The fair value of the replacement equity awards issued by the Company was determined as of the Aetna Acquisition Date. The fair value of the awards attributed to pre-combination services of $367 million is included in the consideration transferred and the fair value of the awards attributed to post-combination services of $232 million has been, or will be, included in the Company's post-combination financial statements as compensation costs.

(3) The purchase price included $807 million of effectively settled liabilities the Company owed to Aetna from their pre-existing pharmacy services relationship.

The transaction has been accounted for using the acquisition method of accounting which requires, among other things, the assets acquired and liabilities assumed to be recognized at their fair values at the date of acquisition. The following table summarizes the estimated fair values of the assets acquired and liabilities assumed at the date of acquisition:

In millions	
Cash and cash equivalents	$ 6,565
Accounts receivable [1]	4,089
Other current assets	3,896
Investments (current and long-term)	17,991
Goodwill	46,684
Intangible assets	23,746
Other long-term assets	8,282
Total assets acquired	111,253
Health care costs payable	5,359
Other current liabilities	10,026
Debt (current and long-term)	8,098
Deferred income taxes	4,574
Other long-term liabilities	13,101
Total liabilities assumed	41,158
Noncontrolling interests	329
Total consideration transferred	$ 69,766

(1) The fair value of premium receivables acquired is $2.4 billion , with the gross contractual amount being $2.8 billion . The Company expects $424 million of premium receivables to be uncollectible. The fair value of other receivables acquired is $1.7 billion , with the gross contractual amount being $1.8 billion . The Company expects $84 million of other receivables to be uncollectible.

The assessment of fair value is preliminary and is based on information that was available to management at the time the consolidated financial statements were prepared. The most significant open items included the valuation of certain intangible assets and investments, the accounting for income taxes and the accounting for contingencies as management is awaiting additional information to complete its assessment of these matters. Measurement period adjustments will be recorded in the period in which they are determined, as if they had been completed at the acquisition date. The finalization of the Company's purchase accounting assessment could result in changes in the valuation of assets acquired and liabilities assumed, which could be material.

Goodwill

Goodwill represents future economic benefits expected to arise from the Company's expanded presence in the health care industry, the assembled workforce acquired, expected purchasing, medical cost and revenue synergies, as well as operating efficiencies and cost savings. The preliminarily valuation of goodwill was allocated to the Company's business segments as follows:

In millions	
Health Care Benefits	$ 44,484
Pharmacy Services	1,500
Retail/LTC	700
Total goodwill	$ 46,684

Approximately $165 million of goodwill is deductible for income tax purposes.

Intangible Assets
The following table summarizes the preliminary fair values and weighted average useful lives for intangible assets acquired in the Aetna Acquisition, each of which is subject to change as the Company finalizes its purchase accounting:

In millions, except weighted average useful life		**Gross Fair Value**	**Weighted Average Useful Life (years)**
Customer relationships [1]	$	13,630	14.4
Standalone Medicare Part D prescription drug plan customer relationship (held for sale)		101	N/A
Technology		1,060	3.0
Provider networks [1]		4,200	20.0
Value of Business Acquired		590	20.0
Trademark (definite-lived)		65	5.0
Trademark (indefinitely-lived)		4,100	N/A
Total intangible assets	$	23,746	15.1

(1) The amortization period for the Company's customer relationships and provider networks includes an assumption of renewal or extension of these arrangements. At the acquisition date, the periods prior to the next renewal or extension for provider networks primarily ranged from one to three years, and the period prior to the next renewal or extension for customer relationships was one year. Any costs related to the renewal or extension of these contracts are expensed as incurred.

Deferred income taxes
The purchase price allocation includes net deferred tax liabilities of $4.6 billion , primarily relating to deferred tax liabilities established on the identifiable acquired intangible assets.

Consolidated results of operations
The Company's consolidated results of operations for the year ended December 31, 2018 , include $5.6 billion of revenues and $146 million of income before income tax provision associated with the results of operations of Aetna from the Aetna Acquisition Date to December 31, 2018 .

During the year ended December 31, 2018 and 2017 , the Company incurred transaction costs of $147 million and $34 million , respectively, associated with the Aetna Acquisition that were recorded within operating expenses.

Unaudited pro forma financial information
The following unaudited pro forma information presents a summary of the Company's combined results of operations for the years ended December 31, 2018 and 2017 as if the Aetna acquisition and the related financing transactions had occurred on January 1, 2017 . The following pro forma financial information is not necessarily indicative of the results of operations as they would have been had the acquisition been effected on the assumed date, nor is it necessarily an indication of trends in future results for a number of reasons, including, but not limited to, differences between the assumptions used to prepare the pro forma information, basic shares outstanding and dilutive equivalents, cost savings from operating efficiencies, potential synergies, and the impact of incremental costs incurred in integrating the businesses.

	Year Ended December 31,			
In millions, except per share data		**2018**		**2017**
Total revenues	$	243,398	$	236,000
Income from continuing operations		1,123		6,813
Basic earnings per share from continuing operations attributable to CVS Health	$	0.87	$	5.25
Diluted earnings per share from continuing operations attributable to CVS Health	$	0.86	$	5.21

The pro forma results for the years ended December 31, 2018 and 2017 include adjustments related to the following purchase accounting and acquisition-related items:

- Elimination of intercompany transactions between CVS Health and Aetna;

- Elimination of estimated foregone interest income associated with (i) cash assumed to have been used to partially fund the Aetna Acquisition and (ii) adjusting the amortized cost of Aetna's investment portfolio to fair value as of the completion of the Aetna Acquisition;
- Elimination of historical intangible asset, deferred acquisition cost and capitalized software amortization expense and addition of amortization expense based on the current preliminary values of identified intangible assets;
- Additional interest expense from (i) the long-term debt issued to partially fund the Aetna Acquisition and (ii) the amortization of the fair value adjustment to assumed long-term debt.
- Additional depreciation expense related to the adjustment of Aetna's property and equipment to fair value;
- Adjustments to align CVS Health's and Aetna's accounting policies;
- Elimination of transaction related costs; and
- Tax effects of the adjustments noted above.

3. Investments

On November 28, 2018, the Company completed the Aetna Acquisition. Prior to the Aetna Acquisition Date, the Company's short term investments balance was comprised of certificates of deposit with initial maturities of greater than three months when purchased that mature in less than one year from the balance sheet date. These investments totaled $111 million as of December 31, 2017 and were classified as available for sale. In addition, the Company had $112 million of additional long-term investments as of December 31, 2017 which primarily consisted of cost method and equity method investments. Since the total amount of investments prior to the Aetna Acquisition was not material to the consolidated financial statements, the Company will include additional disclosures for investments on a prospective basis starting from the Aetna Acquisition Date.

Total investments at December 31, 2018 were as follows:

In millions	Current	Long-term	Total
Debt securities available for sale	$ 2,359	$ 12,896	$ 15,255
Mortgage loans	145	1,216	1,361
Other investments	18	1,620	1,638
Total investments	$ 2,522	$ 15,732	$ 18,254

At December 31, 2018 , the Company held investments of $531 million related to the 2012 conversion of an existing group annuity contract from a participating to a non-participating contract. The conversion occurred prior to the Aetna Acquisition. These investments are included in the total investments of large case pensions supporting non-experience-rated products. Although these investments are not accounted for as Separate Accounts assets, they are legally segregated and are not subject to claims that arise out of the Company's business and only support future policy benefits obligations under that group annuity contract.

Debt Securities

Debt securities available for sale at December 31, 2018 were as follows:

In millions	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
December 31, 2018				
Debt securities:				
U.S. government securities	$ 1,662	$ 26	$ —	$ 1,688
States, municipalities and political subdivisions	2,370	30	(1)	2,399
U.S. corporate securities	6,444	61	(16)	6,489
Foreign securities	2,355	31	(3)	2,383
Residential mortgage-backed securities	567	10	—	577
Commercial mortgage-backed securities	594	11	—	605
Other asset-backed securities	1,097	3	(15)	1,085
Redeemable preferred securities	30	—	(1)	29
Total debt securities [1]	$ 15,119	$ 172	$ (36)	$ 15,255

(1) Investment risks associated with the Company's experience-rated products generally do not impact the Company's consolidated results of operations. At December 31, 2018 , debt securities with a fair value of $916 million , gross unrealized capital gains of $12 million and gross unrealized capital losses of $2 million were included in total debt securities, but support experience-rated products.

The fair value of debt securities at December 31, 2018 is shown below by contractual maturity. Actual maturities may differ from contractual maturities because securities may be restructured, called or prepaid, or the Company intends to sell a security prior to maturity.

In millions	Amortized Cost	Fair Value
Due to mature:		
Less than one year	$ 901	$ 902
One year through five years	5,489	5,521
After five years through ten years	2,973	2,999
Greater than ten years	3,498	3,566
Residential mortgage-backed securities	567	577
Commercial mortgage-backed securities	594	605
Other asset-backed securities	1,097	1,085
Total	$ 15,119	$ 15,255

Mortgage-Backed and Other Asset-Backed Securities
All of the Company's residential mortgage-backed securities at December 31, 2018 were issued by the Government National Mortgage Association, the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation and carry agency guarantees and explicit or implicit guarantees by the United States Government. At December 31, 2018 , the Company's residential mortgage-backed securities had an average credit quality rating of AAA and a weighted average duration of 4.8 years.

The Company's commercial mortgage-backed securities have underlying loans that are dispersed throughout the United States. Significant market observable inputs used to value these securities include loss severity and probability of default. At December 31, 2018 , these securities had an average credit quality rating of AAA and a weighted average duration of 6.3 years.

The Company's other asset-backed securities have a variety of underlying collateral (e.g., automobile loans, credit card receivables, home equity loans and commercial loans). Significant market observable inputs used to value these securities include the unemployment rate, loss severity and probability of default. At December 31, 2018 , these securities had an average credit quality rating of AA and a weighted average duration of 1.3 years.

Summarized below are the debt securities the Company held at December 31, 2018 that were in an unrealized capital loss position:

In millions, except number of securities	Number of Securities	Fair Value	Unrealized Losses
Debt securities:			
U.S. government securities	8	$ 26	$ —
States, municipalities and political subdivisions	54	86	1
U.S. corporate securities	1,399	1,431	16
Foreign securities	243	314	3
Residential mortgage-backed securities	45	1	—
Other asset-backed securities	516	528	15
Redeemable preferred securities	14	23	1
Total debt securities	2,279	$ 2,409	$ 36

Since Aetna's investment portfolio was measured at fair value as of the Aetna Acquisition Date, each of the securities in the table above were in an unrealized loss position for less than 12 months. The Company reviewed the securities in the table above and concluded that they are performing assets generating investment income to support the needs of the Company's businesses. In performing this review, the Company considered factors such as the quality of the investment security based on research performed by the Company's internal credit analysts and external rating agencies and the prospects of realizing the carrying value of the security based on the investment's current prospects for recovery. As of December 31, 2018 , the Company did not intend to sell these securities, and did not believe it was more likely than not that it would be required to sell these securities prior to anticipated recovery of their amortized cost basis.

The maturity dates for debt securities in an unrealized capital loss position at December 31, 2018 were as follows:

	Supporting experience-rated products		Supporting remaining products		Total	
In millions	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Due to mature:						
Less than one year	$ 21	$ —	$ 308	$ —	$ 329	$ —
One year through five years	36	2	557	5	593	7
After five years through ten years	47	—	492	9	539	9
Greater than ten years	49	—	370	5	419	5
Residential mortgage-backed securities	—	—	1	—	1	—
Other asset-backed securities	4	—	524	15	528	15
Total	$ 157	$ 2	$ 2,252	$ 34	$ 2,409	$ 36

Mortgage Loans

The Company's mortgage loans are collateralized by commercial real estate. From the Aetna Acquisition Date through December 31, 2018 , the Company had the following activity in its mortgage loan portfolio:

In millions	
New mortgage loans	$ 4
Mortgage loans fully-repaid	27
Mortgage loans foreclosed	—

The Company assesses mortgage loans on a regular basis for credit impairments, and annually assign a credit quality indicator to each loan. The Company's credit quality indicator is internally developed and categorizes its portfolio on a scale from 1 to 7. These indicators are based upon several factors, including current loan-to-value ratios, property condition, market trends, creditworthiness of the borrower and deal structure. The vast majority of the Company's mortgage loans fall into categories 2 to 4.

- *Category 1* - Represents loans of superior quality
- *Categories 2 to 4* - Represents loans where credit risk is minimal to acceptable; however, these loans may display some susceptibility to economic changes.
- *Categories 5 and 6* - Represents loans where credit risk is not substantial, but these loans warrant management's close attention.
- *Category 7* - Represents loans where collections are potentially at risk; if necessary, an impairment is recorded.

Based upon the most recent assessments at December 31, 2018 , the Company's mortgage loans were given the following credit quality indicators:

In millions, except credit ratings indicator		
1	$	42
2 to 4		1,301
5 and 6		18
7		—
Total	$	1,361

At December 31, 2018 scheduled mortgage loan principal repayments were as follows:

In millions		
2019	$	145
2020		109
2021		269
2022		228
2023		83
Thereafter		527
Total	$	1,361

Net Investment Income

Sources of net investment income for the year ended December 31, 2018 were as follows:

In millions		
Debt securities	$	637
Mortgage loans		6
Other investments		17
Gross investment income		660
Investment expenses		(3)
Net investment income (excluding net realized capital gains or losses)		657
Net realized capital gains		3
Net investment income [1]	$	660

(1) Net investment income in 2018 includes $4 million related to investments supporting experience-rated products.

The Company's net investment income was $21 million and $20 million in 2017 and 2016 , respectively, relating to interest income on debt securities. The Company did not have any material realized capital gains or losses during 2017 or 2016.

The portion of unrealized capital gains and losses recognized during the year ended December 31, 2018 related to investments in equity securities held as of December 31, 2018 was not material.

Excluding amounts related to experience-rated products, proceeds from the sale of available for sale debt securities and the related gross realized capital gains and losses from the Aetna Acquisition Date through December 31, 2018 were as follows: (1)

In millions		
Proceeds from sales	$	389
Gross realized capital gains		2
Gross realized capital losses		(2)

(1) The proceeds from sales and gross realized capital gains and losses exclude the impact of the sales of short-term debt securities which primarily relate to the Company's investments in mutual funds. These investments were excluded from the disclosed amounts because they represent an immaterial amount of aggregate gross realized capital gains or losses and have a high volume of sales activity.

4. Fair Value

The preparation of the Company's consolidated financial statements in accordance with GAAP requires certain assets and liabilities to be reflected at their fair value, and others on another basis, such as an adjusted historical cost basis. In this note, the Company provides details on the fair value of financial assets and liabilities and how it determines those fair values. The Company presents this information for those financial instruments that are measured at fair value for which the change in fair value impacts net income (loss) attributable to CVS Health or other comprehensive income separately from other financial assets and liabilities.

Financial Instruments Measured at Fair Value on the Consolidated Balance Sheets

Certain of the Company's financial instruments are measured at fair value on the consolidated balance sheets. The fair values of these instruments are based on valuations that include inputs that can be classified within one of three levels of a hierarchy established by GAAP. The following are the levels of the hierarchy and a brief description of the type of valuation information ("inputs") that qualifies a financial asset or liability for each level:

- Level 1 – Unadjusted quoted prices for identical assets or liabilities in active markets.
- Level 2 – Inputs other than Level 1 that are based on observable market data. These include: quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets, inputs that are observable that are not prices (such as interest rates and credit risks) and inputs that are derived from or corroborated by observable markets.
- Level 3 – Developed from unobservable data, reflecting the Company's assumptions.

Financial assets and liabilities are classified based upon the lowest level of input that is significant to the valuation. When quoted prices in active markets for identical assets and liabilities are available, the Company uses these quoted market prices to determine the fair value of financial assets and liabilities and classifies these assets and liabilities in Level 1. In other cases where a quoted market price for identical assets and liabilities in an active market is either not available or not observable, the Company estimates fair value using valuation methodologies based on available and observable market information or by using a matrix pricing model. These financial assets and liabilities would then be classified in Level 2. If quoted market prices are not available, the Company determines fair value using broker quotes or an internal analysis of each investment's financial performance and cash flow projections. Thus, financial assets and liabilities may be classified in Level 3 even though there may be some significant inputs that may be observable.

The following is a description of the valuation methodologies used for the Company's financial assets and liabilities that are measured at fair value, including the general classification of such assets and liabilities pursuant to the valuation hierarchy.

Debt Securities – Where quoted prices are available in an active market, debt securities are classified in Level 1 of the fair value hierarchy. The Company's Level 1 debt securities consist primarily of United States Treasury securities.

The fair values of the Company's Level 2 debt securities are obtained using models, such as matrix pricing, which use quoted market prices of debt securities with similar characteristics or discounted cash flows to estimate fair value. The Company reviews these prices to ensure they are based on observable market inputs that include, but are not limited to, quoted prices for similar assets in active markets, quoted prices for identical assets in inactive markets and inputs that are observable but not prices (for example, interest rates and credit risks). The Company also reviews the

methodologies and the assumptions used to calculate prices from these observable inputs. On a quarterly basis, the Company selects a sample of its Level 2 debt securities' prices and compares them to prices provided by a secondary source. Variances over a specified threshold are identified and reviewed to confirm the price provided by the primary source represents an appropriate estimate of fair value. In addition, the Company's internal investment team consistently compares the prices obtained for select Level 2 debt securities to the team's own independent estimates of fair value for those securities. The Company obtained one price for each of its Level 2 debt securities and did not adjust any of these prices at December 31, 2018 . The Company's Level 2 debt securities were not material as of December 31, 2017 .

The Company also values certain debt securities using Level 3 inputs. For Level 3 debt securities, fair values are determined by outside brokers or, in the case of certain private placement securities, are priced internally. Outside brokers determine the value of these debt securities through a combination of their knowledge of the current pricing environment and market flows. The Company obtained one non-binding broker quote for each of these Level 3 debt securities and did not adjust any of these quotes at December 31, 2018 . The total fair value of broker quoted debt securities was $50 million at December 31, 2018 . The Company did not have any Level 3 debt securities as of December 31, 2017. Examples of these broker quoted Level 3 debt securities include certain United States and foreign corporate securities and certain of the Company's commercial mortgage-backed securities as well as other asset-backed securities. For some private placement securities, the Company's internal staff determines the value of these debt securities by analyzing spreads of corporate and sector indices as well as interest spreads of comparable public bonds. Examples of these private placement Level 3 debt securities include certain United States and foreign securities and certain tax-exempt municipal securities.

Equity Securities – The Company currently has two classifications of equity securities: those that are publicly traded and those that are privately placed. Publicly-traded equity securities are classified in Level 1 because quoted prices are available for these securities in an active market. For privately placed equity securities, there is no active market; therefore, these securities are classified in Level 3 because the Company prices these securities through an internal analysis of each investment's financial statements and cash flow projections. Significant unobservable inputs consist of earnings and revenue multiples, discount for lack of marketability and comparability adjustments. An increase or decrease in any of these unobservable inputs would result in a change in the fair value measurement, which may be significant. The Company did not have any Level 3 equity securities as of December 31, 2017.

Derivative Financial Instruments - The fair values of derivative financial instruments are determined using quoted prices in markets that are not active or inputs that are observable for the asset or liability and therefore they are classified as Level 2 in the fair value hierarchy. The fair value of these instruments are recorded in other current assets or accrued expenses, as applicable. The Company did not have any material outstanding derivative financial instruments as of December 31, 2018.

Financial assets and liabilities measured at fair value on a recurring basis on the consolidated balance sheets at December 31, 2018 and 2017 were as follows:

In millions	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2018				
Assets:				
Debt securities:				
U.S. government securities	$ 1,597	$ 91	$ —	$ 1,688
States, municipalities and political subdivisions	—	2,399	—	2,399
U.S. corporate securities	—	6,422	67	6,489
Foreign securities	—	2,380	3	2,383
Residential mortgage-backed securities	—	577	—	577
Commercial mortgage-backed securities	—	605	—	605
Other asset-backed securities	—	1,085	—	1,085
Redeemable preferred securities	—	22	7	29
Total debt securities	1,597	13,581	77	15,255
Equity securities	19	—	54	73
Total	$ 1,616	$ 13,581	$ 131	$ 15,328
December 31, 2017				
Assets:				
Debt securities:				
U.S. corporate securities	$ —	$ 1	$ —	$ 1
Foreign securities	—	110	—	110
Total debt securities	—	111	—	111
Equity securities	—	—	—	—
Derivative financial instruments	—	5	—	5
Total assets	$ —	$ 116	$ —	$ 116
Liabilities:				
Derivative financial instruments	$ —	$ 23	$ —	$ 23

There were no transfers between Levels 1 and 2 during the years ended December 31, 2018 and 2017 . The change in the balance of Level 3 financial assets during 2018 relates to investments acquired in the Aetna Acquisition, which occurred on November 28, 2018. There were no transfers into or out of Level 3 from November 28, 2018 to December 31, 2018.

Financial Instruments Not Measured at Fair Value on the Consolidated Balance Sheets

The carrying value and estimated fair value classified by level of fair value hierarchy for financial instruments carried on the consolidated balance sheets at adjusted cost or contract value at December 31, 2018 and 2017 were as follows:

	Carrying	Estimated Fair Value			
In millions	**Value**	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2018					
Assets:					
Mortgage loans	$ 1,361	$ —	$ —	$ 1,366	$ 1,366
Equity securities [1]	140	N/A	N/A	N/A	N/A
Liabilities:					
Investment contract liabilities:					
With a fixed maturity	5	—	—	5	5
Without a fixed maturity	382	—	—	357	357
Long-term debt	72,709	71,252	—	—	71,252

	Carrying	Estimated Fair Value			
In millions	**Value**	**Level 1**	**Level 2**	**Level 3**	**Total**
December 31, 2017					
Assets:					
Equity securities [1]	$ 47	N/A	N/A	N/A	N/A
Liabilities:					
Long-term debt	25,726	26,756	—	—	26,756

(1) It was not practical to estimate the fair value of these cost-method investments as it represents shares of unlisted companies. See Note 1 ‘‘Significant Accounting Policies’’ for additional information regarding the valuation of cost-method investments.

Separate Accounts Measured at Fair Value on the Consolidated Balance Sheets

As part of the Aetna Acquisition, the Company acquired Separate Accounts assets related to large case pensions products which represent funds maintained to meet specific objectives of contract holders. Since contract holders bear the investment risk of these assets, a corresponding Separate Accounts liability has been established equal to the assets. These assets and liabilities are carried at fair value. Net investment income and capital gains and losses accrue directly to such contract holders. The assets of each account are legally segregated and are not subject to claims arising from the Company’s other businesses. Deposits, withdrawals, net investment income and realized and unrealized capital gains and losses on Separate Accounts assets are not reflected in the consolidated statements of operations, shareholders’ equity or cash flows.

Separate Accounts assets include debt and equity securities. The valuation methodologies used for these assets are similar to the methodologies described above in this Note 4 “Fair Value.” Separate Accounts assets also include investments in common/collective trusts that are carried at fair value. Common/collective trusts invest in other investment funds otherwise known as the underlying funds. The Separate Accounts’ interests in the common/collective trust funds are based on the fair values of the investments of the underlying funds and therefore are classified in Level 2. The assets in the underlying funds primarily consist of equity securities. Investments in common/collective trust funds are valued at their respective net asset value (“NAV”) per share/unit on the valuation date.

Separate Accounts financial assets as of December 31, 2018 were as follows:

In millions	Level 1	Level 2	Level 3	Total
Debt securities	$ 782	$ 2,500	$ 4	$ 3,286
Equity securities	—	3	—	3
Common/collective trusts	—	404	—	404
Total [1]	$ 782	$ 2,907	$ 4	$ 3,693

(1) Excludes $191 million of cash and cash equivalents and accounts receivable at December 31, 2018 .

During 2018 , the Company had an immaterial amount of Level 3 Separate Accounts financial assets and an immaterial amount of gross transfers of Separate Accounts financial assets into or out of Level 3. During 2018 , there were no transfers of Separate Accounts financial assets between Levels 1 and 2. The Company held no Separate Accounts financial assets as of December 31, 2017 .

Offsetting Financial Assets and Liabilities

Subsequent to the Aetna Acquisition Date, certain financial assets and liabilities are offset in the Company's consolidated balance sheets or are subject to master netting arrangements or similar agreements with the applicable counterparty. Financial assets, including derivative assets, subject to offsetting and enforceable master netting arrangements were $13 million as of December 31, 2018.

5. Goodwill and Other Intangibles

Goodwill

Below is a summary of the changes in the carrying amount of goodwill by segment for the years ended December 31, 2018 and 2017 :

In millions	Pharmacy Services	Retail/LTC	Health Care Benefits	Total
Balance at December 31, 2016	$ 21,637	$ 16,612	$ —	$ 38,249
Acquisitions	182	203	—	385
Foreign currency translation adjustments	—	(2)	—	(2)
Impairments	—	(181)	—	(181)
Balance at December 31, 2017	21,819	16,632	—	38,451
Acquisitions	1,569	735	44,484	46,788
Foreign currency translation adjustments	—	(14)	—	(14)
Divestiture of RxCrossroads subsidiary	—	(398)	—	(398)
Impairments	—	(6,149)	—	(6,149)
Balance at December 31, 2018	$ 23,388	$ 10,806	$ 44,484	$ 78,678

Cumulative goodwill impairments as of December 31, 2018 and 2017 were $6.1 billion and $181 million , respectively.

The changes in the carrying amount of goodwill during the years ended December 31, 2018 and 2017 reflect the following activity:

Aetna Acquisition
On November 28, 2018, the Company completed the Aetna Acquisition. The majority of the preliminary valuation of goodwill associated with the Aetna Acquisition was recorded in the Health Care Benefits segment. The Company also allocated a portion of such goodwill to the Retail/LTC and Pharmacy Services segments related to the fair value of identified synergies that are expected to directly benefit those segments. See Note 2 ''Acquisition of Aetna'' for further discussion regarding the Aetna Acquisition.

LTC
During 2018, the LTC reporting unit continued to experience industry wide challenges that have impacted management's ability to grow the business at the rate that was originally estimated when the Company acquired Omnicare and when the 2017 annual goodwill impairment test was performed. These challenges include lower client retention rates, lower occupancy rates in skilled nursing facilities, the deteriorating financial health of numerous skilled nursing facility customers which resulted in a number of customer bankruptcies in 2018, and continued facility reimbursement pressures. In June 2018, LTC management submitted its initial budget for 2019 and updated the 2018 annual forecast which showed a projected deterioration in the financial results for the remainder of 2018 and in 2019, which also caused management to update its long-term forecast beyond 2019. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be impaired and, accordingly, management performed an interim goodwill impairment test as of June 30, 2018. The results of that interim impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in a $3.9 billion pre-tax goodwill impairment charge in the second quarter of 2018. The fair value of the LTC reporting unit was determined using a combination of a discounted cash flow method and a market multiple method. In addition to the lower financial projections, higher risk-free interest rates and lower market multiples of peer group companies contributed to the amount of the second quarter 2018 goodwill impairment charge.

During the third quarter of 2018, the Company performed its required annual impairment tests of goodwill and concluded there was no impairment of goodwill or trade names.

During the fourth quarter of 2018, the LTC reporting unit missed its forecast primarily due to operational issues and customer liquidity issues, including one significant customer bankruptcy. Additionally, LTC management submitted an updated final budget for 2019 which showed significant additional deterioration in the projected financial results for 2019 compared to the analyses performed in the second and third quarters of 2018 primarily due to continued industry and operational challenges, which also caused management to make further updates to its long-term forecast beyond 2019. The updated projections continue to reflect industry wide challenges including lower occupancy rates in skilled nursing facilities, significant deterioration in the financial health of numerous skilled nursing facility customers and continued facility reimbursement pressures. Based on these updated projections, management determined that there were indicators that the LTC reporting unit's goodwill may be further impaired and, accordingly, an interim goodwill impairment test was performed during the fourth quarter of 2018. The results of that impairment test showed that the fair value of the LTC reporting unit was lower than the carrying value, resulting in an additional $2.2 billion goodwill impairment charge in the fourth quarter of 2018. In addition to the lower financial projections, lower market multiples of peer group companies also contributed to the amount of the fourth quarter 2018 goodwill impairment charge. The fair value of the LTC reporting unit was determined using a methodology consistent with the methodology described above for the analyses performed during the second and third quarters of 2018.

As of December 31, 2018 , the remaining goodwill balance in the LTC reporting unit is approximately $431 million .

RxCrossroads
During 2017, the Company began pursuing various strategic alternatives for its RxCrossroads reporting unit. In connection with this effort, the Company performed an interim goodwill impairment test in the second quarter of 2017. The results of that impairment test showed that the fair value of the RxCrossroads reporting unit was lower than the carrying value, resulting in a $135 million pre-tax goodwill impairment charge in the second quarter of 2017.

The TCJA was enacted on December 22, 2017 and reduced the United States federal corporate income tax rate from 35% to 21% effective January 1, 2018 (see Note 10 ''Income Taxes''). As a result, the RxCrossroads deferred income tax liabilities were reduced by $47 million and an income tax benefit of $47 million was recorded in the 2017 statement of operations. The reduction in the deferred income tax liabilities increased the carrying value of the RxCrossroads reporting unit by $47 million which triggered an additional goodwill impairment charge in the RxCrossroads reporting unit of $46 million during the fourth quarter of 2017.

On January 2, 2018, the Company sold its RxCrossroads subsidiary to McKesson Corporation for $725 million , at which time the remaining goodwill of this reporting unit was removed from the consolidated balance sheet.

Intangible Assets

The following table is a summary of the Company's intangible assets as of December 31 :

In millions, except weighted average life	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Life (years)
2018				
Trademarks (indefinitely-lived)	$ 10,498	$ —	$ 10,498	N/A
Customer contracts/relationships and covenants not to compete	26,213	(6,349)	19,864	14.8
Technology	1,060	(31)	1,029	3.0
Provider networks	4,200	(19)	4,181	20.0
Value of Business Acquired	590	(7)	583	20.0
Favorable leases and other	1,177	(808)	369	17.1
Total	$ 43,738	$ (7,214)	$ 36,524	15.3
2017				
Trademark (indefinitely-lived)	$ 6,398	$ —	$ 6,398	N/A
Customer contracts/relationships and covenants not to compete	12,341	(5,536)	6,805	15.3
Favorable leases and other	1,190	(763)	427	16.2
Total	$ 19,929	$ (6,299)	$ 13,630	15.4

Amortization expense for intangible assets totaled $1.0 billion , $817 million and $795 million for the years ended December 31, 2018 , 2017 and 2016 , respectively. The projected annual amortization expense for the Company's intangible assets for the next five years is as follows:

In millions	
2019	$ 2,563
2020	2,350
2021	2,253
2022	1,879
2023	1,844

6. Leases

The Company leases most of its retail and mail order dispensing pharmacy locations, and certain distribution centers and corporate offices under noncancelable operating leases, typically with initial terms of 15 to 25 years and with options that permit renewals for additional periods. The Company also leases certain equipment and other assets under noncancelable operating leases, typically with initial terms of 3 to 10 years.

In December 2015, in connection with the acquisition of the pharmacy and clinic businesses of Target, the Company entered into lease agreements with Target for the pharmacy and clinic space within Target stores. Given that the noncancelable contractual term of the pharmacy lease arrangement exceeds the remaining estimated economic life of the buildings being leased, the Company concluded for accounting purposes that the lease term was the remaining economic life of the buildings. Consequently, most of the individual Target pharmacy and clinic leases are capital leases.

Minimum rent on operating leases is expensed on a straight-line basis over the term of the lease. In addition to minimum rental payments, certain leases require additional payments based on sales volume, as well as reimbursement for real estate taxes, common area maintenance and insurance, which are expensed as incurred.

The following table is a summary of the Company's net rental expense for operating leases for the years ended December 31:

In millions	2018	2017	2016
Minimum rentals	$ 2,528	$ 2,455	$ 2,418
Contingent rentals	28	29	35
Rental expense	2,556	2,484	2,453
Less: sublease income	(21)	(24)	(24)
Total rental expense, net	$ 2,535	$ 2,460	$ 2,429

The following table is a summary of the future minimum lease payments under capital and operating leases as of December 31, 2018 :

In millions	Capital Leases	Operating Leases [1]
2019	$ 74	$ 2,690
2020	73	2,544
2021	73	2,399
2022	73	2,233
2023	73	2,110
Thereafter	875	16,004
Total future lease payments [2]	1,241	$ 27,980
Less: imputed interest	(599)	
Present value of capital lease obligations	$ 642	

(1) Future operating lease payments have not been reduced by minimum sublease rentals of $164 million due in the future under noncancelable subleases.
(2) The Company leases pharmacy and clinic space from Target. Amounts related to such capital and operating leases are reflected above. Amounts due in excess of the remaining estimated economic life of the buildings of approximately $2.1 billion are not reflected herein since the estimated economic life of the buildings is shorter than the contractual term of the lease arrangement.

The Company finances a portion of its store development program through sale-leaseback transactions. The properties are generally sold at net book value, which generally approximates fair value, and the resulting leases generally qualify and are accounted for as operating leases. The operating leases that resulted from these transactions are included in the above table. The Company does not have any retained or contingent interests in the stores and does not provide any guarantees, other than a guarantee of lease payments, in connection with the sale-leaseback transactions. There were no sale-leaseback transactions in 2018. Proceeds from sale-leaseback transactions totaled $265 million and $230 million in 2017 and 2016 , respectively.

7. Health Care Costs Payable

On November 28, 2018 , the Company completed the Aetna Acquisition. Prior to the Aetna Acquisition, the Company's health care costs payable balance was immaterial and related to unpaid pharmacy claims for its stand-alone Medicare Part D PDPs within the Pharmacy Services segment. Accordingly, the Company will include disclosures for health care costs payable for the year ended December 31, 2018. Since the health care costs payable liability related to the Pharmacy Services segment is immaterial, the Company's disclosures will be presented on a consolidated basis and will not be disaggregated between the Pharmacy Services and Health Care Benefits segments.

Health care costs payable consist principally of unpaid fee-for-service medical, dental and pharmacy claims, capitation costs, other amounts due to health care providers pursuant to risk-sharing arrangements and accruals for state assessments within the Health Care Benefits segment. See Note 1 ''Significant Accounting Policies'' for information on how the Company estimates IBNR reserves and health care costs payable as well as changes to those methodologies, if any. The Company's estimate of IBNR liabilities is primarily based on trend and completion factors. Claim frequency is not used in the calculation of the Company's liability. In addition, it is impracticable to disclose claim frequency information for health care claims due to the Company's inability to gather consistent claim frequency information across its multiple claims processing systems. Any claim frequency count disclosure would not be comparable across the Company's different claim processing systems and would not

be consistent from period to period based on the volume of claims processed through each system. As a result, health care claim count frequency was not included in the disclosures included below.

The following table shows the components of the change in health care costs payable during 2018:

In millions		
Health care costs payable, beginning of the period	$	5
Less: Reinsurance recoverables		—
Health care costs payable, beginning of the period, net		5
Acquisitions, net		5,357
Add: Components of incurred health care costs		
Current year		6,594
Prior years		(42)
Total incurred health care costs [(1)]		6,552
Less: Claims paid		
Current year		6,464
Prior years		260
Total claims paid		6,724
Add: Premium deficiency reserve		16
Health care costs payable, end of period, net		5,206
Add: Reinsurance recoverables		4
Health care costs payable, end of period	$	5,210

(1) Total incurred health care costs for the year ended December 31, 2018 in the table above exclude (i) $16 million related to a premium deficiency reserve for the 2019 coverage year related to Medicaid products, (ii) $4 million of benefit costs recorded in the Health Care Benefits segment that are included in Other Insurance Liabilities on the consolidated balance sheet and (iii) $22 million of benefit costs recorded in the Corporate/Other segment that are included in Other Insurance Liabilities on the consolidated balance sheet.

At December 31, 2018 , the Company's liabilities for IBNR plus expected development on reported claims totaled approximately $ 4.1 billion . Substantially all of the Company's liabilities for IBNR plus expected development on reported claims at December 31, 2018 related to the current calendar year.

Due to the proximity of the Aetna Acquisition Date to December 31, 2018 , the Company did not include disclosures related to incurred and paid claim development from November 28, 2018 to December 31, 2018 . The Company will begin including disclosures related to incurred and paid claim development for the year ended December 31, 2019.

8. Borrowings and Credit Agreements

The following table is a summary of the Company's borrowings as of December 31 :

In millions	2018	2017
Short-term debt		
Commercial paper	$ 720	$ 1,276
Long-term debt		
1.9% senior notes due July 2018	—	2,250
2.25% senior notes due December 2018	—	1,250
2.2% senior notes due March 2019	375	—
2.25% senior notes due August 2019	850	850
3.125% senior notes due March 2020	2,000	—
Floating rate notes due March 2020	1,000	—
2.8% senior notes due July 2020	2,750	2,750
3.35% senior notes due March 2021	3,000	—
Floating rate notes due March 2021	1,000	—
4.125% senior notes due May 2021	550	550
2.125% senior notes due June 2021	1,750	1,750
4.125% senior notes due June 2021	500	—
5.45% senior notes due June 2021	600	—
3-Year tranche loan due November 2021	3,000	—
3.5% senior notes due July 2022	1,500	1,500
2.75% senior notes due November 2022	1,000	—
2.75% senior notes due December 2022	1,250	1,250
4.75% senior notes due December 2022	399	399
3.7% senior notes due March 2023	6,000	—
2.8% senior notes due June 2023	1,300	—
4% senior notes due December 2023	1,250	1,250
3.375% senior notes due August 2024	650	650
3.5% senior notes due November 2024	750	—
5% senior notes due December 2024	299	299
4.1% senior notes due March 2025	5,000	—
3.875% senior notes due July 2025	2,828	2,828
2.875% senior notes due June 2026	1,750	1,750
6.25% senior notes due June 2027	372	372
4.3% senior notes due March 2028	9,000	—
4.875% senior notes due July 2035	652	652
3.25% senior exchange debentures due December 2035	—	1
6.625% senior notes due June 2036	771	—
6.75% senior notes due December 2037	533	—
4.78% senior notes due March 2038	5,000	—
6.125% senior notes due September 2039	447	447
5.75% senior notes due May 2041	133	133
4.5% senior notes due May 2042	500	—
4.125% senior notes due November 2042	500	—
5.3% senior notes due December 2043	750	750
4.75% senior notes due March 2044	375	—
5.125% senior notes due July 2045	3,500	3,500
3.875% senior notes due August 2047	1,000	—
5.05% senior notes due March 2048	8,000	—
Capital lease obligations	642	670
Other	19	43
Total debt principal	74,265	27,170

Debt premiums	302	28
Debt discounts and deferred financing costs	(1,138)	(196)
	73,429	27,002
Less:		
Short-term debt (commercial paper)	(720)	(1,276)
Current portion of long-term debt	(1,265)	(3,545)
Long-term debt	$ 71,444	$ 22,181

The following is a summary of the Company's required principal debt repayments due during each of the next five years and thereafter, as of December 31, 2018 :

In millions		
2019	$	1,985
2020		5,775
2021		10,427
2022		4,178
2023		8,581
Thereafter		43,319
Total	$	74,265

Short-term Borrowings

Commercial Paper and Back-up Credit Facilities
The Company had approximately $720 million and $1.3 billion of commercial paper outstanding at weighted average interest rates of 2.8% and 2.0% as of December 31, 2018 and 2017 , respectively. In connection with its commercial paper program, the Company maintains a $1.75 billion 364 -day unsecured back-up revolving credit facility, which expires on May 16, 2019, a $1.25 billion , five -year unsecured back-up revolving credit facility, which expires on July 1, 2020, a $1.0 billion , five -year unsecured back-up revolving credit facility, which expires on May 18, 2022, and a $2.0 billion , five -year unsecured back-up revolving credit facility, which expires on May 17, 2023. The credit facilities allow for borrowings at various rates that are dependent, in part, on the Company's public debt ratings and require the Company to pay a weighted average quarterly facility fee of approximately .03% , regardless of usage. As of December 31, 2018 and 2017 , there were no borrowings outstanding under any of the back-up credit facilities.

Bridge Loan Facility
On December 3, 2017, in connection with the Aetna Acquisition, the Company entered into a $49.0 billion unsecured bridge loan facility commitment. The Company paid $221 million in fees upon entering into the agreement. The fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The bridge loan facility commitment was reduced to $44.0 billion on December 15, 2017 upon the Company entering into a $5.0 billion term loan agreement. The Company recorded $56 million of amortization of the bridge loan facility fees during the year ended December 31, 2017, which was recorded in interest expense in the consolidated statements of operations.

On March 9, 2018, the Company issued an aggregate of $40.0 billion principal amount of unsecured floating rate notes and unsecured fixed rate senior notes, collectively the "2018 Notes". At this time, the bridge loan facility commitment was reduced to $4.0 billion , and the Company paid $8 million in fees to retain the bridge loan facility commitment through the Aetna Acquisition Date. Those fees were capitalized in other current assets and were amortized as interest expense over the period the bridge loan facility commitment was outstanding. The Company recorded $173 million of amortization of the bridge loan facility commitment fees during the year ended December 31, 2018 , which was recorded in interest expense in the consolidated statement of operations. On October 26, 2018, the Company entered into a $4.0 billion unsecured 364 -day bridge term loan agreement to formalize the bridge loan facility discussed above. On November 28, 2018, in connection with the Aetna Acquisition, the $4.0 billion unsecured 364 -day bridge term loan agreement terminated.

Terminated Revolving Credit Facility
On January 3, 2017, the Company entered into a $2.5 billion revolving credit facility. The credit facility allowed for borrowings at various rates that were dependent, in part, on the Company's debt ratings and required the Company to pay a weighted average quarterly facility fee of approximately 0.03% , regardless of usage. The Company terminated this credit facility in May 2017.

Federal Home Loan Bank of Boston
Since the Aetna Acquisition Date, a subsidiary of the Company is a member of the FHLBB. As a member, the subsidiary has the ability to obtain cash advances, subject to certain minimum collateral requirements. The maximum borrowing capacity available from the FHLBB as of December 31, 2018 was approximately $790 million . As of December 31, 2018 , there were no outstanding advances from the FHLBB.

Long-term Borrowings

2018 Notes
On March 9, 2018, the Company issued the 2018 Notes with an aggregate principal amount of $40.0 billion , for total proceeds of approximately $39.4 billion , net of discounts and underwriting fees. The net proceeds of the 2018 Notes were used to fund a portion of the Aetna Acquisition. The 2018 Notes are comprised of the following:

In millions		
3.125% senior notes due March 2020	$	2,000
Floating rate notes due March 2020		1,000
3.35% senior notes due March 2021		3,000
Floating rate notes due March 2021		1,000
3.7% senior notes due March 2023		6,000
4.1% senior notes due March 2025		5,000
4.3% senior notes due March 2028		9,000
4.78% senior notes due March 2038		5,000
5.05% senior notes due March 2048		8,000
Total debt principal	$	40,000

Beginning in December 2017 through March 31, 2018, the Company entered into several interest rate swap and treasury lock transactions to manage interest rate risk. These agreements were designated as cash flow hedges and were used to hedge the exposure to variability in future cash flows resulting from changes in interest rates related to the anticipated issuance of long-term debt to fund the Aetna Acquisition.

In connection with the issuance of the 2018 Notes, the Company terminated all outstanding cash flow hedges. In connection with the hedge transactions, the Company received a net amount of $446 million from the hedge counterparties upon termination, which was recorded as a gain, net of tax, of $331 million in accumulated other comprehensive income and will be reclassified as a reduction of interest expense over the life of the 2018 Notes. See Note 13 ‘‘Other Comprehensive Income (Loss)’’ for additional information. The Company expects to reclassify approximately $18 million , net of tax, in gains associated with these cash flow hedges into net income within the next 12 months.

Term Loan Agreement
On December 15, 2017, in connection with the Aetna Acquisition, the Company entered into a $5.0 billion term loan agreement. The term loan facility under the term loan agreement consists of a $3.0 billion three -year tranche and a $2.0 billion five -year tranche. The term loan agreement allows for borrowings at various rates that are dependent, in part, on the Company’s debt ratings. In connection with the Aetna Acquisition, the Company borrowed $5.0 billion (a $3.0 billion three -year tranche and a $2.0 billion five -year tranche) under term loan agreement in November 2018. The Company terminated the $2.0 billion five-year tranche in December 2018 with the repayment of the borrowing. As of December 31, 2018, the Company had $3.0 billion outstanding under the three -year tranche of the term loan agreement.

Aetna Related Debt
On the Aetna Acquisition Date, the Company assumed long-term debt with a fair value of $8.1 billion , with stated interest rates ranging from 2.2% to 6.75% . The long-term debt assumed is included in the summary of borrowings table above.

2016 Notes
On May 16, 2016, the Company issued $1.75 billion aggregate principal amount of 2.125% unsecured senior notes due June 1, 2021 and $1.75 billion aggregate principal amount of 2.875% unsecured senior notes due June 1, 2026 (collectively, the “ 2016 Notes ”) for total proceeds of approximately $3.5 billion , net of discounts and underwriting fees. The 2016 Notes may be redeemed, in whole at any time, or in part from time to time, at the Company’s option at a defined redemption price plus accrued and unpaid interest to the redemption date. The net proceeds of the 2016 Notes were used for general corporate purposes and to repay certain corporate debt.

Early Extinguishment of Long-Term Debt
On May 16, 2016, the Company announced tender offers for (i) any and all of its 5.75% senior notes due 2017, its 6.60% senior notes due 2019 and its 4.75% senior notes due 2020 (collectively, the “Any and All Notes”) and (ii) up to $1.5 billion aggregate

principal amount of the 4.75% Senior Notes due 2022 issued by its wholly-owned subsidiary Omnicare, the 5.00% Senior Notes due 2024 issued by Omnicare, its 3.875% Senior Notes due 2025, its 6.25% Senior Notes due 2027, its 4.875% Senior Notes due 2035, its 6.125% Senior Notes due 2039 and its 5.75% Senior Notes due 2041 (collectively, the "Maximum Tender Offer Notes" and together with the Any and All Notes, the "Notes"). On May 31, 2016, the Company increased the aggregate principal amount of the tender offers for the Maximum Tender Offer Notes to $2.25 billion . The Company purchased approximately $835 million aggregate principal amount of the Any and All Notes and $2.25 billion aggregate principal amount of the Maximum Tender Offer Notes pursuant to the tender offers, which expired on June 13, 2016. In connection with the purchase of the Notes, the Company paid a premium of $486 million in excess of the debt principal, wrote off $50 million of unamortized deferred financing costs and incurred $6 million in fees, for a total loss on early extinguishment of long-term debt of $542 million , which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

On June 27, 2016, the Company notified the holders of the remaining Any and All Notes that the Company was exercising its option to redeem the outstanding Any and All Notes pursuant to the terms of the Any and All Notes and the Indenture dated as of August 15, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. Approximately $1.1 billion aggregate principal amount of Any and All Notes was redeemed on July 27, 2016. In connection with that redemption, the Company paid a premium of $97 million in excess of the debt principal and wrote off $4 million of unamortized deferred financing costs, for a total loss on early extinguishment of long-term debt of $101 million , which was recorded in income from continuing operations in the consolidated statement of operations for the year ended December 31, 2016.

Debt Covenants

The back-up revolving credit facilities, unsecured senior notes, unsecured floating rate notes and term loan agreement contain customary restrictive financial and operating covenants. These covenants do not include a requirement for the acceleration of the Company's debt maturities in the event of a downgrade in the Company's credit rating. The Company does not believe the restrictions contained in these covenants materially affect its financial or operating flexibility. As of December 31, 2018 , the Company was in compliance with all of its debt covenants.

9. Pension Plans and Other Postretirement Benefits

Defined Contribution Plans

As of December 31, 2018 , the Company sponsors several active 401(k) savings plans that cover all employees who meet plan eligibility requirements. The Company makes matching contributions consistent with the provisions of the respective plans.

At the participant's option, account balances, including the Company's matching contribution, can be invested without restriction among various investment options under each plan. Two of the defined contribution plans offer the Company's common stock fund as an investment option. The Company also maintains nonqualified, unfunded deferred compensation plans for certain key employees. The plans provide participants the opportunity to defer portions of their eligible compensation and for certain nonqualified plans, participants receive matching contributions equivalent to what they could have received under the CVS Health 401(k) Plan or Aetna 401(k) Plan absent certain restrictions and limitations under the Internal Revenue Code. The Company's contributions under the above defined contribution plans were $334 million , $314 million and $295 million in 2018, 2017 and 2016, respectively. The Company's contributions for the year ended December 31, 2018 include contributions to the Aetna Inc. 401(k) plan subsequent to the Aetna Acquisition Date.

Defined Benefit Pension Plans

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna sponsors a tax-qualified pension plan that was frozen in 2010. Aetna also sponsors a non-qualified supplemental pension plan that was frozen in 2007. Aetna's pension plan benefit obligations and the fair value of plan assets were remeasured as of the Aetna Acquisition Date.

Prior to the Aetna Acquisition, during the year ended December 31, 2017 , the Company settled the pension obligations of its existing two tax-qualified defined benefit pension plans by irrevocably transferring pension liabilities to an insurance company through the purchase of group annuity contracts and through lump sum distributions. These purchases, funded with pension plan assets, resulted in pre-tax settlement losses of $187 million in the year ended December 31, 2017 , related to the recognition of accumulated deferred actuarial losses. The settlement losses were recorded in other expense in the consolidated statement of operations. The Company also sponsors several other defined benefit pension plans that are unfunded nonqualified supplemental retirement plans as described in the "Other Postretirement Benefits" section below.

Pension Benefit Obligations and Plan Assets
The following tables outline the change in benefit obligations and plan assets over the specified periods:

In millions	2018	2017
Change in benefit obligation:		
Benefit obligation, beginning of year	$ 131	$ 844
Acquired benefit obligations	5,685	—
Interest cost	25	20
Actuarial loss (gain)	41	(31)
Benefit payments	(41)	(35)
Settlements	—	(667)
Benefit obligation, end of year	$ 5,841	$ 131

In millions	2018	2017
Change in plan assets:		
Fair value of plan assets, beginning of year	$ —	$ 624
Fair value of plan assets acquired	5,709	—
Actual return on plan assets	(17)	32
Employer contributions	12	46
Benefit payments	(41)	(35)
Settlements	—	(667)
Fair value of plan assets, end of year	5,663	—
Funded status	$ (178)	$ (131)

The assets (liabilities) recognized on the consolidated balance sheets at December 31, 2018 and 2017 for the pension plans consisted of the following:

In millions	2018	2017
Accrued benefit assets reflected in other assets	$ 147	$ —
Accrued benefit liabilities reflected in accrued expenses	(25)	(21)
Accrued benefit liabilities reflected in other long-term liabilities	(300)	(110)
Net liabilities	$ (178)	$ (131)

Net Periodic Benefit Costs
The components of net periodic benefit cost for the years ended December 31 are shown below:

In millions	2018	2017	2016
Components of net periodic benefit cost:			
Interest cost	$ 25	$ 20	$ 27
Expected return on plan assets	(33)	(20)	(32)
Amortization of net actuarial loss	2	21	32
Settlement losses	—	187	—
Net periodic benefit cost	$ (6)	$ 208	$ 27

Pension Plan Assumptions
The Company uses a series of actuarial assumptions to determine its benefit obligations and net benefit costs as further detailed below.

Discount Rates - The discount rate for the acquired Aetna plans is determined using a yield curve as of the annual measurement date. Each yield curve consisted of a series of individual discount rates, with each discount rate corresponding to a single point in time, based on high-quality bonds. Projected benefit payments are discounted to the measurement date using the corresponding rate from the yield curve. The weighted average discount rate for the Aetna pension plans was 4.4% in 2018 .

The Company settled the pension obligations of its existing tax-qualified plans during 2017. The discount rates for determining plan benefit obligations (excluding the terminated qualified plan) were approximately 4.0% , 3.5% and 4.0% in 2018 , 2017 and 2016 , respectively. The discount rate for the terminated qualified plan was 3.1% in 2016.

Expected Return on Plan Assets - The expected long-term rate of return on plan assets is determined by using the plan's target allocation and return expectations based on many factors including forecasted long-term capital market real returns and the inflationary outlook on a plan by plan basis. The expected long-term rate of return for the acquired Aetna plans was 6.6% in 2018. See "Pension Plan Assets" below for additional details regarding the Aetna pension plan assets as of December 31, 2018.

The Company settled the pension obligations of its existing tax-qualified plans during 2017. The expected long-term rate of return for these plans ranged from 4.0% to 5.5% in both 2017 and 2016 .

Net Actuarial Losses/Gains - Based on the mortality experience of the acquired Aetna pension plans, in 2018 the Company utilized the RP-2014WC Mortality Table with a generation projection of future mortality improvements using Scale MP-2018 for the acquired Aetna plans.

Pension Plan Assets
As of December 31, 2017, the assets in the Company's prior qualified defined benefit pension plans had been fully liquidated to settle all plan obligations through the purchase of group annuity contracts and through lump sum distributions. On November 28, 2018, the Company completed the Aetna Acquisition. At December 31, 2018, the assets of the Aetna pension plan (the "Aetna Pension Plan") primarily include debt and equity securities held in separate accounts, as well as common/collective trusts and real estate investments. The valuation methodologies used to price these debt and equity securities and common/collective trusts are similar to the methodologies described in Note 4 "Fair Value." Assets of the Aetna pension plan also include investments in other assets that are carried at fair value. The following is a description of the valuation methodology used to price real estate investments and these additional investments, including the general classification pursuant to the fair value hierarchy.

Real Estate - Real estate investments are valued by independent third party appraisers. The appraisals comply with the Uniform Standards of Professional Appraisal Practice, which includes, among other things, the income, cost, and sales comparison approaches to estimating property value. Therefore, these investments are classified in Level 3.

Private equity and hedge fund limited partnerships - Private equity and hedge fund limited partnerships are carried at fair value which is estimated using the NAV per unit as reported by the administrator of the underlying investment fund as a practical expedient to fair value. Therefore, these investments have been excluded from the fair value table below.

Aetna Pension Plan assets with changes in fair value measured on a recurring basis at December 31, 2018 were as follows:

In millions	Level 1	Level 2	Level 3	Total
Debt securities:				
U.S. government securities	$ 511	$ 38	$ —	$ 549
States, municipalities and political subdivisions	—	147	—	147
U.S. corporate securities	—	1,671	5	1,676
Foreign securities	—	177	—	177
Residential mortgage-backed securities	—	339	—	339
Commercial mortgage-backed securities	—	70	—	70
Other asset-backed securities	—	162	—	162
Redeemable preferred securities	—	6	—	6
Total debt securities	511	2,610	5	3,126
Equity securities:				
U.S. Domestic	744	—	—	744
International	356	—	—	356
Domestic real estate	30	—	—	30
Total equity securities	1,130	—	—	1,130
Other investments:				
Real estate	—	—	425	425
Common/collective trusts [(1)]	—	253	—	253
Derivatives	—	2	—	2
Total other investments	—	255	425	680
Total pension investments [(2)]	$ 1,641	$ 2,865	$ 430	$ 4,936

(1) The assets in the underlying funds of common/collective trusts consist of $109 million of equity securities and $144 million of debt securities.
(2) Excludes $98 million of cash and cash equivalents, $465 million of private equity limited partnership investments and $164 million of hedge fund limited partnership investments as the amounts are carried at fair value.

The change in the balance of pension plan assets during 2018 relates to investments acquired in the Aetna Acquisition, which occurred on November 28, 2018. There was an immaterial amount of transfers into or out of Level 3 from November 28, 2018 to December 31, 2018.

The Aetna Pension Plan invests in a diversified mix of assets intended to maximize long-term returns while recognizing the need for adequate liquidity to meet ongoing benefit and administrative obligations. The risk of unexpected investment and actuarial outcomes is regularly evaluated. This evaluation is performed through forecasting and assessing ranges of investment outcomes over short- and long-term horizons and by assessing Aetna Pension Plan's liability characteristics. Complementary investment styles and techniques are utilized by multiple professional investment firms to further improve portfolio and operational risk characteristics. Public and private equity investments are used primarily to increase overall plan returns. Real estate investments are viewed favorably for their diversification benefits and above-average dividend generation. Fixed income investments provide diversification benefits and liability hedging attributes that are desirable, especially in falling interest rate environments.

At December 31, 2018 , target investment allocations for the Aetna Pension Plan were: 31% in equity securities, 57% in debt securities, 6% in real estate, 3% in private equity limited partnerships and 3% in hedge funds. Actual asset allocations may differ from target allocations due to tactical decisions to overweight or underweight certain assets or as a result of normal fluctuations in asset values. Asset allocations are consistent with stated investment policies and, as a general rule, periodically rebalanced back to target asset allocations. Asset allocations and investment performance are formally reviewed periodically throughout the year by the Aetna Pension Plan's Benefit Finance Committee. Forecasting of asset and liability growth is performed at least annually.

Cash Flows
The Company generally contributes to its tax-qualified pension plans based on minimum funding requirements determined under applicable federal laws and regulations. Employer contributions related to the non-qualified supplemental pension plans generally represent payments to retirees for current benefits. The Company contributed $12 million , $46 million and $25 million to the pension plans during 2018 , 2017 and 2016 , respectively. No contributions are required for the Aetna Pension Plan in 2019. The Company expects to make an immaterial amount of contributions for all other pension plans in 2019. The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the pension plan benefit obligation as of December 31, 2018 :

In millions		
2019	$	375
2020		387
2021		411
2022		387
2023		391
2024-2028		1,916

Multiemployer Pension Plans
The Company also contributes to a number of multiemployer pension plans under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in these multiemployer plans are different from single-employer pension plans in the following aspects: (i) assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers, (ii) if a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers, and (iii) if the Company chooses to stop participating in some of its multiemployer plans, the Company may be required to pay those plans an amount based on the underfunded status of the applicable plan, referred to as a withdrawal liability.

None of the multiemployer pension plans in which the Company participates are individually significant to the Company. Total Company contributions to multiemployer pension plans were $18 million , $17 million and $15 million in 2018 , 2017 and 2016 , respectively.

Other Postretirement Benefits

The Company provides postretirement health care and life insurance benefits to certain retirees who meet eligibility requirements. On November 28, 2018, the Company completed the Aetna Acquisition. Aetna also sponsors OPEB plans that provide certain health care and life insurance benefits for retired employees. The Company's funding policy is generally to pay covered expenses as they are incurred. For retiree medical plan accounting, the Company reviews external data and its own historical trends for health care costs to determine the health care cost trend rates. As of December 31, 2018 and 2017 , the Company's other postretirement benefits had an accumulated postretirement benefit obligation of $228 million and $25 million , respectively. Net periodic benefit costs related to these other postretirement benefits were $2 million in 2018 , and $1 million in both 2017 and 2016 .

The Company estimates the following future benefit payments, which are calculated using the same actuarial assumptions used to measure the other postretirement benefit obligation as of December 31, 2018 :

In millions		
2019	$	17
2020		17
2021		17
2022		16
2023		16
2024-2028		76

Pursuant to various collective bargaining agreements, the Company also contributes to multiemployer health and welfare plans that cover certain union-represented employees. The plans provide postretirement health care and life insurance benefits to

certain employees who meet eligibility requirements. Total Company contributions to multiemployer health and welfare plans were $58 million , $58 million and $52 million in 2018 , 2017 and 2016 , respectively.

10. Income Taxes

The income tax provision for continuing operations consisted of the following for the years ended December 31:

In millions	**2018**	**2017**	**2016**
Current:			
Federal	$ 1,480	$ 2,594	$ 2,803
State	499	464	511
	1,979	3,058	3,314
Deferred:			
Federal	22	(1,435)	5
State	1	14	(2)
	23	(1,421)	3
Total	$ 2,002	$ 1,637	$ 3,317

The TCJA was enacted on December 22, 2017. Among numerous changes to existing tax laws, the TCJA permanently reduced the federal corporate income tax rate from 35% to 21% effective on January 1, 2018. The effects of changes in tax rates on deferred tax balances are required to be taken into consideration in the period in which the changes are enacted, regardless of when they are effective. As a result of the reduction of the corporate income tax rate under the TCJA, the Company estimated the revaluation of its net deferred tax liabilities and recorded a provisional noncash income tax benefit of approximately $1.5 billion for year ended December 31, 2017. The Company completed its assessment of the TCJA's final impact in December 2018 and recorded an additional tax benefit of approximately $100 million in the year ended December 31, 2018.

The following table is a reconciliation of the statutory income tax rate to the Company's effective income tax rate for continuing operations for the years ended December 31:

	2018	**2017**	**2016**
Statutory income tax rate	21.0 %	35.0 %	35.0 %
State income taxes, net of federal tax benefit	27.7	4.1	4.1
Effect of the Tax Cuts and Jobs Act	(7.1)	(18.3)	—
Health insurer fee	2.2	—	0.2
Goodwill impairments	89.5	0.8	—
Sale of subsidiary	5.0	—	—
Other	4.1	(1.8)	(0.9)
Effective income tax rate	142.4 %	19.8 %	38.4 %

The following table is a summary of the components of the Company's deferred income tax assets and liabilities as of December 31:

In millions	**2018**	**2017**
Deferred income tax assets:		
Lease and rents	$ 277	$ 291
Inventory	28	31
Employee benefits	243	246
Allowance for doubtful accounts	243	187
Retirement benefits	130	40
Net operating loss and capital loss carryforwards	529	101
Deferred income	104	93
Insurance reserves	467	—
Investments	11	—
Other	242	18
Valuation allowance	(520)	(77)
Total deferred income tax assets	1,754	930
Deferred income tax liabilities:		
Depreciation and amortization	(9,431)	(3,926)
Total deferred income tax liabilities	(9,431)	(3,926)
Net deferred income tax liabilities	$ (7,677)	$ (2,996)

The increase in net deferred income tax liabilities is mainly due to the Aetna Acquisition. As of December 31, 2018, the Company has net operating and capital loss carryovers of approximately $529 million . The Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax planning strategies and recent results of operations. The Company established a valuation allowance of $520 million because it does not consider it more likely than not that these deferred tax assets will be recovered.

A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows:

In millions	**2018**	**2017**	**2016**
Beginning balance	$ 344	$ 307	$ 338
Additions based on tax positions related to the current year	1	62	68
Additions based on tax positions related to prior years	324	32	70
Reductions for tax positions of prior years	(5)	(28)	(100)
Expiration of statutes of limitation	(2)	(10)	(22)
Settlements	(1)	(19)	(47)
Ending balance	$ 661	$ 344	$ 307

The increase in the balance of unrecognized tax benefits in 2018 compared to 2017 and 2016 is mainly due to the Aetna Acquisition.

The Company and most of its subsidiaries are subject to United States federal income tax as well as income tax of numerous state and local jurisdictions. The Company is a participant in the Compliance Assurance Process, which is a program made available by the Internal Revenue Service ("IRS") to certain qualifying large taxpayers, under which participants work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the annual filing of their federal income tax return. The IRS has substantially completed its examinations of the Company's 2015, 2016 and 2017 consolidated United States federal income tax returns. The IRS is currently examining the Company's 2018 consolidated United States federal income tax return.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2018 , no examination has resulted in any proposed adjustments that would result in a material change to the Company's results of operations, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2012. Certain state exams are likely to be concluded and certain state statutes of limitations will lapse in 2019, but the change in the balance of the Company's uncertain tax positions is projected to be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in the income tax provision. The Company accrued interest expense of approximately $19 million , $11 million and $10 million in 2018 , 2017 and 2016 , respectively. The Company had approximately $80 million and $34 million accrued for interest and penalties as of December 31, 2018 and 2017 , respectively.

As of December 31, 2018 , the total amount of unrecognized tax benefits that, if recognized, would affect the Company's effective income tax rate is approximately $597 million , after considering the federal benefit of state income taxes.

11. Stock Incentive Plans

The terms of the CVS Health 2017 Incentive Compensation Plan ("ICP") provide for grants of annual incentive and long-term performance awards to executive officers and other officers and employees of the Company or any subsidiary of the Company, as well as equity compensation to outside directors of CVS Health. Payment of such annual incentive and long-term performance awards will be in cash, stock, other awards or other property, at the discretion of the Management Planning and Development Committee (the "MP&D Committee") of the Company's Board of Directors (the "Board"). The ICP allows for a maximum of 32 million shares of CVS Health common stock to be reserved and available for grants. Prior to the acquisition of Aetna in 2018, the ICP was the only compensation plan under which the Company granted stock options, restricted stock and other stock-based awards to its employees, with the exception of the Company's Employee Stock Purchase Plan ("ESPP"). As of December 31, 2018 , there were approximately 26 million shares of CVS Health common stock available for future grants under the ICP.

As of the Aetna Acquisition Date, approximately 22 million shares of Aetna common stock subject to awards outstanding under the Amended Aetna Inc. 2010 Stock Incentive Plan ("SIP") were assumed by CVS Health. In addition, in accordance with the merger agreement, shares which were available for future issuance under the SIP were converted into approximately 32 million shares of CVS Health common stock reserved and available for issuance pursuant to future awards. As of December 31, 2018 , there were approximately 32 million shares of CVS Health common stock available for future grants under the SIP.

Stock-based Compensation Expense

Stock-based compensation is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service period of the stock award (generally three to five years) using the straight-line method. The following table is a summary of stock-based compensation for each of the respective periods:

In millions	2018	2017	2016
Stock options and stock appreciation rights ("SARs") (1)(2)	$ 70	$ 65	$ 79
Restricted stock units and performance stock units (2)	210	169	143
Total stock-based compensation	$ 280	$ 234	$ 222

(1) Includes the ESPP.
(2) Stock-based compensation for the year ended December 31, 2018 includes $14 million and $27 million associated with accelerated vesting of SARs and restricted stock replacement awards, respectively, issued to Aetna employees who were terminated subsequent to the acquisition.

ESPP

The ESPP provides for the purchase of up to 30 million shares of common stock. Under the ESPP, beginning in 2016, eligible employees could purchase common stock at the end of each six month offering period at a purchase price equal to 90% of the lower of the fair market value on the first day or the last day of the offering period. Prior to 2016, the purchase price was equal

to 85% of the lower of the fair market value on the first day or the last day of the offering period. During 2018 , approximately two million shares of common stock were purchased under the provisions of the ESPP at an average price of $61.40 per share. As of December 31, 2018 , approximately 9 million shares of common stock were available for issuance under the ESPP.

The fair value of stock-based compensation associated with the ESPP is estimated on the date of grant (the first day of the six month offering period) using the Black-Scholes option pricing model.

The following table is a summary of the assumptions used to value the ESPP awards for each of the respective periods:

	2018	2017	2016
Dividend yield (1)	1.45%	1.24%	0.88%
Expected volatility (2)	28.02%	22.70%	20.64%
Risk-free interest rate (3)	1.87%	0.86%	0.45%
Expected life (in years) (4)	0.5	0.5	0.5
Weighted-average grant date fair value	$ 12.26	$ 13.01	$ 14.98

(1) The dividend yield is calculated based on semi-annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is based on the historical volatility of the Company's daily stock market prices over the previous six month period.
(3) The risk-free interest rate is based on the Treasury constant maturity interest rate whose term is consistent with the expected term of ESPP purchases (i.e., six months).
(4) The expected life is based on the semi-annual purchase period.

Restricted Stock Units and Performance Stock Units

The Company's restricted stock units and performance stock units are considered nonvested share awards and require no payment from the employee. Vesting of the Company's performance stock units is dependent upon the degree to which the Company achieves its performance goals, which are set at the time of grant by the MP&D Committee. For each restricted stock unit and performance share stock granted, employees receive one share of common stock, net of taxes, at the end of the vesting period. Compensation cost is recorded based on the market price of the Company's common stock on the grant date and is recognized on a straight-line basis over the requisite service period. On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna performance stock unit and restricted stock unit awards as of the Aetna Acquisition Date were converted into replacement CVS Health restricted stock awards.

As of December 31, 2018 , there was $491 million of total unrecognized compensation cost related to Company restricted stock units and performance stock units that are expected to vest. These costs are expected to be recognized over a weighted-average period of 2.01 years. The total fair value of restricted shares vested during 2018 , 2017 and 2016 was $262 million , $175 million and $218 million , respectively.

The following table is a summary of the restricted stock unit and performance stock unit activity for the year ended December 31, 2018 :

Units in thousands	Units	Weighted Average Grant Date Fair Value
Unvested at beginning of year	5,014	$ 86.92
Granted	10,185	$ 73.18
Vested	(3,757)	$ 68.85
Forfeited	(437)	$ 76.92
Unvested at end of year	11,005	$ 76.18

Stock Options and SARs

All stock option grants are awarded at fair value on the date of grant. The fair value of stock options is estimated using the Black-Scholes option pricing model and stock-based compensation is recognized on a straight-line basis over the requisite

service period. Stock options granted generally become exercisable over a four -year period from the grant date. Stock options generally expire seven years after the grant date.

On November 28, 2018, the Company completed the Aetna Acquisition. All unvested Aetna SARs outstanding as of the Aetna Acquisition Date were converted into replacement CVS Health SARs. The replacement SARs granted will be settled in CVS Health common stock, net of taxes, based on the appreciation of the stock price on the exercise date over the market price on the date of grant. The fair value of SARs is estimated using the Black-Scholes option pricing model and stock-based compensation is recognized on a straight-line basis over the requisite service period. SARs generally become exercisable over a three -year period from the grant date. SARs generally expire ten years after the grant date.

The following table is a summary of stock option and SAR activity that occurred for the years ended December 31, 2018 , 2017 and 2016 :

In millions	**2018**	**2017**	**2016**
Cash received from stock options exercised (including ESPP)	$ 242	$ 329	$ 296
Payments for taxes for net share settlement of equity awards	97	71	72
Intrinsic value of stock options and SARs exercised	79	176	244
Fair value of stock options and SARs vested	324	341	298

The fair value of each stock option and SAR is estimated using the Black-Scholes option pricing model based on the following assumptions at the time of grant:

	2018	**2017**	**2016**
Dividend yield (1)	2.76%	2.56%	1.62%
Expected volatility (2)	21.27%	18.39%	17.22%
Risk-free interest rate (3)	2.77%	1.77%	1.24%
Expected life (in years) (4)	4.8	4.1	4.2
Weighted-average grant date fair value	$ 24.55	$ 9.43	$ 13.00

(1) The dividend yield is based on annual dividends paid and the fair market value of the Company's stock at the grant date.
(2) The expected volatility is estimated using the Company's historical volatility over a period equal to the expected life of each option grant after adjustments for infrequent events such as stock splits.
(3) The risk-free interest rate is selected based on yields from U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of the options being valued.
(4) The expected life represents the number of years the options are expected to be outstanding from grant date based on historical option holder exercise experience.

As of December 31, 2018 , unrecognized compensation expense related to unvested stock options and SARs totaled $58 million , which the Company expects to be recognized over a weighted-average period of 1.2 years. After considering anticipated forfeitures, the Company expects approximately 11 million of the unvested stock options and SARs to vest over the requisite service period.

The following table is a summary of the Company's stock option and SAR activity for the year ended December 31, 2018

In thousands, except weighted average exercise price and remaining contractual term	Shares	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value
Outstanding at December 31, 2017	20,530	$ 75.32		
Granted	7,144	$ 51.06		
Exercised	(2,993)	$ 44.62		
Forfeited	(908)	$ 86.97		
Expired	(864)	$ 81.79		
Outstanding at December 31, 2018	22,909	$ 71.15	4.08	$ 165,245
Exercisable at December 31, 2018	11,436	$ 72.69	2.23	$ 73,784
Vested at December 31, 2018 and expected to vest in the future	22,532	$ 71.18	4.05	$ 163,596

12. Shareholders' Equity

Share Repurchases

The following share repurchase programs have been authorized by the Board:

In billions Authorization Date	Authorized	Remaining as of December 31, 2018
November 2, 2016 ("2016 Repurchase Program")	$ 15.0	$ 13.9
December 15, 2014 ("2014 Repurchase Program")	10.0	—

The share Repurchase Programs, each of which was effective immediately, permit the Company to effect repurchases from time to time through a combination of open market repurchases, privately negotiated transactions, accelerated share repurchase ("ASR") transactions, and/or other derivative transactions. The 2014 Repurchase Program was completed during the second quarter of 2017. The 2016 Repurchase Program can be modified or terminated by the Board at any time.

2018 Activity
During the year ended December 31, 2018 , the Company did not repurchase any shares of common stock pursuant to the 2016 Repurchase Program.

2017 Activity
Pursuant to the authorization under the 2014 Repurchase Program, in August 2016, the Company entered into two fixed dollar ASRs with Barclays Bank PLC ("Barclays") for a total of $3.6 billion . Upon payment of the $3.6 billion purchase price in January 2017, the Company received a number of shares of its common stock equal to 80% of the $3.6 billion notional amount of the ASRs or approximately 36.1 million shares, which were placed into treasury stock in January 2017. The ASRs were accounted for as an initial treasury stock transaction for $2.9 billion and a forward contract for $0.7 billion . In April 2017, the Company received an additional 9.9 million shares of common stock, representing the remaining 20% of the $3.6 billion notional amount of the ASRs, thereby concluding the ASRs. The additional 9.9 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in April 2017.

During the year ended December 31, 2017, the Company repurchased an aggregate of 55.4 million shares of common stock for approximately $4.4 billion under the 2014 and 2016 Repurchase Programs.

2016 Activity
Pursuant to the authorization under the 2014 Repurchase Program, in December 2015, the Company entered into a $725 million fixed dollar ASR with Barclays. Upon payment of the $725 million purchase price in December 2015, the Company received a number of shares of its common stock equal to 80% of the $725 million notional amount of the ASR or approximately 6.2

million shares, which were placed into treasury stock in December 2015. The ASR was accounted for as an initial treasury stock transaction for $580 million and a forward contract for $145 million . The forward contract was classified as an equity instrument and was recorded within capital surplus on the consolidated balance sheet. In January 2016, the Company received an additional 1.4 million shares of common stock, representing the remaining 20% of the $725 million notional amount of the ASR, thereby concluding the ASR. The additional 1.4 million shares of common stock delivered to the Company by Barclays were placed into treasury stock and the forward contract was reclassified from capital surplus to treasury stock in January 2016.

During the year ended December 31, 2016, the Company repurchased an aggregate of 47.5 million shares of common stock for approximately $4.5 billion under the 2014 Repurchase Program.

Dividends

The quarterly cash dividend declared by the Board was $0.50 per share in 2018 and 2017. CVS Health has paid cash dividends every quarter since becoming a public company. Future dividend payments will depend on the Company's earnings, capital requirements, financial condition and other factors considered relevant by the Board.

Regulatory Requirements

On November 28, 2018, the Company completed the Aetna Acquisition. Aetna's insurance business operations are conducted through subsidiaries that principally consist of HMOs and insurance companies. The Company's HMO and insurance subsidiaries report their financial statements in accordance with accounting practices prescribed by state regulatory authorities which may differ from GAAP.

The combined statutory net income for the year ended December 31, 2018 (which includes Aetna and its subsidiaries from November 28, 2018 to December 2018) was not material. The combined statutory capital and surplus at December 31, 2018 of the Company's insurance and HMO subsidiaries was approximately $11.1 billion . From November 28, 2018 to December 31, 2018 , the Company's insurance and HMO subsidiaries paid $909 million of gross dividends to the Company.

In addition to general state law restrictions on payments of dividends and other distributions to shareholders applicable to all corporations, HMOs and insurance companies are subject to further regulations that, among other things, may require those companies to maintain certain levels of equity and restrict the amount of dividends and other distributions that may be paid to their equity holders. In addition, in connection with the Aetna Acquisition, the Company made certain undertakings that require prior regulatory approval of dividends by certain of its HMOs and insurance companies. At December 31, 2018 , these amounts were as follows:

In millions		
Estimated minimum statutory surplus required by regulators	$	5,358
Investments on deposit with regulatory bodies		630
Estimated maximum dividend distributions permitted in 2019 without prior regulatory approval		584

Noncontrolling Interests

At December 31, 2018 , noncontrolling interests were $318 million primarily related to third party interests in the Company's operating entities. The noncontrolling entities' share is included in total shareholders ' equity.

13. Other Comprehensive Income (Loss)

Shareholders' equity included the following activity in accumulated other comprehensive income (loss) in 2018 , 2017 and 2016 :

	At December 31,		
In millions	**2018**	**2017**	**2016**
Net unrealized investment gains (losses):			
Beginning of year balance	$ —	$ —	$ —
Other comprehensive income before reclassifications *($132 pretax)*	97	—	—
Amounts reclassified from accumulated other comprehensive income *($1 pretax)* (1)	—	—	—
Other comprehensive income	97	—	—
End of year balance	97	—	—
Foreign currency translation adjustments:			
Beginning of year balance	(129)	(127)	(165)
Other comprehensive income (loss)	(29)	(2)	38
Other comprehensive income (loss)	(29)	(2)	38
End of year balance	(158)	(129)	(127)
Net cash flow hedges:			
Beginning of year balance	(15)	(5)	(7)
Adoption of new accounting standard (4)	(3)	—	—
Other comprehensive income (loss) before reclassifications *($465, $(18) and $0 pretax)*	344	(11)	—
Amounts reclassified from accumulated other comprehensive loss *($(19), $2 and $3 pretax)* (2)	(14)	1	2
Other comprehensive income (loss)	330	(10)	2
End of year balance	312	(15)	(5)
Pension and OPEB plans:			
Beginning of year balance	(21)	(173)	(186)
Adoption of new accounting standard (4)	(4)	—	—
Other comprehensive loss before reclassifications *($(178), $0 and $0 pretax)*	(132)	—	—
Amounts reclassified from accumulated other comprehensive loss *($11, $249 and $21 pretax)* (3)	8	152	13
Other comprehensive income (loss)	(124)	152	13
End of year balance	(149)	(21)	(173)
Total beginning of year accumulated other comprehensive loss	(165)	(305)	(358)
Adoption of new accounting standard (4)	(7)	—	—
Total other comprehensive income	274	140	53
Total end of year accumulated other comprehensive income (loss)	$ 102	$ (165)	$ (305)

(1) Amounts reclassified from accumulated other comprehensive income for debt securities are included in net investment income within the consolidated statements of operations.
(2) Amounts reclassified from accumulated other comprehensive loss for specifically identified cash flow hedges are included within interest expense in the consolidated statements of operations.
(3) Amounts reclassified from accumulated other comprehensive loss for specifically identified pension and other postretirement benefits are included in other (income) expense in the consolidated statements of operations.
(4) See Note 1 ''Significant Accounting Policies'' for additional information on the adoption of ASU 2018-02 during the first quarter of 2018.

14. Earnings Per Share

Earnings (loss) per share is computed using the two-class method. For periods in which the Company reports net income, diluted earnings per share is determined by using the weighted average number of common and dilutive common equivalent shares outstanding during the period, unless the effect is antidilutive. Due to the loss from continuing operations attributable to CVS Health in the year ended December 31, 2018 , 3 million potentially dilutive common equivalent shares were excluded from

the calculation of diluted earnings per share, as the impact of these shares was antidilutive. In addition, options to purchase 13.2 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the year ended December 31, 2018 because the exercise prices of the options were greater than the average market price of the common shares and, therefore, the effect would be antidilutive. For the same reason, options to purchase 10.4 million and 6.7 million shares of common stock were outstanding, but were excluded from the calculation of diluted earnings per share, for the years ended December 31, 2017 and 2016 , respectively.

The following is a reconciliation of basic and diluted earnings (loss) per share from continuing operations for the years ended December 31:

In millions, except per share amounts	**2018**	**2017**	**2016**
Numerator for earnings per share calculation:			
Income (loss) from continuing operations	$ (596)	$ 6,631	$ 5,320
Income allocated to participating securities	(3)	(24)	(27)
Net (income) loss attributable to noncontrolling interests	2	(1)	(2)
Income (loss) from continuing operations attributable to CVS Health	$ (597)	$ 6,606	$ 5,291
Denominator for earnings per share calculation:			
Weighted average shares, basic	1,044	1,020	1,073
Effect of dilutive securities	—	4	6
Weighted average shares, diluted	1,044	1,024	1,079
Earnings (loss) per share from continuing operations:			
Basic	$ (0.57)	$ 6.48	$ 4.93
Diluted	$ (0.57)	$ 6.45	$ 4.91

15. Reinsurance

The Company utilizes reinsurance agreements primarily to reduce required capital and to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Company to recover a portion of its losses from reinsurers, although they do not discharge the Company's primary liability as the direct insurer of the risks reinsured.

On November 30, 2018, Aetna completed the sale of its standalone Medicare Part D prescription drug plans to a subsidiary of WellCare, effective December 31, 2018. In connection with that sale, subsidiaries of WellCare and Aetna entered into reinsurance agreements under which WellCare has ceded to Aetna 100% of the insurance risk related to the divested standalone Medicare Part D prescription drug plans for the 2019 PDP plan year.

In January 2019, the Company entered into two four -year reinsurance agreements with an unrelated reinsurer that allowed it to reduce required capital and provided collateralized excess of loss reinsurance coverage on a portion of the Health Care Benefits segment's group Commercial Insured business.

Reinsurance recoverables (recorded as other current assets or other assets on the consolidated balance sheets) at December 31, 2018 were as follows:

In millions	
Reinsurer	
Hartford Life and Accident Insurance Company	$ 3,470
Lincoln Life & Annuity Company of New York	424
Constitution Life	320
VOYA Retirement Insurance and Annuity Company	186
All Other	141
Total	$ 4,541

Direct, assumed and ceded premiums earned for the year ended December 31, 2018 were as follows:

In millions		
Direct	$	8,365
Assumed		38
Ceded		(219)
Net premiums	$	8,184

The impact of reinsurance on benefit costs for the year ended December 31, 2018 was as follows:

In millions		
Direct	$	6,773
Assumed		32
Ceded		(211)
Net benefit costs	$	6,594

There is not a material difference between premiums on a written basis versus an earned basis.

The Company also has various agreements with unrelated reinsurers that do not qualify for reinsurance accounting under GAAP, and consequently are accounted for using deposit accounting. These contracts were entered into to reduce the risk of catastrophic loss which in turn reduces the Company's capital and surplus requirements for certain portions of its group term life insurance and group accidental death and dismemberment insurance businesses and certain portions of the Health Care Benefits segment's Medicare Advantage and group Commercial Insured businesses. Total deposit assets and liabilities related to reinsurance agreements that do not qualify for reinsurance accounting under GAAP were not material as of December 31, 2018 .

16. Commitments and Contingencies

Guarantees

The Company has the following significant guarantee arrangements at December 31, 2018 :

- ASC Claim Funding Accounts - The Company has arrangements with certain banks for the processing of claim payments for its ASC customers. The banks maintain accounts to fund claims of the Company's ASC customers. The customer is responsible for funding the amount paid by the bank each day. In these arrangements, the Company guarantees that the banks will not sustain losses if the responsible ASC customer does not properly fund its account. The aggregate maximum exposure under these arrangements is generally limited to $250 million . The Company can limit its exposure to these guarantees by suspending the payment of claims for ASC customers that have not adequately funded the amount paid by the bank.
- Separate Accounts Assets - Certain Separate Accounts assets associated with the large case pensions business in the Corporate/Other segment represent funds maintained as a contractual requirement to fund specific pension annuities that the Company has guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were approximately $1.4 billion at December 31, 2018 . See Note 1 ''Significant Accounting Policies'' for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Accounts balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Account's investment strategy. If contract holders do not maintain the required level of Separate Accounts assets to meet the annuity guarantees, the Company would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2018 exceeded the value of the guaranteed benefit obligation. As a result, the Company was not required to maintain any additional liability for its related guarantees at December 31, 2018 .

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed

to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of December 31, 2018, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, Aetna recorded a discounted estimated liability and expense of $231 million pretax for its estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The Company did not record an asset for expected premium tax offsets for its in force business at December 31, 2018, as the amount was not material. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's results of operations, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The total guaranty fund assessments liability as of December 31, 2018 was $90 million and was recorded in accrued expenses on the consolidated balance sheet.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

<u>Usual and Customary Litigation</u>

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. The Company is defending itself against these claims.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The *Corcoran* plaintiffs have appealed the District Court's decision to the Ninth Circuit. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, moved for judgment on the pleadings, filed a counterclaim and moved the case to Mississippi Circuit Court. The Company's motion for judgment on the pleadings remains pending. The Company is defending itself against these claims.

Manufacturer's Rebate Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning manufacturer's rebates that the Company has negotiated.

Bewley, et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants' motions. The Company is defending itself against these claims.

Klein , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation* . The Company is defending itself against these claims.

In April 2017, the Company received a CID from the Attorney General of Washington requesting documents and information regarding pricing and rebates for insulin products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin pricing. The Office of the Attorney General of Washington has notified the Company that information provided in response to the Washington Attorney General's CID will be shared with the Attorneys General of California, Florida, Minnesota, New Mexico, the District of Columbia and Mississippi. In July 2017, the Company received a CID from the Attorney General of Minnesota requesting documents and information regarding pricing and rebates for insulin and epinephrine products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin and epinephrine pricing. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. Fewer than 100 similar cases that name the Company as a defendant in some capacity are pending in state courts. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). For several of these audits, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served Omnicare with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Company pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Company pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, Omnicare received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, Omnicare also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the arbitrator awarded the claimant hospitals approximately $150 million . The Company is defending itself against the claimant hospitals' claims and has appealed the arbitrator's decision.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's results of operations, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's results of operations, cash flows or financial condition.

Other Legal and Regulatory Proceedings .

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in the Company's Commercial Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's results of operations. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the

Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company currently has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information for which results of operations are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services, Retail/LTC and Health Care Benefits segments' performance based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The chief operating decision maker does not use total assets by segment to make decisions regarding resources. Therefore the total asset disclosure by segment has not been included. See Note 1 ''Significant Accounting Policies'' for a description of the Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other segments and related significant accounting policies.

In 2018 , 2017 and 2016 , approximately 9.8% , 12.3% and 11.7% , respectively, of the Company's consolidated revenues were from Aetna, a Pharmacy Services segment client. On November 28, 2018, the Company completed the Aetna Acquisition. Subsequent to the Aetna Acquisition, transactions with Aetna will continue to be reported within the Pharmacy Services segment, but are eliminated in the Company's consolidated financial statements.

Effective for the first quarter of 2019, the Company will realign the composition of its segments to correspond with changes to its operating model. As a result of this realignment, the Company's Silverscript PDP will move from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company will move Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment.

In millions	Pharmacy Services [1][2]	Retail/ LTC [2]	Health Care Benefits [2]	Corporate/ Other	Intersegment Eliminations [2]	Consolidated Totals
2018:						
Revenues from customers	$ 134,115	$ 83,989	$ 5,504	$ 4	$ (29,693)	$ 193,919
Net investment income [3]	13	—	45	602	—	660
Total revenues	134,128	83,989	5,549	606	(29,693)	194,579
Operating income (loss) [4][5]	4,699	620	276	(805)	(769)	4,021
Depreciation and amortization	712	1,698	170	138	—	2,718
Additions to property and equipment	326	1,350	46	401	—	2,123
2017:						
Revenues from customers	130,596	79,398	—	—	(25,229)	184,765
Net investment income	5	—	—	16	—	21
Total revenues [7]	130,601	79,398	—	16	(25,229)	184,786
Operating income (loss) [4][5][7]	4,657	6,558	—	(936)	(741)	9,538
Depreciation and amortization	712	1,651	—	116	—	2,479
Additions to property and equipment	311	1,398	—	340	—	2,049
2016:						
Revenues from customers	119,963	81,100	—	—	(23,537)	177,526
Net investment income	2	—	—	18	—	20
Total revenues [7]	119,965	81,100	—	18	(23,537)	177,546
Operating income (loss) [4][5][6][7]	4,570	7,437	—	(900)	(721)	10,386
Depreciation and amortization	714	1,642	—	119	—	2,475
Additions to property and equipment	295	1,732	—	252	—	2,279

(1) Total revenues of PSS include approximately $11.4 billion , $10.8 billion and $10.5 billion of Retail Co-Payments for 2018 , 2017 and 2016 , respectively. See Note 1 ‘‘Significant Accounting Policies’’ for additional information about Retail Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between PSS and RLS for 2018, 2017 and 2016. Effective November 28, 2018, intersegment eliminations also relate to intersegment revenue generating activities that occur between HCBS, PSS and/or RLS.

(3) Corporate/Other segment net investment income for 2018 includes interest income of $536 million related to the proceeds of the $40 billion 2018 Notes. This amount is for the period prior to the close of the Aetna Acquisition, which occurred on November 28, 2018.

(4) RLS operating income for 2018 , 2017 and 2016 includes $7 million , $34 million and $281 million , respectively, of acquisition-related integration costs. The integration costs in 2018 and 2017 are related to the acquisition of Omnicare. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target. RLS operating income for 2018 and 2017 also includes goodwill impairment charges of $6.1 billion related to the LTC reporting unit and $181 million related to the RxCrossroads reporting unit, respectively. In addition, RLS operating income for 2017 and 2016 includes $215 million and $34 million , respectively, of charges associated with store rationalization and asset impairment charges in connection with planned store closures related to the Company’s enterprise streamlining initiative. RLS operating income for 2018 also includes a $43 million loss on impairment of long-lived assets primarily related to the impairment of property and equipment and an $86 million loss on the divestiture of the Company’s RxCrossroads subsidiary.

(5) Corporate/Other segment operating loss for 2018 , 2017 and 2016 includes $485 million , $40 million and $10 million , respectively, of divestiture and acquisition-related transaction and integration costs included in operating expenses in the consolidated statements of operations. The transaction and integration costs in 2018 are related to the acquisitions of Aetna and Omnicare. The transaction and integration costs in 2017 are related to the acquisitions of Aetna and Omnicare and the divestiture of RxCrossroads. The integration costs in 2016 are related to the acquisitions of Omnicare and the pharmacy and clinic businesses of Target.

(6) PSS operating income for 2016 includes the reversal of an accrual of $88 million in connection with a legal settlement.

(7) Amounts revised to reflect the reclassification of interest income from interest expense, net to net investment income within total revenues to conform with insurance company presentation which increased total revenues and operating income by $21 million and $20 million in 2017 and 2016, respectively.

In conjunction with the Company's implementation of a new enterprise resource planning system in the first quarter of 2018, the Company changed the manner in which certain shared functional costs are allocated to its reportable segments.

Additionally, in connection with the Aetna Acquisition on November 28, 2018, the Company reclassified interest income from interest expense, net to net investment income within revenues to conform with insurance company presentation. Segment financial information for the years ended December 31, 2017 and 2016 , have been retrospectively adjusted to reflect this change to the Company's cost allocation methodology and net investment income presentation as shown below:

	Year Ended December 31, 2017				
In millions	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Revenues, as previously reported	$ 130,596	$ 79,398	$ —	$ (25,229)	$ 184,765
Adjustments	5	—	16	—	21
Revenues, as adjusted	$ 130,601	$ 79,398	$ 16	$ (25,229)	$ 184,786
Cost of products sold [1]	$ 121,746	$ 56,081	$ —	$ (24,417)	$ 153,410
Adjustments	53	(15)	—	—	38
Cost of products sold	$ 121,799	$ 56,066	$ —	$ (24,417)	$ 153,448
Benefit costs [1]	$ 2,810	$ —	$ —	$ —	$ 2,810
Adjustments	—	—	—	—	—
Benefit costs	$ 2,810	$ —	$ —	$ —	$ 2,810
Operating expenses, as previously reported	$ 1,285	$ 16,848	$ 966	$ (71)	$ 19,028
Adjustments	50	(74)	(14)	—	(38)
Operating expenses, as adjusted	$ 1,335	$ 16,774	$ 952	$ (71)	$ 18,990
Operating income (loss), as previously reported	$ 4,755	$ 6,469	$ (966)	$ (741)	$ 9,517
Adjustments	(98)	89	30	—	21
Operating income (loss), as adjusted	$ 4,657	$ 6,558	$ (936)	$ (741)	$ 9,538

(1) The total of cost of products sold and benefit costs previously was reported as cost of revenues.

	Year Ended December 31, 2016				
In millions	**Pharmacy Services**	**Retail/ LTC**	**Corporate/ Other**	**Intersegment Eliminations**	**Consolidated Totals**
Revenues, as previously reported	$ 119,963	$ 81,100	$ —	$ (23,537)	$ 177,526
Adjustments	2	—	18	—	20
Revenues, as adjusted	$ 119,965	$ 81,100	$ 18	$ (23,537)	$ 177,546
Cost of products sold [1]	$ 111,883	$ 57,362	$ —	$ (22,755)	$ 146,490
Adjustments	66	(23)	—	—	43
Cost of products sold	$ 111,949	$ 57,339	$ —	$ (22,755)	$ 146,533
Benefit costs [1]	$ 2,179	$ —	$ —	$ —	$ 2,179
Adjustments	—	—	—	—	—
Benefit costs	$ 2,179	$ —	$ —	$ —	$ 2,179
Operating expenses, as previously reported	$ 1,225	$ 16,436	$ 891	$ (61)	$ 18,491
Adjustments	42	(112)	27	—	(43)
Operating expenses, as adjusted	$ 1,267	$ 16,324	$ 918	$ (61)	$ 18,448
Operating income (loss), as previously reported	$ 4,676	$ 7,302	$ (891)	$ (721)	$ 10,366
Adjustments	(106)	135	(9)	—	20
Operating income (loss), as adjusted	$ 4,570	$ 7,437	$ (900)	$ (721)	$ 10,386

(1) The total of cost of products sold and benefit costs previously was reported as cost of revenues.

18. Quarterly Financial Information (Unaudited)

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2018:					
Total revenues [1]	$ 45,743	$ 46,922	$ 47,490	$ 54,424	$ 194,579
Operating income (loss) [1]	1,996	(1,373)	2,574	824	4,021
Income (loss) from continuing operations	998	(2,562)	1,390	(422)	(596)
Net income (loss) attributable to CVS Health	998	(2,563)	1,390	(419)	(594)
Per common share data:					
Basic earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Diluted earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ —	$ —	$ —	$ —
Net income (loss) attributable to CVS Health	$ 0.98	$ (2.52)	$ 1.36	$ (0.37)	$ (0.57)
Dividends per common share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of $50 million , $214 million and $221 million was made for the first, second and third quarters of 2018, respectively, to increase revenues and increase interest expense.

In millions, except per share amounts	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
2017:					
Total revenues [1]	$ 44,520	$ 45,689	$ 46,186	$ 48,391	$ 184,786
Operating income [1]	1,799	2,121	2,504	3,114	9,538
Income from continuing operations	962	1,097	1,285	3,287	6,631
Net income attributable to CVS Health	952	1,098	1,285	3,287	6,622
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 0.93	$ 1.07	$ 1.26	$ 3.23	$ 6.48
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.23	$ 6.47
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.22	$ 6.45
Income (loss) from discontinued operations attributable to CVS Health	$ (0.01)	$ —	$ —	$ —	$ (0.01)
Net income attributable to CVS Health	$ 0.92	$ 1.07	$ 1.26	$ 3.22	$ 6.44
Dividends per common share	$ 0.50	$ 0.50	$ 0.50	$ 0.50	$ 2.00

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of $6 million , $4 million , $5 million and $6 million was made for the first, second, third and fourth quarters of 2017, respectively, to increase revenues and increase interest expense.

Five-Year Financial Summary

In millions, except per share amounts	2018 [2]	2017	2016	2015	2014
Statement of operations data:					
Total revenues [1]	$ 194,579	$ 184,786	$ 177,546	$ 153,311	$ 139,382
Operating income [1]	4,021	9,538	10,386	9,496	8,837
Income (loss) from continuing operations	(596)	6,631	5,320	5,230	4,645
Net income (loss) attributable to CVS Health	(594)	6,622	5,317	5,237	4,644
Per common share data:					
Basic earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.48	$ 4.93	$ 4.65	$ 3.98
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —	$ 0.01	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.47	$ 4.93	$ 4.66	$ 3.98
Diluted earnings (loss) per common share:					
Income (loss) from continuing operations attributable to CVS Health	$ (0.57)	$ 6.45	$ 4.91	$ 4.62	$ 3.96
Income (loss) from discontinued operations attributable to CVS Health	$ —	$ (0.01)	$ —	$ 0.01	$ —
Net income (loss) attributable to CVS Health	$ (0.57)	$ 6.44	$ 4.90	$ 4.63	$ 3.96
Dividends per common share	$ 2.00	$ 2.00	$ 1.70	$ 1.40	$ 1.10
Balance sheet and other data:					
Total assets	$ 196,456	$ 95,131	$ 94,462	$ 92,437	$ 73,202
Long-term debt	$ 71,444	$ 22,181	$ 25,615	$ 26,267	$ 11,630
Total shareholders' equity	$ 58,543	$ 37,695	$ 36,834	$ 37,203	$ 37,963
Number of stores (at end of year)	9,967	9,846	9,750	9,681	7,866

(1) Effective for the fourth quarter of 2018, interest income was reclassified from interest expense, net to net investment income within revenues to conform with insurance company presentation. Accordingly, a retrospective reclassification of $21 million, $20 million, $21 million and $15 million was made for years ended December 31, 2017, 2016, 2015 and 2014, respectively, to increase revenues and increase interest expense.

(2) On November 28, 2018, the Company acquired Aetna. Aetna's operations are included in the Company's consolidated financial statements for the period from November 28, 2018 to December 31, 2018 and the period then ended. See Note 2 ''Acquisition of Aetna'' of Notes to Consolidated Financial Statements for additional information.

Report of Independent Registered Public Accounting Firm

To the Shareholders and the Board of Directors of CVS Health Corporation

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of CVS Health Corporation (the Company) as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income (loss), shareholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 28, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2007.

Boston, Massachusetts
February 28, 2019

Exhibit 21.1

Subsidiaries of CVS Health Corporation

Listed below are subsidiaries under CVS Health Corporation at December 31, 2018 with their jurisdictions of organization shown in parentheses. Subsidiaries excluded from the list below are not insurance companies and would not, in the aggregate, constitute a "significant subsidiary" of CVS Health Corporation, as that term is defined in Rule 1-02(w) of Regulation S-X.

- **CVS Foreign, Inc. (New York)**
    - CVS Caremark Indemnity Ltd. (Bermuda)
    - CVS International, L.L.C. (Delaware)

- **CVS Pharmacy, Inc. (Rhode Island)**
    - Aetna Inc. (Pennsylvania)
        - Aetna Health Holdings, LLC (Delaware)
            - Aetna Health of California Inc. (California)
            - Aetna Health Inc. (Connecticut)
            - Aetna Health Inc. (Florida)
            - Aetna Health Inc. (Georgia)
            - Aetna Health Inc. (Maine)
            - Aetna Health Inc. (Michigan)
            - Aetna Health Inc. (New Jersey)
            - Aetna Health Inc. (New York)
                - Aetna Better Health Inc. (New York)
            - Aetna Health Inc. (Pennsylvania)
            - Aetna Health Inc. (Texas)
            - Aetna Better Health of California Inc. (California)
            - Aetna Better Health of Iowa Inc. (Iowa)
            - Aetna Better Health of Texas Inc. (Texas)
            - Aetna Better Health of Washington, Inc. (Washington)
            - Aetna Better Health Inc. (Georgia)
            - Aetna HealthAssurance Pennsylvania, Inc. (Pennsylvania)
            - Aetna Dental of California Inc. (California)
            - Aetna Dental Inc. (New Jersey)
            - Aetna Dental Inc. (Texas)
            - Aetna Rx Home Delivery, LLC (Delaware)
            - Aetna Health Management, LLC (Delaware)
            - Aetna Ireland Inc. (Delaware)
            - Aetna Specialty Pharmacy, LLC (Delaware)
            - Cofinity, Inc. (Delaware)
            - @Credentials Inc. (Delaware)
            - Aetna Better Health Inc. (Pennsylvania)
            - Aetna Better Health Inc. (Connecticut)
            - Aetna Better Health Inc. (Illinois)
            - Aetna Better Health of Kansas Inc. (Kansas)
            - Aetna Better Health, Inc. (Louisiana)
            - Aetna Florida Inc. (Florida)
            - Aetna Better Health Inc. (Ohio)
            - Aetna Better Health of Oklahoma Inc. (Oklahoma)
            - Aetna Better Health of Nevada Inc. (Nevada)
            - Aetna Better Health Inc. (New Jersey)
            - Aetna Better Health of North Carolina Inc. (North Carolina)
            - Aetna Network Services LLC (Connecticut)

- Aetna Risk Assurance Company of Connecticut Inc. (Connecticut)
- Aetna Student Health Agency Inc. (Massachusetts)
- Delaware Physicians Care, Incorporated (Delaware)
- Schaller Anderson Medical Administrators, Incorporated (Delaware)
- Aetna Medicaid Administrators LLC (Arizona)
- iTriage, LLC (Delaware)
- bswift LLC (Illinois)
- Prodigy Health Group, Inc. (Delaware)
    - Niagara Re, Inc. (New York)
    - Performax, Inc. (Delaware)
    - Scrip World, LLC (Utah)
    - Precision Benefit Services, Inc. (Delaware)
    - American Health Holding, Inc. (Ohio)
    - Meritain Health, Inc. (New York)
        - Administrative Enterprises, Inc. (Arizona)
        - U.S Healthcare Holdings, LLC (Ohio)
        - Prime Net, Inc. (Ohio)
        - Professional Risk Management, Inc. (Ohio)
- ADMINCO, Inc. (Arizona)
- Aetna Pharmacy Management Services, LLC (Delaware)
- Coventry Transplant Network, Inc. (Delaware)
- Aetna Health of Iowa Inc. (Iowa)
- Coventry Health Care of Nebraska, Inc. (Nebraska)
- Aetna Health Inc. (Louisiana)
- HealthAssuance Pennsylvania, Inc. (Pennsylvania)
- Coventry Prescription Management Services Inc. (Nevada)
- Coventry Health and Life Insurance Company (Missouri)
    - Aetna Better Health of Kentucky Insurance Company (Kentucky)
- Coventry Health Care of Virginia, Inc. (Virginia)
- Coventry Health Care of Missouri, Inc. (Missouri)
- Aetna Better Health of Missouri LLC (Missouri)
- Coventry Health Care of Illinois, Inc. (Illinois)
- Coventry Health Care of West Virginia, Inc. (West Virginia)
- Coventry HealthCare Management Corporation (Delaware)
- Coventry Health Care of Kansas, Inc. (Kansas)
- Coventry Health Care National Accounts, Inc. (Delaware)
- Aetna Better Health of Michigan Inc. (Michigan)
- Aetna Health of Utah Inc. (Utah)
- Aetna Better Health Inc. (Tennessee)
- Coventry Health Care National Network, Inc. (Delaware)
- Coventry Consumer Advantage, Inc. (Delaware)
- MHNet Specialty Services, LLC (Maryland)
    - Mental Health Network of New York IPA, Inc. (New York)
    - Mental Health Associates, Inc. (Louisiana)
    - MHNet of Florida, Inc. (Florida)
    - MHNet Life and Health Insurance Company (Texas)
- Group Dental Service, Inc. (Maryland)
    - Group Dental Service of Maryland, Inc. (Maryland)
- Florida Health Plan Administrators, LLC (Florida)
    - Coventry Health Care of Florida, Inc. (Florida)
    - Carefree Insurance Services, Inc. (Florida)
    - Coventry Health Plan of Florida, Inc. (Florida)

- First Health Group Corp. (Delaware)
    - First Health Life & Health Insurance Company (Texas)
    - Claims Administration Corp. (Maryland)
- Coventry Health Care Workers' Compensation, Inc. (Delaware)
    - Coventry Rehabilitation Services, Inc. (Delaware)
    - First Script Network Services, Inc. (Nevada)
    - FOCUS HealthCare Management, Inc. (Tennessee)
    - Medical Examinations of New York, P.C. (New York)
    - MetraComp, Inc. (Connecticut)
- Continental Life Insurance Company of Brentwood, Tennessee (Tennessee)
    - American Continental Insurance Company (Tennessee)
- Aetna Life Insurance Company (Connecticut)
    - AHP Holdings, Inc. (Connecticut)
        - Aetna Insurance Company of Connecticut (Connecticut)
        - AE Fourteen, Incorporated (Connecticut)
        - Aetna Life Assignment Company (Connecticut)
    - Aetna ACO Holdings Inc. (Delaware)
        - Innovation Health Holdings, LLC (Delaware)
            - Innovation Health Insurance Company (Virginia)
                - Innovation Health Plan, Inc. (Virginia)
        - Texas Health + Aetna Health Insurance Holding Company LLC (Texas)
            - Texas Health + Aetna Health Insurance Company (Texas)
                - Texas Health + Aetna Health Plan Inc. (Texas)
- Banner Health and Aetna Health Insurance Holding Company LLC (Delaware)
- Banner Health and Aetna Health Insurance Company (Arizona)
- Banner Health and Aetna Health Plan Inc. (Arizona)
- Sutter Health and Aetna Insurance Holding Company LLC (Delaware)
    - Sutter Health and Aetna Administrative Services LLC (Delaware)
    - Sutter Health and Aetna Insurance Company (California)
- Allina Health and Aetna Insurance Holding Company LLC (Delaware)
    - Allina Health and Aetna Insurance Company (Minnesota)
- PE Holdings, LLC (Connecticut)
- Aetna Resources LLC (Delaware)
- Canal Place, LLC (Delaware)
- Aetna Ventures, LLC (Delaware)
- Broadspire National Services, Inc. (Florida)
- Aetna Multi-Strategy 1099 Fund, LLC (Delaware)
- Phoenix Data Solutions LLC (Delaware)
- Aetna Financial Holdings, LLC (Delaware)
    - Aetna Asset Advisors, LLC (Delaware)
    - U.S. Healthcare Properties, Inc. (Pennsylvania)
    - Aetna Capital Management, LLC (Delaware)
        - Aetna Partners Diversified Fund, LLC (Delaware)
    - Aetna Workers' Comp Access, LLC (Delaware)
    - Aetna Behavioral Health, LLC (Delaware)
    - Managed Care Coordinators, Inc. (Delaware)
    - Horizon Behavioral Services, LLC (Delaware)
        - Employee Assistance Services, LLC (Kentucky)
        - Health and Human Resource Center, Inc. (California)
        - Resources for Living, LLC (Texas)
        - The Vasquez Group Inc. (Illinois)
        - Work and Family Benefits, Inc. (New Jersey)

- Aetna Card Solutions, LLC (Connecticut)
- PayFlex Holdings, Inc. (Delaware)
    - PayFlex Systems USA, Inc. (Nebraska)
- Aetna Health and Life lnsurance Company (Connecticut)
- Aetna Health Insurance Company (Pennsylvania)
- Aetna Health Insurance Company of New York (New York)
- AUSHC Holdings, Inc. (Connecticut)
    - PHPSNE Parent Corporation (Delaware)
- Active Health Management, Inc. (Delaware)
    - Health Data & Management Solutions, Inc. (Delaware)
        - Futrix Limited (New Zealand)
    - Aetna Integrated Informatics, Inc. (Pennsylvania)
- Health Re, Inc. (Vermont)
- ASI Wings, LLC (Delaware)
- Healthagen LLC
- Aetna Corporate Services LLC (Delaware)
- Echo Merger Sub, Inc. (Delaware)
- Aetna International Inc. (Connecticut)
    - Aetna Life & Casualty (Bermuda) Ltd. (Bermuda)
    - Aetna Global Holdings Limited (England & Wales)
        - Aetna Insurance (Hong Kong) Limited(Hong Kong)
        - Virtual Home Healthcare LLC (Dubai)
        - Aetna Korea Ltd. (South Korea)
        - Minor Health Entreprise Co, Ltd.
        - Health Care Management Co. Ltd.
            - Aetna Services (Thailand) Limited
        - Aetna Health Insurance (Thailand) Public Company Limited
        - Aetna Holdings (Thailand) Limited
            - Health Care Management Co. Ltd.
            - Minor Health Entreprise Co, Ltd.
                - Aetna Health Insurance (Thailand) Public Company Limited
    - Aetna Global Benefits (Bermuda) Limited (Bermuda)
        - Goodhealth Worldwide (Global) Limited (Bermuda)
        - Aetna Global Benefits (Europe) Limited (England & Wales)
        - Aetna Global Benefits (Asia Pacific) Limited (Hong Kong)
        - Goodhealth Worldwide (Asia) Limited (Hong Kong)
        - Aetna Global Benefits Limited (DIFC, UAE)
        - Aetna Global Benefits (Middle East) LLC (UAE)
        - Pt. Aetna Global Benefits Indonesia (Indonesia)
        - Aetna Global Benefits (Bahamas) Limited (Bahamas)
        - Spinnaker Topco Limited (Bermuda)
            - Spinnaker Bidco Limited (England and Wales)
                - Aetna Holdco (UK) Limited (England and Wales)
                - Aetna Global Benefits (UK) Limited (England and Wales)
                - Aetna Insurance Company Limited (England and Wales)
    - Aetna Insurance (Singapore) Pte. Ltd. (Singapore)
    - Aetna Health Insurance Company of Europe DAC (Ireland)
    - Aetna (Shanghai) Enterprise Services Co. Ltd. (China)
        - Aetna (Beijing) Enterprise Management Services Co., Ltd. (China)
    - Aetna Global Benefits (Singapore) PTE. LTD. (Singapore)
        - Indian Health Organisation Private Limited (India)
    - PT Aetna Management Consulting

- Tianjin An Hai Tai Hua Medical Information Technology Co., Ltd (China)

- CVS Pharmacy, Inc. (continued)

  - Alabama CVS Pharmacy, L.L.C. (Alabama)
  - Alaska CVS Pharmacy, L.L.C. (Alaska)
  - American Drug Stores Delaware, L.L.C. (Delaware)
  - Arkansas CVS Pharmacy, L.L.C. (Arkansas)
  - CareCenter Pharmacy, L.L.C. (Delaware)
  - Caremark Rx, L.L.C. (Delaware)
    - CaremarkPCS, L.L.C. (Delaware)
    - Accordant Health Services, L.L.C. (Delaware)
    - AdvancePCS SpecialtyRx, LLC (Delaware)
    - AdvanceRx.com, L.L.C. (Delaware)
    - CaremarkPCS Health, L.L.C. (Delaware)
      - Caremark IPA, L.L.C. (New York)
    - Caremark PhC, L.L.C. (Delaware)
    - Caremark Ulysses Holding Corp. (New York)
      - MemberHealth LLC (Delaware)
      - UAC Holding, Inc. (Delaware)
        - Pennsylvania Life Insurance Company (Pennsylvania)
    - Caremark, L.L.C. (California)
      - Caremark Arizona Mail Pharmacy, LLC (Arizona)
      - Caremark Arizona Specialty Pharmacy, L.L.C. (Arizona)
      - Caremark California Specialty Pharmacy, L.L.C. (California)
      - Caremark Florida Mail Pharmacy, LLC (Florida)
      - Caremark Florida Specialty Pharmacy, LLC (Florida)
      - Caremark Hawaii Mail Pharmacy, L.L.C. (Hawaii)
      - Caremark Hawaii Specialty Pharmacy, LLC (Hawaii)
      - Caremark Illinois Mail Pharmacy, LLC (Illinois)
      - CVS Caremark Advanced Technology Pharmacy, L.L.C. (Illinois)
      - Caremark Illinois Specialty Pharmacy, LLC (Illinois)
      - Caremark Irving Resource Center, LLC (Texas)
      - Caremark Kansas Specialty Pharmacy, LLC (Kansas)
      - Caremark Logistics, LLC (Delaware)
      - Caremark Louisiana Specialty Pharmacy, LLC (Louisiana)
      - Caremark Maryland Specialty Pharmacy, LLC (Maryland)
      - Caremark Massachusetts Specialty Pharmacy, L.L.C. (Massachusetts)
      - Caremark Michigan Specialty Pharmacy, LLC (Michigan)
      - Caremark Minnesota Specialty Pharmacy, LLC (Minnesota)
      - Caremark New Jersey Specialty Pharmacy, LLC (New Jersey)
      - Caremark North Carolina Specialty Pharmacy, LLC (North Carolina)
      - Caremark Ohio Specialty Pharmacy, L.L.C. (Ohio)
      - Caremark Pennsylvania Specialty Pharmacy, LLC (Pennsylvania)
      - Caremark Redlands Pharmacy, L.L.C. (California)
      - Caremark Repack, LLC (Illinois)
      - Caremark Tennessee Specialty Pharmacy, LLC (Tennessee)
      - Caremark Texas Mail Pharmacy, LLC (Texas)
      - Caremark Texas Specialty Pharmacy, LLC (Texas)
      - Caremark Washington Specialty Pharmacy, LLC (Washington)
      - Central Rx Services, LLC (Nevada)
      - Generation Health, L.L.C. (Delaware)

        - NovoLogix, LLC (Delaware)
    - CaremarkPCS Alabama Mail Pharmacy, LLC (Alabama)
    - CaremarkPCS, L.L.C. (Delaware)
    - CVS Caremark Part D Services, L.L.C. (Delaware)
    - Eckerd Corporation of Florida, Inc. (Florida)
    - Express Pharmacy Services of PA, L.L.C. (Delaware)
    - Ocean Acquisition Sub, L.L.C. (Delaware)
        - Coram LLC (Delaware)
        - Coram Clinical Trials, Inc. (Delaware)
        - T2 Medical, Inc. (Delaware)
            - Coram Healthcare Corporation of Alabama (Delaware)
            - Coram Healthcare Corporation of Florida (Delaware)
            - Coram Healthcare Corporation of Greater D.C. (Delaware)
            - Coram Healthcare Corporation of Greater New York (New York)
            - Coram Healthcare Corporation of Indiana (Delaware)
            - Coram Healthcare Corporation of Mississippi (Delaware)
            - Coram Healthcare Corporation of Nevada (Delaware)
            - Coram Healthcare Corporation of Northern California (Delaware)
            - Coram Healthcare Corporation of Southern California (Delaware)
            - Coram Healthcare Corporation of Southern Florida (Delaware)
            - Coram Specialty Infusion Services, L.L.C. (Delaware)
                - Coram Rx, LLC (Delaware)
                - Coram Healthcare Corporation of North Texas (Delaware)
                - Coram Healthcare Corporation of Utah (Delaware)
                - Coram Healthcare Corporation of Massachusetts (Delaware)
            - Coram Alternate Site Services, Inc. (Delaware)
                - Geneva Woods Management, LLC (Delaware)
    - Part D Holding Company, L.L.C. (Delaware)
        - Accendo Insurance Company (Utah)
        - Silverscript Insurance Company (Tennessee)
- Connecticut CVS Pharmacy, L.L.C. (Connecticut)
- CVS 2948 Henderson, L.L.C. (Nevada)
- CVS AL Distribution, L.L.C. (Alabama)
- CVS Albany, L.L.C. (New York)
- CVS AOC Services, L.L.C. (Delaware)
- CVS Indiana, L.L.C. (Indiana)
- CVS International, L.L.C. (Delaware)
    - CCI Foreign, S'arl (R.C.S. Luxembourg)
        - Beauty Holdings, L.L.C. (Delaware)
            - Drogaria Onofre Ltda. (Brazil)
            - Pamplona Saúde e Beleza LTDA (Brazil)
- CVS Kidney Care, LLC (Delaware)
- CVS Manchester NH, L.L.C. (New Hampshire)
- CVS Michigan, L.L.C. (Michigan)
- CVS Orlando FL Distribution, L.L.C. (Florida)
- CVS PA Distribution, L.L.C. (Pennsylvania)
- CVS PR Center, Inc. (Delaware)
    - Puerto Rico CVS Pharmacy, L.L.C. (Puerto Rico)
    - Caremark Puerto Rico, L.L.C. (Puerto Rico)
    - Caremark Puerto Rico Specialty Pharmacy, L.L.C. (Puerto Rico)
- CVS RS Arizona, L.L.C. (Arizona)
    - Arizona CVS Stores, L.L.C. (Arizona)

    - CVS 3268 Gilbert, L.L.C. (Arizona)
    - CVS 3745 Peoria, L.L.C. (Arizona)
    - CVS Gilbert 3272, L.L.C. (Arizona)
- CVS Rx Services, Inc. (New York)
    - Busse CVS, L.L.C. (Illinois)
    - Goodyear CVS, L.L.C. (Arizona)
    - Sheffield Avenue CVS, L.L.C. (Illinois)
    - South Wabash CVS, L.L.C. (Illinois)
    - Thomas Phoenix CVS, L.L.C. (Arizona)
    - Washington Lamb CVS, L.L.C. (Nevada)
- CVS SC Distribution, L.L.C. (South Carolina)
- CVS State Capital, L.L.C. (Maine)
- CVS TN Distribution, L.L.C. (Tennessee)
- CVS Transportation, L.L.C. (Indiana)
- CVS Vero FL Distribution, L.L.C. (Florida)
- D.A.W., LLC (Massachusetts)
- Delaware CVS Pharmacy, L.L.C. (Delaware)
- Digital eHealth, LLC (Rhode Island)
- District of Columbia CVS Pharmacy, L.L.C. (District of Columbia)
- Enterprise Patient Safety Organization, LLC (Rhode Island)
- E.T.B., INC. (Texas)
- Garfield Beach CVS, L.L.C. (California)
- Georgia CVS Pharmacy, L.L.C. (Georgia)
- German Dobson CVS, L.L.C. (Arizona)
- Grand St. Paul CVS, L.L.C. (Minnesota)
- Highland Park CVS, L.L.C. (Illinois)
- Holiday CVS, L.L.C. (Florida)
- Hook-SupeRx, L.L.C. (Delaware)
- Idaho CVS Pharmacy, L.L.C. (Idaho)
- Iowa CVS Pharmacy, L.L.C. (Iowa)
- Kansas CVS Pharmacy, L.L.C. (Kansas)
- Kentucky CVS Pharmacy, L.L.C. (Kentucky)
- Longs Drug Stores California, L.L.C. (California)
- Louisiana CVS Pharmacy, L.L.C. (Louisiana)
- Maryland CVS Pharmacy, L.L.C. (Maryland)
- Melville Realty Company, Inc. (New York)
- CVS Bellmore Avenue, L.L.C. (New York)
- MinuteClinic, L.L.C. (Delaware)
    - MinuteClinic Diagnostic of Alabama, L.L.C. (Alabama)
    - MinuteClinic Diagnostic of Arizona, LLC (Minnesota)
    - MinuteClinic Diagnostic of Florida, LLC (Minnesota)
    - MinuteClinic Diagnostic of Georgia, LLC (Minnesota)
    - MinuteClinic Diagnostic of Hawaii, L.L.C. (Hawaii)
    - MinuteClinic Diagnostic of Illinois, LLC (Delaware)
    - MinuteClinic Diagnostic of Kentucky, L.L.C. (Kentucky)
    - MinuteClinic Diagnostic of Louisiana, L.L.C. (Louisiana)
    - MinuteClinic Diagnostic of Maine, L.L.C. (Maine)
    - MinuteClinic Diagnostic of Maryland, LLC (Minnesota)
    - MinuteClinic Diagnostic of Massachusetts, LLC (Massachusetts)
    - MinuteClinic Diagnostic of Nebraska, L.L.C. (Nebraska)
    - MinuteClinic Diagnostic of New Hampshire, L.L.C. (New Hampshire)
    - MinuteClinic Diagnostic of New Mexico, L.L.C. (New Mexico)

- MinuteClinic Diagnostic of Ohio, LLC (Ohio)
- MinuteClinic Diagnostic of Oklahoma, LLC (Oklahoma)
- MinuteClinic Diagnostic of Oregon, LLC (Oregon)
- MinuteClinic Diagnostic of Pennsylvania, LLC (Minnesota)
- MinuteClinic Diagnostic of Rhode Island, LLC (Minnesota)
- MinuteClinic Diagnostic of South Carolina, L.L.C. (South Carolina)
- MinuteClinic Diagnostic of Texas, LLC (Minnesota)
- MinuteClinic Diagnostic of Utah, L.L.C. (Utah)
- MinuteClinic Diagnostic of Virginia, LLC (Virginia)
- MinuteClinic Diagnostic of Washington, LLC (Oregon)
- MinuteClinic Diagnostic of Wisconsin, L.L.C. (Wisconsin)
- MinuteClinic Online Diagnostic Services, LLC (Delaware)
- MinuteClinic Telehealth Services, LLC (Delaware)

- Mississippi CVS Pharmacy, L.L.C. (Mississippi)
- Missouri CVS Pharmacy, L.L.C. (Missouri)
- Montana CVS Pharmacy, L.L.C. (Montana)
- Nebraska CVS Pharmacy, L.L.C. (Nebraska)
- New Jersey CVS Pharmacy, L.L.C. (New Jersey)
- North Carolina CVS Pharmacy, L.L.C. (North Carolina)
- Ohio CVS Stores, L.L.C. (Ohio)
- Oklahoma CVS Pharmacy, L.L.C. (Oklahoma)
- Omnicare, Inc. (Delaware)
    - ACS ACQCO CORP. (Delaware)
        - Advanced Care Scripts, Inc. (Florida)
    - Omnicare Holding Company (Delaware)
        - Evergreen Pharmaceutical of California, Inc. (California)
        - JHC Acquisition, LLC (Delaware)
            - Geneva Woods Pharmacy, LLC (Alaska)
                - Geneva Woods Health Services, LLC (Delaware)
                - Geneva Woods Retail Pharmacy LLC (Delaware)
                - Geneva Woods LTC Pharmacy, LLC
                - Geneva Woods Pharmacy Wyoming, LLC (Delaware)
                - Geneva Woods Pharmacy Washington, LLC (Delaware)
                - Geneva Woods Pharmacy Alaska, LLC (Delaware)
        - AMC - Tennessee, LLC (Delaware)
        - CHP Acquisition, LLC (Delaware)
            - Home Pharmacy Services, LLC (Missouri)
        - CP Acquisition, LLC (Oklahoma)
        - Managed Healthcare, LLC (Delaware)
        - Med World Acquisition Corp. (Delaware)
        - Medical Arts Health Care, LLC (Georgia)
        - MHHP Acquisition Company, LLC (Delaware)
        - NCS Healthcare, LLC (Delaware)
            - NCS Healthcare of South Carolina, LLC (Ohio)
            - NCS Healthcare of Tennessee, LLC (Ohio)
            - NCS Healthcare of Kentucky, Inc. (Oh
            - NCS Healthcare of Montana, LLC (Ohio)
            - NCS Healthcare of New Mexico, LLC (Ohio)
            - UNI-Care Health Services of Maine, LLC (New Hampshire)
        - NeighborCare, Inc. (Pennsylvania)
            - Three Forks Apothecary, LLC (Kentucky)
            - NeighborCare Holdings, Inc. (Delaware)

- Badger Acquisition of Kentucky LLC (Delaware)
- NeighborCare Services Corporation (Delaware)
    - D & R Pharmaceutical Services LLC (Kentucky)
    - NeighborCare Pharmacy Services, Inc. (Delaware)
        - APS Acquisition LLC (Delaware)
        - ASCO HealthCare, LLC (Maryland)
        - Badger Acquisition LLC (Delaware)
            - Badger Acquisition of Minnesota LLC (Delaware)
                - Merwin Long Term Care, LLC (Minnesota)
            - Badger Acquisition of Ohio LLC (Delaware)
        - Best Care LTC Acquisition Company, LLC (Delaware)
        - Care Pharmaceutical Services, LP (Delaware)
        - CCRx Holdings, LLC (Delaware)
            - Continuing Care Rx, LLC (Pennsylvania)
            - CCRx of North Carolina LLC (Delaware)
        - Compscript, LLC (Florida)
            - Campo's Medical Pharmacy, LLC (Louisiana)
        - Enloe Drugs, LLC (Delaware)
        - Evergreen Pharmaceutical, LLC (Washington)
        - Home Care Pharmacy, LLC (Delaware)
        - Interlock Pharmacy Systems, LLC (Missouri)
        - Langsam Health Services, LLC (Delaware)
            - LCPS Acquisition, LLC (Delaware)
                - Omnicare Pharmacy of Tennessee LLC (Delaware)
        - Lobos Acquisition, LLC (Delaware)
        - Lo-Med Prescription Services, LLC (Ohio)
            - ZS Acquisition Company, LLC (Delaware)
        - NCS Healthcare of Illinois, LLC (Ohio)
        - NCS Healthcare of Iowa, LLC (Ohio)
            - Martin Health Services, LLC (Delaware)
        - NCS Healthcare of Kansas, LLC (Ohio)
        - NCS Healthcare of Ohio, LLC (Ohio)
        - NCS Healthcare of Wisconsin, LLC (Ohio)
        - North Shore Pharmacy Services LLC (Delaware)
        - Omnicare Indiana Partnership Holding Company LLC (Delaware)
        - Omnicare of New York, LLC (Delaware)
            - NeighborCare of Indiana, LLC (Indiana)
                - Grandview Pharmacy, LLC (Indiana)
            - NeighborCare of Virginia, LLC (Virginia)
        - Omnicare Pharmacies of Pennsylvania West LLC (Pennsylvania)
            - Omnicare Pharmacies of Pennsylvania East LLC (Delaware)
        - Omnicare Pharmacy and Supply Services LLC (South Dakota)
        - Omnicare Pharmacy of the Midwest, LLC (Delaware)
        - Omnicare Property Management, LLC (Delaware)
        - Pharmacy Consultants, LLC (South Carolina)
        - PRN Pharmaceutical Services, LP (Delaware)
        - Roeschen's Healthcare LLC (Wisconsin)
            - PP Acquisition Company LLC (Delaware)
        - Specialized Pharmacy Services, LLC (Michigan)

        - Value Health Care Services LLC (Delaware)
        - VAPS Acquisition Company, LLC (Delaware)
        - Westhaven Services Co, LLC (Ohio)
    - NIV Acquisition, LLC (Delaware)
    - OCR Services, LLC (Delaware)
        - Shore Pharmaceutical Providers, LLC (Delaware)
    - Omnicare of Nevada, LLC (Delaware)
    - Omnicare Pharmacies of the Great Plains Holding, LLC (Delaware)
        - Omnicare of Nebraska LLC (Delaware)
    - Pharmacy Associates of Glenn Falls, LLC (New York)
    - Sterling Healthcare Services, LLC (Delaware)
    - Superior Care Pharmacy, LLC (Delaware)
    - TCPI Acquisition, LLC (Delaware)
    - UC Acquisition, LLC (Delaware)
    - Weber Medical Systems LLC (Delaware)
    - Williamson Drug Company, LLC (Virginia)

- CVS Pharmacy, Inc. (continued)

    - Oregon CVS Pharmacy, L.L.C. (Oregon)
    - Pennsylvania CVS Pharmacy, L.L.C. (Pennsylvania)
    - ProCare Pharmacy Direct, L.L.C. (Ohio)
    - ProCare Pharmacy, L.L.C. (Rhode Island)
    - Red Oak Sourcing, LLC (Delaware)
    - Rhode Island CVS Pharmacy, L.L.C. (Rhode Island)
    - South Carolina CVS Pharmacy, L.L.C. (South Carolina)
    - Tennessee CVS Pharmacy, L.L.C. (Tennessee)
    - Utah CVS Pharmacy, L.L.C. (Utah)
    - Vermont CVS Pharmacy, L.L.C. (Vermont)
    - Virginia CVS Pharmacy, L.L.C. (Virginia)
    - Warm Springs Road CVS, L.L.C. (Nevada)
    - Washington CVS Pharmacy, L.L.C. (Washington)
    - Wellpartner, LLC (Delaware)
    - West Virginia CVS Pharmacy, L.L.C. (West Virginia)
    - Wisconsin CVS Pharmacy, L.L.C. (Wisconsin)
    - Woodward Detroit CVS, L.L.C. (Michigan)

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3ASR No. 333-217596) of CVS Health Corporation, and
(2) Registration Statements (Form S-8 Nos. 333-228622, 333-167746, 333-217853, 333-208805, 333-141481, 333-139470, 333-63664, 333-91253, 333-49407, 333-34927, and 333-28043) of CVS Health Corporation;

of our reports dated February 28, 2019, with respect to the consolidated financial statements of CVS Health Corporation and the effectiveness of internal control over financial reporting of CVS Health Corporation incorporated by reference in this Annual Report (Form 10-K) of CVS Health Corporation for the year ended December 31, 2018.

/s/ Ernst & Young LLP

Boston, Massachusetts
February 28, 2019

Exhibit 31.1

Certification

I, Larry J. Merlo, President and Chief Executive Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;

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

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

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

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

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

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

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

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

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

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

Date: February 28, 2019

By: /s/ LARRY J. MERLO

Larry J. Merlo

President and Chief Executive Officer

Exhibit 31.2

Certification

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of CVS Health Corporation, certify that:

1. I have reviewed this annual report on Form 10-K of CVS Health Corporation;

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

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

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

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

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

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

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

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

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

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

Date: February 28, 2019

By: / s / EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2018 (the “Report”) solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the “Exchange Act”) and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Larry J. Merlo, President and Chief Executive Officer of the Company, certify that, to the best of my knowledge:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Exchange Act; and
2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 28, 2019

/ s / LARRY J. MERLO

Larry J. Merlo

President and Chief Executive Officer

Exhibit 32.2

CERTIFICATION

The certification set forth below is being submitted in connection with the Annual Report of CVS Health Corporation (the "Company") on Form 10-K for the period ended December 31, 2018 (the "Report") solely for the purpose of complying with Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 (the "Exchange Act") and Section 1350 of Chapter 63 of Title 18 of the United States Code.

I, Eva C. Boratto, Executive Vice President and Chief Financial Officer of the Company, certify that, to the best of my knowledge:

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

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 28, 2019

/ s / EVA C. BORATTO

Eva C. Boratto

Executive Vice President and Chief Financial Officer

Donnelley Financial Solutions, Inc.

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2018

OR

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

For the transition period from to

Commission file number 1-37728

Donnelley Financial Solutions, Inc.

(Exact name of registrant as specified in its charter)

Delaware **(State or other jurisdiction of incorporation or organization)**	**36-4829638** **(I.R.S. Employer Identification No.)**
35 West Wacker Drive, Chicago, Illinois **(Address of principal executive offices)**	**60601** **(ZIP Code)**

Registrant's telephone number, including area code—(844) 866-4337

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

Title of each Class	Name of each exchange on which registered
Common Stock (Par Value $0.01)	NYSE

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

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

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

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

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

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

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

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

Emerging growth company ☐

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

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

The aggregate market value of the shares of common stock (based on the closing price of these shares on the NYSE) on June 30, 2018, the last business day of the registrant's most recently completed second fiscal quarter, held by nonaffiliates was $582,894,470.

As of February 22, 2019, 34,116,796 shares of common stock were outstanding.

Documents Incorporated By Reference

Portions of the registrant's proxy statement related to its annual meeting of stockholders scheduled to be held on May 30, 2019 are incorporated by reference into Part III of this Form 10-K.

DONNELLEY FINANCIAL SOLUTIONS, INC.
ANNUAL REPORT ON FORM 10-K
FOR THE YEAR ENDED DECEMBER 31, 2018

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Signatures

PART I

ITEM 1. BUSINESS

Company Overview

Donnelley Financial Solutions, Inc. ("DFIN," or the "Company") is a leading global risk and compliance solutions company. The Company provides regulatory filing and deal solutions via its software-as-a-service ("SaaS"), technology-enabled services and print and distribution solutions to public and private companies, mutual funds and other regulated investment firms, to serve their regulatory and compliance needs. For corporate clients within its capital markets offerings, the Company offers technology-enabled filing solutions that allow U.S. public companies to comply with applicable U.S. Securities and Exchange Commission ("SEC") regulations. The Company's services include filing agent services, digital document creation and online content management tools that support their corporate financial transactions and regulatory reporting. The Company provides solutions to facilitate clients' communications with their shareholders; and virtual data rooms and other deal management solutions. For the investment markets, including alternative investment and insurance investment companies, the Company provides technology-enabled filing solutions including cloud-based tools for creating and filing high-quality regulatory documents and solutions for investors designed to improve the speed of access to and accuracy of investment information. Throughout a company's life cycle, the Company serves its clients' regulatory and compliance needs. The Company's deep industry and regulatory expertise and a commitment to exceptional service guides our clients to navigate a high-stakes and ever-changing regulatory environment.

Global Capital Markets ("GCM")

The Company provides a comprehensive set of solutions to corporate clients, domestically and internationally, to comply with disclosure obligations, create, manage and deliver accurate and timely financial communications, manage public and private transaction processes and provide clients with business intelligence from financial disclosures with data and analytics services. These solutions include the Company's traditional full-service EDGAR filing preparation and filing agent services, technology-enabled services and print and distribution solutions, as well as the Company's increasing SaaS solutions, ActiveDisclosure, Venue Virtual Data Room ("Venue") and EDGAR Online.

The Company's GCM clients consist mainly of companies that are subject to the filing and reporting requirements of the Securities Act of 1933, as amended (the "Securities Act") and the U.S. Securities Exchange Act of 1934, as amended (the "Exchange Act"). In 2018, approximately 34% of GCM net sales were compliance in nature. The Company also supports public and private companies throughout merger and acquisition transaction processes and in public and private capital markets transactions with deal management solutions focused on aiding transactional efficiency from inception to completion. In 2018, approximately 52% of GCM net sales were transactional in nature, approximately 13% of GCM net sales were related to Venue services and the remainder of GCM net sales were related to data and analytics services.

Transaction Solutions

The Company helps GCM clients throughout the course of public and private business transactions. For mergers and acquisition ("M&A") transactions the Company supports deal participants in creating transaction-related registration statements, proxies and prospectuses, files client documents as their filing agent through the SEC's Electronic Data Gathering, Analysis, and Retrieval ("EDGAR") filing system and manages print for distribution to its clients' shareholders. The Company also provides complete initial public offering ("IPO") solutions that support the various stages of the IPO process. Solutions include preparing and filing registration statements and prospectuses, both through the Company's filing agent solution and its Active Disclosure SaaS solution, the Venue virtual data room and secure file sharing SaaS solution and the eBrevia contract analytics SaaS solution.

The Company's cloud-based Venue® Virtual Data Room is a highly secure data room platform that allows GCM clients to share confidential information in real-time throughout the transaction lifecycle. Clients can maintain control over sensitive data when conducting due diligence for M&A, raising capital for an IPO or developing a document repository. Specifically, companies have used Venue to securely organize, manage, distribute and track corporate governance, financing, legal and other documents in an online workspace accessible to internal and outside advisors.

The Company acquired eBrevia, a provider of artificial intelligence-based data extraction and contract analytics software solutions, on December 18, 2018. The eBrevia technology provides enterprise contract review and analysis solutions, leveraging machine learning to produce fast and accurate results. eBrevia's software, which extracts and summarizes key provisions and other information, is leveraged in due diligence, contract management, lease abstraction, and document drafting. The acquisition enhances the Company's Venue Deal Solutions offerings to provide clients with secure data aggregation, due diligence, compliance and risk management solutions.

The Company also offers clients the use of private conferencing facilities in most major cities in the U.S. and international jurisdictions. This service helps clients maintain confidentiality in deal negotiations and provides clients a place to host in-person working groups to meet, strategize and prepare documents for the transactional deal stream. The Company's sites are outfitted to provide around-the-clock service s to support the transaction process .

Compliance Solutions

The Company provides compliance solutions to GCM clients in preparing Exchange Act filings that are compatible with the SEC's EDGAR system. GCM clients leverage the Company's deep industry expertise and experience to successfully navigate the SEC's specified file formats when submitting compliance documents through the EDGAR system .

The Company's cloud-based ActiveDisclosure platform provides GCM clients with end-to-end solutions to collaborate, tag, validate and file with the SEC efficiently.

The Company's strategic investment in AuditBoard gives GCM clients access to their SOXHUB service. AuditBoard is a SaaS technology company that provides a full suite of audit management and compliance solutions for SOX, operational audits, IT compliance, enterprise risk management and workflow management. With AuditBoard, enterprises can collaborate, manage, analyze and report on critical internal controls data in real time.

The Company supports GCM clients in meeting SEC-mandated regulatory filing requirements, including tagged filing in the eXtensible Business Reporting Language (XBRL) format. The Company provides clients with a suite of tagging, review and validation tools to assist them with the XBRL requirements. The Company has accounting and finance professionals that assist its GCM clients with the processes of tag selection, tag review, file creation, validation and distribution.

The Company helps GCM clients elevate their proxy filings from compliance documents to investor-focused strategic communications tools with Proxy Design services. The Company's end-to-end proxy solutions include advisory services, proxy strategy and design, disclosure management, EDGAR filing and expertise, online hosting solutions, print production, distribution and annual meeting services.

EDGAR® Online - Data and Analytics

The Company's EDGAR® Online solution delivers intelligent solutions in financial disclosures, creating and distributing company data and public filings for equities, mutual funds and other publicly traded assets. In addition to providing access to data sets, the Company provides subscription-based proprietary desktop and web tools for data analysis. EDGARPro enables investors, analysts, lawyers, auditors and corporate executives to access detailed company information, as-reported and standardized financial data, SEC filings, stock quotes and news.

Global Investment Markets ("GIM")

The Company provides a comprehensive set of solutions to clients operating in global investment markets domestically and internationally, including United States based mutual funds, hedge and alternative investment funds, insurance companies and overseas investment structures for collective investments (similar to mutual funds in the United States). The Company also provides products to third party service providers and custodians who support investment managers, and sells products and distribution services to broker networks and financial advisors that distribute and sell investment products.

In 2018, approximately 97% of GIM net sales, excluding postage and freight, were compliance in nature, while the remaining 3% of GIM net sales were transactional in nature . In addition, approximately 58% of the Company's 2018 GIM net sales, excluding postage and freight, were derived from clients in the mutual fund industry, while the remaining 42% of net sales were derived from clients in the healthcare and insurance industries. The Company's services and sales teams currently support clients in the United States, Canada, Ireland, the United Kingdom, France, Luxembourg, Poland, India and Australia.

The Company provides U.S. based alternative investment funds and investment insurance companies with solutions to prepare and file registration forms and subsequent ongoing disclosures, as well as XBRL-formatted filings pursuant to the 1940 Act, through the SEC's EDGAR system.

The Company's proprietary FundSuiteArc software platform provides GIM clients with a comprehensive suite of cloud-based products and services that store and manage information in a self-service, central repository for compliance and regulatory documents to be easily accessed, assembled, edited, translated, rendered and submitted to regulators. Some of the products with in FundSuiteArc are cloud-based and include automation and single-source data validation that streamlines processes and drives efficiency for clients. FundSuiteArc includes ArcFiling, ArcReporting, ArcPro, ArcExchange and ArcMarketing. The ArcFiling solution support s the newly required filing of Form N-CEN , as well as the filing of Form N-PORT , for which the initial filing dates begin in April 2019.

Through an investment in, and an agreement with Mediant, the Company provides a suite of software to brokers and financial advisors that enable them to monitor and view shareholder communications. The Company offers various technology and electronic delivery products and services to make the distribution of documents and content more efficient. The Company also supports the distribution, tabulation and solicitation of shareholders for corporate elections and mutual fund proxy events.

The Company provides turn-key proxy services for alternative investment funds and investment insurance companies including discovery, planning and implementation, print and mail management, solicitation, tabulation services, shareholder meeting review and expert support for mutual funds, variable annuities, REITs and other alternative investments.

The Company provides GIM clients with investor communication solutions including printing, digital distribution, e-Delivery and fulfillment systems.

The Company offers to healthcare providers a comprehensive set of solutions to support the creation, ordering and distribution of Pre-enrollment and Post-enrollment information in the form of customized and/or personalized kits, booklets and packets.

Segments

The Company operates in two business segments:

- *United States* . The U.S. segment is comprised of three reporting units: capital markets; investment markets; and language solutions, which was divested in 2018.* The Company services capital market and investment market clients in the U.S. by delivering products and technology-enabled services to help create, manage and deliver financial communications to investors and regulators. The Company provides capital market and investment market clients with communication tools, services and software to allow them to comply with their ongoing regulatory filings. In addition, the U.S. segment provides clients with communications services to create, manage and deliver registration statements, prospectuses, proxies and other communications to regulators and investors. The U.S. segment also includes commercial printing capabilities and language solutions.*
- *International* . The International segment includes operations in Asia, Europe, Canada and Latin America. The international business is primarily focused on working with international capital markets clients on capital markets offerings and regulatory compliance related activities within the United States. In addition, the International segment provides services to international investment market clients to allow them to comply with applicable SEC regulations, as well as language solutions to international clients.*

*The Company sold its Language Solutions business on July 22, 2018. Refer to Note 4, *Acquisitions and Dispositions* , to the Consolidated and Combined Financial Statements. Due to the sale of the Language Solutions business, the Company made changes to the reporting units within the U.S. segment. The former Language Solutions and other reporting unit has been renamed "Language Solutions." Certain results previously included within the former Language Solutions and other reporting unit are now included within the Investment Markets reporting unit. Prior year amounts have been restated to conform to the Company's current reporting unit structure.

The Company reports certain unallocated selling, general and administrative activities and associated expenses within "Corporate", including, in part, executive, legal, finance, marketing and certain facility costs. In addition, certain costs and earnings of employee benefit plans, such as pension income and share-based compensation, are included in Corporate and are not allocated to the reportable segments. Prior to the Separation (as defined below), many of these costs were based on allocations from R.R. Donnelley & Sons Company ("RRD"); however, beginning October 1, 2016, the Company incurs such costs directly.

Products and Services

The Company separately reports its net sales and related cost of sales for its products and services offerings. The Company's services offerings consist of document composition, compliance related EDGAR filing services, transaction solutions, language solutions, and the Company's SaaS solutions, including Venue, FundSuiteArc, ActiveDisclosure and EDGAR Online, among others. The Company's product offerings primarily consist of conventional and digital printed products and related shipping costs.

Company History

Spin-off Transaction

On October 1, 2016, DFIN became an independent publicly traded company through the distribution by RRD of approximately 26.2 million shares, or 80.75%, of DFIN common stock to RRD shareholders (the "Separation"). Holders of RRD common stock received one share of DFIN common stock for every eight shares of RRD common stock held on September 23, 2016. As part of the Separation, RRD retained approximately 6.2 million shares of DFIN common stock, or a 19.25% interest in DFIN, of which 6.1 million shares and 0.1 million shares were subsequently sold in June 2017 and August 2017, respectively. DFIN's common stock began regular-way trading under the ticker symbol "DFIN" on the New York Stock Exchange on October 3, 2016. On October 1, 2016, RRD also completed the previously announced separation of LSC Communications, Inc. ("LSC"), its publishing and retail-centric print services and office products business. On March 28, 2017, RRD completed the sale of 6.2 million shares of LSC common stock (RRD's remaining ownership stake in LSC) in an underwritten public offering. As a result, beginning in the quarter ended June 30, 2017, LSC no longer qualified as a related party of the Company. Beginning in the quarter ended September 30, 2017, RRD no longer qualified as a related party, therefore amounts disclosed related to RRD are presented through June 30, 2017 only.

Language Solutions

On July 22, 2018, the Company sold its Language Solutions business. Prior to its sale, the Language Solutions business supported domestic and international businesses in a variety of industries by helping them adapt their business content into different languages for specific countries, markets and regions through a complete suite of language products and services. The Company provided its language solutions offerings to clients operating in a variety of industries, including the financial, corporate, life sciences and legal industries, among others. In 2018, prior to the sale of the Language Solutions business, the Company provided services to companies in 73 different countries.

eBrevia

On December 18, 2018, the Company acquired eBrevia, a provider of artificial intelligence-based data extraction and contract analytics software solutions. The Company previously held a 12.8% investment in eBrevia prior to the acquisition. The purchase price for the remaining equity of eBrevia, which includes the Company's estimate of contingent consideration, was $23.2 million, net of cash acquired of $0.2 million. $4.1 million of the purchase price, excluding contingent consideration and amounts held in escrow, was payable as of December 31, 2018 and is expected to be paid during 2019. The eBrevia technology provides enterprise contract review and analysis solutions, leveraging machine learning to produce fast and accurate results. eBrevia's software, which extracts and summarizes key legal provisions and other information, is used in due diligence, contract management, lease abstraction, and document drafting. eBrevia's operations are included within the Capital Markets reporting unit in the U.S. segment. The acquisition enhances the Company's Venue Deal Solutions offerings to provide clients with secure data aggregation, due diligence, compliance and risk management solutions.

Competition

Technological and regulatory changes, including the electronic distribution of documents, continue to impact the market for our products and services. In addition to the Company's ongoing innovation in its SaaS solutions, one of the Company's competitive strengths is that it offers a wide array of communications products, compliance services, a global platform, exceptional sales and service and regulatory domain expertise, which provide differentiated solutions for its clients.

The global risk and compliance industry, in general, is highly competitive and barriers to entry have decreased as a result of technology innovation. Despite some consolidation in recent years, the industry remains highly fragmented in the United States and even more so internationally with many in-country alternative providers. The Company expects competition to increase from existing competitors, as well as new and emerging market entrants. In addition, as the Company expands its product and service offerings, it may face competition from new and existing competitors. The Company competes primarily on product quality and functionality, service levels, subject matter regulatory expertise, security, price and reputation.

The imp act of digital technologies has impacted many of the products and markets in which the Company competes , most acutely in the Company's mutual fund, variable annuity and public company compliance business offerings. While the Company offers a high-touch, service oriented experience, technology changes have provided alternatives to the Company's clients that allow them to manage more of the financial disclosure process themselves. The Company has invested in its own SaaS solutions , ActiveDisclosure, FundSuiteArc and Venue to serve clients and increase retention and has invested to expand capabilities and address new market sectors. The future impact of technology on the business is difficult to predict and could result in additional expenditures to restructure impacted operations or develop new technologies. In addition, the Company has made targeted acquisitions and investments in its existing business to offer clients innovative services and solutions, including acquisitions of eBrevia, EDGAR Online and MultiCorpora and investments in AuditBoard (for merly known as Soxhub), Mediant and Peloton that support the Company's position as a technology service leader in this evolving industry.

The Company's competitors for SEC filing services for public company compliance clients include full service financial communications providers, technology point solution providers focused on financial communications and general technology providers. The Company's competitors for SEC filing services for investment markets clients include full service traditional providers, small niche technology providers and local and regional print providers that bid against the Company for printing, mailing and fulfillment services.

Market Volatility/Cyclicality

The Company is subject to market volatility in the United States and world economy, as the success of the transactional offering is largely dependent on the global market for IPOs, secondary offerings, mergers and acquisitions, public and private debt offerings, leveraged buyouts, spinouts and other transactions. A variety of factors impact the global markets, including the regulatory and political environment. Recently, the U.S. IPO market and public debt market were disrupted by the U.S. federal government shutdown that occurred from December 2018 to January 2019. Future government shutdowns could affect volatility of any of these markets. The International segment is particularly susceptible to capital market volatility as most of the International business is capital markets transaction focused. The Company mitigates some of that risk by offering services in higher demand during a down market, like document management tools for the bankruptcy/restructuring process, and also by moving upstream from the filing process with products like Venue, the Company's data room solution. The Company also attempts to balance this volatility through supporting the quarterly/annual public company reporting process through its EDGAR filing services and ActiveDisclosure product, its investment markets regulatory and shareholder communications offering and continues to expand into adjacent growth businesses like data and analytics, which has recurring revenues and is not as susceptible to market volatility and cycles. The quarterly/annual public company reporting process work also subjects the Company to filing seasonality shortly after the end of each fiscal quarter, with peak periods during the course of the year. The seasonality and associated operational implications include the need to increase staff during peak periods through a combined strategy of hiring additional full-time and temporary personnel, increasing the premium time of existing staff, and outsourcing production for a number of services. Additionally, clients and their financial advisors have begun to increasingly rely on web-based services which allow clients to autonomously file and distribute compliance documents with regulatory agencies, such as the SEC. While the Company believes that its ActiveDisclosure and FundSuiteArc solutions are competitive in this space, competitors are continuing to develop technologies that aim to improve clients' ability to autonomously produce and file documents to meet their regulatory obligations. The Company continues to remain focused on driving recurring revenue to mitigate market volatility.

Regulatory Impact

The SEC is adopting new as well as amended rules and forms to modernize the reporting and disclosure of information by registered investment companies. These changes are driving significant regulatory changes which impact the Company's customers within its Investment Markets business. On October 13, 2016, the SEC adopted a new N-PORT filing requirement, which requires certain registered investment companies to report information about their portfolio in XML, a structured data format, on a monthly basis, replacing what was previously a quarterly filing requirement. This rule also includes an annual N-CEN filing in XML, replacing a semi-annual filing requirement. Compliance dates depend on asset size and began as soon as June 1, 2018 for larger funds, with the first N-PORT filing deadlines beginning in April 2019. The Company's ArcFiling software solution can support both filings. The Company expects an increase in services revenue due to the increase in the frequency of filings for registered investment companies.

On June 5, 2018, the SEC adopted Rule 30e-3 which provides certain registered investment companies with an option to electronically deliver shareholder reports and other materials rather than providing such reports in paper. Investors who prefer to receive reports in paper will continue to receive them in that format. While Rule 30e-3 wa s effective January 1, 2019, default electronic distribution pursuant to the rule will begin on January 1, 2021 due to a 24-month transition period, during which registered investment companies must notify investors of the upcoming change in transmission format of shareholder reports. The Company expects a decline in the volume of printed annual and semi-annual shareholder reports in 2021 and beyond as a result of Rule 30e-3.

Raw Materials

The primary raw materials used in the Company's printed products are paper and ink. The paper and ink is sourced from a small set of select suppliers to ensure consistent quality that meets the Company's performance expectations and provides for continuity of supply. The Company believes that the risk of incurring material losses as a result of a shortage in raw materials is unlikely and that the losses, if any, would not have a materially negative impact on the Company's business.

Distribution

The Company's products are distributed to end-users through the U.S or foreign postal services, through retail channels, electronically or by direct shipment to customer facilities.

Customers

For each of the years ended December 31, 2018, 2017 and 2016, no customer accounted for 10% or more of the Company's consolidated and combined net sales.

Technology

The Company invests resources in developing software solutions to complement its services. The Company invests in its core composition systems and client facing solutions and has also adopted market-leading third party systems which have improved the efficiency of its sales and operations processes. The Company has continued to invest in enhancements of its technology-based offerings including EDGAR filing and XBRL services, Venue Virtual Data Room, Venue Deal Solutions, ActiveDisclosure, FundSuiteArc software platform, and its data and analytics solutions. The Company continues to invest in leading and innovative technology such as robotic process automation, machine learning and hybrid cloud architecture.

Cybersecurity & Data Protection

A core aspect of the Company's business relies on technology and software; as a result, the security of those technologies and software, as well as the protection of the confidential information entrusted to the Company by its customers, are key parts of the Company's business and strategy. The DFIN Cybersecurity Program is based upon industry leading frameworks, which include International Standardization Organization #27001 (ISO 27001), Control Objectives for Information Technology (COBIT), and the National Institute of Standards and Technology Framework for Improving Critical Infrastructure Cybersecurity (commonly known as NIST). The Company's technologies and software must also comply with global regulatory and legal requirements such as the European Union's Global Data Protection Regulation (GDPR), Canada's Personal Information Protection and Electronic Documents Act (PIPEA), New York State Department of Finance's 23 NYCRR 500 Cybersecurity Requirements for Financial Services Companies, and other similar regulations. Ensuring that these technologies and software comply with those regulations is a key focus of the Company's efforts.

The Company leverages cybersecurity technologies designed to ensure that client, employee and business confidential data is secure. The Company's cybersecurity portfolio is inclusive of, but not limited to, data encryption, data masking, leading secure software development methodologies, aggressive application and network penetration testing, incident response, digital forensics, least-privileged access controls, anti-malware, virtual private networks and cyber threat intelligence. Additionally, the Company manages a 24x7 Security Operations capability that monitors and responds to cyber threats in real time.

To demonstrate transparency, the Company's commitment to effective cybersecurity and data protection efforts and in pursuit of continuous improvement, the Company undergoes a series of third-party security reviews, including third-party penetration tests.

Environmental Compliance

It is the Company's policy to conduct its global operations in accordance with all applicable laws, regulations and other requirements. It is not possible to quantify with certainty the potential impact of actions regarding environmental matters, particularly remediation and other compliance efforts that the Company may undertake in the future. However, in the opinion of management, compliance with the present environmental protection laws, before taking into account estimated recoveries from third parties, will not have a material adverse effect on the Company's consolidated and combined annual results of operations, financial position or cash flows.

Employees

As of December 31, 2018, the Company had approximately 3,100 employees.

Available Information

The Company maintains a website at www.dfinsolutions.com where the Company's Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and all amendments to those reports, as well as other SEC filings, are available without charge, as soon as reasonably practicable following the time they are filed with, or furnished to, the SEC. The Principles of Corporate Governance of the Company's Board of Directors, the charters of the Audit, Compensation, Corporate Responsibility & Governance Committees of the Board of Directors and the Company's Principles of Ethical Business Conduct are also available on the Investor Relations portion of the Company's website, and will be provided, free of charge, to any shareholder who requests a copy. References to the Company's website address do not constitute incorporation by reference of the information contained on the website, and the information contained on the website is not part of or incorporated by reference in this document.

Special Note Regarding Forward-Looking Statements

The Company has made forward-looking statements in this Annual Report on Form 10-K within the meaning of the "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995 that are subject to risks and uncertainties. These statements are based on the beliefs and assumptions of the Company. Generally, forward-looking statements include information concerning possible or assumed future actions, events, or results of operations of the Company.

These statements may include words such as "anticipates," "estimates," "expects," "projects," "forecasts," "intends," "plans," "continues," "believes," "may," "will," "goals" and variations of such words and similar expressions are intended to identify our forward-looking statements.

Forward-looking statements are not guarantees of performance. These forward-looking statements are subject to a number of important factors, including those factors discussed in detail in " *Item 1A: Risk Factors* " and elsewhere in this Annual Report on Form 10-K, that could cause our actual results to differ materially from those indicated in any such forward-looking statements. These factors include, but are not limited to:

- the volatility of the global economy and financial markets, and its impact on transactional volume;
- failure to offer high quality customer support and services;
- the retention of existing, and continued attraction of additional clients and key employees;
- the growth of new technologies with which we may be able to adequately compete;
- our inability to maintain client referrals;
- vulnerability to adverse events as a result of becoming a stand-alone company following the Separation from RRD, including the inability to obtain as favorable of terms from third-party vendors;
- the competitive market for our products and industry fragmentation affecting our prices;
- the ability to gain client acceptance of our new products and technologies;
- delay in market acceptance of our products and services due to undetected errors or failures found in our products and services;
- failure to maintain the confidentiality, integrity and availability of our systems, software and solutions;

- failure to properly use and protect client and employee information and data;
- the effect of a material breach of security or other performance issues of any of our or our vendors' systems;
- factors that affect client demand, including changes in economic conditions, national or international regulations and clients' budgetary constraints;
- our ability to access debt and the capital markets due to adverse credit market conditions;
- the effect of increasing costs of providing healthcare and other benefits to our employees;
- changes in the availability or costs of key materials (such as ink and paper) or in prices received for the sale of by-products;
- failure to protect our proprietary technology;
- failure to successfully integrate acquired businesses into our business;
- availability to maintain our brands and reputation;
- the retention of existing, and continued attraction of, key employees, including management;
- the effects of operating in international markets, including fluctuations in currency exchange rates;
- the effect of economic and political conditions on a regional, national or international basis;
- lack of market for our common stock;
- lack of history as an operating company and costs associated with being an independent company;
- failure to achieve certain intended benefits of the Separation; and

Because forward-looking statements are subject to assumptions and uncertainties, actual results may differ materially from those expressed or implied by such forward-looking statements. Undue reliance should not be placed on such statements, which speak only as of the date of this document or the date of any document that may be incorporated by reference into this document.

Consequently, readers of the Annual Report on Form 10-K should consider these forward looking statements only as the Company's current plans, estimates and beliefs. The Company does not undertake and specifically declines any obligation to publicly release the results of any revisions to these forward-looking statements that may be made to reflect future events or circumstances after the date of such statements or to reflect the occurrence of anticipated or unanticipated events. The Company undertakes no obligation to update or revise any forward-looking statements in this Annual Report on Form 10-K to reflect any new events or any change in conditions or circumstances.

ITEM 1A. RISK FACTORS

The Company's consolidated and combined results of operations, financial position and cash flows can be adversely affected by various risks. These risks include the principal factors listed below and the other matters set forth in the Annual Report on Form 10-K. You should carefully consider all of these risks.

A significant part of our business is derived from the use of our products and services in connection with financial and strategic business transactions. Economic trends that affect the volume of these transactions may negatively impact the demand for our products and services.

A significant portion of our net sales depends on the purchase of our products and use of our services by parties involved in GCM compliance and transactions. As a result, our business is largely dependent on the global market for IPOs, secondary offerings, mergers and acquisitions, public and private debt offerings, leveraged buyouts, spinouts, bankruptcy and claims processing and other transactions. These transactions are often tied to economic conditions and dependent upon the performance of the overall economy, and the resulting volume of these types of transactions drives demand for our products and services. Downturns in the financial markets, global economy or in the economies of the geographies in which we do business and reduced equity valuations all create risks that could negatively impact our business. For example, in the past, economic volatility has led to a decline in the financial condition of a number of our clients and led to the postponement of their capital markets transactions. To the extent that there is continued volatility, we may face increasing volume pressure. Furthermore, our offerings for GIM clients can be affected by fluctuations in the inflow and outflow of money into investment management funds which determines the number of new funds that are opened, as well as, closed. As a result, we are not able to predict the impact any potential worsening of macroeconomic conditions could have on our results of operations. The level of activity in the financial communications services industry, including the financial transactions and related compliance needs our products and services are used to support, is sensitive to many factors beyond our control, including interest rates, regulatory policies, general economic conditions, our clients' competitive environments, business trends, terrorism and political change, such as the impacts from the 2016 United Kingdom referendum to withdraw from the European Union. In addition, a weak economy could hinder our ability to collect amounts owed by clients. Failure of our clients to pay the amounts owed to us, or to pay such amounts in a timely manner, may increase our exposure to credit risks and result in bad debt write-offs. Unfavorable conditions or changes in any of these factors could negatively impact our results of operations, financial position and cash flow.

The quality of our customer support and services offerings is important to our clients, and if we fail to offer high quality customer support and services, clients may not use our solutions and our net sales may decline.

A high level of customer support is critical for the successful marketing and sale of our solutions. If we are unable to provide a level of customer support and service to meet or exceed the expectations of our clients, we could experience a loss of clients and market share, a failure to attract new clients, including in new geographic regions and increased service and support costs and a diversion of resources. Any of these results could negatively impact our results of operations, financial position and cash flow.

A substantial part of our business depends on clients continuing their use of our products and services. Any decline in our client retention would harm our future operating results.

We do not have long term contracts with most of our GCM and GIM clients, and therefore rely on their continued use of our products and services, particularly for compliance related services. As a result, client retention, particularly during periods of declining transactional volume, is an important part of our strategic business plan. There can be no assurance that our clients will continue to use our products and services to meet their ongoing needs, particularly in the face of competitors' products and services offerings. Our client retention rates may decline due to a variety of factors, including:

- our inability to demonstrate to our clients the value of our solutions;
- the price, performance and functionality of our solutions;
- the availability, price, performance and functionality of competing products and services;
- our clients' ceasing to use or anticipating a declining need for our services in their operations;
- consolidation in our client base;
- the effects of economic downturns and global economic conditions; or
- reductions in our clients' spending levels.

If our retention rates are lower than anticipated or decline for any reason, our net sales may decrease and our profitability may be harmed, which could negatively impact our results of operations, financial position and cash flow.

Our business may be adversely affected by new technologies enabling clients to produce and file documents on their own.

The Company's business may be adversely affected as clients seek out opportunities to produce and file regulatory documentation on their own and begin to implement technologies that assist them in this process. For example, clients and their financial advisors have increasingly relied on web-based services which allow clients to autonomously file and distribute reports required pursuant to the Exchange Act, prospectuses and other materials as a replacement for using our EDGAR filing services. If technologies are further developed to provide our clients with the ability to autonomously produce and file documents to meet their regulatory obligations, and we do not develop products or provide services to compete with such new technologies, our business may be adversely affected by those clients who choose alternative solutions, including self-serving or filing themselves.

Our performance and growth depend on our ability to generate client referrals and to develop referenceable client relationships that will enhance our sales and marketing efforts.

We depend on users of our solutions to generate client referrals for our services. We depend in part on the financial institutions, law firms and other third parties who use our products and services to recommend our solutions to their client base, which allows us to reach a larger client base than we can reach through our direct sales and internal marketing efforts. For instance, a portion of our net sales from GCM clients is derived from referrals by investment banks, financial advisors and law firms that have utilized our services in connection with prior transactions. These referrals are an important source of new clients for our services.

A decline in the number of referrals we receive could require us to devote substantially more resources to the sales and marketing of our services, which would increase our costs, potentially lead to a decline in our net sales, slow our growth and negatively impact our results of operations, financial position and cash flow.

DFIN's historical financial information is not necessarily representative of the results that it would have achieved as a separate, publicly traded company and may not be a reliable indicator of its future results, particularly in light of ongoing costs of operating as a public company.

The historical information about DFIN prior to October 1, 2016 included in this Annual Report on Form 10-K refers to DFIN's business as operated by and integrated with RRD. DFIN's historical financial information for such periods was derived from the consolidated financial statements and accounting records of RRD. Accordingly, such historical financial information does not necessarily reflect the combined statements of income, balance sheets and cash flows that DFIN would have achieved as a separate, publicly traded company during the periods presented or those that DFIN will achieve in the future.

Our business may be adversely affected by the implementation of a new global financial reporting information technology system.

We have implemented a new global financial reporting information technology system. There are inherent risks associated with upgrading or changing systems, including inaccurate data or reporting. In addition, the system implementation may not result in the anticipated improvements and the cost of implementation may outweigh the benefits. System implementation failures and the related costs to remedy such failures could have an adverse effect on our cash flows and financial condition, and may adversely affect the effectiveness of internal controls over financial reporting.

We have incurred substantial indebtedness and the degree to which we are currently leveraged may materially and adversely affect our business and consolidated and combined statements of income, balance sheets and cash flows .

As of December 31, 2018, we had $362.7 million of indebtedness outstanding. Our ability to make payments on and to refinance our indebtedness, as well as any future debt that we may incur, will depend on our ability to generate cash in the future from operations, financings or asset sales. Our ability to generate cash is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control. We may not generate sufficient funds to service our debt and meet our business needs, such as funding working capital or the expansion of our operations. If we are not able to repay or refinance our debt as it becomes due, we may be forced to take disadvantageous actions, including facility closure, staff reductions, reducing financing in the future for working capital, capital expenditures and general corporate purposes, selling assets or dedicating an unsustainable level of our cash flow from operations to the payment of principal and interest on our indebtedness, and restricting future capital return to stockholders. In addition, our ability to withstand competitive pressures and to react to changes in the print and related services industry could be impaired. The lenders who hold our debt could also accelerate amounts due in the event that we default, which could potentially trigger a default or acceleration of the maturity of our other debt.

In addition, our leverage could put us at a competitive disadvantage compared to our competitors who may be less leveraged. These competitors could have greater financial flexibility to pursue strategic acquisitions and secure additional financing for their operations. Our leverage could also impede our ability to withstand downturns in our industry or the economy in general.

The agreements and instruments that govern our debt impose restrictions that may limit our operating and financial flexibility.

The Credit Agreement (as defined below) that governs our Credit Facilities (as defined below) and the indenture that governs the Notes (as defined below) contain a number of significant restrictions and covenants that limit our ability to:

- incur additional debt;
- pay dividends, make other distributions or repurchase or redeem our capital stock;
- prepay, redeem or repurchase certain debt;
- make loans and investments;
- sell, transfer or otherwise dispose of assets;
- incur or permit to exist certain liens; enter into certain types of transactions with affiliates;
- enter into agreements restricting our subsidiaries' ability to pay dividends; and
- consolidate, merge or sell all or substantially all of our assets.

These covenants can have the effect of limiting our flexibility in planning for or reacting to changes in our business and the markets in which we compete. In addition, the Credit Agreement that governs our Credit Facilities requires us to comply with certain financial maintenance covenants. Operating results below current levels or other adverse factors, including a significant increase in interest rates, could result in our being unable to comply with the financial covenants contained in our Term Loan Facility and indenture. If we violate covenants under our Credit Facilities and indenture and are unable to obtain a waiver from our lenders, our debt under our Credit Facilities and indenture would be in default and could be accelerated by our lenders. Because of cross-default provisions in the agreements and instruments governing our debt, a default under one agreement or instrument could result in a default under, and the acceleration of, our other debt.

If our debt is accelerated, we may not be able to repay our debt or borrow sufficient funds to refinance it. Even if we are able to obtain new financing, it may not be on commercially reasonable terms, on terms that are acceptable to us, or at all. If our debt is in default for any reason, our business and consolidated and combined statements of income, balance sheets and cash flows could be materially and adversely affected. In addition, complying with these covenants may also cause us to take actions that are not favorable to holders of the Notes and may make it more difficult for us to successfully execute our business strategy and compete against companies that are not subject to such restrictions.

Despite our substantial indebtedness, we may be able to incur significantly more debt.

Despite our substantial amount of indebtedness, we may be able to incur significant additional debt, including secured debt, in the future. Although the indenture governing our Notes and the Credit Agreement governing the Credit Facilities restrict the incurrence of additional debt, these restrictions are subject to a number of qualifications and exceptions. Also, these restrictions do not prevent us from incurring obligations that do not constitute indebtedness. In addition, as of December 31, 2018, we had $254.7 million available for additional borrowing under our Revolving Facility (as defined in Note 15, *Debt*). The more indebtedness we incur, the further exposed we become to the risks associated with substantial leverage described above.

The highly competitive market for our products and services and industry fragmentation may continue to create adverse price pressures.

The financial communications services industry is highly competitive with relatively low barriers to entry, and the industry remains highly fragmented in North America and internationally. Management expects that competition will increase from existing competitors, as well as new and emerging entrants. Additionally, as we expand our product and service offerings, we may face competition from new and existing competitors. As a result, competition may lead to additional pricing pressure on our products and services, which could negatively impact our results of operations, financial position and cash flow.

The business plan we announced at our 2018 investor day relies on our ability to transform into a software-as-a-service company, and a failure to adapt to technological changes to address the changing demands of clients may adversely impact our business, and if we fail to successfully develop, introduce or integrate new services or enhancements to our products and services platforms, systems or applications, DFIN's reputation, net sales and operating income may suffer.

In May 2018, we introduced our new business plan that focuses on transitioning our business to a software and technology focused company. In order to do that, we must attract new clients for those businesses, and our ability to attract new clients and increase sales to existing clients will depend in large part on our ability to enhance and improve our existing products and services platforms, including our application solutions, and to introduce new functionality either by acquisition or internal development. Our operating results would suffer if our innovations are not responsive to the needs of our clients, are not appropriately timed with market opportunities or are not brought to market effectively. In addition, it is possible that our assumptions about the features that we believe will drive purchasing decisions for our potential clients or renewal decisions for our existing clients could be incorrect. In the past, we have experienced delays in the planned release dates of new products and services and upgrades to such products and services. There can be no assurance that new products or services, or upgrades to our products or services, will be released on schedule or that, when released, they will not contain defects as a result of poor planning, execution or other factors during the product development lifecycle. If any of these situations were to arise, we could suffer adverse publicity, damage to our reputation, loss of net sales, delay in market acceptance or claims by clients brought against us. Moreover, upgrades and enhancements to our platforms may require substantial investment and there can be no assurance that our investments will help us achieve or sustain a durable competitive advantage in our products and services offerings. If clients do not widely adopt our solutions or new innovations to our solutions, we may not be able to justify the investments we have made. If we are unable to develop, license or acquire new solutions or enhancements to existing services on a timely and cost-effective basis, or if our new or enhanced solutions do not achieve market acceptance, our business, results of operations and financial condition will be materially negatively impacted.

Undetected errors or failures found in our products and services may result in loss of or delay in market acceptance of our products and services that could seriously harm our business.

Our products and services may contain undetected errors or scalability limitations at any point in their lives, but particularly when first introduced or as new versions are released. We frequently release new versions of our products and different aspects of our platform are in various stages of development. Despite testing by us and by current and potential clients, errors may not be found in new products and services until after commencement of commercial availability or use, resulting in a loss of or a delay in market acceptance, damage to our reputation, client dissatisfaction and reductions in net sales and margins, any of which could negatively impact our business.

Changes in the rules and regulations to which clients or potential clients are subject may impact demand for our products and services.

Many of our clients are subject to rules and regulations requiring certain printed or electronic communications governing the form, content and delivery methods of such communications, such as SEC Rule 30e-3 which provides certain registered investment companies with an option to electronically deliver shareholder reports and other materials rather than providing such reports in paper. Changes in these regulations may impact clients' business practices and could reduce demand for our products and services. Changes in such regulations could eliminate the need for certain types of communications altogether or such changes may impact the quantity or format of communications.

Our failure to maintain the confidentiality, integrity and availability of our systems, software and solutions could seriously damage our reputation and affect our ability to retain clients and attract new business.

Maintaining the confidentiality, integrity and availability of our systems, software and solutions is an issue of critical importance for us and for our clients and users who rely on our systems to prepare regulatory filings and store and exchange large volumes of information, much of which is proprietary, confidential and may constitute material nonpublic information for our clients. Because our systems contain material nonpublic information about public reporting companies and potential mergers and acquisitions activities prior to its public release, we may be a target of hacking or cybercrime, as evidenced by the hacking of newswire services in 2015 and the SEC's EDGAR system in 2016. Inadvertent disclosure of the information maintained on our systems (or on the systems of the vendors on which we rely) due to human error, breach of our systems through hacking or cybercrime or a leak of confidential information due to employee misconduct, could seriously damage our reputation and could cause significant reputational harm for our clients. Techniques used to obtain unauthorized access to, or to sabotage, systems change frequently and generally are not recognized until launched against a target. Like all software solutions, our software may be vulnerable to these types of attacks. An attack of this type could disrupt the proper functioning of our software solutions, cause errors in the output of our clients' work, allow unauthorized access to sensitive, proprietary or confidential information of ours or our clients and other undesirable or destructive outcomes. Furthermore, our systems allow us to share information that may be confidential in nature to our clients across our offices worldwide. This design allows us to increase global reach for our clients and increase our responsiveness to client demands, but also increases the risk of a security breach or a leak of such information because it allows additional points of access to information by increasing the number of employees and facilities working on certain jobs. In addition, our systems leverage third party outsourcing arrangements, which expedites our responsiveness but exposes information to additional access points. If an actual or perceived information leak or breach of our security were to occur, our reputation could suffer, clients could stop using our products and services and we could face lawsuits and potential liability, any of which could cause our financial performance to be negatively impacted. Though we maintain professional liability insurance that includes coverage if a cybersecurity incident were to occur, there can be no assurance that insurance coverage will be available, responsive, or that available coverage will be sufficient to cover losses and claims related to any cybersecurity incidents we may experience.

A number of core processes, such as software development, sales and marketing, client service and financial transactions, rely on our IT, infrastructure and applications. Defects or malfunctions in our IT infrastructure and applications could cause our products and services offerings not to perform as our clients expect, which could harm our reputation and business. In addition, malicious software, sabotage and other cybersecurity breaches of the types described above could cause an outage of our infrastructure, which could lead to a substantial denial of service and ultimately downtimes, recovery costs and client claims, any of which could negatively impact our results of operations, financial position and cash flow.

Some of our systems and services are developed by third parties or supported by third party hardware and software and our business and reputation could suffer if these third party systems and services fail to perform properly or are no longer available to us.

Some of our systems and services are developed by third parties or rely on hardware purchased or leased and software licensed from third parties. These systems and services, or the hardware and software required to run our existing systems and services, may not continue to be available on commercially reasonable terms or at all. Any loss of the right to use any of this hardware or software could result in delays in the provisioning of our services, which could negatively affect our business until equivalent technology is either developed by us or, if available, is identified, obtained and integrated. In addition, it is possible that our hardware vendors or the licensors of third party software could increase the prices they charge, which could have an adverse impact on our business, operating results and financial condition. Further, changing hardware vendors or software licensors could detract from management's ability to focus on the ongoing operations of our business or could cause delays in the operations of our business.

Additionally, third party software underlying our services can contain undetected errors or bugs, or be susceptible to cybersecurity breaches described above. We may be forced to delay commercial release of our services until any discovered problems are corrected and, in some cases, may need to implement enhancements or modifications to correct errors that we do not detect until after deployment of our services.

Increasing regulatory focus on privacy issues and expanding laws could impact our software products and expose us to increased liability.

Privacy and data security laws apply to our various businesses in all jurisdictions in which we operate. In particular, clients use our software services, including Venue datarooms, to share personal data and information on a confidential basis, and such sharing may be subject to privacy and data security laws. Our global business operates in countries that have more stringent data protection laws than those in the United States. These data protection laws may be inconsistent across jurisdictions and are subject to evolving and differing interpretations. New laws, such as the GDPR which went into effect in May 2018 in Europe, and industry self-regulatory codes have been or are being enacted to protect personal data. Complying with these regulations has been, and will continue to be, costly, and there are or will be significant penalties for failure to comply with these regulations, including significant penalties for failing to comply with GDPR. Further, any perception of our practices, products or services as a violation of individual privacy rights may subject us to public criticism, class action lawsuits, reputational harm, or investigations or claims by regulators, industry groups or other third parties, all of which could disrupt our business and expose us to liability.

Transferring personal data and information across international borders is becoming increasingly complex. For example, Europe has stringent regulations regarding transfer of personal data and information. The mechanisms that we and many other companies rely upon for data transfers from Europe to the United States (e.g., Privacy Shield and Model Clauses) are being contested in the European court systems. We are closely monitoring developments related to requirements for transferring personal data and information. These requirements may result in an increase in the obligations required to provide our services in the EU or in sanctions and fines for non-compliance. Several other countries, including Australia and Japan, have also established specific legal requirements for cross-border transfers of personal information. These developments in Europe and elsewhere could harm our business, financial condition and results of operations.

Adverse credit market conditions may limit our ability to obtain future financing.

We may, from time to time, depend on access to credit markets. Uncertainty and volatility in global financial markets may cause financial markets institutions to fail or may cause lenders to hoard capital and reduce lending. As a result, we may not obtain financing on terms and conditions that are favorable to us, or at all.

Fluctuations in the costs and availability of paper, ink, energy and other raw materials may adversely impact us.

Increases in the costs of these inputs may increase our costs and we may not be able to pass these costs on to clients through higher prices. Moreover, rising raw materials' costs, and any consequent impact on our pricing, could lead to a decrease in demand for our products and services.

If we are unable to protect our proprietary technology and other rights, the value of our business and our competitive position may be impaired.

If we are unable to protect our intellectual property, our competitors could use our intellectual property to market products and services similar to ours, which could decrease demand for our services. We rely on a combination of patents, trademarks, licensing and other proprietary rights laws, as well as third party nondisclosure agreements and other contractual provisions and technical measures, to protect our intellectual property rights. These protections may not be adequate to prevent our competitors from copying or reverse-engineering our technology and services to create similar offerings. Additionally, any of our pending or future patent applications may not be issued with the scope of protection we seek, if at all. The scope of patent protection, if any, we may obtain from our patent applications is difficult to predict and our patents may be found invalid, unenforceable or of insufficient scope to prevent competitors from offering similar services. Our competitors may independently develop technologies that are substantially equivalent or superior to our technology. To protect our proprietary information, we require employees, consultants, advisors, independent contractors and collaborators to enter into confidentiality agreements and maintain policies and procedures to limit access to our trade secrets and proprietary information. These agreements and the other actions we take may not provide meaningful protection for our proprietary information or know-how from unauthorized use, misappropriation or disclosure. Further, existing patent laws may not provide adequate or meaningful protection in the event competitors independently develop technology, products or services similar to ours. Even if the laws governing intellectual property rights provide protection, we may have insufficient resources to take the legal actions necessary to protect our interests. In addition, our intellectual property rights and interests may not be afforded the same protection under the laws of foreign countries as they are under the laws of the United States.

We have in the past acquired and intend in the future to acquire other businesses, and we may be unable to successfully integrate the operations of these businesses and may not achieve the cost savings and increased net sales anticipated as a result of these acquisitions.

Achieving the anticipated benefits of acquisitions will depend in part upon our ability to integrate these businesses in an efficient and effective manner. The integration of companies that have previously operated independently may result in significant challenges, and we may be unable to accomplish the integration smoothly or successfully. In particular, the coordination of geographically dispersed organizations with differences in corporate cultures and management philosophies may increase the difficulties of integration. The integration of acquired businesses may also require the dedication of significant management resources, which may temporarily distract management's attention from the day-to-day operations of the Company. In addition, the process of integrating operations may cause an interruption of, or loss of momentum in, the activities of one or more of the Company's businesses and the loss of key personnel from the Company or the acquired businesses. Further, employee uncertainty and lack of focus during the integration process may disrupt the businesses of the Company or the acquired businesses. The Company's strategy is, in part, predicated on the Company's ability to realize cost savings and to increase net sales through the acquisition of businesses that add to the breadth and depth of the Company's products and services. Achieving these cost savings and net sales increases is dependent upon a number of factors, many of which are beyond the Company's control. In particular, the Company may not be able to realize the benefits of more comprehensive product and service offerings, anticipated integration of sales forces, asset rationalization and systems integration.

Our business is dependent upon brand recognition and reputation, and the failure to maintain or enhance our brand or reputation would likely have an adverse effect on our business.

Our brand recognition and reputation are important aspects of our business. Maintaining and further enhancing our brands and reputation will be important to retaining and attracting clients for our products. We also believe that the importance of our brand recognition and reputation for products will continue to increase as competition in the market for our products and industry continues to increase. Our success in this area will be dependent on a wide range of factors, some of which are out of our control, including the efficacy of our marketing efforts, our ability to retain existing and obtain new clients and strategic partners, human error, the quality and perceived value of our products and services, actions of our competitors and positive or negative publicity. Damage to our reputation and loss of brand equity may reduce demand for our products and services and negatively impact our results of operations, financial position and cash flow.

We may be unable to hire and retain talented employees, including management.

Our success depends, in part, on our general ability to attract, develop, motivate and retain highly skilled employees. The loss of a significant number of our employees or the inability to attract, hire, develop, train and retain additional skilled personnel could have a serious negative effect on our business. We believe our ability to retain our client base and to attract new clients is directly related to our sales force and client service personnel, and if we cannot retain these key employees, our business could suffer. In addition, many members of our management have significant industry experience that is valuable to our competitors. We expect that our executive officers will have non-solicitation agreements contractually prohibiting them from soliciting our clients and employees within a specified period of time after they leave DFIN. If one or more members of our senior management team leave and cannot be replaced with a suitable candidate quickly, we could experience difficulty in managing our business properly, which could negatively impact our results of operations, financial position and cash flow.

The trend of increasing costs to provide health care and other benefits to our employees and retirees may continue.

We provide health care and other benefits to both employees and retirees. For many years, costs for health care have increased more rapidly than general inflation in the U.S. economy. If this trend in health care costs continues, our cost to provide such benefits could increase, adversely impacting our profitability. Changes to health care regulations in the U.S. and internationally may also increase our cost of providing such benefits.

Changes in market conditions, changes in discount rates, or lower returns on assets may increase required pension and other post-retirement benefits plan contributions in future periods.

The funded status of our pension and other post-retirement benefits plans is dependent upon many factors, including returns on invested assets and the level of certain interest rates. As experienced in prior years, declines in the market value of the securities held by the plans coupled with historically low interest rates have substantially reduced, and in the future could further reduce, the funded status of the plans. These reductions may increase the level of expected required pension and other post-retirement benefits plan contributions in future years. Various conditions may lead to changes in the discount rates used to value the year-end benefit obligations of the plans, which could partially mitigate, or worsen, the effects of lower asset returns. If adverse conditions were to continue for an extended period of time, our costs and required cash contributions associated with pension and other post-retirement benefits plans may substantially increase in future periods.

We are exposed to risks related to potential adverse changes in currency exchange rates.

We are exposed to market risks resulting from changes in the currency exchange rates of the currencies in the countries in which we do business. Although operating in local currencies may limit the impact of currency rate fluctuations on the operating results of our non-U.S. activities, fluctuations in such rates may affect the translation of these results into our financial statements. To the extent borrowings, sales, purchases, net sales and expenses or other transactions are not in the applicable local currency, we may enter into foreign currency spot and forward contracts to hedge the currency risk. Management cannot be sure, however, that our efforts at hedging will be successful, and such efforts could, in certain circumstances, lead to losses.

There are risks associated with operations outside the United States.

We have operations outside the United States. We work with capital markets clients around the world, and in 2018 our International segment accounted for 16% of our consolidated net sales. Our operations outside of the United States are primarily focused in Europe, Asia, Canada and Latin America. As a result, we are subject to the risks inherent in conducting business outside the United States, including:

- costs of customizing products and services for foreign countries;
- difficulties in managing and staffing international operations;
- increased infrastructure costs including legal, tax, accounting and information technology;
- reduced protection for intellectual property rights in some countries;
- potentially greater difficulties in collecting accounts receivable, including currency conversion and cash repatriation from foreign jurisdictions;
- increased licenses, tariffs and other trade barriers;
- potentially adverse tax consequences;
- increased burdens of complying with a wide variety of foreign laws, including employment-related laws, which may be more stringent than U.S. laws;
- unexpected changes in regulatory requirements;
- political and economic instability; and
- compliance with applicable anti-corruption and sanction laws and regulations.

We cannot be sure that our investments or operations in other countries will produce desired levels of net sales or that one or more of the factors listed above will not affect our global business.

Our reliance on strategic partnerships as part of our business strategy may adversely affect the development of our business in those areas.

Our business strategy includes pursuing and maintaining strategic partnerships in order to facilitate our entry into adjacent lines of business. This approach may expose us to risk of conflict with our strategic arrangement partners and the need to divert management resources to oversee these partnership arrangements. Further, as these arrangements require cooperation with third party partners, these strategic arrangements may not be able to make decisions as quickly as we would if we were operating on our own or may take actions that are different from what we would do on a standalone basis in light of the need to consider our partners' interests. As a result, we may be less able to respond timely to changes in market dynamics, which could have a material adverse effect on our business, financial condition and results of operations.

ITEM 1B. UNRESOLVED STAFF COMMENTS

The Company has no unresolved written comments from the SEC staff regarding its periodic or current reports under the Securities Exchange Act of 1934.

ITEM 2. PROPERTIES

The Company's corporate office is located in leased office space at 35 West Wacker Drive, Chicago, Illinois, 60601. As of December 31, 2018, the Company leased or owned 42 U.S. facilities, some of which had multiple buildings and warehouses, and these U.S. facilities encompassed approximately 1.3 million square feet. The Company leased 24 international facilities, some of which had multiple buildings and warehouses, encompassing approximately 0.1 million square feet in Europe, Asia, Canada and Latin America. Of the Company's U.S. and international facilities, approximately 0.4 million square feet of space was owned, while the remaining 1.0 million square feet of space was leased.

ITEM 3. LEGAL PROCEEDINGS

For a discussion of certain litigation involving the Company, see Note 12, *Commitments and Contingencies* , to the Consolidated and Combined Financial Statements.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR DONNELLEY FINANCIAL SOLUTIONS, INC.'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Principal Market

DFIN's common stock began regular-way trading under the ticker symbol "DFIN" on the New York Stock Exchange ("NYSE") on October 3, 2016.

Stockholders

As of February 22, 2019, there were 4,620 stockholders of record of the Company's common stock.

Issuer Purchases Of Equity Securities

Period	Total Number of Shares Purchased (a)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Dollar Value of Shares that May Yet be Purchased Under the Plans or Programs
October 1, 2018 - October 31, 2018	37,464	$ 17.41	—	$ —
November 1, 2018 - November 30, 2018	—	—	—	—
December 1, 2018 - December 31, 2018	—	—	—	—
Total	37,464	$ 17.41	—	$ —

(a) Shares withheld for tax liabilities upon vesting of equity awards

Equity Compensation Plans

For information regarding equity compensation plans, see Item 12 of Part III of this Annual Report on Form 10-K

PEER PERFORMANCE TABLE

The following graph compares the cumulative total shareholder return on DFIN's common stock from October 3, 2016, when "regular way" trading in DFIN's common stock began on the NYSE, through December 31, 2018, with the comparable cumulative return of the Standard & Poor's ("S&P") SmallCap 600 Index and a selected peer group of companies. The comparison assumes all dividends have been reinvested and an initial investment of $100 on October 3, 2016. The returns of each company in the peer group have been weighted to reflect their market capitalizations. The stock price performance on the following graph is not necessarily indicative of future stock price performance.

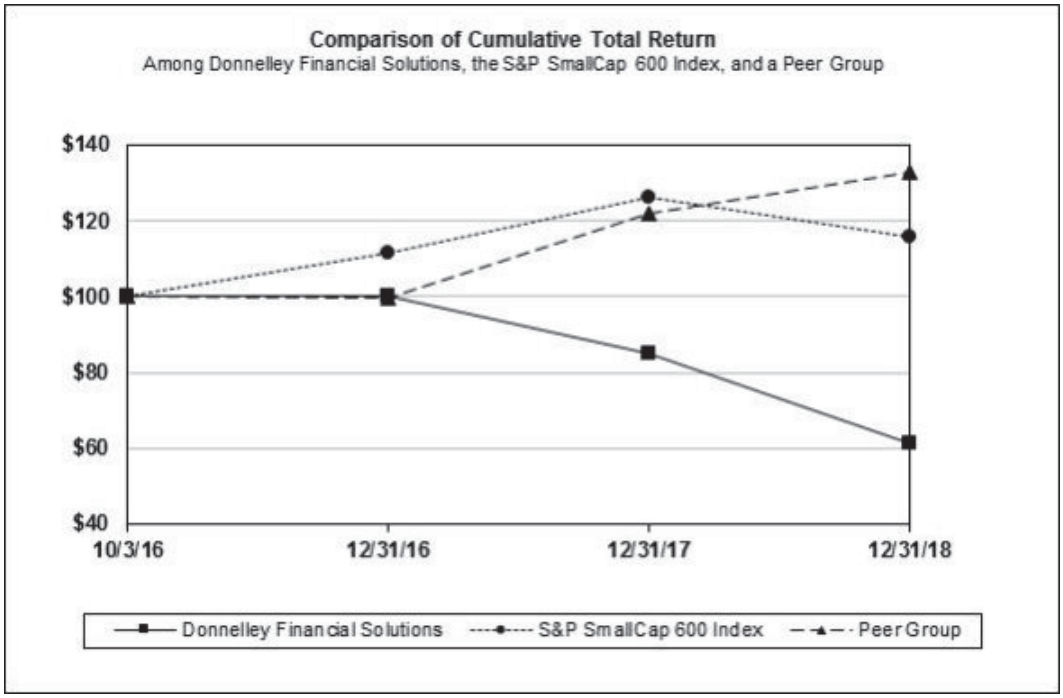

Company Name/Index	Base Period 10/3/2016	Quarter Ended 12/31/2016	Year Ended 12/31/2017	Year Ended 12/31/2018
Donnelley Financial Solutions	100	100.04	84.85	61.08
S&P SmallCap 600 Index	100	111.52	126.28	115.57
Peer Group	100	99.84	121.78	132.59

Below are the specific companies included in the peer group.

Peer Group Companies

Advisory Board Company (a)
ARC Document Solutions Inc
Bottomline Technologies Inc
Broadridge Financial Solutions Inc
CoreLogic Inc
CSG Systems International Inc.
DST Systems Inc. (b)
Dun & Bradstreet Corp
ePlus Inc
Euronet Worldwide Inc
FactSet Research Systems Inc.
Gartner Inc
Henry (Jack) & Associates Inc.
LiveRamp Holdings Inc. (c)
Perficient Inc
Resources Connection Inc
Verint Systems Inc

(a) Advisory Board Company was included through November 17, 2017, when it was acquired by OptumInsight
(b) DST Systems Inc. was included through April 16, 2018, when it was acquired by SS&C Technologies
(c) LiveRamp Holdings Inc. was previously named Acxiom Corp

ITEM 6. SELECTED FINANCIAL DATA

SELECTED FINANCIAL DATA
(in millions, except per share data)

	Year Ended December 31,				
	2018	2017	2016	2015	2014
Consolidated and combined statements of operations data:					
Net sales	$ 963.0	$ 1,004.9	$ 983.5	$ 1,049.5	$ 1,080.1
Net earnings	73.6	9.7	59.1	104.3	57.4
Net earnings per share (a)					
Basic net earnings per share	2.18	0.29	1.81	3.22	1.77
Diluted net earnings per share	2.16	0.29	1.80	3.22	1.77
Consolidated and combined balance sheet data:					
Total assets	868.7	893.5	978.9	817.6	994.2
Long-term debt	362.7	458.3	587.0	—	—
Note payable with an RRD affiliate	—	—	—	29.2	44.0

(a) On October 1, 2016, RRD distributed approximately 26.2 million shares of DFIN common stock to RRD shareholders in connection with the spin-off of DFIN, with RRD retaining approximately 6.2 million shares of DFIN common stock. On June 21, 2017, RRD completed the sale of approximately 6.1 million shares of the Company's common stock in an underwritten public offering. Upon consummation of the offering, RRD retained approximately 0.1 million shares of the Company's common stock which were subsequently sold by RRD on August 4, 2017.

For periods prior to the Separation, basic and diluted earnings per share were calculated using the number of shares distributed and retained by RRD, totaling 32.4 million. The same number of shares was used to calculate basic and diluted earnings per share since there were no DFIN equity awards outstanding prior to the spin-off.

Reflects results of acquired businesses from the relevant acquisition dates.

Includes the following significant items:

	Pre-tax	After-tax
Year ended December 31, 2018		
Net gain on sale of Language Solutions business	$ (53.8)	$ (38.6)
Gain on equity investment	(11.8)	(8.5)
Gain on eBrevia investment	(1.8)	(1.5)
Spin-off related transaction expenses	20.1	14.6
Share-based compensation expense	9.2	6.7
Disposition-related expenses	6.8	5.1
Restructuring, impairment and other charges - net	4.4	3.2
Acquisition-related expenses	0.8	0.5
Investor-related expenses	0.5	0.4

	Pre-tax	After-tax
Year ended December 31, 2017		
Spin-off related transaction expenses	$ 16.5	$ 9.9
Restructuring, impairment and other charges - net	7.1	4.2
Share-based compensation expense	6.8	4.1
Acquisition-related expenses	0.2	0.1

	Pre-tax	After-tax
Year ended December 31, 2016		
Restructuring, impairment and other charges – net	$ 5.4	$ 3.3
Spin-off related transaction expenses	4.9	3.0
Share-based compensation expense	2.5	1.5

	Pre-tax	After-tax
Year ended December 31, 2015		
Restructuring, impairment and other charges – net	$ 4.4	$ 2.8
Share-based compensation expense	1.6	1.0

	Pre-tax	After-tax
Year ended December 31, 2014		
Pension settlement charges	$ 95.7	$ 58.4
Restructuring, impairment and other charges – net	4.8	3.1
Gain on the sale of a building	(6.1)	(3.7)
Gain from the sale of an equity investment	(3.0)	(1.8)
Share-based compensation expense	2.1	1.3

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

The following discussion of DFIN's financial condition and results of operations should be read together with the consolidated and combined financial statements and notes to those statements included in Item 15 of Part IV, *Exhibits, Financial Statement Schedules* , of this Annual Report on Form 10-K.

Business

For a description of the Company's business, segments and product and service offerings, see Item 1, *Business* , of Part I of this Annual Report on Form 10-K.

The Company separately reports its net sales and related cost of sales for its products and services offerings. The Company's services offerings consist of all non-print offerings, including document composition, compliance related EDGAR filing services, transaction solutions, language solutions, and the Company's software-as-a-service ("SaaS") solutions, including Venue Virtual Data Room ("Venue"), FundSuiteArc, ActiveDisclosure and data and analytics, among others. The Company's product offerings primarily consist of conventional and digital printed products and related shipping costs.

Spin-off Transaction

On October 1, 2016, DFIN became an independent publicly traded company through the distribution by RRD of approximately 26.2 million shares, or 80.75%, of DFIN common stock to RRD shareholders (the "Separation"). Holders of RRD common stock received one share of DFIN common stock for every eight shares of RRD common stock held on September 23, 2016. As part of the Separation, RRD retained approximately 6.2 million shares of DFIN common stock, or a 19.25% interest in DFIN, of which 6.1 million shares and 0.1 million shares were subsequently sold in June 2017 and August 2017, respectively.

DFIN's common stock began regular-way trading under the ticker symbol "DFIN" on the New York Stock Exchange on October 3, 2016. On October 1, 2016, RRD also completed the previously announced separation of LSC, its publishing and retail-centric print services and office products business. On March 28, 2017, RRD completed the sale of 6.2 million shares of LSC common stock (RRD's remaining ownership stake in LSC) in an underwritten public offering. As a result, beginning in the quarter ended June 30, 2017, LSC no longer qualified as a related party of the Company. Beginning in the quarter ended September 30, 2017, RRD no longer qualified as a related party, therefore amounts disclosed related to RRD are presented through June 30, 2017 only.

Executive Overview

2018 Overview

Net sales decreased by $41.9 million, or 4.2%, in 2018 compared to 2017, including a $2.7 million, or 0.3%, increase due to changes in foreign exchange rates. Net sales decreased primarily due to the sale of the Language Solutions business, lower volumes in capital markets compliance and mutual fund print and print related services, partially offset by higher SaaS volumes in FundSuiteArc, virtual data room services and ActiveDisclosure, along with higher capital markets transactions.

On July 22, 2018, the Company sold its Language Solutions business, which helped companies adapt their business content into different languages for specific countries, markets and regions, for net proceeds of $77.5 million in cash, all of which was received as of December 31, 2018, resulting in a net gain of $53.8 million, which was recognized in other operating income in the Consolidated Statement of Operations for the year ended December 31, 2018. The Company used approximately $60.0 million of net proceeds from the sale to pay down debt under the Term Loan Credit Facility (as defined in *Liquidity and Capital Resources*) in July 2018 in accordance with the provisions of the Credit Agreement.

On December 18, 2018, the Comp any acquired eBrevia , a leading provider of artificial intelligence-based data extraction and contract analytics software s olutions. The Company previously held a 12. 8 % investment in eBrevia prior to the acquisition. The purchase price for the remaining equity of eBrevia, which includes the Company's estimate of contingent consideration, was $ 23 . 2 million, net of cash acquired o f $0. 2 million. $4.1 million of the purchase price, excluding contingent consideration and amounts held in escrow , was payable as of December 31, 2018 and is expected to be paid during 2019. The eBrevia technology provides leading enterprise contract review and analysis solutions, leveraging machine learning to produce faster and more accurate results. eBrevia's software, which extracts and summarizes key legal provisions and other information, can be used in due diligence, contrac t management, lease abstraction and document drafting.

OUTLOOK

In 2019, the Company expects net sales to decrease slightly due to the sale of Language Solutions during 2018, offset by growth in the Company's SaaS offerings and the acquisition of eBrevia during 2018. The Company's outlook assumes a challenging capital markets environment in the first quarter of the year, returning to more normalized levels for the remainder of the year, and does not expect foreign exchange rates to have a significant impact on results.

In 2019, the Company will adopt Accounting Standards Update No. 2016-02 "Leases (Topic 842)" ("ASU 2016-02"). The Company is in the process of reviewing its existing lease portfolio, which is primarily comprised of real estate leases, to evaluate the impact of ASU 2016-02 on the consolidated financial statements. Refer to Note 23, *New Accounting Pronouncements* , to the consolidated and combined financial statements for further detail.

The Company initiated several restructuring actions in 2017 and 2018 to further reduce the Company's overall cost structure. These restructuring actions included the reorganization of certain functions. These actions, as well as planned actions for 2019, are expected to have a positive impact on operating earnings in 2019 and in future years.

Cash flows from operations in 2019 are expected to benefit from cost control actions and lower interest expense. The Company expects capital expenditures to be in the range of $40.0 million to $45.0 million in 2019, as compared to $37.1 million in 2018.

While expected to decline as compared to 2018, the Company expects to continue to incur spin-off related transition expenses in 2019, including third-party consulting fees and other expenses.

Significant Accounting Policies and Critical Estimates

The preparation of financial statements in conformity with GAAP requires the extensive use of management's estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting periods. Actual results could differ from these estimates. Estimates are used when accounting for items and matters including, but not limited to, allowance for uncollectible accounts receivable, pension, asset valuations and useful lives, income taxes and other provisions and contingencies.

Revenue Recognition

The Company manages highly-customized data and materials, such as Exchange Act, Securities Act and Investment Company Act filings with the SEC on behalf of our customers, manages virtual data rooms and performs XBRL and related services. Clients are provided with EDGAR filing services, XBRL compliance services and translation, editing, interpreting, proof-reading and multilingual typesetting services, among others. The Company's SaaS solutions include the Venue Virtual Data Room, the FundSuiteArc software platform, ActiveDisclosure and data and analytics, among others.

Revenue is recognized upon transfer of control of promised services or products to customers in an amount that reflects the consideration to which the Company expects to be entitled in exchange for those services or products. The Company's arrangements with customers often include promises to transfer multiple services or products to a customer. Determining whether services and products are considered distinct performance obligations that should be accounted for separately requires significant judgment. Certain customer arrangements have multiple performance obligations as certain promises are both capable of being distinct and are distinct within the context of the contract. Other customer arrangements have a single performance obligation as the promise to transfer the individual goods or services is not separately identifiable from other promises in the contracts, and therefore are not distinct.

For arrangements with multiple performance obligations, the transaction price is allocated to the separate performance obligations. As the Company provides customer specific solutions, observable standalone selling price is rar e ly available. As such, standalone selling price is more frequently determined using an estimate of the standalone selling price of each distinct service or product, taking into consideration of historical selling price by customer for distinct service or product. These estimates may vary from the final amounts invoiced to the customer and are adjusted upon completion of all performance obligations.

Because substantially all of the Company's products are customized, product returns are not significant; however, the Company accrues for the estimated amount of customer credits at the time of sale. Refer to Note 2, *Significant Accounting Policies* , to the consolidated and combined financial statements for further discussion.

Certain revenues earned by the Company require significant judgment to determine if revenue should be recorded gross, as a principal, or net of related costs, as an agent. Billings for shipping and handling costs as well as certain postage costs and out-of-pocket expenses are recorded gross.

Refer to Note 3, *Revenue* , to the consolidated and combined financial statements for further detail regarding the impact of the 2018 adoption of Accounting Standards Update No. 2014-09 "Revenue from Contracts with Customers (Topic 606) " ("ASU 2014-09") .

Goodwill and Other Long-Lived Assets

The Company's methodology for allocating the purchase price of acquisitions is based on established valuation techniques that reflect the consideration of several factors, including valuations performed by third-party appraisers when appropriate. Goodwill is measured as the excess of the cost of an acquired entity over the fair value assigned to identifiable assets acquired and liabilities assumed. Goodwill is either assigned to a specific reporting unit or allocated between reporting units based on the relative fair value of each reporting unit. Based on its current organization structure, the Company has identified three reporting units for which cash flows are determinable and to which goodwill may be allocated.

The Company performs its goodwill impairment tests annually as of October 31, or more frequently if an event occurs or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. The Company also performs an interim review for indicators of impairment each quarter to assess whether an interim impairment review is required for any reporting unit. As part of its interim reviews, management analyzes potential changes in the value of individual reporting units based on each reporting unit's operating results for the period compared to expected results as of the prior year's annual impairment test. In addition, management considers how other key assumptions, including discount rates and expected long-term growth rates, used in the last annual impairment test, could be impacted by changes in market conditions and economic events. Based on these interim assessments, management concluded that as of the interim periods, no events or changes in circumstances indicated that it was more likely than not that the fair value for any reporting unit had declined below its carrying amount.

As of October 31, 2018, the Capital Markets, Investment Markets and International reporting units had goodwill. Each of the reporting units were reviewed for impairment using a quantitative assessment.

Quantitative Assessment for Impairment

For each of the reporting units, the estimated fair value of each reporting unit was compared to its carrying amount, including goodwill. If the carrying amount of a reporting unit exceeded the estimated fair value, an impairment loss is generally recognized in an amount equal to that excess, limited to the total amount of goodwill allocated to that reporting unit. The results of the quantitative assessment of goodwill impairment as of October 31, 2018, indicated that the estimated fair values for each of the reporting units exceeded their respective carrying amount. Therefore, no impairment losses were recognized.

The analysis performed included estimating the fair value of each reporting unit using both the income and market approaches. The income approach requires management to estimate a number of factors for each reporting unit, including projected future operating results, economic projections, anticipated future cash flows, discount rates and the allocation of shared or corporate items. The market approach estimates fair value using comparable marketplace fair value data from within a comparable industry grouping. The Company weighted both the income and market approach equally to estimate the concluded fair value of each reporting unit.

The determination of fair value in the quantitative assessment requires the Company to make significant estimates and assumptions. These estimates and assumptions primarily include, but are not limited to: the selection of appropriate peer group companies; control premiums appropriate for acquisitions in the industries in which the Company competes; the discount rate; terminal growth rates; and forecasts of revenue, operating income, depreciation and amortization, restructuring charges and capital expenditures.

As a result of the 2018 annual goodwill impairment test, the Company did not recognize any goodwill impairment losses as the estimated fair values of all reporting units exceeded their respective carrying amounts.

Goodwill Impairment Assumptions

Although the Company believes its estimates of fair value are reasonable, actual financial results could differ from those estimates due to the inherent uncertainty involved in making such estimates. Changes in assumptions concerning future financial results or other underlying assumptions could have a significant impact on either the fair value of the reporting units, the amount of the goodwill impairment charge, or both. Future declines in the overall market value of the Company's equity and debt securities may also result in a conclusion that the fair value of one or more reporting units has declined below its carrying amount.

One measure of the sensitivity of the amount of goodwill impairment charges to key assumptions is the amount by which each reporting unit "passed" (fair value exceeds carrying amount) or "failed" (the carrying amount exceeds fair value) the quantitative assessment. Each of the reporting units that were quantitatively assessed had fair values that exceeded the carrying amounts by between 29.3% and 125.4% of their respective estimated fair values. Relatively small changes in the Company's key assumptions would not have resulted in any reporting units being impaired.

Generally, changes in estimates of expected future cash flows would have a similar effect on the estimated fair value of the reporting unit. That is, a 1.0% decrease in estimated annual future cash flows would decrease the estimated fair value of the reporting unit by approximately 1.0%. The estimated long-term net sales growth rate can have a significant impact on the estimated future cash flows, and therefore, the fair value of each reporting unit. A 1.0% decrease in the long-term net sales growth rate would not have resulted in an impairment loss for any of the reporting units. Of the other key assumptions that impact the estimated fair values, most reporting units have the greatest sensitivity to changes in the estimated discount rate. The estimated discount rate for the reporting units with operations located in the U.S. was 10.0% as of October 31, 2018. The estimated discount rate for the reporting unit with operations in foreign locations was 11.5% as of October 31, 2018. A 1.0% increase in estimated discount rates would not have resulted in an impairment loss for any of the reporting units. The Company believes that its estimates of future cash flows and discount rates are reasonable, but future changes in the underlying assumptions could differ due to the inherent uncertainty in making such estimates. Additionally, further price deterioration or lower volume could have a significant impact on the fair values of the reporting units.

Other Long-Lived Assets

The Company evaluates the recoverability of other long-lived assets, including property, plant and equipment, and certain identifiable intangible assets, whenever events or changes in circumstances indicate that the carrying value of an asset or asset group may not be recoverable. The Company performs impairment tests of indefinite-lived intangible assets on an annual basis or more frequently in certain circumstances. Factors which could trigger an impairment review include significant underperformance relative to historical or projected future operating results, significant changes in the manner of use of the assets or the strategy for the overall business, a significant decrease in the market value of the assets or significant negative industry or economic trends. When the Company determines that the carrying value of long-lived assets may not be recoverable based upon the existence of one or more of the indicators, the assets are assessed for impairment based on the estimated future undiscounted cash flows expected to result from the use of the asset and its eventual disposition. If the carrying value of an asset exceeds its estimated future undiscounted cash flows, an impairment loss is recorded for the excess of the asset's carrying value over its fair value. There was no impairment charge related to intangible assets for the year ended December 31, 2018.

Pension and Other Postretirement Benefits Plans

Our Participation in RRD's Pension and Postretirement Benefits Plans

RRD provided pension and other postretirement healthcare benefits to certain current and former employees of DFIN. DFIN's consolidated and combined statements of operations include expense allocations for these benefits. These allocations were funded through intercompany transactions with RRD which are reflected within net parent company investment in DFIN.

DFIN's Pension and Other Postretirement Benefit Plans

On October 1, 2016, DFIN recorded net pension plan liabilities of $68.3 million (consisting of a total benefit plan liability of $317.0 million, net of plan assets having fair market value of $248.7 million), as a result of the transfer of certain pension plan liabilities and assets from RRD to the Company upon the legal split of those plans. The pension plan asset allocation from RRD was finalized on June 30, 2017, which resulted in a $0.7 million decrease to the fair value of plan assets transferred to the Company from RRD. The Company also recorded a net other postretirement benefit liability of $1.5 million, as a result of the transfer of an other postretirement benefit plan from RRD to the Company.

The Company's primary defined benefit plan is frozen. No new employees are permitted to enter the Company's frozen plan and participants will earn no additional benefits. Benefits are generally based upon years of service and compensation. These defined benefit retirement income plans are funded in conformity with the applicable government regulations. The Company funds at least the minimum amount required for all funded plans using actuarial cost methods and assumptions acceptable under government regulations.

The annual income and expense amounts relating to the pension plan are based on calculations which include various actuarial assumptions including, mortality expectations, discount rates and expected long-term rates of return. The Company reviews its actuarial assumptions on an annual basis as of December 31 (or more frequently if a significant event requiring remeasurement occurs) and modifies the assumptions based on current rates and trends when it is appropriate to do so. The effects of modifications are recognized immediately on the consolidated balance sheets, but are amortized into operating earnings over future periods, with the deferred amount recorded in accumulated other comprehensive income (loss). The Company believes that the assumptions utilized in recording its obligations under its plans are reasonable based on its experience, market conditions and input from its actuaries and investment advisors. The weighted-average discount rate for pension benefits at December 31, 2018 was 4.4%.

A one-percentage point change in the discount rates at December 31, 2018 would have the following effects on the accumulated benefit obligation and projected benefit obligation:

	1.0% Increase	1.0% Decrease
	(in millions)	
Accumulated benefit obligation	$ (28.1)	$ 33.9
Projected benefit obligation	(28.1)	33.9

The Company's defined benefit plan has a risk management approach for its pension plan assets. The overall investment objective of this approach is to further reduce the risk of significant decreases in the plan's funded status by allocating a larger portion of the plan's assets to investments expected to hedge the impact of interest rate risks on the plan's obligation.

The expected long-term rate of return for the plan assets is based upon many factors including expected asset allocations, historical asset returns, current and expected future market conditions and risk. In addition, the Company considered the impact of the current interest rate environment on the expected long-term rate of return for certain asset classes, particularly fixed income. The target asset allocation percentage for the pension plan was approximately 50.0% for return seeking investments and approximately 50.0% for fixed income investments. The expected long-term rate of return on plan assets assumption used to calculate net pension plan expense in 2018 was 6.8% for the Company's pension plans. The expected long-term rate of return on plan assets assumption that will be used to calculate net pension plan expense in 2019 is 6.3%.

A 0.25% change in the expected long-term rate of return on plan assets at December 31, 2018 would have the following effects on 201 8 and 201 9 pension plan (income)/expense:

	2018	2019
	(in millions)	
0.25% increase	$ (0.6)	$ (0.6)
0.25% decrease	0.6	0.6

Accounting for Income Taxes

In the Company's consolidated and combined financial statements, income tax expense and deferred tax balances have been calculated on a separate income tax return basis although, with respect to certain entities, the Company's operations prior to the Separation have historically been included in the tax returns filed by the respective RRD entities of which the Company's business was a part. As a standalone entity post-Separation, the Company files tax returns on its own behalf and its deferred taxes and effective tax rate may differ from those in historical periods.

Significant judgment is required in determining the provision for income taxes and related accruals, deferred tax assets and liabilities and any valuation allowance recorded against deferred tax assets. In the ordinary course of business, there are transactions and calculations where the ultimate tax outcome is uncertain. Additionally, the Company's tax returns are subject to audit by various U.S. and foreign tax authorities. The Company recognizes a tax position in its financial statements when it is more likely than not (*i.e* ., a likelihood of more than fifty percent) that the position would be sustained upon examination by tax authorities. This recognized tax position is then measured at the largest amount of benefit that is greater than fifty percent likely of being realized upon ultimate settlement. Although management believes that its estimates are reasonable, the final outcome of uncertain tax positions may be materially different from that which is reflected in the Company's historical financial statements.

The Company has recorded deferred tax assets related to future deductible items, including domestic and foreign tax loss and credit carryforwards. The Company evaluates these deferred tax assets by tax jurisdiction. The utilization of these tax assets is limited by the amount of taxable income expected to be generated within the allowable carryforward period and other factors. Accordingly, management has provided a valuation allowance to reduce certain of these deferred tax assets when management has concluded that, based on the weight of available evidence, it is more likely than not that the deferred tax assets will not be fully realized. If actual results differ from these estimates, or the estimates are adjusted in future periods, adjustments to the valuation allowance might need to be recorded. As of December 31, 2018 and 2017, valuation allowances of $2.1 million and $1.5 million, respectively, were recorded in the Company's consolidated balance sheets.

On December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118 ("SAB 118"), which provided guidance on accounting for the tax effects of the Tax Act. SAB 118 provides a measurement period of one year from the Tax Act enactment date for companies to complete their accounting. In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the Act for which the accounting is complete. To the extent that a company's accounting for certain income tax effects of the Tax Act is incomplete but it is able to determine a reasonable estimate, it must record a provisional estimate in the financial statements. If a company cannot determine a provisional estimate to be included in the financial statements, it should continue to apply its accounting on the basis of the provisions of the tax laws that were in effect immediately before the enactment of the Tax Act. Due to the timing of the enactment and the complexity involved in applying the provisions of the Tax Act, the Company made reasonable estimates of the tax effects and recorded provisional amounts in its consolidated financial statements for the year ended December 31, 2017.

As a result of the reduction in the U.S. corporate income tax rate from 35% to 21% effective January 1, 2018, the Company revalued its U.S. deferred tax assets and liabilities as of December 31, 2017. The Company recorded a reduction in the value of its net U.S. deferred tax asset of approximately $8.2 million, which was recorded as additional deferred income tax expense in the Company's consolidated statement of operations for the year ended December 31, 2017. Due to the transition to a territorial tax system under the Tax Act, the Company will be deemed to repatriate its foreign subsidiaries' untaxed accumulated earnings and pay a mandatory U.S. federal tax ("the transition tax") of 15.5% on the portion of the earnings that are in cash and cash equivalents and 8.0% on the portion of earnings that are in non-cash and non-cash equivalent assets. The Company estimated this tax liability (federal and state) to be approximately $14.2 million which was recorded as income tax expense in the consolidated statement of operations for the year ended December 31, 2017.

During the year ended December 31, 2018, the Company recorded a $0.1 million increase to the deemed rep atriation tax liability and a $2.2 million benefit related to the revaluation of deferred tax assets and liabilities. The adjustments were the result of the Company's completion of the analysis of the impact of the Tax Act including changes in interpretations and assumptions that the Company previously made for the prior year provisional estimates as well as the impact from additional regulatory guidance issued. As of December 31, 2018, the Company's analysis for the income tax effect s of the Tax Act was completed.

Refer to Note 14, *Income Taxes* , to the consolidated and combined financial statements for further detail on the accounting for income taxes and SAB 118.

Commitments and Contingencies

The Company is subject to lawsuits, investigations and other claims related to environmental, employment, commercial and other matters, as well as preference claims related to amounts received from customers and others prior to their seeking bankruptcy protection. Periodically, the Company reviews the status of each significant matter and assesses potential financial exposure. If the potential loss from any claim or legal proceeding is considered probable and the related liability is estimable, the Company accrues a liability for the estimated loss. Because of uncertainties related to these matters, accruals are based on the best information available at the time. As additional information becomes available, the Company reassesses the related potential liability and may revise its estimates.

With respect to claims made under the Company's third-party insurance for workers' compensation, automobile and general liability, the Company is responsible for the payment of claims below and above insured limits, and consulting actuaries are utilized to assist the Company in estimating the obligation associated with any such incurred losses, which are recorded in accrued and other non-current liabilities. Historical loss development factors for both the Company and the industry are utilized to project the future development of such incurred losses, and these amounts are adjusted based upon actual claims experience and settlements. If actual experience of claims development is significantly different from these estimates, an adjustment in future periods may be required. Expected recoveries of such losses are recorded in other current and other non-current assets.

Accounts Receivable

The Company maintains an allowance for doubtful accounts receivable to account for estimated losses resulting from the inability of its customers to make required payments for products and services. Specific customer provisions are made when a review of significant outstanding amounts, utilizing information about customer creditworthiness and current economic trends, indicates that collection is doubtful. In addition, provisions are made at differing rates, based upon the age of the receivable and the Company's past collection experience. The allowance for doubtful accounts receivable was $7.9 million at December 31, 2018 and $7.3 million at December 31, 2017. The Company also maintains a reserve for potential credit memos and disputed items. The credit memo and disputed items reserve is based on historical credit memos relative to billings as well as specific customer reserves and was $4.7 million at December 31, 2018 and $7.4 million at December 31, 2017. The Company's estimates of the recoverability of accounts receivable could change, and additional changes to the allowance could be necessary in the future, if any major customer's creditworthiness deteriorates or actual defaults are higher than the Company's historical experience.

Off-Balance Sheet Arrangements

Other than non-cancelable operating lease commitments, the Company does not have off-balance sheet arrangements, financings or special purpose entities.

Financial Review

In the financial review that follows, the Company discusses its consolidated and combined results of operations, cash flows and certain other information. In periods prior to the Separation, the combined financial statements were prepared on a stand-alone basis and were derived from RRD's consolidated financial statements and accounting records. There are limitations inherent in the preparation of all carve out financial statements due to the fact that the Company's business was previously part of a larger organization. This discussion should be read in conjunction with the Company's consolidated and combined financial statements and the related notes.

Results of Operations for the Year Ended December 31, 2018 as Compared to the Year Ended December 31, 2017

The following table shows the results of operations for the years ended December 31, 2018 and 2017:

	2018	2017	$ Change	% Change
	(in millions, except percentages)			
Services net sales	$ 618.0	$ 632.1	$ (14.1)	(2.2%)
Products net sales	345.0	372.8	(27.8)	(7.5%)
Net sales	963.0	1,004.9	(41.9)	(4.2%)
Services cost of sales (exclusive of depreciation and amortization)	328.8	328.7	0.1	0.0%
Services cost of sales with RRD affiliates (exclusive of depreciation and amortization)*	—	19.5	(19.5)	(100.0%)
Products cost of sales (exclusive of depreciation and amortization)	258.5	240.9	17.6	7.3%
Products cost of sales with RRD affiliates (exclusive of depreciation and amortization)*	—	32.3	(32.3)	(100.0%)
Cost of sales	587.3	621.4	(34.1)	(5.5%)
Selling, general and administrative expenses (exclusive of depreciation and amortization)	258.2	236.2	22.0	9.3%
Restructuring, impairment and other charges-net	4.4	7.1	(2.7)	(38.0%)
Depreciation and amortization	45.8	44.5	1.3	2.9%
Other operating income	(53.8)	—	(53.8)	100.0%
Income from operations	$ 121.1	$ 95.7	$ 25.4	26.5%

* Beginning in the quarter ended June 30, 2017, LSC no longer qualified as a related party, therefore the 2017 amounts disclosed related to LSC are presented through March 31, 2017 only. Beginning in the quarter ended September 30, 2017, RRD no longer qualified as a related party, therefore the amounts disclosed related to RRD are presented through June 30, 2017 only.

Consolidated and Combined

Net sales of services for the year ended December 31, 2018 decreased $14.1 million, or 2.2%, to $618.0 million, versus the year ended December 31, 2017 including a $2.2 million, or 0.3%, increase due to changes in foreign exchange rates. Net sales of services decreased primarily due to the impact from the sale of the Language Solutions business, lower volumes in capital markets compliance and mutual fund print-related services and a $0.1 million decrease due to the adoption of the new revenue recognition standard, partially offset by growth in SaaS solutions, primarily in FundSuiteArc, virtual data room services and ActiveDisclosure and higher volumes in capital markets transactions.

Net sales of products for the year ended December 31, 2018 decreased $27.8 million, or 7.5%, to $345.0 million versus the year ended December 31, 2017, including a $0.5 million, or 0.1%, increase due to changes in foreign exchange rates. Net sales of products decreased due to lower mutual fund print, capital markets compliance and commercial print volumes, partially offset by higher capital markets transactions volumes.

Services cost of sales decreased $19.4 million, or 5.6%, for the year ended December 31, 2018, versus the year ended December 31, 2017. Services cost of sales decreased primarily due to the impact from the sale of the Language Solutions business, a $0.6 million, or 0.2%, decrease due to the adoption of the new revenue recognition standard and cost control initiatives. As a percentage of net sales, services cost of sales decreased 1.9% due to favorable mix, a decrease in incentive compensation expense and cost control initiatives.

Products cost of sales decreased $14.7 million, or 5.4%, for the year ended December 31, 2018, versus the year ended December 31, 2017. Products cost of sales decreased due to lower mutual fund print, capital markets compliance and commercial print volumes and cost control initiatives. As a percentage of net sales, products cost of sales increased 1.6% primarily due to unfavorable mix, offset by a decrease in incentive compensation expense.

Selling, general and administrative expenses for the year ended December 31, 2018 increased $ 22.0 million, or 9.3% , to $ 258.2 million, as compared to the year ended December 31, 2017 , primarily due to an increase in spin-off related transaction expenses, which include system implementation expenses as a result of transitioning from transition service agreements and disposition-related expenses related to the disposition of Language Solutions . As a percentage of net sales, selling, general, and administrative expenses increased from 23.5% for the year ended December 31, 2017 to 26.8% for year ended December 31, 2018 primarily due to increased spin-off related transaction expenses and disposition-related expenses , partially offset by a decrease in incentive compensation expense .

For the year ended December 31, 2018, the Company recorded net restructuring, impairment and other charges of $4.4 million compared to $7.1 million for the year ended December 31, 2017. For the year ended December 31, 2018, these charges included $3.4 million of employee termination costs for 89 employees, substantially all of whom were terminated as of December 31, 2018. These charges primarily related to the reorganization of certain operations and certain administrative functions. During the year ended December 31, 2018, the Company also incurred $0.8 million of lease termination and other restructuring costs and $0.2 million for other charges associated with the Company's decision to withdraw in 2013 from certain-multi-employer pension plans serving facilities that continued to operate. For the year ended December 31, 2017, these charges included $6.4 million of employee termination costs for 192 employees, all of whom were terminated as of December 31, 2018. These charges were primarily the result of the reorganization of certain administrative functions. The Company also incurred lease termination and other restructuring charges of $0.3 million, $0.2 million of net impairment charges primarily related to leasehold improvements associated with facility closures and $0.2 million associated with the Company's decision to withdraw in 2013 from certain multi-employer pension plans that continued to operate.

Depreciation and amortization for the year ended December 31, 2018 increased $1.3 million, or 2.9%, to $45.8 compared to the year ended December 31, 2017. Depreciation and amortization included $13.7 million and $15.0 million of amortization of other intangible assets related to customer relationships for the years ended December 31, 2018 and 2017, respectively.

Other operating income for the year ended December 31, 2018 included a $53.8 million net gain recognized on the sale of the Language Solutions business.

Income from operations for the year ended December 31, 2018 increased $25.4 million, or 26.5%, to $121.1 million versus the year ended December 31, 2017, primarily due to the gain recognized on the sale of the Language Solutions business, partially offset by lower sales volumes and an increase in disposition-related expenses and spin-off related transaction expenses.

	2018	2017	$ Change	% Change
	(in millions, except percentages)			
Interest expense-net	$ 36.7	$ 42.9	$ (6.2)	(14.5%)

Net interest expense decreased by $6.2 million for the year ended December 31, 2018 versus the year ended December 31, 2017, due to a decrease in average outstanding debt. Refer to " *Liquidity and Capital Resources* " for further discussion.

	2018	2017	$ Change	% Change
	(in millions, except percentages)			
Earnings before income taxes	$ 102.7	$ 56.2	$ 46.5	82.7%
Income tax expense	29.1	46.5	(17.4)	(37.4%)
Effective income tax rate	28.3%	82.7%		

The effective income tax rate was 28.3% for the year ended December 31, 2018 compared to 82.7% for the year ended December 31, 2017. The decrease in the effective tax rate was primarily due to numerous changes in U.S. corporate tax law pursuant to the enactment of the Tax Act, partially offset by an increase in the taxation of certain foreign earnings, referred to in the Tax Act as global intangible low-taxed income, and non-deductible expenses. The effective tax rate for the year ended December 31, 2018 also reflects the impact of the sale of the Language Solutions business. Refer to Note 14, *Income Taxes* , for further details.

Information by Segment

The following tables summarize net sales, income (loss) from operations and certain items impacting comparability within each of the operating segments and Corporate.

U.S.

	Year Ended December 31,	
	2018	2017
	(in millions, except percentages)	
Net sales	$ 811.8	$ 847.9
Income from operations	134.0	127.6
Operating margin	16.5%	15.0%
Gain on sale of Language Solutions business	26.6	—
Spin-off related transaction expenses	16.5	10.0
Restructuring, impairment and other charges-net	2.0	3.9

	Net Sales for the Year Ended December 31			
Reporting unit	2018	2017	$ Change	% Change
	(in millions, except percentages)			
Capital Markets	$ 456.0	$ 455.4	$ 0.6	0.1%
Investment Markets*	342.1	367.2	(25.1)	(6.8%)
Language Solutions*	13.7	25.3	(11.6)	(45.8%)
Total U.S.	$ 811.8	$ 847.9	$ (36.1)	(4.3%)

* Certain prior year amounts were restated to conform to the Company's current reporting unit structure.

Net sales for the U.S. segment for the year ended December 31, 2018 were $811.8 million, a decrease of $36.1 million, or 4.3%, compared to the year ended December 31, 2017, including a $0.5 million, or 0.1%, decrease due to the adoption of the new revenue recognition standard. Net sales decreased due to lower capital markets compliance volumes, lower mutual fund print volumes, the sale of the Language Solutions business and lower commercial print volumes, partially offset by higher volumes in capital markets transactions and growth in SaaS solutions, primarily in FundSuiteArc, virtual data room services and ActiveDisclosure. An analysis of net sales by reporting unit follows:

- Capital Markets: Sales increased slightly due to higher volumes in transactions, virtual data room services, and ActiveDisclosure and a $0.3 million increase due to the adoption of the new revenue recognition standard, partially offset by lower compliance volumes.
- Investment Markets: Sales decreased due to lower volumes in mutual fund print and print-related services, commercial print and healthcare and a $0.8 million decrease due to the adoption of the new revenue recognition standard, partially offset by higher FundSuiteArc volumes.
- Language Solutions: Sales decreased primarily due to the sale of the Language Solutions business in July 2018.

U.S. segment income from operations for the year ended December 31, 2018 increased $6.4 million, or 5.0%, as compared to the year ended December 31, 2017, due to the gain recognized on the sale of the Language Solutions business, cost control initiatives, lower restructuring, impairment and other charges and lower incentive compensation expense, partially offset by lower sales volumes and an increase in spin-off related transaction expenses.

Operating margins increased from 15.0% for the year ended December 31, 2017 to 16.5% for the year ended December 31, 2018 of which 3.3 percentage points was due to the gain on sale of the Language Solutions business and 0.3 percentage points was due to lower restructuring, impairment and other charges. Operating margins were also impacted by an increase in spin-off related transaction expenses which negatively impacted margins by 0.8 percentage points.

International

	Year Ended December 31,	
	2018	2017
	(in millions, except percentages)	
Net sales	$ 151.2	$ 157.0
Income from operations	31.6	7.2
Operating margin	20.9%	4.6%
Gain on sale of Language Solutions business	27.2	—
Restructuring, impairment and other charges-net	1.8	2.2
Disposition-related expenses	1.4	—

Net sales for the International segment for the year ended December 31, 2018 were $151.2 million, a decrease of $5.8 million, or 3.7%, compared to the year ended December 31, 2017 including a $2.7 million, or 1.7%, increase due to changes in foreign exchange rates and a $0.4 million, or 0.3%, increase due to the adoption of the new revenue recognition standard. Net sales decreased due to the sale of the Language Solutions business, partially offset by growth in SaaS solutions, primarily FundSuiteArc, virtual data room services and ActiveDisclosure, and higher volumes capital markets transactions and compliance volumes.

International segment income from operations for the year ended December 31, 2018 increased $24.4 million, or 338.9%, compared to the year ended December 31, 2017, due to the gain recognized on the sale of the Language Solutions business and growth in SaaS solutions, partially offset by lower sales volumes and an increase in disposition-related expenses.

Operating margins increased from 4.6% for the year ended December 31, 2017 to 20.9% for the year ended December 31, 2018 of which 18.0 percentage points was driven by the gain on sale of the Language Solutions business, partially offset by 0.9 percentage points due to higher disposition-related expenses.

Corporate

The following table summarizes unallocated operating expenses and certain items impacting comparability within the activities presented as Corporate:

	Year Ended December 31,	
	2018	2017
	(in millions)	
Operating expenses	$ 44.5	$ 39.1
Share-based compensation expense	9.2	6.8
Disposition-related expenses	5.4	—
Spin-off related transaction expenses	3.6	6.5
Acquisition-related expenses	0.8	0.2
Restructuring, impairment and other charges-net	0.6	1.0
Investor-related expenses	0.5	—

Corporate operating expenses for the year ended December 31, 2018 increased $5.4 million versus the year ended December 31, 2017 due to disposition-related expenses and an increase in share-based compensation expense and acquisition-related expenses, partially offset by a decrease in spin-off related transaction expenses and incentive compensation expense.

Results of Operations for the Year Ended December 31, 2017 as Compared to the Year Ended December 31, 2016

The following table shows the results of operations for the year ended December 31, 2017 and 2016:

	2017	2016	$ Change	% Change
	(in millions, except percentages)			
Services net sales	$ 632.1	$ 598.6	$ 33.5	5.6%
Products net sales	372.8	384.9	(12.1)	(3.1%)
Net sales	1,004.9	983.5	21.4	2.2%
Services cost of sales (exclusive of depreciation and amortization)	328.7	297.1	31.6	10.6%
Services cost of sales with RRD affiliates (exclusive of depreciation and amortization)*	19.5	37.8	(18.3)	(48.4%)
Products cost of sales (exclusive of depreciation and amortization)	240.9	226.2	14.7	6.5%
Products cost of sales with RRD affiliates (exclusive of depreciation and amortization)*	32.3	57.9	(25.6)	(44.2%)
Cost of sales	621.4	619.0	2.4	0.4%
Selling, general and administrative expenses (exclusive of depreciation and amortization)	236.2	210.8	25.4	12.0%
Restructuring, impairment and other charges-net	7.1	5.4	1.7	31.5%
Depreciation and amortization	44.5	43.3	1.2	2.8%
Income from operations	$ 95.7	$ 105.0	$ (9.3)	(8.9%)

* Beginning in the quarter ended June 30, 2017, LSC no longer qualified as a related party, therefore the 2017 amounts disclosed related to LSC are presented through March 31, 2017 only. Beginning in the quarter ended September 30, 2017, RRD no longer qualified as a related party, therefore the amounts disclosed related to RRD are presented through June 30, 2017 only.

Consolidated and Combined

Net sales of services for the year ended December 31, 2017 increased $33.5 million, or 5.6%, to $632.1 million, versus the year ended December 31, 2016 including a $1.0 million, or 0.2%, decrease due to changes in foreign exchange rates. Net sales of services increased due to higher volumes in virtual data room services, mutual fund print-related services, translations services and content management, partially offset by lower capital markets compliance volumes.

Net sales of products for the year ended December 31, 2017 decreased $12.1 million, or 3.1%, to $372.8 million versus the year ended December 31, 2016, including a $0.8 million, or 0.2%, decrease due to changes in foreign exchange rates. Net sales of products decreased due to lower capital markets transactions volumes, healthcare volumes and price pressures in investment markets, partially offset by higher capital markets compliance and mutual fund print volumes.

Services cost of sales increased $13.3 million, or 4.0%, for the year ended December 31, 2017, versus the year ended December 31, 2016. Services cost of sales increased due to higher mutual fund print-related services and content management volumes, an increase in the allocation of information technology expenses from selling, general and administrative expenses to cost of sales and an increase in incentive compensation expense, partially offset by cost control initiatives. As a percentage of net sales, services cost of sales decreased 0.8% due to favorable mix and cost control initiatives.

Products cost of sales decreased $10.9 million, or 3.8%, for the year ended December 31, 2017, versus the year ended December 31, 2016. Products cost of sales decreased due to lower capital markets transaction and healthcare volumes and cost control initiatives. As a percentage of net sales, products cost of sales decreased 0.5% primarily due to a favorable mix of product sales and cost control initiatives.

Selling, general and administrative expenses for the year ended December 31, 2017 increased $25.4 million, or 12.0%, to $236.2 million, as compared to the year ended December 31, 2016, primarily due to an increase in expenses incurred to operate as an independent public company, including selling expenses, employee compensation costs and spin-off related transaction expenses, partially offset by an increase in the allocation of information technology expenses from selling, general and administrative expenses to cost of sales. As a percentage of net sales, selling, general, and administrative expenses increased from 21.4% for the year ended December 31, 2016 to 23.5% for year ended December 31, 2017 primarily due to increased costs of operating as an independent public company, including spin-off related transaction expenses.

For the year ended December 31, 2017 , the Company recorded net restructuring, impairment and other charges of $7.1 million compared to $5.4 million for the year ended December 31, 2016 . For the year ended December 31, 2017 , these charges included $6.4 million of employee termination costs for 192 employees, all of whom were terminated as of December 31, 2018 . These charges primarily related to the reorganization of certain operations and certain administrative functions. During the year ended December 31, 2017 , the Company also incurred $0.3 million of lease termination and other restructuring costs, $0.2 million of net impairment charges primarily related to leasehold improvements associated with facility closures and $0.2 million for other charges associated with the Company's decision to withdraw in 2013 from certain-multi-employer pension plans serving facilities that continued to operate. For the year ended December 31, 2016 , these charges included $3.7 million of employee termination costs for 84 employees, all of whom were terminated as of December 31, 2016 . These charges were primarily the result of the reorganization of certain administrative functions. The Company also incurred lease termination and other restructuring charges of $1.5 million and other charges of $0.2 million associated with the Company's decision to withdraw in 2013 from certain multi-employer pension plans during the year ended December 31, 2016 .

Depreciation and amortization for the year ended December 31, 2017 increased $1.2 million, or 2.8%, to $44.5 compared to the year ended December 31, 2016. Depreciation and amortization included $15.0 million and $14.4 million of amortization of other intangible assets related to customer relationships, trade names and non-compete agreements for the years ended December 31, 2017 and 2016, respectively.

Income from operations for the year ended December 31, 2017 decreased $9.3 million, or 8.9%, to $95.7 million versus the year ended December 31, 2016, due to lower volumes in capital markets transactions and healthcare print and an increase in expenses incurred to operate as an independent public company, including selling expenses, employee compensation costs and spin-off related transaction expenses, partially offset by cost control initiatives and higher volumes in capital markets compliance, virtual data room services, mutual funds print-related services and content management.

	2017	2016	$ Change	% Change
	(in millions, except percentages)			
Interest expense-net	$ 42.9	$ 11.7	$ 31.2	266.7%

Net interest expense increased by $31.2 million for the year ended December 31, 2017 versus the year ended December 31, 2016, due to the issuance of debt in connection with the Separation. Refer to " *Liquidity and Capital Resources* " for further discussion.

	2017	2016	$ Change	% Change
	(in millions, except percentages)			
Earnings before income taxes	$ 56.2	$ 94.3	$ (38.1)	(40.4%)
Income tax expense	46.5	35.2	11.3	32.1%
Effective income tax rate	82.7%	37.3%		

The effective income tax rate was 82.7% for the year ended December 31, 2017 compared to 37.3% for the year ended December 31, 2016. The 2017 effective income tax rate is higher as compared to the 2016 effective income tax rate primarily due to impacts of the changes to U.S. tax legislation as a result of the enactment of the Tax Act, including the transition tax imposed on the Company's accumulated foreign earnings and the remeasurement of the Company's U.S net deferred tax asset. The 2017 effective income tax rate was also impacted by non-deductible expenses incurred by the Company in 2017 which were previously incurred by RRD on behalf of the Company during pre-Separation periods, as well as a one-time favorable change in a valuation allowance in 2016 not present in 2017.

Information by Segment

The following tables summarize net sales, income (loss) from operations and certain items impacting comparability within each of the operating segments and Corporate.

U.S.

	Year Ended December 31,	
	2017	2016
	(in millions, except percentages)	
Net sales	$ 847.9	$ 845.2
Income from operations	127.6	118.4
Operating margin	15.0%	14.0%
Restructuring, impairment and other charges-net	3.9	4.7
Spin-off related transaction expenses	10.0	0.3

Reporting unit	Net Sales for the Year Ended December 31, 2017	2016	$ Change	% Change
	(in millions, except percentages)			
Capital Markets	$ 455.4	$ 466.1	$ (10.7)	(2.3%)
Investment Markets*	367.2	354.5	12.7	3.6%
Language Solutions*	25.3	24.6	0.7	2.8%
Total U.S.	$ 847.9	$ 845.2	$ 2.7	0.3%

* Certain prior year amounts were restated to conform to the Company's current reporting unit structure.

Net sales for the U.S. segment for the year ended December 31, 2017 were $847.9 million, an increase of $2.7 million, or 0.3%, compared to the year ended December 31, 2016. Net sales increased due to higher volumes in capital markets compliance, mutual fund print-related services, virtual data room services, mutual fund print volumes and content management, partially offset by lower capital markets transactions and healthcare volumes. An analysis of net sales by reporting unit follows:

- Capital Markets: Sales decreased due to lower transactions volumes, partially offset by increased compliance volumes and virtual data room services.
- Investment Markets: Sales increased due to higher volumes in mutual fund print-related services, mutual fund print, content management and commercial print, partially offset by lower healthcare volumes and price pressures.
- Language Solutions: Sales increased due to higher translations services volumes.

U.S. segment income from operations for the year ended December 31, 2017 increased $9.2 million, or 7.8%, as compared to the year ended December 31, 2016, due to cost control initiatives and higher volumes in capital markets compliance, mutual fund print-related services, virtual data room services, mutual fund print volumes and content management, partially offset by lower capital markets transactions and healthcare volumes and an increase in selling expenses, spin-off related transaction expenses and incentive compensation expense.

Operating margins increased from 14.0% for the year ended December 31, 2016 to 15.0% for the year ended December 31, 2017 due to cost control initiatives. The increase in operating margins was partially offset by spin-off related transaction expenses which impacted margins by 1.2 percentage points and an increase in selling expenses and incentive compensation expense.

International

	Year Ended December 31,	
	2017	2016
	(in millions, except percentages)	
Net sales	$ 157.0	$ 138.3
Income from operations	7.2	8.8
Operating margin	4.6%	6.4%
Restructuring, impairment and other charges-net	2.2	0.6

Net sales for the International segment for the year ended December 31, 2017 were $157.0 million, an increase of $18.7 million, or 13.5%, compared to the year ended December 31, 2016 including a $1.8 million, or 1.3%, decrease due to changes in foreign exchange rates. Net sales increased due to higher volumes in mutual funds, capital markets transactions, virtual data room and translation services.

International segment income from operations for the year ended December 31, 2017 decreased $1.6 million, or 18.2%, compared to the year ended December 31, 2016, due to an increase in allocated expenses, including information technology expenses and an increase in incentive compensation expense and restructuring, impairment and other charges, partially offset higher volumes in mutual funds, capital markets transactions, virtual data room and translation services and cost control initiatives.

Operating margins decreased from 6.4% for the year ended December 31, 2016 to 4.6% for the year ended December 31, 2017 of which 1.0 percentage points were due to higher restructuring, impairment and other charges. Operating margins were also impacted by an increase in allocated expenses, including information technology expenses and incentive compensation expense, partially offset by cost control initiatives.

Corporate

The following table summarizes unallocated operating expenses and certain items impacting comparability within the activities presented as Corporate:

	Year Ended December 31,	
	2017	2016
	(in millions)	
Operating expenses	$ 39.1	$ 22.2
Share-based compensation expense	6.8	2.5
Spin-off related transaction expenses	6.5	4.6
Restructuring, impairment and other charges-net	1.0	0.1
Acquisition-related expenses	0.2	—

Corporate operating expenses for the year ended December 31, 2017 increased $16.9 million versus the year ended December 31, 2016 due to higher employee compensation costs incurred to operate as an independent public company and an increase in share-based compensation expense and spin-off related transaction expenses.

Non-GAAP Measures

The Company believes that certain Non-GAAP measures, such as Non-GAAP adjusted EBITDA, provide useful information about the Company's operating results and enhance the overall ability to assess the Company's financial performance. The Company uses these measures, together with other measures of performance under GAAP, to compare the relative performance of operations in planning, budgeting and reviewing the performance of its business. Non-GAAP adjusted EBITDA allows investors to make a more meaningful comparison between the Company's core business operating results over different periods of time. The Company believes that Non-GAAP adjusted EBITDA, when viewed with the Company's results under GAAP and the accompanying reconciliations, provides useful information about the Company's business without regard to potential distortions. By eliminating potential differences in results of operations between periods caused by factors such as depreciation and amortization methods, historic cost and age of assets, restructuring, impairment and other charges, acquisition-related expenses and gain or loss on certain equity investments and asset sales, the Company believes that Non-GAAP adjusted EBITDA can provide a useful additional basis for comparing the current performance of the underlying operations being evaluated.

Non-GAAP adjusted EBITDA is not presented in accordance with GAAP and has important limitations as an analytical tool. These measures should not be considered as a substitute for analysis of the Company's results as reported under GAAP. In addition, these measures are defined differently by different companies in our industry and, accordingly, such measures may not be comparable to similarly-titled measures of other companies.

In addition to the factors listed above, the following items are excluded from Non-GAAP adjusted EBITDA:

- ***Spin-off related transaction expenses.*** The Company has incurred expenses related to the Separation to operate as a standalone publicly traded company. These expenses include third-party consulting fees, information technology expenses, employee retention payments, legal fees and other costs related to the Separation, including system implementation expenses related to transitioning from transition service agreements with RRD and LSC. Management does not believe that these expenses are reflective of ongoing operating results. This adjustment does not include expenses incurred prior to the Separation.
- ***Share-based compensation expense*** . Although share-based compensation is a key incentive offered to certain of the Company's employees, business performance is evaluated excluding share-based compensation expenses. Depending upon the size, timing and the terms of grants, non-cash compensation expense may vary but will recur in future periods.
- ***Disposition-related expenses.*** Expenses incurred related to the disposition of the Language Solutions business. These expenses primarily include legal fees, third-party advisory and consulting fees and other costs related to the disposition.
- ***Investor-related expenses.*** Expenses incurred related to non-routine investor matters which include third-party advisory and consulting fees and legal fees.

A reconciliation of GAAP net earnings to Non-GAAP adjusted EBITDA for the years ended December 31, 2018, 2017 and 2016 for these adjustments is presented in the following table:

	Year ended December 31,		
	2018	2017	2016
	(in millions)		
Net earnings	$ 73.6	$ 9.7	$ 59.1
Net gain on sale of Language Solutions business	(53.8)	—	—
Gain on equity investment	(11.8)	—	—
Gain on eBrevia investment	(1.8)	—	—
Spin-off related transaction expenses	20.1	16.5	4.9
Share-based compensation expense	9.2	6.8	2.5
Disposition-related expenses	6.8	—	—
Restructuring, impairment and other charges—net	4.4	7.1	5.4
Acquisition-related expenses	0.8	0.2	—
Investor-related expenses	0.5	—	—
Depreciation and amortization	45.8	44.5	43.3
Interest expense—net	36.7	42.9	11.7
Investment and other income—net	(4.7)	(3.4)	(1.0)
Income tax expense	29.1	46.5	35.2
Non-GAAP adjusted EBITDA	$ 154.9	$ 170.8	$ 161.1

Net gain on sale of Language Solutions business. Included pre-tax gain of $53.8 million for the year ended December 31, 2018.

Gain on equity investment. Included pre-tax gain of $11.8 million for the year ended December 31, 2018.

Gain on eBrevia investment. Included pre-tax gain of $1.8 million for the year ended December 31, 2018 as a result of the acquisition of eBrevia, in which the Company previously held an investment.

Spin-off related transaction expenses. Included pre-tax charges of $ 20.1 million, $ 16.5 million and $4.9 million related to third-party consulting fees, information technology expenses, legal fees and other costs related to the Separation for the year s ended December 31, 2018, 2017 and 2016, respectively.

Share-based compensation expense. Included pre-tax charges of $9.2 million, $6.8 million and $2.5 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Disposition-related expenses. Included pre-tax charges of $6.8 million primarily related to the disposition of the Language Solutions business, including legal fees, third party advisory and consulting fees and other costs for the year ended December 31, 2018.

2018 Restructuring, impairment and other charges—net . The year ended December 31, 2018 included $3.4 million for employee termination costs, $0.8 million of net lease termination and other restructuring costs and $0.2 million for other charges associated with the Company's decision to withdraw in 2013 from certain multi-employer pension plans serving facilities that continued to operate.

2017 Restructuring, impairment and other charges—net . The year ended December 31, 2017 included $6.4 million for employee termination costs, $0.3 million of net lease termination and other restructuring costs, $0.2 million of net impairment charges related to leasehold improvements associated with facility closures and $0.2 million for other charges associated with the Company's decision to withdraw in 2013 from certain multi-employer pension plans serving facilities that continued to operate.

2016 Restructuring, impairment and other charges—net. The year ended December 31, 2016 included $3.7 million for employee termination costs, $1.5 million of lease termination and other restructuring costs and $0.2 million for other charges associated with the Company's decision to withdraw in 2013 from certain multi-employer pension plans serving facilities that continued to operate.

Acquisition-related expenses. Included pre-tax charges of $0.8 million and $0.2 million primarily related to legal expenses for the years ended December 31, 2018 and 2017, respectively, associated with completed or contemplated acquisitions.

Investor-related expenses. Included pre-tax charges of $0.5 million related to non-routine investor matters. These expenses include third-party advisory and consulting fees and legal fees for the year ended December 31, 2018.

Liquidity and Capital Resources

Prior to the Separation, RRD provided financing, cash management and other treasury services to DFIN. The Company's cash balances were swept by RRD and the Company received funding from RRD for operating and investing needs. Cash transferred to and from RRD was recorded as intercompany payables and receivables which are reflected in the net parent company investment in the consolidated and combined financial statements. Subsequent to the Separation, the Company no longer participates in cash management and funding arrangements with RRD.

The Company believes it has sufficient liquidity to support its ongoing operations and to invest in future growth to create value for its shareholders. Cash on hand, operating cash flows and the Company's $300.0 million senior secured revolving credit facility (the "Revolving Facility") are the primary sources of liquidity and are expected to be used for, among other things, payment of interest and principal on the Company's debt obligations, capital expenditures necessary to support productivity improvement and growth, acquisitions and completion of restructuring programs.

The following describes the Company's cash flows for the years ended December 31, 2018 and 2017.

Cash Flows Provided By Operating Activities

Operating cash inflows are largely attributable to sales of the Company's services and products. Operating cash outflows are largely attributable to recurring expenditures for labor, rent, raw materials and other operating activities. For periods prior to the Separation, allocations of operating expenses from RRD are also reflected as operating cash inflows or outflows, including those for pension costs and current income taxes payable.

201 8 compared to 2017

Net cash provided by operating activities was $66.3 million for the year ended December 31, 2018 compared to $91.4 million for the year ended December 31, 2017. The decrease in net cash provided by operating activities reflected timing of customer and supplier payments and higher payments for incentive compensation partially offset by lower payments related to taxes and interest.

2017 compared to 2016

Net cash provided by operating activities was $91.4 million for the year ended December 31, 2017 compared to $106.0 million for the year ended December 31, 2016. The decrease in net cash provided by operating activities reflected higher payments related to interest and taxes and the timing of payments for suppliers and employee-related liabilities, offset by the timing of customer payments.

Cash Flows Used For Investing Activities

2018 compared to 2017

Net cash provided by investing activities was $30.2 million for the year ended December 31, 2018 compared to $31.0 million used in investing for the year ended December 31, 2017. Capital expenditures were $37.1 million during the year ended December 31, 2018, an increase of $9.3 million as compared to the same period of 2017. For the year ended December 31, 2018, cash provided by investing activities included $77.5 million net proceeds from the sale of the Language Solutions business, partially offset by $12.5 million of cash paid for the acquisition of eBrevia. For the year ended December 31, 2017, cash used in investing activities included $3.4 million for the purchase of an investment in AuditBoard.

2017 compared to 2016

Net cash used in investing activities was $31.0 million for the year ended December 31, 2017 compared to $29.3 million for the year ended December 31, 2016. Capital expenditures were $27.8 million during the year ended December 31, 2017, an increase of $1.6 million as compared to the same period of 2016.

Cash Flows Used For Financing Activities

2018 compared to 2017

Net cash used in financing activities for the year ended December 31, 2018 was $99.0 million compared to $45.7 million for the year ended December 31, 2017. Net cash used in financing activities for the year ended December 31, 2018 reflected $97.5 million of payments on long-term debt. Net cash used in financing activities for the year ended December 31, 2017 reflected $133.0 million in payments on long-term debt, offset by a $68.0 million Separation-related payment from RRD and $18.8 million of proceeds from the issuance of common stock.

2017 compared to 2016

Net cash used in financing activities for the year ended December 31, 2017 was $45.7 million compared to $60.0 million for the year ended December 31, 2016. The decrease in net cash used in financing activities reflected $133.0 million in payments on long-term debt in 2017, partially offset by a $68.0 million Separation-related payment from RRD and $18.8 million of proceeds from the issuance of common stock. Net cash used in financing activities for the year ended December 31, 2016 reflected $340.1 million in net transfers to RRD and its affiliates in connection with the Separation and $50.0 million in payments on long-term debt, offset by $348.2 million of proceeds from the issuance of long-term debt.

Contractual Cash Obligations and Other Commitments and Contingencies

The following table quantifies the Company's future contractual obligations as of December 31, 2018:

	Payments Due In						
	Total	2019	2020	2021	2022	2023	Thereafter
	(in millions)						
Debt (a)	$ 372.5	$ —	$ —	$ —	$ —	$ 72.5	$ 300.0
Interest due on debt	161.2	28.7	28.7	28.7	28.7	27.8	18.6
Operating leases (b)	119.6	31.9	26.7	19.2	12.6	10.1	19.1
Outsourced services (c)	38.1	25.5	6.4	5.7	0.5	—	—
Deferred compensation	24.3	4.3	1.4	5.6	5.7	2.7	4.6
Incentive compensation	12.8	12.8	—	—	—	—	—
Multi-employer pension plan withdrawal obligations	5.7	0.4	0.4	0.4	0.4	0.4	3.7
Pension and other postretirement benefits plan contributions (d)	2.7	1.3	1.4	—	—	—	—
Other (e)	16.6	11.2	2.9	0.2	0.2	0.4	1.7
Total as of December 31, 2018	$ 753.5	$ 116.1	$ 67.9	$ 59.8	$ 48.1	$ 113.9	$ 347.7

(a) Excludes unamortized debt issuance costs of $8.6 million and a discount of $1.2 million which do not represent contractual commitments with a fixed amount or maturity date.

(b) Operating leases include obligations to landlords.

(c) Includes information technology, professional, maintenance and other outsourced services.

(d) Includes estimated pension and other postretirement benefits plan contributions for 2019 and 2020 and does not include the obligations for subsequent periods, as the Company is unable to reasonably estimate the ultimate amounts.

(e) Other includes $6.0 million of remaining purchase price for the eBrevia acquisition, purchases of property, plant and equipment of $5.0 million, commercial agreement obligations of $1.8 million, employee restructuring-related severance payments of $0.4 million and miscellaneous other obligations.

Liquidity

The Company maintains cash pooling structures that enable participating international locations to draw on the pools' cash resources to meet local liquidity needs. Foreign cash balances may be loaned from certain cash pools to U.S. operating entities on a temporary basis in order to reduce the Company's short-term borrowing costs or for other purposes.

Cash and cash equivalents were $47.3 million as of December 31, 2018, a decrease of $4.7 million as compared to December 31, 2017.

Cash and cash equivalents of $47.3 million at December 31, 2018 included $29.9 million in the U.S. and $17.4 million at international locations. As a result of the transition tax incurred pursuant to the Tax Act, the Company now has the ability to repatriate any previously taxed foreign cash associated with the foreign earnings subject to the U.S. parent with minimal tax consequences. The Company intends to repatriate earnings up to its net earnings previously subject to U.S. tax. Thus, the Company updated its assertion in 2018 related to indefinite reinvestment on all foreign earnings and other outside basis differences to indicate that the Company remains indefinitely reinvested in operations outside of the U.S. with the exception of the previously taxed foreign cash already subject to U.S. tax. The Company continues to analyze its global working capital and cash requirements to determine the amount of excess cash at its foreign subsidiaries that can be repatriated to the U.S. with minimal additional taxes. The Company has not yet completed its global capital structure analysis. As such, the Company has not recorded deferred taxes attributable to the book-over-tax outside basis differences in its foreign subsidiaries as of December 31, 2018. The Company will record the tax effects related to repatriating any previously taxed foreign cash in the period when the Company begins repatriating this previously taxed foreign cash.

Pursuant to t he Separation and Distribution A greement, the Company received a cash payment of $68.0 million from RRD on April 3, 2017. The proceeds were used to reduce outstanding debt under the Term Loan Credit Facility.

On June 21, 2017, RRD completed the sale of approximately 6.1 million shares of the Company's common stock in an underwritten public offering. RRD retained approximately 0.1 million shares of the Company's common stock upon consummation of the offering which were subsequently sold by RRD on August 4, 2017. In conjunction with the underwritten public offering, the underwriters exercised their option to purchase approximately 0.9 million Option Shares. The Company received approximately $18.8 million in net proceeds from the sale of the Option Shares, after deducting estimated underwriting discounts and commissions. The proceeds were used to reduce outstanding debt under the Revolving Facility.

On October 2, 2017, the Company repriced the Term Loan Credit Facility. As a result, the interest rate was reduced by 100 basis points to LIBOR plus 3.0% and the LIBOR floor was reduced by 25 basis points to 0.75%. Additionally, under the amended Credit Agreement, principal payments are due on a quarterly basis. Other terms, including the outstanding principal, maturity date, and debt covenants such as the minimum interest coverage ratio and the maximum leverage ratio are consistent with the original Credit Agreement .

On December 18, 2018, the Company entered into a second amendment to the Credit Agreement which extended the maturity date of the Revolving Facility to December 18, 2023, reduced the interest rate margin percentages and facility fees applicable to the Revolving Facility, increased the allowable annual dividends from $15.0 million to $20.0 million in the aggregate and modified the financial maintenance and negative covenants in the Credit Agreement.

The Company's debt maturity schedule as of December 31, 2018 is shown in the table below:

	Debt Maturity Schedule						
	Total	2019	2020	2021	2022	2023	Thereafter
Notes [a]	$ 300.0	$ —	$ —	$ —	$ —	$ —	$ 300.0
Borrowings under the Term Loan Credit Facility [b]	72.5	—	—	—	—	72.5	—
Borrowings under the Revolving Facility	—	—	—	—	—	—	—
Total	$ 372.5	$ —	$ —	$ —	$ —	$ 72.5	$ 300.0

(a) Excludes unamortized debt issuance costs of $4.8 million which do not represent contractual commitments with a fixed amount or maturity date.

(b) Excludes unamortized debt issuance costs of $3.8 million and a discount of $1.2 million which do not represent contractual commitments with a fixed amount or maturity date.

The Credit Agreement contains a number of covenants, including, but not limited to, a minimum Interest Coverage Ratio and the Consolidated Net Leverage Ratio, as defined in and calculated pursuant to the Credit Agreement, that, in part, restrict the Company's ability to incur additional indebtedness, create liens, engage in mergers and consolidations, make restricted payments and dispose of certain assets. The Credit Agreement generally allows annual dividend payments of up to $20.0 million in aggregate, though additional dividends may be allowed subject to certain conditions. Each of these covenants is subject to important exceptions and qualifications.

The indenture governing the Notes contains certain covenants applicable to the Company and its restricted subsidiaries, including limitations on: (1) liens; (2) indebtedness; (3) mergers, consolidations and acquisitions; (4) sales, transfers and other dispositions of assets; (5) loans and other investments; (6) dividends and other distributions, stock repurchases and redemptions and other restricted payments; (7) restrictions affecting subsidiaries; (8) transactions with affiliates; and (9) designations of unrestricted subsidiaries. Each of these covenants is subject to important exceptions and qualifications.

As of December 31, 2018 , there were no borrowings under the Revolving Facility. Based on the Company's results of operations for the year ended December 31, 2018 and existing debt, the Company would have had the ability to utilize $ 2 5 4.7 million of the $300.0 million Revolving Facility and not have been in violation of the terms of the agreement. The current availability under the Revolving Facility and net available liquidity as of December 31, 2018 is shown in the table below:

	December 31, 2018
Availability	(in millions)
Revolving Facility	$ 300.0
Availability reduction from covenants	45.3
	$ 254.7
Usage	
Borrowings under the Revolving Facility	—
Impact on availability related to outstanding letters of credit	—
	$ —
Current availability at December 31, 2018	$ 254.7
Cash	47.3
Net Available Liquidity	$ 302.0

The Company was in compliance with its debt covenants as of December 31, 2018, and expects to remain in compliance based on management's estimates of operating and financial results for 2019 and the foreseeable future. However, declines in market and economic conditions or demand for certain of the Company's products and services could impact the Company's ability to remain in compliance with its debt covenants in future periods. As of December 31, 2018, the Company met all the conditions required to borrow under the Credit Agreement and management expects the Company to continue to meet the applicable borrowing conditions.

The failure of a financial institution supporting the Revolving Facility would reduce the size of the Company's committed facility unless a replacement institution was added. As of December 31, 2018, the Revolving Facility is supported by sixteen U.S. and international financial institutions.

As of December 31, 2018, the Company had $3.1 million in outstanding letters of credit and bank guarantees, of which none reduced to the availability under the Revolving Facility.

Acquisitions and Dispositions

During the year ended December 31, 2018, the Company paid $12.5 million, net of cash acquired, for the acquisition of eBrevia. $4.1 million of the purchase price, excluding contingent consideration, was payable as of December 31, 2018 and is expected to be paid during 2019. $1.9 million of the purchase price related to amounts held in escrow was payable as of December 31, 2018 and is expected to be paid during 2020.

During the year ended December 31, 2018, the Company sold its Language Solutions business for net proceeds of $77.5 million in cash, all of which was received as of December 31, 2018. The Company used approximately $60.0 million of net proceeds from the sale to pay down debt under the Term Loan Credit Facility in July 2018 in accordance with the provisions of the Credit Agreement.

Debt Issuances

On September 30, 2016, the Company entered into the Credit Agreement, which provided for the Term Loan Credit Facility and the Revolving Facility. The Term Loan Facility will mature on September 30, 2023. On December 18, 2018, the Company entered into a second amendment to the Credit Agreement which extended the maturity date of the Revolving Facility from September 30, 2021 to December 18, 2023.

On September 30, 2016, the Company issued $300.0 million of 8.250% Senior Notes (the "Notes") due October 15, 2024. Interest on the Notes is due semi-annually on April 15 and October 15, commencing on April 15, 2017.

The Notes were issued pursuant to an indenture where certain wholly-owned domestic subsidiaries of the Company guarantee the Notes (the "Guarantors"). In connection with the offering of the Notes, the Company entered into a registration rights agreement, dated as of September 30, 2016 (the "Registration Rights Agreement"), pursuant to which the Company agreed to file a registration statement with the SEC with respect to an offer to exchange the Notes for registered notes. On March 10, 2017, the Company filed a Registration Statement on Form S-4 (as amended, the "Exchange Offer Registration Statement") to offer to exchange the Notes for registered notes which have terms identical in all material respects to the Notes except that the registered notes are not subject to transfer restrictions or registration rights. The Exchange Offer Registration Statement was declared effective by the SEC on March 22, 2017. An exchange offer for the Notes was launched on March 22, 2017 and settled on April 25, 2017, resulting in the exchange of $299.9 million aggregate principal amount of outstanding Notes for registered notes.

Risk Management

The Company is exposed to interest rate risk on its variable debt. At December 31, 2018, the Company's exposure to rate fluctuations on variable-interest borrowings was $72.5 million.

The Company assesses market risk based on changes in interest rates utilizing a sensitivity analysis that measures the potential loss in earnings, fair values and cash flows based on a hypothetical 10% change in interest rates. Using this sensitivity analysis, such changes would not have a material effect on interest income or expense and cash flows. A hypothetical 10% change in yield would change the fair values of fixed-rate debt at December 31, 2018 by approximately $10.9 million, or 3.6%.

The Company is exposed to the impact of foreign currency fluctuations in certain countries in which it operates. The exposure to foreign currency movements is limited in many countries because the operating revenues and expenses of its various subsidiaries and business units are substantially in the local currency of the country in which they operate. To the extent that borrowings, sales, purchases, revenues, expenses or other transactions are not in the local currency of the subsidiary, the Company is exposed to currency risk and may enter into foreign exchange spot and forward contracts to hedge the currency risk. The Company does not use derivative financial instruments for trading or speculative purposes.

OTHER INFORMATION

Litigation and Contingent Liabilities

For a discussion of certain litigation involving the Company, see Note 12, *Commitments and Contingencies* , to the Consolidated and Combined Financial Statements.

New Accounting Pronouncements and Pending Accounting Standards

Recently issued accounting standards and their estimated effect on the Company's consolidated financial statements are described in Note 23, *New Accounting Pronouncements* , to the Consolidated and Combined Financial Statements.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Market Risk

The Company is exposed to potential fluctuations in earnings, cash flows, and the fair value of certain assets and liabilities due to changes in interest rates and foreign currency exchange rates. The Company manages exposure to these market risks through regular operating and financial activities and, when deemed appropriate, through the use of derivative financial instruments for risk management purposes. As a result, the Company does not anticipate any material losses from these risks. The Company was not a party to any derivative financial instrument at December 31, 2018 or 2017.

The Company discusses risk management in various places throughout this document, including discussions concerning liquidity and capital resources.

Foreign Exchange Risk

While the substantial majority of the Company's business is conducted within the U.S., approximately 16% of the Company's consolidated net sales in 2018 were earned outside of the U.S. The Company has operations internationally that are denominated in foreign currencies, primarily the British Pound and Canadian dollar, exposing the Company to foreign currency exchange risk which may adversely impact financial results. The exposure to foreign currency movements is limited in many countries because the operating revenues and expenses of the Company's various subsidiaries and business units are substantially in the local currency of the country in which they operate. To the extent that borrowings, sales, purchases, revenues, expenses or other transactions are not in the local currency of the subsidiary, the Company is exposed to currency risk and may enter into foreign exchange spot and forward contracts to hedge the currency risk. The Company does not use derivative financial instruments for trading or speculative purposes.

For the year ended December 31, 2018, a hypothetical 10% strengthening of the U.S. dollar relative to multiple currencies would have resulted in a decrease in earnings before income taxes of $3.2 million. A hypothetical 10% strengthening of the U.S. dollar relative to multiple currencies at December 31, 2018 would have resulted in a decrease in total assets of approximately $7.8 million.

Interest Rate Risk

The Company is exposed to interest rate risk on its variable debt. At December 31, 2018, the Company's exposure to rate fluctuations on variable-interest borrowings was $72.5 million.

The Company assesses market risk based on changes in interest rates utilizing a sensitivity analysis that measures the potential loss in earnings, fair values and cash flows based on a hypothetical 10% change in interest rates. Using this sensitivity analysis, such changes would not have a material effect on interest income or expense and cash flows. A hypothetical 10% change in yield would change the fair values of fixed-rate debt at December 31, 2018 by approximately $10.9 million, or 3.6%.

Credit Risk

The Company is exposed to credit risk on accounts receivable balances. This risk is mitigated due to the Company's large, diverse customer base, dispersed over various geographic regions and industrial sectors. No single customer comprised more than 10% of the Company's combined net sales in the years ended December 31, 2018, 2017 or 2016. The Company maintains provisions for potential credit losses and such losses to date have normally been within the Company's expectations. The Company evaluates the solvency of its customers on an ongoing basis to determine if additional allowances for doubtful accounts receivable need to be recorded. Significant economic disruptions or a slowdown in the economy could result in significant additional charges.

Commodities

The primary raw materials used by the Company are paper and ink. To reduce price risk caused by market fluctuations, the Company has incorporated price adjustment clauses in certain sales contracts. Management believes a hypothetical 10% change in the price of paper and other raw materials would not have a significant effect on the Company's combined annual results of operations or cash flows as these costs are generally passed through to its customers. However, such an increase could have an impact on our customers' demand for printed products, and we are not able to quantify the impact of such potential change in demand on our combined annual results of operations or cash flows.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

The financial information required by Item 8 is contained in Item 15 of Part IV of this Annual Report on Form 10-K.

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

None.

ITEM 9A. CONTROL S AND PROCEDURES

(a) Disclosure controls and procedures.

Management, together with the Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of the Company's disclosure controls and procedures (as defined in Rules 13a-15(b) and Rule 15d-15(e) of the Securities Exchange Act of 1934) as of December 31, 2018. Based on that evaluation the Chief Executive Officer and Chief Financial Officer concluded that the Company's disclosure controls and procedures were effective as of December 31, 2018.

(b) Changes in internal control over financial reporting.

Changes in Internal Control Over Financial Reporting. There were no changes in the Company's internal control over financial reporting (as defined in Rule 13a-15(f) and 15d-15(f) under the Exchange Act) during the quarter ended December 31, 2018 that have materially affected or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Management's Annual Report on Internal Control Over Financial Reporting. Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2018 based on the guidelines established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Based on the results of our evaluation, our management has concluded that our internal control over financial reporting was effective as of December 31, 2018.

Deloitte & Touche LLP, an independent registered public accounting firm, who audited the consolidated and combined financial statements of the Company included in this Annual Report on Form 10-K, has also audited the effectiveness of the Company's internal control over financial reporting as stated in its report appearing below.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the stockholders and the Board of Directors of Donnelley Financial Solutions, Inc.

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of Donnelley Financial Solutions, Inc. and subsidiaries (the "Company") as of December 31, 2018, based on criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated and combined financial statements as of and for the year ended December 31, 2018, of the Company and our report dated February 27, 2019, expressed an unqualified opinion on those financial statements and included an explanatory paragraph relating to the allocation of certain assets, liabilities, expenses and income that have historically been held at R.R. Donnelley & Sons Company corporate level, but which are specifically identifiable or attributable to Donnelley Financial Solutions, Inc.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Annual Report on Internal Control Over Financial Reporting* . Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

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

/s/ DELOITTE & TOUCHE LLP

Chicago, Illinois
February 27, 2019

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS AND EXECUTIVE OFFICERS OF DONNELLEY FINANCIAL SOLUTIONS, INC. AND CORPORATE GOVERNANCE

Information regarding directors and executive officers of the Company is incorporated herein by reference to the descriptions under "Proposal 1: Election of Directors," "The Board's Committees and their Functions" and "Section 16(a) Beneficial Ownership Reporting Compliance" of the Company's Proxy Statement for the Annual Meeting of Shareholders scheduled to be held May 24, 2019 (the "2019 Proxy Statement").

The Company has adopted a policy statement entitled *Code of Ethics* that applies to its chief executive officer and senior financial officers. In the event that an amendment to, or a waiver from, a provision of the *Code of Ethics* is made or granted, the Company intends to post such information on its web site, *www.dfsco.com* . A copy of the Company's *Code of Ethics* has been filed as Exhibit 14.1 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018.

EXECUTIVE OFFICERS OF DONNELLEY FINANCIAL SOLUTIONS, INC.

Name, Age and Position with the Company	Officer Since	Business Experience
Daniel N. Leib 52, Chief Executive Officer	2016	Served as RRD's Executive Vice President and Chief Financial Officer from May 2011 to October 2016. Prior to this, served as RRD's Group Chief Financial Officer and Senior Vice President, Mergers and Acquisitions since August 2009 and Treasurer from June 2008 to February 2010. Prior to this, served as RRD's Senior Vice President, Treasurer, Mergers and Acquisitions and Investor Relations since July 2007. Prior to this, from May 2004 to 2007, served in various capacities in financial management, corporate strategy and investor relations.
Thomas F. Juhase 58, Chief Operating Officer	2016	Served as RRD's President, Financial, Global Outsourcing and Document Solutions from 2010 to October 2016. He served as RRD's President, Financial and Global Outsourcing from 2007 to 2010, as President, Global Capital Market, Financial Print Solutions from 2004 to 2007. From 1991 to 2004, Mr. Juhase served in various capacities with RRD in sales and operations in the U.S. and internationally.
David A. Gardella 49, Chief Financial Officer	2016	Served as RRD's Senior Vice President, Investor Relations & Mergers and Acquisitions from 2011 to October 2016. He served as RRD's Vice President, Investor Relations from 2009 to 2011 and as Vice President, Corporate Finance from 2008 to 2009. From 1992 to 2004 and then from 2005 to 2008, Mr. Gardella served in various capacities in financial management and financial planning & analysis.
Jennifer B. Reiners 52, General Counsel	2016	Served as RRD's Senior Vice President, Deputy General Counsel from 2008 to October 2016 and as Vice President, Deputy General Counsel from 2005 to 2008. Prior to this, served in various capacities in the legal department from 1997 to 2008.
Kami S. Turner 44, Controller and Chief Accounting Officer	2016	Served as RRD's Assistant Controller from December 2012 to October 2016. Prior to this, served as Vice President, External Reporting in 2012 and from 2009 to 2011 served in various capacities in finance at RRD.

ITEM 11. EXECUTIVE COMPENSATION

Information regarding executive and director compensation is incorporated by reference to the material under the captions "Compensation Discussion and Analysis," "Human Resources Committee Report," "Executive Compensation," "Potential Payments Upon Termination or Change in Control," and "Director Compensation" of the 2019 Proxy Statement.

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

Information regarding security ownership of certain beneficial owners and management is incorporated herein by reference to the material under the heading "Stock Ownership" of the 2019 Proxy Statement.

Equity Compensation Plan Information

Information as of December 31, 2018 concerning compensation plans under which DFIN's equity securities are authorized for issuance was as follows:

Equity Compensation Plan Information

Plan Category	Number of Securities to Be Issued upon Exercise of Outstanding Options, Warrants and Rights (in thousands) (1)	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (b) (2)	Number of Securities Remaining Available for Future Issuance under Equity Compensation Plans (Excluding Securities Reflected in Column (1)) (in thousands) (3)
Equity compensation plans approved by security holders (a)	1,585.9	$ 21.44	977.3

(a) Includes 950,493 shares issuable upon the vesting of restricted stock units, however, excludes 207,486 of restricted stock awards as these awards are already issued under the Donnelley Financial Solutions Performance Incentive Plan as common stock.

(b) Restricted stock units and restricted stock awards were excluded when determining the weighted-average exercise price of outstanding options, warrants and rights.

(c) All of these shares are available for issuance under the Donnelley Financial Solutions Performance Incentive Plan. The Donnelley Financial Solutions Performance Incentive Plan allows grants in the form of cash or bonus awards, stock options, stock appreciation rights, restricted stock, stock units or combinations thereof. The maximum number of shares of common stock that may be granted with respect to bonus awards, including performance awards or fixed awards in the form of restricted stock or other form, is 3,500,000 in the aggregate, of which 977,314 remain available for issuance.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS AND DIRECTOR INDEPENDENCE

Information regarding certain relationships and related transactions and director independence is incorporated herein by reference to the material under the heading "Certain Transactions," "The Board's Committees and Their Functions" and "Corporate Governance—Independence of Directors" of the 2019 Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

Information regarding principal accounting fees and services is incorporated herein by reference to the material under the heading "The Company's Independent Registered Public Accounting Firm" of the 2019 Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) 1. Financial Statements

The financial statements listed in the accompanying index (page F-1) to the financial statements are filed as part of this Annual Report on Form 10-K.

(b) Exhibits

The exhibits listed on the accompanying index (pages E-1 through E-3) are filed as part of this Annual Report on Form 10-K.

(c) Financial Statement Schedules omitted

Certain schedules have been omitted because the required information is included in the consolidated financial statements and notes thereto or because they are not applicable or not required.

ITEM 16. FORM 10-K SUMMARY

Not applicable.

ITEM 15(a). INDEX TO FINANCIAL STATEMENTS

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Donnelley Financial Solutions, Inc. and Subsidiaries ("DFIN")
Consolidated and Combined Statements of Operations
(in millions, except per share data)

	Year Ended December 31,		
	2018	2017	2016
Services net sales	$ 618.0	$ 632.1	$ 598.6
Products net sales	345.0	372.8	384.9
Total net sales	963.0	1,004.9	983.5
Services cost of sales (exclusive of depreciation and amortization)	328.8	328.7	297.1
Services cost of sales with R.R. Donnelley affiliates (exclusive of depreciation and amortization)*	—	19.5	37.8
Products cost of sales (exclusive of depreciation and amortization)	258.5	240.9	226.2
Products cost of sales with R.R. Donnelley affiliates (exclusive of depreciation and amortization)*	—	32.3	57.9
Total cost of sales	587.3	621.4	619.0
Selling, general and administrative expenses (exclusive of depreciation and amortization)	258.2	236.2	210.8
Restructuring, impairment and other charges-net	4.4	7.1	5.4
Depreciation and amortization	45.8	44.5	43.3
Other operating income	(53.8)	—	—
Income from operations	121.1	95.7	105.0
Interest expense-net	36.7	42.9	11.7
Investment and other income-net	(18.3)	(3.4)	(1.0)
Earnings before income taxes	102.7	56.2	94.3
Income tax expense	29.1	46.5	35.2
Net earnings	$ 73.6	$ 9.7	$ 59.1
Net earnings per share (Note 16):			
Basic net earnings per share	2.18	0.29	1.81
Diluted net earnings per share	2.16	0.29	1.80
Weighted average number of common shares outstanding			
Basic	33.8	33.1	32.6
Diluted	34.0	33.3	32.8

* Beginning in the quarter ended June 30, 2017, LSC Communications, Inc. ("LSC") no longer qualified as a related party, therefore the amounts disclosed related to LSC are presented through March 31, 2017 only. Beginning in the quarter ended September 30, 2017, R.R. Donnelley & Sons Company ("RRD") no longer qualified as a related party, therefore the amounts disclosed related to RRD are presented through June 30, 2017 only.

See Notes to the Consolidated and Combined Financial Statements

Donnelley Financial Solutions, Inc. and Subsidiaries ("DFIN")
Consolidated and Combined Statements of Comprehensive Income
(in millions)

	Year Ended December 31,		
	2018	2017	2016
Net earnings	$ 73.6	$ 9.7	$ 59.1
Other comprehensive income (loss), net of tax:			
Translation adjustments	(5.0)	4.4	(0.1)
Adjustment for net periodic pension and other postretirement benefits plan cost	(2.2)	(0.7)	7.1
Other comprehensive (loss) income, net of tax	(7.2)	3.7	7.0
Comprehensive income	$ 66.4	$ 13.4	$ 66.1

See Notes to the Consolidated and Combined Financial Statements

Donnelley Financial Solutions, Inc. and Subsidiaries ("DFIN")
Consolidated Balance Sheets
(in millions, except per share data)

	December 31,	
	2018	2017
ASSETS		
Cash and cash equivalents	$ 47.3	$ 52.0
Receivables, less allowances for doubtful accounts of $7.9 in 2018 (2017 - $7.3)	172.9	165.2
Inventories	12.1	23.3
Prepaid expenses and other current assets	16.7	29.6
Total current assets	249.0	270.1
Property, plant and equipment-net	32.2	34.7
Software-net	47.8	41.1
Goodwill	450.0	447.4
Other intangible assets-net	37.2	39.9
Deferred income taxes	9.7	22.2
Other noncurrent assets	42.8	38.1
Total assets	$ 868.7	$ 893.5
LIABILITIES		
Accounts payable	$ 72.4	$ 67.8
Accrued liabilities	126.0	119.2
Total current liabilities	198.4	187.0
Long-term debt (Note 15)	362.7	458.3
Deferred compensation liabilities	19.5	22.8
Pension and other postretirement benefits plan liabilities	51.3	52.5
Other noncurrent liabilities	10.8	23.5
Total liabilities	642.7	744.1
Commitments and Contingencies (Note 12)		
EQUITY		
Preferred stock, $0.01 par value		
Authorized: 1.0 shares; Issued: None	—	—
Common stock, $0.01 par value		
Authorized: 65.0 shares;		
Issued: 34.2 shares in 2018 (2017 - 33.8 shares)	0.3	0.3
Treasury stock, at cost: 0.1 shares in 2018 (2017 - less than 0.1 shares)	(2.4)	(0.9)
Additional paid-in-capital	216.5	205.7
Retained earnings	94.3	8.9
Accumulated other comprehensive loss	(82.7)	(64.6)
Total equity	226.0	149.4
Total liabilities and equity	$ 868.7	$ 893.5

See Notes to the Consolidated and Combined Financial Statements

Donnelley Financial Solutions, Inc. and Subsidiaries ("DFIN")
Consolidated and Combined Statements of Cash Flows
(in millions)

	Year Ended December 31,		
	2018	2017	2016
OPERATING ACTIVITIES			
Net earnings	$ 73.6	$ 9.7	$ 59.1
Adjustments to reconcile net earnings to net cash provided by operating activities:			
Depreciation and amortization	45.8	44.5	43.3
Provision for doubtful accounts receivable	4.9	3.9	3.1
Share-based compensation	9.2	6.8	2.5
Deferred income taxes	10.5	12.4	(5.9)
Changes in uncertain tax positions	—	(0.2)	0.9
Net pension plan income	(3.2)	(3.3)	(1.0)
Gain on change in fair value of investment	(13.6)	—	—
Gain on disposition	(53.8)	—	—
Gain on investments and other assets - net	—	0.2	0.1
Other	2.3	2.8	1.0
Changes in operating assets and liabilities - net of acquisitions:			
Accounts receivable - net	(25.3)	18.0	(43.1)
Inventories	(1.6)	0.8	(1.9)
Prepaid expenses and other current assets	1.2	(3.5)	(7.4)
Accounts payable	10.7	(18.3)	42.3
Income taxes payable and receivable	9.2	5.4	(3.6)
Accrued liabilities and other	(1.7)	14.4	17.7
Pension and other postretirement benefits plan contributions	(1.9)	(2.2)	(1.1)
Net cash provided by operating activities	66.3	91.4	106.0
INVESTING ACTIVITIES			
Capital expenditures	(37.1)	(27.8)	(26.2)
Acquisition of business, net of cash acquired	(12.5)	—	—
Sale (purchase) of investment	3.1	(3.4)	(3.5)
Proceeds from disposition	77.5	—	—
Other investing activities	(0.8)	0.2	0.4
Net cash provided by (used in) investing activities	30.2	(31.0)	(29.3)
FINANCING ACTIVITIES			
Revolving facility borrowings	360.0	298.5	—
Payments on revolving facility borrowings	(360.0)	(298.5)	—
Payments on long-term debt	(97.5)	(133.0)	(50.0)
Proceeds from the issuance of common stock	1.2	18.8	—
Treasury share repurchases	(1.5)	(0.9)	—
Debt issuance costs	(1.2)	(2.1)	(9.3)
Separation-related payment from R.R. Donnelley	—	68.0	—
Proceeds from issuance of long-term debt	—	3.1	348.2
Net transfers to Parent and affiliates	—	—	(340.1)
Net change in short-term debt	—	—	(8.8)
Other financing activities	—	0.4	—
Net cash used in financing activities	(99.0)	(45.7)	(60.0)
Effect of exchange rate on cash and cash equivalents	(2.2)	1.1	4.4
Net (decrease) increase in cash and cash equivalents	(4.7)	15.8	21.1
Cash and cash equivalents at beginning of year	52.0	36.2	15.1
Cash and cash equivalents at end of period	$ 47.3	$ 52.0	$ 36.2
Supplemental non-cash disclosure:			
Debt exchange with R.R. Donnelley, including $5.5 million of debt issuance costs	$ —	$ —	$ 300.0
Settlement of intercompany note payable	—	—	29.6
Accrued debt issuance costs	—	—	1.5

See Notes to the Consolidated and Combined Financial Statements

Donnelley Financial Solutions, Inc. and Subsidiaries ("DFIN")
Consolidated and Combined Statements of Equity
(in millions)

	Common Stock		Treasury Stock		Additional Paid-in-Capital	Net Parent Company Investment	Retained Earnings (Accumulated Deficit)	Accumulated Other Comprehensive Loss	Total Equity
	Shares	Amount	Shares	Amount					
Balance at January 1, 2016	—	$ —	—	$ —	$ —	$ 639.5	$ —	$ (16.0)	$ 623.5
Net earnings	—	—	—	—	—	59.9	(0.8)	—	59.1
Net transfers to R.R. Donnelley	—	—	—	—	—	(598.8)	—	—	(598.8)
Separation-related adjustments	—	—	—	—	—	78.0	—	(59.3)	18.7
Reclassification of net parent company investment in connection with the Separation	—	—	—	—	178.6	(178.6)	—	—	—
Issuance of common stock upon separation	32.4	0.3	—	—	—	—	—	—	0.3
Share-based compensation	—	—	—	—	1.3	—	—	—	1.3
Issuance of share-based awards, net of withholdings and other	0.2	—	—	—	—	—	—	—	—
Other comprehensive income	—	—	—	—	—	—	—	7.0	7.0
Balance at December 31, 2016	32.6	$ 0.3	—	$ —	$ 179.9	$ —	$ (0.8)	$ (68.3)	$ 111.1
Net earnings	—	—	—	—	—	—	9.7	—	9.7
Other comprehensive income	—	—	—	—	—	—	—	3.7	3.7
Separation-related adjustments	—	—	—	—	0.2	—	—	—	0.2
Issuance of additional common shares	0.9	—	—	—	18.8	—	—	—	18.8
Share-based compensation	—	—	—	—	6.8	—	—	—	6.8
Issuance of share-based awards, net of withholdings and other	0.3	—	—	(0.9)	—	—	—	—	(0.9)
Balance at December 31, 2017	33.8	$ 0.3	—	$ (0.9)	$ 205.7	$ —	$ 8.9	$ (64.6)	$ 149.4
Net earnings	—	—	—	—	—	—	73.6	—	73.6
Other comprehensive income	—	—	—	—	—	—	—	(7.2)	(7.2)
Adoption of ASU 2018-02	—	—	—	—	—	—	10.9	(10.9)	—
Adoption of ASU 2014-09	—	—	—	—	—	—	0.9	—	0.9
Share-based compensation	—	—	—	—	9.2	—	—	—	9.2
Issuance of share-based awards, net of withholdings and other	0.4	—	0.1	(1.5)	1.6	—	—	—	0.1
Balance at December 31, 2018	34.2	$ 0.3	0.1	$ (2.4)	$ 216.5	$ —	$ 94.3	$ (82.7)	$ 226.0

See Notes to the Consolidated and Combined Financial Statements

Notes to the Consolidated and Combined Financial Statements
(in millions, except per share data, unless otherwise indicated)

Note 1. Overview and Basis of Presentation

Description of Business

Donnelley Financial Solutions, Inc. ("DFIN," or the "Company") is a leading global risk and compliance solutions company. The Company provides regulatory filing solutions, software-as-a-service ("SaaS"), technology-enabled services and print and distribution solutions to public and private companies, mutual funds and other regulated investment firms, to serve their regulatory and compliance needs. For corporate clients within its capital markets offerings, the Company offers technology-enabled filing solutions that allow U.S. public companies to comply with applicable U.S. Securities and Exchange Commission ("SEC") regulations including filing agent services, digital document creation and online content management tools that support their corporate financial transactions and regulatory reporting; solutions to facilitate clients' communications with their shareholders; and virtual data rooms and other deal management solutions. For the investment markets, including alternative investment and insurance investment companies, the Company provides technology-enabled filing solutions including cloud-based tools for creating and filing high-quality regulatory documents and solutions for investors designed to improve the speed and accuracy of their access to investment information. Throughout a company's life cycle, the Company serves its clients' regulatory and compliance needs. The Company's deep industry and regulatory expertise and a commitment to exceptional service guides our clients to navigate a high-stakes and ever-changing regulatory environment.

DFIN's Registration Statement on Form 10, as amended, was declared effective by the U.S. Securities and Exchange Commission (the "SEC") on September 20, 2016. On October 1, 2016, DFIN became an independent publicly traded company through the distribution by R.R. Donnelley & Sons Company ("RRD") of approximately 26.2 million shares, or 80.75%, of DFIN common stock to RRD shareholders (the "Separation"). Holders of RRD common stock received one share of DFIN common stock for every eight shares of RRD common stock held on September 23, 2016. As part of the Separation, RRD retained approximately 6.2 million shares of DFIN common stock, or a 19.25% interest in DFIN. DFIN's common stock began regular-way trading under the ticker symbol "DFIN" on the New York Stock Exchange on October 3, 2016. On October 1, 2016, RRD also completed the previously announced separation of LSC Communications, Inc. ("LSC"), its publishing and retail-centric print services and office products business. On March 28, 2017, RRD completed the sale of 6.2 million shares of LSC common stock (RRD's remaining ownership stake in LSC) in an underwritten public offering. As a result, beginning in the quarter ended June 30, 2017, LSC no longer qualified as a related party of the Company, therefore amounts disclosed related to LSC are presented through March 31, 2017 only.

On March 24, 2017, pursuant to the Stockholder and Registration Rights Agreement, dated as of September 30, 2016, by and between the Company and RRD, the Company filed a Registration Statement on Form S-1 to register the offering and sale of shares of the Company's common stock retained by RRD. The Registration Statement on Form S-1, as amended, was declared effective by the SEC on June 13, 2017. On June 21, 2017, RRD completed the sale of approximately 6.1 million shares of the Company's common stock in an underwritten public offering. Upon the consummation of the offering, RRD retained approximately 0.1 million shares of the Company's common stock which were subsequently sold by RRD on August 4, 2017. In conjunction with the underwritten public offering, the underwriters exercised their option to purchase approximately 0.9 million of the Company's shares (the "Option Shares"). The Company received approximately $18.8 million in net proceeds from the sale of the Option Shares, after deducting estimated underwriting discounts and commissions. The proceeds were used to reduce outstanding debt under the Revolving Facility (as defined in Note 15, *Debt*). Beginning in the quarter ended September 30, 2017, RRD no longer qualified as a related party, therefore amounts disclosed related to RRD are presented through June 30, 2017 only.

On September 14, 2016, the Company and LSC entered into a Separation and Distribution Agreement with RRD to effect the distribution of the Company's and LSC's common stock to RRD's common stockholders (the "Separation and Distribution Agreement"). This agreement governs the Company's relationship with RRD and LSC with respect to pre-Separation matters and provides for the allocation of employee benefit, litigation and other liabilities and obligations attributable to periods prior to the Separation. The Separation and Distribution Agreement also includes an agreement that the Company, RRD and LSC will provide each other with appropriate indemnities with respect to liabilities arising out of the businesses being distributed and retained by RRD in the Separation. The Separation and Distribution Agreement also addresses employee compensation and benefit matters.

In connection with the Separation, the Company entered into transition services agreements separately with RRD and LSC, under which, in exchange for the fees specified in the arrangements, RRD and LSC agree to provide certain services to the Company and the Company agrees to provide certain services to RRD, respectively. These services have included, but are not limited to, information technology, accounts receivable, accounts payable, payroll and other financial and administrative services and functions. Most of the services provided under the transition services agreements terminated at September 30, 2018 or earlier. Under certain transition services agreements, RRD agreed to provide information technology services to the Company for up to 36 months following the Separation. These agreements facilitated the separation by allowing the Company to operate independently prior to establishing stand-alone back office systems across its organization.

At the time of the Separation, the Company entered into a number of commercial and other arrangements with RRD and its subsidiaries. These include, among other things, arrangements for the provision of services, including global outsourcing and logistics services, printing and binding, digital printing, composition, and access to technology. The terms of the arrangements with RRD do not exceed 36 months. Subsequent to the Separation, RRD and LSC are clients of the Company and expect to utilize SaaS solutions and services that the Company provides to all of its clients.

Basis of Presentation

The accompanying consolidated and combined financial statements reflect the consolidated financial position and consolidated results of operations of the Company as an independent, publicly traded company for the periods after the Separation and the combined results of operations for the periods prior to the Separation. Prior to the Separation, the combined financial statements were prepared on a stand-alone basis and were derived from RRD's consolidated financial statements and accounting records. The consolidated and combined financial statements have been prepared in accordance with accounting principles generally accepted in the United States ("GAAP") and in accordance with the rules and regulations of the SEC.

For periods prior to the Separation, the consolidated and combined financial statements include the allocation of certain assets and liabilities that were historically held at the RRD corporate level but which were specifically identifiable or attributable to the Company. Cash and cash equivalents held by RRD were not allocated to DFIN unless they were held in a legal entity that was transferred to DFIN. All intercompany transactions and accounts within DFIN have been eliminated. All intracompany transactions between RRD and DFIN are considered to be effectively settled in the consolidated and combined financial statements at the time the transaction is recorded. The total net effect of the settlement of these intracompany transactions is reflected in the consolidated and combined statements of cash flows as a financing activity and in the consolidated and combined statements of equity as net parent company investment. Net parent company investment is primarily impacted by contributions from RRD which are the result of treasury activities and net funding provided by or distributed to RRD.

Prior to the Separation, the consolidated and combined financial statements include certain expenses of RRD which were allocated to DFIN for certain functions, including general corporate expenses related to information technology, finance, legal, human resources, internal audit, treasury, tax, investor relations and executive oversight. These expenses were allocated to the Company on the basis of direct usage, when available, with the remainder allocated on the pro rata basis of revenue, employee headcount, or other measures. The Company considers the expense methodology and results to be reasonable for all periods presented. However, these allocations may not be indicative of the actual expenses that would have been incurred as an independent public company or the costs that may be incurred in the future.

For periods prior to the Separation, the income tax amounts in the consolidated and combined financial statements were calculated based on a separate income tax return methodology and presented as if the Company's operations were separate taxpayers in the respective jurisdictions.

RRD maintained various benefit and share-based compensation plans at a corporate level. DFIN employees participated in those programs and a portion of the cost of those plans is included in DFIN's consolidated and combined financial statements for periods prior to the Separation. On October 1, 2016, DFIN recorded net pension plan liabilities of $68.3 million (consisting of a total benefit plan liability of $317.0 million, net of plan assets having fair market value of $248.7 million), as a result of the transfer of certain pension plan liabilities and assets from RRD to the Company upon the legal split of those plans. The pension plan asset allocation from RRD was finalized on June 30, 2017, which resulted in a $0.7 million decrease to the fair value of plan assets transferred to the Company from RRD. The Company also recorded a net other postretirement benefit liability of $1.5 million, as a result of the transfer of an other postretirement benefit plan from RRD to the Company. Refer to Note 13, *Retirement Plans* , for further details regarding the Company's pension and other postretirement benefit plans.

DFIN generates a portion of net revenue from sales to RRD's subsidiaries. Included in the consolidated and combined financial statements are net revenues from sales to RRD and affiliates of $8.3 million for the six months ended June 30, 2017 and $19.4 million for the year ended December 31, 2016, respectively. DFIN utilizes RRD for freight and logistics, production of certain printed products and outsourced business services functions. Included in the consolidated and combined financial statements are cost of sales to RRD and affiliates of $51.8 million for the six months ended June 30, 2017 and $95.7 million for the year ended December 31, 2016, respectively. See Note 22, *Related Parties,* for a further description of related party transactions.

Changes in Presentation

Certain prior year amounts have been restated to conform to the Company's current reporting unit structure. Due to the sale of the Language Solutions business, the Company made changes to the reporting units within the U.S. segment. The former Language Solutions and other reporting unit has been renamed "Language Solutions." Certain results previously included within the former Language Solutions and other reporting unit are now included within the Investment Markets reporting unit.

Note 2. Significant Accounting Policies

Use of Estimates —The preparation of consolidated and combined financial statements, in conformity with GAAP, requires the extensive use of management's estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting periods. Actual results could differ from these estimates. Estimates are used when accounting for items and matters including, but not limited to, allowance for uncollectible accounts receivable, inventory obsolescence, asset valuations and useful lives, employee benefits, taxes, restructuring and other provisions and contingencies.

Foreign Operations —Assets and liabilities denominated in foreign currencies are translated into U.S. dollars at the exchange rates existing at the respective balance sheet dates. Income and expense items are translated at the average rates during the respective periods. Translation adjustments resulting from fluctuations in exchange rates are recorded as a separate component of other comprehensive income (loss) while transaction gains and losses are recorded in net earnings. Deferred taxes are not provided on cumulative foreign currency translation adjustments when the Company expects foreign earnings to be indefinitely reinvested.

Fair Value Measurements— Certain assets and liabilities are required to be recorded at fair value on a recurring basis. Fair value is determined based on the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants. The Company records the fair value of its pension plan assets on a recurring basis. See Note 13, *Retirement Plans* , for the fair value of the Company's pension plan assets as of December 31, 2018.

The Company adopted Accounting Standards Update No. 2016-01 "Financial Instruments-Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities" ("ASU 2016-01") on January 1, 2018, which requires that investments in equity securities, except those accounted for under the equity method of accounting or those that result in consolidation, to be measured at fair value with changes in fair value recognized in net income. The Company measures its equity investments that do not have a readily determinable fair value, at cost minus impairment, if any, plus or minus changes resulting from observable price changes in orderly transactions for the identical or a similar investment of the same issuer.

In addition to assets and liabilities that are recorded at fair value on a recurring basis, the Company is required to record certain assets and liabilities at fair value on a nonrecurring basis, generally as a result of acquisitions or the remeasurement of assets resulting in impairment charges. Assets measured at fair value on a nonrecurring basis include long-lived assets held and used, long-lived assets held for sale, goodwill and other intangible assets. The fair value of cash and cash equivalents, accounts receivable, short-term debt and accounts payable approximate their carrying values. The three-tier value hierarchy, which prioritizes valuation methodologies based on the reliability of the inputs, is:

Level 1 — Valuations based on quoted prices for identical assets and liabilities in active markets.

Level 2 — Valuations based on observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets, quoted prices for identical or similar assets and liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data.

Level 3 — Valuations based on unobservable inputs reflecting the Company's own assumptions, consistent with reasonably available assumptions made by other market participants.

Revenue Recognition — The Company manages highly-customized data and materials, such as Exchange Act, Securities Act and Investment Company Act filings with the SEC on behalf of its customers and performs XBRL and related services. The Company's SaaS offerings include the Venue Virtual Data Room, the FundSuiteArc software platform, ActiveDisclosure and data and analytics, among others.

Revenue is recognized upon transfer of control of promised services or products to customers in an amount that reflects the consideration to which the Company expects to be entitled in exchange for those services or products. The Company's arrangements with customers often include promises to transfer multiple services or products to a customer. Determining whether services and products are considered distinct performance obligations that should be accounted for separately requires significant judgment. Certain customer arrangements have multiple performance obligations as certain promises are both capable of being distinct and are distinct within the context of the contract. Other customer arrangements have a single performance obligation as the promise to transfer the individual goods or services is not separately identifiable from other promises in the contracts, and therefore are not distinct. Because substantially all of the Company's products are customized, product returns are not significant; however, the Company accrues for the estimated amount of customer credits at the time of sale.

The Company records deferred revenue in situations when amounts are invoiced but the revenue recognition criteria outlined above are not met. Such revenue is recognized when all criteria are subsequently met.

Certain revenues earned by the Company require significant judgment to determine if revenue should be recorded gross, as a principal, or net of related costs, as an agent. Billings for shipping and handling costs as well as certain postage costs, and out-of-pocket expenses are recorded gross. Revenue is not recognized for customer-supplied postage. The Company's printing operations process paper that may be supplied directly by customers or may be purchased by the Company from third parties and sold to customers. Revenue is not recognized for customer-supplied paper, however revenues for Company-supplied paper are recognized on a gross basis. Revenue is recognized net of any taxes collected from customers, which are subsequently remitted to authorities.

Refer to Note 3, *Revenue* , for a discussion of the impact of the 2018 Accounting Standards Update No. 2014-09 "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09") .

Cash and cash equivalents —The Company considers all highly liquid investments with original maturities of three months or less to be cash equivalents. Short-term securities consist of investment grade instruments of governments, financial institutions and corporations.

Receivables— Receivables are stated net of allowances for doubtful accounts and primarily include trade receivables, notes receivable and miscellaneous receivables from suppliers. No single customer comprised more than 10% of the Company's net sales in 2018, 2017 or 2016. Specific customer provisions are made when a review of significant outstanding amounts, utilizing information about customer creditworthiness and current economic trends, indicates that collection is doubtful. In addition, provisions are made at differing rates, based upon the age of the receivable and the Company's historical collection experience. See Note 7, *Accounts Receivable,* for details of activity affecting the allowance for doubtful accounts receivable.

Inventories —Inventories include material, labor and factory overhead and are stated at the lower of cost or market and net of excess and obsolescence reserves for raw materials. Provisions for excess and obsolete inventories are made at differing rates, utilizing historical data and current economic trends, based upon the age and type of the inventory. Specific excess and obsolescence provisions are also made when a review of specific balances indicates that the inventories will not be utilized in production or sold. Inventory is valued using the First-In, First-Out (FIFO) method.

Long-Lived Assets —The Company assesses potential impairments to its long-lived assets if events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Indefinite-lived intangible assets are reviewed annually for impairment or more frequently if events or changes in circumstances indicate that the carrying value may not be recoverable. An impaired asset is written down to its estimated fair value based upon the most recent information available. Estimated fair market value is generally measured by discounting estimated future cash flows. Long-lived assets, other than goodwill, are recorded at the lower of the carrying value or the fair market value less the estimated cost to sell.

Property, plant and equipment —Property, plant and equipment are recorded at cost and depreciated on a straight-line basis over their estimated useful lives. Useful lives range from 15 to 40 years for buildings, the lesser of 7 years or the lease term for leasehold improvements and from 3 to 15 years for machinery and equipment. Maintenance and repair costs are charged to expense as incurred. Major overhauls that extend the useful lives of existing assets are capitalized. When properties are retired or disposed, the costs and accumulated depreciation are eliminated and the resulting profit or loss is recognized in the results of operations.

Software — The Company incurs costs to develop software applications for internal-use and for the development of SaaS solutions sold to its clients. These costs include both direct costs from third-party vendors and eligible salaries and payroll-related costs of employees. The Company capitalizes costs associated with internal-use software and SaaS solutions when management with the relevant authority authorizes and commits to the funding of the software project and it is probable that the project will be completed and the software will be used to perform the functions intended. Costs associated with upgrades and enhancements of internal-use software and SaaS solutions are capitalized only if such modifications result in additional functionality of the software, whereas costs incurred for preliminary project stage activities, training, project management and maintenance is expensed as incurred.

Capitalized software development costs are amortized over their estimated useful life using the straight-line method, up to a maximum of three years. Amortization expense related to internally-developed software, excluding amortization expense related to other intangible assets, was $24.3 million, $22.5 million and $20.5 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Goodwill —Goodwill is either assigned to a specific reporting unit or allocated between reporting units based on the relative fair value of each reporting unit. The Company's goodwill balances were reallocated from RRD's historical reporting units based on the relative fair values of the businesses.

Goodwill is reviewed for impairment annually as of October 31 or more frequently if events or changes in circumstances indicate that it is more likely than not that the fair value of a reporting unit is below its carrying amount.

For certain reporting units, the Company may perform a qualitative, rather than quantitative, assessment to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. In performing this qualitative analysis, the Company considers various factors, including the excess of prior year estimates of fair value compared to carrying value, the effect of market or industry changes and the reporting units' actual results compared to projected results. Based on this qualitative analysis, if management determines that it is more likely than not that the fair value of the reporting unit is greater than its carrying value, no further impairment testing is performed.

For the remaining reporting units, the Company compares each reporting unit's fair value, estimated based on comparable company market valuations and expected future discounted cash flows to be generated by the reporting unit, to its carrying amount. If the carrying amount exceeds the reporting unit's fair value, the Company will recognize an impairment loss for the amount by which the carrying amount exceeds the fair value.

The Company also performs an interim review for indicators of impairment at each quarter-end to assess whether an interim impairment review is required for any reporting unit. In the Company's annual review at October 31, 2018, and its interim review for indicators of impairment as of December 31, 2018, management concluded that there were no indicators that the fair value of any of the reporting units with goodwill was more likely than not below its carrying amount.

Other intangible assets are recognized separately from goodwill and are amortized over their estimated useful lives. See Note 6, *Goodwill and Other Intangible Assets,* for further discussion of other intangible assets and the related amortization expense

Share-Based Compensation — In periods prior to the Separation, RRD maintained an incentive share-based compensation program for the benefit of its officers, directors, and certain employees, including certain DFIN employees. For those periods share-based compensation expense has been allocated to the Company based on the awards and terms previously granted to the Company's employees as well as an allocation of compensation expense to RRD's corporate and shared functional employees.

Subsequent to the Separation, the Company recognizes share-based compensation expense based on estimated fair values for all share-based awards made to employees and directors, including stock options, restricted stock units ("RSUs"), performance-based restricted stock and performance share units ("PSUs"). The Company recognizes compensation expense for RSUs and PSUs expected to vest on a straight-line basis over the requisite service period of the award. The Company recognizes compensation expense for performance based restricted stock awards granted in 2016 utilizing a graded vesting schedule. Compensation expense for performance based restricted stock awards granted in 2017, which cliff vest, is recognized on a straight-line basis. Compensation expense for stock options is recognized on a straight-line basis over the requisite service period of the award. See Note 17, *Share-Based Compensation,* for further discussion.

Pension and Other Postretirement Benefit Plans — Prior to the Separation, RRD provided pension and other postretirement healthcare benefits to certain current and former employees of DFIN. DFIN's consolidated and combined statements of operations include expense allocations for these benefits. These allocations were funded through intercompany transactions with RRD which are reflected within net parent company investment in DFIN.

On October 1, 2016, DFIN recorded net pension plan liabilities of $68.3 million (consisting of a total benefit plan liability of $317.0 million, net of plan assets having fair market value of $248.7 million), as a result of the transfer of certain pension plan liabilities and assets from RRD to the Company upon the legal split of those plans. The pension plan asset allocation from RRD was finalized on June 30, 2017, which resulted in a $0.7 million decrease to the fair value of plan assets transferred to the Company from RRD. The Company also recorded a net other postretirement benefit liability of $1.5 million, as a result of the transfer of an other postretirement benefit plan from RRD to the Company.

DFIN engages outside actuaries to assist in the determination of the obligations and costs under these plans. The annual income and expense amounts relating to the pension plan are based on calculations which include various actuarial assumptions including, mortality expectations, discount rates and expected long-term rates of return. The Company reviews its actuarial assumptions on an annual basis and makes modifications to the assumptions based on current rates and trends when it is deemed appropriate to do so. The effects of modifications on the value of plan obligations and assets is recognized immediately within other comprehensive income (loss) and amortized into operating earnings over future periods. The Company believes that the assumptions utilized in recording its obligations under its plans are reasonable based on its experience, market conditions and input from its actuaries and investment advisors. Refer to Note 13, *Retirement Plans* , for further discussion.

Taxes on Income - In the Company's combined financial statements prior to Separation, income tax expense and deferred tax balances were calculated on a separate income tax return basis although the Company's operations have historically been included in the tax returns filed by the respective RRD entities of which the Company's business was a part. As a standalone entity, the Company will file tax returns on its own behalf and its deferred taxes and effective tax rate may differ from those in historical periods.

Deferred taxes are provided using an asset and liability method whereby deferred tax assets are recognized for deductible temporary differences and operating loss carryforwards and deferred tax liabilities are recognized for taxable temporary differences. Temporary differences are the differences between the reported amounts of assets and liabilities and their tax basis. Deferred tax assets are reduced by a valuation allowance when, in the opinion of management, it is more likely than not that some portion or all of the deferred tax assets will not be realized. Deferred tax assets and liabilities are adjusted for the effects of changes in tax laws and rates on the date of enactment.

The Company maintains an income taxes payable or receivable account in each jurisdiction and, with the exception of certain entities outside the U.S. that transferred to the Company at Separation, the Company is deemed to settle current tax balances with the RRD tax paying entities in the respective jurisdictions. The Company classifies interest expense and any related penalties related to income tax uncertainties as a component of income tax expense.

The Company is regularly audited by foreign and domestic tax authorities. These audits occasionally result in proposed assessments where the ultimate resolution might result in the Company owing additional taxes, including in some cases, penalties and interest. The Company recognizes a tax position in its financial statements when it is more likely than not (*i.e.,* a likelihood of more than fifty percent) that the position would be sustained upon examination by tax authorities. This recognized tax position is then measured at the largest amount of benefit that is greater than fifty percent likely of being realized upon ultimate settlement. Although management believes that its estimates are reasonable, the final outcome of uncertain tax positions may be materially different from that which is reflected in the Company's financial statements. The Company adjusts such reserves upon changes in circumstances that would cause a change to the estimate of the ultimate liability, upon effective settlement or upon the expiration of the statute of limitations, in the period in which such event occurs. See Note 14, *Income Taxes,* for further discussion.

Commitments and Contingencies - The Company is subject to lawsuits, investigations and other claims related to environmental, employment, commercial and other matters, as well as preference claims related to amounts received from customers and others prior to their seeking bankruptcy protection. Periodically, the Company reviews the status of each significant matter and assesses potential financial exposure. See Note 12, *Commitments and Contingencies* , for further discussion.

Restructuring - The Company records restructuring charges when liabilities are incurred as part of a plan approved by management with the appropriate level of authority for the elimination of duplicative functions, the closure of facilities, or the exit of a line of business, generally in order to reduce the Company's overall cost structure. See Note 5, *Restructuring* , for further discussion.

Note 3. Revenue

Revenue Recognition

The Company manages highly-customized data and materials, such as Exchange Act, Securities Act and Investment Company Act filings with the SEC on behalf of its customers, manages virtual data rooms and performs XBRL and related services. Clients are provided with EDGAR filing services, XBRL compliance services and translation, editing, interpreting, proof-reading and multilingual typesetting services, among others. The Company's SaaS offerings include the Venue Virtual Data Room, the FundSuiteArc software platform, ActiveDisclosure and data and analytics, among others.

Substantially all of the Company's revenue is derived from contracts with an initial expected duration of one year or less. Generally, customer payment is due within ten days upon invoicing.

Revenue is recognized upon transfer of control of promised services or products to customers in an amount that reflects the consideration to which the Company expects to be entitled in exchange for those services or products. The Company's arrangements with customers often include promises to transfer multiple services or products to a customer. Determining whether services and products are considered distinct performance obligations that should be accounted for separately requires significant judgment. Certain customer arrangements have multiple performance obligations as certain promises are both capable of being distinct and are distinct within the context of the contract. Other customer arrangements have a single performance obligation as the promise to transfer the individual goods or services is not separately identifiable from other promises in the contracts, and therefore are not distinct.

Revenue for the Company's services and products is recognized either over time or at a point in time, as outlined below.

Over time

The Company recognizes revenue for certain services over time.

- The Company's SaaS solutions, including the Venue Virtual Data Room, the FundSuiteArc software platform, ActiveDisclosure, data and analytics and others, are generally provided on a subscription basis and allow customers access to use the products over the contract period. As a result, revenue for SaaS solutions are recognized ratably over time as the customer receives the benefit throughout the contract period. The timing of invoicing varies, however the customer may be invoiced before the end of the contract period, resulting in a deferred revenue balance.
- Revenue for warehousing services are recognized ratably over time as the customer receives the benefit throughout the storage period.

Point in time

All remaining revenue arrangements are generally recognized at a point in time and are primarily invoiced upon completion of all services or upon shipment to the customer.

- Certain of these arrangements include multiple performance obligations and revenue is recognized upon completion of each performance obligation, such as when a document is filed with a regulatory agency and upon completion of printing the related document. For arrangements with multiple performance obligations, the transaction price is allocated to the separate performance obligations. The Company provides customer specific solutions and as such, observable standalone selling price is rarely available. Standalone selling price is more frequently determined using an estimate of the standalone selling price of each distinct service or product, taking into consideration historical selling price by customer for each distinct service or product. These estimates may vary from the final amounts invoiced to the customer and are adjusted upon completion of all performance obligations. Customers may be invoiced subsequent to the recognition of revenue for completed performance obligations , resulting in contract asset balances.
- Revenue for arrangements which include assisting customers in completing regulatory filings for transactions, such as mergers and acquisitions or other public capital market transactions, is recognized upon completion of all promises, including the services performed and printing of the related document, if applicable.
- Revenue for arrangements without a regulatory filing generally have a single performance obligation, as the services and products provided are not distinct within the context of the contract, and are recognized upon completion of the services performed or upon completion of printing of the related product.
- Warehousing, fulfillment services and shipping and handling are each separate performance obligations. As a result, when the Company provides warehousing and future fulfillment services, revenue for the composition services performed and printing of the product is recognized upon completion of the performance obligation(s), as control of the inventory has transferred to the customer and the inventory is being stored at the customer's request.

Because substantially all of the Company's products are customized, product returns are not significant; however, the Company accrues for the estimated amount of customer credits at the time of sale.

The Company records deferred revenue when amounts are invoiced but the revenue recognition criteria are not yet met. Such revenue is recognized when all criteria are subsequently met.

Certain revenues earned by the Company require significant judgment to determine if revenue should be recorded gross, as a principal, or net of related costs, as an agent. Billings for shipping and handling costs as well as certain postage costs, and out-of-pocket expenses are recorded gross. Revenue is not recognized for customer-supplied postage. The Company's printing operations process paper that may be supplied directly by customers or may be purchased by the Company from third parties and sold to customers. Revenue is not recognized for customer-supplied paper, however revenues for Company-supplied paper are recognized on a gross basis. Revenue is recognized net of any taxes collected from customers, which are subsequently remitted to authorities.

Adoption of ASU 2014-09

In May 2014, the FASB issued ASU 2014-09, which outlines a single comprehensive model for entities to use in accounting for revenue using a five-step process that supersedes virtually all existing revenue guidance. ASU 2014-09 also requires additional quantitative and qualitative disclosures. On January 1, 2018, the Company adopted the standard and all related amendments, using the modified retrospective approach applied to contracts that were not completed as of January 1, 2018. The Company recognized the cumulative effect of applying the standard as an opening transition adjustment to retained earnings. The comparative periods have not been restated and continue to be reported under the accounting standards in effect for those periods ("Previous Revenue Standard").

As a result of the adoption of ASU 2014-09, revenue recognition has been accelerated for certain arrangements with multiple performance obligations as revenue is now recognized upon the completion of each performance obligation rather than upon completion of all services and shipment of the related document, if applicable. Revenue has also been accelerated for certain inventory which has been invoiced but not yet shipped at the customer's request. Additionally, certain revenues related to virtual data room services have been deferred to be recognized over the term of the contract.

As substantially all of the Company's revenue is derived from contracts with an initial expected duration of one year or less, the Company has applied the practical expedient for performance obligations related to contracts with an initial duration of less than one year and is therefore not required to disclose information regarding remaining performance obligations at the end of the reporting period. The Company has also elected the practical expedient to recognize costs to obtain the contract, primarily commissions, as incurred.

The cumulative effect of the changes made to the Company's consolidated January 1, 2018 balance sheet for the adoption of ASU 2014-09 were as follows:

	Balance at December 31, 2017	Adoption of ASU 2014-09	Balance at January 1, 2018
Assets			
Receivables, less allowances for doubtful accounts	$ 165.2	$ 8.9	$ 174.1
Inventories	23.3	(10.6)	12.7
Deferred income taxes	22.2	(0.5)	21.7
Total assets	893.5	(2.2)	891.3
Liabilities			
Accrued liabilities	119.2	(3.1)	116.1
Equity			
Retained earnings	8.9	0.9	9.8
Total liabilities and equity	$ 893.5	$ (2.2)	$ 891.3

The impact of the adoption of ASU 2014-09 on the Company's consolidated statement of operations for the year ended December 31, 2018 and consolidated balance sheet as of December 31, 2018 was as follows:

	Year Ended December 31, 2018		
	Previous Revenue Standard	Adoption of ASU 2014-09	As Reported
Services net sales	$ 618.1	$ (0.1)	$ 618.0
Products net sales	345.0	—	345.0
Total net sales	963.1	(0.1)	963.0
Services cost of sales (exclusive of depreciation and amortization)	329.4	(0.6)	328.8
Products costs of sales (exclusive of depreciation and amortization)	258.5	—	258.5
Total cost of sales	587.9	(0.6)	587.3
Selling, general and administrative expenses (exclusive of depreciation and amortization)	258.2	—	258.2
Income tax expense	28.9	0.2	29.1
Net earnings	$ 73.3	$ 0.3	$ 73.6
Earnings per share			
Basic	2.17	0.01	2.18
Diluted	2.15	0.01	2.16

	December 31, 2018		
	Previous Revenue Standard	Adoption of ASU 2014-09	As Reported
Assets			
Receivables, less allowances for doubtful accounts	$ 164.4	$ 8.5	$ 172.9
Inventories	22.0	(9.9)	12.1
Deferred income taxes	10.3	(0.6)	9.7
Total assets	870.7	(2.0)	868.7
Liabilities			
Accrued liabilities	129.2	(3.2)	126.0
Equity			
Retained earnings	93.1	1.2	94.3
Total liabilities and equity	$ 870.7	$ (2.0)	868.7

Disaggregation of revenue

The following tables disaggregates revenue by reporting unit and timing of revenue recognition for the year ended December 31, 2018:

	Year Ended December 31, 2018		
	Point in time	Over time	Total
U.S.			
Capital Markets	$ 358.9	$ 97.1	$ 456.0
Investment Markets	291.6	50.5	342.1
Language Solutions	13.7	—	13.7
Total U.S.	664.2	147.6	811.8
International	132.2	19.0	151.2
Total net sales	$ 796.4	$ 166.6	$ 963.0

Contract Balances

Contract assets represent revenue recognized for performance obligations completed before an unconditional right to payment exists, and therefore invoicing has not yet occurred. Contract assets were $ 8.7 million at December 31, 2018 and $9.0 million at January 1, 2018, respectively. Generally, the contract assets balance is impacted by the recognition of additional contract assets, offset by amounts invoiced to customers. For the year ended December 31, 2018, final amounts invoiced to customers exceeded estimates of standalone selling price as of January 1, 2018 for the related arrangements by approximately $0.7 million. Contract assets are included in accounts receivable on the consolidated balance sheet.

Contract liabilities consist of deferred revenue and progress billings which are included in accrued liabilities on the consolidated balance sheet. Changes in contract liabilities were as follows:

Balance at January 1, 2018	$ 14.2
Deferral of revenue	47.1
Revenue recognized	(47.9)
Disposition	(1.6)
Acquisition	0.2
Balance at December 31, 2018	$ 12.0

Note 4. Acquisitions and Dispositions

Acquisition

On December 18, 2018, the Company acquired eBrevia, a leading provider of artificial intelligence-based data extraction and contract analytics software solutions. The eBrevia technology provides leading enterprise contract review and analysis solutions, leveraging machine learning to produce faster and more accurate results. eBrevia's software, which extracts and summarizes key legal provisions and other information, can be used in due diligence, contract management, lease abstraction and document drafting. The acquisition enhances the Company's Venue Deal Solutions offerings to provide clients with secure data aggregation, due diligence, compliance and risk management solutions. The Company previously held a 12.8% investment in eBrevia prior to the acquisition. The purchase price for the remaining equity of eBrevia, which includes the Company's estimate of contingent consideration, was $ 23.2 million, net of cash acquired of $0.2 million. $4.1 million of the purchase price, excluding contingent consideration and amounts held in escrow, was payable as of December 31, 2018 and is expected to be paid during 2019. The fair value of the Company's previously held investment was $3.3 million, resulting in the recognition of a $1.8 million gain, which is reflected in investment and other income in the consolidated statements of operations for the year ended December 31, 2018. The fair value of the previously held investment was determined based on the purchase price paid for the remaining equity less an estimated control premium. The former owners of eBrevia, excluding the Company, may receive additional contingent consideration of up to $3.5 million in cash subject to eBrevia achieving certain financial targets during the twenty-four months post acquisition. As of the acquisition date, the Company estimated the fair value of contingent consideration to be $0.8 million using a probability weighting of the potential payouts. Subsequent changes in the estimated contingent consideration from the final purchase price allocation will be recognized in the Company's consolidated statement of operations. The operations of eBrevia are included within the Capital Markets reporting unit in the U.S. segment.

For the years ended December 31, 2018 and 2017, the Company recorded $0.8 million and $0.2 million, respectively, of acquisition-related expenses associated with acquisitions completed or contemplated within selling, general and administrative expenses in the consolidated statement of operations.

The eBrevia acquisition was recorded by allocating the cost of the acquisition to the assets acquired, including other intangible assets, based on their estimated fair values at the acquisition date. The excess of the cost of the acquisition over the net amounts assigned to the fair value of the assets acquired was recorded as goodwill.

There is no tax deductible goodwill related to the eBrevia acquisition.

The purchase price allocation for eBrevia is preliminary as the Company is still in the process of obtaining data to finalize the estimated fair values of certain account balances. The final purchase price allocation may differ from what is currently reflected in the consolidated financial statements. Based on the current valuation, the preliminary purchase price allocation for this acquisition is as follows:

Accounts receivable	$	0.3
Other intangible assets		11.4
Software		0.8
Goodwill		12.8
Accounts payable and accrued liabilities		(0.4)
Deferred taxes-net		(1.7)
Total purchase price-net of cash acquired		23.2
Less: fair value of the Company's previously held investment in eBrevia		(3.3)
Less: fair value of contingent consideration		(0.8)
Less: payable for initial consideration		(4.1)
Less: amounts held in escrow and liabilities assumed		(2.5)
Net cash paid	$	12.5

Disposition

On July 22, 2018, the Company sold its Language Solutions business, which helped companies adapt their business content into different languages for specific countries, markets and regions, for net proceeds of $77.5 million in cash, all of which was received as of December 31, 2018, resulting in a gain of $53.8 million, which was recognized in other operating income in the consolidated statement of operations for the year ended December 31, 2018. Language Solutions' operating results were included within the Language Solutions reporting unit within the U.S. segment as well as the International segment.

Note 5. Restructuring, Impairment and Other Charges

Restructuring, Impairment and Other Charges recognized in Results of Operations

2018	Employee Terminations	Other Restructuring Charges	Total Restructuring Charges	Other Charges	Total
U.S.	$ 1.0	$ 0.8	$ 1.8	$ 0.2	$ 2.0
International	1.8	—	1.8	—	1.8
Corporate	0.6	—	0.6	—	0.6
Total	$ 3.4	$ 0.8	$ 4.2	$ 0.2	$ 4.4

For the year ended December 31, 2018, the Company recorded net restructuring charges of $3.4 million for employee termination costs for 89 employees, substantially all of whom were terminated as of December 31, 2018. These charges primarily related to the reorganization of certain operations and certain administrative functions. During the year ended December 31, 2018, the Company also incurred $0.8 million of net lease termination and other restructuring costs and $0.2 million for other charges associated with the Company's decision to withdraw in 2013 from certain-multi-employer pension plans serving facilities that continued to operate.

2017	Employee Terminations	Other Restructuring Charges	Total Restructuring Charges	Impairment	Other Charges	Total
U.S.	$ 3.3	$ 0.2	$ 3.5	$ 0.2	$ 0.2	$ 3.9
International	2.1	0.1	2.2	—	—	2.2
Corporate	1.0	—	1.0	—	—	1.0
Total	$ 6.4	$ 0.3	$ 6.7	$ 0.2	$ 0.2	$ 7.1

For the year ended December 31, 2017, the Company recorded net restructuring charges of $6.4 million for employee termination costs for 192 employees, all of whom were terminated as of December 31, 2018. These charges primarily related to the reorganization of certain operations and certain administrative functions. During the year ended December 21, 2017, the Company also incurred $0.3 million of net lease termination and other restructuring costs, $0.2 million of net impairment charges related to leasehold improvements associated with facility closures and $0.2 million for other charges associated with the Company's decision to withdraw in 2013 from certain-multi-employer pension plans serving facilities that continued to operate.

2016	Employee Terminations	Other Restructuring Charges	Total Restructuring Charges	Other Charges	Total
U.S.	$ 3.0	$ 1.5	$ 4.5	$ 0.2	$ 4.7
International	0.6	—	0.6	—	0.6
Corporate	0.1	—	0.1	—	0.1
Total	$ 3.7	$ 1.5	$ 5.2	$ 0.2	$ 5.4

For the year ended December 31, 2016, the Company recorded net restructuring charges of $3.7 million for employee termination costs for 84 employees, all of whom were terminated as of December 31, 2017. These charges primarily related to the reorganization of certain administrative functions. Additionally, the Company incurred lease termination and other restructuring charges of $1.5 million for the year ended December 31, 2016.

Restructuring Reserve

The restructuring reserve as of December 31, 2018 and 2017, and changes during the year ended December 31, 2018, were as follows:

	December 31, 2017	Restructuring Charges	Reversals	Foreign Exchange and Other	Cash Paid	December 31, 2018
Employee terminations	$ 1.3	$ 3.6	$ (0.2)	$ —	$ (4.3)	$ 0.4
Lease terminations and other	2.1	0.8	—	—	(1.6)	1.3
Total	$ 3.4	$ 4.4	$ (0.2)	$ —	$ (5.9)	$ 1.7

The current portion of restructuring reserves of $1.4 million at December 31, 2018 was included in accrued liabilities, while the long-term portion of $0.3 million, primarily related to lease termination costs, was included in other noncurrent liabilities at December 31, 2018.

The Company anticipates that payments associated with the employee terminations reflected in the above table will be substantially completed by June 30, 2019.

The restructuring liabilities classified as “lease terminations and other” consisted of lease terminations, other facility closing costs and contract termination costs. Payments on certain of the lease obligations are scheduled to continue until 2021. Market conditions and the Company’s ability to sublease these properties could affect the ultimate charges related to the lease obligations. Any potential recoveries or additional charges could affect amounts reported in the Company’s financial statements.

The restructuring reserve as of December 31, 2017 and 2016, and changes during the year ended December 31, 2017, were as follows:

	December 31, 2016	Restructuring Charges	Reversals	Foreign Exchange and Other	Cash Paid	December 31, 2017
Employee terminations	$ 1.6	$ 6.5	$ (0.1)	$ —	$ (6.7)	$ 1.3
Lease terminations and other	3.8	3.7	(3.4)	0.3	(2.3)	2.1
Total	$ 5.4	$ 10.2	$ (3.5)	$ 0.3	$ (9.0)	$ 3.4

The current portion of restructuring reserves of $2.7 million at December 31, 2017 was included in accrued liabilities, while the long-term portion of $0.7 million, primarily related to lease termination costs, was included in other noncurrent liabilities at December 31, 2017.

Note 6. Goodwill and Other Intangible Assets

The changes in the carrying amount of goodwill by segment for the years ended December 31, 2018 and 2017 were as follows:

	U.S.	International	Total
Net book value as of January 1, 2017	$ 429.2	$ 17.2	$ 446.4
Foreign exchange and other adjustments	—	1.0	1.0
Net book value as of December 31, 2017	429.2	18.2	447.4
Acquisition	12.8	—	12.8
Disposition	(3.5)	(5.8)	(9.3)
Foreign exchange and other adjustments	—	(0.9)	(0.9)
Net book value as of December 31, 2018	$ 438.5	$ 11.5	$ 450.0

The components of other intangible assets at December 31, 2018 and 2017 were as follows:

	December 31, 2018			December 31, 2017		
	Gross Carrying Amount	Accumulated Amortization	Net Book Value	Gross Carrying Amount	Accumulated Amortization	Net Book Value
Customer relationships	$ 149.3	$ (113.1)	$ 36.2	$ 140.6	$ (100.7)	$ 39.9
Trade names	3.9	(2.9)	1.0	2.9	(2.9)	—
Total other intangible assets	$ 153.2	$ (116.0)	$ 37.2	$ 143.5	$ (103.6)	$ 39.9

During the year ended December 31, 2018, the Company recorded the following additions to other intangible assets:

	December 31, 2018	
	Amount	Amortization Period
Customer relationships	$ 10.4	15.0
Trade name	1.0	5.0
Total	$ 11.4	

Amortization expense for other intangible assets was $13.7 million, $15.0 million and $14.4 million for the years ended December 31, 2018, 2017 and 2016, respectively.

The following table outlines the estimated annual amortization expense related to other intangible assets as of December 31, 2018:

For the year ending December 31,	Amount
2019	$ 14.6
2020	13.0
2021	0.9
2022	0.9
2023	0.9
2024 and thereafter	6.9
Total	$ 37.2

Note 7. Accounts Receivable

Transactions affecting the allowances for doubtful accounts receivable during the years ended December 31, 2018, 2017 and 2016 were as follows:

	2018	2017	2016
Balance, beginning of year	$ 7.3	$ 6.4	$ 4.6
Provisions charged to expense	4.9	3.9	3.1
Write-offs and other	(4.3)	(3.0)	(1.3)
Balance, end of year	$ 7.9	$ 7.3	$ 6.4

Note 8. Inventories

The components of the Company's inventories, net of excess and obsolescence reserves for raw materials and finished goods, at December 31, 2018 and 2017 were as follows:

	2018	2017
Raw materials and manufacturing supplies	$ 4.0	$ 3.3
Work in process	8.1	13.7
Finished goods	—	6.3
Total	$ 12.1	$ 23.3

Note 9. Property, Plant and Equipment

The components of the Company's property, plant and equipment at December 31, 2018 and 2017 were as follows:

	2018	2017
Land	$ 10.0	$ 10.0
Buildings	36.2	36.1
Machinery and equipment	106.3	104.0
	152.5	150.1
Less: Accumulated depreciation	(120.3)	(115.4)
Total	$ 32.2	$ 34.7

During the years ended December 31, 2018, 2017 and 2016, depreciation expense was $7.5 million, $7.0 million and $8.4 million, respectively.

Note 10. Investments

In January 2016, the FASB issued ASU 2016-01, which requires that investments in equity securities, except those accounted for under the equity method of accounting or those that result in consolidation, to be measured at fair value with changes in fair value recognized in net income. The Company adopted ASU 2016-01 on January 1, 2018. Upon adoption of ASU 2016-01, there was no material impact on the Company's consolidated financial position, results of operations or cash flows.

The carrying value of the Company's equity investments within the scope of ASU 2016-01 was $22.1 million and $14.9 million as of December 31, 2018 and December 31, 2017, respectively. The Company measures its equity investments that do not have a readily determinable fair value, at cost minus impairment, if any, plus or minus changes resulting from observable price changes in orderly transactions for the identical or a similar investment of the same issuer. The Company performs an assessment on a quarterly basis to determine whether triggering events for impairment exist and to identify any observable price changes.

The following table summarizes realized and unrealized gains and losses on equity investments recognized in investment and other income in the consolidated statements of operations during the year ended December 31, 2018:

	Year ended December 31, 2018
Net gain on equity securities	$ 11.8
Less: net gain recognized on equity securities sold	(2.4)
Unrealized net gain recognized on equity securities still held at the reporting date	$ 9.4

Refer to Note 4, *Acquisitions and Dispositions* , for further details regarding the determination of the fair value of the Company's previously held investment in eBrevia.

Note 11. Accrued Liabilities

The components of the Company's accrued liabilities at December 31, 2018 and 2017 were as follows:

	2018	2017
Employee-related liabilities	$ 63.3	$ 68.9
Customer-related liabilities	16.1	22.9
Income taxes payable	12.4	1.6
Accrued interest payable	5.8	6.4
Restructuring liabilities	1.4	2.7
Other	27.0	16.7
Total accrued liabilities	$ 126.0	$ 119.2

Employee-related liabilities consist primarily of sales commission, incentive compensation, employee benefit accruals and payroll. Customer-related liabilities consist primarily of deferred revenue and progress billings and volume discount accruals. Other accrued liabilities include miscellaneous operating accruals and other tax liabilities.

Note 12. Commitments and Contingencies

As of December 31, 2018, the Company had commitments of approximately $5.0 million for the purchase of property, plant and equipment related to an incomplete project. In addition, as of December 31, 2018, the Company had commitments of approximately $38.1 million for outsourced services, professional, maintenance and other services and $4.6 million of miscellaneous other obligations. The Company also has contractual commitments of $0.4 million for severance payments related to employee restructuring activities.

Future minimum rental commitments under operating leases are as follows:

Year Ended December 31	Amount
2019	$ 26.4
2020	22.6
2021	16.6
2022	10.9
2023	8.7
2024 and thereafter	16.3
	$ 101.5

The Company has operating lease commitments, including those for vacated facilities, totaling $101.5 million extending through various periods to 2026. Lease terms for some locations provide for rent escalations and renewal options, with some leases requiring payment for taxes, insurance and maintenance. Escalation terms and renewal options vary by market and lease. Future rental commitments for leases have not been reduced by minimum non-cancelable sublease rentals aggregating approximately $28.5 million. The Company remains secondarily liable under these leases in the event that the sub-lessee defaults under the sublease terms. The Company does not believe that material payments will be required as a result of the secondary liability provisions of the primary lease agreements.

Rent expense for facilities in use and equipment was $25.1 million, $27.4 million and $23.8 million for the years ended December 31, 2018, 2017 and 2016, respectively. Rent expense for vacated facilities was recognized as restructuring, impairment and other charges. See Note 5 , *Restructuring, Impairment and Other Charges,* for further details.

Litigation

From time to time, the Company's customers and others file voluntary petitions for reorganization under United States bankruptcy laws. In such cases, certain pre-petition payments received by the Company from these parties could be considered preference items and subject to return. In addition, the Company may be party to certain litigation arising in the ordinary course of business. Management believes that the final resolution of these preference items and litigation will not have a material effect on the Company's consolidated results of operations, financial position or cash flows.

Note 13. Retirement Plans

DFIN's Participation in RRD's Pension and Postretirement Benefit Plans

RRD provided pension and other postretirement healthcare benefits to certain current and former employees of DFIN. DFIN's consolidated and combined statements of operations include expense allocations for these benefits. These allocations were funded through intercompany transactions with RRD which are reflected within net parent company investment in DFIN. Total RRD pension and postretirement benefit plan net income allocated to DFIN, related to pension cost and postretirement benefits was $4.2 million in the year ended December 31, 2016. Included in this amount is an allocation for other postretirement benefit plans for $1.0 million in the year ended December 31, 2016. This allocation is reflected in the Company's selling, general and administrative expenses.

DFIN's Pension and Postretirement Benefit Plans

On October 1, 2016, DFIN recorded net pension plan liabilities of $68.3 million (consisting of a total benefit plan liability of $317.0 million, net of plan assets having fair market value of $248.7 million), as a result of the transfer of certain pension plan liabilities and assets from RRD to the Company upon the legal split of those plans. The pension plan asset allocation from RRD was finalized on June 30, 2017, which resulted in a $0.7 million decrease to the fair value of plan assets transferred to the Company from RRD. The Company also recorded a net other postretirement benefit liability of $1.5 million, as a result of the transfer of an other postretirement benefit plan from RRD to the Company.

The Company's primary defined benefit plan is frozen. No new employees are permitted to enter the Company's frozen plan and participants will earn no additional benefits. Benefits are generally based upon years of service and compensation. These defined benefit retirement income plans are funded in conformity with the applicable government regulations. The Company funds at least the minimum amount required for all funded plans using actuarial cost methods and assumptions acceptable under government regulations.

The annual income and expense amounts relating to the pension plan are based on calculations which include various actuarial assumptions including, mortality expectations, discount rates and expected long-term rates of return. The Company reviews its actuarial assumptions on an annual basis as of December 31 (or more frequently if a significant event requiring remeasurement occurs) and modifies the assumptions based on current rates and trends when it is appropriate to do so. The effects of modifications are recognized immediately on the consolidated balance sheets, but are amortized into operating earnings over future periods, with the deferred amount recorded in accumulated other comprehensive loss. Total pension income was $3.2 million, $3.3 million and $1.0 million in 2018, 2017 and 2016, respectively.

During the first quarter of 2018, the Company adopted Accounting Standards Update No. 2017-07 "Compensation—Retirement Benefits (Topic 715): Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost" ("ASU 2017-07"), which requires an employer to report the service cost component of net periodic benefit cost in the same line item(s) as other employee compensation costs arising from services rendered during the period. The other components of net periodic benefit cost are presented in the income statement separately from the line item(s) that includes the service cost and outside of any subtotal of operating income. ASU 2017-07 was adopted on a retrospective basis. The adoption of ASU 2017-07 resulted in the presentation of net pension income within investment and other income in the consolidated statement of operations instead of selling, general and administrative expenses. Prior period net pension income was also reclassified.

During the year ended December 31, 2014, the Company adopted the Society of Actuaries RP-2014 mortality tables which were used in the calculation of the Company's U.S. pension obligations. The new mortality tables increased the expected life of plan participants, extending the length of time that payments may be required and increasing the plans' total expected benefit payments. During the years ended December 31, 2016, and December 31, 2017, the Company adopted updates to the Society of Actuaries RP-2014 mortality tables. The 2016 and 2017 mortality table updates both resulted in a partial reversal of the 2014 increases in the expected life of plan participants and benefit obligations.

The Company made cash contributions of $1.8 million and $0.1 million to its pension and other postretirement benefit plans, respectively, during the year ended December 31, 2018. The Company expects to make cash contributions of approximately $1.2 million and $0.1 million to its pension and other postretirement benefit plans, respectively, in 2019.

The pension plan obligations are calculated using generally accepted actuarial methods and are measured as of December 31. Actuarial gains and losses for frozen plans are amortized using the corridor method over the average remaining expected life of active plan participants.

The components of the estimated net pension plan income for DFIN's pension plans for the years ended December 31, 2018, 2017 and 2016 were as follows:

	Pension Benefits		
	2018	2017	2016
Interest cost	$ 10.3	$ 10.6	$ 2.4
Expected return on plan assets	(16.0)	(16.0)	(4.1)
Amortization of actuarial loss	2.5	2.1	0.7
Net periodic benefit income	$ (3.2)	$ (3.3)	$ (1.0)
Weighted average assumption used to calculate net periodic benefit expense:			
Discount rate	3.7%	4.2%	3.7%
Expected return on plan assets	6.8%	7.0%	7.3%

Reconciliation of funded status

	Pension Benefits		Other Postretirement Benefits	
	2018	2017	2018	2017
Benefit obligation at beginning of year	$ 309.9	$ 293.3	$ 1.2	$ 1.2
Interest cost	10.3	10.6	—	—
Actuarial (gain) loss	(25.8)	22.9	—	—
Foreign currency translation	—	—	(0.1)	0.1
Benefits paid	(14.0)	(16.9)	(0.1)	(0.1)
Benefit obligation at end of year	$ 280.4	$ 309.9	$ 1.0	$ 1.2
Fair value of plan assets at beginning of year	$ 256.4	$ 235.8	$ —	$ —
Actual return on assets	(15.3)	36.1	—	—
Employer contributions	1.8	2.1	0.1	0.1
Plan transfer	—	(0.7)	—	—
Benefits paid	(14.0)	(16.9)	(0.1)	(0.1)
Fair value of plan assets at end of year	$ 228.9	$ 256.4	$ —	$ —
Funded status at end of year	$ (51.5)	$ (53.5)	$ (1.0)	$ (1.2)

The accumulated benefit obligation for all defined benefit pension and other postretirement benefit plans was $281.4 million and $311.1 million at December 31, 2018 and 2017, respectively.

	Pension Benefits		Other Postretirement Benefits	
	2018	2017	2018	2017
Accrued benefit cost (included in accrued liabilities)	$ (1.2)	$ (2.2)	$ —	$ —
Pension and other postretirement benefits plan liabilities	(50.3)	(51.3)	(1.0)	(1.2)
Net liabilities recognized in the Consolidated Balance Sheets	$ (51.5)	$ (53.5)	$ (1.0)	$ (1.2)

The amounts included in accumulated other comprehensive loss in the Consolidated Balance Sheets excluding tax effects, that have not been recognized as components of net periodic cost at December 31, 2018 and 2017 were as follows:

	Pension Benefits		Other Postretirement Benefits	
	2018	2017	2018	2017
Accumulated other comprehensive (loss) income				
Net actuarial (loss) gain	$ (90.7)	$ (87.6)	$ 0.1	$ 0.1
Total	$ (90.7)	$ (87.6)	$ 0.1	$ 0.1

The pre-tax amounts recognized in other comprehensive income (loss) in 2018, 2017, and 2016 as components of net periodic costs were as follows:

	Pension Benefits		
	2018	2017	2016
Amortization of:			
Net actuarial loss	$ 2.5	$ 2.1	$ 0.7
Amounts arising during the period:			
Net actuarial loss	(5.6)	(2.7)	10.9
Total	$ (3.1)	$ (0.6)	$ 11.6

Actuarial gains and losses in excess of 10.0% of the greater of the projected benefit obligation or the market-related value of plan assets were recognized as a component of net periodic benefit costs over the average remaining service period of a plan's active employees. As a result of the plan freezes, the actuarial gains and losses are recognized as a component of net periodic benefit costs over the average remaining life of a plan's active employees. The amounts in accumulated other comprehensive loss that are expected to be recognized as components of net periodic benefit costs in 2019 are shown below:

	Pension Benefits
Amortization of:	
Net actuarial loss	$ 1.7
Total	$ 1.7

The weighted average assumptions used to determine the benefit obligation at the measurement date were as follows:

	Pension Benefits		Other Postretirement Benefits	
	2018	2017	2018	2017
Discount rate	4.4%	3.7%	3.5%	3.3%

The following table provides a summary of under-funded or unfunded pension benefit plans with projected benefit obligations in excess of plan assets as of December 31, 2018 and 2017:

	Pension Benefits	
	2018	2017
Projected benefit obligation	$ 280.4	$ 309.9
Fair value of plan assets	228.9	256.4

As discussed above, the Company's defined benefit plan is frozen and no new employees are permitted to enter the plan. Participants do not earn additional service benefits. Consequently the projected benefit obligation and accumulated benefit obligation are the same amounts.

Benefit payments are expected to be paid as follows:

	Pension Benefits	Other Postretirement Benefits
2019	$ 16.1	$ 0.1
2020	17.5	0.1
2021	17.4	0.1
2022	18.9	0.1
2023	18.1	0.1
2024-2028	91.8	0.4

Plan Assets

The Company's U.S. pension plans are frozen and the Company has a risk management approach for its U.S. pension plan assets. The overall investment objective of this approach is to reduce the risk of significant decreases in the plan's funded status by allocating a larger portion of the plan's assets to investments expected to hedge the impact of interest rate risks on the plan's obligation. The expected long-term rate of return for plan assets is based upon many factors including asset allocations, historical asset returns, current and expected future market conditions, risk and active management premiums. The target asset allocation percentage as of December 31, 2018, for the primary U.S. pension plan was approximately 50.0% for return seeking investments and approximately 50.0% for fixed income investments.

The Company segregated its plan assets by the following major categories and levels for determining their fair value as of 201 8 :

Cash and cash equivalents— Carrying value approximates fair value. As such, these assets were classified as Level 1. The Company also invests in certain short-term investments which are valued using the amortized cost method. As such, these assets were classified as Level 2.

Equity— The values of individual equity securities were based on quoted prices in active markets. As such, these assets are classified as Level 1.

Fixed income— Fixed income securities are typically priced based on a valuation model rather than a last trade basis and are not exchange-traded. These valuation models involve utilizing dealer quotes, analyzing market information, estimating prepayment speeds and evaluating underlying collateral. Accordingly, the Company classified these fixed income securities as Level 2. Fixed income securities also include investments in various asset-backed securities that are part of a government sponsored program. The prices of these asset-backed securities were obtained by independent third parties using multi-dimensional, collateral specific prepayments tables. Inputs include monthly payment information and collateral performance. As the values of these assets was determined based on models incorporating observable inputs, these assets were classified as Level 2.

Real estate funds— Real estate fund assets are valued by third-party appraisers utilizing valuation approaches based upon current cost to reproduce, discounted cash flows or relative sales value of comparable properties. Key inputs and assumptions used to determine fair value include rental revenue and expenses, revenue and expense growth rates, terminal capitalization rates and discount rates. As the value of these assets was determined based on observable inputs obtained by third parties, the Company classified these assets as Level 2.

The Company invests in certain funds that are valued at calculated net asset value per share ("NAV"), but are not quoted on active markets. The Company believes that the NAV is representative of fair value at the reporting date, as there are no significant restrictions on redemption of these investments or other reasons to indicate that the investment would be redeemed at an amount different than the NAV.

For Level 2 plan assets, management reviews significant investments on a quarterly basis including investigation of unusual fluctuations in price or returns and obtaining an understanding of the pricing methodology to assess the reliability of third-party pricing estimates.

The valuation methodologies described above may generate a fair value calculation that may not be indicative of net realizable value or future fair values. While the Company believes the valuation methodologies used are appropriate, the use of different methodologies or assumptions in calculating fair value could result in different amounts.

The fair values of the Company's pension plan assets at December 31, 2018 and 2017, by asset category were as follows:

	December 31, 2018		
Asset Category	**Total**	**Level 1**	**Level 2**
Cash and cash equivalents	$ 1.5	$ 1.2	$ 0.3
Real estate funds	9.5	—	9.5
Assets measured at NAV	217.9	—	—
Total	$ 228.9	$ 1.2	$ 9.8

	December 31, 2017		
Asset Category	**Total**	**Level 1**	**Level 2**
Cash and cash equivalents	$ 7.0	$ 3.2	$ 3.8
Equity	63.5	63.5	—
Fixed income	87.1	—	87.1
Assets measured at NAV	98.8	—	—
Total	$ 256.4	$ 66.7	$ 90.9

Employer 401(k) Savings Plan — For the benefit of most of its U.S. employees, the Company maintains a defined contribution retirement savings plan (401(k)) that is intended to be qualified under Section 401(a) of the Internal Revenue

Code. Under this plan, employees may contribute a percentage of eligible compensation on both a before-tax and after-tax basis. The Company provided a 401(k) discretionary match to participants in 201 8 and 201 7 , payable to participants' accounts in the first quarter of 201 9 and in the first quarter of 201 8 , respectively . The total expense attributable to the match was $ *1.1* million and $ 3.4 million for the year s ended December 31, 2018 and 2017, respectively . The Company did no t provide a 401(k) discretionary match to participants in 2016 .

Multi-Employer Pension Plans — The Company no longer participates in any active defined benefit multi-employer pension plans. During each of the years ended December 31, 2018, 2017 and 2016, the Company incurred additional charges of $0.2 million related to its complete withdrawal from one multi-employer pension plan in 2013. These charges were recorded as restructuring, impairment and other charges and represent the Company's best estimate of the expected settlement of these withdrawal liabilities. See Note 5, *Restructuring, Impairment and Other Charges,* to the consolidated and combined financial statements for further details of charges related to complete multi-employer pension plan withdrawal liabilities recognized in the consolidated and combined statements of operations.

Note 14. Income Taxes

For periods prior to the Separation, income tax expense and deferred tax balances were calculated on a separate tax return basis although the Company's operations in certain circumstances, particularly the U.S. and Canada, have historically been included in the tax returns filed by the respective RRD entities of which the Company's business was a part. Beginning October 1, 2016, as a stand-alone entity, the Company files tax returns on its own behalf and its deferred taxes and effective tax rate may differ from those in the historical periods.

The Company maintains an income taxes payable or receivable account in each jurisdiction and with the exception of certain entities outside the U.S. that transferred to the Company at Separation, the Company is deemed to settle current tax balances for the period prior to the Separation with the RRD tax-paying entities in the respective jurisdictions. These settlements are reflected as changes in net parent company investment in the consolidated and combined balance sheets.

Income taxes have been based on the following components of earnings from operations before income taxes for the years ended December 31, 2018, 2017 and 2016:

	2018	2017	2016
U.S.	$ 69.3	$ 49.1	$ 84.9
Foreign	33.4	7.1	9.4
Total	$ 102.7	$ 56.2	$ 94.3

The components of income tax expense (benefit) from operations for the years ended December 31, 2018 , 201 7 and 201 6 were as follows:

	2018	2017	2016
Current:			
U.S. Federal	$ 6.9	$ 12.5	$ 28.6
U.S. State and Local	5.3	5.1	9.0
Foreign	6.3	3.4	3.5
Current income tax expense	18.5	21.0	41.1
Non-Current:			
U.S. Federal	0.1	12.5	—
U.S. State and Local	—	0.6	—
Non-current income tax expense	0.1	13.1	—
Deferred:			
U.S. Federal	6.8	13.3	(3.1)
U.S. State and Local	2.9	(0.1)	(0.4)
Foreign	0.8	(0.8)	(2.4)
Deferred income tax expense (benefit)	10.5	12.4	(5.9)
Total	$ 29.1	$ 46.5	$ 35.2

The following table outlines the reconciliation of differences between the U.S. Federal statutory tax rate and the Company's worldwide effective income tax rate:

	2018	2017	2016
Federal statutory tax rate	21.0%	35.0%	35.0%
State and local income taxes, net of U.S. federal income tax benefit	6.5	5.7	5.9
Global intangible low-taxed income provision	2.0	—	—
Non-deductible expenses	1.9	3.6	—
Foreign tax rate differential	1.1	(1.3)	(0.7)
Changes in valuation allowances	0.5	0.5	(1.9)
Adjustment of uncertain tax positions and interest	0.2	(0.4)	0.6
Federal and state transition tax on foreign earnings	0.1	25.3	—
Domestic manufacturing deduction	—	(0.7)	(1.3)
Tax exempt income and expense	(2.9)	—	—
Tax Act revaluation of U.S. net deferred tax assets	(2.2)	14.8	—
Credits and incentives	(1.3)	—	—
Other	1.4	0.2	(0.3)
Effective income tax rate	28.3%	82.7%	37.3%

The 2018 effective income tax rate is lower as compared to the 2017 effective income tax rate mainly due to impacts of the changes to U.S. tax legislation as a result of the enactment of the Tax Cuts and Jobs Act (H.R. 1) ("the Tax Act") on December 22, 2017. The 2018 effective income tax rate was impacted by the global intangible low-taxed income ("GILTI") provision, non-deductible expenses and also reflects the tax impact of the sale of the Language Solutions business. Along with the effects of the Tax Act, the 2017 effective income tax rate was impacted by non-deductible expenses incurred by the Company in 2017 which were previously incurred by RRD on behalf of the Company during pre-Separation periods.

The 2017 effective income tax rate is higher as compared to the 2016 effective income tax rate mainly due to the impact of the Tax Act. The 2017 effective income tax rate was also impacted by non-deductible expenses incurred by the Company in 2017 which were previously incurred by RRD on behalf of the Company during pre-Separation periods, as well as a one-time favorable change in valuation allowances in 2016 not present in 2017.

On December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118 ("SAB 118"), which provided guidance on accounting for the tax effects of the Tax Act. SAB 118 provided a measurement period of one year from the Tax Act enactment date for companies to complete their accounting. In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the Act for which the accounting is complete. To the extent that a company's accounting for certain income tax effects of the Tax Act is incomplete but it is able to determine a reasonable estimate, it must record a provisional estimate in the financial statements. If a company cannot determine a provisional estimate to be included in the financial statements, it should continue to apply its accounting on the basis of the provisions of the tax laws that were in effect immediately before the enactment of the Tax Act. Due to the timing of the enactment and the complexity involved in applying the provisions of the Tax Act, the Company made reasonable estimates of the tax effects and recorded provisional amounts in its consolidated financial statements for the year ended December 31, 2017.

As a result of the reduction in the U.S. corporate income tax rate from 35% to 21% effective January 1, 2018, the Company revalued its U.S. deferred tax assets and liabilities as of December 31, 2017. The Company recorded a reduction in the value of its net U.S. deferred tax asset of approximately $8.2 million, which was recorded as additional deferred income tax expense in the Company's consolidated statement of operations for the year ended December 31, 2017. Due to the transition to a territorial tax system under the Tax Act, the Company will be deemed to repatriate its foreign subsidiaries' untaxed accumulated earnings and pay a mandatory U.S. federal tax ("the transition tax") of 15.5% on the portion of the earnings that are in cash and cash equivalents and 8.0% on the portion of earnings that are in non-cash and non-cash equivalent assets. The Company estimated this tax liability (federal and state) to be approximately $14.2 million which was recorded as income tax expense in the consolidated statement of operations for the year ended December 31, 2017. In accordance with SAB 118, the impact of the revaluation of deferred tax assets ($8.2 million) and the transition tax ($14.2 million) were recorded in the Company's financial statements for the year ended December 31, 2017 as provisional amounts as the Company was able to reasonably estimate the impact of these items. During the year ended December 31, 2018, the Company recorded a $0.1 million increase to the deemed repatriation tax liability and a $2.2 million benefit related to the revaluation of deferred tax assets and liabilities. The adjustments were the result of the Company's completion of the analysis of the impact of the Tax Act including changes in interpretations and assumptions that the Company previously made for the prior year provisional estimates as well as the impact from additional regulatory guidance issued. During the year ended December 31, 2018, the Company also updated its indefinite reinvestment assertion in accordance with SAB 118. There was no financial impact related to the Company's indefinite reinvestment assertion update. As of December 31, 2018, the Company's analysis for the income tax effect of the Tax Act was completed.

As available under the Tax Act, the Company made an election to pay the transition tax liability in installments over eight years. However, since the Company was in a tax overpayment position on its 2017 tax return, the Department of the U.S. Treasury Internal Revenue Service ("IRS") satisfied the full transition tax liability by reducing the overpayment carried forward into the 2018 tax return. Consequently, there is no transition tax payable recorded in the Company's consolidated balance sheet as of December 31, 2018. The Company recorded $13.1 million of this liability as noncurrent taxes payable and $1.1 million as current taxes payable in the Company's consolidated balance sheet as of December 31, 2017.

Along with the change to a territorial tax system, the Tax Act created the GILTI provision. The GILTI provision imposes a tax on foreign income in excess of a deemed return on tangible assets of foreign subsidiary corporations. The Company is subject to the GILTI tax for the year ended December 31, 2018. The determination of whether the Company is subject to the GILTI provision will be an annual analysis of several factors under the provision, including the amount of foreign income generated by the Company's foreign subsidiaries and whether the Company has income subject to the GILTI tax, which may change from year to year. In January 2018, the Financial Accounting Standards Board ("FASB") released guidance on the accounting for GILTI tax, which allows an accounting policy election for companies to either account for deferred taxes related to GILTI inclusions or to treat any taxes on GILTI inclusions as period costs. The Company has adopted the accounting policy to treat taxes on GILTI inclusions as period costs.

Deferred income taxes

The significant deferred tax assets and liabilities at December 31, 2018 and 2017 were as follows:

	2018	2017
Deferred tax assets:		
Pension and other postretirement benefit plans liabilities	$ 15.1	$ 15.9
Net operating losses and other tax carryforwards	9.1	10.1
Accrued liabilities	12.2	11.9
Share-based compensation	3.0	2.9
Allowance for doubtful accounts	2.2	2.5
Interest	1.4	—
Other	0.9	1.2
Total deferred tax assets	43.9	44.5
Valuation allowances	(2.1)	(1.5)
Total deferred tax assets	$ 41.8	$ 43.0
Deferred tax liabilities:		
Accelerated depreciation	$ (12.3)	$ (6.8)
Other intangible assets	(12.6)	(12.8)
Investments	(3.1)	—
Prepaid assets	(1.4)	—
Lease obligations	(1.3)	—
Other	(1.6)	(1.6)
Total deferred tax liabilities	(32.3)	(21.2)
Net deferred tax assets	$ 9.5	$ 21.8

The amounts above are included in the Consolidated Balance Sheets as either a net asset or liability on a jurisdiction by jurisdiction basis.

Transactions affecting the valuation allowances on deferred tax assets during the years ended December 31, 2018, 2017 and 2016 were as follows:

	2018	2017	2016
Balance, beginning of year	$ 1.5	$ 1.2	$ 4.9
Current year expense (benefit)-net	0.7	0.3	(1.5)
Write-offs	—	—	(2.3)
Foreign exchange and other	(0.1)	—	0.1
Balance, end of year	$ 2.1	$ 1.5	$ 1.2

As of December 31, 2018, the Company had domestic and foreign net operating loss deferred tax assets of approximately $9.1 million ($10.1 million at December 31, 2017), of which $1.8 million expires between 2019 and 2027. Limitations on the utilization of these deferred tax assets may apply. The Company has provided valuation allowances to reduce the carrying value of certain deferred tax assets, as management has concluded that, based on the weight of available evidence, it is more likely than not that the deferred tax assets will not be fully realized.

Earnings generated by a foreign subsidiary are presumed to ultimately be transferred to the parent company. Therefore, the establishment of deferred taxes may be required with respect to the excess of the investment value for financial reporting over the tax basis of investments in those foreign subsidiaries (also referred to as book-over-tax outside basis differences). A company may overcome this presumption and forgo recording a deferred tax liability in its financial statements if it can assert that management has the intent and ability to indefinitely reinvest the earnings of its foreign subsidiaries. Prior to the year ended December 31, 201 7 , the Company has not provided deferred U.S., foreign or local income taxes on the book-over-tax outside basis differences of its foreign subsidiaries because such excess has been considered to be indefinitely reinvested in the local country businesses. As a result of the transition tax incurred pursuant to the Tax Act, the Company now has the ability to repatriate any previously taxed foreign cash associated with the foreign earnings subject ed to U.S. tax to the U.S. parent with minimal additional tax consequences. The Company intends to repatriate earnings up to its net earnings previously subject to U.S. tax. Thus, the Company updated its assertion in 2018 related to indefinite reinvestment on all foreign earnings and other outside basis differences to indicate that the Company remains indefinitely reinvested in operations outside of the U.S. with the exception of the previously taxed foreign cash already subject to U.S. tax . The Company continues to analyz e its global working capital and cash requirements to determine the amount of excess cash at its foreign subsidiaries that can be repatriated to the U.S. with minimal additional taxes. T he Company has not yet completed its gl obal capital structure analysis. As such, the Company has not recorded deferred taxes attributable to the book-over-tax outside basis differences in its foreign subsidiaries as of December 31, 2018. The Company will record the tax effects related to repatriating any previously taxed foreign cash in the period when the Company begins repatriating this previously taxed foreign cash.

Cash payments for income taxes for U.S. states and foreign jurisdictions were $10.1 million, $30.5 million and $5.2 million in 2018, 2017 and 2016, respectively. In certain jurisdictions, such as the United States and Canada, the Company is deemed to settle tax balances as of October 1, 2016 with RRD within net parent investment. Total amounts settled with RRD were $2.6 million and $37.2 million for 2017 and 2016, respectively. Cash refunds for income taxes were $0.8 million, $1.0 million and $0.7 million in 2018, 2017 and 2016, respectively.

Uncertain tax positions

Changes in the Company's unrecognized tax benefits at December 31, 2018, 2017 and 2016 were as follows:

	2018	2017	2016
Balance at beginning of year	$ 0.3	$ 1.9	$ 1.0
Additions for tax positions of the current year	0.2	—	—
Additions for tax positions of prior years	0.1	—	0.9
Settlements during the year	(0.1)	(1.4)	—
Releases	(0.2)	(0.2)	—
Balance at end of year	$ 0.3	$ 0.3	$ 1.9

As of December 31, 2018, 2017 and 2016, the Company had $0.3 million, $0.3 million and $1.9 million, respectively, of unrecognized tax benefits. Unrecognized tax benefits of $0.3 million as of December 31, 2018, if recognized, would have decreased income taxes and the corresponding effective income tax rate and increased net earnings. This potential impact on net earnings reflects the reduction of these unrecognized tax benefits, net of certain deferred tax assets and the federal tax benefit of state income tax items.

As of December 31, 2018, no portion of the total amount of unrecognized tax benefits is expected to decrease within twelve months due to the resolution of audits or expirations of statutes of limitations related to U.S. federal, state or international tax positions.

The Company classifies interest expense and any penalties related to income tax uncertainties as a component of income tax expense. The total interest expense/(benefit), net of tax benefits, related to tax uncertainties recognized in the Consolidated and Combined Statements of Operations was de minimis for the year ended December 31, 2018 and was ($0.2) million and $0.3 million for the years ended December 31, 2017 and 2016, respectively. There were no benefits from the reversal of accrued penalties for the years ended December 31, 2018, 2017 and 2016. There were no accrued interest liabilities or accrued penalties related to income tax uncertainties at December 31, 2018 and 2017.

The Company has tax years from 2009 that remain open and subject to examination by certain U.S. state taxing authorities and/or certain foreign tax jurisdictions. During 2017, the Company filed its initial U.S. federal income tax return as a separate company for the stub period October 1, 2016 through December 31, 2016. There are no U.S. federal income tax years prior to the stub period ending December 31, 2016 subject to IRS examination. All U.S. federal income tax years including and subsequent to the stub period ending December 31, 2016 remain open and subject to IRS examination.

Note 15. Debt

On September 30, 2016, in connection with the Separation, the Company entered into a Credit Agreement (the “Credit Agreement”) by and among the Company, the lenders party thereto from time to time and JPMorgan Chase Bank, N.A., as administrative agent. The Credit Agreement provides for (i) a new senior secured term loan B facility in an aggregate principal amount of $350.0 million (the “Term Loan Credit Facility”) and (ii) a new first lien senior secured revolving credit facility in an aggregate principal amount of $300.0 million (the “Revolving Facility”, and, together with the Term Loan Credit Facility, the “Credit Facilities”). The Credit Agreement contains a number of covenants, including a minimum Interest Coverage Ratio and a maximum Net Leverage Ratio, as defined in and calculated pursuant to the Credit Agreement, that, in part, restrict the Company’s ability to incur additional indebtedness, create liens, engage in mergers and consolidations, make restricted payments and dispose of certain assets.

Borrowings under the Term Loan Credit Facility were used to provide $340.2 million of cash to RRD, pursuant to the Separation Agreement, as of September 30, 2016. The remainder of the net proceeds was used for general corporate purposes.

Pursuant to t he Separation and Distribution A greement, the Company received a cash payment of $68.0 million from RRD on April 3, 2017. The proceeds were used to reduce outstanding debt under the Term Loan Credit Facility.

On June 21, 2017, RRD completed the sale of approximately 6.1 million shares of the Company’s common stock in an underwritten public offering. Upon the consummation of the offering, RRD retained approximately 0.1 million shares of the Company’s common stock of the offering which were subsequently sold by RRD on August 4, 2017. In conjunction with the underwritten public offering, the underwriters exercised their option to purchase approximately 0.9 million Option Shares. The Company received approximately $18.8 million in net proceeds from the sale of the Option Shares, after deducting estimated underwriting discounts and commissions. The proceeds were used to reduce outstanding debt under the Revolving Facility.

On October 2, 2017, the Company repriced the Term Loan Credit Facility. As a result, the interest rate was reduced by 100 basis points to LIBOR plus 3.0% and the LIBOR floor was reduced by 25 basis points to 0.75%. Additionally, under the first amended Credit Agreement, principal payments are due on a quarterly basis. Other terms, including the outstanding principal, maturity date, and debt covenants such as the minimum Interest Coverage Ratio and the maximum Leverage Ratio are consistent with the original Credit Agreement.

On December 18, 2018, the Company entered into a second amendment to the Credit Agreement which extended the maturity date of the Revolving Facility to December 18, 2023, reduced the interest rate margin percentages and facility fees applicable to the Revolving Facility, increased the allowable annual dividends from $15.0 million to $20.0 million in the aggregate and modified the financial maintenance and negative covenants in the Credit Agreement. As of December 31, 2018, there were no outstanding borrowings under the Revolving Facility.

On September 30, 2016, also in connection with the Separation, the Company issued $300.0 million of 8.25% senior unsecured notes due October 15, 2024 (the "Notes"). Interest on the Notes is payable semi-annually on April 15 and October 15, commencing on April 15, 2017. The issuance of the Notes was part of a debt exchange that resulted in the settlement of certain of RRD's bonds. The Notes were issued pursuant to an indenture where certain wholly-owned domestic subsidiaries of the Company guarantee the Notes (the "Guarantors"). The Notes are jointly and severally guaranteed, on an unsecured basis, by the Guarantors, which are comprised of each of the Company's existing and future direct and indirect wholly-owned U.S. subsidiaries that guarantee the Company's obligations under the Credit Facilities. The Notes are not guaranteed by the Company's foreign subsidiaries or unrestricted subsidiaries. The Notes and the related guarantees will be the Company and the Guarantors', respective, senior unsecured obligations and will rank equally in right of payment to all present and future senior debt, including the obligations under the Company's Credit Facilities, senior in right of payment to all present and future subordinated debt, and effectively subordinated in right of payment to any of the Company and the Guarantors' secured debt, to the extent of the value of the assets securing such debt. The indenture governing the Notes contains certain covenants applicable to the Company and its restricted subsidiaries, including limitations on: (1) liens; (2) indebtedness; (3) mergers, consolidations and acquisitions; (4) sales, transfers and other dispositions of assets; (5) loans and other investments; (6) dividends and other distributions, stock repurchases and redemptions and other restricted payments; (7) restrictions affecting subsidiaries; (8) transactions with affiliates; and (9) designations of unrestricted subsidiaries. Each of these covenants is subject to important exceptions and qualifications.

In connection with the offering of the Notes, the Company entered into a registration rights agreement, dated as of September 30, 2016 (the "Registration Rights Agreement"), pursuant to which the Company agreed to file a registration statement with the SEC with respect to an offer to exchange the Notes for registered notes. In certain circumstances, the Company may be required to file a shelf registration statement with the SEC registering the resale of the Notes by the holders thereof, in lieu of an exchange offer to such holders. On March 10, 2017, the Company filed a Registration Statement on Form S-4 (as amended, the "Exchange Offer Registration Statement") to offer to exchange the Notes for registered notes which have terms identical in all material respects to the Notes except that the registered notes are not subject to transfer restrictions or registration rights. The Exchange Offer Registration Statement was declared effective by the SEC on March 22, 2017. An exchange offer for the Notes was launched on March 22, 2017 and settled on April 25, 2017, resulting in the exchange of $299.9 million aggregate principal amount of outstanding Notes for registered notes.

The Company's debt as of December 31, 2018 and 2017 consisted of the following:

	December 31, 2018	December 31, 2017
8.25% senior notes due October 15, 2024	$ 300.0	$ 300.0
Term Loan Credit Facility	71.3	168.6
Borrowings under the Revolving Facility	—	—
Unamortized debt issuance costs	(8.6)	(10.3)
Total debt	362.7	458.3
Less: current portion	—	—
Long-term debt	$ 362.7	$ 458.3

The fair value of the senior notes, which was determined using the market approach based upon interest rates available to the Company for borrowings with similar terms and maturities, were determined to be Level 2 under the fair value hierarchy. The fair value of the Company's senior notes was $298.1 million and $321.5 million at December 31, 2018 and 2017, respectively.

The weighted average interest rate on borrowings under the Revolving Facility was 5.0% and 4.4% at December 31, 2018 and 2017, respectively.

As of December 31, 2018, the Company had $3.1 million in outstanding letters of credit and bank guarantees, of which none reduced the availability under the Revolving Facility .

At December 31, 2018, the future maturities of debt were as follows:

	Amount
2019	$ —
2020	—
2021	—
2022	—
2023	72.5
2024 and thereafter	300.0
Total [(a)]	$ 372.5

(a) Excludes unamortized debt issuance costs of $8.6 million and a discount of $1.2 million which do not represent contractual commitments with a fixed amount or maturity date.

The following table summarizes interest expense included in the Consolidated and Combined Statements of Operations:

	2018	2017	2016
Interest incurred	$ 37.1	$ 43.5	$ 12.2
Less: interest capitalized as property, plant and equipment	(0.4)	(0.6)	(0.5)
Interest expense, net	$ 36.7	$ 42.9	$ 11.7

Interest paid was $34.6 million, $40.0 million and $4.8 million in 2018, 2017 and 2016, respectively.

Note 16. Earnings per Share

Basic earnings per share is calculated by dividing net earnings by the weighted average number of common shares outstanding for the period. In computing diluted earnings per share, basic earnings per share is adjusted for the assumed issuance of all potentially dilutive share-based awards, including restricted stock units and restricted stock.

On October 1, 2016, RRD distributed approximately 26.2 million shares of DFIN common stock to RRD shareholders in connection with the spin-off of DFIN, with RRD retaining approximately 6.2 million shares of DFIN common stock. Holders of RRD common stock received one share of DFIN for every eight shares of RRD common stock held on September 23, 2016. Basic and diluted earnings per common share and the average number of common shares outstanding were retrospectively restated for the number of DFIN shares outstanding immediately following this transaction. For periods prior to the Separation, basic and diluted earnings per share were calculated using the number of shares distributed and retained by RRD, totaling 32.4 million. The same number of shares was used to calculate basic and diluted earnings per share since there were no DFIN equity awards outstanding prior to the spin-off.

On June 21, 2017, RRD completed the sale of approximately 6.1 million shares of the Company's common stock in an underwritten public offering. Upon consumption of the offering, RRD retained approximately 0.1 million shares of the Company's common stock which were subsequently sold by RRD on August 4, 2017. Refer to Note 1, *Overview and Basis of Presentation* , for further details.

The reconciliation of the numerator and denominator of the basic and diluted earnings per share calculation and the anti-dilutive share-based awards for the years ended December 31, 2018, 2017 and 2016, were as follows.

	2018	2017	2016
Net earnings per share:			
Basic	$ 2.18	$ 0.29	$ 1.81
Diluted	$ 2.16	$ 0.29	$ 1.80
Numerator:			
Net earnings	$ 73.6	$ 9.7	$ 59.1
Denominator:			
Weighted average number of common shares outstanding	33.8	33.1	32.6
Dilutive awards	0.2	0.2	0.2
Diluted weighted average number of common shares outstanding	34.0	33.3	32.8
Weighted average number of anti-dilutive share-based awards:			
Restricted stock units	0.3	0.2	0.2
Stock options	0.6	0.3	0.2
Total	0.9	0.5	0.4

Note 17. Share-Based Compensation

DFIN's Stock and Incentive Programs for Employees and Directors

The Company's share-based compensation plan under which it may grant future awards, the 2016 Donnelley Financial Solutions, Inc. Performance Incentive Plan ("2016 PIP"), was approved by the Board of Directors to provide incentives to key employees of the Company. Awards under the 2016 PIP may include, cash or stock bonuses, stock options, stock appreciation rights, restricted stock or restricted stock units ("RSUs"). In addition, non-employee members of the Board of Directors may receive awards under the 2016 PIP. There were 3.5 million shares of common stock reserved and authorized for issuance under the 2016 PIP. At December 31, 2018, there were 1.0 million shares of common stock authorized and available for grant under the 2016 PIP.

Impact of the Separation from RRD

Prior to the Separation, RRD maintained an incentive stock program for the benefit of its officers, directors and certain employees, including certain DFIN employees. RRD's share-based compensation programs in which DFIN employees participated included RSUs.

In connection with the Separation, as of October 1, 2016, employee stock options and RSUs were adjusted and converted into new equity awards of DFIN, RRD and/or LSC using a 10-day volume weighted average share price of DFIN, RRD and LSC, as described in the Separation and Distribution Agreement. Converted awards retained the same vesting schedule and expiration date of the original awards. All equity awards converted upon Separation were authorized for issuance under the 2016 PIP. In periods following the Separation, the Company records share-based compensation expense for its employees' equity awards that were converted into DFIN, RRD and/or LSC equity awards.

RRD granted RSU awards which cliff vest three years from the grant date. RSU awards are subject to forfeiture upon termination of employment prior to vesting, subject in some cases to early vesting upon specified events, including death or permanent disability of the grantee, termination of the grantee's employment under certain circumstances or a change in control. The Company records compensation expense of RSU awards based on the fair market value of the awards at the date of grant ratably over the period during which the restrictions lapse. Dividends are not paid on RSUs.

Share-based compensation expense

For all share-based awards granted to employees and directors following the Separation, including stock options, RSUs, performance based restricted stock and performance share units ("PSUs"), the Company recognizes compensation expense based on estimated grant date fair values based on certain assumptions as of the grant date. The Company estimates the number of awards expected to vest based, in part, on historical forfeiture rates and also based on management's expectations

of employee turnover within the specific employee groups receiving each type of award. Forfeitures are estimated at the time of grant and revised, if necessary, in subsequent periods, if actual forfeitures differ from those estimates. The Company recognizes compensation costs for RSUs expected to vest, on a straight-line basis over the requisite service period of the award, which is generally the vesting term of three years . Compensation expense for performance based restricted stock awards granted in 2016, which vest on a graded basis, is recognized utilizing a graded vesting schedule. Compensation expense for performance based restricted stock awards granted in 2017, which cliff vest, is recognized on a straight-line basis over the performance period of the award. The Company recognizes compensation costs for PSUs, which cliff vest, on a straight-line basis over the performance period of the award. Compensation expense for stock options is recognized on a straight-line basis over the requisite service period of the award, which is generally the vesting term of four years .

The stock options, RSUs, performance based restricted stock and PSUs granted during 2017 and 2018 are subject to forfeiture upon termination of employment prior to vesting, subject in some cases to early vesting upon specified events, including death or permanent disability of the grantee or a change in control of the Company. In addition, upon a change in control of the Company, performance based restricted stock and PSUs will be measured at 100% attainment of the target performance metrics and will remain subject to time based vesting until the end of the vesting period; provided that the award will vest in full if, within three months prior to or two years after the date of the change in control of the Company, the grantee's employment is terminated without cause by the Company or for good reason by the grantee.

In periods prior to the Separation, share-based compensation expense includes expense attributable to the Company based on the award terms previously granted to the Company's employees and an allocation of compensation expense for RRD's corporate and shared functional employees. As those share-based compensation plans are RRD's plans, the amounts have been recognized through net parent company investment on the combined balance sheets.

Total compensation expense related to all share-based compensation plans was $9.2 million, $6.8 million and $2.5 million for years ended December 31, 2018, 2017 and 2016, respectively. The income tax benefit related to share-based compensation expense was $2.5 million, $3.0 million and $1.0 million for the years ended December 31, 2018, 2017 and 2016, respectively. As of December 31, 2018, $13.1 million of total unrecognized compensation expense related to share-based compensation plans is expected to be recognized over a weighted-average period of 2.0 years.

During the first quarter of 2017, the Company adopted ASU 2016-09, which identifies areas of simplification for several aspects of accounting for share-based payment transactions. The adoption of ASU 2016-09 represents a change in accounting principle. The Company has adopted all applicable aspects of this guidance on a prospective basis.

Stock Options

The Company granted 324,500 options, with a weighted-average grant date fair market value of $5.83, during the year ended December 31, 2018. The Company granted 177,600 options, with a weighted-average grant date fair market value of $7.77, during the year ended December 31, 2017. There were no options granted during the year ended December 31, 2016. The fair market value of each stock option award was estimated using the Black-Scholes-Merton option pricing model and the Company used the following methods to determine its underlying assumptions:

- Expected volatility was estimated based on a weighted-average of historical volatilities for the Company's peer group
- The risk-free interest rate was based on the U.S Treasury yield curve in effect on the date of grant
- The expected term of options granted was based on the simplified method of using the mid-point between the vesting term and the original contractual term
- The expected dividend yield was based on the Company's current dividend rate

The weighted-average assumptions used to determine the weighted-average fair market value of the stock options granted during the years ended December 31, 2018 and December 31, 2017 were as follows:

	2018	2017
Expected volatility	27.75%	30.71%
Risk-free interest rate	2.71%	2.17%
Expected life (years)	6.25	6.25
Expected dividend yield	0.00%	0.00%

Stock option awards outstanding as of December 31, 2017 and December 31, 2018, and changes during the twelve months ended December 31, 2018, were as follows:

	Shares Under Option (thousands)	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (years)	Aggregate Intrinsic Value (millions)
Outstanding at December 31, 2017	459	$ 22.13	5.1	$ 0.8
Granted	324	17.91	9.2	
Exercised	(104)	11.95		
Cancelled/forfeited/expired	(44)	24.92		
Outstanding at December 31, 2018	635	21.44	7.2	—
Vested and expected to vest at December 31, 2018	607	21.54	7.1	—
Exercisable at December 31, 2018	—	N/A	N/A	N/A

The aggregate intrinsic value in the table above represents the total pre-tax intrinsic value (the difference between the Company's closing stock price on December 31, 2018 and December 31, 2017, respectively, and the exercise price, multiplied by the number of in-the-money options) that would have been received by the option holders had all option holders exercised their in-the-money options on December 31, 2018 and December 31, 2017. This amount will change in future periods based on the fair market value of the Company's stock and the number of options outstanding. Total intrinsic value of options exercised was $1.0 million and $0.1 million for the years ended December 31, 2018 and 2017, respectively. There were no excess tax benefits on stock option exercises for the years ended December 31, 2018 and 2017.

Compensation expense related to stock options was $0.7 million and $0.3 million for the years ended December 31, 2018 and 2017, respectively and was de minimis for the year ended December 31, 2016 . As of December 31, 2018, $2.1 million of total unrecognized compensation expense related to stock options is expected to be recognized over a weighted average period of 2.9 years.

Restricted Stock Units

Nonvested restricted stock unit awards as of December 31, 2017 and December 31, 2018, and changes during the twelve months ended December 31, 2018, were as follows:

	Shares (Thousands)	Weighted Average Grant Date Fair Value
Nonvested at December 31, 2017	598	$ 23.48
Granted	456	17.53
Vested	(278)	
Forfeited	(76)	
Nonvested at December 31, 2018	700	$ 19.60

Compensation expense related to RSUs was $5.2 million, $4.1 million and $1.9 million for the years ended December 31, 2018, 2017 and 2016, respectively. As of December 31, 2018, there was $6.8 million of unrecognized share-based compensation expense related to 0.7 million restricted stock unit awards, with a weighted-average grant date fair value of $19.60, that are expected to vest over a weighted-average period of 1.8 years. The fair value of these awards was determined based on the Company's stock price on the grant date, as the Company currently does not anticipate paying any cash dividends in the foreseeable future.

Restricted Stock

There were no restricted stock awards granted during the year ended December 31, 2018. Compensation expense for the restricted stock awards is currently being recognized based on 100% attainment of the targeted performance metrics for the restricted stock awards granted in 2017 and is being recognized based on 100% actual achievement of the performance

metrics for the restricted stock awards granted in 2016. The total potential payout for awards granted during 2017 range from zero to 129,400 shares, should certain performance targets be achieved. The maximum payout of 156,169 shares was achieved as of December 31, 2017 for the restricted stock awards granted during 2016 , of which 50 % vested during the fourth quarter of 2018 . Compensation expense for restricted stock awards was $ 2.0 million, $ 2.2 million , and $ 0.3 million for th e years ended December 31, 2018, 2017 and 2016, respectively. As of December 31, 2018, there was $ 1.2 million of unrecognized compensation expense related to restricted stock awards, which is expected to be recognized over a weighted average period of 1. 0 year .

Performance Share Units

Nonvested performance share units as of December 31, 2017 and December 31, 2018, and changes during the twelve months ended December 31, 2018, were as follows:

	Shares (Thousands)	Weighted Average Grant Date Fair Value
Nonvested at December 31, 2017	37	$ 22.41
Granted	232	17.65
Forfeited	(18)	
Nonvested at December 31, 2018	251	$ 18.23

During the year ended December 31, 2018, 232,300 performance share units were granted to certain executive officers and senior management, payable upon the achievement of certain established performance targets. The performance period for the shares awarded is January 1, 2018 through December 31, 2020. Distributions under these awards are payable at the end of the performance period in common stock. The total potential payout for awards granted during the year ended December 31, 2018 range from zero to 348,450 shares, should certain performance targets be achieved. The fair value of these awards was determined based on the Company's stock price on the grant date.

Compensation expense for the PSUs granted in 2018 and 2017 is currently being recognized based on 100% attainment of the targeted performance metrics or 232,300 and 37,100 shares, for each respective period. Compensation expense related to PSUs was $1.3 million and $0.2 million for the years ended December 31, 2018 and 2017, respectively. As of December 31, 2018, there was $3.0 million of unrecognized compensation expense related to PSUs, which is expected to be recognized over a weighted average period of 2.1 years.

Note 18. Preferred Stock

The Company has one million shares of $0.01 par value preferred stock authorized for issuance. The Board of Directors may divide the preferred stock into one or more series and fix the redemption, dividend, voting, conversion, sinking fund, liquidation and other rights. The Company has no present plans to issue any preferred stock.

Note 19. Comprehensive Income

The components of other comprehensive income and income tax expense allocated to each component for the years ended December 31, 2018, 2017 and 2016 were as follows:

	2018			2017			2016		
	Before Tax Amount	Income Tax Expense	Net of Tax Amount	Before Tax Amount	Income Tax Expense	Net of Tax Amount	Before Tax Amount	Income Tax Expense	Net of Tax Amount
Translation adjustments	$ (5.0)	$ —	$ (5.0)	$ 4.4	$ —	$ 4.4	$ (0.1)	$ —	$ (0.1)
Adjustment for net periodic pension plan and other postretirement benefits plan cost	(3.1)	(0.9)	(2.2)	(0.6)	0.1	(0.7)	11.9	4.8	7.1
Other comprehensive income	$ (8.1)	$ (0.9)	$ (7.2)	$ 3.8	$ 0.1	$ 3.7	$ 11.8	$ 4.8	$ 7.0

In February 2018, the FASB issued Accounting Standards Update No. 2018-02 "Income Statement—Reporting Comprehensive Income (Topic 220): Reclassification of Certain Income Tax Effects from Accumulated Other Comprehensive Income" ("ASU 2018-02"), which provides entities the option to reclassify tax effects stranded in accumulated other comprehensive income as a result of the Tax Act to retained earnings. The Company early adopted the standard in the fourth quarter of 2018. The impact of the adoption resulted in an increase in accumulated comprehensive loss and an increase in retained earnings of $10.9 million.

The following table summarizes changes in accumulated other comprehensive loss by component for the years ended December 31, 2018, 2017 and 2016:

	Pension and Other Postretirement Benefits Plan Cost	Translation Adjustments	Total
Balance at January 1, 2016	$ —	$ (16.0)	$ (16.0)
Other comprehensive income (loss) before reclassifications	6.7	(0.1)	6.6
Amounts reclassified from accumulated other comprehensive loss	0.4	—	0.4
Transfer of pension plan to parent company, net	(59.3)	—	(59.3)
Net change in accumulated other comprehensive loss	(52.2)	(0.1)	(52.3)
Balance at December 31, 2016	$ (52.2)	$ (16.1)	$ (68.3)
Other comprehensive (loss) income before reclassifications	(2.1)	4.4	2.3
Amounts reclassified from accumulated other comprehensive loss	1.4	—	1.4
Net change in accumulated other comprehensive loss	(0.7)	4.4	3.7
Balance at December 31, 2017	$ (52.9)	$ (11.7)	$ (64.6)
Other comprehensive (loss) income before reclassifications	(4.0)	(5.0)	(9.0)
Amounts reclassified from accumulated other comprehensive loss	1.8	—	1.8
Amounts reclassified in accordance with ASU 2018-02	(10.9)	—	(10.9)
Net change in accumulated other comprehensive loss	(13.1)	(5.0)	(18.1)
Balance at December 31, 2018	$ (66.0)	$ (16.7)	$ (82.7)

Reclassifications from accumulated other comprehensive loss for the years ended December 31, 2018, 2017 and 2016 were as follows:

	2018	2017	2016	Classification in the Consolidated and Combined Statements of Operations
Amortization of pension and other postretirement benefits plan cost:				
Net actuarial loss	$ 2.5	$ 2.1	$ 0.7	(a)
Reclassifications before tax	2.5	2.1	0.7	
Income tax expense	0.7	0.7	0.3	
Reclassifications, net of tax	$ 1.8	$ 1.4	$ 0.4	

(a) These accumulated other comprehensive (loss) income components are included in the calculation of net periodic pension and other postretirement benefits plan (income) expense, a component of which was allocated to DFIN in periods prior to the Separation, and recognized in investment and other income in the consolidated and combined statements of operations (see Note 13, *Retirement Plans*).

Note 20. Segment Information

The Company's segments are summarized below:

United States

The U.S. segment serves capital market and investment market clients in the U.S. by delivering products and services to help create, manage, and deliver, accurate and timely financial communications to investors and regulators. The Company also provides virtual data rooms to facilitate the deal management requirements of capital markets and mergers and acquisitions transactions, and provides data and analytics services that help professionals uncover intelligence from disclosures contained within public filings made with the SEC. The U.S. segment also includes commercial print. In addition, the U.S. segment included language solutions capabilities, through which the Company translated documents and created content in up to 140 different languages for its clients.*

International

The International segment includes the Company's operations in Europe, Asia, Canada and Latin America. The international business is primarily focused on working with international capital markets clients on capital markets offerings and regulatory compliance related activities into or within the United States. In addition, the International segment provided language translation services and shareholder communication services to investment market clients.*

*The Company sold its Language Solutions business on July 22, 2018. Refer to Note 4, *Acquisitions and Dispositions* , for further information.

Corporate

Corporate consists of unallocated general and administrative activities and associated expenses including, in part, executive, legal, finance, communications and certain facility costs. In addition, certain costs and earnings of employee benefit plans, such as pension and other postretirement benefit plan expense (income) and allocated costs for share-based compensation, are included in Corporate and not allocated to the operating segments.

Information by Segment

The Company has disclosed income (loss) from operations as the primary measure of segment earnings (loss). This is the measure of profitability used by the Company's chief operating decision-maker and is most consistent with the presentation of profitability reported within the consolidated financial statements.

	Total Sales	Intersegment Sales	Net Sales	Income (Loss) from Operations	Assets of Operations	Depreciation and Amortization	Capital Expenditures
Year ended December 31, 2018							
U.S.	$ 821.0	$ (9.2)	$ 811.8	$ 134.0	$ 681.9	$ 39.6	$ 34.8
International	153.2	(2.0)	151.2	31.6	77.6	5.7	1.2
Total operating segments	974.2	(11.2)	963.0	165.6	759.5	45.3	36.0
Corporate	—	—	—	(44.5)	109.2	0.5	1.1
Total operations	$ 974.2	$ (11.2)	$ 963.0	$ 121.1	$ 868.7	$ 45.8	$ 37.1

	Total Sales	Intersegment Sales	Net Sales	Income (Loss) from Operations	Assets of Operations	Depreciation and Amortization	Capital Expenditures
Year ended December 31, 2017							
U.S.	$ 856.6	$ (8.7)	$ 847.9	$ 127.6	$ 664.7	$ 38.2	$ 24.7
International	160.8	(3.8)	157.0	7.2	90.4	6.3	1.4
Total operating segments	1,017.4	(12.5)	1,004.9	134.8	755.1	44.5	26.1
Corporate	—	—	—	(39.1)	138.4	—	1.7
Total operations	$ 1,017.4	$ (12.5)	$ 1,004.9	$ 95.7	$ 893.5	$ 44.5	$ 27.8

	Total Sales	Intersegment Sales	Net Sales	Income (Loss) from Operations	Assets of Operations	Depreciation and Amortization	Capital Expenditures
Year ended December 31, 2016							
U.S.	$ 852.6	$ (7.4)	$ 845.2	$ 118.4	$ 672.2	$ 34.5	$ 20.5
International	142.9	(4.6)	138.3	8.8	93.7	4.6	2.6
Total operating segments	995.5	(12.0)	983.5	127.2	765.9	39.1	23.1
Corporate	—	—	—	(22.2)	213.0	4.2	3.1
Total operations	$ 995.5	$ (12.0)	$ 983.5	$ 105.0	$ 978.9	$ 43.3	$ 26.2

Corporate assets primarily consisted of the following items at December 31, 2018 and 2017:

	2018	2017
Software, net	$ 46.9	$ 40.6
Cash and cash equivalents	27.2	43.0
Deferred income tax assets, net of valuation allowances	9.1	18.7

Restructuring, impairment and other charges by segment for 2018, 2017, and 2016 are described in Note 5, *Restructuring, Impairment and Other Charges*.

Note 21. Geographic Area and Products and Services Information

The table below presents net sales and long-lived assets by geographic region for the years ended December 31, 2018, 2017 and 2016.

	U.S.	Europe	Asia	Canada	Other	Consolidated
2018						
Net sales	$ 811.8	$ 59.7	$ 55.5	$ 33.4	$ 2.6	$ 963.0
Long-lived assets (a)	117.2	3.1	2.4	0.1	—	122.8
2017						
Net sales	$ 847.9	$ 70.6	$ 47.2	$ 36.0	$ 3.2	$ 1,004.9
Long-lived assets (a)	107.2	4.5	1.6	0.6	—	113.9
2016						
Net sales	$ 845.2	$ 62.4	$ 39.2	$ 32.1	$ 4.6	$ 983.5
Long-lived assets (a)	107.4	3.1	0.6	0.5	—	111.6

(a) Includes net property, plant and equipment, net software and other noncurrent assets.

The following table summarizes net sales for services and products for the years ended December 31, 2018, 2017 and 2016.

	2018 Net Sales	2017 Net Sales	2016 Net Sales
Capital Markets	$ 408.3	$ 396.7	$ 387.6
Investment Markets*	167.4	164.0	144.4
Language Solutions*	42.3	71.4	66.6
Total services	618.0	632.1	598.6
Investment Markets*	$ 194.0	$ 217.9	$ 216.4
Capital Markets	151.0	154.9	168.5
Language Solutions*	—	—	—
Total products	345.0	372.8	384.9
Total net sales	$ 963.0	$ 1,004.9	$ 983.5

* Prior year amounts were restated to conform to the Company's current reporting unit structure. Refer to Note 1, *Overview and Basis of Presentation* , for further details.

Note 22. Related Parties

On March 28, 2017, RRD completed the sale of 6.2 million shares of LSC common stock (RRD's remaining ownership stake in LSC) in an underwritten public offering. As a result, beginning in the quarter ended June 30, 2017, LSC no longer qualified as a related party of the Company and the amounts disclosed related to LSC are presented through March 31, 2017 only.

On June 21, 2017, RRD completed the sale of approximately 6.1 million shares of the Company's common stock. RRD retained approximately 0.1 million shares of the Company's common stock which RRD sold on August 4, 2017. Beginning in the quarter ended September 30, 2017, RRD no longer qualified as a related party and the amounts disclosed related to RRD are presented through June 30, 2017 only.

Transition Services Agreements

In connection with the Separation, the Company entered into transition services agreements separately with RRD and LSC, under which, in exchange for the fees specified in the arrangements, RRD and LSC agree to provide certain services to the Company and the Company agrees to provide certain services to RRD, respectively. These services have included, but are not limited to, information technology, accounts receivable, accounts payable, payroll and other financial and administrative services and functions. Most of the services provided under the transition services agreements terminated at September 30, 2018 or earlier. Under certain transition services agreements, RRD agreed to provide information technology services to the Company for up to 36 months following the Separation. These agreements facilitated the separation by allowing the Company to operate independently prior to establishing stand-alone back office systems across its organization.

Commercial Arrangements

The Company entered into a number of commercial and other arrangements with RRD and its subsidiaries. These include, among other things, arrangements for the provision of services, including global outsourcing and logistics services, printing and binding, digital printing, composition and access to technology. The terms of the arrangements with RRD do not exceed 36 months. Subsequent to the Separation, RRD and LSC are clients of the Company and expect to utilize SaaS solutions and services that the Company provides to all of its clients.

Stockholder and Registration Rights Agreement

The Company and RRD entered into a Stockholder and Registration Rights Agreement with respect to the Company's common stock retained by RRD pursuant to which the Company agrees that, upon the request of RRD, the Company will use its reasonable best efforts to effect the registration under applicable federal and state securities laws of the shares of the Company's common stock retained by RRD after the Separation. In addition, RRD granted the Company a proxy to vote the shares of the Company's common stock that RRD retained immediately after the Separation in proportion to the votes cast by the Company's other stockholders. This proxy, however, will be automatically revoked as to a particular share upon any sale or transfer of such share from RRD to a person other than RRD, and neither the voting agreement nor the proxy will limit or prohibit any such sale or transfer.

On March 24, 2017, pursuant to the Stockholder and Registration Rights Agreement, the Company filed a Registration Statement on Form S-1 to register the offering and sale of the Company's common stock retained by RRD. The Registration Statement on Form S-1, as amended, was declared effective by the SEC on June 13, 2017. On June 21, 2017, RRD completed the sale of approximately 6.1 million shares of the Company's common stock in an underwritten public offering. Upon consummation of the offering, RRD retained approximately 0.1 million shares of the Company's common stock which were subsequently sold by RRD on August 4, 2017.

Sublease Agreement

In connection with the Separation, the Company assumed an operating lease through 2024 for the Company's headquarters. There is a related non-cancelable sublease rental to RRD for the same period. The Company remains secondarily liable under this lease in the event that the sub-lessee defaults under the sublease terms. The Company does not believe that material payments will be required as a result of the secondary liability provisions of the primary lease agreement.

Allocations from RRD

Prior to the Separation RRD provided DFIN with certain services, which include, but are not limited to information technology, finance, legal, human resources, internal audit, treasury, tax, investor relations and executive oversight. The financial information in these consolidated and combined financial statements does not necessarily include all the expenses that would have been incurred had DFIN been a separate, standalone entity for all periods presented. Prior to the Separation, RRD charged DFIN for these services based on direct usage when possible. When specific identification was not practicable, the pro rata basis of revenue or employee headcount, or some other measure was used. These allocations were reflected as follows in the consolidated and combined financial statements:

	2016
Costs of goods sold allocation	$ 28.0
Selling, general and administrative allocation	129.4
Depreciation and amortization	15.2
Total allocations from RRD	$ 172.6

The Company considers the expense methodology and results to be reasonable for all periods presented. However, these allocations may not be indicative of the actual expenses that the Company would have incurred as an independent public company or the costs it may incur in the future.

Related Party Revenues

DFIN generates a portion of net revenue from sales to RRD's subsidiaries. Net revenues from sales to RRD and affiliates of $8.3 million for the six months ended June 30, 2017 and $19.4 million for the year ended December 31, 2016, were included in the consolidated and combined statement of operations.

Related Party Purchases

DFIN utilizes RRD for freight and logistics and services as well as certain production of printed products. Cost of sales of $32.3 million for the six months ended June 30, 2017 and $57.9 million for the year ended December 31, 2016 were included in the consolidated and combined statement of operations for these purchases.

DFIN also utilizes RRD's business process outsourcing business for certain composition, XBRL and other functions. Cost of sales of $19.5 million for the six months ended June 30, 2017 and $37.8 million for the year ended December 31, 2016 were included in the consolidated and combined statement of operations for these purchases.

Share-Based Compensation Prior to Separation

Prior to the Separation, certain DFIN employees participated in RRD's share-based compensation plans, the costs of which have been allocated to DFIN and recorded in selling, general and administrative expenses in the consolidated and combined statement of operations. Share-based compensation costs allocated to the Company were $1.2 million for the nine months ended September 30, 2016.

Retirement Plans Prior to Separation

Prior to the Separation, DFIN employees participated in pension and other postretirement plans sponsored by RRD. These costs are reflected in the Company's cost of sales and selling, general and administrative expenses in the consolidated and combined statements of operations.

On October 1, 2016, DFIN recorded net pension plan liabilities of $68.3 million (consisting of a total benefit plan liability of $317.0 million, net of plan assets having fair market value of $248.7 million), as a result of the transfer of certain pension plan liabilities and assets from RRD to the Company upon the legal split of those plans. The pension plan asset allocation from RRD was finalized on June 30, 2017, which resulted in a $0.7 million decrease to the fair value of plan assets transferred to the Company from RRD. Refer to Note 13 *, Retirement Plans* , for further details regarding the Company's pension and other postretirement benefit plans.

Centralized Cash Management Prior to Separation

RRD used a centralized approach to cash management and financing of operations. Prior to the Separation, the majority of the Company's foreign subsidiaries were party to RRD's international cash pooling arrangements to maximize the availability of cash for general operating and investing purposes. As part of RRD's centralized cash management process, cash balances were swept regularly from the Company's accounts.

Debt

RRD's third party debt and related interest expense have not been allocated to the Company for any of the periods presented as the Company was not the legal obligor of the debt and the borrowings were not directly related to the Company's business.

Note 23. New Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In February 2018, the FASB issued ASU 2018-02, which provides entities the option to reclassify tax effects stranded in accumulated other comprehensive income as a result of the Tax Act to retained earnings. ASU 2018-02 may be applied either in the period of adoption or retrospectively to each period in which the effect of the Tax Act is recognized. The Company early adopted ASU 2018-02 in the fourth quarter of 2018 and applied it to the period of adoption. The impact of the adoption resulted in an increase in accumulated comprehensive loss and an increase in retained earnings of $10.9 million. Refer to Note 19, *Comprehensive Income* , for further information.

In May 2014, the FASB issued ASU 2014-09, which outlines a single comprehensive model for entities to use in accounting for revenue using a five-step process that supersedes virtually all existing revenue guidance. ASU 2014-09 also requires additional quantitative and qualitative disclosures. In August 2015, the FASB issued Accounting Standards Update No. 2015-14 "Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date" ("ASU 2015-14"), which deferred the effective date of ASU 2014-09 to January 1, 2018. The Company adopted the standard on January 1, 2018 using the modified retrospective approach. The Company recognized the cumulative effect of applying the standard as an opening transition adjustment to retained earnings. The comparative periods have not been restated and continue to be reported under the accounting standards in effect for those periods. Refer to Note 3, *Revenue* , for further information.

In March 2017, the FASB issued ASU 2017-07, which the Company adopted retrospectively in the first quarter of 2018. Refer to Note 13, *Retirement Plans* , for further information.

Recently Issued Accounting Pronouncements

In February 2016, the FASB issued Accounting Standards Update No. 2016-02 "Leases (Topic 842)" ("ASU 2016-02"), which requires lessees to put most leases on the balance sheet but recognize expense on the income statement in a manner similar to current accounting. For lessors, ASU 2016-02 also modifies the classification criteria and the accounting for sales-type and direct financing leases. The standard requires a modified retrospective approach for leases that exist or are entered into after the beginning of the earliest comparative period in the financial statements and is effective in the first quarter of 2019. In July 2018, the FASB issued Accounting Standards Update 2018-11 ("ASU 2018-11"), which provides an optional transition method to apply ASU 2016-02 in the period of adoption and recognize a cumulative-effect opening transition adjustment to retained earnings, without applying the standard to comparative periods. ASU 2018-11 also provides lessors with a practical expedient to account for lease and associated non-lease components as a single component when certain criteria are met.

Early adoption of ASU 2016-02 is permitted; however, the Company will adopt the standard in the first quarter of 2019 and plans to apply the optional transition method upon adoption.

The Company is in the process of reviewing its existing lease portfolio, which is primarily comprised of real estate leases, to evaluate the impact of ASU 2016-02 on the consolidated financial statements. The Company currently expects to recognize a lease liability and corresponding right-of-use asset for substantially all operating lease agreements, which will have a significant impact on the Company's consolidated balance sheet. The Company currently plans to elect the optional package of practical expedients to not reassess prior conclusions related to contracts containing leases, lease classification and initial direct costs and therefore, does not expect the adoption of ASU 2016-02 to have a significant impact on the consolidated statement of operations for existing operating leases. The ultimate impact of the standard will depend on the Company's lease portfolio at the date of adoption. Additionally, the Company is evaluating the processes and internal controls needed to support the changes resulting from the new lease accounting standard. Information about the Company's undiscounted future lease payments and the timing of those payments is disclosed in Note 12, *Commitments and Contingencies* .

Note 24. Guarantor Financial Information

As described in Note 15, *Debt* , on September 30, 2016, the Company issued the Notes. The Guarantors of the Notes, Donnelley Financial, LLC and DFS International Holding, Inc., entered into an agreement pursuant to which each agreed to guarantee the Company's obligations under the Notes. All guarantees are full and unconditional and joint and several. The Guarantors are 100% directly owned subsidiaries of the Company.

The guarantee of the Notes by a subsidiary guarantor will be automatically released under certain situations, including upon the sale or disposition of such subsidiary guarantor to a person that is not DFIN or a subsidiary guarantor of the notes, the liquidation or dissolution of such subsidiary guarantor, and if such subsidiary guarantor is released from its guarantee obligations under the Company's Credit Facilities.

The following tables set forth consolidating statements of operations for the years ended December 31, 2018, 2017, and 2016, consolidating statements of financial position as of December 31, 2018 and December 31, 2017, and consolidating statements of cash flows for the years ended December 31, 2018, 2017, and 2016. The principal consolidating adjustments are to eliminate the investment in subsidiaries and intercompany balances and transactions. For purposes of the tables below, the Company is referred to as "Parent" and the Guarantors are referred to as "Guarantor Subsidiaries."

Notes to the Consolidated and Combined Financial Statements
(in millions, except per share data, unless otherwise indicated)

Consolidating Statements of Operations
Year Ended December 31, 2018

	Parent	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminations	Consolidated
Services net sales	$ —	$ 508.0	$ 116.4	$ (6.4)	$ 618.0
Products net sales	—	313.0	36.8	(4.8)	345.0
Total net sales	—	821.0	153.2	(11.2)	963.0
Services cost of sales (exclusive of depreciation and amortization)	—	258.4	76.6	(6.2)	328.8
Products cost of sales (exclusive of depreciation and amortization)	—	236.7	26.8	(5.0)	258.5
Total cost of sales	—	495.1	103.4	(11.2)	587.3
Selling, general and administrative expenses (exclusive of depreciation and amortization)	—	220.0	38.2	—	258.2
Restructuring, impairment and other charges-net	—	2.6	1.8	—	4.4
Depreciation and amortization	—	40.1	5.7	—	45.8
Other operating income	—	(26.6)	(27.2)	—	(53.8)
Income from operations	—	89.8	31.3	—	121.1
Interest expense (income)-net	37.6	(0.3)	(0.6)	—	36.7
Intercompany interest (income) expense - net	(25.5)	25.6	(0.1)	—	—
Investment and other income-net	—	(16.9)	(1.4)	—	(18.3)
Earnings (loss) before income taxes and equity in net income of subsidiaries	(12.1)	81.4	33.4	—	102.7
Income tax (benefit) expense	(5.9)	27.9	7.1	—	29.1
Earnings (loss) before equity in net income of subsidiaries	(6.2)	53.5	26.3	—	73.6
Equity in net income of subsidiaries	79.8	26.3	—	(106.1)	—
Net earnings (loss)	$ 73.6	$ 79.8	$ 26.3	$ (106.1)	$ 73.6
Comprehensive income (loss)	$ 66.4	$ 72.6	$ 21.3	$ (93.9)	$ 66.4

Notes to the Consolidated and Combined Financial Statements
(in millions, except per share data, unless otherwise indicated)

Consolidating Statements of Operations
Year Ended December 31, 2017

	Parent	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminations	Consolidated
Services net sales	$ —	$ 518.5	$ 121.7	$ (8.1)	$ 632.1
Products net sales	—	338.1	39.1	(4.4)	372.8
Total net sales	—	856.6	160.8	(12.5)	1,004.9
Services cost of sales (exclusive of depreciation and amortization)	—	257.3	78.8	(7.4)	328.7
Services cost of sales with R.R. Donnelley affiliates (exclusive of depreciation and amortization)*	—	18.4	1.1	—	19.5
Products cost of sales (exclusive of depreciation and amortization)	—	221.5	24.5	(5.1)	240.9
Products cost of sales with R.R. Donnelley affiliates (exclusive of depreciation and amortization)*	—	30.1	2.2	—	32.3
Total cost of sales	—	527.3	106.6	(12.5)	621.4
Selling, general and administrative expenses (exclusive of depreciation and amortization)	—	197.4	38.8	—	236.2
Restructuring, impairment and other charges-net	—	4.9	2.2	—	7.1
Depreciation and amortization	—	38.2	6.3	—	44.5
Income from operations	—	88.8	6.9	—	95.7
Interest expense (income) -net	43.1	(0.1)	(0.1)	—	42.9
Investment and other income-net	—	(3.3)	(0.1)	—	(3.4)
Earnings (loss) before income taxes and equity in net income of subsidiaries	(43.1)	92.2	7.1	—	56.2
Income tax (benefit) expense	(16.7)	60.6	2.6	—	46.5
Earnings (loss) before equity in net income of subsidiaries	(26.4)	31.6	4.5	—	9.7
Equity in net income of subsidiaries	36.1	4.5	—	(40.6)	—
Net earnings (loss)	$ 9.7	$ 36.1	$ 4.5	$ (40.6)	$ 9.7
Comprehensive income (loss)	$ 13.4	$ 39.8	$ 8.9	$ (48.7)	$ 13.4

*Beginning in the quarter ended June 30, 2017, LSC no longer qualified as a related party, therefore the amounts disclosed related to LSC are presented through March 31, 2017 only. Beginning in the quarter ended September 30, 2017, RRD no longer qualified as a related party, therefore the amounts disclosed related to RRD are presented through June 30, 2017 only.

Notes to the Consolidated and Combined Financial Statements
(in millions, except per share data, unless otherwise indicated)

Consolidating Statements of Operations
Year Ended December 31, 2016

	Parent	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminations	Consolidated
Services net sales	$ —	$ 502.2	$ 104.1	$ (7.7)	$ 598.6
Products net sales	—	350.4	38.8	(4.3)	384.9
Total net sales	—	852.6	142.9	(12.0)	983.5
Services cost of sales (exclusive of depreciation and amortization)	—	236.0	68.2	(7.1)	297.1
Services cost of sales with R.R. Donnelley affiliates (exclusive of depreciation and amortization)	—	35.6	2.2	—	37.8
Products cost of sales (exclusive of depreciation and amortization)	—	207.0	24.1	(4.9)	226.2
Products cost of sales with R.R. Donnelley affiliates (exclusive of depreciation and amortization)	—	57.3	0.6	—	57.9
Total cost of sales	—	535.9	95.1	(12.0)	619.0
Selling, general and administrative expenses (exclusive of depreciation and amortization)	—	177.0	33.8	—	210.8
Restructuring, impairment and other charges-net	—	4.8	0.6	—	5.4
Depreciation and amortization	—	38.6	4.7	—	43.3
Income from operations	—	96.3	8.7	—	105.0
Interest expense-net	11.7	—	—	—	11.7
Investment and other income-net	—	(0.2)	(0.8)	—	(1.0)
Earnings (loss) before income taxes and equity in net income of subsidiaries	(11.7)	96.5	9.5	—	94.3
Income tax (benefit) expense	(4.3)	38.5	1.0	—	35.2
Earnings (loss) before equity in net income of subsidiaries	(7.4)	58.0	8.5	—	59.1
Equity in net income of subsidiaries	66.5	8.5	—	(75.0)	—
Net earnings (loss)	$ 59.1	$ 66.5	$ 8.5	$ (75.0)	$ 59.1
Comprehensive income (loss)	$ 66.1	$ 73.5	$ 8.6	$ (82.1)	$ 66.1

Notes to the Consolidated and Combined Financial Statements
(in millions, except per share data, unless otherwise indicated)

Consolidating Balance Sheet
December 31, 2018

	Parent	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminations	Consolidated
ASSETS					
Cash and cash equivalents	$ 24.9	$ 5.0	$ 17.4	$ —	$ 47.3
Receivables, less allowances	—	141.6	31.3	—	172.9
Intercompany receivables	—	123.6	—	(123.6)	—
Intercompany short-term note receivable-net	—	—	60.5	(60.5)	—
Inventories	—	10.4	1.7	—	12.1
Prepaid expenses and other current assets	—	13.5	3.2	—	16.7
Total current assets	24.9	294.1	114.1	(184.1)	249.0
Property, plant and equipment-net	—	29.3	2.9	—	32.2
Software-net	—	47.8	—	—	47.8
Goodwill	—	438.5	11.5	—	450.0
Other intangible assets-net	—	32.6	4.6	—	37.2
Deferred income taxes	—	37.2	2.4	(29.9)	9.7
Intercompany long-term note receivable	298.0	—	—	(298.0)	—
Other noncurrent assets	3.6	35.1	4.1	—	42.8
Investments in consolidated subsidiaries	445.9	106.0	—	(551.9)	—
Total assets	$ 772.4	$ 1,020.6	$ 139.6	$ (1,063.9)	$ 868.7
LIABILITIES AND STOCKHOLDERS' EQUITY					
Accounts payable	$ —	$ 61.0	$ 11.4	$ —	$ 72.4
Intercompany payables	120.9	—	2.7	(123.6)	—
Intercompany short-term note payable-net	60.0	0.5	—	(60.5)	—
Accrued liabilities	0.1	109.2	16.7	—	126.0
Total current liabilities	181.0	170.7	30.8	(184.1)	198.4
Long-term debt	362.7	—	—	—	362.7
Intercompany long-term note payable	—	298.0	—	(298.0)	—
Deferred compensation liabilities	—	19.5	—	—	19.5
Pension and other postretirement benefits plan liabilities	—	50.3	1.0	—	51.3
Other noncurrent liabilities	2.7	36.2	1.8	(29.9)	10.8
Total liabilities	546.4	574.7	33.6	(512.0)	642.7
Total equity	226.0	445.9	106.0	(551.9)	226.0
Total liabilities and equity	$ 772.4	$ 1,020.6	$ 139.6	$ (1,063.9)	$ 868.7

Notes to the Consolidated and Combined Financial Statements
(in millions, except per share data, unless otherwise indicated)

Consolidating Balance Sheet
December 31, 2017

	Parent	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminations	Consolidated
ASSETS					
Cash and cash equivalents	$ 8.3	$ 27.9	$ 15.8	$ —	$ 52.0
Receivables, less allowances	—	131.3	33.9	—	165.2
Intercompany receivables	—	146.4	—	(146.4)	—
Intercompany short-term note receivable-net	—	—	30.0	(30.0)	—
Inventories	—	21.3	2.0	—	23.3
Prepaid expenses and other current assets	37.1	14.8	2.8	(25.1)	29.6
Total current assets	45.4	341.7	84.5	(201.5)	270.1
Property, plant and equipment-net	—	31.2	3.5	—	34.7
Software-net	—	40.6	0.5	—	41.1
Goodwill	—	429.2	18.2	—	447.4
Other intangible assets-net	—	32.4	7.5	—	39.9
Deferred income taxes	—	40.5	3.4	(21.7)	22.2
Other noncurrent assets	3.4	30.0	4.7	—	38.1
Investments in consolidated subsidiaries	728.4	85.2	—	(813.6)	—
Total assets	$ 777.2	$ 1,030.8	$ 122.3	$ (1,036.8)	$ 893.5
LIABILITIES AND STOCKHOLDERS' EQUITY					
Accounts payable	$ —	$ 57.9	$ 9.9	$ —	$ 67.8
Intercompany payable	139.5	—	6.9	(146.4)	—
Intercompany short-term note payable-net	30.0	—	—	(30.0)	—
Accrued liabilities	—	127.6	16.7	(25.1)	119.2
Total current liabilities	169.5	185.5	33.5	(201.5)	187.0
Long-term debt	458.3	—	—	—	458.3
Deferred compensation liabilities	—	22.8	—	—	22.8
Pension and other postretirement benefits plan liabilities	—	51.3	1.2	—	52.5
Other noncurrent liabilities	—	42.8	2.4	(21.7)	23.5
Total liabilities	627.8	302.4	37.1	(223.2)	744.1
Total equity	149.4	728.4	85.2	(813.6)	149.4
Total liabilities and equity	$ 777.2	$ 1,030.8	$ 122.3	$ (1,036.8)	$ 893.5

Notes to the Consolidated and Combined Financial Statements
(in millions, except per share data, unless otherwise indicated)

Consolidating Statements of Cash Flows
Year Ended December 31, 2018

	Parent	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminations	Consolidated
OPERATING ACTIVITIES					
Net cash provided by (used in) operating activities	$ 85.9	$ (12.0)	$ (7.6)		$ 66.3
INVESTING ACTIVITIES					
Capital expenditures	—	(35.9)	(1.2)	—	(37.1)
Acquisition of business, net of cash acquired	—	(12.5)	—	—	(12.5)
Sale of investment	—	3.1	—	—	3.1
Proceeds from disposition	—	34.4	43.1	—	77.5
Intercompany note receivable, net	—	—	(30.5)	30.5	—
Other investing activities	—	(0.8)	—	—	(0.8)
Net cash provided by (used in) investing activities	—	(11.7)	11.4	30.5	30.2
FINANCING ACTIVITIES					
Revolving facility borrowings	360.0	—	—	—	360.0
Payments on revolving facility borrowings	(360.0)	—	—	—	(360.0)
Payments on long-term debt	(97.5)	—	—	—	(97.5)
Intercompany note payable, net	29.7	0.8	—	(30.5)	—
Proceeds from the issuance of common stock	1.2	—	—	—	1.2
Treasury stock repurchases	(1.5)	—	—	—	(1.5)
Debt issuance costs	(1.2)	—			(1.2)
Net cash (used in) provided by financing activities	(69.3)	0.8	—	(30.5)	(99.0)
Effect of exchange rate on cash and cash equivalents	—	—	(2.2)	—	(2.2)
Net increase (decrease) in cash and cash equivalents	16.6	(22.9)	1.6	—	(4.7)
Cash and cash equivalents at beginning of year	8.3	27.9	15.8	—	52.0
Cash and cash equivalents at end of period	$ 24.9	$ 5.0	$ 17.4	$ —	$ 47.3
Supplemental non-cash disclosure:					
Intercompany debt allocation	$ (298.0)	$ 298.0	$ —	$ —	$ —

Notes to the Consolidated and Combined Financial Statements
(in millions, except per share data, unless otherwise indicated)

Consolidating Statements of Cash Flows
Year Ended December 31, 2017

	Parent	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminations	Consolidated
OPERATING ACTIVITIES					
Net cash provided by operating activities	$ 39.3	$ 35.7	$ 14.0	$ 2.4	$ 91.4
INVESTING ACTIVITIES					
Capital expenditures	—	(26.4)	(1.4)	—	(27.8)
Purchase of investment	—	(3.4)	—	—	(3.4)
Intercompany note receivable, net	—	—	(14.7)	14.7	—
Other investing activities	—	0.2	—	—	0.2
Net cash (used in) provided by investing activities	—	(29.6)	(16.1)	14.7	(31.0)
FINANCING ACTIVITIES					
Revolving facility borrowings	298.5	—	—	—	298.5
Payments on revolving facility borrowings	(298.5)	—	—	—	(298.5)
Payments on long-term debt	(133.0)	—	—	—	(133.0)
Debt issuance costs	(2.1)	—	—	—	(2.1)
Separation-related payment from R.R. Donnelley	68.0	—	—	—	68.0
Proceeds from the issuance of common stock	18.8	—	—	—	18.8
Proceeds from issuance of long-term debt	3.1	—	—	—	3.1
Treasury stock repurchases	(0.9)	—	—	—	(0.9)
Intercompany note payable, net	14.7	—	—	(14.7)	—
Other financing activities	0.4	—	—	—	0.4
Net cash used in financing activities	(31.0)	—	—	(14.7)	(45.7)
Effect of exchange rate on cash and cash equivalents	—	—	1.1	—	1.1
Net increase (decrease) in cash and cash equivalents	8.3	6.1	(1.0)	2.4	15.8
Cash and cash equivalents at beginning of year	—	21.8	16.8	(2.4)	36.2
Cash and cash equivalents at end of period	$ 8.3	$ 27.9	$ 15.8	$ —	$ 52.0

Notes to the Consolidated and Combined Financial Statements
(in millions, except per share data, unless otherwise indicated)

Consolidating Statements of Cash Flows
Year Ended December 31, 2016

	Parent	Guarantor Subsidiaries	Non-guarantor Subsidiaries	Eliminations	Consolidated
OPERATING ACTIVITIES					
Net cash (used in) provided by operating activities	$ (1.2)	$ 103.2	$ 6.4	$ (2.4)	$ 106.0
INVESTING ACTIVITIES					
Capital expenditures	—	(23.6)	(2.6)	—	(26.2)
Purchase of investment	—	(3.5)	—	—	(3.5)
Other investing activities	—	—	0.4	—	0.4
Net cash (used in) investing activities	—	(27.1)	(2.2)	—	(29.3)
FINANCING ACTIVITIES					
Proceeds from issuance of long-term debt	348.2	—	—	—	348.2
Payments on long-term debt	(50.0)	—	—	—	(50.0)
Net change in short-term debt	—	—	(8.8)	—	(8.8)
Debt issuance costs	(9.3)	—	—	—	(9.3)
Net transfers to Parent and affiliates	(287.7)	(54.4)	2.0	—	(340.1)
Net cash provided by (used in) financing activities	1.2	(54.4)	(6.8)	—	(60.0)
Effect of exchange rate on cash and cash equivalents	—	—	4.4	—	4.4
Net increase (decrease) in cash and cash equivalents	—	21.7	1.8	(2.4)	21.1
Cash and cash equivalents at beginning of year	—	0.1	15.0	—	15.1
Cash and cash equivalents at end of period	$ —	$ 21.8	$ 16.8	$ (2.4)	$ 36.2
Supplemental non-cash disclosure:					
Debt exchange with R.R. Donnelley, including $5.5 million of debt issuance costs	$ 300.0	$ —	$ —	$ —	$ 300.0
Settlement of intercompany note payable	—	29.6	—	—	29.6
Accrued debt issuance costs	1.5	—	—	—	1.5

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the stockholders and the Board of Directors of Donnelley Financial Solutions, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Donnelley Financial Solutions, Inc. and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated and combined statements of operations, comprehensive income, equity and cash flows, for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 27, 2019, expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis of Presentation of the Consolidated and Combined Financial Statements

As described in Note 1, prior to October 1, 2016, the accompanying consolidated and combined financial statements have been derived from the consolidated financial statements and accounting records of R.R. Donnelley & Sons Company. The consolidated and combined financial statements include the allocation of certain assets, liabilities, expenses and income that have historically been held at the R.R. Donnelley & Sons Company corporate level but which are specifically identifiable or attributable to the Company. The consolidated and combined financial statements also include expense allocations for certain corporate functions historically provided by R.R. Donnelley & Sons Company. These costs and allocations may not be reflective of the actual expense which would have been incurred had the Company operated as a separate unaffiliated entity apart from R.R. Donnelley & Sons Company.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ DELOITTE & TOUCHE LLP

Chicago, Illinois
February 27, 2019

We have served as the Company's auditor since 2015.

UNAUDITED INTERIM FINANCIAL INFORMATION
(In millions, except per-share data)

	Year Ended December 31,				
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Full Year
2018					
Net sales	$ 255.2	$ 290.6	$ 216.9	$ 200.3	$ 963.0
Income from operations	19.4	36.2	62.1	3.4	121.1
Net earnings (loss)	7.7	18.9	48.0	(1.0)	73.6
Net earnings (loss) per share:					
Basic net earnings (loss) per share	0.23	0.56	1.42	(0.03)	2.18
Diluted net earnings (loss) per share	0.23	0.56	1.40	(0.03)	2.16
Weighted average number to common shares outstanding					
Basic	33.7	33.8	33.9	33.9	33.8
Diluted	33.9	34.0	34.2	33.9	34.0
2017					
Net sales	$ 267.3	$ 290.2	$ 222.6	$ 224.8	$ 1,004.9
Income from operations	26.4	42.0	17.2	10.1	95.7
Net earnings (loss)	9.3	18.8	5.3	(23.7)	9.7
Net earnings (loss) per share:					
Basic net earnings (loss) per share	0.29	0.57	0.16	(0.71)	0.29
Diluted net earnings (loss) per share	0.28	0.57	0.16	(0.71)	0.29
Weighted average number to common shares outstanding					
Basic	32.6	32.7	33.6	33.6	33.1
Diluted	32.8	32.9	33.8	33.6	33.3

Includes the following significant items:

	Pre-tax					After-tax				
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Full Year	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Full Year
Year ended December 31, 2018										
Net gain on sale of Language Solutions business	$ —	$ —	$ (53.5)	$ (0.3)	$ (53.8)	$ —	$ —	$ (38.4)	$ (0.2)	$ (38.6)
Gain on eBrevia investment	—	—	—	(1.8)	(1.8)	—	—	—	(1.5)	(1.5)
Gain on equity investment	—	—	(11.8)	—	(11.8)	—	—	(8.5)	—	(8.5)
Spin-off related transaction expenses	7.8	8.4	3.7	0.2	20.1	5.6	6.0	2.9	0.1	14.6
Share-based compensation expense	1.8	3.3	2.1	2.0	9.2	1.3	2.4	1.6	1.4	6.7
Disposition-related expenses	0.5	1.5	4.5	0.3	6.8	0.4	1.1	3.2	0.4	5.1
Restructuring, impairment and other charges - net	0.7	2.6	0.8	0.3	4.4	0.5	1.9	0.6	0.2	3.2
Acquisition-related expenses	0.2	0.3	—	0.3	0.8	0.1	0.2	—	0.2	0.5
Investor-related expenses	—	—	—	0.5	0.5	—	—	—	0.4	0.4

	Pre-tax					After-tax				
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Full Year	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Full Year
Year ended December 31, 2017										
Spin-off related transaction expenses	$ 2.7	$ 4.5	$ 2.6	$ 6.7	$ 16.5	$ 1.6	$ 2.7	$ 1.2	$ 4.4	$ 9.9
Restructuring, impairment and other charges – net	3.8	3.2	(0.6)	0.7	7.1	2.3	2.0	(0.4)	0.3	4.2
Share-based compensation expense	1.1	2.4	1.7	1.6	6.8	0.7	1.4	0.8	1.2	4.1
Acquisition-related expenses	—	—	—	0.2	0.2	—	—	—	0.1	0.1

INDEX TO EXHIBITS

3.1	Amended and Restated Certificate of Incorporation of Donnelley Financial Solutions, Inc. (incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K dated September 30, 2016, filed on October 3, 2016)
3.2	Amended and Restated By-laws of Donnelley Financial Solutions, Inc. (incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K dated September 30, 2016, filed on October 3, 2016)
4.1	Indenture, dated as of September 30, 2016, among Donnelley Financial Solutions, Inc., the subsidiary guarantors party thereto and Wells Fargo Bank, National Association, as Trustee (incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K dated September 30, 2016, filed on October 3, 2016)
10.1	Credit Agreement, dated as of September 30, 2016, among Donnelley Financial Solutions, Inc., as Borrower, the lenders party thereto, and JPMorgan Chase Bank, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated September 30, 2016, filed on October 3, 2016)*
10.2	Amendment No. 1 to Credit Agreement, dated as of October 2, 2017, among Donnelley Financial Solutions, Inc., as Borrower, the lenders party thereto, and JPMorgan Chase Bank, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q dated September 30, 2017, filed on November 2, 2017)
10.3	Amendment No. 2 to Credit Agreement, dated as of December 18, 2018, by and among Donnelley Financial Solutions, Inc., the lenders party thereto from time to time and JPMorgan Chase Bank, N.A., as administrative agent (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated December 18, 2018, filed on December 18, 2018)
10.4	2016 Donnelley Financial Solutions, Inc. Performance Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated September 30, 2016, filed on October 3, 2016)*
10.5	Amended and Restated Donnelley Financial Solutions, Inc. 2016 Performance Incentive Plan (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated May 18, 2017, filed on May 23, 2017)*
10.6	Donnelley Financial Solutions, Inc. Non-Employee Director Compensation Plan (incorporated by reference to Exhibit 10.5 to the Company's Annual Report on Form 10-K dated December 31, 2017, filed on February 28, 2018)*
10.7	Policy on Retirement Benefits, Phantom Stock Grants and Stock Options for Directors (incorporated by reference to Exhibit 10.1 to R.R Donnelley & Sons Company Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, filed on August 6, 2008)*
10.8	Donnelley Financial Solutions, Inc. Nonqualified Deferred Compensation Plan, dated as of September 22, 2016 (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K dated September 30, 2016, filed on October 3, 2016)*
10.9	Donnelley Financial Unfunded Supplemental Pension Plan effective October 1, 2016 (incorporated by reference to Exhibit 10.6 to the Company's Annual Report on Form 10-K dated December 31, 2016, filed on February 28, 2017)*
10.10	Donnelley Financial Solutions, Inc. Executive Severance Plan (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated May 30, 2017, filed on June 5, 2017)*
10.11	Letter Agreement to Employment Agreement, dated as of April 20, 2018, between the Company and Daniel N. Leib (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated April 10, 2018, filed on April 16, 2018)*
10.12	Amended and Restated Employment Agreement, dated as of July 13, 2017, between the Company and Daniel N. Leib (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated July 13, 2017, filed on July 14, 2017)*
10.13	Assignment of Employment Agreement and Acceptance of Assignment, dated as of September 29, 2016, between Donnelley Financial Solutions, Inc., R. R. Donnelley & Sons Company and Thomas F. Juhase (incorporated by reference to Exhibit 10.6 to the Company's Current Report on Form 8-K dated September 30, 2016, filed on October 3, 2016)*

10.14	Waiver of Severance Benefits, dated as of June 1, 2017, by and between Thomas F. Juhase and the Company (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K dated May 30, 2017, filed on June 5, 2017)*
10.15	Assignment of Employment Agreement and Acceptance of Assignment, dated as of September 29, 2016, between Donnelley Financial Solutions, Inc., R. R. Donnelley & Sons Company and David A. Gardella (incorporated by reference to Exhibit 10.7 to the Company's Current Report on Form 8-K dated September 30, 2016, filed on October 3, 2016)*
10.16	Waiver of Severance Benefits, dated as of June 1, 2017, by and between David A. Gardella and the Company (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K dated May 30, 2017, filed on June 5, 2017)*
10.17	Assignment of Severance Agreement and Acceptance of Assignment, dated as of September 29, 2016, between Donnelley Financial Solutions, Inc., R. R. Donnelley & Sons Company and Jennifer B. Reiners (incorporated by reference to Exhibit 10.8 to the Company's Current Report on Form 8-K dated September 30, 2016, filed on October 3, 2016)*
10.18	Waiver of Severance Benefits, dated as of June 1, 2017, by and between Jennifer B. Reiners and the Company (incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K dated May 30, 2017, filed on June 5, 2017)*
10.19	Donnelley Financial Solutions Annual Incentive Plan (incorporated by reference to Exhibit 10.1 of the Company's Current Report on Form 8-K dated March 2, 2018, filed on March 13, 2018)*
10.20	Form of Founders Award (Restricted Stock) Agreement (incorporated by reference to Exhibit 10.15 to the Company's Annual Report on Form 10-K dated December 31, 2016, filed on February 28, 2017)*
10.21	Form of Performance Restricted Stock Award Agreement (for 2017) (incorporated by reference to Exhibit 10.16 to the Company's Quarterly Report on Form 10-Q dated March 31, 2017, filed on May 4, 2017)*
10.22	Form of Amendment to Performance Restricted Stock Award Agreement (for 2017) (incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K dated May 30, 2017, filed on June 5, 2017)*
10.23	Form of Performance Share Unit Award Agreement (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K dated December 31, 2017, filed on February 28, 2018)*
10.24	Form of Performance Share Unit Award Agreement (for 2017) (incorporated by reference to Exhibit 10.17 to the Company's Quarterly Report on Form 10-Q dated March 31, 2017, filed on May 4, 2017)*
10.25	Form of Restricted Stock Unit Award Agreement (incorporated by reference to Exhibit 10.18 to the Company's Quarterly Report on Form 10-Q dated March 31, 2017, filed on May 4, 2017)*
10.26	Form of Stock Option Award Agreement (incorporated by reference to Exhibit 10.19 to the Company's Quarterly Report on Form 10-Q dated March 31, 2017, filed on May 4, 2017)*
10.27	Form of Cash Award Agreement (for 2016) converted from R. R. Donnelley & Sons Company to the Company pursuant to the Separation Agreement (incorporated by reference to Exhibit 10.23 to the Company's Annual Report on Form 10-K dated December 31, 2016, filed on February 28, 2017)*
10.28	Agreement regarding title and retention bonus for Thomas Juhase dated March 21, 2016 converted from R.R. Donnelley & Sons Company to the Company pursuant to the Separation Agreement (incorporated by reference to Exhibit 10.25 to the Company's Annual Report on Form 10-K dated December 31, 2016, filed on February 28, 2017)*
10.29	Form of Director Restricted Stock Unit Award (incorporated by reference to Exhibit 10.26 to the Company's Annual Report on Form 10-K dated December 31, 2016, filed on February 28, 2017)*
10.30	Form of Restricted Stock Unit Award Agreement for directors converted from R.R. Donnelley & Sons Company to the Company pursuant to the Separation Agreement (incorporated by reference to Exhibit 10.21 to the R.R. Donnelley & Sons Company Annual Report on Form 10-K for the fiscal year ended December 31, 2004, filed on March 14, 2005)*

10. 31	Form of Restricted Stock Unit Award Agreement for directors converted from R.R. Donnelley & Sons Company to the Company pursuant to the Separation Agreement (incorporated by reference to Exhibit 10.25 to the R.R. Donnelley & Sons Company Annual Report on Form 10-K for the fiscal year ended December 31, 2007, filed on February 27, 2008)*
10.32	Form of Restricted Stock Unit Award Agreement for directors converted from R.R. Donnelley & Sons Company to the Company pursuant to the Separation Agreement (incorporated by reference to Exhibit 10.23 to the R.R. Donnelley & Sons Company Annual Report on Form 10-K for the fiscal year ended December 31, 2008, filed on February 25, 2009)*
10.33	Form of Amendment to Director Restricted Stock Unit Awards converted from R.R. Donnelley & Sons Company to the Company pursuant to the Separation Agreement (incorporated by reference to Exhibit 10.22 to the R.R. Donnelley & Sons Company Annual Report on Form 10-K for the fiscal year ended December 31, 2008, filed on February 25, 2009)*
10.34	Form of Amendment to Director Restricted Stock Unit Awards dated May 21, 2009 converted from R.R. Donnelley & Sons Company to the Company pursuant to the Separation Agreement (incorporated by reference to Exhibit 10.23 to the R.R. Donnelley & Sons Company Quarterly Report on Form 10-Q for the quarter ended June 30, 2009, filed on August 5, 2009)*
10.35	Form of Director Indemnification Agreement (incorporated by reference to Exhibit 10.10 to the Company's Quarterly Report on Form 10-Q dated September 30, 2016, filed on November 9, 2016)
10.36	Agreement, dated February 17, 2019, by and among the Company, Simcoe Capital Management, LLC and, solely for purposes of Section 2(g) thereof, Jeffrey Jacobowitz (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K dated February 17, 2019, filed on February 19, 2019)
14.1	Code of Ethics for the Chief Executive Officer and Senior Financial Officers (incorporated by reference to Exhibit 14.1 to the Company's Annual Report on Form 10-K dated December 31, 2016, filed on February 28, 2017)
21.1	Subsidiaries of the Registrant (filed herewith)
23.1	Consent of Deloitte & Touche LLP (filed herewith)
24.1	Power of Attorney (filed herewith)
31.1	Certification by Daniel N. Leib, President and Chief Executive Officer, required by Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934 (filed herewith)
31.2	Certification by David A. Gardella, Executive Vice President and Chief Financial Officer, required by Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act of 1934 (filed herewith)
32.1	Certification by Daniel N. Leib, President and Chief Executive Officer, required by Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 and Section 1350 of Chapter 63 of Title 18 of the United States Code (filed herewith)
32.2	Certification by David A. Gardella, Executive Vice President and Chief Financial Officer, required by Rule 13a-14(b) or Rule 15d-14(b) of the Securities Exchange Act of 1934 and Section 1350 of Chapter 63 of Title 18 of the United States Code (filed herewith)
101.INS	XBRL Instance Document – the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

* Management contract or compensatory plan or arrangement.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 27th day of February 2019.

DONNELLEY FINANCIAL SOLUTIONS, INC.

By: /S/ DAVID A. GARDELLA

David A. Gardella
Executive Vice President and Chief Financial Officer
(Principal Financial Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated, on the 27th day of February 2019.

Signature and Title

/S/ DANIEL N. LEIB

Daniel N. Leib
President and Chief Executive Officer, Director
(Principal Executive Officer)

/S/ DAVID A. GARDELLA

David A. Gardella
Executive Vice President and Chief Financial Officer
(Principal Financial Officer)

/S/ KAMI S. TURNER

Kami S. Turner
Senior Vice President and Chief Accounting Officer
(Principal Accounting Officer)

/S/ RICHARD L. CRANDALL *

Richard L. Crandall
Chairman of the Board, Director

/S/ LUIS A. AGUILAR *

Luis A. Aguilar
Director

Signature and Title

/S/ NANCY E. CALDWELL *

Nancy E. Caldwell
Director

/S/ CHARLES D. DRUCKER *

Charles D. Drucker
Director

/S/ JULIET S. ELLIS *

Juliet S. Ellis
Director

/S/ GARY G. GREENFIELD *

Gary G. Greenfield
Director

/S/ LOIS M. MARTIN *

Lois M. Martin
Director

By: /S/ JENNIFER B. REINERS

Jennifer B. Reiners
As Attorney-in-Fact

* By Jennifer B. Reiners as Attorney-in-Fact pursuant to Powers of Attorney executed by the directors listed above, which Powers of Attorney have been filed with the Securities and Exchange Commission

Exhibit 21.1

Entity Name	Entity Type	Domestic Jurisdiction
Al Ghurair Donnelley LLC [Less than 50% owned]	Corporation	United Arab Emirates
Bowne International Ltd. [UK]	Limited Liability Company	England and Wales
Bowne International, L.L.C.	Limited Liability Company	Delaware
DFS International Holdings, Inc.	Corporation	Delaware
Donnelley Financial Data Solutions Deutschland GmbH	Limited Liability Company	Frankfurt/Main
Donnelley Financial Solutions Australia Pty Limited	Limited Liability Company	Victoria
Donnelley Financial Solutions Belgium BVBA	Private Limited Liability Company	Belgium
Donnelley Financial Solutions Canada Corporation	Corporation	Nova Scotia
Donnelley Financial Solutions Canada Holdings ULC	Unlimited Company	Nova Scotia
Donnelley Financial Solutions do Brasil Ltda.	Limited Liability Company	Brazil
Donnelley Financial Solutions France Sarl	Limited Liability Company	France
Donnelley Financial Solutions Group UK Limited	Public Limited Company	England and Wales
Donnelley Financial Solutions Holdings UK Limited	Limited Liability Company	England
Donnelley Financial Solutions Hong Kong Limited	Limited Liability Company	Hong Kong
Donnelley Financial Solutions Ireland Limited	Limited Liability Company	Ireland
Donnelley Financial Solutions Japan Inc	Corporation	Tokyo
Donnelley Financial Solutions Luxembourg SARL	Limited Liability Company	Luxembourg
Donnelley Financial Solutions Poland sp. z o.o.	Limited Liability Company	Poland
Donnelley Financial Solutions Russia LLC	Limited Liability Company	Republic of Tatarstan
Donnelley Financial Solutions Singapore Pte. Ltd.	Limited Liability Company	Singapore
Donnelley Financial Solutions UK Limited	Limited Liability Company	England and Wales
Donnelley Financial Solutions, Inc.	Corporation	Delaware
Donnelley Financial, LLC	Limited Liability Company	Delaware
Donnelley Translation Services (Shanghai) Co., Ltd.	Limited Liability Company	China
eBrevia, Inc.	Corporation	Delaware
LATFIN Holdings, LLC	Limited Liability Company	Delaware
Roman Financial Press (Holdings) Limited	Limited Liability Company	British Virgin Islands
RR Donnelley International de Mexico, S.A. de C.V.	Corporation	Mexico

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement No. 333-213915 on Form S-8 of our reports dated February 27, 2019 relating to the consolidated and combined financial statements of Donnelley Financial Solutions, Inc. and subsidiaries, and the effectiveness of Donnelley Financial Solutions, Inc.'s internal control over financial reporting, appearing in this Annual Report on Form 10-K of Donnelley Financial Solutions, Inc. for the year ended December 31, 2018.

/s/ DELOITTE & TOUCHE LLP

Chicago, Illinois
February 27, 2019

Exhibit 24.1

POWER OF ATTORNEY

KNOW ALL BY THESE PRESENTS, that each person whose signature appears below constitutes and appoints David A. Gardella, Jennifer B. Reiners and Kami S. Turner, or any of them, his or her true and lawful attorney-in-fact and agent, with full power of substitution and resubstitution, in any and all capacities, to sign the Annual Report on Form 10-K of Donnelley Financial Solutions, Inc. for its fiscal year ended December 31, 2018 and any and all amendments thereto, and to file the same with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorney-in-fact and agent full power and authority to do and perform each and every act and thing requisite and necessary to be done in and about the premises, as fully to all intents and purposes as he or she might or could do in person, hereby ratifying and confirming all that said attorney-in-fact and agent, or her substitute, may lawfully do or cause to be done by virtue hereof. This Power of Attorney shall be effective from the date on which it is signed until June 30, 2019.

Dated: February 7, 2019

/s/ Luis A. Aguilar
Luis A. Aguilar

/s/ Nanci E. Caldwell
Nanci E. Caldwell

/s/ Richard L. Crandall
Richard L. Crandall

/s/ Charles D. Drucker
Charles D. Drucker

/s/ Juliet S. Ellis
Juliet S. Ellis

/s/ Gary G. Greenfield
Gary G. Greenfield

/s/ Lois M. Martin
Lois M. Martin

Exhibit 31.1

Certification Pursuant to Rule 13a-14(a) and Rule 15d-14(a)
of the Securities Exchange Act of 1934

I, Daniel N. Leib, certify that:

1. I have reviewed this Annual Report on Form 10-K of Donnelley Financial Solutions, Inc.;

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

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

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

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

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

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

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

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

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

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

Date: February 27, 2019

/s/ DANIEL N. LEIB

Daniel N. Leib
President and Chief Executive Officer

Exhibit 31.2

Certification Pursuant to Rule 13a-14(a) and Rule 15d-14(a)
of the Securities Exchange Act of 1934

I, David A. Gardella, certify that:

1. I have reviewed this Annual Report on Form 10-K of Donnelley Financial Solutions, Inc.;

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

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

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

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

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

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

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

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

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

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

Date: February 27, 2019

/s/ DAVID A. GARDELLA
David A. Gardella
Executive Vice President and Chief Financial Officer

Exhibit 32.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER

**CERTIFICATION PURSUANT TO RULE 13a-14(b) OR RULE 15d-14(b)
AND SECTION 1350 OF CHAPTER 63 OF TITLE 18
OF THE UNITED STATES CODE (18 U.S.C. 1350),
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of Donnelley Financial Solutions, Inc. (the "Company") on Form 10-K for the period ending December 31, 2018 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Daniel N. Leib, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that to the best of my knowledge:

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

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

February 27, 2019

/s/ DANIEL N. LEIB

Daniel N. Leib
President and Chief Executive Officer

Exhibit 32.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER

**CERTIFICATION PURSUANT TO RULE 13a-14(b) OR RULE 15d-14(b)
AND SECTION 1350 OF CHAPTER 63 OF TITLE 18
OF THE UNITED STATES CODE (18 U.S.C. 1350),
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of Donnelley Financial Solutions, Inc. (the "Company") on Form 10-K for the period ending December 31, 2018 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, David A. Gardella, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that to the best of my knowledge:

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

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

February 27, 2019

/s/ DAVID A. GARDELLA

David A. Gardella
Executive Vice President and Chief Financial Officer

Edifecs, Inc. and Subsidiaries

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Eliza Corporation

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ANNUAL REPORT 2018

hms®

Moving healthcare forward.

Att E-1867

William C. Lucia
Chairman & Chief Executive Officer

Dear Shareholder:

Our Company executed well in 2018 and our positive operating and financial performance led to strong shareholder returns. Our results included record revenues, improved profitability and a strengthened balance sheet, which provides a solid foundation for continued success in the year ahead.

More specifically, total revenue for the year was just under $600 million after topping $500 million for the first time in 2017. Revenue from commercial customers grew double digits, while payment integrity and total population management revenues were both up in excess of 20%. Earnings per share for the full year increased 36% and adjusted EPS, excluding discrete tax benefits in both years, jumped 46% year-over-year. Net income and adjusted EBITDA were 37% and 30% higher, respectively, as we benefited from strong contribution margin on incremental revenue growth and the early-stage operational efficiencies generated from our technology investments. Operating cash flow in 2018 was nearly $100 million, and we ended the year with very low net debt and a liquidity profile that positions HMS well to continue investing for future business growth.

We also accomplished several important strategic goals in 2018. We leveraged our investments in advanced technologies to streamline operating processes and boost profit margins. We ramped up our cross-selling activities with the Eliza consumer engagement platform in our first full year of ownership. And we expanded our product suite with the launch of an innovative, internally developed clinical analytics and risk stratification tool – Elli. It uses historical claims data to produce actionable, predictive analytics to help identify at-risk and potentially high-cost members as early as the point of enrollment.

We continue to believe the macro backdrop for the services we offer is favorable, and we see significant opportunity for market expansion of the payment accuracy and total population management services we currently offer. We expect that our robust and market-leading data, advanced analytics capabilities, expansive customer base and engaged workforce will serve as a strong foundation to help reduce the cost of health care and improve patient health and overall consumer experience of care, while driving growth for HMS for many years to come.

In fact, we expect the need for the types of services HMS provides will only increase over the next decade. Consistent with what has been a multi-year trend of escalating healthcare spending, CMS recently estimated healthcare costs will grow at a 5.5% annual pace over the next several years – reaching 19.4% of GDP by 2027. These rising costs continue to drive demand for payment accuracy and actionable analytics and technology solutions to improve patient engagement.

As consumers have taken on increased financial responsibility in recent years, new care delivery models focused on treating the whole person – including addressing behavioral and social determinants of health – have gained greater acceptance. These trends have also contributed to heightened interest among payers, providers and consumers in pursuit of solutions which reduce costs, improve health outcomes and enhance the individual member experience.

HMS is well positioned to assist those key constituencies in this important mission. Our approach to total population management provides personalized engagement and care plans at enterprise scale – leading to needed behavioral change, healthier outcomes and more satisfied consumers.

Our introduction of Elli last year significantly enhances our ability to provide actionable insights to customers. We can now create a health profile of new enrollees, for example, so appropriate medical management activities can begin expeditiously – rather than payers and their care management personnel waiting months to identify an individual member's needs. Going forward, we are promoting and selling Elli together with our Essette care management and Eliza multi-model engagement platforms as a comprehensive suite of services to efficiently manage the health of any discrete population.

Looking ahead, we expect 2019 will be another strong year of top line and bottom line growth. We are projecting total revenue will be 8 - 10% higher than last year (excluding the impact of a Medicare RAC reserve release in the first quarter of 2018), and expect both net income and adjusted EBITDA will continue to grow at a rate faster than revenue. We plan to continue our increased investment in technology, in order to develop innovative products, support data security and enhance our IT infrastructure. We believe we are only in the early innings of realizing the full benefits of machine learning, robotics and other technological enhancements that further our automation initiatives and continue to increase efficiencies, lower costs and improve yields across our business.

Our strategic framework for achieving our Company's 2019 operating and financial goals includes four pillars:

- Broadening the use of technology to expand margins and profitability by maintaining a focus on product yield and process improvements, while diligently managing operating expenses;
- Increasing sales by expanding our existing customer relationships and capturing new logos;
- Expanding our market opportunities by continuing to develop innovative new products, pursuing strategic acquisition opportunities, and moving further into markets where HMS is relatively less penetrated, such as self-insured employers, PBMs and other risk-bearing entities; and
- Continuing to focus on employee engagement and a high-performance culture, which rewards outstanding individual achievement and positions HMS to retain and recruit top talent as we grow.

We are very proud of our significant achievements last year, and look forward to 2019 with deep appreciation for the support and encouragement we have received from shareholders. We are confident that we have the right talent, strategic focus and operational tools in place to achieve our objectives this year and in the future.

Sincerely,

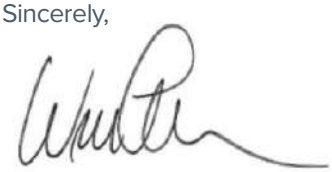

William C. Lucia
Chairman and Chief Executive Officer
April 12, 2019

Safe Harbor: This letter contains certain "forward-looking statements" within the meaning of the U.S. Private Securities Litigation Reform Act of 1995. These statements relate to our current expectations, projections and assumptions about our business, the economy and future events or conditions; they do not relate strictly to historical or current facts. For a discussion identifying important factors that could cause actual results to differ from those stated or implied in our forward-looking statements, see the Company's filings with the SEC, including, but not limited to the "Cautionary Note Regarding Forward-Looking Statements," "Risk Factors," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and "Quantitative and Qualitative Disclosures about Market Risk" in the Form 10-K portion of this Annual Report. Our forward-looking statements speak only as of the date of this letter or as of the date they are made, and we undertake no obligation to update them.

Additionally, this letter contains certain non-GAAP measures that our management believes are relevant and provide our shareholders with useful information about the Company's operating performance because the measures allow them to understand and compare the Company's actual and expected operating results during the prior, current and future periods in a more consistent manner. These non-GAAP measures are not measurements of financial performance or liquidity under GAAP and should not be considered alternatives to the Company's other financial information determined under GAAP. For a reconciliation of these non-GAAP measures to comparable GAAP measures, please refer to Appendix A.

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

Form 10-K

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

For the fiscal year ended December 31, 2018

Or

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

For the transition period from to

Commission File Number 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	11-3656261 (I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX (Address of principal executive offices)	75038 (Zip Code)

(214) 453-3000
(Registrant's telephone number, including area code)

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

Title of each class	Name of each exchange on which registered
Common Stock $0.01 par value	The Nasdaq Stock Market LLC (Nasdaq Global Select Market)

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

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

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

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

The aggregate market value of the registrant's common stock held by non-affiliates as of June 29, 2018 the last business day of the registrant's most recently completed second quarter was approximately $1.8 billion based on the last reported sale price of the registrant's common stock on the Nasdaq Global Select Market on that date. Solely for purposes of this disclosure, shares of common stock held by executive officers, directors and persons who hold 10% or more of the outstanding shares of common stock of the registrant as of such date have been excluded because such persons may be deemed to be affiliates. This determination is not necessarily a conclusive determination for any other purposes.

There were 85,271,867 shares of common stock outstanding as of February 15, 2019.

Documents Incorporated by Reference

Unless provided in an amendment to this Annual Report on Form 10-K, the information required by Part III is incorporated by reference to the registrant's 2019 definitive proxy statement, to the extent stated herein. Such proxy statement or amendment will be filed with the Securities and Exchange Commission within 120 days of the registrant's fiscal year ended December 31, 2018.

HMS HOLDINGS CORP. AND SUBSIDIARIES
ANNUAL REPORT ON FORM 10-K
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Glossary of Terms and Abbreviations

ACA	Patient Protections and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010
ACO	Accountable Care Organization
ADR	Additional Documentation Request
ASO	Administrative Service Only
ASU	Accounting Standards Update
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CMS NHE	CMS National Health Expenditures
COB	Coordination of Benefits
COSO	Committee of Sponsoring Organizations of the Treadway Commission
Credit Agreement	The Amended and Restated Credit Agreement dated as of May 3, 2013, as amended by Amendment No. 1 to Amended and Restated Credit Agreement dated as of March 8, 2017, and as further amended by Amendment No. 2 to Amended and Restated Credit Agreement, dated as of December 19, 2017, by and among HMS Holdings Corp., the Guarantors party thereto, the Lenders party thereto and Citibank, N.A. as Administrative Agent
DSO	Days Sales Outstanding
ERISA	Employment Retirement Income Security Act of 1974
Exchange Act	Securities Exchange Act of 1934, as amended
FASB	Financial Accounting Standards Board
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITECH	Health Information Technology for Economic and Clinical Health
IRC	Internal Revenue Code
IRS	U.S. Internal Revenue Service
LIBO Rate	Intercontinental Exchange London Interbank Offered Rate (or any successor rate determined in accordance with the Credit Agreement)
MCO	Managed care organization
PBM	Pharmacy Benefit Manager
PHI	Protected health information
PI	Payment Integrity
R&D Credit	U.S. Research and Experimentation Tax Credit pursuant to IRC Section 41
RAC	Recovery Audit Contractor
RFP	Request for proposal
SEC	U.S. Securities and Exchange Commission
Securities Act	Securities Act of 1933, as amended
Section 199 Deduction	U.S. Production Activities Deduction pursuant to IRC Section 199
SG&A	Selling, general and administrative
TPL	Third-party liability
TPM	Total Population Management
U.S. GAAP	United States Generally Accepted Accounting Principles
401(k) Plan	HMS Holdings Corp. 401(k) Plan
2006 Stock Plan	HMS Holdings Corp. Fourth Amended and Restated 2006 Stock Plan, as amended by Amendment No. 1 to the HMS Holdings Corp. Fourth Amended and Restated 2006 Stock Plan dated as of February 16, 2012
2011 HDI Plan	HDI Holdings, Inc. Amended 2011 Stock option and Stock Issuance Plan
2016 Omnibus Plan	HMS Holdings Corp. 2016 Omnibus Incentive Plan
2017 Tax Act	Tax Cuts and Jobs Act of 2017
2018 Form 10-K	HMS Holdings Corp. Annual Report on Form 10-K for the year ended December 31, 2018

Cautionary Note Regarding Forward-Looking Statements

For purposes of this 2018 Form 10-K, the terms "HMS," "Company," "we, "us, and "our" refer to HMS Holdings Corp. and its consolidated subsidiaries unless the context clearly indicates otherwise. Included in this 2018 Form 10-K are "forward-looking statements" within the meaning of the U.S. Private Securities Litigation Reform Act of 1995. From time to time, we also provide forward-looking statements in other materials we release to the public, as well as oral forward-looking statements. Such statements relate to our current expectations, projections and assumptions about our business, the economy and future events or conditions. They do not relate strictly to historical or current facts.

We have tried to identify forward-looking statements by using words such as "aim," "anticipate," "believe," "estimate," "expect," "forecast," "future," "intend," "likely," "may," "plan," "project," "seek," "strategy," "target," "will," "would," "could," "should," and similar expressions and references to guidance, although some forward-looking statements may be expressed differently. These statements include, among other things, information concerning our future growth, business strategy, strategic or operational initiatives, our future operating or financial performance, our ability to invest in and utilize our data and analytics capabilities to expand our capabilities, the benefits and synergies to be obtained from completed and future acquisitions, the future performance of companies we have acquired, our future expenses, interest rates and tax rates, our ability to meet our future liquidity requirements, the impact of changes to U.S. healthcare legislation or healthcare spending affecting Medicare, Medicaid or other publicly funded or subsidized health programs, and other statements regarding our possible future actions, business plans, objectives and prospects.

Forward-looking statements are not guarantees and involve risks, uncertainties and assumptions that are difficult to predict. Actual results may differ materially from past results and from those indicated by such forward-looking statements if known or unknown risks or uncertainties materialize, or if underlying assumptions prove inaccurate. These risks and uncertainties include, among other things:

- *our ability to execute our business plans or growth strategy;*
- *our ability to innovate, develop or implement new or enhanced solutions or services;*
- *the nature of investment and acquisition opportunities we are pursuing, and the successful execution of such investments and acquisitions;*
- *our ability to successfully integrate acquired businesses and realize synergies;*
- *significant competition for our solutions and services;*
- *variations in our results of operations;*
- *our ability to accurately forecast the revenue under our contracts and solutions;*
- *our ability to protect our systems from damage, interruption or breach, and to maintain effective information and technology systems and networks;*
- *our ability to protect our intellectual property rights, proprietary technology, information processes and know-how;*
- *our failure to maintain a high level of customer retention or the unexpected reduction in scope or termination of key contracts with major customers;*
- *customer dissatisfaction or our non-compliance with contractual provisions or regulatory requirements;*
- *our failure to meet performance standards triggering significant costs or liabilities under our contracts;*
- *our inability to manage our relationships with data sources and suppliers;*
- *our reliance on subcontractors and other third party providers and parties to perform services;*
- *our ability to continue to secure contracts and favorable contract terms through the competitive bidding process;*
- *pending or threatened litigation;*
- *unfavorable outcomes in legal proceedings;*
- *our success in attracting and retaining qualified employees and members of our management team;*
- *our ability to generate sufficient cash to cover our interest and principal payments under our credit facility;*
- *unexpected changes in tax laws, regulations or guidance and unexpected changes in our effective tax rate;*
- *unanticipated increases in the number or amount of claims for which we are self-insured;*
- *changes in the U.S. healthcare environment or healthcare financing system, including regulatory, budgetary or political actions that affect healthcare spending or the practices and operations of healthcare organizations;*
- *our failure to comply with applicable laws and regulations governing individual privacy and information security or to protect such information from theft and misuse;*
- *our ability to comply with current and future legal and regulatory requirements;*

- *negative results of government or customer reviews, audits or investigations;*
- *state or federal limitations related to outsourcing of certain government programs or functions;*
- *restrictions on bidding or performing certain work due to perceived conflicts of interests;*
- *the market price of our common stock and lack of dividend payments; and*
- *anti-takeover provisions in our corporate governance documents.*

These and other risks are discussed under the headings "Part I, Item 1. Business," "Part I, Item 1A. Risk Factors," "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations," and "Part II, Item 7A. Quantitative and Qualitative Disclosures about Market Risk" of this 2018 Form 10-K and in other documents we file with the SEC.

Any forward-looking statements made by us in this 2018 Form 10-K speak only as of the date on which they are made. We undertake no obligation to publicly update forward-looking statements, whether as a result of new information, future events or otherwise, except as may be required by law. We caution readers not to place undue reliance upon any of these forward-looking statements. You are advised, however, to consult any further disclosures we make on related subjects in our Form 10-Q and Form 8-K reports and our other filings with the SEC.

Market and Industry Data

This 2018 Form 10-K contains market, industry and government data and forecasts that have been obtained from publicly available information, various industry publications and other published industry sources. We have not independently verified the information and cannot make any representation as to the accuracy or completeness of such information. None of the reports and other materials of third party sources referred to in this 2018 Form 10-K were prepared for use in, or in connection with, this 2018 Form 10-K.

Trademarks and Trade Names

We have a number of registered trademarks, including HMS®, as well as the corresponding HMS + logo design mark, HMS IntegritySource®, Eliza®, Essette® and Elli®. These and other trademarks of ours appearing in this 2018 Form 10-K are our property. Solely for convenience, trademarks and trade names of ours referred to in this 2018 Form 10-K may appear without the ® or ™ symbols, but such references are not intended to indicate, in any way, that we will not assert, to the fullest extent under applicable law, our rights or the right of the applicable licensor to these trademarks and trade names. This 2018 Form 10-K contains additional trade names and trademarks of other companies. We do not intend our use or display of other companies' trade names or trademarks to imply an endorsement or sponsorship of us by such companies, or any relationship with any of these companies.

PART I

Item 1. Business

Founded in 1974, HMS is an industry-leading provider of cost containment solutions in the healthcare marketplace. We use healthcare data technology, analytics and related services to deliver coordination of benefits, payment integrity, population risk intelligence, care management and consumer engagement solutions to help payers reduce costs, improve healthcare outcomes and enhance member experiences. We provide coordination of benefits services to government and commercial healthcare payers to ensure that the correct party pays a claim, and payment integrity services to ensure the correct amount is paid. Our total population management solutions provide risk-bearing organizations with reliable intelligence across their member populations to identify risks and improve patient engagement and outcomes. Together these services help move the healthcare system forward for our customers and contribute to bending the healthcare cost curve for the nation.

HMS began its operations as Health Management Systems, Inc., which became our wholly owned subsidiary in March 2003 when we assumed its business in connection with the adoption of a holding company structure. In recent years HMS has grown both organically and through targeted acquisitions of businesses that helped expand our solution suite, including IntegriGuard, LLC (doing business as HMS Federal) in 2009; HealthDataInsights, Inc. ("HDI") in 2011; Essette, Inc. ("Essette") in 2016; and Eliza Holding Corp. ("Eliza") in 2017. We currently operate as one business segment with a single management team that reports to the Chief Executive Officer.

We were originally incorporated in the State of New York in October 2002 and reincorporated in the State of Delaware in July 2013. Our principal executive offices are located at 5615 High Point Drive, Irving, Texas 75038, and our telephone number is (214) 453-3000. As of December 31, 2018, we had approximately 2,500 employees. Additional information about HMS is available on our website at www.hms.com.

Copies of our recent Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and Proxy Statements, as well as amendments to these reports or statements, are available free of charge on our website through the Investor Relations page, as soon as reasonably practicable after we electronically file them with, or furnish them to, the SEC. These materials, as well as similar materials for SEC registrants, may be obtained directly from the SEC through their website at http://www.sec.gov.

The content of any website referred to in this 2018 Form 10-K is not incorporated by reference into this filing unless expressly noted. References to the URLs for these websites are intended to be inactive textual references only.

Our Solutions

We provide solutions that apply broadly across Medicaid, Medicare, commercial at-risk, and employer self-insured populations. Our services span the payment and care continuum from an individual's enrollment in a program before medical service is rendered, to pre-payment review of a claim, through recovery where identification of improper payments is made via audit, and back to the individual where our consumer-driven solutions allow health plans to manage their members on a personal level, and at scale, by using actionable analytics that drive patients to take action to improve health outcomes. Our coordination of benefits and payment integrity services ensure payment accuracy by addressing a wide spectrum of payment errors, including eligibility and coordination of benefits errors, the identification and investigation of potential fraud, and the review of claims on a pre-payment and post-payment basis. Our total population management services assist customers in managing quality, risk, cost and compliance across all lines of business by engaging members, providing the tools to manage their care, and identifying existing or emerging health risk among members. As a result of these services, our customers saved billions of dollars in 2018 through the prevention of erroneous payments, improved clinical outcomes for their members, and reduced enrollment turnover; and they received billions more in cash recoveries for improperly paid claims.

Coordination of Benefits

Industry-leading solution ensures the right payer pays the claim, both prospectively for cost avoidance and retrospectively for recoveries of improper payments

Payment Integrity

Comprehensive solution set to reduce fraud, waste and abuse by identifying and correcting healthcare claims that are billed and paid improperly

Total Population Management

Population and member health management suite of services addresses cost, quality and compliance through risk analytics, member engagement and care management platforms

Our comprehensive solutions offer value throughout the healthcare continuum and include the following:

Coordination of Benefits (COB)

Our COB services are provided primarily for state governments and Medicaid managed care plans, pursuant to Federal law which mandates that Medicaid is the payer of last resort, and draw principally upon proprietary information management and data mining techniques designed to ensure the correct party pays a healthcare claim. We offer cost avoidance services, which include providing validated insurance coverage information that is used by payers to coordinate benefits properly for future claims. With validated insurance information, Medicaid payers can avoid unnecessary costs by ensuring they pay only after all other insurance coverage available has been exhausted. Nevertheless, due to a variety of factors, many Medicaid claims are paid even when there is a known responsible third party. Our customers rely on us to identify Medicaid eligibility, before a claim is submitted, and retrospectively, for those claims that were paid in error, and then recover these payments from the liable third party. We also provide services to assist customers in identifying other third-party insurance and recovering medical expenses where a member is involved in a casualty or tort incident. Lastly, for Medicaid agencies exclusively, we provide estate recovery services to identify and recover Medicaid expenditures from the estates of deceased Medicaid members in accordance with state policies. For the years ended December 31, 2018, 2017 and 2016, our COB services represented 66.4%, 73.4% and 72.2% of our total revenue, respectively.

Analytical services

Analytical services consists of our payment integrity and total population management solutions.

Payment Integrity (PI)

Our PI services ensure healthcare payments are accurate and appropriate. These services are applicable to all customers HMS serves, including federal and state governments, commercial health plans and other at-risk or self-insured entities. Our solutions verify that healthcare services are utilized, billed and paid appropriately. We combine data analytics, clinical expertise and proprietary algorithms and technology to identify and prevent improper payments on submitted claims to optimize savings before a claim is even paid, and on a post-payment basis, to identify and recover overpayments and correct underpayments; detect and prevent fraud, waste and abuse; and identify process improvements. For the years ended December 31, 2018, 2017 and 2016, our PI services represented 24.1%, 20.0% and 27.6% of our total revenue, respectively.

Total Population Management (TPM)

Our TPM services consist of population risk analytics, consumer engagement and care management solutions, which are the result of internal product development and our acquisitions of Essette in 2016 and Eliza in 2017. These solutions help customers better manage quality, cost, compliance and patient outcomes and improve their members' experience. The services span across the care continuum. Our flexible, scalable architecture and modular platform integrates early risk identification, advanced analytics, multi-channel outreach, social engagement and care management components to address our customers' increased focus on consumer engagement, performance management and program design—all key components of an effective population health management program. Our Elli, Eliza and Essette solutions leverage HMS data and advanced analytics to support population risk management, member engagement and care management, respectively, and provide customers with a tailored, integrated platform that addresses core healthcare industry challenges on an enterprise scale. For the years ended December 31, 2018, 2017 and 2016, our TPM services represented 9.5%, 6.6% and 0.2%, of our total revenue, respectively.

Intellectual Property

Our ability to develop and maintain the proprietary aspects of our technology and operate without infringing the proprietary rights of others is important to our business and competitive position. We establish and protect our proprietary technology and intellectual property through a combination of patents, patent applications, trademarks, copyrights, domain names and trade secrets, as well as through contractual rights, including confidentiality, non-disclosure and invention assignment agreements, and other security measures.

As of December 31, 2018, our patent portfolio is comprised of approximately 60 domestic and international patents, and we are currently pursuing several patent applications in the United States and around the world. Our principal trademarks are HMS®, and the corresponding HMS + logo design mark, HMS IntegritySource®, Eliza®, Essette®, and Elli®. We also hold copyrights relating to certain aspects of our solutions and services. While we consider all of our intellectual and proprietary rights important to HMS, we believe our business as a whole is not materially dependent on any particular patent, trademark, license or other intellectual property right.

Customers

We provide our solutions to customers across a broad range of entities within the healthcare industry, including health plans, state agencies, federal programs, private employers and other risk-bearing healthcare organizations. For the years ended December 31, 2018, 2017 and 2016, our total revenue was $598.3 million, $521.2 million and $489.7 million, respectively. No single customer accounted for 10% or more of our total revenue during any period presented.

The composition of our 10 largest customers changes periodically. For the years ended December 31, 2018, 2017 and 2016, our 10 largest customers represented 41.4%, 39.5% and 40.6% of our total revenue, respectively. We provide services under contracts (or subcontracts) that contain various revenue structures, including contingent revenue and to a lesser extent fixed-fee arrangements. The current terms of many of our federal and state government contracts range from one to five years, including renewal terms at the option of the customer. In many instances, we provide our services pursuant to agreements that are subject to periodic reprocurements. Several of our contracts, including those with some of our largest customers, may be terminated for convenience, in whole or in part, by the customer. Because we provide our services pursuant to agreements that are open to competition from various businesses in the U.S. healthcare arena, we cannot provide assurance that our contracts, including those with our largest customers, will not be terminated for convenience or awarded to other parties. Additionally, we cannot provide assurance that any contracts that are renewed will have the same fee structures as the expiring contracts or otherwise be on satisfactory terms. The early termination of key contracts with significant customers, or the inability to renew such contracts on favorable terms or at all, may have an adverse effect on our financial condition, results of operations and cash flows.

In providing solutions and services to our customers, we rely heavily upon our technology systems and networks, as well as on those of third-party providers, to process, transmit, maintain, store and host the confidential, proprietary and sensitive information and data we receive from our customers and other data suppliers, including private insurance plans and financial institutions. The secure processing and maintenance of this information is critical to our operations and business strategy. Although we have spent significant resources to implement security and privacy programs and controls, train our workforce and augment our security measures with the implementation of new technologies and processes, our information technology and infrastructure, and those of third parties on which we rely could continue to be potentially subject to various forms of cyber-attacks, as further discussed under the heading “Part I, Item 1A. Risk Factors.”

Healthcare Landscape

The market for cost containment solutions is large and growing, driven by increasing healthcare costs, rising program enrollment and payment complexities. Established in 1965 under the Social Security Act, Medicaid provides health insurance and long-term care services and support to low-income families and individuals with disabilities in the United States. Medicaid is funded jointly by the federal and state governments and administered by the states. The Balanced Budget Act of 1997 created CHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Medicare is a federal program that is administered by CMS, and provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance and prescription drug benefits. All three of these programs have opted to contract with managed care organizations in whole or in part as a means of delivering quality healthcare to program beneficiaries and controlling costs.

By law, Medicaid programs serve as the payer of last resort and all other sources of coverage must pay for medical costs incurred by a Medicaid-eligible individual. The TPL rules of the Medicaid statute require, among other things, that states take reasonable measures to identify potentially liable third parties and process claims accordingly. Since 1985, we have provided state Medicaid agencies with services to identify third parties with primary liability for paying claims for Medicaid members, and since 2005, we have provided similar services to Medicaid managed care plans.

The Deficit Reduction Act enacted by Congress in 2006 contained provisions to strengthen the TPL rules and created the Medicaid Integrity Program under the Social Security Act to increase the government’s capacity to prevent, detect and address fraud, waste and abuse in the Medicaid program. Later that year, Congress passed the Tax Relief and Health Care Act of 2006, which established the Medicare RAC program. These measures, at both the federal and state level, have strengthened our ability to identify and recover erroneous payments on behalf of our customers. We also serve as a Medicaid RAC to certain states pursuant to provisions of the ACA and became the Medicare RAC for Region D with our acquisition of HDI. We again were awarded a region under the new Medicare RAC contracts in October 2016. Following the implementation of the new Medicare RAC contracts and completion of contract closeout activities for RAC Region D, our original Medicare RAC contract expired on January 31, 2018.

The ACA, generally referred to as Obamacare, was signed into law in 2010 and has made broad-based changes to the U.S. healthcare system, including many provisions impacting healthcare delivery and payment programs, such as employer-sponsored health coverage, Medicaid, Health Insurance Exchanges with premium subsidies and payment integrity efforts. The ACA also further expanded the recovery audit contractor program to states. CMS and various states have proposed Medicaid program design alternatives and changes to enrollment criteria which could impact future Medicaid enrollment. As ACA-related changes develop or are enacted, we will assess their potential impact, including opportunities they may present for our customers and for us.

Industry Trends and Opportunities

U.S. healthcare expenditures continue to escalate and consume an increasingly larger proportion of the U.S. GDP, presenting challenges for payers who wish to contain costs and promote quality healthcare outcomes. For 2019, Medicare and Medicaid are projected to pay approximately 37.9% of the nation's healthcare expenditures and serve over 136.3 million beneficiaries. Many of these beneficiaries are enrolled in managed care plans, which have the responsibility for both patient care and claims adjudication. The dual aims of cost containment and quality healthcare outcomes are the same across all at-risk entities, including commercial health plans and government healthcare programs, such as Medicaid and Medicare.

Within the commercial market, health plans sell policies directly to individuals (on the open market or via health insurance exchanges), contract with employers to underwrite their employees' care, or contract with self-insured employers to oversee benefit administration for their employees. This market also includes a growing number of risk bearing provider-sponsored plans that operate and market health plan benefits. According to CMS NHE projections, private health insurance covered approximately 197.5 million individuals at a cost of approximately $1.24 trillion in 2018.

Several commercial health plans also offer government-sponsored lines of business, including partnering with Medicare, Medicaid and CHIP to oversee care delivery for beneficiaries enrolled in those programs. States continue to focus on improving value, quality and outcomes through arrangements with MCOs. At the end of state fiscal year 2018, 47 states and the District of Columbia operated with some form of managed care, and Alaska reported plans to implement a managed care program in 2019. Comprehensive risk-based managed care continues to be the predominant delivery system for Medicaid services in the US. Among the 39 Medicaid programs with comprehensive risk-based MCOs, 33 reported that 75% or more of their Medicaid beneficiaries were enrolled in MCOs as of July 1, 2018. Of the 32 states that had implemented Medicaid expansion pursuant to the ACA, 27 were using MCOs to cover newly eligible adults as of July 1, 2018. Managed care health plans also continue to assume risk for a growing number of Medicare lives. Approximately 34% of all Medicare beneficiaries, or 20 million lives, were enrolled in Medicare Advantage plans in 2018.

HMS continues to serve government agency fee-for-service programs at the state and federal level. These plans are generally reliant on and susceptible to the government appropriations process that determines their budget and governs the number of beneficiaries they serve. According to the CMS NHE projections, Medicare programs in 2018 covered approximately 59 million people at a cost of approximately $748 billion and Medicaid/CHIP covered approximately 81.2 million people, costing approximately $641 billion. Altogether, it is projected that the government programs we serve covered approximately 140.2 million people at a total cost of nearly $1.39 trillion in 2018.

CMS projects that Medicare enrollment growth will increase by 3.03% in 2019, with expenditures to increase by 7.95% in 2019 compared to 2018; and Medicaid/CHIP enrollment growth will increase by 1.97% in 2019, with expenditures to increase by 5.5% in 2019 compared to 2018. As commercial and government health plans focus on strategies to contain costs across their different lines of business, HMS will continue offering solutions to meet their evolving needs.

Competitors

The U.S. healthcare marketplace is a dynamic industry with a range of businesses currently offering cost containment services, both directly or indirectly (through subcontracting), to some or all of the various healthcare payers, providers, employers and consumers. In addition, with improvements in technology and the growth in healthcare spending, new businesses are incentivized to enter this marketplace. Many customers also have the ability to perform some or all of the needed cost containment services themselves and choose to exercise that option to varying degrees. Therefore, competition is robust as customers have many alternatives available to them in their effort to contain healthcare costs.

We compete based on a variety of factors, including our ability to provide a broad range of solutions that span the entire healthcare claims payment and services continuum. These include payment accuracy solutions focused on COB and PI related functions, as well as TPM solutions which support the ability of payers to better understand and engage consumers, perform effective outreach, and impact both costs and health outcomes.

We have a proven record of delivering results that optimize savings and recoveries, enabled by:

- in-depth government and commercial healthcare program experience;
- clinical staff expertise;
- expansive data resources;

- innovative technology;
- enterprise analytics;
- an extensive insurance eligibility database;
- extensive relationships with customers and other industry stakeholders; and
- an ability to provide customers with actionable intelligence to improve clinical outcomes, optimize patient engagement, and better manage costs.

Our competitors range in size from large, diversified national companies, to small, specialized firms. Some of these competitors have significantly greater financial and technical resources, and others have longer operating histories and greater name recognition than we do in certain markets. Within our payment accuracy portfolio of products and services, we compete primarily with large business outsourcing and technology firms, claims processors and PBMs, clearinghouses, healthcare consulting firms, and other vendors who provide some or all of these solutions to payers. In addition, we frequently work with customers who may elect to perform some or all of their cost avoidance and recovery functions in-house. Within the population health management sector, we compete primarily with vendors who provide care management, consumer engagement, and related technology services. Companies with whom we compete across our offerings include:

- Accenture plc
- Cotiviti Corporation
- EXL Service Holdings, Inc.
- LexisNexis
- Performant Financial Corporation
- CaseNet LLC
- DXC Technology Company
- Experian Health
- MedHok, Inc.
- Welltok, Inc.
- Change Healthcare
- Equian, LLC
- IBM Watson Health
- Optum (subsidiary of UnitedHealthGroup)
- ZeOmega LLC

Business Strategy

We believe that the steadily increasing enrollment and rising expenditures for Medicare and Medicaid, with most new enrollees entering managed care plans; an aging U.S. population with an increasing concentration of individuals with high cost chronic conditions and often co-morbidities; and the overall complexity of the healthcare claims payment system in the U.S. all combine to create substantial growth opportunities for the suite of cost containment solutions we offer.

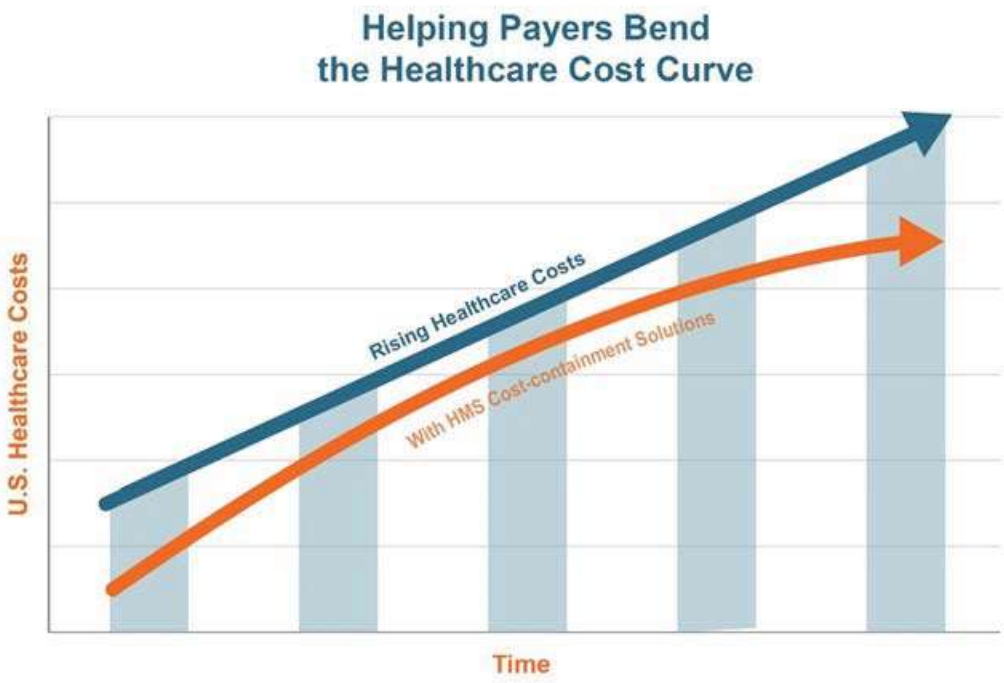

We also believe these factors present growth opportunities for our TPM services. We are focused on growing our business over the course of 2019 and beyond, both organically and inorganically, by leveraging existing key assets (e.g., our data, analytics, in-house expertise, and distribution channel) and pursuing a number of strategic objectives or initiatives, including:

- *Expanding the scope of our relationship with existing customers* – by selling additional solutions and services, including those designed to improve member engagement and improve clinical outcomes.

- *Adding new customers* – by marketing to commercial health plans, including Medicaid managed care and Medicare Advantage plans, at-risk group and individual health lines of business and ASOs; government healthcare payers, including Medicaid agencies, state employee health benefit plans and CHIPs; at-risk provider organizations and ACOs; and commercial self-insured employers.

- *Introducing new innovative solutions and services* – through internal development initiatives designed to enhance or expand our existing suite of cost containment solutions.

- *Utilizing technology tools to leverage a big data environment* – to create a more nimble operating environment, create operating efficiencies, improve the yield on our existing solution suite and identify new revenue opportunities within our current service delivery models.

- *Promoting automation and innovation to improve the efficiency and effectiveness of our services* – by continuing to implement new technology and process improvements designed to increase recovery yields, increase customer satisfaction and achieve greater operating efficiencies.

- *Prudent deployment of capital* – by investing in internal growth initiatives; selectively investing in capabilities, technologies, and assets to complement our core cost-containment expertise; building care management and care coordination adjacencies to complement the Essette and Eliza acquisitions and our internally developed Elli risk intelligence product; and expanding our data analytics capabilities. Our focus may include acquisitions that represent long-term growth potential, target high-growth areas, are accretive to earnings, enhance our technological capabilities and fill a strategic need in our business portfolio as we seek to provide increasingly comprehensive solutions to our customers. We may also repurchase our shares, pursuant to a two-year $50 million authority granted by our Board of Directors in November 2017, which has a remaining unused authority of approximately $29.9 million.

Item 1A. Risk Factors

Our business is subject to significant risks, including the risks and uncertainties described below. You should carefully consider these risks, as well as the other information in this 2018 Form 10-K, including our Consolidated Financial Statements and the related Notes. The occurrence of any of these risks could adversely affect our business, financial condition, results of operations, and cash flows in a material way.

Risks Relating to Our Company

Our ability to expand our business will be adversely affected if we fail to implement our growth strategy.

The size and scope of our business operations have expanded over the past several years, and we currently intend to continue our growth and expansion into new healthcare areas and markets, however, our growth and expansion strategy carries costs and risks that, if not properly managed, could adversely affect our business. Our future growth will depend on, among other things, our ability to successfully execute our business plans, which includes penetrating new markets, broadening and deepening our customer relationships, identifying and executing future acquisitions and strategic partnerships, and increasing the speed and scale at which we deliver our services, all while remaining competitive. We must also be flexible and responsive to customers' needs and changes in the political, economic and regulatory environment in which we operate. The greater size and complexity of our expanding business may put additional strain on our administrative, operational and financial resources and can make optimal resource allocation more difficult to determine. It is possible that we may not be able to maintain or accelerate our growth. A failure to anticipate or properly address the demands and challenges that our growth strategy and potential diversification may have on our resources and existing infrastructure may result in unanticipated costs and inefficiencies that could negatively impact our ability to execute on our business plans and growth goals, which may have a material adverse effect on our business, financial condition, results of operations and cash flows.

If we fail to innovate and develop new or enhanced solutions and services, or if these solutions and services are not adopted by our customers, it could have a material adverse effect on our business, financial condition, results of operations and cash flows.

Part of our growth strategy depends on our ability to respond to the evolving healthcare landscape with new and enhanced solutions and services that our existing and potential customers are willing to adopt. The development, marketing and implementation of these solutions and services may require that we make substantial financial and resource investments. We face risks that our new or modified solutions and services may not be responsive to customer preferences or industry changes, and that the solution and service development initiatives that we prioritize may not yield the gains that we anticipate, if any. If we are unable to predict market preferences or healthcare industry changes, or if we are unable to develop or adapt solutions and services that are responsive to existing and potential customers' needs, we may fail to expand our business, which could constrain our future revenue growth and materially adversely affect our business, financial condition, results of operations and cash flows.

Our acquisition strategy may subject us to considerable business and financial risk.

Historically, to achieve our strategic goals, we have made a significant number of acquisitions that have expanded the solutions and services we offer, provided a presence in complementary business lines, or expanded our geographic presence and/or customer base. We intend to pursue future acquisitions that will continue to expand and complement our business and to periodically engage in discussions regarding such possible acquisitions. We are subject to risks and uncertainties relating to our ability to identify suitable potential acquisition candidates, to consummate additional acquisitions that will be advantageous to us, and to successfully integrate future acquisitions. Future and potential business acquisitions involve a number of risk factors that could affect our operations, including, but not limited to:

- diversion of management's attention and other resources;
- our ability to successfully and timely integrate operational, accounting and technology functions, policies, processes, systems and controls, and to implement these functions, policies, processes, systems and controls, without incurring substantial expenses, delays, difficulties or other issues;
- our ability to integrate personnel and human resource systems as well as the cultures of the acquired business;
- our ability to retain or replace the key personnel of the acquired business;
- our ability to maintain relationships with the customers of the acquired business;
- our ability to expand and further develop the acquired business;
- our ability to cross-sell our solutions and the solutions of the acquired business to our respective customers;
- customer dissatisfaction or performance problems with the acquired business;
- our ability to comply with regulatory requirements and avoid potential conflicts of interest in markets that we serve;
- the misuse of intellectual property by the personnel of the acquired business;
- our ability to successfully enter into unfamiliar markets or manage new business lines;
- assumption of unanticipated legal or financial liabilities and/or negative publicity related to prior acts by the acquired business;
- we may become subject to litigation or other claims in connection with the acquired business, including claims from terminated employees, customers, former shareholders or third parties;
- we may become significantly leveraged as a result of incurring debt to finance an acquisition;
- the acquired business may not perform as projected which could negatively impact earnings or contingent consideration;
- we may suffer impairment of goodwill and other acquired intangible assets; and
- we may suffer dilution to our earnings per share.

If we fail to adequately address these risks, or to successfully integrate the businesses that we acquire, we may not realize cost efficiencies, synergies or other benefits that we anticipated when selecting our acquisition candidates, and our reputation, business, financial condition, results of operations and cash flows could be materially adversely affected.

We face significant competition for our solutions and services and we expect competition to increase, which could materially adversely affect our business, financial condition, results of operations and cash flows.

The market for healthcare cost containment solutions is intensely competitive, driven by rapidly changing technologies, evolving industry standards and customer demands to become more efficient. Our competitors range in size from large, diversified national companies (some of which have emerged as a result of industry consolidation), to small, specialized firms. Some of our competitors may include current or former subcontractors or teaming partners seeking to establish direct relationships with our customers and provide similar services as the prime contractor, as well as current and prospective customers that elect to perform recovery and cost avoidance functions in-house or to develop in-house capacities for solutions and services that we provide or seek to provide. Consolidation among vendors and healthcare providers, as well as the merging of some of our competitors or formation of business alliances with other competitors, have contributed to the increasingly competitive environment. For example, certain state customers have combined or "bundled" TPL services under large-scale IT procurements, as they shift to implementing modular Medicaid Enterprise Systems. As part of this modular approach, they may select a new or less experienced vendor to provide the TPL module based on preferred relationships or favorable pricing. In addition, companies that have invested in proprietary technology different from our own service offerings, such as front-end analytics, have emerged as new competitors due to the rapidly evolving healthcare landscape. There is also increasing sophistication in the solutions and services that our competitors are developing that may become more efficient or appealing to our customers. In order to remain competitive, we may need to quickly develop and market new and enhanced solutions and services responsive to emerging technologies and changes in the healthcare industry, which may require that we make substantial financial and resource investments.

We may not be able to compete successfully against our existing or future competitors. Some of these competitors have significantly greater financial and technical resources, and others have longer operating histories and greater name recognition than we do in certain markets. They may be able to (i) offer lower prices or negotiate fee reductions on our current solutions and services, (ii) respond more quickly than we can to new and emerging technologies and changing customer requirements, (iii) devote greater resources to the sale of their products and the development and implementation of new and improved systems, solutions and services for customers that we serve, and (iv) pursue various acquisitions that allow them to rapidly amass a wide array of capabilities. We may be forced to lower our pricing, unexpectedly increase or enhance our technological or data capabilities, or modify our solution or service offerings. Notwithstanding any changes we make in response to increased competition, the demand for our solutions and services may decrease as a result of increased competition. A failure to be responsive to our existing and potential customers' needs or the changing industry landscape could hinder our ability to maintain or expand our customer base, hire and retain new employees, pursue new business opportunities, complete future acquisitions and operate our business effectively. Any inability to compete effectively could materially adversely affect our business, financial condition, results of operations and cash flows.

You will not be able to rely on our operating results in any particular period as an indication of our future performance because they are subject to significant fluctuation which may cause the market price of our common stock to decrease significantly.

Our revenue and operating results may fail to match our past or projected performance and could vary significantly from period-to-period as a result of a number of factors, some of which are outside of our control. We have experienced fluctuations in our revenue and operating results in the past and they may vary in the future for reasons that include, but are not limited to:

- fluctuations in sales activity given our sales cycle;
- the length of contract and implementation periods;
- the commencement, completion or termination of contracts during any particular quarter;
- contract costs and expenses, which may be incurred in periods prior to revenue being recognized;
- the timing of period revenue recovery projects and third party payers' claim adjudication;
- the billing and budgeting cycles of our customers;
- the timing of government procurement activities, including when contract awards are announced and the time required to resolve bid protests;
- contract renewal discussions, which may result in delayed payments for services already performed;
- changes in the pricing structure or other significant terms in our contract, or the scope of services we perform;
- technological and operational issues affecting our customers, including delays in payment receipt for previously recognized revenue due to certain customers delayed processing of our findings through their systems, and restrictions on our ability to use or access certain data or a lack of integrity or quality in the data or information we receive from certain data sources;
- adjustments to age/quality of receivables and accruals as a result of factors such as delays involving contract limitations or changes, subcontractor performance deficiencies or managerial decisions not to pursue identified claim revenue from customers;
- the impact of service disruptions or delays in the systems or operations of subcontractors, partners, vendors and other third party providers on which we rely on to deliver a single-source solution or service to our customers;
- changes in applicable laws;

- changes in accounting policies or guidelines concerning the timing of recognition of revenue; and
- regulatory changes or general economic conditions as they affect healthcare providers and payers.

We cannot predict the extent to which future variations could occur due to these or other factors. In addition, occasionally our state and federal customers are requested by third party payers to refund payments that we previously recovered for our customers. If our state and federal customers choose to refund money in response to these requests, regardless of whether an error actually occurred in connection with the payments, we may also be required to return contingent revenue which we were previously paid associated with such refunded payment. Consequently, our operating results are subject to significant fluctuation for any particular quarter, fiscal year, or other period, and may not be indicative of future periods. Our business is also subject to seasonal patterns resulting from increased efforts at year-end by certain customers to generate additional savings, complete compliance obligations and close gaps in care. However, taken as a whole, we do not consider our operations to be seasonal to any material degree. Due to all of these factors, our revenue and operating results are difficult to predict and are subject to significant fluctuation, which may cause the market price of our common stock to decrease significantly.

We face challenges associated with forecasting the revenue under our contracts, and any failure to accurately forecast such revenue could have a material adverse effect on our business, financial condition, results of operations and cash flows.

We may not be able to accurately estimate the factors upon which we base our contract pricing, or the costs and timing for implementing and completing our contracts. For a majority of our customer contracts, the payment of our fee is contingent upon the recoveries received by our customers. We also have cost-plus or time-and-materials based contracts with the federal government where our revenue is recognized based on costs incurred plus an estimate of the negotiated fee earned. Our ability to earn a profit on these contracts requires that we accurately estimate the costs involved with these contracts and assess the probability of achieving certain outcomes or milestones within the contracted time period. In addition, we cannot predict with certainty the costs or the period in which implementation or contracts may be completed when we introduce new solutions into the marketplace. For our coordination of benefits and payment integrity services, we may face a long implementation period with a new customer or a new contract with an existing customer, making it difficult to reliably forecast revenue under those contracts. If we do not accurately estimate the costs and timing for completing projects, or if we encounter increased or unexpected costs, delays, failures, liabilities or risks, including those outside of our control, our contracts could prove unprofitable for us or yield lower profit margins than anticipated. Although we believe that we have recorded adequate provisions in our financial statements for losses on our fixed price and cost-plus contracts where applicable, as required under U.S. GAAP, our contract loss provisions may not be adequate to cover all actual future losses.

System interruptions or failures could expose us to liability and harm our business.

Our data and operation centers are essential to our business and our operations depend on our ability to maintain and protect our information systems. We attempt to mitigate the potential adverse effects of a disruption, relocation or change in operating environment; however, the situations we plan for and the amount of insurance coverage that we maintain may not be adequate in every case. Despite systems redundancy and security measures, our systems and operations are vulnerable to damage or interruption from, among other sources:

- power loss, transmission cable cuts and telecommunications failures;
- fire, flood, earthquake and other natural disasters;
- hardware failures or software defects;
- operator error;
- cyber security breaches; and
- physical break-ins, sabotage, intentional acts of vandalism, terrorist attacks and other events beyond our control.

In addition, while there are backup systems in many of our facilities, an extended outage of utility or network services supplied by third party IT vendors may delay or disrupt the delivery or performance of the services we provide for our customers. We also utilize third-party cloud service providers to help us efficiently scale certain cloud-based solutions. If we or our cloud service providers encounter a lengthy business interruption, or in the event our business continuity plans and business interruption insurance coverage are not adequate or fail to compensate us on a timely basis, we could suffer operational disruptions, disputes with customers, civil or criminal penalties, regulatory problems, increases in administrative expenses, loss of our ability to produce timely and accurate financial and other reports, damage to our reputation or customer relationships or other adverse consequences, any of which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

Our systems and networks and those of third parties on which we rely may be subject to cyber security breaches and other disruptions that could compromise our information and harm our business.

In the ordinary course of our business, we rely heavily upon our technology systems and networks, as well as on those of third-party providers, to process, transmit, maintain, store and host the confidential, proprietary and sensitive information and data we receive from our customers and other data suppliers, including private insurance plans and financial institutions. In addition, subcontractors, teaming partners or other third-party vendors may receive or utilize this information on our behalf in support of the services we perform for our customers. The secure processing and maintenance of this information is critical to our operations and business strategy. Although we have spent significant resources to implement security and privacy programs and controls, train our workforce and augment our security measures with the implementation of new technologies and processes, our information technology and infrastructure, and those of third parties on which we rely, could continue to be subject to computer hacking or phishing efforts, acts of vandalism or theft, introduction of malware, computer viruses or other malicious codes, employee error or malfeasance issues, catastrophes, unforeseen events or other cyber-attacks. We may be unable to implement adequate preventive measures to protect against such compromises in the future or to effectively adapt our security measures to evolving security risks. As a result, our technology systems, including our data and our customers' data, could be accessed improperly, made unavailable, improperly modified, corrupted or otherwise breached or compromised, or we could suffer system disruptions, shutdowns and denials of service. Similarly, we could be materially adversely affected by the loss of proprietary, trade secret or confidential technical and financial data if our internal networks are compromised. The occurrence of any of these events could harm the market perception of the effectiveness of our security measures, lead to reputational damage or the loss of our customers' confidence in our solutions, negatively affect our ability to attract new customers, cause existing customers to terminate or not renew their existing contracts with us, or deter them from using our solutions or services in the future, all of which could reduce our revenue, increase our expenses and expose us to potential liability under privacy, security or other applicable laws and regulations. We could also be forced to expend significant resources in response to a security breach, including investigating the cause of the breach, repairing system damage, remediating vulnerabilities in our security procedures, increasing cyber security protection costs by deploying additional personnel and protection technologies, paying regulatory fines and penalties imposed by government regulatory agencies, and damages and other substantial costs associated with litigation, indemnification obligations as well as increased cybersecurity insurance premiums, and undertaking additional remediation efforts such as credit monitoring, all of which could increase our expenses, divert the attention of our management and key personnel away from our business operations and materially adversely affect our business, financial condition, results of operations and cash flows.

Any failure to maintain effective information processing systems and the integrity of the data in, and operations of, those systems could materially adversely affect our business, financial condition, results of operations and cash flows.

Our ability to conduct our operations and accurately report our financial results depends on the integrity of the data in our information systems and the processes performed by those systems. As a result of the services we provide, we process a number of complex transactions that require us to access, store, retrieve, manipulate, manage and transmit the information and data of our customers' and external third parties, as well as our own data. Although we have invested a great deal of time and resources in developing systems, processes and controls that protect the integrity of the data, such measures cannot provide absolute security. It is possible that failures or errors in hardware and software, including those in third-party technology, or technical deficiencies in our systems could result in data loss or corruption, or cause the data that we collect, utilize or disseminate to be incomplete or contain inaccuracies that our customers regard as significant. In addition, these information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs, satisfy customer requests and handle our expansion and growth. Despite our testing and quality control measures, we cannot be certain that errors or system deficiencies will be found and that remediation can be done in a timeframe that is acceptable to our customers, or that customer relationships will not be impaired by the occurrence of errors or the need for remediation. In addition, implementation of upgrades and enhancements may cost more, take longer or require more testing than originally expected. Situations may also arise in which the accuracy of our data analysis or the content and quality of our work product is central to the disposition of claims, controversies or litigation between our customers and third parties that would require us to allocate significant resources to fulfilling our contractual obligations to provide our customers with full and complete access to records, analysis and back-up documentation of our work. Assuring our capacity to fulfill these obligations as well as actually fulfilling them could impose significant burdens on our infrastructure for data storage, maintenance and processing, and require us to incur increased costs to supplement our personnel, data storage and computing resources, which could materially and negatively impact other business operations.

If we are unable to protect our proprietary technology, information, processes, know-how, and other intellectual property and intellectual property rights, or become subject to claims of infringing or misappropriating the intellectual property of third parties, the value of our solutions and services may be diminished and our business may be materially adversely affected.

Our success as a company depends in part upon our ability to protect our core technology and intellectual property. Our expanding operations and efforts to develop new solutions and services also make protection of our intellectual property more critical. We seek to protect our intellectual property and other proprietary information through a combination of patent, trademark, copyright, trade secret and unfair competition laws, confidentiality agreements and invention assignment agreements with employees, consultants and other third parties, as well as through the terms of our agreements with customers and vendors, and other security measures. However, the steps we have taken to deter misappropriation of intellectual property may be insufficient to protect our proprietary information. We may not always be successful at obtaining government registrations for our patents, trademarks, or copyrights that we seek to register. Third parties may also attempt to misuse our company name or trademarks to engage in improper or illegal conduct such as cyber-squatting or other cybercrimes using our marks, and we may not always be successful at quickly obtaining relief from agencies tasked with enforcing parties' rights, or stopping such conduct before harm to third parties occurs. Similarly, misappropriation of our other intellectual property by third parties, or any disclosure or dissemination of our confidential and proprietary trade secrets, business intelligence, queries, algorithms and other similar information by any means, could undermine any competitive advantage we currently derive or may derive from that intellectual property. For example, our current or former employees, consultants or other third parties may unintentionally or willfully disclose our trade secrets, know-how or other confidential and proprietary information to competitors. Competitors have also attempted to use state and/or federal open records laws (such as the federal Freedom of Information Act and analogous state laws) to obtain our proposal responses and other documents we provide to our government customers. We cannot be certain that our efforts to protect the confidential and proprietary trade secret information or intellectual property in these proposals or other documents will always be successful, due to the many factors underlying the various state and federal decisions to release information in response to open records requests (even in spite of our objections and efforts to protect such information). In addition, there remains the possibility that others will independently develop competing technologies that may be equivalent or superior to ours. If our efforts to protect our intellectual property and other proprietary rights are inadequate to prevent unauthorized use or appropriation by third parties or our employees, the value of our brand and other intangible assets may be diminished and others may be able to more effectively compete with our business by offering solutions or concepts that are substantially similar to ours, which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

In addition, third parties may claim that we are infringing upon or misappropriating their intellectual property, or assert other legal challenges to our intellectual property. Our exposure to risks related to the use of intellectual property may also increase as a result of acquisitions because third parties may make infringement and similar or related claims after we have acquired technology. Any of these situations could cause us to expend significant time and resources and to incur substantial costs associated with litigation or legal proceedings that may be necessary to defend ourselves or to enforce our intellectual property rights, in which we may not ultimately prevail, and could result in our being prevented from furnishing certain solutions and services.

Our business could be materially adversely affected if we fail to maintain a high level of customer retention, if our customers elect to reduce the scope of our contracts or terminate them before their scheduled expiration dates or if we fail to meet performance standards under our customer contracts.

We historically have derived and expect to continue to generate a significant portion of our revenue from a limited number of large customers at the federal and state level. Our contracts with these customers are subject to periodic renewal and some permit them to terminate their contracts on short notice, with or without cause. If a customer is dissatisfied with the quality of our work or if we fail to meet performance standards under our contracts, or if our solutions, technical infrastructure or services do not comply with the provisions of our contractual agreements or applicable regulatory requirements, customers might seek to reduce the scope of the services we perform or prematurely terminate their agreements with us, or we could incur additional costs that may impair the profitability of a contract and damage our ability to obtain additional work from that customer, or other current or prospective customers. For example, some of our contracts contain liquidated damages provisions and financial penalties related to performance failures, which if triggered, could materially adversely affect our reputation, business, financial condition, results of operations and cash flows. We also may be required to disclose such liquidated damages or other financial penalties assessed against us in connection with future bids for services with other customers.

In addition, government customers are subject to financial pressures or pressure from stakeholders that may cause them to terminate contracts for our services that may be regarded as non-essential or to redefine or reduce the scope of our contracts by, for example, significantly reducing the volume of data that we are permitted to audit or renewing the contract at lower performance fee levels. Despite our right to prompt and full payment under the terms of our contracts, we could face challenges in obtaining timely or full payments for our properly provided services from our customers. If there is a substantial reduction in the scope of our services under, or a termination of, any of our key contracts with our major customers, or if we are exposed to significant costs, liabilities or negative publicity, our ability to compete for new contracts with current or prospective customer could be damaged and our business, financial condition, reputation, results of operations and cash flows could be materially adversely affected.

We depend on many different entities to supply information and an inability to successfully manage our relationships with a number of these suppliers may harm the quality and availability of our solutions and services.

We obtain the data used in our solutions and services from many sources, including commercial health insurance plans, financial institutions, managed care organizations, government entities and non-government entities. From time to time, challenges arise in managing and maintaining our relationships with data sources that are not our customers and that furnish information to us pursuant to a combination of voluntary cooperation and legal obligations under laws and regulations that are often subject to differing interpretations. If a number of our information sources become unable or unwilling to provide us with certain data under terms and conditions of receipt, processing or use that are acceptable to us and our customers, or if laws and regulations for use and protection of this data changes in a way that disincentivizes our suppliers, or imposes unacceptable or unreasonable conditions, costs, or risks on us, we may not be able to obtain new or favorable agreements with alternative data suppliers. In addition, our ability to normalize and fully utilize the information we receive from various data sources to enhance and improve current services for our customers is an important component of our growth strategy. Although we believe that we have the legal and contractual rights necessary to normalize and use the data we have obtained from these sources for potential or contemplated solution and service offerings, we cannot provide assurance that these entities will permit the use of their data for these purposes. If we lose a number of our data sources or our access to their data, and fail to identify and reach the requisite agreements with suitable alternative suppliers or to successfully integrate their data into our solutions and services, or if there is a lack of accuracy or integrity in the data that current or future suppliers provide, we could experience service disruptions, increased costs, reduced quality of our solutions and services, or performance penalties under our customer contracts, which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

We may rely on subcontractors and other third party providers to provide customers with a single-source solution or service or we may serve as a subcontractor to a third party prime contractor. If these parties fail to satisfy their obligations to us or if we are unable to maintain these relationships, our business, financial condition, results of operations and cash flows could be materially adversely affected.

In some areas of our business we may engage subcontractors, teaming partners, vendors or other third party providers to provide our customers with a single-source solution for a broader range of service needs. These third parties include software vendors, utility and network providers, cloud service providers and other information technology service providers and solution partners. Our ability to deliver and implement solutions and serve our customers effectively depends on these third parties meeting our service standards in both timeliness and quality, and in certain instances, on our ability to obtain customer approval for the use of these third party subcontractors. While we believe that we perform appropriate due diligence on these third parties and take adequate measures to ensure that they comply with the appropriate laws and regulations, we cannot guarantee that they will comply with the terms set forth in their agreements with us. Performance deficiencies or misconduct by subcontractors, teaming partners, vendors or other third party providers may be perceived as inadequacies in our solutions or services or cause us to fail to fulfill our contractual obligations to our customers, which could materially adversely affect our customer relationships and reputation, result in termination of a customer contract, and subject us to a dispute with our customer. In addition, if our third party service providers terminate or refuse to renew their relationships with us or offer their products to us in the future on less advantageous terms, we may not be able to perform or deliver solutions or services for existing customers as expected.

Similarly, we are and may in the future be engaged as a subcontractor to a third party prime contractor. Subcontracting arrangements where we are not the prime contractor pose unique risks to us because we do not have control over the customer relationship, and our ability to generate revenue under such subcontracts is dependent on the prime contractor, its performance and relationship with the customer, and its relationship with us. We cannot be certain that the prime contractor will provide adequate and timely services to the customer, comply with the terms of its prime contract with the customer or its subcontract agreement with us, or that it will construe its contractual rights and obligations in a reasonable way, act appropriately in dealing with us or customers, and remain in compliance with the relevant laws, rules or regulations. Any failure of the prime contractor to adequately perform its obligations under the prime contractor to comply with applicable laws, rules and regulations could materially adversely affect our reputation and subject us to a dispute with the prime contractor or the customer. In the event a prime contract is terminated, whether for non-performance by the prime contractor or otherwise, our subcontract will similarly terminate, and the resulting contract loss could materially adversely affect our business, financial condition, results of operations and cash flows.

We obtain a portion of our business through competitive bidding in response to government requests for proposals. Reprocurements and future contracts may not be awarded through this process on the same level or our contract awards may be challenged by interested parties which could materially adversely affect our business, financial condition, results of operations and cash flows.

In order to market our solutions and compete for contracts with existing and potential state and federal customers, we are often required to respond to government-issued RFPs. These responses typically require us to assemble and submit a large volume of information within a rigid timetable, and to accurately estimate our cost structure for servicing the proposed contract, the time required to establish operations and the likely terms of proposals submitted by our competitors. We may also be required to disclose the occurrence of certain negative events suffered by our business, such as customer disputes, a government inquiry or an adverse judgment or settlement in litigation or a legal proceeding, which could impair our ability to win the contract at issue or have a material adverse effect on our reputation in the industry.

Even if we win these contracts, we may fail to secure favorable contract terms and conditions, or a government's determination to award us the contract may be challenged by an interested party. Under the state and federal laws and regulations governing procurements of goods and services, challenges and award protests may be filed even if there are no valid legal grounds on which to base the protest. The filing of such challenges could potentially delay the start or implementation of the contract if the government agency determines to withhold a contract award or suspend contract performance while the protest is being considered, or to take corrective action on its own, such as soliciting new bids or terminating the contract award or current procurement. In the event of irregularities, we perceive or learn of in the award or bidding process, we also may be forced to file protests in response to RFP awards to other bidders. Resolution of a protest, even in our favor, could force us to expend considerable funds in disputing the potential award or to incur additional expenses to maintain our ability to timely start implementation, which may cause our actual results to differ materially and adversely from those anticipated. In addition, if we are unable to win reprocurements or protests of particular contracts, we may be precluded from entering certain customer markets for the term of the contract awarded to another party. Any failure to continue to obtain contracts in response to government RFPs, to design proposals that result in profitable contracts, to win new contracts or re-procure current contracts after they expire or to prevail in protests or challenges of contract awards could have a material adverse effect on our business, financial condition, results of operations and cash flows.

Adverse judgments or settlements in legal proceedings could materially harm our business, financial condition, operating results and cash flows.

We are subject and may be a party to legal proceedings and claims that arise from time to time in the ordinary course of our business, which may include, but are not limited to, those related to, claims brought by our customers in connection with billing and contractual disputes, subcontracts and teaming agreements, protection of confidential information or trade secrets, claims relating to pending, terminated or completed acquisitions or dispositions, adversary proceedings arising from customer bankruptcies, employment of our workforce and immigration requirements or compliance with any of a wide array of state and federal statutes, rules and regulations that pertain to different aspects of our business. We may also be required to initiate expensive litigation or other proceedings to protect our business interests. There is a risk that we will not be successful or otherwise be able to satisfactorily resolve any pending or future litigation. In addition, litigation and other legal claims are subject to inherent uncertainties and management's view of currently pending legal matters may change in the future. Those uncertainties include, but are not limited to, litigation costs and attorneys' fees, unpredictable judicial or jury decisions and the differing laws and judicial proclivities regarding damage awards among the states in which we operate. Resolution may also require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results. Unexpected outcomes in such legal proceedings, or changes in management's evaluation or predictions of the likely outcomes of such proceedings (possibly resulting in changes in established reserves), could have a material adverse effect on our business, financial condition, results of operations and cash flows.

We may not be able to deliver our solutions and perform services efficiently if we are unable to attract and retain qualified employees.

Our successful delivery of solutions and services and ability to maintain our productivity and profitability is dependent on our ability to identify, recruit, employ, train and retain skilled personnel. The success of recruitment and retention strategies depend on a number of factors, including the competitive demands for employees having the skills we need and the level of compensation required to hire and retain such employees. Customers or competitors may seek to hire away qualified and seasoned employees, which could reduce our ability to innovate and operate effectively. We may not be able to recruit or maintain the personnel necessary to efficiently operate and support our business in the future, and even if our recruitment and retention strategies are successful, our labor costs may increase significantly. Our inability to hire sufficient personnel on a timely basis without significantly increasing our labor costs could materially adversely affect our business, financial condition, results of operations and cash flows.

Our future success depends, in part, on the continued service of members of our management team.

Our ability to execute on our business plans and future success requires that we attract, develop, motivate and retain experienced and innovative executive officers and senior leaders who have successfully managed, designed, implemented and led government services programs or information technology initiatives, or have relevant experience in other healthcare sectors, including data management and analytics. These individuals are in great demand and are likely to remain a limited resource in our industry. The loss of services of one or more members of our management team could adversely affect our business, financial condition, results of operations and cash flows. In addition, to the extent we lose an executive officer or senior leader, we may incur increased expenses in connection with the hiring, promotion or replacement of these individuals and the transition of leadership and critical knowledge.

Our outstanding indebtedness could materially adversely affect our financial condition and our ability to operate our business, and we may not be able to generate sufficient cash flows to meet our debt service obligations or capital requirements.

As of December 31, 2018, the outstanding principal balance under our Credit Agreement was $240.0 million. Our Credit Agreement provides for a senior secured revolving credit facility in an aggregate principal amount equal to $500 million and is secured, subject to certain customary carve-outs and exceptions, by a first priority lien and security interest in substantially all of our tangible and intangible assets. Our outstanding indebtedness and any additional indebtedness we incur may have important consequences for us, including, without limitation, that:

- we may be required to use a substantial portion of our cash flow to pay the principal of and interest on our indebtedness;
- our indebtedness and leverage may increase our vulnerability to adverse changes in general economic and industry conditions, as well as to competitive pressures;
- our indebtedness may expose us to the risk of increased interest rates because certain of our borrowings are and will be at variable interest rates;
- our ability to obtain additional financing for working capital, capital expenditures, acquisitions and for general corporate and other purposes may be limited;
- our indebtedness and leverage may prevent us from taking advantage of business opportunities as they arise or successfully carrying out our plans to expand our business; and
- our flexibility in planning for, or reacting to, changes in our business and our industry may be limited.

Under the Credit Agreement, we are also required to comply with specified financial and operating covenants, which may limit our ability to operate our business as we otherwise might operate it. The Credit Agreement also contains (i) certain affirmative covenants that impose certain reporting and/or performance obligations on us and our restricted subsidiaries, (ii) certain negative covenants that generally limit, subject to various exceptions, us and our restricted subsidiaries from taking certain actions, including, without limitation, incurring indebtedness, creating liens, engaging in mergers and consolidations, disposing of certain assets or property, making certain investments and acquisitions, entering into certain transactions with affiliates, swap agreements or sale-leasebacks, making certain restricted payments, including dividends and share repurchases, changing our fiscal year or the lines of business that we or our restricted subsidiaries conduct to a material extent, and prepaying certain junior indebtedness, (iii) financial covenants consisting of a maximum consolidated leverage ratio and a minimum interest coverage ratio, and (iv) customary events of default for financings of this type.

Our obligations under the Credit Agreement may be declared due and payable upon the occurrence and during the continuance of an event of default, which includes, without limitation: non-payment of principal or reimbursement obligation when due; non-payment of interest, fees and other amounts for a period of five business days after the due date; material inaccuracies of representations and warranties; failure to perform or observe covenants, conditions or agreements (subject to any applicable grace periods); cross-defaults to certain indebtedness; inability to pay debts; certain acts of bankruptcy or insolvency; certain ERISA events; failure to pay certain material judgments; and a change of control as defined in the Credit Agreement. If not cured, an event of default could result in any amounts outstanding, including any accrued interest and unpaid fees, becoming immediately due and payable, and would give our lenders the right to proceed against the collateral granted to them to secure the debt, which would require us to, among other things, seek additional financing in the debt or equity markets, refinance

or restructure all or a portion of our indebtedness, sell selected assets, and/or reduce or delay planned capital or operating expenditures. Such measures might not be sufficient to enable us to service our debt, and any such financing or refinancing might not be available on economically favorable terms or at all. Our ability to make payments of principal and interest on our outstanding credit facility depends upon our future performance and our ability to generate cash flows. If we are unable to generate sufficient cash flows to meet our debt service obligations or are forced to take additional measures to be able to service our indebtedness, our business, financial condition and results of operations could be materially and adversely affected.

Changes in, or interpretations of, tax rules and regulations may materially adversely affect our effective tax rates.

We are a United States-based company subject to various federal, state, U.S. Territory and local tax laws and regulations in multiple U.S. jurisdictions that govern numerous aspects of our business. As we expand our business, we may perform services for new customers located outside of the United States or in a U.S. Territory, which may subject us to foreign tax laws and regulations that could increase our exposure to additional tax liabilities. Our future effective tax rates could be materially affected by various factors, including changes in tax rates of jurisdictions in which we do business, changes in relevant tax and accounting rules, regulations and interpretations, increases in expenses not deductible for tax purposes, including impairments of goodwill, and changes in the valuation of our deferred tax assets and liabilities. For example, in December 2017, Congress enacted the 2017 Tax Act which, among other things, reduced the U.S. corporate tax rate, modified limitations on certain deductions for executive compensation, placed new limitations on interest deductions, repealed the Section 199 Deduction and certain capital investment deductions, and shifted U.S. taxation of multinational corporations from a tax on worldwide income to a territorial system. Any unanticipated changes in our tax rates could affect our future results of operations.

In addition, we are subject to the continual examination of our income tax returns by the IRS and other tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our provision for income taxes and have reserved for potential adjustments that may result. The final determination of any of these examinations could have a material adverse effect on our business, financial condition, results of operations and cash flows.

Our health insurance coverage and self-insurance reserves may not cover future claims, which could materially adversely affect our business, financial condition, results of operations and cash flows.

We maintain various insurance policies for company employee health, workers' compensation, general liability and property damage. We are self-insured for our health plans, and have purchased a fully-insured stop loss policy to help offset our liability for both individual and aggregate claim costs. We are also responsible for losses up to a certain limit for workers' compensation, general liability and property damage insurance.

For policies under which we are responsible for losses, we record a liability that represents our estimated cost of claims incurred and unpaid as of the balance sheet date. Our estimated liability is not discounted and is based on a number of assumptions and factors, including historical trends, actuarial assumptions and economic conditions, and is closely monitored and adjusted when warranted by changing circumstances. Our prior growth could affect the accuracy of estimates based on historical experience. Should a greater amount of claims occur compared to what was estimated or medical costs increase beyond what was expected, our accrued liabilities might not be sufficient and we may be required to record additional expense. Unanticipated changes may also produce materially different amounts of expense than reported under these programs, which could materially adversely affect our business, financial condition, results of operations and cash flows.

Risks Relating to Our Industry

Our business could be materially adversely affected by changes in the U.S. healthcare environment or in laws relating to healthcare programs and policies, particularly as they relate to the ACA and the Medicare and Medicaid programs.

The healthcare industry in which we operate is subject to changing political, economic and regulatory influences that directly affect the practices and operations of federal, state and commercial healthcare organizations in the United States. When the ACA was passed, its emphasis on program integrity, cost containment and expansion of Medicaid created new opportunities to grow our business and our service offerings. However, certain provisions of the ACA have yet to be implemented and there have been a number of judicial and legal challenges to certain aspects of the ACA. In February 2018, 20 states filed suit in the U.S. District Court for the Northern District of Texas alleging that the ACA is unconstitutional in light of the repeal of the penalties associated with the individual mandate. On December 14, 2018, the Court issued a ruling that the mandate was no longer permissible under Congress's taxing power and was thus unconstitutional. As such, the Court further found that the entire ACA is deemed to be invalid because the individual mandate is "essential" and inseverable from the ACA. Although, a stay and partial final judgment has been issued, ensuring that the ACA remains in full effect for the foreseeable future, we cannot predict the outcome of the litigation that has been filed relating to the constitutionality of the ACA. Additionally, since its adoption into law in 2010, there have been continued efforts by Congress to amend, repeal or replace all or part of the ACA. For example, under the 2017 Tax Act, the "individual mandate" introduced by the ACA was repealed effective January 1, 2019. Congress has introduced several other bills to delay, defund or repeal implementation or amend significant provisions of the ACA, though none of these other bills have passed the House and Senate. There have also been a number of proposed and adopted legislative initiatives and healthcare reform proposals from the federal and state governments. These include (i) measures that would fundamentally change the financial structure of the Medicaid program (currently funded jointly by the

states and the U.S. Federal Government), which could result in early termination, reduced scopes or non-renewal of our contracts with certain state government customers, and (ii) changes at the federal level that would reduce reimbursement rates to states, establish new payment models, further limit the Medicare RAC program, or otherwise change the operating environment for our customers and transform the government's involvement in healthcare. In addition to these legislative proposals, the President has taken several steps to limit the functionality of the ACA and advocate for its repeal and replacement since taking office. During 2017, the President signed two executive orders and other directives designed to waive, defer, grant exemptions from or delay the implementation of certain requirements mandated by the ACA.

Another variable that impacts our business will be how state programs, commercial health plans, private employers and other healthcare payers will respond to changes during this continued period of uncertainty surrounding the ACA. These organizations may react to such changed circumstances and financial pressures by taking actions to ramp up, curtail or defer their retention of cost containment providers like us, which could impact the demand for our solutions and services and our ability to increase or maintain sales of our existing solutions and services. While certain changes may present new opportunities to us, our business, financial condition, results of operations and cash flows could be materially adversely affected if we are unable to adapt our solutions and services to meet changing requirements or expand service delivery into new areas, or if the demand for our solutions and services is reduced as a result of future legislative changes affecting Medicare, Medicaid or other publicly funded or subsidized health programs, or efforts to waive, modify or otherwise change or invalidate the ACA. Although we will continue to evaluate the effect that the ACA and its possible invalidation or repeal and replacement may have on our business, it is difficult to predict the full impact and influence that the ACA and the varying healthcare reform measures may have on the U.S. healthcare industry or policy, and any resulting changes may take time to unfold.

Healthcare spending fluctuations, simplification of the healthcare payment process or other aspects of the healthcare financing system, budgetary pressures and/or programmatic changes diminishing the scope of program benefits, or limiting payment integrity initiatives, could reduce the need for and the price of our solutions and services, which would have a material adverse effect on our business, financial condition, results of operations and cash flows.

Our projections and expectations are premised, in part, upon consistent growth rates in the Medicare and Medicaid programs and government spending on these programs, and the impact on the current healthcare financing system overall and need for our solutions and services within that existing framework. Our continued success as a company is based in large part on offering solutions and services that improve the ability of our customers to identify and recover revenue that would otherwise be lost often as a result of procedural inefficiencies and complexities in the healthcare delivery and payment system. However, the need for our solutions and services, the price customers are willing to pay for them and the scope and profitability of our contracts could be negatively affected by a number of factors, including, but not limited to:

- a lower than projected growth in Medicare and Medicaid program enrollment and expenditures;
- changes in the level of federal government spending due to budgetary or deficit considerations, including the continuance of existing programs, as well as budgetary pressures that may drive changes at the state level;
- unanticipated reductions in the scope of healthcare program benefits (such as, for example, state decisions to eliminate coverage of optional Medicaid populations or services or shifting lives into managed care plans);
- the transition of healthcare beneficiaries from fee-for-service plans to value-based plans;
- modifications in provider billing behavior and habits, often in response to the success of our solutions and services or to changes that reduce healthcare spending;
- the adoption of healthcare plans with significantly higher deductibles;

- customer improvements and enhancements to their internal healthcare claims and billing processes;
- the simplification of the healthcare benefit and payment system through legislative or regulatory changes at the federal or state level (for example, legislative changes impacting the scope of mandatory audits, including limits on the look-back period for review in areas where we conduct audits);
- limits placed on ongoing program integrity initiatives, including the Medicare RAC program and state Medicaid RAC programs (for example, limitations or reductions in the amount of reviewable claims we audit, such as the modified ADR limits and sliding scale policy implemented by CMS for the current Medicare RAC contracts, which have a significant impact on the volumes of claims that Medicare RACs are permitted to review for inpatient providers and reduce their ability to identify overpayments and underpayments); and
- legislative healthcare reforms and developments, including the absence of near-term compliance deadlines effected by the ACA, the possible repeal or modification of the ACA, and other legislative actions to reduce program eligibility or services, or reform Medicaid spending.

The occurrence of any of these events, or other changes to the funding of the Medicare and Medicaid programs or limitations in the scope of program eligibility, benefits, initiatives and healthcare spending that materially reduce our revenue or profitability with such programs may have an adverse effect on our future business, financial condition, results of operations and cash flows.

A failure to comply with the laws and regulations that apply to companies in our industry regarding individual privacy and information security could subject us to legal actions, fines and penalties and negatively impact our reputation and operations.

As a cost containment service provider, we often receive, process, transmit and store sensitive data, including PHI and personally identifiable information of individuals, as well as other financial, confidential and proprietary information belonging to our customers, subcontractors, government agencies, data suppliers and other third parties from whom we obtain information. The use and disclosure of that information is regulated at the federal, state, international and industry levels. For example, we are subject to federal regulation under HIPAA, as amended by HITECH, and the Final Omnibus Privacy, Security, Breach Notification, and Enforcement Rule, as well as various state laws. HIPAA also imposes standards and requirements on our business associates (as defined under HIPAA). We are also obligated by our contractual requirements with customers, which may require that we comply with additional privacy regulations imposed upon certain types of customers, such as the federal Gramm-Leach-Bliley Act and other laws.

Even though we take measures to comply with all applicable regulations and to ensure our business associates and subcontractors comply with these laws, regulations and rules, we have less than complete control over our business associates' and subcontractors' actions and practices. We may be exposed to data breach risk if there is unauthorized access to one of our or our subcontractors' secure facilities, or to third-party enterprise cloud storage and cloud computing application services that we use, or from lost or stolen laptops or other portable media from current or former employee theft of data containing PHI, from computer hacking, malware, computer viruses or other malicious codes, phishing or other cyber-attacks, from misdirected mailings containing PHI, or other forms of administrative or operational error. If we or our subcontractors fail to comply with applicable laws; if unauthorized parties gain physical access to one of our facilities and steal or misuse confidential information; if we erroneously use or disclose data in a way that is inconsistent with our granted rights; or if such information is misdirected, lost or stolen during transmission or transport, we may suffer damage to our reputation, potential loss of existing customers and difficulty attracting new customers. We could also be exposed to, among other things, unfavorable publicity, governmental inquiry and oversight, allegations by our customers that we have not performed our contractual obligations, costs to provide notifications or remediation (such as credit monitoring) to affected individuals, fines or other penalties imposed by government regulatory agencies, or litigation by affected parties and possible financial obligations for damages or indemnification obligations related to the theft or misuse of such information, any of which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

In addition, laws, rules and regulations concerning the protection of personal information are subject to frequent change by legislation, regulatory issuances or administrative interpretation. As regulatory focus on privacy issues continues to increase and these laws and regulations continue to expand and become more complex, these potential risks to our business could intensify. Changes in laws or regulations associated with the enhanced protection of certain types of sensitive data, such as healthcare data or other personally identifiable information, along with increased customer demands for enhanced data security infrastructure, could greatly increase our cost of providing our solutions and services, and may subject us to additional liabilities.

We are subject to extensive government regulation, including government and customer audits and investigations relating to our compliance with the laws and regulations applicable to companies in our industry, and a negative finding or other adverse determination could have a material adverse effect on our reputation, business, financial condition, results of operations and cash flows.

A significant portion of our business is regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect individual citizens, including government program beneficiaries, health plan members and their dependents. The federal and state governmental agencies administering these laws and regulations have broad latitude to enforce them. As such, we are subject, on an ongoing basis, to various governmental and customer reviews, audits and investigations to verify our compliance with our contracts and applicable laws and regulations, as well as legal actions and enforcement proceedings. For example, because we receive payments from federal and state governmental agencies, we are subject to laws, such as the Federal Acquisition Regulations, the U.S. Foreign Corrupt Practices Act, federal and state employment, equal opportunity and affirmative action laws, federal and state prompt pay statutes, healthcare fraud, waste and abuse laws and similar legislation. We are also subject to the Federal False Claims Act and similar state statutes, which permit government law enforcement agencies to institute suits against us for violations and, in some cases, to seek double or treble damages, penalties and assessments. In addition, private citizens, acting as whistleblowers, can sue on behalf of the government under the "*qui tam*" provisions of the Federal False Claims Act and similar statutory provisions in many states.

As we expand into new areas of the healthcare industry, we may develop new or enhanced solutions that may further expose us to requirements under additional statutes and legislative schemes that have previously not been relevant to our business, such as the Fair Debt Collection Practices Act and other banking and credit reporting statutes. For example, in connection with our acquisition of Eliza, we became subject to the Telephone Consumer Protection Act of 1991, state and federal audio and telephone recording laws, and other consumer laws and regulations as a result of the member engagement services that we perform. Our increased involvement in population health services and penetration into new markets, such as ACOs, PBMs and commercial self-insured employers, could increase the likelihood and incidence of our being subjected to regulatory scrutiny or legal actions by third parties other than our customers, which may impose significant costs and strain on our resources.

These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer and how we interact with customers, providers, other healthcare payers and the public. If the government discovers improper or illegal activities in the course of audits or investigations, we may be subject to various civil and criminal penalties and administrative sanctions, which may include termination of contracts, forfeiture of profits, suspension of payments, fines and suspensions and debarment from doing business with the government. Similarly, if our customers assert that we have failed to properly perform or comply with our contractual obligations, or if the carriers to which we send billings assert that we have failed to properly comply with applicable federal or state billing rules and regulations, we may be required to provide refunds or make payments to resolve such issues. If we are found to be in violation of any applicable law or regulation, or if we receive an adverse review, audit or investigation from a government agency or customer related to our compliance with such laws or regulations or the terms of our government contracts, any resulting negative publicity, penalties or sanctions could have an adverse effect on our reputation in the industry, impair our ability to compete for new contracts or bid in response to RFPs in one or more jurisdictions, and have a material adverse effect on our business, financial condition, results of operations and cash flows.

Federal and state governments may limit or prohibit outsourcing of certain programs or functions, refuse to grant consents or waivers necessary to permit private entities to perform such work, or impose other limitations on outsourcing or certain vendors that may obstruct cost-effective performance of our contracts.

Federal or state governments could limit or prohibit private contractors like us from operating or performing elements of certain government functions or programs. As a condition of receiving federal funding, state, and local governments may be required to operate such programs with government employees. Under current law, in order to privatize certain functions of government programs, the federal government must grant a consent and/or waiver to the petitioning state or local agency. If the federal government does not grant a necessary consent or waiver, the state or local agency will be unable to outsource that function to a commercial entity. Such a situation could eliminate a contracting opportunity or reduce the value of an existing contract.

Similarly, other state or federal limitations on outsourcing certain types of work to vendors that supplement our workforce could make it more difficult for us to fulfill our contracts in a cost-effective manner. Certain areas of our operations use or involve vendor or subcontractor personnel located outside of the United States, who may (under carefully controlled circumstances) access certain PHI in the course of assisting us with various elements of the services we provide to our customers. The federal government and a number of states have considered laws or issued rules, regulations, and orders that would limit, restrict or wholly prohibit the use of offshore labor in performance of government contracts, or impose sanctions for the use of such resources. Some of our customers have already chosen to contractually limit or restrict our ability to use offshore resources. Intensified restrictions of this type or associated penalties could raise our costs of doing business, expose us to unexpected fines or penalties, increase the prices we must charge to customers to realize a profit and eliminate or significantly reduce the value of existing contracts or potential contract opportunities, any of which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

We may be precluded from bidding on or performing certain work due to work we currently perform, which could materially adversely affect our business, financial condition, results of operations and cash flows.

Various laws, regulations and administrative policies prohibit companies from performing work for government agencies in capacities that might be viewed to create an actual or perceived conflict of interest. In particular, CMS has stringent conflict of interest rules, which can limit our bidding for specific work for CMS, or for other contracts that might conflict, or be perceived by CMS to conflict, with contractual work for CMS. State governments and managed care organizations also have conflict of interest restrictions that could limit our ability to bid for certain work and impede our overall sales strategy. As we continue to expand and diversify our business operations, the likelihood that customers or potential customers will perceive conflicts of interest between our various subsidiaries, solutions, services, activities and customer relationships may increase. Such conflicts, whether real or perceived, could result in a loss of contracts or additional internal structural barriers that delay operational efficiency. We may also need to divest certain existing businesses or reorganize our current management and personnel structure, as well as our corporate organization and entity structure, in order to qualify for new contract awards or to appropriately mitigate conflicts and otherwise accommodate the increasing complexity of our business. Our failure to devote sufficient care, attention and resources to managing these adjustments may result in technical or administrative errors that could expose us to potential liability or adverse regulatory action. In addition, conflict of interest rules and standards change frequently, and are subject to varying interpretations and varying degrees and consistency of enforcement. We may not be successful in navigating these restrictions. If we are prevented from expanding our business or are unable to effectively implement our strategic initiatives due to real or perceived conflicts of interest, our business, financial condition, results of operations and cash flows could be materially adversely affected.

Risks Related to Our Common Stock

The market price of our common stock may be volatile, and fluctuations in the price of our common stock may materially adversely affect our business, financial condition, results of operations and cash flows and materially adversely affect our shareholders.

The market price of our common stock has fluctuated widely and may continue to do so. During the 52-week period ended December 31, 2018, our common stock traded on the Nasdaq Global Select Market as high as $37.38 per share and as low as $15.06 per share. Our stock price is subject to fluctuation as a result of a variety of factors, including factors beyond our control, such as the risk factors described above and those which are related to:

- quarterly or annual earnings results or those of other companies in our industry;
- changes in estimates of our performance or recommendations by securities analysts or in the operating and stock price performance of other companies that investors deem comparable to our company;
- news reports relating to trends, concerns and other issues in the healthcare industry, including perceptions in the marketplace regarding us and our competitors;
- the financial projections we publicly provide and any changes in or failure to meet those projections;
- future sales of shares of common stock in the public market by our executive officers or directors;
- any changes in the number of our outstanding shares, including as a result of share repurchases;
- actual or proposed changes in federal or state laws affecting the healthcare industry;
- changes in accounting principles;
- the public's response to our press releases, or other public announcements, including our filings with the SEC;
- securities class actions, shareholder lawsuits or other litigation; and
- market conditions in the industry and the economy as a whole.

In addition, the stock market often experiences significant price and volume fluctuations. These broad market fluctuations may materially adversely affect the market price of our common stock regardless of our operating performance. When the market price of a company's stock drops significantly, shareholders may institute securities class action litigation against that company. Any litigation against us could cause us to incur substantial costs, divert the time and attention of our management and other resources or otherwise harm our business.

Because we do not intend to pay dividends, you will benefit from an investment in our common stock only if it appreciates in value.

We have not paid or declared cash dividends on any of our capital stock to date and currently intend to retain our future earnings, if any, to fund the development and continued growth of our business and repurchase shares opportunistically from time to time. As a result, we do not expect to pay any cash dividends in the foreseeable future. The success of your investment in our common stock will likely depend entirely upon any future appreciation. There is no guarantee that our common stock will appreciate in value or even maintain the price at which you purchased your shares.

Certain provisions of our certificate of incorporation and bylaws could discourage unsolicited takeover attempts, which could depress the market price of our common stock.

Our certificate of incorporation authorizes the issuance of up to 5,000,000 shares of "blank check" preferred stock with such designations, rights and preferences as may be determined by our Board of Directors. Accordingly, our Board of Directors is empowered, without shareholder approval, to issue preferred stock with dividend, liquidation, conversion, voting or other rights, that could adversely affect the voting power or other rights of holders of our common stock. In the event of issuance, preferred stock could be utilized, under certain circumstances, as a method of discouraging, delaying, or preventing a change in control. Although we have no present intention to issue any shares of preferred stock, it is possible that we will do so in the future. In addition, our bylaws currently require advance notice of shareholder proposals for business to be conducted at meetings of our shareholders and for nominations of candidates for election to our Board of Directors and provide for Delaware as an exclusive forum for certain disputes with our shareholders, all of which could also have the effect of discouraging a change of control.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters and other material leased properties as of December 31, 2018 are shown in the following table:

Location	Approximate Square Footage	Owned/Leased
Irving, TX (corporate headquarters)	242,260	Owned
Las Vegas, NV (office space)	63,593	Leased
Danvers, MA (office space)	38,868	Leased
New York , NY (office space)	34,759	Leased
Westerville, OH (office space)	25,212	Leased
All other locations (23)	80,759	Leased

All other locations consist principally of office space and also include data centers, which are all located in the United States. The above locations have expiration dates through 2026. A portion of the above Las Vegas, NV and New York, NY office spaces are sub-leased. In general, we believe our facilities are suitable to meet our current and reasonably anticipated future needs. See "Lease Commitments" in Note 15 to the Consolidated Financial Statements in Part II, Item 8 for additional information.

Item 3. Legal Proceedings

The information set forth under the caption "Litigation" in Note 15 to the Consolidated Financial Statements in Part II, Item 8 is incorporated herein by reference.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Shareholder Matters and Issuer Purchases of Equity Securities

Market Information

Our common stock is listed on the Nasdaq Global Select Market under the symbol "HMSY".

Holders

As of the close of business on February 15, 2019, there were 252 holders of record of our common stock.

Dividends

We have not paid or declared any cash dividends on our common stock and do not anticipate paying cash dividends in the foreseeable future. Our current intention is to retain future earnings to support the continued growth of our business and possibly for the repurchase of shares from time to time. Our Board of Directors will evaluate various factors, including, without limitation, our future earnings, operating cash flows, financial condition, results of operations and capital requirements in determining whether to pay any cash dividends in the future. In addition, our Credit Agreement generally limits, subject to certain exceptions, our ability to make certain payments or distributions with respect to our capital stock, including cash dividends to our shareholders. These restrictions are described in more detail under the heading "Liquidity and Capital Resources" in Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, and in Note 10 to the Consolidated Financial Statements in Part II, Item 8.

See Part III, Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Shareholder Matters for information relating to securities authorized for issuance under our equity compensation plans.

Repurchases of Shares of Common Stock

On November 1, 2017, the Board of Directors of the Company approved a share repurchase program authorizing the Company to repurchase up to $50.0 million of shares of its common stock from time to time on the open market or in privately negotiated or other transactions. We publicly announced the program in November 2017. The repurchase program is authorized for a period of up to two years, and may be suspended or discontinued at any time. In order to facilitate repurchases, the Company may enter into a Rule 10b5-1 plan from time to time, which would permit shares to be repurchased when the Company might otherwise be precluded from doing so under insider trading laws or because of a self-imposed trading blackout period. All repurchases were made under the program and using cash resources. See "Equity" in Note 11 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding share repurchases. There were no repurchases of shares of common stock in the fourth quarter of 2018.

Period	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program	Maximum Approximate Dollar Value of Shares That May Yet Be Purchased Under the Program
October 1, 2018 to October 31, 2018	—	$ —	—	$ —
November 1, 2018 to November 30, 2018	—	—	—	—
December 1, 2018 to December 31, 2018	—	—	—	—
Total	—	$ —	—	$ 29,933,055

Comparative Stock Performance Graph

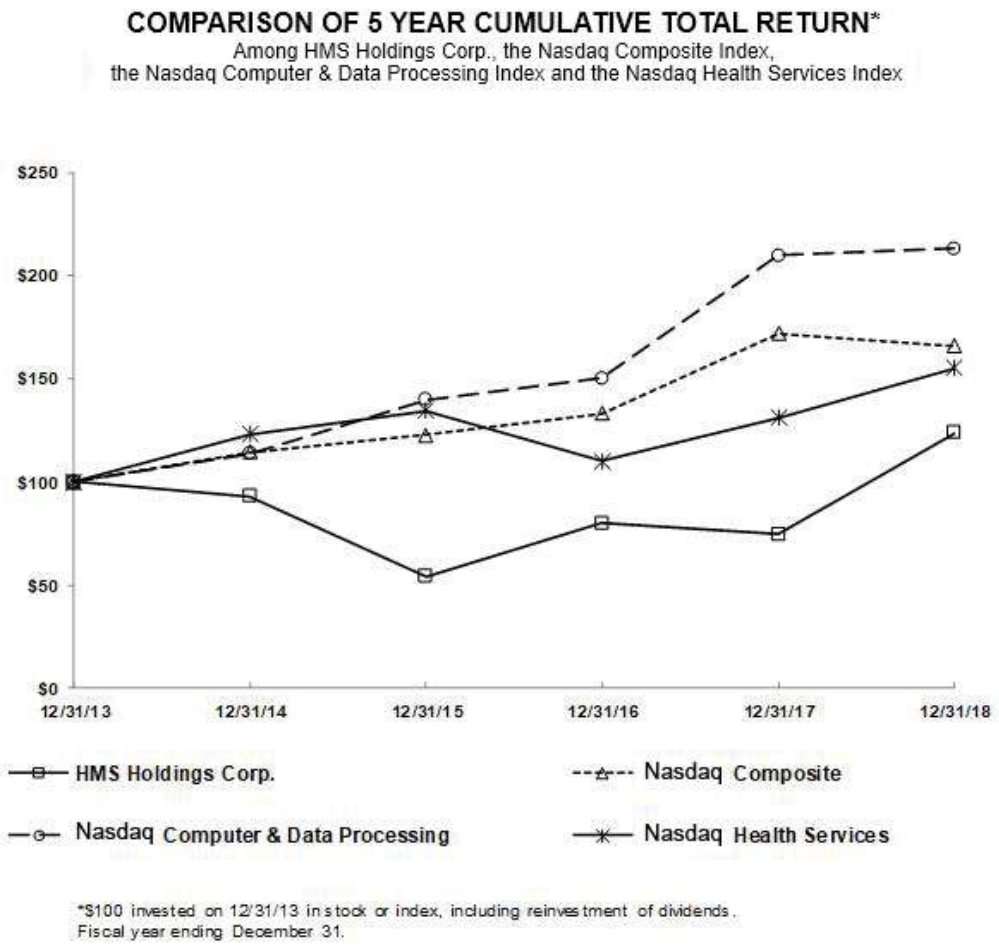

The graph below compares the cumulative total shareholder return on our common stock with the cumulative total shareholder returns of the Nasdaq Composite Index, the Nasdaq Computer & Data Processing Index and the Nasdaq Health Services Index assuming an investment of $100 on December 31, 2013 and the reinvestment of dividends through the year ended December 31, 2018.

	12/31/13	12/31/14	12/31/15	12/31/16	12/31/17	12/31/18
HMS Holdings Corp.	$ 100.00	$ 93.13	$ 54.36	$ 80.00	$ 74.67	$ 123.92
NASDAQ Composite	100.00	114.62	122.81	133.19	172.11	165.84
NASDAQ Computer & Data Processing	100.00	113.68	140.03	150.12	209.72	212.97
NASDAQ Health Services	100.00	123.14	134.70	110.22	131.32	155.16

Notwithstanding anything to the contrary set forth in any of our previous or future filings under the Securities Act or the Exchange Act that might incorporate by reference this 2018 Form 10-K or future filings made by us under those statutes, the Comparative Stock Performance Graph is not deemed filed with the SEC, is not deemed soliciting material and shall not be deemed incorporated by reference into any of those prior filings or into any future filings we make under those statutes, except to the extent that we specifically incorporate such information by reference into a previous or future filing, or specifically request that such information be treated as soliciting material, in each case under those statutes.

Item 6. Selected Financial Data

The following table sets forth selected consolidated financial amounts at and for each of the five fiscal years in the period ended December 31, 2018. It should be read in conjunction with Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, and the Consolidated Financial Statements and Notes thereto, in Part II, Item 8 of this 2018 Form 10-K.

Statement of Operations Data

	Years ended December 31,				
(in thousands, except per share amounts)	2018	2017	2016	2015	2014
Revenue	$ 598,290	$ 521,212	$ 489,720	$ 474,216	$ 443,225
Total operating expenses	535,052	470,781	432,051	426,644	409,021
Operating income	63,238	50,431	57,669	47,572	34,204
Interest expense	(11,310)	(10,871)	(8,519)	(7,812)	(7,931)
Interest income	1,089	295	321	49	57
Income before income taxes	53,017	39,855	49,471	39,809	26,330
Income taxes	(1,972)	(199)	11,835	15,282	12,383
Net income	$ 54,989	$ 40,054	$ 37,636	$ 24,527	$ 13,947
Net Income Per Common Share					
Basic income per common share:					
Net income per common share - basic	$ 0.66	$ 0.48	$ 0.45	$ 0.28	$ 0.16
Diluted income per common share:					
Net income per common share - diluted	$ 0.64	$ 0.47	$ 0.43	$ 0.28	$ 0.16
Weighted average shares:					
Basic	83,625	83,821	84,221	87,881	87,673
Diluted	86,144	85,088	86,987	88,361	88,164

Balance Sheet Data

	Years ended December 31,				
(in thousands)	2018	2017	2016	2015	2014
Cash and cash equivalents	$ 178,946	$ 83,313	$ 175,999	$ 145,610	$ 133,116
Working capital	$ 328,684	$ 199,967	$ 277,478	$ 240,456	$ 226,271
Total assets	$ 1,078,518	$ 975,160	$ 882,755	$ 850,597	$ 880,988
Revolving credit facility	$ 240,000	$ 240,000	$ 197,796	$ 197,796	$ 197,796
Total shareholders' equity	$ 713,396	$ 606,229	$ 556,610	$ 524,702	$ 533,090

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following Management's Discussion and Analysis is intended to help the reader understand the results of operations and financial condition of HMS. You should read this discussion and analysis in conjunction with the other sections of this 2018 Form 10-K, including the Cautionary Note Regarding Forward-Looking Statements appearing prior to Part I, the information in Part I, Item 1A, and the Consolidated Financial Statements and Notes thereto in Part II, Item 8. The historical results set forth in Part II, Item 6, Item 7 and Item 8 of this 2018 Form 10-K should not be taken as necessarily indicative of our future operations or financial results.

Business Overview

HMS provides a broad range of cost containment solutions to help healthcare payers and at-risk providers reduce costs, improve health outcomes and enhance member experiences. Using industry-leading technology, analytics and engagement solutions, we deliver coordination of benefits, payment integrity and total population management solutions through our operating subsidiaries to move the healthcare system forward for our customers. We are managed and operate as one business segment with a single management team that reports to the Chief Executive Officer.

We serve state Medicaid programs, commercial health plans, federal government health agencies, government and private employers, CHIPs and other healthcare payers. We also serve as a subcontractor for certain business outsourcing and technology firms. As of December 31, 2018, our customer base included the following:

- over 40 state Medicaid programs;
- more than 325 health plans, including 23 of the top 25 health plans nationally (based on membership) in support of their multiple lines of business, including Medicaid managed care, Medicare Advantage and group and individual health;
- over 150 private employers;
- CMS, the Centers for Disease Control and Prevention, and the Department of Veterans Affairs; and
- PBMs, third-party administrators and other risk-bearing entities, including independent practice associations, hospital systems, ACOs and specialty care organizations.

Outlook

We have grown our business both organically, through internal innovation and the development of new solutions and services, as well as by acquisition of businesses whose core services strengthened our overall mission to help our customers contain healthcare costs. Our largest growth during 2018 was with commercial health plan customers and we currently expect this market to present the greatest opportunity for continued growth in the year ahead. In addition to cross-sales of our total population management solutions and other internal growth initiatives in 2019, various factors related to the macro healthcare environment are expected to contribute to our expected growth, including:

- an aging U.S. population with high-cost, chronic conditions and often co-morbidities;
- projected growth in Medicare enrollment from 2018 to 2026 is estimated by CMS to be at 24%, with a projected increase in spending of 83% during this same time period;
- Medicaid expenditures are projected to grow 60% from 2018 to 2026 based on CMS NHE projections;
- government program payment error rates remain high at approximately 9%;
- more than half of the U.S. population is projected by CMS to remain covered by employer-sponsored plans;
- continued support for moving the focus of U.S. reimbursement models away from volume of service to quality outcomes; and
- increased healthcare industry focus on improved population health, enhanced consumer outcomes and experience, and reduced costs.

We plan to drive our future growth by leveraging our expertise to expand solution offerings, attracting new customers and broadening our relationships with current customers through the introduction of new services, audit strategies and claim types. Our goal is to develop and build on existing partnerships with our state, federal and commercial health plan customers to provide services that better address their business needs and promote consumer engagement and satisfaction in the constantly evolving healthcare marketplace. We also expect to continue increasing recovery yields from our current services by enhancing our operating and organizational efficiency and by implementing new technologies that will improve the quality, effectiveness and profitability of our service offerings.

We are subject to a number of significant risks in the operation of our business, including operational, strategic, financial and regulatory risks. These include risks related to legal compliance, financial performance and condition, protection of our information technology networks and systems and intellectual property, and other risks. With respect to cybersecurity, the effective operation of our information technology networks and systems, and the secure processing and maintenance of the confidential, proprietary and sensitive information and data we receive from our customers and other data suppliers are critical to our operations and business strategy. Although we have processes and procedures to attempt to mitigate many of the risks that we face, there can be no assurance that such processes or procedures will be successful. For a discussion of certain risks relating to the Company, see the information under the heading "Part I, Item 1A. Risk Factors."

Critical Accounting Policies and Estimates

Our consolidated financial statements are prepared in accordance with U.S. GAAP. The preparation of these consolidated financial statements requires us to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenue, costs and expenses, and related disclosures. We evaluate our estimates and assumptions on an ongoing basis. Our estimates are based on historical experience and various other assumptions that we believe to be reasonable under the circumstances. Our actual results could differ from these estimates. The accounting policies that we believe to be the most critical to an understanding of our financial condition and results of operations and that require the most complex and subjective management judgments are below:

Revenue Recognition

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
The Company recognizes revenue when our customers realize economic benefits from our services when our services are completed.	Due to the range of solutions and services that HMS provides and the differing fee structures associated with each type of contract, revenue may be recognized in irregular increments. A portion of our revenue is recorded net of an estimate of future revenue adjustments, with an offsetting entry to accounts receivable allowance, based on historical patterns of billing adjustments, length of operating and collection cycle and customer negotiations, behaviors and payment patterns. Changes in these estimates are recorded to revenue in the period of change.	If we were to enter any new contracts with differing fee structures or performance obligations or if we were to change any of the judgments or estimates related to estimated future revenue adjustments, it could cause a material increase or decrease in the amount of revenue we report in a particular period.

Estimated Liability for Appeals

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
Under our contracts with certain commercial health plan customers and our Medicare RAC contracts with CMS, we recognize revenue when HMS claim findings are sent to the Company's customers for offset against future claim payments to providers. These contracts permit providers the right to appeal HMS claim findings and to pursue additional appeals if the initial appeal is found in favor of HMS's customer. The total estimated liability for appeals balance was $21.7 million and $30.8 million as of December 31, 2018 and December 31, 2017, respectively. The Company's original Medicare RAC contract with CMS expired on January 31, 2018.	The appeal process established under the Medicare RAC contract with CMS includes five levels of appeals and resolution of appeals can take substantial time to resolve. HMS records (i) a liability for findings which have been adjudicated in favor of providers and (ii) an estimated liability based on the amount of revenue that is subject to appeals and which is probable of being adjudicated in favor of providers following their successful appeal. Our estimated liability is based on the Company's historical experience. As a result of the original Medicare RAC contract expiration, the Company's contractual obligation with respect to any appeals resolved in favor of providers subsequent to the expiration date have ceased and therefore the Company released its estimated return obligation liability and increased revenue by $8.4 million during the first quarter of 2018.	To the extent the amount to be returned to providers following a successful appeal exceeds or is less than the amount recorded, revenue in the applicable period would be reduced or increased by such amount. Any future changes to any of our customer contracts, including modifications to Medicare RAC contracts, may require us to apply different assumptions that could materially affect both the Company's revenue and estimated liability for appeals in future periods.

Business Combinations

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
We record assets acquired and liabilities assumed in a business combination based upon their acquisition date fair values. Goodwill is the excess of acquisition costs over the fair values of assets and liabilities of acquired businesses. During the measurement period, which is up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed, with the corresponding offset to goodwill. Upon the conclusion of the measurement period, any subsequent adjustments are recorded to earnings.	In most instances there is not a readily defined or listed market price for individual assets and liabilities acquired in connection with a business, including intangible assets. We determine fair value through various valuation techniques including discounted cash flow models, quoted market values and third party independent appraisals, as considered necessary. Significant assumptions used in those techniques include, but are not limited to, growth rates, discount rates, customer attrition rates, expected levels of revenues, earnings, cash flows and tax rates.	The use of different valuation techniques and assumptions are highly subjective and inherently uncertain and, as a result, actual results may differ materially from estimates.

Impairment of Goodwill

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
Goodwill is subject to a periodic assessment for impairment. We assess goodwill for impairment on an annual basis as of June 30th of each year or more frequently if an event occurs or changes in circumstances would more likely than not reduce the fair value of a reporting unit below its carrying amount. Assessment of goodwill impairment is at the HMS Holdings Corp. entity level as we operate as a single reporting unit. The Company's carrying amount of goodwill was $487.6 million as of December 31, 2018.	We have the option to perform a qualitative or quantitative assessment to determine if impairment is more likely than not to have occurred. The Company completed the annual impairment test as of June 30, 2018 electing to perform the quantitative assessment of which the first step is to compare the fair value of the reporting unit with its carrying value, including goodwill. In calculating the fair value of the reporting unit, the Company utilized a weighting across three commonly accepted valuation approaches: an income approach, a guideline public company approach, and a merger and acquisition approach. The income approach to determining fair value computes projections of the cash flows that the reporting unit is expected to generate converted into a present value equivalent through discounting. Significant assumptions in the income approach include income projections, a discount rate and a terminal growth value which are all level 3 inputs. The income projections include assumptions for revenue and expense growth which are based on internally developed business plans and largely reflect recent historical revenue and expense trends. The discount rate was based on a risk free rate plus a beta adjusted equity risk premium and specific company risk premium. The terminal growth value is Company specific and was determined analyzing inputs such as historical inflation and the GDP growth rate. The guideline public company approach and merger and acquisition approach are based on pricing multiples observed for similar publicly traded companies or similar market companies that were sold.	The results of the annual impairment assessment provide that the fair value of the reporting unit was significantly in excess of the Company's carrying value, including goodwill; therefore, no impairment was indicated. If actual results are not consistent with our estimates or assumptions, the Company may be exposed to an impairment charge that could materially adversely impact our consolidated financial position and results of operations. There were no impairment charges related to goodwill during the years ended December 31, 2018, 2017, or 2016.

Impairment of Long-Lived and Intangible Assets

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
Long-lived assets, including property and equipment and intangible assets, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of the asset may not be recoverable. When indicators exist, recoverability of assets is measured by a comparison of the carrying value of the asset group to the estimated undiscounted future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized and charged to earnings is measured by the amount by which the carrying value of the asset group exceeds the fair value of the assets.	We use significant judgment in assessing events or changes in circumstances which indicate that the carrying amount of the asset may not be recoverable.	The Company's carrying amount of long-lived assets, including property and equipment and intangible assets was $161.6 million as of December 31, 2018. The Company did not recognize any impairment charges related to long-lived and intangible assets during the years ended December 31, 2018, 2017 or 2016. However, if actual results are not consistent with our estimates or assumptions, we may be exposed to an impairment charge that could materially adversely impact our consolidated financial position and results of operations.

Valuation of Stock-Based Compensation

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
The determination of the fair value of the options on the grant date using the Black-Scholes pricing model and/or the Monte Carlo Simulation is affected by the Company's stock price, as well as assumptions regarding a number of complex and subjective variables. Certain key variables include: the Company's expected stock price volatility over the expected term of the awards; a risk-free interest rate; and any expected dividends. The fair value of all awards also includes an estimate of expected forfeitures.	We estimate stock price volatility based on the historical volatility of the Company's common stock and estimate the expected term of the awards based on the Company's historical option exercises for similar types of stock option awards. The assumed risk-free interest rate is based on the yield on the measurement date of a zero-coupon U.S. Treasury bond with a maturity period equal to the option's expected term. The Company does not anticipate paying any cash dividends in the foreseeable future and therefore, uses an expected dividend yield of zero in the option valuation models. Forfeitures are estimated based on historical experience.	If we were to change any of these judgments or estimates, it could cause a material increase or decrease in the amount of stock compensation expense we report in a particular period. For example, if actual forfeitures vary from estimates, a difference in compensation expense will be recognized in the period the actual forfeitures occur.

Income Taxes

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
Income taxes are accounted for under the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to temporary differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. This method also requires the recognition of future tax benefits for net operating loss carry-forwards.	Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as income or expense in the period that includes the enactment date. A valuation allowance is provided against deferred tax assets to the extent their realization is not more likely than not. Uncertain income tax positions are accounted for by prescribing a minimum recognition threshold that a tax position is required to meet before being recognized in the financial statements. We make adjustments to these reserves in accordance with the income tax accounting guidance when facts and circumstances change, such as the closing of a tax audit or the refinement of an estimate.	To the extent that the final tax outcome of these matters is different than the amounts recorded, such differences will affect the provision for income taxes in the period in which such determination is made, and could have a material impact on our financial condition and operating results. Although the Company believes that it has adequately reserved for uncertain tax positions (including interest and penalties), it can provide no assurance that the final tax outcome of these matters will not be materially different.

Contingencies

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
From time to time, we are involved in legal proceedings in the ordinary course of business. We assess the likelihood of any adverse judgments or outcomes to these contingencies as well as potential ranges or probable losses and establish reserves accordingly.	We record accruals for outstanding legal matters when we believe it is probable that a loss will be incurred and the amount can be reasonably estimated. Significant judgment is required to determine both probability and the estimated amount. We review these provisions at least quarterly and adjust the provisions to reflect the impact of negotiations, settlements, rulings, advice of legal counsel and updated information.	Litigation is inherently unpredictable and is subject to significant uncertainties, some of which are beyond the Company's control. The amount of reserves required may change in future periods due to new developments in each matter or changes in approach to a matter such as a change in settlement strategy which could have a material impact on our financial condition and operating results.

For further information on these critical accounting policies and all other significant accounting policies refer to the discussion under "Business and Summary of Significant Accounting Policies" in our Note 1 to the Consolidated Financial Statements in Part II, Item 8.

Results of Operations

2018 Highlights

- Revenue growth of 14.8%
- Operating income growth of 25.4%
- Cash flow from operations of $96.5 million
- Repurchased approximately 384,000 shares of common stock for $6.0 million
- Net income growth of 37.2%

Comparison of 2018 to 2017 and 2017 to 2016

dollars in millions	Year Ended December 31,			$ Change	% Change	$ Change	% Change
	2018	2017	2016	2018 vs 2017		2017 vs 2016	
Revenue	$ 598.3	$ 521.2	$ 489.7	$ 77.1	14.8%	$ 31.5	6.4%
Cost of Services :							
Compensation	224.9	202.0	189.3	22.9	11.3	12.7	6.7
Information technology	53.4	45.7	37.3	7.7	16.8	8.4	22.5
Occupancy	16.0	17.2	14.0	(1.2)	(7.0)	3.2	22.9
Direct project costs	42.9	41.4	46.3	1.5	3.6	(4.9)	(10.6)
Other operating costs	31.4	28.4	27.8	3.0	10.6	0.6	2.2
Amortization of acquisition related software and intangible assets	33.0	30.4	28.0	2.6	8.6	2.4	8.6
Total Cost of Services	401.6	365.1	342.7	36.5	10.0	22.4	6.5
Selling, general and administrative expenses	113.5	105.7	89.4	7.8	7.4	16.3	18.2
Settlement expense	20.0	-	-	20.0	100.0	-	-
Total Operating Expenses	535.1	470.8	432.1	64.3	13.7	38.7	9.0
Operating Income	63.2	50.4	57.6	12.8	25.4	(7.2)	(12.5)
Interest expense	(11.3)	(10.8)	(8.5)	(0.5)	4.6	(2.3)	27.2
Interest income	1.1	0.3	0.3	0.8	266.7	0.0	0.3
Income before income taxes	53.0	39.9	49.4	13.1	32.8	(9.5)	(19.2)
Income taxes	(2.0)	(0.2)	11.8	(1.8)	900.0	(12.0)	(101.7)
Net Income	$ 55.0	$ 40.1	$ 37.6	$ 14.9	37.2%	$ 2.5	6.6%

Revenue

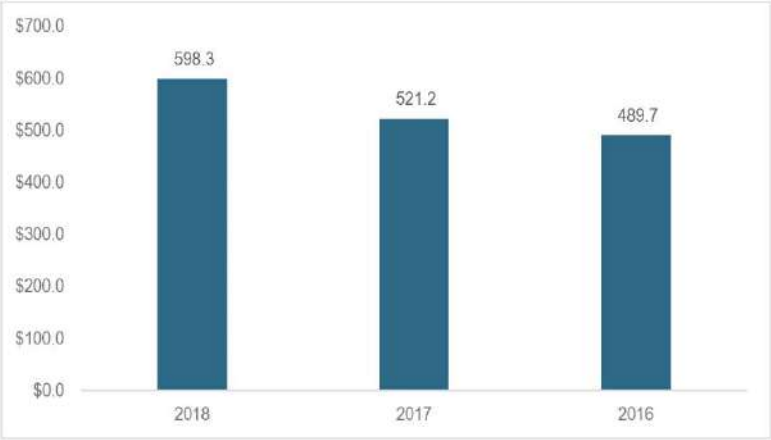

Revenue in Millions

2018 vs. 2017

During the year ended December 31, 2018, revenue was $598.3 million, an increase of $77.1 million or 14.8% compared to $521.2 million for the year ended December 31, 2017.

- By solution, which consists of coordination of benefits and analytical services, and included in analytical services are our payment integrity and total population management solutions:
  - Coordination of benefits product revenue increased $14.4 million or 3.8% which was attributable to yield improvements and the addition of Medicaid enrollees which entered our customer eligibility files in 2018.
  - Payment integrity revenue increased $39.7 million or 38.0% which was attributable to expanded commercial health plan scopes, including the addition of health plans to current contracts and yield improvements. Within payment integrity, Medicare RAC revenue increased $17.8 million which includes an $8.4 million reserve release during the first quarter of 2018 as compared to prior year.
  - Total population management revenue increased $23.0 million or 67.4% of which $21.4 million is due to Eliza (acquired in April 2017). Additionally, Essette revenue increased $1.6 million as compared to prior year.

- By market:
  - Commercial health plan market revenue increased $54.0 million or 20.1% which includes increases of $21.4 million from Eliza (acquired in April 2017) as compared to the prior year and $1.6 million from Essette as compared to prior year. The increases are due to expanded commercial health plan scopes, including the addition of health plans to current contracts and yield improvements.
  - State government market revenue increased $6.9 million or 3.0%, which was attributable to expanded scopes and yield improvements.
  - Federal government market and other revenue increased $16.2 million or 64.8% which includes an $8.4 million Medicare RAC reserve release.

2017 vs. 2016

During the year ended December 31, 2017, revenue was $521.2 million, an increase of $31.5 million or 6.4% compared to $489.7 million for the year ended December 31, 2016.

- By solution, which consists of coordination of benefits and analytical services, and included in analytical services are our payment integrity and total population management solutions:
  - Coordination of benefits service revenue increased $29.0 million or 8.2% which was attributable to yield improvements and the addition of Medicaid enrollees which entered our customer eligibility files in 2017.
  - Payment integrity revenue decreased $30.7 million or 22.8% which was attributable to a $14.7 million decrease in Medicare RAC revenue because the Medicare RAC Region D program ceased generating revenue in late 2016, as expected, and a $16.1 million decrease due to various contract completions and expirations.
  - Total population management revenue increased $33.3 million or 3746.8% almost all of which is due to the Eliza acquisition in April 2017.

- By market:
  - Commercial health plan market revenue increased $39.0 million or 17.0% which was attributable to Eliza contributing revenue of $30.4 million since its acquisition in April 2017, Essette increasing revenue $2.9 million as compared to prior year and expanded commercial health plan scopes, including the addition of health plans to current contracts and yield improvements.
  - State government market revenue increased by $7.9 million or 3.6%, which was attributable to expanded scopes and yield improvements.
  - Federal government market and other revenue decreased $15.4 million, which was primarily attributable to a reduction of Medicare RAC revenue because the Medicare RAC D Region D program ceased generating new claims for active auditing in 2016, as expected.

Cost of Services

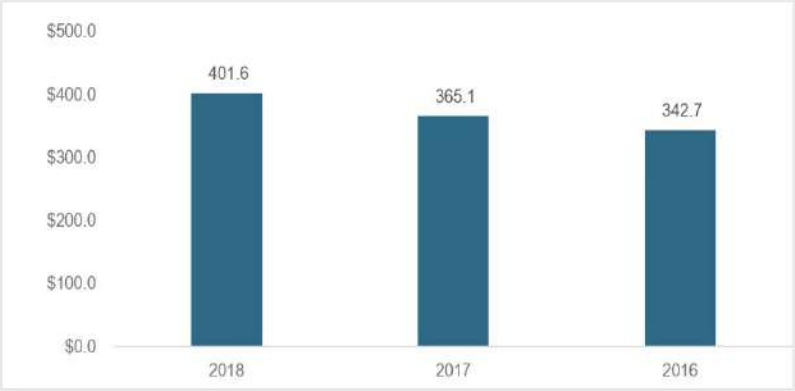

Cost of Services in millions

2018 vs. 2017

During the year ended December 31, 2018, total cost of services was $401.6 million, an increase of $36.5 million or 10.0% compared to $365.1 million for the year ended December 31, 2017. This change resulted primarily from increases in compensation expense of $22.9 million, information technology expense of $7.7 million, other operating costs of $3.0 million and amortization of intangibles expense of $2.6 million.

- The increase in total cost of services relating to Eliza (acquired in April 2017) represented $14.4 million of the increase.
- Excluding Eliza, total cost of services increased by $22.1 million which was primarily related to increases in compensation expenses of $17.0 million related to the overall performance of the Company and information technology expenses of $4.2 million.

2017 vs. 2016

During the year ended December 31, 2017, total cost of services was $365.1 million, an increase of $22.4 million or 6.5% compared to $342.7 million for the year ended December 31, 2016. This change resulted primarily from increases in compensation expense of $12.7 million, information technology expense of $8.4 million, and amortization of intangibles expense of $2.4 million.

- The Eliza acquisition and the related compensation, data processing, occupancy and amortization of intangibles expenses incurred since its acquisition in April 2017 represented $23.4 million of the increase.
- Excluding Eliza, total cost of services decreased by $1.0 million which was primarily related to a reduction in direct project costs partially offset by increases in data processing and compensation expenses.

Selling, General and Administrative Expenses

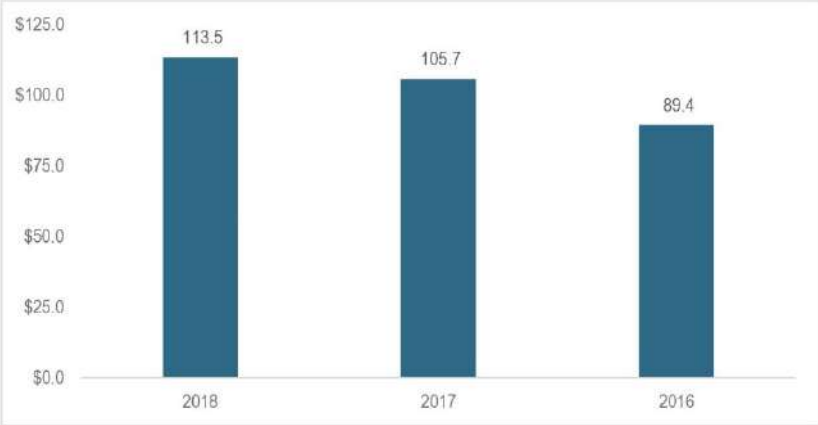

SG&A in millions

2018 vs. 2017

During the year ended December 31, 2018, SG&A expense was $113.5 million, an increase of $7.8 million or 7.4% compared to $105.7 million for the year ended December 31, 2017.

- Eliza (acquired in April 2017) represented $1.9 million of the increase.
- Excluding Eliza, expenses increased by $5.9 million primarily related to increased variable compensation expense due to the overall performance of the Company.

2017 vs. 2016

During the year ended December 31, 2017, SG&A expense was $105.7 million, an increase of $16.3 million or 18.2% compared to $89.4 million for the year ended December 31, 2016.

- The Eliza acquisition and related transaction fees and other SG&A expenses incurred since its acquisition in April 2017 represented $8.7 million of the increase.
- Excluding Eliza, stock compensation expense also increased by $7.3 million primarily due to stock compensation expense for retirement eligible employees.

Income Taxes

2018 vs. 2017

During the year ended December 31, 2018, we recorded an income tax benefit of ($2.0) million, an increased benefit of $1.8 million compared to an income tax benefit of ($0.2) million for the year ended December 31, 2017.

- On December 22, 2017, the 2017 Tax Act was signed into law and includes provisions reducing the federal tax rate for years beginning in 2018 from 35% to 21%.
- Our effective tax rate was (3.7%) for the year ended December 31, 2018 compared to an effective tax rate of (0.5%) for the year ended December 31, 2017. The low 2018 effective tax rate is primarily due to favorable tax benefits related to current year credits, equity compensation, subsidiary basis write off, prior year state tax apportionment changes, uncertain tax position releases, and acquisition adjustments.
- Our normalized effective tax rate of 25.8% for 2018 decreased from our normalized effective tax rate of 36.1% for 2017 primarily due to a lower federal tax rate. The normalized effective tax rate excludes prior years' expense and benefit adjustments recognized in the respective fiscal year.

2017 vs. 2016

During the year ended December 31, 2017, we recorded an income tax benefit of ($0.2) million, a decrease of $12.0 million compared to the year ended December 31, 2016.

- Our effective tax rate was (0.5%) for the year ended December 31, 2017 compared to an effective tax rate of (23.9%) for the year ended December 31, 2016. The decrease is primarily due to the revaluation of our deferred tax liabilities based on the reduced federal tax rate described above.
- Our normalized effective tax rate of 36.1% for 2017 is comparable to our normalized effective tax rate of 36.2% for 2016. The normalized effective tax rate excludes prior years expense and benefit adjustments recognized in the respective fiscal year.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements.

Liquidity and Capital Resources

The following tables should be read in conjunction with the Consolidated Financial Statements and Notes thereto, in Part II, Item 8 of this 2018 Form 10-K.

Our cash and cash equivalents, working capital and available borrowings under our credit facility (based upon the borrowing base and financial covenants in our Credit Agreement) were as follows *(in thousands)*:

	Years ended December 31,	
	2018	2017
Cash and cash equivalents	$ 178,946	$ 83,313
Working capital	$ 328,684	$ 199,967
Available borrowings under credit facility	$ 253,500	$ 254,600

A summary of our cash flows was as follows *(in thousands)*:

	Years ended December 31,		
	2018	2017	2016
Net cash provided by operating activities	$ 96,457	$ 86,464	$ 88,639
Net cash used in investing activities	(30,413)	(204,364)	(39,201)
Net cash provided by/(used in) financing activities	29,589	25,214	(19,049)
Net increase / (decrease) in cash and cash equivalents	$ 95,633	$ (92,686)	$ 30,389

Our cash and cash equivalents and working capital increased as of December 31, 2018 as compared to December 31, 2017, primarily as a result of the cash generated by our operating activities as discussed below.

Our principal source of cash has been our cash flow from operations and our $500 million five-year revolving credit facility. Other sources of cash include proceeds from exercise of stock options and tax benefits associated with stock option exercises. The primary uses of cash are capital investments, compensation expenses, data processing, direct project costs, SG&A expenses and acquisitions. We may also use available cash to repurchase shares of our common stock.

We believe that expected cash flows from operations, available cash and cash equivalents, and funds available under our revolving credit facility will be sufficient to meet our liquidity requirements for the following year, which include:

- the working capital requirements of our operations;
- investments in our business;
- business development activities;
- repurchases of common stock; and
- repayment of our revolving credit facility.

Any projections of future earnings and cash flows are subject to substantial uncertainty. We may need to access debt and equity markets in the future if unforeseen costs or opportunities arise, to meet working capital requirements, fund acquisitions or repay our indebtedness under the Credit Agreement. If we need to obtain new debt or equity financing in the future, the terms and availability of such financing may be impacted by economic and financial market conditions as well as our financial condition and results of operations at the time we seek additional financing.

Cash Flows from Operating Activities

Net cash provided by operating activities for the year ended December 31, 2018 was $96.5 million, a $10.0 million increase from net cash provided by operating activities of $86.5 million for the year ended December 31, 2017. The increase was primarily due to a $14.9 million increase in net income and increases in reconciling items of $14.3 million as compared to prior year. These increases were offset by decreases in operating assets and liabilities of approximately $19.2 million.

Net cash provided by operating activities for the year ended December 31, 2017 was $86.5 million, a $2.1 million decrease from net cash provided by operating activities of $88.6 million for the year ended December 31, 2016. The decrease was primarily due to a decrease in deferred income taxes of $13.0 million related to our revaluation of the Company's deferred tax balances from the federal tax rate of 35% to 21% under the 2017 Tax Act, offset by an increase in stock based compensation expense of $10.9 million primarily related to retirement eligible employees. The decrease was also impacted by changes in operating assets and liabilities and offset by increases in net income, and depreciation and amortization expenses.

Our DSO calculation can be derived by dividing total net accounts receivable at the end of period, by the daily average of the current quarter's annualized revenue. For the year ended December 31, 2018, revenue was $598.3 million, an increase of $77.1 million compared to revenue of $521.2 million for the year ended December 31, 2017. DSO increased by 4 days to 119 days as of December 31, 2018, as compared to 115 days as of December 31, 2017. The change was due to timing delays in certain clients processing our findings through their systems. We do not currently anticipate collection issues with our accounts receivable, however, nor do we currently expect that any extended collections will materially impact our liquidity.

The majority of our customer relationships have been in place for several years. Our future operating cash flows could be adversely affected by a decrease in a demand for our services, delayed payments from customers or if one or more contracts with our largest customers is terminated or not renewed.

Cash Flows from Investing Activities

Net cash used in investing activities for the year ended December 31, 2018 was $30.4 million, a $174.0 million decrease compared to net cash used in investing activities of $204.4 million for the year ended December 31, 2017. This decrease was primarily due to the use of approximately $171.3 million for the Eliza acquisition in April 2017. Purchases of property and equipment and investment in capitalized software also decreased by $2.7 million year over year.

Net cash used in investing activities for the year ended December 31, 2017 was $204.4 million, a $165.2 million increase compared to net cash used in investing activities of $39.2 million for the year ended December 31, 2016. This increase was primarily due to the use of approximately $171.3 million for the Eliza acquisition in April 2017 as compared to the use of approximately $20.7 million for the Essette acquisition in September 2016. Purchases of property and equipment and investment in capitalized software also increased by $12.0 million year over year.

We currently expect to incur capital expenditures of $35-$40 million during the year ended December 31, 2019.

Cash Flows from Financing Activities

Net cash provided by financing activities for the year ended December 31, 2018 was $29.6 million, a $4.4 million increase from net cash provided by financing activities of $25.2 million for the year ended December 31, 2017. This increase was primarily attributable to an increase of $36.0 million of proceeds from exercise of stock options over prior year and an $8.2 million decrease in repurchases of common stock as compared to prior year. Additionally, there was a $39.8 million decrease in proceeds from our credit facility net of deferred financing cost payments.

Net cash provided by financing activities for the year ended December 31, 2017 was $25.2 million, a $44.2 million increase from net cash used in financing activities of $19.0 million for the year ended December 31, 2016. This increase was primarily attributable to $42.2 million of proceeds from additional borrowings under our amended credit facility.

Share Repurchase Program

During the year ended December 31, 2018, we repurchased 0.4 million shares of our common stock for approximately $6.0 million using cash resources. See the discussion under “Repurchases of Shares of Common Stock” under Part II, Item 5 and “Equity” in Note 11 to the Consolidated Financial Statements under Part II, Item 8 for additional information regarding share repurchases.

Credit Agreement

In May 2013, we entered into the Credit Agreement with certain lenders and Citibank, N.A. as administrative agent. The Credit Agreement originally provided for an initial $500 million five-year revolving credit facility maturing on May 3, 2018. On December 19, 2017, we entered into an amendment to the Credit Agreement that, among other things, provided for an extension of the maturity date of our then-existing senior secured revolving credit facility to December 19, 2022, which includes a $50 million sublimit for the issuance of letters of credit and a $25 million sublimit for swingline loans. In addition, the Credit Agreement includes an accordion feature that permits us to increase the revolving credit facility up to the sum of (a) the greater of $120 million and 100% of Consolidated EBITDA (as defined in the Credit Agreement) and (b) additional amounts so long as our first lien leverage ratio (as defined in the Credit Agreement) on a pro forma basis is not greater than 3.00:1.00, in each case subject to obtaining commitments from lenders therefor and meeting certain other conditions.

The obligations and amounts due under the Credit Agreement are secured by a first security priority interest in all or substantially all of our tangible and intangible assets and our material 100% owned subsidiaries’ assets. The Credit Agreement contains customary representations and warranties, affirmative and negative covenants, including financial covenants, and events of default.

As of December 31, 2018, the outstanding principal balance under our revolving credit facility was $240.0 million.

As part of a contractual agreement with a customer, the Company has an outstanding irrevocable letter of credit for $6.5 million, which is issued against our revolving credit facility and expires June 30, 2019.

As of December 31, 2018, we were in compliance with all terms of the Credit Agreement.

See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding our Credit Agreement.

Contractual Obligations

The following table represents the scheduled maturities of our contractual cash obligations and other commitments:

	Payments Due by Period (*in thousands*)				
Contractual Obligations [1]	Total	Less than 1 year	1 - 3 years	3 -5 years	More than 5 years
Operating leases [2]	$ 22,654	$ 5,778	$ 9,162	$ 4,767	$ 2,947
Revolving credit facility [3]	240,000	-	-	240,000	-
Interest expense [4]	41,687	10,494	21,016	10,177	-
Commitment fee [5]	2,610	651	1,320	639	-
Capital leases [6]	8	8	-	-	-
Letter of Credit fee [7]	49	49	-	-	-
Purchase obligations and commitments [8]	26,966	10,180	13,970	2,816	-
Total	$ 333,974	$ 27,160	$ 45,468	$ 258,399	$ 2,947

(1) The Company has excluded long-term unrecognized tax benefits, net of interest and penalties, of $4.8 million from the amounts presented as the timing of these obligations is uncertain.

(2) Represents the future minimum lease payments under non-cancelable operating leases.

(3) Represents scheduled repayments of principal on the revolving credit facility under the terms of our Credit Agreement. See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding the Credit Agreement.

(4) Represents estimates of amounts due on the revolving credit facility based on the interest rate as of December 31, 2018 and on scheduled repayments of principal. See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding the Credit Agreement.

(5) Represents the commitment fee due on the revolving credit facility. See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding the Credit Agreement.

(6) Represents the future minimum lease payments under capital leases.

(7) Represents the fees for the letter of credit issued against the revolving credit facility. See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding the Credit Agreement.

(8) Represents future purchases related to outstanding purchase orders and supplier requisitions.

Recently Issued Accounting Pronouncements

The information set forth under the caption “Summary of Significant Accounting Policies” in Note 1 to the Consolidated Financial Statements in Part II, Item 8 is incorporated herein by reference.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

At December 31, 2018, we were not a party to any derivative financial instruments. We conduct all of our business in U.S. currency and hence do not have direct foreign currency risk. We are exposed to changes in interest rates, primarily with respect to our revolving credit facility under our Credit Agreement. If the effective interest rate for all of our variable rate debt were to increase by 100 basis points (1%), our annual interest expense would increase by a maximum of $2.4 million based on our debt balances outstanding at December 31, 2018. Further, we currently invest substantially all of our excess cash in short-term investments, primarily money market accounts, where returns effectively reflect current interest rates. As a result, market interest rate changes may impact our interest income or expense. The impact will depend on variables such as the magnitude of rate changes and the level of borrowings or excess cash balances. We do not consider this risk to be material. We manage such risk by continuing to evaluate the best investment rates available for short-term, high quality investments.

Item 8. Consolidated Financial Statements and Supplementary Data

The information required by Item 8 is found under Item 15 of this 2018 Form 10-K.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

(a) Evaluation of Disclosure Controls and Procedures

We are responsible for maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) under the Exchange Act) that are designed to ensure that information required to be disclosed in our reports filed under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow for timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management is required to apply its judgment in evaluating the cost-benefit relationship of possible controls and procedures

As required by Rule 13a-15(b) under the Exchange Act, management, with the participation of our Chief Executive Officer and Chief Financial Officer, performed an evaluation of the effectiveness of our disclosure controls and procedures as of December 31, 2018. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by the 2018 Form 10-K.

(b) Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting and for the assessment of the effectiveness of internal control over financial reporting. As defined by Rule 13a-15(f) under the Exchange Act, internal control over financial reporting is a process designed by, or under the supervision of our Chief Executive Officer and our Chief Financial Officer and effected by our Board of Directors, management and other personnel, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the consolidated financial statements for external purposes in accordance with U.S. GAAP.

Our internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect our transactions and dispositions of our assets; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the consolidated financial statements in accordance with generally accepted accounting principles and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on the consolidated financial statements.

In connection with the preparation of our annual consolidated financial statements, management has undertaken an assessment of the effectiveness of our internal control over financial reporting as of December 31, 2018, based on criteria established in the Internal Control-Integrated Framework issued by COSO. Management's assessment included an evaluation of the design of our internal control over financial reporting and testing of the operational effectiveness of those controls. Based on that assessment, we believe that the Company's internal control over financial reporting was effective based on those criteria as of December 31, 2018.

Our independent registered public accounting firm, Grant Thornton LLP, audited our consolidated financial statements and has issued an attestation report on the effectiveness of our internal control over financial reporting as of December 31, 2018, a copy of which is included with this 2018 Form 10-K.

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

(c) Changes in Internal Control Over Financial Reporting

There have been no changes to the Company's internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The information required by this Item 10 is incorporated herein by reference to the applicable disclosure found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders under the captions "*Proposal One: Election of Class II Directors,*" "*Executive Officers,*" "*Section 16(a) Beneficial Ownership Reporting Compliance*," "*Director Nomination Process*," "*Additional Information—Shareholder Proposals and Director Nominations for 2020 Annual Meeting,*" and "*Board Committees and Related Matters*."

Our Board of Directors has adopted a Code of Conduct applicable to all of our directors, officers and employees, including all employees, officers, directors, contractors, contingent workers and business affiliates of HMS subsidiaries. The Code of Conduct is publicly available on our website under the "Investors—Corporate Governance" tab at http://investor.hms.com/corporate-governance.cfm and can also be obtained free of charge by sending a written request to our Corporate Secretary. To the extent permissible under the Nasdaq Marketplace Rules, we intend to disclose amendments to our Code of Conduct, as well as waivers of the provisions thereof, that relate to our principal executive officer, principal financial officer, principal accounting officer, controller or persons performing similar functions on the Company's website under the "Investors—Corporate Governance" tab at http://investor.hms.com/corporate-governance.cfm.

Item 11. Executive Compensation

The information required by this Item 11 is incorporated herein by reference to the applicable disclosure found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders under the captions "*Executive Compensation,*" "*Director Compensation," and "Compensation Committee Interlocks and Insider Participation.*"

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Shareholder Matters

Except as provided below, the information required by this Item 12 is incorporated herein by reference to the applicable disclosure found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders under the caption "*Ownership of HMS Common Stock.*"

Equity Compensation Plan Information

The following table summarizes information about our equity compensation plans as of December 31, 2018. For additional information about our equity compensation plans see the discussion set forth under the caption "Stock-Based Compensation" in Note 13 to the Consolidated Financial Statements in Part II, Item 8.

Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(a)	(b)	(c)
Equity compensation plans approved by shareholders	5,825,734[1]	$ 17.07	4,758,398
Equity compensation plans not approved by shareholders	19,004[2]	$ 12.00	—
Total	5,844,738		

(1) This includes stock options and restricted stock units granted under our 2006 Stock Plan and 2016 Omnibus Plan.

(2) This includes stock options granted under the 2011 HDI Plan, which was assumed in connection with our acquisition of HDI and approved by the Compensation Committee of our Board.

Item 13. Certain Relationships and Related Transactions and Director Independence

The information required by this Item 13 is incorporated herein by reference to the applicable disclosure found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders under the captions "*Certain Relationships and Related Transactions*" and "*Director Independence*."

Item 14. Principal Accounting Fees and Services

The information required by this Item 14 is incorporated herein by reference to the applicable disclosure from the proposal captioned "*Ratification of the Selection of Independent Registered Public Accounting Firm*" found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders.

PART IV

Item 15. Exhibits and Financial Statement Schedules

1. *Financial Statements.*

The financial statements are listed in the Index to Consolidated Financial Statements on page 52.

2. *Financial Statement Schedules.*

Financial Statement Schedule II-Valuation and Qualifying Accounts is set forth on page 82. All other financial statement schedules have been omitted as they are either not required, not applicable or the information is otherwise included.

3. *Exhibits.*

The Exhibits include agreements to which the Company is a party or has a beneficial interest. The agreements have been filed to provide investors with information regarding their respective terms. The agreements are not intended to provide any other actual information about the Company or its business or operations. In particular, the assertions embodied in any representations, warranties, and covenants contained in the agreements may be subject to qualifications with respect to knowledge and materiality different from those applicable to investors and may be qualified by information in confidential disclosure schedules not included with the exhibits. These disclosure schedules may contain information that modifies, qualifies and creates exceptions to the representations, warranties and covenants set forth in the agreements. Moreover, certain representations, warranties, and covenants in the agreements may have been used for the purpose of allocating risk between parties, rather than establishing matters as facts. In addition, information concerning the subject matter of the representations, warranties and covenants may have changed after the date of the respective agreement, which subsequent information may or may not be fully reflected in the Company's public disclosures. Accordingly, investors should not rely on the representations, warranties and covenants in the agreements as characterizations of the actual state of facts about the Company or its business or operations on the date hereof.

Where an exhibit is filed by incorporation by reference to a previously filed registration statement or report, such registration statement or report is identified after the description of the exhibit.

Exhibit Number	Description
2.1	Agreement and Plan of Merger, dated December 16, 2002, among Health Management Systems, Inc., HMS Holdings Corp. and HMS Acquisition Corp. (incorporated by reference to Exhibit A to the Company's Prospectus and Proxy Statement (Reg No. 333-100521) as filed with the SEC on January 24, 2003)
2.2	Agreement and Plan of Merger, dated July 17, 2013, by and between HMS Holdings Corp., a Delaware corporation, and HMS Holdings Corp., a New York corporation (incorporated by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K/12g-3 (File No. 000-50194) as filed with the SEC on July 23, 2013)
2.3	Agreement and Plan of Merger, dated March 10, 2017, by and among HMS Holdings Corp., Echo Acquisition Sub, Inc., Eliza Holding Corp., and Parthenon Investors III, L.P., solely in its capacity as the representative for equity holders of Eliza Holding Corp. (incorporated by reference to Exhibit 2.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on June 6, 2017)
3.1	Conformed copy of Certificate of Incorporation of HMS Holdings Corp., as amended through May 23, 2018 (incorporated by reference to Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on August 6, 2018)

Exhibit Number	Description
3.2	Second Amended and Restated Bylaws of HMS Holdings Corp. dated May 23, 2018 (incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on May 25, 2018)
4.1	Specimen Common Stock Certificate (incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K/12g-3 (File No. 000-50194) as filed with the SEC on July 23, 2013)
10.1.1	HMS Holdings Corp. Fourth Amended and Restated 2006 Stock Plan (incorporated by reference to Exhibit 99.2 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on July 12, 2011)†
10.1.2	Amendment No. 1 to the HMS Holdings Corp. Fourth Amended and Restated 2006 Stock Plan (incorporated by reference to Exhibit 10.6 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on February 29, 2012)†
10.1.3	Form of 2012 Director Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.20 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 1, 2013)†
10.1.4	Form of 2012 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 1, 2013)†
10.1.5	Form of 2013 Executive Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.24 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 1, 2013)†
10.1.6	Form of 2013 Director Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 12, 2014)†
10.1.7	Form of 2013 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 12, 2014)†
10.1.8	Form of March 2014 Executive Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 12, 2014)†
10.1.9	Form of November 2014 Executive Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 10, 2014)†
10.1.10	Form of 2014 Director Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.26 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 2, 2015)†
10.1.11	Form of 2014 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.28 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 2, 2015)†
10.1.12	Form of March 2015 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 11, 2015)†
10.1.13	Form of March 2015 Executive Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 11, 2015)†

Exhibit Number	Description
10.1.14	Form of 2015 Director Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.21 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on February 29, 2016)†
10.1.15	Form of 2015 Director Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on February 29, 2016)†
10.1.16	Form of November 2015 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.23 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on February 29, 2016)†
10.1.17	Form of 2016 Executive and Senior Vice President Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 10, 2016)†
10.1.18	Form of 2016 Executive and Senior Vice President Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 10, 2016)†
10.2.1	HMS Holdings Corp. 2016 Omnibus Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on June 27, 2016)†
10.2.2	Form of Non-Qualified Stock Option Award Agreement for Employees under the 2016 Omnibus Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 9, 2016)†
10.2.3	Form of Restricted Stock Unit Award Agreement for Employees under the 2016 Omnibus Plan (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 9, 2016)†
10.2.4	Form of Non-Qualified Stock Option Award Agreement for Non-Employee Directors under the 2016 Omnibus Plan (incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 9, 2016)†
10.2.5	Form of Restricted Stock Unit Award Agreement for Non-Employee Directors under the 2016 Omnibus Plan (incorporated by reference to Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 9, 2016)†
10.3.1	Executive Employment Agreement, dated March 1, 2013, by and between William C. Lucia and HMS Holdings Corp. (incorporated by reference to Exhibit 10.29 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 1, 2013)†
10.3.2	Letter of Amendment to Executive Employment Agreement, dated April 30, 2013, by and between William C. Lucia and HMS Holdings Corp. (incorporated by reference to Exhibit 10.1 to Amendment No. 1 to the Company's Annual Report on Form 10-K/A (File No. 000-50194) as filed with the SEC on April 30, 2013)†

Exhibit Number	Description
10.3.3	Second Amendment to Executive Employment Agreement, dated January 20, 2015, by and between HMS Holdings Corp. and William C. Lucia (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on January 23, 2015)†
10.3.4	Third Amendment to Executive Employment Agreement, dated February 21, 2018, by and between William C. Lucia and HMS Holdings Corp. (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on February 23, 2018)†
10.4	Amended and Restated Employment Agreement, dated April 2, 2018, by and between Jeffrey S. Sherman and HMS Holdings Corp. (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 7, 2018)†
10.5	Amended and Restated Employment Agreement, dated March 29, 2018, by and between Meredith W. Bjorck and HMS Holdings Corp. (incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 7, 2018)†
10.6	Amended and Restated Employment Agreement, dated March 29, 2018, by and between Douglas M. Williams, Jr. and HMS Holdings Corp. (incorporated by reference to Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 7, 2018)†
10.7	Amended and Restated Employment Agreement, dated April 2, 2018, by and between Emmet O' Gara and HMS Holdings Corp.†
10.8	Amended and Restated Employment Agreement, dated April 2, 2018, by and between Semone Neuman and HMS Holdings Corp. (incorporated by reference to Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 7, 2018)†
10.9	Separation, Waiver and General Release Agreement, dated January 9, 2019, by and between Semone Neuman and HMS Holdings Corp.†
10.10	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on August 6, 2018)†
10.11	HMS Holdings Corp. Director Deferred Compensation Plan, as amended through June 29, 2016 (incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on August 9, 2016)†
10.12	HMS Holdings Corp. Annual Incentive Compensation Plan as amended and restated (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on June 27, 2016)†
10.13.1	Amended and Restated Credit Agreement, dated May 3, 2013, as amended by Amendment No. 1 to Amended and Restated Credit Agreement dated as of March 8, 2017, and as further amended by Amendment No. 2 to Amended and Restated Credit Agreement, dated as of December 19, 2017, by and among HMS Holdings Corp., the Guarantors party thereto, the Lenders party thereto and Citibank, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on December 21, 2017)
10.13.2	Amended and Restated Security Agreement, dated December 19, 2017, by and among HMS Holdings Corp., the Subsidiary Securing Parties party thereto and Citibank, N.A., as Collateral Agent (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on December 21, 2017)
10.14	Settlement Agreement, dated June 27, 2018, by and among Dennis Demetre, Lori Lynn Lewis Demetre, John Alfred Lewis, Christopher Brandon Lewis, and HMS Holdings Corp. (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on August 6, 2018)

Exhibit Number	Description
21.1	HMS Holdings Corp. List of Subsidiaries
23.1	Consent of Grant Thornton LLP
23.2	Consent of KPMG LLP
31.1	Rule 13a-14(a)/15d-14(a) Certification of the Principal Executive Officer of HMS Holdings Corp., as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Rule 13a-14(a)/15d-14(a) Certification of the Principal Financial Officer of HMS Holdings Corp., as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Section 1350 Certification of the Principal Executive Officer of HMS Holdings Corp., as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
32.2	Section 1350 Certification of the Principal Financial Officer of HMS Holdings Corp., as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

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† Indicates a management contract or compensatory plan, contract or arrangement

* The certifications attached hereto as Exhibit 32.1 and Exhibit 32.2 are furnished with this 2018 Form 10-K and shall not be deemed "filed" by the Company for purposes of Section 18 of the Exchange Act

Item 16. Form 10-K Summary

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the Registrant has duly caused this Annual Report on Form 10-K to be signed on its behalf by the undersigned, thereunto duly authorized on February 25, 2019.

HMS Holdings Corp.

/s/ William C. Lucia
William C. Lucia
Chairman of the Board, President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this Annual Report on Form 10-K has been signed below by the following persons on behalf of the Registrant and in the capacities indicated on February 25, 2019.

Signature	Title
/s/ William C. Lucia William C. Lucia	Director, Chairman of the Board, President and Chief Executive Officer (Principal Executive Officer)
/s/ Jeffrey S. Sherman Jeffrey S. Sherman	Executive Vice President, Chief Financial Officer and Treasurer (Principal Financial Officer)
/s/ Greg D. Aunan Greg D. Aunan	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)
/s/ Robert Becker Robert Becker	Director
/s/ Craig R. Callen Craig R. Callen	Director
/s/ William F. Miller III William F. Miller III	Director
/s/ Ellen A. Rudnick Ellen A. Rudnick	Director
/s/ Bart M. Schwartz Bart M. Schwartz	Director
/s/ Richard H. Stowe Richard H. Stowe	Director
/s/ Cora M. Tellez Cora M. Tellez	Director

HMS HOLDINGS CORP. AND SUBSIDIARIES
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Report of Independent Registered Public Accounting Firm

Board of Directors and Shareholders
HMS Holdings Corp.

Opinion on the financial statements

We have audited the accompanying consolidated balance sheets of HMS Holdings Corp. (a Delaware corporation) and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated statements of income, changes in shareholders' equity, and cash flows for each of the two years in the period ended December 31, 2018, and the related notes and financial statement schedule included under Item 15 (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the two years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in the 2013 *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"), and our report dated February 25, 2019 expressed an unqualified opinion.

Basis for opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ GRANT THORNTON LLP

We have served as the Company's auditor since 2017.

Dallas, Texas
February 25, 2019

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
HMS Holdings Corp.:

We have audited the accompanying consolidated balance sheet of HMS Holdings Corp. and subsidiaries as of December 31, 2016, and the related consolidated statements of income, shareholders' equity, and cash flows for the year ended December 31, 2016. In connection with our audit of the consolidated financial statements, we also have audited financial statement schedule II as it relates to the year ended December 31, 2016. These consolidated financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements and financial statement schedule based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of HMS Holdings Corp. and subsidiaries as of December 31, 2016, and the results of their operations and their cash flows for the year ended December 31, 2016, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the related financial statement schedule as it relates to the year ended December 31, 2016, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ KPMG, LLP

Dallas, Texas
June 6, 2017

Report of Independent Registered Public Accounting Firm

Board of Directors and Shareholders
HMS Holdings Corp.

Opinion on internal control over financial reporting

We have audited the internal control over financial reporting of HMS Holdings Corp. (a Delaware corporation) and subsidiaries (the "Company") as of December 31, 2018, based on criteria established in the 2013 *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in the 2013 *Internal Control—Integrated Framework* issued by COSO.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the consolidated financial statements of the Company as of and for the year ended December 31, 2018, and our report dated February 25, 2019 expressed an unqualified opinion on those financial statements.

Basis for opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and limitations of internal control over financial reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

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

/s/ GRANT THORNTON LLP

Dallas, Texas
February 25, 2019

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(in thousands, except share and per share amounts)

	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 178,946	$ 83,313
Accounts receivable, net of allowance of $13,683 and $14,799, at December 31, 2018 and December 31, 2017, respectively	206,772	189,460
Prepaid expenses	19,970	16,589
Income tax receivable	18,817	1,892
Deferred financing costs, net	564	564
Other current assets	240	836
Total current assets	425,309	292,654
Property and equipment, net	94,435	98,581
Goodwill	487,617	487,617
Intangible assets, net	67,140	91,482
Deferred financing costs, net	1,673	2,237
Other assets	2,344	2,589
Total assets	$ 1,078,518	$ 975,160
Liabilities and Shareholders' Equity		
Current liabilities:		
Accounts payable, accrued expenses and other liabilities	$ 74,902	$ 61,900
Estimated liability for appeals	21,723	30,787
Total current liabilities	96,625	92,687
Long-term liabilities:		
Revolving credit facility	240,000	240,000
Net deferred tax liabilities	18,485	21,989
Deferred rent	4,118	4,852
Other liabilities	5,894	9,403
Total long-term liabilities	268,497	276,244
Total liabilities	365,122	368,931
Commitments and contingencies		
Shareholders' equity:		
Preferred stock -- $0.01 par value; 5,000,000 shares authorized; none issued	—	—
Common stock -- $0.01 par value; 175,000,000 shares authorized; 98,924,501 shares issued and 85,261,664 shares outstanding at December 31, 2018; 96,536,251 shares issued and 83,256,858 shares outstanding at December 31, 2017	989	965
Capital in excess of par value	425,748	368,721
Retained earnings	422,235	366,164
Treasury stock, at cost: 13,663,194 shares at December 31, 2018 and 13,279,393 shares at December 31, 2017	(135,576)	(129,621)
Total shareholders' equity	713,396	606,229
Total liabilities and shareholders' equity	$ 1,078,518	$ 975,160

See accompanying notes to the consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME
(in thousands, except per share amounts)

	Year Ended December 31,		
	2018	2017	2016
Revenue	$ 598,290	$ 521,212	$ 489,720
Cost of services:			
Compensation	224,893	202,049	189,271
Information technology	53,428	45,723	37,337
Occupancy	15,968	17,190	14,000
Direct project expenses	42,908	41,347	46,254
Other operating expenses	31,438	28,425	27,778
Amortization of acquisition related software and intangible assets	32,975	30,393	28,030
Total cost of services	401,610	365,127	342,670
Selling, general and administrative expenses	113,442	105,654	89,381
Settlement expense	20,000	-	-
Total operating expenses	535,052	470,781	432,051
Operating income	63,238	50,431	57,669
Interest expense	(11,310)	(10,871)	(8,519)
Interest income	1,089	295	321
Income before income taxes	53,017	39,855	49,471
Income taxes	(1,972)	(199)	11,835
Net Income	$ 54,989	$ 40,054	$ 37,636
Basic income per common share:			
Net income per common share -- basic	$ 0.66	$ 0.48	$ 0.45
Diluted income per common share:			
Net income per common share -- diluted	$ 0.64	$ 0.47	$ 0.43
Weighted average shares:			
Basic	83,625	83,821	84,221
Diluted	86,144	85,088	86,987

See accompanying notes to the consolidated financial statements

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF SHAREHOLDERS' EQUITY
(in thousands, except share and per share amounts)

	Common Stock				Treasury Stock		
	# of Shares Issued	Par Value	Capital in Excess of Par Value	Retained Earnings	# of Shares	Amount	Total Shareholders' Equity
Balance at January 1, 2016	95,263,461	$ 952	$ 330,290	$ 288,474	11,273,746	$ (95,014)	$ 524,702
Net income	-	-	-	37,636	-	-	37,636
Stock-based compensation expense	-	-	13,277	-	-	-	13,277
Purchase of treasury stock	-	-	-	-	1,140,332	(20,470)	(20,470)
Exercise of stock options	510,512	5	2,935	-	-	-	2,940
Vesting of restricted stock awards and units, net of shares withheld for employee tax	192,879	2	(1,477)	-	-	-	(1,475)
Balance at December 31, 2016	95,966,852	$ 959	345,025	$ 326,110	12,414,078	$ (115,484)	$ 556,610
Net income	-	-	-	40,054	-	-	40,054
Stock-based compensation expense	-	-	24,143	-	-	-	24,143
Purchase of treasury stock	-	-	-	-	865,315	(14,137)	(14,137)
Exercise of stock options	172,326	2	2,718	-	-	-	2,720
Vesting of restricted stock awards and units, net of shares withheld for employee tax	397,073	4	(3,165)	-	-	-	(3,161)
Balance at December 31, 2017	96,536,251	$ 965	$ 368,721	$ 366,164	13,279,393	$ (129,621)	$ 606,229
Adoption of accounting standard (Note 1 and 2)	-	-	-	1,082	-	-	1,082
Net income	-	-	-	54,989	-	-	54,989
Stock-based compensation expense	-	-	21,507		-	-	21,507
Purchase of treasury stock	-	-	-	-	383,801	(5,955)	(5,955)
Exercise of stock options	2,017,442	20	38,342	-	-	-	38,362
Vesting of restricted stock units, net of shares withheld for employee tax	370,808	4	(2,822)	-	-	-	(2,818)
Balance at December 31, 2018	98,924,501	$ 989	$ 425,748	$ 422,235	13,663,194	$ (135,576)	$ 713,396

See accompanying notes to the consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)

	Years Ended December 31,		
	2018	2017	2016
Operating activities:			
Net income	$ 54,989	$ 40,054	$ 37,636
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization of property, equipment and software	33,254	27,515	24,882
Amortization of intangible assets	24,342	22,555	20,164
Amortization of deferred financing costs	564	2,258	2,083
Stock-based compensation expense	21,507	24,143	13,277
Deferred income taxes	(3,504)	(20,409)	(7,368)
(Gain) / Loss on disposal of assets	-	209	(948)
Change in fair value of contingent consideration	(35)	(2,865)	-
Release of estimated liability for appeals	(8,436)	-	-
Changes in operating assets and liabilities:			
Accounts receivable	(17,312)	(6,976)	(3,554)
Prepaid expenses	(3,381)	(1,463)	(2,399)
Other current assets	596	165	2,066
Other assets	245	124	234
Income taxes receivable / (payable)	(16,925)	1,462	(7,227)
Accounts payable, accrued expenses and other liabilities	11,181	(340)	12,116
Estimated liability for appeals	(628)	32	(2,323)
Net cash provided by operating activities	96,457	86,464	88,639
Investing activities:			
Acquisition of a business, net of cash acquired	-	(171,321)	(20,678)
Proceeds from sale of cost basis investment	-	-	2,496
Purchases of property and equipment	(11,264)	(17,318)	(13,703)
Investment in capitalized software	(19,149)	(15,725)	(7,316)
Net cash used in investing activities	(30,413)	(204,364)	(39,201)
Financing activities:			
Proceeds from credit facility	-	42,204	-
Payments for deferred financing costs	-	(2,269)	-
Proceeds from exercise of stock options	38,362	2,720	2,940
Payments of tax withholdings on behalf of employees for net-share settlements	(2,818)	(3,161)	(1,475)
Payments on capital lease obligations	-	(143)	(44)
Purchases of treasury stock	(5,955)	(14,137)	(20,470)
Net cash provided by/(used in) financing activities	29,589	25,214	(19,049)
Net increase/(decrease) in cash and cash equivalents	95,633	(92,686)	30,389
Cash and Cash Equivalents			
Cash and cash equivalents at beginning of year	83,313	175,999	145,610
Cash and cash equivalents at end of period	$ 178,946	$ 83,313	$ 175,999
Supplemental disclosure of cash flow information:			
Cash paid for income taxes, net of refunds	$ 22,225	$ 17,995	$ 20,326
Cash paid for interest	$ 10,326	$ 9,944	$ 6,196
Supplemental disclosure of non-cash activities:			
Change in balance of accrued property and equipment purchases	$ 1,305	$ 51	$ 684

See accompanying notes to the consolidated financial statements.

1. Business and Summary of Significant Accounting Policies

(a) Business

HMS is an industry-leading provider of cost containment solutions in the healthcare marketplace. We use healthcare technology, analytics and engagement solutions, to deliver coordination of benefits, payment integrity, population risk analytics, and care management and consumer engagement solutions to help payers reduce costs, improve healthcare outcomes and enhance member experiences. We provide coordination of benefits services to government and commercial healthcare payers to ensure that the correct party pays the claim. Our payment integrity services promote accuracy by fighting fraud, waste and abuse, and our total population management solutions provide risk-bearing organizations with reliable intelligence across their member populations to identify risks and improve patient engagement and outcomes. Together these various services help move the healthcare system forward for our customers. We currently operate as one business segment with a single management team that reports to the Chief Executive Officer.

(b) Summary of Significant Accounting Policies

For certain accounting topics, the description of the accounting policy may be found in the related Note.

(i) Principles of Consolidation

The consolidated financial statements include the Company's accounts and transactions and those of the Company's wholly owned subsidiaries. All intercompany balances and transactions have been eliminated in consolidation.

(ii) Use of Estimates

The preparation of the consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(iii) Cash and Cash Equivalents

The Company considers all highly liquid investments with an original maturity of three months or less to be cash equivalents. Cash equivalents consist of deposits that are readily convertible into cash.

(iv) Concentration of Credit Risk

The Company's policy is to limit credit exposure by placing cash in accounts which are exposed to minimal interest rate and credit risk. HMS maintains cash and cash equivalents in cash depository accounts with large financial institutions with a minimum credit rating of A1/P1 or better, as defined by Standard and Poor's. The balance at these institutions generally exceeds the maximum balance insured by the Federal Deposit Insurance Corporation of up to $250,000 per entity. HMS has not experienced any losses in cash and cash equivalents and believes these cash and cash equivalents do not expose the Company to any significant credit risk.

The Company is subject to potential credit risk related to changes in economic conditions within the healthcare market. However, HMS believes that the billing and collection policies are adequate to minimize the potential credit risk. The Company performs ongoing credit evaluations of customers and generally does not require collateral.

(v) Property and Equipment

Property and equipment are stated at cost less accumulated depreciation. Depreciation is provided over the estimated useful lives of the assets utilizing the straight-line method. HMS amortizes leasehold improvements on a straight-line basis over the shorter of (i) the term of the lease or (ii) the estimated useful life of the improvement. Equipment leased under capital leases is depreciated over the shorter of (i) the term of the lease or (ii) the estimated useful life of the equipment. Capitalized software costs relate to software that is acquired or developed for internal use while in the application development stage. All other costs to develop software for internal use, either in the preliminary project stage or post-implementation stage, are expensed as incurred. Amortization of capitalized software is calculated on a straight-line basis over the expected economic life. Land is not depreciated.

Estimated useful lives are as follows:

Property and Equipment	Useful Life (in years)		
Equipment	2	to	5
Leasehold improvements	5	to	10
Furniture and fixtures		5	
Capitalized software	3	to	10
Building and building improvements		up to 39	

Property and equipment is reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of the asset may not be recoverable. When indicators exist, recoverability of assets is measured by a comparison of the carrying value of the asset group to the estimated undiscounted future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized and charged to earnings is measured by the amount by which the carrying value of the asset group exceeds the fair value of the assets. The Company did not recognize any impairment charges related to property and equipment during the years ended December 31, 2018, 2017 or 2016.

(vi) Intangible assets

The Company records assets acquired and liabilities assumed in a business combination based upon their acquisition date fair values. In most instances there is not a readily defined or listed market price for individual assets and liabilities acquired in connection with a business, including intangible assets. The Company determines fair value through various valuation techniques including discounted cash flow models, quoted market values and third party independent appraisals, as considered necessary. Significant assumptions used in those techniques include, but are not limited to, growth rates, discount rates, customer attrition rates, expected levels of revenues, earnings, cash flows and tax rates. The use of different valuation techniques and assumptions are highly subjective and inherently uncertain and, as a result, actual results may differ materially from estimates.

All of the Company's intangible assets are subject to amortization and are amortized using the straight-line method over their estimated period of benefit. Estimated useful lives are as follows:

Intangible Assets	Useful Life (in years)		
Customer relationships	7	to	15
Restrictive covenants	1	to	3
Trade names	1.5	to	7
Intellectual property	4	to	6

Intangible assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of the asset may not be recoverable. When indicators exist, recoverability of assets is measured by a comparison of the carrying value of the asset group to the estimated undiscounted future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized and charged to earnings is measured by the amount by which the carrying value of the asset group exceeds the fair value of the assets. The Company did not recognize any impairment charges related to intangible assets during the years ended December 31, 2018, 2017 or 2016.

(vii) Goodwill

Goodwill is the excess of acquisition costs over the fair values of assets and liabilities of acquired businesses. During the measurement period, which is up to one year from the acquisition date, the Company may record adjustments to the assets acquired and liabilities assumed, with the corresponding offset to goodwill. Upon the conclusion of the measurement period, any subsequent adjustments are recorded to earnings.

Goodwill is subject to a periodic assessment for impairment. The Company assesses goodwill for impairment on an annual basis as of June 30th of each year or more frequently if an event occurs or changes in circumstances would more likely than not reduce the fair value of a reporting unit below its carrying amount. Assessment of goodwill impairment is at the HMS Holdings Corp. entity level as the Company operates as a single reporting unit. We have the option to perform a qualitative or quantitative assessment to determine if impairment is more likely than not to have occurred. The Company completed the annual impairment test as of June 30, 2018 electing to perform the quantitative assessment of which the first step is to compare the fair value of the reporting unit with its carrying value, including goodwill. In calculating the fair value of the reporting unit, the Company utilized a weighting across three commonly accepted valuation approaches: an income approach, a guideline public company approach, and a merger and acquisition approach. The income approach to determining fair value computes projections of the cash flows that the reporting unit is expected to generate converted into a present value equivalent through discounting. Significant assumptions in the income approach include income projections, a discount rate and a terminal growth value which are all level 3 inputs. The income projections include assumptions for revenue and expense growth which are based on internally developed business plans and largely reflect recent historical revenue and expense trends. The discount rate was based on a risk free rate plus a beta adjusted equity risk premium and specific company risk premium. The terminal growth value is Company specific and was determined analyzing inputs such as historical inflation and the GDP growth rate. The guideline public company approach and merger and acquisition approach are based on pricing multiples observed for similar publicly traded companies or similar market companies that were sold. The results of the annual impairment assessment provide that the fair value of the reporting unit was significantly in excess of the Company's carrying value, including goodwill; therefore, no impairment was indicated. There were no impairment charges related to goodwill during the years ended December 31, 2018, 2017 or 2016. There were no changes in the carrying amount of goodwill for the year ended December 31, 2018.

(viii) Income Taxes

Income taxes are accounted for under the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to temporary differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. This method also requires the recognition of future tax benefits for net operating loss carry-forwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as income or expense in the period that includes the enactment date. A valuation allowance is provided against deferred tax assets to the extent their realization is not more likely than not. Uncertain income tax positions are accounted for by prescribing a minimum recognition threshold that a tax position is required to meet before being recognized in the financial statements. Although the Company believes that it has adequately reserved for uncertain tax positions (including interest and penalties), it can provide no assurance that the final tax outcome of these matters will not be materially different. The Company makes adjustments to these reserves in accordance with the income tax accounting guidance when facts and circumstances change, such as the closing of a tax audit or the refinement of an estimate. To the extent that the final tax outcome of these matters is different than the amounts recorded, such differences will affect the provision for income taxes in the period in which such determination is made, and could have a material impact on our financial condition and operating results.

(ix) Expense Classifications

HMS cost of services is presented in the categories set forth below. Each category within cost of services excludes expenses relating to SG&A functions, which are presented separately as a component of total operating costs. A description of the primary expenses included in each category is as follows:

Cost of Services:

- *Compensation:* Salary, fringe benefits, bonus and stock-based compensation.
- *Information technology:* Hardware, software and data communication costs.
- *Occupancy:* Rent, utilities, depreciation, office equipment and repair and maintenance costs.
- *Direct project expense:* Variable costs incurred from third party providers that are directly associated with specific revenue generating projects and employee travel expenses.
- *Other operating expenses:* Professional fees, temporary staffing, travel and entertainment, insurance and local and property tax costs.
- *Amortization of acquisition related software and intangible assets:* Amortization of the cost of acquisition related software and intangible assets.

SG&A:

- Expenses related to general management, marketing and administrative activities.

(x) Estimating Valuation Allowances and Accrued Liabilities

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amount of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amount of revenue and expenses during the reported period. In particular, management must make estimates of the probability of collecting accounts receivable. When evaluating the adequacy of the accounts receivable allowance, management reviews the accounts receivable based on an analysis of historical revenue adjustments, bad debts, customer concentrations, customer credit-worthiness, current economic trends and changes in customer payment terms. As of December 31, 2018 and 2017, the accounts receivable balance was $206.8 million and $189.5 million, net of allowance of $13.7 million and $14.8 million, respectively.

(xi) Stock-Based Compensation

Long-Term Incentive Award Plans

The Company grants stock options and restricted stock units ("equity awards") to HMS employees and non-employee directors under the 2016 Omnibus Plan, as approved by the Company's shareholders on June 23, 2016. The 2016 Omnibus Plan replaced and superseded the Company's 2006 Stock Plan and 2011 HDI Plan. As of December 31, 2018, the number of securities remaining available for future issuance under equity compensation plans, excluding securities to be issued upon exercise of outstanding options and vesting of restricted stock units, is 4,758,398 shares. All of the Company's employees as well as HMS non-employee directors are eligible to participate in the 2016 Omnibus Plan. Awards granted under the 2016 Omnibus Plan generally vest over one to four years. The exercise price of stock options granted under the 2016 Omnibus Plan may not be less than the fair market value of a share of stock on the grant date, as measured by the closing price of the Company's common stock on the Nasdaq Global Select Market and the term of a stock option may not exceed ten years. Prior to 2018, the Company granted two types of equity awards: 1) equity awards with service conditions and 2) equity awards with market and service conditions. The market condition is based on the Company's common stock price during the applicable measurement period. In 2018, the Company only issued equity awards with service conditions.

Stock-Based Compensation Expense

The Company recognizes stock-based compensation expense equal to the grant date fair value of the award on a straight-line basis over the requisite service period.

The fair value of each option grant with only service-based conditions is estimated using the Black-Scholes pricing model. The fair value of each option grant with market and service-based conditions is estimated using a Monte Carlo simulation model. The fair value of each restricted stock unit is calculated based on the closing sale price of the Company's common stock on the grant date.

The determination of the fair value of the options on the grant date using the Black-Scholes pricing model and/or the Monte Carlo simulation model is affected by the Company's stock price, as well as assumptions regarding a number of complex and subjective variables. Certain key variables include: the Company's expected stock price volatility over the expected term of the awards; a risk-free interest rate; and any expected dividends. The Company estimates stock price volatility based on the historical volatility of the Company's common stock and estimates the expected term of the awards based on the Company's historical option exercises for similar types of stock option awards. The assumed risk-free interest rate is based on the yield on the measurement date of a zero-coupon U.S. Treasury bond with a maturity period equal to the option's expected term. The Company does not anticipate paying any cash dividends in the foreseeable future and therefore, uses an expected dividend yield of zero in the option valuation models. The fair value of all awards also includes an estimate of expected forfeitures. Forfeitures are estimated based on historical experience. If actual forfeitures vary from estimates, a difference in compensation expense will be recognized in the period the actual forfeitures occur. Upon the exercise of stock options or the vesting of restricted stock units, the resulting excess tax benefits or deficiencies, if any, are recognized as income tax expense or benefit.

(xii) Fair Value of Financial Instruments

Financial instruments are categorized into a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value into three broad levels. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). If the inputs used to measure fair value fall within different levels of the hierarchy, the category level is based on the lowest priority level input that is significant to the fair value measurement of the instrument. In the event the fair value is not readily available or determinable, the financial instrument is carried at cost and referred to as a cost method investment. The fair value hierarchy is as follows:

- *Level 1:* Observable inputs such as quoted prices in active markets;
- *Level 2*: Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and
- *Level 3:* Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

(xiii) Leases

HMS accounts for lease agreements as either operating or capital leases, depending on certain defined criteria. Lease costs are amortized on a straight-line basis without regard to deferred payment terms, such as rent holidays, that defer the commencement date of required payments. Additionally, incentives such as tenant improvement allowances, are capitalized and are treated as a reduction of rental expense over the term of the lease agreement.

(xiv) Recent Accounting Guidance

Recently Adopted Accounting Guidance

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers* (Topic 606) ("ASU 2014-09"), which is the new comprehensive revenue recognition standard that supersedes all existing revenue recognition guidance under U.S. GAAP. The Company adopted ASU 2014-09 on January 1, 2018 using the modified retrospective method and the Company recognized the cumulative effect of initially applying the new revenue standard as an adjustment to the opening balance of retained earnings. The financial information for comparative prior periods has not been restated and continues to be reported under the accounting standards in effect for those periods. The effect of adopting ASU 2014-09 in the current annual reporting period as compared with the guidance that was in effect before the change is immaterial. The Company's internal control framework did not materially change, but existing internal controls were modified due to certain changes to business processes and systems to support the new revenue recognition standard as necessary. The Company continues to expect the impact of the adoption of the new standard to be immaterial to its net income and its internal control framework on an ongoing basis.

In March 2016, the FASB issued ASU No. 2016-09, *Compensation – Stock Compensation* (Topic 718): *Improvements to Employee Share-Based Payment Accounting*, ("ASU 2016-09") that changes the accounting for certain aspects of share-based payments to employees. The new guidance requires excess tax benefits and tax deficiencies to be recorded in the income statement when stock awards vest or are settled. In addition, cash flows related to excess tax benefits will no longer be separately classified as a financing activity apart from other income tax cash flows. The standard also allows companies to repurchase more of an employee's vesting shares for tax withholding purposes without triggering liability accounting, clarifies that all cash payments made to tax authorities on an employee's behalf for withheld shares should be presented as a financing activity on the cash flows statement and provides an accounting policy election to account for forfeitures as they occur. ASU 2016-09 is effective for annual reporting periods beginning after December 15, 2016, including interim periods within such annual reporting periods with early adoption permitted. The Company elected to early adopt the new guidance in the fourth quarter of fiscal year 2016 which requires us to reflect any adjustments as of January 1, 2016, the beginning of the annual period that includes the interim period of adoption. The primary impact of adoption was the recognition of excess tax benefits in the provision for income taxes rather than paid-in capital for all periods in fiscal year 2016. Additional amendments to the accounting for income taxes and minimum statutory withholding tax requirements had no impact to retained earnings as of January 1, 2016, where the cumulative effect of these changes are required to be recorded. The Company elected to continue to estimate forfeitures expected to occur to determine the amount of compensation cost to be recognized in each period. Adoption of the new standard resulted in the recognition of net excess tax benefits in the provision for income taxes rather than paid-in capital of $1.9 million for the year ended December 31, 2016. The presentation requirements for cash flows related to employee taxes paid for withheld shares had no impact to any of the 2016 periods presented on the consolidated statements of cash flow since such cash flows have historically been presented as a financing activity.

In August 2016, the FASB issued ASU No. 2016-15, *Statements of Cash Flows* (Topic 230): *Classification of Certain Cash Receipts and Cash Payments* ("ASU 2016-15"). ASU 2016-15 clarifies where certain cash receipts and cash payments are presented and classified in the statement of cash flows. The amendments are effective for annual reporting periods beginning after December 15, 2017, and for interim reporting periods within such annual periods. The Company adopted this guidance on January 1, 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

In January 2017, the FASB issued ASU No. 2017-01, *Business Combinations* (Topic 805) – *Clarifying the Definition of a Business* ("ASU 2017-01"). ASU 2017-01 finalizes previous proposals regarding shareholder concerns that the definition of a business is applied too broadly. The guidance assists entities with evaluating whether transactions should be accounted for as acquisitions of assets or of businesses. The amendments are effective for annual periods beginning after December 15, 2017, including interim periods within those periods. The Company adopted this guidance on January 1, 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

In May 2017, the FASB issued ASU No. 2017-09, *Compensation – Stock Compensation* (Topic 718): *Scope of Modification Accounting*, ("ASU 2017-09"). ASU 2017-09 requires entities to apply modification accounting to changes made to a share-based payment award. The new guidance specifies that entities will apply modification accounting to changes to a share-based payment award only if any of the following are not the same immediately before and after the change: 1) The award's fair value (or calculated value or intrinsic value, if those measurement methods are used), 2) the award's vesting conditions, and 3) the award's classification as an equity or liability instrument. ASU 2017-09 is effective for annual reporting periods beginning after December 15, 2017, including interim periods within such annual periods, with early adoption permitted. The Company adopted this guidance on January 1, 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

In January 2017, the FASB issued ASU No. 2017-04, *Goodwill and Other* (Topic 350): *Simplifying the Test for Goodwill Impairment* ("ASU 2017-04"). This amendment simplifies the manner in which an entity is required to test for goodwill impairment by eliminating Step 2 from the goodwill impairment test. Step 2 measures goodwill impairment loss by comparing the implied fair value of a reporting unit's goodwill with the carrying amount of that goodwill. The amendment simplifies this approach by having the entity (1) perform its annual or interim goodwill impairment test by comparing the fair value of a reporting unit with its carrying amount, and (2) recognize an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value, with the understanding that the loss recognized should not exceed the total amount of goodwill allocated to that reporting unit. The Company elected to early adopt the new guidance in the fourth quarter of fiscal year 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

On August 17, 2018 the SEC issued SEC Final Rule Release No. 33-10532, *Disclosure Update and Simplification* ("Final Rule"). The Final Rule amends certain disclosure requirements to facilitate the disclosure of information to investors and simplify compliance without significantly altering the total mix of information provided to investors. The Final Rule was effective for public entities that are SEC filers on November 5, 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

Recent Accounting Guidance Not Yet Adopted

In February 2016, the FASB issued ASU No. 2016-02, Leases (Topic 842) ("ASU 2016-02"). ASU 2016-02 will require most lessees to recognize a majority of the company's leases on the balance sheet, which will increase reported assets and liabilities. ASU 2016-02 was subsequently amended by ASU No. 2018-01, Land Easement Practical Expedient for Transition to Topic 842; ASU No. 2018-10, Codification Improvements to Topic 842, Leases; and ASU No. 2018-11, Targeted Improvements. The new standard establishes a right-of-use model (ROU) that requires a lessee to recognize a ROU asset and lease liability on the balance sheet for all leases with a term longer than 12 months. Leases will be classified as finance or operating, with classification affecting the pattern and classification of expense recognition in the income statement. ASU 2016-02 is effective for annual reporting periods beginning after December 15, 2018 including interim periods within such annual reporting periods with early adoption permitted. The Company has not early adopted this guidance, and therefore is adopting this guidance on January 1, 2019 and will use the effective date as our date of initial application. Consequently, financial information will not be updated and the disclosures required under the new standard will not be provided for dates and periods prior to the date of adoption. The Company developed a preliminary implementation plan and reviewed historical lease agreements in order to quantify the impact of adoption. Based upon the preliminary implementation plan, the Company expects the adoption of ASU 2016-02 will have a material impact on the consolidated balance sheet due to the recognition of the ROU assets and lease liabilities. The adoption of ASU 2016-02 is not expected to have a material impact on the consolidated statement of income or consolidated statement of cash flow. However, the Company continues to perform the necessary reviews and other implementation considerations, including an evaluation of the incremental borrowing rate, in order to appropriately quantify the changes. While we continue to assess all of the effects of adoption, we currently believe the most significant effects relate to (1) the recognition of new ROU assets and lease liabilities on our balance sheet for our real estate operating leases and (2) financial statement disclosures. We do not expect a significant change in our leasing activities between now and adoption. A range of undiscounted ROU assets and lease liabilities at January 1, 2019 is $28 million to $31 million. We expect to recognize operating lease ROU assets and lease liabilities that reflect the present value of these future payments. The Company plans adopt this guidance using the optional transition method. The new standard also provides practical expedients for an entity's existing and ongoing accounting and we expect to adopt the package of practical expedients as well as the practical expedient to not separate lease and non-lease components of our leases and the short-term lease practical expedient.

In June 2016, the FASB issued ASU No. 2016-13, *Financial Instruments – Credit Losses* ("ASU 2016-13"). ASU 2016-13 introduces the current expected credit losses methodology ("CECL") for estimating allowances for credit losses. ASU 2016-13 applies to all financial instruments carried at amortized cost and off-balance-sheet credit exposures not accounted for as insurance, including loan commitments, standby letters of credit, and financial guarantees. The new accounting standard does not apply to trading assets, loans held for sale, financial assets for which the fair value option has been elected, or loans and receivables between entities under common control. ASU 2016-13 is effective for public entities for fiscal year beginning after December 15, 2019, including interim periods within that fiscal year. Early adoption is permitted. The Company is currently evaluating the impact on the Company's financial statements of adopting this guidance but this guidance is not expected to have a material impact on the Company's financial position, results of operations or internal control framework.

In June 2018, the FASB issued ASU No. 2018-07, *Compensation – Stock Compensation* (Topic 718) – *Improvements to Nonemployee Share Based Payment Accounting*, ("ASU 2018-07"). ASU 2018-07 requires entities to apply similar accounting for share-based payment transactions with non-employees as with share-based payment transactions with employees. ASU 2018-07 is effective for public entities for fiscal year beginning after December 15, 2018, including interim periods within that fiscal year. Early adoption is permitted. The Company is currently evaluating the impact on the Company's financial statements of adopting this guidance but this guidance is not expected to have a material impact on the Company's financial position, results of operations or internal control framework.

2. Revenue

The Company's revenue disaggregated by service for the year ended December 31, 2018 is as follows (*in thousands*):

Coordination of Benefits	$	397,095
Payment Integrity		144,063
Total Population Management		57,132
Total	$	598,290

Coordination of benefits revenue is derived from contracts with state governments and Medicaid managed care plans that typically span 1 to 5 years with the option to renew. Types of service contracts could include: (a) the identification of erroneously paid claims; (b) the delivery of verified commercial insurance coverage information; (c) the identification of paid claims where another third party is liable; and (d) the identification and enrollment of Medicaid members who have access to employer insurance. Most of these types of service contracts contain multiple promises, all of which are not distinct within the context of the contract. Therefore, the promises represent a single, distinct performance obligation for the types of services we offer. Revenue derived from these performance obligations is largely based on variable consideration where, based on the number of claims or amount of findings the Company identified, a contingent or fixed transaction price/recovery percentage is allocated to each distinct performance obligation. The Company utilizes the expected value method to estimate the variable consideration related to the transaction price for its service contracts. Key inputs and assumptions in determining variable consideration includes identified pricing and expected recoveries and/or savings. The expected recoveries and/or savings are based on historical experience of information received from our customers. Revenue is primarily recognized at a point in time when our customers realize economic benefits from our services when our services are completed. However, we have a limited number of fixed fee arrangements where revenue is recognized over time as performance obligations are satisfied within one to three years. Generally, coordination of benefit contract payment terms are not standardized within the respective contract; however, payment is typically due on demand and there is a clear and distinct history of customers making consistent payments.

Analytical services consists of payment integrity services and total population management.

Payment integrity services revenue is derived from contracts with federal and state governments, commercial health plans and other at-risk entities that can span several years with the option to renew. Types of service contracts could include: (a) services designed to ensure that healthcare payments are accurate and appropriate; and (b) the identification of over/(under)payments or inaccurate charges based on a review of medical records. Most of these types of service contracts contain multiple promises, all of which are not distinct within the context of the contract. Therefore, the promises represent a single, distinct performance obligation for the types of services we offer. Revenue derived from these performance obligations is largely based on variable consideration where, based on the number of claims or amount of findings the Company identified, a contingent or fixed transaction price/recovery percentage is allocated to each distinct performance obligation. The Company utilizes the expected value method to estimate the variable consideration related to the transaction price for its service contracts. Key inputs and assumptions in determining variable consideration includes identified pricing and expected recoveries and/or savings. The expected recoveries and/or savings are based on historical experience of information received from our customers. Revenue is primarily recognized at a point in time when our customers realize economic benefits from our services when our services are completed. However, we have a limited number of fixed fee arrangements where revenue is recognized over time as performance obligations are satisfied within one to three years. Generally, payment integrity contract payment terms are not standardized within the respective contract; however, payment is typically due on demand and there is a clear and distinct history of customers making consistent payments.

Total population management revenue is derived from contracts with health plans and other risk-bearing entities that can span several years with the option to renew. Types of service contracts could include: (a) programs designed to improve member engagement; and (b) outreach services designed to improve clinical outcomes. Most of these types of service contracts contain multiple promises, all of which are not distinct within the context of the contract. Therefore, the promises represent a single, distinct performance obligation for the types of services we offer. Revenue derived from these services is largely based on consideration associated with prices per order/transfer and PMPM/PMPY fees. The Company believes the output method is a reasonable measure of progress for the satisfaction of our performance obligations, which are satisfied over time, as it provides a faithful depiction of (1) our performance toward complete satisfaction of the performance obligation under the contract and (2) the value transferred to the customer of the services performed under the contract. The Company has elected the right to invoice practical expedient for recognition of revenue related to its performance obligations when the amount we have the right to invoice the customer corresponds directly with the value to the customer. Additionally, certain total population management contracts have distinct performance obligations related to software license and implementation fees which have historically been recognized as revenue ratably over the life of the contract. Lastly, we have a limited number of fixed fee arrangements where revenue is recognized over time as performance obligations are satisfied within one to three years. Upon adoption of ASC 606, revenue for software licenses is recognized at the beginning of the license period when control is transferred as the license is installed and revenue for implementation fees is recognized when control is transferred over time as the implementation is being performed. As the performance obligation is deemed to have been satisfied and control transferred to our customers for software licenses and implementation fees on or before December 31, 2017, the Company recorded a decrease to deferred revenue and an increase to opening retained earnings of $1.1 million, net of tax, as of January 1, 2018 for the cumulative

impact of adopting ASC 606. Generally, total population management contract payment terms are stated within the contract and are due within an explicitly stated time period (e.g., 30, 45, 60 days) from the date of invoice. A portion of the payment received may relate to future performance obligations and will result in an increase to deferred revenue until the obligation has been met.

The Company's revenue disaggregated by market for the year ended December 31, 2018 is as follows (*in thousands*):

Commercial	$	323,150
State		233,921
Federal		41,219
Total	$	598,290

A portion of the Company's services are deferred and revenue is recognized at a later time. Deferred revenue was approximately $6.4 million as of December 31, 2017; $1.1 million, net of tax, was recorded as a decrease to deferred revenue as of January 1, 2018 as discussed above; and $5.3 million of this amount was recognized as revenue during the year ended December 31, 2018. Deferred revenue was approximately and $5.6 million as of December 31, 2018. Deferred revenue is included in Accounts payable, accrued expenses and other liabilities in the Consolidated Balance Sheets.

Contract modifications are routine in nature and often done to account for changes in the contract specifications or requirements. In most instances, contract modifications are for services that are not distinct, and, therefore, modifications are accounted for as part of the existing contract. The Company has elected to use the practical expedient to expense the incremental costs of obtaining a contract if the amortization period of the asset that the Company would have otherwise recognized is one year or less.

3. Fair Value of Financial Instruments

Financial instruments (principally cash and cash equivalents, accounts receivable, accounts payable and accrued expenses) are carried at cost, which approximates fair value due to the short-term maturity of these instruments. The Company's long-term credit facility is carried at cost, which due to the variable interest rate associated with the revolving credit facility, cost approximates its fair value. The Company has no Level 1 or Level 2 financial instruments and there were no transfers between Level 1 or Level 2 financial instruments. Included in Other liabilities on the Consolidated Balance Sheet is a contingent consideration liability of $0 and $35 thousand at December 31, 2018 and 2017, respectively, is valued using a Monte Carlo simulation and includes unobservable inputs such as expected levels of revenues and discount rates. The liability was classified as level 3 within the fair value hierarchy. Changes in the unobservable inputs in the fair value measurement of this instrument could result in a significant change in the fair value measurement. There were no sales, settlements, purchases, issuances and/or transfers related to this level 3 instrument in 2018 or 2017. There were no other level 3 instruments.

4. Acquisitions

(a) Eliza Holding Corp.

On April 17, 2017, the Company completed the acquisition of 100% of the outstanding capital stock of Eliza, for a purchase price of $171.6 million funded with available liquidity of approximately 75% cash on hand and 25% from the Company's existing credit line.

The allocation of the purchase price to the fair value of the assets acquired and the liabilities assumed as of April 17, 2017, the effective date of the acquisition, is as follows (*in thousands*):

Cash and cash equivalents	$	435
Accounts receivable		8,902
Prepaid expenses		1,427
Property and equipment		1,146
Intangible assets		76,240
Goodwill		107,754
Other assets		63
Accounts payable		(2,620)
Deferred tax liability		(19,681)
Other liabilities		(2,057)
Total purchase price	$	171,609

The purchase price allocated to the intangibles acquired was as follows (*in thousands*):

	Useful Life (in years)		
Customer relationships	15	$	56,200
Intellectual property	6		19,600
Trade name	1.5		310
Restrictive covenants	1		130
Fair value of intangibles acquired		$	76,240

Acquisition costs recorded to selling, general and administrative expenses were as follows (*in thousands*):

Other operating expenses - consulting fees	$	3,515
Other operating expenses - legal fees		832
Other operating expenses - transaction costs		185
Acquisition-related costs	$	4,532

The financial results of Eliza's operations since April 17, 2017 have been included in the Company's consolidated financial statements. Eliza contributed $51.9 million and $30.4 million in revenue to HMS results of operations in the years ended December 31, 2018 and 2017, respectively.

(b) *Essette*

On September 2, 2016, the Company acquired the outstanding capital stock of Essette for a purchase price of $24.2 million funded by cash on hand. The immaterial results of Essette's operations since September 2, 2016 have been included in the Company's consolidated financial statements.

5. Property and Equipment

Property and equipment consisted of the following (*in thousands*):

	December 31,	
	2018	2017
Equipment	$ 95,350	$ 106,768
Leasehold improvements	7,547	8,357
Building	8,624	8,624
Building improvements	14,825	14,546
Land	2,769	2,769
Furniture and fixtures	9,404	10,352
Capitalized software	131,819	125,655
	270,338	277,071
Less: accumulated depreciation and amortization	(175,903)	(178,490)
Property and equipment, net	$ 94,435	$ 98,581

	December 31,		
	2018	2017	2016
Depreciation and amortization expenses related to property and equipment	$ 33,254	$ 27,515	$ 24,882

6. Intangible Assets

Intangible assets consisted of the following (*in thousands*):

	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Amortization Period in Years
December 31, 2018				
Customer relationships	$ 156,790	$ (104,740)	$ 52,050	12.8
Trade names	16,246	(16,215)	31	0.7
Intellectual property	21,700	(6,670)	15,030	4.1
Restrictive covenants	263	(234)	29	0.7
Total	$ 194,999	$ (127,859)	$ 67,140	

	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Amortization Period in Years
December 31, 2017				
Customer relationships	$ 159,290	$ (89,106)	$ 70,184	11.3
Trade names	16,246	(13,916)	2,330	1.0
Intellectual property	21,700	(2,874)	18,826	5.2
Restrictive covenants	263	(121)	142	1.3
Total	$ 197,499	$ (106,017)	$ 91,482	

Amortization expense of intangible assets is expected to approximate the following (*in thousands*):

Year ending December 31,	Amortization
2019	$ 9,195
2020	7,664
2021	7,197
2022	7,197
2023	4,822
Thereafter	31,065
Total	$ 67,140

For the years ended December 31, 2018, 2017 and 2016, amortization expense related to intangible assets was $24.3 million, $22.6 million, and $20.2 million, respectively. In addition, during the year ended December 31, 2018, some of the intangible assets became fully amortized.

7. Accounts Payable, Accrued Expenses and Other Liabilities

Accounts payable, accrued expenses and other liabilities consisted of the following (*in thousands*):

	December 31, 2018	December 31, 2017
Accounts payable, trade	$ 12,394	$ 19,330
Accrued compensation and other	42,833	24,072
Accrued operating expenses	19,675	18,498
Total accounts payable, accrued expenses and other liabilities	$ 74,902	$ 61,900

8. Income Taxes

Income tax expense is as follows (*in thousands*):

	December 31,		
	2018	2017	2016
Current tax expense:			
Federal	$ 2,965	$ 17,008	$ 16,274
State	(1,433)	3,201	2,929
Total current tax expense:	1,532	20,209	19,203
Deferred tax expense (benefit):			
Federal	(2,650)	(19,425)	(7,115)
State	(854)	(983)	(253)
Total deferred tax benefit:	(3,504)	(20,408)	(7,368)
Total income tax expense (benefit)	$ (1,972)	$ (199)	$ 11,835

A reconciliation of the income tax expense calculated using the applicable federal statutory rate to the actual income tax expense is as follows (*in thousands*):

	December 31,					
	2018	%	2017	%	2016	%
Computed at federal statutory rate	$ 11,134	21.0	$ 13,949	35.0	$ 17,315	35.0
State and local tax expense, net of federal benefit	2,367	4.5	2,226	5.6	2,448	5.0
Net permanent deduction and credit tax benefits from current year	(1,143)	(2.2)	(1,513)	(3.8)	(1,509)	(3.1)
Net permanent deduction and credit tax benefits from prior years	-	-	-	-	(6,213)	(12.6)
Net uncertain tax positions excluding current permanent deduction and credit benefits	(3,756)	(7.0)	(373)	(0.9)	-	-
Subsidiary basis write off	(3,423)	(6.5)	-	-	-	-
Equity compensation net tax windfall	(2,890)	(5.5)	-	-	-	-
State tax apportionment changes	(3,737)	(7.0)	-	-	-	-
Disallowed executive compensation	682	1.3	-	-	-	-
Tax Reform - revaluation of deferrals	-	-	(15,130)	(38.0)	-	-
Acquisition adjustments	(1,226)	(2.3)	(1,003)	(2.5)	-	-
Acquisition costs	-	-	697	1.7	203	0.4
Other, net	20	-	948	2.4	(409)	(0.8)
Total income tax expense	$ (1,972)	(3.7)	$ (199)	(0.5)	$ 11,835	23.9

The Company's effective tax rate decreased to (3.7%) for the year ended December 31, 2018 from (0.5%) for the year ended December 31, 2017, primarily from favorable tax benefits relating to current year credits, equity compensation, subsidiary basis write-off, prior year state apportionment changes, uncertain tax position releases and acquisition adjustments. The Company has no adjustments, to any previously recorded provisional amounts, relating to the Tax Cuts and Jobs Act which was enacted on December 22, 2017. During the year ended December 31, 2018 and in conjunction with the Settlement Agreement in Note 15 to the Consolidated Financial Statements, the Company determined that the common stock of its wholly owned subsidiary, Allied Management Group Special Investigation Unit, Inc. was worthless, resulting in the write off of basis for federal income tax purposes.

As a result of an analysis performed during 2016, the Company determined certain activities it performs qualify for (i) R&D Credits provided in IRC Section 41 and (ii) the Section 199 Deduction provided in IRC Section 199. As a result, the Company recognized net tax benefits during the year ended December 31, 2016 of $6.2 million for federal and state R&D Credits and the Section 199 Deduction relating to tax years 2012 through 2015.

Deferred income taxes are recognized for the future tax consequences of temporary differences between the financial statement and tax bases of assets and liabilities. The tax effect of temporary differences that give rise to a significant portion of the deferred tax assets and deferred tax liabilities are as follows *(in thousands*):

	December 31,	
	2018	2017
Deferred tax assets:		
Stock-based compensation	$ 9,545	$ 9,980
Goodwill and intangible assets	5,874	6,524
Allowance for doubtful accounts	3,537	3,822
Deferred rent	696	909
Tenant improvements	569	669
Estimated liability for appeals	5,632	7,775
Net operating loss carry-forwards	1,527	3,358
Tax credit carry-forwards	4,076	3,667
Property and equipment	49	256
Accrued expenses and other	7,839	3,615
Total deferred tax assets	39,344	40,575
Deferred tax liabilities:		
Goodwill and intangible assets	43,400	48,186
Section 481(a) adjustment	5,073	7,413
Prepaid expenses	668	624
Capitalized software cost	8,688	6,341
Total deferred tax liabilities	57,829	62,564
Total net deferred tax liabilities	$ 18,485	$ 21,989

Included in Other liabilities on the Consolidated Balance Sheets, are the total amount of unrecognized tax benefits of approximately $4.8 million and $8.2 million as of December 31, 2018 and 2017, respectively, net of the federal benefit for state issues that, if recognized, would favorably affect the Company's future effective tax rate. Also included in Other Liabilities on the Consolidated Balance Sheets, are accrued liabilities for interest expense and penalties related to unrecognized tax benefits of $0.7 million and $0.6 million as of December 31, 2018 and 2017, respectively. HMS includes interest expense and penalties in the provision for income taxes in the Consolidated Statements of Income. The amount of interest expense, net of federal and state income tax benefits, and penalties in the Consolidated Statements of Income for the years ended December 31, 2018, 2017, and 2016 was $0.1 million, $0.02 million and $0.2 million, respectively. The Company believes it is reasonably possible the amount of unrecognized tax benefits may decrease by $1.7 million during 2019, due to the expiration of the statute of limitations in various jurisdictions.

A reconciliation of the beginning and ending amounts of unrecognized tax benefits are as follows (*in thousands*):

	2018	2017
Unrecognized tax benefits at January 1	$ 8,234	$ 7,433
Additions for tax positions taken during prior periods	399	599
Additions for tax positions taken during current period including amended prior years	360	1,174
Reductions relating to settlements with taxing authorities	(2,227)	-
Reductions related to the expiration of statutes of limitations	(1,927)	(972)
Unrecognized tax benefits at December 31	$ 4,839	$ 8,234

The Company increased the provision for unrecognized tax benefits by $0.4 million during the year ended December 31, 2018, related to tax benefits recognized for current period R&D Credits. At December 31, 2018, HMS had federal and state pre-tax net operating loss and tax credit carryforwards of approximately $24.3 million and $4.1 million, respectively, which will be available to offset future taxable income. If not used, these net operating loss and tax credit carryforwards will begin to expire in 2020 and 2019, respectively. The Company files income tax returns with the U.S. Federal government and various state, territory, and local jurisdictions. HMS is no longer subject to U.S. Federal income tax examinations for years before 2013. The Company settled an audit by the Internal Revenue Service for years 2013 and 2014 which resulted in immaterial assessments and recognition of prior unrecognized tax benefits. HMS operates in a number of state, territory and local jurisdictions. Accordingly, HMS is subject to state, territory and local income tax examinations based upon the various statutes of limitations in each jurisdiction. Previously recognized Texas refund claims were examined by the state and resulted in a favorable apportionment method change for all open tax years.

9. Estimated Liability for Appeals

Under the Company's contracts with certain commercial health plan customers and its Medicare RAC contracts with CMS (included within the Company's PI services revenue), providers have the right to appeal HMS claim findings and to pursue additional appeals if the initial appeal is found in favor of HMS's customer. The appeal process established under the Medicare RAC contracts with CMS includes five levels of appeals, and resolution of appeals can take substantial time to resolve. HMS records a) an actual return obligation liability for findings which have been previously adjudicated in favor of providers and b) an estimated return obligation liability based on the amount of revenue that is subject to appeals and which are probable of being adjudicated in favor of providers following their successful appeal. The Company's estimate is based on the Company's historical experience. To the extent the amount to be returned to providers following a successful appeal exceeds or is less than the amount recorded, revenue in the applicable period would be reduced or increased by such amount.

A roll-forward of the activity in the estimated liability for appeals is as follows (*in thousands*):

	Original RAC contract	RAC 4 contract	Commercial contracts	Total
Balance at December 31, 2016	$ 28,427	$ -	$ 2,328	$ 30,755
Provision	2,054	-	2,729	4,783
Appeals found in providers favor	(2,665)	-	(2,086)	(4,751)
Balance at December 31, 2017	$ 27,816	$ -	$ 2,971	$ 30,787
Provision	108	20	2,038	2,166
Appeals found in providers favor	(108)	-	(2,686)	(2,794)
Release of estimated liability	(8,436)	-	-	(8,436)
Balance at December 31, 2018	$ 19,380	$ 20	$ 2,323	$ 21,723

The Company's original Medicare RAC contract with CMS expired on January 31, 2018. As a result of the original contract expiration, the Company's contractual obligation with respect to any appeals resolved in favor of providers subsequent to the expiration date have ceased and therefore the Company released its estimated return obligation liability and increased revenue by $8.4 million during the first quarter of 2018.

The Company continues to assess the remaining CMS liability for the original Medicare RAC contract to determine management's best estimate of liability for any findings which have been previously adjudicated prior to the expiration of the contract. Any future changes or modifications to the Medicare RAC contracts or to the Company's commercial customer contracts may require the Company to apply different assumptions that could materially affect both the Company's revenue and estimated liability for appeals in future periods.

10. Credit Agreement

In May 2013, we entered into the Credit Agreement with certain lenders and Citibank, N.A. as administrative agent. The Credit Agreement originally provided for an initial $500 million five-year revolving credit facility maturing on May 3, 2018.

On December 19, 2017, the Company entered into an amendment to the Credit Agreement, which, among other things, extended the maturity of its then existing revolving credit facility by five years to December 2022. The availability of funds under the amended revolving credit facility includes sublimits for (a) up to $50 million for the issuance of letters of credit and (b) up to $25 million for swingline loans. In addition, the Company may increase the commitments under its revolving credit facility and/or add one or more incremental term loan facilities, provided that such incremental facilities do not exceed in the aggregate the sum of (i) the greater of $120 million and 100% of Consolidated EBITDA (as defined in the Credit Agreement) and (ii) an additional amount so long as our first lien leverage ratio (as defined in the Credit Agreement) on a pro forma basis is not greater than 3.00:1.00, subject to obtaining commitments from lenders therefor and meeting certain other conditions.

During the year ended December 31, 2018, no principal payments were made against the Company's then existing revolving credit facility. As of December 31, 2018, the outstanding principal balance under the amended revolving credit facility was $240.0 million.

Borrowings under the Credit Agreement will bear interest at a rate equal to, at the Company's election (except with respect to swingline borrowings, which will accrue interest based only at the base rate), either:

- a base rate determined by reference to the greatest of (a) the prime or base commercial lending rate of the administrative agent as in effect on the relevant date, (b) the federal funds effective rate plus 0.50% and (c) the one-month LIBO Rate plus 1.00%, plus an interest margin ranging from 0.50% to 1.00% based on the Company's consolidated leverage ratio for the applicable period; or

- an adjusted LIBO Rate, equal to the LIBO Rate for the applicable interest period multiplied by the statutory reserve rate (equal to (x) one divided by (y) one minus the aggregate of the maximum reserve percentage (including any marginal, special, emergency or supplemental reserves) established by the Board of Governors of the Federal Reserve System of the United States), plus an interest margin ranging from 1.50% to 2.00% based on the Company's consolidated leverage ratio for the applicable period.

In addition to paying interest on the outstanding principal, the Company is required to pay unused commitment fees on the revolving credit facility during the term of the Credit Agreement ranging from 0.375% to 0.250% per annum based on the Company's consolidated leverage ratio and letter of credit fees equal to 0.125% per annum on the aggregate face amount of each letter of credit, as well as customary agency fees.

The Company's obligations under the Credit Agreement are secured, subject to certain customary carve-outs and exceptions, by a first priority lien and security interest in substantially all tangible and intangible assets of the Company and certain subsidiaries of the Company. The Credit Agreement contains certain restrictive covenants, which affect, among other things, the ability of the Company and its subsidiaries to incur indebtedness, create liens, make investments, sell or otherwise dispose of assets, engage in mergers or consolidations with other entities, and pay dividends or repurchase stock. The Company is also required to comply, on a quarterly basis, with two financial covenants: (i) a minimum interest coverage ratio of 3:00:1:00, and (ii) a maximum consolidated leverage ratio of 4.75:1.00 through December 2019 and 4.25:1.00 from and after January 2020. The consolidated leverage ratio is subject to a step-up to 5.25:1.00 for four full consecutive fiscal quarters following a permitted acquisition or similar investment. As of December 31, 2018, the Company was in compliance with all terms of the Credit Agreement.

Interest expense and the commitment fees on the unused portion of the Company's revolving credit facility are as follows *(in thousands)*:

	Years ended December 31,		
	2018	2017	2016
Interest expense	$ 9,294	$ 7,170	$ 4,837
Commitment fees	1,189	1,359	1,518

The Company deferred $2.3 million of financing fees associated with the amendment. At December 31, 2018 and 2017, the unamortized balance of deferred financing costs was $2.2 million and $2.8 million, respectively. The Company amortized deferred financing costs of $0.6 million, $2.3 million and $2.1 million in the years ended December 31, 2018, 2017 and 2016.

As part of a contractual agreement with a customer, the Company has an outstanding irrevocable letter of credit for $6.5 million, which is issued against its revolving credit facility and expires June 30, 2019.

11. Equity

(a) Share Repurchase

Following are the Company's quarterly repurchases of shares of common stock for fiscal year 2018, all of which were made as part of publicly announced plans or programs:

Period	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program	Maximum Approximate Dollar Value of Shares That May Yet Be Purchased Under the Program
January 1, 2018 to March 31, 2018	383,801	$ 15.50	383,801	$ 29,933,055
April 1, 2018 to June 30, 2018	-	-	-	-
July 1, 2018 to September 30, 2018	-	-	-	-
October 1, 2018 to December 31, 2018	-	-	-	-
Total	383,801	$ 15.50	383,801	$ 29,933,055

(b) Preferred Stock

The Company's certificate of incorporation, as amended, authorizes the issuance of up to 5,000,000 shares of "blank check" preferred stock with such designations, rights and preferences as may be determined by the Company's Board of Directors. As of December 31, 2018, no preferred stock had been issued.

12. Employee Benefit Plan

The Company sponsors the 401(k) Plan for eligible employees. Eligible employees must complete 90 days of service in order to enroll in the 401(k) Plan. Participants may make voluntary contributions to the 401(k) Plan of up to 60% of their annual base pre-tax compensation not to exceed the federally determined maximum allowable contribution. In addition, the 401(k) Plan permits the Company to make discretionary contributions. During 2018, HMS matched 100% of the first 4% of pay contributed by each eligible employee and 50% of the next 1% of pay contributed. During 2017 and 2016, HMS matched 100% of the first 3% of pay contributed by each eligible employee and 50% on the next 2% of pay contributed. These matching contributions vest immediately and are not in the form of the Company's common stock.

For the years ended December 31, 2018, 2017 and 2016, HMS contributed $7.3 million, $5.9 million and $4.8 million, respectively, to the 401(k) Plan in the form of matching contributions.

13. Stock-Based Compensation

Stock-Based Compensation Expense

Total stock-based compensation expense in the Company's Consolidated Statements of Income related to the Company's long-term incentive award plans was as follows (*in thousands*):

	Years ended December 31,		
	2018	2017	2016
Cost of services-compensation	$ 7,421	$ 7,354	$ 3,805
Selling, general and administrative	14,086	16,789	9,472
Total	$ 21,507	$ 24,143	$ 13,277

The total tax benefits recognized on stock-based compensation for the years ended December 31, 2018, 2017 and 2016 was $9.1 million, $4.0 million and $4.1 million, respectively.

Stock Options

Stock-based compensation expense related to stock options was approximately $9.6 million, $10.3 million and $6.9 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Presented below is a summary of stock option activity for the year ended December 31, 2018 (*in thousands except for weighted average exercise price and weighted average remaining contractual terms*):

	Number of Options	Weighted Average Exercise Price	Weighted Average-Remaining Contractual Terms	Aggregate-Intrinsic Value
Outstanding balance at December 31, 2017	5,554	$ 17.35		
Granted	1,010	19.58		
Exercised	(2,017)	19.14		
Forfeitures	(114)	17.74		
Expired	(31)	22.34		
Outstanding balance at December 31, 2018	4,402	17.07	5.80	$ 48,339
Expected to vest at December 31, 2018	1,481	$ 18.60	8.22	$ 14,119
Exercisable at December 31, 2018	2,370	$ 15.87	3.83	$ 29,068

As of December 31, 2018 and 2017, the Company had 1,999,069 and 2,372,682, respectively, in unvested options with a weighted-average-grant-date fair value of $7.27 and $6.39, respectively. The weighted-average-grant-date fair value per share of the stock options granted during the years ended December 31, 2018, 2017 and 2016 was $7.52, $7.66 and $5.55, respectively. The weighted-average-grant-date fair value per share of stock options vested during the year ended December 31, 2018 was $6.18. The weighted-average-grant-date fair value per share of the stock options forfeited during the years ended December 31, 2018, 2017 and 2016 was $6.86, $5.24 and $6.26, respectively.

HMS estimated the fair value of each stock option grant on the date of grant using a Black-Scholes option pricing model. Weighted–average assumptions are set forth in the following table:

	Year ended December 31,		
	2018	2017	2016
Expected dividend yield	-	-	-
Risk-free interest rate	2.7%	1.8%	1.2%
Expected volatility	42.4%	44.2%	44.0%
Expected life (years)	6.0	5.0	4.9

HMS estimated the fair value of 2017 and 2016 market condition option grants on the date of grant using a Monte-Carlo simulation model. There were no market condition awards granted in 2018. Assumptions are set forth in the following table:

	Year ended December 31,		
	2018	2017	2016
Expected dividend yield	-	-	-
Risk-free interest rate	-	2.2%	1.6%
Expected volatility	-	52.5%	40.5%
Expected life (years)	-	6.5	4.9

During the years ended December 31, 2018, 2017 and 2016, the Company issued 2,017,442, 172,326 and 510,512 shares, respectively, of the Company's common stock upon the exercise of outstanding stock options and received proceeds of $38.3 million, $2.7 million and $2.9 million, respectively. The total intrinsic value of stock options exercised during the years ended December 31, 2018, 2017 and 2016 was $27.6 million, $0.5 million and $6.3 million, respectively.

As of December 31, 2018, there was approximately $5.5 million of total unrecognized compensation cost related to stock options outstanding, which is expected to be recognized over a weighted average period of 0.9 years.

Restricted Stock Units

Stock-based compensation expense related to restricted stock units was $11.9 million, $13.8 million and $6.4 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Presented below is a summary of restricted stock units activity for the year ended December 31, 2018 (*in thousands, except for weighted average grant date fair value per unit*):

	Number of Units	Weighted Average Grant Date Fair Value per Unit
Outstanding balance at December 31, 2017	1,346	$ 17.65
Granted	766	16.80
Vesting of restricted stock units, net of units withheld for taxes	(371)	17.06
Units withheld for taxes	(163)	17.06
Forfeitures	(90)	17.31
Outstanding balance at December 31, 2018	1,488	$ 17.60

As of December 31, 2018, 1,259,003 restricted stock units remained unvested and there was approximately $9.2 million of unrecognized compensation cost related to restricted stock units, which is expected to be recognized over a weighted average vesting period of 0.87 years. During the years ended December 31, 2018, 2017 and 2016, the Company's vested restricted stock units had a fair value $9.9 million, $9.5 million, and $6.8 million, respectively. The weighted average grant date fair value per share of the restricted stock units vested during the years ended December 31, 2018, 2017 and 2016 was $17.06, $15.39 and $18.64, respectively. The weighted average grant date fair value per share of the restricted stock units forfeited during the years ended December 31, 2018, 2017 and 2016 was $17.31, $15.37 and $16.95, respectively.

14. Earnings per Share

The following table sets forth the computation of basic and diluted earnings per share *(in thousands, except per share amounts)*:

	Years ended December 31,		
	2018	2017	2016
Net income	$ 54,989	$ 40,054	$ 37,636
Weighted average common shares outstanding-basic	83,625	83,821	84,221
Plus: net effect of dilutive stock options and restricted stock units	2,519	1,808	2,766
Weighted average common shares outstanding-diluted	86,144	85,629	86,987
Net income per common share-basic	$ 0.66	$ 0.48	$ 0.45
Net income per common share-diluted	$ 0.64	$ 0.47	$ 0.43

For the years ended December 31, 2018, 2017 and 2016: (i) 804,959, 2,646,100 and 2,070,771 stock options, respectively, and (ii) restricted stock units representing 0, 31,155 and 46,651 shares of common stock, respectively, were not included in the diluted earnings per share calculation because the effect would have been anti-dilutive.

15. Commitments and Contingencies

(a) Lease Commitments

The Company primarily leases office space but also leases information technology equipment and software licenses under operating leases that expire on various dates through 2026. Additionally, the Company has nominal capital leases. Total lease expense, net of office space sublease income for the years ended December 31, 2018, 2017 and 2016 was $3.6 million, $5.1 million and $5.0 million, respectively.

Minimum annual lease payments to be made under operating leases, net of $8.3 million office space sublease payments to be received, for each of the next five years ending December 31 and thereafter are as follows (*in thousands*):

	Operating Lease Payments
2019	$ 5,778
2020	5,420
2021	3,742
2022	2,531
2023	2,236
Thereafter	2,947
Total	$ 22,654

(b) Litigation

In July 2012, Dennis Demetre and Lori Lewis (the "Plaintiffs"), filed an action in the Supreme Court of the State of New York against HMS Holdings Corp., claiming an undetermined amount of damages alleging that various actions by HMS unlawfully deprived the Plaintiffs of the acquisition earn-out portion of the purchase price for Allied Management Group Special Investigation Unit, Inc. ("AMG") under the applicable Stock Purchase Agreement (the "SPA") and that HMS had breached certain contractual provisions under the SPA. The Plaintiffs filed a second amended complaint with two causes of action for breach of contract and one cause of action for breach of implied covenant of good faith and fair dealing. HMS asserted a counterclaim against Plaintiffs for breach of contract based on contractual indemnification costs, including attorneys' fees arising out of the Company's defense of AMG in Kern Health Systems v. AMG, Dennis Demetre and Lori Lewis (the "California Action"), which are recoverable under the SPA. In June 2016, Kern Health Systems and AMG entered into a settlement agreement that resolved all claims in the California Action. In July 2017, the Court issued a decision on the Company's motion for partial summary judgment and granted the motion in part, dismissing one of Plaintiffs' breach of contract causes of action against HMS. On November 3, 2017, following a jury trial, a verdict was returned in favor of the Plaintiffs on a breach of contract claim, and the jury awarded $60 million in damages to the Plaintiffs. On March 14, 2018, the Court held a hearing on the Company's post-trial motion for an order granting it judgment notwithstanding the verdict or, alternatively, setting aside the jury's award of damages. On June 27, 2018, prior to the Court issuing a decision on the motion, the Company entered into a Settlement Agreement (the "Settlement Agreement") with the Plaintiffs, John Alfred Lewis and Christopher Brandon Lewis. Pursuant to the terms of the Settlement Agreement, the Company paid $20 million to resolve all matters in controversy pertaining to the lawsuit.

On July 5, 2018, the Court entered an order to discontinue the lawsuit pursuant to the Stipulation of Discontinuance with Prejudice filed by the parties.

In February 2018, the Company received a Civil Investigative Demand ("CID") from the Texas Attorney General, purporting to investigate possible unspecified violations of the Texas Medicaid Fraud Prevention Act. The Company provided certain documents and information in March 2018 in response to the CID. HMS has not received any further requests for information in connection with this CID.

In September 2018, a former employee filed an action in the New York County Supreme Court entitled Christopher Frey v. Health Management Systems, Inc. alleging retaliation under New York law. The complaint seeks recovery of an unspecified amount of monetary damages, including back pay and other compensatory and equitable relief. The Company has moved to dismiss the complaint and the motion is currently under consideration by the Court. The Company continues to believe that this claim is without merit and intends to vigorously defend this matter.

From time to time, HMS may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of the Company's business, including but not limited to regulatory audits, billing and contractual disputes, employment-related matters and post-closing disputes related to acquisitions. Due to the Company's contractual relationships, including those with federal and state government entities, HMS's operations, billing and business practices are subject to scrutiny and audit by those entities and other multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of the Company's contractual performance. HMS may have contractual disputes with its customers arising from differing interpretations of contractual provisions that define the Company's rights, obligations, scope of work or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results that could affect the Company's business, financial condition, results of operations and cash flows.

HMS records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, HMS does not establish an accrued liability.

16. Customer Concentration

(a) Geographic Information

The Company operates within the United States.

(b) Major Customers

For the years ended December 31, 2018, 2017 and 2016 no one individual Company customer accounted for more than 10% of the Company's total revenue.

(c) Concentration of Revenue

The composition of the Company's ten largest customer's changes periodically. For the years ended December 31, 2018, 2017 and 2016, the Company's ten largest customers represented 41.4%, 39.5% and 40.6% of HMS' total revenue, respectively. Excluding those contracts that contain automatic renewal provisions or evergreen terms, the Company's agreements with the ten current largest customers generally expire between 2019 and 2026. In many instances, HMS provides services pursuant to agreements that may be renewed or subject to a competitive reprocurement process. Several of the Company's contracts, including those with some of its largest customers, may be terminated for convenience.

17. Subsequent Events

Annual Grants to Employees

On February 14, 2019, the Compensation Committee of the Board of Directors approved approximately $21.3 million in stock option and restricted stock unit awards to employees. The awards generally will vest over three years and will be issued three business days subsequent to the filing of this 2018 Form 10-K.

In connection with the preparation of our consolidated financial statements, an evaluation of subsequent events was performed through the date of filing and there were no other events that have occurred that would require adjustments to the financial statements or disclosure.

18. Quarterly Financial Data (Unaudited)

The table below summarizes the Company's unaudited quarterly operating results for the last two fiscal years (*in thousands, except per share amounts*):

2018	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year Ended
Revenue	$ 141,425	$ 146,791	$ 154,246	$ 155,828	$ 598,290
Operating income	$ 11,922	$ (763)	$ 24,231	$ 27,848	$ 63,238
Net income	$ 6,391	$ (3,367)	$ 18,574	$ 33,391	$ 54,989
Net income per common share - basic	$ 0.08	$ (0.04)	$ 0.22	$ 0.40	$ 0.66
Net income per common share - diluted	$ 0.07	$ (0.04)	$ 0.22	$ 0.38	$ 0.64

2017	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year Ended
Revenue	$ 113,733	$ 133,313	$ 125,673	$ 148,493	$ 521,212
Operating income	$ 3,943	$ 14,361	$ 12,861	$ 19,266	$ 50,431
Net income	$ 1,442	$ 6,517	$ 6,372	$ 25,723	$ 40,054
Net income per common share - basic	$ 0.02	$ 0.08	$ 0.08	$ 0.30	$ 0.48
Net income per common share - diluted	$ 0.02	$ 0.08	$ 0.07	$ 0.30	$ 0.47

(1) Second quarter 2018 results include the Company's entry into the Settlement Agreement for the payment of $20.0 million, as described in Note 15.

(2) Fourth quarter 2017 results include a non-cash tax benefit of $15.1 million due to the revaluation of the Company's deferred tax balances pursuant to the tax rate reduction included in the 2017 Tax Act.

SCHEDULE II – VALUATION AND QUALIFYING ACCOUNTS
For the years ended December 31, 2018, 2017 and 2016

Accounts receivable allowance and Estimated liability for appeals as of December 31, 2018, 2017 and 2016 are as follows:

Accounts receivable allowance *(in thousands)*:

	Balance at Beginning of Year	Provision	Recoveries	Charge-offs	Balance at End of Year
Year ended December 31, 2016	$ 11,464	$ 21,583	$ 108	$ (22,383)	$ 10,772
Year ended December 31, 2017	10,772	20,233	-	(16,206)	14,799
Year ended December 31, 2018	14,799	20,453	-	(21,569)	13,683

Estimated liability for appeals *(in thousands)*:

	Balance at Beginning of Year	Provision	Appeals found in providers favor	Release of estimated liability	Balance at End of Year
Year ended December 31, 2016	$ 12,801	$ 721	$ (2,396)	$ -	$ 11,126
Year ended December 31, 2017	11,126	83	(2,665)	-	8,544
Year ended December 31, 2018	8,544	-	(108)	(8,436)	-

The above chart represents the CMS estimated reserve liability only.

Appendix A

HMS HOLDINGS CORP. AND SUBSIDIARIES
(unaudited)

Reconciliation of Net Income to EBITDA and Adjusted EBITDA

(in thousands, except percentages)	Twelve Months Ended	
	December 31, 2018	December 31, 2017
Net Income	$ 54,989	$ 40,054
Net interest expense	10,221	10.576
Income taxes	(1,972)	(199)
Depreciation and amortization of property and equipment and intangible assets	57,596	50,070
Earnings before interest, taxes, depreciation and amortization (EBITDA)	120,834	100,501
Stock-based compensation expense	21,507	24,143
Settlement expense	20,000	-
Adjusted EBITDA	$ 162,341	$ 124,644
% of Revenue	27.1%	23.9%
Adjusted EBITDA, excluding Medicare RAC reserve release	$ 156,041	$ 124,644
% of Revenue	26.5%	23.9%

Reconciliation of Net Income to GAAP EPS (Diluted) and Adjusted EPS (Diluted)

(in thousands, except per share amounts)	Twelve Months Ended	
	December 31, 2018	December 31, 2017
Net Income	$ 54,989	$ 40,054
Stock-based compensation expense	21,507	24,143
Settlement expense	20,000	-
Amortization of acquisition related software and intangible assets	32,975	30,393
Income tax related to adjustments [1]	(19,216)	273
Adjusted net income	$ 110,255	$ 94,863
Weighted average common shares, diluted	86,144	85,088
Diluted GAAP EPS [2]	$ 0.64	$ 0.47
Diluted adjusted EPS	$ 1.28	$ 1.11
Discrete tax benefits	$ 0.19	$ 0.40
Medicare RAC reserve release benefit	$ 0.05	$ -
Diluted adjusted EPS after Medicare RAC reserve release and discrete tax benefits	$ 1.04	$ 0.71

(1) Tax effect of adjustments is computed as the pre-tax effect of the adjustments multiplied by the adjusted annual effective tax rate at period end.

(2) Diluted GAAP EPS for the year ended December 31, 2018 included discrete tax benefits of $0.19 per diluted share, primarily related to state tax apportionments, the closure of routine outstanding prior year tax audits, the exercise of employee stock options, the abandonment of subsidiary stock related to a 2010 acquisition, and year-end federal and state tax adjustments or provision true ups. Diluted GAAP EPS for the year ended December 31, 2017 included a non-cash tax benefit of $0.40 per diluted share, primarily related to federal tax legislation enacted in December 2017.

Board of Directors:

Robert Becker
Retired President and Chief Executive Officer,
Wolters Kluwer Health

Craig R. Callen
Former Senior Advisor,
Crestview Partners

William C. Lucia
Chairman, President and Chief Executive Officer,
HMS Holdings Corp.

William F. Miller III
Senior Executive Advisor,
Beecken, Petty, O'Keefe & Company
Former Chairman of the Board and Chief Executive Officer,
HMS Holdings Corp.

Ellen A. Rudnick
Senior Advisor for Entrepreneurship, Adjunct Faculty,
University of Chicago Booth School of Business

Bart M. Schwartz
Chairman and Chief Executive Officer,
SolutionPoint International, LLC

Richard H. Stowe
Lead Independent Director,
HMS Holdings Corp.
General Partner,
Health Enterprise Partners, LP

Cora M. Tellez
President and Chief Executive Officer,
Sterling HSA

Executive Officers:

William C. Lucia
Chairman, President and Chief Executive Officer

David A. Alexander
Senior Vice President,
Chief Human Resources and Chief Compliance Officer

Meredith W. Bjorck
Executive Vice President,
Chief Legal Officer and Corporate Secretary

Emmet W. O'Gara
Group President, Total Population Management

Maria E. Perrin
Senior Vice President,
Chief Marketing and Strategy Officer

Jeffrey S. Sherman
Executive Vice President,
Chief Financial Officer and Treasurer

Jacob J. Sims
Senior Vice President,
Chief Technology Officer

Tracy A. South
Executive Vice President,
Chief Administrative Officer

Douglas M. Williams Jr.
Executive Vice President,
Chief Operating Officer

Corporate Headquarters:

5615 High Point Drive
Irving, TX 75038
Tel. 214.453.3000
Fax. 214.453.3023

Financial Information

The Company's 2018 Form 10-K, as filed with the SEC, is included in this Annual Report in its entirety with the exception of certain exhibits. Copies of the Company's quarterly earnings results and additional copies of the 2018 Form 10-K, including all exhibits, are available on the Internet at http://investor.hms.com/financial-information/sec-filings or by accessing our filings with the SEC. In addition, shareholders may obtain a paper copy of these materials upon request from our Office of Investor Relations by emailing robert.borchert@hms.com.

Stock Registrar and Transfer Agent

Common stock of HMS Holdings Corp. is traded on the NASDAQ Stock Exchange under the symbol HMSY. Questions with regard to registered shares of HMSY should be submitted to: HMS Holdings Corp. c/o Broadridge Corporate Issuer Solutions, Inc., P.O. Box 1342 Brentwood, NY 11717. Phone: 888.418.5059. Email: shareholder@broadridge.com. Internet: http://www.broadridge.com.

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Equian, LLC

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

FORM 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2018
OR
☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from _____ to _____
Commission file number 001-38769

CIGNA CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**82-4991898**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
900 Cottage Grove Road, Bloomfield, Connecticut	**06002**
(Address of principal executive offices)	*(Zip Code)*

(860) 226-6000
Registrant's telephone number, including area code
(860) 226-6741 or 215-761-5511
Registrant's facsimile number, including area code

SECURITIES REGISTERED PURSUANT TO SECTION 12(B) OF THE ACT:	
Title of each class	Name of each exchange on which registered
Common Stock, Par Value $0.01	**New York Stock Exchange, Inc.**

SECURITIES REGISTERED PURSUANT TO SECTION 12(G) OF THE ACT:
NONE

Indicate by check mark	Yes	No
• if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.	☑	☐
• if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act	☐	☑
• whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days	☑	☐
• whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files)	☑	☐
• if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K	☐	
• whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.		
Large accelerated filer ☑ / Accelerated filer ☐ / Non-accelerated filer ☐ / Smaller reporting company ☐		
Emerging growth company ☐		
• If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.	☐	
• whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).	☐	☑

The aggregate market value of the voting stock held by non-affiliates of the registrant as of June 30, 2018 was approximately $41.2 billion. As of January 31, 2019, 380,058,967 shares of the registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Form 10-K incorporates by reference information from the registrant's definitive proxy statement related to the 2019 annual meeting of shareholders.

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CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. Forward-looking statements are based on Cigna's current expectations and projections about future trends, events and uncertainties. These statements are not historical facts. Forward-looking statements may include, among others, statements concerning future financial or operating performance, including our ability to deliver affordable, personalized and innovative solutions for our customers and clients; future growth, business strategy, strategic or operational initiatives; economic, regulatory or competitive environments, particularly with respect to the pace and extent of change in these areas; financing or capital deployment plans and amounts available for future deployment; our prospects for growth in the coming years; the merger (''Merger'') with Express Scripts Holding Company; and other statements regarding Cigna's future beliefs, expectations, plans, intentions, financial condition or performance. You may identify forward-looking statements by the use of words such as ''believe,'' ''expect,'' ''plan,'' ''intend,'' ''anticipate,'' ''estimate,'' ''predict,'' ''potential,'' ''may,'' ''should,'' ''will'' or other words or expressions of similar meaning, although not all forward-looking statements contain such terms.

Forward-looking statements are subject to risks and uncertainties, both known and unknown, that could cause actual results to differ materially from those expressed or implied in forward-looking statements. Such risks and uncertainties include, but are not limited to: our ability to achieve our financial, strategic and operational plans or initiatives; our ability to predict and manage medical and pharmacy costs and price effectively; our ability to adapt to changes or trends in an evolving and rapidly changing industry; our ability to effectively differentiate our products and services from those of our competitors and maintain or increase market share; our ability to develop and maintain good relationships with physicians, hospitals, other health care providers and pharmaceutical manufacturers; changes in drug pricing; the impact of modifications to our operations and processes; our ability to identify potential strategic acquisitions or transactions and realize the expected benefits (including anticipated synergies) of such transactions in full or within the anticipated time frame, including with respect to the Merger, as well as our ability to integrate operations, resources and systems; the substantial level of government regulation over our business and the potential effects of new laws or regulations or changes in existing laws or regulations; the outcome of litigation, regulatory audits, investigations, actions and/or guaranty fund assessments; uncertainties surrounding participation in government-sponsored programs such as Medicare; the effectiveness and security of our information technology and other business systems; the impact of our debt service obligations on the availability to funds for other business purposes; unfavorable industry, economic or political conditions, including foreign currency movements; acts of war, terrorism, natural disasters or pandemics; as well as more specific risks and uncertainties discussed in Part I, Item 1A—Risk Factors and Part II, Item 7—Management's Discussion and Analysis of Financial Condition and Results of Operations of this Form 10-K and as described from time to time in our future reports filed with the Securities and Exchange Commission (the ''SEC'').

You should not place undue reliance on forward-looking statements that speak only as of the date they are made, are not guarantees of future performance or results, and are subject to risks, uncertainties and assumptions that are difficult to predict or quantify. Cigna undertakes no obligation to update or revise any forward-looking statement, whether as a result of new information, future events or otherwise, except as may be required by law.

PART I

ITEM 1. Business

Overview

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us") is a global health service organization.

Our Mission

To improve the health, well-being and peace of mind of the people we serve

Our Strategy

Go Deeper: To expand and deepen our customer, client and partner relationships, and create depth in targeted sub-segments and geographies

Go Local: To ensure our solution suite and services meet customer, client and partner needs at a local market level

Go Beyond: To innovate and further differentiate our businesses, the experiences we deliver, and our overall social impact

How We Win

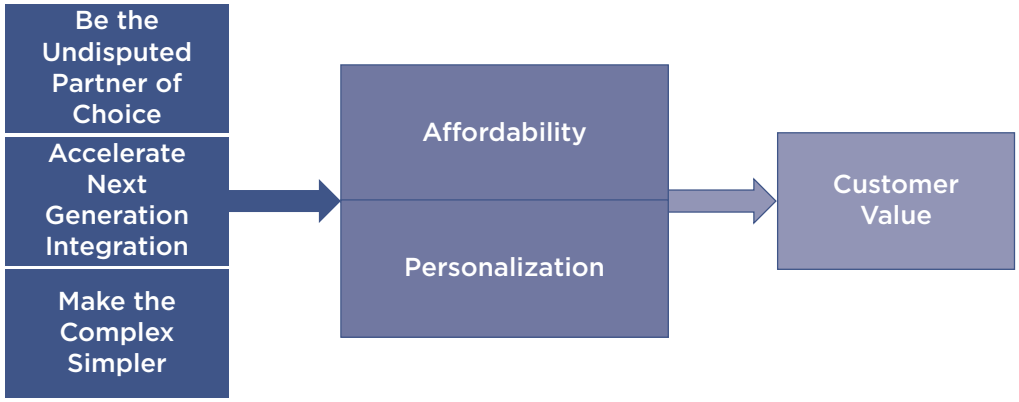

Our revenues are derived principally from premiums on insured products, fees for products and services provided to self-insured plans, pharmacy sales, and investment income. In 2018, our revenues were $48.7 billion and shareholders' net income was $2.6 billion. As described more fully in Note 3 to the Consolidated Financial Statements on page 80 of this Annual Report on Form 10-K ("Form 10-K"), on March 8, 2018, we entered into a merger agreement with Express Scripts Holding Company ("Express Scripts"). The results of Express Scripts have been included in the Company's Consolidated Financial Statements from the date of acquisition. As of December 31, 2018, total assets were $153.2 billion and shareholders' equity was $41.0 billion.

Our combination with Express Scripts creates an enterprise uniquely capable of transforming health care. We now have broader and deeper capabilities, along with meaningful synergies, that accelerate our "Go" strategy to achieve our mission of improving the health, well-being and peace of mind of those we serve. Cigna's employees are champions of the people we serve and over the past decade, our focus has shifted to helping people thrive by offering solutions to prevent and better manage health challenges. When sickness or disability do occur, we support our customers' ability to have broad choices in how they best access high quality, affordable care. We maximize use of evidence-based care,

while delivering best-in-class quality of care for our customers with acute and chronic conditions through enhanced real time data across an expanded platform with industry-leading solutions to support care decisions.

Cigna offers a differentiated set of medical, pharmacy, behavioral, dental, disability, life and accident insurance and related products and services. By combining with Express Scripts, Cigna's expanded capabilities now include: 1) a broader portfolio of specialty services, some of which can be offered on a stand-alone basis; 2) integrated behavioral, medical and pharmacy management services; 3) leading specialty pharmacy expertise; and 4) advanced analytics that help us engage more meaningfully with individuals, plan sponsors we serve, and our provider partners. These capabilities accelerate Cigna's ability to drive improved cost affordability, quality of care and predictability.

Following entry into the merger agreement and throughout the pendency of the transaction, Cigna and Express Scripts designed integration plans to implement a new management and business reporting structure for the combined company upon closing. On December 20, 2018, Cigna completed the acquisition of Express Scripts. As a result, effective in the fourth quarter of 2018 our segments have changed to the following: 1) Integrated Medical, consisting of both a Commercial operating segment that includes our employer-sponsored medical coverage and a Government operating segment that includes Medicare offerings for seniors and individual insurance offerings to non-seniors both on and off the public health insurance exchanges; 2) Health Services, consisting primarily of Cigna's legacy home delivery pharmacy business and Express Scripts' pharmacy benefit management ("PBM") business beginning December 21, 2018; and 3) International Markets, that offers global supplemental benefits and global medical solutions. The remainder of our business is reported in Group Disability and Other, consisting of our group disability and life business together with our corporate owned life insurance ("COLI") business and run-off operations. See Note 1 to the Consolidated Financial Statements on page 72 of this Form 10-K for additional description of our segments. Among our segments, Cigna has four core growth platforms: Commercial, Government, Health Services and International Markets.

As individuals become increasingly involved in their health care purchasing decisions, Cigna continues to focus on delivering **affordable** and **personalized** products and services to customers through employer-based, government-sponsored, health plan client and individual coverage arrangements. In our Integrated Medical business, we collaborate with health care providers to accelerate the transition from volume-based, fee-for-service reimbursement arrangements to a value-based reimbursement model that delivers higher quality of care, lower costs and better health outcomes. We have worked toward achieving better health, affordability, localization and an improved patient experience through increased collaborative care and delivery arrangements with health care providers across the care delivery spectrum, including physician groups of all sizes, specialist groups and hospitals. We have also developed innovative tools and flexible provider arrangements that provide a truly personalized customer experience. These arrangements and tools are discussed in more detail in the "Integrated Medical" section of this Form 10-K that begins on page 3.

Our Health Services business puts medicine within reach for patients, and helps providers improve access to prescription drugs by making them more affordable. We improve patient outcomes and better manage the cost of the pharmacy benefit by:

- Delivering the best care available for those taking prescription medicines;
- Assessing drugs based on efficacy, value and price to assist clients in selecting the most cost-effective formulary;
- Offering cost-effective home delivery pharmacy and specialty services that result in cost savings for plan sponsors and better care for customers;
- Leveraging purchasing volume to deliver discounts to employers and other groups, resulting in leading prescription drug cost trend; and
- Promoting the use of generic and lower-cost brands.

We also work with key stakeholders across the health care system to improve health outcomes and patient satisfaction, increase efficiency in drug distribution and manage costs of the pharmacy benefit. We believe plan sponsors and participants can achieve the best health and financial outcomes when they use our comprehensive set of solutions to manage drug spend.

The ACA and Health Care Reform

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively referred to throughout this Form 10-K as the "ACA" or "PPACA") continues to have a significant impact on our business operations. The future of the ACA is uncertain due to recent court decisions, congressional efforts to repeal and replace the ACA, various executive actions of the current administration, and repeal of the individual mandate as part of H.R.1, An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (referred to throughout this Form 10-K as the "Tax Cuts and Jobs Act" or "U.S. tax reform legislation"). The effects of the ACA, and efforts to repeal and replace it, are discussed throughout this Form 10-K where appropriate, including in the Integrated Medical business description, Regulation, Risk Factors, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), and the Notes to the Consolidated Financial Statements.

Other Information

The financial information included in this Form 10-K for the fiscal year ended December 31, 2018 is in conformity with accounting principles generally accepted in the United States of America ("GAAP") unless otherwise indicated. In the segment discussions that follow, we use the terms "adjusted revenues" and "pre-tax adjusted income from operations" to describe segment results. See the introduction to the MD&A on page 42 of this Form 10-K for definitions of those terms. Industry rankings and percentages set forth herein are for the year ended December 31, 2018 unless otherwise indicated. In addition, statements set forth in this document concerning our rank or position in an industry or particular line of business have been developed internally based on publicly available information unless otherwise noted.

Cigna Holding Company (formerly Cigna Corporation) was incorporated in Delaware in 1981. Halfmoon Parent, Inc. was incorporated in Delaware in March 2018. Halfmoon Parent, Inc. was renamed Cigna Corporation concurrently with the consummation of the combination with Express Scripts. Our annual, quarterly and current reports, proxy statements and other filings, and any amendments to these filings, are made available free of charge on our website (http://www.cigna.com, under the "Investors – Quarterly Reports and SEC Filings" captions) as soon as

reasonably practicable after we electronically file these materials with, or furnish them to, the Securities and Exchange Commission (the "SEC"). We use our website as a channel of distribution for material company information. Important information, including news releases, analyst presentations and financial information regarding Cigna is routinely posted on and accessible at http://www.cigna.com. See "Code of Ethics and Other Corporate Governance Disclosures" in Part III, Item 10 beginning on page 131 of this Form 10-K for additional information available on our website.

Integrated Medical

Integrated Medical consists of a Commercial operating segment that includes our employer-sponsored medical coverage and a Government operating segment that includes Medicare offerings for seniors and individual insurance offerings to non-seniors both on and off the public health insurance exchanges. In 2018, Integrated Medical reported adjusted revenues of $32.8 billion and pre-tax adjusted income from operations of $3.5 billion.

How We Win
• **Broad and deep portfolio of solutions** across Commercial and Government operating segments
• **Commitment** to highest quality health outcomes and customer experiences
• **Collaborative** physician engagement models emphasizing value over volume of services
• **Integrated benefit solutions** that deliver value for our customers, clients and partners
• **Technology and data analytics** powering actionable insights and affordable, personalized solutions
• **Talented and caring people** embracing change and putting customers at the center of all we do

We differentiate ourselves by providing innovative, personalized, and affordable health care benefit solutions based on the unique needs of the individuals and clients we serve. We increase value through our integrated approach and use of technology and data analytics to enhance patient engagement and health care outcomes, underscoring our strategic focus on delivering an industry-leading customer experience. We continue to strengthen our partnerships with providers as we accelerate our transition to a value-based reimbursement system.

We offer a mix of core health insurance products and services to employers, other groups and individuals along with specialty products and services designed to improve the quality of care, lower cost and help customers achieve better health outcomes. Many of these products are available on a standalone basis, but we believe they are most valuable when integrated with a Cigna-administered health plan. Our products are available through several distribution channels including brokers, direct sales, and public and private exchanges. Our three funding solutions (i.e., insured – experience-rated, insured – guaranteed cost, and administrative services only ("ASO") arrangements) enable us to customize the amount of risk taken by, and lower costs for, our customers and clients.

The following chart depicts a high level summary of our principal products and services in this segment as of year-end, with definitions on subsequent pages.

Principal Products & Services	Major Brand(s)	Geography	Funding Solution(s)	Market Segment(s)	Primary Distribution Channel(s)	Primary Competitors
Commercial Medical						
Managed Care	Cigna HealthCare	Nationwide	Insured (experience-rated (“ER”), guaranteed cost (“GC”)) and ASO	Commercial	Brokers, Private Exchanges, Direct	National Insurers, Local Healthplans, Third-Party Administrators (“TPAs”)
Preferred Provider (“PPO”)	Cigna	Nationwide				National Insurers, TPAs
Consumer-Driven	Cigna	Nationwide				National Insurers, Local Health Maintenance Organizations (“HMOs”)
Government Medical						
Individual and Family Plans	Cigna Connect	10 states	GC	Individual	Public and Private Exchanges	Local Healthplans, Start-ups, National Insurers
Medicare Advantage	Cigna-HealthSpring	17 states	GC	Government	Direct, Brokers	National Insurers, Local Healthplans
Medicare Part D	Cigna-HealthSpring, Express Scripts	Nationwide	GC	Government	Direct, Brokers	National Insurers
Medicaid	Cigna-HealthSpring	Texas	GC	Government	Direct, Brokers	National Insurers
Medicare Supplement	Cigna	48 states & District of Columbia	GC	Government	Brokers, Direct, Private Exchanges	National Insurers
Specialty Products and Services						
Stop-Loss	Cigna	Nationwide	GC	Commercial	Brokers, Direct	National Insurers, Specialty Companies
Cost-Containment	Cigna	Nationwide	GC, ER, ASO	Commercial	Direct	National Insurers, Specialty Companies
Consumer Health Engagement	Cigna	Nationwide	GC, ER, ASO	Commercial, Government	Brokers, Direct	National Insurers, Specialty Companies
Pharmacy Management	Cigna	Nationwide	GC, ER, ASO	Commercial, Government	Brokers, Direct	National PBMs
Behavioral Health	Cigna Behavioral Health	Nationwide	GC, ER, ASO	Commercial	Brokers, Direct	National Insurers, Specialty Companies
Dental	Cigna Dental HealthCare	Nationwide	GC, ER, ASO	Commercial, Individual	Brokers, Direct	Dental Insurers, National Insurers
Vision	Cigna Vision	Nationwide	GC, ER, ASO	Commercial, Individual	Brokers, Direct	National Insurers, Specialty Companies

Principal Products & Services

Commercial Medical

- ***Managed Care Plans*** These plans are offered through our insurance companies, HMOs and TPA companies. HMO, Network Open Access and Open Access Plus plans use meaningful cost-sharing incentives to encourage the use of "in-network" versus "out-of-network" health care providers. The national provider network for Managed Care Plans is somewhat smaller than the national network used with the preferred provider ("PPO") plan product line.
- ***PPO Plans*** feature a network with broader provider access than the Managed Care Plans.
- ***Consumer-Driven Products*** are typically paired with a high-deductible medical plan and offer customers a tax-advantaged way to pay for eligible health care expenses. These products, consisting of health savings accounts ("HSAs"), health reimbursement accounts ("HRAs") and flexible spending accounts ("FSAs"), encourage customers to play an active role in managing their health and health care costs. When integrated with a Cigna medical plan, we can deliver a seamless experience for our customers and clients. More than three million customers have one of these integrated product solutions.

Government Medical

- ***Individual and Family Plans*** feature an insurance policy coupled with a network of health care providers in a geographic area who have been selected with cost and quality in mind.
- ***Medicare Advantage Plans*** allow Medicare-eligible beneficiaries to receive health care benefits, including prescription drugs, through a managed care health plan such as our coordinated care plans. Our Medicare Advantage Plans are primarily HMO plans marketed to individuals. A significant portion of our Medicare Advantage customers receive medical care from our value-based models that focus on developing highly engaged physician networks, aligning payment incentives to improved health outcomes and using timely and transparent data sharing.
- ***Medicare Part D Plans*** provide a number of plan options, as well as service and information support, to Medicare and Medicaid eligible customers. Our plans offer the savings of Medicare combined with the flexibility to provide enhanced benefits and a drug list tailored to individuals' specific needs. Eligible beneficiaries benefit from broad network access and value-added services intended to promote wellness and affordability for our eligible beneficiaries.
- ***Medicaid Plans*** provide our low-income customers with the benefit of many of the coordinated care aspects of our Medicare Advantage programs. For customers eligible for both Medicare and Medicaid ("dual eligible") we receive revenue from both the state and the Center for Medicare and Medicaid Services ("CMS").
- ***Medicare Supplement Plans*** provide Medicare-eligible beneficiaries with federally standardized Medigap-style plans. Beneficiaries may select among the various plans with specific plan options to meet their unique needs and may visit, without the need for a referral, any health care professional or facility that accepts Medicare throughout the United States.

Specialty Solutions

- ***Stop-Loss*** insurance coverage is offered to self-insured clients whose group health plans are administered by Cigna. Stop-loss insurance provides reimbursement for claims in excess of a predetermined amount for individuals, the entire group, or both.
- ***Cost-Containment Programs*** are designed to contain the cost of covered health care services and supplies. These programs reduce out-of-network utilization and costs, protect members from balance billing, and educate customers regarding the availability of lower cost in-network services. In addition, under these programs, we negotiate discounts with out-of-network providers, review provider bills and recover overpayments. We charge fees for providing or arranging for these services. These programs may be administered by third-party vendors that have contracted with Cigna.
- ***Consumer Health Engagement*** services are offered to customers covered under plans administered by Cigna or by third-party administrators. These services consist of an array of medical management, disease management and wellness services. Our Medical Management programs include case, specialty and utilization management and a 24-hour nurse information line. Our Health Advocacy program services include early intervention in the treatment of chronic conditions and an array of health and wellness coaching. Additionally, we administer incentives programs designed to encourage customers to engage in health improvement activities.
- ***Pharmacy Management*** services and benefits can be combined with our medical offerings. The comprehensive suite of pharmacy management services available to clients and customers includes benefits management, specialty pharmacy services, clinical solutions, home delivery, and certain medical management services. Cigna's home delivery pharmacy operation along with the Express Scripts PBM, are reported in the Health Services segment and described further there.
- ***Behavioral Health*** services are offered to employers, government entities and other groups sponsoring health benefit plans. These services consist of behavioral health care case management, employee assistance programs ("EAP"), and work/life programs. We focus on integrating our programs and services with medical, pharmacy and disability programs to facilitate customized, holistic care.
- ***Dental*** solutions include dental health maintenance organization plans ("Dental HMO"), dental preferred provider organization ("Dental PPO") plans, exclusive dental provider organization plans, traditional dental indemnity plans and a dental discount program. Employers and other groups can purchase our products on either an insured or self-insured basis as standalone products or in conjunction with medical products. Additionally, individual customers can purchase insured Dental PPO plans as standalone products or in conjunction with individual medical policies.

- ***Vision*** offerings include flexible, cost-effective PPO coverage that includes a range of both in and out-of-network benefits for routine vision services offered in conjunction with our medical and dental product offerings. Our national vision care network includes private practice ophthalmologist and optometrist offices, as well as retail eye care centers.

Funding Solutions

- ***ASO.*** Plan sponsors (i.e., employers, unions and other groups) self-fund all claims, but may purchase stop-loss insurance to limit exposure. We collect fees from plan sponsors for providing access to our participating provider network and for other services and programs including: claims administration; behavioral health services; disease management; utilization management; cost containment; dental; and pharmacy benefit management. Approximately 86% of our commercial medical customers are in ASO arrangements.
- ***Experience-Rated Insurance.*** Premium rates are established at the beginning of a policy period and are typically based on prior claim experience of the policyholder. When claims and expenses are less than the premium charged (an "experience surplus" or "margin"), the policyholder may be credited for a portion of this experience surplus or margin. If claims and expenses exceed the premium charged (an "experience deficit"), we bear these costs. In certain cases, experience deficits incurred while the policy is in effect are accumulated and may be recovered through future policy year experience surpluses or margins. Approximately 6% of commercial medical customers are in experience-rated arrangements.
- ***Guaranteed Cost Insurance.*** Premium rates are established at the beginning of a policy period and, depending on group size, may be based in whole or in part on prior experience of the policyholder or on a pool of similar policyholders. We generally cannot subsequently adjust premiums to reflect actual claim experience until the next annual renewal. The policyholder does not participate, or share in, actual claim experience. We keep any experience surplus or margin if costs are less than the premium charged (subject to minimum medical loss ratio rebate requirements discussed below) and bear the risk for actual costs in excess of the premium charged. Approximately 8% of commercial medical customers are in guaranteed cost arrangements.

In most states, individual and group insurance premium rates must be approved by the applicable state regulatory agency (typically department of insurance) and state or federal laws may restrict or limit the use of rating methods. Premium rates for groups and individuals are subject to state review to determine whether they are adequate, not excessive and not unfairly discriminatory. In addition, the ACA subjects individual and small group policy rate increases above an identified threshold to review by the United States Department of Health and Human Services ("HHS") and requires payment of premium refunds on individual and group medical insurance products if minimum medical loss ratio ("MLR") requirements are not met. The MLR represents the percentage of premiums used to pay medical claims and expenses for activities that improve the quality of care. In our individual business, premiums may also be adjusted as a result of the government risk adjustment program that accounts for the relative health status of our customers. See the "Regulation" section of this Form 10-K for additional information about commercial MLR requirements and risk mitigation programs of the ACA.

Market Segments

- ***Commercial*** comprises employers from the National, Middle Market and Select market segments.
    - ***National.*** Multi-state employers with 5,000 or more U.S.-based, full-time employees. We offer primarily ASO funding solutions in this market segment.
    - ***Middle Market.*** Employers generally with 500 to 4,999 U.S.-based, full-time employees. This segment also includes single-site employers with more than 5,000 employees and Taft-Hartley plans and other groups. We offer ASO, experience-rated and guaranteed cost insured funding solutions in this market segment.
    - ***Select.*** Employers generally with 51-499 eligible employees. We usually offer ASO with stop loss insurance coverage and guaranteed cost insured funding solutions in this market segment.
- ***Individual.*** Consistent with the regulations for Individual ACA compliant plans, we offer these plans only on a guaranteed cost basis in this market segment.
- ***Government*** includes individuals who are Medicare-eligible beneficiaries, as well as employer group sponsored pre- and post-65 retirees. We also have dual-eligible members who receive both Medicare and Medicaid benefits.

Primary Distribution Channels

- ***Brokers.*** Sales representatives distribute our products and services to a broad group of insurance brokers and consultants across the United States.
- ***Direct.*** Cigna sales representatives distribute our products and services directly to employers, unions and other groups or individuals across the United States. Various products may also be sold directly to insurance companies, HMOs and third-party administrators. This may take the form of in-person contact, telephonic or group selling venues.
- ***Private Exchanges.*** We partner with select companies that have created private exchanges where individuals and organizations can acquire health insurance. We actively evaluate private exchange participation opportunities as they emerge in the market, and target our participation to those models that best align with our mission and value proposition.
- ***Public Exchanges.*** Many states have set up public health insurance exchanges for ACA compliant plans on which Cigna may offer individual policies.

Competition

The primary competitive factors affecting our business are quality and cost-effectiveness of service and provider networks; effectiveness of medical care management; products that meet the needs of employers and their employees; total cost management; technology; and effectiveness of marketing and sales. Financial strength, as indicated by ratings issued by nationally recognized rating agencies, is also a competitive factor. Our health advocacy capabilities, holistic approach to consumer engagement, breadth of product offerings, clinical care and medical management capabilities and array of product funding options are competitive advantages. We believe our focus on improving the health, well-being and peace of mind of the customers we serve will allow us to further differentiate ourselves from our competitors.

- ***National Insurers.*** UnitedHealth Group, Aetna (owned by CVS Health), Anthem and Humana compete with us in a variety of products and regions throughout the United States.
- ***Local Healthplans.*** Blue Cross Blue Shield plans, local affiliates of major insurance companies and hospitals, and regional stand-alone managed care and specialty companies compete with us in the states in which we offer managed care products. Additionally, plan sponsors may contract directly with providers.
- ***TPAs.*** Third-party administrators compete with us for ASO business.
- ***Start-ups.*** Recent market entrants Oscar, Bright Health and other health plans seek to disrupt competition primarily in the individual market, in part through technology. Alternative health service models, including consortiums, search for a new approach to obtaining health services.
- ***Dental Insurers.*** Various companies offering primarily dental insurance compete with us on these products.
- ***Specialty Companies.*** Specialty insurance or service companies that offer niche products and services compete with us.

Delivering the Health Care Promise

Cigna's Connected Care strategy engages customers in their health, collaborates with providers to help them improve their performance, and connects customers and providers through aligned health goals, incentives and actionable information to enable better decisions and outcomes. Cigna is committed to developing innovative solutions that span the health care delivery system and can be applied to different types of providers. Currently we have numerous collaborative arrangements with our participating health care providers that reach over 3.6 million customers and are actively developing new arrangements to support our Connected Care strategy.

- ***Accountable Care Program.*** We have over 240 collaborative care arrangements with primary care groups built on the patient-centered medical home and accountable care organization ("ACO") models. Our arrangements span more than 32 states and reach over 2.7 million customers. We are committed to increasing the number of groups over the next several years, with a goal of reaching 280 programs by the end of 2020.
- ***Hospital Quality Program.*** We have contracts with over 500 hospitals with reimbursements tied to quality metrics. We expect to grow this number to over 600 hospitals by the end of 2020.
- ***Specialist Programs.*** We have approximately 250 arrangements with specialist groups in value-based reimbursement arrangements. Our goal is to reach approximately 380 arrangements by the end of 2020. Programs include arrangements with several types of specialist groups around the country including orthopedics, obstetrics and gynecology, cardiology, gastroenterology, oncology, nephrology and neurology. Arrangements include care coordination and episodes of care reimbursements for meeting cost and quality goals.
- ***Independent Practice Associations.*** We have value-based physician engagement models in our Cigna-HealthSpring business that allow physician groups to share financial outcomes with us. The Cigna-HealthSpring clinical model also includes outreach to new and at-risk patients to ensure they are accessing their primary care physician.
- ***Participating Provider Network.*** We provide our customers with an extensive network of participating health care professionals, hospitals and other facilities, pharmacies and providers of health care services and supplies. In most instances, we contract with them directly; however, in some instances, we contract with third parties for access to their provider networks and care management services. In addition, we have entered into strategic alliances with several regional managed care organizations (e.g., Tufts Health Plan, HealthPartners, Inc., Health Alliance Plan and MVP Health Plan) to gain access to their provider networks and discounts.

Technology

Cigna Information Technology supports our ***Go Deeper, Go Local, Go Beyond*** strategy by focusing first and foremost on strong foundational technology services, delivery of a business aligned technology project portfolio and prioritized strategic innovation that creates solutions that differentiate us in the market. Our technology innovation continues to focus on three strategic areas: insights and analytics; digital health; and care delivery and management. Our technology strategy ultimately improves the customer experience, increases engagement and advances population health using data driven insights, utilizing artificial intelligence and machine learning to provide key areas of competitive advantage. Innovation is core to the way we do business and will be a critical factor to our success in the highly dynamic health care industry. Cigna's innovative technology solutions continue to improve affordability and increase personalization: for example the Cigna One Guide® program combines a state-of-the-art digital experience with a human concierge service, and the Cigna SureFit® network allows individual family members to choose their personal care networks consistent with their health needs and provider preferences.

Our business strategy is based upon providing customers with differentiated, easy-to-use, seamless and secure products and solutions that utilize insights from advanced analytics to meet their expectations. We anticipate needs and meet customers where they are, from predicting and preventing chronic diseases, to mining data to reduce payment and claims fraud, to using the data from wearable devices to optimize population health status. In 2018, Cigna advanced its strategic technology leadership position by expanding our digital portfolio with the integration of the Brighter acquisition. Brighter's digital platform for connecting patients with a dental provider, allowing them to review their experience, gain insights to costs and see a dentist's history demonstrates the leadership in the digital engagement of health care customers. We also began the roadmap of leveraging Express Scripts technology value creators. Each of these companies contributes to our business model and strengthens the Cigna portfolio. Further, Cigna will apply the Express Scripts technology toolkit to advance the 360 degree view of the patient through flexible, open and connected solutions. With the combined strengths and capabilities of Cigna and Express Scripts, we see greater opportunities to create novel, highly-tailored customer insights as we mine data and use sophisticated artificial intelligence and machine learning techniques to build better models that help us find solutions to complex questions and improve health care outcomes. We will continue to develop leading data driven solutions such as applying propriety algorithms and machine learning to predict customers that could overdose on prescription opioids.

Data Analytics

Cigna has transformed substantial investments in analytics talent, data infrastructure and machine learning capabilities over the past several years into a closed-loop, self-learning insights system that guides our decision-making and allows us to execute on our strategy. Our "Insights That Matter" analytics process helps our business leaders identify the questions that matter most to our customers and partners while our data science experts focus on answering those questions with innovative methodologies and transform our insights into targeted business actions. We apply advanced analytics across our business and will continue to invest in expanding and strengthening our capabilities to better anticipate, meet and exceed our customers' and partners' expectations.

Health Services

This segment consists of the Express Scripts PBM business beginning December 21, 2018 as well as Cigna's legacy home delivery operations that offer high quality, efficient, and cost-effective mail order, telephone, and on-line pharmaceutical fulfillment services. In 2018, Health Services reported adjusted revenues of $6.6 billion and pre-tax adjusted income from operations of $380 million, including 11 days of Express Scripts results.

How We Win
• **Identifying** products and offering solutions that focus on improving patient outcomes and assist in controlling costs • **Evaluating** medicines for efficacy, value and price to assist clients in selecting a cost-effective formulary • **Offering** home delivery and specialty services that save clients money and provide better care • **Leveraging** purchasing volume to deliver discounts • **Promoting** the use of generics and lower cost brands

The following chart depicts a high level summary of our principal products and services in this segment with definitions on subsequent pages.

Principal Products & Services	*Brands/ Subsidiaries*	*Key Customer(s)*	*Primary Competitors*
Clinical Solutions	RationalMed, ScreenRx, ExpressAlliance, Advanced Opioid Management	Clients, Customers	Independent PBMs, Managed Care PBMs
Value Programs	SafeGuardRx	Clients, Customers, Pharmacies	Independent PBMs, Managed Care PBMs
Specialized Pharmacy Care	Therapeutic Resource Center	Customers	Independent PBMs, Managed Care PBMs, Retail Pharmacies
Home Delivery Pharmacy Services	Tel-Drug, Express Scripts, Therapeutic Resource Centers	Customers	Independent PBMs, Managed Care PBMs, Retail Pharmacies
Specialty Pharmacy Services	Accredo, Freedom Fertility, Tel-Drug	Clients, Customers, Pharmacies	Independent PBMs, Managed Care PBMs, Retail Pharmacies
Retail Network Pharmacy Administration	Express Scripts	Clients, Customers	Independent PBMs, Managed Care PBMs
Benefit Design Consultation	Express Scripts	Clients	Independent PBMs, Managed Care PBMs, Third-Party Benefit Administrators
Drug Utilization Review	Express Scripts	Clients, Customers	Independent PBMs, Managed Care PBMs, Third-Party Benefit Administrators
Drug Formulary Management	Express Scripts	Clients	Independent PBMs, Managed Care PBMs
Drug Claim Adjudication	Express Scripts	Clients	Independent PBMs, Managed Care PBMs, Third-Party Benefit Administrators
Administration of Group Purchasing Organizations ("GPO")	Econdisc, ValoremRx	Clients, Pharmacies	Group Purchasing Organizations
Prescription Card	Inside Rx	Customers	Retail Pharmacies, Discount Programs

Principal Products & Services	*Brands/ Subsidiaries*	*Key Customer(s)*	*Primary Competitors*
Digital Consumer Health and Drug Information	Express Scripts	Customers	Independent PBMs, Managed Care PBMs, Retail Pharmacies
Provider Services	CuraScript Specialty Distribution	Healthcare Providers, Clinics, Hospitals	Specialty drug distributors
Medical Benefit Management Services	eviCore, CareContinuum	Health Plans, Commercial and Government Payors	Health Plans, Third-Party Benefits Administrators, Clinical Solutions and Health Care Data Analytics Companies

Principal Products & Services

Pharmacy Benefit Management Services. Our PBM services drive high quality, cost-effective pharmaceutical care through prescription drug utilization and cost management. We consult with clients to assist in selecting plan design features that balance their requirements for cost control with customer choice and convenience. We focus our solutions to enable better decisions in four important, interrelated areas: benefit choices, drug choices, pharmacy choices and health choices. As a result, we believe we deliver better outcomes, higher customer satisfaction and a more affordable prescription drug benefit. As of December 31, 2018, we operated four high-volume automated dispensing home delivery pharmacies, five non-dispensing prescription processing centers, five customer contact centers, seven specialty home delivery pharmacies, 20 specialty branch pharmacies and eight specialty nursing offices.

- ***Clinical Solutions.*** We offer innovative clinical programs to drive better health outcomes at a lower cost by identifying and addressing unsafe, ineffective and wasteful prescribing; dispensing and utilization of prescription drugs; and intervening with, or supporting interventions with, physicians, pharmacies and customers.
    - RationalMed® evaluates medical, pharmacy and laboratory data to detect critical customer health and safety risks that are addressed through timely notice to physicians, pharmacies, customers and case managers.
    - ScreenRx® uses proprietary predictive models to detect customers at risk for nonadherence and proactively address the problem through customized interventions for each individual customer.

- Express*Alliance*® offers customer care coordination services that enable customer-authorized health care professionals to share a common view of a customer's health record and coordinate customer outreach and counseling.
- Advanced Opioid Management℠ works comprehensively with customers, prescribers and pharmacies to minimize early exposure to opioids while helping prevent progression to overuse and abuse.

Other solutions include Total Performance Management, Concurrent Drug Utilization Review, Advanced Utilization Management, Medication Therapy Management, Digital Report Monitoring and Fraud, Waste and Abuse.

- ***Express Scripts SafeGuardRx®.*** We are the industry leader in offering a suite of solutions aimed at therapy classes that pose significant budgetary threats and clinical challenges to patients. Our solutions are designed to keep our clients ahead of the cost curve while providing customers the personalized care and access they need. These solutions are offered throughout our PBM services and include, but are not limited to: Pulmonary Care Value Program℠; Multiple Sclerosis Care Value Program℠; Inflammatory Conditions Care Value Program℠; Diabetes Care Value Program℠; Hepatitis Cure Value Program®; Cholesterol Care Value Program®; Oncology Care Value Program®; Market Events Protection Program®; and Inflation Protection Program℠. Innovative programs, such as Express Scripts SafeGuardRx, combine utilization management controls with formulary management, the specialized care model of our Therapeutic Resource Center® program (described below) and comprehensive guarantees, and help us to change the market in key specialty categories. Notably, our programs covering oncology and inflammatory conditions have introduced a value-based contracting approach, with payments now tied to a product's effectiveness.
- ***Specialized Pharmacy Care.*** At the center of Express Scripts' condition-specific approach to care are Therapeutic Resource Center services, which are pharmacy practices specializing in caring for customers with the most complex and costly chronic conditions including cardiovascular disease, diabetes, cancer, HIV, asthma, depression and other rare and specialty conditions. Our Therapeutic Resource Center services are designed to optimize the safe and appropriate dispensing of therapeutic agents, minimize waste, and improve clinical and financial outcomes. Through our Therapeutic Resource Center services, specialist pharmacists provide the expert, personalized care that customers increasingly demand.
- ***Home Delivery Pharmacy Services.*** In addition to the order processing that occurs at these home delivery pharmacies, we operate several non-dispensing prescription processing facilities and customer contact centers. Our pharmacies provide greater safety and accuracy than retail pharmacies, convenient access to maintenance medications, and better management of our clients' drug costs through operating efficiencies. We are directly involved with the prescriber and customer through our home delivery pharmacies, and our research shows that we achieve a higher level of generic substitutions, therapeutic interventions and better adherence than is achieved through retail pharmacy networks.
- ***Specialty Pharmacy Services.*** Specialty medications are used primarily for the treatment of complex diseases. These medications are broadly characterized to include those with frequent dosing adjustments, intensive clinical monitoring, the need for customer training, specialized product administration requirements and/or medications limited to certain specialty pharmacy networks by manufacturers. Through a combination of assets and capabilities, we provide an enhanced level of personalized care and therapy management for customers taking specialty medications, increased visibility and improved outcomes for payors, as well as custom programs for biopharmaceutical manufacturers.
    - Accredo Health Group ("Accredo") is focused on dispensing injectable, infused, oral or inhaled drugs that require a higher level of clinical service and support than traditional pharmacies typically offer.
    - Accredo achieves better outcomes for customers and reduces waste for clients through specialty trained clinicians, a nationwide footprint, a network of in-home nursing services, reimbursement and customer assistance programs, and biopharmaceutical services.
    - Our subsidiary Freedom Fertility is a leading specialty pharmacy focused on the needs of fertility customers and providers. Through Freedom Fertility, we provide insurance assistance, customer education, and support.
    - Our subsidiary Care Continuum provides medical benefit drug management services that enable greater oversight of our clients' specialty spend billed through the medical benefit designed to ultimately make specialty drugs more affordable and accessible.
- ***Retail Network Pharmacy Administration.*** We contract with retail pharmacies to provide prescription drugs to customers of the pharmacy benefit plans we manage. In the United States, Puerto Rico and the Virgin Islands, we negotiate with pharmacies to discount drug prices provided to customers and manage national and regional networks responsive to client preferences related to cost containment, convenience of access for customers and network performance. We also manage networks of pharmacies customized for or under direct contract with specific clients and have contracted with pharmacy provider networks to comply with CMS access requirements for the federal Medicare Part D Prescription Drug Program ("Medicare Part D"). All retail pharmacies in our network communicate with us online and in real-time to process prescription drug claims. When a plan member presents their identification card at a network pharmacy, the network pharmacist sends specific member, prescriber and prescription information in an industry-standard format through our systems, which process the claim and respond to the pharmacy with relevant information to process the prescription.
- ***Benefit Design Consultation.*** We consult with our clients on how best to structure and leverage the pharmacy benefit to meet plan objectives for affordable access to the prescription medications people need to stay healthy, and ensure the safe and effective use of those medications.
- ***Drug Utilization Review.*** When prescriptions are presented to our pharmacies or submitted for coverage, we review them electronically and systematically in real-time for safety and effectiveness. We then alert the dispensing pharmacy to detected issues. Issues not adequately addressed at the time of dispensing may also be communicated to the prescriber retrospectively.
- ***Drug Formulary Management.*** Formularies are lists of drugs with designations that may be used to determine drug coverage, customer out-of-pocket costs, and communicate plan preferences in competitive drug categories. Our formulary management services support clients

in establishing formularies that assist customers and physicians in choosing clinically appropriate, cost-effective drugs and prioritize access, safety and affordability. We administer specific formularies on behalf of our clients, including standard formularies developed and offered by Express Scripts and custom formularies in which we play a more limited role. Most of our clients select standard formularies, governed by our National Pharmacy & Therapeutics Committee (the "P&T Committee") that comprises a panel of independent physicians and pharmacists in active clinical practice representing a variety of specialties and practice settings, typically with major academic affiliations. In making formulary recommendations, the P&T Committee considers only the drug's safety and efficacy and not the cost of the drug, including any negotiated manufacturer discount or rebate arrangement. This process is designed to ensure the clinical recommendation is not affected by our financial arrangements. We fully comply with the P&T Committee's clinical recommendations regarding drugs that must be included or excluded from the formulary based on their assessment of safety and efficacy.

- ***Drug Claim Adjudication.*** We process drug claims for home delivery or retail networks through integration of retail network pharmacy administration, benefit design consultation, drug utilization review, drug formulary management and pharmacy fulfillment services. We administer payments to retail networks and bill benefits costs to our clients through our end-to-end adjudication services.
- ***Inside Rx.*** The Inside Rx program delivers broad and affordable access to medication for the uninsured and those navigating the changing health care landscape. Inside Rx partners with participating retail pharmacies and major pharmaceutical companies to provide discounts, via a discount card for customers who would otherwise pay full list price for prescription medications. This program works collaboratively across the pharmacy supply chain with a shared focus to ensure customers have affordable access to medication they need. Inside Rx also provides access to pet prescriptions via our home delivery pharmacy services.
- ***Administration of a Group Purchasing Organization.*** We operate a group purchasing organization ("GPO") that negotiates pricing for the purchase of pharmaceuticals from pharmaceutical manufacturers and suppliers. We also provide various administrative services to GPO participants including negotiation and management of the GPO purchasing contracts. Express Scripts' GPO is a member of the GPO of Walgreens Boots Alliance Development GmbH.
- ***Digital Consumer Health and Drug Information.*** We empower customer decision-making through online and mobile tools that help customers make informed drug, pharmacy and health choices. Information included on our website and mobile application are not part of this annual report.
- ***Provider Services.*** CuraScript Specialty Distribution ("CSD") is a specialty distributor of pharmaceuticals and medical supplies (including injectable and infusible pharmaceuticals and medications to treat specialty and rare or orphan diseases) directly to health care providers, clinics and hospitals in the United States for office or clinic administration. Through our CSD business, we provide distribution services primarily to office and clinic-based physicians who treat customers with chronic diseases and regularly order costly specialty pharmaceuticals. CSD provides competitive pricing on pharmaceuticals and medical supplies, operates three distribution centers, and ships most products overnight within the United States; CSD also provides distribution capabilities to Puerto Rico and Guam. CSD is a contracted supplier with most major group purchasing organizations and leverages our distribution platform to operate as a third-party logistics provider for several pharmaceutical companies.
- ***Medical Benefit Management Services.*** eviCore is a leading provider of integrated medical benefit management solutions that focus on driving adherence to evidence-based guidelines, improving the quality of customer outcomes and reducing the cost of care for our clients. eviCore manages medical benefits in categories including radiology, cardiology, musculoskeletal disorders, sleep disorders, post-acute care, genetic lab, specialty pharmacy and medical oncology. eviCore contracts with health plans and other commercial and governmental payors to promote the appropriate use of health care services and contracts. In certain instances, this occurs through capitated risk arrangements, where we assume the financial obligation for the cost of health care services provided to eligible customers covered by eviCore's health care management programs.

Customers

- ***Clients.*** We provide services to managed care organizations, health insurers, third-party administrators, employers, union-sponsored benefit plans, workers' compensation plans, government health programs, providers, clinics, hospitals and others.
- ***Customers.*** Prescription drugs are dispensed to customers of the clients we serve primarily through networks of retail pharmacies under non-exclusive contracts with us and through our home delivery fulfillment pharmacies, specialty drug fulfillment pharmacies and fertility fulfillment pharmacies.

Our key customers include the United States Department of Defense ("DoD") and Anthem. The DoD's TRICARE Pharmacy Program is the military health care program serving active-duty service customers, National Guard and Reserve customers, and retirees, as well as their dependents. Under our DoD contract, we provide online claims adjudication, home delivery services, specialty pharmacy clinical services, claims processing and contact center support and other services critical to managing pharmacy trend.

On January 30, 2019, Anthem exercised its right to early terminate their pharmacy benefit management services agreement with us, effective March 1, 2019. There is a twelve-month transition period ending March 1, 2020. It is expected that the transition of Anthem's customers will occur at various dates, as informed by Anthem's technology platform migration schedule. Over the next twelve months, we will focus on an effective transition of this relationship and related services over Anthem's accelerated timeline. For further discussion of our Anthem relationship, see the "Executive Summary — Key Transactions and Developments" section of our MD&A located in Part II, Item 7 of the Form 10-K.

Competition

The health care industry has undergone periods of substantial consolidation and may continue to consolidate in the future. We believe the primary competitive factors in the industry include the ability to: negotiate with retail pharmacies to ensure our home delivery pharmacy and retail pharmacy networks meet the needs of our clients and customers; negotiate discounts and rebates on prescription drugs with drug manufacturers; navigate the complexities of government-reimbursed business including Medicare, Medicaid and the Public Exchanges; manage cost and quality of specialty drugs; use the information we obtain about drug utilization patterns and consumer behavior to reduce costs for our clients and customers; and the level of service we provide.

- ***Independent PBMs.*** MedImpact and Navitus Health Solutions compete with us on a variety of products and in various regions throughout the United States.
- ***Managed Care PBMs.*** Aetna Inc. (owned by CVS Health Corporation), Humana, OptumRx (owned by UnitedHealth Group) and Prime Therapeutics (owned by a collection of Blue Cross / Blue Shield Plans) compete with us on a variety of products and in various regions throughout the United States.
- ***Retail Pharmacies.*** CVS Caremark (owned by CVS Health) and Envision Rx (owned by Rite Aid). Wal-Mart Stores, Inc. engages in certain activities competitive with PBMs.
- ***Third-Party Benefits Administrators.*** Third parties that specialize in claim adjudication and benefit administration, such as Argus, are direct competitors. With the emergence of alternative benefit models through Private Exchanges, the competitive landscape also includes brokers, health plans and consultants. Some of these competitors may have greater financial, marketing and technological resources than we do and new market entrants, including strategic alliances aimed at modifying the current health care delivery models or entering the prescription drug sector from another sector of the health care industry, may increase competitiveness as barriers to entry are relatively low.
- ***Clinical Solutions and Health Care Data Analytics Companies.*** Optum (owned by UnitedHealth Group), Anthem, Inc., Magellan Health, HealthHelp, Cotiviti, and Inovalon are among the companies that compete with us in this market.

Quality

- ***Sales and Account Management.*** Our sales and account management teams market and sell PBM solutions and are supported by client service representatives, clinical pharmacy managers and benefit analysis consultants. These teams work with clients to develop innovative strategies that put medicine within reach of customers while helping health benefit providers improve access to and affordability of prescription drugs.
- ***Supply Chain.*** Our supply chain contracting and strategy teams negotiate and manage pharmacy network contracts, pharmaceutical and wholesaler purchasing contracts, and manufacturer rebate contracts. As our clients continue to experience increased cost trends, our supply chain teams develop innovative solutions such as Express Scripts SafeGuardRx and narrow networks to combat these price increases. In addition, our Formulary Consulting team, consisting of pharmacists and financial analysts, provides services to our clients to support formulary decisions, benefit design consultation and utilization management programs.
- ***Clinical Support.*** Our staff of highly trained health care professionals provides clinical support for our PBM and medical benefit management services, including more specialized care for customers with select chronic and complex conditions. We operate condition-specific Therapeutic Resource Center facilities staffed with specialist pharmacists, nurses and other clinicians who provide personal and specialized customer care. Our clinical solutions staff of pharmacists and physicians provides clinical development and operational support for our PBM services. These health care professionals conduct a wide range of activities including identifying emerging medication-related safety issues and alerting physicians, clients, and customers (as appropriate); providing drug information services; managing formulary; and developing utilization management, safety (drug utilization review) and other clinical interventions.
- ***Research and Analytics.*** Our research and analytics team conducts timely, rigorous and objective research that supports evidence-based pharmacy benefit management and evaluates the clinical, economic and individual impact of pharmacy benefits. They also use predictive modeling, machine learning and other analytical tools to develop and improve our products and services. The team also produces the Express Scripts Drug Trend Report, which examines trends in pharmaceutical utilization and cost, the factors triggering those trends and new solutions our clients can implement to control their pharmacy spend while improving the health of their customers.

Technology

Our technology team supports the various management information systems essential to our operations including the pharmacy and medical benefit claims processing systems and specialty pharmacy systems, while seeking opportunities to optimize our technology solutions by consolidating and upgrading our technology platforms.

Uninterrupted point-of-sale electronic retail pharmacy claims processing is a significant operational requirement for our business. Claims in the United States are processed through systems managed and operated domestically by internal resources and an outsourced vendor. We believe we have substantial capacity for growth in our United States claims processing facilities.

We leverage outsourced vendor services to provide certain disaster recovery services for systems located at our data centers. For systems not covered by a third-party vendor arrangement, such as our specialty pharmacy data centers, our corporate disaster recovery organization manages internal recovery services.

Express Scripts is proud of its commitment to innovation in the field of health care. Express Scripts innovations improve patient outcomes while eliminating waste in the health care system. Express Scripts Holding Company and its affiliated companies (individually and/or collectively "Express Scripts") hold more than 170 United States patents. We use these patents to protect our proprietary technological advances.

Our technology platform allows us to safely, rapidly, and accurately adjudicate 1.4 billion adjusted prescriptions annually. Our technology helps retail pharmacies focus on patient care, and our real-time safety checks help avoid hundreds of thousands of medication errors annually. Technology is the backbone to all of our solutions – from our provider-focused advances that improve e-prescribing and electronic prior authorization – to our patient-friendly app and website interfaces, and our continued investments provide an easier, more efficient experience with all of our partners.

Our formulary strategy and our SafeGuardRx program are also rooted in technology that applies our deep pharmacy expertise and data insights more rapidly and comprehensively to drive better clinical and financial outcomes for clients and patients.

Our Health Services business owns and has registered certain trade and service marks with the United States Patent and Trademark Office, including but not limited to the following marks: EXPRESS SCRIPTS®, MEDCO®, ACCREDO®, CURASCRIPTSD®, EVICORE HEALTHCARE®, FREEDOM FERTILITY PHARMACY®, RATIONALMED®, SCREENRX®, EXPRESSALLIANCE®, THERAPEUTIC RESOURCE CENTER®, ADVANCED OPIOID MANAGEMENT℠, SAFEGUARDRX®, CHOLESTEROL CARE VALUE℠, HEPATITIS CURE VALUE℠, MARKET EVENTS PROTECTION℠, ONCOLOGY CARE VALUES℠, DIABETES CARE VALUE℠, INFLAMMATORY CONDITIONS CARE VALUE℠, INFLATION PROTECTION℠, PULMONARY CARE VALUE℠, MULTIPLE SCLEROSIS CARE VALUE℠, and INSIDE RX®.

We also hold a portfolio of patents and pending patent applications. We are not substantially dependent on any single patent or group of related patents.

Suppliers

We maintain an inventory of brand name and generic pharmaceuticals in our home delivery and specialty pharmacies. Our specialty pharmacies also carry biopharmaceutical products to meet the needs of our customers, including pharmaceuticals for the treatment of rare or chronic diseases; if a drug is not in our inventory, we can generally obtain it from a supplier within one business day.

We purchase pharmaceuticals either directly from manufacturers or through authorized wholesalers. Express Scripts uses one wholesaler more than others in the industry, but holds contracts with other wholesalers if needs for an alternate source arise and believes alternative supply is readily available should it be needed. Generic pharmaceuticals are generally purchased directly from manufacturers.

Industry Developments

See the "Industry Developments" section of the MD&A in this Form 10-K beginning on page 47 for discussion of key industry developments impacting this segment.

International Markets

Cigna's International Markets segment has operations in over 30 countries or jurisdictions providing a full range of comprehensive medical and supplemental health, life, and accident benefits to individuals and employers. Products and services include comprehensive health coverage, hospitalization, dental, critical illness, personal accident, term life, and variable universal life. In 2018, International Markets reported adjusted revenues of $5.4 billion and pre-tax adjusted income from operations of $735 million.

How We Win
• Broad range of health and protection related solutions to meet the needs of the growing middle class and globally mobile • Leveraging deep consumer insights to drive product and service innovation • Leading innovative, direct to consumer distribution capabilities • Access to quality, affordable care through one of the **largest global provider networks** • Locally licensed and **compliant** solutions managed by **strong, locally developed talent**

Demand for our products and services is underpinned by the growing global middle class, aging populations, increasing prevalence of chronic conditions, and rising global health care costs. Our focus on product and service innovation means we continue to deliver solutions that meet the evolving needs of individual and group customers. Our distribution channels and funding sources range by product, customer, and geography.

International Markets is well-positioned to address the growing demand for access to quality, affordable care and supplemental health and life protection that fill gaps in public and private care. We distinguish ourselves through differentiated direct-to-consumer distribution, customer insights, product innovation, a leading provider network, and compliant solutions. We identify and pursue attractive market opportunities to bring health and protection solutions and tailor those solutions to the market and customer needs. Over the past several years, we have

extended our product offerings and geographic reach. The chart below provides a high-level summary of our Principal Products and Services in this segment as of year-end, with definitions on subsequent pages.

Principal Products & Services	*Major Brand(s)*	*Geography*	*Funding Solution(s)*	*Key Customer(s)*	*Primary Distribution Channel(s)*	*Primary Competitors*
Global Health Care	Cigna Global Health Benefits Cigna Global IPMI	Worldwide	Experience-rated, Guaranteed Cost, ASO	Multinational Companies, Inter-governmental and Non-governmental Organizations Globally mobile individuals	Brokers, Agents, Direct-to-Consumer	Global insurers
Local Health Care	Cigna CignaTTK CignaCMB	United Kingdom, Spain, Hong Kong, India, China	Experience-rated, Guaranteed Cost, ASO	Employer Groups Individuals	Brokers, Agents, Direct-to-Consumer	Global insurers
Supplemental Health, Life, & Accident	Cigna LINA Korea CignaCMB CignaTTK CignaFinans	Asia Pacific, India, Turkey	Guaranteed Cost	Individuals	Affinity, Bancassurance, Brokers, Agents, Direct-to-Consumer	Global and local foreign insurers

Principal Products & Services

Global Health Care products and services include insurance and administrative services for medical, dental, pharmacy, vision, and life, accidental death and dismemberment, and disability risks. We are leading providers of products and services that meet the needs of multi-national employers, intergovernmental and non-governmental organizations and globally mobile individuals with a focus on keeping employees healthy and productive. The employer benefits products and services are offered through guaranteed cost, experience-rated, and administrative services only funding solutions, while individuals purchase guaranteed cost (insured) coverage. For definitions of funding solutions, see "Funding Solutions" in the "Integrated Medical" description of business section on page 6 of this Form 10-K.

Local Health Care products and services include medical, dental, pharmacy, and vision as well as life coverage. The customers of local health care businesses are employers and individuals located in specific countries where the products and services are purchased. These employer services can similarly be funded through a range of options and individuals purchase on a guaranteed cost basis.

Supplemental Health, Life and Accident Insurance products and services generally provide simple, affordable coverage of risks for the health and financial security of individuals. Supplemental health products provide specified payments for a variety of health risks and include personal accident, accidental death, critical illness, hospitalization, travel, dental, cancer and other dread disease coverages. We also offer customers term and variable universal life insurance and certain savings products in select markets.

Competition

We anticipate that the competitive environment will intensify as insurance and financial services providers more aggressively pursue expansion opportunities across geographies, particularly Asia. We believe competitive factors will include speed-to-market, customer insights, branding, product, distribution and service innovation, underwriting and pricing, efficient management of marketing and operating processes, commission levels paid to distribution partners, the quality of claims, network coverage and medical cost management, and talent acquisition and retention. Additionally, in most overseas markets, perception of commitment to the market and financial strength will likely be an important competitive factor.

Pricing and Reinsurance

Premium rates and fees for our global and local health care products reflect assumptions about future claims, expenses, customer demographics, investment returns, and profit margins. For products using networks of contracted health care professionals and facilities, premiums reflect assumptions about the impact of these contracts and utilization management on future claims. Most contracts permit rate changes at least annually.

The profitability of health care products is dependent upon the accuracy of projections for health care inflation (unit cost, location of delivery of care, currency of incurral and utilization), customer demographics, the adequacy of fees charged for administration and effective medical cost management.

Premium rates for our supplemental benefits products are based on assumptions about mortality, morbidity, customer acquisition and retention, customer demographics, expenses and capital requirements, as well as interest rates. Variable universal life insurance products fees consist of mortality, administrative, asset management and surrender charges assessed against the contract holder's fund balance. Mortality charges on variable universal life may be adjusted prospectively to reflect expected mortality experience. Most contracts permit premium rate changes at least annually.

A global approach to underwriting risk management allows each local business to underwrite and accept risk within specified limits. Retentions are centrally managed through cost effective use of external reinsurance to limit our liability on per life, per risk and per event (catastrophe) bases.

Industry Developments and Other Items Affecting International Markets

South Korea represents our single largest geographic market for International Markets. For information on this concentration of risk for the International Markets segment's business in South Korea. see "Other Items Affecting Results of International Markets" in the International Markets section of the MD&A beginning on page 59 of this Form 10-K.

Pressure on social health care systems, a rapidly aging population and increased wealth and education in developing insurance markets are leading to higher demand for health insurance and financial security products. In the supplemental health, life and accident business, direct marketing channels continue to grow and attract new competitors with industry consolidation among financial institutions and other affinity partners.

Data privacy regulation has tightened in all markets in the wake of data privacy news scandals, impacting affinity partner and customer attitudes toward direct marketing of insurance and other financial services.

Group Disability and Other

As explained further in the introduction to this Form 10-K, Group Disability and Other consists of our Group Disability and Life operating segment, along with COLI and certain run-off businesses reported together in Other Operations. In 2018, Group Disability and Other reported adjusted revenues of $5.1 billion and pre-tax adjusted income from operations of $529 million.

How We Win
• **Disability absence management model** that reduces overall costs to employers • **Integration** of disability products **with medical and specialty offerings,** promoting health and wellness and optimizing employee productivity • **Complementary portfolio** of group disability, life and accident offerings • **Disciplined underwriting, pricing and investment strategies** supporting profitable long-term growth

Group Disability and Life

Our Group Disability and Life operating segment includes our commercial long- and short-term disability products, and our term life and universal life group insurance products. We also offer personal accident insurance and voluntary products and services. These products and services are distributed through brokers and direct sales and are available in fully-insured, experience-rated and ASO arrangements. The following chart depicts a high-level summary of our Principal Products and Services in this segment as of year-end, with definitions on subsequent pages.

Principal Products & Services	Payee	Premium Rates	Funding Solution(s)	Market Segment(s)	Primary Distribution Channel(s)	Primary Competitors
Group Disability						
Long-term Disability	Employer, Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured, ASO	Commercial	Brokers, Direct	National Insurers, Regional Insurers
Short-term Disability	Employer, Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured, ASO	Commercial	Brokers, Direct	National Insurers, Regional Insurers
Group Life						
Term Life	Employer, Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured	Commercial	Brokers, Direct	National Insurers, Regional Insurers
Universal Life	Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured	Commercial	Brokers, Direct	National Insurers, Regional Insurers
Group Accident and Voluntary						
Personal Accident Insurance	Employer, Employee	Preset, guaranteed	Experience-rated Insured, Guaranteed Cost Insured	Commercial	Brokers, Direct	National Insurers, Regional Insurers
Voluntary Products and Services	Employee	Preset, guaranteed	Guaranteed Cost Insured	Commercial	Brokers, Direct	National Insurers, Regional Insurers

Principal Products & Services

Group Disability

- ***Group Long-term and Short-term Disability*** insurance products generally provide a fixed level of income to replace a portion of wages lost due to disability. As part of our group disability insurance products, we also assist employees in returning to work and employers with

resources to manage the cost of employee disability. We are an industry leader in helping employees return to work quickly, enabling higher productivity and lower cost for employers and a better quality of life for employees. While we offer this coverage in all three funding arrangements, most of our coverages are guaranteed cost.

- ***Leave Administration*** solutions help customers effectively manage workforce absence and provide coverage for paid leave. We integrate the administration of our disability insurance products with other disability benefit programs, behavioral programs, medical programs, social security advocacy and administration of the federal Family and Medical Leave Act (''FMLA''), State Leave laws and other leave-of-absence programs. We believe this integration supports greater efficiency and effectiveness in disability claims management, enhances productivity and reduces overall costs to employers. Integration also provides early insight into employees at risk for future disability claims. Coordinating the administration of these disability programs with programs offered by our medical business provides enhanced opportunities to influence outcomes, reduce the cost of both medical and disability events and improve the return-to-work rate.

Group Life Insurance

- ***Group Term Life*** insurance may be employer-paid basic life insurance, employee-paid supplemental life insurance or a combination thereof.
- ***Group Universal Life*** insurance is a voluntary life insurance product in which the owner may accumulate a cash value. The cash value earns interest at rates declared from time to time, subject to a minimum guaranteed contracted rate, and may be borrowed, withdrawn, or, within certain limits, used to fund future life insurance coverage.

Other Products and Services

- ***Personal Accident Insurance*** coverage consists primarily of accidental death and dismemberment and travel accident insurance to employers.
- ***Specialty Insurance Services*** consist of disability and life, accident and hospital indemnity products to professional or trade associations and financial institutions.
- ***Voluntary Products and Services*** include plans that provide employers with administrative solutions designed to provide a complete and simple way to manage their benefits program. These voluntary offerings include accidental injury insurance, critical illness coverage and hospital care coverage, and provide additional dollar payouts to employees for unexpected accidents, hospitalization or more serious illnesses.

Pricing and Reinsurance

Premiums charged for disability and term life insurance products are usually established in advance of the policy period, are generally guaranteed for one to three years, but selectively guaranteed for up to five years. Policies are generally subject to termination by the policyholder or by the insurance company annually. Premium rates reflect assumptions about future claims, expenses, credit risk, investment returns and profit margins. These assumptions may be based in whole or in part on prior experience of the account or on a pool of accounts, depending on the group size and the statistical credibility of the experience that varies by product.

Premiums for group universal life insurance products consist of mortality and administrative charges assessed against the policyholder's fund balance. Interest credited and mortality charges for group universal life may be adjusted prospectively to reflect expected interest and mortality experience. Mortality charges are subject to maximum guaranteed rates and interest credited on cash values is subject to minimum guaranteed rates as stated in the policy.

The premiums for these products are typically collected within the coverage year and then invested in assets that match the duration of the expected benefit payments that occur over many future years (primarily for disability benefits). With significant investments in longer-duration securities, net investment income is a critical element of profitability for this segment.

The effectiveness of return-to-work programs and morbidity levels will impact the profitability of disability insurance products. Our claim experience and industry data indicate a correlation between disability claim incidence levels and economic conditions, with submitted claims rising under adverse economic conditions, although the extent of this impact is unclear. For life insurance products, the degree to which future experience deviates from mortality and expense assumptions also affects profitability.

To reduce our exposure to large individual and catastrophic losses under group life, disability and accidental death policies, as well as our more recent accidental injury and critical illness policies, we purchase reinsurance from a diverse group of unaffiliated reinsurers. Our comprehensive reinsurance program consists of excess of loss treaties and catastrophe coverage designed to mitigate earnings volatility and provide surplus protection.

Market Segments

- ***Commercial.*** Commercial Market Segments are comprised of National, Middle Market and Select.
    - ***National.*** Multi-state employers with 5,000 or more U.S.-based, full-time employees.
    - ***Middle Market.*** Employers generally with 250 to 4,999 U.S.-based, full-time employees.
    - ***Select.*** Employers generally with up to 249 eligible employees.

Primary Distribution Channels

- ***Insurance Broker and Consultants.*** Sales representatives distribute our products and services to a broad group of insurance brokers and consultants across the United States.

- ***Direct.*** Sales representatives distribute our products and services directly to employers, unions and other groups or individuals across the United States. This may take the form of in-person contact, telephonic or group selling venues.

Competition

The principal competitive factors that affect the Group Disability and Life segment are underwriting and pricing, the quality and effectiveness of claims management, relative operating efficiency, investment and risk management, distribution methodologies and producer relations, the breadth and variety of products and services offered, the quality of customer service and, more importantly, the state of the tools and technology available for customers, clients, consultants and producers. For certain products with longer-term liabilities, such as group long-term disability insurance, the financial strength of the insurer, as indicated by ratings issued by nationally recognized rating agencies, is also a competitive factor.

- ***National Insurers.*** Unum, The Hartford, Prudential, Lincoln and MetLife compete with us on a variety of products and regions throughout the United States.

Industry Developments

Employers have expressed a growing interest in employee wellness, absence management and productivity, and recognize a strong link between employee health productivity and profitability. As this interest grows, we believe our healthy lifestyle and return-to-work programs and integrated family medical leave, disability and health care programs position us to deliver integrated solutions for employers and employees. Our strong disability management portfolio and fully integrated programs also provide tools for employers and employees to improve health status. Our focus on managing employees' total absence enables us to increase the number and effectiveness of interventions and minimize disabling events.

The group insurance market remains highly competitive as the rising cost of medical coverage has forced companies to re-evaluate their overall employee benefit spending, resulting in lower volumes of group disability and life insurance business and more competitive pricing. Demographic shifts have further driven demand for products and services that are sufficiently flexible to meet the evolving needs of employers and employees who want innovative, cost-effective insurance solutions, and employers continue to move towards greater employee participatory coverage and voluntary purchases. As the market becomes more retail-focused, our broad suite of voluntary offerings and continued focus on developing additional voluntary products and service capabilities positions us well to meet the needs of both employers and employees.

Over the past few years, there has been heightened review by state regulators of the claims handling practices within the disability and life insurance industry. This has resulted in an increase in coordinated, multi-state examinations that target specific market practices in addition to regularly recurring examinations of an insurer's overall operations conducted by an individual state's regulators. We have been subject to such an examination over the past several years. See Note 19D. to our Consolidated Financial Statements for additional information.

The lower level of interest rates in the United States over the last several years has constrained earnings growth in this segment due to lower yields on our fixed-income investments and higher benefit expenses resulting from the discounting of future claim payments at lower interest rates.

Other Operations

Other Operations includes the following:

Corporate-owned Life Insurance

The principal products of the COLI business are permanent insurance contracts sold to corporations to provide coverage on the lives of certain employees for the purpose of financing employer-paid future benefit obligations. Permanent life insurance provides coverage that, when adequately funded, does not expire after a term of years. The contracts are primarily non-participating universal life policies. Fees for universal life insurance products consist primarily of mortality and administrative charges assessed against the policyholder's fund balance. Interest credited and mortality charges for universal life and mortality charges on variable universal life may be adjusted prospectively to reflect expected interest and mortality experience. To reduce our exposure to large individual and catastrophe losses, we purchase reinsurance from unaffiliated reinsurers.

Run-off Settlement Annuity Business

Our settlement annuity business is a closed, run-off block of single premium annuity contracts. These contracts are primarily liability settlements with approximately 20% of the liabilities associated with guaranteed payments not contingent on survivorship. Non-guaranteed payments are contingent on the survival of one or more parties involved in the settlement.

Run-off Reinsurance

Our reinsurance operations are an inactive business in run-off.

In February 2013, we effectively exited the guaranteed minimum death benefit ("GMDB") and guaranteed minimum income benefit ("GMIB") business by reinsuring 100% of our future exposures, net of retrocessional arrangements in place at that time, up to a specified limit. For additional information regarding this reinsurance transaction and the arrangements that secure our reinsurance recoverables, see Note 8 to our Consolidated Financial Statements.

Individual Life Insurance and Annuity and Retirement Benefits Businesses

This business includes deferred gains recognized from the 1998 sale of the individual life insurance and annuity business and the 2004 sale of the retirement benefits business. For more information regarding the arrangements that secure our reinsurance recoverables for the retirement benefits business, see Note 8 to our Consolidated Financial Statements.

Certain International Run-off Businesses

Certain European, Middle Eastern and Canadian operations are in run-off and included in Other Operations.

Investment Management

General Accounts

Our investment operations provide investment management and related services for our corporate invested assets and the insurance-related invested assets in our General Account ("General Account Invested Assets"). We acquire or originate, directly or through intermediaries, a broad range of investments including private placement and public securities, commercial mortgage loans, real estate, mezzanine, private equity partnerships and short-term investments. Invested assets also include policy loans that are fully collateralized by insurance policy cash values. Invested assets are managed primarily by our subsidiaries and, to a lesser extent, external managers with whom our subsidiaries contract. Net investment income is included as a component of adjusted income from operations for each of our segments and Corporate. Realized investment gains (losses) are reported by segment but excluded from adjusted income from operations. For additional information about invested assets, see the "Investment Assets" section of the MD&A beginning on page 61 and Notes 9 and 10 of our Consolidated Financial Statements.

We manage our investment portfolios to reflect the underlying characteristics of related insurance and contractholder liabilities and capital requirements, as well as regulatory and tax considerations pertaining to those liabilities and state investment laws. Insurance and contractholder liabilities range from short duration health care products to longer term obligations associated with disability and life insurance products and the run-off settlement annuity business. Assets supporting these liabilities are managed in segregated investment portfolios to facilitate matching of asset durations and cash flows to those of corresponding liabilities. Investment strategy and results are affected by the amount and timing of cash available for investment, competition for investments, economic conditions, interest rates and asset allocation decisions. We routinely monitor and evaluate the status of our investments, obtaining and analyzing relevant investment-specific information and assessing current economic conditions, trends in capital markets and other factors such as industry sector, geographic and property-specific information.

Separate Accounts

Our subsidiaries or external advisors manage invested assets of Separate Accounts on behalf of contractholders, including the Cigna Pension Plan, variable universal life products sold through our corporate-owned life insurance business, and other disability and life products. These assets are legally segregated from our other businesses and are not included in General Account Invested Assets. Income, gains and losses generally accrue directly to the contractholders.

Investing in Innovation

In addition to the portfolio investments in our general and separate accounts discussed above that support our insurance operations, in 2018, we began targeted investing within the health care industry specifically. Our recently-formed Cigna Ventures unit has been allotted $250 million to invest in promising startups and growth-stage companies that create new growth possibilities in health care. These targeted investments bring improved care quality, affordability, choice and greater simplicity to customers, patients and clients by harnessing transformative ideas in: 1) insights and analytics; 2) digital health and retail; and 3) care delivery and management.

Regulation

The laws and regulations governing our business continue to increase each year and are subject to frequent change. We are regulated by federal, state and international regulatory agencies that generally have discretion to issue regulations and interpret and enforce laws and rules. These regulations can vary significantly from jurisdiction to jurisdiction, and the interpretation of existing laws and rules also may change periodically. Domestic and international governments continue to enact and consider various legislative and regulatory proposals that could materially impact the health care system.

Many aspects of our business are directly regulated by federal and state laws and administrative agencies, such as HHS, CMS, the Internal Revenue Service ("IRS"), the Departments of Labor ("DOL"), Treasury and Justice ("DOJ"), the Securities and Exchange Commission ("SEC"), state departments of insurance and state boards of pharmacy. Our business practices may also be shaped by judicial decisions.

In addition, aspects of our business are subject to indirect regulation. The self-funded benefit plans sponsored by our employer clients are regulated under federal law. These self-funded clients expect us to assure that our administration of their plans complies with the regulatory requirements applicable to them.

Our business operations and the books and records of our regulated businesses are routinely subject to examination at regular intervals by state insurance and HMO regulatory agencies, state boards of pharmacy, CMS, DOL, IRS and comparable international regulators to assess compliance with applicable laws and regulations. Our operations are also subject to non-routine examinations and investigations by various state and federal regulatory agencies, generally as the result of a complaint. In addition, we may be implicated in investigations of our clients whose group benefit plans we administer on their behalf. As a result, we routinely receive subpoenas and other demands or requests for information from various state insurance and HMO regulatory agencies, state attorneys general, the Office of Inspector General ("OIG"), the DOJ, the DOL and other state, federal and international authorities. We may also be called upon to provide information by members of the U.S. Congress, including testifying before congressional committees and subcommittees regarding certain of our business practices. If Cigna is determined to have failed to comply with applicable laws or regulations, these examinations, investigations, reviews, subpoenas and demands may:

- result in fines, penalties, injunctions, consent orders or loss of licensure;
- require changes in business practices;
- damage relationships with the agencies that regulate us and affect our ability to secure regulatory approvals necessary for the operation of our business; or
- damage our brand and reputation.

Our international subsidiaries are subject to regulations in international jurisdictions where foreign insurers may face more rigorous regulations than their domestic competitors.

The laws and regulations governing our business, as well as the related interpretations, are subject to frequent change and can be inconsistent or in conflict with each other. For a discussion of the risks related to our compliance with these laws and regulations see the Risk Factors section located in Part 1, Item 1A of the Form 10-K. Management continues to be actively engaged with regulators and policymakers with respect to legislation and rule-making. See the "Executive Overview – Health Care Industry Developments and Other Matters Affecting our Integrated Medical and Health Services Segments" section of our MD&A located in Part II, Item 7 of the Form 10-K for a discussion of the anticipated impact of certain recent industry developments.

Patient Protection and the Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (ACA) mandated broad changes affecting many aspects of the health care system. The ACA affects many aspects of health care, including insured and self-insured health benefit plans and pharmacy benefit managers. Our business model is impacted by the ACA, including our relationships with current and future producers and health care providers, products, service providers and technologies. Key provisions of the ACA include the imposition of a non-tax deductible health insurance industry fee and other assessments on health insurers, the creation of health insurance exchanges for individuals and small group employers to purchase insurance coverage and minimum loss ratios for our commercial and Medicare Part D business. Other provisions of the ACA in effect include reduced Medicare Advantage premium rates, the requirement to cover preventive services with no enrollee cost-sharing, banning the use of lifetime and annual limits on the dollar amount of essential health benefits, increasing restrictions on rescinding coverage, extending coverage of dependents up to age 26, enforcement mechanisms and rules related to healthcare fraud and abuse enforcement activities and certain pharmacy benefit transparency requirements. The employer mandate requires employers with 50 or more full-time employees to offer affordable health insurance that provides minimum value (each as defined under the ACA) to full-time employees and their dependents, including children up to age 26, or be subject to penalties based on employer size. The ACA also changed certain tax laws to effectively limit tax deductions for certain employee compensation paid by health insurers.

Since its adoption, there have been several attempts to repeal or limit the utility of the ACA. The current administration has issued several executive orders and approved legislative changes that affect the ACA, the impacts of which are not yet fully known. Among other things, these actions restricted agencies from taking certain actions that would impose a fiscal burden on any state, individual, provider, insurer, recipient of health care services, purchaser of health insurance or maker of medical devices, products or medications; and stopped payment of cost-sharing reduction subsidies to insurers. In December 2017, U.S. tax reform legislation was signed into law that, among other things, reduced the "individual mandate" penalty for individuals without health insurance to zero dollars, effective January 1, 2019. As a result of this change, a federal district court has ruled that the "individual mandate" is unconstitutional thereby leaving in doubt whether the entire ACA is unconstitutional until there is a final judicial determination on appeal.

Additionally, in 2017, the current administration issued an executive order asking the DOL to revise the Employee Retirement Income Security Act of 1974, as amended ("ERISA") regulations to make it easier for employers, particularly small employers, to associate for the purpose of sponsoring large group health plans and thereby avoid the ACA's small group market reform (e.g., community-rating and mandated coverage of essential health benefits) that impaired the affordability of providing health coverage to their employees. In the spring of 2018, the DOL issued final rules that revised the definition of "employer" in the ERISA rules to make it easier for employers, including self-employed individuals, to form bona fide employer groups, all of whose employees would be counted in determining whether they were small or large groups for purposes of the ACA. While the regulation of these groupings by state insurance departments is not affected by the DOL's final association health plan rules, the final rules have resulted in an increase in interest among employers, associations, producers and benefit consultants in forming new groupings for purposes of offering insured or self-funded group health plans.

Medicare and Medicaid Regulations

Through our subsidiaries, we offer individual and group Medicare Advantage, Medicare Pharmacy (Part D) and Medicare Supplement products. We also provide Medicare Part D-related products and services to other Medicare Part D sponsors, Medicare Advantage Prescription Drug Plans and other employers and clients offering Medicare Part D benefits to Medicare Part D eligible beneficiaries. As part of our Medicare Advantage and Medicare Part D business, we contract with CMS to provide services to Medicare beneficiaries. As a result, our ability to obtain payment (and the determination of the amount of such payments), market to, enroll and retain members and expand into new service areas is subject to compliance with CMS' numerous and complex regulations and requirements that are frequently modified and subject to

administrative discretion. Our Medicaid and dual-eligible products are regulated by CMS. State Medicaid agencies audit our performance to determine compliance with contracts and regulations.

CMS evaluates Medicare Advantage plans and Part D plans under its "Star Rating" system. The Star Rating system considers various measures adopted by CMS, including, for example, quality of care, preventative services, chronic illness management, coverage determinations and appeals and customer satisfaction. A plan's Star Rating affects its image in the market and plans that perform very well are able to market more effectively and for longer periods of time than other plans. Medicare Advantage plans' quality-bonus payments are determined by the Star Rating, with plans receiving a rating of four or more stars eligible for such payments. The Star Rating system is subject to change annually by CMS, which may make it more difficult to achieve four stars or greater.

CMS uses a risk-adjustment model which adjusts premiums paid to Medicare Advantage plans according to customers' health status. The risk-adjustment model generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to Medicare Advantage plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on our estimated cost of providing standard Medicare-covered benefits to an enrollee with a "national average risk profile." That baseline payment amount is adjusted to reflect the health status of our enrolled membership. Under the risk-adjustment methodology, Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to the plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program.

On November 1, 2018, CMS released a proposed rule titled "Proposed Rule on Changes to MA and Part D Programs for CY 2020 and 2021" (the "MAPD Proposed Rule") that would revise its Risk Adjustment Data Validation ("RADV") methodology by, among other things, excluding an adjustment for underlying fee-for-service data errors (FFS Adjuster) and extrapolating RADV results at the contract level. On November 30, 2018, CMS released proposed rules titled "Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses" (the "Proposed Part D Rule") that focused on drug pricing, including a proposal to amend the definition of "negotiated price" in Part D to require Part D plans to apply pharmacy price concessions at the point of sale when calculating a Part D beneficiary's copayment. The Proposed MAPD Rule and the Proposed Part D Rule are subject to revision through the comment process.

In February 2019, CMS proposed rules to support the seamless and secure access, exchange and use of electronic health information. In the proposed rules, CMS proposes requirements that Medicaid, the Children's Health Insurance Program, Medicare Advantage plans and qualified health plans in the federally-facilitated exchanges provide enrollees with immediate electronic access to medical claims and other health information electronically by 2020. This proposed rule is subject to revision through a comment process.

Non-compliance with these laws and regulations may result in significant consequences, including fines and penalties, enrollment sanctions, exclusion from the Medicare and Medicaid programs, limitations on expansion, and criminal penalties.

False Claims Act and Anti-Kickback Laws

Our products and services are subject to numerous laws and regulations, including the federal False Claims Act (the "False Claims Act") and federal and state anti-kickback laws. Additionally, the federal government has made investigating and prosecuting health care fraud, waste and abuse a priority. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks in return for customer referrals, billing for unnecessary medical services, upcoding and improper marketing. The regulations and contractual requirements in this area are complex, are frequently modified, and are subject to administrative discretion and judicial interpretation.

False Claims Act and Related Criminal Provisions. The False Claims Act imposes civil penalties for knowingly making or causing to be made false claims or false records or statements with respect to governmental programs, such as Medicare and Medicaid, to obtain reimbursement or for failure to return overpayments. Private individuals may bring qui tam or "whistleblower" suits against providers under the False Claims Act, which authorizes the payment of a portion of any recovery to the individual bringing suit. The ACA amended the federal anti-kickback laws to state any claim submitted to a federal or state healthcare program which violates the anti-kickback laws is also a false claim under the False Claims Act. The False Claims Act generally provides for the imposition of civil penalties and for treble damages, resulting in the possibility of substantial financial liabilities. Criminal statutes similar to the False Claims Act provide that if a corporation is convicted of presenting a claim or making a statement it knows to be false, fictitious or fraudulent to any federal agency, the corporation may be fined. Conviction under these statutes may also result in exclusion from participation in federal and state healthcare programs. Many states have also enacted laws similar to the False Claims Act, some of which may include criminal penalties, substantial fines and treble damages.

Anti-Kickback and Referral Laws. Subject to certain exceptions and "safe harbors," the federal anti-kickback statute generally prohibits, among other things, knowingly and willfully paying, receiving or offering any payment or other remuneration to induce a person to purchase, lease, order or arrange for items (including prescription drugs) or services reimbursable in whole or in part under Medicare, Medicaid or another federal healthcare program. Many states have similar laws, some of which apply similar anti-kickback prohibitions to items or services reimbursable by non-governmental payors. Sanctions for violating these federal and state anti-kickback laws may include criminal and civil fines and exclusion from participation in the federal and state healthcare programs.

Anti-kickback laws have been cited as a partial basis, along with state consumer protection laws described below, for investigations and multi-state settlements relating to financial incentives provided by drug manufacturers to pharmacies and/or payors in connection with "product conversion" or promotion programs. Other anti-kickback laws may be applicable to arrangements with pharmaceutical manufacturers, such as the Public Contracts Anti-Kickback Act, the ERISA Health Plan Anti-Kickback Statute, the federal "Stark Law" and various state anti-kickback restrictions.

In February 2019, HHS proposed changes to the federal anti-kickback safe harbor to exclude regulatory protection for rebates between drug manufacturers and Medicare Part D plans, Medicaid managed care organizations and pharmacy benefit managers in the context of these government programs. The proposed regulations in their current form apply solely to Medicare Part D and Medicaid programs, which include our Government business in the Integrated Medical segment. The proposed regulations also seek to create new safe harbor protections for fixed fee services arrangements between drug manufacturers and pharmacy benefit managers, as well as protections for discounts offered at

the point of sale. HHS has stated that it does not intend for the proposal to have an effect on existing protections for value-based arrangements between manufacturers and plan sponsors under Medicare Part D and Medicaid MCOs. While legislative and regulatory discussions on the other issues raised in the blueprint continue to be the subject of legislative and regulatory activity, they have yet to be implemented in any form.

Federal Civil Monetary Penalties Law. The federal civil monetary penalty statute provides for civil monetary penalties against any person who gives something of value to a Medicare or Medicaid program beneficiary which the person knows or should know is likely to influence the beneficiary's selection of a particular provider for Medicare or Medicaid items or services. Under this law, our wholly-owned home delivery pharmacies, specialty pharmacies and home health providers are restricted from offering certain items of value to influence a Medicare or Medicaid patient's use of services. The ACA also includes several civil monetary provisions, such as penalties for the failure to report and return a known overpayment and failure to grant timely access to the OIG under certain circumstances.

Federal and State Oversight of Government-Sponsored Health Care Programs

Participation in government-sponsored health care programs subjects us to a variety of federal and state laws and regulations and risks associated with audits conducted under these programs. These audits may occur years after the provision of services. Risks include potential fines and penalties, restrictions on our ability to participate or expand our presence in certain programs and restrictions on marketing our plans. For example, with respect to our Medicare Advantage business, CMS and the OIG perform audits to determine a health plan's compliance with federal regulations and contractual obligations, including program audits and compliance with proper coding practices (sometimes referred to as "Risk Adjustment Data Validation Audits" or "RADV audits").

Separately, the DOJ is currently conducting an industry review of the risk adjustment data submission practices and business processes, including review of medical charts, of Cigna and a number of other Medicare Advantage organizations under Medicare Parts C and D.

For our Medicare Part D business, compliance with fraud and abuse enforcement practices is monitored through Recovery Audit Contractor audits in which third-party contractors conduct post-payment reviews on a contingency fee basis to detect and correct improper payments.

Government Procurement Regulations

We have a contract with the DoD, which subjects us to all of the applicable Federal Acquisition Regulations ("FAR") and the DoD FAR Supplement, which govern federal government contracts. Further, there are other federal and state laws applicable to our DoD arrangement and our arrangements with other clients that may be subject to government procurement regulations. In addition, certain of our clients participate as contracting carriers in the Federal Employees Health Benefits Program administered by the Office of Personnel Management, which includes various pharmacy benefit management standards.

Employee Retirement Income Security Act

Our domestic subsidiaries sell most of their products and services to sponsors of employee benefit plans that are governed by ERISA. ERISA is a complex set of federal laws and regulations enforced by the IRS and the DOL, as well as the courts. ERISA regulates certain aspects of the relationship between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Certain of our domestic subsidiaries are also subject to requirements imposed by ERISA affecting claim payment and appeals procedures for individual health insurance and insured and self-insured group health plans and for the insured dental, disability, life and accident plans we administer. Certain of our domestic subsidiaries also may contractually agree to comply with these requirements on behalf of the self-insured dental, disability, life and accident plans they administer. We believe the conduct of our pharmacy benefit management business is not generally subject to the fiduciary obligations of ERISA. However, there can be no assurances that the DOL may not assert that pharmacy benefit managers are fiduciaries. From time to time, states have considered legislation to declare a pharmacy benefit manager or medical benefit manager a fiduciary with respect to its clients.

Plans subject to ERISA can also be subject to state laws and the legal question of whether and to what extent ERISA preempts a state law will continue to be subject to court interpretation.

Privacy, Security and Data Standards Regulations

Many of our activities involve the receipt or use of confidential health and other personal information. In addition, we use aggregated and de-identified data for our own research and analysis purposes and, in some cases, provide access to such data to pharmaceutical manufacturers and third-party data aggregators.

The federal Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") impose minimum standards on health insurers, pharmacy benefit managers, HMOs, health plans, health care providers and clearinghouses for the privacy and security of protected health information. HIPAA also established rules that standardize the format and content of certain electronic transactions, including, but not limited to, eligibility and claims.

The Health Information Technology for Economic and Clinical Health Act ("HITECH") imposes additional contracting requirements for covered entities, the extension of privacy and security provisions to business associates, the requirement to provide notification to various parties in the event of a data breach of protected health information, and enhanced financial penalties for HIPAA violations, including potential criminal penalties for individuals. In the conduct of our business, depending on the circumstances, we may act as either a covered entity or a business associate.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law.

A number of states have adopted data security laws and regulations regulating data security and requiring security breach notification that may apply to us in certain circumstances and are increasingly focused on protecting individuals from identity theft. Neither HIPAA nor the Gramm-Leach-Bliley privacy regulations preempt more stringent state laws and regulations. In addition, international laws, rules and regulations governing the use and disclosure of personal information are generally more stringent than in the United States, and they vary from jurisdiction to jurisdiction.

The Cybersecurity Information Sharing Act of 2015 ("CISA") encourages organizations to share cyber threat indicators with the federal government and, among other things, directs HHS to develop a set of voluntary cybersecurity best practices for organizations in the health care industry. States have also begun to issue regulations specifically related to cybersecurity. In October 2017, the National Association of Insurance Commissioners ("NAIC"), an organization of state insurance regulators, adopted the Insurance Data Security Model Law that creates rules for insurers and other covered entities addressing data security, investigation and notification of breaches. This includes maintaining an information security program based on ongoing risk assessment, overseeing third-party service providers, investigating data breaches and notifying regulators of a cybersecurity event. As the model law is intended to serve as model legislation only, states will need to enact legislation for the model law to become mandatory and enforceable. We will continue to monitor states' activity regarding cybersecurity regulation.

The European Union's General Data Protection Regulation ("GDPR"), which became enforceable in May 2018, introduced a number of new obligations regarding the handling of personal data of European customers. GDPR provides certain individual privacy rights to certain persons whose data we may store and provides for greater penalties for non-compliance than previous European data protection laws. In addition, many countries outside of Europe where we conduct business are considering data protection laws and regulations that include requirements modeled after those in the GDPR.

Consumer Protection Laws

We engage in direct-to-consumer activities and are increasingly offering mobile and web-based solutions to our customers. We are therefore subject to federal and state regulations applicable to electronic communications and other consumer protection laws and regulations, such as the Telephone Consumer Protection Act and the CAN-SPAM Act. In particular, the Federal Trade Commission is increasingly exercising its enforcement authority in the areas of consumer privacy and data security, with a focus on web-based, mobile data and "big data." Federal consumer protection laws may also apply in some instances to privacy and security practices related to personally identifiable information.

Most states have consumer protection laws that have been the basis for investigations and multi-state settlements relating to financial incentives provided by drug manufacturers to retail pharmacies in connection with product conversion programs. Such statutes have also been cited as the basis for claims or investigations by state attorneys general relative to privacy and data security.

Office of Foreign Assets Control Sanctions and Anti-Money Laundering

We are also subject to regulation by the Office of Foreign Assets Control of the Department of the Treasury that administers and enforces economic and trade sanctions against targeted foreign countries and regimes based on U.S. foreign policy and national security goals.

Certain of our products are subject to the Department of the Treasury anti-money laundering regulations under the Bank Secrecy Act.

In addition, we may be subject to similar regulations in non-U.S. jurisdictions in which we operate.

Corporate Practice of Medicine and Other Laws

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

Network Access Legislation

A majority of states now have some form of legislation affecting our ability, or our clients' ability, to limit access to a pharmacy provider network or remove a provider from a network. Such legislation may require us or our clients to admit any retail pharmacy or provider willing to meet the plan's terms and conditions for network participation ("any willing provider" legislation) or may direct that a provider may not be removed from a network except in compliance with certain procedures ("due process" legislation).

Certain states have enacted legislation prohibiting certain pharmacy benefit management clients from imposing additional co-payments, deductibles, limitations on benefits, or other conditions ("Conditions") on covered individuals utilizing a retail pharmacy when the same Conditions are not otherwise imposed on covered individuals utilizing home delivery pharmacies. However, the legislation requires the retail pharmacy to agree to the same reimbursement amounts and terms and conditions as are imposed on the home delivery pharmacies. An increase in the number of prescriptions filled at retail pharmacies may have a negative impact on the number of prescriptions filled through home delivery. We anticipate additional states will consider similar legislation.

Legislation Affecting Plan Design

Some states have enacted legislation that prohibits managed care plan sponsors from implementing certain restrictive benefit plan design features, and many states have introduced legislation to regulate various aspects of managed care plans, including provisions relating to the

pharmacy benefit. For example, some states, under so-called "freedom of choice" legislation, provide members of the plan may not be required to use network providers, but must instead be provided with benefits even if they choose to use non-network providers. Some states have also enacted legislation, which, as described above, can negatively impact the use of cost-saving network configurations for plan sponsors. Other states have enacted legislation purporting to prohibit health plans from offering members financial incentives for use of home delivery pharmacies. Medicare and some states have issued guidance and regulations which limit our ability to fill or refill prescriptions electronically submitted by a physician to our home delivery pharmacy without first obtaining consent from the patient. Such restrictions generate additional costs and limit our ability to maximize efficiencies which could otherwise be gained through the electronic prescription and automatic refill processes. Legislation has been introduced in some states to prohibit or restrict therapeutic intervention, or to require coverage of all Food and Drug Administration approved drugs. Other states mandate coverage of certain benefits or conditions, and require health plan coverage of specific drugs if deemed medically necessary by the prescribing physician. States are also standardizing the process for, and restricting the use of, utilization management rules and shortening the time frames within which prescription drug prior authorization determinations must be made. Even where states do not regulate pharmacy benefit or utilization management companies directly, these laws will apply to many of our clients, including managed care organizations and health insurers.

Pharmacy Benefit Management and Drug Pricing Regulation

Our pharmacy benefit management services are subject to numerous laws and regulations. These laws and regulations govern, and proposed legislation and regulations may govern, critical practices, including disclosure, receipt and retention of rebates and other payments received from pharmaceutical manufacturers; the receipt and retention of transmission fees from contracted pharmacies; use of, administration of, and/or changes to drug formularies, maximum allowable cost list pricing, and/or clinical programs; disclosure of data to third parties; drug utilization management practices; the level of duty a pharmacy benefit manager owes its clients or customers; configuration of pharmacy networks; the operations of our subsidiary pharmacies; disclosure of negotiated provider reimbursement rates; disclosure of negotiated drug rebates, calculation of customer cost share for prescription drug claims; disclosure of fees associated with administrative service agreements and patient care programs that are attributable to customers' drug utilization; and registration or licensing of pharmacy benefit managers. Some states have adopted so-called "most favored nation" legislation which provides that a pharmacy participating in the state Medicaid program must give the state the best price the pharmacy makes available to any third-party plan.

Prescription drug pricing and the role of pharmacy benefit managers have been a focus of the current administration. In May 2018, the current administration announced a blueprint, titled "American Patients First," which considers a series of drug pricing proposals including, among other things, removal of the anti-kickback safe harbor protection for rebates between drug manufacturers and insurers and pharmacy benefit managers and improvements to pricing transparency. In October 2018, Congress enacted laws that prohibited pharmacy benefit managers and insurers from restricting pharmacies from providing drug pricing information to a plan enrollee when there is a difference between the cost of the drug under insurance and the cost of the drug when purchased without insurance. See also, "False Claims Act and Anti-Kickback Laws" for a discussion of HHS' proposed rule changes to the federal anti-kickback safe harbor to exclude regulatory protection for rebates between drug manufacturers and Medicare Part D plans, Medicaid managed care organizations and pharmacy benefit managers in the context of these government programs.

Some states have enacted statutes regulating the use of maximum allowable cost ("MAC") pricing. These statutes, referred to as "MAC Transparency Laws," generally require pharmacy benefit managers to disclose specific information related to MAC pricing to pharmacies and provide certain appeal rights for pharmacies. MAC Transparency Laws also restrict the application of MAC and may require operational changes to maintain compliance with the law. Some states have also enacted laws regulating pharmacy pricing and protecting the profitability of pharmacies for dispensing certain MAC-priced drugs. Some states have enacted laws requiring that the customer cost share for a prescription drug claim not exceed certain price points, such as the pharmacy's usual and customary charge or its contracted reimbursement for the drug.

In March 2018, the NAIC adopted changes to the Health Carrier Prescription Drug Benefit Management Model Act. The changes address issues relating to (i) transparency, accuracy and disclosure regarding prescription drug formularies and formulary changes during a policy year; (ii) accessibility of prescription drug benefits using a variety of pharmacy options; and (iii) tiered prescription drug formularies and discriminatory benefit design. While the actions of the NAIC do not have the force of law, they may influence states to adopt laws based on the model legislation.

The federal Medicaid rebate program requires participating drug manufacturers to provide rebates on all drugs reimbursed through state Medicaid programs, including through Medicaid managed care organizations. Manufacturers of brand name products must provide a rebate equivalent to the greater of (a) 23.1% of the average manufacturer price ("AMP") paid by retail community pharmacies or by wholesalers for certain drugs distributed to retail community pharmacies, or (b) the difference between AMP and the "best price" available to essentially any customer other than the Medicaid program and certain other government programs, with certain exceptions. We negotiate rebates with drug manufacturers and, in certain circumstances, sell services to drug manufacturers. Investigations are being and have been conducted by certain governmental entities which call into question whether a drug's "best price" was properly calculated and reported with respect to rebates paid by the manufacturers to the Medicaid programs. We are not responsible for such calculations, reports or payments.

Pharmacy Regulation

Our home delivery and specialty pharmacies are licensed to do business as a pharmacy in the states in which they are located. Most of the states into which we deliver pharmaceuticals have laws that require out-of-state home delivery pharmacies to register with, or be licensed by, the board of pharmacy or a similar regulatory body in the state. These states generally permit the pharmacy to follow the laws of the state in which the home delivery service is located, although some states require compliance with certain laws in that state as it impacts or relates to drugs distributed or dispensed into those states.

Our various pharmacy facilities also maintain certain Medicare and state Medicaid provider numbers as pharmacies providing services under these programs. Participation in these programs requires our pharmacies to comply with the applicable Medicare and Medicaid provider rules and regulations, and exposes the pharmacies to various changes the federal and state governments may impose regarding reimbursement methodologies and amounts to be paid to participating providers under these programs. In addition, several of our pharmacy facilities are

participating providers under Medicare Part D and, as a condition to becoming a participating provider under Medicare Part D, the pharmacies are required to adhere to certain requirements applicable to Medicare Part D.

Other statutes and regulations affect our home delivery and specialty pharmacy operations, including the federal and state anti-kickback laws and the federal civil monetary penalty law described above. Federal and state statutes and regulations govern the labeling, packaging, advertising, adulteration and security of prescription drugs and the dispensing of controlled substances. The Federal Trade Commission requires mail order sellers of goods generally to engage in truthful advertising, to stock a reasonable supply of the product to be sold, to fill mail orders within thirty days and to provide clients with refunds when appropriate. The United States Postal Service also has significant statutory authority to restrict the delivery of drugs and medicines through the mail.

Financial Reporting, Internal Control and Corporate Governance

Regulators closely monitor the financial condition of licensed insurance companies and HMOs. States regulate the form and content of statutory financial statements, the type and concentration of permitted investments, and corporate governance over financial reporting. Our insurance and HMO subsidiaries are required to file periodic financial reports and schedules with regulators in most of the jurisdictions in which they do business as well as annual financial statements audited by independent registered public accounting firms. Certain insurance and HMO subsidiaries are required to file an annual report of internal control over financial reporting with most jurisdictions in which they do business. Insurance and HMO subsidiaries' operations and accounts are subject to examination by such agencies. Many states have expanded regulations relating to corporate governance and internal control activities of insurance and HMO subsidiaries as a result of model regulations adopted by the NAIC with elements similar to corporate governance and risk oversight disclosure requirements under federal securities laws.

Guaranty Associations, Indemnity Funds, Risk Pools and Administrative Funds

Most states and certain non-U.S. jurisdictions require insurance companies to support guaranty associations or indemnity funds that are established to pay claims on behalf of insolvent insurance companies. Some states have similar laws relating to HMOs and other payors, such as consumer operated and oriented plans (co-ops) established under the ACA. In the United States, these associations levy assessments on member insurers licensed in a particular state to pay such claims. Certain states require HMOs to participate in guaranty funds, special risk pools and administrative funds. For additional information about guaranty funds and other assessments, see Note 19 to our Consolidated Financial Statements.

Certain states continue to require health insurers and HMOs to participate in assigned risk plans, joint underwriting authorities, pools or other residual market mechanisms to cover risks not acceptable under normal underwriting standards, although some states have eliminated these requirements as a result of the ACA.

Solvency and Capital Requirements

Many states have adopted some form of the NAIC model solvency-related laws and risk-based capital rules ("RBC rules") for life and health insurance companies. The RBC rules recommend a minimum level of capital depending on the types and quality of investments held, the types of business written and the types of liabilities incurred. If the ratio of the insurer's adjusted surplus to its risk-based capital falls below statutorily required minimums, the insurer could be subject to regulatory actions ranging from increased scrutiny to conservatorship.

In addition, various non-U.S. jurisdictions prescribe minimum surplus requirements that are based upon solvency, liquidity and reserve coverage measures. Our HMOs and life and health insurance subsidiaries, as well as non-U.S. insurance subsidiaries, are compliant with applicable RBC and non-U.S. surplus rules.

The Risk Management and Own Risk and Solvency Assessment Model Act ("ORSA"), adopted by the NAIC, provides requirements and principles for maintaining a group solvency assessment and a risk management framework and reflects a broader approach to U.S. insurance regulation. ORSA includes a requirement to file an annual ORSA Summary Report in the lead state of domicile. To date, an overwhelming majority of the states have adopted the same or similar versions of ORSA. We file our ORSA report annually as required.

Holding Company Laws

Our domestic insurance companies and certain of our HMOs are subject to state laws regulating subsidiaries of insurance holding companies. Under such laws, certain dividends, distributions and other transactions between an insurance company or an HMO subsidiary and its affiliates may require notification to, or approval by, one or more state insurance commissioners. In addition, the holding company acts of states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO subsidiary without prior regulatory approval.

Marketing, Advertising and Products

In most states, our insurance companies and HMO subsidiaries are required to certify compliance with applicable advertising regulations on an annual basis. Our insurance companies and HMO subsidiaries are also required by most states to file and secure regulatory approval of products prior to the marketing, advertising, and sale of such products.

Licensing and Registration Requirements

Certain subsidiaries contract to provide claim administration, utilization management and other related services for the administration of self-insured benefit plans. These subsidiaries may be subject to state third-party administration and other licensing requirements and regulation, as well as third-party accreditation requirements.

We have received full accreditation for Utilization Review Accreditation Commission Pharmacy Benefit Management version 2.2 Standards, which includes quality standards for drug utilization management, and select subsidiaries have received full accreditation for Utilization

Review Accreditation Commission for Health Utilization Management version 7.2, which includes quality standards for medical utilization management.

Certain states have adopted pharmacy benefit management registration and/or disclosure laws. In addition to registration laws, some states have adopted legislation mandating disclosure of various aspects of our financial practices, including those concerning pharmaceutical company revenue, as well as prescribing processes for prescription switching programs and client and provider audit terms.

Our international subsidiaries are often required to be licensed when entering new markets or starting new operations in certain jurisdictions. The licensure requirements for these subsidiaries vary by country and are subject to change.

International Regulations

Our operations outside the United States expose us to laws of multiple jurisdictions and the rules and regulations of various governing bodies and regulators, including those related to financial and other disclosures, corporate governance, privacy, data protection, data mining, data transfer, intellectual property, labor and employment, consumer protection, direct-to-consumer communications activities, tax, anti-corruption and anti-money laundering. Foreign laws and rules may include requirements that are different from, or more stringent than, similar requirements in the United States.

Our operations in countries outside the United States:

- are subject to local regulations of the jurisdictions where we operate;
- in some cases, are subject to regulations in the jurisdictions where customers reside; and
- in all cases, are subject to the Foreign Corrupt Practices Act (“FCPA”).

In particular, in South Korea where we are selling insurance products directly to individual customers, regulators are focused on protecting the rights of individual customers by enforcing “Treating Customers Fairly” concepts. This regulatory focus results in rigorous data localization requirements, network separation obligations, and system monitoring restrictions, as well as obligations to closely monitor marketing communications and sales scripts. Anti-money laundering requirements in South Korea and other Asian countries where we do business also impose obligations to collect certain information about each customer at time of sale and to risk rank each customer to determine possible future money laundering risk.

The FCPA prohibits offering, promising, providing or authorizing others to give anything of value to a foreign government official or employee to obtain or retain business or otherwise secure a business advantage. Outside of the United States, we may interact with government officials in several different capacities: as regulators of our insurance business; as clients or partners who are state-owned or partially state-owned; as health care professionals who are employed by the government; as hospitals that are state-owned; and as officials issuing permits in connection with real estate transactions. Violations of the FCPA and other anti-corruption laws may result in severe criminal and civil sanctions as well as other penalties, and the SEC and DOJ have increased their enforcement activities with respect to FCPA. The UK Bribery Act of 2010 applies to all companies with a nexus to the United Kingdom. Under this act, any voluntary disclosures of FCPA violations may be shared with United Kingdom authorities, thus potentially exposing companies to liability and potential penalties in multiple jurisdictions.

Miscellaneous

Premiums and fees from CMS represented 16% of our total consolidated revenues for the year ended December 31, 2018 under a number of contracts. We are not dependent on business from one or a few customers. Other than CMS, no one customer accounted for 10% or more of our consolidated revenues in 2018. We are not dependent on business from one or a few brokers or agents. In addition, our insurance businesses are generally not committed to accept a fixed portion of the business submitted by independent brokers and agents, and generally all such business is subject to approval and acceptance.

We had approximately 73,800 employees as of December 31, 2018.

ITEM 1A. Risk Factors

As a large global health service company operating in a complex industry, we encounter a variety of risks and uncertainties that could have a material adverse effect on our business, liquidity, results of operations, financial condition or the trading price of our securities. You should carefully consider each of the risks and uncertainties discussed below, together with other information contained in this Annual Report on Form 10-K, including Management's Discussion and Analysis of Results of Operations and Financial Condition. These risks and uncertainties are not the only ones we face. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect us. The following risk factors have been organized by category for ease of use; however many of the risks may have impacts in more than one category. These categories, therefore, should be viewed as a starting point for understanding the significant risks facing us and not as a limitation on the potential impact of the matters discussed. Risk factors are not necessarily listed in order of importance.

Strategic and Operational Risks

Future performance of our business will depend on our ability to execute our strategic and operational initiatives effectively.

The future performance of our business will depend in large part on our ability to effectively implement and execute our strategic and operational initiatives. Successfully executing on these initiatives depends on a number of factors, including our ability to:

- differentiate our products and services from those of our competitors;
- develop and introduce new and innovative products or programs, particularly in response to government regulation and the increased focus on consumer-directed products;
- grow our commercial product portfolio;
- identify and introduce the proper mix or integration of products that will be accepted by the marketplace;
- identify products and solutions that focus on improving patient outcomes and assist in controlling costs;
- evaluate drugs for efficacy, value and price to assist clients in selecting a cost-effective formulary;
- offer cost-effective home delivery pharmacy and specialty services;
- leverage purchase volume to deliver discounts to health benefit providers;
- attract and retain sufficient numbers of qualified employees;
- attract, develop and maintain collaborative relationships with a sufficient number of qualified partners;
- attract new and maintain existing customer and client relationships;
- transition health care providers from volume-based fee-for-service arrangements to a value-based system;
- improve medical cost competitiveness in our targeted markets;
- manage our medical, pharmacy, administrative, and other operating costs effectively; and
- contract with pharmaceutical manufacturers and pharmacy providers on favorable terms.

For our strategic initiatives to succeed, we must effectively integrate our operations, including with Express Scripts and other acquired businesses, actively work to ensure consistency throughout the organization, and promote a global mind-set along with a focus on individual customers and clients. If we fail to do so, our business may be unable to grow as planned, or the result of expansion may be unsatisfactory. We will be unable to rapidly respond to competitive, economic and regulatory changes if we do not make important strategic and operational decisions quickly, define our appetite for risk specifically, implement new governance, managerial and organizational processes smoothly and communicate roles and responsibilities clearly. If these initiatives fail or are not executed on effectively, our consolidated financial position and results of operations could be negatively affected.

We operate in a highly competitive, evolving and rapidly changing industry and our failure to adapt could negatively impact our business.

The health service industry continues to be dynamic and rapidly evolving. Any significant shifts in the structure of the industry could alter industry dynamics and adversely affect our ability to attract or retain clients. Industry shifts could result (and have resulted) from, among other things:

- a large intra- or inter-industry merger or industry consolidation;
- strategic alliances;
- new or alternative business models;
- continuing consolidation among physicians, hospitals and other health care providers, as well as changes in the organizational structures chosen by physicians, hospitals and health care providers;
- new market entrants, including those not traditionally in the health service industry;
- the ability of larger employers and clients to contract directly with providers;

- technological changes and rapid shifts in the use of technology, such as telemedicine;
- the impact or consequences of legislation or regulatory changes;
- changes in the United States Postal Service or the consolidation of shipping carriers;
- increased drug acquisition cost or unexpected changes to drug pricing trend;
- change in the generic drug market or the failure of new generic drugs to come to market;
- a general decrease in drug utilization; or
- a general increase in utilization under risk-based contracts in the medical benefit management market.

Our failure to anticipate or appropriately adapt to changes in the industry could negatively impact our competitive position and adversely affect our business and results of operations.

Our failure to compete effectively to differentiate our products and services from those of our competitors and maintain or increase market share could materially adversely affect our results of operations, financial position and cash flows.

We operate in a highly competitive environment and an industry subject to significant market pressures brought about by customer and client needs, legislative and regulatory developments and other market factors. In particular markets, our competitors may have greater, better or more established capabilities, resources, market share, reputation or business relationships, or lower profit margin or financial return expectations. Our clients are well informed and organized and can easily move between our competitors and us. Our Express Scripts client contracts generally have three-year terms. As described in greater detail in the description of our business in Item 1 above (see page 11 of this Form 10-K), one of our key clients in the Health Services segment is the United States Department of Defense. If one or more of our large clients either terminates or does not renew a contract for any reason, including as a result of being acquired, or if the provisions of a contract with a large client are modified, renewed or otherwise changed with terms less favorable to us, our results of operations could be adversely affected and we could experience a negative reaction in the investment community resulting in decreases in the trading price of our securities or other adverse effects.

Our success depends, in part, on our ability to compete effectively in our markets, set prices appropriately in highly competitive markets to keep or increase our market share, increase customers as planned, differentiate our business offerings by innovating and delivering products and services that provide enhanced value to our customers, provide quality and satisfactory levels of service, and retain accounts with favorable medical cost experience or more profitable products versus retaining or increasing our customer base in accounts with unfavorable medical cost experience or less profitable products.

We must remain competitive to attract new customers, retain existing customers, and further integrate additional product and service offerings. To succeed in this highly competitive marketplace, it is imperative we maintain a strong reputation. The negative reputational impact of a significant event, including a failure to execute on customer or client contracts or strategic or operational initiatives, or failure to innovate and deliver products and services that demonstrate greater value to our customers, could affect our ability to grow and retain profitable arrangements, which could have a material adverse effect on our business and results of operations.

We face price competition and other pressures that could compress our margins or result in premiums that are insufficient to cover the cost of services delivered to our customers.

While we compete on the basis of many service and quality-related factors, we expect that price will continue to be a significant basis of competition. Our client contracts are subject to negotiation as clients seek to contain their costs, including by reducing benefits offered. Increasingly, our clients seek to negotiate performance guarantees that require us to pay penalties if the guaranteed performance standard is not met. Clients can easily move between our competitors and us. Our clients are well-informed and typically have knowledgeable consultants that seek competing bids from our competitors before contract renewal. In addition, as brokers and benefit consultants seek to enhance their revenue streams, they look to take on services that we typically provide. Each of these events could negatively impact our financial results.

Further, federal and state regulatory agencies may restrict our ability to implement changes in premium rates. Fiscal or other concerns related to the government-sponsored programs in which we participate, such as Medicare, may cause decreasing reimbursement rates, delays in premium payments or insufficient increases in reimbursement rates. Any limitation on our ability to maintain or increase our premium or reimbursement levels, or a significant loss of customers or clients resulting from our need to increase or maintain premium or reimbursement levels, could adversely affect our business, cash flows, financial condition and results of operations.

Premiums in the Integrated Medical segment are generally set for one-year periods and are priced well in advance of the date on which the contract commences or renews. Our revenue on Medicare policies is based on bids submitted mid-year in the year before the contract year. Although we base the premiums we charge and our Medicare bids on our estimate of future health care costs over the contract period, actual costs may exceed what we estimate in setting premiums. Our health care costs also are affected by external events that we cannot forecast or project and over which we have little or no control, as well as changes in customers' health care utilization patterns and provider billing practices. Our profitability depends, in part, on our ability to accurately predict, price for and effectively manage future health care costs. Relatively small differences between predicted and actual medical costs or utilization rates as a percentage of revenue can result in significant changes in our financial results.

Strong competition within the pharmacy benefit business has also generated greater demand for lower product and service pricing, increased revenue sharing and enhanced product and service offerings. These competitive factors have historically applied pressure on our operating margins and caused many companies, including us, to reduce the prices charged for products and services while sharing with clients a greater portion of the formulary fees and related rebates received from pharmaceutical manufacturers. Our inability to maintain positive trends, or

failure to identify and implement new ways to mitigate pricing pressures, could negatively impact our ability to attract or retain clients or sell additional services, which could negatively impact our margins and have a material adverse effect on our business and results of operations.

The reserves we hold for expected medical claims are based on estimates that involve an extensive degree of judgment and are inherently variable. If actual claims exceed our estimates, our operating results could be materially adversely affected, and our ability to take timely corrective actions to contain future costs may be limited.

We maintain and record medical claims reserves on our balance sheet for estimated future payments. Our estimates of health care costs payable are based on a number of factors, including historical claim experience, but this estimation process requires extensive judgment. Considerable variability is inherent in such estimates, and the accuracy of the estimates is highly sensitive to changes in medical claims submission and processing patterns and/or procedures, changes in customer base and product mix, changes in the utilization of medical and/or other covered services, changes in medical cost trends, changes in our medical management practices and the introduction of new benefits and products. If we are not able to accurately and promptly anticipate and detect medical cost trends, our ability to take timely corrective actions to limit future costs and reflect our current benefit cost experience in our pricing process may be limited. Because establishing these reserves is an inherently uncertain process involving estimates of future losses, there can be no certainty that ultimate losses will not exceed existing medical claims reserves.

If we fail to develop and maintain satisfactory relationships with physicians, hospitals and other health service providers, our business and results of operations may be adversely affected.

We contract with physicians, hospitals and other health service providers and facilities to provide health services to our customers. Our results of operations are substantially dependent on our ability to contract for these services at competitive prices. In any particular market, physicians, hospitals and health service providers may enter into exclusive arrangements with competitors or simply refuse to contract with us, demand higher payments or take other actions that could result in higher medical costs or less desirable products or services for our customers. In some markets, certain providers, particularly hospitals, physician/hospital organizations and multi-specialty physician groups, may have significant or controlling market positions that could result in a diminished bargaining position for us. If providers refuse to contract with us, use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected. Establishing collaborative arrangements with physician groups, specialist groups, independent practice associations, hospitals and health care delivery systems is key to our strategic focus to transition from volume-based fee-for-service arrangements to a value-based health care system. If such collaborative arrangements do not result in the lower medical costs that we project or if we fail to attract health care providers to such arrangements, or are less successful at implementing such arrangements than our competitors, our attractiveness to customers may be reduced and our ability to profitably grow our business may be adversely affected.

Our ability to develop and maintain satisfactory relationships with providers may also be negatively impacted by other factors not associated with us, such as changes in Medicare and/or Medicaid reimbursement levels, increasing pressure on revenue and other pressures on health care providers and increasing consolidation activity among hospitals, physician groups and providers. Continuing consolidation among physicians, hospitals and other providers, the emergence of accountable care organizations, vertical integration of providers and other entities, changes in the organizational structures chosen by physicians, hospitals and providers and new market entrants, including those not traditionally in the health care industry, may affect the way providers interact with us and may change the competitive landscape in which we operate. In some instances, these organizations may compete directly with us, potentially affecting the way we price our products and services or cause us to incur increased costs if we change our operations to be more competitive.

Out-of-network providers are not limited by any agreement with us in the amounts they bill. While benefit plans place limits on the amount of charges that will be considered for reimbursement, out-of-network providers have become increasingly sophisticated and aggressive and such limitations can be difficult to enforce. As a result, the outcome of disputes where we do not have a provider contract may cause us to pay higher medical or other benefit costs than we projected.

If we lose our relationship with one or more key pharmaceutical manufacturers, or if the payments made or discounts provided by pharmaceutical manufacturers decline, our business and results of operations could be adversely affected.

We maintain contractual relationships with numerous pharmaceutical manufacturers, which provide us with, among other things:

- discounts for drugs we purchase to be dispensed from our home delivery and specialty pharmacies;
- discounts, in the form of rebates, for drug utilization;
- fees for administering rebate programs, including invoicing, allocating and collecting rebates;
- fees for services provided to pharmaceutical manufacturers by our specialty pharmacies; and
- access to limited distribution specialty pharmaceuticals by our specialty pharmacies.

Our contracts with pharmaceutical manufacturers are typically non-exclusive and terminable on relatively short notice by either party. The consolidation of pharmaceutical manufacturers, the termination or material alteration of our contractual relationships, or our failure to renew such contracts on favorable terms could have a material adverse effect on our business and results of operations. In addition, arrangements between payors and pharmaceutical manufacturers have been the subject of debate in federal and state legislatures and various other public and governmental forums. Adoption of new laws, rules or regulations or changes in, or new interpretations of, existing laws, rules or regulations, relating to any of these programs could materially adversely affect our business and results of operations.

If significant changes occur within the pharmacy provider marketplace, or if other issues arise with respect to our pharmacy networks, including the loss of or adverse change in our relationship with one or more key pharmacy providers, our business and financial results could be impaired.

More than 68,000 retail pharmacies, which represent over 99% of all United States retail pharmacies, participated in one or more of our networks as of December 31, 2018. The ten largest retail pharmacy chains represent approximately 61% of the total number of stores in our largest network. In certain geographic areas of the United States, our networks may be comprised of higher concentrations of one or more large pharmacy chains. Contracts with retail pharmacies are generally non-exclusive and are terminable on relatively short notice by either party. If one or more of the larger pharmacy chains terminates its relationship with us, or is able to renegotiate terms substantially less favorable to us, our customers' access to retail pharmacies and/or our business could be materially adversely affected. The entry of one or more additional large pharmacy chains into the pharmacy benefit management business, the consolidation of existing pharmacy chains or increased leverage or market share by the largest pharmacy providers could increase the likelihood of negative changes in our relationship with such pharmacies. Changes in the overall composition of our pharmacy networks, or reduced pharmacy access under our networks, could have a negative impact on our claims volume and/or our competitiveness in the marketplace, which could cause us to fall short of certain guarantees in our contracts with clients or otherwise impair our business or results of operations.

Changes in drug pricing or industry pricing benchmarks could materially impact our financial performance.

Contracts in the prescription drug industry, including our contracts with retail pharmacy networks and our pharmacy and specialty pharmacy clients, generally use "average wholesale price" or "AWP," which is published by a third party, as a benchmark to establish pricing for prescription drugs. If AWP is no longer published by third parties, we adopt other pricing benchmarks for establishing prices within the industry or future changes in drug prices substantially deviate from our expectations, the short- or long-term impacts may have a material adverse effect on our business and results of operations.

As a global company, we face political, legal, operational, regulatory, economic and other risks that present challenges and could negatively affect our multinational operations and/or our long-term growth.

As a global company, our business is increasingly exposed to risks inherent in foreign operations. These risks can vary substantially by market, and include political, legal, operational, regulatory, economic and other risks, including government intervention that we do not face in our U.S. operations. The global nature of our business and operations may present challenges including, but not limited to, those arising from:

- geopolitical business conditions and demands, including the June 2016 referendum in the United Kingdom to leave the European Union;
- regulation that may discriminate against U.S. companies, favor nationalization or expropriate assets;
- price controls or other pricing issues and exchange controls; restrictions that prevent us from transferring funds out of the countries in which we operate; foreign currency exchange rates and fluctuations and restrictions on converting currencies from foreign operations into other currencies; uncertainty with respect to the interpretation of tax positions;
- reliance on local employees and interpretations of labor laws in foreign jurisdictions;
- managing our partner relationships in countries outside of the United States;
- providing data protection on a global basis and sufficient levels of technical support in different locations;
- the global trend for companies to enact local data residency requirements;
- acts of war, terrorism, natural disasters or pandemics in locations where we operate; and
- general economic and political conditions.

These factors may increase in significance as we continue to expand globally and operating in new foreign markets may require considerable management time before operations generate any significant revenues and earnings. Any one of these challenges could negatively affect our operations or long-term growth. For example, due to the concentration of our international business in South Korea, the International Markets segment is exposed to potential losses resulting from economic and regulatory changes in that country and the geopolitical climate in the Korean Peninsula, as well as foreign currency movements affecting the South Korean currency, that could have a significant impact on the segment's results and our consolidated financial results.

International operations also require us to devote significant resources to implement controls and systems in new markets to comply with, and to ensure that our vendors and partners comply with, U.S. and foreign laws prohibiting bribery, corruption and money laundering, in addition to other regulations regarding, among other things, our products, direct-to-consumer communications, customer privacy, data protection and data residency. Violations of these laws and regulations could result in fines, criminal sanctions against us, our officers or employees, restrictions or outright prohibitions on the conduct of our business and significant reputational harm. Our success depends, in part, on our ability to anticipate these risks and manage these challenges. Our failure to comply with laws and regulations governing our conduct outside the United States or to establish constructive relations with non-U.S. regulators could have a material adverse effect on our business, results of operations, financial condition, liquidity and long-term growth.

We are dependent on the success of our relationships with third parties for various services and functions.

To improve operating costs, productivity and efficiencies, we contract with third parties for the provision of specific services. Our operations may be adversely affected if a third party fails to satisfy its obligations to us, if the arrangement is terminated in whole or in part or if there is a

contractual dispute between us and the third party. Even though contracts are intended to provide certain protections, we have limited control over the actions of third parties. For example, noncompliance with any privacy or security laws and regulations, any security breach involving one of our third-party vendors or a dispute between us and a third-party vendor related to our arrangement could have a material adverse effect on our business, results of operations, financial condition, liquidity and reputation.

Outsourcing also may require us to change our existing operations, adopt new processes for managing these service providers and/or redistribute responsibilities to realize the potential productivity and operational efficiencies. If there are delays or difficulties in changing business processes or our third-party vendors do not perform as expected, we may not realize, or not realize on a timely basis, the anticipated economic and other benefits of these relationships. This could result in substantial costs or regulatory compliance issues, divert management's attention from other strategic activities, negatively affect employee morale or create other operational or financial problems for us. Terminating or transitioning in whole or in part arrangements with key vendors could result in additional costs or penalties, risks of operational delays or potential errors and control issues during the termination or transition phase. We may not be able to find an alternative vendor in a timely manner or on acceptable terms. If there is an interruption in business or loss of access to data resulting from a security breach, termination or transition in services, we may not be able to meet the demands of our customers and, in turn, our business and results of operations could be adversely impacted.

A significant disruption in service within our operations or among our key suppliers or other third parties could materially adversely affect our business and results of operations.

Our business is highly dependent upon our ability to perform, in an efficient and uninterrupted fashion, necessary business functions, such as claims processing and payment, internet support and customer call centers, data centers and corporate facilities, processing new and renewal business, maintaining appropriate shipment and storage conditions for prescriptions (such as temperature and protection from contamination) and mail order processing. In some instances, our ability to provide services or products (including processing and dispensing prescriptions) depends on the availability of services and products provided by suppliers, pharmaceutical manufacturers, vendors or shipping carriers. Any failure or disruption of our performance of, or our ability to perform, key business functions, including through unavailability or cyber-attack of our information technology systems or those of third parties, could cause slower response times, decreased levels of service satisfaction and harm to our reputation. In addition, because our information technology and other systems interface with and depend on third-party systems, we could experience service denials if demand for such service exceeds capacity or a third-party system fails or experiences an interruption. Our failure to implement adequate business continuity and disaster recovery strategies could significantly reduce our ability to provide products and services to our customers and clients, which could have material adverse effects on our business and results of operations.

Acquisitions, including our acquisition of Express Scripts, joint ventures and other transactions involve risks and we may not realize the expected benefits because of integration difficulties, underperformance relative to our expectations and other challenges.

As part of our growth strategy, we regularly consider and enter into strategic transactions, including mergers, acquisitions, joint ventures, licensing arrangements and other relationships (collectively referred to as "strategic transactions"). Our ability to achieve the anticipated benefits of these strategic transactions is subject to numerous uncertainties and risks, including our ability to integrate operations, resources and systems, including data security systems, in an efficient and effective manner.

The success of the Express Scripts acquisition will depend, in part, on our ability to successfully combine the businesses of Cigna and Express Scripts and realize the anticipated benefits, including synergies, cost savings, innovation and operational efficiencies, from the combination. This integration is a complex, costly and time-consuming process, which may divert management's attention from ongoing business concerns.

Key risks of the Express Scripts integration include, but are not limited to, retaining existing clients and attracting new clients on profitable terms; maintaining employee morale and retaining key management and other employees; integrating two unique corporate cultures; consolidating corporate and administrative infrastructures and realizing operational synergies; integrating information technology, communications programs, financial procedures and operations, and other systems, procedures and policies; coordinating geographically separate organizations; managing tax costs or inefficiencies associated with integrating the operations of the combined company; and necessary modifications to internal financial control standards.

Integration activities may result in additional and unforeseen expenses, and the anticipated benefits of integration, including with respect to Express Scripts, may not be fully realized or may take longer to realize than expected. Delays or issues encountered in the integration process could have a material adverse effect on the revenues, expenses, operating results and financial condition of the combined company.

Strategic transactions could result in increased costs, including facilities and systems consolidation costs and costs to retain key employees, decreases in expected revenues, earnings or cash flows, and goodwill or other intangible asset impairment charges. Additional unanticipated costs may be incurred in the integration of Express Scripts' businesses. Although we expect that the elimination of duplicative costs, as well as the realization of other efficiencies related to the integration of those businesses, should allow us to more than offset incremental transaction and merger-related costs over time, this net benefit may not be achieved in the near term, or at all. In addition, the trading price of our securities may decline if, among other things, we are unable to achieve the expected growth in earnings, if our operational cost savings estimates are not realized, or the transaction costs related to the acquisition and integration are greater than expected. The trading price also may decline if we do not achieve the perceived benefits of the acquisition as rapidly or to the extent anticipated by financial or industry analysts.

Further, we may finance strategic transactions by issuing common stock for some or all of the purchase price that could dilute the ownership interests of our shareholders, or by incurring additional debt that could impact our ability to access capital in the future.

In addition, effective internal controls are necessary to provide reliable and accurate financial reports and to mitigate the risk of fraud. The integration of businesses, including Express Scripts, is likely to cause increasing complexity in our systems and internal controls and make them more difficult to manage. Any difficulties in assimilating businesses into our control system could cause us to fail to meet our financial reporting

obligations. Ineffective internal controls could also cause investors to lose confidence in our reported financial information that could negatively impact the trading price of our securities and our access to capital.

Our business depends on our ability to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems.

Our business is highly dependent on maintaining effective information systems as well as the integrity and timeliness of the data we use to serve our customers and health care professionals and to operate our business. If our data were found to be inaccurate or unreliable due to fraud or other error, or if we, or any of the third-party service providers we engage, were to fail to maintain information systems and data integrity effectively, we could experience operational disruptions that may impact our clients, customers and health care professionals and hinder our ability to provide services and products, establish appropriate pricing for products and services, retain and attract clients and customers, establish reserves and report financial results timely and accurately and maintain regulatory compliance, among other things.

Our information technology strategy and execution are critical to our continued success. We must continue to invest in long-term solutions that will enable us to anticipate customer needs and expectations, enhance the customer experience, act as a differentiator in the market and protect against cybersecurity risks and threats. Our success is dependent, in large part, on maintaining the effectiveness of existing technology systems and continuing to deliver and enhance technology systems that support our business processes in a cost-efficient and resource-efficient manner. Increasing regulatory and legislative changes will place additional demands on our information technology infrastructure that could have a direct impact on resources available for other projects tied to our strategic initiatives. In addition, recent trends toward greater consumer engagement in health care require new and enhanced technologies, including more sophisticated applications for mobile devices. Connectivity among technologies is becoming increasingly important. We must also develop new systems to meet current market standards and keep pace with continuing changes in information processing technology, evolving industry and regulatory standards and customer needs. Failure to do so may present compliance challenges and impede our ability to deliver services in a competitive manner. Further, because system development projects are long-term in nature, they may be more costly than expected to complete and may not deliver the expected benefits upon completion. Our failure to effectively invest in, implement improvements to and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems could adversely affect our results of operations, financial position and cash flow.

As a large health service company, we are subject to cyber-attacks or other privacy or data security incidents. If we are unable to prevent or contain the effects of any such attacks, we may suffer exposure to substantial liability, reputational harm, loss of revenue or other damages.

Our business depends on our clients' and customers' willingness to entrust us with their health-related and other sensitive personal information. Computer systems may be vulnerable to physical break-ins, computer viruses or malware, programming errors, attacks by third parties or similar disruptive problems. We have been, and will likely continue to be, the target of computer viruses or other malicious codes, unauthorized access, cyber-attacks or other computer-related penetrations. There have been, and will likely continue to be, large scale cyber-attacks within the health service industry. As we increase the amount of personal information that we store and share digitally, our exposure to data security and related cybersecurity risks increases, including the risk of undetected attacks, damage, loss or unauthorized access or misappropriation of proprietary or personal information, and the cost of attempting to protect against these risks also increases. If disruptions or breaches are not detected quickly, their effect could be compounded. We have implemented security technologies, processes and procedures to protect consumer identity and provide employee awareness training around phishing, malware and other cyber risks; however, there are no assurances that such measures will be effective against all types of breaches.

Cyber-security threats are rapidly evolving and those threats and the means for obtaining access to our proprietary systems are becoming increasingly sophisticated. Cyber-attacks can originate from a wide variety of sources including third parties, such as external service providers, and the techniques used change frequently or are often not recognized until after they have been launched. Those parties may also attempt to fraudulently induce employees, customers or other users of our systems to disclose sensitive information in order to gain access to our data or that of our customers. In addition, while we have certain standards for all vendors that provide us services, our vendors, and in turn, their own service providers, may become subject to the same types of security breaches. Finally, our offices may be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human error or similar events that could negatively affect our systems and our customers' and clients' data.

The costs to eliminate or address security threats and vulnerabilities before or after a cyber-incident could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service and loss of existing or potential customers.

In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about us, our customers or other third-parties could expose our customers' private information and our customers to the risk of financial or medical identity theft. Unauthorized dissemination of confidential and proprietary information about our business and strategy also could negatively affect the achievement of our strategic initiatives. Such events could cause us to breach our contractual confidentiality obligations and violate applicable laws. These events would negatively affect our ability to compete, others' trust in us, our reputation, customer base and revenues and expose us to mandatory disclosure (including to the media), litigation and other enforcement proceedings, material fines, penalties and/or remediation costs, and compensatory, special, punitive and statutory damages, consent orders and other adverse actions, any of which could adversely affect our business, results of operations, financial condition or liquidity.

In managing medical practices and operating onsite clinics and other types of medical facilities, we may be subject to additional liability that could result in significant time and expense.

In addition to contracting with physicians and other health care providers for services, we employ physicians, nurses and other health care professionals at onsite low acuity and primary care practices and infusion clinics that we manage and operate for our customers, as well as certain clinics for our employees. We also provide in-home care through health care professionals that we employ, as well as, through third-party contractors. As such, we are subject to liability for negligent acts, omissions, or injuries occurring at one of these clinics or caused by one of our employees. The defense of any actions may result in significant expenses that could have a material adverse effect on our business, results of operations, financial condition, liquidity and reputation.

Legal and Compliance Risks

Our business is subject to substantial government regulation, as well as new laws or regulations or changes in existing laws or regulations that could have a material adverse effect on our business, results of operations, financial condition and liquidity.

Our business is regulated at the federal, state, local and international levels. The laws and rules governing our business and related interpretations are increasing in number and complexity, are subject to frequent change and can be inconsistent or in conflict with each other.

Noncompliance with applicable regulations by us or our third-party vendors could have material adverse effects on our business, results of operations, financial condition, liquidity and reputation.

We must identify, assess and respond to new trends in the legislative and regulatory environment, as well as comply with the various existing regulations applicable to our business. From time to time, certain legislative and/or regulatory proposals are made which seek to manage the health care industry, including managing prescription drug cost, regulating drug distribution and managing health records. The trading price of our securities may react to the announcement of such proposals. We are unable to predict whether any such policies or proposals will be enacted, or the specific terms thereof. Certain of these policies or proposals could, if enacted, adversely impact our business and results of operations.

Existing or future laws, rules, regulatory interpretations or judgments could force us to change how we conduct our business, affect the products and services we offer, restrict revenue and enrollment growth, increase our costs, including operating, health care technology and administrative costs, and require enhancements to our compliance infrastructure and internal controls environment. We are required to obtain and maintain insurance and other regulatory approvals to market many of our products, increase prices for certain regulated products and consummate some of our acquisitions and dispositions. Delays in obtaining or failure to obtain or maintain these approvals could reduce our revenue or increase our costs. Existing or future laws and rules could also require or lead us to take other actions such as changing our business practices, and could increase our liability.

Further, failure to effectively implement or adjust our strategic and operational initiatives, such as by reducing operating costs, adjusting premium pricing or benefit design or transforming our business model in response to regulatory changes may have a material adverse effect on our results of operations, financial condition and cash flows, including, but not limited to, our ability to maintain the value of our goodwill and other intangible assets.

For more information on regulations to which we are subject, see "Business – Regulation" in Part I, Item 1 of this Form 10-K.

There are various risks associated with participating in government-sponsored programs, such as Medicare, including dependence upon government funding, compliance with government contracts and increased regulatory oversight.

Through our Government business, we contract with CMS and various state governmental agencies to provide managed health care services including Medicare Advantage plans and Medicare-approved prescription drug plans. If we fail to comply with CMS's contractual requirements, including data submission, enrollment and marketing, provider network adequacy, provider directory accuracy, quality measures, claims payment, continuity of care and call center performance, we may be subject to administrative actions, fines or other penalties that could impact our profitability.

Revenues from Medicare programs are dependent, in whole or in part, upon annual funding from the federal government through CMS and/or applicable state or local governments. Funding for these programs is dependent on many factors outside our control including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal or applicable state or local level and general political issues and priorities. These entities generally have the right to not renew or cancel their contracts with us on short notice without cause or if funds are not available. Unanticipated changes in funding, such as the application of sequestration by the federal or state governments or the failure to provide for continued appropriations or regular ongoing scheduled payments to us, could substantially reduce our revenues and profitability.

The Medicare program has been the subject of regulatory reform initiatives. The premium rates paid to Medicare Advantage plans and Medicare Part D plans are established by contract, although the rates differ depending on a combination of factors, many of which are outside our control. The Star Rating system is subject to change annually by CMS, which may make it more difficult to achieve four stars or greater. A plan's Star Rating affects its image in the market and plans that perform well are able to market more effectively and for longer periods of time than other plans. Our Medicare Advantage plans' and Medicare Part D plans' operating results, premium revenue and benefit offerings are likely to continue to be significantly determined by their Star Ratings. A portion of each Medicare Advantage plan's reimbursement is tied to the plan's Star Rating, with those plans receiving a rating of four or more stars eligible for quality-based bonus payments. There can be no assurances that we will be successful in maintaining or improving our Star Ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our Star Ratings. Accordingly, our plans may not be eligible for full level quality bonuses,

which could adversely affect the benefits such plans can offer, reduce membership and/or impact our financial performance. See Part II, Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Information – Health Care Industry Developments and Other Matters Affecting our Global Health Care Segment for additional information on our Star Ratings.

On November 1, 2018, CMS released a proposed rule that would revise its Risk Adjustment Data Validation methodology by, among other things, excluding an adjustment for underlying fee-for-service data errors and extrapolating RADV results at the contract level. If adopted in its current form, the rule could have a detrimental impact to all Medicare Advantage insurers and affect the ability of plans to deliver high quality health care for the population served. While it is uncertain that CMS will issue the rule as proposed, if adopted, it could have a material impact on the Company's future results of operations.

Our participation in health insurance exchanges for individuals and small employers involves uncertainties associated with mix and volume of business and could adversely affect our results of operations, financial position and cash flows. The executive order signed in October 2017 that halted payment of the cost sharing reduction subsidies has created additional uncertainty regarding the future of public health insurance exchanges. Risk adjustment balances are subject to audit and adjustment by CMS.

Any failure to comply with various state and federal health care laws and regulations, including those directed at preventing fraud and abuse in government funded programs, could result in investigations or litigation, such as actions under the federal False Claims Act and similar whistleblower statutes under state laws. This could subject us to damage awards, fines, penalties or other enforcement actions, restrictions on our ability to market or enroll new customers, limits on expansion, restrictions or exclusions from programs or other agreements with federal or state governmental agencies, which could adversely impact our business, cash flows, financial condition, results of operations and reputation.

We face risks related to litigation, regulatory audits and investigations.

We are routinely involved in numerous claims, lawsuits, regulatory audits, investigations and other legal matters arising, for the most part, in the ordinary course of business, including that of administering and insuring employee benefit programs. These legal matters could include benefit claims, breach of contract actions, tort claims, claims arising from consumer protection laws, false claims act laws, claims disputes under federal or state laws and disputes regarding reinsurance arrangements, employment and employment discrimination-related suits, antitrust claims, employee benefit claims, wage and hour claims, tax, privacy, intellectual property and whistleblower claims, shareholder suits and other securities law claims and real estate disputes. In addition, we have incurred and likely will continue to incur liability for practices and claims related to our health care business, such as marketing misconduct, failure to timely or appropriately pay for or provide health care, provider network structure, poor outcomes for care delivered or arranged, provider disputes including disputes over compensation or contractual provisions, ERISA claims, allegations related to calculations of cost sharing and claims related to our administration of self-funded business. There are currently, and may be in the future, attempts to bring class action lawsuits against the company and other companies in our industry; individual plaintiffs also may bring multiple claims regarding the same subject matter against us and other companies in our industry.

Court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic or punitive damages may be sought. We seek to procure insurance coverage to cover some of these potential liabilities. However, certain potential liabilities may not be covered by insurance, insurers may dispute coverage or the amount of insurance may be insufficient to cover the entire damages awarded. In addition, certain types of damages, such as punitive damages, may not be covered by insurance, and insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. It is possible that the resolution of current or future legal matters and claims could result in changes to our industry and business practices, losses material to our results of operations, financial condition and liquidity or damage to our reputation.

We are frequently the subject of regulatory market conduct and other reviews, audits and investigations by state insurance and health and welfare and pharmacy departments, attorneys general, CMS and the OIG and comparable authorities in foreign jurisdictions. With respect to our Medicare Advantage and Medicare Part D businesses, CMS and OIG perform audits to determine a health plan's compliance with federal regulations and contractual obligations, including compliance with proper coding practices and fraud and abuse enforcement practices through audits designed to detect and correct improper payments. The Department of Justice is conducting an industry review of the risk adjustment data submission practices and business processes, including review of medical charts, of Cigna and a number of other Medicare Advantage organizations under Medicare Parts C and D. There also continues to be heightened review by federal and state regulators of business and reporting practices within the health service, disability and life insurance industries, including with respect to claims payment and related escheat practices, and increased scrutiny by other state and federal governmental agencies (such as state attorneys general) empowered to bring criminal actions in circumstances that could have previously given rise only to civil or administrative proceedings.

In addition, various governmental agencies have conducted investigations and audits into certain pharmacy benefit management practices. Many of these investigations and audits have resulted in other companies agreeing to civil penalties, including the payment of money and corporate integrity agreements. We cannot predict what effect, if any, such governmental investigations and audits may ultimately have on us or on the industry in general. However, we may experience government scrutiny and audit activity which may result in the payment or offset of prior reimbursements from the government.

Regulatory audits or reviews or actions by other governmental agencies could result in changes to our business practices, retroactive adjustments to certain premiums, significant fines, penalties, civil liabilities, criminal liabilities or other sanctions, including restrictions on our ability to market certain products or engage in business-related activities, that could have a material adverse effect on our business, results of operation, financial condition and liquidity. In addition, disclosure of an adverse investigation or audit or the imposition of fines or other sanctions could negatively affect our reputation in certain markets and make it more difficult for us to sell our products and services.

A description of material pending legal actions and other legal and regulatory matters is included in Note 19 to our Consolidated Financial Statements included in this Form 10-K. The outcome of litigation and other legal or regulatory matters is always uncertain.

If we fail to comply with applicable privacy, security and data laws, regulations and standards, our business and reputation could be materially and adversely affected.

Most of our activities involve the receipt, use, storage or transmission of a substantial amount of individuals' protected health information and personally identifiable information. We also use aggregated and anonymized data for research and analysis purposes, and in some cases, provide access to such data to pharmaceutical manufacturers and third-party data aggregators and analysts. The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with clients. In some cases, such laws, rules, regulations and contractual requirements also apply to our vendors and require us to obtain written assurances of their compliance with such requirements or may hold us liable for any violations by our vendors. We are also subject to various other consumer protection laws that regulate our communications with customers. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is designed to protect credit card account data as mandated by payment card industry entities. International laws, rules and regulations governing the use and disclosure of such information, such as the GDPR, are generally more stringent than in the United States, and they vary across jurisdictions.

These laws, rules, and contractual requirements are subject to change. Compliance with new privacy, security and data laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. For example, the HITECH amendments to HIPAA may further restrict our ability to collect, disclose and use sensitive personal information and may impose additional compliance requirements on our business.

HIPAA requires covered entities to comply with the HIPAA privacy, security and breach rules. In addition, business associates must comply with the HIPAA security and breach requirements. While we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we have limited oversight or control over their actions and practices. Several of our businesses act as business associates to their covered entity customers and, as a result, collect, use, disclose and maintain sensitive personal information in order to provide services to these customers. HHS has continued its audit program to assess HIPAA compliance efforts by covered entities and has expanded it to include business associates. In addition, HHS has increased its enforcement efforts. These efforts can result in enforcement actions that are the result of investigations brought on by the notification to HHS of a breach. An audit resulting in findings or allegations of noncompliance or the implementation of an enforcement action could have an adverse effect on our results of operations, financial position, cash flows and reputation.

Effective prevention, detection and control systems are critical to maintain regulatory compliance and prevent fraud and failure of these systems could adversely affect us.

Federal and state governments have made investigating and prosecuting health care and other insurance fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities including kickbacks for referral of customers, billing for unnecessary medical services, improper marketing and violations of patient privacy rights. The regulations and contractual requirements applicable to us are complex and subject to change. In addition, ongoing vigorous law enforcement, a highly technical regulatory scheme and the Dodd-Frank Act legislation and related regulations enhance regulators' enforcement powers and whistleblower incentives and protections. Our compliance efforts in this area will continue to require significant resources. Failure of our prevention, detection or control systems related to regulatory compliance or the failure of employees to comply with our internal policies including data systems security or unethical conduct by managers and employees, could adversely affect our reputation and also expose us to litigation and other proceedings, fines and penalties.

In addition, provider or customer fraud that is not prevented or detected could impact our medical costs or those of our self-insured clients. Further, during an economic downturn, we may experience increased fraudulent claims volume that may lead to additional costs due to an increase in disputed claims and litigation.

Economic Risks

Significant stock market or interest rate declines could result in additional unfunded pension obligations resulting in the need for additional plan funding by us and increased pension expenses.

We currently have unfunded obligations in our frozen pension plans. A significant decline in the value of the plans' equity and fixed income investments or unfavorable changes in applicable laws or regulations could materially increase our expenses and change the timing and amount of required plan funding. This could reduce the cash available to us, including our subsidiaries. We are also exposed to interest rate and equity risk associated with our pension and other post-retirement obligations. Sustained declines in interest rates could have an adverse impact on the funded status of our pension plans and our reinvestment yield on new investments. See Note 13 to our Consolidated Financial Statements for more information on our obligations under the pension plans.

Significant changes in market interest rates affect the value of our financial instruments that promise a fixed return or benefit and the value of particular assets and liabilities.

As an insurer, we have substantial investment assets that support insurance and contractholder deposit liabilities. Generally low levels of interest rates on investments, such as those experienced in U.S. and foreign financial markets during recent years, have negatively impacted our level of investment income earned in recent periods.

A substantial portion of our investment assets are in fixed interest-yielding debt securities of varying maturities, fixed redeemable preferred securities and commercial mortgage loans. The value of these investment assets can fluctuate significantly with changes in market conditions. A rise in interest rates would likely reduce the value of our investment portfolio and increase interest expense if we were to access our available lines of credit.

A downgrade in the financial strength ratings of our insurance subsidiaries could adversely affect new sales and retention of current business, and a downgrade in our debt ratings would increase the cost of borrowed funds and could negatively affect our ability to access capital.

Financial strength, claims paying ability and debt ratings by recognized rating organizations are each important factors in establishing the competitive position of insurance and health benefits companies. Ratings information by nationally recognized ratings agencies is broadly disseminated and generally used throughout the industry. We believe that the claims paying ability and financial strength ratings of our principal insurance subsidiaries are important factors in marketing our products to certain customers. Our debt ratings impact both the cost and availability of future borrowings and, accordingly, our cost of capital. Each of the rating agencies reviews ratings periodically and there can be no assurance that current ratings will be maintained in the future. A downgrade of any of these ratings in the future could make it more difficult to either market our products successfully or raise capital to support business growth within our insurance subsidiaries.

Global market, economic and geopolitical conditions may cause fluctuations in equity market prices, interest rates and credit spreads that could impact our ability to raise or deploy capital and affect our overall liquidity.

If the equity and credit markets experience extreme volatility and disruption, there could be downward pressure on stock prices and restricted access to capital for certain issuers without regard to those issuers' underlying financial strength. Extreme disruption in the credit markets could adversely impact our access to, and cost of, capital in the future.

In the event of adverse economic and industry conditions, we may be required to dedicate a greater percentage of our cash flow from operations to the payment of principal and interest on our debt, thereby reducing the funds we have available for other purposes, such as investments and other expenditures in ongoing businesses, acquisitions, dividends and stock repurchases. In these circumstances, our ability to execute our strategy may be limited, our flexibility in planning for or reacting to changes in business and market conditions may be reduced, or our access to capital markets may be limited such that additional capital may not be available or may be available only on unfavorable terms.

In connection with the combination with Express Scripts, we have considerably higher levels of indebtedness than Cigna and Express Scripts previously carried, which will result in higher relative debt service costs and less cash flow from operations available to fund growth, stock repurchases and other corporate purposes during our deleveraging process.

The long-term indebtedness of Cigna was approximately $39.5 billion as of December 31, 2018. This level of indebtedness:

- requires us to dedicate a greater percentage of our cash flow from operations to debt payments, thereby reducing the availability of cash flow to fund capital expenditures, pursue other acquisitions or investments in new technologies, make stock repurchases, pay dividends and for general corporate purposes;
- increases our vulnerability to general adverse economic conditions, including increases in interest rates for our borrowings that bear interest at variable rates and are in a greater amount than floating rate assets held, or if such indebtedness is refinanced at a time when interest rates are higher; and
- limits our flexibility in planning for, or reacting to, changes in or challenges relating to our business and industry.

The covenants to which we have agreed in connection with the financing, and our indebtedness and higher debt-to-equity ratio in comparison to that of Cigna or Express Scripts on a recent historical basis, may have the effect, among other things, of restricting our financial and operating flexibility to respond to changing business and economic conditions, creating competitive disadvantages compared to other competitors with lower debt levels during the deleveraging process.

Unfavorable developments in economic conditions may adversely affect our business, results of operations and financial condition.

Many factors, including geopolitical issues, future economic downturns, availability and cost of credit and other capital and consumer spending can negatively impact the U.S. and global economies. Our results of operations could be materially and adversely affected by the impact of unfavorable economic conditions on our customers (both employers and individuals), health care providers, pharmacy manufacturers, pharmacy providers and third-party vendors. For example:

- Employers may take action to reduce their operating costs by modifying, delaying or canceling plans to purchase our products or making changes in the mix of products purchased that are unfavorable to us.
- Higher unemployment rates and workforce reductions could result in lower enrollment in our employer-based plans (including an increase in the number of employees who opt out of employer-based plans) or our individual plans.
- Because of unfavorable economic conditions or the ACA, employers may stop offering health care coverage to employees or elect to offer this coverage on a voluntary, employee-funded basis as a means to reduce their operating costs.
- Our historical disability claim experience and industry data indicate that submitted disability claims rise under adverse economic conditions.
- If clients are not successful in generating sufficient funds or are precluded from securing financing, they may not be able to pay, or may delay payment of, accounts receivable that are owed to us.
- Our clients or potential clients may force us to compete more vigorously on factors such as price and service to retain or obtain their business.

- Our clients may be acquired, consolidated, or otherwise fail to successfully maintain or grow their business or workforce which could reduce the number of customers we serve or otherwise result in lower than anticipated utilization of our services.
- A prolonged unfavorable economic environment could adversely impact the financial position of hospitals and other health care providers, potentially increasing our medical costs as these providers attempt to maintain revenue levels in their efforts to adjust to their own economic challenges.
- Our third-party vendors could significantly and quickly increase their prices or reduce their output to reduce their operating costs. Our business depends on our ability to perform necessary business functions in an efficient and uninterrupted fashion.

These factors could lead to a decrease in our customer base, revenues or margins and/or an increase in our operating costs.

In addition, during a prolonged unfavorable economic environment, state and federal budgets could be materially and adversely affected, resulting in reduced or delayed reimbursements or payments in state and federal government programs such as Medicare and Social Security or under contracts with government entities. These state and federal budgetary pressures also could cause the government to impose new or a higher level of taxes or assessments on us, such as premium taxes on insurance companies and HMOs and surcharges or fees on select fee-for-service and capitated medical claims. Although we could attempt to mitigate or cover our exposure from such increased costs through, among other things, increases in premiums, there can be no assurance that we will be able to mitigate or cover all of such costs, which may have a material adverse effect on our business, results of operations, financial condition and liquidity.

We are subject to the credit risk of our reinsurers.

We enter into reinsurance arrangements with other insurance companies, primarily to limit losses from large exposures or to permit recovery of a portion of direct losses. We also may enter into reinsurance arrangements in connection with acquisition or divestiture transactions when the underwriting company is not being acquired or sold.

Under all reinsurance arrangements, reinsurers assume insured losses, subject to certain limitations or exceptions that may include a loss limit. These arrangements also subject us to various obligations, representations and warranties with the reinsurers. Reinsurance does not relieve us of liability as the originating insurer. We remain liable to the underlying policyholders if a reinsurer defaults on obligations under the reinsurance arrangement. Although we regularly evaluate the financial condition of reinsurers to minimize exposure to significant losses from reinsurer insolvencies, reinsurers may become financially unsound. If a reinsurer fails to meet its obligations under the reinsurance contract or if the liabilities exceed any applicable loss limit, we will be forced to cover the claims on the reinsured policies.

The collectability of amounts due from reinsurers is subject to uncertainty arising from a number of factors, including whether the insured losses meet the qualifying conditions of the reinsurance contract, whether reinsurers or their affiliates have the financial capacity and willingness to make payments under the terms of the reinsurance contract and the magnitude and type of collateral supporting our reinsurance recoverable, such as holding sufficient qualifying assets in trusts or letters of credit issued. Although a portion of our reinsurance exposures are secured, the inability to collect a material recovery from a reinsurer could have a material adverse effect on our results of operations, financial condition and liquidity.

ITEM 1B. Unresolved Staff Comments

None.

ITEM 2. Properties

Our global real estate portfolio consists of approximately 13.3 million square feet of owned and leased properties. Our domestic portfolio has approximately 11.3 million square feet in 43 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands. Our international properties contain approximately 2.0 million square feet located throughout the following countries: Australia, Belgium, Canada, China, Hong Kong, India, Indonesia, Kenya, Kuwait, Lebanon, Malaysia, New Zealand, Oman, Singapore, South Korea, Spain, Switzerland, Taiwan, Thailand, Turkey, United Arab Emirates, and the United Kingdom.

Our principal domestic office locations include the Wilde Building located at 900 Cottage Grove Road in Bloomfield, Connecticut (our corporate headquarters), Two Liberty Place located at 1601 Chestnut Street in Philadelphia, Pennsylvania, and Express Scripts' corporate offices located at and around One Express Way in St. Louis, Missouri. The Wilde Building measures approximately 893,000 square feet and is owned. Express Scripts' campus measures approximately 1.2 million square feet of leased space and Two Liberty Place measures approximately 322,000 square feet and is leased space.

The home delivery pharmacy operations of Express Scripts consist of five non-dispensing order processing pharmacies, five patient contact centers and four high-volume automated mail order dispensing pharmacies located throughout the United States. Express Scripts' mail order dispensing pharmacies are located in Arizona, Indiana, Missouri and New Jersey. Express Scripts also has seven specialty home delivery pharmacies and 20 specialty branch pharmacies.

We believe our properties are adequate and suitable for our business as presently conducted. The foregoing does not include information on investment properties.

ITEM 3. Legal Proceedings

The information contained under "Litigation Matters" and "Regulatory Matters" in Note 19 to our Financial Statements beginning on page 115 of this Form 10-K, is incorporated herein by reference.

EXECUTIVE OFFICERS OF THE REGISTRANT

All officers are elected to serve for a one-year term or until their successors are elected. Principal occupations and employment during the past five years are listed below.

LISA R. BACUS, 54, Executive Vice President and Chief Marketing Officer of Cigna beginning May 2013 and Chief Customer Officer beginning February 2017; Executive Vice President and Chief Marketer at American Family Insurance from February 2008 until May 2013.

MARK L. BOXER, 59, Executive Vice President and Chief Information Officer of Cigna beginning April 2011; Deputy Chief Information Officer, Xerox Corporation; and Group President, Government Health Care, for Xerox Corporation/Affiliated Computer Services from March 2009 until April 2011.

DAVID M. CORDANI, 53, Chief Executive Officer of Cigna beginning December 2009; Director since October 2009; President beginning June 2008; and Chief Operating Officer from June 2008 until December 2009.

BRIAN C. EVANKO, 42, President, Government Business beginning November 2017; President, U.S. Individual Business from August 2013 to November 2017; Business Financial Officer, Cigna Global Individual, Health, Life and Accident from September 2012 to August 2013; Chief Actuary, Cigna Global Individual, Health, Life and Accident from December 2008 to September 2012.

NICOLE S. JONES, 48, Executive Vice President and General Counsel of Cigna beginning June 2011; Senior Vice President and General Counsel of Lincoln Financial Group from May 2010 until June 2011; Vice President and Deputy General Counsel of Cigna from April 2008 until May 2010; and Corporate Secretary of Cigna from September 2006 until April 2010.

MATTHEW G. MANDERS, 57, President, Strategy and Solutions beginning November 2018; President, Government & Individual Programs and Group Insurance from February 2017 through November 2017; President, U.S. Markets from June 2014 until February 2017; President, Regional and Operations from November 2011 until June 2014; President, U.S. Service, Clinical and Specialty from January 2010 until November 2011; and President, Cigna HealthCare, Total Health, Productivity, Network & Middle Market from June 2009 until January 2010.

STEVEN B. MILLER, 61, Executive Vice President and Chief Clinical Officer beginning December 2018; Senior Vice President and Chief Medical Officer of Express Scripts from October 2007 through December 2018.

JOHN M. MURABITO, 60, Executive Vice President, Human Resources and Services of Cigna beginning August 2003.

ERIC P. PALMER, 42, Executive Vice President and Chief Financial Officer beginning June 2017; Deputy Chief Financial Officer from February 2017 until June 2017; Senior Vice President, Chief Business Financial Officer from November 2015 to February 2017; Vice President, Business Financial Officer, Health Care from April 2012 to November 2015; and Vice President, Business Financial Officer, U.S. Commercial Markets from June 2010 to April 2012.

JASON D. SADLER, 50, President, International Markets beginning June 2014; President, Global Individual Health, Life and Accident from July 2010 until June 2014; and Managing Director Insurance Business Hong Kong, HSBC Insurance Asia Limited from January 2007 until July 2010.

MICHAEL W. TRIPLETT, 57, President, U.S. Markets beginning February 2017; Regional Segment Lead from June 2009 to February 2017.

TIMOTHY C. WENTWORTH, 58, President, Health Services beginning December 2018; Chief Executive Officer of Express Scripts from May 2016 until December 2018; President from February 2014 through December 2018; and Senior Vice President and President, Sales and Account Management from April 2012 until February 2014.

PART II

ITEM 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

The information under the caption "Quarterly Financial Data – Stock and Dividend Data" appears on page 129 of this Form 10-K. As of December 31, 2018, the number of shareholders of record was 38,262. Cigna's common stock is listed with, and trades on, the New York Stock Exchange under the symbol "CI".

Issuer Purchases of Equity Securities

The following table provides information about Cigna's share repurchase activity for the quarter ended December 31, 2018:

Period	Total # of shares purchased [1]	Average price paid per share	Total # of shares purchased as part of publicly announced program [2]	Approximate dollar value of shares that may yet be purchased as part of publicly announced program [3]
October 1-31, 2018	408	$ 213.81	—	$ 2,723,207,261
November 1-30, 2018	2,399	$ 217.59	—	$ 2,723,207,261
December 1-31, 2018	568,958	$ 183.94	288,644	$ 946,464,758
Total	571,765	$ 183.04	288,644	N/A

(1) *Represents shares tendered by employees under the Company's equity compensation plans as follows: 1) payment of taxes on vesting of restricted stock and strategic performance shares and 2) payment of the exercise price and taxes for certain stock options exercised. Employees tendered 408 shares in October, 2,399 shares in November and 280,314 shares in December 2018.*

(2) *Additionally, the Company maintains a share repurchase program, authorized by the Board of Directors. Under this program, the Company may repurchase shares from time to time, depending on market conditions and alternate uses of capital. The timing and actual number of shares repurchased will depend on a variety of factors, including price, general business and market conditions and alternate uses of capital. The share repurchase program may be effected through Rule 10b5-1 plans, open market purchases or privately negotiated transactions, each in compliance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The program may be suspended or discontinued at any time. In 2018, the Company repurchased approximately 1.6 million shares for $330 million. On December 20, 2018, in connection with the merger with Express Scripts, the remaining authority of approximately $2.7 billion expired. The Board re-authorized $1 billion of share repurchase at that time. Remaining authorization under the program was approximately $950 million as of December 31, 2018. From January 1, 2019 through February 27, 2019, the Company repurchased 1.9 million shares for approximately $356 million, leaving the remaining repurchase authority at $590 million as of February 27, 2019.*

(3) *Approximate dollar value of shares is as of the last date of the applicable month.*

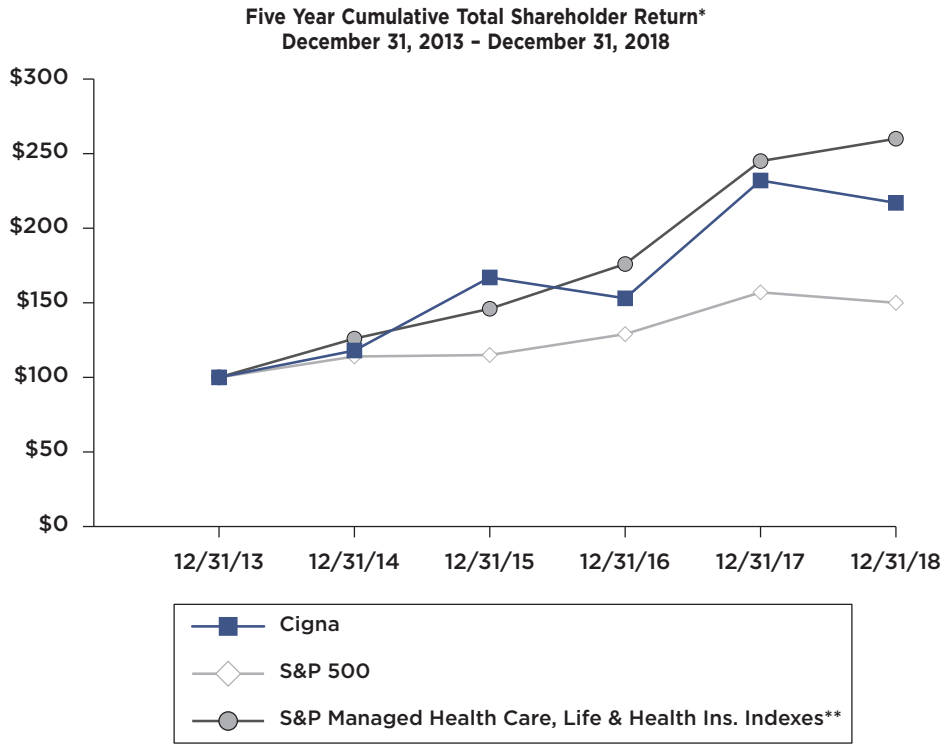

	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
Cigna	$ 100	$ 118	$ 167	$ 153	$ 232	$ 217
S&P 500	$ 100	$ 114	$ 115	$ 129	$ 157	$ 150
S&P Managed Health Care, Life & Health Ins. Indexes**	$ 100	$ 126	$ 146	$ 176	$ 245	$ 260

* *Assumes that the value of the investment in Cigna common stock and each index was $100 on December 31, 2013 and that all dividends were reinvested.*

** *Weighted average of S&P Managed Health Care (75%) and Life and Health Insurance (25%) Indexes.*

ITEM 6. Selected Financial Data

The selected financial data should be read in conjunction with Management's Discussion and Analysis of Financial Condition and Results of Operations and the Consolidated Financial Statements and accompanying notes included elsewhere herein.

Highlights

(Dollars in millions, except per share amounts)	**2018**	2017	2016	2015	2014
Total revenues [(1)(2)]	**$ 48,650**	$ 41,806	$ 39,838	$ 38,098	$ 35,096
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867	$ 2,094	$ 2,102
Net income	**$ 2,646**	$ 2,232	$ 1,843	$ 2,077	$ 2,094
Shareholders' net income per share					
Basic	**$ 10.69**	$ 8.92	$ 7.31	$ 8.17	$ 7.97
Diluted	**$ 10.54**	$ 8.77	$ 7.19	$ 8.04	$ 7.83
Common dividends declared per share	**$ 0.04**	$ 0.04	$ 0.04	$ 0.04	$ 0.04
Cash and investments	**$ 32,829**	$ 31,591	$ 30,000	$ 26,681	$ 25,762
Total assets	**$ 153,226**	$ 61,759	$ 59,366	$ 57,094	$ 55,876
Long-term debt	**$ 39,523**	$ 5,199	$ 4,756	$ 5,020	$ 4,979
Total liabilities	**$ 112,154**	$ 47,999	$ 45,605	$ 45,005	$ 45,021
Shareholders' equity	**$ 41,028**	$ 13,711	$ 13,699	$ 12,011	$ 10,750

(1) Effective January 1, 2018, the Company adopted Accounting Standards Update 2014-09 and related amendments that provided updated guidance on revenue recognition. This new guidance was adopted retrospectively and, accordingly, prior year amounts have been adjusted. See Note 2 to the Consolidated Financial Statements for additional information.

(2) Effective December 31, 2018, as a result of the acquisition of Express Scripts (see Note 3 to the Consolidated Financial Statements), the Company adopted Article 5 of Regulation S-X issued by the Securities and Exchange Commission. As a result, realized investment results are no longer included in revenues. Prior year revenues have been adjusted to conform to the new presentation.

ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

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Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") is intended to provide information to assist you in better understanding and evaluating our financial condition and results of operations. We encourage you to read this MD&A in conjunction with our Consolidated Financial Statements included in Part II, Item 8 of this Annual Report on Form 10-K ("Form 10-K") and the "Risk Factors" contained in Part I, Item 1A of this Form 10-K.

Unless otherwise indicated, financial information in the MD&A is presented in accordance with accounting principles generally accepted in the United States of America ("GAAP"). See Note 2 to our Consolidated Financial Statements for additional information regarding the Company's significant accounting policies. In some of our financial tables in this MD&A, we present either percentage changes or "N/M" when those changes are so large as to become not meaningful. Changes in percentages are expressed in basis points ("bps").

In this MD&A, our consolidated measures "adjusted income from operations," earnings per share on that same basis, and "adjusted revenues" are not determined in accordance with GAAP and should not be viewed as substitutes for the most directly comparable GAAP measures "shareholders' net income," "earnings per share" and "total revenues." As discussed in Note 21, we also use pre-tax adjusted income from operations and adjusted revenues to measure the results of our segments.

We use adjusted income from operations as our principal financial measure of operating performance because management believes it best reflects the underlying results of our business operations and permits analysis of trends in underlying revenue, expenses and profitability. We define adjusted income from operations as shareholders' net income (or income before taxes for the segment metric) excluding realized investment gains and losses, amortization of acquired intangible assets, results of Anthem, Inc. and Coventry Health Care Inc. ("Coventry") (collectively, the "transitioning clients") (see the "Key Transactions and Developments" section of the MD&A for further discussion of transitioning clients) and special items. Beginning in 2018, Cigna's share of certain realized investment results of its joint ventures reported using the equity method of accounting are also excluded. Income or expense amounts excluded from adjusted income from operations because they are not indicative of underlying performance or the responsibility of operating segment management include:

- *Realized investment gains (losses), including changes in market values of certain financial instruments between balance sheet dates, as well as gains and losses associated with invested asset sales.*
- *Amortization of acquired intangible assets, because these relate to costs incurred for acquisitions.*
- *Results of transitioning clients, because those results are not indicative of ongoing results.*
- *Special items, if any, that management believes are not representative of the underlying results of operations due to the nature or size of these matters. See Note 21 to the Consolidated Financial Statements for descriptions of special items.*

Adjusted revenues is defined as total revenues excluding the following adjustments: revenue contributions from transitioning clients, special items and, beginning in 2018, Cigna's share of certain realized investment results of its joint ventures reported using the equity method of accounting.

Executive Overview

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us") is a global health service organization dedicated to a mission of helping those we serve improve their health, well-being and peace of mind. Our evolved strategy in support of our mission is ***Go Deeper, Go Local, Go Beyond*** using a differentiated set of medical, pharmacy, dental, disability, life and accident insurance and related products and services offered by our subsidiaries. For further information on our business and strategy, see Item 1, "Business" in this Form 10-K.

As described more fully in Note 3 to our Consolidated Financial Statements, on March 8, 2018, we entered into a merger agreement with Express Scripts Holding Company ("Express Scripts"). Following entry into the merger agreement and throughout the pendency of the transaction, Cigna and Express Scripts designed integration plans to implement a new management and business reporting structure for the combined company upon closing. On December 20, 2018, we completed the acquisition of Express Scripts and, our segments have changed effective in the fourth quarter of 2018. See Note 1 to our Consolidated Financial Statements for a description of our segments. Prior year financial information has been restated to reflect this new segment presentation. Additionally, as described further in Note 2 to the

Consolidated Financial Statements, we adopted Article 5 of Regulation S-X issued by the Securities and Exchange Commission effective December 31, 2018. Results of 2018 include 11 days of Express Scripts activity beginning December 21.

Financial Summary

Summarized below are certain key measures of our performance for the years ended December 31:

	For the Years Ended December 31,			Increase (Decrease)	Increase (Decrease)
(Dollars in millions, except per share amounts)	**2018**	**2017**	**2016**	**2018 vs. 2017**	**2017 vs. 2016**
Revenues					
Adjusted revenues by segment					
Integrated Medical	**$ 32,791**	$ 29,035	$ 27,395	13%	6%
Health Services	**6,606**	4,241	4,066	56	4
International Markets	**5,366**	4,901	4,537	9	8
Group Disability and Other	**5,061**	5,075	5,108	–	(1)
Corporate, including eliminations	**(1,713)**	(1,446)	(1,268)	(18)	(14)
Adjusted revenues	**48,111**	41,806	39,838	15	5
Revenue contributions from transitioning clients	**459**	–	–	N/M	N/M
Net realized investment (losses) from equity method subsidiaries	**(43)**	–	–	N/M	N/M
Special items reported in transaction-related costs [1]	**123**	–	–	N/M	N/M
Total revenues	**$ 48,650**	$ 41,806	$ 39,838	16%	5%
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867	18%	20%
Adjusted income from operations	**$ 3,557**	$ 2,668	$ 2,104	33%	27%
Earnings per share (diluted)					
Shareholders' net income	**$ 10.54**	$ 8.77	$ 7.19	20%	22%
Adjusted income from operations	**$ 14.22**	$ 10.46	$ 8.10	36%	29%
Pre-tax adjusted income from operations by segment					
Integrated Medical	**$ 3,502**	$ 2,922	$ 2,592	20%	13%
Health Services	**380**	288	268	32	7
International Markets	**735**	654	538	12	22
Group Disability and Other	**529**	517	275	2	88
Corporate	**(403)**	(375)	(362)	(7)	(4)
Consolidated pre-tax adjusted income from operations	**4,743**	4,006	3,311	18	21
Adjustment for transitioning clients	**62**	–	–	N/M	N/M
Income (loss) attributable to noncontrolling interests	**14**	(2)	(20)	800	90
Realized investment (losses) gains	**(124)**	237	169	(152)	40
Amortization of acquired intangible assets	**(235)**	(115)	(151)	(104)	24
Special items	**(879)**	(520)	(330)	(69)	(58)
Income before income taxes	**$ 3,581**	$ 3,606	$ 2,979	(1)%	21%

(1) For additional information related to net investment income included in transaction-related costs, please refer to Note 3 to the Consolidated Financial Statements in this Form 10-K.

Consolidated Results of Operations (GAAP Basis)

Financial Summary

(in millions)	For the Years Ended December 31, 2018	2017	2016	Increase (Decrease) 2018 vs. 2017		Increase (Decrease) 2017 vs. 2016	
Premiums	**$ 36,113**	$ 32,491	$ 30,824	$ 3,622	11%	$ 1,667	5%
Fees and other revenues	**5,578**	5,110	4,901	468	9	209	4
Pharmacy revenues	**5,479**	2,979	2,966	2,500	84	13	–
Net investment income	**1,480**	1,226	1,147	254	21	79	7
Total revenues	**48,650**	41,806	39,838	6,844	16	1,968	5
Medical costs and other benefit expenses	**27,528**	25,263	24,341	2,265	9	922	4
Pharmacy and other service costs	**4,793**	2,456	2,468	2,337	95	(12)	–
Selling, general and administrative expenses	**11,934**	10,030	9,790	1,904	19	240	2
Amortization of acquired intangible assets	**235**	115	151	120	104	(36)	(24)
Total benefits and expenses	**44,490**	37,864	36,750	6,626	17	1,114	3
Income from operations	**4,160**	3,942	3,088	218	6	854	28
Interest expense and other	**(498)**	(252)	(278)	(246)	(98)	26	9
Debt extinguishment costs	**–**	(321)	–	321	100	(321)	N/M
Net realized investment gains (losses)	**(81)**	237	169	(318)	(134)	68	40
Income before income taxes	**3,581**	3,606	2,979	(25)	(1)	627	21
Income taxes	**935**	1,374	1,136	(439)	(32)	238	21
Net income	**2,646**	2,232	1,843	414	19	389	21
Less: net income (loss) attributable to noncontrolling interests	**9**	(5)	(24)	14	280	19	79
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867	$ 400	18%	$ 370	20%
Consolidated effective tax rate	**26.1%**	38.1%	38.1%	1,200bps		–bps	
Medical customers (in thousands)							
Integrated Medical	**15,389**	14,828	13,970	561	4%	858	6%
International Markets	**1,572**	1,549	1,488	23	1	61	4
Total	**16,961**	16,377	15,458	584	4%	919	6%

Reconciliation of Shareholders' Net Income (GAAP) to Adjusted Income from Operations (non-GAAP):

(Dollars in millions, except per share amounts)	For the Years Ended December 31, 2018	2017	2016	Diluted Earnings Per Share For the Years Ended December 31, 2018	2017	2016
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867	**$ 10.54**	$ 8.77	$ 7.19
– Adjustment for transitioning clients	**(47)**	–	–	**(0.19)**	–	–
– Net realized investment losses (gains)	**104**	(156)	(109)	**0.42**	(0.61)	(0.42)
– Amortization of acquired intangible assets	**177**	66	94	**0.71**	0.26	0.36
Special items						
– Transaction-related costs (see Note 3 to our Consolidated Financial Statements)	**669**	33	147	**2.67**	0.13	0.56
– Charges associated with litigation matters discussed in Note 19D. to our Consolidated Financial Statements	**19**	–	25	**0.08**	–	0.10
– U.S. tax reform (see Note 18 to our Consolidated Financial Statements)	**(2)**	196	–	**(0.01)**	0.77	–
– Debt extinguishment costs (see Note 5 to our Consolidated Financial Statements)	**–**	209	–	**–**	0.82	–
– Long-term care guaranty fund assessment (see Note 19C. to our Consolidated Financial Statements)	**–**	83	–	**–**	0.32	–
– Risk corridor allowance (see Note 21 to our Consolidated Financial Statements)	**–**	–	80	**–**	–	0.31
Adjusted income from operations	**$ 3,557**	$ 2,668	$ 2,104	**$ 14.22**	$10.46	$ 8.10

Earnings and Revenue Commentary

Shareholders' net income increased in 2018 compared with 2017, primarily driven by a lower effective tax rate. Income before income taxes was essentially flat, reflecting higher adjusted income from operations, largely offset by reduced realized investment results and higher special item charges due to transaction costs associated with the Express Scripts acquisition. In 2017, the increase in shareholders' net income as compared to 2016 was due to higher adjusted income from operations, with special item charges for debt extinguishment costs and charges resulting from U.S. Tax reform partially offsetting the increase.

Adjusted income from operations increased in 2018 compared with 2017, primarily due to earnings growth across all of our segments, including contributions from the acquired Express Scripts business and the lower effective tax rate in 2018. In 2017, the increase in adjusted income from operations compared with 2016 was due to earnings growth across all of our segments.

Medical customers increased in both 2018 and 2017, compared with each prior year primarily resulting from growth in the Commercial and Government segments. See the Integrated Medical segment section for additional discussion.

Revenues increased in both 2018 and 2017, primarily due to business growth in the Integrated Medical and International Markets segments. In 2018, revenues from the acquired Express Scripts business of $2.6 billion also contributed to the increase. Detailed revenue items are discussed further below.

- ***Premiums*** increased in 2018 compared with 2017, primarily reflecting customer growth in Integrated Medical including contributions from specialty products as well as growth in International Markets. Also contributing to the increase were higher premium rates in our Integrated Medical segment driven by: 1) underlying medical trend; 2) suspension of the government's cost share reduction subsidies; and 3) resumption of the health insurance industry tax. The increase in 2017 compared with 2016 primarily resulted from customer growth in the Commercial segment and in International Markets, partially offset by decreases in Government segment premiums due to Medicare disenrollment.
- ***Pharmacy revenues*** increased in 2018 compared with 2017 primarily resulting from contributions from the acquired Express Scripts business. See the Health Services section of this MD&A for further discussion of pharmacy revenues and costs.
- ***Fees and other revenues***. The increases in both 2018 and 2017 compared with each prior year were primarily attributable to growth in our specialty businesses and an increased customer base for our administrative services only ("ASO") business. In 2018, contributions from the acquired Express Scripts business also contributed to the increase.
- ***Net investment income*** was higher in 2018 compared with 2017, reflecting growth in average assets and higher yields, largely driven by increased partnership income. Net investment income in 2018 also included $123 million earned from proceeds on the debt issued in September 2018 that is reported as a special item. Those debt proceeds were used to finance the Express Scripts acquisition on December 20, 2018. In 2017, net investment income increased compared with 2016, driven by growth in average invested assets, partially offset by lower yields.

Commentary on Other Components of Consolidated Results of Operations

- ***Medical costs and other benefit expenses*** increased in both 2018 and 2017, compared with the prior year, reflecting customer growth in Integrated Medical and International Markets, as well as medical cost inflation in Integrated Medical.
- ***Selling, general and administrative expenses*** increased in 2018 compared with 2017, driven by higher transaction-related costs associated with the acquisition of Express Scripts, resumption of the health insurance industry tax and volume-based expenses reflecting business growth. In 2017, the increase in selling, general and administrative expenses compared with 2016 reflected a long-term care guaranty fund assessment and higher volume-based expenses reflecting business growth. These increases were offset by suspension of the health insurance industry tax in 2017 and a reduction in costs related to our Center for Medicare and Medicaid Services ("CMS") audit response.
- ***Amortization of acquired intangible assets*** increased in 2018 compared with 2017, primarily reflecting the impact of the acquired Express Scripts business. The decrease in 2017 compared with 2016 was driven by the expected continuing decline in amortization from our 2012 acquisition of HealthSpring, Inc.
- ***Interest expense and other*** increased significantly in 2018 compared with 2017, primarily due to $227 million of interest incurred on debt issued in the third quarter of 2018 prior to the acquisition of Express Scripts. This amount is included in the overall special item for transaction-related costs, net of $123 million of investment income earned on the debt proceeds through the closing date of the transaction.
- ***Realized investment results*** declined significantly in 2018 compared with 2017, resulting from lower gains on sales of alternative, partnership and fixed maturity investments as well as mark-to-market losses on equity securities reported in net income as required by Accounting Standards Update 2016-01, Recognition and Measurement of Financial Assets and Liabilities, beginning in 2018 (see Note 2 to our Consolidated Financial Statements). In 2017, realized investment results increased compared with 2016, primarily due to higher gains on sales of alternative and real estate investments, as well as lower impairment losses.
- ***The consolidated effective tax rate*** decreased in 2018 compared with 2017, primarily due to a lower U.S. tax rate in 2018, partially offset by resumption of the non-deductible health insurance industry tax and the absence of the incremental tax benefit recognized in the second quarter of 2017 for certain transaction costs associated with the terminated merger with Anthem. In 2017, the effective tax rate was flat compared with 2016. The unfavorable impact of additional tax expense associated with the U.S. tax reform legislation enacted in 2017 was offset by favorable effects of a suspension of the health insurance industry tax in 2017 and an incremental tax benefit from previously non-deductible transaction-related costs. See Note 18 to our Consolidated Financial Statements for additional information.

Key Transactions and Developments

Acquisition of Express Scripts

As discussed in more detail in Note 3 to the Consolidated Financial Statements, Cigna acquired Express Scripts on December 20, 2018 in a cash and stock transaction valued at $52.8 billion. See the "Liquidity" section of this MD&A for further discussion of the financing of this transaction.

We incurred a significant amount of costs related to this acquisition, both before and after closing. These costs are being reported in "transaction-related costs" as a special item and excluded from adjusted income from operations. The results of Express Scripts are included in Cigna's consolidated financial information from the date of the acquisition.

On January 30, 2019, Anthem exercised its early termination right and terminated the pharmacy benefit management services agreement with us, effective March 1, 2019. There is a twelve-month transition period ending March 1, 2020. It is expected that the transition of Anthem's customers will occur at various dates, as informed by Anthem's technology platform migration schedule. Over the next twelve months, we will focus on an effective transition of this relationship and related services over Anthem's accelerated timeline. We exclude the results of Express Scripts' contract with Anthem (and also Coventry) from our non-GAAP reporting metric "adjusted income from operations." We refer to this adjustment as "transitioning clients."

U.S. Tax Reform Legislation

Major U.S. tax reform legislation was signed into law on December 22, 2017. The legislation reduced the corporate income tax rate from 35% to 21% effective January 1, 2018, among other things. See Note 18 to our Consolidated Financial Statements for further discussion of the impacts of this legislation on our results of operations.

Health Care Industry Developments and Other Matters Affecting Our Integrated Medical and Health Services Segments

The "Regulation" section of this Form 10-K provides a detailed description of The Patient Protection and Affordable Care Act provisions and other legislative initiatives that impact our health care business, including regulations issued by CMS and the Departments of the Treasury and Health and Human Services ("HHS"). The table presented below provides an update of the impact of these items and other matters affecting our Integrated Medical and Health Services segments as of December 31, 2018.

Item	Description
Medicare Advantage	***Medicare Star Quality Ratings ("Star Ratings"):*** Medicare Advantage ("MA") plans must have a Star Rating of four Stars or greater to qualify for bonus payments. Approximately 60% of our Medicare Advantage customers were in a four Star or greater plan for bonus payments received in 2018. We expect this percentage to increase to 72% for bonus payments to be received in 2019 and to 76% in 2020. ***MA Rates:*** Final MA reimbursement rates for 2019 were published by CMS in April 2018. Preliminary MA reimbursement rates for 2020 were published by CMS in February 2019. We do not expect the new rates to have a material impact on our consolidated results of operations in 2019 and 2020. ***Risk Adjustment Validation ("RADV") Audits:*** As discussed in the "Regulation" and "Risk Factors" sections of this Form 10-K, our MA business is subject to reviews, including RADV audits. In 2012, CMS released a payment methodology that provided for sample audit error rates to be extrapolated to the entire MA contract after comparing audit results to a similar audit of Medicare Fee for Service (the "FFS Adjuster"), including any errors in the Medicare FFS data. This comparison is necessary to determine the true economic impact of the audit, if any, because the government uses the Medicare FFS data to determine adjustments to MA payment rates for various health conditions to establish actuarial equivalency in payment rates as required by the Medicare statute. In the fourth quarter of 2018, CMS issued a proposed rule that included, among other things, extrapolation of the error rate related to audit findings without applying the FFS Adjuster. This rule is discussed further in the Regulation section of this Form 10-K on page 20. If adopted in its current form, the rule could have a detrimental impact to all Medicare Advantage insurers and affect the ability of plans to deliver high quality health care for the population served. While it is uncertain that CMS will issue the rule as proposed, if they did, it could have a material impact on the Company's future results of operations.
Health Care Reform Act Tax	***Health Insurance Industry Tax:*** Federal legislation imposed a moratorium on the health insurance industry tax for 2017 and 2019. The industry tax was assessed in 2018 and, under current law, will be imposed in 2020. The industry tax for Cigna in 2018 was $370 million ($205 million for Commercial and $165 million for Government). For our Commercial business, the tax was reflected in our 2018 premium rates and did not have a material effect on shareholders' net income in 2018. For our Medicare business, the earnings impact in 2018 resulting from this renewed tax was somewhat offset with benefit and pricing changes. Because this tax is not deductible for federal income tax purposes, it negatively impacted our effective tax rate in 2018.
Public Health Exchanges	***Market Participation:*** For 2018, we offered individual coverage on six public health insurance exchanges in the following states: Colorado, Illinois, Missouri, North Carolina, Tennessee and Virginia. For 2019, we expanded our individual coverage to Arizona while continuing to offer coverage on all of the other six exchanges as in 2018. ***Cost Sharing Reduction Subsidies:*** The Patient Protection and the Affordable Care Act ("ACA") provides for cost sharing reductions that offset the amount that qualifying customers pay for deductibles, copayments and coinsurance. The federal government provided funding for the cost sharing reduction subsidies to the qualifying customer's insurer until October 2017 when these payments were stopped. The attorneys general of 18 states and the District of Columbia sued the current administration, seeking to require the administration to continue paying these subsidies. In October 2017, the court denied the attorney generals' request for an injunction, allowing the government to stop paying the cost sharing reduction subsidies to insurers during the pendency of the matter. In July 2018, the court granted a motion by the states to dismiss the lawsuit without prejudice, meaning the states may refile a lawsuit at a later time. Certain insurers have sued the federal government for failure to pay cost sharing reduction subsidies as well, and a judge in two of those actions has ruled in favor of the insurers. We will continue to monitor developments. Our premium rates for the 2018 and 2019 plan years reflect the government's decision to cease paying these subsidies.
Prescription Drug Pricing	As discussed in the Regulation section on page 20 of this Form 10-K, prescription drug pricing and the role of pharmacy benefit managers have been a focus of the current administration. In February 2019, the HHS proposed changes to the federal anti-kickback safe harbor to exclude regulatory protection for rebates between drug manufacturers and Medicare Part D plans, Medicaid managed care organizations and pharmacy benefit managers in the context of these government programs. The proposed regulations in their current form apply solely to Medicare Part D and Medicaid programs that include our Government business in the Integrated Medical segment. The proposed regulations also seek to create new safe harbor protections for fixed fee services arrangements between drug manufacturers and pharmacy benefit managers, as well as protections for discounts offered at the point of sale. These proposed regulations, if adopted as written, could affect current industry practices. We do not expect them to have a material effect on our business or results of operations. This area continues to be the subject of legislative and regulatory activity.

Risk Mitigation Programs

In 2016, we recorded an allowance for the balance of our risk corridor receivable based on court decisions and the large program deficit. During 2018, the U.S. Federal Circuit court ruled that health insurers are not entitled to receive amounts due under the risk corridor program that have been withheld by Congress. The plaintiffs have petitioned the U.S. Supreme Court to review this unfavorable decision. As of December 31, 2018, we continue to carry this allowance of $109 million based on the current status of court decisions.

Risk adjustment balances are subject to audit and adjustment by CMS following each program year. In February 2018, a federal judge issued a decision invalidating the use of statewide average premium for risk adjustment purposes. In response, in July 2018, CMS issued a final rule clarifying the 2017 program methodology and addressing issues raised in the ruling by the federal judge. This rule clears the way for CMS to resume risk adjustment collections and payments for the 2017 program year. Despite this final rule, resolution of the legal matter remains uncertain. As of December 31, 2018, our financial statements reflect the risk adjustment balances for the 2018 and 2017 plan years under the rules currently in effect for the program.

The following table presents our balances associated with the risk adjustment program as of December 31, 2018 and 2017.

	Net Receivable (Payable) Balance As of December 31,	
(In millions)	**2018**	**2017**
Risk Adjustment		
Receivables [1]	**$ 32**	$ 69
Payables [2]	**(187)**	(250)
Total risk adjustment balance	**$ (155)**	$ (181)

(1) Receivables, net of allowances, are reported in accounts receivable in the Consolidated Balance Sheets.

(2) Payables are reported in accrued expenses and other liabilities (current) in the Consolidated Balance Sheets.

After-tax charges for the risk adjustment program were $116 million in 2018 and $105 million in 2017, compared with after-tax benefits of $25 million in 2016.

Liquidity And Capital Resources

Financial Summary *(In millions)*	**2018**	**2017**	**2016**
Short-term investments	**$ 316**	$ 199	$ 691
Cash and cash equivalents	**$ 3,855**	$ 2,972	$ 3,185
Short-term debt	**$ 2,955**	$ 240	$ 276
Long-term debt	**$ 39,523**	$ 5,199	$ 4,756
Shareholders' equity	**$ 41,028**	$ 13,711	$ 13,699

Liquidity

We maintain liquidity at two levels: the subsidiary level and the parent company level.

Liquidity requirements at the subsidiary level generally consist of:

- medical costs, pharmacy and other benefit payments;
- expense requirements, primarily for employee compensation and benefits, information technology and facilities costs; and
- income taxes.

Our subsidiaries normally meet their operating requirements by:

- maintaining appropriate levels of cash, cash equivalents and short-term investments;
- using cash flows from operating activities;
- matching investment durations to those estimated for the related insurance and contractholder liabilities;
- selling investments; and
- borrowing from affiliates, subject to applicable regulatory limits.

Liquidity requirements at the parent company level generally consist of:

- debt service and dividend payments to shareholders;
- lending to subsidiaries as needed; and
- pension plan funding.

The parent company normally meets its liquidity requirements by:

- maintaining appropriate levels of cash and various types of marketable investments;
- collecting dividends from its subsidiaries;
- using proceeds from issuance of debt and common stock; and
- borrowing from its subsidiaries, subject to applicable regulatory limits.

Dividends from our insurance, Health Maintenance Organization ("HMO") and foreign subsidiaries are subject to regulatory restrictions. See Note 17 to the Consolidated Financial Statements for additional discussion of these restrictions. Because most of Express Scripts' subsidiaries are not subject to regulatory restrictions on paying dividends, acquiring Express Scripts provides significantly increased financial flexibility to Cigna.

Cash flows for the years ended December 31, were as follows:

(In millions)	2018	2017	2016
Net cash provided by operating activities	**$ 3,770**	$ 4,086	$ 4,026
Net cash (used in) investing activities:			
Cash used to acquire Express Scripts, net of cash acquired	**(24,062)**	–	–
Other acquisitions	**(393)**	(209)	(4)
Net investment (purchases)	**(1,383)**	(1,023)	(2,008)
Purchases of property and equipment and other	**(540)**	(471)	(562)
Net investing activities	**(26,378)**	(1,703)	(2,574)
Net cash provided by (used in) financing activities			
Debt proceeds used to finance Express Scripts acquisition	**22,856**	–	–
Other debt transactions, net	**1,356**	98	(148)
Stock repurchase	**(342)**	(2,725)	(139)
Other, net	**(355)**	(24)	62
Net financing activities	**23,515**	(2,651)	(225)
Foreign currency effect on cash	**(24)**	55	(10)
Change in cash and cash equivalents	**$ 883**	$ (213)	$ 1,217

Operating activities

Cash flows from operating activities consist principally of cash receipts and disbursements for premiums, fees, pharmacy revenues and costs, investment income, taxes, benefit costs and other expenses.

Cash flows from operating activities decreased in 2018 compared with 2017 primarily driven by the timing of settlement of pharmacy payables, partially offset by higher net income.

Cash flows from operating activities increased slightly in 2017 compared with 2016 primarily driven by higher net income, partially offset by lower receipts from Medicare Part D and Medicare Advantage programs and a voluntary pension contribution of $150 million in 2017.

Investing and Financing activities

Our most significant investing and financing activities of 2018 related to acquiring Express Scripts. See Note 3 to the Consolidated Financial Statements for additional information on the acquisition. Cigna financed a portion of the acquisition in cash, primarily with debt financing as shown above and described more fully in Note 5 to the Consolidated Financial Statements, with the remaining required cash coming from cash on hand. In 2018, Cigna also acquired OnePath Life for approximately $480 million, largely with cash held in our foreign operations.

Net investment purchases increased in 2018 compared with 2017, largely due to reinvesting our cash flows into fixed income investments. The decrease in net investment purchases in 2017 compared with 2016 primarily reflects higher cash used for share repurchases in 2017.

Stock repurchases declined in 2018 compared with 2017 as Cigna suspended stock repurchase activity to provide liquidity for the Express Scripts acquisition. Stock repurchase activity was significantly higher in 2017 than 2016, as stock repurchase activity was suspended for much of 2016 during the pendency of the Anthem transaction.

We maintain a share repurchase program authorized by our Board of Directors. Under this program, we may repurchase shares from time to time, depending on market conditions and alternate uses of capital. The timing and actual number of shares repurchased will depend on a variety of factors, including price, general business and market conditions and alternate uses of capital. The share repurchase program may be effected through open market purchases or privately negotiated transactions in compliance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended, including through Rule 10b5-1 trading plans. The program may be suspended or discontinued at any time.

In 2018, we repurchased 1.6 million shares for approximately $330 million. From January 1, 2019 through February 27, 2019 we repurchased 1.9 million shares for approximately $356 million. The remaining share repurchase authority as of February 27, 2019 was $590 million. We repurchased 15.7 million shares for $2.8 billion in 2017 and 0.8 million shares for $110 million in 2016.

Capital Resources

Our capital resources (primarily cash flows from operating activities and proceeds from the issuance of debt and equity securities) provide protection for policyholders, furnish the financial strength to underwrite insurance risks and facilitate continued business growth.

Our acquisition of Express Scripts increased our debt and shareholders' equity in 2018 as follows:

- ***Stock.*** Express Scripts shareholders received 0.2434 of a share of common stock of Cigna for every one share of Express Scripts. Cigna issued 137.6 million additional shares to Express Scripts shareholders.
- ***Debt.*** See Note 5 to the Consolidated Financial Statements for further description of the debt issued to finance the acquisition.
- ***Assumption of Express Scripts Senior Notes.*** See Note 5 to the Consolidated Financial Statements for further description of the notes assumed in the acquisition of Express Scripts.

At December 31, 2018, our debt-to-capitalization ratio was 50.9%. We expect to deleverage to the upper 30s within 18 to 24 months by using cash flows from operating activities.

Cigna entered into a new Revolving Credit Agreement and Term Loan Credit Agreement in financing the Express Scripts acquisition. A select number of subsidiaries guarantee Cigna obligations under the Revolving Credit Agreement and the Term Loan Credit Agreement. See Note 5 to the Consolidated Financial Statements for further information on these guarantees, as well as information on our Revolving Credit Agreement and the Term Loan Credit Agreement. Cigna had $22 million of letters of credit outstanding as of December 31, 2018.

Management, guided by regulatory requirements and rating agency capital guidelines, determines the amount of capital resources that we maintain. Management allocates resources to new long-term business commitments when returns, considering the risks, look promising and when the resources available to support existing business are adequate.

We prioritize our use of capital resources to:

- provide the capital necessary to support growth and maintain or improve the financial strength ratings of subsidiaries and to fund pension obligations;
- consider acquisitions that are strategically and economically advantageous; and
- return capital to investors primarily through share repurchases.

We continue to maintain a capital management strategy to retain overseas a significant portion of the earnings from our foreign operations. These undistributed earnings are deployed outside of the United States predominantly in support of the liquidity and regulatory capital requirements of our foreign operations as well as to support growth initiatives overseas. This strategy does not materially limit our ability to meet our liquidity and capital needs in the United States.

Liquidity and Capital Resources Outlook

At December 31, 2018, there was approximately $4.2 billion in cash and short-term investments, $1.2 billion of which was held by the parent or subsidiaries with no regulatory or other restrictions on transferring cash to the parent via dividend or loan. In 2019, we expect to generate an additional $6.2 billion of capital available for deployment, including $2.1 billion of dividends that our regulated insurance companies may pay without prior regulatory approval. The parent company's cash obligations in 2019 are expected to approximate $3.2 billion primarily for repayment of debt, interest and anticipated dividends. We expect to re-issue the $1.5 billion commercial paper borrowing upon its maturity.

We expect to have sufficient liquidity to meet the obligations discussed above, based on the cash currently available to the parent and current projections for subsidiary dividends and cash flows from the newly acquired Express Scripts operations. In addition, we actively monitor our debt obligations and engage in issuance or redemption activities as needed in accordance with our capital management strategy.

Our cash projections may not be realized and the demand for funds could exceed available cash if our ongoing businesses experience unexpected shortfalls in earnings, or we experience material adverse effects from one or more risks or uncertainties described more fully in the Risk Factors section of this Form 10-K. In those cases, we expect to have the flexibility to satisfy liquidity needs through a variety of measures, including intercompany borrowings. The parent company can borrow an additional $650 million from its insurance subsidiaries without additional state approval. We have additional liquidity available through short-term commercial paper borrowing capacity and the $3.25 billion revolving credit agreement discussed in Note 5 to the Consolidated Financial Statements.

As of December 31, 2018, our unfunded pension liability was $590 million, reflecting a decrease of $98 million from December 31, 2017, primarily attributable to an increase in discount rates of approximately 75 basis points. Contributions required in 2019 under the Pension Protection Act of 2006 are immaterial. See Note 13 to our Consolidated Financial Statements for additional information regarding our pension plans.

Though we believe we have adequate sources of liquidity, significant disruption or volatility in the capital and credit markets could affect our ability to access those markets for additional borrowings or increase costs associated with borrowing funds.

Guarantees and Contractual Obligations

We are contingently liable for various contractual obligations entered into in the ordinary course of business. See the "Liquidity and Capital Resources" section of this MD&A beginning on page 48 for additional background on how we manage our liquidity requirements related to these obligations. The maturities of our primary contractual cash obligations as of December 31, 2018 are estimated to be as follows:

(In millions, on an undiscounted basis)	Total	Less than 1 year	1-3 years	4-5 years	After 5 years
On-Balance Sheet					
Insurance liabilities					
Contractholder deposit funds	$ 7,133	$ 619	$ 741	$ 641	$ 5,132
Future policy benefits	11,517	709	1,224	1,153	8,431
Unpaid claims and claim expenses	8,851	4,967	1,119	719	2,046
Long-term debt	53,968	1,543	11,905	9,396	31,124
Other long-term liabilities	636	137	95	81	323
Off-Balance Sheet					
Purchase obligations	2,295	858	1,012	338	87
Operating leases	861	199	330	200	132
Total	$ 85,261	$ 9,032	$ 16,426	$ 12,528	$ 47,275

On balance sheet:

- ***Insurance liabilities.*** Excluded from the table above are $4 billion of insurance liabilities ($3 billion in contractholder deposit funds; $1 billion in future policy benefits) associated with the sold retirement benefits and individual life insurance and annuity businesses, as well as the reinsured workers' compensation, personal accident and supplemental benefits businesses as their related net cash flows are not expected to impact our cash flows. Excluding these amounts, the sum of the obligations presented above exceeds the corresponding insurance and contractholder liabilities of $22 billion recorded on the balance sheet because some of the recorded insurance liabilities reflect discounting for interest and the recorded contractholder liabilities exclude future interest crediting, charges and fees. The timing and amount of actual future cash flows may differ from those presented above.
    - ***Contractholder deposit funds:*** see Note 7 to our Consolidated Financial Statements for our accounting policy for this liability. Expected future cash flows presented above also include estimated future interest crediting on current fund balances based on current investment yields less the estimated cost of insurance charges and mortality and administrative fees for universal life policies.
    - ***Future policy benefits and unpaid claims and claim expenses:*** see Note 7 to our Consolidated Financial Statements for our accounting policies for these liabilities. Expected future cash flows for these liabilities presented in the table above are undiscounted. The expected future cash flows for guaranteed minimum death benefit ("GMDB," reported in future policy benefits) do not consider any of the related reinsurance arrangements.
- ***Long-term debt*** includes scheduled interest payments. Capital leases are included in long-term debt and primarily represent obligations for information technology network storage, servers and equipment.
- ***Other non-current liabilities*** include estimated payments for guaranteed minimum income benefit ("GMIB") contracts (without considering any related reinsurance arrangements), pension and other postretirement and postemployment benefit obligations, supplemental and deferred compensation plans, interest rate and foreign currency swap contracts, and reinsurance liabilities. Estimated payments of $78 million for deferred compensation, non-qualified and international pension plans and other postretirement and postemployment benefit plans are expected to be paid in less than one year and are included in the table above. We expect to make immaterial contributions to the qualified domestic pension plans during 2019 and they are reflected in the above table. We expect to make payments subsequent to 2019 for these obligations; however, subsequent payments have been excluded from the table as their timing is based on plan assumptions that may materially differ from actual activities. See Note 13 to our Consolidated Financial Statements for further information on pension and other postretirement benefit obligations.

The liability for uncertain tax positions that could result in future payments was $928 million as of December 31, 2018. This amount has been excluded from the table above because we are not able to provide a reasonably reliable estimate of the timing of such future tax payments. See Note 18 for additional information on uncertain tax positions.

Off-Balance Sheet:

- ***Purchase obligations.*** As of December 31, 2018, purchase obligations consisted of estimated payments required under contractual arrangements for future services and investment commitments as follows:

(In millions)	
Fixed maturities	$ 106
Commercial mortgage loans	54
Limited liability entities (other long-term investments)	1,472
Total investment commitments	1,632
Future service commitments	663
Total purchase obligations	$ 2,295

See Note 9 to our Consolidated Financial Statements for additional information.

Our estimated future service commitments primarily represent contracts for certain outsourced business processes and information technology maintenance and support. We generally have the ability to terminate these agreements, but do not anticipate doing so at this time. Purchase obligations exclude contracts that are cancelable without penalty and those that do not contractually require minimum levels of goods or services to be purchased.

- ***Operating leases.*** For additional information, see Note 16 to our Consolidated Financial Statements.

Guarantees

We are contingently liable for various financial and other guarantees provided in the ordinary course of business. See Note 19 to our Consolidated Financial Statements for additional information on guarantees.

Critical Accounting Estimates

The preparation of Consolidated Financial Statements in accordance with GAAP requires management to make estimates and assumptions that affect reported amounts and related disclosures in the Consolidated Financial Statements. Management considers an accounting estimate to be critical if:

- it requires assumptions to be made that were uncertain at the time the estimate was made; and
- changes in the estimate or different estimates that could have been selected could have a material effect on our consolidated results of operations or financial condition.

Management has discussed how critical accounting estimates are developed and selected with the Audit Committee of our Board of Directors and the Audit Committee has reviewed the disclosures presented below.

In addition to the estimates presented in the following table, there are other accounting estimates used in preparing our Consolidated Financial Statements, including estimates of liabilities for future policy benefits, as well as estimates with respect to postemployment and postretirement benefits other than pensions, certain compensation accruals, and income taxes.

Management believes the current assumptions used to estimate amounts reflected in our Consolidated Financial Statements are appropriate. However, if actual experience differs from the assumptions used in estimating amounts reflected in our Consolidated Financial Statements, the resulting changes could have a material adverse effect on our consolidated results of operations and, in certain situations, could have a material adverse effect on our liquidity and financial condition. The table below presents the adverse impacts of certain possible changes in assumptions. The effect of assumption changes in the opposite direction would be a positive impact to our consolidated results of operations, liquidity or financial condition, except for assessing impairment of goodwill and fixed maturities carried at a fair value below cost. The tax rate used to calculate the after-tax impact of assumption changes is based on the new corporate income tax rate discussed in the "Key Developments" section of this MD&A.

See Note 2 to our Consolidated Financial Statements for further information on significant accounting policies.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Goodwill and other intangible assets	
Goodwill represents the excess of the cost of businesses acquired over the fair value of their net assets at the acquisition date. Intangible assets primarily reflect the value of customer relationships and other intangibles acquired in business combinations. Fair values of reporting units are estimated using models and assumptions that we believe a hypothetical market participant would use to determine a current transaction price. The significant assumptions and estimates used in determining fair value include the discount rate and future cash flows. A discount rate is used, corresponding with each reporting unit's weighted average cost of capital, consistent with that used for investment decisions considering the specific and detailed operating plans and strategies within each reporting unit. Projections of future cash flows are consistent with our annual planning process for revenues, claims, operating expenses, taxes, capital levels and long-term growth rates. In addition to these assumptions, we consider market data to evaluate the fair value of each reporting unit. The fair value of intangibles and the amortization method were determined using an income approach that relies on projected future cash flows including key assumptions for the customer attrition and discount rates. Management revises amortization periods if it believes there has been a change in the length of time that an intangible asset will continue to have value. We completed our normal annual evaluations for impairment of goodwill and intangible assets during the third quarter of 2018. The evaluations indicated that the fair value estimates of our reporting units exceed their carrying values by adequate margins and no impairment was required. As a result of the changes in our reportable segments, we reallocated existing goodwill to reporting units based on their relative fair values and updated our evaluations for impairment of goodwill. These evaluations indicated that the fair value estimates of our reporting units continue to exceed their carrying values by adequate margins and no impairments were required. During the fourth quarter of 2018, goodwill and intangible assets increased by $38.4 billion as a result of the acquiring Express Scripts and OnePath Life. Our Government operating segment contracts with CMS and various state governmental agencies to provide managed health care services, including Medicare Advantage plans and Medicare-approved prescription drug plans. Estimated future cash flows for this reporting unit's business incorporate the potential effects of Medicare Advantage reimbursement rates for 2019 and beyond as discussed in the "Executive Overview" section of this MD&A. Revenues from the Medicare programs are dependent, in whole or in part, upon annual funding from the federal government through CMS. Funding for these programs is dependent on many factors including general economic conditions, continuing government efforts to contain health care costs and budgetary constraints at the federal level and general political issues and priorities. Goodwill and other intangibles as of December 31 were as follows (in millions): • **2018 – Goodwill $44,505; Other intangible assets $39,003** • 2017 – Goodwill $6,164; Other intangible assets $345 See Note 15 to our Consolidated Financial Statements for additional discussion of our goodwill and other intangible assets.	If we do not achieve our earnings objectives or our cost of capital rises significantly, the assumptions and estimates underlying these impairment evaluations could be adversely affected and result in future impairment charges that would negatively impact our operating results. Except for the recent acquisitions of Express Scripts and OnePath Life, where fair value equals carrying value, based on our most recent evaluations, the fair value estimates of our reporting units exceed their carrying values by adequate margins. Future changes in the funding for our Medicare programs by the federal government could materially reduce revenues and profitability in our Government reporting unit and have a significant impact on its fair value.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Income taxes – uncertain tax positions	
We evaluate tax positions to determine whether their benefits are more likely than not to be sustained on audit based on their technical merits. If not, we establish a liability for unrecognized tax benefits. These amounts have increased significantly in 2018 as a result of acquiring Express Scripts. The acquired amounts primarily relate to federal and state uncertain positions of the value and timing of deductions and uncertain positions of attributing taxable income to states. Balances that are included in other non-current liabilities on the Consolidated Balance Sheets are as follows: • **2018 – $928 million** • 2017 – $35 million See Note 18 to our Consolidated Financial Statements for additional discussion around uncertain tax positions.	The factors that could impact our estimates of uncertain tax positions include the likelihood of being sustained upon audit based on the technical merits of the tax position and related assumed interest and penalties. If our positions are upheld upon audit, our net income would increase.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Pharmaceutical Manufacturer Receivables	
We bill pharmaceutical manufacturers based on management's interpretation of the contractual terms and estimate contractual allowances at the time a claim is processed for uncertainty in the amount we are entitled to collect. We determine these contractual allowances by reviewing each manufacturer's payment experience and specific known items that potentially could be adjusted under contract terms. We may also record allowances for doubtful accounts based on a variety of factors including the length of time the receivables are past due, the financial health of the manufacturer and our past experience. In determining the fair value of Express Scripts' accounts receivable at the acquisition date, the historical allowances were eliminated. Prospectively, we expect these allowances to become significant to the consolidated financial statements. See Note 2 to our Consolidated Financial Statements for assumptions and methods used to estimate receivables and the related allowances.	Actual contractual allowances could differ from our estimates due to disputes regarding contractual terms, changes in the business environment as well as factors and risks associated with specific customers. Our estimates of the allowance for doubtful accounts could be impacted by changes in economic and market conditions as well as changes to our customers' financial condition.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Unpaid claims and claim expenses – Integrated Medical	
Unpaid claims and claim expenses include both reported claims and estimates for losses incurred but not yet reported. Unpaid claims and claim expenses in Integrated Medical are primarily impacted by assumptions related to completion factors and medical cost trend. Changes in either assumption from actual results could impact the unpaid claims balance as noted below. A large number of factors may cause the medical cost trend to vary from the Company's estimates, including: changes in medical management practices, changes in the level and mix of benefits offered and services utilized, and changes in medical practices. Completion factors may be affected if actual claims submission rates from providers differ from estimates (that can be influenced by a number of factors, including provider mix, and electronic versus manual submissions), or if changes to the Company's internal claims processing patterns occur. Unpaid claims and claim expenses for the Integrated Medical segment as of December 31 were as follows (in millions): • **2018 – gross $2,697; net $2,433** • 2017 – gross $2,420; net $2,158 These liabilities are presented above both gross and net of reinsurance and other recoverables. See Note 7 to our Consolidated Financial Statements for additional information regarding assumptions and methods used to estimate this liability.	Based on studies of our claim experience, it is reasonably possible that a 100 basis point change in the medical cost trend and a 50 basis point change in completion factors could occur in the near term. A 100 basis point increase in the medical cost trend rate would increase this liability by approximately $35 million, resulting in a decrease in net income of approximately $30 million after-tax, and a 50 basis point decrease in completion factors would increase this liability by approximately $80 million, resulting in a decrease in net income of approximately $65 million after-tax.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Unpaid claims and claim expenses – long-term disability reserves	
The liability for long-term disability reserves is the present value of estimated future benefits payments over the expected disability period and includes estimates for both reported claims and for claims incurred but not yet reported. Key assumptions in the calculation of long-term disability reserves include the discount rate and claim resolution rates, both of which are reviewed annually and updated when experience or future expectations would indicate a necessary change. The discount rate is the interest rate used to discount the projected future benefit payments to their present value. The discount rate assumption is based on the projected investment yield of the assets supporting the reserves. Claim resolution rate assumptions involve many factors including claimant demographics, the type of contractual benefit provided and the time since initially becoming disabled. The Company uses its own historical experience to develop its claim resolution rates. Long-term disability reserves as of December 31 were as follows (in millions): • **2018 – gross $4,069; net $3,975** • 2017 – gross $3,884; net $3,790 These liabilities are presented above both gross and net of reinsurance recoverables. See Note 7C. to our Consolidated Financial Statements for additional information regarding assumptions and methods used to estimate this liability.	Based on recent and historical resolution rate patterns and changes in investment portfolio yields, it is reasonably possible that a five percent change in claim resolution rates and a 25 basis point change in the discount rate could occur. A five percent decrease in the claim resolution rate would increase long-term disability reserves by approximately $90 million and decrease net income by approximately $70 million after-tax. A 25 basis point decrease in the discount rate would increase long-term disability reserves by approximately $45 million and decrease net income by approximately $35 million after-tax.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Valuation of fixed maturity investments	
Most fixed maturities are classified as available for sale and are carried at fair value with changes in fair value recorded in accumulated other comprehensive income (loss) within shareholders' equity. Fair value is defined as the price at which an asset could be exchanged in an orderly transaction between market participants at the balance sheet date. Determining fair value for a financial instrument requires management judgment. The degree of judgment involved generally correlates to the level of pricing readily observable in the markets. Financial instruments with quoted prices in active markets or with market observable inputs to determine fair value, such as public securities, generally require less judgment. Conversely, private placements including more complex securities that are traded infrequently are typically measured using pricing models that require more judgment as to the inputs and assumptions used to estimate fair value. There may be a number of alternative inputs to select based on an understanding of the issuer, the structure of the security and overall market conditions. In addition, these factors are inherently variable in nature as they change frequently in response to market conditions. Approximately two-thirds of our fixed maturities are public securities, and one-third are private placement securities. Typically, the most significant input in the measurement of fair value is the market interest rate used to discount the estimated future cash flows of the instrument. Such market rates are derived by calculating the appropriate spreads over comparable U.S. Treasury securities, based on the credit quality, industry and structure of the asset. See Notes 9A. and 10 to our Consolidated Financial Statements for a discussion of our fair value measurements, the procedures performed by management to determine that the amounts represent appropriate estimates and our accounting policy regarding unrealized appreciation on fixed maturities.	If the interest rates used to calculate fair value increased by 100 basis points, the fair value of the total fixed maturity portfolio of $23 billion would decrease by approximately $1.5 billion, resulting in an after-tax decrease to shareholders' equity of approximately $0.9 billion.

Balance Sheet Caption / Nature of Critical Accounting Estimate	Effect if Different Assumptions Used
Assessment of "other-than-temporary" impairments on fixed maturities	
Certain fixed maturities with a fair value below amortized cost are carried at fair value with changes in fair value recorded in accumulated other comprehensive income. For these investments, we have determined that the decline in fair value below its amortized cost is temporary. To make this determination, we evaluated the expected recovery in value and our intent to sell or the likelihood of a required sale of the fixed maturity prior to an expected recovery. In making this evaluation, we considered a number of general and specific factors including the regulatory, economic and market environments, length of time and severity of the decline, and the financial health and specific near term prospects of the issuer. The after-tax amounts as of December 31 in accumulated other comprehensive income for fixed maturities in an unrealized loss position were as follows (in millions): • **2018 – ($370)** • 2017 – ($80) See Note 9 to our Consolidated Financial Statements for additional discussion of our review of declines in fair value, including information regarding our accounting policies for fixed maturities.	If we subsequently determine that the excess of amortized cost over fair value is other-than-temporary for any or all of these fixed maturities, the amount recorded in accumulated other comprehensive income would be reclassified to shareholders' net income as an impairment loss.

Segment Reporting

The following section of this MD&A discusses the results of each of our segments. As a result of the Express Scripts acquisition, during the fourth quarter of 2018, we changed our segment reporting to reflect the new management and business reporting structure of the combined company. Prior year financial information has been restated to conform to the new segment presentation. See Note 1 to our Consolidated Financial Statements for a description of our segments.

In segment discussions, we present adjusted revenues and "pre-tax adjusted income from operations," defined as income before taxes excluding realized investment gains (losses), amortization of acquired intangible assets, results of transitioning clients and special items. Ratios presented in this segment discussion exclude the same items as adjusted income from operations. See Note 21 to our Consolidated Financial Statements for additional discussion of these metrics and a reconciliation of income before income taxes to pre-tax adjusted income from operations.

In these segment discussions, we also present "pre-tax adjusted margin," defined as adjusted income from operations before taxes divided by adjusted revenues.

See the MD&A Executive Overview beginning on page 42 for summarized financial results of each of our reporting segments.

Integrated Medical Segment

The Integrated Medical segment includes the businesses previously reported in "Global Health Care" except as follows: 1) international health care products are now reported in the International Markets segment; 2) mail order pharmacy business is now reported in the Health Services segment; and 3) Medicare supplement business previously reported in "Global Supplemental Benefits" is now reported in Integrated Medical.

The business section of this Form 10-K (see the "Integrated Medical" section beginning on page 3) describes the various products and funding solutions offered by this segment, including the various revenue sources. As described in the introduction to Segment Reporting above, performance of the Integrated Medical segment is measured using pre-tax adjusted income from operations. Key factors affecting profitability for this segment include:

- customer growth;
- revenues from integrated specialty products, including pharmacy services, sold to clients and customers across all funding solutions;
- percentage of Medicare Advantage customers in plans eligible for quality bonus payments;
- benefit expenses as a percentage of premiums (medical care ratio or "MCR") for our insured commercial and government businesses; and
- selling, general and administrative expense as a percentage of adjusted revenues (expense ratio).

We adopted new accounting guidance for revenue recognition effective January 1, 2018. Prior year revenues along with adjusted margin and both the medical care and expense ratios for the Integrated Medical segment have been retrospectively adjusted to conform to this new basis of accounting. See Note 2 to the Consolidated Financial Statements for additional information.

Results of Operations

Financial Summary

(In millions)	For the Years Ended December 31, 2018	2017	2016	Change Favorable (Unfavorable) 2018 vs. 2017		Change Favorable (Unfavorable) 2017 vs. 2016	
Adjusted revenues	**$ 32,791**	$ 29,035	$ 27,395	**$ 3,756**	13%	$ 1,640	6%
Pre-tax adjusted income from operations	**$ 3,502**	$ 2,922	$ 2,592	**$ 580**	20%	$ 330	13%
Adjusted pre-tax margin	**10.7%**	10.1%	9.5%	**60bps**		60bps	
Medical care ratio	**78.9%**	81.0%	80.9%	**210bps**		(10)bps	
Expense ratio	**24.7%**	24.1%	24.8%	**(60)bps**		70bps	

(Dollars in millions, customers in thousands)	As of December 31, 2018	2017	2016	Increase (Decrease) 2018 vs. 2017		Increase (Decrease) 2017 vs. 2016	
Unpaid claims and claim expenses – Integrated Medical	**$ 2,697**	$ 2,420	$ 2,261	**$ 277**	11%	$ 159	7%
Integrated Medical Customers							
Commercial risk	**1,911**	1,792	1,561	**119**	7%	231	15%
Government	**1,407**	1,235	1,015	**172**	14%	220	22%
Total risk	**3,318**	3,027	2,576	**291**	10%	451	18%
Service	**12,071**	11,801	11,394	**270**	2%	407	4%
Total	**15,389**	14,828	13,970	**561**	4%	858	6%

2018 versus 2017

Adjusted revenues increased, primarily due to customer growth in our Commercial and Government segments including contributions from specialty products. Also contributing to the increase were higher premium rates across our businesses reflecting: 1) underlying medical cost trend; 2) the government's suspension of cost share reduction subsidies; and 3) resumption of the health insurance industry tax.

Pre-tax adjusted income from operations increased, reflecting improved margins in our Individual business and strong ongoing performance in our Commercial business, including increased contributions from specialty products.

Medical care ratio. The medical care ratio decreased, reflecting the pricing impact of resumption of the health insurance industry tax and improvement from our Individual business.

Expense ratio. The expense ratio increased, reflecting resumption of the health insurance industry tax and ongoing investments in growth and innovation, partially offset by higher revenues.

2017 versus 2016

Adjusted revenues increased, primarily due to customer growth in our Commercial risk and Individual businesses, partially offset by lower customer enrollment in our Medicare Advantage business.

Pre-tax adjusted income from operations increased, reflecting higher earnings in both our Commercial and Government operating segments. The increase in the Commercial segment reflects customer growth including increased contributions from our specialty products. The Government segment's earnings growth reflects lower operating expenses related to the moratorium of the health insurance industry tax in 2017 and our 2016 CMS audit response as well as favorable claims experience in our Individual business, partially offset by lower customer enrollment in our Medicare Advantage business. Pre-tax adjusted income from operations included favorable prior year reserve development of $148 million for 2017; prior year reserve development in 2016 was not material.

Medical care ratio. The medical care ratio remained fairly consistent, reflecting the 2017 moratorium on the health insurance industry tax offset by improved performance in our Government segment businesses and favorable prior year reserve development.

Expense ratio. The expense ratio decreased, reflecting suspension of the health insurance industry tax in 2017 and lower costs related to our 2016 CMS audit response.

Other Items Affecting Integrated Medical Results

Unpaid Claims and Claim Expenses

Unpaid claims and claim expenses were higher as of December 31, 2018 compared with 2017 and were higher as of December 31, 2017 compared with 2016, primarily due to customer growth and medical cost trend. See Note 7 to our Consolidated Financial Statements for additional information.

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Medical Customers

A medical customer is defined as a person meeting any one of the following criteria:

- is covered under a medical insurance policy, managed care arrangement or service agreement issued by us;
- has access to our provider network for covered services under their medical plan; or
- has medical claims that are administered by us.

Medical customers now include the Medicare Supplement business. For the Integrated Medical segment, medical customers excludes international health care customers.

Our medical customer base was higher at December 31, 2018 compared to December 31, 2017, primarily reflecting growth across our targeted Commercial markets as well as our Government segment businesses. Our medical customer base increased as of December 31, 2017 compared with 2016, reflecting growth across our Commercial and Government segments. The Government segment growth was primarily driven by our Medicare Supplement and Individual businesses, partially offset by declines in our Medicare Advantage business.

Health Services Segment

We established the Health Services segment to include the pharmacy benefit management ("PBM") and health services operations of Express Scripts effective with the acquisition, as well as Cigna's legacy mail order pharmacy business. As described in the introduction to Segment Reporting on page 56, performance of the Health Services Segment is measured using pre-tax adjusted income from operations.

The key factors that impact Health Services revenues and costs of revenues are volume, mix and price. These key factors are discussed further below. See Note 2 for additional information on revenue and cost recognition policies for this segment.

- As our clients' claim volumes increase or decrease, our resulting revenues and cost of revenues correspondingly increase or decrease. Our gross profit could also increase or decrease as a result of changes in purchasing discounts.
- The mix of claims generally considers the type of drug and distribution method used for dispensing and fulfilling. As our mix of drugs changes, our resulting pharmacy revenues and cost of revenues correspondingly may increase or decrease. The primary driver of fluctuations within our mix of claims is the generic fill rate. Generally, higher generic fill rates reduce revenues, as generic drugs are typically priced lower than the branded drugs they replace. However, as ingredient cost paid to pharmacies on generic drugs is incrementally lower than the price charged to our clients, higher generic fill rates generally have a favorable impact on our gross profit. The home delivery generic fill rate is currently lower than the network generic fill rate as fewer generic substitutions are available among maintenance medications (such as therapies for chronic conditions) commonly dispensed from home delivery pharmacies as compared to acute medications that are primarily dispensed by pharmacies in our retail networks.
- Our contract pricing is impacted by our ability to negotiate contracts for pharmacy network, pharmaceutical and wholesaler purchasing, and manufacturer rebates. We are able to reduce the rate of drug price increases and, in some cases, lower our clients' prescription drug spend through our integrated set of solutions, including sharing of significant amounts of pharmaceutical manufacturer rebates with our clients. We refer to this as "management of the supply chain." Inflation also impacts our pricing because most of our contracts provide that we bill clients and pay pharmacies based on a generally recognized price index for pharmaceuticals. Therefore, the rate of inflation for prescription drugs and our efforts to manage this inflation for our clients can affect our revenues and cost of revenues.

In this MD&A, we present revenues, gross profit and pre-tax adjusted income from operations "excluding transitioning clients" in addition to those metrics including transitioning clients. See the "Key Transactions and Developments" section on page 46 of this MD&A for further discussion of transitioning clients and why we present this information.

Results of Operations

Financial Summary

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2018**	**2017**	**2016**	**2018 vs. 2017**		**2017 vs. 2016**	
Total revenues	**$ 7,065**	$ 4,241	$ 4,066	**$ 2,824**	67%	$ 175	4%
Less: revenue contributions from transitioning clients	**(459)**	-	-	**(459)**	N/M	-	N/M
Adjusted revenues	**$ 6,606**	$ 4,241	$ 4,066	**$ 2,365**	56	$ 175	4
Gross profit	**$ 604**	$ 371	$ 344	**$ 233**	63	$ 27	8
Gross profit excluding transitioning clients	**$ 531**	$ 371	$ 344	**$ 160**	43	$ 27	8
Pre-tax adjusted income from operations	**$ 380**	$ 288	$ 268	**$ 92**	32%	$ 20	7%
Pre-tax adjusted margin	**5.8%**	6.8%	6.6%	**(100)bps**		20bps	

2018 versus 2017

Adjusted revenues increased, primarily due to the acquisition of Express Scripts. Excluding the acquired business, revenues increased slightly, reflecting increased utilization of specialty medications and higher prices.

Pre-tax adjusted income from operations before taxes increased, due to the acquisition of Express Scripts. Excluding the acquired business, adjusted income from operations increased, reflecting volume growth due to increased specialty utilization and net savings related to management of supply chain.

2017 versus 2016

Adjusted revenues increased, reflecting increased Commercial customers, specialty medication prices and utilization (e.g., certain injectables), offset by lower oral medication volumes and Medicare customers.

Pre-tax adjusted income from operations before taxes increased, due to Commercial customer growth including increased margin contributions from specialty medications.

International Markets Segment

As described in the business section of this Form 10-K, the International Markets segment includes supplemental health, life and accident business previously reported in the "Global Supplemental Benefits" segment, except for Medicare Supplement business that is now reported in the Integrated Medical segment and certain international businesses in run-off that are now reported in Group Disability and Other. International health care products previously reported in the "Global Health Care" segment are now reported in International Markets.

As described in the introduction to Segment Reporting on page 56, performance of the International Markets segment is measured using pre-tax adjusted income from operations. Key factors affecting pre-tax adjusted income from operations for this segment are:

- premium growth, including new business and customer retention;
- benefit expenses as a percentage of premiums (loss ratio);
- selling, general and administrative expense and acquisition expense as a percentage of revenues (expense ratio and acquisition cost ratio); and
- the impact of foreign currency movements.

Results of Operations

Financial Summary

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	2018	2017	2016	2018 vs. 2017		2017 vs. 2016	
Adjusted revenues	**$ 5,366**	$ 4,901	$ 4,537	**$ 465**	9%	$ 364	8%
Pre-tax adjusted income from operations	**$ 735**	$ 654	$ 538	**$ 81**	12%	$ 116	22%
Pre-tax adjusted margin	**13.7%**	13.3%	11.9%	**40bps**		140bps	
Loss ratio	**57.4%**	57.5%	60.0%	**(10)bps**		250bps	
Acquisition cost ratio	**13.1%**	12.8%	12.9%	**30bps**		10bps	
Expense ratio (excluding acquisition costs)	**18.9%**	19.7%	19.1%	**(80)bps**		(60)bps	

2018 versus 2017

Adjusted revenues increased primarily due to business growth mainly in South Korea, Middle East, Hong Kong and Europe.

Pre-tax adjusted income from operations increased primarily due to business growth, largely in South Korea, and a lower expense ratio, partially offset by a less favorable acquisition cost ratio.

The segment's ***loss ratio*** decreased slightly, reflecting favorable claims experience in South Korea and Europe, largely offset by unfavorable claims experience in North America and other Asian markets.

The ***acquisition cost ratio*** increased due to higher amortization primarily in Korea and Taiwan.

The decrease in the ***expense ratio*** (excluding acquisition costs) was primarily driven by lower value added tax and disciplined expense management.

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2017 versus 2016

Adjusted revenues were higher primarily due to business growth mainly in South Korea and the Middle East.

Pre-tax adjusted income from operations increased primarily due to business growth, largely in South Korea, and lower loss ratios, partially offset by higher expense ratios.

The segment's ***loss ratio*** decreased, reflecting favorable claims in South Korea and Europe.

The ***acquisition cost ratio*** decreased slightly due to lower spending in certain markets.

The increase in the ***expense ratio*** (excluding acquisition costs) was primarily driven by strategic investment in the Middle East and higher value added tax, partially offset by strong expense management.

Other Items Affecting International Markets Results

South Korea is the single largest geographic market for our International Markets segment. South Korea generated 40% of the segment's revenues and 68% of the segment's pre-tax adjusted income from operations in 2018. In 2018, our International Markets segment operations in South Korea represented 5% of our consolidated revenues and 11% of consolidated pre-tax adjusted income from operations.

Group Disability and Other

Group Disability and Other includes the results of the business previously reported in the "Group Disability and Life" segment and "Other Operations" comprising the corporate-owned life insurance ("COLI") business along with run-off of the following businesses: 1) reinsurance; 2) settlement annuity; and 3) the sold individual life insurance and annuity and retirement benefits businesses. In addition, certain international run-off business previously reported in the "Global Supplemental Benefits" segment is now reported in Group Disability and Other.

As described in the introduction of Segment Reporting on page 56, performance of Group Disability and Other is measured using pre-tax adjusted income from operations. Key factors affecting pre-tax adjusted income from operations are:

- premium growth, including new business and customer retention;
- net investment income;
- benefit expenses as a percentage of premiums (loss ratio); and
- selling, general and administrative expense as a percentage of revenues excluding net investment income (expense ratio).

Results of Operations

Financial Summary

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	**2018**	**2017**	**2016**	**2018 vs. 2017**		**2017 vs. 2016**	
Adjusted revenues	**$ 5,061**	$ 5,075	$ 5,108	**$ (14)**	-%	$ (33)	(1)%
Pre-tax adjusted income from operations	**$ 529**	$ 517	$ 275	**$ 12**	2%	$ 242	88%
Pre-tax adjusted margin	**10.5%**	10.2%	5.4%	**30bps**		480bps	

2018 versus 2017

Adjusted revenues decreased slightly, due to the continued run-off of international business and lower life premiums, mostly offset by moderate growth in the group disability business and higher investment income.

Pre-tax adjusted income from operations increased, reflecting improved results in the life business and run-off operations, partially offset by unfavorable disability claims experience.

2017 versus 2016

Adjusted revenues were relatively flat, with higher investment income driven by higher asset levels offset by cancelations in non-core specialty and association products.

Pre-tax adjusted income from operations increased, reflecting significantly improved claim experience in the group disability and life segment.

Corporate

Corporate reflects amounts not allocated to operating segments, including net interest expense (defined as interest on corporate debt less net investment income on investments not supporting segment and other operations), certain litigation matters, compensation cost for stock options, expense associated with our frozen pension plans, charitable contributions, severance, certain overhead and project costs and intersegment eliminations for products and services sold between segments.

Financial Summary

	For the Years Ended December 31,			Change Favorable (Unfavorable)		Change Favorable (Unfavorable)	
(In millions)	2018	2017	2016	2018 vs. 2017		2017 vs. 2016	
Pre-tax adjusted loss from operations	**$ (403)**	$ (375)	$ (362)	**$ (28)**	(7)%	$ (13)	(4)%

2018 versus 2017

Pre-tax adjusted loss from operations was higher, primarily due to higher interest expense.

2017 versus 2016

Pre-tax adjusted loss from operations was higher, primarily due to higher charitable contributions and operating expenses, partially offset by higher net investment income.

Investment Assets

The following table presents our invested asset portfolio, excluding separate account assets, as of December 31, 2018 and 2017. Additional information regarding our investment assets and related accounting policies is included in Notes 2, 9, 10, 11, and 12 to our Consolidated Financial Statements.

(In millions)	2018	2017
Fixed maturities	**$ 22,928**	$ 23,138
Equity securities	**548**	588
Commercial mortgage loans	**1,858**	1,761
Policy loans	**1,423**	1,415
Other long-term investments	**1,901**	1,518
Short-term investments	**316**	199
Total	**$ 28,974**	$ 28,619

Fixed Maturities

Investments in fixed maturities include publicly traded and privately placed debt securities, mortgage and other asset-backed securities and preferred stocks redeemable by the investor. These investments are classified as available for sale and are carried at fair value on our balance sheet. Additional information regarding valuation methodologies, key inputs and controls is included in Note 10 to our Consolidated Financial Statements. More detailed information about fixed maturities by type of issuer and maturity dates is included in Note 9 to our Consolidated Financial Statements.

The following table reflects our fixed maturity portfolio by type of issuer as of December 31, 2018 and 2017.

(In millions)	2018	2017
Federal government and agency	**$ 710**	$ 779
State and local government	**985**	1,287
Foreign government	**2,362**	2,487
Corporate	**18,361**	18,088
Mortgage and other asset-backed	**510**	497
Total	**$ 22,928**	$ 23,138

The fixed maturity portfolio decreased during 2018, reflecting decreased valuations due to increases in market yields and weakening foreign currencies, partially offset by increased investment in fixed maturities. As of December 31, 2018, $20.6 billion, or 90% of the fixed maturities in our investment portfolio were investment grade (Baa and above, or equivalent), and the remaining $2.3 billion were below investment grade. The majority of the bonds that are below investment grade are rated at the higher end of the non-investment grade spectrum. These quality characteristics have not materially changed from the prior year and are consistent with our investment strategy. Fixed maturity investments are diversified by issuer, geography, and industry as appropriate.

Foreign government obligations are concentrated in Asia, primarily South Korea, consistent with our risk management practice and local regulatory requirements of our international business operations. Corporate fixed maturities include private placement assets of $6 billion.

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These investments are generally less marketable than publicly-traded bonds; however yields on these investments tend to be higher than yields on publicly-traded bonds with comparable credit risk. We perform a credit analysis of each issuer, and require financial and other covenants that allow us to monitor issuers for deteriorating financial strength and pursue remedial actions, if warranted.

In addition to amounts classified in fixed maturities on our Consolidated Balance Sheets, we participate in an insurance joint venture in China in which we have a 50% ownership interest. We account for this joint venture on the equity basis of accounting and report it in other assets. This entity had an investment portfolio of approximately $6.3 billion supporting this business that is primarily invested in Chinese corporate and government fixed maturities. There were no investments with a material unrealized loss as of December 31, 2018.

Commercial Mortgage Loans

Our commercial mortgage loans are fixed rate loans, diversified by property type, location and borrower. Loans are secured by high quality commercial properties and are generally made at less than 70% of the property's value at origination of the loan. Property value, debt service coverage, quality, building tenancy and stability of cash flows are all important financial underwriting considerations. We hold no direct residential mortgage loans and do not originate or service securitized mortgage loans.

Commercial real estate capital markets remain very active for well-leased, quality commercial real estate located in strong institutional investment markets. The vast majority of properties securing the mortgages in our mortgage loan portfolio possess these characteristics.

As of December 31, 2018, the $1.9 billion commercial mortgage loan portfolio consisted of approximately 66 loans that are all in good standing. Given the quality and diversity of the underlying real estate, positive debt service coverage and significant borrower cash investment generally ranging between 30 and 40%, we remain confident that borrowers will continue to perform as expected under their contract terms.

Other Long-term Investments

Other long-term investments of $1.9 billion included investments in securities limited partnerships and real estate limited partnerships as well as direct investments in real estate joint ventures. These entities typically invest in mezzanine debt or equity of privately held companies (securities partnerships) and equity real estate. Given our subordinate position in the capital structure of these underlying entities, we assume a higher level of risk for higher expected returns. To mitigate risk, these investments are diversified across approximately 135 separate partnerships, and approximately 70 general partners who manage one or more of these partnerships. Also, the underlying investments are diversified by industry sector or property type, and geographic region. No single partnership investment exceeded 4% of our securities and real estate partnership portfolio.

Problem and Potential Problem Investments

"Problem" bonds and commercial mortgage loans are either delinquent by 60 days or more or have been restructured as to terms, including concessions by us for modification of interest rate, principal payment or maturity date. "Potential problem" bonds and commercial mortgage loans are considered current (no payment is more than 59 days past due), but management believes they have certain characteristics that increase the likelihood that they may become problems.

There were no significant problem or potential problem investments at December 31, 2018 and 2017.

Investment Outlook

Despite the continued strength of the U.S. economy, concerns related to trade and tariffs and rising interest rates contributed to a return of financial market volatility and public equity market declines in 2018. We continue to closely monitor global macroeconomic conditions and trends, including the uncertainty caused by the United Kingdom's decision to exit the European Union, and their potential impact to our investment portfolio. Certain sectors, such as retail, energy and natural gas have been volatile and we expect that to continue. Future realized and unrealized investment results will be driven largely by market conditions that exist when a transaction occurs or at the reporting date. These future conditions are not reasonably predictable; however, we believe that the vast majority of our investments will continue to perform under their contractual terms. Based on our strategy to match the duration of invested assets to the duration of insurance and contractholder liabilities, we expect to hold a significant portion of these assets for the long term. Although future impairment losses resulting from interest rate movements and credit deterioration due to both investment-specific and the global economic uncertainties discussed above remain possible, we do not expect these losses to have a material adverse effect on our financial condition or liquidity.

Market Risk

Financial Instruments

Our assets and liabilities include financial instruments subject to the risk of potential losses from adverse changes in market rates and prices. Consistent with disclosure requirements, the following items have been excluded from this consideration of market risk for financial instruments:

- changes in the fair values of insurance-related assets and liabilities because their primary risks are insurance rather than market risk;
- changes in the fair values of investments recorded using the equity method of accounting and liabilities for pension and other postretirement and postemployment benefit plans (and related assets); and
- changes in the fair values of other significant assets and liabilities such as goodwill, deferred policy acquisition costs, taxes, and various accrued liabilities. Because they are not financial instruments, their primary risks are other than market risk.

Excluding these items, our primary market risk exposures from financial instruments are:

- ***Interest-rate risk*** on fixed-rate, medium-term instruments. Changes in market interest rates affect the value of instruments that promise a fixed return.
- ***Foreign currency exchange rate risk*** of the U.S. dollar primarily to the South Korean won, Euro, New Zealand dollar, Chinese yuan renminbi, and Taiwan dollar. An unfavorable change in exchange rates reduces the carrying value of net assets denominated in foreign currencies.

Our Management of Market Risks

We predominantly rely on three techniques to manage our exposure to market risk:

- ***Investment/liability matching.*** We generally select investment assets with characteristics (such as duration, yield, currency and liquidity) that correspond to the underlying characteristics of our related insurance and contractholder liabilities so that we can match the investments to our obligations. Shorter-term investments generally support shorter-term life and health liabilities. Medium-term, fixed-rate investments support interest-sensitive and health liabilities. Longer-term investments generally support products with longer pay out periods such as annuities and long-term disability liabilities.
- ***Use of local currencies for foreign operations.*** We generally conduct our international business through foreign operating entities that maintain assets and liabilities in local currencies. This technique limits exchange rate risk to our net assets.
- ***Use of derivatives.*** We use derivative financial instruments to minimize certain market risks.

See Note 9 to our Consolidated Financial Statements for additional information about derivative financial instruments.

Effect of Market Fluctuations

Assuming a 100 basis point increase in interest rates and 10% strengthening in the U.S. dollar to foreign currencies, the effect of hypothetical changes in market rates or prices on the fair value of certain financial instruments, subject to the exclusions noted above (particularly insurance liabilities), would have been as follows as of December 31:

	Loss in fair value	
Market scenario for certain non-insurance financial instruments (in billions)	**2018**	**2017**
100 basis point increase in interest rates (excluding long-term debt)	**$ 1.6**	$ 1.6
10% strengthening in U.S. dollar to foreign currencies	**$ 0.4**	$ 0.5

The effect of a hypothetical increase in interest rates, primarily on fixed maturities and commercial mortgage loans, was determined by estimating the present value of future cash flows using various models, primarily duration modeling. The impact of a hypothetical increase to interest rates at December 31, 2018 is consistent with the impact at December 31, 2017, which has been restated to exclude long-term debt, as discussed below.

In the event of a hypothetical 100 basis point increase in interest rates, the fair value of the Company's long-term debt would decrease approximately $2.4 billion at December 31, 2018 and $0.5 billion at December 31, 2017. The impact at December 31, 2018 was greater than that at December 31, 2017 due to additional long-term debt issued in acquiring Express Scripts. Changes in the fair value of our long-term debt do not impact our financial position or operating results. See Note 5 to our Consolidated Financial Statements for additional information about the Company's debt.

The effect of a hypothetical strengthening of the U.S. dollar relative to the foreign currencies of certain financial instruments held by us was estimated to be 10% of the U.S. dollar equivalent fair value. Our foreign operations hold investment assets, such as fixed maturities, cash, and cash equivalents, that are generally invested in the currency of the related liabilities. The effect of a hypothetical 10% strengthening in the U.S. dollar to foreign currencies at December 31, 2018 is consistent with that at December 31, 2017.

ITEM 7A. Quantitative and Qualitative Disclosures About Market Risk

The information contained under the caption "Market Risk" in the MD&A section of this Form 10-K is incorporated by reference.

ITEM 8. Financial Statements and Supplementary Data

Report of Independent Registered Public Accounting Firm

To the Board of Directors
and Shareholders of Cigna Corporation

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Cigna Corporation and its subsidiaries (the "Company") as of December 31, 2018 and 2017, and the related consolidated statements of income, comprehensive income, changes in total equity and cash flows for each of the three years in the period ended December 31, 2018, including the related notes (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control – Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018 based on criteria established in *Internal Control – Integrated Framework* (2013) issued by the COSO.

Basis for Opinions

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

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

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

As described in Management's Annual Report on Internal Control over Financial Reporting, management has excluded Express Scripts Holding Company ("legacy Express Scripts") from its assessment of internal control over financial reporting as of December 31, 2018 because it was acquired by the Company in a purchase business combination during 2018. We have also excluded legacy Express Scripts from our audit of internal control over financial reporting. Legacy Express Scripts is a wholly-owned subsidiary whose total assets and total revenues excluded from management's assessment and our audit of internal control over financial reporting represent 10% and 5%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2018.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

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

/s/ PricewaterhouseCoopers LLP
Hartford, Connecticut
February 28, 2019

We have served as the Company's auditor since 1983.

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Cigna Corporation
Consolidated Statements of Income

(In millions, except per share amounts)	For the years ended December 31, 2018	2017	2016
Revenues			
Premiums	**$ 36,113**	$ 32,491	$ 30,824
Fees and other revenues	**5,578**	5,110	4,901
Pharmacy revenues	**5,479**	2,979	2,966
Net investment income	**1,480**	1,226	1,147
TOTAL REVENUES	**48,650**	41,806	39,838
Benefits and expenses			
Medical costs and other benefit expenses	**27,528**	25,263	24,341
Pharmacy and other service costs	**4,793**	2,456	2,468
Selling, general and administrative expenses	**11,934**	10,030	9,790
Amortization of acquired intangible assets	**235**	115	151
TOTAL BENEFITS AND EXPENSES	**44,490**	37,864	36,750
Income from operations	**4,160**	3,942	3,088
Interest expense and other	**(498)**	(252)	(278)
Debt extinguishment costs	**—**	(321)	—
Net realized investment (losses) gains	**(81)**	237	169
Income before income taxes	**3,581**	3,606	2,979
TOTAL INCOME TAXES	**935**	1,374	1,136
Net income	**2,646**	2,232	1,843
Less: net income (loss) attributable to noncontrolling interests	**9**	(5)	(24)
SHAREHOLDERS' NET INCOME	**$ 2,637**	$ 2,237	$ 1,867
Shareholders' net income per share			
Basic	**$ 10.69**	$ 8.92	$ 7.31
Diluted	**$ 10.54**	$ 8.77	$ 7.19

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation
Consolidated Statements of Comprehensive Income

(In millions)	For the years ended December 31, 2018	2017	2016
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867
Shareholders' other comprehensive income (loss), net of tax			
Net unrealized (depreciation) on securities and derivatives	**(365)**	(37)	(60)
Net translation (losses) gains on foreign currencies	**(152)**	304	(95)
Postretirement benefits liability adjustment	**127**	33	23
Shareholders' other comprehensive (loss) income, net of tax	**(390)**	300	(132)
Shareholders' comprehensive income	**2,247**	2,537	1,735
Comprehensive income attributable to noncontrolling interests			
Net income (loss) attributable to redeemable noncontrolling interests	**9**	—	(7)
Net (loss) attributable to other noncontrolling interests	**—**	(5)	(17)
Other comprehensive (loss) attributable to redeemable noncontrolling interests	**(15)**	(3)	(10)
Total comprehensive (loss) attributable to noncontrolling interests	**(6)**	(8)	(34)
TOTAL COMPREHENSIVE INCOME	**$ 2,241**	$ 2,529	$ 1,701

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

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Cigna Corporation
Consolidated Balance Sheets

(In millions, except per share amounts)	As of December 31, 2018	2017
Assets		
Cash and cash equivalents	**$ 3,855**	$ 2,972
Investments	**2,045**	2,136
Accounts receivable, net	**10,473**	3,155
Inventories	**2,821**	228
Other current assets	**1,236**	820
Total current assets	**20,430**	9,311
Long-term investments	**26,929**	26,483
Reinsurance recoverables	**5,507**	5,763
Deferred policy acquisition costs	**2,821**	2,237
Property and equipment	**4,562**	1,563
Deferred tax assets, net	**–**	39
Goodwill	**44,505**	6,164
Other intangible assets	**39,003**	345
Other assets	**1,630**	1,431
Separate account assets	**7,839**	8,423
TOTAL ASSETS	**153,226**	61,759
Liabilities		
Current insurance and contractholder liabilities	**6,801**	6,317
Pharmacy and service costs payable	**10,702**	305
Accounts payable	**4,366**	184
Accrued expenses and other liabilities	**7,071**	3,963
Short-term debt	**2,955**	240
Total current liabilities	**31,895**	11,009
Non-current insurance and contractholder liabilities	**19,974**	20,530
Deferred tax liabilities, net	**9,453**	—
Other non-current liabilities	**3,470**	2,838
Long-term debt	**39,523**	5,199
Separate account liabilities	**7,839**	8,423
TOTAL LIABILITIES	**112,154**	47,999
Contingencies – Note 19		
Redeemable noncontrolling interests	**37**	49
Shareholders' equity		
Common stock [1]	**4**	74
Additional paid-in capital	**27,751**	2,940
Accumulated other comprehensive loss	**(1,711)**	(1,082)
Retained earnings	**15,088**	15,800
Less: treasury stock, at cost	**(104)**	(4,021)
TOTAL SHAREHOLDERS' EQUITY	**41,028**	13,711
Noncontrolling interests	**7**	–
Total equity	**41,035**	13,711
Total liabilities and equity	**$ 153,226**	$ 61,759
SHAREHOLDERS' EQUITY PER SHARE	**$ 107.71**	$ 56.20

(1) Par value per share, $0.01 in 2018 and $0.25 in 2017; shares issued, 381 million in 2018 and 296 million in 2017; authorized shares, 600 million in 2018 and 2017.

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Cigna Corporation
Consolidated Statements of Changes in Total Equity

(In millions, except per share amounts)	Common Stock	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Shareholders' Equity	Non-controlling Interests	Total Equity	Redeemable Non-controlling Interests
Balance at December 31, 2015	**$ 74**	**$ 2,859**	**$ (1,250)**	**$ 12,121**	**$ (1,769)**	**$ 12,035**	**$ 9**	**$ 12,044**	**$ 69**
Cumulative effect of accounting for revenue recognition				(24)		(24)		(24)	
Balance at December 31, 2015, as retrospectively adjusted	74	2,859	(1,250)	12,097	(1,769)	12,011	9	12,020	69
2016 Activity									
Effect of issuing stock for employee benefit plans		51		(123)	163	91		91	
Other comprehensive (loss)			(132)			(132)		(132)	(10)
Net income (loss)				1,867		1,867	(17)	1,850	(7)
Common dividends declared (per share: $0.04)				(10)		(10)		(10)	
Repurchase of common stock					(110)	(110)		(110)	
Other transactions impacting noncontrolling interests		(18)				(18)	12	(6)	6
Balance at December 31, 2016	**74**	**2,892**	**(1,382)**	**13,831**	**(1,716)**	**13,699**	**4**	**13,703**	**58**
2017 Activity									
Effect of issuing stock for employee benefit plans		51		(258)	455	248		248	
Other comprehensive income (loss)			300			300		300	(3)
Net income (loss)				2,237		2,237	(5)	2,232	–
Common dividends declared (per share: $0.04)				(10)		(10)		(10)	
Repurchase of common stock					(2,760)	(2,760)		(2,760)	
Other transactions impacting noncontrolling interests		(3)				(3)	1	(2)	(6)
Balance at December 31, 2017	**74**	**2,940**	**(1,082)**	**15,800**	**(4,021)**	**13,711**	**–**	**13,711**	**49**
2018 Activity									
Cumulative effect of accounting for financial instruments and hedging			**(10)**	**68**		**58**		**58**	
Reclassification adjustment related to U.S. tax reform legislation			**(229)**	**229**		**–**		**–**	
Retirement of treasury stock	**(13)**	**(529)**		**(3,498)**	**4,040**	**–**		**–**	
Exchange of Old Cigna common stock	**(58)**	**58**				**–**		**–**	
Acquisition of Express Scripts (see Note 3)	**1**	**25,223**				**25,224**	**7**	**25,231**	
Effect of issuing stock for employee benefit plans		**59**		**(138)**	**206**	**127**		**127**	
Other comprehensive (loss)			**(390)**			**(390)**		**(390)**	**(15)**
Net income				**2,637**		**2,637**		**2,637**	**9**
Common dividends declared (per share: $0.04)				**(10)**		**(10)**		**(10)**	
Repurchase of common stock					**(329)**	**(329)**		**(329)**	
Other transactions impacting noncontrolling interests						**–**		**–**	**(6)**
Balance at December 31, 2018	**$ 4**	**$ 27,751**	**$ (1,711)**	**$ 15,088**	**$ (104)**	**$ 41,028**	**$ 7**	**$ 41,035**	**$ 37**

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

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Cigna Corporation
Consolidated Statements of Cash Flows

(In millions)	For the years ended December 31, 2018	2017	2016
Cash Flows from Operating Activities			
Net income	**$ 2,646**	$ 2,232	$ 1,843
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	**695**	566	610
Realized investment losses (gains), net	**81**	(237)	(169)
Deferred income tax (benefit) expense	**(101)**	242	74
Debt extinguishment costs	**–**	321	–
Net changes in assets and liabilities, net of non-operating effects:			
Accounts receivable	**705**	(233)	663
Inventories	**(107)**	(72)	30
Deferred policy acquisition costs	**(237)**	(282)	(213)
Reinsurance recoverable and other assets	**(234)**	115	246
Insurance liabilities	**560**	506	683
Pharmacy and service costs payable	**(842)**	35	(46)
Accounts payable and accrued expenses and other liabilities	**332**	696	171
Other, net	**272**	197	134
NET CASH PROVIDED BY OPERATING ACTIVITIES	**3,770**	4,086	4,026
Cash Flows from Investing Activities			
Proceeds from investments sold:			
Fixed maturities and equity securities	**2,655**	2,012	1,544
Investment maturities and repayments:			
Fixed maturities and equity securities	**2,151**	2,051	1,755
Commercial mortgage loans	**215**	335	316
Other sales, maturities and repayments (primarily short-term and other long-term investments)	**734**	1,702	1,431
Investments purchased or originated:			
Fixed maturities and equity securities	**(5,637)**	(5,628)	(5,191)
Commercial mortgage loans	**(312)**	(430)	(165)
Other (primarily short-term and other long-term investments)	**(1,189)**	(1,065)	(1,698)
Property and equipment purchases, net	**(528)**	(471)	(461)
Acquisitions, net of cash acquired	**(24,455)**	(209)	(4)
Other, net	**(12)**	–	(101)
NET CASH (USED IN) INVESTING ACTIVITIES	**(26,378)**	(1,703)	(2,574)
Cash Flows from Financing Activities			
Deposits and interest credited to contractholder deposit funds	**1,040**	1,230	1,460
Withdrawals and benefit payments from contractholder deposit funds	**(1,151)**	(1,363)	(1,362)
Net change in short-term debt	**1,487**	80	(148)
Payments for debt extinguishment	**–**	(313)	–
Repayment of long-term debt	**(131)**	(1,250)	–
Net proceeds on issuance of long-term debt	**22,856**	1,581	–
Repurchase of common stock	**(342)**	(2,725)	(139)
Issuance of common stock	**68**	131	36
Other, net	**(312)**	(22)	(72)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	**23,515**	(2,651)	(225)
Effect of foreign currency rate changes on cash and cash equivalents	**(24)**	55	(10)
Net increase (decrease) in cash and cash equivalents	**883**	(213)	1,217
Cash and cash equivalents, January 1,	**2,972**	3,185	1,968
Cash and cash equivalents, December 31,	**$ 3,855**	$ 2,972	$ 3,185
Supplemental Disclosure of Cash Information:			
Income taxes paid, net of refunds	**$ 1,019**	$ 1,036	$ 1,064
Interest paid	**$ 267**	$ 240	$ 244

The accompanying Notes to the Consolidated Financial Statements are an integral part of these statements.

Notes to the Consolidated Financial Statements

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Note 1 Description of Business

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna," the "Company," "we," "our" or "us" is a global health service organization dedicated to a mission of helping those we serve improve their health, well-being and peace of mind. Our evolved strategy in support of our mission is ***Go Deeper, Go Local, Go Beyond*** using a differentiated set of medical, pharmacy, dental, disability, life and accident insurance and related products and services offered by our subsidiaries.

The majority of these products are offered through employers and other groups such as governmental and non-governmental organizations, unions and associations. Cigna also offers commercial health and dental insurance, Medicare and Medicaid products and health, life and accident insurance coverages to individuals in the United States and selected international markets. In addition to these ongoing operations, Cigna also has certain run-off operations.

As described more fully in Note 3, on March 8, 2018, the Company entered into a merger agreement with Express Scripts Holding Company ("Express Scripts"). Following entry into the merger agreement and throughout the pendency of the transaction, Cigna and Express Scripts designed integration plans to implement a new management and business reporting structure for the combined company immediately upon closing. On December 20, 2018, Cigna completed the acquisition of Express Scripts. As a result, our segments have changed as described below, effective in the fourth quarter of 2018. Financial data for all prior periods presented was restated to reflect this new segment presentation.

Integrated Medical offers a variety of medical solutions to employers and individuals.

- The ***Commercial*** operating segment serves employers (also referred to as "clients") and their employees (also referred to as "customers") and other groups. This segment provides deeply integrated medical and specialty offerings including medical, pharmacy, dental, behavioral health and vision, health advocacy programs and other products and services to insured and self-insured clients.
- The ***Government*** operating segment offers Medicare Advantage, Medicare Supplement, and Medicare Part D plans to Medicare-eligible beneficiaries as well as Medicaid plans. This operating segment also offers health insurance coverage to individual customers both on and off the public exchanges. This segment includes the acquired Express Scripts' Medicare Part D business.

Health Services includes pharmacy benefits management ("PBM"), pharmacy home delivery, and certain medical management services. This segment includes Express Scripts' business from the date of acquisition with the exception of Express Scripts' Medicare Part D business that is reported in the Government operating segment.

International Markets includes supplemental health, life and accident insurance products and health care coverage in our international markets as well as health care benefits to globally mobile employees of multinational organizations.

The remainder of our business operations are reported in ***Group Disability and Other,*** consisting of the following:

- ***Group Disability and Life*** provides group long-term and short-term disability, group life, accident, voluntary and specialty insurance products and related services.
- ***Corporate-Owned Life Insurance ("COLI")*** offers permanent insurance contracts sold to corporations to provide coverage on the lives of certain employees for the purpose of financing employer-paid future benefit obligations.
- ***Run-off businesses:***
    - ***Reinsurance:*** predominantly comprised of guaranteed minimum death benefit ("GMDB") and guaranteed minimum income benefit ("GMIB") business effectively exited through reinsurance with Berkshire Hathaway Life Insurance Company of Nebraska ("Berkshire") in 2013.
    - ***Settlement Annuity*** business in run-off.
    - ***Individual Life Insurance and Annuity and Retirement Benefits Businesses:*** deferred gains from the sales of these businesses.
    - ***Certain international run-off businesses***

Corporate reflects amounts not allocated to operating segments, including interest expense, net investment income on investments not supporting segment and other operations, interest on uncertain tax positions, certain litigation matters, compensation cost for stock options and related excess tax benefits, expense associated with our frozen pension plans, severance, certain overhead and project costs and intersegment eliminations for products and services sold between segments.

Note 2 Summary of Significant Accounting Policies

Basis of Presentation

The Consolidated Financial Statements include the accounts of Cigna Corporation and its consolidated subsidiaries. Intercompany transactions and accounts have been eliminated in consolidation. These Consolidated Financial Statements were prepared in conformity with accounting principles generally accepted in the United States of America ("GAAP"). The Company adopted Article 5 of Regulation S-X issued by the Securities and Exchange Commission effective December 31, 2018 in conjunction with the acquisition of Express Scripts. As a result, the Company now presents current assets and liabilities on its balance sheet. The Company reclassified realized investment gains (losses) from revenue and now reports them below income from operations with interest expense in our Consolidated Statements of Income, in conformity with Article 5. Prior years' information was reclassified to conform to this new presentation.

Amounts recorded in the Consolidated Financial Statements necessarily reflect management's estimates and assumptions about medical costs, investment valuation, interest rates and other factors. Significant estimates are discussed throughout these Notes; however, actual results could differ from those estimates. The impact of a change in estimate is generally included in earnings in the period of adjustment. Certain reclassifications have been made to prior year amounts to conform to the current presentation.

Variable interest entities. See Note 11 for a discussion of variable interest entities.

Recent Accounting Guidance

Accounting Standard and Adoption Date	Requirements and Effects of Adopting New Guidance
GUIDANCE ADOPTED JANUARY 1, 2018	
Revenue from Contracts with Customers (Accounting Standards Update ("ASU") 2014-09 and related amendments)	Requires: • Revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the Company expects to be entitled in exchange for those goods or services • Additional revenue-related disclosures Effects of adoption: • Applies to the Company's service and pharmacy contracts with customers • Adopted through full retrospective restatement • Cumulative-effect adjustment of $24 million after-tax was recorded, reducing the December 31, 2015 balance of retained earnings. This adjustment established a contract liability for service fee revenue billed that must be deferred and allocated to services performed after a customer contract terminates. Subsequent changes in the contract liability and the related impact to net income and per share amounts since adoption were immaterial. • Immaterial reclassifications were made to prior periods in the Consolidated Statements of Income to conform to the current presentation. The ASU and related interpretive guidance provide clarification on topics including whether all or a part of a contract is within its scope, and the definition of a customer. Companies are required to identify and evaluate distinct performance obligations within their contracts. These clarifications resulted in reclassifications within the Integrated Medical segment affecting premiums, fees and other revenues, benefit expenses, and selling, general and administrative expenses and had no impact on revenue recognition patterns or net income. Expedients and exemptions elected: • Incremental costs of obtaining service and pharmacy contracts for short-term arrangements are expensed as incurred. • The Company does not disclose information about the aggregate amount of transaction price allocated to remaining performance obligations as its contracts are either short-term, or the remaining transaction price consists of variable consideration that relates specifically to wholly unsatisfied future periods of service. See the discussion of the Company's accounting policies for fees and pharmacy revenues beginning on page 79.
Recognition and Measurement of Financial Assets and Financial Liabilities (ASU 2016-01)	Requires: • Entities to measure equity investments at fair value in net income if they are neither consolidated nor accounted for under the equity method Effects of adoption: • Certain limited partnership interests previously carried at cost of approximately $200 million were increased to fair value of approximately $275 million on January 1, 2018. Subsequent changes in fair value are reported in net investment income. • Changes in fair value for equity securities having a readily determinable fair value that were previously reported in accumulated other comprehensive income ("AOCI") are now reported in net realized investment gains (losses). • Cumulative-effect adjustment of $62 million after-tax was recorded, increasing the opening balance of retained earnings in 2018. • See Notes 9 and 10 for updated disclosures about equity securities.

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Accounting Standard and Adoption date	Requirements and Effects of Adopting New Guidance
GUIDANCE ADOPTED JANUARY 1, 2018	
Targeted Improvements to Accounting for Hedging Activities (ASU 2017-12) **Early adopted as of January 1, 2018**	Guidance: • Relaxes eligibility requirements for financial and nonfinancial hedging strategies for hedge accounting and changes how companies assess effectiveness • Amends presentation and disclosure requirements to improve transparency about the uses and results of hedging programs Effects of adoption: • An immaterial amount of retained earnings was reclassified to AOCI, decreasing the opening balance in 2018, for a portion of the hedging instruments that was previously excluded from the assessment of hedge effectiveness for fair value hedges. • See Note 9 for the Company's disclosures about derivatives.
Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income (ASU 2018-02) **Early adopted as of January 1, 2018**	Guidance: • Allows companies to reclassify the tax effects stranded in AOCI to retained earnings as a result of H.R.1, An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (referred to throughout this Form 10-K as "U.S. tax reform" or "U.S. tax reform legislation") • Requires additional disclosures of the Company's accounting policy for releasing income tax effects from AOCI • Allows companies to apply the guidance retrospectively or in the period of adoption Effects of adoption: AOCI of $229 million was reclassified to retained earnings, increasing the opening balance in 2018. See Note 12 for additional information including accounting policy disclosures.

In addition to these standards, the Company adopted the following guidance in first quarter 2018 with no material impact to our financial statements: Intra-Entity Transfers of Assets Other than Inventory (ASU 2016-16), Clarifying the Definition of a Business (ASU 2017-01), Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost (ASU 2017-07), Statement of Cash Flows: Restricted Cash (ASU 2016-18), Gains and Losses from the Derecognition of Nonfinancial Assets (ASU 2017-05), and Stock Compensation Scope of Modification Accounting (ASU 2017-09).

Accounting Guidance Not Yet Adopted

Accounting Standard and Effective Date	Requirements and Expected Effects of New Guidance Not Yet Adopted
Leases (ASU 2016-02 and related amendments) **Required as of January 1, 2019**	Requires: • Balance sheet recognition of assets and liabilities arising from leases, including leases embedded in other contracts • Additional disclosures of the amount, timing and uncertainty of cash flows from leases • Modified retrospective approach for leases in effect as of and after the date of adoption with a cumulative-effect adjustment recorded in retained earnings Expected effects: • The Company will adopt this ASU in the first quarter of 2019 on a modified retrospective basis and will not restate comparative periods. While we are still finalizing our adoption procedures, we estimate the primary impact to our Consolidated Balance Sheet will be an increase to assets and liabilities of approximately $700 million for the right-of-use asset and corresponding lease liability related to existing operating leases. We do not expect the impact to retained earnings to be material. • The Company elected the optional practical expedient to retain the current classification of leases, and therefore, we do not expect a material impact to the Consolidated Statements of Income or Cash Flows. • The Company has implemented a new lease system and developed requisite changes to internal controls over financial reporting. • The Company is continuing to work to develop required disclosures. • The Company adopted this new guidance as of the effective date and will not present comparative periods in the financial statements, as recently allowed.

Accounting Standard and Effective Date	Requirements and Expected Effects of New Guidance Not Yet Adopted
Measurement of Credit Losses on Financial Instruments (ASU 2016-13) **Required as of January 1, 2020, with early adoption permitted as of January 1, 2019**	Requires: • A new approach using expected credit losses to estimate and recognize credit losses for certain financial instruments such as mortgage loans, reinsurance recoverables and other receivables when such instruments are first originated or acquired. • Changes in the criteria for impairment of available-for-sale debt securities • Adoption using a modified retrospective approach with a cumulative-effect adjustment recorded in retained earnings Expected effects: • The Company is continuing to evaluate this new standard and its effects on our financial statements and disclosures. We expect to adopt the standard as of January 1, 2020. • An additional allowance for future expected credit losses for certain financial instruments may be required at adoption.
Simplifying the Test for Goodwill Impairment (ASU 2017-04) **Required as of January 1, 2020, with early adoption permitted as of January 1, 2017**	Guidance: • Simplifies the accounting for goodwill impairment by eliminating the need to determine the fair value of individual assets and liabilities of a reporting unit to measure a goodwill impairment • Redefines the amount of goodwill impairment to equal the amount by which a reporting unit's carrying value exceeds its fair value, limited to the total amount of goodwill of the reporting unit • Requires prospective adoption Expected effects: • The Company is evaluating this new standard and its expected timing of adoption.

Targeted Improvements to the Accounting for Long-Duration Contracts (ASU 2018-12)
 	
Required as of January 1, 2021
	Requires (for insurance entities that issue long-duration contracts):
	• Cash flow assumptions used to measure the liability for future policy benefits for traditional and limited-pay contract to be reconsidered at least annually with any changes reflected in net income.
	• Discount rate assumptions to be reviewed quarterly (based on an upper-medium grade (low credit risk) fixed-income instrument yield that maximizes the use of observable market inputs) with any changes reflected in other comprehensive income.
	• Deferred policy acquisition costs to be amortized on a constant-level basis over the expected term of the related contract.
	• Fair value measurement of all market risk benefits.
	• Additional disclosures, including liability rollforwards and information about significant inputs, judgments, assumptions and methods used in measurement.
	• Transition methods at adoption vary:
	  • Changes to the liability for future policy benefits will use a modified retrospective approach (applied to all contracts on the basis of their carrying amounts as of the beginning of the earliest period presented), with an option to elect a full retrospective transition under certain criteria.
	  • Deferred policy acquisition costs are to be transitioned consistent with the method applied to the liability for future policyholder benefits.
	  • Market risk benefits are required to transition using retrospective application.
	Expected effects:
	• The Company is evaluating the impact of this newly-issued guidance, but it is expected to have a significant impact on our processes, controls, systems and financial results. The new guidance will apply to insurance products predominantly sold in the International Markets segment and Group Disability and Other.

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Significant Accounting Policies

The Company's accounting policies are described either in this Note or in the applicable Notes to the Consolidated Financial Statements as indicated in the table below.

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A. Cash and Cash Equivalents

Cash and cash equivalents are carried at cost that approximates fair value. Cash equivalents consist of short-term investments with maturities of three months or less from the time of purchase. The Company reclassifies cash overdraft positions to liabilities when the legal right of offset does not exist.

B. Accounts Receivable, Net

The following amounts are included within accounts receivable, net:

(In millions)	2018	2017
Insurance customer receivables	**$ 1,888**	$ 1,818
Noninsurance customer receivables	**4,988**	441
Pharmaceutical manufacturers receivable [1]	**3,321**	645
Other receivables	**276**	251
Total accounts receivable, net	**$ 10,473**	$ 3,155

(1) Includes $406 million at December 31, 2018 and $336 million at December 31, 2017 of receivables under noninsurance customer contracts.

These accounts receivable balances primarily include amounts due from clients, third-party payors, customers and pharmaceutical manufacturers. Receivables totaling $1.2 billion related to the acquired Express Scripts business are unbilled as of December 31, 2018 and are typically billed to PBM clients within 30 days based on contractual billing schedules. Unbilled receivables for medical benefit management

services represent amounts due from clients at contracted rates, and are billed when settlement provisions for capitated risk contracts are met, at least annually.

The receivables balances above are reported net of allowances for doubtful accounts of $217 million as of December 31, 2018 and $210 million as of December 31, 2017. The allowances are based on the current status of each customer's receivable balance as well as current economic and market conditions and a variety of other factors including the length of time the receivables are past due, the financial health of customers and our past experience. Receivables are written off against allowances only when such amounts are determined to be not recoverable and all collection attempts have failed. We regularly review the adequacy of these allowances based on a variety of factors, including age of the outstanding receivable and collection history. When circumstances related to specific collection patterns change, estimates of the recoverability of receivables are adjusted.

Express Scripts' receivables were recorded at their estimated fair values at the acquisition date. These fair values considered estimated discounts and claims adjustments issued to customers in the form of client credits, and amounts from third-party payors and pharmaceutical manufacturers that are not considered realizable based on contract terms and historical payment experience.

C. Inventories

Inventories consist of prescription drugs and medical supplies and are stated at the lower of first-in-first-out cost or net realizable value.

D. Reinsurance Recoverables

Reinsurance recoverables represent amounts due from reinsurers for both paid and unpaid claims of the Company's insurance businesses. Most reinsurance recoverables are classified as non-current assets. The current portion of reinsurance recoverables is reported in other current assets and consists primarily of recoverables on paid claims expected to be settled within one year. Reinsurance recoverables are presented net of allowances for uncollectible reinsurance that were immaterial as of December 31, 2018 and 2017.

E. Deferred Policy Acquisition Costs

Costs eligible for deferral include incremental, direct costs of acquiring new or renewal insurance and investment contracts and other costs directly related to successful contract acquisition. Examples of deferrable costs include commissions, sales compensation and benefits, policy issuance and underwriting costs and premium taxes. The Company records acquisition costs differently depending on the product line. Acquisition costs for:

- ***Supplemental health, life and accident insurance products*** (primarily individual products) that comprise the majority of the Company's deferred policy acquisition costs and ***group health and accident insurance products*** are deferred and amortized, generally in proportion to the ratio of periodic revenue to the estimated total revenues over the contract periods.
- ***Universal life products*** are deferred and amortized in proportion to the present value of total estimated gross profits over the expected lives of the contracts.
- ***Other products*** are expensed as incurred.

Deferred policy acquisition costs also include the value of business acquired ("VOBA") for certain acquisitions with material long-duration insurance contracts. The Company recorded amortization of deferred policy acquisition costs of $406 million in 2018, $322 million in 2017 and $292 million in 2016 primarily in selling, general and administrative expenses.

Each year, deferred policy acquisition costs are tested for recoverability. For universal life and other individual products, management estimates the present value of future revenues less expected payments. For group health and accident insurance products, management estimates the sum of unearned premiums and anticipated net investment income less future expected claims and related costs. If management's estimates of these sums are less than the deferred costs, the Company reduces deferred policy acquisition costs and records an additional expense.

F. Other Assets (Current and Non-Current)

Other current assets consist primarily of prepaid expenses, accrued investment income and the current portion of reinsurance recoverables. Other non-current assets consist primarily of GMIB assets and various other insurance-related assets. See Note 8 for the Company's accounting policy for GMIB assets. Additionally, other non-current assets include the carrying value of our equity-method investments in joint ventures in China, India, the U.S. and other foreign jurisdictions.

G. Redeemable Noncontrolling Interests

Products and services are offered in Turkey and India through joint venture entities. The Company is the principal equity holder and primary beneficiary of the Turkey joint venture and accordingly, this entity is consolidated. In 2017, Cigna modified the agreement governing its joint venture in India due to changes in the local regulatory environment that require control by a local partner. As a result of the changes in the joint venture agreement, the Company determined that it is no longer the primary beneficiary of the joint venture and, effective with the third quarter of 2017, no longer consolidates its results.

Redeemable noncontrolling interests on our Consolidated Balance Sheets represent the Turkey joint venture partner's preferred and common stock interests in the entity as of December 31, 2018 and 2017. Our joint venture partner may choose to require the Company to purchase their redeemable noncontrolling interests. We also have the right to require our joint venture partner to sell their redeemable noncontrolling

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interests to us. The redeemable noncontrolling interests were recorded at fair value as of the dates of purchase. When the estimated redemption value for a redeemable noncontrolling interest exceeds its carrying value, an adjustment to increase the redeemable noncontrolling interest is recorded with an offsetting reduction to additional paid-in capital. When an adjustment is made to the carrying value of the redeemable noncontrolling interest, the calculation of shareholders' net income per share will be adjusted if the redemption value exceeds the greater of the carrying value or fair value.

H. Accrued Expenses and Other Current and Non-Current Liabilities

Accrued expenses (current) includes financial and performance guarantee liabilities under pharmacy contracts (see section L), management compensation, and various insurance-related liabilities, including experience-rated refunds, reinsurance contracts and the risk adjustment and minimum medical loss ratio rebate accruals under The Patient Protection and Affordable Care Act. Other non-current liabilities include obligations for pension, other postretirement and postemployment benefits (see Note 13), GMIB contract liabilities (see Note 8) and self-insured exposures not expected to be settled within one year. Legal costs to defend the Company's litigation and arbitration matters are expensed when incurred in cases where the Company cannot reasonably estimate the ultimate cost to defend. If the Company can reasonably estimate the cost to defend, a liability for these costs is accrued when the claim is reported.

I. Translation of Foreign Currencies

The Company generally conducts its international business through foreign operating entities that maintain assets and liabilities in local currencies that are generally their functional currencies. The Company uses exchange rates as of the balance sheet date to translate assets and liabilities into U.S. dollars. Translation gains or losses on functional currencies, net of applicable taxes, are recorded in accumulated other comprehensive income (loss). The Company uses average monthly exchange rates during the year to translate revenues and expenses into U.S. dollars.

J. Premiums and Related Expenses

Premiums for group life, accident and health insurance and managed care coverages are recognized as revenue on a pro rata basis over the contract period. Benefits and expenses are recognized when incurred and, for our Integrated Medical insured business, are presented net of pharmaceutical manufacturer rebates. For experience-rated contracts, premium revenue includes an adjustment for experience-rated refunds based on contract terms and calculated using the customer's experience (including estimates of incurred but not reported claims).

Premium revenue also includes an adjustment to reflect the estimated effect of rebates due to customers under the commercial minimum medical loss ratio provisions of the ACA. These rebates are settled in the year following the policy year.

Premiums received for the Company's Medicare Advantage plans and Medicare Part D products from the Centers for Medicare and Medicaid Services ("CMS") and customers are recognized as revenue ratably over the contract period. CMS provides risk-adjusted premium payments for Medicare Advantage Plans and Medicare Part D products based on the demographics and wellness of customers. The Company recognizes periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured. Additionally, Medicare Part D premiums include payments from CMS for risk sharing adjustments. The risk sharing adjustments are estimated quarterly based on claim experience by comparing actual incurred drug benefit costs to estimated costs submitted in original contracts. These adjustments may result in more or less revenue from CMS. Final revenue adjustments are determined and settled with CMS in the year following the contract year. Premium revenue also includes an adjustment to reflect the estimated effect of rebates due to CMS under the Medicare Advantage and Medicare Part D minimum medical loss ratio provisions of the ACA.

The ACA prescribed three programs to mitigate the risk for participating health insurance companies selling coverage on the public exchanges: risk adjustment, reinsurance and risk corridor. The reinsurance and risk corridor programs expired at the end of 2016, while the permanent risk adjustment program continues.

The risk adjustment program reallocates funds from insurers with lower risk populations to insurers with higher risk populations based on the relative risk scores of participants in non-grandfathered plans in the individual and small group markets, both on and off the exchanges. We estimate our receivable or payable based on the risk of our members compared to the risk of other members in the same state and market, considering data obtained from industry studies and the United States Department of Health and Human Services ("HHS"). Receivables or payables are recorded as adjustments to premium revenue based on our year-to-date experience when the amounts are reasonably estimable and collection is reasonably assured. Final revenue adjustments are determined by HHS in the year following the policy year.

Premiums for individual life, accident and supplemental health insurance and annuity products, excluding universal life and investment-related products, are recognized as revenue when due. Benefits and expenses are matched with premiums.

Revenue for universal life products is recognized as follows:

- Investment income on assets supporting universal life products is recognized in net investment income as earned.
- Charges for mortality, administration and policy surrender are recognized in premiums as earned. Administrative fees are considered earned when services are provided.

Benefits and expenses for universal life products consist of benefit claims in excess of policyholder account balances and income earned by policyholders. Expenses are recognized when claims are incurred, and income is credited to policyholders in accordance with contract provisions.

The unrecognized portion of premiums received is recorded as unearned premiums included in insurance and contractholder liabilities (see Note 7 for further information).

K. Fees and Related Expenses

The majority of the Company's service fees are derived from administrative services only ("ASO") arrangements that allow corporate clients to self-fund claims and assume the risk of medical or other benefit costs. Most of the Company's ASO arrangements are for medical and specialty services, including pharmacy benefits. Generally, the Company's ASO arrangements are short-term. Contract modifications typically occur on renewal and are prospective in nature.

In return for fees from these clients, the Company provides or makes available various services supporting benefit management and claims administration. In addition, services offered through our Integrated Medical segment include access to the Company's participating provider networks, disease management, utilization management, and cost containment services.

In general, the Company considers these services to be a combined performance obligation to provide cost effective administration of plan benefits over the contract period. Fees are billed, due and recognized monthly at contracted rates based on current membership or utilization. This recognition pattern aligns with the benefits from services provided to clients. These revenues are reported in fees and other revenues in the Consolidated Statements of Income.

For most ASO arrangements, the Company is required to perform services for a limited period after a client cancels. If these services will not be separately billed to the client as they are performed, the Company estimates and defers a portion of compensation attributable to this service obligation received in advance. Deferred revenue is recorded as a contract liability and recognized when the related services are performed. The balance was immaterial as of December 31, 2018 and 2017.

The Company may also provide performance guarantees that provide potential refunds to clients if certain service standards, clinical outcomes or financial metrics are not met. If these standards, outcomes and metrics are not met, the Company may be financially at risk up to a stated percentage of the contracted fee or a stated dollar amount. The Company defers revenue by recording a liability for estimated payouts associated with these guarantees within accrued expenses and other liabilities (current). The amount of revenue deferred is estimated for each type of guarantee, using either a most likely amount or expected value method depending upon the nature of the guarantee and the information available to estimate refunds. Estimates are refined each reporting period as additional information on the Company's performance becomes available, and upon final reconciliation and settlement at the end of the guarantee period. Amounts accrued and paid for performance guarantees during the reporting periods were not material.

Rebates from pharmaceutical manufacturers resulting from ASO client utilization at retail pharmacies, net of amounts payable to ASO clients, are compensation for pharmacy services and recorded in fees and other revenues. Rebates generally represent a per-script amount from the manufacturer and are determined based on scripts filled during the reporting period.

Expenses associated with administrative programs and services are recognized in selling, general and administrative expenses as incurred.

The Company also earns fees by providing integrated medical benefit management solutions that drive cost reductions and improve quality outcomes. These solutions were part of the business acquired from Express Scripts. Clients are primarily sponsors of health benefit plans and fees may be stated as a per-member-per-month fee or as a per-claim fee. The Company considers the services to be a single performance obligation to stand ready to provide utilization management services over the contract period (generally three years). In certain arrangements, the Company assumes the financial obligation for third-party provider costs for medical services provided to the health plan's members. Fees are recorded gross in revenues because the Company is acting as a principal in arranging for and controlling the services provided by third-party network providers. Contractual fees vary based on enrollment and provider costs and are estimated, billed, due and recognized monthly. Direct costs associated with these programs are included in pharmacy and service costs.

Certain medical benefit management contracts require the Company to share the results of medical cost experience that differs from specified targets. This variable consideration is estimated at contract inception and adjusted through the contract period. The estimated profits and costs are recognized net in revenues.

L. Pharmacy Revenues and Costs

Pharmacy Revenues. Pharmacy revenues include revenue from the acquired Express Scripts business and the Company's legacy mail order pharmacy business. Pharmacy revenues are recognized when control of the promised goods or services is transferred to clients, in an amount that reflects the consideration the Company expects to receive for those goods or services.

The Express Scripts business provides or makes available various services supporting benefit management and claims administration and is generally obligated to provide prescription drugs to clients' members through multiple distribution methods including retail networks, home delivery and specialty pharmacies. These goods and services are integrated into a single performance obligation to process claims, dispense prescription drugs, and provide other services over the contract period (generally three years). The Company has elected the practical expedient to account for shipping and handling as a fulfillment activity. This performance obligation is satisfied as the business stands ready to fulfill its obligation.

Fees are billed, due and recognized at contract rates either on a periodic basis or as services are provided (such as, based on volume of claims processed). This recognition pattern aligns with the benefits from services provided.

Revenues for dispensing prescription drugs through retail pharmacies consist of the prescription price (ingredient cost and dispensing fee) contracted with clients, including the member co-payment, and any associated fees for services because we act as principal in these arrangements. When a prescription is presented to a retail network pharmacy, we are solely responsible for member eligibility, drug utilization review, drug-to-drug interaction review, any required clinical intervention, plan provision information, payment to the pharmacy and client billing. These revenues are recognized based on the full prescription price when the pharmacy claim is processed and approved for payment. We also provide benefit design and formulary consultation services to clients, and negotiate separate contractual relationships with clients and network pharmacies. These factors indicate that we have control over these transactions until the prescription is dispensed.

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Home delivery and specialty pharmacy revenues are due and recognized as each prescription is shipped, net of reserves for discounts and contractual allowances estimated based on historical experience. Any differences between estimates and actual collections are reflected in operations when payments are received. Historically, adjustments to original estimates and returns have not been material.

We may also provide certain financial and performance guarantees, including a minimum level of discounts a client may receive, generic utilization rates and various service levels. Clients may be entitled to receive performance penalties if we fail to meet guarantees. Actual performance is compared to the guarantee for each measure throughout the period and the Company defers revenue for any estimated payouts within accrued expenses and other liabilities (current). These estimates are adjusted at the end of the guarantee period. Historically, adjustments to original estimates have not been material. The balance was $895 million as of December 31, 2018 and immaterial as of December 31, 2017.

The acquired Express Scripts business and Cigna's legacy home delivery business administer a program through which we receive rebates and administrative fees from pharmaceutical manufacturers. If these rebates and administrative fees are provided in conjunction with claims processing and home delivery services provided to clients, the amount payable to clients is recorded as a reduction of pharmacy revenues. These amounts are based on expected sharing percentages in contractual arrangements. These estimated payables are adjusted when amounts are collected from pharmaceutical manufacturers. Historically, these adjustments have not been material. If pharmacy rebates and administrative fees are provided in a contract that does not include claims processing, the performance obligation is to arrange for the customer to receive these rebates. In these cases, rebates and administrative fees are recorded as pharmacy revenue, net of contractual amounts payable to the client.

Other pharmacy service revenues are earned by distributing specialty pharmaceuticals and medical supplies to providers, clinics and hospitals and services to specialty pharmacy manufacturers. These revenues are recognized as prescriptions and supplies are shipped and services provided.

Pharmacy costs. Pharmacy costs include the cost of prescriptions sold and for the acquired Express Scripts business, network pharmacy claim costs and co-payments. Also included are direct costs of dispensing prescriptions including supplies, shipping and handling. Home delivery costs are recognized when the drug is shipped and retail network costs are recognized when the drug is dispensed. Pharmacy rebates and administrative fees received for providing claims processing and home delivery services are recorded as a reduction of pharmacy costs. Rebates are recognized as prescriptions are shipped or dispensed. For periods following completion of the merger with Express Scripts, the Company records a pharmacy and service costs payable for certain retail network claims based on our performance throughout the period against the contractual pricing guarantee with each pharmacy network.

Note 3 Mergers, Acquisitions and Dispositions

A. Acquisition of Express Scripts

On December 20, 2018, Cigna acquired Express Scripts through a series of mergers (collectively, the "Merger"). Cigna Holding Company (formerly named Cigna Corporation and referred to as "Old Cigna") and Express Scripts each merged with and into a wholly-owned subsidiary of Cigna. As a result of these transactions, Cigna became the parent of the combined company.

Old Cigna shareholders received one share of Cigna common stock in exchange for each share of Old Cigna common stock held immediately prior to the Merger. Express Scripts shareholders received (1) 0.2434 of a share of Cigna common stock and (2) cash of $48.75, without interest, subject to applicable withholding taxes (the "Merger Consideration"), in exchange for each share of Express Scripts common stock held immediately prior to the Merger. Cash consideration was funded primarily through a combination of cash available and debt financing discussed further in Note 5. After completion of the Merger, shares of Cigna common stock were listed for trading on the New York Stock Exchange.

The acquired Express Scripts business accelerates Cigna's ***Go Deeper, Go Local, Go Beyond*** strategy by greatly increasing the Company's ability to put medicine within reach of customers and also helping to make it more affordable. We can improve patient outcomes and help control the cost of the drug benefit by: 1) identifying products and offering solutions that improve patient outcomes and assist in controlling costs; 2) evaluating drugs for efficacy, value and price to select a cost-effective formulary; 3) offering cost-effective home delivery pharmacy and specialty services that produce cost savings for plan sponsors and better care for members; 4) leveraging purchasing volume to provide discounts to health benefit providers; and 5) promoting generic and lower-cost brands.

Merger consideration: The estimated merger consideration of $52.8 billion was calculated as follows:

(Dollars and shares in millions, except per share amounts)		
Cash consideration		
Express Scripts common stock outstanding		**564.3**
Cash consideration per share	**$**	**48.75**
Cash consideration paid to Express Scripts common stockholders	**$**	**27,510**
Cash paid in lieu of fractional shares	**$**	**4**
Cash consideration paid to Express Scripts performance share holders	**$**	**65**
Total cash consideration	**$**	**27,579**
Stock consideration		
Express Scripts common stock outstanding		**564.3**
Per share exchange ratio		**0.2434**
Shares of Cigna issued to Express Scripts common stockholders		**137.3**
Shares of Cigna issued to Express Scripts performance share holders and other equity holders		**0.3**
Shares of Cigna issued to Express Scripts shareholders		**137.6**
Closing price of Cigna common stock on December 20, 2018	**$**	**179.80**
Total stock consideration	**$**	**24,745**
Noncontrolling interest	**$**	**7**
Fair value of other share-based compensation awards	**$**	**479**
Total merger consideration	**$**	**52,810**

Fair value of share-based compensation award. Express Scripts employees' awards of options and restricted stock units of Express Scripts stock were rolled over to Cigna stock options and restricted stock units on the date of the acquisition. Each holder of an Express Scripts stock option or restricted stock unit received 0.4802 of a Cigna stock option or restricted stock award. The Cigna stock option exercise price was determined by using this same conversion ratio. Vesting periods and the remaining life of the options remained consistent with the original Express Scripts awards.

The Company valued the restricted stock units at Cigna's stock price and stock options using a Black-Scholes pricing model as of the acquisition date. The assumptions used were generally consistent with those disclosed in Note 14, except the expected life of these options averaged 4.3 years and the exercise price did not equal the market value at the date of grant.

The fair value of these options and restricted stock unit awards was included in the purchase price to the extent that services had been provided prior to the acquisition based on the grant date of the original Express Scripts award and vesting period. The remaining fair value not included in the purchase price will be recorded as compensation expense in future periods over the remaining vesting periods. Most of the expense is expected to be recognized in 2019 and 2020.

Purchase price allocation: In accordance with GAAP, the total purchase price has been allocated to the tangible and intangible net assets acquired based on management's preliminary estimates of their fair values and may change as additional information becomes available over the next several months. Most of the goodwill ($33.7 billion) is assigned to the Health Services segment, with the remainder to the Integrated Medical segment and is not deductible for federal income tax purposes. The following table summarizes the estimated fair values of assets acquired and liabilities assumed at the closing date.

(In millions)		
Cash and cash equivalents	**$**	**3,517**
Receivables		**7,802**
Inventory		**2,483**
Other current assets		**600**
Property and equipment		**2,973**
Goodwill		**38,361**
Other identifiable intangible assets		**38,725**
Other assets acquired, non-current		**314**
Total assets acquired		**94,775**
Other current liabilities		**18,616**
Long-term debt, including current portion		**12,816**
Deferred income tax liabilities		**9,511**
Other liabilities, non-current assumed		**1,022**
Total liabilities acquired		**41,965**
Total	**$**	**52,810**

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A portion of the purchase price has been allocated to intangible assets that are presented and discussed below.

(In millions)	Estimated Fair Value	Estimated Useful Life in Years	Amortization Method
Customer relationships	**$ 30,210**	**14 - 29**	**Cash flow trended**
Internal-use software [1]	**2,443**	**3 - 7**	**Straight Line**
Trade name – Express Scripts	**8,400**	**N/A**	**Indefinite**
Trade name – Other	**115**	**10**	**Straight Line**
Total	**$ 41,168**		

(1) Reported in property and equipment.

The fair value of the customer relationships and the amortization period and method were determined using an income approach that relies heavily on projected future net cash flows including key assumptions for customer attrition, margins, and discount rates. The estimated useful life reflects the time period and pattern that Cigna expects to receive the benefits of the related cash flows.

The results of Express Scripts have been included in the Company's Consolidated Financial Statements from the date of the acquisition. Revenues of Express Scripts included in the Company's results for 2018 approximated $2.6 billion and Express Scripts' results of operations were immaterial to Cigna's net income.

Unaudited pro forma information. The following table presents selected unaudited pro forma information for the Company assuming the acquisition of Express Scripts had occurred on January 1, 2017. The primary adjustments reflected in the pro forma results relate to the interest expense on the debt issued to fund the Merger, the amortization of the acquired intangible assets and the presentation of transaction related costs. Transaction related costs incurred by the Company and Express Scripts in 2018 have been presented as if they had been incurred on January 1, 2017. The pro forma information does not purport to represent what the Company's actual results would have been if the acquisition had occurred as of the date indicated or what such results would be for any future periods.

	Unaudited	
	Year Ended December 31,	
(In millions, except per share amounts)	2018	2017
Total revenues	**$ 149,544**	$ 143,288
Shareholders' net income	**$ 5,632**	$ 4,435

Pro forma shareholders' net income for the year ended December 31, 2017 includes $1.2 billion in transaction-related costs incurred in connection with the acquisition.

B. Acquisition of OnePath Life NZ Limited ("OnePath Life")

On November 30, 2018, the Company acquired OnePath Life for NZ$700 million (approximately $480 million at closing) using internal cash resources. OnePath Life is one of the largest life insurance companies in New Zealand. This acquisition will support diversifying distribution capabilities and product offerings in the New Zealand market. It will also enable better service delivery to clients and customers. The purchase price has been allocated to the tangible and intangible net assets acquired based on management's preliminary estimates of their fair value and may change as additional information becomes available over the next several months. Goodwill has been assigned to the International Markets segment as of December 31, 2018 and is not tax deductible.

The results of this business have been included in the Company's Consolidated Financial Statements from the date of acquisition and were not material. In addition, the pro forma effects on total revenues and net income assuming the acquisition had occurred January 1, 2017 were not material to the Company for the years ended December 31, 2018 and 2017.

C. Transaction-related Costs

The Company has incurred costs detailed in the table below in the acquisition of Express Scripts, the terminated merger with Anthem, Inc. ("Anthem") and other transactions. These costs consisted primarily of fees for legal, advisory and other professional services, amortization of the Bridge Facility fees in 2018 and interest expense on debt issued to fund the Express Scripts merger through the closing date, net of investment income earned on the debt proceeds. A portion of the costs, primarily legal and advisory fees, related to the completed Express Scripts acquisition are not deductible for federal income tax purposes.

	2018		2017		2016	
(In millions)	Before-tax	After-tax	Before-tax	After-tax	Before-tax	After-tax
Interest expense on newly issued debt	**$ 227**	**$ 179**	$ –	$ –	$ –	$ –
Net investment income on debt proceeds	**(123)**	**(97)**	–	–	–	–
Charitable contributions	**200**	**158**	–	–	–	–
Legal and advisory fees	**204**	**185**	36	23	96	95
Bridge facility fees	**140**	**111**	–	–	–	–
All other transaction-related costs	**204**	**133**	90	69	70	52
Tax (benefit) – previously non-deductible costs	**–**	**–**	–	(59)	–	–
Transaction-related costs, net	**$ 852**	**$ 669**	$ 126	$ 33	$166	$147

Note 4 Earnings Per Share ("EPS")

Accounting policy. The Company computes basic earnings per share using the weighted-average number of unrestricted common and deferred shares outstanding. Diluted earnings per share also includes the dilutive effect of outstanding employee stock options and restricted stock using the treasury stock method and the effect of strategic performance shares.

Basic and diluted earnings per share were computed as follows:

	2018			2017			2016		
(Shares in thousands, dollars in millions, except per share amounts)	**Basic**	**Effect of Dilution**	**Diluted**	**Basic**	**Effect of Dilution**	**Diluted**	**Basic**	**Effect of Dilution**	**Diluted**
Shareholders' net income	**$ 2,637**	**$ –**	**$ 2,637**	$ 2,237	$ –	$ 2,237	$ 1,867	$ –	$ 1,867
Shares									
Weighted average	**246,652**	**–**	**246,652**	250,892	–	250,892	255,360	–	255,360
Common stock equivalents		**3,573**	**3,573**		4,180	4,180		4,287	4,287
Total shares	**246,652**	**3,573**	**250,225**	250,892	4,180	255,072	255,360	4,287	259,647
EPS	**$ 10.69**	**$ (0.15)**	**$ 10.54**	$ 8.92	$ (0.15)	$ 8.77	$ 7.31	$ (0.12)	$ 7.19

The following outstanding employee stock options were not included in the computation of diluted earnings per share because their effect was anti-dilutive.

(In millions)	**2018**	**2017**	**2016**
Anti-dilutive options	**0.9**	0.9	2.3

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Note 5 Debt

The outstanding amounts of debt and capital leases for the years ended December 31 were as follows:

(In millions)	Issuer	2018	2017
Short-term debt			
Current maturities: $1,000 million, 2.25% Senior Notes	Express Scripts	**$ 995**	$ –
Current maturities: $337 million, 7.25% Senior Notes	ESI	**343**	–
Commercial paper	Old Cigna	**1,500**	100
Current maturities: $131 million, 6.35% Notes	Old Cigna	**–**	131
Other, including capital leases	various	**117**	9
Total short-term debt		**$ 2,955**	$ 240
Long-term uncollateralized debt			
Cigna debt (issued to finance acquisition)			
$1,000 million, Floating Rate Notes due 2020	Cigna	**$ 997**	$ –
$1,750 million, 3.2% Notes due 2020	Cigna	**1,743**	–
$1,000 million, Floating Rate Notes due 2021	Cigna	**996**	–
$1,250 million, 3.4% Notes due 2021	Cigna	**1,245**	–
$3,000 million, Floating Rate Term Loan due 2021	Cigna	**2,997**	–
$700 million, Floating Rate Notes due 2023	Cigna	**697**	–
$3,100 million, 3.75% Notes due 2023	Cigna	**3,085**	–
$2,200 million, 4.125% Notes due 2025	Cigna	**2,187**	–
$3,800 million, 4.375% Notes due 2028	Cigna	**3,774**	–
$2,200 million, 4.8% Notes due 2038	Cigna	**2,178**	–
$3,000 million, 4.9% Notes due 2048	Cigna	**2,964**	–
Express Scripts debt (assumed in acquisition)			
$500 million, 4.125% Senior Notes due 2020	Medco	**506**	–
$500 million, 2.600% Senior Notes due 2020	Express Scripts	**493**	–
$400 million, Floating Rate Senior Notes due 2020	Express Scripts	**399**	–
$500 million, 3.300% Senior Notes due 2021	Express Scripts	**499**	–
$1,250 million, 4.750% Senior Notes due 2021	Express Scripts	**1,285**	–
$1,000 million, 3.900% Senior Notes due 2022	Express Scripts	**998**	–
$500 million, 3.050% Senior Notes due 2022	Express Scripts	**481**	–
$1,000 million, 3.000% Senior Notes due 2023	Express Scripts	**959**	–
$1,000 million, 3.500% Senior Notes due 2024	Express Scripts	**966**	–
$1,500 million, 4.500% Senior Notes due 2026	Express Scripts	**1,508**	–
$1,500 million, 3.400% Senior Notes due 2027	Express Scripts	**1,386**	–
$449 million, 6.125% Senior Notes due 2041	Express Scripts	**493**	–
$1,500 million, 4.800% Senior Notes due 2046	Express Scripts	**1,465**	–
Old Cigna debt (pre-acquisition)			
$250 million, 4.375% Notes due 2020	Old Cigna	**248**	249
$300 million, 5.125% Notes due 2020	Old Cigna	**298**	299
$78 million, 6.37% Notes due 2021	CGC	**78**	78
$300 million, 4.5% Notes due 2021	Old Cigna	**297**	299
$750 million, 4% Notes due 2022	Old Cigna	**746**	745
$100 million, 7.65% Notes due 2023	Old Cigna	**100**	100
$17 million, 8.3% Notes due 2023	Old Cigna	**17**	17
$900 million, 3.25% Notes due 2025	Old Cigna	**895**	894
$600 million, 3.05% Notes due 2027	Old Cigna	**595**	594
$259 million, 7.875% Debentures due 2027	Old Cigna	**259**	258
$45 million, 8.3% Step Down Notes due 2033	Old Cigna	**45**	45
$191 million, 6.15% Notes due 2036	Old Cigna	**190**	190
$121 million, 5.875% Notes due 2041	Old Cigna	**119**	119
$317 million, 5.375% Notes due 2042	Old Cigna	**315**	315
$1,000 million, 3.875% Notes due 2047	Old Cigna	**988**	988
Other, including capital leases	Other	**32**	9
Total long-term debt		**$ 39,523**	$ 5,199

Notes issued to fund the Express Scripts acquisition. As presented in the table above, the Company issued private placement Notes with registration rights in the third quarter of 2018 to finance the Express Scripts acquisition. Total proceeds were approximately $20.0 billion. Interest on this debt is generally paid semi-annually except for quarterly interest payments on the floating rate notes.

Term Loan Credit Agreement. Cigna borrowed $3.0 billion under its Term Loan Credit Agreement (the "Term Loan Credit Agreement") to finance the Merger and to pay fees and expenses of the Merger. The Term Loan Credit Agreement is diversified among 26 banks and contains customary covenants and restrictions, including a financial covenant that Cigna's leverage ratio may not exceed 60%. There is no remaining amount available for borrowing under this agreement.

Bridge Facility. In March 2018, Cigna entered into a commitment letter (the "Commitment Letter") with Morgan Stanley Senior Funding, Inc., The Bank of Tokyo-Mitsubishi UFJ, Ltd and 21 additional banks, to provide a $26.7 billion, 364-day senior unsecured bridge facility (the "Bridge Facility") in connection with the Merger. The Company incurred approximately $140 million in fees in 2018 for the Bridge Facility that expired upon the close of the Merger.

Revolving Credit Agreement. Cigna has a Revolving Credit and Letter of Credit Agreement (the "Revolving Credit Agreement") that matures on April 6, 2023 and is diversified among 23 banks.

Cigna can borrow up to $3.25 billion for general corporate purposes, with up to $500 million available for issuance of letters of credit, decreased by $22 million of letters of credit under the Revolving Credit Agreement as of December 31, 2018. The Revolving Credit Agreement also includes an option to increase the facility amount up to $500 million and an option to extend the termination date for additional one year periods, subject to consent of the banks.

The Revolving Credit Agreement contains customary covenants and restrictions, including a financial covenant that the Company's leverage ratio may not exceed 60%.

Cigna is the borrower under the Revolving Credit Agreement and the Term Loan Credit Agreement and certain subsidiaries of Cigna may be required to guarantee these obligations under certain circumstances.

Commercial Paper. Old Cigna issued $1.5 billion under the commercial paper program to finance the Merger.

Assumption of Express Scripts Debt. The Company assumed debt obligations of Express Scripts, ESI and Medco as described in the table above in the acquisition under substantially unchanged terms.

The Company was in compliance with its debt covenants as of December 31, 2018.

Other debt financing transactions. In the third quarter of 2017, Old Cigna entered into the following debt transactions:

- On September 14, 2017, Old Cigna issued $1.6 billion long-term debt and the proceeds were used to pay for the cash tender offer described below. Old Cigna also used the proceeds for general corporate purposes, including the repayment of its Notes that matured in 2018.
- Old Cigna completed a cash tender offer to purchase $1.0 billion of aggregate principal amount of certain of its outstanding debt securities in the third quarter of 2017 and recorded a pre-tax loss of $321 million ($209 million after-tax), primarily for premiums paid.

Old Cigna repaid $131 million and $250 million of long-term notes that matured during the first quarter of 2018 and 2017 respectively.

Maturities of outstanding long-term debt and capital leases are as follows:

	Scheduled Maturities	
(In millions)	**Long-term Debt** [1]	**Capital Leases**
2019	**$ 1,337**	$ 17
2020	**$ 4,700**	$ 14
2021	**$ 7,378**	$ 4
2022	**$ 2,250**	$ 4
2023	**$ 4,917**	$ 4
Maturities after 2023	**$ 20,582**	$ 7

(1) Long-term debt maturity amounts exclude capital leases.

Interest expense on long-term and short-term debt was $507 million in 2018, $243 million in 2017, and $251 million in 2016, excluding losses on the early extinguishment of debt.

Note 6 Common and Preferred Stock

As more fully described in Note 3, Cigna acquired Express Scripts on December 20, 2018. Old Cigna shareholders exchanged each of their shares for a share of Cigna common stock and shareholders of Express Scripts received 0.2434 of a share of Cigna (and $48.75 in cash) for each share of Express Scripts. Following the Merger, Old Cigna was de-listed and shares of Cigna were listed on the New York Stock Exchange for trading.

Cigna (and, prior to the Merger, Old Cigna) has a total of 25 million shares of $1 par value preferred stock authorized for issuance. No shares of preferred stock were outstanding at December 31, 2018, 2017 or 2016.

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The following table presents the share activity of Old Cigna and Cigna for the years ended December 31, 2018, 2017 and 2016.

(Shares in thousands)	2018	2017	2016
Common: Par value $0.25; 600,000 shares authorized – Old Cigna			
Outstanding – January 1,	**243,967**	256,869	256,544
Issued for stock option exercises and other benefit plans	**1,118**	2,761	1,110
Repurchased common stock	**(1,300)**	(15,663)	(785)
Balance, December 20, 2018 (Merger Date)	**243,785**	–	–
Exchange of Old Cigna shares for shares of Cigna	**(243,785)**	–	–
Outstanding – December 31,	**–**	243,967	256,869
Retirement of treasury stock on December 20, 2018	**(52,358)**	–	–
Exchange of Old Cigna certificated treasury stock for new Cigna certificated treasury stock	**(2)**	–	–
Treasury stock – December 31, 2018	**–**	52,178	39,276
Issued – December 31,	**–**	296,145	296,145
Common: Par value $0.01; 600,000 shares authorized – Cigna			
Shares issued to Old Cigna shareholders	**243,785**	–	–
Shares issued to Express Scripts shareholders	**137,337**	–	–
Issued for stock option exercises and other benefit plans including Express Scripts performance share holders	**91**	–	–
Repurchased common stock	**(289)**	–	–
Outstanding – December 31, 2018	**380,924**	–	–
Treasury stock	**570**	–	–
Issued – December 31, 2018	**381,494**	–	–

Note 7 Insurance and Contractholder Liabilities

A. Account Balances – Insurance and Contractholder Liabilities

As of December 31, 2018 and 2017, the Company's insurance and contractholder liabilities comprised the following:

	December 31, 2018			December 31, 2017		
(In millions)	**Current**	**Non-current**	**Total**	Current	Non-current	Total
Contractholder deposit funds	**$ 641**	**$ 7,365**	**$ 8,006**	$ 713	$ 7,483	$ 8,196
Future policy benefits	**740**	**8,981**	**9,721**	706	9,334	10,040
Unpaid claims and claim expenses						
Integrated Medical	**2,678**	**19**	**2,697**	2,401	19	2,420
Other segments	**2,394**	**3,230**	**5,624**	2,178	3,289	5,467
Unearned premiums	**348**	**379**	**727**	319	405	724
Total insurance and contractholder liabilities	**$ 6,801**	**$ 19,974**	**$ 26,775**	$ 6,317	$ 20,530	$ 26,847

Insurance and contractholder liabilities expected to be paid within one year are classified as current.

Accounting Policy – Contractholder Deposit Funds: Liabilities for contractholder deposit funds primarily include deposits received from customers for investment-related and universal life products and investment earnings on their fund balances. These liabilities are adjusted to reflect administrative charges and, for universal life fund balances, mortality charges. In addition, this caption includes: 1) premium stabilization reserves under group insurance contracts representing experience refunds left with the Company to pay future premiums; 2) deposit administration funds used to fund non-pension retiree insurance programs; 3) retained asset accounts; and 4) annuities or supplementary contracts without significant life contingencies. Interest credited on these funds is accrued ratably over the contract period.

Accounting Policy – Future Policy Benefits: Future policy benefits represent the present value of estimated future obligations under long-term life and supplemental health insurance policies and annuity products currently in force. These obligations are estimated using actuarial methods and consist primarily of reserves for annuity contracts, life insurance benefits, GMDB contracts (see Note 8 for additional information) and certain health, life and accident insurance products of our International Markets segment.

Obligations for annuities represent specified periodic benefits to be paid to an individual or groups of individuals over their remaining lives. Obligations for life insurance policies and GMDB contracts represent benefits expected to be paid to policyholders, net of future premiums expected to be received. Management estimates these obligations based on assumptions as to premiums, interest rates, mortality or morbidity, future claim adjudication expenses and surrenders, allowing for adverse deviation as appropriate. Mortality, morbidity and surrender assumptions are based on the Company's own experience and published actuarial tables. Interest rate assumptions are based on management's judgment considering the Company's experience and future expectations, and range from 1% to 9%. Obligations for the run-off settlement annuity business include adjustments for realized and unrealized investment returns consistent with GAAP when a premium deficiency exists.

B. Unpaid Claims and Claim Expenses – Integrated Medical

This liability reflects estimates of the ultimate cost of claims that have been incurred but not reported, including expected development on reported claims, those that have been reported but not yet paid (reported claims in process), and other medical care expenses and services payable that are primarily comprised of accruals for incentives and other amounts payable to health care professionals and facilities. This liability no longer includes amounts from the international health care business now reported in International Markets following our change in segment reporting in 2018. Prior year rollforwards have been updated to reflect this segment change.

Accounting policy. The Company uses actuarial principles and assumptions that are consistently applied each reporting period and recognizes the actuarial best estimate of the ultimate liability along with a margin for adverse deviation. This approach is consistent with actuarial standards of practice that the liabilities be adequate under moderately adverse conditions.

The Company compares key assumptions used to establish the medical costs payable to actual experience for each reporting period. The unpaid claims liability is adjusted through current period shareholders' net income when actual experience differs from these assumptions. Additionally, the Company evaluates expected future developments and emerging trends that may impact key assumptions. The process used to determine this liability requires the Company to make critical accounting estimates that involve considerable judgment, reflecting the variability inherent in forecasting future claim payments. These estimates are highly sensitive to changes in the Company's key assumptions, specifically completion factors and medical cost trends.

The liability is primarily calculated using "completion factors" developed by comparing the claim incurral date to the date claims were paid. Completion factors are impacted by several key items including changes in: 1) electronic (auto-adjudication) versus manual claim processing; 2) provider claims submission rates; 3) membership; and 4) the mix of products. The Company uses historical completion factors combined with an analysis of current trends and operational factors to develop current estimates of completion factors. The Company estimates the liability for claims incurred in each month by applying the current estimates of completion factors to the current paid claims data. This approach implicitly assumes that historical completion rates will be a useful indicator for the current period.

The Company relies more heavily on medical cost trend analysis that reflects expected claim payment patterns and other relevant operational considerations for more recent months. Medical cost trend is primarily impacted by medical service utilization and unit costs that are affected by changes in the level and mix of medical benefits offered, including inpatient, outpatient and pharmacy, the impact of copays and deductibles, changes in provider practices and changes in consumer demographics and consumption behavior.

This liability predominately consists of incurred but not reported amounts and reported claims in process including expected development on reported claims. The total of incurred but not reported liabilities plus expected development on reported claims, including reported claims in process, was $2.5 billion at December 31, 2018 and $2.3 billion at December 31, 2017. The remaining balance in both periods reflects amounts due for physician incentives and other medical care expenses and services payable.

Activity in the unpaid claims liability for the Integrated Medical segment for the years ended December 31 was as follows:

(In millions)	2018	2017	2016
Balance at January 1,	**$ 2,420**	$ 2,261	$ 2,105
Less: Reinsurance and other amounts recoverable	**262**	273	237
Balance at January 1, net	**2,158**	1,988	1,868
Acquired, net	**40**	—	—
Incurred costs related to:			
Current year	**21,331**	19,334	18,085
Prior years	**(173)**	(227)	(70)
Total incurred	**21,158**	19,107	18,015
Paid costs related to:			
Current year	**18,978**	17,179	16,142
Prior years	**1,945**	1,758	1,753
Total paid	**20,923**	18,937	17,895
Balance at December 31, net	**2,433**	2,158	1,988
Add: Reinsurance and other amounts recoverable	**264**	262	273
Balance at December 31,	**$ 2,697**	$ 2,420	$ 2,261

Reinsurance and other amounts recoverable reflect amounts due from reinsurers and policyholders to cover incurred but not reported and pending claims for certain business where the Company administers the plan benefits but the right of offset does not exist. See Note 8 for additional information on reinsurance.

Variances in incurred costs related to prior years' unpaid claims and claims expenses that resulted from the differences between actual experience and the Company's key assumptions were as follows for the years ended December 31:

	2018		2017	
($ in millions)	**$**	**% (1)**	**$**	**% (2)**
Actual completion factors	**$ 92**	**0.5%**	$ 87	0.6%
Medical cost trend	**72**	**0.4**	131	0.7
Other	**9**	**—**	9	—
Total favorable variance	**$ 173**	**0.9%**	$ 227	1.3%

(1) Percentage of current year incurred costs as reported for 2017.

(2) Percentage of current year incurred costs as reported for 2016.

Incurred costs related to prior years in the table above, although adjusted through shareholders' net income, do not directly correspond to an increase or decrease to shareholders' net income. The primary reason for this difference is that decreases to prior year incurred costs pertaining to the portion of the liability established for moderately adverse conditions are not considered as impacting shareholders' net income if they are offset by increases in the current year provision for moderately adverse conditions.

Prior year development increased shareholders' net income by $77 million ($97 million before tax) for the year ended December 31, 2018, compared with $96 million ($148 million before tax) in 2017. Favorable prior year development implies primarily lower than expected utilization of medical services while unfavorable prior year development implies higher than expected utilization of medical services. Prior year development amounts close to zero imply utilization of medical services that are consistent with expectations.

The following table depicts the incurred and paid claims development as of December 31, 2018 (net of reinsurance), claims frequency metrics and incurred but not reported liabilities reported in the Integrated Medical segment. The information about incurred and paid claims development for the year ended December 31, 2017 is presented as supplementary information and is unaudited.

	Incurred Costs			
Incurral Year (in millions)	2017 (Unaudited)	2018	Unpaid Claims & Claim Expenses	Claims Frequency
2017	$ 18,692	**$ 18,528**	$ 22	2.6 million
2018		**20,458**	$ 2,266	2.9 million
Cumulative incurred costs plus acquired for the periods presented		**$ 38,986**		

	Cumulative Costs Paid	
Incurral Year	2017 (Unaudited)	2018
2017	$ 16,628	**$ 18,506**
2018		**18,192**
Cumulative paid costs for the periods presented		**$ 36,698**
Outstanding liabilities for the periods presented, net of reinsurance		**$ 2,288**
Other long-duration liabilities not included in development table above		**145**
Net unpaid claims and claims expenses — Integrated Medical		**2,433**
Reinsurance and other amounts recoverable		**264**
Unpaid claims and claim expenses — Integrated Medical		**$ 2,697**

More than 95% of health claims for an accident year are paid within one year of their incurred date.

There is no single or common claim frequency metric used in the health care industry. The Company believes a relevant metric for its health insurance business is the number of customers for whom an insured medical claim was paid. Customers for whom no insured medical claim was paid are excluded from the calculation. Claims that did not result in a liability are not included in the frequency metric.

C. Unpaid Claims and Claim Expenses – International Markets and Group Disability and Other

This liability now includes amounts from international health care following our change in segment reporting in 2018. Prior year rollforwards have been updated to reflect this segment change.

Accounting policy. Liabilities for unpaid claims and claim expenses are established by book of business within the Company's International Markets segment and Group Disability and Other. Liabilities for unpaid claims and claim expenses within the group disability and life business consist of the following primary products: long-term and short-term disability, life insurance, and accident coverages. Unpaid claims and claim expenses consist of (1) case or claims reserves for reported claims that are unpaid as of the balance sheet date; (2) incurred but not reported reserves for claims when the insured event has occurred but has not been reported to the Company; and (3) loss adjustment expense reserves for the expected costs of settling these claims. The Company consistently estimates incurred but not yet reported losses using actuarial principles and assumptions based on historical and projected claim incidence patterns, claim size and the expected payment period. The Company recognizes the actuarial best estimate of the ultimate liability within a level of confidence, consistent with actuarial standards of practice that the liabilities be adequate under moderately adverse conditions. The Company immediately records an adjustment in medical costs and other benefit expenses when estimates of these liabilities change.

The majority of the Company's liability for disability claims consists of the present value of estimated future benefit payments, including expected development, for each reported claim that is currently receiving benefit payments, or pending a decision on eligibility for benefits, over the expected disability period. The Company projects the expected disability period by using historical resolution rates combined with an analysis of current trends and operational factors to develop current estimates of resolution rates. Expected claim resolution rates may vary based upon the Company's experience for the anticipated disability period, the covered benefit period, the cause of disability, the benefit design and the claimant's age, gender and income level. The gross monthly benefit is reduced (offset) by disability income received under other benefit programs, most commonly Social Security Disability Income, workers' compensation, statutory disability or other group benefit plans. The Company estimates the probability and amount of future offset awards and lapses based on the Company's experience for certain offsets not yet finalized.

The Company also establishes a liability for the expected present value of future benefit payments for known claims that have recently been resolved but may reopen in the future, based on Company experience. Prior to a claim becoming known, the Company establishes a liability for incurred but not reported claims, using standard actuarial techniques and calculations based on completion factors and loss ratio assumptions using the Company's experience combined with an analysis of current trends and operational factors. Completion factors are impacted by several key items including changes in claim inventory levels, claim payment patterns, changes in business volume and other factors. Loss ratio assumptions are developed using historical Company experience, adjusted prospectively for expected changes in the underlying business including rate actions, persistency and inforce growth.

Liability balance details. The liability details for unpaid claims and claim expenses as of December 31 are as follows:

(In millions)	2018	2017
Group Disability and Other		
Group Disability and Life	**$ 4,674**	$ 4,491
Other Operations	**192**	193
Total Group Disability and Other	**4,866**	4,684
International Markets	**758**	783
Unpaid claims and claim expenses Group Disability and Other and International Markets	**$ 5,624**	$ 5,467

The Company discounts certain liabilities, predominantly long-term disability, because benefits payments are made over extended periods. Discount rate assumptions for these liabilities are based on projected investment returns for the supporting asset portfolios. Details of the Company's unpaid claim discounted liability balances as of December 31 were as follows:

(In billions)	2018	2017
Discounted liabilities	**$ 4.2**	$ 4.0
Aggregate amount of discount	**$ 1.1**	$ 1.0
Range of discount rates	**4.2% - 5.2%**	4.5% - 5.2%

Interest is accreted and recognized in medical costs and other benefit expenses in the Consolidated Statements of Income.

Activity in the Company's liabilities for unpaid claims and claim expenses, excluding Other Operations, are presented in the following table. Liabilities associated with Other Operations are excluded because they pertain to obligations for long-duration insurance contracts or, if short-duration, the liabilities have been fully reinsured.

(In millions)	2018	2017	2016
Balance at January 1,	**$ 5,274**	$ 4,997	$ 4,609
Less: Reinsurance	**140**	123	121
Balance at January 1, net	**5,134**	4,874	4,488
Incurred claims related to:			
Current year	**5,350**	5,097	5,116
Prior years			
Interest accretion	**156**	163	161
All other incurred	**(147)**	(43)	85
Total incurred	**5,359**	5,217	5,362
Paid claims related to:			
Current year	**3,391**	3,229	3,221
Prior years	**1,808**	1,757	1,739
Total paid	**5,199**	4,986	4,960
Acquisitions	**23**	—	
Foreign currency	**(41)**	29	(16)
Balance at December 31, net	**5,276**	5,134	4,874
Add: Reinsurance	**156**	140	123
Balance at December 31,	**$ 5,432**	$ 5,274	$ 4,997

Reinsurance in the previous table reflects amounts due from reinsurers related to unpaid claims liabilities. The Company's insurance subsidiaries enter into agreements with other companies primarily to limit losses from large exposures and to permit recovery of a portion of incurred losses. See Note 8 for additional information on reinsurance.

The majority of the liability for unpaid claims and claim expenses is related to disability claims with long-tailed payouts. Interest earned on assets backing these liabilities is an integral part of pricing and reserving. Therefore, interest accreted on prior year balances is shown as a separate component of prior year incurred claims. This interest is calculated by applying the average discount rate used in determining the liability balance to the average liability balance over the period. The remaining prior year incurred claims amount primarily reflects updates to the Company's liability estimates and variances between actual experience during the period relative to the assumptions and expectations reflected in determining the liability. Assumptions reflect the Company's expectations over the life of the book of business and will vary from actual experience in any period, both favorably and unfavorably, with variation in resolution rates being the most significant driver for the long-term disability business. Favorable prior year incurred claims reported in 2018 largely reflect favorable loss ratio experience for long-term disability and life relative to expectations. Favorable prior year incurred claims reported in 2017 largely reflect improved resolution rate experience for long-term disability relative to expectations. Prior year incurred claims reported in 2016 included the impact of changes made to our disability claims management process and a period of elevated life claims.

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Long-term disability development tables. The table below presents information about incurred and paid claims development as of December 31, 2018 (net of reinsurance), total incurred but not reported liabilities, and cumulative claims frequency for the Company's long-term disability book of business. The information about incurred and paid claims development for the years ended 2012 through 2017 is presented as supplementary information and is unaudited. As permitted under GAAP, the Company presented development table information beginning in 2012 because obtaining information beyond this period was impracticable as historical data was not maintained in such detail.

(In millions, except for claims frequency)

	Incurred Claims (undiscounted)							Incurred But Not	
	Unaudited							Reported	Claims
Accident Year	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**Liabilities [1]**	**Frequency**
2012	$ 995	$ 951	$ 889	$ 876	$ 883	$ 880	**$ 861**	$ —	21,183
2013		1,063	1,037	1,062	1,072	1,057	**1,032**	—	23,526
2014			1,158	1,129	1,167	1,146	**1,094**	—	25,314
2015				1,184	1,154	1,185	**1,160**	—	25,737
2016					1,246	1,184	**1,199**	3	25,349
2017						1,226	**1,193**	10	23,382
2018							**1,348**	515	12,025
Cumulative incurred claims for the periods presented							**$ 7,887**		

(1) Incurred but not reported amounts are included in 2018 incurred claims.

	Cumulative Paid Claims						
	Unaudited						
Accident Year	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
2012	$ 81	$ 288	$ 429	$ 504	$ 571	$ 621	**$ 661**
2013		92	342	503	600	670	**732**
2014			111	379	575	667	**743**
2015				114	417	603	**702**
2016					122	411	**598**
2017						110	**396**
2018							**116**
Cumulative paid claims for the periods presented							**$ 3,948**
All outstanding liabilities for the periods presented, net of reinsurance							**$ 3,939**
All outstanding liabilities prior to 2012, net of reinsurance							**921**
Impact of discounting							**(885)**
Liability for long-term disability unpaid claims and claim expenses, net of reinsurance							**$ 3,975**

The claims frequency metric used for the Company's long-term disability line of business represents the number of unique claim events for which benefits have been approved and payments made. Claim events are identified using a unique claimant identifier and incurral date. Thus, if an individual has multiple claims for different disabling events (and therefore different incurral dates), each will be determined to be a unique claim event. However, if an individual receives multiple benefits under more than one policy (for example for supplemental disability benefits such as pension contribution benefits or survivor benefits), the Company treats this as a single claim occurrence because they related to the same claim event. Claims frequency metrics for the most recent year are expected to be low reflecting the long-term disability product features including waiting and elimination periods that result in delayed eligibility for contract benefits. Claims that did not result in a liability are not included in the frequency metric.

The following is supplementary and unaudited information about average historical claims payout patterns for the long-term disability business for the years presented in the development table as of December 31, 2018. The average annual percentage payout of incurred claims, net of reinsurance, is approximately 9% in year one, 24% in year two, 16% in year three, 9% in year four, 7% in year five, 6% in year six and 5% in year seven.

The following table reconciles the long-term disability net incurred and paid claims development table to the liability for unpaid claims and claim expenses in the Company's Consolidated Balance Sheets as of December 31, 2018.

(In millions)	
Net outstanding liabilities — Group Disability and Life businesses	
Long-term disability liabilities, net of reinsurance	**$ 3,975**
Other short-duration insurance books of business, net of reinsurance	**594**
Liabilities for unpaid claims and claim expenses, net of reinsurance	**4,569**
Reinsurance recoverable on unpaid claims — Group Disability and Life businesses	
Long-term disability	**94**
Other short-duration insurance books of business	**11**
Total reinsurance recoverable on unpaid claims	**105**
Total liability for unpaid claims and claim expenses — Group Disability and Life businesses	**4,674**
International Markets segment	**758**
Other Operations	**192**
Unpaid claims and claim expenses — Group Disability and Other and International Markets	**$ 5,624**

The other short-duration insurance books of business, net of reinsurance, primarily include liabilities for life, accident and short-term disability insurance products. Liabilities for these products are typically complete within one year. Claim development on these liabilities is largely driven by completion factors and loss ratio assumptions.

Note 8 Reinsurance

The Company's insurance subsidiaries enter into agreements with other insurance companies to assume and cede reinsurance. Reinsurance is ceded primarily in acquisition and disposition transactions when the underwriting company is not being acquired. Reinsurance is also used to limit losses from large exposures and to permit recovery of a portion of direct or assumed losses. Reinsurance does not relieve the originating insurer of liability. Therefore, reinsured liabilities must continue to be reported along with the related reinsurance recoverables. The Company regularly evaluates the financial condition of its reinsurers and monitors concentrations of its credit risk.

A. Reinsurance Recoverables

The majority of the Company's reinsurance recoverables resulted from acquisition and disposition transactions in which the underwriting company was not acquired. Components of the Company's reinsurance recoverables are presented in the following table. Included in the table below is $297 million as of December 31, 2018 and $282 million as of December 31, 2017 of current reinsurance recoverables that are reported in other current assets.

(Dollars in millions) **Line of Business**	**Reinsurer(s)**	**December 31, 2018**	**December 31, 2017**	**Collateral and Other Terms at December 31, 2018**
Ongoing Operations				
Integrated Medical, International Markets, Group Disability, COLI	Various	**$ 464**	$ 454	Balances range from less than $1 million up to $70 million. Over 70% of the balance is from companies rated as investment grade by Standard & Poor's.
Total recoverables related to ongoing operations		**464**	454	
Acquisition, disposition or runoff activities				
Individual Life and Annuity (sold in 1998)	Lincoln National Life and Lincoln Life & Annuity of New York	**3,312**	3,436	Both companies' ratings were well above the level that would trigger a contractual obligation to fully secure the outstanding balance.
GMDB (effectively exited in 2013)	Berkshire	**893**	928	100% secured by assets in a trust.
Retirement Benefits Business (sold in 2004)	Prudential Retirement Insurance and Annuity	**787**	850	100% secured by assets in a trust.
Supplemental Benefits Business (2012 acquisition)	Great American Life	**261**	283	100% secured by assets in a trust.
Other	Various	**87**	95	100% secured by assets in a trust or other deposits.
Total recoverables related to acquisition, disposition or runoff activities		**5,340**	5,592	
Total reinsurance recoverables		**$ 5,804**	$ 6,046	

The Company bears the risk of loss if its reinsurers and retrocessionaires do not meet or are unable to meet their reinsurance obligations to the Company. The Company reviews its reinsurance arrangements and establishes reserves against the recoverables if recovery is not considered probable.

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B. Effects of Reinsurance

The following table presents direct, assumed and ceded premiums for both short-duration and long-duration insurance contracts. It also presents reinsurance recoveries that have been netted against benefit expenses in the Company's Consolidated Statements of Income.

(In millions)	2018	2017	2016
Premiums			
Short-duration contracts			
Direct	**$ 32,148**	$ 28,838	$ 27,694
Assumed	**77**	199	247
Ceded	**(182)**	(150)	(229)
Total short-duration contract premiums	**32,043**	28,887	27,712
Long-duration contracts			
Direct	**4,268**	3,748	3,259
Assumed	**116**	130	137
Ceded			
Individual life insurance and annuity business sold	**(133)**	(143)	(153)
Other	**(181)**	(131)	(131)
Total long-duration contract premiums	**4,070**	3,604	3,112
Total premiums	**$ 36,113**	$ 32,491	$ 30,824
Reinsurance recoveries			
Individual life insurance and annuity business sold	**$ 249**	$ 259	$ 279
Other	**203**	66	261
Total reinsurance recoveries	**$ 452**	$ 325	$ 540

The effects of reinsurance on written premiums for short-duration contracts were not materially different from the recognized premium amounts shown in the table above.

C. Effective Exit of GMDB and GMIB Business

The Company entered into an agreement with Berkshire to effectively exit the GMDB and GMIB business via a reinsurance transaction in 2013. Berkshire reinsured 100% of the Company's future claim payments in this business, net of other reinsurance arrangements existing at that time. The reinsurance agreement is subject to an overall limit with approximately $3.4 billion remaining at December 31, 2018.

GMDB is accounted for as reinsurance and GMIB assets and liabilities are reported as derivatives at fair value as discussed below. GMIB assets are reported in other current assets and other assets, and GMIB liabilities are reported in accrued expenses and other liabilities and other non-current liabilities.

GMDB

The GMDB exposure arises under annuities written by ceding companies that guarantee the benefit received at death. The Company's exposure arises when the guaranteed minimum death benefit exceeds the fair value of the related mutual fund investments at the time of a contractholder's death.

Accounting policy. The Company estimates the gross liability and reinsurance recoverable with an internal model based on the Company's experience and future expectations over an extended period, consistent with the long-term nature of this product. As a result of the reinsurance transaction, reserve increases have a corresponding increase in the recorded reinsurance recoverable, provided the increased recoverable remains within the overall Berkshire limit (including the GMIB asset presented below).

The following table presents the account value, net amount at risk and average attained age of underlying contractholders for guarantees assumed by the Company in the event of death. The net amount at risk is the amount that the Company would have to pay if all contractholders died as of the specified date. Unless the Berkshire reinsurance limit is exceeded, the Company should be reimbursed in full for these payments.

(Dollars in millions, excludes impact of reinsurance ceded)	2018	2017
Account value	**$ 8,402**	$ 10,109
Net amount at risk	**$ 2,466**	$ 2,112
Average attained age of contractholders (weighted by exposure)	**74**	75
Number of contractholders	**220,000**	245,000

GMIB

The Company reinsured contracts with issuers of GMIB products. The Company's exposure represents the excess of a contractually guaranteed amount over the level of variable annuity account values. Payment by the Company depends on the actual account value in the underlying mutual funds and the level of interest rates when the contractholders elect to receive minimum income payments that must occur within 30 days of a policy anniversary after the appropriate waiting period. The Company has purchased retrocessional coverage ("GMIB assets"), including retrocessional coverage from Berkshire, for these contracts.

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Accounting policy. The Company reports GMIB liabilities and assets as derivatives at fair value because cash flows of these liabilities and assets are affected by equity markets and interest rates, but are without significant life insurance risk and are settled in lump sum payments. The Company receives and pays fees periodically based on either contractholders' account values or deposits increased at a contractual rate. The Company will also pay and receive cash depending on changes in account values and interest rates when contractholders first elect to receive minimum income payments. Cash flows on these contracts are reported in operating activities.

Assumptions used in fair value measurement. GMIB assets and liabilities are established using capital market assumptions and assumptions related to future annuitant behavior (including mortality, lapse, and annuity election rates). The Company classifies GMIB assets and liabilities in Level 3 in the fair value hierarchy described in Note 10 because assumptions related to future annuitant behavior are largely unobservable.

The only assumption expected to impact future shareholders' net income is non-performance risk. The non-performance risk adjustment reflects a market participant's view of nonpayment risk by adding an additional spread to the discount rate in the calculation of both (a) the GMIB liabilities to be paid by the Company, and (b) the GMIB assets to be paid by the reinsurers, after considering collateral.

The Company regularly evaluates each of the assumptions used in establishing these assets and liabilities. Significant decreases in assumed lapse rates or spreads used to calculate non-performance risk of the Company, or significant increases in assumed annuity election rates or spreads used to calculate the non-performance risk of the reinsurers, would result in higher fair value measurements. A change in one of these assumptions is not necessarily accompanied by a change in another assumption.

GMIB liabilities totaling $706 million as of December 31, 2018 and $762 million as of December 31, 2017 were reported in accrued expenses and other liabilities and other non-current liabilities. There were three reinsurers covering 100% of the GMIB exposures as of December 31, 2018 and 2017 as follows:

(In millions) Line of Business	Reinsurer	December 31, 2018	December 31, 2017	Collateral and Other Terms at December 31, 2018
GMIB	Berkshire	**$ 341**	$ 359	100% were secured by assets in a trust.
	Sun Life Assurance Company of Canada	**208**	221	
	Liberty Re (Bermuda) Ltd.	**184**	197	86% were secured by assets in a trust.
Total GMIB recoverables reported in other current assets and other assets		**$ 733**	$ 777	

Amounts included in shareholders net income for GMIB assets and liabilities were not material in 2018, 2017 and 2016.

Note 9 Investments, Investment Income and Gains and Losses

Cigna's investment portfolio consists of a broad range of investments including fixed maturities, equity securities, commercial mortgage loans, policy loans, other long-term investments, short-term investments, and derivative financial instruments. The sections below provide more detail regarding our accounting policies, investment balances, net investment income and realized investment gains and losses. See Note 10 for information about valuation of the Company's investment portfolio. Fixed maturities, commercial mortgage loans, derivative financial instruments, and short-term investments with contractual maturities during the next 12 months are classified on the balance sheet as current investments, unless they are held as statutory deposits or restricted for other purposes, where they are classified in long-term investments. Equity securities classified as current include exchange traded funds that are used in our cash management process. All other investments are classified in long-term investments. The following table summarizes the Company's investments by category and current or long-term classification.

	December 31, 2018			December 31, 2017		
(In millions)	Current	Long-term	Total	Current	Long-term	Total
Fixed Maturities	**$ 1,320**	**$ 21,608**	**$ 22,928**	$ 1,516	$ 21,622	$ 23,138
Equity securities	**377**	**171**	**548**	406	182	588
Commercial mortgage loans	**32**	**1,826**	**1,858**	15	1,746	1,761
Policy loans	**–**	**1,423**	**1,423**	–	1,415	1,415
Other long-term investments	**–**	**1,901**	**1,901**	–	1,518	1,518
Short-term investments	**316**	**–**	**316**	199	–	199
Total	**$ 2,045**	**$ 26,929**	**$ 28,974**	$ 2,136	$ 26,483	$ 28,619

A. Investment Portfolio

Fixed Maturities

Accounting policy. Fixed maturities (including bonds, mortgage and other asset-backed securities and preferred stocks redeemable by the investor) are classified as available for sale and are carried at fair value with changes in fair value recorded in accumulated other comprehensive income (loss) within shareholders' equity. Net unrealized appreciation on investments supporting the Company's run-off settlement annuity business is reported in future policy benefit liabilities rather than accumulated other comprehensive income (loss).

The Company records impairment losses in net income for fixed maturities with fair value below amortized cost that meet either of the following conditions:

- If the Company intends to sell or determines that it is more likely than not to be required to sell these fixed maturities before their fair values recover, an impairment loss is recognized for the excess of the amortized cost over fair value.

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- If the net present value of projected future cash flows of a fixed maturity (based on qualitative and quantitative factors, including the probability of default, and the estimated timing and amount of recovery) is below the amortized cost basis, that difference is recognized as an impairment loss. For mortgage and asset-backed securities, estimated future cash flows are also based on assumptions about the collateral attributes including prepayment speeds, default rates and changes in value.

Debt securities are classified as either current or long-term investments based on their contractual maturities. The amortized cost and fair value by contractual maturity periods for fixed maturities were as follows at December 31, 2018:

(In millions)	Amortized Cost	Fair Value
Due in one year or less	$ 1,323	$ 1,327
Due after one year through five years	6,452	6,522
Due after five years through ten years	10,205	9,992
Due after ten years	4,064	4,577
Mortgage and other asset-backed securities	506	510
Total	$ 22,550	$ 22,928

Actual maturities of these securities could differ from their contractual maturities used in the table above. This could occur because issuers may have the right to call or prepay obligations, with or without penalties.

Gross unrealized appreciation (depreciation) on fixed maturities by type of issuer is shown below.

(In millions)	Amortized Cost	Unrealized Appreciation	Unrealized Depreciation	Fair Value
December 31, 2018				
Federal government and agency	$ 507	$ 204	$ (1)	$ 710
State and local government	920	66	(1)	985
Foreign government	2,214	155	(7)	2,362
Corporate	18,403	411	(453)	18,361
Mortgage and other asset-backed	506	16	(12)	510
Total	$ 22,550	$ 852	$ (474)	$ 22,928
Investments supporting liabilities of the Company's run-off settlement annuity business (included in total above) [1]	$ 2,264	$ 479	$ (40)	$ 2,703
December 31, 2017				
Federal government and agency	$ 541	$ 239	$ (1)	$ 779
State and local government	1,196	93	(2)	1,287
Foreign government	2,360	142	(15)	2,487
Corporate	17,301	868	(81)	18,088
Mortgage and other asset-backed	469	29	(1)	497
Total	$ 21,867	$ 1,371	$ (100)	$ 23,138
Investments supporting liabilities of the Company's run-off settlement annuity business (included in total above) [1]	$ 2,200	$ 681	$ (2)	$ 2,879

(1) Net unrealized appreciation for these investments is excluded from accumulated other comprehensive income.

The Company had commitments to purchase $106 million of fixed maturities as of December 31, 2018, all of which bear interest at a fixed market rate.

Review of declines in fair value. Management reviews fixed maturities with a decline in fair value from cost for impairment based on criteria that include:

- length of time and severity of decline;
- financial health and specific near term prospects of the issuer;
- changes in the regulatory, economic or general market environment of the issuer's industry or geographic region; and
- the Company's intent to sell or the likelihood of a required sale prior to recovery.

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Management believes the unrealized depreciation below to be temporary based on this review, and therefore has not impaired these amounts. The table below summarizes fixed maturities with a decline in fair value from amortized cost by the length of time these securities have been in an unrealized loss position.

	December 31, 2018				December 31, 2017			
(Dollars in millions)	Fair Value	Amortized Cost	Unrealized Depreciation	Number of Issues	Fair Value	Amortized Cost	Unrealized Depreciation	Number of Issues
One year or less								
Investment grade	**$ 7,127**	**$ 7,367**	**$ (240)**	**1,324**	$ 3,272	$ 3,309	$ (37)	797
Below investment grade	**$ 1,185**	**$ 1,240**	**$ (55)**	**1,190**	$ 543	$ 553	$ (10)	643
More than one year								
Investment grade	**$ 3,023**	**$ 3,181**	**$ (158)**	**784**	$ 1,503	$ 1,549	$ (46)	373
Below investment grade	**$ 249**	**$ 270**	**$ (21)**	**245**	$ 155	$ 162	$ (7)	42

Equity Securities

Accounting policy. Upon adopting ASU 2016-01 beginning in 2018, changes in the fair values of equity securities that have a readily determinable fair value (primarily exchange-traded funds) are reported in net realized investment gains (losses). As of December 31, 2018, the fair values of these securities were $415 million and cost was $433 million. Also beginning in 2018, private equity securities of $89 million as of December 31, 2018 without a readily determinable fair value are carried at cost minus impairment, if any, plus or minus changes resulting from observable price changes. The amount of impairments or value changes resulting from observable price changes was not material.

Equity securities also include hybrid investments consisting of preferred stock with call features that are carried at fair value with changes in fair value reported in net realized investment gains (losses) and dividends reported in net investment income. As of December 31, 2018, fair values of these securities were $44 million and cost was $58 million, compared with fair value of $49 million and cost of $61 million as of December 31, 2017.

Commercial Mortgage Loans

Mortgage loans held by the Company are made exclusively to commercial borrowers and are diversified by property type, location and borrower. Loans are generally issued at a fixed rate of interest and are secured by high quality, primarily completed and substantially leased operating properties.

Accounting policy. Commercial mortgage loans are carried at unpaid principal balances or, if impaired, the lower of unpaid principal or fair value of the underlying real estate. See the "Impaired commercial mortgage loans" section below for the Company's accounting policy for impaired commercial mortgage loans. Commercial mortgage loans are classified as either current or long-term investments based on their contractual maturities.

As of December 31, 2018, approximately 93% of the Company's commercial mortgage loan portfolio is scheduled to mature in 2022 or thereafter.

Actual maturities could differ from contractual maturities for several reasons: borrowers may have the right to prepay obligations with or without prepayment penalties; the maturity date may be extended; and loans may be refinanced.

Credit quality. The Company regularly evaluates and monitors credit risk, beginning with the initial underwriting of a mortgage loan and continuing throughout the investment holding period. Mortgage origination professionals employ an internal credit quality rating system designed to evaluate the relative risk of the transaction at origination that is then updated each year as part of the annual portfolio loan review. The Company evaluates and monitors credit quality on a consistent and ongoing basis, classifying each loan as a loan in good standing, potential problem loan or problem loan.

Quality ratings are based on our evaluation of a number of key inputs related to the loan, including real estate market-related factors such as rental rates and vacancies, and property-specific inputs such as growth rate assumptions and lease rollover statistics. However, the two most significant contributors to the credit quality rating are the debt service coverage and loan-to-value ratios. The debt service coverage ratio measures the amount of property cash flow available to meet annual interest and principal payments on debt, with a ratio below 1.0 indicating that there is not enough cash flow to cover the required loan payments. The loan-to-value ratio, commonly expressed as a percentage, compares the amount of the loan to the fair value of the underlying property collateralizing the loan.

The following table summarizes the credit risk profile of the Company's commercial mortgage loan portfolio based on loan-to-value and debt service coverage ratios as of December 31, 2018 and 2017:

	2018			2017		
(Dollars in millions) **Loan-to-Value Ratio**	Carrying Value	Average Debt Service Coverage Ratio	Average Loan-to-Value Ratio	Carrying Value	Average Debt Service Coverage Ratio	Average Loan-to-Value Ratio
Below 60%	**$ 1,132**	**2.14**		$ 1,109	2.03	
60% to 79%	**650**	**1.93**		652	2.24	
80% to 100%	**76**	**1.49**		—	—	
Total	**$ 1,858**	**2.04**	**58%**	$ 1,761	2.11	57%

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The Company's annual in-depth review of its commercial mortgage loan investments is the primary mechanism for identifying emerging risks in the portfolio. The most recent review was completed by the Company's investment professionals in the second quarter of 2018 and included an analysis of each underlying property's most recent annual financial statements, rent rolls, operating plans, budgets, a physical inspection of the property and other pertinent factors. Based on historical results, current leases, lease expirations and rental conditions in each market, the Company estimated the current year and future stabilized property income and fair value for each loan.

The Company re-evaluates a loan's credit quality between annual reviews if new property information is received or an event such as delinquency or a borrower's request for restructure causes management to believe that the Company's estimate of financial performance, fair value or the risk profile of the underlying property has been impacted.

Impaired commercial mortgage loans. A commercial mortgage loan is considered impaired when it is probable that the Company will not collect all amounts due per the terms of the promissory note. Impaired loans are carried at the lower of the unpaid principal balance or fair value of the underlying collateral. Interest income on impaired mortgage loans is only recognized when a payment is received.

There were no impaired commercial mortgage loans as of December 31, 2018 and 2017.

Policy Loans

Accounting policy. Policy loans, primarily associated with our corporate owned life insurance business, are carried at unpaid principal balances plus accumulated interest, the total of which approximates fair value. These loans are collateralized by life insurance policy cash values and therefore have minimal exposure to credit loss. Interest rates are reset annually based on a rolling average of benchmark interest rates.

Other Long-Term Investments

Accounting policy. Other long-term investments include investments in unconsolidated entities. These entities include certain limited partnerships and limited liability companies holding real estate, securities or loans. These investments are carried at cost plus the Company's ownership percentage of reported income or loss, based on the financial statements of the underlying investments that are generally reported at fair value. Income from these investments is reported on a one quarter lag due to the timing of when financial information is received from the general partner or manager of the investments.

Other long-term investments also include investment real estate carried at depreciated cost less any impairment write-downs to fair value when cash flows indicate that the carrying value may not be recoverable. Depreciation is generally recorded using the straight-line method based on the estimated useful life of each asset. Investment real estate as of December 31, 2018 and 2017 is expected to be held longer than one year and includes real estate acquired through the foreclosure of commercial mortgage loans.

Additionally, other long-term investments includes foreign currency swaps carried at fair value. See discussion below for information on the Company's accounting policies for these derivative financial instruments.

Other long-term investments and related commitments are diversified by issuer, property type and geographic regions. The following table provides unfunded commitment and carrying value information for these investments. The Company expects to disburse approximately 26% of the committed amounts in 2019.

	Carrying value as of December 31,		Unfunded Commitments as of
(In millions)	**2018**	**2017**	**December 31, 2018**
Real estate investments	**$ 679**	$ 591	**$ 376**
Securities partnerships	**1,045**	863	**1,063**
Other	**177**	64	**33**
Total	**$ 1,901**	$ 1,518	**$ 1,472**

Short-Term Investments and Cash Equivalents

Accounting policy. Security investments with maturities of greater than three months to one year from time of purchase are classified as short-term, available for sale and carried at fair value that approximates cost. Cash equivalents consist of short-term investments with maturities of three months or less from the time of purchase and are carried at cost that approximates fair value.

Short-term investments and cash equivalents included the following types of issuers:

(In millions)	**December 31, 2018**	**December 31, 2017**
Corporate securities	**$ 581**	$ 1,143
Federal government securities	**$ 82**	$ 604
Foreign government securities	**$ 238**	$ 159
Money market funds	**$ 1,174**	$ 12

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Derivative Financial Instruments

The Company uses derivative financial instruments to manage the characteristics of investment assets (such as duration, yield, currency and liquidity) to meet the varying demands of the related insurance and contract holder liabilities. The Company also uses derivative financial instruments to hedge the risk of changes in the net assets of certain of its foreign subsidiaries due to changes in foreign currency exchange rates. The Company has written and purchased GMIB reinsurance contracts in its run-off reinsurance business that are accounted for as freestanding derivatives and discussed further in Note 8. Derivatives in the Company's separate accounts are excluded from the following discussion because associated gains and losses generally accrue directly to separate account policyholders.

Derivative instruments used by the Company typically include foreign currency swap contracts and foreign currency forward contracts. Foreign currency swap contracts periodically exchange cash flows between two currencies for principal and interest. Foreign currency forward contracts require the Company to purchase a foreign currency in exchange for the functional currency of its operating unit at a future date, generally within three months from the contracts' trade dates.

The Company manages the credit risk of these derivative instruments by diversifying its portfolio among approved dealers of high credit quality, and through routine monitoring of credit risk exposures. Certain of the Company's over-the-counter derivative instruments require either the Company or the counterparty to post collateral or demand immediate payment depending on the amount of the net liability position of the derivative instrument and predefined financial strength or credit rating thresholds. These collateral posting requirements vary by counterparty and amounts posted were not significant as of December 31, 2018 or 2017.

Accounting policy. Derivatives are recorded on our balance sheet at fair value and are classified as current or non-current according to their contractual maturities. Further information on our policies for determining fair value are discussed in Note 10. Derivative cash flows are generally reported in operating activities. The Company applies hedge accounting when derivatives are designated, qualified and highly effective as hedges. Under hedge accounting, the changes in fair value of the derivative and the hedged risk are generally recognized together and offset each other when reported in shareholders' net income. Various qualitative or quantitative methods appropriate for each hedge are used to formally assess and document hedge effectiveness at inception and each period throughout the life of a hedge.

- *Fair value hedges of the foreign exchange-related changes in fair values of certain fixed maturity foreign-denominated bonds:* Swap fair values are reported in long-term investments or other non-current liabilities. Changes in fair values attributable to foreign exchange risk of the swap contracts and the hedged bonds are reported in other realized investment gains and losses. The portion of the swap contracts' changes in fair value excluded from the assessment of hedge effectiveness is recorded in accumulated other comprehensive income and recognized in net investment income as swap coupon payments are accrued, offsetting the foreign denominated coupons received on the designated bonds.
- *Net investment hedges of certain foreign subsidiaries that conduct their business principally in Euros:* The fair values of the swap contracts are reported in other assets or other non-current liabilities. The changes in fair values of these instruments are reported in other comprehensive income, specifically in translation of foreign currencies. The portion of the change in swap fair values relating to foreign exchange spot rates will be recognized in earnings upon deconsolidation of the hedged foreign subsidiaries. The remaining changes in swap fair value are excluded from the effectiveness assessment and recognized in selling, general and administrative expenses as swap coupon payments are accrued. The notional value of hedging instruments matches the hedged amount of subsidiary net assets.
- *Economic hedges for derivatives not designated as accounting hedges:* Fair values of derivative instruments are reported in current investments or accrued expenses and other liabilities. The changes in fair values are reported in net realized investment gains and losses.

Gross fair values of our derivative financial instruments are presented in Note 10. As of December 31, 2018 and 2017, the effects of derivative instruments on the Consolidated Financial Statements were not material, including gains or losses reclassified from accumulated other comprehensive income into shareholders' net income, as well as amounts excluded from the assessment of hedge effectiveness. The following table summarizes the types and notional quantity of derivative instruments held by the Company.

(In millions)		Notional Value as of December 31,	
Type of Instrument	**Purpose**	**2018**	**2017**
Foreign currency swap contracts	*Fair value hedge:* To hedge the foreign exchange-related changes in fair values of certain fixed maturity foreign-denominated bonds. The notional value of these derivatives matches the amortized cost of the hedged bonds.	**$ 525**	$ 318
Foreign currency swap contracts	*Net investment hedge:* To reduce the risk of changes in net assets due to changes in foreign currency spot exchange rates for certain foreign subsidiaries that conduct their business principally in Euros. The notional value of hedging instruments matches the hedged amount of subsidiary net assets.	**$ 439**	$ —
Foreign currency forward contracts	*Economic hedge:* To hedge the foreign exchange related changes in fair values of a U.S. dollar-denominated fixed maturity bond portfolio to reflect the local currency for the Company's foreign subsidiary in South Korea. The notional value of hedging instruments generally aligns with the fair value of the hedged bond portfolio.	**$ 309**	$ 255

Concentration of Risk

The Company did not have a concentration of investments in a single issuer or borrower exceeding 10% of shareholders' equity as of December 31, 2018 and 2017.

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B. Net Investment Income

Accounting policy. When interest and principal payments on investments are current, the Company recognizes interest income when it is earned. The Company recognizes interest income on a cash basis when interest payments are delinquent based on contractual terms or when certain terms (interest rate or maturity date) of the investment have been restructured. For unconsolidated entities that are included in Other long-term investments, investment income is generally recognized according to the Company's share of the reported income or loss on the underlying investments. Investment income attributed to the Company's separate accounts is excluded from our earnings because associated gains and losses generally accrue directly to separate account policyholders.

The components of pre-tax net investment income for the years ended December 31 were as follows:

(In millions)	2018	2017	2016
Fixed maturities	**$ 1,009**	$ 946	$ 899
Equity securities	**28**	14	4
Commercial mortgage loans	**78**	81	91
Policy loans	**70**	69	72
Other long-term investments	**156**	124	98
Short-term investments and cash	**194**	42	26
Total investment income	**1,535**	1,276	1,190
Less investment expenses	**55**	50	43
Net investment income	**$ 1,480**	$ 1,226	$ 1,147

Real estate investments and securities partnerships with a carrying value of $150 million at December 31, 2018 and $191 million at December 31, 2017 were non-income producing during the preceding twelve months.

C. Realized Investment Gains And Losses

Accounting policy. Realized investment gains and losses are based on specifically identified assets and results from sales, investment asset write-downs, changes in the fair values of certain derivatives and equity securities and changes in valuation reserves on commercial mortgage loans.

The following realized gains and losses on investments for the years ended December 31 exclude amounts required to adjust future policy benefits for the run-off settlement annuity business, as well as realized gains and losses attributed to the Company's separate accounts because those gains and losses generally accrue directly to separate account policyholders.

(In millions)	2018	2017	2016
Net realized investment (losses) gains, excluding investment asset write-downs	**$ (34)**	$ 268	$ 227
Write-downs on debt securities	**(43)**	(26)	(35)
Write-downs on other invested assets	**(4)**	(5)	(23)
Net realized investment (losses) gains, before income taxes	**$ (81)**	$ 237	$ 169

Net realized investment losses, excluding investment asset write-downs in 2018 represent primarily mark to market losses on equity securities and derivatives and net losses on sales of fixed maturities, partially offset by net gains on sales of real estate properties held in joint ventures. Net realized investment gains, excluding asset write-downs in 2017 and 2016 represented primarily gains on sales of real estate properties held in joint ventures and gains on sales of fixed maturities and equity securities. Realized losses on equity securities still held at December 31, 2018 were $33 million in 2018.

The following table presents sales information for available-for-sale securities (fixed maturities for the year ended in 2018, and fixed maturities and equity securities for the years ended in 2017 and 2016). Gross gains on sales and gross losses on sales exclude amounts required to adjust future policy benefits for the run-off settlement annuity business.

(In millions)	2018	2017	2016
Proceeds from sales	**$ 2,625**	$ 2,012	$ 1,544
Gross gains on sales	**$ 28**	$ 103	$ 83
Gross losses on sales	**$ (47)**	$ (18)	$ (7)

Note 10 Fair Value Measurements

The Company carries certain financial instruments at fair value in the financial statements including fixed maturities, certain equity securities, short-term investments and derivatives. Other financial instruments are measured at fair value only under certain conditions, such as when impaired.

Fair value is defined as the price at which an asset could be exchanged in an orderly transaction between market participants at the balance sheet date. A liability's fair value is defined as the amount that would be paid to transfer the liability to a market participant, not the amount that would be paid to settle the liability with the creditor.

The Company's financial assets and liabilities carried at fair value have been classified based upon a hierarchy defined by GAAP. The hierarchy gives the highest ranking to fair values determined using unadjusted quoted prices in active markets for identical assets and liabilities (Level 1) and the lowest ranking to fair values determined using methodologies and models with unobservable inputs (Level 3). An asset's or a liability's

classification is based on the lowest level of input that is significant to its measurement. For example, a financial asset or liability carried at fair value would be classified in Level 3 if unobservable inputs were significant to the instrument's fair value, even though the measurement may be derived using inputs that are both observable (Levels 1 and 2) and unobservable (Level 3).

The Company estimates fair values using prices from third parties or internal pricing methods. Fair value estimates received from third-party pricing services are based on reported trade activity and quoted market prices when available, and other market information that a market participant may use to estimate fair value. The internal pricing methods are performed by the Company's investment professionals and generally involve using discounted cash flow analyses, incorporating current market inputs for similar financial instruments with comparable terms and credit quality, as well as other qualitative factors. In instances where there is little or no market activity for the same or similar instruments, fair value is estimated using methods, models and assumptions that the Company believes a hypothetical market participant would use to determine a current transaction price. These valuation techniques involve some level of estimation and judgment that becomes significant with increasingly complex instruments or pricing models.

The Company is responsible for determining fair value, as well as for assigning the appropriate level within the fair value hierarchy, based on the significance of unobservable inputs. The Company reviews methodologies, processes and controls of third-party pricing services and compares prices on a test basis to those obtained from other external pricing sources or internal estimates. The Company performs ongoing analyses of both prices received from third-party pricing services and those developed internally to determine that they represent appropriate estimates of fair value. The controls executed by the Company include evaluating changes in prices and monitoring for potentially stale valuations. The Company also performs sample testing of sales values to confirm the accuracy of prior fair value estimates. The minimal exceptions identified during these processes indicate that adjustments to prices are infrequent and do not significantly impact valuations. Annually, we conduct an on-site visit of the most significant pricing service to review their processes, methodologies and controls. This on-site review includes a walk-through of inputs for a sample of securities held across various asset types to validate the documented pricing process.

A. Financial Assets and Financial Liabilities Carried at Fair Value

The following table provides information as of December 31, 2018 and 2017 about the Company's financial assets and liabilities carried at fair value. Separate account assets that are also recorded at fair value on the Company's Consolidated Balance Sheets are reported separately in the Separate Accounts section as gains and losses related to these assets generally accrue directly to policyholders.

As of December 31, *(In millions)*	Quoted Prices in Active Markets for Identical Assets (Level 1)		Significant Other Observable Inputs (Level 2)		Significant Unobservable Inputs (Level 3)		Total	
	2018	2017	**2018**	2017	**2018**	2017	**2018**	2017
Financial assets at fair value								
Fixed maturities								
Federal government and agency	**$ 209**	$ 253	**$ 501**	$ 526	**$ —**	$ —	**$ 710**	$ 779
State and local government	**—**	—	**985**	1,287	**—**	—	**985**	1,287
Foreign government	**—**	—	**2,356**	2,442	**6**	45	**2,362**	2,487
Corporate	**—**	—	**18,127**	17,658	**234**	430	**18,361**	18,088
Mortgage and other asset-backed	**—**	—	**372**	343	**138**	154	**510**	497
Total fixed maturities	**209**	253	**22,341**	22,256	**378**	629	**22,928**	23,138
Equity securities [1]	**384**	412	**43**	73	**32**	103	**459**	588
Short-term investments	**—**	—	**316**	199	**—**	—	**316**	199
Derivative assets	**—**	—	**53**	2	**—**	—	**53**	2
Real estate funds priced at NAV as a practical expedient [2]							**239**	N/A
Financial liabilities at fair value								
Derivative liabilities	**$ —**	$ —	**$ 10**	$ 25	**$ —**	$ —	**$ 10**	$ 25

(1) Certain private equity securities are no longer carried at fair value under the policy election of ASU 2016-01 (Recognition and Measurement of Financial Assets and Financial Liabilities) beginning in 2018. Such private equity securities of $70 million were included in the Level 3 amount as of December 31, 2017. See Note 9 for additional information on this accounting policy change.

(2) Certain real estate funds are carried at fair value (previously carried at cost) based on the Company's ownership share of the equity of the investee (Net Asset Value ("NAV")) as a practical expedient including changes in the fair value of its underlying investments upon adopting ASU 2016-01 beginning in 2018. The funds have a quarterly redemption frequency, 45-90 day redemption notice period and $57 million in unfunded commitments as of December 31, 2018. See Note 9 for additional information on this accounting change. Prior years are designated as not applicable ("N/A") in this table.

Level 1 Financial Assets

Inputs for instruments classified in Level 1 include unadjusted quoted prices for identical assets in active markets accessible at the measurement date. Active markets provide pricing data for trades occurring at least weekly and include exchanges and dealer markets.

Assets in Level 1 include actively-traded U.S. government bonds and exchange-listed equity securities. A relatively small portion of the Company's investment assets are classified in this category given the narrow definition of Level 1 and the Company's investment asset strategy to maximize investment returns.

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Level 2 Financial Assets and Financial Liabilities

Inputs for instruments classified in Level 2 include quoted prices for similar assets or liabilities in active markets, quoted prices from those willing to trade in markets that are not active, or other inputs that are market observable or can be corroborated by market data for the term of the instrument. Such other inputs include market interest rates and volatilities, spreads and yield curves. An instrument is classified in Level 2 if the Company determines that unobservable inputs are insignificant.

Fixed maturities and equity securities. Approximately 96% of the Company's investments in fixed maturities and equity securities are classified in Level 2 including most public and private corporate debt and hybrid equity securities, federal agency and municipal bonds, non-government mortgage-backed securities and preferred stocks. Third-party pricing services and internal methods often use recent trades of securities with similar features and characteristics because many fixed maturities do not trade daily. Pricing models are used to determine these prices when recent trades are not available. These models calculate fair values by discounting future cash flows at estimated market interest rates. Such market rates are derived by calculating the appropriate spreads over comparable U.S. Treasury securities, based on the credit quality, industry and structure of the asset. Typical inputs and assumptions to pricing models include, but are not limited to, a combination of benchmark yields, reported trades, issuer spreads, liquidity, benchmark securities, bids, offers, reference data, and industry and economic events. For mortgage-backed securities, inputs and assumptions may also include characteristics of the issuer, collateral attributes, prepayment speeds and credit rating.

Nearly all of these instruments are valued using recent trades or pricing models. Less than 1% of the fair value of investments classified in Level 2 represents foreign bonds that are valued using a single unadjusted market-observable input derived by averaging multiple broker-dealer quotes, consistent with local market practice.

Short-term investments are carried at fair value which approximates cost. The Company compares market prices for these securities to recorded amounts on a regular basis to validate that current carrying amounts approximate exit prices. The short-term nature of the investments and corroboration of the reported amounts over the holding period support their classification in Level 2.

Derivative assets and liabilities classified in Level 2 represent over-the-counter instruments such as foreign currency forward and swap contracts. Fair values for these instruments are determined using market observable inputs including forward currency and interest rate curves and widely published market observable indices. Credit risk related to the counterparty and the Company is considered when estimating the fair values of these derivatives. However, the Company is largely protected by collateral arrangements with counterparties and determined that no adjustment for credit risk was required as of December 31, 2018 or 2017. The nature and use of these derivative financial instruments are described in Note 9.

Level 3 Financial Assets and Financial Liabilities

Certain inputs for instruments classified in Level 3 are unobservable (supported by little or no market activity) and significant to their resulting fair value measurement. Unobservable inputs reflect the Company's best estimate of what hypothetical market participants would use to determine a transaction price for the asset or liability at the reporting date.

The Company classifies certain newly issued, privately-placed, complex or illiquid securities in Level 3. Approximately 2% of fixed maturities and equity securities are priced using significant unobservable inputs and classified in this category.

Fair values of mortgage and other asset-backed securities as well as corporate and government fixed maturities are primarily determined using pricing models that incorporate the specific characteristics of each asset and related assumptions including the investment type and structure, credit quality, industry and maturity date in comparison to current market indices, spreads and liquidity of assets with similar characteristics. Inputs and assumptions for pricing may also include collateral attributes and prepayment speeds for mortgage and other asset-backed securities. Recent trades in the subject security or similar securities are assessed when available, and the Company may also review published research in its evaluation, as well as the issuer's financial statements.

Quantitative Information about Unobservable Inputs

The following table summarizes the fair value and significant unobservable inputs used in pricing the following fixed maturities that were developed directly by the Company as of December 31, 2018 and 2017. The range and weighted average basis point amounts ("bps") for liquidity and credit spreads (adjustment to discount rates) reflect the Company's best estimates of the unobservable adjustments a market participant would make to calculate these fair values.

Mortgage and other asset-backed securities. The significant unobservable inputs used to value the following mortgage and other asset-backed securities are liquidity and weighting of credit spreads. An adjustment for liquidity is made as of the measurement date that considers current market conditions, issuer circumstances and complexity of the security structure when there is limited trading activity for the security. An adjustment to weight credit spreads is needed to value a more complex bond structure with multiple underlying collateral and no standard market valuation technique. The weighting of credit spreads is primarily based on the underlying collateral's characteristics and their proportional cash flows supporting the bond obligations.

Corporate and government fixed maturities. The significant unobservable input used to value the following corporate and government fixed maturities is an adjustment for liquidity. An adjustment is needed to reflect current market conditions and issuer circumstances when there is limited trading activity for the security.

As of December 31, *(Fair value in millions)*	Fair Value 2018	Fair Value 2017	Unobservable Input	Unobservable Adjustment Range (Weighted Average) 2018	Unobservable Adjustment Range (Weighted Average) 2017
Fixed maturities					
Mortgage and other asset-backed securities	**$ 138**	$ 154	**Liquidity**	**60 – 340 (70) bps**	60 – 370 (90) bps
			Weighting of credit spreads	**190 – 340 (260) bps**	180 – 290 (230) bps
Corporate and government fixed maturities	**229**	446	**Liquidity**	**50 – 930 (230) bps**	70 – 1,650 (300) bps
Securities not priced by the Company [1]	**11**	29			
Total Level 3 fixed maturities	**$ 378**	$ 629			

(1) The fair values for these securities use single, unadjusted non-binding broker quotes not developed directly by the Company.

Significant increases in liquidity or credit spreads would result in lower fair value measurements while decreases in these inputs would result in higher fair value measurements. The unobservable inputs are generally not interrelated and a change in the assumption used for one unobservable input is not accompanied by a change in the other unobservable input.

Changes in Level 3 Financial Assets and Financial Liabilities Carried at Fair Value

The following table summarizes the changes in financial assets and financial liabilities classified in Level 3 for the years ended December 31, 2018 and 2017. Gains and losses reported in this table may include net changes in fair value that are attributable to both observable and unobservable inputs.

(In millions)	Fixed Maturities & Equity Securities 2018	Fixed Maturities & Equity Securities 2017
Balance at January 1,	**$ 732**	$ 776
Total gains (losses) included in shareholders' net income	**(22)**	25
Losses included in other comprehensive income	**(8)**	(11)
Gains (losses) required to adjust future policy benefits for settlement annuities [1]	**(8)**	7
Purchases, sales, settlements		
Purchases	**22**	133
Sales	**(11)**	(95)
Settlements	**(70)**	(74)
Total purchases, sales and settlements	**(59)**	(36)
Transfers into/(out of) Level 3		
Transfers into Level 3	**44**	275
Transfers out of Level 3 [2]	**(269)**	(304)
Total transfers into/(out of) Level 3	**(225)**	(29)
Balance at December 31,	**$ 410**	$ 732
Total gains (losses) included in shareholders' net income attributable to instruments held at the reporting date	**$ (9)**	$ (9)

(1) Amounts do not accrue to shareholders.

(2) Beginning in 2018, certain private equity securities are no longer carried at fair value under the policy election of ASU 2016-01 (Recognition and Measurement of Financial Assets and Financial Liabilities). Private equity securities of $70 million as of December 31, 2017 are included in the 2018 Transfers out of Level 3 amount.

Total gains and losses included in shareholders' net income in the table above are reflected in the Consolidated Statements of Income as realized investment gains (losses) and net investment income.

Gains and losses included in other comprehensive income in the tables above are reflected in net unrealized appreciation (depreciation) on securities in the Consolidated Statements of Comprehensive Income.

Transfers into or out of the Level 3 category occur when unobservable inputs, such as the Company's best estimate of what a market participant would use to determine a current transaction price, become more or less significant to the fair value measurement. Transfers between Level 2 and Level 3 during 2018 and 2017 primarily reflected changes in liquidity and credit risk estimates for certain private placement issuers across several sectors. As noted above, transfers out of Level 3 during 2018 also include $70 million of private equity securities that are no longer carried at fair value.

Separate Accounts

Accounting policy. Separate account assets and liabilities are contractholder funds maintained in accounts with specific investment objectives. The assets of these accounts are legally segregated and are not subject to claims that arise out of any of the Company's other businesses. These separate account assets are carried at fair value with equal amounts recorded for related separate account liabilities. The investment income and fair value gains and losses of these accounts generally accrue directly to the contractholders and, together with their deposits and withdrawals, are excluded from the Company's Consolidated Statements of Income and Cash Flows. Fees and charges earned for

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mortality risks, asset management or administrative services are reported in either premiums or fees and other revenues. Investments that are measured using the practical expedient of NAV are excluded from the fair value hierarchy.

Fair values of separate account assets at December 31 were as follows:

	Quoted Prices in Active Markets for Identical Assets (Level 1)		Significant Other Observable Inputs (Level 2)		Significant Unobservable Inputs (Level 3)		Total	
(In millions)	2018	2017	2018	2017	2018	2017	2018	2017
Guaranteed separate accounts (See Note 19)	**$ 187**	$ 215	**$ 267**	$ 308	**$ —**	$ —	**$ 454**	$ 523
Non-guaranteed separate accounts [1]	**1,204**	1,536	**5,216**	5,298	**233**	292	**6,653**	7,126
Subtotal	**$ 1,391**	$ 1,751	**$ 5,483**	$ 5,606	**$ 233**	$ 292	**7,107**	7,649
Non-guaranteed separate accounts priced at NAV as a practical expedient [1]							**732**	774
Total separate account assets							**$ 7,839**	$ 8,423

(1) Non-guaranteed separate accounts included $3.8 billion as of December 31, 2018 and $3.9 billion as of December 31, 2017 in assets supporting the Company's pension plans, including $0.2 billion classified in Level 3 as of December 31, 2018 and $0.3 billion classified in Level 3 as of December 31, 2017.

Separate account assets in Level 1 primarily include exchange-listed equity securities. Level 2 assets primarily include:

- corporate and structured bonds valued using recent trades of similar securities or pricing models that discount future cash flows at estimated market interest rates as described above; and
- actively-traded institutional and retail mutual fund investments.

Separate account assets classified in Level 3 primarily support Cigna's pension plans, and include commercial mortgage loans as well as certain newly issued, privately-placed, complex, or illiquid securities that are priced using methods discussed above. Activity, including transfers into and out of Level 3, was not material for 2018 or 2017.

Separate account investments in securities partnerships, real estate, and hedge funds are generally valued based on the separate account's ownership share of the equity of the investee (NAV as a practical expedient), including changes in the fair values of its underlying investments. Substantially all of these assets support the Cigna Pension Plans. The following table provides additional information on these investments.

	Fair Value as of		Unfunded Commitments as of		
(In millions)	December 31, 2018	December 31, 2017	December 31, 2018	Redemption Frequency (if currently eligible)	Redemption Notice Period
Securities partnerships	**$ 477**	$ 458	**$ 308**	Not applicable	Not applicable
Real estate funds	**237**	239	**—**	Quarterly	30-90 days
Hedge funds	**18**	77	**—**	Up to annually, varying by fund	30-90 days
Total	**$ 732**	$ 774	**$ 308**		

B. Assets and Liabilities Measured at Fair Value under Certain Conditions

Some financial assets and liabilities are not carried at fair value each reporting period, but may be measured using fair value only under certain conditions, such as investments when they become impaired including investment real estate and commercial mortgage loans, and certain equity securities with no readily determinable fair value. Recorded values for these asset types representing less than 1% of total investments, were written down to their fair values, resulting in immaterial realized investment losses in 2018 and 2017.

C. Fair Value Disclosures for Financial Instruments Not Carried at Fair Value

The following table includes the Company's financial instruments not recorded at fair value that are subject to fair value disclosure requirements at December 31, 2018 and 2017. In addition to universal life products and capital leases, financial instruments that are carried in the Company's Consolidated Financial Statements at amounts that approximate fair value are excluded from the following table.

	Classification in Fair Value Hierarchy	December 31, 2018		December 31, 2017	
(In millions)		Fair Value	Carrying Value	Fair Value	Carrying Value
Commercial mortgage loans	Level 3	**$ 1,832**	**$ 1,858**	$ 1,766	$ 1,761
Long-term debt, including current maturities, excluding capital leases	Level 2	**$ 40,819**	**$ 40,829**	$ 5,730	$ 5,321

Fair values of off-balance sheet financial instruments were not material as of December 31, 2018 and 2017.

Note 11 Variable Interest Entities

When the Company becomes involved with a variable interest entity, as well as when there is a change in the Company's involvement with an entity, the Company must determine if it is the primary beneficiary and must consolidate the entity. The Company would be considered the primary beneficiary if it has the power to direct the entity's most significant economic activities or has the right to receive benefits or obligation to absorb losses that could be significant to the entity. The Company evaluates the following criteria:

- the structure and purpose of the entity;
- the risks and rewards created by and shared through the entity; and
- the Company's ability to direct its activities, receive its benefits and absorb its losses relative to the other parties involved with the entity including its sponsors, equity holders, guarantors, creditors and servicers.

The Company determined it was not a primary beneficiary in any material variable interest entities as of December 31, 2018 and 2017. The Company's involvement in variable interest entities where it is not the primary beneficiary is described below.

Securities limited partnerships and real estate limited partnerships. The Company owns interests in securities limited partnerships and real estate limited partnerships that are defined as variable interest entities. These partnerships invest in the equity or mezzanine debt of privately held companies and real estate properties. General partners unaffiliated with the Company control decisions that most significantly impact the partnership's operations and the limited partners do not have substantive kick-out or participating rights. The Company's maximum exposure to these entities of $2.9 billion across approximately 130 limited partnerships as of December 31, 2018 includes $1.5 billion reported in long-term investments and commitments to contribute an additional $1.4 billion. The Company's non-controlling interest in each of these limited partnerships is generally less than 10% of the partnership ownership interests.

Other asset-backed and corporate securities. In the normal course of its investing activities, the Company also makes passive investments in certain asset-backed and corporate securities that are issued by variable interest entities whose sponsors or issuers are unaffiliated with the Company. The Company receives fixed-rate cash flows from these investments and the maximum potential exposure to loss is limited to the carrying amount of $0.6 billion as of December 31, 2018 that is reported in fixed maturities. The Company's combined ownership interests are insignificant relative to the total principal amounts issued by these entities.

The Company is also involved in real estate joint ventures, independent physician associations ("IPAs") and a joint venture in India that are variable interest entities. The carrying values and maximum exposures associated with these arrangements are immaterial.

The Company has not provided, and does not intend to provide, financial support to any of the above entities that it is not contractually required to provide. The Company performs ongoing qualitative analyses of its involvement with these variable interest entities to determine if consolidation is required.

Note 12 Accumulated Other Comprehensive Income (Loss) ("AOCI")

AOCI includes the Company's share from entities accounted for using the equity method. AOCI excludes amounts required to adjust future policy benefits for the run-off settlement annuity business and a portion of deferred acquisition costs associated with the corporate-owned life insurance business. Generally, tax effects in AOCI are established at the currently enacted tax rate and reclassified to net income in the same period that the related pre-tax AOCI reclassifications are recognized. As discussed in Note 2, the Company early adopted ASU 2018-02 effective January 1, 2018 and $229 million of stranded tax effects resulting from U.S. tax reform legislation enacted in 2017 were reclassified from AOCI to retained earnings. Changes in the components of accumulated other comprehensive income (loss) were as follows:

(In millions)	2018	2017	2016
Securities and Derivatives			
Beginning balance	**$ 328**	$ 365	$ 425
Reclassification adjustment to retained earnings related to U.S. tax reform legislation [1]	**65**	–	–
Reclassification adjustment to retained earnings related to new financial instruments guidance [1]	**(4)**	–	–
Reclassification adjustment from retained earnings related to new hedging guidance [1]	**(6)**	–	–
Adjusted beginning balance	**383**	365	425
(Depreciation) appreciation on securities and derivatives	**(512)**	34	(48)
Tax benefit (expense)	**100**	(19)	6
Net (depreciation) appreciation on securities and derivatives	**(412)**	15	(42)
Reclassification adjustment for losses (gains) included in shareholders' net income (net realized investment losses (gains))	**60**	(81)	(29)
Reclassification adjustment for losses included in shareholders' net income (selling, general and administrative expenses)	**–**	1	1
Tax (expense) benefit	**(13)**	28	10
Net losses (gains) reclassified from AOCI to net income	**47**	(52)	(18)
Other comprehensive (loss), net of tax	**(365)**	(37)	(60)
Ending balance	**$ 18**	$ 328	$ 365
Translation of foreign currencies			
Beginning balance	**$ (65)**	$ (369)	$ (274)
Reclassification adjustment to retained earnings related to U.S. tax reform legislation [1]	**(4)**	–	–
Adjusted beginning balance	**(69)**	(369)	(274)
Translation of foreign currencies	**(152)**	309	(95)
Tax (expense)	**–**	(5)	–
Net translation of foreign currencies	**(152)**	304	(95)
Ending balance	**$ (221)**	$ (65)	$ (369)
Postretirement benefits liability			
Beginning balance	**$ (1,345)**	$ (1,378)	$ (1,401)
Reclassification adjustment to retained earnings related to U.S. tax reform legislation [1]	**(290)**	–	–
Adjusted beginning balance	**(1,635)**	(1,378)	(1,401)
Reclassification adjustment for amortization of net losses from past experience and prior service costs (selling, general and administrative expenses)	**69**	64	64
Reclassification adjustment for settlement (selling, general and administrative expenses)	**–**	7	–
Tax (expense)	**(15)**	(24)	(22)
Net adjustments reclassified from AOCI to net income	**54**	47	42
Valuation update	**93**	(22)	(29)
Tax (expense) benefit	**(20)**	8	10
Net change due to valuation update	**73**	(14)	(19)
Other comprehensive income, net of tax	**127**	33	23
Ending balance	**$ (1,508)**	$ (1,345)	$ (1,378)

(1) See Note 2 for further information about adjustments resulting from the Company's adoption of new accounting standards in 2018.

Note 13 Pension and Other Postretirement Benefit Plans

A. About our Plans

Pension plans. We froze future benefit accruals for the Company's principal domestic defined benefit pension plans in 2009. The Company also has foreign pension and other postretirement benefit plans that are immaterial to our results of operations, liquidity and financial position. Additionally, in connection with the acquisition of Express Scripts on December 20, 2018, the Company assumed a frozen cash balance retirement plan, the results of which are immaterial to our results of operations, liquidity and financial position.

Other postretirement benefit plans. The Company's postretirement medical plan was frozen in 2013. The Company also offers certain postretirement life insurance benefits through various plans.

Accounting policy. The Company measures the assets and liabilities of its domestic pension and other postretirement benefit plans as of December 31. Benefit obligations are measured at the present value of estimated future payments based on actuarial assumptions. Changes in these assumptions are called net unrecognized actuarial gains (losses) because the Company uses the "corridor" method to account for changes in the benefit obligation when actual results differ from those assumed, or when assumptions change. Under the corridor method, net unrecognized actuarial gains (losses) are initially recorded in accumulated other comprehensive income. When the unrecognized gain (loss) exceeds 10% of the benefit obligation, that excess is amortized to expense over the expected remaining lives of plan participants. The net plan expense is reported in interest expense and other in the Consolidated Statements of Income.

For balance sheet purposes, we measure plan assets at fair value. When the actual return differs from the expected return, those differences are reflected in the net unrealized actuarial gain (loss) discussed above. However, to measure pension benefit costs, we use a "market-related" asset valuation that differs from the actual fair value for domestic pension plan assets invested in non-fixed income investments. The "market-related" value recognizes the difference between actual and expected long-term returns in the portfolio over five years, a method that reduces the short-term impact of market fluctuations on pension costs. The market-related asset value was approximately $4.0 billion, compared with a fair value of approximately $4.2 billion at December 31, 2018.

B. Funded Status and Amounts Included in Accumulated Other Comprehensive Income

The following table summarizes the projected benefit obligations and assets related to our domestic and international pension and other postretirement benefit plans as of, and for the years ended, December 31:

	Pension Benefits		Other Postretirement Benefits	
(In millions)	**2018**	**2017**	**2018**	**2017**
Change in benefit obligation				
Benefit obligation, January 1	**$ 4,969**	$ 4,888	**$ 258**	$ 277
Service cost	**3**	3	**–**	–
Interest cost	**169**	186	**8**	9
Assumed in acquisition	**137**	–	**–**	–
Partial litigation settlement-attorneys' fees	**32**	–	**–**	–
(Gain) loss from past experience	**(235)** [1]	181 [2]	**(31)**	1
Benefits paid from plan assets	**(314)**	(277)	**–**	(3)
Benefits paid – other	**(20)**	(12)	**(25)**	(26)
Benefit obligation, December 31	**4,741**	4,969	**210**	258
Change in plan assets				
Fair value of plan assets, January 1	**4,281**	3,977	**2**	5
Assumed in acquisition	**96**	–	**–**	–
Actual return on plan assets	**85**	418	**–**	–
Benefits paid	**(314)**	(277)	**(2)**	(3)
Contributions	**3**	163	**–**	–
Fair value of plan assets, December 31	**4,151**	4,281	**–**	2
Funded status	**$ (590)**	$ (688)	**$ (210)**	$ (256)
Liability in Consolidated Balance Sheets				
Accrued expenses and other liabilities	**$ (30)**	$ (25)	**$ (23)**	$ (27)
Other non-current liabilities	**$ (560)**	$ (663)	**$ (187)**	$ (229)

(1) Gain reflects an increase in the discount rate and a favorable change in the mortality assumption.

(2) Loss reflects a decrease in the discount rate, partially offset by a favorable change in the mortality assumption.

We fund our qualified pension plans at least at the minimum amount required by the Employee Retirement Income Security Act of 1974 and the Pension Protection Act of 2006. For 2019, contributions to the qualified pension plans are expected to be immaterial. Future years' contributions will ultimately be based on a wide range of factors including but not limited to asset returns, discount rates and funding targets. Non-qualified pension and other postretirement benefit plans are generally funded on a pay-as-you-go basis as there are no plan assets for these plans.

Benefit payments. The following benefit payments are expected to be paid in:

(In millions)	Pension Benefits	Other Postretirement Benefits
2019	**$ 324**	**$ 25**
2020	**$ 311**	**$ 23**
2021	**$ 313**	**$ 22**
2022	**$ 316**	**$ 20**
2023	**$ 318**	**$ 19**
2024-2028	**$ 1,549**	**$ 72**

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Amounts reflected in the pension and other postretirement benefit liabilities shown above that have not yet been reported in net income and therefore are included in accumulated other comprehensive loss consisted of the following as of December 31:

	Pension Benefits		Other Postretirement Benefits	
(In millions)	2018	2017	2018	2017
Unrecognized net gains (losses)	**$ (1,980)**	$ (2,113)	**$ 32**	$ –
Unrecognized prior service cost	**(6)**	(6)	**44**	46
Postretirement benefits liability adjustment	**$ (1,986)**	$ (2,119)	**$ 76**	$ 46

C. Cost of Our Plans

Net pension and other postretirement benefits cost was as follows for the years ended December 31:

	Pension Benefits			Other Postretirement Benefits		
(In millions)	2018	2017	2016	2018	2017	2016
Service cost	**$ 3**	$ 3	$ 2	**$ –**	$ –	$ –
Interest cost	**169**	186	199	**8**	9	11
Expected long-term return on plan assets	**(257)**	(260)	(249)	**–**	–	–
Partial litigation settlement – attorneys' fees	**32**	–	–	**–**	–	–
Amortization of:						
Net loss from past experience	**70**	66	65	**1**	1	1
Prior service cost	**–**	–	1	**(2)**	(3)	(3)
Settlement loss	**–**	7	–	**–**	–	–
Net plan cost	**$ 17**	$ 2	$ 18	**$ 7**	$ 7	$ 9

As further discussed in Note 19, Old Cigna and the Cigna Pension Plan are defendants in a class action lawsuit related to the Plan's conversion of certain employees from an annuity to a cash balance benefit in 1997. In the fourth quarter of 2018, the Court ordered the Plan to pay $32 million representing the attorney fee portion of the settlement. This payment was recognized as an expense in 2018. An offsetting expense credit of $32 million was also recorded to reduce the litigation reserve held, resulting in no impact to net income in 2018 related to this matter. In 2019, barring any new order from the Court, it is expected that: 1) class participants will be notified of their increased benefits; 2) the plan will be amended; and 3) benefits will begin to be paid. However, the exact timing and amount of these actions remain uncertain. The Company's remaining litigation reserve is adequate to cover the expected benefits due to class participants.

D. Assumptions Used for Pension and Other Postretirement Benefit Plans

Management determined the present value of the projected benefit obligation and the accumulated other postretirement benefit obligation and related benefit costs based on the following weighted average assumptions as of and for the years ended December 31:

	2018	2017
Discount rate:		
Pension benefit obligation	**4.23%**	3.51%
Other postretirement benefit obligation	**4.09%**	3.37%
Pension benefit cost	**3.51%**	3.95%
Other postretirement benefit cost	**3.37%**	3.70%
Expected long-term return on plan assets:		
Pension benefit cost	**7.00%**	7.25%
Other postretirement benefit cost	**5.00%**	5.00%
Mortality table for pension and postretirement benefit obligations	**RP 2014 with MP 2018 projection scale**	RP 2014 with MP 2017 projection scale

The Company used the Society of Actuaries mortality table RP2014 and the updated improvement scales published in 2017 and 2018 to value its benefit obligations because the Company's mortality experience closely matched these tables based on internal studies. The updated improvement scales published in 2017 and 2018 both indicated that mortality improvement is expected to be lower than was originally projected when the study was first published in 2014, resulting in decreases to the benefit obligations in both years.

The Company sets discount rates by applying actual annualized yields for high quality bonds at various durations to the expected cash flows of the pension and other postretirement benefits liabilities. A discount rate curve is constructed using an array of bonds in various industries throughout the domestic market, but only selects those for the curve that have an above average return at each duration. Management believes that this curve is representative of the yields that the Company is able to achieve through its plan asset investment strategy.

Expected long-term rates of return on plan assets were developed considering actual long-term historical returns, expected long-term market conditions, plan asset mix and management's investment strategy that continues a significant allocation to domestic and foreign equity securities as well as securities partnerships, real estate and hedge funds. Expected long-term market conditions take into consideration certain key macroeconomic trends including expected domestic and foreign GDP growth, employment levels and inflation.

E. Pension Plan Assets

As of December 31, 2018, pension assets included $3.8 billion invested in the separate accounts of Connecticut General Life Insurance Company and Life Insurance Company of North America, subsidiaries of the Company, as well as an additional $265 million invested directly in funds offered by the buyer of the retirement benefits business, and $116 million invested by others.

The fair values of pension assets by category are as follows as of December 31, 2018 and 2017.

(In millions)	2018	2017
Fixed maturities:		
Federal government and agency	**$ –**	$ 1
Corporate	**1,446**	1,124
Asset-backed	**32**	22
Fund investments	**768**	884
Total fixed maturities	**2,246**	2,031
Equity securities:		
Domestic	**506**	689
International, including funds and pooled separate accounts [1]	**360**	476
Total equity securities	**866**	1,165
Securities partnerships	**477**	457
Real estate funds, including pooled separate accounts [1]	**250**	300
Commercial mortgage loans	**110**	140
Hedge funds	**36**	73
Guaranteed deposit account contract	**107**	63
Cash equivalents and other current assets, net	**59**	52
Total pension assets at fair value	**$ 4,151**	$ 4,281

(1) A pooled separate account has several participating benefit plans and each owns a share of the total pool of investments.

The Company's current target investment allocation percentages (55% fixed income, 25% public equity securities and 20% in other investments, including private equity (securities partnerships) and real estate, are developed by management as guidelines, although the fair values of each asset category are expected to vary as a result of changes in market conditions. The Company would expect to further reduce the allocation to equity securities and other investments and increase the allocation to fixed income investments as funding levels improve.

See Note 10 for further details regarding how fair value is determined, including the level within the fair value hierarchy and the procedures we use to validate fair value measurements. The Company classifies substantially all fixed maturities in Level 2 for pension plan assets. These assets are valued using recent trades of similar securities or are fund investments priced using their daily net asset value that is the exit price. A substantial portion of domestic equity securities within pension assets are classified as Level 1, while international equity funds within pension assets are predominantly classified in Level 2 using daily net asset value.

Securities partnerships, real estate and hedge funds are valued using NAV as a practical expedient and are excluded from the fair value hierarchy. See Note 10 for additional disclosures related to these assets invested in the separate accounts of the Company's subsidiaries. Certain securities as described in Note 10, as well as commercial mortgage loans and guaranteed deposit account contracts, are classified in Level 3 because unobservable inputs used in their valuation are significant.

F. 401(k) Plans

The Company sponsors a 401(k) plan in which the Company matches a portion of employees' pre-tax contributions. Participants in the plan may invest in various funds that invest in the Company's common stock, several diversified stock funds, a bond fund or a fixed-income fund.

The Company may elect to increase its matching contributions if the Company's annual performance meets certain targets. The Company's annual expense for these plans was as follows:

(In millions)	2018	2017	2016
Expense	**$ 196**	$ 122	$ 113

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Note 14 Employee Incentive Plans

A. About Our Plans

The People Resources Committee (the "Committee") of the Board of Directors awards stock options, restricted stock, restricted stock units, deferred stock and strategic performance shares ("SPS") to certain employees. The Committee has issued common stock instead of cash compensation. Prior to the acquisition of Express Scripts, the Company issued shares from Treasury stock for these awards. Following the acquisition, original issues shares were used.

Awards of Express Scripts options and restricted stock units were rolled over to Cigna stock options and restricted stock units in connection with the Express Scripts acquisition on December 20, 2018 as explained further in Note 3. Information in this footnote includes the effect of the Express Scripts rollover awards unless otherwise indicated.

The Company records compensation expense for stock and option awards over their vesting periods primarily based on the estimated fair value at the grant date. Fair value is determined differently for each type of award as discussed below.

Shares of common stock available for award at December 31 were as follows:

(In millions)	2018	2017	2016
Common shares available for award	**25.7**	14.0	6.8

B. Stock Options

Accounting policy. The Company awards options to purchase Cigna common stock at the market price of the stock on the grant date except for rollover option awards issued to Express Scripts employees in connection with the acquisition (see Note 3). Options vest over periods ranging from one to three years and expire no later than 10 years from grant date. Fair value is estimated using the Black-Scholes option-pricing model by applying the assumptions presented below. That fair value is reduced by options expected to be forfeited during the vesting period. The Company estimates forfeitures at the grant date based on our experience and adjusts the expense to reflect actual forfeitures over the vesting period. The fair value of options, net of forfeitures, is recognized in selling, general and administrative expenses on a straight line basis over the vesting period.

Black-Scholes option-pricing model assumptions and the resulting fair value of options are presented in the following table. The average fair value of options, and the expected option life exclude the rollover options granted to Express Scripts employees in connection with the acquisition. See Note 3 for further information.

	2018	2017	2016
Dividend yield	**0.0%**	0.0%	0.0%
Expected volatility	**35.0%**	35.0%	35.0%
Risk-free interest rate	**2.5%**	1.8%	1.2%
Expected option life	**4.4 years**	4.3 years	4.3 years
Weighted average fair value of options	**$ 64.18**	$ 46.38	$ 42.01

The expected volatility reflects the past daily stock price volatility of Cigna stock. The Company does not consider volatility implied in the market prices of traded options to be a good indicator of future volatility because remaining traded options will expire within one year. The risk-free interest rate is derived using the four-year U.S. Treasury bond yield rate as of the award date for the primary annual grant. Expected option life reflects the Company's historical experience.

The following table shows the status of, and changes in, common stock options during the last three years.

	2018		2017		2016	
(Options in thousands)	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price
Outstanding – January 1	**6,156**	**$ 100.79**	7,097	$ 82.01	6,433	$ 68.86
Granted	**7,080**	**$ 143.62**	1,230	$ 149.17	1,336	$ 139.20
Exercised	**(771)**	**$ 88.35**	(2,072)	$ 63.41	(577)	$ 62.09
Expired or canceled	**(95)**	**$ 165.04**	(99)	$ 138.41	(95)	$ 117.18
Outstanding – December 31	**12,370**	**$ 125.46**	6,156	$ 100.79	7,097	$ 82.01
Options exercisable at year-end	**9,446**	**$ 114.22**	3,894	$ 77.36	4,409	$ 58.36

Compensation expense of $61 million related to unvested stock options at December 31, 2018 will be recognized over the next two years (weighted average period).

The table below summarizes information for stock options exercised during the last three years:

(In millions)	2018	2017	2016
Intrinsic value of options exercised	**$ 86**	$ 218	$ 41
Cash received for options exercised	**$ 68**	$ 131	$ 36
Tax benefit from options exercised	**$ 8**	$ 41	$ 11

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The following table summarizes information for outstanding common stock options at December 31, 2018:

	Options Outstanding	Options Exercisable
Number (in thousands)	12,370	9,446
Total intrinsic value (in millions)	$ 804	$ 715
Weighted average exercise price	$ 125.46	$ 114.22
Weighted average remaining contractual life	5.4 years	4.5 years

C. Restricted Stock

The Company awards restricted stock to the Company's employees with vesting periods ranging from three to five years. Recipients of restricted stock awards accumulate dividends during the vesting period, but forfeit their awards and accumulated dividends if their employment terminates before the vesting date.

Accounting policy. Fair value of restricted stock awards is equal to the market price of Cigna's common stock on the date of grant. This fair value is reduced by awards that are expected to forfeit. At the grant date, the Company estimates forfeitures based on experience and adjusts the expense to reflect actual forfeitures over the vesting period. This fair value, net of forfeitures, is recognized in selling, general and administrative expenses over the vesting period on a straight-line basis.

The following table shows the status of, and changes in, restricted stock awards during the last three years.

	2018		2017		2016	
(Awards in thousands)	Grants/Units	Weighted Average Fair Value at Award Date	Grants/Units	Weighted Average Fair Value at Award Date	Grants/Units	Weighted Average Fair Value at Award Date
Outstanding – January 1	1,295	$ 126.44	1,309	$ 97.78	1,642	$ 72.58
Awarded	1,451	$ 183.29	451	$ 155.21	315	$ 138.61
Vested	(560)	$ 112.53	(409)	$ 67.09	(591)	$ 50.01
Forfeited	(48)	$ 150.84	(56)	$ 121.74	(57)	$ 92.51
Outstanding – December 31	2,138	$ 168.12	1,295	$ 126.44	1,309	$ 97.78

The fair value of vested restricted stock at the vesting date for the years ended December 31 was as follows:

(In millions)	2018	2017	2016
Fair value of vested restricted stock	$ 107	$ 62	$ 82

Approximately 10,400 employees held 2.1 million restricted stock awards at the end of 2018 with $174 million of related compensation expense to be recognized over the next two years (weighted average period).

D. Strategic Performance Shares ("SPS")

The Company awards SPSs to executives and certain other key employees generally with a performance period of three years. Half of these shares are subject to a market condition (total shareholder return relative to industry peer companies) and half are subject to a performance condition (cumulative adjusted net income). These targets are set by the Committee. Holders of these awards receive shares of Cigna common stock at the end of the performance period ranging anywhere from 0 to 200% of the original awards.

Accounting policy. Compensation expense for SPSs is recorded over the performance period. Fair value is determined at the grant date for "market condition" SPSs using a Monte Carlo simulation model and not subsequently adjusted regardless of the final outcome. Expense is initially accrued for "performance condition" SPSs based on the most likely outcome, but evaluated for adjustment each period for updates in the expected outcome. Expense is adjusted to the actual outcome (number of shares awarded times the share price at the grant date) at the end of the performance period. The Company estimates forfeitures at the grant date based on experience and adjusts the expense to reflect actual forfeitures over the vesting period.

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The following table shows the status of, and changes in, SPSs during the last three years:

	2018		2017		2016	
(Awards in thousands)	Shares	Weighted Average Fair Value at Award Date	Shares	Weighted Average Fair Value at Award Date	Shares	Weighted Average Fair Value at Award Date
Outstanding – January 1	**778**	**$ 136.57**	942	$ 109.14	1,188	$ 81.68
Awarded	**221**	**$ 197.51**	275	$ 150.06	286	$ 139.05
Vested	**(269)**	**$ 121.57**	(386)	$ 78.91	(494)	$ 60.15
Forfeited	**(23)**	**$ 158.16**	(53)	$ 138.19	(38)	$ 112.70
Outstanding – December 31	**707**	**$ 160.74**	778	$ 136.57	942	$ 109.14

The fair value of vested SPSs at the vesting date for the years ended December 31 was as follows:

	2018		2017		2016	
(Shares in thousands; $ in millions)	Shares	Fair Value	Shares	Fair Value	Shares	Fair Value
Shares of Cigna common stock distributed upon SPS vesting	**380**	**$ 73**	476	$ 70	768	$ 109

Approximately 1,500 employees held 707,000 SPSs at the end of 2018 and $51 million of related compensation expense is expected to be recognized over the next two years. The amount of expense for "performance condition" SPSs may vary based on actual performance in 2019 and 2020.

E. One-Time Employee Stock Award

The Company granted most employees a one-time stock award in 2017 of five shares that immediately vested. Approximately 205,000 shares were issued in connection with this program at a price of $162.96, resulting in a pre-tax cost of $33 million.

F. Compensation Cost and Tax Effects of Share-based Compensation

The Company records tax benefits in shareholders' net income during the vesting period based on the amount of expense being recognized. The difference between tax benefits based on the expense and the actual tax benefit realized are also recorded in net income when stock options are exercised, or when restricted stock and SPSs vest.

(In millions)	2018	2017	2016
Total compensation cost for shared-based awards	**$ 180**	$ 178	$ 128
Tax benefits recognized	**$ 36**	$ 79	$ 57

Note 15 Goodwill, Other Intangibles and Property and Equipment

A. Goodwill

Accounting policy. Goodwill represents the excess of the cost of businesses acquired over the fair value of their net assets. The resulting goodwill is assigned to those reporting units expected to realize cash flows from the acquisition, allocated to reporting units based on relative fair values, primarily reported in the Health Services segment ($33.7 billion), the Integrated Medical segment ($10.5 billion) and, to a lesser extent, the International Markets segment ($0.3 billion)

The Company evaluates goodwill for impairment at least annually during the third quarter at the reporting unit level and writes it down through shareholders' net income if impaired. Fair value of a reporting unit is generally estimated based on either market data or a discounted cash flow analysis using assumptions that the Company believes a hypothetical market participant would use to determine a current transaction price. The significant assumptions and estimates used in determining fair value include the discount rate and future cash flows. A discount rate is selected to correspond with each reporting unit's weighted average cost of capital, consistent with that used for investment decisions considering the specific and detailed operating plans and strategies within that reporting unit. Projections of future cash flows for each reporting unit are consistent with our annual planning process for revenues, claims, operating expenses, taxes, capital levels and long-term growth rates.

Goodwill activity. Goodwill activity during 2018 and 2017 was as follows:

(In millions)	2018	2017
Balance at January 1,	**$ 6,164**	$ 5,980
Goodwill acquired, net	**38,371**	154
Impact of foreign currency translation	**(30)**	30
Balance at December 31,	**$ 44,505**	$ 6,164

The significant increase in goodwill during 2018 reflects the Company's acquisition of Express Scripts as further discussed in Note 3.

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B. Other Intangibles

Accounting policy. The Company's other intangible assets include purchased customer and producer relationships, provider networks and trademarks. The fair value of purchased customer relationships and the amortization method were determined as of the dates of purchase using an income approach that relies on projected future net cash flows including key assumptions for customer attrition and discount rates. The Company amortizes other intangibles on an accelerated or straight-line basis over periods from one to 39 years. Management revises amortization periods if it believes there has been a change in the length of time that an intangible asset will continue to have value. Costs incurred to renew or extend the terms of these intangible assets are generally expensed as incurred.

Components of other assets, including other intangibles. Other intangible assets were comprised of the following at December 31:

(In millions)	Cost	Accumulated Amortization	Net Carrying Value
2018			
Customer relationships	**$ 31,451**	**1,213**	**30,238**
Trade Name – Express Scripts	**8,400**	**–**	**8,400**
Other	**560**	**195**	**365**
Other intangible assets	**40,411**	**1,408**	**39,003**
Value of business acquired (reported in deferred policy acquisition costs)	**665**	**102**	**563**
Total	**$ 41,076**	**1,510**	**39,566**
2017			
Customer relationships	$ 1,280	1,056	224
Other	291	170	121
Other intangible assets	1,571	1,226	345
Value of business acquired (reported in deferred policy acquisition costs)	232	86	146
Total	$ 1,803	1,312	491

The significant increase reflects the intangible assets acquired from Express Scripts as discussed further in Note 3.

C. Property and Equipment

Accounting policy. Property and equipment is carried at cost less accumulated depreciation. Cost includes interest, real estate taxes and other costs incurred during construction when applicable. Internal-use software that is acquired, developed or modified solely to meet the Company's internal needs, with no plan to market externally, is also included in this category. Costs directly related to acquiring, developing or modifying internal-use software are capitalized.

The Company calculates depreciation and amortization principally using the straight-line method generally based on the estimated useful life of each asset as follows: buildings and improvements, 10 to 40 years; purchased software, three to five years; internally developed software, three to seven years; and furniture and equipment (including computer equipment), three to 10 years. Improvements to leased facilities are depreciated over the lesser of the remaining lease term or the estimated life of the improvement. The Company considers events and circumstances that would indicate the carrying value of property, equipment or capitalized software might not be recoverable. An impairment charge is recorded if the Company determines the carrying value of any of these assets is not recoverable. The Company also reviews and shortens the estimated useful lives of these assets, if necessary.

Components of property and equipment. Property and equipment was comprised of the following as of December 31:

(In millions)	Cost	Accumulated Amortization	Net Carrying Value
2018			
Internal-use software	**$ 5,694**	**$ 2,415**	**$ 3,279**
Other property and equipment			
Assets recorded under capital leases [1]	**56**	**4**	**52**
Other property and equipment not recorded under capital leases	**2,208**	**977**	**1,231**
Total other property and equipment	**2,264**	**981**	**1,283**
Total property and equipment	**$ 7,958**	**$ 3,396**	**$ 4,562**
2017			
Internal-use software	$ 2,991	$ 2,184	$ 807
Other property and equipment			
Assets recorded under capital leases [1]	49	31	18
Other property and equipment not recorded under capital leases	1,573	835	738
Total other property and equipment	1,622	866	756
Total property and equipment	$ 4,613	$ 3,050	$ 1,563

(1) Current capital lease agreements are for equipment and generally have a term of 48 months with the equipment expected to be returned to the lessor at termination.

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Components of depreciation and amortization. Depreciation and amortization was comprised of the following for the years ended December 31:

(In millions)	2018	2017	2016
Internal-use software	**$ 323**	$ 298	$ 303
Other property and equipment [1]	**146**	153	158
Value of business acquired (reported in deferred policy acquisition costs)	**16**	18	20
Other intangibles	**210**	97	129
Total depreciation and amortization	**$ 695**	$ 566	$ 610

(1) Other property and equipment includes amortization on assets recorded under capital leases of $9 million in 2018, $14 million in 2017 and $20 million in 2016.

The Company estimates annual pre-tax amortization for intangible assets, including internal-use software, over the next five calendar years to be as follows:

(In millions)	Pre-tax Amortization
2019	**$ 3,169**
2020	**$ 2,164**
2021	**$ 2,062**
2022	**$ 1,844**
2023	**$ 1,777**

Note 16 Leases and Rentals

Description of operating leases. The Company's operating leases are primarily for office space and certain computer and other equipment. Some of these leases include renewal options and other incentives that are amortized over the life of the lease. Leases active in 2018 had terms ranging from one month to 18 years.

Rental expense and payments. For the years ended December 31, net rental expenses for operating leases were approximately:

(In millions)	2018	2017	2016
Net rental expense for operating leases	**$ 162**	$ 162	$ 151

Future net minimum rental payments under non-cancelable operating leases were approximately $860 million as of December 31, 2018, payable as follows:

(In millions)	Operating Lease Payments
2019	**$ 199**
2020	**$ 182**
2021	**$ 148**
2022	**$ 116**
2023	**$ 84**
2024 and thereafter	**$ 132**

The Company also has capital lease arrangements. See Note 15 and Note 5 for further information on assets recorded under capital leases and our related obligations.

Note 17 Shareholders' Equity and Dividend Restrictions

State insurance departments and foreign jurisdictions that regulate certain of the Company's subsidiaries prescribe accounting practices (differing in some respects from GAAP) to determine statutory net income and surplus. The Company's life, accident and health insurance and Health Maintenance Organization ("HMO") subsidiaries are regulated by such statutory requirements. Regulatory changes in the jurisdiction of one of our foreign insurance affiliates caused a significant increase in surplus in 2017, primarily from beginning to include deferred policy acquisition costs as an admitted asset. The statutory net income of the Company's life, accident and health insurance and HMO subsidiaries for the years ended, and their statutory surplus as of December 31, were as follows:

(In billions)	2018	2017	2016
Net income	**$ 3.4**	$ 2.5	$ 2.0
Surplus	**$ 12.2**	$ 10.4	$ 8.5

The Company's HMO and life, accident and health insurance subsidiaries are also subject to minimum statutory surplus requirements and may be required to maintain investments on deposit with state departments of insurance or other regulatory bodies. Additionally, these subsidiaries may be subject to regulatory restrictions on the amount of annual dividends or other distributions (such as loans or cash advances) that

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insurance companies may extend to their parent companies without prior approval. As of December 31, 2018, these amounts, including restricted GAAP net assets of the Company's subsidiaries, were as follows:

(In billions)	2018
Minimum statutory surplus required by regulators	**$ 3.9**
Investments on deposit with regulatory bodies	**$ 0.6**
Maximum dividend distributions permitted in 2019 without regulatory approval	**$ 2.1**
Maximum loans to the parent company permitted without regulatory approval	**$ 1.3**
Restricted GAAP net assets of Cigna Corporation's subsidiaries	**$ 15.5**

Permitted practices used by the Company's insurance subsidiaries in 2018 that differed from prescribed regulatory accounting had an immaterial impact on statutory net income and surplus.

Note 18 Income Taxes

Accounting policy. Deferred income taxes are reflected in the balance sheet for differences between the financial and income tax reporting bases of the underlying assets and liabilities, and established based upon enacted tax rates and laws. Deferred income tax assets are recognized when available evidence indicates that realization is more likely than not, and to the extent this standard is not met a valuation allowance is established. The deferred income tax provision generally represents the net change in deferred income tax assets and liabilities during the reporting period excluding adjustments to accumulated other comprehensive income or amounts recorded in connection with a business combination. The current income tax provision generally represents estimated amounts due on income tax returns for the year reported to various jurisdictions plus the effect of any uncertain tax positions. The Company recognizes a liability for uncertain tax positions if management believes the probability that the positions will be sustained is less than 50 percent.

Income taxes attributable to the Company's foreign operations are generally provided using the respective foreign jurisdictions' tax rate.

The Company's foreign operations continue to retain a significant portion of their earnings overseas. These undistributed earnings are deployed outside of the United States in support of the liquidity and capital needs of our foreign operations as well as to support growth initiatives overseas. The Company generally does not intend to repatriate these earnings.

A. Income Tax Expense

The federal corporate income tax rate declined to 21% effective January 1, 2018 because of U.S. tax reform legislation enacted in late 2017. As a result, the Company's U.S. income tax expense and effective tax rate were notably lower in 2018. Prior year consolidated tax expense included a $232 million charge due to U.S. tax reform, driven by revaluation of deferred tax balances and the deemed repatriation tax on accumulated foreign earnings. The Company has continued to evaluate the provisional tax reform adjustments first recorded in 2017. The one-year measurement period under SEC requirements has expired with only minor adjustments to the initial amounts recorded.

The components of income taxes for the years ended December 31 were as follows:

(In millions)	2018	2017	2016
Current taxes			
U.S. income taxes	**$ 804**	$ 974	$ 935
Foreign income taxes	**185**	122	95
State income taxes	**47**	36	32
Total current taxes	**1,036**	1,132	1,062
Deferred taxes (benefits)			
U.S. income taxes (benefits)	**(75)**	204	69
Foreign income taxes	**8**	39	9
State income tax (benefits)	**(34)**	(1)	(4)
Total deferred taxes (benefits)	**(101)**	242	74
Total income taxes	**$ 935**	$ 1,374	$ 1,136

Total income taxes for the years ended December 31 were different from the amount computed using the nominal federal income tax rate for the following reasons:

	2018		2017		2016	
(In millions)	$	%	$	%	$	%
Tax expense at nominal rate	**$ 752**	**21.0%**	$ 1,262	35.0%	$ 1,043	35.0%
Effect of U.S. tax reform legislation	**(4)**	**(0.1)**	232	6.4	–	0.0
Effect of foreign earnings	**74**	**2.1**	(70)	(1.9)	(57)	(1.9)
Health insurance industry tax	**78**	**2.2**	–	0.0	108	3.6
State income tax (net of federal income tax benefit)	**10**	**0.3**	23	0.6	18	0.6
Other	**25**	**0.6**	(73)	(2.0)	24	0.8
Total income taxes	**$ 935**	**26.1%**	$ 1,374	38.1%	$ 1,136	38.1%

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Consolidated pre-tax income from the Company's foreign operations was approximately 15% of the Company's pre-tax income in 2018. The comparable amount in prior years was 14% in 2017 and 11% in 2016. South Korean operations produced a majority of the Company's foreign pre-tax earnings.

The effective tax rate for 2018 of 26.1% was considerably lower than the 38.1% rate for 2017. The decline was due to the reduction in the U.S. tax rate, and was partially offset by reinstatement of the non-deductible health insurance industry tax. The health insurance industry tax will again be suspended for 2019.

The Company continues to retain a significant portion of its foreign earnings overseas, where they are generally subject to a higher tax rate than that imposed in the U.S. Additional deferred tax liabilities of approximately $135 million for foreign withholding taxes would have been recorded if these earnings were intended to be remitted. A portion of these withholding taxes may be eligible for credit against the Company's U.S. tax liability.

B. Deferred Income Taxes

Deferred income tax assets and liabilities as of December 31 were as follows:

(In millions)	2018	2017
Deferred tax assets		
Employee and retiree benefit plans	**$ 411**	$ 279
Other insurance and contractholder liabilities	**402**	358
Loss carryforwards	**255**	105
Other accrued liabilities	**340**	101
Other	**205**	91
Deferred tax assets before valuation allowance	**1,613**	934
Valuation allowance for deferred tax assets	**(199)**	(72)
Deferred tax assets, net of valuation allowance	**1,414**	862
Deferred tax liabilities		
Depreciation and amortization	**838**	176
Acquisition-related basis differences	**9,792**	320
Policy acquisition expenses	**211**	190
Unrealized appreciation on investments and foreign currency translation	**(29)**	102
Other	**55**	35
Total deferred tax liabilities	**10,867**	823
Net deferred income tax (liabilities) assets	**$ (9,453)**	$ 39

The net deferred tax balance changed significantly due to the Company's acquisition of Express Scripts, primarily representing deferred tax liabilities on the intangible assets recognized in purchase accounting. No deferred tax liability has been recognized for goodwill that is nondeductible for tax purposes. Also certain prior year balances have been reclassified to align with our presentation as of December 31, 2018.

Management believes that future results will generally be sufficient to realize the Company's gross deferred tax assets. The Company establishes a valuation allowance when it determines that it is not at least more likely than not the asset will be recognized. The Company has recognized deferred tax assets related to federal, state and foreign losses, a portion of which have been offset by a valuation allowance. There are multiple expiration dates associated with these losses, though a significant portion expires in 2021.

C. Uncertain Tax Positions

A reconciliation of unrecognized tax benefits for the years ended December 31 was as follows:

(In millions)	2018	2017	2016
Balance at January 1,	**$ 35**	$ 31	$ 31
Increase due to prior year positions	**40**	–	–
Increase due to business combinations	**860**	–	–
Increase due to current year positions	**6**	7	10
Reduction related to settlements with taxing authorities	**(1)**	(1)	(2)
Reduction related to lapse of applicable statute of limitations	**(12)**	(2)	(8)
Balance at December 31,	**$ 928**	$ 35	$ 31

The liability for uncertain tax positions has increased significantly due to the Company's acquisition of Express Scripts, the majority of which would impact shareholder's net income, if recognized. It is reasonably possible that the liability for uncertain tax positions could decline over the intervening twelve months.

The Company classifies net interest expense on uncertain tax positions as a component of income tax expense, but excludes this amount from the disclosed liability for uncertain tax positions. The liability for net interest expense was not material as of December 31, 2018 or 2017.

D. Other Tax Matters

The statute of limitations for Cigna's consolidated income tax returns through 2014 has closed, and there are no pending examinations. The Company has filed an amended 2014 consolidated tax return and the claim is subject to Internal Revenue Service ("IRS") review. The IRS has examined Express Scripts' tax returns for 2010 through 2012, for which there is a significant disputed tax matter, and is currently examining returns for 2013 through 2015. The Company conducts business in a number of state and foreign jurisdictions, and may be engaged in multiple audit proceedings at any given time. Generally, no further state or foreign audit activity is expected for tax years prior to 2011 for Cigna's entities and 2006 for Express Scripts' entities.

Note 19 Contingencies and Other Matters

The Company, through its subsidiaries, is contingently liable for various guarantees provided in the ordinary course of business.

A. Financial Guarantees: Retiree and Life Insurance Benefits

The Company guarantees that separate account assets will be sufficient to pay certain life insurance or retiree benefits. For the majority of these benefits, the sponsoring employers are primarily responsible for ensuring that assets are sufficient to pay these benefits and are required to maintain assets that exceed a certain percentage of benefit obligations. If employers fail to do so, the Company or an affiliate of the buyer of the retirement benefits business (Prudential Retirement Insurance and Annuity Company or "Prudential") has the right to redirect the management of the related assets to provide for benefit payments. As of December 31, 2018, employers maintained assets that exceeded the benefit obligations under these arrangements of approximately $455 million. Approximately 11% of these are reinsured by Prudential. The remaining guarantees are provided by the Company with minimal reinsurance from third parties. The Company establishes an additional liability if management believes that the Company will be required to make payment under the guarantees; there were no additional liabilities required for these guarantees, net of reinsurance, as of December 31, 2018. Separate account assets supporting these guarantees are classified in Levels 1 and 2 of the GAAP fair value hierarchy (see Note 10).

The Company does not expect that these financial guarantees will have a material effect on the Company's consolidated results of operations, liquidity or financial condition.

B. Certain Other Guarantees

The Company had indemnification obligations as of December 31, 2018 in connection with acquisition and disposition transactions. These indemnification obligations are triggered by the breach of representations or covenants provided by the Company, such as representations for the presentation of financial statements, the filing of tax returns, compliance with law or the identification of outstanding litigation. These obligations are typically subject to various time limitations, defined by the contract or by operation of law, such as statutes of limitation. In some cases, the maximum potential amount due is subject to contractual limitations based on a percentage of the transaction purchase price, while in other cases limitations are not specified or applicable. The Company does not believe that it is possible to determine the maximum potential amount due under these obligations because not all amounts due under these indemnification obligations are subject to limitation. There were no liabilities for these indemnification obligations as of December 31, 2018.

C. Guaranty Fund Assessments

The Company operates in a regulatory environment that may require its participation in assessments under state insurance guaranty association laws. The Company's exposure to assessments for certain obligations of insolvent insurance companies to policyholders and claimants is based on its share of business written in the relevant jurisdictions.

In first quarter 2017, the Commonwealth Court of Pennsylvania entered an order of liquidation of Penn Treaty Network America Insurance Company, together with its subsidiary American Network Insurance Company (collectively "Penn Treaty," a long-term care insurance carrier), triggering guaranty fund coverage and a charge of approximately $130 million before-tax ($85 million after-tax). As of December 31, 2018, the recorded liability for this assessment was approximately $42 million. Updates to the amount of the Penn Treaty assessment were not material in 2018. A portion of this assessment is expected to be offset in the future by premium tax credits that will be recognized in the period received.

D. Legal and Regulatory Matters

The Company is routinely involved in numerous claims, lawsuits, regulatory inquiries and audits, government investigations, including under the federal False Claims Act and state false claims acts initiated by a government investigating body or by a qui tam relator's filing of a complaint under court seal, and other legal matters arising, for the most part, in the ordinary course of managing a global health services business. Additionally, the Company has received and is cooperating with subpoenas or similar processes from various governmental agencies requesting information, all arising in the normal course of its business. Except for the specific matters noted below, the Company believes that the legal actions, regulatory matters, proceedings and investigations currently pending against it should not have a material adverse effect on the Company's results of operations, financial condition or liquidity based upon our current knowledge and taking into consideration current accruals. This includes certain matters previously discussed in Express Scripts' annual and quarterly reports that are no longer disclosed because they are not considered material legal proceedings for the combined company. Disputed tax matters arising from audits by the IRS or other state and foreign jurisdictions, including those resulting in litigation, are accounted for under GAAP guidance for uncertain tax positions. Further information on income tax matters can be found in Note 18.

Pending litigation and legal or regulatory matters that the Company has identified with a reasonably possible material loss are described below. When litigation and regulatory matters present loss contingencies that are both probable and estimable, the Company accrues the estimated loss by a charge to shareholders' net income. The estimated loss is the Company's best estimate of the probable loss at the time or an amount within a range of estimated losses reflecting the most likely outcome or the minimum amount of the range (if no amount is better than any other estimated amount in the range.) For material pending litigation and legal or regulatory matters discussed below, the Company provides disclosure in the aggregate of accruals and range of loss, or a statement that such information cannot be estimated. In light of the uncertainties involved in these matters, there is no assurance that their ultimate resolution will not exceed the amounts currently accrued by the Company. The Company has accrued approximately $190 million ($150 million after-tax) as of December 31, 2018 for the matters discussed below under "Litigation Matters" as well as litigation related to certain of the Company's claim operating practices and disputes around reimbursement rates to providers. Due to numerous uncertain factors presented in these cases, it is not possible to estimate an aggregate range of loss (if any) for these matters at this time. In light of the uncertainties involved in these matters, there is no assurance that their ultimate resolution will not exceed the amounts currently accrued by the Company. An adverse outcome in one or more of these matters could be material to the Company's results of operations, financial condition or liquidity for any particular period.

Litigation Matters

Amara cash balance pension plan litigation. In December 2001, Janice Amara filed a class action lawsuit in the U.S. District Court for the District of Connecticut against Cigna Corporation and the Cigna Pension Plan (the "Plan") on behalf of herself and other similarly situated Plan participants affected by the 1998 conversion to a cash balance formula. The plaintiffs allege various violations of the Employee Retirement Income Security Act of 1974 ("ERISA"), including that the Plan's cash balance formula discriminates against older employees; that the conversion resulted in a wear-away period (when the pre-conversion accrued benefit exceeded the post-conversion benefit); and that the Plan communications contained inaccurate or inadequate disclosures about these conditions.

In 2008, the District Court (1) affirmed the Company's right to convert to a cash balance plan prospectively beginning in 1998; (2) found for plaintiffs on the disclosure claim only; and (3) required the Company to pay pre-1998 benefits under the pre-conversion traditional annuity formula and post-1997 benefits under the post-conversion cash balance formula. From 2008 through 2015, this case has undergone a series of court proceedings that resulted in the original District Court order being largely upheld. In 2015, the Company submitted to the District Court its proposed method for calculating the additional pension benefits due to class members and plaintiffs responded in August 2015.

Since then, there has been continued litigation regarding the calculation of benefits, attorneys' fees, and the administration of the remedy payments. On November 29, 2018, the Court ordered the Pension Plan to pay attorneys' and incentive fees of $32 million, and that the Plan must pay any past due lump sums and back benefits within 90 days of the Order. These payments were made as ordered in December 2018. Barring any new Order by the Court impacting the timing, the Company expects to amend the Plan and commence remedy benefit payments in 2019. Once these events occur, the Plan will reflect the additional remedy benefits ordered by the Court as an increase to the pension liability (see Note 13) and the Company will reduce the remaining litigation reserve accordingly. Management believes that the Company's remaining reserve is adequate as of December 31, 2018.

Litigation related to the Merger. Following announcement of the Company's Merger Agreement with Express Scripts as discussed in Note 3, putative class action complaints (collectively the "complaints") have been filed against Express Scripts and the Express Scripts board of directors. Certain of these complaints also include Cigna, Old Cigna, Cigna Merger Sub and Express Scripts Merger Sub as defendants. The complaints alleged that the registration statement filed in connection with the Merger (and certain amendments thereto) omitted material information in violation of Sections 14(a) and 20(a) of the Exchange Act, rendering the registration statement false and misleading. The parties entered into a settlement agreement in November 2018 and notices of voluntary dismissal have been filed.

Cigna Litigation with Anthem. In February 2017, the Company delivered a notice to Anthem terminating the 2015 merger agreement, and notifying Anthem that it must pay the Company the $1.85 billion reverse termination fee pursuant to the terms of the merger agreement. Also in February 2017, the Company filed suit against Anthem in the Delaware Court of Chancery (the "Chancery Court") seeking declaratory judgments that the Company's termination of the merger agreement was valid and that Anthem was not permitted to extend the termination date. The complaint also sought payment of the reverse termination fee and additional damages in an amount exceeding $13 billion, including the lost premium value to the Company's shareholders caused by Anthem's willful breaches of the merger agreement.

On February 15, 2017, the Chancery Court granted Anthem's motion for a temporary restraining order and temporarily enjoined the Company from terminating the merger agreement. In May 2017, the Chancery Court denied Anthem's motion for a preliminary injunction to enjoin Cigna from terminating the merger agreement but stayed its ruling pending Anthem's determination as to whether to seek an appeal. Anthem subsequently notified Cigna and the Chancery Court that it did not intend to appeal the Chancery Court's decision. As a result, the merger agreement was terminated.

The litigation between the parties remains pending. Trial commenced on February 25, 2019 and we await the outcome. We believe in the merits of our claims and dispute Anthem's claims, and we intend to vigorously defend ourselves and pursue our claims. The outcomes of lawsuits are inherently unpredictable, and we may be unsuccessful in the ongoing litigation or any future claims or litigation.

Express Scripts Litigation with Anthem. In March 2016, Anthem filed a lawsuit in the United States District Court for the Southern District of New York alleging various breach of contract claims against Express Scripts relating to the parties' rights and obligations under the periodic pricing review section of the pharmacy benefit management agreement between the parties, including allegations that Express Scripts failed to negotiate new pricing concessions in good faith, as well as various alleged service issues. Anthem requests the court enter declaratory judgment that Express Scripts is required to provide Anthem competitive benchmark pricing, that Anthem can terminate the agreement, and that Express Scripts is required to provide Anthem with post-termination services at competitive benchmark pricing for one year following any termination by Anthem. Anthem claims it is entitled to $13.0 billion in additional pricing concessions over the remaining term of the agreement as well as $1.8 billion for one year following any contract termination by Anthem, and $150 million in damages for service issues ("Anthem's Allegations"). On April 19, 2016, in response to Anthem's complaint, Express Scripts filed its answer denying Anthem's Allegations in their entirety and asserting affirmative defenses and counterclaims against Anthem. The court subsequently granted Anthem's motion to dismiss

two of six counts of Express Scripts' amended counterclaims. The current scheduling order runs through the completion of summary judgment briefing in December 2019. There is no tentative trial date.

Regulatory Matters

Civil Investigative Demand. The U.S. Department of Justice ("DOJ") is conducting an industry review of Medicare Advantage organizations' risk adjustment practices under Medicare Parts C and D, including medical chart reviews and health exams. The Company is currently responding to information requests (civil investigative demands) received from the DOJ (U.S. Attorney's Offices for the Eastern District of Pennsylvania and the Southern District of New York). We will continue to cooperate with the DOJ's investigation.

Disability claims regulatory matter. During the second quarter of 2013, the Company finalized an agreement with the Departments of Insurance for Maine, Massachusetts, Pennsylvania, Connecticut and California (together, the "monitoring states") related to the Company's long-term disability claims handling practices. The agreement requires primarily: (1) enhanced procedures related to documentation and disposition and (2) a two-year monitoring period followed by a re-examination that began in the second quarter of 2016. Management believes the Company has addressed the requirements of the agreement. If the monitoring states find material non-compliance with the agreement upon re-examination, the Company may be subject to additional costs and penalties or requests to change its business practices that could negatively impact future earnings for this business.

Note 20 Condensed Consolidating Financial Information

Effective with the Merger that closed on December 20, 2018 (see Note 3 for further information) the senior notes issued by Cigna, Old Cigna, Express Scripts, Inc. ("ESI"), Medco Health Solutions, Inc. ("Medco"), and Express Scripts became jointly and severally and fully and unconditionally (subject to certain customary release provisions, including sale, exchange, transfer or liquidation of the guarantor subsidiary) guaranteed by Cigna, Old Cigna, ESI, Medco and Express Scripts, as applicable. Details of these debt obligations are presented in Note 5. The following condensed consolidating financial information has been prepared in accordance with the requirements as prescribed by the SEC in Regulation S-X. The condensed consolidating financial information presented below is not indicative of what the financial position, results of operations or cash flows would have been had each of the entities operated as an independent company during the periods for various reasons, including, but not limited to, intercompany transactions and integration of systems.

The condensed consolidating financial information is presented separately for:

(i) Cigna (the Parent Company), guarantor, the issuer of additional guaranteed obligations;

(ii) Old Cigna (former Parent Company for the fiscal years ended 2017 and 2016), guarantor, the issuer of additional guaranteed obligations;

(iii) Express Scripts, guarantor, the issuer of additional guaranteed obligations;

(iv) ESI, guarantor, the issuer of additional guaranteed obligations;

(v) Medco, guarantor, the issuer of additional guaranteed obligations;

(vi) Non-guarantor subsidiaries, on a combined basis;

(vii) Consolidating entries and eliminations representing adjustments to (a) eliminate intercompany transactions between or among Cigna, Old Cigna, Express Scripts, ESI, Medco and the non-guarantor subsidiaries, (b) eliminate the investments in our subsidiaries and (c) record consolidating entries; and

(viii) Cigna and subsidiaries on a consolidated basis.

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Condensed Consolidating Statements of Income

	For the year ended December 31, 2018							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Revenues								
Premiums	$ —	$ —	$ —	$ —	$ —	$ 36,113	$ —	$ 36,113
Fees and other revenues	—	—	—	23	7	5,596	(48)	5,578
Pharmacy revenues	—	—	—	1,866	418	4,165	(970)	5,479
Net investment income	123	1	2	—	—	1,354	—	1,480
Total revenues	123	1	2	1,889	425	47,228	(1,018)	48,650
Benefits and expenses								
Medical costs and other benefit expenses	—	—	—	—	—	27,528	—	27,528
Pharmacy and other service costs	—	—	—	1,763	417	3,583	(970)	4,793
Selling, general and administrative expenses	200	535	—	44	8	11,195	(48)	11,934
Amortization of acquired intangible assets	—	—	—	94	13	128	—	235
Total benefits and expenses	200	535	—	1,901	438	42,434	(1,018)	44,490
Income (loss) from operations	(77)	(534)	2	(12)	(13)	4,794	—	4,160
Interest and other income (expense)	(244)	(264)	15	(17)	(10)	22	—	(498)
Intercompany interest income (expense)	(5)	(58)	(15)	7	5	66	—	—
Net realized investment (losses)	(1)	—	—	—	—	(80)	—	(81)
Income (loss) before income taxes	(327)	(856)	2	(22)	(18)	4,802	—	3,581
Total income tax (benefit) expense	(74)	(163)	—	(4)	(4)	1,180	—	935
Income (loss) before equity in earnings of subsidiaries	(253)	(693)	2	(18)	(14)	3,622	—	2,646
Equity in earnings (loss) of subsidiaries	2,890	3,613	(32)	(33)	29	—	(6,467)	—
Net income (loss)	2,637	2,920	(30)	(51)	15	3,622	(6,467)	2,646
Less: Net income attributable to noncontrolling interests	—	—	—	—	—	9	—	9
Shareholders' net income (loss)	$ 2,637	$ 2,920	$ (30)	$ (51)	$ 15	$ 3,613	$ (6,467)	$ 2,637
Other comprehensive (loss), net of tax	(390)	(390)	—	—	—	(536)	926	(390)
Shareholders' comprehensive income (loss)	$ 2,247	$ 2,530	$ (30)	$ (51)	$ 15	$ 3,077	$ (5,541)	$ 2,247

Condensed Consolidating Statements of Income

	For the year ended December 31, 2017							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Revenues								
Premiums	$ —	$ —	$ —	$ —	$ —	$ 32,491	$ —	$ 32,491
Fees and other revenues	—	—	—	—	—	5,110	—	5,110
Pharmacy revenues	—	—	—	—	—	2,979	—	2,979
Net investment income	—	—	—	—	—	1,226	—	1,226
Total revenues	—	—	—	—	—	41,806	—	41,806
Benefits and expenses								
Medical costs and other benefit expenses	—	—	—	—	—	25,263	—	25,263
Pharmacy and other service costs	—	—	—	—	—	2,456	—	2,456
Selling, general and administrative expenses	—	195	—	—	—	9,835	—	10,030
Amortization of acquired intangible assets	—	—	—	—	—	115	—	115
Total benefits and expenses	—	195	—	—	—	37,669	—	37,864
Income (loss) from operations	—	(195)	—	—	—	4,137	—	3,942
Interest and other (expense)	—	(246)	—	—	—	(6)	—	(252)
Intercompany interest income (expense)	—	(18)	—	—	—	18	—	—
Debt extinguishment (costs)	—	(321)	—	—	—	—	—	(321)
Net realized investment gains	—	—	—	—	—	237	—	237
Income (loss) before income taxes	—	(780)	—	—	—	4,386	—	3,606
Total income tax (benefit) expense	—	(194)	—	—	—	1,568	—	1,374
Income (loss) before equity in earnings of subsidiaries	—	(586)	—	—	—	2,818	—	2,232
Equity in earnings of subsidiaries	—	2,823	—	—	—	—	(2,823)	—
Net income	—	2,237	—	—	—	2,818	(2,823)	2,232
Less: Net (loss) attributable to noncontrolling interests	—	—	—	—	—	(5)	—	(5)
Shareholders' net income	$ —	$ 2,237	$ —	$ —	$ —	$ 2,823	$ (2,823)	$ 2,237
Other comprehensive income, net of tax	—	300	—	—	—	269	(269)	300
Shareholders' comprehensive income	$ —	$ 2,537	$ —	$ —	$ —	$ 3,092	$ (3,092)	$ 2,537

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Condensed Consolidating Statements of Income

	For the year ended December 31, 2016							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Revenues								
Premiums	$ —	$ —	$ —	$ —	$ —	$ 30,824	$ —	$ 30,824
Fees and other revenues	—	—	—	—	—	4,901	—	4,901
Pharmacy revenues	—	—	—	—	—	2,966	—	2,966
Net investment income	—	—	—	—	—	1,147	—	1,147
Total revenues	—	—	—	—	—	39,838	—	39,838
Benefits and expenses								
Medical costs and other benefit expenses	—	—	—	—	—	24,341	—	24,341
Pharmacy and other service costs	—	—	—	—	—	2,468	—	2,468
Selling, general and administrative expenses	—	281	—	—	—	9,509	—	9,790
Amortization of acquired intangible assets	—	—	—	—	—	151	—	151
Total benefits and expenses	—	281	—	—	—	36,469	—	36,750
Income (loss) from operations	—	(281)	—	—	—	3,369	—	3,088
Interest and other (expense)	—	(244)	—	—	—	(34)	—	(278)
Intercompany interest income (expense)	—	(3)	—	—	—	3	—	—
Net realized investment gains	—	—	—	—	—	169	—	169
Income (loss) before income taxes	—	(528)	—	—	—	3,507	—	2,979
Total income tax (benefit) expense	—	(146)	—	—	—	1,282	—	1,136
Income (loss) before equity in earnings of subsidiaries	—	(382)	—	—	—	2,225	—	1,843
Equity in earnings of subsidiaries	—	2,249	—	—	—	—	(2,249)	—
Net income	—	1,867	—	—	—	2,225	(2,249)	1,843
Less: Net (loss) attributable to noncontrolling interests	—	—	—	—	—	(24)	—	(24)
Shareholders' net income	$ —	$ 1,867	$ —	$ —	$ —	$ 2,249	$ (2,249)	$ 1,867
Other comprehensive (loss), net of tax	—	(132)	—	—	—	(154)	154	(132)
Shareholders' comprehensive income	$ —	$ 1,735	$ —	$ —	$ —	$ 2,095	$ (2,095)	$ 1,735

Condensed Consolidating Balance Sheets

	As of December 31, 2018							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Assets								
Cash and cash equivalents	$ 243	$ —	$ 633	$ 43	$ —	$ 2,936	$ —	$ 3,855
Investments	—	—	—	—	—	2,045	—	2,045
Accounts receivable, net	—	—	—	4,206	748	5,519	—	10,473
Inventories	—	—	—	—	—	2,821	—	2,821
Other current assets	14	59	—	310	—	1,063	(210)	1,236
Total current assets	257	59	633	4,559	748	14,384	(210)	20,430
Long-term investments	—	10	—	—	—	26,919	—	26,929
Reinsurance recoverables	—	—	—	—	—	5,507	—	5,507
Deferred policy acquisition costs	—	—	—	—	—	2,821	—	2,821
Property and equipment	—	—	—	2,432	—	2,130	—	4,562
Investments in subsidiaries	68,969	27,544	52,035	17,115	8,117	—	(173,780)	—
Intercompany receivables	—	4,505	—	7,425	2,335	24,882	(39,147)	—
Goodwill	—	—	31,049	—	—	13,456	—	44,505
Other intangible assets	—	—	8,400	18,962	7,040	4,601	—	39,003
Other assets	48	198	—	68	74	1,488	(246)	1,630
Separate account assets	—	—	—	—	—	7,839	—	7,839
TOTAL ASSETS	$ 69,274	$ 32,316	$ 92,117	$ 50,561	$ 18,314	$ 104,027	$ (213,383)	$ 153,226
Liabilities								
Current insurance and contractholder liabilities	$ —	$ —	$ —	$ —	$ —	$ 6,801	$ —	$ 6,801
Pharmacy and service costs payable	—	—	—	8,422	1,579	701	—	10,702
Accounts payable	22	—	—	834	4	3,506	—	4,366
Accrued expenses and other liabilities	396	182	129	1,387	189	4,998	(210)	7,071
Short-term debt	—	1,500	995	353	—	107	—	2,955
Total current liabilities	418	1,682	1,124	10,996	1,772	16,113	(210)	31,895
Non-current insurance and contractholder liabilities	—	—	—	—	—	19,974	—	19,974
Deferred tax liabilities, net	—	—	2,001	5,012	1,685	1,001	(246)	9,453
Other non-current liabilities	—	685	—	497	290	1,998	—	3,470
Intercompany payables	4,965	4,361	29,569	—	—	252	(39,147)	—
Long-term debt	22,863	5,110	10,932	24	506	88	—	39,523
Separate account liabilities	—	—	—	—	—	7,839	—	7,839
TOTAL LIABILITIES	28,246	11,838	43,626	16,529	4,253	47,265	(39,603)	112,154
Redeemable noncontrolling interests	—	—	—	—	—	37	—	37
TOTAL SHAREHOLDERS' EQUITY	41,028	20,478	48,491	34,032	14,061	56,718	(173,780)	41,028
Noncontrolling interests	—	—	—	—	—	7	—	7
TOTAL EQUITY	41,028	20,478	48,491	34,032	14,061	56,725	(173,780)	41,035
TOTAL LIABILITIES AND EQUITY	$ 69,274	$ 32,316	$ 92,117	$ 50,561	$ 18,314	$ 104,027	$ (213,383)	$ 153,226

Condensed Consolidating Balance Sheets

	As of December 31, 2017							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Assets								
Cash and cash equivalents	$ –	$ 9	$ –	$ –	$ –	$ 2,963	$ –	$ 2,972
Investments	–	63	–	–	–	2,073	–	2,136
Accounts receivable, net	–	–	–	–	–	3,155	–	3,155
Inventories	–	–	–	–	–	228	–	228
Other current assets	–	31	–	–	–	789	–	820
Total current assets	–	103	–	–	–	9,208	–	9,311
Long-term investments	–	–	–	–	–	26,483	–	26,483
Reinsurance recoverables	–	–	–	–	–	5,763	–	5,763
Deferred policy acquisition costs	–	–	–	–	–	2,237	–	2,237
Property and equipment	–	–	–	–	–	1,563	–	1,563
Investments in subsidiaries	–	22,631	–	–	–	–	(22,631)	–
Intercompany receivables	–	200	–	–	–	2,980	(3,180)	–
Deferred tax assets, net	–	221	–	–	–	(182)	–	39
Goodwill	–	–	–	–	–	6,164	–	6,164
Other intangible assets	–	–	–	–	–	345	–	345
Other assets	–	–	–	–	–	1,431	–	1,431
Separate account assets	–	–	–	–	–	8,423	–	8,423
TOTAL ASSETS	$ –	$ 23,155	$ –	$ –	$ –	$ 64,415	$ (25,811)	$ 61,759
Liabilities								
Current insurance and contractholder liabilities	–	–	–	–	–	6,317	–	6,317
Pharmacy and service costs payable	–	–	–	–	–	305	–	305
Accounts payable, accrued expenses and other liabilities	–	270	–	–	–	3,877	–	4,147
Short-term debt	–	231	–	–	–	9	–	240
Total current liabilities	–	501	–	–	–	10,508	–	11,009
Non-current insurance and contractholder liabilities	–	–	–	–	–	20,530	–	20,530
Intercompany payables	–	2,980	–	–	–	200	(3,180)	–
Other non-current liabilities	–	851	–	–	–	1,987	–	2,838
Long-term debt	–	5,112	–	–	–	87	–	5,199
Separate account liabilities	–	–	–	–	–	8,423	–	8,423
TOTAL LIABILITIES	–	9,444	–	–	–	41,735	(3,180)	47,999
Redeemable noncontrolling interests	–	–	–	–	–	49	–	49
SHAREHOLDERS' EQUITY	–	13,711	–	–	–	22,631	(22,631)	13,711
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	$ –	$ 23,155	$ –	$ –	$ –	$ 64,415	$ (25,811)	$ 61,759

Condensed Consolidating Cash Flow Statements

	For the year ended December 31, 2018							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Net cash provided by (used in) operating activities	$ 145	$ 2,416	$ (36)	$ 80	$ (304)	$ 3,987	$ (2,518)	$ 3,770
Cash Flows from Investing Activities								
Net change in loans due (from) affiliates	—	(4,412)	(200)	—	—	(1,121)	5,733	—
Proceeds from investments sold:								
Fixed maturities and equity securities	—	—	—	—	—	2,655	—	2,655
Investment maturities and repayments:								
Fixed maturities and equity securities	—	—	—	—	—	2,151	—	2,151
Commercial mortgage loans	—	—	—	—	—	215	—	215
Other sales, maturities and repayments (primarily short-term and other long-term investments)	—	63	—	—	—	671	—	734
Investments purchased or originated:								
Fixed maturities and equity securities	—	(10)	—	—	—	(5,627)	—	(5,637)
Commercial mortgage loans	—	—	—	—	—	(312)	—	(312)
Other sales, maturities and repayments (primarily short-term and other long-term investments)	—	—	—	—	—	(1,189)	—	(1,189)
Property and equipment purchases, net	—	—	—	(6)	—	(522)	—	(528)
Acquisitions, net of cash acquired	(27,115)	—	1,676	23	—	961	—	(24,455)
Other, net	—	—	—	—	—	(12)	—	(12)
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	(27,115)	(4,359)	1,476	17	—	(2,130)	5,733	(26,378)
Cash Flows from Financing Activities								
Net change in amounts due to (from) affiliates	4,437	1,121	(807)	(54)	304	732	(5,733)	—
Intercompany dividends paid	—	—	—	—	—	(2,518)	2,518	—
Deposits and interest credited to contractholder deposit funds	—	—	—	—	—	1,040	—	1,040
Withdrawals and benefit payments from contractholder deposit funds	—	—	—	—	—	(1,151)	—	(1,151)
Net change in short-term debt	—	1,400	—	—	—	87	—	1,487
Payments for debt extinguishment	—	—	—	—	—	—	—	—
Repayment of long-term debt	—	(131)	—	—	—	—	—	(131)
Net proceeds on issuance of long-term debt	22,856	—	—	—	—	—	—	22,856
Repurchase of common stock	(32)	(310)	—	—	—	—	—	(342)
Issuance of common stock	1	67	—	—	—	—	—	68
Other, net	(49)	(213)	—	—	—	(50)	—	(312)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	27,213	1,934	(807)	(54)	304	(1,860)	(3,215)	23,515
Effect of foreign currency rate changes on cash and cash equivalents	—	—	—	—	—	(24)	—	(24)
Net increase (decrease) in cash and cash equivalents	243	(9)	633	43	—	(27)	—	883
Cash and cash equivalents, January 1,	—	9	—	—	—	2,963	—	2,972
Cash and cash equivalents, December 31,	$ 243	$ —	$ 633	$ 43	$ —	$ 2,936	$ —	$ 3,855

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Condensed Consolidating Cash Flow Statements

	For the year ended December 31, 2017							
(In millions)	Cigna	Old Cigna	Express Scripts Holding Company	Express Scripts, Inc.	Medco Health Solutions, Inc.	Non-Guarantors	Eliminations and Consolidation Adjustments	Consolidated
Net cash provided by operating activities	$ –	$ 602	$ –	$ –	$ –	$ 4,242	$ (758)	$ 4,086
Cash Flows from Investing Activities								
Net change in loans due (from) affiliates	–	–	–	–	–	(1,955)	1,955	–
Proceeds from investments sold:								
Fixed maturities and equity securities	–	–	–	–	–	2,012	–	2,012
Investment maturities and repayments:								
Fixed maturities and equity securities	–	–	–	–	–	2,051	–	2,051
Commercial mortgage loans	–	–	–	–	–	335	–	335
Other sales, maturities and repayments (primarily short-term and other long-term investments)	–	–	–	–	–	1,702	–	1,702
Investments purchased or originated:								
Fixed maturities and equity securities	–	–	–	–	–	(5,628)	–	(5,628)
Commercial mortgage loans	–	–	–	–	–	(430)	–	(430)
Other sales, maturities and repayments (primarily short-term and other long-term investments)	–	(6)	–	–	–	(1,059)	–	(1,065)
Property and equipment purchases, net	–	–	–	–	–	(471)	–	(471)
Acquisitions, net of cash acquired	–	–	–	–	–	(209)	–	(209)
Other, net	–	(11)	–	–	–	11	–	–
NET CASH (USED IN) INVESTING ACTIVITIES	–	(17)	–	–	–	(3,641)	1,955	(1,703)
Cash Flows from Financing Activities								
Net change in amounts due to affiliates	–	1,955	–	–	–	–	(1,955)	–
Intercompany dividends paid	–	–	–	–	–	(758)	758	–
Deposits and interest credited to contractholder deposit funds	–	–	–	–	–	1,230	–	1,230
Withdrawals and benefit payments from contractholder deposit funds	–	–	–	–	–	(1,363)	–	(1,363)
Net change in short-term debt	–	100	–	–	–	(20)	–	80
Payments for debt extinguishment	–	(313)	–	–	–	–	–	(313)
Repayment of long-term debt	–	(1,250)	–	–	–	–	–	(1,250)
Net proceeds on issuance of long-term debt	–	1,581	–	–	–	–	–	1,581
Repurchase of common stock	–	(2,725)	–	–	–	–	–	(2,725)
Issuance of common stock	–	131	–	–	–	–	–	131
Other, net	–	(73)	–	–	–	51	–	(22)
NET CASH (USED IN) FINANCING ACTIVITIES	–	(594)	–	–	–	(860)	(1,197)	(2,651)
Effect of foreign currency rate changes on cash and cash equivalents	–	–	–	–	–	55	–	55
Net decrease in cash and cash equivalents	–	(9)	–	–	–	(204)	–	(213)
Cash and cash equivalents, January 1,	–	18	–	–	–	3,167	–	3,185
Cash and cash equivalents, December 31,	$ –	$ 9	$ –	$ –	$ –	$ 2,963	$ –	$ 2,972

Condensed Consolidating Cash Flow Statements

	For the year ended December 31, 2016							
(In millions)	**Cigna**	**Old Cigna**	**Express Scripts Holding Company**	**Express Scripts, Inc.**	**Medco Health Solutions, Inc.**	**Non-Guarantors**	**Eliminations and Consolidation Adjustments**	**Consolidated**
Net cash provided by operating activities	$ –	$ 376	$ –	$ –	$ –	$ 4,230	$ (580)	$ 4,026
Cash Flows from Investing Activities								
Net change in loans due to affiliates	–	–	–	–	–	78	(78)	–
Proceeds from investments sold:								
Fixed maturities and equity securities	–	–	–	–	–	1,544	–	1,544
Investment maturities and repayments:								
Fixed maturities and equity securities	–	–	–	–	–	1,755	–	1,755
Commercial mortgage loans	–	–	–	–	–	316	–	316
Other sales, maturities and repayments (primarily short-term and other long-term investments)	–	–	–	–	–	1,431	–	1,431
Investments purchased or originated:								
Fixed maturities and equity securities	–	–	–	–	–	(5,191)	–	(5,191)
Commercial mortgage loans	–	–	–	–	–	(165)	–	(165)
Other sales, maturities and repayments (primarily short-term and other long-term investments)	–	(3)	–	–	–	(1,695)	–	(1,698)
Property and equipment purchases, net	–	–	–	–	–	(461)	–	(461)
Acquisitions, net of cash acquired	–	–	–	–	–	(4)	–	(4)
Other, net	–	(8)	–	–	–	(93)	–	(101)
NET CASH (USED IN) INVESTING ACTIVITIES	–	(11)	–	–	–	(2,485)	(78)	(2,574)
Cash Flows from Financing Activities								
Net change in amounts due (from) affiliates	–	(78)	–	–	–	–	78	–
Intercompany dividends paid	–	–	–	–	–	(580)	580	–
Deposits and interest credited to contractholder deposit funds	–	–	–	–	–	1,460	–	1,460
Withdrawals and benefit payments from contractholder deposit funds	–	–	–	–	–	(1,362)	–	(1,362)
Net change in short-term debt	–	(100)	–	–	–	(48)	–	(148)
Payments for debt extinguishment	–	–	–	–	–	–	–	–
Repayment of long-term debt	–	–	–	–	–	–	–	–
Net proceeds on issuance of long-term debt	–	–	–	–	–	–	–	–
Repurchase of common stock	–	(139)	–	–	–	–	–	(139)
Issuance of common stock	–	36	–	–	–	–	–	36
Other, net	–	(82)	–	–	–	10	–	(72)
NET CASH (USED IN) FINANCING ACTIVITIES	–	(363)	–	–	–	(520)	658	(225)
Effect of foreign currency rate changes on cash and cash equivalents	–	–	–	–	–	(10)	–	(10)
Net increase in cash and cash equivalents	–	2	–	–	–	1,215	–	1,217
Cash and cash equivalents, January 1,	–	16	–	–	–	1,952	–	1,968
Cash and cash equivalents, December 31,	$ –	$ 18	$ –	$ –	$ –	$ 3,167	$ –	$ 3,185

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Note 21 Segment Information

See Note 1 for a description of our segments. Effective with the fourth quarter of 2018, the Company uses adjusted income from operations on a before-tax basis as its principal financial measure of segment operating performance. Prior year segment information has been adjusted to reflect this change and a description of our basis for reporting segment operating results is outlined below. Intersegment transactions primarily reflect home delivery pharmacy sales to insured customers of the Integrated Medical segment. These transactions are eliminated in consolidation.

The Company uses "pre-tax adjusted income from operations" as its principal financial measure of segment operating performance because management believes it best reflects the underlying results of business operations and permits analysis of trends in underlying revenue, expenses and profitability. Pre-tax adjusted income from operations is defined as income before taxes excluding realized investment results, amortization of acquired intangible assets, results of transitioning clients and special items. Income or expense amounts that are excluded from adjusted income from operations because they are not indicative of underlying performance or the responsibility of operating segment management include:

- Realized investment gains (losses), including changes in market values of certain financial instruments between balance sheet dates, as well as gains and losses associated with invested asset sales
- Amortization of acquired intangible assets, because these relate to costs incurred for acquisitions
- Results of transitioning clients, because those results are not indicative of ongoing results
- Special items, if any, that management believes are not representative of the underlying results of operations due to the nature or size of these matters. Further context about these items is provided in the footnotes listed in the table below.

The following table presents the special items recorded by the Company for the years ended December 31, 2018, 2017 and 2016.

(In millions)

Description of Special Item Charges (Benefits) and Financial Statement Line Item(s)	After-tax	Before-tax
Year ended December 31, 2018		
Transaction-related costs		
– Selling, general and administrative expenses (see Note 3)	**$ 587**	**$ 748**
– Interest expense and other (see Note 3)	**179**	**227**
– Net investment income (see Note 3)	**(97)**	**(123)**
Total transaction-related costs	**$ 669**	**$ 852**
Charges associated with litigation matters (Selling, general and adminstrative expenses, see Note 19D.)	**$ 19**	**$ 25**
Charges associated with U.S. tax reform		
– Selling, general and administrative expenses	**$ 1**	**$ 2**
– Tax expense (see Note 18)	**(3)**	**—**
Total charges associated with U.S. tax reform	**$ (2)**	**$ 2**
Year ended December 31, 2017		
Transaction-related costs (see Note 3)	$ 33	$ 126
Charges associated with U.S. tax reform		
– Selling, general and administrative expenses	$ (36)	$ (56)
– Tax expense (see Note 18)	232	–
Total charges associated with U.S. tax reform	$ 196	$ (56)
Debt extinguishment costs (see Note 5)	$ 209	$ 321
Long-term care guaranty fund assessment (Selling, general and administrative expenses, see Note 19D. for details)	$ 83	$ 129
Year ended December 31, 2016		
Transaction-related costs (see Note 3)	$ 147	$ 166
Charges associated with litigation matters (Selling, general and administrative expenses, see Note 19D. for details)	$ 25	$ 40
Risk corridor allowance (Selling, general and administrative expenses)	$ 80	$ 124

Summarized segment financial information for the years ended December 31, was as follows:

(In millions)	Integrated Medical	Health Services	International Markets	Group Disability and Other	Corporate and Eliminations	Total
2018						
Revenues from external customers [1]	$ 31,759	$ 5,902	$ 5,174	$ 4,335	$ –	$ 47,170
Inter-segment revenues	573	1,154	–	14	(1,741)	–
Net investment income	459	9	149	712	151	1,480
Total revenues	32,791	7,065	5,323	5,061	(1,590)	48,650
Revenue contributions from transitioning clients	–	(459)	–	–	–	(459)
Net realized investment results from equity method subsidiaries [2]	–	–	43	–	–	43
Special items reported in transaction-related costs	–	–	–	–	(123)	(123)
Adjusted revenues	$ 32,791	$ 6,606	$ 5,366	$ 5,061	$ (1,713)	$ 48,111
Depreciation and amortization	$ 466	$ 120	$ 55	$ 53	$ 1	$ 695
Income (loss) before taxes	$ 3,342	$ 329	$ 670	$ 497	$ (1,257)	$ 3,581
Pre-tax adjustments to reconcile to adjusted income from operations						
Adjustment for transitioning clients	–	(62)	–	–	–	(62)
(Income) loss attributable to noncontrolling interests	–	–	(14)	–	–	(14)
Net realized investment (gains) losses	36	–	61	25	2	124
Amortization of acquired intangible assets	99	113	18	5	–	235
Special items						
Transaction-related costs	–	–	–	–	852	852
Charges associated with litigation matters	25	–	–	–	–	25
U.S. tax reform	–	–	–	2	–	2
Pre-tax adjusted income (loss) from operations	$ 3,502	$ 380	$ 735	$ 529	$ (403)	$ 4,743

(In millions)	Integrated Medical	Health Services	International Markets	Group Disability and Other	Corporate and Eliminations	Total
2017						
Revenues from external customers [1]	$ 28,193	$ 3,250	$ 4,774	$ 4,363	$ –	$ 40,580
Inter-segment revenues	476	988	–	12	(1,476)	–
Net investment income	366	3	127	700	30	1,226
Total revenues	$ 29,035	$ 4,241	$ 4,901	$ 5,075	$ (1,446)	$ 41,806
Adjusted revenues	$ 29,035	$ 4,241	$ 4,901	$ 5,075	$ (1,446)	$ 41,806
Depreciation and amortization	$ 470	$ –	$ 61	$ 31	$ 4	$ 566
Income (loss) before taxes	$ 2,859	$ 288	$ 667	$ 614	$ (822)	$ 3,606
Pre-tax adjustments to reconcile to adjusted income from operations						
(Income) loss attributable to noncontrolling interests	1	–	1	–	–	2
Net realized investment (gains) losses	(137)	–	(31)	(69)	–	(237)
Amortization of acquired intangible assets	93	–	17	5	–	115
Special items						
Transaction-related costs	–	–	–	–	126	126
U.S. tax reform	–	–	–	(56)	–	(56)
Debt extinguishment costs	–	–	–	–	321	321
Long-term care guaranty fund assessment	106	–	–	23	–	129
Pre-tax adjusted income (loss) from operations	$ 2,922	$ 288	$ 654	$ 517	$ (375)	$ 4,006

(1) Includes the Company's share of the earnings of its joint ventures reported in the International Markets segment using the equity method of accounting.

(2) Beginning in 2018, includes the Company's share of the realized investment gains (losses) of its joint ventures reported using the equity method of accounting.

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(In millions)	Integrated Medical	Health Services	International Markets	Group Disability and Other	Corporate and Eliminations	Total
2016						
Revenues from external customers [1]	$ 26,695	$ 3,169	$ 4,424	$ 4,403	$ –	$ 38,691
Inter-segment revenues	395	894	–	–	(1,289)	–
Net investment income	305	3	113	705	21	1,147
Total revenues	$ 27,395	$ 4,066	$ 4,537	$ 5,108	$ (1,268)	$ 39,838
Adjusted revenues	$ 27,395	$ 4,066	$ 4,537	$ 5,108	$ (1,268)	$ 39,838
Depreciation and amortization	$ 519	$ –	$ 61	$ 29	$ 1	$ 610
Income (loss) before taxes	$ 2,417	$ 268	$ 497	$ 324	$ (527)	$ 2,979
Pre-tax adjustments to reconcile to adjusted income from operations						
(Income) loss attributable to noncontrolling interests	2	–	18	–	–	20
Net realized investment (gains) losses	(116)	–	2	(54)	(1)	(169)
Amortization of acquired intangible assets	125	–	21	5	–	151
Special items						
Transaction-related costs	–	–	–	–	166	166
Risk corridor allowance	124	–	–	–	–	124
Charges associated with litigation matters	40	–	–	–	–	40
Pre-tax adjusted income (loss) from operations	$ 2,592	$ 268	$ 538	$ 275	$ (362)	$ 3,311

(1) Includes the Company's share of the earnings of its joint ventures reported in the International Markets segment using the equity method of accounting.

Revenue from external customers includes premiums, pharmacy revenues, and fees and other revenues. The following table presents these revenues by premium, service and product type for the years ended December 31:

(In millions)	2018	2017	2016
Insurance premiums			
Integrated Medical premiums (ASC 944)			
Commercial Premiums			
Risk	**$ 10,710**	$ 9,439	$ 7,911
Stop loss	**4,008**	3,483	3,082
Other	**1,038**	917	886
Government			
Medicare Advantage	**5,832**	5,534	6,621
Medicare Part D	**764**	764	1,122
Other	**4,496**	3,494	2,640
Total Integrated Medical premiums	**26,848**	23,631	22,262
International Markets premiums	**5,043**	4,619	4,273
Domestic disability, life and accident premiums	**4,000**	3,973	4,002
Other premiums	**222**	268	287
Total premiums	**36,113**	32,491	30,824
Services (ASC 606)			
Fees	**5,588**	5,053	4,844
Other external revenues	**20**	57	57
Total services	**5,578**	5,110	4,901
Products (Pharmacy revenues) (ASC 606)			
Home delivery and specialty revenues	**3,997**	2,979	2,966
Network revenues	**1,415**	–	–
Other	**67**	–	–
Total pharmacy revenues	**5,479**	2,979	2,966
Total revenues from external customers	**$ 47,170**	$ 40,580	$ 38,691

Foreign and U.S. revenues from external customers for the three years ended December 31 are shown below. The Company's foreign revenues are generated by its foreign operating entities. In the periods shown, no foreign country contributed more than 5% of consolidated revenues from external customers.

(In millions)	2018	2017	2016
United States	**$ 42,773**	$ 36,555	$ 35,011
South Korea	**2,093**	1,892	1,666
All other foreign countries	**2,304**	2,133	2,014
Total	**$ 47,170**	$ 40,580	$ 38,691

Revenues from CMS were 16% of consolidated revenues in 2018 and 2017, compared with 19% in 2016. These amounts were reported in the Integrated Medical segment.

Quarterly Financial Data *(unaudited)*

The following unaudited quarterly financial data is presented on a consolidated basis for each of the years ended December 31, 2018 and December 31, 2017. Quarterly financial results necessarily rely heavily on estimates. This and certain other factors, such as the seasonal nature of portions of the insurance business, suggest the need to exercise caution in drawing specific conclusions from quarterly consolidated results.

	Three Months Ended			
(In millions, except per share amounts)	March 31,	June 30,	September 30,	December 31,
Consolidated Results				
2018				
Total revenues	**$ 11,413**	**$ 11,480**	**$ 11,457**	**$ 14,300**
Income before income taxes	**1,218**	**1,102**	**1,033**	**228**
Shareholders' net income	**915[1]**	**806[1]**	**772[1]**	**144[1]**
Shareholders' net income per share				
Basic	**3.78**	**3.32**	**3.18**	**0.56**
Diluted	**3.72**	**3.29**	**3.14**	**0.55**
2017				
Total revenues	$ 10,428	$ 10,374	$ 10,372	$ 10,632
Income before income taxes	890	1,134	824	758
Shareholders' net income	598[1]	813[1]	560[1]	266[1]
Shareholders' net income per share				
Basic	2.34	3.20	2.25	1.09
Diluted	2.30	3.15	2.21	1.07
Stock and dividend data				
2018				
Price range of common stock – high	**$ 227.13**	**$ 182.10**	**$ 208.73**	**$ 226.61**
– low	**$ 163.02**	**$ 163.80**	**$ 166.88**	**$ 176.52**
Dividends declared per common share	**$ 0.04**	**$ –**	**$ –**	**$ –**
2017				
Price range of common stock – high	$ 154.83	$ 173.21	$ 188.36	$ 212.46
– low	$ 133.52	$ 146.70	$ 166.81	$ 183.08
Dividends declared per common share	$ 0.04	$ –	$ –	$ –

(1) Shareholders' net income includes the following after-tax charges (benefits), described in Note 21 to the Consolidated Financial Statements:

	March 31,	June 30,	September 30,	December 31,
2018 Transaction-related costs	***$ 50***	***$ 109***	***$ 108***	***$ 402***
2018 Charges associated with litigation matters	***–***	***–***	***35***	***(16)***
2018 U.S. tax reform	***–***	***–***	***(5)***	***3***
Total 2018 charges	***$ 50***	***$ 109***	***$ 138***	***$ 389***

	March 31,	June 30,	September 30,	December 31,
2017 U.S. tax reform	*$ –*	*$ –*	*$ –*	*$ 196*
2017 Debt extinguishment costs	*–*	*–*	*209*	*–*
2017 Long-term care guaranty fund assessment	*83*	*–*	*–*	*–*
2017 Transaction-related costs	*49*	*(47)*	*6*	*25*
Total 2017 charges (benefits)	*$ 132*	*$ (47)*	*$ 215*	*$ 221*

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ITEM 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

ITEM 9A. Controls and Procedures

A. Disclosure Controls and Procedures

Based on an evaluation of the effectiveness of Cigna's disclosure controls and procedures conducted under the supervision and with the participation of Cigna's management, Cigna's Chief Executive Officer and Chief Financial Officer concluded that, as of the end of the period covered by this report, Cigna's disclosure controls and procedures are effective to ensure that information required to be disclosed by Cigna in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms.

B. Internal Control Over Financial Reporting

Management's Annual Report on Internal Control over Financial Reporting

Management of Cigna Corporation is responsible for establishing and maintaining adequate internal controls over financial reporting. The Company's internal controls were designed to provide reasonable assurance to the Company's management and Board of Directors that the Company's consolidated published financial statements for external purposes were prepared in accordance with accounting principles generally accepted in the United States. The Company's internal control over financial reporting includes those policies and procedures that:

(i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets and liabilities of the Company;

(ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with accounting principles generally accepted in the United States, and that receipts and expenditures of the Company are being made only in accordance with authorization of management and directors of the Company; and

(iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisitions, use or disposition of the Company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements.

Management assessed the effectiveness of the Company's internal controls over financial reporting as of December 31, 2018. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in *Internal Control-Integrated Framework (2013).* Based on management's assessment and the criteria set forth by COSO, it was determined that the Company's internal controls over financial reporting are effective as of December 31, 2018.

Management's assessment of the effectiveness of internal controls over financial reporting excludes Express Scripts, which was acquired on December 20, 2018 (See Note 3 in the accompanying consolidated financial statements for additional information).

Express Scripts' total assets (excluding goodwill and intangible assets recorded in connection with the acquisition) and total revenues excluded from our assessment of internal control over financial reporting represent approximately 10% and 5%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2018.

The Company's independent registered public accounting firm, PricewaterhouseCoopers LLP, has audited the effectiveness of the Company's internal control over financial reporting, as stated in their report located on page 65 in this Form 10-K.

Change in Internal Control over Financial Reporting

As of December 31, 2018, management is in the process of evaluating and integrating the internal controls of the acquired Express Scripts business into the Company's existing operations. Other than the controls enhanced or implemented to integrate the Express Scripts business, there has been no change in Cigna's internal controls over financial reporting during the year ended December 31, 2018 that has materially affected, or is reasonably likely to affect, Cigna's internal controls over financial reporting.

ITEM 9B. Other Information

None.

PART III

ITEM 10. Directors, Executive Officers and Corporate Governance

A. Directors of the Registrant

The information under the captions "Corporate Governance Matters – Process for Director Elections," " – Board of Directors' Nominees" and " – Board Meetings and Committees" (as it relates to Audit Committee disclosure) in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

B. Executive Officers of the Registrant

See PART I – "Executive Officers of the Registrant" on page 38 in this Form 10-K.

C. Code of Ethics and Other Corporate Governance Disclosures

The information under the caption "Corporate Governance Matters – Codes of Ethics" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

D. Section 16(a) Beneficial Ownership Reporting Compliance

The information under the caption "Ownership of Cigna Common Stock – Section 16(a) Beneficial Ownership Reporting Compliance" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

ITEM 11. Executive Compensation

The information under the captions "Corporate Governance Matters – Non-Employee Director Compensation," "Compensation Matters – Compensation Discussion and Analysis," " – Report of the People Resources Committee" and " – Executive Compensation Tables" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

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ITEM 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The following table presents information regarding Cigna's equity compensation plans as of December 31, 2018:

Plan Category	(a) [1] Securities To Be Issued Upon Exercise Of Outstanding Options, Warrants And Rights	(b) [2] Weighted Average Exercise Price Per Share Of Outstanding Options, Warrants And Rights	(c) [3] Securities Remaining Available For Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected In Column (a))
Equity Compensation Plans Approved by Security Holders	15,099,184	$ 125.46	28,891,766
Equity Compensation Plans Not Approved by Security Holders	–	–	–
Total	15,099,184	$ 125.46	28,891,766

(1) Includes, in addition to outstanding stock options:
(i) 103,322 restricted stock units, 111,315 deferred shares, and 1,401,071 strategic performance shares that are reported at the maximum 200% payout rate granted under the Cigna Long-Term Incentive Plan, the Corporation Stock Plan, and the Cigna Corporation Director Equity Plan;
(ii) 140,744 shares of common stock underlying stock option awards granted under the HealthSpring, Inc. Amended and Restated 2006 Equity Incentive Plan which was approved by HealthSpring, Inc.'s shareholders before Cigna's acquisition of HealthSpring, Inc. in January 2012; and
(iii) 897,338 shares of common stock underlying stock option awards and 1,013,890 restricted stock units granted under the Express Scripts Holding Company 2016 Long-Term Incentive Plan, 8,758 deferred shares granted under the Express Scripts, Inc. Executive Deferred Compensation Plan of 2005, 2,877,922 shares of common stock underlying stock option awards and 63,904 restricted stock units granted under the Express Scripts, Inc. 2011 Long-Term Incentive Plan, 2,249,731 shares of common stock underlying stock option awards and 26,238 restricted stock units granted under the Medco Health Solutions, Inc. 2002 Stock Incentive Plan, and 119,948 shares of common stock underlying stock option awards granted under the Accredo Health, Incorporated 2002 Long-Term Incentive Plan, which were all approved by the applicable company's shareholders before Cigna's acquisition of Express Scripts in December 2018.

(2) The weighted-average exercise price is based only on outstanding stock options. The outstanding stock options assumed due to Cigna's acquisition of HealthSpring, Inc. have a weighted-average exercise price of $22.45. The outstanding stock options assumed due to Cigna's acquisition of Express Scripts, in aggregate, have a weighted-average exercise price of $135.57. Excluding the assumed options from these acquisitions results in a weighted-average exercise price of $117.64.

(3) Includes 239,222 shares of common stock available as of the close of business December 31, 2018 for future issuance under the Cigna Corporation Director Equity Plan, 25,838,360 shares of common stock available as of the close of business on December 31, 2018 for future issuance under the Cigna Long-Term Incentive Plan, which includes 13,120,666 shares of common stock available assumed from the Express Scripts, Inc. 2016 Long-Term Incentive Plan, and 2,814,184 shares of common stock available as of the close of business December 31, 2018 for future issuance under the Express Scripts, Inc. Executive Deferred Compensation Plan of 2005. Because no further grants may be made under the HealthSpring, Inc. Amended and Restated 2006 Equity Incentive Plan, the Express Scripts, Inc. 2016 Long-Term Incentive Plan, the Express Scripts, Inc. 2011 Long-Term Incentive Plan, the Medco Health Solutions, Inc. 2002 Stock Incentive Plan, and the Accredo Health, Incorporated 2002 Long-Term Incentive Plan, shares available for issuance under these plans are not included.

The information under the captions "Ownership of Cigna Common Stock – Stock Held by Directors, Nominees and Executive Officers" and "Ownership of Cigna Common Stock – Stock Held by Certain Beneficial Owners" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

ITEM 13. Certain Relationships and Related Transactions, and Director Independence

The information under the captions "Corporate Governance Matters – Director Independence" and " – Certain Transactions" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

ITEM 14. Principal Accountant Fees and Services

The information under the captions "Audit Matters – Policy for the Pre-Approval of Audit and Non-Audit Services" and " – Fees to Independent Registered Public Accounting Firm" in Cigna's definitive proxy statement related to the 2019 annual meeting of shareholders is incorporated by reference.

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PART IV

ITEM 15. Exhibits and Financial Statement Schedules

(a) (1) The following Financial Statements appear on pages 65 through 129:

Report of Independent Registered Public Accounting Firm.

Consolidated Statements of Income for the years ended December 31, 2018, 2017 and 2016.

Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017 and 2016.

Consolidated Balance Sheets as of December 31, 2018 and 2017.

Consolidated Statements of Changes in Total Equity for the years ended December 31, 2018, 2017 and 2016.

Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017 and 2016.

Notes to the Consolidated Financial Statements.

(2) The financial statement schedules are listed in the Index to Financial Statement Schedules on page FS-1.

(b) The exhibits listed in the accompanying "Index to Exhibits" in this Item 15 are filed or incorporated by reference as part of this Annual Report on Form 10-K.

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Index to Exhibits

Number	Description	Method of Filing
2.1(a)	Agreement and Plan of Merger, dated as of March 8, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Express Scripts Holding Company, Cigna Holding Company (formerly Cigna Corporation), Halfmoon I, Inc., and Halfmoon II, Inc.	Filed by Cigna Holding Company ("CHC") as Exhibit 2.1 to the Current Report on Form 8-K on March 13, 2018 and incorporated herein by reference.
2.1(b)	Amendment No. 1, dated as of June 27, 2018, to the Agreement and Plan of Merger, dated as of March 8, 2018, by and among Cigna Corporation, Express Scripts Holding Company, Cigna Holding Company, Halfmoon I, Inc. and Halfmoon II, Inc.	Filed by CHC as Exhibit 2.1 to the Current Report on Form 8-K on July 2, 2018 and incorporated herein by reference.
3.1	Amended and Restated Certificate of Incorporation of the registrant as last amended December 20, 2018	Filed by the registrant as Exhibit 3.1 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
3.2	Amended and Restated By-Laws of the registrant as last amended December 20, 2018	Filed by the registrant as Exhibit 3.2 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.1(a)	Indenture, dated as of September 17, 2018, between Cigna Corporation (formerly Halfmoon Parent, Inc.) and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on September 21, 2018 and incorporated herein by reference.
4.1(b)	Supplemental Indenture, dated as of September 17, 2018, between Cigna Corporation (formerly Halfmoon Parent, Inc.) and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.2 to the Current Report on Form 8-K on September 21, 2018 and incorporated herein by reference.
4.1(c)	Second Supplemental Indenture dated as of December 20, 2018, by and among Express Scripts Holding Company, Cigna Holding Company and U.S. Bank National Association, as Trustee	Filed by the registrant as Exhibit 4.7 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.2	Registration Rights Agreement, dated as of September 17, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.) and Morgan Stanley & Co. LLC, Merrill Lynch, Pierce, Fenner & Smith Incorporated, J.P. Morgan Securities LLC and Wells Fargo Securities, LLC, as representatives of the Initial Purchasers named in Schedule I to the Purchase Agreement	Filed by CHC as Exhibit 4.3 to the Current Report on Form 8-K on September 21, 2018 and incorporated herein by reference.
4.3(a)	Senior Indenture dated August 16, 2006 between Cigna Holding Company (formerly Cigna Corporation) and U.S. Bank National Association	Filed by CHC as Exhibit 4.1(a) to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
4.3(b)	Supplemental Indenture No. 1 dated November 10, 2006 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1(b) to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
4.3(c)	Supplemental Indenture No. 2 dated March 15, 2007 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1(c) to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2011 and incorporated herein by reference.
4.3(d)	Supplemental Indenture No. 3 dated March 7, 2008 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on March 10, 2008 and incorporated herein by reference.
4.3(e)	Supplemental Indenture No. 5 dated May 17, 2010 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 99.2 to the Current Report on Form 8-K on May 28, 2010 and incorporated herein by reference.
4.3(f)	Supplemental Indenture No. 6 dated December 8, 2010 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 99.2 to the Current Report on Form 8-K on December 9, 2010 and incorporated herein by reference.
4.3(g)	Supplemental Indenture No. 7 dated March 7, 2011 between Cigna Holding Company and U.S. Bank National Association	Filed by CHC as Exhibit 99.2 to the Current Report on Form 8-K on March 8, 2011 and incorporated herein by reference.
4.3(h)	Supplemental Indenture No. 8 dated November 10, 2011 between Cigna Holding Company and U.S. Bank National Associated	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on November 14, 2011 and incorporated herein by reference.
4.3(i)	Supplemental Indenture No. 9 dated as of March 20, 2015, between Cigna Holding Company and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K on March 26, 2015 and incorporated herein by reference.
4.3(j)	Supplemental Indenture No. 10 dated as of September 14, 2017 between Cigna Holding Company and U.S. Bank National Association, as trustee	Filed by CHC as Exhibit 4.1 to the Current Report on Form 8-K filed September 14, 2017 and incorporated herein by reference.
4.3(k)	Supplemental Indenture No. 11 dated as of December 20, 2018, by and among Cigna Corporation, Cigna Holding Company and U.S. Bank National Association, as trustee	Filed by the registrant as Exhibit 4.1 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.4(a)	Indenture dated January 1, 1994 between Cigna Holding Company (formerly Cigna Corporation) and Marine Midland Bank	Filed by CHC as Exhibit 4.2 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
4.4(b)	Supplemental Indenture No. 1 dated as of December 20, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Cigna Holding Company and HSBC Bank USA, National Association (as successor to Marine Midland Bank, N.A.), as Trustee	Filed by the registrant as Exhibit 4.2 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.5(a)	Indenture dated June 30, 1988 between Cigna Holding Company (formerly Cigna Corporation) and Bankers Trust Company	Filed by CHC as Exhibit 4.3 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
4.5(b)	Supplemental Indenture No. 1 dated as of December 20, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Cigna Holding Company and Deutsche Bank Trust Company Americas, a New York banking corporation (as successor to Bankers Trust Company), as Trustee	Filed by the registrant as Exhibit 4.3 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.6(a)	Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company (formerly Aristotle Holding, Inc.), the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by Express Scripts, Inc. ("ESI") as Exhibit 4.1 to the Current Report on Form 8-K filed November 25, 2011 and incorporated herein by reference.

Number	Description	Method of Filing
4.6(b)	Third Supplemental Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESI as Exhibit 4.4 to the Current Report on Form 8-K on November 25, 2011 and incorporated herein by reference.
4.6(c)	Fourth Supplemental Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESI as Exhibit 4.5 to the Current Report on Form 8-K on November 25, 2011 and incorporated herein by reference.
4.6(d)	Seventh Supplemental Indenture, dated as of February 9, 2012, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee, related to Express Scripts Holding Company's 3.900% senior notes due 2022	Filed by ESI as Exhibit 4.3 to the Current Report on Form 8-K filed February 10, 2012 and incorporated herein by reference.
4.6(e)	Eighth Supplemental Indenture, dated as of April 2, 2012, among Express Scripts, Inc., Express Scripts Holding Company, Medco Health Solutions, Inc., the other subsidiaries of Express Scripts Holding Company party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by Express Scripts Holding Company ("ESRX") as Exhibit 4.1 to the Current Report on Form 8-K on April 6, 2012 and incorporated herein by reference.
4.6(f)	Eleventh Supplemental Indenture, dated as of June 5, 2014, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on June 5, 2014 and incorporated herein by reference.
4.6(g)	Twelfth Supplemental Indenture, dated as of June 5, 2014, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on June 5, 2014 and incorporated herein by reference.
4.6(h)	Thirteenth Supplemental Indenture, dated as of June 5, 2014, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on June 5, 2014 and incorporated herein by reference.
4.6(i)	Sixteenth Supplemental Indenture, dated as of February 25, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on February 25, 2016 and incorporated herein by reference.
4.6(j)	Seventeenth Supplemental Indenture, dated as of February 25, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on February 25, 2016 and incorporated herein by reference.
4.6(k)	Eighteenth Supplemental Indenture, dated as of July 5, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on July 5, 2016 and incorporated herein by reference.
4.6(l)	Nineteenth Supplemental Indenture, dated as of July 5, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on July 5, 2016 and incorporated herein by reference.
4.6(m)	Twentieth Supplemental Indenture, dated as of July 5, 2016, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on July 5, 2016 and incorporated herein by reference.
4.6(n)	Twenty-Second Supplemental Indenture, dated as of November 30, 2017, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.1 to the Current Report on Form 8-K on November 30, 2017 and incorporated herein by reference.
4.6(o)	Twenty-Third Supplemental Indenture, dated as of November 30, 2017, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee and Calculation Agent	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on November 30, 2017 and incorporated herein by reference.
4.6(p)	Twenty-Fourth Supplemental Indenture, dated as of November 30, 2017, among Express Scripts Holding Company, the Subsidiary Guarantors party thereto and Wells Fargo Bank, National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on November 30, 2017 and incorporated herein by reference.
4.6(q)	Twenty-Fifth Supplemental Indenture dated as of December 20, 2018, by and among Cigna Corporation, Express Scripts Holding Company and Wells Fargo Bank, National Association, as Trustee	Filed by the registrant as Exhibit 4.4 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.7(a)	Indenture, dated as of June 9, 2009, among Express Scripts, Inc., the Subsidiary Guarantors party thereto and Union Bank, N.A., as Trustee	Filed by ESI as Exhibit 4.1 to the Current Report on Form 8-K on June 10, 2009 and incorporated herein by reference.
4.7(b)	Third Supplemental Indenture, dated as of June 9, 2009, among Express Scripts, Inc., the Subsidiary Guarantors party thereto and Union Bank, N.A., as Trustee	Filed by ESI as Exhibit 4.4 to the Current Report on Form 8-K on June 10, 2009 and incorporated herein by reference.
4.7(c)	Seventh Supplemental Indenture, dated as of November 21, 2011, among Express Scripts, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and Union Bank, N.A., as Trustee	Filed by ESI as Exhibit 4.6 to the Current Report on Form 8-K on November 25, 2011 and incorporated herein by reference.
4.7(d)	Eighth Supplemental Indenture, dated as of April 2, 2012, among Express Scripts, Inc., Express Scripts Holding Company, Medco Health Solutions, Inc., the other subsidiaries of Express Scripts Holding Company party thereto and Union Bank, N.A., as Trustee	Filed by ESRX as Exhibit 4.2 to the Current Report on Form 8-K on April 6, 2012 and incorporated herein by reference.

Number	Description	Method of Filing
4.7(e)	Ninth Supplemental Indenture dated as of December 20, 2018, by and among Cigna Corporation (formerly Halfmoon Parent, Inc.), Express Scripts, Inc. and MUFG Union Bank, N.A. (as successor to Union Bank, N.A.), as Trustee	Filed by the registrant as Exhibit 4.5 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
4.8(a)	Indenture, dated as of March 18, 2008, between Medco Health Solutions, Inc. and U.S. Bank Trust National Association, as Trustee	Filed by Medco Health Solutions, Inc. ("Medco") as Exhibit 4.1 to the Current Report on Form 8-K on March 18, 2008 and incorporated herein by reference.
4.8(b)	Form of Medco Solutions, Inc. 4.125% Notes due 2020	Filed by Medco as Exhibit 4.2 to the Current Report on Form 8-K on September 10, 2010 and incorporated herein by reference.
4.8(c)	First Supplemental Indenture, dated as of April 2, 2012, among Medco Health Solutions, Inc., Express Scripts Holding Company, the other subsidiaries of Express Scripts Holding Company party thereto and U.S. Bank Trust National Association, as Trustee	Filed by ESRX as Exhibit 4.3 to the Current Report on Form 8-K on April 6, 2012 and incorporated herein by reference.
4.8(d)	Second Supplemental Indenture dated as of December 20, 2018, by and among Cigna Corporation, Medco Health Solutions, Inc. and U.S. Bank Trust National Association, as Trustee	Filed by the registrant as Exhibit 4.6 to the Current Report on Form 8-K on December 20, 2018 and incorporated herein by reference.
Exhibits 10.1 through 10.40 are identified as compensatory plans, management contracts or arrangements pursuant to Item 15 of Form 10-K.		
10.1(a)	Cigna Long-Term Incentive Plan as amended and restated effective as of April 26, 2017 (the "Cigna LTIP")	Filed by the registrant as Exhibit 10.1 to the Current Report on Form 8-K on May 1, 2017 and incorporated herein by reference.
10.1(b)	Amendment No. 1, effective January 25, 2018, to the Cigna LTIP	Filed by CHC as Exhibit 10.3 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2018 and incorporated herein by reference.
10.1(c)	Form of Cigna LTIP: Strategic Performance Share Grant Agreement	Filed by CHC as Exhibit 10.4 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.1(d)	Form of Cigna LTIP: Nonqualified Stock Option Grant Agreement	Filed by CHC as Exhibit 10.5 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.1(e)	Form of Cigna LTIP: Restricted Stock Grant Agreement	Filed by CHC as Exhibit 10.6 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.1(f)	Form of Cigna LTIP: Restricted Stock Unit Grant Agreement	Filed by CHC as Exhibit 10.7 to Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.2(a)	HealthSpring, Inc. Amended and Restated 2006 Equity Incentive Plan (the "HealthSpring Equity Incentive Plan")	Filed by the registrant as Exhibit 4.4 to the Registration Statement on Form S-8 (No. 333-228930) filed December 20, 2018 and incorporated herein by reference.
10.2(b)	HealthSpring Equity Incentive Plan: Form of Restricted Share Award	Filed by CHC as Exhibit 10.4 to the Quarterly Report on Form 10-Q for the period ended March 31, 2013 and incorporated herein by reference.
10.2(c)	HealthSpring Equity Incentive Plan: Form of Non-Qualified Stock Option Agreement	Filed by CHC as Exhibit 10.5 to the Quarterly Report on Form 10-Q for the period ended March 31, 2013 and incorporated herein by reference.
10.3	Cigna Corporation Stock Plan, as amended through July 2000	Filed by CHC as Exhibit 10.7 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.4	Cigna Stock Unit Plan, as amended and restated effective February 22, 2017	Filed by CHC as Exhibit 10.5 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2017 and incorporated herein by reference.
10.5(a)	Express Scripts Holding Company 2016 Long-Term Incentive Plan (the "ESRX LTIP")	Filed by ESRX as Appendix A to ESRX's Definitive Proxy Statement on Schedule 14A for its 2016 Annual Meeting of Stockholders, filed March 21, 2016 and incorporated herein by reference.
10.5(b)	Form of Stock Option Grant Notice for Non-Employee Directors used with respect to grants of stock options by Express Scripts Holding Company to non-employee directors under the ESRX LTIP	Filed by ESRX as Exhibit 10.4 to the Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.5(c)	Form of Restricted Stock Unit Grant Notice used with respect to grants of restricted stock units by Express Scripts Holding Company under the ESRX LTIP	Filed by ESRX as Exhibit 10.5 to the Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.5(d)	Form of Stock Option Grant Notice used with respect to grants of stock options by Express Scripts Holding Company under the ESRX LTIP	Filed by ESRX as Exhibit 10.7 to Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.6(a)	Express Scripts, Inc. 2011 Long-Term Incentive Plan (as amended and restated effective April 2, 2012) (the "ESI LTIP")	Filed by the registrant as Exhibit 4.10 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.6(b)	Form of Stock Option Grant Notice for Non-Employee Directors used with respect to grants of stock options by Express Scripts Holding Company under the ESI LTIP	Filed by ESRX as Exhibit 10.6 to Quarterly Report on Form 10-Q for the quarter ended June 30, 2012 and incorporated herein by reference.
10.6(c)	Form of Stock Option Grant Notice used with respect to certain grants of stock options by Express Scripts Holding Company prior to 2013 under the ESI LTIP	Filed by ESRX as Exhibit 10.14 to the Current Report on Form 8-K on April 2, 2012 and incorporated herein by reference.
10.6(d)	Form of Restricted Stock Unit Grant Notice used with respect to grants of restricted stock units by Express Scripts Holding Company under the ESI LTIP	Filed by ESRX as Exhibit 10.2 to the Quarterly Report on Form 10-Q for the quarter ended March 31, 2013 and incorporated herein by reference.
10.6(e)	Form of Stock Option Grant Notice used with respect to grants of stock options by Express Scripts Holding Company under the ESI LTIP	Filed by ESRX as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarter ended March 31, 2013 and incorporated herein by reference.
10.7(a)	Medco Health Solutions, Inc. 2002 Stock Incentive Plan (as amended and restated effective April 2, 2012).	Filed by the registrant as Exhibit 4.11 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.7(b)	Form of terms and conditions for director stock option and restricted stock unit awards	Filed by Medco as Exhibit 10.2 to the Current Report on Form 8-K on February 8, 2005 and incorporated herein by reference.

Number	Description	Method of Filing
10.8	Accredo Health, Incorporated 2002 Long-Term Incentive Plan	Filed by the registrant as Exhibit 4.12 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.9	Deferred Compensation Plan for Directors of Cigna Corporation, as amended and restated January 1, 1997	Filed by CHC as Exhibit 10.1 the Annual Report on Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.10	Cigna Deferred Compensation Plan, as amended and restated October 24, 2001	Filed by CHC as Exhibit 10.14 to the Annual Report on Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.11	Cigna Deferred Compensation Plan of 2005 effective as of January 1, 2005	Filed by the registrant as Exhibit 4.6 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.12	Express Scripts, Inc. Amended and Restated Executive Deferred Compensation Plan (effective December 31, 2004 and grandfathered for the purposes of Section 409A of the Code)	Filed by ESI as Exhibit No. 10.1 to the Current Report on Form 8-K on May 25, 2007 and incorporated herein by reference.
10.13	Express Scripts, Inc. Executive Deferred Compensation Plan of 2005 (as amended and restated effective December 20, 2018)	Filed by the registrant as Exhibit 4.13 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.14(a)	Cigna Supplemental Pension Plan as amended and restated effective August 1, 1998	Filed by CHC as Exhibit 10.15(a) to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.14(b)	Amendment No. 1 to the Cigna Supplemental Pension Plan, amended and restated effective as of September 1, 1999	Filed by CHC as Exhibit 10.15(b) to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.14(c)	Amendment No. 2 dated December 6, 2000 to the Cigna Supplemental Pension	Filed by CHC as Exhibit 10.16(c) to the Annual Report on Form 10-K for the year ended December 31, 2011 and incorporated herein by reference.
10.15(a)	Cigna Supplemental Pension Plan of 2005 effective as of January 1, 2005	Filed by CHC as Exhibit 10.15 to the Annual Report on Form 10-K for the year ended December 31, 2007 and incorporated herein by reference.
10.15(b)	Amendment No. 1 to the Cigna Supplemental Pension Plan of 2005	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2009 and incorporated herein by reference.
10.16	Cigna Supplemental 401(k) Plan effective January 1, 2010	Filed by the registrant as Exhibit 4.7 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.17	Cigna Corporation Non-Employee Director Compensation Program amended and restated effective February 26, 2014	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2014 and incorporated herein by reference.
10.18	Cigna Corporation Non-Employee Director Compensation Program, amended and restated effective January 1, 2019	Filed herewith.
10.19	Cigna Corporation Director Equity Plan	Filed by the registrant as Exhibit 4.5 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.20	Cigna Restricted Share Equivalent Plan for Non-Employee Directors as amended and restated effective January 1, 2008	Filed by CHC as Exhibit 10.4 to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
10.21	Deferred Compensation Plan of 2005 for Directors of Cigna Corporation, Amended and Restated effective April 28, 2010	Filed by the registrant as Exhibit 4.8 to the Registration Statement on Form S-8 (No. 333-228930) on December 20, 2018 and incorporated herein by reference.
10.22	Form of Indemnification Agreement with Express Scripts Holding Company's executive officers and former members of the Express Scripts Holding Company's board of directors	Filed by ESRX as Exhibit 10.1 to the Current Report on Form 8-K on March 5, 2014 and incorporated herein by reference.
10.23	Cigna Executive Severance Benefits Plan as amended and restated effective October 23, 2018	Filed herewith.
10.24	Description of Severance Benefits for Executives in Non-Change of Control Circumstances	Filed by CHC as Exhibit 10.10 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.25	Cigna Executive Incentive Plan amended and restated as of January 1, 2012	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2012 and incorporated herein by reference.
10.26	Description of Cigna Corporation Financial Services Program	Filed by CHC as Exhibit 10.18 to the Annual Report on Form 10-K for the year ended December 31, 2009 and incorporated herein by reference.
10.27	Offer Letter for Eric P. Palmer dated June 16, 2017	Filed by CHC as Exhibit 10.1 to the Current Report on Form 8-K on June 19, 2017 and incorporated herein by reference.
10.28	Nicole Jones' Offer of Employment dated April 27, 2011	Filed by CHC as Exhibit 10.2 to the Quarterly Report on Form 10-Q for the period ended March 31, 2012 and incorporated herein by reference.
10.29	Employment Agreement for Jason D. Sadler dated May 7, 2010	Filed by CHC as Exhibit 10.1(a) to the Quarterly Report on Form 10-Q for the period ended March 31, 2015 and incorporated herein by reference.
10.30	Promotion letter for Jason Sadler dated June 2, 2014	Filed by CHC as Exhibit 10.1(b) to the Quarterly Report on Form 10-Q for the period ended March 31, 2015 and incorporated herein by reference.

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Number	Description	Method of Filing
10.31	Retention Agreement by and between Cigna Corporation and Mr. Timothy Wentworth, dated as of May 12, 2018.	Filed by the registrant as Exhibit 10.1 to Amendment No. 1 to the Registration Statement on Form S-4 (No. 333-224960) on June 20, 2018 and incorporated herein by reference.
10.32	Express Scripts Holding Company Executive Employment Agreement with Timothy Wentworth dated May 4, 2016	Filed by ESRX as Exhibit 10.1 to the Current Report on Form 8-K on May 4, 2016 and incorporated herein by reference.
10.33	Schedule regarding Amended Deferred Stock Unit Agreements effective December 31, 2008 with John M. Murabito and Form of Amended Deferred Stock Unit Agreement	Filed by CHC as Exhibit 10.20 to the Annual Report on Form 10-K for the year ended December 31, 2008 and incorporated herein by reference.
10.34	Retention Agreement between the Cigna Corporation and Steven B. Miller dated October 9, 2018	Filed herewith.
10.35	Agreement and Release between the Company and Matthew G. Manders dated October 16, 2017	Filed by CHC as Exhibit 10.1 to the Current Report on Form 8-K on October 18, 2017 and incorporated herein by reference.
10.36	Agreement and Release between the Company and Thomas A. McCarthy dated June 16, 2017	Filed by CHC as Exhibit 10.2 to the Current Report on Form 8-K on June 19, 2017 and incorporated herein by reference.
10.37	Advisory Services Agreement between the Company and Thomas A. McCarthy dated June 16, 2017	Filed by CHC as Exhibit 10.3 to the Current Report on Form 8-K on June 19, 2017 and incorporated herein by reference.
10.38	Promotion letter for Christopher Hocevar dated January 30, 2017	Filed by CHC as Exhibit 10.8 to the Quarterly Report on Form 10-Q for the period ended March 31, 2018 and incorporated herein by reference.
10.39	Agreement and Release between the Company and Christopher J. Hocevar dated September 26, 2018	Filed by CHC as Exhibit 10.1 to the Quarterly Report on Form 10-Q for the period ended September 30, 2018 and incorporated herein by reference.
10.40	Agreement and Release between the Company and Alan Muney, M.D. effective December 21, 2018	Filed herewith.
10.41(a)	Revolving Credit and Letter of Credit Agreement, dated as of April 6, 2018	Filed by CHC as Exhibit 10.1 to Current Report on Form 8-K on April 12, 2018 and incorporated herein by reference.
10.41(b)	Additional Guarantor Supplement dated as of December 20, 2018, by Express Scripts Holding Company and Cigna Holding Company to that certain Revolving Credit and Letter of Credit Agreement dated as of April 6, 2018, by and among Cigna Holding Company, Cigna Corporation, JPMorgan Chase Bank, N.A., as administrative agent, and the other parties thereto.	Filed by the registrant as Exhibit 4.8 to the Current Report on Form 8-K filed December 20, 2018 and incorporated herein by reference.
10.42(a)	Term Loan Credit Agreement, dated as of April 6, 2018	Filed by CHC as Exhibit 10.2 to Current Report on Form 8-K on April 12, 2018 and incorporated herein by reference.
10.42(b)	Additional Guarantor Supplement dated as of December 20, 2018, by Express Scripts Holding Company and Cigna Holding Company to that certain Term Loan Credit Agreement dated as of April 6, 2018, by and among Cigna Holding Company, Cigna Corporation, Morgan Stanley Senior Funding, Inc., as administrative agent, and the other parties thereto.	Filed by the registrant as Exhibit 4.9 to the Current Report on Form 8-K filed December 20, 2018 and incorporated herein by reference.
10.43	Master Transaction Agreement, dated February 4, 2013 among Connecticut General Life Insurance Company, Berkshire Hathaway Life Insurance Company of Nebraska and, solely for purposes of Sections 3.10, 6.1, 6.3, 6.4, 6.6, 6.9 and Articles II, V, VII, and VIII, thereof, National Indemnity Company (including the Forms of Retrocession Agreement, the Collateral Trust Agreement, the Security and Control Agreement, the Surety Policy and the ALC Model Purchase Option Agreement as exhibits)	Filed by CHC as Exhibit 10.29 to the Annual Report on Form 10-K for the year ended December 31, 2012 and incorporated herein by reference.
21	Subsidiaries of the Registrant	Filed herewith.
23	Consent of Independent Registered Public Accounting Firm	Filed herewith.
31.1	Certification of Chief Executive Officer of Cigna Corporation pursuant to Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934	Filed herewith.
31.2	Certification of Chief Financial Officer of Cigna Corporation pursuant to Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934	Filed herewith.
32.1	Certification of Chief Executive Officer of Cigna Corporation pursuant to Rule 13a-14(b) or Rule 15d-14(b) and 18 U.S.C. Section 1350	Furnished herewith.
32.2	Certification of Chief Financial Officer of Cigna Corporation pursuant to Rule 13a-14(b) or Rule 15d-14(b) and 18 U.S.C. Section 1350	Furnished herewith.
101	The following materials from Cigna Corporation's Annual Report on Form 10-K for the year ended December 31, 2018, formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Changes in Total Equity; (vi) the Notes to Consolidated Financial Statements; and (vii) Financial Statement Schedules I, II, III, IV and V.	Filed herewith.

Item 16. 10-K SUMMARY

None.

SIGNATURES

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

CIGNA CORPORATION

Date:	February 28, 2019
By:	/s/ Eric P. Palmer
	Eric P. Palmer
	Executive Vice President and Chief Financial Officer (Principal Financial Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated as of February 28, 2019.

Signature	Title
/s/ David M. Cordani **David M. Cordani**	Chief Executive Officer and Director (Principal Executive Officer)
/s/ Eric P. Palmer **Eric P. Palmer**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)
/s/ Mary T. Agoglia Hoeltzel **Mary T. Agoglia Hoeltzel**	Senior Vice President, Tax and Chief Accounting Officer (Principal Accounting Officer)
/s/ William J. DeLaney **William J. DeLaney**	Director
/s/ Eric J. Foss **Eric J. Foss**	Director
/s/ Elder Granger, M.D. **Elder Granger, M.D.**	Director
/s/ Isaiah Harris, Jr. **Isaiah Harris, Jr.**	Chairman of the Board
/s/ Mark McClellan, M.D. **Mark McClellan, M.D.**	Director
/s/ Roman Martinez IV **Roman Martinez IV**	Director
/s/ Kathleen M. Mazzarella **Kathleen M. Mazzarella**	Director
/s/ John M. Partridge **John M. Partridge**	Director
/s/ William L. Roper, M.D. **William L. Roper, M.D.**	Director
/s/ Eric C. Wiseman **Eric C. Wiseman**	Director
/s/ Donna F. Zarcone **Donna F. Zarcone**	Director
/s/ William D. Zollars **William D. Zollars**	Director

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Cigna Corporation and Subsidiaries

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Schedules other than those listed above are omitted because they are not required or are not applicable, or the required information is shown in the financial statements or notes thereto.

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Report of Independent Registered Public Accounting Firm on Financial Statement Schedules

To the Board of Directors and Shareholders of Cigna Corporation

Our audits of the consolidated financial statements referred to in our report dated February 28, 2019 (which report and consolidated financial statements are included under Item 8 in this Annual Report on Form 10-K) also included an audit of the financial statement schedules listed in Item 15(a)(2) of this Form 10-K. In our opinion, these financial statement schedules present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements.

/s/ PricewaterhouseCoopers LLP
Hartford, Connecticut
February 28, 2019

Cigna Corporation and Subsidiaries
Schedule I – Condensed Financial Information of Cigna Corporation (Registrant)

Statements of Income

	For the years ended December 31,		
	Cigna*	Old Cigna*	Old Cigna*
(in millions)	2018	2017	2016
Revenues			
Net investment income	$ 123	$ —	$ —
Total revenues	123	—	—
Operating expenses			
Selling, general and administrative expenses	200	195	281
Total operating expenses	200	195	281
Income (loss) from operations	(77)	(195)	(281)
Interest and other (expense)	(244)	(246)	(244)
Intercompany interest (expense)	(5)	(18)	(3)
Debt extinguishment costs	—	(321)	—
Realized investment (loss)	(1)	—	—
Loss before taxes	(327)	(780)	(528)
Income tax (benefit)	(74)	(194)	(146)
Loss of Parent Company	(253)	(586)	(382)
Equity in income of subsidiaries	2,890	2,823	2,249
Shareholders' net income	2,637	2,237	1,867
Shareholders' other comprehensive income (loss)			
Net unrealized (depreciation) on securities and derivatives	(365)	(37)	(60)
Net translation gains (losses) of foreign currencies	(152)	304	(95)
Postretirement benefits liability adjustment	127	33	23
Shareholders' other comprehensive income (loss):	(390)	300	(132)
Shareholders' comprehensive income	$ 2,247	$ 2,537	$ 1,735

* As described in Note 3, on December 20, 2018, through the "Merger," Old Cigna merged into a wholly-owned subsidiary of Cigna, and Cigna became the Registrant. Refer to Note 20 for Condensed Consolidated Financial Statements of Cigna and Old Cigna.

Cigna Corporation and Subsidiaries
Schedule I – Condensed Financial Information of Cigna Corporation (Registrant)

Balance Sheets

	As of December 31,	
	Cigna*	Old Cigna*
(in millions)	2018	2017
Assets		
Cash and cash equivalents	$ 243	$ 9
Short-term investments	—	63
Other current assets	14	31
Total current assets	257	103
Intercompany receivable	—	200
Investments in subsidiaries	68,969	22,631
Other noncurrent assets	48	221
TOTAL ASSETS	$ 69,274	$ 23,155
Liabilities		
Short-term debt	$ —	$ 231
Other current liabilities	418	270
Total current liabilities	418	501
Intercompany payable	4,965	2,980
Long-term debt	22,863	5,112
Other noncurrent liabilities	—	851
TOTAL LIABILITIES	28,246	9,444
Shareholders' Equity		
Common stock (shares issued, 381 and 296; authorized, 600)	4	74
Additional paid-in capital	27,751	2,940
Accumulated other comprehensive loss	(1,711)	(1,082)
Retained earnings	15,088	15,800
Less treasury stock, at cost	(104)	(4,021)
TOTAL SHAREHOLDERS' EQUITY	41,028	13,711
TOTAL LIABILITIES AND SHAREHOLDERS' EQUITY	$ 69,274	$ 23,155

* As described in Note 3, on December 20, 2018, through the "Merger," Old Cigna merged into a wholly-owned subsidiary of Cigna, and Cigna became the Registrant. Refer to Note 20 for Condensed Consolidated Financial Statements of Cigna and Old Cigna.

Cigna Corporation and Subsidiaries
Schedule I – Condensed Financial Information of Cigna Corporation (Registrant)

Statements of Cash Flows

	For the years ended December 31,		
	Cigna*	**Old Cigna***	**Old Cigna***
(in millions)	**2018**	**2017**	**2016**
Cash Flows from Operating Activities			
Shareholders' net income	**$ 2,637**	$ 2,237	$ 1,867
Adjustments to reconcile shareholders' net income to net cash provided by operating activities			
Equity in income of subsidiaries	**(2,890)**	(2,823)	(2,249)
Dividends received from subsidiaries	**—**	758	580
Other liabilities	**412**	(224)	(9)
Debt extinguishment costs	**—**	321	—
Other, net	**(14)**	333	187
NET CASH PROVIDED BY OPERATING ACTIVITIES	**145**	602	376
Cash Flows from Investing Activities			
Short-term investment purchased, net	**—**	(6)	(3)
Other, net	**(27,115)**	(11)	(8)
NET CASH (USED IN) PROVIDED BY INVESTING ACTIVITIES	**(27,115)**	(17)	(11)
Cash Flows from Financing Activities			
Net change in amounts due to (from) affiliates	**4,437**	1,955	(78)
Net change in short-term debt	**—**	100	(100)
Payments for debt extinguishment	**—**	(313)	—
Repayment of long-term debt	**—**	(1,250)	—
Net proceeds on issuance of long-term debt	**22,856**	1,581	—
Issuance of common stock	**1**	131	36
Common dividends paid	**—**	(10)	(10)
Repurchase of common stock	**(32)**	(2,725)	(139)
Tax withholding on stock compensation and other	**(49)**	(63)	(72)
NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES	**27,213**	(594)	(363)
Net increase (decrease) in cash and cash equivalents	**243**	(9)	2
Cash and cash equivalents, beginning of year	**—**	18	16
Cash and cash equivalents, end of year	**$ 243**	$ 9	$ 18

* *As described in Note 3, on December 20, 2018, through the "Merger," Old Cigna merged into a wholly-owned subsidiary of Cigna, and Cigna became the Registrant. Refer to Note 20 for Condensed Consolidated Financial Statements of Cigna and Old Cigna.*

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Cigna Corporation and Subsidiaries
Schedule I – Condensed Financial Information of Cigna Corporation (Registrant)

Notes to Condensed Financial Statements

The accompanying condensed financial statements should be read in conjunction with the Consolidated Financial Statements and the accompanying notes thereto contained in this Annual Report on Form 10-K ("Form 10-K").

Note 1 – For purposes of these condensed financial statements, Cigna Corporation's (the "Company") wholly-owned and majority-owned subsidiaries are recorded using the equity basis of accounting.

Note 2 – See Note 5 – Debt included in Part II, Item 8 of this Form 10-K for a description of the short-term and long-term debt obligations of Cigna Corporation and its subsidiaries. Maturity of the Company's long-term debt is as follows:

(In millions)	
2019	$ —
2020	$ 2,750
2021	$ 5,250
2022	$ —
2023	$ 3,800
Maturities after 2023	$ 11,200

Note 3 – Intercompany liabilities of the Company consist primarily of payables to Old Cigna of $4.3 billion as of December 31, 2018. Intercompany liabilities of Old Cigna consisted primarily of payables to Cigna Holdings, Inc. of $2.8 billion as of December 31, 2017. Interest was accrued at an average monthly rate of 2.33% for 2018 and 1.47% for 2017.

Note 4 – The Company had guarantees of approximately $19.6 billion as of December 31, 2018. These guarantees are related to outstanding debt of certain wholly-owned subsidiaries as described in Note 5 and Note 20. In 2018, no payments have been made on these guarantees.

Cigna Corporation and Subsidiaries
Schedule II – Valuation and Qualifying Accounts and Reserves

(in millions) **Description**	**Balance at beginning of year**	**Charged (Credited) to costs and expenses**	**Charged (Credited) to other accounts**	**Other deductions**	**Balance at end of year**
2018					
Allowance for doubtful accounts					
Premiums, accounts and notes receivable	**$ 207**	**$ 18**	**$ (3)**	**$ (5)**	**$ 217**
Deferred tax asset valuation allowance	**$ 72**	**$ (5)**	**$ 132**	**$ –**	**$ 199**
Reinsurance recoverables	**$ 3**	**$ (1)**	**$ –**	**$ –**	**$ 2**
2017					
Investment asset valuation reserves					
Commercial mortgage loans	$ 5	$ 1	$ –	$ (6)	$ –
Allowance for doubtful accounts					
Premiums, accounts and notes receivable	$ 200	$ 19	$ (11)	$ (1)	$ 207
Deferred tax asset valuation allowance [1]	$ 87	$ 11	$ (26)	$ –	$ 72
Reinsurance recoverables	$ 3	$ –	$ –	$ –	$ 3
2016					
Investment asset valuation reserves					
Commercial mortgage loans	$ 15	$ –	$ –	$ (10)	$ 5
Allowance for doubtful accounts					
Premiums, accounts and notes receivable	$ 75	$ 134	$ (8)	$ (1)	$ 200
Deferred tax asset valuation allowance	$ 71	$ 21	$ (5)	$ –	$ 87
Reinsurance recoverables	$ 3	$ –	$ –	$ –	$ 3

(1) Deferred tax valuation allowance amount includes amount assumed from Express Scripts in 2018.

Exhibit 21 Subsidiaries of the Registrant

Listed below are subsidiaries of Cigna Corporation as of December 31, 2018 with their jurisdictions of organization. Those subsidiaries not listed would not, in the aggregate, constitute a "significant subsidiary" of Cigna Corporation, as that term is defined in Rule 1-02(w) of Regulation S-X.

Entity Name	Jurisdiction
Accredo Health Group, Inc.	Delaware
Allegiance Life & Health Insurance Company, Inc.	Montana
Allegiance Re, Inc.	Montana
American Retirement Life Insurance Company	Ohio
Benefits Management Corp.	Montana
Bravo Health Mid-Atlantic, Inc.	Maryland
Bravo Health Pennsylvania, Inc.	Pennsylvania
CareAllies, Inc.	Delaware
Central Reserve Life Insurance Company	Ohio
Ceres Sales of Ohio, LLC	Ohio
Cigna & CMB Life Insurance Company Limited	China
Cigna Apac Holdings Limited	Bermuda
Cigna Arbor Life Insurance Company	Connecticut
Cigna Beechwood Holdings, SdC/MTS	Belgium
Cigna Behavioral Health of California, Inc.	California
Cigna Behavioral Health of Texas, Inc.	Texas
Cigna Behavioral Health, Inc.	Minnesota
Cigna Bellevue Alpha, LLC	Delaware
Cigna Benefits Financing, Inc.	Delaware
Cigna Brokerage & Marketing (Thailand) Limited	Thailand
Cigna Cedar Holdings, Ltd.	Malta
Cigna Chestnut Holdings, Ltd.	United Kingdom
Cigna Corporate Services, LLC	Delaware
Cigna Data Services (Shanghai) Company Limited	China
Cigna Dental Health of California, Inc.	California
Cigna Dental Health of Colorado, Inc.	Colorado
Cigna Dental Health of Delaware, Inc.	Delaware
Cigna Dental Health of Florida, Inc.	Florida
Cigna Dental Health of Illinois, Inc.	Illinois
Cigna Dental Health of Kansas, Inc.	Kansas
Cigna Dental Health of Kentucky, Inc.	Kentucky
Cigna Dental Health of Maryland, Inc.	Maryland
Cigna Dental Health of Missouri, Inc.	Missouri
Cigna Dental Health of New Jersey, Inc.	New Jersey
Cigna Dental Health of North Carolina, Inc.	North Carolina
Cigna Dental Health of Ohio, Inc.	Ohio
Cigna Dental Health of Pennsylvania, Inc.	Pennsylvania
Cigna Dental Health of Texas, Inc.	Texas
Cigna Dental Health of Virginia, Inc.	Virginia
Cigna Dental Health Plan of Arizona, Inc.	Arizona
Cigna Dental Health, Inc.	Florida
Cigna Elmwood Holdings, SPRL	Belgium
Cigna Europe Insurance Company S.A.-N.V.	Belgium
Cigna European Services (UK) Limited	United Kingdom
Cigna Finans Emeklilik ve Hayat A.S.	Turkey
Cigna Global Holdings, Inc.	Delaware
Cigna Global Insurance Company Limited	Guernsey, C.I
Cigna Global Reinsurance Company, Ltd.	Bermuda
Cigna Global Wellbeing Holdings Limited	United Kingdom
Cigna Global Wellbeing Solutions Limited	United Kingdom
Cigna Health and Life Insurance Company	Connecticut
Cigna Health Corporation	Delaware
Cigna Health Management, Inc.	Delaware
Cigna Health Solutions India Pvt. Ltd.	India
Cigna Healthcare Holdings, Inc.	Colorado
Cigna Healthcare Mid-Atlantic, Inc.	Maryland
Cigna Healthcare of Arizona, Inc.	Arizona
Cigna Healthcare of California, Inc.	California
Cigna Healthcare of Colorado, Inc.	Colorado
Cigna Healthcare of Connecticut, Inc.	Connecticut
Cigna Healthcare of Florida, Inc.	Florida
Cigna Healthcare of Georgia, Inc.	Georgia
Cigna Healthcare of Illinois, Inc.	Illinois
Cigna Healthcare of Indiana, Inc.	Indiana
Cigna Healthcare of Maine, Inc.	Maine
Cigna Healthcare of Massachusetts, Inc.	Massachusetts
Cigna Healthcare of New Hampshire, Inc.	New Hampshire
Cigna Healthcare of New Jersey, Inc.	New Jersey
Cigna Healthcare of North Carolina, Inc.	North Carolina

Entity Name	Jurisdiction
Cigna Healthcare of Pennsylvania, Inc.	Pennsylvania
Cigna Healthcare of South Carolina, Inc.	South Carolina
Cigna Healthcare of St. Louis, Inc.	Missouri
Cigna Healthcare of Tennessee, Inc.	Tennessee
Cigna Healthcare of Texas, Inc.	Texas
Cigna Healthcare of Utah, Inc.	Utah
Cigna HLA Technology Services Company Limited	Hong Kong
Cigna Holdings Overseas, Inc.	Delaware
Cigna Holdings, Inc.	Delaware
Cigna Hong Kong Holdings Company Limited	Hong Kong
Cigna Insurance Public Company Limited	Thailand
Cigna Insurance Middle East S.A.	Lebanon
Cigna Insurance Services (Europe) Limited	United Kingdom
Cigna Intellectual Property, Inc.	Delaware
Cigna International Corporation	Delaware
Cigna International Health Services Kenya Limited	Kenya
Cigna International Health Services SDN BHD	Malaysia
Cigna International Health Services BVBA	Belgium
Cigna International Health Services, LLC	Florida
Cigna International Services, Inc.	Delaware
Cigna International Services Australia Pty. Ltd.	Australia
Cigna Investment Group, Inc.	Delaware
Cigna Investments, Inc.	Delaware
Cigna Korean Chusik Hoesa	South Korea
Cigna Laurel Holdings, Ltd.	Bermuda
Cigna Legal Protection UK Ltd.	United Kingdom
Cigna Life Insurance Company of Canada	Canada
Cigna Life Insurance Company of Europe S.A.- N.V.	Belgium
Cigna Life Insurance Company of New York	New York
Cigna Life Insurance New Zealand Limited	New Zealand
Cigna Linden Holdings, Inc.	Delaware
Cigna Magnolia Holdings, Ltd.	Bermuda
Cigna Myrtle Holdings, Ltd.	Malta
Cigna Nederland Alpha Cooperatief U.A.	Netherlands
Cigna Nederland Beta B.V.	Netherlands
Cigna Nederland Gamma B.V.	Netherlands
Cigna Oak Holdings, Ltd.	United Kingdom
Cigna Palmetto Holdings, Ltd.	Bermuda
Cigna Poplar Holdings, Inc.	Delaware
Cigna Sequoia Holdings, SPRL	Belgium
Cigna Taiwan Life Assurance Company Limited	Taiwan
CignaTTK Health Insurance Company Limited	India
Cigna Walnut Holdings, Ltd.	United Kingdom
Cigna Willow Holdings, Ltd.	United Kingdom
Cigna Worldwide General Insurance Company Limited	Hong Kong
Cigna Worldwide Insurance Company	Delaware
Cigna Worldwide Life Insurance Company Limited	Hong Kong
Connecticut General Corporation	Connecticut
Connecticut General Life Insurance Company	Connecticut
Express Scripts, Inc.	Delaware
Express Scripts Holding Company	Delaware
FirstAssist Administration Limited	United Kingdom
Great-West Healthcare of Illinois, Inc.	Illinois
Grown Ups New Zealand Limited	New Zealand
Health-Lynx LLC	New Jersey
Healthsource, Inc.	New Hampshire
HealthSpring, Inc.	Delaware
HealthSpring of Alabama, Inc.	Alabama
HealthSpring of Florida, Inc.	Florida
HealthSpring Life & Health Insurance Company, Inc.	Texas
HealthSpring of Tennessee, Inc.	Tennessee
KDM Thailand Limited	Thailand
Life Insurance Company of North America	Pennsylvania
LINA Financial Services	South Korea
LINA Life Insurance Company of Korea	South Korea
Loyal American Life Insurance Company	Ohio
MCC Independent Practice Association of New York, Inc.	New York
Medco Health Solutions, Inc.	Delaware
NewQuest, LLC	Texas
NewQuest Management Northeast, LLC	Delaware
Olympic Health Management Services, Inc.	Washington
Oz Parent, Inc.	Delaware
Provident American Life and Health Insurance Company	Ohio
PT Asuransi Cigna	Indonesia
Qualcare Alliance Networks, Inc.	New Jersey
Qualcare Captive Insurance Company Inc. PCC	New Jersey

Entity Name	Jurisdiction
Qualcare Management Resources Limited Liability Company	New Jersey
Qualcare, Inc.	New Jersey
RHP (Thailand) Limited	Thailand
Scibal Associates, Inc.	New Jersey
Sterling Life Insurance Company	Illinois
Tel-Drug, Inc.	South Dakota
Tel-Drug of Pennsylvania, LLC	Pennsylvania
Temple Insurance Company Limited	Bermuda
United Benefit Life Insurance Company	Ohio

EXHIBIT 23 Consent of Independent Registered Public Accounting Firm

We hereby consent to the incorporation by reference in the Registration Statements on Form S-8 (Nos. 333-228930 and 333-228931) of Cigna Corporation of our reports dated February 28, 2019 relating to the financial statements and financial statement schedules and the effectiveness of internal control over financial reporting, which appear in this Form 10-K.

/s/ PricewaterhouseCoopers LLP
Hartford, Connecticut
February 28, 2019

EXHIBIT 31.1 Certification

I, DAVID M. CORDANI, certify that:

1. I have reviewed this Annual Report on Form 10-K of Cigna Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ David M. Cordani

Chief Executive Officer

Date: February 28, 2019

Aetna Better Health® of Kentucky
Att E-2123

EXHIBIT 31.2 Certification

I, ERIC P. PALMER, certify that:

1. I have reviewed this Annual Report on Form 10-K of Cigna Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
   b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
   a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Eric P. Palmer

Chief Financial Officer

Date: February 28, 2019

EXHIBIT 32.1 Certification of Chief Executive Officer of Cigna Corporation pursuant to 18 U.S.C. Section 1350

I certify that, to the best of my knowledge and belief, the Annual Report on Form 10-K of Cigna Corporation for the fiscal period ending December 31, 2018 (the "Report"):

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

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Cigna Corporation.

/s/ David M. Cordani

David M. Cordani
Chief Executive Officer
February 28, 2019

Aetna Better Health® of Kentucky
Att E-2125

EXHIBIT 32.2 Certification of Chief Financial Officer of Cigna Corporation pursuant to 18 U.S.C. Section 1350

I certify that, to the best of my knowledge and belief, the Annual Report on Form 10-K of Cigna Corporation for the fiscal period ending December 31, 2018 (the "Report"):

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

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of Cigna Corporation.

/s/ Eric P. Palmer

Eric P. Palmer
Chief Financial Officer
February 28, 2019

Health Management Systems, Inc.

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ANNUAL REPORT 2018

hms®

Moving healthcare forward.

William C. Lucia
Chairman & Chief Executive Officer

Dear Shareholder:

Our Company executed well in 2018 and our positive operating and financial performance led to strong shareholder returns. Our results included record revenues, improved profitability and a strengthened balance sheet, which provides a solid foundation for continued success in the year ahead.

More specifically, total revenue for the year was just under $600 million after topping $500 million for the first time in 2017. Revenue from commercial customers grew double digits, while payment integrity and total population management revenues were both up in excess of 20%. Earnings per share for the full year increased 36% and adjusted EPS, excluding discrete tax benefits in both years, jumped 46% year-over-year. Net income and adjusted EBITDA were 37% and 30% higher, respectively, as we benefited from strong contribution margin on incremental revenue growth and the early-stage operational efficiencies generated from our technology investments. Operating cash flow in 2018 was nearly $100 million, and we ended the year with very low net debt and a liquidity profile that positions HMS well to continue investing for future business growth.

We also accomplished several important strategic goals in 2018. We leveraged our investments in advanced technologies to streamline operating processes and boost profit margins. We ramped up our cross-selling activities with the Eliza consumer engagement platform in our first full year of ownership. And we expanded our product suite with the launch of an innovative, internally developed clinical analytics and risk stratification tool – Elli. It uses historical claims data to produce actionable, predictive analytics to help identify at-risk and potentially high-cost members as early as the point of enrollment.

We continue to believe the macro backdrop for the services we offer is favorable, and we see significant opportunity for market expansion of the payment accuracy and total population management services we currently offer. We expect that our robust and market-leading data, advanced analytics capabilities, expansive customer base and engaged workforce will serve as a strong foundation to help reduce the cost of health care and improve patient health and overall consumer experience of care, while driving growth for HMS for many years to come.

In fact, we expect the need for the types of services HMS provides will only increase over the next decade. Consistent with what has been a multi-year trend of escalating healthcare spending, CMS recently estimated healthcare costs will grow at a 5.5% annual pace over the next several years – reaching 19.4% of GDP by 2027. These rising costs continue to drive demand for payment accuracy and actionable analytics and technology solutions to improve patient engagement.

As consumers have taken on increased financial responsibility in recent years, new care delivery models focused on treating the whole person – including addressing behavioral and social determinants of health – have gained greater acceptance. These trends have also contributed to heightened interest among payers, providers and consumers in pursuit of solutions which reduce costs, improve health outcomes and enhance the individual member experience.

HMS is well positioned to assist those key constituencies in this important mission. Our approach to total population management provides personalized engagement and care plans at enterprise scale – leading to needed behavioral change, healthier outcomes and more satisfied consumers.

Our introduction of Elli last year significantly enhances our ability to provide actionable insights to customers. We can now create a health profile of new enrollees, for example, so appropriate medical management activities can begin expeditiously – rather than payers and their care management personnel waiting months to identify an individual member's needs. Going forward, we are promoting and selling Elli together with our Essette care management and Eliza multi-model engagement platforms as a comprehensive suite of services to efficiently manage the health of any discrete population.

Looking ahead, we expect 2019 will be another strong year of top line and bottom line growth. We are projecting total revenue will be 8 - 10% higher than last year (excluding the impact of a Medicare RAC reserve release in the first quarter of 2018), and expect both net income and adjusted EBITDA will continue to grow at a rate faster than revenue. We plan to continue our increased investment in technology, in order to develop innovative products, support data security and enhance our IT infrastructure. We believe we are only in the early innings of realizing the full benefits of machine learning, robotics and other technological enhancements that further our automation initiatives and continue to increase efficiencies, lower costs and improve yields across our business.

Our strategic framework for achieving our Company's 2019 operating and financial goals includes four pillars:

- Broadening the use of technology to expand margins and profitability by maintaining a focus on product yield and process improvements, while diligently managing operating expenses;
- Increasing sales by expanding our existing customer relationships and capturing new logos;
- Expanding our market opportunities by continuing to develop innovative new products, pursuing strategic acquisition opportunities, and moving further into markets where HMS is relatively less penetrated, such as self-insured employers, PBMs and other risk-bearing entities; and
- Continuing to focus on employee engagement and a high-performance culture, which rewards outstanding individual achievement and positions HMS to retain and recruit top talent as we grow.

We are very proud of our significant achievements last year, and look forward to 2019 with deep appreciation for the support and encouragement we have received from shareholders. We are confident that we have the right talent, strategic focus and operational tools in place to achieve our objectives this year and in the future.

Sincerely,

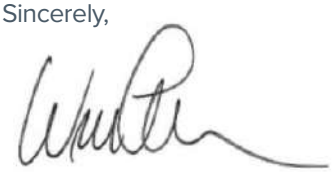

William C. Lucia
Chairman and Chief Executive Officer
April 12, 2019

Safe Harbor: This letter contains certain "forward-looking statements" within the meaning of the U.S. Private Securities Litigation Reform Act of 1995. These statements relate to our current expectations, projections and assumptions about our business, the economy and future events or conditions; they do not relate strictly to historical or current facts. For a discussion identifying important factors that could cause actual results to differ from those stated or implied in our forward-looking statements, see the Company's filings with the SEC, including, but not limited to the "Cautionary Note Regarding Forward-Looking Statements," "Risk Factors," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and "Quantitative and Qualitative Disclosures about Market Risk" in the Form 10-K portion of this Annual Report. Our forward-looking statements speak only as of the date of this letter or as of the date they are made, and we undertake no obligation to update them.

Additionally, this letter contains certain non-GAAP measures that our management believes are relevant and provide our shareholders with useful information about the Company's operating performance because the measures allow them to understand and compare the Company's actual and expected operating results during the prior, current and future periods in a more consistent manner. These non-GAAP measures are not measurements of financial performance or liquidity under GAAP and should not be considered alternatives to the Company's other financial information determined under GAAP. For a reconciliation of these non-GAAP measures to comparable GAAP measures, please refer to Appendix A.

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

Form 10-K

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

For the fiscal year ended December 31, 2018

Or

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

For the transition period from to

Commission File Number 000-50194

HMS HOLDINGS CORP.

(Exact name of registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	11-3656261 (I.R.S. Employer Identification No.)
5615 High Point Drive, Irving, TX (Address of principal executive offices)	75038 (Zip Code)

(214) 453-3000
(Registrant's telephone number, including area code)

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

Title of each class	Name of each exchange on which registered
Common Stock $0.01 par value	The Nasdaq Stock Market LLC (Nasdaq Global Select Market)

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

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

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

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

The aggregate market value of the registrant's common stock held by non-affiliates as of June 29, 2018 the last business day of the registrant's most recently completed second quarter was approximately $1.8 billion based on the last reported sale price of the registrant's common stock on the Nasdaq Global Select Market on that date. Solely for purposes of this disclosure, shares of common stock held by executive officers, directors and persons who hold 10% or more of the outstanding shares of common stock of the registrant as of such date have been excluded because such persons may be deemed to be affiliates. This determination is not necessarily a conclusive determination for any other purposes.

There were 85,271,867 shares of common stock outstanding as of February 15, 2019.

Documents Incorporated by Reference

Unless provided in an amendment to this Annual Report on Form 10-K, the information required by Part III is incorporated by reference to the registrant's 2019 definitive proxy statement, to the extent stated herein. Such proxy statement or amendment will be filed with the Securities and Exchange Commission within 120 days of the registrant's fiscal year ended December 31, 2018.

HMS HOLDINGS CORP. AND SUBSIDIARIES
ANNUAL REPORT ON FORM 10-K
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Glossary of Terms and Abbreviations

ACA	Patient Protections and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010
ACO	Accountable Care Organization
ADR	Additional Documentation Request
ASO	Administrative Service Only
ASU	Accounting Standards Update
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CMS NHE	CMS National Health Expenditures
COB	Coordination of Benefits
COSO	Committee of Sponsoring Organizations of the Treadway Commission
Credit Agreement	The Amended and Restated Credit Agreement dated as of May 3, 2013, as amended by Amendment No. 1 to Amended and Restated Credit Agreement dated as of March 8, 2017, and as further amended by Amendment No. 2 to Amended and Restated Credit Agreement, dated as of December 19, 2017, by and among HMS Holdings Corp., the Guarantors party thereto, the Lenders party thereto and Citibank, N.A. as Administrative Agent
DSO	Days Sales Outstanding
ERISA	Employment Retirement Income Security Act of 1974
Exchange Act	Securities Exchange Act of 1934, as amended
FASB	Financial Accounting Standards Board
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITECH	Health Information Technology for Economic and Clinical Health
IRC	Internal Revenue Code
IRS	U.S. Internal Revenue Service
LIBO Rate	Intercontinental Exchange London Interbank Offered Rate (or any successor rate determined in accordance with the Credit Agreement)
MCO	Managed care organization
PBM	Pharmacy Benefit Manager
PHI	Protected health information
PI	Payment Integrity
R&D Credit	U.S. Research and Experimentation Tax Credit pursuant to IRC Section 41
RAC	Recovery Audit Contractor
RFP	Request for proposal
SEC	U.S. Securities and Exchange Commission
Securities Act	Securities Act of 1933, as amended
Section 199 Deduction	U.S. Production Activities Deduction pursuant to IRC Section 199
SG&A	Selling, general and administrative
TPL	Third-party liability
TPM	Total Population Management
U.S. GAAP	United States Generally Accepted Accounting Principles
401(k) Plan	HMS Holdings Corp. 401(k) Plan
2006 Stock Plan	HMS Holdings Corp. Fourth Amended and Restated 2006 Stock Plan, as amended by Amendment No. 1 to the HMS Holdings Corp. Fourth Amended and Restated 2006 Stock Plan dated as of February 16, 2012
2011 HDI Plan	HDI Holdings, Inc. Amended 2011 Stock option and Stock Issuance Plan
2016 Omnibus Plan	HMS Holdings Corp. 2016 Omnibus Incentive Plan
2017 Tax Act	Tax Cuts and Jobs Act of 2017
2018 Form 10-K	HMS Holdings Corp. Annual Report on Form 10-K for the year ended December 31, 2018

Cautionary Note Regarding Forward-Looking Statements

For purposes of this 2018 Form 10-K, the terms "HMS," "Company," "we, "us, and "our" refer to HMS Holdings Corp. and its consolidated subsidiaries unless the context clearly indicates otherwise. Included in this 2018 Form 10-K are "forward-looking statements" within the meaning of the U.S. Private Securities Litigation Reform Act of 1995. From time to time, we also provide forward-looking statements in other materials we release to the public, as well as oral forward-looking statements. Such statements relate to our current expectations, projections and assumptions about our business, the economy and future events or conditions. They do not relate strictly to historical or current facts.

We have tried to identify forward-looking statements by using words such as "aim," "anticipate," "believe," "estimate," "expect," "forecast," "future," "intend," "likely," "may," "plan," "project," "seek," "strategy," "target," "will," "would," "could," "should," and similar expressions and references to guidance, although some forward-looking statements may be expressed differently. These statements include, among other things, information concerning our future growth, business strategy, strategic or operational initiatives, our future operating or financial performance, our ability to invest in and utilize our data and analytics capabilities to expand our capabilities, the benefits and synergies to be obtained from completed and future acquisitions, the future performance of companies we have acquired, our future expenses, interest rates and tax rates, our ability to meet our future liquidity requirements, the impact of changes to U.S. healthcare legislation or healthcare spending affecting Medicare, Medicaid or other publicly funded or subsidized health programs, and other statements regarding our possible future actions, business plans, objectives and prospects.

Forward-looking statements are not guarantees and involve risks, uncertainties and assumptions that are difficult to predict. Actual results may differ materially from past results and from those indicated by such forward-looking statements if known or unknown risks or uncertainties materialize, or if underlying assumptions prove inaccurate. These risks and uncertainties include, among other things:

- *our ability to execute our business plans or growth strategy;*
- *our ability to innovate, develop or implement new or enhanced solutions or services;*
- *the nature of investment and acquisition opportunities we are pursuing, and the successful execution of such investments and acquisitions;*
- *our ability to successfully integrate acquired businesses and realize synergies;*
- *significant competition for our solutions and services;*
- *variations in our results of operations;*
- *our ability to accurately forecast the revenue under our contracts and solutions;*
- *our ability to protect our systems from damage, interruption or breach, and to maintain effective information and technology systems and networks;*
- *our ability to protect our intellectual property rights, proprietary technology, information processes and know-how;*
- *our failure to maintain a high level of customer retention or the unexpected reduction in scope or termination of key contracts with major customers;*
- *customer dissatisfaction or our non-compliance with contractual provisions or regulatory requirements;*
- *our failure to meet performance standards triggering significant costs or liabilities under our contracts;*
- *our inability to manage our relationships with data sources and suppliers;*
- *our reliance on subcontractors and other third party providers and parties to perform services;*
- *our ability to continue to secure contracts and favorable contract terms through the competitive bidding process;*
- *pending or threatened litigation;*
- *unfavorable outcomes in legal proceedings;*
- *our success in attracting and retaining qualified employees and members of our management team;*
- *our ability to generate sufficient cash to cover our interest and principal payments under our credit facility;*
- *unexpected changes in tax laws, regulations or guidance and unexpected changes in our effective tax rate;*
- *unanticipated increases in the number or amount of claims for which we are self-insured;*
- *changes in the U.S. healthcare environment or healthcare financing system, including regulatory, budgetary or political actions that affect healthcare spending or the practices and operations of healthcare organizations;*
- *our failure to comply with applicable laws and regulations governing individual privacy and information security or to protect such information from theft and misuse;*
- *our ability to comply with current and future legal and regulatory requirements;*

- *negative results of government or customer reviews, audits or investigations;*
- *state or federal limitations related to outsourcing of certain government programs or functions;*
- *restrictions on bidding or performing certain work due to perceived conflicts of interests;*
- *the market price of our common stock and lack of dividend payments; and*
- *anti-takeover provisions in our corporate governance documents.*

These and other risks are discussed under the headings "Part I, Item 1. Business," "Part I, Item 1A. Risk Factors," "Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations," and "Part II, Item 7A. Quantitative and Qualitative Disclosures about Market Risk" of this 2018 Form 10-K and in other documents we file with the SEC.

Any forward-looking statements made by us in this 2018 Form 10-K speak only as of the date on which they are made. We undertake no obligation to publicly update forward-looking statements, whether as a result of new information, future events or otherwise, except as may be required by law. We caution readers not to place undue reliance upon any of these forward-looking statements. You are advised, however, to consult any further disclosures we make on related subjects in our Form 10-Q and Form 8-K reports and our other filings with the SEC.

Market and Industry Data

This 2018 Form 10-K contains market, industry and government data and forecasts that have been obtained from publicly available information, various industry publications and other published industry sources. We have not independently verified the information and cannot make any representation as to the accuracy or completeness of such information. None of the reports and other materials of third party sources referred to in this 2018 Form 10-K were prepared for use in, or in connection with, this 2018 Form 10-K.

Trademarks and Trade Names

We have a number of registered trademarks, including HMS®, as well as the corresponding HMS + logo design mark, HMS IntegritySource®, Eliza®, Essette® and Elli®. These and other trademarks of ours appearing in this 2018 Form 10-K are our property. Solely for convenience, trademarks and trade names of ours referred to in this 2018 Form 10-K may appear without the ® or ™ symbols, but such references are not intended to indicate, in any way, that we will not assert, to the fullest extent under applicable law, our rights or the right of the applicable licensor to these trademarks and trade names. This 2018 Form 10-K contains additional trade names and trademarks of other companies. We do not intend our use or display of other companies' trade names or trademarks to imply an endorsement or sponsorship of us by such companies, or any relationship with any of these companies.

PART I

Item 1. Business

Founded in 1974, HMS is an industry-leading provider of cost containment solutions in the healthcare marketplace. We use healthcare data technology, analytics and related services to deliver coordination of benefits, payment integrity, population risk intelligence, care management and consumer engagement solutions to help payers reduce costs, improve healthcare outcomes and enhance member experiences. We provide coordination of benefits services to government and commercial healthcare payers to ensure that the correct party pays a claim, and payment integrity services to ensure the correct amount is paid. Our total population management solutions provide risk-bearing organizations with reliable intelligence across their member populations to identify risks and improve patient engagement and outcomes. Together these services help move the healthcare system forward for our customers and contribute to bending the healthcare cost curve for the nation.

HMS began its operations as Health Management Systems, Inc., which became our wholly owned subsidiary in March 2003 when we assumed its business in connection with the adoption of a holding company structure. In recent years HMS has grown both organically and through targeted acquisitions of businesses that helped expand our solution suite, including IntegriGuard, LLC (doing business as HMS Federal) in 2009; HealthDataInsights, Inc. ("HDI") in 2011; Essette, Inc. ("Essette") in 2016; and Eliza Holding Corp. ("Eliza") in 2017. We currently operate as one business segment with a single management team that reports to the Chief Executive Officer.

We were originally incorporated in the State of New York in October 2002 and reincorporated in the State of Delaware in July 2013. Our principal executive offices are located at 5615 High Point Drive, Irving, Texas 75038, and our telephone number is (214) 453-3000. As of December 31, 2018, we had approximately 2,500 employees. Additional information about HMS is available on our website at www.hms.com.

Copies of our recent Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and Proxy Statements, as well as amendments to these reports or statements, are available free of charge on our website through the Investor Relations page, as soon as reasonably practicable after we electronically file them with, or furnish them to, the SEC. These materials, as well as similar materials for SEC registrants, may be obtained directly from the SEC through their website at http://www.sec.gov.

The content of any website referred to in this 2018 Form 10-K is not incorporated by reference into this filing unless expressly noted. References to the URLs for these websites are intended to be inactive textual references only.

Our Solutions

We provide solutions that apply broadly across Medicaid, Medicare, commercial at-risk, and employer self-insured populations. Our services span the payment and care continuum from an individual's enrollment in a program before medical service is rendered, to pre-payment review of a claim, through recovery where identification of improper payments is made via audit, and back to the individual where our consumer-driven solutions allow health plans to manage their members on a personal level, and at scale, by using actionable analytics that drive patients to take action to improve health outcomes. Our coordination of benefits and payment integrity services ensure payment accuracy by addressing a wide spectrum of payment errors, including eligibility and coordination of benefits errors, the identification and investigation of potential fraud, and the review of claims on a pre-payment and post-payment basis. Our total population management services assist customers in managing quality, risk, cost and compliance across all lines of business by engaging members, providing the tools to manage their care, and identifying existing or emerging health risk among members. As a result of these services, our customers saved billions of dollars in 2018 through the prevention of erroneous payments, improved clinical outcomes for their members, and reduced enrollment turnover; and they received billions more in cash recoveries for improperly paid claims.

Coordination of Benefits

Industry-leading solution ensures the right payer pays the claim, both prospectively for cost avoidance and retrospectively for recoveries of improper payments

Payment Integrity

Comprehensive solution set to reduce fraud, waste and abuse by identifying and correcting healthcare claims that are billed and paid improperly

Total Population Management

Population and member health management suite of services addresses cost, quality and compliance through risk analytics, member engagement and care management platforms

Our comprehensive solutions offer value throughout the healthcare continuum and include the following:

Coordination of Benefits (COB)

Our COB services are provided primarily for state governments and Medicaid managed care plans, pursuant to Federal law which mandates that Medicaid is the payer of last resort, and draw principally upon proprietary information management and data mining techniques designed to ensure the correct party pays a healthcare claim. We offer cost avoidance services, which include providing validated insurance coverage information that is used by payers to coordinate benefits properly for future claims. With validated insurance information, Medicaid payers can avoid unnecessary costs by ensuring they pay only after all other insurance coverage available has been exhausted. Nevertheless, due to a variety of factors, many Medicaid claims are paid even when there is a known responsible third party. Our customers rely on us to identify Medicaid eligibility, before a claim is submitted, and retrospectively, for those claims that were paid in error, and then recover these payments from the liable third party. We also provide services to assist customers in identifying other third-party insurance and recovering medical expenses where a member is involved in a casualty or tort incident. Lastly, for Medicaid agencies exclusively, we provide estate recovery services to identify and recover Medicaid expenditures from the estates of deceased Medicaid members in accordance with state policies. For the years ended December 31, 2018, 2017 and 2016, our COB services represented 66.4%, 73.4% and 72.2% of our total revenue, respectively.

Analytical services

Analytical services consists of our payment integrity and total population management solutions.

Payment Integrity (PI)

Our PI services ensure healthcare payments are accurate and appropriate. These services are applicable to all customers HMS serves, including federal and state governments, commercial health plans and other at-risk or self-insured entities. Our solutions verify that healthcare services are utilized, billed and paid appropriately. We combine data analytics, clinical expertise and proprietary algorithms and technology to identify and prevent improper payments on submitted claims to optimize savings before a claim is even paid, and on a post-payment basis, to identify and recover overpayments and correct underpayments; detect and prevent fraud, waste and abuse; and identify process improvements. For the years ended December 31, 2018, 2017 and 2016, our PI services represented 24.1%, 20.0% and 27.6% of our total revenue, respectively.

Total Population Management (TPM)

Our TPM services consist of population risk analytics, consumer engagement and care management solutions, which are the result of internal product development and our acquisitions of Essette in 2016 and Eliza in 2017. These solutions help customers better manage quality, cost, compliance and patient outcomes and improve their members' experience. The services span across the care continuum. Our flexible, scalable architecture and modular platform integrates early risk identification, advanced analytics, multi-channel outreach, social engagement and care management components to address our customers' increased focus on consumer engagement, performance management and program design—all key components of an effective population health management program. Our Elli, Eliza and Essette solutions leverage HMS data and advanced analytics to support population risk management, member engagement and care management, respectively, and provide customers with a tailored, integrated platform that addresses core healthcare industry challenges on an enterprise scale. For the years ended December 31, 2018, 2017 and 2016, our TPM services represented 9.5%, 6.6% and 0.2%, of our total revenue, respectively.

Intellectual Property

Our ability to develop and maintain the proprietary aspects of our technology and operate without infringing the proprietary rights of others is important to our business and competitive position. We establish and protect our proprietary technology and intellectual property through a combination of patents, patent applications, trademarks, copyrights, domain names and trade secrets, as well as through contractual rights, including confidentiality, non-disclosure and invention assignment agreements, and other security measures.

As of December 31, 2018, our patent portfolio is comprised of approximately 60 domestic and international patents, and we are currently pursuing several patent applications in the United States and around the world. Our principal trademarks are HMS®, and the corresponding HMS + logo design mark, HMS IntegritySource®, Eliza®, Essette®, and Elli®. We also hold copyrights relating to certain aspects of our solutions and services. While we consider all of our intellectual and proprietary rights important to HMS, we believe our business as a whole is not materially dependent on any particular patent, trademark, license or other intellectual property right.

Customers

We provide our solutions to customers across a broad range of entities within the healthcare industry, including health plans, state agencies, federal programs, private employers and other risk-bearing healthcare organizations. For the years ended December 31, 2018, 2017 and 2016, our total revenue was $598.3 million, $521.2 million and $489.7 million, respectively. No single customer accounted for 10% or more of our total revenue during any period presented.

The composition of our 10 largest customers changes periodically. For the years ended December 31, 2018, 2017 and 2016, our 10 largest customers represented 41.4%, 39.5% and 40.6% of our total revenue, respectively. We provide services under contracts (or subcontracts) that contain various revenue structures, including contingent revenue and to a lesser extent fixed-fee arrangements. The current terms of many of our federal and state government contracts range from one to five years, including renewal terms at the option of the customer. In many instances, we provide our services pursuant to agreements that are subject to periodic reprocurements. Several of our contracts, including those with some of our largest customers, may be terminated for convenience, in whole or in part, by the customer. Because we provide our services pursuant to agreements that are open to competition from various businesses in the U.S. healthcare arena, we cannot provide assurance that our contracts, including those with our largest customers, will not be terminated for convenience or awarded to other parties. Additionally, we cannot provide assurance that any contracts that are renewed will have the same fee structures as the expiring contracts or otherwise be on satisfactory terms. The early termination of key contracts with significant customers, or the inability to renew such contracts on favorable terms or at all, may have an adverse effect on our financial condition, results of operations and cash flows.

In providing solutions and services to our customers, we rely heavily upon our technology systems and networks, as well as on those of third-party providers, to process, transmit, maintain, store and host the confidential, proprietary and sensitive information and data we receive from our customers and other data suppliers, including private insurance plans and financial institutions. The secure processing and maintenance of this information is critical to our operations and business strategy. Although we have spent significant resources to implement security and privacy programs and controls, train our workforce and augment our security measures with the implementation of new technologies and processes, our information technology and infrastructure, and those of third parties on which we rely could continue to be potentially subject to various forms of cyber-attacks, as further discussed under the heading “Part I, Item 1A. Risk Factors.”

Healthcare Landscape

The market for cost containment solutions is large and growing, driven by increasing healthcare costs, rising program enrollment and payment complexities. Established in 1965 under the Social Security Act, Medicaid provides health insurance and long-term care services and support to low-income families and individuals with disabilities in the United States. Medicaid is funded jointly by the federal and state governments and administered by the states. The Balanced Budget Act of 1997 created CHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Medicare is a federal program that is administered by CMS, and provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance and prescription drug benefits. All three of these programs have opted to contract with managed care organizations in whole or in part as a means of delivering quality healthcare to program beneficiaries and controlling costs.

By law, Medicaid programs serve as the payer of last resort and all other sources of coverage must pay for medical costs incurred by a Medicaid-eligible individual. The TPL rules of the Medicaid statute require, among other things, that states take reasonable measures to identify potentially liable third parties and process claims accordingly. Since 1985, we have provided state Medicaid agencies with services to identify third parties with primary liability for paying claims for Medicaid members, and since 2005, we have provided similar services to Medicaid managed care plans.

The Deficit Reduction Act enacted by Congress in 2006 contained provisions to strengthen the TPL rules and created the Medicaid Integrity Program under the Social Security Act to increase the government’s capacity to prevent, detect and address fraud, waste and abuse in the Medicaid program. Later that year, Congress passed the Tax Relief and Health Care Act of 2006, which established the Medicare RAC program. These measures, at both the federal and state level, have strengthened our ability to identify and recover erroneous payments on behalf of our customers. We also serve as a Medicaid RAC to certain states pursuant to provisions of the ACA and became the Medicare RAC for Region D with our acquisition of HDI. We again were awarded a region under the new Medicare RAC contracts in October 2016. Following the implementation of the new Medicare RAC contracts and completion of contract closeout activities for RAC Region D, our original Medicare RAC contract expired on January 31, 2018.

The ACA, generally referred to as Obamacare, was signed into law in 2010 and has made broad-based changes to the U.S. healthcare system, including many provisions impacting healthcare delivery and payment programs, such as employer-sponsored health coverage, Medicaid, Health Insurance Exchanges with premium subsidies and payment integrity efforts. The ACA also further expanded the recovery audit contractor program to states. CMS and various states have proposed Medicaid program design alternatives and changes to enrollment criteria which could impact future Medicaid enrollment. As ACA-related changes develop or are enacted, we will assess their potential impact, including opportunities they may present for our customers and for us.

Industry Trends and Opportunities

U.S. healthcare expenditures continue to escalate and consume an increasingly larger proportion of the U.S. GDP, presenting challenges for payers who wish to contain costs and promote quality healthcare outcomes. For 2019, Medicare and Medicaid are projected to pay approximately 37.9% of the nation's healthcare expenditures and serve over 136.3 million beneficiaries. Many of these beneficiaries are enrolled in managed care plans, which have the responsibility for both patient care and claims adjudication. The dual aims of cost containment and quality healthcare outcomes are the same across all at-risk entities, including commercial health plans and government healthcare programs, such as Medicaid and Medicare.

Within the commercial market, health plans sell policies directly to individuals (on the open market or via health insurance exchanges), contract with employers to underwrite their employees' care, or contract with self-insured employers to oversee benefit administration for their employees. This market also includes a growing number of risk bearing provider-sponsored plans that operate and market health plan benefits. According to CMS NHE projections, private health insurance covered approximately 197.5 million individuals at a cost of approximately $1.24 trillion in 2018.

Several commercial health plans also offer government-sponsored lines of business, including partnering with Medicare, Medicaid and CHIP to oversee care delivery for beneficiaries enrolled in those programs. States continue to focus on improving value, quality and outcomes through arrangements with MCOs. At the end of state fiscal year 2018, 47 states and the District of Columbia operated with some form of managed care, and Alaska reported plans to implement a managed care program in 2019. Comprehensive risk-based managed care continues to be the predominant delivery system for Medicaid services in the US. Among the 39 Medicaid programs with comprehensive risk-based MCOs, 33 reported that 75% or more of their Medicaid beneficiaries were enrolled in MCOs as of July 1, 2018. Of the 32 states that had implemented Medicaid expansion pursuant to the ACA, 27 were using MCOs to cover newly eligible adults as of July 1, 2018. Managed care health plans also continue to assume risk for a growing number of Medicare lives. Approximately 34% of all Medicare beneficiaries, or 20 million lives, were enrolled in Medicare Advantage plans in 2018.

HMS continues to serve government agency fee-for-service programs at the state and federal level. These plans are generally reliant on and susceptible to the government appropriations process that determines their budget and governs the number of beneficiaries they serve. According to the CMS NHE projections, Medicare programs in 2018 covered approximately 59 million people at a cost of approximately $748 billion and Medicaid/CHIP covered approximately 81.2 million people, costing approximately $641 billion. Altogether, it is projected that the government programs we serve covered approximately 140.2 million people at a total cost of nearly $1.39 trillion in 2018.

CMS projects that Medicare enrollment growth will increase by 3.03% in 2019, with expenditures to increase by 7.95% in 2019 compared to 2018; and Medicaid/CHIP enrollment growth will increase by 1.97% in 2019, with expenditures to increase by 5.5% in 2019 compared to 2018. As commercial and government health plans focus on strategies to contain costs across their different lines of business, HMS will continue offering solutions to meet their evolving needs.

Competitors

The U.S. healthcare marketplace is a dynamic industry with a range of businesses currently offering cost containment services, both directly or indirectly (through subcontracting), to some or all of the various healthcare payers, providers, employers and consumers. In addition, with improvements in technology and the growth in healthcare spending, new businesses are incentivized to enter this marketplace. Many customers also have the ability to perform some or all of the needed cost containment services themselves and choose to exercise that option to varying degrees. Therefore, competition is robust as customers have many alternatives available to them in their effort to contain healthcare costs.

We compete based on a variety of factors, including our ability to provide a broad range of solutions that span the entire healthcare claims payment and services continuum. These include payment accuracy solutions focused on COB and PI related functions, as well as TPM solutions which support the ability of payers to better understand and engage consumers, perform effective outreach, and impact both costs and health outcomes.

We have a proven record of delivering results that optimize savings and recoveries, enabled by:

- in-depth government and commercial healthcare program experience;
- clinical staff expertise;
- expansive data resources;

- innovative technology;
- enterprise analytics;
- an extensive insurance eligibility database;
- extensive relationships with customers and other industry stakeholders; and
- an ability to provide customers with actionable intelligence to improve clinical outcomes, optimize patient engagement, and better manage costs.

Our competitors range in size from large, diversified national companies, to small, specialized firms. Some of these competitors have significantly greater financial and technical resources, and others have longer operating histories and greater name recognition than we do in certain markets. Within our payment accuracy portfolio of products and services, we compete primarily with large business outsourcing and technology firms, claims processors and PBMs, clearinghouses, healthcare consulting firms, and other vendors who provide some or all of these solutions to payers. In addition, we frequently work with customers who may elect to perform some or all of their cost avoidance and recovery functions in-house. Within the population health management sector, we compete primarily with vendors who provide care management, consumer engagement, and related technology services. Companies with whom we compete across our offerings include:

- Accenture plc
- Cotiviti Corporation
- EXL Service Holdings, Inc.
- LexisNexis
- Performant Financial Corporation
- CaseNet LLC
- DXC Technology Company
- Experian Health
- MedHok, Inc.
- Welltok, Inc.
- Change Healthcare
- Equian, LLC
- IBM Watson Health
- Optum (subsidiary of UnitedHealthGroup)
- ZeOmega LLC

Business Strategy

We believe that the steadily increasing enrollment and rising expenditures for Medicare and Medicaid, with most new enrollees entering managed care plans; an aging U.S. population with an increasing concentration of individuals with high cost chronic conditions and often co-morbidities; and the overall complexity of the healthcare claims payment system in the U.S. all combine to create substantial growth opportunities for the suite of cost containment solutions we offer.

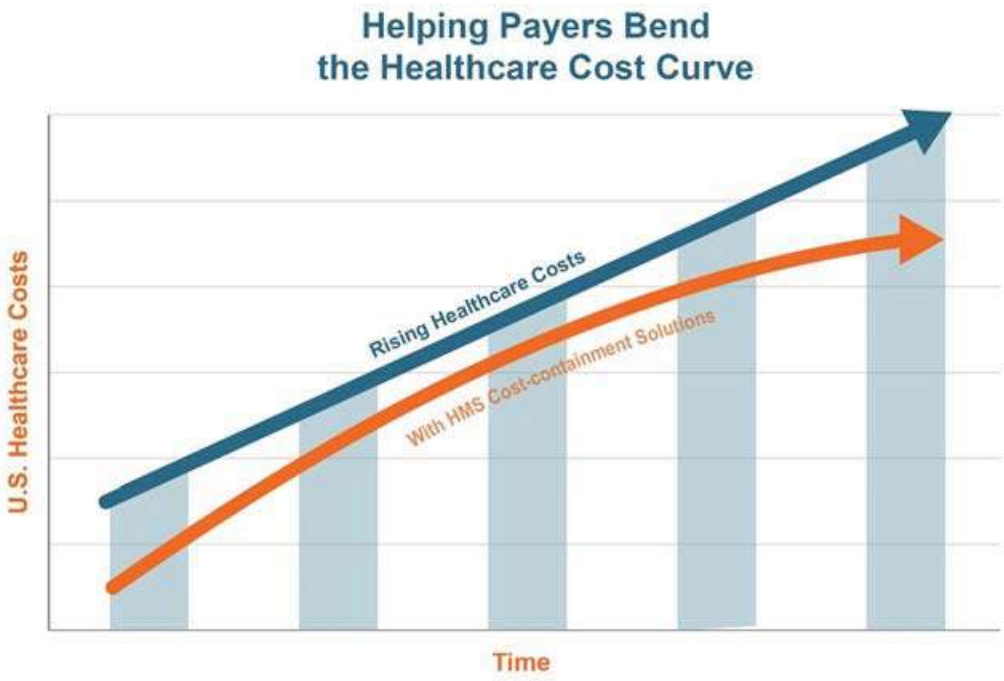

We also believe these factors present growth opportunities for our TPM services. We are focused on growing our business over the course of 2019 and beyond, both organically and inorganically, by leveraging existing key assets (e.g., our data, analytics, in-house expertise, and distribution channel) and pursuing a number of strategic objectives or initiatives, including:

- *Expanding the scope of our relationship with existing customers* – by selling additional solutions and services, including those designed to improve member engagement and improve clinical outcomes.

- *Adding new customers* – by marketing to commercial health plans, including Medicaid managed care and Medicare Advantage plans, at-risk group and individual health lines of business and ASOs; government healthcare payers, including Medicaid agencies, state employee health benefit plans and CHIPs; at-risk provider organizations and ACOs; and commercial self-insured employers.

- *Introducing new innovative solutions and services* – through internal development initiatives designed to enhance or expand our existing suite of cost containment solutions.

- *Utilizing technology tools to leverage a big data environment* – to create a more nimble operating environment, create operating efficiencies, improve the yield on our existing solution suite and identify new revenue opportunities within our current service delivery models.

- *Promoting automation and innovation to improve the efficiency and effectiveness of our services* – by continuing to implement new technology and process improvements designed to increase recovery yields, increase customer satisfaction and achieve greater operating efficiencies.

- *Prudent deployment of capital* – by investing in internal growth initiatives; selectively investing in capabilities, technologies, and assets to complement our core cost-containment expertise; building care management and care coordination adjacencies to complement the Essette and Eliza acquisitions and our internally developed Elli risk intelligence product; and expanding our data analytics capabilities. Our focus may include acquisitions that represent long-term growth potential, target high-growth areas, are accretive to earnings, enhance our technological capabilities and fill a strategic need in our business portfolio as we seek to provide increasingly comprehensive solutions to our customers. We may also repurchase our shares, pursuant to a two-year $50 million authority granted by our Board of Directors in November 2017, which has a remaining unused authority of approximately $29.9 million.

Item 1A. Risk Factors

Our business is subject to significant risks, including the risks and uncertainties described below. You should carefully consider these risks, as well as the other information in this 2018 Form 10-K, including our Consolidated Financial Statements and the related Notes. The occurrence of any of these risks could adversely affect our business, financial condition, results of operations, and cash flows in a material way.

Risks Relating to Our Company

Our ability to expand our business will be adversely affected if we fail to implement our growth strategy.

The size and scope of our business operations have expanded over the past several years, and we currently intend to continue our growth and expansion into new healthcare areas and markets, however, our growth and expansion strategy carries costs and risks that, if not properly managed, could adversely affect our business. Our future growth will depend on, among other things, our ability to successfully execute our business plans, which includes penetrating new markets, broadening and deepening our customer relationships, identifying and executing future acquisitions and strategic partnerships, and increasing the speed and scale at which we deliver our services, all while remaining competitive. We must also be flexible and responsive to customers' needs and changes in the political, economic and regulatory environment in which we operate. The greater size and complexity of our expanding business may put additional strain on our administrative, operational and financial resources and can make optimal resource allocation more difficult to determine. It is possible that we may not be able to maintain or accelerate our growth. A failure to anticipate or properly address the demands and challenges that our growth strategy and potential diversification may have on our resources and existing infrastructure may result in unanticipated costs and inefficiencies that could negatively impact our ability to execute on our business plans and growth goals, which may have a material adverse effect on our business, financial condition, results of operations and cash flows.

If we fail to innovate and develop new or enhanced solutions and services, or if these solutions and services are not adopted by our customers, it could have a material adverse effect on our business, financial condition, results of operations and cash flows.

Part of our growth strategy depends on our ability to respond to the evolving healthcare landscape with new and enhanced solutions and services that our existing and potential customers are willing to adopt. The development, marketing and implementation of these solutions and services may require that we make substantial financial and resource investments. We face risks that our new or modified solutions and services may not be responsive to customer preferences or industry changes, and that the solution and service development initiatives that we prioritize may not yield the gains that we anticipate, if any. If we are unable to predict market preferences or healthcare industry changes, or if we are unable to develop or adapt solutions and services that are responsive to existing and potential customers' needs, we may fail to expand our business, which could constrain our future revenue growth and materially adversely affect our business, financial condition, results of operations and cash flows.

Our acquisition strategy may subject us to considerable business and financial risk.

Historically, to achieve our strategic goals, we have made a significant number of acquisitions that have expanded the solutions and services we offer, provided a presence in complementary business lines, or expanded our geographic presence and/or customer base. We intend to pursue future acquisitions that will continue to expand and complement our business and to periodically engage in discussions regarding such possible acquisitions. We are subject to risks and uncertainties relating to our ability to identify suitable potential acquisition candidates, to consummate additional acquisitions that will be advantageous to us, and to successfully integrate future acquisitions. Future and potential business acquisitions involve a number of risk factors that could affect our operations, including, but not limited to:

- diversion of management's attention and other resources;
- our ability to successfully and timely integrate operational, accounting and technology functions, policies, processes, systems and controls, and to implement these functions, policies, processes, systems and controls, without incurring substantial expenses, delays, difficulties or other issues;
- our ability to integrate personnel and human resource systems as well as the cultures of the acquired business;
- our ability to retain or replace the key personnel of the acquired business;
- our ability to maintain relationships with the customers of the acquired business;
- our ability to expand and further develop the acquired business;
- our ability to cross-sell our solutions and the solutions of the acquired business to our respective customers;
- customer dissatisfaction or performance problems with the acquired business;
- our ability to comply with regulatory requirements and avoid potential conflicts of interest in markets that we serve;
- the misuse of intellectual property by the personnel of the acquired business;
- our ability to successfully enter into unfamiliar markets or manage new business lines;
- assumption of unanticipated legal or financial liabilities and/or negative publicity related to prior acts by the acquired business;
- we may become subject to litigation or other claims in connection with the acquired business, including claims from terminated employees, customers, former shareholders or third parties;
- we may become significantly leveraged as a result of incurring debt to finance an acquisition;
- the acquired business may not perform as projected which could negatively impact earnings or contingent consideration;
- we may suffer impairment of goodwill and other acquired intangible assets; and
- we may suffer dilution to our earnings per share.

If we fail to adequately address these risks, or to successfully integrate the businesses that we acquire, we may not realize cost efficiencies, synergies or other benefits that we anticipated when selecting our acquisition candidates, and our reputation, business, financial condition, results of operations and cash flows could be materially adversely affected.

We face significant competition for our solutions and services and we expect competition to increase, which could materially adversely affect our business, financial condition, results of operations and cash flows.

The market for healthcare cost containment solutions is intensely competitive, driven by rapidly changing technologies, evolving industry standards and customer demands to become more efficient. Our competitors range in size from large, diversified national companies (some of which have emerged as a result of industry consolidation), to small, specialized firms. Some of our competitors may include current or former subcontractors or teaming partners seeking to establish direct relationships with our customers and provide similar services as the prime contractor, as well as current and prospective customers that elect to perform recovery and cost avoidance functions in-house or to develop in-house capacities for solutions and services that we provide or seek to provide. Consolidation among vendors and healthcare providers, as well as the merging of some of our competitors or formation of business alliances with other competitors, have contributed to the increasingly competitive environment. For example, certain state customers have combined or "bundled" TPL services under large-scale IT procurements, as they shift to implementing modular Medicaid Enterprise Systems. As part of this modular approach, they may select a new or less experienced vendor to provide the TPL module based on preferred relationships or favorable pricing. In addition, companies that have invested in proprietary technology different from our own service offerings, such as front-end analytics, have emerged as new competitors due to the rapidly evolving healthcare landscape. There is also increasing sophistication in the solutions and services that our competitors are developing that may become more efficient or appealing to our customers. In order to remain competitive, we may need to quickly develop and market new and enhanced solutions and services responsive to emerging technologies and changes in the healthcare industry, which may require that we make substantial financial and resource investments.

We may not be able to compete successfully against our existing or future competitors. Some of these competitors have significantly greater financial and technical resources, and others have longer operating histories and greater name recognition than we do in certain markets. They may be able to (i) offer lower prices or negotiate fee reductions on our current solutions and services, (ii) respond more quickly than we can to new and emerging technologies and changing customer requirements, (iii) devote greater resources to the sale of their products and the development and implementation of new and improved systems, solutions and services for customers that we serve, and (iv) pursue various acquisitions that allow them to rapidly amass a wide array of capabilities. We may be forced to lower our pricing, unexpectedly increase or enhance our technological or data capabilities, or modify our solution or service offerings. Notwithstanding any changes we make in response to increased competition, the demand for our solutions and services may decrease as a result of increased competition. A failure to be responsive to our existing and potential customers' needs or the changing industry landscape could hinder our ability to maintain or expand our customer base, hire and retain new employees, pursue new business opportunities, complete future acquisitions and operate our business effectively. Any inability to compete effectively could materially adversely affect our business, financial condition, results of operations and cash flows.

You will not be able to rely on our operating results in any particular period as an indication of our future performance because they are subject to significant fluctuation which may cause the market price of our common stock to decrease significantly.

Our revenue and operating results may fail to match our past or projected performance and could vary significantly from period-to-period as a result of a number of factors, some of which are outside of our control. We have experienced fluctuations in our revenue and operating results in the past and they may vary in the future for reasons that include, but are not limited to:

- fluctuations in sales activity given our sales cycle;
- the length of contract and implementation periods;
- the commencement, completion or termination of contracts during any particular quarter;
- contract costs and expenses, which may be incurred in periods prior to revenue being recognized;
- the timing of period revenue recovery projects and third party payers' claim adjudication;
- the billing and budgeting cycles of our customers;
- the timing of government procurement activities, including when contract awards are announced and the time required to resolve bid protests;
- contract renewal discussions, which may result in delayed payments for services already performed;
- changes in the pricing structure or other significant terms in our contract, or the scope of services we perform;
- technological and operational issues affecting our customers, including delays in payment receipt for previously recognized revenue due to certain customers delayed processing of our findings through their systems, and restrictions on our ability to use or access certain data or a lack of integrity or quality in the data or information we receive from certain data sources;
- adjustments to age/quality of receivables and accruals as a result of factors such as delays involving contract limitations or changes, subcontractor performance deficiencies or managerial decisions not to pursue identified claim revenue from customers;
- the impact of service disruptions or delays in the systems or operations of subcontractors, partners, vendors and other third party providers on which we rely on to deliver a single-source solution or service to our customers;
- changes in applicable laws;

- changes in accounting policies or guidelines concerning the timing of recognition of revenue; and
- regulatory changes or general economic conditions as they affect healthcare providers and payers.

We cannot predict the extent to which future variations could occur due to these or other factors. In addition, occasionally our state and federal customers are requested by third party payers to refund payments that we previously recovered for our customers. If our state and federal customers choose to refund money in response to these requests, regardless of whether an error actually occurred in connection with the payments, we may also be required to return contingent revenue which we were previously paid associated with such refunded payment. Consequently, our operating results are subject to significant fluctuation for any particular quarter, fiscal year, or other period, and may not be indicative of future periods. Our business is also subject to seasonal patterns resulting from increased efforts at year-end by certain customers to generate additional savings, complete compliance obligations and close gaps in care. However, taken as a whole, we do not consider our operations to be seasonal to any material degree. Due to all of these factors, our revenue and operating results are difficult to predict and are subject to significant fluctuation, which may cause the market price of our common stock to decrease significantly.

We face challenges associated with forecasting the revenue under our contracts, and any failure to accurately forecast such revenue could have a material adverse effect on our business, financial condition, results of operations and cash flows.

We may not be able to accurately estimate the factors upon which we base our contract pricing, or the costs and timing for implementing and completing our contracts. For a majority of our customer contracts, the payment of our fee is contingent upon the recoveries received by our customers. We also have cost-plus or time-and-materials based contracts with the federal government where our revenue is recognized based on costs incurred plus an estimate of the negotiated fee earned. Our ability to earn a profit on these contracts requires that we accurately estimate the costs involved with these contracts and assess the probability of achieving certain outcomes or milestones within the contracted time period. In addition, we cannot predict with certainty the costs or the period in which implementation or contracts may be completed when we introduce new solutions into the marketplace. For our coordination of benefits and payment integrity services, we may face a long implementation period with a new customer or a new contract with an existing customer, making it difficult to reliably forecast revenue under those contracts. If we do not accurately estimate the costs and timing for completing projects, or if we encounter increased or unexpected costs, delays, failures, liabilities or risks, including those outside of our control, our contracts could prove unprofitable for us or yield lower profit margins than anticipated. Although we believe that we have recorded adequate provisions in our financial statements for losses on our fixed price and cost-plus contracts where applicable, as required under U.S. GAAP, our contract loss provisions may not be adequate to cover all actual future losses.

System interruptions or failures could expose us to liability and harm our business.

Our data and operation centers are essential to our business and our operations depend on our ability to maintain and protect our information systems. We attempt to mitigate the potential adverse effects of a disruption, relocation or change in operating environment; however, the situations we plan for and the amount of insurance coverage that we maintain may not be adequate in every case. Despite systems redundancy and security measures, our systems and operations are vulnerable to damage or interruption from, among other sources:

- power loss, transmission cable cuts and telecommunications failures;
- fire, flood, earthquake and other natural disasters;
- hardware failures or software defects;
- operator error;
- cyber security breaches; and
- physical break-ins, sabotage, intentional acts of vandalism, terrorist attacks and other events beyond our control.

In addition, while there are backup systems in many of our facilities, an extended outage of utility or network services supplied by third party IT vendors may delay or disrupt the delivery or performance of the services we provide for our customers. We also utilize third-party cloud service providers to help us efficiently scale certain cloud-based solutions. If we or our cloud service providers encounter a lengthy business interruption, or in the event our business continuity plans and business interruption insurance coverage are not adequate or fail to compensate us on a timely basis, we could suffer operational disruptions, disputes with customers, civil or criminal penalties, regulatory problems, increases in administrative expenses, loss of our ability to produce timely and accurate financial and other reports, damage to our reputation or customer relationships or other adverse consequences, any of which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

Our systems and networks and those of third parties on which we rely may be subject to cyber security breaches and other disruptions that could compromise our information and harm our business.

In the ordinary course of our business, we rely heavily upon our technology systems and networks, as well as on those of third-party providers, to process, transmit, maintain, store and host the confidential, proprietary and sensitive information and data we receive from our customers and other data suppliers, including private insurance plans and financial institutions. In addition, subcontractors, teaming partners or other third-party vendors may receive or utilize this information on our behalf in support of the services we perform for our customers. The secure processing and maintenance of this information is critical to our operations and business strategy. Although we have spent significant resources to implement security and privacy programs and controls, train our workforce and augment our security measures with the implementation of new technologies and processes, our information technology and infrastructure, and those of third parties on which we rely, could continue to be subject to computer hacking or phishing efforts, acts of vandalism or theft, introduction of malware, computer viruses or other malicious codes, employee error or malfeasance issues, catastrophes, unforeseen events or other cyber-attacks. We may be unable to implement adequate preventive measures to protect against such compromises in the future or to effectively adapt our security measures to evolving security risks. As a result, our technology systems, including our data and our customers' data, could be accessed improperly, made unavailable, improperly modified, corrupted or otherwise breached or compromised, or we could suffer system disruptions, shutdowns and denials of service. Similarly, we could be materially adversely affected by the loss of proprietary, trade secret or confidential technical and financial data if our internal networks are compromised. The occurrence of any of these events could harm the market perception of the effectiveness of our security measures, lead to reputational damage or the loss of our customers' confidence in our solutions, negatively affect our ability to attract new customers, cause existing customers to terminate or not renew their existing contracts with us, or deter them from using our solutions or services in the future, all of which could reduce our revenue, increase our expenses and expose us to potential liability under privacy, security or other applicable laws and regulations. We could also be forced to expend significant resources in response to a security breach, including investigating the cause of the breach, repairing system damage, remediating vulnerabilities in our security procedures, increasing cyber security protection costs by deploying additional personnel and protection technologies, paying regulatory fines and penalties imposed by government regulatory agencies, and damages and other substantial costs associated with litigation, indemnification obligations as well as increased cybersecurity insurance premiums, and undertaking additional remediation efforts such as credit monitoring, all of which could increase our expenses, divert the attention of our management and key personnel away from our business operations and materially adversely affect our business, financial condition, results of operations and cash flows.

Any failure to maintain effective information processing systems and the integrity of the data in, and operations of, those systems could materially adversely affect our business, financial condition, results of operations and cash flows.

Our ability to conduct our operations and accurately report our financial results depends on the integrity of the data in our information systems and the processes performed by those systems. As a result of the services we provide, we process a number of complex transactions that require us to access, store, retrieve, manipulate, manage and transmit the information and data of our customers' and external third parties, as well as our own data. Although we have invested a great deal of time and resources in developing systems, processes and controls that protect the integrity of the data, such measures cannot provide absolute security. It is possible that failures or errors in hardware and software, including those in third-party technology, or technical deficiencies in our systems could result in data loss or corruption, or cause the data that we collect, utilize or disseminate to be incomplete or contain inaccuracies that our customers regard as significant. In addition, these information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs, satisfy customer requests and handle our expansion and growth. Despite our testing and quality control measures, we cannot be certain that errors or system deficiencies will be found and that remediation can be done in a timeframe that is acceptable to our customers, or that customer relationships will not be impaired by the occurrence of errors or the need for remediation. In addition, implementation of upgrades and enhancements may cost more, take longer or require more testing than originally expected. Situations may also arise in which the accuracy of our data analysis or the content and quality of our work product is central to the disposition of claims, controversies or litigation between our customers and third parties that would require us to allocate significant resources to fulfilling our contractual obligations to provide our customers with full and complete access to records, analysis and back-up documentation of our work. Assuring our capacity to fulfill these obligations as well as actually fulfilling them could impose significant burdens on our infrastructure for data storage, maintenance and processing, and require us to incur increased costs to supplement our personnel, data storage and computing resources, which could materially and negatively impact other business operations.

If we are unable to protect our proprietary technology, information, processes, know-how, and other intellectual property and intellectual property rights, or become subject to claims of infringing or misappropriating the intellectual property of third parties, the value of our solutions and services may be diminished and our business may be materially adversely affected.

Our success as a company depends in part upon our ability to protect our core technology and intellectual property. Our expanding operations and efforts to develop new solutions and services also make protection of our intellectual property more critical. We seek to protect our intellectual property and other proprietary information through a combination of patent, trademark, copyright, trade secret and unfair competition laws, confidentiality agreements and invention assignment agreements with employees, consultants and other third parties, as well as through the terms of our agreements with customers and vendors, and other security measures. However, the steps we have taken to deter misappropriation of intellectual property may be insufficient to protect our proprietary information. We may not always be successful at obtaining government registrations for our patents, trademarks, or copyrights that we seek to register. Third parties may also attempt to misuse our company name or trademarks to engage in improper or illegal conduct such as cyber-squatting or other cybercrimes using our marks, and we may not always be successful at quickly obtaining relief from agencies tasked with enforcing parties' rights, or stopping such conduct before harm to third parties occurs. Similarly, misappropriation of our other intellectual property by third parties, or any disclosure or dissemination of our confidential and proprietary trade secrets, business intelligence, queries, algorithms and other similar information by any means, could undermine any competitive advantage we currently derive or may derive from that intellectual property. For example, our current or former employees, consultants or other third parties may unintentionally or willfully disclose our trade secrets, know-how or other confidential and proprietary information to competitors. Competitors have also attempted to use state and/or federal open records laws (such as the federal Freedom of Information Act and analogous state laws) to obtain our proposal responses and other documents we provide to our government customers. We cannot be certain that our efforts to protect the confidential and proprietary trade secret information or intellectual property in these proposals or other documents will always be successful, due to the many factors underlying the various state and federal decisions to release information in response to open records requests (even in spite of our objections and efforts to protect such information). In addition, there remains the possibility that others will independently develop competing technologies that may be equivalent or superior to ours. If our efforts to protect our intellectual property and other proprietary rights are inadequate to prevent unauthorized use or appropriation by third parties or our employees, the value of our brand and other intangible assets may be diminished and others may be able to more effectively compete with our business by offering solutions or concepts that are substantially similar to ours, which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

In addition, third parties may claim that we are infringing upon or misappropriating their intellectual property, or assert other legal challenges to our intellectual property. Our exposure to risks related to the use of intellectual property may also increase as a result of acquisitions because third parties may make infringement and similar or related claims after we have acquired technology. Any of these situations could cause us to expend significant time and resources and to incur substantial costs associated with litigation or legal proceedings that may be necessary to defend ourselves or to enforce our intellectual property rights, in which we may not ultimately prevail, and could result in our being prevented from furnishing certain solutions and services.

Our business could be materially adversely affected if we fail to maintain a high level of customer retention, if our customers elect to reduce the scope of our contracts or terminate them before their scheduled expiration dates or if we fail to meet performance standards under our customer contracts.

We historically have derived and expect to continue to generate a significant portion of our revenue from a limited number of large customers at the federal and state level. Our contracts with these customers are subject to periodic renewal and some permit them to terminate their contracts on short notice, with or without cause. If a customer is dissatisfied with the quality of our work or if we fail to meet performance standards under our contracts, or if our solutions, technical infrastructure or services do not comply with the provisions of our contractual agreements or applicable regulatory requirements, customers might seek to reduce the scope of the services we perform or prematurely terminate their agreements with us, or we could incur additional costs that may impair the profitability of a contract and damage our ability to obtain additional work from that customer, or other current or prospective customers. For example, some of our contracts contain liquidated damages provisions and financial penalties related to performance failures, which if triggered, could materially adversely affect our reputation, business, financial condition, results of operations and cash flows. We also may be required to disclose such liquidated damages or other financial penalties assessed against us in connection with future bids for services with other customers.

In addition, government customers are subject to financial pressures or pressure from stakeholders that may cause them to terminate contracts for our services that may be regarded as non-essential or to redefine or reduce the scope of our contracts by, for example, significantly reducing the volume of data that we are permitted to audit or renewing the contract at lower performance fee levels. Despite our right to prompt and full payment under the terms of our contracts, we could face challenges in obtaining timely or full payments for our properly provided services from our customers. If there is a substantial reduction in the scope of our services under, or a termination of, any of our key contracts with our major customers, or if we are exposed to significant costs, liabilities or negative publicity, our ability to compete for new contracts with current or prospective customer could be damaged and our business, financial condition, reputation, results of operations and cash flows could be materially adversely affected.

We depend on many different entities to supply information and an inability to successfully manage our relationships with a number of these suppliers may harm the quality and availability of our solutions and services.

We obtain the data used in our solutions and services from many sources, including commercial health insurance plans, financial institutions, managed care organizations, government entities and non-government entities. From time to time, challenges arise in managing and maintaining our relationships with data sources that are not our customers and that furnish information to us pursuant to a combination of voluntary cooperation and legal obligations under laws and regulations that are often subject to differing interpretations. If a number of our information sources become unable or unwilling to provide us with certain data under terms and conditions of receipt, processing or use that are acceptable to us and our customers, or if laws and regulations for use and protection of this data changes in a way that disincentivizes our suppliers, or imposes unacceptable or unreasonable conditions, costs, or risks on us, we may not be able to obtain new or favorable agreements with alternative data suppliers. In addition, our ability to normalize and fully utilize the information we receive from various data sources to enhance and improve current services for our customers is an important component of our growth strategy. Although we believe that we have the legal and contractual rights necessary to normalize and use the data we have obtained from these sources for potential or contemplated solution and service offerings, we cannot provide assurance that these entities will permit the use of their data for these purposes. If we lose a number of our data sources or our access to their data, and fail to identify and reach the requisite agreements with suitable alternative suppliers or to successfully integrate their data into our solutions and services, or if there is a lack of accuracy or integrity in the data that current or future suppliers provide, we could experience service disruptions, increased costs, reduced quality of our solutions and services, or performance penalties under our customer contracts, which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

We may rely on subcontractors and other third party providers to provide customers with a single-source solution or service or we may serve as a subcontractor to a third party prime contractor. If these parties fail to satisfy their obligations to us or if we are unable to maintain these relationships, our business, financial condition, results of operations and cash flows could be materially adversely affected.

In some areas of our business we may engage subcontractors, teaming partners, vendors or other third party providers to provide our customers with a single-source solution for a broader range of service needs. These third parties include software vendors, utility and network providers, cloud service providers and other information technology service providers and solution partners. Our ability to deliver and implement solutions and serve our customers effectively depends on these third parties meeting our service standards in both timeliness and quality, and in certain instances, on our ability to obtain customer approval for the use of these third party subcontractors. While we believe that we perform appropriate due diligence on these third parties and take adequate measures to ensure that they comply with the appropriate laws and regulations, we cannot guarantee that they will comply with the terms set forth in their agreements with us. Performance deficiencies or misconduct by subcontractors, teaming partners, vendors or other third party providers may be perceived as inadequacies in our solutions or services or cause us to fail to fulfill our contractual obligations to our customers, which could materially adversely affect our customer relationships and reputation, result in termination of a customer contract, and subject us to a dispute with our customer. In addition, if our third party service providers terminate or refuse to renew their relationships with us or offer their products to us in the future on less advantageous terms, we may not be able to perform or deliver solutions or services for existing customers as expected.

Similarly, we are and may in the future be engaged as a subcontractor to a third party prime contractor. Subcontracting arrangements where we are not the prime contractor pose unique risks to us because we do not have control over the customer relationship, and our ability to generate revenue under such subcontracts is dependent on the prime contractor, its performance and relationship with the customer, and its relationship with us. We cannot be certain that the prime contractor will provide adequate and timely services to the customer, comply with the terms of its prime contract with the customer or its subcontract agreement with us, or that it will construe its contractual rights and obligations in a reasonable way, act appropriately in dealing with us or customers, and remain in compliance with the relevant laws, rules or regulations. Any failure of the prime contractor to adequately perform its obligations under the prime contractor to comply with applicable laws, rules and regulations could materially adversely affect our reputation and subject us to a dispute with the prime contractor or the customer. In the event a prime contract is terminated, whether for non-performance by the prime contractor or otherwise, our subcontract will similarly terminate, and the resulting contract loss could materially adversely affect our business, financial condition, results of operations and cash flows.

We obtain a portion of our business through competitive bidding in response to government requests for proposals. Reprocurements and future contracts may not be awarded through this process on the same level or our contract awards may be challenged by interested parties which could materially adversely affect our business, financial condition, results of operations and cash flows.

In order to market our solutions and compete for contracts with existing and potential state and federal customers, we are often required to respond to government-issued RFPs. These responses typically require us to assemble and submit a large volume of information within a rigid timetable, and to accurately estimate our cost structure for servicing the proposed contract, the time required to establish operations and the likely terms of proposals submitted by our competitors. We may also be required to disclose the occurrence of certain negative events suffered by our business, such as customer disputes, a government inquiry or an adverse judgment or settlement in litigation or a legal proceeding, which could impair our ability to win the contract at issue or have a material adverse effect on our reputation in the industry.

Even if we win these contracts, we may fail to secure favorable contract terms and conditions, or a government's determination to award us the contract may be challenged by an interested party. Under the state and federal laws and regulations governing procurements of goods and services, challenges and award protests may be filed even if there are no valid legal grounds on which to base the protest. The filing of such challenges could potentially delay the start or implementation of the contract if the government agency determines to withhold a contract award or suspend contract performance while the protest is being considered, or to take corrective action on its own, such as soliciting new bids or terminating the contract award or current procurement. In the event of irregularities, we perceive or learn of in the award or bidding process, we also may be forced to file protests in response to RFP awards to other bidders. Resolution of a protest, even in our favor, could force us to expend considerable funds in disputing the potential award or to incur additional expenses to maintain our ability to timely start implementation, which may cause our actual results to differ materially and adversely from those anticipated. In addition, if we are unable to win reprocurements or protests of particular contracts, we may be precluded from entering certain customer markets for the term of the contract awarded to another party. Any failure to continue to obtain contracts in response to government RFPs, to design proposals that result in profitable contracts, to win new contracts or re-procure current contracts after they expire or to prevail in protests or challenges of contract awards could have a material adverse effect on our business, financial condition, results of operations and cash flows.

Adverse judgments or settlements in legal proceedings could materially harm our business, financial condition, operating results and cash flows.

We are subject and may be a party to legal proceedings and claims that arise from time to time in the ordinary course of our business, which may include, but are not limited to, those related to, claims brought by our customers in connection with billing and contractual disputes, subcontracts and teaming agreements, protection of confidential information or trade secrets, claims relating to pending, terminated or completed acquisitions or dispositions, adversary proceedings arising from customer bankruptcies, employment of our workforce and immigration requirements or compliance with any of a wide array of state and federal statutes, rules and regulations that pertain to different aspects of our business. We may also be required to initiate expensive litigation or other proceedings to protect our business interests. There is a risk that we will not be successful or otherwise be able to satisfactorily resolve any pending or future litigation. In addition, litigation and other legal claims are subject to inherent uncertainties and management's view of currently pending legal matters may change in the future. Those uncertainties include, but are not limited to, litigation costs and attorneys' fees, unpredictable judicial or jury decisions and the differing laws and judicial proclivities regarding damage awards among the states in which we operate. Resolution may also require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results. Unexpected outcomes in such legal proceedings, or changes in management's evaluation or predictions of the likely outcomes of such proceedings (possibly resulting in changes in established reserves), could have a material adverse effect on our business, financial condition, results of operations and cash flows.

We may not be able to deliver our solutions and perform services efficiently if we are unable to attract and retain qualified employees.

Our successful delivery of solutions and services and ability to maintain our productivity and profitability is dependent on our ability to identify, recruit, employ, train and retain skilled personnel. The success of recruitment and retention strategies depend on a number of factors, including the competitive demands for employees having the skills we need and the level of compensation required to hire and retain such employees. Customers or competitors may seek to hire away qualified and seasoned employees, which could reduce our ability to innovate and operate effectively. We may not be able to recruit or maintain the personnel necessary to efficiently operate and support our business in the future, and even if our recruitment and retention strategies are successful, our labor costs may increase significantly. Our inability to hire sufficient personnel on a timely basis without significantly increasing our labor costs could materially adversely affect our business, financial condition, results of operations and cash flows.

Our future success depends, in part, on the continued service of members of our management team.

Our ability to execute on our business plans and future success requires that we attract, develop, motivate and retain experienced and innovative executive officers and senior leaders who have successfully managed, designed, implemented and led government services programs or information technology initiatives, or have relevant experience in other healthcare sectors, including data management and analytics. These individuals are in great demand and are likely to remain a limited resource in our industry. The loss of services of one or more members of our management team could adversely affect our business, financial condition, results of operations and cash flows. In addition, to the extent we lose an executive officer or senior leader, we may incur increased expenses in connection with the hiring, promotion or replacement of these individuals and the transition of leadership and critical knowledge.

Our outstanding indebtedness could materially adversely affect our financial condition and our ability to operate our business, and we may not be able to generate sufficient cash flows to meet our debt service obligations or capital requirements.

As of December 31, 2018, the outstanding principal balance under our Credit Agreement was $240.0 million. Our Credit Agreement provides for a senior secured revolving credit facility in an aggregate principal amount equal to $500 million and is secured, subject to certain customary carve-outs and exceptions, by a first priority lien and security interest in substantially all of our tangible and intangible assets. Our outstanding indebtedness and any additional indebtedness we incur may have important consequences for us, including, without limitation, that:

- we may be required to use a substantial portion of our cash flow to pay the principal of and interest on our indebtedness;
- our indebtedness and leverage may increase our vulnerability to adverse changes in general economic and industry conditions, as well as to competitive pressures;
- our indebtedness may expose us to the risk of increased interest rates because certain of our borrowings are and will be at variable interest rates;
- our ability to obtain additional financing for working capital, capital expenditures, acquisitions and for general corporate and other purposes may be limited;
- our indebtedness and leverage may prevent us from taking advantage of business opportunities as they arise or successfully carrying out our plans to expand our business; and
- our flexibility in planning for, or reacting to, changes in our business and our industry may be limited.

Under the Credit Agreement, we are also required to comply with specified financial and operating covenants, which may limit our ability to operate our business as we otherwise might operate it. The Credit Agreement also contains (i) certain affirmative covenants that impose certain reporting and/or performance obligations on us and our restricted subsidiaries, (ii) certain negative covenants that generally limit, subject to various exceptions, us and our restricted subsidiaries from taking certain actions, including, without limitation, incurring indebtedness, creating liens, engaging in mergers and consolidations, disposing of certain assets or property, making certain investments and acquisitions, entering into certain transactions with affiliates, swap agreements or sale-leasebacks, making certain restricted payments, including dividends and share repurchases, changing our fiscal year or the lines of business that we or our restricted subsidiaries conduct to a material extent, and prepaying certain junior indebtedness, (iii) financial covenants consisting of a maximum consolidated leverage ratio and a minimum interest coverage ratio, and (iv) customary events of default for financings of this type.

Our obligations under the Credit Agreement may be declared due and payable upon the occurrence and during the continuance of an event of default, which includes, without limitation: non-payment of principal or reimbursement obligation when due; non-payment of interest, fees and other amounts for a period of five business days after the due date; material inaccuracies of representations and warranties; failure to perform or observe covenants, conditions or agreements (subject to any applicable grace periods); cross-defaults to certain indebtedness; inability to pay debts; certain acts of bankruptcy or insolvency; certain ERISA events; failure to pay certain material judgments; and a change of control as defined in the Credit Agreement. If not cured, an event of default could result in any amounts outstanding, including any accrued interest and unpaid fees, becoming immediately due and payable, and would give our lenders the right to proceed against the collateral granted to them to secure the debt, which would require us to, among other things, seek additional financing in the debt or equity markets, refinance

or restructure all or a portion of our indebtedness, sell selected assets, and/or reduce or delay planned capital or operating expenditures. Such measures might not be sufficient to enable us to service our debt, and any such financing or refinancing might not be available on economically favorable terms or at all. Our ability to make payments of principal and interest on our outstanding credit facility depends upon our future performance and our ability to generate cash flows. If we are unable to generate sufficient cash flows to meet our debt service obligations or are forced to take additional measures to be able to service our indebtedness, our business, financial condition and results of operations could be materially and adversely affected.

Changes in, or interpretations of, tax rules and regulations may materially adversely affect our effective tax rates.

We are a United States-based company subject to various federal, state, U.S. Territory and local tax laws and regulations in multiple U.S. jurisdictions that govern numerous aspects of our business. As we expand our business, we may perform services for new customers located outside of the United States or in a U.S. Territory, which may subject us to foreign tax laws and regulations that could increase our exposure to additional tax liabilities. Our future effective tax rates could be materially affected by various factors, including changes in tax rates of jurisdictions in which we do business, changes in relevant tax and accounting rules, regulations and interpretations, increases in expenses not deductible for tax purposes, including impairments of goodwill, and changes in the valuation of our deferred tax assets and liabilities. For example, in December 2017, Congress enacted the 2017 Tax Act which, among other things, reduced the U.S. corporate tax rate, modified limitations on certain deductions for executive compensation, placed new limitations on interest deductions, repealed the Section 199 Deduction and certain capital investment deductions, and shifted U.S. taxation of multinational corporations from a tax on worldwide income to a territorial system. Any unanticipated changes in our tax rates could affect our future results of operations.

In addition, we are subject to the continual examination of our income tax returns by the IRS and other tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our provision for income taxes and have reserved for potential adjustments that may result. The final determination of any of these examinations could have a material adverse effect on our business, financial condition, results of operations and cash flows.

Our health insurance coverage and self-insurance reserves may not cover future claims, which could materially adversely affect our business, financial condition, results of operations and cash flows.

We maintain various insurance policies for company employee health, workers' compensation, general liability and property damage. We are self-insured for our health plans, and have purchased a fully-insured stop loss policy to help offset our liability for both individual and aggregate claim costs. We are also responsible for losses up to a certain limit for workers' compensation, general liability and property damage insurance.

For policies under which we are responsible for losses, we record a liability that represents our estimated cost of claims incurred and unpaid as of the balance sheet date. Our estimated liability is not discounted and is based on a number of assumptions and factors, including historical trends, actuarial assumptions and economic conditions, and is closely monitored and adjusted when warranted by changing circumstances. Our prior growth could affect the accuracy of estimates based on historical experience. Should a greater amount of claims occur compared to what was estimated or medical costs increase beyond what was expected, our accrued liabilities might not be sufficient and we may be required to record additional expense. Unanticipated changes may also produce materially different amounts of expense than reported under these programs, which could materially adversely affect our business, financial condition, results of operations and cash flows.

Risks Relating to Our Industry

Our business could be materially adversely affected by changes in the U.S. healthcare environment or in laws relating to healthcare programs and policies, particularly as they relate to the ACA and the Medicare and Medicaid programs.

The healthcare industry in which we operate is subject to changing political, economic and regulatory influences that directly affect the practices and operations of federal, state and commercial healthcare organizations in the United States. When the ACA was passed, its emphasis on program integrity, cost containment and expansion of Medicaid created new opportunities to grow our business and our service offerings. However, certain provisions of the ACA have yet to be implemented and there have been a number of judicial and legal challenges to certain aspects of the ACA. In February 2018, 20 states filed suit in the U.S. District Court for the Northern District of Texas alleging that the ACA is unconstitutional in light of the repeal of the penalties associated with the individual mandate. On December 14, 2018, the Court issued a ruling that the mandate was no longer permissible under Congress's taxing power and was thus unconstitutional. As such, the Court further found that the entire ACA is deemed to be invalid because the individual mandate is "essential" and inseverable from the ACA. Although, a stay and partial final judgment has been issued, ensuring that the ACA remains in full effect for the foreseeable future, we cannot predict the outcome of the litigation that has been filed relating to the constitutionality of the ACA. Additionally, since its adoption into law in 2010, there have been continued efforts by Congress to amend, repeal or replace all or part of the ACA. For example, under the 2017 Tax Act, the "individual mandate" introduced by the ACA was repealed effective January 1, 2019. Congress has introduced several other bills to delay, defund or repeal implementation or amend significant provisions of the ACA, though none of these other bills have passed the House and Senate. There have also been a number of proposed and adopted legislative initiatives and healthcare reform proposals from the federal and state governments. These include (i) measures that would fundamentally change the financial structure of the Medicaid program (currently funded jointly by the

states and the U.S. Federal Government), which could result in early termination, reduced scopes or non-renewal of our contracts with certain state government customers, and (ii) changes at the federal level that would reduce reimbursement rates to states, establish new payment models, further limit the Medicare RAC program, or otherwise change the operating environment for our customers and transform the government's involvement in healthcare. In addition to these legislative proposals, the President has taken several steps to limit the functionality of the ACA and advocate for its repeal and replacement since taking office. During 2017, the President signed two executive orders and other directives designed to waive, defer, grant exemptions from or delay the implementation of certain requirements mandated by the ACA.

Another variable that impacts our business will be how state programs, commercial health plans, private employers and other healthcare payers will respond to changes during this continued period of uncertainty surrounding the ACA. These organizations may react to such changed circumstances and financial pressures by taking actions to ramp up, curtail or defer their retention of cost containment providers like us, which could impact the demand for our solutions and services and our ability to increase or maintain sales of our existing solutions and services. While certain changes may present new opportunities to us, our business, financial condition, results of operations and cash flows could be materially adversely affected if we are unable to adapt our solutions and services to meet changing requirements or expand service delivery into new areas, or if the demand for our solutions and services is reduced as a result of future legislative changes affecting Medicare, Medicaid or other publicly funded or subsidized health programs, or efforts to waive, modify or otherwise change or invalidate the ACA. Although we will continue to evaluate the effect that the ACA and its possible invalidation or repeal and replacement may have on our business, it is difficult to predict the full impact and influence that the ACA and the varying healthcare reform measures may have on the U.S. healthcare industry or policy, and any resulting changes may take time to unfold.

Healthcare spending fluctuations, simplification of the healthcare payment process or other aspects of the healthcare financing system, budgetary pressures and/or programmatic changes diminishing the scope of program benefits, or limiting payment integrity initiatives, could reduce the need for and the price of our solutions and services, which would have a material adverse effect on our business, financial condition, results of operations and cash flows.

Our projections and expectations are premised, in part, upon consistent growth rates in the Medicare and Medicaid programs and government spending on these programs, and the impact on the current healthcare financing system overall and need for our solutions and services within that existing framework. Our continued success as a company is based in large part on offering solutions and services that improve the ability of our customers to identify and recover revenue that would otherwise be lost often as a result of procedural inefficiencies and complexities in the healthcare delivery and payment system. However, the need for our solutions and services, the price customers are willing to pay for them and the scope and profitability of our contracts could be negatively affected by a number of factors, including, but not limited to:

- a lower than projected growth in Medicare and Medicaid program enrollment and expenditures;
- changes in the level of federal government spending due to budgetary or deficit considerations, including the continuance of existing programs, as well as budgetary pressures that may drive changes at the state level;
- unanticipated reductions in the scope of healthcare program benefits (such as, for example, state decisions to eliminate coverage of optional Medicaid populations or services or shifting lives into managed care plans);
- the transition of healthcare beneficiaries from fee-for-service plans to value-based plans;
- modifications in provider billing behavior and habits, often in response to the success of our solutions and services or to changes that reduce healthcare spending;
- the adoption of healthcare plans with significantly higher deductibles;

- customer improvements and enhancements to their internal healthcare claims and billing processes;
- the simplification of the healthcare benefit and payment system through legislative or regulatory changes at the federal or state level (for example, legislative changes impacting the scope of mandatory audits, including limits on the look-back period for review in areas where we conduct audits);
- limits placed on ongoing program integrity initiatives, including the Medicare RAC program and state Medicaid RAC programs (for example, limitations or reductions in the amount of reviewable claims we audit, such as the modified ADR limits and sliding scale policy implemented by CMS for the current Medicare RAC contracts, which have a significant impact on the volumes of claims that Medicare RACs are permitted to review for inpatient providers and reduce their ability to identify overpayments and underpayments); and
- legislative healthcare reforms and developments, including the absence of near-term compliance deadlines effected by the ACA, the possible repeal or modification of the ACA, and other legislative actions to reduce program eligibility or services, or reform Medicaid spending.

The occurrence of any of these events, or other changes to the funding of the Medicare and Medicaid programs or limitations in the scope of program eligibility, benefits, initiatives and healthcare spending that materially reduce our revenue or profitability with such programs may have an adverse effect on our future business, financial condition, results of operations and cash flows.

A failure to comply with the laws and regulations that apply to companies in our industry regarding individual privacy and information security could subject us to legal actions, fines and penalties and negatively impact our reputation and operations.

As a cost containment service provider, we often receive, process, transmit and store sensitive data, including PHI and personally identifiable information of individuals, as well as other financial, confidential and proprietary information belonging to our customers, subcontractors, government agencies, data suppliers and other third parties from whom we obtain information. The use and disclosure of that information is regulated at the federal, state, international and industry levels. For example, we are subject to federal regulation under HIPAA, as amended by HITECH, and the Final Omnibus Privacy, Security, Breach Notification, and Enforcement Rule, as well as various state laws. HIPAA also imposes standards and requirements on our business associates (as defined under HIPAA). We are also obligated by our contractual requirements with customers, which may require that we comply with additional privacy regulations imposed upon certain types of customers, such as the federal Gramm-Leach-Bliley Act and other laws.

Even though we take measures to comply with all applicable regulations and to ensure our business associates and subcontractors comply with these laws, regulations and rules, we have less than complete control over our business associates' and subcontractors' actions and practices. We may be exposed to data breach risk if there is unauthorized access to one of our or our subcontractors' secure facilities, or to third-party enterprise cloud storage and cloud computing application services that we use, or from lost or stolen laptops or other portable media from current or former employee theft of data containing PHI, from computer hacking, malware, computer viruses or other malicious codes, phishing or other cyber-attacks, from misdirected mailings containing PHI, or other forms of administrative or operational error. If we or our subcontractors fail to comply with applicable laws; if unauthorized parties gain physical access to one of our facilities and steal or misuse confidential information; if we erroneously use or disclose data in a way that is inconsistent with our granted rights; or if such information is misdirected, lost or stolen during transmission or transport, we may suffer damage to our reputation, potential loss of existing customers and difficulty attracting new customers. We could also be exposed to, among other things, unfavorable publicity, governmental inquiry and oversight, allegations by our customers that we have not performed our contractual obligations, costs to provide notifications or remediation (such as credit monitoring) to affected individuals, fines or other penalties imposed by government regulatory agencies, or litigation by affected parties and possible financial obligations for damages or indemnification obligations related to the theft or misuse of such information, any of which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

In addition, laws, rules and regulations concerning the protection of personal information are subject to frequent change by legislation, regulatory issuances or administrative interpretation. As regulatory focus on privacy issues continues to increase and these laws and regulations continue to expand and become more complex, these potential risks to our business could intensify. Changes in laws or regulations associated with the enhanced protection of certain types of sensitive data, such as healthcare data or other personally identifiable information, along with increased customer demands for enhanced data security infrastructure, could greatly increase our cost of providing our solutions and services, and may subject us to additional liabilities.

We are subject to extensive government regulation, including government and customer audits and investigations relating to our compliance with the laws and regulations applicable to companies in our industry, and a negative finding or other adverse determination could have a material adverse effect on our reputation, business, financial condition, results of operations and cash flows.

A significant portion of our business is regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect individual citizens, including government program beneficiaries, health plan members and their dependents. The federal and state governmental agencies administering these laws and regulations have broad latitude to enforce them. As such, we are subject, on an ongoing basis, to various governmental and customer reviews, audits and investigations to verify our compliance with our contracts and applicable laws and regulations, as well as legal actions and enforcement proceedings. For example, because we receive payments from federal and state governmental agencies, we are subject to laws, such as the Federal Acquisition Regulations, the U.S. Foreign Corrupt Practices Act, federal and state employment, equal opportunity and affirmative action laws, federal and state prompt pay statutes, healthcare fraud, waste and abuse laws and similar legislation. We are also subject to the Federal False Claims Act and similar state statutes, which permit government law enforcement agencies to institute suits against us for violations and, in some cases, to seek double or treble damages, penalties and assessments. In addition, private citizens, acting as whistleblowers, can sue on behalf of the government under the "*qui tam*" provisions of the Federal False Claims Act and similar statutory provisions in many states.

As we expand into new areas of the healthcare industry, we may develop new or enhanced solutions that may further expose us to requirements under additional statutes and legislative schemes that have previously not been relevant to our business, such as the Fair Debt Collection Practices Act and other banking and credit reporting statutes. For example, in connection with our acquisition of Eliza, we became subject to the Telephone Consumer Protection Act of 1991, state and federal audio and telephone recording laws, and other consumer laws and regulations as a result of the member engagement services that we perform. Our increased involvement in population health services and penetration into new markets, such as ACOs, PBMs and commercial self-insured employers, could increase the likelihood and incidence of our being subjected to regulatory scrutiny or legal actions by third parties other than our customers, which may impose significant costs and strain on our resources.

These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer and how we interact with customers, providers, other healthcare payers and the public. If the government discovers improper or illegal activities in the course of audits or investigations, we may be subject to various civil and criminal penalties and administrative sanctions, which may include termination of contracts, forfeiture of profits, suspension of payments, fines and suspensions and debarment from doing business with the government. Similarly, if our customers assert that we have failed to properly perform or comply with our contractual obligations, or if the carriers to which we send billings assert that we have failed to properly comply with applicable federal or state billing rules and regulations, we may be required to provide refunds or make payments to resolve such issues. If we are found to be in violation of any applicable law or regulation, or if we receive an adverse review, audit or investigation from a government agency or customer related to our compliance with such laws or regulations or the terms of our government contracts, any resulting negative publicity, penalties or sanctions could have an adverse effect on our reputation in the industry, impair our ability to compete for new contracts or bid in response to RFPs in one or more jurisdictions, and have a material adverse effect on our business, financial condition, results of operations and cash flows.

Federal and state governments may limit or prohibit outsourcing of certain programs or functions, refuse to grant consents or waivers necessary to permit private entities to perform such work, or impose other limitations on outsourcing or certain vendors that may obstruct cost-effective performance of our contracts.

Federal or state governments could limit or prohibit private contractors like us from operating or performing elements of certain government functions or programs. As a condition of receiving federal funding, state, and local governments may be required to operate such programs with government employees. Under current law, in order to privatize certain functions of government programs, the federal government must grant a consent and/or waiver to the petitioning state or local agency. If the federal government does not grant a necessary consent or waiver, the state or local agency will be unable to outsource that function to a commercial entity. Such a situation could eliminate a contracting opportunity or reduce the value of an existing contract.

Similarly, other state or federal limitations on outsourcing certain types of work to vendors that supplement our workforce could make it more difficult for us to fulfill our contracts in a cost-effective manner. Certain areas of our operations use or involve vendor or subcontractor personnel located outside of the United States, who may (under carefully controlled circumstances) access certain PHI in the course of assisting us with various elements of the services we provide to our customers. The federal government and a number of states have considered laws or issued rules, regulations, and orders that would limit, restrict or wholly prohibit the use of offshore labor in performance of government contracts, or impose sanctions for the use of such resources. Some of our customers have already chosen to contractually limit or restrict our ability to use offshore resources. Intensified restrictions of this type or associated penalties could raise our costs of doing business, expose us to unexpected fines or penalties, increase the prices we must charge to customers to realize a profit and eliminate or significantly reduce the value of existing contracts or potential contract opportunities, any of which could have a material adverse effect on our business, financial condition, results of operations and cash flows.

We may be precluded from bidding on or performing certain work due to work we currently perform, which could materially adversely affect our business, financial condition, results of operations and cash flows.

Various laws, regulations and administrative policies prohibit companies from performing work for government agencies in capacities that might be viewed to create an actual or perceived conflict of interest. In particular, CMS has stringent conflict of interest rules, which can limit our bidding for specific work for CMS, or for other contracts that might conflict, or be perceived by CMS to conflict, with contractual work for CMS. State governments and managed care organizations also have conflict of interest restrictions that could limit our ability to bid for certain work and impede our overall sales strategy. As we continue to expand and diversify our business operations, the likelihood that customers or potential customers will perceive conflicts of interest between our various subsidiaries, solutions, services, activities and customer relationships may increase. Such conflicts, whether real or perceived, could result in a loss of contracts or additional internal structural barriers that delay operational efficiency. We may also need to divest certain existing businesses or reorganize our current management and personnel structure, as well as our corporate organization and entity structure, in order to qualify for new contract awards or to appropriately mitigate conflicts and otherwise accommodate the increasing complexity of our business. Our failure to devote sufficient care, attention and resources to managing these adjustments may result in technical or administrative errors that could expose us to potential liability or adverse regulatory action. In addition, conflict of interest rules and standards change frequently, and are subject to varying interpretations and varying degrees and consistency of enforcement. We may not be successful in navigating these restrictions. If we are prevented from expanding our business or are unable to effectively implement our strategic initiatives due to real or perceived conflicts of interest, our business, financial condition, results of operations and cash flows could be materially adversely affected.

Risks Related to Our Common Stock

The market price of our common stock may be volatile, and fluctuations in the price of our common stock may materially adversely affect our business, financial condition, results of operations and cash flows and materially adversely affect our shareholders.

The market price of our common stock has fluctuated widely and may continue to do so. During the 52-week period ended December 31, 2018, our common stock traded on the Nasdaq Global Select Market as high as $37.38 per share and as low as $15.06 per share. Our stock price is subject to fluctuation as a result of a variety of factors, including factors beyond our control, such as the risk factors described above and those which are related to:

- quarterly or annual earnings results or those of other companies in our industry;
- changes in estimates of our performance or recommendations by securities analysts or in the operating and stock price performance of other companies that investors deem comparable to our company;
- news reports relating to trends, concerns and other issues in the healthcare industry, including perceptions in the marketplace regarding us and our competitors;
- the financial projections we publicly provide and any changes in or failure to meet those projections;
- future sales of shares of common stock in the public market by our executive officers or directors;
- any changes in the number of our outstanding shares, including as a result of share repurchases;
- actual or proposed changes in federal or state laws affecting the healthcare industry;
- changes in accounting principles;
- the public's response to our press releases, or other public announcements, including our filings with the SEC;
- securities class actions, shareholder lawsuits or other litigation; and
- market conditions in the industry and the economy as a whole.

In addition, the stock market often experiences significant price and volume fluctuations. These broad market fluctuations may materially adversely affect the market price of our common stock regardless of our operating performance. When the market price of a company's stock drops significantly, shareholders may institute securities class action litigation against that company. Any litigation against us could cause us to incur substantial costs, divert the time and attention of our management and other resources or otherwise harm our business.

Because we do not intend to pay dividends, you will benefit from an investment in our common stock only if it appreciates in value.

We have not paid or declared cash dividends on any of our capital stock to date and currently intend to retain our future earnings, if any, to fund the development and continued growth of our business and repurchase shares opportunistically from time to time. As a result, we do not expect to pay any cash dividends in the foreseeable future. The success of your investment in our common stock will likely depend entirely upon any future appreciation. There is no guarantee that our common stock will appreciate in value or even maintain the price at which you purchased your shares.

Certain provisions of our certificate of incorporation and bylaws could discourage unsolicited takeover attempts, which could depress the market price of our common stock.

Our certificate of incorporation authorizes the issuance of up to 5,000,000 shares of "blank check" preferred stock with such designations, rights and preferences as may be determined by our Board of Directors. Accordingly, our Board of Directors is empowered, without shareholder approval, to issue preferred stock with dividend, liquidation, conversion, voting or other rights, that could adversely affect the voting power or other rights of holders of our common stock. In the event of issuance, preferred stock could be utilized, under certain circumstances, as a method of discouraging, delaying, or preventing a change in control. Although we have no present intention to issue any shares of preferred stock, it is possible that we will do so in the future. In addition, our bylaws currently require advance notice of shareholder proposals for business to be conducted at meetings of our shareholders and for nominations of candidates for election to our Board of Directors and provide for Delaware as an exclusive forum for certain disputes with our shareholders, all of which could also have the effect of discouraging a change of control.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters and other material leased properties as of December 31, 2018 are shown in the following table:

Location	Approximate Square Footage	Owned/Leased
Irving, TX (corporate headquarters)	242,260	Owned
Las Vegas, NV (office space)	63,593	Leased
Danvers, MA (office space)	38,868	Leased
New York , NY (office space)	34,759	Leased
Westerville, OH (office space)	25,212	Leased
All other locations (23)	80,759	Leased

All other locations consist principally of office space and also include data centers, which are all located in the United States. The above locations have expiration dates through 2026. A portion of the above Las Vegas, NV and New York, NY office spaces are sub-leased. In general, we believe our facilities are suitable to meet our current and reasonably anticipated future needs. See "Lease Commitments" in Note 15 to the Consolidated Financial Statements in Part II, Item 8 for additional information.

Item 3. Legal Proceedings

The information set forth under the caption "Litigation" in Note 15 to the Consolidated Financial Statements in Part II, Item 8 is incorporated herein by reference.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Shareholder Matters and Issuer Purchases of Equity Securities

Market Information

Our common stock is listed on the Nasdaq Global Select Market under the symbol "HMSY".

Holders

As of the close of business on February 15, 2019, there were 252 holders of record of our common stock.

Dividends

We have not paid or declared any cash dividends on our common stock and do not anticipate paying cash dividends in the foreseeable future. Our current intention is to retain future earnings to support the continued growth of our business and possibly for the repurchase of shares from time to time. Our Board of Directors will evaluate various factors, including, without limitation, our future earnings, operating cash flows, financial condition, results of operations and capital requirements in determining whether to pay any cash dividends in the future. In addition, our Credit Agreement generally limits, subject to certain exceptions, our ability to make certain payments or distributions with respect to our capital stock, including cash dividends to our shareholders. These restrictions are described in more detail under the heading "Liquidity and Capital Resources" in Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, and in Note 10 to the Consolidated Financial Statements in Part II, Item 8.

See Part III, Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Shareholder Matters for information relating to securities authorized for issuance under our equity compensation plans.

Repurchases of Shares of Common Stock

On November 1, 2017, the Board of Directors of the Company approved a share repurchase program authorizing the Company to repurchase up to $50.0 million of shares of its common stock from time to time on the open market or in privately negotiated or other transactions. We publicly announced the program in November 2017. The repurchase program is authorized for a period of up to two years, and may be suspended or discontinued at any time. In order to facilitate repurchases, the Company may enter into a Rule 10b5-1 plan from time to time, which would permit shares to be repurchased when the Company might otherwise be precluded from doing so under insider trading laws or because of a self-imposed trading blackout period. All repurchases were made under the program and using cash resources. See "Equity" in Note 11 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding share repurchases. There were no repurchases of shares of common stock in the fourth quarter of 2018.

Period	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program	Maximum Approximate Dollar Value of Shares That May Yet Be Purchased Under the Program
October 1, 2018 to October 31, 2018	—	$ —	—	$ —
November 1, 2018 to November 30, 2018	—	—	—	—
December 1, 2018 to December 31, 2018	—	—	—	—
Total	—	$ —	—	$ 29,933,055

Comparative Stock Performance Graph

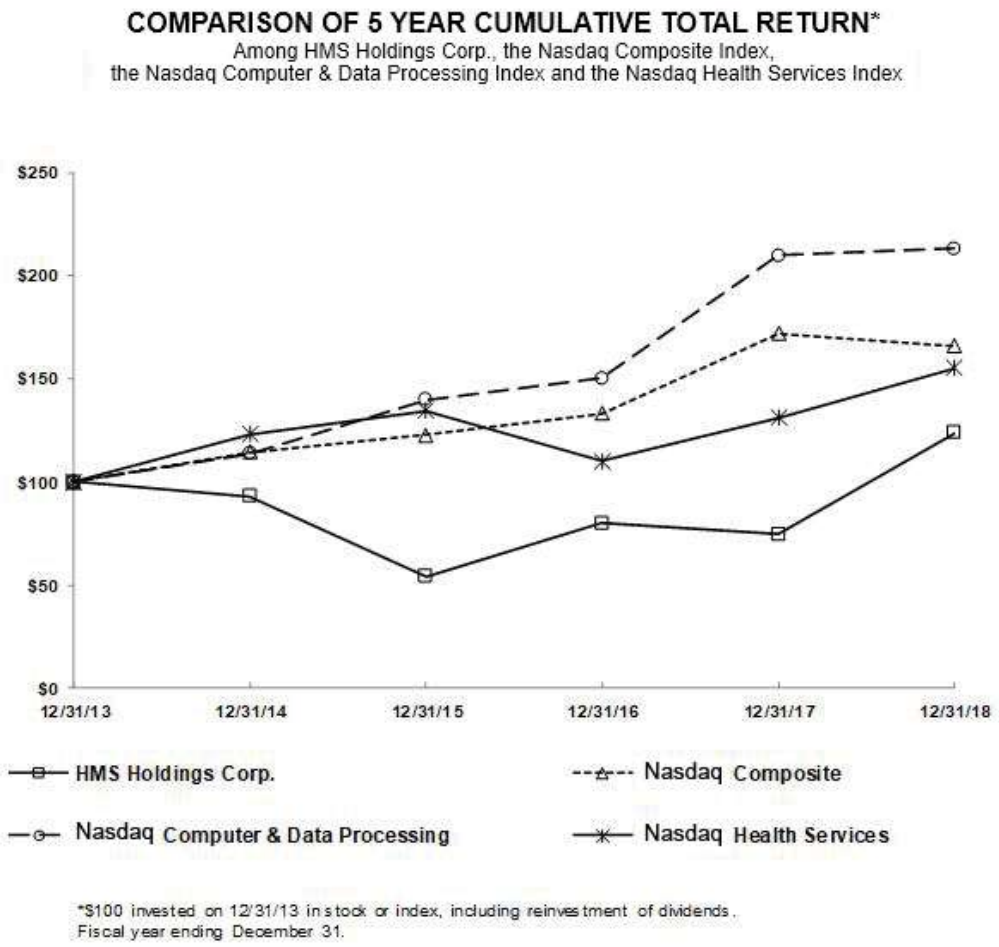

The graph below compares the cumulative total shareholder return on our common stock with the cumulative total shareholder returns of the Nasdaq Composite Index, the Nasdaq Computer & Data Processing Index and the Nasdaq Health Services Index assuming an investment of $100 on December 31, 2013 and the reinvestment of dividends through the year ended December 31, 2018.

	12/31/13	12/31/14	12/31/15	12/31/16	12/31/17	12/31/18
HMS Holdings Corp.	$ 100.00	$ 93.13	$ 54.36	$ 80.00	$ 74.67	$ 123.92
NASDAQ Composite	100.00	114.62	122.81	133.19	172.11	165.84
NASDAQ Computer & Data Processing	100.00	113.68	140.03	150.12	209.72	212.97
NASDAQ Health Services	100.00	123.14	134.70	110.22	131.32	155.16

Notwithstanding anything to the contrary set forth in any of our previous or future filings under the Securities Act or the Exchange Act that might incorporate by reference this 2018 Form 10-K or future filings made by us under those statutes, the Comparative Stock Performance Graph is not deemed filed with the SEC, is not deemed soliciting material and shall not be deemed incorporated by reference into any of those prior filings or into any future filings we make under those statutes, except to the extent that we specifically incorporate such information by reference into a previous or future filing, or specifically request that such information be treated as soliciting material, in each case under those statutes.

Item 6. Selected Financial Data

The following table sets forth selected consolidated financial amounts at and for each of the five fiscal years in the period ended December 31, 2018. It should be read in conjunction with Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations, and the Consolidated Financial Statements and Notes thereto, in Part II, Item 8 of this 2018 Form 10-K.

Statement of Operations Data

	Years ended December 31,				
(in thousands, except per share amounts)	2018	2017	2016	2015	2014
Revenue	$ 598,290	$ 521,212	$ 489,720	$ 474,216	$ 443,225
Total operating expenses	535,052	470,781	432,051	426,644	409,021
Operating income	63,238	50,431	57,669	47,572	34,204
Interest expense	(11,310)	(10,871)	(8,519)	(7,812)	(7,931)
Interest income	1,089	295	321	49	57
Income before income taxes	53,017	39,855	49,471	39,809	26,330
Income taxes	(1,972)	(199)	11,835	15,282	12,383
Net income	$ 54,989	$ 40,054	$ 37,636	$ 24,527	$ 13,947
Net Income Per Common Share					
Basic income per common share:					
Net income per common share - basic	$ 0.66	$ 0.48	$ 0.45	$ 0.28	$ 0.16
Diluted income per common share:					
Net income per common share - diluted	$ 0.64	$ 0.47	$ 0.43	$ 0.28	$ 0.16
Weighted average shares:					
Basic	83,625	83,821	84,221	87,881	87,673
Diluted	86,144	85,088	86,987	88,361	88,164

Balance Sheet Data

	Years ended December 31,				
(in thousands)	2018	2017	2016	2015	2014
Cash and cash equivalents	$ 178,946	$ 83,313	$ 175,999	$ 145,610	$ 133,116
Working capital	$ 328,684	$ 199,967	$ 277,478	$ 240,456	$ 226,271
Total assets	$ 1,078,518	$ 975,160	$ 882,755	$ 850,597	$ 880,988
Revolving credit facility	$ 240,000	$ 240,000	$ 197,796	$ 197,796	$ 197,796
Total shareholders' equity	$ 713,396	$ 606,229	$ 556,610	$ 524,702	$ 533,090

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following Management's Discussion and Analysis is intended to help the reader understand the results of operations and financial condition of HMS. You should read this discussion and analysis in conjunction with the other sections of this 2018 Form 10-K, including the Cautionary Note Regarding Forward-Looking Statements appearing prior to Part I, the information in Part I, Item 1A, and the Consolidated Financial Statements and Notes thereto in Part II, Item 8. The historical results set forth in Part II, Item 6, Item 7 and Item 8 of this 2018 Form 10-K should not be taken as necessarily indicative of our future operations or financial results.

Business Overview

HMS provides a broad range of cost containment solutions to help healthcare payers and at-risk providers reduce costs, improve health outcomes and enhance member experiences. Using industry-leading technology, analytics and engagement solutions, we deliver coordination of benefits, payment integrity and total population management solutions through our operating subsidiaries to move the healthcare system forward for our customers. We are managed and operate as one business segment with a single management team that reports to the Chief Executive Officer.

We serve state Medicaid programs, commercial health plans, federal government health agencies, government and private employers, CHIPs and other healthcare payers. We also serve as a subcontractor for certain business outsourcing and technology firms. As of December 31, 2018, our customer base included the following:

- over 40 state Medicaid programs;
- more than 325 health plans, including 23 of the top 25 health plans nationally (based on membership) in support of their multiple lines of business, including Medicaid managed care, Medicare Advantage and group and individual health;
- over 150 private employers;
- CMS, the Centers for Disease Control and Prevention, and the Department of Veterans Affairs; and
- PBMs, third-party administrators and other risk-bearing entities, including independent practice associations, hospital systems, ACOs and specialty care organizations.

Outlook

We have grown our business both organically, through internal innovation and the development of new solutions and services, as well as by acquisition of businesses whose core services strengthened our overall mission to help our customers contain healthcare costs. Our largest growth during 2018 was with commercial health plan customers and we currently expect this market to present the greatest opportunity for continued growth in the year ahead. In addition to cross-sales of our total population management solutions and other internal growth initiatives in 2019, various factors related to the macro healthcare environment are expected to contribute to our expected growth, including:

- an aging U.S. population with high-cost, chronic conditions and often co-morbidities;
- projected growth in Medicare enrollment from 2018 to 2026 is estimated by CMS to be at 24%, with a projected increase in spending of 83% during this same time period;
- Medicaid expenditures are projected to grow 60% from 2018 to 2026 based on CMS NHE projections;
- government program payment error rates remain high at approximately 9%;
- more than half of the U.S. population is projected by CMS to remain covered by employer-sponsored plans;
- continued support for moving the focus of U.S. reimbursement models away from volume of service to quality outcomes; and
- increased healthcare industry focus on improved population health, enhanced consumer outcomes and experience, and reduced costs.

We plan to drive our future growth by leveraging our expertise to expand solution offerings, attracting new customers and broadening our relationships with current customers through the introduction of new services, audit strategies and claim types. Our goal is to develop and build on existing partnerships with our state, federal and commercial health plan customers to provide services that better address their business needs and promote consumer engagement and satisfaction in the constantly evolving healthcare marketplace. We also expect to continue increasing recovery yields from our current services by enhancing our operating and organizational efficiency and by implementing new technologies that will improve the quality, effectiveness and profitability of our service offerings.

We are subject to a number of significant risks in the operation of our business, including operational, strategic, financial and regulatory risks. These include risks related to legal compliance, financial performance and condition, protection of our information technology networks and systems and intellectual property, and other risks. With respect to cybersecurity, the effective operation of our information technology networks and systems, and the secure processing and maintenance of the confidential, proprietary and sensitive information and data we receive from our customers and other data suppliers are critical to our operations and business strategy. Although we have processes and procedures to attempt to mitigate many of the risks that we face, there can be no assurance that such processes or procedures will be successful. For a discussion of certain risks relating to the Company, see the information under the heading "Part I, Item 1A. Risk Factors."

Critical Accounting Policies and Estimates

Our consolidated financial statements are prepared in accordance with U.S. GAAP. The preparation of these consolidated financial statements requires us to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenue, costs and expenses, and related disclosures. We evaluate our estimates and assumptions on an ongoing basis. Our estimates are based on historical experience and various other assumptions that we believe to be reasonable under the circumstances. Our actual results could differ from these estimates. The accounting policies that we believe to be the most critical to an understanding of our financial condition and results of operations and that require the most complex and subjective management judgments are below:

Revenue Recognition

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
The Company recognizes revenue when our customers realize economic benefits from our services when our services are completed.	Due to the range of solutions and services that HMS provides and the differing fee structures associated with each type of contract, revenue may be recognized in irregular increments. A portion of our revenue is recorded net of an estimate of future revenue adjustments, with an offsetting entry to accounts receivable allowance, based on historical patterns of billing adjustments, length of operating and collection cycle and customer negotiations, behaviors and payment patterns. Changes in these estimates are recorded to revenue in the period of change.	If we were to enter any new contracts with differing fee structures or performance obligations or if we were to change any of the judgments or estimates related to estimated future revenue adjustments, it could cause a material increase or decrease in the amount of revenue we report in a particular period.

Estimated Liability for Appeals

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
Under our contracts with certain commercial health plan customers and our Medicare RAC contracts with CMS, we recognize revenue when HMS claim findings are sent to the Company's customers for offset against future claim payments to providers. These contracts permit providers the right to appeal HMS claim findings and to pursue additional appeals if the initial appeal is found in favor of HMS's customer. The total estimated liability for appeals balance was $21.7 million and $30.8 million as of December 31, 2018 and December 31, 2017, respectively. The Company's original Medicare RAC contract with CMS expired on January 31, 2018.	The appeal process established under the Medicare RAC contract with CMS includes five levels of appeals and resolution of appeals can take substantial time to resolve. HMS records (i) a liability for findings which have been adjudicated in favor of providers and (ii) an estimated liability based on the amount of revenue that is subject to appeals and which is probable of being adjudicated in favor of providers following their successful appeal. Our estimated liability is based on the Company's historical experience. As a result of the original Medicare RAC contract expiration, the Company's contractual obligation with respect to any appeals resolved in favor of providers subsequent to the expiration date have ceased and therefore the Company released its estimated return obligation liability and increased revenue by $8.4 million during the first quarter of 2018.	To the extent the amount to be returned to providers following a successful appeal exceeds or is less than the amount recorded, revenue in the applicable period would be reduced or increased by such amount. Any future changes to any of our customer contracts, including modifications to Medicare RAC contracts, may require us to apply different assumptions that could materially affect both the Company's revenue and estimated liability for appeals in future periods.

Business Combinations

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
We record assets acquired and liabilities assumed in a business combination based upon their acquisition date fair values. Goodwill is the excess of acquisition costs over the fair values of assets and liabilities of acquired businesses. During the measurement period, which is up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed, with the corresponding offset to goodwill. Upon the conclusion of the measurement period, any subsequent adjustments are recorded to earnings.	In most instances there is not a readily defined or listed market price for individual assets and liabilities acquired in connection with a business, including intangible assets. We determine fair value through various valuation techniques including discounted cash flow models, quoted market values and third party independent appraisals, as considered necessary. Significant assumptions used in those techniques include, but are not limited to, growth rates, discount rates, customer attrition rates, expected levels of revenues, earnings, cash flows and tax rates.	The use of different valuation techniques and assumptions are highly subjective and inherently uncertain and, as a result, actual results may differ materially from estimates.

Impairment of Goodwill

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
Goodwill is subject to a periodic assessment for impairment. We assess goodwill for impairment on an annual basis as of June 30th of each year or more frequently if an event occurs or changes in circumstances would more likely than not reduce the fair value of a reporting unit below its carrying amount. Assessment of goodwill impairment is at the HMS Holdings Corp. entity level as we operate as a single reporting unit. The Company's carrying amount of goodwill was $487.6 million as of December 31, 2018.	We have the option to perform a qualitative or quantitative assessment to determine if impairment is more likely than not to have occurred. The Company completed the annual impairment test as of June 30, 2018 electing to perform the quantitative assessment of which the first step is to compare the fair value of the reporting unit with its carrying value, including goodwill. In calculating the fair value of the reporting unit, the Company utilized a weighting across three commonly accepted valuation approaches: an income approach, a guideline public company approach, and a merger and acquisition approach. The income approach to determining fair value computes projections of the cash flows that the reporting unit is expected to generate converted into a present value equivalent through discounting. Significant assumptions in the income approach include income projections, a discount rate and a terminal growth value which are all level 3 inputs. The income projections include assumptions for revenue and expense growth which are based on internally developed business plans and largely reflect recent historical revenue and expense trends. The discount rate was based on a risk free rate plus a beta adjusted equity risk premium and specific company risk premium. The terminal growth value is Company specific and was determined analyzing inputs such as historical inflation and the GDP growth rate. The guideline public company approach and merger and acquisition approach are based on pricing multiples observed for similar publicly traded companies or similar market companies that were sold.	The results of the annual impairment assessment provide that the fair value of the reporting unit was significantly in excess of the Company's carrying value, including goodwill; therefore, no impairment was indicated. If actual results are not consistent with our estimates or assumptions, the Company may be exposed to an impairment charge that could materially adversely impact our consolidated financial position and results of operations. There were no impairment charges related to goodwill during the years ended December 31, 2018, 2017, or 2016.

Impairment of Long-Lived and Intangible Assets

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
Long-lived assets, including property and equipment and intangible assets, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of the asset may not be recoverable. When indicators exist, recoverability of assets is measured by a comparison of the carrying value of the asset group to the estimated undiscounted future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized and charged to earnings is measured by the amount by which the carrying value of the asset group exceeds the fair value of the assets.	We use significant judgment in assessing events or changes in circumstances which indicate that the carrying amount of the asset may not be recoverable.	The Company's carrying amount of long-lived assets, including property and equipment and intangible assets was $161.6 million as of December 31, 2018. The Company did not recognize any impairment charges related to long-lived and intangible assets during the years ended December 31, 2018, 2017 or 2016. However, if actual results are not consistent with our estimates or assumptions, we may be exposed to an impairment charge that could materially adversely impact our consolidated financial position and results of operations.

Valuation of Stock-Based Compensation

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
The determination of the fair value of the options on the grant date using the Black-Scholes pricing model and/or the Monte Carlo Simulation is affected by the Company's stock price, as well as assumptions regarding a number of complex and subjective variables. Certain key variables include: the Company's expected stock price volatility over the expected term of the awards; a risk-free interest rate; and any expected dividends. The fair value of all awards also includes an estimate of expected forfeitures.	We estimate stock price volatility based on the historical volatility of the Company's common stock and estimate the expected term of the awards based on the Company's historical option exercises for similar types of stock option awards. The assumed risk-free interest rate is based on the yield on the measurement date of a zero-coupon U.S. Treasury bond with a maturity period equal to the option's expected term. The Company does not anticipate paying any cash dividends in the foreseeable future and therefore, uses an expected dividend yield of zero in the option valuation models. Forfeitures are estimated based on historical experience.	If we were to change any of these judgments or estimates, it could cause a material increase or decrease in the amount of stock compensation expense we report in a particular period. For example, if actual forfeitures vary from estimates, a difference in compensation expense will be recognized in the period the actual forfeitures occur.

Income Taxes

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
Income taxes are accounted for under the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to temporary differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. This method also requires the recognition of future tax benefits for net operating loss carry-forwards.	Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as income or expense in the period that includes the enactment date. A valuation allowance is provided against deferred tax assets to the extent their realization is not more likely than not. Uncertain income tax positions are accounted for by prescribing a minimum recognition threshold that a tax position is required to meet before being recognized in the financial statements. We make adjustments to these reserves in accordance with the income tax accounting guidance when facts and circumstances change, such as the closing of a tax audit or the refinement of an estimate.	To the extent that the final tax outcome of these matters is different than the amounts recorded, such differences will affect the provision for income taxes in the period in which such determination is made, and could have a material impact on our financial condition and operating results. Although the Company believes that it has adequately reserved for uncertain tax positions (including interest and penalties), it can provide no assurance that the final tax outcome of these matters will not be materially different.

Contingencies

Description	Judgments and Uncertainties	Effect if Actual Results Differ from Assumptions
From time to time, we are involved in legal proceedings in the ordinary course of business. We assess the likelihood of any adverse judgments or outcomes to these contingencies as well as potential ranges or probable losses and establish reserves accordingly.	We record accruals for outstanding legal matters when we believe it is probable that a loss will be incurred and the amount can be reasonably estimated. Significant judgment is required to determine both probability and the estimated amount. We review these provisions at least quarterly and adjust the provisions to reflect the impact of negotiations, settlements, rulings, advice of legal counsel and updated information.	Litigation is inherently unpredictable and is subject to significant uncertainties, some of which are beyond the Company's control. The amount of reserves required may change in future periods due to new developments in each matter or changes in approach to a matter such as a change in settlement strategy which could have a material impact on our financial condition and operating results.

For further information on these critical accounting policies and all other significant accounting policies refer to the discussion under "Business and Summary of Significant Accounting Policies" in our Note 1 to the Consolidated Financial Statements in Part II, Item 8.

Results of Operations

2018 Highlights

- Revenue growth of 14.8%
- Operating income growth of 25.4%
- Cash flow from operations of $96.5 million
- Repurchased approximately 384,000 shares of common stock for $6.0 million
- Net income growth of 37.2%

Comparison of 2018 to 2017 and 2017 to 2016

dollars in millions	Year Ended December 31,			$ Change	% Change	$ Change	% Change
	2018	2017	2016	2018 vs 2017		2017 vs 2016	
Revenue	$ 598.3	$ 521.2	$ 489.7	$ 77.1	14.8%	$ 31.5	6.4%
Cost of Services :							
Compensation	224.9	202.0	189.3	22.9	11.3	12.7	6.7
Information technology	53.4	45.7	37.3	7.7	16.8	8.4	22.5
Occupancy	16.0	17.2	14.0	(1.2)	(7.0)	3.2	22.9
Direct project costs	42.9	41.4	46.3	1.5	3.6	(4.9)	(10.6)
Other operating costs	31.4	28.4	27.8	3.0	10.6	0.6	2.2
Amortization of acquisition related software and intangible assets	33.0	30.4	28.0	2.6	8.6	2.4	8.6
Total Cost of Services	401.6	365.1	342.7	36.5	10.0	22.4	6.5
Selling, general and administrative expenses	113.5	105.7	89.4	7.8	7.4	16.3	18.2
Settlement expense	20.0	-	-	20.0	100.0	-	-
Total Operating Expenses	535.1	470.8	432.1	64.3	13.7	38.7	9.0
Operating Income	63.2	50.4	57.6	12.8	25.4	(7.2)	(12.5)
Interest expense	(11.3)	(10.8)	(8.5)	(0.5)	4.6	(2.3)	27.2
Interest income	1.1	0.3	0.3	0.8	266.7	0.0	0.3
Income before income taxes	53.0	39.9	49.4	13.1	32.8	(9.5)	(19.2)
Income taxes	(2.0)	(0.2)	11.8	(1.8)	900.0	(12.0)	(101.7)
Net Income	$ 55.0	$ 40.1	$ 37.6	$ 14.9	37.2%	$ 2.5	6.6%

Revenue

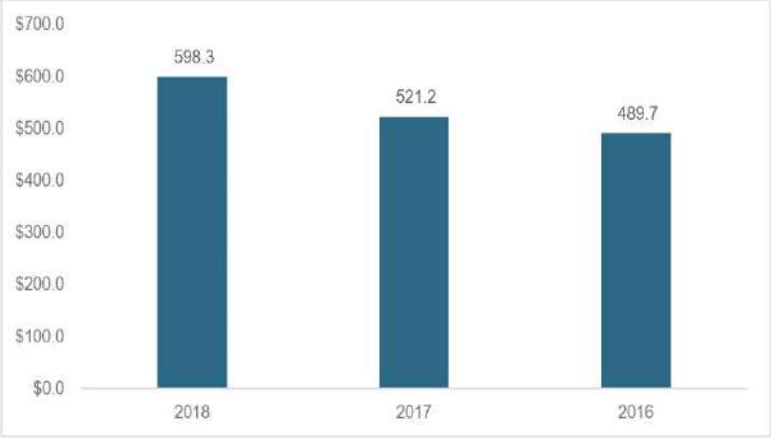

Revenue in Millions

2018 vs. 2017

During the year ended December 31, 2018, revenue was $598.3 million, an increase of $77.1 million or 14.8% compared to $521.2 million for the year ended December 31, 2017.

- By solution, which consists of coordination of benefits and analytical services, and included in analytical services are our payment integrity and total population management solutions:
  - Coordination of benefits product revenue increased $14.4 million or 3.8% which was attributable to yield improvements and the addition of Medicaid enrollees which entered our customer eligibility files in 2018.
  - Payment integrity revenue increased $39.7 million or 38.0% which was attributable to expanded commercial health plan scopes, including the addition of health plans to current contracts and yield improvements. Within payment integrity, Medicare RAC revenue increased $17.8 million which includes an $8.4 million reserve release during the first quarter of 2018 as compared to prior year.
  - Total population management revenue increased $23.0 million or 67.4% of which $21.4 million is due to Eliza (acquired in April 2017). Additionally, Essette revenue increased $1.6 million as compared to prior year.

- By market:
  - Commercial health plan market revenue increased $54.0 million or 20.1% which includes increases of $21.4 million from Eliza (acquired in April 2017) as compared to the prior year and $1.6 million from Essette as compared to prior year. The increases are due to expanded commercial health plan scopes, including the addition of health plans to current contracts and yield improvements.
  - State government market revenue increased $6.9 million or 3.0%, which was attributable to expanded scopes and yield improvements.
  - Federal government market and other revenue increased $16.2 million or 64.8% which includes an $8.4 million Medicare RAC reserve release.

2017 vs. 2016

During the year ended December 31, 2017, revenue was $521.2 million, an increase of $31.5 million or 6.4% compared to $489.7 million for the year ended December 31, 2016.

- By solution, which consists of coordination of benefits and analytical services, and included in analytical services are our payment integrity and total population management solutions:
  - Coordination of benefits service revenue increased $29.0 million or 8.2% which was attributable to yield improvements and the addition of Medicaid enrollees which entered our customer eligibility files in 2017.
  - Payment integrity revenue decreased $30.7 million or 22.8% which was attributable to a $14.7 million decrease in Medicare RAC revenue because the Medicare RAC Region D program ceased generating revenue in late 2016, as expected, and a $16.1 million decrease due to various contract completions and expirations.
  - Total population management revenue increased $33.3 million or 3746.8% almost all of which is due to the Eliza acquisition in April 2017.

- By market:
  - Commercial health plan market revenue increased $39.0 million or 17.0% which was attributable to Eliza contributing revenue of $30.4 million since its acquisition in April 2017, Essette increasing revenue $2.9 million as compared to prior year and expanded commercial health plan scopes, including the addition of health plans to current contracts and yield improvements.
  - State government market revenue increased by $7.9 million or 3.6%, which was attributable to expanded scopes and yield improvements.
  - Federal government market and other revenue decreased $15.4 million, which was primarily attributable to a reduction of Medicare RAC revenue because the Medicare RAC D Region D program ceased generating new claims for active auditing in 2016, as expected.

Cost of Services

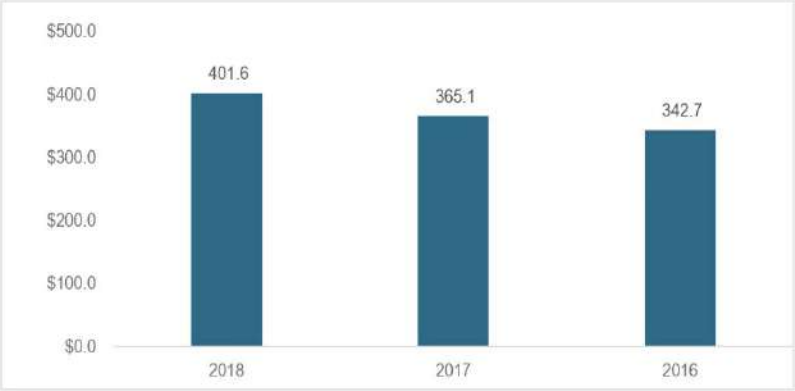

Cost of Services in millions

2018 vs. 2017

During the year ended December 31, 2018, total cost of services was $401.6 million, an increase of $36.5 million or 10.0% compared to $365.1 million for the year ended December 31, 2017. This change resulted primarily from increases in compensation expense of $22.9 million, information technology expense of $7.7 million, other operating costs of $3.0 million and amortization of intangibles expense of $2.6 million.

- The increase in total cost of services relating to Eliza (acquired in April 2017) represented $14.4 million of the increase.
- Excluding Eliza, total cost of services increased by $22.1 million which was primarily related to increases in compensation expenses of $17.0 million related to the overall performance of the Company and information technology expenses of $4.2 million.

2017 vs. 2016

During the year ended December 31, 2017, total cost of services was $365.1 million, an increase of $22.4 million or 6.5% compared to $342.7 million for the year ended December 31, 2016. This change resulted primarily from increases in compensation expense of $12.7 million, information technology expense of $8.4 million, and amortization of intangibles expense of $2.4 million.

- The Eliza acquisition and the related compensation, data processing, occupancy and amortization of intangibles expenses incurred since its acquisition in April 2017 represented $23.4 million of the increase.
- Excluding Eliza, total cost of services decreased by $1.0 million which was primarily related to a reduction in direct project costs partially offset by increases in data processing and compensation expenses.

Selling, General and Administrative Expenses

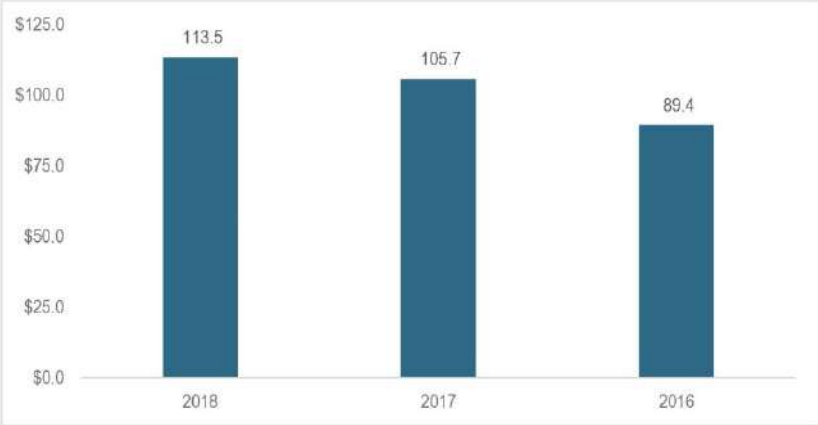

SG&A in millions

2018 vs. 2017

During the year ended December 31, 2018, SG&A expense was $113.5 million, an increase of $7.8 million or 7.4% compared to $105.7 million for the year ended December 31, 2017.

- Eliza (acquired in April 2017) represented $1.9 million of the increase.
- Excluding Eliza, expenses increased by $5.9 million primarily related to increased variable compensation expense due to the overall performance of the Company.

2017 vs. 2016

During the year ended December 31, 2017, SG&A expense was $105.7 million, an increase of $16.3 million or 18.2% compared to $89.4 million for the year ended December 31, 2016.

- The Eliza acquisition and related transaction fees and other SG&A expenses incurred since its acquisition in April 2017 represented $8.7 million of the increase.
- Excluding Eliza, stock compensation expense also increased by $7.3 million primarily due to stock compensation expense for retirement eligible employees.

Income Taxes

2018 vs. 2017

During the year ended December 31, 2018, we recorded an income tax benefit of ($2.0) million, an increased benefit of $1.8 million compared to an income tax benefit of ($0.2) million for the year ended December 31, 2017.

- On December 22, 2017, the 2017 Tax Act was signed into law and includes provisions reducing the federal tax rate for years beginning in 2018 from 35% to 21%.
- Our effective tax rate was (3.7%) for the year ended December 31, 2018 compared to an effective tax rate of (0.5%) for the year ended December 31, 2017. The low 2018 effective tax rate is primarily due to favorable tax benefits related to current year credits, equity compensation, subsidiary basis write off, prior year state tax apportionment changes, uncertain tax position releases, and acquisition adjustments.
- Our normalized effective tax rate of 25.8% for 2018 decreased from our normalized effective tax rate of 36.1% for 2017 primarily due to a lower federal tax rate. The normalized effective tax rate excludes prior years' expense and benefit adjustments recognized in the respective fiscal year.

2017 vs. 2016

During the year ended December 31, 2017, we recorded an income tax benefit of ($0.2) million, a decrease of $12.0 million compared to the year ended December 31, 2016.

- Our effective tax rate was (0.5%) for the year ended December 31, 2017 compared to an effective tax rate of (23.9%) for the year ended December 31, 2016. The decrease is primarily due to the revaluation of our deferred tax liabilities based on the reduced federal tax rate described above.
- Our normalized effective tax rate of 36.1% for 2017 is comparable to our normalized effective tax rate of 36.2% for 2016. The normalized effective tax rate excludes prior years expense and benefit adjustments recognized in the respective fiscal year.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements.

Liquidity and Capital Resources

The following tables should be read in conjunction with the Consolidated Financial Statements and Notes thereto, in Part II, Item 8 of this 2018 Form 10-K.

Our cash and cash equivalents, working capital and available borrowings under our credit facility (based upon the borrowing base and financial covenants in our Credit Agreement) were as follows *(in thousands)*:

	Years ended December 31,	
	2018	2017
Cash and cash equivalents	$ 178,946	$ 83,313
Working capital	$ 328,684	$ 199,967
Available borrowings under credit facility	$ 253,500	$ 254,600

A summary of our cash flows was as follows *(in thousands)*:

	Years ended December 31,		
	2018	2017	2016
Net cash provided by operating activities	$ 96,457	$ 86,464	$ 88,639
Net cash used in investing activities	(30,413)	(204,364)	(39,201)
Net cash provided by/(used in) financing activities	29,589	25,214	(19,049)
Net increase / (decrease) in cash and cash equivalents	$ 95,633	$ (92,686)	$ 30,389

Our cash and cash equivalents and working capital increased as of December 31, 2018 as compared to December 31, 2017, primarily as a result of the cash generated by our operating activities as discussed below.

Our principal source of cash has been our cash flow from operations and our $500 million five-year revolving credit facility. Other sources of cash include proceeds from exercise of stock options and tax benefits associated with stock option exercises. The primary uses of cash are capital investments, compensation expenses, data processing, direct project costs, SG&A expenses and acquisitions. We may also use available cash to repurchase shares of our common stock.

We believe that expected cash flows from operations, available cash and cash equivalents, and funds available under our revolving credit facility will be sufficient to meet our liquidity requirements for the following year, which include:

- the working capital requirements of our operations;
- investments in our business;
- business development activities;
- repurchases of common stock; and
- repayment of our revolving credit facility.

Any projections of future earnings and cash flows are subject to substantial uncertainty. We may need to access debt and equity markets in the future if unforeseen costs or opportunities arise, to meet working capital requirements, fund acquisitions or repay our indebtedness under the Credit Agreement. If we need to obtain new debt or equity financing in the future, the terms and availability of such financing may be impacted by economic and financial market conditions as well as our financial condition and results of operations at the time we seek additional financing.

Cash Flows from Operating Activities

Net cash provided by operating activities for the year ended December 31, 2018 was $96.5 million, a $10.0 million increase from net cash provided by operating activities of $86.5 million for the year ended December 31, 2017. The increase was primarily due to a $14.9 million increase in net income and increases in reconciling items of $14.3 million as compared to prior year. These increases were offset by decreases in operating assets and liabilities of approximately $19.2 million.

Net cash provided by operating activities for the year ended December 31, 2017 was $86.5 million, a $2.1 million decrease from net cash provided by operating activities of $88.6 million for the year ended December 31, 2016. The decrease was primarily due to a decrease in deferred income taxes of $13.0 million related to our revaluation of the Company's deferred tax balances from the federal tax rate of 35% to 21% under the 2017 Tax Act, offset by an increase in stock based compensation expense of $10.9 million primarily related to retirement eligible employees. The decrease was also impacted by changes in operating assets and liabilities and offset by increases in net income, and depreciation and amortization expenses.

Our DSO calculation can be derived by dividing total net accounts receivable at the end of period, by the daily average of the current quarter's annualized revenue. For the year ended December 31, 2018, revenue was $598.3 million, an increase of $77.1 million compared to revenue of $521.2 million for the year ended December 31, 2017. DSO increased by 4 days to 119 days as of December 31, 2018, as compared to 115 days as of December 31, 2017. The change was due to timing delays in certain clients processing our findings through their systems. We do not currently anticipate collection issues with our accounts receivable, however, nor do we currently expect that any extended collections will materially impact our liquidity.

The majority of our customer relationships have been in place for several years. Our future operating cash flows could be adversely affected by a decrease in a demand for our services, delayed payments from customers or if one or more contracts with our largest customers is terminated or not renewed.

Cash Flows from Investing Activities

Net cash used in investing activities for the year ended December 31, 2018 was $30.4 million, a $174.0 million decrease compared to net cash used in investing activities of $204.4 million for the year ended December 31, 2017. This decrease was primarily due to the use of approximately $171.3 million for the Eliza acquisition in April 2017. Purchases of property and equipment and investment in capitalized software also decreased by $2.7 million year over year.

Net cash used in investing activities for the year ended December 31, 2017 was $204.4 million, a $165.2 million increase compared to net cash used in investing activities of $39.2 million for the year ended December 31, 2016. This increase was primarily due to the use of approximately $171.3 million for the Eliza acquisition in April 2017 as compared to the use of approximately $20.7 million for the Essette acquisition in September 2016. Purchases of property and equipment and investment in capitalized software also increased by $12.0 million year over year.

We currently expect to incur capital expenditures of $35-$40 million during the year ended December 31, 2019.

Cash Flows from Financing Activities

Net cash provided by financing activities for the year ended December 31, 2018 was $29.6 million, a $4.4 million increase from net cash provided by financing activities of $25.2 million for the year ended December 31, 2017. This increase was primarily attributable to an increase of $36.0 million of proceeds from exercise of stock options over prior year and an $8.2 million decrease in repurchases of common stock as compared to prior year. Additionally, there was a $39.8 million decrease in proceeds from our credit facility net of deferred financing cost payments.

Net cash provided by financing activities for the year ended December 31, 2017 was $25.2 million, a $44.2 million increase from net cash used in financing activities of $19.0 million for the year ended December 31, 2016. This increase was primarily attributable to $42.2 million of proceeds from additional borrowings under our amended credit facility.

Share Repurchase Program

During the year ended December 31, 2018, we repurchased 0.4 million shares of our common stock for approximately $6.0 million using cash resources. See the discussion under "Repurchases of Shares of Common Stock" under Part II, Item 5 and "Equity" in Note 11 to the Consolidated Financial Statements under Part II, Item 8 for additional information regarding share repurchases.

Credit Agreement

In May 2013, we entered into the Credit Agreement with certain lenders and Citibank, N.A. as administrative agent. The Credit Agreement originally provided for an initial $500 million five-year revolving credit facility maturing on May 3, 2018. On December 19, 2017, we entered into an amendment to the Credit Agreement that, among other things, provided for an extension of the maturity date of our then-existing senior secured revolving credit facility to December 19, 2022, which includes a $50 million sublimit for the issuance of letters of credit and a $25 million sublimit for swingline loans. In addition, the Credit Agreement includes an accordion feature that permits us to increase the revolving credit facility up to the sum of (a) the greater of $120 million and 100% of Consolidated EBITDA (as defined in the Credit Agreement) and (b) additional amounts so long as our first lien leverage ratio (as defined in the Credit Agreement) on a pro forma basis is not greater than 3.00:1.00, in each case subject to obtaining commitments from lenders therefor and meeting certain other conditions.

The obligations and amounts due under the Credit Agreement are secured by a first security priority interest in all or substantially all of our tangible and intangible assets and our material 100% owned subsidiaries' assets. The Credit Agreement contains customary representations and warranties, affirmative and negative covenants, including financial covenants, and events of default.

As of December 31, 2018, the outstanding principal balance under our revolving credit facility was $240.0 million.

As part of a contractual agreement with a customer, the Company has an outstanding irrevocable letter of credit for $6.5 million, which is issued against our revolving credit facility and expires June 30, 2019.

As of December 31, 2018, we were in compliance with all terms of the Credit Agreement.

See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding our Credit Agreement.

Contractual Obligations

The following table represents the scheduled maturities of our contractual cash obligations and other commitments:

	Payments Due by Period (*in thousands*)				
Contractual Obligations [1]	Total	Less than 1 year	1 - 3 years	3 -5 years	More than 5 years
Operating leases [2]	$ 22,654	$ 5,778	$ 9,162	$ 4,767	$ 2,947
Revolving credit facility [3]	240,000	-	-	240,000	-
Interest expense [4]	41,687	10,494	21,016	10,177	-
Commitment fee [5]	2,610	651	1,320	639	-
Capital leases [6]	8	8	-	-	-
Letter of Credit fee [7]	49	49	-	-	-
Purchase obligations and commitments [8]	26,966	10,180	13,970	2,816	-
Total	$ 333,974	$ 27,160	$ 45,468	$ 258,399	$ 2,947

(1) The Company has excluded long-term unrecognized tax benefits, net of interest and penalties, of $4.8 million from the amounts presented as the timing of these obligations is uncertain.

(2) Represents the future minimum lease payments under non-cancelable operating leases.

(3) Represents scheduled repayments of principal on the revolving credit facility under the terms of our Credit Agreement. See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding the Credit Agreement.

(4) Represents estimates of amounts due on the revolving credit facility based on the interest rate as of December 31, 2018 and on scheduled repayments of principal. See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding the Credit Agreement.

(5) Represents the commitment fee due on the revolving credit facility. See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding the Credit Agreement.

(6) Represents the future minimum lease payments under capital leases.

(7) Represents the fees for the letter of credit issued against the revolving credit facility. See Note 10 to the Consolidated Financial Statements in Part II, Item 8 for additional information regarding the Credit Agreement.

(8) Represents future purchases related to outstanding purchase orders and supplier requisitions.

Recently Issued Accounting Pronouncements

The information set forth under the caption “Summary of Significant Accounting Policies” in Note 1 to the Consolidated Financial Statements in Part II, Item 8 is incorporated herein by reference.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

At December 31, 2018, we were not a party to any derivative financial instruments. We conduct all of our business in U.S. currency and hence do not have direct foreign currency risk. We are exposed to changes in interest rates, primarily with respect to our revolving credit facility under our Credit Agreement. If the effective interest rate for all of our variable rate debt were to increase by 100 basis points (1%), our annual interest expense would increase by a maximum of $2.4 million based on our debt balances outstanding at December 31, 2018. Further, we currently invest substantially all of our excess cash in short-term investments, primarily money market accounts, where returns effectively reflect current interest rates. As a result, market interest rate changes may impact our interest income or expense. The impact will depend on variables such as the magnitude of rate changes and the level of borrowings or excess cash balances. We do not consider this risk to be material. We manage such risk by continuing to evaluate the best investment rates available for short-term, high quality investments.

Item 8. Consolidated Financial Statements and Supplementary Data

The information required by Item 8 is found under Item 15 of this 2018 Form 10-K.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

(a) Evaluation of Disclosure Controls and Procedures

We are responsible for maintaining disclosure controls and procedures (as defined in Rule 13a-15(e) under the Exchange Act) that are designed to ensure that information required to be disclosed in our reports filed under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and that such information is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate, to allow for timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management is required to apply its judgment in evaluating the cost-benefit relationship of possible controls and procedures

As required by Rule 13a-15(b) under the Exchange Act, management, with the participation of our Chief Executive Officer and Chief Financial Officer, performed an evaluation of the effectiveness of our disclosure controls and procedures as of December 31, 2018. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by the 2018 Form 10-K.

(b) Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting and for the assessment of the effectiveness of internal control over financial reporting. As defined by Rule 13a-15(f) under the Exchange Act, internal control over financial reporting is a process designed by, or under the supervision of our Chief Executive Officer and our Chief Financial Officer and effected by our Board of Directors, management and other personnel, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the consolidated financial statements for external purposes in accordance with U.S. GAAP.

Our internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect our transactions and dispositions of our assets; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of the consolidated financial statements in accordance with generally accepted accounting principles and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of our assets that could have a material effect on the consolidated financial statements.

In connection with the preparation of our annual consolidated financial statements, management has undertaken an assessment of the effectiveness of our internal control over financial reporting as of December 31, 2018, based on criteria established in the Internal Control-Integrated Framework issued by COSO. Management's assessment included an evaluation of the design of our internal control over financial reporting and testing of the operational effectiveness of those controls. Based on that assessment, we believe that the Company's internal control over financial reporting was effective based on those criteria as of December 31, 2018.

Our independent registered public accounting firm, Grant Thornton LLP, audited our consolidated financial statements and has issued an attestation report on the effectiveness of our internal control over financial reporting as of December 31, 2018, a copy of which is included with this 2018 Form 10-K.

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

(c) Changes in Internal Control Over Financial Reporting

There have been no changes to the Company's internal control over financial reporting during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

None.

Item 10. Directors, Executive Officers and Corporate Governance

The information required by this Item 10 is incorporated herein by reference to the applicable disclosure found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders under the captions "*Proposal One: Election of Class II Directors,*" "*Executive Officers,*" "*Section 16(a) Beneficial Ownership Reporting Compliance*," "*Director Nomination Process*," "*Additional Information—Shareholder Proposals and Director Nominations for 2020 Annual Meeting,*" and "*Board Committees and Related Matters*."

Our Board of Directors has adopted a Code of Conduct applicable to all of our directors, officers and employees, including all employees, officers, directors, contractors, contingent workers and business affiliates of HMS subsidiaries. The Code of Conduct is publicly available on our website under the "Investors—Corporate Governance" tab at http://investor.hms.com/corporate-governance.cfm and can also be obtained free of charge by sending a written request to our Corporate Secretary. To the extent permissible under the Nasdaq Marketplace Rules, we intend to disclose amendments to our Code of Conduct, as well as waivers of the provisions thereof, that relate to our principal executive officer, principal financial officer, principal accounting officer, controller or persons performing similar functions on the Company's website under the "Investors—Corporate Governance" tab at http://investor.hms.com/corporate-governance.cfm.

Item 11. Executive Compensation

The information required by this Item 11 is incorporated herein by reference to the applicable disclosure found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders under the captions "*Executive Compensation,*" "*Director Compensation,*" *and "Compensation Committee Interlocks and Insider Participation.*"

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Shareholder Matters

Except as provided below, the information required by this Item 12 is incorporated herein by reference to the applicable disclosure found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders under the caption "*Ownership of HMS Common Stock.*"

Equity Compensation Plan Information

The following table summarizes information about our equity compensation plans as of December 31, 2018. For additional information about our equity compensation plans see the discussion set forth under the caption "Stock-Based Compensation" in Note 13 to the Consolidated Financial Statements in Part II, Item 8.

Plan Category	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(a)	(b)	(c)
Equity compensation plans approved by shareholders	5,825,734[1]	$ 17.07	4,758,398
Equity compensation plans not approved by shareholders	19,004[2]	$ 12.00	—
Total	5,844,738		

(1) This includes stock options and restricted stock units granted under our 2006 Stock Plan and 2016 Omnibus Plan.

(2) This includes stock options granted under the 2011 HDI Plan, which was assumed in connection with our acquisition of HDI and approved by the Compensation Committee of our Board.

Item 13. Certain Relationships and Related Transactions and Director Independence

The information required by this Item 13 is incorporated herein by reference to the applicable disclosure found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders under the captions "*Certain Relationships and Related Transactions*" and "*Director Independence*."

Item 14. Principal Accounting Fees and Services

The information required by this Item 14 is incorporated herein by reference to the applicable disclosure from the proposal captioned "*Ratification of the Selection of Independent Registered Public Accounting Firm*" found in our definitive proxy statement to be filed with the SEC pursuant to Regulation 14A under the Exchange Act in connection with HMS Holdings Corp.'s 2019 Annual Meeting of Shareholders.

PART IV

Item 15. Exhibits and Financial Statement Schedules

1. *Financial Statements.*

The financial statements are listed in the Index to Consolidated Financial Statements on page 52.

2. *Financial Statement Schedules.*

Financial Statement Schedule II-Valuation and Qualifying Accounts is set forth on page 82. All other financial statement schedules have been omitted as they are either not required, not applicable or the information is otherwise included.

3. *Exhibits.*

The Exhibits include agreements to which the Company is a party or has a beneficial interest. The agreements have been filed to provide investors with information regarding their respective terms. The agreements are not intended to provide any other actual information about the Company or its business or operations. In particular, the assertions embodied in any representations, warranties, and covenants contained in the agreements may be subject to qualifications with respect to knowledge and materiality different from those applicable to investors and may be qualified by information in confidential disclosure schedules not included with the exhibits. These disclosure schedules may contain information that modifies, qualifies and creates exceptions to the representations, warranties and covenants set forth in the agreements. Moreover, certain representations, warranties, and covenants in the agreements may have been used for the purpose of allocating risk between parties, rather than establishing matters as facts. In addition, information concerning the subject matter of the representations, warranties and covenants may have changed after the date of the respective agreement, which subsequent information may or may not be fully reflected in the Company's public disclosures. Accordingly, investors should not rely on the representations, warranties and covenants in the agreements as characterizations of the actual state of facts about the Company or its business or operations on the date hereof.

Where an exhibit is filed by incorporation by reference to a previously filed registration statement or report, such registration statement or report is identified after the description of the exhibit.

Exhibit Number	Description
2.1	Agreement and Plan of Merger, dated December 16, 2002, among Health Management Systems, Inc., HMS Holdings Corp. and HMS Acquisition Corp. (incorporated by reference to Exhibit A to the Company's Prospectus and Proxy Statement (Reg No. 333-100521) as filed with the SEC on January 24, 2003)
2.2	Agreement and Plan of Merger, dated July 17, 2013, by and between HMS Holdings Corp., a Delaware corporation, and HMS Holdings Corp., a New York corporation (incorporated by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K/12g-3 (File No. 000-50194) as filed with the SEC on July 23, 2013)
2.3	Agreement and Plan of Merger, dated March 10, 2017, by and among HMS Holdings Corp., Echo Acquisition Sub, Inc., Eliza Holding Corp., and Parthenon Investors III, L.P., solely in its capacity as the representative for equity holders of Eliza Holding Corp. (incorporated by reference to Exhibit 2.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on June 6, 2017)
3.1	Conformed copy of Certificate of Incorporation of HMS Holdings Corp., as amended through May 23, 2018 (incorporated by reference to Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on August 6, 2018)

Exhibit Number	Description
3.2	Second Amended and Restated Bylaws of HMS Holdings Corp. dated May 23, 2018 (incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on May 25, 2018)
4.1	Specimen Common Stock Certificate (incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K/12g-3 (File No. 000-50194) as filed with the SEC on July 23, 2013)
10.1.1	HMS Holdings Corp. Fourth Amended and Restated 2006 Stock Plan (incorporated by reference to Exhibit 99.2 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on July 12, 2011)†
10.1.2	Amendment No. 1 to the HMS Holdings Corp. Fourth Amended and Restated 2006 Stock Plan (incorporated by reference to Exhibit 10.6 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on February 29, 2012)†
10.1.3	Form of 2012 Director Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.20 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 1, 2013)†
10.1.4	Form of 2012 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 1, 2013)†
10.1.5	Form of 2013 Executive Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.24 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 1, 2013)†
10.1.6	Form of 2013 Director Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 12, 2014)†
10.1.7	Form of 2013 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 12, 2014)†
10.1.8	Form of March 2014 Executive Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 12, 2014)†
10.1.9	Form of November 2014 Executive Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 10, 2014)†
10.1.10	Form of 2014 Director Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.26 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 2, 2015)†
10.1.11	Form of 2014 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.28 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 2, 2015)†
10.1.12	Form of March 2015 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 11, 2015)†
10.1.13	Form of March 2015 Executive Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 11, 2015)†

Exhibit Number	Description
10.1.14	Form of 2015 Director Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.21 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on February 29, 2016)†
10.1.15	Form of 2015 Director Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.22 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on February 29, 2016)†
10.1.16	Form of November 2015 Executive Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.23 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on February 29, 2016)†
10.1.17	Form of 2016 Executive and Senior Vice President Non-Qualified Stock Option Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 10, 2016)†
10.1.18	Form of 2016 Executive and Senior Vice President Restricted Stock Unit Agreement under the 2006 Stock Plan (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 10, 2016)†
10.2.1	HMS Holdings Corp. 2016 Omnibus Incentive Plan (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on June 27, 2016)†
10.2.2	Form of Non-Qualified Stock Option Award Agreement for Employees under the 2016 Omnibus Plan (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 9, 2016)†
10.2.3	Form of Restricted Stock Unit Award Agreement for Employees under the 2016 Omnibus Plan (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 9, 2016)†
10.2.4	Form of Non-Qualified Stock Option Award Agreement for Non-Employee Directors under the 2016 Omnibus Plan (incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 9, 2016)†
10.2.5	Form of Restricted Stock Unit Award Agreement for Non-Employee Directors under the 2016 Omnibus Plan (incorporated by reference to Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on November 9, 2016)†
10.3.1	Executive Employment Agreement, dated March 1, 2013, by and between William C. Lucia and HMS Holdings Corp. (incorporated by reference to Exhibit 10.29 to the Company's Annual Report on Form 10-K (File No. 000-50194) as filed with the SEC on March 1, 2013)†
10.3.2	Letter of Amendment to Executive Employment Agreement, dated April 30, 2013, by and between William C. Lucia and HMS Holdings Corp. (incorporated by reference to Exhibit 10.1 to Amendment No. 1 to the Company's Annual Report on Form 10-K/A (File No. 000-50194) as filed with the SEC on April 30, 2013)†

Exhibit Number	Description
10.3.3	Second Amendment to Executive Employment Agreement, dated January 20, 2015, by and between HMS Holdings Corp. and William C. Lucia (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on January 23, 2015)†
10.3.4	Third Amendment to Executive Employment Agreement, dated February 21, 2018, by and between William C. Lucia and HMS Holdings Corp. (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on February 23, 2018)†
10.4	Amended and Restated Employment Agreement, dated April 2, 2018, by and between Jeffrey S. Sherman and HMS Holdings Corp. (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 7, 2018)†
10.5	Amended and Restated Employment Agreement, dated March 29, 2018, by and between Meredith W. Bjorck and HMS Holdings Corp. (incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 7, 2018)†
10.6	Amended and Restated Employment Agreement, dated March 29, 2018, by and between Douglas M. Williams, Jr. and HMS Holdings Corp. (incorporated by reference to Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 7, 2018)†
10.7	Amended and Restated Employment Agreement, dated April 2, 2018, by and between Emmet O' Gara and HMS Holdings Corp.†
10.8	Amended and Restated Employment Agreement, dated April 2, 2018, by and between Semone Neuman and HMS Holdings Corp. (incorporated by reference to Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on May 7, 2018)†
10.9	Separation, Waiver and General Release Agreement, dated January 9, 2019, by and between Semone Neuman and HMS Holdings Corp.†
10.10	Form of Indemnification Agreement (incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on August 6, 2018)†
10.11	HMS Holdings Corp. Director Deferred Compensation Plan, as amended through June 29, 2016 (incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on August 9, 2016)†
10.12	HMS Holdings Corp. Annual Incentive Compensation Plan as amended and restated (incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on June 27, 2016)†
10.13.1	Amended and Restated Credit Agreement, dated May 3, 2013, as amended by Amendment No. 1 to Amended and Restated Credit Agreement dated as of March 8, 2017, and as further amended by Amendment No. 2 to Amended and Restated Credit Agreement, dated as of December 19, 2017, by and among HMS Holdings Corp., the Guarantors party thereto, the Lenders party thereto and Citibank, N.A., as Administrative Agent (incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on December 21, 2017)
10.13.2	Amended and Restated Security Agreement, dated December 19, 2017, by and among HMS Holdings Corp., the Subsidiary Securing Parties party thereto and Citibank, N.A., as Collateral Agent (incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K (File No. 000-50194) as filed with the SEC on December 21, 2017)
10.14	Settlement Agreement, dated June 27, 2018, by and among Dennis Demetre, Lori Lynn Lewis Demetre, John Alfred Lewis, Christopher Brandon Lewis, and HMS Holdings Corp. (incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q (File No. 000-50194) as filed with the SEC on August 6, 2018)

Exhibit Number	Description
21.1	HMS Holdings Corp. List of Subsidiaries
23.1	Consent of Grant Thornton LLP
23.2	Consent of KPMG LLP
31.1	Rule 13a-14(a)/15d-14(a) Certification of the Principal Executive Officer of HMS Holdings Corp., as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Rule 13a-14(a)/15d-14(a) Certification of the Principal Financial Officer of HMS Holdings Corp., as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Section 1350 Certification of the Principal Executive Officer of HMS Holdings Corp., as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
32.2	Section 1350 Certification of the Principal Financial Officer of HMS Holdings Corp., as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002*
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	XBRL Taxonomy Extension Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

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† Indicates a management contract or compensatory plan, contract or arrangement

* The certifications attached hereto as Exhibit 32.1 and Exhibit 32.2 are furnished with this 2018 Form 10-K and shall not be deemed "filed" by the Company for purposes of Section 18 of the Exchange Act

Item 16. Form 10-K Summary

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the Registrant has duly caused this Annual Report on Form 10-K to be signed on its behalf by the undersigned, thereunto duly authorized on February 25, 2019.

HMS Holdings Corp.

/s/ William C. Lucia
William C. Lucia
Chairman of the Board, President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this Annual Report on Form 10-K has been signed below by the following persons on behalf of the Registrant and in the capacities indicated on February 25, 2019.

Signature	Title
/s/ William C. Lucia William C. Lucia	Director, Chairman of the Board, President and Chief Executive Officer (Principal Executive Officer)
/s/ Jeffrey S. Sherman Jeffrey S. Sherman	Executive Vice President, Chief Financial Officer and Treasurer (Principal Financial Officer)
/s/ Greg D. Aunan Greg D. Aunan	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)
/s/ Robert Becker Robert Becker	Director
/s/ Craig R. Callen Craig R. Callen	Director
/s/ William F. Miller III William F. Miller III	Director
/s/ Ellen A. Rudnick Ellen A. Rudnick	Director
/s/ Bart M. Schwartz Bart M. Schwartz	Director
/s/ Richard H. Stowe Richard H. Stowe	Director
/s/ Cora M. Tellez Cora M. Tellez	Director

HMS HOLDINGS CORP. AND SUBSIDIARIES
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Report of Independent Registered Public Accounting Firm

Board of Directors and Shareholders
HMS Holdings Corp.

Opinion on the financial statements

We have audited the accompanying consolidated balance sheets of HMS Holdings Corp. (a Delaware corporation) and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated statements of income, changes in shareholders' equity, and cash flows for each of the two years in the period ended December 31, 2018, and the related notes and financial statement schedule included under Item 15 (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the two years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in the 2013 *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"), and our report dated February 25, 2019 expressed an unqualified opinion.

Basis for opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ GRANT THORNTON LLP

We have served as the Company's auditor since 2017.

Dallas, Texas
February 25, 2019

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders
HMS Holdings Corp.:

We have audited the accompanying consolidated balance sheet of HMS Holdings Corp. and subsidiaries as of December 31, 2016, and the related consolidated statements of income, shareholders' equity, and cash flows for the year ended December 31, 2016. In connection with our audit of the consolidated financial statements, we also have audited financial statement schedule II as it relates to the year ended December 31, 2016. These consolidated financial statements and financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements and financial statement schedule based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of HMS Holdings Corp. and subsidiaries as of December 31, 2016, and the results of their operations and their cash flows for the year ended December 31, 2016, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the related financial statement schedule as it relates to the year ended December 31, 2016, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

/s/ KPMG, LLP

Dallas, Texas
June 6, 2017

Report of Independent Registered Public Accounting Firm

Board of Directors and Shareholders
HMS Holdings Corp.

Opinion on internal control over financial reporting

We have audited the internal control over financial reporting of HMS Holdings Corp. (a Delaware corporation) and subsidiaries (the "Company") as of December 31, 2018, based on criteria established in the 2013 *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in the 2013 *Internal Control—Integrated Framework* issued by COSO.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) ("PCAOB"), the consolidated financial statements of the Company as of and for the year ended December 31, 2018, and our report dated February 25, 2019 expressed an unqualified opinion on those financial statements.

Basis for opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and limitations of internal control over financial reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

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

/s/ GRANT THORNTON LLP

Dallas, Texas
February 25, 2019

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(in thousands, except share and per share amounts)

	December 31, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$ 178,946	$ 83,313
Accounts receivable, net of allowance of $13,683 and $14,799, at December 31, 2018 and December 31, 2017, respectively	206,772	189,460
Prepaid expenses	19,970	16,589
Income tax receivable	18,817	1,892
Deferred financing costs, net	564	564
Other current assets	240	836
Total current assets	425,309	292,654
Property and equipment, net	94,435	98,581
Goodwill	487,617	487,617
Intangible assets, net	67,140	91,482
Deferred financing costs, net	1,673	2,237
Other assets	2,344	2,589
Total assets	$ 1,078,518	$ 975,160
Liabilities and Shareholders' Equity		
Current liabilities:		
Accounts payable, accrued expenses and other liabilities	$ 74,902	$ 61,900
Estimated liability for appeals	21,723	30,787
Total current liabilities	96,625	92,687
Long-term liabilities:		
Revolving credit facility	240,000	240,000
Net deferred tax liabilities	18,485	21,989
Deferred rent	4,118	4,852
Other liabilities	5,894	9,403
Total long-term liabilities	268,497	276,244
Total liabilities	365,122	368,931
Commitments and contingencies		
Shareholders' equity:		
Preferred stock -- $0.01 par value; 5,000,000 shares authorized; none issued	—	—
Common stock -- $0.01 par value; 175,000,000 shares authorized; 98,924,501 shares issued and 85,261,664 shares outstanding at December 31, 2018; 96,536,251 shares issued and 83,256,858 shares outstanding at December 31, 2017	989	965
Capital in excess of par value	425,748	368,721
Retained earnings	422,235	366,164
Treasury stock, at cost: 13,663,194 shares at December 31, 2018 and 13,279,393 shares at December 31, 2017	(135,576)	(129,621)
Total shareholders' equity	713,396	606,229
Total liabilities and shareholders' equity	$ 1,078,518	$ 975,160

See accompanying notes to the consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME
(in thousands, except per share amounts)

	Year Ended December 31,		
	2018	2017	2016
Revenue	$ 598,290	$ 521,212	$ 489,720
Cost of services:			
Compensation	224,893	202,049	189,271
Information technology	53,428	45,723	37,337
Occupancy	15,968	17,190	14,000
Direct project expenses	42,908	41,347	46,254
Other operating expenses	31,438	28,425	27,778
Amortization of acquisition related software and intangible assets	32,975	30,393	28,030
Total cost of services	401,610	365,127	342,670
Selling, general and administrative expenses	113,442	105,654	89,381
Settlement expense	20,000	-	-
Total operating expenses	535,052	470,781	432,051
Operating income	63,238	50,431	57,669
Interest expense	(11,310)	(10,871)	(8,519)
Interest income	1,089	295	321
Income before income taxes	53,017	39,855	49,471
Income taxes	(1,972)	(199)	11,835
Net Income	$ 54,989	$ 40,054	$ 37,636
Basic income per common share:			
Net income per common share -- basic	$ 0.66	$ 0.48	$ 0.45
Diluted income per common share:			
Net income per common share -- diluted	$ 0.64	$ 0.47	$ 0.43
Weighted average shares:			
Basic	83,625	83,821	84,221
Diluted	86,144	85,088	86,987

See accompanying notes to the consolidated financial statements

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF SHAREHOLDERS' EQUITY
(in thousands, except share and per share amounts)

	Common Stock				Treasury Stock		
	# of Shares Issued	Par Value	Capital in Excess of Par Value	Retained Earnings	# of Shares	Amount	Total Shareholders' Equity
Balance at January 1, 2016	95,263,461	$ 952	$ 330,290	$ 288,474	11,273,746	$ (95,014)	$ 524,702
Net income	-	-	-	37,636	-	-	37,636
Stock-based compensation expense	-	-	13,277	-	-	-	13,277
Purchase of treasury stock	-	-	-	-	1,140,332	(20,470)	(20,470)
Exercise of stock options	510,512	5	2,935	-	-	-	2,940
Vesting of restricted stock awards and units, net of shares withheld for employee tax	192,879	2	(1,477)	-	-	-	(1,475)
Balance at December 31, 2016	95,966,852	$ 959	345,025	$ 326,110	12,414,078	$ (115,484)	$ 556,610
Net income	-	-	-	40,054	-	-	40,054
Stock-based compensation expense	-	-	24,143	-	-	-	24,143
Purchase of treasury stock	-	-	-	-	865,315	(14,137)	(14,137)
Exercise of stock options	172,326	2	2,718	-	-	-	2,720
Vesting of restricted stock awards and units, net of shares withheld for employee tax	397,073	4	(3,165)	-	-	-	(3,161)
Balance at December 31, 2017	96,536,251	$ 965	$ 368,721	$ 366,164	13,279,393	$ (129,621)	$ 606,229
Adoption of accounting standard (Note 1 and 2)	-	-	-	1,082	-	-	1,082
Net income	-	-	-	54,989	-	-	54,989
Stock-based compensation expense	-	-	21,507		-	-	21,507
Purchase of treasury stock	-	-	-	-	383,801	(5,955)	(5,955)
Exercise of stock options	2,017,442	20	38,342	-	-	-	38,362
Vesting of restricted stock units, net of shares withheld for employee tax	370,808	4	(2,822)	-	-	-	(2,818)
Balance at December 31, 2018	98,924,501	$ 989	$ 425,748	$ 422,235	13,663,194	$ (135,576)	$ 713,396

See accompanying notes to the consolidated financial statements.

HMS HOLDINGS CORP. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(in thousands)

	Years Ended December 31,		
	2018	2017	2016
Operating activities:			
Net income	$ 54,989	$ 40,054	$ 37,636
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization of property, equipment and software	33,254	27,515	24,882
Amortization of intangible assets	24,342	22,555	20,164
Amortization of deferred financing costs	564	2,258	2,083
Stock-based compensation expense	21,507	24,143	13,277
Deferred income taxes	(3,504)	(20,409)	(7,368)
(Gain) / Loss on disposal of assets	-	209	(948)
Change in fair value of contingent consideration	(35)	(2,865)	-
Release of estimated liability for appeals	(8,436)	-	-
Changes in operating assets and liabilities:			
Accounts receivable	(17,312)	(6,976)	(3,554)
Prepaid expenses	(3,381)	(1,463)	(2,399)
Other current assets	596	165	2,066
Other assets	245	124	234
Income taxes receivable / (payable)	(16,925)	1,462	(7,227)
Accounts payable, accrued expenses and other liabilities	11,181	(340)	12,116
Estimated liability for appeals	(628)	32	(2,323)
Net cash provided by operating activities	96,457	86,464	88,639
Investing activities:			
Acquisition of a business, net of cash acquired	-	(171,321)	(20,678)
Proceeds from sale of cost basis investment	-	-	2,496
Purchases of property and equipment	(11,264)	(17,318)	(13,703)
Investment in capitalized software	(19,149)	(15,725)	(7,316)
Net cash used in investing activities	(30,413)	(204,364)	(39,201)
Financing activities:			
Proceeds from credit facility	-	42,204	-
Payments for deferred financing costs	-	(2,269)	-
Proceeds from exercise of stock options	38,362	2,720	2,940
Payments of tax withholdings on behalf of employees for net-share settlements	(2,818)	(3,161)	(1,475)
Payments on capital lease obligations	-	(143)	(44)
Purchases of treasury stock	(5,955)	(14,137)	(20,470)
Net cash provided by/(used in) financing activities	29,589	25,214	(19,049)
Net increase/(decrease) in cash and cash equivalents	95,633	(92,686)	30,389
Cash and Cash Equivalents			
Cash and cash equivalents at beginning of year	83,313	175,999	145,610
Cash and cash equivalents at end of period	$ 178,946	$ 83,313	$ 175,999
Supplemental disclosure of cash flow information:			
Cash paid for income taxes, net of refunds	$ 22,225	$ 17,995	$ 20,326
Cash paid for interest	$ 10,326	$ 9,944	$ 6,196
Supplemental disclosure of non-cash activities:			
Change in balance of accrued property and equipment purchases	$ 1,305	$ 51	$ 684

See accompanying notes to the consolidated financial statements.

1. Business and Summary of Significant Accounting Policies

(a) Business

HMS is an industry-leading provider of cost containment solutions in the healthcare marketplace. We use healthcare technology, analytics and engagement solutions, to deliver coordination of benefits, payment integrity, population risk analytics, and care management and consumer engagement solutions to help payers reduce costs, improve healthcare outcomes and enhance member experiences. We provide coordination of benefits services to government and commercial healthcare payers to ensure that the correct party pays the claim. Our payment integrity services promote accuracy by fighting fraud, waste and abuse, and our total population management solutions provide risk-bearing organizations with reliable intelligence across their member populations to identify risks and improve patient engagement and outcomes. Together these various services help move the healthcare system forward for our customers. We currently operate as one business segment with a single management team that reports to the Chief Executive Officer.

(b) Summary of Significant Accounting Policies

For certain accounting topics, the description of the accounting policy may be found in the related Note.

(i) Principles of Consolidation

The consolidated financial statements include the Company's accounts and transactions and those of the Company's wholly owned subsidiaries. All intercompany balances and transactions have been eliminated in consolidation.

(ii) Use of Estimates

The preparation of the consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(iii) Cash and Cash Equivalents

The Company considers all highly liquid investments with an original maturity of three months or less to be cash equivalents. Cash equivalents consist of deposits that are readily convertible into cash.

(iv) Concentration of Credit Risk

The Company's policy is to limit credit exposure by placing cash in accounts which are exposed to minimal interest rate and credit risk. HMS maintains cash and cash equivalents in cash depository accounts with large financial institutions with a minimum credit rating of A1/P1 or better, as defined by Standard and Poor's. The balance at these institutions generally exceeds the maximum balance insured by the Federal Deposit Insurance Corporation of up to $250,000 per entity. HMS has not experienced any losses in cash and cash equivalents and believes these cash and cash equivalents do not expose the Company to any significant credit risk.

The Company is subject to potential credit risk related to changes in economic conditions within the healthcare market. However, HMS believes that the billing and collection policies are adequate to minimize the potential credit risk. The Company performs ongoing credit evaluations of customers and generally does not require collateral.

(v) Property and Equipment

Property and equipment are stated at cost less accumulated depreciation. Depreciation is provided over the estimated useful lives of the assets utilizing the straight-line method. HMS amortizes leasehold improvements on a straight-line basis over the shorter of (i) the term of the lease or (ii) the estimated useful life of the improvement. Equipment leased under capital leases is depreciated over the shorter of (i) the term of the lease or (ii) the estimated useful life of the equipment. Capitalized software costs relate to software that is acquired or developed for internal use while in the application development stage. All other costs to develop software for internal use, either in the preliminary project stage or post-implementation stage, are expensed as incurred. Amortization of capitalized software is calculated on a straight-line basis over the expected economic life. Land is not depreciated.

Estimated useful lives are as follows:

Property and Equipment	Useful Life (in years)		
Equipment	2	to	5
Leasehold improvements	5	to	10
Furniture and fixtures		5	
Capitalized software	3	to	10
Building and building improvements		up to 39	

Property and equipment is reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of the asset may not be recoverable. When indicators exist, recoverability of assets is measured by a comparison of the carrying value of the asset group to the estimated undiscounted future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized and charged to earnings is measured by the amount by which the carrying value of the asset group exceeds the fair value of the assets. The Company did not recognize any impairment charges related to property and equipment during the years ended December 31, 2018, 2017 or 2016.

(vi) Intangible assets

The Company records assets acquired and liabilities assumed in a business combination based upon their acquisition date fair values. In most instances there is not a readily defined or listed market price for individual assets and liabilities acquired in connection with a business, including intangible assets. The Company determines fair value through various valuation techniques including discounted cash flow models, quoted market values and third party independent appraisals, as considered necessary. Significant assumptions used in those techniques include, but are not limited to, growth rates, discount rates, customer attrition rates, expected levels of revenues, earnings, cash flows and tax rates. The use of different valuation techniques and assumptions are highly subjective and inherently uncertain and, as a result, actual results may differ materially from estimates.

All of the Company's intangible assets are subject to amortization and are amortized using the straight-line method over their estimated period of benefit. Estimated useful lives are as follows:

Intangible Assets	Useful Life (in years)		
Customer relationships	7	to	15
Restrictive covenants	1	to	3
Trade names	1.5	to	7
Intellectual property	4	to	6

Intangible assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of the asset may not be recoverable. When indicators exist, recoverability of assets is measured by a comparison of the carrying value of the asset group to the estimated undiscounted future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized and charged to earnings is measured by the amount by which the carrying value of the asset group exceeds the fair value of the assets. The Company did not recognize any impairment charges related to intangible assets during the years ended December 31, 2018, 2017 or 2016.

(vii) Goodwill

Goodwill is the excess of acquisition costs over the fair values of assets and liabilities of acquired businesses. During the measurement period, which is up to one year from the acquisition date, the Company may record adjustments to the assets acquired and liabilities assumed, with the corresponding offset to goodwill. Upon the conclusion of the measurement period, any subsequent adjustments are recorded to earnings.

Goodwill is subject to a periodic assessment for impairment. The Company assesses goodwill for impairment on an annual basis as of June 30th of each year or more frequently if an event occurs or changes in circumstances would more likely than not reduce the fair value of a reporting unit below its carrying amount. Assessment of goodwill impairment is at the HMS Holdings Corp. entity level as the Company operates as a single reporting unit. We have the option to perform a qualitative or quantitative assessment to determine if impairment is more likely than not to have occurred. The Company completed the annual impairment test as of June 30, 2018 electing to perform the quantitative assessment of which the first step is to compare the fair value of the reporting unit with its carrying value, including goodwill. In calculating the fair value of the reporting unit, the Company utilized a weighting across three commonly accepted valuation approaches: an income approach, a guideline public company approach, and a merger and acquisition approach. The income approach to determining fair value computes projections of the cash flows that the reporting unit is expected to generate converted into a present value equivalent through discounting. Significant assumptions in the income approach include income projections, a discount rate and a terminal growth value which are all level 3 inputs. The income projections include assumptions for revenue and expense growth which are based on internally developed business plans and largely reflect recent historical revenue and expense trends. The discount rate was based on a risk free rate plus a beta adjusted equity risk premium and specific company risk premium. The terminal growth value is Company specific and was determined analyzing inputs such as historical inflation and the GDP growth rate. The guideline public company approach and merger and acquisition approach are based on pricing multiples observed for similar publicly traded companies or similar market companies that were sold. The results of the annual impairment assessment provide that the fair value of the reporting unit was significantly in excess of the Company's carrying value, including goodwill; therefore, no impairment was indicated. There were no impairment charges related to goodwill during the years ended December 31, 2018, 2017 or 2016. There were no changes in the carrying amount of goodwill for the year ended December 31, 2018.

(viii) Income Taxes

Income taxes are accounted for under the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for the future tax consequences attributable to temporary differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. This method also requires the recognition of future tax benefits for net operating loss carry-forwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized as income or expense in the period that includes the enactment date. A valuation allowance is provided against deferred tax assets to the extent their realization is not more likely than not. Uncertain income tax positions are accounted for by prescribing a minimum recognition threshold that a tax position is required to meet before being recognized in the financial statements. Although the Company believes that it has adequately reserved for uncertain tax positions (including interest and penalties), it can provide no assurance that the final tax outcome of these matters will not be materially different. The Company makes adjustments to these reserves in accordance with the income tax accounting guidance when facts and circumstances change, such as the closing of a tax audit or the refinement of an estimate. To the extent that the final tax outcome of these matters is different than the amounts recorded, such differences will affect the provision for income taxes in the period in which such determination is made, and could have a material impact on our financial condition and operating results.

(ix) Expense Classifications

HMS cost of services is presented in the categories set forth below. Each category within cost of services excludes expenses relating to SG&A functions, which are presented separately as a component of total operating costs. A description of the primary expenses included in each category is as follows:

Cost of Services:

- *Compensation:* Salary, fringe benefits, bonus and stock-based compensation.
- *Information technology:* Hardware, software and data communication costs.
- *Occupancy:* Rent, utilities, depreciation, office equipment and repair and maintenance costs.
- *Direct project expense:* Variable costs incurred from third party providers that are directly associated with specific revenue generating projects and employee travel expenses.
- *Other operating expenses:* Professional fees, temporary staffing, travel and entertainment, insurance and local and property tax costs.
- *Amortization of acquisition related software and intangible assets:* Amortization of the cost of acquisition related software and intangible assets.

SG&A:

- Expenses related to general management, marketing and administrative activities.

(x) Estimating Valuation Allowances and Accrued Liabilities

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amount of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amount of revenue and expenses during the reported period. In particular, management must make estimates of the probability of collecting accounts receivable. When evaluating the adequacy of the accounts receivable allowance, management reviews the accounts receivable based on an analysis of historical revenue adjustments, bad debts, customer concentrations, customer credit-worthiness, current economic trends and changes in customer payment terms. As of December 31, 2018 and 2017, the accounts receivable balance was $206.8 million and $189.5 million, net of allowance of $13.7 million and $14.8 million, respectively.

(xi) Stock-Based Compensation

Long-Term Incentive Award Plans

The Company grants stock options and restricted stock units ("equity awards") to HMS employees and non-employee directors under the 2016 Omnibus Plan, as approved by the Company's shareholders on June 23, 2016. The 2016 Omnibus Plan replaced and superseded the Company's 2006 Stock Plan and 2011 HDI Plan. As of December 31, 2018, the number of securities remaining available for future issuance under equity compensation plans, excluding securities to be issued upon exercise of outstanding options and vesting of restricted stock units, is 4,758,398 shares. All of the Company's employees as well as HMS non-employee directors are eligible to participate in the 2016 Omnibus Plan. Awards granted under the 2016 Omnibus Plan generally vest over one to four years. The exercise price of stock options granted under the 2016 Omnibus Plan may not be less than the fair market value of a share of stock on the grant date, as measured by the closing price of the Company's common stock on the Nasdaq Global Select Market and the term of a stock option may not exceed ten years. Prior to 2018, the Company granted two types of equity awards: 1) equity awards with service conditions and 2) equity awards with market and service conditions. The market condition is based on the Company's common stock price during the applicable measurement period. In 2018, the Company only issued equity awards with service conditions.

Stock-Based Compensation Expense

The Company recognizes stock-based compensation expense equal to the grant date fair value of the award on a straight-line basis over the requisite service period.

The fair value of each option grant with only service-based conditions is estimated using the Black-Scholes pricing model. The fair value of each option grant with market and service-based conditions is estimated using a Monte Carlo simulation model. The fair value of each restricted stock unit is calculated based on the closing sale price of the Company's common stock on the grant date.

The determination of the fair value of the options on the grant date using the Black-Scholes pricing model and/or the Monte Carlo simulation model is affected by the Company's stock price, as well as assumptions regarding a number of complex and subjective variables. Certain key variables include: the Company's expected stock price volatility over the expected term of the awards; a risk-free interest rate; and any expected dividends. The Company estimates stock price volatility based on the historical volatility of the Company's common stock and estimates the expected term of the awards based on the Company's historical option exercises for similar types of stock option awards. The assumed risk-free interest rate is based on the yield on the measurement date of a zero-coupon U.S. Treasury bond with a maturity period equal to the option's expected term. The Company does not anticipate paying any cash dividends in the foreseeable future and therefore, uses an expected dividend yield of zero in the option valuation models. The fair value of all awards also includes an estimate of expected forfeitures. Forfeitures are estimated based on historical experience. If actual forfeitures vary from estimates, a difference in compensation expense will be recognized in the period the actual forfeitures occur. Upon the exercise of stock options or the vesting of restricted stock units, the resulting excess tax benefits or deficiencies, if any, are recognized as income tax expense or benefit.

(xii) Fair Value of Financial Instruments

Financial instruments are categorized into a three-level fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value into three broad levels. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). If the inputs used to measure fair value fall within different levels of the hierarchy, the category level is based on the lowest priority level input that is significant to the fair value measurement of the instrument. In the event the fair value is not readily available or determinable, the financial instrument is carried at cost and referred to as a cost method investment. The fair value hierarchy is as follows:

- *Level 1:* Observable inputs such as quoted prices in active markets;
- *Level 2*: Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and
- *Level 3:* Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

(xiii) Leases

HMS accounts for lease agreements as either operating or capital leases, depending on certain defined criteria. Lease costs are amortized on a straight-line basis without regard to deferred payment terms, such as rent holidays, that defer the commencement date of required payments. Additionally, incentives such as tenant improvement allowances, are capitalized and are treated as a reduction of rental expense over the term of the lease agreement.

(xiv) Recent Accounting Guidance

Recently Adopted Accounting Guidance

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers* (Topic 606) ("ASU 2014-09"), which is the new comprehensive revenue recognition standard that supersedes all existing revenue recognition guidance under U.S. GAAP. The Company adopted ASU 2014-09 on January 1, 2018 using the modified retrospective method and the Company recognized the cumulative effect of initially applying the new revenue standard as an adjustment to the opening balance of retained earnings. The financial information for comparative prior periods has not been restated and continues to be reported under the accounting standards in effect for those periods. The effect of adopting ASU 2014-09 in the current annual reporting period as compared with the guidance that was in effect before the change is immaterial. The Company's internal control framework did not materially change, but existing internal controls were modified due to certain changes to business processes and systems to support the new revenue recognition standard as necessary. The Company continues to expect the impact of the adoption of the new standard to be immaterial to its net income and its internal control framework on an ongoing basis.

In March 2016, the FASB issued ASU No. 2016-09, *Compensation – Stock Compensation* (Topic 718): *Improvements to Employee Share-Based Payment Accounting*, ("ASU 2016-09") that changes the accounting for certain aspects of share-based payments to employees. The new guidance requires excess tax benefits and tax deficiencies to be recorded in the income statement when stock awards vest or are settled. In addition, cash flows related to excess tax benefits will no longer be separately classified as a financing activity apart from other income tax cash flows. The standard also allows companies to repurchase more of an employee's vesting shares for tax withholding purposes without triggering liability accounting, clarifies that all cash payments made to tax authorities on an employee's behalf for withheld shares should be presented as a financing activity on the cash flows statement and provides an accounting policy election to account for forfeitures as they occur. ASU 2016-09 is effective for annual reporting periods beginning after December 15, 2016, including interim periods within such annual reporting periods with early adoption permitted. The Company elected to early adopt the new guidance in the fourth quarter of fiscal year 2016 which requires us to reflect any adjustments as of January 1, 2016, the beginning of the annual period that includes the interim period of adoption. The primary impact of adoption was the recognition of excess tax benefits in the provision for income taxes rather than paid-in capital for all periods in fiscal year 2016. Additional amendments to the accounting for income taxes and minimum statutory withholding tax requirements had no impact to retained earnings as of January 1, 2016, where the cumulative effect of these changes are required to be recorded. The Company elected to continue to estimate forfeitures expected to occur to determine the amount of compensation cost to be recognized in each period. Adoption of the new standard resulted in the recognition of net excess tax benefits in the provision for income taxes rather than paid-in capital of $1.9 million for the year ended December 31, 2016. The presentation requirements for cash flows related to employee taxes paid for withheld shares had no impact to any of the 2016 periods presented on the consolidated statements of cash flow since such cash flows have historically been presented as a financing activity.

In August 2016, the FASB issued ASU No. 2016-15, *Statements of Cash Flows* (Topic 230): *Classification of Certain Cash Receipts and Cash Payments* ("ASU 2016-15"). ASU 2016-15 clarifies where certain cash receipts and cash payments are presented and classified in the statement of cash flows. The amendments are effective for annual reporting periods beginning after December 15, 2017, and for interim reporting periods within such annual periods. The Company adopted this guidance on January 1, 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

In January 2017, the FASB issued ASU No. 2017-01, *Business Combinations* (Topic 805) – *Clarifying the Definition of a Business* ("ASU 2017-01"). ASU 2017-01 finalizes previous proposals regarding shareholder concerns that the definition of a business is applied too broadly. The guidance assists entities with evaluating whether transactions should be accounted for as acquisitions of assets or of businesses. The amendments are effective for annual periods beginning after December 15, 2017, including interim periods within those periods. The Company adopted this guidance on January 1, 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

In May 2017, the FASB issued ASU No. 2017-09, *Compensation – Stock Compensation* (Topic 718): *Scope of Modification Accounting*, ("ASU 2017-09"). ASU 2017-09 requires entities to apply modification accounting to changes made to a share-based payment award. The new guidance specifies that entities will apply modification accounting to changes to a share-based payment award only if any of the following are not the same immediately before and after the change: 1) The award's fair value (or calculated value or intrinsic value, if those measurement methods are used), 2) the award's vesting conditions, and 3) the award's classification as an equity or liability instrument. ASU 2017-09 is effective for annual reporting periods beginning after December 15, 2017, including interim periods within such annual periods, with early adoption permitted. The Company adopted this guidance on January 1, 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

In January 2017, the FASB issued ASU No. 2017-04, *Goodwill and Other* (Topic 350): *Simplifying the Test for Goodwill Impairment* ("ASU 2017-04"). This amendment simplifies the manner in which an entity is required to test for goodwill impairment by eliminating Step 2 from the goodwill impairment test. Step 2 measures goodwill impairment loss by comparing the implied fair value of a reporting unit's goodwill with the carrying amount of that goodwill. The amendment simplifies this approach by having the entity (1) perform its annual or interim goodwill impairment test by comparing the fair value of a reporting unit with its carrying amount, and (2) recognize an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value, with the understanding that the loss recognized should not exceed the total amount of goodwill allocated to that reporting unit. The Company elected to early adopt the new guidance in the fourth quarter of fiscal year 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

On August 17, 2018 the SEC issued SEC Final Rule Release No. 33-10532, *Disclosure Update and Simplification* ("Final Rule"). The Final Rule amends certain disclosure requirements to facilitate the disclosure of information to investors and simplify compliance without significantly altering the total mix of information provided to investors. The Final Rule was effective for public entities that are SEC filers on November 5, 2018. The adoption of this guidance did not have a material effect on the Company's consolidated financial statements.

Recent Accounting Guidance Not Yet Adopted

In February 2016, the FASB issued ASU No. 2016-02, Leases (Topic 842) ("ASU 2016-02"). ASU 2016-02 will require most lessees to recognize a majority of the company's leases on the balance sheet, which will increase reported assets and liabilities. ASU 2016-02 was subsequently amended by ASU No. 2018-01, Land Easement Practical Expedient for Transition to Topic 842; ASU No. 2018-10, Codification Improvements to Topic 842, Leases; and ASU No. 2018-11, Targeted Improvements. The new standard establishes a right-of-use model (ROU) that requires a lessee to recognize a ROU asset and lease liability on the balance sheet for all leases with a term longer than 12 months. Leases will be classified as finance or operating, with classification affecting the pattern and classification of expense recognition in the income statement. ASU 2016-02 is effective for annual reporting periods beginning after December 15, 2018 including interim periods within such annual reporting periods with early adoption permitted. The Company has not early adopted this guidance, and therefore is adopting this guidance on January 1, 2019 and will use the effective date as our date of initial application. Consequently, financial information will not be updated and the disclosures required under the new standard will not be provided for dates and periods prior to the date of adoption. The Company developed a preliminary implementation plan and reviewed historical lease agreements in order to quantify the impact of adoption. Based upon the preliminary implementation plan, the Company expects the adoption of ASU 2016-02 will have a material impact on the consolidated balance sheet due to the recognition of the ROU assets and lease liabilities. The adoption of ASU 2016-02 is not expected to have a material impact on the consolidated statement of income or consolidated statement of cash flow. However, the Company continues to perform the necessary reviews and other implementation considerations, including an evaluation of the incremental borrowing rate, in order to appropriately quantify the changes. While we continue to assess all of the effects of adoption, we currently believe the most significant effects relate to (1) the recognition of new ROU assets and lease liabilities on our balance sheet for our real estate operating leases and (2) financial statement disclosures. We do not expect a significant change in our leasing activities between now and adoption. A range of undiscounted ROU assets and lease liabilities at January 1, 2019 is $28 million to $31 million. We expect to recognize operating lease ROU assets and lease liabilities that reflect the present value of these future payments. The Company plans adopt this guidance using the optional transition method. The new standard also provides practical expedients for an entity's existing and ongoing accounting and we expect to adopt the package of practical expedients as well as the practical expedient to not separate lease and non-lease components of our leases and the short-term lease practical expedient.

In June 2016, the FASB issued ASU No. 2016-13, *Financial Instruments – Credit Losses* ("ASU 2016-13"). ASU 2016-13 introduces the current expected credit losses methodology ("CECL") for estimating allowances for credit losses. ASU 2016-13 applies to all financial instruments carried at amortized cost and off-balance-sheet credit exposures not accounted for as insurance, including loan commitments, standby letters of credit, and financial guarantees. The new accounting standard does not apply to trading assets, loans held for sale, financial assets for which the fair value option has been elected, or loans and receivables between entities under common control. ASU 2016-13 is effective for public entities for fiscal year beginning after December 15, 2019, including interim periods within that fiscal year. Early adoption is permitted. The Company is currently evaluating the impact on the Company's financial statements of adopting this guidance but this guidance is not expected to have a material impact on the Company's financial position, results of operations or internal control framework.

In June 2018, the FASB issued ASU No. 2018-07, *Compensation – Stock Compensation* (Topic 718) – *Improvements to Nonemployee Share Based Payment Accounting*, ("ASU 2018-07"). ASU 2018-07 requires entities to apply similar accounting for share-based payment transactions with non-employees as with share-based payment transactions with employees. ASU 2018-07 is effective for public entities for fiscal year beginning after December 15, 2018, including interim periods within that fiscal year. Early adoption is permitted. The Company is currently evaluating the impact on the Company's financial statements of adopting this guidance but this guidance is not expected to have a material impact on the Company's financial position, results of operations or internal control framework.

2. Revenue

The Company's revenue disaggregated by service for the year ended December 31, 2018 is as follows (*in thousands*):

Coordination of Benefits	$	397,095
Payment Integrity		144,063
Total Population Management		57,132
Total	$	598,290

Coordination of benefits revenue is derived from contracts with state governments and Medicaid managed care plans that typically span 1 to 5 years with the option to renew. Types of service contracts could include: (a) the identification of erroneously paid claims; (b) the delivery of verified commercial insurance coverage information; (c) the identification of paid claims where another third party is liable; and (d) the identification and enrollment of Medicaid members who have access to employer insurance. Most of these types of service contracts contain multiple promises, all of which are not distinct within the context of the contract. Therefore, the promises represent a single, distinct performance obligation for the types of services we offer. Revenue derived from these performance obligations is largely based on variable consideration where, based on the number of claims or amount of findings the Company identified, a contingent or fixed transaction price/recovery percentage is allocated to each distinct performance obligation. The Company utilizes the expected value method to estimate the variable consideration related to the transaction price for its service contracts. Key inputs and assumptions in determining variable consideration includes identified pricing and expected recoveries and/or savings. The expected recoveries and/or savings are based on historical experience of information received from our customers. Revenue is primarily recognized at a point in time when our customers realize economic benefits from our services when our services are completed. However, we have a limited number of fixed fee arrangements where revenue is recognized over time as performance obligations are satisfied within one to three years. Generally, coordination of benefit contract payment terms are not standardized within the respective contract; however, payment is typically due on demand and there is a clear and distinct history of customers making consistent payments.

Analytical services consists of payment integrity services and total population management.

Payment integrity services revenue is derived from contracts with federal and state governments, commercial health plans and other at-risk entities that can span several years with the option to renew. Types of service contracts could include: (a) services designed to ensure that healthcare payments are accurate and appropriate; and (b) the identification of over/(under)payments or inaccurate charges based on a review of medical records. Most of these types of service contracts contain multiple promises, all of which are not distinct within the context of the contract. Therefore, the promises represent a single, distinct performance obligation for the types of services we offer. Revenue derived from these performance obligations is largely based on variable consideration where, based on the number of claims or amount of findings the Company identified, a contingent or fixed transaction price/recovery percentage is allocated to each distinct performance obligation. The Company utilizes the expected value method to estimate the variable consideration related to the transaction price for its service contracts. Key inputs and assumptions in determining variable consideration includes identified pricing and expected recoveries and/or savings. The expected recoveries and/or savings are based on historical experience of information received from our customers. Revenue is primarily recognized at a point in time when our customers realize economic benefits from our services when our services are completed. However, we have a limited number of fixed fee arrangements where revenue is recognized over time as performance obligations are satisfied within one to three years. Generally, payment integrity contract payment terms are not standardized within the respective contract; however, payment is typically due on demand and there is a clear and distinct history of customers making consistent payments.

Total population management revenue is derived from contracts with health plans and other risk-bearing entities that can span several years with the option to renew. Types of service contracts could include: (a) programs designed to improve member engagement; and (b) outreach services designed to improve clinical outcomes. Most of these types of service contracts contain multiple promises, all of which are not distinct within the context of the contract. Therefore, the promises represent a single, distinct performance obligation for the types of services we offer. Revenue derived from these services is largely based on consideration associated with prices per order/transfer and PMPM/PMPY fees. The Company believes the output method is a reasonable measure of progress for the satisfaction of our performance obligations, which are satisfied over time, as it provides a faithful depiction of (1) our performance toward complete satisfaction of the performance obligation under the contract and (2) the value transferred to the customer of the services performed under the contract. The Company has elected the right to invoice practical expedient for recognition of revenue related to its performance obligations when the amount we have the right to invoice the customer corresponds directly with the value to the customer. Additionally, certain total population management contracts have distinct performance obligations related to software license and implementation fees which have historically been recognized as revenue ratably over the life of the contract. Lastly, we have a limited number of fixed fee arrangements where revenue is recognized over time as performance obligations are satisfied within one to three years. Upon adoption of ASC 606, revenue for software licenses is recognized at the beginning of the license period when control is transferred as the license is installed and revenue for implementation fees is recognized when control is transferred over time as the implementation is being performed. As the performance obligation is deemed to have been satisfied and control transferred to our customers for software licenses and implementation fees on or before December 31, 2017, the Company recorded a decrease to deferred revenue and an increase to opening retained earnings of $1.1 million, net of tax, as of January 1, 2018 for the cumulative

impact of adopting ASC 606. Generally, total population management contract payment terms are stated within the contract and are due within an explicitly stated time period (e.g., 30, 45, 60 days) from the date of invoice. A portion of the payment received may relate to future performance obligations and will result in an increase to deferred revenue until the obligation has been met.

The Company's revenue disaggregated by market for the year ended December 31, 2018 is as follows (*in thousands*):

Commercial	$	323,150
State		233,921
Federal		41,219
Total	$	598,290

A portion of the Company's services are deferred and revenue is recognized at a later time. Deferred revenue was approximately $6.4 million as of December 31, 2017; $1.1 million, net of tax, was recorded as a decrease to deferred revenue as of January 1, 2018 as discussed above; and $5.3 million of this amount was recognized as revenue during the year ended December 31, 2018. Deferred revenue was approximately and $5.6 million as of December 31, 2018. Deferred revenue is included in Accounts payable, accrued expenses and other liabilities in the Consolidated Balance Sheets.

Contract modifications are routine in nature and often done to account for changes in the contract specifications or requirements. In most instances, contract modifications are for services that are not distinct, and, therefore, modifications are accounted for as part of the existing contract. The Company has elected to use the practical expedient to expense the incremental costs of obtaining a contract if the amortization period of the asset that the Company would have otherwise recognized is one year or less.

3. Fair Value of Financial Instruments

Financial instruments (principally cash and cash equivalents, accounts receivable, accounts payable and accrued expenses) are carried at cost, which approximates fair value due to the short-term maturity of these instruments. The Company's long-term credit facility is carried at cost, which due to the variable interest rate associated with the revolving credit facility, cost approximates its fair value. The Company has no Level 1 or Level 2 financial instruments and there were no transfers between Level 1 or Level 2 financial instruments. Included in Other liabilities on the Consolidated Balance Sheet is a contingent consideration liability of $0 and $35 thousand at December 31, 2018 and 2017, respectively, is valued using a Monte Carlo simulation and includes unobservable inputs such as expected levels of revenues and discount rates. The liability was classified as level 3 within the fair value hierarchy. Changes in the unobservable inputs in the fair value measurement of this instrument could result in a significant change in the fair value measurement. There were no sales, settlements, purchases, issuances and/or transfers related to this level 3 instrument in 2018 or 2017. There were no other level 3 instruments.

4. Acquisitions

(a) Eliza Holding Corp.

On April 17, 2017, the Company completed the acquisition of 100% of the outstanding capital stock of Eliza, for a purchase price of $171.6 million funded with available liquidity of approximately 75% cash on hand and 25% from the Company's existing credit line.

The allocation of the purchase price to the fair value of the assets acquired and the liabilities assumed as of April 17, 2017, the effective date of the acquisition, is as follows (*in thousands*):

Cash and cash equivalents	$	435
Accounts receivable		8,902
Prepaid expenses		1,427
Property and equipment		1,146
Intangible assets		76,240
Goodwill		107,754
Other assets		63
Accounts payable		(2,620)
Deferred tax liability		(19,681)
Other liabilities		(2,057)
Total purchase price	$	171,609

The purchase price allocated to the intangibles acquired was as follows (*in thousands*):

	Useful Life (in years)		
Customer relationships	15	$	56,200
Intellectual property	6		19,600
Trade name	1.5		310
Restrictive covenants	1		130
Fair value of intangibles acquired		$	76,240

Acquisition costs recorded to selling, general and administrative expenses were as follows (*in thousands*):

Other operating expenses - consulting fees	$	3,515
Other operating expenses - legal fees		832
Other operating expenses - transaction costs		185
Acquisition-related costs	$	4,532

The financial results of Eliza's operations since April 17, 2017 have been included in the Company's consolidated financial statements. Eliza contributed $51.9 million and $30.4 million in revenue to HMS results of operations in the years ended December 31, 2018 and 2017, respectively.

(b) *Essette*

On September 2, 2016, the Company acquired the outstanding capital stock of Essette for a purchase price of $24.2 million funded by cash on hand. The immaterial results of Essette's operations since September 2, 2016 have been included in the Company's consolidated financial statements.

5. Property and Equipment

Property and equipment consisted of the following (*in thousands*):

	December 31,	
	2018	2017
Equipment	$ 95,350	$ 106,768
Leasehold improvements	7,547	8,357
Building	8,624	8,624
Building improvements	14,825	14,546
Land	2,769	2,769
Furniture and fixtures	9,404	10,352
Capitalized software	131,819	125,655
	270,338	277,071
Less: accumulated depreciation and amortization	(175,903)	(178,490)
Property and equipment, net	$ 94,435	$ 98,581

	December 31,		
	2018	2017	2016
Depreciation and amortization expenses related to property and equipment	$ 33,254	$ 27,515	$ 24,882

6. Intangible Assets

Intangible assets consisted of the following (*in thousands*):

	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Amortization Period in Years
December 31, 2018				
Customer relationships	$ 156,790	$ (104,740)	$ 52,050	12.8
Trade names	16,246	(16,215)	31	0.7
Intellectual property	21,700	(6,670)	15,030	4.1
Restrictive covenants	263	(234)	29	0.7
Total	$ 194,999	$ (127,859)	$ 67,140	

	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted Average Amortization Period in Years
December 31, 2017				
Customer relationships	$ 159,290	$ (89,106)	$ 70,184	11.3
Trade names	16,246	(13,916)	2,330	1.0
Intellectual property	21,700	(2,874)	18,826	5.2
Restrictive covenants	263	(121)	142	1.3
Total	$ 197,499	$ (106,017)	$ 91,482	

Amortization expense of intangible assets is expected to approximate the following (*in thousands*):

Year ending December 31,	Amortization
2019	$ 9,195
2020	7,664
2021	7,197
2022	7,197
2023	4,822
Thereafter	31,065
Total	$ 67,140

For the years ended December 31, 2018, 2017 and 2016, amortization expense related to intangible assets was $24.3 million, $22.6 million, and $20.2 million, respectively. In addition, during the year ended December 31, 2018, some of the intangible assets became fully amortized.

7. Accounts Payable, Accrued Expenses and Other Liabilities

Accounts payable, accrued expenses and other liabilities consisted of the following (*in thousands*):

	December 31, 2018	December 31, 2017
Accounts payable, trade	$ 12,394	$ 19,330
Accrued compensation and other	42,833	24,072
Accrued operating expenses	19,675	18,498
Total accounts payable, accrued expenses and other liabilities	$ 74,902	$ 61,900

8. Income Taxes

Income tax expense is as follows (*in thousands*):

	December 31,		
	2018	2017	2016
Current tax expense:			
Federal	$ 2,965	$ 17,008	$ 16,274
State	(1,433)	3,201	2,929
Total current tax expense:	1,532	20,209	19,203
Deferred tax expense (benefit):			
Federal	(2,650)	(19,425)	(7,115)
State	(854)	(983)	(253)
Total deferred tax benefit:	(3,504)	(20,408)	(7,368)
Total income tax expense (benefit)	$ (1,972)	$ (199)	$ 11,835

A reconciliation of the income tax expense calculated using the applicable federal statutory rate to the actual income tax expense is as follows (*in thousands*):

	December 31,					
	2018	%	2017	%	2016	%
Computed at federal statutory rate	$ 11,134	21.0	$ 13,949	35.0	$ 17,315	35.0
State and local tax expense, net of federal benefit	2,367	4.5	2,226	5.6	2,448	5.0
Net permanent deduction and credit tax benefits from current year	(1,143)	(2.2)	(1,513)	(3.8)	(1,509)	(3.1)
Net permanent deduction and credit tax benefits from prior years	-	-	-	-	(6,213)	(12.6)
Net uncertain tax positions excluding current permanent deduction and credit benefits	(3,756)	(7.0)	(373)	(0.9)	-	-
Subsidiary basis write off	(3,423)	(6.5)	-	-	-	-
Equity compensation net tax windfall	(2,890)	(5.5)	-	-	-	-
State tax apportionment changes	(3,737)	(7.0)	-	-	-	-
Disallowed executive compensation	682	1.3	-	-	-	-
Tax Reform - revaluation of deferrals	-	-	(15,130)	(38.0)	-	-
Acquisition adjustments	(1,226)	(2.3)	(1,003)	(2.5)	-	-
Acquisition costs	-	-	697	1.7	203	0.4
Other, net	20	-	948	2.4	(409)	(0.8)
Total income tax expense	$ (1,972)	(3.7)	$ (199)	(0.5)	$ 11,835	23.9

The Company's effective tax rate decreased to (3.7%) for the year ended December 31, 2018 from (0.5%) for the year ended December 31, 2017, primarily from favorable tax benefits relating to current year credits, equity compensation, subsidiary basis write-off, prior year state apportionment changes, uncertain tax position releases and acquisition adjustments. The Company has no adjustments, to any previously recorded provisional amounts, relating to the Tax Cuts and Jobs Act which was enacted on December 22, 2017. During the year ended December 31, 2018 and in conjunction with the Settlement Agreement in Note 15 to the Consolidated Financial Statements, the Company determined that the common stock of its wholly owned subsidiary, Allied Management Group Special Investigation Unit, Inc. was worthless, resulting in the write off of basis for federal income tax purposes.

As a result of an analysis performed during 2016, the Company determined certain activities it performs qualify for (i) R&D Credits provided in IRC Section 41 and (ii) the Section 199 Deduction provided in IRC Section 199. As a result, the Company recognized net tax benefits during the year ended December 31, 2016 of $6.2 million for federal and state R&D Credits and the Section 199 Deduction relating to tax years 2012 through 2015.

Deferred income taxes are recognized for the future tax consequences of temporary differences between the financial statement and tax bases of assets and liabilities. The tax effect of temporary differences that give rise to a significant portion of the deferred tax assets and deferred tax liabilities are as follows *(in thousands*):

	December 31,	
	2018	2017
Deferred tax assets:		
Stock-based compensation	$ 9,545	$ 9,980
Goodwill and intangible assets	5,874	6,524
Allowance for doubtful accounts	3,537	3,822
Deferred rent	696	909
Tenant improvements	569	669
Estimated liability for appeals	5,632	7,775
Net operating loss carry-forwards	1,527	3,358
Tax credit carry-forwards	4,076	3,667
Property and equipment	49	256
Accrued expenses and other	7,839	3,615
Total deferred tax assets	39,344	40,575
Deferred tax liabilities:		
Goodwill and intangible assets	43,400	48,186
Section 481(a) adjustment	5,073	7,413
Prepaid expenses	668	624
Capitalized software cost	8,688	6,341
Total deferred tax liabilities	57,829	62,564
Total net deferred tax liabilities	$ 18,485	$ 21,989

Included in Other liabilities on the Consolidated Balance Sheets, are the total amount of unrecognized tax benefits of approximately $4.8 million and $8.2 million as of December 31, 2018 and 2017, respectively, net of the federal benefit for state issues that, if recognized, would favorably affect the Company's future effective tax rate. Also included in Other Liabilities on the Consolidated Balance Sheets, are accrued liabilities for interest expense and penalties related to unrecognized tax benefits of $0.7 million and $0.6 million as of December 31, 2018 and 2017, respectively. HMS includes interest expense and penalties in the provision for income taxes in the Consolidated Statements of Income. The amount of interest expense, net of federal and state income tax benefits, and penalties in the Consolidated Statements of Income for the years ended December 31, 2018, 2017, and 2016 was $0.1 million, $0.02 million and $0.2 million, respectively. The Company believes it is reasonably possible the amount of unrecognized tax benefits may decrease by $1.7 million during 2019, due to the expiration of the statute of limitations in various jurisdictions.

A reconciliation of the beginning and ending amounts of unrecognized tax benefits are as follows (*in thousands*):

	2018	2017
Unrecognized tax benefits at January 1	$ 8,234	$ 7,433
Additions for tax positions taken during prior periods	399	599
Additions for tax positions taken during current period including amended prior years	360	1,174
Reductions relating to settlements with taxing authorities	(2,227)	-
Reductions related to the expiration of statutes of limitations	(1,927)	(972)
Unrecognized tax benefits at December 31	$ 4,839	$ 8,234

The Company increased the provision for unrecognized tax benefits by $0.4 million during the year ended December 31, 2018, related to tax benefits recognized for current period R&D Credits. At December 31, 2018, HMS had federal and state pre-tax net operating loss and tax credit carryforwards of approximately $24.3 million and $4.1 million, respectively, which will be available to offset future taxable income. If not used, these net operating loss and tax credit carryforwards will begin to expire in 2020 and 2019, respectively. The Company files income tax returns with the U.S. Federal government and various state, territory, and local jurisdictions. HMS is no longer subject to U.S. Federal income tax examinations for years before 2013. The Company settled an audit by the Internal Revenue Service for years 2013 and 2014 which resulted in immaterial assessments and recognition of prior unrecognized tax benefits. HMS operates in a number of state, territory and local jurisdictions. Accordingly, HMS is subject to state, territory and local income tax examinations based upon the various statutes of limitations in each jurisdiction. Previously recognized Texas refund claims were examined by the state and resulted in a favorable apportionment method change for all open tax years.

9. Estimated Liability for Appeals

Under the Company's contracts with certain commercial health plan customers and its Medicare RAC contracts with CMS (included within the Company's PI services revenue), providers have the right to appeal HMS claim findings and to pursue additional appeals if the initial appeal is found in favor of HMS's customer. The appeal process established under the Medicare RAC contracts with CMS includes five levels of appeals, and resolution of appeals can take substantial time to resolve. HMS records a) an actual return obligation liability for findings which have been previously adjudicated in favor of providers and b) an estimated return obligation liability based on the amount of revenue that is subject to appeals and which are probable of being adjudicated in favor of providers following their successful appeal. The Company's estimate is based on the Company's historical experience. To the extent the amount to be returned to providers following a successful appeal exceeds or is less than the amount recorded, revenue in the applicable period would be reduced or increased by such amount.

A roll-forward of the activity in the estimated liability for appeals is as follows (*in thousands*):

	Original RAC contract	RAC 4 contract	Commercial contracts	Total
Balance at December 31, 2016	$ 28,427	$ -	$ 2,328	$ 30,755
Provision	2,054	-	2,729	4,783
Appeals found in providers favor	(2,665)	-	(2,086)	(4,751)
Balance at December 31, 2017	$ 27,816	$ -	$ 2,971	$ 30,787
Provision	108	20	2,038	2,166
Appeals found in providers favor	(108)	-	(2,686)	(2,794)
Release of estimated liability	(8,436)	-	-	(8,436)
Balance at December 31, 2018	$ 19,380	$ 20	$ 2,323	$ 21,723

The Company's original Medicare RAC contract with CMS expired on January 31, 2018. As a result of the original contract expiration, the Company's contractual obligation with respect to any appeals resolved in favor of providers subsequent to the expiration date have ceased and therefore the Company released its estimated return obligation liability and increased revenue by $8.4 million during the first quarter of 2018.

The Company continues to assess the remaining CMS liability for the original Medicare RAC contract to determine management's best estimate of liability for any findings which have been previously adjudicated prior to the expiration of the contract. Any future changes or modifications to the Medicare RAC contracts or to the Company's commercial customer contracts may require the Company to apply different assumptions that could materially affect both the Company's revenue and estimated liability for appeals in future periods.

10. Credit Agreement

In May 2013, we entered into the Credit Agreement with certain lenders and Citibank, N.A. as administrative agent. The Credit Agreement originally provided for an initial $500 million five-year revolving credit facility maturing on May 3, 2018.

On December 19, 2017, the Company entered into an amendment to the Credit Agreement, which, among other things, extended the maturity of its then existing revolving credit facility by five years to December 2022. The availability of funds under the amended revolving credit facility includes sublimits for (a) up to $50 million for the issuance of letters of credit and (b) up to $25 million for swingline loans. In addition, the Company may increase the commitments under its revolving credit facility and/or add one or more incremental term loan facilities, provided that such incremental facilities do not exceed in the aggregate the sum of (i) the greater of $120 million and 100% of Consolidated EBITDA (as defined in the Credit Agreement) and (ii) an additional amount so long as our first lien leverage ratio (as defined in the Credit Agreement) on a pro forma basis is not greater than 3.00:1.00, subject to obtaining commitments from lenders therefor and meeting certain other conditions.

During the year ended December 31, 2018, no principal payments were made against the Company's then existing revolving credit facility. As of December 31, 2018, the outstanding principal balance under the amended revolving credit facility was $240.0 million.

Borrowings under the Credit Agreement will bear interest at a rate equal to, at the Company's election (except with respect to swingline borrowings, which will accrue interest based only at the base rate), either:

- a base rate determined by reference to the greatest of (a) the prime or base commercial lending rate of the administrative agent as in effect on the relevant date, (b) the federal funds effective rate plus 0.50% and (c) the one-month LIBO Rate plus 1.00%, plus an interest margin ranging from 0.50% to 1.00% based on the Company's consolidated leverage ratio for the applicable period; or

- an adjusted LIBO Rate, equal to the LIBO Rate for the applicable interest period multiplied by the statutory reserve rate (equal to (x) one divided by (y) one minus the aggregate of the maximum reserve percentage (including any marginal, special, emergency or supplemental reserves) established by the Board of Governors of the Federal Reserve System of the United States), plus an interest margin ranging from 1.50% to 2.00% based on the Company's consolidated leverage ratio for the applicable period.

In addition to paying interest on the outstanding principal, the Company is required to pay unused commitment fees on the revolving credit facility during the term of the Credit Agreement ranging from 0.375% to 0.250% per annum based on the Company's consolidated leverage ratio and letter of credit fees equal to 0.125% per annum on the aggregate face amount of each letter of credit, as well as customary agency fees.

The Company's obligations under the Credit Agreement are secured, subject to certain customary carve-outs and exceptions, by a first priority lien and security interest in substantially all tangible and intangible assets of the Company and certain subsidiaries of the Company. The Credit Agreement contains certain restrictive covenants, which affect, among other things, the ability of the Company and its subsidiaries to incur indebtedness, create liens, make investments, sell or otherwise dispose of assets, engage in mergers or consolidations with other entities, and pay dividends or repurchase stock. The Company is also required to comply, on a quarterly basis, with two financial covenants: (i) a minimum interest coverage ratio of 3:00:1:00, and (ii) a maximum consolidated leverage ratio of 4.75:1.00 through December 2019 and 4.25:1.00 from and after January 2020. The consolidated leverage ratio is subject to a step-up to 5.25:1.00 for four full consecutive fiscal quarters following a permitted acquisition or similar investment. As of December 31, 2018, the Company was in compliance with all terms of the Credit Agreement.

Interest expense and the commitment fees on the unused portion of the Company's revolving credit facility are as follows *(in thousands)*:

	Years ended December 31,		
	2018	2017	2016
Interest expense	$ 9,294	$ 7,170	$ 4,837
Commitment fees	1,189	1,359	1,518

The Company deferred $2.3 million of financing fees associated with the amendment. At December 31, 2018 and 2017, the unamortized balance of deferred financing costs was $2.2 million and $2.8 million, respectively. The Company amortized deferred financing costs of $0.6 million, $2.3 million and $2.1 million in the years ended December 31, 2018, 2017 and 2016.

As part of a contractual agreement with a customer, the Company has an outstanding irrevocable letter of credit for $6.5 million, which is issued against its revolving credit facility and expires June 30, 2019.

11. Equity

(a) Share Repurchase

Following are the Company's quarterly repurchases of shares of common stock for fiscal year 2018, all of which were made as part of publicly announced plans or programs:

Period	Total Number of Shares Purchased	Average Price Paid Per Share	Total Number of Shares Purchased as Part of Publicly Announced Program	Maximum Approximate Dollar Value of Shares That May Yet Be Purchased Under the Program
January 1, 2018 to March 31, 2018	383,801	$ 15.50	383,801	$ 29,933,055
April 1, 2018 to June 30, 2018	-	-	-	-
July 1, 2018 to September 30, 2018	-	-	-	-
October 1, 2018 to December 31, 2018	-	-	-	-
Total	383,801	$ 15.50	383,801	$ 29,933,055

(b) Preferred Stock

The Company's certificate of incorporation, as amended, authorizes the issuance of up to 5,000,000 shares of "blank check" preferred stock with such designations, rights and preferences as may be determined by the Company's Board of Directors. As of December 31, 2018, no preferred stock had been issued.

12. Employee Benefit Plan

The Company sponsors the 401(k) Plan for eligible employees. Eligible employees must complete 90 days of service in order to enroll in the 401(k) Plan. Participants may make voluntary contributions to the 401(k) Plan of up to 60% of their annual base pre-tax compensation not to exceed the federally determined maximum allowable contribution. In addition, the 401(k) Plan permits the Company to make discretionary contributions. During 2018, HMS matched 100% of the first 4% of pay contributed by each eligible employee and 50% of the next 1% of pay contributed. During 2017 and 2016, HMS matched 100% of the first 3% of pay contributed by each eligible employee and 50% on the next 2% of pay contributed. These matching contributions vest immediately and are not in the form of the Company's common stock.

For the years ended December 31, 2018, 2017 and 2016, HMS contributed $7.3 million, $5.9 million and $4.8 million, respectively, to the 401(k) Plan in the form of matching contributions.

13. Stock-Based Compensation

Stock-Based Compensation Expense

Total stock-based compensation expense in the Company's Consolidated Statements of Income related to the Company's long-term incentive award plans was as follows (*in thousands*):

	Years ended December 31,		
	2018	2017	2016
Cost of services-compensation	$ 7,421	$ 7,354	$ 3,805
Selling, general and administrative	14,086	16,789	9,472
Total	$ 21,507	$ 24,143	$ 13,277

The total tax benefits recognized on stock-based compensation for the years ended December 31, 2018, 2017 and 2016 was $9.1 million, $4.0 million and $4.1 million, respectively.

Stock Options

Stock-based compensation expense related to stock options was approximately $9.6 million, $10.3 million and $6.9 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Presented below is a summary of stock option activity for the year ended December 31, 2018 (*in thousands except for weighted average exercise price and weighted average remaining contractual terms*):

	Number of Options	Weighted Average Exercise Price	Weighted Average-Remaining Contractual Terms	Aggregate-Intrinsic Value
Outstanding balance at December 31, 2017	5,554	$ 17.35		
Granted	1,010	19.58		
Exercised	(2,017)	19.14		
Forfeitures	(114)	17.74		
Expired	(31)	22.34		
Outstanding balance at December 31, 2018	4,402	17.07	5.80	$ 48,339
Expected to vest at December 31, 2018	1,481	$ 18.60	8.22	$ 14,119
Exercisable at December 31, 2018	2,370	$ 15.87	3.83	$ 29,068

As of December 31, 2018 and 2017, the Company had 1,999,069 and 2,372,682, respectively, in unvested options with a weighted-average-grant-date fair value of $7.27 and $6.39, respectively. The weighted-average-grant-date fair value per share of the stock options granted during the years ended December 31, 2018, 2017 and 2016 was $7.52, $7.66 and $5.55, respectively. The weighted-average-grant-date fair value per share of stock options vested during the year ended December 31, 2018 was $6.18. The weighted-average-grant-date fair value per share of the stock options forfeited during the years ended December 31, 2018, 2017 and 2016 was $6.86, $5.24 and $6.26, respectively.

HMS estimated the fair value of each stock option grant on the date of grant using a Black-Scholes option pricing model. Weighted–average assumptions are set forth in the following table:

	Year ended December 31,		
	2018	2017	2016
Expected dividend yield	-	-	-
Risk-free interest rate	2.7%	1.8%	1.2%
Expected volatility	42.4%	44.2%	44.0%
Expected life (years)	6.0	5.0	4.9

HMS estimated the fair value of 2017 and 2016 market condition option grants on the date of grant using a Monte-Carlo simulation model. There were no market condition awards granted in 2018. Assumptions are set forth in the following table:

	Year ended December 31,		
	2018	2017	2016
Expected dividend yield	-	-	-
Risk-free interest rate	-	2.2%	1.6%
Expected volatility	-	52.5%	40.5%
Expected life (years)	-	6.5	4.9

During the years ended December 31, 2018, 2017 and 2016, the Company issued 2,017,442, 172,326 and 510,512 shares, respectively, of the Company's common stock upon the exercise of outstanding stock options and received proceeds of $38.3 million, $2.7 million and $2.9 million, respectively. The total intrinsic value of stock options exercised during the years ended December 31, 2018, 2017 and 2016 was $27.6 million, $0.5 million and $6.3 million, respectively.

As of December 31, 2018, there was approximately $5.5 million of total unrecognized compensation cost related to stock options outstanding, which is expected to be recognized over a weighted average period of 0.9 years.

Restricted Stock Units

Stock-based compensation expense related to restricted stock units was $11.9 million, $13.8 million and $6.4 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Presented below is a summary of restricted stock units activity for the year ended December 31, 2018 (*in thousands, except for weighted average grant date fair value per unit*):

	Number of Units	Weighted Average Grant Date Fair Value per Unit
Outstanding balance at December 31, 2017	1,346	$ 17.65
Granted	766	16.80
Vesting of restricted stock units, net of units withheld for taxes	(371)	17.06
Units withheld for taxes	(163)	17.06
Forfeitures	(90)	17.31
Outstanding balance at December 31, 2018	1,488	$ 17.60

As of December 31, 2018, 1,259,003 restricted stock units remained unvested and there was approximately $9.2 million of unrecognized compensation cost related to restricted stock units, which is expected to be recognized over a weighted average vesting period of 0.87 years. During the years ended December 31, 2018, 2017 and 2016, the Company's vested restricted stock units had a fair value $9.9 million, $9.5 million, and $6.8 million, respectively. The weighted average grant date fair value per share of the restricted stock units vested during the years ended December 31, 2018, 2017 and 2016 was $17.06, $15.39 and $18.64, respectively. The weighted average grant date fair value per share of the restricted stock units forfeited during the years ended December 31, 2018, 2017 and 2016 was $17.31, $15.37 and $16.95, respectively.

14. Earnings per Share

The following table sets forth the computation of basic and diluted earnings per share *(in thousands, except per share amounts)*:

	Years ended December 31,		
	2018	2017	2016
Net income	$ 54,989	$ 40,054	$ 37,636
Weighted average common shares outstanding-basic	83,625	83,821	84,221
Plus: net effect of dilutive stock options and restricted stock units	2,519	1,808	2,766
Weighted average common shares outstanding-diluted	86,144	85,629	86,987
Net income per common share-basic	$ 0.66	$ 0.48	$ 0.45
Net income per common share-diluted	$ 0.64	$ 0.47	$ 0.43

For the years ended December 31, 2018, 2017 and 2016: (i) 804,959, 2,646,100 and 2,070,771 stock options, respectively, and (ii) restricted stock units representing 0, 31,155 and 46,651 shares of common stock, respectively, were not included in the diluted earnings per share calculation because the effect would have been anti-dilutive.

15. Commitments and Contingencies

(a) Lease Commitments

The Company primarily leases office space but also leases information technology equipment and software licenses under operating leases that expire on various dates through 2026. Additionally, the Company has nominal capital leases. Total lease expense, net of office space sublease income for the years ended December 31, 2018, 2017 and 2016 was $3.6 million, $5.1 million and $5.0 million, respectively.

Minimum annual lease payments to be made under operating leases, net of $8.3 million office space sublease payments to be received, for each of the next five years ending December 31 and thereafter are as follows (*in thousands*):

	Operating Lease Payments
2019	$ 5,778
2020	5,420
2021	3,742
2022	2,531
2023	2,236
Thereafter	2,947
Total	$ 22,654

(b) Litigation

In July 2012, Dennis Demetre and Lori Lewis (the "Plaintiffs"), filed an action in the Supreme Court of the State of New York against HMS Holdings Corp., claiming an undetermined amount of damages alleging that various actions by HMS unlawfully deprived the Plaintiffs of the acquisition earn-out portion of the purchase price for Allied Management Group Special Investigation Unit, Inc. ("AMG") under the applicable Stock Purchase Agreement (the "SPA") and that HMS had breached certain contractual provisions under the SPA. The Plaintiffs filed a second amended complaint with two causes of action for breach of contract and one cause of action for breach of implied covenant of good faith and fair dealing. HMS asserted a counterclaim against Plaintiffs for breach of contract based on contractual indemnification costs, including attorneys' fees arising out of the Company's defense of AMG in Kern Health Systems v. AMG, Dennis Demetre and Lori Lewis (the "California Action"), which are recoverable under the SPA. In June 2016, Kern Health Systems and AMG entered into a settlement agreement that resolved all claims in the California Action. In July 2017, the Court issued a decision on the Company's motion for partial summary judgment and granted the motion in part, dismissing one of Plaintiffs' breach of contract causes of action against HMS. On November 3, 2017, following a jury trial, a verdict was returned in favor of the Plaintiffs on a breach of contract claim, and the jury awarded $60 million in damages to the Plaintiffs. On March 14, 2018, the Court held a hearing on the Company's post-trial motion for an order granting it judgment notwithstanding the verdict or, alternatively, setting aside the jury's award of damages. On June 27, 2018, prior to the Court issuing a decision on the motion, the Company entered into a Settlement Agreement (the "Settlement Agreement") with the Plaintiffs, John Alfred Lewis and Christopher Brandon Lewis. Pursuant to the terms of the Settlement Agreement, the Company paid $20 million to resolve all matters in controversy pertaining to the lawsuit.

On July 5, 2018, the Court entered an order to discontinue the lawsuit pursuant to the Stipulation of Discontinuance with Prejudice filed by the parties.

In February 2018, the Company received a Civil Investigative Demand ("CID") from the Texas Attorney General, purporting to investigate possible unspecified violations of the Texas Medicaid Fraud Prevention Act. The Company provided certain documents and information in March 2018 in response to the CID. HMS has not received any further requests for information in connection with this CID.

In September 2018, a former employee filed an action in the New York County Supreme Court entitled Christopher Frey v. Health Management Systems, Inc. alleging retaliation under New York law. The complaint seeks recovery of an unspecified amount of monetary damages, including back pay and other compensatory and equitable relief. The Company has moved to dismiss the complaint and the motion is currently under consideration by the Court. The Company continues to believe that this claim is without merit and intends to vigorously defend this matter.

From time to time, HMS may be subject to investigations, legal proceedings and other disputes arising in the ordinary course of the Company's business, including but not limited to regulatory audits, billing and contractual disputes, employment-related matters and post-closing disputes related to acquisitions. Due to the Company's contractual relationships, including those with federal and state government entities, HMS's operations, billing and business practices are subject to scrutiny and audit by those entities and other multiple agencies and levels of government, as well as to frequent transitions and changes in the personnel responsible for oversight of the Company's contractual performance. HMS may have contractual disputes with its customers arising from differing interpretations of contractual provisions that define the Company's rights, obligations, scope of work or terms of payment, and with associated claims of liability for inaccurate or improper billing for reimbursement of contract fees, or for sanctions or damages for alleged performance deficiencies. Resolution of such disputes may involve litigation or may require that HMS accept some amount of loss or liability in order to avoid customer abrasion, negative marketplace perceptions and other disadvantageous results that could affect the Company's business, financial condition, results of operations and cash flows.

HMS records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, HMS does not establish an accrued liability.

16. Customer Concentration

(a) Geographic Information

The Company operates within the United States.

(b) Major Customers

For the years ended December 31, 2018, 2017 and 2016 no one individual Company customer accounted for more than 10% of the Company's total revenue.

(c) Concentration of Revenue

The composition of the Company's ten largest customer's changes periodically. For the years ended December 31, 2018, 2017 and 2016, the Company's ten largest customers represented 41.4%, 39.5% and 40.6% of HMS' total revenue, respectively. Excluding those contracts that contain automatic renewal provisions or evergreen terms, the Company's agreements with the ten current largest customers generally expire between 2019 and 2026. In many instances, HMS provides services pursuant to agreements that may be renewed or subject to a competitive reprocurement process. Several of the Company's contracts, including those with some of its largest customers, may be terminated for convenience.

17. Subsequent Events

Annual Grants to Employees

On February 14, 2019, the Compensation Committee of the Board of Directors approved approximately $21.3 million in stock option and restricted stock unit awards to employees. The awards generally will vest over three years and will be issued three business days subsequent to the filing of this 2018 Form 10-K.

In connection with the preparation of our consolidated financial statements, an evaluation of subsequent events was performed through the date of filing and there were no other events that have occurred that would require adjustments to the financial statements or disclosure.

18. Quarterly Financial Data (Unaudited)

The table below summarizes the Company's unaudited quarterly operating results for the last two fiscal years (*in thousands, except per share amounts*):

2018	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year Ended
Revenue	$ 141,425	$ 146,791	$ 154,246	$ 155,828	$ 598,290
Operating income	$ 11,922	$ (763)	$ 24,231	$ 27,848	$ 63,238
Net income	$ 6,391	$ (3,367)	$ 18,574	$ 33,391	$ 54,989
Net income per common share - basic	$ 0.08	$ (0.04)	$ 0.22	$ 0.40	$ 0.66
Net income per common share - diluted	$ 0.07	$ (0.04)	$ 0.22	$ 0.38	$ 0.64

2017	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year Ended
Revenue	$ 113,733	$ 133,313	$ 125,673	$ 148,493	$ 521,212
Operating income	$ 3,943	$ 14,361	$ 12,861	$ 19,266	$ 50,431
Net income	$ 1,442	$ 6,517	$ 6,372	$ 25,723	$ 40,054
Net income per common share - basic	$ 0.02	$ 0.08	$ 0.08	$ 0.30	$ 0.48
Net income per common share - diluted	$ 0.02	$ 0.08	$ 0.07	$ 0.30	$ 0.47

(1) Second quarter 2018 results include the Company's entry into the Settlement Agreement for the payment of $20.0 million, as described in Note 15.

(2) Fourth quarter 2017 results include a non-cash tax benefit of $15.1 million due to the revaluation of the Company's deferred tax balances pursuant to the tax rate reduction included in the 2017 Tax Act.

SCHEDULE II – VALUATION AND QUALIFYING ACCOUNTS
For the years ended December 31, 2018, 2017 and 2016

Accounts receivable allowance and Estimated liability for appeals as of December 31, 2018, 2017 and 2016 are as follows:

Accounts receivable allowance *(in thousands)*:

	Balance at Beginning of Year	Provision	Recoveries	Charge-offs	Balance at End of Year
Year ended December 31, 2016	$ 11,464	$ 21,583	$ 108	$ (22,383)	$ 10,772
Year ended December 31, 2017	10,772	20,233	-	(16,206)	14,799
Year ended December 31, 2018	14,799	20,453	-	(21,569)	13,683

Estimated liability for appeals *(in thousands)*:

	Balance at Beginning of Year	Provision	Appeals found in providers favor	Release of estimated liability	Balance at End of Year
Year ended December 31, 2016	$ 12,801	$ 721	$ (2,396)	$ -	$ 11,126
Year ended December 31, 2017	11,126	83	(2,665)	-	8,544
Year ended December 31, 2018	8,544	-	(108)	(8,436)	-

The above chart represents the CMS estimated reserve liability only.

Appendix A

HMS HOLDINGS CORP. AND SUBSIDIARIES
(unaudited)

Reconciliation of Net Income to EBITDA and Adjusted EBITDA

(in thousands, except percentages)	Twelve Months Ended	
	December 31, 2018	December 31, 2017
Net Income	$ 54,989	$ 40,054
Net interest expense	10,221	10.576
Income taxes	(1,972)	(199)
Depreciation and amortization of property and equipment and intangible assets	57,596	50,070
Earnings before interest, taxes, depreciation and amortization (EBITDA)	120,834	100,501
Stock-based compensation expense	21,507	24,143
Settlement expense	20,000	-
Adjusted EBITDA	$ 162,341	$ 124,644
% of Revenue	27.1%	23.9%
Adjusted EBITDA, excluding Medicare RAC reserve release	$ 156,041	$ 124,644
% of Revenue	26.5%	23.9%

Reconciliation of Net Income to GAAP EPS (Diluted) and Adjusted EPS (Diluted)

(in thousands, except per share amounts)	Twelve Months Ended	
	December 31, 2018	December 31, 2017
Net Income	$ 54,989	$ 40,054
Stock-based compensation expense	21,507	24,143
Settlement expense	20,000	-
Amortization of acquisition related software and intangible assets	32,975	30,393
Income tax related to adjustments [1]	(19,216)	273
Adjusted net income	$ 110,255	$ 94,863
Weighted average common shares, diluted	86,144	85,088
Diluted GAAP EPS [2]	$ 0.64	$ 0.47
Diluted adjusted EPS	$ 1.28	$ 1.11
Discrete tax benefits	$ 0.19	$ 0.40
Medicare RAC reserve release benefit	$ 0.05	$ -
Diluted adjusted EPS after Medicare RAC reserve release and discrete tax benefits	$ 1.04	$ 0.71

(1) Tax effect of adjustments is computed as the pre-tax effect of the adjustments multiplied by the adjusted annual effective tax rate at period end.

(2) Diluted GAAP EPS for the year ended December 31, 2018 included discrete tax benefits of $0.19 per diluted share, primarily related to state tax apportionments, the closure of routine outstanding prior year tax audits, the exercise of employee stock options, the abandonment of subsidiary stock related to a 2010 acquisition, and year-end federal and state tax adjustments or provision true ups. Diluted GAAP EPS for the year ended December 31, 2017 included a non-cash tax benefit of $0.40 per diluted share, primarily related to federal tax legislation enacted in December 2017.

Board of Directors:

Robert Becker
Retired President and Chief Executive Officer,
Wolters Kluwer Health

Craig R. Callen
Former Senior Advisor,
Crestview Partners

William C. Lucia
Chairman, President and Chief Executive Officer,
HMS Holdings Corp.

William F. Miller III
Senior Executive Advisor,
Beecken, Petty, O'Keefe & Company
Former Chairman of the Board and Chief Executive Officer,
HMS Holdings Corp.

Ellen A. Rudnick
Senior Advisor for Entrepreneurship, Adjunct Faculty,
University of Chicago Booth School of Business

Bart M. Schwartz
Chairman and Chief Executive Officer,
SolutionPoint International, LLC

Richard H. Stowe
Lead Independent Director,
HMS Holdings Corp.
General Partner,
Health Enterprise Partners, LP

Cora M. Tellez
President and Chief Executive Officer,
Sterling HSA

Executive Officers:

William C. Lucia
Chairman, President and Chief Executive Officer

David A. Alexander
Senior Vice President,
Chief Human Resources and Chief Compliance Officer

Meredith W. Bjorck
Executive Vice President,
Chief Legal Officer and Corporate Secretary

Emmet W. O'Gara
Group President, Total Population Management

Maria E. Perrin
Senior Vice President,
Chief Marketing and Strategy Officer

Jeffrey S. Sherman
Executive Vice President,
Chief Financial Officer and Treasurer

Jacob J. Sims
Senior Vice President,
Chief Technology Officer

Tracy A. South
Executive Vice President,
Chief Administrative Officer

Douglas M. Williams Jr.
Executive Vice President,
Chief Operating Officer

Corporate Headquarters:

5615 High Point Drive
Irving, TX 75038
Tel. 214.453.3000
Fax. 214.453.3023

Financial Information

The Company's 2018 Form 10-K, as filed with the SEC, is included in this Annual Report in its entirety with the exception of certain exhibits. Copies of the Company's quarterly earnings results and additional copies of the 2018 Form 10-K, including all exhibits, are available on the Internet at http://investor.hms.com/financial-information/sec-filings or by accessing our filings with the SEC. In addition, shareholders may obtain a paper copy of these materials upon request from our Office of Investor Relations by emailing robert.borchert@hms.com.

Stock Registrar and Transfer Agent

Common stock of HMS Holdings Corp. is traded on the NASDAQ Stock Exchange under the symbol HMSY. Questions with regard to registered shares of HMSY should be submitted to: HMS Holdings Corp. c/o Broadridge Corporate Issuer Solutions, Inc., P.O. Box 1342 Brentwood, NY 11717. Phone: 888.418.5059. Email: shareholder@broadridge.com. Internet: http://www.broadridge.com.

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Inovalon Holdings, Inc.

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Attachment 1 – FORM 10Q

Confidential & Proprietary

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-Q

(Mark One)

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

For the quarterly period ended September 30, 2019

or

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

For the transition period from to

Commission File Number 001-36841

Inovalon Holdings, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**47-1830316**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
4321 Collington Road, Bowie, Maryland	**20716**
(Address of principal executive offices)	(Zip Code)

(301) 809-4000

Registrant's telephone number, including area code

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

Title of Each Class	Name Of Each Exchange On Which Registered	Ticker Symbol
Class A Common Stock, $0.000005 par value per share	NASDAQ Global Select Market	INOV

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

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

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

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

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

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

As of October 18, 2019, the registrant had 75,593,318 shares of Class A common stock outstanding and 79,387,495 shares of Class B common stock outstanding.

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INOVALON HOLDINGS, INC.

FORM 10-Q
FOR THE THREE AND NINE MONTHS ENDEDSEPTEMBER 30, 2019

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PART I—FINANCIAL INFORMATION

Item 1. ***Consolidated Financial Statements***

INOVALON HOLDINGS, INC.
CONSOLIDATED BALANCE SHEETS
(Unaudited, in thousands, except share and par value amounts)

	September 30, 2019	December 31, 2018
ASSETS		
Current assets:		
Cash and cash equivalents	$ 133,555	$ 115,591
Short-term investments	—	7,000
Accounts receivable (net of allowances of $3,918 and $3,350 at September 30, 2019 and December 31, 2018, respectively)	127,415	104,405
Prepaid expenses and other current assets	20,596	34,801
Income tax receivable	5,408	10,330
Total current assets	286,974	272,127
Non-current assets:		
Property, equipment and capitalized software, net	139,415	141,758
Operating lease right-of-use assets	45,098	—
Goodwill	955,881	956,029
Intangible assets, net	495,994	535,343
Other assets	19,828	16,158
Total assets	$ 1,943,190	$ 1,921,415
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued expenses	$ 29,196	$ 31,295
Accrued compensation	32,582	25,298
Other current liabilities	25,047	51,384
Deferred revenue	18,012	20,628
Credit facilities	9,800	9,800
Operating lease liabilities	8,811	—
Finance lease liabilities	2,420	2,905
Total current liabilities	125,868	141,310
Non-current liabilities:		
Credit facilities, less current portion	935,135	939,514
Operating lease liabilities, less current portion	44,252	—
Finance lease liabilities, less current portion	13,005	13,927
Other liabilities	55,512	33,406
Deferred income taxes	95,475	110,669
Total liabilities	1,269,247	1,238,826
Commitments and contingencies (Note 7)		
Stockholders' equity:		
Common stock, $0.000005 par value, 900,000,000 shares authorized, zero shares issued and outstanding at each of September 30, 2019 and December 31, 2018, respectively	—	—
Class A common stock, $0.000005 par value, 750,000,000 shares authorized; 90,218,331 shares issued and 75,598,156 shares outstanding at September 30, 2019; 86,679,575 shares issued and 72,059,400 shares outstanding at December 31, 2018	1	—
Class B common stock, $0.000005 par value, 150,000,000 shares authorized; 79,387,495 shares issued and outstanding at September 30, 2019; 80,608,685 shares issued and outstanding at December 31, 2018	—	1
Preferred stock, $0.0001 par value, 100,000,000 shares authorized, zero shares issued and outstanding at September 30, 2019 and December 31, 2018, respectively	—	—
Additional paid-in-capital	632,759	618,674
Retained earnings	273,528	270,471
Treasury stock, at cost, 14,620,175 shares at September 30, 2019 and December 31, 2018, respectively	(199,817)	(199,817)
Other comprehensive loss	(32,528)	(6,740)
Total stockholders' equity	673,943	682,589
Total liabilities and stockholders' equity	$ 1,943,190	$ 1,921,415

See notes to consolidated financial statements.

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INOVALON HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF OPERATIONS
(Unaudited, in thousands, except per-share amounts)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Revenue	$ 166,453	$ 145,809	$ 468,921	$ 391,362
Expenses:				
Cost of revenue[1]	42,940	36,422	121,261	108,928
Sales and marketing[1]	16,172	11,785	44,004	31,732
Research and development[1]	9,060	7,580	25,159	21,546
General and administrative[1]	49,306	47,203	148,623	156,773
Depreciation and amortization	26,903	26,571	81,370	69,857
Restructuring expense	—	—	—	9,464
Total operating expenses	144,381	129,561	420,417	398,300
Income (Loss) from operations	22,072	16,248	48,504	(6,938)
Other income and (expenses):				
Interest income	619	325	1,893	1,874
Interest expense	(16,700)	(16,824)	(49,891)	(34,274)
Other expense, net	(7)	(210)	(18)	(1,841)
Income (Loss) before taxes	5,984	(461)	488	(41,179)
(Benefit from) Provision for income taxes	(858)	383	(2,569)	(13,035)
Net income (loss)	$ 6,842	$ (844)	$ 3,057	$ (28,144)
Net income (loss) attributable to common stockholders, basic and diluted	$ 6,621	$ (844)	$ 2,965	$ (28,144)
Net income (loss) per share attributable to common stockholders, basic and diluted:				
Basic net income (loss) per share	$ 0.04	$ (0.01)	$ 0.02	$ (0.19)
Diluted net income (loss) per share	$ 0.04	$ (0.01)	$ 0.02	$ (0.19)
Weighted average shares of common stock outstanding:				
Basic	148,456	147,339	148,124	144,662
Diluted	148,797	147,339	148,473	144,662

(1) Includes stock-based compensation expense as follows:

Cost of revenue	$ 116	$ 101	$ 271	$ 154
Sales and marketing	535	308	1,174	376
Research and development	475	643	1,224	1,601
General and administrative	4,659	3,702	11,137	9,015
Total stock-based compensation expense	$ 5,785	$ 4,754	$ 13,806	$ 11,146

See notes to consolidated financial statements.

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INOVALON HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)
(Unaudited, in thousands)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Net income (loss)	$ 6,842	$ (844)	$ 3,057	$ (28,144)
Other comprehensive income (loss):				
Realized losses on cash flow hedges reclassified from accumulated other comprehensive income, net of tax of $(317), $(403), $(680) and $(671), respectively	677	849	1,445	1,419
Net change in unrealized (losses) gains on cash flow hedges, net of tax of $3,003, $(1,561), $12,786 and $(1,498), respectively	(6,561)	3,303	(27,245)	3,168
Realized losses on short-term investments reclassified from accumulated other comprehensive income, net of tax of $0, $0, $0 and $(319), respectively	—	—	—	716
Net change in unrealized gains and (losses) on available-for-sale investments, net of tax of $0, $(15), $(6) and $76, respectively	—	40	12	(164)
Reclassification of income tax effects of the Tax Cuts and Jobs Act of 2017	—	—	—	(102)
Comprehensive income (loss)	$ 958	$ 3,348	$ (22,731)	$ (23,107)

See notes to consolidated financial statements.

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INOVALON HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(Unaudited, in thousands, except share amounts)

	Issued Class A Common Stock		Issued Class B Common Stock		Treasury Stock		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Total Stockholders' Equity
	Shares	Amount	Shares	Amount	Shares	Amount				
Balance—January 1, 2019	86,679,575	$ —	80,608,685	$ 1	(14,620,175)	$(199,817)	$ 618,674	$270,471	$ (6,740)	$ 682,589
Stock-based compensation expense	—	—	—	—	—	—	5,163	—	—	5,163
Conversion Class B to Class A common stock	460,000	—	(460,000)	—	—	—	—	—	—	—
Issuance of shares related to restricted stock units and awards, net of forfeitures	759,409	—	—	—	—	—	—	—	—	—
Shares withheld for employee taxes upon conversion of restricted stock	(82,978)	—	—	—	—	—	(1,086)	—	—	(1,086)
Other comprehensive loss	—	—	—	—	—	—	—	—	(8,054)	(8,054)
Net loss	—	—	—	—	—	—	—	(8,323)	—	(8,323)
Balance—March 31, 2019	87,816,006	$ —	80,148,685	$ 1	(14,620,175)	$(199,817)	$ 622,751	$262,148	$ (14,794)	$ 670,289
Stock-based compensation expense	—	—	—	—	—	—	2,740	—	—	2,740
Exercise of stock options	85,038	—	139,270	—	—	—	1,817	—	—	1,817
Conversion Class B to Class A common stock	460	—	(460)	—	—	—	—	—	—	—
Issuance of shares related to restricted stock units and awards, net of forfeitures	753,800	—	—	—	—	—	—	—	—	—
Shares withheld for employee taxes upon conversion of restricted stock	(105,349)	—	—	—	—	—	(1,400)	—	—	(1,400)
Other comprehensive loss	—	—	—	—	—	—	—	—	(11,850)	(11,850)
Net income	—	—	—	—	—	—	—	4,538	—	4,538
Balance—June 30, 2019	88,549,955	$ —	80,287,495	$ 1	(14,620,175)	$(199,817)	$ 625,908	$266,686	$ (26,644)	$ 666,134
Stock-based compensation expense	—	—	—	—	—	—	5,721	—	—	5,721
Exercise of stock options	169,023	—	—	—	—	—	1,504	—	—	1,504
Conversion Class B to Class A common stock	900,000	1	(900,000)	(1)	—	—	—	—	—	—
Issuance of shares related to restricted stock units and awards, net of forfeitures	614,795	—	—	—	—	—	—	—	—	—
Shares withheld for employee taxes upon conversion of restricted stock	(15,442)	—	—	—	—	—	(374)	—	—	(374)
Other comprehensive loss	—	—	—	—	—	—	—	—	(5,884)	(5,884)
Net income	—	—	—	—	—	—	—	6,842	—	6,842
Balance—September 30, 2019	90,218,331	$ 1	79,387,495	$ —	(14,620,175)	$(199,817)	$ 632,759	$273,528	$ (32,528)	$ 673,943

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INOVALON HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY (Continued)
(Unaudited, in thousands, except share amounts)

	Issued Class A Common Stock		Issued Class B Common Stock		Treasury Stock		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive (Loss) Income	Total Stockholders' Equity
	Shares	Amount	Shares	Amount	Shares	Amount				
Balance—January 1, 2018	77,588,018	$ —	80,957,495	$ 1	(14,620,175)	$(199,817)	$ 534,159	$308,905	$ (476)	$ 642,772
Stock-based compensation expense	—	—	—	—	—	—	3,723	—	—	3,723
Exercise of stock options	211,002	—	—	—	—	—	1,450	—	—	1,450
Conversion Class B to Class A common stock	348,810	—	(348,810)	—	—	—	—	—	—	—
Issuance of shares related to restricted stock units and awards, net of forfeitures	452,657	—	—	—	—	—	—	—	—	—
Shares withheld for employee taxes upon conversion of restricted stock	(33,980)	—	—	—	—	—	(459)	—	—	(459)
Other comprehensive income	—	—	—	—	—	—	—	—	379	379
Adjustment to retained earnings for adoption of ASC 606	—	—	—	—	—	—	—	628	—	628
Adjustment to retained earnings for adoption of ASU 2018-02	—	—	—	—	—	—	—	102	—	102
Net loss	—	—	—	—	—	—	—	(16,834)	—	(16,834)
Balance—March 31, 2018	78,566,507	$ —	80,608,685	$ 1	(14,620,175)	$(199,817)	$ 538,873	$292,801	$ (97)	$ 631,761
Stock-based compensation expense	—	—	—	—	—	—	2,609	—	—	2,609
Issuance of common stock related to business combination	7,598,731	—	—	—	—	—	70,000	—	—	70,000
Exercise of stock options	21,059	—	—	—	—	—	163	—	—	163
Issuance of shares related to restricted stock units and awards, net of forfeitures	466,474	—	—	—	—	—	—	—	—	—
Shares withheld for employee taxes upon conversion of restricted stock	(60,521)	—	—	—	—	—	(610)	—	—	(610)
Other comprehensive income	—	—	—	—	—	—	—	—	466	466
Net loss	—	—	—	—	—	—	—	(10,466)	—	(10,466)
Balance—June 30, 2018	86,592,250	$ —	80,608,685	$ 1	(14,620,175)	$(199,817)	$ 611,035	$282,335	$ 369	$ 693,923
Stock-based compensation expense	—	—	—	—	—	—	4,732	—	—	4,732
Exercise of stock options	2,000	—	—	—	—	—	15	—	—	15
Issuance of shares related to restricted stock units and awards, net of forfeitures	(139,879)	—	—	—	—	—	—	—	—	—
Shares withheld for employee taxes upon conversion of restricted stock	(6,662)	—	—	—	—	—	—	—	—	—
Other comprehensive income	—	—	—	—	—	—	—	—	4,192	4,192
Net loss	—	—	—	—	—	—	—	(844)	—	(844)
Balance—September 30, 2018	86,447,709	$ —	80,608,685	$ 1	(14,620,175)	$(199,817)	$ 615,782	$281,491	$ 4,561	$ 702,018

See notes to consolidated financial statements.

INOVALON HOLDINGS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, in thousands)

	Nine Months Ended September 30,	
	2019	2018
Cash flows from operating activities:		
Net income (loss)	$ 3,057	$ (28,144)
Adjustments to reconcile net income to net cash provided by operating activities:		
Stock-based compensation expense	13,806	11,146
Depreciation	42,021	39,240
Amortization of intangibles	39,349	30,617
Amortization of debt issuance costs and debt discount	3,251	2,076
Deferred income taxes	(2,780)	(11,651)
Restructuring expense, non-cash	—	8,583
Change in fair value of contingent consideration	67	9,364
Other	1,230	614
Changes in assets and liabilities:		
Accounts receivable	(23,577)	(1,046)
Prepaid expenses and other current assets	(944)	(6,606)
Income taxes receivable	5,059	1,612
Other assets	(4,196)	(4,686)
Accounts payable and accrued expenses	1,508	(5,444)
Accrued compensation	6,295	8,551
Other current and non-current liabilities	(6,728)	6,695
Deferred revenue	(2,617)	2,094
Payment for acquisition-related contingent consideration	(2,549)	—
Net cash provided by operating activities	72,252	63,015
Cash flows from investing activities:		
Maturities of short-term investments	6,964	92,207
Sales of short-term investments	—	161,772
Purchases of property and equipment	(14,022)	(19,943)
Investment in capitalized software	(25,972)	(30,369)
Acquisition, net of cash acquired of $0 and $23,850, respectively	—	(1,082,740)
Net cash used in investing activities	(33,030)	(879,073)
Cash flows from financing activities:		
Proceeds from credit facility borrowings, net of discount	—	965,300
Repayment of credit facility borrowings	(7,350)	(236,250)
Payments for debt issuance costs	—	(18,269)
Proceeds from exercise of stock options	3,321	1,628
Finance lease liabilities paid	(1,769)	(709)
Tax payments for equity award issuances	(2,860)	(1,070)
Payment for acquisition-related contingent consideration	(12,600)	—
Net cash (used in) provided by financing activities	(21,258)	710,630
Increase (Decrease) in cash and cash equivalents	17,964	(105,428)
Cash and cash equivalents, beginning of period	115,591	208,944
Cash and cash equivalents, end of period	$ 133,555	$ 103,516
Supplementary cash flow disclosure:		
Income taxes received, net	$ (5,058)	$ (3,597)
Interest paid	47,861	27,618
Non-cash transactions:		
Operating lease obligations incurred	20,830	—
Finance lease obligations incurred	20	4,602
Accruals for purchases of property, equipment	2,260	7,700
Accruals for investment in capitalized software	2,018	2,450
Acquisition consideration	—	84,156

See notes to consolidated financial statements.

INOVALON HOLDINGS, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

1. BASIS OF PRESENTATION

The accompanying unaudited consolidated financial statements have been prepared by Inovalon Holdings, Inc. ("Inovalon" or the "Company") in accordance with accounting principles generally accepted in the United States ("GAAP") for interim financial reporting and as required by Rule 10-01 of Regulation S-X. Accordingly, the unaudited consolidated financial statements may not include all of the information and notes required by GAAP for audited financial statements. The year-end December 31, 2018 consolidated balance sheet data included herein was derived from audited financial statements but does not include all disclosures required by GAAP for complete financial statements. In the opinion of the Company's management, the accompanying unaudited consolidated financial statements contain all adjustments, consisting of items of a normal and recurring nature, necessary to present fairly the Company's financial position as of September 30, 2019, the results of operations, comprehensive income (loss), and stockholders' equity, for the three and nine month periods ended September 30, 2019 and 2018, and cash flows for the nine months ended September 30, 2019 and 2018. The results of operations for the three and nine month periods ended September 30, 2019 and 2018 are not necessarily indicative of the results to be expected for the full year. The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts of assets and liabilities, and related disclosures, as of the date of the financial statements, and the amounts of revenue and expenses reported during the period. Actual results could differ from estimates. The information contained herein should be read in conjunction with the audited financial statements included in the Company's Annual Report on Form 10-K for the year ended December 31, 2018 (the "2018 Form 10-K").

Certain prior period amounts have been reclassified within the current and non-current liabilities section of the consolidated balance sheets to conform with current period presentation. Such reclassifications had no impact on current and non-current liabilities as previously reported.

The accompanying unaudited consolidated financial statements include the accounts of Inovalon and its wholly owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation.

The Company's management considers events or transactions that occur after the balance sheet date but before the financial statements are issued to provide additional evidence relative to certain estimates or to identify matters that require additional disclosure. Subsequent events have been evaluated through the date of issuance of these financial statements.

Recently Adopted Accounting Standards

In February 2016, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2016-02, *Leases (Topic 842)*, and in July 2018 and in March 2019 issued subsequent clarifying guidance (collectively, "ASU 2016-02"). ASU 2016-02 requires the recognition of lease assets and lease liabilities on the balance sheet and enhanced disclosure about leasing arrangements. The Company adopted the new standard on January 1, 2019 using the additional transition approach, while prior period amounts are not adjusted and continue to be reported in accordance with the Company's historic accounting under Accounting Standards Codification ("ASC") 840. Refer to "Note 4—Leases."

In June 2018, the FASB issued ASU 2018-07, *Compensation–Stock Compensation (Topic 718)*. ASU 2018-07 expands the scope of ASC 718, *Compensation–Stock Compensation: Improvements to Nonemployee Share-Based Payment Accounting,* to include share-based payment transactions for acquired goods and services from non-employees. This update includes changing the accounting for non-employee stock-based compensation as it relates to the award measurement date, the fair value measurement of the awards, and forfeitures, among other changes to align the accounting with ASC 718. The Company adopted the new standard on January 1, 2019. There was no material impact of adoption on its consolidated financial statements and notes disclosures.

In October 2018, the FASB issued ASU 2018-16, *Derivatives and Hedging (Topic 815): Inclusion of the Secured Overnight Financing Rate (SOFR) Overnight Index Swap (OIS) Rate as a Benchmark Interest Rate for Hedge Accounting Purposes* in response to the potential transition away from the London Interbank Offer Rate ("LIBOR"). This update permits the use of the Overnight Index Swap Rate based on the Secured Overnight Financing Rate as a U.S. benchmark interest rate for hedge accounting purposes under ASC Topic 815. The Company will apply the requirements of the new standard for any new or redesignated hedging agreements. Refer to "Note 6—Fair Value Measurements."

Recently Issued Accounting Standards

There have been no developments to recently issued accounting standards, including the expected dates of adoption and estimated effects on the Company's consolidated financial statements and note disclosures, from those disclosed in the 2018 Form 10-K, that would be expected to impact the Company except for the following:

In June 2016, the FASB issued ASU 2016-13, *Financial Instruments–Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments* and subsequent clarifying guidance ("ASU 2016-13"). ASU 2016-13 replaces the current incurred

loss impairment method with a methodology that reflects the amortized cost basis net of expected credit losses that are calculated based on certain relevant information. The standard also amends the credit loss guidance for available-for-sale debt securities and requires the measurement and recognition of an expected allowance for credit losses for financial assets held at amortized cost. This guidance is effective for public companies for fiscal years, and interim periods within those fiscal years, beginning after December 15, 2019. The Company plans to adopt the requirements of the new standard on January 1, 2020 using the modified-retrospective approach. The Company determined that the standard is applicable to its accounts receivables and available-for-sale debt securities. The Company is in the process of evaluating and documenting the methodology for application, identifying and designing changes to processes and internal controls, and determining the impact of adoption on the consolidated financial statements and notes disclosures.

2. REVENUE

The Company primarily derives its revenues through the sale or subscription licensing of its platform solutions and services. The following table disaggregates revenue by offering (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Platform solutions[1]	$ 151,454	$ 130,523	$ 421,695	$ 347,698
Services[2]	14,999	15,286	47,226	43,664
Total revenue	$ 166,453	$ 145,809	$ 468,921	$ 391,362

(1) Platform solutions include arrangements for technology-based offerings representing subscription-based cloud-based platform offerings and legacy platform solutions that are not cloud-based and not billed under a subscription-based contract structure.

(2) Services include advisory, implementation, and support services under time and materials, fixed price, or retainer-based contracts.

Contract Balances

The Company had an unbilled receivables balance of $24.5 million and $20.5 million as of September 30, 2019 and December 31, 2018, respectively. Unbilled receivables are classified as accounts receivable on the consolidated balance sheet. The Company had deferred commissions of $11.9 million and $5.7 million as of September 30, 2019 and December 31, 2018, respectively.

The Company had a deferred revenue balance of $18.0 million and $20.6 million as of September 30, 2019 and December 31, 2018, respectively. Revenue recognized during the three and nine months ended September 30, 2019 that was included in the deferred revenue balance at the beginning of the year was $3.7 million and $16.8 million, respectively.

3. NET INCOME (LOSS) PER SHARE

Holders of all outstanding classes of common stock participate ratably in earnings on an identical per share basis as if all shares were a single class. Basic earnings per share ("EPS") is computed by dividing net income (loss) by the weighted average number of shares of common stock (Class A common stock and Class B common stock) outstanding during the period. Diluted EPS is computed by dividing net income by the sum of the weighted average number of shares of common stock outstanding and potentially dilutive securities outstanding during the period under the treasury stock method. If the Company incurs a loss from continuing operations, diluted EPS is computed in the same manner as basic EPS. Potentially dilutive securities include stock options, restricted stock units ("RSUs") and restricted stock awards ("RSAs"). Under the treasury stock method, dilutive securities are assumed to be exercised at the beginning of the periods and as if funds obtained thereby were used to purchase common stock at the average market price during the period. Securities are excluded from the computations of diluted earnings per share if their effect would be anti-dilutive to EPS.

On February 18, 2015, the date of the completion of the Company's IPO, the Company's 2015 Omnibus Incentive Plan (the "2015 Plan") became effective. The 2015 Plan provided for the grant of incentive stock options, within the meaning of Section 422 of the Internal Revenue Code of 1986, as amended (the "Code"), to the Company's employees and any parent and subsidiary employees, and for the grant of non-qualified stock options, stock appreciation rights, restricted stock, RSAs, RSUs, dividend equivalent rights, cash-based awards (including annual cash incentives and long-term cash incentives), and any combination thereof to the Company's employees, directors, and consultants and to employees, directors, and consultants of certain affiliated entities. At the Company's annual meeting of stockholders held on June 5, 2019, the Company's stockholders, upon the recommendation of the Board of Directors of the Company (the "Board"), approved the Amended and Restated 2015 Omnibus Incentive Plan (the "Amended Plan"), which was previously adopted by the Board on February 14, 2019, subject to the approval by the stockholders. The Amended Plan (i) increases the maximum number of shares of the Company's Class A common stock available for issuance

by 6,000,000 shares to a total of 13,335,430; (ii) removes the provisions regarding Section 162(m) of the Code that are no longer relevant due to recent changes to the Code pursuant to the Tax Cuts and Jobs Act of 2017, which eliminated the "performance-based compensation" exception to the deduction limitation under Section 162(m) of the Code; and (iii) extends the term of the Amended Plan until the tenth anniversary of the date of Board approval of the Amended Plan.

The Company has issued RSAs under the Amended Plan. The Company considers issued and unvested RSAs to be participating securities as the holders of these RSAs have a non-forfeitable right to dividends in the event of the Company's declaration of a dividend on shares of Class A and Class B common stock. Subsequent to the issuance of the participating securities, the Company applied the two-class method required in calculating net income (loss) per share of Class A and Class B common stock. Under the two-class method, net income attributable to common stockholders is determined by allocating undistributed earnings, calculated as net income, less earnings attributable to participating securities. The net income per share attributable to common stockholders is allocated based on the contractual participation rights of the Class A common stock and Class B common stock as if the income for the period has been distributed. As the liquidation and dividend rights are identical for both classes of common stock, the net income attributable to common stockholders is allocated on a proportionate basis. If the Company incurs a loss from continuing operations, losses are not allocated to participating securities.

The following table reconciles the weighted average shares outstanding for basic and diluted EPS for the periods indicated (in thousands, except per share amounts):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Basic				
Numerator:				
Net income (loss)	$ 6,842	$ (844)	$ 3,057	$ (28,144)
Undistributed earnings allocated to participating securities	(221)	—	(92)	—
Net income (loss) attributable to common stockholders—basic	$ 6,621	$ (844)	$ 2,965	$ (28,144)
Denominator:				
Weighted average shares used in computing net income (loss) per share attributable to common stockholders—basic	148,456	147,339	148,124	144,662
Net income (loss) per share attributable to common stockholders—basic	$ 0.04	$ (0.01)	$ 0.02	$ (0.19)
Diluted				
Numerator:				
Net income (loss) attributable to common stockholders—diluted	$ 6,621	$ (844)	$ 2,965	$ (28,144)
Denominator:				
Number of shares used for basic EPS computation	148,456	147,339	148,124	144,662
Effect of dilutive securities	341	—	349	—
Weighted average shares used in computing net income (loss) per share attributable to common stockholders—diluted	148,797	147,339	148,473	144,662
Net income (loss) per share attributable to common stockholders—diluted	$ 0.04	$ (0.01)	$ 0.02	$ (0.19)

The computation of diluted EPS does not include certain awards, on a weighted average basis, because their inclusion would have an anti-dilutive effect on EPS. The awards excluded because of their anti-dilutive effect are as follows (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Awards excluded from the computation of diluted net income (loss) per share because their inclusion would have been anti-dilutive	—	62	3	109

4. LEASES

The Company adopted ASU 2016-02 as of January 1, 2019. Leases held on or after January 1, 2019 are presented under ASC 842, while prior period amounts are not adjusted and continue to be reported in accordance with the Company's historic accounting under ASC 840. The Company recorded a right-of-use asset of $34.8 million and a lease liability of $40.5 million. Additionally, the Company recorded a reclassification of $2.1 million from current liabilities and $3.6 million from non-current liabilities, related to deferred rent, cease-use lease liabilities, and tenant improvement liabilities related to the implementation of ASC 842.

The Company elected the following practical expedients under ASC 842-10-65-1 including (1) the package of transition provisions related to expired and existing leases that allows an entity to use the historical assessment of whether contracts are or contain leases, lease classification, and initial direct costs, and (2) the practical expedient that allows for the use of hindsight in determining the lease term.

The Company determines whether a contract is or contains a lease at inception. At the lease commencement date, the Company records a liability for the lease obligation and a corresponding asset representing the right to use the underlying asset over the lease term. Leases with an initial term of 12 months or less are not recorded on the consolidated balance sheet and are recognized in expense using a straight-line basis for all asset classes. Variable lease payments are expensed as incurred, which primarily include maintenance costs, services provided by the lessor, and other charges reimbursed to the lessor.

The Company leases office space, data center facilities, printers, and equipment with remaining lease terms ranging fromone year to twelve years, some of which contain renewal or purchase options. The exercise of these options is at the Company's sole discretion. The Company has entered into sublease agreements for unoccupied leased office space and records sublease income netted against rent expense. Additionally, the Company is required to maintain a standby letter of credit in the amount of $1.0 million to satisfy the requirements of a certain lease agreement.

Certain of the Company's leases contain lease and non-lease components. For leases held on or after January 1, 2019, the Company has elected the practical expedient under ASC 842-10-15-37 for all asset classes which allows companies to account for lease and non-lease components as a single lease component.

The Company's leases do not contain an implicit rate of return, therefore an incremental borrowing rate was determined. The Company assessed which rate would be most reflective of a reasonable rate the Company would be able to borrow based on asset class and lease term.

Finance lease right-of-use assets of $14.9 million are included in property, equipment, and capitalized software, net on the consolidated balance sheet.

The following table presents components of lease expense for the three and nine months ended September 30, 2019 (in thousands):

	Three Months Ended September 30, 2019	Nine Months Ended September 30, 2019
Finance lease cost		
Amortization of right-of-use assets	$ 492	$ 1,533
Interest on lease liabilities	120	381
Operating lease cost	3,042	8,654
Variable lease cost	494	1,806
Sublease income	(275)	(910)
Total lease cost	$ 3,873	$ 11,464

Maturities of lease liabilities as of September 30, 2019 are as follows (in thousands):

	Operating Leases	Finance Leases
2019	$ 909	$ 738
2020	5,875	2,937
2021	8,748	2,381
2022	8,288	1,185
2023	6,835	1,275
Thereafter	37,585	8,816
Total future minimum lease payments	68,240	17,332
Less: Interest	(15,177)	(1,907)
Total	$ 53,063	$ 15,425

Future non-cancellable lease payments as of December 31, 2018 are as follows (in thousands):

	Operating Leases	Finance Leases
Year ending December 31,		
2019	$ 11,250	$ 3,509
2020	7,059	2,567
2021	5,898	2,017
2022	5,303	1,181
2023	3,821	1,275
Thereafter	15,599	8,831
Total future minimum lease payments	48,930	19,380
Less: Interest	—	(2,548)
Total	$ 48,930	$ 16,832

Supplemental cash flow information related to leases for thethree and nine months ended September 30, 2019 are as follows (in thousands):

	Three Months Ended September 30, 2019	Nine Months Ended September 30, 2019
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows for operating leases	$ 3,076	$ 10,065
Operating cash flows for financing leases	121	381
Financing cash flows for financing leases	596	1,769
Right-of-use assets obtained in exchange for lease liabilities:		
Operating leases	$ 255	$ 21,055
Finance leases	—	20

Supplemental balance sheet information related to leases as ofSeptember 30, 2019 are as follows:

	September 30, 2019
Weighted average remaining lease term:	
Operating leases	5 years
Financing leases	8 years
Weighted average discount rate:	
Operating leases	4.8%
Financing leases	3.0%

5. DEBT

On April 2, 2018, the Company entered into a credit agreement (the "2018 Credit Agreement") with a group of lenders and Morgan Stanley Senior Funding, Inc. ("MSSF"), as administrative agent, providing for (i) a term loan B facility with the Company as borrower in a total principal amount of $980.0 million (the "2018 Term Facility"); and (ii) a revolving credit facility with the Company as borrower in a total principal amount of up to $100.0 million (the "2018 Revolving Facility" and, together with the 2018 Term Facility, the "2018 Credit Facilities"). The 2018 Revolving Facility will terminate on April 2, 2023 and the 2018 Term Facility will mature on April 2, 2025. The entire $980.0 million 2018 Term Facility was borrowed on April 2, 2018 and was used to pay off all of the Company's existing debt obligations as well as to provide the financing necessary to fund, in part, the cash consideration paid to acquire ABILITY (as defined in Note 8—Business Combinations). As of September 30, 2019, the Company had $100.0 million available to it consisting of $99.0 million on the 2018 Revolving Facility and a letter of credit of $1.0 million.

At the option of the Company, the loans outstanding under the 2018 Term Facility will bear interest either at: (i) Adjusted LIBOR plus an applicable rate of 3.50% or (ii) the Alternate Base Rate ("ABR") plus an applicable margin. The Company may elect interest periods of one, two, three or six months for Adjusted LIBOR borrowings. As set forth in the 2018 Credit Agreement, the ABR is the higher of: (i) the rate that MSSF as administrative agent announces from time to time as its prime or base commercial

lending rate, as in effect from time to time, (ii) the Federal Funds Effective Rate plus ½ of 1.0% and (iii) one-month Adjusted LIBOR plus1.0%.

The following table discloses the outstanding debt at each balance date as follows (in thousands):

	September 30, 2019	December 31, 2018
2018 Term Facility[1]	$ 944,935	$ 949,314
Less: current portion	9,800	9,800
Non-current Credit Facilities	$ 935,135	$ 939,514

(1) The 2018 Term Facility is presented net of unamortized deferred financing fees and original issue discount ("OID") of$25.3 million and $28.2 million as of September 30, 2019 and December 31, 2018, respectively.

The Company and its Restricted Subsidiaries (as defined in the 2018 Credit Agreement) are subject to certain affirmative and negative covenants under the 2018 Credit Agreement, and the 2018 Credit Agreement includes certain customary representations and warranties of the Company. As of September 30, 2019, the Company is in compliance with the covenants under the 2018 Credit Agreement.

Subsequent Event

On October 4, 2019, the Company made a voluntary cash payment of$50.0 million from its existing cash balance on its outstanding debt reducing the principal balance under the 2018 Term Facility.

6. FAIR VALUE MEASUREMENTS

The following table presents the fair value hierarchy for financial assets and liabilities measured at fair value on a recurring basis as of September 30, 2019 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash equivalents:				
Money market funds	$ 41,761	$ —	$ —	$ 41,761
Short-term investments:				
Corporate notes and bonds	—	—	—	—
Other current liabilities:				
Interest rate swaps	—	(7,979)	—	(7,979)
Contingent consideration	—	—	(2,282)	(2,282)
Other liabilities				
Interest rate swaps	—	(39,857)	—	(39,857)
Contingent consideration	—	—	(14,460)	(14,460)
Total	$ 41,761	$ (47,836)	$ (16,742)	$ (22,817)

The following table presents the fair value hierarchy for financial assets and liabilities measured at fair value on a recurring basis as of December 31, 2018 (in thousands):

	Level 1	Level 2	Level 3	Total
Cash equivalents:				
Money market funds	$ 34,064	$ —	$ —	$ 34,064
Short-term investments:				
Corporate notes and bonds	—	7,000	—	7,000
Other current liabilities:				
Interest rate swaps	—	(1,778)	—	(1,778)
Contingent consideration	—	—	(15,182)	(15,182)
Other liabilities:				
Interest rate swaps	—	(8,151)	—	(8,151)
Contingent consideration	—	—	(16,642)	(16,642)
Total	$ 34,064	$ (2,929)	$ (31,824)	$ (689)

The Company determines the fair value of its security holdings based on pricing from its pricing vendors. The valuation techniques used to measure the fair value of financial instruments having Level 2 inputs were derived from non-binding consensus prices that are corroborated by observable market data or quoted market prices for similar instruments. Such market prices may be quoted prices in active markets for identical assets (Level 1 inputs) or pricing determined using inputs other than quoted prices that are observable either directly or indirectly (Level 2 inputs). The Company performs procedures to ensure that appropriate fair values are recorded such as comparing prices obtained from other sources.

The following table presents financial instruments measured at fair value using unobservable inputs (Level 3) (in thousands):

	Fair Value Measurements Using Unobservable Inputs (Level 3)	
	September 30, 2019	December 31, 2018
Balance, beginning of period	$ (31,824)	$ (7,400)
Fair value adjustment[(1)(2)]	449	(6,159)
Accretion expense (recognized in general and administrative expenses)	(516)	(1,053)
Settlement of liability	15,149	—
Contingent consideration attributable to and assumed from ABILITY Acquisition	—	(17,212)
Total	$ (16,742)	$ (31,824)

(1) During 2019, the Company recognized an adjustment of $0.7 million recognized in general and administrative expenses related to the change in fair value of contingent consideration, partially offset by an adjustment of $0.3 million recognized in goodwill, which was a purchase accounting adjustment attributable to the ABILITY Acquisition.

(2) During 2018, the Company recognized an adjustment of $5.6 million in general and administrative expenses related to the change in fair value of contingent consideration, and an adjustment of $0.6 million recognized in goodwill, which was a purchase accounting adjustment attributable to the ABILITY Acquisition.

2018 Credit Facilities

The Company records debt on the balance sheet at carrying value. The estimated fair value of the Company's debt is determined based on Level 2 inputs including current market rates for similar types of borrowings. The following table presents the carrying value and fair value of the Company's debt (including the current portion thereof) as of September 30, 2019 (in thousands):

	September 30, 2019
Carrying value	$ 944,935
Fair value	$ 949,660

Interest Rate Swaps

In connection with the 2018 Credit Agreement, the Company entered into four interest rate swaps during the second quarter of 2018, each of which mature in March 2025, to mitigate the risk of a rise in interest rates. These interest rate swaps mitigate the exposure on the variable component of interest on the Company's 2018 Credit Facility. The interest rate swaps fix the LIBOR component of interest on $700.0 million of the 2018 Term Facility at a weighted average rate of approximately 2.8%. See "Note 5—Debt" for additional information. These interest rate swaps are designated as cash flow hedges and are deemed highly effective under ASC 815, *Derivatives and Hedging*. The interest rate swaps are recorded on the balance sheet at fair value as either assets or liabilities and any changes to the fair value are recorded through accumulated other comprehensive income and reclassified into interest expense in the same period in which the hedged transaction is recognized in earnings. Cash flows from interest rate swaps are reported in the same category as the cash flows from the items being hedged.

The following table presents the fair value of interest rate swaps on the balance sheet as ofSeptember 30, 2019 (in thousands):

	Liability Derivative	
	Balance Sheet Location	Fair Value
Interest rate swap contract	Other current liabilities	$ (7,979)
Interest rate swap contract	Other liabilities	$ (39,857)

The following table presents the fair value of interest rate swaps on the balance sheet as ofDecember 31, 2018 (in thousands):

	Liability Derivative	
	Balance Sheet Location	Fair Value
Interest rate swap contract	Other current liabilities	$ (1,778)
Interest rate swap contract	Other liabilities	$ (8,151)

The following table presents the location and amount of gains and losses on interest rate swaps included in other comprehensive income ("OCI") and the statement of operations for the three and nine months ended September 30, 2019 and 2018 (in thousands):

Three Months Ended September 30, 2019	Gain (Loss) recognized in OCI	Statement of Operations Location	(Gain) Loss reclassified from OCI
Interest rate swap contract	$ (9,564)	Interest expense	$ 994

Nine Months Ended September 30, 2019	Gain (Loss) recognized in OCI	Statement of Operations Location	(Gain) Loss reclassified from OCI
Interest rate swap contract	$ (40,031)	Interest expense	$ 2,125

Three Months Ended September 30, 2018	Gain (Loss) recognized in OCI	Statement of Operations Location	(Gain) Loss reclassified from OCI
Interest rate swap contract	$ 4,865	Interest expense	$ 1,252

Nine Months Ended September 30, 2018	Gain (Loss) recognized in OCI	Statement of Operations Location	(Gain) Loss reclassified from OCI
Interest rate swap contract	$ 4,666	Interest expense	$ 2,090

The net amount of accumulated other comprehensive loss expected to be reclassified to interest expense in the next12 months is $8.1 million.

7. COMMITMENTS AND CONTINGENCIES

Legal Proceedings—From time to time the Company is involved in various litigation matters arising out of the normal course of business. The Company consults with legal counsel on those issues related to litigation and seeks input from other experts and advisors with respect to such matters. Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve discretionary amounts, present novel legal theories, are in the early stages of the proceedings, or are subject to appeal. Whether any losses, damages or remedies ultimately resulting from such matters could reasonably have a material effect on the Company's business, financial condition, results of operations, or cash flows will depend on a number of variables, including, for example, the timing and amount of such losses or damages (if any) and the structure and type of any such remedies. The Company's management does not presently expect any litigation matters to have a material adverse impact on the consolidated financial statements of the Company.

There have been no significant or material developments to current legal proceedings, including the estimated effects on the Company's consolidated financial statements and note disclosures, subsequent to the disclosure previously provided in Note 11 of the Notes to the Consolidated Financial Statements in the 2018 Form 10-K, other than the following update with respect to the *Xiang v. Inovalon Holdings, Inc., et.al*., No. 1:16-cv-04923 case filed in the United States District Court for the Southern District of New York on June 24, 2016 against the Company, certain officers, directors and underwriters in the Company's initial public offering. As previously disclosed, on February 20, 2019, the parties executed a settlement agreement, which was subject to Court approval, providing for the dismissal of all claims against the defendants in connection with the securities class action suit, and providing for a payment to the class of $17 million, of which the Company agreed to contribute $1.7 million, which was recorded in the Company's 2018 financial statements, with the remaining amounts paid by the Company's insurance carriers. On July 15, 2019, the Court entered an Order and Final Judgment, granting final approval of the settlement and dismissing the litigation.

8. BUSINESS COMBINATIONS

2018 Acquisition

ABILITY Network, Inc.

On April 2, 2018, the Company completed the acquisition (the "ABILITY Acquisition") of Butler Group Holdings, Inc., a Delaware corporation ("Butler"), and its wholly-owned subsidiaries, including, without limitation, ABILITY Network Inc., a Delaware corporation ("ABILITY"), for aggregate consideration of $1.19 billion (the "Purchase Price") in cash and restricted shares of the Company's Class A Common Stock.

ABILITY is a leading cloud-based Software-as-a-service ("SaaS") technology company helping to simplify the administrative and clinical complexities of healthcare. Through the *my*ABILITY® software platform, an integrated set of cloud-based applications for providers, ABILITY provides core connectivity, administrative, clinical, and quality analysis, management, and performance improvement capabilities to more than 44,000 acute, post-acute and ambulatory point-of-care provider facilities. The extensive datasets, on-demand compute capability, advanced analytics, and broad healthcare ecosystem connectivity enabled by the Inovalon ONE® Platform provide a significant expansion of application offerings within the *my*ABILITY® software platform while also expanding the nature and reach of high-value solutions for Inovalon's existing payer, pharma, and device client-base. The combination of Inovalon and ABILITY creates a vertically integrated cloud-based platform empowering the achievement of real-time, value-based care from payers, manufacturers, and diagnostics all the way to the patient's point of care.

A summary of the final composition of the stated Purchase Price and fair value of the stated Purchase Price is as follows (in thousands):

Purchase Price	$	1,220,800
Working capital adjustment		(630)
Shareholder payable adjustment		880
Subtotal		1,221,050
Fair value adjustments:		
Restricted stock marketability discount		(30,000)
Total fair value purchase price	$	1,191,050

The final composition of the fair value of the consideration transferred is as follows (in thousands):

Cash	$	1,107,220
Issuance of Class A common stock		70,000
Contingent consideration		14,460
Working capital adjustment		(630)
Total fair value purchase price	$	1,191,050

The ABILITY Acquisition was accounted for using the acquisition method of accounting under ASC No. 805, *Business Combinations*, which requires that assets acquired and liabilities assumed are recognized at their estimated fair values. The excess of the aggregate consideration over the estimated fair values has been allocated to goodwill.

In addition, ASC No. 805 requires that the consideration transferred be measured at the closing date of the ABILITY Acquisition at the then-current market prices. The Company finalized the Purchase Price allocation as of March 31, 2019.

The following table summarizes the net assets acquired and liabilities assumed (in thousands):

	Fair Value
Cash and cash equivalents	$ 23,850
Accounts receivable	16,739
Income tax receivable[2]	688
Prepaid expenses and other current assets	3,025
Property and equipment	3,095
Goodwill[1][2]	770,949
Intangible assets[1]	490,000
Other assets	1,252
Accounts payable and accrued expenses	(6,863)
Deferred revenue	(7,000)
Other current liabilities	(507)
Other liabilities	(5,291)
Deferred tax liabilities[2]	(98,887)
Total consideration transferred	$ 1,191,050

(1) The Company allocated a portion of the goodwill associated with the ABILITY Acquisition to the Inovalon reporting unit based on expected revenue synergies. As a result, the fair value of the customer relationships intangible asset was adjusted by $23.0 million.

(2) The Company recognized a net purchase accounting adjustment of $1.8 million resulting in a decrease to goodwill. This adjustment was driven by a $7.5 million decrease to deferred tax liabilities primarily attributable to the tax impact related to the reduction to the fair value of the customer relationships intangible assets and an adjustment to income tax receivable of $0.2 million. These reductions to goodwill were partially offset by a $5.0 million increase in deferred tax liabilities related to tax basis goodwill and provision-to-tax adjustments from ABILITY's 2017 tax return filings and an adjustment of $0.9 million to the shareholder payable attributable to the ABILITY Acquisition.

The amounts attributed to identified intangible assets are summarized in the table below (in thousands):

	Estimated Useful Life	Fair Value	Measurement Period Adjustments	Adjusted Fair Value
Customer relationships	12-14 years	$ 408,000	$ (23,000)	$ 385,000
Technology	12-14 years	86,000	—	86,000
Trade names	16-18 years	19,000	—	19,000
Total intangible assets		$ 513,000	$ (23,000)	$ 490,000

Acquisition-related costs were expensed as incurred. During 2018, the Company incurred acquisition-related costs of $6.5 million. Acquisition-related costs were recognized within "General and administrative" expenses in the accompanying consolidated statements of operations.

The following table presents revenue and income before taxes of ABILITY, included in the consolidated statements of operations (in thousands):

	Three Months Ended September 30, 2018	Nine Months Ended September 30, 2018
Revenue	$ 37,922	$ 75,442
Income before taxes	$ (7,547)	$ (1,749)

The following pro forma financial information is based on Inovalon's and Butler's historical consolidated financial statements as adjusted to give effect to pro forma events that are (1) directly attributable to the ABILITY Acquisition, (2) factually supportable, and (3) with respect to the unaudited pro forma combined statements of operations, expected to have a continuing impact on the combined results. The pro forma adjustments include, but are not limited to: (i) amortization of acquired intangible assets, (ii) net increase to interest expense resulting from the extinguishment of the 2014 Credit Facilities and historical Butler debt, borrowings under the 2018 Term Facility and the amortization of related debt issuance costs, and (iii) elimination of non-recurring acquisition

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and integration-related expenses. The following consolidated pro forma financial information is unaudited and gives effect to the transactions as if they had occurred on January 1, 2018 (in thousands):

	Three Months Ended September 30, 2018	Nine Months Ended September 30, 2018
Revenue	$ 145,809	$ 428,726
Loss before taxes	$ (19)	$ (43,638)

The unaudited pro forma revenue and loss before taxes was prepared for informational purposes only based on estimates and assumptions that the Company believes to be reasonable and is not necessarily indicative of the results of operations that would have occurred if the ABILITY Acquisition had been completed on the date indicated nor of the future financial position or results of operations following completion of the ABILITY Acquisition.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

The following discussion and analysis should be read in conjunction with our unaudited consolidated financial statements and the related notes included elsewhere in this Quarterly Report on Form 10-Q and with our audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2018, as filed with the Securities and Exchange Commission (the "SEC") on February 20, 2019 (the "2018 Form 10-K"). Unless we otherwise indicate or the context requires, references to the "Company," "Inovalon," "we," "our," and "us" refer to Inovalon Holdings, Inc. and its consolidated subsidiaries.

Note Regarding Forward-Looking Statements

This Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). All statements contained in this Quarterly Report other than statements of historical fact, including but not limited to statements regarding our future results of operations and financial position, our business strategy and plans, market growth, and our objectives for future operations, are forward-looking statements. The words "believe," "may," "see," "will," "estimate," "continue," "anticipate," "intend," "expect," and similar expressions are intended to identify forward-looking statements. We have based these forward-looking statements largely on our current expectations and projections about future events and trends that we believe may affect our financial condition, results of operations, business strategy, short-term and long-term business operations and objectives and financial needs. Moreover, we operate in a very competitive and rapidly changing environment. New risks emerge from time to time. It is not possible for our management to predict all risks, nor can we assess the impact of all factors on our business or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements we may make. In light of these risks, uncertainties and assumptions, the future events and trends discussed in this Quarterly Report may not occur and actual results could differ materially and adversely from those anticipated or implied in the forward-looking statements.

Factors that may cause actual results to differ from expected results include, among others:

- our future financial performance, including our ability to continue and manage our growth;
- our ability to retain our client base and sell additional services to them;
- the effect of the concentration of our revenue among our top clients;
- our ability to innovate and adapt our platforms and toolsets;
- the effects of regulations applicable to us, including regulations relating to data protection and data privacy;
- the effects of consolidation in the healthcare industry;
- the ability to successfully integrate our acquisitions, including ABILITY, and the ability of the acquired business to perform as expected;
- the ability to enter into new agreements with existing or new platforms, products, and solutions in the timeframes expected, or at all;
- the successful implementation and adoption of new platforms, products and solutions;
- the effects of changes in tax legislation for jurisdictions within which we operate, including recent changes in U.S. tax laws;
- the ability to protect the privacy of our clients' data and prevent security breaches;
- the effect of current or future litigation;
- the effect of competition on our business;
- the efficacy of our platforms and toolsets; and
- the timing and size of business realignment and restructuring charges.

Forward-looking statements are only current predictions and are subject to known and unknown risks, uncertainties, and other factors that may cause our actual results, levels of activity, performance, or achievements to be materially different from those anticipated by such statements. These factors include, among other factors, those set forth in our 2018 Form 10-K, under the heading Part I, Item 1A, "Risk Factors."

You should not rely upon forward-looking statements as predictions of future events. The events and circumstances reflected in the forward-looking statements may not be achieved or occur. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, levels of activity, performance, or achievements. We are

under no duty to, and we disclaim any obligation to, update any of these forward- looking statements after the date of this Quarterly Report or to conform these statements to actual results or revised expectations.

Overview

We are a leading provider of cloud-based platforms empowering data-driven healthcare. Through the Inovalon ONE® Platform, Inovalon brings to the marketplace a national-scale capability to interconnect with the healthcare ecosystem, aggregate and analyze data in real-time, and empower the application of resulting insights to drive meaningful impact at the point of care. Leveraging its Platform, unparalleled proprietary datasets, and industry-leading subject matter expertise, Inovalon enables better care, efficiency, and financial performance across the healthcare ecosystem. From health plans and provider organizations, to pharmaceutical, medical device, and diagnostics companies, Inovalon's unique achievement of value is delivered through the effective progression of "Turning Data into Insight, and Insight into Action®." Supporting thousands of clients, including 24 of the top 25 U.S. health plans, 22 of the top 25 global pharma companies, 19 of the top 25 U.S. healthcare provider systems, and many of the leading pharmacy organizations, device manufacturers, and other healthcare industry constituents, Inovalon's technology platforms and analytics are informed by data pertaining to more than 980,000 physicians, 546,000 clinical facilities, 287 million Americans, and 48 billion medical events.

We generate the substantial majority of our revenue through the sale or subscription licensing of our platform solutions, as well as revenue from related arrangements for advisory, implementation, and support services.

Quarterly Key Metrics

We review certain metrics quarterly, including the key metrics shown in the table below. We believe the key metrics illustrated in the table below are indicative of our overall level of analytical activity and our underlying growth in the business. Data resulting from the integration with ABILITY is not yet fully reflected within the MORE² Registry® dataset and is therefore not fully reflected within the related data metrics below as of this date.

	September 30,	
	2019	2018
	(in thousands)	
MORE² Registry® dataset metrics[1]		
Unique patient count[2]	287,523	261,226
Medical event count[3]	48,135,368	40,062,034
Trailing twelve month Patient Analytics Months (PAM)[1][4]	58,262,450	47,100,324

(1) MORE² Registry® dataset metrics and Trailing twelve month PAM, each of which is presented in the table, are key operating metrics that management uses to assess our level of operational activity. While we believe that each of these metrics is indicative of our overall level of analytical activity and the underlying growth in our business, increases or decreases in these metrics do not necessarily correlate to proportional increases or decreases in revenue, or net income. For instance, although increased levels of analytical activity historically have corresponded to increases in revenue over the long term, differences in fees charged for different analytical packages exist and differences in how analytics trigger the applicability of our data-driven intervention platforms may result in increases in analytical activity that do not result in proportional increases in revenue, or net income (and vice versa). Accordingly, while we believe the presentation of these operating metrics is helpful to investors in understanding our business, these metrics have limitations and should not be considered as substitutes for analysis of our financial results reported under generally accepted accounting principles ("GAAP"). In addition, we believe that other companies, including companies in our industry, do not present similar operating metrics and that there is no commonly accepted method of calculating these metrics, which may reduce their usefulness as comparative measures.

(2) Unique patient count is defined as each unique, longitudinally matched, de-identified natural person represented in our MORE² Registry® as of the end of the period presented.

(3) Medical event count is defined as the total number of discrete medical events as of the end of the period presented (for example, a discrete medical event typically results from the presentation of a patient to a physician for the diagnosis of diabetes and congestive heart failure in a single visit, the presentation of a patient to an emergency department for chest pain, etc.).

(4) PAM is defined as the sum of the analytical processes performed on each respective patient within patient populations covered by clients under contract. As used in the metric, an "analytical process" is a distinct set of data calculations undertaken by us which is initiated and completed within our platform solutions to examine a specific question such as whether a patient is believed to have a condition such as diabetes, or worsening of the disease, during a specific time period.

Trends and Factors Affecting Our Future Performance

A number of factors influence our growth and performance. We see many of these factors as being more quantitatively driven, such as the rate of growth of the underlying data counts within our datasets, the ongoing investment in innovation, and our revenue mix of subscription-based platform offerings. Additionally, there are several factors that influence our growth and performance that are less quantitatively driven, including seasonality, macro-economic forces, and trends within healthcare (such as payment models, incentivization, and regulatory oversight) that can be driven by changes in federal and state laws and regulations, as well as private sector market forces.

Growth of Datasets. Healthcare costs in the United States have been increasing significantly for many years. This rise in healthcare costs has driven a broad transition from consumption-based payment models to quality and value-based payment models across the healthcare landscape. As a result, the specific disease and comorbidity status, clinical and quality outcomes, resource utilization, and care details of the individual patient have become increasingly relevant to the various constituents across the healthcare delivery system. Concurrently, the count and complexity of diseases, diagnostics, and treatments—as well as payment models and regulatory oversight requirements—have soared. In this setting, granular data has become critical to determining and improving quality and financial performance in healthcare. Our MORE^2 Registry® is our largest principal dataset and serves as a proxy for our general growth of datasets within Inovalon. The growth of our datasets that inform our analytical capabilities and comparative analytics is a key aspect of our provision of value to our clients and is indicative of our overall growth and capabilities.

Innovation and Platform Development. Our business model is based upon our ability to deliver value to our clients through our platform solutions and related services focused on the achievement of meaningful and measurable improvements in clinical quality outcomes and financial performance in healthcare. Our ability to deliver this value is dependent in part on our ability to continue to innovate, design new capabilities, enter into new agreements with clients for new platforms, and bring these capabilities to market in an enterprise scale. Our continued ability to innovate our platform and bring differentiated capabilities to market is an important aspect of our business success.

Our investment in innovation includes costs for research and development, capitalized software development, and capital expenditures related to hardware and software platforms on which our platform solutions are deployed as summarized below (in thousands, except percentages).

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Investment in Innovation:				
Research and development[1]	$ 9,060	$ 7,580	$ 25,159	$ 21,546
Capitalized software development[2]	9,787	8,446	26,495	30,108
Research and development infrastructure investments[3]	—	996	1,581	10,488
Total investment in innovation	$ 18,847	$ 17,022	$ 53,235	$ 62,142
As a percentage of revenue				
Research and development[1]	5%	5%	5%	6%
Capitalized software development[2]	6%	6%	6%	8%
Research and development infrastructure investments[3]	—%	1%	—%	2%
Total investment in innovation	11%	12%	11%	16%

(1) Research and development primarily includes employee costs related to the development and enhancement of our service offerings.

(2) Capitalized software development includes capitalized costs incurred to develop and enhance functionality for our platform solutions.

(3) Research and development infrastructure investments include strategic capital expenditures related to hardware and software platforms under development or enhancement.

Mix of Subscription-Based Platform Offerings and Legacy Solutions. In 2018, we executed an intentional transition in our offering portfolio from legacy platform solutions to subscription-based cloud-based platform offerings with add-on advisory services. Subscription-based cloud-based platform offerings are generally defined as modular, cloud-based solutions that utilize dynamic, high-speed cloud-based compute and storage, offer enhanced data visualization capabilities, and are tied to subscription-based contract structures where revenue is predominantly based on factors such as the number of patients under contract or similar relevant metrics (e.g., the number of prescriptions issued), the size of the client, and/or a specific period of time. Additionally, we expanded our offerings of cloud-based SaaS solutions enabled by the Inovalon ONE® Platform which utilize Artificial Intelligence

and machine learning application. Legacy platform solutions are generally defined as solutions historically not cloud-based in nature and not tied to subscription-based contract structures. We believe subscription-based cloud-based platform offerings provide more advanced capabilities, higher value, and greater visibility to clients, as well as improved visibility, market differentiation, and financial performance for us. Over time, we expect that subscription-based cloud-based platform offerings will continue to represent an increasing share of our total revenue, contributing to an increasing base of recurring revenue.

Additionally, through the ABILITY acquisition, we have expanded our subscription-based cloud-based platform offering revenues and we continue to achieve revenue synergies realized through i) the infusion of Inovalon's data and analytics into ABILITY's existing offerings, ii) the combination of the Inovalon ONE® Platform and *my*ABILITY® Platform capabilities to introduce new and more vertically integrated offerings which appeal to both organizations' traditional market base, iii) the enhancement of Inovalon's offerings from ABILITY's provider point-of-care data, connectivity, and workflow presence, and iv) the leveraging of ABILITY's sales channel, techniques and capacity.

Breadth of Healthcare Industry Connectivity. The healthcare industry is undergoing a significant transition as it becomes increasingly data-driven. As part of this transition, participants across the healthcare industry, including health plans, pharmaceutical companies, medical device manufacturers, and diagnostic companies, are increasingly interested in achieving timely and seamless access to relevant data and being able to drive impact directly with providers and their patients. Concurrently, providers are also increasingly interested in access to more advanced analytical tools to support and improve their clinical and financial performance. Enhancing and expanding our industry connectivity with payer administrative systems, provider facilities, diagnostic systems, pharmacy systems, healthcare industry systems (e.g., electronic healthcare record systems, health information exchange systems, claims processing systems, decision support systems, etc.), and other healthcare clinical and business systems, offers the potential for increased differentiation in the healthcare marketplace as well as improved efficiency of our operations.

Client and Analytical Process Count Growth. Our business is generally driven by the number of underlying patients for which our platform solutions are being utilized. As such, we track the number of analytical processes that we run on patients each month in fulfillment of our client contracts, as totaled for the trailing 12 months. We believe that PAM is indicative of our overall level of analytical activity, and we expect our period-to-period comparisons of our PAM to be indicative of underlying growth of our business, although changes in levels of analytical activity do not always directly translate to changes in financial performance of our business. Differences in fees charged for different analytical packages exist and differences in how analytics trigger the applicability of our data-driven intervention platforms may result in increases in analytical activity that do not result in proportional increases in revenue, or net income (and vice versa). Therefore, in situations in which a new engagement is initiated for analytical processes that have a higher than average fee rate, revenue could expand disproportionately faster than the increase in PAM. Likewise, if engagements for analytical processes that have a higher than average fee rate are concluded then such conclusions can negatively affect revenue disproportionately more than PAM.

Seasonality. The nature of our customers' end-market results in partial seasonality reflected in both revenue and cost of revenue differences during the year. Regulatory impact of data submission deadlines in, for example, January, March, June, and September drive some degree of predictable timing of analytics and data processing activity variances from quarter to quarter. Further, regulatory clinical encounter deadlines of June 30th and December 31st drive predictable intervention concentrations variances from quarter to quarter. The timing of these factors results in analytical and intervention activity mix variances, which have limited predictable impact in the aggregate on our financial performance from quarter to quarter. However, quarter to quarter financial performance may increasingly vary from historical seasonal trends as we continue to expand into adjacent markets and increase the portion of our revenue generated from new offerings. Further, we also expect the impact of seasonality to decrease over time as we expand our mix of revenue generated from a subscription-based model. The timing of new contract signings and their respective implementations can also lead to variances in our seasonal revenue performance.

Regulatory, Economic and Industry Trends. Our clients are affected, sometimes directly and sometimes counter-intuitively, by macro-economic trends such as economic growth (or economic recession), inflation, and unemployment. Further, industry trends in federal and state laws and regulations, as well as emerging trends in private sector payment models, affect our clients' businesses and their need for technologies and services to support these challenges. These factors have various effects on our business, and on occasion have resulted in the slowing or cessation of the decision-making process by clients adopting our technologies and services. On the other hand, changes in macro-economic trends and the industry landscape have accelerated the need for our technologies and services from time-to-time, particularly as regulators introduce complex requirements with which our clients must comply.

Critical Accounting Policies and Estimates

Our discussion and analysis of our financial condition and results of operations are based on our unaudited consolidated financial statements, which have been prepared in accordance with GAAP. In connection with the preparation of our unaudited consolidated financial statements, we are required to make assumptions and estimates about future events and apply judgments that affect the reported amounts of assets and liabilities, the disclosures of contingent assets and liabilities as of the date of the financial statements, and the reported amounts of revenues and expenses during the reporting periods. We base our assumptions,

estimates, and judgments on historical experience, current trends, and other factors we believe to be relevant at the time we prepare our unaudited consolidated financial statements. The accounting estimates used in the preparation of our unaudited consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained, and as our operating environment changes. On a regular basis, we review the accounting policies, assumptions, and evaluate and update our assumptions, estimates, and judgments to ensure that our unaudited consolidated financial statements are presented fairly and in accordance with GAAP. However, because future events and their effects cannot be determined with certainty, actual results could differ from our assumptions and estimates, and such differences could be material.

Critical accounting policies are those policies that affect our more significant judgments and estimates used in the preparation of our unaudited consolidated financial statements. For a more detailed discussion of our critical accounting policies, please refer to our 2018 Form 10-K.

Components of Results of Operations

Revenue

We earn revenue primarily through the sale or subscription licensing of our platform solutions, as well as revenue from related arrangements for advisory, implementation, and support services.

Platform solutions include arrangements for technology-based offerings representing subscription-based cloud-based platform offerings, including solutions offered through the *my*ABILITY® software platform, and legacy platform solutions that are not cloud-based and not billed under a subscription-based contract structure. Our platform solutions revenue is driven primarily by cloud-based data connectivity, analytics, intervention, and visualization software that enables the identification and resolution of gaps in care, quality, utilization, compliance, and/or other gaps that may impact our clients' achievement of greater healthcare quality and financial performance associated with value-based care. Revenue is predominantly based on the number of clients, the number of patients or similar relevant metrics (e.g., the number of prescriptions issued), the size of the client, the number of analytical services contracted for by a client and the contractually negotiated price of such services. Additionally, revenue is based on the number of identified and/or resolved gaps in care, quality, utilization, compliance, and/or other gaps resulting from our analytical services at a contractually negotiated transactional price for each identified and/or resolved gap.

The majority of our platform solutions contracts contain a series of separately identifiable and distinct services that represent performance obligations that are satisfied over time. Revenue is allocated to platform solutions by determining the standalone selling price of each performance obligation. Revenue is generally recognized on our platform offerings over the contract term. For certain contracts, we have determined that we will recognize revenue when we have the right to invoice.

As our platform solutions are increasingly integrated into our clients' operations, the timing and delivery of implementations vary.

Service revenue represents revenue that is generated from strategic advisory, implementation and support services. Revenue from our services arrangements is generally provided under time and materials, fixed-price, or retainer-based contracts, based on agreed upon billing rates applied to direct labor hours expended plus the costs of other items used in the performance of the contract. We recognize revenue when we have the right to invoice the customer using the allowable practical expedient since the right to invoice the customer corresponds with the performance obligations completed. Revenues under fixed-price and retainer-based contracts are recognized ratably over the contract period or upon contract completion.

Cost of Revenue

Cost of revenue consists primarily of expenses for employees who provide direct contractual services to our clients, including salaries, benefits, discretionary incentive compensation, employment taxes, severance, and equity compensation costs. Cost of revenue also includes expenses associated with the integration, and verification of data and other service costs incurred to fulfill our revenue contracts. Cost of revenue does not include allocated amounts for occupancy expense and depreciation and amortization. Many of the elements of our cost of revenue are relatively variable and semi-variable, and can be reduced in the near-term to help offset any decline in our revenue.

Our business and operational models are designed to be highly scalable and leverage variable costs to support revenue generating activities. While we may grow our headcount over time to capitalize on our market opportunities, we believe our increased investment in automation, electronic health record integration capabilities, and economies of scale in our operating model, will position us to grow our platform solutions revenue at a greater rate than our cost of revenue.

Sales and Marketing

Sales and marketing expense consists primarily of employee-related expenses, including salaries, benefits, commissions, discretionary incentive compensation, employment taxes, severance, and equity compensation costs for our employees engaged in sales, sales support, business development, and marketing. Sales and marketing expense also includes operating expenses for

marketing programs, research, trade shows and brand messages, and public relations costs. Our sales and marketing expense excludes any allocation of occupancy expense and depreciation and amortization.

We expect our sales and marketing expenses to continue to increase in absolute dollar terms as we strategically invest to expand our business, although it may vary from period to period as a percentage of total revenues.

Research and Development

Research and development expense (one component of our investment in innovation) consists primarily of employee-related expenses, including salaries, benefits, discretionary incentive compensation, employment taxes, severance, and equity compensation costs for our software developers, engineers, analysts, project managers, and other employees engaged in the development and enhancement of our service offerings. Research and development expense also includes certain third party consulting fees. Our research and development expense excludes any allocation of occupancy expense and depreciation and amortization.

We expect to continue our focus on developing new product offerings and enhancing our existing product offerings. As a result, we expect our research and development expense to increase in absolute dollars, although it may vary from period to period as a percentage of revenue.

General and Administrative

Our general and administrative expense consists primarily of employee-related expenses including salaries, benefits, discretionary incentive compensation, employment taxes, severance, and equity compensation costs, for employees who are responsible for management information systems, administration, human resources, finance, legal, and executive management. General and administrative expense also includes occupancy expenses (including rent, utilities, communications, and facilities maintenance), professional fees, consulting fees, insurance, travel, contingent consideration, transaction costs, integration costs, and other expenses. Our general and administrative expense excludes depreciation and amortization.

In the near term, we expect our general and administrative expense to continue to increase in absolute dollars to support business growth. Over the long term, we expect general and administrative expense to decrease as a percentage of revenue.

Depreciation and Amortization Expense

Our depreciation and amortization expense consists primarily of depreciation of fixed assets, amortization of capitalized software development costs, and amortization of acquisition-related intangible assets.

We expect our depreciation and amortization expense to increase as we expand our business organically and through acquisitions.

Interest Income

Interest income represents interest earned net of amortization of premium for purchased interest from our available-for-sale short-term investments.

We expect our interest income to fluctuate in proportion to the amount of funds we invest, according to our corporate investment policy, in available-for-sale short-term investments and considering prevailing available interest rate yields on such investment grade debt securities.

Interest Expense

Interest expense represents interest incurred on our 2018 Credit Facilities (as defined below, under the heading Liquidity and Capital Resources—Debt) and related interest rate swaps.

We expect our interest expense to increase in connection with the debt commitment discussed in “Note5—Debt” and to fluctuate in proportion to our outstanding principal balance under the 2018 Credit Facilities (as defined below, under the heading Liquidity and Capital Resources—Debt) and the prevailing London Interbank Offer Rate (“LIBOR”) interest rate.

Provision for Income Taxes

Provision for income taxes consists of federal and state income taxes in the United States and foreign income taxes from the territory of Puerto Rico, including deferred income taxes reflecting the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes, and excess tax benefits or deficiencies derived from exercises of stock options and vesting of restricted stock.

Our effective tax rate has decreased due to the Tax Cuts and Jobs Act of 2017 (the “Tax Act”), which was signed into law on December 22, 2017 and was effective January 1, 2018, and in the future may fluctuate due to the recognition of excess tax benefits and tax deficiencies associated with stock-based compensation transactions which are considered to be discrete items.

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RESULTS OF OPERATIONS

The following table sets forth our consolidated statement of operations data for each of the periods presented (in thousands, except percentages):

	Three Months Ended September 30,		Change from 2018 to 2019		Nine Months Ended September 30,		Change from 2018 to 2019	
	2019	2018	$	%	2019	2018	$	%
Revenue	$ 166,453	$ 145,809	$ 20,644	14 %	$ 468,921	$ 391,362	$ 77,559	20 %
Expenses:								
Cost of revenue[1]	42,940	36,422	6,518	18 %	121,261	108,928	12,333	11 %
Sales and marketing[1]	16,172	11,785	4,387	37 %	44,004	31,732	12,272	39 %
Research and development[1]	9,060	7,580	1,480	20 %	25,159	21,546	3,613	17 %
General and administrative[1]	49,306	47,203	2,103	4 %	148,623	156,773	(8,150)	(5)%
Depreciation and amortization	26,903	26,571	332	1 %	81,370	69,857	11,513	16 %
Restructuring expense	—	—	*	*%	—	9,464	*	*%
Total operating expenses	144,381	129,561	14,820	11 %	420,417	398,300	22,117	6 %
Income (Loss) from operations	22,072	16,248	5,824	36 %	48,504	(6,938)	55,442	799 %
Other income and (expenses):								
Interest income	619	325	294	90 %	1,893	1,874	19	1 %
Interest expense	(16,700)	(16,824)	124	(1)%	(49,891)	(34,274)	(15,617)	46 %
Other expense, net	(7)	(210)	*	*%	(18)	(1,841)	*	*
Income (Loss) before taxes	5,984	(461)	6,445	*%	488	(41,179)	41,667	101 %
(Benefit from) Provision for income taxes	(858)	383	(1,241)	(324)%	(2,569)	(13,035)	10,466	(80)%
Net income (loss)	$ 6,842	$ (844)	$ 7,686	911 %	$ 3,057	$ (28,144)	$ 31,201	111 %

(1) Includes stock-based compensation expense as follows:

Cost of revenue	$ 116	$ 101	$ 15	15 %	$ 271	$ 154	$ 117	76 %
Sales and marketing	535	308	227	74 %	1,174	376	798	212 %
Research and development	475	643	(168)	(26)%	1,224	1,601	(377)	(24)%
General and administrative	4,659	3,702	957	26 %	11,137	9,015	2,122	24 %
Total stock-based compensation expense	$ 5,785	$ 4,754	$ 1,031	22 %	$ 13,806	$ 11,146	$ 2,660	24 %

* Asterisk denotes not meaningful.

The following table sets forth our consolidated statement of operations data for each of the periods presented as a percentage of revenue:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2019	2018	2019	2018
Revenue	100 %	100 %	100 %	100 %
Expenses:				
Cost of revenue	26 %	25 %	26 %	28 %
Sales and marketing	10 %	8 %	9 %	8 %
Research and development	5 %	5 %	5 %	6 %
General and administrative	30 %	32 %	32 %	40 %
Depreciation and amortization	16 %	18 %	17 %	18 %
Restructuring expense	— %	— %	— %	2 %
Total operating expenses	87 %	88 %	89 %	102 %
Income (Loss) from operations	13 %	12 %	11 %	(2)%
Other income and (expenses):				
Interest income	*%	*%	*%	*%
Interest expense	(10)%	(12)%	(11)%	(9)%
Other expense, net	*%	*%	*%	*%
Income (Loss) before taxes	3 %	— %	*%	(11)%
(Benefit from) Provision for income taxes	(1)%	*%	(1)%	(3)%
Net income (loss)	4 %	— %	1 %	(8)%

* Asterisk denotes not meaningful.

Comparison of the Three and Nine Months Ended September 30, 2019 and 2018

Revenue

Revenue for the three months ended September 30, 2019 was $166.5 million, an increase of $20.6 million, or 14%, compared with revenue of $145.8 million for the three months ended September 30, 2018. This increase was primarily attributable to an increase of $11.9 million in revenue from existing clients and $8.7 million in revenue contributed from new clients signed resulting from continued adoption of subscription-based platform offerings including cloud-based SaaS solutions enabled by the Inovalon ONE® Platform.

Revenue for the nine months ended September 30, 2019 was $468.9 million, an increase of $77.6 million, or 20%, compared with revenue of $391.4 million for the nine months ended September 30, 2018. This increase was primarily attributable to $39.8 million in revenue from the acquired business of ABILITY, through the anniversary date of the acquisition, an increase of $29.4 million in revenue contributed from new clients signed resulting from continued adoption of subscription-based platform offerings including cloud-based SaaS solutions enabled by the Inovalon ONE® Platform, and an increase of $8.3 million in revenue from existing clients.

Cost of Revenue

During the three months ended September 30, 2019, cost of revenue increased by $6.5 million, or 18%, compared with the three months ended September 30, 2018. The increase in cost of revenue was primarily attributable to an increase in employee-related expense and third-party client-servicing expense, which together contributed $5.6 million. Cost of revenue as a percentage of revenue was 26% and 25% for the three months ended September 30, 2019 and 2018, respectively.

During the nine months ended September 30, 2019, cost of revenue increased by $12.3 million, or 11%, compared with the nine months ended September 30, 2018. The increase in cost of revenue was primarily attributable to an increase in employee-related expense and third-party client-servicing expense, which together contributed $10.3 million, and incremental cost of revenue of $5.0 million attributable to the acquired business of ABILITY, through the anniversary date of the acquisition, which was partially offset by a decrease in professional third-party costs of $2.8 million. Cost of revenue as a percentage of revenue was 26% and 28% for the nine months ended September 30, 2019 and 2018, respectively, reflecting the factors discussed above as well as an increase in the mix of higher-margin platform solutions and cloud-based SaaS solutions as a percentage of revenue.

Sales and Marketing

During the three months ended September 30, 2019, sales and marketing expenses increased by $4.4 million, or 37%, compared with the three months ended September 30, 2018. The increase was primarily attributable to an increase in employee-related expenses of $3.2 million and an increase in advertising expenses of $1.0 million. Sales and marketing expenses as a percentage of revenue was 10% and 8% for the three months ended September 30, 2019 and 2018, respectively.

During the nine months ended September 30, 2019, sales and marketing expenses increased by $12.3 million, or 39%, compared with the nine months ended September 30, 2018. The increase was primarily attributable to an increase in employee-related expenses of $5.5 million, incremental expense of $5.3 million attributable to the acquired business of ABILITY, through the anniversary date of the acquisition, and an increase in advertising expenses of $1.4 million. Sales and marketing expenses as a percentage of revenue was 9% and 8% for the nine months ended September 30, 2019 and 2018, respectively.

Research and Development

During the three months ended September 30, 2019, research and development expense increased by $1.5 million, or 20%, compared with the three months ended September 30, 2018. The increase was primarily attributable to an increase in professional third-party costs of $2.6 million, which was partially offset by a decrease in employee-related expenses of $0.4 million.

During the nine months ended September 30, 2019, research and development expense increased by $3.6 million, or 17%, compared with the nine months ended September 30, 2018. The increase was primarily attributable to incremental expense of $2.5 million attributable to the acquired business of ABILITY, through the anniversary date of the acquisition and an increase in employee-related expenses of $2.4 million, which was partially offset by a decrease in professional third-party costs of $0.8 million.

General and Administrative

During the three months ended September 30, 2019, general and administrative expenses increased by $2.1 million, or 4%, compared with the three months ended September 30, 2018. The increase was primarily attributable to an increase in employee-related expenses of $3.3 million and an increase in stock-based compensation of $1.0 million, which was partially offset by an adjustment in the prior year to increase the fair value of contingent consideration that was not present in the current year resulting in a reduction in expense of $1.1 million, and a decrease in professional third-party costs of $0.8 million. General and administrative expenses as a percentage of revenue was 30% and 32% for the three months ended September 30, 2019 and 2018, respectively.

During the nine months ended September 30, 2019, general and administrative expenses decreased by $8.2 million, or 5%, compared with the nine months ended September 30, 2018. The decrease was primarily attributable to an adjustment in the prior year to increase the fair value of contingent consideration that was not present in the current year resulting in a reduction in expense of $11.4 million, a decrease in professional third-party costs of $4.3 million, and a decrease in transaction and integration costs of $4.2 million, which was partially offset by incremental expenses of $7.5 million attributable to the acquired business of ABILITY, through the anniversary date of the acquisition, and an increase in stock-based compensation of $2.1 million. General and administrative expenses as a percentage of revenue was 32% and 40% for the nine months ended September 30, 2019 and 2018, respectively.

Depreciation and Amortization

During the three months ended September 30, 2019, depreciation and amortization expense increased by $0.3 million, or 1%, compared with the three months ended September 30, 2018.

During the nine months ended September 30, 2019, depreciation and amortization expense increased by $11.5 million, or 16%, compared with the nine months ended September 30, 2018. The increase was primarily attributable to an increase in amortization of acquired intangible assets of$8.7 million.

Interest Income

During the three months ended September 30, 2019, interest income increased by $0.3 million, compared with the three months ended September 30, 2018. During the nine months ended September 30, 2019, interest income was flat compared with thenine months ended September 30, 2018.

Interest Expense

During the three months ended September 30, 2019, interest expense decreased by $0.1 million, compared with the three months ended September 30, 2018.

During the nine months ended September 30, 2019, interest expense increased by $15.6 million, compared with the nine months ended September 30, 2018. The increase in interest expense was primarily attributable to an increase in borrowings in connection with the 2018 Term Facility (as defined below, under the heading Liquidity and Capital Resources—Debt) and an increase in expense related to the interest rate swaps entered into in connection with the 2018 Term Facility.

(Benefit from) Provision For Income Taxes

During the three months ended September 30, 2019, the benefit from income taxes was $0.9 million compared to a provision for income taxes of $0.4 million for the three months ended September 30, 2018. During the nine months ended September 30, 2019, the benefit from income taxes was $2.6 million compared to $13.0 million for the nine months ended September 30, 2018. Our effective tax rate for the nine months ended September 30, 2019 was approximately (526.4)%, compared with approximately 31.7% for the nine months ended September 30, 2018. The change in our effective tax rate is primarily due to the impact of our discrete items as a percentage of income before taxes in each respective period.

Liquidity and Capital Resources

Sources of Liquidity

Our principal sources of liquidity have been cash generated by operating activities and proceeds from our 2018 Credit Facilities. Our cash generated from such means has been sufficient to fund our growth, including our capital expenditures. As of September 30, 2019, our cash and cash equivalents totaled $133.6 million, compared with $114.9 million of cash, cash equivalents, and short-term investments as of September 30, 2018, of which $11.4 million represented short-term, available-for-sale, investment grade, domestic debt-securities.

We believe our current cash, cash equivalents, expected cash generated by operating activities, and availability of cash under our 2018 Credit Facilities are sufficient to fund our operations, finance our strategic initiatives, and fund our investment in innovation and new service offerings, for the foreseeable future. There can be no assurance that we will continue to generate cash flows at or above current levels or that we will be able to maintain our ability to borrow under our 2018 Credit Facilities.

Debt

On September 19, 2014, we entered into a Credit and Guaranty Agreement with a group of lenders and Goldman Sachs Bank USA, as administrative agent, providing for a senior unsecured term loan facility in the original principal amount of $300.0 million (the "2014 Term Facility") and a senior unsecured revolving credit facility in the maximum principal amount of $100.0 million (the "2014 Revolving Credit Facility" and, together with the Term Facility, the "2014 Credit Facilities").

On April 2, 2018, we paid in full all existing debt obligations under the 2014 Credit Facilities and terminated all commitments to extend further credit thereunder. On April 2, 2018, we entered into a credit agreement with a group of lenders and Morgan Stanley Senior Funding, Inc., as administrative agent, to provide a secured credit facility which is comprised of: (i) a term loan B facility with us as borrower in a total principal amount of $980.0 million (the "2018 Term Facility"); and (ii) a revolving credit facility with us as borrower in a total principal amount of up to $100.0 million (the "2018 Revolving Facility" together with the 2018 Term Facility, the "2018 Credit Facilities"). As of September 30, 2019, we had $100.0 million available to us consisting of $99.0 million under the 2018 Revolving Facility and a letter of credit of $1.0 million. See "Note 5—Debt" in the Notes to our unaudited consolidated financial statements included under Part I, Item 1 within this Quarterly Report on Form 10-Q for additional information.

As of September 30, 2019, we had outstanding indebtedness under the 2018 Term Facility and finance lease liabilities of $944.9 million and $15.4 million, respectively. As of September 30, 2018, we had outstanding indebtedness under the 2018 Term Facility and finance lease liabilities of $950.8 million and $16.3 million, respectively. The 2018 Term Facility has a seven year term and is an amortizing facility with quarterly principal payments and monthly interest payments. Scheduled principal payments totaling $7.4 million and scheduled interest payments totaling $47.9 million were paid during the nine months ended September 30, 2019. As of September 30, 2019, we were in compliance with the covenants under the 2018 Credit Agreement.

On October 4, 2019, we made a voluntary incremental cash payment of $50.0 million in excess of our required payments from our existing cash balance on our outstanding debt reducing the principal balance under the 2018 Term Facility. As of the date of this filing, our 2018 Revolving Facility remained undrawn.

Cash Flows

Operating Cash Flow Activities

Cash provided by operating activities during the nine months ended September 30, 2019 was $72.3 million, representing an increase of $9.2 million compared with the nine months ended September 30, 2018. The increase in cash provided by operating activities was primarily driven by an increase in operating income and an increase of $1.5 million in cash received for income taxes due to net tax refunds, which was partially offset by an increase of $20.2 million in cash paid for interest.

Investing Cash Flow Activities

Cash used in investing activities during the nine months ended September 30, 2019 was $33.0 million compared with $879.1 million during the nine months ended September 30, 2018. The change in cash used in investing activities was primarily due to

the acquisition of ABILITY in the prior year, which was partially offset by a decrease in sales and maturities of short term investments of $247.0 million and a decrease in capital expenditures of $10.3 million.

We make investments in innovation, including research and development expense, capital software development costs, and research and development infrastructure investments, on a recurring basis.

Financing Cash Flow Activities

Cash used in financing activities during the nine months ended September 30, 2019 was $21.3 million, compared with cash provided by financing activities of $710.6 million during the nine months ended September 30, 2018. The change in cash used in financing activities was primarily due to proceeds from the 2018 Term Facility net of repayment of the 2014 Credit Facility borrowings in the prior year and payment for acquisition-related contingent consideration in the current year.

Contractual Obligations

During the nine months ended September 30, 2019, there have been no material changes, outside of the ordinary course of business, in our contractual obligations previously disclosed under the caption "Contractual Obligations" in our 2018 Form 10-K.

Off-Balance Sheet Arrangements

As of September 30, 2019, we did not have any off-balance sheet arrangements.

Recently Issued Accounting Standards

Recently issued accounting standards and their expected impact, if any, are discussed in "Note 1—Basis of Presentation", in the notes to our unaudited consolidated financial statements, included under Item 1 within this Quarterly Report on Form 10-Q and in "Note 2—Summary of Significant Accounting Policies," in the notes to our consolidated financial statements, included under Item 15 within our 2018 Form 10-K.

Item 3. ***Quantitative and Qualitative Disclosures About Market Risk***

There have been no material changes to our market risk subsequent to the previous disclosure in Part I—Item 1A ("Risk Factors") of our 2018 Form 10-K.

Item 4. ***Controls and Procedures***

Disclosure Controls and Procedures

Our management, with the participation of our chief executive officer ("CEO") and chief financial officer ("CFO"), has evaluated the effectiveness of our disclosure controls and procedures, (as defined in Rules 13a- 15(e) and 15d- 15(e) under the Exchange Act), as of the end of the period covered by this Quarterly Report on Form 10-Q. Based on such evaluation, our CEO and CFO have concluded that, as of September 30, 2019, our disclosure controls and procedures were designed at a reasonable assurance level to ensure that material information relating to Inovalon Holdings, Inc., including its consolidated subsidiaries, is made known to our CEO and CFO by others within those entities, particularly during the period in which this report was being prepared and that our disclosure controls and procedures were effective in providing reasonable assurance that information we are required to disclose in reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the rules and forms of the SEC, and that such information is accumulated and communicated to our management, including our CEO and CFO, as appropriate, to allow timely decisions regarding required disclosure.

Changes in Internal Control

There have been no changes in the Company's internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) of the Exchange Act) during the three months ended September 30, 2019 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

PART II—OTHER INFORMATION

Item 1. Legal Proceedings

See "Note 7—Commitments and Contingencies" in the Notes to our unaudited consolidated financial statements included under Part I, Item 1 within this Quarterly Report on Form 10-Q.

Item 1A. Risk Factors

For a discussion of potential risks and uncertainties related to our Company see the information in Part I, Item 1A ("Risk Factors") of our2018 Form 10-K for the year ended December 31, 2018. There have been no material changes to the risk factors previously disclosed in our2018 Form 10-K.

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

Unregistered Sales of Equity Securities

None.

Use of Proceeds from Registered Securities

None.

Purchases of Equity Securities by the Issuer or Affiliated Purchasers

The following table presents a summary of share repurchases made by the Company during the quarter endedSeptember 30, 2019:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares (or approximate dollar value) that May Yet be Purchased under the Plans or Programs
July 1 – July 31	—	$ —	—	$ —
August 1 – August 31	—	—	—	—
September 1 – September 30[(1)]	42,384	16.85	42,384	—
Total	42,384	$ 16.85	42,384	$ —

(1) On September 3, 2019, we directed the administrator of the Company's Employee Stock Purchase Plan ("ESPP") to purchase 42,384 shares of Class A common stock in the open market for a total of approximately $0.7 million, for issuance to the ESPP participants at a discounted price of $14.38 per share. The Company may, in its discretion, based on market conditions, relative transaction costs and the Company's need for additional capital, continue to instruct the plan administrator to make semi-annual open market purchases of Class A common stock for ESPP participants to coincide with the ESPP's designated semi-annual purchase dates.

Item 3. Defaults Upon Senior Securities

Not applicable.

Item 4. Mine Safety Disclosures

Not applicable.

Item 5. Other Information

None.

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Item 6. Exhibits

EXHIBIT INDEX

Exhibit Number		Description of Document
31.1	*	Certification of Chief Executive Officer pursuant to Rule 13a-14(a)/15d-14(a) of the Securities Exchange Act of 1934, as amended, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	*	Certification of Chief Financial Officer pursuant to Rule 13a-14(a)/15d-14(a) of the Securities Exchange Act of 1934, as amended, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	**	Certification of Chief Executive Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	**	Certification of Chief Financial Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	*	Inline XBRL Instance Document (the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document)
101.SCH	*	Inline XBRL Taxonomy Extension Schema Document
101.CAL	*	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	*	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	*	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	*	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104	*	Cover Page Interactive Data File (formatted as inline XBRL and contained in Exhibit 101)

* Filed herewith.

** This certification is deemed not filed for purposes of Section 18 of the Securities Exchange Act of 1934, as amended (Exchange Act), or otherwise subject to the liability of that section, nor shall it be deemed incorporated by reference into any filing under the Securities Act of 1933, as amended (Securities Act), or the Exchange Act.

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SIGNATURES

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

Date: October 30, 2019

INOVALON HOLDINGS, INC.

By: /s/ KEITH R. DUNLEAVY, M.D.

Keith R. Dunleavy, M.D.
Chief Executive Officer & Chairman
(Principal Executive Officer)

By: /s/ JONATHAN R. BOLDT

Jonathan R. Boldt
Chief Financial Officer
(Principal Financial Officer)

EXHIBIT 31.1

CERTIFICATION

I, Keith R. Dunleavy, M.D., certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Inovalon Holdings, Inc.;

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

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

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

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

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

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

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

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

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

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

/s/ KEITH R. DUNLEAVY, M.D.

Keith R. Dunleavy, M.D.
Chief Executive Officer & Chairman
(Principal Executive Officer)

Date: October 30, 2019

EXHIBIT 31.2

CERTIFICATION

I, Jonathan R. Boldt, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Inovalon Holdings, Inc.;

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

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

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

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

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

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

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

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

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

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

/s/ JONATHAN R. BOLDT

Jonathan R. Boldt
Chief Financial Officer
(Principal Financial Officer)

Date: October 30, 2019

EXHIBIT 32.1

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

In connection with the Quarterly Report of Inovalon Holdings, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2019 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Keith R. Dunleavy, M.D., the Chief Executive Officer and Chairman of the Company, certify, to my knowledge, pursuant to 18 U.S.C. §1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ KEITH R. DUNLEAVY, M.D.

Keith R. Dunleavy, M.D.
Chief Executive Officer & Chairman
(Principal Executive Officer)

Date: October 30, 2019

EXHIBIT 32.2

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In connection with the Quarterly Report of Inovalon Holdings, Inc. (the "Company") on Form 10-Q for the period ended September 30, 2019 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Jonathan R. Boldt, the Chief Financial Officer of the Company, certify, to my knowledge, pursuant to 18 U.S.C. §1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JONATHAN R. BOLDT

Jonathan R. Boldt
Chief Financial Officer
(Principal Financial Officer)

Date: October 30, 2019

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Language Line Services, Inc.

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Registration Document

Annual financial report

2018

Teleperformance
each interaction matters

Att E-2353

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Teleperformance
each interaction matters

2018 REGISTRATION DOCUMENT

including the annual financial report

Incorporation by reference

In accordance with Article 28 of European Regulation No. 809/2004 of April 29th, 2004, the reader is asked to refer to previous Registration Documents for certain information.

1. Relating to the 2017 financial year

The management report, the consolidated and Company accounts as well as the corresponding statutory auditors' reports and the statutory auditors' special report on regulated agreements and commitments, contained in the Registration Document filed with the *Autorité des marchés financiers*, on March 2nd, 2018 under number D.18-0095.

2. Relating to the 2016 financial year

The management report, the consolidated and Company accounts as well as the corresponding statutory auditors' reports and the statutory auditors' special report on regulated agreements and commitments, contained in the Registration Document filed with the *Autorité des marchés financiers*, on March 2nd, 2017 under number D.17-0122.

Information included in these two Registration Documents other than that referred to above may have been replaced or updated by information included in this Registration Document.

AUTORITÉ DES MARCHÉS FINANCIERS
AMF

This Registration Document was filed with the *Autorité des marchés financiers* on March 4th, 2019, in accordance with Article 212-13 of the AMF's General Regulation.

It may be relied upon within the scope of a financial transaction if supplemented by an information document approved by the AMF. It was drawn up by the issuer and is binding on its signatories.

This document is available online on the websites of Teleperformance (www.teleperformance.com) and the *Autorité des marchés financiers* (www.amf-france.org).

Att E-2355

TELEPERFORMANCE IN 2018

GROUP PROFILE

Founded in 1978 by Daniel Julien, Teleperformance is a global leader in outsourced high value-added services solutions for businesses. It is the worldwide preferred partner "High Tech / High Touch" of fast-growing and leading companies in their market and fast developing for the implementation of strategies to optimize their customer experience and business processes. Teleperformance thus offers its clients a global and integrated offer, falling into two categories of services in 2018:

High value-added services to businesses

Core services
- Customer care
- Technical support
- Customer acquisition
- Back-office services

Specialized services
- On-line interpreting
- Visa application management
- Debt collection

Setting up a third category of activities in October 2018: Teleperformance D.I.B.S. (Digital Integrated Business Services) following the acquisition of Intelenet.

Intelenet is a major player in integrated services for business process management, digital transformation and high value-added consulting.

MISSION

Teleperformance is a company of people serving other people by helping them find solutions to their daily problems, in an environment that is increasingly complex in terms of interaction methods, security issues and technological breakthroughs.

Teleperformance offers a unique approach to help its clients imagine, design and conduct their business in a more innovative and efficient way, through a comprehensive and adaptable portfolio of consulting services and solutions.

This "High Tech / High Touch" approach combines technologies and emotional intelligence. It is today the true DNA of Teleperformance.

HIGH TECH

Expertise in advanced technological tools
- Optimized and well performing proprietary IT tools
- Reliable, user-friendly and digital solutions integrating Robotic Process Automation (RPA) procedures
- Expertise of Intelenet in digital transformation solutions

HIGH TOUCH

Emotionnal intelligence (E.I)
- 300,000+ employees
- High value-added global solutions requiring empathy and sales capabilities
- Hiring and training
- Support and Great Place To Work®
- Management and performance evaluation

VALUES

"The five Teleperformance values are the pillars of our corporate culture and guarantee the excellence of our services and solutions"

Cosmos | Integrity
I say what I do & I do what I say

Air | Innovation
I create and I improve

Earth | Respect
I treat others with kindness and empathy

Fire | Commitment
I'm passionate and engaged

Metal | Professionnalism
I do things right the very first time

HIGHLIGHTS OF THE YEAR

CREATION OF TELEPERFORMANCE D.I.B.S., DIGITAL INTEGRATED BUSINESS SERVICES, FOLLOWING THE ACQUISITION OF INTELENET

Teleperformance D.I.B.S. (Digital Integrated Business Services) is a new category of activity created by Teleperformance, that mainly brings together the activities of Intelenet, a major player in high value-added services and digital transformation solutions acquired in October 2018, and Praxidia consulting activities.

With 58,000 employees, Intelenet manages more than 40 centers in 11 countries in North and South America, Europe, the Middle East, India and the Philippines. It supports more than 110 leading clients in more than 25 languages and offers multinational companies innovative solutions recognized for their excellence.

Att E-2356

GLOBAL LEADERSHIP

Teleperformance has the largest geographical footprint in the industry and is capable of handling programs in 265 languages. With more than 850 clients worldwide, the Group generates revenue of €4.4 billion, of which 50% from multinationals.

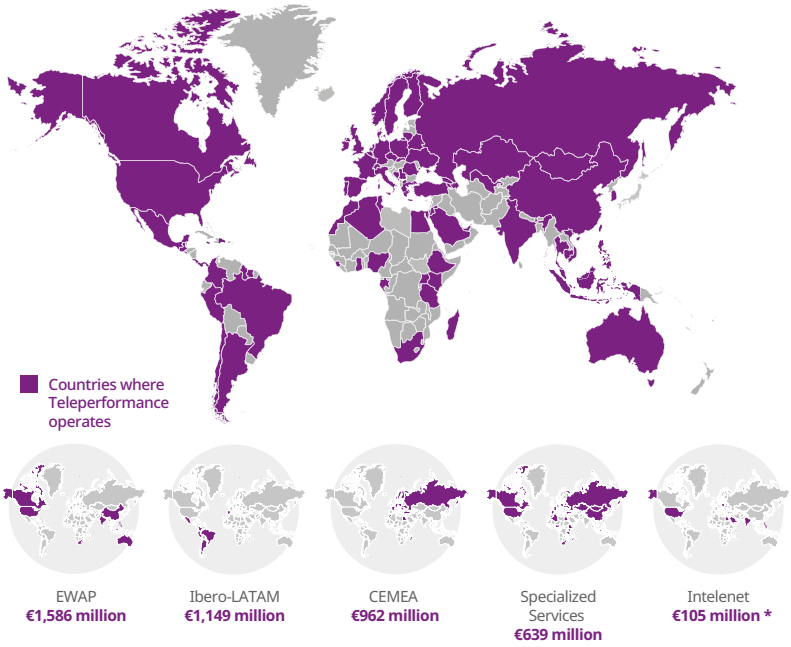

** 3-month consolidation.*

In 2018, Teleperformance started operations in new countries like in Bosnia, Taiwan and, with the acquisition of Intelenet, Guatemala and Saudi Arabia.

KEY FIGURES

OPERATIONS IN

80 COUNTRIES

265 LANGUAGES

170 MARKETS

850+ CLIENTS

300,000+ EMPLOYEES

SUCCESSFUL ISSUE OF A 7-YEAR BOND FOR €750M

Teleperformance successfully completed in July 2018 a €750 million bond offering with a coupon of 1.875% and a 2025 maturity.

This issue enabled the group to refinance the acquisition of Intelenet, improve its financial flexibility, extend the maturity of its debt and diversify its financial resources.

Standard & Poor's has confirmed Teleperformance's rating of "BBB-" – Investment grade – with a stable outlook, the highest rating in the customer experience sector.

NEW VISUAL IDENTITY

Teleperformance unveiled in September its new brand identity and logo in line with its status as a genuinely global group where innovation and technology play a central role in support of the human experience.

This new visual identity stands for what Teleperformance is today and the transformation it has undertaken in recent years.

The launch of the new visual identity was accompanied by a global advertising campaign in order to convey the strengths and values of Teleperformance.

TELEPERFORMANCE CONFIRMED ITS LEADERSHIP IN SECURITY AND DATA PROTECTION

On February 12th, 2018, Teleperformance was BCR (Binding Corporate Rules) approved by the CNIL (*commission nationale de l'informatique et des libertés*). The group was the first player in its sector to obtain this approbation.

Internal organization and procedures are fully compliant with the General Data Protection Regulation (GDPR) effective May 25th, 2018.

Att E-2357

KEY FINANCIAL FIGURES

GROWTH AND PROFITABILITY

Revenue
(€M)

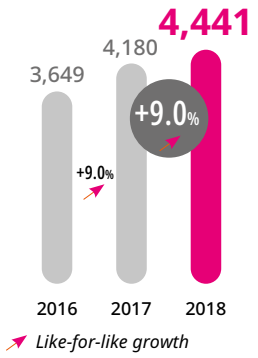

Current EBITDA
(€M)

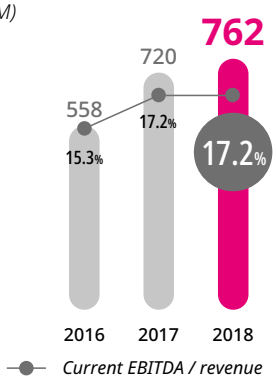

Current EBITA
(€M)

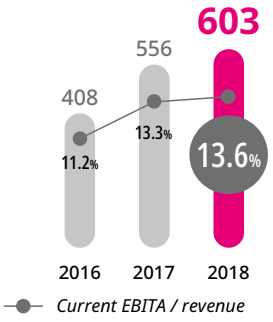

Net free cash flow
(€M)

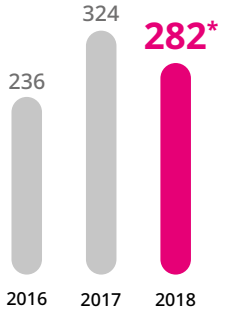

** Including €25m of non-recurring*

Net result Group share
(€M)

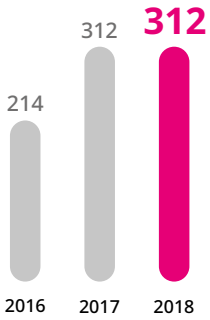

Dividend per share
(€)

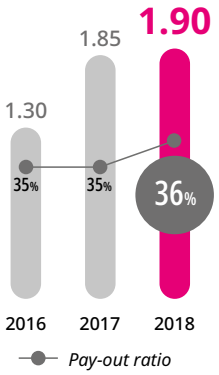

A DIVERSIFIED AND PROFITABLE PORTFOLIO OF ACTIVITIES

Revenue breakdown by activity and linguistic region in 2018 *vs* 2017 (€M)

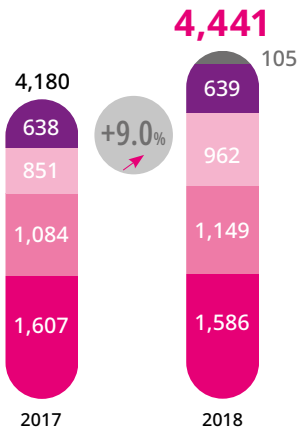

Current EBITA breakdown by activity in 2018 *vs* 2017 (€M)

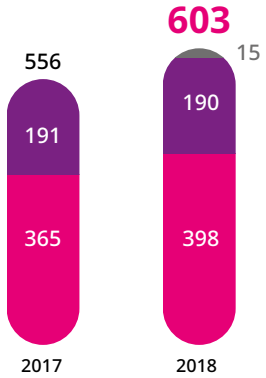

Like-for-like growth

** 3-month consolidation of Intelenet*

This information is provided in various chapters of the Registration Document and defined in the 4.1.1 *Alternative Performance Measures (APMs) section.*

Att E-2358

KEY EXTRA FINANCIAL FIGURES

HIGH TOUCH STRATEGY

Headcount evolution since 2012

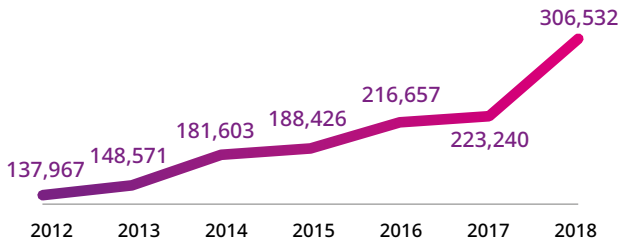

Evolution of training hours since 2012

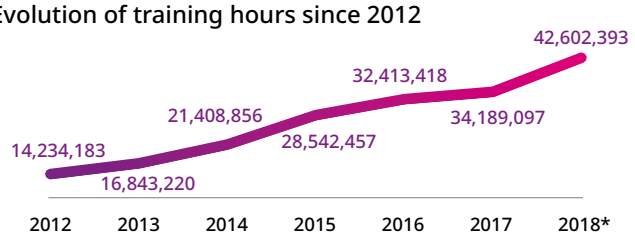

** Excluding Intelenet.*

Evolution of the share of women in management since 2012

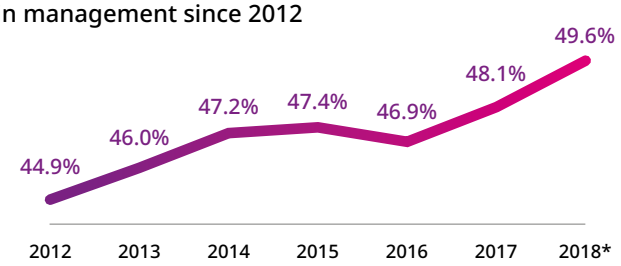

** Excluding Intelenet.*

DIVERSITY POLICY WITHIN THE BOARD OF DIRECTORS

1
LEAD INDEPENDENT DIRECTOR

9
INDEPENDENT DIRECTORS
64%

6
WOMEN
43%

6 REPRESENTED NATIONALITIES

China · Colombia · United States · France · Philippines · United Kingdom

ENVIRONMENT AND COMMITMENT IN FAVOR OF COMMUNITIES

0.71 -8%

CARBON FOOTPRINT TONNE PER EMPLOYEE

5.5

MILLION OF US DOLLARS OF DONATIONS IN CASH AND IN KIND *

** As part of the Citizen of the World program.*

85,374

VOLUNTEERED HOURS*

** As part of the Citizen of the World program.*

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MESSAGE FROM THE CHAIRMAN AND CHIEF EXECUTIVE OFFICER

3 QUESTIONS TO DANIEL JULIEN

What are the key takeaways from the Group's 2018 results?

In 2018, Teleperformance generated strong like-for-like growth of +9%, well above the market average, and also achieved an improvement in its EBITA margin. We demonstrated our Group's exceptional agility, by restoring our growth drive in the EWAP region, notably thanks to new developments in the digital economy ecosystem, and by sustaining our ramp-up in the CEMEA region. Once again, we've strengthened our position as worldwide leader in outsourced customer experience management.

In what way was 2018 a key year for the Group's future?

Beyond financial results, we significantly strengthened our global footprint in our three operating geographies in 2018.

Thanks to the October 2018 acquisition of India-based outsourcing company Intelenet, which employs 58,000 people and specializes in integrating digital solutions into client processes, we have significantly enhanced our services offering, particularly in banking, hospitality, transportation and healthcare.

Today, the services offered by Teleperformance are classified into three categories:

- Core Services, which cover customer care, technical support and customer acquisition.
- Digital Integrated Business Services (D.I.B.S), which cover the end-to-end outsourcing of client processes.
- High-value Specialized Services, which include online interpreting, visa application management and services related to debt collection.

Together, our enhanced organization and expanded skills base are enabling us to effectively meet our clients' needs in terms of their development and digital transformation.

Since end-2012, Teleperformance has recorded like-for-like growth of more than +5% for 27 straight quarters, as well as an improvement in EBITA margin every year. This performance has earned us our status as a growth company and we fully intend to continue in this direction.

This approach and success are based on our High Tech / High Touch DNA. The efficiency gains offered by artificial intelligence technology with the development of automated systems show the High Tech side in our customer experience activities. We have to remain, first and foremost, a great place to work, because our business is primarily based on the excellence, the fulfilment and the emotional intelligence displayed by our 300,000 employees in delighting our customers. This is what we call our High Touch approach.

Reflecting this evolution and our values, we unveiled the new brand identity and logo of Teleperformance in early September, expressing its status as a truly global enterprise where innovation and technology play a central role in supporting the human experience. The new, resolutely contemporary, multicultural and digital identity reflects the Group's evolution in recent years.

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We are looking forward to the coming years with confidence and ambition

How do you see 2019, which has only just started, and the longer term?

We are looking forward to the coming years with confidence and ambition. Our targets for 2019 are like-for-like revenue growth of at least +7% and an improvement in EBITA margin before non-recurring items of +20 basis points.

Looking further ahead, we have confirmed our 2022 targets, at constant scope of consolidation, to revenue of at least €6 billion and EBITA before non-recurring items of at least €850 million. We will also continue to implement our carefully controlled strategy of selective acquisitions, while maintaining our commitment to financial discipline. The successful implementation of this strategy should enable us to raise these targets at a later date.

I would like to thank all our stakeholders, customers, employees, partners, the communities where we operate all over the world and naturally our shareholders for their loyalty, commitment and renewed support in 2018 in our development as an efficient, front-ranking and value-creating organization. I am particularly pleased to present, for the first time in this year's Registration Document, the Sustainable and Responsible Investment business model that underpins our continuous improvement process.

A VALUE CREATION BUSINESS MODEL

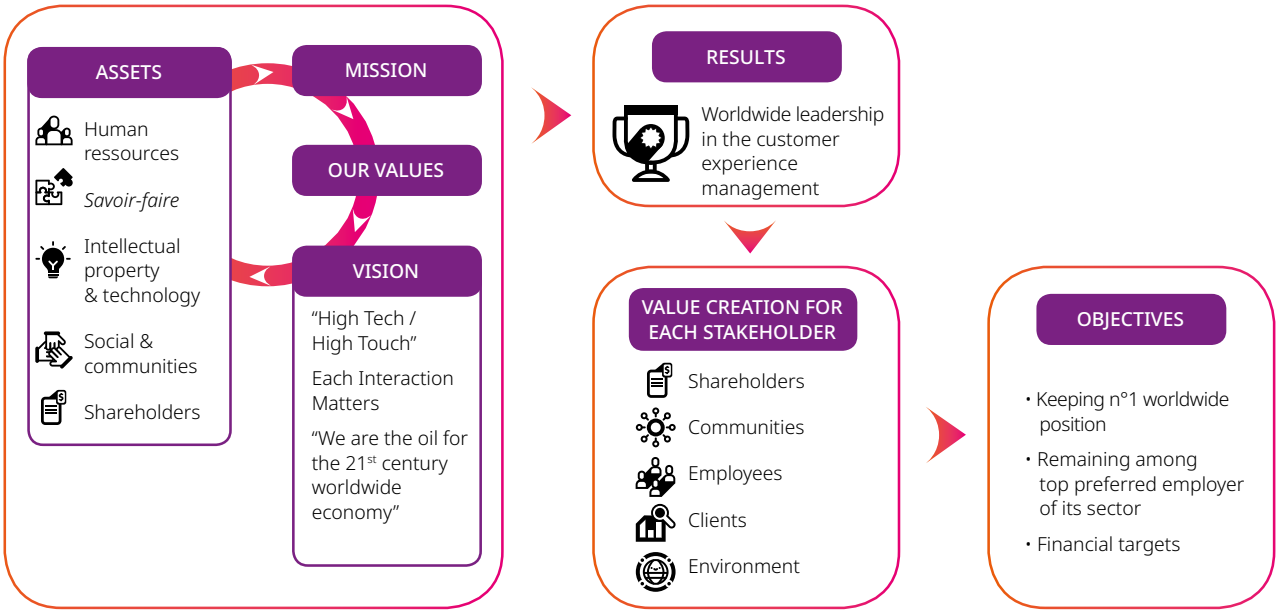

A RECOGNIZED MODEL

10 Great Place to Work® awards won in 2018

EWAP region (3)

Ibero-LATAM region (7)

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A TEAM OF EXPERIENCED MANAGERS TO DEVELOP, INNOVATE, DELIVER, CONTROL

EXECUTIVE COMITTEE OF TELEPERFORMANCE

Daniel Julien
Chairman & CEO
Chairman of the Executive Committee

SPECIALIZED SERVICES

Scott Klein
President

TELEPERFORMANCE D.I.B.S.

Bhupender Singh
President

CORE SERVICES

Jeffrey Balagna
Chief Operating Officer

Agustin Grisanti
Ibero-LATAM President

Brian Johnson

and

David Rizzo
EWAP co-Presidents

Yannis Tourcomanis
CEMEA President

CONTROL / SUPPORT

Olivier Rigaudy
Deputy CEO, in charge of Finance

João Cardoso
Chief R&D and Digital Integration

Fabricio Coutinho
Chief Marketing Officer

Lyle Hardy
Chief Information Officer

Leigh Ryan
Chief Legal & Compliance Officer

Alan Winters
Chief Administrative Officer

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AN EXPERT, BALANCED AND INDEPENDENT BOARD OF DIRECTORS TO SET THE GROUP'S STRATEGIC ORIENTATIONS

BOARD OF DIRECTORS OF TELEPERFORMANCE

DIRECTOR

1. Daniel Julien (Chairman)
2. Jean Guez
3. Bernard Canetti
4. Leigh Ryan
5. Philippe Dominati

INDEPENDANT DIRECTOR

6. Wai Ping Leung
7. Christobel E. Selecky
8. Angela Maria Sierra-Moreno
9. Robert Paszczak
10. Alain Boulet
11. Emily Abrera
12. Stephen Winningham
13. Pauline Ginestié

LEAD INDEPENDANT DIRECTOR

14. Patrick Thomas

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1 Introduction to the group and risks

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1.3.3 Procedures for periodic assessment of the situation of the subsidiaries, suppliers or subcontractors with which an established business relationship is maintained 47
1.3.4 Hotline policy for reporting the existence or materialization of risks 47
1.3.5 System for monitoring measures in place and assessing their efficacy 47

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1.1 THE GROUP

1.1.1 Major stages of the Group's development

Key dates in the Group's development and evolution

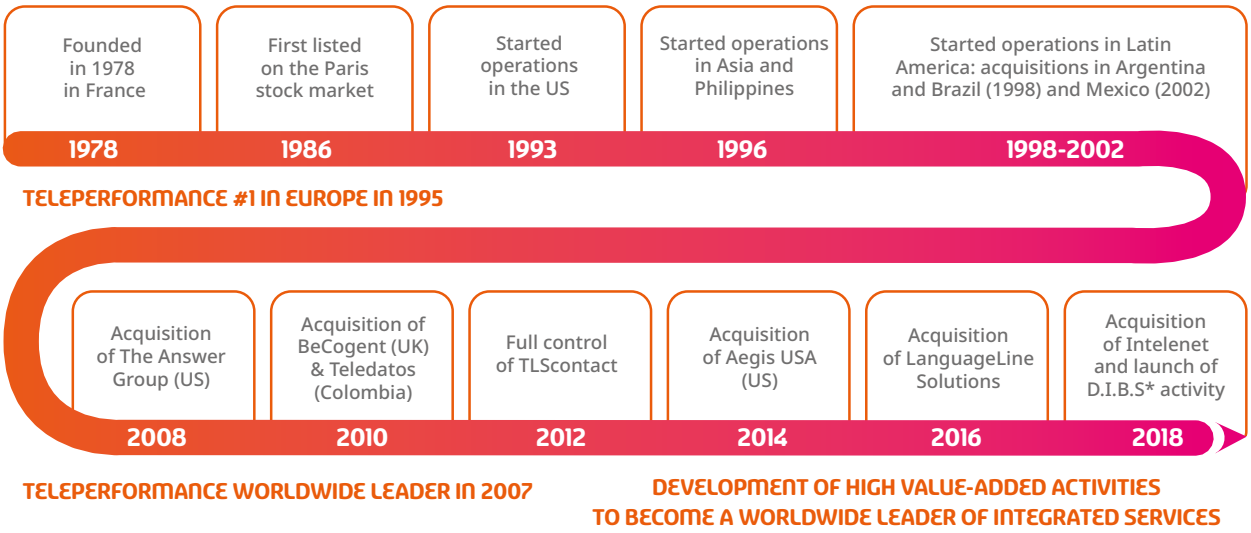

* *Digital Integrated Business Services.*

1978-1995: Building Teleperformance's European leadership

1978

The Teleperformance Group was founded in Paris by Daniel Julien, currently Group Chairman and Chief Executive Officer. During the initial years, the Company's principal activity consisted of providing telemarketing services to French clients operating mainly in the media, financial services and insurance industries.

1986

The Company became the French market leader and began to expand globally by opening subsidiaries in Belgium and Italy.

1988

The Company continued to expand in Europe, with new subsidiaries opened in Spain, Germany, Sweden and the UK.

1989

Daniel Julien and Jacques Berrebi joined forces at the head of Rochefortaise de Communication, the parent company of Teleperformance International listed on the Paris Stock Exchange. Ten years later, Rochefortaise Communication and Teleperformance International merged to form SR. Teleperformance. This company became Teleperformance in 2006.

1990

Teleperformance set up its first outsourced customer care centers and carried out its first customer satisfaction surveys.

1993

Teleperformance opened its first contact center in the US.

1995

Teleperformance became the European market leader and continued to strengthen its position over the following years with new subsidiaries in Switzerland, Norway, Greece, Finland, the Netherlands and Denmark.

1996-2007: Building Teleperformance's world leadership

1996

Teleperformance gained a foothold in Asia with the opening of contact centers in the Philippines, followed by Singapore.

1998

Teleperformance began operations in Latin America by acquiring companies in Brazil and Argentina. Four years later, Teleperformance continued its growth through the acquisition of a company in Mexico.

2003

The Group shifted its operations focus back on contact centers, gradually selling off its marketing services and health communication operations. In the same year, Teleperformance became the No. 2 global customer experience management provider.

2004

The Group continued to expand by moving into Eastern Europe: Poland, Czech Republic and Slovakia, and two years later, Russia.

2007

The Group became the world leader in outsourced customer experience management thanks to the rapid growth of its international operations, both organically and through acquisitions.

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2007-2015: Consolidating world leadership

2008

Teleperformance acquired The Answer Group, a high-level provider of technical support to the US market in the telecommunications, Internet access, cable TV, specialized retail and original equipment manufacturer (OEM) industries.

2009

Teleperformance reorganized its France-based legal entities and operations forming a new subsidiary Teleperformance France.

2010

Teleperformance significantly strengthened its presence in the UK through the acquisition of beCogent, active in particular in the sectors of retail, financial services, telecoms and Internet service providers. At the same time, Teleperformance continued its expansion in Latin America: after the acquisition of Teledatos in Colombia in 2009, a company was created in Costa Rica.

2011

Teleperformance adopted a Board of Directors structure; Daniel Julien became Chairman and CEO. A year later, co-founder Jacques Berrebi resigned from his position as board advisor and stepped down from his operating duties.

2013

The board of directors separated the roles of Chairman of the Board and Chief Executive Officer, appointing Daniel Julien as Chairman and Paulo César Salles Vasques as CEO.

2014

Teleperformance reinforced its position as world leader and its presence on the North American market by acquiring Aegis USA Inc., a leader in the management of outsourced contact centers in the USA.

TLScontact, a Teleperformance outsourced services management subsidiary working for governments, started a contract with the British government's Visas and Immigration department *(UKVI)*. Teleperformance ramped up its value-enhancing operations across the world by establishing visa application centers in 15 new countries.

2015

In addition, the Group confirmed its global leadership by adopting the legal form of a European company and the name Teleperformance SE.

2016-2018: Developing specialized services and integrated digital transformation services

2016

Teleperformance launched a new specialized services range provided by LanguageLine Solutions LLC, a US-based over-the-phone and video interpretation solutions leader, which it acquired in 2016 together with the TLScontact visa application and accounts receivable management business.

2017

The Group received its first public long-term debt rating, "BBB-" investment grade, the best financial rating of the sector, from Standard & Poors (S&P). It successfully completed a €600 million 7-year bond issue, which helped fund the LanguageLine Solutions LLC acquisition.

In October, following the resignation of Paulo César Salles Vasques as Group Chief Executive Officer, the Board of Directors decided to combine the duties of Chairman and Chief Executive Officer, and appointed Daniel Julien as Group Chairman and Chief Executive Officer. He therefore assumed responsibility for the successful completion of the five-year plan announced during the year.

2018

Teleperformance formed a new business categorie, Teleperformance D.I.B.S. (Digital Integrated Business Services), which primarily covers the operations of Intelenet, a major value-enhancing and digital transformation services provider, that it acquired on October 4th, 2018, and the Praxidia consulting business that it launched in April 2018. The Intelenet acquisition was funded by a €750 million bond placement.

Teleperformance launched its new visual identity and "TP" logo symbolizing its transformation and its new market focus on high value-added digital transformation integrated services.

1.1.2 A "High Tech / High Touch" corporate outsourced services management world leader in full evolution

1.1.2.1 Introduction: Teleperformance, a "High Tech / High Touch" company

As world outsourced customer experience management leader with more than 300,000-plus employees across 80 countries, the Group delivers advisory and integrated solutions to corporations and governments worldwide to manage and optimize all aspects of the customer experience cycle on their behalf, as well as providing high value-added specialized services. The Group manages programs in 265 languages and dialects on behalf of major multinationals operating in various industries.

Throughout 2018, services provided fell into the following **business categories:**

- **Core Services,** including customer relations, technical support, customer acquisition and back-office services;
- **Specialized Services,** high value-added services including online interpreting, visa application management, data analytics and accounts receivable management.

In October 2018, the Group created a further business category: Digital Integrated Business Services (Teleperformance D.I.B.S.) primarily comprising:

- Intelenet's business process management and digital transformation services, a company acquired in October 2018;
- High value-added consulting and data analysis solutions of Praxidia, which was formed in April 2018;
- Teleperformance business process management and digital solutions.

For the first time, Teleperformance will present its operations broken down between three business categories when it releases its first quarter 2019 revenues.

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Teleperformance's offering in all areas is multi-channel and meets consumer demand *via* phone, email, SMS, website chat, face-to-face or social media. It furthermore covers the entire customer experience supply chain from back office data processing to dealing with consumers/front office users. It is suited for all business sectors and is available in several languages.

Teleperformance has extensive resources with which to fulfill its mission. The Group offers businesses around the world its know-how in terms of human resource management, management of dedicated customer experience infrastructures as well as high-performance technology ensuring quality, security and reliability.

The Company also draws on its own worldwide chain of local, "nearshore" or "offshore" contact centers to meet the needs of many markets.

Teleperformance pitches itself as a "High Tech / High Touch" business alluding to the two underlying pillars of its value-adding business model: a human touch and technology.

1.1.2.2 Teleperformance business segments

1.1.2.2.1 Core Services

2018 key figures

	Region	Revenue *(in millions of euros) (in % total Group rev)*	Total headcount at December 31st, 2018	Number of countries of operations	Client key sectors
Core Services		3,697 (84%)	235,823	53	All sectors
Linguistic regions	EWAP	1,586 (36%)	101,654	12	All sectors
	Ibero-LATAM region	1,149 (26%)	86,774	13	All sectors
	CEMEA	962 (22%)	47,395	29	All sectors

Core Services cover a broad services offering primarily comprising technical support, customer care, customer acquisition and back-office services (excl. Intelenet services).

Core Services worldwide break down into three broad linguistic regions:

- English-speaking and Asia-Pacific (EWAP);
- Ibero-LATAM;
- Continental Europe, Middle-East and Africa (CEMEA).

Teleperformance's Core Services offering is multi-channel: its solutions cover the management of all types of consumer or citizen interaction channels to contact firms and government agencies, by voice (*i.e.* phone, video and face-to-face) and non-voice (*i.e.* chat, email and social media) services. These services are backed both by worldwide quality standards and state-of-the art IT systems.

Most of the Group Core Services consist of managing incoming calls from consumers or citizens requesting information. Management of outgoing calls, which is a smaller Group business, largely comprises customer acquisition services.

To fulfill its mission, the Group has a global chain of contact centers providing domestic, offshore and multilingual services in 265 languages.

Breakdown of Core Services revenue (2018)

By service type

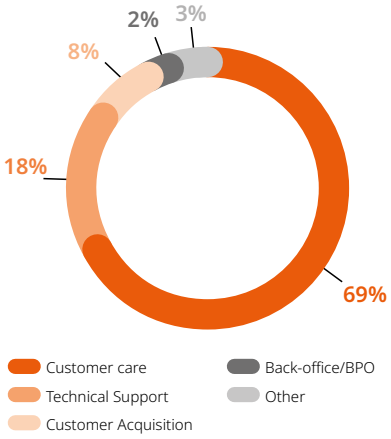

By contact type

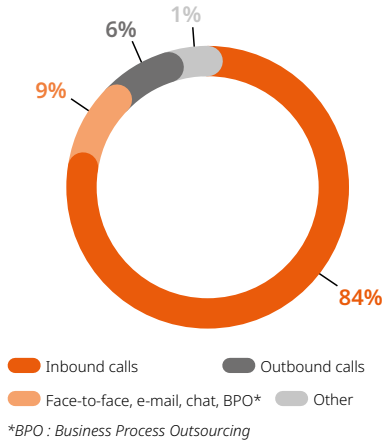

By linguistic region

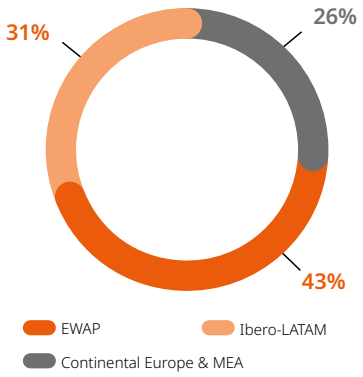

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Details of main service type

Service type	Description of services and solutions
Customer relations	• Subscriptions/sale of new goods and services including cross-selling and upselling • Invoice explanations and payment requests • Claim processing and dispute resolution • Pro-active steps to boost customer relations, such as welcome offers, satisfaction questionnaires and contract renewal reminders • Specialized new e-services, such as online gaming assistance and social media content moderation services
Technical support	• Corrective action procedure management and coordination • Customer assistance to introduce various products (e.g. equipment, software and networks) and software (operating systems, databases and programming environments) as well as post installation assistance (BtoC) • Assistance to install, operate and repair networks, and set up firewalls and data distribution (BtoB) Teleperformance provides several levels of support: • Level 1 – solutions to standard problems based on specific processes • Level 2 – solving more complex problems by phone, remote systems access or onsite • Level 3 – high level assistance for one-off and critical cases
Customer acquisition	• Generating leads and scheduling appointments • Services to check cross-sale and additional sales data • Loyalty program and management • Surveys and programs to attract customers • Customer account management
Back office services (excluding Intelenet)	Back office services provide transparent procedures between back and front office operations, guaranteeing a more efficiently managed, better quality customer experience. Teleperformance's backoffice services break down as follows: • Fraud prevention • Order and account management • Invoicing and refunds • Coding • Debt collection

A global offer of domestic and offshore solutions

Backed by a global integrated domestic, nearshore and offshore network of operations in 36 countries, Teleperformance offers a unique range of sourcing solutions worldwide in all languages tailored to all customer needs and limits.

The offshore service is defined as the ability to serve a market from contact centers located in another country, using the language of the country where the market is located. Teleperformance's offshore solutions mainly serve the North American market from Mexico (nearshore) and the Philippines (offshore), in English and Spanish, and some European markets (nearshore solutions).

Map of offshore/nearshore Group locations and main markets covered

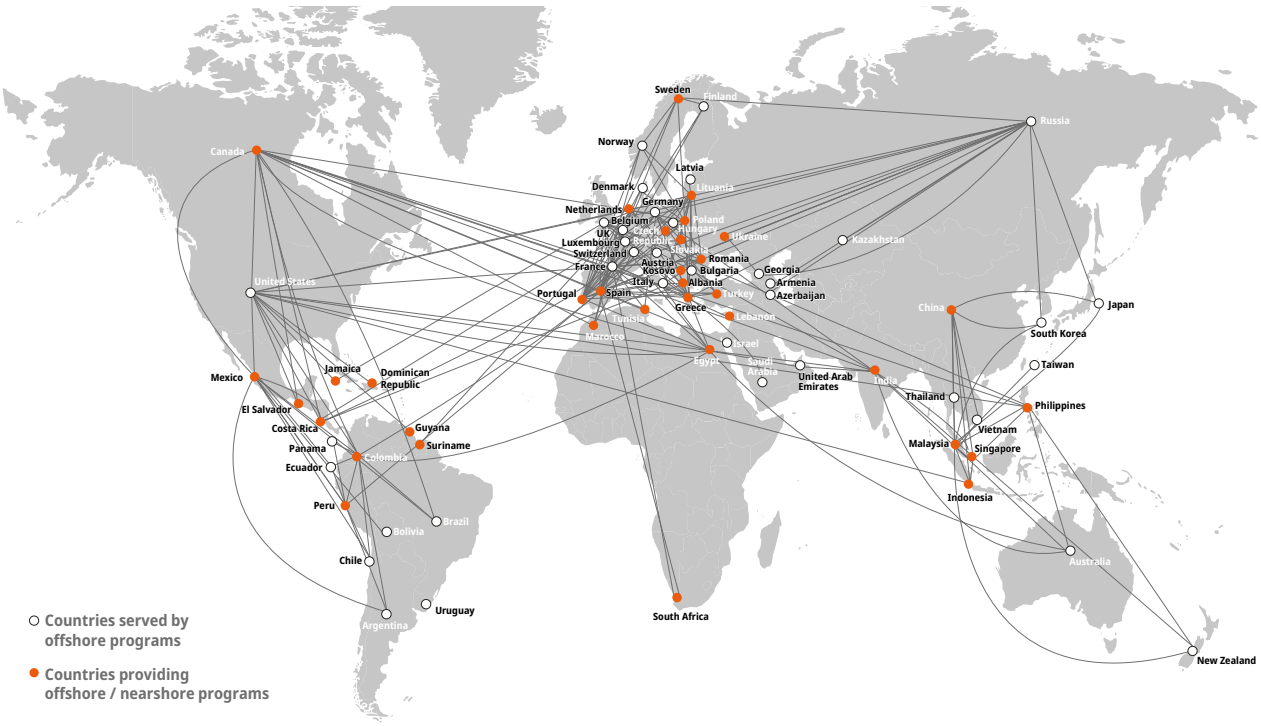

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Breakdown of Core Services revenue by program type

(in % of total revenue)	2018	2017	2016
Domestic	57%	60%	62%
Nearshore/offshore	43%	40%	38%

Example of specialized regional services: multilingual platforms

Teleperformance develops specialized services tailored to client needs all around the world.

Teleperformance pioneers development of multilingual hubs delivering optimal customer experience management multi-channel solutions to big multinationals. Such hubs house staff from across the world who work together on Pan-European and Pan-Asian programs.

Teleperformance's multilingual offering is a genuine distinguishing factor covering 140 markets in over 40 different languages from five regional hubs located in Portugal, Netherlands, Greece, Malaysia and Egypt. Criteria applied to selecting these locations are very exacting. Hubs should be set up in appealing, stable cities with an educated, multicultural population.

Multilingual hub location

A solution regularly awarded the Great Place to Work® label

Teleperformance's multilingual hubs regularly receive the prestigious Great Place To Work® label. The Group attracts top class staff by offering a unique multicultural workplace in highly livable cities steeped in history.

Everything is provided to help staff and supervisors move and settle in to their new surroundings: they are provided plane tickets and temporary hotel stay, and leisure activities are offered so that they feel at home in their new location.

1.1.2.2.2 Specialized Services

2018 key figures

	Region	Total headcount at December 31st, 2018	Number of countries of operations	Client key sectors
Specialized Services		12,521	58	All sectors
Main companies	LanguageLine Solutions (LLS)	6,114*	17	Healthcare Government agencies Banking and insurance Telecommunications
	TLScontact	1,727	44	Government agencies/ Authorities
	AllianceOne Receivables Management (ARM)	4,071	3	Financial services Government agencies Telecommunications
	Praxidia	598	6	All sectors

* *Excluding external interpreters under contracts with LLS.*

2018 Specialized Services revenues amounted to €639 million and accounted for 14% of total Group revenue. The Group does not disclose revenues of individual Specialized Services companies.

LanguageLine Solutions (LLS)

Founded in 1982 and acquired by Teleperformance in September 2016, LanguageLine Solutions is the leading provider of over-the-phone and video interpreting solutions in North America, serving a range of companies and institutions in the healthcare, insurance, financial services, telecommunications and public sectors. Headquartered in Monterey (California – United States), LLS posted US$388 million revenues in the most recent year prior to Teleperformance's acquisition in 2016, which has consolidated the Group's global leadership in the high value-added services sector while boosting revenues and earnings.

LanguageLine Solutions provides essential services to a wide range of clients in sectors where Teleperformance already has a strong presence with its core service activities. In 2018, LLS offered services in nearly 260 languages to 28,000 customers in the United States, Canada and the UK, backed by efficient top class network of nearly 9,600 employed and freelance interpreters.

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Details of main service type

Service type	Description of services and solutions
Over-the-phone interpreting (OPI)	• 24/7, year-round fast access by phone to top-class interpreters covering nearly 260 languages
Video remote interpreting (VRI)	• Direct face-to-face interaction thanks to dedicated equipment or mobile platforms that improve the communication experience, due to the addition of visual cues and body language • Specially suited for groups and young children
On-site interpreting (OSI)	• Required for more complex interactions regarding confidential issues • Involving several participants or young children
Other services	• Document translation and localization services These services are often selected in addition to online interpreting services already provided to a client • Specific training and equipment related to linguistic services

Breakdown of LanguageLine Solutions revenue by language service type (2018)

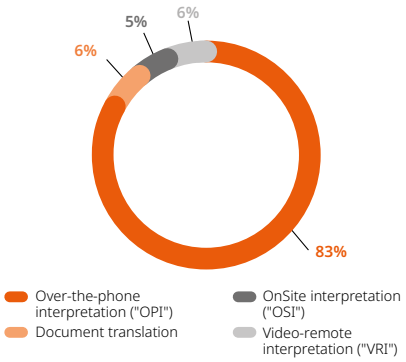

Breakdown of LanguageLine Solutions workforce by language (2018)

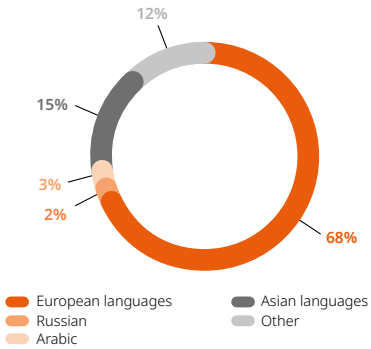

Breakdown of LanguageLine Solutions revenue by client sector (2018)

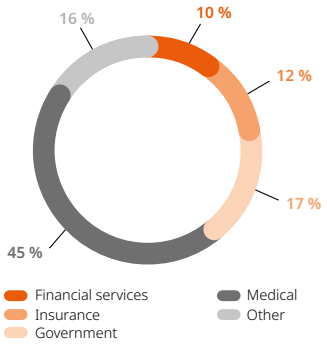

A global network of interpreters working from home

In 2011, LanguageLine Solutions made a major change to the management of its interpreter database, by switching from a contact center system to a work-at-home (WAH) system. The 9,600 LLS interpreters are currently spread across 17 countries. Over 6,000 are LLS employees and the rest are sub-contracted or freelance workers under contract with the country.

The expanding pool of WAH interpreters is a key strategic advantage enabling LLS to provide a constant supply of interpreters perfectly tailored to demand. They represent more than 80% of all interpreters working for the firm.

LanguageLine Solutions interpreters can deliver top quality of service thanks to the ERP Olympus cloud platform system.

Synergies with other Teleperformance Group business activities

In 2017, the first synergies between Teleperformance Core Services and LanguageLine Solutions' were developed in recruitment. In 2018, over 700 Arabic, Spanish, Italian, Portuguese and Russian interpreters were recruited to serve the US market thanks to Teleperformance's major presence in Egypt, Colombia, Albania, Portugal and Lithuania. These synergies have a positive impact on the Company's business growth and margins.

Teleperformance aims to progressively develop LLS' business on all markets and generate synergies between its various activities.

TLScontact

TLScontact is a major player in the global outsourced visa application management market. Its business involves assisting government clients in processing visa applications submitted by persons wishing to travel to a country requiring such a document, as securely, efficiently and quickly as possible.

The company opened its first visa application center in Beijing in 2007, on behalf of the French embassy. It joined Teleperformance's global network in 2010 in order to step up its expansion.

Its revenue has thus increased from €4 million in 2009 to almost €150 million today. Its success can be attributed to state-of-the-art technology such as biometrics and digitization techniques for data security, its ability to comply with standards and certifications required by its industries, such as the ISO/IEC 27001 certification obtained in 2009, and strong demand from governments for solutions that meet their budget requirements and help generate tourism to their countries.

TLScontact has 145 centers in Europe, Asia and Africa, handling over 6 million visa request interactions per year, serving governments in the Schengen zone (France, Switzerland, Italy, Germany, Denmark, the Netherlands, Hungary and Belgium) Commonwealth countries including the UK and countries with specific regulations (Cyprus, Kazakhstan).

TLScontact has a robust and unique business model. While it enters into long-term contracts with governments, it is usually individual applicants who pay for TLScontact services in addition to visa costs and so they expect top quality application handling service. As a "one-stop shop" for visa applicants, TLScontact is able to offer them a range of high

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value-added products and services (travel insurance policies, VIP or fast track processing, etc.).

Lastly, the outsourcing market continues to evolve with new governments signing up, who are won over by the value-added solution, and TLScontact in particular in view of the strong productivity gains that the company offers.

The outlook for TLScontact's business growth is strong, based not only on a continued increase in tourism from Asia, but also on the company's ability to take advantage of its visa application expertise, client portfolio and global network integrated with that of Teleperformance, in order to break into other markets centered around the issuance of identification documents, such as residence permits and driver's licenses.

Changes in the geo-political and geo-economic landscape in certain regions (*e.g.* Brexit, crises in the Middle East, etc.) have created several business opportunities for TLScontact, given the influx of people to accommodate and process.

AllianceOne Receivables Management (ARM)

ARM is a major player on the North American outsourced accounts receivable management market. The firm offers a comprehensive range of debt collection services and contact center solutions designed to meet the needs of clients, primarily in the North American market. The company has close to 4,000 employees operating in the United States, Canada and Jamaica.

ARM offers outbound and inbound call programs, as well as back office services. The company offers both first- and third-party services, either acting directly on behalf of a client, or on behalf of an entity tasked with recovering a debt for its own client. The range of services meets clients' cost and service requirements, which are determined depending on the specific characteristics of the labor markets in which the Company operates.

Praxidia

To support companies in their goal to constantly improve the customer experience, in 2018 Teleperformance launched Praxidia, a new high value-added consulting solution.

Praxidia is backed by the Group's unique knowledge of companies' grassroots customer experience requirements throughout the world. The client company benefits from the Group's expertise in over twenty key sectors, state-of-the-art R&D facilities (CX Lab) and data analytics solutions.

Teleperformance is a pioneer in high value-added data analysis services to manage customer and employee experience.

Its unique expertise is based on teams of leading specialists and recognized know-how in predictive and prescriptive analytics, process and data flow management, end client feedback management and specific qualitative and quantitative research techniques.

The roll-out of global analytical solutions is designed to create value for clients and employees. These solutions are effective in helping client companies obtain long-term benefits, both in terms of quality and cost, from a customer experience approach that is both proactive and understanding.

Praxidia's goal is to become the customer experience partner of choice, fully in line with the Group's strategy to ramp up its service offering. This solution expands the high value-added services range offered to the Group's global accounts and thus enables it to deepen its partnership with them over the long term. This new solution, resulting from the natural evolution of Teleperformance's core business towards greater added-value and an increased focus on technology, is one of the cornerstones of the Group's ongoing transformation.

After acquiring Intelenet in October 2018, the Group created a new business category called Teleperformance D.I.B.S. (Digital Integrated Business Services). Praxidia merged with Intelenet's Knowledge Services business (see section 1.1.2.2.3 – *Acquisition of Intelenet and creation of Teleperformance D.I.B.S.*) to become Praxidia Knowledge Services, a new Teleperformance D.I.B.S. division specializing in consulting, forecast modeling, data analysis and high value-added automated solutions.

Praxidia is a genuine expert in digital transformation systems and procedures and employed close to 600 people in 2018, mainly in the United States, the United Kingdom, Italy and France.

1.1.2.2.3 Acquisition of Intelenet and creation of Teleperformance D.I.B.S.

Intelenet key figures in 2018

	Revenue *(in millions of euros)*	Total headcount as of 12/31/2018	Number of countries of operations	Main client segments
Intelenet	410	58,144	11	• Financial services • Tourism and airline companies • Distribution • Healthcare

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Intelenet's business

Teleperformance completed the Intelenet acquisition on October 4th, 2018.

Intelenet was founded in 2000 in Bombay (India) and is a key player in high-end services such as multi-channel customer experience management, back-office, HR management as well as financial and administrative management. At the time of the acquisition, the company had over 110 leading clients, mainly in English-speaking countries, India and the Middle East.

Intelenet clients operate mainly in banking, financial services and insurance, travel, tourism, e-commerce and healthcare.

Revenue breakdown by service type (2019E*)

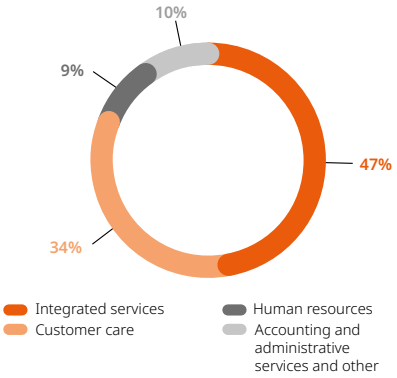

Revenue breakdown by client sector (2019E*)

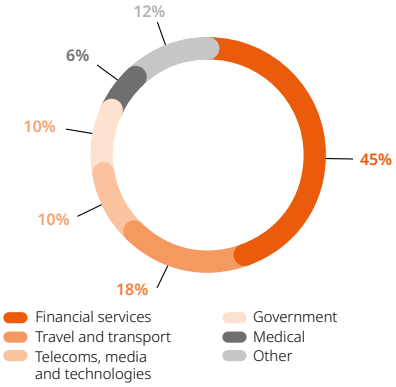

Revenue breakdown by region (2019E*)

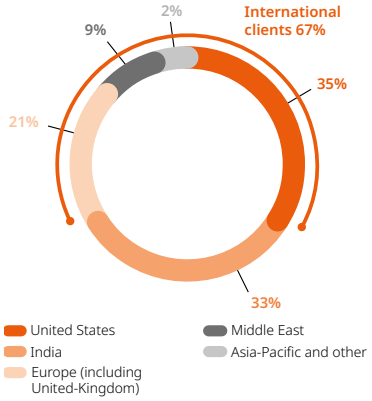

* *Intelenet estimates as of March 31st, 2019 released for the announcement of Teleperformance's June 2018 acquisition.*

Thanks to integrated solutions, Intelenet helps clients boost revenue, enhance quality and reduce operating costs while improving customer satisfaction:

- the company delivers proprietary solutions designed by multi-skilled consultants including 200-plus highly-qualified engineers and expert business and procedure consultants;
- digital integration underpinned by robotic process automation;
- best-in-class operations with more than 58,000 employees working in 40 centers mainly in India, the Philippines, the United Arab Emirates, Poland and Guatemala.

The Intelenet acquisition was strategic for Teleperformance for three reasons:

- Intelenet's high value-added integrated solutions and expertise in corporate digital transformation reinforce Teleperformance's offering significantly;
- Intelenet's leading position in India also consolidates the Group's presence on this growing market;
- Intelenet's expertise in a wide range of sectors enables Teleperformance to continue diversifying its global client base.

The acquisition also marks a big leap forward in Teleperformance's five-year strategic plan.

Details of main service type

Transaction Processing Vertical	2 sector examples • Healthcare: transaction processing related to the Revenue Cycle Management (RCM) in the US healthcare system • Financial services: transaction processing related to product underwriting
Human Resources Outsourcing	Workforce administration service outsourcing Payroll service outsourcing
Finance & Accounting Services	Risk management Procure to pay/client order processing
Customer Management Services	E-services Social media Contact centers
Consulting/Knowledge Services	Analytics services Guidance on operational services Optimization optimization
Digital Offerings	Robotic solutions Artificial Intelligence Machine learnings

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Teleperformance D.I.B.S. – a new legal entity

Teleperformance D.I.B.S., or Digital Integrated Business Services, is the new business category launched by Teleperformance f in October 2018, which encompasses Intelenet's operations, Teleperformance's business management procedures and digital platform services, and Praxidia's high value-added consulting and analysis services.

The majority of Teleperformance D.I.B.S.'s business lies in integrated services and dedicated support services. By combining business-critical processing service experience and know-how, Teleperformance D.I.B.S. can offer clients integrated transformation solutions across the entire supply chain.

1.1.2.3 The four essential elements underpinning Teleperformance's success

1.1.2.3.1 Recognized global leadership

Teleperformance is a partner of choice on the big multinationals market and a highly reputed global employer in its market.

Teleperformance currently owns 218,000 computer workstations covering more than 160 markets and has over 300,000 employees in 400-plus contact centers in 80 different countries. The Group runs programs in 265 languages and dialects on behalf of over 850 clients, mainly big multinationals operating in various sectors.

The Group has a stable and strong corporate client base around the world. The revenue breakdown per region and the Group's total workforce in Core Services reflect its position as world leader on its main market.

Core Services break down into three broad linguistic regions as follows:

- English-speaking and Asia-Pacific (EWAP);
- Ibero-LATAM;
- Continental Europe, Middle-East and Africa (CEMEA).

The breakdown of the countries of operation is presented in section 1.6.2 *Operational organization chart.*

Breakdown of revenue by business and linguistic region (2018)

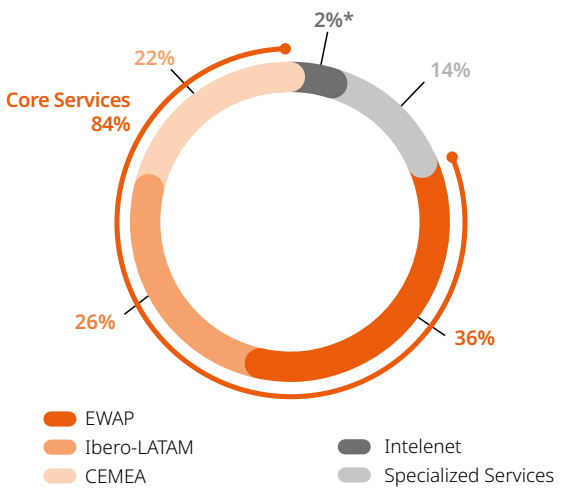

** 3-month consolidation in 2018.*

Breakdown of workforce by business and linguistic region at December 31st, 2018

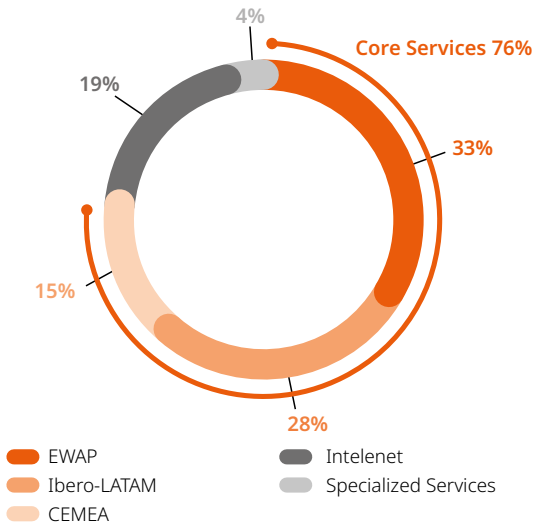

Total headcount of the Group's top 10 countries at December 31st, 2018

Country	Total headcount
India	72,594
Philippines	41,292
United States	34,228
Mexico	19,338
Brazil	19,259
Colombia	17,871
Portugal	9,534
Greece	8,034
United Kingdom	7,833
Tunisia	7,198

1.1.2.3.2 A diversified client base

With over 850 clients generating 97% of revenues excluding those of LanguageLine Solutions, Teleperformance has the most diversified client base in the industry. This subsidiary, LanguageLine Solutions, US market leader in over-the-phone interpreting services, has further boosted diversity by bringing an additional 28,000 (including many individual) clients.

Teleperformance develops offers that meet the specific needs of every business sector. The Group is particularly well positioned in the telecommunications, technology and consumer electronics, financial services, healthcare and insurance, public services and retail sectors.

This diversification trend continued in 2018 with industries other than telecommunications, internet and pay TV accounting for 80% of Group revenues, up from 60% in 2014.

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Breakdown of revenue by client business sector

(in % of total revenue)	2018	2017	2016*
Telecoms, Internet	14%	14%	19%
Pay TV	6%	7%	9%
"Telecommunications" sector	**20%**	**21%**	**28%**
Technology, consumer electronics, media	14%	14%	14%
Financial services	12%	12%	13%
Healthcare and insurance	13%	14%	7%
Public sector	7%	7%	6%
Travel agencies, hotels, airlines	6%	6%	6%
Retail, e-commerce	8%	7%	6%
Energy	3%	3%	4%
Other	17%	16%	16%
"Non-telecommunications" sector	**80%**	**79%**	**72%**
TOTAL	**100%**	**100%**	**100%**

** The 2016 revenue breakdown excludes LanguageLine Solutions, company acquired in September 2016.*

The Teleperformance offering is at the cutting edge in an increasingly digital customer environment. The contribution of digital economy players covers a wide range of sectors, presented in the chart below.

The share of new economy clients in the Group revenue surged from 5% in 2013 to 19% in 2018 (chart below). The most prominent sectors in this e-services environment include retail, transport, leisure, travel agencies, consumer goods and social media. This change contributes significantly to the Group's strong revenue growth worldwide. It is a reflection of the Group's ability to meet the new customer experience requirements of new economy players.

Contribution of new economy players to the Group's 150 top clients' revenue

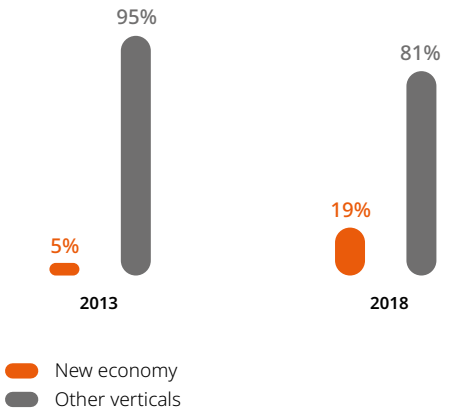

Client portfolio concentration rate *(in % of total revenue*)*

	2018	2017	2016
Top client	8%	8%	7%
Top 5	18%	20%	20%
Top 10	28%	30%	30%
Top 20	41%	43%	44%
Top 50	58%	61%	61%
Top 100	72%	75%	75%

* *Excluding LanguageLine Solutions revenues given the specific nature of LanguageLine Solutions' interpreting business, with 28,000 clients including individual users, this company, a Group subsidiary since September 2016, was not included in the calculation of the concentration rates.*

Despite Teleperformance's status as the partner of choice of a large number of leading multinationals in their industries, no one client accounts for over 8% of revenues, excluding LanguageLine Solution business. The biggest client accounted for 7.4% of 2018 Group revenues.

The concentration of the client base has slightly reduced overall since the previous year.

Moreover, thanks to its world market leadership, the Group earns over 50% of its revenues from multinational clients it serves in more than two markets.

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1.1.2.3.3 High Tech positioning: technology and data analysis

The Group develops and acquires technology to deliver cutting-edge services as a major player in digital transformations.

An integrated global IT and telecommunications network

Teleperformance delivers client services underpinned by a complex high-tech platform tapping into several data technologies covering state-of-the-art connection systems, computer hardware and software.

The Group's IT and telecoms networks cover all continents in the world and are based on MPLS (MultiProtocol Label Switching) systems, which are specific data transmission systems used for all kinds of traffic, *e.g.* voice, IPv4 and IPv6 packets and even Ethernet or ATM frames. These networks come with sophisticated connection systems as well as hacking prevention and detection features.

The Group continues to streamline the architecture of systems and technological standards. The Group has a wide range of proprietary technical tools and solutions, tested and scalable mainly in managing customer relations, operations, human resources and security.

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The main solutions and tools are described per field below:

A comprehensive range of high-tech, proprietary tools and solutions

Human resources and operations

Solution type	Description of services and solutions
CCMS	Integrated software package for the management of on-site services (Contact Center Management System – CCMS) created in 1998 and rolled out worldwide across the Group from 2005. The software helped to standardize operational processes and shore up security of business data production processes.
Olympus	Developed for US-based online interpreting services. Created in 2013, LanguageLine Solutions® OlympusSM is a schedule management cloud-based platform. For online service orders, the platform enables users to find the right interpreter among the company's 9,600 interpreters working from home, the right language among 260 languages on offer, the right area of expertise (healthcare, law, finance, insurance, etc.) and level required (from making an appointment to a medical diagnosis) in record time. This system can meet any interpreting service demand coming from all channels including voice, video and chat.
TLSconnect	Developed for visa application management services to governments. Created in 2007, TLSconnect is a real-time software management suite that supports and records every operational process step required to process visa applications, allowing users to administer processing flow and quickly clear any operational bottlenecks. Analytical features and automated reports assist management in assessing the efficiency of operations across different performance metrics.

Customer relations and automation

Solution type	Description of services and solutions
TP Client & TP Marketing	Evolutive CRM platforms enabling omni-channel interaction with voice, video, chat, email, bots or social media. Created in 1999, the late 2017 version includes new features to manage chat interactions. This CRM tool is the basis of the Group's integrated omni-channel strategy; to date it has been implemented with more than 200 clients.
TP Bot	An automated and smart service in partnership with Artificial Solutions and integrated into TP Client in 2017. Advanced natural language processing functionality, support for various languages and interfaced with all social media platforms. The fields of application are varied and include the IoT (smart cars, smart homes etc.), mobile apps and smart websites.

Intelenet's consulting and technological offer: Technology, Analytics and Process Consulting (TAP™)

Intelenet has been part of Teleperformance D.I.B.S. since October 2018 and offers technological and consulting solutions including automatic procedures and data analysis.

This high value-added service is flexible and responsive, meeting the needs of clients aiming to improve their customer satisfaction in a dynamic environment while minimizing overheads.

The firm has an excellent track record in terms of results achieved using the solution, as well as in terms of stable, long term client relations.

TAP™ pillars

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Example of a high-tech digital transformation solution

The TAP™ package can result in installing an automated, smart system tailored to each client sector.

iFARE is an Intelenet solution designed for the travel and hospitality sector that integrates AI technology into an airline ticketing fare calculator. It provides a more user-friendly experience while reducing operating costs. iFARE has been praised for its excellence on many occasions and is an award-winning solution.

Security

Solution type	Description of services and solutions
TP Observer	Real-time agent monitoring and security alerts in case of fraudulent behavior. Audio and visual monitoring of workstations and their immediate environment. This solution was created in 2007 and the latest version was rolled out late 2017.
Secure Contact (Secure IVR)	Launched in 2015, the objective is to protect client private data given over the phone (*e.g.* credit card details) by activating an automated processing feature that prevents the agent from viewing the data.

1.1.2.3.4 A High Touch positioning: human and procedure management

Human management: emotional intelligence and working environment

The Group constantly strives for excellence in the service it delivers to its clients. This goal is achieved through a quality human resource strategy (High Touch). In fact, the Group manages a genuine global "army" of over 300,000 people serving clients.

Teleperformance makes its employees the focus of its business. The Group is committed to being an employer of choice in its market, and considers this a pre-requisite in creating value for the various stakeholders: a happy employee is vital in satisfying end-users and thus Teleperformance's clients.

Accordingly, Teleperformance adopts various management procedures and initiatives to insure the objective is met, notably in employee recruitment, training and career development as well as wellbeing and workplace safety (see section 2.3.2 *HR development* and section 2.3.3 *Creating safe and healthy workplaces focused on wellbeing*).

As a responsible company, Teleperformance considers it a duty to monitor employee fulfillment closely. As such, programs and procedures were designed to stimulate human IQ (intellectual quotient) and EQ (emotional quotient).

Taking care of work place environment quality is another pillar underlying Teleperformance's High Touch strategy. The relevance of its approach to employee wellbeing and offering a unique workplace environment has been recognized by independent entities that specialize in this field.

10 Teleperformance subsidiaries received a Great Place to Work® award in 2018:

- three EWAP subsidiaries:
  - China,
  - Philippines,
  - India, where Teleperformance was ranked top BPO firm for the 5th year running;
- seven Ibero-LATAM subsidiaries,
  - Brazil for the 9th year running,
  - Mexico (two subsidiaries),
  - Salvador for the 5th year running,
  - Dominican Republic for the 4th year running,
  - Colombia for the 1st time,
  - Portugal for the 8th year running.

Teleperformance's High-Touch strategy aims to improve employee satisfaction and stand out as a company focused on the future (see section 2.3. *An employer of choice*).

Procedures: general principles

Management procedures for specific operations to deliver the required level of quality, to measure and ensure their consistency worldwide in a demanding environment in terms of personal and data security.

At the subsidiaries, the Group has implemented TOPS (Teleperformance Operational Processes and Standards), BEST (Baseline Enterprise Standard for Teleperformance), as well as business standards such as the COPC (Customer Operations Performance Centers) standard and the French Customer Contact Center Service standard. The system is also based on international management standards such as ISO 9001.

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Three examples of operations management procedures

Procedure	Objectives
TOPS (Teleperformance Operational Processes and Standards)	TOPS are a process used to manage daily performance. The TOPS process allows performance and quality to be optimized, while managers are able to dedicate the majority of their working time to their agents. It was designed by the Group to manage its operations in a standardized manner in each subsidiary. It allows for improved quality control. TOPS was rolled out at all Group subsidiaries. The process is backed by the group's integrated software suite for service management *(CCMS – see next section)*. TOPS provides a reference framework for Teleperformance that is tailored to its operations.
BEST (Baseline Enterprise Standard for Teleperformance)	BEST are qualitative standard manuals guaranteeing high-end service quality, high performance rates and proactive management of existing and future programs. BEST also serves to reinforce best practices in human resources management and projects for all Teleperformance operations worldwide.
COPC (Customer Operations Customer Centers)	The COPC-2000® standard supplies contact center management teams with the necessary information to improve their operational performance. COPC certification also provides a model for global performance management linking all of the Company's business areas. It also ensures operational consistency by meeting the high performance criteria required by the COPC standard. Teleperformance develops its own team of approved coordinators and COPC-qualified internal auditors.

Procedures to optimize working methods

Lean Six Sigma

One of the Teleperformance Institute's five priorities for 2018 was to usher in a corporate Six Sigma culture. Teleperformance's facility provides e-learning and face-to-face training courses for all Group management staff (supervisors, platform managers and operations directors, etc.).

With the support of an external partner, certification training was provided to 126 group managers. In all, 5,172 managers passed the first e-learning level qualification. The goal is to have 1,700 managers Yellow or Green Belt certified by the end of 2019.

Expanding training courses and setting up new HR procedures

In 2018, the Group developed training courses to build on staff skills and commitment (see section 2.3.2.1 – *Employee training*).

Examples:

- Putting on extra training courses (recruitment and training basics) for recruiters, trainers and account and quality managers;
- All employees attended at least one Teleperformance safety standards training course in 2018. As part of a drive to improve the Group's safety culture, access to online safety training was extended: more than 17,000 managers completed additional training;
- Developing regional centers of excellence: selected supervisors attended two-week training courses focused on best practices in their fields. Many already exist in the CEMEA region, the new centers of excellence are currently under development in China and the Philippines.

Teleperformance launched new employee performance evaluation procedures named Objectives and Key Results (OKR) late 2018. Implementing OKR is an integrated approach to the employee performance management system. The procedures will be rolled out in phases across the Group throughout 2019.

OKR stand out from standard planning practices as they are frequently defined, monitored and updated, generally every quarter. OKRs are a quick and easy way to build creative skills and plan for the future within each team.

Security procedures and standards

In an increasingly complex and challenging environment with regard to data security, Teleperformance has become a leader in this field within its business sector. Clients recognize this positioning as a major differentiating factor.

The Group is fully compliant with international standards such as ISO 27001 and the PCI (Payment Card Industry) and HIPAA (Health Insurance Portability & Accountability Act) standards.

In 2015, the Group rolled out a set of ground-breaking security policies worldwide called the Essential Compliance and Security Policies (GECSP), designed to establish norms and standards to identify potential fraud or hacking risks. The "closed circuit" personal data protection procedures are bolstered by a compliance audit department (see section 1.2.1.1 *Data security and protection risks*) and is based on proprietary technology designed to:

- inform managers of agents' unauthorized access to information;
- provide a standard and secure method enabling agents to take notes while switching from one screen to another, thus minimizing risk of data leaks;
- manage and monitor end-to-end compliance, from proof of download required by the GECSP to reports sent to senior management.

These standards have made it clear that the current digital transformation is riddled with new challenges in terms of fraud and data leaks worldwide.

In 2016, the Group decided to strengthen its data protection policies in line with the EU's new general data protection regulations (GDPR) which took effect May 25th, 2018. The new policies enabled Teleperformance to comply with the new GDPR as soon as they took effect.

Teleperformance is fully aware of its duty towards its clients and employees in terms of protecting private data collected and used in everyday operations. In February 2018, Teleperformance was BCR (Binding Corporate Rules) approved by CNIL (the French national data protection authority), a supervisory authority within the European Union. BCRs provide Teleperformance legal ground to make safe international data transfers within and outside the EU. Teleperformance is currently the only BCR-approved international corporate services company as both data controller and data processor.

Teleperformance also set up a Global Privacy Office last year to oversee the Group's privacy protection plan. The office actively monitors changes in regulations in all countries where Teleperformance operates.

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1.1.3 Group markets and positioning

1.1.3.1 Core services and Intelenet markets and competitive environment

1.1.3.1.1 Markets

Core Services: customer experience management market

The global market in customer experience management relating to Teleperformance's Core Services business was valued at around US$320-350 billion, up from US$280-300 billion in 2010. This market growth was driven by an ongoing increase in the volume of omnichannel consumer and brand interactions, supported by the mobile and digital boom.

"Non-voice" channels (email, SMS, social media and chat) turn in double-digit annual growth; "voice" remains the main channel by far, albeit with slower growth.

This market excludes debt collection, visa application management and online interpreting services markets, which are included amongst the Group's by Specialized Services (see section 1.1.3.2 *Group Specialized Services Markets*).

Change in customer experience management global market outsourcing rate (2010-2017)
(in billions of US dollars)

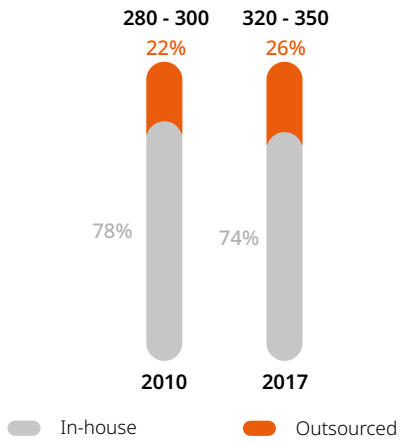

Sources: Everest (2018).

The outsourced customer interaction management market comprises customer relations, technical support and customer acquisition.

It was worth around US$83 billion in 2017 according to Everest, corresponding to an outsourcing rate of 26%. Frost and Sullivan valued this market at US$72 billion in 2017, up 5.3% over 2016. For the 2018-2020 period, Frost and Sullivan estimates outsourcing market growth in value at around 5% per year.

Market growth has thus far been driven by the positive impact of the mobile internet revolution, reflected in rapid growth of mobile online devices such as smartphones and tablets. Today, the rapid expansion of new services designed to assist consumers and citizens in their daily lives, such as the IoT or cloud services, have given rise to new needs such as social media content moderation, which further boost growth prospects.

Digital solutions share of outsourced customer experience management market (2017-2022E)

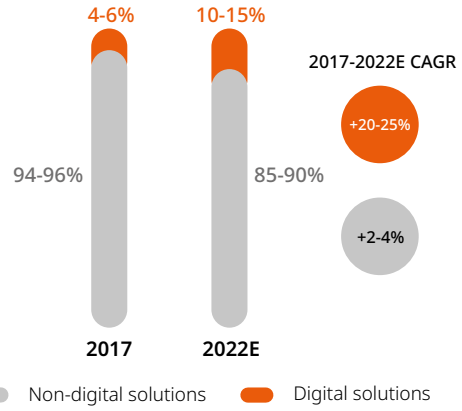

Sources: Everest (2018).

The market's growth is driven by a surge in digital solutions. From 2017 to 2022, Everest estimated the average growth rate at 20-25% per year compared to just 2-4% for the "non-digital" market. Digital solutions should represent around 10 to 15% of the outsourced customer experience market by 2022, up from 4-6% in 2017.

Regional breakdown of the outsourced customer experience management global market (2017: US$72 billion estimated)

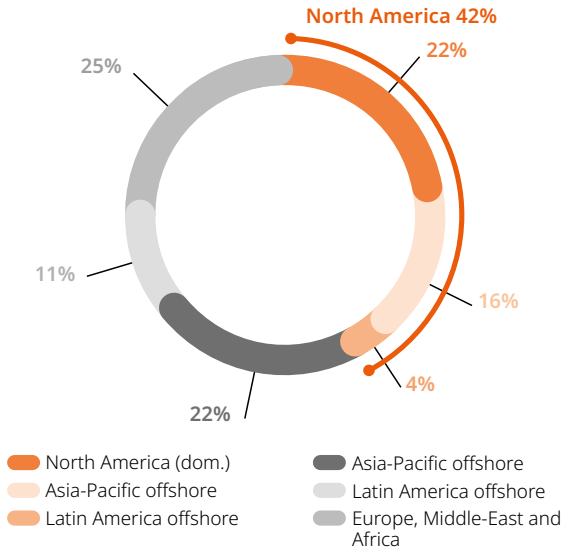

Source: Frost & Sullivan (2017).

The biggest market is North America, which accounts for 42% of the world market. Over half of the US market is served from US-based contact centers, the rest being handled from centers in the Asia-Pacific region (Philippines, India, etc.) and Latin America (Mexico, Colombia, etc.).

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Outsourced customer experience management global market growth forecast by region (2017E-2020E)

(in billions of US dollars)	2017E	2018E	2019E	2020E
North America (domestic)	15.8	16.1	16.4	16.6
% growth		+1.9%	+1.8%	+1.7%
LATAM nearshore for North America	2.9	3.1	3.3	3.5
% growth		+7.8%	+7.1%	+6.6%
APAC offshore for North America	11.7	12.6	13.4	14.4
% growth		+7.3%	+7.0%	+6.6%
Total North America	**30.4**	**31.8**	**33.1**	**34.5**
% growth		+4.5%	+4.4%	+4.2%
LATAM (domestic)	7.5	7.8	8.2	8.7
% growth		+3.1%	+5.3%	+5.3%
Asia-Pacific (domestic)	15.9	16.8	17.9	18.9
% growth		+6.1%	+6.0%	+6.0%
EMEA	17.9	18.7	19.6	20.5
% growth		+4.4%	+4.5%	+4.8%
Total outsourced market	**71.7**	**75.1**	**78.8**	**82.6**
% growth		+4.7%	+4.9%	+4.9%

Source: Frost & Sullivan (2017).

The Asia-Pacific region is one of the fastest growing markets with 6% average annual growth rate forecast from 2018 to 2020, driven mainly by China and India.

The Latin American region serving the nearshore North American market is also booming and should grow by around +7% per year.

The ongoing expansion of the outsourcing market will continue to be underpinned by three trends:

- a permanent need for companies to improve customer service in a secure and controlled environment while optimizing costs by outsourcing customer experience management to a best-in-class provider;
- some market leaders dominating the new economy and digital clients;
- outsourcing leaders now offer reliable solutions backed by extensive experience (quality, security, sector expertise) and dedicated integrated resources (offshore/nearshore and omnichannel solutions, automation).

Intelenet's market

To fully meet clients' complex and growing needs, the Group formed a new category of business, Teleperformance D.I.B.S. after acquiring Intelenet in October 2018. Intelenet's market includes integrated business process management, digital transformation services, as well as knowledge services management. This market mainly encompasses services processed by offshore centers located in India serving English-speaking markets.

Size and evolution of Intelenet market (2017-2021E)
(in billions of US dollars)

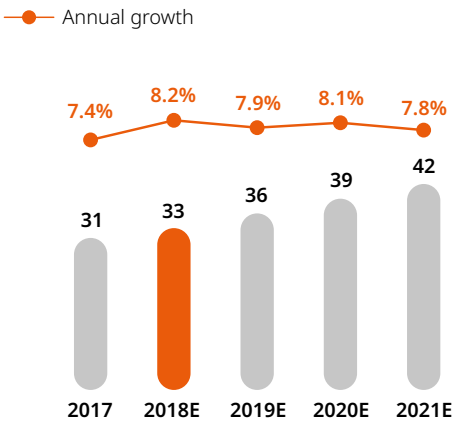

Source: IDC (2018), NASSCOM, IBEF, World Bank, companies, internal estimates.

The 2018 market was estimated to be worth US$33 billion, up 8.2% year-on-year. Market growth from 2018 to 2021 in value is estimated at 8% p.a., which is set to continue to increase as ever more companies go digital. The trend includes new complex needs in business process automation, cyber security, social media and omni-channel offers.

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1.1.3.1.2 Group's competitive environment and position

Direct competition in outsourced customer experience management

Teleperformance is the world leader in the outsourced customer experience market, which remains highly fragmented. With Core Services revenues of €3.7 billion (US$4.1 billion), the Group's global market share amounts to 6%.

In 2017, the top 8 companies held 28% of the outsourced market.

Teleperformance's global positioning, services and diverse client base give it a step ahead most direct American and regional competitors in terms of both revenue and earnings.

Ranking of the global top ten outsourced customer experience management market firms by number of countries of operations (2018)

#	Competitors	Countries
1	Teleperformance	80
2	Convergys/Concentrix	40
3	Webhelp	35
4	Arvato CRM	25
5	Sitel	25
6	Transcom	21
7	Sykes	21
8	Sutherland	20
9	TTEC	15
10	Alorica	14

Source: Group and corporate data.

In 2018, in the growing digital global market, which is becoming more complex in terms of data protection, multi-channel interaction management and high-tech innovations, the industry continued to consolidate led by the market leaders. The Group estimates this trend will continue in the foreseeable future.

Competitive environment expanded to include consulting and IT firms

Teleperformance started serving new market segments when Praxidia was created and Intelenet was bought in 2018. As such the competitive landscape is progressively enlarging to consulting and IT companies.

The growing complexity of Core Services' markets and Intelenet's business process management has prompted demand to converge to meet the needs of clients, who increasingly require global, high value-added services from leading players.

Accordingly, Teleperformance has developed a unique from the field to board room positioning with a view to marketing a real global offering competing against specific players in every market segment.

An expanding competitive environment*

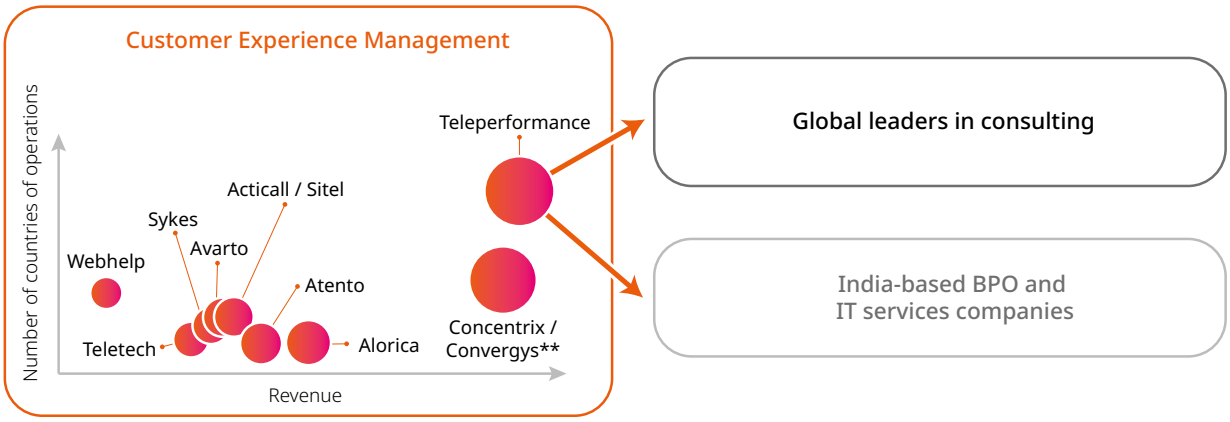

* *Bubbles scaled in proportion of revenue generated.*
** *Following acquisition in 2018 by Synnex, Convergys merged with Concentrix, a Synnex subsidiary.*

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1.1.3.2 Group Specialized Services markets

1.1.3.2.1 Online interpreting services

Online interpreting services include telephone (over-the-phone interpreting, or OPI) and video (over-the-video interpreting, or OVI) solutions. These make up the bulk of LanguageLine Solutions' business. While video interpreting services remain relatively small, they are growing quickly.

These services represented a worldwide market worth US$2.2 billion, *i.e.* 5% of the total language services market, estimated at over US$47 billion. The United States accounted for some 40% of the worldwide OPI and OVI market.

The US OPI and VPI markets were worth more than US$900 million in 2018.

2012-2018E US OPI and VPI service market trends

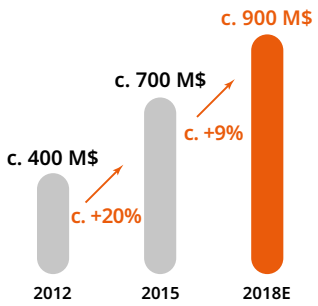

Source: Common Sense Advisory.

The outlook for growth in the online interpreting market is primarily driven by the following factors:

- new technologies and functionalities enabling a broader application of language solutions;
- organizations focusing on their core business, leading to the outsourcing of interpreting services;
- growing regulatory requirements in key sectors (health, insurance, etc.) continues to generate client demand;
- the number of US residents who speak languages other than English at home is increasing and will reach around 67 million by 2020 in the United States, *i.e.* around 20% of the US population.

Increase in number of Americans who speak another language than English at home *(in millions of people)*

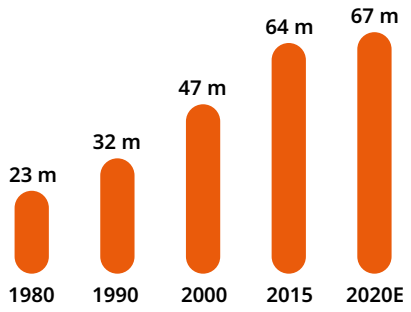

Source: US Census Bureau – National Population projections and LLS estimates.

LanguageLine Solutions is the leading provider of telephone and video interpreting solutions in North America, serving a range of companies and institutions in the healthcare, insurance, financial services, telecommunications and public sectors.

1.1.3.2.2 Visa application management services

The visa application management business in which TLScontact is engaged for the Schengen zone and English-speaking countries represented a market of some 36 million annual visa applications in 2018 and strong growth is expected over the next four years. This market is worth €1 billion per year.

Changes in number of visa applications for the Schengen zone and English-speaking countries between 2013 and 2022E *(in millions of applications)*

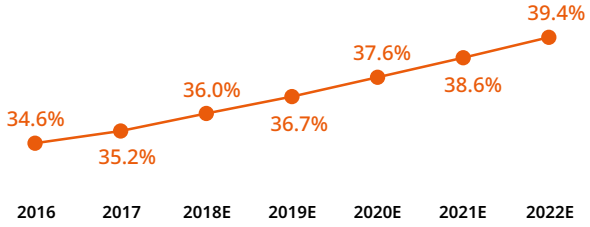

Source: TLScontact estimates.

With around a 10% market share in the Schengen zone and English-speaking countries combined, TLScontact is a major player on the outsourced visa application market. The 2013 agreement with the UK government (UKVI) has sharply raised TLScontact's share of the English-speaking market.

TLScontact's main rival is market-leader VFS.

The outsourced visa application management market will continue to grow, underpinned by the following trends:

- continued increase in the number of international tourists, estimated at around 3% over the next decade (according to the World Tourism Organization);
- governments' ongoing need to optimize their costs and improve services in an increasingly sophisticated environment in terms of security and technology;
- additional service offerings for visa applicants (travel insurance, fast-track services).

1.1.3.2.3 Others

The global outsourced debt recovery management market is currently estimated at over US$30 billion, according to Kaulkin & Ginsberg. Teleperformance earned 2% of its revenue from this market in 2018.

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1.1.4 Group strategy

1.1.4.1 History and vision

Over the last few years, the Teleperformance Group has successfully transformed itself. First, the Group stepped up its development and widened its core services offering. It then diversified its activities and sources of revenue within its high value-added services, combining strong organic growth with improved margins.

Customer experience markets are developing fast; human capital, security and innovation are key factors to success. Clients are increasingly exacting, seeking strong support in meeting the challenges of an all-digital landscape, while staying at the cutting edge in terms of service quality and data security. They require tailored solutions, and Teleperformance is the sole market player able to support its clients anywhere in the world and at any time, with a quality of service that meets the highest standards across all channels.

Numerous opportunities are opening up for Teleperformance.

The Group strives to shore up its presence in high-growth and high value-added regions and sectors, while continuing to innovate *via* the integration of omnichannel and digital solutions and seizing the potential offered by artificial intelligence.

These new levers complement ambitious yet realistic financial targets.

1.1.4.2 Long-term strategic growth plan

1.1.4.2.1 Solid outlook

The goal of this strategy is to create value through sustainable and profitable development of the Group's operations and *via* organic growth and targeted acquisitions.

Sustained organic growth

To tap into the growing and increasingly complex outsourced integrated corporate services market while continuing to deliver sustained organic growth until 2022, Teleperformance has adopted four main strategies:

- strengthen sector expertise in high-potential segments and environments, such as IT, retail, financial services and IoT;
- digital and omnichannel integration aiming at more efficient and fluid management of client interactions, with the gradual integration of artificial intelligence into the Group's omnichannel solutions, facilitated by the acquisition of Intelenet in October 2018;
- continuing to develop a global, high value-added offering, including data analysis and top-class consulting services. Teleperformance's approach is underpinned by an in-depth grasp of companies' grassroots customer experience requirements, all over the world. Client companies benefit from the Group's solid track record in terms of expertise in over twenty key sectors and state-of-the-art R&D facilities (CX Lab);
- continued expansion into BRICS (Brazil, Russia, India, China and South Africa) and MIST (Mexico, Indonesia, South Korea and Turkey) countries.

Pursuit of targeted acquisitions

The Group's acquisitions strategy primarily targets medium-sized companies offering a robust business and financial model and synergies with the Group's client base, operations and business activity.

The Group specifically keeps an eye out for all opportunities in high-value specialized services that would shore up its business, revenue and earnings.

The outsourced market continues to offer attractive growth opportunities in many parts of the world and presents definite consolidation potential. This positive trend is bolstered by an increasingly complex and digitized environment, with steady growth in customer interactions.

The acquisition of LanguageLine Solutions in September 2016 reflected the Group's strategic decision to develop high value-added specialized services.

The October 2018 Intelenet acquisition confirms the Group's transformation plan. The strategic acquisition mainly enables the Group to significantly bolster its offering with high value-added integrated solutions and to tap into Intelenet's expertise, AI-embedded software and automated procedures designed for the digital transformations of companies. As a result, the Group is ramping up its presence in India, a very promising domestic and offshore market.

Via its targeted acquisitions, the Teleperformance Group is gradually positioning itself as a globally recognized high-end player in Business Process Outsourcing (BPO).

1.1.4.2.2 2022 targets

Teleperformance intends to continue posting average organic growth a year above market growth until 2022. The Group's objective is to attain revenues of at least €6 billion in 2022 at constant perimeter.

Thanks to a positive impact on Group margins from the continued improvement of Core Services' margins, and the increased contribution from Specialized Services and digital transformation services, the Group targets a recurring EBITA of at least €850 million in 2022 at constant perimeter.

Meanwhile, management plans to pursue its targeted acquisition strategy. Any acquisition will lead to higher long-term objectives.

1.1.5 2018 Highlights

1.1.5.1 Development and investments

1.1.5.1.1 Acquisition of Intelenet and launch of D.I.B.S. operations

Teleperformance completed the Intelenet acquisition on October 4th, 2018.

Founded in 2000 and headquartered in Mumbai India, Intelenet is a key player in the provision of high-end services encompassing omnichannel customer experience management, back-office, HR management as well as financial and administrative management. At the time of the acquisition, the company had over 110 leading clients, mainly in English-speaking countries, India and the Middle East.

Intelenet clients operate mainly in banking, financial services and insurance, travel, tourism, e-commerce and healthcare.

As a result of this acquisition, Teleperformance created a new business category, Teleperformance D.I.B.S. (Digital Integrated Business Services); it includes mainly Intelenet's high value activities and Praxidia's consulting solutions.

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1.1.5.1.2 Launching a new visual identity

Teleperformance revealed its new visual identity and logo on September 5th, 2018, to reflect a truly global group focused on innovation and technology at the service of people. 'TP' is an abbreviation and familiar term for Teleperformance and will be used in all media, including the new TP website. The new logo illustrates what the Group has now become having transformed itself over the last few years.

1.1.5.1.3 €750 million bond issue

In July 2018, Teleperformance successfully issued a €750 million bond paying 1.875% p.a. interest and maturing in 2025. The bond funded the October 2018 Intelenet acquisition while also giving the Company more financial flexibility and allowing it to extend debt maturity and diversify its sources of finance. The successful issue attests to the market's confidence in the Group's credit rating. Standard & Poor's confirmed Teleperformance's BBB- rating – Investment grade – with a stable outlook, the best credit rating awarded in the customer experience sector.

1.1.5.1.4 Consolidating Group security leadership

In February 2018, Teleperformance became BCR (Binding Corporate Rules) approved by CNIL (the French national data protection authority), a supervisory authority within the European Union. BCRs provide Teleperformance legal ground to make safe international data transfers within and outside the EU. Teleperformance is currently the only BCR-approved international corporate services company as both data controller and data processor.

The EU's new general data protection regulations (GDPR) took effect May 25th, 2018. Group organization and procedures regarding data security now comply with the new security regulations after the investments it has made since 2016 into tightening data protection policies.

1.1.5.1.5 Extensions, new facilities and capital expenditure

Extensions and new facilities

In 2018, Teleperformance continued implementing its global development strategy by opening new facilities:

- in the English-speaking and Asia-Pacific regions (EWAP): Philippines, India, Canada and China;
- in the Ibero-LATAM region: Portugal, Mexico, Colombia and Peru;
- in Continental Europe & MEA (CEMEA) regions: mainly Tunisia, Morocco, Russia, Greece and Poland.

The Group has also increased the number of workstations at existing sites:

- in the English-speaking and Asia-Pacific regions (EWAP), Canada, China and Jamaica;
- in the Ibero-LATAM region, mainly Brazil, Spain, Mexico, Peru, Argentina and Portugal;
- in Continental Europe & MEA (CEMEA) regions, mainly Greece, Turkey, Romania, Tunisia, Russia, Dubai and Egypt.

18,000 new workstations were created in total over the year, a sharp increase year-on-year.

Capital expenditure

The Group's production capacity continued to increase despite tight control over expenditure.

(in millions of euros)	2018	2017	2016
Net capital expenditure	196	147	190
% of revenue	4.4%	3.5%	5.2%

The Group strictly monitors the volume and return on capital expenditure per project, notably when supporting rapid business growth in booming markets, in order to optimize the allocation of Group capital.

1.1.5.2 Awards

In 2018, Teleperformance once again received numerous awards from prestigious institutions and reputable independent consulting firms around the world, both for its market leadership and its world-class services in its industry, as well as for its HR development strategy, security and innovation capacity and commitment to social and environmental responsibility. The following list states the main awards received over the year by topic.

1.1.5.2.1 Teleperformance's leadership and world-class services

- Everest Group named Teleperformance the worldwide leader in management of outsourced contact centers for the 6th consecutive year;
- Seven 2018 Frost & Sullivan prizes awarded to Teleperformance:
  - Contact Center Outsourcing Company of the Year – Europe,
  - Contact Center Service Provider of the Year – Asia-Pacific,
  - Growth Excellence Leadership – Asia-Pacific,
  - Growth Excellence Leadership for the contact center outsourcing industry – China,
  - Company of the Year – Argentina,
  - Competitive Strategy Innovation and Leadership – Brazil,
  - Security & Compliance Competitive Strategy Innovation and Leadership – World;
- Teleperformance won the following European Contact Centre & Customer Service Awards (ECCCSA):
  - the best multilingual solution and the silver medal for the Employer of the Year in Greece,
  - the gold medal for the Best Large Outsourcing Partnership in Russia,
  - the silver medal for the best multi-channel/omnichannel customer experience in Portugal,
  - the silver medal for the Best Small Outsourcing Partnership in Romania.
- Teleperformance is ranked top Global Impact Sourcing by the IAOP (International Association of Outsourcing Professionals) in the Impact Sourcing in a Large Organization category;

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- Teleperformance in India won six Contact Center World awards in the following categories: Best Community Spirit, Best Recruitment, Best Customer Service, Best Use of Social Media; Best Outsourcing Partnership with a Marquee E-Commerce Client, Best Contact Center;
- Teleperformance SE won the 2018 SAP Quality Award in the SAP innovation category.

1.1.5.2.2 Excellence in social and environmental responsibility

- Teleperformance earns the Verego label for corporate social responsibility for all of its locations.
- Great Place to Work® (GPTW): ten Teleperformance subsidiaries received a Great Place to Work® award in 2018:
  - three EWAP subsidiaries:
    - China,
    - Philippines,
    - India, where Teleperformance was ranked top of the BPO sector for the 5th year running;
  - seven subsidiaries in the Ibero-LATAM region:
    - Brazil for the 9th year running,
    - Mexico (two subsidiaries),
    - Salvador for the 5th year running,
    - Dominican Republic for the 4th year running,
    - Colombia for the 1st time,
    - Portugal for the 8th year running.
- Global Best Employers™ Program awarded to Teleperformance in 2018 by AON Hewitt in 7 countries:
  - Albania,
  - Guyana,
  - India,
  - Lithuania,
  - Morocco,
  - Tunisia,
  - Lebanon, for the TLScontact subsidiary;
- Best Place to Work® awarded to three countries:
  - Tunisia,
  - Albania,
  - Lebanon.

1.1.6 Organization chart (December 31st, 2018)

1.1.6.1 Teleperformance SE and subsidiaries

The parent company Teleperformance SE operates as a holding company *vis-à-vis* its subsidiaries while also performing management, control, support and advisory functions for the Group's companies, receiving fees for these services.

Moreover, Teleperformance collects a brand royalty charged to all subsidiaries. Note 23, *Relations with related companies* to the Company financial statements (page 197 of this Registration Document) gives details of the Company's relations with its subsidiaries.

The Company is also head of the French tax group, which includes French subsidiaries in which the parent company holds over 95% of the capital.

Detailed information on Teleperformance's main subsidiaries is summarized in the table of subsidiaries and shareholdings in the notes to the Company financial statements (pages 198 and 199 of this Registration Document).

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1.1.6.2 Operational organization chart*

Core Services			Specialized Services				
CEMEA	**EWAP**	**Ibero-LATAM**	**LanguageLine Solution**	**TLScontact**	**ARM**	**Praxidia**	**Intelenet**
Albania	Australia	Argentina	Canada	Albania	Canada	France	Egypt
Belgium	Canada	Brazil	Costa Rica	Algeria	Jamaica	Italia	Guatemala
Bosnia-Herzegovina	China	Chile	Panama	Armenia	USA	Luxemburg	India
Czech Republic	India	Colombia	Taiwan	Azerbaijan		Mauritius	Jordan
Denmark	Indonesia	Costa Rica	UK	Belarus		Netherlands	Mauritius
Egypt	Ireland	Dominican Republic	USA	Cambodia		UK	Poland
United Arab Emirates	Japan	Guyana		Canada		USA	Philippines
Finland	Korea	Mexico		China			Saudi Arabia
France	Malaysia	Peru		Egypt			UAE
Germany	Philippines	Portugal		Ethiopia			UK
Greece	Singapore	Salvador		France			USA
Italia	South Africa	Spain		Gabon			
Kosovo	UK			Georgia			
Lebanon	USA			Germany			
Lithuania				Ghana			
Luxemburg				Indonesia			
Madagascar				Ireland			
Morocco				Italy			
Netherlands				Jordan			
Suriname				Kazakhstan			
Norway				Kenya			
Poland				Kosovo			
Romania				Lebanon			
Russia				Luxemburg			
Slovakia				Madagascar			
Sweden				Morocco			
Switzerland				Mauritius			
Tunisia				Malaysia			
Turkey				Mongolia			
Ukraine				Montenegro			
				Netherlands			
				Nigeria			
				Philippines			
				Poland			
				Russia			
				Serbia			
				Sierra Leone			
				Singapore			
				South Africa			
				Spain			
				Switzerland			
				Tanzania			
				Thailand			
				Tunisia			
				Turkey			
				Uganda			
				UK			
				Ukraine			
				USA			
				Uzbekistan			
				Vietnam			

** Countries where Teleperformance branches and subsidiaries are located by business and linguistic region.*

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1.2 RISKS AND CONTROL

RISKS' IDENTIFICATION & ANALYSIS

INSURANCE GLOBAL PROGRAMS

INTERNAL CONTROL LAYOUT AND INTERNATIONAL STANDARDS

Overall policy

The objective of the risk management policy is to identify and analyze the risks that the Group faces and set appropriate risk limits and controls.

Responsibilities

Supervision

It is the Board of Directors' responsibility to define and oversee the framework for managing Group risks, the consequences of which are liable to impact the Company's business, earnings, staff, assets, environment, objectives or reputation.

This framework is regularly reviewed. In 2017, KPMG made a diagnostic study of it. The positive findings and the areas for improvement revealed by this review were presented to the Board after being presented to the Audit and Compliance Committee.

Through training and management rules and procedures, the Group aims to develop a rigorous and constructive control environment where all employees have a clear understanding of their role and duties.

Organization

Identifying, analysing, measuring and processing risk is the responsibility of the Group's three main departments: finance, legal & compliance and operations, at Company and Group level. This organization provides the framework for the risk management scheme.

This management scheme stems from the interaction of the three main departments with general management, the Audit and Compliance Committee and the functional and operational departments, which perform day-to-day management of the risks within their respective remits.

Implementation and continuous improvement

This interaction under the risk management scheme is embodied, among others, in joint exercises involving the main departments.

In 2018, this work related to compliance and protection topics such as:

- cross-functional review of the legal, operational or security-related aspects of the Group sites;
- mapping risks of corruption;
- instituting a crisis-management plan.

In 2019, the Group intends to continue its process of generalizing and formalizing risk mapping on the basis of its internal-control self-assessment scheme, deployed to all its subsidiaries.

Presentation of this section

This section was prepared jointly by the main departments that play a key role in identifying and controlling the main risks. It is based on the *Reference Framework* prescribed by the *Autorité des Marchés Financiers* (AMF – French financial markets authority).

First, this section outlines the risk factors to which the Group is exposed in relation to its business operations. Secondly, insurance and risk coverage are presented, and lastly, the internal control and risk management systems, application of which is ensured by Teleperformance senior management and staff, in order to anticipate and control these risks.

However, the Group cannot provide an absolute guarantee regarding the achievement of objectives and the total elimination of risks. Furthermore, other risks of which the Group is currently unaware, or which it does not consider material as of the date of this Registration Document, may also impact its business, reputation or results.

1.2.1 Risk factors

The Group's strategy factors in, among others, the risks described below.

	Operating Risks	General risks	Financial Risks
Priority Risks			
	Business-related risks	Growth through acquisition of companies	Credit
	Technological evolution	Foreign operations	Liquidity
	Potential client dependency		Market
	Data security and protection		
	Competition risks		
Other Risks			
	Regulatory and legislative changes	Suppliers	Equity
	Fostering customer loyalty	Other Risks (Legal, Ethical and Employment)	
	Human Resources, employees and executive officers		

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Risk management falls within the framework of the Group's schemes for risk management and internal control, as described hereafter. Those schemes have a role in enhancing control of group activities.

The risk management schemes for grave breaches of human rights, personal health and safety, and environmental breaches, are described in part 2.

1.2.1.1 Operating risks

Risks relating to the level of activity

Risk identification

Teleperformance's level of business is contractually related to that of its clients. A decline in a client's business, whether or not arising from a general economic downturn, can affect the Group's business.

A client may also request that certain contractual conditions be amended. The price, which is a determining factor for certain business sectors (particularly in the telecommunications sector), or allocation of entrusted volumes are other aspects that can impact the Group's business.

Risk management

Contractual clauses enable guarantees to be obtained in relation to certain criteria, such as volume, end-user satisfaction, as well as service quality, IT infrastructure, security systems and feedback provided by employees.

The duration of contracts in the inbound calls business, which accounts for most of the Group's revenue, varies between two and five years.

The Group also attaches particular importance to assessing its customers' satisfaction, and has instituted a stringent customer-relations management process that it maintains throughout the conduct of projects.

Risks entailed in technological evolution

Risk identification

Teleperformance operates in an environment subject to very fast-paced technological evolution. The Group must ensure that it adapts to new customer needs for services and innovation in order to anticipate increasing demand for solutions, particularly digital ones, for radically transforming the customer experience.

Risk management

Teleperformance ensures that it responds to customer demands, particularly by its Innovation department, by evolving its services in customer relations services, consulting and data analysis, and also its high-value-added specialized services and its integrated digital solutions. In this respect, Teleperformance enjoys worldwide recognition for having boosted its digital-technology capabilities.

Risks relating to potential client dependency

Risk identification

Although Teleperformance's business depends on its ability to renew its contracts and to sign new ones on profitable terms, no Group client represents more than 8% of revenue.

Risk management

With more than 850 clients, excluding LanguageLine Solutions, – as indicated in section 1.1 – Teleperformance has the most diversified client base in the industry.

Risks relating to data security and protection

Securing the technological platform

Risk identification

Teleperformance delivers its services to clients through a complex technological platform that integrates various aspects of information technologies: powerful telephone technology, hardware and software.

Risk management

All of the Group's subsidiaries and workstations delivering Core Services are currently networked *via* dedicated data connections and phone lines.

The Group ensures that the requisite security measures and insurance cover are applied in the context of its activities.

Each subsidiary adheres to internal data security and protection standards, as well as to international security and quality standards, in particular ISO 27001 and ISO 22301. In addition, Teleperformance complies with PCI Data Security standards whenever it is required to do so by its clients.

Personal data protection and security

Risk identification

The Group's activity requires its subsidiaries, acting as data controllers, to collect, process and transfer personal data regarding our employees. When acting on behalf of its clients, Teleperformance acts as a data processor and collects and processes personal data of the customers of its clients.

The Group must not only meet legal requirements as well as any contractual commitments to its clients, but also more than 300 compliance criteria in the field of security. Non-compliance with statutory and contractual requirements could lead to adverse consequences for the Group's performance.

Electronic fraud cases have continued to increase throughout the world, as evidenced by the most significant cases published in the international press. In addition, many other incidents are settled confidentially, in the normal course of business.

Risk management

In 2015, the Group implemented a set of security rules ("Global Essential Compliance and Security Policies" or "GECSPs"), designed to anticipate possible risks of fraud or violation of legal security rules. The Group established an internal compliance audit function, which reviews our operational sites on a rotating 24-month schedule for adherence to the GECSPs and client requirements. In addition, external auditors carry out audits of selected sites in order to assess compliance with the GECSPs and other security processes implemented in our sites.

In addition, a Global Compliance and Security Council, chaired by the Global Deputy Chief Compliance Officer and Chief Privacy Officer meets quarterly to review security incidents, if any, ensure regular compliance with the GECSPs, and review results of the internal and external audits and other compliance matters. As Teleperformance places special attention on security matters, all regional CEOs and relevant operational and compliance officers attend the Global Compliance and Security Council meetings.

Also, as of February 1st, 2016, Teleperformance appointed a Worldwide Chief Legal Officer and Chief Compliance Officer, who reports directly to the Group Chairman and CEO. Teleperformance also appointed a Global Deputy Chief Compliance Officer and Chief Privacy Officer, who reports to the Chief Legal Officer and Chief Compliance Officer. These officers provide reports of activities to the Audit and Compliance Committee of the Board.

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As part of the Group's ongoing efforts to manage these functions proactively, we have also created the Global Privacy Office. This office is comprised of the Global Deputy Chief Compliance Officer and Chief Privacy Officer, along with 3 regional Senior Vice-Presidents of Privacy/Data Protection Officers. The Global Privacy Office is responsible for implementing the Group's global privacy policy and ensuring that Teleperformance is in full compliance with privacy regulations around the world, such as the European Commission's General Data Protection Regulation ("GDPR"), which went into effect as from May 25th, 2018.

Teleperformance also has a Global Technology and Privacy Committee, which is chaired by the Chief Information Security Officer. The members of this Committee are the Global Chief Information Officer and all regional Chief Information Officers, as well as the Global Deputy Chief Compliance Officer and Chief Privacy Officer, and the regional Senior Vice Presidents of Privacy/Data Protection Officers. The main function of this Committee is to evaluate all new and existing technologies prior to deployment to ensure that a Privacy Impact Assessment (PIA) has been completed. This process ensures that Teleperformance evaluates the privacy implications of the technologies we use in collecting or processing data as both a Data On Processor and a Data Controller.

On February 12th, 2018, Teleperformance obtained certification of its Binding Corporate Rules ("BCRs") from the CNIL (French data protection authority). As the BCRs are implemented across all subsidiaries of the Group our subsidiaries follow them as both Data Controllers and Data Processors, which allow Teleperformance to transfer and process data globally.

Competition risks

Risk identification

The outsourced customer experience management market is fragmented and competitive. In each of the countries where it operates, the Group is faced with fierce competition comprising international and national businesses.

These are generally companies specializing in contact center management, or companies offering outsourced general services and developing niche activities incorporated in a package offer.

This environment may lead to certain constraints on prices, whether in connection with the award of a new contract or with the renewal of a contract with an existing client. The rise in such constraints in all of the Group's markets could affect its business and profitability.

Risk management

In order to manage any risk of price constraints while catering for its clients' needs, the Group has developed several strengths to set itself apart from its competitors:

- time-tested management and unrivaled credibility;
- human capital development strategy that guarantees quality and reliability of service;
- a highly client-oriented culture;
- a unique integrated network combining domestic, nearshore and offshore solutions;
- constant innovation strategy aimed at increasing the value-added of the Group's services;
- worldwide presence to support the Group's global clients;
- secure processes in line with contractual provisions with clients *(see Security and data protection risk)*.

Risks from regulatory and legislative changes

Risk identification

In each country where the Group operates, its business may be subject to specific statutes and regulations in the fields of labor law, competition law, consumer and data protection law and company law.

The enactment of any regulation having a restrictive effect on the Group's activity could impact growth.

Governments may adopt legislation to restrict outsourcing of activities or to protect consumers' interests. For example, this has been the case in numerous countries that have adopted regulations giving individuals the option not to receive telemarketing cold calls. The risk of such regulations adversely impacting the Group's growth, viewed as a major risk in the past, is lessened in view of the nature of the Group's activities today.

Risk management

For many years, the Group has significantly increased its incoming-call activity and reduced the share of its business line of outgoing calls to private individuals. The revenue breakdown by business line is set out in point 1.1 *Introduction to the Group*.

Customer loyalty risks

Risk identification

Teleperformance's activity depends on its ability to retain and renew contracts with existing clients and to successfully win and negotiate new contracts. This ability is generally assessed in light of various criteria such as quality, security, cost and any item enabling differentiation from competitors.

Risk management

At December 31st, 2018, the average duration of a client relationship is 12 years. This loyalty is the result of a highly client-focused Group culture, reflected in rigorous procedures, a good understanding of client expectations and a highly responsive company structure: specific management of strategic accounts, regular activity reports, a marketing research laboratory, regular and detailed client satisfaction surveys and introduction of rapid response operational teams.

Risks relating to Human Resources, employees and executive officers

Risk identification

The quality of the Group's services relies largely on its ability to attract, train, motivate and foster loyalty in its talented people and maintain a level of training aimed at constantly improving its standards.

Risk management

The staff turnover rate is closely and regularly monitored by the Group. It not only impacts hiring and training costs, but also the quality of the services delivered to clients, and therefore the Group's operating profit.

In Europe (Continental Europe, Middle East and Africa), the turnover rate is lower than in countries where economic growth is higher and where working conditions are more flexible.

In a business sector characterized by high staff turnover, the Group has sought to develop its hiring capacity (employees, executives, etc.) and loyalty programs. The Group is backed by a number of strengths, including its market leadership and ability to offer employees an award-winning work environment, staff benefits, on-the-job training and career prospects within a global Group.

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Risk identification

The departure of certain executive officers could have a negative impact on the Group's revenue and earnings. In order to protect the Group's legitimate and best interests, certain Group executive officers are bound by non-compete clauses and undertakings towards the Group.

Risk management

In order to motivate and retain the key executives and best performing talents within the Group, it introduced performance share plans in April and November 2016, June 2017 and January 2018.

1.2.1.2 General risks

Risks relating to growth through business acquisitions

Risk identification

Acquisitions form part of the Group's development strategy. In practice, they may give rise to risks.

Risk management

The Group has significant experience in carrying out acquisitions. As part of its external growth strategy, Teleperformance takes all steps to identify acquisition targets, in terms of country, product or job synergies, as well as identifying risks associated with these acquisitions. The Group then implements the customary procedures under its consolidation policy for acquired companies.

The goodwill shown under the Group's balance sheet assets is valued every year in order to determine whether it should be written down. The assumptions made in estimating future earnings and cash flows at the time of these valuations may not be confirmed by subsequent actual results.

Capitalized goodwill as of December 31st, 2018 amounted to €2,304 million and represents 39% of total assets.

Group risks due to foreign operations

Risk identification and management

As part of its development and due to the actual nature of its business, the Group carries out a major portion of its business outside France, particularly in emerging markets.

Risks inherent to conducting business in these countries, such as social, political and economic instability, late payments or unexpected changes to legislation, can have consequences on the Group's operations and thus affect its earnings.

On the basis of ratings published at the end of February 2019 by COFACE, which constantly monitors the development of emerging countries and releases ratings per country, the Group's concentration per production region are as follows:

- 69% of revenue in countries where the situation is regarded as favorable and low-risk or implying acceptable risks; these include major contributors to the Group revenue, notably the USA, Philippines and UK;
- 23% of revenue in countries where the situation is uncertain, including Brazil, Tunisia and Turkey;
- 8% of revenue in countries where economic and political outlook is considered to be very uncertain, notably El Salvador, Algeria and Albania.

Other risks

Supplier-related risks

Risk identification

The top Group suppliers are mainly temping agencies, IT hardware and software suppliers and telephone operators.

Risk management

The Group considers its risk to be limited. Additionally, for a given service or product it contacts several suppliers, all leaders in their market.

Legal risks

Risk identification

The Group operates in a certain number of countries where failure to comply with applicable domestic legislation could expose the Group to legal action by employees or shareholders or an administrative or regulatory authority.

In the ordinary course of business, the Group is involved or risks being involved in various administrative or court proceedings. Within the scope of some of these proceedings, monetary claims are made or may be made against the Group. Provisions have been booked for these claims pursuant to IFRS.

The Group estimates that provisions booked for the risks, disputes and proceedings of which it is aware or that are currently pending are sufficient so as not to affect the Group's consolidated financial position should the Group experience a negative outcome in any of such cases.

Risk management

In order to anticipate risks relating to non-compliance with legislative or regulatory changes, the Group's network of lawyers based in its operating regions tracks changes in legislation and regulations.

To the Company's knowledge, there is not, to date, any other governmental or legal court action or arbitration, apart from what is mentioned in this section and in note 9.5 *Litigation to the consolidated financial statements*, nor any court action of which the Company is aware that is pending or threatened, that may have or has had a material impact on the financial position or earnings of the Company or Group in the last 12 months.

Ethical risks

Risk identification

As of December 31st, 2018, the Group operates in 80 countries. It operates and develops its business in countries where risk of corruption is considered high. The Group may therefore be exposed to corruption risk with regard to some of its employees or partners, which would affect its reputation.

Risk management

As part of its operations, including in relation to purchases and sales, the Group ensures that all acts of corruption are prohibited. These zero-tolerance principles are set out in the Code of Conduct, which is published on the Group's website. Furthermore, in accordance with the French Sapin II law, the Group has developed a corruption risk map, which will be reviewed by the Audit and Compliance Committee. The anti-corruption policy is implemented under the responsibility of the Group's Legal & Compliance department.

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The Group's Code of Ethics setting forth Teleperformance's values, as well as the principles for respecting diversity in dealings with third parties with which the Group is involved, is published on the Group's website.

Employment risks

Risk identification and management

Within the normal framework of its business, the Group is involved in a number of employment disputes.

In accordance with applicable accounting principles, these disputes are recognized under provisions for risks. These provisions amounted to €14.8 million at December 31st, 2018 and mainly concerned disputes with former employees, in particular in Argentina, Brazil and France.

In the future, the Group may further restructure or reorganize its business in some countries. These restructuring or reorganization operations may involve closing down or merging sites in order to adapt to the needs of an ever-changing market. Although Group management pays particular attention to such restructurings, they could nevertheless damage the Group's relationships with its employees, which could lead to employment disputes or, generally, disruptions that might negatively impact the Group's reputation, revenue, financial position or earnings.

1.2.1.3 Financial risks

The Group is exposed to the following risks:

- credit risk;
- liquidity risk;
- market risk;
- equity risk.

This section provides information on the Group's exposure to each of the above risks, its objectives, policy and procedures for measuring and managing risk, as well as its share capital and equity management.

Quantitative disclosures appear elsewhere in the consolidated financial statements.

It is the Board of Directors' role to define and oversee the Group's risk management framework. Monitoring, measuring and overseeing financial risk is the responsibility of the Group's Finance Department, for the Group and each of the Group companies.

The objective of the Group's risk management policy is to identify and analyze the risks that the Group faces, to set appropriate risk limits and controls, and to manage the risks and ensure that the limits defined are respected. The policy and the risk management systems are reviewed regularly so as to respond to changes in the market and in the Group's activities. Through training and management rules and procedures, the Group aims to develop a rigorous and constructive control environment where all employees have a clear understanding of their role and duties.

The internal audit department performs both periodic and ad hoc reviews of risk management controls and procedures, reporting to the Audit & Compliance Committee.

All strategic decisions relating to the hedging policy for financial risks are the responsibility of the Group's Finance Department.

Credit risk

Risk identification

Credit risk is the Group's risk of financial loss in the event that a client or counterparty to a financial instrument fails to meet their contractual obligations. This risk primarily concerns customer receivables and short-term investments.

The Group's exposure to credit risk is mainly influenced by the individual characteristics of its clients. The Group's largest client accounts for 7.4% of global revenue. In addition, sales to telecommunications clients and Internet service providers represent a total of 15.5% of Core Services revenue. No country accounts for more than 10% of trade receivables, with the exception of the United States which represented approximately 36% of total trade receivables at December 31st, 2018.

Risk management

Credit risk is continuously monitored by the Group Finance Department, through monthly reports and quarterly Executive Committee meetings.

The Group does not require specific credit guarantees for its trade receivables and other current assets.

The Group determines the level of its impairment losses by estimating losses incurred on trade receivables and other current assets.

The Group provides performance guarantees on contracts when requested by certain clients. Guarantees are disclosed in note 9.4 *Guarantees and other contractual obligations* of the consolidated financial statements.

Liquidity risk

Risk identification

Liquidity risk is the risk that the Group may not be able to meet its debts when they become due.

Risk management

The Group policy in respect of its financing is to maintain, at all times, sufficient liquidity to finance Group assets, short-term cash requirements and development, both in terms of amount and duration, and at the lowest possible cost.

For several years now the Group has implemented a centralized cash management policy when permitted by local legislation. Companies included in the cash pooling represent over 65% of Group revenues.

In countries where cash pooling is not permitted, short-term cash management is provided by the subsidiaries' operational management team, which generally has access to short-term bank facilities, plus, in some cases, confirmed credit line facilities from the parent company.

All medium and long-term financing is authorized and overseen by the Group's Finance Department.

The Group obtains financing in the form of loans, credit lines and bond issues from top-tier credit and financial institutions, repayment of which falls due between 2019 and 2026 as stated under note 7.4 *Financial liabilities* of the consolidated financial statements.

The available balance of the multi-currency syndicated credit line (€, USD) is 300 million euros and the balance available on credit lines contracted from a number of banks is 200 million euros at December 31st, 2018.

Net debt at December 31st, 2018 amounted to €2,100.7 million, compared to €1,326.37 million at December 31st, 2017.

Given the timing of our borrowings and the Group's ability to generate free cash flow, liquidity risk is low.

Information relating to liquidity risk is provided in note 7.4 *Financial liabilities* of the consolidated financial statements.

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Market risk

Market risk is the risk that changes in market prices, such as foreign exchange rates, interest rates and the cost of equity instruments, will affect the Group's results or the value of its financial instruments. The objective of managing market risk is to manage and control the market risk exposure, keeping it within acceptable limits, while maximizing return.

Foreign exchange risk

Risk identification

The Group is particularly exposed to foreign exchange risk on revenues and charges denominated in a currency other than each company's functional currency, *i.e.* principally the US dollar.

Risk management

The Group hedges currency risk on sales and charges, notably between the Mexican, Philippine and Colombian peso, the Indian rupee and the US dollar. These hedges are more fully described in note 7.5 *Currency hedging operations* of the consolidated financial statements.

The Group is also exposed to currency risk on its borrowings denominated in currencies other than the euro or the functional currency of Group companies.

Group policy is as follows:

- the Group hedges loans granted to subsidiaries with loans or advances in the same currency and with the same maturities, or with foreign exchange contracts;
- the principal bank loans granted to Group companies are denominated in the functional currency of the borrower;
- interest due on borrowings is denominated in the same currency as the cash flows generated by the underlying operations of the Group, primarily the euro, US dollar and pound sterling. This provides an economic hedge without resorting to derivatives.

Finally, the Group is exposed to foreign exchange risk when translating foreign subsidiaries' financial statements for consolidation purposes.

The translation difference on Group consolidated revenue is disclosed in note 7.8 *Exposure to exchange risk due to consolidation* of the consolidated financial statements, which shows the breakdown of revenue by currency over the last two years.

The impact of changing foreign exchange rates on the Group's revenue, profit before tax and net profit Group share are disclosed in note 7.8 *Exposure to exchange risk due to consolidation* of the consolidated financial statements.

Sensitivity to interest rate changes

Risk identification

The Group is exposed to interest rate risk on its financial liabilities and cash holdings. Amounts subject to interest rate risk are as stated below:

Net debt	12/31/2018	Fixed rate	Subject to interest rate risk	12/31/2017	Fixed rate	Subject to interest rate risk
Total financial liabilities	2,437	1,986*	5451	1,611	1,179	432
Total cash and cash equivalents	(336)		(336)	(285)		(285)
NET DEBT	**2,101**	**1,986**	**115**	**1,326**	**1,179**	**147**

** Of which €400 million hedged by fixed-rate/variable-rate swaps.*

A 100 basis-point increase in interest rates would lead to a €5.8 million increase in our financial costs, while a reduction in interest rates by 100 basis points would reduce our financial costs by €6.5 million.

Equity risk

Risk identification and management

The Group limits its exposure to equity risk by investing available cash reserves in short-term liquid investments, certificates of deposit, and low risk financial instruments such as mutual funds, while choosing top-tier financial institutions and avoiding significant concentration. Group management does not expect any counterparty to default.

Short-term liquid investments at December 31st, 2018 amounted to €35.7 million, principally represented by money market funds and mutual funds.

Share capital and equity management

The Group's policy on share capital and equity management is to maintain a strong equity base so as to keep the confidence of investors, creditors and the market, and to support future business development. The Group pays close attention to its net debt and debt-to-equity ratio.

The debt-to-equity ratio is as follows:

(€ millions)	12/31/2018	12/31/2017
Net debt	2,101	1,326
Total shareholders' equity	2,225	1,922
DEBT-TO-EQUITY RATIO	**0.94**	**0.69**

From time to time the Group buys back its own shares on the market. On March 30th, 2018, Teleperformance SE and Kepler Chevreux entered into a new liquidity contract, implemented as from April 13th, 2018 and compliant with the AMAFI ethical charter allowed under the applicable regulations. This contract replaces the one signed on January 8th, 2017 with Oddo Corporate Finance. The amount of funds committed to this arrangement is €5.6 million. The number of treasury shares held at the end of the year is set out in note 6.1 *Share capital* of the consolidated financial statements.

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1.2.2 Insurance, risk coverage and crisis management

1.2.2.1 Overall Group insurance strategy

Teleperformance's insurance strategy is designed to safeguard the Group's assets in view of risks to which they might be exposed.

The strategy aims to standardize and optimize coverage, manage insurance policies centrally and minimize costs.

The Group has set up international insurance programs covering property damage, loss of profits and civil liability. Insurance policies are taken out *via* brokers with top-class international insurance companies.

Coverage caps are established in line with the Group's inherent business risks, taking into account its claims experience and market conditions, and comply with local regulations.

A third-party organization may be entitled to audit and analyze the insurance programs to ensure the risk coverage is appropriate and sufficient.

The Group does not have a captive insurer and there are no material risks that the Group self-insures.

Total premiums paid for 2018 amounted to €7.3 million.

1.2.2.2 Insurance programs

General and professional liability insurance

The Group has set up a centrally managed general and professional liability insurance program in Europe. In principle, all subsidiaries are covered by this program, either under the Group policy or under separate policies managed locally in accordance with local regulations.

Coverage for any new entity is always assessed in advance so as to define the conditions of their inclusion in the global program.

The terms and conditions of this program can be amended to take into account changes in business activities, the insurance market and risks incurred.

Property damage and business interruption insurance

The Group has set up a property and business interruption insurance program in Europe also covering many non-European CEMEA countries. The scheme extends to subsidiaries in other parts of the world whenever this is possible with regard to local legislation and the opportunities for optimizing cover and costs.

Non-consolidated subsidiaries are insured separately in accordance with applicable local legislation and regulations.

"Cyber" risks

A "cyber" risks insurance program supplements the existing policies for damage, business interruption and civil liability. These policies in combination cover the Group amongst others for any damage incurred to 3rd parties and any business interruption arising from the unavailability, alteration, theft and/or disclosure of its customer and operating data, together with the related incident-management costs

Other risks

The Group is covered by other insurance policies. Depending on the type of risks involved, these policies are taken out either at local level, in accordance with the legislation in force in each country, or at global level in order to optimize insurance costs and the level of coverage required.

1.2.2.3 Crisis management

In 2018, Teleperformance instituted a Group-wide crisis-management scheme to anticipate and manage sudden, unforeseen and major events with a likely negative impact on staff, the continuity of the Group's activity, financial results or reputation.

This scheme is based on:

- a manual containing all the procedures and rules associated with crisis management: alert reporting, the composition of the crisis-management unit, the unit's operating rules, the dedicated communication tools for crisis management;
- a training program for staff and managers;
- regular crisis exercises contributing to fostering awareness among staff and managers of the features specific to crisis management, and also contributing to continuous improvement of the scheme.

1.2.3 Risk management and internal control procedures

1.2.3.1 Choice of reference framework

For the drafting of this section, the Group based itself on the *Reference Framework* of the Autorité des Marchés financiers (AMF) updated in July 2010.

Firstly, the risk management and internal control systems are defined and their objectives set out. Then, the components of the system and the key players involved are summarized.

Finally, the application guide included in the *Reference Framework* is taken into account in order to define the risk management and internal control procedures with regard to financial and accounting information published by the Group.

The scope of application for the risk management and internal control procedures described below covers the parent company and all of its consolidated companies. In the event that new entities are consolidated, these procedures are systematically and progressively implemented.

1.2.3.2 Risk management and internal control definition and objectives

Definition of internal control

The Group has adopted the definition in the AMF *Reference Framework:*

Internal control consists of a set of resources, behaviors, procedures and actions that contribute to the management of the Group's activities, the effectiveness of its operations and the efficient use of its resources. It should enable it to manage in an appropriate manner any significant risks, be they operational, financial or relating to compliance.

The system that has been defined and implemented within Teleperformance specifically aims to ensure:

- *compliance with laws and regulations;*
- *implementation of the instructions and directions given by management, following discussions and in agreement with the Board of Directors;*
- *proper functioning of the Group's internal processes, especially those relating to the protection of its assets; and*
- *the reliability of financial information.*

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The definition of internal control does not cover all of the initiatives taken by the executive or management bodies, such as defining the Company's strategy, setting objectives, making management decisions, dealing with risks and monitoring performance.

Furthermore, internal control cannot provide an absolute guarantee that the Company's objectives will be achieved (...). It cannot prevent Group personnel from committing fraud, contravening legal or regulatory provisions, or communicating misleading information outside the Company about its situation.

Internal control and risk management

Risk management and internal control systems complement each other in controlling the Company's activities.

The internal control system relies on the risk management system to identify the main risks that need to be controlled. The risk management system includes controls that are part of the internal control system.

1.2.3.3 Risk management and internal control system components

Introduction

The main directions for internal control are determined in accordance with the Group's objectives.

These objectives have been communicated to the relevant managers and employees in the Group so that they understand and comply with the general policy of the organization with regards to risks and controls. The risk management and internal control systems rely on five closely related components, set out below.

Control environment, values and Code of Ethics

The control environment is a fundamental component of risk management and internal control systems and forms the common basis of the systems.

Teleperformance values

The Group's internal control system is based on five core values: *Integrity, Respect, Professionalism, Innovation and Commitment.* These values infuse the Group's leadership strategy and form the key value charter for our employees and our subsidiaries.

The Group's values are brought to the attention of all Teleperformance personnel. Teleperformance places great emphasis on its managers' ability to live up to these values on a daily basis. The training programs are described in section 2. *A benchmark employer*.

The Code of Conduct covering Teleperformance's values, as well as the principles for respecting diversity in dealings with third parties with which the Group is involved, was published on the Group's website. It also incorporates the United Nations Global Compact, joined by Teleperformance in July 2011. The principles of the Compact are also described in section 2.

Organization and responsibilities

The Group's organization is based on two categories of services: core services, *i.e.* customer relations and technical support services, and specialized services, which include interpreting, management of visa applications, analytics solutions and debt collection services.

In October 2018, a third family of services, Teleperformance D.I.B.S (Digital Integrated Services) was created following the acquisition of Intelenet.

All of the senior managers and executives of corporate functions make up the Executive Committee, which is headed by the CEO.

The Executive Committee's role mainly consists of implementing decisions taken by the Board of Directors and senior management. One of the Executive Committee's roles is to advise the CEO and oversee the development and monitoring of policies that enable the Group to attain its various objectives in terms of global growth, technological decisions, the implementation of identical operating procedures for the entire network, as well as development of human resources.

Within the linguistic regions, the Group's organization relies on matrix management structures to establish a direct link across countries, business lines, sales teams and support functions.

The objective is to foster the Group's expansion, in a uniform fashion, with performance regularly and closely monitored by the Board of Directors.

Human resources management

Human resources management is a major component of the internal control system, and even more so in our industry where "*each interaction matters*".

Our human resources policy for Teleperformance employees is defined by a constant quest for excellence in recruiting, building employee loyalty, developing talent and enhancing employee skills. Our aim is to enable everyone to perform their duties well and for the Group to achieve its objectives.

These human-resources programs are developed and deployed under a dedicated scheme of governance, with the appointment of a Human Resources Director in 2018. All these programs are described in section 2.3 *A benchmark employer*.

These activities contribute to the development of employees, so that the Group continues to be a rewarding company for them, while giving them the ability to quickly take on a management role within the Group.

Information systems

Group management and the Information Systems Department determine the Group's strategic directions for production tools and information systems for subsidiaries. They ensure that the development of information systems is consistent with Group objectives.

The Information Systems Department also issues directives on security, data protection and business continuity. These directives are based on compliance with international standards, ISO 27001, PCI (Payment Card Industry), HIPAA (Health Insurance Portability and Accountability Act) and the European Data Protection Directive in order to satisfy regulatory requirements specific to each business sector or to obtain the certifications requested by clients.

Management and industry procedures

The internal control system also depends on subsidiaries implementing TOPS (Teleperformance Operational Processes and Standards), BEST (Baseline Enterprise Standard for Teleperformance), as well as business standards such as the COPC (Customer Operations Performance Centers) standard or the French Customer Contact Center Service standard.

This system is based on international management processes such as the Six Sigma approach. Since 2018, the Group has been systematically developing the use of this methodology, providing training for all its managers, so as to develop a common language grounded in the notions of measurement, analysis and control. This development plan is described in section 2.3.2 *Human-resources development*.

The standardization and application of these procedures and standards enable us to make our global network more internally consistent, while providing greater control over our operations.

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Information sharing

The Group has a policy of internally releasing all relevant financial or operating information enabling employees to perform their job.

Under the responsibility of a dedicated department, key employees can share knowledge, know-how and best practices within the Group *via* intranet. This global knowledge management system encourages those involved to exchange and circulate useful information.

Group information and procedures are also regularly communicated to the managers of all subsidiaries at international seminars or presentations. These rules are also reiterated at Company Board meetings. Subsidiary executives are expected to communicate instructions from Group management to their employees.

The heads of corporate support departments also inform their teams of specialized personnel at meetings and training sessions.

Risk management system

Definition

In the operation of its business, the Group is exposed to a variety of risks *that could affect the Company's personnel, assets, environment, objectives or reputation.*

Risk management is a lever for anticipating the main potential threats to the Group, whether internal or external, *in order to preserve its value, assets and reputation, help it achieve its targets, ensure that actions taken are consistent with Group values and rally employees in support of a shared vision of key risks*.

Organizational framework

The risk management system depends on dedicated management tools, procedures and risk managers as described in the introduction to this section and under 1.2.1 *Risk factors*.

Group management is particularly vigilant when preparing and circulating these management tools. These tools enable management as well as each subsidiary to implement the measures and procedures necessary to manage our business and prevent risks, with regard to the rules that define Teleperformance's objectives and strategy.

This monitoring process, along with the operating priorities and the management controls to be adopted with respect to the analysis of these risks, is reviewed with all Group managers, meeting together as a group or at the time of Board meetings or management meetings.

Process and control

Key risks are identified and analyzed under 1.2.1 *Risk factors* in this section, along with the measures that can be used to limit their consequences. Key risks are monitored by the Group management.

In addition, a formal analysis of the key procedural points for oversight related to subsidiaries' financial reporting was carried out in February 2018 on the basis of the self-assessment internal control scheme, described in point *Process of preparing accounting and financial reporting* in this section.

The results of this analysis, as well as related monitoring, were presented during Audit & Compliance Committee meetings in April, July and November 2018.

In 2019, the Group intends to carry on with its process for generalizing and formalizing risk mapping based on the internal-control self-assessment process, for application in all of its subsidiaries.

Control activities

In addition to measures already listed under 1.2.1 *Risk Factors*, the current paragraph indicated centralized and decentralized activities taken in order to limit the risks liable to affect the achievements of our objectives. Control activities are designed both by the Group's management through centralized control procedures and by local management through decentralized control procedures.

Centralized control procedures

The internal control procedures centralized at headquarters cover areas common to all companies within the Group. These procedures involve finance, legal, IT and sales activities.

Financial procedures

Section 1.2.3.5 provides details of the financial procedures related to the processing of financial information.

The Group's policy for managing foreign exchange and interest rate risks, which aims to limit these risks, preserve sales margins and control interest charges, is presented in the "Risk factors" section.

Legal procedures

As part of its responsibilities, the Group Legal Department oversees the Group's compliance with applicable laws and regulations in the countries where it operates, through its local network of lawyers. It also plays a central role in monitoring changes in laws and regulations and advising the various Group entities.

The Group's Legal Department has for several years implemented a monitoring system for the trademarks used and registered by companies within the Group, and in particular a system for a worldwide monitoring of our corporate name, our domain names, the "Teleperformance" brand name and other flagship brands of the Group. The purpose is to be able to contest registrations or use of trademarks or other intellectual property rights by competitors and to avoid misuse of these assets, especially on the Internet.

A procedure defining the powers of the subsidiary CEOs to commit their subsidiaries legally vis-à-vis third parties has been implemented under the supervision of the holding company's Legal Department and the Group's senior management.

In a drive to reduce the legal risks inherent in client contracts, the Group defined a series of best practices for certain provisions in client contracts that present a particular risk and for bids in response to requests for proposals. Any departure from these rules requires specific approval from the relevant CEOs. In addition, all global contracts with clients are reviewed by the Group's lawyers before being signed, such that risks are limited and drawn to the attention of management.

Major litigation or litigation risks are monitored directly or coordinated by the Group Chief Legal Officer, who is assisted by a local network of lawyers.

With respect to the protection of personal data, the Group applies a global policy in order to ensure that personal data is collected, processed and transferred within the Group in accordance with applicable legislation.

Since 2013, the Group's Legal Department has implemented a system to monitor and manage the legal affairs and legal teams of its subsidiaries and holdings throughout the world.

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IT and security procedures

The Group has streamlined its security technology to reflect best market practices and to introduce the technology required contractually by its clients or pursuant to applicable regulations. This technology aims to reduce the introduction of malware, protect personal data and detect and prevent intrusions.

All personal data is collected and processed in accordance with applicable laws and the Group's Global Essential Compliance and Security Policies (GECSP) applicable at each Teleperformance site, specifically designed to prevent potential acts of fraud or breaches of security standards.

The third-party certifications requested by clients and obtained by Group subsidiaries also serve as a guarantee that the application of strict control procedures will be verified in order to ensure compliance with security and/or quality standards and processes.

The Group has a large, global operational team composed of specially trained IT, compliance and security experts tasked with identifying and assessing security risks and resolving and remedying security issues. This team implements comprehensive anti-fraud programs for the duration of business relations with Group clients and their customers. These programs focus on technological innovation, such as rapid detection of fraud and secure exchange of identifiable personal information between the caller and the customer.

The Group's Global Essential Compliance and Security Policies also include physical security procedures in our contact centers.

Sales procedures

To manage its sales processes, Teleperformance has created a set of best practices to follow in order to standardize the approach to managing requests for proposals. Key international requests for proposals (RFPs) are handled directly by specialized staff.

Decentralized procedures

Local internal control procedures are decentralized at the individual subsidiary level, where the management team is responsible for their implementation to prevent risks and comply with local legislation. The team also ensures that these procedures operate smoothly, in accordance with instructions given by senior management, which are reviewed at the meetings of each subsidiary's Board of Directors or equivalent body.

Oversight of the internal control system

Group senior management

The Executive Committee monitors the internal control system to ensure that the system is relevant and suited to the Group's objectives. The Committee incorporates the Group's support functions and linguistic regions management and is supervised by the Board of Directors.

This includes regular reviews on the part of management and supervisory staff. It falls within the scope of their day-to-day activities and ensures that each organizational process is consistent with the Group's vision and strategy.

The role of internal audit

In 2018, audit assignments were carried out in Group subsidiaries by the Internal Audit departments of the three main divisions (finance, legal and compliance and operations), according to the annual audit plan and priorities set by management during the year. These audits focused primarily on the control procedures implemented at local level.

As part of its work, the Internal Audit team defines action plans with each subsidiary's management, under the supervision of Group management, to ensure that internal control procedures are continually improved.

1.2.3.4 The parties involved in internal control

The risk management and internal control departments form an integral part of the Group's organization.

The Board of Directors

The Board of Directors is charged with several tasks: it upholds the interests of employees, implements the Company's policy and performs the necessary checks and verifications. The Board also represents shareholders.

Pursuant to its duties, the Board of Directors closely monitors the Group's results on a regular basis, and reviews all types of risks (financial, commercial, operational, legal or personnel-related) relating to its business.

Audit and Compliance Committee

The Audit Committee, the organization and functions of which are explained in section 3, is responsible for preparing the control procedures carried out by the Board of Directors on accounting and financial matters and on the process of preparing the financial information and of risk management.

The Audit & Compliance Committee actively monitors areas within its remit. Based on the information it receives, this monitoring allows it to intervene at any time deemed necessary or appropriate and may lead it, where it detects warning signals as part of its mission, to discuss the matter with senior management and to convey the appropriate information to the Board.

The Executive Committee and local management

The Executive Committee includes the linguistic region and support managers.

The Executive Committee is responsible for devising and monitoring policies and procedures to enable the Group to achieve its various objectives, and control procedures to make sure that these internal rules, together with all the rules governing the Group's business and corporate activities, are followed.

Guidelines and procedures are communicated to the subsidiaries' local management, which is responsible for implementing them with the support of regional, operating and support managers.

The Global Compliance and Security Council

The Group Global Compliance and Security Council chaired by the Deputy Chief Compliance Officer and Chief Privacy Officer meets to review any security incidents and analyze the potential risk of such incidents.

To manage these functions proactively, a Global Privacy Office was created, as well as a Global Technology and Privacy Committee.

The functioning and management of these committees, and the various parties involved, are described in paragraph *Personal data protection and security*.

The Group Internal Audit Department

The Group is audited internally by a central team that reports to the Group Deputy Chief Executive Officer and Chief Financial Officer, who is a member of the Executive Committee. The Internal Audit Department also reports to the Audit & Compliance Committee as part of its duties.

The Internal Audit Department helps develop internal control tools and benchmarks. It carries out the missions included in the annual planning cycle approved by Group management and reviewed by the Audit Committee. The summary report on the accomplishment and findings of the assignments together with the stage of completion of action plans are presented to the Audit & Compliance Committee and shared with the auditors.

The Legal & Compliance and Operations departments also have an internal audit team, which presents its findings to the Executive Committee.

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Departments and employees

Each department is involved in internal control by drafting and following policies and procedures designed to meet the Group's various goals, as well as by ensuring compliance with related control procedures and rules concerning the Group's business and operations.

Each employee is also involved in the internal control process, according to their respective level of expertise and access to information, so as to ensure its effective operation and regular review.

1.2.3.5 Description of the risk management and internal control system for published accounting and financial information

This section derives from the Application Guide for Internal Control Procedures Related to the Accounting and Financial Information Published by the Issuers, taken from the AMF Reference Framework.

Definition and scope

The accounting and financial information risk management and internal control system ensures the preparation of reliable information that fulfills legal and regulatory requirements.

The accounting and financial internal control system encompasses the processes used to manage and produce published information as well as the system for managing risks that could affect these processes, *i.e.* that could affect the reliability, due transfer and completeness of the information.

Within the scope of preparation of the consolidated financial statements, the accounting and financial internal control process encompasses the parent company and consolidated companies ("the Group" as defined above).

Management processes in the accounting and financial organization

Organization and responsibilities

General organization

The Finance Department has a corporate practice and an operational practice. These two practices manage the organization of accounting and financial matters within the Group.

Corporate and operational practices

Within the corporate practice, dedicated teams of specialists ensure the implementation of accounting and financial management, under the supervision of senior management, in the following areas: consolidation and reporting, treasury, internal audit and financial communication.

The consolidation and reporting teams have joined together and are now managed by a single department, which also supervises the accounts of the holding company in Paris.

The Treasury Department processes and centralizes movements of the Group's funds, manages its means of financing and hedges exchange rate and interest rate risks.

The Internal Audit Department reviews the internal control processes inherent in published accounting and financial information.

The department dedicated to investor relations and the market reporting system is described below in the paragraph entitled *Financial communication*.

The operational practice includes the Chief Financial Officers in charge of the linguistic regions and specialized services.

Responsibilities

The preparation of the Group's consolidated financial statements is the responsibility of the Group Chief Financial Officer, who relies on the Chief Financial Officers of the Group's linguistic regions and subsidiaries. The latter, along with senior management, are in charge of implementing a financial organization that conforms to Group best practices and ensures that accounting and financial information is reliable and consistent for the purpose of the financial statements published by the Group.

The information system and management tool

The consolidation of accounting information, monthly reporting and budgets are managed on a single information system used by all Group subsidiaries.

This Group information system was implemented in order to meet information security and reliability requirements. It enables a detailed monthly financial report to be produced using the Group's model. It also allows a precise analysis of the formation of cash flows and results and compares them with budgets.

The Group information system is continually being updated in line with the Company's requirements in terms of organization and management indicators.

Accounting standards

The Group's accounting standards comply with IFRS issued by the IASB and adopted by the European Union. These standards have been used as the guidelines for preparing the consolidated financial statements since 2005. All consolidated subsidiaries are required to apply them.

The Chief Financial Officers of all subsidiaries are familiarized with the accounting definitions and principles, which may be consulted on the Group consolidation and management system, to ensure that they are applied consistently across the Group and that all financial information complies with such standards. An Accounting Guide setting out the standards applied in the preparation of the consolidated financial statements may be downloaded from the Group intranet site.

The Group Finance Department, with the help of the statutory auditors, keeps a constant watch on new IFRS under development, in order to alert management and anticipate their impact on the Group's accounts.

The statutory auditors

The statutory auditors of the parent company carry out a limited review of the consolidated financial statements for the six months ended June 30th and a full audit of the parent company and consolidated financial statements for the year ended December 31st.

Senior managers must concert with the auditors, as the former are responsible for the preparation of the financial statements and the implementation of accounting and financial internal control systems.

The auditors took part in all Audit Committee meetings for the 2018 financial year. They informed the Audit Committee of their work on Group procedures, presented the Committee with their conclusions on the financial statements and reported on the key points raised during the audit. The auditors also presented their audit plan to the Audit Committee.

Audit and Compliance Committee

Matters related to financial information that were reviewed at Audit Committee meetings in 2018 are described in the section concerning the work of the Board of Directors.

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Process of preparing accounting and financial reporting

Operational processes related to the production of accounting and financial information

Group procedures and best practices have been established in respect of the main operational processes used by subsidiaries for the production of accounting and financial information, particularly sales, payroll, purchases and fixed assets, in order to ensure that such entries are monitored and that they comply with the authorization and accounting rules set out in the AMF Reference Framework application guide.

Use of the application guide

The Group uses the *application guide* to review internal control procedures for the main processes used to post entries in the accounts, by implementing a self-assessment system for each subsidiary.

Self-assessment questionnaires taken from the *application guide* and adapted to the Group and its business are completed yearly by all Group managers and Chief Financial Officers. The action plans put in place following this self-assessment are monitored by the Internal Audit Department. The results of the questionnaires and information on the monitoring of action plans are provided to Group management and presented to the Audit & Compliance Committee. A selection of the answers to the questionnaires from the main subsidiaries is also checked by those subsidiaries' auditors.

These questionnaires enable each subsidiary to review its financial and accounting information internal control procedures and to prepare the confirmation letters signed by the subsidiaries' directors and forwarded to Group management.

Accounts closing

The process of closing the Group's accounts involves checks at every information reporting and processing stage, in accordance with a schedule set by the Finance Department and communicated to all subsidiaries.

Information forwarded by subsidiaries is inspected by the head office consolidation staff, who eliminate internal transactions, test for consistency and check the items that pose the greatest risk.

The accounts are consolidated at Group level, without any intermediate consolidation stage. The Group Finance Department therefore has sole authority to make consolidation entries.

The published consolidated financial statements are prepared by the Group Finance Department on the basis of the largest subsidiaries' audited financial statements.

The main accounting options and estimates used by the Group are reviewed with the auditors before the accounts are finalized.

Approval of the accounts

The subsidiaries' Chief Executive Officers give Group management a formal commitment, expressed in a letter of representation, that the subsidiary's financial statements present a true and fair view of the subsidiary's affairs, that they use the AMF *Reference Framework*, that no fraud has been detected and that all legal and regulatory provisions have been complied with.

Finally, the consolidated financial statements are presented by the Group Chief Financial Officer to the Audit & Compliance Committee. Within the purview of its responsibilities, the Committee examines them in preparation for the meetings and deliberations of the Board of Directors, which reviews and approves them.

Financial communication

The Group Finance Department, *via* its investor relations department, sees that all information is provided in accordance with market requirements, within the legal time frames and under the conditions stipulated by law and regulations in force, thus satisfying market requirements.

Teleperformance applies best market practices in this area. The Group provides shareholders with an extensive database of information on its activities and the latest news *via* its website at www.teleperformance.com.

The Group also organizes regular meetings with the financial community, not only on the occasion of result disclosures, but throughout the year at the major European, US and Asian stock exchanges.

1.3 VIGILANCE PLAN

In accordance with Article L.225-102-4 of the French Commercial Code, the Teleperformance Group vigilance plan ("Vigilance Plan") is designed to present the reasonable vigilance measures implemented Group-wide in order to identify the risks and prevent serious harm to human rights and fundamental freedoms, health and safety and the environment resulting from the operations of the Company and the companies it controls within the meaning of Article L.233-16 (II) of the French Commercial Code, whether directly or indirectly, and from the operations of suppliers or subcontractors with which an established business relationship is maintained, where such operations form part of this relationship.

Teleperformance employs approximately 300,000 people in approximately 80 countries and therefore carries on its business in a wide range of, sometimes, complex economic and socio-cultural environments liable to generate risks that fall within the scope of the Vigilance Plan.

Teleperformance is determined to ensure that the Group's core values are applied and upheld, not only by all managers and employees, but also by the suppliers and subcontractors with which it has an established business relationship. While compliance with applicable laws and regulations in each of the Group's operating countries is conducive to safeguarding the objectives pursued by the Group and the Vigilance Plan, in 2011 Teleperformance joined the United Nations Global Compact, thereby committing to abide by the principles of the Universal Declaration of Human Rights.

The Vigilance Plan covers three areas: human rights, health and safety, and the environment. Various working groups comprising representatives of the Compliance, Sustainability & Responsibility, Information System Security, Procurement, Internal Audit and Legal departments and senior management, are involved in drawing up and implementing the Plan.

A number of tools and procedures have already been introduced Group-wide, and certain information and procedures are described in the Teleperformance Registration Document. Other tools and procedures are currently under review and will be enhanced in order to meet new regulatory requirements and make allowance for the Group's new consolidation scope. In 2018, Teleperformance introduced an improved vigilance system.

The measures covered by the Vigilance Plan concern the following five areas: (i) risk identification and mapping, (ii) deployment of systems for mitigating risk and preventing serious harm, (iii) risk assessment procedures, (iv) establishment of a hotline policy and internal reporting system and (v) system for monitoring measures in place.

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1.3.1 A risk map designed to identify and analyze risks and establish a risk hierarchy

The main risks identified by the Group under the Vigilance Plan involve serious harm to human rights and fundamental freedoms, health and safety and the environment. The risks identified as such will be documented within the framework of the Group global risk map.

1.3.1.1 Risks of serious harm to human rights and fundamental freedoms

As a Group that operates in approximately 80 countries, acutely aware of the diversity of socio-cultural environments within which it operates, Teleperformance promotes respect for all internationally recognized human rights and fundamental freedoms.

The Group's success and reputation are closely related to how Teleperformance conducts all its business activities in a responsible manner in accordance with its core values.

Teleperformance has identified two levels of issues regarding the infringement of human rights and fundamental freedoms.

- Within the Group, Teleperformance strives to uphold the principles related to fundamental labor rights, in particular:
  - non-discrimination in respect of employment and occupation (hiring, promotion...);
  - prohibition and elimination of all forms of forced or compulsory labor;
  - upholding freedom of association and the right to collective bargaining.
- On the outside, the Group is committed to exercising vigilance in identifying potential adverse impacts, whether direct or indirect, of its business in order to prevent and, if necessary, rectify such impacts. The Group asks each of its subsidiaries to work with suppliers and subcontractors that agree to comply with the Group's requirements in this area and who abide by the Supplier Policy[1].

  The behavior expected of suppliers and subcontractors with regard to human rights covers the following issues:
  - respect for human rights,
  - prohibition of child labor,
  - prohibition of forced and compulsory labor,
  - elimination of all forms of discrimination in respect of employment and occupation,
  - occupational health and safety,
  - freedom of association and the right to collective bargaining.

1.3.1.2 Risks of serious harm to health and safety

Risks to health and safety can materialize at any stage of the value chain. Among the potential victims of health and safety risks, the Group includes its employees at their place of work, Group clients and their customers. Teleperformance has identified the following main health and safety risks:

- for its employees:
  - occupational safety,
  - eliminating the risks of industrial accidents and occupational illness;
- for its clients and their customers:
  - personal data security.

1.3.1.3 Risks of serious harm to the environment

Teleperformance's business activity is non-polluting. Nevertheless, Teleperformance's global Environmental Policy[2] and the practical implementation of that policy are designed to reduce the Group's carbon footprint through sustainable measures that prioritize the circular economy in order to enable future generations to meet their own needs. Teleperformance seeks to foster awareness among all its employees and encourages them to adopt a set of environmentally-friendly behaviors at the workplace (reduce energy and paper consumption, etc.) and while performing their work duties outside the Company (minimize air travel, use public transport, etc.).

The risks of serious harm to the environment include the following events and risks:

- pollution: gradual or accidental pollution of the air and soil;
- resource consumption: excessive consumption of resources (water, electricity, paper, etc.).

On the supplier and subcontractor side, harm to the environment includes the risks of pollution, damage to ecosystems, waste of natural resources and dependence on fossil fuels.

1.3.2 Tailored measures to mitigate risks and prevent serious harm

Teleperformance has introduced measures to mitigate risks or prevent serious harm that are tailored to different circumstances. These measures are deployed at the Group and subsidiary levels, as well as with suppliers and other stakeholders. They are adapted in accordance with changing circumstances or risks identified in accordance with audit findings and messages reported *via* the various hotlines already set up or undergoing deployment.

These mainly consist of the following codes and policies:

- Code of Ethics;
- Code of Conduct, including Anti-corruption and influence peddling;
- Environmental Policy;
- Equal Opportunity Policy;
- Privacy Policy;
- Health and Safety Policy;
- Supplier Policy;
- Global Essential Compliance and Security Policies.

(1) The Group Supplier Policy, which is currently under review, is available on the Group's website.
(2) See 2017 Registration Document and Group environmental policy available on the Group's website.

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1.3.3 Procedures for periodic assessment of the situation of the subsidiaries, suppliers or subcontractors with which an established business relationship is maintained

The Group has set up procedures for assessing its subsidiaries, suppliers and subcontractors. These procedures are conducted by Group teams or in consultation with external organizations in order to identify and prevent risks of serious harm to human rights, fundamental freedoms, health and safety.

Suppliers and subcontractors shall be periodically assessed, at subsidiaries' level, in accordance with the Group Supplier Policy. On the basis of the supplier assessment process and the replies made to the related questionnaire, supplier risk is assessed with regard to supplier practices in relation to human rights, labor rights and combating corruption.

In 2018, the Internal Audit Department conducted a review of compliance of the Group's sites with the local regulations concerning health and safety measures. This review has been made with the Compliance Department.

The Compliance Department conducts every year a number of annual compliance and security audits.

Since 2008, Teleperformance has measured employee satisfaction *via* the *E-Sat* **E**mployee **Sat**isfaction Survey. The aim of the survey is to gain a better understanding of how employees view the Group's business activity and their contributions towards it. The survey is conducted by a team focused on continuously improving the methods and processes used as well as on the results obtained.

By giving employees a chance to express their expectations and potential criticisms, E-Sat helps to improve working conditions and foster job fulfillment. Accordingly, action and improvement plans are drawn up, implemented and monitored in each subsidiary under the responsibility of the local HR director. In order to ensure continuous improvement of these plans, progress on each project is monitored on a monthly basis by a dedicated head office team.

1.3.4 Hotline policy for reporting the existence or materialization of risks

Teleperformance fosters a culture of openness and dialog that allows each person to express their point of view and voice their concerns. Employees are free to approach their line manager, human resources manager, corporate counsel or compliance officer.

The Group is currently rolling out a hotline policy and internal reporting system to encourage employees to report risks. This is similar to the Global Ethics Hotline Policy designed to encourage employees to report the existence of conduct or situations in breach of the Code of Conduct, including anti-corruption and influence peddling.

1.3.5 System for monitoring measures in place and assessing their efficacy

Teleperformance has continued to strengthen its organization, procedures and monitoring tools with regard to human rights, health and safety and the environment in order to verify the due application and continuous improvement of the Vigilance Plan:

- internal reporting system and indicators for monitoring the implementation of measures in place (confirmation letter from subsidiaries, employee and customer satisfaction surveys, etc.);
- information and training sessions (understanding of the law, the Group Vigilance Plan, Supplier Policy, etc.) provided to senior managers and employees;
- periodic audits;
- creation of a crisis management unit ensuring that all relevant persons at Teleperformance are duly informed and correctly deployed in the event of an incident, discussion with stakeholders and implementation of corrective or adaptive measures;
- discussions with stakeholders and implementation of remedial or preventive measures;
- organizational system headed by the Chief Administrative Officer, whose remit primarily includes compliance, sustainability & responsibility, and human resources. The Chief Administrative Officer reports to the Group Chairman and Chief Executive Officer and the Group Chief Legal and Compliance Officer.

  He assesses the results obtained in connection with the Vigilance Plan and reports to the Audit & Compliance Committee of the Board of Directors on progress with measure.

  This organization also includes a specific team in charge of drawing up the materiality matrix on the basis of discussions held with stakeholders at the Group's subsidiaries, which identifies and analyzes issues in the same areas targeted by the Vigilance Plan.

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2.1 GROUP OVERVIEW AND BUSINESS MODEL

New uses relating to the simultaneous development of the Internet and smartphones have profoundly changed the business-client relationship. Consumers now have the power. Connected at all times, they seek instant access to brands to obtain **all kinds of information on the go, *via* their preferred communication channel (voice, chat, SMS, social media, etc.**).

The gradual yet constant development of multi-channel communication is therefore now a requirement, while social media amplifies consumer satisfaction (or dissatisfaction) towards the brand or distributor. Brands are therefore faced with more independent, educated and involved consumers, who need to be taken into account with regard to these new tools and behaviors.

In light of this growing complexity and the resulting technological sophistication, consumer brands are having to rethink their approach to customer relations.

Since its creation, the Teleperformance Group has been at the very heart of this challenge. A true partner to companies for multichannel customer experience management, Teleperformance has refined its business model in order to meet the technological and human challenges of its customers and provide them with cutting-edge data security and data privacy solutions.

The diagram below summarizes the Teleperformance Group business model:

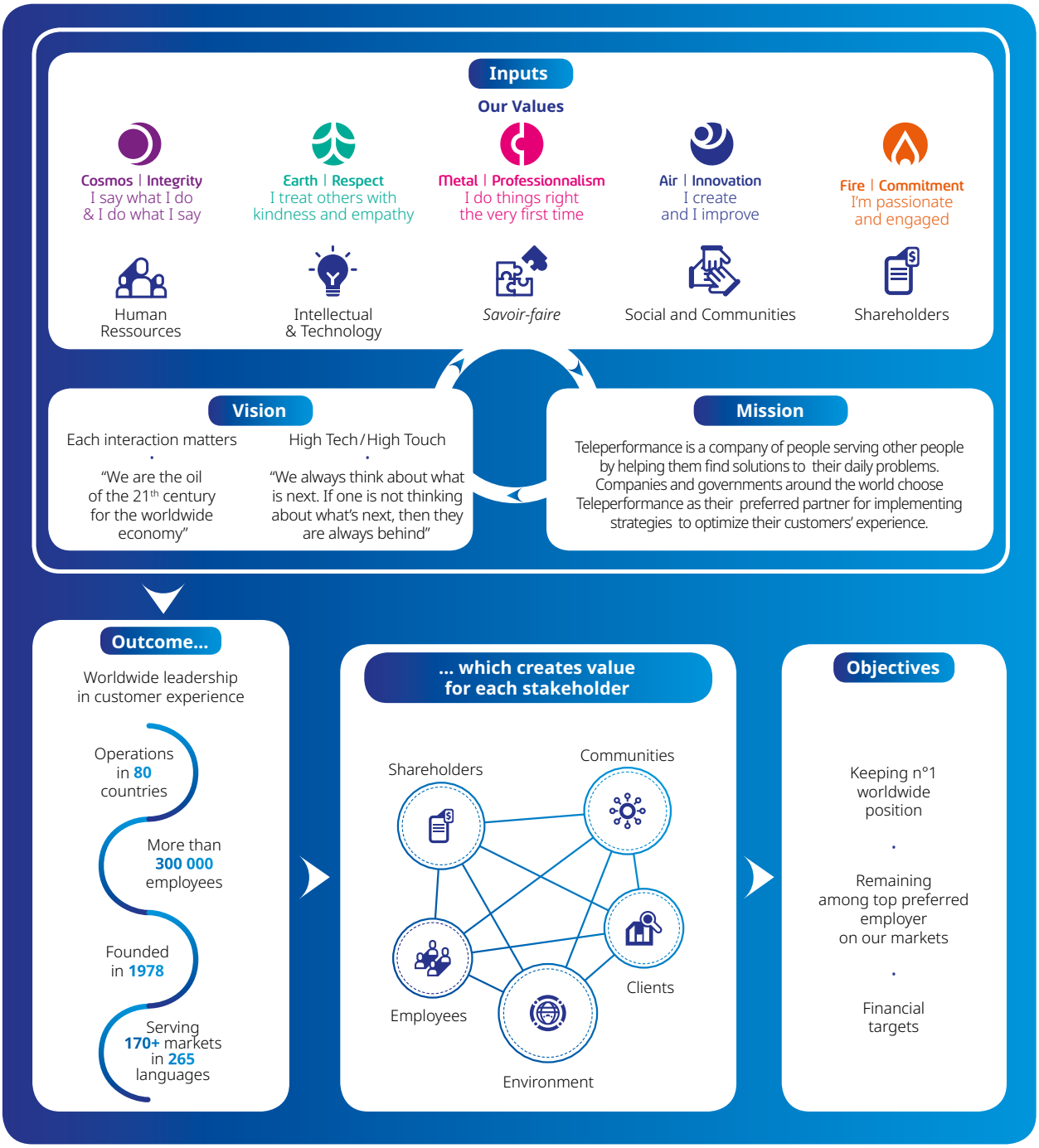

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- The Group has set itself the **task** of "helping brands and businesses find solutions for their customers' day-to-day challenges". The Group therefore specializes in handling their relations with brands and governments.
- **The Group's vision is that,** in an increasingly automated world, driven by a growing need for efficiency and speed, **"Each interaction counts"**. This slogan illustrates the *high-touch* strategy rolled out in 2018 (cf. section 1.1.2 A *"High Tech / High Touch" corporate outsourced services management world leader in full evolution*) and shows that Teleperformance is continuing its digital transformation by seeking out, hiring, training and supporting the growth of its employees. Teleperformance also contributes to a smoother, more secure globalized digital economy, which is becoming increasingly complex.
- **Teleperformance makes use of a range of resources** in order to achieve its objectives, be they technological, corporate, financial, or relating to human resources, founded on expertise. They are presented in the diagram above and include all of the resources and assets used to achieve the Group's objective. These assets and resources are deployed in strict compliance with the Group's values, which must be observed throughout the world in all of its locations and departments.

  These values form the foundation of the Group and its unique set of standards:

  - **integrity:** *I say what I do & I do what I say;*
  - **respect:** *I treat others with kindness and empathy;*
  - **professionalism:** *I do things correctly the first time;*
  - **innovation:** *I create and I improve;*
  - **commitment:** *I am passionate and committed.*
- **Teleperformance has become the global leader** in the outsourced customer experience market and operates on every inhabited continent around the world. With a foothold in 80 countries and more than 400 centers, **the Group employs more than 300,000 people** and supports the lives of 1 million people around the world. Teleperformance serves more than 850 customers on 170 separate markets, covering many of the 500 biggest global companies, in 265 languages. In 2018, Group revenues amounted to €4.4 billion. A detailed description of Teleperformance's activities and markets can be found in section 1.1 *The Group*.
- Over the last few years, the Group has posted significant growth, doubling in size primarily through organic growth, however also thanks to target acquisitions. This growth, combined with an improvement in profitability and free cash flow have made the Group a success, which benefits all of the Group's stakeholders.
- Below is a description of how the Group creates value for its stakeholders: It is based on the **universal principle of individual satisfaction: employee satisfaction is the first step in ensuring consumer satisfaction, and therefore that of Teleperformance's clients. This "satisfaction chain" needs to work properly in order to be able to create value for the Group's other stakeholders** (communities, lenders and shareholders).

  There is a strong and sustainable correlation between these two factors on all of the Group's markets. It sits at 0.9.

  - Quite logically, **the focus placed on the Group's 300,000 employees,** their working conditions, compensation, training and management are the cornerstone of the Group. The Group's objective is to make each interaction count: by offering in-depth training to its employees, it helps them strengthen their emotional intelligence and well-being. Teleperformance has rolled out a whole series of initiatives and instruments in this area, enabling it to monitor progress and ensure this objective is reached, in a line of business that has its own unique demands.
  - **Customer satisfaction is, without question, an essential part** of the Teleperformance business model. It is shaped by the quality of the teams, their language proficiency and their technical and digital capacity to provide end users with a fast and accurate response. It relies on flawless organization and discipline allowing continuous and consistent customer service. The security of data entrusted to the Group is a key part of the quality of the relationship. All of these aspects are subject to rigorous procedures and regular measures.
  - Teleperformance operates in many countries and therefore participates in developing local community support policies, by providing long-term support in the education sector or by helping more disadvantaged individuals. In addition, Teleperformance offers ad-hoc support during one-off events, such as climate disasters that may hit the countries or regions in which the Group is established.
  - Despite the Group's low environmental impact, it deploys **specific policies to reduce its consumption of electricity, water and paper. Teleperformance also prioritizes the reduction of its carbon footprint** by limiting air travel whenever possible, and by supporting local initiatives aiming to encourage Teleperformance employees' to pool their daily commutes.
  - In the financial sector, Teleperformance commits to **ethical business practices in line with its values**. The Group strongly believes that an efficient governance structure calls for excellence and profitable results. It is therefore committed to generating value for its shareholders, the key to the Group's independence, sustainability and development. The Group applies the corporate governance best practices. Lastly, it has implemented a fiscal policy in all the regions it operates in.
- The Group has set itself challenging goals. Its ambition is not simply to maintain its position as the **undisputed market leader, but instead to take the lead in all areas in relation to its competitors.**

In order to accomplish this goal, Teleperformance wants **to maintain its status as the sector's preferred employer on a global scale** and plans to build a headcount of between 400,000 to 500,000 employees in 4-5 years' time.

In terms of financial performance, the Group has confirmed its target of reaching by 2022 at least €6 billion in revenues at constant perimeter and an EBITA before non-recurring items of at least €850 million at constant perimeter.

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2.2 STRATEGY AND KEY NON-FINANCIAL RISKS

2.2.1 Strategy and governance

Corporate social responsibility and sustainable development are intrinsically integrated into the Teleperformance Group's **strategy**. They are based on three key non-financial challenges and targets and are subject to dedicated programs:

- being **the market's preferred employer**;
- **boosting customer satisfaction** with leading global brands that partner with Teleperformance;
- **being a responsible corporate citizen** within the Group's sphere of influence.

A **dedicated governance structure was set up** to ensure the success of these programs and objectives. In 2018, the Group appointed a *Chief Business Administrator*, responsible for Human Resources. Their mission is to implement a policy ensuring the Group maintains its status as the preferred employer on the market and improve its corporate responsibility performance. The Deputy Chief Executive Officer is responsible for implementing and monitoring these policies.

In January 2019, the Group appointed a Corporate Social Responsibility Director, under the direct supervision of the Deputy CEO. Their mission is to coordinate the Group's CSR strategy, harmonize the various CSR initiatives and closely monitor the whole.

The different programs are coordinated and monitored by a steering committee comprising support functions and industry experts, specialists in their respective fields. These working groups formulate action plans, internal directives and global programs, and monitor the outcome of initiatives rolled out.

2.2.2 CSR goals and key risks

While drafting its next CSR report, the Group organized a series of internal interviews with its management teams, aiming to identify the main non-financial challenges facing its business. This initiative aimed to identify the main ways in which the Group's business impacts its key stakeholders, namely individuals, communities and the environment. These impacts depend on the role fulfilled by the Group, as an employer, service provider and corporate citizen.

Discussions with representative stakeholders will continue along these lines over the coming months, in order to enable the Group to better understand each party's key challenges, and define the most relevant action to take.

This internal exercise made it possible to precisely define and prioritize the main issues facing Teleperformance on a daily basis. They are presented below, and help to highlight the main objectives that the Group has set for itself and to better assess the policies it implements in relation to these topics. The main financial and non-financial risks identified that make it possible to define these CSR goals and challenges are set out in 1.2 *Risks and control*.

The Group's key CSR challenges

	Our impacts on individuals	Our impacts on communities	Our impacts on environment
Our roles as an employer	Improve the quality of life and employability of employees	Provide local development opportunities	Promote environmental responsibility in the group
Our roles as a service provider	Promoting secure consumer access to reliable and fast information	Develop an ethical business practice	Provide services that reduce carbon emissions
Our roles as a corporate citizen	Ensuring diversity and equality of opportunity for our employees	Support communities where Teleperformance operates	Promote sustainable use of resources

All of these goals are in line with the United Nations Global Compact, which Teleperformance joined in 2011. The Group that all of its subsidiaries apply and comply with the its fundamental principles.
This is the most important global initiative in terms of sustainable development. It is based on a commitment by companies to implement the ten sustainable development principles, as follows:

Human rights	1. Support and respect the protection of internationally proclaimed human rights 2. Make sure to not be complicit in human rights abuses
International labor standards	3. Uphold the freedom of association and the effective recognition of the right to collective bargaining 4. Contribute to the elimination of all forms of forced and compulsory labor 5. Contribute to the effective abolition of child labor 6. Contribute to the elimination of all forms of forced and compulsory labor
Environment	7. Support a precautionary approach to environmental challenges 8. Undertake initiatives to promote greater environmental responsibility 9. Encourage the development and diffusion of environmentally friendly technologies
Anti-corruption	10. Work against corruption in all its forms, including extortion and bribery.

Teleperformance's commitment in this regard is reflected by the incentives it has introduced to adopt and improve the practices described in the Group Code of Ethics, Equal Opportunity Policy and Supplier Policy, all of which are based on Teleperformance values.

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2.3 AN EMPLOYER OF CHOICE

Teleperformance makes its employees the focus of its business. The Group is committed to being an employer of choice, an essential prerequisite in creating value for the various stakeholders. A happy employee is the first step in ensuring customer satisfaction, and therefore satisfying Teleperformance's clients.

To this end, the Group deploys a number of initiatives and tools in the areas of hiring, professional training and development, human rights, diversity and inclusion, wellbeing and work safety to monitor the progress and successful outcome of this goal.

The Group also launched a High Touch strategy that covers the entire human resources value chain. The High Touch strategy targets Teleperformance's employees and both direct and indirect customers and is illustrated by the catchphrase that reflects Teleperformance's identity and mission: "Each Interaction Matters". Teleperformance is pursuing its digital transformation by hiring, training, supervising and supporting the growth of its employees. As a responsible company, the Group is committed to fostering its employees' all-round development. To this end, it develops programs and processes to stimulate the Intelligence Quotient (IQ) and the Emotional Intelligence (EI) of the human mind.

Teleperformance plans to launch a specific training program on EI for all its employees in 2019. Hiring processes, job descriptions, evaluations and compensation criteria will be reviewed in order to take EI into account.

Teleperformance's High-Touch strategy aims to boost employee happiness and help it stand out from the crowd as a forward-looking company.

Teleperformance is fully committed to providing a unique work environment, and earns recognition from independent entities on a regular basis. For example, in 2018 ten Group subsidiaries were honored with awards from the *Great Place to Work®* Institute:

- three subsidiaries in the English-speaking region: in China, the Philippines and India, where the Group received the # 1 BPO in India Award for the 5th time by the Great Place to Work Institute;
- seven subsidiaries in the Ibero-LATAM region: in Brazil for the 9th consecutive year, in Mexico (for 2 subsidiaries), in El Salvador for the 5th consecutive year, in the Dominican Republic for the 4th consecutive year, in Colombia for the 1st year and in Portugal for the 8th consecutive year.

Competing companies must submit to a rigorous selection process to receive these awards. The ranking is based on employees' perception of their company (the Great Place to Work Trust Index© Survey) as well as company human resources management practices which are measured by a tool developed by the Institute.

Award and rankings given by independent entities on employee workplace satisfaction are now taken into account in the compensation scheme for executive officers (see section 3.2.2 *Remuneration of executive officers*).

2.3.1 Driving significant job creation

The information contained in this section concerns all Group consolidated companies unless otherwise specified.

2.3.1.1 Breakdown of total headcount by age, gender and linguistic region at December 31st, 2018

	Men	Women	Total	< 25 years old	< 35 years old	< 45 years old	> 45 years old
English-speaking and Asia-Pacific region (excl. USA)	38,390	40,431	78,821	33,926	32,714	8,298	3,883
Ibero-LATAM region	41,503	45,271	86,774	37,587	33,470	11,095	4,622
Continental Europe, Middle East & Africa	22,381	27,339	49,720	12,248	22,091	10,190	5,191
LLS excl. USA	27	56	83	16	38	22	7
Intelenet	36,371	21,773	58,144	23,981	27,111	5,739	1,313
Holding companies	27	28	55	3	16	17	19
Total excluding USA	**138,699**	**134,898**	**273,597**	**108,006**	**115,578**	**35,384**	**15,044**
United States			32,935				
TOTAL			**306,532**				

The breakdown of total staff by age and gender exclude the US subsidiaries, as local regulations prohibit collecting this data.

The Group's business growth mirrored a consistent increase in total staff over the last six years:

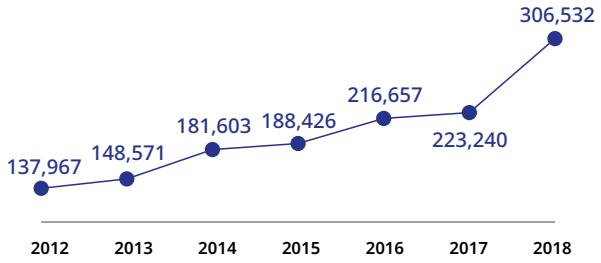

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2.3.1.2 Full-time equivalent workforce in 2018 by linguistic region

	2018 workforce	2018 payroll expenses *(in millions of euros)*	2017 workforce	2017 payroll expenses *(in millions of euros)*
English-speaking and Asia-Pacific region	91,013	1,150	84,225	1,159
Ibero-LATAM region	71,384	748	65,324	704
Continental Europe & MEA	39,979	739	36,670	668
LanguageLineSolutions	3,843	148	3,779	148
Intelenet	44,922	63*		
Holding companies	49	18	53	18
TOTAL	**251,190**	**2,867**	**190,049**	**2,575**

* *The payroll expense of Intelenet relates to the period from October 4th, 2018 to December 31st, 2018.*

Salaries are determined in accordance with the laws in effect in the countries in which the Group operates.

2.3.1.3 Change in total headcount in 2018 by type of employment contract

	Permanent contract	Fixed-term contract	Temporary	Total
AS OF 01/01/2018	**165,358**	**47,687**	**10,195**	**223,240**
Change in scope	56,619	2	0	56,621
Hiring	194,470	40,538	10,764	245,772
Lay-offs	-32,404	-4,299	-944	-37,647
Transfers	5,360	-4,642	45	763
Other departures	-145,133	-28,120	-8,964	-182,217
AS OF 12/31/2018	**244,270**	**51,166**	**11,096**	**306,532**

The Group is unable to determine the exact number of disabled employees working for the Group, given that this information is considered to be discriminatory in some countries, like the United States and Italy.

2.3.1.4 Employee compensation and loyalty schemes

The Group compensation policy is based on shared principles, and is applied in a decentralized manner in line with the regulatory framework and local labor and market conditions. This policy aims to:

- *attract and retain talented individuals;*
- *reward individual and collective performance;*
- *be fair and consistent in line with the Group's financial and operational objectives.*

Teleperformance regularly invites its most valuable managers into a profit-sharing scheme through a bonus performance share plan, in compliance with its rules of governance. These bonus share plans are allotted on a case-by-case basis and aim to reward managers' loyalty and solid contribution to the Group's development. This is an exceptional compensation scheme and is therefore distinct from the Group's general compensation policy applicable to all employees. A detailed summary of the performance shares allotted by the Group is presented in section 7.2.5.3 *Performance shares granted under no consideration*.

Certain group subsidiaries have set up local staff incentive schemes. For example, the operating subsidiary in France implemented an open-ended profit-sharing scheme.

As of today, Teleperformance SE that employs less than 50 employees, does not have profit-sharing schemes in place. Teleperformance SE, on a voluntary basis, is studying the implementation in 2019 of such schemes for its employees.

2.3.2 Human resources development

Employee development is the Group's central focus. It is essential in providing our direct and indirect customers with the best possible service. The Group is making significant investments in this area. This policy is based on a number of training and employee development programs offered to new employees and throughout their career.

The Group has developed specific on and off-site training programs for both agents and the management team. These training programs cover a wide range of subjects, from Teleperformance culture to customer-specific training, professional development, safety and security, compliance and confidentiality.

2.3.2.1 Employee training

Training is a key factor in managing the Group's human resources, particularly given that its business relies on a large workforce.

The Group largely attained its target of a 3% increase in training hours provided across the Group in 2018. 42,602,393 training hours were provided in 2018, representing an increase of 25%.

Training falls under four separate programs:

- *Teleperformance Academy for the training of agents;*
- *Teleperformance Institute for the training of managers;*
- *Teleperformance University for high-potential employees;*
- *Continuous training on the e-learning platform for all employees.*

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Teleperformance Academy

Specially designed for agents, Teleperformance Academy offers training that aims to optimize knowledge transfer and foster learning.

Since 2014, all new employees systematically attend an orientation seminar on their first day at Teleperformance, with a strong focus on group culture, values and safety.

Furthermore, training programs covering new campaigns are specifically provided to seconded agents, whether in order to support a new customer or the launch of a new product, or develop a new line of services. Depending on the specifications agreed upon with the client, these training sessions last on average between one week for simple operations to five weeks for more complex products requiring more in-depth knowledge.

In 2018, a total of 35,461,684 training hours were provided to agents *versus* 33,387,568 total hours in 2017. This represents 184 hours on average per agent in 2018 *versus* 179 hours in 2017.

Teleperformance Institute

Teleperformance Institute provides e-learning and "face to face" training to all Group management staff (supervisors, platform managers, operations directors, etc.).

In view of its global presence and desire to involve a maximum number of employees, the Group has developed a remote e-learning solution. For the sake of greater independence, the e-learning platform has been developed in-house since late 2011, and is available in the main Group languages. Thanks to this platform, Teleperformance employees were able to develop their leadership, communication, time management and project management skills. This represents 750,726 training hours in 2018, *i.e.* 1.8% of the total number of training hours in 2018, up from 1.4% in 2017.

This year, the training platform scored a resounding success with an average of 40,638 unique visitors per month (up from 31,435 in 2017). This performance may be attributed to the platform recast and expanded content offer.

In 2018, the Teleperformance Institute focused on five areas:

1) Developing the Six Sigma culture within the Group.

With the support of an external partner, certification training was provided to 126 group managers. 5,172 managers have obtained the first level of e-learning certification. The goal is to have 1,700 managers Yellow or Green Belt certified by the end of 2019.

2) Extending complementary training in "hiring" and "training fundamentals" to recruiters, instructors, account and quality managers, and training managers.

These courses were prepared in 2017, so that all supervisors would receive the same training and learn about the same basic targets during their first six months in their new post.

3) In 2018, a large majority of managers attended at least one course in Teleperformance safety standards. At the end of these e-learning sessions, every employee takes a test to assess the skills they've acquired. In 2018, as part of a drive to improve the Group's safety culture, access to online safety training was extended: more than 17,000 managers completed additional training.

4) Continuing to develop regional centers of excellence.

Selected supervisors complete a two-week course in best practices in their business line. Already well-established and recognized in the CEMEA region, these regional centers of excellence are currently being rolled out in China and the Philippines.

5) Continuing to roll-out the internal training quality standard (improvement of instructor training) and certification of Group subsidiaries.

In addition, over 1,000 training modules are available on the e-learning platform to help employees develop their skills in a wide variety of areas including hiring, soft skills and IT.

Teleperformance University

Teleperformance University is an executive program divided into six modules, three of which are provided face-to-face on-site and three *via* the e-learning platform:

- innovation, CX Lab and "Atlantic experience" (Lisbon, Portugal);
- marketing, solutions and strategy (São Paulo, Brazil);
- operations, IT and security (Salt Lake City, USA);
- social and environmental responsibility, NPS (Net Promoter Score) and Six Sigma (Manila, Philippines);
- finance (Athens, Greece);
- business development and final support (Guadalajara, Mexico).

Each module lasts one week and the whole training program is completed in ten months.

80% of the classes are delivered by senior leaders from Teleperformance. However, external instructors are also brought, including professors from renowned universities, who provide a more academic perspective.

This in-house university is geared towards high-potential managers aiming to become future senior leaders in the Group.

During the training, the multicultural and global scope of the Group is emphasized.

18 participants from 13 countries completed the training course over the academic year from September 2017 to July 2018. The next cohort, currently completing a course running September 2018-June 2019, has twice as many participants and has thus been divided into two groups.

2.3.2.2 Professional development

The Group aims to encourage employees' professional fulfillment, within a work environment that promotes performance and fosters skills development. Teleperformance has introduced a set of measures to help employees and drive their professional development.

Exclusively designed for Teleperformance employees, the JUMP program was rolled out in order to:

- promote career development within the Group;
- identify high-potential employees and prepare them to take on management positions;
- encourage leadership at every level of the business;
- encourage internal promotions.

This program is based on a dual training program offering both technical and behavioral training, as well as personal development plans.

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2.3.3 Creation of a work environment that favors wellbeing, health and safety

With over 300,000 employees operating in 80 countries, Teleperformance requires matters of health and safety to be handled with the same level of expertise and according to the same standards across all regions. The quality and safety of the working environment must enable Group employees to realize their potential.

2.3.3.1 Health and safety policy organization and approach

The safety management system implemented by Teleperformance aims to efficiently control risks and prevent potential staff injuries in the performance of their duties. The health and safety policy rolled out by the Group goes beyond local regulatory requirements. In addition to focusing on employer and employee responsibilities, it also aims to increase awareness of workplace hazards and promote the use of preventative measures for all parties involved.

Each Group entity has its own Health and Safety department, supervised by both the local management team and the central Health and Safety department.

The Teleperformance health and safety management policy aims to act as a consistent approach integrating risk assessment within the corporate culture. The central Health and Safety department works closely with each subsidiary through its direct involvement with the local management team, and *via* an operating relationship with all health and safety experts forming part of the Teleperformance global network.

Network of health and safety experts and training

One or more health and safety experts are appointed by the local managing director of each subsidiary. The main role of an expert is to ensure the subsidiary's compliance with the Group Health and Safety policy *via* the implementation of rules and procedures defined by the Group. In order to maintain a consistent approach and a high degree of compliance, the constant development of health and safety experts' expertise and skills is essential. In this regard, specific training sessions are provided covering the requirements and practices set out in the Teleperformance Health and Safety policy. In order to monitor and assess the network's expertise, the health and safety experts are asked to complete questionnaires throughout their training.

Staff training

Teleperformance aims to promote a health and safety culture and related expertise across all levels of the organization. As part of the orientation program, new employees complete mandatory health and safety training. The goal is to raise their awareness and knowledge of these areas from the very beginning of their assignment.

Video to raise awareness of health and safety challenges

In 2018, the Group created and released a teaching video on health and safety at work. In this fun and informative video, an executive manager explains that health and safety are crucial factors for any organization. The video is played in waiting areas at call centers, as well as in recruitment, relaxation and even operating areas. There are multiple language versions and is an efficient way to get key messages to everyone involved.

Local Health and Safety committees, risk assessment and site inspections

In an effort to strengthen the global organization and ensure consistency at the local level, every subsidiary has its own local Health and Safety committee. These local committees handle the collective issues facing the sites, enabling managers to efficiently implement the group Health and Safety policy at their entities.

One of the cornerstones of the safety management policy is the identification of risks facing the Group, on both a global and local level. Assessments are carried out at least once a year at each site in order to identify potential risks and formulate appropriate solutions to reduce them. The Group audits local risk assessments on a regular basis in order to improve their accuracy.

2.3.3.2 Supporting the local roll-out of the Teleperformance Health and Safety policy

Toolkit: safety directives

Teleperformance is committed to providing all of its employees and subcontractors a safe working environment, while reducing the risk of injury and illness to the extent possible. To achieve this, the Group provides all of its subsidiaries with a health and safety "toolkit" on its intranet. This includes directives and best practices on subjects such as evacuation drills, emergency containment, smoke detectors and alarms, emergency exits, and pandemic prevention plans. The health and safety experts are also given tools (models, best practices, etc.) concerning health and safety training provided to new employees, site inspections, and risk assessments. Furthermore, every year the Group examines local tools in order to identify new best practices to share with the parties concerned.

An excellent working environment: guidelines relating to work premises

The working environment is an integral part of an employee's life. Teleperformance aims to create a positive environment, focusing on wellbeing and culture at work, in which employees feel fulfilled. This includes open-plan spaces that encourage cooperation and discussions, fitness rooms on-site at subsidiaries, free bike parking spaces and healthy and varied meals in cafeterias.

Since 2009, Teleperformance has implemented a global standard for its sites, guaranteeing a healthy, safe and pleasant working environment. It covers 12 areas, including lighting, acoustics, IT, safety, team-focused management, sustainable development, cleanliness and wellbeing in eight zones, such as operating areas, relaxation spaces and cafeterias.

This standard includes plans and guidelines covering hiring, training, workspace design and shared or leisure areas. It is updated yearly on the basis of internal and external references, in order to guarantee compliance with market changes and trends, employee expectations and international safety principles.

Passion 4U: wellbeing and stress reduction

Group employees spend a substantial amount of time and energy at work. Teleperformance therefore plays a vital role in improving their health, wellbeing and, ultimately, their quality of life, both as an employer and as a contributor to the health of broader society. In this context, Teleperformance teaches its employees about health in order

to encourage them to make healthy decisions on a daily basis – at home, within their communities and at work.

The global Passion *4U* initiative promotes wellbeing and a better quality of life at work. By ramping up awareness of the benefits of adopting healthy habits and reducing stress, this program encourages the sharing of best practices between all of the Group's entities. All of the Passion *4U* initiatives are rolled out locally and include measures to reduce stress, promote work-life balance, encourage health and healthy eating, as well as ergonomics, fitness, sport, etc.

Main themes	Examples of the policies in place
Stress reduction	The stress inherent to any workplace can result in health and safety issues. Identifying stress factors is essential. In this regard, the Group focuses on creating ergonomic workspaces, relaxation areas, flexible schedules and programs to combat specific types of stress, aiming to encourage wellbeing and cultivate a feeling of belonging.
Work-life balance	A healthy work-life balance is essential for every employee. Having too little time to relax can give rise to stress and impact employees' health. Thanks to its staff management processes and programs, Teleperformance aims to bring balance back to its employees' lives, specifically through family-inclusive programs, childcare subsidies, flexible work schedules and telework solutions.
Health and healthy eating	Healthy eating, regular physical exercise and getting enough sleep can help employees reduce stress and illness, and have a better sense of wellbeing. Local campaigns are organized with a focus on specific issues, such as smoking, obesity, sleep disorders and hydration. Weeks dedicated to health initiatives are also organized. The Group provides access to health platforms, health specialists and dietitians, on-site doctors and nurses, and complementary healthcare.
Ergonomics	Given that the positions Teleperformance offers are predominantly sedentary, workplace ergonomics are an important health and safety factor. Through local and global campaigns, the Group aims to create a working environment that takes employee diversity into account with regard to size, height, age, and different working environments in terms of noise/hearing, lighting/sight, temperature and design.
Fitness	In order to promote its employees' wellbeing, performance and health, Teleperformance encourages them to do physical exercise through initiatives such as fitness, yoga and zumba classes at work, stretching exercises, encouraging them to ride to work, sports days and active breaks.
Sports club	Teleperformance fosters physical and emotional wellbeing as well as quality of life through games, fun and a spirit of camaraderie. The Teleperformance sports club is one of the most successful employee engagement initiatives. In 2018, the Group had 453 soccer teams, 156 volleyball teams and offered a wide range of other sports such as basketball, tennis, bowling, badminton and softball.
For Fun festival	Nine years ago, Teleperformance launched an ambitious and lively competition for employees looking to share their love of art, music, dance, short films and photography: the For Fun Festival. This annual global initiative showcases the Group's most talented employees. The objective is to create a fun, joyous atmosphere, encouraging a sense of pride in belonging to a group and helping to promote the Group's cultural diversity. In 2018, almost 6,000 employees from 28 different countries took part in this competition.

2.3.3.3 Workplace accidents

In 2018, the frequency rate was 6.8.

The work environment doesn't present any serious risks in terms of workplace accidents. In fact, excluding travel accidents, the vast majority of the rare workplace accidents were the result of slips or falls resulting in bruises or fractures. All workplace accidents and incidents are reported and recorded. Each of these accidents is also analyzed in detail to determine the root cause and continually improve the safety of the Group's employees and to reduce the identified risks.

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2.3.3.4 Preventing workplace accidents: audits and inspections

In an effort to ensure each entity's compliance with the Group's health and safety policy, a global, remote auditing system has been set up. Site inspections were also recently added. Depending on the level of maturity and the results obtained by each site, specific support from the Group or complete H&S audits are offered.

	Objectives	Methodology	2018 audits
Remote H&S audits	Remotely assess whether the key health and safety elements comply with the Group H&S requirements, identify discrepancies and prepare an action plan to rectify them.	Each company sends documents showing proof of its compliance with the Group's minimum requirements, via the Group's compliance platform. Each supporting document is examined remotely by a Group H&S auditor. Compliance reports are issued monthly to all managing directors relating to their entity, and every three months to the management team.	More than 250 sites audited in 2018. In 2019, additional sites will be audited as part of the Group's expansion.
On-site H&S inspections	Conducting a H&S site inspection and determining whether the key elements are satisfactory, or if any findings, whether positive or negative, have been drawn up for the Company.	These inspections are conducted by the safety and internal compliance audit team, trained in the most critical health and safety aspects and according to a two-stage approach: 1. Prior evaluation; 2. On-site inspections using an evaluation grid. The findings of the inspection are forwarded to the Company's management team, which then requests an action plan with monthly follow-ups. The overall findings are sent to Group management every quarter.	137 sites were inspected in 2018 (as of April).
Full audit and H&S support	Evaluating an entire site in order to assess compliance with Group requirements and international guiding principles and local regulations.	These audits will be conducted by the Group H&S team according to a two-stage approach: 1. Prior evaluation; 2. On-site audit using a comprehensive H&S audit evaluation sheet. The findings of the audit are forwarded to the Company's management team, which then requests an action plan with monthly follow-ups. The overall findings will be sent to Group management every month.	Launch of the process in 2019.
Compliance of H&S licenses	Verification that all sites have the health and safety licenses required by local legislation.	An initial investigation (phase 1) was conducted by each subsidiary in order to identify all of the licenses required for each site. Next (phase 2), each license identified was recorded in the internal system.	Phases 1 and 2 were completed in 2018.
Customer audits	The subcontracting policies of most major international clients consider the matter of employee health and safety important. In this context, customers conduct their own on-site H&S audits.	The methodology varies depending on each customer.	Data unavailable.

2.3.3.5 Work organization

Working hours

The Group's human rights charter sates that "working hours are capped at 48 hours per week, except for overtime, which is applied on an individual basis and always in compliance with local legislation".

Accordingly, the working hours of staff employed in contact centers and sales and administrative offices is organized in strict compliance with working time legislation, which varies from country to country.

Group employees work according to different procedures, mainly depending on clients' needs and local preferences, in compliance with the applicable statutory and regulatory provisions of each country. The Group may hire employees under full-time and part-time contracts and also hires temporary workers in order to achieve the flexibility required by its business operations, essentially in Continental Europe, Middle East and Africa.

The statutory number of daily and weekly working hours therefore varies considerably from one employee or country to the next.

The Group is committed to reducing absenteeism at its sites. Absenteeism is an ongoing measure of wellbeing and motivation. It is covered in a monthly report and a separate analysis per subsidiary, site and region. This indicator is reviewed at each subsidiary's Board of Directors meeting. The average rate of absenteeism was 6.8% excluding Intelenet in 2018, with a number of regional differences depending on the local social and regulatory environment: the English-speaking and Asia-Pacific region posted a rate of 7.6%, the Ibero-LATAM region 6.3% and Continental Europe, Middle East & Africa 6.6%.

WAHA programs

Core Services

Teleperformance's WAHA (Work At Home Agents) solution combines the services of highly qualified and effective agents, a flexible organizational structure, cutting-edge communications technology and the strictest security standards in the market.

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This service model enables all types of candidates to access agent functions:

- people in remote locations (rural areas);
- disabled people (difficulties getting around);
- people with a specific profile and not seeking to work at a traditional contact center (seniors, homemakers, etc.).

The WAHA training model guarantees agent excellence. The management of remote agents, which is the result of several years' application, has become particularly effective in creating close ties, developing loyalty to the Company and to the brand and improving efficiency.

The number of Teleperformance agents working under the WAHA program is growing constantly. However, this figure remains marginal: at December 31st, 2018, only 2,976 Core Services employees were working under this model.

An incentive policy to significantly develop this practice was implemented in 2018.

The development of remote work (telework) within the Group

Subsidiary	Examples of telework
United States, Indonesia	The WAHA model was developed several years ago. WAHA agents are generally promoted to these roles after having proven themselves are the Group's traditional contact centers.
India	Most of our WAHA agents are women, who appreciate this opportunity to achieve a better work-life balance.
Holding	In accordance with the French law, in 2018 the holding company implemented a master agreement permitting up two days of telework per week.

Specialized Services

The number of Specialized Services employees who work from home is very high. Indeed, the organization of the LanguageLine Solutions interpreting business is based on an efficient network of 9,600 interpreters (including both employees and third-parties), more than 80% of whom work from home.

2.3.4 Labor relations

Since its creation, Teleperformance has been developing its business on the basis of its convictions and values, while remaining committed to its social responsibility: the Group is aware of the role played by trade unions in the representation and promotion of employees' interests, and aims to build its reputation as an ethical company that applies good practices with regard to employee relations and complies with local regulations. Teleperformance maintains regular dialog with recognized trade unions and other employee legal representatives. Social dialog takes place at every level within the Company and may exist in different forms depending on the culture, customs, practices and applicable legislation in each country.

2.3.4.1 Social dialog

Multiple channels of dialog and communication

Although the corporate culture favors direct access to the Group's managers and executives, Teleperformance has set up a number of initiatives at its subsidiaries to encourage discussion and communication with employees.

Examples of initiatives to encourage discussion with employees

Initiatives	Regions	Solutions
Informal and confidential discussions with management	Germany, Tunisia, Greece	Offer employees the opportunity to talk about current operations at the site and share their views, without the involvement of their direct supervisor, and in a friendly atmosphere.
Formal discussion with local management teams and managers	Worldwide	Organization of regular meetings between management and staff representatives or, where they exist, trade unions.
	China	Monthly meeting with newly recruited employees
	Albania, Argentina, Colombia, United States	Regular Chat with management.
	Colombia, Egypt, Greece, Russia, Salvador, United States	Focus Group between agents and managers.
	United States, Canada	Deployment of an online communication tool enabling employees to anonymously share their concerns with HR and management.

Employee satisfaction

An extensive employee satisfaction survey (E-Sat) is conducted every year. First launched in 2008, the aim of the survey is to gain a better understanding of how employees view their work.

This survey is conducted by a team that ensures the continuous improvement of the method and procedures. An external partner provides the results of a benchmark survey covering all countries in which the Group operates, thus enabling each subsidiary to compare its results with those of the local market.

In 2018, 118,509 employees at 68 subsidiaries working in 47 countries (48% of the Group's total headcount excluding Intelenet) completed the survey.

Taking employee opinion into account serves as a means of improving working conditions and promoting their professional development.

Under the responsibility of each local Human Resources Director, action plans are drawn up and implemented in each subsidiary on the basis of the results. In order to ensure continuous improvement in results, progress on each project is monitored on a monthly basis by a dedicated head office team.

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Collective bargaining agreements

Certain group subsidiaries have a specific collective bargaining agreement. If no specific agreement exists, the labor laws in the country in question apply. Collective bargaining agreements are also regularly entered into each year with staff representatives. These agreements generally provide for the number of working hours, the notice period in the event of departure, salary increases, vacation time, the length of parental leave, payment of public holidays, or team rotas, etc.

In 2018, Teleperformance's subsidiary in France, Teleperformance France, entered into a majority collective bargaining agreement with three of its representative trade unions relating to negotiated collective contract termination at company level. During this procedure, Teleperformance France's management made the express commitment not to dismiss any of its employees for a twelve-month period following the first phase of departures under this agreement.

European Works Council

Launched in 2014 and officially registered in 2015, a Works Council currently comprising 19 standing members represents employees in the 18 European countries in which the Group operates. In 2018, the Works Council met Group management representatives three times, either in plenary session or in the form of a seven-member delegation (the officers), to discuss the economic and financial situation and major changes made during the year at European level.

2.3.4.2 Employee benefits

These benefits are managed locally, depending on the usual practices in effect in each country, and cover four main areas:

Bonuses

According to their financial performance, Group subsidiaries can decide to grant bonuses.

A bonus of €600 (net) was paid to all of the subsidiary's employees who receive gross wages of less than €30,000. 1,700 employees benefited from this one-off measure, *i.e.* over half of the subsidiary's employees.

Extra leave

Almost half of Teleperformance employees benefit from extra holidays in addition to the local statutory allowance. This additional leave varies in accordance with the corporate agreement specific to each Group subsidiary; for instance, it involves two extra days for all employees in Tunisia, 4-10 additional days in Germany depending on the facility, 2-5 days in the United Kingdom, to which up to 5 days may be added depending on length of service, and to up to 12 days in China and 25 days in the United States depending on length of service and seniority. Lastly, some subsidiaries grant exceptional leave for family events not covered by local legislation, for example five days' paternity leave in India, and time off for the wedding of a close relative in Colombia.

Subsidized meals

The majority of employees receive partially or fully subsidized meals, depending on local laws and customs: access to a canteen, restaurant vouchers or food purchase vouchers.

In some countries, such as Brazil and France, this is a statutory requirement. In other countries, it is a benefit offered to its employees.

Many subsidiaries negotiate reduced prices for their employees, usually with restaurants located near the office.

Preferential rates

Employees at most Group subsidiaries benefit from negotiated rates on various services other than restaurants, and sometimes enjoy them free of charge. These discounted or free services are offered through the works councils, where they exist, or by the HR Department at each subsidiary, sometimes in partnership with clients.

These preferential rates primarily apply in three priority areas:

Areas	Employee eligibility	Examples of offers
Cultural and recreational activities	Most of our employees benefit from individual or family discounts or free access to cultural events or recreational activities.	In 2018, 182 children of Teleperformance employees in Greece took advantage of a range of activities offered over a six-week period. Teleperformance employees in the United Kingdom also benefit from preferential rates at certain museums and theaters.
Tourist activities	More than three quarters of our employees are entitled to discounts with a number of travel agencies, hotels and airlines.	Reduced plane tickets are offered in Tunisia. "All-inclusive" trips at preferential rates are offered in the United Kingdom.
Sporting activities	Nearly all of our Group employees can participate in sporting activities at a reduced cost.	Employees at certain sites are offered free gym membership, such as in the United States and Morocco. At most other sites, Teleperformance has negotiated preferential rates with sports clubs. The Group promotes friendly sports matches between employees, by subsidizing the creation of in-house company teams (see further details under section 2.3.3.2 *Supporting the local roll-out of the Teleperformance Health and Safety policy*).

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2.3.5 Diversity and equal opportunities

The Teleperformance equal employment opportunity policy is based on the sixth principle of the United Nations Global Compact:

"*The elimination of discrimination in respect of employment and occupation*" (see section 2.2.2 *CSR goals and key risks*).

The purpose of this policy is to provide guidelines to the subsidiaries so that procedures promoting equal access to employment, the elimination of discrimination, diversity, integration and non-discriminatory hiring are respected.

The selection process is not founded solely on the type of vacant position. "It shall also offer equal opportunities to all candidates, independently of personal characteristics such as race, color, gender, religion, political opinion, nationality, background, age, health, union membership or sexual orientation.

2.3.5.1 Measures taken to promote gender equality[1]

The Group has introduced a set of procedures and guidelines in order to promote equal treatment for men and women:

- in addition to Group guidelines, subsidiaries implement local equal opportunities policies;
- gender is not specified in Teleperformance's internal hiring process, and therefore cannot influence the recruiting officer;
- salary bands, classification, career opportunities and work schedules are not based on gender;
- the annual employee satisfaction survey generates an alert when a correlation is detected between the degree of satisfaction expressed and the gender of the respondents.

Teleperformance's goal is to maintain an even overall breakdown between men and women. In 2018, women represented 52.5% of total headcount excluding Intelenet and men 47.5%.

Change in the percentage of women in the total headcount

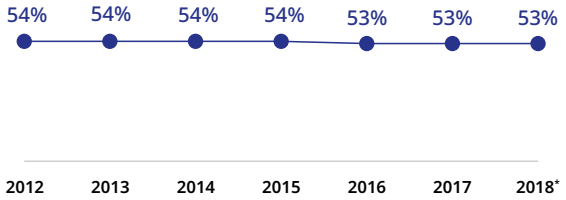

** Excluding Intelenet.*

All of the measures rolled out to promote gender equality have resulted in an increase in the number of women in management positions from 44.9% in 2012 to 49.6% in 2018 (excluding Intelenet).

Change in the number of women in management positions since 2012

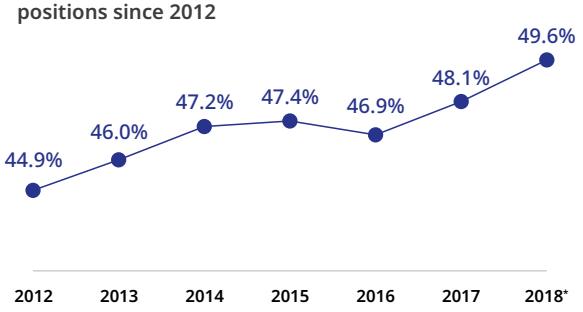

** Excluding Intelenet.*

There are six women on the Board of Directors of Teleperformance SE, representing 43% of Board members, a ratio that complies with the recommendations of the APEF-MEDEF corporate governance code and statutory provisions regarding gender balance on Boards of Directors.

In addition, each subsidiary rolls out local initiatives geared towards gender relations in accordance with cultural issues:

Country	Examples of local initiatives
India	in 2014, Teleperformance India set up "Gendersmart", an extensive system of targeted communications to schools and higher education establishments in order to present our corporate culture and the safety and security measures that have been implemented for employees. Flexible working hours compatible with family life are also offered, as well as teleworking options, the right to maternity leave irrespective of seniority as well as a guaranteed return to the same position and salary.
Greece	A large-scale communication campaign on diversity was rolled out in 2018, highlighting the development and careers of women at Teleperformance.
Tunisia	In accordance with the Social Responsibility Label certification, a certain number of indicators are closely monitored, such as the ratio of training hours between men and women, the percentage of women on the Management Committee and the percentage of women among the ten highest salaries at the Company.
Argentina	Checks for bias in the hiring process are organized on a regular basis.
El Salvador	All focus groups at the subsidiary must comprise both men and women. Meanwhile, a plan to prevent sexual harassment has also been implemented.

(1) All of the figures presented in this chapter exclude the subsidiaries in the United States, for which local laws prohibit collecting information on the gender of employees.

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2.3.5.2 Measures taken in favor of employment and integration of disabled workers

The Group employs disabled workers and complies with applicable local legislation on hiring, non-discrimination, and workstation layout. In addition to its legal obligations, wheelchair access at the centers has also been taken into account; a number of premises have already been adapted.

Local initiatives are implemented to promote the hiring of disabled workers.

Main local initiatives implemented to promote the hiring of disabled workers

Country	Initiatives
United States	Teleperformance attends student job fairs in order to present the employment and career opportunities it offers to disabled people.
France	The "Handiperformant" program was set up in order to help those with disabilities gain access to the professional world. This program includes daily personal support, reorganization of workstations and an internal policy of raising awareness so that each person's differences and specificities are considered as assets conducive to working better together.
Colombia	Teleperformance has signed agreements with governmental and private foundations in order to make contact with disabled personnel, essentially amputees and crutch-bound employees; workstations are regularly adapted in consultation with the relevant employees.

2.3.5.3 Measures taken to promote the hiring and retention of senior workers

The types of jobs on offer mainly attract those joining the headcount for the first time. This results in a high proportion of students, which is particularly significant in certain countries.

Teleperformance makes sure that the senior age group is not left out. A number of local initiatives have been developed:

Country	Examples of initiatives
United States	The US subsidiary posts its job offers on a wide range of websites and at jobs fairs, including those organized for veterans.
Norway, Switzerland	One week of extra leave for employees older than 60.
Colombia	The Colombian subsidiary employs seniors already eligible for retirement due to their skill set, in compliance with local laws.
United Kingdom	Active partnership with government agencies and NGOs working to ensure that job offers are available to people of all ages and backgrounds.

2.3.5.4 Anti-discrimination policy

Given the Group's international scale and the development of multilingual centers, Teleperformance naturally hires people of different origin and nationality to work in its facilities. Specific programs are therefore organized to encourage the welcoming and integration of foreigners.

In Europe and Asia, Teleperformance is leading the way in the development of multi-lingual hubs that combine employees of all nationalities at the same location, to serve pan-European and pan-Asian programs. These platforms offer major multinational groups dedicated and optimized omnichannel solutions in the customer experience management field. The Teleperformance multilingual offering serves 140 markets in over 40 different languages, from five regional hubs located in Portugal, the Netherlands, Greece, Malaysia and Egypt.

Teleperformance Greece organizes Greek culture days for all new foreign employees, and provides assistance to help them set themselves up in their new country.

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2.4 A MAJOR SOCIAL COMMITMENT

Sharing the economic value it has created is an important principle adopted by Teleperformance. The Group is committed to ensuring that this economic value also benefits society, by examining its overall needs and challenges. Teleperformance is committed to seeing social progress alongside its own success.

2.4.1 Driving innovation and development through streamlined information distribution

The heart of the Group's business lies in quickly and accurately responding to consumers and citizens in need of information, contacts or solutions to their day-to-day problems. Teleperformance serves a broad spectrum of customers in this sector, handling more than 1.5 billion interactions every year worldwide. "Each interaction matters" for Teleperformance. This catchphrase reflects the importance it places on excellence in its line of business, which is the cornerstone of its success.

Teleperformance is a major player in the provision of innovative, multilingual solutions in local communities. This mission contributes to the social, economic and cultural development of Teleperformance's various markets.

Consumers' and citizens' needs are often largely ignored or unfulfilled by the different internal structures in place at large companies. Teleperformance's goal is to streamline its relationship with customers, citizens, brands and governments, despite processes that are becoming increasingly complex. Consequently, the Group has a role to play in informing and educating the broader public about processes and functions that require human assistance. This can be easily understood when it comes to technical support for everyday devices and digital services. Teleperformance is thus working with more and more global brands and social networks looking to moderate their users' online publications.

The ability to effectively and rapidly distribute reliable, verified information to a large multilingual customer base is one of the Group's fundamental qualities, making it an effective vehicle for distributing, developing and spreading innovation.

2.4.2 End-user satisfaction is one of the Group's key priorities

Consumer satisfaction is the key focus of the Group's business. In order to effectively track this, Teleperformance has developed a set of tools and processes that help measure performance.

The Group's main clients complete regular, standardized satisfaction questionnaires, which are processed by specific and dedicated teams. Results are monitored quarterly on a global scale according to customer or geographical area and, if necessary, corrective actions are taken. Each team's focus on quality and progress has resulted in real dedication to their customers. This dedication and understanding of real-world expectations are essential to delivering excellent service.

2.4.3 Measures in favor of regional and community development

Diversity and inclusion are integral values at Teleperformance. The Group aims to work with partners who share these values, in order to effect positive and significant change within local communities.

2.4.3.1 A strong foothold in regions and communities

Site location strategy

The choice of the Group's site locations is primarily based on an employment area approach. The business relies on a considerably large headcount. It is vital that the Group has suitable candidates nearby. Sites are therefore mainly located:

- in areas that are easy to access *via* a large public transport network; while proximity to an airport is also a priority for the centers dedicated to offshore business;
- near universities, in order to facilitate the recruitment of suitable candidates and multilingual personnel;
- in regions where the unemployment rate is high.

An important local employer

The Group is generally considered a major employer in most of its operating regions.

Teleperformance Philippines, which employs over 38,000 people operating from 24 centers spread across the country, is even the second largest private-sector employer in the Philippines. Therefore, Teleperformance's impact on the local economy and employment market is considerable, especially in Manila where the Group operates from 18 centers.

For example, the economic and social impact of the three sites located in Tucuman, in Argentina, is substantial. With some 4,000 employees, the Group is one of the five main employment providers in the region.

On a smaller scale, the Group's presence in smaller towns outside large cities has a significant impact on the local economy: in Newry in Northern Ireland, Teleperformance employs over 900 people and is considered one of the town's leading employers for some 30,000 inhabitants.

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Employment partnerships with local players

Teleperformance works in partnership with government employment agencies and schools on a regular basis.

Examples of major initiatives in place

Types of partners	Country	Partners	Examples of initiatives
Government agencies	Philippines	Technical Education and Skills Development Authority (TESDA); Department of Labor and Employment (DOLE); Public Employment Service Office (PESO)	Participation in training and skills validation programs in partnership with local authorities.
	Argentina	Employment agencies in the province of Tucuman	Candidates are put in contact with Teleperformance by employment agencies, and undergo the usual hiring and selection processes. If hired, the state covers a portion of their salary for a certain period of time.
	El Salvador	Ministry of Labor and Social Security	Development of educational programs aiming to help young people acquire and cultivate the skills they need to kick-start their careers.
Educational institutions	France	Nouvelle Aquitaine Region	Teleperformance provides training and sits on accredited prior learning panels for Baccalaureate and Bachelor's degrees.
	Morocco	Institut français du Maroc; the National Agency for the Promotion of Employment and Skills (ANAPEC)	Teleperformance provides introductory training to applicants having previously failed a recruitment test due to their lack of French language skills; once they've completed a three month course, they can then apply again.
	Northern Ireland	Young Enterprise Northern Ireland (charity aiming to encourage young people's goals and entrepreneurial skills)	For a number of years, a group of around fifteen volunteers at the Enniskillen site in Northern Ireland have given presentations on the world of work to students at a dozen primary and secondary schools.

In addition, most subsidiaries receive interns or students under apprenticeship and professional qualification contracts.

Combating tax avoidance

The Group believes that combating tax avoidance and paying taxes are actions that show support for regions and communities.

Through its subsidiaries, the Group pays taxes owing in all of the countries where it operates. It complies with applicable legislation that, in addition to the payment of taxes, requires the relevant tax returns to be submitted. It does not have nor makes use of any specific policy that would enable it to avoid paying tax, for example by way of complex arrangements. The current tax rate of 28% in 2018, as set out in Note 5 *Income tax* of section 5.6 *Notes to the consolidated financial statements*.

2.4.3.2 Charity and mutual assistance

In addition to emergency operations aimed at providing financial and material assistance to victims of natural or humanitarian disasters, the Teleperformance Group and its subsidiaries regularly support humanitarian initiatives on a local or national scale.

The diagram below shows the Group's main fields of action in terms of assistance and charity. Each of them is presented in more detail in the sections that follow.

Primary beneficiaries of the Group's main assistance and charity initiatives

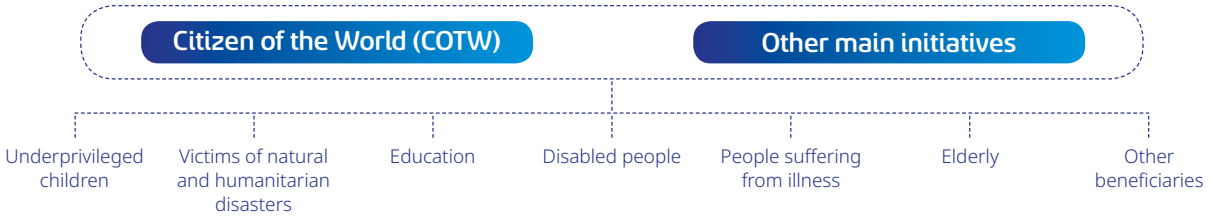

Citizen of the World

Founded in 2006, the Citizen of the World (COTW) initiative initially aimed to help meet the most basic needs of the world's most at-risk children. Since then, the program's scope of influence has gradually been extended to other beneficiaries, for example in response to natural or humanitarian disasters all over the world, and education. COTW is part of Teleperformance's Corporate Social Responsibility efforts, which reinforce its commitment to take care of the community and help those in need. The Group encourages its employees to actively participate in these initiatives.

At each Teleperformance subsidiary, one or more COTW Ambassadors are appointed by the CEO. The Ambassadors' main responsibilities are to plan and carry out philanthropic activities, leveraging ties with local NGOs and associations, and encouraging employees to get involved in their communities and make a difference through global and local COTW actions.

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All charities are selected at local level, following Group due diligence guidelines, ensuring that the charity is legitimate and operates ethically. Receipts of donations made to registered charities are to be signed and reported to both the local CFO and the Group through an online tracking tool on the 10th of every month, along with the description of the campaign, its main objectives and the nature of the in-kind donations.

In order to ramp-up and unify its efforts, the Group organizes monthly COTW meetings, where internal and external best practices are shared, as well as ad hoc trainings on specific topics, policies and procedures.

Main ongoing COTW program initiatives

Initiatives	Description
Participation in international days	Zero Discrimination Day, International Women's Day, Earth Hour, International Peace Day, World Habitat Day and Human Rights Day.
Clothing/Food Drive	Organization of events and activities to raise money and collect non-perishable food and clothing items to supply local families and children in need. Employees are encouraged to get involved in their local campaigns by volunteering in the collection and distribution process.
Health drive	Cash drives for medicines, toiletries and hygiene kits, as well as other essential healthcare items. With the belief that health equals wealth, the goal is to help ill and disabled children around the world by partnering with organizations that provide medical care.
School drive	Collection of school supplies for children in need returning to school, helping them access quality education.
Holiday drive	Collection of toys and encouraging donations to local selected charities bringing joy to children and families in need during the end-of-year holiday period. This initiative aims to give back to the less fortunate in our communities by spreading holiday cheer all around the world.

As part of the Citizen of the World program, in 2018 Teleperformance collected from its employees the equivalent of 5.5 million US dollars in cash and kind, as well as over 600 computers, exceeding targets.

Aid for victims of natural and humanitarian disasters

Teleperformance encourages its employees to get involved in supporting victims of natural and humanitarian disasters. Over the last 12 years, Group employees volunteered 517,331 hours of their time – including 85,374 hours in 2018 alone, in order to help those in need and victims of natural disasters.

Main actions to support victims in 2018

Natural or humanitarian disaster	Support provided by Teleperformance
Hurricanes Michael and Florence in the USA	Teleperformance USA provided essential supplies to affected populations.
Flooding in the Nabeul region in Tunisia	Partnership with the Red Crescent for a clothing and blanket drive for victims.
Fires in Algarve in Portugal	Employees were invited to participate in a bike riding challenge: for every kilometer tallied by employees on an exercise bike, Teleperformance provided one kilo of food; 500 kg of food was offered to the families affected.
Summer fires in Attica in Greece	Collection of essential items.
Refugees	Employees at Teleperformance UK offer their support to female refugees who are the sole caregiver for their children.

Aid to the elderly

Subsidiaries regularly partner with local or national charities that support the elderly.

Programs supported	Country	Actions
Fondation Hôpitaux de Paris-Hôpitaux de France	France	As part of the "Plus de Vie" (literally, "more life") fundraiser for hospitalized elderly people, Teleperformance France provides four of its customer relations centers free of charge to register donation pledges from individuals. This major charity campaign will finance a large number of projects aimed at combating pain, encouraging family reunions and improving the reception and comfort of elderly people.
Consiente abuelitos	Colombia	Provision of sanitary products to elderly people in need by volunteer workers.

Aid for underprivileged children

Teleperformance's commitment, in coordination with local associations and organizations, takes various forms, such as visiting and organizing activities at orphanages and pediatric hospitals, collecting toys, clothing and school accessories, etc.

Amongst the various initiatives carried out in 2018, Group subsidiaries organized or helped hand out food, clothing, and toys at a center for women and children escaping domestic violence in Albania. They are also involved in a tuberculosis prevention program, handing out multivitamins and food supplements to children with deficiencies, in partnership with the Red Cross in Russia.

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Actions in support of disabled people

A large number of local initiatives are organized by the subsidiaries to help disabled people.

For example, in partnership with *Emel Tounès*, the Group's Tunisian subsidiary is an ongoing partner to the "Un bouchon, un sourire" association, which organizes the recycling of used plastic caps. The resale of the recycled material helps fund projects for people with disabilities. In Greece, a similar project helps children who are victims of traffic accidents by paying for wheelchairs. In Spain, Teleperformance works with *Caps for a new life*, which finances orthopedic equipment not covered by social security for children from low-income families.

Actions to support those suffering from illness

Teleperformance also provides assistance to people suffering from illness. In 2018, the following initiatives were carried out:

- in partnership with the *Juegaterapia* foundation, volunteers at the Madrid site in Spain helped organize a party and games for hospitalized children;
- Teleperformance UK continued its partnership with the Teenage Cancer Trust, a foundation that provides assistance and support to teenagers suffering from cancer.

Other charitable initiatives

Other local initiatives are organized for communities in need. Some of the various programs implemented worldwide in 2018 include:

- Teleperformance India organized clothing distribution to people living in slums;
- during the month of Ramadan, Teleperformance Tunisia coordinated collections of food and clothing for three humanitarian organizations: SOS Villages d'enfants, DARNA and Red Crescent;

lastly, there are a large number of social responsibility programs aimed at assisting local communities. Computers that no longer serve a professional purpose are donated to local charities. In 2018, one of the US subsidiaries donated some 300 computers to an association working for the homeless.

External training

Many of the Group's Latin-American subsidiaries have signed agreements with local universities in cities where Teleperformance operates. These agreements enable Teleperformance employees to enjoy discounted tuition fees.

In Mexico, agreements have been signed with 34 universities and institutes of technology, in cities where Teleperformance is based. Teleperformance employees are entitled to tuition fee discounts of 20-70%.

2.4.4 Fair practices and data protection

Teleperformance is deeply committed to fair practices, which must guarantee integrity and honesty between Teleperformance, its stakeholders, and its direct and indirect customers. Fair practices are essential components of an effective and comprehensive CSR policy.

2.4.4.1 Fair trade practices

Commitments to ethical business practices

The United Nations Global Compact

A signatory to the United Nations Global Compact since 2011, Teleperformance is committed to upholding and promoting the ten fundamental principles of the Global Compact relating to human rights, working conditions, the environment and anti-corruption (cf. section 2.2.2 *CSR goals and key risks*).

Teleperformance Values

The Teleperformance Group's business ethics commitments are based on its five core values: Integrity, Respect, Professionalism, Innovation and Commitment. These values underpin the Group's strategy and reflect Teleperformance's firm commitment to fair business practices in compliance with applicable laws and regulations.

Teleperformance Code of Ethics

Established in 2013, the Teleperformance Code of Ethics defines the rules, attitudes, actions and behavior expected and adopted by the Group, its directors and employees vis-à-vis all stakeholders (employees, service providers, suppliers, clients, customers, shareholders and other external partners including the media and public bodies). It sets out the general ethical principles incumbent on all Group employees, whatever their status or duties. The Code draws on the Group's values as well as referring to international standards such as the principles of the United Nations Global Compact. It is in keeping with the Group's firm and unflagging commitment to act as a responsible, human and morally irreproachable corporate citizen. It fulfills the regulatory and statutory requirements applicable to the Group's operations and should be read, in particular, in conjunction with the anti-corruption Code of Conduct (see hereafter). Compliance with these Code is a condition for membership in the Teleperformance Group, whose reputation is based on the fair practices and relationships that the Group builds with all of its partners and stakeholders, both internal and external.

The complete text of the Code of Ethics may be viewed on the Group website (https://www.teleperformance.com/en-us/codes-and-policies/code-of-ethics).

Anti-corruption measures

Managing corruption risk

Anti-corruption measures form part of the Group Global Compliance Framework, which the Group has updated significantly during 2018. The Teleperformance Group recognizes the importance of establishing rules and standards designed to prevent exposure of the Group to risks of corruption and influence peddling. These rules and standards help to safeguard the Group's reputation and maintain the trust of its partners and stakeholders, both internal and external. The Group's anti-corruption policy is based on the United Nations Global Compact principles and on compliance with local legislation and regulations prohibiting corruption. It is designed to foster employee awareness of the rules of proper conduct, particularly with regard to relationships with third parties.

In 2016, the Group set up a Compliance Department, thereby confirming its increased vigilance and the strengthening of anti-corruption practices, as well as establishing an identifiable authority on these matters for all Group subsidiaries.

In 2018, after review by the Audit and Compliance Committee and approval by the Board of Directors, Teleperformance strengthened these measures and set up a system aimed at reinforcing Group-wide anti-corruption measures. Notable features of this system include a corruption risk map and a specific anti-corruption Code of Conduct, and the Global Ethics Hotline Policy currently being implemented across the Group.

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Measures taken to prevent corruption

Eliminating corruption is one the commitments made by the Group towards its employees, clients, customers and partners. The Group has adopted a "zero tolerance" principle. The Teleperformance Code of Conduct states that "at Teleperformance, all acts of corruption, bribery and extortion in any form are strictly forbidden."

As part of its continuous improvement process, the Group continued to formally record anti-corruption procedures in 2018. The main initiatives, placed under the supervision of the Deputy Chief Executive Officer and the Group Chief Legal and Compliance Officer are:

- corruption risk mapping, which aims to identify, analyze and manage the risks inherent to the Group's business activity and geographical exposure. The methodology is mainly based on interviews conducted with operating managers in the subsidiaries and in "support" functions, covering questions relating to the relevant business activities and internal and external stakeholders;
- publication of the Code of Conduct, which may be viewed on the Group website (www.teleperformance.com) and which reaffirms the Group's commitments to combating corruption and influence peddling, as well as other behavior related to business ethics and fair practices (regarding gifts, donations, conflicts of interest, etc.). Designed to serve as a practical guide, it defines the rules that each employee must follow and the behavior to be avoided, as well as providing a contact for questions. It also provides for disciplinary measures to be taken, in accordance with local statutory and regulatory provisions, for prohibited or non-compliant behavior;
- creation of a guide setting out internal procedures introduced to prevent risks of corruption;
- implementation of "due diligence" measures to reinforce the Group's vigilance regarding the integrity of third parties with which it deals (clients, customers, suppliers, intermediaries, subcontractors, etc.);
- update of the anti-corruption e-learning module for Group employees;
- implementation of the Global Ethics Hotline Policy, a whistleblowing system placed under the responsibility of the Worldwide Chief Legal Officer and Chief Compliance Officer which is currently being implemented for all Group employees. The hotline is designed to enable employees to report behavior or events that may constitute acts of corruption that could seriously harm the Group's business or reputation or cause it to incur liability. Alerts submitted *via* this system are treated confidentially. Where applicable, the hotline works in tandem with other existing whistleblowing channels in accordance with applicable local legislation.

Governance of the system has been placed under the responsibility of the Group Deputy Chief Executive Officer and the Legal and Compliance Departments. The procedures are rolled out with the help of designated personnel in the relevant operational departments and the compliance officers appointed at the subsidiary level. The Audit and Compliance Committee oversees the system and ensures the effective implementation of its measures.

Suppliers and subcontractors

Teleperformance makes sure that its subcontractors and suppliers are committed to an ethical approach and that they respect the principles of its "Supplier Policy", which was first drawn up in 2015.

This policy forms part of the Group Global Compliance Framework and refers in particular to the provisions of the Code of Ethics and the anti-corruption Code of Conduct. It ensures the consistency of procurement processes, the continuous improvement of procurement practices and their understanding by all internal and external stakeholders (*e.g.* employees, decision-makers, suppliers and subcontractors).

The implementation of this policy has led to the creation of a more centralized "Procurement" function. With the support of the Group Executive Committee, the Procurement Department is responsible for ensuring that the procurement process adheres to and is consistent with the Group's values and the Group Global Compliance Framework at every step of the relationship.

In practice, the policy sets out the expectations and behaviors to be adopted by the Group and its employees as well as by suppliers and their employees. The policy provides for the assessment of major suppliers *via* questionnaires at least once every two years. The policy also contains provisions regarding confidentiality, compliance with statutory and regulatory provisions and values of integrity, and prevention of conflicts of interest.

In line with the Group's organizational structure, the Procurement Department is organized around the three management regions (Ibero-LATAM, EWAP, CEMEA) in Core Services and by business line in Specialized Services. Accordingly, each region or business line can implement specific measures in addition to Teleperformance's global recommendations under the supervision of a regional procurement director, who provides guidance to each subsidiary in its region regarding the measures to be taken in order to make allowance for local considerations.

In 2016, this Supplier Policy was reviewed by an independent auditor (Verego) as part of the social responsibility certification process.

Teleperformance Group's Supplier Policy may be viewed on the website (www.teleperformance.com).

Teleperformance purchases mainly computer hardware and software, telecommunications services, and property and services related to its contact centers. Furthermore, Teleperformance makes very limited use of outsourcing. The Core Services operations (customer relations) are not outsourced.

Code of Conduct regarding transactions on securities

Teleperformance has introduced a Code of Conduct relating to transactions on securities pursuant to the recommendations of the *Autorité des marchés financiers* (French Financial Markets Authority) guide on prevention of insider misconduct in listed companies. The guide applies primarily to Group senior management and members of the Board of directors. The procedures in place are described in section 3.3.3.1 – *Code of Conduct relating to securities transactions*.

Measures taken to promote consumer health and safety

The operation of the Group's business typically entails limited risk of harm to consumers' health or physical safety.

2.4.4.2 Personal data protection and security

In an increasingly complex and challenging environment with regard to data security, Teleperformance has become a leader in this field within its business sector. Clients recognize this positioning as a major differentiating factor.

The Group is fully compliant with international standards such as ISO 27001 and the PCI (Payment Card Industry) and HIPAA (Health Insurance Portability & Accountability Act) standards.

In 2015, the Group implemented worldwide 14 innovative security rules called the Global Essential Compliance and Security Policies (GECSP), designed to identify potential risks of fraud or breach of security rules and standards. They relate to the following thematic:

1. *Security data analytics policy*
2. *Clean desk policy*
3. *Infrastructure hardening policy*
4. *Fraud hotline reward & security awareness policy*
5. *Security and fraud communication policy*

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6. *Facility access control policy*
7. *Contractual compliance policy*
8. *Security awareness training policy*
9. *Security guard post orders policy*
10. *ID badge policy*
11. *Login provisioning and de- provisioning policy*
12. *Risk discovery and fraud prevention policy*
13. *Social media confidentiality policy*
14. *Employee confidentiality policy*

The "closed circuit" personal data protection framework is strengthened by a compliance audit function (see section 1.2.1.1 *Risks relating to data security and protection*) and is based on proprietary technology designed to:

- inform managers of agents' unauthorized access to information;
- provide a standard and secure method enabling agents to take notes while switching from one screen to another, thus reducing the risk of data leaks;
- manage and monitor end-to-end compliance, from proof of download required by the GECSP to reports sent to senior management.

These standards are the result of the fact that the digital transformation that is happening around the world now brings with its new challenges in the area of fraud or data leakage risk.

In 2016, the Group embarked on furthering our stance on protection of data as the EU approved the new GDPR (General Data Protection Regulation) that would go into effect on May 25th, 2018. An important global project was launched to ensure Teleperformance would be ready and compliant with the regulation as the GDPR went into effect on May 25th, 2018.

Also, Teleperformance understood its obligations to its clients and its own people in both the protection and transfer of sensitive data collected and interact with on a daily basis. With this, Teleperformance sets out to obtain Binding Corporate Rules (BCR's) from the EU. BCR's are a legal framework that allows Teleperformance to transfer data within and outside of the EU safely and securely. Teleperformance is the only global BPO company to have obtained BCRs as both a Data Controller and Data Processor.

The Group received notification form the *Commission Nationale de l'Informatique et des Libertés* (The CNIL – French data protection authority), on behalf of the European Union, in February 2018 that Teleperformance's BCRs had been approved for the BCR's.

Also in 2018 Teleperformance created the Global Privacy Office. It is this office, headed by our Chief Privacy Officer, that is responsible for the management of our global privacy program. The Privacy Office also proactively monitors global changes to privacy regulations in all major geographies of the world in which the company both operate from, service clients from or service data subjects.

2.5 PROMOTING TELEPERFORMANCE'S ENVIRONMENTAL RESPONSIBILITY

The Group's main environmental objectives at all of its subsidiaries include reducing energy consumption, limiting packaging and paper waste and cutting back on travel (both air and road transport).

2.5.1 Citizen of the Planet (COTP)

Teleperformance's business activities inherently give rise to very little pollution. Nevertheless, Teleperformance is aware of the responsibility incumbent on each citizen and aims to minimize the negative impact of its activity on the environment by acting in a sustainable way, so as to ensure that future generations can meet their own needs.

The Citizen of the Planet (COTP) program was launched 10 years ago and aims to ensure that Teleperformance operates in an environmentally friendly and responsible manner.

Teleperformance is committed to raising individual environmental awareness, and so encourages its employees to apply a set of environmentally friendly principles to all aspects of their professional and personal life.

The welcome guide given to newly employed agents includes a chapter dedicated to environmental protection. It offers new employees useful advice and information, encouraging them to participate in the various Citizen of the Planet local initiatives.

Every employee is made aware of environmentally friendly practices and initiatives on a daily basis *via* poster campaigns aimed at reducing water consumption, and using electronic signatures to cut down on paper waste and reduce negative environmental impacts, etc. Many subsidiaries regularly circulate the site's energy and water consumption statistics and their evolving carbon footprint, to increase employees' environmental awareness.

The Social and Environmental Responsibility Committee determines the overall environmental policy and checks that the resources are appropriate for achieving the targets set. Meanwhile, the directors of each subsidiary are responsible for implementing and monitoring environmental policy at local level. Citizen of the Planet coordinators at each facility are responsible for reporting environmental information, which is forwarded to the head office *via* monthly reports.

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Several subsidiaries have decided to formalize their efforts in this area by instigating procedures to obtain internationally recognized certification:

Certification	Description	Results
ISO 14001	Introduced in 1996 by the International Organization for Standardization (ISO), this standard is based on the principle of continuous improvement of environmental performance through limitation of the Company's carbon footprint.	The Istanbul site in Turkey, as well as our Ashby-de-la-Zouch site in the United Kingdom, have obtained ISO 14001 certification. The remaining UK sites will adopt the recommended environmental standards and procedures as soon as possible.
LEED certification (Leadership in Energy and Environmental Design)	LEED certified buildings are designed to enable reductions in energy consumption, CO_2 emissions, water consumption and generation of solid waste.	The Glasgow site in Scotland, Cebu IT Park in the Philippines, Beijing and Foshan in China and three sites in Colombia have obtained LEED certification.
HQE (high environmental quality) certification for commercial buildings	This standard aims to ensure that environmental concerns are taken into account during the commercial use of buildings.	The building in which Teleperformance France is located received the French "NF HQE" high environmental quality certification for occupied commercial buildings for its impact on the environment and its energy consumption.

2.5.2 Reducing the Group's carbon footprint

Given its locations, the Group has relatively limited exposure to climate change risks.

Its business does not generate material direct emissions into the atmosphere, water or ground and does not create any particular noise disturbance for the local community. The Group's business has no material direct impact on biodiversity.

However, Teleperformance strives to support the circular economy:

- by prioritizing the use of recycled paper;
- by providing employees with used battery and ink cartridge collecting bins;
- by installing metal can and plastic goblet collectors in break rooms and cafeterias;
- locally, Teleperformance has developed and encourages a wide range of initiatives aimed at raising global awareness amongst employees about their impact on the environment.

At constant consolidation scope, the carbon footprint per Teleperformance employee fell 7.7% between 2017 and 2018; it represents 0.712 tonnes per employee in 2018 *versus* 0.772 tonnes in 2017. This reduction is mainly due to the decrease in electricity consumption per employee. In 2018, the target set in 2015 to reduce each employee's carbon footprint was achieved.

The Group's carbon footprint in terms of emission sources taken into account came to 160,319 tons in 2018.

As reported, a 2.2% increase in the Group's overall carbon footprint compared to the previous year (156,919 tons in 2017) was recorded. This is primarily due to the increase in staff.

In 2018, energy, water and paper consumption and air travel all increased. This is also due to the increase in the Group's total headcount, resulting from the Group's strong growth.

For the purposes of comparison, the amounts of consumption reported below are presented both in total and at constant headcount per employee (full-time equivalent).

2.5.2.1 Energy consumption

Electricity (in MWh)

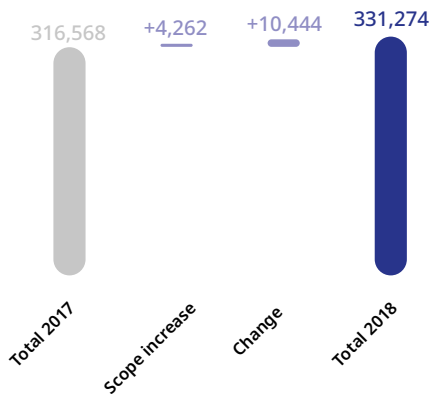

Energy consumption per employee (kWh per employee)

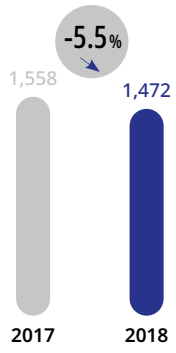

Energy consumption in 2018 amounted to 331,274,449 kWh compared to 316,567,896 kWh in 2017.

Energy consumption per employee fell 5.5% to 1,472 kWh in 2018 from 1,558 kWh in 2017.

Teleperformance is constantly refining its energy efficiency through measures such as the widespread use of low-energy light bulbs, the installation of motion detectors, brightness detectors, timers and the optimization of air conditioning systems.

The Group uses renewable energies as part of its energy mix: a portion of the electricity supplied by current providers is derived from renewable energy (wind farms and solar power in particular), depending on the region.

2.5.2.2 Water consumption

Water (in thousands of m³)

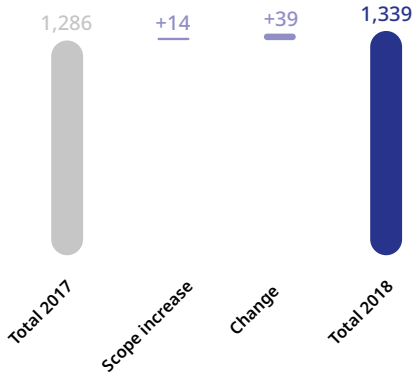

Water consumption per employee (m³ per employee)

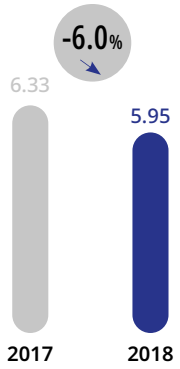

Water consumption in 2018 amounted to 1,338,931 m³ compared to 1,285,691 m³ in 2017.

At constant headcount, water consumption per employee is down 6.0%: 5.95 m³ per employee in 2018 *versus* 6.33 m³ in 2017.

In 2018, several subsidiaries carried out works to reduce their water consumption, such as the installation of automatic mixer faucets in Greece.

Awareness-raising initiatives amongst employees were launched, such as posters encouraging them not to waste water, and the publication of the local energy use and consumption report.

2.5.2.3 Paper consumption

Paper (in tons)

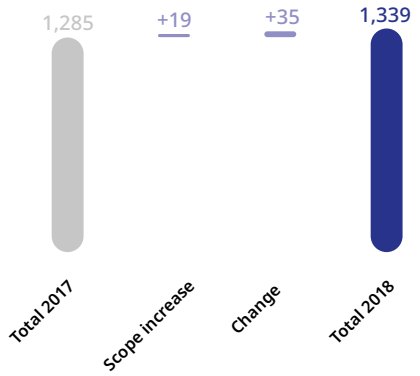

Paper consumption per employee (in Kg per employee)

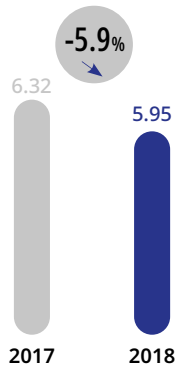

Paper consumption in 2018 came to 1,339 tons, compared to 1,285 tons in 2017.

At constant headcount, paper consumption per employee fell 5.9% from 6.32 kg per employee in 2017 to 5.95 kg in 2018.

This decrease in paper consumption per employee is particularly marked in the CEMEA region (down 13.9%). This is the result of a series of measures, including reducing the number of individual printers, growing use of tablets, double-sided printing, electronic signatures for Group employees, in order to avoid unnecessary printing and thus minimize each employee's carbon footprint, and global use of digital documentation.

Certain initiatives at subsidiaries have been rolled out on a broader scale. For example, online payslips, adopted by the Portuguese subsidiary in 2007, have been gradually adopted by the rest of the Group. In 2018, around 90% of employees received their payslips online.

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2.5.2.4 Travel

Air travel

Air travel (thousands of km)

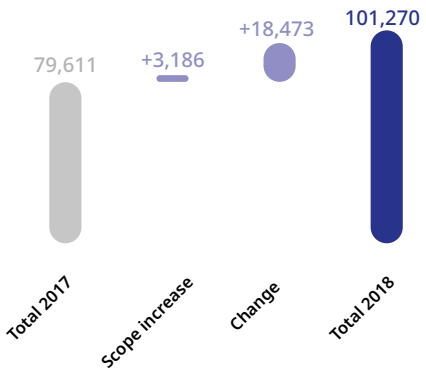

Air travel per employee (in Km per employee)

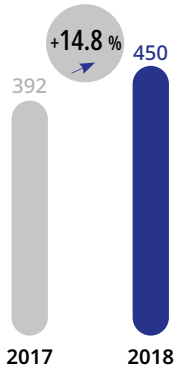

Air travel in 2018 amounted to 101,269,765 km, up from 79,611,371 km in 2017.

450 km per employee was recorded in 2018, compared to 392 km in 2017, an increase of 14.8%.

This increase mainly results from an increase in employee travel in the EWAP region, which represents half of the Group's air travel. It is the result of a strengthening of the data security policy, which has led to multiple trips by US experts to Philippine subsidiaries.

The travel monitoring policy rolled out in early 2018 in the Ibero-LATAM region resulted in a 7% decrease in air travel, despite a 9% increase in staff.

In order to reduce travel and shrink its carbon footprint, the Group has been encouraging the use of video-conferencing and Internet phone calls by employees wherever possible. Otherwise, trains are preferred to air travel.

Promotion of public transport

Most Group facilities are located in areas that are easily accessible by public transport. Where this is not the case, or simply to encourage employees to avoid using their personal vehicles, contracts with private transportation companies can be implemented.

For example, a system of regular shuttle buses has been made available at no charge to employees at all of the centers in North Africa, the Philippines and Jamaica, as well as centers in Gurgaon in India, Xi'an in China, Usak and Balikesir in Turkey, Cairo in Egypt, and Água Branca and Lapa in Brazil. These buses are widely used: nearly nine out of ten employees at the six Moroccan sites benefit from the 144 shuttles at their disposal, as well as 400 employees at the Xian site in China.

Free shuttle and taxi services exist in other regions on a more selective basis, mostly for employees working outside normal hours, for example in El Salvador, Mexico and Russia, or for those residing in remote or dangerous areas.

In the absence of or in addition to shuttle buses organized by the subsidiary, some subsidiaries subsidize all or part of their employees' public transport season tickets.

Promotion of "green" transport

Teleperformance and its subsidiaries encourage their employees to use the greenest forms of transport possible.

The primary initiative is to promote the use of bicycles. Cycling to work is particularly suited to sites located in downtown areas, and several campaigns have been set up to encourage employees to prioritize using their bicycles, especially when traveling to and from work.

Examples of initiatives encourage bike riding:

Country	Initiatives
Colombia	Employees can borrow bicycles for free from a partner rental firm located on Company premises.
Albania	Teleperformance has sponsored the building of 26 bike sheds throughout the city of Durres with capacity for 520 bicycles.
Brazil	Inter-site purchases are carried out by a company that makes deliveries by bicycle.

In addition to these initiatives, the Group encourages the use of less harmful fuels. In India for example, employee shuttles run on natural gas.

Promotion of car-sharing

Car-sharing is included in our Group recommendations regarding site layout.

Ride-sharing is sometimes organized by Teleperformance, for example in Mexico. It is widely encouraged *via* posters displayed in break rooms, ads on the Company intranet and by means of special reserved parking spaces.

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2.5.2.5 Business-specific recycling

The need to be at the cutting edge of technological innovations requires us to frequently renew our installed IT and telephone base, a key resource in the Group's business sector.

Teleperformance is committed to recycling this equipment once it is no longer fit for professional use.

Accordingly, Teleperformance's approach to recycling obsolete equipment combines ethical and environmental concerns.

Equipment	Measures in place	Action taken
Computers/Phones	**1.** disposal of sensitive material/equipment according to specific standards and charters **2.** donation to nurseries, schools and community-oriented NGOs.	In 2018, around 2,700 computers were recycled for sustainable disposal and 600 were donated throughout the world.
Paper	Double-sided printing is applied systematically and preference is given to purchasing recycled paper. Most subsidiaries recycle paper by installing special containers for this purpose in each department. Used paper is recovered for recycling by a third party, often in conjunction with local charitable programs.	In the Philippines, the proceeds from paper recycling are donated to the Kythe Foundation, a local NGO working for hospitalized children, to pay electricity bills.

Given the sensitive data that they may contain, all computers are wiped clean before leaving the Company. In some locations, such as the United States, hard drives are systematically removed and destroyed.

2.6 A RECOGNIZED CSR POLICY

The Group's CSR approach contributes to creating and fostering trusting and long-term relationships with each of its stakeholders, especially employees, customers and suppliers, while respecting the local cultures and customs in the countries where Teleperformance operates. Priority initiatives, which are at the heart of the Group's business, are a source of motivation for employees and are designed to improve the Company's social, societal and environmental impact, as well as its financial performance.

Teleperformance strives to exceed every one of its social responsibility objectives, through its programs to assist people in need and its contribution to environmental protection. Assessed by numerous non-financial ratings agencies and included on Socially Responsible Investment (SRI) indexes, Teleperformance's track record in terms of CSR is gaining recognition.

In 2018, Teleperformance was ranked among the top five global performers in the Business Support Services study published by Vigeo.

2.6.1 Certification

2.6.1.1 Verego SRS

In 2018, for the fourth year running, Teleperformance was awarded Verego *Social Responsibility Standard* certification, the most prestigious award in the area of corporate social responsibility, for all of its facilities worldwide. This enterprise-wide certification was renewed in early 2019.

Created in 2010, the Verego SRS assessment systems define a set of core social responsibility requirements designed to serve as a framework for organizations wishing to establish and manage their own social responsibility programs and objectives.

Teleperformance received certification in all five Verego SRS areas: Leadership, Ethics, People, Community and Environment. Performance is assessed according to specific criteria in each of the five certification areas.

Verego certifications reflect Teleperformance's drive to exceed every one of its social responsibility objectives, through its programs to assist people in need and its contribution to environmental protection.

2.6.1.2 Eco Vadis

In 2018, EcoVadis, a collaborative platform for rating the social and environmental performance of global supply chains, once again awarded two medals to a number of Teleperformance subsidiaries:

- Gold medal – Teleperformance France;
- Silver medal – Teleperformance Nordic (*i.e.* Sweden, Norway, Denmark and Finland).

These awards are based on online analyses covering a broad range of issues, which were completed for Teleperformance France in February 2019 and Teleperformance Nordic in September 2018.

EcoVadis assessment covers the environment, labor practices, human rights, business ethics and responsible procurement.

These two EcoVadis awards are proof of the structured, proactive CSR approach and effective policies and measures on crucial issues applied by the Company.

They amount to recognition, on the part an independent appraiser, of the excellence of Teleperformance's CSR policy, the continuous improvement of its performance and its standing as a reliable long-term partner.

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2.6.2 Non-financial rating

The Group places great importance on its non-financial ratings and, through the quality and transparency of the data it supplies, aims to obtain ratings that reflect its CSR initiatives as accurately as possible.

Teleperformance is actively involved with three established and recognized non-financial rating agencies: MSCI, Sustainalytics and Vigeo. Through regular reviews, these agencies encourage the Group to improve and better understand the changing requirements. Teleperformance has received the following ratings from these three agencies:

Rating agency	2018 rating	Change
MSCI	AA	Stable since July 2014
Sustainalytics	68/100	Up from 67/100 in 2017

Teleperformance also receives a rating from Vigeo; this rating has improved each year since 2010.

2.6.3 ESG stock market indexes

The Teleperformance share is included in the following ESG indexes:

- Euronext *Vigeo Eurozone* 120 since December 2015, which selects the 120 leading companies in terms of CSR in the eurozone;
- international *FTSE4Good* index since June 2018, which identifies socially responsible companies that comply with environmental, social and governance criteria.

2.7 METHODOLOGY

Pursuant to the provisions of Articles L. 225-102-1 and R. 225-105-1 of the French Commercial Code, the Group must provide information on the measures that have been adopted with regard to the social and environmental consequences of its activity.

The Group has been committed to this endeavor for 12 years: in 2006 it initiated and piloted Citizen of the World, a program of charitable, humanitarian and collective welfare action plans, and in 2008 it launched an environmental program named Citizen of the Planet.

By adhering to the United Nations Global Compact in July 2011, Teleperformance was confirming its intent to position itself as a responsible corporate citizen, thereby undertaking to abide by the charter of values drawn up by the United Nations. Every year since then the Group has renewed its commitment, publishing the three elements of the "Communication on Progress" on its website:

- statement signed by the Chief Executive expressing continued support for the Global Compact;
- detailed description of improvement measures implemented in each issue area and the procedures employed;
- quantitative measurement of outcomes obtained or expected.

Teleperformance's business is not industrial and does not generate any significant air, water or ground pollution; the Group does not manufacture transformed products nor consume raw materials.

Given the tertiary nature of the Group's business as a service provider, the issues it faces with regard to social, labor and environmental responsibility are essentially human.

Consequently, the Group has decided that this section on the Group's non-financial performance should focus on the human aspects: employees and stakeholders, the territorial and social impact of its activities, and actions in favor of communities and regional development, etc.

The issues listed below have not been dealt with, as they are considered irrelevant at Group level in view of the fact that our activity consists of the provision of services:

- resources dedicated to preventing environmental risks and pollution;
- the amount of provisions and guarantees for environmental risks;
- land use;
- measures implemented to preserve or promote biodiversity;
- prevention, reduction or compensation measures regarding air, water and ground pollution seriously affecting the environment;
- measures related to noise pollution and any other form of pollution specific to a business activity;
- animal wellfare;
- food waste;
- responsible, fair and sustainable food.

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2.7.1 Scope and collection of information

Data reported by the subsidiaries is verified internally to ensure consistency. It is then audited by KPMG's CSR specialists.

Data	Collection and monitoring	Period	Change in scope
Quantitative staff information	This data is gathered using the Group's reporting and consolidation tool This data is monitored by the Reporting and Consolidation Department, mainly via consistency checks and a comparative analysis with the previous year.	The data is valid as of December 31st, 2018.	It covers 100% of the headcount, for all subsidiaries in the consolidation scope (see note 13. in the Notes to the Consolidated Financial Statements). Data related to training, absenteism and workplace accidents excludes Intelenet that represents 19% of the total headcount.
Quantitative environmental information	This data is gathered via monthly reporting. This data is checked by the Reporting and Consolidation Department, which collects the supporting documents and performs consistency checks and a comparative analysis with the previous year.	For a given year N, the period covered runs from October 1st, year N-1 to September 30th, year N.	The scope of the published information for the reference period covers 88% of Group revenues, except in the case of water consumption, for which some subsidiaries (Argentina, France, Australia, United Arab Emirates, Switzerland, Sweden, Norway, Denmark and almost half of the centers in the United States) either lack the information to date or are unable to obtain it, given that water consumption is not itemized separately under rental charges. Accordingly, water consumption data covers only 80% of Group revenue.
Qualitative information	This data is gathered *via* a specific questionnaire sent to the biggest subsidiaries' finance departments. This data is checked via a comparative analysis and collection of supporting documentation.	This data is valid as of December 31st, 2018.	Qualitative information was gathered from the Group's most representative subsidiaries, covering 91% of employees; Canada, Costa Rica and all of the TLS Contact and Praxidia sites have been excluded.

2.7.2 Main indicators

To guarantee the consistency of the information treported, guidelines were introduced and circulated to all Group subsidiaries. These guidelines specify the exact definitions and formulas to use when reporting quantitative information. In some cases, a given subsidiary may not monitor a requested indicator internally and therefore cannot provide the relevant information.

Further information on the indicators set out in this report are provided below:

Year-end headcount	The year-end headcount includes all persons who had an employment contract and were in salaried employment at the Group's various subsidiaries, together with all temporary employees as of December 31st.
Average headcount	The average headcount was calculated by dividing the number of hours scheduled for the year by the standard annual number of hours worked. The standard annual number of hours worked is specific to each country, depending on local regulations.
Training hours	The number of training hours indicated may have been slightly underestimated, given that some subsidiaries only count training hours offered to agents. However, given that agents account for around 84% of the headcount and are clearly the main beneficiaries of training, this difference is unlikely to be material.
Industrial accident frequency rate	Number of accidents resulting in time off work divided by the number of paid hours of production multiplied by one million. The number of industrial accidents does not include accidents that occurred during travel between home and work.
Rate of absenteeism	This is the number of hours related to unscheduled absences divided by the number of remunerated production hours and unscheduled absences (not remunerated). Scheduled absences (holiday, maternity leave, training, etc.) are excluded from the calculation. The rate of absenteeism only concerns agents.
Management	This encompasses all functions other than those of agents and supervisors.
Dismissals	These are positions eliminated by the employer for economic reasons or due to internal restructuring, or due to gross negligence or incompetence leading to dismissal at the employer's initiative.
Other departures	This includes departures due to termination of contract by mutual agreement, expiry of contract, resignation or the transfer of an employee to another Group entity.
Water consumption	Total annual mains water consumption in cubic meters.
Energy consumption	Total annual consumption in kilowatts. Emission factors are specific to each country and are taken from the International Energy Agency (IEA) website.
Paper consumption	Total annual paper consumption (printer and toilet paper) in tons. The following conversion factors were used: 1 ton of paper = 400 reams of A4 or 200,000 sheets. 1 ton = 2,200 rolls of toilet paper. The emission factor is 0.41 ton of CO_2 per ton of paper consumed (source: ADEME).
Air travel	Number of kilometers traveled. This is calculated by multiplying the total number of journeys made by the "average distance in kilometers per country" (the most frequent return flight in the subsidiary is taken as the benchmark) using the following website: http://www.carbonneutralcalculator.com/flightcalculator.aspx The Group uses the distance from Paris to London as the benchmark given that the sales staff, who are the most frequent travelers within the Group, mainly take domestic flights. The conversion factor for air travel is 0.18 kg of CO_2 per kilometer traveled. This is calculated by dividing the CO_2 emissions generated by the Paris-London trip (0.07 ton of CO_2) by the same distance (377 km).
Carbon footprint	Carbon footprint corresponds to greenhouse gas emissions related to energy and paper consumption and the number of air kilometers traveled.

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2.8 REPORT BY THE INDEPENDENT THIRD PARTY, ON THE CONSOLIDATED NON-FINANCIAL PERFORMANCE STATEMENT IN THE MANAGEMENT REPORT

For the year ended December 31st, 2018

This is a free English translation of the Statutory Auditors' report issued in French and is provided solely for the convenience of English-speaking readers. This report should be read in conjunction with, and construed in accordance with, French law and professional standards applicable in France.

2

To the Shareholders,

In our capacity as independent third party of Teleperformance SE, certified by the French Accreditation Committee (*Comité Français d'Accréditation* or COFRAC) under number 3-1049[1], and member firm of the KPMG International network, as one of your statutory auditors, we hereby report to you on the consolidated non-financial performance statement for the year ended December 31th, 2018 (hereinafter the "Statement"), included in the Group Management Report, in accordance with the legal and regulatory provisions of Articles L.225 102-1, R.225-105 and R.225-105-1 of the French Commercial Code (*code de commerce*).

Responsibility of the Company

It is the Management Board's responsibility to prepare a Statement in accordance with legal and regulatory provisions, including a presentation of the business model, a description of the main non-financial risks, a presentation of policies applied to mitigate these risks and the outcomes of those policies, including key performance indicators.

The Statement has been prepared applying the procedures of the company (hereinafter the "Guidelines"), the most significant aspects of which are presented in the Statement (or available upon request at the company's headquarters).

Independence and quality control

Our independence is defined by the provisions of Article L.822-11-3 of the French Commercial Code and the French Code of Ethics (*code de déontologie*) for statutory auditors. Moreover, we have implemented a quality control system that includes documented policies and procedures to ensure compliance with applicable ethical rules, professional standards, laws and regulations.

Independent third party's responsibility

On the basis of our work, it is our responsibility to express a limited assurance opinion about whether:

- the Statement complies with the provisions of Article R.225-105 of the French Commercial Code;
- the information provided is fairly presented in accordance with Article R.225-105-I(3) and II of the French Commercial Code concerning policy outcomes, including key performance indicators and actions relating to the main risks (hereinafter the "Information");

However, it is not our responsibility to express an opinion on:

- the company's compliance with any other applicable legal and regulatory provisions, [relating, in particular, to the duty of care requirement and the fight against corruption and tax evasion];
- the compliance of products and services with applicable regulatory provisions.

Nature and scope of our work

We performed our work described below in compliance with Article A.225-1 et seq. of the French Commercial Code, defining the conditions under which the independent third party performs its engagement, and with the professional guidance issued by the French Institute of Statutory Auditors (*Compagnie nationale des commissaires aux comptes* or CNCC) relating to this engagement, and with ISAE 3000 (International standard on assurance engagements other than audits or reviews of historical financial information).

We conducted work to form an opinion on the Statement's compliance with legal and regulatory provisions and the fair presentation of the Information therein:

- we gained an understanding of the activity of all companies in the consolidation scope, of the entity's exposure to the main social and environmental risks relating to the business activity and, if applicable, of its effects on respect for human rights and the fight against corruption and tax evasion, including any related policies and their outcomes;
- we assessed the appropriateness of the Guidelines in terms of their relevance, completeness, reliability, neutrality and clarity, by taking into consideration, where relevant, the sector's best practices;
- we verified that the Statement covers every category of information required under Article L.225-102-1, Paragraph III concerning social and environmental matters as well as respect for human rights and the fight against corruption and tax evasion;
- we verified that the Statement presents the business model and the main risks relating to the activity of all companies in the consolidation scope, including – if relevant and proportionate – risks due to its business relationships, products or services, in accordance with the disclosures required under Article R.225-105-I, and policies, due diligence procedures and outcomes, including key performance indicators;

(1) *Scope available at www.cofrac.fr.*

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- we verified that the Statement presents the disclosures required under article R.225-105-II if they are relevant given the main risks or policies presented;
- We obtained an understanding of the process for identifying, prioritizing and validating the main risks;
- we enquired about the existence of internal control and risk management procedures implemented by the company;
- we verified that the Statement includes a clear, substantiated explanation of the lack of policy for one or more of these risks;
- we verified that the Statement covers all companies in the consolidation scope in accordance with Article L.233-16 within the limits specified in the Statement;
- we assessed the data collection process implemented by the entity to ensure the completeness and fair presentation of the policy outcomes and key performance indicators that must be mentioned in the Statement;
- for key performance indicators and the other quantitative outcomes[1] that we considered the most important, we set up:
  - analytical procedures to verify that data collected are correctly consolidated and that any changes to the data are consistent,
  - tests of details based on sampling to verify that definitions and procedures are correctly applied and to reconcile data with supporting documents. The work was carried out with a selection of entities contributing[2] to the reported data and represents between 16% and 19% of consolidated data of key performance indicators and results selected for these tests;
- we referred to documentary sources and conducted interviews to corroborate the due diligence procedures that we deemed the most important[3] (organization, policies, actions, qualitative outcomes);
- we assessed the overall consistency of the Statement based on our understanding of the company.

We believe that the sampling methods and sample sizes we have used, based on our professional judgment, are sufficient to provide a basis for our limited assurance opinion. A higher level of assurance would have required us to carry out more extensive procedures.

Due to the use of sampling techniques and other limitations inherent to information and internal control systems, the risk of not detecting a material misstatement in the Statement cannot be totally eliminated.

Means and resources

Our work drew on the skills of five individuals.

To assist us in conducting our work, we called on our firm's sustainable development and corporate social responsibility specialists. We conducted around ten interviews with the individuals responsible for preparing the Statement.

Opinion

Based on our work, and given the scope of our responsibilities, we have no material misstatements to report that would call into question the Statement's compliance with the applicable regulatory provisions, or the fair presentation of the information, taken as a whole, in accordance with the Guidelines.

Paris la Défense, February 28th, 2019
KPMG S.A.

French original signed by

Anne Garans
Partner
Sustainability Services

Jacques Pierre
Partner

(1) Total headcount at 31.12 and breakdown by gender and age; Average FTE by category; Number of recruitments; Number of departures; Number of training hours; Absenteeism rate (for agents only); Electricity consumption; Greenhouse gas emissions (scope 2).

(2) Teleperformance China, Teleperformance Portugal, Telephilippines (Philippines), Teleperformance USA.

(3) Occupational health and safety conditions; Salaries and their evolutions; Training policies; Collective agreements outcomes; Measures implemented to promote gender equality; Measures implemented to reduce greenhouse gas generated by employees' transportations; Partnership and sponsorship actions; Measures implemented to prevent corruption.

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3 Corporate Governance

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This report constitutes the report of the Board of Directors on corporate governance presented to the Shareholders' Meeting of Teleperformance SE to be held on May 9th, 2019, in accordance with the provisions of Articles L.225-37-2 to L.225-37-5 of the French Commercial Code. It was drawn up with the assistance of the senior management, the financial department and the legal department on the basis, in particular, of the works of the Board of Directors. It has been presented to the Remuneration and Appointments Committee before approval by the Board of Directors at its meeting held on February 28th, 2019.

3.1 GOVERNANCE

3.1.1 Governance structure

Choice of the method of exercise of executive management

Under the terms of Article 19 of the Articles of association, executive management is exercised under the responsibility of either the Chairman of the Board or another individual appointed by the Board of Directors and who has the title of Chief Executive Officer *(directeur général)*.

The Board of Directors chooses between these two ways of exercising the executive management. The shareholders and third parties must be informed of this choice in accordance with the terms laid down by law.

The Chief Executive Officer has full powers to act in any circumstances in the Company's name. He must exercise his powers within the limits of the corporate purpose and subject to the powers expressly reserved by law to general meetings of shareholders and the Board of Directors.

Upon proposal by the Chief Executive Officer, the Board of Directors may appoint one or more individuals responsible for assisting the Chief Executive Officer, with the title of Deputy Chief Executive Officer *(directeur général délégué)*. With the Chief Executive Officer's agreement, the Board of Directors determines the scope and duration of the powers granted to the Deputy Chief Executive Officers. The Deputy Chief Executive Officers have the same powers as the Chief Executive Officer *vis-à-vis* third parties.

The AFEP-MEDEF code, which does not favour any particular type of structure, provides that the Board of Directors may opt between a separation or a combination of the functions of Chairman of the Board and Chief Executive Officer depending on specific requirements. The chosen structure and the arguments for it are notified to shareholders and third parties.

The combined shareholders' meeting held on May 31st, 2011 approved the Company's change of its governance from a dual structure consisting of a Supervisory Board and a Management Board to a single governance structure consisting of a Board of Directors.

At its meeting held on May 30th, 2013, the Board of Directors, upon recommendation of its Remuneration and Appointments Committee, decided to separate the roles of Chairman of the Board and Chief Executive Officer and to implement a governance structured around an Executive Chairman and a Chief Executive Officer.

At its meeting held on October 13th, 2017, the Board of Directors, upon recommendation of its Remuneration and Appointments Committee, put an end to the separation of functions adopted in 2013 and appointed a Deputy Chief Executive Officer. This choice results from the wishes expressed by shareholders to see the governance structure evolve and from a thorough study and analysis on the Group's governance conducted under the aegis of the Remuneration and Appointments Committee and, in particular, its Chairman.

This governance structure set up in October 2017 is thus based on a Chairman and Chief Executive Officer, Mr. Daniel Julien, founder and historical leader of the Group, a Deputy Chief Executive Officer, Mr. Olivier Rigaudy and an expanded Executive Committee in terms of skills and expertise.

The combination of the functions of Chairman of the Board and Chief Executive Officer and the appointment of a Deputy Chief Executive Officer enables the Group to assert a more transparent, rectilinear and, above all, flexible management organization structure in order to encourage the acceleration of the strategic decision-making process and decision-making circuits so that decisions can be implemented more quickly to meet the Group's current and future challenges.

In an effort to strengthen the continuity in the balance of powers and the active and constructive exchanges within it, the Board created, at its meeting held on February 28th, 2018, the function of Lead Independent director. The Board set forth the missions of the Lead Independent director and enshrined them in its Internal Regulations (see section 3.1.3.2.3 *Lead Independent director* below). It also decided to appoint Mr. Patrick Thomas, independent director, as Lead Independent director.

On the occasion of its annual discussion on the choice of governance structure, the Board, at its meeting held on February 28th, 2019, decided to maintain this governance structure, considering it the most suitable to the Company, the Group, its imperatives, its challenges and its strategy in the short and long-terms.

The limitations brought to the powers of the executive management are described in the Internal Regulations of the Board of Directors (see section 3.1.3.2.2 below) and in the Articles of association.

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3.1.2 Corporate Governance Code

The Company refers to the AFEP-MEDEF corporate governance code for listed companies amended in June 2018 (the "AFEP-MEDEF code") and available on the MEDEF website (www.medef.com). In accordance with Article L.225-37-4 of the French Commercial Code, the report of the Board of Directors on corporate governance specifies the provisions of the AFEP-MEDEF code that have been set aside and the reasons therefore. The table below shows recommendations of the code that have not been applied by the Company, the practices of Teleperformance SE and the justifications of this non-application.

Recommendations of the AFEP-MEDEF code set aside or not applied	Teleperformance SE's practices and justifications
Non-compete compensation (§23) §23.3 When the agreement is concluded, the Board must incorporate a provision that authorizes it to waive the application of this agreement when the officer leaves.	The Board of Directors, at its meeting held on November 30th, 2017, upon recommendation of its Remuneration and Appointments Committee, authorized the amendment of the non-compete agreement entered into between Mr. Daniel Julien, Chairman and Chief Executive Officer, the Company and its subsidiary Teleperformance Group, Inc. The third amendment to this agreement was signed on December 1st, 2017. It is reminded that this agreement, entered into in 2006, and subsequently amended by decisions of the Board meetings held on May 31st, 2011, November 30th, 2011 and November 30th, 2017, was approved by the shareholders' meetings held on June 1st, 2006, May 29th, 2012 and April 20, 2018. At the same meeting held on November 30th, 2017, the Board also authorized the non-compete agreement between the Company and its Deputy Chief Executive Officer, Mr. Olivier Rigaudy. This agreement was signed on February 1st, 2018. The Board of Directors has made the choice, for these two agreements, in the deliberate interest of the Group, not to introduce a stipulation likely to make the non-compete obligation of its executive officers uncertain at the time of their departure. Teleperformance is a leader in its market. The success and sustainability of the Group is based on the vision instilled by its leaders, the strength of its values, the involvement of its talents and a complex organization to make agile a multinational present in nearly 80 countries and employing nearly 300,000 people. In addition, in the context of changes in the world today, the Group has entered a phase of transformation, particularly digital, involving important strategic and technical choices and a profound evolution of its business model. The elements which allow this mutation are the fruit of investments in reflection and experimentation. The protection of business secrets and, more generally, information on the strategy and organization of the Group is therefore essential for its durability and the effective protection of its legitimate interests. For this purpose, the Board of Directors wants to adopt a clear position with regard to key executive officers in the event of departure: they prohibit any competition, in any form whatsoever, during the contract period. The exercise of an option to waive the non-compete obligation at the time of departure is based, presumably, on conjectures as to the activity of the outgoing officer in the months following his departure. Through these non-compete agreements, the obligations of key officers after their departure are unambiguous and create a strong, clear and engaging relationship for both parties. The Board of Directors believes that the introduction of an opt-out option to its benefit would weaken this policy, to the detriment of protecting the interests of the Group.
§23.4 The Board must also make provision for no non-competition benefit to be paid once the officer claims his or her pension rights. In any event, no benefit can be paid over the age of 65.	With regard to recommendation 23.4 of the AFEP-MEDEF code, introduced in June 2018, the Board of Directors decided not to amend the provisions of the non-compete agreements, as approved by the shareholders meeting held on April 20th, 2018 (*supra,* about §23), to introduce a condition of age given the management criteria and the Group policy on the departure of corporate officers as reminded above (*supra,* about §23) which must remain independent of the age of the outgoing officer. Protecting the Group's strategic interests in case of departure is essential. The Board wishes to protect the Group not only from direct competition situations but also from more passive situations, such as consulting, allowing the disclosure, even indirectly, of information about the Group which together form its essence and the cement of its success. The risk against which the Group wishes to protect itself by the conclusion of such agreements does not disappear, in fact, with age.
§23.6 The non-competition benefit must be paid in instalments during its term.	The provisions of the non-compete agreements provide for (as has the case since their conclusion): • (i) with regard to the agreement incumbent on Mr. Daniel Julien, Chairman and Chief Executive Officer: a single payment of the non-compete compensation; • (ii) with regard to the agreement incumbent on Mr. Olivier Rigaudy, Deputy Chief Executive Officer: a single or several payments (over 12 months) as chosen by the Deputy Chief Executive Officer. The non-compete agreements provide for recovering mechanisms on a prorated basis of the compensation already paid in the event of death.
Representation of employee shareholders and employees (§7) Within a group, the directors representing employees elected or appointed in accordance with the legal requirements sit on the Board of the Company that declares that it refers to the provisions of this code in its report on corporate governance. recommendation.	Since 2015, Teleperformance SE has been a European company. As such, it has a Work Council of the European Company currently consisting of 19 employees representing 18 countries of the European Economic Area. This council is presided over by a representative of the Company and meets at least once a year. This representative body, which is additional to national processes, is more adapted to the international and European dimension of the Group and enables employees to be involved in the Group's considerations. The Group's choice was to place employee representation at the level that it considers to be the most relevant, in accordance with the objective of employee representation governed by the provisions of Article L.225-27-1 of the French Commercial Code. In France, a director representing employees was appointed to the main operational French subsidiary, Teleperformance France SA (and not at the level of the holding company, Teleperformance SE). In Teleperformance France SA, the director representing employees has a deliberative voice and the same rights, is subject to the same obligations, including confidentiality, and incurs the same responsibilities as the other directors. The Company is attentive to the application of the legal provisions regarding employee representation on boards of directors and in particular Article L.225-27-1 of the French Commercial Code. It also remains vigilant to legislative and regulatory developments in this matter and in particular those under discussion in the framework of the proposition of law known as the "PACTE law".

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3.1.3 The Board of Directors

3.1.3.1 Composition of the Board of Directors

The Board of Directors currently consists of fourteen members:

- nine are foreign nationals or binationals, representing 64%, six nationalities being represented;
- nine have the status of independent directors in 2018 as defined by the internal regulations of the Board and the recommendations of the AFEP-MEDEF code.

The Board is composed of recognized and experienced professionals in their respective business sectors and of international dimension: counsel, marketing, banking, health, communication, distribution, international relations, public relations, BtoB, experts in customer service, and finance. These skills are considered key in the Group's development phase and in line with the strategy pursued. They match the activities and businesses of the main clients of the Group.

Information on the Company's individual directors, and the list of their offices and positions, is provided in the paragraphs *List of directors in office and Main activities exercised by directors in office* hereafter.

Term of office

Pursuant to the provisions of Article 14 of the articles of association, directors are appointed for a three-year term, which expires at the end of the ordinary shareholders' meeting called to approve the financial statements for the year ended and held in the year in which the appointment expires. Directors may be re-elected.

The ordinary shareholders' meeting may appoint one or several directors for a two-year term, on an exceptional basis, and solely to enable the implementation or continuation of the staggering of directors' terms. The Board of Directors shall seek to propose the appointment or re-appointment of directors to the ordinary shareholders' meeting on a rolling basis, in order to avoid the simultaneous expiry of all of the directors' terms.

Age limit

The number of directors aged 70 or above may not exceed one-third of the number of directors in office.

The Chairman of the Board of Directors may remain in office until the age of 76, and the Chief Executive Officer and Deputy Chief Executive Officers may remain in office until the age of 70.

It will be proposed to the shareholders' meeting to be held on May 9th, 2019, to change the statutory age limit for the Chief Executive Officer and for the Deputy Chief Executive Officer from 70 to 75 (24th and 25th resolutions) and the age limit for a third of the directors in office from 70 to 75 (23rd resolution). In fact, upon recommendation of its Remuneration and Appointment Committees, the Board considered that age should not be a criterion taking priority over expertise, competence, results and engagement of persons with regard to the Group. Furthermore, a low age limit can have the indirect consequence of complicating the search for the necessary balance in the composition of the Board which must be able to combine, primarily, the diversification expected in terms of expertise, experience, nationality, gender and independence.

Ownership of shares in the Company

Pursuant to the internal regulations, each director must hold at least 500 shares of the Company during his or her term of office. The number of shares held by each director is presented in the paragraph *List of directors in office* below and equals, in value, to more than one year's directors' fees.

Furthermore, executive officers must retain in the registered form, further to grants of performance shares or equivalents, at least 30% of the shares acquired until the end of their office (see section 3.2.2 below).

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List of directors in office

	Personal information				Experience		Position on the Board			
	Age	Gender	Nationality	Number of shares	Number of directorships in listed corporations[1]	Independence	Date of first appointment[2]	End of term of office[3]	Length of service on the Board as of 2018/12/31	Participation in Board Committees
EXECUTIVE OFFICERS										
Mr. Daniel Julien	66	M	French and American	974,314	0	No	05/31/2011	GM 2021	29 years[4]	-
INDEPENDENT DIRECTORS										
Ms. Emily Abrera	71	F	Philippines	1,000	0	Yes	11/27/2012	GM 2021	6 years	Remuneration and Appointments Committee
Mr. Alain Boulet	69	M	French	600	0	Yes	05/31/2011	GM 2019[5]	8.5 years	Audit and Compliance Committee (Chairman)
Ms. Pauline Ginestié	48	F	French and British	1,000	1	Yes	04/28/2016	GM 2019[5]	2.5 years	-
Ms. Wai Ping Leung	66	F	Chinese and British	1,000	0	Yes	04/28/2016	GM 2019[5]	2.5 years	-
Mr. Robert Paszczak	68	M	American	1,014	0	Yes	05/31/2011	GM 2019[5]	8.5 years	Remuneration and Appointments Committee (Chairman)
Ms. Christobel Selecky	63	F	American	1,000	0	Yes	05/07/2014	GM 2020	4.5 years	-
Ms. Angela Maria Sierra-Moreno	64	F	Colombian	1,000	0	Yes	05/07/2014	GM 2020	4.5 years	-
Mr. Patrick Thomas	71	M	French	500	2	Yes	11/30/2017	GM 2019[5]	1 year	-
Mr. Stephen Winningham	69	M	American and British	1,000	0	Yes	05/31/2011	GM 2021	8.5 years	Audit and Compliance Committee
NON-INDEPENDENT DIRECTORS										
Mr. Bernard Canetti	69	M	French	1,000	0	No	05/31/2011	GM 2020	13.5 years	Remuneration and Appointments Committee
Mr. Philippe Dominati	64	M	French	1,000	0	No	05/31/2011	GM 2020	22.5 years	-
Mr. Jean Guez	73	M	French	1,000	0	No	05/31/2011	GM 2020	8.5 years	Audit and Compliance Committee
Ms. Leigh Ryan	65	F	American	1,000	0	No	04/28/2016	GM 2019[5]	2.5 years	-

(1) In companies other than the Company.
(2) The date indicated is the date of the first appointment as director following the change in the Company's governance from a structure with a Management Board and a Supervisory Board to a Board of Directors, as adopted by the combined shareholders' meeting held on May 31st, 2011.
(3) The Company has adopted a system of staggering directors' appointments, which explains why expiry dates vary.
(4) It is reminded that Mr. Daniel Julien is the founder of the Group.
(5) Renewals proposed to the Shareholders' meeting to be held on May 9th, 2019.

For the purposes of their appointments, the directors and the executive management are domiciled at the Company's registered office.

Qualification as Independent director

The Board conducts an annual review of the independence of its members, upon recommendation of the Remuneration and Appointments Committee.

The Board of Directors endeavors to ensure that at least half of its members meet the definition of independence in the AFEP-MEDEF code. It designates as independent or not its members according to a preliminary recommendation submitted by the Remuneration and Appointments Committee tasked with examining the personal situation of the director in question based on the criteria for independence set out in paragraph 8.5 of the AFEP-MEDEF code, it being specified that the Board may consider that a given member who fulfills the above independence criteria should not, however, be classified as independent given their specific situation or that of the Company, and vice versa.

The Committee, for the preparation of its opinion, endeavours that all the officerships held by directors in other companies having business relationships with the Company will not be of a nature as to compromise

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the independence and/or the performance of the duties of the directors concerned while taking into account the transaction entered into by the Group with those companies. Its analysis also concerns the other aspects of the business relationship (duration, importance, etc.) when such business relationship exists. In the latter case, those are concluded at arms' length and their amounts are not significant for each party.

Such agreements, if any, are described in paragraph *Statements on the situation of members of the administrative, management and supervisory bodies* hereafter and are, in any case, entered into at market conditions and their amounts are not material either for the Group or for the other party. As of the date of preparation of this Registration Document, this agreement concerns only a director (Mr. Daniel Julien) who is not independent. Thus, none of the directors qualified as independent, with regards to the criteria set forth below, have contracted directly or indirectly business relationships with the Company or the Group.

The independence criteria of the AFEP-MEDEF code are the following:

Criterion 1	**Employee or executive officer during the previous 5 years** Not to be, and not having been for the previous 5 years: • an employee or an executive officer of the Company; • an employee, executive officer or director of a company that the Company consolidates; • an employee, executive officer or director of its parent company or a company that the latter consolidates.
Criterion 2	**Cross-directorships** Not to have been for the past 5 years an executive officer of a company in which the Company holds a directorship, directly or indirectly, or in which an employee appointed as such or an executive officer of the Company holds a directorship.
Criterion 3	**Significant business relationships** Not to be a customer, supplier, commercial banker, investment banker or consultant: • that is significant to the Company or its Group; or • for which the Company or its Group represents a significant portion of its activity. The evaluation of the significance or otherwise of the relationship with the Company or its group must be debated by the Board and the quantitative and qualitative criteria that led to this evaluation (continuity, economic dependence, exclusivity, etc.) must be explicitly stated in the annual report.
Criterion 4	**Family ties** Not to be related by close family ties to an executive officer.
Criterion 5	**Auditor** Not to have been an auditor of the Company within the previous 5 years.
Criterion 6	**Period of office exceeding 12 years** Not to have been a director of the Company for more than 12 years. The loss of the status of independent director occurs on the date of the 12th anniversary.
Criterion 7	**Status of non-executive officer** A non-executive officer cannot be considered independent if he or she receives variable remuneration in cash or in the form of securities or any remuneration linked to the performance of the Company or Group.
Criterion 8	**Status of the major shareholder** Directors representing major shareholders of the Company or its parent company may be considered independent provided these shareholders do not take part in the control of the Company. However, beyond a 10% threshold in capital or voting rights, the Board, upon a report from the Appointments Committee, should systematically review the qualification as independent in the light of the composition of the share capital of the Company and the existence of a potential conflict of interest.

For the purposes of interpreting this table:

- the Group includes the Company and any related company;
- a related company is any company that controls the Company, or any company controlled by the Company;
- control is understood within the meaning of Article L.233-3 of the French Commercial Code;
- an executive director is any person who has been appointed as a member of a corporate body (management board, supervisory board or board of directors) and any person appointed to a senior management position.

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The qualification retained by the Board of Directors, upon recommendation of its Remuneration and Appointments Committee, for each of the directors as of December 31st, 2018 and as of the date of preparation of this Registration Document is the following:

	Criteria[1]								
Name	**Criteria 1**	**Criteria 2**	**Criteria 3**	**Criteria 4**	**Criteria 5**	**Criteria 6**	**Criteria 7**	**Criteria 8**	**Qualification retained by the Board**
Daniel Julien	X	•	•	•	•	X	•	•	Non-independent
Emily Abrera	•	•	•	•	•	•	•	•	Independent
Alain Boulet	•	•	•	•	•	•	•	•	Independent
Bernard Canetti	•	•	•	•	•	X	•	•	Non-independent
Philippe Dominati	X	•	•	•	•	X	•	•	Non-independent
Pauline Ginestié	•	•	•	•	•	•	•	•	Independent
Jean Guez	X	•	•	•	•	•	•	•	Non-independent
Wai Ping Leung	•	•	•	•	•	•	•	•	Independent
Robert Paszczak	•	•	•	•	•	•	•	•	Independent
Leigh Ryan	X	•	•	•	•	•	•	•	Non-independent
Christobel Selecky	•	•	•	•	•	•	•	•	Independent
Angela Maria Sierra-Moreno	•	•	•	•	•	•	•	•	Independent
Patrick Thomas	•	•	•	•	•	•	•	•	Independent
Stephen Winningham	•	•	•	•	•	•	•	•	Independent

(1) In this table:
- • *means that the independent criterion is satisfied;*
- X *means that the independent criterion is not satisfied.*

Diversity policy within the Board of Directors

The Board of Directors gives particular importance to the balance of its composition and those of its committees, in particular in terms of diversity. It relies upon the works of the Remuneration and Appointment Committee which proposes, as often as circumstances require, the desirable evolutions of the composition of the Board and its committees depending on the Group's strategy.

The works of the Committee aim in particular to ensure the synergy of the directors' competences and the diversity of their profiles, to maintain an independence rate within the Board with regard to the governance structure of the Company and its shareholders, to seek a balanced representation of women and men on the Board, and to promote an adapted representation of directors with different nationalities, in order to assure the shareholders and the market that its missions are performed with independence, objectivity and expertise required.

At its meeting held on November 30th, 2018, the Board of Directors reviewed, pursuant to the provisions of Article L.225-37-4 6° of the French Commercial Code, its diversity policy applied within it, the objectives of that policy, the manner in which it is implemented as well as the results obtained in 2018.

It considered that, in terms of Board composition, the objectives set for 2018 of maintaining a balanced representation of women and men within the Board, maintaining the presence of multiple nationalities and maintaining the presence of diversified national and international expertise and experience, are still met. Indeed, the Board comprises 14 members including 6 women (43%), 9 independent directors (64%) and representatives of 6 different nationalities. It comprises within it experienced and recognized professionals in their respective business sectors of a complementary nature and international dimension.

In terms of independence of its members, the Board also noted that, with a rate of independent directors at 64%, the objective of a continued independent rate higher than half of the members is still met.

With regard to the objective of diversity in terms of age, it lastly noted that less than a third of directors in office were over 70 years old.

Given all those elements, the Board considered that its composition was still fully satisfactory in 2018 with regards to the relevant diversity criteria. However, it intends to remain vigilant by examining all the factors of improvement that could, in the future, be beneficial to the dynamism of the Group.

The diversity policy within the senior management is described in section 3.1.4 *Executive Management.*

Aetna Better Health® of Kentucky Att E-2437

Main activities exercised by directors in office

Daniel Julien
Chairman and Chief Executive Officer

66 years old

Nationalities:
French and American

Number of shares held:
974,314

Term of office:
GM 2021

EXPERTISE AND EXPERIENCE

Daniel Julien was born on December 23rd, 1952 and holds an Economics Degree from Paris X University. In 1978, he founded the Teleperformance telemarketing company in a Paris office with only ten telephone lines, at the age of 25. By 1985, only a few years later, Teleperformance had become the market leader in France. The Group opened subsidiaries in Belgium and Italy the following year. In 1988, the Group continued its European development by adding subsidiaries in Spain, Germany, Sweden and the United Kingdom, and in 1995 it became the European market leader. In 1993, under the leadership of its founder, the Group continued its international expansion by opening a call center in the United States, followed by Asia in 1996 and then Latin America, including Mexico in 2002 and Argentina and Brazil in 2004. The Group founded by Daniel Julien has been the global leader in the customer relations management market since 2007.

Daniel Julien was Chairman of the Management Board of the Company and then Chairman and CEO from May 2011 to May 2013 further to the change of governance structure (from a dualist to a monistic governance structure). From May 2013 to October 2017, he served as the Group executive Chairman. Since October 13th, 2017, he serves Chairman and Chief Executive Officer.

CURRENT DIRECTORSHIPS

Teleperformance Group

- Chairman of the Board and Chief Executive Officer of Teleperformance Group, Inc. (USA)
- Director of various overseas subsidiaries of the Teleperformance Group (USA, Canada, India and UK)

Other (non-listed companies)

- Director of Frens Inmobiliaria, S.A. de C.V. (Mexico)
- Director of DJ Plus Operadora Inmobiliaria, S. de R.L. de C.V. (Mexico)
- Director of DJ Plus S. de R.L. de C.V. (Mexico)

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

None

Att E-2438 Aetna Better Health® of Kentucky

Emily Abrera

Independent director and member of the Remuneration and Appointments Committee

71 years old

Nationality:

Filipino

Number of shares held:

1,000

Term of office:

GM 2021

EXPERTISE AND EXPERIENCE

Emily Abrera was born on August 6th, 1947 and took up Journalism and Mass Communications at the University of the Philippines. In 1979, she joined the Philippine subsidiary of McCann Erickson, a global advertising communications Group, as creative director. She was appointed President in 1992 and became Chairman and Chief Executive Officer of the Company in 1999. Her exemplary management contributed to the agency's success and sustained leadership in a highly competitive environment. After retiring in May 2004, Ms. Abrera served as Chairman of McCann Worldgroup Asia-Pacific from 2008 to 2010, as well as Chairman Emeritus of McCann Worldgroup in the Philippines.

Ms. Abrera is involved in a number of public interest causes which include literacy, children's and women's rights and protection of the environment. She serves as Chairman of the Board of the Cultural Center of the Philippines since 2006 and the Children's Hour Philippines organization since 2009. She is also a Board member of the Philippine Eagle Foundation, the Philippine Board on Books for Young People and the Philippine Cancer Society among others.

Ms. Emily Abrera was co-opted to the Board of Directors of the Company on November 27th, 2012. This appointment (cooptation) was ratified at the shareholders' meeting held on May 30th, 2013.

CURRENT DIRECTORSHIPS

Teleperformance Group

None.

Other (non-listed companies)

- President of the Foundation for Communication Initiatives (Philippines)
- Chairwoman of the Board of CCI Asia
- Director of Pioneer Insurance
- Director of Splash Corporation
- Director of J. Romero Advertising

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

None

Aetna Better Health® of Kentucky Att E-2439

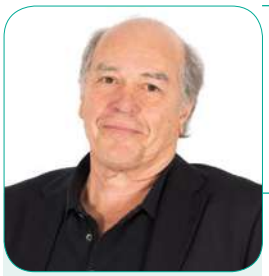

Alain Boulet

Independent director and Chairman of the Audit and Compliance Committee

69 years old

Nationality:

French

Number of shares held:

600

Term of office:

GM 2019

EXPERTISE AND EXPERIENCE

Mr. Alain Boulet was born on June 24th, 1949 and holds a Degree in Psychology, ethology and behavioral sciences from Nanterre University. Between 1975 and 1985, within the Time Warner Group, he designs and implements mail orders to win new clients and build customer loyalty for Southern Europe and then creates the first call centers dedicated to Time Group customers.

In 1985, he became the founding Chairman of the ONE agency. Initially based around its know-how on the mail-order business, the agency will become one of the leaders in terms of design and implementation of customer relationship management and communication strategies both for business to business and for business to consumer. He became Chairman of the SR Marketing Services in 1999, the group acting on the entire specialized marketing services chain. The expertise offered covering upstream and research with qualitative and quantitative studies businesses, data mining or predictive models, as well as the downstream with all specialized communication businesses such as sales promotion, Direct marketing or the Web to Field Marketing, animation and stimulation of sales networks.

As a specialist of Relationship Marketing, data processing and analysis, he has worked, since 2008, as a web marketing consultant for companies in the financial sector integrating e-commerce in their marketing and sales approach.

Mr. Alain Boulet was appointed a director of the Company on May 31st, 2011.

CURRENT DIRECTORSHIPS

Teleperformance Group

None

Other

None

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

None

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Bernard Canetti

Director and member of the Remuneration and Appointments Committee

69 years old

Nationality:

French

Number of shares held:

1,000

Term of office:

GM 2020

EXPERTISE AND EXPERIENCE

Bernard Canetti was born on May 7th, 1949 and graduated from the ESCP Europe Business School in 1972. Bernard Canetti's career has been focused on publishing and innovation. He was Chief Executive Officer of Éditions Robert Laffont's mail-order business until 1984, when he joined the Guilde Internationale du Disque, which he merged with the Editions Atlas Group in 1986. As CEO, then Chairman and CEO, he turned the Company, over 25 years into a profitable and powerful Group operating in 29 countries and market leader for online and mail-order sales of cultural collections and mass-market textile products. In 2010, he founded Comme J'aime and became the Company's Chairman. Following a spectacular growth, Comme J'aime is currently the leader in France of nutritional re-education programs for overweight people. At the end of 2012, he repurchased the Centre Européen de Formation (European Training Centre) and became the Company's Chairman. He transformed the Company into one of the main private establishments providing remote professional training and correspondence courses on the French market. In 2015, he set up and presided over Xynergy Group, a holding company which owns and manages Comme J'aime and the Centre européen de Formation.

Mr. Bernard Canetti was appointed to the Supervisory Board of the Company on June 23rd, 2005, and became a director on May 31st, 2011, following the change in the governance structure adopted at the shareholders' meeting.

CURRENT DIRECTORSHIPS

Teleperformance Group

None

Other (non-listed companies)

- Chairman of Comme J'aime SAS (France) and Comme J'aime Italie SAS (Italy)
- Chairman of Centre Européen de Formation SAS (France)
- Chairman of Xynergy Groupe SAS (France)
- Director of Productions Jacques Canetti and Editions Majestic (France)
- Manager of Bernard Canetti Entreprises EURL (France)

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

- Chairman of Provea SAS, Éditions Atlas SAS and Éditions Atlas Inc. (Canada)
- Director of Marathon SAS

Aetna Better Health® of Kentucky Att E-2441

Philippe Dominati
Director

64 years old

Nationality:
French

Number of shares held:
1,000

Term of office:
GM 2020

EXPERTISE AND EXPERIENCE

Mr. Philippe Dominati was born on April 12th, 1954 and holds a Degree in Law from Paris II-Assas University and a Degree in Political Science from Metz University.

Philippe Dominati was a Councilor in Paris (8th District) from 1989 to 2001 and a Regional Councilor for Ile-de-France (Paris region) from 1992 to 2004. He has been senator from Paris and a member of the French Finance Commission since September 2004. Philippe Dominati chaired the Senatorial Investigation Committee on the flight of capital and assets from France.

Mr. Philippe Dominati was appointed to the Supervisory Board of the Company in June 1996, and became a director on May 31st, 2011, following the change in the governance structure adopted at the shareholders' meeting.

CURRENT DIRECTORSHIPS

Teleperformance Group

- Chairman of the Board of Directors of Teleperformance France SA (France)

Other (non-listed companies)

- Manager of Isado SARL (France)
- Manager of Trocadéro SCP (France)

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

None

Att E-2442 Aetna Better Health® of Kentucky

Pauline Ginestié
Independent director

48 years old

Nationalities:
French and British

Number of shares held:
1,000

Term of office:
GM 2019

EXPERTISE AND EXPERIENCE

Born on December 30th, 1970, Pauline Ginestié holds an MBA from the Columbia Business School of Columbia University in New York. She holds a diploma in Economics and Finance from Sciences-Po Paris and a Masters degree in English Literature from the Paris X University. She started her career as an auditor with Price Waterhouse Coopers in Paris. In 1999, she joined NetValue USA as product and project manager, then Register.com in 2001.

Starting 2002, she became a freelance digital business consultant. In 2008, she obtained a Master of Sciences in human computer interaction and ergonomics from University College London, then joined Foviance, a user experience consultancy. She holds expertise in usability and customer experience acquired over the past 14 years. Since 2012, she has been an independent customer experience consultant and since 2017, she has been an independent director of PCAS.

Ms. Pauline Ginestié was appointed a director at the shareholders' meeting held on April 28th, 2016.

CURRENT DIRECTORSHIPS

Teleperformance Group

None

Other

Listed companies:

- Director of PCAS (France)

Non-listed companies:

None

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

None

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Aetna Better Health® of Kentucky Att E-2443

Jean Guez

Director and member of the Audit and Compliance Committee

73 years old

Nationality:

French

Number of shares held:

1,000

Term of office:

GM 2020

EXPERTISE AND EXPERIENCE

Mr. Jean Guez was born on November 25th, 1945 and is a graduate of the Montpellier Business School and the Paris Institute of Corporate Administration. He also holds a Degree in Chartered Accountancy. From October 1967, he worked as a trainee chartered accountant at SETEC (Paris), and then at Peat Marwick Mitchell (KPMG) from December 1968. In 1972, after qualifying as a chartered accountant and statutory auditor, he joined SO.CO.GE.RE as Chief Executive Officer, a position he held until 1982, when he joined Sofintex as a Managing Partner. He then became a partner of the BDO France Group in 2000, and then of the Deloitte Group in 2006. He is currently a Managing Partner at Conseil CSA.

Mr. Jean Guez was appointed to the Supervisory Board of the Company on January 29th, 2010, and became a director on May 31st, 2011, following the change in the governance structure adopted at the shareholders' meeting.

CURRENT DIRECTORSHIPS

Teleperformance Group

- Director of Société Tunisienne de Telemarketing SA (Tunisia)
- Director of Société Méditerranéenne de Teleservices SA (Tunisia)
- Director of Société Anonyme Marocaine d'Assistance Client SA (Morocco)
- Director of Luxembourg Contact Centers SARL (Luxemburg)

Other (non-listed companies)

- Manager of Cabinet SCA
- Co-manager of SCI Sinimmo
- President of SAS République Participation Conseil
- President of SASU Troubat

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

None

Att E-2444 Aetna Better Health® of Kentucky

Wai Ping Leung
Independent director

66 years old

Nationalities:

Chinese citizen with British nationality

Number of shares held:

1,000

Term of office:

GM 2019

EXPERTISE AND EXPERIENCE

Born on November 3rd, 1952, Ms. Wai Ping Leung holds a master of science in biology from the Northeastern University.

She has been in the apparel industry since 1982 and has experience in supply chain management, retail and marketing. In 1994, she served as regional director responsible for export sales of apparel to European countries at Inchcape Buying Services, which was a global sourcing network and acquired by the Li & Fung Group in 1995. From 2000 to 2010, she served as an executive director and was appointed member of the Li & Fung Board, a company listed in the Hong Kong Stock Exchange, in charge of the exports to Europe and the USA. From 2011 to 2017, she has been the President of LF Fashion, a company of the Li & Fung Group. In July 2017, she was appointed as CEO of Cobalt Fashion Holding Limited, a joint venture company formed by LH Pegasus Holding Limited and South Ocean Knitters Holdings Limited.

Ms. Wai Ping Leung has also served on advisory Boards for the Hong Kong Exporters' Association, the Hong Kong Trade Development Council, the Clothing Industry Training Authority, the Hong Kong Export Credit Insurance Corporation, and former Chairman of the vetting Committee for the Professional Services Development Assistance Scheme of Commerce and Economic Development Bureau of the Hong Kong Government.

Ms. Wai Ping Leung was appointed a director at the shareholders' meeting held on April 28th, 2016.

CURRENT DIRECTORSHIPS

Teleperformance Group

None

Other (non-listed companies)

- Director of various subsidiaries in the Li & Fung Limited Group
- Director of various subsidiaries in the Cobalt Fashion Group
- Director of Purple Wise Ltd
- Director of Sable Industries Ltd
- Director of Karex Ltd
- Director of Atko Ltd
- Director of Sun alliance Ltd
- Director of Great Bluebell Development Inc.

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

- Director of various subsidiaries of the Li & Fung Limited Group

Aetna Better Health® of Kentucky Att E-2445

Robert Paszczak

Independent director and Chairman of the Remuneration and Appointments Committee

68 years old

Nationality:

American

Number of shares held:

1,014

Term of office:

GM 2019

EXPERTISE AND EXPERIENCE

Born on August 10th, 1950, Robert Paszczak received a degree in Finance at Northern Illinois University (United States) in 1972. Having risen through the ranks in a national commercial finance company, he became Vice-President of the Gary-Wheaton Bank Group in 1981, and then became the director of commercial lending in 1982, a position he held until 1991, when he was appointed director of the Gary-Wheaton Corporation. In 1993, following the acquisition of Gary-Wheaton Bank by First National Bank of Chicago, he continued to serve as Vice-President in charge of commercial banking of Gary-Wheaton Bank. As a result of mergers, between 1995 and 2009, he held successive positions as senior Vice-President at First National Bank of Chicago, American National Bank & Trust Company of Chicago, Bank One Corporation and JP Morgan Chase Bank. He was appointed vice-Chairman of Wheaton Bank & Trust (Wintrust Financial) in March 2010 and became Chairman of the Board in 2013. Robert Paszczak is very involved in charitable organizations.

Mr. Robert Paszczak was appointed to the Supervisory Board of the Company on June 2nd, 2010, and has been a director since May 31st, 2011, following the change in the governance structure adopted at the shareholders' meeting.

CURRENT DIRECTORSHIPS

Teleperformance Group

None

Other (non-listed companies)

- Chairman of Wheaton Bank & Trust (Wintrust Group) (USA)
- Director of Euclid Beverage (USA)

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

None

Att E-2446 Aetna Better Health® of Kentucky

Leigh Ryan
Director

65 years old

Nationality:
American

Number of shares held:
1,000

Term of office:
GM 2019

EXPERTISE AND EXPERIENCE

Ms. Leigh Ryan was born on November 6th, 1953, and holds a Bachelor's degree in International Relations from Pomona College in Claremont, California. She also holds a Juris Doctorate degree in Law from Georgetown University, where she was an editor of Law and Policy in International Business. On February 1st, 2016, Ms. Ryan was appointed Chief Legal Officer and Chief Compliance Officer *of* the Teleperformance Group. Prior to February 1st, 2016, Ms. Ryan was a partner with Paul Hastings LLP, an international law firm with 22 offices in the United States, Europe and Asia. Ms. Ryan has over 35 years of experience in corporate finance transactions, securities offerings, mergers and acquisitions, commercial transactions and corporate governance. She has substantial transactional experience in the telecommunications, technology, customer care and media industries, as well as the apparel and aircraft industries. In addition to practicing law full-time, Ms. Ryan was Global Chair of Talent Acquisition (attorney recruiting) at Paul Hastings for over 10 years.

Before joining Teleperformance, Ms. Ryan served as outside counsel to the Teleperformance Group for over 20 years, including advising on numerous acquisitions in the US, Mexico and Colombia.

Ms. Ryan is a member of the New York and California Bars. She is an Honorary Member of the Board of Directors of La Jolla Music Society, having served on the Board for 12 years, including 2 years as Chair of the Board. She also served as a member of the Advisory Board of *the* Corporate Counsel Institute in Washington, D.C. for over 13 years.

Ms. Leigh Ryan was appointed a director at the shareholders' meeting held on April 28th, 2016.

CURRENT DIRECTORSHIPS

Teleperformance Group

- Director and Chairwoman of various overseas subsidiaries of the Teleperformance Group (USA, UK, Canada, Costa Rica, India and Panama)

Other

None

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

None

Aetna Better Health® of Kentucky Att E-2447

Christobel Selecky
Independent director

63 years old

Nationality:
American

Number of shares held:
1,000

Term of office:
GM 2020

EXPERTISE AND EXPERIENCE

Ms. Christobel Selecky was born on March 9th, 1955, and holds a Bachelor's Degree in Political Science and Philosophy from the University of Delaware (United States) and a Masters' Degree in Public Relations and Communications from Syracuse University (New York). Ms. Selecky has over 30 years' experience in the healthcare sector as a director, manager and company founder. In 1981, she joined FHP International Corporation, a NASDAQ-listed company that administered managed healthcare plans, operated medical and dental clinics, hospitals, and pharmacies, and sold health and workers compensation insurance. She became the President of FHP's largest business unit, the California Health Plan, with US$2 billion in annual revenues serving more than 1 million Medicare, Medicaid, and Commercial health plan members. In 1996, she became co-founder, Chairman, and Chief Executive Officer of LifeMasters Supported Selfcare Inc., a company that provided outsourced, call center-based disease and care management services as part of health care plans and benefits granted by employers, and by public sector employee retirement plans, unions and trusts. The Company provided its services to more than 1 million people in the United States. She has been working as an independent consultant since 2010 and provides strategic advice and recommendations to teams of managers and investors involved or seeking to become involved in the healthcare sector at both national and international level.

Ms. Selecky chairs the Board of Directors and chairs the Compensation, Governance and Nominating Committee of Satellite Healthcare, one of the United States' leading not-for-profit providers of kidney dialysis and related services since 1974. She also serves on the Board of Directors, chairs the Quality and Risk Management Committee, and serves on the Audit Committee of Verity Health System, which operates six hospitals in Northern and Southern California. Finally, she serves on the Board of Directors, chairs the Finance Committee, and serves on the Compensation Committee of SCAN Health Plan, one of the nation's oldest and largest not-for-profit Medicare Advantage health plans. She is also an Adjunct Professor in the University of California, Irvine Paul Merage School of Business MBA program teaching Healthcare Entrepreneurship.

Deeply involved in the charitable sector, Christobel Selecky recently completed two terms as a member of the Board of trustees, Vice Chair and Chair of the Audit Committee of United Cerebral Palsy, a US national non-profit organization for people with disabilities, and the immediate past chair of the Board of Directors of Population Health Alliance, a nonprofit organization promoting public health care activities through advocacy, research and education.

Ms. Christobel Selecky was appointed a director at the shareholders' meeting held on May 7th, 2014.

CURRENT DIRECTORSHIPS

Teleperformance Group

None

Other (non-listed companies)

- Director of Satellite Healthcare Inc. (USA)
- Director of Verity Health System (USA)
- Director of SCAN Health Plan (USA)

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

- Director of Memorial Care Innovation Fund (USA) and American Specialty Health Inc. (USA)
- Member of the Advisory Committee of Houlihan Lokey (USA)

Att E-2448 Aetna Better Health® of Kentucky

Angela Maria Sierra-Moreno
Independent director

64 years old

Nationality:
Colombian

Number of shares held:
1,000

Term of office:
GM 2020

EXPERTISE AND EXPERIENCE

Ms. Angela Maria Sierra-Moreno was born on August 30th, 1954 and holds a Degree in Bacteriology from the *Colegio Mayor de Antioquia* University (Colombia) and a Masters' Degree in Science from the University of Ohio (United States).

Angela Maria Sierra-Moreno has acquired over 20 years' experience in the customer management field in various business sectors. From 1995 to 2002, Ms. Sierra-Moreno was Vice-President in charge of Services at ACES, where one of her main tasks was to coordinate initiatives aimed at changing the Company's culture, in accordance with its requirements and those of the outside environment.

In 2002, she joined Avianca as Vice-President in charge of Services and Human Resources. In this capacity, she contributed to developing a corporate strategy aimed at setting up a customer-centric organizational structure by designing and implementing processes, tools and mechanisms dedicated to customer service for the Company's global operations. Ms. Sierra-Moreno has been an organizational management consultant since 2010, and advises companies and organizations operating in various business sectors on customer relationship management, Human Resources, and cultural and organizational change.

Ms. Angela Maria Sierra-Moreno was appointed a director at the shareholders' meeting held on May 7th, 2014.

CURRENT DIRECTORSHIPS

Teleperformance Group

None

Other (non-listed companies)

- Director of LASA SA (Colombia)
- Director of Prestigio (Colombia)

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

- Director of Dinamica (Colombia)

Aetna Better Health® of Kentucky Att E-2449

© Thomas Laisné

71 years old

Nationality:
French

Number of shares held:
500

Term of office:
GM 2019

Patrick Thomas

Independent director and Lead Independent director

EXPERTISE AND EXPERIENCE

Patrick Thomas was born on June 16th, 1947 and is a graduate of the *École Supérieure de Commerce de Paris* (ESCP). He served as Chief Executive Officer of Pernod Ricard U.K. from 1986 to 1989. From 1997 to 2000 he chaired the Lancaster Group, and from 2000 to 2003 he served as Chairman and Chief Executive Officer of the British company William Grant & Sons. Finally, he was Chief Executive Officer of Hermès International from 1989 to 1997. He rejoined the Hermès Group from 2003 to 2014 as Chief Executive Officer and then manager of Hermès International.

Mr. Patrick Thomas was co-opted to the Board of Directors of the Company on November 30th, 2017. This cooptation was ratified at the shareholders' meeting held on April 20th, 2018. He also was appointed the Lead Independent director at the Board meeting held on February 28th, 2018.

CURRENT DIRECTORSHIPS

Teleperformance Group

None

Other

Listed companies:

- Director, member of the compensation committee and chairman of the appointments and governance committee of Renault SA (France)
- Vice-chairman of the supervisory board and chairman of the compensation committee of Laurent Perrier SA (France)

Non-listed companies:

- Member of the supervisory board of Leica Camera AG (Germany)
- Member of the supervisory board of Château Palmer (France)
- Chairman of the supervisory board, chairman of the compensation committee and chairman of the invesments committee of Ardian (France)
- Vice-chairman of the supervisory board of Massilly Holding (France)
- Chairman and director of Shang Xia Trading (China)
- Chairman and director of Full More Group (Hong Kong)

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

- Director of Lacoste (France)
- Vice-chairman and member of the supervisory board of Gaulme (France)
- Director and censor (non-voting director) of Remy Cointreau (France)
- Manager of Hermès International and various terms of office in subsidiaries of the Hermès Group

Att E-2450 Aetna Better Health® of Kentucky

Stephen Winningham

Independent director and member of the Audit and Compliance Committee

69 years old

Nationalities:

American and British

Number of shares held:

1,000

Term of office:

GM 2021

EXPERTISE AND EXPERIENCE

Mr. Stephen Winningham was born on December 1st, 1949, and holds a Masters in Business Degree (Finance & marketing) from Columbia University and pursued additional studies in Economics at New York University. He has 30 years of international experience in the banking field. He began his banking career at Citibank, NA, before moving to Drexel Burnham Lambert. He then held management positions at Paine Webber Inc. and Kidder Peabody & Co. in New York, which have since then merged with the UBS Group. He was managing director of Salomon Brothers-Citigroup from 1996 to 2007, when he was based in New York and Hong Kong. He became managing director of Lloyds Banking in London in 2007, specifically responsible for global finance institutions, and then for key accounts in 2009. Stephen Winningham has been a managing director and Co-Head of the Corporate Finance – Europe, Middle East and Africa – department at Houlihan Lokey in London since February 2012. He is also co-Founder and Chairman of City Harvest, a London charity addressing hunger.

Mr. Stephen Winningham was appointed to the Supervisory Board of the Company on June 2nd, 2010 and has been a director since May 31st, 2011 following the change in the governance structure adopted at the shareholders' meeting.

CURRENT DIRECTORSHIPS

Teleperformance Group

None

Other (non-listed companies)

- Managing director of Houlihan Lokey (United Kingdom)

DIRECTORSHIPS EXPIRED WITHIN THE LAST FIVE YEARS

Teleperformance Group

None

Other

None

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Evolution of the composition of the Board during 2018

In compliance with the AMF recommendation No. 2012-02, the table hereafter presents in a summarized manner the changes which occurred during 2018 in the Board's composition. This position is set as of December 31st, 2018.

	Departure	Appointment	Renewal/cooptation	Comments
Board of Directors	-	-	Ratification of the temporary appointment of Mr. Patrick Thomas as a director. Ms. Emily Abrera and Messrs. Daniel Julien, Bernard Canetti, Jean Guez and Stephen Winningham were renewed as directors.	Diversification in the Board's composition: Competence/ Independence/Knowledge of the Group/Lead Independent director
Audit and Compliance Committee	-	-	-	-
Remuneration and Appointments Committee	-	-	-	-
Others	-	-	-	-

Proposals to the shareholders' meeting on the composition of the Board of Directors

It is proposed that the shareholders' meeting to be held on May 9th, 2019 to renew the terms of office of six directors which are expiring. If the shareholders' meeting approves the propositions submitted:

- the terms of office of Ms. Pauline Ginestié, Wai Ping Leung and Leigh Ryan and Mr. Patrick Thomas will be renewed for 3 years;
- the terms of office of Messrs Alain Boulet and Robert Paszczak will be renewed for 2 years.

In accordance with the diversity policy presented above (see *Diversity policy within the Board of Directors*), if the shareholders' meeting approves all the propositions thus submitted, these renewals will allow to maintain:

- a strong rate of independence, *i.e.*, 64%.

  The Board of Directors, upon proposal from its Remuneration and Appointments Committee, considered that Ms. Pauline Ginestié, Ms. Wai Ping Leung, Mr. Alain Boulet, Mr. Robert Paszczak and Mr. Patrick Thomas continue to be qualified as independent in application of the independence criteria of the AFEP-MEDEF code (*supra* paragraph *Qualification as independent director*);
- a percentage of women of 43%, thus complying with the legal provisions on the matter;
- a continued strong internationalization of its composition with six nationalities represented and 64% of non-French directors or binationals;
- a strong knowledge and expertise of the Group, its business and specificities necessary to the good functioning of the Board.

Statements on the situation of members of the administrative, management and supervisory bodies

Family ties

To the Company's knowledge, there are no family ties between the directors.

Absence of conviction or indictment of corporate officers

To the Company's knowledge, as of the date of the present Registration Document, during the past five years, none of the directors or members of the executive management:

- had been convicted for fraud, or indicted and/or sentenced to an official public sanction by any statutory or regulatory authority;
- had been involved in a bankruptcy, a sequestration of assets or a liquidation procedure;
- had been prevented by a court order from acting in the capacity of a member of an issuer's administrative, management or supervisory body or from being involved in the management or conduct of an issuer's business affairs.

Absence of conflicts of interests

The internal regulations of the Board of Directors states that each director must inform the Chairman of the Board of any conflict situation, even potential, between the Company's interests and his or her direct or indirect interests, or those of the shareholder Group that they represent. In addition, said director must abstain from the discussions and corresponding deliberations.

To the Company's knowledge, as of the date of this Registration Document:

- no conflicts of interest are identified between the duties of each director and member of the executive management to the Company and/or the Group in respect of their position as corporate officers and their private interests or other duties;
- no arrangement or agreement exists with the principal shareholders, customers or suppliers wherein one of the members of the Board of Directors or the executive management has been selected in such capacity;
- no restriction has been accepted by members of the Board of Directors or the executive management concerning the transfer of their holdings in the Company, other than restrictions attached to performance shares granted to them or in connection with the long-term incentive plan.

Service agreements or agreements entered into with a director

Mr. Daniel Julien, Chairman and Chief Executive Officer and non-independent director, is a 35% shareholder in a company that owns a building leased since 2010 to Servicios Hispanic Teleservices S.C. (Mexico). The total rental income amounted to US$591,973.95 in 2018 compared to US$577,843.62 in 2017.

This agreement is qualified as an ordinary agreement concluded on normal terms.

Loans and guarantees granted to directors

The Company has not granted any loans nor guarantees to any of its directors.

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Interests in Group companies held by directors

In 2018, pursuing its policy of repurchasing minority shareholders, the Group acquired the shareholdings held by the three minority shareholders in the company GN Research S.A. (Luxembourg) (now named Praxidia S.A.) including 10% of the share capital held by Mr. Daniel Julien purchased for a total amount of €910,000. Following these transactions, the Group owns 100% of the share capital (compared to 67% before these repurchases) of Praxidia S.A.

This transaction was carried out on the basis of the market value determined as a result of the valuation made by an independent expert. The Audit and Compliance Committee reviewed the works of that expert and retained the lower range of its valuation for this transaction. This transaction was completed on these bases and was approved by the Board of Directors, Mr. Julien did not take part in the discussions or in the vote.

Mr. Daniel Julien, Chairman and Chief Executive Officer, holds 7% of the share capital of Hong Kong Asia CRM Ltd (Hong Kong).

To the Company's knowledge, no other director or member of the executive management has investments or interests in the subsidiaries or interests in the Company, either directly or indirectly, excluding the shares held in connection with a corporate officership within the Group.

3.1.3.2 Organization and functioning of the Board of Directors

3.1.3.2.1 Internal Regulations of the Board of Directors

On May 31st, 2011, the Company's Board of Directors adopted its internal rules, amended on February 28th 2019, aimed at explaining its role and procedures, in accordance with the legal and statutory provisions and corporate governance rules applicable to listed companies. The main provisions of the Board of Directors' internal regulations are described below.

Directors' rights and obligations

The Board of Directors may perform any checks and controls that it deems appropriate at any time. It may ask the Company to forward to it any documents of any kind that are useful for the performance of its assignment, regardless of whether such documents are issued by the Company or are intended for it. The directors are entitled to have any documents and information forwarded to them, in order to perform this assignment. This right shall be exercised *via* the Chairman of the Board of Directors; the directors may not personally interfere in the management of the Company or directly request the documents and information required.

The Board of Directors' internal rules also set out the obligations incumbent on directors, specifically with regard to corporate ethics, confidentiality, conflicts of interest and the possession of insider information.

Managing conflicts of interest

As part of the management of conflicts of interest, the Board of Directors authorizes regulated agreements and commitments and settles any potential situation of conflict of interest involving common directors within the Group.

The internal regulations of the Board provide that every director is required to inform the Chairman of the Board of Directors of any conflict situation, even a potential situation, between the Company's interests and their direct or indirect interests, or, if applicable, those of the shareholder Group that they represent. In addition, they must abstain from attending the debate and taking part in voting the related resolution.

Information – Training – Conditions for preparing the works of the Board – Confidentiality

Members of the Board of Directors receive all the documents, technical materials and information that are appropriate and necessary for the performance of their mission and to prepare their discussions. The Board may ask for any reports, documents and research prepared by the Group prior to any meeting and may commission any external technical studies at the Company's expenses. The annual timetable for the Board of Directors' meetings is communicated to the directors and the statutory auditors several months in advance.

The Board of Directors is continually informed by its Chairman, by various means, of all material events and transactions relating to the Company. In addition, where the Chairman considers it necessary, the Board of Directors may hear the Group's key Officers, in order for them to present their specific area of activity within the Group or the situation of the regional subsidiaries for which they are responsible.

When appointed to the Board, each director receives the information regarding the Company and the Group as well as, if he or she considers it to be necessary, a supplementary training relating to the Company's specific accounting, financial and operational features of the Group, its business sector and its social and environmental responsibility issues. Interviews are set up with the Chairman and Chief Executive Officer, the Deputy Chief Executive Officer and/or the Group Chief Legal Officer. The formation of directors continues beyond their appointment, specifically through site visits and constitutes a continuing process.

The Board of Directors is a collegial body; its decisions are binding on all of its members. Directors and any person who attends its meetings are bound by a strict non-disclosure obligation and duty of discretion on information disclosed by the Company and received during the discussions of the Board and its Committees, and those of a confidential nature, or presented as such by the Chairman of the Board of Directors. In addition, if the Board of Directors is aware of confidential and precise information that is likely to have a material impact on the share price of the Company or of the companies controlled by the Company when it is published, within the meaning of Article L.233-3 of the French Commercial Code, the directors must comply with the regulations applicable to insider dealings and insider misconduct, and in particular, must refrain from disclosing this information to a third party as long as it has not been made public, and must refrain from performing any transactions involving the Company's securities.

Board meetings

The Board of Directors meets at least once a quarter, in order to discuss the progress of the Company's affairs and their foreseeable development. It is convened by the Chairman. If the position of Chairman is vacant, or if the Chairman is prevented from attending, the Board of Directors may be convened on a given agenda by the Chief Executive Officer, the appointed Vice-Chairman, where applicable, or by any director.

Meetings may be held in any location, as indicated in the notice. An attendance register is kept and is signed by the members of the Board of Directors attending the meeting. At least half of the Board members must be physically present for the Board's decisions to be valid.

Decisions are taken by majority vote of the members who are present or represented; each member who is present or represented has one vote, and each member who is present may only hold one proxy. The Chairman of the meeting has the casting vote in the event of a tied vote.

The Board of Directors may invite anyone that it chooses to attend all or part of its meetings. The Board decides whether to hear these speakers individually or collectively.

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Directors may attend the Board meetings by means of videoconferencing or telecommunications facilities, in accordance with the applicable statutory and regulatory provisions. These attendees are considered present for the calculation of the quorum and majority, except in the case of meetings relating to the approval of the annual parent company financial statements and the management report.

Minutes of proceedings

The Board of Directors' discussions are recorded in minutes that are entered into a special ledger held at the registered office. The minutes shall mention the use of the videoconference and telecommunication systems described in the previous sub-paragraphs, where applicable.

The minutes are signed by the Chairman of the meeting and by at least one director; in the event that the Chairman of the meeting is prevented from attending, the minutes are signed by at least two directors. In addition to the information required by law, these minutes specify the nature of the information provided to members of the Board of Directors, and provide a summary of the discussions, as well as an indication of the manner whereby each of the members present or represented voted on each item in the agenda.

At each Board meeting, the Chairman shall provide each member in attendance with a copy of the minutes of the previous meeting as approved by the Board of Directors.

Committees

The Board of Directors may decide to set up internal Committees, for which it determines the membership and remits, and which perform their activities under its responsibility. The Board decided to create two permanent specialized Committees: the Audit and Compliance Committee and the Remuneration and Appointments Committee.

Each Committee reports to the Board of Directors on its work and informs the Board of any points that it considers problematic or requiring a decision, thereby assisting the Board's discussions. At each Board meeting, the Chairman of each Committee shall provide each Board member in attendance with a report on the Committee's work since the last Board meeting.

3.1.3.2.2 Missions and duties

Pursuant to legal and regulatory provisions, the articles of association and its internal regulations, the Board of Directors has the following duties:

- approving the annual and consolidated financial statements and the management report;
- establishing management forecasts documents;
- convening and setting the agenda for the shareholders' meeting;
- deciding whether to issue bonds;
- authorizing sureties, endorsements and guarantees;
- prior authorization of regulated agreements and commitments;
- setting up specialized Committees and determining their missions;
- deciding whether to pay any interim dividends;
- reviewing and determining the guidelines for the Company's business;
- selection of the organization structure of executive management;
- appointing and dismissing the Chairman, the Chief Executive Officer, and the Deputy Chief Executive Officers;
- co-opting members of the Board under the conditions determined by the regulations in force;
- defining the remuneration policy for executive officers and distribution of directors' fees within the global amount decided by the shareholders' meeting amongst Board members;
- determining the number of performance shares that executive officers are required to retain in registered form until the end of their term of office, in the event of the award of options or performance shares;
- reviewing the main issues in the field of corporate social responsibility;
- promoting long-term value creation by the Company by considering the social and environmental aspects of its activities;
- regularly reviewing, in relation to the strategy it has defined, the opportunities and risks, such as financial, legal, operational, social and environmental risks, as well as the measures taken accordingly;
- ensuring, if applicable, the implementation of a mechanism to prevent and detect corruption and influence peddling;
- ensuring that the executive officers implement a policy of non-discrimination and diversity, notably with regard to the balanced representation of men and women on the governing bodies;
- setting up the report on corporate governance.

Furthermore, the Board of Directors determines or authorizes expressly and prior to their completion the following issues:

- approving consolidated annual budgets;
- any significant (commercial, industrial, financial, real estate or other) transaction that the management plans, not comprised under the approved strategy or budget, including, in particular, moveable or immoveable investment by external or internal growth, where the amount represents more than 20% of the Group's net assets as reports in the latest consolidated financial statements approved by the Board of Directors;
- concluding alliances of any kind involving a material proportion of consolidated revenues;
- proposing dividend distributions to general meetings of shareholders.

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Status of the current delegations and authorizations granted to the Board by the combined shareholders' meetings held on April 28th, 2016 and June 23rd, 2017 and propositions of authorizations submitted to the shareholders' meeting to be held on May 9th, 2019, on share capital increases

	Date of shareholders' meeting (Resolution No.)	Maximum nominal amount *(in euros)*	Duration (expiry)	Use made during 2018
ISSUES WITH PREFERENTIAL SUBSCRIPTION RIGHTS FOR SHAREHOLDERS				
Capital increase by issues of shares and securities giving access to the share capital, for which the primary security is not a debt instrument with maintenance of preferential subscription rights for shareholders*	June 23rd, 2017 (18th)	40 million(1)	26 months (Aug. 2019)	None
Capital increase by issues of shares and securities giving access to the share capital or to the issuance of debt instruments with maintenance of preferential subscription rights for shareholders*	**May 9th, 2019 (19th)**	**50 million(2)**	**26 months (July 2021)**	-
ISSUES WITHOUT PREFERENTIAL SUBSCRIPTION RIGHTS FOR SHAREHOLDERS				
Capital increase by issues of securities giving access to the share capital without preferential subscription rights for shareholders by public offering but with obligation to confer a mandatory priority right of 5 trading days minimum*	June 23rd, 2017 (19th)	28 million(3)	26 months (Aug. 2019)	None
Capital increase by issues of shares and securities giving access to the share capital without preferential subscription rights for shareholders by public offering or by remuneration of securities in a public offering but with obligation to confer a mandatory priority right of 5 trading days minimum*	**May 9th, 2019 (20th)**	**28 million(4)**	**26 months (July 2021)**	-
ISSUES RESERVED FOR EMPLOYEES AND, WHERE APPLICABLE, EXECUTIVE OFFICERS				
Free grants of performance shares to employees and/or executive officers	April 28th, 2016 (16th) **May 9th, 2019 (22nd)**	2.5% of the share capital(5) **3% of the share capital(6)**	38 months (June 2019) **38 months (July 2022)**	Used in 2018 in respect of 7,000 shares(7)
Capital increases reserved for members of a company or Group savings scheme	June 23rd, 2017 (20th) **May 9th, 2019 (21st)**	2 million **2 million**	26 months (Aug. 2019) **26 months (July 2021)**	None -
OTHER ISSUES				
Capital increase by capitalization of premiums, reserves or profits*	June 23rd, 2017 (17th) **May 9th, 2019 (18th)**	142 million **142 million**	26 months (Aug. 2019) **26 months (July 2021)**	None -

* *Suspended during a public offering.*
(1) On this amount is applied the maximum amount set in the 19th resolution approved by the shareholders' meeting held on June 23rd, 2017.
(2) On this amount is applied the maximum amount set in the 20th resolution submitted to the approval of the shareholders' meeting to be held on May 9th, 2019. Maximum of €500 million for debt instruments.
(3) This amount is applied to the maximum amount set in the 18th resolution approved by the shareholders' meeting of June 23rd, 2017. Maximum of €300 million for debt instruments.
(4) This amount is applied to the maximum amount set in the 19th resolution submitted to the approval of the shareholders' meeting to be held on May 9th, 2019. Maximum of €300 million for debt instruments.
(5) Limitation of the number of performance shares that may be granted to executive officers to 0.612% of the share capital within this envelope.
(6) Limitation of the number of performance shares that may be granted, each year, to executive officers at 0.15% of the share capital within this envelope.
(7) See section 7.2.5.3 of the present Registration Document. It is specified that the Board of Directors decided to grant, on January 2nd and February 28th, 2018, a total of 7,000 performance shares on the basis of said authorization.

Status of the authorizations granted to the Board by the shareholders' meetings held on June 23rd, 2017 and April 20th, 2018 and propositions of authorizations submitted to the combined shareholders' meeting to be held on May 9th, 2019 on share repurchases and their cancellation

	Date of shareholders' meeting (resolution No.)	Duration (expiry)	Terms
Share repurchases*	April 20th, 2018 (17th) **May 9th, 2019 (16th)**	18 months (October 2018) **18 months (Nov. 2020)**	Maximum purchase price per share: €180 Limit: 10% of the total number of shares **Maximum purchase price per share: €180** **Limit: 10% of the total number of shares**
Cancellation of shares	June 23rd, 2017 (16th) **May 9th, 2019 (17th)**	26 months (August 2019) **26 months (July 2021)**	10% of the total number of shares on date of cancellation decision **10% of the total number of shares on date of cancellation decision**

* *Suspended during a public offering.*

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3.1.3.2.3 Lead Independent director

Following the decision to combine the functions of Chairman and Chief Executive Officer, and further to the continued improvement of the governance within the Company, the Board of Directors, at its meeting held on February 28th, 2018, decided, upon recommendation of the Chairman and Chief Executive Officer and the Remuneration and Appointments Committee, to create the function of a Lead Independent director and to amend, as a consequence, the Internal Regulations of the Board of Directors defining the modalities of the appointment of such Lead Independent director, as well as his or her missions. The creation of the function of Lead Independent director is part of the guarantees set up by the Company in order to reinforce the balance and control of powers, in accordance with the principles of good governance.

Appointment of the Lead Independent director

When the functions of Chairman of the Board and Chief Executive Officer are exercised by the same person, the Board of Directors appoints, among the directors qualified as independent by the Board of Directors, a Lead Independent director, on the recommendation of the Remuneration and Appointments Committee.

The appointed Lead Independent director holds this position while in office as a director, unless otherwise decided by the Board of Directors, which may choose to terminate his or her duties at any time. If for any reason the director is no longer qualified as independent, his or her position as Lead Independent director will be terminated.

The Lead Independent director may be a member of one or more of the Committees of the Board of Directors.

Functions of the Lead Independent director

Interim role: continuity of governance

- In the event that the Chairman is absent at a meeting of the Board of Directors, the Lead Independent director presides over the meeting.
- In the event of a temporary or durable unavailability of the Chairman to fulfill his functions, the Lead Independent director becomes interim Chairman. He or she replaces the Chairman until the Chairman becomes available again or until a new Chairman is elected.

  If necessary, he or she organizes the selection and appointment of a new Chairman of the Board.
- If, during the interim, it becomes necessary to appoint a new Chief Executive Officer, the Lead Independent director also organizes the selection process and appointment of this new Chief Executive Officer.

Relationships with shareholders

- The Lead Independent director is, with the Chairman, the Chief Executive Officer and the Deputy Chief Executive Officer, the shareholders' dedicated contact on issues that fall within the remit of the Board.
- The Lead Independent director shall keep the Chairman, the Chief Executive Officer and the Board informed of the main topics raised by shareholders.

Means of the Lead Independent director

The Lead Independent director:

- convenes, organizes and chairs, at least once a year, a meeting of the independent directors where topics of their choice are discussed;
- can attend, with no voting rights, all meetings of the Board Committees of which he or she is not a member and participate in their work; he or she shall also attend, if invited by the Chief Executive Officer and/or the Deputy Chief Executive Officer, meetings of the Executive Committee;
- can suggest to the Chairman additional items to the agenda of Board meetings;
- has access to all documents, information and people that he or she deems necessary to fulfill his or her functions;
- reports once a year to the Board of Directors on the execution of his or her functions.

Report of the Lead independent director on his activity in 2018

Mr. Patrick Thomas, independent director, was appointed Lead Independent director by decision of the Board of Directors held on February 28th, 2018.

At the meeting of the Board of Directors held on February 28th, 2019, Mr. Thomas gave a report on his activity under his mission as Lead Independent director. During the 2018 financial year, the Lead independent director has especially performed and taken part in the following works:

- Knowledge of the Group: the Lead Independent director visited various operational sites and various contact centers in the USA during work sessions and operational review with the Chairman and Chief Executive Officer and during the Board executive seminar in India. These visits were the occasion to become familiar with the businesses and specificities of the Group, to meet leaders, managers and agents and to discover some of the Group's initiatives in terms of corporate and environmental responsibility;
- Meetings with directors: the Lead Independent director had the occasion to meet individually independent directors in order to listen to their comments and suggestions on the Board's functioning and their modalities of access to information and their means of questioning and expression;
- Meetings with members of the Executive Committee: the Lead Independent director met with all the members of the Executive Committee and received from each of them a description of their history as well as their missions and responsibilities within the Group;
- Access and meetings with Group managers: at his request, the Lead Independent director talked with the Deputy Chief Executive Officer, the Internal Audit Director, the Risk and Insurance Director and the Secretary of the Board, allowing him to get acquainted with the Group's governance, audit processes and missions and remuneration structure of executive officers and managers;
- Succession plans: the Board of directors trusted the Lead Independent director with a specific mission in terms of succession planning. He has thus actively taken part in the reflection leading to the setting up of succession plans for executive officers and members of the Executive Committee. The objective of these succession plans is twofold: on the one hand, to face urgent situations or temporary unavailability of key officers and on the other hand, to ensure a sustained continuity of executive management in the long-term. These plans were designed and set up in cooperation with the Chairman and Chief Executive Officer, the Deputy Chief Executive Officer and Executive Committee members. They were shared with the Chairmen of the two specialized committees. These plans ensure the continuity of the governance in any type of situation and are meant to be reassessed. They are in essence confidential;
- Governance: during the financial year, the Lead Independent director reviewed the good functioning of the Group's governance. He found that there was a good alignment of the current governance structure with regard to the functioning of the Company and to the requirements of a listed company. He highlighted that, in particular, the fluidity of the interactions between the different actors within the management of the Company;
- Participation in Board Committees meetings: the Lead Independent director met with the Chairmen of the Board's Committees several times. He also attended some meetings and was associated with the works of the Remuneration and Appointment Committee (particularly in terms of remuneration of executive directors) and of the Audit and Compliance Committee.

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3.1.3.2.4 Assessment of the functioning and works of the Board of Directors

In accordance with the AFEP-MEDEF code recommendations, once a year, the Board of Directors proceeds with a discussion of its works and that of its specialized Committees. It reviews its composition, as well as the organization and functioning of the Board and the Committees. In addition, a formal assessment of the Board's work is performed every three years, with the support of the Remuneration and Appointments Committee or by an independent director assisted by an outside consultant. The purpose of the assessment is to check that important issues have been appropriately prepared and discussed, and to assess each member's effective contribution to the Board's work.

In early 2019, an evaluation was conducted with the assistance of an external counsel. The latter has sent each director a detailed questionnaire in order to gather their opinions, comments and suggestions concerning the composition, the organization and the functioning of the board and the committees, and, more generally, on the Group's governance. To ensure complete freedom in the directors' answers, these have not been disclosed to the company. However, the conclusions of this evaluation were presented and discussed at the meeting of the Remuneration and Appointments Committee held on February 28th, 2019 and at the meeting of the Board of Directors held on February 28th, 2019.

This assessment shows a very positive appreciation of the directors on the organization and functioning of the Board and its committees.

In particular, the directors consider that the number of directors and the composition of the board in terms of nationality, independence, feminization, diversity and experience are very satisfactory. They wish for the future to see the process of refreshing the board continue, especially at the occasion of the renewal of terms of office. This process should also strengthen the Board's current expertise in the areas of new technologies and innovation.

A positive unanimous assessment emerges from the assessment of the relevance of the group's governance. Directors particularly appreciate the quality and the transparency of the discussions with the executive management.

Directors are satisfied with the topics discussed at board meetings, including those related to strategic, social, environmental and financial issues. If the board is satisfied with the succession plan put in place, some directors would like it to be regularly put back on the agenda in the future to ensure that it does not need to be updated. In this sense, the development of talents within the group is a subject that some directors would like to deepen further.

Directors also emphasize the quality and completeness of the information provided, while wishing to obtain more research notes on the market in which the group evolves and its evolution. Finally, they unanimously welcome the interest and quality of the annual seminar, which allows them to meet the main managers and to get a very detailed understanding of the group's strategy and operations.

Directors welcome how the Board and committee meetings are organized, conducive to good communication and effective individual participation, particularly because of the amount of discussion time allowed. They are particularly satisfied with the work done, the professionalism of the members and the dynamism of the Board and its committees.

The Board of Directors noted that the wishes and improvements identified during the previous formal evaluation conducted in 2015 were taken into account in a positive and proactive manner and contribute to the satisfaction of the directors and to the proper functioning of the Board of Directors and its committees.

3.1.3.3 Meetings and works of the Board of Directors in 2018

The Board of Directors

The Board of Directors met four times in 2018 and during a five-day seminar held for the purpose of reviewing operating strategy. During that seminar, held in one of the Group's operational sites, the directors had the opportunity to visit sites, meet and exchange on strategy with all key managers of the Group and to learn about of local initiatives in terms of corporate, social and environmental responsibility.

The directors' attendance rate was 93%. Board meetings lasted, in average, between three to four hours.

The Company's Statutory Auditors were invited to and attended the Board of Directors' meetings called to approve the half-yearly and annual financial statements.

The Group Chief Financial Officer and the Secretary of the Board regularly attended these meetings, primarily to present the financial statements and their reports, to receive any authorizations required and to provide any explanations and information enabling the Board to make decisions knowingly.

The following table provides a breakdown of individual members' attendance rate in 2018:

Directors	02/28/2018	04/20/2018	07/26/2018	11/30/2018	Total
Daniel Julien	Yes	Yes	Yes	Yes	100%
Emily Abrera	Yes	Yes	Yes	Yes	100%
Alain Boulet	Yes	Yes	Yes	No	75%
Bernard Canetti	Yes	Yes	Yes	No	75%
Philippe Dominati	Yes	Yes	Yes	Yes	100%
Pauline Ginestié	Yes	Yes	Yes	Yes	100%
Jean Guez	Yes	Yes	No	Yes	75%
Wai Ping Leung	Yes	Yes	Yes	Yes	100%
Robert Paszczak	Yes	Yes	Yes	Yes	100%
Leigh Ryan	Yes	Yes	Yes	Yes	100%
Christobel Selecky	Yes	Yes	Yes	Yes	100%
Angela Maria Sierra-Moreno	Yes	Yes	Yes	Yes	100%
Patrick Thomas	Yes	Yes	Yes	Yes	100%
Stephen Winningham	Yes	Yes	Yes	No	75%
ATTENDANCE RATE	**100%**	**100%**	**93%**	**79%**	**93%**

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In addition to recurring issues relating to the business review, adjustment of annual forecasts, authorizations to be granted and the review of Group growth transactions, the Board of Directors specifically decided on the following points during its four meetings:

- examination and approval of the parent company and consolidated financial statements for the year ended December 31st, 2017, of the management report and the examination of management forecast documents;
- setting of the variable remuneration for 2017 for executive officers;
- review of directors' independence criteria and re-examination of the independence of each director;
- proposal to renew directorships and ratification of a directorship;
- designation of the Lead Independent director and determination of his missions;
- amendments to the Internal Regulations of the Board of Directors and to the Audit and Compliance Committee;
- convening of the shareholders' meeting held on April 20th, 2018, setting of the agenda for the meeting and approval of the reports and resolutions including the votes on remuneration paid or granted in connection with financial year 2017 ("say on pay");
- setting up and adoption of the report of the Board of Directors on corporate governance in respect of financial year ended December 31st, 2017;
- review of regulated and arm's length agreements and commitments in respect of financial year ended December 31st, 2017;
- renewal of the authorization given to the Chairman and Chief Executive Officer in terms of sureties, endorsements and guarantees and increase of the annual global envelope on the matter;
- grant of performance shares of February 28th, 2018;
- renewal of the term of office of the Chairman and Chief Executive Officer;
- composition of the Committees of the Board;
- determination of the directors' fees for the 2017 financial year;
- implementation of the share repurchase program;
- authorization of the Intelenet acquisition and its financing;
- review of the structure and modalities of financing of the Group;
- examination and approval of the consolidated accounts at June 30th, 2018, the half-yearly financial report and management forecast documents;
- renewal of the delegation on issues of bonds and debt securities;
- 2018 forecasts and 2019 budget;
- remuneration policy of executive officers for 2019;
- diversity policy within the Board and the committee set up by executive management in order to assist it regularly in the performance of its general duties: objectives, modalities of implementation and 2018 results, particularly with regard to gender balance in the 10% of positions with the highest level of responsibility;
- yearly discussion on the professional and employment equal treatment policy.

The Committees of the Board of Directors

In the performance of its missions and duties, the Board is assisted by two specialized Committees: the Audit and Compliance Committee and the Remuneration and Appointments Committee.

The works performed by the Committees, which report on their work after each of their meetings, assist the Board of Directors in its discussions and decision making. The Board Committees work on assignments entrusted to them by the Board. They actively prepare their works and inform the Board of all points which appear to raise an issue or require a decision, thus facilitating its deliberations. They also provide any advice and recommendation to the Board as falls within their remit, but have no power of decision, subject to the decisions that the Audit and Compliance Committee may adopt pursuant to applicable legal and regulatory provisions, under the responsibility of the Board.

The Audit and Compliance Committee

The internal regulations of the Audit and Compliance Committee have been drafted in accordance with the final report of the AMF working group on Audit Committees dated July 22nd, 2010. They were updated by decision of the Board of Directors at its meeting held on February 28th, 2018.

Composition

The Audit and Compliance Committee is composed of at least three members of the Board of Directors, as chosen by the Board. No executive officer sits on this Committee.

The Audit and Compliance Committee members are appointed for the term of their office as members of the Board of Directors.

As of the date of this report, the Audit and Compliance Committee consists of three members, two of whom are independent:

Alain Boulet	Chairman, independent
Jean Guez	Member
Stephen Winningham	Member, independent

In accordance with the recommendations of the AFEP-MEDEF code, at least two thirds of the Committee's members are independent.

The three members have the specific financial and accounting skills required to perform their duty of due diligence and to accomplish their duties. The skills are characterized by their professional experience, which they have acquired in senior management positions in companies, banks, or working for an audit firm or in the capacity of chartered accountant or statutory auditor, as described in section 3.1.3.3 above.

Responsibilities

The Chairman of the Audit and Compliance Committee reports to the Board of Directors on all of the Committee's works.

Missions

The Audit and Compliance Committee's overall remit is to monitor issues relating to the preparation and control of financial and accounting information. It prepares the background work for the Board's approval of the annual (parent company and consolidated) financial statements and its review of the half-yearly financial statements, at least two days prior to the relevant Board meeting.

As part of its specific remit, the Committee is primarily responsible for monitoring:

- the financial information preparation process;
- the effectiveness of the internal control and risk management systems;
- the statutory audit of the parent company and consolidated accounts performed by the statutory auditors;
- the independence of the statutory auditors.

The purpose of this statutory assignment is to prepare and facilitate the oversight work of the Board of Directors, anticipate potential problems, identify all risks, notify the Board of those risks and issue appropriate recommendations to the Board.

The Audit and Compliance Committee manages the process for selecting and reappointing the statutory auditors when their term of office expires and gives a recommendation when the renewal of their term of office is contemplated.

The Audit and Compliance Committee approves the provision by the statutory auditors of services other than the certification of financial statements.

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The Committee may invite anyone that it chooses to take part in some or all of its meetings and decides whether to hear its speakers individually or as a Group.

In practice, the Committee invites to its meetings the statutory auditors, the Company's Chief Financial Officer, the Chief Audit Officer and the Consolidation director as well as other members of the financial management team, as and when required.

The Audit and Compliance Committee may use external experts when circumstances so require, once it has informed the Chairman of the Board or the Board itself.

Meetings in 2018

The Audit and Compliance Committee met four times in 2018.

Meetings of the Audit and Compliance Committee were held over two days before the meetings of the Board of Directors to review accounts, in accordance with the recommendations of the AFEP-MEDEF code which provides for sufficient time to have available and review the financial statements.

Members	02/26/2018	05/24/2018	07/24/2018	11/22/2018	Total
Alain Boulet	Yes	Yes	Yes	Yes	100%
Jean Guez	Yes	Yes	No	Yes	75%
Stephen Winningham	Yes	Yes	Yes	Yes	100%
ATTENDANCE RATE	**100%**	**100%**	**67%**	**100%**	**92%**

The statutory auditors attended all four meetings. Patrick Thomas attended the meeting of the Audit and Compliance Committee dated November 22nd, 2018 as Lead Independent director.

The Audit and Compliance Committee reviewed the following items in particular in 2018:

- the statutory audit of the parent company and consolidated financial statements performed by the statutory auditors:
  - the Group Chief Financial Officer's presentation of the financial statements. The exposure to financial risks and off-balance sheet commitments contained in the annexes of the accounts provided to Committee members,
  - the program of reviews carried out by the statutory auditors, the findings of those reviews and the accounting options selected,
  - the parent company and consolidated financial statements as of December 31st, 2017,
  - the half-yearly summary consolidated financial statements as of June 30th, 2018,
  - the statutory auditors certified without qualification the consolidated financial statements as of December 31st, 2017 and identified no misstatements in the summary consolidated financial statements as of June 30th, 2018,
  - the review of related parties;
- the effectiveness of the internal control and risk management systems:
  - Internal Regulations of the Audit Committee – which becomes the Audit and Compliance Committee,
  - organization of internal audit within the Group and Internal Audit Charter,
  - internal audit plan for the 2018 financial year,
  - overview of the assignments performed by the Internal Audit Department and follow-up,
  - presentation of the 2018 internal control self-assessment questionnaires,
  - results and follow-up of the self-assessment questionnaires completed by the subsidiaries,
  - corruption risk mapping,
  - approval of the Code of Conduct and the Ethics Hotline policy,
  - implementation of the crisis management plan,
  - certification of the Group on the Binding Corporate Rules within the framework of the General Regulation on Data Protection,
- the financial information preparation process:
  - point of information by the statutory auditors on the closing procedure of the 2017 financial year;
- the independence of the statutory auditors:
  - delivery to the Committee of the statutory auditors' annual independence declaration in respect of the year ended December 31st, 2017,
  - review of the amount and breakdown of the statutory auditors' fees,
  - update of the rules regarding the Audit Committee's approval of the provision of services that may be entrusted to the statutory auditors,
  - approval of the provision of services other than the certification of financial statements.

The Remuneration and Appointments Committee

Composition

In accordance with the recommendations of the AFEP-MEDEF code, the Committee does not include any executive officers and consists mostly of independent directors. It is also chaired by an independent director.

The Remuneration and Appointments Committee is currently comprised of three members, two of whom are independent:

Robert Paszczak	Chairman, independent
Emily Abrera	Member, independent
Bernard Canetti	Member

The Committee can invite anyone that it chooses to take part in some or all of its meetings. The Committee decides whether to hear its invitees individually or as a Group. The Committee's meetings take place in the absence of the executive officers, except if the Committee wishes to hear or ask them to contribute to the works on selection and appointments.

Missions

The Remuneration and Appointments Committee issues opinions and recommendations regarding:

- the determination of the remuneration policy and of the benefits granted to executive officers, including determining the variable portion by assessing the definition of the rules for setting this variable portion and the annual application of these rules;
- the overall policy for granting performance shares, together with the conditions attached to the final vesting of these shares;
- the global amount and rules of allocation of directors' fees;
- the succession plans;
- the candidates for membership of the Board of Directors, their status as independents, and annual review of such quality in accordance with the criteria defined by the AFEP-MEDEF code and/or the renewal of terms of office of directors.

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Meetings in 2018

The Remuneration and Appointments Committee met three times in 2018, and the attendance rate was 89%.

Members	02/27/2018	04/20/2018	11/28/2018	Total
Robert Paszczak	Yes	Yes	Yes	100%
Emily Abrera	Yes	Yes	Yes	100%
Bernard Canetti	Yes	Yes	No	67%
ATTENDANCE RATE	**100%**	**100%**	**67%**	**89%**

In 2018, the Committee's work and discussions focused mainly on the following issues:

- reviewing the independence of the directors;
- renewal of directorships to be proposed to the 2018 shareholders' meeting and propositions to the Board on the Committee's composition;
- assessment of the performance conditions of the June 23rd, 2017 performance shares plan;
- 2017 variable remuneration, determination of the 2018 and 2019 remuneration policies for the executive officers;
- review and analysis on the opportunity to suspend or maintain the employment contract of the Deputy Chief Executive Officer;
- designation of the Lead Independent director and determination of his missions;
- amendments of the Internal Regulations of the Board of Directors and the Audit and Compliance Committee;
- proposal of beneficiary and approval of the plan regulations for the performance shares plan of February 28th, 2018;
- review and adoption of the Board's report on corporate governance;
- discussion on letter to shareholders for the shareholders' meeting;
- recommendation to the Board on the modalities of allocation of directors' fees for financial year 2017;
- definition of the diversity policy applied to Board members with regards to criteria such as age, gender or qualifications and professional experience, as well as the objectives of that policy, its implementation modalities and its results obtained during the 2018 financial year;
- authorization of grant of performance shares and increase the envelope of directors' fees to be submitted to the approval of the 2019 shareholders' meeting;

During one of its meetings, the Committee requested the attendance, expertise and advice of the Chairman of the Board, it being specified that the latter was not consulted for the examination and recommendations concerning the elements of his remuneration.

3.1.4 The Executive Management

Composition

Daniel Julien

Chairman and Chief Executive Officer and Chairman of the Executive Committee

Individual information and the list of terms of office of Mr. Daniel Julien are described in section 3.1.3.1 above.

Olivier Rigaudy

Deputy Chief Executive Officer and Group Chief Financial Officer

Born on May 4th, 1959, Mr. Olivier Rigaudy is a graduate of the Paris *Institut d'Études Politiques* and holds a Masters' degree in Business Law and a Postgraduate Accounting Studies Diploma (DECS). He began his career in the audit department at KPMG. He then joined the Finance Management of the Pechiney Group in the Mergers & Acquisitions Department before serving as Director of Finance and Investors Relations at Club Méditerranée in 1992. He served as Chief Financial Officer of the Castorama (Kingfisher) Group from 1999 to 2003 and as Corporate Secretary of Conforama from 2004 to 2009.

He joined the Teleperformance Group in February 2010 as Group Chief Financial Officer and was appointed Deputy Chief Executive Officer of Teleperformance SE on October 13th, 2017.

Mr. Rigaudy holds directorships in various French and overseas subsidiaries of the Teleperformance Group. He does not hold any directorships in companies outside the Group.

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The Executive Committee

The Chairman and Chief Executive Officer is assisted by an Executive Committee comprising the Group's key managers who are based around the world. As of the date of preparation of this Registration Document, the Executive Committee is presided over by the Chairman and Chief Executive Officer and is composed of:

- the Deputy Chief Executive Officer and Group Chief Financial Officer;
- the Group Chief Legal Officer and Chief Compliance Officer;
- the Group Chief Operating Officer;
- the President of the Ibero-LATAM region;
- the Co-Presidents of the English-speaking and Asia-Pacific region;
- the President of the Continental Europe, Middle-East and Africa region;
- the President of Teleperformance D.I.B.S. (Digital Integrated Business Services) division;
- the President of the Specialized services division;
- the Chief Research and Development and Digital Integration Officer;
- the Chief Administrative Officer;
- the Chief Marketing Officer and;
- the Chief Information Officer.

The Executive Committee is responsible for the Group's operational management. It meets at least twice per month. It implements the strategic orientations, ensures the coherence of the actions undertaken by all of the subsidiaries and discusses the major operational initiatives necessary to the development of the Group and to its performance.

Missions

The Chairman and Chief Executive Officer has been granted full powers to act in the Company's name in all circumstances. He exercises his powers within the scope of the corporate objects and subject to the powers expressly conferred by law on the general meeting of shareholders and the Board of Directors. In addition, the Chairman and Chief Executive Officer represents the Company in its relations with third parties and exercises his powers within the limits provided for by the articles of association and the Board of Directors' internal rules (see section 3.1.3.2.2 of this Registration Document). The Chairman and Chief Executive Officer is assisted by a Deputy Chief Executive Officer whose powers are determined by the articles of association. Furthermore, the Board of Directors determines or authorizes expressly and prior to their completion the following issues:

- approving consolidated annual budgets;
- any significant (commercial, industrial, financial, real estate or other) transaction that the general management plans, not comprised under the approved strategy or budget, including, in particular, moveable or immoveable investment by external or internal growth, where the amount represents more than 20% of the Group's net assets as reports in the latest consolidated financial statements approved by the Board of Directors;
- concluding alliances of any kind involving a material proportion of consolidated revenues;
- proposing dividend distributions to general meetings of shareholders.

Diversity policy within the senior management

Pursuant to the provisions of Article L.225-37-4 6° of the French Commercial Code, the Board of Directors is required to describe how the Company seeks to achieve a balanced representation of women and men on any committees set up, if applicable, by senior management in order to assist it in the performance of its duties and with regard to gender balance in the 10% of positions with the highest level of responsibility.

The Group Executive Committee is made up of the Chairman and Chief Executive Officer, the Deputy Chief Executive Officer, the four regional Presidents (co-Presidency in the case of the EWAP region) and Group senior executives. As of today, 14 people currently sit on this committee, including one woman.

Achieving diversity and balanced representation is a permanent objective for Teleperformance as it offers an openness beneficial to the optimal development of the Group. This diversity is, above all, multi-criteria: it is reflected in a wide range of attributes, including social mix, skills, expertise, experience, culture and background. The aim is not only to hire, develop and retain employees with diverse personal characteristics – above all, it is to build on such differences, ensuring that everyone can contribute to meeting the Group's targets by fulfilling their maximum potential.

This objective is also expanded at all levels of the Group, both regional and local.

In particular with regard to balanced representation of women and men, it is reminded that as of December 31st, 2018, women represented 52.5% of Group headcount (excluding subsidiaries in the USA where local regulations do not allow to check the data collected on such issue and excluding Intelenet). As of the same date, the percentage of women in management positions was 49.6%.

As an example, at regional level, it should be noted that in the Continental Europe, Middle-East and Africa region (CEMEA), women represented 57% of this region Management Committee members.

In addition, the Group identified the 169 employees representing the top 10% of positions in terms of responsibility. Among these 169 employees, 31 are women (*i.e.*18.3%). At the Company level, the top 10% positions comprises 11 people including six women. Teleperformance remains vigilant by examining all the factors of improvement of diversity within it, particularly in terms of gender balance, that could be beneficial to the Group's development and its dynamism.

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3.2 REMUNERATION OF DIRECTORS AND EXECUTIVE OFFICERS

3.2.1 Remuneration of directors

3.2.1.1 Rules for allocation of directors' fees

Within the overall annual limit of €720,000 decided by the shareholders' meeting held on June 23rd, 2017 (until further decision), the Board of Directors decides, upon recommendation of the Remuneration and Appointments Committee, of the allocation rules of directors' fees amongst its members. These rules take into account, in compliance with the recommendations of the AFEP-MEDEF code and with the provisions of its internal regulations, (i) the membership of the Board and its specialized Committees and (ii) the effective attendance of directors and (iii) the directors' place of residence. They thus contain a significant variable portion (excepted for the few directors that are not members of a committee).

The Chairman and Chief Executive Officer, as a director, and, if applicable, directors holding an employment contract with a subsidiary of the Group, do not receive any directors' fees from the Company or any of its subsidiaries.

The directors' fees for a financial year are paid the following year.

For the 2016 financial year (directors' fees paid in June 2017), the following rules, which were decided by the Board at its meeting held on July 28th, 2015, were applied:

- each director received an annual fixed fee of €20,000 and a variable amount of €3,500 per meeting subject to attendance;
- each Committee member received a variable fee of €2,500 per meeting attended. The Committee Chairmen received an annual fixed fee of €5,000;
- a fee of €1,500 for participating in a Board or Committee meeting was paid for directors traveling from a country outside Europe.

At its meeting held on June 23rd, 2017, the Board decided to pay an exceptional fee to the directors in view of their work, time spent and their commitment in preparing the works of the Board and its Committees both during and between meetings.

For the 2017 financial year (directors' fees paid in June 2018), the Board, at its meeting held on April 20th, 2018, set the following rules:

- each director received an annual fixed fee of €22,500 and a variable amount of €5,000 per meeting subject to attendance;
- each member of the Remuneration and Appointments Committee received a variable fee of €3,000 per meeting attended and the Committee Chairman received an annual fixed fee of €10,000;
- each member of the Audit and Compliance Committee received a variable fee of €3,500 per meeting attended and the Committee Chairman received an annual fixed fee of €12,500;
- A fee of €1,500 for participating in a Board or Committee meeting for directors traveling from a country in Europe (excluding France) or of €3,000 for participating in a Board or Committee meeting for directors traveling from a country outside Europe, was paid to directors.

Upon recommendation of the Remuneration and Appointments Committee and based on a study conducted by an external independent firm, the Board of Directors, at its meeting held on February 28th, 2019, decided to propose to the shareholders' meeting to set the global annual maximum amount of director' fees at €1,000,000. The increase thus proposed is justified in particular by the necessity to add new skills within the Board, by the creation of the function of Lead Independent director and by the modification of the Group's dimension and environment. Subject to the approval of this resolution by the shareholders' meeting to be held on May 9th, 2019, the allocation rules will be further reviewed, while keeping the general principles on the matter, at the occasion of the allocation of directors' fees for the 2018 financial year to be paid in 2019.

The gross amount of directors' fees paid in 2017 (in respect of the 2016 financial year) amounted to €599,775[1] and those paid in 2018 (in respect of the 2017 financial year) €699,875..

(1) Of which €41,398 paid to Directors whose term of office was not renewed.

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3.2.1.2 Directors' fees and other remuneration paid to directors

Table 3 of the AMF recommendations – Individual breakdown of the amounts of directors' fees and other remuneration paid to directors (gross amounts)

	Montants versés en 2017	Montants versés en 2018
Daniel Julien, *Chairman and Chief Executive Officer*		
• Directors' fees	n/a	n/a
• Other remuneration	*see section 3.2.2.1*	*see section 3.2.2.1*
Emily Abrera, *director*		
• Directors' fees	€53,200	€71,500
• Other remuneration	-	-
Alain Boulet, *director*		
• Directors' fees	€56,200	€68,041
• Other remuneration	-	-
Bernard Canetti, *director*		
• Directors' fees	€61,200	€69,459
• Other remuneration	-	-
Philippe Dominati, *director*		
• Directors' fees	€46,200	€47,500
• Other remuneration (1)	€60,000	€80,000
Pauline Ginestié, *director* (2)		
• Directors' fees	€36,289	€53,500
• Other remuneration	-	-
Jean Guez, *director*		
• Directors' fees	€52,700	€61,500
• Other remuneration	-	-
Wai Ping Leung, *director* (2)		
• Directors' fees	€34,289	€59,500
• Other remuneration	-	-
Robert Paszczak, *director*		
• Directors' fees	€63,200	€81,500
• Other remuneration	-	-
Leigh Ryan, *director* (2)		
• Directors' fees	n/a	n/a
• Other remuneration	$1,150,000 (3)	$1,173,000 (4)
Christobel Selecky, *director*		
• Directors' fees	€50,700	€59,500
• Other remuneration	-	-
Angela Maria Sierra-Moreno, *director*		
• Directors' fees	€50,700	€59,500
• Other remuneration	-	-
Patrick Thomas, *director* (5)		
• Directors' fees	-	€1,875
• Other remuneration	-	-
Stephen Winningham, *director*		
• Directors' fees	€53,700	€66,500
• Other remuneration	-	-

(1) Mr. Philippe Dominati receives directors' fees as Chairman of the Board of Directors of Teleperformance France SA.
(2) Director since April 28th, 2016.
(3) Ms. Leigh Ryan, director since April 28th, 2016, holds an employment contract with Teleperformance Group, Inc., US subsidiary of the Company, as Group Chief Legal Officer and Chief Compliance Officer under which she received, for 2017, a fixed gross remuneration of US$1,150,000 and benefits in kind for a total amount of US$49,884. These benefits in kind consist of a healthcare insurance plan, a life insurance policy and the matching contribution paid by Teleperformance Group, Inc. under the non-qualified deferred compensation plan (described in section 3.2.2.1 – benefits in kind below). She does not receive any directors' fees from the Company nor any Group subsidiaries in which she holds directorships. No performance shares were granted to her in 2017.
(4) For 2018, the remuneration elements of Ms. Leigh Ryan, as Group Chief Legal Officer and Chief Compliance Officer, are composed of a fixed gross remuneration of US$1,173,000 and benefits in kind for a total amount of US$63,034. These benefits in kind consist of a healthcare insurance plan, a retirement contribution, a life insurance policy and the matching contribution paid by Teleperformance Group, Inc. under the non-qualified deferred compensation plan (described in section 3.2.2.1 – benefits in kind below). No performance shares were granted in 2018.
(5) Director since November 30th, 2017.

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3.2.2 Remuneration of executive officers

The Group's remuneration policy for senior executives (including executive officers) is designed to support the Group's strategy. It also seeks to align the interests of the employees concerned with those of the shareholders as it establishes a link between performance and remuneration while guaranteeing a competitive compensation offer in accordance with the Group's different businesses and services and the different geographic markets in which it operates.

The remuneration policy, designed in a simple and transparent manner, pursues three main objectives:

- attracting, developing and retaining talents and high potential as well as recognized skills;
- encouraging performance;
- aligning remuneration levels with the performances of the Group and of the subsidiaries concerned, if applicable.

Remuneration must thus be competitive and consistent with regard to observed market practices. They are structured around the following components:

- a fixed remuneration the amount of which takes into account the position, the level of responsibilities carried out, the experience and recognized technical skills and leadership;
- a variable remuneration subject to (i) performance criteria adapted, consistent with the environment in which the person concerned operates as well as the short-term and long-term performance and objectives of the Group and (ii) relevant qualitative criteria with regard to the Group's objective.

  This variable remuneration is defined under a maximum amount. It is not a target amount that may vary due to exceptional items or if objectives are exceeded. Group policy has always sought to establish a close link between remuneration and performance over the long-term while discouraging conduct and situations that could lead to major or even excessive risk-taking in pursuit of short-term gains. This is the reason why the variable part of the remuneration is equal to the fixed part and is subjected to the achievement of ambitious objectives linked to the Group's strategy;
- an indemnity due in respect of a non-compete agreement (the specificities of which can differ depending on applicable legal and regulatory requirements) the objective of which is to protect the legitimate interests of the Group and all its external and internal stakeholders following in the event of departure of an executive;
- benefits in kind;
- the eligibility for long-term share-based profit-sharing schemes (performance shares, long-term incentive plan, etc.) granted subject to performance and presence conditions.

  The policy stems from the desire to associate key managers and senior executives in the Group's long-term development and align their interests with those of the shareholders by giving them an interest in the value of the Company shares. It is based on the following principles:

  - the acquisition (vesting) of performance shares is subject to performance and presence criteria applicable to both executive officers and all employee beneficiaries;
  - the performance conditions are in line with the long-term Group strategy as defined by the Board of Directors;
  - the performance and presence criteria are assessed and measured over a three-year period; their determination and expected levels of achievement are decided by the Board of Directors which, after recommendation of the Remuneration and Appointments Committee, sets the thresholds for calculating the performance expected or achieved and for determining the number of shares definitively vested;
  - with regards to frequency, the Group decided, starting in 2019, to modify its practice in the matter to provide from now on a grant every year and not every three years. The Group thus wished to adapt its practice to the market and its shareholders' expectations;
  - the number of performance shares granted to a beneficiary is determined in accordance with his or her role and responsibilities and, where applicable, local considerations;
  - long-term incentive plans are subject to identical rules and performance and presence criteria as performance share grants;
  - if a beneficiary leaves the Company, he or she does not retain the shares granted under a performance share or long-term incentive plan and not yet definitively vested, unless otherwise decided by the Board of Directors which would decide in compliance with the recommendations of the AFEP-MEDEF code in this respect (prorate, retention of performance conditions and justifications of its decision);
  - executive officers must retain at least 30% of shares vested until the end of their term of office and have taken the commitment not to engage in hedging transactions (see section 3.3.3.3 hereafter).

This remuneration structure is reviewed each year by the Board of Directors, on the basis of the works of its Remuneration and Appointments Committee. On this occasion, the Board discusses the opportunity to amend the remuneration or its structure due to circumstances (new functions, acquisitions, integrations, new businesses, new countries, etc.) having an impact on the Company, its Group or its organization. In any case, the Board of Directors ensures that the principles on which its remuneration policy is based and contained in paragraph 24.1.2 of the AFEP-MEDEF code are respected.

The remuneration elements paid to the executive officers of Teleperformance SE are determined by the Board of Directors, upon recommendation of the Remuneration and Appointments Committee and taking into account the shareholders' expectations collected during a continuous exchange. That Committee, which composition, missions and works are described in section 3.1.3.3 above, is chaired and composed in majority by independent directors. It also prepares its recommendations on the basis of studies conducted by external independent firms specialized in remuneration issues.

Pursuant to legal and regulatory provisions, the remuneration elements paid or granted in respect of financial year 2018 in accordance with the principles and criteria approved by the shareholders' meeting held on April 20th, 2018 (see section 3.2.2.1 hereafter) and the remuneration policy for 2019 (see section 3.2.2.2 below), are submitted to the approval of the shareholders' meeting to be held on May 9th, 2019 and are presented below.

3.2.2.1 Fixed, variable and exceptional elements of the total remuneration and the benefits of all kind paid or granted to executive officers in 2018 (in application of the principles and criteria approved by the shareholders' meeting held on April 20th, 2018)

The remuneration elements of Mr. Daniel Julien, it being reminded that he served as executive Chairman until October 13th, 2017 and has served as Chairman and Chief Executive Officer since that date, were determined, for 2017, by the Board of Directors, upon recommendation of the Remuneration and Appointments Committee, at its meetings held on December 1st, 2016 and February 28th, 2017. For 2018, his remuneration elements were determined by the Board of Directors at its meetings held on November 30th, 2017 and February 28th, 2018.

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The remuneration elements of Mr. Olivier Rigaudy, Deputy Chief Executive Officer since October 13th, 2017, were determined, for 2018, by the Board of Directors, upon recommendation of the Remuneration and Appointments Committee, at its meetings held on November 30th, 2017 and February 28th, 2018. It is reminded that Mr. Rigaudy did not receive any remuneration in respect of his office for the period from October 13th, 2017 to December 31st, 2017.

Based on the principles and criteria for the determination, allocation and grant of elements comprising the total remuneration and benefits of all kind due to executive officers as approved by the shareholders' meeting held on April 28th, 2018, the remuneration is paid, in its entirety, to Mr. Julien, Chairman and Chief Executive Officer, by the US subsidiary, Teleperformance Group, Inc., of which Mr. Julien is an executive officer, and to Mr. Rigaudy, Deputy Chief Executive Officer, by Teleperformance SE.

The remuneration is denominated and paid, in US dollars by the US subsidiary Teleperformance Group, Inc., for the Chairman and Chief Executive Officer, and in euros, by Teleperformance SE for the Deputy Chief Executive Officer, the Group bearing thus the social costs and contributions in those countries pursuant to applicable local regulations. It is reminded that the payment of the variable remuneration, in respect of 2018, is conditional on the positive vote of the sharelholders' meeting to be held on May 9th, 2019.

Fixed, variable and exceptional elements of the total remuneration and the benefits of all kind paid or granted in connection with financial year 2018 to Mr. Daniel Julien, Chairman and Chief Executive Officer

Table 1 of the AMF recommendations – Summary table on remuneration and stock options and shares granted to Mr. Daniel Julien, Chairman and Chief Executive Officer *(gross amounts – in euros)*

	2018*	2017*
Remuneration due in connection with the financial year (detailed in table 2)	4,487,593	4,705,583
Value of multi-year variable remuneration granted during the financial year	n/a	n/a
Value of stock options granted during the financial year	n/a	n/a
Value of performance shares granted during the financial year** (detailed in table 6)	n/a	n/a
TOTAL	**4,487,593**	**4,705,583**

* *Remuneration denominated in a foreign currency for a given year is converted into euros at the average exchange rate for the year (for 2018, €1 = US$ 1.184 and for 2017, €1 = US$ 1.129).*

** *It is reminded that the Group's was to provide for a grant of performance shares or equivalent mechanisms every three years. The last grant was implemented in April 2016.*

Table 2 of the AMF recommendations – Summary remuneration table of Mr. Daniel Julien, Chairman and Chief Executive Officer *(gross amounts – in euros)*

	2018(1)		2017(1)	
	Amounts due	Amounts paid(2)	Amounts due	Amounts paid(2)
Fixed remuneration	2,217,061	2,296,242	3,321,523	3,321,523
Annual variable remuneration	2,217,061(3)	1,266,892(4)	1,328,609	1,328,609
Multi-year variable remuneration	n/a	n/a	n/a	n/a
Exceptional remuneration	n/a	n/a	n/a	n/a
Directors' fees	n/a	n/a	n/a	n/a
Benefits in kind	53,471	53,471	55,450	55,450
TOTAL	**4,487,593**	**3,616,605**	**4,705,583**	**4,705,583**

(1) Remuneration denominated in a foreign currency for a given year is converted into euros at the average exchange rate for the year (for 2018, €1 = US$ 1.184 and for 2017, €1 = US$ 1.129).

(2) The remuneration paid includes the portion of the remuneration payable in respect of the current financial year and the balance of the remuneration payable in respect of the previous financial year and not paid during that year.

(3) The payment of the variable remuneration in respect of financial year 2018 is subject to the approval of the remuneration elements paid or granted for 2018 by the shareholders' meeting to be held on May 9th, 2019, pursuant to the provisions of article L.225-100 II of the French Commercial Code.

(4) The payment of the variable remuneration in respect of financial year 2017 is subject to the approval of the remuneration elements paid or granted for 2017 by the shareholders' meeting to be held on April 20th, 2018, pursuant to the provisions of article L.225-100 II of the French Commercial Code.

DETAILS OF REMUNERATION ELEMENTS OF MR. DANIEL JULIEN FOR THE 2018 FINANCIAL YEAR

For financial year 2018, the remuneration elements of Mr. Daniel Julien, Chairman and Chief Executive Officer, reflect the remuneration policy duly approved by the shareholders' meeting held on April 20th, 2018 (9th resolution).

Fixed remuneration

For 2018, the fixed remuneration of Mr. Daniel Julien, Chairman and Chief Executive Officer, was set at the gross amount of US$2,625,000 (*i.e.* €2,217,061), reduced compared to the previous financial year for which it was set at US$3,750,000, amount unchanged since 2013.

Variable remuneration

Upon recommendation of the Remuneration and Appointments Committee, the Board of Directors set the amount of variable remuneration for 2018 at the maximum amount of US$2,625,000, subject to performance criteria. It represents a level equal to his fixed remuneration.

Furthermore, the variable remuneration of Mr. Daniel Julien for 2018 is subject to a clawback scheme that is triggered in the event that all or part of this remuneration was received as the result of an accounting fraud affecting the consolidated financial statements, for which the Chairman and Chief Executive Officer was responsible or acted as an accomplice. This scheme will be implemented if, during either of the two years following the year in which the Chairman and Chief Executive

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Officer received said remuneration, the Board of Directors identifies such fraud. The amount of variable remuneration that the Chairman and Chief Executive Officer would not have received if the fraud had not been committed will be repaid to the Company.

The Board of Directors set the quantitative and qualitative performance criteria, described below for the 2018 variable remuneration. The Board has introduced a point-based calculation system, in order to determine the full or partial fulfillment of said criteria. The maximum number of points that may be granted for the various quantitative and qualitative criteria is 100 points, a maximum of 80 points for quantitative criteria and a maximum of 20 points for qualitative criteria.

Taking into account the results, the recommendations of the Remuneration and Appointments Committee, and after approval of the financial items by the Audit and Compliance Committee, the Board of Directors, at its meeting held on February 28th, 2019, set the amount of the variable remuneration for 2018 of Mr. Daniel Julien at a gross amount of US$2,625,000, *i.e.* €2,217,061. Pursuant to the provisions of Article L.225-100 II of the French Commercial Code, the payment of the variable remuneration is subject to the approval of the remuneration elements paid or granted in respect of 2018 by the shareholders' meeting to be held on May 9th, 2019. The breakdown by criteria is described hereafter.

Quantitative criteria

The quantitative criteria, which have an 80-point weighting, relate to the growth rate in revenue and the EBITA, and represent the performance achieved by the Group throughout the network and exclude the impact of currency and perimeter effects for the turnover criterion and excludes non-recurring items with respect to the criterion related to EBITA.

The tables below describe the number of points, the targets set by the Board and the level of achievement confirmed by the Board at its meeting held on February 28th, 2019.

Current EBITA margin ratio

Number of points awarded	Target
0 point	less than 13%
10 points	Equal to 13% and less than 13.15%
20 points	Equal to 13.15% and less than 13.3%
30 points	Equal to 13.3% and less than 13.5%
40 points	Equal to 13.5% and above
TOTAL OF POINTS DEFINITELY GRANTED	**40 POINTS**

As to this criterion, upon recommendations of the Audit and Compliance Committee and of the Remuneration and Appointments Committee, the Board of Directors noted that the EBITA margin amounted to 13.6% and thus granted 40 points.

Organic revenue growth (excluding currency gains and losses)

Number of points awarded	Target
0 point	less than 3%
10 points	Equal to 3% and less than 4%
20 points	Equal to 4% and less than 5%
30 points	Equal to 5% and less than 6%
40 points	Equal to 6% and above
TOTAL OF POINTS DEFINITELY GRANTED	**40 POINTS**

As to this criterion, upon recommendations of the Audit and Compliance Committee and of the Remuneration and Appointments Committee, the Board of Directors noted that the organic revenue growth amounted to 9% and thus granted 40 points.

Qualitative criteria

The qualitative criteria, which have a 20-point weighting, relate to the mobilization and deployment of efforts in terms of external growth which is an element of the Group's strategy. The Board reviewed the level of achievement of the qualitative criteria with regard to the whole process leading to the Intelenet acquisition finalized on October 4th, 2018. This acquisition constitutes a major step in the Group's transformation led by the executive team for many years. It offers the Group the possibility to continue the quality upgrade of its offer by developing specifically the Group's digital capacities in order to sustain its growth and improve its operational profitability. The acquisition was welcomed by the stock market. It creates value for Teleperformance with a positive impact on revenue growth as well as operating margin and strengthens the Group's capacity to achieve its strategic objectives for 2022 of a revenue of at least €6 billion and an EBITA of at least €850 million (excluding acquisitions).

It was conducted by Mr. Julien and Mr. Rigaudy which went to India and the United States on several occasions. The Board particularly noted and welcomed, their personal involvement to mobilize the different specialized teams of the Group (financing and treasury, tax, consolidation, legal...) and to determine and map the great steps and guidelines of the acquisition process until its achievement and integration within the Group. It was conducted without any investment bank being commissioned on this project, thus resulting in substantial savings for the Group.

In its analysis, the Board also took into account the optimization of the existing financing covenants and those necessary in order to prepare for a potential acquisition in 2018.

As a result and given the very positive response by the markets, it was decided that the number of points granted was of 20 out of the 20 points allocated to these qualitative criteria.

Long-term remuneration

During financial year 2018, no performance shares or shares granted under a long-term incentive plan were granted to Mr. Daniel Julien. It is reminded that the Group policy was, until now, to grant performance shares (or equivalent mechanisms) every three years. The last grant was implemented in April 2016.

The Board decided, starting in 2019, to review the frequency of grants (one grant per year) (see introduction of section 3.2.2 above).

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Benefits in kind

The benefits in kind granted to Mr. Julien consist of a company car, a healthcare insurance plan and the matching contribution for 2018 paid under the non-qualified deferred compensation plan.

This mechanism of non-qualified deferred compensation plan, similar to a deferred savings scheme, set up by the US subsidiary, Teleperformance Group, Inc, enables the beneficiaries to defer, at their own initiative, a portion of their remuneration within the limit of US$200,000 per year. Once deferred, Teleperformance Group, Inc. then matches 25% of this amount with a limit fixed at US$50,000 per year. The deferred and matched amounts are paid on the date of departure.

As of December 31st, 2018, Mr. Julien deferred the payment of US$200,000 matched by Teleperformance Group, Inc. to a total of US$50,000, *i.e.* €42,230.

Table 11 of the AMF recommendations – Summary of undertakings taken in favor of executive officers

Executive Officer	Employment contract	Additional pension scheme	Payments or benefits due or to be due upon termination or change of responsibilities	Payments relating to a non-compete agreement
Daniel Julien Chairman and Chief Executive Officer since October 13th, 2017 Expiry of term of office: GM 2021	No	No	No	Yes

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Employment contract

The Chairman and Chief Executive Officer is not bound to the Company or any of its subsidiaries by an employment contract.

Additional pension scheme

Mr. Daniel Julien does not benefit from any additional pension scheme.

Payments or benefits due or to be due upon termination or change of responsibilities

The executive officers are not entitled to any payments or benefits due or to be due as a result of termination of their appointment or a change in their responsibilities.

Payments relating to a non-compete agreement

With the concern of protecting the Group's interests, the Board of Directors authorized, since 2006, the conclusion of a non-compete agreement between the Group and Mr. Daniel Julien. This agreement was concluded on May 18th, 2006 and approved by the shareholders' meeting held on June 1st, 2006. It was subsequently amended by the decisions of the Board of Directors of May 31st, 2011 and November 30th, 2011, approved by the ordinary shareholders' meeting held on May 29th, 2012.

At its meeting held on November 30th, 2017, the Board of Directors decided to authorize the amendment of the terms of the non-compete agreement between Teleperformance SE, Teleperformance Group, Inc. and Daniel Julien, in order to limit the duration of the non-competition and non-poaching obligations at 2 years. This undertaking will be remunerated by a compensation limited to 2 years of gross remuneration (fixed and variable) paid in respect of the calendar year preceding the year of departure compared to an indemnity which previously could have reached 3 years of compensation. The agreement thus amended is a continuation of the policy on this matter and the will of the Board to protect the best interests of the Group and all its internal and external stakeholders (customers, employees, shareholders) in case of departure, whatever the cause, of Mr. Daniel Julien. It will also limit the financial impact for the Group insofar as the amount of the remuneration provided in consideration for the obligations incumbent on Mr. Daniel Julien is reduced. The amendment to the agreement was entered into on December 1st, 2017 and was approuved by the shareholders' meeting held on April 20th, 2018.

It is reminded that this agreement contains commitments, by Mr. Julien, of non-competition and non-poaching. As such, Mr. Julien is prohibited, for a period of 2 years, in all countries in which the Group operates at the time of the effective date of departure, directly or indirectly, to collaborate or participate, in any way whatsoever (in particular, as an employee, executive or non-executive officer, director, external consultant...), in a business activity and/or a company that competes with the Group. In addition, he must refrain from soliciting, directly or indirectly, the senior managers of the Group during the same period. The agreement provides for a nine-month mutual notice in the event of termination of employment within the Group.

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SHAREHOLDERS' VOTE ON REMUNERATION ELEMENTS PAID OR GRANTED IN RESPECT OF THE 2018 FINANCIAL YEAR TO MR. DANIEL JULIEN, CHAIRMAN AND CHIEF EXECUTIVE OFFICER

In accordance with the provisions of Article L.225-100 II of the French Commercial Code, the fixed, variable and exceptional elements of the total remuneration and benefits of all kind paid or granted to each executive officer in respect of the year ended are submitted to the shareholders' vote.

It is then proposed to the shareholders' meeting to be held on May 9th, 2019 to issue a favorable vote on the fixed, variable and exceptional elements of the total remuneration and benefits of all kind paid or granted to Mr. Julien, Chairman and Chief Executive Officer in respect of the year ended December 31st, 2018. It is reminded that the shareholders' meeting held on April 20th, 2018 issued a favorable vote on the remuneration policy of Mr. Daniel Julien with 95.13% of favorable votes and the elements and structure of his remuneration evolved after the shareholders' expectations were taken into account by the Board of Directors. These evolutions are described in section 3.2.2.1 below.

Remuneration elements paid or granted in respect of 2018 to Mr. Daniel Julien

	Amounts or book value subject to vote*	Comments
Fixed remuneration	US$2,625,000, *i.e.*, €2,217,061	The gross fixed annual remuneration of Mr. Julien was approved by the Board of Directors at US$2,625,000. This amount was reduced following the evolution of the remuneration structure as of January 1st, 2018 (modifying the breakdown between the fixed and variable parts of the remuneration to raise it respectively from 70%/30% to 50%/50%).
Annual variable remuneration	US$2,625,000, *i.e.*, €2,217,061 (amount to be paid *after approval of the shareholders' meeting to be held on May 9th, 2019*)	At its meeting held on February 28th, 2019, the Board of Directors, upon recommendation of the Remuneration and Appointments Committee, and after approval of financial items by the Audit and Compliance Committee, set the amount of variable remuneration of Mr. Julien for the 2018 financial year as follows: • with regard to the quantitative criteria (increase in revenues excluding currency gains and losses, and increase in the current EBITA margin ratio), all of the 80 points assigned to these criteria were granted; • with regard to the qualitative criteria, all of the 20 points assigned to these criteria were granted. The amount of the 2018 variable remuneration has, accordingly, been set at US$2,625,000 *i.e.*, €2,217,061. The performance criteria as well as their expected and recorded fulfillment levels are described in section 3.2.2.1. *Variable remuneration* of the 2018 Registration Document. This remuneration is coupled with a clawback mechanism.
Multi-year variable remuneration in cash	n/a	Mr. Julien does not benefit from any multi-year variable remuneration.
Exceptional remuneration	n/a	Mr. Julien does not benefit from any exceptional remuneration.
Stock options, performance shares or other grants of securities	n/a	Mr. Julien does not benefit from any grant of stock purchase or subscription options. During the year 2018, no performance shares or equivalent scheme were granted to Mr. Daniel Julien by the Company or one of its subsidiaries. It is reminded that the Group's policy on the matter, for 2018, was to grant performance shares every three years. The last grant was decided in April 2016. The Group decided to amend its practice subject to the approval by the shareholders' meeting to be held on May 9th, 2019, in favour of a remuneration policy including a grant every year starting in 2019.
Directors' fees	n/a	Mr. Julien does not receive any directors' fees from the Company or its subsidiaries.
Benefits in kind	US$63,310, *i.e.*, €53,471	The benefits in kind granted to Mr. Julien comprise a company car, healthcare insurance plan and the matching contribution for 2018 paid under the non-qualified deferred compensation plan described in section 3.2.2.1 *Benefits in kind* of the 2018 Registration Document.

* *Remunerations in foreign currencies are converted into euros at the average annual rate.*

Remuneration elements paid or granted for 2018 financial year to Mr. Daniel Julien that are or have already been voted upon by the shareholders' meeting under the procedure for regulated agreements and commitments

	Amounts subject to vote	Comments
Termination payments	n/a	Mr. Julien does not benefit from any indemnity or payment in connection with the termination of his position.
Non-compete compensation	No payment	As founder of the Group, Mr. Julien is entitled to receive compensation under a non-compete agreement. This non-compete agreement, concluded in 2006 and subsequently modified, was amended upon authorization of the Board of Directors at its meeting held on November 30th, 2017 in order to limit the duration of the obligations incumbent on Mr. Julien at two years and correlatively limit the compensation at two-years' remuneration (fixed and variable). The amendment No 3 to this agreement, entered into on December 1st, 2017, was approved by the shareholders' meeting held on April 20th, 2018 (4th resolution) and is described in section 3.2.2.1 *Payments relating to a non-compete agreement* of the 2018 Registration Document.
Additional pension scheme	n/a	Mr. Julien does not benefit from any additional pension scheme.

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Fixed, variable and exceptional elements of the total remuneration and the benefits of all kind paid or granted in connection with financial year 2018 to Mr. Olivier Rigaudy, Deputy Chief Executive Officer

On October 13th, 2017, upon proposal of the Chairman and Chief Executive Officer, the Board of Directors appointed Mr. Olivier Rigaudy as Deputy Chief Executive Officer. Following the combination of the functions of Chairman and Chief Executive Officer, given the Teleperformance Group's dimension and the necessity to rationalize the decision and representation process at Group level, the Chairman and Chief Executive Officer wished to have the possibility of entrusting a Deputy Chief Executive Officer with missions related to the general management and, in particular, the representation of the Company, and that the latter be a trusted person, based in France and with a solid knowledge of the Group. He thus proposed to the Board of Directors the candidacy of Mr. Olivier Rigaudy.

It was essential that Mr. Olivier Rigaudy, who was serving as Chief Financial Officer since 2010, continues to perform these duties in accordance with his employment contract, in complete independence from the assistance mission to the Chairman and Chief Executive Officer, which is linked to the function of Deputy Chief Executive Officer. The Board of Directors, upon recommendation of its Remuneration and Appointments Committee, thus decided to maintain his employment contract binding, since 2010, Mr. Rigaudy to the Company as Group Chief Financial Officer. Indeed, it considered that the duties of Mr. Rigaudy in respect of his office correspond to a mission to be distinguished from his employees' and technical duties.

The continuation of Mr. Rigaudy's employment contract is in line with the recommendation 21.2 of the AFEP-MEDEF code which provides that the employment contract must be terminated upon the appointment, as this recommendation does not apply to the Deputy Chief Executive Officer (reaffirmed by the application guide of the ADEP-MEDEF code of June 2018 published in January 2019).

At its meeting held on November 30th, 2017, the Board decided to set up his remuneration in respect of his duties of Deputy Chief Executive Officer as of January 1st, 2018. Mr. Rigaudy did not receive any remuneration in respect of his office for the period from October 13th, 2017 to December 31st, 2017.

In the interest of transparency, all the elements of the total remuneration of Mr. Rigaudy for 2018, both in respect of his term of office as Deputy Chief Executive Officer and of his employment contract as Group Chief Financial Officer are summarized in the table below.

	Officership as Deputy Chief Executive Officer (submitted to Shareholders' vote by law)	**Employment contract as Group Chief Financial Officer**	**Total remuneration**
Fixed remunerations (gross annual amounts)	€80,000	€520,000	€600,000 (50%)
Variable remunerations (gross annual maximum amounts) subject to distinct performance conditions	€380,000 (with clawback mechanism) – **payment conditional to a positive vote at the shareholders' meeting to be held on May 9th, 2019**	€220,000	€600,000 (50%)
Benefits in kind	n/a	Use of a company car	
Non-compete undertakings	Undertaking of 1 year compensated by an indemnity representing 1-year remuneration (fixed and variable) paid in respect of his executive functions as an employee and/or executive officer within the Group.		No implementation in 2018.
Other remuneration elements	**No additional indemnity in case of departure is provided under his employment contract** other than the indemnities set forth in application of legal provisions, it being specified that **the amount of these indemnities would not exceed, in any case, an amount equivalent to 2 years of his total remuneration.**		
Long-term remuneration (performance shares)	No grant in 2018.		

Table 1 of the AMF recommendations – Summary table on remuneration and stock options and shares granted to Mr. Olivier Rigaudy, Deputy Chief Executive Officer *(gross amounts – in euros)*

In the interest of transparency, this table includes the remuneration due to Mr. Olivier Rigaudy under his employment contract as Group Chief Financial Officer.

	2018	**2017****
Remuneration due in connection with the financial year (detailed in table 2)	1,208,779	748,779
Value of multi-year variable remuneration granted during the financial year	n/a	n/a
Value of stock options granted during the financial year	n/a	n/a
Value of performance shares granted during the financial year* (detailed in table 6)	n/a	n/a
TOTAL	**1,208,779**	**748,779**

* *It is reminded that, in 2018, the Group's policy in terms of performance shares grants (or equivalent mechanisms) provided for a grant every three years.*

** *In the interest of transparency, the amounts related to the 2017 financial year 2017, due and paid, are indicated for the full year. It is reminded that Mr. Rigaudy was appointed Deputy Chief Executive Officer on October 13th, 2017 and that he did not receive any remuneration in respect of his office in 2017.*

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Table 2 of the AMF recommendations – Summary remuneration table of Mr. Olivier Rigaudy, Deputy Chief Executive Officer
(gross amounts – in euros)

In the interest of transparency, this table includes the remuneration due to Mr. Olivier Rigaudy in respect of his employment contract as Deputy Chief Financial Officer. This remuneration is described for financial year 2017 as a full year. It is reminded that Mr. Rigaudy was appointed Deputy Chief Executive Officer on October 13th, 2017.

	2018		2017*	
	Amounts due	Amounts paid(2)	Amounts due	Amounts paid(1)
Fixed remuneration				
• in respect to the office	80,000	80,000	n/a	n/a
• under the employment contract	520,000	520,000	520,000	520,000
Annual variable remuneration				
• in respect to the office	380,000(2)	0(2)	n/a	n/a
• under the employment contract	220,000(3)	220,000(4)	220,000	263,000(5)
Multi-year variable remuneration	n/a	n/a	n/a	n/a
Exceptional remuneration	n/a	n/a	n/a	n/a
Non-compete compensation	n/a	n/a	n/a	n/a
Directors' fees	n/a	n/a	n/a	n/a
Benefits in kind				
• in respect to the office	n/a	n/a	n/a	n/a
• under the employment contract	8,779	8,779	8,779	8,779
TOTAL	**1,208,779**	**828,779**	**748,779**	**813,779**

* *In the interest of transparency, the amounts related to the 2017 financial year, due and paid, are indicated for the full year. It is reminded that Mr. Rigaudy was appointed Deputy Chief Executive Officer on October 13th, 2017 and that he did not receive any remuneration in respect of his office in 2017.*
(1) *The remuneration paid includes the portion of the remuneration payable in respect of the current financial year and the balance of the remuneration payable in respect of the previous financial year and not paid during that year.*
(2) *The payment of the variable remuneration for 2018 is conditional to the approval of the remuneration elements paid or granted in respect of 2018 by the shareholders' meeting to be held on May 9th, 2019 pursuant to the provisions of Article L.225-100 II of the French Commercial Code.*
(3) *The amount corresponds to the variable remuneration, subject to objectives to be achieved, set forth under his employment contract in respect of financial year 2018 to be paid in 2019.*
(4) *The amount corresponds to the variable remuneration, subject to objectives to be achieved, set forth under his employment contract in respect of financial year 2017 paid in 2018.*
(5) *The amount paid in February 2017 and this before his entry in office as Deputy Chief Executive Officer, includes an exceptional bonus (€65,000) linked to the personal implication as Group Chief Financial Officer in the acquisition process, financing of Language Line Solutions and the refinancing of the Group in 2016 and early 2017.*

DETAILS OF REMUNERATION ELEMENTS OF MR. OLIVIER RIGAUDY FOR THE 2018 FINANCIAL YEAR

For financial year 2018, the remuneration elements of Mr. Olivier Rigaudy, Deputy Chief Executive Officer, reflects the remuneration policy, in respect of his term of office, duly approved by the shareholders' meeting held on April 20th, 2018 in its 10th resolution (by 71.54% of favorable votes).

Fixed remuneration

For 2018, the amount of fixed annual remuneration of Mr. Olivier Rigaudy, as Deputy Chief Executive Officer, was set at €80,000. Furthermore, in 2018, Mr. Rigaudy received, in respect of his salaried functions of Group Chief Financial Officer, a fixed annual (gross) remuneration of €520,000, in accordance with the provisions of his employment contract.

Variable remuneration

Upon recommendation of the Remuneration and Appointments Committee, the Board of Directors set the maximum amount of variable remuneration of Mr. Olivier Rigaudy, in respect of his office as Deputy Chief Executive Officer for the 2018 financial year, at €380,000 subject to performance criteria. These performance criteria as well as the number of maximum points granted to each of these qualitative and quantitative criteria are identical to those determined for the Chairman and Chief Executive Officer, it being specified that personal involvements are taken into account in the determination of the achievement of the qualitative criteria (see section 3.2.2.1 *Variable remuneration* above).

Taking into account the results, the recommendations of the Remuneration and Appointments Committee, and after approval on financial items of the Audit and Compliance Committee, the Board of Directors, at its meeting held on February 28th, 2019, set the amount of the variable remuneration for 2018 of Mr. Olivier Rigaudy in his quality as Deputy Chief Executive Officer, at a gross amount of €380,000. Pursuant to the provisions of Article L.225-100 II of the French Commercial Code, the payment of this variable remuneration is conditional to the approval of the remuneration elements paid or granted in connection with financial year 2018 by the shareholders' meeting to be held on May 9th, 2019.

With regard to the detail, criteria by criteria, basis of this variable remuneration, identical to the one applicable to the variable remuneration of Mr. Daniel Julien, it is referred to the section 3.2.2.1 *Variable remuneration* above.

It is reminded that the variable remuneration of the Deputy Chief Executive Officer for 2018 is subject, such as for the Chairman and Chief Executive Officer, to a clawback scheme that is triggered in the event that all or part of this remuneration was received as the result of an accounting fraud affecting the consolidated financial statements, for which the Deputy Chief Executive Officer was responsible or acted as an accomplice. This scheme will be implemented if, during either of the two years following the year in which the Deputy Chief Executive Officer received said remuneration, the Board of Directors identifies such fraud. The amount of variable remuneration that the Deputy Chief Executive Officer would not have received if the fraud had not been committed will be repaid to the Company.

In addition, the employment contract as Group Chief Financing Officer provides for a maximum (gross) variable remuneration of €220,000 in respect of financial year 2018, determined in relation to performance criteria specific to technical and salaried functions described in the section *Employment contract* hereafter.

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In the interest of transparency, these performance criteria and their level of achievement, for 2018, are described on the table below. They were reviewed by the Remuneration and Appointments Committee.

Performance Criteria (employment contract)	Ratio	Comments	Levels of achievement
Management of the performance to achieve 2018 results (including free cash-flow generation for the Group)	30%	Achievement of levels of growth, margin rate, levels of currency gains, levels of cash-flow.	100%
Renegotiation of Group financing agreements	30%	Renegotiation of credit conditions (ratios, covenants…) and US private placements (USPP).	100%
Deployment of an accounting management system and of a Digital Board Room	20%	• Implementation of a new accounting software shared in France, Turkey, Albania, Germany, Italy, Tunisia. • Deployment of the SAP Hana solution for the digital monitoring of the Group's performance. • Deployment of an integrated management system (ERP).	100%
Study and assessment of the impact of the IFRS 16 norm on the consolidated financial statements	10%	Implementation of the ANAPLAN solution, automated management system of rents and their accounting treatment.	100%
Continuation of dialog with shareholders and development of the Teleperformance audience in the financial and investors communities	10%	Increase of the pace of roadshow and development of shareholdings in Asia.	100%

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Long-term remuneration

During financial year 2018, no performance shares or shares under a long-term incentive plan were granted to Mr. Olivier Rigaudy. It is reminded that the policy applicable did provide for a grant every three years.

Benefits in kind

Mr. Rigaudy did not receive any benefits in kind in respect of his office. It is reminded that, under his employment contract, he benefits from the use of a company car.

Table 11 of the AMF recommendations – Summary of undertakings taken in favor of executive officers

Executive Officer	Employment contract	Additional pension scheme	Payments or benefits due or to be due upon termination or change of responsibilities	Payments relating to a non-compete agreement
Olivier Rigaudy Deputy Chief Executive Officer	Yes	No	No	Yes

Employment contract

As described previously, the Board of Directors, upon recommendation of its Remuneration and Appointments Committee, decide to maintain the employment contract as Group Chief Financial Officer of Mr. Olivier Rigaudy.

This employment contract entered on February 1st, 2010, and therefore prior to his appointment, corresponds to the performance of technical functions, distinct from those related to his office as Deputy Chief Executive Officer, entrusted to Mr. Olivier Rigaudy since October 13th, 2017. In this regard, he is especially responsible for the facilitation and the supervision of accounting, financial and legal departments, the relations with banking institutions as part of the Group's financing operations and the monitoring of the Group's accounting closings.

As part of his office, he is required to take on additional functions and responsibilities of a different nature and of a more political logic. He assists the Chairman and Chief Executive Officer in the implementation of the Group's overall strategy in accordance with the orientations set by the Board of Directors and in the preparation of the Company's development plan as well as structural changes of the Group. In addition, these executive management functions give him the power to represent the Company under the authority of the Chairman and Chief Executive Officer thus allowing to rationalize the decision process.

His salaried functions and his term of office thus add up without being combined. Each of the actions undertaken by Mr. Olivier Rigaudy fall, without any ambiguity, under either his salaried function or his term of office as Deputy Chief Executive Officer.

The continuation of the employment contract takes into account the Group's economic and operational reality and considers Mr. Rigaudy's seniority within the Group and encourages the promotion of employees to the functions of senior executive managers. Finally, it is compliant with legal provisions and the recommendations of the AFEP-MEDEF code on the matter.

As a result, Mr. Olivier Rigaudy receives a distinct remuneration for his duties as Group Chief Financial Officer and for his office as Deputy Chief Executive Officer, of which the breakdown reflects the respective importance of the two missions.

Mr. Olivier Rigaudy thus continues to receive, in consideration for his duties as Group Chief Financial Officer, the remuneration provided for under his employment contract (a fixed (gross) annual remuneration of €520,000 and a maximum variable (gross) annual remuneration of €220,000). It is taken into account in the determination of the total remuneration and in the determination of the weight of the fixed and variable parts.

Additional pension scheme

There is no additional pension scheme in favor of the Deputy Chief Executive Officer.

Payments or benefits due or to be due upon termination or change of responsibilities

The executive officers are not entitled to any payments or benefits due or to be due as a result of termination of their appointment or a change in their responsibilities. Under his employment contract as Group Chief Financial Officer, Mr. Rigaudy does not benefit from any specific payment or benefit due or to be due as a result of termination of their appointment or a change in their responsibilities. That agreement continues to be governed by the legal provisions on termination of his employment contract (in particular, severance pay in the case of termination by the employer, no indemnity in case of resignation or dismissal for gross or willful misconduct).

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Furthermore, in accordance with the law, any subsequent amendment of Mr. Rigaudy's employment contract will follow the process of regulated related-party agreements (prior authorization by the Board of Directors, subsequent approval at the shareholders' meeting).

Payments relating to a non-compete agreement

The Board of Directors, upon recommendation of the Remuneration and Appointments Committee and in compliance with the Group's policy in terms of departure of key managers, authorized, at its meeting held on November 30th, 2017, the conclusion of a non-compete agreement between the Company and Mr. Olivier Rigaudy, Deputy Chief Executive Officer. This agreement was entered into on February 1st, 2018.

In this regard, Mr. Rigaudy undertakes to refrain, for a period of one year following his departure, in all the countries in which the Group operates at that date, from (i) collaborating with, (ii) taking part in, and (iii) investing in a business activity and/or company that competes with the Teleperformance Group or poaching its employees or officers, in any way whatsoever. In the event of departure, whatever the cause with the exception of death, Mr. Rigaudy shall receive a compensation capped at 1 year's (fixed and variable) gross remuneration as consideration for the performance of executive duties, as an employee and/or executive director within the Group. In accordance with the provisions of Articles L.225-38 *et seq.* of the French Commercial Code, this non-compete agreement was approved by the shareholders' meeting held on April 20th, 2018.

SHAREHOLDERS' VOTE ON REMUNERATION ELEMENTS PAID OR GRANTED IN RESPECT OF THE 2018 FINANCIAL YEAR TO MR. OLIVIER RIGAUDY, IN RESPECT OF HIS OFFICE AS DEPUTY CHIEF EXECUTIVE OFFICER

In accordance with the provisions of Article L.225-100 II of the French Commercial Code, the fixed, variable and exceptional elements of the total remuneration and benefits of all kind paid or granted to each executive officer in respect of the year ended are submitted to the shareholders' vote.

It is then proposed to the shareholders' meeting to be held on May 9th, 2019 to issue a favorable vote on the fixed, variable and exceptional elements of the total remuneration and benefits of all kind paid or granted to Mr. Olivier Rigaudy, Deputy Chief Executive Officer, in respect of the year ended December 31st, 2018 (it being specified that the remuneration received under his employment contract are not submitted to the vote).

Remuneration elements paid or granted to Mr. Olivier Rigaudy, in respect of his term of office as Deputy Chief Executive Officer, for the 2018 financial year

	Amounts or book value subject to vote*	Comments
Fixed remuneration	€80,000	The gross fixed annual remuneration of Mr. Olivier Rigaudy was set by the Board of Directors at €80,000 for 2018.
Annual variable remuneration	€380,000 (amount to be paid *after approval of the shareholders' meeting to be held on May 9th, 2019*)	At its meeting held on February 28th, 2019, the Board of Directors, upon recommendation of the Remuneration and Appointments Committee, and after approval of financial items by the Audit and Compliance Committee, set the amount of variable remuneration of Mr. Olivier Rigaudy for the 2018 financial year as follows: • with regard to the quantitative criteria (increase in revenues excluding currency gains and losses, and increase in the current EBITA margin ratio), all of the 80 points assigned to these criteria were granted; • with regard to the qualitative criteria all of the 20 points assigned to these criteria were granted. The amount of the 2018 variable remuneration of Mr. Olivier Rigaudy has, accordingly, been set €380,000. The performance criteria and their expected and recorded fulfillment levels are set out in section 3.2.2.1 *Variable remuneration* of the 2018 Registration Document. This remuneration is coupled with a clawback mechanism.
Multi-year variable remuneration in cash	n/a	Mr. Olivier Rigaudy does not benefit from any multi-year variable remuneration.
Exceptional remuneration	n/a	Mr. Olivier Rigaudy does not benefit from any exceptional remuneration.
Stock options, performance shares or other grants of securities	n/a	Mr. Olivier Rigaudy does not benefit from any grant of stock purchase or subscription options. During the year 2018, no performance shares or equivalent scheme were granted to Mr. Olivier Rigaudy by the Company or one of its subsidiaries. It is reminded that the Group's policy on the matter, for 2018, was to grant performance shares every three years. The last grant was decided in April 2016. The Group decided to amend its practice, subject to the approval by the shareholders' meeting held on May 9th, 2019, in favour of a remuneration policy including a grant every year starting in 2019.
Directors' fees	n/a	Mr. Olivier Rigaudy does not receive any directors' fees from the Company or its subsidiaries.
Benefits in kind	n/a	Mr. Olivier Rigaudy does not receive any benefits in kind in respect of his term of office.

* *These amounts correspond to amounts paid or granted to Mr. Olivier Rigaudy in connection with financial 2018 in respect of his office as Deputy Chief Executive Officer. It being reminded that Mr. Rigaudy received a distinct remuneration under his employment contract and described above.*

Remuneration elements paid or granted to Mr. Olivier Rigaudy, in respect of his term of office, for 2018 financial year that are or have already been voted upon by the shareholders' meeting under the procedure for regulated agreements and commitments

	Amounts subject to vote	Comments
Termination payments	n/a	Mr. Rigaudy does not benefit from any indemnity or payment in connection with the termination of his position.
Non-compete compensation	No payment	Mr. Rigaudy, Deputy Chief Executive Officer, is bound by a non-compete agreement authorized by the Board of Directors at its meeting held on November 30th, 2017, entered into on February 1st, 2018 and approved by the shareholders' meeting held on April 20th, 2018 (5th resolution) and detailed in section 3.2.2.1 *Payments relating to a non-compete agreement* of the 2018 Registration Document.
Additional pension scheme	n/a	Mr. Rigaudy does not benefit from any additional pension scheme.

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3.2.2.2 Presentation of the remuneration policy applicable to executive officers for 2019

In drawing up its recommendations on 2019 remuneration for executive officers of the Company, the Remuneration and Appointments Committee has taken into account in particular the results of the votes expressed by shareholders at the meetings held on June 23rd, 2017 and April 20th, 2018, the Group's evolution, its environment and its activities. It also took into account a study on remuneration of Group executive officers conducted, at its request, by an external independent firm specialized in terms of remuneration. The latter determined comparable situations to those of the Teleperformance Group in order to proceed with relevant and adapted comparisons. That peer group comprises 33 listed companies in France, both in the CAC 40 and SBF 120 indices[(1)], and 27 listed companies in the USA[(2)] on different markets. The choice of these companies was made by considering:

- the market capitalization of the companies concerned;
- their size with regard to turnover;
- their important footprint in the USA;
- the number of employees (higher than 5,000 in France, higher than 10,000 in the USA);
- the nature of the business (services to companies, IT services, consulting, research, data processing...);
- business weight outside of France (at least higher than 50%);
- the total shareholders' return (or TSR) at least higher than 0 consecutively for 3 years.

Based on this peer group, the firm compared the policies and practices on remuneration of executive officers with regard to three criteria (TSR, activity growth, EBITDA growth) assessed over 1 and 3 years compared to the French and US peer group.

The firm's conclusions are the following:

- Teleperformance is positioned as one of the highest performing companies of the peer group, with regard to the criteria referred to above, irrespective of the period and criteria concerned;
- the fixed part of the executive remuneration is one the most important of the peer group. This is due to the absence of annual grant of performance shares under the long-term policy then applicable (one grant every three years), the policy is to be modified in 2019 (one grant every year);
- the quality and regularity of the Group's results leads to the regular achievement of stringent quantitative and qualitative performance criteria attached to the variable part of the remuneration;
- overall, the remuneration policy applied within the Group is positioned on the high end of the French peer group but is, however, slightly below median level of the US peer group.

The study conducted by the independent specialized firm confirms the good adequacy of structures and individual amounts of the remuneration of executive directors with the Group's size, its level of performance, the localization of its interests with regard to a representative peer group.

Based on this analysis and upon proposal of the Remuneration and Appointments Committee, the Board at its meetings held on November 30th, 2018 and February 28th, 2019, reviewed and set the principles and criteria for the determination, allocation and grant of the elements comprising the total remuneration and benefits of all kind for the Chairman and Chief Executive Officer and the Deputy Chief Executive Officer for the 2019 financial year.

The Board of Directors thus decided, for 2019, upon recommendation of the Remuneration and Appointments Committee, to:

- maintain unchanged the global maximum amount of the remuneration, fixed and variable parts, of (i) the Chairman and Chief Executive Officer and this for the sixth consecutive year (unchanged since 2013) and (ii) the Deputy Chief Executive Officer;
- maintain unchanged the allocation between the fixed part and the variable part approved in 2018 for the Chairman and Chief Executive Officer and the Deputy Chief Executive Officer (the fixed part representing 50% of the total remuneration and the variable part representing also 50%) and to introduce qualitative criteria related to corporate, social and environmental responsability aspects in the variable annual remuneration.

In drawing up its recommendations, the Remuneration and Appointments Committee also considered (i) the approval expressed by the shareholders' meeting held on April 20th, 2018 on the remuneration policy applicable to the Chairman and Chief Executive Officer (resolution approved at 95.13%) and (ii) the expectations expressed by shareholders on the remuneration policy applicable to the Deputy Chief Executive Officer (resolution approved at 71.54%).

In accordance with the principles of good governance to which it is attached, the Board reexamined the opportunity of the continuation or the suspension of the employment contract of Mr. Rigaudy. On this occasion, it reviewed:

- the operational reality of the Group: the functions of Group Chief Financial Officer are distinct from the ones of Deputy Chief Executive Officer and correspond to different responsibilities;
- the age and seniority within the Group of the concerned person: the Teleperformance Group is an organization structured around historical leaders and professionals having a strong knowledge of the Group and a great expertise of its businesses. Its long-term strategy lies in securing key identified talents and senior managers. Thus, the Board considers that the automatic termination or suspension of employment contracts could create a hindrance on internal promotions and access to high executive leadership. Mr. Rigaudy has been the Group Chief Financial Officer since 2010 and the Board wished, and deemed strongly necessary, to maintain his seniority, in particular with regard to the undesirable additional costs that would be caused to the Company (retirement, health insurance...) by suspending or terminating the employment contract;
- the level and degree of transparency of the Group in terms of remuneration of its executive managers: the Group described in a precise manner all the remuneration elements received by executive managers whether they correspond to a term of office or salaried functions. These elements are taken into account for the determination of the level of total remuneration.

The Board concluded on the appropriateness of the analysis conducted at the time of that appointment (on this analysis see *supra* paragraph *employment contract* in the section 3.2.2.1 of the present Registration Document for 2018) and, as a result, to the appropriateness of maintaining, without suspending, the employment contract of Mr. Rigaudy while reaffirming the imperative of a necessary transparency and comprehensiveness of all the remuneration elements of any nature.

(1) The companies of the French peer group are: AccorHotels, Alstom, Alten, Altran Technologies, Aperam, Arkema, Atos, Biomerieux, Bureau Veritas, Capgemini, Dassault Aviation, Dassault Systemes, Edenred, Elice, Eramet, Essilor International, Eurofins Scientific, Imerys, Ipsos, Legrand, Nexans, Plastic Omnium, Sartorius Stedim Biotech, Seb Groupe, Solvay, Spie, STMicroelectonics, Tarkett, TechnipFMC, Thales, Ubisoft, Vivendi, Worldline.

(2) The Companies of the US peer group are: ABM Industries Incorporated, Amphenol Corporation, Booz Allen Hamilton Holding Corp., Broadridge Financial Solutions, Inc., Caci International Inc, Cintas Corporation, Convergys Corporation, Epam Systems, Inc., Equifax Inc., Gartner, Inc., Genpact Limited, Global Payments Inc., Healthcare Services Group, Inc., Kar Auction Services, Inc., Leidos Holdings, Inc., Maximus, Inc., Parker-Hannifin Corporation, Paychex, Inc., Plexus Corp., Sanmina Corporation, Science Applications Intl Corp., Stanley Black & Decker, Inc., The Brink's Company, The Western Union Company, Total System Services, Inc., Unifirst Corporation, XPO Logistics, Inc.

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Furthermore, some shareholders wished to express themselves, at shareholders' meetings, on the remuneration in respect of the employment contract and not only under the term of office. The Remuneration and Appointments Committee and the Board examined this request with regard to applicable legal provisions in terms of shareholders' vote on remuneration policy ("say on pay"). The provisions of Article L.225-37-2 of the French Commercial Code provide that the shareholders' vote concerns only the amounts due in respect of a term of office. The French Market Authority *(Autorité des marches financiers)* in its 2018 report on corporate governance and remuneration of executive officers in listed companies confirms this interpretation and reminds that the amounts that are not due in respect of a term of office are excluded from the vote (page 75). As a result:

- the Board decided to comply with the law applying the say on pay process on remuneration in respect of a term of office, it being understood that shareholders will be able to express themselves on any amendment of the employment contract under the mechanism of regulated related-party agreements;
- the Board agreed to continue to ensure the transparency and the comprehensiveness of the information given to shareholders on the total remuneration due or paid to executive officers, irrespective of it being under a term of office or an employment contract.

In relation to long-term share-based profit-sharing schemes, the Board of Directors, upon recommendation of the Remuneration and Appointments Committee, decided to modify some of the principles of allocation in order to make its policy in this matter more compliant with shareholders' expectations, the recommendations of the AFEP-MEDEF code and the practices commonly observed and in order to rebalance the variable part of the remuneration of executive officers in accordance with the findings of the study on remuneration conducted by the specialized firm. Subject to the approval of the shareholders' meeting, the principles of the new policy on the matter are the following:

- the acquisition (vesting) of performance shares is subject to performance and presence criteria applicable to both executive officers and all employee beneficiaries;
- the performance conditions, assessed over a three-year period, are in line with the long-term strategy as defined by the Board of Directors. The Board, upon recommendation of the Remuneration and Appointments Committee, sets the thresholds for calculating the performance expected or achieved and for determining the number of shares definitively vested. The performance criteria consist in the achievement of three financial measurable and verifiable criteria to facilitate the measure of the achievement or non-achievement: two internal criteria (Group organic growth and operating profitability) and one external criteria (stock performance) compared to a representative index over each achievement period. They are cumulative: they do not offset each other and no criteria is excluded to the benefit of others that would be achieved.
- with regard to frequency of grants, it is intended, starting in 2019, to have a grant every year compared to a grant every three years prior to 2019. This modification will allow to reduce the fixed part of the remuneration of executive officers to nearly 30% of the total corresponding to a level in line with the one observed in the study on remuneration conducted in 2018;
- the number of performance shares granted to a beneficiary is determined in accordance with his or her role and responsibilities and, where applicable, local consideration. The maximum number of performance shares that can be granted to executive officers cannot exceed 15% of the total number of performance shares granted each year;
- long-term incentive plans, if implemented, are subject to the same rules and performance and presence criteria as performance share grants;
- if a beneficiary leaves the Company, he or she does not retain the shares granted under a performance share or long-term incentive plan and not yet definitively vested, unless otherwise decided by the Board of Directors, which would decide in compliance with the recommendations of the AFEP-MEDEF code in this respect (prorata, retention of performance criteria and justifications of its decision);
- executive officers must retain at least 30% of shares vested until the end of their term of office and will need to take the commitment not to engage in hedging transactions.

The Board also discussed the continuation of the remuneration proposed for the functions of Chairman and Chief Executive Officer on the one hand, and of the Deputy Chief Executive Officer, on the other hand, in light of a change of governance structure or appointment of a new executive director external to the Group. In such circumstances, the Board of Directors will conduct a global analysis of the situation of the officer concerned, it being specified that the remuneration and its criteria will be set in accordance with existing practices within the Group and principles consistently affirmed. The individual expertise and experience of the officer concerned would also be taken in to consideration.

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Structure and criteria of determination of the remuneration of the Chairman and Chief Executive Officer

Reminder of the evolution of the remuneration elements of the Chairman and Chief Executive Officer over the last three years

Financial year	2017	2018	2019	Observation
Fixed remuneration	US$3,750,000	US$2,625,000	US$2,625,000	Modification of the allocation between the fixed and variable parts (from 70%/30% to 50%/50%); **BUT** global remuneration amount (fixed and variable) unchanged since 2013; **AND** introduction of a clawback mechanism in 2018 (maintained for 2019); **AND** introduction, in 2019, of qualitative quantifiable performance criteria in terms of corporate and environmental responsibility.
Variable remuneration	US$1,500,000 (subject to performance criteria)	US$2,625,000 (subject to performance criteria) Introduction of a clawback mechanism	US$2,625,000 (subject to performance criteria) Clawback mechanism	
Long-term remuneration	Performance shares grant every three years (last grant decided in 2016).	Performance shares grant every three years (last grant decided in 2016).	Performance shares grant every year.	Modification due to practices observed and shareholders' expectations.
Benefits in kind	Use of a company car, benefit of a healthcare insurance plan and the matching contribution under the non-qualified deferred compensation plan.			Unchanged.
Non-compete undertaking	Undertaking of 2 years compensated by an indemnity corresponding to 2.5 years of remuneration or of 3 years compensated by an indemnity of 3 years at the Board's choice.	Undertaking of 2 years compensated by an indemnity capped at 2 years of remuneration (fixed and variable).		Modification to cap the compensation amount at 2-years remuneration to limit the financial impact for the Group while protecting the interests of all the stakeholders.

Fixed remuneration

For 2019, the annual fixed part of the remuneration of the Chairman and Chief Executive Officer, Mr. Daniel Julien, was set at the gross amount of US$2,625,000 (identical amount to the one set in 2018). It is reminded that the fixed part of the remuneration of Mr. Julien was reduced as of January 1st, 2018 from US$3,750,000 (unchanged from 2013 to 2017) to US$2,625,000.

Annual variable remuneration

The maximum amount of the variable remuneration of the Chairman and Chief Executive Officer for 2019, was set at a gross amount of US$2,625,000, an amount equivalent to that of its fixed annual remuneration (similarly to 2018).

The performance criteria for said variable remuneration were defined by the Board of Directors upon recommendation of its Remuneration and Appointments Committee, at its meeting held on November 30th, 2018. These conditions consist (i) for 80% of the maximum amount, in quantitative performance criteria (achievement of levels of revenues for 40% and of EBITA for 40%) and (ii) for 20%, in qualitative criteria corresponding, in accordance with the recommendations of the AFEP-MEDEF code, to identified priorities in terms of corporate and environmental responsibilities for 2019, namely:

- Corporate responsibility of the Company (for 10%):
  - Objective: continuation of the obtention of awards related to company employee and staff satisfaction ("Best Place to Work"/"Great Place To Work"/"AON Best Employer») issued by independent bodies,
  - Assessment elements: maintaining the number of awards obtained during the 2018 financial year (*i.e.* 10 awards);
- Data security (for 5%):
  - Objective: the integration of the entities and teams from the Intelenet acquisition into the Group's General Data Protection Regulation (GDPR) program,
  - Assessment elements:
    - Implementation of GDPR,
    - Audits,
    - Reports to the Audit and Compliance Committee;
- Group's capacity to face crisis situations: the Group set up in 2018 a crisis management process consisting in the organization, the means, the processes and the tools to prepare itself and face the occurrence of a crisis of a natural (catastrophe), economical, physical type or related to information, to reputation and to human resources, and to draw conclusions from it in order to improve them. The Board of Directors wished to include in its qualitative objectives the consideration of the importance of such a process enabling the Group to integrate all stakeholders, assess the different *scenarii* with a high degree of objectivity and take quick decisions. The measure of the achievement of that objective will be assessed with the help of an external consultant in charge of assessing two crisis management exercises in 2019:
  - Objective: the successful deployment of the crisis management process set up in 2018;
  - Assessment elements:
    - the deployment of the process through two successful exercises in 2019, upon the assessment of an external consultant,
    - number of persons trained throughout the Group (permanent members, alternate members, replacements...).

The expected levels of achievement of these conditions were set by the Board of Directors in a precise manner and are not made public for confidentiality reasons. The levels of achievement will be effectively noted and acknowledged by the Board and disclosed retrospectively (*i.e.*, for the 2019 remuneration, in the Registration Document for 2019 published in 2020).

Furthermore, the variable remuneration of the Chairman and Chief Executive Officer for 2019 remains subject to a clawback scheme set up in 2018 and described in section 3.2.2.1 *Variable remuneration*.

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It is reminded that, in accordance with the provisions of Articles L.225-37-2 and L.225-100 II of the French Commercial Code, the payment of the variable remuneration granted, in respect of financial year 2019 to Mr. Daniel Julien, is subject to the approval by an ordinary shareholders' meeting to be held in 2020 of the remuneration elements in respect of 2019 for his office as Chairman and Chief Executive Officer.

Long-term remuneration (performance share grants or similar schemes)

In application of its new grant policy explained above, and subject to approval of the grant of performance shares authorization by the shareholders' meeting to be held on May 9th, 2019, the Board, upon recommendation of its Remuneration and Appointments Committee, decided that the maximum amount of performance shares that could be granted, each year, to the Chairman and Chief Executive Officer, shall not exceed 66,667 shares over the duration of the authorization. This annual cap is higher compared to the number corresponding and comparable to the previous grant (58,333 shares). The Board, upon proposal of the Remuneration and Appointments Committee, considered that this increase is justified and is in the shareholders' interest and especially took into account:

- the global remuneration of Mr. Daniel Julien is unchanged since 2013;
- the structure and achievement criteria of his remuneration and variable part became more stringent for the person concerned (reduction of the fixed part, introduction of a clawback mechanism) event though the results are steadily increasing;
- The definitive acquisition of the total number of shares granted subject to performance conditions pursuant to this policy is set in a longer period of time than in the past (five years compared to three years previously);
- the Group's size has doubled;
- the complexity of the Group's environment due, particularly, to recent acquisitions, their integration and the international development of operations increased.

Based on all these factual elements, the increase of the number of shares is justified and it also allows to align the shareholders' interests with those of the executive officer.

Benefits in kind

Benefits in kind granted to the Chairman and Chief Executive Officer comprise a company car, healthcare insurance plan and the matching contribution, in case of deferred remuneration payment, under the non-qualified deferred compensation plan, which is similar to a deferred savings plan, described in section 3.2.2.1 *Benefits in kind* above.

Deferred remuneration: compensation under non-compete undertakings or agreements

The Chairman and Chief Executive Officer is bound to the Group by a non-compete agreement, the modalities of which, described in section 3.2.2.1 *Compensation under a non-compete undertaking* above, were amended by the Board of Directors held on November 30th, 2017. The non-compete and non-solicitation undertakings are now capped at 2 years and the corresponding indemnity is capped at 2 years remuneration (fixed and variable), as approved by the Shareholders' meeting held on April 20th, 2018.

Other remuneration items

The remuneration structure of the Chairman and Chief Executive Officer does not provide for compensation or remuneration granted upon the taking or termination of duties, exceptional remuneration, multi-year variable remuneration, additional or complementary pension scheme, stock-option grants or the retention of performance shares, or equivalent scheme. In accordance with the recommendations of the AFEP-MEDEF code, in the event of departure of the executive officer before the end of the period envisaged for the assessment of the performance criteria for the long-term compensation mechanisms, continued entitlement to all or part of the performance shares or equivalent mechanisms must be evaluated and justified by the Board (prorata, continuation of the performance criteria and justifications of its decision).

Summary of the benefits granted to the Chairman and Chief Executive Officer

	Voluntary departure/ Dismissal for gross or wrongful misconduct	Forced departure	Retirement
Termination compensation	-	-	-
Non-compete compensation	2 years gross remuneration (fixed and variable) paid in respect of the calendar year preceding the year of departure.		
Additional pension	-	-	-
The impact on performance shares not definitely acquired	Loss (unless decided otherwise, in the latter case, by the Board of Directors which would decide in accordance with the recommendations of the AFEP-MEDEF code on the matter).		No accelerated vesting, *prorata* applied and performance conditions remain applicable.

Structure and criteria of determination of the remuneration of the Deputy Chief Executive Officer

It is reminded that the total remuneration of the Deputy Chief Executive Officer was the object of a study conducted by a specialized firm (see section 3.2.2.2 above) which found that the remuneration is positioned on the high end of the French peer group but slightly below median level of the US peer group. Considering the structure and the business geography of the Group, the Board maintained the total remuneration of the Deputy Chief Executive Officer at the same level, as it is justified.

Fixed remuneration

For 2019, the annual fixed part of the remuneration of Mr. Olivier Rigaudy, as Deputy Chief Executive Officer, was maintained at the gross amount of €80,000 (identical amount compared to the one for 2018).

Furthermore, it is reminded that Mr. Rigaudy, Deputy Chief Executive Officer, is bound to the Company by an employment contract as Group Chief Financial Officer since February 1st, 2010. In that regard, he will receive, in respect to his salaried functions, the remuneration set forth in his employment contract, *i.e.* an annual fixed (gross) remuneration of €520,000 (identical amount to the one received for 2018).

Annual variable remuneration

The maximum amount of the variable remuneration of the Deputy Chief Executive Officer was maintained at a gross amount of €380,000 (identical amount to the one set for 2018).

Furthermore, it is reminded that Mr. Olivier Rigaudy will receive in respect of his salaried functions of Deputy Chief Executive Officer, the remuneration set forth in his employment contract, *i.e.* a maximum variable (gross) remuneration of €220,000 for the 2019 financial year (identical to the amount for 2018), determined on the basis of performance criteria specific to his technical and salaried duties. This remuneration shall not be increased by the payment of exceptional bonuses.

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The performance criteria for said variable remuneration were defined by the Board of Directors upon recommendation of its Remuneration and Appointments Committee, at its meeting held on November 30th, 2018. These conditions consist (i) for 80% of the maximum amount, in quantitative performance criteria (achievement of levels of revenues for 40% and of EBITA for 40%) and (ii) for 20%, in qualitative criteria corresponding, in accordance with the recommendations of the AFEP-MEDEF code, to identified priorities in terms of corporate, social and environmental responsibilities for 2019, namely:

- corporate responsibility of the Company (for 10%);
- data security (for 5%);
- the Group's capacity to face crisis situations (for 5%).

The performance criteria and the maximum number of points granted for each of the qualitative and quantitative criteria are identical to those determined for the annual variable remuneration of the Chairman and Chief Executive Officer, it being specified that the personal implications will be taken into account (see above) in the determination of the achievement of qualitative criteria.

The expected levels of achievement of these conditions were set by the Board of Directors in a precise manner and are not made public for confidentiality reasons. The levels of achievement will be effectively noted and acknowledged by the Board and disclosed retrospectively (*i.e.*, for the 2019 remuneration, in the Registration Document for 2019 published in 2020).

Furthermore, the variable remuneration of the Deputy Chief Executive Officer for 2019 remains subject, as for the Chairman and Chief Executive Officer, to a clawback scheme described in section 3.2.2.1 above.

It is reminded that, in accordance with the provisions of Articles L.225-37-2 and L.225-100 II of the French Commercial Code, the payment of the variable remuneration granted in respect of financial year 2019, in respect of his office is subject to the approval by an ordinary shareholders' meeting of his remuneration elements.

In the interest of transparency, the Company makes public the objectives of the variable remuneration of Mr. Rigaudy in respect of his employment contract, which for 2019 are the following:

- monitoring of the performance, financial profitability and return and cash (50%);
- finalization of the deployment of the ERP system in Europe and analysis before its implementation in India (15%);
- increase of the Group's analyst coverage (15%);
- repurchase of minority interests in the Group (10%);
- implementation of a relevant organization in terms of corporate and environmental responsibility (10%).

Long-term remuneration (performance share grants or similar schemes)

In application of its new grant policy explained above, and subject to approval of the grant of performance shares authorization by the Shareholders' meeting to be held on May 9th, 2019, the Board, upon recommendation of its Remuneration and Appointments Committee, decided that the maximum amount of performance shares that could be granted, each year, to the Deputy Chief Executive Officer, shall not exceed 22,000 shares over a three-years period. This number, reduced by over 60% compared to the grant in favor of the former Chief Executive Officer, results in a total variable remuneration (short and long-term) of 72% (all objectives achieved) of the person to align these objectives to the shareholders' interests.

Benefits in kind

The Deputy Chief Executive Officer does not receive any benefits in respect of his term of office. It is reminded that, in respect of his employment contract, he benefits from the use of a company car.

Deferred remuneration: compensation under non-compete undertakings or agreements

The Deputy Chief Executive Officer is bound to the Group by a non-compete agreement, the modalities of which are described in section 3.2.2.1 *Compensation under a non-compete agreement* above and which was authorized by the Board of Directors held on November 30th, 2017 and approved by the shareholders' meeting held on April 20th, 2018. This non-compete agreement, of a 1-year duration, is compensated at 1-year remuneration (fixed and variable) paid in respect of executive functions as an employee and/or executive officer within the Group.

Other remuneration items

The remuneration structure of the Deputy Chief Executive Officer does not provide for compensation or remuneration granted upon the taking or termination of duties, exceptional remuneration, multi-year variable remuneration, additional or complementary pension scheme, stock-option grants or the retention of performance shares, or equivalent scheme. In accordance with the recommendations of the AFEP-MEDEF code, in the event of departure of the executive officer before the end of the period envisaged for the assessment of the performance criteria for the long-term compensation mechanisms, continued entitlement to all or part of the performance shares or equivalent mechanisms must be evaluated and justified by the Board (*prorata*, continuation of the performance criteria and justifications of its decision).

Furthermore, his employment contract does not provide for compensation or remuneration granted upon the taking or termination of his duties, exceptional remuneration, multi-year variable remuneration, additional or complementary pension scheme, stock-option or performance shares grants or retention.

Summary of the benefits granted to the Deputy Chief Executive Officer

	Voluntary departure/ Dismissal for gross or wrongful misconduct	Forced departure	Retirement
Termination compensation*	-	No indemnity due in respect of his employment contract.	-
Non-compete compensation	1-year remuneration (fixed and variable) paid in respect of executive functions as an employee and/or executive officer within the Group.		
Additional pension	-	-	-
The impact on performance shares not definitely acquired	Loss (unless decided otherwise, in the latter case, by the Board of Directors which would decide in accordance with the recommendations of the AFEP-MEDEF code on the matter).		No accelerated vesting, *prorata* applied and performance conditions remain applicable.

* *In respect of his employment contract, Mr. Rigaudy can benefit (i) from indemnities, particularly dismissal indemnities, due in application of the French law provisions on termination of employment contracts at the Company's initiative and (ii) from retirement indemnities due in application of the French law provisions in the event of case of retirement.*

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3.2.2.3 Stock subscription or purchase options and performance shares grants to executive officers

a. Stock subscription or purchase options

Stock subscription or purchase options granted to or exercised by executive officers during the financial year (information required in Tables 4 and 5 of the AMF recommendations)

None.

History of grants of stock options (information required in Table 8 of the AMF recommendations)

None.

Stock subscription or purchase options granted or exercised by the top 10 beneficiaries other than executive officers (information required in Table 9 of the AMF recommendations)

None.

b. Performance shares and equivalent schemes

During the financial year 2018, no performance shares were granted in favour of Mr. Daniel Julien and Mr. Olivier Rigaudy.

Table 10 of the AMF recommendations – Overview of performance share plans granted by Teleperformance SE

The characteristics of the share performance plans are described in section 7.2.5.3 of present Registration Document.

Plan Number	130730TP	160428TP	161102TP	170623TP	180102TP	180228TP
Date of shareholders' meeting	05/30/2013	04/28/2016	04/28/2016	04/28/2016	04/28/2016	04/28/2016
Date of Board of Directors meeting	07/30/2013	04/28/2016	11/02/2016	06/23/2017	11/30/2017	02/28/2018
Grant date	07/30/2013	04/28/2016	11/02/2016	06/23/2017	01/02/2018	02/28/2018
Total number of share rights granted	840,000	914,300	151,508	11,600	6,000	1,000
Total number of beneficiaries	126	239	29	1	1	1
of which total number granted to executive officers:						
• Daniel Julien*	-	-	-	-	-	-
• Olivier Rigaudy **	-	-	-	-	-	-
Definitive vesting date	07/30/2016	04/28/2019	11/02/2019	06/23/2020	01/02/2021	02/28/2021
End of lock-in period	07/30/2018	n/a	n/a	n/a	n/a	n/a
Performance criteria***	Yes	Yes	Yes	Yes	Yes	Yes
Nature of shares granted	New or existing shares	New or existing shares	New or existing shares	New or existing shares	New or existing shares	new or existing shares
Total number of share rights cancelled or lapsed	205,000	103,700	11,632	0	0	0
Number of shares definitively vested	635,000	-	-	-	-	-
Number of rights outstanding	-	810,600	139,876	11,600	6,000	1,000

* *Since 2013, the grants in favor of executive officers have been made under the plans called long-term incentive described hereafter.*
** *Deputy Chief Executive Officer since October 13th, 2017.*
*** *The performance criteria are described in section 7.2.5.3 of the Registration Document for 2018.*

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Information required under table 6 of the AMF recommendations – Overview of long-term incentive plans implemented by Teleperformance Group, Inc.

	TGI plan 2013	TGI plan 2016
Grant date	07/30/2013	04/28/2016
Total number of share rights granted	300,000	350,000
Total number of beneficiaries	2	2
• Daniel Julien	150,000	175,000
• Paulo César Salles Vasques*	150,000	175,000
Definitive vesting date	08/01/2016	04/29/2019
End of lock-in period	07/30/2018	n/a
Performance criteria**	Yes	Yes
Valuation of the shares, at the grant date, for each beneficiary, according to the method used for consolidation accounts	€5,050,500	€13,160,000***
Total number of share rights cancelled or lapsed	0	70,959
Number of shares definitively vested	300,000	0
Number of rights outstanding	0	279,041

* *Chief Executive Officer until October 13th, 2017.*
** *The performance criteria are described in section 7.2.5.3.*
*** *It is reminded that no grant was carried out in 2018, the Group's policy in terms of performance shares grants (or equivalent mechanisms) provides for a grant every three years.*
The valuation of the performance shares was determined according to the method used for the consolidated financial statements as at December 31st, 2016 and taking into account the following elements: This grant is subject to presence and performance criteria (see section 7.2.5.3). It is reminded that three criteria showing the best performance level out of the four criteria defined by the Board of Directors will be used to determine the number of shares definitively vested. Furthermore, given that one of the criteria is a market criterion (evolution of the share price compared to the SBF120 index), this criterion was taken into account in calculating the fair value of the performance shares. However, in accordance with the three best criteria rule, there is no guarantee that the market criterion will actually be applied. Accordingly, two fair values have been calculated. In application of the market criterion, the fair value was calculated at €48.51 per share. Excluding the market criterion, the fair value was calculated at €75.20 per share. As of December 31st, 2016, the fair value retained is €75.20.

The company Teleperformance Group, Inc., 100% US subsidiary of Teleperformance SE, implemented two long-term incentive plans settled in Teleperformance SE shares:

- in July 2013, involving a total amount of 300,000 shares granted to two beneficiaries, Mr. Julien then Chairman of the Board and Mr. Salles Vasques then Chief Executive Officer. The definitive vesting of the shares is subject to presence and performance conditions that are identical to those approved by the Board of Directors at its meeting held on July 30th, 2013 (Plan 130730TP). The shares were definitively acquired by the beneficiaries on August 1st, 2016 and the lock-in period ended on July 30th, 2018. These conditions are described in section 3.5.2.4 of the 2016 Registration Document;
- in April 2016, involving a total amount of 350,000 shares granted to two beneficiaries, Mr. Julien then Chairman of the Board and Mr. Salles Vasques then Chief Executive Officer. The definitive vesting of the shares is subject to presence and performance conditions that are identical to those approved by the Board of Directors at its meeting held on April 28th, 2016 (Plan 160428TP).

With regards to the shares granted to Mr. Paulo César Salles Vasques, it is reminded the following:

- following the termination of the executive functions of Mr. Salles Vasques in the Group, the Board of Directors, at its meeting held on October 13th, 2017, decided, pursuant to Recommendation 24.5.1 of the AFEP-MEDEF code, to reduce *prorata temporis* the right to acquire the 175,000 performance shares granted in April 2016 so as only to take into account the period during which, over the three years of the plan, he served as Chief Executive Officer and was in charge of executive functions. The maximum number of performance shares that may be definitively acquired by Mr. Paulo César Salles Vasques at the end of this period was thus reduced to 104,041. These shares are all subject to the performance conditions initially set;
- in addition, the Board, with the acceptance of Mr. Paulo César Salles Vasques, further decided to submit the acquisition of 50% of these 104,041 shares not only to the conditions set out in the long-term incentive plan but also to the achievement by him of objectives within the framework of the duties he accepted to retain within Teleperformance CRM SA, Brazilian subsidiary, in order to allow the keeping and development of the Group's business in Brazil.

The Board of Directors, at its meeting held on February 28th, 2019, upon recommandation of the Remuneration and Appointments Committee, noted that the conditions were met (see section 7.2.5.3 *Performance shares granted under no consideration*). Subject to the beneficiaries' presence at the end of the acquisition period, Teleperformance Group, Inc. will be required to deliver to the beneficiaries the Teleperformance SE shares which would have been previously purchased on the market.

Performance shares that became available during financial year 2018 (information required under Table 7 of the AMF recommendations)

Performance shares that became available for each executive director	Plan No and date	Number of shares which became available during the financial year	Vesting conditions
Daniel Julien	TGI plan 2013 dated July 30, 2013	150,000	Yes (conditions of performance(2) and of presence)
Olivier Rigaudy(1)	n/a	n/a	n/a

(1) Deputy Chief Executive Officer since October 13th ,2017.
(2) The performance conditions are described in section 7.2.5.3 of the present Registration Document.

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3.3 COMPLEMENTARY INFORMATION ON CORPORATE GOVERNANCE

3.3.1 Specific conditions relating to the attendance of shareholders at general meetings

The terms and conditions of shareholder participation in general meetings are set out in chapter 7, section 7.1.2.4 *Shareholders' meetings* of the 2018 Registration Document.

3.3.2 Factors liable to have an impact in the event of a public offering

In accordance with the provisions of Article L.225-37-5 of the French Commercial Code, the elements below are liable to have an impact in the event of a public offering:

- capital structure: see section 7.3 *Shareholding*;
- restrictions provided for by the articles of association on the exercise of voting rights and share transfers or clauses in agreements brought to the Company's notice in application of Article L.233-11 of the French Commercial Code: none;
- direct or indirect holdings in the Company's capital of which it is aware under Articles L.233-7 and L.233-12 of the French Commercial Code: see section 7.3 *Shareholding*;
- the list of holders of any security providing special rights of control and a description thereof: none (subject to double voting rights described in section 7.1.2.3 *Description of rights, privileges and restrictions, if any, on existing shares and each class of shares*);
- the means of control provided for in a putative employee shareholding system when the rights of control are not exercised by the employees: none;
- shareholders' agreements known to the Company that may involve restrictions on share transfers and the exercise of voting rights: see section 7.3.2 *Shareholders' agreements*;
- rules applying to the appointment and replacement of members of the Board of Directors and to amendments to the Company's articles of association: see sections 7.1.2.2 *Administration and management of the Company* and 7.1.2.8 *Changes in share capital, shareholder rights and articles of association*;
- the powers of the Board of Directors, particularly in relation to share issuance or buyback: see section 7.2.4.1 *Current authorizations* and 7.2.4.4 *Share buy-back program – Description of the new program*;
- company agreements that are modified or terminated by any change of control except where such disclosure, unless required by law, would cause serious detriment to its interests: see section 7.3.3 *Change of control of the Company*; and
- agreements providing for compensation to Board members or employees if they resign or are dismissed without real and serious cause or if their employment terminates as the result of a public offering: none.

3.3.3 Transactions on Company's shares

3.3.3.1 Code of conduct relating to securities transactions

The Company complies with the position-recommendation No 2016-08 issued by the *Autorité des marchés financiers* (AMF-French Financial Markets Authority) on October 26th, 2016 and with the AFEP-MEDEF code. The Board of Directors adopted a code of conduct regarding securities transactions at its November 30th, 2011 meeting. This code specifies in particular the prohibition for insiders and related persons from using and/or disclosing insider information, and from advising another person to do insiders trading on the Company's financial instruments on the basis of insider information. The code was amended at the meeting of the Board of Directors held on February 28th, 2019.

3.3.3.2 Determination of black-out periods

Transactions involving the purchase or sale of the Company's securities or financial instruments are prohibited during the periods included between the date when insiders[(1)] become aware of specific information regarding the course of business or outlook which is likely to have a material influence on the share price if it were to be made public, and the date when that information is made public.

In addition, transactions are also prohibited during a period of:

- 30 calendar days prior to the publication date (inclusive) of the press release of the (parent company and consolidated) annual and half-yearly financial statements; this period expires on the day following publication (at midnight); and
- 15 calendar days prior to the publication date (inclusive) of the press release of the quarterly reporting; this period expires on the day following publication (at midnight).

Regarding the sale of performance shares in accordance with the Code of Conduct relating to securities transactions, it is strictly forbidden for beneficiaries of performance shares allocated free of charge to transfer their shares following the end of the lock-in period during the blackout periods defined below:

- the period beginning 10 trading days before the date (inclusive) set for the publication of the press release of annual and consolidated financial statements and expiring 3 trading days after the date of publication (inclusive) of such financial statements;
- the period beginning 10 trading days before the date (inclusive) set for the publication of the press release of the half-year consolidated financial statements and the publication of quarterly financial information and expiring 3 trading days after the date of publication (inclusive) of such financial statements;
- the period beginning when the beneficiary becomes aware of insider information (other than the quarterly financial statements and information referred to above) and expiring 10 trading days after the date (inclusive) on which this information is made public.

The Company draws up and issues at the beginning of each calendar year a timetable setting out periods during which transactions on Company's securities are prohibited. This timetable also specifies that the indicated periods do not affect the existence of other black-out periods arising as a result of awareness of specific information directly or indirectly relating to the Company, which is likely to have a material impact on the Teleperformance SE share price if it were to be made public.

(1) Executive officers and equivalent persons, as well as any person who has access to insider information on a regular or occasional basis.

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3.3.3.3 Prohibition of hedging transactions

In accordance with the recommendations of the AFEP-MEDEF code, hedging transactions involving the Company's securities are prohibited. The executive officers have given a formal undertaking not to use transactions that hedge their risk on the shares arising from performance shares. To the Company's knowledge, no hedging instrument was implemented.

3.3.3.4 Summary of securities transactions carried out by Board of Directors and Executive Committee members

Pursuant to Article 223-26 of the AMF General Regulation, the securities transactions performed in 2018, as reported to the Company and to the AMF, are summarized below:

	Nature	Date	Number of shares	Average unit price
Patrick Thomas Director	Acquisition	04/06/2018	500	€124.50
David Rizzo Member of the Executive Committee	Sale	07/31/2018	12,000	€156.5640
Alan Truitt Member of the Executive Committee	Sale	08/02/2018	10,000	€157.8530
Brian Johnson Member of the Executive Committee	sales	08/06/2018	3,000	€160.00
		08/09/2018	3,000	€160.00
		08/09/2018	3,000	€161.00
		08/20/2018	1,000	€162.50
		08/20/2018	500	€163.00
		08/20/2018	500	€163.50
		08/21/2018	500	€164.00
		08/22/2018	500	€164.50

3.3.4 Regulated agreements and commitments

No new regulated agreements or commitments were authorized by the Board of Directors during the 2018 financial year.

Pursuant to legal and regulatory provisions, the Board of Directors, at its meeting held on February 28th, 2019, carried out the annual review of the regulated agreements and commitments entered into before 2018 and the performance of which is continued during the financial year 2018. The statutory auditors' special report on regulated agreements and commitments referred to in Articles L.225-38 *et seq.*, and L.225-42-1 *et seq.* of the French Commercial Code is provided hereafter.

3.3.5 Statutory Auditors' special report on regulated agreements and commitments

This is a free translation into English of the Statutory Auditors' special report on regulated agreements and commitments issued in French and is provided solely for the convenience of English-speaking readers. This report on regulated agreements and commitments should be read in conjunction with, and construed in accordance with, French law and professional auditing standards applicable in France.

For the year ended December 31st, 2018

To the annual general meeting of Teleperformance SE,

In our capacity as statutory auditors of your company, we hereby report to you on its regulated agreements and commitments.

The terms of our engagement require us to communicate to you, based on information provided to us, the principal terms and conditions of those agreements and commitments brought to our attention or which we may have discovered during the course of our audit, as well as the reasons justifying that such agreements and commitments are in the Company's interest, without expressing an opinion on their usefulness and appropriateness or identifying such other agreements and commitments, if any. It is your responsibility, under the terms of Article R.225-31 of the French Commercial Code, to assess the interest involved in respect of the conclusion of these agreements and commitments for the purpose of approving them.

Our role is also to provide you with the information set forth in Article R.225-31 of the French Commercial Code relating to the implementation during the past year of agreements and commitments previously approved by the Shareholders' Meeting, if any.

We conducted the procedures we deemed necessary in accordance with relevant professional guidelines issued by the French Institute of Auditors relating to this engagement.

Regulated agreements or commitments submitted for the approval of this shareholders' meeting

Regulated agreements or commitments authorised during the year

We hereby inform you that we have not been advised of any agreement or commitment authorized during the year to be submitted to the approval of the Shareholders' Meeting pursuant to Article L.225-38 of the French Commercial Code.

Regulated agreements or commitments which were approved in prior years by the shareholders in general meeting

We hereby inform you that we have not been advised of any agreement or commitment previously approved by the Shareholders' Meeting which remained in force during the year.

Paris La Défense, 28 February 2019
The Statutory Auditors

KPMG Audit IS
Jacques Pierre
Partner

Deloitte & Associés
Philippe Battisti Ariane Bucaille
Partners

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4.1 REVIEW OF THE GROUP'S FINANCIAL POSITION AND RESULTS

The accounting principles used by the Group to prepare its consolidated accounts are described in note 1 of the section 5.6 *Notes to the consolidated financial statements*.

The preparation of financial statements in conformity with IFRS requires making estimates and assumptions which affect the amounts reported in the financial statement, especially with respect to the following items:

- impairment of intangible assets and goodwill;
- the measurement of share-based payments expense;
- provisions for risks and expenses;
- the measurement of intangible assets acquired as part of a business combination;
- deferred taxation.

The estimates are based on information available at the time of preparation of the financial statements and may be revised in a future period if circumstances change of if new information is obtained. Actual results may differ from these estimates.

4.1.1 Alternative Performance Measures (APMs)

EBITDA before non recurring items (Earnings Before Interest, Taxes, Depreciation and Amortization):

	2018	2017
Operating profit	**485**	**355**
Depreciation and amortization	159	164
Amortization of intangible assets acquired as part of business combination	88	87
Impairment loss on goodwill	0	67
Share-based payments	23	24
Other operating income and expense	7	23
EBITDA BEFORE NON RECURRING ITEMS	**762**	**720**

EBITA before non recurring items (Earnings Before Interest Taxes and Amortization):

	2018	2017
Operating profit	**485**	**355**
Amortization of intangible assets acquired as part of business combination	88	87
Impairment loss on goodwill	0	67
Share-based payments	23	24
Other operating income and expense	7	23
EBITA BEFORE NON RECURRING ITEMS	**603**	**556**

Net free cash flow:

	2018	2017
Net cash flow from operating activities	**523**	**516**
Acquisition of intangible assets and property, plant and equipment	-197	-148
Proceeds from disposals of intangible assets and property, plant and equipment	1	1
Financial interest paid/received	-45	-45
NET FREE CASH FLOW	**282**	**324**

Net debt:

	12/31/2018	12/31/2017
Non-current liabilities		
Financial liabilities	2,224	1,387
Current liabilities		
Financial liabilities	213	224
Cash and cash equivalent	**-336**	**-285**
NET DEBT	**2,101**	**1,326**

Change in like-for-like revenue:
Change in revenue at constant rates and scope of consolidation, corresponding to (current year revenue – last year revenue at current year rates – revenue from acquisitions at current year rates)/last year revenue at current year rates.

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4.1.2 2018 Group's results

4.1.2.1 Business

Revenue amounted to €4,441 million in the year ended December 31st, 2018, representing a year-on-year increase of +9.0% at constant exchange rates and scope of consolidation (like-for-like) and of +6.2% as reported. The gap between the reported and the like-for-like figures was attributable to the €203 million negative currency effect stemming from the decline in the US dollar, Brazilian real and Argentine peso against the euro, mainly in the first half of the year.

Highlights of the 4th quarter included faster like-for-like growth in Core Services and the consolidation of Intelenet as from October 1st, 2018.

2018 revenues and change by region *versus* 2017

(in millions of euros)	12/31/2018	12/31/2017	Reported	Like-for-like*
CORE SERVICES	**3,697**	**3,542**	**+4.4%**	**+9.8%**
English-speaking & Asia-Pacific	1,586	1,607	-1.3%	+2.8%
Continental Europe, Middle East & Africa	962	851	+13.0%	+15.4%
Ibero-LATAM	1,149	1,084	+6.0%	+16.0%
INTELENET	**105**	**-**	**-**	**-**
SPECIALIZED SERVICES	**639**	**638**	**+0.0%**	**+4.3%**
TOTAL	**4,441**	**4,180**	**+6.2%**	**+9.0%**

* *At constant exchange rates and consolidation scope.*

Change in annual Group revenues over the last three years

Change *(in %)*	Reported	Like-for-like*
2018	+6.2%	+9.0%
2017	+14.6%	+9.0%
2016	+7.4%	+7.4%

* *At constant exchange rates and consolidation scope.*

Core Services

Core Services revenue amounted to €3,697 million in 2018, a year-on-year increase of +9.8% like-for-like and +4.4% as reported, primarily due to the decline in the US dollar against the euro.

The like-for-like gain was lifted by the sustained solid performance in the Ibero-LATAM and Continental Europe & MEA (CEMEA) regions and by the steady upturn in growth throughout the year in the English-speaking & Asia-Pacific (EWAP) region.

English-speaking & Asia-Pacific (EWAP)

Revenue in the EWAP region came to €1,586 million for the year, up +2.8% compared with 2017 like-for-like and +1.3% as reported, primarily due to the negative currency effect related to the decline in the US dollar against the euro.

In North America, Teleperformance continued to diversify its client portfolio. Among the leading client segments in the region, the fastest growing are consumer electronics, e-tailing, fast-moving consumer goods and transportation services, with demand from the entertainment, online education and automotive industries continuing to ramp up rapidly.

As expected, the UK outsourced customer experience management market continued to be impacted by the uncertainty caused by Brexit.

After a disappointing year in 2017, growth was robust in Asia in 2018, led by successful contract wins in the consumer electronics, e-tailing and financial services segments. Development in the region continued to be driven by China and India, the most promising markets for outsourced business services. In addition, the Malaysian unit fully benefited from the ramp-up of its multilingual facility in Penang, which provides large accounts in the Internet services industry.

Ibero-LATAM

Business continued to expand at a very healthy pace over the year, delivering revenue of €1,149 million for 2018. This represented an increase of +16.0% like-for-like and of +6.0% as reported, primarily due to the decline in the US dollar, the Brazilian real and the Colombian and Argentine pesos against the euro.

One of the region's primary growth drivers during the year was Portugal, where the Group's business was lifted by the rapid expansion of multilingual hubs serving fast growing multinationals in such industries as e-tailing, entertainment and fast-moving consumer goods. In Spain, business growth is strong in 2018 in a wide variety of segments, such as information technologies and consumer goods.

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The Group is continuing to leverage the appeal of nearshore, pan-American solutions in Mexico and Colombia, where it is growing its business in a wide range of industries, including healthcare and financial services in Mexico and airlines and telecoms in Columbia. It is also tapping into buoyant domestic markets in both countries.

Business in Brazil remained robust, in an economic and geopolitical environment that seems to be stabilizing. Growth was still subdued in 2018, however, despite a good performance in the entertainment and consumer goods segments.

The rapid ramp-up of operations in the Peruvian market, which the Group entered in 2017, also contributed to strong business growth in the region.

To support this growth, Teleperformance continued to expand its existing locations and open major new facilities, especially in Colombia, Mexico and Portugal (see section 1.1.5.1.5 *Extensions, new facilities and capital expenditure*).

Continental Europe & MEA (CEMEA)

In the CEMEA region, revenue rose by +15.4% like-for-like to €962 million in 2018, or by +13.0% as reported.

The factors driving this growth performance remain unchanged, led by a very good sales dynamic with multinational clients and fast-growing local market leaders in a wide range of industries.

The fastest growing regional segments are still e-tailing, leisure and entertainment, travel agencies, transportation services and fast-moving consumer goods. The main revenue contributors, such as consumer electronics and financial services, continued to grow at a satisfactory pace.

Revenue generated by the multilingual hubs in Greece and the operations in Egypt, Turkey and Eastern Europe (Russia, Poland and Romania) rose significantly over the year.

Business growth in France picked up speed throughout the year on the ramp-up of contracts signed primarily in energy and utilities, financial services, transportation services and e-tailing.

Regional revenue was also lifted by faster growth in business in Sweden and Italy.

Specialized Services

Revenue from Specialized Services totaled €639 million in 2018, a like-for-like gain of +4.3% compared with 2017. On a reported basis, growth was stable for the year. The currency effect primarily stemmed from the US dollar's decline against the euro, particularly during the first six months, and mainly concerned the LanguageLine Solutions business.

LanguageLine Solutions' online interpreting services and TLScontact's visa application management business enjoyed satisfactory growth throughout the year, despite the negative impact of the following non-recurring items:

- at LanguageLine Solutions, (i) a technical incident in the first quarter that was quickly resolved but which had a negative impact on billed service volumes; and (ii) an unfavorable basis of comparison in the fourth quarter, due to the surge in new demand for interpreting services following the hurricanes in the United States in 2017, whose revenue impact was not recorded until the final quarter;
- at TLScontact, a change in the third quarter in the method for invoicing the volumes processed on behalf of UK Visas and Immigration, which had a negative impact on revenue growth. The method was changed during the renewal in 2018 of the contract first signed in 2013.

Revenue from ARM's debt collection services in North America was stable overall for the year.

The growth dynamic in the LanguageLine Solutions and TLScontact businesses, which together account for around 80% of Specialized Services revenue, remains very positive, which should feed through to more robust gains in 2019.

Intelenet

Intelenet, which has been consolidated since October 1st, 2018, contributed €105 million to fourth quarter revenue (see section 1.1.5.1.1 *Acquisition of Intelenet and launch of D.I.B.S. operations*).

4.1.2.2 Results

EBITDA before non-recurring items stood at €762 million for the year, up +6.0% compared with 2017.

EBITA before non-recurring items rose by +8.6% to €603 million from €556 million the year before. The margin on revenue widened by 30 basis points to 13.6% from 13.3% in 2017, in line with the Group's financial target of at least 13.5% for the year. The further improvement in profitability in 2018 was led by the following key factors:

- the higher margin in the Core Services business, primarily reflecting the upturn in profitability in the EWAP and CEMEA regions;
- the sustained high margin on Specialized Services' operations;
- the first-time consolidation in fourth-quarter 2018 of Intelenet, whose margin is higher than the Group average.

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EBITA before non-recurring items by activity

(in millions of euros)	2018	2017
CORE SERVICES	**398**	**365**
% of revenue	**10.8%**	**10.3%**
English-speaking & Asia-Pacific (EWAP)	147	141
% of revenue	9.3%	8.8%
Ibero-LATAM	136	134
% of revenue	11.8%	12.3%
Continental Europe & MEA (CEMEA)	68	43
% of revenue	7.1%	5.0%
Holding companies	47	47
SPECIALIZED SERVICES	**190**	**191**
% of revenue	**29.8%**	**29.9%**
INTELENET	**15**	**N/A**
% of revenue	**13.7%**	**N/A**
TOTAL	**603**	**556**
% OF REVENUE	**13.6%**	**13.3%**

Core Services

Core Services reported EBITA before non-recurring items of €398 million in 2018, up from €365 million in 2017 and representing a margin of 10.8% *versus* 10.3% the year before.

The 50-bps improvement was primarily driven by the upturn in margins in the EWAP region, after two years of erosion, and the ongoing margin recovery in the CEMEA region. Margins in the Ibero-LATAM region remain high, despite a slight slippage due to the ramp-up of large new facilities.

English-speaking & Asia-Pacific (EWAP)

EBITA before non-recurring items in the EWAP region rose to €147 million from €141 million in 2017, while the margin widened to 9.3% from 8.8% the year before.

As expected, margins started to improve in the second half, as the adverse impact of certain non-recurring factors from 2017 faded during the period and recently signed contracts began to ramp up. These developments reflected a return to stronger growth in the Group's Philippines-based offshore operations in a variety of industries, including telecommunications, online travel agencies and e-tailing.

The profitability of operations in India and China is steadily rising, thanks to the upsurge in business at the recently opened facilities.

The Group is committed to continuing to improve its margins in the region in 2019.

Ibero-LATAM

EBITA before non-recurring items in the Ibero-LATAM region rose to €136 million in 2018 from €134 million in 2017.

Margin remained high, at 11.8%, albeit lower than the 12.3% reported in 2017 due to the cost of ramping up major new sites, notably including the new multilingual capabilities being developed in Portugal and the new contact centers opened in Colombia and Peru.

The Group is committed to maintaining its margins in the region in 2019.

Continental Europe & MEA (CEMEA)

In 2018, Teleperformance continued to improve the profitability of its CEMEA operations, whose €68 million in EBITA before non-recurring items represented a margin of 7.1%, *versus* €43 million and 5.1% in 2017. The gain was primarily led by the following factors:

- Continued solid, profitable growth in business with global and premium clients in a number of countries in Southern and Eastern Europe, such as Greece with its highly efficient multilingual solutions, and Russia;
- Steadily rising margins in a number of countries, including France and the Nordics but also Germany and Italy, where the development of nearshore solutions has enhanced the Group's local competitiveness.

The Group is committed to continuing to improve its margins in the region in 2019.

Specialized Services

In 2018, Specialized Services reported EBITA before non-recurring items of €190 million and a margin of 29.8%, both virtually unchanged year-on-year.

Margins continued to trend upwards at LanguageLine Solutions and TLScontact over the year, but contracted in the ARM debt collection business.

Set up in early 2018, the Praxidia consulting business saw margins temporarily dampened by the sales and R&D investments committed early 2018 during its deployment phase.

Specialized Services margins are expected to remain high in 2019.

Intelenet

Consolidated since October 1st, 2018, Intelenet contributed €15 million in EBITA before non-recurring items, representing a margin of 13.7% after holding company overheads. This was in line with the guidance issued when the company's acquisition was announced in June 2018.

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4.1.2.3 Results

Operating profit rose to €485 million, *versus* €355 million in 2017. This included:

- amortization of intangible assets on acquisitions in an amount of €88 million;
- €23 million in accounting expenses on the performance share plans;
- €8 million in other non-recurring expenses mainly corresponding to the acquisition-related costs of the Intelenet transaction and the costs in connection with the change to the Teleperformance visual identity occurred during the fourth quarter of 2018.

The financial result represented a net expense of €50 million, similar to 2017.

Income tax expense amounted to €122 million, similar to 2017 excluding the effect of the US tax reform which resulted in a profit of €131 million. In 2017, the Group recognized an income tax credit of €9 million.

Net profit attributable to minority interests represented €1 million.

Net profit-Group share came to €312 million for the year, similar to 2017. Diluted earnings per share amounted to €5.29, *versus* €5.31 in 2017.

The Board of directors will recommend, at the annual general meeting on May 9th, 2019, that shareholders approve an increase in the 2018 dividend to €1.90 per share from the €1.85 paid in respect of 2017. This would correspond to a payout ratio of 36%, in slightly up from the prior year.

4.1.3 Cash flow and capital structure

In order to finance the acquisition of Intelenet, occurred on October 4th, 2018, the Group has issued bonds in the amount of €750 million on July 2nd, 2018 with a coupon of 1.875%, maturing in 2025 and has taken out a loan of €164 million repayable in four equal installments on June 8th, 2020, 2021, 2022 and 2023.

Consolidated financial structure

Long-term capital

As of December 31st *(in millions of euros)*	**2018**	**2017**	**2016**
Shareholders' equity	2,225	1,922	1,921
Non-current financial liabilities	2,224	1,387	1,688
Total non-current capital	4,449	3,309	3,610

Short-term capital

As of December 31st *(in millions of euros)*	**2018**	**2017**	**2016**
Current financial liabilities	213	224	261
Cash and cash equivalents	336	285	282
Cash surplus, net of current financial liabilities	123	61	21

The main financial liabilities are subject to covenants, which were all complied with as of December 31st, 2018.

Source and amount of cash flow

As of December 31st *(in millions of euros)*	**2018**	**2017**	**2016**
Internally generated funds from operations	572	574	442
Change in working capital requirements	-49	-58	17
Net cash flow from operating activities	**523**	**516**	**459**
Investment and capital expenditure	- 960	-152	- 1,582
Proceeds from disposals	11	1	3
Net cash flow from investing activities	**- 949**	**-151**	**- 1,579**
Change in ownership interest in controlled entities	-14	- 39	- 33
Dividends paid/purchases of treasury stock	-143	- 76	- 85
Financial interest paid	- 45	- 45	- 33
Net change in financial liabilities	765	-293	1,341
Net cash flow from financing activities	**563**	**-453**	**1,190**
CHANGE IN CASH AND CASH EQUIVALENTS	**137**	**-88**	**70**

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Internally generated funds from operations amounted to €572 million, *versus* €574 million in 2017. This slight decrease generated a working capital requirement of €49 million *versus* €58 million in 2017.

Net capital expenditure highly increased and amounted €196 million from €147 million in the previous year *i.e.* 4.4% of the revenue *versus* 3.5% in 2017. This reflects the Group's desire for growth in key markets.

Group net free cash flow up to €281 million from €324 million in 2017. This slight decrease is notably due to the exceptional payments related to the acquisition of Intelenet and the change of the Group's visual identity. The interest paid are stable from last year and amounted €45 million.

After the payment of €112 million in dividends, net debt stood at €2,101 million at December 31st, 2018 *versus* €1,326 million the previous year.

4.1.4 Key figures of the main subsidiaries

The key figures of the subsidiaries whose revenue exceeded 10% of the Group's consolidated revenue are presented below:

Selected financial data	Teleperformance USA *(in thousands of US dollars)*
Non-current assets	871,833
Current assets	492,616
Total assets	**1,364,449**
Shareholder's equity	432,402
Non-current liabilities	690,078
Current liabilities	241,969
Total equity and liabilities	**1,364,449**
Revenue	977,216
NET PROFIT	**2,626**

4

4.2 REVIEW OF THE COMPANY'S FINANCIAL POSITION AND RESULTS

4.2.1 Balance sheet

4.2.1.1 Investments

Teleperformance has issued bonds in the amount of €750 million in order to finance the acquisition of Intelenet (an international leader in the field of Business Process Solutions) through its Dutch subsidiary DCC. The bonds bear a coupon of 1.875% and mature on July 2nd, 2025. Teleperformance has also obtained a loan of €164 million from Natixis, repayable in four equal installments on June 8th, 2020, 2021, 2022 and 2023.

DCC is held by LCC, a directly owned subsidiary of Teleperformance, and the financing of the Intelenet acquisition was structured by way of a loan of €890 million of which €848 million was subsequently incorporated in share capital.

Furthermore, Teleperformance has made a number of loans to its subsidiaries during 2018 in relation to their cash management, in a total amount of €66 million, principally to:

- Teleperformance France, of €20 million, which was subsequently incorporated in share capital;
- Teleperformance Canada, of CAD16 million (€10.5 million);
- Teleperformance Australia, of AUD11.8 million (€7.7 million);
- In & Out Spa (Italy), of €5 million, including €3 million which was subsequently incorporated in share capital.

4.2.1.2 Shareholders' equity

The share capital at December 31st, 2018 amounted to €144,450,000, comprising 57,780,000 shares, each of a €2.50 nominal value.

4.2.1.3 Financing arrangements

The Company has a syndicated credit facility of €300 million which expires in February 2023. Draw-downs under the facility may be made either in euros or in US$ and are repayable in fine. No amounts were drawn down under the facility during 2017 or 2018.

The Company also has four US private placements, obtained in 2014 and 2016, redeemable in fine with the following principal conditions:

- US$160 million at a fixed interest rate of 3.64%, redeemable in December 2021;
- US$165 million at a fixed interest rate of 3.98%, redeemable in December 2024;
- US$75 million at a fixed interest rate of 3.92%, redeemable in December 2023;
- US$175 million at a fixed interest rate of 4.22%, redeemable in December 2026.

On September 16th, 2016, Teleperformance obtained a loan of US$500 million repayable in four equal installments on August 20th, 2018 and August 19th, 2019, 2020 and 2021. During 2018, in addition to the June 5th, 2018 prepaid installment of US$125 million due on August 20th, Teleperformance also repaid a further amount of US$50 million in advance in November. This latter repayment reduces the installment due on August 19th, 2019.

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On November 23rd, 2018, Teleperformance subscribed commercial paper issues, totaling €134 million as of December 31st, 2018.

The Company has also two outstanding bond issues:

- on April 7th, 2017, an issue of €600 million at a nominal interest rate of 1.50%, redeemable on April 3rd, 2024; and
- on July 2nd, 2018, an issue of €750 million at a nominal interest rate of 1.875%, redeemable on July 2nd, 2025.

As in 2017, the issue expenses relating to the new bond issue, of €2.3 million, were fully expensed in the year.

The premium due on redemption of this issue is presented as an asset in an amount of €6.3 million and will be amortized over the period to redemption.

Finally, Teleperformance obtained a loan from Natixis in an amount of €164 million, repayable in four equal installments on June 8th, 2020, 2021, 2022 and 2023.

At December 31st, 2018, the Company was in compliance with all financial ratios.

4.2.1.4 Invoices received or issued whose payment is overdue at the year-end (schedule prescribed under Article D.441-4-1 of the French Commercial Code)

	Article D.441-I – 1°: Invoices received whose payment is overdue at the year-end						Article D.441-I – 2°: Invoices issued whose payment is overdue at the year-end					
	Not overdue	1 – 30 days	31 – 60 days	61 – 90 days	Over 90 days	Total overdue	Not overdue	1 – 30 days	31 – 60 days	61 – 90 days	Over 90 days	Total overdue
(A) Overdue payments by tranche												
No. invoices	65					**102**	3					**204**
Total amount of invoices overdue, excluding VAT *(in thousands of euros)*	9,086	28,932	158	163	1,399	**30,652**	696	15,368	336		3,719	**19,423**
Overdue invoices as a % of year's purchases, excluding VAT	11.91%	37.92%	0.21%	0.21%	1.83%	**40.17%**						
Overdue invoices as a % of year's revenues, excluding VAT							0.64%	14.22%	0.31%		3.44%	**17.97%**
(B) Amount of disputed or unrecorded invoices excluded from (A)												
No. of invoices excluded												
Total amount of invoices excluded												
(C) Credit terms used (contractual or legal) – article L. 441-6 of the French Commercial Code												
Credit terms used in the calculation of overdue amounts	☐ Contractual: ☑ Legal: 30 days						☑ Contractual: on receipt ☐ Legal:					

4.2.2 Income statement

4.2.2.1 Operating activity

The Company's activity is that of a holding company in respect of its subsidiaries; it also provides management, supervisory, assistance and advisory functions for group companies, in return for which it receives management fees. Teleperformance also receives intellectual property royalties which are charged to all group subsidiaries.

Revenues amounted to €108.1 million, a slight increase over those of 2017 (€107.0 million).

Net income from operations was €20.1 million in 2018, compared with €50.7 million in 2017, the reduction being principally due to an equalization of the respective level of profits realized by Teleperformance and its subsidiary TGI from their operations based on the Group's intangible assets, following changes in 2017 to the international transfer pricing guidelines governing intra-group recharging policies within multinational enterprises.

4.2.2.2 Financial result

2018 financial result amounting to €180.4 million, compared with that of 2017 (€44.8 million), is analyzed as follows:

(in millions of euros)	2018	2017
Dividends	116.4	37.9
Financial interest (net)	17.0	15.5
Financial debt waiver (net)	-3.0	-3.1
Foreign exchange gains and losses	0.8	18.5
Provisions on shareholdings subsidiaries	49.2	-24.0
TOTAL	**180.4**	**44.8**

Following a review of the recoverable amounts of its shareholdings as of December 31st, 2018, the Company released a provision of €50.0 million made previously on Teleperformance France.

As in 2017, the Company has waived receivables due from its subsidiary Teleperformance France in respect of the year's intellectual property royalties and management services, in an amount of €3.0 million (2017: €2.7 million).

4.2.2.3 Net income

Profit on ordinary activities before income taxes in 2018 amounted to €200.6 million, compared with €95.4 million in 2017.

After 2018 income taxes of €7.8 million (2017: €24.4 million), 2018 net income amounted to €190.3 million, compared with €71.3 million in 2017.

4.2.2.4 Taxation

The French group tax result showed a profit of €12.1 million in 2018.

In accordance with the provisions of Article 223(4) of the French Tax Code, it is stipulated that the overall amount of costs and expenses falling within the provisions of Article 39(4) of the French Tax Code amounted to €26,575 for the financial year ended December 31st, 2018. The non-deductibility of these costs and expenses represents an income tax amount of €9,150.

4.3 TRENDS AND OUTLOOK

4.3.1 Outlook

Based on its performance in 2018 and the growth investments committed during the year, Teleperformance is ambitiously looking forward to 2019, as demonstrated in its annual financial targets for revenue growth and margins:

- like-for-like revenue growth at least +7%;
- an improvement by +20 basis points in EBITA margin before non-recurring items.

The Group is also confident about its ability to continue to generate a strong level of cash flow during the year, enabling it to pursue its dynamic development strategy while maintaining strict financial discipline.

4.3.2 Risks and uncertainties

The Group's business is subject to market risks (sensitivity to economic and financial factors), as well as to the political and geopolitical uncertainties related to its global footprint. A detailed description of these risks is provided in section 1.2.1 *Risk Factors* of this Registration Document.

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5.1 CONSOLIDATED STATEMENT OF FINANCIAL POSITION

(in millions of euros)	Notes	12/31/2018	12/31/2017
ASSETS			
Non-current assets			
Goodwill	4	2,304	1,676
Other intangible assets	3.2	1,231	946
Property, plant and equipment	3.1	497	423
Financial assets	7.2	59	43
Deferred tax assets	5.2	35	28
Total non-current assets		**4,126**	**3,116**
Current assets			
Current income tax receivable	5.3	175	62
Accounts receivable – Trade	3.3	1,048	896
Other current assets	3.3	147	93
Other financial assets	7.2	56	38
Cash and cash equivalents	7.4	336	285
Total current assets		**1,762**	**1,374**
TOTAL ASSETS		**5,888**	**4,490**

(in millions of euros)	Notes	12/31/2018	12/31/2017
EQUITY AND LIABILITIES			
Equity			
Share capital	6.1	144	144
Share premium		575	575
Translation reserve		-58	-165
Other reserves		1,556	1,356
Equity attributable to owners of the Company		**2,217**	**1,910**
Non-controlling interests		8	12
Total equity		**2,225**	**1,922**
Non-current liabilities			
Provisions	9.2	22	15
Financial liabilities	7.4	2,224	1,387
Deferred tax liabilities	5.2	306	234
Total non-current liabilities		**2,552**	**1,636**
Current liabilities			
Provisions	9.2	90	52
Current income tax	5.3	130	90
Accounts payable – Trade	3.9	147	141
Other current liabilities	3.9	531	425
Financial liabilities	7.4	213	224
Total current liabilities		**1,111**	**932**
TOTAL EQUITY AND LIABILITIES		**5,888**	**4,490**

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5.2 CONSOLIDATED STATEMENT OF INCOME

(in millions of euros)	Notes	2018	2017
REVENUES	**3.10**	**4,441**	**4,180**
Other revenues	3.10	5	8
Personnel		-2,923	-2,746
External expenses	3.11	-738	-700
Taxes other than income taxes		-22	-22
Depreciation and amortization		-159	-164
Amortization of intangible assets acquired as part of a business combination		-88	-87
Impairment loss on goodwill			-67
Share-based payments	3.4	-23	-24
Other operating income and expenses	3.12	-8	-23
Operating profit		**485**	**355**
Income from cash and cash equivalents		4	1
Interest on financial liabilities		-60	-60
Net financing costs	**7.3**	**-56**	**-59**
Other financial income and expenses	7.3	6	9
Financial result		**-50**	**-50**
Profit before taxes		**435**	**305**
Income tax	5.1	-122	9
Net profit		**313**	**314**
Net profit – Group share		**312**	**312**
Net profit attributable to non-controlling interests		1	2
Earnings per share *(in euros)*	**6.3**	**5.40**	**5.40**
Diluted earnings per share *(in euros)*	**6.3**	**5.29**	**5.31**

5.3 CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME

(in millions of euros)	2018	2017
NET PROFIT	**313**	**314**
May not be reclassified to profit or loss in a subsequent period		
May be reclassified to profit or loss in a subsequent period		
Gains (losses) on foreign exchange hedges (before tax)	18	11
Income tax on gains (losses) on foreign exchange hedges	-6	-4
Translation differences	107	-265
Other recognized income and expenses	**119**	**-258**
TOTAL COMPREHENSIVE INCOME	**432**	**56**
Group share	431	54
Attributable to non-controlling interests	1	2

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5.4 CONSOLIDATED STATEMENT OF CASH FLOWS

(in millions of euros)	Notes	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES			
Net profit – Group share		312	312
Net profit attributable to non-controlling interests		1	2
Income tax expense (credit)		122	-9
Net financial interest expense		44	53
Non-cash items of income and expense	8.1	263	363
Income tax paid		-170	-147
Internally generated funds from operations		***572***	***574***
Change in working capital requirements	***8.2***	***-49***	***-58***
Net cash flow from operating activities		**523**	**516**
CASH FLOWS FROM INVESTING ACTIVITIES			
Acquisition of intangible assets and property, plant and equipment		-197	-148
Loans made		-1	
Proceeds from disposals of intangible assets and property, plant and equipment		1	1
Loans repaid		10	
Acquisition of subsidiaries, net of cash acquired	8.3	-762	-4
Net cash flow from investing activities		**-949**	**-151**
CASH FLOWS FROM FINANCING ACTIVITIES			
Acquisition net of disposal of treasury shares		-31	-1
Change in ownership interest in controlled entities		-14	-39
Dividends paid to parent company shareholders		-107	-75
Dividends paid to minority shareholders		-5	
Financial interest paid/received		-45	-45
Increase in financial liabilities		2,569	1,729
Repayment of financial liabilities		-1,804	-2,022
Net cash flow from financing activities		**563**	**-453**
Change in cash and cash equivalents		**137**	**-88**
Effect of exchange rates on cash held		**-87**	**92**
NET CASH AT JANUARY 1ST	**8.5**	**283**	**279**
NET CASH AT DECEMBER 31ST	**8.5**	**333**	**283**

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5.5 CONSOLIDATED STATEMENT OF CHANGES IN EQUITY

	Attributable to owners of the Company							
(in millions of euros)	**Share capital**	**Share premium**	**Translation reserve**	**Retained earnings**	**Impact of financial hedging instruments**	**Equity attributable to owners of the Company**	**Non-controlling interests**	**Total**
AT DECEMBER 31ST, 2016*	**144**	**575**	**100**	**1,099**	**-7**	**1,911**	**10**	**1,921**
Translation differences from foreign operations			-265			-265		-265
Net profit				312		312	2	314
Net gains on foreign exchange hedges (after tax)					7	7		7
Total recognized income and expenses	**0**	**0**	**-265**	**312**	**7**	**54**	**2**	**56**
Fair value of incentive plan share awards				21		21		21
Treasury shares				-1		-1		-1
Dividends (€1.30 per share)				-75		-75		-75
AT DECEMBER 31ST, 2017, AS PUBLISHED	**144**	**575**	**-165**	**1,356**	**0**	**1,910**	**12**	**1,922**
AT DECEMBER 31ST, 2017, AS RESTATED**	**144**	**575**	**-165**	**1,359**	**-3**	**1,910**	**12**	**1,922**
Translation differences from foreign operations			107			107		107
Net profit				312		312	1	313
Net gains on foreign exchange hedges (after tax)					12	12		12
Total recognized income and expenses	**0**	**0**	**107**	**312**	**12**	**431**	**1**	**432**
Operations on non-controlling interests				-13		-13		-13
Fair value of incentive plan share awards				25		25		25
Treasury shares				-31		-31		-31
Dividends (€1.85 per share)				-107		-107	-5	-112
Hyperinflation adjustment				2		2		2
AT DECEMBER 31ST, 2018	**144**	**575**	**-58**	**1,547**	**9**	**2,217**	**8**	**2,225**

* *Restated following the finalization of the measurement of the fair values of the identifiable assets and liabilities acquired of LanguageLine Solutions LLC in the second half of 2017.*

** *Restated following the adoption of IFRS 9 (see note 1.2 Bases of preparation of section 5.6 Notes to the consolidated financial statements).*

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5.6 NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

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Highlight of 2018

On October 4th, 2018, the Group acquired Intelenet, a high-end business services and digital transformation solutions provider. The transaction amounted to US$1,045 million (see note 2.2 *Change in consolidation scope*).

The transaction was financed as disclosed in note 7.4 *Financial liabilities*.

Note 1. Principal accounting policies, judgements and estimates

Note 1.1 Reporting entity

Teleperformance ("the Company") is a company domiciled in France.

The Company's consolidated financial statements for the year ended December 31st, 2018 include the Company and its subsidiaries, together referred to as "the Group".

The financial statements were approved by the Board of Directors on February 28th, 2019 and will be submitted to the shareholders' meeting to be held on May 9th, 2019.

All financial information presented in euro has been rounded to the nearest million.

Note 1.2 Bases of preparation

The consolidated financial statements for the year ended December 31st, 2018 have been prepared in accordance with International Financial Reporting Standards (IFRS) as adopted by the European Union as of the reporting date, and comply with the presentation requirements of revised IAS 1 as amended.

The accounting policies applied by the Group in these consolidated financial statements are the same as those applied by the Group in its consolidated financial statements as at and for the year ended December 31st, 2017, with the exception of the new standards, amendments and interpretations set out in note 1.2.1 *Change in accounting policies*.

The financial statements are prepared on the historical cost basis except for the following assets and liabilities measured at fair value: derivative financial instruments and financial instruments held for trading.

Non-current assets and disposal groups held for sale are stated at the lower of carrying amount and fair value less costs to sell.

Since July 2018, Argentina is considered to be a hyperinflationary economy in terms of IAS 29. As a result, the financial statements of the subsidiary which has the Argentine peso as its functional currency have been restated for the effects of inflation before translation into euros at the closing rate. The restatement, representing an increase in group equity of €2.6 million, did not have a significant impact on the Group's financial statements.

1.2.1 Change in accounting policies

New standards and interpretations applicable from January 1st, 2018

IFRS 15, which relates to revenues, is obligatory from January 1st, 2018. Prior to its adoption, the Group performed an assessment of its potential accounting effects and concluded that there was no significant impact on the financial statements from its adoption. In particular:

- the Group's services are realized on the basis of signed customer contracts;
- in performing the contracts, the services rendered by the Group form a single contractual arrangement;
- consideration for services rendered is defined contractually, and there is no significant financial component. Variable pricing is restricted to bonuses or penalties applicable in certain contracts based on achieving or missing contractual ratios related to operations. The related amounts are not significant and may be reliably determined at each reporting date;
- the allocation of the consideration due under the transaction is straight-forward as there is only a single contractual arrangement;
- revenue is therefore recognized as services are rendered using a volume basis.

IFRS 9, which relates to financial instruments, is obligatory from January 1st, 2018 and has modified IAS 39 in three principal areas, but has had no significant impact on the Group's consolidated financial statements:

- the retrospective application of the first area "classification and measurement of financial instruments" has had no significant impact on the Group's accounting methods in respect of the measurement of its financial assets and financial liabilities as of January 1st, 2018;
- the application of the second area "impairment of financial assets" which replaces the IAS 39 incurred loss model by an expected credit loss impairment model has had no significant impact at January 1st, 2018 on the basis of analysis performed by the Group;
- the application of the third principal area "hedge accounting" for which the group has opted has resulted in the Group's retrospective restatement of the time value of foreign currency options and forward purchase contracts, amounting to an increase as of January 1st, 2018 of €4.3 million (excluding deferred tax impacts) in the change in the time value of these derivative instruments, recognized in a distinct component of comprehensive income. Except for this restatement, the prospective application of this modification has had no significant impact on the Group's accounting methods in respect of its recognition of hedging transactions or of its derivative financial instruments.

The following standards, amendments and interpretations:

- amendments to IFRS 2, on the classification and measurement of share-based payment transactions;
- IFRIC 22 interpretation on foreign currency transactions and advance consideration;

came into force with effect from January 1st, 2018 but did not have a significant impact on the group's financial statements.

Standards and interpretations adopted by the European Union but not yet applicable as of December 31st, 2018

The Group has elected not to early apply the following new standards:

- IFRS 16 on leases;
- amendments to IFRS 9 on prepayment features with negative compensation;
- IFRIC 23 on uncertainty over income tax treatments.

These standards and interpretations are required to be applied from January 1st, 2019.

With respect to its application of IFRS 16 on leases, the Group confirms the disclosures made in the 2017 full year financial statements, in that it intends to elect to apply the modified retrospective method.

On the basis of the lease contracts in force as of September 30th, 2018, which are mainly in respect of real estate, it expects an increase in its financial liabilities of approximately €600 million at the date of adoption. This amount excludes the effect of the recent acquisition of Intelenet which is currently being measured and which will be finalized during 2019.

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The Group has implemented and put into operation a practical automated solution to compute and manage the adjustments required under the standard.

The accounting policies set out below have been applied consistently to all periods presented in the consolidated financial statements.

1.2.2 Estimates

The preparation of financial statements in conformity with IFRS requires making estimates and assumptions which affect the amounts reported in the financial statements, especially with respect to the following items:

- impairment of intangible assets and goodwill;
- the measurement of share-based payments expense;
- provisions for risks and expenses;
- the measurement of intangible assets acquired as part of a business combination;
- deferred taxation.

The estimates are based on information available at the time of preparation of the financial statements, and may be revised, in a future period, if circumstances change, or if new information is available. Actual results may differ from these estimates.

Note 1.3 Impairment

Non-financial assets

Non-financial assets of the Group (non-current assets) are reviewed at each reporting date to determine the amounts of any impairment losses that should be recognized.

Financial assets

A financial asset is considered to be impaired if there is objective evidence that one or more events have had a negative effect on the asset's estimated future cash flows.

The impairment loss of a financial asset measured at amortized cost is calculated as the difference between its carrying amount and the present value of the estimated future cash flows discounted at the original effective interest rate of financial assets.

An impairment test is performed individually on each significant financial asset. Other assets are tested in groups with similar credit risks.

Impairment losses are recognized in the statement of income.

Note 1.4 Determination of fair values

Certain accounting policies and disclosures require determining the fair value of financial and non-financial assets and liabilities. Additional information about assumptions used in determining fair value is disclosed, where necessary, in the specific notes for the asset or liability involved. In general, fair values for significant asset and liability categories are determined as follows:

Property, plant and equipment

The fair value of property, plant and equipment that is recognized following a business combination, principally buildings, is based on market value. The market value of a building is the estimated amount which would be obtained from the sale of the asset under normal conditions between a buyer and a seller at the measurement date.

Intangible assets

The fair value of brand names and software acquired during a business combination is based on the discounted present value of estimated royalties avoided through their acquisition.

The fair value of customer relationships acquired during a business combination is based on the multi-period excess earnings method, under which the asset is measured at the amount of estimated cash flows net of a reasonable return allocated to other assets.

Accounts receivable – Trade and Other current assets

The fair value of Accounts receivable – Trade and Other current assets is estimated as the present value of future cash flows discounted at the market rate of interest at the reporting date.

Derivatives

The fair value of forward currency contracts is based on their quoted market price when available. If no quoted market price is available, the fair value is estimated by discounting to the present value the difference between the contractual forward price and the current forward price on the residual term of the contract, by using an interest rate based on the money market.

The fair value of interest rate swaps is based on estimations provided by the banks and corresponds to the estimated amount that the Group would receive or pay to terminate the swap at the reporting date, taking into account current interest rates and counterparty risk.

Non-derivative financial liabilities

The fair value, which is determined for disclosure purposes, is based on the present value of future cash flows generated by principal and interest repayments, discounted at the market interest rate at the reporting date.

For finance lease agreements, the market interest rate is determined from similar lease agreements.

Share-based payments

The fair value of incentive plan shares awarded to employees is measured principally using the market price of the share at the grant date, the expected dividends and the post-vesting retention period, as well as performance conditions when these are market conditions.

The service and performance conditions necessary for vesting are not considered when determining fair value when these are not market conditions.

Note 1.5 Glossary

EBITA or current EBITA: (Earnings Before Interest, Taxes and Amortization): Operating profit before amortization of intangible assets acquired as part of a business combination, goodwill impairment charges and non-recurring items.

NOPAT: operating profit excluding non-recurring items times the effective rate of taxation.

Capital Employed: the total of goodwill, intangible assets and property, plant and equipment, and items of working capital.

ROCE: rate of Return On Capital Employed calculated using the NOPAT/ Capital Employed formula.

Non-recurring items: principally comprises restructuring costs, incentive share award plan expense, costs of closure of subsidiary companies, transaction costs for the acquisition of companies, and all other expenses that are unusual by reason of their nature or amount.

Net financial indebtedness or Net debt: the total of current and non-current financial liabilities, less cash and cash equivalents.

Note 2 Scope of consolidation

Note 2.1 Accounting policies and methods

2.1.1 Bases of consolidation

Subsidiaries

Subsidiaries are entities controlled by the Company. Control exists when it is exposed, or has the rights, to variable returns from its involvement with an entity and has the ability to affect those returns through its power over it.

In assessing control, potential voting rights that presently are exercisable or convertible are taken into account.

The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Associates

The Company holds no entity in which the Group has significant influence, but not control, over the financial and operating policies.

Transactions eliminated in the consolidated financial statements

Balances, any unrealized gains and losses, and income and expenses arising from intra-group transactions are eliminated in preparing the consolidated financial statements.

2.1.2 Foreign currencies

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate at the dates of the transactions.

Monetary assets and liabilities denominated in foreign currencies at the reporting date are translated into euros at the foreign exchange rate at that date. Foreign exchange differences arising on translation are recognized as financial income or expenses. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction.

Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated using the exchange rate at the date the fair value was determined.

Financial statements of foreign operations

The functional currency of a foreign operation outside the euro zone is in general its local currency except in certain cases where most of its financial flows are realized with reference to another currency.

The assets and liabilities of foreign operations, including goodwill and fair value adjustments arising on consolidation, are translated into euros using the exchange rate at the reporting date.

The income and expenses of foreign operations are translated into euros using the average foreign exchange rate of the period, unless the exchange rate has fluctuated significantly. Foreign exchange differences resulting from translations are recognized in the translation reserve, as a separate equity component.

When a subsidiary has foreign operations in an economy defined as hyperinflationary by the IASB and its functional currency is the currency of the concerned country, its financial statements are restated for the effects of inflation before translation into euros using the exchange rate at the reporting date.

Net investment in foreign operations

Foreign exchange differences arising from the translation of a net investment in foreign operations and of related hedges are recognized in the translation reserve. They are recognized in profit or loss on disposal of the foreign operations.

2.1.3 Business combinations

Following changes to IFRS 3 and IAS 27 in 2008, the Group modified its accounting for business combinations and purchases of and purchase commitments on non-controlling interests for acquisitions after December 31st, 2009.

Since January 1st, 2010, the Group has applied revised IFRS 3 prospectively. A business combination may therefore be recognized, at the election of the Group, according to either of the following two options set out in revised IFRS 3:

- measurement of non-controlling interests as the proportionate interest in identifiable assets and liabilities;
- measurement of non-controlling interests at fair value (the full goodwill method).

The Group has elected to measure non-controlling interests as the proportionate interest in identifiable assets and liabilities for its acquisitions made since 2010.

Should the Group give a put option to minority shareholders at the time that control is transferred, a financial liability is recognized for the current value of the commitment, with an equivalent reduction in equity. Subsequent changes in fair value of the liability are recognized directly in equity.

Since 2010, transaction costs, other than those concerning the issue of debt or equity that the Group incurs in connection with a business combination, are expensed as incurred.

Note 2.2 Change in consolidation scope

On October 4th, 2018, the Group finalized its acquisition of the entire share capital of the Intelenet group, a major provider in the field of high-end omnichannel customer experience, and back-office, human resources management and finance and administration services. Intelenet is located principally in India and the Philippines with around 58,000 employees.

The operation which was announced on June 14th, 2018, has obtained the approval of the relevant regulatory authorities and is fully consolidated with effect from October 1st, 2018.

Consideration for the transaction was made in cash in the definitive amount of US$1,045 million, of which US$922 million represented the acquisition price of the shares; the balance concerns loans granted to the acquired entity. The purchase agreement does not include a future price adjustment clause. Transaction costs of a total of €4.7 million have been recognized in other operating expenses.

The following schedule sets out management's best estimate as of the reporting date of the fair values of the identifiable assets and liabilities of Intelenet at the acquisition date:

(in millions of euros)	**Provisional fair values at 10/01/2018**
NON-CURRENT ASSETS	
Intangible assets	318
Property, plant and equipment	38
Deferred tax assets	18
Other non-current assets	10
Total non-current assets	**384**
CURRENT ASSETS	
Current income tax receivable	68
Accounts receivable – Trade	77
Other current assets	16
Cash and cash equivalents	35
Total current assets	**196**
TOTAL ASSETS	**580**

(in millions of euros)	**Provisional fair values at 10/01/2018**
NON-CURRENT LIABILITIES	
Provisions	5
Deferred tax liabilities	85
Financial liabilities	65
Total non-current liabilities	**155**
CURRENT LIABILITIES	
Provisions	47
Current income tax	26
Accounts payable – Trade	6
Other current liabilities	90
Total current liabilities	**169**
TOTAL LIABILITIES	**324**
Net assets, acquired 100%	**256**
Acquisition price	**794**
Provisional amount of goodwill	**538**

The Group is currently undertaking the measurement of the assets and liabilities of the acquired entity and has recognized provisionally the fair value of the intangible asset represented by customer relationships in an amount of €310.8 million, with a related deferred tax liability of €84.5 million. A contingent liability of €35.7 million has also been recognized in the opening statement of financial position. The provisional amount of goodwill recognized is €537.7 million, which will be finalized during the next few months. This work was performed with the assistance of external experts.

In terms of strategic rationale for the goodwill, the Group considers that the savoir-faire of Intelenet in the field of enterprise digital transformations will help it to enlarge its customer offering, and to improve its positioning in the Indian market.

Intelenet has contributed to Group results as follows in 2018:

(in millions of euros)	**10/01/2018 to 12/31/2018**
Revenues	105
Operating profit*	14
Net profit*	9

* *Before amortization of intangible assets related to the acquisition.*

Revenues and net profit for full-year 2018 amounted to €410 million and €35 million (excluding any amortization of the intangible assets recognized at the time of the acquisition), respectively.

Note 3 Operational activity

Note 3.1 Property, plant and equipment

Owned assets

Items of property, plant and equipment are stated at cost less accumulated depreciation (see below) and impairment losses (see accounting policy, note 1.3 *Impairment*).

Cost includes the asset's directly attributable acquisition costs.

Where parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate items of property, plant and equipment.

Leased assets

Leases in terms of which the Group assumes substantially all the risks and rewards of ownership are classified as finance leases.

Any other lease agreement is an operating lease. Such leased assets are not recognized in the Group's statement of financial position. The Company has no real estate held under a finance lease agreement.

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Subsequent expenditure

The Group recognizes in the carrying amount of an item of property, plant and equipment the cost of replacing part of such an item when that cost is incurred, if it is probable that the future economic benefits of the item will flow to the Group and the cost of the item can be measured reliably.

All costs of routine repairs and maintenance are recognized in the statement of income as an expense when incurred.

Depreciation

Depreciation is charged to the statement of income on a straight-line basis over the estimated useful life of each part of an item of property, plant and equipment, from the time it is ready for use. Improvements made to buildings held on an operating lease are depreciated over the shorter of the lease period and the useful life.

The estimated useful lives are as follows:

Buildings:	20 to 25 years
Office and IT equipment:	3 to 5 years
Other:	3 to 10 years

Depreciation methods, useful lives and residual values are reviewed at the end of each reporting period.

Land is not depreciated.

Property, plant and equipment is analyzed as follows:

(in millions of euros) **Gross**	**Land & buildings**	**Telephone and IT equipment**	**Other**	**In progress**	**Total**
At December 31st, 2016	**470**	**540**	**218**	**23**	**1,251**
Transfer	20	-3	6	-26	-3
Increase	42	48	24	26	140
Decrease	-12	-23	-15		-50
Translation differences	-46	-47	-17	-2	-112
At December 31st, 2017	**474**	**515**	**216**	**21**	**1,226**
Change in consolidation scope*	7	16	16		39
Transfer	14	10		-26	-2
Increase	46	58	37	36	177
Decrease	-8	-23	-8		-39
Translation differences	1	4			5
Hyperinflation adjustment	5	2	1		8
AT DECEMBER 31st, 2018	**539**	**582**	**262**	**31**	**1,414**

(in millions of euros) **Accumulated depreciation**	**Land & buildings**	**Telephone and IT equipment**	**Other**	**In progress**	**Total**
At December 31st, 2016	**-240**	**-404**	**-131**		**-775**
Transfer	-3	7	-5		-1
Expense	-52	-64	-27		-143
Decrease	11	22	15		48
Translation differences	22	36	10		68
At December 31st, 2017	**-262**	**-403**	**-138**		**-803**
Transfer	-1	-4	2		-3
Expense	-51	-59	-28		-138
Decrease	7	23	8		38
Translation differences	-1	-4	-1		-6
Hyperinflation adjustment	-2	-2	-1		-5
AT DECEMBER 31st, 2018	**-310**	**-449**	**-158**	**0**	**-917**

(in millions of euros) **Carrying amount**	**Land & buildings**	**Telephone and IT equipment**	**Other**	**In progress**	**Total**
At December 31st, 2016	**230**	**136**	**87**	**23**	**476**
At December 31st, 2017	**212**	**112**	**78**	**21**	**423**
AT DECEMBER 31st, 2018	**229**	**133**	**104**	**31**	**497**

* *The line item "Change in consolidation scope" relates to the acquisition of Intelenet in October 2018.*

"Other" comprises principally office equipment and furniture, and motor vehicles. No impairment loss has been recorded on these assets.

The Group relies only to a minor extent on finance lease financing and, in consequence, the disclosure of the amount of non-current assets held under finance leases is not significant.

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Note 3.2 Other intangible assets

These mainly include:

- brand names, customer relationships and technologies measured and recognized as part of a business combination;
- software acquired by the Group with a finite useful life, which is recognized at cost less accumulated depreciation and impairment losses (see accounting policy, note 1.3 *Impairment*).

Expenditure relating to internally generated brands is expensed when incurred.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalized only when it increases the future economic benefits of the specific asset. All other costs are expensed as incurred.

Amortization

Amortization is charged to the statement of income on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Other intangible assets are amortized from the date on which they are available for use. The estimated useful lives are as follows:

Software:	3 to 6 years
Brand names:	3 to 10 years
Customer relationships:	9 to 15 years

Other intangible assets are analyzed as follows:

	Assets recognized as part of a business combination		Other		
(in millions of euros) **Gross**	**Software**	**Brand names and customer relationships**	**Software**	**Other**	**Total**
At December 31st, 2016	**62**	**1,197**	**183**	**1**	**1,443**
Change in consolidation scope				2	2
Transfer			21		21
Increase			12		12
Decrease			-28		-28
Translation differences	-7	-144	-14		-165
At December 31st, 2017	**54**	**1,053**	**175**	**3**	**1,285**
Change in consolidation scope		311	7		318
Transfer			6	-1	4
Increase			16		16
Decrease			-6		-6
Translation differences	3	64	1		67
AT DECEMBER 31st, 2018	**57**	**1,428**	**199**	**2**	**1,685**

	Assets recognized as part of a business combination		Other		
(in millions of euros) **Accumulated depreciation and impairment losses**	**Software**	**Brand names and customer relationships**	**Software**	**Other**	**Total**
At December 31st, 2016	**-3**	**-129**	**-139**	**0**	**-271**
Transfer			-15	-2	-17
Expense	-10	-77	-20	-1	-108
Decrease			28		28
Translation differences	1	19	9		29
At December 31st, 2017	**-12**	**-187**	**-137**	**-3**	**-339**
Transfer			-2	1	-1
Expense	-9	-79	-21		-109
Decrease			6		6
Translation differences	-1	-10	-1		-11
AT DECEMBER 31st, 2018	**-22**	**-275**	**-155**	**-2**	**-454**

	Assets recognized as part of a business combination		Other		
(in millions of euros) **Carrying amount**	**Software**	**Brand names and customer relationships**	**Software**	**Other**	**Total**
At December 31st, 2016	**59**	**1,068**	**44**	**1**	**1,172**
At December 31st, 2017	**43**	**866**	**37**	**0**	**946**
AT DECEMBER 31st, 2018	**35**	**1,152**	**43**	**0**	**1,231**

An intangible asset represented by customer relationships in an amount of €310.8 million at the acquisition date has been recognized in respect of the acquisition of Intelenet (*see note 2.2 Change in consolidation scope*).

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Note 3.3 Accounts receivable – Trade and Other current assets

Accounts receivable – Trade and Other current assets are initially recognized at fair value, then at amortized cost less any impairment losses.

	12/31/2018			12/31/2017
(in millions of euros)	**Gross**	**Write-downs**	**Net**	**Net**
Accounts receivable – Trade	1,061	-13	1,048	896
Other receivables	20	-8	12	10
Taxation recoverable	63		63	39
Advances and receivables on non-current assets	10		10	3
Prepaid expenses	62		62	41
TOTAL	**1,216**	**-21**	**1,195**	**989**

Accounts receivable – Trade is analyzed by geographical region as follows

(in millions of euros)	12/31/2018	12/31/2017
English-speaking & APAC	395	362
Ibero-LATAM	271	253
Continental Europe & MEA	213	190
Specialized Services	93	91
Intelenet	76	-
TOTAL	**1,048**	**896**

The payment schedule of Accounts receivable – Trade is as follows

(in millions of euros)	12/31/2018	12/31/2017
Not yet due	833	700
Overdue < 30 days	148	136
Overdue < 60 days	36	30
Overdue < 90 days	14	13
Overdue < 120 days	12	10
Overdue > 120 days	5	7
TOTAL	**1,048**	**896**

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Factoring arrangements

Under a factoring agreement in place, receivables are sold without recourse, subject to the following principal conditions:

- that they comply with the eligibility conditions set out in the agreement;
- that they are not subject to reasonable dispute by the customer; and
- that in the event of non-payment by the customer, the Group will respect the procedures set out in the insurance policy.

The Group and a number of its subsidiaries use factoring arrangements which comply with criteria for derecognition. The outstanding amounts concerned totaled €72.1 million and €48.1 million at December 31st, 2018 and 2017, respectively.

Under the agreements, the Group retains the credit control and receipt functions in respect of the sold receivables on behalf of the factor.

Note 3.4 Share-based payments

The Group has implemented plans, which were in effect during the current year, under which incentive shares are allocated free of charge to group employees and company officers.

The fair value of the incentive plan shares, measured on the grant date by an independent actuary, is recognized as share-based payment expense over the vesting period with a corresponding increase in equity.

The amount recognized as an expense is adjusted at each reporting date to reflect the actual number of incentive plan shares that are expected to vest, so that, when vesting occurs, total expense and equity instruments correspond to the actual number of shares vesting in the group personnel and company officers.

Incentive share award plans – Authorization given at the Shareholders' Meeting of April 28th, 2016

The Board of Directors' meetings on April 28th and November 2nd, 2016 approved free awards of 1,065,808 incentive plan shares to group personnel, including company officers of subsidiary companies, under the authorization given at the Shareholders' Meeting of April 28th, 2016, limited to a maximum of 2.5% of the share capital of the Company at the grant date. The Board meeting on April 28th, 2016 also approved the setting-up of a long-term incentive plan for the senior management personnel who are company officers of the Company, with the free award of 350,000 shares. The two plans have identical conditions for vesting.

The features of these plans are as follows:

	04/28/2016 plan	11/02/2016 plan
Date of Board meeting allocating the awards	04/28/2016	11/02/2016
Vesting period	04/28/2016 to 04/28/2019	11/02/2016 to 11/02/2019
Grant date	04/28/2016	11/02/2016
Number of share awards*	1,264,300	151,508
Number of canceled shares**	-170,659	-11,632
Number of outstanding share awards at December 31st, 2018	1,093,641	139,876
Fair value of each share award at the grant date (taking into account the market condition)	€48.51	€72.40
Fair value of each share award at the grant date (without taking into account the market condition)	€75.20	€88.80
* *Including for company officers of the Company.*	*350,000*	*0*
** *Including for company officers of the Company.*	*-70,959*	*0*

Vesting of the free share awards is conditional on the beneficiaries remaining with the Group until at least the end of the vesting period and on meeting performance conditions relating to the financial years between 2016 and 2018.

The Board of Directors has defined four performance criteria; the number of shares allocated is determined on the basis of the average of the percentages obtained by the three best–performing criteria.

In view of the above principles and the results achieved in the period 2016/2018, the three best–performing criteria are those concerning the increase in revenues, the EBITA margin rate and the performance of Teleperformance SE's share price compared with the SBF 120 share index. All beneficiaries are therefore entitled to 100% of their free share awards. The fair values are those which take account of the market condition *i.e.* €48.51 for the April 28th, 2016 plan and €72.40 for the November 2nd, 2016 plan, which results in 2018 expense of €22.5 million.

In order to meet the requirements of its long-term incentive plan, TGI, the US subsidiary, purchased a total of 180,499 shares in the market during the second half of 2018, in an amount of €30.2 million.

The Board of Directors' meeting on June 23rd, 2017, November 30th, 2017 and February 28th, 2018 approved free awards of a total of 18,600 incentive plan shares to group personnel, including company officers of group companies, under the authorization given at the Shareholders' Meeting of April 28th, 2016. Vesting of these free share awards is conditional on each beneficiary remaining with the Group until at least the end of the vesting period and on meeting certain performance conditions. The related expense in respect of these plans amounted to €0.7 million in 2018.

Note 3.5 Short-term employee benefits

Liabilities for short-term benefits are measured on an undiscounted basis and recognized when the corresponding service is rendered.

A provision is recognized for the amount the Group expects to pay under short-term cash-settled profit-sharing and bonus schemes if the Group has a present legal or constructive obligation to make such payments as a result of past services by an employee and if the obligation can be reliably estimated.

Note 3.6 Employee termination payments

Termination payments are recognized as expenses when the Group is committed, with no realistic possibility of withdrawal, to a formal detailed plan to lay off employees before their normal retirement date.

Termination payments for voluntary redundancies are recognized if the Group has offered an incentive to encourage voluntary redundancies, if it is probable that such an offer will be accepted and if the number of individuals accepting the offer can be reliably estimated.

Note 3.7 Employee benefits – Defined contribution plans

Obligations for contributions to defined contribution plans are recognized as an expense as incurred.

Such expenses totaled €14.2 million in 2018 compared with an amount of €12.2 million in 2017.

Note 3.8 Other long-term employee benefits

The only long-term employee benefits of the Group are the post-employment benefits that are described in note 9.3 *Post-employment benefits: defined benefit plans*.

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Note 3.9 Accounts payable – Trade and Other current liabilities

Accounts payable – Trade and Other current liabilities are recognized initially at fair value, and subsequently at amortized cost.

(in millions of euros)	12/31/2018	12/31/2017
Accounts payable – Trade	147	141
Other payables	193	162
Taxes payable	73	57
Accrued expenses	218	173
Other operating liabilities	47	33
TOTAL	**678**	**566**

Other operating liabilities at December 31st, 2018 include the negative fair values of derivative financial instruments entered into for the purpose of hedging foreign currency exposures, for €9.1 million, compared with € 5.7 million at the end of 2017.

Note 3.10 Income

Revenues

The Group offers its customers consultancy services and integrated solutions to manage and optimize, on their behalf, the complete customer relationship experience, as well as Specialized Services with high added-value content.

The service offer is set out in two categories:

- Core Services, which covers customer relationship operations, technical assistance and customer acquisition;
- Specialized Services have a high added-value content, and concern principally on-line interpretation services and visa application management.

The revenues related to these various services, which represent single contractual arrangements, are recognized as the services are rendered. Revenue therefore corresponds to contractual billing rights.

In Core Services, the services are recognized principally as a function either of time spent (*e.g.* through telephone, chat or e-mail) or of volumes processed by our personnel (*e.g.* the number of calls or sales made). The services rendered are tracked using internal or external operating tools. Certain contracts provide for bonuses or penalties based on achieving or missing contractual ratios related to operations; the related amounts are not significant and may be reliably determined at each reporting date.

In Specialized Services, on-line interpretation services are principally rendered by our translators and interpreters on a time basis and revenue is recognized on the basis of work done. Revenues in relation to visa application management are recognized based on applications processed.

Costs to secure contracts are negligible and are therefore expensed as incurred. Costs of performing contracts are not covered by IFRS 15 and do not have a specific accounting treatment under the standard.

Due to the type of services rendered by the Group and in the absence of firm contractual commitments at the reporting date, no information with respect to outstanding orders as defined under IFRS 15 is followed by the Group.

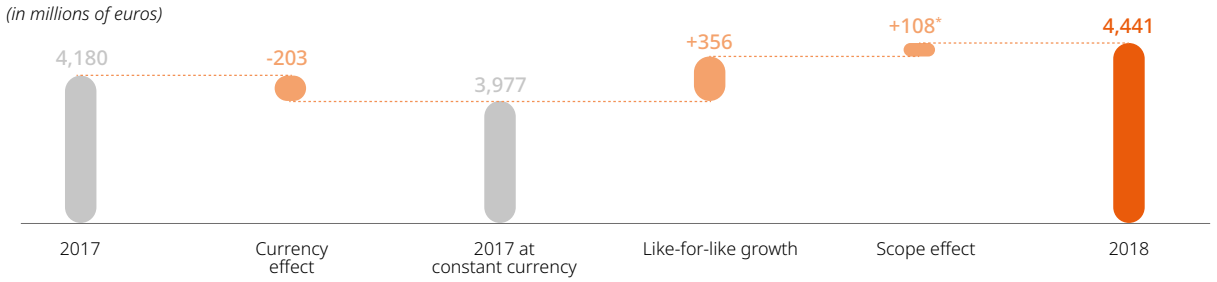

** Relates to Intelenet, acquired in the second half of 2018.*

Group revenues amounted to €4,441.0 million in 2018, representing an increase (on the basis of published figures) of 6.2% compared to 2017. At constant scope and exchange rates, the increase was 9.0%.

Other revenues

Other revenues mainly consist of government grants that are recognized in the statement of financial position under Other receivables when there is reasonable assurance that they will be received and that the Group will comply with the conditions attached to them. Grants that compensate the Group for costs incurred are recognized in the statement of income in the period in which the expenses are incurred. Grants that cover all or part of the cost of an asset are recognized in the statement of income over the useful life of the asset.

Following the introduction in 2012 of the French tax credit for competitiveness and employment (*Crédit d'impôt pour la compétitivité et l'emploi* – CICE), the Group opted to recognize it under Other revenues.

In 2018, grants amounted to €5.7 million compared with €7.7 million in 2017, including €2.1 million and €2.7 million for the CICE in 2018 and 2017, respectively.

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Note 3.11 External expenses

These consist mainly of property rents and charges, telecommunications, other rentals, travel and entertainment, and fees.

Operating leases

Payments made under operating leases are recognized in the statement of income on a straight-line basis over the term of the lease agreement. Any lease incentives received (such as temporary rent holidays) are also recognized in income over the same period.

The Group rarely owns its premises and finance lease agreements are therefore a little-used form of financing. Most premises are held on operating leases, and the related commitments are disclosed in note 9.4 *Guarantees and other contractual obligations*.

(in millions of euros)	2018	2017
Property rents and charges	-228	-209
Telecommunication	-96	-102
Hire and maintenance of equipment	-82	-75
Travel and entertainment	-63	-51
Office cleaning and security	-49	-47
Operating expenses	-55	-38
Staff recruitment	-36	-30
Fees	-33	-42
Consumable supplies	-17	-17
Other	-79	-89
TOTAL	**-738**	**-700**

Note 3.12 Other operating income and expenses

This line item includes income and expenses that are unusual in terms of their rarity or amount. It mainly includes capital gains and losses on disposal of intangible assets and property, plant and equipment, certain restructuring and termination costs, significant litigation, acquisition transaction and closure costs of subsidiaries, etc.

(in millions of euros)	2018	2017
Other operating income		
Other operating expenses	-8	-23
TOTAL	**-8**	**-23**

Other operating expenses in 2018 comprise principally the acquisition-related costs of the Intelenet transaction and the costs in connection with the change to the Teleperformance visual identity. Other operating expenses in 2017 comprised principally the estimated costs relating to the restructuring of the French business and a provision made in respect of a non-compete agreement.

Note 3.13 Segment reporting

An operating segment is a component of an entity:

- which engages in business activities from which it may earn revenues and incur expenses, including revenues and expenses relating to transactions with other components of the same entity;
- whose operating results are reviewed regularly by the entity's chief operating decision maker in order to allocate resources and assess its performance; and
- for which discrete financial information is available.

Segments may be aggregated when they have similar economic characteristics.

With effect from January 1st, 2017, group activity as followed by the chief executive officer is now split into the following two segments:

- the Core Services segment which includes customer care, technical support and new customer acquisitions and is divided into three principal management regions:
  - English-speaking & APAC, which covers the activities in the following countries: Canada, USA, United Kingdom, South Africa, China, Indonesia, India, the Philippines, Singapore, Australia and Malaysia,
  - Ibero-LATAM, which covers the activities in the following countries: Argentina, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Guyana, El Salvador, Peru, Mexico, Spain and Portugal,
  - Continental Europe & MEA, which covers the activities in the countries of the EMEA region with the exception of the United Kingdom, Spain and Portugal;
- the Specialized Services segment which includes the interpreting services of LanguageLine Solutions, the visa application management services for government departments offered by TLScontact, Praxidia's analytics solutions and the accounts receivable credit management services of AllianceOne Receivables Management (ARM) in North America.

Following the acquisition of Intelenet, a new organization will be put in place during 2019. Intelenet's business is in the process of being integrated within the Group and is provisionally considered to be a distinct segment in 2018.

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Segment information is set out below:

Inter-segment operations are not significant and are not identified separately.

(in millions of euros) 2018	Core Services				Specialized Services	Intelenet	Total
	English-speaking & APAC	Ibero-LATAM	Continental Europe & MEA	Holding companies			
Revenues	**1,586**	**1,149**	**962**		**639**	**105**	**4,441**
Operating profit	**130**	**131**	**68**	**20**	**128**	**8**	**485**
Capital expenditure	51	60	58		25	3	197
Intangible assets and Property, plant and equipment (carrying amounts)	1,009	299	229	2	1,559	934	4,032
Depreciation and amortization of non-current assets	-80	-48	-29	-1	-80	-9	-247

(in millions of euros) 2017	Core Services				Specialized Services		Total
	English-speaking & APAC	Ibero-LATAM	Continental Europe & MEA	Holding companies			
Revenues	**1,607**	**1,084**	**851**		**638**		**4,180**
Operating profit	**124**	**130**	**-38**	**14**	**125**		**355**
Capital expenditure	51	47	30	1	19		148
Intangible assets and Property, plant and equipment (carrying amounts)	1,004	282	207	2	1,550		3,045
Depreciation and amortization of non-current assets	-92	-47	-28	-1	-83		-251
Impairment loss on goodwill			-67				-67

Note 4 Goodwill

Note 4.1 Accounting policies and methods

In a business combination, goodwill is calculated as disclosed in note 2.1.3 *Business combinations*.

Impairment

The recoverable amount of goodwill is estimated at each reporting date. Goodwill is measured at cost less accumulated impairment losses. It is allocated to a cash-generating unit (CGU) or a group of CGUs, and is not subject to amortization but is tested for impairment at least annually.

An impairment loss is recognized whenever the carrying amount of an asset or its CGU or group of CGUs exceeds its recoverable amount. Impairment losses are recognized, and presented in a distinct line item, in the income statement.

An impairment loss recognized in respect of a CGU (or group of CGUs) is allocated to a reduction in the carrying amount of assets in the CGU (or group of CGUs) in the following order:

- goodwill; then
- other intangible assets and property, plant and equipment, proportionate to their carrying amounts.

The recoverable amount of an asset or CGU is the higher of its value in use and its fair value less costs to sell. In assessing value in use, the estimated future cash flows net of tax are discounted to their present value using a discount rate that reflects current market assessments of the time value of money and the risks specific to the asset.

Discount rates are post-tax rates applied to cash flows after tax, and result in the determination of recoverable amounts identical to those that would have been obtained using pre-tax rates to cash flows excluding tax.

The Group determines its discount rates by taking into account the average risk-free rates with a maturity of between 20 and 30 years observed over 12 months, the market risk premium, and Teleperformance's average weekly beta over 2 years (given the absence of comparable enterprises). The risk-free rate and the risk premium are specific to each geographical area with similar characteristics.

An impairment loss in respect of goodwill may not be reversed.

Note 4.2 Determination of the principal cash-generating units or groups of cash-generating units (referred to below as a CGU)

Subsidiaries are grouped together to form a CGU in the following cases:

- there are significant inter-relationships formed by the existence of the same customers with common cash flows;
- existence of close ties of certain subsidiaries with their offshore production units;
- presence in the same geographical region, with a similar economic context and common management.

At December 31st, 2018, the principal CGUs were determined to be as follows:

North America & FHCS CGU

This CGU is formed by the Core Services subsidiaries located in the USA and Canada, and the offshore subsidiaries in India, the Philippines and Jamaica. The recoverable amount represented by this CGU is €2,471 million.

Nearshore CGU

This CGU is formed by the Core Services businesses of subsidiaries located in Mexico, Costa Rica, El Salvador and the Dominican Republic. The recoverable amount represented by this CGU is €794 million.

Central Europe CGU

This CGU is formed by the Core Services businesses of subsidiaries located in Germany, Switzerland and the Netherlands. The recoverable amount represented by this CGU is €125 million.

United Kingdom CGU

This CGU is formed by the Core Services businesses of subsidiaries located in the United Kingdom and the offshore subsidiary in South Africa. The recoverable amount represented by this CGU is €272 million.

French Speaking Market (FSM) CGU

This CGU is formed by the Core Services business of the French subsidiary and the production subsidiaries in Tunisia, Morocco, Lebanon and Madagascar. These companies were brought together in 2008 under common management and a single brand name. The recoverable amount represented by this CGU is €263 million.

LanguageLine Solutions CGU

This CGU, which forms part of the Specialized Services segment, was created in 2016 following the acquisition of LanguageLine Solutions. The recoverable amount represented by this CGU is €2,211 million.

Intelenet CGU

Following the acquisition of Intelenet in October 2018, goodwill of €566 million has been recognized on a provisional basis as of December 31st, 2018. As disclosed in note 2.2 *Change in consolidation scope*, the Group is currently undertaking the measurement of the assets and liabilities of the acquired entity.

Other CGU

There are 14 other CGUs, including the Spanish market, Southern Europe, Eastern Europe, TLScontact, ARM, etc. but which represent individually less than 2% of total goodwill.

Note 4.3 Determination of the recoverable amount of CGUs

The recoverable value of CGUs is represented by the value in use.

The Group has not used any other measurement methods, for example that of fair value less costs to sell.

Recoverable amounts are determined by geographical region, calculated on the basis of the present value of estimated cash flow forecasts for the next five years. The cash flows of the first year are based on the following year's budget. The cash flows of the following two years are obtained from the three-year plans prepared by CGU managements, approved by Group management. The cash flows of the two last years are based on the three-year plans, incorporating future growth and profitability rates considered reasonable for each CGU. The terminal values calculated after five years assume perpetual future growth equal to inflation and are based on the cash flows of the final year. Cash flows are discounted using the weighted average cost of capital (WACC) of each geographical region.

Reasonableness checks are made to ensure that the WACC is consistent with the ROCE (see note 1.5 *Glossary*).

In the event that cash flow forecasts have been shown on a number of occasions to be inaccurate or when there is uncertainty in respect of a particular market, the Group may decide to limit the forecasts to a three-year horizon.

In 2018, due to the shortfall on the Central Europe CGU budget, the forecasts used in calculating its recoverable amount were limited to a three-year horizon.

No impairment loss on goodwill has been recognized in 2018.

Note 4.4 Change in goodwill and Allocation of goodwill by CGU

Changes in goodwill in 2017 and 2018 are set out below:

(in millions of euros) **Goodwill**	**Gross**	**Accumulated impairment losses**	**Net**
At December 31st, 2016	**1,961**	**-23**	**1,938**
Change in consolidation scope*	4		4
Translation differences	-200	1	-199
Impairment losses		-67	-67
At December 31st, 2017	**1,765**	**-89**	**1,676**
Change in consolidation scope*	538		538
Translation differences	90		90
Impairment losses			0
AT DECEMBER 31st, 2018	**2,393**	**-89**	**2,304**

* *The line items "Change in consolidation scope" relate to the acquisitions of Wibilong in November 2017 and of Intelenet in October 2018.*

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The following schedule sets out the allocation of goodwill and the discount rate for the principal CGUs:

	Goodwill				Discount rate	
	12/31/2018		12/31/2017		2018	2017
(in millions of euros)	Gross	Carrying amount	Gross	Carrying amount		
LanguageLine Solutions	746	746	714	714	6.5%	6.9%
North America & FHCS	611	596	587	571	6.5%	6.9%
Intelenet*	566	566	-	-		-
Nearshore	111	111	106	106	8.9%	9.1%
Central Europe	94	50	93	49	5.4%	5.7%
United Kingdom	67	67	68	68	5.5%	6.0%
FSM	53	30	53	30	5.9%	5.8%
Other	145	138	144	138		
TOTAL	**2,393**	**2,304**	**1,765**	**1,676**		

* *As Intelenet was acquired in the second half of 2018, no impairment testing has been performed as of December 31st, 2018.*

Note 4.5 Sensitivity analysis

In order to identify CGUs at risk of impairment, the Group performs sensitivity analyses on all CGUs incorporating an increase in the discount rates selected and a reduction of 200 base points in the EBITA rates used in the calculation of the terminal values.

In the event that a CGU is identified under this test, additional sensitivity analyses are performed using further changes in operational assumptions *e.g.* revenue growth.

As of December 31st, 2018, the only CGU identified as at risk of an impairment loss was the Central Europe CGU. At that date, the carrying amount of its goodwill was €50 million.

The following chart shows the impact of increases of 100 and 200 basis points in the discount rate combined with reductions of 100 and 200 basis points in profitability on the terminal value calculation for this CGU.

The amounts in the chart show the difference between the CGU's recoverable and carrying amounts, restricted to the carrying amount of its goodwill. A negative amount therefore indicates a potential impairment loss.

Sensitivity analysis Centrale Europe

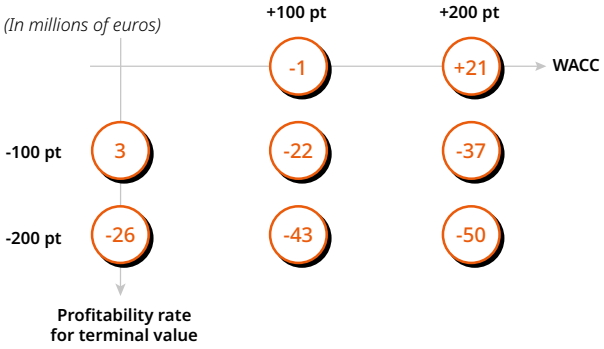

Note 5 Income tax

Note 5.1 Income tax expense

Income tax expense reported in the income statement comprises current and deferred tax except to the extent that it relates to items recognized directly in equity, in which case it is recognized in equity.

The French levy on the added value of companies (CVAE) and certain foreign taxes such as the Italian IRAP come within the scope of IAS 12 and are therefore recognized as a tax expense.

As a result, current tax comprises:

- the expected amount of tax payable on the taxable income of the period (determined using tax rates that have been enacted or substantively enacted at the reporting date);
- any adjustment of the amount of tax payable in respect of previous years;
- CVAE, IRAP, etc.

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In 2018, the Group recognized income tax expense of €121.7 million compared with an income tax credit of €9.3 million in 2017. The credit recognized in 2017 was due principally to the effect of the US tax reform on the measurement of deferred tax liabilities, as shown by the comparative amounts in the following schedule. In 2018, the Group has returned to an effective tax rate of 28%, which is less than the standard French rate of tax as explained in the following schedule:

(in millions of euros)	2018	2017
Consolidated net profit	**313**	**314**
Current tax expense	140	160
Deferred tax expense (credit)	-18	-169
Profit before tax	**435**	**305**
Standard rate of tax in France	33.33%	34.43%
Expected tax expense	**-145**	**-105**
CVAE	-1	-2
IRES/IRAP	-1	-1
Tax on dividends	1	3
Effect of foreign jurisdictions' tax rates	38	25
US tax on retained earnings		-15
Change in US tax rate		147
Impairment loss on goodwill		-23
Other permanent differences, other items	-10	-17
Change in unrecognized deferred tax assets	-4	-3
TOTAL	**-122**	**9**

Note 5.2 Deferred tax

Deferred tax is calculated and recognized using the liability method, providing for all temporary differences between the carrying amount of assets and liabilities for financial reporting purposes and the amounts used for taxation purposes.

Deferred tax assets and liabilities are measured using the tax rate that is expected to apply in the period when the asset is realized and the liability settled, according to tax laws that have been enacted or substantively enacted at the reporting date.

Deferred tax assets and liabilities are netted by tax entity for presentation in the statement of financial position.

A deferred tax asset is recognized only to the extent that it is likely that future taxable profits will be available against which the asset can be utilized. Deferred tax assets are reduced to the extent that it is no longer probable that the related tax benefit will be realized.

(in millions of euros)	Deferred tax assets	Deferred tax liabilities	Net	including assets from tax losses
At December 31st, 2016	**31**	**444**	**-413**	**7**
Recognized in profit or loss	-9	-178	169	
Translation differences	-2	-40	38	
Offset of assets and liabilities	8	8	0	
At December 31st, 2017	**28**	**234**	**-206**	**7**
Change in consolidation scope	14	81	-67	
Recognized in profit or loss	-4	-22	18	
Recognized in equity	4	6	-2	
Translation differences	-1	13	-14	
Offset of assets and liabilities	-6	-6	0	
AT DECEMBER 31st, 2018	**35**	**306**	**-271**	**7**

Deferred tax liabilities related to intangible assets recognized as part of a business combination amounted to €301.9 million at December 31st, 2018 (€224.4 million at December 31st, 2017). The increase is due principally to the acquisition of Intelenet.

Deferred tax assets amounted to €34.6 million at December 31st, 2018 (€27.6 million at December 31st, 2017) including amounts relating to tax losses carried forward of €6.7 million.

The Group has tax losses of approximately €171 million, of which €130 million have no expiry date.

Deferred tax assets of €34.5 million at December 31st, 2018 (€20.8 million at December 31st, 2017) relating to tax losses carried forward were not recognized as their recovery was not considered probable.

Note 5.3 Current income tax assets and liabilities

Changes in these two line items between December 31st, 2017 and 2018 are principally due to the acquisition of Intelenet.

Note 6 Equity and Earnings per share

Note 6.1 Share capital

Share capital at December 31st, 2018 amounted to €144,450,000 consisting of 57,780,000 shares, with a nominal value of €2.50 each, fully paid-up.

	12/31/2018		12/31/2017
Number of shares issued and fully paid up	57,780,000		57,780,000
including treasury shares of	220,526		25,400
Dividend distributions in respect of the financial year*	109.8	**	106.9
Dividend per share *(in euros)*	1.90	**	1.85

* *Based on the number of shares in issue at December 31st.*
** *As proposed to the shareholders' meeting on May 9th, 2019.*

There were no movements on the share capital of Teleperformance during 2018.

Note 6.2 Treasury shares

Treasury shares are shown as a deduction from total equity. On disposal, the proceeds, net of transaction costs and income tax, are recognized in equity.

At December 31st, 2018, the Group held:

- 40,027 treasury shares acquired under the liquidity contract for a total of €5.6 million;
- 180,499 treasury shares in an amount of €30.2 million to meet the requirements of a long-term incentive plan (see note 3.4 *Share-based payments*).

These amounts are shown as a deduction from equity.

Note 6.3 Earnings per share

The Group reports both basic and diluted earnings per ordinary share. Basic earnings per share is calculated by dividing the net profit attributable to holders of ordinary shares by the weighted average number of ordinary shares outstanding during the year, excluding treasury shares.

Diluted earnings per share is determined by adjusting the net profit attributable to ordinary shareholders and the weighted average number of ordinary shares outstanding by the effects of all potentially diluting ordinary shares. These adjustments concern the incentive share awards granted to employees when the required performance conditions have been met at the end of the financial year.

	2018	2017
Net profit – Group share	**312**	**312**
Weighted average number of shares used to calculate basic earnings per share	57,706,532	57,767,405
Dilutive effect of share awards	1,180,409	986,702
Weighted average number of shares used to calculate diluted earnings per share	58,886,941	58,754,107
Basic earnings per share *(in euros)*	**5.40**	**5.40**
Diluted earnings per share *(in euros)*	**5.29**	**5.31**

Weighted average number of shares used to calculate basic and diluted earnings per share

	2018	2017
Ordinary shares in issue at January 1st	57,780,000	57,780,000
less: treasury shares held	-73,468	-12,595
TOTAL	**57,706,532**	**57,767,405**

Note 7 Financial assets and liabilities

Note 7.1 Accounting policies and methods

7.1.1 Financial assets

Current and non-current financial assets comprise the following:

- loans and receivables measured at amortized cost: this category principally includes advances to staff and guarantee deposits paid mainly in the context of commercial property leases. On initial recognition, these loans and receivables are stated at fair value plus directly attributable costs; at each reporting date, these assets are measured at amortized cost;
- derivative financial instruments used to hedge exposure to foreign exchange and interest rate risks, measured at fair value at each reporting date;
- net asset warranties obtained as part of an acquisition: when the warranty relates to a specific asset or liability of the target entity at the date of a business combination, it is recognized separately from goodwill and is measured using the same method as the item being warranted.

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7.1.2 Financial liabilities

Non-current financial liabilities include loan transactions with banks or other financial institutions, bond issues and liabilities to certain minority interests.

Current financial liabilities comprise similar transactions as those described above but with settlement expected within one year.

Borrowings are recognized initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortized cost, with any difference between cost and redemption value being recognized in profit or loss over the period of the borrowings on an effective interest rate basis.

Debt issuance costs are initially recorded as a reduction of the corresponding loan, and subsequently taken into account in calculating the effective interest rate and recognized in the income statement over the period of the loan.

7.1.3 Cash and cash equivalents

Cash and cash equivalents comprise cash balances, demand deposits and investments in mutual funds made with a short-term objective, measured at fair value, with changes in fair value recognized in the statement of income.

Bank overdrafts that are repayable on demand and form an integral part of the Group's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are classified in the statement of financial position as Other current financial liabilities.

7.1.4 Financial income and expenses

Financial income comprises interest receivable on funds invested, dividend income, fair value increases in financial assets at fair value through profit or loss and foreign exchange gains.

Profits on hedging instruments covering revenues are recognized in operating profit. Interest income is recognized in profit or loss as it accrues, using the effective interest rate method. Dividends are recognized as soon as the Group acquires the right to receive the payment, *i.e.*, in the case of listed shares, on the ex-dividend date.

Financial expenses comprise interest payable on borrowings, the effect of the unwinding of discounted provisions, foreign exchange losses, decreases in fair value of financial assets at fair value through profit or loss, and impairment losses recognized in respect of financial assets.

All costs related to borrowings are recognized in profit or loss using the effective interest rate method. In the event that a loan may be reimbursed by anticipation, the probable residual duration of the loan is estimated at each reporting date and used to spread the any issue expenses under the effective interest rate method.

7.1.5 Derivative financial instruments

The Group uses derivative financial instruments to reduce its exposure to foreign exchange and interest rate risks arising from its activities. From time to time, the Group may use derivative financial instruments, contracted with high-grade financial institutions to reduce counterparty risk.

Financial instruments used to hedge the fair value of financial borrowings are recognized as financial liabilities.

Financial instruments used to hedge other transactions are recognized as other current or non-current assets and liabilities, depending on their maturity and accounting classification. They are measured at fair value at the date of transaction. Changes in the fair value of the instruments are recognized in profit or loss, except for cash flow hedges.

The Group applies hedge accounting when the hedging relationship has been identified, formalized and documented from its inception, and that it has been shown to be effective.

The accounting treatment of these financial instruments depends on the category into which they fall:

- cash flow hedges: the effective portion is recognized through equity. The amounts recognized in equity are reclassified to profit or loss when the hedged items affect profit or loss, either in operating profit when they concern the cover of a commercial transaction or in financial result when they cover a financial operation. The ineffective portion of changes in fair value of cash flow hedges is recognized in profit or loss as financial income or expense;
- fair value hedges: they are recognized in financial result.

Note 7.2 Financial assets

(in millions of euros)	Current	Non-current	12/31/2018	12/31/2017
Loans	2		2	11
Derivative financial instruments	32		32	9
Guarantee deposits	12	59	71	52
Indemnification asset	10		10	9
Gross financial assets	**56**	**59**	**115**	**81**
Write-downs			0	
CARRYING AMOUNT	**56**	**59**	**115**	**81**

The indemnification asset of €9.5 million (US$10.9 million) relates to the acquisition of Aegis USA Inc.in 2014 (see note 9.2 *Change in provisions*).

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Note 7.3 Financial result

(in millions of euros)	2018	2017
Income from cash and cash equivalents	**4**	**1**
Interest expense	-52	-49
Bank commissions	-8	-11
Financing costs	**-60**	**-60**
Net financing costs	**-56**	**-59**
Foreign exchange gains	26	33
Foreign exchange losses	-23	-24
Other financial income	3	
Other financial income (expenses)	**6**	**9**
FINANCIAL RESULT	**-50**	**-50**

Note 7.4 Financial liabilities

7.4.1 Loans from financial institutions, bonds and US private placements (USPPs)

Analysis by category of loan

At December 31st, 2018, the Group had obtained and utilized the following financing arrangements:

(in millions of euros/currencies) **Category of loan**	Amount in currency at 12/31/2018	Currency	Amount in € at 12/31/2018	Interest type	Rate	Maturity	Financial covenant
2016 bonds	600	EUR	600	Fixed*	Coupon: +1.50%	2024.04	no
2018 bonds	750	EUR	750	Fixed**	Coupon: +1.875%	2025.07	no
US private placement (2016) Tranche C	75	USD	65	Fixed	+3.92%	2023.12	yes
US private placement (2016) Tranche D	175	USD	153	Fixed	+4.22%	2026.12	yes
2016 bank loan	325	USD	284	Floating	Libor $ +0.85%	2021.08	yes
2018 bank loan	164	EUR	164	Floating	Euribor +1.00%	2023.06	yes
US private placement (2014) Tranche A	160	USD	140	Fixed	+3.64%	2021.12	yes
US private placement (2014) Tranche B	165	USD	144	Fixed	+3.98%	2024.12	yes
Commercial paper	134	EUR	134	Fixed	-0.14% à -0.19%	2019.03	no
Syndicated multicurrency facility***		EUR	0	Floating	Euribor +0.40%	2023.02	yes
		USD	0	Floating	Libor $ +0.40%	2023.02	yes
Bank facilities***		EUR	0	Floating	Euribor +0.50%	2019.06	no
		EUR	0	Floating	Euribor +0.40%	2019.06	no
		EUR	0	Floating	Euribor +0.50%	2019.06	yes
		EUR	0	Floating	Euribor +0.40%	2019.07	no
		USD	0	Floating	Libor $ +0.40%	2019.07	no
TOTAL LOANS			**2,434**				
Loan issuance expense			-13				
Loan hedging instruments			-5				
Bank overdrafts and advances			3				
Other financial liabilities			18				
TOTAL FINANCIAL LIABILITIES			**2,437**				

* *A swap of fixed to floating interest rates has been contracted over €200 million as well as interest rate caps over €120 million.*
** *A swap of fixed to floating interest rates has been contracted over €200 million as well as interest rate caps over €100 million.*
*** *A syndicated multicurrency facility of €300 million and bank facilities of €200 million.*

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Schedule of loans by principal currency and type of interest rate

(in millions of euros) Type of interest rate	Total	EUR	USD	CLP
• fixed	1,986*	1,484	502	
• floating	448	164	284	
AT DECEMBER 31st, 2018	**2,434**	**1,648**	**786**	**0**

Type of interest rate	Total	EUR	USD	CLP
• fixed	1,179	699	479	1
• floating	414		414	
AT DECEMBER 31st, 2017	**1,593**	**699**	**893**	**1**

* *Including €400 million covered by fixed to floating swaps.*

Covenants

The following financial liabilities are subject to financial covenants, which were all complied with as of December 31st, 2018:

US private placements of US$250 million and US$325 million

At December 31st, 2018, the relevant ratios were as follows:

	Contractual	Actual
Consolidated equity *(in millions of euros)*	> 1,595	2,225
Consolidated net debt*/consolidated EBITDA*	≤ 2.75x	2.57x

* *As defined in the contracts.*

Syndicated multicurrency facility €300 million, 2016 bank loan of US$325 million, CMCCIC bank facility of €50 million, and the 2018 bank loan of €164 million

At December 31st, 2018, the relevant ratio was as follows:

	Contractual	Actual
Consolidated net debt*/consolidated EBITDA*	≤ 2.75x	2.57x

* *As defined in the contracts.*

7.4.2 Net financial indebtedness: Schedule of debt maturities

(in millions of euros)	12/31/2018	Current	Non-current*	12/31/2017	Current	Non-current
Bank loans	448	66	382	418	106	312
Commercial paper	134	134		105	105	
USPP loans	502		502	480		480
Bonds	1,350		1,350	600		600
Loan issuance expense/premiums	-13	-2	-11	-10	-4	-6
Loan hedging instruments	-5	-5		5	5	
Bank overdrafts and advances	3	3		2	2	
Other financial liabilities	18	17	1	11	10	1
Total financial liabilities	**2,437**	**213**	**2,224**	**1,611**	**224**	**1,387**
Marketable securities	36	36		32	32	
Cash and bank	300	300		253	253	
Total cash and cash equivalents	**336**	**336**		**285**	**285**	
NET DEBT	**2,101**	**-123**	**2,224**	**1,326**	**-61**	**1,387**

* *Due after five years: €1,636 million.*

The acquisition of Intelenet by the Group on October 4th, 2018 has been financed as follows:

- a bond issue of €750 million on July 2nd, 2018 with a coupon of 1.875%, maturing in 2025;
- a loan of €164 million repayable in four equal installments on June 8th, 2020, 2021, 2022 and 2023.

The bond redemption premium amounting to €.6.7 million and the issuance expenses of the financing, of €4.7 million, are included in the determination of the effective interest rates.

During 2018, in addition to the first installment of US$125 million due on the US$500 million loan obtained in 2016, the Group also repaid in advance a further amount of US$50 million which reduces the next installment due on August 19th, 2019.

The Group has the following unutilized facilities as of December 31st, 2018:

- a syndicated multicurrency (€ and US$) of €300 million expiring in February 2023;
- three credit lines of €50 million each, negotiated during the first half of 2018 and which will expire in the first half of 2019;
- a credit line of €50 million, negotiated during the second half of 2018 and which will expire in the second half of 2019.

The Group relies only to a minor extent on finance lease financing and, in consequence, the amount of its finance lease liabilities is not significant (€0.7 million and €1.3 million at December 31st, 2018 and 2017, respectively).

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7.4.3 Interest rate risk

The Group has an exposure to interest rate risks on its financial liabilities and its short-term liquid investments. The following schedule identifies the amounts subject to interest rate risk:

(in millions of euros) **Net debt**	**12/31/2018**	**Fixed rate**	**Subject to interest rate risk**	**12/31/2017**	**Fixed rate**	**Subject to interest rate risk**
Total financial liabilities	2,437	1,986*	451	1,611	1,179	432
Cash and cash equivalents	-336		-336	-285		-285
NET DEBT	**2,101**	**1,986**	**115**	**1,326**	**1,179**	**147**

* *Including €400 million covered by fixed to floating swaps.*

An increase of 100 basis points in the interest rate would lead to an increase in financial expense of €5.8 million, whereas a reduction of the same scale would result in a reduction of €6.5 million in financial expense.

Note 7.5 Foreign exchange and interest rate hedging operations

Revenues and operating expenses of group companies may be denominated in a currency other than their functional currency. In order to reduce exposure to exchange rate risk, hedge contracts have been entered into, principally between the following currencies:

- the US dollar and the Mexican peso;
- the US dollar and the Colombian peso;
- the US dollar and the Philippine peso;
- the US dollar and the Indian rupee;
- the pound sterling and the Indian rupee;
- the euro and the US dollar, the Colombian peso, the Turkish lira, the Tunisian dinar.

The policy of the Group is cover its highly probable forecast transactions denominated in foreign currency, usually up to 12 months ahead but longer in certain cases. The Group uses forward exchange contracts and plain vanilla foreign exchange options.

In addition, currency hedges are in place to cover the exchange risk between currencies managed within the cash pool and the euro (in particular the US dollar) as well as certain loans between Teleperformance SE and its subsidiaries.

The Group has also put in place interest rate hedges in order to convert certain liabilities from fixed to floating rates, as well as caps to limit the impact of possible high interest rate rises.

The principal derivative financial instruments in place at the year-end are as follows:

(in millions of euros) **Derivative financial instruments at December 31st, 2018**	**Notional amount in currency**	**Notional amount in € at 12/31/2018**	**Fair value in € at 12/31/2018**	**In equity**	**In 2018 profit or loss**
Hedge of forecast transactions					
USD/MXN	61	53	1	1	
USD/MXN*	9	8			
MXN/USD	546	24	1	1	
MXN/USD*	88	4			
USD/PHP	9,054	151	2	2	
USD/PHP*	1,850	31			
COP/EUR	24	24	-1		-1
COP/EUR*	4	4			
COP/USD	64	56	-3	-2	-1
COP/USD*	26	23	-1		-1
EUR/TND	45	13	-1	-1	
USD/INR	247	216	4	4	
USD/INR*	10	9			
USD/CAD	12	10			
USD/CAD*	2	2			
AUD/INR	10	6			
GBP/INR	144	161	11	11	
USD interest caps	**500**	**437**	**2**	**2**	
EUR interest caps	**670**	**670**	**4**		**4**
Hedge of intra-group loans					
• in USD	298	260	2		2
• in PHP	7,911	132	4		4
• in GBP	11	13			
Cash pool hedges					
• in GBP	20	22			
• in USD	107	93			

* *Not eligible for hedge accounting.*

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(in millions of euros) **Derivative financial instruments at December 31st, 2017**	**Notional amount in currency**	**Notional amount in € at 12/31/2017**	**Fair value in € at 12/31/2017**	**In equity**	**In 2017 profit or loss**
Hedge of forecast transactions					
USD/PHP	9,448	158	5	3	2
USD/PHP*	5,885	99			
COP/USD	33	28	1		
COP/USD*	14	12			
MXN/USD	60	49	-2	-2	
MXN/USD*	11	9			
EUR/TND	57	19			
COP/EUR	15	15			
USD/MXN	422	18	-1	-1	
USD/MXN*	106	4			
USD/INR	11	9			
EUR/USD	13	10			
Cross Currency Interest Swap EUR/USD	**55**	**46**	**-5**		**-5**
USD interest caps	**400**	**334**			
Interest rate swap, fixed to floating	**200**	**200**			
EUR interest cap	**120**	**120**			
Hedge of intra-group loans					
• in USD	268	224	5		5
• in PHP	7,059	118	-3		-3
Cash pool hedges					
• in USD	165	138	-2		-2

* *Not eligible for hedge accounting.*

At December 31st, 2018, the fair value of derivative financial instruments amounted to €28.7 million (December 31st, 2017: -€1.7 million) of which €32.5 million is presented in Other financial assets, €9.1 million in Other current liabilities and €5.3 million as a reduction in other financial liabilities.

Counterparty credit risk (Credit value adjustment – CVA) and own credit risk (Debt value adjustment – DVA) are taken account of in the fair values of hedging instruments, but the amounts are not significant.

Note 7.6 Carrying amount and fair value of financial assets and financial liabilities by category

The fair value hierarchy is made up of three levels:

- level 1: unadjusted quoted prices in active markets for identical assets or liabilities that the entity can access at the measurement date;
- level 2: inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly (*i.e.* as prices) or indirectly (*i.e.* derived from prices);
- level 3: unobservable inputs for the asset or liability.

The following schedule shows the carrying amounts of financial assets and financial liabilities and their fair values, by accounting category as defined under IFRS 9, at December 31st, 2018:

	Accounting category					Fair value (FV)			
(in millions of euros) **12/31/2018**	Financial assets and liabilities at FV through profit or loss	Financial assets and liabilities at FV through OCI (may be reclassified to profit or loss in a subsequent period)	Financial assets and liabilities at FV through OCI (may not be reclassified to profit or loss in a subsequent period)	Financial assets and liabilities at amortized cost	**Total carrying amount**	Lev 1	Lev 2	Lev 3	**Total**
FINANCIAL ASSETS									
I – Non-current financial assets	**0**	**0**	**0**	**59**	**59**	**0**	**59**	**0**	**59**
Guarantee deposits				59	**59**		59		**59**
II – Derivative instruments – assets	**0**	**32**	**0**	**0**	**32**	**0**	**32**	**0**	**32**
Hedging instruments		32			**32**		32		**32**
III – Current financial assets	**36**	**0**	**0**	**1,519**	**1,555**	**336**	**1,219**	**0**	**1,555**
Loans				2	**2**		2		**2**
Guarantee deposits				12	**12**		12		**12**
Indemnification asset				10	**10**		10		**10**
Accounts receivable – Trade				1,048	**1,048**		1,048		**1,048**
Other current assets				147	**147**		147		**147**
Marketable securities	36				**36**	36			**36**
Cash and bank				300	**300**	300			**300**
TOTAL FINANCIAL ASSETS	**36**	**32**	**0**	**1,578**	**1,646**	**336**	**1,310**	**0**	**1,646**
FINANCIAL LIABILITIES									
I – Long-term financial liabilities	**0**	**0**	**0**	**2,234**	**2,234**	**0**	**2,234**	**0**	**2,234**
Bank loans				382	**382**		382		**382**
USPP loans				502	**502**		502		**502**
Bonds				1,350	**1,350**		1,350		**1,350**
II – Derivative instruments – liabilities	**0**	**4**	**0**	**0**	**4**	**0**	**4**	**0**	**4**
Loan hedging instruments		-5			**-5**		-5		**-5**
Exchange rate hedging instruments		9			**9**		9		**9**
III – Current financial liabilities	**0**	**0**	**0**	**877**	**877**	**3**	**874**	**0**	**877**
Short-term portion of bank loans				66	**66**		66		**66**
Commercial paper				134	**134**		134		**134**
Loan issuance expense/ premiums				-13	**-13**		-13		**-13**
Accounts payable – Trade				147	**147**		147		**147**
Bank overdrafts and advances				3	**3**	3			**3**
Other financial liabilities				18	**18**		18		**18**
Other current liabilities				522	**522**		522		**522**
TOTAL FINANCIAL LIABILITIES	**0**	**4**	**0**	**3,111**	**3,115**	**3**	**3,112**	**0**	**3,115**

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The following schedule shows the carrying amounts of financial assets and financial liabilities and their fair values as published at December 31st, 2017:

	Accounting category					Fair value (FV)			
(in millions of euros) **12/31/2017**	Financial instruments at FV through profit or loss	Derivative financial instruments	Loans and receivables	Financial liabilities at amortized cost	**Total**	Lev 1	Lev 2	Lev 3	**Total**
FINANCIAL INSTRUMENTS: ASSETS									
I – Financial assets at fair value	**32**	**9**	**0**	**0**	**41**	**32**	**9**	**0**	**41**
Exchange rate hedging instruments		9			**9**		9		**9**
Marketable securities	32				**32**	32			**32**
II – Financial assets at amortized cost	**0**	**0**	**1,270**	**0**	**1,270**	**253**	**1,017**	**0**	**1,270**
Loans			11		**11**		11		**11**
Guarantee deposits			8		**8**		8		**8**
Indemnification asset			9		**9**		9		**9**
Accounts receivable – Trade			896		**896**		896		**896**
Other assets			93		**93**		93		**93**
Cash and bank			253		**253**	253			**253**
FINANCIAL INSTRUMENTS: LIABILITIES									
I – Financial liabilities at fair value	**0**	**11**	**0**	**0**	**11**	**0**	**11**	**0**	**11**
Loan hedging instruments		5			**5**		5		**5**
Exchange rate hedging instruments		6			**6**		6		**6**
II – Financial liabilities at amortized cost	**0**	**0**	**2**	**2,173**	**2,175**	**2**	**2,173**	**0**	**2,175**
Bank loans				418	**418**		418		**418**
Commercial paper				105	**105**		105		**105**
USPP loans				480	**480**		480		**480**
Bonds				600	**600**		600		**600**
Other financial liabilities				11	**11**		11		**11**
Bank overdrafts and advances			2		**2**	2			**2**
Accounts payable – Trade				140	**140**		140		**140**
Other liabilities				419	**419**		419		**419**

There were no transfers between the different levels of fair value for assets and liabilities measured using this method.

Note 7.7 Financial risk management

The Group has an exposure to the following risks:

- credit risk;
- liquidity risk;
- market risk;
- equity risk.

Set out below is information on the Group's exposure to each of the above risks, its objectives, policy and procedures for measuring and managing risk, as well as its share capital and equity management.

Quantitative disclosures appear elsewhere in the consolidated financial statements.

The Board of Directors defines and oversees the Group's risk management framework. Monitoring, measuring and overseeing financial risk is the responsibility of the Group's Finance Department, for the Group and each of the Group companies.

The objective of the Group's risk management policy is to identify and analyze the risks that the Group faces, to set appropriate risk limits and controls, and to manage the risks and ensure that the limits defined are respected. The policy and the risk management systems are reviewed regularly so as to respond to changes in the market and in the Group's activities. Through its training and management rules and procedures, the Group aims to develop a rigorous and constructive control environment in which every employee has a clear understanding of his or her role and duties.

The Internal Audit Department performs both periodic and *ad hoc* reviews of risk management controls and procedures, reporting to the Audit and Compliance Committee.

All strategic decisions relating to the hedging policy for financial risks are the responsibility of the Group's Finance Department.

7.7.1 Credit risk

Risk factors

Credit risk is the Group's risk of financial loss in the event that a customer or counterparty to a financial instrument fails to meet his contractual obligations. This risk primarily concerns customer receivables and short-term investments.

The Group's exposure to credit risk is mainly influenced by the individual characteristics of its customers. Sales to the principal customer of the Group account for 7.4% of group revenues. In addition, sales to telecommunications sector customers and internet access providers represent a total of 15.5% of the revenues of our Core Services business. No country accounts for over 10% of customer receivables with the exception of the United States which represented approximately 36% of total customer receivables as of December 31st, 2018.

Risk management

Credit risk is continuously monitored by the Group's Finance Department, through monthly reports and quarterly Executive Committee meetings.

The Group does not require specific credit guarantees for its customer and other receivables.

The Group determines the level of its impairment losses by estimating losses incurred on customer and other receivables.

The Group provides contract performance guarantees at the request of some customers. The guarantees provided are disclosed in note 9.4 *Guarantees and other contractual obligations*.

7.7.2 Liquidity risk

Risk factors

Liquidity risk is the risk that the Group would experience difficulty in repaying its liabilities at the due date.

Risk management

The policy of the Group in respect of its financing is to maintain at all times sufficient liquidity to finance group assets, short-term cash requirements, and its development, both in terms of amount and duration, and at the lowest possible cost.

Over recent years, the Group has implemented a centralized cash management policy when in conformity with local legislation applying to its subsidiaries. Cash pool member companies represent over 65% of group revenues.

In those countries where cash-pooling is not permitted, short-term cash management is provided by subsidiaries' operational management which generally has access to short-term bank facilities, plus, in some cases, confirmed credit line facilities from the parent company.

All medium- and long-term financing operations are authorized and overseen by the Group's Finance Department.

The Group obtains its financing in the form of loans, credit lines and bond issues with high-grade financial institutions, with maturities ranging from 2019 through 2026 as disclosed in note 7.4 *Financial liabilities*.

As of December 31st, 2018, the unutilized balances on outstanding facilities represented €300 million on the multicurrency (€, US$) syndicated facility and €200 million on the credit lines negotiated with a number of banks.

Net debt at December 31st, 2018 was €2,100.7 million, compared with €1,326.3 million at the end of 2017.

Given the maturities of our borrowings and the Group's capacity to generate free cash flow, liquidity risk is considered to be low.

Additional disclosures relating to liquidity risk are set out in note 7.4 *Financial liabilities*.

7.7.3 Market risk

Market risk is the risk that changes in market prices, such as foreign exchange rates, interest rates and the cost of equity instruments, will affect the Group's results or the value of its financial instruments. The objective of managing market risk is to manage and control the market risk exposure, keeping it within acceptable limits, while optimizing returns.

Foreign exchange risk

Risk factors

The Group is exposed in particular to foreign exchange risk on revenues and expenditure denominated in a currency, generally the US dollar, which is not the functional currency of the group company concerned.

Risk management

The Group hedges this risk in respect of revenues and expenditure mainly for rate movements between the Mexican, Philippines and Colombian pesos, the Indian rupee and the US dollar. Additional disclosures on these hedging operations are given in note 7.5 *Foreign exchange and interest rate hedging operations*.

The Group is also exposed to exchange risk on loans denominated in currencies other than the euro or the functional currencies of group entities.

Group policy is as follows:

- the Group hedges loans made to subsidiaries with loans or advances in the same currency and with the same maturities, or with foreign exchange contracts;
- the principal bank loans of group companies are denominated in the functional currency of the borrower;
- interest due on borrowings is denominated in the same currency as the cash flows generated by the underlying operations of the Group, primarily the euro, the US dollar and the pound sterling. This provides an economic hedge without resorting to the use of derivatives.

Finally, the Group is exposed to foreign exchange risk when translating foreign subsidiaries' financial statements for consolidation purposes.

The translation effect on the consolidated revenues of the Group is disclosed in note 7.8 *Exposure to exchange risk from translation of the financial statements of foreign subsidiaries on consolidation* which shows the breakdown of revenues by currency over the last two years.

The impact of changing foreign exchange rates on the Group's revenues, profit before tax and net profit – Group share is disclosed in note 7.8 *Exposure to exchange risk from translation of the financial statements of foreign subsidiaries on consolidation*.

Interest rate risk

See note 7.4 *Financial liabilities*.

7.7.4 Equity risk

Risk factors and management

The Group limits its exposure to equity risk by investing available cash reserves in short-term liquid investments, certificates of deposit, and in low risk financial instruments such as mutual funds, while choosing high-grade financial institutions and avoiding significant concentration. Group management does not expect any counterparty to default.

Short-term liquid investments at December 31st, 2018 amounted to €35.7 million, principally represented by money market or mutual funds.

Share capital and equity management

The Group's policy on share capital and equity management is to maintain a strong equity base so as to keep the confidence of investors, creditors and the market, and to support future business development. The Group therefore pays close attention to its net indebtedness and the debt/equity ratio.

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The gearing ratio is determined as follows:

(in millions of euros)	12/31/2018	12/31/2017
Net debt	2,101	1,326
Equity	2,225	1,922
GEARING RATIO	**0.94**	**0.69**

From time to time, the Group may buy back its own shares on the market. On March 30th, 2018, Teleperformance SE and Kepler Chevreux concluded a new liquidity agreement, taking effect from April 13th, 2018, which complies with the Code of Conduct established by the AMAFI (French Association of Financial markets) and current regulations.

This agreement replaced that signed with Oddo Corporate Finance on January 8th, 2007. The amount of funds committed to this arrangement is €5.6 million. The number of treasury shares held at the end of the year is set out in note 6.1 *Share Capital*.

Note 7.8 Exposure to exchange risk from translation of the financial statements of foreign subsidiaries on consolidation

In order to indicate the exposure of the Group to exchange risk from translation of the financial statements of foreign subsidiaries on consolidation, an analysis of group revenues by principal currency in 2018 and 2017 is set out in the following schedule:

(in millions of euros)	2018		2017	
Revenues	**Amount**	**%**	**Amount**	**%**
Euro	1,071	24.1%	919	22,0%
US dollar	1,843	41.5%	1,888	45.2%
Indian rupee	134	3.0%	26	0.6%
Brazilian real	210	4.7%	243	5.8%
Mexican peso	101	2.3%	95	2.3%
Pound sterling	288	6.5%	293	7.0%
Colombian peso	165	3.7%	165	3.9%
Yuan	117	2.6%	96	2.3%
Other	512	11.5%	455	10.9%
TOTAL	**4,441**	**100%**	**4,180**	**100%**

Sensitivity of profit before tax and equity to a change of 1% in the exchange rate of the euro against other currencies

The Group estimates that an increase or decrease of 1% in the exchange rate of the euro against other currencies would have impacted 2018 profit before tax and equity by approximately €3.3 million and €22.0 million, respectively.

Effect of changes in exchange rates

The effect of changes in exchange rates on statement of income line items is as follows:

(in millions of euros)	2018	2017 at 2018 rates	2017
Revenues	4,441	3,972	4,180
Operating profit	485	333	355
Financial result	-50	-44	-50
NET PROFIT	**313**	**298**	**314**
Net profit – Group share	312	295	312

At December 31st, 2018, the Group's exposure to exchange risk may be summarized as follows:

	12/31/2018				12/31/2017			
(in millions of euros)	**Assets**	**Liabilities**	**Net position before hedging**	**Net position after hedging**	**Assets**	**Liabilities**	**Net position before hedging**	**Net position after hedging**
Euro	730	2,734	-2,004	-2,003	626	1,876	-1,250	-1,250
US dollar	2,929	410	2,519	2,527	2,844	401	2,443	2,441
Indian rupee	1,190	222	968	968	54	23	31	31
Brazilian real	101	35	66	66	114	37	77	77
Mexican peso	143	28	115	116	127	19	108	107
Pound sterling	159	36	123	134	176	37	139	139
Colombian peso	108	25	83	80	98	27	71	71
Philippines peso	90	41	49	55	102	41	61	63
Other	405	123	282	282	340	96	244	243
TOTAL	**5,855**	**3,654**	**2,201**	**2,225**	**4,481**	**2,557**	**1,924**	**1,922**

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Note 7.9 Foreign currency exchange rates

Principal currencies	Country	Average 2018 rate	Closing rate at 12/31/2018	Average 2017 rate	Closing rate at 12/31/2017
EUROPE					
Pound sterling	United Kingdom	0.88	0.90	0.88	0.89
AMERICAS AND ASIA					
Brazilian real	Brazil	4.31	4.44	3.60	3.97
Colombian peso	Colombia	3,488.00	3,722.00	3,332.00	3,577.00
US dollar	United States	1.18	1.15	1.13	1.20
Indian rupee	India	80.85	79.73	73.50	76.61
Mexican peso	Mexico	22.73	22.49	21.33	23.66
Philippine peso	Philippines	62.41	60.11	56.94	59.80

The statement of income of Intelenet was consolidated for the period from October 1st to December 31st, 2018 at an average rate of 82.241 Indian rupees = €1; the rate used for the translation of the opening statement of financial position was 83.916 Indian rupees = €1.

Note 8 Cash flows

Note 8.1 Non-cash items of income and expense

(in millions of euros)	2018	2017
Depreciation and amortization	247	251
Impairment loss on goodwill		67
Increase in provisions, net of releases	-1	22
Unrealized gains and losses on financial instruments	-4	1
Share-based payments	21	22
TOTAL	**263**	**363**

Note 8.2 Change in working capital requirements

(in millions of euros)	2018	2017
Accounts receivable – Trade	-70	-109
Accounts payable – Trade	40	37
Other	-19	14
TOTAL	**-49**	**-58**

The increases in Accounts receivable – Trade and Accounts payable – Trade are principally due to the increase in the level of activity.

Note 8.3 Acquisition of subsidiaries, net of cash acquired

This principally concerns the acquisition of Intelenet (see the disclosures in note 2.2 *Change in consolidation scope*).

The Group carried out this acquisition in October 2018 for an amount of €793.6 million. Intelenet had cash resources of €35.3 million, resulting in a net cash outflow of €758.3 million.

Note 8.4 Explanation of the change in net debt in 2018

(In millions of euros)

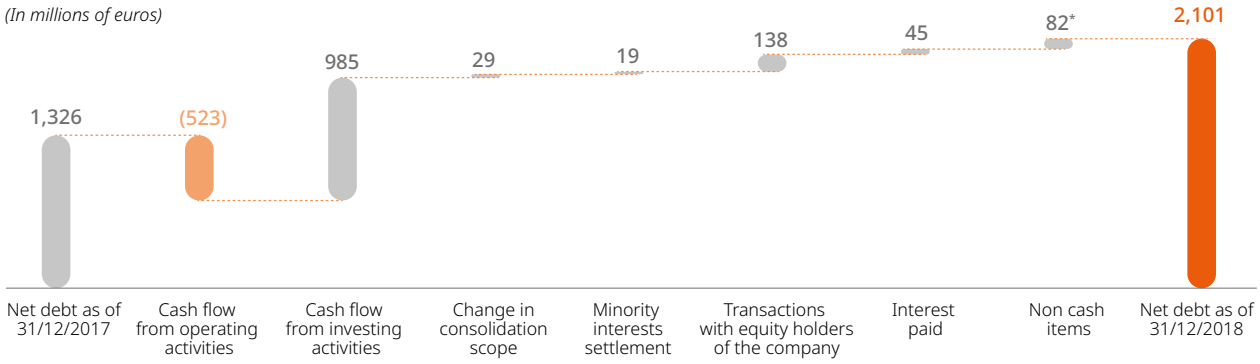

** Including effect of exchange rate € 92 million.*

Transactions with equity holders represent dividend payments of €112 million and net purchases of treasury shares, for €31 million.

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Note 8.5 Analysis of cash and cash equivalents presented in the consolidated statement of cash flows

(in millions of euros)	2018	2017
Bank overdrafts and advances	-3	-2
Marketable securities	36	32
Cash and bank	300	253
CASH AND CASH EQUIVALENTS/NET CASH	**333**	**283**

Note 9 Provisions, litigation, commitments and other contractual obligations

Note 9.1 Accounting policies and methods

A provision is recognized in the statement of financial position when the Group has a present legal or constructive obligation resulting from a past event, the obligation can be reliably estimated and it is probable that an outflow of economic benefits will be required to settle the obligation. The amount of the provision represents management's best estimate of the outflow required, and is discounted when the time value effect is significant.

Provisions relating to post-employment benefits, in particular defined benefit plans which represent most of the Group's provisions for future expenses, are recognized as follows.

The net obligation of the Group is calculated separately for each plan by estimating the amount of future benefits that employees have earned in return for services rendered as of the reporting date. This amount is discounted to determine its present value, and the fair value of any plan assets is deducted. The discount rate is the yield at the reporting date on AA credit-rated bonds that have maturity dates approximating to the terms of the Group's obligations. The obligations are measured using the projected unit credit method.

Actuarial gains and losses are recognized as Other recognized income and expenses in comprehensive income.

Note 9.2 Change in provisions

(in millions of euros)	12/31/2017	Increases	Releases utilized	Releases unutilized	Translation differences	Other	12/31/2018
NON-CURRENT							
Retirement benefits	14	3		-1		5	21
Other expenses	1						1
Total	**15**	**3**	**0**	**-1**	**0**	**5**	**22**
CURRENT							
Risks	33	10	-4	-1		42	80
Other expenses	19	1	-8	-2			10
Total	**52**	**11**	**-12**	**-3**	**0**	**42**	**90**
TOTAL	**67**	**14**	**-12**	**-4**	**0**	**47**	**112**

(in millions of euros)	12/31/2016	Increases	Releases utilized	Releases unutilized	Translation differences	Other	12/31/2017
NON-CURRENT							
Retirement benefits	12	3			-1		14
Other expenses	1						1
Total	**13**	**3**	**0**	**0**	**-1**	**0**	**15**
CURRENT							
Risks	37	10	-8	-2	-4		33
Other expenses	2	17					19
Total	**39**	**27**	**-8**	**-2**	**-4**	**0**	**52**
TOTAL	**52**	**30**	**-8**	**-2**	**-5**	**0**	**67**

Provisions for risks at December 31st, 2018 include:

- a contingent liability of €37.6 million in respect of tax risks identified during the Intelenet acquisition;
- a contingent liability of €10.0 million (US$11.5 million) in respect of risks identified during the Aegis USA Inc. acquisition process in 2014, including tax risks of €9.5 million. An equivalent asset of €9.5 million has been recognized, as these risks are covered by a contractual net asset warranty.

Provisions for risks also include other risks in a total amount of €32.6 million, of which €14.8 million relates to personnel-related risks, principally concerning lawsuits with former employees, particularly in Argentina, Brazil, USA and France.

The provisions for other expenses at December 31st, 2018 include principally the balance of the provision set up in 2017 for the restructuring of the French business.

As legal proceedings are ongoing for most of these disputes, their settlement date is uncertain.

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Note 9.3 Post-employment benefits: defined benefit plans

These principally concern:

- the lump-sum payments made to employees on their retirement under the provisions of French national wage agreements and labor law;
- defined benefit pension plans in Norway, Greece, India, the Philippines, El Salvador and certain Mexican entities.

Commitments related to the lump-sum benefits in France are measured with the following actuarial assumptions:

	2018	2017
Discount rate	1.57%	1.29%
Rate of annual increase in remuneration	1.5%/2.5%	1.5%/2.5%
Rate of employer social charges	38%/45%	38%/45%

The other commitments are individually not significant and are measured by actuaries taking into account local conditions.

Change in the actuarial liability in 2018

(in millions of euros)	France	Other countries	Total
At December 31st, 2016	**7**	**5**	**12**
In 2017 profit or loss	1	2	3
In other comprehensive income	-1	1	0
Translation differences		-1	-1
At December 31st, 2017	**7**	**7**	**14**
In 2018 profit or loss		3	3
In other comprehensive income	-1		-1
Translation differences			0
Change in consolidation scope*		5	5
At December 31st, 2018	**6**	**15**	**21**

* *Related to the acquisition of Intelenet in October 2018.*

The liability at December 31st, 2018 presented as Other countries principally concerns our subsidiaries in India, Greece, the Philippines and El Salvador, for amounts of €5.7 million, €2.0 million, €2.0 million and €1.9 million, respectively.

The amount of the liability in the consolidated statement of financial position, representing the benefit obligation less the fair value of plan assets was:

- €9.8 million at December 31st, 2014;
- €9.8 million at December 31st, 2015;
- €12.1 million at December 31st, 2016;
- €14.4 million at December 31st, 2017;
- €20.9 million at December 31st, 2018.

Analysis of plan assets

	2018	2017
Actuarial liability	**24**	**18**
Equities	12.1%	10.9%
Bonds	12.5%	13.2%
Money market	11.0%	14.0%
Held to maturity bonds	29.4%	27.2%
Loans & Receivables	25.2%	23.3%
Real estate	9.1%	10.0%
Other	0.7%	1.4%
Plan assets	**3**	**4**
Provision in the statement of financial position	**21**	**14**

Company officers represent an amount of €0.2 million in the provision for retirement benefits at December 31st, 2018.

Note 9.4 Guarantees and other contractual obligations

Guarantee commitments

Teleperformance SE issued a performance guarantee in November 2013 to the Secretary of State for the Home Department of the United Kingdom covering the duration of a commercial contract entered into with a Group subsidiary. The maximum amount covered by the guarantee is £60 million.

Teleperformance SE has issued a performance guarantee in December 2013 to Apple Inc. relating to the obligations of certain subsidiaries undertaken in respect of a commercial contract. The guarantee was given for the duration of the commercial contract. The maximum amount covered by the guarantee is the greater of (i) US$60 million and (ii) the total amount of sums paid by Apple to the subsidiaries concerned during the calendar year preceding the date of the loss event.

In October 2017, Teleperformance Europe Middle-East and Africa SAS, a subsidiary of Teleperformance SE, issued a comfort letter in favor of Klarna in connection with a new commercial agreement entering into effect from January 1st, 2018 covering services to be supplied by it and subsidiaries of Teleperformance SE in Sweden, Finland, Denmark, Germany, the Netherlands, Norway, the United Kingdom and Austria.

Teleperformance SE has issued a performance guarantee to Barclays Bank PLC with respect to the obligations of its subsidiary TP Portugal under a commercial contract. The guarantee was signed in 2014 and will remain in force for the duration of the contract.

In July 2017, Teleperformance Portugal SA, a subsidiary of Teleperformance SE, entered into a promissory lease agreement concerning office premises under construction. In this context, guarantees have been issued by Teleperformance SE and its subsidiary, under the form of a joint and several guarantee for a total amount limited to €42 million and for the duration stated in the agreement.

In 2017, Teleperformance SE has issued a comfort letters in favor of Canon, a partner with which Ypiseria 800-Teleperformance A.E., a subsidiary of Teleperformance SE, has entered into a new commercial relationship.

Net asset warranties received in connection with the acquisition of shareholdings

The agreements entered into for the acquisitions of Aegis USA Inc., City Park Technologies, LanguageLine Holding LLC and Wibilong SAS contain net asset warranties intended to indemnify the acquirer against any prior existing liabilities that were not disclosed at the time of the acquisitions.

The duration of each commitment is generally between twelve months and three years from the date of completion of the acquisitions except in certain cases for tax-related liabilities for which the duration of the commitments corresponds to the date of prescription of each potential liability.

These commitments are guaranteed by either:

- certain amounts held by a bank in escrow, to be released in full after one, two or three years from the date of acquisition, as applicable, in the absence of any request for indemnification; or
- a first demand guarantee issued by a high-grade bank, expiring after 18 months from the date of acquisition, as applicable, in the absence of any request for indemnification; or
- representations and warranty insurance covering certain of the warranties for either three or six years after the date of acquisition, depending on the nature of the warranty.

Assets secured against financial liabilities

There were no group assets pledged as collateral for borrowings at the end of 2018.

Maturity of contractual obligations recognized in the statement of financial position

(in millions of euros)	Total 12/31/2018	Under 6 months	6 – 12 months	Total 2019	2020 to 2023	After
Bank loans	448		66	66	382	
Commercial paper	134	134		134		
USPP loans	502			0	205	297
Bonds	1,350			0		1,350
Bank overdrafts and advances	3	3		3		
Other loans and financial liabilities	18	17		17	1	

(in millions of euros)	Total 12/31/2018	Under 6 months	6 – 12 months	Total 2018	2019 to 2022	After
Bank loans	418	2	104	106	312	
Commercial paper	105	105		105		
USPP loans	480			0	134	346
Bonds	600			0		600
Bank overdrafts and advances	2	2		2		
Other loans and financial liabilities	11	10		10	1	

Maturity of operating lease obligations (not recognized in the statement of financial position)

(in millions of euros)	Total 12/31/2018	Under 6 months	6 – 12 months	Total 2019	2020	2021	2022	2023	After
Operating leases	847	98	94	192	164	129	100	76	186

(in millions of euros)	Total 12/31/2017	Under 6 months	6 – 12 months	Total 2018	2019	2020	2021	2022	After
Operating leases	597	74	74	148	125	103	72	54	95

The commitments represent future real estate lease payments as stipulated in each lease agreement over the shorter of the lease term or the minimum term at the end of which the lease may be terminated without penalty.

The increase in commitments is principally due to the consolidation of Intelenet, for €71.7 million; the remainder represents new lease agreements and renewals, net of lease payments made in 2018.

Note 9.5 Litigation

As a result of the normal course of business, Teleperformance and its subsidiaries are party to a number of judicial, administrative or arbitration proceedings. The risk of loss from such proceedings is provided for when the loss is probable and can be reliably quantified. Amounts provided at December 31st, 2018 total €28.5 million.

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Note 10 Related party disclosures

Note 10.1 Principal related party transactions

During the first half of 2018, minority interests in a group entity were acquired for a total consideration of €14.0 million, of which €0.9 million concerned a senior executive, a company officer of the group. The purchase price was determined on the basis of a report prepared by an independent appraiser.

The group is not aware of any other significant operations undertaken with related parties during 2018.

Note 10.2 Remuneration of company officers (Executive Committee – Comex)

Remuneration of company officers in respect of the 2018 and 2017 financial years is summarized as follows:

(in millions of euros) **Remuneration**	**2018**	**2017**
Short-term benefits	14	18
Contract termination payments		9
TOTAL	**14**	**27**

The Group has obtained non-compete agreements from certain senior management personnel. In respect of the two principal company officers, the length of the commitments are as follows:

- Mr. Daniel Julien: a period of two years, for which he would be entitled to receive an amount representing two years' remuneration subject to his respecting a nine-month notice period;
- Mr. Olivier Rigaudy: a period of one year, for which he would be entitled to receive an amount representing one year's' remuneration.

Note 11 Audit fees of the statutory auditors of Teleperformance SE (excluding those paid to members of their international networks)

The audit fees of the statutory auditors of Teleperformance SE in respect of the 2018 financial year are analyzed as follows:

	KPMG		**Deloitte & Associés**	
(in thousands of euros)	**Audit certification**	**Services other than audit certification[1]**	**Audit certification**	**Services other than audit certification[2]**
Issuer	524	931	308	165
Fully consolidated subsidiaries	101		127	
TOTAL	**625**	**931**	**435**	**165**

(1) Nature of non-audit services rendered by KPMG to the parent company and its subsidiaries: a due diligence engagement in connection with the acquisition of Intelenet, comfort letter in connection with a bond issue, engagements for the verification of the existence and the fairness of certain personnel, environmental or societal information to be submitted to independent third party entities, attestations issued in respect of compliance with financial covenants.

(2) Nature of non-audit services rendered by Deloitte & Associés to the parent company and its subsidiaries: comfort letter, due diligence engagement, attestation of certain financial information, attestation issued in respect of compliance with financial covenants.

Note 12 Events after the reporting date

None.

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Note 13 List of consolidated companies

		% interest	% control
Parent company	Teleperformance SE	100	100
CORE SERVICES			
Continental Europe & MEA			
Albania	Albania Marketing Service ShpK	100	100
	CC Albania Sh.p.K.	100	100
	Service 800 Albania Sh.p.K	100	100
Bosnia-Herzegovina	Teleperformance B-H d.o.o.	100	100
Czech Republic	Lion Teleservices CZ, a. s.	100	100
Denmark	Teleperformance Denmark A/S	100	100
Egypt	Service 800 Egypt for Communication (Teleperformance) SAE	96	96
Finland	Teleperformance Finland OY	100	100
France	Teleperformance Europe Middle East and Africa	100	100
	Teleperformance France	100	100
	Teleperformance Intermediation	100	100
Germany	Teleperformance Germany at Home Solutions GmbH	100	100
	Teleperformance Germany Financial Services GmbH	100	100
	Teleperformance Germany S.a.r.l & Co.KG	100	100
	Teleperformance Support Services GmbH	100	100
Greece	Customer Value Management (CVM)	100	100
	Direct Response Service SA	100	100
	Mantel SA	100	100
	Ypiresia 800 Teleperformance AE	100	100
Italy	In & Out S.p.A.	100	100
Kosovo	twenty4help Kosovo sh.p.k.	100	100
Lebanon	Teleperformance Lebanon S.A.L.	100	100
Lithuania	UAB Teleperformance LT	100	100
Luxembourg	Telepeformance Germany Sarl	100	100
Madagascar	Teleperformance Madagascar	99	99
Morocco	Société Anonyme Marocaine d'Assistance Client S.A	100	100
Netherlands	PerfectCall BV	100	100
	PerfectCall Financial Services BV	100	100
Norway	Teleperformance Norge AS	100	100
Poland	Teleperformance Polska Sp.zo.o.	100	100
	TPG Katowice Sp.zo.o.	100	100
Romania	S 800 Customer Service Provider SRL	100	100
	Service 800 contact center – Agent de Asigurare SRL	100	100
	The Customer Management Company SRL	100	100
Russia	Direct Star LLC	100	100
Slovakia	Lion Teleservices SK, spol. s r.o.	100	100
Sweden	Teleperformance Nordic AB	100	100
Switzerland	SCMG AG	100	100
Tunisia	Société Méditerranéenne de Teleservices	100	100
	Société Tunisienne de Telemarketing	100	100
Turkey	Metis Bilgisayar Sistemliri Sanayi ve Ticaret A.S	100	100
Ukraine	Limited Liability Company "KCU"	100	100

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		% interest	% control
English-speaking & APAC			
Australia	Teleperformance Australia Pty Ltd	100	100
Canada	MMCC Solutions Canada company	100	100
China	Beijing Interactive CRM Technology Service Limited	85	100
	Guangdong North Asia United CRM Technologies Limited	85	100
	Nanning North Asia United CRM Technologies Co., Ltd	85	100
	North Asia United CRM Technologies (Beijing), Ltd	85	100
	North Asia United CRM Technologies (Xian), Ltd	85	100
	Teleperformance Information Technologies (Kunming) Co., Ltd	85	100
Hong Kong	Hong Kong Asia CRM Limited	85	85
India	CRM Services India Private Limited	100	100
Indonesia	P.T. Telemarketing Indonesia	100	100
Malaysia	Teleperformance Malaysia SDN.BHD	100	100
Philippines	E-Konflux Solutions Inc.	100	100
	Telephilippines Inc.	100	100
	TPPH – CRM Inc.	100	100
	TPPH – FHCS Inc.	100	100
Singapore	Telemarketing Asia (Singapore) PTE Ltd	100	100
South Africa	TP South Africa Trading (PTY) Ltd	100	100
United Kingdom	MM Group Ireland Limited	100	100
	Teleperformance Holdings Limited	100	100
	Teleperformance Limited	100	100
USA	Teleperformance Delaware, Inc.	100	100
	TP USA – FHCS, Inc.	100	100
	TP USA, Inc.	100	100
	Merkafon Management Corporation	100	100
Ibero-LATAM			
Argentina	Citytech SA	100	100
Brazil	SPCC – Sao Paulo Contact Center Ltda	100	100
	Teleperformance CRM SA	100	100
Chile	TP Chile S.A	100	100
Colombia	Teleperformance Colombia SAS	100	100
Costa Rica	Costa Rica Contact Center CRCC S.A	100	100
El Salvador	Compania Salvadoreña de Teleservices, SACV	100	100
Guyana	Guyana Call Center Inc.	100	100
Mexico	Hispanic Teleservices Corporation (HTC)	100	100
	Hispanic Teleservices de Guadalajara, S.A. DE C.V.	100	100
	Impulsora Corporativa Internacional, S.A. DE C.V.	100	100
	Merkafon de Mexico, S.A. DE C.V.	100	100
	Merkafon International, Ltd	100	100
	Servicios Hispanic Teleservices, S.C.	100	100
	TP Nearshore, S. DE R.L. de C.V.	100	100
Peru	Teleperformance Peru S.A.C.	100	100
Portugal	Teleperformance Portugal, S.A.	100	100
Spain	Teleperformance Espana SAU	100	100
	Teleperformance Mediacion de Agencia de Seguros, S.L	100	100
	Teleperformance Servicios Auxiliares, S.L.U	100	100
	twenty4Help Knowledge Service Espana S.L	100	100

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		% interest	% control
SPECIALIZED SERVICES			
TLSContact			
Albania	TLScontact Albania Sp.h.k	100	100
Algeria	SARL TLS Contact	100	100
Armenia	TLScontact AM Limited Liability Company	100	100
Azerbaijan	TLScontact Azerbaijan LLC	100	100
Belarus	Unitary Enterprise Providing Services "TLSContact"	100	100
China	Beijing TLScontact Consulting Co, Ltd	100	100
Egypt	TLScontact Egypt	100	100
France	TLScontact Algérie	100	100
	TLScontact France	100	100
Gabon	TLScontact Gabon	100	100
Georgia	TLScontact Georgia LLC	100	100
Germany	TLScontact Deutschland GmbH	100	100
Hong Kong	TLScontact Limited	100	100
Indonesia	PT. TLScontact Indonesia	100	100
Ireland	TLScontact (Ireland) Ltd	100	100
Italy	TLScontact Italia S.R.L	100	100
Kazakhstan	TLScontact Kazakhstan Limited Liability Partnership	100	100
Kenya	TeleContact Limited	100	100
Kosovo	TLScontact Kosovo	100	100
Lebanon	TLScontact Lebanon SARL	100	100
Luxembourg	TLS Group SA	100	100
Madagascar	TLScontact Madagascar	100	100
Mauritius	TLScontact (Mau) Ltd	100	100
Mongolia	TLScontact Mongolia	100	100
Montenegro	LLC «TLScontact » d.o.o. Podgorica	100	100
Morocco	TLScontact Maroc SARLAU	100	100
Netherlands	TLScontact Netherlands B.V.	100	100
Nigeria	TLScontact Processing Services Limited	100	100
Philippines	TLScontact Philippines Corporation	100	100
Russia	LLC TLScontact (RU)	100	100
Serbia	TLScontact doo Beograd-Stari Grad	100	100
Sierra Leone	TLScontact (SL) Ltd	100	100
South Africa	TLScontact South Africa (PTY) Ltd	100	100
Spain	TLScontact Espana SL	100	100
Switzerland	TLScontact Switzerland GmbH	100	100
Tanzania	TLScontact (Tanzania) Ltd	100	100
Thailand	TLScontact Enterprises (Thailand) Co., Ltd	100	100
	TLScontact International Co., Ltd	100	100
Tunisia	Société Tunisienne d'assistance et de services (STAS)	100	100
	TLScontact Tunisie	100	100
Turkey	TLS Danismanlik HVTLS	100	100
Uganda	TLS Contact Limited	100	100
Ukraine	TLScontact Ukraine Limited Liability Company	100	100
United Kingdom	Application Facilitation Services Limited	100	100
	Teleperformance Contact Limited	100	100
	TLScontact (UK) Limited	100	100
Uzbekistan	TLS Contact Limited Liability Company	100	100
Vietnam	TLSContact Vietnam Company Limited	100	100

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		% interest	% control
Praxidia			
France	Praxidia	100	100
Italy	Praxidia S.p.A	100	100
Luxembourg	Praxidia SA	100	100
Netherlands	Praxidia BV	100	100
United Kingdom	Praxidia Services Limited UK	100	100
USA	Praxidia US Inc.	100	100
AllianceOne Receivables Management			
Canada	AllianceOne Limited	100	100
Jamaica	Outsourcing Management International Inc, Ltd	100	100
USA	AllianceOne Incorporated (AllianceOne)	100	100
	AllianceOne Receivables Management, Inc (ARMI)	100	100
LanguageLine Solutions			
United Kingdom	Language Line Services UK Limited	100	100
USA	Language Line holdings II, Inc.	100	100
Wibilong			
France	Wibilong S.A.S	84	84
INTELENET			
Egypt	Intelenet LLC	100	100
Guatemala	Intelenet Lat Am Services SA	100	100
India	Intelenet BPO Holdings Pvt Ltd	100	100
	Intelenet Business Services Ltd	98	98
	Intelenet Global Services Pvt Ltd	100	100
	Tixigo Tourism Services Pvt Ltd	100	100
Jordan	Intelenet Global Services (Jordan) LLC	100	100
Mauritius	Eagle BPO Mauritius	100	100
	Intelenet Global Investment Ltd	100	100
	Snow Holding Company Ltd	100	100
Philippines	Intelenet Global Philippines Inc.	100	100
Poland	Intelenet European Services sp.zo.o.	100	100
Saudi Arabia	Intelenet Saudi Company	100	100
United Arab Emirates	Intelenet Global Business Services LLC	100	100
	Intelenet Global Services FZ-LLC	100	100
United Kingdom	Intelenet BPO UK Ltd	100	100
	Intelenet Global (UK) Ltd	100	100
	Intelenet Global BPO (UK) Ltd	100	100
USA	Intelenet America LLC	100	100
	Intelenet Inc.	100	100
	I-Service Inc.	100	100
	Windfall Investment Company Inc.	100	100
OTHER			
France	Teleperformance Management Services	100	100
Luxembourg	Luxembourg Contact Center S.A.R.L	100	100
Netherlands	Dutch Contact Centers BV	100	100
USA	Teleperformance Group Inc.	100	100

All group companies are fully consolidated.

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5.7 STATUTORY AUDITORS' REPORT ON THE CONSOLIDATED FINANCIAL STATEMENTS

This is a translation into English of the statutory auditors' report on the consolidated financial statements of the Company issued in French and it is provided solely for the convenience of English speaking users.

This statutory auditors' report includes information required by European regulation and French law, such as information about the appointment of the statutory auditors or verification of the management report and other documents provided to shareholders.

This report should be read in conjunction with, and construed in accordance with, French law and professional auditing standards applicable in France.

For the year ended December 31st, 2018

To the annual general meeting of Teleperformance SE,

Opinion

In compliance with the engagement entrusted to us by your annual general meeting, we have audited the accompanying consolidated financial statements of Teleperformance SE for the year ended December 31st, 2018.

In our opinion, the consolidated financial statements give a true and fair view of the assets and liabilities and of the financial position of the Group as at December 31st, 2018 and of the results of its operations for the year then ended in accordance with International Financial Reporting Standards as adopted by the European Union.

The audit opinion expressed above is consistent with our report to the audit and compliance committee.

Basis for Opinion

Audit Framework

We conducted our audit in accordance with professional standards applicable in France. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our responsibilities under those standards are further described in the *Statutory Auditors' Responsibilities for the Audit of the Consolidated Financial Statements* section of our report.

Independence

We conducted our audit engagement in compliance with independence rules applicable to us, for the period from January 1st, 2018 to the date of our report and specifically we did not provide any prohibited non-audit services referred to in Article 5(1) of Regulation (EU) N° 537/2014 or in the French Code of ethics (*Code de déontologie*) for statutory auditors.

Emphasis of Matter

Without qualifying the above opinion, we draw attention to the following matter described in note 1.2.1. *Changes in accounting policies* to the consolidated financial statements, relating to a change in accounting method resulting from the first application of IFRS 15 and IFRS 9 on revenue recognition and financial instruments, respectively.

Justification of Assessments - Key Audit Matters

In accordance with the requirements of Articles L.823-9 and R.823-7 of the French Commercial Code (Code de commerce) relating to the justification of our assessments, we bring your attention to the key audit matters relating to the risk of material misstatement that, in our professional judgment, were of most significance in our audit of the consolidated financial statements of the current period, as well as how we addressed these risks.

These matters were addressed in the context of our audit of the consolidated financial statements as a whole, and in forming our opinion thereon. We do not provide a separate opinion on specific items of the consolidated financial statements.

Impairment of goodwill

(Note 4 to the consolidated financial statements)

Identified risk

As of December 31st, 2018, goodwill is recorded in the Statement of financial position for a net carrying amount of €2,304 million, *i.e.* 39% of total assets.

Goodwill is allocated to cash generating units (CGUs) or groups of CGUs and tested for impairment at least annually. An impairment loss is recognized in the Statement of income whenever the carrying amount of a CGU or group of CGUs to which goodwill is allocated exceeds its recoverable amount.

The recoverable amount of a CGU and group of CGUs is based on its value in use, assessed using the discounted cash flows method. Future cash flows are determined over a five year period. Cash flows for the first three years are based on the three-year plan prepared by CGU management and approved by Group management. Cash flows for the following two years are derived from the three-year plan by applying growth and profit rates considered reasonable for the related CGUs. Depending on the circumstances, the group can limit the use of cash flows to a three-year period. The terminal value is based on the cash flows of the last year and assumes a perpetual growth rate equal to inflation.

Sensitivity analyses are performed by the group by simulating an erosion of the recoverable amount through an increase in the discount rate or a decrease in the EBITA rate (as set out in note 1.5 to the consolidated financial statements) in the terminal value. When a sensitive CGU is identified, further analyses are performed to assess the sensitivity to changes in operational assumptions such as revenue growth.

We considered the impairment of goodwill to be a key audit matter considering the weight of these assets on the consolidated statement of financial position, the importance of management judgment in determining the cash flow assumptions, discount and long-term growth rates and the sensitivity of the recoverable amount to changes in the underlying assumptions.

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Our audit approach

For the significant CGU or group of CGU to which goodwill is allocated or for those presenting a specific risk of impairment that we deemed material, our work consisted in:

- obtaining an understanding of the process by which the impairment tests are performed and assessing the appropriateness of the Group's valuation methodology with the applicable accounting standard;
- reconciling the carrying value of the CGUs or groups of CGUs used for impairment testing purposes with the consolidated financial statements;
- assessing the reasonableness of future cash flows through:
  - an analysis of the appropriateness of the forecast process by comparing actual flows with initial forecasts;
  - a reconciliation of the CGU or group of CGUs budgets and forecasts used to determine the future cash flows with those approved by group management;
- assessing the appropriateness of the long-term growth rates and discount rates used for each CGU or group of CGUs with the assistance of our valuation experts;
- performing our own sensitivity analyses on EBITA rates used in the calculation of terminal values and on discount rates.

Accounting for Intelenet acquisition

(Note 2.2 to the consolidated financial statements)

Identified risk

Teleperformance completed in October 2018 the acquisition of Intelenet, a specialized group providing business services and digital transformation solutions, for an amount of €794 million.

The key attributes of this transaction are detailed in note 2.2. to the consolidated financial statements. As part of this acquisition, the Group recorded a €538 million preliminary goodwill, after recognizing the acquiree's identifiable assets and liabilities. Notably, the Group recorded a €310.8 million intangible asset relating to "customers' relationships" and a €35.7 million liability relating to tax risks.

We consider the accounting for Intelenet acquisition and the appropriateness of the information disclosed in the notes to the consolidated financial statements to be a key audit matter considering the significance of this acquisition and the importance of management's judgments and estimates, especially to identify the acquired assets and liabilities and to determine their relative fair value in accordance with the applicable accounting standard.

Our audit approach

Our work consisted in:

- obtaining an understanding of the processes by which the Group has identified and assessed the fair value of the acquired assets and liabilities and determined the preliminary goodwill amount, with the provision that this assessment will be completed over the coming months as stated in note 2.2. to the consolidated financial statements;
- performing a critical review of the valuation works prepared by independent experts relating to the fair value assessment of the acquired assets and liabilities, particularly with regards to the "customers' relationships" intangible assets valuation;
- assessing with the assistance of our valuation experts the appropriateness of the models and assumptions retained to assess the fair value of the acquired assets and liabilities, particularly the intangible assets valuation methods and the discount rates applied;
- assessing the appropriateness of the information disclosed in note 2.2 to the consolidated accounts.

Specific verifications

As required by law we have also verified in accordance with professional standards applicable in France the information pertaining to the Group presented in the management report of the board of directors.

We have no matters to report as to its fair presentation and its consistency with the consolidated financial statements.

We attest that the consolidated declaration of extra-financial performance report required under Article L.225-102-1 of the French Commercial Code (*Code de commerce*) is included in the Group management report, being specified that, in accordance with the provisions of Article L.823 -10 of this Code, we have not verified the fair presentation of the information contained in this statement or the consistency with the consolidated financial statements and this information must be reported by an independent third party.

Other Legal and Regulatory Requirements

Appointment of the Statutory Auditors

We were appointed as statutory auditors of Teleperformance SE by the annual general meeting held on May 31st, 2011.

As at December 31st, 2018, Deloitte & Associés and KPMG Audit IS were in the twentieth year and thirty-second year of total uninterrupted engagement respectively, which is the twelfth year since securities of the Company were admitted to trading on a regulated market, due to the mergers and acquisitions of audit firms that occurred before our appointment as statutory auditors.

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Responsibilities of Management and Those Charged with Governance for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with International Financial Reporting Standards as adopted by the European Union and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is responsible for assessing the Company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is expected to liquidate the Company or to cease operations.

The audit and compliance committee is responsible for monitoring the financial reporting process and the effectiveness of internal control and risk management systems and where applicable, its internal audit, regarding the accounting and financial reporting procedures.

The consolidated financial statements were approved by the board of directors.

Statutory Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Objectives and audit approach

Our role is to issue a report on the consolidated financial statements. Our objective is to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with professional standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these consolidated financial statements.

As specified in Article L.823-10-1 of the French Commercial Code (*Code de commerce*), our statutory audit does not include assurance on the viability of the Company or the quality of management of the affairs of the Company.

As part of an audit conducted in accordance with professional standards applicable in France, the statutory auditor exercises professional judgment throughout the audit and furthermore:

- identifies and assesses the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, designs and performs audit procedures responsive to those risks, and obtains audit evidence considered to be sufficient and appropriate to provide a basis for his opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtains an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the internal control;
- evaluates the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management in the consolidated financial statements;
- assesses the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Company's ability to continue as a going concern. This assessment is based on the audit evidence obtained up to the date of his audit report. However, future events or conditions may cause the Company to cease to continue as a going concern. If the statutory auditor concludes that a material uncertainty exists, there is a requirement to draw attention in the audit report to the related disclosures in the consolidated financial statements or, if such disclosures are not provided or inadequate, to modify the opinion expressed therein;
- evaluates the overall presentation of the consolidated financial statements and assesses whether these statements represent the underlying transactions and events in a manner that achieves fair presentation;
- obtains sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the consolidated financial statements. The statutory auditor is responsible for the direction, supervision and performance of the audit of the consolidated financial statements and for the opinion expressed on these consolidated financial statements.

Report to the audit and compliance committee

We submit a report to the audit and compliance committee which includes in particular a description of the scope of the audit and the audit program implemented, as well as the results of our audit. We also report, if any, significant deficiencies in internal control regarding the accounting and financial reporting procedures that we have identified.

Our report to the audit and compliance committee includes the risks of material misstatement that, in our professional judgment, were of most significance in the audit of the consolidated financial statements of the current period and which are therefore the key audit matters, that we are required to describe in this audit report.

We also provide the audit and compliance committee with the declaration provided for in Article 6 of Regulation (EU) N° 537/2014, confirming our independence within the meaning of the rules applicable in France, such as they are set in particular by Articles L.822-10 to L.822-14 of the French Commercial Code (*Code de commerce*) and in the French Code of Ethics (*Code de déontologie*) for statutory auditors. Where appropriate, we discuss with the audit and compliance committee the risks that may reasonably be thought to bear on our independence, and the related safeguards.

Paris La Défense, February 28th, 2019
The statutory auditors

French original signed by

KPMG AUDIT IS

Jacques Pierre
Partner

Deloitte & Associés

Philippe Battisti Ariane Bucaille
Partners

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6 Parent company financial statements

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6.1 BALANCE SHEET – ASSETS, AT DECEMBER 31

		2018			2017
(in thousands of euros)	Notes	Cost	Acc. depn., amort. and provisions	Net	Net
Intangible fixed assets	2	4,000	3,875	125	186
Tangible fixed assets	2	5,371	3,507	1,864	1,879
Financial fixed assets					
Investments in subsidiaries and affiliates	3.1	2,915,736	224,316	2,691,420	1,724,531
Receivables from subsidiaries and affiliates	3.2	1,099,588	380	1,099,208	1,187,670
Other		381		381	381
Total financial fixed assets		4,015,705	224,696	3,791,009	2,912,582
Total fixed assets		**4,025,076**	**232,078**	**3,792,998**	**2,914,647**
Advances paid		29		29	
Accounts receivable – Trade	6	20,050		20,050	14,452
Other receivables	6 and 7	89,449	1,638	87,811	84,841
Marketable securities	4	9,930		9,930	5,254
Derivative financial instruments – positive fair values	5	22,623		22,623	26,413
Cash and bank		114,961		114,961	87,463
Prepaid expenses	6	34,124		34,124	9,767
Total current assets		**291,166**	**1,638**	**289,528**	**228,190**
Bond redemption premiums		8,925		8,925	3,171
Unrealized exchange losses	12	48,857		48,857	75,242
TOTAL ASSETS		**4,374,024**	**233,716**	**4,140,308**	**3,221,250**

6.2 BALANCE SHEET – SHAREHOLDERS' EQUITY AND LIABILITIES, AT DECEMBER 31

(in thousands of euros)	Notes	2018	2017
Share capital	8	144,450	144,450
Issue, merger and contribution premiums		575,727	575,727
Legal reserve		14,445	14,445
Other reserves		69,333	86,884
Retained earnings		41	18,001
Net income for the period		190,345	71,341
Regulated provisions		43	6
Total shareholders' equity	**8**	**994,384**	**910,854**
Provisions for contingencies and expenses	**9**	**10,168**	**5,257**
Bonds	10.1	1,363,884	606,700
Loans from financial institutions	10.1	953,404	898,930
Other loans and financial liabilities	10.2	571,271	542,156
Total financial liabilities		**2,888,559**	**2,047,786**
Advances received		11	9
Accounts payable – Trade	11	49,972	23,482
Tax, personnel and social security liabilities	11	12,952	13,652
Other liabilities	11	98,224	107,714
Derivative financial instruments – negative fair values	11	7,933	23,346
Deferred income	11	16,918	5,192
Total liabilities*		**3,074,569**	**2,221,181**
Unrealized exchange gains	12	61,187	83,958
TOTAL SHAREHOLDERS' EQUITY AND LIABILITIES		**4,140,308**	**3,221,250**
* *Amount due in more than one year.*		*2,397,945*	*1,665,830*

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6.3 INCOME STATEMENT, YEAR ENDED DECEMBER 31

(in thousands of euros)	Notes	2018	2017
Revenues	15.1	108,050	106,964
Release of depreciation, amortization and provisions			458
Other income		2,268	14
Total operating income		**110,318**	**107,436**
Purchases and external expenses	15.2	76,292	45,584
Taxes other than income taxes		1,184	1,494
Wages and social charges		10,260	8,200
Depreciation, amortization and increase in provisions		564	752
Other expenses		1,889	723
Total operating expenses		**90,189**	**56,753**
Net income from operations	15	**20,129**	**50,683**
Net income from investments in subsidiaries and affiliates		116,395	37,921
Interest income from loans		70,425	66,630
Other interest and related income		14,250	8,424
Foreign exchange gains		92,647	115,845
Release of provisions and transferred expenses		52,762	49,884
Total financial income *		**346,479**	**278,704**
Amortization and increase in provisions		8,167	72,794
Interest and related expenses		70,057	62,643
Foreign exchange losses		87,784	98,513
Total financial expenses**		**166,008**	**233,950**
Net financial income	**16**	**180,471**	**44,754**
Profit on ordinary activities before income taxes		**200,600**	**95,437**
Net amount of:			
• capital gains/(losses) on disposal of fixed assets		1	-134
• other non-operating income and expenses		-2,491	457
Exceptional result	**17**	**-2,490**	**323**
Income taxes	18.2	7,765	24,419
NET INCOME		**190,345**	**71,341**
* *Including income from group companies.*		*238,524*	*151,767*
** *Including expenses from group companies.*		*14,356*	*82,103*

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6.4 NOTES TO THE PARENT COMPANY FINANCIAL STATEMENTS

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Note 1 Accounting principles, rules and methods

The parent company financial statements are based on information available at the time of preparation and are presented in compliance with the principles and methods of the revised general chart of accounts in force since October 16th, 2014 and of ANC regulation n°2014-03 revised, in compliance with the principles of matching and prudence, and using the going concern basis.

Recognition of assets and liabilities, and income and expenses in the financial statements is made on the basis of historical costs.

Note 1.1 Highlights of the financial year

Teleperformance has issued bonds in the amount of €750 million in order to finance the acquisition of Intelenet (an international leader in the field of Business Process Solutions) through its Dutch subsidiary DCC. The bonds bear a coupon of 1.875% and mature on July 2nd, 2025. Teleperformance has also obtained a loan of €164 million from Natixis, repayable in four equal installments on July 8th, 2020, 2021, 2022 and 2023.

DCC is held by LCC, a directly owned subsidiary of Teleperformance, and the financing of the Intelenet acquisition was structured by way of a loan of €890 million of which €848 million was subsequently incorporated in share capital.

Note 1.2 Investments in subsidiaries and affiliates

Investments in subsidiaries and affiliates are recognized at acquisition cost, including transaction costs.

Teleperformance carries out impairment tests of its investments in subsidiaries and affiliates at each reporting date. The recoverable amount of investments in subsidiaries and affiliates is represented by their value in use. This is determined either on the basis of the Company's share of equity, adjusted as necessary, in each investment, or using discounted estimated future cash flows, less net debt. The cash flows of the first year are based on the following year's budget while those of the two succeeding years are obtained from the three-year plans prepared by the management of each subsidiary and approved by group management.

Cash flows for the next two years are based on those in the three-year plans adjusted by future growth and profitability rates judged to be reasonable for each subsidiary. The terminal values calculated after five years assume perpetual future growth equal to inflation based on the cash flows of the final year.

In the event that cash flow forecasts have been shown on a number of occasions to be inaccurate or when there is uncertainty in respect of a particular market, the Company may decide to limit the forecasts used to a three-year horizon.

Cash flows are discounted using the weighted average cost of capital of the geographical zone in which the subsidiary is based.

The estimates are based on information available at the time of preparation of the financial statements, and may be revised in a future period if circumstances change or if new information is available.

The 2018 impairment testing resulted in the following changes to the amount of accumulated impairment losses:

(in thousands of euros)	Increase	Decrease
Teleperformance France		50,000
Teleperformance EMEA		348
TOTAL	**0**	**50,348**

The principal discount rates applied, specific to each geographical zone, are as follows:

• United Kingdom	5.5%
• Central Europe	5.4%
• France	5.9%
• North America	6.5%
• Southern Europe	
◦ Italy	7.3%
◦ Spain	6.9%

Increases and decreases in provisions for impairment losses of investments in subsidiaries and affiliates are included in the financial result, except for any reversals on the disposal of shares, which are included in the exceptional result.

Note 1.3 Receivables from subsidiaries and affiliates

Loans made to group companies are presented under the heading "Receivables from subsidiaries and affiliates" within financial fixed assets. When denominated in a currency other than the euro, they are translated to euro at closing rates.

Note 1.4 Interest and exchange risk management

The company is exposed to exchange and/or interest rate risks through the following transactions:

- loans and borrowings with its subsidiaries denominated in foreign currency in the context of financing transactions;
- receivables and payables with its subsidiaries denominated in foreign currency from transactions in the normal course of business;
- centralized cash-pooling accounts denominated in foreign currency;
- loans from financial institutions.

The Company uses derivative financial instruments, contracted with a number of financial institutions of good standing, to manage its exposure to these risks. These financial instruments comprise principally currency swaps, forward currency sales and purchases, exchange options, and interest rate swaps.

In compliance with regulation ANC n°2015-05 dated July 2nd, 2015, the Company applies hedge accounting when a hedge relationship has been so identified in the management system and when the qualifying criteria are fulfilled. The Company recognizes derivative financial instruments to which hedge accounting is not applied in accordance with the principles applying to unrelated open positions.

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When hedge accounting is applicable, the fair value of derivative financial instruments is recognized in a symmetrical manner with the hedged item.

Gains and losses realized on expired hedge instruments when the hedged item remains on the balance sheet are deferred (as deferred income or prepaid expenses) until the hedged item is realized.

When the Company has unrelated open positions, the fair value of the financial instruments is recognized on the balance sheet and a provision for unrealized losses is made when this is negative.

As part of its strategy for the management of the Group's exchange risk, the Company hedges the forecast transactions of its subsidiaries using derivative exchange instruments contracted with financial institutions and the subsidiaries concerned. These transactions are accounted for as unrelated open positions.

Note 1.5 Centralized cash management

Advances from Teleperformance to its subsidiaries relating to the cash pool are presented in "Other receivables", while amounts lent to it are shown in "Other loans and financial liabilities".

Note 1.6 Incentive share award plans

The Board of Directors' meetings on April 28th and November 2nd, 2016 approved free awards of 914,300 and 151,508 incentive plan shares, respectively, to group personnel, including company officers of group subsidiaries, under the authorization given at the shareholders' general meeting of April 28th, 2016, limited to a maximum of 2.5% of the share capital of the Company at the grant date.

Vesting of the free share awards is conditional on the beneficiaries remaining with the Group until at least the end of the vesting period and on meeting certain performance conditions relating to the financial years from 2016 to 2018. As of December 31st, 2018, it has been determined that the performances realized met the conditions for the vesting of 100% of the awards.

However, final vesting remains subject to the beneficiaries remaining with the Group until at least the end of the relevant vesting period.

The Board of Directors has also approved the free awards under the authorization referred to above.

- 11,600 incentive plan shares to a company officer of a group subsidiary, at its meeting on June 23rd, 2017;
- 6,000 incentive plan shares to an employee of a group subsidiary, at its meeting on November 30th, 2017;
- 1,000 incentive plan shares to an employee of a group subsidiary, at its meeting on February 28th, 2018.

Note 1.7 Deductions at source for personal income tax

In connection with the introduction in France of a system of deduction at source for personal income tax, effective from January 1st, 2019, Teleperformance has shown the theoretical amounts of income tax due on employees' pay slips, starting in September 2018, under a transitional option made available by the French tax agency (*Direction Générale des Finances Publiques*).

With effect from January 1st, 2019, Teleperformance will make the related payroll deductions, acting as the income tax collector in respect of its French employees. The French accounting standards body (ANC) has issued regulation n°2018-02 creating the accounts code 4421 for payroll deductions for employee income tax.

Note 2 Tangible and intangible fixed assets

	12/31/2018			12/31/2017		
(in thousands of euros)	Cost	Accumulated depreciation, amortization and impairment losses	Net	Cost	Accumulated depreciation, amortization and impairment losses	Net
Intangible fixed assets	4,000	3,875	125	3,923	3,737	186
Tangible fixed assets	5,371	3,507	1,864	5,110	3,231	1,879
• Land	305		305	305		305
• Buildings	3,707	2,629	1,078	3,480	2,492	988
• Other	1,359	878	481	1,325	739	586
TOTAL	**9,371**	**7,382**	**1,989**	**9,033**	**6,968**	**2,065**

Note 2.1 Cost

(in thousands of euros)	At 01/01/2018	Increases	Decreases	At 12/31/2018
Intangible fixed assets	3,923	77		4,000
Tangible fixed assets	5,110	261	0	5,371
• Land	305			305
• Buildings	3,480	227		3,707
• Other	1,325	34		1,359
TOTAL	**9,033**	**338**	**0**	**9,371**

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Note 2.2 Accumulated depreciation, amortization and impairment losses

(in thousands of euros)	At 01/01/2018	Increases	Decreases	At 12/31/2018
Intangible fixed assets	3,737	138		3,875
Tangible fixed assets	3,232	275	0	3,507
• Land				0
• Buildings	2,493	136		2,629
• Other	739	139		878
TOTAL	**6,969**	**413**	**0**	**7,382**

Note 2.3 Expected useful lives

All tangible and intangible fixed assets are depreciated or amortized on a straight-line basis, based on their category and expected useful life in the business:

	Expected useful life
INTANGIBLE FIXED ASSETS	
• software	3 – 5 years
TANGIBLE FIXED ASSETS	
• buildings*	15 – 25 years
• building improvements	8 – 10 years
• IT equipment	3 – 5 years
• Other	5 – 10 years
◦ Miscellaneous improvements	5 – 10 years
◦ Automobiles	5 years
◦ Office furniture	10 years

* *According to the nature of the building and the type of component.*

Note 3 Financial fixed assets

Gross amount

(in thousands of euros)	Au 01/01/2018	Increases	Decreases	Au 31/12/2018
Investments in subsidiaries and affiliates	1,999,195	916,542	1	2,915,736
Receivables from subsidiaries and affiliates	1,187,670	1,065,490	1,153,572	1,099,588
Other	381			381
TOTAL	**3,187,246**	**1,982,032**	**1,153,573**	**4,015,705**

Accumulated impairment losses

(in thousands of euros)	At 01/01/2018	Increases	Decreases	At 12/31/2018
Investments in subsidiaries and affiliates	274,664		50,348	224,316
Receivables from subsidiaries and affiliates		380		380
Other				0
TOTAL	**274,664**	**380**	**50,348**	**224,696**

Note 3.1 Investments in subsidiaries and affiliates – change in gross amount

GROSS AMOUNT AT JANUARY 1st, 2018	**1,999,195**
Acquisitions of shares:	**44,550**
Albania Marketing Services	44,500
Teleperformance Management Services	50
Subscriptions to share capital increases	**871,991**
Luxembourg Contact Centers	847,733
Teleperformance France	20,000
In & Out Spa (Italy)	3,000
Teleperformance Peru	1,258
GROSS AMOUNT AT DECEMBER 31st, 2018	**2,915,736**

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Note 3.2 Receivables from subsidiaries and affiliates

Teleperformance has made a number of loans to its subsidiaries during 2018 in relation to their cash management, in a total amount of €956 million, principally to:

- Luxembourg Contact Centers, of €890 million, including €848 million which was subsequently incorporated in share capital;
- Teleperformance France, of €20 million, which was subsequently incorporated in share capital
- Teleperformance Canada, of CAD16 million (€10.5 million);
- Teleperformance Australia, of AUD11.8 million (€7.7 million);
- In & Out Spa (Italy), of €5 million, including €3 million which was subsequently incorporated in share capital.

(in thousands of euros)	At 01/01/2018	Increases	Decreases	At 12/31/2018	Amount due in more than one year
Luxembourg Contact Centers		896,157	853,189	42,968	
Dutch Contact Centers	670		496	174	
Praxidia Luxembourg		200	200	0	
Praxidia France	2,006	6	6	2,006	
Praxidia Ltd		1,855	23	1,832	
LLS UK	8,474	22	2,439	6,057	
Teleperformance Lebanon	961	4,490	2,184	3,267	
Service 800 Rumania	3,830	1,099	80	4,849	
Lion Teleservices CZ		601	1	600	
Lion Teleservices SK	380	10	10	380	
Teleperformance Australia		7,662	7,662	0	
Teleperformance France		20,000	20,000	0	
SCMG (Switzerland)	785	738	34	1,489	
TLS Luxembourg				0	
Teleperformance USA	508,926	44,034	40,620	512,340	445,724
Teleperformance Group Inc (USA)	641,323	58,793	195,133	504,983	436,682
Teleperformance Canada	6,004	10,598	12,098	4,504	
In & Out Spa (Italy)		5,007	3,000	2,007	
Teleperformance Malaysia	3,072	2,303	5,375	0	
TPG Katowice (Poland)		1,715	5	1,710	
Teleperformance Madagascar	4,348	3,458	1,843	5,963	
Wibilong		1,639		1,639	
Teleperformance Lithuania	1,115		1,115	0	
Metis	3,771	1,103	2,054	2,820	
Société méditéranéenne de Telemarketing (Morocco)	2,005	4,000	6,005	**0**	
TOTAL	**1,187,670**	**1,065,490**	**1,153,572**	**1,099,588**	**882,406**
Analysis of changes:					
Share capital increases			867,733		
Interest		6,847	733		
Foreign exchange differences		102,320	55,123		
New loans		956,323			
Repayments			229,983		

Note 4 Marketable securities

Marketable securities amounted to €9.9 million.

These include an amount of €4.3 million invested in money market and mutual funds with a market value of the same amount as of December 31st, 2018.

At December 31st, 2018, the Company also held 40,027 own shares under a liquidity agreement with a carrying value of €5.6 million. Related purchases and sales in 2018 are set out in the following schedule:

Number of treasury shares held at January 1, 2018	25,400
Number of shares bought in 2018 under the buy-back program commencing June 23, 2017	451,182
Number of shares sold in 2018 under the buy-back program commencing June 23, 2017	460,182
Number of shares bought in 2018 under the buy-back program commencing April 20, 2018	505,564
Number of shares sold in 2018 under the buy-back program commencing April 20, 2018	481,937
Number of treasury shares held at December 31, 2018	40,027
Carrying value of treasury shares held at December 31, 2018	5,594,059.11

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Note 5 Derivative financial instruments

In accordance with the revised ANC regulation (n°2015-05 dated July 2nd, 2015) which took effect from January 1st, 2017 applying to derivative financial instruments and to hedging operations, the positive and negative fair values of financial instruments are presented in separate line items "Derivative financial instruments" among the balance sheet assets or liabilities, respectively, with a corresponding entry in "Other liabilities" or "Other receivables", respectively.

Derivative financial instruments *(in thousands of euros)*	**Notional amount in foreign currency**	**Notional amount in euros at 12/31/2018**	**Fair value in euros at 12/31/2018**	**Positive fair values**	**Negative fair values**
WITHOUT HEDGE ACCOUNTING					
Currency hedges of subsidiaries' forecast transactions					
USD/PHP 2018	2,908,301	48,381	870	978	-108
COP/USD 2018	10,000	8,734	-715	118	-833
COP/EUR 2018	5,900	5,900	-230	0	-230
MXN/USD 2018	26,067	22,766	670	670	0
USD/MXN 2018	232,793	10,350	291	291	0
USD/INR 2018	3,750	3,275	-53	0	-53
TRY/EUR 2018	2,050	2,050	38	40	-2
COP/USD 2019	67,000	58,515	-2,015	403	-2,419
COP/EUR 2019	21,950	21,950	-556	165	-720
USD/PHP 2019	25,284,000	420,608	4,583	5,303	-721
MXN/USD 2019	154,000	134,498	1,650	2,467	-817
USD/CAD 2019	37,650	32,882	918	1,275	-357
USD/MXN 2019	1,386,960	61,664	716	1,072	-357
USD/INR 2019	57,100	49,869	2,037	2,212	-175
EUR/USD 2019	32,250	28,166	461	567	-105
EUR/TRY 2019	6,800	6,800	740	858	-117
EUR caps	270,000	270,000	-958	0	-958
USD caps	500,000	436,681	1,759	1,759	
Sub-total			**10,207**	**18,179**	**-7,972**
WITH HEDGE ACCOUNTING					
Interest rate swap, fixed to floating	400,000	400,000	4,466	4,466	0
Hedges of intragroup loans granted					
• in USD	265,714	232,065	2,417	2,752	-335
• in GBP	7,019	7,847	41	43	-1
• in TRY	15,000	2,476	495	495	0
• in CHF	1,618	1,436	-53	0	-53
• in PLN	7,140	1,660	4	4	0
• in CAD	7,000	4,486	170	170	0
• in CZK	15,000	583	1	1	0
Hedges of intragroup loans received					
• in PHP	7,434,025	123,668	1,588	1,892	-303
• in USD	7,900	6,900	19	23	-4
• in GBP	10,000	11,179	17	18	-1
• in SGD	2,300	1,475	2	2	0
Cash pool account hedges					
• in USD	85,000	74,236	-209	0	-209
• in MXN	60,000	2,668	26	27	-2
• in GBP	20,000	22,358	110	110	0
• in NOK	10,000	1,005	22	22	0
• in PLN	15,000	3,487	10	10	0
• in CZK	26,500	1,030	-7	0	-7
• in SEK	25,000	2,438	-6	0	-6
Sub-total				**10,035**	**-919**
TOTAL				**28,214**	**-8,891**

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Note 6 Maturity of receivables

(in thousands of euros)	Gross amount at 12/31/2018	Due under 1 year	Due between 1 and 5 years	Due after 5 years
Fixed assets				
• Receivables from subsidiaries and affiliates	1,099,588	217,182	588,646	293,760
• Other financial assets	381		381	
Current assets				
• Advances paid	29	29		
• Accounts receivable – Trade	20,050	20,050		
• Current accounts: cash pooling	49,865	49,865		
• Adjustment account for financial instrument fair values	7,711	7,711		
• Adjustment account for financial instrument fair values	30,931	30,931		
• including accrued income of 4,514 related to hedge accounting and taxes				
• Miscellaneous receivables	942		942	
• Prepaid expenses*	34,124	34,124		
TOTAL	**1,243,621**	**359,892**	**589,969**	**293,760**

* *Including 33 437 related to hedge accounting (see note 1.4).*

Note 7 Impairment losses on assets (excluding financial fixed assets)

(in thousands of euros)	At 01/01/2018	Increases	Decreases	At 12/31/2018
Accounts receivable – Trade				0
Subsidiaries' current accounts		696		696
Miscellaneous receivables	942			942
TOTAL	**942**	**696**	**0**	**1,638**

Note 8 Change in shareholders' equity

(in thousands of euros)	At 01/01/2018	Appropriation of 2017 net income	Dividend distribution	2018 net income	Other changes	At 12/31/2018
• Share capital	144,450					144,450
• Issue, merger and contribution premiums	575,727					575,727
• Legal reserve	14,445					14,445
• Other reserves – not distributable	25					25
• Other reserves	86,859		-17,551			69,308
• Retained earnings	18,001	71,341	-89,301			41
• Net income for the period	71,341	-71,341		190,345		190,345
• Regulated provisions	6				37	43
TOTAL SHAREHOLDERS' EQUITY	**910,854**	**0**	**-106,852**	**190,345**	**37**	**994,384**

The share capital at December 31st, 2018 amounted to €144,450,000, comprising 57,780,000 shares, each of a €2.50 nominal value.

Regulated provisions are in respect of fiscal depreciation, increases in which are classified as exceptional expense and presented on the line item Depreciation, amortization and increase in provisions, net of releases.

Note 9 Provisions for contingencies and expenses

			Decreases		
(in thousands of euros)	At 01/01/2018	Increases	A*	B*	At 12/31/2018
Unrealized foreign exchange losses	1,080	2,532	1,080		2,532
Unrealized losses on hedging instruments	1,334	3,570	1,334		3,570
Employee retirement benefits	1,670	151			1,821
Employer social charges on free share awards	1,173	1,072			2,245
TOTAL	**5,257**	**7,325**	**2,414**	**0**	**10,168**

* *A Release utilized.*
* *B Release not utilized.*

Note 9.1 Employee retirement benefits

Commitments for payment of retirement and post-employment benefits arising from labor agreements and legal requirements are classified as provisions for contingencies and expenses, and have been measured using the projected unit credit method, under the following actuarial assumptions:

Discount rate	1.57*
Annual rate of increase in salaries	2.50%
Rate of social charges	45%

* *iBoxx € Corporates AA 10+ rate at December 31st, 2018 (source: Markit.com).*

Actuarial differences are recognized immediately in the income statement.

Change in the provision for retirement benefits

AT THE BEGINNING OF THE YEAR	**1,670**
+ service cost	167
+ interest	16
+ actuarial gains and losses	-32
including changes in assumptions	*-9*
including new participants	*3*
including withdrawals in the year	*-26*
AT THE END OF THE YEAR*	**1,821**

* *Including €205 thousand for the benefit of a company officer.*

Note 10 Financial liabilities

Certain loans are subject to covenants in the form of financial ratios as disclosed in the notes 7.4.2 of the consolidated financial statements (section 5.6).

At December 31st, 2018, the Company was in compliance with all of these financial ratios.

The Company has a syndicated credit facility of €300 million which expires in February 2023. Draw-downs under the facility may be made either in euros or in US$, and are repayable in fine. No amounts were drawn down under the facility during 2017 or 2018.

The Company also has four US private placements, obtained in 2014 and 2016, redeemable in fine with the following principal conditions:

- US$160 million at a fixed interest rate of 3.64%, redeemable in December 2021;
- US$165 million at a fixed interest rate of 3.98%, redeemable in December 2024;
- US$75 million at a fixed interest rate of 3.92%, redeemable in December 2023;
- US$175 million at a fixed interest rate of 4.22%, redeemable in December 2026.

On September 16th, 2016, Teleperformance obtained a loan of US$500 million repayable in four equal installments on August 20th, 2018 and August 19th, 2019, 2020 and 2021. During 2018, in addition to the installment of US$125 million due on August 20th but repaid in advance on June 5th, 2018, Teleperformance also repaid a further amount of US$50 million in advance in November. This latter repayment reduces the installment due on August 19th, 2019.

In December 2018, Teleperformance subscribed commercial paper issues in a total amount of €134 million.

The Company has also two outstanding bond issues:

- on April 7, 2017, an issue of €600 million at a nominal interest rate of 1.50%, redeemable on April 3, 2024; and
- on July 2, 2018, an issue of €750 million at a nominal interest rate of 1.875%, redeemable on July 2, 2025.

As in 2017, the issue expenses relating to the new bond issue, of €2.3 million, were fully expensed in the year.

The premium due on redemption of this issue is presented as an asset in an amount of €6.3 million and will be amortized over the period to redemption.

Finally, Teleperformance obtained a loan from Natixis in an amount of €164 million, repayable in four equal installments on June 8, 2020, 2021, 2022 and 2023.

Note 10.1 Bonds and Loans from financial institutions

(in thousands of euros)	At 12/31/2018	At 12/31/2017
BONDS		
• Principal	1,350,000	600,000
• Accrued interest	13,884	6,700
Sub-total	**1,363,884**	**606,700**
LOANS FROM FINANCIAL INSTITUTIONS		
• 7-year US private placement of US$160 million	139,738	133,411
• 10-year US private placement of US$165 million	144,105	137,580
• 7-year US private placement of US$75 million	65,502	62,537
• 10-year US private placement of US$175 million	152,838	145,919
• 7-year bank loan of US$325 million	283,843	416,910
• 5-year bank loan of €164 million	164,133	
• Accrued interest	2,623	2,401
• Bank overdrafts and advances	622	172
Sub-total	**953,404**	**898,930**
TOTAL	**2,317,288**	**1,505,630**

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Note 10.2 Other loans and financial liabilities

(in thousands of euros)	At 12/31/2018	At 12/31/2017
OTHER LOANS AND FINANCIAL LIABILITIES		
• Current accounts: cash pooling	241,984	257,989
• Commercial paper	134,000	105,000
• Loans from subsidiaries (by country)		
◦ Loans from Philippines	127,818	112,792
◦ Loans from Hong Kong	4,367	
◦ Loans from Albania		5,500
◦ Loans from Russia	5,000	
◦ Loans from Luxembourg	40,359	48,630
◦ Loans from Singapore	2,087	
◦ Loans from Indonesia	1,921	
◦ Loans from United Kingdom	11,179	10,144
• Accrued loan interest	2,449	1,896
• Other	107	205
TOTAL	**571,271**	**542,156**

Note 11 Maturity of liabilities

(in thousands of euros)	At 12/31/2018	Due under 1 year	Due between 1 and 5 years	Due after 5 years
FINANCIAL LIABILITIES				
• Bonds and Loans from financial institutions	2,317,288	82,632	587,713	1,646,943
• Loans and other financial liabilities	571,271	467,846	103,318	107
Sub-total, financial liabilities	**2,888,559**	**550,478**	**691,031**	**1,647,050**
Advances received	11	11		
Accounts payable – Trade[1]	49,972	49,972		
Tax, personnel and social security	12,951	12,951		
Other liabilities[2][3][4]	98,224	32,903	65,321	
Derivative financial instruments – negative fair values	7,933	7,933		
Deferred income[5]	16,918	16,918		
TOTAL	**3,074,568**	**671,166**	**756,352**	**1,647,050**

(1) Including accrued invoices *9,410*
(2) Including accrued expenses relating to hedge accounting, lease term adjustments and directors' fees. *3,103*
(3) Including income taxes saved on subsidiaries' tax losses utilized *73,298*
(4) Including adjustment accounts for financial fair values *21,819*
(5) In respect of hedge accounting (see note 1.4).

Note 12 Unrealized exchange gains and losses on assets and liabilities denominated in foreign currencies

(in thousands of euros)	Unrealized exchange losses	Unrealized exchange gains	Net	Provision for unrealized exchange losses
UNDER HEDGE ACCOUNTING				
Loans to subsidiaries	26,705	21,287		
Loans from subsidiaries	153	14,837		
Loans from financial institutions	19,467	22,197		
Sub-total	**46,324**	**58,321**	**-11,997**	**0**
OTHER RECEIVABLES AND LIABILITIES				
Loans to subsidiaries		2,676		
Loans from financial institutions	1,622			1,622
Loans from subsidiaries				
Accounts receivable – Trade	52	163		52
Accounts payable – Trade	858	26		858
TOTAL	**48,857**	**61,186**		**2,532**

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Note 13 Exposure of the Company to interest rate risks

The Company's exposure to interest rate risks at December 31st, 2018 is summarized as follows:

(in thousands of euros)	Gross amount	Due under 1 year	Due between 1 and 5 years	Due after 5 years
FINANCIAL ASSETS				
• Group loans and advances	1,099,588	217,182	588,646	293,760
• Current accounts: cash pooling	49,865	49,865		
Total financial assets, including:	**1,149,453**	**267,047**	**588,646**	**293,760**
• Accrued interest and other assets	6,847	6,847		
• At a fixed rate	80,889	80,889		
• At a floating rate(2)	1,061,717	179,311	588,646	293,760
FINANCIAL LIABILITIES				
• Bonds and Loans from financial institutions	2,317,288	82,632	587,713	1,646,943
• Loans and other financial liabilities	571,271	467,846	103,318	107
Total financial liabilities, including:	**2,888,559**	**550,478**	**691,031**	**1,647,050**
• Accrued interest and other liabilities	19,686	19,579		107
• At a fixed rate(1)	2,013,639	161,456	205,240	1,646,943
• At a floating rate(2)	855,234	369,443	485,791	

(1) Including €400 million concerning the two bond issues with a fixed to floating interest rate swap.
(2) Floating rates are based on EURIBOR, LIBOR US$ or LIBOR £ (with maturities between three months and one year), and the Central Bank of the Philippines' rate applying to long-term loans.

Note 14 Exposure of the Company to exchange risks

The Company's exposure to exchange risks at December 31st, 2018 is summarized as follows:

(in thousands of currency)	Currency amounts at 12/31/2018	Less: hedged loans	Exchange risk exposure
GROUP LOANS AND ADVANCES			
US dollars	1,162,070	1,140,714	21,356
Swiss francs	1,618	1,618	
Pound sterling	7,019	7,019	
Polish zlotys	7,140	7,140	
Canadian dollars	7,000	7,000	
Czech crowns	15,000	15,000	
Turkish lira	15,000	15,000	

(in thousands of currency)	Currency amounts at 12/31/2018	Less: hedged loans	Exchange risk exposure
LOANS FROM FINANCIAL INSTITUTIONS			
US dollars	900,000	875,000	25,000
LOANS FROM SUBSIDIARIES			
Philippine pesos	7,434,025	7,434,025	
US dollars	7,900	7,900	
Pound sterling	10,000	10,000	
Singapore dollars	2,300	2,300	

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Note 15 Net income from operations

Note 15.1 Revenues

(in thousands of euros)	2018 France	2018 Rest of the World	2017 France	2017 Rest of the World
• Royalties and management fees	2,493	104,563	2,337	100,765
• Rents and rental charges	544		476	
• Other	173	277	3,223	164
TOTAL	**3,210**	**104,840**	**6,036**	**100,929**

As the parent company of the Group, the activity of Teleperformance SE is that of a holding company in respect of its subsidiaries; it also provides management, supervisory, assistance and advisory functions for group companies, in return for which it receives management fees.

Teleperformance also receives Intellectual property royalties which are charged to all group subsidiaries.

The increase in royalty income is principally due to the increase in consolidation scope.

Note 15.2 Purchases and external expenses

Following changes in 2017 to the international transfer pricing guidelines governing intra-group recharging policies within multinational enterprises, Teleperformance SE and its subsidiary Teleperformance Group Inc have balanced out the level of profits realized from their respective contributions to the Group's intangible assets, which explains the increase in the former's expenses in 2018 compared to those of 2017.

Note 16 Financial result

(in thousands of euros)	2018 Income	2018 Expense	2018 Net	2017 Net
Dividends	116,395		116,395	37,921
Provisions on shareholdings	50,348		50,348	-24,054
Other impairment provisions		1,076	-1,076	329
Amortization of bond redemption premiums		989	-989	-381
Financial debt waiver		2,963	-2,963	-3,088
Provisions for unrealized exchange losses	1,080	2,532	-1,452	2,530
Provisions for unrealized losses on financial instruments	1,334	3,570	-2,236	-1,334
Foreign exchange gains and losses	92,276	87,784	4,492	17,332
Interest on short-term investments	85,046	67,083	17,963	15,507
Disposal of marketable securities		11	-11	-8
TOTAL	**346,479**	**166,008**	**180,471**	**44,754**

As in 2017, the Company has waived a receivable due from its subsidiary Teleperformance France in respect of the year's brand royalties and management services.

The Company has also fully written down the receivables amounting to €1 million due by its Slovakian subsidiary Lion Teleperformance which has been put into liquidation.

Note 17 Exceptional result

(in thousands of euros)	2018 Income	2018 Expense	2018 Net	2017 Net
Capital operations			0	328
• Tangible and intangible fixed assets			0	0
• Financial fixed assets	2	1	1	-134
• Other	1,397	4,154	-2,757	462
Revenue operations	303		303	0
Depreciation, amortization and increase in provisions, net of releases		37	-37	-6
TOTAL	**1,702**	**4,192**	**-2,490**	**322**

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Note 18 Income taxes

Note 18.1 French tax group

The companies in the 2018 French tax group are as follows:

- Teleperformance;
- Teleperformance France;
- Teleperformance emea;
- Teleperformance Intermédiation.

With effect from January 1st, 2013, the tax savings for the Group resulting from the utilization of tax losses of members under the French tax group mechanism are immediately transferred by Teleperformance to the relevant loss-making subsidiaries. Prior tax savings outstanding of €43.9 million (recognized as a liability[1]) will also be transferred back in the event of a subsidiary exiting the tax group or utilizing the tax losses itself.

(1) See footnote (3) to note 11: Amount of income taxes saved on subsidiaries' tax losses utilized.

Note 18.2 Analysis of 2018 income tax expense

			Income taxes				
			Retraitements				
(in thousands of euros)	Pre-tax income	Theoretical expense	Fiscal adjustments	Effect of tax group	Other items (tax credits and assessments)	Actual expense	Net income
Profit on ordinary activities	200,600	51,690	-41,303	-1,134	-633	8,620	191,980
• Standard rate (33.33%)	150,251	51,690	-41,303	-1,134	-633	8,620	141,631
• Long-term rate (0%)	50,349						50,349
Exceptional result	-2,490	-855	0	0	0	-855	-1,635
• Standard rate (33.33%)	-2,490	-855				-855	-1,635
• Long-term rate (0%)						0	0
TOTAL	**198,110**	**50,835**	**-41,303**	**-1,134**	**-633**	**7,765**	**190,345**

The French group tax result showed a profit of €12.1 million in 2018.

The 2018 tax charge was €7.8 million, compared with €24.4 million in 2017.

Note 18.3 Unrecognized deferred tax assets and liabilities at December 31st, 2018

Change in unrecognized deferred tax assets and liabilities

(in thousands of euros)	At beginning of year		Change		At end of year	
	Asset	Liability	Asset	Liability	Asset	Liability
I. CERTAIN OR POTENTIAL TIMING DIFFERENCES						
1 Items not currently deductible						
1.1 Deductible in the following year						
• Unrealized exchange gains	807		1,028	807	1,028	
• Gains to 12/31/2018 on settled derivative financial instruments			4,531		4,531	
• Net loss in 2017 on settled derivative financial instruments	506			506		
• Other	426		791	426	791	
1.2 Deductible in subsequent years						
• Retirement benefits	575		622	575	622	
2 Income not currently taxed						
• Unrealized exchange losses		372	372	785		785
• Losses to 12/31/2018 on settled derivative financial instruments				8,056		8,056
TOTAL	**2,314**	**372**	**7,343**	**11,156**	**6,971**	**8,841**
NET CHANGE IN UNRECOGNIZED DEFERRED TAX ASSETS, NET OF LIABILITIES				**-3,812**		

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Note 19 Commitments

Note 19.1 Guarantees *(in thousands of euros)*

In favor of private or public organizations

In respect of commitments of French subsidiaries	Total	Expiry date
UBS real estate KMBH (Teleperformance France)	398	03/07/2020
Cuvier Montreuil (GN Research France)	181	03/31/2025
TOTAL	**579**	

In favor of financial institutions

In respect of commitments of foreign subsidiaries	Beneficiary banks	Total	Expiry date
Citytech Argentina	HSBC	1,472	06/30/2019
Citytech Argentina	Bank Boston	2,620	
TP Chile	HSBC Chile	2,358	07/21/2019
TP Chile	Citi Bank Banco de Chile	1,642	07/20/2019
Société Méditeranéenne de Télémarketing	Citi	1,343	09/30/2028
Société Méditeranéenne de Télémarketing	Citi	1,661	09/30/2028
Service 800 Egypt	CA Egypt	436	03/21/2019
LCC	SG Bank & Trust	1,000	12/31/2019
Metis Bilgisayar Sistemleri	HSBC Turkey	2,183	02/23/2019
Metis Bilgisayar Sistemleri	HSBC Turkey	2,009	10/25/2019
TOTAL		**16,724**	

Note 19.2 Warranty commitments

Teleperformance SE gave a performance guarantee in November 2013 to the Secretary of State for the Home Department of the United Kingdom covering the duration of a commercial contract entered into with a group subsidiary. The maximum amount covered by the guarantee is £60 million.

Teleperformance SE has issued a performance guarantee in December 2013 to Apple Inc. relating to the obligations of certain subsidiaries undertaken in respect of a commercial contract. The guarantee was given for the duration of the commercial contract. The maximum amount covered by the guarantee is the greater of (i) US$60 million and (ii) the total amount of sums paid by Apple Inc. to the subsidiaries concerned during the calendar year preceding the date of the loss event.

Teleperformance SE has issued a performance guarantee to Barclays Bank PLC with respect to the obligations of its subsidiary TP Portugal under a commercial contract. The guarantee was signed in 2014 and will remain in force for the duration of the contract.

In July 2017, Teleperformance Portugal SA, a subsidiary of Teleperformance SE, undertook to enter into a lease in respect of office buildings under construction. Related guarantee commitments have been given by Teleperformance SE, in particular a joint and several guarantee and a bank guarantee for a maximum amount of €36 million for the stipulated contract duration.

In 2017, Teleperformance SE issued comfort letters in favor of Canon, a partner with which Ypiresia 800-Teleperformance A.E., a subsidiary of Teleperformance SE, has entered into a new commercial arrangement.

Finally, Teleperformance SE has given comfort letters to a number of banks to guarantee commitments of its subsidiaries located in Colombia, Australia, Egypt, France, Italy, Greece, Peru, Luxembourg, Brazil, Spain, Germany, Tunisia and the Czech Republic in a total amount of €39.8 million.

Note 19.3 Net asset warranty

The agreement entered into for the acquisition of Wibilong SAS contains net asset warranties intended to indemnify the acquirer against any prior existing liabilities that were not disclosed at the time of the acquisition.

The duration of each commitment is generally of two years from the date of completion of the acquisition except in certain cases for tax-related liabilities for which the duration of the commitment corresponds to the date of prescription of each potential liability.

These commitments are guaranteed by:

- amounts held by a bank in escrow, to be released in full after two years from the date of acquisition, in the absence of any request for indemnification, or
- representations and commitments covering certain guarantees.

Note 19.4 Other commitments

The French individual rights to training program (DIF) has been superseded from January 1st, 2015 by the introduction of the individual training account (CPF). The outstanding entitlement of 2,181 hours existing under the DIF as of December 31st, 2014 may be utilized until December 31st, 2020. During 2018, 60 training hours were utilized.

The outstanding commitment in respect of the CPF amounted to 2,144 hours at the end of 2018.

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Note 20 Work-force

At December 31st, 2018, the Company's work-force consisted of 41 persons, representing 36 managers and supervisors and five other employees. The change during the year was as follows:

Employment categories	At December 31st, 2017	Change	At December 31st, 2018
Other	4	1	5
Managers	40	-4	36
TOTAL	**44**	**-3**	**41**

Note 21 Remuneration of company officers

The total amount of all types of remuneration paid in 2018 amounted to €3,376 thousand (of which €2,383 thousand for management bodies and the balance for supervisory bodies) compared with €93 thousand in 2017.

This increase is principally the result of changes in 2017 to the international transfer pricing guidelines governing intra-group recharging policies within multinational enterprises.

The amount of directors' fees paid to directors in 2018 in respect of the 2017 financial year amounted to €700 thousand compared with €600 thousand paid in 2017.

Note 22 Statutory auditors' fees

The audit fees of the statutory auditors of Teleperformance SE in respect of the 2018 financial year are analyzed as follows:

	KPMG		Deloitte & Associés	
(in thousands of euros)	Audit	Other[1]	Audit	Other[2]
TOTAL	**524**	**931**	**305**	**165**

(1) Nature of non-audit services rendered by KPMG to Teleperformance: a due diligence engagement in connection with the acquisition of Intelenet, comfort letter in connection with a bond issue, engagements for the verification of the existence and the fairness of certain personnel, environmental or societal information to be submitted to independent third-party entities, attestations issued in respect of compliance with financial covenants.
(2) Nature of non-audit services rendered by Deloitte & Associés to Teleperformance: comfort letter, due diligence engagement, attestation of certain financial information, attestation issued in respect of compliance with financial covenants.

Note 23 Balances and transactions with group companies

Balance sheet *(in thousands of euros)*	Net amount at 12/31/2018
ASSETS	
• Investments in subsidiaries and affiliates	2,691,420
• Receivables from subsidiaries and affiliates	1,099,208
• Accounts receivable – Trade	20,050
• Other receivables	49,411
LIABILITIES	
• Financial liabilities	434,821
• Accounts payable – Trade	40,072
• Other liabilities	73,309

Income statement *(in thousands of euros)*	Net amount at 12/31/2018
INCOME	
• Net income from investments in subsidiaries and affiliates	116,395
• Other financial income	71,781
• Release of provisions	50,348
EXPENSES	
• Financial expenses	13,287
• Increase in provisions	1,076

Note 24 Related parties

As all relevant transactions were entered into at arms' length conditions, no further information is disclosed with respect to related parties.

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6.5 SCHEDULE OF SUBSIDIARIES AND INVESTMENTS, DECEMBER 31

(in thousands of euros)	Gross amount of share-holding	Carrying value of share-holding	Dividends received	Loans and advances (gross)	Commit-ments given	% Holding
I. DETAILED INFORMATION						
Subsidiaries with the gross amount of its shareholding exceeding 1% of the parent company's share capital						
A. Subsidiaries (more than 50% owned by the Company)						
Teleperformance Intermédiation 21-25 rue Balzac – 75008 Paris	6,647	4,847				100
Teleperformance Europe, Middle East and Africa 21-25 rue Balzac – 75008 Paris	9,609	5,093	1,000			100
Teleperformance France 12-14, rue Sarah Bernhardt – 92600 Asnières-sur-Seine	374,276	156,276				100
Compania Salvadorena de Teleservices S.A. de C.V Edificio Plaza Olímpica Avenida Olímpica y Pasaje 3 Segundo Nivel San Salvador – El Salvador	6,000	6,000	13,164			100
Luxembourg Contact Centers 153-155 C rue du Kiem L-8030 Strassen – Luxembourg	980,009	980,009	50,000	42,969		100
Teleperformance Holdings Limited Spectrum House, Bond Street BS1 3LG Bristol – Royaume-Uni	108,25	108,525				100
SPCC – Sao Paulo Contact Center Ltda Prédio 25, Espaço 01, Mezanino, Sala A Lapa, CEP 05069 – 010 Sao Paulo – Brazil	62,365	62,365	11,383			100
Teleperformance Spain S.A.U. Avenida de Burgos 8A – 28036 Madrid – Spain	29,780	29,780				100
YPIRESIA 800 Teleperformance Thisseos 330 – 17675 Kallithea – Greece	5,572	5,572	13,000			100
Teleperformance Portugal SA Parque das Naçoes, Lais dos argonautas Lote 2.34.01, 1990 – 011 Lisbon – Portugal	7,754	7,754	17,100			95
Teleperformance Nordic AB St Eriksgatan 115 – 11385 Stockholm – Sweden	6,586	6,586				100
Telemarketing Asia (Singapore) Pte Ltd 29 Tai Seng Avenue, 534119 Singapore	3,221	3,221				100
In & Out S.p.A. Via Di Priscilla 101 – 00199 Rome – Italy	61,405	61,405		2,000		100
Albania Marketing Services Bruga Iliria km 12.6 Ndertesa NR, 32 Tirana Albania	44,500	44,500	9,500			
Teleperformance Peru Av La Floresta N°497, Piso 5°, San Borja Lima – Peru	5,054	5,054				100
Wibilong 10, rue de Castiglione 75001 PARIS	4,819	4,819		1,630		84
Teleperformance Colombia S.A.S. Calle 70 A 4 41 – Bogota DC – Colombia	72,058	72,058				100
Citytech S.A 1 Bouchard 680, piso 10 – Buenos Aires – Argentina	7,517	7,517				88
Teleperformance Group Inc. 1601 Washington Av. Suite 400 – Miami Beach FL 33139 – USA	1,118,060	1,118,060		502,184		100
B. Shareholdings (10 – 50% of the share capital held by the Company): none						
II. CUMULATIVE INFORMATION						
A. Subsidiaries not set out in section I:						
a) French subsidiaries (in total)	none					
b) Foreign subsidiaries (in total)	1,978	1,978		6,488		
B. Shareholdings not set out in section I: none						

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6.5 Schedule of subsidiaries and investments, December 31st, 2018

(in thousands of local currency)	Local currency	2018 share capital	Total 2018 equity excluding share capital	2018 statutory net income	2018 revenue
I. DETAILED INFORMATION					
Subsidiaries with the gross amount of its shareholding exceeding 1% of the parent company's share capital					
A. Subsidiaries (more than 50% owned by the Company)					
Teleperformance Intermédiation 21-25 rue Balzac – 75008 Paris	EUR	3,750	-498	-135	907
Teleperformance Europe, Middle East and Africa 21-25 rue Balzac – 75008 Paris	EUR	2,500	2,679	1,309	89,081
Teleperformance France 12-14, rue Sarah Bernhardt – 92600 Asnières-sur-Seine	EUR	59,000	-29,002	-7,885	165,423
Compania Salvadorena de Teleservices S.A. de C.V Edificio Plaza Olímpica Avenida Olímpica y Pasaje 3 Segundo Nivel San Salvador – El Salvador	USD	12	49,488	22,190	108,060
Luxembourg Contact Centers 153-155 C rue du Kiem L-8030 Strassen – Luxembourg	EUR	978,232	209,068	75,865	0
Teleperformance Holdings Limited Spectrum House, Bond Street BS1 3LG Bristol – United Kingdom	GBP	62,704	7,926	564	0
SPCC – Sao Paulo Contact Center Ltda Prédio 25, Espaço 01, Mezanino, Sala A Lapa, CEP 05069 – 010 Sao Paulo – Brazil	BRL	156,500	102,909	37,991	0
Teleperformance Spain S.A.U. Avenida de Burgos 8A – 28036 Madrid – Spain	EUR	8,751	-435	1,532	92,403
YPIRESIA 800 Teleperformance Thisseos 330 – 17675 Kallithea – Greece	EUR	2,100	64,024	30,290	211,108
Teleperformance Portugal SA Parque das Naçoes, Lais dos argonautas Lote 2.34.01, 1990 – 011 Lisbon – Portugal	EUR	885	48,494	23,674	245,849
Teleperformance Nordic AB St Eriksgatan 115 – 11385 Stockholm – Sweden	SEK	277	204,213	26,718	729,142
Telemarketing Asia (Singapore) Pte Ltd 29 Tai Seng Avenue, 534119 Singapore	SGD	4,000	5,299	644	11,130
In & Out S.p.A. Via Di Priscilla 101 – 00199 Rome – Italy	EUR	2,828	276	-3,912	95,721
Albania Marketing Services Bruga Iliria km 12.6 Ndertesa NR, 32 Tirana Albania	EUR	90	7,007	3,848	29,862
Teleperformance Peru Av La Floresta N°497, Piso 5°, San Borja Lima – Peru	PEN	19,308	2,025	1,519	33,278
Wibilong 10, rue de Castiglione 75001 PARIS	EUR	277	-2,050	-2,118	1,313
Teleperformance Colombia S.A.S. Calle 70 A 4 41 – Bogota DC – Colombia	MCOP	134,265	259,713	56,479	587,916
Citytech S.A 1 Bouchard 680, piso 10 – Buenos Aires – Argentina	ARS	43,626	269,396	63,181	2,133,403
Teleperformance Group Inc. 1601 Washington Av. Suite 400 – Miami Beach FL 33139 – USA	USD	452	1,534,293	115,856	0
B. Shareholdings (10 – 50% of the share capital held by the Company): none					
II CUMULATIVE INFORMATION					
A. Subsidiaries not set out in section I					
a) French subsidiaries (in total)					
b) Foreign subsidiaries (in total)					
B. Shareholdings not set out in section I: none					

2018 Exchange rates	Closing	Average
ARS	43,1452	33,0291
BRL	4,444	4,3108
MCOP	3,722	3,4881
GBP	0,8945	0,8844
PEN	3,863	3,884
SEK	10,2548	10,2523
SGD	1,5591	1,5942
USD	1,145	1,1836

6.6 STATUTORY AUDITORS' REPORT ON THE ANNUAL FINANCIAL STATEMENTS

This is a translation into English of the statutory auditors' report on the financial statements of the Company issued in French and it is provided solely for the convenience of English speaking users.

This statutory auditors' report includes information required by European regulation and French law, such as information about the appointment of the statutory auditors or verification of the management report and other documents provided to shareholders.

This report should be read in conjunction with, and construed in accordance with, French law and professional auditing standards applicable in France.

For the year ended December 31st, 2018

To the annual general meeting of Teleperformance SE,

Opinion

In compliance with the engagement entrusted to us by your annual general meeting, we have audited the accompanying financial statements of Teleperformance SE for the year ended December 31st, 2018.

In our opinion, the financial statements give a true and fair view of the assets and liabilities and of the financial position of the Company as at December 31st, 2018 and of the results of its operations for the year then ended in accordance with French accounting principles.

The audit opinion expressed above is consistent with our report to the audit and compliance committee.

Basis for Opinion

Audit Framework

We conducted our audit in accordance with professional standards applicable in France. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our responsibilities under those standards are further described in the *Statutory Auditors' Responsibilities for the Audit of the Financial Statements* section of our report.

Independence

We conducted our audit engagement in compliance with independence rules applicable to us, for the period from January 1st, 2018 to the date of our report and specifically we did not provide any prohibited non-audit services referred to in Article 5(1) of Regulation (EU) N° 537/2014 or in the French Code of ethics (*Code de déontologie*) for statutory auditors.

Justification of Assessments - Key Audit Matters

In accordance with the requirements of Articles L.823-9 and R.823-7 of the French Commercial Code (*Code de commerce*) relating to the justification of our assessments, we bring your attention to the key audit matter relating to risk of material misstatement that, in our professional judgment, was of most significance in our audit of the financial statements of the current period, as well as how we addressed this risk.

This matter was addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon. We do not provide a separate opinion on specific items of the financial statements.

Impairment of investments in subsidiaries

(Notes 1.2 and 3 to the annual financial statements)

Identified risk

As of December 31st, 2018 investments in subsidiaries were recorded in the balance sheet for a net carrying amount of €2,691 million, *i.e.* 65% of total assets.

The company assesses the value in use of its investments in subsidiaries at each reporting date. This is determined either on the basis of the company's share of equity in each investment, possibly revalued, or on the basis of discounted future cash flows method adjusted for net debt. Future cash flows are determined over a 5 year period. Cash flows for the first three years are based on the three year plan prepared by the management of subsidiaries and approved by Group management. Cash flows for the following two years are derived from the three year plan on the basis of growth and profit rates considered reasonable for the related subsidiaries. Depending on the circumstances, the Company can limit the use of cash flows over a three-year period. The terminal value is based on the cash flows of the last year and assumes perpetual growth rate equal to inflation.

The 2018 impairment review has resulted in a €50 million reversal of the provision on the investments in Teleperformance France.

We considered the impairment of investments in subsidiaries to be a key audit matter considering the weight of these assets on the balance sheet, the importance of management's judgments to determine the assumptions relating to cash flows forecasts, discount and long-term growth rates.

Our audit approach

For the significant investments in subsidiaries or for those for which a specific risk of impairment has been identified, our work consisted in:

- obtaining an understanding of the process by which the value in use of the company's investment in subsidiaries has been estimated;
- when the value in use has been estimated using the company's share of equity:
  - a reconciliation of the share of equity used for impairment testing purposes with the financial statement of the related subsidiary,
  - an assessment of the appropriateness of any revaluation made;
- when the value in use has been estimated using a discounted cash flows approach:
  - assessing the reasonableness of future cash flows by analyzing the ability of the company to estimate future cash flows by comparing actual realizations with initial forecasts,
  - reconciling the forecasts used to determine the future cash flows with those approved by group management,
  - assessing the appropriateness of the long term growth rates and discount rates used with the assistance of our valuation experts,
  - reconciling the net indebtness used for impairment testing purposes with the subsidiary accounts.

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Specific verifications

We have also performed, in accordance with professional standards applicable in France, the specific verifications required by French law.

Verification of the management report and of the other documents with respect to the financial position and the financial statements provided to the Shareholders

We have no matters to report as to the fair presentation and the consistency with the financial statements of the information given in the management report of the Board of Directors and in the other documents with respect to the financial position and the financial statements provided to the shareholders.

We attest the fair presentation and the consistency with the financial statements of the information relating to payment terms, required under Article D.441-4 of the French Commercial Code (*Code de commerce*).

We attest that the consolidated declaration of extra-financial performance, required under Article L.225-102-1 of the French Commercial Code (*Code de commerce*), is included in the management report, being specified that, in accordance with the provisions of Article L.823-10 of this Code, we have not verified the fair presentation and the consistency with the annual financial statements of the information provided in this declaration and this information must be reported by an independent third party.

Report on corporate governance

We attest that the Board of Directors' report on corporate governance sets out the information required by Articles L.225-37-3 and L.225-37-4 of the French Commercial Code (*Code de commerce*).

Concerning the information given in accordance with the requirements of Article L.225-37-3 of the French Commercial Code (*Code de commerce*) relating to remunerations and benefits received by the directors and any other commitments made in their favour, we have verified its consistency with the financial statements, or with the underlying information used to prepare these financial statements and, where applicable, with the information obtained by your company from controlling and controlled companies. Based on this work, we attest the accuracy and fair presentation of this information.

With respect to the information relating to items that your company considered likely to have an impact in the event of a public purchase offer or exchange, provided pursuant to Article L.225-37-5 of the French Commercial Code (*Code de commerce*), we have agreed these to the source documents communicated to us. Based on our work, we have no observations to make on this information.

Other information

In accordance with French law, we have verified that the required information concerning the controlling interests and the identity of the shareholders and holders of the voting rights has been properly disclosed in the management report.

Report on Other Legal and Regulatory Requirements

Appointment of the Statutory Auditors

We were appointed as statutory auditors of Teleperformance SE by the annual general meeting held on May 31st, 2011.

As at December 31st, 2018 Deloitte & Associés and KPMG Audit IS were in the twentieth year and thirty-second year of total uninterrupted engagement respectively, which are the twelfth year since securities of the Company were admitted to trading on a regulated market, due to the mergers and acquisitions of audit firms that occured before our appointement as statutory auditors.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with French accounting principles and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the Company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is expected to liquidate the Company or to cease operations.

The audit and compliance is responsible for monitoring the financial reporting process and the effectiveness of internal control and risks management systems and where applicable, its internal audit, regarding the accounting and financial reporting procedures.

The financial statements were approved by the Board of Directors.

Statutory Auditors' Responsibilities for the Audit of the Financial Statements

Objectives and audit approach

Our role is to issue a report on the financial statements. Our objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with professional standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As specified in Article L.823-10-1 of the French Commercial Code (*Code de commerce*), our statutory audit does not include assurance on the viability of the Company or the quality of management of the affairs of the Company.

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As part of an audit conducted in accordance with professional standards applicable in France, the statutory auditor exercises professional judgment throughout the audit and furthermore:

- identifies and assesses the risks of material misstatement of the financial statements, whether due to fraud or error, designs and performs audit procedures responsive to those risks, and obtains audit evidence considered to be sufficient and appropriate to provide a basis for his opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtains an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the internal control;
- evaluates the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management in the financial statements;
- assesses the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Company's ability to continue as a going concern. This assessment is based on the audit evidence obtained up to the date of his audit report. However, future events or conditions may cause the Company to cease to continue as a going concern. If the statutory auditor concludes that a material uncertainty exists, there is a requirement to draw attention in the audit report to the related disclosures in the financial statements or, if such disclosures are not provided or inadequate, to modify the opinion expressed therein;
- evaluates the overall presentation of the financial statements and assesses whether these statements represent the underlying transactions and events in a manner that achieves fair presentation.

Report to the Audit and Compliance Committee

We submit a report to the audit and compliance committee which includes in particular a description of the scope of the audit and the audit program implemented, as well as the results of our audit. We also report, if any, significant deficiencies in internal control regarding the accounting and financial reporting procedures that we have identified.

Our report to the audit and compliance committee includes the risks of material misstatement that, in our professional judgment, were of most significance in the audit of the financial statements of the current period and which are therefore the key audit matters that we are required to describe in this report.

We also provide the audit and compliance with the declaration provided for in Article 6 of Regulation (EU) N° 537/2014, confirming our independence within the meaning of the rules applicable in France such as they are set in particular by Articles L.822-10 to L.822-14 of the French Commercial Code (*Code de commerce*) and in the French Code of Ethics (*Code de déontologie*) for statutory auditors. Where appropriate, we discuss with the audit and compliance committee the risks that may reasonably be thought to bear on our independence, and the related safeguards.

Paris La Défense, February 28th, 2019
The statutory auditors

French original signed by

KPMG AUDIT IS

Jacques Pierre
Partner

Deloitte & Associés

Philippe Battisti Ariane Bucaille
Partners

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6.7 FIVE-YEAR SUMMARY

(in euros)	2014	2015	2016	2017	2018
I SHARE CAPITAL AT THE END OF THE YEAR					
Share capital	143,004,225	143,004,225	144,450,000	144,450,000	144,450,000
Number of shares issued	57,201,690	57,201,690	57,780,000	57,780,000	57,780,000
Maximal number of potential shares					
• by exercise of subscription rights					
• by allocation of incentive plan shares			1,034,208	990,476	969,076
II SELECTED INCOME STATEMENT INFORMATION					
Revenue, excluding VAT	57,397,383	67,520,049	70,670,559	106,964,855	108,049,908
Net income (loss) excluding income taxes, depreciation and amortization, and provisions	69,534 471	149,573,842	73,962,829	119,422,233	154,115,898
Income taxes	12,383,835	22,083,024	19,276,634	24,418,956	7,765,016
Net income (loss) after income taxes, depreciation and amortization, and provisions	49,492,955	120,002,281	41,705,613	71,341,012	190,344,786
Dividends distributed	52,625,554	68,642,028	75,114,000	106,893,000	109,782,000
III SELECTED INFORMATION PER SHARE					
Net income (loss) excluding depreciation and amortization, and provisions	1.00	2.23	0.95	1.64	2.53
Net income (loss) after income taxes, depreciation and amortization, and provisions	0.87	2.10	0.72	1.23	3.29
Dividends distributed	0.92	1.20	1.30	1.85	1.90*
IV STAFF					
Number of salaried staff	47	46	47	44	41
Total remuneration	5,780,319	4,291,841	5,200,098	4,955,371	6,311,387
Amount of employee fringe benefits (social security, staff benefits)	2,441,474	1,902,873	2,189,472	3,244,785	3,948,665

* *To be proposed to the AGM to be held on May 9, 2019.*

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7.1 INFORMATION ABOUT THE COMPANY

7.1.1 General information about the Company

Corporate name

Teleperformance SE

Registration location and number – LEI

Paris Trade and Companies Register No. 301 292 702

APE business activity code: 6420Z

LEI: 9695004GI61FHFFNRG61

Registered office and central administration

21-25, rue Balzac – 75008 Paris – France

Telephone: +33 1 53 83 59 00

Legal form – applicable law

The combined shareholders' meeting held on May 7th, 2015 approved the conversion of the legal form of the Company by adopting the form of a European Company *(Societas Europaea)*. Since June 23rd, 2015, effective date of conversion, Teleperformance is a European Company having its registered office in France. It is governed by the provisions of the European Council Regulation (EC) No. 2157/2001 dated October 8th, 2001 governing the statutes of European companies, the provisions of the European Council Directive No. 2001/86/CE of October 8th, 2001, the provisions of the French Commercial Code for companies in general and European companies in particular and by its articles of association.

Date of incorporation and term

The Company was incorporated on October 9th, 1910. It will expire on October 9th, 2059, except in the event of extension or early dissolution.

Financial year

From January 1st to December 31st every year.

Access to legal documents and regulated information

Legal documents relating to the Company are available for review at the Company's registered office (21-25, rue Balzac – 75008 Paris, France).

Permanent and occasional regulated information is available on the Company's website at www.teleperformance.com, section "Investor Relations".

7.1.2 Memorandum and articles of association

7.1.2.1 Corporate purpose

Under the terms of Article 3 of the articles of association, the Company's purpose in France and abroad is as follows:

1. all industrial, commercial, personality and realty transactions of all kinds;
2. publishing and the publication of all documents, books, works, reviews and periodicals of all kinds as well as the direct and indirect promotion, merchandising, advertising and marketing of books, publications and films;
3. all activities as a service provider in the retail or specialized communication and advertising sector.

   Within the scope of this business activity, designing and performing promotional, public relations, marketing, telemarketing and teleservices actions, purchase of advertising space, space brokerage, and the publication and production of audiovisual works;
4. the creation of branch offices and agencies in France and in all countries as well as directly or indirectly participating in any form whatsoever in all operations which may be connected to the above-mentioned objects by creating new companies, subscribing to issues for companies being formed, or purchasing shares of existing companies or in any other way as well as taking of financial interests;
5. providing advice to third parties and its direct and indirect subsidiaries in financial, commercial, administrative and legal matters.

7.1.2.2 Administration and management of the Company

Board of Directors

The Company is managed by a Board of Directors comprising 3 to 18 members, subject to the statutory exception in the event of a merger. Directors may be individuals or legal entities.

Pursuant to Article 17 of the articles of association, the Board of Directors manages and administers the Company. Subject to the powers expressly reserved by law to general meetings of shareholders and within the limits of the corporate purpose, it examines any issue relating to the normal running of the Company and through its deliberations, deals with matters that affect it. It has the powers and authority as specified under the French Commercial Code. The Board meets at least once a quarter in order to review the Company's operations and future outlook.

The Board of Directors' missions include, but are not limited to, the following:

- approving the annual company and consolidated financial statements;
- convening general meetings of shareholders;
- deciding to issue bonds;
- approving regulated related-party agreements;
- authorizing sureties, endorsements and guarantees;
- setting up all Committees and determining their powers;
- deciding on interim dividend distributions.

Furthermore, the Board of Directors determines or authorizes expressly and prior to their completion:

- approval of consolidated annual budgets;
- any significant (commercial, industrial, financial, real estate or other) transaction that the general management plans, not comprised under the approved strategy or budget, including, in particular, moveable or immoveable investment by external or internal growth, where the amount represents more than 20% of the Group's net assets as reports in the latest consolidated financial statements approved by the Board of Directors;
- conclusion of alliances of any kind involving a material proportion of consolidated revenues;
- proposal of dividend distributions to general meetings of shareholders.

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Executive management

Under the terms of Article 19 of the articles of association, executive management is exercised under the responsibility of either the Chairman of the Board or another individual appointed by the Board of Directors and who has the title of Chief Executive Officer *(directeur général)*.

The Board of Directors chooses between these two ways of exercising the executive management. The shareholders and third parties must be informed of this choice in accordance with the terms laid down by law.

The Chief Executive Officer has full powers to act in any circumstances in the Company's name. He must exercise his powers within the limits of the corporate purpose and subject to the powers expressly reserved by law to general meetings of shareholders and the Board of Directors.

Upon proposal by the Chief Executive Officer, the Board of Directors may appoint one or more individuals responsible for assisting the Chief Executive Officer, with the title of Deputy Chief Executive Officer *(directeur général délégué)*. With the Chief Executive Officer's agreement, the Board of Directors determines the scope and duration of the powers granted to the Deputy Chief Executive Officers. They have the same powers as the Chief Executive Officer *vis-à-vis* third parties.

The composition and modalities related to the Board of Directors and the executive management of the Company are described in section 3 of the present Registration Document.

7.1.2.3 Description of rights, privileges and restrictions, if any, on existing shares and each class of shares

Form of securities

Under the terms of Articles 6, 10 and 11.1 of the articles of association, all bearer and registered shares, as decided by the shareholder, belong to the same class, except where legal or regulatory provisions impose, in certain cases, shares to be under the registered form. Shares are fully negotiable unless legal or regulatory provisions provide otherwise.

Under Article 12 of the articles of association, shares are indivisible with respect to the Company. Joint owners of shares must be represented *vis-à-vis* the Company and at general meetings by only one of them who shall be deemed to be the sole owner, or by a single agent. In the event of a disagreement, the single agent can be designated by a court on application from the first co-owner to act.

Unless the Company is notified of an agreement to the contrary, beneficial owners *(usufruitiers)* of shares validly represent bare owners *(nu-propriétaires)* vis-à-vis the Company. However, the voting right belongs to the beneficial owners in ordinary general meetings and to the bare owners at extraordinary or special general meetings.

The voting right for pledged shares is exercised by the owner and not by the pledgee.

Voting rights of shareholders

Under the terms of Article 25 of the articles of association, each shareholder has as many votes as they possess or represent shares. However, a double voting right is granted to all paid up shares for which proof is provided of registration in the name of the same shareholder for at least four years.

The provision concerning double voting rights was introduced in the Company's articles of association by the Extraordinary shareholders' meeting held on June 26th, 1985. Said meeting established a five-year holding period, which was reduced to four years by a resolution of extraordinary shareholders' meeting held on June 17th, 1996.

The double voting right automatically ceases for any share that has been converted into a bearer share or transferred. The new owner recovers the double voting right only once the share has been registered in the shareholder's name for four years; however, the fixed time period is not interrupted and the acquired right is maintained when the transfer is from a registered owner to a registered owner as a result of a succession, a division of community of property between spouses, of donation *inter vivos* benefitting a spouse or a person with a degree of relationship which entitles them to inherit.

In the event of an increase in share capital by capitalization of reserves, profits or issue premiums, the double voting right is granted, as soon as they are issued, to the registered shares allotted free of charge to a shareholder in proportion to the old shares with respect to which he benefits from this right.

If the Company is merged or split up, the double voting rights can be exercised within the beneficiary company or companies if their articles of association provide for such voting rights.

7.1.2.4 Shareholders' meetings

Convening general meetings

Under the terms of Article 23 of the articles of association, general meetings are convened in accordance with the law and with the provisions of the European Council Regulation (EC) No. 2157/2001 of October 8th, 2001 governing the statutes of European companies. shareholders who have held registered shares for at least a month when the notice to attend is published are furthermore invited to attend any meeting by ordinary letter or, at their request and cost, by registered letter.

The Company publishes the information and documents required by law in the *Bulletin des annonces légales obligatoires* (legal gazette) and on its website, within the legal time limits.

If a meeting has been unable to deliberate because the required quorum was not reached, the second meeting, and if necessary the second adjourned meeting is convened in the manner and within the time period provided under current regulations. The notice and invitations to attend this second meeting must reproduce the date and the agenda of the first meeting.

Agenda

Under the terms of Article 24 of the articles of association, the agenda for meetings appears in the notice and convening letters. It is established by the party in charge of the convening.

However, one or more shareholders are entitled to have points or draft resolutions included in the agenda, pursuant to applicable legal and regulatory provisions.

The meeting cannot consider a matter which is not included in the agenda. Nevertheless, it can, in all cases, dismiss one or more directors and replace them.

An agenda for a meeting cannot be modified the second time it is convened.

Assistance or representation at general meetings (Article 25 of the articles of association)

In accordance with legal and regulatory provisions, any shareholder is entitled to participate in general meetings and to take part to its deliberations in person or through a proxy, regardless of the number of shares held, by simply providing proof of his or her identity, so long as the shares are fully paid-up and registered in an account in the shareholders' name or in the name of the intermediary registered on his or her behalf pursuant to the seventh paragraph of Article L.228-1 of the French Commercial Code, as at midnight (Paris time) on the second business day preceding the meeting, either in the registered securities accounts held by the Company, or in the bearer securities accounts held by the authorized intermediary.

A shareholder can be represented by another shareholder, by his or her spouse, by his or her civil partner (*partenaire pacsé*) or by any individual or legal entity it chooses. The proxy must provide evidence of his or her authority in this case.

Quorum and deliberations (Articles 27 and 28 of the articles of association)

The ordinary general meeting can only validly deliberate, when first convened, if the shareholders present or represented or voting by correspondence hold at least one fifth of the shares with voting rights. No quorum is required when a meeting is convened for a second time.

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Resolutions are adopted by a majority of the votes cast and shall not include votes attaching to shares in respect of which the shareholder has abstained or has returned a blank (except the blank proxy to the Chairman) or spoilt ballot paper.

The extraordinary general meeting can only validly deliberate if the shareholders which are present or represented, or who vote by correspondence hold at least, when first convened, one-quarter and, when convened a second time, one-fifth of the shares with voting rights.

The meeting passes resolutions on a two-thirds majority of votes cast and shall not include votes attaching to shares in respect of which the shareholder has abstained or has returned a blank (except the blank proxy to the Chairman) or spoilt ballot paper.

7.1.2.5 Earnings

Under the terms of Article 32 of the articles of association, the net income for each financial year, after deducting the Company's overheads and other charges including amortization and provisions, constitutes the net profits or losses for the financial year.

At least one twentieth of net income less any retained losses brought forward shall be deducted from the net income to form a reserve fund known as "legal reserve". This withdrawal to the legal reserve shall cease to be compulsory when said reserve reaches an amount equal to one-tenth of share capital. It shall resume if the "legal reserve" falls below this proportion for any reason.

The balance, plus any retained earnings brought forward, constitutes earnings that may be distributed to shareholders by way of dividends.

However, shareholders' general meetings can deduct from the profit, before any dividends are paid, any sums it considers necessary, either to be carried forward to the next financial year, or to be entered into one or more general or special reserve accounts, for which the meeting shall freely determine the appropriation or use.

In addition, general meetings may decide to distribute sums from optional reserves, either to supply or supplement a dividend, or as an exceptional dividend. In this case, the general meeting resolution must expressly state the reserve accounts from which the amounts are withdrawn.

Shareholders' meetings, or otherwise the Board of Directors, lay down the dividend terms of payment.

However, dividends must be paid out within a maximum period of nine months after the financial year end. This period can be prolonged by judicial decision.

No dividends can be claimed back from shareholders, unless payments of fictitious dividends or fixed or interim interests, prohibited by law, provided that the Company proved that the beneficiaries know of the irregular nature of this dividend or could not have been unaware of it in the circumstances.

Dividends which are unclaimed within five years are time-barred.

Any retained losses, after the general meeting has approved the financial statements, shall be posted to a special reserve asset account, which will remain until they are offset and eventually written off against earnings of future financial years.

The general meeting called to approve the annual financial statements has the power to grant each shareholder the option to receive all or part of the dividend distributed, or any interim dividends, either in cash or in the form of shares.

7.1.2.6 Identification of holders of securities

Under the terms of Article 13 of the articles of association, the Company reserves the right, at any time and at its own expenses, to request from the central custodian, any and all information concerning its shareholders or holders of securities conferring immediately or in future the right to vote at general meetings, their identity and address, the number of securities held by each one and any restrictions affecting such securities.

7.1.2.7 Shareholding thresholds crossings

The articles of association do not provide for any disclosure requirements in the event of crossing shareholding thresholds, which remains governed by legal and regulatory provisions in force.

7.1.2.8 Changes in share capital, shareholder rights and articles of association

Share capital and shareholder rights can be changed under legal and regulatory provisions as the Company's articles of association do not provide for any more restrictive specific rules. Similarly, the articles of association are modified under the legal and regulatory provisions.

7.1.2.9 Provisions which have the effect of delaying, deferring or preventing a change in control

There are no special provisions in the articles of association, which have the effect of delaying, deferring or preventing a change in control of the Company.

7.2 SHARE CAPITAL

7.2.1 Amount of issued share capital

As of December 31st, 2018, the Company's share capital amounted to €144,450,000 divided into 57,780,000 fully paid-up shares of the same class, each with a par value of €2.50.

As of December 31st, 2018, these 57,780,000 shares represented 58,861,116 theoretical (or gross) voting rights and 58,633,526 actual (or net) voting rights. As of January 31st, 2019, they represent 58,860,515 theoretical (or gross) voting rights and 58,597,286 actual (or net) voting rights.

The difference between the number of shares and voting rights results from the existence of double voting rights.

The difference between the number of theoretical (or gross) voting rights and the number of actual (or net) voting rights corresponds to the number of treasury shares as well as to the shares held by the Group (shares held by Teleperformance Group, Inc., 100% subsidiary of the Teleperformance SE, deprived of voting rights).

7.2.2 Securities not representing share capital

None.

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7.2.3 Authorized and non-issued share capital

The status of delegations and authorizations approved by the shareholders' meetings held on April 28th, 2016, June 23rd, 2017 and April 20th, 2018 and the propositions of delegations and authorizations to be submitted to the shareholders' meeting to be held on May 9th, 2019 are described in the report on corporate governance (see section 3.1.3.2.2 of this Registration Document).

7.2.4 Shares held by the Company

7.2.4.1 Current authorizations

Status of the authorizations approved by the Shareholders' Meetings held on June 23rd, 2017 and April 20th, 2018 and propositions of authorizations submitted to the Combined Shareholders' Meeting to be held on May 9th, 2019:

	Date of shareholders' meeting (resolution No.)	Duration (expiry)	Terms
Share repurchases*	April 20th, 2018 (17th)	18 months (Oct. 2019)	Maximum purchase price per share: €180 Limit: 10% of the total number of shares
	May 9th, 2019 (16th)	**18 months (Nov. 2020)**	**Maximum purchase price per share: €180 Limit: 10% of the total number of shares**
Cancellation of shares	June 23rd, 2017 (16th)	26 months (August 2019)	10% of the total number of shares on date of cancellation decision
	May 9th, 2019 (17th)	**26 months (July 2021)**	**10% of the total number of shares on date of cancellation decision**

* *Authorization suspended during a public offering.*

7.2.4.2 Treasury shares

As of December 31st, 2018, the Company owned 40,027 treasury shares all held in connection with the liquidity contract.

As of January 31st, 2019, the Company held 23,610 treasury shares, all held in connection with the liquidity contract.

At those dates, no shares were allocated to cover performance share plans, nor for the purposes of cancellation.

7.2.4.3 Shares held by the Group

Teleperformance Group, Inc. (TGI), a 100% US subsidiary of the Company owns Teleperformance SE shares. These shares were purchased by TGI in connection with the implementation of the long-term incentive plan decided by TGI in April 2016 (see section 3.2.2.3 *Stock subscription or purchase options and performance shares grants to executive officers*). These purchases were carried out as follows:

- pursuant to an agreement entered into with Oddo BHF, on August 1st, 2018, with effect on August 16th, 2018, by which that independent investment service provider, has purchased, for and on behalf of TGI, 170,000 Teleperformance SE shares;
- pursuant to an agreement entered into with Goldman Sachs International, on December 10th, 2018, with effect on December 24th, 2018 by which that independent investment service provider, has purchased, for and on behalf of TGI, 109,041 Teleperformance SE shares (of which 10,499 shares as of December 31st, 2018).

As of February 28th, 2019, TGI owned 279,041 Teleperformance SE shares, purchased at a gross weighted average price of €158.40 and for a total gross amount of €44,201,197.07.

7.2.4.4 Share buy-back program – Description of the new program

Summary of the current buy-back program

The Shareholders' Meeting held on April 20th, 2018 authorized the Board of Directors to purchase the Company's own shares, for an 18-month period, and terminated the previous authorization granted by the Combined Shareholders' Meeting held on June 23rd, 2017.

Pursuant to said authorization, the Board of Directors at its meeting held on April 20th, 2018 resolved to set up a new share buy-back program limited to 10% of the share capital with a maximum purchase price per share of €180.

The objectives of this share buy-back program are as follows:

- ensure the coverage of stock option plans and/or performance share plans (or similar plans) in favor of Group employees and/or corporate officers, as well as all share allocations under Company or Group savings plans (or similar plans) and profit-sharing schemes and/or all other forms of share allocation to Group employees and/or executive officers;
- ensure the coverage of securities giving rights to the share capital of the Company in accordance with the regulations in force;
- retain the purchased shares and subsequently deliver them as consideration of an exchange or a payment in connection with possible external growth transactions, it being specified that shares acquired for this purpose cannot exceed 5% of the Company's share capital;
- stimulate the secondary market or ensure the liquidity of the Teleperformance share through the activities of an investment service provider under a liquidity agreement in compliance with the AMAFI Code of ethics authorized by the regulations, it being specified that, in this context, the number of shares taken into account for the calculation of the limit, corresponds to the number of shares purchased, after deduction of the number of shares resold;
- possibly cancel the shares repurchased pursuant to the authorization granted by the Shareholders' Meeting held on June 23rd, 2017 in its 16th extraordinary resolution;
- carry out, in general, any transaction permitted under current regulations.

Liquidity contract

The Company, Oddo & Cie and Oddo Corporate and Finance have terminated the liquidity agreement entered into on January 5th, 2007, effective April 11th, 2018 at the close of business. On March 30th, 2018, the Company entered into a liquidity contract with Kepler Cheuvreux, effective as of April 13th, 2018, pursuant to the AMAFI Code of ethics approved by the regulations in force.

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Following the French Market Authority Decision No. 2018-01 dated July 2nd, 2018 concerning the implementation of liquidity contracts on share capital pursuant to the accepted practice, an amendement to the liquidity contract, in compliance with the new practice approved by the regulations, was entered into with Kepler Cheuvreux on January 14th, 2019 with effect as of January 1st, 2019.

As at December 31st, 2018, assets held in the liquidity account were as follows: 40,027 shares and €2,361,837.76.

Share repurchases or reallocations in connection with other objectives

None.

Summary of the purchase and sale transactions on Company's own shares during 2018

Number of shares purchased	956,746
Average purchase price	€135.90
Number of shares sold	942,119
Average sale price	€135.72
Trading costs	€56,603.34 (excl. taxes)
Number of treasury shares held as of December 31st, 2018	40,027
Percentage of share capital held by the Company as of December 31st, 2018	0.069%
Book value of treasury shares held as of December 31st, 2018*	€5,594,059.11
Market value of treasury shares held as of December 31st, 2018**	€5,587,769.20
Total nominal value of treasury shares*** as of December 31st, 2018	€100,067.50
Number of shares canceled over the last 24 months****	0

* *Book value before impairment.*
** *Based on the average purchase price, i.e. €139.75 per share.*
*** *All treasury shares held as of December 31st, 2018 are shares held pursuant to the objective of stimulating the secondary market or ensuring the liquidity of the Teleperformance share through the activities of an investment service provider under a liquidity agreement pursuant to the regulations in force.*
**** *No cancellation in 2018.*

New share buy-back program

It will be proposed to the Shareholders' Meeting to be held on May 9th, 2019 to renew the authorization for the Company to purchase its own shares under the following terms:

Program objectives

- ensure the coverage of stock option plans and/or performance share plans (or similar plans) in favor of Group employees and/or corporate officers, as well as all share allocations under Company or Group savings plans (or similar plans) and profit-sharing schemes and/or all other forms of share allocation to Group employees and/or executive officers;
- ensure the coverage of securities giving right to the share capital of the Company in accordance with the regulations in force;
- retain shares purchased for the purpose of subsequently delivering them as consideration of an exchange or payment in connection with possible external growth transactions, it being specified that shares acquired for this purpose cannot exceed 5% of the Company's share capital;
- stimulate the secondary market or the liquidity of the Teleperformance share through the activities of an investment services provider under a liquidity contract in compliance with the practises permitted by the regulations, it being specified that, in this context, the number of shares taken into account for the calculation of the limit, corresponds to the number of shares purchased, after deduction of the number of shares resold;
- possibly cancel the repurchased shares, pursuant to the authorization to be granted by the Shareholders' Meeting to be held on May 9th, 2019 in its 17th extraordinary resolution;
- carry out, in general, any transaction permitted under current regulations.

Terms of repurchases

These shares purchases may be carried out by any means, including by the acquisition of blocks of trade, and at the time that the Board of Directors shall determine. The Company retains the right to use optional mechanisms or derivative instruments pursuant to applicable regulations. The maximum portion of share capital that may be transferred by way of a block of trade may be equivalent to the entire share repurchase program. These repurchases shall not be executed during the period of a public offering initiated by a third party on the Company's shares and until the end of the period of the public offering.

Maximum proportion of share capital, maximum number and characteristics of the shares and maximum purchase price

The maximum percentage of shares which may be repurchased under the authorization proposed to the shareholders' meeting to be held on May 9th, 2019 is set at 10% of the total number of shares comprising the share capital (or 5,778,000 shares as of the date of the present Registration Document), it being specified that this limit shall be applied as of the date of purchase, in order to take account of any transactions that increase or reduce share capital occurring during the term of the program. The number of shares taken into account for the calculation of this limit shall be the number of shares purchased less the number of shares sold during the duration of the program in connection with the liquidity objective.

Given that the Company may not hold more than 10% of its share capital, and as the number of treasury shares held on January 31st, 2019 amounted to 23,610 (*i.e.*, 0.04% of the share capital), the maximum number of shares that can be purchased stands at 5,754,390 representing 9.96% of the share capital unless existing treasury shares are transferred or canceled.

The maximum purchase price proposed to the shareholders' meeting to be held on May 9th, 2019 is set at €180 per share. Therefore, the maximum transaction amount is set at €1,035,790,200 based on a number of shares of 57,780,000.

Term of the program

In accordance with the resolution which will be submitted for approval to the shareholders' meeting to be held on May 9th, 2019, the share buy-back program will be implemented over a period of 18 months following the date of said meeting expiring on November 8th, 2021.

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7.2.5 Potential share capital

7.2.5.1 Securities giving access to the Company's share capital

None.

7.2.5.2 Stock options

Options granted by the Company

None.

Options granted by companies controlled by the Company

None.

7.2.5.3 Performance shares granted under no consideration

Pursuant to the authorizations granted by the combined shareholders meetings dated May 30th, 2013 (21st resolution) and April 28th, 2016 (16th resolution), the Company's Board of Directors has implemented six performance share plans for the benefit of some Group employees and corporate officers.

Details of the performance share plans

Performance shares granted under no consideration are subject to a vesting period of three years running from the date of grant. The definitive grant is subject to the beneficiaries continued presence and achievement of performance criteria. Following the vesting period, depending on the actual increase in indicators set by the Board of Directors, the beneficiaries definitively acquire, depending of the plans regulations, either all, 75%, 50% or none of the shares granted. For the plans granted under the authorization of May 30th, 2013, the shares definitively vested must be retained by the beneficiaries for a period of two years.

Synthesis of the outstanding performance share plans granted by the Company

Plan Ref.	130730TP	160428TP	161102TP	170623TP	180102TP	180228TP
Date of shareholders' meeting	05/30/2013	04/28/2016	04/28/2016	04/28/2016	04/28/2016	04/28/2016
Date of Board meeting	07/30/2013	04/28/2016	11/02/2016	06/23/2017	11/30/2017	02/28/2018
Grant date	07/30/2013	04/28/2016	11/02/2016	06/23/2017	01/02/2018	02/28/2018
Total number of share rights granted	840,000	914,300	151,508	11,600	6,000	1,000
Total number of beneficiaries	126	239	29	1	1	1
of which total number granted to executive officers:						
• Daniel Julien*	-	-	-	-	-	-
• Olivier Rigaudy**	-	-	-	-	-	-
Vesting date	07/30/2016	04/28/2019	11/02/2019	06/23/2020	01/02/2021	02/28/2021
End of lock-in period	07/30/2018	-	-	-	-	-
Performance criteria	YES	YES	YES	YES	YES	YES
Nature of shares granted	New or existing shares	New or existing shares	New or existing shares	New or existing shares	New or existing shares	New or existing shares
Total number of share rights cancelled or lapsed	205,000	103,700	11,632	0	0	0
Number of shares definitively vested	635,000	-	-	-	-	-
Number of outstanding rights	-	810,600	139,876	11,600	6,000	1,000

* *See below section Performance shares granted by companies controlled by the Company.*
** *Deputy Chief Executive Officer since October 13th, 2017.*

As of February 28th, 2019, on all plans, there were 969,076 outstanding rights to performance shares that may be acquired by beneficiaries (after deducting acquired shares or canceled shares due to beneficiaries' departures).

With regard to the plans 161102TP, 170623TP, 180102TP and 180228TP, the vesting of shares may have no dilutive effect in respect of existing shares or, in the case of new shares, may lead to the issue of 969,076 new shares, representing a potential maximum share capital increase of €2,422,690 and a maximum potential dilution of 1.7%.

Grant under the authorization given by the shareholders' meeting held on May 30th, 2013

Plan dated July 30th, 2013 (Plan 130730TP)

At its meeting held on July 30th, 2013, the Board of Directors decided to grant a total of 840,000 performance shares of the Company in favor of 126 beneficiaries. The vesting period for this plan is three years, *i.e.* until July 30th, 2016. The retention period was two years, *i.e.* until July 30th, 2018.

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As described in section 2.2.5.3 of the 2016 Registration Document, the Board of Directors, at its meeting held on February 24th, 2016, has, upon recommendation of the Remuneration and Appointments Committee, and after review of financial items by the Audit Committee, noted that the fixed performance conditions were met. As a result, a total of 635,000 shares, of which 56,690 existing shares and 578,310 new shares, were transferred on August 1st, 2016 (1st business day following the date of definitive acquisition) to the beneficiaries that met the attendance requirement on July 30th, 2016. The two-year retention period for these shares ended on July 30th, 2018. Furthermore, as the modalities of the long-term incentive plan (see section 3.5.2.4 *Grant of stock options and performance shares to executive directors of the 2016 Registration Document*) were identical to those set by the Board of Directors for the performance share plan, the latter authorized the Company Teleperformance Group, Inc. to take an identical decision regarding the achievement of the performance conditions of the long-term incentive plan. It is specified that the executive directors which benefited from that plan did not take part to such decision.

Grants under the authorization given by the shareholders' meeting held on April 28th, 2016 and currently ongoing

Plan dated April 28th, 2016 (Plan 160428TP)

At its meeting held on April 28th, 2016, upon recommendation of the Remuneration and Appointments Committee, the Board of Directors decided to grant a total of 914,300 performance shares of the Company in favor of 239 beneficiaries, in the form of new shares to be issued or existing shares. The vesting period for this plan is three years, *i.e.* from April 28th, 2016 to April 28th, 2019 inclusive. This grant is not subject to any lock-in period, which will thus be freely transferrable immediately upon vesting as from April 29th, 2019. The definitive acquisition of the performance shares thus granted is subject, for all beneficiaries, in addition to the performance criteria described hereafter, to a condition of presence as at the date of definitive acquisition, *i.e.* April 28th, 2019.

The Board of Directors decided to make the definitive vesting of the performance shares conditional upon the achievement of the performance criteria based on the achievement of three out of four performance criteria indicative of the Group's performance and measured over a three-year period starting from January 1st, 2016 to December 31st, 2018 as described below:

- the first performance criterion is based on the average growth of Group consolidated revenues (at constant exchange rate and scope of consolidation) (the "Average Revenue Growth");
- the second performance criterion is based on the average margin rate of the Group consolidated EBITA (excluding non-recurring items) (the "Average EBITA Margin");
- the third performance criterion consists of the difference between the three-year average of (A) the annual performance of the Teleperformance SE share price and (B) the annual performance of the SBF120 index, in each case measured over the period from January 1st, 2016 through December 31st, 2018 (the "Stock Price Evolution");
- the fourth performance criterion consists of the effectiveness in managing the Group strategic and technological evolutions in a fast moving and challenging environment (the "Long-Term Qualitative Criterion").

Out of the four performance criteria, only those three representing the best level of performance, according to the performance targets for quantitative and for the Long-Term Qualitative Criterion, as set forth below (the "Eligible Criteria") will be taken into consideration in order to determine the percentage of shares credit. The determination of the Eligible Criteria shall be made by the Board of Directors upon proposition of the Remuneration and Appointments Committee.

The final percentage of shares credit shall be equal to the addition of percentages of shares credit determined for each of the three performance criteria showing the best level of performance, as described hereafter, divided by three. Such a percentage of shares credit will then be applied to the number of performance shares originally allocated to each beneficiary in order to calculate the final number of shares. The final performance shares acquired by each beneficiary shall be rounded up to the nearest whole number.

Performance targets for quantitative criteria

Percentage of shares credit	0%	50%	75%	100%
Average Revenue Growth	Below 3.5%	Higher than 3.5% but less than 5.0% (both inclusive)		Above 5.0%
Average EBITA Margin	Below 10.3%	Higher than 10.3% (inclusive) but less than 10.4%	Higher than 10.4% (inclusive) but less than 10.5%	10.5% (inclusive) and above
Stock Price Evolution *vs.* annual performance of the SBF 120 index	Negative evolution	Above 0 and up to 2.5% (inclusive)		Above 2.5%

Performance targets for the qualitative criterion

The introduction of a qualitative criterion relating to the Group's strategic and technological evolutions is important for the Board as it materializes one of Teleperformance's priorities in the long-term. The Board considered that the preparation of the Group to strategic technological evolutions and its ability to face a new technological environment could become an important competitive advantage and create value for all its stakeholders.

In order to assess this criterion, three sub-criteria will be analyzed, each one with three tests, so that the evaluation shall be quite detailed and specific:

- ability of the management to develop a vision of the impact of technologies on the Group's future:
  - selection of the relevant technologies and new economy practices,
  - quality of the information collection on these technologies and practices,
  - strength of its network of contacts in the field;
- acquisition and adoption of new technologies:
  - in the area of production,
  - in the area of products and services,
  - acquisitions that give access to necessary technologies and/or practices;
- benchmark of the Group practices with competitors:
  - in the area of production,
  - in the area of products and services,
  - acquisitions that give access to necessary technologies and/or practices.

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A maximum of 15 points were allocated for each sub-criterion (5 by test). The percentage of shares credit allocated is as follows:

Number of points	Percentage of shares credit
0 to 25	0%
25 (inclusive) to 35	50%
35 (inclusive) to 45	100%

The Board of Directors, at its meeting held on February 28th, 2019, upon recommendation of its Remuneration and Appointments Committee, examined the levels of achievement of the performance criteria and noted that:

- the average growth rate of Group consolidated revenues (at constant exchange rate and scope of consolidation) amounted to 8.5%;
- the average margin rate of the Group consolidated EBITA (excluding non-recurring items) was set at 13.2%;
- the average rate of the annual performance of the share price compared to the annual performance of the SBF120 index was set at 73%.

With regards to the qualitative criteria, the Board, upon recommendation of its Remuneration and Appointments Committee, has reviewed the levels of achievement of the three sub-criteria and each of its tests. A similar analysis on the achievement and assessment of the 30 sub-criteria was conducted by the Research and development and digital integration teams.

The results were thus compiled criterion by criterion to which was attached a percentage of achievement depending on the actual achievement assessed as of December 31st, 2018. The compilation of these criteria resulted in a rate of global achievement of 65.2%.

Consequently, the Board of Directors, upon recommendation of its Remuneration and Appointments Committee, retained the three quantitative criteria as they presented the best level of performance, and has thus noted that the performance conditions were met and determined on that basis that the percentage of shares credit was set at 100%. Therefore, all the performance shares will be vested by the beneficiaries that will meet the attendance requirement on the vesting date, *i.e.* on April 28th, 2019.

Other grants decided by the Board of Directors

Under that same authorization, the Board decided to implement, for beneficiaries who have joined the Group or in the context of internal promotion, the plans described below. It is reminded that those additional grants did not concern executive officers of the Company and that the shares issued at the time of vesting are in the form of new shares to be issued or existing shares.

- **Plan dated November 2nd, 2016 (Plan 161102TP):** this plan grants a total of 151,508 performance shares in favor of 29 beneficiaries. The vesting period for this plan is three years, *i.e.* from November 2nd, 2016 to November 2nd, 2019 inclusive. This grant is not subject to any lock-in period and the performance shares can be disposed of at the end of the vesting period if the performance and the presence criteria are met.

  This plan was set up in favor of some senior executives of Teleperformance and of Language Line. In order to create and maintain cohesion and team spirit. The performance criteria are identical to those defined in the April 28th, 2016 plan (Plan 160428TP). Therefore, all the performance shares granted will be definitely acquired by the beneficiaries on November 2nd, 2019 (subject to the presence condition on that same date).

- **Plan dated June 23rd, 2017 (Plan 170623TP):** this plan grants a total of 11,600 performance shares in favor of one beneficiary. The vesting period for this plan is three years, *i.e.* from June 23rd, 2017 to June 23rd, 2020 inclusive. This grant is not subject to any lock-in period, which means that beneficiaries may dispose of their performance shares at the end of the vesting period if the performance criteria and the presence condition are met, *i.e.* as from June 24th, 2020.

  The definitive vesting of shares is subject to performance criteria based on levels of revenues and EBIT of a subsidiary of the Group and to a presence condition on the vesting date, *i.e.* on June 23rd, 2020.

- **Plan dated January 2nd, 2018 (Plan 180102TP):** this plan grants a total of 6,000 performance shares in favor of one beneficiary. The grant date for this plan is January 2nd, 2018 and the vesting period is three years, *i.e.* from January 2nd, 2018 to January 2nd, 2021.

  The definitive vesting of shares is subject to performance criteria based on levels of revenues and EBITDA of subsidiaries of the Group, measured over three years, *i.e.* from January 1st, 2018 to December 31st, 2020. This grant is not subject to any lock-in period, which means that the beneficiary may dispose of the performance shares at the end of the vesting period if the performance criteria and the presence condition are met, *i.e.* as from January 3rd, 2021.

- **Plan dated February 28th, 2018 (Plan 180228TP):** this plan grants a total of 1,000 performance shares in favor of one beneficiary. The vesting period is three years, *i.e.* from February 28th, 2018 to February 28th, 2021.

  The definitive vesting of shares is subject to performance criteria based on the achievement of internal projects linked to US subsidiaries of the Group, measured over three years, *i.e.* from February 28th, 2018 to February 28th, 2021. This grant is not subject to any lock-in period and that the beneficiary may dispose of the performance shares at the end of the vesting period if the performance criteria and the presence condition are met, *i.e.* as from March 1st, 2021.

Performance shares granted to the top ten non-executive employees

The performance share plans granted in 2018 did not concern non-executive employees of Teleperformance SE.

Performance shares granted by companies controlled by the Company

No performance shares were granted in 2018 by companies controlled by the Company.

It is reminded that Teleperformance Group, Inc., wholly-owned subsidiary of Teleperformance SE, implemented two long-term incentive plans based on Teleperformance SE shares:

- in July 2013, involving a total of 300,000 shares to the benefit of two beneficiaries, Mr. Julien, then Chairman of the Board of Directors and Mr. Paulo Cesar Salles Vasques, then Chief Executive Officer. The definitive vesting was subject to conditions of attendance and performance criteria identical to those adopted by the Company's Board of Directors for the July 30th, 2013 performance shares plan (Plan 130730TP). These performance shares were acquired by the beneficiaries on August 1st, 2016 and the retention period ended on July 31st, 2018;
- in April 2016, involving a total of 350,000 shares to the benefit of two beneficiaries, Mr. Julien, then Chairman of the Board of Directors and Mr. Paulo Cesar Salles Vasques, then Chief Executive Officer. The definitive vesting of shares is subject to conditions of attendance and performance criteria identical to those adopted by the Company's Board of Directors for the April 28th, 2016 performance share plan (Plan 160428TP). The Board of Directors, at its meeting held on February 28th, 2019, noted the achievement of the performance criteria (see Plan dated April 28th, 2016 (Plan 160428TP) above). Subject to the presence of the beneficiaries at the end of the vesting period, Teleperformance will deliver to the beneficiaries the Teleperformance SE shares that it would have previously purchased on the market.

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With regards to the shares granted to Mr Paulo César Salles Vasques, it is reminded the following:

- Following the termination of the executive functions of Mr. Paulo César Salles Vasques within the Group, the Board of Directors, at its meeting held on October 13th, 2017, decided, in accordance with recommendation 24.5.1 of the AFEP-MEDEF code, to reduce prorata temporis the right to acquire the 175,000 performance shares granted in April 2016 to take into account only the length of time during which, over the 3-year period of the plan, he has served as Chief Executive Officer and has been in charge of executive functions. The maximum number of shares that may be definitively acquired by Mr. Paulo César Salles Vasques at the end of this period has thus been reduced to 104,041. These shares are all subject to the performance conditions initially set.
- In addition, the Board, in agreement with Mr. Paulo César Salles Vasques, has also submitted the acquisition of 50% of these 104,041 shares, not only under the initial conditions, but also to the achievement by him of objectives in the framework of the non-executive functions that he has agreed to pursue within the Brazilian subsidiary, Teleperformance CRM SA, in order to maintain and develop the Group's business in Brazil.

  The Remuneration and Appointments Committee, on the basis of a report prepared by the President of the Ibero-LATAM region, the Chief Executive Officer in charge of Brazil, and in consultation with the Chairman and Chief Executive Officer and the Deputy Chief Executive Officer, found that these additional conditions were met. It is reminded that these additional criteria consisted in securing, for the long-term, relationships with the main clients in Brazil created and developed by Mr. Vasques during the period he was at leading operations in Brazil, but also following his appointment as Chief Executive Officer. He has thus facilitated the transition of these major clients by putting his knowledge of their specificities at the service of the Group. He has participated in quarterly meetings held in Brazil and in the United States, in the presence of Brazil's operational teams and the Group Chief Operations Officer and these same clients. He has provided the Group with his experience and expertise throughout this transition period and prepared detailed activity reports to the Chairman and Chief Executive Officer, the Deputy Chief Executive Officer, the President of the Ibero-LATAM region and Group Chief Operations Officer.

  As a result, subject to the presence condition, all the performance shares will be definitely acquired by the beneficiaries subject to the presence condition.

The terms of these long-term incentive plans are also described in section 3.2.2.3 *Stock subscription or purchase options and performance shares grants to executive officers* of the present Registration Document. As of February 28th, 2019, there were 279,041 outstanding rights to performance shares that may be acquired by beneficiaries.

7.2.6 Changes in share capital over the past three years

		Amount			Cumulated share capital	
Description	Date	**Nominal** *(in euros)*	**Issue or contribution premium** *(in euros)*	**Number of new shares issued/ canceled**	**In shares**	**In euros**
Share capital at 12/31/2015	12/31/2015	2.50	n/a	n/a	57,201,690	143,004,225.00
Performance share plan (July 30th, 2013 plan)	08/01/2016	2.50	n/a	578,310	57,780,000	144,450,000.00

7.3 SHAREHOLDING

7.3.1 Evolution of breakdown of share capital and voting rights

The tables below show the number of shares and corresponding percentages of share capital and voting rights held by the main known shareholders of Teleperformance SE over the last three financial years.

To the Company's knowledge, no material change occurred between December 31st, 2018 and the filing date of the present Registration Document, except concerning the information presented in section 7.3.1.4 below.

7.3.1.1 Breakdown of share capital and voting rights at December 31st, 2018

	Share capital		Theoretical voting rights		Actual voting rights	
At December 31st, 2018	**Number**	**%**	**Number**	**%**	**Number**	**%**
BlackRock Fund Advisors, LLC	2,772,300	4.8%	2,772,300	4.7%	2,772,300	4.7%
NN Group N.V.	2,253,500	3.9%	2,253,500	3.8%	2,253,500	3.8%
Fidelity Management & Research Company	2,051,600	3.6%	2,051,600	3.5%	2,051,600	3.5%
The Vanguard Group, Inc.	1,634,800	2.8%	1,634,800	2.8%	1,634,800	2.8%
Aberdeen Standard Investments	1,378,500	2.4%	1,378,500	2.3%	1,378,500	2.4%
Daniel Julien	974,314	1.7%	1,798,628	3.1%	1,798,628	3.1%
Main identified shareholders	**11,065,014**	**19.2%**	**11,889,328**	**20.2%**	**11,889,328**	**20.3%**
Other shareholders (public)	46,487,396	80.5%	46,744,198	79.4%	46,744,198	79.7%
Treasury shares	227,590	0.4%	227,590	0.4%	0	0.0%
TOTAL	**57,780,000**	**100%**	**58,861,116**	**100%**	**58,633,526**	**100%**

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7.3.1.2 Changes in the breakdown of share capital and voting rights in the last three years

At December 31st	2018 Number of shares	2018 % shares	2018 % actual voting rights	2017 Number of shares	2017 % shares	2017 % actual voting rights	2016 Number of shares	2016 % shares	2016 % actual voting rights
BlackRock Fund Advisors, LLC	2,772,300	4.8%	4.7%	2,709,100	4.7%	4.6%	2,887,400	5.0%	4.7%
NN Group N.V.	2,253,500	3.9%	3.8%	2,970,000	5.1%	5.0%	3,253,400	5.6%	9.9%
Fidelity Management & Research Company	2,051,600	3.6%	3.5%	1,321,500	2.3%	2.2%	1,728,900	3.0%	2.8%
The Vanguard Group	1,634,800	2.8%	2.8%	1,430,400	2.5%	2.4%	1,252,100	2.2%	2.0%
Aberdeen Standard Investments	1,378,500	2.4%	2.4%	366,200*	0.6%	0.6%	421,500*	0.7%	0.7%
Daniel Julien	974,314	1.7%	3.1%	974,314	1.7%	3.1%	974,314	1.7%	2.7%
Main identified shareholders	**11,065,014**	**19.2%**	**20.3%**	**9,771,514**	**16.9%**	**18.10%**	**10,517,614**	**18.2%**	**22.8%**
Other shareholders (public)	46,487,396	80.5%	79.3%	47,983,086	83.0%	82.0%	47,248,386	81.8%	77.2%
Treasury shares	227,590	0.4%	0.4%	25,400	0.0%	0.0%	14,000	0.4%	0.0%
TOTAL	**57,780,000**	**100%**	**100%**	**57,780,000**	**100%**	**100%**	**57,780,000**	**100%**	**100%**

* *Based on a Teleperformance SE shareholder identity study as of September 30th/shares held by Standard Life PLC before merging with Aberdeen Asset Management PLC on August 14th, 2017*

To the Company's knowledge as of December 31st, 2018 there is no other shareholder that directly or indirectly, acting alone or in concert, holds over 5% of the Company's share capital or voting rights.

With regard to the breakdown of the share capital described above, no shareholder directly or indirectly holds control of the Company within the meaning of Article L.233-3 of the French Commercial Code.

Geographical breakdown of institutional shareholders at September 30th,2018*

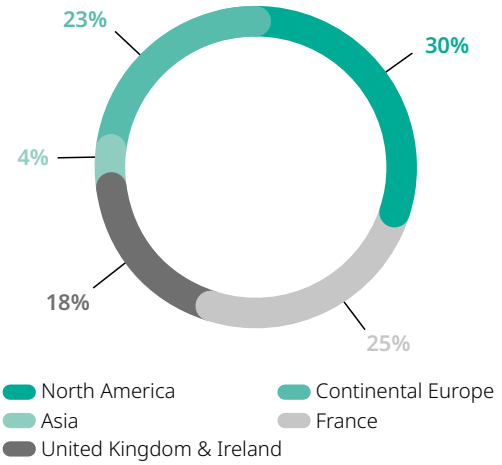

* *Based on a Teleperformance SE shareholder identity study as of September 30th, 2018, which identified 374 institutional investors.*

As of September 30th, 2018, institutional investors held 86% of the Company's share capital, compared to 85% the previous year.

7.3.1.3 Company shares held by employees

In accordance with the provisions of Article L.225-102 of the French Commercial Code, as of December 31st, 2018, the employees of the Company and related companies within the meaning of Article L.225-180 of the French Commercial Code hold no share of the Company (it being specified that only performance shares granted in accordance with Article L.225-97-1 of the French Commercial Code to employees pursuant to authorizations given after August 7th, 2015 are to be taken into account in this status).

7.3.1.4 Major changes in the breakdown of share capital

In accordance with Article L.233-13 of the French Commercial Code, and in light of the information received pursuant to Articles L.233-7 and L.233-12 of said code, the following threshold crossings occurred during the last three financial years:

Since the end of the last financial year

By letter received on February 27th, 2019, the company BlackRock Inc., acting on behalf of clients and funds which it manages, stated that it crossed upwards, on February 26th, 2019, the threshold of 5% of the capital of the company and that it held 2,904,481 shares representing the same amount of voting rights, *i.e.* 5.03% of share capital and 4.93% of voting rights of the company (AMF Notice No 219C0358 dated February 28th, 2019).

By letter received on February 28th, 2019, the same company stated that it crossed downward, on February 27th, 2019, the threshold of 5% of the capital of the company and that it held 2,847,012 shares representing the same amount of voting rights, *i.e.* 4.93% of share capital and 4.84% of voting rights of the company (AMF Notice No 219C0370 dated March 1st, 2019).

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In 2018

Declaration date	AMF Notice No	Transaction date	Registered intermediary or fund manager	Legal threshold	Nature of change	Number of shares	% of share capital	% of voting rights
01/04/2018	218C0031	01/03/2018	BlackRock Inc.	5% of share capital and voting rights	downward	2,882,730	4.99%	4.90%
01/09/2018	218C0062	01/08/2018	BlackRock Inc.	5% of share capital	upwards	2,910,046	5.04%	4.94%
01/10/2018	218C0076	01/09/2018	BlackRock Inc.	5% of voting rights	upwards	2,962,543	5.13%	5.03%
01/11/2018	218C0087	01/10/2018	BlackRock Inc.	5% of voting rights	downward	2,932,429	5.08%	4.98%
01/12/2018	218C0107	01/11/2018	BlackRock Inc.	5% of share capital	downward	2,861,566	4.95%	4.86%
02/08/2018	218C0381	02/07/2018	BlackRock Inc.	5% of share capital	upwards	2,912,628	5.04%	4.95%
02/12/2018	218C0405	02/09/2018	BlackRock Inc.	5% of share capital	downward	2,836,918	4.91%	4.82%
02/22/2018	218C0467	02/21/2018	BlackRock Inc.	5% of share capital	upwards	2,894,322	5.01%	4.92%
02/23/2018	218C0475	02/22/2018	BlackRock Inc.	5% of share capital	downward	2,856,795	4.94%	4.85%
02/26/2018	218C0482	02/23/2018	BlackRock Inc.	5% of share capital and voting rights	upwards	3,000,838	5.19%	5.10%
02/28/2018	218C0506	02/27/2018	BlackRock Inc.	5% of share capital and voting rights	downward	2,865,661	4.96%	4.87%
06/21/2018	218C1094	06/19/2018	NN Group N.V.	5% of share capital and voting rights	downward	2,830,473	4.90%	4.81%
09/27/2018	218C1594	09/26/2018	BlackRock Inc.	5% of share capital	upwards	2,907,264	5.03%	4.94%
09/27/2018	218C1599	09/27/2018	BlackRock Inc.	5% of share capital	downward	2,869,246	4.97%	4.88%
10/01/2018	218C1606	09/28/2018	BlackRock Inc.	5% of share capital	upwards	2,889,470	5.001%	4.91%
10/02/2018	218C1616	10/01/2018	BlackRock Inc.	5% of voting rights	upwards	2,947,593	5.10%	5.01%
10/04/2018	218C1631	10/03/2018	BlackRock Inc.	5% of voting rights	downward	2,889,872	5.002%	4.91%
10/05/2018	218C1640	10/04/2018	BlackRock Inc.	5% of share capital	downward	2,869,980	4.97%	4.88%
10/10/2018	218C1664	10/09/2018	BlackRock Inc.	5% of share capital and voting rights	upwards	2,960,975	5.12%	5.03%
10/12/2018	218C1675	10/11/2018	BlackRock Inc.	5% of voting rights	downward	2,905,323	5.03%	4.94%
10/15/2018	218C1679	10/12/2018	BlackRock Inc.	5% of voting rights	upwards	2,006,701	5.20%	5.11%
10/23/2018	218C1712	10/22/2018	BlackRock Inc.	5% of voting rights	downward	2,920,062	5.05%	4.96%
10/30/2018	218C1748	10/29/2018	BlackRock Inc.	5% of share capital	downward	2,879,058	4.98%	4.89%
11/01/2018	218C1760	10/31/2018	BlackRock Inc.	5% of share capital	upwards	2,891,833	5.005%	4.91%
11/02/2018	218C1770	11/01/2018	BlackRock Inc.	5% of share capital	downward	2,878,476	4.98%	4.89%
11/05/2018	218C1780	11/02/2018	BlackRock Inc.	5% of share capital	upwards	2,890,213	5.002%	4.91%
11/07/2018	218C1799	11/06/2018	BlackRock Inc.	5% of share capital	downward	2,862,332	4.95%	4.86%
11/22/2018	218C1879	11/21/2018	BlackRock Inc.	5% of share capital	upwards	2,909,157	5.03%	4.94%
11/26/2018	218C1891	11/23/2018	BlackRock Inc.	5% of share capital	downward	2,848,664	4.93%	4.84%

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In 2017

Declaration date	AMF Notice No	Transaction date	Registered intermediary or fund manager	Legal threshold	Nature of change	Number of shares	% of share capital	% of voting rights
02/23/2017*	217C0527	08/12/2016	NN Group N.V.	10% of voting rights	downward	3,253,419	5.69%	9.98%
07/17/2017	217C1612	07/14/2017	BlackRock Inc.	5% of share capital	upwards	2,897,105	5.01%	4.72%
07/19/2017	217C1647	07/18/2017	BlackRock Inc.	5% of share capital	downward	2,872,697	4.97%	4.68%
08/02/2017	217C1804	07/28/2017	NN Group N.V.	5% of voting rights	downward	3,064,934	5.30%	4.99%
08/04/2017	217C1826	08/02/2017	NN Group N.V.	5% of voting rights	upwards	3,038,934	5.26%	5.16%
08/08/2017	217C1861	08/07/2017	BlackRock Inc.	5% of share capital	upwards	2,903,329	5.02%	4.93%
08/10/2017	217C1887	08/09/2017	BlackRock Inc.	5% of share capital	downward	2,883,201	4.99%	4.90%
08/14/2017	217C1917	08/11/2017	BlackRock Inc.	5% of share capital and voting rights	upwards	2,988,068	5.17%	5.08%
08/15/2017	217C1918	08/14/2017	BlackRock Inc.	5% of voting rights	downward	2,931,926	5.07%	4.98%
08/16/2017	217C1919	08/15/2017	BlackRock Inc.	5% of voting rights	upwards	2,954,917	5.11%	5.02%
08/18/2017	217C1949	08/17/2017	BlackRock Inc.	5% of voting rights	downward	2,917,234	5.05%	4.96%
08/21/2017	217C1957	08/18/2017	BlackRock Inc.	5% of voting rights	upwards	2,946,221	5.10%	5.01%
08/22/2017	217C1962	08/21/2017	BlackRock Inc.	5% of voting rights	downward	2,909,894	5.04%	4.94%
08/23/2017	217C1974	08/22/2017	BlackRock Inc.	5% of share capital	downward	2,835,821	4.91%	4.82%
09/11/2017	217C2108	09/08/2017	BlackRock Inc.	5% of share capital	upwards	2,892,258	5.01%	4.91%
09/12/2017	217C2117	09/11/2017	BlackRock Inc.	5% of share capital	downward	2,709,452	4.69%	4.60%
12/05/2017	217C2839	12/04/2017	BlackRock Inc.	5% of share capital and voting rights	upwards	2,972,360	5.14%	5.05%
12/06/2017	217C2856	12/05/2017	BlackRock Inc.	5% of voting rights	downward	2,916,114	5.05%	4.95%
12/07/2017	217C2869	12/06/2017	BlackRock Inc.	5% of share capital	downward	2,863,626	4.96%	4.87%
12/08/2017	217C2882	12/07/2017	BlackRock Inc.	5% of share capital and voting rights	upwards	2,998,516	5.19%	5.09%
12/11/2017	217C2897	12/08/2017	BlackRock Inc.	5% of voting rights	downward	2,920,497	5.05%	4.96%
12/12/2017	217C2907	12/11/2017	BlackRock Inc.	5% of share capital	downward	2,878,312	4.98%	4.89%
12/13/2017	217C2915	12/12/2017	BlackRock Inc.	5% of share capital	upwards	2,909,898	5.04%	4.94%
12/14/2017	217C2934	12/13/2017	BlackRock Inc.	5% of share capital	downward	2,882,990	4.99%	4.90%
12/15/2017	217C2941	12/14/2017	BlackRock Inc.	5% of share capital	upwards	2,893,260	5.01%	4.92%
12/21/2017	217C2995	12/20/2017	BlackRock Inc.	5% of share capital	downward	2,852,969	4.94%	4.85%
12/22/2017	217C3005	12/21/2017	BlackRock Inc.	5% of share capital	upwards	2,922,447	5.06%	4.96%
12/29/2017	217C3047	12/28/2017	BlackRock Inc.	5% of voting rights	upwards	2,962,081	5.13%	5.03%

* *By letter dated February 23rd, 2017, NN Group N.V. stated, for regularization purposes, that it crossed downwards, on August 12th, 2016, indirectly through the intermediary of controlled companies, the threshold of 10% of the voting rights of the Company and that it held, at the same date, 3,253,419 shares representing 6,073,870 voting rights, i.e. 5.69% of the share capital and 9.98% of the voting rights. This crossing resulted from the selling of shares on the market. Furthermore, NN Group N.V. indicated that it held, as of February 22nd, 2017, indirectly through the intermediary of controlled companies, 3,253,419 shares of the Company representing 6,073,870 voting rights, i.e. 5.63% of the share capital and 9,89% of the voting rights.*
The entirety of the declaration of crossing is available on the website of the Autorité des marchés financiers (www.amf-france.org) in the notice No. 217C0527 dated February 24th, 2017.

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In 2016

Declaration date	AMF notice No	Transaction date	Registered intermediary or fund manager	Legal threshold	Nature of change	Number of Shares	% of share capital	% of voting rights
02/22/2016 02/23/2016*	216C0551	07/12/2015	NN Group N.V	10% of voting rights	upwards	3,299,144	5.77%	10.50%
05/25/2016	216C1220	05/20/2016	BlackRock Inc.	5% of share capital and voting rights	upwards	3,314,128	5.79%	5.45%
05/26/2016	216C1233	05/23/2016	BlackRock Inc.	5% of share capital and voting rights	downward	2,463,198	4.31%	4.05%
06/16/2016	216C1395	06/15/2016	BlackRock Inc.	5% of share capital	upwards	2,921,580	5.11%	4.80%
06/17/2016	216C1417	06/16/2016	BlackRock Inc.	5% of share capital	downward	2,709,582	4.74%	4.45%
08/30/2016	216C1942	08/16/2016	BlackRock Inc.	5% of share capital	upwards	2,923,687	5.11%	4.81%
09/20/2016	216C2120	09/19/2016	BlackRock Inc.	5% of voting rights	upwards	3,081,406	5.33%	5.02%
10/04/2016	216C2250	10/03/2016	BlackRock Inc.	5% of voting rights	downward	3,048,115	5.28%	4.96%
10/07/2016	216C2295	10/06/2016	BlackRock Inc.	5% of voting rights	upwards	3,086,664	5.34%	5.03%
11/09/2016	216C2529	11/08/2016	BlackRock Inc.	5% of voting rights	downward	3,051,243	5.28%	4.97%
11/15/2016	216C2571	11/14/2016	BlackRock Inc.	5% of share capital	downward	2,795,530	4.84%	4.55%
12/14/2016	216C2821	12/13/2016	BlackRock Inc.	5% of share capital	upwards	2,896,290	5.01%	4.72%
12/15/2016	216C2833	12/14/2016	BlackRock Inc.	5% of share capital	downward	2,821,648	4.88%	4.60%

* *By letter dated February 22nd, 2016, completed by a letter dated February 23rd, 2016, the Company NN Group N.V. stated, for regularization purposes, that it crossed upwards, on July 12th, 2015, indirectly through the intermediary of controlled companies, the threshold of 10% of the voting rights of the Company and that it held, at the same date, 3,299,144 shares representing 6,421,343 voting rights, i.e. 5.77% of the share capital and 10.50% of the voting rights. This crossing resulted from the grant of double voting rights. It is specified that the portion of voting rights exceeding 10% would be temporarily suspended pursuant to the applicable legal provisions. Furthermore, NN Group N.V. indicated that it held, as of February 22nd, 2016, indirectly through the intermediary of controlled companies, 3,291,016 shares of the Company representing 6,413,215 voting rights, i.e. 5.75% of the share capital and 10.49% of the voting rights.*
By the same letters, a statement of intent has been made whereby NN Group N.V. and the entities members of its Group stated, in particular, that they do not consider acquiring additional Teleperformance SE shares and do not consider requesting the appointment of representatives within the Board of Directors of Teleperformance SE.
The entirety of the statement of intent and the declaration of crossing are available on the website of the Autorité des marchés financiers (www.amf-france.org) in the notice No. 216C0551 dated February 24th, 2016.

7.3.2 Shareholders' agreements

To the Company's knowledge, as of the date of this Registration Document, there is no agreement between shareholders of the Company.

7.3.3 Change of control of the Company

To the Company's knowledge, no agreement has been entered into that might entail a change of control of the Company if implemented.

7.4 STOCK MARKET LISTING

7.4.1 Listing References

Teleperformance SE shares (ISIN Code: FR0000051807, symbol: TEP) have been listed on the Paris Stock Exchange (Euronext Paris, Compartment A) since January 18th, 2007.

They are eligible for the deferred settlement service (*service de règlement différé* or SRD) and for stock savings plans (*plan d'épargne en actions*).

Teleperformance SE shares are included in the following indexes: SBF 120, CAC Large 60, CAC Next 20, CAC All Tradable, CAC Support Services, STOXX Europe 600, MSCI Global Standard and S&P Europe 350.

Since 2012, Teleperformance SE shares have been included in the support services sector (2790) according to the ICB European classification.

In relation to social and environmental responsibility and corporate governance matters, Teleperformance SE shares have been included in the Euronext Vigeo Eurozone 120 index since December 2015 and in the FTSE4Good index since June 2018.

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7.4.2 Information on traded volumes and share price movements

7.4.2.1 Monthly evolution of the readjusted share prices over the last 18 months

	High *(in euros)*	Low *(in euros)*	Closing price *(in euros)*	Number of shares traded	Value traded *(in million euros)*	Number of trading sessions
2017						
August	121.15	111.90	115.60	1,641,155	191.3	23
September	126.65	115.25	126.30	1,964,936	240.5	21
October	129.00	119.50	125.40	2,834,332	353.7	22
November	128.60	119.20	124.35	6,685,504	826.7	22
December	124.80	116.60	119.45	2,981,731	356.7	19
2018						
January	127.90	118.00	122.10	2,470,823	305.2	22
February	122.80	111.00	117.10	2,801,711	327.9	20
March	129.40	117.20	126.00	3,347,560	416.5	21
April	134.70	121.00	132.90	2,428,911	310.5	20
May	138.80	132.50	135.20	2,466,858	334.0	22
June	153.60	134.80	151.30	3,939,991	569.9	21
July	162.20	149.60	156.80	2,930,990	457.3	22
August	167.10	155.70	165.50	2,590,491	418.8	23
September	171.70	159.40	162.50	2,569,321	426.1	20
October	165.50	141.10	145.60	3,673,477	559.1	23
November	154.50	135.60	146.20	2,718,164	395.5	22
December	150.40	133.20	139.60	2,076,573	293.4	19
2019						
January	152.60	133.70	150.30	2,596,320	374.91	22

Source: Euronext Paris.

7.4.2.2 Changes in the Company's adjusted share price over 2 years, as compared to the CAC Large 60 index *(base 100 as of December 30th, 2016)*

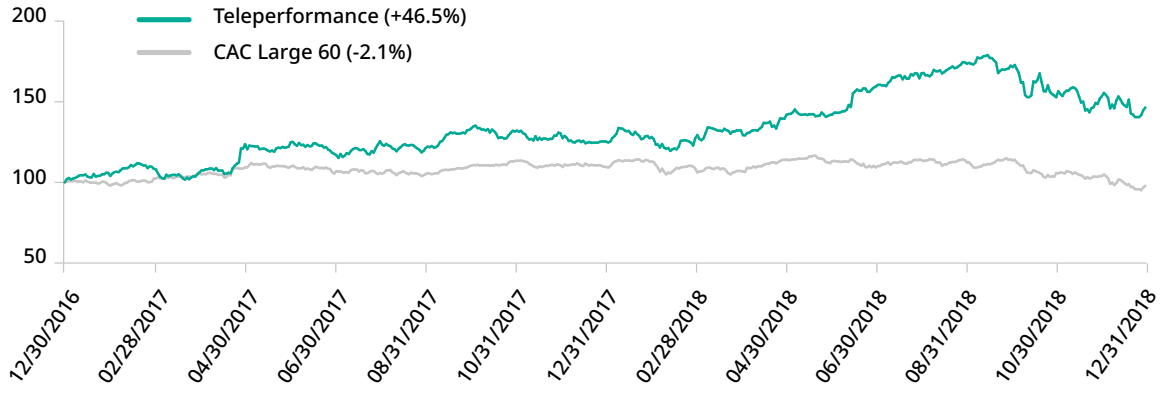

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7.4.2.3 Adjusted monthly average volumes traded per day

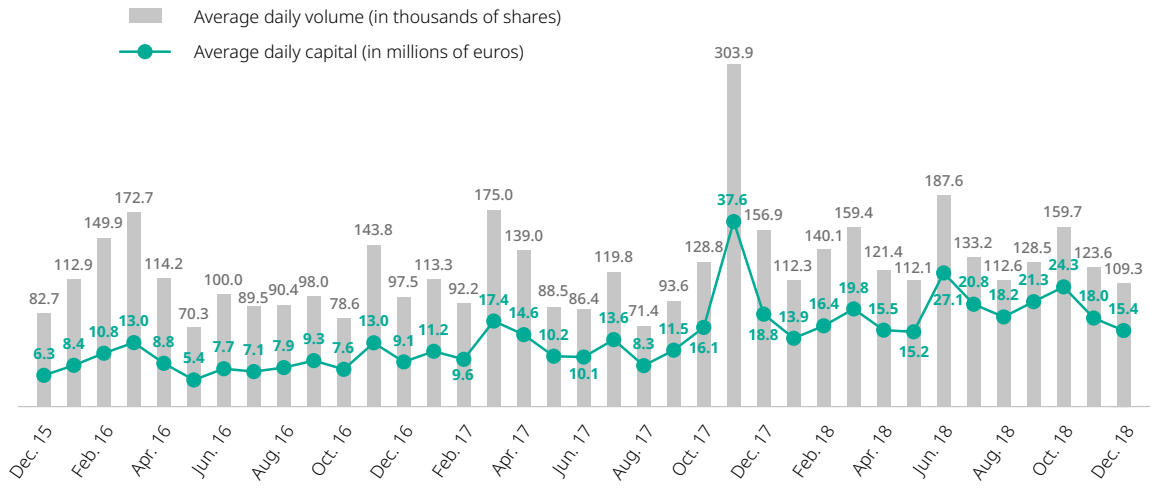

7.5 DIVIDENDS

7.5.1 Dividend pay-out policy

The Board of Directors determines the dividend pay-out policy after review of various criteria including Group and Company earnings and financial situation.

In accordance with the law, unclaimed dividends lapse and are paid over to the State following a five-year period.

7.5.2 Dividends paid in respect of the last five financial years

Dividend for financial year*	Gross dividend per share	Total amount**	Distribution rate***
2013	€0.80	€45,808,152.00	35%
2014	€0.92	€52,625,554.80	35%
2015	€1.20	€68,642,028.00	35%
2016	€1.30	€75,114,000.00	35%
2017	€1.85	€106,893,000.00	35%

* *Paid the following year.*
** *Including unpaid dividends on the Company's treasury shares posted to "Retained earnings".*
*** *Calculated on the basis of consolidated net profit.*

Dividends distributed for the last three financial years were eligible for a 40% tax allowance.

It is specified that the Board of Directors has decided to propose to the Shareholders' Meeting to be held on May 9th, 2019 to fix the gross amount of dividend for 2018 at €1.90 per share.

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7.6 FINANCIAL COMMUNICATION

7.6.1 Mission statement

The Group is committed to maintaining a sustainable and trust-based relationship with its shareholders and all other members of the financial community. The duties of the Group's investor relations team are to facilitate access to information regarding the Group's earnings, outlook and strategic developments.

To that end, and in order to ensure ongoing clarity and transparency, a number of dedicated documents have been published and frequent meetings are organized throughout the year with the financial community.

The Group is also committed to informing the market of its policy in terms of social and environmental responsibility and has dedicated a whole section of this report to these topics (see section 2 – *Extra-financial performance reporting*).

A key feature of 2018 was the Group's continued efforts to improve the quality of its communication to the financial community.

Teleperformance's website dedicated to shareholders and the financial community has been modernized to reflect Teleperformance's new visual identity in September 2018. Access to information about the Group's results, prospects and strategic developments has thus been optimized. The Group also organized its first investor roadshow in Asia to diversify and strengthen its institutional shareholding.

This investor friendly approach has been distinguished in two leading European rankings within the financial community: winner of the 2018 Best Investor Relations Professional award by Institutional Investor in the annual rankings of All Europe Executive Team in the Business and Professional Services sector, and bronze medal in the Corporates Best for Investor Relations category – Support & Business Services – from the European Extel Ranking.

7.6.2 Dedicated information accessible to all shareholders

Financial and regulatory information and a large number of dedicated documents are made available to all shareholders in the Teleperformance's website dedicated to the financial community (www.teleperformanceinvestorrelations.com).

This extensive database of the Group's financial and regulated communication notably includes:

- all financial and strategic information provided to financial markets and Group shareholders, including quarterly information, press releases, slideshow as well as audio and video recordings and broadcasts of results presentation meetings and theme conferences, letters to shareholders;
- regulated information circulated in compliance with the European Transparency Directive of December 15th, 2004, which includes the Registration Document containing the annual financial report, the half-yearly report, both filed with the French financial markets authority *(Autorité des marchés financiers)*, the articles of association and information concerning corporate governance;
- the documents relating to the shareholders' meeting including notice of meetings, draft resolutions, ballot papers and meeting brochures.

These documents can be sent by mail on request, *via* the Group website, or to the Investor Relations Department by email, telephone or mail.

Legal information (articles of association, minutes of shareholders' meetings, statutory auditors' reports) can be consulted at the head office.

The Group regularly publishes its results and notices of shareholders' meetings in the national press.

7.6.3 Regular meetings with institutional investors and financial analysts

The investor relations team, together with various senior Group executives and in compliance with best practices in communication, regularly holds information meetings with institutional investors and financial analysts, including SRI (socially responsible investing) specialists, in France and abroad. Group management also meets corporate governance teams from shareholder organizations in the run-up to shareholders' meetings.

Every quarter, the Group presents its results and/or revenues to the financial community *via*:

- a conference call to present Q1 and Q3 revenues and a conference webcast for H1 results, when senior management presents an update of operations during the period and answers questions from investors and analysts;
- a physical conference held in Paris on release of the annual results, with live streaming and a subsequent download facility on the Group's website; management presents the financial results and key developments of the past year as well as the Group's financial outlook, and answers questions from investors and analysts.

In addition, Teleperformance is in constant communication throughout the year with the financial community *via* meetings, conference calls and site visits, as well as investor roadshows and theme conferences organized by financial brokers. These thematic conferences bring together primarily European companies operating in the business services and business process outsourcing sector, so that they can meet investors on the main European and US financial markets.

The Company share is covered by around 15 financial broker research firms (sell-side analysts), and this number continued to grow in 2018 with the addition of a number of London-based analysts specialized in business services.

In 2018, Teleperformance held around 270 meetings and conference calls with investors. The Group has organized a roadshow in Asia for the first year and intends to increase its presence in this region in 2019 in order to continue the geographical diversification of its shareholding.

Site visits were organized throughout the year for investors and analysts:

- in Athens, Greece, to present the Group's pan-European multilingual platforms;
- in Asnières-sur-Seine, France, to present one of the Group's 14 worldwide Omnichannel Customer Journey Showrooms;
- in Salt Lake City, USA, at the Group's US operational headquarters.

Throughout the year, Teleperformance continued to develop its relationships with bond investors. A bond issue of €750 million has been oversubscribed nearly three times by a diversified investor base leading. Standard & Poor's has confirmed in 2018 the Teleperformance rating of "BBB-" – Investment grade – with a stable outlook, the highest score in the customer experience sector.

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7.6.4 Shareholders' meetings

All shareholders, regardless of the number of shares they hold (at least one share held on the second working day prior to the relevant shareholders' meeting), are entitled to participate in shareholders' meetings.

The annual shareholders' meeting, which took place in 2018 in the Étoile Saint-Honoré conference center in Paris, is a key moment of dialog between shareholders and Group management for an update on operations during the year. For shareholders, it is also an opportunity to play an active role in the life of the Group through their vote.

The procedure for convening shareholders' meetings, drafting and publishing agendas and the rules for participation in meetings are presented in section 7.1.2.4 *Shareholders' meetings*.

In addition to the usual voting procedures, shareholders may vote prior to meetings or appoint a proxy *via* "Votaccess", an online voting platform. This platform is available to registered shareholders as well as to shareholders having subscribed to online services offered by their financial institution, if the latter offers access to the Votaccess platform.

Details on voting procedures are available on the Company's website (www.teleperformanceinvestorrelations.com) in the section Shareholders/General meetings, as well as in the Notice of meeting (brochure) also available online.

The investor relations team is also available to guide shareholders through the various attendance and voting procedures.

7.6.5 Registration of securities in the holder's name

Teleperformance SE offers its shareholders the benefit of direct registration of their securities in their names, which confers the following advantages:

No management fees

Registered shareholders are fully exempted from custody fees, as well as from the expenses inherent to the day-to-day management of their securities, such as conversion into bearer securities, the transfer of securities, changes of legal status (transfers, donations, inheritance, etc.), securities transactions (capital increase, share allotments, etc.) and the payment of dividends.

Guaranteed personalized information

Registered shareholders receive personalized information regarding:

- notices to attend shareholders' meetings, with systematic dispatch of the meeting notice, single postal voting form and proxy voting form, admission card request form and the statutory information documents;
- the management of securities, taxation and the organization of the shareholders' meeting.

Furthermore, an online service is available to them to consult their share account and place market orders: www.planetshares.bnpparibas.com.

Easier access to the shareholders' meeting

Like all of the Company's shareholders, registered shareholders are automatically called to attend the shareholders' meeting and benefit from the advantage of not being required to make a prior application for an attendance certificate in order to vote.

In addition to the usual voting procedures, registered shareholders may vote before meetings or appoint a proxy *via* Votaccess, an online voting platform (see section 7.6.4 *Shareholders' meetings*).

Registration procedure

In order to convert your securities into direct registered securities or to receive more information regarding security registration, please contact:

BNP Paribas Securities Services
Grands Moulins de Pantin
9, rue du Débarcadère
93761 Pantin Cedex – France
Telephone: +33 1 57 43 02 30
email: paris.bp2s.registered.shareholders@bnpparibas.com

7.6.6 Bearer shares

Bearer shares are recorded in an investment account of a financial intermediary (*i.e.* a bank, stock broker, online broker, etc.). The advantage of holding shares in this way is that all equity investments in a portfolio can be held together in the same account, for example in a "PEA" (Private Equity Plan) account. Teleperformance SE cannot identify bearer shareholders.

To participate in the shareholders' meeting, bearer shareholders must obtain a certificate from the financial intermediary holding their Teleperformance investments that confirms that the intermediary has registered their shares in its books, by no later than midnight (Paris time) on the second working day prior to the relevant shareholders' meeting.

7.6.7 Indicative schedule for financial publications

Q1 2019 revenues	April 24th, 2019
Annual shareholders' meeting	May 9th, 2019
Ex-dividend date	May 13th, 2019
Dividend payment	May 15th, 2019
H1 2019 results	July 25th, 2019
Q3 2019 revenues	October 30th, 2019

7.6.8 Contact

Teleperformance SE
Investor Relations Department,
21-25, rue Balzac – 75008 Paris, France

Tel.: +33 1 53 83 59 87
email: investor@teleperformance.com

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8 Additional information

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8.1 PERSON RESPONSIBLE FOR THE REGISTRATION DOCUMENT

Statement by the person responsible for the Registration Document

"I hereby certify, after having taken all reasonable measures to this effect, that the information contained in this Registration Document is, to the best of my knowledge, in accordance with the facts and makes no omission likely to affect its import.

I certify, to the best of my knowledge, that the accounts have been prepared in accordance with applicable accounting standards and give a fair view of the assets, liabilities and financial position and profit or loss of the Company and all the undertakings included in the consolidation, and that the management report, which details are contained in the table presented in section 8.5 of this Registration Document, presents a fair review of the development and performance of the business and financial position of the Company and all the undertakings included in the consolidation as well as a description of the main risks and uncertainties to which they are exposed.

I have obtained a completion letter from the auditors stating that they have audited the information contained in this Registration Document about the financial position and accounts and that they have read this document in its entirety."

March 4, 2019

Daniel Julien

Chairman and Chief Executive Officer

8.2 STATUTORY AUDITORS

Primary auditors	First appointment date	Date of expiry of current term of office
KPMG Audit IS Tour Eqho, 2, avenue Gambetta 92066 Paris La Défense – France Tel: +33 1 55 68 68 68	5/31/2011	2023 shareholders' meeting
Deloitte & Associés 6, place de la Pyramide 92908 Paris La Défense Cedex – France Tel: +33 1 40 88 28 00	5/31/2011	2023 shareholders' meeting

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8.3 CROSS-REFERENCE TABLE OF THE REGISTRATION DOCUMENT

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Applicable provisions		Comments on the financial year	Pages
French Commercial Code	L.225-102	Statement of employee participation in the share capital as of the balance sheet date and proportion of share capital represented by shares held by employees under the Company savings scheme and by current and former employees within company mutual funds and the nominative shares owned directly by employees pursuant to the provisions of Article L.225-197-1 of the French Commercial Code	215
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French Commercial Code General Regulation of the AMF	L.621-18-2 223-26	Summary statement on securities transactions by persons exercising managerial responsibilities and closely related persons	127
French Commercial Code	L.233-13	Companies controlled and share of the capital of the Company they hold	209
French Commercial Code	L.232-1	Statement of existing branches	n/a
French Commercial Code	L.4.41-6-1, D.4.41-4 and A 441-2	Payment terms of suppliers and clients	136
Applicable provisions		**Documents attached**	
French Commercial Code	L.225-102-3	Report on the payments made in favor of authorities of each countries or territories on which the Company carries out its activities.	n/a
French Commercial Code	L.225-37-2 to L.225-37-5	Report on corporate governance	77

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8.6 CROSS-REFERENCE TABLE TO THE CORPORATE GOVERNANCE REPORT

Applicable provisions		Elements related to remuneration	Pages
French Commercial Code	L.225-37-2	Principles and criteria for determining, allocating and granting the fixed, variable and exceptional elements of the total remuneration and the benefits of all kind of the Chairman and Chief Executive Officer and Deputy Chief Executive Officer, in respect of their positions	110; 119
French Commercial Code	L.225-37-3	Total remuneration and benefits of all kind paid to each executive director during the financial year	108; 110; 119
French Commercial Code	L.225-37-3	Description of fixed, variable and exceptional elements of the total remuneration and the benefits of all kind as well as the criteria determining them or the circumstances under which they are granted	110; 119
French Commercial Code	L.225-37-3 and D.225-104-1	Commitments of any kind made by the Company in favor of its executive directors related to remuneration, payments or benefits due or liable to be due upon the assumption, termination or alteration of these responsibilities or at a later date, in particular pension commitments and other life benefits	113; 117
French Commercial Code	L.225-184	Options granted, subscribed to or purchased during the year by executive officers and by the first ten non-executive officers of the Company, and options granted to all employee beneficiaries by category	n/a
French Commercial Code	L.225-185	Terms and conditions pertaining to the exercise of options by executive officers and directors and lock-in conditions	n/a
French Commercial Code	L.225-197-1	Lock-in conditions pertaining to performance shares granted to executive directors	120
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French Commercial Code	L.225-37-4	List of all offices held and duties performed by each director in all companies during the financial year	84
French Commercial Code	L.225-37-4	Relevant agreements, concluded directly or by a third-party, between, on the one hand, and depending on the situation, the Chief Executive Officer, one of the deputy Chief Executive Officers, one of the directors or one of the shareholders holding over 10% of voting rights and, on the other hand, another company who, directly or indirectly, holds more than half the share capital (unless it is an agreement on current transactions and signed under normal conditions)	127
French Commercial Code	L.225-37-4	Table summarizing currently valid authorizations given by the shareholders' meetings to the Board of Directors in respect of capital increases	101
French Commercial Code	L.225-37-4	Choice on one of the methods of exercising the general management in case of modification	78
French Commercial Code	L.225-37-4	Composition, conditions for preparing and organizing the works of the Board of Directors	80; 99
French Commercial Code	L.225-37-4	Description of the diversity policy applied to members of the Board of Directors with regards to criteria such as age, gender or professional qualifications and experience, description of the objectives of that policy, its modalities of implementation and the results obtained during the past financial year and information on how the Company seeks to achieve balanced representation of women and men on any committees set up, if applicable, by executive management in order to assist it in the performance of its duties and with regard to gender balance in the 10% of positions with the highest level of responsibility	83; 107
French Commercial Code	L.225-37-4	Limits on the powers of the chief executive officer set forth by the Board	107
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French Commercial Code	L.225-37-4	Specific conditions relating to the attendance of shareholders at general meetings	126
French Commercial Code	L.225-37-5	Factors liable to have an impact in the event of a public offering	**126**

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8.7 CROSS-REFERENCE TABLE ON THE EXTRA-FINANCIAL PERFORMANCE STATEMENT

Pursuant to Decree No. 2017-1265 of August 9th, 2017 implementing the Ordinance No 2017-1180 of 225 of Act July 19th, 2017 related to the publication of non-financial information by certain large companies and certain group of companies.

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8.8 GENERAL OBSERVATIONS

In this Registration Document, unless stipulated to the contrary, the terms "Company" and "Teleperformance" refer to Teleperformance SE and the term "Group" refers to the Company and its subsidiaries and shareholdings.

This Registration Document contains information on the Group's objectives and forecasts, in particular in the section 4.3 *Trends and Outlook*.

This information is occasionally referred to using the future or conditional tense and prospective terms such as "think", "aim", "expect", "intend", "should", "strive", "estimate", "believe", "wish", "may/might", etc. Such information is based on data, assumptions and estimates which the Company believes to be reasonable. It is subject to change or amendment owing to uncertainties notably relating to the risks inherent in any business as well as the political, economic, financial and regulatory environment and competition. Moreover, some of the risks described in section 1.2.1 *Risk Factors* should they materialize, may affect the Group's business and our ability to achieve our objectives and forecasts.

The prospective statements, objectives and forecasts contained in this Registration Document could be affected by known and unknown risks, uncertainties or other factors that might result in the Group's future results, performance and achievements differing significantly from the objectives and forecasts made or suggested herein. These factors could include changes to the economic and business environment and regulations as well as the factors set out in section 1.2.1 *Risk Factors*.

The Company makes no commitment and gives no warranty as to the realization of the objectives and forecasts set out in this Registration Document.

Investors are asked to pay close attention to each of the risk factors described in section 1.2.1 *Risk Factors* of the present document prior to making an investment decision. Our business, situation or financial results or our objectives and forecasts may be negatively impacted should some or all of these risks materialize. Furthermore, other risks that have not yet been identified or which we consider to be of little significance may also have a negative impact and investors could lose some or all of their investment.

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Design and production: côtécorp.
Tel.: +33 (0)1 55 32 29 74

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Consolidated financial statements as of December 31st, 2017

2017

Teleperformance
Transforming Passion into Excellence

6. Consolidated financial statements

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6.1 Consolidated statement of financial position *(in millions of euros)*

ASSETS	Notes	12.31.2017	12.31.2016*
Non-current assets			
Goodwill	D	1,676	1,938
Other intangible assets	C.2	946	1,172
Property, plant and equipment	C.1	423	476
Financial assets	G.2	43	55
Deferred tax assets	E.2	28	31
Total non-current assets		3,116	3,672
Current assets			
Current income tax receivable		62	46
Accounts receivable - Trade	C.3	896	871
Other current assets	C.3	93	100
Other financial assets	G.2	38	24
Cash and cash equivalents	G.4	285	282
Total current assets		1,374	1,323
Total assets		**4,490**	**4,995**

EQUITY AND LIABILITIES	Notes	12.31.2017	12.31.2016*
Equity			
Share capital	F.1	144	144
Share premium		575	575
Translation reserve		-165	100
Other reserves		1,356	1,092
Equity attributable to owners of the Company		1,910	1,911
Non-controlling interests		12	10
Total equity		1,922	1,921
Non-current liabilities			
Provisions	I.2	15	13
Financial liabilities	G.4	1,387	1,688
Deferred tax liabilities	E.2	234	444
Total non-current liabilities		1,636	2,145
Current liabilities			
Provisions	I.2	52	39
Current income tax		90	61
Accounts payable - Trade	C.9	141	126
Other current liabilities	C.9	425	442
Financial liabilities	G.4	224	261
Total current liabilities		932	929
Total equity and liabilities		**4,490**	**4,995**

** Restated following the finalization of the measurement of the fair values of the identifiable assets and liabilities acquired of LanguageLine Solutions LLC, see note B2.*

6.2 Consolidated statement of income *(in millions of euros)*

	Notes	*2017*	*2016*
Revenues	**C.10**	**4,180**	**3,649**
Other revenues	C.10	8	5
Personnel		-2,746	-2,435
External expenses	C.11	-700	-642
Taxes other than income taxes		-22	-19
Depreciation and amortization		-164	-150
Amortization of intangible assets acquired as part of a business combination		-87	-41
Impairment loss on goodwill		-67	
Share-based payments	C.4	-24	-22
Other operating income and expenses	C.12	-23	-6
Operating profit		**355**	**339**
Income from cash and cash equivalents		1	1
Interest on financial liabilities		-60	-35
Net financing costs	**G.3**	**-59**	**-34**
Other financial income and expenses	G.3	9	-5
Financial result		**-50**	**-39**
Profit before taxes		**305**	**300**
Income tax	E.1	9	-83
Net profit		**314**	**217**
Net profit - Group share		**312**	**214**
Net profit attributable to non-controlling interests		2	3
Earnings per share (in euros)	**F.3**	**5.40**	**3.73**
Diluted earnings per share (in euros)	**F.3**	**5.31**	**3.67**

6.3 Consolidated statement of comprehensive income *(in millions of euros)*

	2017	*2016*
Net profit	**314**	**217**
May not be reclassified to profit or loss in a subsequent period		
May be reclassified to profit or loss in a subsequent period		
Gains (losses) on foreign exchange hedges (before tax)	11	-1
Income tax on gains (losses) on foreign exchange hedges	-4	0
Translation differences	-265	31
Other recognized income and expenses	**-258**	**30**
Total comprehensive income	**56**	**247**
Group share	54	244
Attributable to non-controlling interests	2	3

6.4 Consolidated statement of cash flows *(in millions of euros)*

Cash flows from operating activities	Notes	*2017*	*2016*
Net profit - Group share		312	214
Net profit attributable to non-controlling interests		2	3
Income tax expense (credit)		-9	83
Net financial interest expense		53	29
Non-cash items of income and expense	H.1	363	196
Income tax paid		-147	-83
Internally generated funds from operations		***574***	***442***
Change in working capital requirements	**H.2**	***-58***	***17***
Net cash flow from operating activities		**516**	**459**

Cash flows from investing activities			
Acquisition of intangible assets and property, plant and equipment		-148	-192
Loans made			-10
Proceeds from disposals of intangible assets and property, plant and equipment		1	2
Loans repaid			1
Acquisition of subsidiaries	H.3	-4	-1,380
Net cash flow from investing activities		**-151**	**-1,579**

Cash flows from financing activities			
Acquisition net of disposal of treasury shares		-1	-17
Change in ownership interest in controlled entities		-39	-33
Dividends paid to parent company shareholders		-75	-68
Financial interest paid/received		-45	-33
Increase in financial liabilities		1,729	2,696
Repayment of financial liabilities		-2,022	-1,355
Net cash flow from financing activities		**-453**	**1,190**
Change in cash and cash equivalents		***-88***	***70***
Effect of exchange rates on cash held		***92***	***-45***
Net cash at January 1st	**H.5**	**279**	**254**
Net cash at December 31st	**H.5**	**283**	**279**

6.5 Consolidated statement of changes in equity *(in millions of euros)*

	Attributable to owners of the Company							Total
	Share capital	Share premium	Translation reserve	Retained earnings	Impact of financial hedging instruments	Equity attributable to owners of the Company	Non-controlling interests	
At December 31, 2015	**143**	**575**	**69**	**978**	**-7**	**1,758**	**7**	**1,765**
Translation differences from foreign operations			31			31		**31**
Net profit				214		214	3	**217**
Actuarial gains/ (losses) on employee benefits				-1		-1		**-1**
Total recognized income and expenses	***0***	***0***	***31***	***213***	***0***	***244***	***3***	***247***
Operations on non-controlling interests				-26		-26		**-26**
Fair value of incentive plan share awards	1			20		21		**21**
Treasury shares				-17		-17		**-17**
Dividends (€1.20 per share)				-68		-68		**-68**
At December 31, 2016	**144**	**575**	**100**	**1,100**	**-7**	**1,912**	**10**	**1,922**
At December 31, 2016*	**144**	**575**	**100**	**1,099**	**-7**	**1,911**	**10**	**1,921**
Translation differences from foreign operations			-265			-265		**-265**
Net profit				312		312	2	**314**
Net gain on foreign exchange hedges (after tax)					7	7		**7**
Total recognized income and expenses	***0***	***0***	***-265***	***312***	***7***	***54***	***2***	***56***
Operations on non-controlling interests						0		**0**
Fair value of incentive plan share awards				21		21		**21**
Treasury shares				-1		-1		**-1**
Dividends (€1.30 per share)				-75		-75		**-75**
At December 31, 2017	***144***	***575***	***-165***	***1,356***	***0***	***1,910***	***12***	***1,922***

** Restated following the finalization of the measurement of the fair values of the identifiable assets and liabilities acquired of LanguageLine Solutions LLC, see note B2.*

6.6 Notes to the consolidated financial statements *(in millions of euros)*

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Highlights of 2017

During the first half of 2017, the Group issued a bond of €600 million at a nominal interest rate of 1.50%, redeemable in 2024, in order to complete the refinancing of its acquisition of LanguageLine Solutions LLC.

The US tax reform adopted at the end of December 2017 has had the following two principal impacts on the financial statements (see note E. *Income tax* for the related amounts):

- The remeasurement of deferred taxes recognized by US subsidiaries using a federal tax rate of 21% compared with the previous rate of 35%;
- The recognition of tax expense on the undistributed results of the foreign subsidiaries of US companies.

A. Principal accounting policies, judgements and estimates

A.1 Reporting entity

Teleperformance ("the Company") is a company domiciled in France.

The Company's consolidated financial statements for the year ended December 31st, 2017 include the Company and its subsidiaries, together referred to as "the Group".

The financial statements were approved by the Board of Directors on February 28th, 2018, and will be submitted to the shareholders' meeting to be held on April 20th, 2018.

All financial information presented in euro has been rounded to the nearest million.

A.2 Basis of preparation

The consolidated financial statements for the year ended December 31st, 2017 have been prepared in accordance with International Financial Reporting Standards (IFRS) as adopted by the European Union as of the reporting date, and comply with the presentation requirements of revised IAS 1 as amended.

The following standards, amendments and interpretations:

- Amendments to IAS 12, on the recognition of deferred tax assets for unrealized losses;
- Amendments to IAS 7 concerning the statement of cash flows;

are required to be applied from January 1st, 2017 but their adoption has not had a significant impact on the consolidated financial statements.

The Group has not elected to early adopt the following standards:

- IFRS 15 "Revenue from contracts with customers";
- IFRS 9 "Financial instruments".

These standards are required to be applied from January 1st, 2018.

The Group has completed its assessment of the impact of IFRS 15 on its revenues and does not expect a significant impact on its financial statements from its adoption in view of the nature of the Group's business.

The Group has also commenced its assessment of the impact of IFRS 9 "Financial instruments" and does not expect a significant impact on its financial statements following its adoption, in particular in respect of the presentation and recognition of credit risk. The Group uses foreign exchange hedging instruments on a regular basis and the adoption of IFRS 9 should result in a reduction of the volatility it experiences in the related results of these operations.

The assessment of the impact of the new standard IFRS 16 on leases, which comes into effect on January 1st, 2019, is still in progress. Its impact is expected to be limited principally to the Group's real estate lease contracts. On the basis of the current status of the initial analyses and of the lease portfolio as at December 31st, 2016, the impact on the amount of financial liabilities is expected to be an increase in the range of approximately 500 – 600 million euros. The Group intends to elect to apply the modified retrospective method in respect of its transitional application. The use of a practical solution to compute and manage the adjustments required under the standard is in course of implementation.

The accounting policies applied by the Group in these consolidated financial statements are the same as those applied by the Group in its consolidated financial statements as at and for the year ended December 31st, 2016, with the exception of the new standards, amendments and interpretations set out above.

The financial statements are prepared on the historical cost basis except for the following assets and liabilities measured at fair value: derivative financial instruments, financial instruments held for trading, financial instruments classified as available for sale.

Non-current assets and disposal groups held for sale are stated at the lower of carrying amount and fair value less costs to sell.

The accounting policies set out below have been applied consistently to all periods presented in the consolidated financial statements.

Estimates

The preparation of financial statements in conformity with IFRS requires making estimates and assumptions which affect the amounts reported in the financial statements, especially with respect to the following items:

- impairment of intangible assets and goodwill;
- the measurement of share-based payments expense;
- provisions for risks and expenses;
- the measurement of intangible assets acquired as part of a business combination;
- deferred taxation.

The estimates are based on information available at the time of preparation of the financial statements, and may be revised, in a future period, if circumstances change, or if new information is available. Actual results may differ from these estimates.

A.3 Impairment

Non-financial assets

Non-financial assets of the Group (non-current assets) are reviewed at each reporting date to determine the amounts of any impairment losses that should be recognized.

Financial assets

A financial asset is considered to be impaired if there is objective evidence that one or more events have had a negative effect on the asset's estimated future cash flows.

The impairment loss of a financial asset measured at amortized cost is calculated as the difference between its carrying amount and the present value of the estimated future cash flows discounted at the original effective interest rate of financial assets.

An impairment test is performed individually on each significant financial asset. Other assets are tested in groups with similar credit risks.

Impairment losses are recognized in the statement of income.

A.4 Determination of fair values

Certain accounting policies and disclosures require determining the fair value of financial and non-financial assets and liabilities. Additional information about assumptions used in determining fair value is disclosed, where necessary, in the specific notes for the asset or liability involved. In general, fair values for significant asset and liability categories are determined as follows:

Property, plant and equipment

The fair value of property, plant and equipment that is recognized following a business combination, principally buildings, is based on market value. The market value of a building is the estimated amount which would be obtained from the sale of the asset under normal conditions between a buyer and a seller at the measurement date.

Intangible assets

The fair value of brand names and software acquired during a business combination is based on the discounted present value of estimated royalties avoided through their acquisition.

The fair value of customer relationships acquired during a business combination is based on the multi-period excess earnings method, under which the asset is measured at the amount of estimated cash flows net of a reasonable return allocated to other assets.

Accounts receivable – Trade and Other current assets

The fair value of Accounts receivable – Trade and Other current assets is estimated as the present value of future cash flows discounted at the market rate of interest at the reporting date.

Derivatives

The fair value of forward currency contracts is based on their quoted market price when available. If no quoted market price is available, the fair value is estimated by discounting to the present value the difference between the contractual forward price and

the current forward price on the residual term of the contract, by using an interest rate based on the money market.

The fair value of interest rate swaps is based on estimations provided by the banks and corresponds to the estimated amount that the Group would receive or pay to terminate the swap at the reporting date, taking into account current interest rates and counterparty risk.

Non-derivative financial liabilities

The fair value, which is determined for disclosure purposes, is based on the present value of future cash flows generated by principal and interest repayments, discounted at the market interest rate at the reporting date.

For finance lease agreements, the market interest rate is determined from similar lease agreements.

Share-based payments

The fair value of incentive plan shares awarded to employees is measured principally using the market price of the share at the grant date, the expected dividends and the post-vesting retention period, as well as performance conditions when these are market conditions.

The service and performance conditions necessary for vesting are not considered when determining fair value when these are not market conditions.

A.5 Glossary

EBITA or current EBITA: (*Earnings Before Interest, Taxes and Amortization*): Operating profit before amortization of intangible assets acquired as part of a business combination, goodwill impairment charges and non-recurring items.

ROCE: rate of *Return On Capital Employed* calculated using the NOPAT/Capital Employed formula.

NOPAT: operating profit excluding non-recurring items times the effective rate of taxation.

Capital Employed: the total of goodwill, intangible assets and property, plant and equipment, and items of working capital.

Non-recurring items: principally comprises restructuring costs, incentive share award plan expense, costs of closure of subsidiary companies, transaction costs for the acquisition of companies, and all other expenses that are unusual by reason of their nature or amount.

Net financial indebtedness or Net debt: the total of current and non-current financial liabilities, less cash and cash equivalents.

B. Scope of consolidation

B.1 Accounting policies and methods

B.1.1 Basis of consolidation

Subsidiaries

Subsidiaries are entities controlled by the Company. Control exists when it is exposed, or has the rights, to variable returns from its involvement with an entity and has the ability to affect those returns through its power over it.

In assessing control, potential voting rights that presently are exercisable or convertible are taken into account.

The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Associates

The Company holds no entity in which the Group has significant influence, but not control, over the financial and operating policies.

Transactions eliminated in the consolidated financial statements

Balances, any unrealized gains and losses, and income and expenses arising from intra-group transactions are eliminated in preparing the consolidated financial statements.

B.1.2 Foreign currencies

Foreign currency transactions

Transactions in foreign currencies are translated at the foreign exchange rate at the dates of the transactions.

Monetary assets and liabilities denominated in foreign currencies at the reporting date are translated into euros at the foreign exchange rate at that date. Foreign

exchange differences arising on translation are recognized as financial income or expenses. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction.

Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated using the exchange rate at the date the fair value was determined.

Financial statements of foreign operations

The functional currency of a foreign operation outside the euro zone is in general its local currency except in certain cases where most of its financial flows are realized with reference to another currency.

The assets and liabilities of foreign operations, including goodwill and fair value adjustments arising on consolidation, are translated into euros using the exchange rate at the reporting date.

The income and expenses of foreign operations are translated into euros using the average foreign exchange rate of the period, unless the exchange rate has fluctuated significantly. Foreign exchange differences resulting from translations are recognized in the translation reserve, as a separate equity component.

The Company has no foreign operations in any country defined by the IASB as a hyperinflationary economy.

Net investment in foreign operations

Foreign exchange differences arising from the translation of a net investment in foreign operations and of related hedges are recognized in the translation reserve. They are recognized in profit or loss on disposal of the foreign operations.

B.1.3 Business combinations

Following changes to IFRS 3 and IAS 27 in 2008, the Group modified its accounting for business combinations and purchases of and purchase commitments on non-controlling interests for acquisitions after December 31st, 2009.

Since January 1st, 2010, the Group has applied revised IFRS 3 prospectively. A business combination may therefore be recognized, at the election of the Group, according to either of the following two options set out in IFRS 3R:

- measurement of non-controlling interests as the proportionate interest in identifiable assets and liabilities;

- measurement of non-controlling interests at fair value (the full goodwill method).

The Group has elected to measure non-controlling interests as the proportionate interest in identifiable assets and liabilities for its acquisitions made since 2010.

Should the Group give a put option to minority shareholders at the time that control is transferred, a financial liability is recognized for the current value of the commitment, with an equivalent reduction in equity. Subsequent changes in fair value of the liability are recognized directly in equity.

Since 2010, transaction costs, other than those concerning the issue of debt or equity that the Group incurs in connection with a business combination, are expensed as incurred.

B.2 Change in consolidation scope

The group made no significant acquisition or disposal during 2017. It did however make a niche acquisition in the case of Wibilong, a French start-up which is a pioneer in the field of collaborative brand and consumer solutions. Wibilong realized revenues of approximately €1 million in 2016 and has been fully consolidated with effect from November 2017.

At the beginning of September 2017, the group finalized its measurement of the fair values of the identifiable assets and liabilities acquired of LanguageLine Solutions LLC. The principal restatement concerns the US tax rate in respect of intangible assets which had been slightly over-estimated.

The following schedule sets out the revised fair values of the identifiable assets and liabilities of LanguageLine Solutions LLC as of the date of acquisition:

In millions of US$	**Fair values at 09/19/2016**
Non-current assets	
Intangible assets	983
Property, plant and equipment	9
Deferred tax assets	2
Other non-current assets	4
Total non-current assets	998
Current assets	
Current tax assets	4
Accounts receivable - Trade	77
Other current assets	6
Cash and cash equivalents	10
Total current assets	97
TOTAL ASSETS	1,095
Non-current liabilities	
Provisions	1
Deferred tax liabilities	378
Total non-current liabilities	379
Current liabilities	
Provisions	6
Accounts payable - Trade	8
Other current liabilities	20
Total current liabilities	34
TOTAL LIABILITIES	413
Net assets, acquired 100%	**682**
Acquisition price	**1,538**
Goodwill	**856**

Following these changes, a number of line items in the consolidated statement of financial position of the Company as of December 31st, 2016 have been restated, as follows:

Consolidated statement of financial position, December 31, 2016 (selected line items)	*As published*	*Restatements*	*After restatements*
Non-current assets			
Goodwill	1,952	-14	1,938
Intangible assets	1,175	-3	1,172
Property, plant and equipment	476		476
Financial assets	55		55
Deferred tax assets	30	1	31
Total non-current assets	**3,688**	**-16**	**3,672**
Non-current liabilities			
Provisions	13		13
Financial liabilities	1,688		1,688
Deferred tax liabilities	464	-20	444
Total non-current liabilities	**2,165**	**-20**	**2,145**
Provisions (current)	34	5	39
Total equity	**1,922**	**-1**	**1,921**

The notes to the consolidated financial statements have been updated to reflect the restated amounts.

C. Operational activity

C.1 Property, plant and equipment

Owned assets

Items of property, plant and equipment are stated at cost less accumulated depreciation (see below) and impairment losses (see accounting policy, note A.3 *Impairment*).

Cost includes the asset's directly attributable acquisition costs.

Where parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate items of property, plant and equipment.

Leased assets

Leases in terms of which the Group assumes substantially all the risks and rewards of ownership are classified as finance leases.

Any other lease agreement is an operating lease. Such leased assets are not recognized in the Group's statement of financial position. The Company has no real estate held under a finance lease agreement.

Subsequent expenditure

The Group recognizes in the carrying amount of an item of property, plant and equipment the cost of replacing part of such an item when that cost is incurred, if it is probable that the future economic benefits of the item will flow to the Group and the cost of the item can be measured reliably.

All costs of routine repairs and maintenance are recognized in the statement of income as an expense when incurred.

Depreciation

Depreciation is charged to the statement of income on a straight-line basis over the estimated useful life of each part of an item of property, plant and equipment, from the time it is ready for use. Improvements made to buildings held on an operating lease are depreciated over the shorter of the lease period and the useful life.

The estimated useful lives are as follows:

Buildings	20 to 25 years
Office and IT equipment	3 to 5 years
Other	3 to 10 years

Depreciation methods, useful lives and residual values are reviewed at the end of each reporting period.

Land is not depreciated.

Property, plant and equipment is analyzed as follows:

Cost	*Land & buildings*	*Telephone and IT equipment*	*Other*	*In progress*	*Total*
At December 31, 2015	**402**	**473**	**211**	**12**	**1,098**
Change in consolidation scope *	1	4		2	7
Transfer	19	14	-16	-17	0
Increase	57	65	29	27	178
Decrease	-7	-19	-5	0	-31
Translation differences	-2	3	-1	-1	-1
At December 31, 2016	**470**	**540**	**218**	**23**	**1,251**
Transfer	20	-3	6	-26	-3
Increase	42	48	24	26	140
Decrease	-12	-23	-15		-50
Translation differences	-46	-47	-17	-2	-112
At December 31, 2017	**474**	**515**	**216**	**21**	**1,226**

Accumulated depreciation and impairment losses	*Land & buildings*	*Telephone and IT equipment*	*Other*	*In progress*	*Total*
At December 31, 2015	**-192**	**-351**	**-127**		**-670**
Change in consolidation scope *		1			1
Transfer	-9	-9	18		0
Expense	-46	-62	-23		-131
Decrease	7	19	4		30
Translation differences		-2	-3		-5
At December 31, 2016	**-240**	**-404**	**-131**		**-775**
Transfer	-3	7	-5		-1
Expense	-52	-64	-27		-143
Decrease	11	22	15		48
Translation differences	22	36	10		68
At December 31, 2017	**-262**	**-403**	**-138**		**-803**

Carrying amount	*Land & buildings*	*Telephone and IT equipment*	*Other*	*In progress*	*Total*
At December 31, 2015	**210**	**122**	**84**	**12**	**428**
At December 31, 2016	**230**	**136**	**87**	**23**	**476**
At December 31, 2017	**212**	**112**	**78**	**21**	**423**

** The line item "Change in consolidation scope" relates to the acquisition of LanguageLine Solutions LLC in September 2016.*

"Other" comprises principally office equipment and furniture, and motor vehicles. No impairment loss has been recorded on these assets.

The Group relies only to a minor extent on finance lease financing and, in consequence, the disclosure of the amount of non-current assets held under finance leases is not significant.

C.2 Other intangible assets

These mainly include:

- brand names, customer relationships and technologies measured and recognized as part of a business combination;
- software acquired by the Group with a finite useful life, which is recognized at cost less accumulated depreciation and impairment losses (see accounting policy, note A.3 *Impairment*).

Expenditure relating to internally generated brands is expensed when incurred.

Subsequent expenditure

Subsequent expenditure on intangible assets is capitalized only when it increases the future economic benefits of the specific asset. All other costs are expensed as incurred.

Amortization

Amortization is charged to the statement of income on a straight-line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Other intangible assets are amortized from the date on which they are available for use. The estimated useful lives are as follows:

Software	3 to 6 years
Brand names	3 to 10 years
Customer relationships	9 to 15 years

Other intangible assets are analyzed as follows:

Gross	Software	Brand names and customer relationships	Other	Total
At December 31, 2015	**157**	**331**	**2**	**490**
Change in consolidation scope	70	808		878
Transfer	3		-1	2
Increase	14			14
Decrease	-5			-5
Translation differences	6	58		64
At December 31, 2016	**245**	**1,197**	**1**	**1,443**
Change in consolidation scope			2	2
Transfer	21			21
Increase	12			12
Decrease	-28			-28
Translation differences	-21	-144		-165
At December 31, 2017	**229**	**1,053**	**3**	**1,285**

Accumulated amortization and impairment	Software	Brand names and customer relationships	Other	Total
At December 31, 2015	**-122**	**-86**	**-1**	**-209**
Transfer	-3		1	-2
Expense	-19	-42		-61
Decrease	5			5
Translation differences	-3	-1		-4
At December 31, 2016	**-142**	**-129**	**0**	**-271**
Transfer	-15		-2	-17
Expense	-30	-77	-1	-108
Decrease	28			28
Translation differences	10	19		29
At December 31, 2017	**-149**	**-187**	**-3**	**-339**

Carrying amount	Software	Brand names and customer relationships	Other	Total
At December 31, 2015	**35**	**245**	**1**	**281**
At December 31, 2016	**103**	**1,068**	**1**	**1,172**
At December 31, 2017	**80**	**866**	**0**	**946**

At December 31st, 2017, brand names and customer relationships amounted to €87.6 million and €778.8 million, respectively.

Following the acquisition of LanguageLine Solutions LLC in 2016, a total amount of €866.6 million was allocated to the brand name, the customer relationships and the technologies developed internally. It was determined, after analysis, that the LLS brand name has an indefinite life and it is therefore not amortized. The carrying amount of this asset at December 31st, 2017 was €87.6 million.

C.3 Accounts receivable – Trade and Other current assets

Accounts receivable – Trade and Other current assets are initially recognized at fair value, then at amortized cost less any impairment losses.

	12/31/2017			12/31/2016
	Gross	Write-downs	Net	Net
Accounts receivable - Trade	901	-5	896	871
Other receivables	20	-10	10	12
Taxation recoverable	39		39	37
Advances and receivables on non-current assets	3		3	8
Prepaid expenses	41		41	43
Total	1,004	-15	989	971

Accounts receivable – Trade is analyzed by geographical region as follows:

	12/31/2017	12/31/2016
English-speaking & APAC	362	385
Ibero-LATAM	253	227
Continental Europe & MEA	190	169
Specialized services	91	90
Total	896	871

The payment schedule of Accounts receivable – Trade is as follows:

	12/31/2017	12/31/2016
Not yet due	700	706
Overdue< 30 days	136	114
Overdue< 60 days	30	21
Overdue< 90 days	13	10
Overdue< 120 days	10	13
Overdue> 120 days	7	7
Total	896	871

Factoring arrangements

Under a factoring agreement in place, receivables are sold without recourse, subject to the following principal conditions:

- that they comply with the eligibility conditions set out in the agreement;
- that they are not subject to reasonable dispute by the customer, and
- that in the event of non-payment by the customer, the Group will respect the procedures set out in the insurance policy.

The Group and a number of its subsidiaries use factoring arrangements which comply with criteria for derecognition. The outstanding amounts concerned totaled €48.1 million and €50.5 million at December 31st, 2017 and 2016, respectively.

Under the agreements, the Group retains the credit control and receipt functions in respect of the sold receivables on behalf of the factor.

C.4 Share-based payments

The Group has implemented plans, which were in effect during 2017, under which incentive shares are allocated free of charge to group employees and company officers.

The fair value of the incentive plan shares, measured on the grant date by an independent actuary, is

recognized as share-based payment over the vesting period with a corresponding increase in equity.

The amount recognized as an expense is adjusted at each reporting date to reflect the actual number of incentive plan shares that are expected to vest, so that, when vesting occurs, total expense and equity instruments correspond to the actual number of shares vesting in the group personnel and company officers.

Incentive share award plans – Authorization given at the shareholders' general meeting of April 28th, 2016

The Board of Directors' meetings on April 28th and November 2nd, 2016 approved free awards of 1,065,808 incentive plan shares to group personnel, including company officers of subsidiary companies, under the authorization given at the shareholders' general meeting of April 28th, 2016, limited to a maximum of 2.5% of the share capital of the Company at the grant date. The board meeting on April 28th, 2016 also approved the setting-up of a long-term incentive plan for the senior management personnel who are company officers of the Company, with the free award of 350,000 shares. The two plans have identical conditions for vesting.

The features of these plans are as follows:

	04/28/16 plan	11/02/16 plan
Date of board meeting allocating the awards	04/28/2016	11/02/2016
Vesting period	04/28/2016 to 04/28/2019	11/02/2016 to 11/02/2019
Grant date	04/28/2016	11/02/2016
Number of share awards*	1,264,300	151,508
Number of canceled shares**	-152,259	-11,632
Number of outstanding share awards at December 31, 2017	1,112,041	139,876
Fair value of each share award at the grant date (taking into account the market condition)	€48.51	€72.40
Fair value of each share award at the grant date (without taking into account the market condition)	€75.20	€88.80
* including for company officers of the Company	350,000	0
** including for company officers of the Company	-70,959	0

Vesting of the free share awards is conditional on the beneficiaries remaining with the Group until at least the end of the vesting period and on meeting performance conditions relating to the financial years between 2016 and 2018.

The Board of Directors has defined four performance criteria as set out below; the number of shares allocated is determined on the basis of the average of the percentages obtained by the three best–performing criteria.

As one of the four criteria is a market condition (the change in the share price compared with the SBF 120 share index), this is required to be taken into account in the calculation of the fair value of the incentive share awards.

However, it is uncertain whether this market condition will be applied, as only three of the four criteria will in fact be used in the final determination of the number of shares allocated. Two fair values have therefore been calculated, with and without the inclusion of the market condition. As of December 31st, 2017, it is considered probable that the market condition will be required to obtain the highest number of shares and the amount of expense recognized in respect of the plans is therefore based on the fair values indicated above, of €48.51 and €72.40 per share, which results in 2017 expense of €21.5 million.

Percentage obtained	0%	50%	75%	100%
Average increase in revenues at constant exchange rates and consolidation scope	Under 3.5%	Between 3.5% and 5.0% (inclusive)		Over 5.0%
Average rate of EBITA margin, excluding non-recurring items	Under 10.3%	Over 10.3% but less than 10.4%	10.4% or over, but less than 10.5%	10.5% or over
Change in Teleperformance SE's share price compared with the SBF 120 share index	Negative	Between 0% and 2.5% (inclusive)		Over 2.5%
Qualititive condition	0 - 25 points	25 points or more, but less than 35 points		From 35 to 45 points

The Board of Directors' meeting on June 23rd, 2017 approved free awards of 11,600 incentive plan shares to a company officer of a subsidiary, under the authorization given at the shareholders' general meeting of April 28th, 2016. Vesting of these free share awards is conditional on the beneficiary remaining with the Group until at least the end of the vesting period and on meeting certain performance conditions. The related expense in respect of this plan amounted to €0.2 million in 2017.

Following the resignation of Mr. Paulo César Salles Vasques from all of his appointments, with the exception of those of non-executive chairman and director of Teleperformance CRM SA, the Group's Brazilian subsidiary, he has renounced his entitlement to 70,959 shares out of the total award of 175,000 shares granted to him under the long-term incentive plan set up at the board meeting on April 28th, 2016. This has resulted in the immediate recognition of expense of €1.8 million relating to the residual vesting period of the renounced shares. Half of his remaining share awards, representing 52,021 shares, are subject to additional non-market performance conditions in respect of his assignments in Brazil.

C.5 Short-term employee benefits

Liabilities for short-term benefits are measured on an undiscounted basis and recognized when the corresponding service is rendered.

A provision is recognized for the amount the Group expects to pay under short-term cash-settled profit-sharing and bonus schemes if the Group has a present legal or constructive obligation to make such payments as a result of past services by an employee and if the obligation can be reliably estimated.

C.6 Employee termination payments

Termination payments are recognized as expenses when the Group is committed, with no realistic possibility of withdrawal, to a formal detailed plan to lay off employees before their normal retirement date.

Termination payments for voluntary redundancies are recognized if the Group has offered an incentive to encourage voluntary redundancies, if it is probable that such an offer will be accepted and if the number of individuals accepting the offer can be reliably estimated.

C.7 Employee benefits – Defined contribution plans

Obligations for contributions to defined contribution plans are recognized as an expense as incurred.

Such expenses totaled €12.2 million in 2017 compared with an amount of €9.8 million in 2016.

C.8 Other long-term employee benefits

The only long-term employee benefits of the Group are the post-employment benefits that are described in note I.3 *Post-employment benefits: defined benefit plans.*

C.9 Accounts payable – Trade and Other current liabilities

Accounts payable – Trade and Other current liabilities are recognized initially at fair value, and subsequently at amortized cost.

	12/31/2017	*12/31/2016*
Accounts payable - Trade	141	126
Other payables	162	158
Taxes payable	57	56
Accrued expenses	173	160
Other operating liabilities	33	68
Total	566	568

Other operating liabilities at December 31st, 2017 include the negative fair values of derivative financial instruments entered into for the purpose of hedging foreign currency exposures, for €5.7 million, compared with € 23.9 million at the end of 2016.

C.10 Income

Revenues

Revenues from services rendered are measured at the fair value of the consideration received or receivable taking into account trade rebates and other discounts granted by the Group.

Consideration is received in the form of cash or cash equivalents, and income arising in the course of ordinary activities is determined as the amount of cash or cash equivalents received or receivable.

These revenues are recognized in the statement of income in proportion to the stage of completion of the transaction at the reporting date.

When contract billings are based on time spent, revenues are estimated using the actual billable time.

When contract billings are based on call volumes handled, or the number of workstations or staff allocated, revenues are estimated using billable volumes.

For certain contracts, our service is rendered through the sale of our customers' products (e.g. insurance, bank cards.) The related revenues are recognized only when definitively acquired.

Revenues subject to quantitative targets are recognized only when these have been met.

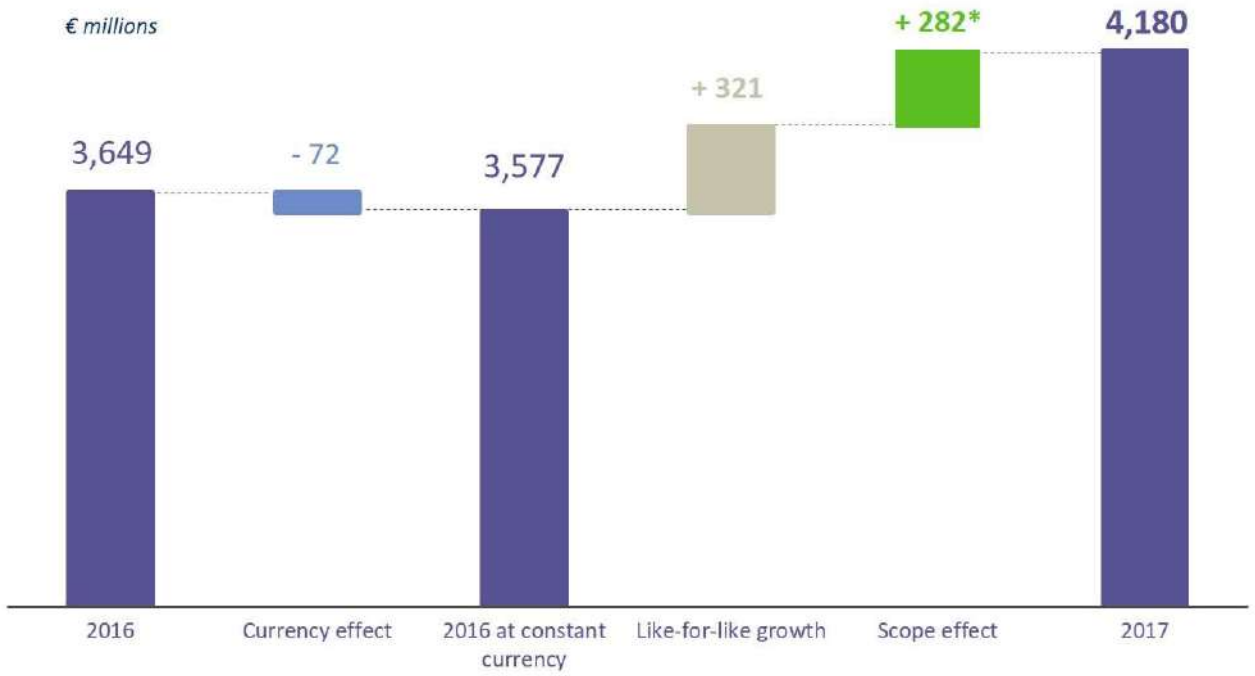

*Relates to LanguageLine Solutions LLC, acquired in the second half of 2016.

Group revenues amounted to €4,180.4 million in 2017, representing an increase (on the basis of published figures) of 14.6% compared to 2016.

At constant scope and exchange rates, the increase was 9.0%.

Other revenues

Other revenues mainly consist of government grants that are recognized in the statement of financial position under Other receivables when there is reasonable assurance that they will be received and that the Group will comply with the conditions attached to them. Grants that compensate the Group for costs incurred are recognized in the statement of income in the period in which the expenses are incurred. Grants that cover all or part of the cost of an asset are recognized in the statement of income over the useful life of the asset.

Following the introduction in 2012 of the French tax credit for competitiveness and employment (*Crédit d'impôt pour la compétitivité et l'emploi - CICE*), the Group opted to recognize it under Other revenues.

In 2017, grants amounted to €7.7 million compared with €5.2 million in 2016, including €2.8 million for the *CICE* in each year.

C.11 External expenses

These consist mainly of property rents and charges, telecommunications, other rentals, travel and entertainment, and fees.

Operating leases

Payments made under operating leases are recognized in the statement of income on a straight-line basis over the term of the lease agreement. Any lease incentives received (such as temporary rent holidays) are also recognized in income over the same period.

The Group rarely owns its call centers and finance lease agreements are therefore a little-used form of financing. Most call centers are held on operating leases, and the related commitments are disclosed in note I.4 *Guarantees and other contractual obligations.*

	2017	2016
Property rents and charges	-209	-196
Telecommunication	-102	-93
Hire and maintenance of equipment	-75	-66
Travel and entertainment	-51	-46
Office cleaning and security	-47	-44
Operating expenses	-38	-43
Staff recruitment	-30	-34
Fees	-42	-33
Consumable supplies	-17	-15
Other	-89	-72
Total	-700	-642

C.12 Other operating income and expenses

This line item includes income and expenses that are unusual in terms of their rarity or amount. It mainly includes capital gains and losses on disposal of intangible assets and property, plant and equipment, certain restructuring and termination costs, significant litigation, acquisition transaction and closure costs of subsidiaries, etc.

	2017	2016
Other operating income		0
Other operating expenses	-23	-6
Total	-23	-6

Other operating expenses in 2017 comprise principally the estimated costs relating to the reorganization of the French business and to a provision made in respect of a non-compete agreement.

C.13 Segment reporting

An operating segment is a component of an entity:

- which engages in business activities from which it may earn revenues and incur expenses, including revenues and expenses relating to transactions with other components of the same entity;
- whose operating results are reviewed regularly by the entity's chief operating decision maker in order to allocate resources and assess its performance; and
- for which discrete financial information is available.

Segments may be aggregated when they have similar economic characteristics.

With effect from January 1st, 2017, group activity as followed by the chief executive officer is now split into the following two segments:

▪ the Core services segment which includes customer care, technical support and new customer acquisitions and is divided into three principal management regions:

- English-speaking & APAC, which covers the activities in the following countries: Canada, USA, United Kingdom, South Africa, China, Indonesia, India, Philippines, Singapore, Jamaica, Guyana, Australia and Malaysia;
- Ibero-LATAM, which covers the activities in the following countries: Argentina, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Peru, Mexico, Spain and Portugal;
- Continental Europe & MEA, which covers the activities in the countries of the EMEA region with the exception of the United Kingdom, Spain and Portugal.

▪ The Specialized services » which includes the interpreting services of LanguageLine Solutions, the visa application management services for government departments offered by TLScontact, GN Research's analytics solutions and the accounts receivable credit management services of AllianceOne Receivables Management (ARM) in North America.

Segment information is set out below:

Inter-segment operations are not significant and are not identified separately.

As a result of the new operational organization, the 2016 comparable amounts have been restated accordingly.

2017	CORE SERVICES				SPECIALIZED SERVICES	TOTAL
	English-speaking & APAC	*Ibero-LATAM*	*Continental Europe & MEA*	*Holding companies*		
Revenues	**1,607**	**1,084**	**851**		**638**	**4,180**
Operating profit	**124**	**130**	**-38**	**14**	**125**	**355**
Capital expenditure	51	47	30	1	19	148
Intangible assets and Property, plant and equipment (carrying amounts)	1,004	282	207	2	1,550	3,045
Depreciation and amortization of non-current assets	-92	-47	-28	-1	-83	-251
Impairment loss on goodwill			-67			-67

2016 proforma	CORE SERVICES				SPECIALIZED SERVICES	TOTAL
	English-speaking & APAC	*Ibero-LATAM*	*Continental Europe & MEA*	*Holding companies*		
Revenues	**1,628**	**884**	**802**		**335**	**3,649**
Operating profit	**144**	**89**	**31**	**8**	**67**	**339**
Capital expenditure	85	59	37		11	192
Intangible assets and Property, plant and equipment (carrying amounts)	1,175	312	273	2	1,824	3,586
Depreciation and amortization of non-current assets	-92	-41	-26		-32	-191
Impairment loss on goodwill						0

D. Goodwill

D.1 Accounting policies and methods

In a business combination, goodwill is calculated as disclosed in note B.1.3 *Business combinations*.

Impairment

The recoverable amount of goodwill is estimated at each reporting date. Goodwill is measured at cost less accumulated impairment losses. It is allocated to cash-generating units (CGUs) or groups of cash-generating units, and is not subject to amortization but is tested for impairment at least annually.

An impairment loss is recognized whenever the carrying amount of an asset or its CGU or group of CGUs exceeds its recoverable amount. Impairment losses are recognized in profit or loss.

An impairment loss recognized in respect of a CGU (or group of CGUs) is allocated to a reduction in the carrying amount of assets in the CGU (or group of CGUs) in the following order:

- goodwill, then

- other intangible assets and property, plant and equipment, proportionate to their carrying amounts.

The recoverable amount of an asset or CGU is the higher of its value in use and its fair value less costs to sell. In assessing value in use, the estimated future cash flows net of tax are discounted to their present value using a discount rate that reflects current market assessments of the time value of money and the risks specific to the asset.

Discount rates are post-tax rates applied to cash flows after tax, and result in the determination of recoverable amounts identical to those that would have been obtained using pre-tax rates to cash flows excluding tax.

The Group determines its discount rates by taking into account the average risk-free rates with a maturity of between 20 and 30 years observed over 12 months, the market risk premium, and Teleperformance's average weekly beta over 2 years (given the absence of comparable enterprises). The risk-free rate and the risk premium are specific to each geographical area with similar characteristics.

An impairment loss in respect of goodwill may not be reversed.

D.2 Determination of the principal cash-generating units ("CGUs") or groups of cash-generating units

Subsidiaries are grouped together to form a CGU in the following cases:

- there are significant inter-relationships formed by the existence of the same customers with common cash flows;
- existence of close ties of certain subsidiaries with their offshore production units;
- presence in the same geographical region, with a similar economic context and common management.

At December 31st, 2017, the principal CGUs were determined to be as follows:

North America CGU

This CGU is formed by the Core services subsidiaries located in the USA and Canada, and the offshore subsidiaries in India, the Philippines, Jamaica and Guyana. The recoverable amount represented by this CGU is €1,655 million.

Nearshore CGU

This CGU is formed by the Core services businesses of subsidiaries located in Mexico, Costa Rica, El Salvador and the Dominican Republic. The recoverable amount represented by this CGU is €724 million.

Central Europe CGU

This CGU is formed by the Core services businesses of subsidiaries located in Germany, Switzerland and the Netherlands. The recoverable amount represented by this CGU is €92 million.

United Kingdom CGU

This CGU is formed by the Core services businesses of subsidiaries located in the United Kingdom and the offshore subsidiary in South Africa. The recoverable amount represented by this CGU is €303 million.

French Speaking Market (FSM) CGU

This CGU is formed by the Core services business of the French subsidiary and the production subsidiaries in Tunisia, Morocco, Lebanon and Madagascar. These companies were brought together in 2008 under common management and a single brand name. The recoverable amount represented by this CGU is €47 million.

LanguageLine Solutions CGU

This CGU was created in 2016 following the acquisition of LanguageLine Solutions LLC in September 2016 and belongs to "specialized services" business. The recoverable amount represented by this CGU is €2,051 million.

As disclosed in note B.2 *Change in consolidation scope,* the Group has finalized the measurement of the fair values of the identifiable assets and liabilities acquired, which resulted in goodwill and a brand name with an indefinite life, with carrying amounts of €713.9 million and €87.6 million, respectively, at December 31st, 2017.

Other CGUs

There are 13 other CGUs, including the Spanish market, Southern Europe, Eastern Europe, TLScontact and ARM, but which represent individually less than 3% of total goodwill.

D.3 Determination of the recoverable amount of CGUs

The recoverable value of CGUs is represented by the value in use.

The Group has not used any other measurement methods, for example that of fair value less costs to sell.

Recoverable amounts are determined by geographical region, calculated using the estimated cash flow forecasts of the next five years. The cash flows of the first year are based on the following year's budget. The cash flows of the following two years are obtained from the three-year plans prepared and approved by CGU and Group managements respectively. Those of the final two years are based on the three-year plans integrating growth and profitability rates judged to be reasonable for the specific CGU. The terminal values calculated after five years assume perpetual future growth equal to inflation and are based on the cash flows of the final year. The cash flows are discounted to present value using the weighted average cost of capital (WACC) of each geographical region.

Reasonableness checks are made to ensure that the WACC is consistent with the ROCE (see note A.5 *Glossary*).

In the event that cash flow forecasts have been shown subsequently on a number of occasions to be inaccurate or when there is uncertainty in respect of a particular market, the Group may decide to limit the forecasts to a three-year horizon.

In 2017, due to the shortfall on the Central Europe CGU budget and to uncertainty surrounding the principal customer of the FSM CGU, the forecasts used in calculating the recoverable amounts were therefore limited to a three-year horizon.

Impairment losses on goodwill were recognized on the Central Europe and FSM CGUs, amounting to €44 million and €23 million, respectively.

D.4 Change in goodwill and Allocation of goodwill by CGU

Changes in goodwill in 2016 and 2017 are set out below:

Goodwill	Gross	Accumulated impairment losses	Carrying amount
At December 31, 2015	**1,146**	**-23**	**1,123**
Change in consolidation scope*	766		766
Translation differences	49		49
At December 31, 2016	**1,961**	**-23**	**1,938**
Change in consolidation scope*	4		4
Translation differences	-200	1	-199
Impairment losses		-67	-67
At December 31, 2017	**1,765**	**-89**	**1,676**

* the line items "Change in consolidation scope" relate to the acquisitions of LanguageLine Solutions LLS in September 2016 and of Wibilong in November 2017.

The following schedule sets out the allocation of goodwill and the discount rate for the principal CGUs.

	Goodwill				Discount rate	
	12/31/2017		*12/31/2016*		*2017*	*2016*
	Gross	*Carrying amount*	*Gross*	*Carrying amount*		
LanguageLine Solutions LLC	714	714	810	810	6.9%	
North America & FHCS	587	571	714	698	6.9%	7.3%
Nearshore	106	106	118	118	9.1%	10.0%
Central Europe	93	49	94	94	5.7%	5.7%
United Kingdom	68	68	70	70	6.0%	7.0%
FSM	53	30	53	53	5.8%	6.4%
Other	144	138	102	95		
Total	1,765	1,676	1,961	1,938		

The reduction in the discount rates between 2016 and 2017 is principally due to a reduction in the beta risk utilized in the calculations.

D.5 Sensitivity analysis

In order to identify CGUs at risk of impairment, the Group performs sensitivity analyses on all CGUs incorporating an increase in the discount rates selected or a reduction of 200 base points in the EBITA rates used in the calculation of the terminal values.

In the event that a CGU is identified under this test, additional sensitivity analyses are performed using further changes in operational assumptions e.g. revenue growth.

At the end of 2017, the goodwill allocated to the Europe Central and FSM CGUs was subject to impairment write-downs. These CGUs were alone in being identified as at risk of impairment as of December 31st, 2017. The carrying amount of the related goodwill as of that date was €49 million and €30 million, respectively. As disclosed in note D.3 *Determination of the recoverable amount of CGUs*, the assumptions used in the impairment testing of these CGUs were applied to forecasts with three-year horizons. The profitability rates used in computing the terminal values were represented by ROCEs which were substantially less than the discount rate (WACC) and it is therefore highly unlikely that the former could reduce further without being compensated by a reduction in the WACC (and this, on calculations to infinity). The most pertinent operational assumption for the sensitivity analysis was therefore considered to be that for revenue growth.

The following table shows the impact of reductions of 100 and 200 basis points in revenue growth over the three forecast years, with a starting point for the revenue growth used in the terminal value calculations represented by the inflation rate of 2%. The amounts in the table show the difference between the CGU's recoverable and carrying amounts. A negative amount therefore indicates a further potential impairment loss.

Sensitivity analysis	*-100 pt*	*-200 pt*
Central Europe CGU	-3	-5
FSM CGU	-2	-5

E. Income tax

E.1 Income tax expense

Income tax expense reported in the income statement comprises current and deferred tax except to the extent that it relates to items recognized directly in equity, in which case it is recognized in equity.

The French levy on the added value of companies (*CVAE*) and certain foreign taxes such as the Italian *IRAP* come within the scope of IAS 12 and are therefore recognized as a tax expense.

As a result, current tax comprises:

- the expected amount of tax payable on the taxable income of the period (determined using tax rates that have been enacted or substantively enacted at the reporting date);
- any adjustment of the amount of tax payable in respect of previous years;
- *CVAE*, *IRAP* etc.

In 2017, the Group recognized an income tax credit of €9.3 million, compared with income tax expense of €82.8 million in 2016. This change is due principally to the effect of the US tax reform on the measurement of deferred tax liabilities, as disclosed in the following schedule.

	2017	*2016*
Consolidated net profit	**314**	**217**
Current tax expense	160	97
Deferred tax expense (credit)	-169	-14
Profit before tax	**305**	**300**
Standard rate of tax in France	34.43%	34.43%
Expected tax expense	**-105**	**-103**
CVAE	-2	-2
IRES/IRAP	-1	-1
Tax on dividends	3	-2
Effect of foreign jurisdictions' tax rates	25	24
US tax on retained earnings	-15	
Change in US tax rate	147	
Impairment loss on goodwill	-23	
Other permanent differences, other items	-17	-1
Change in unrecognized deferred tax assets	-3	2
Total	9	-83

E.2 Deferred tax

Deferred tax is calculated and recognized using the liability method, providing for all temporary differences between the carrying amount of assets and liabilities for financial reporting purposes and the amounts used for taxation purposes.

Deferred tax assets and liabilities are measured using the tax rate that is expected to apply in the period when the asset is realized and the liability settled, according to tax laws that have been enacted or substantively enacted at the reporting date.

Deferred tax assets and liabilities are netted by tax entity for presentation in the statement of financial position.

A deferred tax asset is recognized only to the extent that it is likely that future taxable profits will be available against which the asset can be utilized. Deferred tax assets are reduced to the extent that it is no longer probable that the related tax benefit will be realized.

	Deferred tax assets	*Deferred tax liabilities*	*Net*	*including assets from tax losses*
At December 31, 2015	**36**	**110**	**-74**	**15**
Change in consolidation scope	7	338	-331	
Recognized in profit or loss	5	-9	14	
Translation differences	-1	21	-22	
Offset of assets and liabilities	-16	-16	0	
At December 31, 2016	**31**	**444**	**-413**	**7**
Recognized in profit or loss	-9	-178	169	
Translation differences	-2	-40	38	
Offset of assets and liabilities	8	8	0	
At December 31, 2017	**28**	**234**	**-206**	**7**

Deferred tax liabilities related to intangible assets recognized as part of a business combination amounted to €224.4 million at December 31st, 2017 (€432.0 million at December 31st, 2016).

Deferred tax assets amounted to €27.6 million at December 31st, 2017 (€31.2 million at December 31st, 2016) including amounts relating to tax losses carried forward of €6.8 million.

The Group has tax losses of approximately €103 million, of which €91 million have no expiry date.

Deferred tax assets of €20.8 million at December 31st, 2017 (€22.6 million at December 31st, 2016) relating to tax losses carried forward were not recognized as their recovery was not considered probable.

The US tax reform adopted at the end of December 2017 had the following two principal effects on the 2017 financial statements:

- remeasurement of the deferred taxes recognized in US group companies using a federal income tax rate of 21%, compared with the previous rate of 35%, resulting in a profit of €146.8 million;
- recognition of expense of €15.5 million on the undistributed earnings of the foreign subsidiaries of US companies. The related payments will be spread over a period of eight years.

F. Equity and Earnings per share

F.1 Share capital

Share capital at December 31st, 2017 amounted to €144,450,000 consisting of 57,780,000 shares, with a nominal value of €2.50 each, fully paid-up.

	12/31/2017	*12/31/2016*
Number of shares issued and fully paid up	57,780,000	57,780,000
Including treasury shares of	25,400	14,000
Dividend distributions in respect of the financial year*	106.9 **	75.1
Dividend per share (in €)	1.85 **	1.30

** based on the number of shares in issue at December 31st.*
*** as proposed to the shareholders' meeting on April 20th, 2018.*

There were no movements on the share capital of Teleperformance during 2017.

F.2 Treasury shares

Treasury shares are shown as a deduction from total equity. On disposal, the proceeds, net of transaction costs and income tax, are recognized in equity.

At December 31st, 2017, the Group held 25,400 treasury shares acquired under the liquidity contract for a total of €3.0 million. This amount is shown as a deduction from equity.

F.3 Earnings per share

The Group reports both basic and diluted earnings per ordinary share. Basic earnings per share is calculated by dividing the net profit attributable to holders of ordinary shares by the weighted average number of ordinary shares outstanding during the year, excluding treasury shares.

Diluted earnings per share is determined by adjusting the net profit attributable to ordinary shareholders and the weighted average number of ordinary shares outstanding by the effects of all potentially diluting ordinary shares. These adjustments concern the incentive share awards granted to employees when the required performance conditions have been met at the end of the financial year.

	2017	*2016*
Net profit - Group share	**312**	**214**
Weighted average number of shares used to calculate basic earnings per share	57,767,405	57,263,301
Dilutive effect of share awards	986,702	954,552
Weighted average number of shares used to calculate diluted earnings per share	58,754,107	58,217,853
Basic earnings per share (in €)	5.40	3.73
Diluted earnings per share (in €)	5.31	3.67

Weighted average number of shares used to calculate basic and diluted earnings per share

	2017	*2016*
Ordinary shares in issue at January 1st	57,780,000	57,201,690
Less: treasury shares held	-12,595	-178,561
Shares issued	0	240,172
Total	57,767,405	57,263,301

G. Financial assets and liabilities

G.1 Accounting policies and methods

G.1.1 Financial assets

Current and non-current financial assets comprise the following:

- loans and receivables measured at amortized cost: this category principally includes advances to staff and guarantee deposits paid mainly in the context of commercial property leases. On initial recognition, these loans and receivables are stated at fair value plus directly attributable costs; at each reporting date, these assets are measured at amortized cost.
- derivative financial instruments used to hedge exposure to foreign exchange and interest rate risks, measured at fair value at each reporting date.
- net asset warranties obtained as part of an acquisition: when the warranty relates to a specific asset or liability of the target entity at the date of a business combination, it is recognized separately from goodwill and is measured using the same method as the item being warranted.

G.1.2 Financial liabilities

Non-current financial liabilities include loan transactions with banks or other financial institutions, bond issues and liabilities to certain minority interests.

Current financial liabilities comprise similar transactions as those described above but with settlement expected within one year.

Borrowings are recognized initially at fair value less attributable transaction costs. Subsequent to initial recognition, interest-bearing borrowings are stated at amortized cost, with any difference between cost and redemption value being recognized in profit or loss over the period of the borrowings on an effective interest rate basis.

Debt issuance costs are initially recorded as a reduction of the corresponding loan, and subsequently taken into account in calculating the effective interest rate and recognized in the income statement over the period of the loan.

G.1.3 Cash and cash equivalents

Cash and cash equivalents comprise cash balances, demand deposits and investments in mutual funds made with a short-term objective, measured at fair value, with changes in fair value recognized in the statement of income.

Bank overdrafts that are repayable on demand and form an integral part of the Group's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are classified in the statement of financial position as Other current financial liabilities.

G.1.4 Financial income and expenses

Financial income comprises interest receivable on funds invested, dividend income, fair value increases in financial assets at fair value through profit or loss and foreign exchange gains.

Profits on hedging instruments covering revenues are recognized in operating profit. Interest income is recognized in profit or loss as it accrues, using the effective interest rate method. Dividends are recognized as soon as the Group acquires the right to receive the payment, i.e., in the case of listed shares, on the ex-dividend date.

Financial expenses comprise interest payable on borrowings, the effect of the unwinding of discounted provisions, foreign exchange losses, decreases in fair value of financial assets at fair value through profit or loss, and impairment losses recognized in respect of financial assets.

All costs related to borrowings are recognized in profit or loss using the effective interest rate method. In the event that a loan may be reimbursed by anticipation, the probable residual duration of the loan is estimated at each reporting date and used to spread the any issue expenses under the effective interest rate method.

G.1.5 Derivative financial instruments

The Group uses derivative financial instruments to reduce its exposure to foreign exchange and interest rate risks arising from its activities. From time to time, the Group may use derivative financial instruments, contracted with high-grade financial institutions to reduce counterparty risk.

Financial instruments used to hedge the fair value of financial borrowings are recognized as financial liabilities.

Financial instruments used to hedge other transactions are recognized as other current or non-current assets and liabilities, depending on their maturity and accounting classification. They are measured at fair value at the date of transaction. Changes in the fair value of the instruments are recognized in profit or loss, except for cash flow hedges.

The Group applies hedge accounting when the hedging relationship has been identified, formalized and documented from its inception, and that it has been shown to be effective.

The accounting treatment of these financial instruments depends on the category into which they fall:

- cash flow hedges: the effective portion is recognized through equity. The amounts recognized in equity are reclassified to profit or loss when the hedged items affect profit or loss, either in operating profit when they concern the cover of a commercial transaction or in financial result when they cover a financial operation. The ineffective portion of changes in fair value of cash flow hedges is recognized in profit or loss as financial income or expense;
- fair value hedges: they are recognized in financial result.

G.2 Financial assets

	Current	*Non-current*	*Total 12/31/2017*	*Total 12/31/2016*
Loans	11		11	12
Derivative financial instruments	9		9	3
Guarantee deposits	9	43	52	53
Indemnification asset	9		9	11
Gross financial assets	**38**	**43**	**81**	**79**
Write-downs			0	
Carrying amount	38	43	81	79

The indemnification asset of €9.3 million (US$11.1 million) relates to the acquisition of Aegis USA Inc. in 2014 (see note I.2 *Change in provisions*).

G.3 Financial result

	2017	*2016*
Income from cash and cash equivalents	**1**	**1**
Interest expense	-49	-24
Bank commissions	-11	-11
Financing costs	**-60**	**-35**
Net financing costs	-59	-34
Foreign exchange gains	33	30
Foreign exchange losses	-24	-35
Other financial income (expenses)	9	-5
Financial result	-50	-39

The increase in interest expense is principally related to the acquisition of LanguageLine Solutions LLC in September 2016.

G.4 Financial liabilities

G.4.1 Loans from financial institutions, bonds and US private placements (USPPs)

Analysis by category of loan

At December 31st, 2017, the Group had obtained and utilized financing totaling €1,593.3 million, as follows:

Category of loan	*Amount in currency at 12/31/2017*	*Currency*	*Amount in € at 12/31/2017*	*Interest type*	*Rate*	*Maturity*	*Financial covenant*
Teleperformance SE							
Bond	600	€	600	Fixed*	Coupon of +1.50%	2024.04	no
US private placement Tranche A	75	USD	63	Fixed	+3.92%	2023.12	yes
US private placement Tranche B	175	USD	146	Fixed	+4.22%	2026.12	yes
Bank loan	500	USD	417	Floating	Libor $ + 1.7%	2021.08	yes
US private placement Tranche A	160	USD	133	Fixed	+3.64%	2021.12	yes
US private placement Tranche B	165	USD	138	Fixed	+3.98%	2024.12	yes
Commercial paper	105	€	105	Fixed	-0.15%	2018.03	no
Syndicated multi-currency facility**		€	0	Floating	Euribor + 0.6%	2022.02	yes
		USD	0	Floating	Libor $ + 1.50%	2022.02	yes
Total			1,602				
Loan issuance expense/premiums & discounts			-10				
Total Teleperformance SE			1,592				
Other group companies							
Bank loan			1				
Total Other group companies			1				
Total Group			**1,593**				

** a swap of fixed to floating interest rates has been contracted over €200 million.*
*** a facility of €300 million is unutilized at 12.31.2017*

Schedule of loans by principal currency and type of interest rate

Type of interest rate	Total	€	USD	CLP	COP	MAD
- fixed	1,179	699	479	1		
- floating	414		414			
At December 31, 2017	1,593	699	893	1	0	0
Type of interest rate	Total	€	USD	CLP	COP	MAD
- fixed	580	30	545	2	2	1
- floating	1,301	703	595		3	
At December 31, 2016	1,881	733	1,140	2	5	1

Covenants

The following financial liabilities are subject to financial covenants:

- syndicated multi-currency facility of €300 million;
- bank loan of US$500 million;
- two US private placements of US$250 million and US$325 million;

At December 31st, 2017, the relevant ratios were as follows:

	Contractual	Actual
Consolidated net debt/Total equity	≤ 0.90x	0.69x
Consolidated net debt/Consolidated EBITDA	≤ 2.50x	1.88x

G.4.2 Net financial indebtedness: Schedule of debt maturities

	12/31/2017	Current	Non-current*	12/31/2016	Current	Non-current
Bank loans	418	106	312	1,314	171	1,143
Commercial paper	105	105		30	30	
USPP	480		480	545		545
Bond	600		600	0		
Loan issuance expense/premiums & discounts	-10	-4	-6	-8	-7	-1
Cross Currency Interest Swap on loan	5	5		17	17	
Bank overdrafts and advances	2	2		3	3	0
Due to minority shareholders	0	0	0	39	39	
Other borrowing and financial liabilities	11	10	1	9	8	1
Total financial liabilities	**1,611**	**224**	**1,387**	**1,949**	**261**	**1,688**
Marketable securities	32	32		7	7	
Cash and bank	253	253		275	275	
Total cash and cash equivalents	**285**	**285**		**282**	**282**	
Net debt	1,326	-61	1,387	1,667	-21	1,688

** due after 5 years: €946 million*

The Group relies only to a minor extent on finance lease financing and, in consequence, the amount of its finance lease liabilities is not significant (€1.3 million and €1.8 million at December 31st, 2017 and 2016, respectively).

The group has also made a payment of €38.5 million during the first half of 2017 relating to the balance of deferred consideration due on the acquisition of minority interests.

G.4.3 Interest rate risk

The Group has an exposure to interest rate risks on its financial liabilities and its short-term liquid investments. The following schedule identifies the amounts subject to interest rate risk:

Net debt	12/31/2017	Fixed rate	Subject to interest rate risk	12/31/2016	Fixed rate	Subject to interest rate risk
Total financial liabilities	1,611	1,179	432	1,949	619	1,330
Cash and cash equivalents	-285		-285	-282		-282
Net debt	**1,326**	**1,179**	**147**	**1,667**	**619**	**1,048**

A change of 100 basis points in the interest rate would have had an impact of €3.3 million in 2017 and of €9.2 million in 2016.

G.5 Foreign exchange hedging operations

Revenues and operating expenses of Group companies may be denominated in a currency other than their functional currency. In order to reduce exposure to exchange rate risk, hedge contracts have been entered into, principally between the following currencies:

- the US dollar and the Mexican peso;
- the US dollar and the Colombian peso;
- the Philippine peso and the US dollar;
- the Colombian peso, the Turkish lira, the Tunisian dinar and the euro.

The policy of the Group is cover its highly probable forecast transactions denominated in foreign currency, usually up to 12 months ahead. The Group uses forward exchange contracts and plain vanilla foreign exchange options.

In addition, currency hedges are in place to cover the exchange risk between currencies managed within the cash pool and the euro (in particular the US dollar) as well as certain loans between Teleperformance SE and its subsidiaries.

The principal derivative financial instruments in place at the year-end are as follows:

Derivative financial instruments at December 31, 2017	*Notional amount in currency*	*Notional amount in € at 12/31/2017*	*Fair value in € at 12/31/2017*	*In equity*	*In 2017 profit or loss*
Hedge of forecast transactions					
USD/PHP 2017	1,298	22	1		1
USD/PHP 2017*	4,160	70	0		0
COP/USD 2017*	14	12	0		0
MXN/USD 2017	13	10	0		0
EUR/TND 2018	57	19	0	0	0
COP/USD 2018	33	28	1	0	0
COP/EUR 2018	15	15	0	0	0
USD/PHP 2018	8,150	136	4	3	1
USD/PHP 2018*	1,725	29	0		0
USD/MXN 2018	422	18	-1	-1	0
USD/MXN 2018*	106	4	0		0
MXN/USD 2018	47	39	-2	-2	0
MXN/USD 2018*	11	9	0		0
USD/INR 2018	11	9	0	0	0
EUR/USD 2018	13	10	0	0	0
Cross Currency Interest Swap EUR/USD	55	46	-5		-5
USD interest caps	400	334	0		0
Interest rate swap, fixed to floating	200	200	0		0
€ interest cap	120	120	0		0
Hedge of intra-group loans					
in USD	268	224	5		5
in PHP	7,059	118	-3		-3
Cash pool hedges					
in USD	165	138	-2		-2

* not eligible for hedge accounting

Derivative financial instruments at December 31, 2016	*Notional amount in currency*	*Notional amount in € at 12/31/2016*	*Fair value in € at 12/31/2016*	*In equity*	*In 2016 profit or loss*
Hedge of forecast transactions					
USD/MXN 2016	10	9	-1		-1
USD/MXN 2017	40	38	-2	-2	0
USD/MXN 2017*	5	4	0		0
MXN/USD 2016	197	9	-1		-1
MXN/USD 2017	706	32	-3	-3	0
MXN/USD 2017*	140	6	0		0
USD/PHP 2016	2,395	46	0		0
USD/PHP 2017	9,105	174	-6	-5	-1
USD/PHP 2017*	1,900	36	-1		-1
COP/EUR 2017	24	24	0	0	0
COP/EUR 2017*	4	4	0		0
COP/USD 2017	43	41	0	0	0
COP/USD 2017*	7	6	0		0
USD/INR 2017	21	20	0	0	0
USD/INR 2017*	4	4	0		0
EUR/TND 2017	52	21	0	0	0
Cross Currency Interest Swap EUR/USD	85	81	-17		-17
USD interest caps	400	380	0		0
Hedge of intra-group loans					
in GBP	6	7	1		1
in USD	140	133	-7		-7
in PHP	4,486	86	1		1
Cash pool hedges					
in MXN	1,570	72	-1		-1
in USD	45	43	0		0

* not eligible for hedge accounting

At December 31st, 2017, the fair value of derivative financial instruments amounted to -€1.7 million (December 31st, 2016: -€37.7 million) of which €9.0 million is presented in Other financial assets, €5.7 million in Other current liabilities and €5.0 million in Other financial liabilities.

Counterparty credit risk (Credit value adjustment – CVA) and own credit risk (Debt value adjustment – DVA) are taken account of in the fair values of hedging instruments, but the amounts are not significant.

G.6 Carrying amount and fair value of financial assets and financial liabilities by category

The fair value hierarchy is made up of three levels:

Level 1: unadjusted quoted prices in active markets for identical assets or liabilities that the entity can access at the measurement date;

Level 2: inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly (i.e. as prices) or indirectly (i.e. derived from prices);

Level 3: unobservable inputs for the asset or liability.

The following schedules show the carrying amounts of financial assets and financial liabilities and their fair values, by level of hierarchy:

	Accounting category					Fair value			
12/31/2017	Financial instruments at fair value through profit or loss	Derivative financial instruments	Loans and receivables	Financial liabilities at amortized cost	**Total**	Lev 1	Lev 2	Lev 3	**Total**
Financial instruments: Assets									
I - Financial assets at fair value	32	9	0	0	**41**	32	9	0	**41**
Exchange rate hedging instruments		9			**9**		9		**9**
Marketable securities	32				**32**	32			**32**
II - Financial assets at amortized cost	0	0	1,270	0	**1,270**	253	1,017	0	**1,270**
Loans			11		**11**		11		**11**
Guarantee deposits			8		**8**		8		**8**
Indemnification asset			9		**9**		9		**9**
Accounts receivable - Trade			896		**896**		896		**896**
Other assets			93		**93**		93		**93**
Cash and bank			253		**253**	253			**253**
Financial instruments: Liabilities									
I - Financial liabilities at fair value	0	11	0	0	11	0	11	0	11
Loan hedging instruments		5			**5**		5		**5**
Exchange rate hedging instruments		6			**6**		6		**6**
II - Financial liabilities at amortized cost	0	0	2	2,173	**2,175**	2	2,173	0	**2,175**
Bank loans				418	**418**		418		**418**
Commercial paper				105	**105**		105		**105**
USPP loans				480	**480**		480		**480**
Bond				600	**600**		600		**600**
Other financial liabilities				11	**11**		11		**11**
Bank overdrafts and advances			2		**2**	2			**2**
Accounts payable - Trade				140	**140**		140		**140**
Other liabilities				419	**419**		419		**419**

12/31/2016	Accounting category					Fair value			
	Financial instruments at fair value through profit or loss	Derivative financial instruments	Loans and receivables	Financial liabilities at amortized cost	**Total**	Lev 1	Lev 2	Lev 3	**Total**
Financial instruments: Assets									
I - Financial assets at fair value	7	3	0	0	**10**	7	3	0	**10**
Exchange rate hedging instruments		3			**3**		3		**3**
Marketable securities	7				**7**	7			**7**
II - Financial assets at amortized cost	0	0	1,322	0	**1,322**	275	1,047	0	**1,322**
Loans			12		**12**		12		**12**
Guarantee deposits			53		**53**		53		**53**
Indemnification asset			11		**11**		11		**11**
Accounts receivable - Trade			871		**871**		871		**871**
Other assets			100		**100**		100		**100**
Cash and bank			275		**275**	275			**275**
Financial instruments: Liabilities									
I - Financial liabilities at fair value	0	41	0	0	41	0	41	0	41
Loan hedging instruments		17			**17**		17		**17**
Exchange rate hedging instruments		24			**24**		24		**24**
II - Financial liabilities at amortized cost	0	0	3	2,442	**2,445**	3	2,442	0	**2,445**
Bank loans				1,314	**1,314**		1,314		**1,314**
Commercial paper				30	**30**		30		**30**
USPP loans				545	**545**		545		**545**
Other financial liabilities				9	**9**		9		**9**
Bank overdrafts and advances			3		**3**	3			**3**
Accounts payable - Trade				126	**126**		126		**126**
Other liabilities				418	**418**		418		**418**

There were no transfers between the different levels of fair value for assets and liabilities measured using this method.

G.7 Financial risk management

The Group has an exposure to the following risks:

- credit risk
- liquidity risk
- market risk
- equity risk

Set out below is information on the Group's exposure to each of the above risks, its objectives, policy and procedures for measuring and managing risk, as well as its share capital and equity management.

Quantitative disclosures appear elsewhere in the consolidated financial statements.

The Board of Directors defines and oversees the Group's risk management framework. Monitoring, measuring and overseeing financial risk is the responsibility of the Group's Finance Department, for the Group and each of the Group companies.

The objective of the Group's risk management policy is to identify and analyze the risks that the Group faces, to set appropriate risk limits and controls, and to manage the risks and ensure that the limits defined are respected. The policy and the risk management systems are reviewed regularly so as to respond to changes in the market and in the Group's activities. Through its training and management rules and procedures, the Group aims to develop a rigorous and constructive control environment in which every employee has a clear understanding of his or her role and duties.

The Internal Audit Department performs both periodic and *ad hoc* reviews of risk management controls and procedures, reporting to the Audit and Compliance Committee.

All strategic decisions relating to the hedging policy for financial risks are the responsibility of the Group's Finance Department.

G.7.1 Credit risk

Credit risk is the Group's risk of financial loss in the event that a customer or counterparty to a financial instrument fails to meet his contractual obligations. This risk primarily concerns customer receivables and short-term investments.

Customer and other receivables

The Group's exposure to credit risk is mainly influenced by the individual characteristics of its customers. Sales to the principal customer of the Group account for 6.9% of group global revenues. In addition, sales to telecommunications sector customers and internet access providers represent a total of 16.7% of group revenues for Core service segment. No country accounts for over 10% of customer receivables with the exception of the United States which represented approximately 38% of total customer receivables as of December 31st, 2017.

Credit risk is continuously monitored by the Group's Finance Department, through monthly reports and quarterly Executive Committee meetings.

The Group does not require specific credit guarantees for its customer and other receivables.

The Group determines the level of its impairment losses by estimating losses incurred on customer and other receivables.

Guarantees

The Group provides contract performance guarantees at the request of some customers. The guarantees provided are disclosed in note I.4 *Commitments and other contractual obligations*.

G.7.2 Liquidity risk

Liquidity risk is the risk that the Group would experience difficulty in repaying its liabilities at the due date.

The policy of the Group in respect of its financing is to maintain at all times sufficient liquidity to finance group assets, short-term cash requirements, and its development, both in terms of amount and duration, and at the lowest possible cost.

Over recent years, the Group has implemented a centralized cash management policy when in conformity with local legislation applying to its subsidiaries. Cash pool member companies represent slightly over 60% of group revenues.

In those countries where cash-pooling is not permitted, short-term cash management is provided by subsidiaries' operational management which generally has access to short-term bank facilities, plus, in some cases, confirmed credit line facilities from the parent company.

All medium- and long-term financing operations are authorized and overseen by the Group's Finance Department.

The Group obtains its financing in the form of loans, credit lines and bond issues with high-grade financial institutions, with maturities ranging from 2018 through 2026 as disclosed in note G.4 *Financial liabilities*.

The outstanding balance available on the multi-currency (€, US$) syndicated facility as of December 31st, 2017 amounted to €300 million.

Net debt at December 31st, 2017 was €1,326.3 million, compared with €1,666.8 million at the end of 2016.

Given the maturities of our borrowings and the Group's capacity to generate free cash flow, liquidity risk is considered to be low.

Additional disclosures relating to liquidity risk are set out in note G.4 *Financial liabilities*.

G.7.3 Market risk

Market risk is the risk that changes in market prices, such as foreign exchange rates, interest rates and the cost of equity instruments, will affect the Group's results or the value of its financial instruments. The objective of managing market risk is to manage and control the market risk exposure, keeping it within acceptable limits, while optimizing returns.

Foreign exchange risk

The Group is exposed in particular to foreign exchange risk on revenues denominated in a currency, generally the US dollar, which is not the functional currency of the group company concerned.

The Group hedges this risk mainly in respect of rate changes between the Mexican, Philippines and Colombian pesos, and the US dollar. Additional disclosures on these hedging operations are given in note G.5 *Currency hedging operations*.

The Group is also exposed to exchange risk on loans denominated in currencies other than the euro or the functional currencies of group entities.

Group policy is as follows:

- the Group hedges loans made to subsidiaries with loans or advances in the same currency and with the same maturities, or with foreign exchange contracts;
- the principal bank loans of Group companies are denominated in the functional currency of the borrower;
- interest due on borrowings is denominated in the same currency as the cash flows generated by the underlying operations of the Group, primarily the euro, the US dollar and the £ sterling. This provides an economic hedge without resorting to the use of derivatives.

Finally, the Group is exposed to foreign exchange risk when translating foreign subsidiaries' financial statements for consolidation purposes.

The translation effect on the consolidated revenues of the Group is disclosed in note G.8 *Exposure to exchange risk from translation of foreign subsidiaries' financial statements on consolidation* which shows the breakdown of revenues by currency over the last two years.

The impact of changing foreign exchange rates on the Group's revenues, profit before tax and net profit - Group share is disclosed in note G.8 *Exposure to exchange risk from translation of foreign subsidiaries' financial statements on consolidation.*

Interest rate risk

See note G.4 *Financial liabilities*.

G.7.4 Equity risk

The Group limits its exposure to equity risk by investing available cash reserves in short-term liquid investments, certificates of deposit, and in low risk financial instruments such as mutual funds, while choosing high-grade financial institutions and avoiding significant concentration. Group management does not expect any counterparty to default.

Short-term liquid investments at December 31st, 2017 amounted to €31.8 million, principally represented by money market or mutual funds.

Share capital and equity management

The Group's policy on share capital and equity management is to maintain a strong equity base so as to keep the confidence of investors, creditors and the market, and to support future business development. The Group therefore pays close attention to its net indebtedness and the debt/equity ratio.

The gearing ratio is determined as follows:

	12/31/2017	12/31/2016
Net debt	1,326	1,667
Equity	1,922	1,921
Gearing ratio	0.69	0.87

From time to time, the Group may buy back its own shares on the market. Oddo Corporate Finance has acted on its behalf under a liquidity agreement since January 8th, 2007. The agreement complies with the Code of Conduct established by the AFEI (French Association of Investment Firms) as approved by the AMF, the French stock exchange regulator. The amount of funds committed to this arrangement is €3.0 million. The number of treasury shares held at the end of the year is set out in note F.1 *Share Capital*.

G.8 Exposure to exchange risk from translation of the financial statements of foreign subsidiaries on consolidation

In order to indicate the exposure of the Group to exchange risk from translation of the financial statements of foreign subsidiaries on consolidation, an analysis of Group revenues by principal currency in 2017 and 2016 is set out in the following schedule:

Revenues	*2017*		*2016*	
	Amount	%	Amount	%
Euro	919	22.0%	856	23.5%
US dollar	1,888	45.2%	1,624	44.5%
Brazilian real	243	5.8%	185	5.1%
Mexican peso	95	2.3%	85	2.3%
£ sterling	293	7.0%	291	8.0%
Colombian peso	165	3.9%	124	3.4%
Yuan	96	2.3%	92	2.5%
Autres	481	11.5%	392	10.7%
Total	4,180	100%	3,649	100%

Sensitivity of profit before tax and equity to a change of 1% in the exchange rate of the euro against other currencies

The Group estimates that an increase or decrease of 1% in the exchange rate of the euro against other currencies would have impacted 2017 profit before tax and equity by approximately €2.7 million and €9.5 million, respectively.

Effect of changes in exchange rates

The effect of changes in exchange rates on statement of income line items is as follows:

	2017	*2016 at 2017 rates*	*2016*
Revenues	4,180	3,577	3,649
Operating profit	355	329	339
Financial result	-50	-34	-39
Net profit	314	213	217
Net profit - Group share	312	209	214

At December 31st, 2017, the Group's exposure to exchange risk may be summarized as follows:

	Assets	Liabi-lities	Net position before hedging	Net position after hedging
12/31/2017				
Euro	626	1,876	-1,250	-1,250
USD	2,844	401	2,443	2,441
BRL	114	37	77	77
MXN	127	19	108	107
GBP	176	37	139	139
COP	98	27	71	71
PHP	102	41	61	63
Other	394	119	275	274
Total	4,481	2,557	1,924	1,922

	Assets	Liabi-lities	Net position before hedging	Net position after hedging
12/31/2016				
Euro	668	2,156	-1,488	-1,505
USD	3,311	616	2,695	2,684
BRL	110	27	83	82
MXN	128	38	90	87
GBP	188	33	155	156
COP	103	31	72	72
PHP	129	39	90	84
Other	355	93	262	261
Total	4,992	3,033	1,959	1,921

G.9 Foreign currency exchange rates

Principal currencies	*Country*	*Average 2017* rate	*Closing rate at* 12/31/2017	*Average 2016* rate	*Closing rate at* 12/31/2016
Europe					
£ sterling	United Kingdom	0.88	0.89	0.82	0.86
Americas and Asia					
Brazilian real	Brazil	3.60	3.97	3.86	3.43
Colombian peso	Colombia	3,332.00	3,577.00	3,376.00	3,155.00
US dollar	United States	1.13	1.20	1.11	1.05
Mexican peso	Mexico	21.33	23.66	20.66	21.77
Philippines peso	Philippines	56.94	59.80	52.55	52.27

The statement of income of LanguageLine Solutions LLC was consolidated for the period from September 19th to December 31st, 2016 at an average rate of $1.089 = €1; the rate used for the conversion of the opening statement of financial position was $1.117 = €1.

H. Cash flows

H.1 Non-cash items of income and expense

	2017	2016
Depreciation and amortization	251	191
Impairment loss on goodwill	67	
Increase in provisions, net of releases	22	-15
Unrealized gains and losses on financial instruments	1	-2
Share-based payments	22	22
Total	363	196

H.2 Change in working capital requirements

	2017	2016
Accounts receivable - Trade	-109	-45
Accounts payable - Trade	37	50
Other	14	12
Total	-58	17

The increases in Accounts receivable – Trade and Accounts payable -Trade are principally due to the increase in the level of activity.

H.3 Acquisition of subsidiaries

At the beginning of November 2017, the Group acquired Wibilong, a French start-up which is a pioneer in the field of collaborative brand and consumer solutions.

H.4 Explanation of the change in net debt in 2017

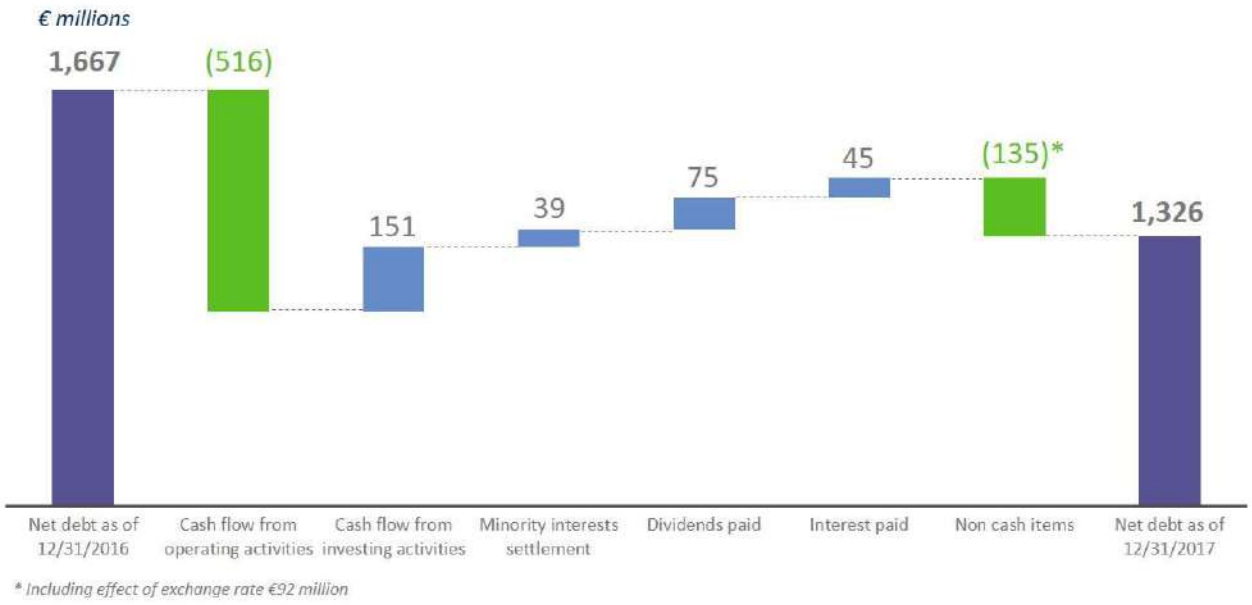

H.5 Analysis of cash and cash equivalents presented in the consolidated statement of cash flows

	Total 2017	Total 2016
Bank overdrafts and advances	-2	-3
Marketable securities	32	7
Cash and bank	253	275
Cash and cash equivalents	283	279

I. Provisions, litigation, commitments and other contractual obligations

I.1 Accounting policies and methods

A provision is recognized in the statement of financial position when the Group has a present legal or constructive obligation resulting from a past event, the obligation can be reliably estimated and it is probable that an outflow of economic benefits will be required to settle the obligation. The amount of the provision represents management's best estimate of the outflow required, and is discounted when the time value effect is significant.

Provisions relating to post-employment benefits, in particular defined benefit plans which represent most of the Group's provisions for future expenses, are recognized as follows:

The net obligation of the Group is calculated separately for each plan by estimating the amount of future benefits that employees have earned in return for services rendered as of the reporting date. This amount is discounted to determine its present value, and the fair value of any plan assets is deducted. The discount rate is the yield at the reporting date on AA credit-rated bonds that have maturity dates approximating to the terms of the Group's obligations. The obligations are measured using the projected unit credit method.

Actuarial gains and losses are recognized as Other recognized income and expenses in comprehensive income.

I.2 Change in provisions

	12/31/2016	Increases	Releases		Translation	Other	12/31/2017
			utilized	unutilized	differences		
Non-current							
Retirement benefits	12	3			-1		14
Other expenses	1						1
Total	13	3	0	0	-1	0	15
Current							
Risks	37	10	-8	-2	-4		33
Other expenses	2	17					19
Total	39	27	-8	-2	-4	0	52
TOTAL	**52**	**30**	**-8**	**-2**	**-5**	**0**	**67**

	12/31/2015	Increases	Releases		Translation	Other	12/31/2016
			utilized	unutilized	differences		
Non-current							
Retirement benefits	10	2					12
Other expenses	0	1					1
Total	10	3	0	0	0	0	13
Current							
Risks	68	10	-29	-20	-1	9	37
Other expenses	2	1	-1				2
Total	70	11	-30	-20	-1	9	39
TOTAL	**80**	**14**	**-30**	**-20**	**-1**	**9**	**52**

Provisions for risks at December 31st, 2017 include a contingent liability of €9.8 million (US$11.7 million), in respect of risks identified during the Aegis USA Inc. acquisition process in 2014, including tax risks of €9.3 million. An equivalent asset of €9.3 million has been recognized, as these are covered by a contractual net asset warranty.

Provisions for risks also include other risks in a total amount of €23.9 million, of which €11.5 million relates to personnel-related risks, principally concerning lawsuits with former employees, particularly in Argentina, Brazil and France.

The provisions for other expenses at December 31st, 2017 include principally a provision for the reorganization of the French business.

As legal proceedings are ongoing for most of these disputes, their settlement date is uncertain.

I.3 Post-employment benefits: defined benefit plans

These principally concern:

- the lump-sum payments made to employees on their retirement under the provisions of French national wage agreements and labor law;

- defined benefit pension plans in Norway, Greece, India, the Philippines, El Salvador and certain Mexican entities.

Commitments related to the lump-sum benefits in France are measured with the following actuarial assumptions:

	2017	*2016*
Discount rate	1.29%	1.31%
Rate of annual increase in remuneration	1.5%/2.5%	1.5%/2.5%
Rate of employer social charges	38%/45%	38%/45%

The other commitments are individually not significant and are measured by actuaries taking into account local conditions.

Change in the actuarial liability in 2017 and 2016:

	France	*Other countries*	*Total*
At December 31, 2015	**6**	**4**	**10**
In 2016 profit or loss	1	1	2
In other comprehensive income			0
At December 31, 2016	**7**	**5**	**12**
In 2017 profit or loss	1	2	3
In other comprehensive income	-1	1	0
Translation differences		-1	-1
At December 31, 2017	**7**	**7**	**14**

The liability at December 31st, 2017 presented as Other countries principally concerns our subsidiaries in Greece, El Salvador and India, for amounts of €1.7 million, €1.6 million and €1.4 million, respectively.

The amount of the liability in the consolidated statement of financial position, representing the benefit obligation less the fair value of plan assets was:

- €7.8 million at December 31st, 2013;
- €9.8 million at December 31st, 2014;
- €9.8 million at December 31st, 2015;
- €12.1 million at December 31st, 2016;
- €14.4 million at December 31st, 2017.

Analysis of plan assets

	2017	*2016*
Actuarial liability	18	16
Equities	10.9%	6.7%
Bonds	13.2%	12.2%
Money market	14.0%	23.6%
Hold to maturity bonds	27.2%	31.7%
Loans & Receivables	23.3%	18.1%
Real estate	10.0%	7.4%
Other	1.4%	0.3%
Plan assets	4	4
Provision in the statement of financial position	14	12

Company officers represent an amount of €0.2 million in the provision for retirement benefits at December 31st, 2017.

I.4 Guarantees and other contractual obligations

Guarantee commitments

Teleperformance SE issued a performance guarantee in November 2013 to the Secretary of State for the Home Department of the United Kingdom covering the duration of a commercial contract entered into with a Group subsidiary. The maximum amount covered by the guarantee is £60 million.

Teleperformance SE has issued a performance guarantee in December 2013 to Apple Inc. relating to the obligations of certain subsidiaries undertaken in respect of a commercial contract. The guarantee was given for the duration of the commercial contract. The maximum amount covered by the guarantee is the

greater of (i) US$60 million and (ii) the total amount of sums paid by Apple to the subsidiaries concerned during the calendar year preceding the date of the loss event.

In October 2017, Teleperformance Europe Middle-East and Africa SAS, a subsidiary of Teleperformance SE, issued a comfort letter in favor of Klarna in connection with a new commercial agreement entering into effect from January 1st, 2018 covering services to be supplied by it and subsidiaries of Teleperformance SE in Sweden, Finland, Denmark, Germany, the Netherlands, the United Kingdom and Austria.

Teleperformance SE has issued a performance guarantee to Barclays Bank PLC with respect to the obligations of its subsidiary TP Portugal under a commercial contract. The guarantee was signed in 2014 and will remain in force for the duration of the contract.

In July 2017, Teleperformance Portugal SA, a subsidiary of Teleperformance SE, entered into a promissory lease agreement concerning office premises under construction. In this context, guarantees have been issued by Teleperformance SE and its subsidiary, under the form of a joint and several guarantee for a total amount limited to €42 million and for the duration stated in the agreement.

In 2017, Teleperformance SE has issued a comfort letters in favor of Canon, a partner with which Ypiseria 800-Teleperformance A.E., a subsidiary of Teleperformance SE, has entered into a new commercial relationship.

Net asset warranties received in connection with the acquisition of shareholdings

The agreements entered into for the acquisitions of Aegis USA Inc., City Park Technologies, LanguageLine Holding LLC and Wibilong SAS contain net asset warranties intended to indemnify the acquirer against any prior existing liabilities that were not disclosed at the time of the acquisitions.

The duration of each commitment is generally between twelve months and three years from the date of completion of the acquisitions except in certain cases for tax-related liabilities for which the duration of the commitments corresponds to the date of prescription of each potential liability.

These commitments are guaranteed by either:

- certain amounts held by a bank in escrow, to be released in full after one, two or three years from the date of acquisition, as applicable, in the absence of any request for indemnification, or
- a first demand guarantee issued by a high-grade bank, expiring after 18 months from the date of acquisition, as applicable, in the absence of any request for indemnification, or
- representations and warranty insurance covering certain of the warranties for either three or six years after the date of acquisition, depending on the nature of the warranty.

Assets secured against financial liabilities

There were no group assets pledged as collateral for borrowings at the end of 2017.

Maturity of contractual obligations recognized in the statement of financial position

	Total 12/31/2017	*Under 6 months*	*6 - 12 months*	*Total 2018*	*2019 to 2022*	*After*
Bank loans	418	2	104	106	312	
Commercial paper	105	105		105		
USPP loans	480			0	134	346
Bonds	600			0		600
Bank overdrafts and advances	2	2		2		
Other loans and financial liabilities	11	10		10	1	

	Total 12/31/2016	Under 6 months	6 - 12 months	Total 2017	2018 to 2021	After
Bank loans	1,314	43 *	128	171	1,143	
Commercial paper	30	30		30		
USPP loans	545			0	151	394
Bank overdrafts and advances	3	3		3		
Other loans and financial liabilities	24	7	17	24		
Due to minority interests	39	39		39		

* *including €35 million drawn down on the revolving credit line of €300 million maturing on February 3rd, 2021.*

Maturity of operating lease obligations (not recognized in the statement of financial position)

	Total 12/31/2017	Under 6 months	6 - 12 months	Total 2018	2019	2020	2021	2022	After
Operating leases	597	74	74	148	125	103	72	54	95

	Total 12/31/2016	Under 6 months	6 - 12 months	Total 2017	2018	2019	2020	2021	After
Operating leases	587	72	72	144	134	103	73	43	90

The commitments represent future real estate lease payments as stipulated in each lease agreement over the shorter of the lease term or the minimum term at the end of which the lease may be terminated without penalty.

I.5 Litigation

As a result of the normal course of business, Teleperformance and its subsidiaries are party to a number of judicial, administrative or arbitration proceedings. The risk of loss from such proceedings is provided for when the loss is probable and can be reliably quantified. Amounts provided at December 31st, 2017 total €21.4 million.

J. Related party disclosures

J.1 Related party transactions

There are no transactions with related parties that are significant and/or entered into at conditions that are not at arm's length.

J.2 Remuneration of company officers (Executive committee - Comex)

Remuneration of company officers in respect of the 2017 and 2016 financial years is summarized as follows:

Remuneration	2017	2016
Short-term benefits	18	15
Contract termination payments	9	
Incentive share award grants		36
Total	27	51

The Group has obtained non-compete agreements from some of its senior management personnel. In respect of Mr. Daniel Julien, the Group Chairman and Chief Executive Officer, his commitment was modified at the end of 2017 and is now for a period of two years, for which he would be entitled to receive an amount representing two years' remuneration subject to his respecting a nine-month notice period.

K. Audit fees of the statutory auditors of Teleperformance SE (excluding those paid to members of their international networks)

The audit fees of the statutory auditors of Teleperformance SE in respect of the 2017 financial year are analyzed as follows:

(in thousands of euros)	***KPMG***		***Deloitte & Associés***	
	Audit certification	*Services other than audit certification (1)*	*Audit certification*	*Services other than audit certification (2)*
Issuer	398	150	392	131
Fully consolidated subsidiaries	99	8	126	
Total	497	158	518	131

(1) Nature of non-audit services rendered by KPMG to the parent company and its subsidiaries: issue of comfort letter, engagements for the verification of the existence and the fairness of certain personnel, environmental or societal information to be submitted to independent third party entities, consultation relating to anti-corruption compliance measures, consultation in respect of the adoption of an accounting standard, attestations issued in respect of financial ratios.

(2) Nature of non-audit services rendered by Deloitte & Associés to the parent company and its subsidiaries: issue of comfort letter, due diligence engagement, attestation issued in respect of financial information, attestation issued in respect of financial ratios.

L. Events after the reporting date

At the beginning of February 2018, the Company renegotiated favorably the covenants applicable to certain of its financial liabilities (see note G.4 *Financial liabilities)*. The revised covenants will be applicable for the June 30th, 2018 closing and subsequently.

M. Scope of consolidation

		% interest	% control
Parent company	**Teleperformance SE**	100	100
	Core Services		
	Continental Europe & MEA		
Albania	CC Albania Sh.p.K	100	100
	Service 800 Albania Sh.p.K	100	100
Germany	Teleperformance Support Services GmbH	100	100
	Teleperformance Germany S.a.r.l & Co.KG	100	100
	Teleperformance Germany At Home Solutions GmbH	100	100
	Teleperformance Germany Financial Services GmbH	100	100
Denmark	Teleperformance Denmark A/S	100	100
Egypt	Service 800 Egypt for Communication (Teleperformance) SAE	96	96
Finland	Teleperformance Finland OY	100	100
France	Teleperformance France	100	100
	Teleperformance Europe Middle East and Africa	100	100
	Teleperformance Intermediation	100	100
Greece	Ypiresia 800 Teleperformance Anonimi Etaireia Parohis Ypiresion	100	100
	Direct Response Service SA	100	100
	Mantel SA	100	100
	Customer Value Management (CVM)	100	100
Italy	In & Out S.p.A.	100	100
Lebanon	Teleperformance Lebanon S.A.L	100	100
Lithuania	UAB "Teleperformance LT"	100	100
Kosovo	twenty4help Kosovo sh.p.k.	100	100
Luxembourg	Teleperformance Germany Sarl	100	100
Madagascar	Teleperformance Madagascar	99	99
Morocco	Société Anonyme Marocaine d'Assistance Client S.A	100	100
Norway	Teleperformance Norge AS	100	100

		% interest	% control
Netherlands	PerfectCall BV	100	100
	PerfectCall Financial Services BV	100	100
Poland	Teleperformance Polska Spółka z ograniczoną odpowiedzialnością	100	100
	TPG Katowice Spolka Z Ograniczona Odpowiedzialnoscia	100	100
Czech Republic	Lion Teleservices CZ, a.s	100	100
Romania	The Customer Management Company SRL	100	100
	S 800 Customer Service Provider SRL	100	100
	Service 800 contact center – Agent de Asigurare SRL	100	100
Russia	Direct Star LLC	100	100
Sweden	Teleperformance Nordic AB	100	100
Slovakia	Lion Teleservices SK, spol. s r.o.	100	100
Switzerland	SCMG AG	100	100
Tunisia	Société Tunisienne de Telemarketing	100	100
	Société Méditerranéenne de Teleservices	100	100
Turkey	Metis Bilgisayar Sistemliri Sanayi ve Ticaret A.S	100	100
Ukraine	Limited Liability Company "KCU"	100	100

	English-speaking & Asia Pacific		
Australia	Teleperformance Australia Pty Ltd	100	100
South Africa	TP South Africa Trading (PTY) Ltd	100	100
Canada	MMCC Solutions Canada company	100	100
China	North Asia United CRM Technologies (Beijing), Ltd	85	100
	Beijing Interactive CRM Technology Service Limited	85	100
	North Asia United CRM Technologies (Xian), Ltd	85	100
	Nanning North Asia United CRM Technologies Co., Ltd	85	100
	Teleperformance Information Technologies (Kunming) Co., Ltd.	85	100
	Guangdong North Asia United CRM Technologies Limited	85	100
Guyana	Guyana call Center Inc	100	100
Hong Kong	Hong Kong Asia CRM Limited	85	85
India	CRM Services India Private Limited	100	100
Indonesia	P.T. Telemarketing Indonesia	100	100

		% interest	% control
Malaysia	Teleprformance Malaysia SDN.BHD	100	100
Philippines	Telephilippines incorporated	100	100
	TPPH - FHCS, Inc.	100	100
	TPPH-CRM Inc.	100	100
United Kingdom	Teleperformance Holdings Limited	100	100
	Teleperformance Limited	100	100
	MM Group Ireland Limited	100	100
Singapore	Telemarketing Asia (Singapore) PTE LTD	100	100
USA	TP USA, Inc	100	100
	Americall Group, Inc	100	100
	Merkafon Management Corporation	100	100
	Teleperformance Delaware, Inc	100	100
	TP USA – FHCS, Inc	100	100

	Ibero-LATAM		
Argentina	Citytech SA	100	100
Brazil	Teleperformance CRM SA	100	100
	SPCC – Sao Paulo Contact Center Ltda	100	100
Chile	TP Chile S.A	100	100
Colombia	Teleperformance Colombia SAS	100	100
Costa Rica	Costa Rica Contact Center CRCC S.A	100	100
Spain	Teleperformance Espana SAU	100	100
	twenty4Help Knowledge Service Espana S.L	100	100
	Teleperformance Mediacion de Agencia de Seguros, S.L	100	100
	Teleperformance Servicios Auxiliares, S.L.U	100	100
Mexico	TP Nearshore, S. DE R.L. de C.V.	100	100
	Merkafon de Mexico, S.A. DE C.V.	100	100
	Impulsora Corporativa Internacional, S.A. DE C.V.	100	100
	Servicios Hispanic Teleservices, S.C.	100	100
	Hispanic Teleservices de Guadalajara, S.A. DE C.V.	100	100
	Merkafon International, Ltd	100	100

		% interest	% control
	Hispanic Teleservices Corporation ("HTC")	100	100
Peru	Teleperformance Peru S.A.C.	100	100
Portugal	Teleperformance Portugal, S.A.	100	100
El Salvador	Compania Salvadorena de Teleservices, Sociedad Anónima de Capital Variable	100	100
	Specialized Services		
	TLS Contact		
Luxembourg	TLS Group SA	100	100
South Africa	TLScontact South Africa (PTY) Ltd	100	100
Albania	TLScontact Albania Sp.h.k	100	100
Algeria	SARL TLS Contact	100	100
Germany	TLScontact Deutschland GmbH	100	100
Armenia	TLScontact AM Limited Liability Company	100	100
Azerbaijan	TLScontact Azerbaijan LLC	100	100
Belorussia	Unitary Enterprise Providing Services "TLSContact"	100	100
China	Beijing TLScontact Consulting Co, Ltd	100	100
Egypt	TLScontact Egypt	100	100
Spain	TLScontact Espana SL	100	100
France	TLScontact France	100	100
	TLScontact Algérie	100	100
Gabon	TLScontact Gabon	100	100
Georgia	TLScontact Georgia LLC	100	100
Hong Kong	TLScontact Limited	100	100
Mauritius	TLScontact (Mau) Ltd	100	100
Indonesia	PT. TLScontact Indonesia	99	99
Ireland	TLScontact (Ireland) Ltd	100	100
Italy	TLScontact Italia S.R.L	100	100
Kazakhstan	TLScontact Kazakhstan Limited Liability Partnership	100	100
Kenya	TeleContact Limited	100	100
Lebanon	TLScontact Lebanon SARL	100	100

		% interest	% control
Madagascar	TLScontact Madagascar	100	100
Morocco	TLScontact Maroc SARLAU	100	100
Montenegro	LLC «TLScontact » d.o.o. Podgorica	100	100
Nigeria	TLScontact Processing Services Limited	100	100
Uganda	TLS Contact Limited	100	100
Uzbekistan	TLS Contact Limited Liability Company	100	100
Philippines	TLScontact Philippines Corporation	100	100
United Kingdom	TLScontact (UK) Limited	100	100
	Teleperformance Contact Limited	100	100
	Application Facilitation Services Limited	100	100
Russia	LLC TLScontact (RU)	100	100
Serbia	TLScontact doo Beograd-Stari Grad	100	100
Sierra Leone	TLScontact (SL) Ltd	100	100
Switzerland	TLScontact Switzerland GmbH	100	100
Tanzania	TLScontact (Tanzania) Ltd	100	100
Thailand	TLScontact International Co, Ltd	100	100
	TLScontact Enterprises (Thaïlande) Co, Ltd	100	100
Tunisia	TLScontact Tunisie	100	100
	Société Tunisienne d'assistance et de services (STAS)	100	100
Turkey	TLS Danismanlik HVTLS	100	100
Ukraine	TLScontact Ukraine Limited Liability Company	100	100
Vietnam	TLSContact Vietnam Company Limited	100	100
	GN Research		
Albania	Albania Marketing Services Sh.p.K	67	100
Germany	GN Research Germany GmbH	67	100
France	GN Research France	67	100
Italy	GN Research S.p.A. a socio unico	67	100
Luxembourg	GN Research SA	67	67

		% interest	% control
	Alliance One Receivables Management		
Canada	AllianceOne Limited	100	100
Jamaica	Outsourcing Management International Inc, Ltd	100	100
USA	AllianceOne Incorporated ("AllianceOne")	100	100
	AllianceOne Receivables Management, Inc ("ARMI")	100	100
	LanguageLine Solutions LLC		
United Kingdom	Language Line Services UK Limited	100	100
USA	Language Line holdings II, Inc.	100	100
	Wibilong		
France	Wibilong S.A.S	84.43	84.43
	Other		
Luxembourg	Luxembourg Contact Center S.A.R.L	100	100
Netherlands	Dutch Contact Centers BV	100	100
USA	Teleperformance Group Inc.	100	100

All group companies are fully consolidated.

6.7 Statutory auditors' report on the consolidated financial statements

This is a translation into English of the statutory auditors' report on the financial statements of the Company issued in French and it is provided solely for the convenience of English speaking users.

This statutory auditors' report includes information required by European regulation and French law, such as information about the appointment of the statutory auditors or verification of the management report and other documents provided to shareholders.
This report should be read in conjunction with, and construed in accordance with, French law and professional auditing standards applicable in France.

For the year ended 31 December 2017

To the annual general meeting of Teleperformance SE,

Opinion

In compliance with the engagement entrusted to us by your annual general meeting, we have audited the accompanying consolidated financial statements of Teleperformance SE for the year ended 31 December 2017.

In our opinion, the consolidated financial statements give a true and fair view of the assets and liabilities and of the financial position of the Group as at 31 December 2017 and of the results of its operations for the year then ended in accordance with International Financial Reporting Standards as adopted by the European Union.

The audit opinion expressed above is consistent with our report to the audit and compliance committee.

Basis for Opinion

Audit framework

We conducted our audit in accordance with professional standards applicable in France. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Our responsibilities under those standards are further described in the Statutory Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report.

Independence

We conducted our audit engagement in compliance with independence rules applicable to us, for the period from 1st January 2017 to the date of our report and specifically we did not provide any prohibited non-audit services referred to in Article 5(1) of Regulation (EU) No 537/2014 or in the French Code of ethics (code de déontologie) for statutory auditors.

Justification of Assessments - Key Audit Matters

In accordance with the requirements of Articles L.823-9 and R.823-7 of the French Commercial Code (Code de commerce) relating to the justification of our assessments, we bring your attention to the key audit matter relating to risk of material misstatement that, in our professional judgment, was of most significance in our audit of the consolidated financial statements of the current period, as well as how we addressed this risk.

This matter was addressed in the context of our audit of the consolidated financial statements as a whole, and in forming our opinion thereon. We do not provide a separate opinion on specific items of the consolidated financial statements.

Impairment of goodwill (Note D to the consolidated financial statements)

Identified risk

As of 31 December 2017, goodwill are recorded in the statement of financial position for a net carrying amount of €1,676 million, i.e. 37% of total assets.

Goodwill are allocated to cash generating units (CGUs) or groups of CGUs and tested for impairment at least annually. An impairment loss is recognized in the statement of income whenever the carrying amount of CGUs or groups of CGUs exceeds its recoverable value. As of 31 December 2017, the group has impaired the value of the FSM and Central Europe goodwill for €67 million (€23 million and €44 million respectively).

The recoverable amount of the CGUs and groups of CGUs is based on the value in use, assessed using the discounted cash flows method. Future cash flows are determined over a 5 year period. Cash flows for the first three years are based on the three year plan

prepared by CGUs management and approved by Group management. Cash flows for the following two years are derived from the three-year plan on the basis of growth and profit rates considered reasonable for the related CGUs. Depending on the circumstances, the group can limit the use of cash flows over a three-year period. The terminal value is based on the cash flows of the last year and assumes perpetual growth rate equal to inflation.

Sensitivity analyses are performed by the group by simulating an erosion of the recoverable value through an increase in the discount rate or a decrease in the EBITA rate (as set out in note A.5) in the terminal value. When a sensitive CGU is identified, further analysis are performed to assess the sensitivity to changes in operational assumptions such as the revenue growth.

We considered the impairment of goodwill to be a key audit matter considering the weight of these assets on the consolidated statement of financial position, the importance of management's judgments to determine the assumptions relating to cash flow forecasts, discount and long-term growth rates and the sensitivity of the recoverable value to changes in the underlying assumptions.

Our audit approach

For the significant cash generating units or for those presenting a specific risk of impairment that we deemed material, our work consisted in:

- Obtaining an understanding of the process by which the impairment tests are performed and assessing the appropriateness of the group's valuation methodology with the applicable accounting standard;
- Reconciling the carrying value of the CGUs or groups of CGUs used for impairment testing purposes with the consolidated accounts;
- Assessing the reasonableness of future cash flows through:
  - An analysis of the appropriateness of the forecast process by comparing actual realisation with initial forecasts;
  - A reconciliation of the budget and the forecasts used to determine the future cash flows with those approved by group management;
- Assessing the appropriateness of the long term growth rates and discount rates used for each CGU or group of CGUs with the assistance of our valuation experts;
- Performing our own sensitivity analysis on EBITA rates used in the calculation of terminal values and on discount rates.

Verification of the Information Pertaining to the Group Presented in the Management Report

As required by law we have also verified in accordance with professional standards applicable in France the information pertaining to the Group presented in the management report of the board of directors.

We have no matters to report as to its fair presentation and its consistency with the consolidated financial statements.

Report on Other Legal and Regulatory Requirements

Appointment of the Statutory Auditors

We were appointed as statutory auditors of Teleperformance SE by the annual general meeting held on 31st May 2011.

As at 31st December 2017 Deloitte & Associés and KPMG Audit IS were in the nineteenth year and thirty-first year of total uninterrupted engagement respectively, which are the eleventh year since securities of the Company were admitted to trading on a regulated market, due to the mergers and acquisitions of audit firms that occured before our appointement as statutory auditors.

Responsibilities of Management and Those Charged with Governance for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with International Financial Reporting Standards as adopted by the European Union and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is responsible for assessing the Company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is expected to liquidate the Company or to cease operations.

The audit and compliance committee is responsible for monitoring the financial reporting process and the effectiveness of internal control and risks management systems and where applicable, its internal audit, regarding the accounting and financial reporting procedures.

The consolidated financial statements were approved by the board of directors.

Statutory Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Objectives and audit approach

Our role is to issue a report on the consolidated financial statements. Our objective is to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with professional standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these consolidated financial statements.

As specified in Article L.823-10-1 of the French Commercial Code (code de commerce), our statutory audit does not include assurance on the viability of the Company or the quality of management of the affairs of the Company.

As part of an audit conducted in accordance with professional standards applicable in France, the statutory auditor exercises professional judgment throughout the audit and furthermore:

- Identifies and assesses the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, designs and performs audit procedures responsive to those risks, and obtains audit evidence considered to be sufficient and appropriate to provide a basis for his opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- Obtains an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the internal control;
- Evaluates the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management in the consolidated financial statements;
- Assesses the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Company's ability to continue as a going concern. This assessment is based on the audit evidence obtained up to the date of his audit report. However, future events or conditions may cause the Company to cease to continue as a going concern. If the statutory auditor concludes that a material uncertainty exists, there is a requirement to draw attention in the audit report to the related disclosures in the consolidated financial statements or, if such disclosures are not provided or inadequate, to modify the opinion expressed therein;
- Evaluates the overall presentation of the consolidated financial statements and assesses whether these statements represent the underlying transactions and events in a manner that achieves fair presentation;
- Obtains sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the Group to express an opinion on the consolidated financial statements. The statutory auditor is responsible for the direction, supervision and performance of the audit of the consolidated financial statements and for the opinion expressed on these consolidated financial statements.

Report to the audit and compliance committee

We submit a report to the audit and compliance committee which includes in particular a description of the scope of the audit and the audit program implemented, as well as the results of our audit. We also report, if any, significant deficiencies in internal control regarding the accounting and financial reporting procedures that we have identified.

Our report to the audit and compliance committee includes the risks of material misstatement that, in our professional judgment, were of most significance in the audit of the consolidated financial statements of the current period and which are therefore the key audit matters, that we are required to describe in this audit report.

We also provide the audit and compliance committee with the declaration provided for in Article 6 of Regulation (EU) N° 537/2014, confirming our independence within the meaning of the rules applicable in France such as they are set in particular by Articles L.822-10 to L.822-14 of the French Commercial Code (code de commerce) and in the French Code of Ethics (code de déontologie) for statutory auditors. Where appropriate, we discuss with the audit and compliance committee the risks that may reasonably be thought to bear on our independence, and the related safeguards.

Paris La Défense and Neuilly sur seine ont the 28th February 2018

The statutory auditors

French original signed by

KPMG Audit IS	Deloitte & Associés
Jacques Pierre	Philippe Battisti
Associé	*Associé*

Teleperformance SE
European company
With a share capital of €144,450,000
RCS number 301 292 702 Paris
21/25 rue Balzac – 75008 Paris – France
Tél : +33 1 53 83 59 00

For more information :
teleperformance.com

Follow us:

/teleperformanceglobal

@teleperformance

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blog.teleperformance.com

/company/teleperformance

MCG Health LLC

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Subcontractor Attestation: Financial Viability

Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky (Aetna) is in the process of responding to Commonwealth of Kentucky Request for Proposal Medicaid Managed Care Organization (MCO) –All Regions RFP 2000000202 (RFP) and anticipates naming MCG Health, LLC ("Subcontractor") as a proposed subcontractor in its RFP response.

(1) Please choose the appropriate option below.

_X___Subcontractor hereby verifies and confirms to Aetna that it has had sustained bottom line profitability and has had no current areas of significant financial risk for the past three calendar years or Subcontractor's fiscal years.

____Subcontractor has ***not*** had sustained bottom line profitability and/or has experienced current areas of significant financial risk during the past three calendar years or Subcontractor's fiscal years

(2) Subcontractor verifies and confirms that if it checked the second option in subsection (1) above, indicating that is has ***not*** had sustained bottom line profitability and/or has experienced current areas of significant financial risk during the past three calendar years or Subcontractor's fiscal years, it has provided a full and complete explanation of any such matters below. (please attach additional pages if necessary).

_____
_____
_____
_____
_____
_____
_____

(3) By signing below, the individual executing this form on behalf of the Subcontractor affirms that he or she is a duly authorized representative of Subcontractor.

MCG Health, LLC
By: _____
Print Name: _John Pollard_____
Title: _____Chief Financial Officer_____
Date: _____01/22/2020_____

Proprietary

WELLS FARGO

Wells Fargo Bank, NA
Technology, Media & Telecom Group
90 South 7th Street, 15th FL
Minneapolis, MN 55402

June 26, 2019

Aetna Better Health of Kentucky
Aetna Medicaid
Attn: Jonathan E. Copley, Esq. CEO
9900 Corporate Campus Drive – Suite 1000
Louisville, KY 40223

RE: Bank Reference

Dear Mr. Copley:

Wells Fargo Bank had a sustained relationship with the Hearst Corporation ("Hearst") and its subsidiaries for over one hundred and twenty years, and as such receives annual and quarterly financial statements.

Hearst Corporation is a valued customer to bank, and their accounts with us are maintained in good order.

Wells Fargo Bank has worked closely with Hearst in various areas of finance and treasury operations and are known by us to be reputable company. Based on our dealings with the company, we can recommend Hearst as being responsible for its business commitments.

Very truly yours,

Jhana Pittman
Wells Fargo Bank

cc: Carlton J. Charles (Hearst)

Nanthealth, Inc.

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NANTHEALTH, INC.

FORM 10-K
(Annual Report)

Filed 04/01/19 for the Period Ending 12/31/18

Address	9920 JEFFERSON BLVD CULVER CITY, CA, 90232
Telephone	(310) 853-7513
CIK	0001566469
Symbol	NH
SIC Code	7374 - Services-Computer Processing and Data Preparation
Industry	Advanced Medical Equipment & Technology
Sector	Healthcare
Fiscal Year	12/31

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2018

OR

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

For the transition period from to

Commission File Number: 001-37792

NantHealth, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**27-3019889**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
9920 Jefferson Blvd. Culver City, California	**90232**
(Address of principal executive offices)	**(Zip Code)**

(310) 883-1300

Registrant's telephone number, including area code

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

Title of each class	Name of each exchange on which registered
Common Stock, par value $0.0001 per share	**NASDAQ Global Select Market**

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

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES ☐ NO ☒

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. YES ☐ NO ☒

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

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

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

Emerging growth company ☒

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

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES ☐ NO ☒

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the Registrant on June 30, 2018 , based on a closing price $3.31 per share of common stock on the NASDAQ Global Select Market on June 30, 2018 , was approximately $128.9 million .

The number of shares of Registrant's common stock, $0.0001 par value per share, outstanding as of March 26, 2019 was 109,921,647 .

DOCUMENTS INCORPORATED BY REFERENCE

As noted herein, the information called for by Part III is incorporated by reference to specified portions of the Registrant's definitive proxy statement to be filed in conjunction with the Registrant's 2019 Annual Meeting of Stockholders, which is expected to be filed not later than 120 days after the Registrant's fiscal year ended December 31, 2018.

NantHealth, Inc.

Form 10-K
For the year ended December 31, 2018
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We own or have rights to trademarks and service marks that we use in connection with the operation of our business. NantHealth, Inc. and our logo as well as other brands such as DeviceConX, GPS Cancer, Liquid GPS, HBox, Vitality, VitalsConX, NaviNet, Eviti, Eviti | Connect, Eviti | IQ, and other marks relating to our Eviti product line are used in this Annual Report on Form 10-K. Solely for convenience, the trademarks and service marks referred to in this Annual Report on Form 10-K are listed without the (sm) and (TM) symbols, but we will assert, to the fullest extent under applicable law, our rights or the rights of the applicable licensors to these trademarks, service marks and trade names. Additionally, we do not intend for our use or display of other companies’ trade names, trademarks, or service marks to imply a relationship with, or endorsement or sponsorship of us by, these other companies.

SPECIAL NOTE REGARDING FORWARD LOOKING STATEMENTS

This Annual Report on Form 10-K, or this Annual Report, including, without limitation, Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and Item 1A, “Risk Factors,” contains “forward-looking statements” within the meaning of the Private Securities Litigation Reform Act of 1995. In some cases you can identify these statements by forward-looking words such as “believe,” “may,” “will,” “might,” “estimate,” “continue,” “anticipate,” “intend,” “could,” “should,” “would,” “project,” “plan,” “outlook,” “target,” “expect,” or similar expressions, or the negative or plural of these words or expressions. These forward-looking statements include, but are not limited to, statements concerning the following:

- the structural change in the market for healthcare in the United States, including uncertainty in the healthcare regulatory framework and regulatory developments in the United States and foreign countries;
- the evolving treatment paradigm for cancer, including physicians’ use of molecular information and targeted oncology therapeutics and the market size for molecular information products;
- physicians’ need for precision medicine products and any perceived advantage of our solutions over those of our competitors, including the ability of our comprehensive platform to help physicians treat their patients’ cancers;
- our ability to generate revenue from sales of products enabled by our molecular and biometric information platforms to physicians in clinical settings;
- our ability to increase the commercial success and to accelerate commercial growth of our sequencing and molecular analysis solutions and our other products and services;
- our plans or ability to obtain reimbursement for our sequencing and molecular analysis solutions, including expectations as to our ability or the amount of time it will take to achieve successful reimbursement from third-party payers, such as commercial insurance companies and health maintenance organizations, and government insurance programs, such as Medicare and Medicaid;
- our ability to effectively manage our growth, including the rate and degree of market acceptance of our solutions;
- our ability to offer new and innovative products and services, including new features and functionality for our existing products and services;
- our ability to attract new partners and clients;
- our ability to estimate the size of our target market;
- our ability to maintain and enhance our reputation and brand recognition;
- consolidation in the healthcare industry;
- competition which could limit our ability to maintain or expand market share within our industry;
- restrictions and penalties as a result of privacy and data protection laws;
- our use of “open source” software;
- our ability to use, disclose, de-identify or license data and to integrate third-party technologies;
- data loss or corruption due to failures or errors in our systems and service disruptions at our data centers;
- breaches or failures of our security measures;
- our reliance on Internet infrastructure, bandwidth providers, data center providers, other third parties and our own systems for providing services to our users;
- risks related to future acquisition opportunities;
- the requirements of being a public company;
- our ability to attract and retain key personnel;
- our expectations regarding the period during which we qualify as an emerging growth company under the Jumpstart Our Business Startups Act, or the JOBS Act;
- our ability to obtain and maintain intellectual property protection for our solutions and not infringe upon the intellectual property of others;
- our ability to implement our comprehensive restructuring plan that includes a wide range of organizational efficiency initiatives and other cost reduction opportunities; and
- our financial performance expectations, including our expectations regarding our revenue, cost of revenue, gross profit or gross margin, operating expenses, including changes in research and development, sales and marketing and general and administrative expenses, and our ability to achieve and maintain future profitability.

We caution you that the foregoing list does not contain all of the forward-looking statements made in this Annual Report.

These forward-looking statements are based on current expectations and assumptions that are subject to risks and uncertainties, which could cause our actual results to differ materially from those reflected in the forward-looking statements. These statements are within the meaning of the "safe harbor" provisions of the Private Securities Litigation Reform Act of 1995. These statements appear throughout this Annual Report and are statements regarding our intent, belief, or current expectations, primarily based on our current assumptions, expectations and projections about future events and trends that may affect our business, financial conditions, operating results, cash flows or prospects, as well as related industry developments. You should not place undue reliance on these forward-looking statements, which apply only as of the date of this Annual Report. Our actual results could differ materially from those anticipated in these forward-looking statements for many reasons, including the risks faced by us and described in Part I, Item 1A, "Risk Factors," and in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 of this Annual Report. We undertake no obligation to update any forward-looking statements for any reason to conform these statements to actual results or to changes in our expectations, except as required by law.

PART I

Item 1. Business

Overview

NantHealth is a next-generation healthcare technology company that is transforming the way critical diseases, such as cancer, are known and treated. Specifically, we employ precision medicine and technology to give physicians, payers, pharma and patients more actionable information.

To accomplish this, we employ a unique systems-based approach to personalized healthcare providing leading solutions across the continuum of care for physicians, payers patients and biopharmaceutical organizations, enabling the use of cutting edge data and technology towards the goals of empowering clinical decision support and improving patient outcomes. NantHealth's comprehensive product portfolio combines the latest technology in molecular analysis (GPS Cancer and Liquid GPS), payer/provider collaboration platforms that exchange information in near-real time (NaviNet and Eviti), and connected care solutions that deliver Medical Device Interoperability (MDI) through vendor neutral medical device connectivity.

As a pioneer in the era of big data and augmented intelligence, we believe we are uniquely positioned to benefit from multiple significant market opportunities as healthcare providers and payers transition from fee-for-service to value-based reimbursement models and accelerate their pursuit of evidence-based clinical practice.

Our mission is to improve the delivery of healthcare and optimize patient outcomes by leveraging the latest advancements in precision medicine and software technology to enable true value-based care. We derive revenue from sales of software-as-a-service, licensed software and maintenance, hardware, services, and molecular analysis services (including GPS Cancer and Liquid GPS) to healthcare providers, payers and self-insured employers.

We Are Uniquely Positioned to Address Transformative Shifts across the Healthcare Continuum

The efficiency and effectiveness of the current healthcare system is often hindered by the complex, dynamic interplay of three uncoordinated and segregated domains: the knowledge domain, the care delivery domain, and the payer domain. The disparate nature of these domains, and their often-inconsistent incentives and conflicting priorities, can inhibit interoperability and coordination. We believe two simultaneous, transformative shifts are highlighting these critical deficiencies of the current healthcare environment:

1. ***A rapid evolution from traditional fee-for-service to patient-centered and patient-empowered, value-based models driven by quantifiable measures of outcomes relative to cost*** . Unsustainable escalating healthcare costs, which we believe is due to broken fee-for-service models, is driving many stakeholders and governments towards alternative delivery models. Despite significant investments in Electronic Health Records ("EHRs") and other technologies designed to enable the transition to more value-based care, we believe that, in a fee-for-service model, the economic incentives generally discourage coordination amongst healthcare stakeholders and encourage volume-driven (rather than outcomes-driven) decision-making. This model results in healthcare and financial data that remains largely segregated into "walled gardens." Thus, patient data often remains static and cannot be easily shared or interpreted due to siloed legacy proprietary platforms that lack interoperability.

2. ***A paradigm shift to molecularly precise and real-time biometric-driven medicine, with both massive volumes and rapidly expanding repositories of complex data from traditional and novel sources.*** Advances in molecular medicine require healthcare providers to promptly aggregate, evaluate and synthesize hundreds to thousands of relevant facts in real time to arrive at a single patient decision. Molecular profiling often generates hundreds of gigabytes of data per patient, which must then be transported, stored, analyzed and interpreted with supercomputing and/or high-performance computing environments. We believe the rapid pace of medical advancements, the massive amount of molecular data and the frequency of biometric information is overwhelming many providers' ability to process that information at the point of care, thereby inhibiting the paradigm shift to individualized medicine.

We believe these shifts , and the associated challenges , require next-generation and advanced technology systems that deliver more information, faster and with more relevance and accuracy than the healthcare continuum has experienced. Our unique portfolio of health care technology solutions allow us to collect , interpret and deliver data to provide decision support and help both payers and providers effectively transition to value-based care. Given the magnitude of these shifts and the difficulty involved in addressing the associated challenges, we believe our solution platforms are unmatched and serve to position NantHealth at the forefront of multiple large and growing market opportunities We have invested significant capital , healthcare and biotechnology expertise over nearly a decade to develop, acquire and integrate the components that we believe address many of the challenges faced by stakeholders across the continuum of care.

Our Strategy

Our goal is to become the leading evidence-based, personalized healthcare company transforming the way critical diseases, such as cancer, are known and treated. We seek to enable clients and clinicians to deliver improved patient outcomes and more effective treatment decisions for critical illnesses by applying novel molecular analysis tailored to the specific molecular profiles of patient tissues and blood and providing technology solutions that provide near real-time access to large scale clinical data. To accomplish this goal, we plan to deploy NantHealth solutions designed to address and accelerate the transformational shifts occurring in healthcare: rapid evolution from traditional fee-for-service to value-based models and the paradigm shift to molecularly precise and real-time biometric driven medicine. The key elements of our strategy include:

- **Driving global reimbursement, awareness, and adoption of GPS Cancer and Liquid GPS.** To drive the growth of GPS Cancer and Liquid GPS in the United States, we have deployed an integrated, multi-pronged strategy to (1) obtain reimbursement through large national and regional payers and self-insured employers and (2) strategically drive oncologist awareness and adoption in those regions with reimbursement. Likewise, we are pursuing international growth through a combination of reseller agreements and other unique partnership models to yield predictable and recurring revenue. To date, we have announced agreements and agreements in principle for US insurance coverage for GPS Cancer and Liquid GPS with health plans, providers and self-insured employers, as well as reseller agreements in multiple countries outside of the US. We are also increasing recognition of GPS Cancer and Liquid GPS through strategically engaging and educating oncologists and other key oncology stakeholders, and communicating patient outcomes through peer-reviewed journals and conference presentations.

- **Increasing sales of NantHealth solutions to healthcare providers, payers, pharma, and self-insured employers.** We are marketing NantHealth solutions to healthcare providers transitioning from fee-for-service reimbursement models to value-based care models in pursuit of improved patient outcomes and lower costs. We believe we are positioning NantHealth as a next-generation payer intermediary and partner with healthcare payers and self-insured employers as they roll out value-based model partnerships and transition to value-based precision care.

- **Broadening usage of our solutions among existing clients.** Our broad portfolio of NantHealth solutions affords us a unique ability to expand our agreements with existing clients through cross-selling opportunities. We are actively focused on leveraging existing relationships to create these opportunities to drive additional revenue for our solutions including GPS Cancer , Liquid GPS and NantHealth software solutions such as NaviNet, Eviti, DeviceConX, and VitalsConX. Many of our clients are already successfully using certain components of our solutions, and we are working to demonstrate the full value of our integrated systems infrastructure and platforms.

- **Expanding our business in international markets.** We are executing our go-to-market strategies internationally, creating global awareness of our brand and taking steps towards our goal of broader adoption worldwide.

- **Developing new features and functionality for NantHealth solutions.** We plan to continue to leverage NantHealth solutions to create new features and functionality that our clients can use to drive improved patient outcomes and lower the cost of care. This includes expansion of our molecular profiling portfolio, which we expect to broaden clinical utility and enhance usability.

- **Complementing internal growth with strategic acquisitions.** We believe opportunities exist for us to enhance our competitive position by acquiring additional companies with complementary products and technologies and/or acquiring rights to proprietary products or technologies from third parties.

Our Industry

Today, the U.S. healthcare landscape is being redefined by the shift toward value-based reimbursement models and an explosion of the quantity, frequency and complexity of data. We believe there is a demand for platforms that utilize a molecularly precise and systems-based approach to addressing the following underlying transformative shifts and challenges.

A rapid evolution from traditional fee-for-service to patient-centered and patient-empowered, value-based models driven by quantifiable measures of outcomes relative to cost.

In response to the rising cost of healthcare, government and private payers and providers are introducing value-based care models. In value-based models, providers assume increased levels of clinical and financial responsibility for patient outcomes, instead of being reimbursed strictly based on the quantity of services provided. We believe that healthcare platforms that efficiently assist healthcare stakeholders to transition to these value-based models will be best positioned to capture this opportunity.

Challenges associated with the adoption of value-based models

The healthcare continuum can be viewed as an aggregation of three distinct domains:

- The knowledge domain, including academic centers, scientific institutions and companies that discover and commercialize medical and scientific knowledge;
- The care delivery domain, including hospitals, community practices, physicians and other constituents that deliver healthcare to patients; and
- The payer domain, including insurers, governments and self-insured employers that administer and provide funding to the healthcare system.

The disparate and fragmented nature of these domains and economic incentives under traditional fee-for-service models frequently result in overtreatment, high costs and suboptimal patient outcomes. Fee-for-service models are as a general matter inherently site-centric, volume driven, reactive in nature and uncoordinated. In contrast, value-based models are generally more patient-centric, outcomes-focused, proactive and coordinated across the care continuum.

Despite a clear need, the design and implementation of next-generation interoperable systems has been limited due to reliance on legacy, site-specific, fee-for-service technology systems and infrastructure. Since the passage of the HITECH Act in 2009, providers and payers have made significant investments in EHRs, and other technologies meant to enable the transition to value-based care. Despite extensive investment and coordination, the introduction of value-based models has been limited due to the shortcomings of legacy, proprietary systems and the reliance on unstructured data that hinders interoperability and cannot be sufficiently shared or manipulated to produce actionable findings. Value-based models require collection and analysis of longitudinal treatment, outcomes and financial data at the patient level, regardless of treatment site. Critically, these systems must also securely safeguard patient data in compliance with stringent HIPAA and other privacy regulations. We believe that there is a significant need for interoperability platforms that dynamically access, normalize, integrate and update information from disparate sources across the healthcare continuum in real time. Secure interoperability platforms can allow for more comprehensive solutions development that proactively connect, deliver business and clinical intelligence and enable enhanced provider and patient engagement.

A paradigm shift to molecularly precise and real-time biometric-driven medicine, with both massive volumes and rapidly expanding categories of complex data from traditional and novel sources.

The collection and interpretation of molecular profiles and near real-time biometric monitoring has the potential to dramatically improve quality and outcomes.

Evolution to comprehensive molecular analysis

Advances in sequencing over the last 15 years and the associated cost efficiencies have led to the development of targeted therapeutics initiating the transformation from “one size fits all” treatments to personalized, molecularly precise medicine. Single marker and gene panel diagnostic tests have now advanced from the research to clinical care settings. Oncology is leading the rapid advances in molecular testing and the development of targeted therapeutics based on increasing understanding of the impact of molecular profile on disease progression. Recent publications, including The Cancer Genome Atlas Research Network genomic and molecular characterization studies, support selection of treatment regimens based on the underlying molecular pathways and related genomic alterations in the genetic profile of the tumor compared with the patient’s own germline, as opposed to the anatomical location of the cancer in the patient’s body. Cancer is increasingly understood to be a heterogeneous collection of rare diseases, with hundreds of patient-specific, cancer-promoting mutated proteins, some known and many more unknown, called neoepitopes. Identifying and targeting these mutated proteins is requiring more comprehensive genomic and proteomic analysis, which is increasingly becoming embedded in drug approvals. As a result, we believe comprehensive genomic and proteomic analysis is positioned to become the standard of clinical care, replacing single marker or gene panels in treating cancer patients.

Oncology has been an early adopter of precision medicine due to the cost as well as inconsistent and often poor clinical outcomes associated with many traditional “trial-and-error” treatment regimens. While oncology represents the most immediate opportunity, we believe other disease areas are beginning to experience a similar evolution, with immune-related diseases, central nervous system disorders and transplants having a high potential for adoption of personalized medicine. We believe technologies that enable the capture, aggregation and analysis of massive volumes of genomic data will further bolster the growth of precision medicine and its expansion from cancer to additional disease states. Over time, we believe this will lead to identification of drugs that target specific pathways by using a universal personalized companion diagnostics platform, ultimately resulting in improved clinical outcomes.

Limitations of the existing single marker and gene panel approach

The human genome is comprised of approximately 20,000 genes and 3 billion DNA base pairs. Until recently, scientists have focused on less than 2% of the genome that is responsible for coding proteins. As a result, most diagnostic tests today only analyze specific genes, or gene panels, exploring only a fraction of the human genome, while incorporating “a priori” assumptions that capture only a subset of the most common gene alterations. These alterations are calculated relative to a reference genome of a population instead of a patient’s own healthy tissue, or germline. Gene panels that utilize a reference genome often fail to capture key, medically actionable mutations or incorrectly highlight mutations present in both the germline and cancer tissue. Analyses that exclude whole genome sequencing, RNA analysis and comparisons to an individual’s germline instead of a reference genome can lead to materially false positive and false negative results. A more comprehensive molecular analysis would allow providers to develop personalized treatment regimens, replacing existing costly “trial-and-error” approaches to treatment. A comprehensive molecular analysis, including both germline and cancer tissue, would make no assumptions as to the molecular driver of the patient’s disease and would capture mutations that are commonly missed by gene panels.

Challenges associated with the adoption of comprehensive molecular analysis

Comprehensive molecular analysis combines whole genome-to-germline comparison and RNA expression as confirmation of the presence of variants. Comprehensive molecular analysis has been difficult to perform in a practical, timely and cost-effective manner because it has long run times to complete sequencing, creates hundreds of gigabytes of complex data per patient, which must be transported, stored and analyzed with supercomputing and/or high-performance computing environments in a clinically relevant period of time, and requires large capital investments required to perform sequencing at scale. Furthermore, the absence of adaptive machine learning algorithms to enable efficient medical interpretation and effective expression analysis has inhibited the ability to derive value from the massive amount of data produced by comprehensive molecular analysis. Accordingly, comprehensive molecular analysis has primarily been utilized in the academic and research settings, and not in the clinical setting to inform treatment decisions. Finally, there have been insurance coverage and reimbursement challenges for comprehensive molecular analysis solutions, limiting their adoption.

Increasing proliferation and importance of real-time biometric data and its adoption in hospitals and other patient care settings

Several trends are contributing to the rising importance and availability of biometric data, including the increasing prevalence of connected devices in multiple care settings and the opportunity for proactive patient interventions to improve health outcomes. As hospital systems implement EHRs, they have installed hardware and software solutions to connect medical devices to collect periodic sampling of key patient metrics such as respiratory rate, blood pressure and heart rate. Providers have expanded these technologies into other care settings, including skilled nursing facilities, nursing homes, outpatient facilities and patients’ homes. Concurrently, with the advent of connected devices, activity monitors and remote patient monitoring devices are achieving widespread adoption, allowing for the increased quantification of key biometric signals. Healthcare professionals have the potential to gain a more comprehensive view of an individual’s health on a real-time basis across care settings through increased adoption of patient monitoring devices. The increased availability of quantifiable biometric data allows for the implementation of decision support tools and proactive treatment interventions, potentially utilizing care pathways and learning algorithms to improve care outcomes.

Challenges associated with leveraging quantifiable, real-time biometric analysis in multiple care settings

An increasing amount of biometric data is being generated by the proliferation of connected devices. However, complexities associated with synthesizing this data into actionable insights remain an obstacle. Although many hospital-based medical devices can continuously stream data to an EHR, frequently the EHR can only accept periodic data, potentially missing a critically relevant patient episode. There is also a lack of comprehensive solutions that support physician decision-making in real time. The absence of effective data interpretation supported by adaptive machine learning or other algorithms is evidenced by “alarm fatigue” among many healthcare providers (a condition that can occur when one is exposed to many frequent alarms or alters and consequently becomes desensitized to them) as they struggle to establish optimal event thresholds.

Growth in complexity and its promise for value-based models

Advances in molecular medicine and real-time biometrics require healthcare providers to promptly aggregate, evaluate and synthesize hundreds to thousands of relevant facts to arrive at a single patient decision. With the enormous complexity of genomics and expression analysis derived from comprehensive molecular analysis, the pace of medical advancements, and the significant amount of data being created every day by patient care, payment and regulatory compliance systems, it is nearly impossible for a practicing physician to interpret and synthesize the deluge of complex information required for patient treatment.

We believe there is a considerable need for advanced adaptive machine learning algorithms to collect, index and analyze rich biometric, phenotypic, genomic and proteomic data at scale to support physician decision-making. Although this complexity creates significant challenges, it also presents opportunities for developers of systems infrastructures, platforms and learning systems that can identify clinically meaningful correlations that can be employed to improve patient outcomes in a cost-effective manner.

Our Market Opportunity

We believe the increasing focus on value-based reimbursement models and evidence-based, personalized medicine will drive validation and adoption of NantHealth solutions. Recent statistics show that 38% of Americans will be diagnosed with cancer at some point in their lives, resulting in an estimated cost of $174 billion by 2020. Additionally, we see the precision medicine market growing substantially as comprehensive diagnostics and evidence-based medicine become increasingly important across multiple disease areas and likely assuming greater share of the combined biopharmaceutical and diagnostics markets. We believe several factors support adoption of our universal molecular analysis solutions GPS Cancer and Liquid GPS, which enables an increased understanding of molecular pathways and their targets, such as:

- Improved pharmacoeconomics, including the use of more cost-effective drugs approved for other indications (such as asthma and diabetes) in cancer treatment regimens;
- A clearer understanding of critical drug resistance information;
- Increased adoption of bundled payments as providers and payers recognize the efficiency of optimized therapies; and
- Increased awareness and published clinical results demonstrating the benefits of evidence-based molecular medicine.

We believe the potential addressable market for NantHealth solutions will continue to grow in relation to the market-share gains of value-based models and the adoption of precision medicine.

NantHealth Solutions

Our NantHealth solutions comprise a highly differentiated, integrated model for the delivery of healthcare, comprised of our unique molecular profiling solutions, software, and hardware systems infrastructure, which integrates patient data management, bioinformatics, and molecular medicine, enabling value-based care and evidence-based clinical practice. Our platform and our multi-domain solutions are designed to address some of the most pressing cross-domain challenges across the healthcare continuum. Our solutions are single-domain and cross-domain offerings that can be applied, for example, within a hospital system or for a hospital system and a commercial insurance provider in an Accountable Care Organization, or ACO, crossing multiple domains. We believe unique systems-based approach positions us (i) to deliver 21st century molecular and biometric signature-driven precision medicine and potentially change the current paradigm of uncoordinated healthcare and (ii) as a next-generation payer intermediary who facilitates payment for value.

- **Cancer Care Solutions** . Our comprehensive set of interoperability, advanced molecular analysis, risk stratification and decision support solutions (Eviti) can enable our clients to improve decision-making and coordinate care across the healthcare continuum. Our GPS Cancer molecular profiling solution is the only comprehensive and commercially available molecular profiling solution that integrates whole genome (comparing both a patient's normal and tumor tissue), RNA and molecular pathways information into a clinical report that analyzes this data and identifies actionable targets and potential clinical treatment options. Liquid GPS is NantHealth's blood-based molecular test that provides oncologists with a powerful tool for noninvasive tumor profiling and quantitative monitoring of treatment response. Liquid GPS looks beyond cfDNA to cfRNA, which allows profiling and trending of actionable biomarkers that cannot be assessed through cfDNA alone. In addition to providing molecular insight into key guidelines-based biomarkers (e.g., EGFR, ALK, ROS1, KRAS), this powerful RNA-based approach enables a variety of capabilities and applications not typically available from a liquid biopsy test.

- **Provider Solutions** . Our provider solution software, comprised of an integration of our various solutions, including DeviceConX, VitalsConX and NaviNet, leverage the data available on our systems infrastructure to enable patient-centered engagement and coordination across care locations. Our NantHealth software solutions include real-time vitals connectivity, and clinical and administrative workflows including eligibility and benefits, claims, referral and readmissions management solutions. Our device connectivity modules and flexible applications analyze and interpret patient and provider-specific information and can deliver critical clinical and administrative insights.

- **Payer Solutions** . Our NantHealth payer software solutions establish daily access to the clinical practice and caregiver and leverage the data available on our systems infrastructure to facilitate payment for value. We believe our position between the payer and the provider allows us to align incentives as a next-generation payer intermediary, to help payers ensure consistent evidence-based treatment pathways and to accelerate pre-adjudication and lower administrative overhead for providers. This can ultimately drive quality of care and streamline workflows while improving control over the administrative and operating costs associated with eligibility and benefits, claims processing, referrals, authorizations, document exchange and review utilization. Our multi-payer collaboration solution, NaviNet Open, offers provider end users a uniform set of workflows and services across many or all the payers with whom they routinely collaborate. This multipayer experience benefits payers and providers alike. Providers can benefit from a uniform experience and toolset across multiple payer relationships, and the payer can benefit from the uniform application of best practices, tools, and options, as well as the reduction in costly errors and phone-based interactions that can stem from a non-uniform end-user experience.

We designed our NantHealth solutions to enable providers, payers, pharma and self-insured employers to overcome challenges encountered across the knowledge, care delivery, and payer domains within the healthcare continuum.

We are a leading vendor of payer-provider collaboration solutions (NaviNet Open), with a national provider network of approximately 870,000 active user accounts on the NaviNet platform across all 50 states.

In this Annual Report, “active user account” means a NaviNet Open user account for which the applicable user has established or reset their permanent password in the previous 120 days.

Our Systems Infrastructure

Our unique interoperable systems infrastructure has been built over the last decade to address the knowledge, care delivery and payer domains. As of December 31, 2018, our NantHealth solutions or their components have been widely adopted, processing nearly 50 million payer-provider transactions per month with approximately 853,000 active user accounts nationwide.

NantHealth's systems-based approach enables the near real-time transfer and clinical translation of genomic analysis, biometric signal data and actionable information to the care delivery domain, with access to a HIPAA-compliant cloud, providing the coordination of reimbursement between the care delivery domain and the payer domain.

Our Systems Infrastructure is comprised of:

- Access to next-generation genomic analysis technologies with near real-time bioinformatics, provided as part of GPS Cancer through our affiliate, NantOmics, and as part of our own Liquid GPS test;
- Access to a secure HIPAA-compliant cloud environment; and
- Device connectivity in over 390 client sites, active hospitals/facilities, to what we estimate to be approximately 41,000 medical devices and collecting over 15.4 billion vital signals annually with the ability to connect to over 500 medical device models.

Our access to CAP- and CLIA-certified sequencing capability, coupled with supercomputer environments, enables us to deliver comprehensive genomic analysis. We have established a HIPAA-compliant, secure and scalable cloud computing, storage and transport infrastructure capable of processing, storing and transporting petabytes of diverse, protected patient data. Our device connectivity and near real-time biometric monitoring software and hardware solutions allow us to aggregate data through the open architecture platform, from one of the largest libraries of in-hospital and remote medical devices and wearables on the market. Our cloud-based NantHealth software solutions accesses, integrates and updates information from disparate clinical, operational and financial systems to create a dynamic and actionable dataset. This framework enables us, our clients and third-party partners to develop an integrated ecosystem of compatible applications.

We believe other organizations have not yet been able to integrate these components in a similarly near real-time and continuous manner, and this personalized, evidence-based molecular approach, combined with our NantHealth solutions, significantly differentiates us from our competitors. In addition, third parties may use our solutions to deliver drugs to patients in a more predictive, preventative and evidence-based manner, potentially improving patient outcomes and pharmacoeconomics.

Product Overviews

Precision Insights

NantHealth's GPS Precision Insights molecular profiling provides comprehensive DNA, RNA, Tumor and Normal Analysis combined with pharmacogenomics data. Each patient's molecular analysis is evaluated for applicability to evidence-based therapies advancing the promise of precision medicine while retaining the values of standard of care practice. NantHealth's Liquid GPS cfDNA and cfRNA platforms provide non-invasive insights into therapeutic selection of targeted therapy, chemotherapy, and immunotherapy.

GPS Cancer:

GPS Cancer is a comprehensive molecular profile that integrates whole genome (DNA) sequencing of tumor and normal germline samples and whole transcriptome (RNA) sequencing, providing oncologists with insights into the unique molecular signature of a patient's cancer to inform personalized treatment strategies. The results of the GPS Cancer profile can provide oncologists with insight into cancer therapies that may have potential benefit - including active clinical trials - and those therapies to which the cancer may be resistant. GPS Cancer profiling is conducted in CLIA-certified and CAP-accredited laboratories.

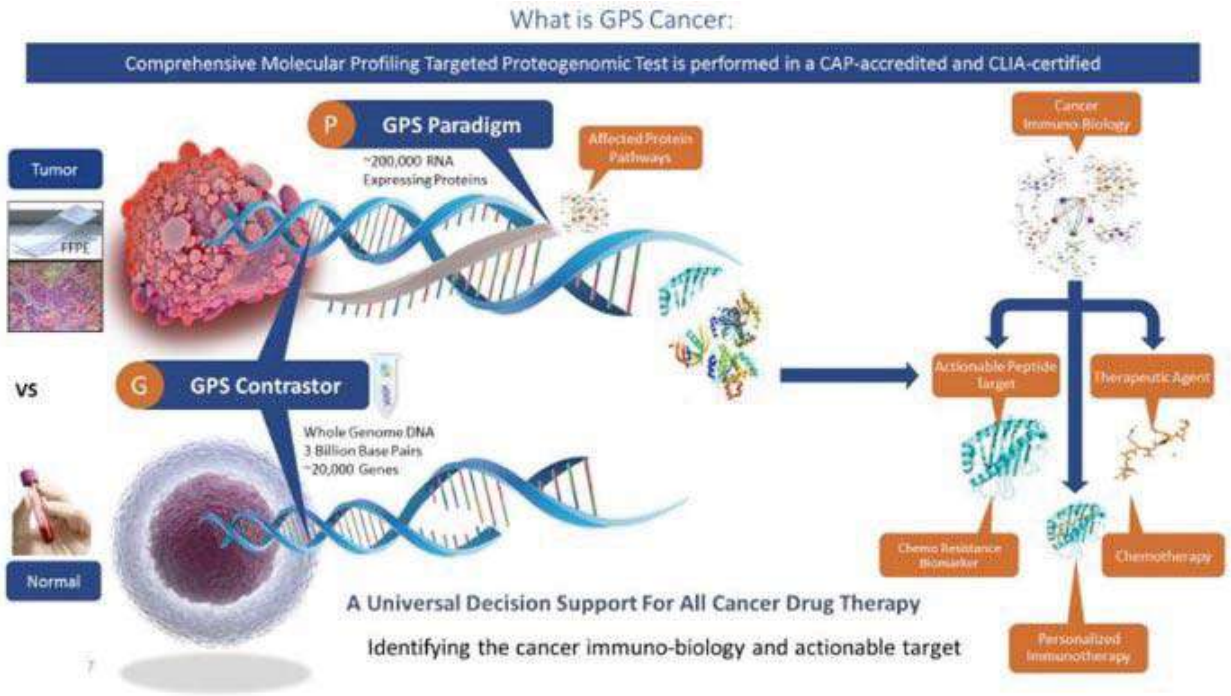

GPS Cancer compares a total of 6 billion DNA base pairs between a patient's healthy normal (or germline) sample and the tumor sample (usually Formalin-Fixed, Paraffin-Embedded-FFPE or fresh frozen tissue) each encoding for over 20,000 genes. All the RNA (over 200,000 transcripts) from the tumor sample is sequenced to confirm and give evidence of expression of mutations found in the genome. We identify affected molecular pathways that are drivers of a patient's cancer by analyzing DNA and RNA sequence data against our curated database of over 15,000 nodes within approximately 1,500 protein pathways.

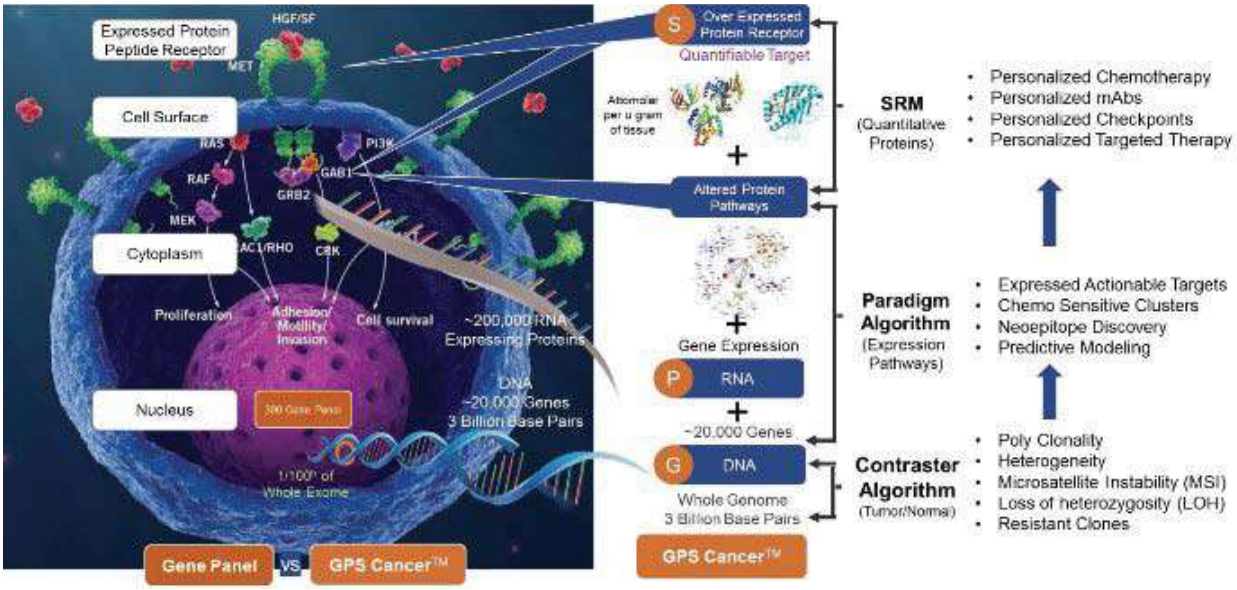

Cancer is increasingly understood to be a heterogeneous collection of rare diseases. As such, understanding genomic alterations in tumor samples can help to identify potential treatment options for the personalized management of people with cancer.

Whole genome sequencing of a person's tumor sample against their normal sample highlights molecular alterations that are specific to their tumor DNA, and RNA sequencing subsequently confirms the alterations identified in the DNA of a person's tumor. Whole genome sequencing and RNA sequencing can provide vital clinical information about individual molecular alterations in tumors that result in abnormal proteins, which can be important targets for many cancer therapies.

GPS Cancer identifies genomic alterations with high clinical relevance to each person's tumor. The alterations are then matched to drugs that might be effective against tumors containing the specific change. By identifying the totality of alterations from whole genome sequencing, honing in on alterations that are associated with protein expression from RNA sequencing, a more accurate and comprehensive molecular profile is assembled that can inform the therapeutic options available to oncology care providers and their patients.

By enabling informed therapy selection and utilization, GPS Cancer brings various opportunities to impact both cost and quality of care for individuals with cancer, such as:

- *Avoiding ineffective therapy usage:* By providing molecular insight into sensitivity or resistance to specific drugs, GPS Cancer may help oncologists identify regimens that are unlikely to benefit the patient. This insight may help avoid use of high-cost therapies that are unlikely to help the patient.
- *Decreasing treatment cycles through improved therapy selection:* Therapies selected based on molecular evidence of likely benefit may require fewer cycles to achieve response.
- *Increasing clinical trial participation:* For many advanced cancers, standard-of-care drug options are quickly exhausted, and clinical trials represent a source of additional options for patients. GPS Cancer helps identify trials that may be applicable to the patient based on their tumor's molecular profile.

For example, according to a presentation at ASCO 2015, it was estimated that a typical patient receiving a combination therapy of two checkpoint inhibitors, one anti-PD-1 agent and one anti-CTLA-4 agent, would cost approximately $300,000 with approximately $60,000 being the patient's out-of-pocket cost (assuming a 20% copay). Applying this figure to the nearly 600,000 patients dying from metastatic cancer annually (no adjuvant therapy), the treatment would cost society nearly $174 billion annually. Studies suggest that cancer therapeutics such as immune checkpoint inhibitors are more effective when there is a high neoantigen and nonsynonymous mutation (i.e., results in a change in the amino acid sequence) burden in the tumor. We have presented our data at ASCO 2018 which we believe shows that GPS Cancer is superior to other panel tests in accurately measuring tumor mutation burden. We believe GPS Cancer's ability to identify mutation burden and neoepitopes through its comprehensive omics analysis will serve as a critical and novel source for both pre-treatment efficacy analysis and individualized immunotherapies for cancer patients.

GPS Cancer Report

Our GPS Cancer solution further leverages novel adaptive machine learning algorithms that match the identified alterations to an extensive and evolving library of signaling pathways, drugs and drug targets, regardless of indication, to provide predictive analyses that can enable the physician to make decisions regarding the potential efficacy of personalized therapies, as well as points of resistance. GPS Cancer results are available to the ordering physician in a concise report. While the GPS Cancer report does not recommend treatments, it can enable the treating physician to develop a personalized treatment plan after discussing with the patient the available treatment options and the potential risks associated with each treatment option. The GPS Cancer report can be utilized by the physician in several ways. The report may:

- List targets based on DNA/RNA analysis that may be treated by FDA-approved drugs either in an on-label or off-label manner based on peer-reviewed clinical data;
- List findings that suggest a particular targeted therapy which the physician would otherwise use may not work due to a potential resistance marker;
- Provide information on key biomarkers that inform the use of immunotherapy, including PD-L1, tumor mutational burden, and microsatellite instability (MSI);
- Provide information on key pharmacogenomic markers of chemotherapy drug toxicity and thromboembolic risk;
- Provide the information necessary for the physician to decide whether it is appropriate to place the patient in a clinical trial; and
- Provide key information based on germline sequencing, including germline mutations in cancer predisposition genes and confirmation of provenance - i.e., that the tumor being tested comes from the intended patient.

Pharmacogenomics

Our GPS Cancer test results includes information on a patient's pharmacogenomic profile to provide insight on germline alterations implicated in increased toxicity or altered metabolism of anti-cancer drugs. This information is presented in a patient's GPS Cancer test report.

Specifically, we have added an analysis of eight pharmacogenomic genes, CYP2d6, CYP3A5, DPYD, F5, G6PD, NUDT15, TPMT, and UGT1A1, and their associations with the following drugs: Azathioprine, Belinostat, Capecitabine, Dabrafenib, Eltrombopag olamine, Fluorouracil, Irinotecan, Mercaptopurine, Nilotinib, Pazopanib, Rasburicase, Tacrolimus, Tamoxifen, Tegafur, and Thioguanine. Sources used for pharmacogenomic implications include prescribing information, primary scientific literature, and guidelines published by the Clinical Pharmacogenomics Implementation Consortium (CPIC, see www.cpicpgx.org). In addition, the F5 (Factor V) gene is screened for the Leiden variant that confers increased risk of thromboembolic events.

Insurance Coverage

We announced our first coverage/reimbursement contract for GPS Cancer with a large health plan in January 2016, which represented the nation's first such insurance coverage for a whole genome molecular analysis platform. Subsequently, we have signed contracts for the reimbursement of GPS Cancer by additional health insurance plans (including plans covering various city employees in multiple states) and self-insured employer groups (including a large employer with a national footprint). We believe reimbursement arrangements with health insurance plans and self-insured employers will continue to grow.

Competitive Advantage of GPS Cancer's Comprehensive Molecular Analysis Capabilities

Current approaches to enabling precision cancer care have various limitations described below. GPS Cancer is specifically designed to help oncologists overcome these challenges.

Clinical challenge #1: DNA-only, tumor-only gene panels (i.e., without tumor-germline comparison) may result in inaccurate mutation calls in druggable targets.

GPS Cancer includes:

- RNA sequencing to confirm DNA alterations that may result in expression of abnormal proteins; and
- Tumor-germline comparison to (1) help avoid inappropriate therapies due to misinterpretation of inherited mutations as somatic and (2) confirm provenance - i.e., that the tumor being tested comes from that patient.

Many of the current gene panels on the market are limited to only a small fraction of the genome and fail to cover the full molecular profile of a patient's tumor. Because these panels measure less than 2% of the approximately 20,000 genes and less than 0.04% of the entire genome, the results may be fraught with a significant number of false negatives, potentially leading to erroneous clinical decisions. Furthermore, many gene panel tests fail to directly compare the patient's tumor to the patient's normal (or germline) genome, potentially leading to false positives by suggesting a mutation is in the cancer alone when it is really a normal variant.

Unlike most commercially available genomic tests, which are based on interrogation of predefined alterations in only a small fraction of the genome, GPS Cancer is based on whole genome sequencing (of tumor and normal samples), and RNA sequencing. GPS Cancer compares 6 billion DNA base pairs (tumor and normal), sequences 200,000 RNA transcripts and provides analysis for over 15,000 nodes within approximately 1,500 protein pathways.

The importance of this precise and comprehensive approach has been increasingly emphasized by a growing body of evidence.

In 2015, Johns Hopkins released a study identifying the limitations of tumor-only sequencing, concluding that "a tumor-only sequencing approach could not definitively identify germline changes in cancer-predisposing genes and led to additional false-positive findings comprising 31% and 65% of alterations identified in targeted and exome analyses, respectively, including in potentially actionable genes. These data suggest that matched tumor-normal sequencing analyses are essential for precise identification and interpretation of somatic and germline alterations and have important implications for the diagnostic and therapeutic management of cancer patients."

The limitations of DNA-only molecular testing were revealed in 2015, where data were presented on 3,783 patients at the 2015 annual meeting of the American Society of Clinical Oncology, or ASCO, entitled "Genomics, Transcriptomics, and Proteomics in the Clinical Setting: Integrating Whole Genome and RNA Sequencing with Quantitative Proteomics to Better Inform Clinical Treatment Selection" showed that only a small number of altered DNA actually resulted in increased expression of a given actionable gene. In many instances, increased expression of an actionable gene could not be traced back to an alteration in the DNA. In a largest proportion of positive mutation calls as determined by the gene panel, no increased RNA expression occurred, thus potentially resulting in a false positive gene panel reading.

Further evidence was presented at ASCO 2018, entitled "Seventeen percent of NGS 50 gene panel variants are not expressed in RNAseq" which showed that in a standard 50 gene clinical gene panel (Oncomine V1) of commonly altered genes in cancer, approximately 17% of variants are not expressed in the RNA. Epigenetic silencing can occur for many reasons and this is not evaluated by standard DNA-only tests.

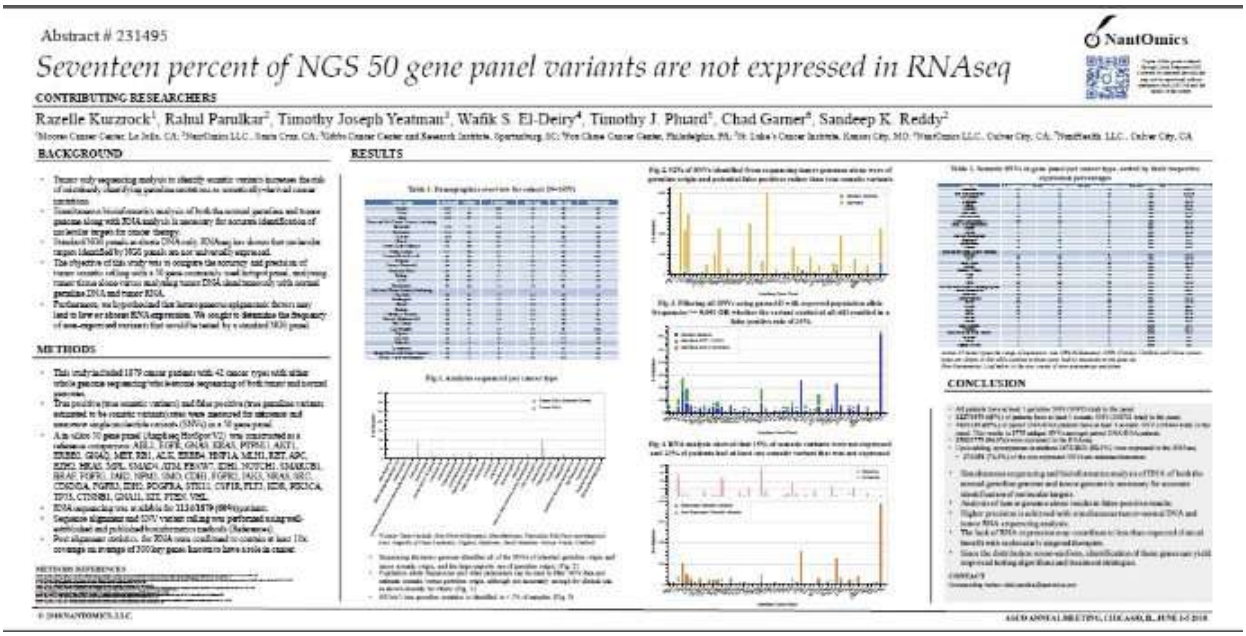
Abstract # 231495

Seventeen percent of NGS 50 gene panel variants are not expressed in RNAseq

NantOmics

CONTRIBUTING RESEARCHERS

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BACKGROUND

RESULTS

METHODS

CONCLUSION

GPS Cancer is the only comprehensive and commercially available clinical cancer platform incorporating and integrating whole genome (comparing both a patient's normal and tumor tissue), RNA and molecular pathways information into a clinical report that analyzes this data and identifies actionable targets to inform clinical treatment decisions.

ADDITIONAL MOLECULAR ANALYSES PERFORMED	
Tumor Mutation Burden	**LOW** (47 non-synonymous / 1.9 per Mb) (pg. 4)
Microsatellite Status	**STABLE** (MSS) (pg. 5)
Immunotherapy Sensitivity	**1 of 4 INDICATORS DETECTED** (pg. 5)
Chemotherapy Sensitivity/Resistance	**2 of 8 INDICATORS DETECTED** (pg. 6)
RNA Fusion Analysis	**3 FUSIONS DETECTED** (*NTRK2* Internal, *TCF3* Internal, ...) (pg. 6)
Germline Cancer Predisposition Screening	**NO DELETERIOUS, TRUNCATING VARIANTS DETECTED** (pg. 8)
Cancer Pharmacogenomics Screening	**IMPLICATIONS FOR 1 DRUG** (Tacrolimus) (pg. 10)

GPS in Rare Diseases and Chronic Illnesses

Although we are deploying GPS initially for cancer, we believe this solution has potential application in identifying molecular profiles and germline mutations in rare diseases and chronic illnesses. Our molecular profile solutions have been used by a large academic research institution to examine the genomic familial drivers of cardiac disease and to perform additional research in ALS, obesity, suicide and diabetes, among other diseases.

GPS Cancer: Proprietary Methods and Software

Patents with claims related to GPS Cancer are issued or allowed in the United States and internationally, and GPS Cancer is the subject of several U.S. and foreign patent applications. The proprietary methods and software components underlying GPS Cancer include:

- **Liquid Tissue** . Extracts lysates from FFPE tissue using proprietary methods to examine tumor-normal proteins and genomes.
- **Transporter Software** . Securely transfers unassembled data from sequencing instruments to the analytical custom-designed supercomputing environment.
- **Contraster Software** . Rapidly identifies genomic variants in a patient's tumor samples and compares it to that patient's germline or proprietary database of disease associated genes.
- **Paradigm Software.** Integrates DNA sequencing data from the contraster software with RNA sequencing data to identify alterations in cellular signaling behavior that are driving disease progression. The algorithm matches the alterations to the library of all known signaling pathways and all drugs and drug targets, irrespective of indication, to potentially help predict the effectiveness of personalized therapies and points of resistance.

Liquid GPS

Liquid GPS is NantHealth's blood-based molecular test that provides oncologists with a powerful tool for noninvasive tumor profiling and quantitative monitoring of treatment response. Liquid GPS looks beyond cfDNA to cfRNA, which allows profiling and trending of actionable biomarkers that cannot be assessed through cfDNA alone. In addition to providing molecular insight into key guidelines-based biomarkers (e.g., EGFR, ALK, ROS1, KRAS), this powerful RNA-based approach enables a variety of capabilities and applications not typically available from a liquid biopsy test

Key Applications

Targeted therapy monitoring

In addition to assessing guideline-recommended mutations (e.g., EGFR, BRAF, KRAS, and NRAS), Liquid GPS provides cfRNA-based testing and monitoring for gene fusions and translocations (i.e., ALK, ROS1). RNA has also been shown to be a more accurate indicator of fusions and translocations compared to DNA, which can miss or incorrectly classify gene fusions.

Immunotherapy monitoring

With immunotherapy increasingly becoming a central component of care in many cancers, molecular tools are evolving to give oncologists new and earlier insights into their effectiveness in each patient. Liquid GPS includes 4 analytes associated with approved and investigational immunotherapies - PDL1, CTLA-4, LAG-3, and TIM-3. PD-L1 via Liquid GPS's cfRNA analysis has been demonstrated to correlate to measurement by IHC. Not only can this information inform an oncologist's initial treatment selection, it can also be used to monitor response over time. In fact, blood-based PD-L1 assessment has been shown to objectively differentiate between true progression and pseudoprogression, which may help to avoid erroneously changing treatment due to pseudoprogression.

Chemotherapy monitoring

Liquid GPS includes 11 analytes associated with response or resistance to commonly used chemotherapies, including ERCC1 to inform use of platinums and TUBB3 to inform use of taxanes.

Define Right Treatment Before Treatment Begins (Eviti):

The rapid advancement of molecular and biometric medicine is overwhelming many physicians' cognitive ability, while uncoordinated, non-evidence-based treatment pathways are increasing costs and reducing the quality of care.

Within our oncology solutions, Eviti, our decision support solution, provides evidence-based clinical decision support, which is a critical element to ensure optimal treatment regimens. Eviti is a SaaS-based clinical decision support solution that centralizes clinical content, treatment cost data from Medicare reimbursements and treatment toxicity data. The clinical content is curated by our dedicated team of clinicians, including oncologists and nurses, who convert published literature and clinical trials into structured information that can be used for decision support. The Eviti Advisor product is an overlay on this platform and allows physicians to access this data to better inform treatment decisions. Thus, physicians can readily stay abreast of the latest advances in cancer care.

Eviti provides value to our clients through its access to over 7,200 federally-registered clinical trials updated weekly and over 3,500 evidence-based treatment regimens for the treatment of cancer arising from over 40 different anatomical locations. Unique to the care delivery domain, physicians also benefit from improved claim processing by using our Eviti platform that issues a pre-authorization "Eviti code" when the physician chooses an approved evidence-based clinical pathway, thereby validating appropriate treatment and pre-adjudicating the claim. This is an important step in that payers and providers are collaborating on high-value, evidence-based clinical pathways as opposed to non-value-added reimbursements and denials of payments.

Eviti is typically sold to health plans on a per member (or life) per month basis. These health plans sponsor the solution and provide Eviti free of charge to oncologists and their staffs.

The snapshot of our system below illustrates how different cancer treatment options for a patient is presented to compare treatments across a variety of metrics, including expected treatment outcome, plan compliance and costs. By providing the oncologist with this comparison, we believe Eviti drives compliance and a greater number of treatments to be in accordance with evidence-based pathways.

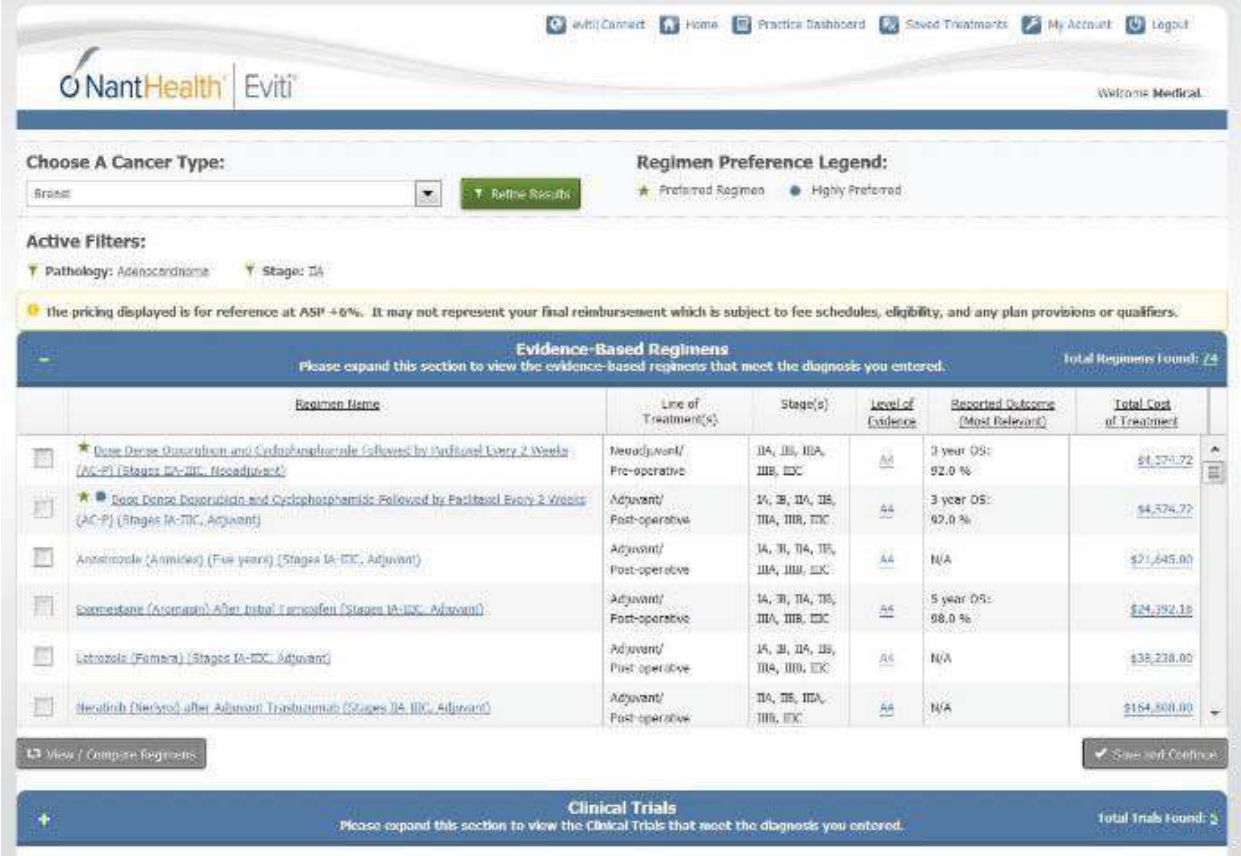

Provider Engagement (NantHealth Software Solutions):

Our web-based and mobile ***NantHealth software solutions*** include near real-time vitals connectivity, clinical and administrative workflow, eligibility and benefits, claims, and referral management solutions.

Connected Care Software Solutions:

- **Device Connectivity Suite:** Our device connectivity and near real-time biometric software and hardware suite allow us to aggregate data from one of the largest libraries of in-hospital and remote medical devices on the market. Utilizing our hardware and software platform, we can extract data from various disparate provider systems, payer systems and consumer devices across the care continuum. Our offerings can enable the near real-time collection and integration of quantifiable biometric and phenotypic data into EHRs and other clinical systems, resulting in the enrichment of the holistic patient health record which can improve care and treatment. In addition, our offerings can improve care coordination and data aggregation across care settings to facilitate transitioning patients to lower cost care settings such as a skilled nursing facility or the patient's home.

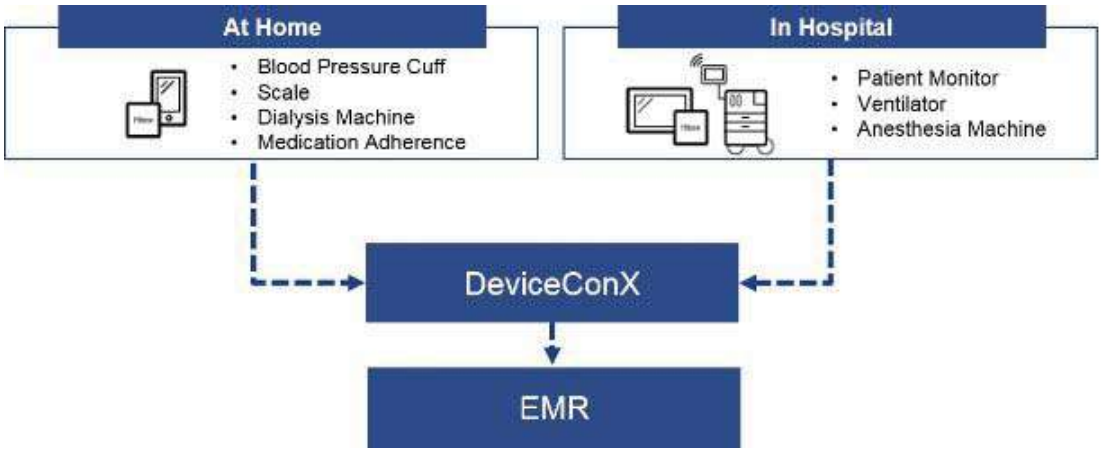

- **DeviceConX, or DCX:** DCX is a device data normalization software that connects to hundreds of inpatient and outpatient clinical devices and converts data into a standard format that can be integrated into EHR systems and other clinical systems. This offering provides physicians with a real-time and integrated snapshot of a patient's physiological data. Our software is scalable and can be embedded across the care continuum, including inpatient, outpatient and home settings. In addition, our platform can enable connectivity with both networked and non-networked medical devices and can eliminate the need for manual data entry by clinicians, which can result in time savings and potentially eliminate transcription errors and adverse events in patients. DCX is installed in over 390 client sites, active hospitals/facilities, across the United States, Canada, Denmark, Sweden, and Singapore.

- **HBox:** The HBox is an Internet of Medical Things, or IoMT, and Internet of Things, or IoT, hardware hub that provides wired or wireless connectivity to multiple monitoring devices and transmits the data into remote monitoring centers and third-party EHR systems, giving providers near real-time access to physiological data. Several home monitoring devices have been tested and integrated with the HBox to support remote monitoring, readmission management and care coordination solutions and services. The HBox integrates with various weight scales, pulse oximeters and blood pressure monitors and mobile health devices. For non-networked medical devices, we use our proprietary DeviceEscort adapter and HBox to wirelessly connect to nearly any medical device that is capable of outputting discrete medical data. HBox is currently installed at client sites in both the United States, Canada, Denmark, Sweden, and Singapore.

- **VitalsConX, or VCX, a NantHealth Software Solutions:** In addition to DCX and HBox, we also provide a tablet-optimized application that sits on top of our DCX platform to provide clinicians more convenient and ubiquitous access to capture a wide array of patient vitals such as respiratory rate, blood pressure and heart rate in addition to performing patient assessments. Our solution can enable a more efficient patient rounding and assessment workflow by providing a near real-time stream of data from the patient's bedside unlike periodic sampling typically entered into an EHR hours later.

NaviNet Open:

NaviNet Open is America's leading payer-provider collaboration platform, enabling health plans and providers to align incentives, boost quality measures, and lower costs. NaviNet Open's multi-payer platform connects health plans with their provider networks to improve communications and facilitate administrative transactions. NaviNet delivers vital administrative and clinical information to provider offices in near real-time, vastly improving the ease and speed of communications between health plans and providers.

NaviNet increases operating efficiency and lowers administrative waste for health plans and providers by reducing the volume of customer service phone calls and manual processes involved. As of December 31, 2018, NaviNet Open supported approximately 870,000 active user accounts nationwide, processing more than 50 million payer-provider transactions across 49 health plans.

NaviNet Open solutions include:

- **Plan Central:** Provides our health plan partners with the ability to deliver a branded custom-content experience to their provider networks, allowing plans to own and manage their communications to users in support of their business. Plan Central is valued by our partners as a single access point for all provider and end-user communications, transactions, and content, delivering ease of use and increased provider satisfaction.

- **Eligibility and Benefits:** Delivers membership verification, insurance coverage, and payment information, such as copayments, deductibles, and benefit intelligence to provider offices in real-time - information that is highly valued by providers and members alike. Provider offices can verify insurance and benefit coverage at the time of a patient visit or as part of the billing cycle.

- **Claims Status Inquiry:** Lets provider offices access detailed financial and claim status information in real-time - automating the delivery of claim receipt confirmation, adjudication status, and payment details. This eliminates the need for provider offices to call health plans directly to maintain a healthy revenue cycle and improves provider satisfaction.

- **Claims Management:** A collection of powerful claim applications that consist of Claim Submission, pre- and post-adjudication Corrections and Adjustments, Claim Attachments, Claim Investigation and a multi-payer Claims Log where users manage their claim submissions. Our integrated Claims Management solution simplifies payment efforts by eliminating phone calls, costly paper claims, and other manual processes associated with claims follow-up, correction, and resubmission. Providers now gain access to a powerful set of claim tools, without needing a sophisticated EMR or practice management system.

- **Referrals:** Lets provider offices submit and access referrals in real-time, guiding patients to the best specialist at the most affordable cost. Referrals empowers provider staff with more referral information - such as benefit tiers, preferred providers, and patient payment implications. Administrative staff becomes better equipped to navigate complex sub-networks, while health plans optimize in-network referrals to reduce leakage and lower costs.

- **Authorizations:** Lets provider offices submit authorizations to health plans and access real-time authorization information, such as status updates and approvals. The authorizations workflow is optimized to make it simple for health plans to configure fields and add additional business logic and links to third party applications. Providers can upload any documents needed for authorization processing, further streaming workflows and lowering costs.

- **Document Exchange:** Modernizes communication between health plans and providers by transmitting administrative and clinical information in near real-time. This application lets health plans and providers share risk adjustment information, quality measurement data, and performance reports, among other data. Providers are notified of care gaps within their existing workflows, making it easy to upload supporting documents.
  NaviNet Open Document Exchange enables health plans and providers to thrive in a world of value-based care by providing near real-time access to critical information at the point of care.

- **AllPayer** provides standard eligibility, benefit, and claim status information to provider offices for hundreds of commercial and government plans through the NaviNet portal. Building on the rich, multi-payer experience of NaviNet Open, AllPayer allows provider offices to quickly find the information they need, without having to jump between portals or spend unnecessary time on the phone with health plans.

NantHealth Systems Infrastructure to Enable NantHealth Solutions:

We host our applications and serve all our clients from four redundant data centers in geographically diverse locations. These infrastructure-hosting services also include capabilities such as secure server and application hosting, secure offsite backup, disaster recovery and business continuity solutions.

Due to the sensitive nature of our clients' data, we have a heightened focus on data security and protection. We have implemented healthcare IT industry-standard processes, policies and tools through all levels of our software development and network administration, including regularly scheduled vulnerability scanning and third-party penetration testing to reduce the risk of vulnerabilities in our system. Our clinical decision support platform achieved initial URAC accreditation in Health Utilization Management, or HUM, during September 2010 and was re-accredited during August 2016 for another 3-year period. Our payer solutions products have been accredited under the Health Network Accreditation Program of the Electronic Healthcare Network Accreditation Commission since 2006 and were re-certified in January 2019 for two years.

Our Relationship with NantOmics and Allscripts

We have worldwide, exclusive rights from NantOmics to resell their proprietary GPS Cancer product to institutional clients, including payers, self-insured employers and healthcare providers. NantOmics provides whole genome, whole exome and RNA sequencing, along with related computational and data management and bioinformatics services. We provide these services as part of our comprehensive molecular analysis offering. Under the agreement, we are responsible for various aspects of delivering our sequencing and molecular analysis solutions, including patient engagement and communications with providers such as providing interpretations of our GPS Cancer reports and resolving any disputes, ensuring customer satisfaction, and managing billing and collections. Our current agreement with NantOmics expires in December 2020, subject to renewal for up to an additional nine years if certain thresholds are met. The terms of the agreement include an annual minimum of $2.0 million in fees for years 2016-2020, $25.0 million in fees for years 2021-2023 and $50.0 million in fees for years 2024-2029 paid to NantOmics.

In May 2015, we and Allscripts Healthcare, LLC, or Allscripts Healthcare, an affiliate of Allscripts, entered into a mutual license and reseller agreement, or the Mutual License and Reseller Agreement, which was subsequently amended and restated in June 2015, pursuant to which we each appointed the other as a non-exclusive marketer and reseller to eligible, approved customers of various products and services, including our DeviceConX, VitalxConX, HBox, Device Escort and Eviti Advisor products and services and Allscripts Healthcare's FollowMyHealth, Care Director, EPSi and dbMotion products and services. In addition, we and Allscripts Healthcare each designated the other as a preferred partner-i.e., subject to certain exceptions and limitations, our DeviceConX family of products and services are the exclusive medical device integration products and services that may be marketed and sold by Allscripts Healthcare, and Allscripts Healthcare's scheduled products and services are the exclusive products and services of the same required functionality that may be marketed and sold by us. Each party retained ownership of any data generated and collected in connection with its respective products, though each party granted the other a non-exclusive, fully paid-up license to use its data, as well as to use its trademarks, marketing materials and product documentation in connection with the marketing and resale of products and services. The agreement has an initial term of five (5) years and renews automatically for successive one (1) year periods, unless terminated by us or Allscripts Healthcare. Each party has the right to terminate the agreement in the event the other party commits a material, uncured breach, is declared insolvent, suffers a prolonged force majeure event, becomes ineligible for federal healthcare programming or undergoes a change-in-control involving such party's competitor. In June 2015, Allscripts purchased a 10% equity stake in our company for $200.0 million in cash. In addition, NantCapital, LLC, or NantCapital, announced a $100.0 million investment into Allscripts. NantCapital's investment was executed through a private placement of Allscripts common stock. The investments and commercial agreement strengthened the partnership between Allscripts and our company, originally announced in March 2015, to develop an integrated, evidence-based, personalized approach to healthcare solutions, and specifically cancer care. We plan to use Allscripts' scale, global network of hospital and physician clients and leading software solutions, combined with our clinical platform, applications and connectivity devices to build out the infrastructure for new personalized, precision medicine programs for our clients to improve cancer care. Together, our goal is for physicians and patients to have the tools to stay engaged and active and provide the necessary intervention as early as possible. On August 3, 2017, we entered into an asset purchase agreement with Allscripts Healthcare Solutions, Inc., pursuant to which we agreed to sell to Allscripts substantially all of the assets of the company's provider/patient engagement solutions business, including our FusionFX solution and components of its NantOS software connectivity solutions. The sale was completed on August 25, 2017. Concurrent with the sale to AllScripts and as contemplated by the asset purchase agreement, we and Allscripts modified the amended and restated mutual license and reseller agreement dated June 26, 2015, which was further amended on December 30, 2017, such that, among other things, we committed to deliver a minimum of $95.0 million of total bookings over a ten-year period ("Bookings Commitment") from referral transactions and sales of certain Allscripts products under this agreement. In the event of a Bookings Commitment shortfall at the end of the ten-year period, we may be obligated to pay 70% of the shortfall, subject to certain credits. We will earn 30% commission from Allscripts on each software referral transaction that results in a booking with Allscripts. We account for the Bookings Commitment at its estimated fair value over the life of the agreement and, as of December 31, 2018, we estimate it to be $16.9 million .

Our Clients

NantHealth solutions and technology platforms are used by key healthcare stakeholders, including healthcare providers, payers, self-insured employers, academic institutions and biotechnology and pharmaceutical companies. NantHealth solutions, coupled with our engagement methodology, is designed to be tailored to meet the large-scale needs of governmental organizations and private entities while remaining convenient, intuitive and configurable at the user level. We believe that this provides us with a significant advantage over a siloed, single vendor approach, which often requires the removal or replacement of existing information technology infrastructure and applications. While historically many of our solutions have been consumed on a stand-alone basis, we are increasingly bundling our solutions as our clients look for comprehensive approaches that leverage our learning algorithms.

Our total revenue was $89.5 million and $86.7 million in 2018 and 2017 respectively. For the year ended December 31, 2018 , three customers each accounted for more than 10% of our revenue. For the year ended December 31, 2017 , two customers each accounted for more than 10% of our revenue.

Sales and Marketing

Our sales organization is primarily comprised of direct sales executives and pre-sales support teams organized by account type and domain and subject matter expertise. We also leverage strategic reseller arrangements and a channel relationship coverage team.

- **Direct sales organization:** We leverage domain and subject matter expertise, market credibility, thought leadership, and relationships of our executives, senior management, and product leaders in our sales efforts. Our direct sales organization is divided into two focused teams, one dedicated to commercializing our GPS Cancer solution, and the other focused on NantHealth's health information technology solutions portfolio. These two primary direct coverage teams include both sales professionals searching for new accounts and client engagement sales professionals responsible for developing existing accounts. Furthermore, sales professionals have unique expertise and specialized coverage for health plans, self-insured employers, health systems, and individual providers. Our account management organization is responsible for the continuity of current client relationships and the expansion of those relationships to include additional solutions and services.

  We have a pre-sales organization that includes clinical, business and technical customer alignment teams to support our sales organization in addition to executive sponsorship with members of our senior management team.

- **Resale and channel partnership:** In the United States, we have entered strategic resale arrangements with major partners, including EHR vendors (including Allscripts), in-hospital medical devices manufacturers and health plans who resell our solutions to their customer base. Internationally, we have entered resale arrangements with other strategic distributors to accelerate our market adoption. Reseller revenue in 2018 and 2017 was $14.5 million and $14.8 million , respectively.

  We also maintain business relationships with individuals and organizations that promote or support our sales or services. We refer to these individuals and organizations as our channel partners. These channel partners generally do not make sales directly like our resale partners, but instead provide us with leads that we use to develop new business through our direct sales force. These relationships enable access to broader hospital and physician clients, leading software solutions and multiple cross-selling opportunities.

We complement our sales efforts with a marketing organization that plans and execute marketing and communication strategies that are centered on initiatives that drive awareness of our company and solutions. These initiatives include educating the market about our company broadly, as well as solutions-specific campaigns for lead generation. Marketing efforts also include participation in speaking engagements and strategic interfacing with key business and trade media personnel. We employ a broad array of specific events to facilitate these initiatives, including, but not limited to, sponsorship and partnership of key industry conferences such as HIMSS and or ASCO, events and client-focused programs such as key partner user groups.

Our sales cycle can vary significantly and typically ranges from 6 months to 18 months from initial contact to contract execution. The sales cycle significantly differs based on the domain, type of solution and size of the client. Implementation, training and professional services are normally rendered based on a mutually agreed upon timetable.

Competition

The competitive landscape is highly fragmented, and to our knowledge, no single competitor currently offers similarly expansive capabilities and solution offerings in comprehensive molecular analysis, software, and systems infrastructure, particularly with a focus on creating a learning system. Our primary competitors can be characterized by the following categories of companies that provide capabilities or solutions that compete with one or more of our platforms or solutions:

- Molecular analysis vendors, such as Caris Life Sciences, Inc., Foundation Medicine, Inc., Guardant Health, Inc., Paradigm Diagnostics, Inc., Personal Genome Diagnostics, Inc. and Tempus Labs;
- Payer-provider collaboration vendors, such as Availity, LLC, Change Healthcare, Inc. (formerly Emdeon), Experian Information Solutions, Inc. (including its Passport division), Healthx, Inc. and Health Trio, LIC;

- Medical device data system and device connectivity vendors, such as Capsule Technologies, Inc. (formerly Qualcomm Life), Cerner Corporation, Bernoulli Enterprise, Inc., General Electric Company and Medical Information Technology, Inc.; and
- H ealthcare information technology decision support vendors such as The Advisory Board Company, Castlight Health, Inc., or Castlight Health, Evolent Health, eviCore Healthcare, HealthCatalyst, Inc., or HealthCatalyst, International Business Machines Corporation, or IBM, Inovalon Holdings, Inc., or Inovalon and Truven Health Analytics, or Truven (acquired by IBM).

The principal competitive factors in our industry include:

- Breadth and depth of application functionality;
- Ease of use and performance;
- Network strength and level of user adoption;
- Client testimonials and recommendations;
- Breadth of client base;
- Cloud-based delivery model;
- Competitive and understandable pricing;
- Ability to deliver actionable information in a relevant time period;
- Size and scope of payer clinical policy knowledge;
- Sale and marketing capabilities of vendor;
- Financial stability of vendor;
- Ability to integrate with legacy enterprise infrastructures and third-party applications; and
- Ability to innovate and respond rapidly to client needs and regulatory changes.

We believe we will compete favorably despite competing against a broad, diverse set of businesses and with increasing competition as other established and emerging companies enter our industry, client requirements evolve, and new products and technologies are introduced. Moreover, some of our actual and potential competitors have certain advantages over us, such as greater financial, technical, marketing, research and development and other resources, stronger brand and business user recognition, larger installed customer bases, larger intellectual property portfolios and broader global distribution and presence.

Research and Development

Our research and development efforts consist primarily of new product research and development, significant product improvements, the development of our knowledge base, the development of our online tools, such as our online portal and mobile applications, and the improvement and augmentation of our learning system.

Our ability to compete and attract new clients depends, in large part, on our continuous commitment to rapidly introduce new applications, technologies, features, and functionality. Our research and development team is responsible for the design and development of our applications and software tools. We follow state-of-the-art practices in software development using modern programming languages, data storage systems, and other tools.

Research and development expenses decreased $12.9 million or 38.2% , from $33.9 million in 2017 to $20.9 million in 2018 . This decrease was largely driven by a decrease of $8.4 million in personnel expenses due to our restructuring in 2017, offset by the addition of research and development personnel from NantHealth Labs, which reduced headcount allocated to research and development by around 26%. There was also a $2.7 million decrease in stock compensation related to the reduction in research and development headcount, and an equity award granted in November 2017, a portion of which vested immediately increasing the expense recognized for 2017. The lower headcount and lower overall bonus payments in 2018 led to a $0.5 million decrease in bonus expense. Also, we saw a $0.7 million decline in expense from external research and development resources as development projects were performed internally.

We expect that our overall research and development expenses will increase in absolute dollars as we continue to innovate our informational technology capabilities, develop additional products, and expand our data management resources.

Intellectual Property

We strive to protect and enhance the proprietary technology, inventions, and improvements that are commercially important to our business, including seeking, maintaining, and defending patent rights, whether developed internally or acquired from third parties. Our policy is to seek to protect our proprietary position by, among other methods, filing patent applications in the United States and in jurisdictions outside of the United States related to our proprietary technology, inventions, and improvements that are important to the development and implementation of our business. We also rely on trade secrets and know-how relating to our proprietary technology, continuing innovation, and acquisition and in-licensing opportunities to develop, strengthen, and maintain our proprietary position in the field of molecular diagnostics and healthcare technology products and services.

Our commercial success may depend in part on our ability to obtain and maintain patent and other proprietary protection for our technology, inventions, and improvements; to preserve the confidentiality of our trade secrets; to defend and enforce our proprietary rights, including our patents; and to operate without infringing on the valid and enforceable patents and other proprietary rights of third parties.

We have developed and acquired numerous patents and patent applications and we possess substantial know-how and trade secrets relating to the development and commercialization of healthcare technology products and services. As of December 31, 2018 , our patent portfolio consisted of the following matters relating to our proprietary technology and inventions: (i) seven issued U.S. patents, including six U.S. utility patents and one U.S. design patent; (ii) eighteen pending U.S. patent applications, including sixteen U.S. utility patent applications and two U.S. design patent applications; (iii) one issued patent outside the United States; and (iv) seventeen patent applications pending in jurisdictions outside the United States. Of these U.S. and non-U.S. patents and applications, two patents and seven applications were jointly owned.

Individual patents extend for varying periods of time, depending upon the date of filing of the patent application, the date of patent issuance, and the legal term of patents in the countries in which they are obtained.

Generally, patents issued for applications filed in the United States are effective for 20 years from the earliest effective filing date. The patent term may be adjusted to compensate for delayed patent issuance, when such delays are caused by the patent office or successful appeals against patent office actions. There is no limit on this patent term adjustment. The duration of patents outside of the United States varies in accordance with provisions of applicable local law, but typically is also 20 years from the earliest effective filing date. We estimate that our issued U.S. patents will expire on dates ranging from 2022 to 2036. If patents are issued on our pending U.S. patent applications, the resulting patents are projected to expire on dates ranging from 2026 to 2038. However, the actual protection afforded by a patent varies on a product-by-product basis, from country-to-country, and depends upon many factors, including the type of patent, the scope of its coverage, the availability of legal remedies in a particular country, and the validity and enforceability of the patent.

The patent positions of companies like ours are generally uncertain and involve complex legal and factual questions. No consistent policy regarding the scope of claims allowable in patents in the field of healthcare information technology has emerged in the United States. The patent situation outside of the United States is even more uncertain. Changes in either the patent laws or their interpretation in the United States and other countries may diminish our ability to protect our inventions and enforce our intellectual property rights, and more generally could affect the value of our intellectual property. In particular, our ability to stop third parties from making, using, selling, offering to sell, or importing products that infringe our intellectual property will depend in part on our success in obtaining and enforcing patent claims that cover our technology, inventions, and improvements.

With respect to our intellectual property, we cannot be sure that patents will be granted with respect to any of our pending patent applications or with respect to any patent applications filed by us in the future, nor can we be sure that any of our existing patents or any patents that may be granted to us in the future will be commercially useful in protecting our products and the processes involved in using those products. Moreover, even our issued patents do not guarantee us the right to practice our technology in relation to the commercialization of our products. However, the area of patent and other intellectual property rights in healthcare technology is an evolving one with many risks and uncertainties, and third parties may have blocking patents that could be used to prevent us from commercializing our patented products and practicing our proprietary technology. Our issued patents and those that may issue in the future may be challenged, invalidated, or circumvented, which could limit our ability to stop competitors from marketing related products or limit the length of the term of patent protection that we may have for our products. In addition, the rights granted under any issued patents may not provide us with protection or competitive advantages against competitors with similar technologies. Furthermore, our competitors may independently develop similar technologies. For these reasons, we may have competition for our products and services. Moreover, because of the extensive time required for development and testing of a potential product or service, it is possible that, before any particular product or service can be commercialized, any related patent may expire or remain in force for only a relatively short period following commercialization, thereby reducing any advantage of the patent.

We may also rely, in some circumstances, on trade secrets to protect our technology. However, trade secrets are difficult to protect. We seek to protect our technology and product candidates, in part, by entering confidentiality agreements with those who have access to our confidential information, including our employees, contractors, consultants, collaborators, and advisors. We also seek to preserve the integrity and confidentiality of our proprietary technology and processes by maintaining physical security of our premises and physical and electronic security of our information technology systems. Although we have confidence in these individuals, organizations, and systems, agreements or security measures may be breached and we may not have adequate remedies for any breach. In addition, our trade secrets may otherwise become known or may be independently discovered by competitors. To the extent that our employees, contractors, consultants, collaborators, and advisors use intellectual property owned by others in their work for us, disputes may arise as to the rights in related or resulting know-how and inventions.

For this and more comprehensive risks related to our proprietary technology, inventions, improvements and products, please see the section captioned “Risk Factors-Risks Related to Intellectual Property.”

Associates and Culture

We view our employees, which we refer to as associates, and company culture as integral to the successful execution of our vision and mission. As a result, our leadership team prioritizes establishing trusting relationships with our clients, our partners, and each other. We encourage our associates to “rise up” to the challenge and believe that this collective mindset has enabled us to attract and retain some of the best minds in technology, bioscience and healthcare to build and advance our offering. Our core values, which we seek to reflect in our work are:

- Building and cultivating RELATIONSHIPS with our clients and each other. Treating individuals with dignity and respect and contributing to the success of others.
- Demonstrating INTEGRITY by being intellectually honest, doing what you say, and engaging with others from a point of honesty and trust.
- Delivering excellence in SERVICE. Aspiring to be the best through quality outcomes, partnering to optimize solutions, and holding self and others accountable for success.
- Actively seeking out the opportunity to ELEVATE by speaking up, contributing feedback and ideas, and advancing the organization’s mission and purpose.

As of December 31, 2018 , we had a total of 543 full-time associates in the United States and the United Kingdom. Associate engagement is a core tenant of our leadership focus and monitor of our performance and organizational health. None of our associates are represented by a labor union or covered by a collective bargaining agreement. We have not experienced any work stoppages, and we consider our relations with our associates to be good.

Government Regulation

The products and services that we provide are regulated by federal, state and foreign governmental authorities. Failure to comply with the applicable laws and regulations can subject us to repayment of amounts previously paid to us, significant civil and criminal penalties, loss of licensure, certification, or accreditation, or exclusion from government healthcare programs. The significant areas of regulation are summarized below.

Clinical Laboratory Improvement Amendments of 1988 and State Regulation

The Omics services we perform fall under CLIA. A clinical laboratory is required to hold certain federal and state licenses, certifications, and permits to conduct business. As to federal certifications, Congress passed CLIA in 1988, establishing quality standards for all laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test was performed. The laboratory that performs our Omics services is CLIA-certified and is also required to meet certain laboratory licensing requirements for states with regulations beyond CLIA.

Under CLIA, a laboratory is any facility which performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention or treatment of disease, or the impairment or assessment of health. CLIA regulates virtually all clinical laboratories by requiring they be certified by the federal government and comply with various operational, personnel, facilities administration, quality, and proficiency requirements intended to ensure that their clinical laboratory testing services are accurate, reliable, and timely. Laboratories must register and list their tests with CMS, the agency that oversees the CLIA program. CLIA compliance and certification is also a prerequisite to be eligible to bill for services provided to governmental payer program beneficiaries and for many private payers. CLIA is user-fee funded. Therefore, all costs of administering the program must be covered by the regulated facilities, including certification and survey costs.

Clinical laboratories are subject to survey and inspection every two years to assess compliance with program standards and may be subject to additional unannounced inspections. Laboratories performing high complexity testing are required to meet more stringent requirements than laboratories performing less complex tests. In addition, a laboratory, like the one which performs our Omics services, that is certified as “high complexity” under CLIA, may develop, manufacture, validate, and use proprietary tests referred to as laboratory developed tests, or LDTs. CLIA requires full validation, including accuracy, precision, specificity, sensitivity, and establishment of a reference range for any LDT used in clinical testing.

In addition to the federal certification requirements under CLIA, certain states require clinical laboratories to maintain a state license. State licensure authorities typically regulate the day-to-day operations of a clinical laboratory, including the training and skills required of its personnel and quality control. Certain states may also mandate proficiency testing, which requires the clinical laboratory to verify the accuracy of any test or procedure it performs. In addition, certain states require out-of-state laboratories to be licensed if they accept specimens from those states. CLIA provides that a state may adopt laboratory regulations that are more stringent than those under federal law. In some cases, state licensure programs substitute for the federal CLIA program. In other instances, the state’s regulations may be in addition to the CLIA program. If a laboratory is out of compliance with state laws or regulations governing licensed laboratories, penalties for violation vary from state to state but may include suspension, limitation, revocation or annulment of the license, assessment of financial penalties or fines, or imprisonment.

FDA

The FDA regulates the sale and distribution in interstate commerce of medical devices under the Federal Food, Drug, and Cosmetic Act, or the FDCA, including in vitro diagnostic devices, reagents, and instruments used to perform diagnostic testing. Devices must undergo premarket review by the FDA prior to commercialization unless the device is of a type exempted from such review by statute, regulation, or pursuant to the FDA’s exercise of enforcement discretion. The FDA, to date, has generally not exercised its authority to actively regulate the development and use of LDTs, which are tests that are designed, manufactured, validated, and used within a single laboratory, and, therefore, we do not believe that the LDTs and other tests performed by the Omics laboratory currently require premarket clearance or approval. It is likely that the FDA will more actively regulate LDTs in the future, which could lead to premarket and post-market obligations. In October 2014, the FDA issued draft guidance documents stating that the FDA intends to change its policy and describing an approach to regulating LDTs using a risk-based, phased-in approach. In November 2016, the FDA stated that it had decided to delay finalizing its draft guidance on regulating LDTs, and it would be seeking input from the new presidential administration and Congress on the subject. Based on the request of stakeholders and the significant amount of feedback to the 2014 Draft Guidance, in January 2017, the FDA issued a Discussion Paper on LDTs in which it announced that it would not issue a final guidance on the oversight of LDTs and provided a prospective oversight framework that focuses on new and significantly modified high and moderate risk LDTs. Subject to certain limitations, the proposed focused oversight would mostly exempt a wide range of LDTs from FDA oversight, which include, but are not limited to, previously marketed LDTs (these “grandfathered” LDTs would still be subject to adverse event reporting), traditional LDTs, and low risk LDTs. In the Discussion Paper, FDA proposes a risk-based, phased in approach for premarket review of new and significantly modified LDTs and such premarket review would not be duplicative of CMS’s post market oversight of laboratory operations or clinical utility determinations. FDA also proposes to leverage existing CMS/CLIA requirements related to quality systems and expanding third party premarket review, including coordination with a range of programs, including New York’s Clinical Laboratory Evaluation Program. In the meantime, the laboratory that performs the Omics services will maintain its CLIA certification, which permits the use of LDTs for the purpose of providing information for treatment and other clinical purposes.

The FDA regulations pertaining to medical devices govern, among other things, the research, design, development, pre-clinical and clinical testing, manufacture, safety, effectiveness, clearance or approval, record-keeping, packaging, labeling, storage, adverse event reporting, advertising, promotion, marketing, sales, distribution, and import and export of medical devices. Pursuant to the FDCA, and its implementing regulations, medical devices are subject to varying degrees of regulatory control and are classified in one of three classes depending on the controls the FDA determines necessary to reasonably ensure their safety and effectiveness.

Class I devices are those for which reasonable assurance of safety and effectiveness can be provided by adherence to the FDA’s general controls for medical devices, which include applicable portions of the FDA’s QSR, facility registration and product listing, reporting of adverse medical events, and appropriate, truthful, and non-misleading labeling, advertising and promotional materials. Many Class I devices are exempt from premarket regulation; however, some Class I devices require premarket clearance by the FDA through the 510(k) premarket notification process described below.

Class II devices are subject to the FDA's general controls, and any other special controls, such as performance standards, post market surveillance, and FDA guidelines, deemed necessary by the FDA to provide reasonable assurance of the devices' safety and effectiveness. Premarket review and clearance by the FDA for Class II devices are accomplished through the 510(k) premarket notification procedure, although some Class II devices are exempt from the 510(k) requirements. Premarket notifications are subject to user fees, unless a specific exemption applies. To obtain 510(k) clearance, a manufacturer must submit a premarket notification demonstrating that the proposed device is "substantially equivalent" to a predicate device, which is a previously cleared 510(k) device or a pre-amendment device that was in commercial distribution before May 28, 1976, for which the FDA has not yet called for the submission of a premarket approval, or PMA, application. In determining substantial equivalence, the FDA assesses whether the proposed device has the same intended use and technical characteristic as the predicate device, or whether the proposed device has different technological characteristics, but the information submitted in the premarket notification demonstrates the device is as safe and effective as a legally marketed device and does not raise different questions of safety and effectiveness than the predicate device. The FDA may request additional information, including clinical data. Under the FDCA, and its implementing regulations, a manufacturer submits a premarket notification 90 days before introducing a device into interstate commerce, but the FDA's review of the premarket notification can take significantly longer. If the FDA determines that the device is substantially equivalent to the predicate device(s), the subject device may be marketed. However, if the FDA determines that a device is not substantially equivalent to the predicate device(s), then the device would be regulated as a Class III device, discussed below. If a manufacturer obtains a 510(k) clearance for its device and then makes a modification that could significantly affect the device's safety or effectiveness, a new premarket notification must be submitted to the FDA.

Class III devices are those deemed by FDA to pose the greatest risk, such as those that are life-sustaining or life-supporting and for which reasonable assurance of the device's safety and effectiveness cannot be assured solely by the general controls and special controls described above. Some pre-amendment Class III devices for which the FDA has not yet required a PMA require the FDA's clearance of a premarket notification in order to be marketed. However, most Class III devices are required to undergo the PMA process in which the manufacturer must demonstrate reasonable assurance of the safety and effectiveness of the device to the FDA's satisfaction. A PMA application must provide valid scientific evidence, typically extensive preclinical and clinical trial data, and information about the device and its components regarding, among other things, device design, manufacturing, and labeling. PMA applications (and supplemental PMA applications) are subject to significantly higher user fees than are 510(k) premarket notifications. Some PMA applications are exempt from a user fee, for example, a small business's first PMA.

Even if regulatory approval or clearance of a device is granted, the FDA may impose limitations on the uses and indications for which the device may be labeled and promoted, and the device remains subject to significant regulatory requirements. Medical devices may be marketed only for the uses and indications for which they are cleared or approved. Device manufacturers must register their facilities and list their devices with the FDA. A device manufacturer's manufacturing processes and those of some of its suppliers are required to comply with the applicable portions of the QSR, which covers quality management, design, production and process controls, quality assurance, labeling, packaging, shipping, and complaint handling. Device manufacturers must submit to the FDA medical device reports for deaths, serious injuries, and certain malfunctions and report certain field corrections and product recalls or removals. Some manufacturers also may be subject to post-market surveillance regulations. Facility records and manufacturing processes are subject to periodic unscheduled inspections by the FDA.

Failure to comply with applicable regulatory requirements can result in enforcement action by the FDA, which may include any of the following sanctions: public warning letters, fines, injunctions, civil or criminal penalties, recall or seizure of products, operating restrictions, partial suspension or total shutdown of production, delays in or denial of 510(k) clearance or PMA applications for new products, challenges to existing 510(k) clearances or PMA applications, and a recommendation by the FDA to disallow a device manufacturer from entering into government contracts. The FDA also has the authority to request repair, replacement, or refund of the cost of any device manufactured or distributed. If a supplier fails to maintain compliance with a device manufacturer's quality requirements, the manufacturer may have to qualify a new supplier and could experience manufacturing delays as a result.

HIPAA and HITECH

Under the administrative simplification provisions of HIPAA, as amended by the HITECH Act, the HHS issued regulations that establish uniform standards governing the conduct of certain electronic healthcare transactions and protecting the privacy and security of protected health information used or disclosed by healthcare providers and other covered entities. Three principal regulations with which we are required to comply have been issued in final form under HIPAA: privacy regulations, security regulations, and standards for electronic transactions, which establish standards for common healthcare transactions. The privacy and security regulations were extensively amended in 2013 to incorporate requirements from the HITECH Act.

The privacy regulations cover the use and disclosure of protected health information by healthcare providers and other covered entities. They also set forth certain rights that an individual has with respect to his or her protected health information maintained by a covered entity, including the right to access or amend certain records containing protected health information, or to request restrictions on the use or disclosure of protected health information. The security regulations establish requirements for safeguarding the confidentiality, integrity, and availability of protected health information that is electronically transmitted or electronically stored. The HITECH Act, among other things, makes certain of HIPAA's privacy and security standards applicable to business associates of covered entities, and established certain protected health information security breach notification requirements. A covered entity must notify affected individual(s) and the HHS when there is a breach of unsecured protected health information. The HIPAA privacy and security regulations establish a uniform federal "floor" that covered entities and their business associates must meet and do not supersede state laws that are more stringent or provide individuals with greater rights with respect to the privacy or security of, and access to, their records containing protected health information. HIPAA also governs patient access to laboratory test reports. Effective October 6, 2014, individuals (or their personal representatives, as applicable), have the right to access test reports directly from clinical laboratories and to direct that copies of those test reports be transmitted to persons or entities designated by the individual.

These laws contain significant fines and other penalties for wrongful use or disclosure of protected health information. Additionally, to the extent that we submit electronic healthcare claims and payment transactions that do not comply with the electronic data transmission standards established under HIPAA and the HITECH Act, payments to us may be delayed or denied.

In addition to the federal privacy regulations, there are several state laws regarding the privacy and security of health information and personal data that are applicable to our operations. The compliance requirements of these laws, including additional breach reporting requirements, and the penalties for violation vary widely and new privacy and security laws in this area are evolving. Massachusetts, for example, has a state law that protects the privacy and security of personal information of Massachusetts residents that is more prescriptive than HIPAA. Many states have also implemented genetic testing and privacy laws imposing specific patient consent requirements and protecting test results. In some cases, we are prohibited from conducting certain tests without a certification of patient consent by the physician ordering the test. Requirements of these laws and penalties for violations vary widely. We believe that we have taken the steps required of us to comply with health information privacy and security statutes and regulations in all jurisdictions, both state and federal. However, we may not be able to maintain compliance in all jurisdictions where we do business. Failure to maintain compliance, or changes in state or federal laws regarding privacy or security, could result in civil and/or criminal penalties and could have a material adverse effect on our business.

Federal, State and Foreign Fraud and Abuse Laws

In the United States, there are various fraud and abuse laws with which we must comply and we are potentially subject to regulation by various federal, state and local authorities, including CMS, other divisions of the HHS (e.g., the Office of Inspector General), the U.S. Department of Justice, and individual U.S. Attorney offices within the Department of Justice, and state and local governments. We also may be subject to foreign fraud and abuse laws.

In the United States, the federal Anti-Kickback Statute prohibits, among other things, knowingly and willfully offering, paying, soliciting or receiving remuneration to induce, or in return for patient referrals for, or purchasing, leasing, ordering, recommending or arranging for the purchase, lease or order of, any healthcare item or service reimbursable under a governmental payer program. Courts have stated that a financial arrangement may violate the Anti-Kickback Statute if any one purpose of the arrangement is to encourage patient referrals or other federal healthcare program business, regardless of whether there are other legitimate purposes for the arrangement. The definition of "remuneration" has been broadly interpreted to include anything of value, including gifts, discounts, credit arrangements, payments of cash, consulting fees, waivers of co-payments, ownership interests, and providing anything at less than its fair market value. Recognizing that the Anti-Kickback Statute is broad and may technically prohibit many innocuous or beneficial arrangements within the healthcare industry, the HHS issued a series of regulatory "safe harbors." These safe harbor regulations set forth certain provisions, which, if met, will assure healthcare providers and other parties that they will not be prosecuted under the federal Anti-Kickback Statute. Although full compliance with these provisions ensures against prosecution under the federal Anti-Kickback Statute, the failure of a transaction or arrangement to fit within a specific safe harbor does not necessarily mean that the transaction or arrangement is illegal or that prosecution under the federal Anti-Kickback Statute will be pursued. Many states also have anti-kickback statutes, some of which may apply to items or services reimbursed by any third-party payer, including commercial insurers.

In addition, federal false claims laws, including the federal civil False Claims Act, prohibit, among other things, any person or entity from knowingly presenting, or causing to be presented, a false claim for payment to, or approval by, the federal government or knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim to the federal government. As a result of a modification made by the Fraud Enforcement and Recovery Act of 2009, a claim includes “any request or demand” for money or property presented to the U.S. government. Recently, several pharmaceutical and other healthcare companies have been prosecuted under these laws for allegedly providing free product to customers with the expectation that the customers would bill federal programs for the product. Other companies have been prosecuted for causing false claims to be submitted because of the companies’ marketing of the product for unapproved, and thus generally non-reimbursable, uses. The civil monetary penalties statute imposes penalties against any person or entity who, among other things, is determined to have presented or caused to be presented a claim to a federal health program that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent.

HIPAA created additional federal criminal statutes that prohibit knowingly and willfully executing, or attempting to execute, a scheme to defraud or to obtain, by means of false or fraudulent pretenses, representations or promises, any money or property owned by, or under the control or custody of, any healthcare benefit program, including private third-party payers and knowingly and willfully falsifying, concealing or covering up by trick, scheme or device, a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services.

In addition, various states have enacted false claim laws analogous to the federal False Claims Act, although many of these state laws apply where a claim is submitted to any third-party payer and not merely a governmental payer program. If our operations are found to be in violation of any of the federal and state healthcare laws described above or any other governmental regulations that apply to us, we may be subject to significant penalties, including without limitation, civil, criminal and/or administrative penalties, damages, fines, disgorgement, exclusion from participation in government programs, such as Medicare and Medicaid, injunctions, private “qui tam” actions brought by individual whistleblowers in the name of the government, or refusal to allow us to enter into government contracts, contractual damages, reputational harm, administrative burdens, diminished profits and future earnings, and the curtailment or restructuring of our operations, any of which could adversely affect our ability to operate our business and our results of operations.

In Europe, various countries have adopted anti-bribery laws providing for severe consequences, in the form of criminal penalties and/or significant fines, for individuals and/or companies committing a bribery offence. Violations of these anti-bribery laws, or allegations of such violations, could have a negative impact on our business, results of operations and reputation. For instance, in the United Kingdom, under the Bribery Act 2010, which went into effect in July 2011, a bribery occurs when a person offers, gives or promises to give a financial or other advantage to induce or reward another individual to improperly perform certain functions or activities, including any function of a public nature. Bribery of foreign public officials also falls within the scope of the Bribery Act 2010. Under the new regime, an individual found in violation of the Bribery Act 2010 faces imprisonment of up to 10 years. In addition, the individual can be subject to an unlimited fine, as can commercial organizations for failure to prevent bribery.

Federal and State Physician Self-referral Prohibitions

Under a federal law directed at “self-referral,” commonly known as the “Stark Law,” there are prohibitions, with certain exceptions, on referrals for certain designated health services, including laboratory services, that are covered by the Medicare and Medicaid programs by physicians who personally, or through a family member, have an investment or ownership interest in, or a compensation arrangement with, an entity performing the tests. The prohibition also extends to payment for any testing referred in violation of the Stark Law. A person who engages in a scheme to circumvent the Stark Law’s referral prohibition may be fined up to $100,000 for each such arrangement or scheme. In addition, any person who presents or causes to be presented a claim to the Medicare or Medicaid programs in violation of the Stark Law is subject to civil monetary penalties of up to $15,000 per bill submission, an assessment of up to three times the amount claimed and possible exclusion from participation in federal governmental payer programs. Bills submitted in violation of the Stark Law may not be paid by Medicare or Medicaid, and any person collecting any amounts with respect to any such prohibited bill is obligated to refund such amounts. Many states have comparable laws that are not limited to Medicare and Medicaid referrals.

Corporate Practice of Medicine

Numerous states have enacted laws prohibiting business corporations, such as us, from practicing medicine and employing or engaging physicians to practice medicine, generally referred to as the prohibition against the corporate practice of medicine. These laws are designed to prevent interference in the medical decision-making process by anyone who is not a licensed physician. For example, California's Medical Board has indicated that determining what diagnostic tests are appropriate for a particular condition and taking responsibility for the ultimate overall care of the patient, including providing treatment options available to the patient, would constitute the unlicensed practice of medicine if performed by an unlicensed person. Violation of these corporate practice of medicine laws may result in civil or criminal fines, as well as sanctions imposed against us and/or the physician through licensure proceedings. Typically, such laws are only applicable to entities that have a physical presence in the state.

Healthcare Reform

The United States and some foreign jurisdictions are considering or have enacted several legislative and regulatory proposals designed to change the healthcare system in ways that could affect our business. In the United States, there is significant interest in promoting changes in the health care system with the stated goal of containing healthcare costs, improving quality or expanding access. For example, the ACA contains certain measures that may be significant for our business. The ACA includes, among other things, provisions regarding initiatives to revise Medicare payment methodologies; the coordination and promotion of research on comparative clinical effectiveness of different technologies and procedures; and initiatives to promote quality indicators in payment methodologies. The ACA also includes an annual excise tax on device manufacturers of 2.3% of the price for which manufacturers sell their devices. The excise tax has been temporarily suspended for calendar years 2016 through 2019, but will be reinstated in 2020 without additional Congressional action.

There have been other health reform measures taken since the enactment of the ACA. For example, the Budget Control Act of 2011, among other things, created measures for spending reductions by Congress. A Joint Select Committee on Deficit Reduction, tasked with recommending a targeted deficit reduction of at least $1.2 trillion for fiscal year 2013 through fiscal year 2021, was unable to reach required goals, thereby triggering the legislation's automatic reduction (known as sequestration) to several government programs. This includes aggregate reductions to Medicare payments to providers of 2% per fiscal year, beginning April 1, 2013, which, following passage of subsequent legislation, will remain in effect through 2025 unless additional Congressional action is taken. Furthermore, on January 2, 2013, the American Taxpayer Relief Act of 2012 was signed into law, which, among other things, increased the statute of limitations for the government to recover overpayments to providers from three years to five years.

The current presidential administration and Congress are also expected to attempt broad sweeping changes to the current health care laws. We face uncertainties that might result from modification or repeal of any of the provisions of the ACA, including as a result of current and future executive orders and legislative actions. The impact of those changes on us and potential effect on the participants in the health care system as a whole is currently unknown. But, any changes to the ACA are likely to have an impact on our results of operations and may have a material adverse effect on our results of operations. We cannot predict what other healthcare programs and regulations will ultimately be implemented at the federal or state level or the effect of any future legislation or regulation in the United States may have on our business.

European Regulation

International sales of medical devices are subject to foreign governmental regulations, which vary substantially from country to country. The time required to obtain clearance or approval by a foreign country may be longer or shorter than that required for FDA clearance or approval, and the requirements may be different.

The primary regulatory body in Europe is the European Commission, which has adopted numerous directives and has promulgated standards regulating the design, manufacture, clinical trials, labeling and adverse event reporting for medical devices. Devices that comply with the requirements of a relevant directive will be entitled to bear the European Conformity Marking, or CE Mark, indicating that the device conforms to the essential requirements of the applicable directives and, accordingly, can be commercially distributed throughout the member states of the European Union, and other countries that comply with or mirror these directives. The method of assessing conformity varies depending on the type and class of the product, but normally involves a combination of self-assessment by the manufacturer and a third-party assessment by a notified body, an independent and neutral institution appointed by a country to conduct the conformity assessment. This third-party assessment may consist of an audit of the manufacturer's quality system, review of technical documentation, and specific testing of the manufacturer's device. Such an assessment may be required in order for a manufacturer to commercially distribute the product throughout these countries. We previously received authorization to affix the CE Mark to our HBox device connectivity hardware under Directive 2006/95/EC. The final form of the European Medical Device Regulation, which will replace Europe's Medical Device Directive, was adopted on May 25, 2017 and it becomes effective on May 25, 2 020. The Medical Device Regulation will apply in parallel with the Medical Device Directive for a transition period of three years. Our standard DeviceConX software product is not regulated under the European Medical Device Regulation or Europe's Medical Device Directive, but we are currently pursuing a version of our DeviceConX software that may be distributed in Europe and that meets the European Medical Device Regulation, which software would bear a CE Mark upon completion of applicable assessments.

Other Regulatory Requirements

The laboratory performing the Omics services is subject to federal, state and local regulations relating to the handling and disposal of regulated medical waste, hazardous waste and biohazardous waste, including chemical, biological agents and compounds, blood and bone marrow samples, and other human tissue. Typically, the laboratory uses outside vendors who are contractually obligated to comply with applicable laws and regulations to dispose of such waste. These vendors are licensed or otherwise qualified to handle and dispose of such waste.

The U.S. Occupational Safety and Health Administration has established extensive requirements relating to workplace safety for healthcare employers, including requirements to develop and implement programs to protect workers from exposure to blood-borne pathogens by preventing or minimizing any exposure through needle stick or similar penetrating injuries.

Backlog

We have no material backlog of orders.

Geographic and Segment Information

During 2018 , substantially all of our long-lived assets were located within the United States and United Kingdom.

Revenue from international markets were approximately 2% of our consolidated revenue for 2018 and approximately 2% of our consolidated revenue for 2017 .

We operate in one segment. The Company has one business activity and does not segregate its business for internal reporting. Accordingly, management has determined that the Company operates in one reportable segment.

Seasonality

Our revenues are not seasonal in nature.

Corporate Information

We were founded in 2010 as a Delaware limited liability company under the name “About Advanced Health, LLC.” In 2011, our affiliates NantWorks, LLC, or NantWorks, and California Capital Equity, LLC, or Cal Cap, purchased certain assets from Abraxis Bioscience, LLC, which were subsequently contributed to us. We subsequently changed our name to “All About Advanced Health, LLC,” and then to “Nant Health, LLC.” On June 1, 2016, in connection with our initial public offering, we converted from a limited liability company into a Delaware corporation and changed our name from Nant Health, LLC to NantHealth, Inc., which we refer to as the “LLC Conversion.” In conjunction with the LLC Conversion, (a) all of our outstanding units were automatically converted into shares of our common stock, based on the relative rights of our pre-IPO equity holders as set forth in the Nant Health, LLC limited liability company agreement, or the LLC Agreement, and (b) we adopted and filed a certificate of incorporation with the Secretary of State of the State of Delaware and adopted bylaws. Our principal executive offices are located at 9920 Jefferson Blvd, Culver City, CA 90232 and our telephone number is (310) 883-1300. Our corporate website address is www.nanthealth.com. We make available on our website, free of charge, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and any amendments to those reports, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission, or SEC. Our SEC reports can be accessed through the investor relations page of our website located at http:// http://ir.nanthealth.com/.

The contents of our website are not a part of, and are not incorporated by reference into, this Annual Report on Form 10-K or any other report or document we file with the SEC, and any references to our website are intended to be inactive textual references only.

Item 1A. Risk Factors

Investing in our common stock involves a high degree of risk. You should carefully consider the risks described below, as well as all other information included in this Annual Report on Form 10-K, including our financial statements and the related notes thereto and Item 7, “Management’s Discussion and Analysis of Financial Condition and Results of Operations”, any of which may be relevant to decisions regarding an investment in or ownership of our common stock. Our future operating results may vary substantially from anticipated results due to a number of risks and uncertainties, many of which are beyond our control. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties that we are unaware of, or that we currently believe are not material, may also become important factors that affect us. The following discussion highlights some of these risks and uncertainties and the possible impact of these risks on future results of operations. If any of the following risks actually occurs, our business, financial condition, operating results, prospects and ability to accomplish our strategic objectives could be materially harmed. As a result, the trading price of our common stock could decline and you could lose all or part of your investment. Additional risks and uncertainties not presently known to us or that we currently deem immaterial may also impair our business operations and the market price of our common stock.

Risks related to our business approach

We are an early, commercial-stage company attempting to integrate a complex learning system to address a wide range of healthcare issues, and we may not be successful in doing so.

We are an early, commercial-stage company with a business model based upon a novel approach to healthcare. NantHealth solutions are designed to address many of the key challenges healthcare constituents face by enabling them to acquire and store sequencing and molecular analysis data, combine diagnostic inputs with phenotypic and cost data, analyze datasets, securely deliver that data to providers in a clinical setting to aid selection of the appropriate treatments, monitor patient biometric data and progression on a real-time basis, and demonstrate improved patient outcomes and costs. In addition, through our acquisition of NantHealth Labs, Inc. ("NantHealth Labs", formerly Liquid Genomics) in 2018, we have expanded into the liquid biopsy analysis market. Integration across our systems infrastructure and platforms may take longer than we expect or may never occur at all.

We have engaged and may in the future engage in the acquisition or disposition of other companies, technologies, and businesses which could divert our management’s attention, result in additional dilution to our stockholders and otherwise disrupt our operations and harm our operating results.

Due to the above factors, it may take longer than we expect, or we may never be able, to fully integrate our system as planned. If our integration efforts are not successful we may not be able to attract new clients and to expand our offerings to existing clients.

The success of NantHealth solutions is dependent upon the robustness of the information we and others input into the system to achieve maximum network effects, and if we are unable to amass and input the requisite data to achieve these effects, our business will be adversely affected.

NantHealth solutions become more valuable as more accurate and clinically relevant information is integrated into them, and our ultimate outputs and recommendations to a patient, provider or payer are therefore highly dependent on the information that is input into our system. As a result, we need to consistently and continuously have access to and integrate the most medically relevant and cutting edge clinical data and research studies with patient-specific real-time DNA and RNA analysis and biometric data. To have access to biometric data in particular, we rely on patients, provider and payers to adopt devices that are compatible with our systems and they may not adopt such devices on a scale or at a rate sufficient to support our offerings or at all. Further, to have access to certain other data points, we rely in part on third parties to develop applications to generate more data to be integrated into NantHealth solutions. These third parties may never develop applications compatible with our software solutions or may develop them at a slower rate than our ability to address shifts in healthcare. In addition, if such third-party solutions are not produced to specification, are produced in accordance with modified specifications, or are defective, they may not be compatible with our systems. In such case, the reliability and performance of our products may be compromised. To the extent we are unable to amass enough data, keep an inflow of current and continuous data or integrate and access the data we currently have to continue to populate NantHealth solutions, the network effects we expect will not be fully realized and our business may be adversely affected.

We may be unable to appropriately allocate our financial and human resources across our broad array of product and service offerings.

We have a broad array of product and service offerings. Our management team is responsible for allocating resources across these products and services and may forego or delay pursuit of opportunities with certain products or services that later prove to have greater commercial potential. In August 2017, we announced a comprehensive restructuring plan that included a wide range of organizational efficiency initiatives and other cost reduction opportunities. In addition, in February 2018, we acquired NantHealth Labs and have expanded into the liquid biopsy analysis market, through Liquid GPS. We intend to leverage our current sales and marketing efforts to drive provider acceptance and adoption of Liquid GPS. In addition, we recently introduced the GPS Complete test. This and other resource allocation decisions may cause us to fail to capitalize on attractive products or services or market opportunities. Our spending on current and future research and development programs and future products or services may not yield commercially viable products or services or may fail to optimize the anticipated network effects of NantHealth solutions. If our management team is unable to appropriately prioritize the allocation of our resources among our broad range of products and services in an efficient manner, our business may be adversely affected.

Risks related to our financial condition and capital requirements

We have a limited operating history, which may make it difficult to evaluate our current business and predict our future performance.

We were organized as a limited liability company in Delaware and began operations in 2010. In June 2016, we converted to a Delaware corporation. Additionally, our business has operated as part of the larger NantWorks, LLC, or NantWorks, group of affiliated companies. Our limited independent operating history, particularly in light of the increasingly complex and rapidly evolving healthcare and technology markets in which we operate, may make it difficult to evaluate our current business and predict our future performance. In addition, we have acquired numerous companies or businesses over the past three years, including certain assets of NaviNet, and most recently NantHealth Labs. In addition, in August 2017, we sold our provider/patient engagement solutions business to Allscripts. We have had limited experience operating these businesses as a whole and as such, it may be difficult to evaluate our current business and predict our future operating performance. In light of the foregoing, any assessment of our profitability or prediction about our future success or viability is subject to significant uncertainty. We have encountered and will continue to encounter risks and difficulties frequently experienced by early, commercial-stage companies in rapidly evolving industries. If we do not address these challenges successfully, our business results will suffer.

We have a history of significant losses, which we expect to continue, and we may never achieve or sustain profitability in the future.

We have incurred significant net losses in each fiscal year since inception and expect to continue to incur net losses for the foreseeable future. We experienced net losses of $192.2 million and $175.2 million during the years ended December 31, 2018 and 2017 , respectively. As of December 31, 2018 , we had an accumulated deficit of $884.1 million . The losses and accumulated deficit were primarily due to the substantial investments we made to grow our business and enhance our systems infrastructure and platforms. We have grown our business through research and development and the acquisition of assets, businesses and customers. We anticipate that our operating expenses will increase substantially in the foreseeable future as we seek to continue to grow our business, including through strategic acquisitions, and build and further penetrate our client base and develop our product and service offerings, including GPS Cancer and Liquid GPS. These efforts may prove more expensive than we currently anticipate, and we may not succeed in increasing our revenue sufficiently to offset these higher expenses.

Our prior losses, combined with our expected future losses, have had and will continue to have an adverse effect on our stockholders' equity and working capital. We expect to continue to incur operating losses for the foreseeable future and may never become profitable on a quarterly or annual basis, or if we do, we may not be able to sustain profitability in subsequent periods. Our failure to achieve and sustain profitability in the future would negatively affect our business, financial condition, results of operations and cash flows, and could cause the market price of our common stock to decline.

We may need to raise additional capital to fund our existing operations, develop our solutions, commercialize new products and expand our operations.

Based on our current business plan, we believe the net proceeds from our convertible notes offering completed in 2016, together with our current cash, cash equivalents, marketable securities, and our ability to borrow from affiliated entities, will be sufficient to meet our anticipated cash requirements over at least the next 12 months. If our available cash balances and anticipated cash flow from operations are insufficient to satisfy our liquidity requirements, we may seek to sell common or preferred equity or convertible debt securities, enter into a credit facility or another form of third-party funding, or seek other debt financing.

We may consider raising additional capital in the future to expand our business, to pursue strategic investments, to take advantage of financing opportunities, or for other reasons, including to:

- increase our sales and marketing efforts to drive market adoption of NantHealth solutions (including GPS Cancer, Liquid GPS, and NantHealth software solutions);
- address competitive developments;
- fund development and marketing efforts of any future platforms and solutions;
- expand adoption of GPS Cancer and Eviti platform solutions into critical illnesses outside of oncology;
- acquire, license or invest in complimentary businesses, technologies or service offerings; and
- finance capital expenditures and general and administrative expenses.

Our present and future funding requirements will depend on many factors, including:

- our success in driving adoption of our molecular analysis solutions, including GPS Cancer and Liquid GPS;
- our success in making our molecular analysis solutions reimbursable by payers;
- our ability to achieve revenue growth;
- the cost of expanding our products and service offerings, including our sales and marketing efforts;
- our ability to achieve interoperability across all of our acquired businesses, technologies and service offerings to deliver networking effects to our clients;
- the effect of competing technological and market developments;
- costs related to international expansion; and
- the potential cost of and delays in product development as a result of any regulatory oversight applicable to our products.

The various ways we could raise additional capital carry potential risks. If we raise funds by issuing equity securities, dilution to our stockholders could result. Any equity securities issued also could provide for rights, preferences or privileges senior to those of holders of our common stock. If we raise funds by issuing debt securities, those debt securities would have rights, preferences and privileges senior to those of holders of our common stock. The terms of debt securities issued or borrowings pursuant to a credit agreement could impose significant restrictions on our operations.

W e have identified a material weakness in our internal control over financial reporting. Failure to maintain effective internal controls could cause our investors to lose confidence in us and adversely affect the market price of our common stock. If our internal controls are not effective, we may not be able to accurately report our financial results or prevent fraud.

Section 404 of the Sarbanes-Oxley Act of 2002, or Section 404, requires that we maintain internal control over financial reporting that meets applicable standards. We may err in the design or operation of our controls, and all internal control systems, no matter how well designed and operated, can provide only reasonable assurance that the objectives of the control system are met. Because there are inherent limitations in all control systems, there can be no assurance that all control issues have been or will be detected. If we are unable, or are perceived as unable, to produce reliable financial reports due to internal control deficiencies, investors could lose confidence in our reported financial information and operating results, which could result in a negative market reaction and a decrease in our stock price.

We are required, pursuant to Section 404, to furnish a report by management on, among other things, the effectiveness of our internal control over financial reporting. We will need to disclose any material weaknesses identified by our management in our internal control over financial reporting. As an “emerging growth company,” we are availing ourselves of the exemption from the requirement that our independent registered public accounting firm attest to the effectiveness of our internal control over financial reporting under Section 404. However, we may no longer avail ourselves of this exemption when we cease to be an “emerging growth company.” When our independent registered public accounting firm is required to undertake an assessment of our internal control over financial reporting, the cost of our compliance with Section 404 will correspondingly increase. Our compliance with applicable provisions of Section 404 will require that we incur substantial accounting expense and expend significant management time on compliance-related issues as we implement additional corporate governance practices and comply with reporting requirements. Moreover, if we are not able to comply with the requirements of Section 404 applicable to us in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the U.S. Securities and Exchange Commission, or SEC, or other regulatory authorities, which would require additional financial and management resources.

In connection with our 2018 audit, we identified a material weakness in relation to the valuations of our related party equity method investment in NantOmics (see Note 10 to our Consolidated Financial Statements) and the Bookings Commitment liability (see Note 12 to our Consolidated Financial Statements). We have designed and implemented, or expect to implement, measures that we believe address this material weakness, including, among other things, controls to consider all required elements needed to support the measurement of fair value of a liability and assess the reasonableness of assumptions underlying prospective financial information used in the fair value measurement of the Company’s investment in a related party. We have incurred and will continue to incur significant costs to remediate this weakness, primarily personnel costs, external consulting and legal fees, system implementation costs, and related indirect costs including the use of facilities and technology, and we expect to incur additional costs to remediate this weakness. We may not be successful in implementing these remediation efforts or in developing other internal controls, which may undermine our ability to provide accurate, timely and reliable reports on our financial and operating results. Further, we will not be able to fully assess whether the steps we are taking will remediate the material weakness in our internal control over financial reporting until we have completed our implementation efforts and sufficient time passes in order to evaluate their effectiveness. In addition, if we identify additional errors that result in material weaknesses in our internal control over financial reporting, we may not detect errors on a timely basis and our financial statements may be materially misstated. Moreover, in the future we may engage in business transactions, such as acquisitions, reorganizations or implementation of new information systems that could negatively affect our internal control over financial reporting and result in material weaknesses.

If we identify new material weaknesses in our internal control over financial reporting, if we are unable to comply with the requirements of Section 404 in a timely manner, if we are unable to assert that our internal control over financial reporting is effective, or if our independent registered public accounting firm is unable to express an opinion as to the effectiveness of our internal control over financial reporting, we may be late with the filing of our periodic reports, investors may lose confidence in the accuracy and completeness of our financial reports and the market price of our common stock could be negatively affected. As a result of such failures, we could also become subject to investigations by the stock exchange on which our securities are listed, the SEC, or other regulatory authorities, and become subject to litigation from investors and stockholders, which could harm our reputation, financial condition or divert financial and management resources from our core business, and would have a material adverse effect on our business, financial condition and results of operations.

We are involved in pending securities litigation and an adverse resolution of such litigation may adversely affect our business, financial condition, results of operations and cash flows.

The Company has been named as a defendant in lawsuits arising out of our initial public offering and later public statements. In March 2017, a number of putative class action securities complaints were filed in U.S. District Court California, naming as defendants the Company and certain of our executive officers and directors. Certain plaintiffs also named as defendants are investment banks who were underwriters in our initial public offering. The complaints generally allege that defendants made material misstatements and omissions in violation of the federal securities laws. The outcomes of litigation are difficult to predict. Plaintiffs may seek recovery of a substantial amount. The monetary and other impact of this action may remain unknown for substantial periods of time. The cost to defend, settle or otherwise resolve this matter may be significant and divert management's attention from the operations of the Company. We cannot assure you that we will prevail in this lawsuit. If we are ultimately unsuccessful in this matter, we could be required to pay substantial amounts which might materially adversely affect our business, operating results and financial condition. For additional information regarding this and other lawsuits in which we are involved, see Part I, Item 3, Legal Proceedings.

Risks related to our sequencing and molecular analysis solutions

We may not be able to generate sufficient revenue from our sequencing and molecular analysis solutions, including GPS Cancer, or our relationships with sequencing and molecular analysis customers, to achieve and maintain profitability.

We believe our commercial success depends significantly upon our ability to successfully market and sell our sequencing and molecular analysis solutions to continue to expand our current relationships and develop new relationships with physicians, self-insured employers, payers and healthcare providers, and expand adoption of sequencing and molecular analysis for disease indications outside oncology. Net revenue from our sequencing and molecular analysis solutions represented 3.5% and 2.9% of our total net revenue for the years ended December 31, 2018 and 2017 , respectively. The demand for sequencing and molecular analysis may decrease or may not continue to increase at historical rates for a number of reasons. Our clients may decide to decrease or discontinue their use of sequencing and molecular analysis due to changes in research and product development plans, financial constraints or utilization of internal molecular testing resources or molecular tests performed by others, which are circumstances outside of our control. In addition to reducing our revenue, this may reduce our exposure to early stage research that facilitates the incorporation of newly developed information about cancer and other diseases into our molecular analysis solutions. Further, we may be unsuccessful in expanding our clients' use of sequencing and molecular analysis outside of oncology.

In addition, our expansion into the liquid tumor profiling market may not be successful and may fail to generate the levels of revenue that we project. The future growth of our market and the success of Liquid GPS depends on many factors beyond our control, including recognition and acceptance by the scientific community, and the growth, prevalence, and costs of competing methods of tumor analysis. Additionally, our success depends on the ability of our sales organization to successfully sell Liquid GPS into these markets.

We are currently not profitable. Even if we succeed in increasing adoption of sequencing and molecular analysis by physicians, self-insured employers, payers and healthcare providers, and maintaining and creating relationships with our existing and new clients, we may not be able to generate sufficient revenue from sequencing and molecular analysis to achieve profitability.

Sequencing and molecular analysis may have limited utility unless we or third parties are able to successfully establish links between genomic sequencing and expression analysis and disease and treatment pathways.

Full genomic sequencing and expression analysis may have limited utility on a stand-alone basis. We believe the real value is derived by linking genomic sequencing and RNA analysis with disease pathways to help enable the discovery and development of personalized treatments. We do not currently, and do not expect in the future to, engage in research regarding disease pathways or engage in the development or commercialization of specific therapeutics or drugs. Instead, we will rely on third parties to do so. If, however, third-party time and funding is not devoted to determining disease pathways or to discovering, developing and marketing therapeutics or drugs specific to such pathways, sequencing and molecular analysis and GPS Cancer will be perceived to have limited utility and our business may be adversely affected.

Our success will depend on our ability to use rapidly changing genetic data to interpret molecular analysis results accurately and consistently, and our failure to do so would have an adverse effect on our operating results and business.

Our success depends on our ability to provide reliable, high-quality molecular profiling tests that incorporate rapidly-evolving information about the role of genes and gene variants in disease and clinically relevant outcomes associated with those variants. The accuracy and reproducibility we have demonstrated to date may not continue, particularly for clinical samples, as molecular analysis volume increases. Errors, including as a result of molecular analysis failing to detect genomic variants with high accuracy, or omissions, including as a result of failing to or incompletely or incorrectly identify the significance of gene variants, could have a significant adverse impact on our business. Hundreds of genes can be implicated in some disorders and overlapping networks of genes and symptoms can play a role in multiple conditions. We also rely on clinicians to interpret what we report and to incorporate specific information about an individual patient into the physician's treatment decision. As a result, a substantial amount of judgment is required in order to interpret testing results for an individual patient and to develop an appropriate patient report. Due to such errors in judgment, patient outcomes may not be improved even if our molecular analysis services perform to our expectations.

The efficiency of sequencing and molecular analysis, including GPS Cancer and Liquid GPS, and the results that we achieve depend on the design and operation of our test processes, which use a number of complex and sophisticated biochemical, informatics, optical, and mechanical processes, many of which are highly sensitive to external factors. An operational or technology failure in one of these complex processes or fluctuations in external variables may result in processing efficiencies that are lower than we anticipate or that vary between testing runs. In addition, we regularly evaluate and if necessary, refine our processes. These refinements may initially result in unanticipated issues that further reduce our test run yields or increase the variability of our test run yields. Low test run yields can cause variability in our operating results and damage our reputation. In addition, although we believe GPS Cancer is a comprehensive molecular profiling solution, no solution is fully comprehensive, and it will need to be continually improved in line with improvements in science and technology and potential developments by our competitors. If GPS Cancer proves to not be fully comprehensive, customer demand for GPS Cancer may be adversely affected.

GPS Cancer can determine whether specific genes are over- or under-expressed which can affect protein levels and, as a result, cancer phenotype and drug efficacy in a particular patient. Such gene expression can also capture the effect of post-translational modifications, which can have equally significant implications on how a cancer is expressed in a patient and in turn may impact treatment decisions. Our sequencing and molecular analysis solutions (including GPS Cancer and Liquid GPS) represent a novel and largely unproven approach to the characterization and monitoring of cancer and may not be accurate based on the evolving understanding of how DNA and RNA analysis relate to disease progression and drug efficacy and resistance. As a result, the marketing, sale and use of our sequencing and molecular analysis solutions could subject us to liability for errors in, misunderstandings of, or inappropriate reliance on, information we provide to physicians or geneticists, and lead to claims against us if someone were to allege that our solutions failed to perform as they were designed, if we failed to correctly interpret results, or if the ordering physician were to misinterpret our results or improperly rely on them when making a clinical decision. A product liability or professional liability claim could result in substantial financial and reputational damage and be costly and time-consuming for us to defend. Although we maintain liability insurance, including for errors and omissions, we cannot assure you that our insurance would fully protect us from the financial impact of defending against these types of claims or any judgments, fines or settlement costs arising out of any such claims. Any liability claim, including an errors and omissions liability claim, brought against us, with or without merit, could increase our insurance rates or prevent us from securing insurance coverage in the future. Additionally, any liability lawsuit could cause injury to our reputation or cause us to suspend sales of our sequencing and or molecular analysis solutions. The occurrence of any of these events could have an adverse effect on our business, reputation and results of operations.

Our sequencing and molecular analysis solutions may never achieve significant commercial market acceptance.

Our sequencing and molecular analysis solutions may never gain significant acceptance in the marketplace and, therefore, may never generate substantial revenue or profits for us. Our ability to achieve commercial market acceptance for our sequencing and molecular analysis solutions will depend on several factors, including:

- our ability to convince key thought leaders, physicians and caregivers and other key oncology stakeholders of the clinical utility of our entire product offering and its potential advantages over existing sequencing tests, specifically, the advantages of our RNA sequencing, which maps oncology disease pathways versus a patient's own germline, and our liquid tumor profiling tests;
- the willingness of physicians, self-insured employers, payers and healthcare providers to utilize our sequencing and molecular analysis services; and
- the willingness of commercial third-party payers and government payers to reimburse for our molecular services, the scope and amount of which will affect patients' willingness or ability to pay for our molecular analysis services and likely heavily influence our customers' decisions to recommend our molecular analysis services.

Further, today's most advanced diagnostics tests analyze narrow gene panels that capture only a limited number of the most common gene alterations, as compared to GPS Cancer, which sequences the patient's whole genome (comparing both a patient's normal and tumor tissue) and performs RNA sequencing, gene expression and statistical analysis. These narrow gene panels for specific treatments or disease areas are much less expensive than GPS Cancer. Although we believe that the advantages of sequencing the patient's whole genome for the treatment of cancer, as well as running additional RNA tests, outweigh the costs, key thought leaders, physicians and other caregivers, other key oncology stakeholders and payers may not agree. Further, if advances in the understanding of disease states and pathways do not reveal a benefit to whole genome and RNA sequencing in areas beyond cancer then the market potential for our sequencing and molecular analysis services will be limited. Failure to achieve widespread commercial market acceptance for our sequencing and molecular analysis solutions could materially harm our business, financial condition and results of operations.

If we cannot compete successfully with our competitors for our sequencing and molecular analysis solutions, we may be unable to increase or sustain our revenue or achieve and sustain profitability.

Personalized molecular analysis is a new area of science, and we face competition from companies that offer products, or have conducted research, to profile genes and gene expression in various cancers. Our principal competition for GPS Cancer comes from diagnostic companies that also offer whole genome sequencing. We also compete with diagnostic companies offering molecular diagnostic tests that capture only a single marker or test panels that capture a limited number of the most well-known gene alterations, known as hotspot panel tests. In addition, academic research centers, diagnostic companies and next-generation sequencing, or NGS, platform developers are offering or developing NGS-based testing. NGS-based testing also has the capability to provide whole genome sequencing to compete with GPS Cancer.

Our competitors with respect to GPS Cancer include companies such as Foundation Medicine, Inc., or Foundation Medicine, Caris Life Sciences, Inc., or Caris Life Sciences, Personal Genome Diagnostics, Inc., or Personal Genome Diagnostics, Guardant Health, Inc., and Paradigm Diagnostics, Inc. and Tempus Labs.

With the acquisition of NantHealth Labs, we expanded our product offerings to include liquid tumor profiling services and our principal competitors include Guardant Health, Inc., Foundation Medicine, Inc., Genomic Health, Inc. and Biocept, Inc.

Many hospitals and academic medical centers may also seek to perform the type of molecular testing we perform at their own facilities. As such, our competition may include entities such as the University of Michigan, Baylor Medical Genetics Laboratories, Washington University in St. Louis, Memorial Sloan Kettering Cancer Center and other academic hospitals and research centers. In addition to developing kits, some diagnostic companies also provide NGS platforms. Illumina, Inc., Thermo Fisher Scientific Corporation, Invitae Corporation, and other companies develop NGS platforms that are being sold directly to research centers, biopharmaceutical companies and clinical laboratories. While many of the applications for these platforms are focused on the research and development markets or testing for conditions outside of oncology, these companies have launched and will continue to commercialize products focused on the clinical oncology market. Although we believe GPS Cancer is a comprehensive molecular profiling solution, our competitors may develop more comprehensive or superior alternative offerings. We believe diagnostic platform providers will seek to place sequencing machines in laboratories to develop NGS-based laboratory-developed tests, or LDTs. In addition, we believe these companies will also develop their own diagnostic kits approved by the FDA, which can be sold to the clients who have purchased their platforms. Also, many private companies are developing information technology-based tools to support the integration of NGS-based testing into the clinical setting.

Additionally, some of our competitors' molecular analysis tests are being used in FDA clinical trials as companion diagnostics. Because companion diagnostics help identify whether a patient's disease expresses the molecular target, or biomarker, for the particular drug, they can help ensure the drug's efficacy and are sometimes required by the FDA to be used with certain drugs. Our molecular analysis solutions may not have the DNA and RNA analysis capability on par with a companion diagnostic to guide therapeutic treatments for certain customers. Further, the FDA requires a companion diagnostic test if a new drug works on a specific genetic or biological target that is present in some, but not all, patients with a certain cancer or disease. Even if it is shown to be on par with FDA-approved companion diagnostics, physicians and payors may still not choose to use our molecular analysis solutions. If physicians and payers utilize and pay for these FDA-approved companion diagnostic tests instead of our solutions, our business may be adversely affected.

Any of these competitors could have technological, financial and market access advantages that are not currently available to us.

The molecular diagnostics industry is subject to rapidly changing technology, which could make sequencing and molecular analysis solutions and other products we may develop or license in the future obsolete.

Our industry is characterized by rapid technological changes, frequent new product introductions and enhancements and evolving industry standards, all of which could make our sequencing and molecular analysis solutions or other products we develop or license obsolete. Our future success will depend on our ability to keep pace with the evolving needs of our clients on a timely and cost-effective basis and to pursue new market opportunities that develop as a result of technological and scientific advances. In recent years, there have been numerous advances in technologies relating to the diagnosis and treatment of cancer. There have also been advances in methods used to analyze very large amounts of genomic information. We must continuously enhance our products and solutions, and we may also need to develop or license new technologies, to keep pace with evolving standards of care. If we do not update our products and solutions to reflect new scientific knowledge about cancer biology, information about new cancer therapies, or relevant clinical trials, our solutions could become obsolete and our molecular analysis revenue growth would be limited or eliminated, which would have a material adverse effect on our business, financial condition and results of operations.

If we are not able to establish relationships with, or lose the support of, key thought leaders or payers' key decision makers, it may be difficult to establish our products and solutions as a standard of care for patients with cancer, which may limit our revenue growth and ability to achieve profitability.

We are establishing relationships with leading oncology thought leaders and payors' key decision makers. If we are unable to establish these relationships, or these key thought leaders or payers' key decision makers determine that the products or services that we develop or license are not clinically or operationally effective or that alternative technologies and services are more effective or cost-efficient, or if they elect to use and promote internally developed products, we would encounter significant difficulty driving adoption of our products and solutions and/or validating them as a standard of care, which would limit our revenue growth and our ability to achieve profitabilit y.

Ethical, legal and social concerns related to the use of genomic information could reduce demand for our sequencing and molecular analysis solutions.

Genomic testing, like that conducted using GPS Cancer, has raised ethical, legal and social issues regarding privacy and the appropriate uses of the resulting information. Governmental authorities could, for social or other purposes, limit or regulate the use of genomic information or genomic testing, particularly for those diseases that have no known cure. These concerns may lead patients to refuse to use, or clinicians to be reluctant to order, whole genome genomic tests even if permissible.

Ethical and social concerns may also influence U.S. and foreign patent offices and courts with regard to patent protection for technology relevant to our business. These and other ethical, legal and social concerns may limit market acceptance of our products or reduce the potential markets for products enabled by our sequencing and molecular analysis solutions, either of which could have an adverse effect on our business, financial condition or results of operations.

Risks related to our system infrastructure and software solutions business

The market for our systems infrastructure and software solutions is new and unproven and may not grow.

We believe our future success will depend in large part on establishing and growing a market for our systems infrastructure and that are able to provide operational intelligence, particularly designed to collect and index machine data. Our systems infrastructure is designed to address interoperability challenges across the healthcare continuum. It integrates big data with real time resources and applies machine learning algorithms to inform and optimize treatment decisions. In order to grow our business, we intend to expand the functionality of our offering to increase its acceptance and use by the broader market. In particular our systems infrastructure is targeted at those in the healthcare continuum that are transitioning from fee-for-service to a value-based reimbursement model. While we believe this to be the current trend in healthcare, this trend may not continue in the future. Our systems infrastructure is less effective with a traditional fee-for-service model and if there is a reversion in the industry towards fee-for-service, or a shift to another model, we would need to update our offerings and we may not be able to do so effectively or at all. It is difficult to predict client adoption and renewal rates, client demand for our software, the size and growth rate of the market for our solutions, the entry of competitive products or the success of existing competitive products. Many of our potential clients may already be party to existing agreements for competing offerings that may have lengthy terms or onerous termination provisions, and they may have already made substantial investments into those platforms which would result in high switching costs. Any expansion in our market depends on several factors, including the cost, performance and perceived value associated with such operating system and software applications particularly considering the shifting market dynamics. Although we have experienced rapid adoption of our systems infrastructure and software solutions, the rate may slow or decline in the future, which would harm our business and operating results. In addition, while many large hospital systems and payers use our solutions, many of these entities use only certain of our offerings, and we may not be successful in driving broader adoption of our solutions among these existing users, which would limit our revenue growth.

If the market for our offerings does not achieve widespread adoption or there is a reduction in demand for our offerings in our market caused by a lack of customer acceptance, technological challenges, lack of accessible machine data, competing technologies and products, decreases in corporate spending, weakening economic conditions, or otherwise, it could result in reduced customer orders, early terminations, reduced renewal rates or decreased revenues, any of which would adversely affect our business operations and financial results. You should consider our business and prospects in light of the risks and difficulties we may encounter in this new and unproven market.

The data and information that we provide to our clients, and their constituents, could be inaccurate or incomplete, which could harm both patients and our business, financial condition and results of operations.

Some of our software solutions store and display data from a variety of third-party sources for use in treating patients and to search and compare options for healthcare services and treatments. As part of our Eviti platform solutions, we provide up-to-date information regarding cancer research, along with a list of potential treatments and relevant clinical trials seeking enrollment. Most of this data comes from health plans, our clients, published guidelines, peer-reviewed journals and other third parties. Because data in the healthcare industry is often fragmented in origin, inconsistent in format and often incomplete, the overall quality of certain types of data we receive can be poor. If these data are incorrect or incomplete or if we make mistakes in the capture or input of their data, or in our interpretation or analysis of such data, adverse consequences, including patient death and serious injury, may occur and give rise to product liability and other claims against us. In addition, a court or government agency may take the position that our storage and display of health information exposes us to personal injury liability or other liability for wrongful delivery or handling of healthcare services or erroneous health information. While we maintain insurance coverage, we cannot assure that this coverage will prove to be adequate or will continue to be available on acceptable terms, if at all. Even unsuccessful claims could result in substantial costs, reputational damage, and diversion of management resources. A claim brought against us that is uninsured or under-insured could harm our business, financial condition and results of operations.

Our use of open source technology could impose limitations on our ability to commercialize our offerings.

Our offerings incorporate open source software components that are licensed to us under various public domain licenses. Some open source software licenses require users who distribute open source software as part of their software to publicly disclose all or part of the source code to such software or make available any derivative works of the open source code on unfavorable terms or at no cost. There is little or no legal precedent governing the interpretation of many of the terms of these licenses and therefore the potential impact of such terms on our business is not fully known or predictable. There is a risk that such licenses could be construed in a manner that imposes unanticipated conditions or restrictions on our ability to market our software products and services. While we monitor our use of open source software and try to ensure that none is used in a manner that would require us to disclose our source code or that would otherwise breach the terms of an open source agreement, such use could inadvertently occur and we may be required to release our proprietary source code, pay damages for breach of contract, re-engineer one or more of our offerings, discontinue sales of one or more of our offerings in the event re-engineering cannot be accomplished on a timely basis or take other remedial action that may divert resources away from our development efforts, any of which could cause us to breach obligations to our clients, harm our reputation, result in customer losses or claims, increase our costs or otherwise adversely affect our business and operating results.

If we are not able to enhance our systems infrastructure or software solutions to achieve market acceptance and keep pace with technological developments, our business will be harmed.

Our ability to attract new subscribers and licensees, and increase revenue from existing subscribers and licensees, depends in large part on our ability to enhance and improve our existing offerings and to introduce new products and services, including products and services designed for a mobile user environment. To grow our business, we must develop products and services that reflect the changing nature of business management software and expand our offering. The success of any enhancements to our offerings depends on several factors, including timely completion, adequate quality testing and sufficient demand. Any new product or service that we develop may not be introduced in a timely or cost-effective manner, may contain defects or may not achieve the market acceptance necessary to generate sufficient revenue. If we are unable to successfully develop new products or services, enhance our existing offerings to meet subscriber requirements or otherwise gain market acceptance, our business and operating results will be harmed.

In addition, because many of our offerings are available over the Internet, we need to continuously modify and enhance them to keep pace with changes in Internet-related hardware, software, communications and database technologies and standards. If we are unable to respond in a timely and cost-effective manner to these rapid technological developments and changes in standards, our offerings may become less marketable, less competitive or obsolete, and our operating results will be harmed. If new technologies emerge that are able to deliver competitive products and applications at lower prices, more efficiently, more conveniently or more securely, such technologies could adversely impact our ability to compete. Our offerings must also integrate with a variety of network, hardware, mobile, and software platforms and technologies, and we need to continuously modify and enhance them to adapt to changes and innovation in these technologies. Any failure of our offerings to operate effectively with future infrastructure platforms and technologies could reduce the demand for such offerings. If we are unable to respond to these changes in a cost-effective manner, our offerings may become less marketable, less competitive or obsolete, and our operating results may be adversely affected.

Our data suppliers might restrict our use of or refuse to license data, which could lead to our inability to provide certain products or services.

A portion of the data that we use is either purchased or licensed from third parties or is obtained from our customers for specific customer engagements. Although we typically enter into long-term contractual arrangements with many of these suppliers of data, at the time of entry into a new contract or renewal of an existing contract, suppliers may increase restrictions on our use of such data, increase the price they charge us for data or refuse altogether to license the data to us. In addition, during the term of any data supply contract, suppliers may fail to adhere to our data quality control standards or fail to deliver data. Further, although no single individual data supplier is material to our business, if a number of suppliers collectively representing a significant amount of data that we use for one or more of our services were to impose additional contractual restrictions on our use of or access to data, fail to adhere to our quality-control standards, repeatedly fail to deliver data or refuse to provide data, now or in the future, our ability to provide those services to our clients could be materially adversely impacted, which may harm our operating results and financial condition.

We believe that we have rights necessary to use the data that is incorporated into our offerings. However, in the future, data providers could withdraw their data from us if there is a competitive reason to do so, or if legislation is passed restricting the use of the data, or if judicial interpretations are issued restricting use of the data that we currently use in our products and services. If a substantial number of data providers were to withdraw their data, our ability to provide our offerings to our clients could be materially adversely impacted.

For example, in order to deliver the full functionality offered by some of our solutions, we need access, on behalf of our customers, to sources of pricing and claims data, much of which is managed by a limited number of health plans and other third parties. We have developed various long-term and short-term data sharing relationships with certain health plans and other third parties, including many of the largest health plans in the United States. The health plans and other third parties that we currently work with may, in the future, change their position and limit or eliminate our access to pricing and claims data, increase the costs charged to us for access to data, provide data to us in more limited or less useful formats, or restrict our permitted uses of data. Furthermore, some health plans have developed or are developing their own proprietary price and quality estimation tools and may perceive continued cooperation with us as a competitive disadvantage and choose to limit or discontinue our access to pricing and claims data. Failure to continue to maintain and expand our access to pricing and claims data will adversely impact our ability to continue to serve existing clients and expand our offerings to new clients.

If the validity of an informed consent from a patient enrolled in a clinical trial with one of our clients was challenged, we could be forced to stop using some of our resources, which would hinder the development efforts for our sequencing and molecular analysis solutions.

We have implemented measures designed to ensure that clinical data and genetic and other biological samples that we receive from our customers have been collected from subjects who have provided appropriate informed consent for purposes which extend to our product development activities. We seek to ensure that these data and samples are provided for processing via our molecular profiling solution in a manner that does not use readily individually identifiable information of the subject. We also have measures in place to ensure that the subjects from whom the data and samples are collected do not retain or have conferred on them any proprietary or commercial rights to the data or any discoveries derived from them. Further, our clients may conduct clinical trials in several different countries, and, to a large extent, we rely upon them to comply with the subject's informed consent and with local law and international regulation. The collection of data and samples in many different countries results in complex legal questions regarding the adequacy of informed consent and the status of genetic material under many different legal systems. The subject's informed consent obtained in any country could be challenged in the future, and those informed consents could prove invalid, unlawful, or otherwise inadequate for our purposes. Any findings against us, or our clients, could deny us access to or force us to stop using some of our clinical samples, which would hinder our molecular profiling solution development efforts. We could become involved in legal challenges, which could consume our management and financial resources.

Failure by our clients to obtain proper permissions and waivers may result in claims against us or may limit or prevent our use of data which could harm our business.

We require our clients and business associates to provide necessary notices and to obtain necessary permissions and waivers for use and disclosure of the information that we receive, and we require contractual assurances from them that they have done so and will do so. If they do not obtain necessary permissions and waivers, then our use and disclosure of information that we receive from them or on their behalf may be limited or prohibited by state or federal privacy laws or other laws. This could impair our functions, processes and databases that reflect, contain or are based upon such data and may prevent use of such data. In addition, this could interfere with or prevent creation or use of rules, analyses or other data-driven activities that benefit us. Moreover, we may be subject to claims or liability for use or disclosure of information by reason of lack of valid notice, permission or waiver. These claims or liabilities could subject us to unexpected costs and adversely affect our operating results.

Our sales cycle can be lengthy and unpredictable, which may cause our revenue and operating results to fluctuate significantly.

Our sales cycle can be lengthy and unpredictable. Our sales efforts involve educating our customers about the use and benefits of our offerings and solutions, including the technical capabilities of our solutions and the potential cost savings and productivity gains achievable by deploying them. Additionally, many of our potential clients are typically already in long-term contracts with their current providers and face significant costs associated with transitioning to our offerings and solutions. As a result, potential customers typically undertake a significant evaluation process, which frequently involves not only NantHealth solutions and component systems infrastructure and platforms but also their existing capabilities and solutions and can result in a lengthy sales cycle. We spend substantial time, effort and money on our sales efforts without any assurance that our efforts will produce any sales. In addition, purchases of NantHealth solutions and component systems infrastructure are frequently subject to budget constraints, multiple approvals and unplanned administrative, processing and other delays. For example, currently, hospitals in the United States face significant uncertainty over the continuing impact of federal government budgets, and continuing changes in the implementation and deadlines for compliance with the Patient Protection and Affordable Care Act of 2010, or ACA, and other healthcare reform legislation, as well as potential future statutes and rulemaking. Many of our potential hospital clients have used all or a significant portion of their revenues to comply with federal mandates to adopt electronic medical records to maintain their Medicaid and Medicare reimbursement levels. In the event we are unable to manage our lengthy and unpredictable sales cycle, our business may be adversely affected.

We bill our clients and recognize revenue over the term of the contract for certain of our products. As a result near term declines in new or renewed agreements for these products may not be reflected immediately in our operating results and may be difficult to discern.

A portion of our revenue in each quarter is derived from agreements entered with our clients during previous quarters. Consequently, a decline in new or renewed agreements in any one quarter may not be fully reflected in our revenue for that quarter. Such declines, however, would negatively affect our revenue in future periods and the effect of significant downturns in sales of and market demand for certain of our solutions, and potential changes in our rate of renewals or renewal terms, may not be fully reflected in our results of operations until future periods. In addition, we may be unable to adjust our cost structure rapidly, or at all, to take account for reduced revenue. Our subscription model for certain of our solutions also makes it difficult for us to increase our total revenue through additional sales in any quarterly period, as revenue from new clients for those products must be recognized over the applicable term of the agreement. Accordingly, the effect of changes in the industry impacting our business or changes we experience in our new sales may not be reflected in our short-term results of operations.

A large portion of our revenue is derived from a small group of our clients, and the loss of such clients could adversely affect our business.

During the year ended December 31, 2017 , we derived 10.6% of our revenue from a single reseller, who contracts with various health plans and other healthcare entities to manage the utilization of specialty health services for their covered members, and another 10.2% of our revenue through a customer relationship with a major health plan from our acquisition of NaviNet. During the year ended December 31, 2018 , we derived 15.3% of our revenue through this reseller and another 12.8% and 11.8% of our revenue through two of NaviNet's major customers. We cannot guarantee that these clients will continue to contract for our services or acquire new services. The contract governing the reseller relationship is terminable without cause upon 12 months' written notice, but the health plan customer cannot terminate without cause. Additionally, the reseller may not be successful in reselling our products to its covered members, or covered members may reduce their orders for our products for several reasons. If this happens, our revenue could be greatly reduced, which would materially and adversely affect our business.

If our existing clients do not continue or renew their agreements with us, renew at lower fee levels or decline to purchase additional applications and services from us, our business and operating results will suffer.

We expect to derive a significant portion of our revenue from renewal of existing customer agreements, and sales of additional applications and services to existing clients. As a result, achieving high customer satisfaction to keep existing clients and sell additional platform offerings is critical to our future operating results.

Factors that may affect the renewal rate for our offerings and our ability to sell additional solutions include:

- the price, performance and functionality of our offerings;
- the availability, price, performance and functionality of competing solutions;
- our ability to develop complementary applications and services;
- our continued ability to access the pricing and claims data necessary to enable us to deliver reliable data in our cost estimation and price transparency offering to customers;
- the stability, performance and security of our hosting infrastructure and hosting services;
- changes in healthcare laws, regulations or trends; and
- the business environment of our clients, in particular, headcount reductions by our clients.

For our SaaS solutions, we typically enter into master services agreements with our clients. These agreements generally have stated terms of three to five years. Our clients have no obligation to renew their subscriptions for our offering after the term expires. In addition, our clients may negotiate terms less advantageous to us upon renewal, which may reduce our revenue from these clients. Factors that are not within our control may contribute to a reduction in our contract revenue. For instance, our clients may reduce their number of employees, which would result in a corresponding reduction in the number of employee users eligible for our offering and thus a lower aggregate monthly services fee. Our future operating results also depend, in part, on our ability to sell new solutions to our existing customers. If our clients fail to renew their agreements, renew their agreements upon less favorable terms or at lower fee levels, or fail to purchase new solutions from us, our revenue may decline, or our future revenue may be constrained.

In addition, a significant number of our customer agreements allow our clients to terminate such agreements for convenience at certain times, typically with one to three months advance notice. Any cancellations of such agreements would have a negative result on our business and results of operations.

If any new applications and services we may develop or acquire are not adopted by our customers, or if we fail to continue to innovate and develop or acquire new applications and services that are adopted by customers, then our revenue and operating results will be adversely affected.

In addition to past investments made in NantHealth solutions, and component systems infrastructure and platforms, we have invested, and will continue to invest, significant resources in research and development and in acquisitions to enhance our existing offerings and introduce new high-quality applications and services. For example, we recently expanded into the liquid tumor profiling market through our acquisition of NantHealth Labs. If existing clients are not willing to make additional payments for such new applications or services, or if new clients do not value such new applications or services, our business and operating results will be harmed. If we are unable to predict user preferences or our industry changes, or if we are unable to modify our offering and services on a timely basis, we might lose clients. Our operating results would also suffer if our innovations and acquisitions are not responsive to the needs of our clients, are not appropriately timed with market opportunity or are not effectively brought to market.

Security breaches, loss of data and other disruptions could compromise sensitive information related to our business and/or protected health information or prevent us from accessing critical information and expose us to liability, which could adversely affect our business and our reputation.

In the ordinary course of our business, we and our clients, consultants, contractors and business associates collect and store petabytes of sensitive data, including legally protected health information, personally identifiable information, intellectual property and proprietary business information owned or controlled by ourselves or our clients, payers, providers and partners. We manage and maintain our applications and data by utilizing a combination of on-site systems, managed data center systems, and cloud-based data center systems. These applications and data encompass a wide variety of business-critical information, including research and development information, commercial information and business and financial information. We face four primary risks relative to protecting this critical information, including loss of access risk, inappropriate disclosure risk, inappropriate modification risk and the risk of being unable to adequately monitor our controls over the first three risks.

The secure processing, storage, maintenance and transmission of this critical information is vital to our operations and business strategy, and we devote significant resources to protecting such information. Although we take measures to protect sensitive information from unauthorized access or disclosure, our information technology and infrastructure, and that of our third-party billing and collections provider, may be vulnerable to attacks by hackers or viruses or breached due to employee error, malfeasance or other disruptions. Any such breach or interruption could compromise our networks and the information stored there could be accessed by unauthorized parties, publicly disclosed, lost or stolen. Any such access, disclosure or other loss of information could result in legal claims or proceedings, liability under laws that protect the privacy of personal information, such as the Health Insurance Portability and Accountability Act, or HIPAA, and regulatory penalties. Although we have implemented security measures and a formal, dedicated enterprise security program to prevent unauthorized access to patient data, there is no guarantee we can continue to protect our online portal or will be able to protect our mobile applications from breach. Unauthorized access, loss or dissemination could also disrupt our operations, including our ability to conduct our analyses, provide test results, bill payers, providers or patients, process claims and appeals, provide customer assistance services, conduct research and development activities, collect, process and prepare company financial information, provide information about our products and other patient and physician education and outreach efforts through our website, manage the administrative aspects of our business and damage our reputation, any of which could adversely affect our business.

The U.S. Office of Civil Rights may impose penalties on us if we do not fully comply with requirements of HIPAA. Penalties will vary significantly depending on factors such as whether we knew or should have known of the failure to comply, or whether our failure to comply was due to willful neglect. These penalties include civil monetary penalties of $100 to $50,000 per violation, up to an annual cap of $1,500,000 for identical violations. A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA may face a criminal penalty of up to $50,000 per violation and up to one-year imprisonment. The criminal penalties increase to $100,000 per violation and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 per violation and up to 10 years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain, or malicious harm. The U.S. Department of Justice is responsible for criminal prosecutions under HIPAA. Furthermore, in the event of a breach as defined by HIPAA, we have specific reporting requirements to the Office of Civil Rights under the HIPAA regulations as well as to affected individuals, and we may also have additional reporting requirements to other state and federal regulators, including the Federal Trade Commission, and/or to the media. Issuing such notifications can be costly, time and resource intensive, and can generate significant negative publicity. Breaches of HIPAA may also constitute contractual violations that could lead to contractual damages or terminations.

In addition, the interpretation and application of consumer, health-related and data protection laws in the United States, Europe and elsewhere are often uncertain, contradictory and in flux. It is possible that these laws may be interpreted and applied in a manner that is inconsistent with our practices. If so, this could result in government-imposed fines or orders requiring that we change our practices, which could adversely affect our business. In addition, these privacy regulations vary between states, may differ from country to country, and may vary based on whether testing is performed in the United States or in the local country. Complying with these various laws could cause us to incur substantial costs or require us to change our business practices and compliance procedures in a manner adverse to our business.

We rely on Internet infrastructure, bandwidth providers, data center providers, other third parties and our own systems for providing services to our users, and any failure or interruption in the services provided by these third parties or our own systems could expose us to litigation and negatively impact our relationships with clients, adversely affecting our brand and our business.

Our ability to deliver our internet-based services is dependent on the development and maintenance of the infrastructure of the Internet by third parties. This includes maintenance of a reliable network backbone with the necessary speed, data capacity and security for providing reliable Internet access and services. Our services are designed to operate without interruption in accordance with our service level commitments. However, we expect that we will in the future experience interruptions and delays in services and availability from time to time. We rely on internal systems as well as third-party vendors, including data center providers and bandwidth providers, to provide our services. We store, process and transport petabytes of data and the nature of our business requires us to scale our storage capacity. In the event we are unable to scale appropriately, we may lose clients or fail to realize the network effects of our system and our business may be impaired. We do not maintain redundant systems or facilities for some of these services. In the event of a catastrophic event with respect to one or more of these systems or facilities, we may experience an extended period of system unavailability, which could negatively impact our relationship with users. To operate without interruption, both we and our service providers must guard against:

- damage from fire, power loss and other natural disasters;
- communications failures;
- software and hardware errors, failures and crashes;
- security breaches, computer viruses and similar disruptive problems; and

- other potential interruptions.

Any disruption in the network access or co-location services provided by third-party providers or any failure of or by third-party providers or our own systems to handle current or higher volume of use could significantly harm our business. We exercise limited control over third-party vendors, which increases our vulnerability to problems with services they provide.

Any errors, failures, interruptions or delays experienced in connection with third-party technologies and information services or our own systems could negatively impact our relationships with clients and adversely affect our business and could expose us to third-party liabilities. Although we maintain insurance for our business, the coverage under our policies may not be adequate to compensate us for all losses that may occur. In addition, we cannot provide assurance that we will continue to be able to obtain adequate insurance coverage at an acceptable cost.

The reliability and performance of the Internet may be harmed by increased usage or by denial-of-service attacks. The Internet has experienced a variety of outages and other delays as a result of damages to portions of its infrastructure, and it could face outages and delays in the future. These outages and delays could reduce the level of Internet usage as well as the availability of the Internet to us for delivery of our internet-based services. Any failure to offer high-quality technical support services may adversely affect our relationships with our clients and harm our financial results.

Because of the complexity of the issues facing healthcare providers and payers and the inherent complexity of our solutions to such issues, our clients depend on our support organization to resolve any technical issues relating to our offering. In addition, our sales process is highly dependent on the quality of our offerings, our business reputation and on strong recommendations from our existing clients. Any failure to maintain high-quality and highly responsive technical support, or a market perception that we do not maintain high-quality and highly responsive support, could harm our reputation, adversely affect our ability to sell our offering to existing and prospective clients, and harm our business, operating results and financial condition.

We offer technical support services with our offerings and we may be unable to respond quickly enough to accommodate short-term increases in customer demand for support services, particularly as we increase the size of our customer base. We also may be unable to modify the format of our support services to compete with changes in support services provided by competitors. It is difficult to predict customer demand for technical support services and if customer demand increases significantly, we may be unable to provide satisfactory support services to our clients and their constituents. Additionally, increased customer demand for these services, without corresponding revenue, could increase costs and adversely affect our operating results.

If we cannot implement NantHealth solutions and component systems infrastructure and platforms for customers in a timely manner, we may lose customers and our reputation may be harmed.

Our clients have a variety of different data formats, enterprise applications and infrastructures, and NantHealth solutions and component systems infrastructure and platforms, must support our clients' data formats and integrate with complex enterprise applications and infrastructures. Similarly, our connectivity devices and applications must interact with a wide variety of devices and data formats. If our platforms do not currently support a customer's required data format or appropriately integrate with a customer's applications and infrastructure, then we must configure our systems infrastructure to do so, which increases our expenses. Additionally, we do not control our clients' implementation schedules. As a result, if our clients do not allocate internal resources necessary to meet their implementation responsibilities or if we face unanticipated implementation difficulties, the implementation may be delayed. Further, our implementation capacity has at times constrained our ability to successfully implement our offering for our clients in a timely manner, particularly during periods of high demand. If the customer implementation process is not executed successfully or if execution is delayed, we could incur significant costs, customers could become dissatisfied and decide not to increase usage of our offering, or not to use our offering beyond an initial period prior to their term commitment or, in some cases, revenue recognition could be delayed. In addition, competitors with more efficient operating models with lower implementation costs could penetrate our customer relationships.

Additionally, large and demanding enterprise clients, who currently comprise most of our customer base, may request or require specific features or functions unique to their business processes, which increase our upfront investment in sales and deployment efforts and the revenue resulting from the clients under our typical contract length may not cover the upfront investments. If prospective large customers require specific features or functions that we do not offer, then the market for our offering will be more limited and our business could suffer.

In addition, supporting large clients could require us to devote significant development services and support personnel and strain our personnel resources and infrastructure. Furthermore, if we are unable to address the needs of these clients in a timely fashion or further develop and enhance our offering, or if a client or its constituents are not satisfied with the quality of work performed by us or with the offerings delivered or professional services rendered, then we could incur additional costs to address the situation, we may be required to issue credits or refunds for pre-paid amounts related to unused services, the profitability of that work might be impaired and the client's dissatisfaction with our offerings could damage our ability to expand the number of applications and services purchased by that client. Furthermore, if a client or its constituents do not opt into or need certain aspects of our offering, there may not be enough demand for that aspect of our offering to warrant future purchases by that client, or the client may seek to terminate their relationship with us. These clients may not renew their agreements, seek to terminate their relationship with us or renew on less favorable terms. Moreover, negative publicity related to our client relationships, regardless of its accuracy, may further damage our business by affecting our ability to compete for new business with current and prospective clients. If any of these were to occur, our revenue may decline, and our operating results could be adversely affected.

We face intense competition in our markets, and we may be unable to compete effectively for new clients.

Although our product offerings target the new and emerging market for evidence-based personalized healthcare technology solutions, we compete against a variety of large software vendors and smaller specialized companies, open source initiatives and custom development efforts, which provide solutions in the specific markets we address. Our principal competitors include:

- Payer-provider collaboration vendors such as Availity, LLC, Change Healthcare, Inc. (formerly Emdeon), Experian Information Solutions, Inc. (including its Passport division), Healthx, Inc. and HealthTrio, LLC;
- Medical device data system and device connectivity vendors, such as Qualcomm Technologies, Inc. (formerly Capsule Tech, Inc.), Cerner Corporation, Bernoulli Enterprise, Inc., General Electric Company and Medical Information Technology, Inc.; and
- Healthcare information technology decision support vendors such as The Advisory Board Company, Castlight Health, Inc., or Castlight Health, eviCore healthcare, HealthCatalyst, Inc., or HealthCatalyst, International Business Machines Corporation, or IBM, Inovalon Holdings, Inc., or Inovalon, and Truven Health Analytics, or Truven (acquired by IBM).

The principal competitive factors in our markets include product features, performance and support, product scalability and flexibility, ease of deployment and use, total cost of ownership and time to value. Some of our actual and potential competitors have advantages over us, such as longer operating histories, significantly greater financial, technical, marketing or other resources, stronger brand and business user recognition, larger intellectual property portfolios and broader global distribution and presence. Further, competitors may be able to offer products or functionality similar to ours at a more attractive price than we can by integrating or bundling their software products with their other product offerings. In addition, our industry is evolving rapidly and is becoming increasingly competitive. Larger and more established companies may focus on creating a learning system or solutions that could directly compete with one or more of our offerings. If companies move a greater proportion of their data and computational needs to the cloud, new competitors may emerge which offer services comparable to ours or that are better suited for cloud-based data, and the demand for one or more of our offerings may decrease. Smaller companies could also launch new products and services that we do not offer and that could gain market acceptance quickly.

In recent years, there have been significant acquisitions and consolidation by and among our actual and potential competitors. We anticipate this trend of consolidation will continue, which will present heightened competitive challenges to our business. In particular, consolidation in our industry increases the likelihood of our competitors offering bundled or integrated products, and we believe that it may increase the competitive pressures we face with respect to our solutions. If we are unable to differentiate one or more of our offerings from the integrated or bundled products of our competitors, such as by offering enhanced functionality, performance or value, we may see decreased demand for those solutions, which would adversely affect our business, results of operations, financial condition and cash flows. Further, it is possible that continued industry consolidation may impact our clients' and prospective clients' perceptions of the viability of smaller or even medium-sized software firms and, consequently, their willingness to use technology solutions from such firms. Similarly, if customers seek to concentrate their technology purchases in the product portfolios of a few large providers, we may be at a competitive disadvantage regardless of the performance and features of our offerings. We believe that in order to remain competitive at the large enterprise level, we will need to develop and expand relationships with resellers and large system integrators that provide a broad range of products and services. If we are unable to compete effectively, our business, results of operations, financial condition and cash flows could be materially and adversely affected.

The healthcare technology industry in which we operate is subject to rapidly changing technologies and trends, each of which could contribute to making our products obsolete.

The markets for cloud-based data platforms and internet-based business services such as NantHealth solutions and component systems infrastructure and platforms and their associated offerings, are in the early stages of development, but the market is competitive even at this stage, and we expect it to attract increased competition, which could make it hard for us to succeed. We currently face competition for one or more of our offerings from a range of companies, including EHR vendors such as Allscripts, Cerner, Epic, and GE Healthcare, and healthcare IT decision support vendors such as Castlight Health, IBM, Inovalon and Truven (acquired by IBM). In addition, large, well-financed health plans, with whom we cooperate and on whom we depend in order to obtain the pricing and claims data we need to deliver our offerings to customers have in some cases developed their own cost and quality estimation tools and provide these solutions to their customers at discounted prices or often for free. If enterprises do not perceive the benefits of our services, then the market for these services may not develop at all, or it may develop more slowly than we expect, either of which would materially adversely affect our operating results. In addition, as a new company in this unproven market, we have limited insight into trends that may develop and affect our business. We may make errors in predicting and reacting to relevant business trends, which could harm our business. If any of these risks occur, it could materially adversely affect our business, financial condition or results of operations.

Healthcare industry consolidation could impose pressure on our prices, reduce our potential client base and reduce demand for one or more of our offerings.

Many hospitals, imaging centers and third-party payers have consolidated to create larger healthcare enterprises with greater market and purchasing power. In addition, group purchasing organizations and managed care organizations could increase pressure on providers of healthcare related services to reduce prices. If this consolidation trend continues, it could reduce the size of our potential customer base and give the resulting enterprises greater bargaining or purchasing power, which may lead to erosion of the prices for our software or decreased margins for our offerings.

Our offerings may experience quality problems from time to time that can result in decreased sales, decreased operating margins and harm to our reputation.

We sell complex hardware and software products and services that may contain design and manufacturing defects. Sophisticated operating system software and applications, such as those sold by us, often contain “bugs” that can unexpectedly interfere with the software’s intended operation. Our online services may from time to time experience outages, service slowdowns, or errors. Defects may also occur in components and products we purchase from third parties. There can be no assurance we will be able to detect and fix all defects in the hardware, software and services third parties sell to us. Failure to do so could result in lost revenue, significant warranty and other expenses and harm to our reputation.

Risks related to our connected care solutions, hardware and software

We rely on third-party manufacturers to manufacture our connected care devices, such as HBox, GlowPack and GlowCap. Any failure by a third-party manufacturer to produce supplies for us may delay or impair our ability to provide our connected care devices, which are an integral part of our learning ecosystem.

We rely upon third parties for the manufacture of our connected care devices and intend to continue to do so in the future. We currently do not have any material agreements with third-party manufacturers for our connected care devices. As demand for our products increase, we may seek to enter into long-term third-party manufacturing agreements. If our third-party manufacturers are unable to deliver sufficient quantities of products on a timely basis or we encounter difficulties in our relationships with these manufacturers, the manufacture and sale of our products may be disrupted, and our business, operating results and reputation could be adversely affected. If we are unable to arrange for third-party manufacturing sources, or unable to do so on commercially reasonable terms, we may not be able to deliver our products to clients in a timely manner, or at all.

Reliance on third-party manufacturers entails risks to which we would not be subject if we manufactured product candidates ourselves, including reliance on the third party to comply with applicable regulatory laws, the possibility of breach of the manufacturing agreement by the third party because of factors beyond our control and the possibility of termination or nonrenewal of the agreement by the third party, based on its own business priorities, at a time that is costly or damaging to us. In addition, the FDA and other regulatory authorities require that certain of our connected care devices be manufactured in compliance with Quality System Regulations, or QSR, and similar standards in foreign markets where we sell our products. Any failure by our third-party manufacturers to comply with QSR or failure to scale up manufacturing processes as needed, including any failure to deliver sufficient quantities of products in a timely manner, could have a material adverse effect on our business, financial condition, operating results and cash flows. In addition, such failure could be the basis for action by the FDA to withdraw approvals for product candidates previously granted to us and for other regulatory action.

Our solutions, including our connectivity care hardware and software may experience design or manufacturing defects from time to time that can result in reduced network effects to NantHealth solutions and component systems infrastructure and platforms which could materially and adversely affect our business.

We sell hardware and software solutions, including our connected care hardware and software, that could contain design or manufacturing defects in their materials, hardware, or software. These defects could include defective materials or components, or “bugs” that can unexpectedly interfere with the products’ intended operations or result in inaccurate data. Failure to detect, prevent, or fix defects could result in a variety of consequences, including returns of products, regulatory proceedings, product recalls, and litigation, which could harm our revenue and operating results. If our products fail to provide accurate measurements and data to users, then the network effects of our adaptive clinical learning system may be materially and adversely impacted.

Our solutions, including our connectivity connected care hardware and software could give rise to product liability claims and product recall events that could materially and adversely affect our financial condition and results of operations.

The development, manufacturing and sale of medical devices expose us to significant risk of product liability claims, product recalls and, occasionally, product failure claims. We face an inherent business risk of financial exposure to product liability claims if the use of our connected care devices, including our connectivity suite hardware and software results in personal injury or death. Substantial product liability litigation currently exists within the medical device industry. Some of our connected care devices may become subject to product liability claims and/or product recalls. Future product liability claims and/or product recall costs may exceed the limits of our insurance coverages or such insurance may not continue to be available to us on commercially reasonable terms, or at all. In addition, a significant product liability claim or product recall could significantly damage our reputation for producing safe, reliable and effective products, making it more difficult for us to market and sell our products in the future. Consequently, a product liability claim, product recall or other claim could have a material adverse effect on our business, financial condition, operating results and cash flows.

The sale of medical device products in the United States is subject to government regulations and we may not be able to obtain certain necessary clearances or approvals.

The design, manufacturing, labeling, distribution and marketing of medical devices in the United States are subject to extensive and rigorous regulation by the FDA. Unless an exemption applies, we or our collaborative partners must obtain prior clearance or approval from the FDA for medical devices we intend to commercialize, which can be expensive and uncertain and can cause lengthy delays before we can begin selling our products. We cannot be sure that:

- we or any collaborative partner will make timely filings with the FDA;
- the FDA will act favorably or quickly on these submissions;
- we or any collaborative partner will not be required to submit additional information;
- we or any collaborative partner will not be required to submit an application for premarket approval, rather than a 510(k) premarket notification submission as described below; or
- other significant difficulties and costs related to obtaining FDA clearance or approval will not be encountered.

The FDA may impose strict labeling or other requirements as a condition of its clearance or approval, any of which could limit our ability to market our products. Further, if we or our collaborative partners wish to modify a product after FDA clearance of a premarket notification or approval of a premarket approval application, including changes in indications or other modifications that could affect safety and efficacy, additional clearances or approvals will be required from the FDA. Any request by the FDA for additional data, or any requirement by the FDA that we or our collaborative partners conduct clinical studies or submit to the more rigorous and lengthier premarket approval process, could result in substantial expenses and significant delays in bringing our products to market. Similarly, any labeling or other conditions or restrictions imposed by the FDA on the marketing of our products could hinder our ability to effectively market our products. Any of the above actions by the FDA could delay or prevent altogether our ability to market and distribute our products. Further, there may be new FDA policies or changes in FDA policies that could be adverse to us.

Even if we obtain clearance or approval to sell medical device products, we are subject to ongoing requirements and inspections that could lead to the restriction, suspension or revocation of our clearance.

Ongoing compliance with applicable regulatory requirements will be strictly enforced in the United States through periodic inspections by state and federal agencies, including the FDA, and in international jurisdictions by comparable regulatory authorities. In the past, we have conducted investigations designed to determine whether we meet such regulatory requirements and have identified non-conformances and areas that need improvement. Though we strive to comply with such regulations, there can be no guarantee that the applicable regulators will find that we are in compliance with such regulations in the future. Failure to comply with these regulatory requirements could result in, among other things, warning letters, fines, injunctions, civil penalties, recall or seizure of products, total or partial suspension of production, failure to obtain premarket clearance or premarket approval for devices, withdrawal of approvals previously obtained, and criminal prosecution. The restriction, suspension or revocation of regulatory clearances and approvals or any other failure to comply with regulatory requirements would limit our ability to operate and could increase our costs.

Risks related to our relationships with other companies

Our ability to achieve profitability is dependent upon the success of NantOmics.

We currently secure all of our rights to our sequencing and molecular analysis solutions, including GPS Cancer, from NantOmics. The prospects for these offerings depend in part on the expertise and financial strength of NantOmics, which is controlled by Dr. Patrick Soon-Shiong, our Chairman and Chief Executive Officer. We rely on NantOmics to handle certain aspects of our sequencing and molecular analysis solutions, including GPS Cancer, including but not limited to:

- acquiring appropriate and cost-efficient supplies to produce our sequencing and molecular analysis solutions;
- delivering our sequencing and molecular analysis solutions in a timely manner to us;
- continuing to keep our sequencing and molecular analysis solutions up to date and on pace with current clinical and market developments;
- filing, prosecuting and maintaining patents that cover our sequencing and molecular analysis solutions;
- complying with CLIA regulations and maintaining a CLIA license and all other applicable state laboratory licenses, including through periodic inspections; and
- hiring qualified personnel experienced in completing highly complex laboratory tests.

We are responsible for various aspects of delivering our sequencing and molecular analysis solutions, including but not limited to communications with patients and providers such as providing interpretations of the GPS Cancer reports and resolving any disputes, ensuring customer satisfaction, billing and collections and patient and physician engagement. At December 31, 2018, September 30, 2018, June 30, 2017 and December 31, 2016, we determined that other than temporary impairments of $14.8 million, $80.4 million, $33.9 million and $29.8 million, respectively, in the value of the investment in NantOmics had occurred, predominantly attributed to declines in the value of goodwill. The estimated decline in fair value at December 31, 2018 was primarily due to altered pricing assumptions for the reseller agreement between the Company and NantOmics. The estimated declines in fair value at September 30, 2018, June 30, 2017 and December 31, 2016 were primarily caused by changes in projected GPS Cancer revenue, due to delays in the Company's GPS Cancer revenue growth and changes in the risk profile of our financial projections for NantOmics. If NantOmics is unable to successfully handle its aspects of our sequencing and molecular analysis solutions or we are unable to successfully handle our aspects of delivering our sequencing and molecular analysis solutions, our business will be adversely affected.

If we are unable to renew our agreement with NantOmics or locate a suitable replacement upon expiration of such agreement at comparable prices, our business would be materially and adversely affected.

Our second amended and restated exclusive reseller agreement with NantOmics, as amended, or the Reseller Agreement, expires on December 31, 2020, subject to three potential three-year renewal options if we complete specified projected GPS Cancer test thresholds. Although NantOmics generally does not have the right to terminate prior to that date, we may be unable to renew such agreement or execute a new arrangement at comparable favorable prices to provide us with molecular profiling tests. In addition, we may not be able to achieve our projected renewal thresholds. Furthermore, NantOmics currently has what we believe is the most comprehensive and clinically validated CAP- and CLIA-certified whole genome and RNA laboratory. If we were unable to fulfill our delivery requirements for our sequencing and molecular analysis solutions to our clients, our business would be materially and adversely affected.

Additionally, through our agreement with NantOmics, we purchase our sequencing and molecular analysis solutions, including GPS Cancer, at a discount to market price. We also receive revenue from our sale of NantOmics' whole genome sequencing and RNA analysis. If we are reimbursed at an amount equal to or less than a certain threshold, our GPS Cancer solution will not be profitable and our business will be materially and adversely affected. Since we expect that pricing pressure from government and third party payers, increasing competition from companies and others offering whole genome sequencing and reductions in the costs of providing whole genome sequencing as technologies mature, will combine to drive the price of whole genome sequencing down, we cannot guarantee that the price we are able to charge for our GPS Cancer solution will continue to yield a profit under the terms of the exclusive reseller agreement.

We rely on third-party computer hardware and software that may be difficult to replace or which could cause errors or failures of our service which could damage our reputation, harm our ability to attract and maintain clients and decrease our revenue.

We rely on computer hardware purchased or leased and software licensed from third parties in order to offer our service. These licenses are generally commercially available on varying terms; however, it is possible that this hardware and software may not continue to be available on commercially reasonable terms, or at all. Any loss of the right to use any of this hardware or software could result in delays in providing NantHealth solutions (including Eviti, Navinet apps, Connected Care solutions, and our sequencing and molecular analysis solutions) until equivalent technology is either developed by us, or, if available, is identified, obtained and integrated, which could harm our business. Any errors or defects in third-party hardware or software could result in errors or a failure of our service which could damage our reputation, harm our ability to attract and maintain clients and decrease our revenue.

We are heavily dependent on our senior management, particularly Dr. Patrick Soon-Shiong, and a loss of a member of our senior management team in the future could harm our business.

If we lose members of our senior management, we may not be able to find appropriate replacements on a timely basis, and our business could be adversely affected. Our existing operations and continued future development depend to a significant extent upon the continued performance and active participation of certain key individuals, including Dr. Patrick Soon-Shiong, our Chairman, Chief Executive Officer and our principal stockholder. Although we expect Dr. Patrick Soon-Shiong will continue to devote on average at least 20 hours per week to our company, he will continue to primarily focus on NantKwest, Inc., or NantKwest, a publicly-traded, clinical-stage immunotherapy company, of which he is Chairman and Chief Executive Officer. Dr. Patrick Soon-Shiong will also devote time to other companies operating under NantWorks, a collection of multiple companies in the healthcare and technology space that Dr. Patrick Soon-Shiong founded in 2011. We do not believe Dr. Patrick Soon-Shiong has any material conflicting obligations as a result of his involvement with other companies. Additionally, we are dependent on commercial relationships with various other parties affiliated with NantWorks and with Dr. Patrick Soon-Shiong, including NantOmics, as described in Note 18 of the accompanying notes to the Consolidated Financial Statements, and we may enter into additional relationships in the future. If Dr. Patrick Soon-Shiong was to cease his affiliation with us or with NantWorks, these entities may be unwilling to continue these relationships with us on commercially reasonable terms, or at all. The risks related to our dependence upon Dr. Patrick Soon-Shiong are particularly acute given his ownership percentage and role in our company. If we were to lose Dr. Patrick Soon-Shiong, we may not be able to find appropriate replacements on a timely basis and our financial condition and results of operations could be materially adversely affected. We have not entered into, nor do we intend to enter into, an employment agreement with Dr. Patrick Soon-Shiong.

We face significant competition for employees from other healthcare-related companies, which include both publicly-traded and privately-held companies, and we may not be able to hire new employees quickly enough to meet our needs. To induce valuable employees to remain at our company, in addition to salary and cash incentives, we have provided equity incentives that vest over time and, in some cases, upon the occurrence of certain events. The value to employees of these equity incentives that vest over time may be significantly affected by movements in our stock price that are beyond our control and may at any time be insufficient to counteract more lucrative offers from other companies. Although we have employment agreements with certain of our key employees, these employment agreements provide for at-will employment, which means that any of our employees could leave our employment at any time, with or without notice. We do not maintain "key man" insurance policies on the lives of these individuals or the lives of any of our other employees.

If we and NantOmics are unable to support demand for our sequencing and molecular analysis solutions, including GPS Cancer and Liquid GPS, including ensuring that we have adequate capacity to meet increased demand, or we or NantOmics are unable to successfully manage the evolution of its molecular information platform, our business could suffer.

As our volume grows, we and NantOmics will need to increase capacity and improve processes to support growing demand. Our sequencing and molecular analysis solutions will need additional certified laboratory scientists and other scientific and technical personnel to process higher volumes of our molecular information products. Portions of our process are not automated and will require additional personnel to scale. We and NantOmics will also need to purchase additional equipment, some of which can take several months or more to procure, setup and validate, and will need to increase our software and computing capacity to meet increased demand. There is no assurance that any of these increases in scale, expansion of personnel, equipment, software and computing capacities, or process enhancements will be successfully implemented.

As additional products are commercialized, including molecular profiling solutions for additional disease indications, we and NantOmics will need to incorporate new equipment, implement new technology systems and laboratory processes, and hire new personnel with different qualifications. Failure to manage growth or a transition to new technologies or processes could result in turnaround time delays, higher product costs, declining product quality, deteriorating customer service, and slower responses to competitive challenges. A failure in any one of these areas could make it difficult for us to meet market expectations for our products and could damage our reputation and the prospects for our business.

Risks related to our business generally

We have in the past and may in the future acquire other companies or technologies, which could divert our management's attention, result in dilution to our stockholders and otherwise disrupt our operations and adversely affect our operating results.

Part of our business model is the acquisition of technologies and businesses that promote our transformational vision for personalized healthcare. We have in the past and may in the future seek to acquire or invest in additional businesses, applications, services and/or technologies that we believe complement or expand our offerings, enhance our technical capabilities or otherwise offer growth opportunities. The pursuit of potential acquisitions may divert the attention of management and cause us to incur various expenses in identifying, investigating and pursuing suitable acquisitions, whether or not they are consummated.

For example, in January 2016, we acquired NaviNet to bolster our payer platform and, in February 2018, we acquired NantHealth Labs to expand into the liquid tumor profiling market. Realizing the benefits of these acquisitions and any future acquisition depend upon the successful integration into our existing operations, and we may not be able to integrate the acquired personnel, operations and technologies successfully, or effectively manage the combined business following the acquisition. We also may not realize the anticipated benefits from any acquired business due to several factors, including:

- inability to integrate or benefit from acquired technologies or services in a profitable manner;
- unanticipated costs or liabilities associated with the acquisition;
- difficulty integrating the accounting systems, operations and personnel of the acquired business;
- difficulties and additional expenses associated with supporting legacy products and hosting infrastructure of the acquired business;
- difficulty converting the customers of the acquired business onto our platform and contract terms, including disparities in the revenue, licensing, support or professional services model of the acquired company;
- difficulty in cross-selling our existing solutions and offerings to the acquired business' customers;
- diversion of management's attention from other business concerns;
- adverse effects to our existing business relationships with business partners and customers as a result of the acquisition;
- the potential loss of key employees;
- use of resources that are needed in other parts of our business; and
- use of substantial portions of our available cash to consummate the acquisition.

In addition, a significant portion of the purchase price of companies we acquire may be allocated to acquired goodwill and other intangible assets, which must be assessed for impairment at least annually. As of December 31, 2018 , the value of our goodwill and intangible assets, net of accumulated amortization was $115.9 million and $64.7 million , respectively. If our acquisitions do not yield expected returns, we have in the past, and may in the future, be required to take charges to our operating results based on this impairment assessment process, which could adversely affect our results of operations.

Acquisitions could also result in dilutive issuances of equity securities or the incurrence of debt, which could adversely affect our operating results. In addition, if the acquisition of NaviNet, NantHealth Labs, or any other business we may acquire in the future fails to meet our expectations, our operating results, business and financial position may suffer.

We cannot assure you that we will be successful in integrating certain assets of NaviNet, NantHealth Labs, or any other businesses or technologies we may acquire. The failure to successfully integrate these businesses could have a material adverse effect on our business, financial condition, or results of operations.

I f our new components and enhancements to our test platform do not achieve sufficient market acceptance, our financial results and competitive position will suffer.

We and NantOmics spend substantial amounts of time and money to research and develop new tests and to optimize the utility and value of our tests for physicians and their patients. When we develop a new component or enhancement to our test platform, we typically incur expenses and expend resources upfront to develop, market and promote the new component. Therefore, when we develop and introduce new components or enhancements to our test platform, they must achieve high levels of market acceptance in order to justify the amount of our investment in developing and bringing them to market. For example, if GPS Cancer and Liquid GPS do not garner widespread market adoption and implementation, our growth prospects, future financial results and competitive position could suffer.

Our new components or enhancements to our test platform and changes to our test platform could fail to attain sufficient market acceptance for many reasons, including:

- our failure to predict physician and patient market demand accurately in terms of test platform functionality and to supply a test platform that meets this demand in a timely fashion
- delays in releasing to the market our new components or enhancements to our test platform to the market;
- failing to keep our sequencing and molecular analysis solutions up to date and on pace with current clinical and market developments;
- complexity in the implementation or utilization of the new components and enhancements;
- negative publicity about their performance or effectiveness;
- introduction or anticipated introduction of competing test platforms and products by our competitors;
- poor business conditions for our physician customers, causing them to delay IT purchases.

If our new components or enhancements and changes do not achieve adequate acceptance in the market, physician customers and their patients may choose to use a competitor's platform instead, our competitive position would be impaired, and our revenue would be diminished. The adverse effect on our financial results may be particularly acute because of the significant research, development, marketing, sales and other expenses we would have incurred in connection with the new components or enhancements.

Business disruptions could seriously harm our future revenue and financial condition and increase our costs and expenses.

Our operations, and those of our contractors and consultants, could be subject to earthquakes, power shortages, telecommunications failures, water shortages, floods, hurricanes, typhoons, fires, extreme weather conditions, medical epidemics, acts of terrorism, acts of war and other natural or man-made disasters or business interruptions, for which we are predominantly self-insured. Our corporate headquarters are in Culver City, California near major earthquake faults and fire zones. We attempt to mitigate these risks through various means including redundant infrastructure, disaster recovery plans, separate test systems and change control and system security measures, but our precautions will not protect against all potential problems. If our clients' access is interrupted because of problems in the operation of our facilities, we could be exposed to significant claims by clients or their patients, particularly if the access interruption is associated with problems in the timely delivery of funds due to clients or medical information relevant to patient care. The occurrence of any of these business disruptions could seriously harm our operations and financial condition and increase our costs and expenses.

As of the date of this Annual Report on Form 10-K, we serve our clients primarily from third-party data hosting facilities. We do not control the operation of these third-party facilities, and they are vulnerable to damage or interruption from earthquakes, floods, fires, power loss, telecommunications failures and similar events. They are also subject to break-ins, sabotage, intentional acts of vandalism and similar misconduct. Despite precautions taken at these facilities, the occurrence of a natural disaster or a crime, a decision to close the facilities without adequate notice or other unanticipated problems at these facilities could result in lengthy interruptions in our service. Even with the disaster recovery arrangements, our service could be interrupted.

We may, from time to time, transition our data hosting to new or alternative providers. In connection with these transitions, we will be moving, transferring or installing some of our equipment, data and software to and in other facilities. Despite precautions taken during this process, any unsuccessful transfers may impair the delivery of our one or more of our offerings. Further, any damage to, or failure of, our systems generally could result in interruptions in one or more of our offerings. Interruptions in our service may reduce our revenue, cause us to issue credits or pay penalties, may cause clients to terminate one or more of our offerings and may adversely affect our renewal rates and our ability to attract new clients. Our business may also be harmed if our clients and potential clients believe one or more of our offerings are unreliable.

If we fail to develop widespread brand awareness, our business may suffer.

We believe that developing and maintaining widespread awareness of our brand is critical to achieving widespread adoption of our offering and attracting new customers. Brand promotion activities may not generate customer awareness or increase revenue, and even if they do, any increase in revenue may not offset the expenses we incur in building our brand. If we fail to successfully promote and maintain our brand, or incur substantial expenses in doing so, we may fail to attract or retain customers necessary to realize a sufficient return on our brand-building efforts, or to achieve the widespread brand awareness that is critical for broad customer adoption of our offerings.

Our marketing efforts depend significantly on our ability to receive positive references from our existing customers.

Our marketing efforts depend significantly on our ability to call on our current customers to provide positive references to new, potential customers. Given our limited number of long-term customers, the loss or dissatisfaction of any customer could substantially harm our brand and reputation, inhibit the market adoption of our offerings and impair our ability to attract new customers and maintain existing customers. Any of these consequences could have a material adverse effect on our business, financial condition and results of operations.

If we become subject to product liability or other litigation, we may incur substantial liabilities and may be required to limit commercialization of our current and any future products.

We are from time to time subject to legal proceedings and claims that arise in the ordinary course of business, such as claims brought by our clients in connection with commercial disputes and employment claims made by our current or former employees. For example, two of our former employees filed a complaint against us alleging they were terminated in violation of Florida's Whistleblower Act, which was settled. Litigation, regardless of merit, may result in substantial costs and may divert management's attention and resources, which may harm our business.

Our services, some of which involve recommendations and advice to healthcare providers regarding complex business and operational processes, regulatory and compliance issues and patient treatment options, may give rise to liability claims by our members or by third parties who bring claims against us. In addition, third parties, including former employees, have in the past, and may in the future, file lawsuits alleging non-compliance with government regulations. Investigating and defending such claims, even if they lack merit, may require significant time and resources and could damage our reputation and harm our business.

In addition, our home healthcare services business, which includes a skilled nursing facility, employs healthcare providers in the home care setting. Healthcare providers in the home care setting increasingly are the subject of litigation, and we cannot assure you that we would not also be the subject of such litigation based on our offerings. In addition, the marketing, sale and use of our offering could lead to the filing of product liability claims were someone to allege that one or more of our offerings identified inaccurate or incomplete information regarding the genomic alterations of the tumor or malignancy analyzed, reported inaccurate or incomplete information concerning the available therapies for a certain type of cancer, or otherwise failed to perform as designed. We may also be subject to liability for errors in, a misunderstanding of, or inappropriate reliance upon, the information we provide in the ordinary course of our business activities. A product liability claim could result in substantial damages and be costly and time-consuming for us to defend.

We maintain product and other insurance, but this insurance may not fully protect us from the financial impact of defending against product liability or other claims. Any product liability or other claim brought against us, with or without merit, could increase our insurance rates or prevent us from securing insurance coverage in the future. Additionally, any product liability lawsuit could damage our reputation, or cause current clients to terminate existing agreements and potential clients to seek other vendors, any of which could impact our results of operations.

We are subject to changes in and interpretations of financial accounting matters that govern the measurement of our performance, one or more of which could adversely affect our business.

Based on our reading and interpretations of relevant guidance, principles or concepts issued by, among other authorities, the American Institute of Certified Public Accountants, the Financial Accounting Standards Board and the Securities and Exchange Commission, or SEC, we believe our current sales and licensing contract terms and business arrangements have been properly reported. However, this guidance involves interpretations, and there continue to be issued interpretations and guidance for applying the relevant standards to a wide range of sales and licensing contract terms and business arrangements that are prevalent in the software industry. For example, we must apply significant judgment to determine whether revenue should be recognized on a gross or net basis for our reseller arrangements, including revenue under our reseller agreement with NantOmics. Disagreement with the regulators as to our current interpretations and any future changes by the regulators of existing accounting standards or changes in our business practices could result in changes in our revenue recognition and/or other accounting policies and practices that could adversely affect our business.

Failure to manage our future growth effectively could increase our expenses, decrease our revenue and prevent us from implementing our business strategy.

We have been experiencing a period of growth. To manage our anticipated future growth effectively, we must continue to maintain and may need to enhance our information technology infrastructure, financial and accounting systems and controls and manage expanded operations in geographically-diverse locations. We also must attract, train and retain a significant number of qualified sales and marketing personnel, professional services personnel, software engineers, technical personnel and management personnel. Failure to manage our rapid growth effectively could lead us to over invest or under invest in technology and operations, could result in weaknesses in our infrastructure, systems or controls, could give rise to operational mistakes, losses, loss of productivity or business opportunities, and could result in loss of employees and reduced productivity of remaining employees. Our growth could require significant capital expenditures and may divert financial resources from other projects, such as the development of new services. If our management is unable to effectively manage our growth, our expenses may increase more than expected, our revenue could decline or may grow more slowly than expected, and we may be unable to implement our business strategy.

Our estimates of market opportunity and forecasts of market growth may prove to be inaccurate, and even if the market in which we compete achieves the forecasted growth, our business could fail to grow at similar rates, if at all.

Our market opportunity estimates and growth forecasts are subject to significant uncertainty and are based on assumptions and estimates that may not prove to be accurate. Our estimates and forecasts regarding the size and expected growth of the healthcare information technology and molecular analysis markets may prove to be inaccurate. Even if the markets in which we compete meet our size estimates and forecasted growth, our business could fail to grow at similar rates, if at all.

The industry-and market-related estimates we rely upon are based on various assumptions and may prove to be inaccurate.

Industry-and market-related estimates we rely upon, including, without limitation, estimates related to our market size and industry data, are subject to uncertainty and are based on assumptions which may not prove to be accurate. This may have negative consequences, such as us overestimating our potential market opportunity.

We are exposed to risks related to our international operations and failure to manage these risks may adversely affect our operating results and financial condition.

We are a global company with operations both inside and outside the United States. For example, we have foreign wholly owned subsidiaries, including NantHealth Singapore Pte Ltd., New NantHealth Canada, Inc. and Navinet Limited. As a result, a portion of our operations are conducted by and/or rely on entities outside the United States. We may therefore be denied access to our customers or suppliers as a result of economic, legislative, political and military conditions in such countries.

International operations are subject to several other inherent risks, and our future results could be adversely affected by several factors, including:

- requirements or preferences for domestic products or solutions, which could reduce demand for our products;
- differing existing or future regulatory and certification requirements;
- management communication and integration problems resulting from cultural and geographic dispersion;
- greater difficulty in collecting accounts receivable and longer collection periods;
- difficulties in enforcing contracts;
- difficulties and costs of staffing and managing non-U.S. operations;
- the uncertainty of protection for intellectual property rights in some countries;
- tariffs and trade barriers, export regulations and other regulatory and contractual limitations on our ability to sell our products;

- greater risk of a failure of foreign employees to comply with both U.S. and foreign laws, including export and antitrust regulations, the FCPA and any trade regulations ensuring fair trade practices;
- heightened risk of unfair or corrupt business practices in certain geographies and of improper or fraudulent sales arrangements that may impact financial results and result in restatements of, or irregularities in, financial statements;
- potentially adverse tax consequences, including multiple and possibly overlapping tax structures; and
- political and economic instability, political unrest and terrorism.

In addition, the expansion of our existing international operations and entry into additional international markets has required, and will continue to require, significant management attention and financial resources. These factors and other factors could harm our ability to gain future revenues and, consequently, materially impact our business, financial condition and results of operations.

The United Kingdom's vote to leave the European Union will have uncertain effects and could adversely affect us.

On June 23, 2016, a referendum was held on the UK's membership in the European Union, or the EU, the outcome of which was a vote in favor of leaving the EU, or the Brexit. Negotiations began in March 2017 to determine the future terms of the UK's relationship with the EU, including the terms of trade between the UK and the EU and the rest of the world. Article 50 of the Treaty of the European Union, or Article 50, allows a member state to decide to withdraw from the European Union in accordance with its own constitutional requirements. On February 1, 2017, the UK Parliament voted in favor of allowing the UK to start the process of leaving the European Union and authorized the filing an Article 50 notice to that end, which was delivered to the European Union in March 2017. Delivery of the Article 50 notice commenced a two-year period for the United Kingdom to exit from the European Union, although this period can be extended with the unanimous agreement of the European Council. Without any such extension (and assuming that the terms of withdrawal have not already been agreed), the United Kingdom's membership in the European Union would end automatically on the expiration of that two-year period. The effects of Brexit will depend on agreements the UK makes to retain access to EU markets either during a transitional period or more permanently. Brexit creates an uncertain political and economic environment in the UK and potentially across other EU member states for the foreseeable future, including during any period while the terms of Brexit are being negotiated and such uncertainties could impair or limit our ability to transact business in the member EU states. Further, Brexit could adversely affect European and worldwide economic or market conditions and could contribute to instability in global financial markets, and the value of the Pound Sterling currency or other currencies, including the Euro. We are exposed to the economic, market and fiscal conditions in the UK and the EU and to changes in any of these conditions. Depending on the terms reached regarding Brexit, it is possible that there may be adverse practical and/or operational implications on our business. A significant amount of the regulatory regime that applies to us in the UK is derived from EU directives and regulations. For so long as the UK remains a member of the EU, those sources of legislation will (unless otherwise repealed or amended) remain in effect. However, Brexit could change the legal and regulatory framework within the UK where we operate and is likely to lead to legal uncertainty and potentially divergent national laws and regulations as the UK determines which EU laws to replace or replicate. Consequently, no assurance can be given as to the impact of Brexit and, in particular, no assurance can be given that our operating results, financial condition and prospects would not be adversely impacted by the result.

Risks related to intellectual property

We may be unable to adequately protect, and we may incur significant costs in enforcing, our intellectual property and other proprietary rights.

Our success depends in part on our ability to enforce our intellectual property and other proprietary rights. We rely upon a combination of trademark, trade secret, copyright, patent and unfair competition laws, as well as license and access agreements and other contractual provisions, to protect our intellectual property and other proprietary rights. In addition, we attempt to protect our intellectual property and proprietary information by requiring certain of our employees and consultants to enter into confidentiality, noncompetition and assignment of inventions agreements. Any disclosure to or misappropriation by third parties of our confidential proprietary information could enable competitors to quickly duplicate or surpass our technological achievements, eroding our competitive position in the market. Moreover, we do not have any written contractual agreements with respect to any intellectual property and technology that relate to our business developed in the future by our Chairman and Chief Executive Officer, Dr. Patrick Soon-Shiong. In the event we are unable to protect our intellectual property and proprietary information, including in particular with respect to such property or information created by Dr. Patrick Soon-Shiong, our business would be adversely affected. In addition, our attempts to protect our intellectual property may be challenged by others or invalidated through administrative process or litigation.

We have developed, acquired, and licensed numerous patents and patent applications and we possess substantial know-how and trade secrets relating to the development and commercialization of healthcare technology products and services. In January 2016, we acquired NaviNet, a leading payer-provider collaboration platform, and in February 2018 we acquired NantHealth Labs, a liquid tumor profiling company. As part of these and other acquisitions, we acquired patents and other intellectual property. As of December 31, 2018, our patent portfolio consisted of the following matters relating to our proprietary technology and inventions: (i) seven issued U.S. patents, including six U.S. utility patents and one U.S. design patent; (ii) eighteen pending U.S. patent applications, including sixteen U.S. utility patent applications and two U.S. design patent applications; (iii) one issued patent outside the United States; and (iv) seventeen patent applications pending in jurisdictions outside the United States. Of these U.S. and non-U.S. patents and applications, two patents and seven applications were jointly owned. We believe we have intellectual property rights that are necessary to commercialize our healthcare technology products and services. However, our patent applications may not result in issued patents, and, even if issued, the patents may be challenged and invalidated. Moreover, our patents and patent applications may not be sufficiently broad to prevent others from practicing our technologies or developing competing products. We also face the risk that others may independently develop similar or alternative technologies or may design around our proprietary property.

If any patents are issued in the future, they may not provide us with any competitive advantages, or may be successfully challenged by third parties. Agreement terms that address non-competition are difficult to enforce in many jurisdictions and may not be enforceable in any particular case. To the extent that our intellectual property and other proprietary rights are not adequately protected, third parties might gain access to our proprietary information, develop and market products or services similar to ours, or use trademarks similar to ours, each of which could materially harm our business. Existing United States federal and state intellectual property laws offer only limited protection. Moreover, the laws of other countries in which we now, or may in the future, conduct operations or contract for services may afford little or no effective protection of our intellectual property. Further, our platforms incorporate open source software components that are licensed to us under various public domain licenses. While we believe we have complied with our obligations under the various applicable licenses for open source software that we use, there is little or no legal precedent governing the interpretation of many of the terms of certain of these licenses and therefore the potential impact of such terms on our business is somewhat unknown. The failure to adequately protect our intellectual property and other proprietary rights could materially harm our business.

The patent application process, also known as patent prosecution, is expensive and time consuming, and we and any current or future licensors and licensees may not be able to prepare, file and prosecute all necessary or desirable patent applications at a reasonable cost or in a timely manner. It is also possible that we or any current or future licensors or licensees, will fail to identify patentable aspects of inventions made in the course of development and commercialization activities before it is too late to obtain patent protection on them. Moreover, in some circumstances, we may not have the right to control the preparation, filing and prosecution of patent applications, or to maintain the patents, covering technology that we license from or license to third parties and are therefore reliant on our licensors or licensees. Therefore, these and any of our patents and applications may not be prosecuted and enforced in a manner consistent with the best interests of our business. Defects of form in the preparation or filing of our patents or patent applications may exist, or may arise in the future, for example, with respect to proper priority claims, inventorship, and the like, although we are unaware of any such defects that we believe are of material importance. If we or any current or future licensors or licensees, fail to establish, maintain or protect such patents and other intellectual property rights, such rights may be reduced or eliminated. If any current or future licensors or licensees are not fully cooperative or disagree with us as to the prosecution, maintenance or enforcement of any patent rights, such patent rights could be compromised. If there are material defects in the form, preparation or prosecution of our patents or patent applications, such patents or applications may be invalid and unenforceable. Any of these outcomes could impair our ability to prevent competition from third parties, which may have an adverse impact on our business.

The strength of patent rights involves complex legal and scientific questions and can be uncertain. This uncertainty includes changes to the patent laws through either legislative action to change statutory patent law or court action that may reinterpret existing law or rules in ways affecting the scope or validity of issued patents. The patent applications that we own or license may fail to result in issued patents in the United States or foreign countries with claims that cover our products or services. Even if patents do successfully issue from the patent applications that we own or license, third parties may challenge the validity, enforceability or scope of such patents, which may result in such patents being narrowed, invalidated or held unenforceable. Any successful challenge to our patents could deprive us of exclusive rights necessary for the successful commercialization of our products and services. Furthermore, even if they are unchallenged, our patents may not adequately protect our products and services, provide exclusivity for our products and services, or prevent others from designing around our claims. If the breadth or strength of protection provided by the patents we hold or pursue with respect to our products and services is challenged, it could dissuade companies from collaborating with us to develop, or threaten our ability to commercialize, our products and services.

Patents have a limited lifespan. In the United States, the natural expiration of a utility patent is generally 20 years after its effective filing date and the natural expiration of a design patent is generally 14 years after its issue date, unless the filing date occurred on or after May 13, 2015, in which case the natural expiration of a design patent is generally 15 years after its issue date. Various extensions may be available; however, the life of a patent, and the protection it affords, is limited. Without patent protection for our products and services, we may be open to competition. Further, if we encounter delays in our development efforts, the period of time during which we could market our products and services under patent protection would be reduced.

In addition to the protection afforded by patents, we also rely on trade secret protection to protect proprietary know-how that may not be patentable or that we elect not to patent, processes for which patents may be difficult to obtain or enforce, and any other elements of our products and services that involve proprietary know-how, information or technology that is not covered by patents. However, trade secrets can be difficult to protect. We cannot be certain that our trade secrets and other confidential proprietary information will not be disclosed despite having such confidentiality agreements. If the steps taken to maintain our trade secrets are deemed inadequate, we may have insufficient recourse against third parties for misappropriating any trade secrets. In addition, in some situations, any confidentiality agreement we may have with an employee, consultant, advisor, or others may conflict with, or be subject to, the rights of third parties with whom our employees, consultants, or advisors have previous employment or consulting relationships. To the extent that our employees, consultants, advisors, or contractors use any intellectual property owned by third parties in their work for us, disputes may arise as to the rights in any related or resulting know-how and inventions. Misappropriation or unauthorized disclosure of our trade secrets could significantly affect our competitive position and may have a material adverse effect on our business. Furthermore, trade secret protection does not prevent competitors from independently developing substantially equivalent information and techniques and we cannot guarantee that our competitors will not independently develop substantially equivalent information and techniques. The FDA, as part of its Transparency Initiative, is currently considering whether to make additional information of life science companies publicly available on a routine basis, including information that we may consider to be trade secrets or other proprietary information, and it is not clear at the present time how the FDA's disclosure policies may change in the future, if at all.

Obtaining and maintaining our patent protection depends on compliance with various procedural, documentary, fee payment and other requirements imposed by governmental patent agencies, and our patent protection could be reduced or eliminated for non-compliance with these requirements.

The United States Patent and Trademark Office, or USPTO, and various foreign governmental patent agencies require compliance with a number of procedural, documentary, fee payment and other similar provisions during the patent prosecution process. Periodic maintenance fees and various other governmental fees on any issued patent and/or pending patent applications are due to be paid to the USPTO and foreign patent agencies in several stages over the lifetime of a patent or patent application. We have systems in place to remind us to pay these fees, and we employ an outside firm and rely on our outside counsel to pay these fees. While an inadvertent lapse may sometimes be cured by payment of a late fee or by other means in accordance with the applicable rules, there are many situations in which noncompliance can result in abandonment or lapse of the patent or patent application, resulting in partial or complete loss of patent rights in the relevant jurisdiction. If we fail to maintain the patents and patent applications directed to our products and services, our competitors might be able to enter the market earlier than should otherwise have been the case, which would have a material adverse effect on our business.

Litigation or other proceedings or third-party claims of intellectual property infringement could require us to spend significant time and money and could prevent us from selling our products and services.

Our commercial success depends in part on our avoiding infringement of the patents and proprietary rights of third parties, for example, the intellectual property rights of competitors. Our research, development and commercialization activities may be subject to claims that we infringe or otherwise violate patents owned or controlled by third parties. Numerous U.S. and foreign issued patents and pending patent applications, which are owned by third parties, exist in the fields in which we are developing our products and services. As the healthcare technology industry expands and more patents are issued, the risk increases that our activities related to our products and services may give rise to claims of infringement of the patent rights of others. We cannot assure you that our products and services will not infringe existing or future patents. The coverage of patents is subject to interpretation by the courts, and the interpretation is not always uniform. We may not be aware of patents that have already issued that a third party, for example, a competitor in our market, might assert are infringed by our products and services. It is also possible that patents of which we are aware, but which we do not believe are relevant to our products and services, could nevertheless be found to be infringed by our product candidates. Nevertheless, we are not aware of any issued patents that we believe would prevent us from marketing our healthcare products and services. There may also be patent applications that have been filed but not published that, when issued as patents, could be asserted against us.

Third parties have asserted and may in the future assert that we are employing their proprietary technology without authorization. As we continue to commercialize our products and services in their current or updated forms, launch new products and services and enter new markets, we expect that competitors will claim that our products and services infringe their intellectual property rights as part of business strategies designed to impede our successful commercialization and entry into new markets. We occasionally receive letters from third parties inviting us to take licenses under, or alleging that we infringe, their patents or trademarks. Third parties may have obtained, and may in the future obtain, patents under which such third parties may claim that the use of our technologies constitutes patent infringement.

If we are sued for patent infringement, we would need to demonstrate that our products or services either do not infringe the patent claims of the relevant patent or that the patent claims are invalid or unenforceable, and we may not be able to do this. Proving that a patent is invalid and/or unenforceable is difficult. For example, in the United States, providing invalidity requires a showing of clear and convincing evidence to overcome the presumption of validity enjoyed by issued patents. We could incur substantial costs and divert the attention of our management and technical personnel in defending ourselves or our licensors against any of these claims. Defense of these claims, regardless of their merit, would cause us to incur substantial expenses and, would be a substantial diversion of employee resources from our business. Any adverse ruling or perception of an adverse ruling in defending ourselves against these claims could have a material adverse impact on our business. Furthermore, parties making claims against us may be able to obtain injunctive or other relief, which could block our ability to develop, commercialize, and sell products or services, and could result in the award of substantial damages against us, potentially including treble damages and attorneys' fees if we are found to have willfully infringed a patent. In the event of a successful claim of infringement or misappropriation against us, we may be required to pay damages and obtain one or more licenses from third parties, pay royalties to the third party, redesign any infringing product, or be prohibited from selling certain products or services, all of which could have a material adverse impact on our business. Redesigning any infringing products may be commercially impractical, not readily feasible, and/ or require substantial time and monetary expenditure. Further, we cannot predict whether any required license would be available at all or whether it would be available on commercially reasonable terms.

In addition, we may be unable to obtain these licenses at a reasonable cost, if at all. We could therefore incur substantial costs related to royalty payments for licenses obtained from third parties, which could negatively affect our gross margins. Even if we were able to obtain a license, it could be non-exclusive, thereby giving our competitors access to the same technologies licensed to us. Ultimately, we could be prevented from commercializing a product, or be forced to cease some aspect of our business operations, if, as a result of actual or threatened patent infringement claims, we are unable to enter into licenses on acceptable terms. Moreover, we could encounter delays in product or service introductions while we attempt to develop alternative products or services. Defense of any lawsuit or failure to obtain any of these licenses on favorable terms could prevent us from commercializing products and services, and the prohibition of sale of any of our products and services would materially affect our ability to grow and maintain profitability and have a material adverse impact on our business.

Defending ourselves in litigation is very expensive, particularly for a company of our size, and time-consuming. In addition to infringement claims against us, we may become a party to other patent litigation and other proceedings, including interference, derivation, or post-grant proceedings declared or granted by the USPTO and similar proceedings in foreign countries, regarding intellectual property rights with respect to our current or future products. The cost to us of any patent litigation or other proceeding, even if resolved in our favor, could be substantial. Some of our competitors may be able to sustain the costs of litigation or administrative proceedings more effectively than we can because of greater financial resources. Patent litigation and other proceedings may also absorb significant management time. Uncertainties resulting from the initiation and continuation of patent litigation or other proceedings could impair our ability to compete in the marketplace. The occurrence of any of the foregoing could have a material adverse effect on our business, financial condition, or results of operations.

We may become involved in lawsuits to protect or enforce our patents or other intellectual property, or the patents of our licensors, which could be expensive, time consuming and ultimately unsuccessful.

Competitors may infringe or misappropriate our patents, trademarks, copyrights or other intellectual property, including our existing patents or patents that may issue to us in the future, or the patents of our licensors to which we have a license. To counter infringement or unauthorized use, we may be required to file infringement or inventorship claims to stop third party infringement, unauthorized use, or to correct inventorship, which can be expensive and time consuming and divert the time and attention of our management and scientific personnel. Any claims that we assert against perceived infringers could provoke these parties to assert counterclaims against us alleging that we infringe their patents, in addition to counterclaims asserting that our patents are invalid or unenforceable, or both. These competitors may further challenge the scope, validity or enforceability of our licensors' patents, requiring our licensors to engage in complex, lengthy and costly litigation or other proceedings. In any patent infringement proceeding, there is a risk that a court will decide that a patent of ours or of our licensors' is invalid or unenforceable, in whole or in part, and that we do not have the right to stop the other party from using the invention at issue. There is also a risk that, even if the validity of such patents is upheld, the court will construe the patent's claims narrowly or decide that we do not have the right to stop the other party from using the invention at issue on the grounds that our patent claims do not cover the invention. An adverse outcome in a litigation or proceeding involving our patents could limit our ability to assert our patents against those parties or other competitors and may curtail or preclude our ability to exclude third parties from making and selling similar or competitive products. Any of these occurrences could adversely affect our competitive business position, business prospects and financial condition. Similarly, if we assert trademark infringement claims, a court may determine that the marks we have asserted are invalid or unenforceable, or that the party against whom we have asserted trademark infringement has superior rights to the marks in question. In this case, we could ultimately be forced to cease use of such trademarks. An adverse determination of any litigation or other proceedings could put one or more of our patents at risk of being invalidated, held unenforceable or interpreted narrowly and could put our patent applications at risk of not issuing.

Interference, derivation or other proceedings, brought at the USPTO or any foreign patent authority may be necessary to determine the priority or patentability of inventions with respect to our patent applications or those our collaborators. Litigation or USPTO proceedings brought by us may fail. An unfavorable outcome in any such proceeding could require us to cease using the related technology or to attempt to license rights to it from the prevailing party or could cause us to lose valuable intellectual property rights. Our business could be harmed if the prevailing party does not offer us a license on commercially reasonable terms, if any license is offered at all. Even if we are successful, domestic or foreign litigation, or USPTO or foreign patent office proceedings may result in substantial costs and distraction to our management. We may not be able, alone or with collaborators, to prevent misappropriation of our trade secrets, confidential information or proprietary rights, particularly in countries where the laws may not protect such rights as fully as in the United States.

Even if we establish infringement, the court may decide not to grant an injunction against further infringing activity and instead award only monetary damages, which may or may not be an adequate remedy. Furthermore, because of the substantial amount of discovery required in connection with intellectual property litigation, there is a risk that some of our confidential information could be compromised by disclosure during litigation. There could also be public announcements of the results of hearings, motions or other interim proceedings or developments. If securities analysts or investors perceive these results to be negative, it could have a material adverse effect on the price of shares of our common stock. Moreover, there can be no assurance that we will have sufficient financial or other resources to file and pursue such infringement claims, which typically last for years before they are concluded. Even if we ultimately prevail in such claims, the monetary cost of such litigation and the diversion of the attention of our management and scientific personnel could outweigh any benefit we receive as a result of the proceedings.

Enforcing our intellectual property rights through litigation is very expensive, particularly for a company of our size, and time-consuming. Some of our competitors may be able to sustain the costs of litigation or administrative proceedings more effectively than we can because of greater financial resources. Patent litigation and other proceedings may also absorb significant management time. Uncertainties resulting from the initiation and continuation of patent litigation or other proceedings could impair our ability to compete in the marketplace. The occurrence of any of the foregoing could have a material adverse effect on our business, financial condition, or results of operations.

Furthermore, because of the substantial amount of discovery required in connection with intellectual property litigation or administrative proceedings, there is a risk that some of our confidential information could be comprised by disclosure. In addition, during the course of litigation or administrative proceedings, there could be public announcements of the results of hearings, motions, or other interim proceedings or developments or public access to related documents. If investors perceive these results to be negative, the market price for our common stock could be significantly harmed.

We may not be able to protect our intellectual property rights throughout the world.

Third parties may attempt to commercialize competitive products or services in foreign countries where we do not have any patents or patent applications where legal recourse may be limited. This may have a significant commercial impact on our foreign business operations.

Filing, prosecuting and defending patents on our products and services in all countries throughout the world would be prohibitively expensive, and our intellectual property rights in some countries outside the United States can be less extensive than those in the United States. The requirements for patentability may differ in certain countries, particularly developing countries. For example, Europe has a heightened requirement for patentability of software inventions. Thus, even in countries where we do pursue patent protection, there can be no assurance that any patents will issue with claims that cover our products. In addition, the laws of some foreign countries do not protect intellectual property rights to the same extent as laws in the United States and in some cases may even force us to grant a compulsory license to competitors or other third parties. Consequently, we may not be able to prevent third parties from practicing our inventions in all countries outside the United States or from selling or importing products concerning our healthcare technology into the United States or other jurisdictions. Competitors may use our technologies in jurisdictions where we have not obtained patent protection to develop their own products and services and further, may export otherwise infringing products and services to territories where we have patent protection, but enforcement on infringing activities is inadequate. These products or services may compete with ours, and our patents or other intellectual property rights may not be effective or sufficient to prevent them from competing.

Many companies have encountered significant problems in protecting and defending intellectual property rights in foreign jurisdictions. The legal systems of certain countries, particularly certain developing countries, do not favor the enforcement of patents and other intellectual property protection, which could make it difficult for us to stop the infringement of our patents or marketing of competing products in violation of our proprietary rights generally. Proceedings to enforce our patent rights in foreign jurisdictions could result in substantial costs and divert our efforts and attention from other aspects of our business, could put our patents at risk of being invalidated or interpreted narrowly and our patent applications at risk of not issuing, and could provoke third parties to assert claims against us. We may not prevail in any lawsuits that we initiate and the damages or other remedies awarded, if any, may not be commercially meaningful. In addition, certain countries in Europe and certain developing countries, including India and China, have compulsory licensing laws under which a patent owner may be compelled to grant licenses to third parties. In those countries, we may have limited remedies if our patents are infringed or if we are compelled to grant a license to our patents to a third party, which could materially diminish the value of those patents. This could limit our potential revenue opportunities. Accordingly, our efforts to enforce our intellectual property rights around the world may be inadequate to obtain a significant commercial advantage from the intellectual property that we own or license. Finally, our ability to protect and enforce our intellectual property rights may be adversely affected by unforeseen changes in foreign intellectual property laws.

Developments in U.S. patent law could have a negative impact on our business.

As is the case with other healthcare technology companies, our success is in part dependent on intellectual property, particularly on obtaining and enforcing patents. Obtaining and enforcing patents in the healthcare technology industry involves both technological and legal complexity, and therefore, is costly, time consuming, and inherently uncertain. In addition, the United States has recently enacted and has now implemented wide-ranging patent reform legislation. Further, recent United States Supreme Court rulings have either narrowed the scope of patent protection available in certain circumstances or weakened the rights of patent owners in certain situations. In addition to increasing uncertainty with regard to our ability to obtain patents in the future, this combination of events has created uncertainty with respect to the value of patents once obtained. Changes in U.S. patent law could diminish the value of patents in general, thereby impairing our ability to protect our products and services.

For our United States patent applications containing a claim not entitled to priority before March 16, 2013, there is a greater level of uncertainty in the patent law. In September 2011, the Leahy-Smith America Invents Act, or the America Invents Act, or AIA, was signed into law. The AIA includes a number of significant changes to United States patent law, including provisions that affect the way patent applications will be prosecuted and enforced in any patent litigation. The USPTO developed regulations and procedures to govern administration of the AIA, and many of the substantive changes to patent law associated with the AIA. It is not clear what other, if any, impact the AIA will have on the operation of our business. Moreover, the AIA and its implementation could increase the uncertainties and costs surrounding the prosecution of our patent applications and the enforcement or defense of our issued patents, all of which could have a material adverse effect on our business and financial condition.

An important change introduced by the AIA is that, as of March 16, 2013, the United States transitioned to a “first-to-file” system for deciding which party should be granted a patent when two or more patent applications are filed by different parties claiming the same invention. A third party that files a patent application in the USPTO on or after March 16, 2013 before us could therefore be awarded a patent covering an invention of ours even if we were the first to conceive of the invention. This will require us to be cognizant going forward of the time from invention to filing of a patent application. Furthermore, our ability to obtain and maintain valid and enforceable patents depends on whether the differences between our technology and the prior art allow our technology to be patentable over the prior art. Because patent applications in the United States and most other countries are confidential for a period of time after filing, we cannot be certain that we were the first to either file any patent application related to our products or services or invent any of the inventions claimed in our patents or patent applications.

Among some of the other changes introduced by the AIA are changes that limit where a patentee may file a patent infringement suit and provide opportunities for third parties to challenge any issued patent in the USPTO. This applies to all of our United States patents, even those issued before March 16, 2013. Because of a lower evidentiary standard in USPTO proceedings necessary to invalidate a patent claim compared to the evidentiary standard in United States federal court, a third party could potentially provide evidence in a USPTO proceeding sufficient for the USPTO to hold a claim invalid even though the same evidence may be insufficient to invalidate the claim if first presented in a district court action.

Two cases, one involving diagnostic method claims and the other involving “gene patents” were decided by the Supreme Court. On March 20, 2012, the Supreme Court issued a decision in *Mayo Collaborative v. Prometheus Laboratories* , or Prometheus, a case involving patent claims directed to optimizing the amount of drug administered to a specific patient. According to that decision, Prometheus’ claims failed to incorporate sufficient inventive content above and beyond mere underlying natural correlations to allow the claimed processes to qualify as patent-eligible processes that apply natural laws. On June 13, 2013, the Supreme Court subsequently decided *Association for Molecular Pathology v. Myriad Genetics* , or Myriad, a case brought by multiple plaintiffs challenging the validity of patent claims held by Myriad Genetics, Inc. relating to the breast cancer susceptibility genes BRCA1 and BRCA2, holding that isolated genomic DNA that exists in nature, such as the DNA constituting the BRCA1 and BRCA2 genes, is not patentable subject matter, but that cDNA, which is an artificial construct created from RNA transcripts of genes, may be patent eligible.

On July 3, 2012, the USPTO issued a memorandum to patent examiners providing interim guidelines for examining process claims for patent eligibility in view of the Supreme Court decision in Prometheus. The guidance indicates that claims directed to a law of nature, a natural phenomenon, or an abstract idea that do not meet the eligibility requirements should be rejected as non-statutory subject matter.

Furthermore, a case involving financial software was even more recently decided by the Supreme Court. On June 19, 2014, the Supreme Court issued a decision in *Alice Corp. Pty. Ltd. v. CLS Bank Int’l* , or Alice, a case involving patent claims directed to methods of exchanging obligations as between parties so as to mitigate settlement risk in financial transactions, computer systems configured to carry out the method, and computer-readable media containing program code for performing the method. In Alice, the Court applied the analytic framework from Prometheus and extended its application to all types of claims. According to that decision, Alice Corp.’s claims failed to incorporate sufficient inventive content above and beyond the mere idea of intermediated transaction to allow the claimed processes to qualify as patent-eligible processes that apply the idea in a particular way to solve a problem.

On December 16, 2014, the USPTO issued interim guidelines for examining claims for patent eligibility in view of the Supreme Court decision in Alice. The guidance indicates that claims reciting an abstract idea that do not include significantly more than the idea itself should be rejected as non-statutory subject matter. We cannot assure you that our efforts to seek patent protection for our technology, products, and services will not be negatively impacted by the decision in Alice, rulings in other cases, or changes in guidance or procedures issued by the USPTO. Since then, the USPTO has issued several memoranda on the topic of patent eligible subject matter, including those dated May 4, 2016, May 19, 2016, July 14, 2016, November 2, 2016, and December 5, 2017.

More specifically, we cannot fully predict what impact the Supreme Court’s decisions in Prometheus, Myriad and Alice may have on the ability of healthcare technology companies or other entities to obtain or enforce patents relating to genomic discoveries, diagnostic products and services or computer-implemented inventions in the future. Despite the USPTO’s guidance described above, these contours of when certain claims allegedly directed to laws of nature, natural phenomenon or abstract ideas meet the patent eligibility requirements are not clear and may take many years to develop via interpretation in the courts.

There are many patents claiming diagnostic methods based on similar or related correlations that issued before Prometheus, and although some of these patents may be invalid under the standard set forth in Prometheus, until successfully challenged, these patents are presumed valid and enforceable, and certain third parties could allege that we infringe, or request that we obtain a license to, these patents. Whether based on patents issued prior to or after Prometheus, we could have to defend ourselves against claims of patent infringement, or choose to license rights, if available, under patents claiming such methods. Similarly, there are many patents claiming software and/or business methods that include an abstract idea that issued before Alice, and although some of these patents may be invalid under the standard set forth in Prometheus and Alice, until successfully challenged, these patents are presumed valid and enforceable, and certain third parties could allege that we infringe, or request that we obtain a license to, these patents. Whether based on patents issued prior to or after Alice, we could have to defend ourselves against claims of patent infringement, or choose to license rights, if available, under patents claiming such software or business methods. In any of the foregoing or in other situations involving third-party intellectual property rights, if we are unsuccessful in defending against claims of patent infringement, we could be forced to pay damages or be subjected to an injunction that would prevent us from utilizing the patented subject matter in question if we are unable to obtain a license on reasonable terms. Such outcomes could materially affect our ability to offer our products and have a material adverse impact on our business. Even if we are able to obtain a license or successfully defend against claims of patent infringement, the cost and distraction associated with the defense or settlement of these claims could have a material adverse impact on our business. Moreover, one or more of our pending United States patent applications may be rejected based on the changes in the law and the standards set forth in Prometheus, Myriad, Alice, or other cases. Our ability to secure United States patent rights could be impaired if we cannot overcome such rejections, which could have a material adverse impact on our business. In addition, one or more of our issued United States patents could be challenged on the basis of the law and the standards set forth in Prometheus, Myriad, Alice, or other cases, which could have a material adverse impact on our business. Further, on July 30, 2015, in response to the public comment on the Interim Eligibility Guidance, the USPTO issued an update pertaining to the Interim Eligibility Guidance. The Updated Eligibility Guidance includes additional examples from the case law and is intended to assist examiners in applying the Interim Eligibility Guidance during the patent examination process.

If we fail to comply with our obligation in any of the agreements under which we license intellectual property rights from third parties or otherwise experience disruptions to our business relationships with our licensors, we could lose license rights that are important to our business.

Licensing of intellectual property rights is important to our business and involves complex legal, business and scientific issues.

Disputes may arise between us and our licensors regarding intellectual property rights subject to a license agreement, including:

- the scope of rights granted under the license agreement and other interpretation-related issues;
- our right to sublicense intellectual property rights to third parties under collaborative development relationships; and
- our diligence obligations with respect to the use of the licensed technology in relation to our development and commercialization of our product candidates, and what activities satisfy those diligence obligations.

While we would expect to exercise all rights and remedies available to us, including seeking to cure any breach by us, and otherwise seek to preserve our rights under the patents licensed to us, we may not be able to do so in a timely manner, at an acceptable cost or at all. Generally, the loss of any one of our current licenses, or any other license we may acquire in the future, could materially harm our business, prospects, financial condition and results of operations.

Confidentiality agreements with employees and others may not adequately prevent disclosure of our trade secrets and other proprietary information and may not adequately protect our intellectual property, which could limit our ability to compete.

Because we operate in the highly technical field of research and development, we rely in part on trade secret protection in order to protect our proprietary trade secrets and unpatented know-how. However, trade secrets are difficult to protect, and we cannot be certain that others will not develop the same or similar technologies on their own. Enforcing a claim that a party illegally obtained and is using our trade secrets or know-how is difficult, expensive and time consuming, and the outcome is unpredictable. In addition, courts outside the United States may be less willing to protect trade secrets or know-how. The failure to obtain or maintain trade secret protection could adversely affect our competitive position.

We may be subject to claims that our employees, consultants or independent contractors have wrongfully used or disclosed confidential information of third parties.

We have received confidential and proprietary information from third parties. In addition, we employ individuals who were previously employed at other healthcare companies. We may be subject to claims that we or our employees, consultants or independent contractors have inadvertently or otherwise improperly used or disclosed confidential information of these third parties or our employees' former employers. Further, we may be subject to ownership disputes in the future arising, for example, from conflicting obligations of consultants or others who are involved in developing our products and services. We may also be subject to claims that former employees, consultants, independent contractors or other third parties have an ownership interest in our patents or other intellectual property. Litigation may be necessary to defend against these and other claims challenging our right to and use of confidential and proprietary information. If we fail in defending any such claims, in addition to paying monetary damages, we may lose our rights therein. Such an outcome could have a material adverse effect on our business. Even if we are successful in defending against these claims, litigation could result in substantial cost and be a distraction to our management and employees.

We rely in part on trademarks to distinguish our products and services from those of other entities. Trademarks may be opposed or cancelled and we may be involved in lawsuits or other proceedings to protect or enforce our trademarks.

We rely on trademarks, in the United States and in certain foreign jurisdictions, to distinguish our products and services in the minds of our customers and our business partners from those of other entities. Third parties may challenge our pending trademark applications through opposition proceedings in the United States, or comparable proceedings in foreign jurisdictions, in which they seek to prevent registration of a mark. Our registered trademarks may be subject to cancellation proceedings in the United States, or comparable proceedings in foreign jurisdictions, in which a third party seeks to cancel an existing registration. To enforce our trademark rights, we may be involved in lawsuits or other proceedings which could be expensive, time-consuming and uncertain.

Our corporate name, NantHealth, and the names of our products and services have not been trademarked in each market where we operate and plan to operate. Our trademark applications for our corporate name or the name of our products and services may not be allowed for registration, and our registered trademarks may not be maintained or enforced. During trademark registration proceedings, we may receive rejections, which we may be unable to overcome in our responses. If we do not secure registrations for our trademarks, we may encounter more difficulty in enforcing them against third parties than we otherwise would.

Risks related to reimbursement and government regulation

If we fail to comply with applicable health information privacy and security laws and other state and federal privacy and security laws, we may be subject to significant liabilities, reputational harm and other negative consequences, including decreasing the willingness of current and potential customers to work with us.

We are subject to data privacy and security regulation by both the federal government and the states in which we conduct our business. HIPAA established uniform federal standards for certain "covered entities," which include certain healthcare providers, healthcare clearinghouses, and health plans, governing the conduct of specified electronic healthcare transactions and protecting the security and privacy of protected health information, or PHI. The Health Information Technology for Economic and Clinical Health Act, or HITECH Act, which became effective on February 17, 2010, makes HIPAA's security standards directly applicable to "business associates," which are independent contractors or agents of covered entities that create, receive, maintain, or transmit PHI in connection with providing a service for or on behalf of a covered entity. The HITECH Act also increased the civil and criminal penalties that may be imposed against covered entities, business associates and certain other persons, and gave state attorneys general new authority to file civil actions for damages or injunctions in federal courts to enforce HIPAA's requirements and seek attorney's fees and costs associated with pursuing federal civil actions.

A portion of the data that we obtain and handle for or on behalf of our clients is considered PHI, subject to HIPAA. We are also required to maintain similar business associate agreements with our subcontractors that have access to PHI of our customers in rendering services to us or on our behalf. Under HIPAA and our contractual agreements with our HIPAA-covered entity health plan customers, we are considered a "business associate" to those customers and are required to maintain the privacy and security of PHI in accordance with HIPAA and the terms of our business associate agreements with our clients, including by implementing HIPAA-required administrative, technical and physical safeguards. We have incurred, and will continue to incur, significant costs to establish and maintain these safeguards and, if additional safeguards are required to comply with HIPAA regulations or our clients' requirements, our costs could increase further, which would negatively affect our operating results. Furthermore, we cannot guarantee that such safeguards have been and will continue to be adequate. If we have failed, or fail in the future, to maintain adequate safeguards, or we or our agents or subcontractors use or disclose PHI in a manner prohibited or not permitted by HIPAA, our subcontractor business associate agreements, or our business associate agreements with our customers, or if the privacy or security of PHI that we obtain and handle is otherwise compromised, we could be subject to significant liabilities and consequences, including, without limitation:

- breach of our contractual obligations to clients, which may cause our clients to terminate their relationship with us and may result in potentially significant financial obligations to our clients;
- investigation by the federal and state regulatory authorities empowered to enforce HIPAA and other data privacy and security laws, which include the U.S. Department of Health and Human Services, or HHS, the Federal Trade Commission and state attorneys general, and the possible imposition of civil and criminal penalties;
- private litigation by individuals adversely affected by any misuse of their personal health information for which we are responsible; and
- negative publicity, which may decrease the willingness of current and potential future customers to work with us and negatively affect our sales and operating results.

Further, we publish statements to end users of our services that describe how we handle and protect personal information. If federal or state regulatory authorities or private litigants consider any portion of these statements to be untrue, we may be subject to claims of deceptive practices, which could lead to significant liabilities and consequences, including, without limitation, damage to our reputation and costs of responding to investigations, defending against litigation, settling claims and complying with regulatory or court orders.

Federal or state governmental authorities may impose additional data security standards or additional privacy or other restrictions on the collection, use, maintenance, transmission and other disclosures of health information. Legislation has been proposed at various times at both the federal and the state level that would limit, forbid or regulate the use or transmission of medical information outside of the United States. Such legislation, if adopted, may render our use of off-shore partners for work related to such data impracticable or substantially more expensive. Alternative processing of such information within the United States may involve substantial delay in implementation and increased cost.

We may be, or may become, subject to data protection laws and regulations, and our failure to comply with such laws and regulations could lead to government enforcement actions and significant penalties against us, and adversely impact our operating results.

The European Union, the EU, has adopted data protection laws and regulations which may apply to us in certain circumstances, or in the future. The laws impose significant compliance obligations on us and is commonly known as the GDPR, the General Data Protection Regulation. The GDPR, which is wide-ranging in scope and applicability, imposes several requirements relating to the consent of the individuals to whom the personal data relates, the information provided to the individuals, the security and confidentiality of the personal data, data breach notification and the use of third party processors in connection with the processing of personal data, including clinical trials. The GDPR also imposes strict rules on the transfer of personal data out of the EU to the U.S., provides an enforcement authority and imposes large penalties for noncompliance, including the potential for fines of up to €20 million or 4% of the annual global revenues of the noncompliant company, whichever is greater. The recent implementation of the GDPR has increased our responsibility and liability in relation to personal data that we process, including with respect to our employees in the European Union, and we may in the future be required to put in place additional mechanisms to ensure compliance with the GDPR, which could divert management's attention and increase our cost of doing business. In addition, other new regulation or legislative actions regarding data privacy and security (together with applicable industry standards) may increase our costs of doing business. In this regard, we expect that there will continue to be new proposed laws, regulations and industry standards relating to privacy and data protection in the United States, the EU and other jurisdictions, and we cannot determine the impact such future laws, regulations and standards may have on our business.

If we fail to comply with federal and state healthcare laws and regulations, including those governing submissions of false or fraudulent claims to government healthcare programs and financial relationships among healthcare providers, we may be subject to civil and criminal penalties or loss of eligibility to participate in government healthcare programs.

We are subject to certain federal and state laws and regulations designed to protect patients, governmental healthcare programs, and private health plans from fraudulent and abusive activities. These laws include anti-kickback restrictions and laws prohibiting the submission of false or fraudulent claims. These laws are complex and their application to our specific products, services and relationships may not be clear and may be applied to our business in ways that we do not anticipate. Federal and state regulatory and law enforcement authorities have recently increased enforcement activities with respect to Medicare and Medicaid fraud and abuse regulations and other reimbursement laws and rules. From time to time in the future, we may receive inquiries or subpoenas to produce documents in connection with such activities. We could be required to expend significant time and resources to comply with these requests, and the attention of our management team could be diverted to these efforts. Furthermore, third parties have in the past alleged, and may in the future allege that we have sought federal funding in a manner that may violate federal or state law. Though we dispute such allegations, if we are found to be in violation of any federal or state fraud and abuse laws, we could be subject to civil and criminal penalties, and we could be excluded from participating in federal and state healthcare programs such as Medicare and Medicaid. The occurrence of any of these events could significantly harm our business and financial condition.

Provisions in Title XI of the Social Security Act, commonly referred to as the federal Anti-Kickback Statute, prohibit the knowing and willful offer, payment, solicitation or receipt of remuneration, directly or indirectly, in cash or in kind, in return for or to reward the referral of patients or arranging for the referral of patients, or in return for the recommendation, arrangement, purchase, lease or order of items or services that are covered, in whole or in part, by a federal healthcare program such as Medicare or Medicaid. The definition of “remuneration” has been broadly interpreted to include anything of value such as gifts, discounts, rebates, waiver of payments or providing anything at less than its fair market value. Many states have adopted similar prohibitions against kickbacks and other practices that are intended to induce referrals which are applicable to all patients regardless of whether the patient is covered under a governmental health program or private health plan. We attempt to scrutinize our business relationships and activities to comply with the federal Anti-Kickback Statute and similar laws and we attempt to structure our sales and group purchasing arrangements in a manner that is consistent with the requirements of applicable safe harbors to these laws. We cannot assure you, however, that our arrangements will be protected by such safe harbors or that such increased enforcement activities will not directly or indirectly have an adverse effect on our business, financial condition or results of operations. Any determination by a state or federal agency that any of our activities or those of our vendors or customers violate any of these laws could subject us to civil or criminal penalties, monetary fines, disgorgement, individual imprisonment, contractual damages, reputational harm, diminished profits and future earnings and curtailment of our operations, could require us to change or terminate some portions of operations or business, could disqualify us from providing services to healthcare providers doing business with government programs and, thus, could have an adverse effect on our business.

Our business is also subject to numerous federal and state laws, including without limitation the civil False Claims Act, that forbid the knowing submission or “causing the submission” of false or fraudulent information or the failure to disclose information in connection with the submission and payment of claims for reimbursement to Medicare, Medicaid, federal healthcare programs or private health plans. Analogous state laws and regulations may apply to our arrangements and claims involving healthcare items or services reimbursed by non-governmental third-party payers. Additionally, HIPAA also imposes criminal and civil liability for, among other things, executing a scheme to defraud any healthcare benefit program or making false statements relating to healthcare matters.

These laws and regulations may change rapidly, and it is frequently unclear how they apply to our business. Errors created by our products or consulting services that relate to entry, formatting, preparation or transmission of claim or cost report information may be determined or alleged to be in violation of these laws and regulations. Any failure of our products or services to comply with these laws and regulations could result in substantial civil or criminal liability, monetary fines, disgorgement, individual imprisonment, contractual damages, reputational harm, diminished profits and future earnings and curtailment of our operations, could adversely affect demand for our one or more of our offerings, could invalidate all or portions of some of our customer contracts, could require us to change or terminate some portions of our business, could require us to refund portions of our services fees, could cause us to be disqualified from serving clients doing business with government payers and could have an adverse effect on our business.

Our activities are also subject to state and federal self-referral laws, including the federal Physician Self-referral Law, commonly known as the Stark Law, which prohibits physicians from referring Medicare or Medicaid patients to providers of “designated health services” with whom the physician or a member of the physician’s immediate family has an ownership interest or compensation arrangement, unless a statutory or regulatory exception applies, and similar state equivalents that may apply regardless of payer. In addition, our activities may also implicate state laboratory licensure laws, as well as the corporate practice of medicine prohibition in certain states that maintain such laws or regulations. Our failure to abide by these state and federal laws could result in substantial fines and penalties.

If commercial third-party payers or government payers fail to provide coverage or adequate reimbursement, or if there is a decrease in the amount of reimbursement for our sequencing and molecular analysis solutions, including GPS Cancer, or future products we develop, if any, our revenue and prospects for profitability would be harmed.

In both domestic and foreign markets, sales of our sequencing and molecular analysis solutions, including GPS Cancer, and other products and services we develop will depend, in large part, upon the availability of reimbursement from third-party payers. These third-party payers include government healthcare programs such as Medicare, managed care providers, private health insurers, and other organizations. In particular, we believe that obtaining a positive national coverage decision and favorable reimbursement rate from the Centers for Medicare and Medicaid Services, or CMS, for our sequencing and molecular analysis solutions, including GPS Cancer, will be a necessary element in achieving material commercial success. Physicians and patients may not order our sequencing and molecular analysis solutions unless commercial third-party payers and government payers pay for all, or a substantial portion, of the list price, and certain commercial third-party payers may not agree to reimburse our sequencing and molecular analysis solutions if CMS does not issue a positive coverage decision.

There is currently no national coverage decision that determines whether and how our sequencing and molecular analysis solutions, including GPS Cancer, are covered by Medicare. In the absence of a national coverage decision, local Medicare contractors, or MACs, that administer the Medicare program in various regions have some discretion in determining local coverage and therefore payment for tests. We do not currently receive any payment for our sequencing and molecular analysis solutions provided to patients covered by Medicare. If CMS or an applicable MAC does not issue a coverage decision with respect to our sequencing and molecular analysis solutions, or if CMS or an applicable MAC withdraws its coverage policies after reimbursement is obtained, reviews and adjusts the rate of reimbursement, or stops paying for our sequencing and molecular analysis solutions altogether, our revenue and results of operations would be adversely affected.

Commercial third-party payers and government payers are increasingly attempting to contain healthcare costs by demanding price discounts or rebates and limiting both coverage on which diagnostic products they will pay for and the amounts that they will pay for new molecular diagnostic products. Because of these cost-containment trends, commercial third-party payers and government payers that currently provide reimbursement for, or in the future cover, our sequencing and molecular analysis solutions, including GPS Cancer, may reduce, suspend, revoke, or discontinue payments or coverage at any time. Further, a payer's decision to provide coverage for a product or service does not imply that an adequate reimbursement rate will be approved. Additionally, one payer's determination to provide coverage does not assure that other payers will also provide coverage. Adequate third party reimbursement may not be available to enable us to maintain price levels sufficient to realize an appropriate return on our investment.

As a result, there is significant uncertainty surrounding whether the use of products that incorporate new technology, such as our sequencing and molecular analysis solutions, including GPS Cancer, will be eligible for coverage by commercial third-party payers and government payers or, if eligible for coverage, what the reimbursement rates will be for those products. The fact that a diagnostic product has been approved for reimbursement in the past, for any particular indication or in any particular jurisdiction, does not guarantee that such a diagnostic product will remain approved for reimbursement or that similar or additional diagnostic products will be approved in the future. Reimbursement of NGS-based cancer products by commercial third-party payers and government payers may depend on a number of factors, including a payer's determination that products enabled by our molecular profiling solution are:

- not experimental or investigational;
- medically necessary;
- appropriate for the specific patient;
- cost-effective;
- supported by peer-reviewed publications;
- included in clinical practice guidelines; and
- supported by clinical utility studies.

As a result, our efforts to receive reimbursement on behalf of patients will take a substantial amount of time and may require the development of clinical data to demonstrate the clinical utility of our products and improve patient outcomes, or commercial third-party payers and government payers may never cover or provide adequate payment for our sequencing and molecular analysis solutions, including GPS Cancer, or future molecular profiling tools we license or develop. Our strategy to achieve broad reimbursement coverage is focused on demonstrating the clinical utility and economic benefits of our sequencing and molecular analysis solutions, engaging with thought leaders, oncologists and other caregivers, patient advocacy groups and other key oncology stakeholders and thereby increasing demand. For example, in January 2016, a large health plan announced that it would provide insurance coverage for GPS Cancer, representing the nation's first such insurance coverage for a whole genome and RNA molecular diagnostic platform. Since that time, additional contracts with other large commercial payers have been signed, and efforts are now underway to pursue single case agreements which yield reimbursements from other non-contracted payers. Even in light of these developments, however, there is no assurance that we will continue to succeed in any of these areas or that, even if we do succeed, we will receive favorable reimbursement decisions. If adequate third-party reimbursement is unavailable we may not be able to maintain price levels sufficient to realize an appropriate return on investment in product development. Furthermore, if a commercial third-party payer or government payer denies coverage, it may be difficult for us to collect from the patient, and we may not be successful.

In addition, we are generally considered a "non-contracting provider" by commercial third-party payers because we generally have not entered into specific contracts to provide our molecular analysis services to their covered patients, and as a result we take on primary responsibility for obtaining reimbursement on behalf of patients. If we were to become a contracting provider with additional payers in the future, the amount of overall reimbursement we receive may decrease if we receive less revenue per product that is reimbursed at a contracted rate than at a non-contracted rate, which could have a negative impact on our revenue. Further, we may be unable to collect payments from patients beyond that which is paid by their coverage and will experience lost revenue as a result.

If we fail to comply with the way states and the FDA regulates tests that are developed, manufactured, validated and performed by laboratories like NantOmics, such failure could result in delay or additional expense in offering our tests and tests that we may develop in the future.

Several states require that we and NantOmics hold laboratory licenses to test specimens from patients in those states. Other states may have similar requirements or may adopt similar requirements in the future. We may be subject to regulation in foreign jurisdictions as we seek to expand international distribution of our offerings, which may require review of our offerings in order to offer our services or may have other limitations such as prohibitions on the export of tissue necessary for us to use our GPS Cancer solution that may limit our ability to distribute outside of the United States.

In addition, NantOmics is subject to the Clinical Laboratory Improvement Amendments of 1988, or CLIA, a federal law that regulates clinical laboratories that perform testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, or treatment of disease. CLIA regulations mandate specific standards in the areas of personnel qualifications, administration, and participation in proficiency testing, patient test management, quality control, quality assurance, and inspections. NantOmics has a current certificate of accreditation under CLIA to conduct our genomic sequencing and molecular analyses through our accreditation by the College of American Pathologists, or CAP. To renew this certificate, NantOmics is subject to survey and inspection every two years. Moreover, CLIA inspectors may make random inspections of NantOmics' clinical reference laboratory.

Any sanction imposed under CLIA, its implementing regulations, or state or foreign laws or regulations governing licensure, or NantOmics' failure to renew a CLIA certificate, a state or foreign license, or accreditation, could have a material adverse effect on our business. Most CLIA deficiencies are not classified as "condition-level" deficiencies, and there are no adverse effects upon the laboratory operations as long as the deficiencies are corrected. Remediation of these deficiencies is a routine matter, with corrections occurring within several hours or weeks. More serious CLIA deficiencies could rise to the level of "condition-level" deficiencies, and CMS has the authority to impose a wide range of sanctions, including revocation of the CLIA certification along with a bar on the ownership or operation of a CLIA-certified laboratory by any owners or operators of the deficient laboratory. There is an administrative hearing procedure that can be pursued by the laboratory in the event of imposition of such sanctions, during which the sanctions are stayed, but the process can take a number of years to complete. If NantOmics was to lose its CLIA certification or CAP accreditation, we would not be able to offer our GPS Cancer solution services, which would result in material harm to our business and results of operations.

While the FDA currently exercises its enforcement discretion for LDTs by not enforcing its regulations, the FDA has stated that it has a mandate to regulate in this field and that it intends to address LDT regulation using a risk-based, phased-in approach similar to the existing *in vitro* diagnostic framework. Moreover, the FDA could disagree with our current assessment that NantOmics' sequencing services is an LDT, and could require us or NantOmics to seek clearance or approval for such sequencing services for clinical use. If the FDA requires us or NantOmics to seek clearance or approval to offer NantOmics' sequencing services for GPS Cancer or any of our future offerings for clinical use, we may not be able to obtain such approvals on a timely basis, or at all. Failure to comply with applicable regulatory requirements can result in enforcement action by the FDA, which may include any of the following sanctions: warning letters; fines; injunctions; civil or criminal penalties; recall or seizure of current or future products; operating restrictions; partial suspension or total shutdown of production; denial of applications; or challenges to clearances or approvals. We cannot provide any assurance that FDA regulation, including premarket review, will not be required for our GPS Cancer solution or any other molecular profiling solution we offer in the future. If premarket review is required, our business could be negatively impacted if we are required to stop selling our molecular profiling solution pending its clearance or approval or if such approval is delayed by new requirements.

Healthcare policy changes, including recently enacted legislation reforming the U.S. healthcare system, may have a material adverse effect on our financial condition, results of operations and cash flows.

In March 2010, the ACA was enacted in the United States, which made a number of substantial changes in the way healthcare is financed by both governmental and private insurers. Among other things, the ACA:

- requires each medical device manufacturer to pay an excise tax equal to 2.3% of the price for which such manufacturer sells its medical devices. This tax may apply to GPS Cancer and some or all of our products which are in development. The excise tax was been temporarily suspended for calendar years 2016 and 2017. On January 22, 2018, the United States Congress extended the suspension for an additional two years. Accordingly, the medical device excise tax does not apply to the sale of taxable medical devices by the manufacturer, producer or importer of the device during the period beginning on January 1, 2016 and ending on December 31, 2019, but will be reinstated in 2020 without additional Congressional action.
- mandates a reduction in payments for clinical laboratory services paid under the Medicare Clinical Laboratory Fee Schedule of 1.75% for the years 2011 through 2015. In addition, a productivity adjustment is made to the fee schedule payment amount.
- creates initiatives to promote quality indicators in payment methodologies and the coordination and promotion of research on comparative clinical effectiveness of different technologies and procedures.

We cannot predict whether future healthcare initiatives will be implemented at the federal or state level, or how any future legislation or regulation may affect us. The taxes imposed by the new federal legislation and the expansion of government's role in the U.S. healthcare industry, as well as changes to the reimbursement amounts paid by payers for our current and future offerings or our medical procedure volumes, may reduce our profits and have a materially adverse effect on our business, financial condition, results of operations, and cash flows. Moreover, Congress has proposed on several occasions to impose a 20% coinsurance on patients for clinical laboratory tests reimbursed under the Medicare Clinical Laboratory Fee Schedule, which would require us to bill patients for these amounts. Because of the relatively low reimbursement for many clinical laboratory tests, in the event that Congress were to ever enact such legislation, the cost of billing and collecting for these tests would often exceed the amount actually received from the patient and effectively increase our costs of billing and collecting.

Furthermore, the current presidential administration and Congress are also expected to attempt broad sweeping changes to the current health care laws. The House of Representatives recently voted to pass the American Health Care Act (the AHCA). As proposed, the AHCA would repeal many provisions of the Affordable Care Act. The Senate is currently expected to consider an alternative version of the AHCA and it is expected that Congress will continue to consider this or similar legislation to repeal and replace some or all elements of the Affordable Care Act. We face uncertainties that might result from modification or repeal of any of the provisions of the Affordable Care Act, including as a result of current and future executive orders and legislative actions. The impact of those changes on us and potential effect on biosimilar manufacturing industry as a whole is currently unknown. But, any changes to the Affordable Care Act are likely to have an impact on our results of operations and may have a material adverse effect on our results of operations. We cannot predict what other healthcare programs and regulations will ultimately be implemented at the federal or state level or the effect of any future legislation or regulation in the United States may have on our business.

We are subject to U.S. and foreign anti-corruption and anti-money laundering laws with respect to our operations and non-compliance with such laws can subject us to criminal and/or civil liability and harm our business.

We are subject to the U.S. Foreign Corrupt Practices Act of 1977, as amended, or the FCPA, the U.S. domestic bribery statute contained in 18 U.S.C. § 201, the U.S. Travel Act, the USA PATRIOT Act, and possibly other state and national anti-bribery and anti-money laundering laws in countries in which we conduct activities. Anti-corruption laws are interpreted broadly and prohibit companies and their employees, agents, third-party intermediaries, joint venture partners and collaborators from authorizing, promising, offering, or providing, directly or indirectly, improper payments or benefits to recipients in the public or private sector. We currently engage in business and sales with government and state-owned hospitals outside of the United States. In addition, we engage third-party intermediaries to promote and sell our products and solutions abroad and/or to obtain necessary permits, licenses, and other regulatory approvals. We or our third-party intermediaries may have direct or indirect interactions with officials and employees of government agencies or state-owned or affiliated entities. We can be held liable for the corrupt or other illegal activities of these third-party intermediaries, our employees, representatives, contractors, partners, and agents, even if we do not explicitly authorize or have actual knowledge of such activities.

We have adopted an anti-corruption policy that, mandates compliance with the FCPA and other anti-corruption laws applicable to our business throughout the world. However, we cannot assure you that our employees and third-party intermediaries will comply with this policy or such anti-corruption laws. Noncompliance with anti-corruption and anti-money laundering laws could subject us to whistleblower complaints, investigations, sanctions, settlements, prosecution, other enforcement actions, disgorgement of profits, significant fines, damages, other civil and criminal penalties or injunctions, suspension and/or debarment from contracting with certain persons, the loss of export privileges, reputational harm, adverse media coverage, and other collateral consequences. If any subpoenas, investigations, or other enforcement actions are launched, or governmental or other sanctions are imposed, or if we do not prevail in any possible civil or criminal litigation, our business, financial condition and results of operations could be materially harmed. In addition, responding to any action will likely result in a materially significant diversion of management's attention and resources and significant defense and compliance costs and other professional fees. In certain cases, enforcement authorities may even cause us to appoint an independent compliance monitor which can result in added costs and administrative burdens.

We are subject to governmental export and import controls that could impair our ability to compete in international markets due to licensing requirements and subject us to liability if we are not in compliance with applicable laws.

Our products and solutions are subject to export control and import laws and regulations, including the U.S. Export Administration Regulations, U.S. Customs regulations, and various economic and trade sanctions regulations administered by the U.S. Treasury Department's Office of Foreign Assets Controls. Exports of our products and solutions outside of the United States must be made in compliance with these laws and regulations. If we fail to comply with these laws and regulations, we and certain of our employees could be subject to substantial civil or criminal penalties, including the possible loss of export or import privileges, fines, which may be imposed on us and responsible employees or managers and, in extreme cases, the incarceration of responsible employees or managers.

In addition, changes in our products or solutions or changes in applicable export or import laws and regulations may create delays in the introduction, provision, or sale of our products and solutions in international markets, prevent customers from using our products and solutions or, in some cases, prevent the export or import of our products and solutions to certain countries, governments or persons altogether. Any limitation on our ability to export, provide, or sell our products and solutions could adversely affect our business, financial condition and results of operations.

We may be subject to fines, penalties or legal liability, if it is determined that we are practicing medicine without a license through our Eviti or molecular analysis solutions.

State laws prohibit the practice of medicine without a license. Our Eviti reports delivered to physicians provide information regarding FDA-approved therapies and clinical trials that oncologists may use in making treatment decisions for their patients, and our molecular analysis reports provide detailed DNA and RNA data about a patient and can make personalized therapy recommendations based on that data. We make members of our organization available to clinicians to discuss the information provided in the report. Our customer service representatives provide support to our clients, including assistance in interpreting the results of Eviti and our molecular analysis reports. A governmental authority or third party could allege that the identification of available therapies and clinical trials in our reports and the related customer service we provide constitute the practice of medicine. A state may seek to have us discontinue the inclusion of certain aspects of our reports or the related services we provide or subject us to fines, penalties, or licensure requirements. Any determination that we are practicing medicine without a license may result in significant liability to us and harm to our reputation and/or our Eviti and molecular analysis businesses.

Errors or illegal activity on the part of our clients may result in claims against us.

We rely on our clients, and we contractually obligate them, to provide us with accurate and appropriate data and directives for our actions. We rely upon our clients, as users of our solutions and systems infrastructure, for key activities to produce proper claims for reimbursement. Failure of clients to provide these data and directives or to perform these activities may result in claims against us that our reliance was misplaced.

Our services present the potential for embezzlement, identity theft or other similar illegal behavior by our employees or subcontractors with respect to third parties.

Our services also involve the use and disclosure of personal and business information that could be used to impersonate third parties or otherwise gain access to their data or funds. If any of our employees or subcontractors takes, converts or misuses such funds, documents or data, we could be liable for damages, and our business reputation could be damaged or destroyed.

Risks related to our convertible notes

Servicing our debt requires a significant amount of cash, and we may not have sufficient cash flow from our business to pay our substantial debt.

Our ability to make scheduled payments of the principal of, to pay interest on or to refinance our indebtedness, including the notes, depends on our future performance, which is subject to economic, financial, competitive and other factors beyond our control. Our business may not continue to generate cash flow from operations in the future sufficient to service our debt and make necessary capital expenditures. If we are unable to generate such cash flow, we may be required to adopt one or more alternatives, such as selling assets, restructuring debt or obtaining additional equity capital on terms that may be onerous or highly dilutive. Our ability to refinance our indebtedness will depend on the capital markets and our financial condition at such time. We may not be able to engage in any of these activities or engage in these activities on desirable terms, which could result in a default on our debt obligations.

We may pay any interest make-whole payment on our notes by delivering shares of our common stock, which could result in significant dilution to our stockholders.

Beginning on or after the date that is one year after the last date of original issuance of the notes, we will in certain circumstances make an interest make-whole payment to a converting holder, payable in cash or shares of our common stock. If we elect, or are deemed to have elected, to pay any interest make-whole payment by delivering shares of our common stock, the number of shares of common stock a converting holder of notes will receive will be the number of shares that have a value equal to the amount of the interest make-whole payment to be paid to such holder in shares of our common stock, divided by the product of (x) 95% and (y) the simple average of the daily VWAP of our common stock for the 10 trading days ending on and including the trading day immediately preceding the conversion date, which could result in significant dilution to our stockholders.

The accounting method for convertible debt securities that may be settled in cash, such as the notes, could have a material effect on our reported financial results.

In May 2008, the Financial Accounting Standards Board, which we refer to as FASB, issued FASB Staff Position No. APB 14-1, *Accounting for Convertible Debt Instruments That May Be Settled in Cash Upon Conversion (Including Partial Cash Settlement)* , which has subsequently been codified as *Accounting Standards Codification 470-20, Debt with Conversion and Other Options* , which we refer to as ASC 470-20. Under ASC 470-20, an entity must separately account for the liability and equity components of the convertible debt instruments (such as the notes) that may be settled entirely or partially in cash upon conversion in a manner that reflects the issuer's economic interest cost. The effect of ASC 470-20 on the accounting for the notes is that the equity component is required to be included in the additional paid-in capital section of stockholders' equity on our consolidated balance sheet, and the value of the equity component would be treated as original issue discount for purposes of accounting for the debt component of the notes. As a result, we will be required to record a greater amount of non-cash interest expense in current periods presented as a result of the amortization of the discounted carrying value of the notes to their face amount over the term of the notes. We will report lower net income in our financial results because ASC 470-20 will require interest to include both the current period's amortization of the debt discount and the instrument's coupon interest, which could adversely affect our reported or future financial results, the trading price of our common stock and the trading price of the notes.

In addition, under certain circumstances, convertible debt instruments (such as the notes) that may be settled entirely or partly in cash are currently accounted for utilizing the treasury stock method, the effect of which is that the shares issuable upon conversion of the notes are not included in the calculation of diluted earnings per share except to the extent that the conversion value of the notes exceeds their principal amount. Under the treasury stock method, for diluted earnings per share purposes, the transaction is accounted for as if the number of shares of common stock that would be necessary to settle such excess, if we elected to settle such excess in shares, are issued. We cannot be sure that the accounting standards in the future will continue to permit the use of the treasury stock method. If we are unable to use the treasury stock method in accounting for the shares issuable upon conversion of the notes, then our diluted earnings per share would be adversely affected.

Risks related to our common stock

Our Chairman and Chief Executive Officer, and entities affiliated with him, collectively own a significant majority of our common stock and will exercise significant influence over matters requiring stockholder approval, regardless of the wishes of other stockholders.

As of December 31, 2018 , our Chairman and Chief Executive Officer, Dr. Patrick Soon-Shiong, and entities affiliated with him, collectively beneficially own approximately 64% of the voting power of our common stock. As a result, Dr. Patrick Soon-Shiong and his affiliates have significant influence over management and significant control over matters requiring stockholder approval, including the annual election of directors and significant corporate transactions, such as a merger or other sale of our company or assets, for the foreseeable future. This concentrated control will limit stockholders' ability to influence corporate matters and, as a result, we may take actions that our stockholders do not view as beneficial. As a result, the market price of our common stock could be adversely affected.

Dr. Patrick Soon-Shiong, our Chairman and Chief Executive Officer and our principal stockholder, has significant interests in other companies which may conflict with our interests.

Our Chairman and Chief Executive Officer, Dr. Patrick Soon-Shiong, is the founder of NantWorks. The various NantWorks companies are currently exploring opportunities in the immunotherapy, infectious disease and inflammatory disease fields. In particular, NantOmics provides us with its sequencing and molecular analysis solution for our GPS Cancer solution. NantWorks is the largest member of NantOmics, holding approximately 84% of the outstanding equity and approximately 99% of the outstanding voting equity as of December 31, 2018 . As a result, they or other companies affiliated with Dr. Patrick Soon-Shiong may compete with us for business opportunities or, in the future, develop products that are competitive with ours. As a result, Dr. Patrick Soon-Shiong's interests may not be aligned with the interests of our other stockholders, and he may from time to time be incentivized to take certain actions that benefit his other interests and that our other stockholders do not view as being in their interest as investors in our company. Moreover, even if they do not directly relate to us, actions taken by Dr. Patrick Soon-Shiong and the companies and charitable organizations with which he is involved could have a negative impact on our business.

Our certificate of incorporation contains a waiver of the corporate opportunities doctrine for NantWorks and its affiliates, which includes our Chairman and Chief Executive Officer, and therefore covered persons have no obligations to make opportunities available to us.

NantWorks, which is controlled by our Chairman and Chief Executive Officer, and its affiliates, beneficially owns approximately 64% of the voting power of our common stock as of December 31, 2018 .

NantWorks and its affiliates engage in a broad spectrum of activities across the life science, biopharmaceutical, healthcare information technology and technology sectors. In the ordinary course of their business activities, NantWorks and its affiliates may from time to time acquire and hold interests in businesses that compete directly or indirectly with us. Our certificate of incorporation provides that none of NantWorks, any of its affiliates and all of their respective partners, principals, directors, officers, members, managers and/or employees, including any of the foregoing who serve as officers or directors of our company, to the fullest extent permissible by law, have any duty to bring business opportunities to our attention or to refrain from engaging, directly or indirectly, in the same business activities or similar business activities or lines of business in which we operate. NantWorks or its affiliates may also pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. In addition, NantWorks may have an interest in pursuing acquisitions, divestitures and other transactions that, in its judgment, could enhance its investment, even though such transactions might involve risks to you.

We can provide no assurances that we will be able to maintain an active, liquid and orderly trading market will develop for our common stock or what the market price of our common stock will be and as a result it may be difficult for you to sell your common stock.

Prior to our initial public offering in June 2016, there was no public market for our common stock. Although our common stock is listed on The NASDAQ Global Select Market, the market for our shares has demonstrated varying levels of trading activity. Further, because a significant amount of our common stock following our initial public offering is and is expected to continue to be held by our Chairman and Chief Executive Officer, Dr. Patrick Soon-Shiong , and entities affiliated with him, we have relatively small historic trading volumes. As a result of these and other factors, you may not be able to sell your common stock quickly or at or above the price you purchased your stock or at all. Further, an inactive market may also impair our ability to raise capital by selling additional common stock and may impair our ability to enter into strategic collaborations or acquire companies or products by using our common stock as consideration.

The trading price of our common stock has been and may continue to be volatile. This volatility may affect the price at which you could sell our common stock, the notes and any common stock you receive upon conversion of your notes.

The trading price of our common stock has been and may continue to be volatile and could be subject to wide fluctuations in response to various factors. The trading price of the notes and our common stock may fluctuate widely in response to various factors, some of which are beyond our control, including:

- announcements by us or our competitors of new products, significant contracts, commercial relationships or capital commitments and the timing of these introductions or announcements;
- adverse regulatory or reimbursement announcements;
- announcements by us or our competitors of significant acquisitions, strategic collaborations, joint ventures or capital commitments;
- the results of our efforts to develop additional offerings;
- our dependence on our customers, partners and collaborators;
- regulatory or legal developments in the United States or other countries;
- reimbursement decisions regarding our future molecular profiling solutions, including GPS Cancer;
- developments or disputes concerning patent applications, issued patents or other proprietary rights;
- the recruitment or departure of key management or other personnel;
- our ability to successfully commercialize our future products;
- the level of expenses related to any of our products;
- actual or anticipated changes in estimates as to financial results, development timelines or recommendations by securities analysts;
- actual or anticipated quarterly variations in our financial results or those of our competitors;
- any change to the composition of the board of directors or key personnel;
- expiration of contractual lock-up agreements with our executive officers, directors and security holders;
- sales of common stock by us or our stockholders in the future, as well as the overall trading volume of our common stock;
- changes in the structure of healthcare payment systems;
- commencement of, or our involvement in, litigation, including claims by our equityholders pertaining to our conversion from a Delaware limited liability company into a Delaware corporation or the pending class action litigation;
- general economic, industry and market conditions and other factors that may be unrelated to our operating performance or the operating performance of our competitors, including changes in market valuations of similar companies; and
- the other factors described in this “Risk Factors” section.

In addition, the stock market in general, and the NASDAQ and the healthcare industry in particular, have from time to time experienced volatility that often has been unrelated to the operating performance of the underlying companies. These broad market and industry fluctuations may adversely affect the market price of our common stock or the notes, regardless of our operating performance. In several recent situations where the market price of a stock has been volatile, holders of that stock have instituted securities class action litigation against the company that issued the stock. If any of our stockholders were to bring a lawsuit against us, the defense and disposition of the lawsuit could be costly and divert the time and attention of our management and would harm our business operating results or financial condition.

Our common stock may be delisted from The Nasdaq Global Select Market if we cannot maintain compliance with Nasdaq’s continued listing requirements.

In order to maintain our listing on Nasdaq, we are required to comply with the Nasdaq requirements, which includes maintaining a minimum bid price. In particular, we are required to maintain a minimum bid price of $1.00, and we traded below that threshold between November 30, 2018 and January 15, 2019. On January 16, 2019, we received a notice from Nasdaq stating that we were not in compliance with Nasdaq Listing Rule 5450(a)(1) (the "Minimum Bid Price Rule") because our common stock failed to maintain a minimum closing bid price of $1.00 for 30 consecutive business days. This notice had no immediate effect on the Nasdaq listing or trading of the company's common stock. On March 21, 2019, we received a notice from Nasdaq confirming that we had regained compliance with the Minimum Bid Price Rule.

Even though we have regained compliance with the Minimum Bid Price Rule, in the future we may fail to maintain compliance with the minimum bid price requirement, and our stock may be delisted. Delisting from the Nasdaq Global Select Market or any Nasdaq market could make trading our common stock more difficult for investors, potentially leading to declines in our share price and liquidity. Without a Nasdaq market listing, stockholders may have a difficult time getting a quote for the sale or purchase of our stock, the sale or purchase of our stock would likely be made more difficult and the trading volume and liquidity of our stock could decline. Delisting from Nasdaq could also result in negative publicity and could also make it more difficult for us to raise additional capital. The absence of such a listing may adversely affect the acceptance of our common stock as currency or the value accorded by other parties. Further, if we are delisted, we would also incur additional costs under state blue sky laws in connection with any sales of our securities. These requirements could severely limit the market liquidity of our common stock and the ability of our stockholders to sell our common stock in the secondary market. If our common stock is delisted by Nasdaq, our common stock may be eligible to trade on an over-the-counter quotation system, such as the OTCQB market, where an investor may find it more difficult to sell our stock or obtain accurate quotations as to the market value of our common stock. We cannot assure you that our common stock, if delisted from Nasdaq, will be listed on another national securities exchange or quoted on an over-the counter quotation system. If our common stock is delisted, it may come within the definition of "penny stock" as defined in the Securities Exchange Act of 1934, or the Exchange Act, and would be covered by Rule 15g-9 of the Exchange Act. That Rule imposes additional sales practice requirements on broker-dealers who sell securities to persons other than established customers and accredited investors. For transactions covered by Rule 15g-9, the broker-dealer must make a special suitability determination for the purchaser and receive the purchaser's written agreement to the transaction prior to the sale. Consequently, Rule 15g-9, if it were to become applicable, would affect the ability or willingness of broker-dealers to sell our securities, and accordingly would affect the ability of stockholders to sell their securities in the public market. These additional procedures could also limit our ability to raise additional capital in the future.

We may pay any interest make-whole payment by delivering shares of our common stock, which could result in significant dilution to our stockholders and cause our stock price to fall.

On or after the date that is one year after the last date of original issuance of the notes, we will in certain circumstances make an interest make-whole payment, as described under "Description of notes-Conversion rights-Settlement upon conversion," to a converting holder, payable in cash or shares of our common stock. If we elect, or are deemed to have elected, to pay any interest make-whole payment by delivering shares of our common stock, the number of shares of common stock a converting holder of notes will receive will be the number of shares that have a value equal to the amount of the interest make-whole payment to be paid to such holder in shares of our common stock, divided by the product of (x) 95% and (y) the simple average of the daily VWAP of our common stock for the 10 trading days ending on and including the trading day immediately preceding the conversion date, which could result in significant dilution to our stockholders.

We have incurred and will continue to incur costs as a result of operating as a public company and our management has been and will be required to devote substantial time to public company compliance initiatives.

As a public company, listed in the United States, we have incurred and will continue to incur significant legal, accounting and other expenses due to our compliance with regulations and disclosure obligations applicable to us, including compliance with the Sarbanes-Oxley Act of 2002, or the Sarbanes-Oxley Act, as well as rules implemented by the SEC and the Nasdaq. The SEC and other regulators have continued to adopt new rules and regulations and make additional changes to existing regulations that require our compliance. In July 2010, the Dodd-Frank Wall Street Reform and Consumer Protection Act, or the Dodd-Frank Act, was enacted. There are significant corporate governance and executive compensation related provisions in the Dodd-Frank Act that have required the SEC to adopt additional rules and regulations in these areas. Stockholder activism, the current political environment, and the current high level of government intervention and regulatory reform may lead to substantial new regulations and disclosure obligations, which may lead to additional compliance costs and impact, in ways we cannot currently anticipate, the manner in which we operate our business. Our management and other personnel have and will continue to devote a substantial amount of time to these compliance programs and monitoring of public company reporting obligations and, as a result of the new corporate governance and executive compensation related rules, regulations, and guidelines prompted by the Dodd-Frank Act and further regulations and disclosure obligations expected in the future, we will likely need to devote additional time and costs to comply with such compliance programs and rules. These rules and regulations will cause us to incur significant legal and financial compliance costs and will make some activities more time-consuming and costly.

To continue to comply with the requirements of being a public company, we may need to undertake various activities, including implementing new internal controls and procedures and hiring new accounting or internal audit staff. The Sarbanes-Oxley Act requires that we maintain effective disclosure controls and procedures and internal control over financial reporting. We are continuing to develop and refine our disclosure controls and other procedures that are designed to ensure that information required to be disclosed by us in the reports that we file with the SEC is recorded, processed, summarized and reported within the time periods specified in SEC rules and forms, and that information required to be disclosed in reports under the Securities Exchange Act of 1934, or the Exchange Act, is accumulated and communicated to our principal executive and financial officers. Our current controls and any new controls that we develop may become inadequate and weaknesses in our internal control over financial reporting may be discovered in the future. For example, we have identified a material weakness in our internal control over financial reporting related to our valuations of the Bookings Commitment liability and our related party equity method investment in NantOmics, as more fully described in Item 9A of our Form 10-K. In addition, in connection with our preparation of the Consolidated and Combined Financial Statements for the year ended December 31, 2017, several control deficiencies relative to Information Technology general controls were not remediated prior to year end. These deficiencies primarily related to change management controls over our general ledger and financial reporting system. We performed an assessment and determined that it did not rise to the level of a material weakness, but did represent a significant deficiency in our internal control over financial reporting. A control deficiency is considered a significant deficiency if it represents a deficiency, or a combination of deficiencies, in internal control over financial reporting that is less severe than a material weakness, yet important enough to merit attention by those responsible for oversight of a company's financial reporting.

We cannot assure you that the measures we have taken, or will take, to remediate the material weakness and significant deficiencies will be effective or that we will be successful in implementing them. Moreover, we cannot assure you that we have identified all significant deficiencies or material weaknesses or that we will not in the future have additional significant deficiencies or material weaknesses, in particular as we seek to transition to a more developed internal control environment and continue to grow as a company in terms of size, complexity of business and potentially in connection with future strategic transactions. Our independent registered public accounting firm has not evaluated any of the measures we have taken, or that we propose to take, to address these significant deficiencies or the material weakness discussed above.

Any failure to develop or maintain effective controls could adversely affect the results of periodic management evaluations regarding the effectiveness of our internal control over financial reporting which we may be required to include in our periodic reports that we file with the SEC under Section 404 of the Sarbanes-Oxley Act, harm our operating results, cause us to fail to meet our reporting obligations, or result in a restatement of our prior period financial statements. In the event that we are not able to demonstrate compliance with the Sarbanes-Oxley Act, that our internal control over financial reporting is perceived as inadequate or that we are unable to produce timely or accurate financial statements, investors may lose confidence in our operating results and the price of our common stock could decline. In addition, if we are unable to continue to meet these requirements, we may not be able to remain listed on Nasdaq.

In addition, our independent registered public accounting firm did not perform an evaluation of our internal control over financial reporting during any period in accordance with the provisions of the Sarbanes-Oxley Act. Had our independent registered public accounting firm performed an evaluation of our internal control over financial reporting in accordance with the provisions of the Sarbanes-Oxley Act, additional control deficiencies amounting to significant deficiencies or material weaknesses may have been identified. Our independent registered public accounting firm may not be required to formally attest to the effectiveness of our internal control over financial reporting until the later of our second annual report or the first annual report required to be filed with the SEC following the date we are no longer an "emerging growth company" as defined in the JOBS Act, depending on whether we choose to rely on certain exemptions set forth in the JOBS Act. We cannot assure you that there will not be additional material weaknesses or significant deficiencies in our internal controls in the future. If we are unable to remediate the material weakness, assert that our internal control over financial reporting is effective, or if our independent registered public accounting firm is unable to express an opinion on the effectiveness of our internal control over financial reporting, we could lose investor confidence in the accuracy and completeness of our financial reports, which could have a material adverse effect on the price of our common stock.

New legislation that would change U.S. or foreign taxation of international business activities or other tax-reform policies, including the imposition of tax based on gross income, could seriously harm our business.

Reforming the taxation of international businesses has been a priority for politicians, and a wide variety of potential changes have been proposed. Some proposals, several of which have been enacted, impose incremental taxes on gross revenue, regardless of profitability. Any changes in the taxation of such activities may increase our worldwide effective tax rate and the amount of taxes we pay and seriously harm our business.

For example, the Tax Cuts and Jobs Act, or the Tax Act, was enacted on December 22, 2017 and significantly reforms the U.S. Internal Revenue Code of 1986, as amended, or the Code. The Tax Act lowers U.S. federal corporate income tax rates, changes the utilization of future net operating loss carryforwards, allows for the expensing of certain capital expenditures, and puts into effect sweeping changes to U.S. taxation of international business activities. As a result, our net U.S. deferred tax assets and corresponding valuation allowances will be revalued at the new U.S. corporate rate. We continue to examine the impact this tax reform legislation may have on our business. The impact of this tax reform on us and on holders of our common stock is uncertain and could seriously harm our business.

Our ability to use our net operating loss carryforwards to offset future taxable income may be subject to certain limitations.

In general, under Section 382 of the Internal Revenue Code of 1986, as amended, or the Code, a corporation that undergoes an "ownership change" is subject to annual limitations on its ability to use its pre-change net operating loss carryforwards ("NOLs") or other tax attributes, to offset future taxable income or reduce taxes. We believe that we have recently undergone one or more ownership changes and accordingly, our ability to use our NOLs may be limited.

Additionally, the Tax Act, which was enacted on December 22, 2017, significantly reforms the Code, including changes to the rules governing net operating loss carryforwards. For net operating loss carryforwards arising in tax years beginning after December 31, 2017, the Tax Act limits a taxpayer's ability to utilize such carryforwards to 80% of taxable income. In addition, net operating loss carryforwards arising in tax years ending after December 31, 2017 can be carried forward indefinitely, but carryback is generally prohibited. Net operating loss carryforwards generated by us before January 1, 2018 will not be subject to the taxable income limitation and will continue to have a twenty-year carryforward period. However, the changes in the carryforward and carryback periods as well as the new limitation on use of net operating losses may significantly impact our ability to use net operating loss carryforwards generated after December 31, 2017, as well as the timing of any such use, and could seriously harm our business.

We do not anticipate paying any cash dividends on our common stock in the foreseeable future.

We do not currently intend to pay any cash dividends on our common stock in the foreseeable future. We currently intend to retain all of our future earnings, if any, to finance the growth and development of our business. In addition, the terms of any future debt agreements may preclude us from paying dividends. As a result, capital appreciation, if any, of our common stock may be investors' sole source of gain for the foreseeable future.

We are an "emerging growth company" and a "smaller reporting company," and the reduced disclosure requirements applicable to emerging growth companies and smaller reporting companies could make our common stock less attractive to investors.

We are an "emerging growth company," as defined in the JOBS Act, and may remain an "emerging growth company" for up to five years following the completion of our initial public offering or December 31, 2021. We would cease to be an emerging growth company upon the earliest of: (i) the last day of the fiscal year following the fifth anniversary of the completion of our initial public offering; (ii) the last day of the fiscal year during which we have annual gross revenue of at least $1.07 billion; (iii) the date on which we are deemed to be a ''large accelerated filer'' under the Exchange Act (we will qualify as a large accelerated filer as of the first day of the first fiscal year after we have (a) more than $700.0 million in outstanding common equity held by our non-affiliates and (b) been public for at least 12 months; the value of our outstanding common equity will be measured each year on the last business day of our second fiscal quarter); or (iv) the date on which we have, during the previous three-year period, issued more than $1.0 billion in non-convertible debt securities. For as long as we remain an "emerging growth company," we are permitted and intend to rely on exemptions from certain disclosure requirements that are applicable to other public companies that are not "emerging growth companies." These exemptions include:

- being permitted to provide only two years of audited financial statements, in addition to any required unaudited interim financial statements, with correspondingly reduced "Management's Discussion and Analysis of Financial Condition and Results of Operations" disclosure;
- not being required to comply with the auditor attestation requirements in the assessment of our internal control over financial reporting;
- not being required to comply with any requirement that may be adopted by the Public Company Accounting Oversight Board regarding mandatory audit firm rotation or a supplement to the auditor's report providing additional information about the audit and the financial statements;
- reduced disclosure obligations regarding executive compensation; and
- exemptions from the requirements of holding a nonbinding advisory vote on executive compensation and stockholder approval of any golden parachute payments not previously approved.

We have taken advantage of reduced reporting requirements in our public filings. In particular, we have not included all of the executive compensation related information that would be required if we were not an emerging growth company. In addition, the JOBS Act provides that an emerging growth company can take advantage of an extended transition period for complying with new or revised accounting standards, delaying the adoption of these accounting standards until they would apply to private companies. We have irrevocably elected not to avail ourselves of this exemption and, as a result, we will adopt new or revised accounting standards on the relevant dates on which adoption of such standards is required for other public companies. Even after we no longer qualify as an emerging growth company, we may, under certain circumstances, still qualify as a "smaller reporting company," which would allow us to take advantage of many of the same exemptions from disclosure requirements, including reduced disclosure obligations regarding executive compensation in our periodic reports and proxy statements. We cannot predict whether investors will find our common stock less attractive as a result of our reliance on these exemptions. If some investors find our common stock less attractive as a result, there may be a less active trading market for our common stock and the market price of our common stock may be reduced or may be more volatile.

Because we are relying on the exemptions from corporate governance requirements as a result of being a "controlled company" within the meaning of the NASDAQ listing standards, you do not have the same protections afforded to stockholders of companies that are subject to such requirements.

Our Chairman and Chief Executive Officer, Dr. Patrick Soon-Shiong, and entities affiliated with him, control a majority of our common stock. As a result, we are a "controlled company" within the meaning of NASDAQ listing standards. Under these rules, a company of which more than 50% of the voting power is held by an individual, a group or another company is a "controlled company" and may elect not to comply with certain NASDAQ corporate governance requirements, including (1) the requirement that a majority of the board of directors consist of independent directors and (2) the requirement that we have a nominating and corporate governance committee that is composed entirely of independent directors with a written charter addressing the committee's purpose and responsibilities. We have elected to rely on certain of these exemptions, and do not have a nominating and corporate governance committee. Accordingly, you will not have the same protections afforded to stockholders of companies that are subject to all of the NASDAQ corporate governance requirements.

If securities or industry analysts do not publish research or publish inaccurate or unfavorable research about our business, our share price and trading volume could decline.

The trading market for our common stock will depend on the research and reports that securities or industry analysts publish about us or our business. We do not have any control over these analysts. There can be no assurance that analysts will cover us or provide favorable coverage. If one or more of the analysts who cover us downgrade our stock or change their opinion of our stock, our share price would likely decline. If one or more of these analysts cease coverage of our company or fail to regularly publish reports on us, we could lose visibility in the financial markets, which could cause our share price or trading volume to decline.

We are not subject to the provisions of Section 203 of the Delaware General Corporation Law, which could negatively affect your investment.

We elected in our amended and restated certificate of incorporation to not be subject to the provisions of Section 203 of the Delaware General Corporation Law, or Section 203. In general, Section 203 prohibits a publicly held Delaware corporation from engaging in a “business combination” with an “interested stockholder” for a period of three years after the date of the transaction in which the person became an interested stockholder, unless the business combination is approved in a prescribed manner. A “business combination” includes a merger, asset sale or other transaction resulting in a financial benefit to the interested stockholder. An “interested stockholder” is a person who, together with affiliates and associates, owns (or, in certain cases, within three years prior, did own) 15% or more of the corporation’s voting stock. Our decision not to be subject to Section 203 will allow, for example, Dr. Patrick Soon-Shiong, our Chairman and Chief Executive Officer (who, with entities affiliated with him, beneficially own approximately 64% of the voting power of our common stock, as of December 31, 2018), to transfer shares in excess of 15% of our voting stock to a third-party free of the restrictions imposed by Section 203. This may make us more vulnerable to takeovers that are completed without the approval of our board of directors and/or without giving us the ability to prohibit or delay such takeovers as effectively.

Some provisions of our charter documents and Delaware law may have anti-takeover effects that could discourage an acquisition of us by others, even if an acquisition would be beneficial to our stockholders, and may prevent attempts by our stockholders to replace or remove our current management.

Provisions in our amended and restated certificate of incorporation and amended and restated bylaws, as well as provisions of Delaware law, could make it more difficult for a third party to acquire us or increase the cost of acquiring us, even if doing so would benefit our stockholders. These provisions include:

- a requirement that special meetings of stockholders be called only by the board of directors, the president or the chief executive officer;
- advance notice requirements for stockholder proposals and nominations for election to our board of directors; and
- the authority of the board of directors to issue preferred stock on terms determined by the board of directors without stockholder approval and which preferred stock may include rights superior to the rights of the holders of common stock.

These anti-takeover provisions and other provisions in our amended and restated certificate of incorporation and amended and restated bylaws could make it more difficult for stockholders or potential acquirers to obtain control of our board of directors or initiate actions that are opposed by the then-current board of directors and could also delay or impede a merger, tender offer or proxy contest involving our company. These provisions could also discourage proxy contests and make it more difficult for you and other stockholders to elect directors of your choosing or cause us to take other corporate actions you desire. Any delay or prevention of a change of control transaction or changes in our board of directors could cause the market price of our common stock to decline.

Claims for indemnification by our directors and officers may reduce our available funds to satisfy successful third-party claims against us and may reduce the amount of money available to us.

Our amended and restated certificate of incorporation and amended and restated bylaws provide that we will indemnify our directors and officers, in each case to the fullest extent permitted by Delaware law. In addition, as permitted by Section 145 of the Delaware General Corporation Law, our amended and restated bylaws and our indemnification agreements that we have entered into with our directors and officers provide that:

- We will indemnify our directors and officers for serving us in those capacities or for serving other business enterprises at our request, to the fullest extent permitted by Delaware law. Delaware law provides that a corporation may indemnify such person if such person acted in good faith and in a manner such person reasonably believed to be in or not opposed to the best interests of the registrant and, with respect to any criminal proceeding, had no reasonable cause to believe such person’s conduct was unlawful.

- We may, in our discretion, indemnify employees and agents in those circumstances where indemnification is permitted by applicable law.
- We are required to advance expenses, as incurred, to our directors and officers in connection with defending a proceeding, except that such directors or officers shall undertake to repay such advances if it is ultimately determined that such person is not entitled to indemnification.
- We will not be obligated pursuant to our amended and restated bylaws to indemnify a person with respect to proceedings initiated by that person against us or our other indemnitees, except with respect to proceedings authorized by our board of directors or brought to enforce a right to indemnification.
- The rights conferred in our amended and restated bylaws are not exclusive, and we are authorized to enter into indemnification agreements with our directors, officers, employees and agents and to obtain insurance to indemnify such persons.
- We may not retroactively amend our bylaw provisions to reduce our indemnification obligations to directors, officers, employees and agents.

To the extent that a claim for indemnification is brought by any of our directors or officers, it would reduce the amount of funds available for use in our business.

Our amended and restated certificate of incorporation designates the Court of Chancery of the State of Delaware as the sole and exclusive forum for certain types of actions and proceedings that may be initiated by our stockholders, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our directors, officers or other employees.

Our amended and restated certificate of incorporation provides that, unless we consent in writing to the selection of an alternative forum, the Court of Chancery of the State of Delaware shall be the sole and exclusive forum for (i) any derivative action or proceeding brought on our behalf, (ii) any action asserting a claim of breach of a fiduciary duty owed by any of our directors, officers or other employees to us or our stockholders, (iii) any action asserting a claim arising pursuant to any provision of the Delaware General Corporation Law, our amended and restated certificate of incorporation or our amended and restated bylaws, or (iv) any action asserting a claim against us governed by the internal affairs doctrine. Any person or entity purchasing or otherwise acquiring any interest in shares of our capital stock shall be deemed to have notice of and consented to the provisions of our amended and restated certificate of incorporation described above. This choice of forum provision may limit a stockholder's ability to bring a claim in a judicial forum that it finds favorable for disputes with us or our directors, officers or other employees, which may discourage such lawsuits against us and our directors, officers and other employees. Alternatively, if a court were to find these provisions of our amended and restated certificate of incorporation inapplicable to, or unenforceable in respect of, one or more of the specified types of actions or proceedings, we may incur additional costs associated with resolving such matters in other jurisdictions, which could adversely affect our business, financial condition or results of operations.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters are located in Culver City, California, where we occupy facilities totaling approximately 8,000 square feet on a month-to-month basis pursuant to a Shared Services Agreement with NantWorks. We use these facilities for administration, sales and marketing, research and development, engineering, client support, and professional services. In addition, we have 5 U.S. locations across four states and one international location. Our key facilities include the following:

- United States
  - Boston, Massachusetts
  - Panama City, Florida
  - Philadelphia, Pennsylvania
  - Phoenix, Arizona
  - Prescott, Arizona

- International
  - Belfast, Northern Ireland

We believe that our facilities are adequate to meet our needs in the near term, and that, if needed, suitable additional space will be available to accommodate any expansion of our operations.

The following table outlines our facilities location, square footage, and use:

City	State	Country	Sqft	Type	Business Nature/Use
Boston	MA	USA	31,752	Lease	Administrative, sales, client support, R&D, engineering, professional services
Panama City	FL	USA	51,288	Lease	Administrative, sales, client support, R&D, engineering, professional services
Belfast	NI	UK	15,500	Lease	R&D, engineering, administrative
Phoenix	AZ	USA	4,865	Lease	Administrative, sales, client support, professional services
Prescott	AZ	USA	860	Lease	Sales, client support, professional services
Philadelphia	PA	USA	14,183	Lease	Administrative, sales, client support, R&D, engineering, professional services
			118,448		

Item 3. Legal Proceedings

We are from time to time subject to claims and litigation that arise in the ordinary course of our business. We intend to defend vigorously any such litigation that may arise under all defenses that would be available to us. Except as discussed below, in the opinion of management, the ultimate outcome of proceedings of which management is aware, even if adverse to us, would not have a material adverse effect on our Consolidated Financial Condition or Results of Operations. Regardless of the outcome, litigation can have an adverse impact on us because of defense and settlement costs, diversion of management resources and other factors.

Securities Litigation

In March 2017, a number of putative class action securities complaints were filed in U.S. District Court for the Central District of California, naming as defendants the Company and certain of our current or former executive officers and directors. These complaints have been consolidated with the lead case captioned Deora v. NantHealth, Inc., 2:17-cv-01825. ("Deora") In June 2017, the lead plaintiffs filed an amended consolidated complaint, which generally alleges that defendants violated federal securities laws by making material misrepresentations in NantHealth's IPO registration statement and in subsequent public statements. In particular, the complaint refers to various third-party articles in alleging that defendants misrepresented NantHealth's business with the University of Utah, donations to the university by non-profit entities associated with our founder Dr. Soon-Shiong, and orders for GPS Cancer. The lead plaintiffs seek unspecified damages and other relief on behalf of putative classes of persons who purchased or acquired NantHealth securities in the IPO or on the open market from June 1, 2016 through May 1, 2017. In March 2018, the court largely denied Defendants' motion to dismiss the consolidated amended complaint. In September 2018, the lead plaintiffs filed a motion for certification of two plaintiff classes. We believe that the claims lack merit and intend to vigorously defend the litigation.

In May 2017, a putative class action complaint was filed in California Superior Court, Los Angeles County, asserting claims for violations of the Securities Act based on allegations similar to those in Deora. That case is captioned Bucks County Employees Retirement Fund v. NantHealth, Inc., BC 662330. The parties have agreed to stay the case until the next case management conference, scheduled for September 17, 2019. We believe that the claims lack merit and intend to vigorously defend the litigation.

In April 2018, two putative shareholder derivative actions-captioned Engleman v. Soon-Shiong, Case No. 2018-0282-AGB, and Petersen v. Soon-Shiong, Case No. 2018-0302-AGB were filed in the Delaware Court of Chancery. The plaintiff in the Engleman action previously filed a similar complaint in California Superior Court, Los Angeles County, which was dismissed based on a provision in the Company's charter requiring derivative actions to be brought in Delaware. The Engleman and Petersen complaints contain allegations similar to those in Deora, but assert causes of action on behalf of NantHealth against various of the Company's current or former executive officers and directors for alleged breaches of fiduciary duty, abuse of control, gross mismanagement, and unjust enrichment. The Company is named solely as a nominal defendant. In July 2018, the court issued an order consolidating the Engleman and Petersen actions as In re NantHealth, Inc. Stockholder Litigation, Lead C.A. No. 2018-0302-AGB, appointing Petersen as lead plaintiff, and designating the Petersen complaint as the operative complaint. On September 20, 2018, the defendants moved to dismiss the complaint. In October 2018, in response to the motion to dismiss, Petersen filed an amended complaint. In November 2018, the defendants moved to dismiss the amended complaint. In January 2019, the defendants filed their opening brief in support of the motion to dismiss the amended complaint. We believe that the claims lack merit and intend to vigorously defend the litigation.

In April 2018, a putative shareholder derivative action captioned Shen v. Soon-Shiong was filed in U.S. District Court for the District of Delaware. The complaint contains allegations similar to those in Deora, but asserts causes of action on behalf of NantHealth against various of the Company's current or former executive offers and directors for alleged breaches of fiduciary duty and unjust enrichment, as well as alleged violations of the federal securities laws based on alleged misstatements or omissions in the Company's 2017 proxy statement. The parties have agreed to stay the case pending a decision on defendants' motion to dismiss in the derivative action in the Delaware Court of Chancery.

Real Estate Litigation

On March 9, 2018, PayPal, Inc. ("PayPal") commenced an action against the Company in the Superior Court Department of the Trial Court of the Commonwealth of Massachusetts, for Suffolk County. The action was originally captioned PayPal, Inc. v. NantHealth, Inc., Civil Action No. 18-0780-E. On April 10, 2018, the Superior Court transferred the case to its Business Litigation Section, where it is currently pending and captioned as PayPal, Inc. v. NantHealth, Inc., Civil Action No. 18-0780-BLS1. This action arises out of a Sublease Agreement that PayPal and the Company entered into on or about November 30, 2017. The Sublease Agreement pertained to commercial real estate that PayPal leased at One International Place in Boston, Massachusetts. On January 25, 2018, we notified PayPal that we were electing to terminate the Sublease Agreement.

In its Verified Complaint, and a contemporaneous notice of default that the Company disputed, PayPal alleges that the Company breached the Sublease Agreement. In addition, PayPal asserts claims for breach of the covenant of good faith and fair dealing, and violations of Massachusetts General Laws, Chapter 93A, sections 2 and 11, and seeks a declaratory judgment recognizing and enforcing the terms of the Sublease Agreement. Among other relief, PayPal seeks damages, treble damages, interest, costs, and attorneys' fees.

On April 12, 2018, the Company filed its answer and jury demand in the action. On August 2, 2018, PayPal requested a status conference with the court in order to discuss PayPal's potential filing of a motion for partial judgment on the pleadings pursuant to Mass. R. Civ. P. 12(c). A Rule 16 Litigation Control Conference ("Rule 16 Conference") was held on August 22, 2018. During the Rule 16 Conference, the court denied PayPal's request for leave to file a motion for partial judgment on the pleadings. Following the Rule 16 Conference, the court issued a tracking order setting deadlines and other procedures that would apply to this action.

On September 26, 2018, we filed our Assented to Motion for Leave to Amend Its Answer. The court granted our motion on October 3, 2018. On October 9, 2018, we filed and served our amended answer and jury demand.

On January 8, 2019, the parties filed a joint motion to extend certain of the tracking order deadlines, which motion the court granted by endorsed order dated January 9, 2019.

The parties are currently engaged in discovery, including non-party discovery.

The Company denies any liability to PayPal and intend to vigorously defend the action.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information for Common Stock

Our common stock trades on the Nasdaq Global Select Market under the symbol "NH".

Holders of Record

As of March 26, 2019 , we had approximately 144 holders of record of our common stock. We believe the actual number of stockholders is greater than the number of record holders and includes stockholders who are beneficial owners but whose shares are held in street name by brokers and other nominees. This number of holders of record also does not include stockholders whose shares may be held in trust or by other entities.

Dividend Policy

No cash dividends were declared for our common stock during the fiscal years ended in 2018 and 2017 . We currently intend to retain all available funds and any future earnings for use in the operation of our business and do not anticipate paying any dividends on our common stock in the foreseeable future. Any future determination to declare dividends will be made at the discretion of our board of directors and will depend on, among other factors, our financial condition, operating results, capital requirements, general business conditions and other factors that our board of directors may deem relevant.

Recent Sales of Unregistered Securities

None.

Repurchases of Equity Securities by the Issuer

We did not make any stock repurchases during the twelve months ended December 31, 2018 .

Use of Proceeds

Our initial public offering of 6,900,000 shares of common stock was effected through a registration statement on Form S-1 (File No. 333-211196), which was declared effective on June 1, 2016. Our initial public offering closed on June 7, 2016 and resulted in net proceeds of approximately $83.6 million, after deducting underwriting discounts and commissions of approximately $4.9 million and other offering expenses of approximately $8.1 million. No payments for such expenses were made directly or indirectly to (i) any of our officers or directors; (ii) any persons owning 10% or more of any class of our class of our equity securities; or (iii) any of our affiliates.

Jefferies LLC, Cowen and Company, LLC, First Analysis Securities Corporation, Canaccord Genuity Inc. and FBR Capital Markets & Co. acted as the underwriters. There has been no material change in the planned use of proceeds from our initial public offering as described in our final prospectus filed with the SEC on June 3, 2016 pursuant to Rule 424(b) of the Securities Act.

Item 6. Selected Financial Data

Omitted, as not required for a smaller reporting company.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following is a discussion and analysis of our financial condition and the results of operations as of and for the periods presented below. The following discussion and analysis should be read in conjunction with the "Consolidated Financial Statements" and notes thereto included elsewhere in this Annual Report on Form 10-K, or Annual Report. This discussion contains forward-looking statements that are based on the beliefs, assumptions, and information currently available to our management, and are subject to known and unknown risks, uncertainties, and other factors that may cause our actual results to differ materially from those expressed or implied by such forward-looking statements. These risks, uncertainties, and other factors include, among others, those described in greater detail elsewhere in this Annual Report, particularly in Item 1A, "Risk Factors".

Overview

We are a leading next-generation, evidence-based, personalized healthcare company focused on enabling our clients to fundamentally change the diagnosis and treatment of cancer and other critical illnesses. We believe a molecular-driven, systems-based approach to making clinical treatment decisions based on large-scale, real time biometric and phenotypical data will become the standard of care initially for patients with cancer and, ultimately, other critical illnesses. We derive revenue from selling molecular sequencing and analysis services (including our unique, comprehensive GPS Cancer test, for which we obtained exclusive rights from an affiliate that provides sequencing and analysis of tumor & normal samples and our liquid/blood-based tumor profiling test service, Liquid GPS, which analyzes cell-free DNA (cfDNA) and cell-free RNA (cfRNA)), and from selling software solutions to healthcare payers, self-insured employers and healthcare systems.

We market certain of our solutions as a comprehensive integrated solution that includes our molecular sequencing and analysis services, Clinical Decision Support, and Payer Engagement solutions. We also market our molecular sequencing and analysis services, Clinical Decision Support, Payer Engagement and Connected Care solutions on a stand-alone basis. To accelerate our commercial growth and enhance our competitive advantage, we intend to continue to:

- introduce new marketing, education and engagement efforts and foster relationships across the oncology community to drive adoption of molecular sequencing and analysis services;
- pursue reimbursement of molecular sequencing and analysis services from regional and national third-party payers and government payers;
- publish scientific and medical advances;
- strengthen our commercial organization to increase our NantHealth solutions client base and to broaden usage of our solutions by existing clients; and
- develop new features and functionality for NantHealth solutions to address the needs of current and future healthcare provider and payer, self-insured employer and biopharmaceutical company clients.

Since our inception, we have devoted substantially all of our resources to the development and commercialization of NantHealth solutions, as well as the commercial launch and expansion of our molecular sequencing and analysis business. To complement our internal growth and expertise, we have made several strategic acquisitions of companies, products and technologies. We have incurred significant losses since our inception and, as of December 31, 2018 , our accumulated deficit was approximately $ 884.1 million . We expect to continue to incur operating losses over the near term as we drive adoption of our molecular sequencing and analysis solutions (including GPS Cancer and Liquid GPS), expand our commercial operations, and invest further in NantHealth solutions.

We plan to (i) continue investing in our infrastructure, including but not limited to solution development, sales and marketing, implementation and support, (ii) continue efforts to make infrastructure investments within an overall context of maintaining reasonable expense discipline, (iii) add new clients through maintaining and expanding sales, marketing and solution development activities, (iv) expand our relationships with existing clients through delivery of add-on and complementary solutions and services and (v) continue our commitment of service in support of our client satisfaction programs.

2018 Acquisition of NantHealth Labs (formerly Liquid Genomics, Inc.)

On February 28, 2018, we acquired 100% of the equity of NantHealth Labs, Inc. (“NantHealth Labs”, formerly Liquid Genomics, Inc.), a company that provides liquid biopsy analysis of gene expressions and mutations using cell free RNA and DNA, pursuant to an assignment agreement dated February 1, 2018 between the Company and NantOmics, LLC a related party. The purchase price for the acquisition consisted of 9,088,362 Series A-2 units of NantOmics previously owned by the Company that were transferred at the closing plus 564,779 of Series A-2 units of NantOmics owned by the Company that were transferred to NantOmics as of May 31, 2018.

We believe that we have a substantial opportunity to leverage NantHealth Labs' testing as a complementary offering to our current portfolio of sequencing and molecular analysis solutions. There are significant synergies available and we intend to leverage our current sales and marketing efforts to drive provider acceptance and adoption. A key value proposition for liquid biopsy tests is ease of use (e.g., no tissue biopsy necessary, and fast delivery time). This complements our GPS Cancer test by enabling repeated measurement and monitoring of select biomarker response to therapy. NantHealth Labs services are provided under the "Liquid GPS" brand.

2018 Impact of Hurricane Michael

On October 10, 2018, our leased Panama City, Florida office was hit by Hurricane Michael. Due to the geographic spread of our customers, no revenue was lost. However, certain implementation revenues for our software and hardware related business were delayed until later in the fourth quarter and into 2019, due to the disruption caused to our personnel living in the region. Personnel costs for time not worked by our employees in the region during the initial period of recovery totaled $0.7 million. Our office suffered water damage, which temporarily disabled our on-site servers, and delayed filing of our Form 10-Q for the period ended September 30, 2018. We spent $0.1 million directly on maintaining operations and repairing our office.

Evolution of GPS Cancer Test Platform

NantHealth and NantOmics, LLC (our exclusive technology partner for the GPS Cancer test) are continually taking steps to optimize the utility and value of our tests for physicians and their patients. To this end, we have leveraged our deep experience with RNA sequencing, bioinformatics and statistics to expand the clinical utility of the GPS Cancer test, while also streamlining and improving our lab workflow by consolidating to next-generation sequencing as our sole testing platform. A fundamental result of this work is that the key cancer treatment biomarkers previously assessed using our proprietary quantitative proteomics platform are, beginning in April 2018, now assessed solely via RNA sequencing, gene expression and statistical analysis. This change is based on the established clinical and scientific utility of tumor RNA sequencing. The tumor RNA transcriptome reveals gene and somatic variant expression, identifies gene fusions and validates their expression, and determines the relevance of gene copy number alterations. GPS Cancer currently assesses RNA expression of over 19,000 genes in a tumor sample and we have shown significant concordance between our RNA and proteomics expression platforms. We believe this change will result in operational efficiencies, an improved cost structure and more rapid transfer of scientific advancements in expression analysis to our clinical report. We also believe that our proprietary quantitative proteomics platform remains the most advanced technology available and a strategic asset of NantOmics. This platform continues to have potential commercial and research applications going forward.

2017 Asset Purchase Agreement with Allscripts

On August 3, 2017, we entered into an asset purchase agreement, which we refer to as the "APA," with Allscripts Healthcare Solutions, Inc., or “Allscripts”, pursuant to which we agreed to sell to Allscripts substantially all of the assets of our provider/patient engagement solutions business, including our FusionFX solution and components of its NantOS software connectivity solutions (the “Business”). On August 25, 2017, we and Allscripts completed the sale pursuant to the APA.

Allscripts conveyed to us 15,000,000 shares of our common stock at par value of $0.0001 per share that were previously owned by Allscripts as consideration for the transaction. We retired the shares of stock. Allscripts also paid $1.7 million of cash consideration to us as an estimated working capital payment, and we recorded a receivable of $1.0 million related to final working capital adjustments. We are also responsible for paying Allscripts for fulfilling certain customer service obligations of the business post-closing.

Concurrent with the closing and as contemplated by the APA, we and Allscripts modified the amended and restated mutual license and reseller agreement dated June 26, 2015, which was further amended on December 30, 2017, such that, among other things, the Company committed to deliver a minimum of $95.0 million of total bookings over a ten-year period ("Bookings Commitment") from referral transactions and sales of certain Allscripts products under this agreement (see Note 3 of the Consolidated Financial Statements). In the event of a Bookings Commitment shortfall at the end of the ten-year period, we may be obligated to pay 70% of the shortfall, subject to certain credits. We will earn 30% commission from Allscripts on each software referral transaction that results in a booking with Allscripts. We account for the Bookings Commitment at its estimated fair value over the life of the agreement. As of December 31, 2018, the estimated fair value was $16.9 million, and at December 31, 2017, the fair value was estimated not to be material.

The sale of the Business qualified as a discontinued operations because it comprised operations and cash flows that could be distinguished, operationally and for financial reporting purposes, from the rest of the Company. The disposal of the Business sold to Allscripts represented a strategic shift in our operations as the sale enables us to focus on molecular sequencing and analysis, clinical decision support, connected care and payer engagement.

2017 Corporate Restructuring Plan

In August 2017, we committed to and began implementation of a comprehensive restructuring plan that includes a wide range of organizational efficiency initiatives and other cost reduction opportunities. The plan will allow us to focus on our core competencies of molecular sequencing and analysis, clinical decision support, connected care and payer engagement. We incurred charges from this restructuring related to severance and other cash expenditures and recognized the majority of the expenses related to this restructuring in the year ended December 31, 2017.

Non-GAAP Net Loss from Continuing Operations and Non-GAAP Net Loss Per Share from Continuing Operations

Adjusted net loss from continuing operations and adjusted net loss per share from continuing operations are financial measures that are not prepared in conformity with United States generally accepted accounting principles (U.S. GAAP). Our management believes that the presentation of Non-GAAP financial measures provides useful supplementary information regarding operational performance, because it enhances an investor's overall understanding of the financial results for our core business. Additionally, it provides a basis for the comparison of the financial results for our core business between current, past and future periods. Other companies may define these measures in different ways. Non-GAAP financial measures should be considered only as a supplement to, and not as a substitute for or as a superior measure to, financial measures prepared in accordance with U.S. GAAP.

Non-GAAP net loss from continuing operations excludes the effects of (1) loss from equity method investments including impairment losses, (2) stock based compensation expense, (3) intangible amortization, (4) corporate restructuring expenses, (5) acquisition related sales incentives, which have been recorded as contra revenue, (6) change in fair value of derivatives liability, (7) change in fair value of the Bookings Commitment, (8) non-cash interest expense related to convertible notes, (9) securities litigation costs, (10) impairment of investments without readily determinable fair value, and (11) the impacts of certain income tax benefits and provisions from non-cash activity.

The following table reconciles Net loss from continuing operations to Net loss from continuing operations - Non-GAAP and Shares outstanding to Shares outstanding - Non-GAAP for the years ended December 31, 2018 and 2017 :

(Dollars in thousands, except per share amounts)	Year Ended December 31,	
	2018	2017
Net loss from continuing operations	$ (190,433)	$ (131,399)
Adjustments to GAAP net loss:		
Corporate restructuring from continuing operations (1)	—	2,422
Acquisition related sales incentive	1,420	2,732
Intangible amortization from continuing operations	9,150	9,388
Loss from related party equity method investment including impairment loss	108,409	50,334
Non-cash interest expense related to convertible notes	5,019	4,417
Change in fair value of derivatives liability	(7)	(264)
Change in fair value of Bookings Commitment	16,947	—
Stock-based compensation expense from continuing operations	5,657	8,102
Securities litigation costs	1,317	777
Impairment of equity securities	1,750	—
Tax benefit resulting from certain non-cash tax items	(3,760)	(1,976)
Total adjustments to GAAP net loss from continuing operations	145,902	75,932
Net loss - Non-GAAP from continuing operations	$ (44,531)	$ (55,467)
Weighted average shares outstanding	109,168,798	116,737,860
Net loss per share from continuing operations - Non-GAAP	**$ (0.41)**	**$ (0.47)**

The following table reconciles Net loss per share to Net loss per share Non-GAAP for the years ended December 31, 2018 and 2017 :

	Year Ended December 31,	
	2018	2017
Net loss per common share from continuing operations - GAAP	$ (1.74)	$ (1.12)
Adjustments to GAAP net loss per common share from continuing operations:		
Corporate restructuring from continuing operations (1)	—	0.02
Acquisition related sales incentive	0.01	0.02
Intangible amortization from continuing operations	0.08	0.08
Loss from related party equity method investment including impairment loss	0.98	0.43
Non-cash interest expense related to convertible notes	0.05	0.04
Change in fair value of derivatives liability	—	—
Change in fair value of Bookings Commitment	0.16	—
Stock-based compensation expense from continuing operations	0.05	0.07
Securities litigation costs	0.01	0.01
Impairment of equity securities	0.02	—
Tax benefit resulting from certain non-cash tax items	(0.03)	(0.02)
Total adjustments to GAAP net loss per common share from continuing operations	1.33	0.65
Net loss per common share from continuing operations - Non-GAAP	**$ (0.41)**	**$ (0.47)**

(1) Corporate restructuring includes accrued bonus reversal of $0.5 million for the year ended December 31, 2017.

Components of Our Results of Operations

Revenue

We generate our revenue from the sale of software-as-a-service, software, hardware and services, sequencing and molecular analysis and home health care services. Our systems infrastructure and platforms support the delivery of both personalized comprehensive sequencing and molecular analysis and the implementation of value-based care models across the healthcare continuum. We generate revenue from the following sources:

Software-as-a-service related - SaaS related revenue is generated from our clients' access to and usage of our hosted software solutions on a subscription basis for a specified contract term. In SaaS arrangements, the customer cannot take possession of the software during the term of the contract and generally only has the right to access and use the software and receive any software upgrades published during the subscription period. Solutions sold under a SaaS model include our Eviti platform solutions and NaviNet.

Software and hardware related - Software and hardware related revenue is generated from the license of our software, on a perpetual basis, the sale of hardware and professional services that are complementary to the software and may or may not be required for the software to function as desired by the customer. The services are generally provided in the form of implementation and training services and do not include maintenance revenue. The software is installed on the customer's site or the customer's designated vendor's site and is not hosted by us or by a vendor contracted by us. We also generate revenue from the resale of third-party software and hardware to our clients. Our software license and hardware solutions include DeviceConX software and HBox.

Maintenance - Maintenance revenue includes ongoing post contract client support ("PCS") or maintenance on software and hardware during the PCS term. Additionally, PCS includes ongoing development of software updates and upgrades provided to the customer on a when-and-if-available basis. We sell our DeviceConX solution with maintenance contracts.

Sequencing and molecular analysis - Sequencing and molecular analysis revenue is generated by providing customers with reports of the results of performing sequencing and analysis of whole genome DNA, RNA, and/or proteomic testing under our reseller agreement with NantOmics, LLC ("NantOmics"), and from blood samples via our liquid/blood-based tumor profiling platform through our subsidiary, NantHealth Labs, Inc. ("NantHealth Labs", formerly Liquid Genomics, Inc.). Revenue is recognized at a point in time, when reports of results are transferred to the ordering physician or institution, or on a cash basis; or ratably over time for the period of a stand-ready obligation to provide blood-based tumor profiling services.

Home health care services - Home health care services revenue includes revenue related to nursing and therapy services provided to patients in a home care setting.

Cost of Revenue

Cost of revenue includes associated salaries and fringe benefits, stock-based compensation, consultant costs, direct reimbursable travel expenses, depreciation related to software developed for internal use, depreciation related to lab equipment, and other direct engagement costs associated with the design, development, sale and installation of systems, including system support and maintenance services for customers. System support includes ongoing customer assistance for software updates and upgrades, installation, training and functionality. All service costs, except development of internal use software and deferred implementation costs, are expensed when incurred. Amortization of deferred implementation costs are also included in cost of revenue. Cost of revenue associated with each of our revenue sources consists of the following types of costs:

Software-as-a-service related - SaaS related cost of revenue includes personnel-related costs, amortization of deferred implementation costs, depreciation of internal use software, and other direct costs associated with the delivery and hosting of our subscription services.

Software and hardware related - Software and hardware related cost of revenue includes third-party software and hardware costs directly associated with solutions, including purchasing and receiving costs, and includes direct costs associated with software implementation services provided to our customers. Software and hardware related cost of revenue also includes hardware costs directly related to bringing manufactured products to their final selling destination.

Maintenance - Maintenance cost of revenue includes personnel-related costs and other direct costs associated with the ongoing support or maintenance provided to our customers.

Sequencing and molecular analysis - Sequencing and molecular analysis cost of revenue includes personnel-related costs associated with fulfillment of these services, including those of our subsidiary, NantHealth Labs, and amounts due to NantOmics under the reseller agreement for the sequencing and analysis of whole genome, DNA, RNA, and/or proteomic results. It also includes depreciation of internal use software and lab equipment.

Home health care services - Home health care services cost of revenue includes direct expenses relating to our nursing and therapy services provided to patients in a home care setting.

We plan to continue to expand our capacity to support our growth, which will result in higher cost of revenue in absolute dollars. We expect cost of revenue to decrease as a percentage of revenue over time as we expand NantHealth solutions and realize economies of scale.

Operating Expenses

Our operating expenses consist of selling, general and administrative, research and development, and amortization of software license and acquisition-related assets.

Selling, general and administrative

Selling, general and administrative expense consists primarily of personnel-related expenses for our sales and marketing, finance, legal, human resources, and administrative associates, stock-based compensation, advertising and marketing promotions of NantHealth solutions, and corporate shared services fees from NantWorks. It also includes trade show and event costs, sponsorship costs, point of purchase display expenses and related amortization as well as legal costs, facility costs, consulting and professional fees, insurance and other corporate and administrative costs.

We continue to review our other selling, general and administrative investments and expect to drive cost savings through greater efficiencies and synergies across our company. Additionally, we expect to continue to incur additional costs for legal, accounting, insurance, investor relations and other costs associated with operating as a public company. These increases include additional costs we expect to incur associated with compliance with the Sarbanes-Oxley Act and other regulations governing public companies as well as increased costs for directors' and officers' liability insurance and an enhanced investor relations function. However, we expect our selling, general and administrative expense to decrease as a percentage of revenue over the long term as our revenue increases and we realize economies of scale.

Research and development

Research and development expenses consist primarily of personnel-related costs for associates working on development of solutions, including salaries, benefits and stock-based compensation. Also included are non-personnel costs such as consulting and professional fees to third-party development resources.

The majority of our research and development expenses are related to developing new software solutions and improving our existing software solutions. A portion of research and development costs are related to the personnel operating costs of the laboratory operations of NantHealth Labs.

We expect our research and development expenses to continue to increase in absolute dollars and as a percentage of revenue as we continue to make significant investments in developing new solutions and enhancing the functionality of our existing solutions with a focus on cancer care. However, we expect our research and development expenses to decrease as a percentage of revenue over the long term as we realize economies of scale from our developed technology.

Amortization of Acquisition Related Assets

Amortization of acquisition related assets consists of non-cash amortization expense related to our non-revenue generating technology as well as amortization expense that we recognize on intangible assets that we acquired through our investments.

Interest Expense, net

Interest expense, net primarily consists of interest expense associated with our outstanding borrowings, including coupon interest expense, amortization of debt discounts and amortization of deferred financing offering cost, offset by interest income earned on our cash and cash equivalents and marketable securities.

Other Income (Expense), net

Other income (expense), net consists primarily of unrealized and realized gains (losses), dividends received from our marketable securities, change in fair value of derivative liability and other non-recurring items.

Loss from Equity Method Investment Including Impairment Loss

Loss from equity method investments consists of our pro rata share of losses of a company that we own an ownership interest in and account for under the equity method of accounting including impairment loss. We regularly evaluate our investments, which are not carried at fair value, for other than temporary impairment in accordance with U.S. GAAP.

Provision for (Benefit from) Income Taxes

Provision for income taxes consists of U.S. federal and state and foreign income taxes. We are required to allocate the provision for income taxes between continuing operations and other categories for earnings, such as discontinued operations. To date, we have no significant U.S. federal, state and foreign cash income taxes because of our LLC status prior to June 1, 2016 and current and accumulated net operating losses.

We record a valuation allowance when it is more likely than not that some portion or all of a deferred tax asset will not be realized. In making such a determination, we consider all the available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, and ongoing prudent and feasible tax planning strategies in assessing the amount of the valuation allowance. When we establish or reduce the valuation allowance against the deferred tax assets, our provision for income taxes will increase or decrease, respectively, in the period such determination is made.

Results of Operations

The following table sets forth our Consolidated Statements of Operations data for each of the periods indicated:

(Dollars in thousands except per share amounts)	Year Ended December 31,	
	2018	2017
Revenue:		
Software-as-a-service related	$ 65,646	$ 60,730
Software and hardware related	4,534	7,648
Maintenance	9,834	10,421
Total software-related revenue	80,014	78,799
Sequencing and molecular analysis	3,129	2,554
Home health care services	6,321	5,323
Total net revenue	89,464	86,676
Cost of Revenue:		
Software-as-a-service related	23,691	21,939
Software and hardware related	3,335	4,749
Maintenance	924	749
Amortization of developed technologies	4,933	5,172
Total software-related cost of revenue	32,883	32,609
Sequencing and molecular analysis	8,055	6,084
Home health care services	3,331	2,829
Total cost of revenue	44,269	41,522
Gross profit	45,195	45,154
Operating Expenses:		
Selling, general and administrative	70,763	74,976
Research and development	20,916	33,862
Amortization of acquisition-related assets	4,217	4,216
Total operating expenses	95,896	113,054
Loss from operations	(50,701)	(67,900)
Interest expense, net	(17,120)	(16,168)
Other (loss) income, net	(17,876)	800
Loss from related party equity method investment, including impairment	(108,409)	(50,334)
Loss from continuing operations before income taxes	(194,106)	(133,602)
Benefit from income taxes	(3,673)	(2,203)
Net loss from continuing operations	(190,433)	(131,399)
Loss from discontinued operations, net of tax	(1,719)	(43,812)
Net loss	$ (192,152)	$ (175,211)
Basic and diluted net loss per share		
Continuing operations - common stock	$ (1.74)	$ (1.12)
Discontinued operations - common stock	$ (0.02)	$ (0.37)
Total net loss per common stock	$ (1.76)	$ (1.49)
Weighted average shares outstanding:		
Basic and diluted - common stock	109,168,798	116,737,860

The following table sets forth our Consolidated Statements of Operations data as a percentage of revenue for each of the periods indicated (Unaudited):

	Year Ended December 31,	
	2018	2017
Revenue:		
Software-as-a-service related	73.3%	70.1%
Software and hardware related	5.1%	8.8%
Maintenance	11.0%	12.0%
Total software-related revenue	89.4%	90.9%
Sequencing and molecular analysis	3.5%	2.9%
Home health care services	7.1%	6.2%
Total net revenue	100.0%	100.0%
Cost of Revenue:		
Software-as-a-service related	26.5%	25.3%
Software and hardware related	3.7%	5.5%
Maintenance	1.0%	0.9%
Amortization of developed technologies	5.6%	5.9%
Total software-related cost of revenue	36.8%	37.6%
Sequencing and molecular analysis	9.0%	7.0%
Home health care services	3.7%	3.3%
Total cost of revenue	49.5%	47.9%
Gross profit	50.5%	52.1%
Operating Expenses:		
Selling, general and administrative	79.1%	86.4%
Research and development	23.4%	39.1%
Amortization of acquisition-related assets	4.7%	4.9%
Total operating expenses	107.2%	130.4%
Loss from operations	(56.7%)	(78.3%)
Interest expense, net	(19.1%)	(18.7%)
Other (loss) income, net	(20.0%)	0.9%
Loss from related party equity method investment, including impairment	(121.2%)	(58.0%)
Loss from continuing operations before income taxes	(217.0%)	(154.1%)
Benefit from income taxes	(4.1%)	(2.5%)
Net loss from continuing operations	(212.9%)	(151.6%)
Loss from discontinued operations, net of tax	(1.9%)	(50.5%)
Net loss	(214.8%)	(202.1%)

Comparison of the years ended December 31, 2017 and 2018

Revenue

(Dollars in thousands)	Year Ended December 31,		Period-To-Period Change	
	2018	2017	2018 vs. 2017	
	Amount	Amount	Amount	Percentage
Software-as-a-service related	$ 65,646	$ 60,730	4,916	8.1 %
Software and hardware related	4,534	7,648	(3,114)	-40.7 %
Maintenance	9,834	10,421	(587)	-5.6 %
Total software-related revenues	80,014	78,799	1,215	1.5 %
Sequencing and molecular analysis	3,129	2,554	575	22.5 %
Home health care services	6,321	5,323	998	18.7 %
Total net revenue	$ 89,464	$ 86,676	$ 2,788	3.2 %

Comparison of the years ended December 31, 2017 and 2018

Total revenue increased $2.8 million , or 3.2% , from $86.7 million for the year ended December 31, 2017 to $89.5 million for the year ended December 31, 2018 . Our total revenue growth was driven primarily by growth in our SaaS, home health care services, and sequencing and molecular analysis revenue categories.

Total software-related revenue was $80.0 million for the year ended December 31, 2018 compared to $78.8 million for the year ended December 31, 2017 , an increase of 1.2 million , or 1.5% . The increase in total software-related revenue was primarily driven by SaaS revenue from our NaviNet product. This increase was partially offset by a decrease in our software and hardware line of business because of the timing of completed implementations as compared to the prior year.

Software and hardware revenue decreased $3.1 million , or 40.7% , for the year ended December 31, 2018 compared to the prior year. The primary driver of this decrease was lower revenue from completed implementations of DeviceConX compared to the prior year.

SaaS revenue was $65.6 million for the year ended December 31, 2018 , an increase of $4.9 million , or 8.1% , from $60.7 million compared to the prior year. This growth was primarily driven by higher revenue from our NaviNet product due to a higher number of implementations being completed during the year.

Maintenance revenue decreased $0.6 million , or 5.6% , from $10.4 million in the year ended December 31, 2017 to $9.8 million for the year ended December 31, 2018 . This decrease was primarily driven by the timing of recognition of maintenance fees on an individual contract in the prior year, which had been deferred until implementation was complete under the previous revenue recognition guidance. This decrease was partially offset by a larger customer base for DeviceConX post contract support maintenance services compared to the prior year.

Sequencing and molecular analysis revenue increased from $2.6 million for the year ended December 31, 2017 to $3.1 million for the year ended December 31, 2018. This increase was due to the acquisition of NantHealth Labs and the resulting addition of the Liquid GPS test to our products during 2018, which provided $0.8 million of revenue in 2018. GPS Cancer revenues declined slightly driven by a change in product mix on tests performed and reimbursed as we transitioned a part of our sequencing and molecular analysis business to the Liquid GPS test to accommodate a growing segment of the market.

Currently, we recognize revenue from customers with executed contracts, and from customers without a contractual agreement where we recognize revenue on a cash basis given the uncertainty of reimbursement. As the company gains additional insurance coverage, including coverage under government insurance programs, we expect to be able to reduce the portion of GPS Cancer revenue which is recognized on a cash basis.

The commercial team's efforts are focused on increasing reimbursement of the GPS Cancer profile by developing partnerships, which include pilot arrangements with commercial insurance and self-insured employers, expanding physician relationships, and enhancing operational performance and efficiencies. The partnership strategy that we developed for commercial health plans supports an alignment with designated provider/oncology groups within the health plan's network. We work directly with the physician groups to support education of test ordering and interpretation and enable aggregate review of results with the plans. In the initial pilot arrangement that we have with commercial health plan, reimbursement is recognized for each test order throughout the pilot arrangement and the GPS Cancer profile value is assessed by the plan with the goal of full medical policy adoption at pilot end.

We have also continued focused efforts to enhance reimbursement from plans when profiles are ordered and there is no payer contract in place. We are actively engaging plans with detail which supports a physician's reason for ordering. Our utilization of pre-authorizations and supporting documentation assists in the overall billing and appeal process, optimizing payment with payers, who do not have a formal agreement with us. The GPS Cancer profile provides all information that can be found in other market molecular tests that physicians deem necessary for treatment recommendation and expands insight for the oncologist with the comprehensive information available on each patient tested.

In parallel with the private payer activities described above, we are also making extensive efforts to achieve coverage from governmental programs such as Medicare, using approval pathways including FDA in-vitro medical device clearance. Those activities are ongoing but have uncertainty on the timelines as to formal approval.

Home health care services revenue increased $1.0 million , or 18.7% , from $5.3 million in 2017 to $6.3 million for the year ended December 31, 2018 . This was a result of increased home visits in the year, partially as a result of the territory of our home health care services expanding to Prescott, Arizona.

We believe that significant opportunities exist for expanded cross-selling across our products and across our existing customer base, including Eviti and NaviNet customer bases. We also believe that our customer base and our product solutions provide unique opportunities to expand the volume of GPS Cancer and Liquid GPS analysis reporting to our customer base. Maintaining our current customer base will be important to our future maintenance and SaaS recurring revenue streams.

Cost of Revenue

(Dollars in thousands)	Year Ended December 31,		Period-To-Period Change	
	2018	2017	2018 vs. 2017	
	Amount	Amount	Amount	Percentage
Software–as-a-service	$ 23,691	$ 21,939	$ 1,752	8.0 %
Software and hardware	3,335	4,749	(1,414)	-29.8 %
Maintenance	924	749	175	23.4 %
Amortization of developed technologies	4,933	5,172	(239)	-4.6 %
Total software-related cost of revenue	32,883	32,609	274	0.8 %
Sequencing and molecular analysis	8,055	6,084	1,971	32.4 %
Home health care services	3,331	2,829	502	17.7 %
Total cost of revenue	$ 44,269	$ 41,522	$ 2,747	6.6 %

Comparison of the years ended December 31, 2017 and 2018

Cost of revenue increased $2.7 million , or 6.6% , from $41.5 million in the year ended December 31, 2017 to $44.3 million for the year ended December 31, 2018 . The primary driver of this increase was an additional $3.4 million depreciation from newly capitalized internally developed software supporting software-as-a-service and sequencing and molecular analysis solutions.

Total software-related cost of revenue increased $0.3 million , or 0.8% , from $32.6 million in 2017 to $32.9 million for the year ended December 31, 2018 . The primary driver of this was a $2.8 million increase in SaaS cost of revenue primarily attributed to increased depreciation of internally developed software, compared to amortization of deferred implementation costs in the prior year under ASC 605, attributable to our NaviNet solutions. This was partially offset by reductions in costs associated with purchased software and reduced salary costs associated with our software and hardware business.

Sequencing and molecular analysis cost of revenue increased $2.0 million , or 32.4% , from $6.1 million in 2017 compared to $8.1 million in 2018 . This increase was due to the addition of NantHealth Labs during 2018, which introduced laboratory expenses of $0.4 million and led to personnel expenses increasing $0.6 million. There was also an increase of $0.5 million in relation to the depreciation of internally developed software related to GPS Cancer and Liquid GPS.

Cost of revenue associated with the cost of tests performed by NantOmics increased by $0.3 million for 2018 compared to the prior year. We record the cost of revenue expense upon delivery of the GPS Cancer report to our clients. As a result, there will be a timing difference between the revenue recorded and the cost of revenue recorded. In addition, the cost of revenue is recorded as defined by the applicable contract with our clients and as outlined in the amended and restated Reseller Agreement ("Reseller Agreement") for genomic and proteomic sequencing services and related bioinformatics and analysis services with NantOmics. On December 18, 2017, the Company and NantOmics executed Amendment No. 1 to the Second Amended Reseller Agreement. The Second Amended Reseller Agreement was amended to allow fee adjustments with respect to services completed by NantOmics between the amendment effective date of October 1, 2017 to June 30, 2018.

We believe that there are opportunities going forward to grow the volume of sequencing and molecular analysis activity which would increase the associated costs of delivering such revenue. We record the cost of revenue expense upon delivery of the GPS Cancer report to our clients. There may be a timing difference between the revenue recorded and the cost of revenue recorded in the event that revenue recognition is delayed. Sequencing and molecular analysis revenue in the current period was limited to what could be recognized on a cash basis due to uncertainty over reimbursement for the GPS Cancer profiles delivered in the period. As we gain additional insurance coverage and reimbursement experience, we expect to be able to reduce the portion of GPS revenue which is recognized on a cash basis.

Home health care services cost of revenue increased $0.5 million , or 17.7% , from $2.8 million in 2017 to $3.3 million for the year ended December 31, 2018 . This was in line with revenue growth, as more personnel were hired and consultants used in order to meet the higher number of visits performed in the year.

Selling, General and Administrative

(Dollars in thousands)	Year Ended December 31,		Period-To-Period Change	
	2018	2017	2018 vs. 2017	
	Amount	Amount	Amount	Percentage
Selling, general and administrative	$ 70,763	$ 74,976	$ (4,213)	(5.6)%

Comparison of the years ended December 31, 2017 and 2018

For the year ended December 31, 2018 , selling, general and administrative expenses decreased $4.2 million , or 5.6% , from $75.0 million in 2017 to $70.8 million in 2018 . This decrease was due to a $2.6 million decrease in corporate shared services expenses charged to us by affiliated companies, as we have developed additional functional areas internally and started providing services to affiliated entities, which we charge back, offsetting corporate shared services expenses. There was also a $1.2 million decline in personnel costs, largely due to a reduced bonus payout for 2018.

Research and Development

(Dollars in thousands)	Year Ended December 31,		Period-To-Period Change	
	2018	2017	2018 vs. 2017	
	Amount	Amount	Amount	Percentage
Research and development	$ 20,916	$ 33,862	$ (12,946)	(38.2)%

Comparison of the years ended December 31, 2017 and 2018

Research and development expenses decreased $12.9 million , or 38.2% , from $33.9 million in 2017 to $20.9 million in 2018 . This decrease was largely driven by a decrease of $8.4 million in personnel expenses due to our restructuring in 2017, offset by the addition of research and development personnel from NantHealth Labs, which reduced headcount allocated to research and development by around 26%. There was also a $2.7 million decrease in stock compensation expense related to the reduction in research and development headcount, and an equity award granted in November 2017, a portion of which vested immediately increasing the expense recognized for 2017. The lower headcount and lower overall bonus payments in 2018 led to a $0.5 million decrease in bonus expense. Also, we saw a $0.7 million decline in expense from external research and development resources as development projects were performed internally and a reduction of $0.3 million from travel expense, related to cost control measures.

Interest Expense, Net

(Dollars in thousands)	Year Ended December 31,		Period-To-Period Change	
	2018	2017	2018 vs. 2017	
	Amount	Amount	Amount	Percentage
Interest expense, net	$ (17,120)	$ (16,168)	$ (952)	5.9%

In December 2016, we issued an aggregate principal amount of $107.0 million of our 5.5% convertible senior notes due 2021 (the "Convertible Notes") in a private placement offering to qualified institutional buyers pursuant to Rule 144A under the Securities Act of 1933, as amended (the "Securities Act"), as amended and to non-U.S. persons pursuant to Regulation S under the Securities Act, of which $10 million were issued to a related party. The Convertible Notes will mature on December 15, 2021 unless earlier converted, redeemed or repurchased in accordance with the terms of the Convertible Notes. Please see the section entitled "Liquidity and Capital Resources" below and Note 11 to our audited consolidated financial statements included in Item 8 of this Annual Report on Form 10-K for further discussion of the Convertible Notes.

In January 2016, we executed a demand promissory note with NantCapital (the "NantCapital Note"), a personal investment vehicle for Dr. Patrick Soon-Shiong, our Chairman and Chief Executive Officer. Through December 31, 2018 , the total advances made by NantCapital to us pursuant to the NantCapital Note amounted to approximately $112.7 million. We can request additional advances subject to approval from NantCapital. The NantCapital Note bears interest at a per annum rate of 5.0% compounded annually and computed on the basis of the actual number of days in the year.

In May 2016, the NantCapital Note was amended and restated to provide that all outstanding principal and accrued and unpaid interest was due and payable on June 30, 2021, and not on demand. On December 15, 2016, in connection with the offering of the Convertible Notes, we entered into a Second Amended and Restated Promissory Note which amended and restated the Second Amended and Restated Promissory Note, dated May 9, 2016, between us and NantCapital, to extend the maturity date of the Second Amended and Restated Promissory Note to June 30, 2022 and to subordinate the Second Amended and Restated Promissory Note in right of payment to the Convertible Notes.

Please see the section entitled "Liquidity and Capital Resources" below and Note 18 to our audited consolidated financial statements included in Item 8 of this Annual Report on Form 10-K for further discussion of these notes.

Comparison of the years ended December 31, 2017 and 2018

Interest expense, net, increased by $1.0 million , from $16.2 million for the year ended December 31, 2017 to $17.1 million for the year ended December 31, 2018 . This increase was attributable to a $0.6 million increase in interest expense from the amortization of debt discounts on the Convertible Notes issued in 2016 and a $0.3 million increase in interest expense from the NantCapital Note, due to interest accruals.

Other Income (Expense), net

(Dollars in thousands)	Year Ended December 31,		Period-To-Period Change	
	2018	2017	2018 vs. 2017	
	Amount	Amount	Amount	Percentage
Other income (expense), net	$ (17,876)	$ 800	$ (18,676)	-2,334.5 %

Comparison of the years ended December 31, 2017 and 2018

Other income or expense moved by $18.7 million , from an income of $0.8 million for the year ended December 31, 2017 to an expense of $17.9 million for the year ended December 31, 2018 . The expense was mainly driven by a $16.9 million increase in the fair value of the Bookings Commitment liability, as a result of changes in the status of identified opportunities, reductions in the estimated value of identified opportunities and delays in executing management's planned sales strategy. There was a further expense due to a $1.8 million impairment loss on our investment in Innovative Oncology Business Solutions Inc. These expenses were offset by other income associated with the services performed under the transition services agreement with Allscripts.

Loss from Related Party Equity Method Investment including impairment loss

(Dollars in thousands)	Year Ended December 31,		Period-To-Period Change	
	2018	2017	2018 vs. 2017	
	Amount	Amount	Amount	Percentage
Loss from related party equity method Investment including impairment loss	$ (108,409)	$ (50,334)	$ (58,075)	115.4%

Comparison of the years ended December 31, 2017 and 2018

For the year ended December 31, 2018 , loss from equity method investment increased $ 58.1 million compared to the prior year, from $50.3 million during the year ended December 31, 2017 to $108.4 million during the year ended December 31, 2018 .

This increase was primarily due to impairment charges of $14.8 million and $80.4 million at December 31, 2018 and September 30, 2018, respectively, as a result of our determination that the fair value of our investment in NantOmics had declined below our carrying value and that this decline in value was other than temporary. The decline in the fair value of our investment in NantOmics at December 31, 2018 was primarily caused by changes in the pricing assumed in the Reseller Agreement. At September 30, 2018, the impairment was primarily caused by changes in projected GPS Cancer revenue, due to delays in our GPS Cancer revenue growth.

Our loss from equity investments in the year ended December 31, 2017 included a $36.0 million impairment charge, as a result of our determination that the fair value of our investment in NantOmics had declined below our carrying value as of June 30, 2017 and that this decline in value was other than temporary. The decline in the fair value of our investment in NantOmics was primarily caused by a change in the risk profile of our financial projections for NantOmics resulting from the delay in our GPS Cancer revenue growth.

The increase in loss from equity method investments was due to the impairment above, our pro rata share of losses from our investment in NantOmics, and the amortization of the basis difference in the investment. We report our share of NantOmics' loss and the amortization of basis difference using a one quarter lag.

Provision for (Benefits from) Income taxes

(Dollars in thousands)	Year Ended December 31,		Period-To-Period Change	
	2018	2017	2018 vs. 2017	
	Amount	Amount	Amount	Percentage
Provision for (benefit from) income taxes	$ (3,673)	$ (2,203)	$ (1,470)	66.7%

Comparison of the years ended December 31, 2017 and 2018

For the year ended December 31, 2018 , the benefit from income taxes in continuing operations was $3.7 million , compared with a $2.2 million benefit for income taxes during the year ended December 31, 2017 .

The 2018 tax benefit is mainly due to the Tax Cuts and Jobs Act of 2017 that allowed net operating losses generated in 2018 to be carried forward indefinitely.

In 2017, we recorded a benefit from income taxes in the continuing operations in the amount of $3.0 million due to the tax law changes under the Tax Cuts and Jobs Act of 2017.

On December 22, 2017, the Tax Cuts and Jobs Act of 2017, or the Tax Act, was signed into law making significant changes to the Code. Changes include, but are not limited to, a corporate tax rate decrease to 21% effective for tax years beginning after December 31, 2017. This change in tax rate resulted in a reduction in our net U.S. deferred tax assets before valuation allowance by $46.5 million, which was mostly offset by a reduction in our valuation allowance. The other provisions of the Tax Act, including the one-time transition tax on the mandatory deemed repatriation of cumulative foreign earnings, did not have a material impact on our financial statements as of December 31, 2017.

In December 2017, the SEC issued Staff Accounting Bulletin No. 118 ("SAB 118"), which provides guidance on accounting for the income tax effects of the TCJA. SAB 118 provides a measurement period that should not extend beyond one year from the TCJA enactment date for companies to complete the accounting relating to the TCJA under Accounting Standards Codification Topic 740, "Income Taxes" ("ASC 740"). In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the TCJA for which the accounting under ASC 740 is complete. To the extent that a company's accounting for TCJA-related income tax effects is incomplete, but the company is able to determine a reasonable estimate, it must record a provisional estimate in its financial statements. If a company cannot determine a provisional estimate to be included in its financial statements, it should continue to apply ASC 740 on the basis of the provisions of the tax laws that were in effect immediately before the enactment of the TCJA. The Company has completed its evaluation of the potential impacts of the Act of 2017 on its December 31, 2018 financial statements under the one-year measurement period provided under SAB 118. No adjustment has been recorded as there were no material changes between the provisional estimate and the final accounting for the Act.

Liquidity and Capital Resources

Sources of Liquidity

As of December 31, 2018 , we had cash and cash equivalents and marketable securities of $18.3 million , compared to $61.7 million as of December 31, 2017 , of which $0.1 million and $0.2 million , respectively, related to foreign subsidiaries. We believe our existing cash, cash equivalents and ability to borrow from affiliated entities will be sufficient to fund operations through at least 12 months following the issuance date of the financial statements based upon our Chairman and CEO's intent and ability to support our operations with additional funds as required. We may also seek to sell additional equity, through one or more follow-on public offerings or in separate financings, or sell additional debt securities or obtain a credit facility. However, we may not be able to secure such financing in a timely manner or on favorable terms. Without additional funds, we may choose to delay or reduce our operating or investment expenditures. Further, because of the risk and uncertainties associated with the commercialization of our existing products as well as products in development, we may need additional funds to meet its needs sooner than planned. To date, our primary sources of capital were private placement of membership interests prior to its IPO, debt financing agreements, including the NantCapital Note, convertible notes, and our IPO.

Convertible Notes

In December 2016, we entered into a purchase agreement (the "Purchase Agreement") with J.P. Morgan Securities LLC and Jefferies LLC, as representatives of the several initial purchasers named therein (collectively, the "Initial Purchasers"), to issue and sell $90.0 million in aggregate principal amount of our 5.50% Convertible Senior Notes due 2021 (the "Convertible Notes") in a private placement to qualified institutional buyers pursuant to Rule 144A under the Securities Act and to non-U.S. persons pursuant to Regulation S under the Securities Act. In December 2016, we entered into a purchase agreement (the "Cambridge Purchase Agreement") with Cambridge Equities, L.P., an entity affiliated with Dr. Patrick Soon-Shiong, our Chairman and Chief Executive Officer ("Cambridge"), to issue and sell $10.0 million in aggregate principal amount of the Convertible Notes in a private placement pursuant to an exemption from the registration requirements of the Securities Act afforded by Section 4(a)(2) of the Securities Act. In December 2016, pursuant to the exercise of the overallotment by the Initial Purchasers, we issued an additional $7.0 million principal amount of the Convertible Notes. The total net proceeds from this offering were approximately $102.7 million, comprised of $9.9 million from Cambridge and $92.8 million from the Initial Purchasers, after deducting of Initial Purchasers' discount and debt issuance costs of $4.3 million in connection with the Convertible Notes offering.

On December 21, 2016, we entered into an Indenture, relating to the issuance of the Convertible Notes (the “Indenture”), by and between us and U.S. Bank National Association, as trustee (the “Trustee”). The interest rates are fixed at 5.50% per year, payable semi-annually on June 15 and December 15 of each year, beginning on June 15, 2017. The Convertible Notes will mature on December 15, 2021, unless earlier repurchased by us or converted pursuant to their terms. The initial conversion rate of the Convertible Notes is 82.3893 shares of common stock per $1 thousand principal amount of Convertible Notes (which is equivalent to an initial conversion price of approximately $12.14 per share). Prior to the close of business on the business day immediately preceding September 15, 2021, the Convertible Notes will be convertible only under the following circumstances: (1) during any calendar quarter commencing after March 31, 2017 (and only during such calendar quarter), if, for at least 20 trading days (whether or not consecutive) during the 30 consecutive trading day period ending on the last trading day of the immediately preceding calendar quarter, the last reported sale price of our common stock on such trading day is greater than or equal to 120% of the conversion price on such trading day; (2) during the five business day period after any five consecutive trading day period in which, for each day of that period, the trading price per $1 thousand principal amount of the Convertible Notes for such trading day was less than 98% of the product of the last reported sale price of the Company’s common stock and the conversion rate on such trading day; or (3) upon the occurrence of specified corporate transactions. Upon conversion, the Convertible Notes will be settled in cash, shares of the Company’s common stock or any combination thereof at our option.

Upon the occurrence of a fundamental change (as defined in the Indenture), holders may require us to purchase all or a portion of the Convertible Notes in principal amounts of $1 thousand or an integral multiple thereof, for cash at a price equal to 100% of the principal amount of the Convertible Notes to be purchased plus any accrued and unpaid interest to, but excluding, the fundamental change purchase date. The conversion rate will be subject to adjustment upon the occurrence of certain specified events.

NantCapital Notes

In January 2016, we issued the NantCapital Note to NantCapital, a personal investment vehicle for Dr. Patrick Soon-Shiong, our Chairman and CEO. As of December 31, 2018 , the total advances made by NantCapital to us pursuant to the NantCapital Note was approximately $112.7 million. In May 2016, the NantCapital Note was amended and restated to provide that all outstanding principal and accrued and unpaid interest is due and payable on June 30, 2021, and not on demand. On December 15, 2016, in connection with the offering of the Convertible Notes, we entered into a Second Amended and Restated Promissory Note which amended and restated the Amended and Restated Promissory Note, dated May 9, 2016, between us and NantCapital, to, among other things, extend the maturity date of the NantCapital Note and to subordinate the NantCapital Note in right of payment to the Convertible Notes. We can request additional advances subject to NantCapital approval, and the NantCapital Note bears interest at a per annum rate of 5.0% compounded annually and computed on the basis of the actual number of days in the year. NantCapital has the option, but not the obligation, to require us to repay any such amount in cash, Series A-2 units of NantOmics (based on a per unit price of $1.484) held by us, shares of our common stock based on a per share price of $18.6126 (if such equity exists at the time of repayment), or any combination of the foregoing at the sole discretion of NantCapital.

On August 8, 2018, we executed a promissory note in favor of NantCapital, with a maturity date of June 15, 2022. The note bears interest at a per annum rate of 9.75% and is compounded annually, interest payments on outstanding amounts are due on June 15 and December 15 of each calendar year. No advances have currently been made under the promissory note. The note allows us to request advances, up to a maximum commitment of $100.0 million. Advances can be requested of up to $10.0 million per calendar quarter until March 31, 2019 and following that, up to $20.0 million per calendar quarter until December 31, 2020, after which no further advances can be requested. The promissory note is subordinated to the Convertible Notes. The promissory note includes customary negative covenants and a Performance to Plan - Adjusted EBITDA covenant, that stipulates, in order for the Company to draw on the promissory note, the profit measure, as defined in the promissory note, may not negatively deviate from board approved financial plans by more than 25%. At December 31, 2018 , we were in compliance with the covenants.

If we raise additional funds by issuing equity securities or securities convertible into equity, our stockholders could experience dilution. Additional debt financing, if available, may involve covenants restricting our operations or our ability to incur additional debt. Any additional debt financing or additional equity that we raise may contain terms that are not favorable to us or our stockholders and require significant debt service payments, which diverts resources from other activities. Additional financing may not be available at all, or in amounts or on terms acceptable to us. If we are unable to obtain additional financing, we may be required to delay the development, commercialization and marketing of our products and scale back our business and operations.

Cash Flows

The following table sets forth our primary sources and uses of cash for the periods indicated:

	Year Ended December 31,	
	2018	2017
Cash provided by (used in):		
Operating activities	$ (29,632)	$ (81,148)
Investing activities	(10,478)	(12,275)
Financing activities	(2,159)	(5,335)
Effect of exchange rate changes on cash and cash equivalents	(300)	65
Net decrease in cash and cash equivalents	$ (42,569)	$ (98,693)

To date, our operations have been primarily financed through the proceeds from related party promissory notes and through equity issuances, including net cash proceeds from our IPO and net cash proceeds from our Convertible Notes private placement. In June 2016, we sold 6,900,000 shares of common stock at a price of $14.00 per share, which includes 400,000 shares sold to the underwriter upon exercise of their overallotment option to purchase additional shares of our company. We raised net proceeds of $83.6 million from our IPO, after underwriting fees, discounts and commissions of $4.9 million and other offering costs of $8.1 million. In December 2016 we issued Convertible Notes to related party and others for net proceeds of $102.7 million, $9.9 million from Cambridge and $92.8 million from others, respectively, after deducting underwriting discounts and commissions and offering costs of $4.3 million.

Operating Activities

Our cash flows from operating activities have been driven by rate of revenue, billings, and collections, the timing and extent of spending to support product development efforts, and enhancements to existing services, and the timing of general and administrative expenses, and the continuing market acceptance of our solution. In addition, our net loss in the year ended December 31, 2018 has been significantly greater than our use of cash for operating activities due to the inclusion of substantial non-cash charges.

Cash used in operating activities of $29.6 million in the year ended December 31, 2018 was a result of our continued investments in sales and marketing, research and development, costs associated with public company reporting and corporate governance requirements, and other expenses incurred to grow our business. In the year ended December 31, 2018 , $156.6 million , or 81% of our net loss of $192.2 million consisted of non-cash items, including a $108.4 million equity in net loss of a related party investment, $22.4 million of depreciation and amortization, $16.9 million increase in the fair value of the Bookings Commitment liability, $5.7 million in stock-based compensation, and $5.0 million amortization of debt discounts and deferred financing offering costs, partially offset by a $3.8 million decrease in deferred tax liabilities.

Cash used in operating activities in the year ended December 31, 2018 included a $1.7 million reduction in accounts payable, a $4.8 million reduction in accrued and other liabilities, a $3.8 million decrease in net deferred tax liabilities, a $0.6 million decrease in deferred revenue. The cash used in operating activities was offset by a $3.1 million cash inflow due to the change in other assets and liabilities, a $2.3 million decrease in prepaid expenses and other current assets, a $0.3 million decrease in inventories, and an increase of $6.0 million in related party payables, net.

Cash used in operating activities of $81.1 million in the year ended December 31, 2017 was a result of our continued significant investments in research and development, sales and marketing, and costs associated with public company reporting and corporate governance requirements, and other expenses incurred to grow our business. In the year ended December 31, 2017, $102.7 million, or 59% of our net loss of $175.2 million consisted of non-cash items, including a $4.5 million in stock-based compensation, $28.1 million of depreciation and amortization, a $50.3 million equity in net loss of a related party investment, $9.6 million of loss on sale of business and dissolution of business component, $5.1 million deferred income taxes, net expense, a $0.2 million provision for accounts receivable bad debts, a $0.7 million inventory provision, $4.4 million amortization of debt discounts and deferred financing offering costs, and partially offset by a $0.3 million decrease in fair value of derivatives liability.

Cash used in operating activities in the year ended December 31, 2017 included a decrease in prepaid expenses and other current assets of $0.6 million, a $2.2 million increase in deferred implementation costs due to an increase in business activity associated with the growth of our business, $1.9 million in reduction in accounts payable, $6.3 million reduction in accrued and other liabilities, a $1.0 million decrease in deferred revenue, and a $0.3 million increase in other assets and liabilities. The cash used in operating activities was offset by a $0.2 million decrease in inventories, an increase of $2.8 million in related party payables, net, and a decrease of $0.6 million of related party receivable, net.

Investing Activities

Our primary investing activities have consisted of acquisitions to expand our features and functionality of NantHealth solutions and capital expenditures to develop our software as well as to purchase computer equipment and furniture and fixtures in support of expanding our infrastructure.

We used $10.5 million of cash in investing activities in the year ended December 31, 2018 , primarily comprised of purchases of equipment and investments in our capitalized software.

We used $12.3 million of cash in investing activities in the year ended December 31, 2017, primarily comprised of $13.6 million of purchases of equipment and investments in our capitalized software and $0.4 million of purchases of marketable securities, partially offset by $1.7 million of cash consideration as an estimated working capital payment related to the Allscripts sale.

Financing Activities

Cash used in financing activities in the year ended December 31, 2018 of $2.1 million was due to payment to tax authorities on the employee's behalf to satisfy withholding requirements on income earned from vested shares.

Cash used in financing activities in the year ended December 31, 2017 of $5.3 million was due to payment to tax authorities on the employee's behalf to satisfy withholding requirements on income earned from vested shares.

Contractual Obligations, Commitments and Contingencies

Our principal commitments consist of obligations under our outstanding debt obligations, non-cancellable leases for our office space and certain equipment and vendor contracts to provide research services, and purchase obligations and minimum commitments under license agreements and reseller agreements. The following table summarizes these contractual obligations as of December 31, 2018 in thousands:

	Payments Due by Period				
Contractual Obligations	**Total**	**Less than 1 year**	**1-3 years**	**3-5 years**	**More than 5 years**
Purchasing obligations	$ 383,500	$ 2,500	$ 28,000	$ 51,000	$ 302,000
Long term debt obligations:					
Related party promissory note	154,685	—	—	154,685	—
Related party convertible notes	10,000	—	—	10,000	—
Other convertible notes	97,000	—	—	97,000	—
Operating leases and capital leases obligations	20,528	3,201	6,435	5,959	4,933
Total Obligations	$ 665,713	$ 5,701	$ 34,435	$ 318,644	$ 306,933

In September 2016, we entered into a Second Amended and Restated Reseller Agreement, ("Reseller Agreement"), for genomic and proteomic sequencing services and related bioinformatics and analysis services with NantOmics, with an effective date of June 19, 2015. The Reseller Agreement has a contract period from June 2015 through December 31, 2020, subject to three potential three-year renewal options if we meet certain GPS Cancer thresholds. We agreed to pay NantOmics non-cancellable annual minimum fees of $2.0 million for each of the calendar years from 2016 through 2020, and subject to us exercising at least one of our renewal options, we are required to pay annual minimum fees to NantOmics of $25.0 million for each of the calendar years from 2021 through 2023 and $50.0 million per year for each of the calendar years from 2024 through 2029. We have the ability to terminate this agreement without cause. The Reseller Agreement permits us to use vendors other than NantOmics to provide any or all of the services that are currently being provided by NantOmics and clarifies that we are responsible for order fulfillment and branding.

New Accounting Pronouncements

See Note 2, “Summary of Significant Accounting Policies” of accompanying Notes to Consolidated Financial Statements for a discussion of new accounting standards.

Off-Balance Sheet Arrangements

During the periods presented, we did not have any off-balance sheet arrangements.

Related Party Transactions

See Note 18 of accompanying notes to Consolidated Financial Statements for a discussion of related party transactions.

Critical Accounting Policies and Significant Judgments and Estimates

This Management's Discussion and Analysis of our Financial Condition and Results of Operations is based on our Consolidated Financial Statements, which we have prepared in accordance with accounting principles generally accepted in the United States. The preparation of our financial statements requires us to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of our financial statements, as well as the reported revenues and expenses during the reported periods. We evaluate these estimates and judgments on an ongoing basis. We base our estimates on historical experience and on various other factors that we believe are reasonable under the circumstances, the results of which form the basis for making judgments about the carrying value of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates under different assumptions or conditions.

Transition to FASB ASC 606

On January 1, 2018, we adopted ASC 606, *Revenue from Contracts with Customers* , using the modified retrospective method applied to those contracts which were not completed as of January 1, 2018. Results for reporting periods beginning after January 1, 2018 are presented in accordance with ASC 606, while prior period amounts continue to be reported in accordance with our historic accounting under ASC 605 and ASC 985-605.

Revenue Recognition for the Company's revenue accounting beginning January 1, 2018 under ASC 606

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration we expect to receive in exchange for those products or services. Revenue is recognized net of sales taxes collected from customers, which are subsequently remitted to governmental authorities. Our revenue is generated from the following sources:

- **Software-as-a-service related ("SaaS")** - SaaS related revenue is generated from customers' access to and usage of our hosted software solutions on a subscription basis for a specified contract term. In SaaS arrangements, the customer cannot take possession of the software during the term of the contract and generally has the right to access and use the software and receive any software upgrades published during the subscription period.

  SaaS contracts are accounted for as a single performance obligation, as implementation and hosting services are not distinct. As a result, we recognize all fees, including any up front initial system implementation services or other fees, ratably over time from when the system implementation or deployment services are completed, and where necessary accepted by the customer, over the contract term, as stated, or with consideration of termination for convenience clauses as discussed below **.**

- **Software and hardware related** - Software and hardware related revenue is generated from the license of our software, on a perpetual basis, the sale of hardware and professional services that are complementary to the software and may or may not be required for the software to function as desired by the customer. The services are generally provided in the form of implementation and training services and do not include maintenance revenue. The software is installed on the customer's site or the customer's designated vendor's site and is not hosted by us or by a vendor contracted by us. See the section below " *Contracts with Software, Hardware, and Implementation Services"* for details of our judgments and recognition of revenue relating to this category.

- **Maintenance** - Maintenance revenue includes ongoing post contract client support ("PCS") or maintenance on software and hardware during the PCS term. Additionally, PCS includes ongoing development of software updates and upgrades provided to the client on a when-and-if-available basis. Revenue is recognized over the maintenance term.

- **Sequencing and molecular analysis** - Sequencing and molecular analysis revenue is generated by providing customers with reports of the results of performing sequencing and analysis of whole genome DNA, RNA and/or proteomic testing under our reseller agreement with NantOmics, LLC ("NantOmics"), and from blood samples via its liquid/blood-based tumor profiling platform through our subsidiary, NantHealth Labs, Inc. ("NantHealth Labs", previously named Liquid Genomics, Inc.) (see Note 18 of the financial statements). Revenue is recognized at a point in time, when reports of results are transferred to the ordering physician or institution, or when cash is received as described below, or ratably over time for the period of stand-ready obligation to provide blood-based tumor profiling services.

  Our sequencing and molecular analysis revenue is primarily generated from payments received from commercial third-party payers, hospitals and other provider networks and patients. We report revenue from arrangements with these customers on a gross basis in accordance with ASC 606. When reports are transferred to the ordering physician or institution, but we cannot conclude whether there is a contract with a customer, based on the assessment of collectibility, revenue recognition is deferred until non-refundable payment is received or payment is considered probable.

- **Home health care services** - Home health care services revenue includes the sale of nursing and therapy services provided to patients in a home care setting. These revenues are recognized at a point in time or over time, as services are provided.

Management assesses whether contracts entered into at, or near, the same time, should be combined, based on evaluation of the commercial objectives of the contracts.

Certain of our customer contracts allow for termination for convenience, with advanced notice, without substantive termination penalty. In these cases, we have concluded the contract term is equal to the remaining noncancellable period. Such termination rights do not allow for refunds other than prepaid PCS or other services. These provisions do not affect when we commence revenue recognition.

Contracts with Multiple Promises for Goods and Services

We engage in various contracts with promises for multiple goods and services, which may generate revenue across any of the sources noted above.

In certain contracts, we recognize our proprietary software, hardware, PCS, results of sequencing and molecular analysis, certain professional services and other software-related services as distinct performance obligations.

Standalone selling prices (“SSP”) are required to be allocated and revenue recognized for each distinct performance obligation within each contract. The SSP for each performance obligation is determined by considering contracts in which the good or service is sold separately, and other factors including market conditions and our experience selling similar goods and services, as well as costs and margins achieved. In some cases, to estimate the SSP, we first estimate the selling price of each performance obligation for which an SSP is observable and then estimate the SSP of the remaining performance obligation as the residual contractual amount.

Contracts with Software, Hardware, and Implementation Services

We have some contracts where we provide implementation services involving significant integration of our licensed software and hardware, with customer networks that maintain patient electronic health records. These contracts represent a single performance obligation to the customer for a combined output due to the significant service of integrating the hardware, software and professional services. Revenue for the single performance obligation is recognized over time based on actual, or estimated, direct implementation labor hours, as a measure of progress.

In certain of those contracts, our performance also requires significant customization of our licensed software. For such contracts, we will also record revenue over time using the percentage of completion method to estimate the satisfaction of our performance obligations. However, where we lack history and experience with certain projects involving the development of software according to customer specified criteria, we may be initially unable to reasonably estimate total direct software development labor hours to be expected under the project. As a result, we would not be able to reasonably measure our progress toward complete satisfaction of our single performance obligation.

As a result, in these contracts, we will commence recognizing revenue when we conclude that we can reasonably measure our progress and determine that costs will be recoverable, which is typically at or near the time of the customers' acceptance of the software and the related professional services. At that point, substantially all of the uncertainty related to our ability to reasonably estimate direct labor hours to satisfy our performance obligations will have been resolved, and we will be able to reasonably measure the remaining progress toward complete satisfaction of our remaining professional services obligations. In such cases, we will commence recording revenue, at the date of meeting the customer acceptance criteria, with a cumulative catch up for the work performed to date using direct labor hours as a measure of progress consistent with other contracts involving software, hardware and implementation services. Recognition will continue for our performance obligation over the remaining performance period using the same measure of progress. A provision for the entire loss, from such a contract, will be recognized in any period it becomes evident that the contract will not be profitable.

Other contracts for perpetual software licenses, hardware, and implementation services do not include a service of software development or significant integration. Therefore, the perpetual software licenses, hardware, and implementation services are considered separate, distinct performance obligations. Software revenue is recognized upon the later of the license term commencement or the date the software is provided to the customer, hardware revenue is recognized upon delivery, and implementation revenue is recognized over time based on actual, or estimated, direct implementation labor hours as a measure of progress.

We delineate between contracts with, or without, a service of significant integration by considering the complexity of the integration services and whether such services can be performed by the customer or another third party. We have both reseller arrangements with gross revenue presentation due to our control of goods and services before transfer to the customer, and others with net revenue presentation due to the reseller's control of goods and services before transfer to the customer. We assess control in terms of relevant indicators of performance, inventory, and pricing risk, such as which party negotiates pricing with the end customer and which party is ultimately responsible for fulfilling services, transferring goods and services, and ensuring support.

Revenue Recognition for the Company's revenue accounting before January 1, 2018 under ASC 605 and ASC 985

Revenue is recognized when persuasive evidence of an arrangement exists, services or products have been provided to the client, fees are fixed or determinable, and collectibility is reasonably assured. While most of the our arrangements include short-term payment terms, we on occasion provide payment terms to clients in excess of one year from the date of contract signing. We do not recognize revenue for arrangements containing these extended payment terms until such payments become due. Certain of our customer arrangements allow for termination for convenience with advanced notice. Such termination rights do not allow for refunds other than prepaid PCS or other services. These provisions do not affect the recognition of revenue. We also have certain arrangements which allow for termination and refunds of fees in the event that software acceptance by the customer has not occurred. In these instances, we will defer all revenue until software acceptance has occurred.

The sequencing and molecular analysis revenue is primarily generated from payments received from commercial third-party payers, hospitals and other provider networks and patients. We report revenue from arrangements with these customers on a gross basis in accordance with ASC 605-45, *Principal Agent Considerations* . We recognize revenue from these arrangements when all revenue recognition criteria have been met or on a cash basis when it cannot conclude that the fees are fixed or determinable and collectibility is reasonably assured. We use judgment in our assessment of whether the fees are fixed or determinable and whether collectibility is reasonably assured in determining when to recognize revenue in the future as it continues to gain payment experience with our customers. Accordingly, we expect to recognize revenue on a cash basis when we cannot conclude that the fees from a particular customer are fixed or determinable and collectibility is reasonably assured until it has a sufficient history to reliably estimate payment patterns from such customer.

We engage in various multiple-element arrangements, which may generate revenue across any of the sources noted above. For multiple-element software arrangements that involve the sale of our proprietary software, PCS, and other software-related services, VSOE of fair value is required to allocate and recognize revenue for each element. VSOE of fair value is determined based on the price charged in which each deliverable is sold separately. We have established VSOE for PCS on certain of our software solutions using the Stated Renewal Method. In this instance, we have determined that our stated renewals are substantive and appropriate for use in the Stated Renewal Method. We have not yet established VSOE of fair value for any element other than PCS for our arrangements. In situations where VSOE of fair value exists for PCS but not a delivered element (typically the software license and services elements), the residual method is used to allocate revenue to the undelivered element equal to its VSOE value with the remainder allocated to the delivered elements. In situations in which VSOE of fair value does not exist for all of the undelivered software-related elements, revenue is deferred until only one undelivered element remains (typically the PCS element) and then recognized following the pattern of delivery of the final undelivered element. Our multiple element arrangements typically provide for renewal of PCS terms upon expiration of the original term. The amounts of these PCS renewals are recognized as revenue ratably over the specified PCS renewal period.

For non-software arrangements that include multiple elements, primarily consisting of our SaaS agreements, revenue recognition involves the identification of separate units of accounting after consideration of combining and/or segmenting contracts and allocation of the arrangement consideration to the units of accounting on the basis of their relative selling price. The selling price used for each deliverable is based on VSOE of fair value, if available, third party evidence, or TPE, of fair value if VSOE is not available, or our best estimate of selling price if neither VSOE nor TPE is available. In determining the units of accounting for these arrangements, we evaluate whether each deliverable has standalone value as defined in the Financial Accounting Standards Board's guidance. Our SaaS arrangements are treated as a single unit of accounting as the professional services do not have standalone value. As a result, we recognize initial system implementation and deployment fees ratably over a period of time from when the system implementation or deployment services are completed and accepted by the customer over the longer of the life of the agreement or the estimated customer life. SaaS revenue consists of revenue earned from clients (typically on a monthly basis) for use of our subscription or license-based solutions and services. We recognize revenue from such contracts ratably over the contract period.

If an arrangement to deliver software requires significant production, modification or customization of the licensed software, we account for the arrangement as a construction-type contract. Currently we recognize revenue for these arrangements using the completed-contract method as it does not currently have sufficient information to reliably estimate the percentage of completion for these projects. We consider these arrangements to be substantially complete upon the clients' acceptance of the software and related professional services and consistently apply this policy to all contract accounting arrangements.

Transaction processing fees are recognized on a monthly basis based on the number of transactions processed and the fee per transaction.

Revenue derived from reseller arrangements is recognized when the resellers, in turn, sell the software solution to their clients and installation of the software solution has occurred, provided all other revenue recognition criteria are met. This is commonly referred to as the sell-through method and we defer recognition until there is a sell-through by the reseller to an actual end user clients and acceptance by the end user has occurred.

Stock-Based Compensation

We account for stock-based compensation arrangements granted to employees in accordance with ASC 718, *Compensation—Stock Compensation,* by measuring the grant date fair value of the award and recognizing the resulting expense over the period during which the employee is required to perform service in exchange for the award.

We account for stock-based compensation arrangements issued to non-employees using the fair value approach prescribed by ASC 505-50, *Equity-Based Payments to Non-Employees* . The value of non-employee stock-based compensation is re-measured at the end of each reporting period until the award vests and is recognized as stock-based compensation expense over the period during which the non-employee provides the services.

Stock-based compensation expense for both employee and non-employee awards is recognized on a straight-line basis over the appropriate service period for awards that are only subject to service conditions and is recognized using the accelerated attribution method for awards that are subject to performance conditions. Stock-based compensation expense is only recognized for awards subject to performance conditions if it is probable that the performance condition will be achieved.

All excess tax benefits and tax deficiencies are recognized as income tax benefit or expense in the income statement as discrete items in the reporting period in which they occur, and such tax benefits and tax deficiencies are not included in the estimate of an entity's annual effective tax rate, applied on a prospective basis. The recognition of excess tax benefits is not deferred until the benefit is realized through a reduction to taxes payable. When we apply the treasury stock method, in calculating diluted earnings per share, excess tax benefits, if applicable, are excluded and deficiencies from the calculation of assumed proceeds since such amounts are recognized in the income statement. Excess tax benefits if applicable, are classified as operating activities in the same manner as other cash flows related to income taxes on the statement of cash flows. We have elected to account for forfeitures when they occur. Cash paid by us when directly withholding shares for tax withholding purposes is classified as a financing activity in the Statement of Cash Flows.

Profits Interest Plan

On December 3, 2013, we adopted the Profits Interests Plan and reserved an aggregate of 63.8 million Series C units for issuance to our associates, consultants and contractors in consideration for bona fide services provided.

The Series C units were considered profits interests of us and did not entitle their holders (the "Series C members") to receive distributions if we were liquidated immediately after the grant. Instead, the Series C members were entitled to receive an allocation of a portion of our profits and losses arising after the date of the grant and, subject to vesting conditions, distributions made of a portion of our profits arising after the grant date of the Series C units. Grants of the Series C units were either fully vested, partially vested, or entirely unvested at the time of the grant as determined by our Board of Directors.

Series C members were not entitled to receive any distributions until our aggregate distributions exceeded a hurdle amount applicable to those Series C units. The hurdle amount for each grant was determined by the Board of Directors at the date of issuance of such units. After all other members received their applicable hurdle amount, the Series C members were entitled to receive their percentage interest of such excess distributions.

Prior to the LLC Conversion on June 1, 2016, we had 3.5 million Series C units outstanding. Upon the LLC Conversion on June 1, 2016, we issued 28,973 shares of common stock to holders of vested Series C units and 10,462 shares of restricted stock to holders of unvested Series C units. The shares of restricted stock issued to holders of unvested profits interest are subject to forfeiture until becoming fully vested in accordance with the terms of the original Series C unit grant agreements.

Stock compensation expense for the Series C units/restricted stock issued to the nonemployees is calculated based on the fair value of the award on each balance sheet date and the attribution of that cost is being recognized ratably over the vesting period.

Phantom Unit Plan

On March 31, 2015, we approved the Phantom Unit Plan. The maximum number of phantom units that may be issued under the Phantom Unit Plan is equal to 11.6 million minus the number of issued and outstanding Series C units. As of December 31, 2018 , we had 0.6 million phantom units outstanding under the Phantom Unit Plan. Each grant of phantom units made to a participant under the Phantom Unit Plan vests over a defined service period, subject to completion of a liquidity event, and is subject to forfeiture upon termination of the participant's continuous service to us for any reason. Our IPO satisfied the liquidity event condition, and the phantom units now entitle their holders to cash or non-cash payments in an amount equal to the number of vested units held by that participant multiplied by the fair market value of our common stock, as determined by our board of directors.

We intend to settle all vested phantom unit payments held by United States-based participants in shares of our common stock and classified these awards as equity awards in our Consolidated Balance Sheets. Awards held by participants who are based outside of the United States will be settled in cash and are classified within accrued expenses on our Consolidated Balance Sheet as of December 31, 2018 and 2017 . In order to satisfy payroll withholding tax obligations triggered by the issuance of shares of common stock to holders of vested phantom units, we issue recipients a net lower number of shares of common stock to satisfy tax withholding obligations and remitted a cash payment for the related withholding taxes.

During the years ended December 31, 2018 and 2017 , the Company issued 0.3 million and 0.9 million shares, respectively, of common stock to participants of the Phantom Unit Plan based in the United States, after withholding approximately 0.2 million and 0.5 million shares, respectively, to satisfy tax withholding obligations. The Company made a cash payment of $0.6 million and $3.1 million to cover employee withholding taxes upon the settlement of these vested phantom units during the years ended December 31, 2018 and 2017 . During the years ended December 31, 2018 and 2017 the Company also paid $0.1 million and $0.3 million , respectively, to cash-settle 16 thousand and 59 thousand vested phantom units, respectively, held by participants of the Phantom Unit Plan based outside of the United States, and to pay cash in lieu of fractional shares for vested units held by participants based in the United States.

Change in fair value of Bookings Commitment

We account for the Bookings Commitment at its estimated fair value over the life of the agreement and, as of December 31, 2018 the estimated fair value was $16.9 million and at December 31, 2017 the fair value was estimated not to be material. We value the liability using a Monte Carlo simulation based on management's estimate of its performance in securing bookings and resulting annual payments, discounted at the cost of debt in a range of 17% to 20% based on a yield curve, to calculate the fair value of the liability. The change in the fair value of the Bookings Commitment of $16.9 million for the year ended December 31, 2018 was due to changes in the status of identified opportunities, reductions in the estimated value of identified opportunities and delays in executing management's planned sales strategy.

We base our assumptions on projected financial information that we believe is reasonable, but those assumptions require judgment and are forward looking in nature. However, actual results may differ materially from those projections. The fair value of the Bookings Commitment is most sensitive to management's estimate of the discount rate applied to present value the liability. If the discount rate applied was 2% lower, the fair value of the liability would increase by $2.5 million.

Change in fair value of derivative liability

We have classified the interest make-whole provision of our convertible notes due 2021 issued in December 2016 as a derivative liability that is recorded at fair value. This derivative liability is subject to re-measurement at each balance sheet date and we recognize any change in fair value in our Consolidated and Combined Statements of Operations and Comprehensive Loss as a change in fair value of the derivative liability. The change in the fair value of this derivative liability of $7,000 and $0.3 million for the year ended December 31, 2018 and 2017 is due primarily to the change in the value of our common stock.

Income taxes

FASB ASC Topic 740, *Income Taxes* (“Topic 740”), provides the accounting treatment for uncertainty in income taxes recognized in an enterprise’s financial statements. Topic 740 prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. Topic 740 also provides guidance on derecognizing, classification, interest and penalties, accounting in interim periods, disclosure and transition.

Significant management judgment is required in determining our provision for income taxes, our deferred tax assets and liabilities, tax contingencies, unrecognized tax benefits, and any required valuation allowance, including taking into consideration the probability of the tax contingencies being incurred. Management assesses this probability based upon information provided to us by our tax advisers, our legal advisers and similar tax cases. If at a later time our assessment of the probability of these tax contingencies changes, our accrual for such tax uncertainties may increase or decrease.

Tax Cuts and Jobs Act, or the Tax Act, was enacted on December 22, 2017 and significantly reformed the U.S. Internal Revenue Code of 1986, as amended, or the Code. The Tax Act lowers U.S. federal corporate income tax rates, changes the utilization of future net operating loss carryforwards, allows for the expensing of certain capital expenditures, and puts into effect sweeping changes to U.S. taxation of international business activities. As a result, our net U.S. deferred tax assets and corresponding valuation allowances will be revalued at the new U.S. corporate rate. We continue to examine the impact this tax reform legislation may have on our business. The impact of this tax reform on us and on holders of our common stock is uncertain and could seriously harm our business.

In December 2017, the SEC issued Staff Accounting Bulletin No. 118 (“SAB 118”), which provides guidance on accounting for the income tax effects of the TCJA. SAB 118 provides a measurement period that should not extend beyond one year from the TCJA enactment date for companies to complete the accounting relating to the TCJA under Accounting Standards Codification Topic 740, “Income Taxes” (“ASC 740”). In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the TCJA for which the accounting under ASC 740 is complete. To the extent that a company’s accounting for TCJA-related income tax effects is incomplete, but the company is able to determine a reasonable estimate, it must record a provisional estimate in its financial statements. If a company cannot determine a provisional estimate to be included in its financial statements, it should continue to apply ASC 740 on the basis of the provisions of the tax laws that were in effect immediately before the enactment of the TCJA. The Company has completed its evaluation of the potential impacts of the Act of 2017 on its December 31, 2018 financial statements under the one year measurement period provided under SAB 118. No adjustment has been recorded as there were no material changes between the provisional estimate and the final accounting for the Act.

Utilization of Net Operating Loss Carryforwards

We had federal, state and foreign income tax NOL carryforwards of approximately $395.4 million , $288.9 million and nil, respectively, available to offset taxable income in tax year 2019 and thereafter. The federal NOL's will start to expire in year 2021.

Under Sections 382 and 383 of the Code, if a corporation undergoes an “ownership change” (generally defined as a greater than 50% change (by value) in its equity ownership over a three-year period), the corporation’s ability to use its pre-change net operating loss carry forwards and other pre-change tax attributes to offset its post-change income may be limited. We believe that we have recently undergone one or more ownership changes. The above NOL amounts do not include the NOLs expected to expire before they can be utilized under Section 382.

The occurrence of such ownership changes could limit our ability to utilize our NOLs and possibly other tax attributes. Limitations imposed on our ability to use NOLs and other tax attributes to offset future taxable income could cause us to pay U.S. federal income taxes earlier than we otherwise would if such limitations were not in effect. Any further ownership change also could cause such NOLs and other tax attributes to expire unused, thereby reducing or eliminating the benefit of such NOLs and other tax attributes to us and adversely affecting our future cash flows.

In addition, we may determine that varying state laws with respect to NOL utilization may result in lower limits, or an inability to utilize NOLs in some states altogether, which could result in us incurring additional state income taxes. In the event that state law results in lower limits, or an inability to utilize loss carryforwards, or we become subject to federal alternative minimum tax, this could adversely affect our future cash flows.

Business Combinations

We account for business combinations using the acquisition method of accounting. Under the acquisition method, assets acquired and liabilities assumed are recorded at their respective fair values as of the acquisition date. Any excess of the purchase price over the estimated fair values of the net assets acquired is recorded as goodwill. We routinely monitor the factors impacting the acquired assets and liabilities. Transaction related costs are expensed as incurred. The operating results of the acquired business are reflected in our Consolidated and Combined Financial Statements as of the acquisition date.

Software Developed for Internal Use

We account for the costs of computer software obtained or developed for internal use in accordance with FASB ASC 350, " *Intangibles — Goodwill and Other* " ("ASC 350"). Computer software development costs are expensed as incurred, except for internal use software that qualify for capitalization as described below, and include employee related expenses, including salaries, benefits and stock-based compensation expenses; costs of computer hardware and software; and costs incurred in developing features and functionality. These capitalized costs are included in property and equipment on the Consolidated Balance Sheets. We expense costs incurred in the preliminary project and post implementation stages of software development and capitalize costs incurred in the application development stage and costs associated with significant enhancements to existing internal use software applications. Software costs are amortized using the straight-line method over an estimated useful life of three years commencing when the software project is ready for its intended use.

Goodwill and Intangible Assets

Goodwill acquired in a business combination and determined to have an indefinite useful life is not amortized but is tested for impairment annually as of October 1 or between annual tests when an impairment indicator exists. In the event there is a change in reporting units or segments, we will test for impairment at the reporting unit. A component of an operating segment is a reporting unit if the component constitutes a business for which discrete financial information is available and segment management regularly reviews the operating results of that component.

As part of the annual impairment test, we may conduct an assessment of qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. In a qualitative assessment, we would consider the macroeconomic conditions, including any deterioration of general conditions, industry and market conditions, including any deterioration in the environment where the reporting unit operates, increased competition, changes in the products/services and regulator and political developments; cost of doing business; overall financial performance, including any declining cash flows and performance in relation to planned revenues and earnings in past periods; other relevant reporting unit specific facts, such as changes in management or key personnel or pending litigation, and events affecting the reporting unit, including changes in the carrying value of net assets.

If an optional qualitative goodwill impairment assessment is not performed, we are required to determine the fair value of each reporting unit. If a reporting unit’s fair value is lower than its carrying value, we must determine the amount of implied goodwill that would be established if the reporting unit was hypothetically acquired on the impairment test date. If the carrying amount of a reporting unit’s goodwill exceeds the amount of implied goodwill, we would record an impairment loss equal to the excess.

At September 30, 2018, due to declines in our stock price, we carried out an interim impairment assessment, using the optional qualitative goodwill impairment assessment. Macroeconomic and industry conditions, including specific indicators of the market value of our business, outweighed the negative impairment indicators in our overall financial performance.

The determination of fair value of a reporting unit is based on a combination of a market approach that considers benchmark company market multiples and an income approach that uses discounted cash flows for each reporting unit utilizing Level 3 inputs. Under the income approach, we determine the fair value based on the present value of the most recent income projections for each reporting unit and calculates a terminal value utilizing a terminal growth rate. The significant assumptions under this approach include, among others: income projections, which are dependent on sales to new and existing clients, new solution introductions, client behavior, competitor pricing, operating expenses, the discount rate and the terminal growth rate. The cash flows used to determine fair value are dependent on a number of significant management assumptions based on historical experience, expectations of future performance, and the expected economic environment. Estimates are subject to change given the inherent uncertainty in predicting future results. Additionally, the discount rate and the terminal growth rate are based on judgment of the rates that would be utilized by a hypothetical market participant.

Accounting guidance requires that definite-lived intangible assets be amortized over their respective estimated useful lives and reviewed for impairment whenever events or changes in circumstances indicate that their carrying amounts may not be recoverable. We estimate the useful lives of the intangible assets and ratably amortize the value over the estimated useful lives of those assets. If the estimates of the useful lives change, we will amortize the remaining book value over the remaining useful lives or, if an asset is deemed to be impaired, a write-down of the value of the asset to its fair value may be required at such time.

Investment in Related Party

Investment in and advances to a related party in which we have a substantial ownership interest of approximately 20% to 50%, or for which we exercise significant influence but not control over policy decisions, are accounted for by the equity method. An investment in a limited liability company that is similar to a partnership is also accounted for under the equity method if more than minor influence over the operation of the investee exists (generally through more than 3-5% ownership). As part of that accounting, we recognize gains and losses that arise from the issuance of stock by a related party that results in changes in the proportionate share of the dollar amount of the related party's equity.

The investment in related party is assessed for possible impairment when events indicate that the fair value of the investment may be below the carrying value. When such a condition is deemed to be other than temporary, the carrying value of the investment is written down to its fair value, and the amount of the write-down is included in net loss. In making the determination as to whether a decline is other than temporary, we consider such factors as the duration and extent of the decline, the investee's financial performance, and our ability and intention to retain the investment for a period that will be sufficient to allow for any anticipated recovery in the investment's market value. The new cost basis of the investment is not changed for subsequent recoveries in fair value.

In the case of our related party investee, NantOmics, a privately held limited liability company, the fair value of our equity method investment is estimated using the income approach. The income approach utilizes a discounted cash flow model incorporating management's expectations of the investee's future revenue, operating expenses, and earnings before interest, taxes, depreciation and amortization, capital expenditures and an anticipated tax rate ("EBITDA"). The related cash flow forecasts are discounted using an estimated weighted average cost of capital ("WACC") at the date of valuation.

We base our assumptions on projected financial information that we believe is reasonable, but those assumptions require judgment and are forward looking in nature. However, actual results may differ materially from those projections. The most impactful assumptions would include estimated revenues, estimated EBIDTA margins and the WACC. For example, if NantOmics' revenues were subsequently materially lower than expected, if significant adverse changes were to occur in its operating environment, if a significant increase in the discount rate were to be needed, and/or if changes in other assumptions were to happen, our estimate of the fair value of our equity investment in NantOmics could change materially.

Qualitative matters that may impact our estimates of the fair value of our equity investment in NantOmics include assumptions regarding the timing and ramp of provider, payer and pharma adoption of genomic and RNA tests, accompanying market pricing pressures on our GPS Test and resultant impact on amounts owed by us under a reseller arrangement to NantOmics, potential success of alternate diagnostic testing solutions from competitors, regulatory impacts, technological shifts and advances in diagnostic testing for cancer, and laboratory operational matters that may impact NantOmics' ability to deliver its services in sufficient scale.

At December 31, 2018, September 30, 2018 and June 30, 2017 as a result of our analysis of the estimated fair value of our investment, we recorded other than temporary impairments on our equity method investment in NantOmics of $14.8 million , $80.4 million and $36.0 million , respectively. It is reasonably possible that the estimate of the impairment will change in the near term if future NantOmics revenues are materially lower than expected; if future EBITDA margins are materially lower than expected; and/or, if we were to determine that the WACC used in a future discounted cash flow model would need to be significantly increased. These three estimates represent the most significant drivers of the estimated fair value of the discounted cash flow model. To demonstrate, as of December 31, 2018, while holding all other estimates in our estimated discounted cash flow model constant, a 100 basis point decline in our discrete and terminal period revenue growth rate and EBITDA margins, and a 100 basis point increase in the WACC used in the model would have resulted in increases in the other than temporary impairment of $ 3.7 million , $ 0.9 million , and $ 3.6 million , respectively, on our equity method investment in NantOmics.

Differences between the carrying value of an equity investment and its underlying equity in the net assets of the related party are assigned to the extent practicable to specific assets and liabilities based on our analysis of the various factors giving rise to the difference. When appropriate, our share of the related party's reported earnings is adjusted quarterly to reflect the difference between these allocated values and the related party's historical book values, as well as our equity share of other than temporary impairments identified.

JOBS Act

On April 5, 2012, the Jumpstart Our Business Startups Act of 2012, or the JOBS Act, was enacted. Section 107 of the JOBS Act provides that an "emerging growth company" can take advantage of the extended transition period provided in Section 7(a)(2)(B) of the Securities Act for complying with new or revised accounting standards. In other words, an "emerging growth company" can delay the adoption of certain accounting standards until those standards would otherwise apply to private companies. We have irrevocably elected not to avail ourselves of this extended transition period and, as a result, we adopt new or revised accounting standards on the relevant dates on which adoption of such standards is required for other public companies. Subject to certain conditions set forth in the JOBS Act, as an "emerging growth company," we intend to rely on certain exemptions and reduced reporting requirements provided by the JOBS Act, including those relating to (i) providing an auditor's attestation report on our system of internal control over financial reporting pursuant to Section 404(b) of the Sarbanes-Oxley Act and (ii) complying with any requirement that may be adopted by the Public Company Accounting Oversight Board regarding mandatory audit firm rotation or a supplement to the auditor's report providing additional information about the audit and the financial statements, known as the auditor discussion and analysis. We will remain an "emerging growth company" until the earliest of (i) the last day of our first fiscal year in which we have total annual gross revenues of $1.07 billion or more, (ii) the date on which we are deemed to be a "large accelerated filer" under the rules of the SEC with at least $700 million of outstanding equity securities held by non-affiliates, (iii) the date on which we have issued more than $1 billion in non-convertible debt during the previous three years, or (iv) the last day of our fiscal year following the fifth anniversary of the date of the completion of our initial public offering.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Interest Rate Risk

As of December 31, 2018 , we had $18.3 million in cash and cash equivalents and marketable securities which were held for working capital purposes. Our cash and cash equivalents and marketable securities are comprised primarily of mutual funds listed on active exchanges, U.S. treasury securities, money market funds, and cash held in FDIC - insured institutions. Our investments are made for capital preservation purposes. We do not enter into investments for trading or speculative purposes. All our investments are denominated in U.S. dollars. If overall interest rates had decreased by 10% during the periods presented, our interest income would not have been materially affected.

Credit Risk

Our cash equivalents and our portfolio of marketable securities are subject to market risk due to changes in interest rates. Fixed rate securities may have their market value adversely affected due to a rise in interest rates, while floating rate securities may produce less income than expected if interest rates fall. Due in part to these factors, our future investment income may fall short of expectations due to changes in interest rates or we may suffer losses in principal if we are forced to sell securities that decline in market value due to changes in interest rates.

Foreign Currency Risk

We maintain offices in the United Kingdom and have selected clients in the Canada, Europe, the Middle East, Southeast Asia and United Kingdom. However, due to the low volume of activity outside the United States, the foreign currency risk is minimal. The effect of a 10% adverse change in exchange rates on foreign currency denominated cash and payables as of December 31, 2018 would not have been material. However, fluctuations in currency exchange rates could harm our business in the future.

Item 8. Consolidated and Combined Financial Statements and Supplementary Data

NantHealth, Inc.

Consolidated Financial Statements
Years Ended December 31, 2018 and 2017
(Dollars in thousands, except per share amounts)

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NantOmics, LLC

Consolidated and Combined Financial Statements
Years Ended December 31, 2018 and 2017
(Dollars in thousands, except per unit amounts)

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Report of Independent Registered Public Accounting Firm

To the Stockholders and the Board of Directors of NantHealth, Inc.

Opinion of the Financial Statements

We have audited the accompanying consolidated balance sheets of NantHealth, Inc. (the Company) as of December 31, 2018 and 2017 , the related consolidated statements of operations, comprehensive loss, stockholders' equity and cash flows for each of the two years in the period ended December 31, 2018 , and the related notes (collectively referred to as the “consolidated financial statements”). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2018 and 2017 , and the results of its operations and its cash flows for each of the two years in the period ended December 31, 2018 , in conformity with U.S. generally accepted accounting principles.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company’s financial statements based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. As part of our audits we are required to obtain an understanding of internal control over financial reporting but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion.

Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2013.

Los Angeles, California
March 29, 2019

NantHealth, Inc.
Consolidated Balance Sheets
(Dollars in thousands, except per share amounts)

	December 31,	
	2018	2017
Assets		
Current assets		
Cash and cash equivalents	$ 18,305	$ 61,660
Accounts receivable, net	15,286	11,491
Inventories	496	839
Deferred implementation costs	—	1,960
Related party receivables, net	1,007	585
Prepaid expenses and other current assets	4,350	5,358
Total current assets	39,444	81,893
Property, plant, and equipment, net	22,978	18,517
Deferred implementation costs, net of current	—	3,951
Goodwill	115,930	114,625
Intangible assets, net	64,703	69,424
Investment in related party	40,000	156,863
Related party receivable, net of current	1,611	1,727
Other assets	1,671	2,195
Total assets	$ 286,337	$ 449,195
Liabilities and Stockholders' Equity		
Current liabilities		
Accounts payable	$ 1,650	$ 3,164
Accrued and other current liabilities	13,832	18,134
Deferred revenue	16,263	10,057
Related party payables, net	4,791	4,504
Total current liabilities	36,536	35,859
Deferred revenue, net of current	6,704	7,126
Related party liabilities	17,708	11,500
Related party promissory note	112,666	112,666
Related party convertible note, net	8,378	7,947
Convertible notes, net	79,433	74,845
Deferred income taxes, net	2,437	5,838
Other liabilities	19,644	112
Total liabilities	283,506	255,893
Stockholders' equity		
Common stock, $0.0001 par value per share, 750,000,000 shares authorized; 109,491,277 and 108,383,602 shares issued and outstanding at December 31, 2018 (including 1 share of restricted stock) and 2017 (including 3,490 shares of restricted stock), respectively	11	10
Additional paid-in capital	887,289	886,669
Accumulated deficit	(884,122)	(693,233)
Accumulated other comprehensive loss	(347)	(144)
Total stockholders' equity	2,831	193,302
Total liabilities and stockholders' equity	$ 286,337	$ 449,195

The accompanying notes are an integral part of these Consolidated Financial Statements.

NantHealth, Inc.
Consolidated Statements of Operations
(Dollars in thousands, except per share amounts)

	Year Ended December 31,	
	2018	2017
Revenue:		
Software-as-a-service related	$ 65,646	$ 60,730
Software and hardware related	4,534	7,648
Maintenance	9,834	10,421
Total software-related revenue	80,014	78,799
Sequencing and molecular analysis	3,129	2,554
Home health care services	6,321	5,323
Total net revenue	89,464	86,676
Cost of Revenue:		
Software-as-a-service related	23,691	21,939
Software and hardware related	3,335	4,749
Maintenance	924	749
Amortization of developed technologies	4,933	5,172
Total software-related cost of revenue	32,883	32,609
Sequencing and molecular analysis	8,055	6,084
Home health care services	3,331	2,829
Total cost of revenue	44,269	41,522
Gross profit	45,195	45,154
Operating Expenses:		
Selling, general and administrative	70,763	74,976
Research and development	20,916	33,862
Amortization of acquisition-related assets	4,217	4,216
Total operating expenses	95,896	113,054
Loss from operations	(50,701)	(67,900)
Interest expense, net	(17,120)	(16,168)
Other (loss) income, net	(17,876)	800
Loss from related party equity method investment, including impairment	(108,409)	(50,334)
Loss from continuing operations before income taxes	(194,106)	(133,602)
Benefit from income taxes	(3,673)	(2,203)
Net loss from continuing operations	(190,433)	(131,399)
Loss from discontinued operations, net of tax	(1,719)	(43,812)
Net loss	$ (192,152)	$ (175,211)
Basic and diluted net loss per share		
Continuing operations - common stock	$ (1.74)	$ (1.12)
Discontinued operations - common stock	$ (0.02)	$ (0.37)
Total net loss per common stock	$ (1.76)	$ (1.49)
Weighted average shares outstanding:		
Basic and diluted - common stock	109,168,798	116,737,860

The accompanying notes are an integral part of these Consolidated Financial Statements.

NantHealth, Inc.
Consolidated Statements of Comprehensive Loss
(Dollars in thousands)

	Year Ended December 31,	
	2018	**2017**
Net loss	$ (192,152)	$ (175,211)
Other comprehensive loss, net of reclassification adjustments and taxes:		
Amounts reclassified from accumulated other comprehensive loss [1]	—	(977)
Other comprehensive (loss) income from foreign currency translation	(203)	312
Comprehensive loss	$ (192,355)	$ (175,876)

[1] See Note 3 for a discussion of this reclassification of foreign currency translation adjustment.

The accompanying notes are an integral part of these Consolidated Financial Statements.

NantHealth, Inc.
Consolidated Statements of Changes in Stockholders' Equity
(Dollars in thousands)

	Common Stock		Additional Paid-In Capital	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Total Equity
	Shares	Amount				
Balance at December 31, 2016	121,250,437	$ 12	$ 886,334	$ (475,273)	$ 521	$ 411,594
Stock-based compensation expense	—	—	5,670	—	—	5,670
Shares issued in connection with employee stock plans, net of shares withheld for employee taxes	2,133,165	—	(5,335)	—	—	(5,335)
Retirement of stock	(15,000,000)	(2)	—	(42,749)	—	(42,751)
Other comprehensive loss	—	—	—	—	(665)	(665)
Net loss	—	—	—	(175,211)	—	(175,211)
Balance at December 31, 2017	108,383,602	10	886,669	(693,233)	(144)	193,302
Modified retrospective adjustment on adoption of ASC 606	—	—	—	1,263	—	1,263
Stock-based compensation expense	—	—	5,936	—	—	5,936
Shares issued in connection with employee stock plans, net of shares withheld for employee taxes	1,107,675	1	(2,067)	—	—	(2,066)
Assignment of NantHealth Labs, Inc.	—	—	(3,249)	—	—	(3,249)
Other comprehensive loss	—	—	—	—	(203)	(203)
Net loss	—	—	—	(192,152)	—	(192,152)
Balance at December 31, 2018	109,491,277	$ 11	$ 887,289	$ (884,122)	$ (347)	$ 2,831

The accompanying notes are an integral part of these Consolidated Financial Statements.

NantHealth, Inc.
Consolidated Statements of Cash Flows
(Dollars in thousands)

	Year Ended December 31,	
	2018 (1)	**2017** (1)
Cash flows from operating activities:		
Net loss	$ (192,152)	$ (175,211)
Adjustments to reconcile net loss to net cash used in operating activities:		
Loss on sale of business and dissolution of a business component	—	9,648
Provision for bad debt expense	7	220
Inventory provision	—	692
Depreciation and amortization	22,355	28,055
Loss from related party equity method investment including impairment loss	108,409	50,334
Amortization of debt discounts and deferred financing offering cost	5,018	4,417
Change in fair value of derivatives liability	(7)	(264)
Change in fair value of Bookings Commitment	16,947	—
Impairment of equity securities	1,750	—
Deferred income taxes, net	(3,769)	5,059
Stock-based compensation	5,657	4,511
Other noncash expense	219	—
Changes in operating assets and liabilities, net of business combinations:		
Accounts receivable, net	406	4
Inventories	343	196
Related party receivables, net	(306)	623
Prepaid expenses and other current assets	2,270	(588)
Deferred implementation costs	48	(2,214)
Accounts payable	(1,667)	(1,852)
Accrued and other current liabilities	(4,822)	(6,321)
Deferred revenue	570	(999)
Related party payables, net	6,026	2,832
Other assets and liabilities	3,066	(290)
Net cash used in operating activities	(29,632)	(81,148)
Cash flows from investing activities:		
Proceeds from sale of business, net of cash disposed	—	1,721
Assignment of NantHealth Labs, Inc., net of cash acquired (see Note 18)	68	—
Purchase of property and equipment including internal use software	(10,546)	(13,636)
Purchases of marketable securities	—	(360)
Net cash used in investing activities	(10,478)	(12,275)
Cash flows from financing activities:		
Capital lease obligation payment	(93)	—
Tax payments related to stock issued, net of stock withheld, for vested phantom units	(2,066)	(5,335)
Net cash used in financing activities	(2,159)	(5,335)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	(300)	65
Net decrease in cash, cash equivalents and restricted cash	(42,569)	(98,693)
Cash, cash equivalents and restricted cash, beginning of period (2)	62,010	160,703
Cash, cash equivalents and restricted cash, end of period (2)	$ 19,441	$ 62,010

NantHealth, Inc.
Consolidated Statements of Cash Flows (Continued)
(Dollars in thousands)

	Year Ended December 31,	
	2018	**2017** [1]
Supplemental disclosure of cash flow information:		
Interest paid	$ (5,885)	$ (5,778)
Interest received	13	63
Noncash investing and financing activities:		
Noncash consideration (common stock) from sale of Business (Note 3) and subsequent retirement of stock	—	42,749
Purchases of property and equipment (including internal use software)	(529)	(759)
Assignment of NantHealth Labs, Inc. (see Note 18)	(8,956)	—

[1] The statement for 2017 includes provider/patient engagement solutions business.
[2] Cash and cash equivalents included restricted cash of $ 350 and $ 1,136 at December 31, 2017 and December 31, 2018, respectively, and $350 at December 31, 2016.

The accompanying notes are an integral part of these Consolidated Financial Statements.

Note 1 Description of Business and Basis of Presentation

Nature of Business

Nant Health, LLC was formed on July 7, 2010, as a Delaware limited liability company. On June 1, 2016, Nant Health, LLC converted into a Delaware corporation (the “LLC Conversion”) and changed its name to NantHealth, Inc. (“NantHealth”). NantHealth, together with its subsidiaries (the “Company”), is a healthcare IT company converging science and technology. The Company works to transform clinical delivery with actionable clinical intelligence at the moment of decision, enabling clinical discovery through real-time machine learning systems. The Company markets certain of its solutions as a comprehensive integrated solution that includes our molecular sequencing and analysis services, clinical decision support, and payer engagement solutions. The Company also markets molecular sequencing and analysis services, clinical decision support, payer engagement and connected care solutions. NantHealth is a majority-owned subsidiary of NantWorks, LLC (“NantWorks”), which is a subsidiary of California Capital Equity, LLC (“Cal Cap”). The three companies were founded by and are led by Dr. Patrick Soon-Shiong.

On August 25, 2017, the Company sold substantially all of the assets of the Company's provider/patient engagement solutions business. The sale enabled the Company to focus on its core competencies of genomic sequencing, clinical decision support, connected care, and payer engagement.

As of December 31, 2018 , the Company conducted the majority of its operations in the United States, the United Kingdom, Singapore and Canada.

Basis of Presentation and Principles of Consolidation

The accompanying Consolidated Financial Statements include the financial statements of NantHealth and its wholly owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation. These Consolidated Financial Statements have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP"). Certain reclassifications have been made to prior period amounts to conform to the current year presentation.

The results of operations of the entities disposed of are included in the Consolidated Financial Statements up to the date of disposal and, where appropriate, these operations have been reflected as discontinued operations.

The Consolidated Financial Statements for the year ended December 31, 2017 have been derived from the audited Consolidated Financial Statements at that date, without retrospective application of ASC 606, *Revenue from Contracts with Customers* . The adoption of ASC 606 led to the treatment of certain products and services being accounted for as a single performance obligation. As a result, the Company changed the names of several of its reported revenue categories. Software and hardware has become Software and hardware related, Software-as-a-service has become Software-as-a-service related, and Other services has become Home health care services. Classification in prior periods has been conformed to the current period presentation.

The accompanying Consolidated Financial Statements have been prepared assuming the Company will continue as a going concern, which contemplates the realization of assets and the satisfaction of liabilities in the normal course of business, and do not include any adjustments to reflect the possible future effects on the recoverability and classification of assets or amounts and classification of liabilities that may result from the outcome of this uncertainty. The Company believes its existing cash, cash equivalents and ability to borrow from affiliated entities will be sufficient to fund operations through at least 12 months following the issuance date of the financial statements based upon the Company’s Chairman and CEO’s intent and ability to support the Company’s operations with additional funds as required. The Company may also seek to sell additional equity, through one or more follow-on public offerings or in separate financings, or sell additional debt securities or obtain a credit facility. However, the Company may not be able to secure such financing in a timely manner or on favorable terms. Without additional funds, the Company may choose to delay or reduce its operating or investment expenditures. Further, because of the risk and uncertainties associated with the commercialization of the Company's existing products as well as products in development, the Company may need additional funds to meet its needs sooner than planned. To date, the Company's primary sources of capital were private placement of membership interests prior to its IPO, debt financing agreements, including the promissory note with Nant Capital, LLC (“NantCapital”), convertible notes, and its IPO.

Note 2 Summary of Significant Accounting Policies

Use of Estimates

The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the Consolidated and Combined Financial Statements and accompanying notes. Actual results may differ from those estimates. The estimates and assumptions used in the accompanying Consolidated and Combined Financial Statements are based upon management's evaluation of the relevant facts and circumstances at the balance sheet date. On an ongoing basis, the Company evaluates its estimates, including those related to revenue recognition, accounts receivable allowance, inventory provisions, useful lives of long-lived assets and intangible assets, income taxes, stock-based compensation, impairment of long-lived assets and intangible assets, expected performance against minimum reseller commitments and the fair value of its investments and derivatives liability. The Company bases its estimates on historical experience and on various other assumptions that are believed to be reasonable, the results of which can affect the reported amounts of assets and liabilities as of the date of the financial statements, as well as the reported amounts of revenue and expenses during the periods presented.

Variable Interest Entities

The Company evaluates its ownership interests, contractual rights and other interests in entities to determine if the entities are variable interest entities ("VIEs"), if it has a variable interest in those entities, and the nature and extent of those interests. These evaluations are highly complex and involve judgment, the use of estimates and assumptions based on available historical information. In order for the Company to be the primary beneficiary of a VIE, it must have both (1) the power to direct the activities of a VIE that most significantly affect the VIE's economic performance and (2) the obligation to absorb losses or the right to receive benefits that, in either case, could potentially be significant to the VIE. The Company consolidates entities of which it is the primary beneficiary.

The Company determines whether it is the primary beneficiary of a VIE upon its initial involvement with the VIE and reassesses whether it is the primary beneficiary on an ongoing basis. This determination is based upon an analysis of the design of the VIE, including the VIE's structure and activities, the power to make significant economic decisions held by the Company and by other parties, and the variable interests owned by the Company and other parties.

Revenue from Contracts with Customers

Transition to FASB ASC 606

On January 1, 2018, the Company adopted ASC 606 using the modified retrospective method applied to those contracts which were not completed as of January 1, 2018. Results for reporting periods beginning after January 1, 2018 are presented in accordance with ASC 606, while prior period amounts continue to be reported in accordance with the Company's historic accounting under ASC 605 and ASC 985-605, which are described below.

The Company recorded a decrease of $1,263 , net of tax, to the opening accumulated deficit as of January 1, 2018 due to the cumulative impact of adopting ASC 606. The most significant changes were to begin recognizing revenues from certain software and hardware implementation projects based on an estimate of percentage of completion, rather than at completion of the contract; to recognize estimated revenues from nursing and therapy services as the services are performed, rather than on final determination of contractual billable amounts; and to capitalize commissions as assets for contracts with performance obligations of more than one year. The adoption also led to certain costs, in relation to Software-as-a-Service ("SaaS") contracts, previously treated as deferred implementation costs in current and long-term assets, being treated as software developed for internal use. This resulted in an increase of $5,827 of software developed for internal use being recorded at January 1, 2018, with a corresponding decrease in deferred implementation costs.

On implementing ASC 606, the Company concluded that its accounts receivable should be reported separately from deferred revenue. Therefore, the outstanding and unpaid invoices for undelivered services are not excluded from accounts receivable. This led to an increase of $5,247 in accounts receivable and a corresponding increase in deferred revenue at January 1, 2018.

This table summarizes the impact on the Company's consolidated financial statements due to the adoption of ASC 606:

	As Reported December 31, 2017	Adjustments due to ASC 606	Balance as at January 1, 2018
Balance Sheet			
Accounts receivable, net	$ 11,491	$ 5,247	$ 16,738
Deferred implementation costs, current	1,960	(1,960)	—
Prepaid expenses and other current assets	5,358	1,117	6,475
Property, plant, and equipment, net	18,517	5,827	24,344
Deferred implementation costs, net of current	3,951	(3,949)	2
Other assets	2,195	562	2,757
Deferred revenue, current	10,057	3,184	13,241
Deferred revenue, net of current	7,126	2,030	9,156
Deferred income taxes	5,838	367	6,205

The impact of the adoption of ASC 606 as of December 31, 2018 is presented here:

	As of December 31, 2018		
	As Reported	Adjustments due to ASC 606	Without new Revenue Standard
Balance Sheet			
Accounts receivable, net	$ 15,286	$ (5,659)	$ 9,627
Deferred implementation costs, current	—	2,830	2,830
Prepaid expenses and other current assets	4,350	(666)	3,684
Property, plant, and equipment, net	22,978	(5,961)	17,017
Deferred Implementation costs, net of current	—	3,322	3,322
Other assets	1,671	(498)	1,173
Deferred revenue, current	16,263	(2,404)	13,859
Deferred revenue, net of current	6,704	(529)	6,175
Deferred income taxes	2,437	(72)	2,365

The impact of the adoption of ASC 606 during the year ended December 31, 2018 is presented here:

	Year Ended December 31, 2018		
	As Reported	Adjustments due to ASC 606	Without new Revenue Standard
Statement of Operations			
Total net revenue	$ 89,464	$ (2,255)	$ 87,209
Cost of revenue	44,269	(108)	44,161
Operating expenses	95,896	302	96,198
Benefit from income taxes	(3,673)	225	(3,448)

The Company's accounting policies under the new standard are applied prospectively and are noted below.

Revenue Recognition under ASC 605

Revenue represents the consideration received or receivable from clients for solutions and services provided by the Company. The Company's revenue is generated from the following sources:

- **Software-as-a-service ("SaaS") related** - SaaS revenue is generated from clients' access to and usage of the Company's hosted software solutions on a subscription basis for a specified contract term, which is usually monthly. In SaaS arrangements, the client cannot take possession of the software during the term of the contract and generally has the right to access and use the software and receive any software upgrades published during the subscription period.

- **Software and hardware related** - Software and hardware revenue is generated from the sale of the Company's software, on either a perpetual or term license basis, and the sale of hardware. The software is installed on the client's site or the client's designated vendor's site and is not hosted by the Company or by a vendor contracted by the Company. The Company also sells third-party software and hardware to its clients. Software and hardware related revenue also includes revenue from professional services provided that are generally complementary to the software and may or may not be required for the software to function as desired by the client. The services are generally provided in the form of training and implementation services during the software license period and do not include post contract client support.

- **Maintenance** - Maintenance revenue includes ongoing post contract client support ("PCS") or maintenance during the paid PCS term. Additionally, PCS includes ongoing development of software updates and upgrades provided to the client on a when and if available basis.

- **Sequencing and molecular analysis** - Sequencing and molecular analysis revenue is generated by the process of performing sequencing and analysis of whole genome DNA (or whole exome DNA based on tissue quantity and quality), RNA and proteomic results under the Company's reseller agreement with NantOmics, LLC ("NantOmics") (see Note 18).

- **Home health care services** - Home health care services revenue includes the sale of nursing and therapy services provided to patients in a home care setting and any other services not included in the preceding revenue sources.

Revenue is recognized when persuasive evidence of an arrangement exists, services or products have been provided to the client, fees are fixed or determinable, and collectibility is reasonably assured. While most of the Company's arrangements include short-term payment terms, the Company on occasion provides payment terms to clients in excess of one year from the date of contract signing. The Company does not recognize revenue for arrangements containing these extended payment terms until such payments become due. Certain of the Company's customer arrangements allow for termination for convenience with advanced notice. Such termination rights do not allow for refunds other than prepaid PCS or other services. These provisions do not affect when the Company commences revenue recognition. The Company also has certain arrangements which allow for termination and refunds of fees in the event that software acceptance by the customer has not occurred. In these instances, the Company will defer all revenue until software acceptance has occurred.

The Company's clinical sequencing and molecular analysis revenue is primarily generated from payments received from commercial third-party payers, hospitals and other provider networks and patients. The Company reports revenue from arrangements with these customers on a gross basis in accordance with ASC 605-45, *Principal Agent Considerations* . The Company recognizes revenue from these arrangements when all revenue recognition criteria have been met or on a cash basis when it cannot conclude that the fees are fixed or determinable and collectibility is reasonably assured. The Company uses judgment in its assessment of whether the fees are fixed or determinable and whether collectibility is reasonably assured in determining when to recognize revenue in the future as it continues to gain payment experience with its customers. Accordingly, the Company expects to recognize revenue on a cash basis when it cannot conclude that the fees from a particular customer are fixed or determinable and collectibility is reasonably assured until it has a sufficient history to reliably estimate payment patterns from such customer.

The Company engages in various multiple-element arrangements, which may generate revenue across any of the sources noted above. For multiple-element software arrangements that involve the sale of the Company's proprietary software, PCS and other software-related services, vendor-specific objective evidence ("VSOE") of fair value is required to allocate and recognize revenue for each element. VSOE of fair value is determined based on the price charged in which each deliverable is sold separately. The Company has established VSOE for PCS on certain of its software solutions using the Stated Renewal Method. In this instance, the Company has determined that its stated renewals are substantive and appropriate for use in the Stated Renewal Method. The Company has not yet established VSOE of fair value for any element other than PCS for a portion of its arrangements. In situations where VSOE of fair value exists for PCS but not a delivered element (typically the software license and services elements), the residual method is used to allocate revenue to the undelivered element equal to its VSOE value with the remainder allocated to the delivered elements. In situations in which VSOE of fair value does not exist for all of the undelivered software-related elements, revenue is deferred until only one undelivered element remains (typically the PCS element) and then recognized following the pattern of delivery of the final undelivered element. The Company's multiple element arrangements typically provide for renewal of PCS terms upon expiration of the original term. The amounts of these PCS renewals are recognized as revenue ratably over the specified PCS renewal period.

For non-software arrangements that include multiple-elements, primarily consisting of the Company's SaaS agreements and research sequencing and molecular analysis agreements, revenue recognition involves the identification of separate units of accounting after consideration of combining and/or segmenting contracts and allocation of the arrangement consideration to the units of accounting on the basis of their relative selling price. The selling price used for each deliverable is based on VSOE of fair value, if available, third party evidence ("TPE") of fair value if VSOE is not available, or the Company's best estimate of selling price ("BESP") if neither VSOE nor TPE is available. In determining the units of accounting for these arrangements, the Company evaluates whether each deliverable has stand-alone value as defined in the FASB's guidance. The Company's SaaS arrangements are treated as a single unit of accounting as the professional services do not have standalone value. As a result, the Company recognizes initial system implementation and deployment fees ratably over a period of time from when the system implementation or deployment services are completed and accepted by the customer over the longer of the life of the agreement or the estimated customer life.

If an arrangement to deliver software requires significant production, modification or customization of the licensed software, the Company accounts for the arrangement as a construction-type contract. The Company currently recognizes revenue for these arrangements using the completed-contract method as it does not currently have sufficient information to reliably estimate the percentage of completion for these projects. The Company considers these arrangements to be substantially complete upon the clients' acceptance of the software and related professional services and consistently applies this policy to all contract accounting arrangements.

Transaction processing fees are recognized on a monthly basis based on the number of transactions processed and the fee per transaction.

Revenue derived from reseller arrangements is recognized when the resellers, in turn, sell the software solution to their clients and installation of the software solution has occurred, provided all other revenue recognition criteria are met. This is commonly referred to as the sell-through method and the Company defers recognition until there is a sell-through by the reseller to an actual end user clients and acceptance by the end user has occurred.

The Company expense as incurred incremental direct costs incurred related to the acquisition or origination of customer contracts.

Cost of Revenue under ASC 605

Cost of revenue includes associate salaries, bonuses and benefits, stock-based compensation, consultant costs, direct reimbursable travel expenses, depreciation related to software developed for internal use and other direct engagement costs associated with the design, development, sale and installation of systems, including system support and maintenance services for clients. System support includes ongoing client assistance for software updates and upgrades, installation, training and functionality. All service costs except deferred implementation costs are expensed when incurred. Amortization of deferred implementation costs are also included in cost of revenue. Cost of revenue associated with each of the Company's revenue sources consists of the following types of costs:

- **Software-as-a-service related** - SaaS cost of revenue includes personnel-related costs, amortization of deferred implementation costs and other direct costs associated with the delivery and hosting of the Company's subscription services.

- **Software and hardware related** - Software and hardware cost of revenue includes third-party software and hardware costs directly associated with solutions, including purchasing and receiving costs. It also includes personnel-related, amortization of deferred implementation costs and other direct costs associated with the Company's software training and implementation services provided to our clients.

- **Maintenance** - Maintenance cost of revenue includes personnel-related costs and other direct costs associated with the ongoing support or maintenance provided to the Company's clients.

- **Sequencing and molecular analysis** - Sequencing and molecular analysis cost of revenue includes (a) personnel-related costs associated with these services and (b) amounts due to NantOmics under the reseller agreement (see Note 19) for the sequencing and analysis of whole genome DNA (or whole exome DNA based on tissue quantity and quality), RNA, and proteomic results.

- **Home health care services** - Home health care services cost of revenue includes personnel and direct expenses relating to the Company's nursing and therapy services provided to patients in a home care setting.

Revenue Recognition under ASC 606

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration we expect to receive in exchange for those products or services. Revenue is recognized net of sales taxes collected from customers, which are subsequently remitted to governmental authorities. The Company's revenue is generated from the following sources:

- **Software-as-a-service ("SaaS") related** - SaaS related revenue is generated from customers' access to and usage of the Company's hosted software solutions on a subscription basis for a specified contract term. In SaaS arrangements, the customer cannot take possession of the software during the term of the contract and generally has the right to access and use the software and receive any software upgrades published during the subscription period.

  SaaS contracts are accounted for as a single performance obligation, as implementation and hosting services are not distinct. As a result, the Company recognizes all fees, including any up front initial system implementation service fees, or other fees, ratably over time from when the system implementation or deployment services are completed, and where necessary accepted by the customer, over the contract term, as stated, or with consideration of termination for convenience clauses as discussed below **.**

- **Software and hardware related** - Software and hardware related revenue is generated from the license of the Company's software, on a perpetual basis, the sale of hardware and professional services that are complementary to the software and may or may not be required for the software to function as desired by the customer. The services are generally provided in the form of implementation and training services and do not include maintenance revenue. The software is installed on the customer's site or the customer's designated vendor's site and is not hosted by the Company or by a vendor contracted by the Company. See the section below " *Contracts with Software, Hardware, and Implementation Services"* for details of management's judgments and recognition of revenue relating to this category.

- **Maintenance** - Maintenance revenue includes ongoing post contract client support ("PCS") or maintenance during the paid PCS term. Additionally, PCS includes ongoing development of software updates and upgrades provided to the client on a when and if available basis. Revenue is recognized over the maintenance term.

- **Sequencing and molecular analysis** - Sequencing and molecular analysis revenue is generated by providing customers with reports of the results of performing sequencing and analysis of whole genome DNA (or whole exome DNA based on tissue quantity and quality), RNA, and/or proteomic testing under the Company's reseller agreement with NantOmics, and from blood samples via its liquid/blood-based tumor profiling platform through the Company's subsidiary, NantHealth Labs, Inc. ("NantHealth Labs", formerly Liquid Genomics, Inc.) (see Note 18). Revenue is recognized at a point in time, when reports of results are transferred to the ordering physician or institution, or when cash is received as described below; or ratably over time for the period of a stand-ready obligation to provide blood-based tumor profiling services.

  The Company's sequencing and molecular analysis revenue is primarily generated from payments received from commercial third party payers, hospitals and other provider networks and patients. The Company reports revenue from arrangements with these customers on a gross basis in accordance with ASC 606. When reports are transferred to the ordering physician or institution, but the Company cannot conclude whether there is a contract with a customer, based on the assessment of collectibility, revenue recognition is deferred until non-refundable payment is received or payment is considered probable.

- **Home health care services** - Home health care services revenue includes the sale of nursing and therapy services provided to patients in a home care setting. These revenues are recognized at a point in time or over time, as services are provided.

Certain of the Company's customer contracts allow for termination for convenience, with advanced notice, without substantive termination penalty. In these cases, the Company has concluded the contract term is equal to the remaining noncancelable period. Such termination rights do not allow for refunds other than prepaid PCS or other services. These provisions do not affect when the Company commences revenue recognition.

Management assesses whether contracts entered into at, or near, the same time, should be combined, based on evaluation of the commercial objectives of the contracts.

As of December 31, 2018 , the Company has allocated a total transaction price of $15,666 to unfulfilled performance obligations that are expected to be fulfilled within three years . Excluded from this amount are contracts of less than one year and variable consideration that relates to the value of services provided.

Contracts with Multiple Promises for Goods and Services

The Company engages in various contracts with promises for multiple goods and services, which may generate revenue across any of the sources noted above.

In certain contracts, the Company recognizes its proprietary software, hardware, PCS, results of sequencing and molecular analysis, certain professional services, and other software-related services as distinct performance obligations.

Standalone selling prices ("SSP") are required to be allocated and revenue recognized for each distinct performance obligation within each contract. The SSP for each performance obligation is determined by considering contracts in which the good or service is sold separately and other factors, including market conditions and the Company's experience selling similar goods and services, as well as costs and margins achieved. In some cases, to estimate the SSP, the Company first estimates the selling price of each performance obligation for which an SSP is observable and then estimates the SSP of the remaining performance obligation as the residual contractual amount.

Contracts with Software, Hardware, and Implementation Services

The Company has some contracts where it provides implementation services involving significant integration of its licensed software and hardware, with customer networks that maintain patient electronic health records. These contracts represent a single performance obligation to the customer for a combined output due to the significant service of integrating the hardware, software and professional services. Revenue for the single performance obligation is recognized over time based on actual, or estimated, direct implementation labor hours, as a measure of progress.

In certain of those contracts, the Company's performance also requires significant customization of its licensed software. For such contracts, the Company will also record revenue over time using the percentage of completion method to estimate the satisfaction of its performance obligations. However, where the Company lacks history and experience with certain projects involving the development of software according to customer specified criteria, the Company may be initially unable to reasonably estimate total direct software development labor hours to be expected under the project. As a result, the Company would not be able to reasonably measure its progress toward complete satisfaction of its single performance obligation.

As a result, in these contracts, the Company will commence recognizing revenue when it concludes that it can reasonably measure its progress and determine that costs will be recoverable, which is typically at or near the time of the customers' acceptance of the software and the related professional services. At that point, substantially all of the uncertainty related to its ability to reasonably estimate direct labor hours required to satisfy its performance obligations will have been resolved, and the Company will be able to reasonably measure the remaining progress toward complete satisfaction of its remaining professional services obligations. In such cases, the Company will commence recording revenue, at the date of meeting the customer acceptance criteria, with a cumulative catch up for the work performed to date using direct labor hours as a measure of progress consistent with other contracts involving software, hardware and implementation services. Recognition will continue for its performance obligation over the remaining performance period using the same measure of progress. A provision for the entire loss, from such a contract, will be recognized in any period it becomes evident that the contract will not be profitable.

Other contracts for perpetual software licenses, hardware, and implementation services do not include a service of software development or significant integration. Therefore, the perpetual software licenses, hardware, and implementation services are considered separate, distinct performance obligations. Software revenue is recognized upon the later of the license term commencement or the date the software is provided to the customer, hardware revenue is recognized upon delivery, and implementation revenue is recognized over time based on actual, or estimated, direct implementation labor hours as a measure of progress.

The Company delineates between contracts with, or without, a service of significant integration by considering the complexity of the integration services and whether such services can be performed by the customer or another third party. The Company has both reseller arrangements with gross revenue presentation due to the Company's control of goods and services before transfer to the customer, and others with net revenue presentation due to the reseller's control of goods and services before transfer to the customer. The Company assesses control in terms of relevant indicators of performance, inventory, and pricing risk, such as which party negotiates pricing with the end customer and which party is ultimately responsible for fulfilling services, transferring goods and services, and ensuring support.

Contract Balances

The Company records deferred revenue when cash payments are received, or payment is due, in advance of its fulfillment of performance obligations. There were revenues of $13,518 recognized during the year ended December 31, 2018 , that were included in the deferred revenue balance at the beginning of the year.

Contract assets are recognized when a contractual performance obligation has been satisfied, but payment is not due until the completion of additional performance obligations, or the right to receive payment becomes unconditional. Contract assets reduced to $434 at December 31, 2018 from $796 at January 1, 2018, due to payments from customers.

Assets Recognized from the Costs to Obtain a Contract with a Customer

The Company recognizes an asset for the incremental costs to obtain a contract with a customer, where the stated contract term, with expected renewals, is longer than one year. The Company amortizes these assets over the expected period of benefit. These costs are generally employee sales commissions, with amortization of the balance recorded in selling, general and administrative expenses. The value of these assets was $1,163 at December 31, 2018 and $866 at January 1, 2018, and amortization during the year ended December 31, 2018 was $605 .

Where management is not able to conclude that the costs of a contract will be recovered, costs to obtain the contract are expensed as incurred.

Practical Expedients

The Company does not disclose the value of unsatisfied performance obligations for: contracts with an original expected length of one year or less; or where variable consideration, related to the Company's performance, is allocated to goods and services delivered as a series and accounted for as a single performance obligation.

Cost of Revenue under ASC 606

Cost of revenue includes associate salaries, bonuses and benefits, stock-based compensation, consultant costs, direct reimbursable travel expenses, depreciation related to software developed for internal use and other direct engagement costs associated with the design, development, sale and installation of systems, including system support and maintenance services for clients. System support includes ongoing client assistance for software updates and upgrades, installation, training and functionality. All service costs except deferred implementation costs are expensed when incurred. Amortization of deferred implementation costs are also included in cost of revenue. Cost of revenue associated with each of the Company's revenue sources consists of the following types of costs:

- **Software-as-a-service related** - SaaS related cost of revenue includes personnel-related costs, amortization of deferred implementation costs, depreciation of internal use software, and other direct costs associated with the delivery and hosting of the Company's subscription services.

- **Software and hardware related** - Software and hardware related cost of revenue includes third-party software and hardware costs directly associated with solutions, including purchasing and receiving costs, and includes direct costs associated with the Company's software implementation services provided to our customers. Software and hardware related cost of revenue also includes hardware costs directly related to bringing manufactured products to their final selling destination, including costs of design and compliance for proprietary hardware products.

- **Maintenance** - Maintenance cost of revenue includes personnel-related costs and other direct costs associated with the ongoing support or maintenance provided to the Company's clients.

- **Sequencing and molecular analysis** - Sequencing and molecular analysis cost of revenue includes (a) personnel-related costs associated with these services, (b) amounts due to NantOmics under the reseller agreement (see Note 18) for the sequencing and analysis of whole genome DNA (or whole exome DNA based on tissue quantity and quality), RNA, and proteomic results, and (c) lab supply and equipment costs from processing blood samples via its liquid/blood-based tumor profiling platform. It also includes depreciation of internal use software.

- **Home health care services** - Home health care services cost of revenue includes personnel-related, as well as direct expenses relating to the Company's nursing and therapy services provided to patients in a home care setting.

Selling, General and Administrative Expenses

Selling, general and administrative expense consists primarily of shared service fees from NantWorks, personnel-related expenses for our sales and marketing, finance, legal, human resources, and administrative associates, stock-based compensation, and advertising and marketing promotions of NantHealth solutions. This includes amortization of deferred commission costs. It also includes trade show and event costs, sponsorship costs, as well as legal costs, consulting and professional fees, insurance and other corporate and administrative costs. Advertising costs are expensed as incurred.

Research and Development Expenses

Research and development ("R&D") costs incurred to establish the technological feasibility of software to be sold are expensed as incurred. These expenses include the costs of the Company's proprietary R&D efforts, as well as costs incurred in connection with certain licensing arrangements.

Development costs, consisting primarily of employee salaries and benefits (including stock-based compensation), incurred in the research and development of new software products and maintenance to existing software products are expensed as incurred. These costs are associated with both the preliminary project stage and post-implementation stage of internally developed software. Costs associated with the application development stage are capitalized.

Stock-Based Compensation

The Company accounts for stock-based compensation arrangements granted to employees in accordance with ASC 718, *Compensation–Stock Compensation,* by measuring the grant date fair value of the award and recognizing the resulting expense over the period during which the employee is required to perform service in exchange for the award.

The Company accounts for stock-based compensation arrangements issued to non-employees using the fair value approach prescribed by ASC 505-50, *Equity-Based Payments to Non-Employees.* The value of non-employee stock-based compensation is re-measured at the end of each reporting period until the award vests and is recognized as stock-based compensation expense over the period during which the non-employee provides the services.

Stock-based compensation expense for both employee and non-employee awards is recognized on a straight-line basis over the appropriate service period for awards that are only subject to service conditions and is recognized using the accelerated attribution method for awards that are subject to performance conditions. Stock-based compensation expense is only recognized for awards subject to performance conditions if it is probable that the performance condition will be achieved.

All excess tax benefits and tax deficiencies are recognized as income tax benefit or expense in the income statement as discrete items in the reporting period in which they occur, and such tax benefits and tax deficiencies are not included in the estimate of an entity's annual effective tax rate, applied on a prospective basis. The recognition of excess tax benefits is not deferred until the benefit is realized through a reduction to taxes payable. When the Company applies the treasury stock method, in calculating diluted earnings per share, excess tax benefits, if applicable, are excluded and deficiencies from the calculation of assumed proceeds since such amounts are recognized in the income statement. Excess tax benefits if applicable, are classified as operating activities in the same manner as other cash flows related to income taxes on the statement of cash flows.

The Company has elected to account for forfeitures when they occur. Cash paid by the Company when directly withholding shares for tax withholding purposes is classified as a financing activity in the Consolidated Statements of Cash Flows (see Note 14 and Note 16).

Change in Fair Value of Derivative Liability

The Company has classified the interest make-whole provision of its convertible notes and related party convertible note due June 2021 and issued in December 2016 as a derivative liability as part of other liabilities and related party liabilities, respectively, in the Consolidated Balance Sheets and is recorded at fair value. This derivative liability is subject to re-measurement at each balance sheet date, and the Company recognizes any change in fair value in the Company's Consolidated Statements of Operations as a change in fair value of the derivative liability. The change in the fair value of this derivative liability is primarily due to the change in the value of the Company's common stock (see Note 13).

Change in Fair Value of Bookings Commitment

The Company has classified the Bookings Commitment assumed on the disposal of the provider/patient engagement solutions business described in Note 3 as part of other liabilities in the Consolidated Balance Sheets. This liability is subject to re-measurement at each balance sheet date, and the Company recognizes any changes in fair value within other expenses. The change in the fair value of this liability is primarily due to changes in management's estimates of performance against the Bookings Commitment.

Income Taxes

The Company records the federal and state tax provision of the consolidated group and foreign tax provision of its foreign subsidiaries.

ASC 740, *Income Taxes* , provides the accounting treatment for uncertainty in income taxes recognized in an enterprise’s financial statements. ASC 740 prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. ASC 740 also provides guidance on derecognizing, classification, interest and penalties, accounting in interim periods, disclosure, and transition.

As part of the process of preparing our Consolidated Financial Statements, the Company is required to estimate its provision for income taxes in each of the tax jurisdictions in which the Company conducts business. This process involves estimating our actual current tax expense in conjunction with the evaluation and measurement of temporary differences resulting from differing treatment of certain items for tax and accounting purposes. These temporary differences result in the establishment of deferred tax assets and liabilities, which are recorded on a net basis and included in the Company's Consolidated Balance Sheets. The Company then evaluates on a periodic basis the probability that the net deferred tax assets will be recovered and therefore realized from future taxable income and to the extent the Company believes that recovery is not more likely than not, a valuation allowance is established to address such risk resulting in an additional related provision for income taxes during the period.

Significant management judgment is required in determining its provision for income taxes, its deferred tax assets and liabilities, tax contingencies, unrecognized tax benefits, and any required valuation allowance, including taking into consideration the probability of the tax contingencies being incurred. Management assesses this probability based upon information provided by its tax advisers, its legal advisers and similar tax cases. If at a later time its assessment of the probability of these tax contingencies changes, its accrual for such tax uncertainties may increase or decrease.

The Company has a valuation allowance due to management’s overall assessment of risks and uncertainties related to its future ability to realize and, hence, utilize certain deferred tax assets, primarily consisting of net operating losses, carry forward temporary differences and future tax deductions.

The effective tax rate for annual and interim reporting periods could be impacted if uncertain tax positions that are not recognized are settled at an amount which differs from the Company's estimate. Finally, if the Company is impacted by a change in the valuation allowance resulting from a change in judgment regarding the realizability of deferred tax assets, such effect will be recognized in the interim period in which the change occurs.

Net Income (Loss) Per Share

Basic net income (loss) per share is computed by dividing the net income (loss) by the weighted-average number of shares of common stock outstanding during the period. Diluted net income (loss) per share is computed by dividing the net income (loss) by the weighted-average number of shares of common stock outstanding during the period, adjusted to give effect to potentially dilutive securities. However, potentially dilutive securities are excluded from the computation of diluted net income (loss) per share to the extent that their effect is anti-dilutive. The Company applies treasury method in calculating weighted average dilutive number of shares for its stock plans.

Foreign Currency Translation

The Company has operations and holds assets in various foreign countries. The local currency is the functional currency for the Company's subsidiaries in the United Kingdom, Canada and Singapore. Assets and liabilities are translated at end-of-period exchange rates while revenues and expenses are translated at the average exchange rates in effect during the period. Equity is translated at historical rates and the resulting cumulative translation adjustments are included as a component of accumulated other comprehensive income until the translation adjustments are realized.

Segment Reporting

The chief operating decision maker for the Company is its Chief Executive Officer. The Chief Executive Officer reviews financial information presented on a consolidated basis for purposes of allocating resources and evaluating financial performance. The Company has one business activity and there are no segment managers who are held accountable for operations, operating results, or plans for levels or components below the consolidated unit level. Accordingly, management has determined that the Company operates in one reportable segment.

Business Combinations

Business combinations are accounted for using the acquisition method of accounting. Under the acquisition method, assets acquired and liabilities assumed are recorded at their respective fair values as of the acquisition date. Any excess of the purchase price over the estimated fair values of the net assets acquired is recorded as goodwill. Management routinely monitors the factors impacting the acquired assets and liabilities. Transaction related costs are expensed as incurred. The operating results of the acquired business are reflected in the Company's Consolidated Financial Statements as of the acquisition date.

Fair Value of Financial Instruments

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements are classified and disclosed in one of the following three categories:

- Level 1—Quoted prices for identical assets or liabilities in active markets;
- Level 2—Quoted prices for similar assets or liabilities in active markets or quoted prices for identical or similar assets or liabilities in markets that are not active or are directly or indirectly observable; and
- Level 3—Unobservable inputs that reflect estimates and assumptions.

The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, accounts receivable, accounts payable, notes payable, deferred revenue, and other current monetary assets and liabilities approximate fair value because of the immediate or short-term maturity of these financial instruments.

In accordance with this guidance, the Company measures its cash equivalents and marketable securities at fair value. The Company's cash equivalents are classified within Level 1. Cash equivalents are valued primarily using quoted market prices utilizing market observable inputs.

The Company's investment securities as of December 31, 2018 include certificates of deposit that are classified by management as held-to-maturity since the Company has the positive intent and ability to hold to maturity. The fair value of these investments approximate carrying values, and the Company has classified these instruments as Level 2 in the fair value hierarchy.

The Company's fair value estimate of the Bookings Commitment and convertibles notes and interest make-whole provision of the convertible notes are based on Level 3 inputs.

Cash and Cash Equivalents

The Company considers all unrestricted, highly liquid investments with an initial maturity of three months or less to be cash equivalents. These amounts are stated at cost, which approximates fair value. At December 31, 2018 and 2017 , cash equivalents were deposited in financial institutions and consisted of immediately available fund balances. Cash and cash equivalents are maintained at stable financial institutions, generally at amounts in excess of federally insured limits, which represents a concentration of credit risk. The Company has not experienced any losses on deposits of cash and cash equivalents to date.

Accounts Receivable and Allowance for Doubtful Accounts

Accounts receivable are recorded at the invoiced amount, net of allowances for doubtful accounts. The allowance for doubtful accounts is based on management's assessment of the collectibility of accounts. The Company regularly reviews the adequacy of the allowance for doubtful accounts by considering the age of each outstanding invoice and the collection history of each client to determine whether a specific allowance is appropriate. Accounts receivable deemed uncollectible are charged against bad debt expense when identified.

Prior to the adoption of ASC 606, the Company reported accounts receivable net of amounts related to post contract client support ("PCS") and other services that were billed but not yet delivered at each period end.

Concentrations of Risk

The following table summarizes the number of customers that individually comprise greater than 10% of revenues and/or 10% of accounts receivable, and their aggregate percentages of total revenues and total billed and unbilled accounts receivable:

Period	Significant Customers	Percentage of Total Revenues					Percentage of Total Accounts Receivable				
		A	B	C	D	E	A	B	C	D	E
Year Ended December 31, 2018	4	15.2%	12.4%	11.6%	—%	—%	—%	—%	11.6%	10.8%	—%
Year Ended December 31, 2017	5	14.1%	11.0%	—%	—%	—%	—%	15.7%	18.1%	11.3%	10.1%

Inventories

Inventories are stated at the lower of cost (first-in, first out basis) and net realizable value at December 31, 2018 and 2017.

Insurance Recoveries

The Company records probable insurance recoveries gross of related liabilities. The income and expense related to these amounts are recorded net in selling, general and administrative expenses. If the recoveries exceed the loss recognized in the financial statements, such recoveries are recorded in other income, net once any contingencies relating to the insurance claim have been resolved.

Property, Plant and Equipment, net

Property, plant and equipment received in connection with business combinations are recorded at fair value. Property, plant and equipment acquired in the normal course of business are recorded at cost. Depreciation is computed on a straight line basis over the estimated useful lives of the related assets (see Note 7). Maintenance and repairs are charged to expense as incurred while expenditures for refurbishments and improvements that significantly add to the productive capacity or extend the useful life of an asset are capitalized.

The Company accounts for the costs of computer software obtained or developed for internal use in accordance with ASC 350, *Intangibles—Goodwill and Other* . Computer software development costs are expensed as incurred, except for internal use software costs that qualify for capitalization as described below, and include employee related expenses, including salaries, benefits and stock-based compensation expenses; costs of computer hardware and software; and costs incurred in developing features and functionality. These capitalized costs are included in property and equipment on the Consolidated Balance Sheets. The Company expenses costs incurred in the preliminary project and post implementation stages of software development and capitalizes costs incurred in the application development stage and costs associated with significant enhancements to existing internal use software applications. Software costs are amortized using the straight-line method commencing when the software project is ready for its intended use.

Deferred Implementation Costs

The Company provides SaaS and information technology management services under long-term arrangements which require the Company to perform system implementation activities. In some cases, the arrangements either contain provisions requiring customer acceptance of the setup activities prior to commencement of the ongoing services arrangement or the system implementation services do not have separate value from the service revenue. Up-front fees billed during the setup phase for these arrangements are deferred and setup costs that are direct and incremental to the contract are capitalized. The costs deferred consist of employee compensation (including stock-based compensation) and benefits for those employees directly involved with performing system implementation or deployment services, as well as other direct and incremental costs.

The Company defers costs estimated to be realizable based on contracted implementation revenue and estimated margin from the service contract. The Company periodically reviews the deferred implementation contracts for recoverability. The costs are amortized to cost of revenue ratably over a period of time from when the system implementation or deployment services are completed and accepted to the end of the contract term or the expected customer life, whichever is longer.

Goodwill and Intangible Assets

Goodwill acquired in a business combination and determined to have an indefinite useful life is not amortized but is tested for impairment annually as of October 1 or between annual tests when an impairment indicator exists. In the event there is a change in reporting units or segments, the Company will test for impairment at the reporting unit. A component of an operating segment is a reporting unit if the component constitutes a business for which discrete financial information is available and segment management regularly reviews the operating results of that component.

As part of the annual impairment test, the Company may conduct an assessment of qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount. In a qualitative assessment, the Company would consider the macroeconomic conditions, including any deterioration of general conditions, industry and market conditions, including any deterioration in the environment where the reporting unit operates, increased competition, changes in the products/services and regulator and political developments; cost of doing business; overall financial performance, including any declining cash flows and performance in relation to planned revenues and earnings in past periods; other relevant reporting unit specific facts, such as changes in management or key personnel or pending litigation, and events affecting the reporting unit, including changes in the carrying value of net assets.

If an optional qualitative goodwill impairment assessment is not performed, the Company is required to determine the fair value of each reporting unit. If a reporting unit’s fair value is lower than its carrying value, the Company must determine the amount of implied goodwill that would be established if the reporting unit was hypothetically acquired on the impairment test date. If the carrying amount of a reporting unit’s goodwill exceeds the amount of implied goodwill, the Company would record an impairment loss equal to the excess (see Note 9).

The determination of fair value of a reporting unit is based on a combination of a market approach that considers the Company's market capitalization and an income approach that uses discounted cash flows for the Company's single reporting unit utilizing Level 3 inputs. Under the income approach, the Company determines the fair value based on the present value of the most recent income projections for its single reporting unit and calculates a terminal value utilizing a terminal growth rate. The significant assumptions under this approach include, among others: income projections, which are dependent on sales to new and existing clients, new solution introductions, client behavior, competitor pricing, operating expenses, the discount rate, and the terminal growth rate. The cash flows used to determine fair value are dependent on a number of significant management assumptions based on historical experience, expectations of future performance, and the expected economic environment. Estimates are subject to change given the inherent uncertainty in predicting future results. Additionally, the discount rate and the terminal growth rate are based on judgment of the rates that would be utilized by a hypothetical market participant.

Accounting guidance requires that definite-lived intangible assets be amortized over their respective estimated useful lives and reviewed for impairment whenever events or changes in circumstances indicate that their carrying amounts may not be recoverable. Amortization of finite-lived intangible assets is provided over their estimated useful lives on a straight-line basis or the pattern in which economic benefits are consumed, if reliably determinable. If the estimates of the useful lives change, the Company amortizes the remaining book value over the remaining useful lives or, if an asset is deemed to be impaired, a write-down of the value of the asset to its fair value may be required at such time. The Company reviews its finite-lived intangible assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable.

Investment in Related Party

Investment in and advances to related party in which the Company has a substantial ownership interest of approximately 20% to 50% , or for which the Company exercises significant influence but not control over policy decisions, are accounted for by the equity method. Investment in a limited liability company that is similar to a partnership is also accounted for under the equity method if more than minor influence over the operation of the investee exists (generally through more than 3 - 5% ownership). As part of that accounting, the Company recognizes gains and losses that arise from the issuance of stock by a related party that results in changes in the Company’s proportionate share of the dollar amount of the related party’s equity.

Investment in related party is assessed for possible impairment when events indicate that the fair value of the investment may be below the Company's carrying value. When such a condition is deemed to be other than temporary, the carrying value of the investment is written down to its fair value, and the amount of the write-down is included in net loss. In making the determination as to whether a decline is other than temporary, the Company considers such factors as the duration and extent of the decline, the investee's financial performance, and the Company's ability and intention to retain its investment for a period that will be sufficient to allow for any anticipated recovery in the investment's market value. The new cost basis of investments in these equity investees is not changed for subsequent recoveries in fair value. The fair value of the related party equity method investment would be determined using the income approach. The income approach utilizes a discounted cash flow model incorporating management's expectations for future revenue, operating expenses, and earnings before interest, taxes, depreciation and amortization, capital expenditures and an anticipated tax rate. The related cash flow forecasts are discounted using an estimated weighted-average cost of capital at the date of valuation.

Differences between the Company's carrying value of an equity investment and its underlying equity in the net assets of the related party are assigned to the extent practicable to specific assets and liabilities based on the Company's analysis of the various factors giving rise to the difference. When appropriate, the Company's share of the related party's reported earnings is adjusted quarterly to reflect the difference between these allocated values and the related party's historical book values.

Deferred Revenue

The Company records deferred revenue when it receives cash from clients prior to meeting the applicable revenue recognition criteria. The Company uses judgment in determining the period over which the deliverables are recognized as revenue. As of December 31, 2018 and 2017 , current and non-current deferred revenue are comprised of deferrals for fees related to software licenses, SaaS arrangements, PCS services, non-PCS services and other revenue. Non-current deferred revenue as of December 31, 2018 is expected to be recognized in a period more than 12 months after that date.

Recently Adopted Accounting Pronouncements

Effective January 1, 2018, the Company adopted Accounting Standard Update ("ASU") No. 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities* , associated with the recognition and measurement of financial assets and liabilities. During the first quarter of 2018, the FASB issued further clarifications with the issuance of ASU No. 2018-03, effective for fiscal years beginning after December 15, 2017 and interim periods beginning after June 15, 2018, and ASU No. 2018-04, effective upon issuance. The Company adopted ASU No. 2018-03 and ASU No. 2018-04 effective January 1, 2018 concurrently with ASU No. 2016-01. ASU No. 2016-01 requires that equity investments, except those accounted for under the equity method of accounting, be measured at fair value and changes in fair value are recognized in net income. ASU No. 2016-01 also provides a new measurement alternative for equity investments that do not have a readily determinable fair value (cost method investments). These investments are measured at cost, less any impairment, adjusted for observable price changes. The amendments related to equity securities without readily determinable fair values (including disclosure requirements) are applied prospectively to equity investments that exist as of the date of adoption. Effective January 1, 2018, the Company elected to record its preferred stock equity investment in Innovative Oncology Business Solutions, Inc. ("IOBS"), which does not have a readily determinable fair value using the alternative method. Adoption of these ASUs did not have a material effect on the Company's accounting for equity investments, fair value disclosures and other disclosure requirements.

The Company owns non-marketable equity securities that are accounted for as an equity investment at cost minus impairment and plus or minus changes resulting from observable price changes because the preferred stock held by the Company is not considered in-substance common stock and such preferred stock does not have a readily determinable fair value. All investments are reviewed on a regular basis for possible impairment. If an investment's fair value is determined to be less than its net carrying value, the investment is written down to its fair value. Such an evaluation is judgmental and dependent on specific facts and circumstances. Factors considered in determining whether an impairment indicator is present include: the investees' earning performance, change in the investees' industry and geographic area in which it operates, offers to purchase or sell the security for a price less than the cost of the investment, issues that raise concerns about the investee's ability to continue as a going concern and any other information that the Company may be aware of related to the investment. Factors considered in determining whether an observable price change has occurred include: the price at which the investee issues equity instruments similar to those of the Company's investment and the rights and preferences of those equity instruments compared to the Company's.

Effective January 1, 2018, the Company adopted ASU No. 2016-15, *Classification of Certain Cash Receipts and Cash Payments* . ASU No. 2016-15 adds or clarifies guidance on the classification of certain cash receipts and payments in the statement of cash flows. Also, effective January 1, 2018, the Company adopted ASU No. 2016-18, *Statement of Cash Flows: Restricted Cash, a consensus of the FASB's Emerging Issues Task Force* . ASU No. 2016-18 requires that the statement of cash flows explains the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. Entities are required to reconcile such total to amounts on the balance sheet and disclose the nature of the restrictions. Prior periods were retrospectively adjusted to conform to the current period's presentation. There was no material impact on the Company's Consolidated Statements of Cash Flows on adoption of these ASUs.

In May 2017, the FASB issued ASU No. 2017-09, *Compensation-Stock Compensation (Topic 718): Scope of Modification Accounting* . The amendments in ASU No. 2017-09 provide guidance about which changes to the terms or conditions of a share-based payment award require an entity to apply modification accounting. Pursuant to ASU No. 2017-09, an entity should account for the effects of a modification unless all of the following are met: (1) the fair value (or calculated value or intrinsic value, if such an alternative measurement method is used) of the modified award is the same as the fair value (or calculated value or intrinsic value, if such an alternative measurement method is used) of the original award immediately before the original award is modified; (2) the vesting conditions of the modified award are the same as the vesting conditions of the original award immediately before the original award is modified; and (3) the classification of the modified award as an equity instrument or a liability instrument is the same as the classification of the original award immediately before the original award date is modified. ASU No. 2017-09 became effective for all entities for annual periods, and interim periods within those annual periods, beginning after December 15, 2017. Early adoption was permitted, including adoption in any interim period for which financial statements had not yet been issued or made available for issuance. The amendments of this ASU should be applied prospectively to an award modified on or after the adoption date. The Company adopted ASU No. 2017-09 in the beginning in the first quarter of 2018. If the Company encounters a change to the terms or conditions of any of its share-based payment awards, the Company will evaluate the need to apply modification accounting based on the new guidance. The general treatment for modifications of share-based payment awards is to record the incremental value arising from the change as additional compensation cost. The adoption of this ASU did not result in a significant impact to the Company's Consolidated Financial Statements.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission ("SEC") did not have, nor are believed by management to have, a material impact on the Company's present or future Consolidated Financial Statements.

Upcoming Accounting Standard Pronouncements

In August 2018, the FASB issued ASU 2018-15, Intangibles, *Goodwill and Other, Internal-Use Software,* to provide guidance on customer's accounting for implementation costs incurred in a cloud computing arrangement that is a service contract. The standard provides guidance on a customer's accounting for implementation, set-up, and other upfront costs incurred in a cloud computing arrangement that is hosted by the vendor, i.e. a service contract. Under the new guidance, customers will apply the same criteria for capitalizing implementation costs as they would for an arrangement that has a software license. This updated will become effective for annual periods beginning January 1, 2020, early adoption is permitted and should be applied either retrospectively or prospectively to all implementation costs incurred after the date of adoption. The Company is still evaluating the impact of this ASU.

In June 2018, the FASB issued ASU No. 2018-07, *Stock Compensation (Topic 718)* : *Improvements to Nonemployee Share-Based Payment Accounting,* to simplify accounting for non-employee stock-based compensation. Upon adoption of ASU No. 2018-07, in most cases expense recognition for non-employee stock compensation will be in line with employee stock compensation, using a grant date fair value, without periodic revaluation. This update will become effective beginning in the first quarter of 2019, and early adoption is permitted. The Company is still evaluating the impact of this ASU.

In January 2017, the FASB issued ASU No. 2017-04, *Intangibles-Goodwill and Other (Topic 350)* , to simplify the accounting for goodwill impairment. This guidance, among other things, removes step 2 of the goodwill impairment test thus eliminating the need to determine the fair value of individual assets and liabilities of the reporting unit. Upon adoption of ASU No. 2017-04, goodwill impairment will be the amount by which a reporting unit's carrying value exceeds its fair value, not to exceed the carrying amount of goodwill. This may result in more or less impairment being recognized than under current guidance. This ASU will become effective for the Company's annual and interim goodwill impairment tests beginning in the first quarter of 2020, and early adoption is permitted. The Company is still evaluating the impact of this ASU.

In June 2016, the FASB issued ASU No. 2016-13, *Measurement of Credit Losses on Financial Instruments* , which changes how companies measure credit losses on most financial instruments measured at amortized cost, such as loans, receivables and held-to-maturity debt securities. Rather than generally recognizing credit losses when it is probable that the loss has been incurred, the revised guidance requires companies to recognize an allowance for credit losses for the difference between the amortized cost basis of a financial instrument and the amount of amortized cost that the company expects to collect over the instrument's contractual life. ASU No. 2016-13 is effective for fiscal periods beginning after December 15, 2019 and must be adopted as a cumulative effect adjustment to retained earnings. Early adoption is permitted. The Company is evaluating the potential effects of the adoption of this guidance on the Company's Consolidated Financial Statements.

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)* , which is aimed at making leasing activities more transparent and comparable and requires substantially all leases be recognized by lessees on their balance sheet as a right-of-use asset and corresponding lease liability, including leases currently accounted for as operating leases. This guidance will become effective for interim and annual reporting periods beginning with the year ending December 31, 2019. Early adoption is permitted.

The Company expects that this guidance will have a material impact on the Consolidated Balance Sheets when adopted at January 1, 2019. However, it is not expected to have a material impact on the Consolidated Statements of Operations. In July 2018, the FASB issued ASU No. 2018-11, *Leases (Topic 842): Targeted Improvements* , to provide a new transition method. Under this method, an entity initially applies the new leases standard at the adoption date and recognizes a cumulative-effect adjustment to the opening balance of retained earnings in the period of adoption. The Company expects to use this transition method. On adoption, the Company will elect the package of transition practical expedients and therefore will not: reassess whether expired or existing contracts are or contain leases; reassess the lease classification of expired or existing leases; reassess initial direct costs for any existing leases. On adoption, the Company expects to make an accounting policy election to treat colocation facilities with lease terms of less than one year as short-term leases. The Company is implementing new business processes and controls around the review of lease agreements, including processes to track information relevant to new disclosures. The Company has analyzed its lease portfolio and prepared calculations of the modified retrospective impact to its Consolidated Financial Statements. The most significant impact of adoption will relate the recognition of right of use assets and lease liabilities, in relation to operating leases of office space, the Company expects to recognize material right of use assets and lease liabilities. There will be no impact on retained earnings or the Consolidated Statement of Operations upon adoption. The Company will update its accounting policies to comply with Topic 842 in the first quarter of 2019.

Note 3 Discontinued Operations

Sale to Allscripts

On August 3, 2017, the Company entered into an asset purchase agreement (the “APA”) with Allscripts Healthcare Solutions, Inc. (“Allscripts”), pursuant to which the Company agreed to sell to Allscripts substantially all of the assets of the Company’s provider/patient engagement solutions business, including the Company’s FusionFX solution and components of its NantOS software connectivity solutions (the “Business”). On August 25, 2017, the Company and Allscripts completed the sale of the Business (the "Disposition") pursuant to the APA.

Allscripts conveyed to the Company 15,000,000 shares of Company's common stock at par value of $0.0001 per share that were previously owned by Allscripts as consideration for the acquired Business upon Disposition. Allscripts paid the Company $1,742 of cash consideration as an estimated working capital payment, and the Company recorded a receivable of $1,021 related to final working capital adjustments. The Company is also responsible for paying Allscripts for fulfilling certain customer service obligations of the Business post-closing. As of December 31, 2018 , the Company accrued $1,372 in accrued and other current liabilities for these obligations, which includes estimates for certain unresolved items.

Concurrent with the closing of the Disposition and as contemplated by the APA, (a) the Company and Allscripts modified the amended and restated mutual license and reseller agreement dated June 26, 2015, which was further amended on December 30, 2017, such that, among other things, the Company committed to deliver a minimum of $95,000 of total bookings over a ten -year period (“Bookings Commitment”) from referral transactions and sales of certain Allscripts products; (b) the Company and Allscripts each licensed certain intellectual property to the other party pursuant to a cross license agreement; (c) the Company agreed to provide certain transition services to Allscripts pursuant to a transition services agreement; and (d) the Company licensed certain software and agreed to sell certain hardware to Allscripts pursuant to a software license and supply agreement. In the event of a Bookings Commitment shortfall at the end of the ten -year period, the Company may be obligated to pay 70% of the shortfall, subject to certain credits. The Company will earn 30% commission from Allscripts on each software referral transaction that results in a booking with Allscripts. The Company accounts for the Bookings Commitment at its estimated fair value over the life of the agreement and, as of December 31, 2018, the estimated fair value was $16,947 . The fair value was estimated not to be material as of December 31, 2017 (see Note 12).

During the years ended December 31, 2018 and December 31, 2017 , the Company recorded other income of $465 and $348 , respectively, associated with the services under the transition services agreement.

The total loss on sale to Allscripts consisted of the following:

Cash received as consideration	$	1,742
Deferred consideration related to working capital adjustments		1,021
Estimated costs to be incurred by the Company to fulfill certain customer service obligations of the Business post-closing		(883)
Fair value of common stock		42,750
Net consideration received		44,630
Less: Carrying value of net assets sold		(55,255)
Plus: Reclassification of cumulative translation adjustments of foreign subsidiaries		117
Loss from sale of Business	$	(10,508)

The sale of the Business qualified as discontinued operations because it comprised operations and cash flows that could be distinguished, operationally and for financial reporting purposes, from the rest of the Company. The disposal of the Business represented a strategic shift in the Company's operations as the sale enables the Company to focus on genomic sequencing, clinical decision support, connected care and payer engagement.

The operating results of the Company's discontinued operations are as follows:

	Year Ended December 31,	
	2018	**2017**
Major line items constituting loss from discontinued operations		
Net revenue	—	7,619
Cost of revenue	—	16,318
Selling, general and administrative	1,719	8,891
Research and development	—	7,571
Amortization of software license and acquisition-related assets	—	1,978
Other expense (income)	—	134
Loss from sale of Business	—	10,508
Gain from dissolution of a business component	—	(860)
Loss from discontinued operations, before income taxes	(1,719)	(36,921)
Provision for income taxes	—	6,891
Loss from discontinued operations, net of income taxes	(1,719)	(43,812)

Cumulative translation adjustment gains or losses of foreign subsidiaries related to divested Business are reclassified into income once the liquidation of the respective foreign subsidiaries is substantially complete. At the completion of the sale of the Business, the Company reclassified $117 of cumulative translation adjustment gains from accumulated comprehensive loss to the Company's loss from sale of the Business.

The significant operating and investing cash and noncash items of the discontinued operations included in the Consolidated Statements of Cash Flows for the years ended December 31, 2018 and 2017 were as follows:

	Year Ended December 31,	
	2018	**2017**
Depreciation and amortization from discontinued operations	$ —	$ 8,829
Loss from sale of Business	—	10,508
Proceeds from sale of Business	—	1,721
Capital expenditures	—	4,673

Concurrent with the sale to Allscripts, the Company performed a reorganization of its operations intended to improve efficiency and better align the Company's costs and employment structure with its strategic plans. The reorganization includes a workforce reduction. Upon signing release agreements, impacted employees were eligible to receive severance payments in specified amounts and general benefits for specified periods in accordance with our policies and local requirements.

In the year ended December 31, 2017 , the Company recorded restructuring charges of approximately $2,422 associated with the termination of the employees. In connection with the termination, the Company reversed previously estimated bonus accrual of $533 and stock-based compensation of $1,549 as a result of the forfeiture of unvested awards. The Company recorded these charges in cost of revenue, general and administrative, and research and development from continuing operations expenses based on responsibilities of the impacted employees.

Dissolution of Net.Orange Ltd

On August 29, 2017, the Company dissolved its wholly owned U.K. subsidiary, Net.Orange Ltd. The Company reclassified $ 860 of cumulative translation adjustment gains from accumulated comprehensive loss to the Company's results of discontinued operations.

Note 4 Accounts Receivable, net

Previously, accounts receivable, net excluded amounts related to post contract client support (“PCS”) and other services that were billed but not yet delivered at each period end. These undelivered services were also excluded from the deferred revenue balances on the accompanying Consolidated Balance Sheets. The amount of outstanding and unpaid invoices excluded from both the accounts receivable and deferred revenue balances as of December 31, 2017 was $6,198 . Due to the implementation of ASC 606, outstanding and unpaid invoices for undelivered services are included in accounts receivable at December 31, 2018 .

Accounts receivable are included on the Consolidated Balance Sheets net of the allowance for doubtful accounts. A summary of activity in the allowance for doubtful accounts for the years ended December 31, 2018 and 2017 is as follows:

	Balance at beginning of the period	Additions to expense	(Write offs) / Recoveries	Balance at end of the period
Year ended December 31, 2018	$ 149	37	(23)	$ 163
Year ended December 31, 2017	$ 70	79	—	$ 149

Note 5 Inventories

Inventories as of December 31, 2018 and 2017 consisted of the following:

	December 31,	
	2018	2017
Finished goods	$ 496	$ 839
Inventories	$ 496	$ 839

Note 6 Prepaid Expenses and Other Current Assets and Accrued and Other Current Liabilities

Prepaid expenses and other current assets as of December 31, 2018 and 2017 consisted of the following:

	December 31,	
	2018	2017
Prepaid expenses	$ 1,485	$ 2,791
Restricted cash [1]	—	350
Other current assets	2,865	2,217
Prepaid expenses and other current assets	$ 4,350	$ 5,358

[1] Additional $1,136 of non-current restricted cash as of December 31, 2018 is included in the Company's Consolidated Balance Sheets as part of Other assets. Restricted cash relates to compensating balances against letters of credit, with an equal maximum credit availability, provided to lessors under operating lease agreements.

Accrued and other current liabilities of December 31, 2018 and 2017 consisted of the following:

	December 31,	
	2018	2017
Payroll and related costs	$ 5,803	$ 7,051
NaviNet acquisition accrued earnout	1,700	5,408
Other accrued and other current liabilities	6,329	5,675
Accrued and other current liabilities	$ 13,832	$ 18,134

Note 7 Property, Plant and Equipment, net

Property, plant and equipment, net as of December 31, 2018 and 2017 consisted of the following:

	Useful life (in years)	December 31,	
		2018	2017
Computer equipment and software	3-5	$ 14,058	$ 13,998
Furniture and equipment	5-7	3,732	3,211
Leasehold and building improvements [1]		7,450	4,233
Property, plant, and equipment, excluding internal use software		25,240	21,442
Less: Accumulated depreciation and amortization		(17,884)	(15,248)
Property, plant and equipment, excluding internal use software, net		7,356	6,194
Construction in progress, internal use software		903	629
Internal use software	3	31,565	17,690
Less: Accumulated depreciation and amortization, internal use software		(16,846)	(5,996)
Internal use software, net		15,622	12,323
Property, plant and equipment, net		$ 22,978	$ 18,517

[1] Useful lives for leasehold and building improvements represent the term of the lease or the estimated life of the related improvements, whichever is shorter.

Depreciation expense from continuing and discontinued operations was $12,643 and $12,363 for the years ended December 31, 2018 and 2017 , respectively, of which $9,189 and $5,792 , respectively, related to internal use capitalized software development costs.

Amounts capitalized to internal use software related to continuing operations for the years ended December 31, 2018 and 2017 were $6,690 and $7,333 , respectively.

Note 8 Intangible Assets, net

The Company's definite-lived intangible assets as of December 31, 2018 and 2017 consisted of the following:

	December 31, 2018			
	Customer Relationships	Developed Technologies	Trade Name	Total
Gross carrying amount	$ 52,000	$ 36,700	$ 3,000	$ 91,700
Accumulated amortization	(10,400)	(14,347)	(2,250)	(26,997)
Intangible assets, net	$ 41,600	$ 22,353	$ 750	$ 64,703

	December 31, 2017			
	Customer Relationships	Developed Technologies	Trade Name	Total
Gross carrying amount	$ 52,000	$ 32,000	$ 3,000	$ 87,000
Accumulated amortization	(6,933)	(9,143)	(1,500)	(17,576)
Intangible assets, net	$ 45,067	$ 22,857	$ 1,500	$ 69,424

Amortization of definite-lived intangible assets is provided over their estimated useful lives on a straight-line basis or the pattern in which economic benefits are consumed, if reliably determinable. The Company reviews its definite-lived intangible assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Amortization expense from continuing and discontinued operations was $9,150 and $15,692 for the years ended December 31, 2018 and 2017 , respectively.

The estimated future intangibles amortization expense over the next five years and thereafter for the intangible assets that exist as of December 31, 2018 is as follows:

	Amounts
2019	$ 9,150
2020	8,400
2021	8,400
2022	8,400
2023	3,828
Thereafter	26,525
Total future intangibles amortization expense	$ 64,703

Note 9 Goodwill

Goodwill as of December 31, 2018 and 2017 was $115,930 and $114,625 , respectively, net of goodwill allocated to discontinued operations of $16,444 . The value of goodwill associated with the discontinued operations was based on the relative fair value of the Business disposed to the total reporting unit as of August 25, 2017 (see Note 3).

On February 28, 2018, the Company recognized $1,305 of goodwill related to the assignment of NantHealth Labs (see Note 18).

Goodwill acquired in a business combination and determined to have an indefinite useful life is not amortized but is tested for impairment annually as of October 1 or between annual tests when an impairment indicator exists.

Note 10 Investments

Equity method investment

Investment in NantOmics

In 2015, the Company purchased a total of 169,074,539 Series A-2 units of NantOmics, LLC ("NantOmics"), a related party of the Company, for an aggregate purchase price of $250,774 . The Series A-2 units do not have any voting rights and represent approximately 14.28% of NantOmics' issued and outstanding membership interests. NantOmics is majority owned by NantWorks and delivers molecular diagnostic capabilities with the intent of providing actionable intelligence and molecularly driven decision support for cancer patients and their providers at the point of care.

The Company applies the equity method to account for its investment in NantOmics as the interest in the equity is similar to a partnership interest. Further, the Company has the ability to exert significant influence over the operating and financial policies of the entity since NantWorks controls both NantHealth and NantOmics. The difference between the carrying amount of the investment in NantOmics and the Company's underlying equity in NantOmics' net assets relate to both definite and indefinite-lived intangible assets. The Company attributed $28,195 and $14,382 of these differences to NantOmics' developed technologies and its reseller agreement with the Company, respectively, prior to the application of developed technology intangibles included in NantOmics net assets, and the remaining basis differences were attributed to goodwill. The Company amortizes the basis differences related to the definite-lived intangible assets over the assets' estimated useful lives and records these amounts as a reduction in the carrying amount of its investment and an increase in its equity method loss.

The investment in related party is assessed for possible impairment when events indicate that the fair value of the investment may be below the carrying value. When such a condition is deemed to be other than temporary, the carrying value of the investment is written down to its fair value, and the amount of the write-down is included in net loss. In making the determination as to whether a decline is other than temporary, the Company considers such factors as the duration and extent of the decline, the investee's financial performance, and the Company's ability and intention to retain the investment for a period that will be sufficient to allow for any anticipated recovery in the investment's market value. The new cost basis of the investment is not changed for subsequent recoveries in fair value.

The fair value of the Company's equity method investment is determined using the income approach. The income approach utilizes a discounted cash flow model incorporating management's expectations for future revenue, operating expenses, and earnings before interest, taxes, depreciation and amortization, capital expenditures and an anticipated tax rate. The related cash flow forecasts are discounted using an estimated weighted-average cost of capital at the date of valuation. Differences between the carrying value of an equity investment and its underlying equity in the net assets of the related party are assigned to the extent practicable to specific assets and liabilities based on our analysis of the various factors giving rise to the difference. When appropriate, the Company's share of the related party's reported earnings is adjusted quarterly to reflect the difference between these allocated values and the related party's historical book values.

At December 31, 2018, September 30, 2018 and June 30, 2017, the Company determined that other-than-temporary-impairments of $14,768 , $80,444 and $35,991 , respectively, in the value of the investment in NantOmics had occurred, predominantly attributed to declines in the value of goodwill and intangible assets. The decline in fair value at December 31, 2018 was primarily caused by altered pricing assumptions for the reseller agreement between the Company and NantOmics. The declines in fair value at September 30, 2018 and June 30, 2017 were primarily caused by changes in projected GPS Cancer revenue, due to delays in the Company's GPS Cancer revenue growth and changes in the risk profile of the financial projections for NantOmics. The Company based its financial projections on information that the Company believed was reasonable; however, actual results may differ materially from those projections. The other than temporary impairments were based on judgments and estimates that were forward looking in nature and it is reasonably possible that the estimate of the impairments of the equity method investment in NantOmics will change in the near term due to the following: actual NantOmics cash distribution is materially lower than expected, significant adverse changes in NantOmics' operating environment, increase in the discount rate, and changes in other key assumptions. Risks and uncertainties are related to assumptions regarding future financial performance, commercial acceptance of product and service offerings, risk of reimbursement for the Company's sequencing and molecular analysis solution, developments in the healthcare and molecular diagnostics industry, NantOmics' ability to integrate its business acquisitions, regulatory risks, and other general business risks including unanticipated adverse changes in NantOmics' operating environment.

On February 28, 2018, the Company transferred 9,088,362 of the Series A-2 units to NantOmics as consideration for the assignment of NantHealth Labs, Inc. (see Note 18). An additional 564,779 units were transferred from the Company to NantOmics by May 31, 2018. This reduced NantHealth's ownership of NantOmics to approximately 13.58% .

The Company reports its share of NantOmics' income or loss and the amortization of basis differences using a one quarter lag. For the years ended December 31, 2018 and 2017 , the Company recognized losses of $108,409 and $50,334 , respectively, related to this investment.

The Company used the following summarized financial information for NantOmics for the trailing twelve months ended September 30, 2018 and September 30, 2017 to record its equity investment method losses for the years ended December 31, 2018 and 2017 , respectively:

	Trailing Twelve Months Ended	
	September 30, 2018	**September 30, 2017**
Sales	5,817	7,103
Gross loss	(8,528)	(7,167)
Loss from operations	(45,481)	(48,989)
Impairments on equity	(19,976)	—
Net loss	(61,031)	(57,958)
Net loss attributable to NantOmics	(59,622)	(54,784)
Other comprehensive loss	(4,291)	—

Other investments

Investment in IOBS

On June 16, 2015, the Company invested $1,750 in Innovative Oncology Business Solutions, Inc. (“IOBS”) in exchange for 1,750,000 shares of IOBS’s Series A preferred stock. IOBS offers community oncology practices an alternative medical home model for oncology patients that improves health outcomes, enhances patient care experiences and significantly reduces costs of care. The shares of preferred stock represent 35.0% of the outstanding equity of IOBS on an as-converted basis. The Company applied the cost method to account for its investment because the preferred stock is not considered in-substance common stock, is not considered a debt instrument as the Company cannot unilaterally demand redemption of the preferred stock and the preferred stock does not have a readily determinable fair value.

As of December 31, 2018 and 2017 , IOBS was considered a variable interest entity. The Company is not the primary beneficiary of IOBS because it only has the right to elect two of five directors. All major decisions of IOBS require the majority vote by the members of the board of directors, including decisions made to manage the business including hiring and firing of officers and other critical management functions. Therefore, the Company does not consolidate IOBS.

During July 2018, the management of IOBS informed their board of directors that a transition plan had been agreed to migrate all current customers of the company to a business partner, as IOBS was unable to profitably serve those customers. The management of IOBS continues to seek ways to monetize the intellectual property held by the company, but future cash flows are uncertain. Therefore, the Company concluded that the investment in IOBS was impaired as of June 30, 2018. Given the level of uncertainty on future cash flows and the limited assets of IOBS available for distribution, the Company concluded the fair value of the investment was zero as of June 30, 2018 and recognized an impairment charge of $1,750 in other expenses, net. No other arrangements exist that could require the Company to provide additional financial support or otherwise expose the Company to a loss.

Note 11 Convertible Notes

In December 2016, the Company entered into the Purchase Agreement with J.P. Morgan Securities LLC and Jefferies LLC, as representatives of the several initial purchasers named therein (collectively, the “Initial Purchasers”), to issue and sell $90,000 in aggregate principal amount of its 5.50% senior convertible notes due 2021 ("Convertible Notes") in a private placement to qualified institutional buyers pursuant to Rule 144A under the Securities Act of 1933, as amended (the “Securities Act”), and to non-U.S. persons pursuant to Regulation S under the Securities Act. In December 2016, the Company entered into a purchase agreement (the “Cambridge Purchase Agreement”) with Cambridge Equities, L.P. (“Cambridge”), an entity affiliated with Dr. Patrick Soon-Shiong, the Company’s Chairman and Chief Executive Officer, to issue and sell $10,000 in aggregate principal amount of the Convertible Notes in a private placement pursuant to an exemption from the registration requirements of the Securities Act afforded by Section 4(a)(2) of the Securities Act. In December 2016, pursuant to the exercise of the overallotment by the Initial Purchasers, the Company issued an additional $7,000 principal amount of the Convertible Notes. The total net proceeds from this offering were approximately $102,714 , $9,917 from Cambridge and $92,797 from the Initial Purchasers, after deducting Initial Purchasers’ discount and debt issuance costs of $4,286 in connection with the Convertible Notes offering.

On December 21, 2016, the Company entered into an indenture, relating to the issuance of the Convertible Notes (the “Indenture”), by and between the Company and U.S. Bank National Association, as trustee (the “Trustee”). The interest rates are fixed at 5.50% per year, payable semi-annually on June 15 and December 15 of each year, beginning on June 15, 2017. The Convertible Notes will mature on December 15, 2021, unless earlier repurchased by the Company or converted pursuant to their terms.

In connection with the offering of the Convertible Notes, on December 15, 2016, the Company entered into a Second Amended and Restated Promissory Note which amends and restates the Amended and Restated Promissory Note, dated May 9, 2016, between the Company and NantCapital, to, among other things, extend the maturity date of the Promissory Note to June 30, 2022 and to subordinate the Promissory Note in right of payment to the Convertible Notes (See Note 19).

The initial conversion rate of the Convertible Notes is 82.3893 shares of common stock per $1 principal amount of Convertible Notes (which is equivalent to an initial conversion price of approximately $12.14 per share). Prior to the close of business on the business day immediately preceding September 15, 2021, the Convertible Notes will be convertible only under the following circumstances:

(1) during any calendar quarter commencing after March 31, 2017 (and only during such calendar quarter), if, for at least 20 trading days (whether or not consecutive) during the 30 consecutive trading day period ending on the last trading day of the immediately preceding calendar quarter, the last reported sale price of the Company’s common stock on such trading day is greater than or equal to 120% of the conversion price on such trading day;

(2) during the five business day period after any five consecutive trading day period in which, for each day of that period, the trading price per $1 principal amount of the Convertible Notes for such trading day was less than 98% of the product of the last reported sale price of the Company’s common stock and the conversion rate on such trading day; or

(3) upon the occurrence of specified corporate transactions as described in the Indenture agreement.

Upon conversion, the Convertible Notes will be settled in cash, shares of the Company’s common stock or any combination thereof at the Company’s option.

Upon the occurrence of a fundamental change (as defined in the Indenture), holders may require the Company to purchase all or a portion of the Convertible Notes in principal amounts of $1 or an integral multiple thereof, for cash at a price equal to 100% of the principal amount of the Convertible Notes to be purchased plus any accrued and unpaid interest to, but excluding, the fundamental change purchase date. The conversion rate will be subject to adjustment upon the occurrence of certain specified events.

On or after the date that is one year after the last date of original issuance of the Convertible Notes, if the last reported sale price of the Company’s common stock for at least 20 trading days (whether or not consecutive) during the period of 30 consecutive trading days ending within the five trading days immediately preceding a conversion date is greater than or equal to 120% of the conversion price on each applicable trading day, the Company will make an interest make-whole payment to a converting holder (other than a conversion in connection with a make-whole fundamental change in which the conversion rate is adjusted) equal to the sum of the present values of the scheduled payments of interest that would have been made on the Convertible Notes to be converted had such Convertible Notes remained outstanding from the conversion date through the earlier of (i) the date that is three years after the conversion date and (ii) the maturity date if the Convertible Notes had not been so converted. The present values of the remaining interest payments will be computed using a discount rate equal to 2.0% . The Company may pay any interest make-whole payment either in cash or in shares of its common stock, at the Company’s election as described in the Indenture.

The Company accounts for convertible debt instruments that may be settled in cash upon conversion (including partial cash settlement) by recording the liability and equity components of the convertible debt separately. The liability component is computed based on the fair value of a similar liability that does not include the conversion option. The liability component includes both the value of the embedded interest make-whole derivative and the carrying value of the Convertible Notes. The equity component is computed based on the total debt proceeds less the fair value of the liability component. The equity component is also recorded as debt discount and amortized as interest expense over the expected term of the Convertible Notes.

The liability component of the Convertible Notes on the date of issuance was computed as $83,079 , consisting of the value of the embedded interest make-whole derivative of $1,499 and the carrying value of the Convertible Notes of $81,580 . Accordingly, the equity component on the date of issuance was $23,921 . If the debt will be considered current at the balance sheet date, the liability component of the convertible notes will be classified as current liabilities and presented in current portion of convertible notes debt and the equity component of the convertible debt will be considered a redeemable security and presented as redeemable equity on the Company's Consolidated Balance Sheet.

Offering costs of $4,286 related to the issuance of the Convertible Notes are allocated to the liability and equity components in proportion to the allocation of the proceeds and accounted for as deferred financing offering costs and equity issuance costs, respectively. Approximately $972 of this amount was allocated to equity and the remaining $3,314 have been capitalized as deferred financing offering costs.

The debt discounts and deferred financing offering costs on the Convertible Notes are being amortized to interest expense over the contractual terms of the Convertible Notes, using the effective interest method at an effective interest rate of 12.82% .

As of December 31, 2018 , the remaining life of the Convertible Notes is approximately 36 months .

The following table summarizes how the issuance of the Convertible Notes is reflected in the Company's Consolidated Balance Sheets as of December 31, 2018 and 2017 :

	Related party	Others	Total
Balance as of December 31, 2018			
Gross proceeds	$ 10,000	$ 97,000	$ 107,000
Unamortized debt discounts and deferred financing offering costs	(1,622)	(17,567)	(19,189)
Net carrying amount	$ 8,378	$ 79,433	$ 87,811
Balance as of December 31, 2017			
Gross proceeds	$ 10,000	$ 97,000	$ 107,000
Unamortized debt discounts and deferred financing offering costs	(2,053)	(22,155)	(24,208)
Net carrying amount	$ 7,947	$ 74,845	$ 82,792

The following table sets forth the Company's interest expense incurred for the years ended December 31, 2018 and 2017 :

	Year Ended December 31,					
	2018			2017		
	Related party	Others	Total	Related party	Others	Total
Coupon interest expense	$ 550	$ 5,335	$ 5,885	$ 550	$ 5,335	$ 5,885
Amortization of debt discounts	420	4,020	4,440	373	3,536	3,909
Amortization of deferred financing offering costs	11	568	579	10	499	509
Total convertible notes interest expense	$ 981	$ 9,923	$ 10,904	$ 933	$ 9,370	$ 10,303

Note 12 Fair Value Measurements

Assets and liabilities measured at fair value on a recurring basis as of December 31, 2018 and 2017 consisted of the following:

	December 31, 2018			
	Total fair value	Quoted price in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets - Cash equivalents	$ 18,306	$ 18,306	$ —	$ —
Assets - Held-to-maturity securities	1,136	—	1,136	—
Liabilities - Bookings Commitment	16,947	—	—	16,947
Liabilities - Interest make-whole derivative	—	—	—	—

	December 31, 2017			
	Total fair value	Quoted price in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets - Cash equivalents	$ 57,683	$ 57,683	$ —	$ —
Assets - Held-to-maturity securities	361	—	361	—
Liabilities - Interest make-whole derivative	7	—	—	7
Liabilities - Bookings Commitment	—	—	—	—

The Company's intangible assets and goodwill are initially measured at fair value and any subsequent adjustment to the initial fair value occurs only if an impairment charge is recognized. The fair values of the Company's cash equivalents (consisting of mainly money market accounts) are based on quoted market prices in active markets with no valuation adjustment.

The Company's investment securities as of December 31, 2018, and 2017 include certificates of deposit. The fair value of these investments approximate carrying values, and the Company has classified these instruments as Level 2 in the fair value hierarchy.

Level 3 Inputs

Convertible Note derivative liability

In December 2016, the Company issued $107,000 in aggregate principal amount of Convertible Notes due December 15, 2021, of which $10,000 issued to a related party (see Note 11). The Convertible Notes include an interest make-whole feature whereby if a noteholder converts any of the Convertible Notes one year after the last date of original issuance of the Convertible Notes, they are entitled, in addition to the other consideration payable or deliverable in connection with such conversion, to an interest make-whole payment equal to the sum of the present values of the scheduled payments, computed using a discount rate equal to 2.0% , of interest that would have been made on the Convertible Notes to be converted had such Convertible Notes remained outstanding from the conversion date through the earlier of (i) the date that is three years after the conversion date and (ii) the maturity date if the Convertible Notes had not been so converted. The Company may pay any interest make-whole payment either in cash or in shares of its common stock, at the Company's election as described in the Indenture. The Company has determined that this feature is an embedded derivative and have recognized the fair value of this derivative as a liability in the Company's Consolidated Balance Sheet, with subsequent changes to fair value recorded through earnings at each reporting period on the Company's Consolidated Statements of Operations as change in fair value of derivative liability.

The fair value of the derivative liability includes the estimated volatility and risk free rate. The higher/lower the estimated volatility, the higher/lower the value of the liability. The higher/lower the risk free interest rate, the higher/lower the value of the liability.

Bookings Commitment

The Company values the Bookings Commitment, assumed upon the disposal of the provider/patient engagement solutions business (see Note 3), using a Monte Simulation model to calculate average payments due under the Bookings Commitment, based on management's estimate of its performance in securing bookings and resulting annual payments, discounted at the cost of debt in a range of 17% to 20% based on a yield curve, to calculate the fair value of the liability. The change in fair value is recorded as an unrealized gain or loss through earnings within other (loss) income, net, in the Company's Consolidated Statements of Operations.

The fair value of the Bookings Commitment is dependent on management's estimate of the probability of success on individual opportunities and the cost of debt applied in discounting the liability. The higher the probability of success on each opportunity, the lower the fair value of the Bookings Commitment liability. The lower the cost of debt applied, the higher the value of the liability.

The fair market value for level 3 securities may be highly sensitive to the use of unobservable inputs and subjective assumptions. Generally, changes in significant unobservable inputs may result in significantly lower or higher fair value measurements.

The following tables set forth a summary of changes in the fair value of Level 3 liabilities for the years ended December 31, 2018 and 2017 :

	December 31, 2017	Additions	Change in fair value	December 31, 2018
Interest make-whole derivative - related party and others	7	—	(7)	—
Bookings Commitment	—	—	16,947	16,947
	$ 7	$ —	$ 16,940	$ 16,947

	December 31, 2016	Additions	Change in fair value	December 31, 2017
Interest make-whole derivative liability:				
Related party	$ 25	$ —	$ (25)	$ —
Others	246	—	(239)	7
	$ 271	$ —	$ (264)	$ 7

As of December 31, 2018 , the estimated fair value and carrying value of the Company's Convertible Notes were:

	Fair value	Carrying value	Face value
5.5% convertible senior notes due December 15, 2021:			
Balance as of December 31, 2018			
Related party	$ 5,879	$ 8,378	$ 10,000
Others	57,031	79,433	97,000
	$ 62,910	$ 87,811	$ 107,000
Balance as of December 31, 2017			
Related party	$ 7,327	$ 7,947	$ 10,000
Others	71,076	74,845	97,000
	$ 78,403	$ 82,792	$ 107,000

The fair value shown above represents the fair value of the debt instrument, inclusive of both the debt and equity components, but excluding the derivative liability. The carrying value represents only the carrying value of the debt component.

The fair value of the convertible notes is determined by unobservable inputs that are supported by minimal non-active market activity and that are significant to determining the fair value of the debt instrument.

Note 13 Commitments and Contingencies

The Company's principal commitments consist of obligations under its outstanding debt obligations, noncancelable leases for its office space and certain equipment and vendor contracts to provide research services, and purchase obligations under license agreements and reseller agreements.

Lease Arrangements

The Company leases both real estate and equipment used in its operations and classifies those leases as either operating or capital leases for accounting purposes. As of December 31, 2018 and 2017 , the Company had no material capital leases and the remaining lives of its operating leases ranged from one to six years , certain operating leases include extension options at then current market rates.

Rental expense associated with operating leases is charged to expense on a straight-line basis and is included in the Consolidated Statements of Operations. For the years ended December 31, 2018 and 2017 , the rental expense from continuing and discontinued operations was charged to selling, general and administrative expense in the amount of $3,930 and $4,513 respectively.

As of December 31, 2018 , the Company's future minimum rental commitments under its noncancelable operating leases are as follows:

	Amounts
2019	$ 3,201
2020	3,292
2021	3,143
2022	3,184
2023	2,775
Thereafter	4,933
Total minimum rental commitments	$ 20,528

Related Party Promissory Note

On January 4, 2016, the Company executed a $112,666 demand promissory note in favor of NantCapital to fund the acquisition of NaviNet, On May 9, 2016 and December 15, 2016, the promissory note with NantCapital was amended to provide that all outstanding principal and accrued interest is due and payable on June 30, 2022, and not on demand and the Company subordinated the Promissory Note in right of payment to the Convertible Notes (see Note 11).

Indenture Obligations Under Convertible Notes

On December 21, 2016, the Company entered into the Indenture relating to the issuance of the $107,000 Convertible Notes, by and between the Company and U.S. Bank National Association the Trustee. The interest rates are fixed at 5.50% per year, payable semi-annually on June 15 and December 15 of each year, beginning on June 15, 2017. The Convertible Notes will mature on December 15, 2021, unless earlier repurchased by the Company or converted pursuant to their terms (see Note 11).

Purchase Obligations Under License Agreements and Reseller Agreements

In September 2016, the Company entered into a Second Amended and Restated Reseller Agreement for genomic and proteomic sequencing services and related bioinformatics and analysis services with NantOmics, with an effective date of June 19, 2015 (see Note 18).

Regulatory Matters

The Company is subject to regulatory oversight by the U.S. Food and Drug Administration and other regulatory authorities with respect to the development, manufacturing, and sale of some of the solutions. In addition, the Company is subject to the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act and related patient confidentiality laws and regulations with respect to patient information. The Company reviews the applicable laws and regulations regarding effects of such laws and regulations on its operations on an on-going basis and modifies operations as appropriate. The Company believes it is in substantial compliance with all applicable laws and regulations. Failure to comply with regulatory requirements could have a significant adverse effect on the Company's business and operations.

Securities Litigation

In March 2017, a number of putative class action securities complaints were filed in U.S. District Court for the Central District of California, naming as defendants the Company and certain of our executive officers and directors. These complaints have been consolidated with the lead case captioned Deora v. NantHealth, Inc., 2:17-cv-01825. In June 2017, the lead plaintiffs filed an amended consolidated complaint, which generally alleges that defendants violated federal securities laws by making material misrepresentations in NantHealth's initial public offering registration statement and in subsequent public statements. In particular, the complaint refers to various third-party articles in alleging that defendants misrepresented NantHealth's business with the University of Utah, donations to the university by non-profit entities associated with our founder Dr. Soon-Shiong, and orders for GPS Cancer. The lead plaintiffs seek unspecified damages and other relief on behalf of putative classes of persons who purchased or acquired NantHealth securities in the IPO or on the open market from June 1, 2016 through May 1, 2017. In March 2018, the court largely denied Defendants' motion to dismiss the consolidated amended complaint. In September 2018, the lead plaintiffs filed a motion for certification of two plaintiff classes. The Company believes that the claims lack merit and intend to vigorously defend the litigation.

In May 2017, a putative class action complaint was filed in California Superior Court, Los Angeles County, asserting claims for violations of the Securities Act based on allegations similar to those in Deora. That case is captioned Bucks County Employees

Retirement Fund v. NantHealth, Inc., BC 662330. The parties have agreed to stay the case until the next case management conference, scheduled for September 17, 2019. The Company believes that the claims lack merit and intends to vigorously defend the litigation.

In April 2018, two putative shareholder derivative actions-captioned Engleman v. Soon-Shiong, Case No. 2018-0282-AGB, and Petersen v. Soon-Shiong, Case No. 2018-0302-AGB-were filed in the Delaware Court of Chancery. The plaintiff in the Engleman action previously filed a similar complaint in California Superior Court, Los Angeles County, which was dismissed based on a provision in the Company's charter requiring derivative actions to be brought in Delaware. The Engleman and Petersen complaints contain allegations similar to those in Deora, but assert causes of action on behalf of NantHealth against various of the Company's current or former executive officers and directors for alleged breaches of fiduciary duty, abuse of control, gross mismanagement, and unjust enrichment. The Company is named solely as a nominal defendant. In July 2018, the court issued an order consolidating the Engleman and Petersen actions as In re NantHealth, Inc. Stockholder Litigation, Lead C.A. No. 2018-0302-AGB, appointing Petersen as lead plaintiff, and designating the Petersen complaint as the operative complaint. On September 20, 2018, the defendants moved to dismiss the complaint. In October 2018, in response to the motion to dismiss, Petersen filed an amended complaint. In November 2018, the defendants moved to dismiss the amended complaint. In January 2019, the defendants filed their opening brief in support of the motion to dismiss the amended complaint. The Company believes that the claims lack merit and intends to vigorously defend the litigation.

In April 2018, a putative shareholder derivative action captioned Shen v. Soon-Shiong was filed in U.S. District Court for the District of Delaware. The complaint contains allegations similar to those in Deora, but asserts causes of action on behalf of NantHealth against various of the Company's current or former executive offers and directors for alleged breaches of fiduciary duty and unjust enrichment, as well as alleged violations of the federal securities laws based on alleged misstatements or omissions in the Company's 2017 proxy statement. The parties have agreed to stay the case pending a decision on defendants' motion to dismiss in the derivative action in the Delaware Court of Chancery.

The monetary and other impact of these actions may remain unknown for substantial periods of time. The cost to defend, settle or otherwise resolve these matters may be significant and divert management's attention. The Company cannot provide assurance that it will prevail in these lawsuits. If the Company is ultimately unsuccessful in these matters, the Company could be required to pay substantial amounts which might materially adversely affect its business, operating results and financial condition.

Real Estate Litigation

On March 9, 2018, PayPal, Inc. ("PayPal") commenced an action against the Company in the Superior Court Department of the Trial Court of the Commonwealth of Massachusetts, for Suffolk County. The action was originally captioned PayPal, Inc. v. NantHealth, Inc., Civil Action No. 18-0780-E. On April 10, 2018, the Superior Court transferred the case to its Business Litigation Section, where it is currently pending and captioned as PayPal, Inc. v. NantHealth, Inc., Civil Action No. 18-0780-BLS1. This action arises out of a Sublease Agreement that PayPal and the Company entered into on or about November 30, 2017. The Sublease Agreement pertained to commercial real estate that PayPal leased at One International Place in Boston, Massachusetts. On January 25, 2018, the Company notified PayPal that we were electing to terminate the Sublease Agreement.

In its Verified Complaint, and a contemporaneous notice of default that the Company disputed, PayPal alleges that the Company breached the Sublease Agreement. In addition, PayPal asserts claims for breach of the covenant of good faith and fair dealing, and violations of Massachusetts General Laws, Chapter 93A, sections 2 and 11, and seeks a declaratory judgment recognizing and enforcing the terms of the Sublease Agreement. Among other relief, PayPal seeks damages, treble damages, interest, costs, and attorneys' fees.

On April 12, 2018, the Company filed its answer and jury demand in the action. On August 2, 2018, PayPal requested a status conference with the court in order to discuss PayPal's potential filing of a motion for partial judgment on the pleadings pursuant to Mass. R. Civ. P. 12(c). A Rule 16 Litigation Control Conference ("Rule 16 Conference") was held on August 22, 2018. During the Rule 16 Conference, the court denied PayPal's request for leave to file a motion for partial judgment on the pleadings. Following the Rule 16 Conference, the court issued a tracking order setting deadlines and other procedures that would apply to this action.

On September 26, 2018, the Company filed its Assented to Motion for Leave to Amend Its Answer. The court granted the Company's motion on October 3, 2018. On October 9, 2018, the Company filed and served its amended answer and jury demand.

On January 8, 2019, the parties filed a joint motion to extend certain of the tracking order deadlines, which motion the court granted by endorsed order dated January 9, 2019.

The parties are currently engaged in discovery, including non-party discovery.

The Company denies any liability to PayPal and intend to vigorously defend the action.

Note 14 Income Taxes

The components of the provision for income taxes are presented in the following table:

	Year Ended December 31,	
	2018	2017
Current:		
Federal	$ 2	$ (498)
State	42	17
Foreign	52	100
Total current provision	96	(381)
Deferred:		
Federal	(3,418)	(3,001)
State	(418)	1,179
Foreign	67	—
Total deferred benefit	(3,769)	(1,822)
Provision for (benefit from) income taxes, net	$ (3,673)	$ (2,203)

The provision for income taxes differs from the amount of income tax determined by applying the applicable U.S. statutory federal income tax rate to pretax loss as a result of the following differences:

	Year Ended December 31,	
	2018	2017
United States federal tax at statutory rate	21.00 %	34.00 %
Items affecting federal income tax rate:		
State tax rate, net of federal benefit	3.85 %	3.53 %
Valuation allowance	(22.00)%	1.41 %
Stock compensation	(0.62)%	(1.95)%
"Tax Act" 2017 impact	— %	(34.83)%
Other adjustments	(0.33)%	(0.51)%
Effective income tax rate	1.90 %	1.65 %

On December 22, 2017, the Tax Cuts and Jobs Act of 2017 (the "Act") was signed into law making significant changes to the Internal Revenue Code. Changes include, but are not limited to, a corporate tax rate decrease from 35% to 21% effective for tax years beginning after December 31, 2017, the transition of U.S. international taxation from a worldwide tax system to a territorial system, and a one-time transition tax on the mandatory deemed repatriation of cumulative foreign earnings as of December 31, 2017.

In December 2017, the SEC issued Staff Accounting Bulletin No. 118 (“SAB 118”), which provides guidance on accounting for the income tax effects of the TCJA. SAB 118 provides a measurement period that should not extend beyond one year from the TCJA enactment date for companies to complete the accounting relating to the TCJA under Accounting Standards Codification Topic 740, “Income Taxes” (“ASC 740”). In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the TCJA for which the accounting under ASC 740 is complete. To the extent that a company’s accounting for TCJA-related income tax effects is incomplete, but the company is able to determine a reasonable estimate, it must record a provisional estimate in its financial statements. If a company cannot determine a provisional estimate to be included in its financial statements, it should continue to apply ASC 740 on the basis of the provisions of the tax laws that were in effect immediately before the enactment of the TCJA. The Company has completed its evaluation of the potential impacts of the Act of 2017 on its December 31, 2018 financial statements under the one year measurement period provided under SAB 118. No adjustment has been recorded as there were no material changes between the provisional estimate and the final accounting for the Act.

The Act subjects a US shareholder to current tax on global intangible low-taxed income (GILTI) earned by certain foreign subsidiaries. The FASB Staff Q&A, Topic 740 No. 5 *Accounting for Global Intangible Low-Taxed Income,* states that an entity can make an accounting policy election to either recognize deferred taxes for temporary differences expected to

reverse as GILTI in future years or provide for the tax expense related to GILTI in the year the tax is incurred. We have elected to recognize the tax on GILTI as a period expense in the period the tax is incurred.

As of December 31, 2018 and December 31, 2017, the Company had an immaterial amount of unremitted earnings related to certain foreign subsidiaries. The Company intends to continue to reinvest its foreign earnings indefinitely and do not expect to incur any significant taxes related to such amounts.

Significant components of the Company's deferred tax assets and liabilities as of December 31, 2018 and 2017 are as follows:

	December 31,	
	2018	2017
Deferred income tax assets:		
Accounts payable and accrued expenses	$ 8,090	$ 1,520
Inventory impairment	495	466
Deferred revenue	5,438	3,458
Allowance for doubtful accounts	546	178
Property, plant and equipment, net	691	1,098
Intangibles	3,409	4,865
Investments	48,836	22,404
Stock compensation	2,159	3,487
Other	1,321	32
Net operating loss carryforwards	104,404	93,689
Less: Valuation allowance	(140,788)	(97,324)
Total deferred income tax assets	34,601	33,873
Deferred income tax liabilities:		
State taxes	(5,339)	(3,397)
Intangible assets, net	(25,630)	(28,768)
Convertible notes	(4,241)	(5,437)
Deferred implementation cost	(1,633)	(1,960)
Other	(195)	(149)
Total deferred income tax liabilities	(37,038)	(39,711)
Deferred income taxes, net	$ (2,437)	$ (5,838)

The realization of deferred income tax assets may be dependent on the Company's ability to generate sufficient income in future years in the associated jurisdiction to which the deferred tax assets relate. The Company considers all available positive and negative evidence, including scheduled reversals of deferred income tax liabilities, projected future taxable income, tax planning strategies, and recent financial performance. Based on the review of all positive and negative evidence, including a three year cumulative pre-tax loss, the Company concluded that except for the deferred tax liability recorded on amortization of certain goodwill due to its indefinite life and deferred tax liability in excess of deferred tax asset for certain separate state and city jurisdictions, it should record a full valuation allowance against all other net deferred income tax assets at December 31, 2018 and 2017 as none of these deferred income tax assets were more likely than not to be realized as of the balance sheet dates. However, the amount of the deferred income tax assets considered realizable may be adjusted if estimates of future taxable income during the carryforward period are increased or if objective negative evidence in the form of cumulative losses is no longer present. In addition, at December 31, 2018 , the position of the valuation allowance for deferred tax assets for which subsequently recognized tax benefits will be credited directly to contributed capital is $350 .

A summary of activity in the valuation reserve deducted from deferred tax assets for the years ended December 31, 2018 2017 is as follows:

	Balance at beginning of the period	Additions (Adjustments)	Deductions	Balance at the end of the period
Year to Date December 31, 2018	$ 97,323	43,464	—	$ 140,787
Year to Date December 31, 2017	$ 88,291	9,032	—	$ 97,323

The Company records a tax benefit from uncertain tax positions only if it is more likely than not the tax position will be sustained with the taxing authority having full knowledge of all relevant information. The Company records a liability for unrecognized tax benefits from uncertain tax positions as discrete tax adjustments in the first period that the more-likely-than-not threshold is not met. As of December 31, 2018 and 2017 , the Company had no unrecognized tax benefits. Unrecognized tax benefits are recorded consistent with ASU No. 2013-11, *Income Taxes (Topic 740): Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists (a consensus of the FASB Emerging Issues Task Force)* , in two parts. In 2017, the Company filed the accounting method change on the account receivable, account payable and other liabilities; therefore, the Company more likely than not did not have any uncertain tax positions in at December 31, 2017. Therefore, the Company reversed the ASC 740 reserve on these items as well as any net operating loss associated with them.

	December 31,	
	2018	2017
Balance as of January 1	$ —	$ 977
Increases/(decreases) related to tax positions taken during the current year	—	(977)
Balance as of December 31	$ —	$ —

The Company's policy is to recognize interest and penalties related to uncertain tax positions in income tax expense. As of December 31, 2018 and 2017 , there are no material interest and penalties associated with unrecognized tax benefits recorded in the Company's Consolidated Statements of Operations or Consolidated Balance Sheets. Any changes to unrecognized tax benefits recorded as of December 31, 2018 that are reasonably possible to occur within the next 12 months are not expected to be material.

The Company is no longer subject to income tax examination by the U.S. federal, state or local tax authorities for years ended December 31, 2012 or prior; however, its tax attributes, such as net operating loss ("NOL") carryforwards and tax credits, are still subject to examination in the year they are used. The Company is currently under an IRS audit for the tax year ended December 31, 2016.

As of December 31, 2018 , the Company had federal, state and foreign NOL carryforwards of $395,368 , $288,901 and $0 , respectively, expiring at various dates through 2038. Utilization of the NOL carryforwards is subject to annual limitations due to ownership change limitations that occurred or could occur in the future as provided by Section 382 of the Internal Revenue Code of 1986, as amended, as well as similar state and foreign provisions. These ownership changes may limit the amount of the NOL carryforwards that can be utilized annually to offset future taxable income. The total NOL amounts above do not include the NOLs expected to expire.

Note 15 Stockholders' Equity

Amended Certificate of Incorporation

In accordance with the Company's amended and restated certificate of incorporation, which was filed immediately following the closing of its IPO, the Company is authorized to issue 750,000,000 shares of common stock, with a par value of $0.0001 per share, and 20,000,000 shares of undesignated preferred stock, with a par value of $0.0001 per share. Holders of the Company's common stock are entitled to one vote for each share held on all matters submitted to a vote of its stockholders. Holders of the Company's common stock have no cumulative voting rights. Further, as of December 31, 2018 and 2017 , holders of the Company's common stock have no preemptive, conversion, redemption or subscription rights and there are no sinking fund provisions applicable to the Company's common stock. Upon liquidation, dissolution or winding-up of the Company, holders of the Company's common stock are entitled to share ratably in all assets remaining after payment of all liabilities and the liquidation preferences of any outstanding shares of preferred stock. Subject to preferences that may be applicable to any outstanding shares of preferred stock, holders of the Company's common stock are entitled to receive dividends, if any, as may be declared from time to time by the Company's board of directors. As of December 31, 2018 and 2017 , there were no outstanding shares of preferred stock.

Other Equity Contributions

In December 2016, the Company entered into an agreement to provide genomic and proteomic sequencing and related bioinformatics services to an institution related to cancer research. The agreement provides that the institution pay the Company a fixed per-test fee in exchange for the services to be provided by the Company. A private charitable 501(c)(3) non-profit organization controlled by the Company's Chairman and CEO also made a charitable gift to the institution in December 2016. The gift does not contractually or otherwise require the institution to use the Company's molecular profiling solutions or any of the Company's other products or services. No amounts related to this arrangement have been recognized in the Company's Consolidated Balance Sheets or Consolidated Statements of Operations as of or for the years ended December 31, 2018 and 2017.

Note 16 Stock-Based Compensation

The following table reflects the components of stock-based compensation expense recognized in the Company's Consolidated Statements of Operations:

	Year Ended December 31,	
	2018	**2017**
Series C / Restricted Stock:		
Research and development	$ 86	$ 111
Phantom units:		
Cost of revenue	367	186
Selling, general and administrative	4	(341)
Research and development	347	144
Discontinued operations	—	(3,591)
Total phantom units stock-based compensation expense	718	(3,602)
Stock options:		
Selling, general and administrative	—	(49)
Restricted Stock Units:		
Cost of revenue	27	26
Selling, general and administrative	4,664	5,223
Research and development	162	2,802
Total restricted stock units stock-based compensation expense	4,853	8,051
Total stock-based compensation expense	5,657	4,511
Amount capitalized to internal-use software and deferred implementation costs	530	784
Total stock-based compensation cost	$ 6,187	$ 5,295

Retired Profits Interests Plan

On December 3, 2013, the Company adopted the Profits Interests Plan under which it had reserved an aggregate of 63,750,000 Series C units for issuance to associates, consultants and contractors of the Company in consideration for bona fide services provided to the Company.

The Series C units were considered profits interests of the Company and did not entitle their holders (the "Series C Members") to receive distributions if the Company were liquidated immediately after the grant. Instead, the Series C Members were entitled to receive an allocation of a portion of the profit and loss of the Company arising after the date of the grant and, subject to vesting conditions, distributions made out of a portion of the profits of the Company arising after the grant date of the Series C units. Grants of the Series C units were either fully vested, partially vested, or entirely unvested at the time of the grant as determined by the Board.

Series C Members were not entitled to receive any distributions until the aggregate distributions made by the Company exceeded a hurdle amount applicable to those Series C units. The hurdle amount for each grant was determined by the Board at the date of issuance of such units. After all other members received their applicable hurdle amount, the Series C Members were entitled to receive their percentage interest of such excess distributions.

As of December 31, 2015 and through the date of the LLC Conversion, the Company had 3,470,254 Series C units outstanding.

Upon the LLC Conversion on June 1, 2016, the Company issued 28,973 shares of common stock to holders of vested Series C units and 10,462 shares of restricted stock to holders of unvested Series C units. The shares of restricted stock issued to holders of unvested profits interests are subject to forfeiture until becoming fully vested in accordance with the terms of the original Series C unit grant agreements (see Restricted Stock below).

Phantom Unit Plan

On March 31, 2015, the Company approved the Nant Health, LLC Phantom Unit Plan (the "Phantom Unit Plan"). The maximum number of phantom units that may be issued under the Phantom Unit Plan is equal to 11,590,909 minus the number of issued and outstanding Series C units of the Company. As of December 31, 2018 , there were 588,852 phantom units outstanding under the Phantom Unit Plan, after giving effect to the 1 -for- 5.5 reverse stock split. Each grant of phantom units made to a participant under the Phantom Unit Plan vests over a defined service period, and the majority of grants are subject to completion of a liquidity event. The Company's IPO satisfied the liquidity event condition and the phantom units subject to completion of a liquidity event now entitle their holders to cash or noncash payments in an amount equal to the number of vested units held by that participant multiplied by the fair market value of one share of the Company's common stock at the Company's option on the date each phantom unit vests. After the Company's IPO, the Company will no longer issue any units under the Phantom Unit Plan.

The Company intends to settle all vested phantom unit payments held by United States-based participants in shares of the Company's common stock and classifies these awards as equity awards in its Consolidated Balance Sheets. Awards held by participants who are based outside of the United States are estimated to be settled in cash and are classified within accrued and other current liabilities on the Consolidated Balance Sheet as of December 31, 2018 .

The following table summarizes the activity related to the unvested phantom units during the years ended December 31, 2018 and 2017 :

	Number of Units	Weighted Average Grant Date Value per Phantom Unit
Unvested phantom units outstanding - December 31, 2016	4,322,081	$ 14.95
Granted	113,656	$ 4.75
Vested	(1,440,822)	$ 14.14
Forfeited	(1,702,130)	$ 15.31
Unvested phantom units outstanding - December 31, 2017	1,292,785	$ 15.01
Vested	(518,373)	$ 15.20
Forfeited	(185,560)	$ 14.63
Unvested phantom units outstanding - December 31, 2018	588,852	$ 14.95

The Company has previously granted phantom units to employees of related companies who are providing services to the Company under the shared services agreement with NantWorks (see Note 18) as well as certain consultants of the Company. No phantom units were granted during the years ended December 31, 2018 or 2017. Stock-based compensation expense for the phantom units issued to these participants is re-measured at the end of each reporting period until the awards vest. All other grants of phantom units have been made to employees of the Company. The Company uses the accelerated attribution method to recognize expense for phantom units with vesting that was subject to the completion of a liquidity event and the straight-line method for other phantom unit awards. The grant date fair value of the phantom units granted prior to LLC Conversion was estimated using both an option pricing method and a probability weighted expected return method.

As of December 31, 2018 , the Company had $687 of unrecognized stock-based compensation expense related to phantom units which will be recognized over a weighted-average period of 1.1 years . Of that amount, $680 of unrecognized expense is related to employee grants with a weighted-average period of 1.1 years and $7 of unrecognized expense is related to non-employee grants with a weighted-average period of 1.1 years .

During the years ended December 31, 2018 and 2017 , the Company issued 325,312 and 888,569 shares, respectively, of common stock to participants of the Phantom Unit Plan based in the United States, after withholding approximately 177,343 and 492,974 shares, respectively, to satisfy tax withholding obligations. The Company made a cash payment of $569 and $3,059 to cover employee withholding taxes upon the settlement of these vested phantom units during the years ended December 31, 2018 and 2017 , respectively. During the years ended December 31, 2018 and 2017 , the Company also paid $55 and $300 to cash-settle 15,717 and 59,279 vested phantom units, respectively, held by participants of the Phantom Unit Plan based outside of the United States and to pay cash in lieu of fractional shares for vested units held by participants based in the United States.

2016 Equity Incentive Plan

In May and June of 2016, the Company's Board of Directors adopted and the Company's stockholders approved the 2016 Equity Incentive Plan (the "2016 Plan") in connection with the Company's IPO. The 2016 Plan provides for the grant of incentive stock options, non-statutory stock options, restricted stock, restricted stock units, stock appreciation rights, performance units and performance shares to employees, directors and consultants. A total of 6,000,000 shares of common stock were reserved for issuance pursuant to the 2016 Plan.

In April 2018, the Company's Board of Directors adopted and, in June 2018, the Company's stockholders approved an amendment to the 2016 Plan, to reserve a further 6,800,000 shares of common stock for issuance pursuant to the 2016 Plan. Following the approval of the amendment, a total of 12,800,000 shares of common stock were reserved for issuance pursuant to the 2016 Plan.

Restricted Stock

The Company issued 10,462 shares of restricted stock under the 2016 Plan during the year ended December 31, 2016 in connection with the conversion of the Series C units, of which 3,490 and 3,486 were vested and converted into unrestricted common stock during 2018 and 2017 , respectively, and as of December 31, 2018 , there were no shares of restricted stock remaining to be vested and converted.

Stock compensation expense for the Series C units/restricted stock issued to the nonemployees is calculated based on the fair value of the award on each balance sheet date and the attribution of that cost is being recognized ratably over the vesting period.

Stock Options

During the year ended December 31, 2016, the Company issued 500,000 stock options under the 2016 Plan to Mark Burnett, who was a non-employee member of the Company's Board of Directors, with an exercise price of $14.00 . The award is being accounted for pursuant to ASC 505-50. Stock compensation expense issued to the non-employee is calculated based on the fair value of the award on each balance sheet date and the attribution of that cost is being recognized ratably over the vesting period. The Company has utilized the Black-Scholes option-pricing model to determine the fair value of the stock options.

Mark Burnett did not seek nomination for re-election at the Annual Meeting of Stockholders on June 8, 2018. As a result, 125,000 unvested options were terminated, and as of December 31, 2018, all previously vested options had expired unexercised.

Restricted Stock Units

The Company intends to settle all vested restricted stock unit payments held by United States-based participants, except for certain awards to the Chief Operating Officer, in shares of the Company's common stock and classifies these awards as equity awards in its Consolidated Balance Sheets. Awards held by participants who are based outside of the United States, and those awards agreed with participants to be settled in cash, will be settled in cash and are classified within accrued and other current liabilities on the Consolidated Balance Sheets as of December 31, 2018 and 2017.

The following table summarizes the activity related to the unvested restricted stock units during the years ended December 31, 2018 and 2017 :

	Number of Units	Weighted-Average Grant-Date Fair Value
Unvested restricted stock units outstanding - December 31, 2016	—	$ —
Granted	5,147,190	$ 3.43
Vested	(1,975,448)	$ 3.43
Forfeited	(65,718)	$ 3.39
Unvested restricted stock units outstanding - December 31, 2017	3,106,024	$ 3.43
Granted	853,736	$ 1.46
Vested	(1,583,399)	$ 3.18
Forfeited	(563,400)	$ 3.39
Unvested restricted stock units outstanding - December 31, 2018	1,812,961	$ 2.74

Unrecognized compensation expense related to unvested restricted stock units was $3,562 at December 31, 2018 , which is expected to be recognized as expense over the weighted-average period of 1.5 years .

During the year ended December 31, 2018, the Company issued 782,364 shares of common stock to participants of the 2016 Plan based in the United States, after withholding approximately 472,965 shares to satisfy tax withholding obligations. During the year ended December 31, 2018, the Company made cash payments of $1,495 to cover employee withholding taxes upon the settlement of these vested restricted stock units. During the year ended December 31, 2018, the Company also paid $300 to cash-settle 100,025 vested restricted stock units by agreement with the Chief Operating Officer in relation to certain grants made to him and to pay cash in lieu of fractional shares for vested units held by participants based in the United States.

Note 17 Net Income (Loss) Per Share

The following table sets forth reconciliations of the numerators and denominators used to compute basic and diluted net income (loss) per share of common stock and redeemable common stock for the years ended December 31, 2018 and 2017 :

	Year ended December 31,	
	2018	2017
	Common Stock	Common Stock
Income (loss) per share numerator:		
Net loss from continuing operations	$ (190,433)	$ (131,399)
Net loss from discontinued operations	(1,719)	(43,812)
Net loss for basic and diluted net loss per share	$ (192,152)	$ (175,211)
Income (loss) per share denominator:		
Weighted-average shares for basic net income (loss) per share	109,168,798	116,737,860
Effect of dilutive securities	—	—
Weighted-average shares for dilutive net income (loss) per share	109,168,798	116,737,860
Basic and diluted net loss per share from continuing operations	$ (1.74)	$ (1.12)
Basic and diluted net loss per share from discontinued operations	$ (0.02)	$ (0.37)
Basic and diluted net loss per share	$ (1.76)	$ (1.49)

The following number of potential common shares at the end of each period were excluded from the calculation of diluted net loss per share attributable to common stockholders because their effect would have been anti-dilutive for the periods presented:

	Year Ended December 31,	
	2018	2017
Unvested restricted stock	—	3,490
Unvested phantom units	588,852	1,292,785
Unexercised stock options	—	500,000
Unvested restricted stock units	1,812,961	3,106,024
Convertible notes	8,815,655	8,815,655

Note 18 Related Party Transactions

NantWorks Shared Services Agreement

In October 2012, the Company entered into a shared services agreement with NantWorks that provides for ongoing services from NantWorks in areas such as public relations, information technology and cloud services, human resources and administration management, finance and risk management, environmental health and safety, sales and marketing services, facilities, procurement and travel, and corporate development and strategy (the "Shared Services Agreement"). The Company was billed quarterly for such services at cost, without mark-up or profit for NantWorks, but including reasonable allocations of employee benefits, facilities and other direct or fairly allocated indirect costs that relate to the associates providing the services. The Company incurred $2,214 and $5,174 of expenses during the years ended December 31, 2018 and 2017 , respectively, related to selling, general and administrative services provided to the Company by NantWorks and affiliates, net of services provided to NantWorks and affiliates. Additionally, the Company incurred $356 and $239 of expenses during the years ended December 31, 2018 and 2017 , respectively, related to research and development services provided by NantWorks and its subsidiaries.

Related Party Receivables and Payables

As of December 31, 2018 and 2017 , the Company had related party receivables, net of payables of $2,618 and $2,312 , respectively. The related party receivables, net as of December 31, 2018 and 2017 primarily consisted of a receivable from Ziosoft KK of $1,915 and $2,082 , respectively, which was related to the sale of Qi Imaging. As of December 31, 2018 and 2017 , the Company had related party payables, net of receivables balances including related party liabilities of $22,499 and $16,004 , respectively, which primarily relate to amounts owed to NantWorks pursuant to the Shared Services Agreement, amounts owed to NantOmics under the Second Amended Reseller Agreement (defined below) and interest payable. The balance of the related party receivables and payables represent amounts paid by affiliates on behalf of the Company or vice versa.

Amended Reseller Agreement

On June 19, 2015, the Company entered into a five and a half year exclusive Reseller Agreement with NantOmics for sequencing and bioinformatics services (the "Original Reseller Agreement"). NantOmics is a majority owned subsidiary of NantWorks and is controlled by the Company's Chairman and CEO. On May 9, 2016, the Company and NantOmics executed an Amended and Restated Reseller Agreement (the “Amended Reseller Agreement”), pursuant to which the Company received the worldwide, exclusive right to resell NantOmics’ quantitative proteomic analysis services, as well as related consulting and other professional services, to institutional customers (including insurers and self-insured healthcare providers) throughout the world. The Company retained its existing rights to resell NantOmics’ genomic sequencing and bioinformatics services. Under the Amended Reseller Agreement, the Company is responsible for various aspects of delivering its sequencing and molecular analysis solutions, including patient engagement and communications with providers such as providing interpretations of the reports delivered to the physicians and resolving any disputes, ensuring customer satisfaction, and managing billing and collections. On September 20, 2016, the Company and NantOmics further amended the Reseller Agreement (the "Second Amended Reseller Agreement"). The Second Amended Reseller Agreement permits the Company to use vendors other than NantOmics to provide any or all of the services that are currently being provided by NantOmics and clarifies that the Company is responsible for order fulfillment and branding.

The Second Amended Reseller Agreement grants to the Company the right to renew the agreement (with exclusivity) for up to three renewal terms, each lasting three years , if the Company achieves projected volume thresholds, as follows: (i) the first renewal option can be exercised if the Company completes at least 300,000 tests between June 19, 2015 and June 30, 2020; (ii) the second renewal option can be exercised if the Company completes at least 570,000 tests between July 1, 2020 and June 30, 2023; and (iii) the third renewal option can be exercised if the Company completes at least 760,000 tests between July 1, 2023 and June 30, 2026. If the Company does not meet the applicable volume threshold during the initial term or the first or second exclusive renewal terms, the Company can renew for a single additional three year term, but only on a non-exclusive basis.

The Company agreed to pay NantOmics noncancelable annual minimum fees of $2,000 per year for each of the calendar years from 2016 through 2020 and, subject to the Company exercising at least one of its renewal options described above, the Company is required to pay annual minimum fees to NantOmics of at least $25,000 per year for each of the calendar years from 2021 through 2023 and $50,000 per year for each of the calendar years from 2024 through 2029.

On December 18, 2017, the Company and NantOmics executed Amendment No. 1 to the Second Amended Reseller Agreement. The Second Amended Reseller Agreement is amended to allow fee adjustments with respect to services completed by NantOmics between the amendment effective date of October 1, 2017 to June 30, 2018.

As of December 31, 2018 and 2017 , the Company had $394 and $419 , respectively, of outstanding related party payables under the Second Amended Reseller Agreement. During the years ended December 31, 2018 and 2017 , direct costs of $5,238 and $4,891 , respectively, were recorded as cost of revenue related to the Second Amended Reseller Agreement.

Cambridge Purchase Agreement

On December 15, 2016, the Company entered into a purchase agreement (the “Cambridge Purchase Agreement”) with Cambridge Equities, L.P., an entity affiliated with the Company's Chairman and CEO Dr. Patrick Soon-Shiong (“Cambridge”), to issue and sell $10,000 in aggregate principal amount of the Convertible Notes in a private placement pursuant to an exemption from the registration requirements of the Securities Act afforded by Section 4(a)(2) of the Securities Act. The Cambridge Purchase Agreement includes customary representations, warranties and covenants by the Company and customary closing conditions (See Note 12). The accrued and unpaid interest on the Convertible Notes was $24 at both December 31, 2018 and 2017 , as part of current related party liabilities on the Consolidated Balance Sheets.

Assignment of NantHealth Labs, Inc. (formerly Liquid Genomics, Inc.)

On July 5, 2018 Liquid Genomics, Inc. filed a certificate of amendment to its certificate of incorporation with the secretary of state for Delaware to change its name to NantHealth Labs, Inc. ("NantHealth Labs").

On February 28, 2018, the Company acquired 100% of the equity of NantHealth Labs, a company that provides liquid biopsy analysis of gene expressions and mutations using cell-free RNA and DNA, pursuant to an assignment agreement dated February 1, 2018 between the Company and NantOmics, a related party. The purchase price for the acquisition consisted of 9,088,362 Series A-2 units of NantOmics previously owned by the Company that were transferred at the closing plus 564,779 of Series A-2 units of NantOmics owned by the Company that were transferred to NantOmics during May 2018.

The Company and NantOmics are controlled by the Company's Chairman and CEO, therefore no gain or loss was recognized on the transaction. The difference in the purchase price and the historical cost of the assets and liabilities acquired was recorded as a distribution from equity at the assignment date. The transaction did not cause a material change in the reporting entity, and the Company has not retrospectively adjusted its previously issued financial statements. The consolidation of NantHealth Labs at February 28, 2018 added $808 to the Company's sequencing and molecular analysis revenue for the year ended December 31, 2018. This revenue was substantially all earned from agreements with affiliates, described below. As a result of consolidating NantHealth Labs at February 28, 2018, the net loss of the Company increased by $2,223 during the year ended December 31, 2018.

The intangible assets acquired are amortized over the estimated useful life of 13 years.

	Amounts
NantOmics Series A-2 shares transferred, or to be transferred, to NantOmics	$ 8,956
Assets and liabilities of NantHealth Labs at assignment:	
Goodwill	1,305
Intangible asset	4,429
Other assets	251
Liabilities assumed	(814)
Net assets acquired at assignment	5,171
Recorded as distribution from additional paid-in capital	$ 3,785

Liquid Tumor Profiling Services Agreements

In March 2018, NantHealth Labs, a wholly-owned subsidiary of the Company, and NantKwest, Inc. ("NantKwest"), an affiliate, entered into agreements whereby NantHealth Labs is providing liquid tumor profiling services to NantKwest for clinical trials, on an annual, stand-ready, basis from the date of the first test of each participant, with revenues recognized ratably over time for the period of the stand-ready obligation.

In June 2018, NantHealth Labs entered into similar agreements to provide liquid tumor profiling services to Altor BioScience ("Altor"), NantCell, Inc. ("NantCell"), and NantBioScience, Inc. ("NantBio"), all affiliates of the Company.

Under these agreements, the Company recorded $590 of revenue during the year ended December 31, 2018. As of December 31, 2018, the Company has $540 of accounts receivable from related parties and $375 of deferred revenue due to these agreements.

Related Party Promissory Notes

On January 4, 2016, the Company executed a $112,666 demand promissory note in favor of NantCapital to fund the acquisition of NaviNet. The note bears interest at a per annum rate of 5.0% , compounded annually and computed on the basis of the actual number of days elapsed and a year of 365 or 366 days, as the case may be. The unpaid principal and any accrued and unpaid interest on the note was originally due and payable on demand in either (i) cash, (ii) shares of the Company's common stock based on per share price of $18.6126 , (iii) Series A-2 units of NantOmics based on a per unit price of $1.484 to the extent such equity is owned by the Company or (iv) any combination of the foregoing, all at the option of NantCapital. Subject to the preceding sentence, the Company may prepay the outstanding amount at any time, either in whole or in part, without premium or penalty and without the prior consent of NantCapital. On May 9, 2016, the promissory note with NantCapital was amended to provide that all outstanding principal and accrued interest is due and payable on June 30, 2021, and not on demand. On December 15, 2016, in connection with the offering of the Convertible Notes, the Company entered into a Second Amended and Restated Promissory Note which amends and restates the Amended and Restated Promissory Note, dated May 9, 2016, between the Company and NantCapital, to, among other things, extend the maturity date of the Promissory Note to June 30, 2022 and to subordinate the Promissory Note in right of payment to the Convertible Notes (See Note 11). No other terms of the promissory note were changed. As of December 31, 2018 and 2017 , the total principal and interest outstanding on the note amounted to $130,374 and $124,166 , respectively. The accrued and unpaid interest on the note was $17,708 and $11,500 at December 31, 2018 and 2017 , respectively, as part of noncurrent related party liabilities on the Consolidated Balance Sheet. The Company can request additional advances subject to NantCapital approval. The NantCapital Note bears interest at a per annum rate of 5.0% compounded annually and computed on the basis of the actual number of days in the year. NantCapital has the option, but not the obligation, to require us to repay any such amount in cash, Series A-2 units of NantOmics (based on a per unit price of $1.484) held by us, shares of the Company's common stock based on a per share price of $18.6126 (if such equity exists at the time of repayment), or any combination of the foregoing at the sole discretion of NantCapital.

On January 22, 2016, the Company executed a demand promissory note in favor of NantOmics. The principal amount of the initial advance totaled $20,000 . On March 8, 2016, NantOmics made a second advance to the Company for $20,000 . The note bears interest at a per annum rate is 5.0% and is compounded annually. In May and June of 2016, the Company executed amendments to the demand promissory note with NantOmics, which provide that all unpaid principal of each advance owed to NantOmics and any accrued and unpaid interest would convert automatically into shares of the Company’s common stock after pricing of the Company’s IPO and immediately after conversion of the Company from a limited liability company to a corporation. On June 1, 2016, approximately $40,590 of principal and accrued interest under the promissory note with NantOmics was converted into 2,899,297 shares of the Company’s common stock in connection with the IPO. The Company can request additional advances subject to NantOmics approval, and as of December 31, 2018 and 2017 , there was no outstanding balance on the promissory note.

On August 8, 2018, the Company executed a promissory note in favor of NantCapital, with a maturity date of June 15, 2022. The note bears interest at a per annum rate of 9.75% and is compounded annually, with interest payments on outstanding amounts due on June 15 and December 15 of each calendar year. No advances have currently been made under the note. The note allows the Company to request advances, up to a maximum commitment of $100,000 . Advances can be requested of up to $10,000 per calendar quarter until March 31, 2019 and, following that, up to $20,000 per calendar quarter until December 31, 2020, after which no further advances can be requested. The promissory note is subordinated to the Convertible Notes (see Note 11). The promissory note includes customary negative covenants and a Performance to Plan - Adjusted EBITDA covenant that stipulates, in order for the Company to draw on the promissory note, the profit measure, as defined in the agreement, may not negatively deviate from board approved financial plans by more than 25% . At December 31, 2018 , the Company was in compliance with the covenants.

Note 19 Employee Retirement Plan

The Company has a qualified defined contribution plan (the “NantHealth 401(k) Plan”) under Section 401(k) of the Internal Revenue Code covering eligible associates, including associates at certain of its subsidiaries. Associate contributions to the NantHealth 401(k) Plan are voluntary. The Company contributes a 100% match up to 3.0% of the participant’s eligible annual compensation, which contribution fully vests after three years of service. Participants’ contributions are limited to their annual tax deferred contribution limit as allowed by the Internal Revenue Service. For the years ended December 31, 2018 and 2017 , the Company’s total matching contributions to the NantHealth 401(k) Plan were $1,328 and $2,050 , respectively.

Note 20 Selected Quarterly Financial Information (Unaudited)

The following tables show a summary of the Company’s quarterly financial information for each of the four quarters of the years ended December 31, 2018 and 2017 (Unaudited):

	Year Ended December 31, 2018			
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Net revenue	$ 22,263	$ 22,047	$ 22,292	$ 22,862
Cost of revenue	11,068	10,582	11,226	11,393
Gross profit	11,195	11,465	11,066	11,469
Operating expenses	26,942	25,331	22,890	20,733
Loss from operations	(15,747)	(13,866)	(11,824)	(9,264)
Net loss from continuing operations	(21,975)	(21,806)	(97,432)	(49,220)
(Loss) gain from discontinued operations, net of tax	(193)	(1,591)	(32)	97
Net loss	(22,168)	(23,397)	(97,464)	(49,123)
Basic and diluted net loss per share:				
Continued operations - common stock	$ (0.20)	$ (0.20)	$ (0.89)	$ (0.45)
Discontinued operations - common stock	$ —	$ (0.01)	$ —	$ —
Total net loss per common stock	$ (0.20)	$ (0.21)	$ (0.89)	$ (0.45)
Basic and diluted net income per redeemable common stock	N/A	N/A	N/A	N/A

	Year Ended December 31, 2017			
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Net revenue	$ 19,104	$ 23,514	$ 21,760	$ 22,298
Cost of revenue	11,518	9,652	11,472	8,880
Gross profit	7,586	13,862	10,288	13,418
Operating expenses	27,415	28,655	26,324	30,660
Loss from operations	(19,829)	(14,793)	(16,036)	(17,242)
Net loss from continuing operations	(28,126)	(57,696)	(23,015)	(22,562)
(Loss) income from discontinued operations, net of tax	(12,989)	(12,368)	(19,383)	928
Net loss	(41,115)	(70,064)	(42,398)	(21,634)
Basic and diluted net income (loss) per share:				
Continued operations - common stock	$ (0.23)	$ (0.48)	$ (0.20)	$ (0.21)
Discontinued operations - common stock	$ (0.11)	$ (0.10)	$ (0.17)	$ 0.01
Total net loss per common stock	$ (0.34)	$ (0.58)	$ (0.37)	$ (0.20)
Basic and diluted net income per redeemable common stock	N/A	N/A	N/A	N/A

Note 21 Subsequent Events

On March 21, 2019, we received a notice from Nasdaq stating that we had regained compliance with Nasdaq Listing Rule 5450(a) (1) (the "Minimum Bid Price Rule") because our common stock maintained a minimum closing bid price of $1.00 for 10 consecutive business days. This followed the notice of January 16, 2019, stating that we were not in compliance the Minimum Bid Price Rule, because our common stock failed to maintain a minimum closing bid price of $1.00 for 30 consecutive business days.

REPORT OF INDEPENDENT AUDITORS

To the Board of Directors and Members of
NantOmics, LLC and Subsidiaries

We have audited the accompanying consolidated financial statements of NantOmics, LLC and Subsidiaries, which comprise the consolidated balance sheet as of December 31, 2018, and the related consolidated statement of operations and comprehensive loss, changes in members' equity, and cash flows for the year ended December 31, 2018, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated and combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility
Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated and combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of NantOmics, LLC and Subsidiaries as of December 31, 2018, and the consolidated results of their operations and their consolidated cash flows for the year ended December 31, 2018, in accordance with accounting principles generally accepted in the United States of America.

/s/ Ernst & Young LLP

Los Angeles, California
March 29, 2019

INDEPENDENT AUDITORS' REPORT

To the Board of Directors and Members of
NantOmics, LLC and Subsidiaries

We have audited the accompanying consolidated and combined financial statements of NantOmics, LLC and Subsidiaries, which comprise the consolidated balance sheets as of December 31, 2017 and 2016, and the related consolidated and combined statements of operations and comprehensive loss, changes in members' equity, and cash flows for the years ended December 31, 2017, 2016 and 2015, and the related notes to the consolidated and combined financial statements.

Management's Responsibility for the Consolidated and Combined Financial Statements
Management is responsible for the preparation and fair presentation of these consolidated and combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated and combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility
Our responsibility is to express an opinion on these consolidated and combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated and combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated and combined financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated and combined financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the consolidated and combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated and combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the consolidated and combined financial statements referred to above present fairly, in all material respects, the financial position of NantOmics, LLC and Subsidiaries as of December 31, 2017 and 2016, and the results of their operations and their cash flows for the years ended December 31, 2017, 2016 and 2015, in accordance with accounting principles generally accepted in the United States of America.

/s/ Mayer Hoffman McCann, P.C.
March 16, 2018
Los Angeles, California

Member of Kreston International - a global network of independent accounting firms

NantOmics, LLC and Subsidiaries
Consolidated Balance Sheets
(In thousands, except unit amounts)

	December 31,	
	2018	2017
Assets		
Current assets		
Cash and cash equivalents	$ 7,367	$ 5,925
Accounts receivable, net of allowance of $0 and $167 at December 31, 2018 and 2017, respectively	99	280
Related party accounts receivable, net of allowance of $0 at December 31, 2018 and 2017	481	710
Related party notes receivable	167,045	158,320
Prepaid expenses and other current assets	693	1,697
Total current assets	175,685	166,932
Property and equipment, net	17,624	34,946
Marketable securities - available for sale	1,578	8,843
Cost method investments	—	5,000
Goodwill	7,623	8,928
Intangible assets, net	4,232	10,473
Other assets	71	225
Total assets	$ 206,813	$ 235,347
Liabilities and Members' Equity		
Current liabilities		
Accounts payable	$ 3,155	$ 12,036
Accrued expenses	1,585	3,203
Related party payables	12,848	7,783
Related party promissory notes payable	92,816	63,170
Deferred revenue, current	5,000	5,000
Other current liabilities	2,779	706
Total current liabilities	118,183	91,898
Deferred revenue, non-current	2,303	2,474
Other non-current liabilities	686	3,499
Total liabilities	121,172	97,871
Members' equity		
Series A-1 units: 1,008,412 and 1,008,105 units issued and outstanding at December 31, 2018 and 2017, respectively	31,896	27,585
Series A-2 units: 166,160 and175,813 units issued and outstanding at December 31, 2018 and 2017, respectively	249,568	258,524
Series B units: 150,000 units authorized, 8,457 units issued and outstanding at December 31, 2018 and 2017 (excluding liability-classified units)	2,713	2,129
Accumulated deficit	(193,373)	(147,420)
Total NantOmics members' equity	90,804	140,818
Non-controlling interests	(5,163)	(3,342)
Total members' equity	85,641	137,476
Total liabilities and members' equity	$ 206,813	$ 235,347

The accompanying notes are an integral part of these Consolidated and Combined Financial Statements.

NantOmics, LLC and Subsidiaries
Consolidated and Combined Statements of Operations and Comprehensive Loss
(In thousands)

	Year Ended December 31,	
	2018	**2017**
Revenue:		
Related party revenue	$ 5,632	$ 5,126
Third party revenue	547	953
Net revenue	6,179	6,079
Cost of Revenue:		
Cost of revenue	10,734	14,274
Amortization of acquisition-related assets	224	1,059
Total cost of revenue	10,958	15,333
Gross loss	(4,779)	(9,254)
Operating Expenses:		
Selling, general and administrative (including related party shared service expenses of $1,679 and $2,230 for the years ended December 31, 2018 and 2017)	11,082	12,969
Research and development	23,050	26,952
Total operating expenses	34,132	39,921
Loss from operations	(38,911)	(49,175)
Impairments on equity investments	(12,265)	(19,976)
Interest income (expense), net	4,589	6,364
Other income (expense), net	(337)	134
Loss before income taxes	(46,924)	(62,653)
Provision for income taxes	—	—
Net loss and comprehensive loss	(46,924)	(62,653)
Less: Net loss attributable to non-controlling interests	(971)	(2,346)
Net loss attributable to NantOmics	$ (45,953)	$ (60,307)

The accompanying notes are an integral part of these Consolidated and Combined Financial Statements.

NantOmics, LLC and Subsidiaries
Consolidated and Combined Statements of Changes in Members' Equity
(In thousands, except per unit amounts)

	Series A-1 Units		Series A-2 Units		Series B Units		Accumulated	NantOmics, LLC	Non-controlling	Total
	Units	Amount	Units	Amount	Units	Amount	Deficit	Equity	Interests	Equity
Balance at December 31, 2016	1,007,805	$27,713	175,813	$258,524	8,457	$ 1,574	$ (87,113)	$ 200,698	$ (542)	$ 200,156
Non-cash contributions by Parent	—	402	—	—	—	—	—	402	—	402
Forgiveness of related party receivables	—	(452)	—	—	—	—	—	(452)	—	(452)
Acquisition of Liquid Genomics	—	(53)	—	—	—	—	—	(53)	—	(53)
Equity based compensation	—	(33)	—	—	—	555	—	522	—	522
Issuance of membership interests	300	295	—	—	—	—	—	295	(741)	(446)
Contribution of non-controlling interests by Parent	—	644	—	—	—	—	—	644	(644)	—
Forgiveness of TRM liabilities	—	(931)	—	—	—	—	—	(931)	931	—
Net loss	—	—	—	—	—	—	(60,307)	(60,307)	(2,346)	(62,653)
Balance at December 31, 2017	1,008,105	27,585	175,813	258,524	8,457	2,129	(147,420)	140,818	(3,342)	137,476
Non-cash contributions by Parent	—	177	—	—	—	—	—	177	—	177
Equity based compensation	—	28	—	—	—	584	—	612	—	612
Issuance of membership interests	307	296	—	—	—	—	—	296	(751)	(455)
Assignment of non-controlling interests	—	(23)	—	—	—	—	—	(23)	(99)	(122)
Assignment of Liquid Genomics	—	3,833	(9,653)	(8,956)	—	—	—	(5,123)	—	(5,123)
Net loss	—	—	—	—	—	—	(45,953)	(45,953)	(971)	(46,924)
Balance at December 31, 2018	1,008,412	$31,896	166,160	$249,568	8,457	$ 2,713	$ (193,373)	$ 90,804	$ (5,163)	$ 85,641

The accompanying notes are an integral part of these Consolidated and Combined Financial Statements.

NantOmics, LLC and Subsidiaries
Consolidated and Combined Statements of Cash Flows
(In thousands)

	Year Ended December 31,	
	2018	**2017**
Cash flows from operating activities:		
Net loss	$ (46,924)	$ (62,653)
Adjustments to reconcile net loss to net cash used in operating activities:		
Depreciation	9,813	9,545
Amortization	1,872	2,473
Equity-based compensation	612	2,199
Impairments	12,265	19,976
Non-cash interest items, net	(8,725)	(8,264)
Non-cash contributions by Parent	177	402
Other	120	64
Net changes in operating assets and liabilities, net of business combinations:		
Accounts receivable, net	176	(12)
Related party accounts receivable, net	229	2,488
Prepaid and other current assets	(32)	814
Other assets	153	23
Accounts payable	(7,930)	1,806
Accrued expenses and other liabilities	(2,114)	(417)
Related party payables	4,947	2,430
Deferred revenue	(171)	(220)
Net cash used in operating activities	(35,532)	(29,346)
Cash flows from investing activities:		
Purchases of property and equipment	(794)	(5,865)
Proceeds from sale of fixed assets	8,626	—
Acquisition of businesses, net of cash acquired	—	(4,308)
Assignment of businesses, net of cash assigned	(68)	—
Purchases of marketable securities	—	(6)
Proceeds from sales of marketable securities	—	89
Investments in related party notes receivable	—	(1,175)
Purchase of non-controlling interests	(578)	(446)
Net cash provided by/(used in) investing activities	7,186	(11,711)
Cash flows from financing activities:		
Repayments of notes payable	—	(54)
Repayments of capital lease obligations	(108)	(330)
Proceeds from issuance of related party promissory notes payable	29,896	42,157
Net cash provided by financing activities	29,788	41,773
Net increase in cash and cash equivalents	1,442	716
Cash and cash equivalents, beginning of year	5,925	5,209
Cash and cash equivalents, end of year	$ 7,367	$ 5,925

The accompanying notes are an integral part of these Consolidated and Combined Financial Statements.

NantOmics, LLC and Subsidiaries
Consolidated and Combined Statements of Cash Flows
(In thousands)

	Year Ended December 31,	
	2018	**2017**
Supplemental disclosure of cash flow information:		
Non-cash transactions:		
Purchase of intangible assets in exchange for forgiveness of notes receivable	$ —	$ 1,193
Forgiveness of related party receivables	—	452
Forgiveness of TRM liabilities	—	931
Acquisition of assets included in accounts payable and related party payables	679	8,802
Contribution of non-controlling interests by parent	—	644
Supplemental cash flow information:		
Cash paid for interest	9	14
Cash paid for income taxes	—	—

The accompanying notes are an integral part of these Consolidated and Combined Financial Statements.

1. Description of Business and Basis of Presentation

Nature of Business

NantOmics, LLC ("NantOmics"), a Delaware limited liability company, was formed on September 20, 2012. NantOmics, together with its subsidiaries (together, the "Company"), delivers molecular diagnostic capabilities with the intent of providing actionable intelligence and molecularly driven decision support for cancer patients and their providers at the point of care. It also has a highly scalable cloud-based infrastructure capable of storing and processing thousands of genomes a day, computing genomic variances in near real-time and correlating proteomic pathway analysis with quantitative multiplexed protein expression analysis from the same micro-dissected tumor sample used for genomic analysis. NantOmics is a majority-owned subsidiary of NantWorks, LLC ("NantWorks" or "Parent"), which is a subsidiary of California Capital Equity, LLC ("Cal Cap"). The three companies were founded and are led by Dr. Patrick Soon-Shiong.

NantOmics conducts its operations directly and through the following subsidiaries, all of which are based in the United States.

- *Expression Pathology, Inc. doing business as OncoPlex Diagnostics* (" *OncoPlex* ") - formed under the laws of the State of Maryland on December 6, 2001, provides molecular diagnostics through a CAP-accredited, CLIA-certified oncology laboratory linking clinical proteomics and genomics to support personalized patient care.

- *Five3 Genomics, LLC ("Five3G")* - formed under the laws of the State of Delaware on May 20, 2010, to commercialize certain patent rights which were licensed from The Regents of the University of California on December 20, 2010. Five3G provides data processing and analysis services for personalized cancer therapy, matching treatments to specific genetic aberrations discovered in the cancer cells of individual patients.

- *NantCare, LLC, formerly known as NantCRO ("NantCare")* - formed under the laws of the State of Delaware on April 4, 2014, provides clinical research services to support the pharmaceutical, biotechnology, medical device and various other industries.

Basis of Presentation

The consolidated and combined financial statements and accompanying notes have been prepared in accordance with accounting principles generally accepted in the United States of America.

The accompanying consolidated and combined financial statements include the financial statements of entities in which the Company has a controlling financial interest. Equity interests of the Company's subsidiaries that are not owned by the Company are referred to as non-controlling interests. Intercompany balances and transactions between the consolidated entities have been eliminated.

On July 31, 2017, NantOmics acquired Liquid Genomics, Inc. ("Liquid Genomics") from NantCell, Inc. ("NantCell"), an entity controlled by the Company's Chairman and Chief Executive Officer ("CEO") (see Note 3). The assets and liabilities of Liquid Genomics were recorded at their carryover basis since NantOmics and NantCell are under common control. The results of operations, equity accounts and cash flows of Liquid Genomics have been combined with the Company beginning on March 31, 2017, the date of inception of common control, through July 31, 2017, the date of acquisition by NantOmics. On February 28, 2018, the Company sold its 100% interest in Liquid Genomics to NantHealth pursuant to an assignment agreement dated February 1, 2018 (see Note 3).

The accompanying consolidated and combined financial statements have been prepared assuming the Company will continue as a going concern, which contemplates the realization of assets and the satisfaction of liabilities in the normal course of business, and do not include any adjustments to reflect the possible future effects on the recoverability and classification of assets or amounts and classification of liabilities that may result from the outcome of this uncertainty. The Company believes its existing cash, cash equivalents, outstanding amounts of notes receivable and ability to borrow from affiliated entities will be sufficient to fund operations through at least 12 months following the issuance date of the financial statements based upon the Company's Chairman and CEO's intent and ability to support the Company's operations with additional funds as required. The Company may also seek to sell additional equity or sell additional debt securities or obtain a credit facility. However, the Company may not be able to secure such financing in a timely manner or on favorable terms. Without additional funds, the Company may choose to delay or reduce its operating or investment expenditures.

2. Summary of Significant Accounting Policies

Use of *Estimates*

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. The estimates and assumptions used in the accompanying consolidated and combined financial statements are based upon management's evaluation of the relevant facts and circumstances at the balance sheet date. On an ongoing basis, the Company evaluates its estimates, including those related to revenue recognition, the accounts receivable allowance, useful lives of long-lived assets and intangible assets, and income taxes. The Company bases its estimates on historical experience and on various other assumptions that are believed to be reasonable, the results of which can affect the reported amounts of assets and liabilities as of the date of the consolidated and combined financial statements, as well as the reported amounts of revenue and expenses during the periods presented.

Variable Interest Entities

The Company evaluates its ownership interests, contractual rights and other interests in entities to determine if the entities are variable interest entities ("VIEs"), if it has a variable interest in those entities and the nature and extent of those interests. These evaluations are highly complex and involve judgment, the use of estimates and assumptions based on available historical information. In order for the Company to be the primary beneficiary of a VIE, it must have both (1) the power to direct the activities of a VIE that most significantly affect the VIE's economic performance and (2) the obligation to absorb losses or the right to receive benefits that, in either case, could potentially be significant to the VIE. The Company consolidates entities of which it is the primary beneficiary.

The Company determines whether it is the primary beneficiary of a VIE upon its initial involvement with the VIE and reassesses whether it is the primary beneficiary on an ongoing basis. This determination is based upon an analysis of the design of the VIE, including the VIE's structure and activities, the power to make significant economic decisions held by the Company and by other parties and the variable interests owned by the Company and other parties.

Non-controlling Interests

Non-controlling interests are classified as a separate component of equity in the consolidated balance sheets and consolidated and combined statements of changes in members' equity. Additionally, net loss attributable to non-controlling interests is reflected separately from consolidated net loss in the consolidated and combined statements of operations and comprehensive loss and changes in members' equity.

The Company records the non-controlling interests' share of income or loss based on the percentage of ownership interest retained by the respective non-controlling interest holders. The net loss attributable to the members of NantOmics is the total consolidated net loss less the net loss attributable to the non-controlling interests.

Revenue Recognition

Revenue represents the consideration received or receivable from customers for products and services provided by the Company. Revenues are generated from the following sources:

- *Genomic sequencing and bioinformatics services* - diagnostic services utilizing whole genome sequencing and RNA sequencing of a patient's tumor, with the patient's normal sample, to identify molecular alterations in the DNA and RNA of the patient's tumor .

- *Quantitative proteomics services* - proprietary clinical services that allow oncologists to determine the optimal treatment plan for oncology patients, based on a molecular analysis of both the mutant genes and dysfunctional proteins that drive the cellular biochemistry responsible for an individual's cancer.

- *Research services* - contract research services for bio-pharmaceutical companies related to cancer drug development generally sold under fixed price contracts.

- *Other revenue* - includes translational research services, the commercial sale of gene mutation and protein expression panel testing kits and license revenues based on net sales of the licensees' use of the Company's patented process.

The Company recognizes revenue when (1) persuasive evidence of an arrangement exists, (2) delivery has occurred, (3) the fee is fixed or determinable, and (4) collectibility is reasonably assured. The Company recognizes revenue on a cash basis when it cannot conclude that criterion (3) and (4) have been met.

On June 19, 2015, the Company entered into an exclusive Reseller Agreement with NantHealth, pursuant to which the Company granted to NantHealth the worldwide, exclusive right to resell the Company's genomic sequencing and bioinformatics services to commercial third-party payors, self-insured health plans, hospitals and other provider networks ("Institutional Customers") (see Note 13). On May 9, 2016, the Company also granted to NantHealth the worldwide, exclusive right to resell the Company's quantitative proteomic analysis services to Institutional Customers. Unless first granted by the Company to NantHealth on a case-by-case basis, NantHealth does not have the right to resell the Company's genomic and proteomic sequencing and related bioinformatics services to research, academic or educational institutions, pharmaceutical or biotechnology companies or individual patients or consumers.

Revenue from the Company's genomic and proteomic sequencing and bioinformatics services sold by NantHealth under the Reseller Agreement is recognized when the Company delivers the completed genomic and proteomic reports which summarize the tests' results to NantHealth's customer and all other revenue recognition criteria have been met. The Company reports revenue from these arrangements based on the amount of fees owed by NantHealth to the Company.

The Company currently recognizes revenue on a cash basis from historical sales of its proteomics services for which the Company receives payments from third-party payors and from patients, who make co-payments, pay deductibles or from other amounts that the Company has been unable to collect from third-party payors. The Company granted NantHealth the right to sell to these customers and therefore the Company doesn't expect to sell to these customers directly in the future.

Research service revenue is recognized using the proportional performance method. Unless it is determined as part of the Company's regular contract performance review that overall progress on a contract is not consistent with costs expended to date, the Company recognizes revenue based on the percentage of costs incurred to date in relation to total estimated costs expected upon completion of the contract.

Revenue from product sales is recognized upon shipment or delivery, depending on terms of the arrangement. License and royalty revenue is recognized in the period in which the royalty is earned.

For arrangements that include multiple elements, the Company identifies the separate units of accounting and allocates the total arrangement consideration to the units of accounting on the basis of their relative selling price. The selling price used for each deliverable is based on vendor-specific objective evidence of fair value ("VSOE"), if available, third party evidence of fair value ("TPE") if VSOE is not available or the Company's best estimate of selling price if neither VSOE nor TPE is available. In determining the units of accounting for these arrangements, the Company evaluates whether each deliverable has value to the customer on a standalone basis.

Deferred Revenue

The Company recognizes deferred revenue for amounts it collects from its customers prior to satisfying the Company's revenue recognition policy. The Company uses judgment in determining the period over which the deliverables are recognized as revenue. Non-current deferred revenue is expected to be earned more than one year after the balance sheet date.

Fair Value Measurement

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements are classified and disclosed in one of the following three categories:

- Level 1 - Quoted prices for identical assets or liabilities in active markets;
- Level 2 - Quoted prices for similar assets or liabilities in active markets or quoted prices for identical or similar assets or liabilities in markets that are not active or are directly or indirectly observable; and
- Level 3 - Unobservable inputs that reflect estimates and assumptions.

The carrying amounts reported in the balance sheet for cash and cash equivalents, accounts receivable, accounts payable and other current monetary assets and liabilities approximate fair value because of the immediate or short-term maturity of these financial instruments.

The Company's goodwill and other intangible assets and its investments in non-marketable equity securities are measured at fair value on a non-recurring basis and are adjusted to fair value only if an impairment charge is recognized.

Cash and Cash Equivalents

The Company considers all unrestricted, highly liquid investments with an initial maturity of three months or less to be cash equivalents. These amounts are stated at cost, which approximates fair value. As of December 31, 2018 and 2017, cash equivalents were deposited in financial institutions and consisted of immediately available fund balances. Cash and cash equivalents were maintained at stable financial institutions, generally at amounts in excess of federally insured limits, which represent a concentration of credit risk. The Company has not experienced any losses on deposits of cash and cash equivalents to date.

Marketable Securities

The Company's marketable securities consist of an investment in NantHealth's common stock and are reported on the balance sheet at fair value based upon quoted market prices (see Note 7).

The Company classifies its investment in NantHealth as an available-for-sale equity security. Any unrealized gains and losses on the NantHealth investment, which are deemed to be temporary, are reported as a separate component of members' equity. A decline in the market value of any available-for-sale security below its carrying value that is determined to be other-than-temporary would result in a charge to earnings and decrease in the security's carrying value down to its newly established fair value. Factors evaluated to determine if an investment is other-than-temporarily impaired include significant deterioration in earnings performance, credit rating, asset quality or business prospects of the issuer, adverse changes in the general market condition in which the issuer operates, the Company's intent to hold to maturity and an evaluation as to whether it is more likely than not that the Company will not have to sell the investment before recovery of its cost basis and issues that raise concerns about the issuer's ability to continue as a going concern.

Accounts Receivable and Allowance for Doubtful Accounts

Accounts receivable and related party accounts receivable are generated from genomic sequencing services, research services, licenses and royalties and product sales to various commercial entities. The Company does not record accounts receivable associated with amounts billed to third-party payors and directly to patients for proteomics services because this revenue is recognized on a cash basis. Management determines the allowance for doubtful accounts by regularly evaluating the age of individual customer receivables and considering a customer's financial condition, credit history and current economic conditions. Management has recorded an allowance for doubtful accounts for those amounts that it has determined may not be collectible.

Property and Equipment, net

Property and equipment received in connection with business combinations are recorded at fair value. Property and equipment acquired in the normal course of business are recorded at cost. Depreciation is computed on a straight line basis over the estimated useful lives of the related assets (see Note 4). Maintenance and repairs are charged to expense as incurred while expenditures for refurbishments and improvements that significantly add to the productive capacity or extend the useful life of an asset are capitalized. The estimated useful lives of the assets are as follows:

Equipment acquired under capital lease	3 to 5 years
Equipment and other	3 to 10 years
Computer equipment and software	3 to 4 years

Business Combinations

Business combinations are accounted for using the acquisition method of accounting. Under the acquisition method, assets acquired and liabilities assumed are recorded at their respective fair values as of the acquisition date. Any excess of the purchase price over the estimated fair values of the net assets acquired is recorded as goodwill. Management routinely monitors the factors impacting the acquired assets and liabilities. Transaction related costs are expensed as incurred. The operating results of the acquired business are reflected in the Company's consolidated and combined financial statements as of the acquisition date.

Goodwill and Intangible Assets

Goodwill acquired in a business combination and determined to have an indefinite useful life is not amortized but is tested for impairment annually or between annual tests when an impairment indicator exists. The Company evaluates goodwill based upon its reporting units, which are defined as operating segments or, in certain situations, one level below the operating segment. If an optional qualitative goodwill impairment assessment is not performed, the Company is required to determine the fair value of each reporting unit using a quantitative test. If a reporting unit's fair value is lower than its carrying value, the Company must determine the amount of implied goodwill that would be established if the reporting unit was hypothetically acquired on the impairment test date. If the carrying amount of a reporting unit's goodwill exceeds the amount of implied goodwill, an impairment loss equal to the excess would be recorded.

The determination of fair value of a reporting unit is based on a combination of a market approach that considers benchmark company market multiples and an income approach that uses discounted cash flows for each reporting unit utilizing Level 3 inputs. Under the income approach, the Company determines the fair value based on the present value of the most recent income projections for each reporting unit and calculates a terminal value utilizing a terminal growth rate. The significant assumptions under this approach include, among others: income projections, which are dependent on sales to new and existing customers, new product introductions, customer behavior, competitor pricing, operating expenses, the discount rate, and the terminal growth rate. The cash flows used to determine fair value are dependent on a number of significant management assumptions based on historical experience, expectations of future performance and the expected economic environment. Estimates are subject to change given the inherent uncertainty in predicting future results. Additionally, the discount rate and the terminal growth rate are based on judgment of the rates that would be utilized by a hypothetical market participant.

Accounting guidance requires that definite-lived intangible assets be amortized over their respective estimated useful lives and reviewed for impairment whenever events or changes in circumstances indicate that their carrying amounts may not be recoverable. The Company estimates the useful lives of the intangible assets and ratably amortizes the value over the estimated useful lives of those assets. If the estimates of the useful lives change, the Company will amortize the remaining book value over the remaining useful lives or, if an asset is deemed to be impaired, a write-down of the value of the asset to its fair value may be required at such time.

Cost Method Investments

The Company owns non-marketable equity securities that are accounted for under the cost method because the investments are not in the form of common stock or in-substance common stock. All investments are reviewed on a regular basis for possible impairment. If an investment's fair value is determined to be less than its net carrying value and the decline is determined to be other-than-temporary, the investment is written down to its fair value. Such an evaluation is judgmental and dependent on specific facts and circumstances. Factors considered in determining whether an other-than-temporary decline in value has occurred include: market value of the investment based on most recent rounds of financing by the investee; length of time that the market value was below its cost basis; financial condition and business prospects of the investee; the Company's intent and ability to retain the investment for a sufficient period of time to allow for recovery in market value of the investment; issues that raise concerns about the investee's ability to continue as a going concern; any other information that the Company may be aware of related to the investment.

Research and Development Expenses

Research and development ("R&D") costs are expensed as incurred and include salary and benefits, professional fees, laboratory supplies, depreciation on laboratory and computer equipment, and allocated shared service expenses.

Equity Based Compensation

The Company accounts for equity based compensation awards by expensing the estimated grant date fair value of the award over the requisite service period. The Company records stock-based compensation expense on a straight-line basis over the requisite service period of the grant and in accordance with Accounting Standard Update ("ASU") No. 2016-09, *Compensation—Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting* ("ASU 2016-09"), made an accounting policy election to account for forfeitures as they occur rather than by applying an estimated forfeiture rate at the time of grant.

Income Taxes

The Company is a limited liability company that has subsidiaries that are limited liability companies and one subsidiary that is a corporation. The loss of the entities classified as pass-through entities for tax purposes flow directly through to the members of the Company.

The net loss of the corporations are accounted under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases using enacted tax rates in effect for the year in which the differences are expected to affect taxable income. Tax benefits are recognized when it is more likely than not that a tax position will be sustained during an audit. Deferred tax assets are reduced by a valuation allowance if current evidence indicates that it is considered more likely than not that these benefits will not be realized. Management has evaluated the Company's tax positions and has concluded that the Company has taken no uncertain tax positions that require adjustment to the financial statements. The Company is no longer subject to income tax examination by the U.S. federal, state or local tax authorities for years ended December 31, 2014 and prior.

Concentrations of Risk

For the years ended December 31, 2018 and 2017, one related party customer accounted for 89% and 82% of the Company's revenue, respectively.

Recent Accounting Pronouncements

In August 2018, FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework-Changes to the Disclosure Requirements for Value Measurement* ("ASU 2018-13") which modifies the disclosure requirements on fair value measurements. This ASU is effective for fiscal years beginning after December 15, 2019. The Company is currently evaluating the impact that ASU 2018-13 will have on its consolidated and combined financial statements and related disclosures.

In June 2018, FASB issued ASU 2018-07, *Compensation - Stock Compensation (Topic 718): Improvements to Nonemployee Share Based Payment Accounting* ("ASU 2018-07"). Under this ASU, the accounting for share-based payments to nonemployees and employees will be substantially aligned, primarily by permitting the measurement of nonemployee awards to be fixed at the grant date. The amendments in this ASU are effective for fiscal years beginning after December 15, 2018. The Company is currently evaluating the impact that ASU 2018-07 will have on its consolidated and combined financial statements and related disclosures.

In January 2017, the Financial Accounting Standards Board ("FASB") issued ASU 2017-04, *Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment* ("ASU 2017-04"), a standard which simplifies the accounting for goodwill impairment. The guidance removes Step 2 of the goodwill impairment test, which requires a hypothetical purchase price allocation. Goodwill impairment will now be the amount by which a reporting unit's carrying value exceeds its fair value, not to exceed the carrying amount of goodwill. The revised guidance will be applied prospectively, and is effective for the Company's annual goodwill impairment tests in fiscal years beginning after December 15, 2020. Early adoption is permitted for goodwill impairment tests performed on testing dates after January 1, 2017. The Company is currently evaluating the effect that ASU 2017-04 will have on its consolidated and combined financial statements and related disclosures.

In January 2017, the FASB issued ASU 2017-01, *Business Combinations (Topic 805): Clarifying the Definition of a Business* ("ASU 2017-01"). The amendments in this update clarify the definition of a business with the objective of adding guidance to assist entities with evaluating whether transactions should be accounted for as acquisitions or disposals of assets or businesses. The definition of a business affects many areas of accounting including acquisitions, disposals, goodwill and consolidation. The guidance is effective for the Company for annual periods beginning after December 15, 2017 and should be applied prospectively on or after the effective date. The Company adopted ASU 2017-01 on January 1, 2018 and the adoption did not have any impact on its consolidated financial statements.

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)* ("ASU 2014-09") and issued subsequent amendments to the initial guidance in August 2015, March 2016, April 2016, May 2016 and December 2016 within ASU 2015-14, ASU 2016-08, ASU 2016-10, ASU 2016-12 and ASU 2016-20, respectively , which amend the guidance in former Accounting Standards Codification ("ASC") Topic 605, *Revenue Recognition* . This guidance requires that entities recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In July 2015, the FASB decided to delay the effective date of ASU 2014-09 by one year. Additionally, in September 2017, the FASB issued ASU 2017-13, *Revenue Recognition (Topic 605), Revenue from Contracts with Customers (Topic 606), Leases (Topic 840), and Leases (Topic 842)* ("ASU 2017-13") , which delayed the effective date of ASU 2014-09 for the Company to align with the effective date of non-public companies. As a result, the Company is required to apply the new standard beginning January 1, 2019. The Company is currently evaluating the effect that the new revenue standard will have on its consolidated and combined financial statements and related disclosures.

In June 2016, the FASB issued ASU 2016-13, Financial Instruments - Credit Losses. The amendment updates the guidance for measuring and recording credit losses on financial assets measured at amortized cost by replacing the incurred-loss model with an expected-loss model. Accordingly, these financial assets will be presented at the net amount expected to be collected. This new standard also requires that credit losses related to available-for-sale debt securities be recorded as an allowance through net income rather than reducing the carrying amount under the current, other-than-temporary-impairment model. The new standard is effective for interim and annual periods beginning on December 15, 2020, but may be adopted earlier, as of the fiscal years beginning after December 15, 2018. With certain exceptions, adjustments are to be applied using a modified-retrospective approach by reflecting adjustments through a cumulative-effect impact on retained earnings as of the beginning of the fiscal year of adoption. The Company is currently evaluating the effect that ASU 2016-13 will have on its consolidated and combined financial statements and related disclosures.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)* ("ASU 2016-02"), to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities, including for operating leases, on the balance sheet and disclosing key information about leasing arrangements. As a result of the guidance in ASU 2017-13, this guidance is effective for the Company's financial statement periods beginning January 1, 2020 and after. Additionally, the FASB issued ASU 2018-11, *Leases (Topic 842): Targeted Improvements* ("ASU 2018-11"), which offers an additional transition method whereby entities may apply the new leases standard at the adoption date and recognize a cumulative-effect adjustment to the opening balance of retained earnings rather than application of the new leases standard at the beginning of the earliest period presented in the financial statements. The Company is currently evaluating the effect that ASU 2016-02 and ASU 2018-11 will have on its consolidated and combined financial statements and related disclosures.

3. Business Combinations

2017 Acquisitions

Liquid Genomics

On July 31, 2017, the Company acquired 100% of the outstanding equity interests in Liquid Genomics from NantCell, a related party, in exchange for $7,241. The purchase price consisted of $5,000 to reimburse NantCell for the approximate $5,000 worth of NantCell's common stock that was issued to the former Liquid Genomics stockholders at the time of NantCell's merger with Liquid Genomics on March 31, 2017 plus an additional $2,241 which represented the amount of funding provided by NantCell to Liquid Genomics between March 31 and July 31, 2017.

The value of the identifiable assets acquired for the Liquid Genomics acquisition is shown in the table below:

Cash and cash equivalents	$	152
Developed technology		4,579
Goodwill		1,305
Property and equipment, net		357
Other assets		166
Accounts payable		(234)
Accrued expenses		(144)
Capital lease obligations		(197)
Other current liabilities		(24)
Related party payables		(31)
Related party promissory note payables		(250)
Total assets acquired and liabilities assumed	$	5,679

The Company accounted for the transaction as the acquisition of a business between entities under common control since both NantCell and the Company are controlled by the Company's Chairman and CEO. Therefore, the Company recognized the assets and liabilities of Liquid Genomics at historical cost. The Company recorded the difference between the $7,241 cash paid to NantCell and the historical cost of Liquid Genomics' net assets as an equity transaction with its Parent.

The estimated useful life of the acquired developed technology intangible is thirteen years.

On February 28, 2018, the Company sold 100% of the equity of Liquid Genomics, pursuant to an assignment agreement dated February 1, 2018 between the Company and NantHealth, a related party. The purchase price for the acquisition consisted of 9,088,362 Series A-2 units of NantOmics previously owned by NantHealth that were transferred at the closing plus 564,779 of Series A-2 units of NantOmics owned by NantHealth that were transferred to the Company during May 2018. The Company and NantHealth are controlled by the Company's Chairman and CEO, therefore no gain or loss was recognized on the transaction. The transaction did not cause a material change in the reporting entity, and the Company has not retrospectively adjusted its previously issued financial statements.

Genos

On January 24 and February 15, 2017, the Company purchased convertible notes under a secured note purchase agreement with Genos Research, Inc. ("Genos") with a principal amount of $675 and $500, respectively. On April 13, 2017, NantOmics paid $30 in cash and forgave $1,193 of principal and interest outstanding under the convertible notes in exchange for certain of Genos' assets, including its proprietary technology platform (see Note 5). The Company accounted for the transaction as a business combination and attributed the consideration transferred of $1,223 to Genos' developed technology. The estimated useful life of the acquired developed technology is seven years.

4. Property and Equipment, net

Property and equipment as of December 31, 2018 and 2017 consisted of the following:

	December 31,			
		2018		2017
Equipment and other	$	32,967	$	47,204
Equipment acquired under capital leases		—		1,856
Computer equipment and software		5,727		6,610
		38,694		55,670
Less: accumulated depreciation		(21,070)		(20,724)
Property and equipment, net	$	17,624	$	34,946

Depreciation expense was $9,813 and $9,545 for the years ended December 31, 2018 and 2017, respectively.

5. Intangible Assets and Goodwill

Intangible Assets

As of December 31, 2018 and 2017, definite-lived intangible assets consisted of the following:

	December 31, 2018	
	Developed Technologies	Total
Gross carrying amount	$ 15,823	$ 15,823
Accumulated amortization	(11,591)	(11,591)
Intangible assets, net	$ 4,232	$ 4,232

	December 31, 2017	
	Developed Technologies	Total
Gross carrying amount	$ 20,523	$ 20,523
Accumulated amortization	(10,050)	(10,050)
Intangible assets, net	$ 10,473	$ 10,473

During the year ended December 31, 2017, the Company recorded $1,223 and $4,700 of intangible assets related to developed technologies as a result of the Genos asset purchase and Liquid Genomics acquisitions, respectively (see Note 3). The developed technologies are amortized over a period of seven and thirteen years, respectively. During the year ended December 31, 2018, the Company wrote off $4,700 of intangible assets derived from the Liquid Genomics acquisition as a result of the subsequent assignment of Liquid Genomics to NantHealth (see Note 3).

Amortization expense was $1,872 and $2,473 for the years ended December 31, 2018 and 2017, respectively.

The estimated future amortization expense for the intangible assets that exist as of December 31, 2018 is as follows:

For the year ended December 31,	Amounts
2019	$ 1,589
2020	1,589
2021	646
2022	175
2023	175
Thereafter	58
	$ 4,232

Goodwill

The change in the net carrying amount of goodwill for the years ended December 31, 2018 and 2017 is provided below.

	Amounts
Balance at December 31, 2016	$ 7,623
Activity during the year:	
Acquisitions (see Note 3)	1,305
Balance at December 31, 2017	8,928
Activity during the year:	
Assignment (see Note 3)	(1,305)
Balance at December 31, 2018	$ 7,623

During the year ended December 31, 2017, the Company added $1,305 of goodwill related to the acquisition of Liquid Genomics (See Note 3). During the year ended December 31, 2018, the $1,305 of goodwill related to the acquisition of Liquid Genomics was subsequently written off as a result of the Company's assignment of Liquid Genomics to NantHealth (see Note 3).

6. Cost Method Investments

OptraSCAN, Inc.

On October 14, 2016, the Company purchased 4,900 shares of Series A preferred stock from OptraSCAN, Inc. ("OptraSCAN") at a cash purchase price of $5,000. OptraSCAN is an on-demand digital pathology company that was formed shortly before the Company's initial investment and is considered by the Company to be a variable interest entity (see Note 13 for the disclosures related to the Company's involvement with other variable interest entities). The Company uses the cost method to account for this investment because the shares of the investee's preferred stock are not voting common stock, were not considered in-substance common stock and do not have readily determinable fair values .

The shares of preferred stock owned by the Company as of December 31, 2016 represented 49.0% of the outstanding equity of OptraSCAN on an as-converted, non-diluted basis and entitled the Company to appoint two directors to OptraSCAN's five-person Board of Directors. Since all significant decisions of OptraSCAN require a majority vote by the members of its Board of Directors, including decisions related to the hiring, firing and setting the compensation levels of all key executives and the approval of the annual operating budget, the Company does not have the power over the activities that most significantly impact the economic performance of OptraSCAN. Therefore, the Company is not considered the primary beneficiary and does not have a controlling interest in OptraSCAN as of December 31, 2016.

The $5,000 carrying amount of this investment represents the Company's maximum exposure to loss as of December 31, 2017 as the Company has not committed to providing additional financial support to OptraSCAN. As of December 31, 2018, certain factors arose that raised doubts about OptraSCAN's ability to continue operating as a going concern. As a result, the Company qualitatively determined that the investment was not recoverable and recognized other-than-temporary impairment for the full investment of $5,000 during the year ended December 31, 2018. This amount is classified within impairments on equity investments on the consolidated and combined statement of operations and comprehensive loss.

7. Fair Value Measurements

Assets and liabilities measured at fair value on a recurring basis as of December 31, 2018 and 2017 consisted of the following:

	December 31, 2018			
	Total fair value	Quoted price in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash equivalents	$ 5,121	$ 5,121	$ —	$ —
Marketable securities - available for sale	1,578	1,578	—	—
Total assets	$ 6,699	$ 6,699	$ —	$ —
Liabilities:				
Other current liabilities (see Note 11)	$ 2,711	$ —	$ —	$ 2,711
Total liabilities	$ 2,711	$ —	$ —	$ 2,711

	December 31, 2017			
	Total fair value	Quoted price in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)
Assets:				
Cash equivalents	$ 5,039	$ 5,039	$ —	$ —
Marketable securities - available for sale	8,843	8,843	—	—
Total assets	$ 13,882	$ 13,882	$ —	$ —
Liabilities:				
Other non-current liabilities (see Note 11)	$ 2,739	$ —	$ —	$ 2,739
Total liabilities	$ 2,739	$ —	$ —	$ 2,739

The Company's goodwill and other intangible assets and its investments in non-marketable equity securities are measured at fair value on a non-recurring basis and are adjusted to fair value only if an impairment charge is recognized. No impairments were recorded for these assets during the years ended December 31, 2018 and 2017.

8. Commitments and Contingencies

Lease Arrangements

The Company leases equipment under various non-cancellable capital leases and office space under various operating leases, which expire at various dates through March 2026. Rental expense associated with operating leases is charged to expense in the year incurred and is included in the consolidated and combined statements of operations and comprehensive loss. Rent expense totaled $2,336 and $2,215 for the years ended December 31, 2018 and December 31, 2017, respectively.

The following is a schedule of the future minimum lease payments required under these leases as of December 31, 2018:

	Operating Leases
For the year end December 31,	
2019	$ 1,181
2020	891
2021	521
2022	1,015
2023	1,045
Thereafter	2,464
Total minimum lease payments	$ 7,117

The Company classifies the current portion of capital lease obligations within other current liabilities and the non-current portion within other non-current liabilities. The Company is recognizing the total cost of its office leases ratably over the lease period. The difference between rent paid and rent expense is reflected as deferred rent and is classified within other non-current liabilities in the accompanying consolidated balance sheets.

Regulatory Matters

The Company is subject to regulatory oversight by the U.S. Food and Drug Administration and other regulatory authorities with respect to the development, manufacturing, and sale of some of the products. In addition, the Company is subject to the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act and related patient confidentiality laws and regulations with respect to patient information. The Company reviews the applicable laws and regulations regarding effects of such laws and regulations on its operations on an ongoing basis and modifies operations as appropriate. The Company believes it is in substantial compliance with all applicable laws and regulations. Failure to comply with regulatory requirements could have a significant adverse effect on the Company's business and operations.

Legal Matters

The Company is, from time to time, subject to claims and litigation arising in the ordinary course of business. The Company intends to defend vigorously any such litigation that may arise under all defenses that would be available to it. In the opinion of management, the ultimate outcome of proceedings of which management is aware, even if adverse to the Company, would not have a material adverse effect on the consolidated and combined financial statements. As legal proceedings are inherently unpredictable, the Company's assessments involve significant judgment regarding future events.

9. Income Tax

The components of the Company's provision (benefit) for income taxes are presented in the following tables:

	Year Ended December 31,	
	2018	**2017**
Current:		
Federal	$ —	$ —
State	—	—
Total current provision	—	—
Deferred:		
Federal	3,501	(4,359)
State	1,138	1,758
Less: valuation allowance	(4,639)	2,601
Total deferred benefit	—	—
Provision for income taxes	$ —	$ —

The Company's provision for income taxes differs from the amount of income tax determined by applying the applicable federal and state statutory income tax rates to the loss before income taxes due to the valuation allowance for the full amount of the net deferred tax assets.

Since the losses of the pass-through entities flow directly to the members of the Company for tax purposes, no provision for income taxes has been reflected in the consolidated and combined financial statements for these entities.

Deferred income taxes reflect temporary differences in the recognition of revenue and expenses for income tax reporting and financial statement purposes. Significant components of the Company's deferred tax assets as of December 31, 2018 and 2017 are as follows:

	December 31,	
	2018	2017
Deferred tax assets		
Net operating loss carryforwards	$ 18,719	$ 20,235
Charitable contributions	—	13
Equity Compensation	21	6
Accrual to cash differences	308	478
Depreciation and amortization	792	553
Compensation accrual	—	22
Bad debt	—	47
	19,840	21,354
Less: Valuation allowance	(19,840)	(21,305)
Net deferred tax assets	$ —	$ 49
Deferred tax liabilities		
Depreciation and amortization	—	(29)
Capital lease	—	(20)
Net deferred tax liabilities	—	(49)
Deferred Tax Assets/(Liabilities)	$ —	$ —

The realization of deferred tax assets may be dependent on the Company's ability to generate sufficient income in future years in the associated jurisdiction to which the deferred tax assets relate. The Company considers all available positive and negative evidence, including scheduled reversals of deferred tax liabilities, projected future taxable income, tax planning strategies, and recent financial performance. Based on the review of all positive and negative evidence, including a three year cumulative pre-tax loss, it was concluded that a full valuation allowance should be recorded against all net deferred tax assets at December 31, 2018 and 2017 as none of the deferred tax assets were more likely than not to be realized as of the balance sheet dates. As a result of the assignment of Liquid Genomics to NantHealth on February 28, 2018 (see Note 3), there was a decrease of $3,051 to the total valuation allowance during the year ended December 31, 2018 and as of December 31, 2018, deferred tax assets and liabilities related to Liquid Genomics are not included in the consolidated balances.

The Company paid no income taxes during the years ended December 31, 2018 and 2017. The Company has net operating loss ("NOL") carryforwards as of December 31, 2018 of approximately $68,027, which may be available to offset future taxable income. The Tax Cuts and Jobs Act of 2018, which was enacted on December 22, 2017, significantly reforms the Internal Revenue Code (the "Code"), including changes to the rules governing net operating loss carryforwards. For net operating loss carryforwards arising in tax years beginning after December 31, 2017, the Tax Act limits a taxpayer's ability to utilize such carryforwards to 80% of taxable income. In addition, net operating loss carryforwards arising in tax years ending after December 31, 2017 can be carried forward indefinitely, but carryback is generally prohibited. Net operating loss carryforwards generated before January 1, 2018 will not be subject to the taxable income limitation and will continue to have a twenty-year carryforward period. However, the changes in the carryforward and carryback periods as well as the new limitation on use of net operating losses may significantly impact our ability to use net operating loss carryforwards generated after December 31, 2017.

Under Sections 382 and 383 of the Code, NOL carryforwards may become subject to annual limitations due to ownership changes that could occur in the future. The Company has not performed a comprehensive Section 382 study to determine any potential loss limitation resulting from past changes in ownership of its corporate subsidiary, and therefore it cannot be certain it will be able to fully utilize the NOL carryforwards to offset future taxable income.

10. Members' Equity

As of December 31, 2018 and 2017, the Company had three series of outstanding membership interests: Series A-1, Series A-2 and Series B units.

Rights and Preferences

Series A-1 and A-2 Units

Each holder of the outstanding Series A-1 units is entitled to one vote on each matter submitted to a vote of the members. The members vote together as a single class on all matters on which they are entitled to vote and all actions taken by the members will be deemed approved upon consent by the members representing a majority of the outstanding Series A-1 units. Except for the initial capital contributions, no members are obligated to make additional contributions. Series A-2 units do not have any voting rights. The Series A-1 and A-2 units have the characteristics noted below.

Non-liquidating distributions - Holders of the Series A-1 and A-2 units are entitled to receive distributions from the Company as determined by its board of directors (the "Board"). Any non-liquidating distributions will be made to all members based on their respective percentage interests as of the distribution date.

Capital proceeds and liquidating distributions - The Board may make distributions of cash proceeds arising from the sale or other disposition of assets ("Capital Proceeds") or upon liquidation, dissolution, or winding up of the Company ("Liquidating Distributions"). Prior to a qualified initial public offering ("IPO"), distributions of Capital Proceeds and Liquidating Distributions are made in the following order: first to the holders of the Series A-1 and A-2 units on a pro rata basis in proportion to the number of their Series A-1 and A-2 units, until their "Unreturned Capital" has been reduced to zero; second to the holders of Series B units (the "Series B Members") on a pro rata basis in proportion to the number of their Series B units until their "Unreturned Capital", if any, has been reduced to zero; and thereafter, to all members based on their respective percentage interests as of the distribution date. Each member's "Unreturned Capital" is the difference between (1) the aggregate capital contributions by that member and (2) any Capital Proceeds or Liquidating Distributions previously distributed to that member. As of December 31, 2018 and 2017, the holders of the Series A-1 and A-2 units had cumulative Unreturned Capital balances of $1,260,656 and $1,269,157, respectively.

Upon a qualified IPO, the priority rights of the holders of the Series A-1, A-2 and B units will immediately terminate and distributions of Capital Proceeds or Liquidating Distributions will be made to the holders of the Series A-1, A-2 and B units based on their respective percentage interests as of the distribution date, subject to the applicable hurdle amount for the Series B units.

Series B Non-Voting Units

The Company has reserved an aggregate of 150,000 Series B units for issuance to employees, consultants, contractors and other service providers of the Company and its subsidiaries in consideration for bona fide services provided to the Company. Series B units do not have any voting or information rights.

The Series B units are considered profits interests of the Company and do not represent an interest in the capital of the Company, and would not entitle the Series B Members to receive distributions if the Company were liquidated immediately after the grant. Instead, the Series B Members are entitled to receive a pro rata allocation of a portion of the profit and loss of the Company arising after the date of the grant and distributions made out of a portion of the profits of the Company arising after the grant date of the Series B units.

Series B Members will not be entitled to receive any distributions until the aggregate distributions made by the Company exceed a hurdle amount applicable to those Series B units. The hurdle amount is determined by the Board at the date of issuance of such units. After all other members have received distributions equal to the hurdle amount, the Series B Members will be entitled to receive their percentage interest of such excess distributions.

11. Equity Based Compensation

NantOmics Profits Interests Plan

The Company has reserved 150,000 Series B units for issuance to employees, consultants, contractors and other service providers of the Company pursuant to the Profits Interests Plan. As of December 31, 2018 and 2017, there were 11,205 and 11,362 of outstanding Series B units, respectively.

As of December 31, 2018 and 2017, there were 2,748 and 2,905 outstanding Series B units, respectively, which provide their holders with the option to require the Company to purchase all of their vested Series B units at $1.484 per unit if the Company has not completed an initial public offering or a sale prior to June 30, 2019. These awards are measured at fair value at the end of each reporting period until settlement using both an option pricing method and a geometric Brownian motion and are classified within other current liabilities and other non-current liabilities on the consolidated balance sheets as of December 31, 2018 and 2017, respectively.

The remaining Series B units do not provide the holders with an option to require the Company to purchase their vested units and are therefore classified as a component of members' equity in the consolidated balance sheets. The fair value of the equity-classified Series B units was estimated at the date of grant using both an option pricing method and a probability weighted expected return method.

The primary inputs used to estimate the fair values of the Series B units are presented below:

	December 31,	
	2018	**2017**
Risk-free interest rate	2.53-2.56%	1.75-1.93%
Expected dividend yield	0.0%	0.0%
Expected volatility	45%	45%
Expected life in years	0.5-1.6	1-2.6

The estimated volatility was based on the historical equity volatility of comparable companies.

A summary of the Company's outstanding, nonvested, liability-classified Series B units and changes during the year ended December 31, 2018 is presented below:

Liability Classified Awards	**Number of Series B Units Outstanding**	**Weighted Average Grant Date Fair Value**
Nonvested outstanding, beginning of year	699	$ 0.45
Granted	—	$ 0.45
Vested	(542)	$ 0.45
Forfeited	(157)	$ 0.45
Nonvested outstanding, end of year	—	$ 0.45

A summary of the Company's outstanding, nonvested, equity-classified Series B units and changes during the year ended December 31, 2018 is presented below:

Equity Classified Awards	**Number of Series B Units Outstanding**	**Weighted Average Grant Date Fair Value**
Nonvested outstanding, beginning of year	2,512	$ 0.34
Vested	(1,004)	$ 0.34
Nonvested outstanding, end of year	1,508	$ 0.34

During the years ended December 31, 2018 and December 31, 2017, the Company recognized total equity based compensation expense for the Series B units, including both the equity- and liability-classified awards, of $612 and $2,199, respectively. As of December 31, 2018, total unrecognized equity based compensation expense of approximately $224 is expected to be recognized over a weighted average period of 0.2 years.

12. Employee Retirement Plan

The Company has various employee retirement plans that it accounted for during the years ended December 31, 2018 and 2017.

NantOmics and Five3G

The Company has a qualified defined contribution plan through a NantWorks Retirement Plan (the “NantWorks 401(k) Plan”) under Section 401(k) of the Internal Revenue Code covering eligible employees, including employees at certain of its subsidiaries, who have completed 30 days of service. Employee contributions to the NantWorks 401(k) Plan are voluntary. The Company contributes a 100% match up to 3.0% of the participant’s eligible annual compensation, which contribution fully vests after three years of service. Participants’ contributions are limited to their annual tax deferred contribution limit as allowed by the Internal Revenue Service. For the years ended December 31, 2018 and December 31, 2017, the Company’s total matching contributions to the 401(k) Plan were $243 and $272, respectively.

13. Related Party Transactions

Investment by NantHealth and Exclusive Reseller Agreement

On June 19 and June 30, 2015, the Company issued a total of 168,464 of Series A-2 units to NantHealth in exchange for $250,000. Additionally, on September 8, 2015, the Company acquired a 54.0% equity interest in TRM, which was later dissolved in 2017, from NantHealth in exchange for $250 in cash and 611 of NantOmics’ Series A-2 units. During February and May 2018, NantHealth transferred a total of 9,653,141 Series A-2 units of NantOmics previously owned by NantHealth back to NantOmics as part of the Liquid Genomics sale (see Note 3). The Series A-2 units owned by NantHealth represent approximately 13.6% and 14.3% of the Company’s total issued and outstanding membership interests as of December 31, 2018 and December 31, 2017, respectively. NantHealth is majority owned by NantWorks and is a transformational healthcare cloud-based IT company converging science and technology through a single integrated clinical platform, to provide actionable health information at the point of care.

In conjunction with NantHealth’s original investment in NantOmics, the Company entered into an exclusive Reseller Agreement with NantHealth on June 19, 2015 and subsequently amended this agreement on May 9, 2016 (the “First Amended Reseller Agreement”). Under the First Amended Reseller Agreement, the Company granted to NantHealth the worldwide, exclusive rights to resell the Company’s genomic sequencing, quantitative proteomic analysis services and bioinformatics services, as well as related consulting and other professional services, to Institutional Customers. NantHealth does not have the right to resell such services for research or educational purposes, for consumer applications, for the development, evaluation, trial, analysis or regulatory approval of any pharmaceutical product or treatment or to individual patients or consumers, unless the Company grants such right to NantHealth on a case-by-case basis. Under the First Amended Reseller Agreement, NantHealth is responsible for various aspects of delivering its sequencing and molecular analysis solutions, including patient engagement and communications with providers such as providing interpretations of the reports delivered to the physicians and resolving any disputes, ensuring customer satisfaction and managing billing and collections. On September 20, 2016, the Company and NantHealth further amended the First Amended Reseller Agreement (the "Second Amended Reseller Agreement"), which permits NantHealth to use vendors other than the Company to provide any or all of the services and clarifies that NantHealth is responsible for order fulfillment and branding.

The Second Amended Reseller Agreement grants to NantHealth the right to renew the agreement with exclusivity for up to three renewal terms, each lasting three years, if NantHealth achieves projected volume thresholds, as follows: (i) the first renewal option can be exercised if NantHealth sells at least 300 tests between June 19, 2015 and June 30, 2020; (ii) the second renewal option can be exercised if NantHealth sells at least 570 tests between July 1, 2020 and June 30, 2023; and (iii) the third renewal option can be exercised if NantHealth sells at least 760 tests between July 1, 2023 and June 30, 2026. If NantHealth does not meet the applicable volume threshold during the initial term or the first or second exclusive renewal terms, NantHealth has the right to renew for a single additional three year term, but only on a non-exclusive basis.

Under the Second Amended Reseller Agreement, the Company is entitled to a variable, per-service fee, depending on the net amount billed by NantHealth to its customer. NantHealth is obligated to pay to NantOmics non-cancellable annual minimum fees of at least $2,000 per year for each of the calendar years from 2016 through 2020 and, subject to NantHealth exercising at least one of its renewal options described above, at least $25,000 per year for each of the calendar years from 2021 through 2023 and at least $50,000 per year for each of the calendar years from 2024 through 2029. The Company invoices for its services on a monthly basis and such invoices are due and payable within 45 days of receipt. NantHealth has the right to terminate the agreement for convenience on six months’ prior written notice, and each party has the right to terminate the agreement in the event there is a material, uncured breach or ineligibility for federal healthcare programming by the other party.

On June 30, 2017, NantHealth and NantOmics executed a letter in which NantOmics agreed to forgive certain receivables from NantHealth under the Second Amended and Restated Exclusive Reseller Agreement. As a result of the execution of this letter, the Company determined that $452 in revenue previously recorded during the year ended December 31, 2016 was no longer collectible. Due to the fact that NantOmics and NantHealth are under common control, the Company recorded the forgiveness of the receivable as an equity transaction with its Parent as of December 31, 2017.

For the years ended December 31, 2018 and December 31, 2017, the Company recognized $5,497 and $5,013, respectively, of revenue and had $465 and $503 of outstanding related party accounts receivable as of December 31, 2018 and 2017 related to the Reseller Agreement with NantHealth.

Sequencing Agreement with NantKwest, Inc.

On June 18, 2015, the Company entered into a genomic and proteomic sequencing agreement with NantKwest, Inc. (“NantKwest”), a company that is controlled by NantOmics’ Chairman and CEO. The Company is entitled to receive from NantKwest a fixed, per-sample fee, determined based on the type of services being provided. The Company invoices NantKwest on a monthly basis for services performed in the preceding month and invoices are payable within 30 days of receipt. The agreement has an initial term of five years and renews automatically for successive one year periods, unless terminated earlier. For the years ended December 31, 2018 and December 31, 2017, the Company recognized related party revenue of $135 and $113, respectively, under this arrangement in the consolidated and combined statements of operations and comprehensive loss. The Company had $16 and $100 of outstanding related party accounts receivable as of December 31, 2018 and 2017 related to the sequencing services agreement.

Master Services Agreement with Altor BioScience Corporation

On October 10, 2016, the Company entered into a master services agreement (“MSA”) with Altor BioScience Corporation (“Altor”) for the provision of certain laboratory services by the Company to Altor, a subsidiary of NantCell. The MSA has an initial term of five years or until termination or expiration without renewal of the last work order still in effect at the end of five years after the effective date, whichever is longer and unless terminated sooner. All amounts invoiced to Altor by the Company are payable within 30 days of receipt. Under the MSA, Altor has granted to the Company an exclusive, perpetual and royalty free license to any and all rights, including intellectual property rights, arising in the performance of the services in certain diagnostic fields. The Company has not recognized any amounts related to the MSA in the consolidated and combined financial statements as of December 31, 2018 and December 31, 2017.

NantWorks Shared Service Agreement

The consolidated and combined financial statements include significant transactions with NantWorks involving services provided to the Company pursuant to a Shared Services Agreement, such as public relations, information technology and cloud services, human resources and administration management, finance and risk management, facilities, procurement and travel, and corporate development and strategy. The costs of services have been directly charged or allocated to the Company by NantWorks using methods management believes are reasonable. These methods include reasonable estimates of percentages of NantWorks’ employees’ time or specific man hours, square footage percentage of shared facilities and infrastructure costs dedicated to the Company activities and specific reimbursement for services performed by third parties for NantWorks for the direct benefit of the Company. The Company was billed for such services at cost, without mark-up or profit for NantWorks, but including reasonable allocations of employee benefits, facilities and other direct or fairly allocated indirect costs that relate to the employees providing the services. The Company incurred $1,679 and $2,230 of expenses during the years ended December 31, 2018 and December 31, 2017, respectively, related to general and administrative services provided by NantWorks and its affiliates under this agreement. Such charges and allocations are not necessarily indicative of what would have been incurred if the Company had hired a third party to perform these services.

Purchase of Property and Equipment

On June 24, 2016, the Company entered into an agreement with NantHealth UK, Ltd. (“NantHealth UK”), a wholly owned subsidiary of NantHealth, whereby the Company purchased storage and other computer equipment from NantHealth UK in exchange for a cash payment of $144. The purchase price represented the net book value of the equipment as of the effective date. The Company accounted for the asset acquisition at carryover basis because NantHealth UK and the Company are under common control. The amount owed to NantHealth UK is classified within related party payables on the consolidated balance sheet as of December 31, 2018 and December 31, 2017, respectively.

Sale of Fixed Assets

On April 30, 2018 and May 31, 2018 OncoPlex and NantOmics entered into an agreement and subsequent amendment whereby OncoPlex and NantOmics sold various fixed assets to an affiliate of the Company. The purchase price of $8,363 represented the net book value of the fixed assets as of the transaction date. The Company accounted for the asset sale at carryover basis because the affiliate to which the fixed assets were sold and the Company are under common control.

Related Party Notes Receivable

On September 4, 2015, Mox Networks, LLC (“Mox”), an affiliate of the Company, executed a demand promissory note in favor of the Company. The principal amount of the initial advance made by the Company to Mox totaled $10,000. On February 24 and March 8, 2016, the Company advanced an additional $5,559 and $14,000, respectively, to Mox under the demand promissory note executed on September 4, 2015. The note receivable bears interest at a per annum rate of 8.0%, compounded annually and computed on the basis of the actual number of days elapsed and a year of 365 or 366 days, as the case may be. As of December 31, 2018, and December 31, 2017, the total interest receivable on this note was $7,112 and $4,595, respectively, and is included in related party notes receivable on the consolidated balance sheet. The unpaid principal and any accrued and unpaid interest on the note receivable are due and payable by Mox on demand by the Company. Mox may prepay the outstanding amount at any time, either in whole or in part, without premium or penalty and without the prior consent of the Company.

The Company does not have any representation on Mox’s Board of Directors and does not otherwise have the power over the activities that most significantly impact its economic performance. As a result, while Mox is a variable interest entity, the Company is not considered the primary beneficiary of Mox. The unpaid principal and accrued and unpaid interest on the note receivable represents the Company’s maximum exposure to loss as of December 31, 2018 and December 31, 2017 as the Company had not committed to providing additional financial support to Mox. See Note 6 for disclosures related to the Company’s involvement with other variable interest entities.

On January 4, 2016, Nant Capital, LLC ("NantCapital"), an affiliate of the Company, executed a demand promissory note in favor of the Company. The principal amount of the advance made by the Company to NantCapital totaled $112,666. The note receivable bears interest at a per annum rate of 5.0%, compounded annually and computed on the basis of the actual number of days elapsed and a year of 365 or 366 days, as the case may be. As of December 31, 2018 and 2017, the total interest receivable on this note was $17,708 and $11,500, respectively, and is included in related party notes receivable on the consolidated balance sheet. The unpaid principal and any accrued and unpaid interest on the note receivable are due and payable by NantCapital on demand by the Company in either (i) cash, (ii) equity of NantHealth, to the extent such equity is owned by NantCapital, (iii) Series A-2 units of the Company or (iv) any combination of the foregoing, all at the option of the Company. Subject to the preceding sentence, NantCapital may prepay the outstanding amount at any time, either in whole or in part, without premium or penalty and without the prior consent of the Company.

Investment in NantHealth

On January 22, 2016, NantHealth executed a demand promissory note in favor of the Company. The principal amount of the initial advance made by the Company to NantHealth totaled $20,000. On March 8, 2016, the Company made a second advance to NantHealth for $20,000. Prior to the note converting into shares of NantHealth's common stock as discussed below, the note receivable bore interest at a per annum rate of 5.0%. In May and June of 2016, NantHealth executed amendments to the demand promissory note in favor of the Company which provide that all unpaid principal of each advance owed to the Company and any accrued and unpaid interest would convert automatically into shares of NantHealth's common stock after pricing of NantHealth's initial public offering and immediately after conversion of NantHealth from a limited liability company to a corporation, based on the initial public offering price of NantHealth's common stock. On June 1, 2016, approximately $40,590 of principal and accrued interest on the note was converted into approximately 2,899 shares of NantHealth's common stock, representing approximately 2.4% of NantHealth's common stock then outstanding.

As of December 31, 2017, the Company's investment in NantHealth had a cost basis of $28,819 and a fair value of $8,843. The Company concluded that the unrealized $19,976 loss was other-than-temporary based on the decline in the fair value of NantHealth's common stock since the investment was previously impaired as of December 31, 2016. As of December 31, 2018, the Company's investment in NantHealth had a cost basis of $8,843 and a fair value of $1,578. The Company concluded that the unrealized $7,265 loss was other-than-temporary based on the decline in the fair value of NantHealth's common stock since the investment was previously impaired as of December 31, 2017. The Company currently does not intend to dispose of its NantHealth common stock. The other-than-temporary impairments of $7,265 and $19,976 are classified within impairments on equity investments in the consolidated and combined statement of operations and comprehensive loss for the years ended December 31, 2018 and December 31, 2017, respectively.

Related Party Payables

As of December 31, 2018 and 2017, the Company had related party payables of $12,848 and $7,783, respectively. The related party payables balance at December 31, 2018 primarily consisted of $3,026 of borrowings from an affiliate, $2,729 owed to NantWorks pursuant to the Shared Services Agreement, and $6,733 for accrued and unpaid interest on the related party promissory notes. The related party payables balance at December 31, 2017 primarily consisted of $3,026 of borrowings from an affiliate, $1,826 owed to NantWorks pursuant to the Shared Services Agreement, and $2,322 for accrued and unpaid interest on the related party promissory notes.

Related Party Promissory Notes Payable

On May 1, 2014, the Company executed a convertible demand promissory note with NantWorks. The outstanding principal amount of advances made by the related party to the Company pursuant to these notes totaled $296 and $296 as of December 31, 2018 and 2017, respectively. On January 22 and March 30, 2016, the Company transferred to NantWorks marketable securities having a fair value of $8,730 and made a cash payment of $1,236 as a partial repayment of multiple advances made pursuant to the convertible demand promissory note in favor of NantWorks. The repayment amounts consisted of $9,483 of principal and $483 of accrued interest. The note bears interest at a per annum rate of 3.0%, compounded annually and computed on the basis of the actual number of days in a year. NantWorks may, at its sole discretion, and at any time, convert the aggregate amount of the unpaid principal and any accrued and unpaid interest on the convertible promissory note into equity securities of the Company. As of December 31, 2018 and 2017, the total interest outstanding on this note amounted to $25 and $16, respectively, and is included in related party payables in the consolidated balance sheets.

On September 14, 2016, the Company executed a demand promissory note with NantCapital. The principal amount of advances made by NantCapital to the Company pursuant to these notes totaled $86,349 and $61,388 as of December 31, 2018 and 2017, respectively. The note bears interest at a per annum rate of 5.0%, compounded annually and computed on the basis of 365 or 366 days, as the case may be. As of December 31, 2018 and 2017, the total interest outstanding on this note amounted to $6,484 and $2,213, respectively, and is included in related party payables on the consolidated balance sheet.

On April 27, 2011, TRM executed a demand promissory note with an affiliate. The principal amount of the advance made by the related party to TRM totaled $75 as of December 31, 2018 and December 31, 2017. The note bears interest at a per annum rate of 5.0%, compounded annually. In December 2017, this note was assigned to NantOmics as part of the dissolution of TRM (see Note 5). As of December 31, 2018 and 2017, the total interest outstanding on this note amounted to $34 and $29, respectively, and is included in related party payables on the consolidated balance sheet.

On January 24, 2017, the Company executed a demand promissory note with an affiliate. The principal amount of advances made by the affiliate to the Company pursuant to these notes totaled $1,160 as of December 31, 2018 and December 31, 2017. The note bears interest at a per annum rate of 5.0%, compounded annually and computed on the basis of 365 or 366 days, as the case may be. As of December 31, 2018 and December 31, 2017, the total interest outstanding on this note amounted to $114 and $54 respectively, and is included in related party payables on the consolidated balance sheet.

On March 1, 2017, Liquid Genomics executed a promissory note with NantWorks. The principal amount of the advance made by the related party to Liquid Genomics totaled $250 as of December 31, 2017. The note bears interest at a per annum rate of 5.0%, compounded annually. As of December 31, 2017, the total interest outstanding on this note amounted to $10 and is included in related party payables on the consolidated balance sheet. On February 28, 2018, the Company sold its 100% interest in Liquid Genomics to NantHealth pursuant to an assignment agreement dated February 1, 2018 (see Note 3).

On September 1, 2018, NantOmics executed a demand promissory note with an affiliate. The principal amount of advances made by the affiliate to NantOmics pursuant to this note totaled $4,936 as of December 31, 2018. The note bears interest at a per annum rate of 5%, compounded annually and computed on the basis of 365 or 366 days, as the case may be. As of December 31, 2018, the total interest outstanding on this note amounted to $75, and is included in related party payables on the consolidated balance sheet.

The unpaid principal and any accrued and unpaid interest on the convertible promissory note and all of the promissory notes with the related parties are due and payable on demand. The Company and its subsidiaries may prepay the outstanding amounts at any time, either in whole or in part, without premium or penalty.

Deemed Capital Contribution by Parent

In 2018 and 2017, the Company benefited from the use of certain equipment owned by an entity controlled by NantWorks. The Company recorded a non-cash expense of $177 and $402 and a corresponding capital contribution on behalf of NantWorks in the consolidated and combined financial statements for the year ended December 31, 2018 and 2017, respectively. The amount of the expense represents the depreciation expense that the Company would have recognized had it owned such assets during the period of use.

Related Party Sublease Income

In January 2017, OncoPlex entered into a sublease agreement with Precision Biologics, Inc. ("Precision Biologics"),a related party, related to its Rockville, Maryland, laboratory and office space, with an initial lease from November 1, 2016 through March 31, 2022. The sublease includes a portion of the premises consisting of approximately 3,758 rentable square feet of space. The monthly base rent is $7 per month, with an annual 3% increase. The lease was subsequently terminated on April 10, 2018. For the year ended December 31, 2018 and December 31, 2017, the Company recognized $28 and $97 in other income on the consolidated statement of operations under the sublease agreement.

14. Subsequent Events

The Company has evaluated subsequent events through March 29, 2019, the date on which the consolidated and combined financial statements were available to be issued. There are no significant events that require disclosure in these consolidated and combined financial statements.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

Our disclosure controls and procedures are designed to ensure that information required to be disclosed in the reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms and that such information is accumulated and communicated to management, including the Chief Executive Officer and Chief Financial Officer, to allow timely decisions regarding required disclosure.

Under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, we conducted an evaluation of the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act) as of the end of the period covered by this report. Based on this evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were not effective as of such date due to a material weakness in our internal control over financial reporting related to our valuations of the Bookings Commitment liability and our related party equity method investment in NantOmics. As described below, we are implementing procedures to ensure that our disclosure controls and procedures are effective in the future.

Management’s Annual Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting. Internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles (“GAAP”). Internal control over financial reporting includes policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are transacted in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company’s assets that could have a material effect on the financial statements.

Our management, under the supervision of our Chief Executive Officer and Chief Financial Officer, conducted an assessment of the effectiveness of its internal control over financial reporting as of December 31, 2018 based on the criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (“COSO”). Based on this assessment, management concluded that our internal control over financial reporting was not effective as of December 31, 2018 because of the material weakness described below.

A material weakness is defined as “a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the Company’s annual or interim financial statements will not be prevented or detected on a timely basis.”

Management identified the following material weakness related to its valuations of the Bookings Commitment liability and the Company's related party equity method investment in NantOmics that has caused management to conclude that as of December 31, 2018, our internal control over financial reporting was not effective:

- Management failed to design internal controls surrounding certain complex and non-recurring transactions that would support the identification of and consideration of all evidence in reaching certain accounting conclusions. Accordingly, management’s control activities did not effectively i) consider all required elements needed to support the measurement of fair value of a liability or ii) assess the reasonableness of assumptions underlying prospective financial information used in the fair value measurement of the Company’s investment in a related party.

Remediation Actions

The Company has implemented an agenda-driven meeting between Sales and Accounting leadership wherein specific elements of the Bookings Commitment (potential customers, amounts, expected dates and market factors) are discussed. This will allow for supporting evidence to be reviewed and the key unobservable inputs for management’s fair value measurement of the liability to be

quantified. This new control will be performed at least quarterly and will engage key Company personnel to obtain measurement inputs as well as to integrate external economic data which impact the valuation.

The Company has implemented a control whereby the best available input assumptions and financial forecasts relative to NantOmics will be obtained timely so that detailed analyses of the Company's investment in NantOmics can be assessed for impairment. Such analyses will require review and approval.

Changes in Internal Control Over Financial Reporting

Except for the identification of the material weakness described above, there were no changes to our internal control over financial reporting identified in connection with the evaluation required by Rule 13a-15(d) and 15d-15(d) of the Exchange Act that occurred during the quarter ended December 31, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations in the Effectiveness of Controls

Management recognizes that a control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints and that management is required to apply its judgment in evaluating the benefits of possible controls and procedures relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud or error, if any, have been detected. These inherent limitations include the realities that judgments in decision making can be faulty, and that breakdowns can occur because of a simple error or mistake. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. The design of any system of controls also is based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions; over time, controls may become inadequate because of changes in conditions, or the degree of compliance with policies or procedures may deteriorate. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected.

Item 9B. Other Information

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The information required by this item will be contained in our definitive proxy statement to be filed with the Securities and Exchange Commission on Schedule 14A in connection with our 2019 Annual Meeting of Stockholders "Proxy Statement", which is expected to be filed not later than 120 days after the end of our fiscal year ended December 31, 2018, and is incorporated herein by reference.

Item 11. Executive Compensation

The information required by this item will be contained in the Proxy Statement under the heading "Executive Compensation" and "Director Compensation," and is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The information required by this item will be contained in the Proxy Statement under the headings "Security Ownership of Certain Beneficial Owners and Management" and "Equity Compensation Plan Information," and is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by this item will be contained in the Proxy Statement under the headings “Security Ownership of Certain Beneficial Owners and Management” and “Equity Compensation Plan Information,” and is incorporated herein by reference.

Item 14. Principal Accounting Fees and Services

The information required by this item will be contained in the Proxy Statement under the heading “Principal Accounting Fees and Services” and is incorporated herein by reference.

PART IV

Item 15. Exhibits, Financial Statement Schedules

(a) The consolidated financial statements schedules and exhibits filed as part of this Annual Report on Form 10-K are as follows:

(1) Consolidated financial statements

Reference is made to the consolidated financial statements identified in the “Index to Financial Statements” under Part II, Item 8 of this Annual Report.

(2) Financial Statement Schedules

All other schedules not listed above have been omitted because the information required to be set forth therein is not applicable or is otherwise in the consolidated financial statements or notes thereto.

(3) Exhibits

The documents listed in the Exhibit Index of this Annual Report are incorporated by reference or are filed with this Annual Report, in each case as indicated therein (numbered in accordance with Item 601 of Regulation S-K).

Exhibits Index

The exhibits listed in the accompanying index to exhibits are filed as part of, or incorporated by reference into, this Annual Report on Form 10-K.

		Incorporated by Reference				
Number	Exhibit Title	Form	File No.	Exhibit	Filing Date	Filed Herewith
3.1	Amended and Restated Certificate of Incorporation.	10-Q	001-37792	3.1	August 15, 2016	
3.2	Amended and Restated Bylaws.	10-Q	001-37792	3.2	August 15, 2016	
10.1.1+	Second Amended and Restated NantOmics Exclusive Reseller Agreement, dated as of September 20, 2016, by and between the Registrant and NantOmics, LLC.	10-Q	001-37792	10.1	November 10, 2016	
10.1.2+	Amended and Restated NantOmics Exclusive Reseller Agreement, dated as of May 9, 2016, by and between the Registrant and NantOmics, LLC.	S-1/A	333-211196	10.1	June 1, 2016	
10.2+	NantHealth License Agreement, dated June 19, 2015, by and between the Registrant and NantOmics, LLC, as amended.	S-1/A	333-211196	10.2	June 1, 2016	
10.3#	2016 Equity Incentive Plan and form of agreement thereunder.	8-K	001-37792	10.1	June 11, 2018	
10.4#	2016 Executive Incentive Compensation Plan.	S-1	333-211196	10.13	May 6, 2016	
10.5	Amended and Restated Promissory Note, between Registrant and NantCapital LLC, dated May 9, 2016.	S-1/A	333-211196	10.18	May 11, 2016	
10.6	Amended and Restated Promissory Note, between Registrant and NantOmics, LLC, dated May 23, 2016.	S-1/A	333-211196	10.19	May 24, 2016	
10.7	Side Letter Agreement, between Registrant and NantWorks, LLC, dated May 22, 2016.	S-1/A	333-211196	10.21	May 23, 2016	
10.8	Indenture, dated December 21, 2016, between NantHealth, Inc. and U.S. Bank National Association.	8-K	001-37792	10.2	December 21, 2016	
10.9	Form of 5.50% Convertible Senior Note due 2021 (included in Exhibit 4.1).	8-K	001-37792	4.1	December 21, 2016	
10.10	Purchase Agreement, dated December 15, 2016, by and among NantHealth, Inc. and J.P. Morgan Securities LLC and Jefferies LLC, as representative of the initial purchasers named therein.	8-K	001-37792	10.1	December 21, 2016	
10.11	Purchase Agreement, dated December 15, 2016, by and between NantHealth, Inc. and Cambridge Equities, L.P..	8-K	001-37792	10.2	December 21, 2016	
10.12	Second Amended and Restated Promissory Note, dated December 15, 2016, by and between NantHealth, Inc. and Nant Capital LLC.	8-K	001-37792	10.3	December 21, 2016	
10.13	Asset Purchase Agreement dated as of August 3, 2017, between Allscripts Healthcare Solutions, Inc. and NantHealth Inc.	8-K	001-37792	2.1	August 31, 2017	
10.14+	Amendment No.1 to Second Amended and Restated Reseller Agreement, dated December 18, 2017, by and between NantHealth, Inc. and NantOmics, LLC.	10-K	001-37792	10.14	March 16, 2018	
10.15	Assignment Agreement, dated February 1, 2018, by and between the Company and NantOmics, LLC.	10-Q/A	001-37792	10.1	July 11, 2018	

Number	Exhibit Title	Incorporated by Reference				Filed Herewith
		Form	File No.	Exhibit	Filing Date	
10.16	Promissory note dated August 8, 2018, by the Company to the benefit of Nant Capital, LLC.	10-Q	001-37792	10.1	August 9, 2018	
10.17#	Amended and Restated Consulting Agreement dated September 12, 2018, between the Company and Mr. Bob Petrou	10-Q	001-37792	10.2	November 21, 2018	
10.18#	Transition Agreement and Release dated September 11, 2018, between the Company and Mr. Paul Holt	10-Q	001-37792	10.3	November 21, 2018	
21.1	Subsidiaries					X
23.1	Consent of Ernst & Young LLP					X
23.2	Consent of Mayer Hoffman McCann, P.C.					X
23.3	Consent of Ernst & Young LLP					X
24.1	Power of Attorney (Contained on Signature Page to this Annual Report on Form 10-K).					X
31.1	Certification of Principal Executive Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.					X
31.2	Certification of Principal Financial Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.					X
32.1 *	Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.					X
32.2 *	Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.					X
101.INS**	XBRL Instance Document.					X
101.SCH**	XBRL Taxonomy Extension Schema Document.					X
101.CAL**	XBRL Taxonomy Extension Calculation Linkbase Document.					X
101.DEF**	XBRL Taxonomy Extension Definition Linkbase Document.					X
101.LAB**	XBRL Taxonomy Extension Label Linkbase Document.					X
101.PRE**	XBRL Taxonomy Extension Presentation Linkbase Document.					X

Represents a management contract or compensatory plan.

+ Confidential treatment granted with respect to certain portions of this exhibit. Omitted portions filed separately with the Securities and Exchange Commission.

* As contemplated by SEC Release No. 33-8212, these exhibits are furnished with this Annual Report on Form 10-K and are not deemed filed with the Securities and Exchange Commission and are not incorporated by reference in any filing of NantHealth, Inc. under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, whether made before or after the date hereof and irrespective of any general incorporation language contained in such filings.

** XBRL (eXtensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of sections 11 or 12 of the Securities Act of 1933, as amended, is deemed not filed for purposes of section 18 of the Securities Exchange Act of 1934, as amended, and is otherwise not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, as amended, the Registrant has duly caused this Annual Report on Form 10-K to be signed on its behalf by the undersigned, thereunto duly authorized.

NantHealth, Inc.

Date: March 29, 2019

By: /s/ Patrick Soon-Shiong
Name: Patrick Soon-Shiong
Its: Chairman, Chief Executive Officer and Director
(Principal Executive Officer)

By: /s/ Bob Petrou
Name: Bob Petrou
Its: Chief Financial Officer
(Principal Financial and Accounting Officer)

POWER OF ATTORNEY

Each person whose signature appears below constitutes and appoints Patrick Soon-Shiong and Bob Petrou, and each of them, as his or her true and lawful attorney-in-fact and agent, with full power of substitution and resubstitution, for him or her and in his or her name, place and stead, in any and all capacities, to sign any and all amendments to this Annual Report on Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact and agents, and each of them, full power and authority to do and perform each and every act and thing requisite and necessary to be done in connection therewith, as fully to all intents and purposes as he or she might or could do in person, hereby ratifying and confirming all that said attorneys-in-fact and agents, or any of them, or their or his substitutes, may lawfully do or cause to be done by virtue thereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this Annual Report on Form 10-K has been signed below by the following persons on behalf of the Registrant in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Patrick Soon-Shiong Patrick Soon-Shiong	Chairman, Chief Executive Officer and Director (Principal Executive Officer)	March 29, 2019
/s/ Bob Petrou Bob Petrou	Chief Financial Officer (Principal Financial and Accounting Officer)	March 29, 2019
/s/ Ron Louks Ron Louks	Chief Operating Office and Director	March 29, 2019
/s/ Michael S. Sitrick Michael S. Sitrick	Director	March 29, 2019
/s/ Kirk K. Calhoun Kirk K. Calhoun	Director	March 29, 2019
/s/ Michael Blaszyk Michael Blaszyk	Director	March 29, 2019

Exhibit 21.1

NantHealth, Inc.

Subsidiaries

Name of Subsidiary	Jurisdiction of Organization
NaviNet, Inc.	Delaware
NaviNet Limited	United Kingdom
Assisteo Holding, Inc.	Delaware
AZ Home Health, LLC	Delaware
NantHealth Labs, Inc.	Delaware
NantHealth Singapore Pte Ltd	Singapore
New Nant Health Canada, Inc.	Canada

Note : Subsidiary companies excluded from the above listing, if considered in the aggregate, would not constitute a significant subsidiary.

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3 No. 333-223744) of NantHealth, Inc., and

(2) Registration Statement (Form S-8 Nos. 333-211886 and 333-225670) pertaining to the 2016 Equity Incentive Plan and Phantom Unit Plan of NantHealth, Inc.

of our report dated March 29, 2019 , with respect to the consolidated financial statements of NantHealth, Inc., included in this Annual Report (Form 10-K) of NantHealth, Inc. for the year ended December 31, 2018 .

/s/ Ernst & Young LLP

Los Angeles, California

March 29, 2019

Exhibit 23.2

Consent of Independent Auditors

We hereby consent to the incorporation by reference in the registration statements (Nos. 333-211886 and 333-225670) on Form S-8 and (No. 333-223744) on Form S-3 of NantHealth, Inc. of our report dated March 16, 2018, with respect to the consolidated and combined financial statements of NantOmics, LLC and subsidiaries, which comprise the consolidated balance sheet as of December 31, 2017, and the related consolidated and combined statements of operations and comprehensive loss, changes in members' equity, and cash flows for the year ended December 31, 2017, and the related notes to the consolidated and combined financial statements, which report appears in the Annual Report on Form 10-K of NantHealth, Inc. for the year ended December 31, 2018.

/s/ Mayer Hoffman McCann, P.C.

Los Angeles, California

March 29, 2019

Exhibit 23.3

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3 No. 333-223744) of NantHealth, Inc., and

(2) Registration Statement (Form S-8 Nos. 333-211886 and 333-225670) pertaining to the 2016 Equity Incentive Plan and Phantom Unit Plan of NantHealth, Inc.

of our report dated March 29, 2019 with respect to the consolidated financial statements of NantOmics, LLC and subsidiaries, which comprise the consolidated balance sheet as of December 31, 2018 , and the related consolidated statements of operations and comprehensive loss, changes in members' equity, and cash flow for the year ended December 31, 2018 , and the related notes to the consolidated financial statements.

/s/ Ernst & Young LLP

Los Angeles, California

March 29, 2019

Exhibit 24.1

POWER OF ATTORNEY

Each person whose signature appears below constitutes and appoints Patrick Soon-Shiong and Bob Petrou, and each of them, as his or her true and lawful attorney-in-fact and agent, with full power of substitution and resubstitution, for him or her and in his or her name, place and stead, in any and all capacities, to sign any and all amendments to this Annual Report on Form 10-K, and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, granting unto said attorneys-in-fact and agents, and each of them, full power and authority to do and perform each and every act and thing requisite and necessary to be done in connection therewith, as fully to all intents and purposes as he or she might or could do in person, hereby ratifying and confirming all that said attorneys-in-fact and agents, or any of them, or their or his substitutes, may lawfully do or cause to be done by virtue thereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this Annual Report on Form 10-K has been signed below by the following persons on behalf of the Registrant in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Patrick Soon-Shiong Patrick Soon-Shiong	Chairman, Chief Executive Officer and Director (Principal Executive Officer)	March 29, 2019
/s/ Bob Petrou Bob Petrou	Chief Financial Officer (Principal Financial and Accounting Officer)	March 29, 2019
/s/ Ron Louks Ron Louks	Chief Operating Officer and Director	March 29, 2019
/s/ Michael S. Sitrick Michael S. Sitrick	Director	March 29, 2019
/s/ Kirk K. Calhoun Kirk K. Calhoun	Director	March 29, 2019
/s/ Mark Burnett Mark Burnett	Director	March 29, 2019
/s/ Michael Blaszyk Michael Blaszyk	Director	March 29, 2019

Exhibit 31.1

CERTIFICATION OF CHIEF EXECUTIVE OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Patrick Soon-Shiong, certify that:

1. I have reviewed this Annual Report on Form 10-K of NantHealth, Inc.;

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

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

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

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

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

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

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

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

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

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

Date: March 29, 2019

By: /s/ Patrick Soon-Shiong
Dr. Patrick Soon-Shiong
Chairman, Chief Executive Officer and Director
(Principal Executive Officer)

Exhibit 31.2

CERTIFICATION OF CHIEF FINANCIAL OFFICER
PURSUANT TO SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Bob Petrou, certify that:

1. I have reviewed this Annual Report on Form 10-K of NantHealth, Inc.;

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

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

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

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

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

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

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

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

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

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

Date: March 29, 2019

By: /s/ Bob Petrou
Bob Petrou
Chief Financial Officer
(Principal Financial and Accounting Officer)

Exhibit 32.1

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

Pursuant to the requirement set forth in Rule 13a-14(b) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and Section 1350 of Chapter 63 of Title 18 of the United States Code (18 U.S.C. §1350), I, Patrick Soon-Shiong, hereby certify that, to my knowledge:

(i) the Company's Annual Report on Form 10-K for the year ended December 31, 2018 to which this Certification is attached as Exhibit 32.1 (the "Report") fully complies with the requirements of section 13(a) or 15(d) of the Exchange Act, and

(ii) that the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of NantHealth, Inc.

Date: March 29, 2019

By: /s/ Patrick Soon-Shiong
Dr. Patrick Soon-Shiong
Chairman, Chief Executive Officer and Director
(Principal Executive Officer)

This certification accompanies the Annual Report on Form 10-K to which it relates, is not deemed filed with the Securities and Exchange Commission and is not to be incorporated by reference into any filing of NantHealth, Inc. under the Securities Act of 1933, as amended, or the Exchange Act (whether made before or after the date of the Form 10-K), irrespective of any general incorporation language contained in such filing.

Exhibit 32.2

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

Pursuant to the requirement set forth in Rule 13a-14(b) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and Section 1350 of Chapter 63 of Title 18 of the United States Code (18 U.S.C. §1350), I, Bob Petrou, hereby certify that, to my knowledge:

(i) the Company's Annual Report on Form 10-K for the year ended December 31, 2018 to which this Certification is attached as Exhibit 32.2 (the "Report") fully complies with the requirements of section 13(a) or 15(d) of the Exchange Act, and

(ii) that the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of NantHealth, Inc.

Date: March 29, 2019

By: /s/ Bob Petrou
Chief Financial Officer
(Principal Financial and Accounting Officer)

This certification accompanies the Annual Report on Form 10-K to which it relates, is not deemed filed with the Securities and Exchange Commission and is not to be incorporated by reference into any filing of NantHealth, Inc. under the Securities Act of 1933, as amended, or the Exchange Act (whether made before or after the date of the Form 10-K), irrespective of any general incorporation language contained in such filing.

Office Ally, Inc.

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Red Card Holdings, LLC

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Symphony Performance Health Holdings, Inc.

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Unite USA, Inc.

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Welltok, Inc.

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Attachment F

Kentucky | Transforming Health Care | **Aetna**

Attachment F
Litigation Tables

Table A - Aetna Better Health of Kentucky Litigation ..... Att F-3

Table B - Aetna's Medicaid Litigation in States Other than Kentucky..... Att F-11

Table C - Aetna's Medicare Litigation ..... Att F-17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare ..... Att F-25

Table E - CVS Health Litigation ..... Att F-357

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Table A - Aetna Better Health of Kentucky Litigation

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Table A - Aetna Better Health of Kentucky Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Franklin Circuit Court, KY, No. 13-CI-118	J.T., a minor, by and through his Guardian Jamie Daniel v. Commonwealth of Kentucky, Coventry Health and Life Insurance Company, et al.	2/1/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	1/13/15
26th Judicial Circuit Court, Harlan County, KY, No. 13-CI-0090	Ison, Lenville v. Coventry Health and Life Insurance Company, Inc. d/b/a Coventry Cares of Kentucky, et al.	2/14/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/21/18
26th Judicial Circuit Court, Harlan County, KY, No. 13-CI-0167	Coots, Tina v. Commonwealth of Kentucky, Coventry Health and Life Insurance Company, et al.	3/22/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	3/24/16
Circuit Court of Clark County, 2nd Division, KY, No. 13-CI-00245	Wilson, Jennifer and Brandon McCoy v. Coventry Cares of Kentucky, a product of Coventery Health and Life Insurance Co.; Chamberlain Clinic; and Jeffrey D. Chamberlain, M.D.	5/14/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/30/15
26th Judicial Circuit Court of Harlan County, KY, No. 13-CI-00334	Lindsay, Robert v. Commonwealth of Kentucky; Cabinet for Health and Family Services; Coventry Health and Life Insurance Company d/b/a CoventryCares of Kentucky	6/10/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/7/18

Table A - Aetna Better Health of Kentucky Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
26th Judicial Circuit Court, Harlan County, KY, No. 13-CI-00345	Lankford, Myrtle v. Commonwealth of Kentucky's Cabinet for Health and Family Services; Coventry Health and Life Insurance Company d/b/a CoventryCares of Kentucky	6/18/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/23/19
26th Judical Circuit Court, Harlan County, KY, No. 13-CI-00717	Wilson, Christopher v. Commonwealth of Kentucky; Cabinet for Health and Family Services; Coventry Health and Life Insurance Company d/b/a Coventry Cares of Kentucky	12/20/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/7/18
26th Judicial Circuit Court, Harlan County, KY, No. 13-CI-00721	Carroll, Alexis, a minor, by and through her next friend and authorized respresentative, Phyllis Wilson v. Commonwealth of Kentucky; Cabinet for Health and Family Services; Coventry Health and Life Insurance Company d/b/a CoventryCares of Kentucky	12/26/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/7/18
26th Judicial Circuit, Harlan Circuit Court, KY, No. 14-CI-00049	Bowyer, Paula v. Commonwealth of Kentucky; Cabinet for Health and Family Services; Coventry Health and Life Insurance, Inc. d/b/a Coventry Cares of Kentucky	2/7/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/12/18
Harlan County Circuit Court, 26th Judicial Circuit, KY, No. 14-CI-00101	Middleton, Judy v. Commonwealth of Kentucky; Cabinet for Health and Family Services; Coventry Health and Life Insurance Company d/b/a CoventryCares of Kentucky	3/7/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/8/18

Table A - Aetna Better Health of Kentucky Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Western District of Kentucky, Louisville Division, No. 3:14-CV-291-S	E.D., by and through her adoptive parents, Cynthia and Daniel Davies v. Audrey Tayse Haynes; Lawrence Kissner; and Coventry Health and Life Insurance Company	4/4/14	Benefit Coverage Determination	Unspecified	None	Closed - Complaint Withdrawn	10/17/14
Circuit Court, Franklin County, KY, No. 14-CI-00463	Lachance, Tanya, as parent and guardian of L.L., a minor v. Commonwealth of Kentucky; Cabinet for Health and Family Services; and Coventry Health and Life Insurance Corporation dba CoventryCares of Kentucky	4/16/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/15/18
26th Judicial Circuirt, Harlan Circuit Court, Commonwealth of KY, No. 14-CI-0024	Hornsby, Linda v. Commonwealth of Kentucky; Cabinet For Health and Family Services; Coventry Health and Life Insurance Company d/b/a CoventryCares of Kentucky	5/8/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/8/18
44th Judicial Circuit Court, Bell Circuit Court, Commonwealth of Kentucky, 14-CI-00274	Gore, Donald v. Commonwealth of Kentucky; Cabinet for Health and Family Services; Coventry Health and Life Insurance Company d/b/a Coventry Cares of Kentucky	7/9/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/12/18
Jefferson County Circuit Court, KY, No. 14 CI 006016	E.D., by and through her adoptive parents, Cynthia and Daniel Davies v. Coventry Health and Life Insurance Company	11/20/14	Benefit Coverage Determination	Unspecified	None	Closed - Administrative Procedure - Aetna Favor	9/14/15

Table A - Aetna Better Health of Kentucky Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Harlan County Circuit Court, Commonwealth of Kentucky, No. 14-CI-00542	Sexton, Lettie, by and through her authorized representative, Appalachian Regional Healthcare, Inc. v. Coventry Health and Life Insurance Company d/b/a CoventryCares, Inc.; Commonwealth of Kentucky; and Cabinet for Health and Family Services	11/25/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	12/24/19
26th Judicial Circuit Court, Harlan County, KY, No. 14-CI-00548	Skidmore, Tina v. Commonwealth of Kentucky; Cabinet for Health and Family Services; Coventry Health and Life Insurance Company d/b/a CoventryCares of Kentucky	11/26/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/21/18
Commonwealth of Kentucky, Franklin Circuit Court, No. 14-CI-1533	L.J., a minor, by and through her guardian Becky Johnson v. Commonwealth of Kentucky; Cabinet for Health and Family Services; Department for Medicaid Services; and Coventry Health and Life Insurance Company	12/23/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/23/19
26th Judicial Circuit Court, Harlan Circuit, KY, No. 15-CI-00005	Smith, Leslie v. Commonwealth of Kentucky, Cabinet for Health and Family Services; Coventry Health and Life Insurance Company d/b/a Coventry Cares of Kentucky	1/5/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/8/18
26th Judicial Circuit, Harlan Circuit Court, KY, No. 15-CI-00004	Blevins, Timothy v. Commonwealth of Kentucky, Cabinet for Health and Family Services; Coventry Health and Life Insurance Company d/b/a Coventry Cares of Kentucky	1/5/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/7/18

Table A - Aetna Better Health of Kentucky Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Commonwealth of Kentucky, Clay County Circuit Court, No. 15-CI-00027	Collins, Harold, by and through his authorized representative, Appalachian Regional Healthcare, Inc. v. Commonwealth of Kentucky; Cabinet for Health and Family Services; and Coventry Health and Life Insurance Company d/b/a CoventryCares/MHNET Behavioral Health	2/13/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/7/18
Commonwealth of Kentucky, Letcher County Circuit Court, No. 15-CI-00038	Osborne, Carl, by and through his authorized representative, Appalachian Regional Healthcare, Inc. v. Commonwealth of Kentucky; Cabinet for Health and Family Services; and Coventry Health and Life Insurance Company d/b/a CoventryCares/MHNET Behavioral Health	2/13/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/7/18
Commonwealth of Kentucky, Circuit Court, Franklin County, No. 15-CI-783	Davies, Cynthia and Daniel, as parents and guardians of E.D., a minor v. Commonwealth of Kentucky; Cabinet for Health and Family Services; and Coventry Health and Life Insurance Company d/b/a CoventryCares of Kentucky	7/21/15	Benefit Coverage Determination	Unspecified	None	Open	
Circuit Court, Franklin County, KY, No. 15-CI-858	Stephen Lawson v. Commonwealth of Kentucky; Cabinet for Health and Family Services; Department for Medicaid Services; and Coventry Health and Life Insurance Company d/b/a CoventryCares of Kentucky	8/7/15	Benefit Coverage Determination	Unspecified	None	Open	
Commonwealth of Kentucky, Circuit Court, Franklin County, No. 15-CI-001046	Cornett, Christopher v. Coventry Heatlh and Life Insurance Company a/k/a CoventryCares of Kentucky; Cabinet for Health and Family Services; and Commonwealth of Kentucky	9/28/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/21/18

Table A - Aetna Better Health of Kentucky Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Commonwealth of Kentucky, Floyd Circuit Court, No. 15-CI-00800	Dye, Trenity, by and through his authorized representative, Appalachian Regional Healthcare, Inc. v. Commonwealth of Kentucky; Cabinet for Heatlh and Family Services; Audrey Tayse Haynes; Coventry Health and Life Insurance Company d/b/a CoventryCares d/b/a MHNet Behavioral Health	11/6/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/5/19
41st Judicial Circuit Court, Clay County, KY, No. 18-CI-108	Murrell, Nancy, as mother and next friend of Elizabeth Mickel; and Kenneth Mickel, as father and next friend of Koby Mickel v. Aetna Better Health of Kentucky Insurance Company	4/12/18	Benefit Coverage Determination	Unspecified	None	Open	

Table B - Aetna's Medicaid Litigation in States Other than Kentucky

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Table B - Aetna's Medicaid Litigation in States Other than Kentucky

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Maricopa County AZ, No. LC2011-000238-001	Harman, David v. Mercy Care Plan and Arizona Health Care Cost Containment System	4/8/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	7/11/12
Superior Court of Arizona, Maricopa County, No. LV2011 000780	Cancino, Deanna M. v. Arizona Health Care Cost Containment Administration (d/b/a AHCCCS), an Arizona state agency; Thomas J. Betlach, Director of AHCCCS; Healthcare Group of Arizona; Southwest Catholic Health Network Corporation (d/b/a Mercy Healthcare Group), an Arizona Corporation	12/9/11	Benefit Coverage Determination	Unspecified	None	Closed - Appeal/Post Trial - Aetna Favor	3/6/14
8th Judicial Circuit Court, Dupage County, IL, No. 2014MR000102	Matthews, Kevin and Andrea B. Matthews v. Aetna Better Health of Illinois	1/23/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/3/15
8th Judicial Circuit Court, Dupage County, IL, No. 2014L000670	Berry, Andrea v. Aetna Better Health; Jensen Hendrix; Toyas Jackson	7/8/14	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	12/29/14

Table B - Aetna's Medicaid Litigation in States Other than Kentucky

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Ohio, Eastern Division, No. 2:15-cv-00896-EAS-EPD	Parker, Lisa v. John McCarthy, Director, Ohio Department of Medicaid; Aetna Better Health of Ohio; CareStar, Inc.	3/16/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/27/16
Superior Court of Arizona for the County of Maricopa, No. LC2015-000370-001 DT	Swanson, Alfred v. Arizona Department of Health Services; Mercy Maricopa Integrated Care	2/26/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	8/18/17
Superior Court, Maricopa County, AZ, No. LC2016-000100-001-DT	Pomeroy, Douglas Lee v. Office of Administrative Hearings now known as Douglas Lee Pomeroy v. Arizona Department of Health Services; Mercy Maricopa Integrated Care	3/9/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	7/21/17
County Court, Miami-Dade County, FL, No. 16-17517SP23	Manopla, Maurice v. Coventry Health Care Inc. of Florida	10/17/16	Benefit Coverage Determination	Compensatory 5000.00	None	Closed - Settled	12/14/16

Table B - Aetna's Medicaid Litigation in States Other than Kentucky

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
24th Judicial District Court, Jefferson Parish, LA, No. 772133	Doe, Jane and John, individually and on behalf of their minor children W.W. and M.W. v. Aetna Better Health, Inc. d/b/a Aetna Better Health of Louisiana	5/16/17	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/24/17
Court of Common Pleas, Franklin County, OH, No. 18CV008527	Savage, Leo Victor v. Aetna Better Health of Ohio	10/11/18	Benefit Coverage Determination	Contract 5000.00 Punitive 1000000.00	None	Closed - Settled	3/4/19

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Table C - Aetna's Medicare Litigation

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Table C - Aetna's Medicare Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court in the State of Maryland, Howard County Case No.: 100100020592007	Sotirelis, James v. Aetna Insurance Company of Connecticut and First Data Merchant Services Corporation	5/10/07	Benefit Coverage Determination	Contract 129.00 Costs 80.00 Fees 150.00	None	Closed - Failure of Plaintiff to Prosecute	12/5/11
Court of Common Pleas, Philadelphia County, PA , December Term, 2009, No. 03231	O'Neal, Bonnie Lee v. Aetna and Aetna Rx Home Delivery	12/30/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/11/11
Court of Common Pleas, Allegheny County, PA, No. GD-10-4144	Kovach, Maryann as Executrix of the Estate of Richard S. Kovach, Deceased v. Coventry Health Care, Inc.; and HealthAmerica Pennsylvania, Inc.	3/10/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/3/15
Superior Court of California, County of San Bernardino, San Bernardino Distict, No. SMCDS1103057	Culverhouse, Carl R. v. Aetna Health of California Inc.	9/22/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/19/11
Marion Municipal Court, Marion, OH, No. CVF 1200620	Levering Management Inc. v. Hariett Carroll, et al. v. Aetna, Inc. and Aetna Medicare	5/11/12	Benefit Coverage Determination	Contract 25000.00 Punitive 25000.00	None	Closed - Settled	11/25/13
Superior Court of New Jersey, Special Civil Part, Middlesex County, No. DC-007982-12	Raritan Bay Medical Center v. Larry Cole and Michelle Murphy v. Aetna US Healthcare Medicare and John Does 1-10	5/18/12	Benefit Coverage Determination	Compensatory 15000.00 Fees 66.00	None	Closed - Pretrial - Judgment in Favor of Aetna	4/2/13
Ocean Special Civil Part, New Jersey, No. OCN SC-001856-12	Wetstein MD v. Frascella, Estate of William v. Aetna	7/6/12	Benefit Coverage Determination	Contract 8750.00	None	Closed - Settled	10/4/12

Table C - Aetna's Medicare Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California for the County of Riverside, No. BAS1200115	Kovacic, Marcia Louise v. Aetna Health of California Inc.	7/18/12	Benefit Coverage Determination	Compensatory 6600.00 Punitive 3400.00	None	Closed - Trial - Aetna Favor	11/27/12
Milford District Court, Milford, MA, No. 1266SC000630	Thomson, Gerald J. v. Aetna Life Insurance Company	9/21/12	Benefit Coverage Determination	Unspecified	447.28	Closed - Judgment - Against Aetna	3/11/13
Civil Court of the City of New York, Small Claims Part 45, NY, No. 133 SCQ 2013 101.	Jimenez, Damaris v. Aetna Medicare	1/22/13	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	6/20/13
Magisterial District Court 32-2-43, Delaware County, PA, No. MJ-32243-CV-0000017-2013	Gupta, Vijai P. v. Aetna	2/14/13	Benefit Coverage Determination	Compensatory 1600.00	None	Closed - Settled	7/1/13
Court of Common Pleas, Cuyahoga County, OH, No. CV 14-825246	Renaissance Health Center v. Philip Senko and Carol Senko v. Aetna Inc.	5/20/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/15/15
Philadelphia Municipal Court, First Judicial District, PA, No. SC-14-03-13-4371	GS Operator, LP a/k/a Glendale Uptown Home v. Jewel Hill v. Aetna Medicare PEBTF; Independence Blue Cross	7/3/14	Benefit Coverage Determination	Contract 7821.00	None	Closed - Trial - Aetna Favor	9/24/14
Superior Court for the District of Columbia, Civil Division, No. 2014SC2002789	Huberman, R. Carole and Sheldon Bierman v. Aetna Life Insurance Company	7/24/14	Benefit Coverage Determination	Contract 746.96	None	Closed - Settled	8/15/14

Table C - Aetna's Medicare Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court for the District of Columbia, Civil Division, DC, No. 2014 SC2 003723	Huberman, R. Carole v. Aetna Life Insurance Company	10/7/14	Benefit Coverage Determination	Contract 2029.74	None	Closed - Settled	11/10/14
15th Judicial Circuit Court, Palm Beach County, FL, No. 50 2014 CA 015453XXXXMB	Collini, Beulah M. v. Coventry Health Care	12/31/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	8/25/15
District Court of Maryland, Anne Arundel County, No. D-07-CV-15-002925	Schaaf, Gordon v. Aetna Insurance	5/5/15	Benefit Coverage Determination	Contract 155.00 Costs 38.00 Fees 200.00	None	Closed - Settled	8/12/15
Superior Court of California, County of San Diego, No. 37-2016-00004328-CU-BC-CTL	Weaver, James C. v. Aetna Health of California Inc; Does 1-100 inclusive	2/8/16	Benefit Coverage Determination	Contract 898.75	None	Closed - Settled	12/23/16
American Arbitration Association, NJ, No. 01-16-0000-9821	Carney, III, George H. v. Aetna Health Inc.	3/21/16	Benefit Coverage Determination	Compensatory 674.98 Costs 1250.00	None	Closed - Settled	7/12/16
Superior Court of California, County of Los Angeles, No. BC614769	Helmy, Abol G. v. Aetna Health of California, Inc.; and Does 1 - 50, inclusive	3/25/16	Benefit Coverage Determination	Unspecified	None	Closed - Complaint Withdrawn	7/27/16
5th Judicial Circuit Court, Marion County, FL, No. 16CC000363AX	Hubbard, Jacquelyn H. v. Juanita Ransom	5/13/16	Benefit Coverage Determination	Compensatory 15000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/8/16

Table C - Aetna's Medicare Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas, Allegheny County, PA, No. 16-008131	Wilson, Jayne E., Executor of the Estate of Francis T. Zavacky v. Coventry Health Care, Inc; Karen Wolz; Lindsay Wolz; Nationwide Mutual Insurance Company	5/13/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/9/16
U.S. District Court for the Middle District of Florida, No. 5:16-cv-337-OC-41PRL	Hubbard, Jacquelyn H. v. Christopher A. Ciano; Aetna/Coventry Healthcare of Florida	5/16/16	Benefit Coverage Determination	Compensatory 100000.00	None	Closed - Pretrial - Judgment in Favor of Aetna	12/9/16
Superior Court of New Jersey, Law Division, Union County, No. UNN-L-4237-16	Campbell, Scott v. Centerpath Behavioral Health, Inc. f/k/a UCPC Behaviorial Health; Richard Thomas, MA, LPC; Aetna Health Inc.; Aetna Behavioral Health, LLC; Inovalon Inc., John Does (1-5) and Fictitious Corporations (1-5)	12/14/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/18/17
Superior Court, Los Angeles County, CA, No. BC650488	Helmy, Abol G. v. Aetna Health of California, Inc.; and Does 1 - 50, inclusive	2/14/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/4/18
1st Judicial Circuit Court, Small Claims, Yankton County, SD, No. 66SMC17-000484	VanBeek, John M. v. Coventry Healthcare	6/28/17	Benefit Coverage Determination	Contract 1090.80 Fees 35.08	None	Closed - Settled	10/31/17
Court of Common Pleas, Bucks County, PA, No. 2017-04366-0000	Lorenzo, Maryann, et al. v. Aetna Health, Inc; and Silver Lake Center, Inc d/b/a Silver Lake Nursing & Rehabilitation Center	7/6/17	Benefit Coverage Determination	Contract 50000.00 Punitive 10000000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/19/18
Supreme Court of the State of New York, County of New York, No. 654897/17	O'Dwyer & Bernstein, LLP v. Aetna, Inc.	7/19/17	Benefit Coverage Determination	Contract 196762.25	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/18/17

Table C - Aetna's Medicare Litigation

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Central District of California, Western District, No. 2:17-cv-06022-MWF-PJW	Yagman, Stephen v. Natassia Kelly; Billa Joe Goldicky; Chelsea Jeffers; Mark T. Bertolini; Karen S. Lynch (Rohan); Allen Wise; First Health Life & Heath Ins Co; Aetna Life Insurance Co, et al.	8/14/17	Class Action	Compensatory 75000.00 Punitive 1000000.00	None	Closed - Settled	9/13/18
Court of Common Pleas, Philadelphia County, PA, No. 170802869	Fernandez, Sr., Carlos v. Aetna	8/29/17	Benefit Coverage Determination	Contract 50000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/6/17
11th Judicial Circuit Court, Miami-Dade County, FL, No. 2017-025426-CA-01	Blum, Bentley J. a/k/a Joseph Blum v. Aetna Health Inc.	11/15/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/6/18
Circuit Court, Kanawha County, WV, No. 18-C-331	Gibson, Donald Ray v. India Morris; Jessica Mae Surface; and Coventry Healthcare of West Virginia, Inc.	3/14/18	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/27/18
Superior Court, Riverside County, CA, No. RIC1819360	Vaccarino, Rosalie v. Aetna Inc.; Aetna Health of California, Inc.; Regal Medical Group, Inc.; and Does 1-100, inclusive	9/21/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/24/19
U.S. District Court for the Western District of Pennsylvania (Pittsburgh), No. 2:18-cv-01403-MJH	Domitrovich, William, by and through his designated appointed respresentative, wife, JoAnn Domitrovich v. Aetna, Inc; Alex Azar; Scott Brady; Jeff Sessions	10/19/18	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/24/19
District Court, Allegheny County, Commonwealth of Pennsylvania, No. MJ-05232-CV-0000070-2019	Molitierno, Frances L. v. Aetna Coventry Advantra	3/7/19	Benefit Coverage Determination	Contract 11979.68	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/26/19

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Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

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Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. 022448-09	Hackensack University Medical v. Antoshak, Steven and Helen v. Aetna	10/8/02	Benefit Coverage Determination	Contract 1293.51 Costs 87.00	None	Closed	5/6/10
District Court of the County of Suffolk, State of New York, Fourth District, Hauppauge	Good Samaritan Hospital v. Julie Muscara v. Aetna and Aetna U.S. Healthcare, Inc. as successor in interest to Pru-Care	1/10/03	Benefit Coverage Determination	Contract 8559.55 Fees 2824.65	None	Closed - Pretrial - Aetna Dismissed Voluntarily	2/22/10
County Court, Denver County, CO	McKinnon, Hull v. Aetna Health Insurance	5/7/03	Benefit Coverage Determination	Compensatory 230.72	None	Closed - Failure of Plaintiff to Prosecute	1/25/10
State of Michigan, 36th District Court	Oakwood Hospital, A Michigan non-profit corporation v. Nikisha James v. Aetna Insurance Company	5/23/03	Benefit Coverage Determination	Contract 9170.49 Interpleaded 1757.66	None	Closed - Failure of Plaintiff to Prosecute	4/29/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas of Daughin County, Pennsylvania; No. 2004-CV-1353-CV	Bisker, Sue Barbara; Menasana Clinic; The Rehabilitation Team; and Greater Baltimore Medical Center v. Coventry Health Care, Inc. d/b/a HealthAssurance	3/30/04	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/10/15
In the Court of Common Pleas, Montgomery County, No. 06-31049	Abington Memorial Hospital v. Deborah Diviney v. Aetna Health Plan, Inc. d/b/a Aetna	12/12/05	Benefit Coverage Determination	Contract 7348.50	None	Closed - Aetna Dismissed	9/6/12
Court of Common Pleas of Northampton County, PA, No. C48CV2006-921	Olick, Thomas W. v. James Kearney, The Knights of Columbus and Aetna	3/14/06	Benefit Coverage Determination	Compensatory 2000.00 Punitive 1000000.00	None	Closed	1/24/13
Superior Court of New Jersey, Law Division, Special Civil Part, No. DC-0099855-08	Direnzo, John P. v. Aetna Insurance Co.	3/24/06	Benefit Coverage Determination	Contract 4715.87 Costs 57.00	None	Closed - Settled	6/3/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court, City of New York, No. 1386-04	Staten Island University Hospital v. Edward Fedak and Diane Fedak v. Aetna US Healthcare	4/6/06	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	10/5/10
New York City Civil Court, Small Claims Division, No. SCNY-1631-2006	McGovern, Gerard F. v. Aetna US Healthcare Inc.	4/13/06	Benefit Coverage Determination	Compensatory 5000.00	None	Closed - Settled	7/20/12
New Jersey Superior Court, Middlesex County, Special Civil Part, No. DC-5745-06	Pediatric Ophthalmology Associates v. Daniel Pickett v. Aetna Health, Inc.	5/15/06	Benefit Coverage Determination	Compensatory 343.00 Fees 46.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/7/12
Superior Court of New Jersey Law Division, Special Civil Part, Bergen County, No. DC-5628-06	Hackensack University Medical Center v. Elena Migilaccio v. Aetna Health Insurance Company	5/16/06	Benefit Coverage Determination	Unspecified	None	Closed	3/25/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, No. 009479-06	Hospital and Doctor's Service Bureau v. Kathleen O'Hare; Brendan O'Hare and Aetna	6/2/06	Benefit Coverage Determination	Contract 4462.84	None	Closed - Settled	8/30/12
Superior Court of New Jersey Law Division, Essex County	Atanacio, Paulino and Lydita, husband and wife v. New Jersey Manunfacturers Insurance Company; Aetna Life Insurance Company; The Saint Barnabas System Health Plan; New Jersey Department of Health and Senior Services	6/6/06	Benefit Coverage Determination	Contract 750.00	None	Closed - Settled	4/28/10
Superior Court of New Jersey, Law Division, Special Civil Part, Burlington County Law, No. DC-4398-06	Hackensack University Medical Center v. Leonard H. Niedermayer v. Aetna Health, Inc.	6/30/06	Benefit Coverage Determination	Contract 5413.00	None	Closed - Complaint Withdrawn	8/30/12
Superior Court of New Jersey, Civil Law Division, Camden County, No. CAM-L-05785-06	Ayers, Ellis and Carol v. Aetna US Healthcare	8/7/06	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/28/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Supreme Court of the State of New York, County of Nassau, No. 06-013868	Roer, Gregory and Patrica v. Aetna Health, Inc.	8/25/06	Benefit Coverage Determination	Compensatory 8000.00	None	Closed - Settled	3/18/13
Superior Court of New Jersey, Law Division, Mercer County, No. MER-L-2505-06	McKinney, Richard L. v. Aetna	9/26/06	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed with Prejudice	9/6/12
Superior Court of New Jersey, Law Division, Special Civil Part, Passaic County, No. DC-16837-06	New Jersey Anesthesia Associates v. Ramanuja C. Sanduga v. New Jersey Re-Insurance Company and Aetna Life Insurance Company	12/13/06	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/6/12
Circuit Court of the 9th Judicial Circuit, No. 06-CA-010791-0	Hammond, Theodore and Carol v. Aetna Health Inc.	12/19/06	Benefit Coverage Determination	Contract 54591.39	None	Closed - Settled	2/17/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court, District of NJ, Docket No.: 07CV1934(JHR)	Hunt, Janice v. Dell Inc. Comprehensive Welfare Benefits Plan and Aetna, Inc. as Third-Party Administrators of the Plan	4/25/07	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/28/10
Superior Court of New Jersey, Law Division, Monmouth County, Docket No.: MON-L-2171-07	Gross, Fern v. Aetna Health, Inc.	4/27/07	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/3/11
American Arbitration Association, No. 72 193 00477 07	Dampf, Sarah v. Aetna Health of California, Inc.	5/5/07	Benefit Coverage Determination	Compensatory 28365.00	125000.00	Closed - Trial - Against Aetna	1/9/13
U.S. District Court for the District of New Jersey, MDL No. 2020, Master File No. 07-3541 (FSH)	In re: Aetna UCR Litigation	7/30/07	Class Action	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/14/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas of Bucks County, Pennsylvania - Docket No. 0705992	MacFarlan, Jr., David M. v. Aetna, Inc. and Praxair Healthcare Services	8/1/07	Benefit Coverage Determination	Contract 20225.00	None	Closed - Failure of Plaintiff to Prosecute	9/13/10
Superior Court of New Jersey, Law Division, Camden County, No. L-4514-07	Nitla, Jayakamur and Amritha R. v. Michele Blaskuitch; Aetna US Healthcare and AAA Mid-Atlantic Insurance Group	8/30/07	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/6/10
United States District Court, Central District of California, No. CV0705830GHK (CWx)	Gregg, Beverly v. Aetna Life Insurance Company; The DirectTV-Retiree Medical Insurance Plan	9/7/07	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/16/10
Superior Court of New Jersey, Law Division, Bergen County, Special Civil Part, No. DC-015689-07	Holy Name Hospital v. Abdallah Ali and Khadija Ali v. Railroad Employees National Health and Welfare Plan; CSX Corporation; Aetna Health and Life Insurance Company; New Jersey State Health Benefits Program; NJ Plus; Horizon Blue Cross Blue Shield of NJ	11/7/07	Benefit Coverage Determination	Contract 12024.76	None	Closed - Settled	4/29/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In the Court of Common Pleas, State of South Carolina, County of Greenville, No. 2007-CP-23-7904	Faigle, Sandra Joan v. Aetna Life Insurance Company	11/20/07	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/21/10
Supreme Court of the State of New York, County of Queens, No. 28947/07	Kally, Mimi v. Aetna Life Insurance Company	11/21/07	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	8/23/10
U.S. District Court for the District of Colorado, No. 07-CV-02682-JLK-KLM	Philippus, Suzanne, Individually, and as the Personal Representative of the Estate of Terry Phillippus, deceased v. Aetna Health, Inc., a Connecticut Insurance company, and Time Warner Telecom, Inc., a Colorado corporation	12/26/07	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	9/13/10
New Jersey Department of Labor and Industry, Division of Workers' Compensation, Camden, NJ, No. 2008-1329	Hagan, Dawn v. Lowes #751	2/28/08	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/13/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In The Circuit Court of the 17th Judicial Circuit In and For Broward County - Docket No.: 0809649	Teetor, Brendon v. Aetna Health Inc.; Julie Kasen and United Benefit Services, Inc.	3/4/08	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/5/11
United States District Court for the Western District of Oklahoma, Docket No. CJ-2008-1961 This Court is for the Christian File 2008000588	Christian, Clay v. Aetna, Inc. and Aetna Life Insurance Company	4/3/08	Benefit Coverage Determination	Contract 75000.00	None	Closed - Settled	1/25/10
Circuit Court Escambia County, FL, No. 2009 CA 00221	Hall, Linda S.; Diana L. Luke; Justin M. Paiva, on behalf of themselves and all others similarly situated v. Aetna Health Inc.	4/8/08	Class Action	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	12/6/10
Court of Common Pleas Philadelphia County, PA, April Term, 2008, No. 000601	Kaszupski, Alaina, on behalf of herself and all others similarly situated v. Aetna Health, Inc.	4/9/08	Class Action	Unspecified	None	Closed - Settled	7/22/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S.District Court for the District of Connecticut, No. 3:08cv00654-CFD	Weintraub, Jeffrey M., o/b/o himself and all others similarly situated v. Ingenix Inc; UnitedHealth Group Inc; Oxford Health Plans; Aetna Inc; Cigna Corporation; Empire BlueCross BlueShield; Humana Inc; Group Health Ins Inc; Health Ins Plan of NY; Health Net Inc	4/29/08	Class Action	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/14/18
Superior Court of New Jersey Law Division, Passaic County Case No. PAS-L-2174-08	Feola, Vincenzo v. Abraham Nunez: Mireya A. Nunez: Aetna Insurance Co. and N.J. Cure Insurance Co.	5/22/08	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/21/10
Superior Court of New Jersey Mercer County, No: DC-006661-08	American Trading Company v. Mireille Chery v. Aetna	6/21/08	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/22/10
Civil Court of the City of New York, No. 86481/03	Brooklyn Hospital v. Tamika Cummings v. Aetna	7/11/08	Benefit Coverage Determination	Unspecified	None	Closed - Judgment - Aetna Favor	9/30/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Florida, Fort Lauderdale Division, No. 08-CV-61164-Dimitrouleas-Rosenbaum	McKinney, Virginia v. Aetna Health Insurance Company and Bank of America Corp., f/k/a Nations Bank	7/23/08	Benefit Coverage Determination	Unspecified	None	Closed	2/22/10
Superior Court of New Jersey, Law Division, Special Civil Part, Camden County, NJ, No. DC-006487-08	Holy Redeemer Hospital v. Josie Dillon v. Aetna Insurance Company, its agents, representatives, or servants; HIP Health Insurance of New York, its agents, representatives, or servants	7/28/08	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	1/24/13
Civil Court of the City of New York, Small Claims Part, No. SC NY 2818/2008	Smith, Paul E. v. Aetna	8/4/08	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/30/10
Civil Court of the City of New York, Small Claims Part, No. SCNY 2817/2008	Smith, Paul E. v. Aetna	8/4/08	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/30/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of the City of New York, Small Claims Part, No. SCNY 2819/2008	Smith, Paul E. v. Aetna	8/4/08	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/30/10
Superior Court for the State of California County of Los Angeles Docket No.:BC396195	Barrowes, Logan v. Aetna Health of California, Inc.	8/12/08	Benefit Coverage Determination	Unspecified	358779.45	Closed - Judgment - Against Aetna	9/19/12
Superior Court of New Jersey, Burlington County, Special Civil Part, No. DC-8073-08	American Trading Co., assignee to Mary's Place Pediatric Rehab v. Dennis Saric v. Aetna Health Insurance	9/23/08	Benefit Coverage Determination	Compensatory 5620.00 Costs 71.00 Fees 125.00	None	Closed - Pretrial - Judgment in Favor of Aetna	9/22/10
Superior Court of New Jersey, Atlantic County, Law Division, Special Civil Part, No. DC-010528-08	Shore Memorial Hospital v. James W. and Lesly Boyes v. Home Depot; Aetna Ins. Co.; United Healthcare Ins. Co.	9/24/08	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/21/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, County of Los Angeles, Los Angeles, Central District, Small Claims Division, No. LAM08M10828	Ilyashenko, Irina v. Aetna Life Insurance Company	9/26/08	Benefit Coverage Determination	Compensatory 1330.84	None	Closed - Settled	7/9/10
Superior Court of Washington in and for King County, No. 08-2-34700-1 SEA	Woodley, Gordon v. Aetna Health Inc.; Alaska Air Group Inc.; Welfare Benefit Plan & Trust; Alaska Airlines Inc. Pension/Benefit Administrative Commission	10/8/08	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/3/10
Superior Court of New Jersey, Sussex County, No. SSX-L-66-08	Fritzky, Richard v. Aetna Health, Inc. t/a Aetna, IRA Klien, M.D	10/20/08	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	5/5/10
In the Circuit Court of the Fifteenth Judicial Circuit in and for Palm Beach County, Florida/ Case No.: 50-08-CA-33520	Kirk, Mark v. Aetna Life Insurance Company	10/22/08	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/7/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Ocean County, Special Civil Part, No. 010810 08	Ocean Medical Center v. Glenn Cowan v. Aetna Healthcare Insurance Company and Ocean Medical Center	10/22/08	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/9/13
U.S. District Court for the Southern District of California, No. 08CV2126 LAB JMA	Gerstl, Jeffrey and Rachel v. Aetna Inc., a Delaware corporation; Aetna Life Insurance Company, a Delaware corporation; Aetna Health Inc., a Connecticut corporation; Aetna Health of California Inc., a California corporation	11/17/08	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/3/10
Los Angeles Superior Court, Northwest District, Van Nuys Courthouse East, Small Claims Division, No. LAV08V10324	Villalobos, Dalia v. Aetna Health of California Inc.	11/24/08	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/4/12
Superior Court of New Jersey, Law Division, Essex County, No. ESX-L-9299-08	Eutsey, Barbara v. Midland Tours, Inc.; Darrel T. Williams; Christopher G. Peters and Aetna Health Insurance	12/3/08	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/3/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
United States District Court, Northern District of California, No. CV085685MMC	Eliza Laffin v. Aetna Life Insurance Co. and Adobe Systems Inc.	12/19/08	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/2/10
Superior Court of New Jersey, Law Division, Special Civil Part, Gloucester County	Cape Regional Medical Center v. Harry and Deborah Evangelista v. Aetna Health Insurance Co.	12/23/08	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/28/10
Civil Court of the City of New York, Small Claims Part, No. NSC 4789/07	Digilio, Susan E. v. Aetna	12/28/08	Benefit Coverage Determination	Contract 1300.00	None	Closed - Settled	6/3/11
Trial Court of Massachusetts, District Court Department, Northampton Division, No. 0845-CV-597	The Cheshire Medical Center v. Alan Musgrave and Elizabeth Musgrave v. Aetna; Aetna Student Health: Aetna Life Insurance Company and Chickering Claims Administrators, Inc.	1/2/09	Benefit Coverage Determination	Contract 14548.53 Interest 1222.98	None	Closed - Settled	1/29/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Maricopa County Justice Courts, McDowell Mountain Justice Court, Small Claims Division, AZ, No. CC2009039810	Bucur, Lillia v. Eric Wittala, DDS and Aetna	1/22/09	Benefit Coverage Determination	Compensatory 577.41	None	Closed - Settled	5/16/10
Civil Court of the City of New York, County of Bronx, No. 29337-08/bx	Montefiore Medical Center v. Constance Opoku individually and as PNG of Sharlene Owusu v. Aetna	1/23/09	Benefit Coverage Determination	Unspecified	None	Closed	6/29/10
U.S. District Court for the District of New Jersey, No. 2:2009cv00468	Seney, John, indiv. & on behalf of all othearly situated v. Aetna Health Inc. (PA), Aetna Health Management, LLC, Aetna Life Insurance Company, Aetna Health and Life Insurance Company, Aetna Health Inc. & Aetna Insurance Company of CT	1/28/09	Class Action	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/14/18
Superior Court of California, County of Los Angeles, Los Angeles, Central District, Stanley Mosk Courthouse, Small Claims Division, No. LAM 09M00954	Ilyashenko, Irina v. Aetna Life Insurance	1/30/09	Benefit Coverage Determination	Compensatory 4525.83	None	Closed - Settled	4/1/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Iowa, Central Division, No. 4:08-CV-255-JEG-RAW	Browder, Ruby Sue v. The CBE Group Inc Litigation Center; Kevin D. Ahrenholz; Aetna Incorporated	2/2/09	Benefit Coverage Determination	Unspecified 3000000.00	None	Closed - Pretrial - Judgment in Favor of Aetna	8/4/11
Superior Court of California, County of Orange, Small Claims Division, No. 30-2009-00242476-SC-SC-CJC	Flannagan, David v. Aetna Insurance Co.	2/4/09	Benefit Coverage Determination	Compensatory 344.26	None	Closed	4/1/11
Circuit Court, Crittenden County, AR, No. CIV-09-160	Rowlett, Thomas v. Coventry Health & Life Insurance Company, et al.	3/5/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/7/14
Circuit Court, Crittenden County, AR, No. CIV-09-160	Rowlett, Thomas v. Coventry Health & Life Insurance Company, et al.	3/5/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/7/14

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In the District Court for the County of Monroe, Docket No. 08M5000GC	Mercy Memorial Hospital v. Sheryl L. Verespej v. Aetna Health Inc.	3/5/09	Benefit Coverage Determination	Contract 3207.98	None	Closed - Settled	1/25/10
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. 001253-09	Hackensack Anesthesiology Assoociates v. Peter Res v. Aetna Health	3/14/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/6/10
District Court of the Twentieth Judicial District, Sanders County, MT, No. DV-09-44	McCullugh, Leo and Lisa Bowden v. St. Patrick Hospital and Health Sciences Center, Aetna Life Insurance Company, LifeCenter Northwest and John Does 1-5	3/18/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/16/10
Superior Court of New Jersey, Morris County, Law Division, Special Civil Part, No. DC-001515-09	St. Clares Hospital v. Dan Skidmore v. Aetna Insurance Company	3/20/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/13/10

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Mississippi, Western Division, No. 5:09-cv-4LDCB-JMR	Hall, Theresa v. Newmarket Corporation, Aetna, Inc. d/b/a Aetna U.S. Life Insurance Company, and John Does 1-10	3/24/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/27/12
Court of Common Pleas, Fifth Judicial Circuit, Richmond County, SC, No. 2009-CP-40-2284	Turner, Gail v. CSC Exclusive Access Plan, and Aetna Life Insurance Co.	3/27/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/5/10
Superior Court of NJ, Special Civil Part, Middlesex County, No.: DC-000284-09	Fitch, Asha v. Aetna Health Inc.	3/31/09	Benefit Coverage Determination	Contract 4076.69	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/28/11
Superior Court of New Jersey, Law Division, Middlesex County, No. DC-6196-09	Vizzone, D.O., Jerald P. v. Anglin, Rea & Cahalane, P.A. and Kimberly Myers v. Aetna Health Management, LLC and Liberity Mutual Insurance Company	4/2/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/29/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas, Summit County, OH, No. 2009-06-4808	Drews, Vickie v. Summa Health System and Aetna Life Insurance Company	4/3/09	Benefit Coverage Determination	Contract 2308.10	None	Closed - Settled	1/28/10
Superior Court of New Jersey, Law Division: Bergen County Case No: BER-L-3134-09	Alcantara, Rosa v. Aetna, Inc., ABC Corporation I-X	4/3/09	Benefit Coverage Determination	Contract 33994.00 Costs 3000.00	None	Closed - Settled	1/26/10
Superior Court of New Jersey, Camden County, Law Division, Special Civil Part, No. DC-4548-09	Allied Orthotics and Prosthetics v. Michael Loveland v. Aetna Insurance Company (n.k.a. ING Insurance Company of America)	4/15/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	2/26/10
U.S. District Court for the District of New Jersey, No. 178509CVNLH-JS	Rosenberg, Scott v. Lincoln Financial Group, Ceridian CobraServ, Aetna Cobra Individual Billing Administration, International Business Machines Corporation	4/15/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	4/13/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Middlesex County, Law Division, No. Mid-L- 3545-09	Watson, Donna and Jerry and Laura Watson v. Aetna Life Insurance Company, Carewise Health/SHPS Solution, John Does 1 to 10, Fictitious Names, ABC Corporation 1 to 10, Fictitious Corporations	4/24/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	8/17/11
Trial Court of Massachusetts, Small Claims Session No.: 09-SC-705	Queeney, Thomas v. Aetna Inc.	4/27/09	Benefit Coverage Determination	Contract 1635.00 Costs 40.00	927.38	Closed - Trial - Against Aetna	1/29/10
Supreme Court of the State of New York, County of Kings, No. 10501/09	Manko, Nella v. Aetna Health Inc.; U.S. Healthcare, Inc.; Lenox Hill Hospital; Dana A. Mannor, M.D.; Matthew L. Lubin, M.D.; Jane Doe	4/29/09	Benefit Coverage Determination	Compensatory 3000000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	5/28/15
19th Judicial District Court, Parish of East Baton Rouge, LA, No. C577886 Section 22	Thibodeaux Reech, Cindy v. Aetna Life Insurance Company	4/30/09	Benefit Coverage Determination	Contract 25165.16	None	Closed - Settled	5/20/10

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey Essex County Law Division Docket No.: ESX-L-3264-09	Saint Fort, Elysee v. Nicholas Emelumba; Anderlyn N. Emelumba and Aetna Health Insurance	5/4/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/8/11
3rd Judicial District Court Salt Lake Co. Utah, 90907502	Platt, Grant v. Altius Health Plans	5/5/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/18/15
Superior Court of New Jersey, Law Division, Special Civil Part, Middlesex County, No. DC-010695-09	Buscetta, Vito v. Aetna	5/8/09	Benefit Coverage Determination	Contract 10000.00	None	Closed - Settled	2/5/10
Superior Court of New Jersey, Hudson County, Law Division, Special Civil Part, No. DC-008981-09	Bayonne Medical Center v. Shirle Greene v. Aetna Health Management, LLC	5/14/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	7/2/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, County of Los Angeles, Alhambra Courthouse, Small Claims Division, No. 19-2009-102-00631	Lu, Kevin v. Aetna Health and Life Insurance Company	5/20/09	Benefit Coverage Determination	Compensatory 7000.00	None	Closed - Settled	12/15/10
Circuit Court for the County of Ingham, State of Michigan No.: 09-746-NF	Dennis, Dena Karlena v. Allstate Insurance Company and Aetna Health Inc.	5/21/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/21/10
U.S. District Court, District of New Jersey, Case No. 2:33-av-00001	Andriuli, Frank v. Merck Co., Inc. and Aetna Inc.	5/27/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/5/10
Hamilton County Municipal Court, Hamilton County, OH, No. 09CV09693	Bethesda Hospital v. Tracy Matzet and Mark Walriven v. Aetna, Inc. and Strategic Resource Company	6/2/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/25/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
12th Judicial Circuit, Houghton County, MI, No. 09-14115-CK	Marquette General Hospital, Inc. v. Bonita Neveau v. Aetna Health, Inc.	6/5/09	Benefit Coverage Determination	Contract 32127.84	None	Closed - Settled	4/14/10
In the District Court of Tulsa County, State of OK, docket No. CS-2010-04935	Cunningham, Julie v. Aetna Life Insurance Company	6/9/09	Benefit Coverage Determination	Contract 1600.00	None	Closed - Settled	2/10/12
Circuit Court of the 18th Judicial Circuit, In and For Seminole County, FL No. 09-cv-5124-15-W	Gil-Pasquel, Kenneth v. Aetna Insurance Company of Connecticut	6/19/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/12/10
District Magistrate Court West Chester, PA, Docket No.: CV-0000253-09	McGinnis, Brian Joseph v. Aetna Life Insurance Company	6/19/09	Benefit Coverage Determination	Contract 2495.00 Costs 93.36	None	Closed - Settled	2/5/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, Harbor Justice Center, Laguna Hills Facility, Small Claims Division, No. 30-2009-00279564-SC-SC-HNB	Orbe, Robert James v. Aetna Life Insurance Company	6/26/09	Benefit Coverage Determination	Compensatory 7500.00	None	Closed - Settled	2/5/10
United States District Court, District of New Jersey, No. 09-CV-3228	Res, Peter v. Aetna Health Inc.	7/2/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/31/10
Small Claims Court, Justice of the Peace, Precinct 1 Place 1, Wichita County, TX, No. SC4255	Schwarz, Debra v. Aetna Life Insurance Company	7/6/09	Benefit Coverage Determination	Contract 732.55	None	Closed - Settled	1/25/10
In the Court for the Fifth Judicial Circuit of Illinois, Clay County, IL, No. 09-L-5	Lewis, Annie O. and Herbert E. v. Aetna Insurance Agency, Inc. a/k/a ING Insurance Services, Inc.	7/7/09	Benefit Coverage Determination	Contract 38165.92 Fees 60000.00	None	Closed - Settled	7/24/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Passaic County, No. PAS-L-3091-09	Hammer, Michael and Lois v. Ear, Nose, Throat and Facial Plastic Surgeons, PA, Wayne Surgical Cetner and Aetna Health Inc. t/a Aetna Health Insurance Company	7/17/09	Benefit Coverage Determination	Contract 3975.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	2/5/10
District Court of MD, Prince George's County, Docket No.: 050200256692009	Anylem, Thony v. SRC, an Aetna Company	7/28/09	Benefit Coverage Determination	Contract 413.65 Costs 36.35	None	Closed - Settled	5/6/10
State of Connecticut - Superior Court - Centralized Small Claims No.: SCC-257250	Clapp, Jessica v. Aetna Health/Dental	7/30/09	Benefit Coverage Determination	Contract 642.00	None	Closed - Settled	1/26/10
In the United States District Court for the Southern District of Texas, Houston Division, No. 4:09-cv-02943	Stehling, Martha v. Aetna Health and Life Insurance Company and RCG Information Technology, Inc. Health Care Plan	7/31/09	Benefit Coverage Determination	Contract 31500.00 Unspecified 52500.00	None	Closed	11/25/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court of Cleveland County, OK, No. CG-09-1735L	Ragon, Ladora Jan v. Aetna, inc. and Aetna Life Insurance Company	8/4/09	Benefit Coverage Determination	Contract 2800.00 Unspecified 10000.00	None	Closed - Settled	8/30/11
United States District Court, Southern District of Florida, West Palm Beach Division, No. 09-CV-81128-MARRA/JOHNSON	Hering, Rosemary v. Aetna Health, Inc.	8/4/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/12/10
Hillsborough County Circuit Court, No. 06-12119	Brown, Douglas v. State Farm Fire and Casualty Company; Dr. Robert C. Nucci; Dr. Wendell Bulmer and Aetna Health, Inc.	8/5/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/30/11
Superior Court of New Jersey Law Division, Special Civil Part Camden County, Docket No.: SC-2313-09	Alibrando, Matthew and Cynthia v. Aetna	8/5/09	Benefit Coverage Determination	Contract 855.00 Costs 22.00	None	Closed - Settled	2/22/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Fourth Judicial District Court, Utah County, UT, No. 098200295	Storey, Chelsea v. Cirque Lodge, Inc. and Aetna Health and Life Insurance	8/6/09	Benefit Coverage Determination	Compensatory 10215.00	None	Closed - Settled	6/15/10
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. DC-023231-09	LaBarbiera, Joseph v. Aetna Health Management, LLC	8/12/09	Benefit Coverage Determination	Contract 15000.00	None	Closed - Settled	4/29/10
Superior Court of California, County of Orange, No. 30200900293581SCSCWJC	Torjkov, Vladimir v. Aetna Life Insurance Company	8/14/09	Benefit Coverage Determination	Costs 3610.00	None	Closed - Pretrial - Judgment in Favor of Aetna	5/6/10
Supreme Court of the State of New York, Docket No.: 09-112620	Berman, Harvey v. Aetna Life Insurance Company	8/17/09	Benefit Coverage Determination	Contract 21194.95	None	Closed - Pretrial - Aetna Dismissed by Court Order	10/21/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Essex County, No. ESX-L6772-09	Haskine, Pauline v. Aetna	8/19/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/22/10
United States District Court - Middle District of Florida, Docket No.: 8:09-CV-1770-T26	Blaikie, Linda v. RSight, Inc. d/b/a RSight Investigations, Inc.; Staffing Concepts, Inc. d/b/a SCI Companies and Aetna Health, Inc. a/k/a Aetna	8/28/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/28/12
Small Claims, Judicial District Court, Docket No. 09C02832SC	Mozdzierz, Monika v. Aetna Insurance	8/29/09	Benefit Coverage Determination	Contract 1000.00 Unspecified 55.00	None	Closed - Settled	1/25/10
Magistrate District No. 15-2-05, County of Chester, West Chester, PA, No. CV-0000360-09	Jordan, Christopher v. Aetna Life Insurance Company	9/4/09	Benefit Coverage Determination	Costs 93.36	None	Closed - Settled	1/25/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Union County, No. UNN DC 11466 09	Oral & Maxillofacial Surgery c/o MWM v. Ruth Conlan and Aetna	9/4/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/24/13
State Court of Fulton County, GA, No. 09V5166267C	Ohai, Luminate v. Aetna	9/9/09	Benefit Coverage Determination	Contract 7535.95	None	Open	
The District Court, Douglas County, Nebraska- docket No. 1093 No. 714	Claborn, Billy E. v Aetna	9/11/09	Benefit Coverage Determination	Contract 60000.00	None	Closed - Settled	12/13/10
Superior Court of New Jersey Law Division, Special Civil Part Monmouth County, Docket No.: DC-014435-09	Cagnassaola, Louis v. Aetna	9/16/09	Benefit Coverage Determination	Contract 1461.00 Costs 365.25 Fees 3202.25	None	Closed - Settled	5/7/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of new Jersey, Law Division, Somerset County, Docket No.: L-1749-09	Fendel, Sylvia v. Aetna, Inc.	9/28/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/19/10
Magistrate Court, Cherokee County Georgia, Docket No. 2009-4487CC	Longino, John v. Aetna Health Insurance Company	9/29/09	Benefit Coverage Determination	Contract 15000.00	None	Closed - Aetna Dismissed with Prejudice	4/11/11
U.S. District Court for the District of South Carolina, Spartanburg Division, No. 7:092552-HMH	Wallace, Timothy Shane v. Aetna, Inc. and Aetna Life Insurance Company	9/30/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/29/10
District Court of Maryland for Baltimore, No. 080400322992009	Strzelczyk, Jeffrey v. Ronald Williams	10/5/09	Benefit Coverage Determination	Contract 2121.72	None	Closed - Settled	4/14/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court, City and County of Denver, Colorado, No. 2009CV9444	Nottingham, Spencer C. v. Aetna Life Insurance Company and Aetna Health, Inc.	10/6/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/21/10
Connecticut Superior Court, Small Claims Session, No. SCC 227447	Westerly Hospital v. Crystal Young v. Aetna Life Insurance Company	10/7/09	Benefit Coverage Determination	Contract 4508.32	None	Closed - Settled	2/8/10
Trial Court of Massachusetts, Small Claims Session No.: 0966SC788	Berke, III, Carl v. Aetna Life Insurance Company	10/8/09	Benefit Coverage Determination	Contract 375.00 Costs 30.00	None	Closed - Settled	1/28/10
U.S. District Court for the Western District of Virginia, Docket No.: 309CV00071	McDonough, James E., Jr., Executor of the Estate of James E. McDonough v. Aetna Life Insurance Company and Vivendi Holding I Corp.	10/9/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/25/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Illinois, No. 1:09-cv-6475	Kanten, Wynn v. OP Therapy, Inc. d/b/a In-House Rehabilitation Solutions and In-House Rehabilitation Solutions, Aetna Health of Illinois Inc. and Aetna Health Inc.	10/14/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	3/31/11
Supreme Court of the State of New York, County of New York No.: 114267/09	Stern, Jeffrey by his Guardian Margot T. Stern v. Aetna and Aetna Inc.	10/15/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/29/10
County Court in and for Hillsborough County, FL, No. 0930657	Rojas, Ezequiel v. Aetna Health Inc.	10/16/09	Benefit Coverage Determination	Unspecified	None	Closed - Complaint Withdrawn	9/29/10
District Court of Maryland for Baltimore County, Docket No.: 080400325372009	Chaudhry, Kosar v. Aetna Health Insurance Company	10/16/09	Benefit Coverage Determination	Contract 6000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/7/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court for the County of Oakland, No. 08-094762-NI	Ocampo, Divina v. Liberty Mutual Insurance Company, Aetna Inc., Costco Wholesale Corp. - NOT YET SERVED	10/19/09	Benefit Coverage Determination	Contract 25000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/29/10
Commonwealth of Pennsylvania, County of Chester, Mag. Dist. Ct. 15-2-05, Docket No.: 0000412-09	Weaver, Deborah v. Aetna Life Insurance Company	10/19/09	Benefit Coverage Determination	Contract 6015.00	None	Closed - Settled	2/22/10
In the District Court of Dallas County Texas 134th Judicial District, Docket No.: 09-14392	Henry, Michael J. v. Aetna Life Insurance Company	10/22/09	Benefit Coverage Determination	Contract 57077.20	None	Closed	9/13/10
Superior Court of New Jersey Law Division, Ocean County Special Civil Part, Docket No.: SC 3530-09	Carson, Kenneth v. Aetna Insurance Inc.	10/26/09	Benefit Coverage Determination	Contract 2529.76	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/8/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
52-2 Judicial District Court, Docket No. 2009-C01400GC	Crittenton Hospital v. Scott B. Lowes v. Strategic Resources Company a/k/a SRC, an Aetna Company	11/9/09	Benefit Coverage Determination	Contract 14720.65	None	Closed - Pretrial - Aetna Dismissed Voluntarily	2/22/10
United States District Court - Middle District of Florida, Docket No.: 2-09-CV-734-FTM	Burdett, Jack, individual and as a parent and natural guardian of Mark Burdett v. Aetna Life Insurance Company	11/9/09	Benefit Coverage Determination	Contract 199975.44	None	Closed - Settled	11/1/11
Arizona Superior Court, County of Maricopa, No. CV2009-093616	Fishman, Felicia A. v. Southwest Catholic Health Network Corporation d/b/a Mercy Healthcare Group	11/10/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/30/11
The United States District Court for the Northern District of Alabama	Lankford, Barbara v. Unicare Life & Health Insurance Company, Aetna Health and Life Insurance Company	11/12/09	Benefit Coverage Determination	Contract 17434.98	None	Closed - Settled	8/23/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
United States District Court for the Southern District of West Virginia, No. 2:09-1254	Miller, Amanda v. CSX Transportation, Inc.: Railroad Employees National Health and Welfare Plan; National Carriers' Conference Committee; Aetna Life Insurance Company; Cooperating Railway Labor Organizations; United Healthcare Inc.	11/16/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/19/10
District Court 15-2-05, Docket No.: CV-0000442-09	McDonald, Laura v. Aetna Life Insurance Company	12/2/09	Benefit Coverage Determination	Contract 3946.50	None	Closed - Settled	4/27/10
Superior Court of New Jersey, Law Division, Mercer County, No.: MER-L-3056-09	Babice, Michael and Maryann v. Aetna Health, Inc.	12/2/09	Benefit Coverage Determination	Contract 17000.00	None	Closed - Settled	9/3/10
Supreme Court of the State of New York, County of New York Case No.: 09117133	Skrable, Holly M. and Scott Skrable v. Aetna Insurance Company	12/7/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/27/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court for the County of Monroe, Docket No. 53C08-0908-SC-04083	Collection Associates, LLC v. Chris Lavelle v. Aetna Life Insurance Company	12/9/09	Benefit Coverage Determination	Contract 10000.00	None	Closed - Settled	10/14/10
U.S. District Court for the Central District of California, No. CV00-9088 DSF (RCX)	King, Simonette, Brandon King, Stanley Thomas and Renette King-Thomas v. Aetna Life Insurance Company	12/10/09	Benefit Coverage Determination	Compensatory 250000.00	None	Closed - Settled	4/3/12
In the Circuit Court for Williamson County, TN, No. 09721	Cothron, Kristen L. v. Aetna Life Insurance Company and Blue Cross Blue Shield of Tennessee, Inc.	12/14/09	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/27/15
U.S. District Court for the District of Connecticut	Sprick, Linda F. v. Union Carbide Retiree Medical Care Program - MAP Plus Plan; Union Carbide Corporation; Dow Chemical Company; Aetna, Inc.	12/17/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/23/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Western District of Michigan, No. 2:09-cv-236	Moses, Jamero T. v. Prison Health Services Inc., American International Group, Aetna Insurance	12/17/09	Benefit Coverage Determination	Contract 75000.00	None	Closed - Pretrial - Judgment in Favor of Aetna	6/6/12
Superior Court of New Jersey, Law Divison, Special Civil Part, Monmouth County, No. DC-005049-09	Meade, Patricia v. County of Monmouth and Aetna Insurance Company	12/21/09	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	5/7/10
Superior Court of California, County of Ventura, Small Claims Division, No. 56-2009-00364328-SC-SC-SIM	Buraye, Elizabeth v. Aetna Health and Life Insurance Company	12/22/09	Benefit Coverage Determination	Compensatory 7500.00	None	Closed - Settled	12/15/10
Civil Court of the City of New York, Small Claims Part, No. SCK 8236/09	Simonson, Alexander v. Aetna Health, Inc.	12/29/09	Benefit Coverage Determination	Unspecified	None	Closed	5/7/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court, Jackson County, State of Oregon, Small Claims Division, No. 098130	Hay, Peter Douglas v. Aetna Life Insurance Company	12/30/09	Benefit Coverage Determination	Contract 2000.00	None	Closed - Settled	3/12/10
District Court 15-2-05, West Chester, County of Chester, PA, No. CV-11-10	Titter, Donald v. Aetna Life Insurance Company	1/11/10	Benefit Coverage Determination	Compensatory 2065.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/22/10
U.S. District Court for the Northern District of California, No. C10-00143	Silver, Alan John and Mary Ellen Silver, Individually and on behalf of all others similarly situated v. Aetna Health Inc, PA Corp., Aetna Health Management, LLC, Aetna Life Insurance Company, Aetna Health and Life Insurance Company, Aetna Health, Inc, Aetna Insurance Company of Connecticut, United Health Group, Inc., Ingenix, Inc. and Does 1-10	1/12/10	Class Action	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/14/18
District Court 15-2-05, West Chester, Chester County, PA, No. CV-15-10	Grater, Jordan v. Aetna Life Insurance Company	1/12/10	Benefit Coverage Determination	Compensatory 6750.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/22/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court 15-2-05, West Chester, County of Chester, PA, No. CV-14-10	Troisi, Judith v. Aetna Life Insurance Company	1/12/10	Benefit Coverage Determination	Compensatory 4065.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/22/10
Superior Court of New Jersey, Law Division, Special Civil Part, Union County, No. 013934-09	Associated Radiologists, Inc. v. Mark Vicendese v. Aetna, Inc,	1/13/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/29/10
District Court of Maryland for Montgomery County	Pope, Leslie v. Aetna	1/14/10	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/22/10
District Court 15-2-05, West Chester, Chester County, PA, No. CV- 18-10	Madden, Jack v. Aetna Life Insurance Company	1/15/10	Benefit Coverage Determination	Compensatory 5300.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/23/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Trial Court of MA, Small Claims Session, No. 10S00109	Eriksen, Erik v. Rajan Parmeswar (V.P. Controller, Aetna Legal Support Services)	1/15/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/29/10
U.S. District Court for the District of Maryland, No.: 8:10-cv-00171-PJM	Primmer, L. Frank v. PSI Family Services, Inc.; PSI Family Services Welfare Benefit Plan; and Aetna Life Insurance Company	1/25/10	Benefit Coverage Determination	Contract 3769.84	None	Closed - Settled	2/3/11
Circuit Court of Chilton County, AL, No. CV-2010-14R	Kuznetz, Lyse v. Aetna Life Insurance Company, et al.	1/28/10	Benefit Coverage Determination	Contract 100000.00	None	Closed - Settled	8/13/10
Superior Court of Arizona, County of Pima, No. C20100748	Todd, Elizabeth A. v. Aetna Life Insurance Company	1/28/10	Benefit Coverage Determination	Compensatory 70000.00	None	Closed - Settled	2/15/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of California, No. C10-00456	Garber, David v. Aetna, Inc.; Aetna Life Insurance Company; Aetna Health, Inc.; Aetna Health of California, Inc.	2/1/10	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/16/10
U.S. District Court for the Western District of Michigan No. 1:10-cv-105	Claeys, Craig J., as of next friend of Carver Claeys v. Aetna Life Insurance Company; United Parcel Service of America, Inc. and UPS Retired Employees' Health Care Plan	2/3/10	Benefit Coverage Determination	Unspecified	None	Closed	10/29/10
USDC, Middle District of FL, Docket No.: 2:10-cv-71-36DNF	Frost, David v. Aetna Health, Inc.,a Florida corporation	2/4/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/29/10
In the County Court for Sarasota County, Florida, Case No.: 2010 SC 000379 NC	Richmond, Morgan v. Aetna Health Inc C/O Clarence King President	2/11/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/7/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court Magisterial District 26-3-04, No. CV-0000058-10	Herman, Michael v. Aetna Life Insurance Company	2/16/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/9/10
U.S. District Court for the District of Utah, Central Division, No. 2:10-cv-00118-TS	Michael B., Mary B. and Samuel B. v. Aetna Healthfund HRA 90-Aexcel Plus For Retirees/LTD Plan and Aetna Life Insurance Company	2/16/10	Benefit Coverage Determination	Compensatory 89669.00	None	Closed - Settled	12/28/11
Superior Court of California, County of San Bernardino, No. CIVDS1001718	Penrice, Niare v. United Parcel Service, Aetna Insurance Company, Does 1 to 100	2/18/10	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	9/1/10
Superior Court of California, San Diego County, CA, Small Claims Division, No. 37-2010-00001189-SC-SC-CTL	Barry, Jonathan v. Aetna Health of California Inc.	2/19/10	Benefit Coverage Determination	Compensatory 4453.88	None	Closed - Settled	9/3/10

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Passaic County, No. DC-897-10	Dicovsky, MD, Carlos v. Soto, Victor M. v. United Group Programs, Inc. and Aetna Insurance Co.	2/24/10	Benefit Coverage Determination	Contract 2787.30	None	Closed - Settled	9/21/10
United States District Court, District of New Jersey, No. 1:10-CV-00762-RMD-AMD	Kaufman, Kenneth v. Aetna Life Insurance Company d/b/a Aetna and Raymours Furniture Company, Inc. d/b/a Raymour & Flanigan Furniture	2/26/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/6/10
State of Wisconsin, Circuit Court, Milwaukee County, Small Claims Division - No.: 09-SC-010787	Lanham, John S., DPM & Associates, Sc v. Paul Buck, Jr., Defendant/Third-Party Plaintiff and Corina Buck, Defendant/Third-Party Plaintiff and Aetna Life Insurance Company a/k/a Aetna, Inc.	3/1/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/3/10
Toledo Municipal Court, Lucas County, OH, No. CV-10-03859	Fitzpatrick, Janet M. v. Aetna Life Insurance Co.	3/2/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/7/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court of Washington County, Docket No. CV 10-700-2	Smith, Charles v. Aetna Insurance	3/4/10	Benefit Coverage Determination	Contract 3158.00	None	Closed - Settled	4/15/10
Court of Common Pleas, County of Lexington, SC; 2010-CP-3201035	Russell, Ernie v. Wellpath Select, Inc., et al.	3/5/10	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	11/19/15
Superior Court of California, County of Los Angeles, Santa Monica Couthouse, Small Claims Division, No. SM10A00647	Carter, Bret v. Aetna Health of California, Inc.	3/5/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/14/10
Superior Court of New Jersey, Special Civil Part, Hudson County - Docket No.: DC-002942-10	Hackensack University Medical Center v. Gayle Pratko v. Aetna Health, Inc. a/k/a Aetna Health Insurance	3/5/10	Benefit Coverage Determination	Contract 880.06	None	Closed - Settled	7/20/10

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Justice of the Peace, Harris County, TX, Precinct Five, Place One, No. SC51C0106686	Perets, Guy v. Aetna Life Insurance Company	3/8/10	Benefit Coverage Determination	Contract 9877.28	None	Closed - Settled	9/21/10
Fresno County Superior Court, CA, No. 10 CE SC 00555	Takelian, Shiraz v. Impact Medical Group and Aetna Life Insurance Company	3/10/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/13/10
U.S. District Court, Northern District of Ohio, Eastern Division No.: 1:10-cv-00513-CAB	Shrimpton, Brian and Brian Shrimpton for and on behalf of spouse, Patricia Shrimpton v. Quest Diagnostics Incorporated and Aetna, Inc.	3/10/10	Benefit Coverage Determination	Compensatory 50000.00	None	Closed - Settled	9/3/10
District Court of the County of Suffolk	John T. Mather Memorial Hospital v. Elizabeth Myers v. Aetna Health Inc.	3/11/10	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	7/16/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Ocean County, No. DC-023158-09	Southern Ocean County Hospital v. John Cangelosi v. Aetna Health, Inc.	3/22/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/20/10
10th Judicial District Court, Parish of Natchitoches, docket No.,83,270-A	Kelley, Deena L. v. Aetna Life Insurance Company and First America Inc.	3/25/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/23/11
Circuit Court of the 13th Judicial Circuit, Hillsborough County, FL, No. 10-ca-006904 D	Duncan, Shannon v. Tampa Bay Surgery Center Inc., and Aetna Health Inc.	3/26/10	Benefit Coverage Determination	Contract 31843.60	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/4/13
Second Judicial District Court, State of New Mexico, County of Bernalillo, No. cv-2010-03963	Wells, Veronica v. Aetna Life Insurance Company and Lockheed Martin Corporation Flexible Benefits Plan	3/30/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/3/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Part, Passaic County, No. DC004220-10	Hackensack University Medical v. Helen Shawah v. Aetna Inc.	4/1/10	Benefit Coverage Determination	Contract 1754.40	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/3/11
Superior Court of New Jersey, Law Division, Union County, Docket No.: UNN-L-1404-10	Thompson, Tanya Smith v. New Jersey Manufacturers Insurance Company; Aetna Insruance Company	4/1/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/13/12
United States District Court for the Southern District of West Virginia, No. 2:09-1254	Weinman, Cynthia Lynne v. Aetna Life Insurance Company	4/9/10	Benefit Coverage Determination	Costs 345.00 Punitive 3283.00	None	Closed - Settled	7/19/10
County Court at Law No. 1 of Dallas County, TX, No. CC-10-02621-A	Koehler, Nancy v. Aetna Health Inc.	4/20/10	Benefit Coverage Determination	Contract 2300.00	None	Closed - Settled	2/25/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
The Circuit Court of the Twenty Third Judicial Circuit of Missouri, Docket No. 09JEAC00760	Universal Oral & Maxillo Facial Surgeons v. Susan G. Emily v. Aetna Life Insurance Company	4/20/10	Benefit Coverage Determination	Contract 1399.23	None	Closed - Aetna Dismissed with Prejudice	11/29/10
Superior Court of New Jersey, Law Division, Bergen County, No. DC-11723-10	Hackensack University Medical Center v. Alisa Glayat v. Aetna Life Insurance Co.	4/23/10	Benefit Coverage Determination	Contract 3538.20	None	Closed	6/8/11
Superior Court of New Jersey, Law Division, Ocean County, No. L382-10	Southern Ocean County Hospital v. Bernard Laufgas v. Connecut General Life Ins. Co. and Aetna	4/26/10	Benefit Coverage Determination	Contract 15000.00	None	Closed - Settled	10/21/11
Superior Court of California, Orange County, Small Claims, Harbor-Laguna Hills Facility, No. 30-2010-00368678	Bilbeisi, Wathiq and Sharon v. Aetna Life Insurance Company	4/28/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/16/10

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In the Court of Common Pleas of Bradford County, No. 10CV000262	Schultz, Lynette v. Aetna Insurance Company	4/30/10	Benefit Coverage Determination	Unspecified	None	Closed	10/21/10
The 40th District Court, Docket No. 10-0407-GC	William Beaumont Hospital v. Deborah M. Cooper v. Aetna Insurance	5/7/10	Benefit Coverage Determination	Contract 10578.70	None	Closed - Settled	9/21/10
Ada County, Fourth Judicial District, State of Idaho, No. CV-OC-1009188	The Estate of Marie Cortabitarte and Jack Cortabitarte v. Aetna Life Insurance Company	5/12/10	Benefit Coverage Determination	Compensatory 25000.00	None	Closed - Settled	9/22/10
Trial Court of the Commonwealth, Boston Municipal Court Dept. - Central Division, No.: 10-SC-1338	Brown, Dana v. Aetna Health, Inc.	5/14/10	Benefit Coverage Determination	Contract 850.00	None	Closed - Settled	4/25/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of CT, Small Claims, No. SCC332074	Matharu, Amrik v. Aetna	5/18/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/21/10
District Court of Maryland for Baltimore County	Nowinski, Maryann E. v. Aetna Life Insurance Company	5/20/10	Benefit Coverage Determination	Contract 139.52	None	Closed - Settled	6/3/11
Superior Court of New Jersey Law Division, Special Civil Part Burlington County - Docket No.: DC-005663-10	South Jersey Radiology Associates v. Michelle Padilla-Georgia ad Steven Georgia v. Aetna and USAA Automobile Insurance Company	5/22/10	Benefit Coverage Determination	Contract 2608.00	None	Closed - Settled	7/30/10
Civil Court of New York County, NY, No. 030331NCV2010	DeSantis, Gregory v. Aetna Health Inc.	5/25/10	Benefit Coverage Determination	Contract 4901.44	None	Closed - Settled	6/3/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
24th Judicial Dist. Court Parish of Jefferson; 687-765	Besancon, Lorraine and John Besancon v. Coventry Health Care of Louisiana, Inc., et al.	5/26/10	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	1/30/15
Circuit Court of the State of Oregon, County of Deschutes, No. 10CV04535T	Patterson, Andrea Marie v. Aetna Life Insurance Company	5/26/10	Benefit Coverage Determination	Contract 12076.41	None	Closed - Aetna Dismissed with Prejudice	9/15/10
Civil Court of City of New York, Brooklyn, Small Claims Part, No. SCK3178/10	Simonson, Alexander C v. Aetna Health, Inc.	5/27/10	Benefit Coverage Determination	Contract 4400.00	None	Closed - Settled	9/6/12
U.S. District Court for the District of Utah, Central Division, No. 2:10-CV-489 TC	Ian G. and Tammy G. for and on behalf of K. B., a minor v. Aetna Life Insurance Company; Niscayah, Inc. and The Niscayah Medical Benefits Plan	5/28/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/11/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Concord District Court, Docket No.: 10-SC-465	Schwager, Anna v. Aetna c/o Ronald Williams, CEO	6/1/10	Benefit Coverage Determination	Contract 1960.00 Costs 72.00	None	Closed - Settled	10/21/10
In the Butler County Area Court, Area III, Civil Division, Butler County, OH, No. CVF1000131	Towne, Peter A. d/b/a Peter Towne Physical Therapy v. Robert Thomason v. Aetna Insurance Company	6/2/10	Benefit Coverage Determination	Contract 8500.00	None	Closed - Settled	9/13/10
Superior Court of California, County of Los Angeles, West District, Beverly Hills Courthouse, Small Claims Division, No. BH 10S01021	Hertzberg, Rachel v. Aetna Life Insurance Company	6/9/10	Benefit Coverage Determination	Compensatory 3998.00	None	Closed - Settled	4/1/11
Superior Court of California, County of San Francisco, No. CSM-10-834102	Germain, Christopher K. v. Aetna Life Insurance Company	6/14/10	Benefit Coverage Determination	Contract 3282.00 Punitive 4218.00	None	Closed - Settled	8/30/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In the General Court of Justice District Court Division - Small Claims, State of North Carolina, Mecklenberg County, Docket No.: 10CVM71430	Gibby, Daniel J. v. Aetna Health of the Carolinas v. Charlotte Surgery Center, LTD.	6/15/10	Benefit Coverage Determination	Contract 4701.78	None	Closed - Settled	9/21/10
In the District Court of Jefferson County, Texas, 136th Judicial District, No. D187,097	Fountain, Sarah v. Aetna Life Insurance Company	6/17/10	Benefit Coverage Determination	Contract 44000.00 Costs 30000.00	None	Closed - Aetna Dismissed without Prejudice	6/10/11
Superior Court of New Jersey, Law Division, Special Civil Part, Burlington County, Docket No.: DC-008400-10	Cohen, Bruce and Michelle v. Aetna Health, Inc.	6/21/10	Benefit Coverage Determination	Contract 14374.88	None	Closed - Settled	9/13/10
Arizona Superior Court, County of Pima, No. C20105017	Hill, Sean Steven v. Aetna Life Insurance Company and Chickering Claims Administrators, Inc.	6/25/10	Class Action	Unspecified	None	Closed - Settled	8/16/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Massachusetts, No. 1:10-CV-11082-WGY	Elsenbeck, Matthew K. v. CVS Caremark and Aetna, Inc.	6/25/10	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/20/10
District Court Clark County, NV, No. A-10-619787-C	Palmateer, Dale J. v. Aetna Life Insurance Company; The Daily Racing Form Group Health Plan	6/29/10	Benefit Coverage Determination	Compensatory 100000.00	None	Closed - Settled	11/30/12
In the United States District Court for the Western District of Texas, San Antonio Division, No. 5:10-cv-532-OLG	Richter, Lisa v. Aetna Life Insurance Company	6/29/10	Benefit Coverage Determination	Contract 1500.00	None	Closed - Judgment - Aetna Favor	11/14/11
Superior Court, Centralized Small Claim, CT, No. SCC-340082	White, Patricia Kelly and Robert White Jr. v. Aetna Life Insurance Company	6/29/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/22/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of the City of New York , Small Claims Part, No. SCNY 2196-10	Isaacson, Allen I. v. Aetna Life Insurance Company	7/1/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/3/11
Superior Court of Caliofornia, County of Santa Clara, Santa Clara Courthouse, Small Claims Division, No. 710SC040307	Galbreath, John v. Aetna Insurance and Costco Wholesale Corporation	7/6/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/7/10
Superior Court of New Jersey, County of Hudson, Civil Division 2, Case No.: HUD-L-6385-09	Valdes, Maximo v. Quick Chek Corporation; Aetna Insurance Company and Ceridian Corporation	7/6/10	Benefit Coverage Determination	Unspecified	None	Closed - Complaint Withdrawn	4/25/11
Superior Court of New Jersey, Law Division, Middlesex County, Docket No.: MID-L-4094-10	Prinzo, Penelope, as Administrator Ad Prosequendum for the Estate of Joseph Prinzo v. Oxford Healthcare and Aetna Healthcare	7/6/10	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/3/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of South Carolina, No. 7:10-1746-RBH	Simmons, Cynthia v. Aetna Health and Life Insurance Company	7/6/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/5/11
Second Judicial District of the State of Nevada, County of Washoe, No. CV10-02048	Lyman, Seth v. The Mega Life and Health Insurance Company; Aetna Life Insurance Company; Aetna Student Health; Does 1-50	7/7/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/8/11
Superior Court of the State of Arizona, County of Pima, No. C20105371	Lofgreen, Taunya v. Aetna Health Inc. (Pennsylvania) FN d/b/a Aetna Life Insurance Company	7/9/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/28/11
District Court, County of Oklahoma, OK, No. SC-2010-12240	Brown, Brian E. and Anny Duangvilay v. SRC, An Aetna Company	7/12/10	Benefit Coverage Determination	Contract 964.26	None	Closed - Settled	9/13/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, County of Los Angeles, West Los Angeles Courthouse, Small Claims Division, No. 10W01264	Crist, Andrew Thomas and Beverly Arbuckle Crist v. Aetna Life Insurance, Inc.	7/15/10	Benefit Coverage Determination	Compensatory 280.00	None	Closed - Settled	12/15/10
Snohomish County District Court, Everett Division, WA, No. S10-448	Sheehan, III, William A. v. Nordstrom Inc., Aetna Health Inc.	7/16/10	Benefit Coverage Determination	Compensatory 4600.00	None	Closed - Aetna Dismissed with Prejudice	10/4/10
United States District Court for the Northern District of Georgia, Atlanta Division, Docket No.: 1:10 CV-2245	Thompson, William L. v. Aetna Health Inc.	7/16/10	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	1/24/13
Superior Court of New Jersey, Law Division, No. DC-002721-10	Hamilton Surgery Center v. Robert Philogene	7/19/10	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	8/23/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Texas, Dallas Division, No. 3-10CV1463-K	Threadgill, Grant v. Aetna Life Insurance Company, Inc.	7/26/10	Benefit Coverage Determination	Contract 10500.00 Contract 75000.00	None	Closed - Settled	3/11/11
Superior Court of California, County of Los Angeles, Small Claims, Northeast District, Pasadena Courthouse, Small Claims Division, No. PAS10S00997	Morgan, Carol Campbell v. Aetna Life Insurance Corporation	7/28/10	Benefit Coverage Determination	Compensatory 4851.80	None	Closed - Settled	4/1/11
Civil Court of the City of New York, County of New York, No. 042467 2010	Ayoub, Lara v. Aetna Student Health Agency d/b/a Aetna Life Insurance Company	7/30/10	Benefit Coverage Determination	Contract 14046.40	None	Closed - Settled	4/14/11
In the Medina Municipal Court, Medina County, OH, Docket No. 10-CVF 01048	Southwest General Health Center v. Carolyn Andrisin v. Aetna	8/6/10	Benefit Coverage Determination	Contract 8119.80	None	Closed - Settled	2/7/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Maricopa County Justice Courts, AZ, Highland Justice Court, Small Claims, No. CC2010469911SC	Kapoor, Maya L. v. Aetna Student Health Agency, Inc.	8/13/10	Benefit Coverage Determination	Compensatory 2500.00	None	Closed - Settled	12/29/11
Superior Court of California, County of Los Angeles, West District, No. LAW 10W01444 Never served - Improper Service 10/8/2010	Donahue, Barbara v. Aetna Insurance Company of Conneticut	8/16/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/20/12
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. SC-3370-10	Bussanich, Robin v. Aetna Dental	8/17/10	Benefit Coverage Determination	Contract 632.00	None	Closed - Settled	3/22/11
Berea Municipal Court, Docket No. 10-CVF 01804	Priti Nair MD Inc. v. Marse D. Ratliff v. Aetna Life Insurance Co.	8/18/10	Benefit Coverage Determination	Contract 2969.63	None	Closed - Settled	12/16/10

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Union County, No. DC-007683-09	Burgess Lee Berlin, MD, PA v. Vitoria Simoes improperly pleas as Vitoria Simoes a/k/a Maria V. Simoes Antonio Mendes v. Aetna Health, Inc.	8/18/10	Benefit Coverage Determination	Contract 15000.00	None	Closed - Settled	6/8/11
County Court Hillsborough, Docket No.: 10-021271	Rojas, Ezequiel v. Barry Z. Levine and Aetna Health Inc.	8/19/10	Benefit Coverage Determination	Costs 334.92	None	Closed - Settled	11/22/10
Superior Court of New Jersey, Law Division Special Civil Part Monmouth County, No. SC-3068-10	Schechter, Robert & Penny v. Aetna Health, Inc.	8/19/10	Benefit Coverage Determination	Contract 1145.00 Fees 22.00	None	Closed - Settled	6/3/11
U.S. District Court for the District of New Jersey, No. 1:10-CV-04244-NLH-JS	Freedman, Richard L. v. Aetna Health, Inc.	8/19/10	Benefit Coverage Determination	Contract 22500.00	None	Closed - Settled	4/11/11

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of Washington for King County, No. 10-2-29400-7 SEA	D.F. and S.F., by and through their parents, A.F. and R.F.; S.M.-O, by and through his parents, S.M. and D.O.; on their own behalf and on behalf of all similarly situated individuals v. Washington State Health Care Authority; Aetna Life Insurance Company; Public Employees Benefits Board; Doug Porter, Administrator of the Washington State Health Care Authority and Chairman of the Public Employees Benefits	8/20/10	Class Action	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/10/10
Superior Court of New Jersey, Law Division, Special Civil Part Essex County, Docket No.: DC-025918-10	Rosenrauch, Arie v. Aetna Health (NJ) Inc. (No. DC-025918-10)	8/24/10	Benefit Coverage Determination	Contract 1200.00 Fees 32.00	None	Closed - Pretrial - Judgment in Favor of Aetna	9/11/13
U.S. District Court for the Southern District of Texas, Houston Division, No. 4:cv-3124	Farr, David Everett v. Aetna Health, Inc., Aetna Health Insurance Company, Aetna Health and Life Insurance Company	8/30/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/6/11
Superior Court of New Jersey, Middlesex County, Special Civil Part, No. DC-021963-10	Dolnick, Craig v. Aetna FSA	8/31/10	Benefit Coverage Determination	Contract 922.71	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/6/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court , South Central Judicial District, County of Morton, No. 2006 746442	State of North Dakota by Workforce Safety & Insurance v. Tammy S. Berndt v. Ferrelgas Medical Plan	9/1/10	Benefit Coverage Determination	Contract 14442.09	None	Closed - Settled	1/22/13
Warren County General District Court, VA, No. V10-2099	Cecci, Julie A. v. Aetna Health Inc.	9/2/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/6/10
In the United States District Court Eastern District of Michigan Southern Division, No. 2:10-cv-13602-VAR-PJK	Zepeda, Jr., Enrique v. Aetna Health Inc.	9/9/10	Benefit Coverage Determination	Contract 17000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/12/11
Common Pleas Court, Lucas County, OH, No. G-4801-CI-02010006377-000	Strong, Anna v. Aetna Life Insruance Co.	9/10/10	Benefit Coverage Determination	Contract 25000.00	None	Closed - Settled	8/24/11

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Special Civil Part, Monmouth County, No. DC-016631-08	Garden State Anesthesia-Raritan Bay v. Edward Donnely, Jr. v. Aetna	9/16/10	Benefit Coverage Determination	Contract 2961.00 Costs 3.00 Fees 65.00	None	Closed - Settled	6/8/11
Fulton County Magistrate Court, GA, No. 10MS119140	Adbul-Nour, Nabil J. v. Aetna Insurance Company of Connecticut	9/20/10	Benefit Coverage Determination	Contract 875.00	None	Closed - Settled	4/5/11
US. District Court for the Distict of New Jersey, No. 2:10-cv-04912-SRC-MAS	Denton, John H. and Holly W. v. Aetna Health Inc; Aetna Health Management, LLC; Aetna Health and Life Insurance Company; and Aetna Insurance Company of Connecticut	9/20/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/4/11
Commonwealth of Pennsylvania, County of Chester, No. CV-277-10	Kingma, Peter v. Aetna Life Insurance Company	9/21/10	Benefit Coverage Determination	Contract 1450.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/29/12

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Commonwealth of Pennsylvania, County of Chester, No. CV278-10	Moore, Sarah v. Aetna Life Insurance Company	9/21/10	Benefit Coverage Determination	Contract 2335.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/29/12
U.S. District Court for the District of Oregon, No. CV10-1152-HU	Green, Derek v. Aetna Life insurance Company and Yahoo! Inc. Health and Welfare Benefit Plan	9/22/10	Benefit Coverage Determination	Contract 4544460.00	None	Closed - Settled	12/9/10
Superior Court of the State of California, County of San Bernardino, No. CIVDS 1013242	Brady, Kimberly S. v. Arrowhead Regional Medical Center; Anthem Blue Cross Life and Health Insurance Company; Aetna Life Insurance Company and Does 1 - 10	9/23/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/2/11
Civil Court of the City of New York, County of New York, Docket, No.: CV-028051-10/NY	The New York and Presbyterian Hospital v. Silvia A. Medford aka Silvia A. Medfordkruse aka Silvia A. Kruse aka Silvia A. Nedford v. Strategic Resource Company	9/24/10	Benefit Coverage Determination	Contract 20722.38	None	Closed	6/17/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
United States District Court for the District of Columbia	Zalduondo, Carolina v. Aetna Health Inc.	9/24/10	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	8/21/13
Civil Court of the City of New York, Small Claims Part, No. SCK 5406/10	Simonson, Alexander C. v. Aetna Health, Inc.	9/27/10	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	9/6/12
United States District Court for the District of Oregon, No. CV 10 1193	Dunne, Marie Claire v. ING Insurance Services Inc. d/b/a and/or f/k/a Aetna Insurance Company	9/29/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/20/11
Fresno County Superior Court, Small Claims, No. 10CESC02107	Nguyen, Tan Van v. Aetna Health of California	10/6/10	Benefit Coverage Determination	Unspecified	None	Closed - Trial - Aetna Favor	12/9/10

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of the State of California, County of Orange, No. 30-2010 00414580	PLC Land Company v. Aetna Life Insurance Company	10/6/10	Benefit Coverage Determination	Damages/Injuries 19303766.00	None	Closed - Settled	2/2/12
United States District Court, District of Oregon, Portland Division, No. CV 10-1227 MO	Hynes, Rebekah v. Aetna Life Insurance Company	10/7/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/17/11
Court of Common Pleas, Philadelphia County, No. October 2010 001278	Roman, William v. Aetna Health, Inc.	10/12/10	Benefit Coverage Determination	Contract 5973.60	None	Closed - Settled	10/21/11
Stow Municipal Court, Summit County, OH, No. 2010CVF03727	Wilkins, Vincenza J. v. Aetna Health and Life Insurance Company	10/12/10	Benefit Coverage Determination	Contract 5000.00 Interest 0.00	None	Closed - Settled	3/5/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, County of Orange, Case No. 30-2010-00420445	Michael, Brendalyn Ann v. Aetna Health of California Inc., South Coast Medical Center and CMRE Financial Services	10/19/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/29/11
Hamilton County Municipal Court, Cincinnati, OH, No. 10CV13484	Reconstructive Orthopaedics & Sports Medicine, Inc. v. Michael Sharpe v. Aetna U.S. Healthcare	10/20/10	Benefit Coverage Determination	Contract 2854.78	None	Closed - Settled	7/5/12
In the Circuit Court for the County of Wayne, No. 080217082NF	Parker, Omarko v. Nationwide Mutual Firm Insurance Company v. Aetna Health Insurance	10/22/10	Benefit Coverage Determination	Contract 14993.52	None	Closed	12/7/11
Fairfax County Circuit Court, Small Claims Division, Docket No.: 10-27-488	Raucheisen, Michael T. v. Aetna Life Insurance Company	11/1/10	Benefit Coverage Determination	Contract 991.76 Costs 58.00	None	Closed - Settled	4/5/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Ohio, Eastern Division, No. 2:10-cv-00985	Hatfield, Judy v. Trinity Health Corporation; Mount Carmel Health and Aetna Life Insurance Company	11/2/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/7/12
Supreme Court State of New York, County of Suffolk, No. 40615/10	Pinarli, Esin v. Aetna Student Health and Aetna Life Insurance Company	11/3/10	Benefit Coverage Determination	Contract 35475.97	None	Closed - Settled	9/10/13
In the Court of Common Pleas of Bucks County, PA, No. 10-11399	Schmid, Tiffany v. Aetna Health, Inc.	11/4/10	Benefit Coverage Determination	Contract 17939.50	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/8/11
Superior Court of New Jersey, Somerset County, Law Division, Docket No.: SOM-L-1706-10	Vivar-Perez, Jessica v. Eugene F. Demkowicz; NJPLIGA; Aetna Insruance Co; John Doe 1-5 and ABC Insurance Co. 1-5	11/4/10	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/29/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In the United States District Court for the Southern District of Texas, Houston Division, Docket No. 4:10-cv-04439	O'Donohoe, John F. and Mary O'Donohoe v. Exxonmobil Medicare Supplement Plan	11/8/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/13/11
In the County Court, in and for Palm Beach County, Florida, Docket No.: 2010 SC: 012518XXXXMB	Mayer, Robert J. v. Aetna Health, Inc.	11/9/10	Benefit Coverage Determination	Contract 2100.00 Fees 250.00	None	Closed - Settled	12/3/10
444th Judicial Disrict Court, Cameron County, TX 2010-DCL-6938H	Peralta, Edna v. Aetna Life Insurance Company	11/10/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/11/11
Supreme Court of the State of New York, County of New York, No. 10/114808	Campisi, Philip J. v. Aetna Life Insurance Company	11/12/10	Benefit Coverage Determination	Contract 20561.00	None	Closed - Settled	4/5/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Middlesex County, No. MID-DC-026486-10	Beke, M.D., Theodore v. Marilyn Marie v. Aetna Insurance Company	11/17/10	Benefit Coverage Determination	Contract 4950.00 Costs 57.00	None	Closed - Settled	6/6/11
Fairfax County General District Court, Docket No.: GC10029532-00	Jacoboski, Robert Bryan v. Aetna Life Insurance Company	11/23/10	Benefit Coverage Determination	Contract 2309.89 Costs 58.00	None	Closed - Settled	4/5/11
U.S. District Court for the Central District of California, No. CV10-9068 VBF (SHX)	Hoffman, Joni v. Aetna Life Insurance Company	11/23/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/28/11
Maricopa County Justice Court, Small Claims	Gonzalez, Eric v. Aetna Health Insurance Company	11/30/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/29/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Maricopa County Justice Courts, State of Arizona, North Valley Justice Court, Docket No.: CC2010-560563SC	Gonzalez, Eric v. Aetna Health Insurance Company	11/30/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/29/11
City of Richmond, General District Court, Civil Division, No. 10055299	Wilder, Detanya v. Aetna Life Insurance Company Co.	12/13/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/3/11
Superior Court of California, County of Los Angeles, West District, No. SC110722	Viale, Charles v. Aetna Life Insurance Company, Aetna Health of California, Inc., Does 1 through 50	12/15/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/21/11
Superior Court, Monmouth County, Special Civil Part, No. DC-021815-10	Riverview Medical Center v. Lorenzo Cifelli v. Aetna	12/16/10	Benefit Coverage Determination	Contract 2076.53 Costs 48.00 Fees 56.35	None	Closed - Settled	3/22/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court California, County of San Diego, Small Claims, No. 37-2010-00018655-SC	Ahmed, Meraj v. Aetna Insurance Company of Connecticut	12/21/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/28/11
Civil Court of theCity of New York, County of Kings, No. CV-115351-10/KI	Platsky, Jack v. Aetna, Inc.	12/23/10	Benefit Coverage Determination	Contract 1400.00	None	Closed - Settled	6/8/11
Circuit Court Jackson County, State of Oregon, Small Claims Division	Hay, Peter Douglas v. Aetna Insurance Co.	12/28/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/4/11
Superior Court of New Jersey, Law Division, Camden County, No. CAM-L-0002-11	Markart, Frederick v. 21st Century Assurance Company f/k/a American International Insurance Co. of Delaware; Aetna Health Inc., and/or John Does	12/28/10	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/22/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Commonwealth of Kentucky, Fayette Circuit Court, 8th Division, No. 2011-CI-42	Wesley, Misty Lynn v. Xerox/ACS/Aetna	1/3/11	Benefit Coverage Determination	Contract 2000000.00	None	Closed - Failure of Plaintiff to Prosecute	2/1/12
The General Court of Justice, Distict Court Division, Pamlico County, No. 10 CVD 139	Two Rivers Healthcare - Trent f/k/a New Bern Healthcare Center v. Haralson Gordon v. Aetna Life Insurance Company	1/3/11	Benefit Coverage Determination	Contract 11344.10 Interest 3636.32	None	Closed - Settled	7/1/13
Court of Common Pleas, Allegheny County, PA, No. GD-11-202	Ringel, Raymond V. v. J&J Associates; James A. Laux; John Conway; James A. Laux; and John Conway d/b/a J & J Associates; HealthAmerica, Inc.; and Coventry Health and Life Insurance Company	1/4/11	Benefit Coverage Determination	Compensatory 65000.00 Unspecified 10000.00	None	Open	
In the United States District Court for the District of Colorado, No. 1:10-cv-01198-PAB-CBS	Hester, Rachel A. v. Aetna Life Insurance Company	1/5/11	Benefit Coverage Determination	Unspecified	None	Closed	4/25/11

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In the United States District Court for the District of Colorado, No. 1:11-cv-00087-WYD-MEH	Rawson, Lisa , individually and as mother and next of friend to her minor children Jacob Rawson, Michael Rawson, Catherine Rawson, Matthew Rawson, and Thomas Rawson v. Aetna Life Insurance Company	1/12/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed with Prejudice	7/20/11
Superior Court of New Jersey, Law Division, Salem County, No. SML-L-0025-11	Ocheltree, Ashley v. Edward Bailey, Old Reliable Auto Sales, Jeannine Alfieri, Aetna Insurance Company, Stubini's, New Jersey Manufacturers Insurance Company, Aetna insurance Company, John Doe, John Doe, Inc., John B. Doe, Inc., John A. Doe and/or John A. Doe, Inc.	1/12/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/3/13
Superior Court of New Jersey, Cape May County, Special Civil Part, No. DC-003652-10	Cape May Regional Medical Center v. Sandra G. Novick v. Aetna Insurance Company	1/14/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/24/11
Justice Court of Harrison County, MS, No. BV052/1116	Hudson, Jennifer v. Aetna Health & Life Ins. Co.	1/19/11	Benefit Coverage Determination	Costs 71.00	None	Closed - Settled	4/5/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Arizona, No. 2:11-cv-00161-FJM	Doe, Jane v. Nova Financial and Investments Corporation d/b/a Nova Home Loans, Plan Administrator for the Nova Financial and Investments Corporation Group; Nova Financial and Investments Corporation d/b/a Nova Home Loans Group Health Plan and Aetna Life Insurance Company, et al.	1/25/11	Class Action	Unspecified	None	Closed	8/16/11
Superior Court of California, County of Los Angeles, Northwest District, Van Nuys Courthouse East, No. LAV 11V00442	Cohen, Judy v. Aetna Life Insurance Company	1/28/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/28/11
U.S. District Court for the Central District of California, No. CV11-0895 JHN (JEMx)	Wohl, Richard v. Aetna Life Insurance Company and Coast to Coast Computer Products/Gevity Group Coverage Plan	1/28/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/9/11
U.S. District Court for the District of New Jersey, No. 3:33-av-00001	Heinel, Christopher and Foundation Asset Management v. Aetna Health, Inc.; Corporate Health Insurance Company; Amerihealth Insurance Company of New Jersey and Amerihealth HMO, Inc.	1/28/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/30/12

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In the County Court in and For Palm Beach County, FL, No. 2011SC000885	Duckrow, Valerie v. Aetna Rx Home Delivery, LLC	1/31/11	Benefit Coverage Determination	Contract 482.53	None	Closed - Settled	6/16/11
Philadelphia Municipal Court, First Judicial District of PA, No. SC-10-06-07-4411	Medical Management Solutions, LLC, assignee of accounts receivable for Allied Medical Group v. Madeline Holmes v. Independence Blue Cross; Keystone Health Plan East and Aetna Insurance Company	2/3/11	Benefit Coverage Determination	Contract 1132.30	None	Closed - Settled	10/31/11
U.S. District Court for the District of South Carolina, No. 3:11-cv-00293-CMC	Laag, Alice v. Aetna Life Insurance Company	2/4/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/3/11
U.S. District Court for the Southern District of Florida, Miami Division, No. 1:11-cv-20422-JAL	Koogle, Nona v. Aetna Life Insurance Company	2/7/11	Benefit Coverage Determination	Contract 21000.00	None	Closed - Settled	6/18/14

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas, Cuyahoga County, OH, No. CV 11 748010	Verhiley, Mary K., a minor by and through her parents and next friends, Clare Verhiley and Thomas Verhiley and Clare Verhiley and Thomas Verhiley, individually v. Aetna Health, Inc.	2/7/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/18/11
District Court of the State of New York, Nassau County, No. CV-004884-11	Spampinato, Renato and Susan Spampinato as Mother and Natural Guardian of Nicholas Spampinato v. Aetna Health, Inc.	2/9/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/27/11
Superior Court of New Jersey, Law Division, Special Civil Part, Mercer County, No. DC000548-11	Tracy, Joseph, Ph.D. v. Bryan Clifford and Gail Clifford v. Aetna Insurance Company	2/10/11	Benefit Coverage Determination	Costs 56.00 Fees 1500.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	8/26/11
Supreme Court of MO on appeal from the Circuit Court of St. Louis County; No. SC93134, on appeal from 11SL-CC00535	Nevils, Jodie as a Class Action on behalf of himself & all others similarly situated v. Group Health Plan, Inc.	2/14/11	Class Action	Unspecified	None	Closed - Appeal/Post Trial - Aetna Favor	7/11/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Special Civil Part, Ocean County, No. DC 001495-11	Wetstein, M.D., Lewis v. David Bohola and Catherine D. Bohola v. Aetna Health Insurance Company and Aetna Health Inc.	2/15/11	Benefit Coverage Determination	Contract 3170.87	None	Closed - Settled	6/3/11
Superior Court of Arizona, County of Maricopa, No. CV2011-003851	Murphy, Janet and Steven v. Aetna Life Insurance Company	2/16/11	Benefit Coverage Determination	Unspecified	None	Closed - Trial - Aetna Favor	9/14/12
U.S. District Court for the Eastern District of Michigan, Southern Division, No. 2:10-cv-15054	Seals, Nicholas J. v. D. Scott, B. Gordon, B. Clement, C. Murphy, B. Upston, , K. Nibbelink, V. Stevenson, A. Neff, A. Edelman, C. Ives, Prison Health Service Inc., Correctional Medical Services Inc., Aetna	2/19/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	8/4/14
In the Circuit Court of the 13th Judicial Circuit, Hillsborough County, FL, No. 11 02348	Munford, Janica v. Dr. Gordon Zuerndorfer and Aetna Health, Inc.	2/21/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/29/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Minnesota, No. CV-00434-MJD-SER	Boardman, Jerrold v. Federal National Mortage Association a/k/a Fannie Mae; Aetna Life Insurance Company and United Behavioral Health	2/22/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/29/11
In the United States District Court for the Western District of Oklahoma, No. 5:11-cv-208-F	Burch, Erin v. Aetna Life Insurance Company	3/1/11	Benefit Coverage Determination	Contract 75000.00	None	Closed - Settled	7/19/11
Superior Court of New Jersey, Law Division, Essex County, Special Civil Part, No. PAS-DC-000476-11	Arias, Ana M. v. Aetna	3/4/11	Benefit Coverage Determination	Contract 4828.45	None	Closed	4/5/11
Circuit Court of the Nineteenth Judicial Circuit, Lake County, IL, No. 11SC1611	Bray, Hillis H. v. Aetna Health Inc.	3/7/11	Benefit Coverage Determination	Contract 1218.67	None	Closed - Pretrial - Aetna Dismissed Voluntarily	5/18/11

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas, Miami County, Ohio, No. 11-173	White, Jr., Ronald D. v. Hewitt Benefit Resources, Aetna Life Insurance Company, SCI Funeral & Cemetary Purchasing	3/7/11	Benefit Coverage Determination	Contract 15000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/21/12
County of West Chester, State of New York, No. cv-004457	Community Hospital of Dobbs Ferry v. Jasper Cokely v. Aetna Life Insurance Company	3/10/11	Benefit Coverage Determination	Contract 4319.09	None	Closed - Settled	9/11/13
Superior Court of California, County of Los Angeles, No. BC457887	Exley, Ray Warren v. Aetna Life Insurance Company and Does 1-100, inclusive	3/22/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/30/11
Chesapeake General District Court, Commonwealth of Virginia., No. GV11-5670	Suddeth, Debbie L. v. Aetna	3/24/11	Benefit Coverage Determination	Compensatory 4132.30 Costs 56.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	7/25/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of New York, County of Richmond, No. CV-006661-11/RI	Papapietro, Anthony v. Aetna Inc.	3/30/11	Benefit Coverage Determination	Contract 1910.16	None	Closed - Aetna Dismissed	11/17/11
Circuit Court of the Nineteenth Judicial Circuit, Martin County, FL, No. 11-456CA	Hatcher, David and AnnMarie v. Aetna Health Inc. and RAD MSO of Florida, Inc., d/b/a MedSolutions, Inc.	4/1/11	Benefit Coverage Determination	Compensatory 15000.00	None	Closed - Settled	8/15/12
Superior Court of New Jersey, Sussex County, Special Civil, Small Claims, No. SC-174-11	Minadeo, Nicholas v. Aetna, Inc.	4/1/11	Benefit Coverage Determination	Contract 234.00 Costs 17.00	None	Closed - Settled	9/7/12
District Magistrate Court 38-1-04, Montgomery County, Abington, PA, No. CV-0000114-11	Durney, Robert J. v. Orthopaedic Specialty Center; Abington Memorial Hospital and Aetna Customer Relations Center	4/4/11	Benefit Coverage Determination	Contract 936.96 Fees 124.55	None	Closed - Settled	6/16/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Eastern District of Texas, Beaumont Division, No. 1:11-cv-00161-RC	Londow, Darrie C. v. Aetna Health, Inc. formerly known as Aetna US Healthcare, Inc; Railroad Employees National Health and Welfare Plan and National Carriers' Conference Committee	4/5/11	Benefit Coverage Determination	Contract 16162.40	None	Closed - Settled	8/7/12
U.S. District Court for the Eastern District of Michigan, No. 2:112-cv-11254	Rhinehart, Kenneth A. v. D. Scott, B. Gardon, B. Clement, C. Ives, K. Hamblin, J. Potter, Prison Health services Inc., Aetna Inc., Dr. V. Stevenson, Dr. P. Vemuri, Dr. A. Edelman	4/8/11	Benefit Coverage Determination	Compensatory 2300000.00 Punitive 840000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	3/15/18
Superior Court of California, County of Los Angeles, CA, No. 11W00558	Dolkhani, Nahid v. California Fertility Partners and Aetna Health California Inc.	4/8/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/29/11
Superior Court of California, County of Los Angeles, Central District, Small Claims, No. LAM11W03317	Pike, Shane v. Aetna Insurance Company of Connecticut	4/8/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/19/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Trial Court of Massachusetts, Boston Municipal Court Department, East Boston, MA, No. 1105SC000173	Rey, Wilson v. Mark Bertolini (Aetna) Insurance	4/8/11	Benefit Coverage Determination	Contract 693.00 Fees 50.00	None	Closed - Settled	10/21/11
U.S. District Court for the District of Utah, Central Division, No. 1:11-cv-00052-DN	Rick S. and S.S,. v. Aetna Life Insurance Company	4/8/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/4/11
Circuit Court of Cook County, First Municipal District, IL, No. 10M121691	Athletico v. Michael Gamboa v. Aetna Health of Illinois, Inc.	4/11/11	Benefit Coverage Determination	Contract 5423.72	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/15/11
Supreme Court of NY, County of Monroe, No. 11/4700	Hunt, Donna v. Aetna Life Insurance Company	4/14/11	Benefit Coverage Determination	Contract 2648.66	None	Closed - Settled	8/30/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Trial Court of Massachusetts, Small Claims Session, Brookline Division, Norfolk County, No. 1109SC103	Liang, Susan v. Aetna Health Inc.	4/19/11	Benefit Coverage Determination	Compensatory 630.00 Contract 210.00 Costs 50.00 Fees 300.00	None	Closed - Settled	8/10/11
United States District Court for the Northern District of Illinois, Eastern District, No. 1:10-CV-05282	Krukowski, Cynthia v. Aetna Health of Illinois, Inc.; Omicron Technologies, Inc; Marilynn G. Rabb Foundation and Lionel Rabb	4/21/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/30/12
United States District Court, Eastern District of Louisiana, No. 2:10-cv-02047-CJB-KWR	Digirolamo, Duane J. v. Aetna Health Management LLC	4/30/11	Benefit Coverage Determination	Contract 3611.00	None	Closed - Settled	9/19/11
Superior Court of California, Santa Monica Courthouse, Small Claims Division, Los Angeles County, No. 11A01074	Selvo, Gerald Victor v. Aetna Health of California, Inc.	5/3/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/29/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
United States District Court, District of Utah, Central Division, No. 2:11-CV-417 SA	Greg C.; Michelle C.; Joan M.; John M.; and Avalon Hills Residential Treatment Center v. Horizon Blue Cross Blue Shield of New Jersey; Magellan Behavioral Health; The Prudential Welfare Benefit Plan and Aetna Life Insurance Company	5/6/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	12/28/11
Superior Court of California, Santa Clara County, No. 211-SC07987	Fish, Robin v. Aetna Life Insurance Company	5/9/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/25/11
General District Court, City of Charlottesville, VA. No. GV11-1718	Murphy, Trina v. Aetna Insurance of Connecticut	5/10/11	Benefit Coverage Determination	Contract 15000.00 Costs 54.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/18/11
U.S. District Court for the District of New Jersey, No. 2:11-cv-02672-PGS-ES	Coutts, Robert v. Aetna Health and Aetna Life Insurance Company/US Healthcare; Verizon Managed Care Network and Medical Expense Plan for Mid-Atlantic Associates and Verizon Communications, Inc.	5/11/11	Benefit Coverage Determination	Contract 75000.00	None	Closed - Settled	7/5/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Western District of Michigan, Southern Division, No. 1:11-cv-516	Russell, Matthew W. v. Aetna Life Insurance Company and Bank of America Corporate Benefits Committee	5/19/11	Benefit Coverage Determination	Contract 37814.51	None	Closed - Settled	1/5/12
In the State Court of Gwinnett County, GA, No. 11C-04436-6	Porter, Thomas v. ADP Benefits Services Inc.; Aetna Health and Life Insurance Company and United Healthcare Insurance Company	5/25/11	Benefit Coverage Determination	Compensatory 250000.00 Punitive 10000000.00	None	Closed - Settled	7/12/11
U.S. District Court for the District of Montana, Missoula Division, No.CV-11-81-MDWMJCC	Peterson, Michael v. Time Insurance Company, Assurant Health, John Alden Life Insurance Company, Aetna US Healthcare, Aetna Health & Life Insurance Company, John Does 1, 2, and 3	5/25/11	Benefit Coverage Determination	Unspecified	None	Closed - Appeal/Post Trial - Aetna Favor	4/8/14
Superior Court of California, San Francisco County, No. CSM-11-837621	Kwong, Wendy v. Aetna Life Insurance Company	5/31/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/25/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Woburn District Court, MA, No. 1153SC000693	Apetogbo, Agbessi v. Aetna Inc.	6/1/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/16/11
Superior Court, Judicial District of Waterbury, CT	Suchenski, Louis v. Aetna Health Management, Inc.	6/3/11	Benefit Coverage Determination	Contract 21300.00	None	Closed - Settled	10/11/13
Superior Court of California, County of Los Angeles, Beverly Hills Facility, Small Claims Division, No.11S00874	Roe, Linda v. Aetna Life Insurance Company	6/6/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/16/11
Circuit Court of Kanawha County, West Virginia, No. 11-c-679	Charleston Area Medical Center, Inc. a West Virginia corporation v. Loretta Toppins v. Verizon Communications, Inc.	6/9/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/16/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, County of San Bernardino, Rancho Cucamonga District, Small Claims Division, No. SMCRS 1101363	Macedo, Vannessa Marie v. Aetna Life Insurance Company	6/10/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/1/11
Magistrate Court of Fulton County, GA, No. 11MS131702	Severinsen, Michael v. Aetna Health and Life Insurance	6/13/11	Benefit Coverage Determination	Contract 963.00 Costs 76.50 Interest 96.30	None	Closed - Settled	1/12/12
Superior Court of California, County of Los Angele, Santa Monica Courthouse, No. 11A01480	Breitman, Julia M. v. Aetna Life Insurance Company and Aetna Health of California, Inc.	6/13/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	12/29/11
Superior Court of California, County of Los Angeles, Santa Monica Courthouse, Small Claim, No. 11A01477	Breitman, Reid v. Aetna Life Insurance Company and Aetna Health of California, Inc.	6/13/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/29/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, County of Los Angeles, Santa Monica Courthouse, Small Claim, No. 11A01478	Breitman, Julia M.; Breitman, Reid v. Aetna Life Insurance Company and Aetna Health of California, Inc.	6/13/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	12/29/11
Superior Court of California, County of Los Angeles, Santa Monica Courthouse, Small Claim, No. 11A01479	Breitman, Julia M.; Breitman, Reid v. Aetna Life Insurance Company and Aetna Health of California, Inc.	6/13/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	12/29/11
Superior Court of California, County of Los Angeles, Santa Monica Courthouse, Small Claim, No. 11A01481	Breitman, Julia M. v. Aetna Life Insurance Company and Aetna Health of California, Inc.	6/13/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	12/29/11
Superior Court of California, County of Los Angeles, Santa Monica Courthouse, Small Claim, No. 11A01482	Breitman, Julia M. v. Aetna Life Insurance Company and Aetna Health of California, Inc.	6/13/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	12/29/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, County of Los Angeles, Santa Monica Courthouse, Small Claim, No. 11A01483	Breitman, Julia M. v. Aetna Life Insurance Company and Aetna Health of California, Inc.	6/13/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	12/29/11
Superior Court of California, County of Los Angeles, Santa Monica Courthouse, Small Claim, No. 11A01484	Breitman, Julia M. v. Aetna Life Insurance Company and Aetna Health of California, Inc.	6/13/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	12/29/11
American Aribitration Association, 74 420 00186 11 One Sansome Street, #1600 San Francisco, CA 94104-4449 Ph.(415) 981-3901	Kravitz, Ronald S. v. Aetna Dental Appeals	6/16/11	Benefit Coverage Determination	Unspecified	3475.00	Closed - Arbitration - Against Aetna	3/9/12
Magistrate Court of Fulton County, GA, No. 11MS5131944	Drozjock, Christopher J v. Aetna Health Inc	6/17/11	Benefit Coverage Determination	Contract 2536.00 Costs 76.50	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/18/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of the City of New York, County of New York, No. 028695 2011	Sohoni, Neera K. and Venkatrao S. Sohoni v. Aetna Life Insurance Company	6/20/11	Benefit Coverage Determination	Compensatory 11000.00 Contract 1878.19	None	Closed - Settled	1/12/12
Superior Court of California, County of San Diego, Kearny Mesa Facility, Small Claims Division No. 37-2011-00004177-SC-SC-CTL	Schroder, Stephanie v. Aetna Life Insurance Company	6/24/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/29/11
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. DC-022640-11	Brasileiro-Lima, Joanne v. Aetna Health, Inc.; Hackensack University Medical Center and John Doe, a person, persons or entity whose identity is not presently known	6/24/11	Benefit Coverage Determination	Compensatory 3091.50 Punitive 10290.50	None	Closed - Settled	10/17/11
101st Judicial District Court, Dallas County, TX, No. DC-11-07969	Hutchison, Suzanne v. Aetna Life Insurance Company	6/28/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/20/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In the Arkon Municipal Court, Summit County, OH, No. 11 CV 03753	Schreiber, Stephen J. v. Copley Health Center, Inc.; John Doe Corporation and Aetna Life Insurance Company	7/8/11	Benefit Coverage Determination	Compensatory 1370.00	None	Closed - Settled	9/8/11
In the County Court, Dallas County, TX, No. CC-11-04878-D	Lewis, Kevin and Monica Lewis v. Aetna Life Insurance Company	7/13/11	Benefit Coverage Determination	Contract 31653.34	None	Closed - Settled	11/21/11
Superior Court of New Jersey, Law Division, Essex County, No. DC-019665-11	Palma, Gregory v. Aetna	7/14/11	Benefit Coverage Determination	Contract 2500.00	None	Closed - Settled	1/24/13
74th Judical District Court, Bay County, MI, No. 11-4388-SC	Reno, Wayne T. v. Aetna	7/18/11	Benefit Coverage Determination	Contract 1455.00	None	Closed - Settled	8/23/11

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Essex County, No. ESX-L-5842-11	McLaurin, Sabirah v. CBA Industries, Inc./CBA Financial., Richard W. Iwanski, John Doe (a fictiitious name), Aetna Life Insurance Company and New Jersey Manufacturers Insurance Company ("NJM")	7/18/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/27/12
U.S. District Court for the Eastern District of Texas, Beaumont Division, No. 1:11-cv-00337-MAC	Smith, Craig v. Arkema Inc. Benefits Department, as Administrator of the Arkema Inc Flexible Benefits Plan and Aetna Life Insurance Company, as Administrator of the Arkema Inc. Flexible Benefits Plan	7/18/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/6/12
State Court of Cobb County, GA, No. 11-A-3125-7	Jordan, Melody and Thomas Jordan v. David Ugorji; Venture Physical Therapy and Aetna Insurance Company	7/29/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	3/30/16
U.S. District Court for the Northern District of West Virginia at Clarksburg, No. 1:11-cv-00116-IMK	Meek, Kim, an individual; William Meek, an individual , and Kim Meek, as next of friend for Grace Meek, an infant v. Cemex, Inc. Medical Plan; an Employee Welfare Benefit Plan; Aetna Life Insurance Company, a Connecticut corporation; and Does 1-10, inclusive	7/29/11	Benefit Coverage Determination	Contract 20995.00	None	Closed - Settled	3/16/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
334th Judicial District Court, Harris County, TX, No. 2011-45140	Eastland, Thomas E. v. Aetna Life Insurance Company	8/1/11	Benefit Coverage Determination	Contract 40000.00	None	Closed - Settled	8/2/12
County Court, El Paso County, Colorado Springs, CO, No. 11C26680	Budget Control Services Inc. v. Cheryl Kinnaird v. Aetna	8/1/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/7/12
U.S. District Court for the District of Arizona, No. 2:11-cv-01498-LOA	Messina, Sunday L., individually and as next of friend of D.M. v. Aetna Health Inc., The Health Insurance Plan of Paychex Business Solutions, Inc.	8/1/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/21/13
Civil Court of the City of New York, County of New York, Small Claims Part 45, No. 2407SCNY2011	Lux, Karen v. Aetna Health Inc.	8/3/11	Benefit Coverage Determination	Compensatory 5000.00	None	Closed - Settled	9/14/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, San Diego County, No. 37-2011-00005024-SC-SC-CTL	Delos Reyes, Roberto v. Aetna Health of California Inc.	8/3/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/19/11
Maricopa County Justice Courts, McDowell Mountain Precinct, AZ, No. cc 2011-152742SC	Trapp, Laurie M. v. Aetna Life Insurance Co.	8/9/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/19/12
Superior Court of California, County of Ventura, Small Claims, No. 56-2011-00401902-SC-SC-VTA	Good, Kathleen M v. Aetna Dental of California, Inc.	8/9/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/19/11
Small Claims Court, Justice of the Peac, Precinct No. 2, Tarrant County, TX, No. SC16237	Miller, Steven Wesley v. Aetna Health Insurance	8/10/11	Benefit Coverage Determination	Contract 9140.60	None	Closed - Settled	3/9/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Prince William General District Court, Manassas, VA, No. GV11-13697	Hmaey, Mohamed M v. Aetna, Inc	8/15/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/30/11
U.S. District Court for the Eastern District of Kentucky, No. 2:11-CV-00067-DCR-CJS	Pettit, Joseph A v. Chevron Phillips Chemical Co., LP and Metropolitan Life Insurance Company and Aetna Life Insurance Company	8/17/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/13/12
Magistrate District Court No. 38-1-06, Montgomery County, Narberth, PA, No CV-0000166-11	Forman, Nancy v. Aetna Inc., d/b/a Aetna Student Health, Aetna Life Insurance Company, individually and D/B/A Aetna Student Health	8/23/11	Benefit Coverage Determination	Contract 205.00	None	Closed - Settled	9/11/13
188th Judicial District Court, Gregg County, TX, No. 2011-1956-A	Mayden, Whitney and Kyle Mayden v Aetna Health, Inc., Aetna Life Insurance Company, and Aetna Inc.	8/29/11	Benefit Coverage Determination	Contract 225775.00	None	Closed - Settled	8/14/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
In the 9th Circuit Court for the County of Kalamazoo, State of Michigan, No. 2011-0446-NF	Townsend, Dallas Dale v. Progressive Marathon Insurance Company and Aetna Life Insurance Company	8/29/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/6/12
District Court of Maryland for Montgomery County, No. 0601000205382011	Holtz, Gerald I. v Aetna	9/7/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/29/12
Hamilton County Municipal Court, Cincinatti, OH, No. 11 CV 22163	Reconstructive Orthopaedics & Sports Medicine, Inc. v. Tina L. Stenson v. Aetna Life Insurance Company	9/12/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/5/14
Circuit Court of the Thirteenth Judicial District in and for Hillsborough County, FL, No. 11 11583	Antonio, Aidza v. Florida Surgery Center Enterprises, LLC d/b/a Tampa Outpatient Surgical Facility, Inc; Gulf-to-Bay Anesthesiology Associates, P.A.; and Aetna Health Insurance Company	9/13/11	Benefit Coverage Determination	Contract 75000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/5/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Broward County Court, FL, No. 1110185CONO	Christensen, Chad v. Aetna Health, Inc.	9/15/11	Benefit Coverage Determination	Contract 100.00	None	Closed - Settled	9/14/12
Superior Court of New Jersey, Law Division, Union County, No. DC-24792-10	Newark Diagnostic Radiology v. Vate A. Tchero v. Aetna Health Administrators, LLC	9/15/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/5/12
Civil Court of the City of New York, Manhattan Small Claims Part, NY, No. 16338 SCNY 2011 1	Dempsey, John v. Aetna Insurance	9/17/11	Benefit Coverage Determination	Contract 3192.00	None	Closed - Trial - Aetna Favor	6/27/13
County Court Douglas County, NE, No. CI11-13149	General Service Bureau, Inc. v. Susan Utoft v. Aetna, Inc.	9/19/11	Benefit Coverage Determination	Damages/Injuries 2000.00	None	Closed - Settled	1/30/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Rochester District Court, Stafford County, NH, No. 11-SC-424	Turner, Catherine v. Aetna Health Insurance	9/19/11	Benefit Coverage Determination	Compensatory 2466.00 Costs 72.00	None	Closed - Settled	1/12/12
Superior Court, Judicial District of New Britain at New Britain, CT, No. HHB-CV-11-6010100-S	Bristol Hospital, Inc. v. Alexandra Bouteiller and Thomas Bouteiller v. Aetna Health Inc. and Dr. Makram Gedeon	9/19/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/10/12
Superior Court of New Jersey, Law Division, No. DC-024592-11	The Valley Hospital v. Barbara P. Hyslop v. Aetna	9/20/11	Benefit Coverage Determination	Compensatory 16277.30	None	Closed - Settled	8/6/12
Superior Court of Fulton County, GA, No. 2011CV206214	Greene, Kelly v. Aetna Health Insurance Company	9/27/11	Benefit Coverage Determination	Contract 40633.89	None	Closed	1/10/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Cape May County, No. DC-002626-11	Utz, Daniel v. Aetna	9/27/11	Benefit Coverage Determination	Unspecified	None	Closed - Dismissed with Prejudice	9/6/12
Magistrate Court of Fulton County, GA, No. 11MS136974	Medeiros, Jose A. v. Aetna Life Insurance	10/5/11	Benefit Coverage Determination	Contract 25550.00	None	Closed - Settled	9/6/12
Court of Common Pleas Fifth Judicial Circuit, County of Kershaw, SC, No. 2011-CP-28-823	Estate of John R. Cook v. Aetna Life Insurance Company as the administrator of DuPont Beneflex Medical Care Plan and Medical Assistance Program	10/7/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/14/12
Circuit Court for the Tenth Judicial Circuit, Polk County, FL, No. 2011-CA-004597	Props-Berry, Korinna v. Aetna Health, Inc.	10/17/11	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	7/5/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Divison, No. OCN-L-00318508	Robert Wood Johnson University Hospital v. Linda L. Ferrara v. Horizon Healthcare Administrator Inc.,; IBEW Local Union No. 102 Welfare Fund; Aetna Health Inc.	10/19/11	Benefit Coverage Determination	Compensatory 90000.00	None	Closed - Aetna Dismissed	11/27/12
U.S. Distict Court for the District of Kansas, No. 11-cv-2587 RDR/KGS	Echavarria, Alex v. Unisys Corporation and Aetna Life Insurance Company	10/25/11	Benefit Coverage Determination	Contract 16546.00	None	Closed - Settled	1/12/12
348th Judicial District Court, Tarrant County, TX, No. 348 256284 11	Maxwell, Stephen C. v. Aetna Life Insurance Company	11/1/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/14/12
City Court of the City of Yonkers, County of Westchester, NY, No. 662/11	Premier Orthropedics of Westchester and Rockland, P.C. v. Jasper Cokely v. Aetna Insurance Company	11/1/11	Benefit Coverage Determination	Contract 2763.00	None	Closed - Settled	9/10/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court, District of Montana, No. 2:11-cv-00068-RFC-CSO	Davis, Susan K., as Administrator of the Estate of Charles Davis v. New York Life Insurance Company; New York Life Insurance Company Health Insurance Plan; and Aetna Life Insurance Company	11/1/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/28/12
U.S. District Court for the Western District of Kentucky at Louisville, No. 3-11-cv-616-S	Gaughan, Michael and Alice Gaughan v. Aetna Health, Inc. and UBS Financial Services Inc. Group Health and Welfare Benefits Plan	11/2/11	Benefit Coverage Determination	Contract 30000.00	None	Closed - Settled	10/25/12
U.S. District Court for the Southern District of Florida, Miami Divison, No. 1:11-cv-23971	Morales, Ruth v. Aetna Life Insurance Company	11/3/11	Benefit Coverage Determination	Document Services 360.00	None	Closed - Settled	2/3/12
Superior Court of California, County of Los Angeles, North Valley District, Chatsworth Facility, Small Claims Division. No. CHA 11W0222	Borenstein, Laurie v. Aetna Health and Life Insurance Corporation	11/4/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/4/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Camden County, No. L-5607-11	Flaherty, Thomas v. Aetna Health Inc.	11/9/11	Benefit Coverage Determination	Contract 22500.00	None	Closed - Failure of Plaintiff to Prosecute	9/22/16
Superior Court of New Jersey, Law Division, Camden County, No. L-5607-11	Flaherty, Thomas v. Aetna Health Inc.	11/9/11	Benefit Coverage Determination	Contract 22500.00	None	Closed - Failure of Plaintiff to Prosecute	9/22/16
Superior Court of New Jersey, Law Division, Mercer County, No. MER-L-2798-11	Citizens United Reciprocal Exchange v. Aetna, Inc. and Allcare Medcial and Pain Management Group	11/9/11	Benefit Coverage Determination	Unspecified	None	Closed - Judgment - Aetna Favor	1/6/14
Superior Court of Califorinia, Los Angeles County, No. CHA 11W02224	Borenstein, Laurie v. Aetna Health & Life Insurance Corp.	11/13/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	4/4/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of the State of New York, County of New York, No. 061376-11	Anderton, Ricky D., on his behalf and on behalf of his infant daugher Avery C. Anderton and Dr. Milton Waner v. Aetna Health, Inc.	11/18/11	Benefit Coverage Determination	Contract 25000.00	None	Closed - Complaint Withdrawn	7/2/12
Superior Court of California, County of Alameda, No. RG11605021	Linford, Ian v. Jacqueline Saenz; Aetna Life Insurance Company; Cardinal Care; Aetna Student Health; Highland Hospital; Alliance Once Receivables Management, Inc and Does 1-150, inclusive	11/18/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/29/13
Superior Court of Walker County, GA, No. 115UCV1375	Alexander, William Daniel v. Aetna Life Insurance Company	11/22/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/15/12
Court of Common Pleas, Licking County, OH, No. 11CV1586	Williams, John v. THK Manufacturing of America, Inc.; John C. Beeler; Aetna Health, Inc. and MedSolutions	11/23/11	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed with Prejudice	10/4/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
King County District Court - West Division, WA, No. 115-6949	Nguyen, Hung T. v. co Mark T. Bertolini President of Aetna	12/1/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/7/12
Superior Court of New Jersey, Law Division, Middlesex County, No. MID-L-7989-10	University Hospital Rahway v. Dante Laudadio and Angela Laudadio v. Horizon Blue Cross; Aetna; City of Newark; John Does 1-10	12/2/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/17/13
Circuit Court, Baltimore County, MD, No. 03-C-11-011331	Greater Baltimore Medical Center v. Shakurah Charles v. Aetna Inc. T/A Aetna Life Insurance Company	12/8/11	Benefit Coverage Determination	Contract 3649.59	None	Closed - Settled	12/13/12
Superior Court of California, County of Los Angeles, North Valley District, Chatsworth Courthouse, Small Claims, CA, No. CHA 11W03566	Schwartz, Dennis v. Aetna Life Insurance Company	12/12/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/29/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Divison, Union County, No. UNN-L-003448-11	St. Clare's Hospital v. Rosa Mercado v. Aetna Insurance Company	12/16/11	Benefit Coverage Determination	Contract 24829.59	None	Closed - Settled	1/24/13
U.S. District Court for the Northern District of Illinois, No. 1:11-cv-08988	Luebkert, Elizabeth v. Aetna Life Insurance Company	12/19/11	Benefit Coverage Determination	Contract 4440.00	None	Closed - Settled	3/28/12
County Court, Nolan County, TX, No. 2130	Young, Jonathan Spencer and John S. Young v. Aetna Student Health, Inc d/b/a Efekta Insurance	12/28/11	Benefit Coverage Determination	Contract 2131.00	None	Closed - Settled	2/10/12
Municipal Court, Cuyahoga County, OH, No. 11CVI0023362	Fredle, Vicki M. v. Aetna, Inc.	12/30/11	Benefit Coverage Determination	Contract 165.00	None	Closed - Settled	1/24/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, San Diego County, No. 37-2100-00103250-CU-BC-CTL	Mulford, Conrad v. Aetna Health of California, Inc; Anthem Blue Cross Life and Health Insurance Company; and Does 1-50 inclusive	12/30/11	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/20/13
Superior Court of New Jersey Law Divison: Bergen County Special Civil Part, No. DC-033755-11	The Valley Hospital v. Philip A. Follety, Jr. v. Aetna	1/5/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/24/13
Superior Court of New Jersey, Law Division, Mercer County, No. MER-L-2427-09	Barclay, Eileen v. Jonathan Macciocca, Aetna Inc., New Jersey Manufacturers Insurance Company	1/5/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/3/13
U.S. District Court for the Southern District of California, No. 12 CV 0049 MMA POR	Foley, Siobhan v. Aetna Insurance Company and Does 1-10, inclusive	1/6/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/30/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Denver County Court, CO, No. 12 S 00049	Yelenick, John v. Aetna Health and Life Insurance Company	1/10/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/24/12
Superior Court of New Jersey, Law Division, Hudson County, No. DC-30332-11	Brown, Victor K., Esq. v. Natalie Navarro v. Aetna Insurance, SRC, an Aetna Co.	1/10/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/30/12
Circuit Court for the Tenth Judicial Circuit, Peoria County, IL, No. 2006-LM-814	OSF Healthcare Systems, Inc. d/b/a Saint Francis Medical Center v. Iola M. Woolsey v. Aetna Health Inc d/b/a Aetna Life Insurance Company	1/11/12	Benefit Coverage Determination	Contract 14791.94	None	Closed - Settled	9/30/13
Superior Court of New Jersey, Law Division, Essex County, No. SC-139-12	Hinnant, Sherie v. Aetna and Aetna Life Insurance Company	1/11/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/13/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Loudoun County General District Court, VA, No. 11-7887	Thompson, Mark G. v. Aetna Health Inc.	1/18/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/10/13
68th C District Court, Dallas County, TX, No. 12-00770	Norwood, Deborah v. Aetna Life Insurance Company	1/23/12	Benefit Coverage Determination	Contract 40245.13	None	Closed - Complaint Withdrawn	7/19/12
Circuit Court of the First Judicial Circuit, Okaloosa County, FL, No. 2011 CA 002833 S	Thomas, Shana v. Aetna Life Insurance Company	1/23/12	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed	2/7/13
New Hampshire Circuit Court, 10th Circuit, Seabrook District Division, No. 441-2012-SC-20	Lynch, Daniel v. Aetna Life Insurance Company	1/24/12	Benefit Coverage Determination	Contract 1500.00	None	Closed - Judgment - Aetna Favor	3/11/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Toledo Municipal Court, Civil Division, Lucas County, OH, No. CVI-12-01517	Cloud, Kevin v. Aetna Student Health & University of Toledo	1/25/12	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed without Prejudice	4/25/12
U.S. District Court for the District of South Carolina, Charleston Division, No. 2:12-cv-00207-DCN	Rosenberg, David, individually and Marcelle Rosenberg, individually and as Guardian ad Litem of AR, a minor v. Aetna Life Insurance Company	1/27/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/25/14
Baton Rouge City Court, Small Claims Division, LA, No. 11-11078-A	Woman's Hospital Foundation v. Marquis Bowen, Clifton J. Ivey v. Aetna Better Heatlh	1/30/12	Benefit Coverage Determination	Contract 1034.74	None	Closed - Failure of Plaintiff to Prosecute	11/19/15
Superior Court, King County, WA, No. 12-2-01519-8 SEA	Spencer, Kristen v. Aetna Life Insurance Co.	2/1/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	9/26/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Eastern District of Michigan, Southern Division, No. 2:11-cv-15323-AC-LJM	Walker, LaJuan v. Nationwide Mutual Fire Insurance Company; PharMerica Corporation; Aetna Life Insurance Company and United Healthcare, a division of United Health Group	2/1/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/17/13
United States District Court, District of Utah, Central Division, No. 2:12-CV-00139 BCW	Bennett, Wendy & Robert Osborne v. Aetna Life Ins. Co., CIBER Inc. & The Ciber Inc. Aetna Choice POS II Group Benefit Plan	2/1/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/24/12
American Arbitration Association, TX, No. 70-187-E-00090-12	Women Partners in OB/GYN v. Aetna Health, Inc.	2/12/12	Benefit Coverage Determination	Contract 32772.62	None	Closed - Settled	4/9/13
State of Wisconsin, Circuit Court, Adam County, No. 10 CV 269	Gazic, Jeremy J. and American Family Mutual Insurance Company v. Nicholas J. Ziemer; Allstate Property and Casualty Insurance Company and Aetna Life Insurance Company	2/16/12	Benefit Coverage Determination	Compensatory 4058.49	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/14/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
American Arbitration Association, CA, No. 72 420 0018612	Roberts, Aubrey F., daughter of Kevin M. Roberts v. Aetna Health Insurance of California	2/21/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/14/13
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. DC-296-12	Hackensack University Medical Center v. Wendy R. Edson v. Aetna Insurance Company	2/27/12	Benefit Coverage Determination	Contract 8526.00	None	Closed - Settled	6/29/12
Civil Court of the City of New York, County of Queens, No. CV-008136-12/QU	North Shore University Hospital at Manhassett v. Patricia A. Riley v. Aetna Legal	3/1/12	Benefit Coverage Determination	Contract 5699.00	None	Closed - Settled	3/27/14
250th District Court, Travis County, TX, No. D-1-GN-12 000668	Ogden, A.L. v. Aetna Life Insurance Company	3/6/12	Benefit Coverage Determination	Contract 16500.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/17/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Magisterial Distict Court 38-2-02, Montgomery County, PA, No. MJ-38202-CV-0000058-2012	Keith, Ken v. Xybion Corporation and Aetna, Inc.	3/6/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/27/13
United State District Court, Southern District of California - 12CV0582 HNLS	Murray, Paul v. Aetna Health of California, Inc. and Does 1-100, inclusive	3/8/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/7/12
Civil Court of New York, New York County, No. CV-007625-12/NY	McComsey, Anya v. Aetna Medical Insurance	3/9/12	Benefit Coverage Determination	Contract 3200.00	None	Closed - Settled	7/5/13
Superior Court of New Jersey, Law Division, Special Civil Part, Morris County, No. DC-1262-12	Active Care Physical Therapy v. Norman Iosiovich v. Aetna Life Insurance Company	3/12/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/21/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Nevada, No. 2:12-cv-00416-MMD-GWF	Honey, Regina C., indiv. & as natural parent of Addison M. Honey; & Lucas R. Honey; Adam D. Honey, indiv. & as natural parent of Addison M. Honey, & Lucas R. Honey v. Dignity Health d/b/a St. Rose Dominican Hospital-Siena Campus; Conexis Benefit Administrators, LP; Conexis, LLC; PayFlex Systems, USA, Inc., Doe Entities IV and Roe Individuals VI-X	3/13/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/16/14
9th Circuit Court, Kalamazoo County, MI, No. 2012-0153	McQuitty, Sarah Katherine f/k/a Sarah Katherine Gerger v. Progressive Michigan Insurance Company and Aetna Health Inc.	3/19/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/25/13
U.S. District Court for the District of Montana, Missoula Division, No. 9:12-cv-00040-DLC-JCL	Peterson, Michael and Michael Peterson as the Personal Representative of the Estate of Joshua Peterson v. Aetna US Healthcare; Aetna Health & Life Insurance Company; Securitas; John Does 1-3	3/19/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/9/12
U.S. District Court for the District of Utah, Central Division, No. 2:12-cv-00269-SA	Richardson, Austin, parent and guardian of B.R., a minor v. Aetna Life Insurance Company	3/20/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/21/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of the City of New York, New York County, Small Claims Part 45, No. 151.SCH 2012 1	Cuna, Anne Sophie v. Aetna Network Service Coordinator	3/26/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/15/13
Court of Common Pleas, Philadelphia County, PA, September Term, 2011, No. 01840	Thomas Jefferson University Hospital v. Christine Mulligan v. Aetna Life Insurance Co. & Aetna Student Health Agency, Inc. d/b/a Aetna Student Health	3/29/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/30/13
35th Judicial Circuit Court, Stoddard County, MO, No. 10SD-CC00134	St. Francis Medical Center v. Swadhin Patnaik and Venessa Pandian v. Aetna	3/30/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/6/12
U.S. District Court for the Southern District of California, No. 12-CV-0797 JAH JMA	Martella, Kerri v. Aetna Life Insurance Company and Does 1-10, inclusive	4/3/12	Benefit Coverage Determination	Contract 7413.52	None	Closed - Settled	9/18/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of California, No. 12-CV-0900 BEN NLS	Cao, Bing v. Aetna and Does 1 - 10, inclusive	4/3/12	Benefit Coverage Determination	Contract 8696.13	None	Closed - Settled	3/21/13
Superior Court of New Jersey, Law Division, Special Civil Part, Union County, No. DC-006161-12	Schneier, Julie v. Aetna Health Inc and/or Aetna Life Insurance Inc.	4/5/12	Benefit Coverage Determination	Contract 15000.00	None	Closed - Settled	7/2/12
United States District Court, Eastern District of Texas, No. 4:12-cv-164	Culham, Dorothy Abzanka v. Hewlett-Packard Company Comprehensive Welfare Benefits Plan; Hewlett-Packard Company and Aetna, Inc. d/b/a Aetna Life Insurance Company	4/5/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/27/13
Circuit Court of Putnam County, WV, No. 12-C-109	Winter, Gregory Delbert and his wife, Sherri Rene Winter v. Active Health Management, Inc.; Wells Fargo Third Party Administrators, Inc. and Public Employee Insurance Agency	4/10/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/14/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Passaic County, NJ, No. DC-003468-12	Hackensack University Medical Center v. Yuliya Paskaleva v. Aetna Health	4/10/12	Benefit Coverage Determination	Contract 1460.71	None	Closed - Settled	1/24/13
U.S. District Court for the District of Alaska, No. 3:12-cv-00078-HRH	Reynolds, Allen v. Aetna Life Insurance Co., and Alaska Railroad Corp., and Alaska Railroad Corp. Group Plan	4/10/12	Benefit Coverage Determination	Compensatory 34642.00	None	Closed - Settled	9/26/13
18th Judicial Circuit Court, Brevard County, FL, No. 05-2012-SC-027548	Zarski, Angela v. Aetna Life Insurance Company	4/17/12	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	4/12/13
Court of Common Pleas, Dauphin County, PA, No. 2012-1-02	Wood, Jeffrey J. v. SRC, an Aetna Company	4/23/12	Benefit Coverage Determination	Contract 963.00	None	Closed - Failure of Plaintiff to Prosecute	10/1/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of California, No. 12-cv-0933 CAB WMC	Banister-Clow, Helen v. Aetna Life Insurance Company and Does 1 - 10, inclusive	4/26/12	Benefit Coverage Determination	Contract 5857.42	None	Closed - Settled	9/14/12
Magistrate Court of Fulton County, GA, No. 12MS147419	Spears, Gale v. Aetna Insurance Company	4/30/12	Benefit Coverage Determination	Contract 14000.00	None	Closed - Settled	7/5/13
Superior Court of New Jersey, Law Division, Special Civil Part, Monmouth County, No. SC1504-12	Kohn, Stan R. v. Aetna	5/1/12	Benefit Coverage Determination	Contract 3000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	5/20/13
Superior Court of New Jersey, Civil Division, Sussex County, No. SSX-L-144-12	Morristown Memorial Hospital v. Timothy M. Karl and Diane Karl v. Aetna Life Insurance Company and Allstate Insurance Company	5/4/12	Benefit Coverage Determination	Contract 20861.77	None	Closed - Settled	9/3/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
17th Judicial Circuit Court, Broward County, FL, No. CACE 12-23732-04	Tender Care Centers, Inc. v. Hiriam Rios, as guardian for Daniel J. Rios, a minor v. Aetna Life Insurance Company	5/5/12	Benefit Coverage Determination	Contract 36796.86	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/8/13
U.S. District Court for the District of Minnesota, No: 12-CV-01121-RHK-AJB	Mueller, Donald v. SPX Corporation and Aetna Life Insurance Company	5/8/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	6/19/13
Superior Court of California, Orange County, No. 03-2012-00568470	Bousman, Angela v. Aetna Health of California Inc, a California corporation; Aetna Insurance Company of Connecticut; Aetna Life Insurance Company and Does 1 - 50, inclusive	5/11/12	Benefit Coverage Determination	Compensatory 100000.00	None	Closed - Settled	3/19/13
Small Claim Court, 20th Judicial District, Lee County, FL, No. 12-SC-001838	Advanced Pain Management Specialist, P.A. a/a/o Paul Sipala v. Aetna Insurance Company of Connecticut	5/17/12	Benefit Coverage Determination	Costs 100.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/7/12

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Ohio, Western Division, No. 3:12-CV-01260	Sommer, Jeffrey, individually & in respresentative capacity as the personal representative of, & Administrator of the Estate of Maricarol J. Sommer and as parent & natural guardian of A.S. and M.S., minors; et al. v. Navistar; Aetna Life Insurance aka and/or dba Aetna	5/18/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/13/14
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. DC-10161-12	Advanced Surgery Center of Clifton LLC v. Ana Liranzo v. Aetna	5/22/12	Benefit Coverage Determination	Contract 7093.55	None	Closed - Complaint Withdrawn	8/13/12
Superior Court of New Jersey, Law Division, Special Civil Part, Passaic County, No. DC-005368-12	Bromley, Arvilk W. v. Aetna SRC	5/22/12	Benefit Coverage Determination	Contract 5000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/13/12
Harris County Justice of the Peace, Precinct 8, Place 2, Houston, TX, No. SC82C0030504	Coleman, Susan S. v. Aetna Life Insurance Co.	5/29/12	Benefit Coverage Determination	Contract 2660.00	None	Closed - Settled	12/6/12

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of California, No. CV 12 2819	Dennis F. and Carol F., individually, as guardian for Grace F and as representatives of the class similarly situated individuals, et al. v. Aetna Life Insurance Company	5/31/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/12/18
U.S. District Court for the Eastern District of Pennsylvania, No. 2:12-cv-03055-CDJ	Heimberger, Richard v. Securitas Security Service USA Inc.; Strategic Resource Company, and Aetna Life Insurance Company	5/31/12	Benefit Coverage Determination	Contract 100000.00	None	Closed - Settled	9/24/13
U.S. District Court, Central District of California No. CV12-04827	Heerschap, Henry v. Onair Employee Welfare Benefit Plan; Aetna Life Insurance Company	6/1/12	Benefit Coverage Determination	Compensatory 117000.00	None	Closed - Settled	1/9/13
Circuit Court of Bollinger County, Missouri; No. 11BO-CC00010	Credit Bureau Systems, Inc. v. Darin W. Shell v. Coventry Health Care of Missouri, Inc.	6/7/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/8/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Botetourt County General District Court, VA, No. 12000422	Crutchman, Richard Wayne v. Aetna Life Insurance Company	6/12/12	Benefit Coverage Determination	Contract 25000.00 Costs 56.00 Fees 1500.00	None	Closed - Aetna Dismissed	3/19/13
County Court at Law No. 5, Bexar County, TX, No. 378333	Roibon, Federico v. Aetna Life Insurance Company	6/13/12	Benefit Coverage Determination	Contract 18000.00	None	Closed - Settled	2/20/13
County Court at Law No. 4, Dallas County, TX, No. CC-12-03804-D	Hobbs, Christopher D. v. Aetna Health Inc.	6/20/12	Benefit Coverage Determination	Contract 3199.25	None	Closed - Settled	10/12/12
County Civil Court at Law No. 3, Harris County, TX, No. 1016497	Melendez, Rich v. Aetna Health Insurance Company and Surgical Specialists of Clear Lake , PLLC	6/25/12	Benefit Coverage Determination	Contract 5944.00 Costs 1000.00	None	Closed - Settled	11/16/12

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of NY, No. 1:12-cv-05139-RA-FM	Warren, Harold v. Columbia Presbyterian Hospital; Columbia Presbyterian Benefits Committee; Columbia Presbyterian Benefits Office Joy Rodes; Wage Works Cobra Insurance; Aetna Inc.; Empire Blue Cross Blue Shield	6/29/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	11/6/19
Circuit Court of the 11th Judicial Circuit, Miami-Dade County, FL, #12-25489CA 42	Hoffman, Carla v. Aetna Life Insurance Company, Inc.	7/6/12	Benefit Coverage Determination	Contract 15000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	10/8/13
Superior Court of New Jersey, Law Division, Gloucester County, No. L-588-11	Maahs, Marc J. v. Walter A. Cincuir Agustin, High Point Safety and Insurance Company, Aetna, Inc., John Does 1-10, ABC Corporations 1-20 and XYZ Entities 1-10	7/6/12	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed with Prejudice	1/24/13
U.S. District Court for the District of New Jersey, No. 1:12-cv-04180-RMB-KMW	Young, Aloha, on behalf of herself and all others similarly situated v. Aetna Life Insurance Company and Aetna Inc.	7/9/12	Class Action	Unspecified	None	Closed - Settled	12/5/12

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Western District of Louisiana, Lafayette Division, No. 6:12-CV-01874-RFD-CMH	Robichaux, Tami v. Aetna Life Insurance Co	7/10/12	Benefit Coverage Determination	Contract 22579.86	None	Closed - Settled	8/21/13
Superior Court of California for the County of Orange, No. 30-2012-00582966-SC-SC-WJC	Dickson, John Allen v. Aetna Life Insurance Company	7/12/12	Benefit Coverage Determination	Compensatory 2602.56	None	Closed - Settled	9/4/12
U.S. District Court, District of New Jersey, No. 3:12-CV-04314-FLW-DEA	Brian V.W., individually and on behalf of Nicholas V.W. v. Aetna Life Insurance Company	7/12/12	Benefit Coverage Determination	Contract 220000.00	None	Closed - Settled	9/18/13
59th Judicial District of Michigan, No. 12-0357-GC	Spectrum Health-United Spectrum Health-Urgent Care v. Mark Johnston v. Aetna	7/16/12	Benefit Coverage Determination	Contract 900.00	None	Closed - Settled	8/27/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Supreme Court of the State of New York, County of New York, No. 652419 / 2012	Bainton, J. Joseph v. Aetna Life Insurance Company	7/16/12	Benefit Coverage Determination	Contract 102833.26	None	Closed - Settled	4/22/13
County Civil Courts Department, Harris County, Texas, No. 991233-003	Memorial Herman Hospital System v. Cindi Clack v. Aetna Health, Inc.	7/17/12	Benefit Coverage Determination	Contract 19346.50	None	Closed - Settled	6/28/13
3rd Judicial District Court, Wayne County, Detroit , Michigan, No. 12008419NF	Murray, Renee v. Allstate Insurance Company and Aetna Life Insurance Company	7/25/12	Benefit Coverage Determination	Contract 39906.00	None	Closed - Settled	8/6/13
Superior Court of New Jersey Law Division, Special Civil Part, Small Claims Section, Gloucester County, No. SC-723-12	Bochanski, John J. v. Aetna Life Insurance Company	7/27/12	Benefit Coverage Determination	Contract 695.10 Fees 22.00	None	Closed - Settled	5/17/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Passaic County, No. DC-009749-12	Chilton Memorial Hospital v. Matthew Lyle and Erin Lyle v. Aetna Inc.	7/31/12	Benefit Coverage Determination	Compensatory 50.00 Contract 9469.69 Costs 7.00 Fees 2500.00	None	Closed - Settled	9/3/13
21st Judicial District Court, Parish of Tangipahoa, LA, No. 2012-0002468	Vallot, Robert Taylor and Frank Vallot v. Aetna Life Insurance Company	8/1/12	Benefit Coverage Determination	Contract 27800.00	None	Closed - Settled	2/21/13
Civil Court of the City of New York, County of Queens, Small Claims Part 45, No. 3036 SCQ 2012 1	Hanna, Mounir v. Aetna Health Inc.	8/9/12	Benefit Coverage Determination	Contract 355.71	None	Closed - Settled	11/25/13
Loudon County General District Court, Leesburg, VA, No. GV12007139-00	Kianpour, Khojasteh v. Aetna Life Insurance Company	8/9/12	Benefit Coverage Determination	Compensatory 2797.70	None	Closed - Trial - Aetna Favor	12/11/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Oregon, Portland Division, No. 3:12-cv-01475-SI	Nanson, David v. Aetna, Inc., a Connecticut corporation	8/14/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/20/12
Superior Court of New Jersey, Law Division, Middlesex County, No. MID-L-5687-12	Buzy, Kelly, as Administratrix Ad Prosequendem, for the Estate of Debra Lee Keefe v. Progressive Garden State Insurance Company; Aetna Insurance; ABC Corps 1-10; John Does 1-10	8/17/12	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	10/4/13
Superior Court of New Jersey, Law Division, Mercer County, No. L2009-12	Sweetser, Daniel v. Aetna Health Insurance Company	8/18/12	Benefit Coverage Determination	Damages/Injuries 25000.00	None	Closed - Aetna Dismissed without Prejudice	9/19/13
200th Judicial District Court, Travis County, TX, No. D-1-GN-12-002532	Schwartz, Peter and Alycia Schwartz v. Aetna Life Insurance Company	8/20/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/22/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, San Diego County, No. 37-2012-00004624-SC-SC-CTL	Kilian, Volker v. Aetna Health of California Inc.	8/20/12	Benefit Coverage Determination	Compensatory 949.11	None	Closed - Settled	11/30/12
Superior Court for the County of San Diego, Small Claims, No. 37-2012-00004899-SC-SC-CTL	Tipton, Scott N. v. Aetna Life Insurance Company	8/24/12	Benefit Coverage Determination	Compensatory 1950.00	None	Closed - Settled	11/27/12
11th Judicial Circuit Court, Miami-Dade County, FL, No. 12-35294CA13	Soto, Rachael v. Coventry Health Care of Florida, Inc.	9/6/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	2/6/15
35th Judicial District Court, MI, No. 11 V 6713 GC	St. Mary Mercy Hospital, an assumed name of Trinity Health-Michigan v. Manoj Karwa v. Aetna Inc. and Ascension Health Alliance	9/7/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/11/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court, Prince George's County, MD, No. 0502-0025539-2012	Jones, Percy W III v. Aetna Health Insurance Company	9/10/12	Benefit Coverage Determination	Contract 30000.00	None	Closed - Settled	12/17/13
Small Claims Division, First City Court, LA, No. 12-30340	Appelbaum, Edward A. v. Aetna Health and Life Insurance Company	9/14/12	Benefit Coverage Determination	Contract 400.00 Costs 111.00	None	Closed - Settled	12/19/12
Court of Common Pleas, Allegheny County, PA, No. GD-17592	Fontana, Anthony v. Coventry Health and Life Insurance Company, a corporation and trading and doing business as HealthAmerica; HealthAmerica Pennsylvania, Inc, as the trustee of the HealthAmerica Ohio Insurance Trust; and HealthAmericaOne	9/20/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/4/15
County Court, Pinellas County, Small Claims Division, FL, No. 12006467SCNORTH	Gavron, Janice v. Aetna Health Inc.	9/25/12	Benefit Coverage Determination	Contract 3766.41 Fees 150.00	None	Closed - Complaint Withdrawn	12/11/12

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Camden County, No. L-4269-12	Riendeau, Raymond and Teresa Riendeau v. Geraldine Petruska and/or Jane Doe(s) 1-100; Aetna Life Insruance Company, et al.	10/3/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/21/15
District Court of Douglas County, NE, No. CI12-9304.	Smith, Laura v. Aetna Life Insurance Company and Alegent Health-Bergan Mercy Health System	10/4/12	Benefit Coverage Determination	Contract 7155.00 Costs 95.00 Fees 750.00	None	Closed - Settled	8/21/13
Superior Court of New Jersey, Law Division, Monmouth County, No. L-4157-12	Sommers, Arlene as Executrix of the Estate of Richard Sommers v. Aetna Life Insurance Company	10/9/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/6/13
Superior Court, J.D. New London, CT, No: KNL-CV-12-6015263-S.	Potter, Lindsay v. Aetna Life Insurance Company	10/12/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/5/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California for the County of San Diego, Small Claims, No. 37-2012-00005977-SC-SC-CTL	Baker, Adam v. Aetna Health of California Inc.	10/16/12	Benefit Coverage Determination	Compensatory 9619.00	None	Closed - Settled	2/13/13
Superior Court of California for the County of Ventura, Small Claims, No. 56-2012-00425804-SC-SC-VTA	Merewether, Scott E. v. Aetna Life Insurance Company	10/16/12	Benefit Coverage Determination	Compensatory 796.00	None	Closed - Trial - Aetna Favor	11/29/12
Superior Court of California for Los Angeles County, Small Claims, No. CHA 12W03964	Dolgin, Bruce and Elaine Dolgin v. Anthem Blue Cross Life and Health Insurance and Aetna Rx Home Delivery, LLC	10/18/12	Benefit Coverage Determination	Compensatory 820.40	525.83	Closed - Judgment - Against Aetna	3/6/13
Superior Court of California, Orange County, No. 30-2012-00609330-SC-SC-HLH	Limjoco, Christine and Ron Bisbee v. Aetna Health of California, Inc. d/b/a Aetna	10/23/12	Benefit Coverage Determination	Compensatory 5950.00	None	Closed - Settled	4/23/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Municipal Court of Mansfield, OH, No. 2012 CVH 2404	Levering Management, Inc. d/b/a Winchester Terrace v. Blankenship, Kristina A., Successor Trustee of the Walden L. Kenyon and Margaret M. Kenyon Revocable Living Trust u/a dated 3/2/1994, et al. and Kristina A. Blankenship, on behalf of Margaret M. Kenyon, deceased v. Aetna Medicare a/k/a Aetna Life Insurance Company	10/25/12	Benefit Coverage Determination	Contract 9220.87	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/25/13
District Court for Polk County, IA, No. CL126421	Houston, Kevin Lee v. Aetna Rx Home Delivery, LLC; Aetna Health Holding, LLC and Aetna, Inc.	10/26/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/31/14
United States District Court of Utah, Central Divison, No. 2:12-cv-01005-DN	Joel J. v. Aetna Life Insurance Company	10/29/12	Benefit Coverage Determination	Compensatory 75000.00	None	Closed - Settled	7/6/16
U.S. District Court for the Central District of California, No. CV12-09364	Sterling, Alvera v. Aetna Life Insurance Company	10/31/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/31/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Illinois, No. 1:12-cv-08851	Graffia, David, as father of A.G., a minor v. Aetna Life Insurance Company and Open Access Managed Choice-High Deductible Health Plan	11/5/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/2/13
King County District Court, Civil Department, WA, No. 123-2146	Koch, Kenneth v. Aetna (#123-2146)	11/9/12	Benefit Coverage Determination	Compensatory 179.00	None	Closed - Aetna Dismissed without Prejudice	1/9/13
King County District Court, Civil Division, WA, No. 123-1980	Koch, Kenneth v. Aetna (#123-1980)	11/9/12	Benefit Coverage Determination	Compensatory 179.00	None	Closed - Aetna Dismissed without Prejudice	1/9/13
Superior Court of New Jersey, Law Division, Middlesex County, No. MID-L-6458 12	Brustowicz, Bernard v. New Jersey Manufacturers Insurance Company and Aetna Health Plans	11/11/12	Benefit Coverage Determination	Contract 48220.19	None	Closed - Settled	2/12/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Middlesex County, No. DC-017083-12	Perth Amboy Anesthesia v. Irving Torres, et al. v. Empire Blue Cross and Blue Shield; Aetna Insurance Company	11/12/12	Benefit Coverage Determination	Contract 1663.57 Fees 48.00	None	Closed - Settled	8/26/13
County Court, Pinellas County, Small Claims Division, FL, No. 12-0073630-SC North	Gavron, Janice N. v. Aetna Health Inc. (12-7363 SC)	11/14/12	Benefit Coverage Determination	Contract 4561.23	None	Closed - Complaint Withdrawn	12/11/12
Court of Common Pleas, County of Charleston, SC, No. 12-CP-10-7796	Aspinwall, Lane and Electronic Document Discovery Storage and Access, LLC, d/b/a EDDSA, LLC v. Paycheck Business Systems, Inc., Paychex Insurance Agency, Inc., Paychex, Inc., Paychex North America, Inc. and Aetna Life Insurance Company	11/29/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/30/13
Superior Court of New Jersey, Law Division, Morris County, No. MRS L-002912 12	Siwek, Susan v. Aetna Insurance Company	11/29/12	Benefit Coverage Determination	Contract 207289.06	None	Closed - Pretrial - Aetna Dismissed by Court Order	8/15/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Colorado, No. 1:12-cv-03147	Stegner, Melissa v. Cooperative Benefit Administrators, Inc., National Rural Electric Cooperative Association, Cofinity f/k/a Sloans Lake Managed Care	12/3/12	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	5/29/14
United States District Court for the District of South Dakota, No. 12-4205	Ballard, Jeff v. Bright Horizon's Family Solutions Preferred Provider Organization	12/3/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/23/13
236th Judicial District Court of Tarrant County, TX, No. 236-263162-12	Bonham, Diana M. & Fred A. Fisher v. Aetna Life Insurance Company & Your Benefits Resources, a Trademark of Hewitt Associates LLC	12/10/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/27/13
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. BER-DC-024587-12	The Valley Hospital v. Christopher M. Borrin v. Travelers Insurance Company and Aetna Insurance Company	12/14/12	Benefit Coverage Determination	Compensatory 1463.63 Fees 56.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/19/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Essex County, No. L-7790-12	Vizzone, D.O., Jerald v. Armando Mottola v. Aetna Insurance Company	12/17/12	Benefit Coverage Determination	Contract 38000.00	None	Closed - Settled	11/6/13
Magistrate Court, Fulton County, Atlanta, GA, No. 12MS157705	Snow, Timothy v. Aetna Life Insurance Company	12/21/12	Benefit Coverage Determination	Contract 1450.00 Interest 152.25	None	Closed - Settled	4/5/13
4th Judicial District Court, Parish of Ouachita, No. 12-3949	Guerriero, Sherry K. v, Aetna Life Insurance Company	12/28/12	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/9/13
Monroe Circuit Court, Small Claims, Bloomington, IN, No. 53C081212SC004337	Schultz, Frederick M. v. Aetna Health, Inc.	12/28/12	Benefit Coverage Determination	Contract 5097.30	None	Closed - Settled	9/27/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
United States District Court for the Southern District of New York, White Plans, No. 13-CV-0289	Curran, Bridget M., individually and as Natural Guardian of C.F.C, a minor v. Aetna Life Insurance Company; TriNet Group, Inc., and The TriNet Open Access Managed Choice Plan	1/14/13	Benefit Coverage Determination	Contract 119658.42	None	Closed - Pretrial - Judgment in Favor of Aetna	9/15/16
District Court, Montgom County, Rockville, Maryland, No. 060100014612013	Ross, Ramsey v. Aetna Life Insurance Company	1/17/13	Benefit Coverage Determination	Contract 2740.00	None	Closed - Settled	11/12/13
U.S. District Court for the Eastern District of Virginia, No. 1:13-cv-00062-LMB-TCB	Locraft, Francis J. v. Air Line Pilots Association, International; Aetna, Inc.; Assurant Employee Benefits and Union Security Insurance Company	1/17/13	Benefit Coverage Determination	Unspecified	None	Closed - Aetna Dismissed	3/5/13
U.S. District Court for the Central District of California, No. CV13-00411	Shimizu, Paul v. Aetna Life Insurance Company; Merck & Company, Inc.; and Does 1-10, inclusive	1/18/13	Benefit Coverage Determination	Compensatory 115000.00	None	Closed - Settled	9/13/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Atlantic County, No. L 438-13	Roche, Michelle, Jay Minerley and Tim Singleton, Individually and as Class Representatives v. Aetna, Inc., Aetna Health, Inc. (a NJ corp.), Aetna Health Insurance Co., Aetna Life Insurance Co., and The Rawlings Company, LLC	1/25/13	Class Action	Unspecified	None	Open	
27th Judicial Circuit Court for St. Clair County, MO, No. 12SR-AC00080	Healthcare Collections LTD v. Brad Hoeme v. Coventry Health Care, owned by Coventry Health Care of Missouri, Inc.	1/25/13	Benefit Coverage Determination	Contract 5389.85 Costs 325.00 Interest 1043.17	None	Closed - Settled	11/12/13
Trial Court of Massachusetts, Wareham District Court, West Wareham, Small Claims, No. 1360SC000062	Turcotte, Brittany v. Aetna Life Insurance Company	1/25/13	Benefit Coverage Determination	Contract 756.50 Costs 50.00	None	Closed - Settled	5/15/13
Superior Court of California, Contra Costa County, No. MSC13-0103	Morelan, Anthony C. v. Aetna Life Insurance Company	1/28/13	Benefit Coverage Determination	Compensatory 2331.49	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/26/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Providence, RI, No. 13-499	Mosca, Jeffrey v. Aetna Life Insurance Company; Aetna Inc; Aetna Health Insurance Company; Aetna Health and Life Insurance Company; Aetna Group	1/29/13	Benefit Coverage Determination	Contract 1520.00	None	Closed - Settled	3/8/13
U.S. District Court for the Central District of California, No. CV13-00635	Ballas, Leslie v. Aetna Life Insurance Company	1/29/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/18/13
U.S. District Court for the Southern District of Texas, Houston Division, No. 4:13-cv-00231	Hollingshead, Joe, Individually and as Representative of All Persons Similarly Situated v. Aetna Health, Inc.	1/30/13	Class Action	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	12/31/14
Circuit Court, Laurel County, Commonwealth of Kentucky, No. 13-CI-00085	Minarik, Peter v. Mail Handlers Benefit Plan	1/30/13	Benefit Coverage Determination	Contract 16915.70 Fees 1645.62	None	Closed - Settled	5/10/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Third Judicial District Court, Salt Lake City, UT, No. 130900739	Debbie M. and Patrick M., individually and as guardians of C. M., a minor v. Aetna Life Insurance Company	2/1/13	Benefit Coverage Determination	Compensatory 50000.00	None	Closed - Settled	11/25/14
Superior Court of New Jersey, Law Division, Ocean County, No. OCN-L-389-13	Soto, Jr., Pedro v. Jonathan P. Meyer; Aetna Life Insurance Company, et al.	2/4/13	Benefit Coverage Determination	Contract 46305.76	None	Closed - Settled	6/20/13
Superior Court of New Jersey, Law Division, Special Civil Part, Sussex County, No. DC-004624-12	Bergen Anesthesia Group v. Diane Mickens v. GEICO; The Valley Hospital and Aetna	2/8/13	Benefit Coverage Determination	Contract 4625.00	None	Closed - Settled	6/20/13
United States District Court for the Southern District of Texas, Houston Divison, No. 4:13-cv-00359	Koening, Kenneth Raymond; Powell, Richard; North Cypress Medical Center Operating Company, LTD; et al. v. Aetna Life Insurance Company	2/12/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/2/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Massachusetts, No. 1:13-CV-10279-JLT	Summersgill, Robert, personal representative of The Estate of Jean Summersgill v. E.I. Dupont DeNemours & Company and Aetna Life Insurance Company	2/14/13	Benefit Coverage Determination	Contract 223560.00	None	Closed - Pretrial - Judgment in Favor of Aetna	2/15/16
Metropolitan General Sessions Court, Davidson County, Nashville, Tennessee, No. 13GC3335	Calvo, Amanda v. Aetna, Inc.	2/18/13	Benefit Coverage Determination	Contract 25000.00	None	Closed	3/22/13
Superior Court of New Jersey, Law Division, Union County, No. UNN-L-000732-13	Crovetto, Fernando v. Aetna Inc. and ABC Corp(s) 1-10	2/22/13	Benefit Coverage Determination	Contract 15486.33	None	Closed - Settled	4/1/15
Superior Court for Maricopa County, AZ, No. CV2013-092573	Price, Mark v. Aetna Health, Inc.; Aetna Life Insurance Company	2/26/13	Benefit Coverage Determination	Compensatory 46000.00	None	Closed - Settled	12/11/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Nebraska; No. 13-cv-71	Schreier, Philip v. Coventry Health Care of Nebraska, Inc.	3/4/13	Benefit Coverage Determination	Unspecified	None	Closed	8/19/13
Civil Court of the City of New York, Kings County, Small Claims Part 45, No. 998 SCK 2013 1	Brown, David E. v. Aetna Health, Inc.	3/6/13	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	7/18/13
Supreme Court, Tompkins County, NY, No. 2013-0240	Jones, Christopher H. and Vanessa C. Kai v. Aetna Inc.; Aetna Life Insurance Company (ALIC); Aetna Student Health Agency Inc. a/k/a Aetna Student Health Agency, Inc; Chickering Claims Administrator, Inc.	3/11/13	Benefit Coverage Determination	Contract 60000.00	None	Closed - Settled	12/29/15
U.S. District Court for the District of Minnesota, No. 0:13-cv-00557	Nystrom, Quinn v. AmerisourceBergen, Corp; AmerisourceBergen Group Health and Welfare Plan (Plan No. 625) and Aetna Life Insurance Company	3/11/13	Benefit Coverage Determination	Contract 45000.00	None	Closed - Pretrial - Judgment in Favor of Aetna	12/31/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Special Civil Division, Essex County, No. DC-006425-13	Schwartz, Susan C. v. Aetna Health, Inc. and ABC Corps 1-5	3/19/13	Benefit Coverage Determination	Compensatory 15000.00	None	Closed - Settled	5/30/14
Superior Court of Arizonia, County of Maricopa, No. CV2013-002760	Fredlake, Michele and Christopher Fredlake v. Aetna Health and Life Insurance Company; Aetna Health Inc. (Pennsylvania) FN; Morrison Vein Institute, LTD; John and Jane Does 1-10; White Partnerships 1-10; and Black Corporations 1-10	3/20/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/11/13
Superior Court of New Jersey, Middlesex County, Law Division, Special Civil Part, Small Claims Section, No. SC 547-13	Vasquez, Ana L. v. Aetna U.S. Healthcare	3/26/13	Benefit Coverage Determination	Compensatory 2241.06	None	Closed - Failure of Plaintiff to Prosecute	10/3/13
Superior Court of Peach County, Georgia; No. 13-V-0104	Privette, Terrie Lynn v. Coventry Health Care of Georgia, Inc.	3/27/13	Benefit Coverage Determination	Contract 20204.80 Punitive 11602.40	None	Closed - Settled	10/18/13

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Nebraska; No. 13-cv-3067	Kreifels, Michelle & Douglas Kreifels v. Coventry Health Care of Nebraska, Inc. & Coventry Health Care, Inc.	3/27/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/7/14
Court of Common Pleas, Laurens County, SC, No. 2013-CP-30-272	Paden, Ralph E. and Jennifer N. Paden v. Aetna, Inc, individually d/b/a Aetna Health Insurance Company of New York; Aetna Life Insurance Company; Aetna Health, Inc; Aetna Health of California, Inc; Aetna Dental, Inc; Aetna Dental of California, Inc; and Aetna Health Insurance Company	3/28/13	Benefit Coverage Determination	Unspecified	None	Closed	5/24/13
Superior Court of New Jersey, Law Division, Gloucester County, No. L 404-13	Williams, Willene v. Stacy Stockdill; Aaron Stockdill; Washington Township School System; Aetna Life Insurance Company; Liberty Mutual Mid-Atlantic Insurance Company	4/2/13	Benefit Coverage Determination	Contract 15000.00	None	Closed - Pretrial - Judgment in Favor of Aetna	11/8/13
Majistrate District No. MDJ-39-3-03, Franklin County, Pleasant Hall, PA, No. MDJ-39303-CV-0000035-2013	Kmiec, Tom v. Aetna	4/4/13	Benefit Coverage Determination	Contract 917.70 Costs 89.03 Fees 12.00	None	Closed - Settled	8/26/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Georgia, Altanta Division, No. 1:13-cv-01108-CAP	Spelman, Jr, Steven; Amanda Holloway-Spelman; Steven Spelman and Amanda Holloway-Spelman as guardians for Isabella Spelman v. Aetna Health Inc. Georgia and JA Designs, LLC	4/4/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/8/14
Roanoke City General District Court, Roanoke, VA, No. 13004428	Erwin, Elizabeth M. v. Aetna Insurance Company of Connecticut	4/8/13	Benefit Coverage Determination	Contract 25000.00 Costs 58.00	None	Closed - Settled	8/14/13
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. DC 005976-13	Hackensack University Medical Center v. Michael W. Hanlon v. Aetna Health, Inc.	4/11/13	Benefit Coverage Determination	Contract 3051.53	None	Closed - Settled	11/1/13
U.S. District Court for the Eastern District of Pennsylvania, No. 5:13-cv-02153-JHS	Eugene, Joseph, house of Nagy, as Private Attorney General v. Aetna, Inc.; Kennedy PC; HCR Manorcare; Northhampton County; ABC Corporations (1-5); and John Does (1-5)	4/19/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	7/12/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Bergen County, No. BER-L-3014-13.	Levin & Malkin, P.C. v. Aetna Health, Inc. and John Does 1-99 and Business Entites 1-99 said names being fictitious and presently unknown, jointly and individually	4/19/13	Benefit Coverage Determination	Contract 2400.00	None	Closed - Settled	8/26/13
Superior Court of New Jersey, Ocean County, Law Division, No. L-361-13	Jersey Shore University Medical Center v. William Thomas v. Aetna	4/29/13	Benefit Coverage Determination	Contract 97336.01	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/21/13
191st Judicial District Court, Dallas County, Texas; No. DC1305108	Akers, Sharon v. Aetna Life Insurance Company	5/8/13	Benefit Coverage Determination	Contract 15000.00 Fees 5000.00 Interest 22500.00	None	Closed - Settled	9/23/13
Superior Court of New Jersey, Bergen County, Law Division, Special Civil Part, Small Claims, No. SC 1276-13	Polanco, Jorqe R. v. Aetna Dental Insurance PPO	5/9/13	Benefit Coverage Determination	Contract 1172.40	None	Closed - Settled	8/28/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
52-2 Judicial District Court, MI, No. 12-C03269 GC	St. Joseph Mercy Hospital v. Robin Lynne O'Grady v. Aetna Life Insurance Company	5/13/13	Benefit Coverage Determination	Contract 5725.92	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/30/13
U.S. District Court for the District of Montana, Missoula Division; No. CV-13-93-M-DLC	Appling, Jason v. Costco Employee Benefits Program, with Aetna Life Insurance Company, as its Administrator and/or Fiduciary	5/14/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/6/14
Fifth Judicial Circuit, Small Claims Court, Aberdeen, SD, No. 06SMC13-000691	Foht, Lydia R. v. Aetna Life Insurance Company	5/20/13	Benefit Coverage Determination	Compensatory 301.57	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/2/13
Superior Court of New Jersey, Burlington County, Law Division, Special Civil Part, No. BUR-DC-011925-12	Morristown Memorial v. Michael Gerhart and Sharon Gerhart v. Aetna Insurance Company	5/22/13	Benefit Coverage Determination	Contract 2482.83 Costs 64.65 Fees 48.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/6/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court of the 17th Judicial Ciricuit in and for Broward County, FL; No. CACE-2012-07908-25	Rehabilitation, Inc. d/b/a Ft. Lauderdale Health & Rehabilitation Center v. Susan Ries v. Coventry Health Care, Inc.; First Health Network; and Covenant Administrators, Inc.	5/23/13	Benefit Coverage Determination	Contract 17169.27	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/4/15
U.S. District Court of Maryland, Cecil County; No. 030200006112013	Options for Senior America v. Monnie Dancy v. Aetna Life Insurance Company and National Accounts CRT	5/23/13	Benefit Coverage Determination	Contract 15660.25 Interest 2818.85	None	Closed - Settled	9/26/13
Supreme Court of the State of New York, County of New York, No. 153229/2013	Neuroaxis Neurosurgical Associates, P.C. v. Jeffrey Thomas v. Aetna Life Insurance Company, Aetna Health, Inc. and Aetna Health Insurance Company of New York, Inc.	5/29/13	Benefit Coverage Determination	Contract 41479.35	None	Closed - Settled	4/22/15
Superior Court of California, County of Alameda, Ca, No. RS13681394	Keir, Harold Victor v. Aetna Life Insurance Company	5/29/13	Benefit Coverage Determination	Contract 808.00 Costs 1800.00	None	Closed - Settled	8/23/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of California, No. CV 13 2554	Elizabeth L., James L., and Olivia L., individually and as representatives of the class of similarly situated individuals; and L.M. and N.M., as guardians of M.M., as representives of the class of similarly situated individuals v. Aetna Life Insurance Company	6/6/13	Class Action	Compensatory 248000.00	None	Closed - Appeal/Post Trial - Aetna Favor	5/11/17
Circuit Court for Fairfax County, VA, No. CL-2013-0009813	Adams, Carol v. Aetna Life Insurance Company	6/6/13	Benefit Coverage Determination	Contract 36789.97	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/8/13
Superior Court of California, County of Los Angeles, Southwest District, Small Claims, Inglewood, No. ING 13S03135	Ibrahim, Lara v. Aetna Insurance Company of Connecticut	6/6/13	Benefit Coverage Determination	Compensatory 8796.00	None	Closed - Settled	12/6/13
Superior Court of California, County of Ventura, Small Claims, No. 56-2013-00443280-SC-SC-SIM	Meyer, Marcy v. Aetna Health of California; Aetna Life Insurance Company	6/6/13	Benefit Coverage Determination	Compensatory 340.00	None	Closed - Trial - Aetna Favor	12/6/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Camden County, No. L-2448-13	Fulton, Jr., Gardner v. Bernard K. Woods, Jr.; Bernard K. Woods, Sr.; Aetna Life Insurance Company and/or ABC Corporation 1-100; Personal Service Insurance Company and/or Def Corporation 1-100	6/11/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	8/20/14
Coral Gables District County Court, Miami-Dade County, FL, No. 13 10010SP25	Fabregas, Ernesto v. Aetna Inc. and Mark T. Bertolini, Chairman, CEO & President	6/11/13	Benefit Coverage Determination	Contract 867.00	None	Closed - Settled	7/18/13
Court of Common Pleas, Auglaize County, OH, No. 2013 CV 0130	Miller, Brendan v. Aetna U.S. Healthcare	6/19/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/6/13
17th Judicial Circuit Court, Broward County, FL, No. 13-013839-CACE-14	Smith, Jane, a Florida resident, individually and on behalf of all other similarly situated Florida residents v. Coventry Health Care of Florida, Inc.	6/25/13	Class Action	Unspecified	None	Closed - Settled	8/24/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Common Pleas Court of Ohio, Wayne County, No 13-CV-0361	Maurer, Toni & Thomas v. Wayne County Board of County Commissioners and Aetna	6/27/13	Benefit Coverage Determination	Unspecified	None	Closed - Appeal/Post Trial - Aetna Favor	2/1/16
Circuit Court of S. Clair Co. 20th Judicial Circuit IL; 11-AR-147	Yarber, Traci L. v. Susan L. Morse, Marketplace Magazine f/k/a Marketing Matters Publishing, Group Health Plan and Coventry Health and Life Insurance Company	6/27/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/13/14
Superior Court of New Jersey, Camden County, Law Division; No. L-2838-13	Golden, Damir v. Aetna, Inc. and/or Government Employees Insurance Company, jointly, severally, individually and/or in the alternative	7/2/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/20/13
U.S. District Court for the Eastern District of New York, No. CV 13 3858	Tholl, Claudia v. Bank of America Corporation; Aetna Health and Life Insurance Company; and United Healthcare Insurance Company of New York	7/11/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	12/31/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
24th Judicial District Court for the Parish of Jefferson, Louisiana; No. 728-831	Lemke, Diane L. and Edward L. Lemke v. Aetna Life Insurance Company; Entergy Corporation	7/12/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/24/14
Comonwealth of Pennsylvania, County of York, No. MJ-19101-CV-0000091-2013	Heim, Larry C. v. Aetna Rx Home Delivery	7/15/13	Benefit Coverage Determination	Contract 1162.80 Fees 90.00	None	Closed - Settled	12/3/13
Civil Court, City of New York, County of Kings, Small Claims Part 45, Brooklyn, NY, No. 16198 SCK 2013 1	Eisenberg, Maureen v. Aetna	7/18/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/3/13
Circuit Court of Brooke County, West Virginia; No. 11-C-60-MJG	Weirton Medical Center v. Gina Pearson, now known as Gina Y. Chicone v. Carelink Health Plan, Inc.	7/25/13	Benefit Coverage Determination	Contract 5564.36	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/7/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Middle District of Alabama, Southern Division; No. 1:13-cv-00530	Whatley, Melody L. v. Army Fleet Support, LLC; Aetna Life Insurance Company; Blue Cross and Blue Shield of Alabama	7/25/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/15/14
U.S. District Court for the Eastern District of Kentucky; No. 5:13-cv-00241-KSF	Williams, John Everett and Michelle Josie Williams v. Aetna Life Insurance Company; The Central Georgia Electric Membership Corp. d/b/a Central Georgia EMC Welfare Plan; The Central Georgia Electrical Membership Corp. d/b/a Central Georgia EMC	7/29/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/18/15
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. DC-014698-13	Hackensack Anestesiology Associates, P.A. v. Philip DeSimone v. Aetna, Inc.	8/6/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/13/14
Superior Court of New Jersey, Law Division, Special Civil Part, Burlington County, No. SC-1269-13	Rijs, Geneva and Kevin v. Aetna and Virtua	8/7/13	Benefit Coverage Determination	Compensatory 324.77	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/26/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
22nd Judicial District Court, Parish of St. Tammany, Louisiana, No. 201313732H	Hayman, Loreta P. and Michael A. Hayman v. Coventry Health Care of Louisiana, Inc.	8/9/13	Benefit Coverage Determination	Contract 3149.03	None	Closed - Settled	12/20/13
Superior Court of California, County of Santa Cruz, Small Claims, Watsonville, CA, No. WS130539	O'Keefe, Mary S. v. Aetna Inc. and Mark Bertolini	8/9/13	Benefit Coverage Determination	Contract 2720.88 Costs 201.72 Punitive 1500.00	None	Closed - Settled	10/18/13
Iowa District Court for Mahaska County, Iowa; No. SCSC030576	Stream, Lynette v. Coventry Health Care of Iowa Inc.	8/12/13	Benefit Coverage Determination	Contract 4000.00	None	Closed - Settled	11/12/13
Superior Court of California, County of Los Angeles, Southwest District, Inglewood Courthouse, Small Claims, No. ING13S04463	Braunegg, George G. v. Aetna Life Insurance Company	8/15/13	Benefit Coverage Determination	Compensatory 10000.00	None	Closed - Settled	12/6/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
7th Judicial Circuit Court, St. John's County, FL, No. CA13-1252	Della Porta, John, on behalf of himself and all others similarly situated v. Aetna Health, Inc.	8/19/13	Class Action	Unspecified	None	Closed - Settled	12/31/14
Jefferson Circuit Court, Division 9, KY, No. 13-CI-002527	Johnston, Carol and Steven Johnston v. Aetna	8/22/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/12/14
U.S. District Court for the District of Utah, Central Division, No. 2:13-cv-00795-BSJ	Egan, Kathryn S. v. Aetna Life Insurance Company	8/27/13	Benefit Coverage Determination	Compensatory 69278.25	None	Closed - Settled	6/25/14
Broward County, FL, No. 13-09718 CONO	Christensen, Chad v. Aetna Health, Inc.	8/27/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/16/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, Los Angeles County, CA; No. LAV 13V06527	Tennen, Ken v. First Health Group Corp.	8/28/13	Benefit Coverage Determination	Contract 550.00	None	Closed - Settled	10/2/13
Superior Court of California, County of Orange, Small Claims Division; No. 30-2013-00670253-SC-SC-CJC	Laub, Rick and Mary Laub v. Aetna Life Insurance Company	9/3/13	Benefit Coverage Determination	Compensatory 1640.00	None	Closed - Settled	12/31/13
Superior Court of New Jersey, Law Division, Special Civil Part, Union County, No. DC-009854-13.	Midatlantic Neonatology v. Michelle Berkey and Robert Berkey v. Aetna and United HealthCare Services, Inc.	9/4/13	Benefit Coverage Determination	Contract 904.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/3/13
Civil Court of New York, County of New York, Small Claims Part 45, No. 2430 SCNY 2013 1	Miller, John E. v Aetna Health Inc.	9/5/13	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	12/3/13

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Justice of the Peace, Precinct 2, Place 2, Brazoria County, Texas; No. DSM-2950A	Massengale, James L. v. Aetna Health Inc.	9/9/13	Benefit Coverage Determination	Compensatory 560.41 Fees 116.00	None	Closed - Settled	12/6/13
Superior Court of New Jersey, Law Division, Special Civil Part, Camden County, No. SC-1801-13.	Zerone, Timothy v. Aetna Inc.	9/9/13	Benefit Coverage Determination	Contract 1878.00 Costs 22.00 Fees 750.00	None	Closed - Settled	3/6/14
Superior Court of New Jersey, Law Division, Special Civil Part, Middlesex County; No. DC-014259-13	Eckel, Craig R. v. Aetna Insurance Company, Scripps Mercy Hospital; Progressive Management Systems; and John Does 1-9	9/9/13	Benefit Coverage Determination	Contract 15000.00 Costs 82.00	None	Closed - Pretrial - Judgment in Favor of Aetna	3/13/14
Superior Court of New Jersey, Law Division, Essex County, No. ESX-L-7123-13	Stokley, Jermaine v. Aetna Life Insurance Company d/b/a Aetna Health Plan	9/11/13	Benefit Coverage Determination	Unspecified	None	Closed - Dismissed with Prejudice	1/15/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Gloucester County, No. GLO-L-723-13	Virtua-West Jersey Health Systems, Inc. v. Shannon Behan, et al. v. Horizon BCBS and Aetna	9/16/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/28/14
52nd Distict Court, 4th Division, Small Claims, Michigan, No. 13-C02392 SC	Guo, Daniel v. Aetna FSA	9/19/13	Benefit Coverage Determination	Compensatory 318.45	None	Closed - Settled	10/28/13
Superior Court of New Jersey, Law Division, Special Civil Part, Monmouth County, No. DC-010526-13	Surgicare Ambulatory Center Inc. v. Cassandra Barnes v. Aetna Inc.	9/19/13	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	3/13/14
Superior Court of New Jersey, Law Division, Essex County, No. ESX-L-7157-13	McCallum, Kenya v. Robert M. Hunt, Jr.; Aetna U.S. Healthcare, et al.	9/22/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/21/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
20th Judicial Circuit Court, Lee County, FL, No. 13-CA-001165	Lee Memorial Health System v. Andrew J. Montero v. Aetna Health, Inc.	9/25/13	Benefit Coverage Determination	Compensatory 65287.13	None	Closed - Settled	5/30/14
First Judicial District Court, Scott County, MN	Lati, Andrea L. v. Aetna Life Insurance Company	10/8/13	Benefit Coverage Determination	Contract 705.10	None	Closed - Settled	12/4/13
U.S. District Court for the Western District of Texas, Austin Divison, No. 1:13-cv-00907	Lueck, Robert v. Aetna Life Insurance Company and Hazelden Foundation	10/9/13	Benefit Coverage Determination	Compensatory 26244.61	None	Closed - Settled	3/17/14
Superior Court of New Jersey, General Equity, Ocean County, No. C000195	In the matter of Carmine Caruso, by and through his guardian, Anne Caruso v. Aetna	10/10/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/27/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Special Civil Part, Small Claims Section, Bergen County, No. SC-2754-13	Trigub, Alina v. Aetna	10/11/13	Benefit Coverage Determination	Compensatory 599.04 Fees 22.00	None	Closed - Settled	12/23/13
Superior Court of California, County of Los Angeles, No. 13M09186	Stafford, M.D., Vivi Robyn v. Aetna Health of California, Inc. d/b/a Aetna	10/15/13	Benefit Coverage Determination	Compensatory 9950.00	None	Closed - Settled	1/31/14
15th Judicial Circuit Court, Palm Beach County, FL, No. 2013CA015695	Pasternack, Dana, as parent and natural guardian of Jacob Pasternack v. Aetna Health, Inc.	10/16/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/29/14
Superior Court of Fulton County, GA, No. 2013 CV 237787	Givens, Kelly J. v. Aetna Life Insurance Company	10/16/13	Benefit Coverage Determination	Contract 31743.10	None	Closed - Settled	3/14/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court of Dale County, AL, No. 26-CV-2013-900166	Hughes, Jena and William Hughes v. Aetna Life Insurance Company	10/17/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/6/14
Superior Court of New Jersey, Law Division, Special Civil Part, Mercer County, No. SC-1213-13	Chernev, Nevena v. Aetna Health, Inc.	10/17/13	Benefit Coverage Determination	Contract 1271.60	None	Closed - Settled	1/15/14
Civil Court of the City of New York, County of New York, Small Claims Part 45, No. 2842 SCNY 2013 1	Root, Oren v. Aetna Life Insurance Company	10/22/13	Benefit Coverage Determination	Compensatory 1000.00	None	Closed - Settled	12/31/13
Superior Court of New Jersey, Law Division, Special Civil Part, Gloucester County, No. DC-005549-13	Virtua West Jersey Health System v. Kimberly A. Billington v. Health Assurance Pennsylvania Inc.	10/25/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/30/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Essex County, No. L-006515-13	North Jersey Orthopaedic and Sports Medicine v. Andrew Valeriani v. Dr. Michael C. Russonella; Bollinger, Inc; Bollinger Insurance Solutions; Aetna Health, Inc; Meadowlands Hospital Medical Center; Elite Anesthesia, LLC, et al.	10/29/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/8/14
Jackson County Circuit Court, MO, No. 1316-CV28157	Noland, Deborah, Individually and on behalf of others similarly situated v. ACS Recovery Services, Inc.; and Coventry Health Care of Kansas, Inc.	11/5/13	Class Action	Unspecified	None	Closed - Complaint Withdrawn	5/23/17
El Paso County Court, CO, No. 2013c040753	Credit Systems, Inc. v. Letticia Ruiz v. Brien Whittington; Aetna Health & Life Insurance Company d/b/a Aetna Casualty; Aetna Health, Inc; Aetna Health Insurance Company	11/19/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/28/14
Tennessee Department of State, Roane County Circuit Court; No. 73GS1-2013-CV-1529	Smith, Hugh C. v. Aetna, Inc. and U.S. Aetna	11/25/13	Benefit Coverage Determination	Contract 1364.64	None	Closed - Settled	3/6/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Philadelphia Municipal Court for the First Judicial District of Pennsylvania, No. SC-13-12-09-4546	Smith, Randolph v. Aetna Life Insurance Company	12/9/13	Benefit Coverage Determination	Compensatory 12078.00	None	Closed - Settled	6/20/14
Circuit Court of the Eighteenth Judicial Circuit, Brevard County, Florida, No. 05-2013-CA-041623	Coble, Douglas Frank & Cheryl Coble v. Aetna Life Insurance Company; and Bank of America Corporation	12/12/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/15/14
17th Judicial Circuit Court, Broward County, FL, No. CACE-13-26836	Howard, Michael v. Coventry Health Plan of Florida, Inc. and Raymond J. Ackerman Insurance, Inc.	12/16/13	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/31/14
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. SC000129124	Schnoll, Tracy v. Aetna Life Insurance Company	12/19/13	Benefit Coverage Determination	Contract 2200.00	None	Closed - Settled	3/14/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court for the City of New York, County of New York, Small Claims Part 45, No. 16525.SCNY 2013 1	Morin, John v. Aetna	12/23/13	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	5/30/14
U.S. District Court for the State of Utah, Central Division, No. 2:13-CV-01119 DB	Olsen, Michael v. Aetna Life Insurance Company and The Tesoro Medical Plan	12/23/13	Benefit Coverage Determination	Compensatory 24700.20	None	Closed - Settled	11/25/14
Circuit Court of the 17th Judicial Circuit, Winnebago County, Illinois, No. 2013 SC 2025	Mutual Management Services Company, LLC v. Larbi John Murray and Florentina Murray v. Aetna Health Inc.	12/26/13	Benefit Coverage Determination	Contract 2375.00	None	Closed - Settled	7/25/14
Lima Municipal Court, Lima, OH, No. 13CVF02359	Lima Memorial Hospital v. Bonnie Edgin v. Aetna Life Insurance Company	12/30/13	Benefit Coverage Determination	Compensatory 3244.00	None	Closed - Settled	6/9/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of Connecticut, Small Claims, New Britain+B350	Santacroce, Anthony v. Aetna Life Insurance Company	1/2/14	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	8/28/14
Supreme Court of the State of New York, Rockland County, No. 036502/2012	Westchester County Health Care Corporation v. Anthony Gustave v. Aetna Life Insurance Company	1/6/14	Benefit Coverage Determination	Contract 137291.28	None	Closed - Settled	5/26/15
Superior Court of California, County of Los Angeles, Van Nuys, Small Claims, No. 14V00352	Pritikin, Jeffrey v. Aetna Insurance Company of Connecticut	1/9/14	Benefit Coverage Determination	Compensatory 2571.00	None	Closed - Settled	5/2/14
Circuit Court, Dane County, Wisconsin, No. 14SC0414	Gilbertson, Erek; Scott Gilbertson and Patrice Qualey v. Benefit Plan Administrators of Eau Claire, Inc.; and American Health Holding, Inc.	1/15/14	Benefit Coverage Determination	Contract 4538.90	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/25/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
American Arbitration Association, Florida, No. 32 460 00064 14	Wilkinson, Mark on behalf of his daughter MW v. Aetna Health Inc.	1/27/14	Benefit Coverage Determination	Compensatory 18000.00	None	Closed - Settled	6/20/14
U.S. District Court for the Western District of Kentucky, No. 3:14-cv-00029-M	Collins, Cathy, in her capacity as guardian for Suzanne Collins v. United Parcel Service, Inc.; United Parcel Service, Inc. Flexible Benefit Plan; and Aetna Life Insurance Company	1/28/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/25/14
Magisterial District Court 38-1-21, Blue Bell, County of Montgomery, PA, No. MJ-38121-CV-0000022-2014	Wydan, Anthony v. Aetna Insurance	1/28/14	Benefit Coverage Determination	Compensatory 9000.00	None	Closed - Settled	6/20/14
Superior Court of New Jersey, Law Division, Union County, No. UNN-L-2809-13	Cherilus, Enithe v. Gregory B. Shaffer; Professional Climate Control; Cure Auto Insurance; and Aetna	2/3/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/17/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Supreme Court for the State of New York, County of New York, No. 151025/2014	Brower, Jake, by and through his legal guardians, John Brower and Lisa Brower v. Aetna Health, Inc.	2/4/14	Benefit Coverage Determination	Compensatory 1000000.00	None	Closed - Settled	9/18/17
3rd Judicial District Court, Salt Lake County, UT, No. 140901324	Crystal L. v. Salt Lake County	2/21/14	Benefit Coverage Determination	Compensatory 63200.00	None	Closed - Settled	11/25/14
District Court, Scott County, IA, No. SC196417	Proske, Joseph and Melissa v. Aetna	2/25/14	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	8/20/14
149th Judical District Court, Brazoria County, TX, No. 76066-CV	In Re: Dora Ann Burnett, et al. v. Conoco Phillips; Aetna Life Insurance Company, et al.	2/27/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	7/29/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Central District of California, No. 2:14-cv-01957-JAK-JC	Krowne, Andrew and Jennifer v. Aetna Life Insurance Company	3/5/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/3/15
U.S. District Court for the District of Utah, Central Divsion, No. 2:14-cv-00159-DAK	Lawyer, Daniel v. Aetna Life Insurance Company; and FamilyLink.com	3/5/14	Benefit Coverage Determination	Compensatory 56523.79	None	Closed - Settled	2/17/15
Superior Court of New Jersey, Law Division, Middlesex County, No. MID-L-1536-14	Gonzales, Antonio v. Aetna, Inc. and State Farm Indemnity Company	3/6/14	Benefit Coverage Determination	Contract 8270.27	None	Closed - Settled	5/30/14
U.S. District Court of the Eastern District of Pennsylvania, No. 2:14-cv-01434-GP	Carnavil, Stephen v. Aetna Life Insurance Company	3/11/14	Benefit Coverage Determination	Contract 58970.00	None	Closed - Settled	10/9/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of Maricopa County, AZ, No. LC2014-000136-DOI	Faraci, Clifford v. Aetna Life Insurance Company; Arizona Department of Insurance	3/18/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/28/14
District Court of Douglas County, NE, No. CI 14-2293	Lord, John L. v. Aetna Life Insurance Company d/b/a Aetna Health, Inc and/or d/b/a Aetna Health Management, LLC	3/24/14	Benefit Coverage Determination	Contract 30000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	10/23/14
Chancery Court , Madison County, TN, No. 71680	Morris, Ayla v. Coventry Health Care of Louisiana, Inc; and Coventry Health & Life Insurance Company a/k/a Coventryone	3/25/14	Benefit Coverage Determination	Contract 58230.00	None	Closed - Settled	11/18/14
18th Judicial District Court, Sedgwick County, KS, No. 14LM04025	Hague, Matthew v. Coventry Health Care, Inc; Coventry Health Care of Kansas, Inc; MHNet Behavioral Health; and MHNet Speciality Services, LLC	3/26/14	Benefit Coverage Determination	Contract 22500.00	None	Closed - Settled	11/10/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court of Maryland, Baltimore County, No. 080400085462014	Ellin, David v. Aetna Insurance Company	3/28/14	Benefit Coverage Determination	Contract 3120.00	None	Closed - Settled	6/5/14
Superior Court of California, County of Santa Clara, No. 114SC055853	Reed, Sharloyn v. Aetna Life Insurance Company	4/3/14	Benefit Coverage Determination	Compensatory 7500.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	7/31/14
U.S. District Court for the Southern Distict of California, No. 14-cv-0895-BEN-DHB	Keller, Michael v. Aetna Health and Life Insurance Company	4/15/14	Benefit Coverage Determination	Compensatory 113890.30	None	Closed - Settled	11/25/14
Superior Court of New Jersey, Law Division, Special Civil Part, Camden County, No. DC-003609-14	Kennedy Health Systemes v. Britt, Walter and Terri Britt v. Aetna Health Insurance	4/17/14	Benefit Coverage Determination	Contract 6509.43	None	Closed - Settled	2/5/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Ocean County, No. DC-002490-14	Liberty Healthcare v. Florence Berlinski v. Aetna Life Insurance Company	4/17/14	Benefit Coverage Determination	Contract 2240.00	None	Closed - Settled	8/8/14
U.S. District Court for the Northern District of Texas, Dallas Division, No. 3:14-cv-01447-G	Bush, Connie and James Carney v. Aetna Life Insurance Company; and Thomas Reuters Holdings, Inc.	4/21/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/24/14
Superior Court of California, Small Claims, County of Orange, No. 30-2014-00717644-SC-SC-HNB	Van Dyke, Le Roy v. Aetna Life Insurance Company	4/21/14	Benefit Coverage Determination	Compensatory 9235.06	None	Closed - Settled	11/25/14
U.S. District Court for the Southern District of Illinois, No. 14-cv-00457-DRH-SCW	Schulter, Pamela v. Aetna Life Insurance Company	4/22/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/31/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:14-cv-00311 BCW	Richard R. and Susanna R. v. Computer Sciences Corporation; CSC Preferred Access Plan; and Aetna Life Insurance Company	4/24/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	7/28/14
Supreme Court of the Turks and Caicos Islands, No. 113/14	Duncanson, Beryn v. International Insurance Agency LTD; Aetna International Medical Insurance	5/9/14	Benefit Coverage Determination	Compensatory 6935.30	None	Open	
21st Judicial District Court, Parish of Livingston, LA, No. 145118F	Ensor, Pamela G. v. Coventry Health Care of Louisiana, Inc.	5/9/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/5/15
Superior Court of New Jersey, Law Division, Special Civil Part, Ocean County, No. DC-014085-13	Ira Klemons DDS PhD PC v. Megan Pyle v. Aetna Insurance; ABC Insurance Co I-III	5/14/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/11/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Grant County Superior Court No. 2, IN, No. 27D02-1405-PL-332	Royal, Mark and Nicole Royal v. Aetna Life Insurance Company	5/14/14	Benefit Coverage Determination	Contract 15523.97	None	Closed - Settled	11/10/14
U.S. District Court for the District of Maryland at Greenbelt, No. 8:14-CV-01745-DKC	Doe, Jane, individually and, as Guardian of John Doe, a minor v. Aetna Health, Inc.; United States Office of Personnel Management	5/30/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/10/14
9th Judicial Circuit Court, McDonough County, IL, No. 2014-LM-45	Ferguson, Molly J. v. Coventry Health Care of Illinois, Inc., an Illinois Corporation	6/2/14	Benefit Coverage Determination	Contract 15575.00	None	Closed - Settled	9/24/15
24th Judicial District for the Parish of Jefferson, LA, No. 738993	Nguyen, Anna v. Coventry Health Care of Louisiana, Inc.	6/2/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/31/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
General Sessions Court Part II, Mt. Pleasant, Maury County, TN, No. 2014-CV-741	Cahill, Regena v. Aetna Health Inc.	6/4/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/15/15
Superior Court of Delaware, New Castle County, No. N14C-06-046 PRW	Kessler, Brian v. Aetna Health Inc.	6/4/14	Benefit Coverage Determination	Contract 26469.28	None	Closed - Pretrial - Judgment in Favor of Aetna	4/17/15
District Court, Howard County, Ellicott City, MD, No. 100100023382014	Xu, Shaobei v. Aetna Life Insurance Company	6/4/14	Benefit Coverage Determination	Contract 560.00	None	Closed - Settled	8/8/14
4th Judicial District Court, Hennepin County, MN, No. 27-CO-14-4671	Migault, Laurent v. Aetna Health Management	6/12/14	Benefit Coverage Determination	Contract 5774.69 Fees 70.00	None	Closed - Settled	10/22/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court, Prince George's County, MD, No. CAE14-13708	Simonds, Danielle L. v. Aetna Health Inc.	6/12/14	Benefit Coverage Determination	Contract 9325.71	None	Closed - Settled	1/15/15
Court of General Sessions, Williamson County, TN, 2014-CV-341	Brentwood Pediatrics v. Shane K. McNeill v. Aetna, Inc.	6/13/14	Benefit Coverage Determination	Compensatory 1029.30	None	Closed - Settled	10/14/14
Civil Court of the City of New York, County of New York, Small Claims Part 45	Bauman, Michael v. Aetna	6/23/14	Benefit Coverage Determination	Contract 1300.00	None	Closed - Trial - Aetna Favor	8/28/14
Circuit Court, St. Josepsh County, IN, No. 71C01-1406-CT-000200	Schmitt, Margaret v. Aetna Life Insurance Company	6/23/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/4/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
American Arbitration Association, Los Angeles, CA, No. 01-14-0000-3242	Thompson, Dana v. Aetna Health of California, Inc.	6/23/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/16/15
U.S. District Court for the District of Utah, Central Division, No. 2:14-cv-00470-EJF	Rogers, Peggy, Personal Representative for the Estate of Paul D. Rodgers v. Aetna Life Insurance Company	6/26/14	Benefit Coverage Determination	Compensatory 74346.11 Fees 119900.00	None	Closed - Settled	2/17/15
Justice Court Precinct 3, Place 1, Dallas County, TX, No. JS 14-30788A	Grodin, Melissa and Stella Grodin v. Aetna Health, Inc.	6/27/14	Benefit Coverage Determination	Compensatory 1642.82	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/8/14
Superior Court of New Jersey, Law Division, Burlington County, No. BUR-L-636-14	Klein, MD, Jeffrey D. v. Mark Zimmerman v. Aetna Health Inc. d/b/a Aetna Health Insurance Company, Its Affiliates, Group Subsidiaries and Assigns and John Does 1-10	6/30/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/2/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
46th Judicial District Court, MI, No. GC142609	Spelker, Bradford J. v. Aetna Health and Life Insurance Company; and Citizens Insurance Company of America	7/1/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/4/15
Superior Court of California, County of Orange, Small Claims, No. 30-2014-00732428-SC-SC-CJC	Chin, Jeremy Aaron v. Aetna, Inc.	7/7/14	Benefit Coverage Determination	Compensatory 8162.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/25/14
District Court, Denver County, CO, No. 2014CV032661	De Arment, Sophia Claire v. Aetna Life Insurance Company	7/8/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/9/15
U.S. District Court for the District of Utah, Central Division, No. 2:14-cv-00498-EJF	Higley, Donald v. Aetna Life Insurance Company	7/8/14	Benefit Coverage Determination	Compensatory 28281.41 Fees 129690.00	None	Closed - Settled	2/17/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, County of Orange, Newport Beach, No. 30-2014-00734178-SC-SC-HNB	Garmon, Gregory Paul v. Aetna Health of California, Inc.	7/16/14	Benefit Coverage Determination	Compensatory 1755.00	None	Closed - Settled	11/25/14
Superior Court of New Jersey, Law Division, Essex County, No. ESX-L-4377-14	Delucas-Kolodziej, Cheryl; Emily Kolodziej, an infant by her Guardian Ad Litem, Cheryl Delucas-Kolodziej v. John Kolodziej; Aetna; Aetna Life Insurance Company; Aetna Health Administrators; Aetna Health, Inc, et al.	7/19/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/30/17
Superior Court of New Jersey, Law Division, Special Civil Part, Essex County, No. DC-012899-14	Currie, Ericka v. Aetna Corporate Headquarters	7/21/14	Benefit Coverage Determination	Fees 57.00 Unspecified 15000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/31/14
21st Judicial Circuit Court, St. Louis County, MO, No. 14SL-AC20392	Harrison, Michael T. v. Coventry Health & Life Insurance Company	7/22/14	Benefit Coverage Determination	Contract 25000.00	None	Closed - Settled	1/15/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Nevada, No. 3:14-cv-00380-MMD-WGC	Hubbard, Mary v. Aetna Life Insurance Company and Does I though XXX, inclusive	7/22/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/2/15
U.S. District Court for the Western District of Texas, San Antonio Division, No. 5:14-cv-665	Kidder, Charles v. Aetna Life Insurance Company; Tyco International Management Company; Plan Administrator for the Tyco International Health and Welfare Benefits Plan; Tyco International Heatlh and Welfare Benefits Plan; and Sedgwick Claims Management Services	7/24/14	Benefit Coverage Determination	Contract 86239.56 Unspecified 8026.98	None	Closed - Trial - Aetna Favor	6/27/16
Superior Court of New Jersey, Law Division, Special Civil Part, Monmouth County, No. SC-02117-14	Ciolek, Robert and Alana Ciolek v. Aetna Life Insurance Company	7/26/14	Benefit Coverage Determination	Contract 576.20 Fees 22.00	None	Closed - Settled	9/5/14
157th Judicial District Court, Harris County, TX, No. 2014-44005	Norris, Jeffrey and Leigh Miche Norris v. Aetna Life Insurance Company	7/31/14	Benefit Coverage Determination	Contract 75000.00	None	Closed - Settled	10/9/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of the City of New York, New York County, No. 1974.SCNY 2014 1	Rosenberg, Brian v. Aetna Life Insurance Company	7/31/14	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	12/29/14
U.S. District Court for the Central District of California, No. 2:14-cv-06024-FMO-MRW	Stephen B. v. Aetna Life Insurance Company	7/31/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/16/16
Superior Court of New Jersey, Law Division, Essex County, No. DC-013992-14	Brantley, Rhylette v. Aetna Inc.	8/5/14	Benefit Coverage Determination	Contract 4150.00	None	Closed - Settled	2/26/15
District Court, Small Claims, Jefferson County, Louisville, KY, No. 14-S-001000	DeFazio, John Douglas v. Aetna Health Management	8/6/14	Benefit Coverage Determination	Unspecified	None	Closed - Trial - Aetna Favor	10/27/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Magesterial District Court, Delaware County, No. MJ-32253-CV-0000060-2014	Mulholland, Paul v. Aetna Life Insurance	8/6/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/10/14
11th Judicial Circuit Court, Miami-Dade County, FL, No. 16800718	Porter, Christina, individually and as legal guardian for John Porter Spuches v. Coventry Health Care of Florida, Inc.	8/6/14	Benefit Coverage Determination	Contract 15575.90	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/25/14
Superior Court of New Jersey Law Division, Middlesex County, NJ, No. DC-009355-14	JFK Johnson Rehab Institute v. Antonio Abano & Gemma Abano v. Aetna Health, Inc.; ABC Entities 1-10, individually and in their official capacity	8/11/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/1/15
U.S. District Court for the Western District of Texas, Austin Division, No. A14CV0761LY	Jones, Scottie v. Chevron Phillips Chemical Company LP Health and Welfare Trust; Aetna Inc, et al.	8/13/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	4/21/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Georgia, No. 1:14-cv-02627-ODE	N.H. v. Coventry Health Care of Georgia, Inc.	8/14/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/14/15
Superior Court of New Jersey, Law Divison, Gloucester County, No. L-1031014	Virtua Memorial Hospital of Burlington County v. Anthony J. Saban v. Aetna Health, Inc.	8/14/14	Benefit Coverage Determination	Contract 59794.55	None	Closed - Pretrial - Aetna Dismissed by Court Order	11/24/14
Superior Court of New Jersey, Law Division, Special Civil Part, Burlington County, No. DC-006363-14	Pine, Thomas A. v. Justin Green, Rhonda Manders, Aetna Insurance	8/15/14	Benefit Coverage Determination	Compensatory 56.49 Fees 57.00	None	Closed - Settled	9/22/14
Civil Court of the City of New York, Small Claims, No. 1635/14	Lipsman, Angela v. Aetna Healthcare	8/18/14	Benefit Coverage Determination	Contract 490.00	None	Closed - Settled	11/18/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Justice Court County of Gallatin, Bozeman, MT, No. CV14-1001	Alkhalifa, Agell v. ING Insurance, Inc. d/b/a Aetna Global Benefits	8/20/14	Benefit Coverage Determination	Compensatory 2280.50	None	Closed - Settled	3/31/15
U.S. District Court for the District of Nevada, No. 3:14-cv-00430-LRH-VPC	Jones, Jr. Max v. Sylvia Mathews Burwell, in her capacity as the Secretary of Health and Human Services	8/22/14	Benefit Coverage Determination	Compensatory 10000.00 Costs 11000.00	None	Closed - Settled	9/11/15
Superior Court of Polk County, Georgia, No. 2014CV-628S	Floyd Healthcare Mang, Inc. d/b/a Floyd Medical Center v. Ginger D. Slaughter v. Aetna Health, Inc. a/k/a Aetna Life Insurance	8/25/14	Benefit Coverage Determination	Contract 2843.25 Costs 257.00 Interest 476.73	None	Closed - Settled	12/17/14
Superior Court of the State of Washington, Clark County, No. 14-2-02532-1	Kosterow, Kim L. v. Aetna Life Insurance Company, Connecticut corporation; and Buckman Laboratories International, Inc.	8/29/14	Benefit Coverage Determination	Compensatory 90000.00	None	Closed - Settled	5/4/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Civil Part, Gloucester County, No. L-1217-14	Mattson, Joan and Eric Mattson, individually and as class representative on behalf of other similarly situated v. Aetna Life Insurance Company d/b/a Aetna, Inc.; The Rawlings Company, LLC d/b/a The Rawlings Group; SNJ Regional Employee Benefit Fund; Cooper Univeristy Health Care d/b/a Cooper Univeristy Hospital d/b/a Cooper Hospital/University Medical Center d/b/a Cooper University	9/2/14	Class Action	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	2/18/16
Travis County Court Number 1, TX, No. C-1-CV-14-008150	Ogden, R.M. and A.L. Ogden v. Aetna Life Insurance Company	9/2/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/11/16
Superior Court of California, County of Los Angeles, No. 14D07014	Pavesic, Ronald and Dr. Michael Wooten v. Aetna Healthcare	9/4/14	Benefit Coverage Determination	Compensatory 7080.00	None	Closed - Settled	11/13/15
Superior Court of California, County of Los Angeles, No. 14D07015	Pavesic, Ronald and Dr. Michael Wooten v. Aetna Healthcare	9/4/14	Benefit Coverage Determination	Compensatory 5773.00	None	Closed - Settled	10/15/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
15th Judicial District Court, Washtenaw County, MI, No. CIV14-1459-SC	Poirier, Noelle C. v. Aetna Health Inc.	9/4/14	Benefit Coverage Determination	Contract 1310.00	None	Closed - Settled	4/15/15
15th Judicial District Court, Washtenaw County, MI, No. CIV14-1460-SC	Poirier, Noelle C. v. Aetna Health Inc.	9/4/14	Benefit Coverage Determination	Contract 627.86	None	Closed - Settled	4/15/15
Chesterfield County General District Court, VA, No	Tuck, Terry v. Aetna Life Insurance Company	9/4/14	Benefit Coverage Determination	Contract 25000.00	None	Closed - Settled	12/29/14
Circuit Court of the City of Roanoke, VA, No. CL 14-1702	Williams, Jeffrey v. Aetna Life Insurance Company d/b/a Aetna	9/11/14	Benefit Coverage Determination	Contract 34951.15	None	Closed - Settled	2/26/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Somerset County, No. SOM-L-1205-14	Verasawmi, Vinoo v. Amguard Insurance Company; Aetna Insurance Company; NJM Insurance Group; and/or XYZ Insurance Company	9/12/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	2/15/16
3rd Judicial Circuit Court, Wayne County, MI, No. 2013-014800-NF	Hasson, Ramzi v. Courtney Lynn Cole; Auto Club Insurance Association; and Aetna Health Inc.	9/16/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/6/15
U.S. District Court for the Western District of Pennsylvania, No. 2:14-cv-01280-AJS	Hildebrand, Jeffery v. Aetna Health, Inc.	9/18/14	Benefit Coverage Determination	Contract 5675.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/21/15
U.S. District Court for the Northern District of Oklahoma, No. 4:14-CV-00578-GKF-TLW	Castellanos, Lasay E. v. Coventry Health Care of Kansas, Inc.	9/30/14	Benefit Coverage Determination	Contract 75000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/16/17

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Middle District of Florida, Jacksonville Division, No. 3:14-CV-01197-BJD-JBT	Milam, II, Jon Barrett v. Aetna Life Insurance Company	10/2/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/31/15
Loudoun County General Circuit Court, VA, No. CV14008014-00	Botwick, Elliott v. Chickering Claims Administrators, Inc.; Aetna Student Health; Aetna Student Health Agency, Inc.; and Aetna Life Insurance Company	10/6/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/9/15
U.S. District Court for the Northern District of California, No. 4:14-cv-04556-KAW	Von Blohn, Kimber; Elaine Von Blohn and Chris Von Blohn v. Aetna Health, Inc, a Connecticut Corporation, in its capacity as fiduciary claims administrator and insurer of the ERISA-regulated Saudi Arabian Oil Company Retiree Medical Payment Plan; and the Saudi Arabian Oil Company Retiree Medical Payment Plan	10/10/14	Benefit Coverage Determination	Compensatory 30000.00	None	Closed - Settled	2/3/15
Superior Court of New Jersey, Law Division, Ocean County, No. OCN-L-1851-14	Jersey Shore University Medical Center v. Whitney Cutino v. Ameriprise Auto & Home Insurance Company; Aetna Health Inc.; IDS Property Casualty Insurance Company	10/14/14	Benefit Coverage Determination	Unspecified	None	Closed - Case Tendered	11/6/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
City of Richmond General District Court, Civil Division, VA, No. 14035295	Essen, Otto-obong H. v. Coventry Healthcare of Virginia, Inc.	10/15/14	Benefit Coverage Determination	Contract 423.10 Costs 58.00	None	Closed - Settled	2/6/15
Douglas County Court, NE, No. CI 14-4281	The Wellness Pointe v. Lyn Sharp-Blaine a/k/a Lynette Sharp-Blaine v. Coventry Healthcare of Nebraska, Inc.	10/17/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/3/15
Circuit Court, County of Multnomah, OR, No. 14CV15588	Harris, Stephanie and Scott Harris v. Aetna Insurance Agency, Inc.	10/18/14	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/26/14
17th Judicial Circuit Court, Broward County, FL, No. 14-017078 COCE 52	Palmer Law Group, P.A. v. Coventry Health Care of Florida, Inc.	10/20/14	Benefit Coverage Determination	Contract 1298.02 Costs 232.00 Fees 750.00 Interest 12.67	None	Closed - Settled	12/1/14

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:14-cv-00773-DN-EJF	Gritton, Bryan v. Aetna Life Insurance Company	10/24/14	Benefit Coverage Determination	Contract 12863.12	None	Closed - Settled	4/28/15
Civil Court, City of of New York, County of Queens, NY, No. CV-37902-12/QU	Queens Hospital Center of the NYCHHC v. Lisa Nickles v. Aetna Inc.	10/31/14	Benefit Coverage Determination	Contract 4503.59	None	Closed - Settled	1/8/15
52-1 District Court of Oakland, MI, No. 14-C06230-GC	Beaumont Health System v. Fetters, Ginette v. Aetna	11/13/14	Benefit Coverage Determination	Compensatory 5019.89	None	Closed - Settled	4/21/15
Circuit Court for Oakland County, MI, No. 2014-144190-CK	Clapp, Jon M., by his Attorney-in-Fact, Karen Clapp v. Aetna Life Insurance Company; and County of Oakland	11/20/14	Benefit Coverage Determination	Contract 204515.00	None	Closed - Settled	11/18/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Magisterial District Court 23-3-03, County of Berks, Oley, PA, No. MJ-23303-CV-0000201-2014	Hyland, Thomas W. v. Health America Pennsylvania d/b/a Health America & Health America One and Health Assurance; Coventry Health & Life Insurance Company	11/26/14	Benefit Coverage Determination	Punitive 9774.00	None	Closed - Settled	6/2/15
Magisterial District Court 38-1-13, Montgomery County, Conshohocken, PA, No. MJ-38113-CV-00002240-2014	Millinghausen, Svitlana v. Aetna Life Insurance Company	11/28/14	Benefit Coverage Determination	Contract 12000.00 Costs 174.33	None	Closed - Pretrial - Aetna Dismissed by Court Order	2/6/15
New Britain Small Claims, Superior Court, CT, No. SCC 558744	Marinelli, Heather v. Aetna Inc.	12/1/14	Benefit Coverage Determination	Compensatory 925.00 Costs 90.00	None	Closed - Settled	12/23/14
Chesapeake General District Court, VA, No. GV14-20854	Reith III, William W. v. Aetna Health Inc.	12/1/14	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	2/5/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas, Stark County, OH, No. 2014 CV 02351	Summa Health System v. Shawna M. Postlewait v. Aetna Health and Life Insurance Company	12/1/14	Benefit Coverage Determination	Contract 25000.00	None	Closed - Settled	7/15/15
Civil Court of the City of New York, County of Kings, No. CV-032282-12/KI	Kings County Hospital of the NYCHHC v. Karen Mack v. Aetna Ins Co	12/5/14	Benefit Coverage Determination	Compensatory 23000.00	None	Closed - Settled	4/28/15
Broward County Court, FL, No. COCE-14-023260	Kaplan, Linda v. Coventry Health Plan of Florida, Inc.	12/8/14	Benefit Coverage Determination	Contract 6972.35	None	Closed - Settled	3/28/16
Superior Court of New Jersey, Law Division, Special Civil Part, Hudson County, No. DC-014967-14	New Jersey Healthcare Specialist, P.C. v. Margarita Portillo v. Aetna Life Insurance Company	12/10/14	Benefit Coverage Determination	Compensatory 1500.46	None	Closed - Settled	2/13/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Small Claims, Camden County, No. SC 2377-14	Pendergast, John v. Aetna Life Insurance Company	12/16/14	Benefit Coverage Determination	Contract 473.10 Fees 42.00	None	Closed - Settled	2/6/15
U.S. District Court for the Southern Distric of California, No. 14CV2986 LAB DHB	Doe, John, on behalf of himself and all others similarly situated v. Aetna, Inc.; Aetna Healthcare, Inc.; Aetna Specialty Pharmacy, LLC; and Does 1-10, inclusive	12/19/14	Class Action	Unspecified	None	Closed - Settled	5/17/18
3rd Judicial District, Canyon County, Small Claims Division, ID, No. CV-2014-12932-N	Redmond, Paul v. Altius Health Plans, Inc.; Coventry Healthcare of Idaho	12/30/14	Benefit Coverage Determination	Compensatory 3000.00	None	Closed - Settled	3/31/15
U.S. District Court for the District of Utah, Central Division, No. 2:15-cv-00002-PMW	I.K. mother of J.K., a minor v. Altius Health Plans	1/5/15	Benefit Coverage Determination	Contract 11694.59 Punitive 109340.00	None	Closed - Settled	5/24/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California, County of Los Angeles, Small Claims Office, No. 14M09071	Nason, Lance v. Aetna Healthcare Systems, Inc.	1/5/15	Benefit Coverage Determination	Compensatory 5000.00	None	Closed - Settled	3/31/15
Fairfax County General District Court, VA, No. GV15000484-00	Acund, Kassandra, a minor child by her father and next best friend, Edward Santos v. Aetna Health and Life Insurance Company	1/9/15	Benefit Coverage Determination	Contract 1181.25 Costs 58.00	None	Closed - Settled	5/20/15
Fairfax County General District Court, VA, No. GV15000486	Romero, Skarlet v. Aetna Health and Life Insurance Company	1/9/15	Benefit Coverage Determination	Contract 11319.00 Costs 58.00	None	Closed - Settled	5/20/15
Fairfax County General District Court, VA, No. GV15-000487	Santos, Edward v. Aetna Health and Life Insurance Company	1/9/15	Benefit Coverage Determination	Contract 1966.00 Costs 58.00	None	Closed - Settled	5/20/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Fairfax County General District Court, VA, No. GV15-000485	Santos, Malachi, a minor child by his father and next best friend, Edward Santos v. Aetna Health and Life Insurance Company	1/9/15	Benefit Coverage Determination	Contract 765.50 Costs 58.00	None	Closed - Settled	5/20/15
General District Court, Chesterfield County, VA, No. GV15001121-00	Frazier, Jr., Wesley J. & Katherine S. Frazier v. Coventry Health Care of VA, Inc.	1/13/15	Benefit Coverage Determination	Contract 25000.00 Costs 56.00	None	Closed - Settled	12/4/15
U.S. District Court for the Southern District of New York, No. 1:15-cv-00283	Fisher, Jacqueline v. Aetna Life Insurance Company	1/15/15	Class Action	Unspecified	None	Open	
5th Judicial District, County of Washington, UT, No. 150500022	Eaton, Mary Beth v. Altius Health Plans	1/20/15	Benefit Coverage Determination	Costs 12608.08	None	Closed - Settled	7/22/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
9th Judicial Circuit Court, Orange County, FL, No. 2015-CA-000380-O	Gluskin-Habin, Annette and Ronald Habin v. Aetna Life Insurance Company	1/23/15	Benefit Coverage Determination	Contract 45000.00	None	Closed - Settled	10/31/16
Superior Court of New Jersey, Law Division, Gloucester County, No. L-105-15	Williams, Willene v. Liberty Mutual Mid-Atlantic Insurance Company and/or ABC Corporation (1-100); Aetna Life Insurance Company and/or DEF Corporation (1-100)	1/28/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/12/15
General District Court for Loudoun County, VA, No. GV15-000543	Noumbo, Michel v. Innovation Health Plan, Inc.	2/4/15	Benefit Coverage Determination	Contract 3625.20	None	Closed - Settled	3/24/15
Superior Court of New Jersey, Law Division, Civil Part, Hudsson County, No. HUD-L-256-15	Faherty, Emily v. Hoboken Medical Center; Aetna; John Doe and John Doe Corporation	2/5/15	Benefit Coverage Determination	Contract 20000.00	None	Closed - Settled	6/1/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Prince William County General District Court, VA, No. GV15001798-00	Johnson, Heinz v. Aetna, Inc.	2/10/15	Benefit Coverage Determination	Contract 12211.43	None	Closed - Complaint Withdrawn	5/29/15
U.S. District Court for the Central District of California, Central Division, No. 2:15-cv-00960	Tykeson, Eric v. Aetna Life Insurance Company, a Connecticut corporation; and Does 1 - 10 inclusive	2/10/15	Benefit Coverage Determination	Compensatory 113000.00	None	Closed - Trial - Against Aetna	6/27/16
22nd Judicial District Court for the Parish of St. Tammany, LA, No. 2015-10560	Easley, Deborah v. Coventry Health Care of Louisiana, Inc.	2/13/15	Benefit Coverage Determination	Unspecified	None	Open	
U.S. District Court for the Eastern District of Virginia, No. 3:15cv763	Stillion, Teresa H. and Ellen Ott Matter v. Hospital Corporation of America; Aetna, Inc., et al.	2/15/15	Benefit Coverage Determination	Contract 16981.00	None	Closed - Settled	8/17/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Illinois, Eastern Division, No. 1:15-cv-01522	Griffin, John v. Sherwin-Williams Co; Sherwin-Williams Co, as Plan Administrator of Sherwin-Williams Retiree Medical Plan; Aetna Life Insurance Company, a Connecticut corporation, as agent for Plan Administrator Sherwin-Williams Co.	2/19/15	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/16/16
County Court, Miami - Dade County, FL, No. 15-000763-CC-26	Newcomer, Colleen B. v. Aetna Life Insurance Company	2/24/15	Benefit Coverage Determination	Contract 15000.00	None	Closed - Settled	11/11/15
Superior Court of California, County of Orange, Small Claims, No. 30-2015-00773454-SC-SC-HNB	Tong, Tian v. Newport Harbor Radiology Associates Medical Group, Inc; CMRE Financial Services, Inc; Aetna Health and Life Insurance Company	2/25/15	Benefit Coverage Determination	Compensatory 662.45	None	Closed - Settled	3/31/15
21st Judicial Circuit Court, St. Louis County, MO, No. 15SLSC00181	Palatnik, Noach v. Coventry Health & Life Insurance	2/26/15	Benefit Coverage Determination	Compensatory 1200.00 Contract 175.00 Punitive 500.00	None	Closed - Settled	6/25/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Magisterial District Court 38-1-24, Schwenksville, PA, No. MJ-38124-CV-0000093-2015	Fitzsimmons, Gregory and Kerri Fitzsimmons v. Aetna, Inc.; Timoth Kelly	3/4/15	Benefit Coverage Determination	Contract 12000.00	None	Closed - Failure of Plaintiff to Prosecute	1/9/18
Superior Court of California, County of Ventura, Small Claims Court, No. 56-2015-00464800-SC-SC-SIM	Buraye, Fredy E. v. Aetna Health and Life Insurance Company	3/9/15	Benefit Coverage Determination	Compensatory 7096.00	None	Closed - Settled	4/30/15
District Court of Pottawattamie County, IA, No. 04781 LACV112772	Cavallaro, III, Joseph A. v. Coventry Health Care of Iowa, Inc.	3/10/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/11/15
64-A Judicial District Court, Ionia County, MI, No. 15-0386-SC	Henry, Katherine and Michael Henry; Marie Henry-Ebe v. Cofinity, Inc.; SecureOne Benefit Administrators, Inc.; Advantage Benefits Group; Custom Profile / Cup Acquisition, LLC	3/13/15	Benefit Coverage Determination	Contract 1019.75	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/2/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of Arizona, County of Maricopa, No. CV2015-051339	Rodriguez, Alexandra; Martin Rodriguez, a minor by and through Alexandra Rodriguez, his mother v. Aetna Health Inc.; John and Jane Does 1 - 10; Black Corporations 1-XX	3/13/15	Benefit Coverage Determination	Compensatory 46757.50	None	Closed - Settled	7/10/15
7th Judicial Circuit Court, Genesee County, MI, No. 14-101948-NF	Pitts, Patrice v. Auto Owners Insurance Co; Home Owners Insurance Co; Aetna, Inc.	3/17/15	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	1/22/16
Superior Court of New Jersey, Law Division, Monmouth County, No. MON-L-1921-14	Jersey Shore University Medical Center v. Carrie L. Jackson, Executor of the Estate of Robert Jackson v. United Healthcare a/k/a United Healthcare Services, Inc.; and Aetna a/k/a Aetna Life Insurance Company	3/19/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/25/15
Court of Common Pleas, County of Lexington, SC, No. 2015CP3201055	Spence, Zachariah v. Aetna Health Insurance	3/23/15	Benefit Coverage Determination	Contract 23000.00 Punitive 51500.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/3/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Eastern District of Louisiana, No. 2:14-cv-02987-KDE-JCW	Gremillion, Pamela and Garrett Gremillion v. Lockheed Martin Corporation Group Benefits Plan; Lockheed Martin Corporation; Aetna Life Insurance Company; Forrest General Health Services Inc. d/b/a Forrest General Hospital; and Pine Grove Behavioral Health and Addictive Services	3/25/15	Benefit Coverage Determination	Compensatory 24500.00	None	Closed - Settled	10/6/15
First Judicial District Court for Lewis and Clark County, MT, No. DDV-2015-193	Boster, Anne K. v. Aetna Life Insurance Company	3/27/15	Benefit Coverage Determination	Contract 268025.67	None	Closed - Settled	9/8/16
District Court for Maryland, Howard County, No. CV-1001-0000020-2015	Vittetoe, Robin G. v Aetna Life Insurance Company	4/6/15	Benefit Coverage Determination	Contract 2566.93 Fees 28.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	5/20/15
Court of Common Pleas, Warren County, Lebanon, OH, No. 15CV87082	Meadows, Bruce C., representative for Medicare Advantage Plan members of/or Domiciled in Ohio v. Aetna Insurance Company; Ohio State Retiree Systems; Ohio Department of Insurance; Ohio Senior Health Insurance Information Program; and all relevant persons and entities thereof	4/10/15	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	11/11/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
3rd Judicial Circuit Court, County of Wayne, MI, No. 15-004908-CZ	Carter, Alvin Bennie v. W. W. Grainer, Inc; United Healthcare Services, Inc.; and Aetna Life Insurance Company	4/13/15	Benefit Coverage Determination	Contract 51094.45	None	Closed - Settled	10/8/15
Superior Court of California, County of San Francisco, Small Claims, No. CSM-15-849539	Nazif, Fae v. St Francis Memorial Hospital; Aetna Health and Life Insurance Company	4/15/15	Benefit Coverage Determination	Compensatory 1936.00	None	Closed - Trial - Aetna Favor	10/29/15
Superior Court of New Jersey, Middlesex County, No. MID-L-1152-15	Robert Wood Johnson University Hospital v. Bianca Cortes v. Aetna, Inc.	4/24/15	Benefit Coverage Determination	Contract 30393.96	None	Closed - Settled	8/17/15
11th Judicial Circuit Court, St. Charles County, MO, No. 1411-AC07520	Lenox, Jayson and Kelly Lenox v. Group Health Plan; Coventry Healthcare, Inc.; and MHNet Behavioral Health	4/29/15	Benefit Coverage Determination	Compensatory 13599.00	None	Closed - Settled	10/13/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Charles County District Court, MD, No. 040200000022015	Krahling, Kathleen v. Aetna Life Insurance Company	5/7/15	Benefit Coverage Determination	Costs 9181.37	None	Closed - Failure of Plaintiff to Prosecute	7/2/15
District Court of Maryland, Montgomery County, No. 060100076192015	Smith, Marc J. v. Coventry Healthcare of Delaware, Inc.	5/11/15	Benefit Coverage Determination	Contract 1817.18 Fees 2500.00	None	Closed - Settled	7/16/15
District Court of Oklahoma County, OK, No. CJ-2015-2826	Cunningham, Ron, Individually, and as Personal Representative of the Estate of Orrana Cunningham v. Aetna Life Insurance Company; Oklahoma City Firefighters Health and Welfare Trust VEBA; Hudelson & Associates	5/18/15	Benefit Coverage Determination	Unspecified	None	Open	
District Court, Tulsa County, OK, No. CJ-2015-01951	Wolf, Cynthia A. v. Coventry Health & Life Insurance Company	5/21/15	Benefit Coverage Determination	Contract 75000.00	None	Closed - Settled	9/11/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
380th Judicial District Court, Collin County, TX, No. 380-02063-2015	Mosser, Nicholas D., on behalf of himself and alleges similarly situated v. Aetna Life Insurance Company; eHealth Insurance Services Inc.	5/27/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/29/19
Justice Court of Harris County, Precinct 5, Place 2, TX, No. CV52C0365356	Rokohl, Philip Andrew v. Aetna Health Inc.	5/27/15	Benefit Coverage Determination	Contract 3857.44	None	Closed - Settled	6/24/15
Lewiston District Court, ME	Tepler, Micaela v. Aetna Health, Inc.	5/27/15	Benefit Coverage Determination	Contract 6000.00	None	Closed - Settled	8/12/15
Superior Court, Judicial District of New Haven, CT, No. NNH-CV-14-6050192-S	Anthony Lombardozzi v. Aetna Health Inc. d/b/a U.S. Healthcare	6/1/15	Benefit Coverage Determination	Contract 15755.26	None	Closed - Settled	6/15/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Eastern District of New York, No. 15cv3169	Egan, Elyshia v. Aetna Life Insurance Company	6/1/15	Benefit Coverage Determination	Contract 28800.00	None	Closed - Settled	12/23/16
21st District Court, Bastrop County, TX, No. 086-21	Morris, Gary K. v. Aetna Health and Life Insurance Company	6/4/15	Benefit Coverage Determination	Compensatory 50000.00 Contract 3072.48 Fees 5200.00 Unspecified 750000.00	None	Closed - Settled	4/5/16
American Arbitration Association, San Diego, CA, No. 01-15-0003-4268	Smith, Hunter Michael v. Aetna Health of California, Inc.	6/4/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/4/15
U.S. District Court for the Central District of Utah, No. 1:15-cv-00073-PMW	Raymond C. v. Aetna Life Insurance Company; Lockheed Martin Corporation; and The LM Healthworks Plan	6/5/15	Benefit Coverage Determination	Compensatory 137265.25	None	Closed - Settled	12/20/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Eastern District of Pennsylvania, No. 5:15-cv-03276-EGS	R.S. c/o Gregory B. Heller v. Aetna Life Insurance Company	6/10/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/14/16
Dreamy Draw Judicial District Court, Marciopa County, AZ, No. CC2015-103321 SC	Wulfert, Amy v. Aetna Inc.	6/10/15	Benefit Coverage Determination	Contract 2448.99	None	Closed - Settled	10/13/15
U.S. District Court for the Northern District of California, No. 4:15-cv-02632-DMR	Stewart, Maria and Neil Stewart, on behalf of themselves and all others similarly situated v. Applied Materials, Inc.; Aetna Life Insurance Company; and Aetna Health of California, Inc.	6/12/15	Class Action	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/9/15
Court of Common Pleas, Montgomery County, PA, No. 2015-13441-0	Millinghausen, Svitlana T. v. Aetna Life Insurance Company	6/15/15	Benefit Coverage Determination	Contract 11745.48	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/17/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Magistrate Court of Greenville County, SC, No. 2015CV2310300822	Ellsworth, Bryce and Lynne Ellsworth v. Coventry Health Care of the Carolinas Inc.	6/23/15	Benefit Coverage Determination	Contract 7500.00 Costs 273.25	None	Closed - Settled	6/28/16
General District Court, Chesterfield County, VA, No. V15-11057	White, George M. v. Coventry Healthcare of Virginia	6/23/15	Benefit Coverage Determination	Contract 2837.00 Costs 56.00	None	Closed - Settled	8/5/15
22nd Judicial District Court, Parish of St. Tammany, LA, No. 2015-12662 J	Lapara, Gail Weixel, in her capacity as Independent Executrix of the Succession of Donald E. Lapara, Jr. v. Coventry Health Care of Louisiana, Inc. and Acadian Ambulance Service, Inc.	6/26/15	Benefit Coverage Determination	Contract 7979.96	None	Open	
Circuit Court for Baltimore City, MD, No. 24-C-15-003360 OG	Weiss, Paul M. v. Coventry Healthcare of Delaware, Inc.; and Coventry Health and Life Insurance Company	6/26/15	Benefit Coverage Determination	Compensatory 10000.00 Punitive 100000.00	None	Closed - Settled	3/24/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
New York County Civil Court, NY, No. 1604.SCNY 2015 1	Drabek, Warren v. Aetna Health Insurance	7/1/15	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	3/24/16
U.S. District Court for the Northern District of Alabama, No. 2:15-cv-01138-TMP	Daily, John Keith, individually and on behalf of the class of persons described herein v. The Rawlings Company, LLC and Aetna Life Insurance Company	7/7/15	Class Action	Unspecified	None	Closed - Settled	4/5/16
U.S. District Court for the District of Nebraska, No. 4:15-cv-03070-JMG-CRZ	Lacy, Howard; Mandy Lacy; and Howard and Mandy Lacy, on Behalf of Minor Children, Tori Lacy, Paige Lacy, Hunter Lacy and Cody Lacy v. PayFlex Systems USA, Inc. and Valmont Industries, Inc.	7/7/15	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/15/15
Court of Common Pleas, Columbus, OH, No. 15cv-07-5589	Orders, Frank v. State Teachers Retirement System of Ohio	7/7/15	Benefit Coverage Determination	Unspecified	None	Closed - Complaint Withdrawn	8/30/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
General District Court, Prince William County, VA, No. GV 15009468-00	Ochoa, Maria v. Aetna Life Insurance Company	7/8/15	Benefit Coverage Determination	Contract 3181.00 Costs 56.00 Fees 2500.00	None	Closed - Settled	4/20/16
442nd Judicial District Court, Denton County, TX, No. 15-05850-442	Murdock, John, individually and as Attorney-in-Fact of Nancy Murdock v. Aetna; Aetna Life Insurance Company; and Aetna Health Management, LLC	7/13/15	Benefit Coverage Determination	Unspecified	None	Closed - Complaint Withdrawn	11/11/15
U.S. Equal Employment Opportunity Commission, Las Vegas, NV, No. 487-2015-01271	Dondero, Terese and dependent child, Jace Williams v. Aetna; Allstate; Allstate Cafeteria Plan	7/17/15	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	11/28/16
Court of Common Pleas, Franklin County, OH, No. 15CV001707	OhioHealth Corp. v. Cody L. Brant v. Aetna Insurance Company	7/17/15	Benefit Coverage Determination	Contract 13894.65	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/17/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of California, San Francisco/Oakland Division, No. 3:15-cv-03334-WHO	Sanzone-Ortiz, Anna M., individually and on behalf of others similarly situated v. Aetna Health of California, Inc.; and Aetna, Inc.	7/20/15	Class Action	Unspecified	None	Closed - Settled	12/19/16
U.S. District Court for the District of Utah, Northern Division, No. 1:15-cv-00092-DN	Dori S. and Griffin K. v. Aetna Life Insurance Company; and Chipotle Mexican Grill Inc. Benefit Plan	7/22/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/28/16
Supreme Court of the State of New York, County of New York, No. 157614/2015	Ferber, Natalie v. Aetna Life Insurance Company; and Aetna Corp.	7/23/15	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/22/17
Montgomery County Magisterial District Court 38-1-21, Blue Bell, PA, No. MJ-38121-CV-0000229-2015	Himsworth, Mark F. v. Aetna	7/24/15	Benefit Coverage Determination	Contract 4357.50 Costs 162.50	None	Closed - Pretrial - Aetna Dismissed Voluntarily	7/11/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Western District of Pennsylvania, No. 2:15-cv-00986-LPL	Allen, Michelle v. Coventry Health and Life Insurance Company t/d/b/a HealthAmerica Pennsylvania, Inc.	7/29/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/11/15
Connecticut Superior Court, Small Claims Division	Del Sole, Melanie S. v. Aetna, Inc.; and Aetna Provider Services	7/30/15	Benefit Coverage Determination	Contract 2080.00	None	Closed - Settled	9/11/15
U.S. District Court for the Southern District of California, No. 3:15-cv-01713-H-MDD	Brown, Glenda and Charles David Brown v. Hitachi Consulting Health Plan; and Aetna Life Insurance Company	8/3/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/20/16
1st Judicial District Court, Newtown County, TX, No. CV-2015-13902	Bean, Bobby Allen v. Aetna Life Insurance Company Inc. d/b/a Aetna or d/b/a TRSAetna	8/6/15	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/21/15

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Central District of California, No. 2:15-cv-05974	Cockcroft, Barnaby v. Aetna Life Insurance Company; and Does 1-10, inclusive	8/6/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/1/16
189th Judicial District Court, Harris County, TX, No. 2015-46117	Heffner, Ramona v. Atria Management Company, LLC; Aetna Health and Life Insurance Company; Aetna Health Management, LLC; Aetna Health Inc.; and Aetna Better Health of Texas Inc.	8/6/15	Benefit Coverage Determination	Contract 1259.00 Punitive 250000.00	None	Closed - Settled	4/21/16
Circuit Court, Broward County, FL, No. 15004543	Alvarez, Vidalina Ramos v. Coventry Health Care of Florida, Inc.	8/7/15	Benefit Coverage Determination	Contract 815.00	None	Closed - Settled	11/4/15
Superior Court of New Jersey, Union County, No. DC-008059-15	Horowitz, Mark Bruce v. Charles A. Loguda, M.D. and Aetna Customer Resolution Team	8/10/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/3/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court, Brown County, WI, No. 15SC-4405	Simurdiak, Bruce Carl v. Aetna Inc.	8/10/15	Benefit Coverage Determination	Compensatory 15000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/8/15
Philadelphia Municipal Court, First Judicial District of Pennsylvania, No. SC-15-08-14-4517	Livshits, Ilya and Solomon Livshits v. Aetna	8/14/15	Benefit Coverage Determination	Contract 5682.34	None	Closed - Settled	12/2/15
Circuit Court, Small Claims, Cook County, IL, No. 20151118524	Huberman, R. Carole and Sheldon Bierman v. Aetna Life Insurance Company	8/15/15	Benefit Coverage Determination	Contract 1677.24	None	Closed - Pretrial - Aetna Dismissed by Court Order	12/17/15
U.S. District Court for the Southern District of New York, No. 7:15-cv-06462	Pinkham, Karen v. Aetna Life Insurance Company; and Toys 'R' Us, Inc.	8/17/15	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	11/8/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
1st District Court of the County of Suffolk, Hauppauge, NY, No. SMC-12-53333	Clinical Practice Plan; CPP North Shore University v. Jennifer Urban v. Aetna Health Inc.	8/18/15	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/22/16
189th Judicial District Court, Harris County, TX, No. 2015-48537	Arnett, Robin v. Aetna Life Insurance Company; and Lowe's Companies, Inc.	8/19/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/15/16
Superior Court of the District of Columbia, Civil Division, Small Claim and Conciliation Branch, No. 2015SC2003596	Shah, Mit v. Aetna Health Inc.	8/25/15	Benefit Coverage Determination	Contract 1269.00	None	Closed - Settled	11/11/15
Trial Court of Massachusetts, Lawrence Division, Small Claims, No. 1518SC001890	Brennan, Peter v. Aetna Life Insurance Company	8/28/15	Benefit Coverage Determination	Contract 2275.00 Costs 100.00	None	Closed - Settled	1/29/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of California for the County of El Dorado, Small Claims, No. SC 2015 0275	Brost, Andrew C. v. Aetna Life Insurance Company	8/28/15	Benefit Coverage Determination	Compensatory 4000.00	None	Closed - Settled	1/8/16
Hillsborough County Circuit Court, FL, No. 15-CC-022268	Mason, II, Roger D. v. Coventry Health Plan of Florida Inc.	8/31/15	Benefit Coverage Determination	Contract 2938.35 Fees 1750.00	None	Open	
District Court of Maryland for Baltimore County, No. 080400231652015	Goetz, Donald v. Aetna Insurance	9/2/15	Benefit Coverage Determination	Contract 29990.00	None	Closed - Complaint Withdrawn	1/22/16
U.S. District Court for the District of Connecticut, No. 3:15-cv-01319-JCH	Meidl, Christopher, on his own behalf and on behalf of all others similarly situated v. Aetna Inc.; Aetna Life Insurance Company; and MCMC, LLC	9/3/15	Class Action	Unspecified	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Florida, No. 9:15-cv-81278-KAM	Ferguson, Jr., Thomas C. v. Aetna Life Insurance Company	9/14/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/16/16
County Court at Law No. 5, Dallas County, TX, No. CC-15-04707-E	Fraga, Brenda Yohana v. Aetna Life Insurance Company	9/16/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/2/15
Civil Court for the City of New York, County of Queens, Small Claims Part 45, No. 16169 SCQ 2015 1	Tsao, Susana Y. d/b/a Yufang Tsao v. Aetna	9/17/15	Benefit Coverage Determination	Contract 272.00	None	Closed - Settled	1/22/16
Superior Court of New Jersey, Law Division, Special Civil Part, Ocean County, No. DC-007401-15	Atlantic Neurosurgical Specialists v. Brenda and Jeffrey Williamson v. Aetna Insurance Company	9/21/15	Benefit Coverage Determination	Contract 15094.00	None	Closed - Settled	5/3/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of the City of New York, New York County, NY, No. 16488.SCNY 2015 1	Toptani, Edward v. Aetna Health Inc.	9/21/15	Benefit Coverage Determination	Compensatory 5000.00	None	Closed - Failure of Plaintiff to Prosecute	1/22/16
Superior Court of California for the County of Orange, No. 30-2015-00811734-CU-IC-CJC	Washington, Gillen v. Aetna Inc; Aetna Life Insurance Company; and Does 1-100, inclusive	9/25/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/3/19
U.S. District Court for the District of Utah, Central Division, No. 2:15-cv-00705-BCW	Jean, Daniel v. Aetna Health of Utah, Inc.	9/30/15	Benefit Coverage Determination	Compensatory 20534.97	None	Closed - Settled	5/4/16
Superior Court of New Jersey, Ocean County, No. OCN-DC-4322-15	Ocean County Medical Center v. Charles Savage v. Aetna Insurance Company	10/5/15	Benefit Coverage Determination	Contract 2613.00	None	Closed - Settled	3/24/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of the City of New York, County of Queens, Small Claims Part 47, No. 20096 SCQ 2015 2	Rocchio, Dennis M. v. Aetna Denta; Aetna Health Inc.	10/5/15	Benefit Coverage Determination	Unspecified	None	Closed - Trial - Aetna Favor	2/24/17
Civil Court of the City of New York, County of New York, Small Claims Part 45, No. 2580 SCNY 2015 1	Ross, Marshall v. Aetna	10/9/15	Benefit Coverage Determination	Contract 1245.62	None	Closed - Settled	1/22/16
General District Court of Justice, Cabarrus County, NC, No. 13 CVD 831	CMC-Mercy v. Neliah Kasu v. Aetna Health of the Carolinas, Inc; Aetna Life Insurance Company	10/19/15	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	8/23/16
Civil Court of the City of New York, County of New York, Small Claims Part 45, No. 2707 SCNY 2015 1	Issaacson, Allen I. v. Aetna Life Insurance Company	10/19/15	Benefit Coverage Determination	Contract 580.00	None	Closed - Settled	1/22/16

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Texas, Houston Division, No. 4:15-cv-03091	Wheelock, Cindy and Jeffrey Wheelock v. Aetna Life Insurance Company	10/20/15	Benefit Coverage Determination	Contract 75000.00	None	Closed - Settled	3/30/16
General District Court, Newport News County, VA, No. GV15019764-00	Hill, Gary v. Aetna Health Insurance Company	10/23/15	Benefit Coverage Determination	Contract 3100.00 Costs 72.32	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/15/16
Superior Court of California, San Mateo County, No. SCS-132659	White, Jay C. v. Aetna Life Insurance Company	10/28/15	Benefit Coverage Determination	Compensatory 4996.80	None	Closed - Settled	2/9/16
Superior Court, Third Judicial District, Anchorage, AK, No. 3AN-15-10516CI	Bosek, Rebecca L. and Matthew H. Viergutz v. Aetna Life Insurance Company	10/29/15	Benefit Coverage Determination	Compensatory 1663.07 Punitive 100000.00	None	Closed - Settled	3/22/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Department of Labor and Workforce Development, Division of Workers' Compensation, NJ, No. 2013-20488	Fabbioli, Cynthia v. L-3 Communications; and Aetna Life Insurance Company	11/3/15	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/15/16
48th Judicial District Court, Oakland County, MI, No. 15-32451-GC	William Beaumont Hospital v. Chrisitina M. Recchia v. Aetna Health Insurance Company	11/6/15	Benefit Coverage Determination	Compensatory 5413.00	None	Closed - Settled	2/9/16
U.S. District Court for the District of Utah, Central Division, No. 2:15-cv-00788-DBP	Porter, Jon B. v. Altius Health Plans, Inc.; and Westminster College	11/9/15	Benefit Coverage Determination	Compensatory 12694.04 Contract 118701.93 Fees 118701.93 Fees 367620.00	None	Closed - Settled	10/28/16
Magistrate Court, Spartanburg County, SC, No. 2015CV4210108903	Suddeth, Jr., Samuel J. v. Coventry Health Care of the Carolinas	11/9/15	Benefit Coverage Determination	Contract 5542.00	None	Closed - Settled	3/11/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
13th Judicial District Court, Yellowstone County, MT, No. DV 15-1470	Rabinowitz, M.D., Arthur J. v. Montana Health Cooperative; and Altius Health Plans Inc.	11/12/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/13/18
District Court, Howard County, MD, No. 100100045422015	Hoffman, Robert; Lori Hoffman; Bradley Hoffman v. Chesapeake Urology Associates, P.A.; and PayFlex Systems, USA, Inc.	11/13/15	Benefit Coverage Determination	Contract 681.69	None	Closed - Settled	3/24/16
U.S. District Court for the Southern District of Ohio, Eastern Division, No. 2:15-cv-2991	Orders, Frank v. State Teachers Retirement System of Ohio	11/13/15	Benefit Coverage Determination	Unspecified	None	Closed - Complaint Withdrawn	8/30/16
U.S. District Court for the Central District of California, No. 2:15-cv-08842-DSF-AS	Turner, Stacey v. BP Corporation North America Inc. Consolidated Welfare Benefit Plan	11/13/15	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	6/9/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, San Francisco County, CA, No. CSM-15-851024	Wilen, Jacob v. Aetna Health and Life Insurance Company	11/13/15	Benefit Coverage Determination	Punitive 8919.45	None	Closed - Settled	1/20/16
U.S. District Court for the Northern District of Texas, Dallas Division, No. 3:15-cv-03679-D	Baker, Charlize Marie v. Aetna Life Insurance Company; L-3 Communications Corp.	11/16/15	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	3/6/18
County Court at Law No. 2, Tarrant County, TX, No. 2015-006638-2	Loughry, Lori v. Aetna Life Insurance Company	11/17/15	Benefit Coverage Determination	Compensatory 32999.90	None	Closed - Settled	11/30/16
Superior Court, Passaic County, NJ, No. L-001365-15	Vantage Health System v. Grace Seecoomar a/k/a Grace Munoz v. Aetna Health Insurance	11/18/15	Benefit Coverage Determination	Compensatory 26485.70	None	Closed - Settled	12/19/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Small Claims Court, Precinct 4, Collin County, TX, No. 04-SC-15-00186	Bellovich, Bruce v. Aetna Life Insurance Company	11/24/15	Benefit Coverage Determination	Contract 3900.00 Costs 121.00	None	Closed - Settled	5/3/16
City of Richmond General District Court, Commonwealth of Virginia, No. 15042189	Rush, Emily v. Aetna Health, Inc.	11/24/15	Benefit Coverage Determination	Contract 6007.00 Costs 46.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	2/16/16
Superior Court of the District of Columbia, DC, No. 2015SC305212	Huberman, R. Carole and Sheldon Bierman v. Aetna Life Insurance Company	12/9/15	Benefit Coverage Determination	Contract 2936.73	None	Closed - Settled	1/22/16
Court of Common Pleas, Hamilton County, OH, No. A1506758	Taylor, Marcia A. v. Yazmin E. Carrillo; Mary Carrillo; MJC Cleaning Service; Safeco Insurance Company of Illinois; and Costco Wholesale Corporation	12/11/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/20/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Law Division, Union County	Ruggieri, Mara C. and Juan Ruggieri v. Progressive Insurance Company; Aetna Insurance Company, et al.	12/14/15	Benefit Coverage Determination	Contract 17559.41	None	Closed - Failure of Plaintiff to Prosecute	6/28/16
U.S. District Court for the District of Utah, No. 2:15-cv-00886-BCW	Poirier, Jean-Paul v. Aetna Health of Utah Inc. and Edwards LifeSciences (U.S.) Inc.	12/16/15	Benefit Coverage Determination	Compensatory 15561.37 Fees 112420.00	None	Closed - Settled	5/12/16
53rd Judicial District Court, Travis County, TX, No. D-1-GN-15-005760	Lawrence, Sheri A. Kunkel v. Aetna Life Insurance Company	12/17/15	Benefit Coverage Determination	Unspecified	None	Closed - Trial - Aetna Favor	4/25/18
General District Court, Fairfax County, VA, No. GV15029200-00	Abdalla, Muhayed Khalafalla Mohammed v. Innovation Health Insurance Company	12/22/15	Benefit Coverage Determination	Contract 19281.05	None	Closed - Complaint Withdrawn	3/4/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Florida, No. 0:15-cv-62685-CMA	Doe, John, on behalf of himself and all others similarly situated v. Coventry Health Care, Inc.; Coventry Health and Life Insurance Company; Coventry Health Plan of Florida, Inc.; Coventry Health Care of Florida, Inc.; Aetna, Inc.; Aetna Life Insurance Co.; and Does 3-10, inclusive	12/22/15	Class Action	Unspecified	None	Closed - Settled	8/7/17
U.S. District Court for the District of Montana, Great Falls Division, No. 4:15-cv-00110-GF-BMM	Hamilton, Stephen v. MHNet	12/23/15	Benefit Coverage Determination	Contract 21177.00 Punitive 100000.00	None	Closed - Settled	8/22/18
District Court, Polk County, IA, No. SC-SC-578181	Koegel, Paula L. v. Aetna Health, Inc. d/b/a Coventry Health Care	12/31/15	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/6/16
Circuit Court, Multnomah County, OR, No. 15SC48880	Soich, Miroslav v. Aetna	12/31/15	Benefit Coverage Determination	Compensatory 2282.35	None	Closed - Trial - Aetna Favor	5/30/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:16-cv-00009-CW	John G. and Nicholas G. v. Aetna Life Insurance Company; and Bank of America Group Benefits Program	1/4/16	Benefit Coverage Determination	Compensatory 59000.00	None	Closed - Settled	8/22/17
U.S. District Court for the Southern District of New York, No. 1:16-cv-00144	Fisher, Jacqueline v. Aetna Life Insurance Company	1/8/16	Class Action	Unspecified	None	Open	
U.S. District Court of the Virgin Islands, Division of St. Croix, No. 1:16-cv-00003-WAL-GWC	Minns, Michael v. Indemnity Insurance Company of North America; and Good Health Worldwide Limited	1/12/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/20/17
Circuit Court of Laclede County, MO, No. 16LA-CC00008	Boyd, Lisa D. and Steven Boyd v. Coventry Health and Life Insurance Company	1/21/16	Benefit Coverage Determination	Contract 27350.15	None	Closed - Settled	6/28/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court, Santa Rosa County, FL, No. _____	Luntsford, Rebecca v. Coventry Health Care of Florida, Inc.	1/22/16	Benefit Coverage Determination	Contract 20270.72	None	Closed - Failure of Plaintiff to Prosecute	3/11/16
334th Judicial District Court, Harris County, TX, No. 2016-04804	Brown, Laura v. Aetna Life Insurance Company	1/26/16	Benefit Coverage Determination	Contract 128217.17	None	Closed - Settled	2/28/17
District Court, Linn County, IA, No. 06571 SCSC218421	Ciha, Steven Lee v. Aetna Life Insurance Company	1/27/16	Benefit Coverage Determination	Contract 1000.00	None	Closed - Settled	4/5/16
Court of Common Pleas, Seneca County, OH, No. 16CV0027	Hackworth, Tamela L. v. Melanie Mowry; Prudential Insurance, et al.	1/27/16	Benefit Coverage Determination	Compensatory 1240000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	8/5/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
General District Court, Henrico County, VA, No. GV16-2664	Bean, Dawn Marie v. Aetna Health and Life Insurance Company; Aetna Health, Inc.; Aetna Health Insurance Company; Aetna Health Insurance Company of Connecticut; Aetna Health Plans; Aetna Life Insurance Company; Aetna Insurance Company; Aetna, Inc.; and Aetna	2/3/16	Benefit Coverage Determination	Contract 25000.00	None	Closed - Complaint Withdrawn	3/28/16
3rd Judicial District Court, County of Salt Lake, UT, No. 160900824	J.A., guardian of M.B., a minor v. Altius Health Plans, Inc.	2/3/16	Benefit Coverage Determination	Compensatory 16885.54	None	Closed - Settled	8/25/16
U.S. District Court for the Central District of Utah, No. 2:16-cv-00098-PMW	Philip P.; Sharon P.; and Kaitlin P. v. Aetna Life Insurance Company; Aetna Behavioral Health; and General Electric Medical Benefits Plan	2/4/16	Benefit Coverage Determination	Compensatory 230000.00	None	Closed - Settled	3/26/18
Civil Court of the City of New York, County of New York, Small Claims Part 45, No. 248 SCNY 2016 1	Madell, Rebecca R. v. Aetna Life Insurance Company	2/5/16	Benefit Coverage Determination	Contract 710.00	None	Closed - Settled	6/15/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Illinois, Eastern Division, No. 1:16-cv-02055	Tolleson, Wanda, as executor for the estate of Richard Tolleson; and Aviation West Charters, LLC d/b/a Angel MedFlight v. Kraft Foods Global, Inc. Retiree Health and Life Benefits Plan; and Kraft Heinz Food Company	2/9/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/10/17
Superior Court of California for the County of Los Angeles, No. BC609936	Hassankhel, Nazrullah; Saifora Hassankhel; Ibrahim Hassankhel v. Aetna Health of California, Inc; Aetna Life Insurance Company; Aetna Health Management, LLC; Does 1 -100 inclusive	2/10/16	Benefit Coverage Determination	Contract 128217.17	None	Closed - Settled	9/22/17
U.S. District Court for the District of Arizona, No. 2:16-cv-00308-JZB	B.P., a minor by and through her parents and Guardians, Craig P. and Patricia P., husband and wife v. Aetna Life Insurance Company; Aetna Behavioral Health, LLC; Aetna Health, Inc.	2/11/16	Benefit Coverage Determination	Compensatory 112344.99	None	Closed - Settled	12/21/16
Euclid Municipal Court, OH, No. 16CVI00506	Moster, Daniel P. v. Mark T. Bertolini; Aetna Inc.	2/17/16	Benefit Coverage Determination	Contract 3000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/30/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas, Lucas County, OH, No. CI16-1317	Bay Park Community Hospital v. Julie Steingraber v. John Credico, MD; Aetna Life Insurance Company	2/18/16	Benefit Coverage Determination	Contract 16770.50	None	Closed - Complaint Withdrawn	7/21/16
U.S. District Court for the District of Maryland, No. JKB-16-442	Davis, Caryn; and Steven Davis v. Aetna Insurance Company of Connecticut	2/18/16	Benefit Coverage Determination	Contract 117345.00	None	Closed - Settled	12/28/16
Superior Court of New Jersey, Law Division, Passaic County, No. PAS-L-2996-15	Elite Surgical Center, LLC v. Ryan F. Gesell v. American Health Holdings Inc. a Division or Affiliate of Aetna Better Health, Inc.; and Anthem Company; and Empire Healthcare Assurance Inc. d/b/a Blue Cross/Blue Shield	2/22/16	Benefit Coverage Determination	Contract 19264.48	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/19/16
U.S. District Court for the Central District of Utah, No. 1:16-cv-00022-DN	Gordon D. (Dale) v. Aetna Life Insurance Company; The UBS Financial Services Inc. Medical, Dental and Life Insurance Plan	2/22/16	Benefit Coverage Determination	Compensatory 250000.00	None	Closed - Settled	7/17/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Chesterfield County General District Court, VA, No. GV16000680	Ortho Virginia, Inc. v. Roy R. Harrison, Jr. v. Aetna Life Insurance Company	2/26/16	Benefit Coverage Determination	Contract 17850.71 Costs 56.00	None	Closed - Settled	9/29/16
Superior Court of New Jersey, Union County, Law Division, Special Civil Part, No. DC-001058-16	Practice Associates Medical Group PA v. Marcell Smith a/k/a Marcel Hillary v. Aetna Life Insurance Company	3/7/16	Benefit Coverage Determination	Contract 2563.50 Costs 57.00 Fees 66.27	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/22/16
District Court, Frederick County, MD, No. 110100006312016	Shaffer, Aysha M. v. Aetna Inc.; and Mark T. Bertolini	3/7/16	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	6/15/16
U.S. District Court for the Northern District of Texas, No. 3:15-cv-02675-B	Thawar, Gulnar v. 7-Eleven, Inc; PayFlex Systems USA Inc.	3/9/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/20/16

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Florida, Miami Division, No. 1:16-cv-20874-UU	Howard, Ashlee v. Aetna Life Insurance Company; Graham Holdings Company Flexible Benefits Program	3/10/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/21/16
District Court, Oklahoma County, OK, No. CJ-2016-1344	Holman, Travis B. and Melissa B. Beyers-Holman v. Coventry Health & Life Insurance Company d/b/a ConventryOne; and Green Insurance Associates, Inc.	3/11/16	Benefit Coverage Determination	Contract 85000.00 Punitive 75000.00	None	Closed - Settled	12/18/18
Supreme Court of the State of New York; County of Suffolk, NY, No. 603956/2016	Liberty Mutual Insurance Company v. Danielle L. Hanna, et al. v. Aetna, Inc. d/b/a Aetna a/k/a Aetna Health Management Systems LLC individually and as administrator for United Parcel Service of American, Inc.	3/14/16	Benefit Coverage Determination	Unspecified	None	Open	
46th District Court, MI, No. 16-1054-NF	Murray, Renee v. Allstate Insurance Company; Aetna Life Insurance Company	3/14/16	Benefit Coverage Determination	Compensatory 1987.62	None	Closed - Pretrial - Aetna Dismissed Voluntarily	5/12/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas, Lake County, OH, No. 15CV001490	Rhodes, James, et al. v. Jason M. Peck; Aetna Inc., et al., CCP Lake Count, O, No. 15CV001490 - CT Corp - JoAnne Cash JCash@TroverSolutions.com	3/14/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Judgment in Favor of Aetna	5/19/16
U.S. District Court for the District of Utah, Central Division, No. 2:16-cv-00211-PMW	M.K., mother of R.K. v. Aetna Health of Utah; and Adobe Systems Incorporated	3/16/16	Benefit Coverage Determination	Compensatory 11542.21	None	Closed - Pretrial - Aetna Dismissed Voluntarily	5/5/16
District Court, Linn County, IA, No. LACV084739	Bush, Glenda v. Coventry Health Care of Iowa, Inc. a/k/a Aetna Health of Iowa, Inc.	3/21/16	Benefit Coverage Determination	Compensatory 24000.00	None	Closed - Settled	11/23/16
U.S. District Court for the Northern District of California, No. 4:16-cv-01398-DMR	Alison B. and Daniel B. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Contract 200810.00	None	Closed - Settled	3/12/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
United States District Court, Northern District of California, Case no. 4:16-cv-01406-KAW	Cheryl N. and Tristan W. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/12/18
United States District Court, Northern District of California, Case no. 3:16-cv-01403-LB	Dagmar W. and Samantha W. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Compensatory 41064.00	None	Closed - Settled	3/12/18
U.S. District Court for the Northern District of California, No. 3:16-cv-01395-LB	Kim B. and Aviva B. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Contract 130000.00	None	Closed - Settled	3/12/18
U.S. District Court for the Northern District of California, No. 4:16-cv-01405-DMR	Lloyd B. and Talya B. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Compensatory 51700.00	None	Closed - Settled	3/12/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of California, No. 3:16-cv-01399-LB	Mark L. and Elaine L. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Contract 202592.00	None	Closed - Settled	3/12/18
U.S. District Court for the Northern District of California, No. 4:16-cv-01400-DMR	Perry P. and Evan P. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Contract 153510.00	None	Closed - Settled	3/12/18
U.S. District Court for the Northern District of California, No. 5:16-cv-01401-HRL	R.M. and M.M. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Compensatory 34000.00	None	Closed - Settled	3/12/18
U.S. District Court for the Northern District of California, No. 4:16-cv-01404-DMR	Richard R. and Susanna R. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Contract 174350.00	None	Closed - Settled	3/12/18

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of California, No. 3:16-cv-01397-JCS	Rodney K. and Brian K. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Contract 174160.00	None	Closed - Settled	3/12/18
U.S. District Court for the Northern District of California, No. 4:16-cv-01402-DMR	William B. and Ryan B. v. Aetna Life Insurance Company	3/22/16	Benefit Coverage Determination	Contract 32480.00	None	Closed - Settled	3/12/18
Court of Common Pleas, Dauphin County, PA, No. 2016-CV-2428-CV	Turns, Kay A. v. Aetna Life Insurance Company	3/28/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/28/17
Superior Court of New Jersey, Law Division, Special Civil Part, Bergen County, No. DC-003691-16	Hackensack University Medical Center v. Tara Wolfe v. Aetna	3/30/16	Benefit Coverage Determination	Contract 6635.06	None	Closed - Pretrial - Aetna Dismissed by Court Order	8/8/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Yakima County, WA, No. 16-20086139	Villarreal, Alma and Benny v. Inland Empire Electrical Workers Health and Welfare Trust (IEEW); IEEW Board of Trustees; Aetna Insurance Company; Rehn and Associates; David Kimmet; Kristin Knox; and John Does 1-20	3/30/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/9/16
U.S. District Court for the Northern District of California, No. 3:16-cv-01707-JSC	Batson, Jennifer v. L-3 Communications Group Health Plan for Active Participants (501); Aetna Inc., et al.	4/5/16	Benefit Coverage Determination	Contract 15000.00	None	Closed - Settled	12/2/16
3rd Judicial District Court, Salt Lake County, UT, No. 160902215	Scholzen, Timothy v. Altius Health Plans	4/5/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/28/16
Circuit Court of Jackson County, MO, No. 1616-CV08754	Kaplan, Chad v. The University of Missouri; and Coventry Health Care of Missouri, Inc.	4/14/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/31/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Eastern District of Virginia, No. 3:16-cv-00219-JAG	Bean, Dawn v. Aetna Life Insurance Company; Capital One Financial Corp. Employee Welfare Benefits Plan; HCA Health Services of Virginia, Inc.	4/15/16	Benefit Coverage Determination	Contract 75793.31	None	Closed - Settled	5/31/16
16th Circuit Court, Macomb County, MI, No. 16-1311-NF	Rzadkowolski, Lauren v. Progressive Michigan Insurance Company; Aetna Life Insurance Company; and Aetna, Inc.	4/20/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/2/17
Superior Court, Fulton County, GA, No. 2016CV274145	Bound, Thomas A. v. Aetna Life Insurance Company	4/22/16	Benefit Coverage Determination	Contract 2151.27 Punitive 63025.40	None	Closed - Settled	10/11/16
U.S. District Court for the District of New Jersey, No. 3:16-cv-02313-MAS-TJB	Bonaforte, Cynthia v. Aetna Life Insurance Company d/b/a Aetna; and ICON Clinical Research, Inc.	4/25/16	Benefit Coverage Determination	Contract 89630.48	None	Closed - Settled	5/10/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Essex County, Law Division, Special Civil Part, No. DC-015588-15	Metamorphosis Plastic Surgery v. Sham Singh v. Aetna Insurance	4/25/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	7/20/18
U.S. District Court for the Eastern District of Pennsylvania, No. 5:13-cv-05957-JLS	ManorCare of Easton PA, LLC d/b/a ManorCare Health Services-Easton v. Joseph Eugene Nagy, the Estate of Joseph A. Nagy v. Manorcare of Easton PA LLC; Kennedy PC; Northampton County; Aetna, Inc.; Heartland Hospice; Dr. Edward Cumbo; Dr. Dilip Bera; Brakeley Park Center; New Eastwood Care and Rehab; Commonwealth of Pennsylvania; Dr. Keyurkumar Dalsaniya; Dr. Stephen Ksiazek;	4/29/16	Benefit Coverage Determination	Punitive 5000000.00	None	Closed - Failure of Plaintiff to Prosecute	11/29/18
U.S. District Court for the District of Utah, Central Division, No. 2:16-cv-00354-DN	Herrera, Patricia v. Aetna Insurance Company	5/2/16	Benefit Coverage Determination	Contract 238509.66	None	Closed - Settled	8/11/17
U.S. District Court for the District of South Carolina, Spartanburg Division, No. 7:16-cv-01470-HMH	Pennington, Richard v. Aetna Life Insurance Company	5/6/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/11/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court, Shelby County, MO, No. 17SB-CC00006	Zachariah, Matthew v. Coventry Healthcare of Missouri, Inc.	5/9/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/6/17
District Court, Concord Division, Small Claims, MA, No. 1647SC000201	Maruca-Milhaven, Lisa v. PayFlex Systems, USA, Inc.; New York Life Insurance Company FSA & HRA Employee Benefit Plans	5/16/16	Benefit Coverage Determination	Contract 800.00 Costs 50.00	None	Closed - Trial - Aetna Favor	8/25/16
1st District Court, Ronkonkoma Court, Suffolk County, NY, No. CV-8789-15/CE	L.I. Anesthesiologists, PLLC v. Louis Zanardi v. Aetna Life Insurance Company	5/17/16	Benefit Coverage Determination	Contract 3437.90	None	Closed - Settled	1/12/17
Circuit Court, Winnebago County, WI, No. 16CV00504BR6	Reinke, Timothy A. v. Aetna Life Insurance Company; M. Catherine Twomey, et al., Circuit Court, Winnebago County, WI, No. 16CV00504BR6 - CT Corp. - TRC	5/20/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	5/26/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Maricopa County Justice Court, AZ, No. CC2016-09-2081SC	Towers, Todd v. Aetna Health Inc.; and Sonora Quest Laboratories, LLC	5/20/16	Benefit Coverage Determination	Contract 1641.14	None	Closed - Settled	11/29/16
Civil Court, Small Claims, Part 47, New York County, NY, No. 1100 SCNY 2016 1	Toptani, Edward G. v. Aetna Health Inc.	5/23/16	Benefit Coverage Determination	Compensatory 5000.00	None	Closed - Settled	9/22/16
U.S. District Court for the District of Utah, Central Division, No. 2:16-cv-00439-DBP	Michael P.; Karilyn P.; and Kirstyn P. (Perry) v. Aetna Life Insurance Company; and Becton, Dickson and Company Group Life and Health Plan	5/24/16	Benefit Coverage Determination	Contract 115000.00	None	Closed - Settled	2/15/18
U.S. District Court for the District of Utah, Northern Division, No. 2:16-cv-00466-CW	Anne S.; David S.; and Ryan S. (Slosky) v. Aetna Choice POS II Plus Medical Plan; Aetna Life Insurance Company; and Vanderbilt University	6/2/16	Benefit Coverage Determination	Contract 150000.00	None	Closed - Settled	7/17/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Eastern District of Pennsylvania, No. 2:16-cv-02727-JS	B.S.F. (Ford) v. Aetna, Inc.; Aetna Life Insurance Company	6/3/16	Benefit Coverage Determination	Contract 85833.32	None	Closed - Settled	2/28/17
U.S. District Court for the District of Utah, Central Division, No. 2:16-cv-00499-DB	K.S., mother of B.S. (Sorenson), a minor v. Altius Health Plans	6/7/16	Benefit Coverage Determination	Contract 43556.13	None	Closed - Settled	1/12/18
Supreme Court, Queens County, NY, No. 706732/2016	Alvir, Evelyn v. Aetna Life Insurance Company of Hartford a/k/a Aetna Life Insurance Company a/k/a Aetna, Inc.	6/8/16	Benefit Coverage Determination	Compensatory 250000.00	None	Closed - Settled	11/15/17
U.S. District Court for the District of Utah, Central Division, No. 2:16-cv-00629-PMW	D.S. v. Altius Health Plans, Inc.; and Whitaker Construction Co., Inc.	6/15/16	Benefit Coverage Determination	Contract 19393.61 Costs 46970.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
3rd Judicial District Court, Salt Lake County, UT, No. 160903787	H.C. v. Altius Health Plans, Inc.	6/15/16	Benefit Coverage Determination	Contract 18365.43	None	Closed - Settled	7/19/17
Superior Court, Santa Clara County, San Jose, CA, No. 16SC065190	Mimar, Tibet v. Aetna Better Health of CA	6/21/16	Benefit Coverage Determination	Contract 560.00	None	Closed - Settled	10/31/16
17th Judicial Circuit Court, Broward County, FL, No. 43086991	Christian, Michael L. v. The School Board of Broward County, Florida	6/22/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/30/17
U.S. District Court for the District of Utah, Central Division, No. 1:16-cv-00093-DBP	Brian C. and Rhonda C. (Cannon), individually and as guardians of A.C., a minor v. ValueOptions; Aetna Life Insurance Company; and ConocoPhillips Medical and Dental Assistance Plan	6/29/16	Benefit Coverage Determination	Compensatory 128000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/15/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
67th Judicial District Court, Genesee County, MI, No. C1601182GC	Goyette, Rachel M. v. Aetna Insurance Company	7/6/16	Benefit Coverage Determination	Compensatory 801.27	None	Closed - Settled	10/31/16
District Court, Wyandotte County, KS, No. 2016-LM-002961	Penney, Lavetta R. v. Coventry Healthcare of Kansas	7/7/16	Benefit Coverage Determination	Compensatory 1192.12	None	Closed - Settled	12/9/16
District Court, Prince George's County, MD, No. 0502-0006562-2016	Anne Arundel Medical Center v. Krystal Smith, Individually and as Parent and Next Friend of Gerald R. Wills, III, a Minor v. Aetna Health, Inc.	7/8/16	Benefit Coverage Determination	Contract 6550.95	None	Closed - Settled	9/8/16
Small Claims Court, Washington County, UT, No. 168700332	Hartline, Sherry v. Aetna, Inc.	7/11/16	Benefit Coverage Determination	Contract 6766.87 Costs 200.00	None	Closed - Settled	9/16/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Justice Court, Small Claims, Dallas County, TX, No. JS16-00107K	Wiggins, Samotta v. Rock Tenn Company; Westrock Co.; and Aetna	7/14/16	Benefit Coverage Determination	Contract 8796.11	None	Closed - Pretrial - Aetna Dismissed by Court Order	7/10/18
U.S. District Court for the District of Utah, Central Division, No. 2:16-cv-00798-DBP	Mary C; Stephen C.; and Claire C. (Coffey) v. Aetna Life Insurance Company; Lockheed Martin Corporation; and The LM Healthworks Plan	7/15/16	Benefit Coverage Determination	Contract 160000.00	None	Closed - Settled	9/7/17
General District Court, Albermarle County, VA, No. GV16003276-00	Wanninger, Eric J. v. PayFlex Systems USA Inc.	7/22/16	Benefit Coverage Determination	Compensatory 1285.00	None	Closed - Settled	12/9/16
Superior Court, Small Claims, DC, No. 2016SC202656	Huberman, R. Carole v. Aetna Life Insurance Company	7/25/16	Benefit Coverage Determination	Compensatory 1365.76	None	Closed - Pretrial - Aetna Dismissed by Court Order	9/6/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Contra Costa County, CA, No. MSC16-0592	Sher-Betts, Candice v. Quest Diagnostics Clinical Laboratories, Inc.; and Aetna Life Insurance Company	7/27/16	Benefit Coverage Determination	Contract 4000.00	None	Closed - Settled	10/31/16
Superior Court, Contra Costa County, CA, No. MSC16-0591	Betts, A. Mitchell and Michael Drabinsky v. Quest Diagnostics Clinical Laboratories, Inc.; and Aetna Life Insurance Company	8/1/16	Benefit Coverage Determination	Contract 10000.00	None	Closed - Settled	10/31/16
Superior Court, Passaic County, NJ, No. PAS-L-2684-16	Clase, Angel v. Aetna Better Health of New Jersey; John Does 1-10; ABC Corp. 1-10	8/2/16	Benefit Coverage Determination	Compensatory 140731.21	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/30/17
Court of Common Pleas, Spartanburg County, SC, No. 2016-CP-42-2863	Quinn, Brigitte v. Coventry Health Care of the Carolinas, Inc.	8/2/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/20/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court, Clayton County, IA, No. SCSC 018680	Gundersen Clinic, Ltd. v. Michael Theodore Knipfel v. Aetna Health of Iowa, Inc.	8/3/16	Benefit Coverage Determination	Compensatory 2073.50 Costs 5000.00	None	Closed - Settled	9/27/16
Court of Common Pleas, Allegheny County, PA, No. GD-16-014394	Vanderveen, Donna v. Aetna Health Inc; Aetna, Inc.; Aetna Life Insurance Company; Allegheny Genera Hospital; Allegheny Health Network; and State Collection Service Inc.	8/3/16	Benefit Coverage Determination	Contract 41163.20	None	Closed - Settled	7/21/17
General District Court, Fairfax County, VA, No. GV16015579-00	Naroditsky, Gene v. Innovation Healthcare; Aetna	8/12/16	Benefit Coverage Determination	Compensatory 5000.00	None	Closed - Settled	11/29/16
County Court at Law No. 5, Dallas County, TX, No. CC-16-04131-E	Diggs, David v. Aetna Health, Inc.	8/17/16	Benefit Coverage Determination	Contract 30000.00	None	Closed - Settled	11/9/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Small Claims Division, DC, No. 2016SC2003143	Huberman, R. Carole v. Aetna Life Insurance Company (No. 2016SC2003143)	8/20/16	Benefit Coverage Determination	Other 1912.30	None	Closed - Settled	11/3/16
Superior Court of New Jersey, Law Division, Morris County, Special Civil Part, No. DC-004584-16	Morristown Medical Center; Overlook Medical Center v. Marco Laracca v. Aetna Health Insurance Inc.	8/30/16	Benefit Coverage Determination	Contract 3000.00	None	Closed - Settled	4/23/19
11th Judicial Circuit Court, Miami-Dade County, FL, No. 2016-022957-CA (21)	Leiva, Meyling v. Coventry Health Care of Florida, Inc.	9/2/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/13/17
General District Court, City of Richmond, Commonwealth of Virginia, No. 16031653	Archer, Monica v. Coventry Health Care of Virginia	9/4/16	Benefit Coverage Determination	Compensatory 3848.40 Costs 46.00	None	Closed - Settled	12/21/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Texas, Houston Division, No. 4:16-cv-02785	Rotan, Kendal, individually, and as next friend of H.R., and as next friend of L.R. v. Aetna Life Insurance Company	9/14/16	Benefit Coverage Determination	Contract 150000.00	None	Closed - Settled	3/8/18
80th Judicial District Court, Harris County, TX, No. 2016-64086	Firat, Cem v. Aetna Life Insurance Company and The Archdiocese of Galveston/Houston	9/21/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/20/17
125th District Court, Harris County, TX, No. 2016-61795	Railsback, Donald E. v. Aetna, Inc. d/b/a Aetna Health Inc.	9/21/16	Benefit Coverage Determination	Contract 1000000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	1/31/17
U.S. District Court, District of Utah, No. 2:16-cv-01016 JNP	Patterson, Robert; and John Patterson v. Coventry Health Care f/k/a Altius Health Plans, Inc; and MHNet Speciality Services, Inc. d/b/a MHNet Behavioral Health	9/30/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/11/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Nevada, No. 2:16-cv-02317-JCM-PAL	Gneiting, Reese and Megan Gneiting v. Aetna Life Insurance Company	10/4/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	2/24/17
11th Judicial Circuit Court, Miami-Dade County, FL, No. 2016025881CA0113	Lopez, Victor Haroldo v. Aetna Health Inc. d/b/a Coventry Health Care of Florida, Inc.	10/5/16	Benefit Coverage Determination	Contract 75000.00	None	Closed - Pretrial - Judgment in Favor of Aetna	3/13/18
Circuit Court, Brown County, WI, No. 16SC4759	Parks, Darius and Angela v. Bellin Health; ADT Security Services; and Aetna, Inc.	10/7/16	Benefit Coverage Determination	Contract 10000.00	None	Closed - Settled	1/30/17
Superior Court, Camden County, NJ, No. CAM-DC-008148-16	South Jersey Radiology Associates v. Carmen Y. Chapman v. Liberty Mutual Mid-Atlantic Insurance Company; and Aetna Life Insurance Company	10/13/16	Benefit Coverage Determination	Contract 1436.76 Fees 2569.76	None	Closed - Settled	1/4/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
3rd Judicial District Court, Salt Lake County, UT, No. 160906486	N.D. (Day) v. Altius Health Plans, Inc.	10/17/16	Benefit Coverage Determination	Contract 14337.58	None	Closed - Settled	12/12/17
U.S. District Court for the Northern District of Texas, Dallas Division, No. 3:16-cv-02927-D	Wiggins, Samotta v. Westrock RTK Rock Tenn Company f/k/a Rock Tenn, Inc.; Copay Plan of RockTenn, Inc.; Aetna Life Insurance Company; and Rawlings Co.	10/18/16	Benefit Coverage Determination	Contract 4996.11	None	Closed - Pretrial - Aetna Dismissed by Court Order	7/21/17
Circuit Court of St. Louis County, MO, No. 16SL-CC03923	Rauch, Fred A. v. Coventry Health Care of Missouri, Inc.; and Coventry Health and Life Insurance Company	10/20/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/20/17
General District Court of Justice, Gaston County, NC, No. 16-CVD-3375	Bowers, Edward P. v. Coventry Health Care of the Carolinas, Inc.	10/27/16	Benefit Coverage Determination	Contract 13323.16	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/20/16

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
7th Judicial Circuit Court, Small Claims, Clay County, MO, No. 16CY-CV10021	Fambrough, William Louis v. Roger Noel Farah; and Coventry Health Care, Inc.	10/28/16	Benefit Coverage Determination	Contract 2972.50	None	Closed - Complaint Withdrawn	1/10/17
U.S. District Court for the Eastern District of Michigan, Southern Division, No. 2:16-cv-13877-VAR-APP	Tompkins, Marie A. v. Michigan UFCW Unions and Employers Administrator, LLC; Aetna Life Insurance Company; The Kroger Company; and Allstate Insurance Company	11/1/16	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/20/16
U.S. District Court for the Middle District of Florida, Orlando Division, No. 6:16-cv-01922-ACC-DCI	St. Louis, Philip v. Aetna Health Inc.	11/2/16	Benefit Coverage Determination	Unspecified	None	Closed - Trial - Aetna Favor	7/17/18
Civil Court, Small Claims, New York County, NY, No. 16621 SCNY 2016 1	Lettiere, Danielle v. Aetna Health Inc.	11/3/16	Benefit Coverage Determination	Contract 1200.00	None	Closed - Settled	3/23/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Ocean County, NJ, No. OCN-L-3013-16	Jerome, Ronald J. v. Aetna Health Insurance; and John Doe	11/4/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/8/18
Circuit Court, Waukesha County, WI, 16CV02037	Estate of Joshua J. Lang, by its Special Administratrix Amy M. Lang v. Aetna Life Insurance Company	11/7/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/28/17
Court of Common of Pleas, Spartanburg County, SC, No. 2016CP4204105	Elmore, Kathryn v. Coventry Health and Life Insurance Company	11/16/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/2/17
20th Judicial Circuit Court, Lee County, FL, No. 16-CA-004000	Ledley, Aubri v. Aetna Life Insurance Company	11/17/16	Benefit Coverage Determination	Contract 15738.11	None	Closed - Settled	7/21/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
63rd District Court, Michigan, No. D16C05400-GC	West Michigan Anesthesia v. Jonathan Krumenacker v. Coventry Health Care of Florida, Inc.	11/18/16	Benefit Coverage Determination	Contract 3776.30	None	Closed - Settled	7/19/17
U.S. District Court for the Eastern District of Michigan, No. 5:16-cv-14127-JCO-SDD	Hogan, Daniel D. v. Aetna Life Insurance Company	11/21/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/10/17
Superior Court, Pinal County, AZ, No. CV201602006	Olsen, Amber Marie v. State of Arizona, Department of Administration; and Aetna Life Insurance Company	11/21/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/12/18
U.S. District Court for the Southern District of Texas, Houston Division, No. 4:16-cv-03513	Parks, William A. v. Global Hunter Securities, LLC; Global Hunter Securities, LLC Welfare Plan; and Aetna Life Insurance Company	11/28/16	Benefit Coverage Determination	Contract 32999.90	None	Closed - Settled	1/11/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, San Diego County, CA, No. 37-2016-00041418-CU-NP-CTL	Stevenson, Jesse v. Aetna Health of California, Inc.; Sharp Rees Stealy Medical Group; and Does 1-10, inclusive	11/28/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/11/18
U.S. District Court for the District of Utah, Northern Division, No. 1:16-cv-00169-DB	Robert M.; Barbara M.; and Alicia M. v. Aetna Life Insurance Company; and AstraZeneca Medical Plan	12/14/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/17/18
Superior Court, Middlesex County, NJ, No. MID-DC-011630-16	St. Peter's University Medical Center v. Jeanne Goll v. Aetna Life Insurance Company	12/22/16	Benefit Coverage Determination	Contract 2622.29	None	Closed - Pretrial - Aetna Dismissed Voluntarily	5/11/17
U.S. District Court for the District of Utah, Northern Division, No. 1:16-cv-00175 PMW	Patricia P.; Clark P.; and Elizabeth P.; v. Aetna Life Insurance Company	12/27/16	Benefit Coverage Determination	Contract 86000.00	None	Closed - Settled	1/11/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
44th Judicial District Court, Oakland County, MI, No. 16-04436-SC	Shub, Faina v. Aetna	12/29/16	Benefit Coverage Determination	Contract 2779.27	None	Closed - Settled	6/19/17
2nd Judicial District Court, Washoe County, NV, No. CV16-02543	Burns, James B. v. Aetna Life Insurance Company	12/30/16	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/20/17
U.S. District Court for the Eastern District of PA, No. 5:17-cv-00002-JLS	T.M. v. Aetna Life Insurance Company	1/3/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/20/17
Magistrate Court, Fulton County, GA, No. 17MS083368	Cropsey, Sandra J. v. Coventry Health Care of Georgia, Inc.	1/4/17	Benefit Coverage Determination	Contract 17564.34 Punitive 7435.66	None	Closed - Settled	11/20/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas, Montgomery County, OH, No. 2017 CV 00152	DePriest, Debra L. v. Aetna, Inc.	1/11/17	Benefit Coverage Determination	Contract 60000.00 Punitive 25000.00	None	Closed - Settled	2/20/17
Superior Court, San Diego County, CA, No. 37-2017-00343121-SC-SC-NC	Mogar, John v. Aetna Health of California, Inc.; and Aetna Life Insurance Company	1/17/17	Benefit Coverage Determination	Compensatory 1760.00	None	Closed - Settled	6/15/17
U.S. District Court for the Western District of North Carolina, Charlotte Division, No. 3:17-cv-00023-RJC-DCK	Bowers, Edward P. v. Coventry Health Care of the Carolinas, Inc.	1/18/17	Benefit Coverage Determination	Contract 13323.16	None	Closed - Settled	10/25/17
U.S. District Court for the Eastern District of New York, No. 2:17-cv-00281-JMA-GRB	Wigley, Bruce v. Aetna Life Insurance Company	1/20/17	Benefit Coverage Determination	Contract 496895.00	None	Closed - Settled	5/16/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of New Jersey, Law Division, Somerset County, No. SOM-L-684-16	Scott, Donnie A. v. Mihee Kim; IDS Property Casualty Insurance Company; Aetna; John Doe I-X; ABC Corp I-X; ABC Employer I-X	1/24/17	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/22/17
Superior Court of New Jersey, Law Division, Hunterdon County, No. HNT-L-533-16	Atlantic Neurosurgical Specialist v. Denise A. Pianucci and Brian Pianucci v. Aetna Health, Inc.	1/31/17	Benefit Coverage Determination	Compensatory 27873.31	None	Closed - Settled	3/27/17
U.S. District Court for the Central District of California, No. CV17-00975	Helman, Christopher v. Aetna Life Insurance Company; and Does 1-10 inclusive	2/7/17	Benefit Coverage Determination	Compensatory 30000.00	None	Closed - Settled	10/29/18
Superior Court, Middlesex County, NJ, No. MID-L-0849-17	Caceres, Ariel v. Raphael Inoa; Graceland Adult Medical Daycare; Adultcare, Inc.; Adultcare Daycare Inc.; Drive New Jersey Insurance Company; Aetna Health Inc., et al.	2/8/17	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	2/27/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
16th Judicial District Court, Ford County, KS, No. 2017-CV-000024	Kisner, John v. Coventry Health & Life Insurance a/k/a Coventry Health Care of Kansas a/k/a Coventry Health Care of Kansas, Inc.; and AirMD, LLC d/b/a LifeTeam	2/16/17	Benefit Coverage Determination	Contract 41789.44 Punitive 10000.00	None	Closed - Settled	6/15/18
15th Judicial Circuit Court, Palm Beach County, FL, No. 50-2017-CC-000473-XXXX-MB	Cadet, Maguene and Marc v. AML Diagnostics, Inc.; Mark Rosenberg, MD, P.A.; and The Business Office, P.C. v. Cadet v. Aetna Health Inc.	2/21/17	Benefit Coverage Determination	Contract 3668.00	None	Closed - Settled	5/8/18
State Court, Gwinnett County, GA, No. 17-C-00885-2	Lopez, Wilber v. Aetna Insurance Company, and/or Aetna Group of Subsidiary Companies, including Aetna Life Insurance Co, and its affiliates; Aetna	2/21/17	Benefit Coverage Determination	Contract 54575.38	None	Closed - Settled	3/12/18
Circuit Court, Roanoke, VA, No. 770CL17000348-00	Hopkins, Isabel Walker v. Aetna Insurance Company of Connecticut	2/23/17	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/7/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Northern Division, No. 2:17-cv-00137-CW	Elizabeth M., as parent and legal guardian of E.M., a minor v. Aetna Life Insurance Company; and Benefit Plan CA MC HSA HDHP $2000 80/50	2/24/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/11/18
Superior Court, Washington, DC, No. 17-0001588	Boghossian, Blake v. George Washington University; Aetna Life Insurance Company; Aetna Student Health; and Dr. Imran Riaz, Psy.D.	2/27/17	Benefit Coverage Determination	Compensatory 25000000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	7/14/17
Ithaca City Court, Small Claims, Tompkins County, NY, No. SC-046907-17/IT	Kalas, Rayna v. Cornell University; Aetna Life Insurance Co.; and Mary George Opperman	2/27/17	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	7/11/17
General District Court, Fairfax County, VA, No. GV17003519	Larson, II, Lars E. and Rebecca C. Larson v. Aetna Health and Life Insurance Company	2/27/17	Benefit Coverage Determination	Contract 1603.00 Costs 58.00	None	Closed - Settled	4/20/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
11th Judicial Circuit Court, Miami-Dade County, FL, No. 2017-002783-CA-01	Barquero, Elizabeth v. Coventry Health and Life Insurance Company	2/28/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/21/17
General District Court, Fairfax County, VA, No. GV17003541-00	Graell, Antonio E.; Mirna E. Martinez v. Aetna (Medical Insurance Company)	3/1/17	Benefit Coverage Determination	Contract 462.72 Fees 876.49	None	Closed - Settled	4/20/17
Civil Court, Small Claims, New York County, NY, No. 469 SCNY 2017 1	Giannone, Jonathan A. v. Aetna Student Health Agency, Inc.	3/2/17	Benefit Coverage Determination	Contract 1500.00	None	Closed - Settled	6/2/17
U.S. District Court for the Central District of California, No. 8:17-cv-00387	Tenney, Jonathan P. v. Aetna Life Insurance Company; Bank of America, N.A.; Bank of America Group Benefits Program; and Does 1-10, inclusive	3/3/17	Benefit Coverage Determination	Compensatory 160000.00	None	Closed - Settled	9/24/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Circuit Court, Prince William County, VA, No. 153CL17001843-00	Towers, Hilary v. Innovation Health Insurance Company	3/3/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/6/17
County Court, Saunders County, NE, No. CI 17-34	Credit Management Services, Inc. v. Emily Hass v. Saunders Medical Center; and Coventry Health Care of Nebraska, Inc.	3/6/17	Benefit Coverage Determination	Contract 11990.47	None	Closed - Settled	1/11/18
U.S. District Court for the Southern District of Florida, No. 9:17-cv-80275-KAM	Forss, Lauri H. v. Aetna Life Insurance Company	3/6/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/12/17
U.S. District Court for the Southern District of Florida, No. 9:17-cv-80318-DMM	Grewal, Jeevraj S. v. Aetna Life Insurance Company	3/10/17	Benefit Coverage Determination	Contract 400000.00	None	Closed - Settled	8/30/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court, Anne Arundel County, MD, No. D-07-CV-17-003054	Anne Arundel Medical Center v. Maria A. Harsanyi v. Aetna Life Insurance Company	3/13/17	Benefit Coverage Determination	Contract 3353.40	None	Closed - Settled	11/8/17
U.S. District Court for the Northern District of California, San Jose Division, No. 5:17-cv-01374-BLF	Nelson, Heidi v. Aetna Life Insurance Company; The Board of Trustees of the Leland Stanford Junior University; and The Stanford Health Care Alliance Plan	3/14/17	Benefit Coverage Determination	Contract 80000.00	None	Closed - Settled	10/17/17
U.S. District Court for the District of Utah, Central Division, No. 1:17-cv-00040-DBP	Ira M. and Daniel M. v. Aetna Life Insurance Company	3/15/17	Benefit Coverage Determination	Contract 60000.00	None	Closed - Settled	3/26/18
7th Judicial Circuit Court, St. John's, FL, No. CA17-0302	Caldwell, William M. and Catherine E. Caldwell v. Aetna Health, Inc.	3/16/17	Benefit Coverage Determination	Contract 20261.80	None	Closed - Settled	6/5/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
General District Court, Fairfax County, VA, No. GV17005666-00	Du, Yi v. Aetna Insurance Company	3/22/17	Benefit Coverage Determination	Contract 2112.00 Costs 58.00	None	Closed - Settled	5/15/17
Court of Common Pleas, Montgomery County, PA, No. 2017-06378	Price, Lawrence C. v. Aetna Inc.	3/29/17	Benefit Coverage Determination	Unspecified	None	Closed - Complaint Withdrawn	5/23/17
U.S. District Court for the Northern District of Georgia, Atlanta Division, No. 1:17-cv-01167-CAP	Doe, John and Jane, as parents and guardian of Julie Doe v. Aetna Life Insurance Company a/k/a Aetna Health Incorporated	3/31/17	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, Maricopa County, AZ, No. CV2017-000742	Hadley, Georgina S. and Adam J. Hadley v. Aetna Health Inc.; Aetna Health Insurance Company; Aetna Life Insurance Company; John Does I-X; Jane Does I-X; ABC Corporations I-X; JKL Limited Liability Companies I-X; and XYZ Partnerships I-X	4/6/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/21/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Maricopa County, AZ, No. CV2017-052247	Moeur, Susan v. Aetna Health Inc.	4/7/17	Benefit Coverage Determination	Compensatory 253039.00	None	Closed - Settled	2/14/18
Superior Court, Middlesex County, NJ, No. MID-DC-002703-17	Raritan Bay Medical Center v. Gerald and Jeanne Goll v. Aetna Life Insurance Company	4/12/17	Benefit Coverage Determination	Contract 1000.00 Costs 164.00	None	Closed - Settled	9/21/17
District Court, Montgomery County, MD, No. 060100067862017	Santos, Jose G. v. Aetna Life Insuarnce Company	4/14/17	Benefit Coverage Determination	Contract 7768.62	None	Closed - Settled	7/14/17
U.S. District Court for the District of New Jersey, No. 3:17-cv-02647-FLW-LHG	Michele M. v. Aetna Health, Inc.	4/18/17	Benefit Coverage Determination	Contract 104000.00	None	Closed - Settled	3/8/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Illinois, Eastern Division, No. 1:17-cv-02963	Shackleford, Cindy H. v. Aetna Life Insurance Company; Bank of America Retiree Group Benefits Program-Aetna Select EPO Component Retiree Health Insurance Plan; Bank of America Corporation; and Bank of America Corporation Corporate Benefits Committee	4/19/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/25/18
U.S. District Court for the Eastern District of New York, No. 2:17-cv-02444-ADS-AKT	Peppiatt, Sandra A. v. Aetna Life Insurance Company; and Bank of America Corporation	4/24/17	Benefit Coverage Determination	Contract 205946.11	None	Closed - Pretrial - Aetna Dismissed by Court Order	3/9/18
U.S. District Court for the District of Utah, Central Division, No. 2:17-cv-00314-DS	R.R. v. Credit Corp Solutions, Inc.; and Altius Health Plans	4/24/17	Benefit Coverage Determination	Contract 22296.90	None	Closed - Settled	5/25/18
Circuit Court, Tallapoosa County, AL, No. 70-CV-2017-900044	Dodson, Brian v. Aetna Life Insurance Company	4/28/17	Benefit Coverage Determination	Contract 30004.98	None	Closed - Pretrial - Judgment in Favor of Aetna	4/12/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Northern Division, No. 2:17-cv-00338-TC	Randy L. and Rochelle L., individually and as guardians of A.L., a minor v. Aetna Life Insurance Company; Anthem Blue Cross and Blue Shield	5/3/17	Benefit Coverage Determination	Contract 67566.14	None	Closed - Settled	10/29/18
American Arbitration Association, Hawthorne, NJ, No. 01-17-0007-4103	Marengo, Stephen v. Aetna Health, Inc.	5/8/17	Benefit Coverage Determination	Contract 185502.00	None	Closed - Settled	1/10/19
U.S. District Court for the District of New Jersey, No. 2:17-cv-03351	E.S. by and through her parents and guardians, To.S. and Ti.S. indiv & on behalf of similarly situated individuals v. Marsh & McLennan Companies, Inc. and Aetna Life Insurance Company	5/11/17	Class Action	Unspecified	None	Open	
3rd Judicial District Court, Salt Lake County, UT, No. 170903170	N.A.R. v. Altius Health Plans, Inc.	5/15/17	Benefit Coverage Determination	Contract 18131.85	None	Closed - Settled	2/18/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Bergen County, NJ, No. DC-5337-17	Hackensack Radiology Group, P.A. v. David Katz v. GHI; and Aetna	5/16/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/20/17
Superior Court, Burlington County, NJ, No. BUR-DC-2612-17	Ocean Medical Center v. Kristen F. Skibicki and Edward J. Skibicki v. Aetna Inc.	5/18/17	Benefit Coverage Determination	Contract 5000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/5/17
District Court, Lawrence Division, MA, No. 1718SC001214	Staudt, James v. Aetna	5/22/17	Benefit Coverage Determination	Compensatory 20550.00	None	Closed - Settled	8/11/17
U.S. District Court for the District of New Jersey, No. 2:17-cv-03732-CCC-JBC	Tatarsky, Michael v. Aetna, Inc.	5/25/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/12/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Court of Common Pleas, Philadelphia County, PA, No. 170504019	Humphrey, Wayne v. Aetna Health Inc.; Aetna Health Holdings LLC; and Aetna Health Insurance Company	5/26/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/31/18
Court of Common Pleas, Lucas County, OH, No. CI0201504274	Credit Adjustments, Inc. v. Nicholas Daudelin v. Aetna Health, Inc.; and Medical Mutual of Ohio	5/30/17	Benefit Coverage Determination	Contract 16838.76	None	Closed - Settled	3/9/18
District Court, Douglas County, NE, No. D01CI170004563	Vopalka-Fischer, Patricia v. Coventry Health Care of Nebraska, Inc.	5/31/17	Benefit Coverage Determination	Contract 40069.85	None	Closed - Settled	8/4/17
Court of Common Pleas, Northampton County, PA, No. C-48-CV-2017-5538	Miller, David, individually and as guardian for Christopher Miller, a minor v. Aetna Insurance; and United Concordia	6/21/17	Benefit Coverage Determination	Compensatory 38075.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/25/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Middlesex County, NJ, No. DC-13254-16	Raritan Bay Medical Center v. Patience Brooks v. Geico Indemnity Company and Aetna, Inc.	6/21/17	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	3/15/18
Superior Court, Union County, NJ, No. UNN-L-4059-16	IGEA Brain Spine, P.A. v. Nicholas McKay v. Aetna	6/26/17	Benefit Coverage Determination	Contract 352900.00	None	Closed - Settled	5/30/18
District Court of Maryland for Baltimore County, No. 080400275972016	Sinai Hospital of Baltimore, Inc. v. Christina M. Coster v. Aetna	7/5/17	Benefit Coverage Determination	Compensatory 2573.69	None	Closed - Pretrial - Aetna Dismissed by Court Order	10/5/17
162nd Judicial District Court, Dallas County, TX, No. DC-17-08093	Hagens, Carol Joy v. Aetna Life Insurance Company	7/7/17	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	12/20/17

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Small Claims, Allen County, IN, No. 02D01-1707-SC-10623	Sholl, David John v. Aetna, Inc.	7/17/17	Benefit Coverage Determination	Contract 16000.00 Fees 97.00	None	Closed - Settled	11/21/17
Justice Court, Precinct 4, Galveston County, TX, No. 17-NSC04-0116	Bayless, Marshall & Martha Bayless v. CT Corporation System on behalf of Aetna Health Inc.	7/25/17	Benefit Coverage Determination	Contract 10000.00	None	Closed - Settled	11/28/17
281st Judicial District, Harris County, TX, No. 2017-35487	Mastriani, John V. v. Traveler Property & Casualty f/k/a Aetna Insurance Co.	7/25/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/3/19
25th Judicial District Court, Wayne County, MI, No. 16-L-1230-GC	Oakwood Health Systems v. Adam Laske v. Aetna Health Inc.; and Beacon Health Options, Inc.	7/25/17	Benefit Coverage Determination	Compensatory 14704.53	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/8/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Maryland, No. 8:17-cv-02132-PJM	Payton, Ellery K. v. Kforce Government Solutions, Inc.; Kforce, Inc.; Aetna Health, Inc.; Aetna Life Insurance Company; and Aetna, Inc.	7/28/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/27/18
U.S. District Court for the District of Utah, Central Division, No. 2:17-cv-00878-EJF	Edward R., individually and as guardian of E.R., a minor v. Aetna Life Insurance Company	8/2/17	Benefit Coverage Determination	Contract 50000.00	None	Closed - Settled	8/7/18
Commonwealth of Pennsylvania, Tioga County, PA, No. MJ-04302-CV-0000066-2017	Estate of Edith Smith v. Aetna Life Insurance Co.	8/9/17	Benefit Coverage Determination	Contract 11181.08	None	Closed - Pretrial - Aetna Dismissed by Court Order	3/15/18
Civil Court, Small Claims, New York County, NY, No. 16522 SCNY 2017 4	Torok, Ronald v. Aetna	8/10/17	Benefit Coverage Determination	Compensatory 3480.00	None	Closed - Settled	2/23/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, King County, WA, No. 17-2-21315-2 SEA	Anderson, Kenneth v. Aetna Life Insurance Company	8/17/17	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/9/18
11th Judicial Circuit Court, Miami-Dade County, FL, No. 2017-020016-CA-01	Casal, Jesus v. Coventry Health Care of Florida, Inc.	8/21/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/18/17
District Court, Cleveland County, OK, No. SC-17-3831-P	Norman Regional Hospital Authority d/b/a Norman Regional Hospital v. Allison C. Bailey v. Assurant Health / Aetna Health, Inc.	8/29/17	Benefit Coverage Determination	Compensatory 2488.24	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/25/17
Circuit Court, County of Washtenaw, MI, No. 17-585-NF	Trudell, Kristen v. Safeco Insurance Company of America; Aetna Health, Inc.; Sinai-Grace Hospital; Legacy SHGD; and Henry Ford Hospital	8/30/17	Benefit Coverage Determination	Contract 25000.00	None	Closed - Settled	6/18/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Essex County, NJ, No. ESX-L-4967-17	Adarkwah, Mary v. Saint Joseph's Healthcare System; Progressive Insurance; Progressive Garden State Insurance Company; Aetna Inc.; Aetna Health and Life Insurance Company; Aetna Health Insurance Company; Aetna Life Insurance Company; and John Does 1-20	9/5/17	Benefit Coverage Determination	Contract 20348.00	None	Closed - Settled	11/21/17
4th Judicial District Court, Missoula County, MT, No. DV-17-942	Evans, John and Bessie v. Aetna, Inc.; Aetna Health of Utah Inc.; Coventry Health Care of Altius, Inc.; Altius Health Plans, Inc.; Montana Health Co-Op; and John Does 1-10	9/18/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	1/17/19
332nd Judicial District Court, Hidalgo County, TX, No. C-4334-17-F	Wells, Kevin v. Sitel Operating Corporation; and PayFlex Systems USA, Inc.	9/18/17	Benefit Coverage Determination	Contract 200000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	7/9/18
U.S. District Court for the District of Utah, Central Division, No. 2:17-cv-01037-DB	Thomas M. and Marcia M. v. Aetna Life Insurance Company	9/19/17	Benefit Coverage Determination	Contract 125000.00	None	Closed - Settled	2/18/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Small Claims, Sacramento County, CA, No. 17SC03455	Chirwa, Elitas Mazhyanga v. Aetna Life Insurance Company; and UC Davis Health System (Patient Billing)	9/25/17	Benefit Coverage Determination	Contract 10000.00	None	Closed - Settled	12/14/17
Court of Common Pleas, Lexington County, SC, No. 2017CP3203493	Lehman, Jr., Royce v. Coventry Health Care of the Carolinas, Inc.; and Aetna Life Insurance Company	9/25/17	Benefit Coverage Determination	Contract 370720.50	None	Closed - Settled	3/4/19
U.S. District Court for the Southern District of Florida, No. 1:17-cv-23513-DPG	Sarah S. v. Aetna Health Management, LLC	9/25/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/5/18
3rd Judicial District Court, Salt Lake County, UT, No. 170906245	Kieryn, M.D., Anne v. Altius Health Plans, Inc.; Iasis Healthcare Corporation; University of Utah Hospital and Medical Center; University of Utah; The State of Utah; Cardon Healthcare, Inc.; and Med-Data Incorporated	9/29/17	Benefit Coverage Determination	Contract 280000.00	None	Closed - Settled	10/12/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
162nd Judicial District Court, Dallas County, TX, No. DC-17-13570	Matonis, Jared v. Aetna Health Inc.	10/3/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/27/18
U.S. District Court for the District of Utah, Northern Division, No. 2:17-cv-01104-DB	Norman G. v. Aetna Life Insurance Company; and Quest Diagnostics, Inc. Benefit Plan	10/3/17	Benefit Coverage Determination	Contract 170000.00	None	Closed - Settled	4/30/19
District Court, Tulsa County, OK, No. SC-2017-15797	Wang, Shiyun v. PayFlex Systems USA Inc.	10/5/17	Benefit Coverage Determination	Compensatory 1150.00	None	Closed - Settled	12/14/17
18th Judicial Circuit Court, Du Page County, IL, No. 2017MR001348	Rapier, Nancy as Guardian of David Rapier, a disabled adult v. Aetna Life Insurance Company	10/6/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/18/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Orange County, CA, No. 30-2017-00948869-SC-SC-CJC	Slack, Roy v. Aetna Life Insurance Company	10/11/17	Benefit Coverage Determination	Contract 3941.50	None	Closed - Settled	3/8/18
U.S. District Court for the District of Utah, Northern Division, No. 2:17-cv-01128-TS	Brian N.; Nicole N.; and Nicholas N. v. Coventry Healthcare of Nebraska, Inc.; and MHNet Behavioral Health	10/12/17	Benefit Coverage Determination	Contract 120000.00	None	Open	
12th Judicial Circuit Court, Will County, IL, No. 17SC06304	Murray, Valerie v. Aetna Insurance Co. c/o Aetna Inc.	10/12/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/9/18
U.S. District Court for the District of Utah, Central Division, No. 2:17-cv-01216-DBP	Roy C. and Rachel C. v. Aetna Life Insurance Company; and KPMG LLP Health and Welfare Plan	10/12/17	Benefit Coverage Determination	Contract 140000.00	None	Closed - Settled	4/5/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Commonwealth of Pennsylvania County of Magisterial District Court, Montgomery County, PA, No. MJ-38121-CV-0000388-2017	Bozhko, Elena v. Aetna	10/13/17	Benefit Coverage Determination	Compensatory 380.00 Costs 87.00	None	Closed - Settled	3/13/18
193rd Judicial District Court, Dallas County, TX, No. DC-17-14183	Cooley, Angel v. Aetna Life Insurance Company and The Teacher Retirement System of Texas	10/13/17	Benefit Coverage Determination	Compensatory 13016.00	None	Closed - Settled	1/15/19
Salt Lake County Justice Court, Small Claims Division, UT, No. 178600958	Badger, Cindy v. Aetna Health Insurance	10/18/17	Benefit Coverage Determination	Contract 4724.58 Fees 125.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/28/17
Civil Court, Small Claims, Kings County, NY, No. 3673 SCK 2017 1	Greenberger, Jordan D. v. Aetna	10/18/17	Benefit Coverage Determination	Compensatory 2285.00	None	Closed - Trial - Aetna Favor	4/26/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Orange County, Newport Beach, CA, No. 30-2017-00951178-SC-SC-HNB	Tavakoli, Sepehr and Ladan Nasiri v. Aetna Life Insurance Company	10/23/17	Benefit Coverage Determination	Contract 748.00	None	Closed - Settled	2/15/18
District Court of Maryland for Montgomery County, No. 06010182392017	Doyle, Thomas E. v. Aetna Health Incorporated	10/24/17	Benefit Coverage Determination	Compensatory 23091.43	None	Closed - Settled	5/21/18
Circuit Court, Richmond, VA, No. CL17-00500400-8	Mansini, Pamela v. Aetna Life Insurance Company; Commonwealth of Virginia; and The Rawlings Company	10/24/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/31/18
19th Judicial Circuit Court, Lake County, IL, No. 17 SC 5673	Smart, Kyle E. v. Aetna Life Insurance Company; and Gregory A. Turowski, M.D.	10/25/17	Benefit Coverage Determination	Compensatory 10000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/10/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court, Small Claims, Bronx County, NY, No. 16136 SCB 2017 1	Weitzman, Tami v. Aetna Health Inc.	10/27/17	Benefit Coverage Determination	Contract 3402.14	None	Closed - Settled	3/16/18
Circuit Court, Cook County, IL, No. 2017-M4-006638	Menolascino, Jennifer A. v. Health Enrollment Center; and First Health	11/1/17	Benefit Coverage Determination	Contract 10000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	6/26/18
Circuit Court, Arlington County, VA, No. 013CL17002590-01	Passage Health International v. Ma Amparo Gazdik v. Aetna International, Inc.	11/1/17	Benefit Coverage Determination	Contract 325010.82	None	Closed - Settled	11/7/18
Superior Court, Solano County, CA, No. USC083027	Jacobson, Kristin and Alexa v. Aetna Life Insurance Company	11/8/17	Benefit Coverage Determination	Contract 1999.00 Punitive 8001.00	None	Closed - Settled	3/8/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
6th Judicial Circuit Court, Hooksett County, NH, No. 447-2017-SC-00340	Trocha, Carri; and Siegfried Trocha v. Aetna Life Insurance Company	11/8/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/15/18
U.S. District Court for the Eastern District of Texas, Texarkana Division, No. 5:17-cv-00190	Torrey, Lisa; Kathryn Kocurek, individually and on behalf of the Estate of J. David Kocurek, Ph.D.; Lana Barnes, individually and on behalf of the Estate of Al Barnes; Amy Hanneken; Jane Powell; Carol Fisch; Christopher Valerio; Steven Ward; Randy Sykes; Brienna Reed; Rosetta Fuller; Adriana Monteiro Moreira; Jessica McKinnie; Kristine Woodard; Gail Meads; Dr. Michael Fundenberger; Gayle Clarke; Allison	11/10/17	Benefit Coverage Determination	Unspecified	None	Open	
U.S. District Court for the District of Utah, Northern Division, No. 2:17-cv-01200-BCW	Hilary M. and Jessica P. v. Aetna Life Insurance Company; and Sanofi-Aventis U.S. LLC Choice POS II Medical Plan	11/14/17	Benefit Coverage Determination	Unspecified	None	Open	
Civil Court, Queens County, NY, No. 3932 SCQ 2017 1	Zheng, Yuan c/o Zixian Qi, Esq. v. Aetna	11/16/17	Benefit Coverage Determination	Contract 678.60	None	Closed - Settled	3/26/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Burlington County, NJ, No. BUR-DC-2649-17	Burnett, Regina v. Aetna Insurance Company	11/27/17	Benefit Coverage Determination	Contract 3500.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	1/18/18
3rd Judicial District Court, Salt Lake County, UT, No. 170907492	E.S. v. Altius Health Plans, Inc.; and Salt Lake County	11/27/17	Benefit Coverage Determination	Contract 10212.37	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/17/19
Department of Licensing and Regulatory Affairs, Workers' Compensation Agency, Lansing, MI	Little, Jr., Ronald J. v. Aetna Inc., et al.	11/27/17	Benefit Coverage Determination	Contract 5345.62	None	Open	
General District Court, Alexandria County, VA, No. _____	Sheikh, Amna v. Innovation Health Insurance Company	11/29/17	Benefit Coverage Determination	Compensatory 2336.95	None	Closed - Failure of Plaintiff to Prosecute	5/8/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Eastern District of Pennsylvania, No. 2:17-cv-05415-GAM	McNeill, Dawn v. The Boeing Company Consolidated Health and Welfare Benefit Plan; The Employee Benefit Plans Committee; The Boeing Company; and Aetna Life Insurance Company	12/1/17	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily.	7/9/18
15th Judicial Circuit Court, Palm Beach County, FL, No. 50-2017-CA-013208XXXXMB	Kotselapova, Alina v. Coventry Health Care of Florida, Inc.	12/5/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/23/18
Court of Common Pleas, Franklin County, OH, No. 17CV010778	Cox, Stephenie; and Kevin Cox v. Michael L. Amend; State Farm Mutual Automobile Insurance Company; Aetna Inc.; and Aetna Life Insurance Company - NOT YET SERVED	12/6/17	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	6/25/18
Court of Common Pleas, Montgomery County, PA, No. 2017-28493	Baumann, Ronald v. C&S Wholesale Grocers, Inc.; Robesonia Logistics, LLC; Richard B. Cohen; and Aetna, Inc. d/b/a Aetna Health Insurance Co.	12/8/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	3/9/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, San Diego County, CA, No. 37-2017-00047190-SC-SC-CTL	Killian, Neda v. Aetna Life Insurance Company	12/8/17	Benefit Coverage Determination	Compensatory 4110.01	None	Closed - Settled	7/24/18
U.S. District Court for the District of Colorado, No. 1:17-cv-03040-MJW	Bland, Bradin and Craig Hospital v. ExxonMobil Medical Plan; Aetna Life Insurance Company	12/15/17	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/2/19
Superior Court, Small Claims, Los Angeles County, CA, No. 17SMSC02437	Jonelis, David v. Aetna Life Insurance Company	12/19/17	Benefit Coverage Determination	Compensatory 9975.00	None	Closed - Settled	10/29/18
3rd Judicial Circuit Court, Wayne County, MI, No. 17-012676-NF	Peake, Robert v. Broadspire Services, Inc.; Broadspire Management Services, Inc.; Broadspire National Services, Inc., et al.	12/26/17	Benefit Coverage Determination	Contract 25000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/14/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of South Carolina, No. 3:17-3498-MBS	Cornell, Kimberly v. Coventry Health Care of the Carolinas, Inc.	1/2/18	Benefit Coverage Determination	Compensatory 410000.00	None	Closed - Settled	11/29/18
Superior Court of New Jersey, Law Division, Special Civil Part, Monmouth County, No. DC-5037-16	Procare Rehabilitation, LLC v. Michael Bartow v. Aetna Life Insurance Company	1/2/18	Benefit Coverage Determination	Contract 8370.00	None	Closed - Settled	12/17/18
U.S. District Court of Utah, Central Division, No. 2:18-cv-00010-EJF	Francisco S., individually and as guardian of M.S. minor v. Aetna Life Insurance Company; and World Bank Group Medical Insurance Plan	1/3/18	Benefit Coverage Determination	Contract 175000.00	None	Open	
Circuit Court, Small Claims, Tallapoosa County, Alexander City, AL, No. 70-SM-2015-900145	Russell Medical Center v. Brian Dodson v. Aetna Life Insurance Company - Investigating a Default Judgment against Aetna Life Insurance Company	1/12/18	Benefit Coverage Determination	Contract 2724.15	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
17th Judicial Circuit Court, Broward County, FL, No. CONO-18-000498	Heller, William A. v. Aetna Health, Inc.	1/16/18	Benefit Coverage Determination	Contract 5000.00	None	Open	
District Court of Pontotoc County, OK, No. CJ-2016-191	ACS-RMA, LLC v. Chad Ainsworth v. Valley View Regional Hospital; Aetna, Inc, et al.	1/19/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/30/18
U.S. District Court for the Southern District of Texas, Houston Division, No. 4:18-cv-00294	Collins, Buina v. Aetna, Inc.; The Dow Chemical Company; and The Dow Chemical Company Retiree Medical Care Program	1/31/18	Benefit Coverage Determination	Unspecified	None	Open	
Circuit Court, Jackson County, MO, No. 1816 CV03100	Haller, R. v. Coventry Health and Life insurance Company	2/6/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/15/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00126-TC	Marcy C. and Hart C. v. Aetna Life Insurance Company; and Computer Sciences Corporation Employee Benefits Plan	2/8/18	Benefit Coverage Determination	Contract 60000.00	None	Closed - Settled	4/1/19
U.S. District Court for the Northern District of California, No. 4:18-cv-932	Lundin, Nichol, individually and on behalf of all others similarly situated v. Aetna Inc; Aetna Health and Life Insurance Company of Connecticut; and Aetna Health of California Inc.	2/13/18	Class Action	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/23/18
U.S. District Court for the District of New Jersey, No. 2:18-cv-02758	Magnanini, Hillary B., and her husband, Robert A. Magnanini, individually, and as guardian ad litum for C.M. v. Aetna Life Insurance Co.; Aetna Health Inc.; Aetna Health Insurance Co.; and ABC Corps. 1-10	2/27/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/29/19
U.S. District Court for the Western District of Virginia, Roanoke Division, No. 7:18-cv-00091-MFU	Hester, Alison v. Carilion Clinic Medical Plan; and Aetna Life Insurance Company	3/1/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	8/20/19

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00216-RJS	Melissa P., individually and as guardian of Sean P. v. Aetna Life Insurance Company; and the Lockheed Martin Corporation Group Benefits Plan	3/12/18	Benefit Coverage Determination	Contract 92000.00	None	Closed - Settled	8/2/19
Superior Court, Middlesex County, NJ, No. MID-L-6896-17	Atlantic Neurosurgical Specialists v. Gregory J. Millman v. Aetna Life Insurance Company	3/13/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/25/18
U.S. District Court for the Southern District of Texas, Galveston Division, No. 3:18-cv-00076	Dews, Angela v. Aetna Inc.; Michael Hardaway; and U.S. Pain and Spine Institute, LLC	3/15/18	Benefit Coverage Determination	Contract 83000.00 Punitive 1000000.00	None	Closed - Settled	6/12/18
Superior Court, Cape May County, NJ, No. CPM-DC-2332-17	Cape Regional Medical Center v. Tanya and Drew Aldinger v. Aetna Insurance Company	3/26/18	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	7/11/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Maricopa County, AZ, No. CV2018-002051	Reyes, Roman J. v. Costco Wholesale Corporation; John Does I-X; ABC Corporations I-X; and Black and White Partnerships and/or Sole Proprietorships I-X	3/27/18	Benefit Coverage Determination	Contract 50000.00 Costs 1400.00	None	Closed - Settled	6/26/18
San Marcos Justice Court, Maricopa County, AZ, No. CC2018073882SC	Emerson, Christopher v. Aetna Life Insurance Company	4/12/18	Benefit Coverage Determination	Compensatory 3500.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/4/18
Municipal Court of Perrysburg, Wood County, OH, No. CVF1800395	Promedica Flower Hospital v. Sylvia Dapkus v. Aetna	4/13/18	Benefit Coverage Determination	Compensatory 5283.00	None	Closed - Settled	12/17/18
Superior Court, Gwinnett County, GA, No. 18A 03362-10	Goss, Geraldine "Gerri" Thornton v. Aetna, Inc.; Aetna Life Insurance Company; OptumHealth Care Solutions, LLC f/k/a OptumHealth Care Solutions, Inc.; OptumInsight Inc.; and John Does 1-20	4/16/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	4/9/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
3rd Judicial District Court, Salt Lake County, UT, No. 180902799	E.P. v. Altius Health Plans, Inc.	4/19/18	Benefit Coverage Determination	Contract 13265.30	None	Closed - Pretrial - Aetna Dismissed Voluntarily	7/5/18
3rd Judicial Circuit Court, Madison County, IL, No. 2018L000520	Monken, Jennifer v. Coventry Health & Life Insurance Company	4/20/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	2/4/19
Civil Court, Small Claims, Richmond County, NY, No. 300 SCR 2018 1	Elimelekh, Jacob v. Aetna Insurance Company	4/25/18	Benefit Coverage Determination	Contract 2929.00	None	Closed - Settled	6/8/18
U.S. District Court for the Central District of Utah, Central Division, No. 2:18-cv-00343-EJF	Gregg O. v. Aetna Life Insurance Company; and Lockheed Martin Corporation Medical Benefits Plan	4/26/18	Benefit Coverage Determination	Contract 93000.00	None	Closed - Settled	7/1/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00351-DB	Harvey T.; Jane R.; and William T. v. Aetna Life Insurance Company; and Invesco Life Cycle Flex Plan	4/27/18	Benefit Coverage Determination	Contract 107000.00	None	Open	
Superior Court, Camden County, NJ, No. CAM-L-1699-18	Ratkowiak, Teresa v. Dominique Walker and/or Jane Doe(s) 1-100; Aetna Life Insurance Company and/or ABC Corporation 1-100, et al.	5/2/18	Benefit Coverage Determination	Unspecified	None	Open	
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00380-CW	John H. and Carol H. v. Aetna Life Insurance Company; and Blue Shield of California	5/10/18	Benefit Coverage Determination	Compensatory 169000.00	None	Open	
District Court, Douglas County, NE, No. D01CI180004789	Kowalski, Miranda v. Coventry Health Care of Nebraska, Inc.; United Health Care Services, Inc.; and CHI Nebraska d/b/a CHI Health	5/24/18	Benefit Coverage Determination	Compensatory 18096.97	None	Closed - Pretrial - Aetna Dismissed Voluntarily	8/23/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Iowa District Court for Pottawattamie County, No. LACV 117682	Accredited Collection Service, Inc. v. Adam L. Mouw, et al. v. United Health Care; and Coventry Health Care, Inc.	6/1/18	Benefit Coverage Determination	Compensatory 15876.04	None	Open	
Superior Court, Small Claims Session, Norwalk, CT, FST-CV-18-6036918-S	Waggoner, Lindsay N. v. Aetna Insurance Company	6/2/18	Benefit Coverage Determination	Compensatory 684.50 Costs 95.00	None	Closed - Settled	7/20/18
Circuit Court, Washington County, Wisconsin, No. 2018SC000245	Neurological Monitoring Associates, LLC v. Joy Kernats v. Aetna	6/11/18	Benefit Coverage Determination	Compensatory 4654.79	None	Closed - Settled	10/1/18
Superior Court, Monmouth County, NJ, No. MON-L-4361-17	Advanced Orthopedics and Sports Medicine Institute v. Howard and Michelle Benson v. Collexx Inc.; and Aetna Life Insurance Company	6/12/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/9/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Florida, No. 9:18-cv-80773-DMM	H.H., individually and on behalf of all others similarly situated; and V.G., individually and on behalf of all others similarly situated v. Aetna Life Insurance Company	6/14/18	Class Action	Unspecified	None	Closed - Settled	9/25/19
Circuit Court of Jefferson County, Alabama, No. 01-CV-2018-902406	Swain, Orethaniel and Monica Swain v. American International Group, Inc.; Coventry Health Care Workers' Compensation, Inc., et al.	6/14/18	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court of California for Orange County, Small Claims, No. 30-2018-01000385-SC-SC-CJC	Dao, Nghiep D. v. Aetna Dental of California Inc.; and Ibrite Dental	6/20/18	Benefit Coverage Determination	Contract 25.00 Punitive 1000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/29/18
Circuit Court, Jackson County, Kansas City, MO, No. 1816-CV16327	Hayden, Jennifer; and Patrick Hayden v. Aetna, Inc.	6/21/18	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/2/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
4th Judicial Circuit Court, Duval County, FL, No. 16-2018-CA-004208	McCullough, Elise Mary v. Aetna Life Insurance Company	6/26/18	Benefit Coverage Determination	Unspecified	None	Open	
9th Judicial Circuit Court, Merrimack, NH, No. 457-2018-SC-00273	Loomer, III, Earle R. a/k/a Rick Loomer v. Aetna Life Insurance Company, Inc.	6/29/18	Benefit Coverage Determination	Contract 3214.00	None	Closed - Administrative Procedure - Aetna Favor	8/24/18
Superior Court, Morris County, NJ, No. MRS-L-1293-18	Weed, Nancy v. Aetna Health, Inc.	7/2/18	Benefit Coverage Determination	Contract 45946.33	None	Closed - Settled	1/2/19
Superior Court of California for the County of San Mateo, Small Claims, No. 18-SCS-00898	Burgman, Dr. Anne v. Aetna Health Insurance	7/10/18	Benefit Coverage Determination	Compensatory 676.72	None	Closed - Settled	10/29/18

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Chancery Court, Jackson County, MS, No. 17-2072-DNH	Toche, Heather v. VT Halter Marine, Inc. Employee Welfare Benefit Plan (a/k/a VT Halter Marine, Inc. Group Benefit Plan); VT Halter Marine, Inc.; Hub International, Inc.; Hub International Healthcare Solutions, LLC; MCMC, LLC; American Health Holding, Inc.; Doe Defendants 1-5 (Herein "The Payor-Defendants); and M.D. Anderson Cancer Center; and The Gardens Pharmacy, LLC	7/13/18	Benefit Coverage Determination	Contract 100000.00	None	Open	
Superior Court, Small Claims, San Bernardino County, Fontana District, CA, No. SMCFS1804408	Martinez, J D v. Aetna Life Insurance Company	7/17/18	Benefit Coverage Determination	Contract 1095.80	None	Closed - Settled	10/29/18
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00576-EJF	Alison L.; Scott L. and Morgan L. v. Aetna Life Insurance Company	7/19/18	Benefit Coverage Determination	Contract 80000.00	None	Open	
U.S. District Court for the Southern District of Texas, No. 4:18-cv-02524	Randall L. v. Aetna Life Insurance Company - NOT YET SERVED	7/20/18	Benefit Coverage Determination	Contract 34400.00	None	Closed - Settled	1/8/19

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court, Polk County, IA, No. SCSC620251	Rosendahl, Dana; and Laurie Rosendahl v. Aetna; and Coventry Health Care	7/26/18	Benefit Coverage Determination	Contract 4492.94	None	Closed - Settled	10/30/18
Superior Court, San Diego County, CA, No. 37-2018-00038749-SC-SC-CTL	Amisano, Guido Charles v. Aetna Life Insurance Company	8/3/18	Benefit Coverage Determination	Compensatory 6216.16	None	Closed - Settled	4/1/19
Superior Court, San Mateo County, CA, No. 18-SCS-01014	Aragon, Francis Mikkel v. Aetna Health Insurance	8/8/18	Benefit Coverage Determination	Contract 4900.00	None	Closed - Settled	10/29/18
Superior Court, Los Angeles County, CA, No. EC068772	Audelo, Mark and Yvonne v. California Business Bureau Inc.; and Aetna Life Insurance Company	8/15/18	Benefit Coverage Determination	Contract 43012.00	None	Closed - Settled	7/31/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Small Claims, San Diego County, CA, No. 37-2018-00040836-SC-SC-CTL	Kamada, Cyrus M. v. bSwift, LLC	8/15/18	Benefit Coverage Determination	Contract 3665.40	None	Closed - Settled	12/13/18
Civil Court of the City of New York, County of Richmond, Small Claims Part 47, No. 597.SCR 2018 1	DeMarco, Eugene v. Hanger Prosthetics and Orthotics	8/22/18	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	11/8/18
Circuit Court, Cook County, IL, No. 2018L009383	Avery, Natalie v. Aetna Life Insurance Co.	8/29/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/27/19
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00691-EJF	Matt H.; and Claire H. v. Aetna Health and Life Insurance Company	9/4/18	Benefit Coverage Determination	Contract 167000.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Ohio, Western Division, Cincinnati, No. 1:18-cv-00631-SJD-SKB	Aaron, Frieda, et al. v. Aetna; Aetna Better Health, Inc.; Aetna Kentucky; Medicaid Coventry Care; Coventry Health Care, et al.	9/7/18	Benefit Coverage Determination	Unspecified	None	Open	
U.S. District Court for the Northern District of Georgia, Atlanta Division, No. 1:18-cv-04246-ELR	Eads, David and Catherine Eads, as parent and guardian of Anna Eads v. Aetna Life Insurance Company a/k/a Aetna Health Incorporated	9/7/18	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	11/15/18
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00717-JNP	James C.; Merilee C.; and J.C. v. Aetna Health and Life Insurance Company; and Lockheed Martin Corporation Group Benefits Plan	9/11/18	Benefit Coverage Determination	Contract 126000.00	None	Open	
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00724-BCW	Linda O. and Graham O., individually and as guardians of J.O. v. Aetna Health and Life Insurance Company; and the Alvarez & Marsal Inc. Health Plan	9/13/18	Benefit Coverage Determination	Contract 171000.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Charlottesville General District Court, Small Claims Division, VA, No. GV18-3366	Baker, Laura E. v. UVA Health System; Pamela M. Sutton-Wallace, CEO; and Aetna Life Insurance Company	9/14/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	5/17/19
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00753-EJF	Timothy D.; Sue D.; and M.D. v. Aetna Health and Life Insurance Company; and the KPMG LLP Medical Benefits Plan	9/20/18	Benefit Coverage Determination	Contract 106000.00	None	Open	
Circuit Court, Williamson County, Franklin, TN, No. 2018-478	Bernard, Charles Wayne v. Aetna Insurance Company a/k/a Aetna Life Insurance Company	9/21/18	Benefit Coverage Determination	Contract 3295.00	None	Closed - Settled	8/16/19
Circuit Court, Deschutes County, OR, No. 18CV42650	Minkiewicz, Megan v. Aetna Life Insurance Company	9/21/18	Benefit Coverage Determination	Contract 19392.56	None	Closed - Settled	7/2/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Eastern District of Texas, Marshall Division, No. 2:18-cv-00402-RWS	S.S. v. Aetna Life Insurance Company	9/21/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	9/20/19
6th Judicial Circuit Court, Oakland County, MI, No. 2018-168696-NF	Woolsey, Tyler v. Broadspire Services, Inc.; Broadspire National Services; Broadspire Management Services, Inc., et al.	9/24/18	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/19/18
U.S. District Court for the Eastern District of Virginia, No. 1:18-cv-01246-LO-TCB	Rosman, Daniel v. E*Trade Financial Corporation, Health Benefits Plan; E*Trade Financial Corporation; and Aetna Life Insurance Company	9/28/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/12/18
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00318-BCW	D.H. v. Altius Health Plans of Utah, Inc.	10/1/18	Benefit Coverage Determination	Contract 17054.82	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Riverside County, Palm Springs Branch, CA, No. PSC1806153	CareForward Health, LLC v. Aetna Health and Life Insurance Company; T. Anderson; S. Bromley; and Does 1-10, inclusive	10/10/18	Benefit Coverage Determination	Contract 27087.68	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/17/19
District Court, Wyandotte County, KS, No. 2018-CV-000834	Hayden, Jennifer v. Aetna Life Insurance Company; and Omar J. Khan, M.D.	10/11/18	Benefit Coverage Determination	Unspecified	None	Open	
Justice Court, Las Vegas Township, Clark County, NV, No. 18A003388	Ku, James v. Aetna Health Inc.	10/12/18	Benefit Coverage Determination	Contract 586.32	None	Closed - Settled	1/22/19
U.S. District Court for the Western District of Pennsylvania, No. 2:18-cv-01375-CRE	Gianantonio, Krista Fullen v. Aetna Life Insurance Company d/b/a Aetna	10/15/18	Benefit Coverage Determination	Contract 10291.00	None	Closed - Settled	8/17/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
165th Judicial District Court, Harris County, TX, No. 2018-75496	Taylor, Jonathan and Britton Taylor v. Aetna Health Insurance	10/18/18	Benefit Coverage Determination	Contract 100000.00 Punitive 1000000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	3/26/19
U.S. District Court for the Northern District of Illinois, Eastern Division, No. 1:18-cv-07136	I.P. o/b/o D.S. v. Fox Health Plan; and Aetna Life Insurance Company	10/24/18	Benefit Coverage Determination	Contract 155000.00	None	Open	
Superior Court, Morris County, NJ, No. MRS-L-2104-18	Hennighan, Joseph and Barbara v. New Jersey Spine Center; Aetna, Inc., et al.	10/29/18	Benefit Coverage Determination	Unspecified	None	Open	
District Court, South Boston, Commonwealth of Massachusetts, No. 1803CV000099	Volney, Bron v. Aetna Inc.	10/29/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	6/7/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
1st Judicial District Court, Carson City, NV, No. 18OC002691B	Sarajena, Jonathan v. Renown Health; Aetna Health, Inc.; and Does I-V	11/6/18	Benefit Coverage Determination	Contract 22000.00	None	Closed - Pretrial - Aetna Dismissed by Court Order	3/29/19
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-00878-BCW	Tracey A.; Michael M.; and L.M. v. Aetna Health and Life Insurance Company; and the Synthetic Genomics Health Plan	11/7/18	Benefit Coverage Determination	Contract 255000.00	None	Open	
Superior Court, Clear Lake Circuit, IN, No. 45D09-1811-SC-005953	Hein, Lavern v. Antonio Trejo; and David Stambaugh	11/8/18	Benefit Coverage Determination	Contract 2759.55	None	Closed - Settled	1/22/19
Magisterial District Court, Montgomery County, Commonwealth of Pennsylvania, No. MJ-38103-CV-0000274-2018	Feldman, Robyn and Lawrence v. Aetna Health Holdings LLC	11/14/18	Benefit Coverage Determination	Contract 12000.00	None	Closed - Settled	2/22/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Municipal Court, Small Claims, Berea County, OH, No. 18CVI02855	Sberna, Robert v. Aetna Life Insurance Company	11/30/18	Benefit Coverage Determination	Contract 6000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	1/17/19
Superior Court, Small Claims, Camden County, NJ, No. CAM-SC-2283-18	Edney-James, Beverly v. Aetna	12/3/18	Benefit Coverage Determination	Contract 397.00	None	Closed - Settled	1/15/19
17th Judicial Circuit Court, Broward County, FL, No. CACE-18-027922	Houlahan, Brian and Jessica v. Coventry Health Care of Florida, Inc.; Healthcare Insurance Solutions of America Inc.; and Darren Fishman, Individually and as Agent of Coventry and Healthcare Insurance Solutions of America	12/3/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/15/19
Superior Court, Morris County, NJ, No. MRS-DC-8598-18	AHS Hospital Corp. d/b/a Morristown Medical Center v. John J. Crandall and/or John Doe (1-10) v. Aetna Insurance - NOT YET SERVED	12/6/18	Benefit Coverage Determination	Contract 750.00	None	Closed - Complaint Withdrawn	3/11/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Essex County, NJ, No. ESX-DC-017076-18	Pleasantdale Ambulatory Care v. Frank G. Anagboguh v. Aetna Insurance Corporation	12/6/18	Benefit Coverage Determination	Contract 1205.34	None	Open	
Civil Court, Small Claims, New York County, NY, No. 16727 SCNY 2018 1	Torok, Ronald v. Aetna	12/6/18	Benefit Coverage Determination	Contract 1300.00	None	Closed - Settled	4/30/19
Superior Court, 1st Judicial District, Juneau, AK, No. 1JU-18-01061CI	Timothy, Jackie and Kammie Timothy v. Aetna Life Insurance Company	12/10/18	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, Essex County, NJ, No. ESX-DC-2569-18	Vicarisi, Pamela v. Aetna Insurance	12/10/18	Benefit Coverage Determination	Contract 3570.00	None	Open	

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of Florida, Fort Pierce Division, No. 2:18-cv-14502-RLR	Golphin, Sharon v. Aetna Life Insurance Company; and Kids Connected by Design, Inc.	12/12/18	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/8/19
Circuit Court, Chancery Division, Cook County, IL, No. 2018-CH-15554	Fletcher, Christopher and Theresa Goldberg v. Aetna Inc.	12/14/18	Benefit Coverage Determination	Contract 110000.00	None	Closed - Settled	8/15/19
288th Judicial District Court, Bexar County, TX, No. 2018CI23757	McAlpin, Ronald L. v. Aetna Life Insurance Company	12/19/18	Benefit Coverage Determination	Contract 70000.00	None	Closed - Settled	11/5/19
U.S. District Court for the District of Utah, Central Division, No. 2:18-cv-01964-RJS	Louis L.; and L.L. v. Aetna Health and Life Insurance Company; and the Cox Enterprises Inc. Welfare Benefits Plan	12/21/18	Benefit Coverage Determination	Contract 135000.00	None	Open	

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Magisterial District Court, Delaware County, Newton Square, Commonwealth of Pennsylvania, No. MJ-32243-CV-0000237-2018	Gupta, Jyoti v. PayFlex Systems USA, Inc.	12/31/18	Benefit Coverage Determination	Contract 3580.22	None	Closed - Settled	6/14/19
U.S. District Court for the District of New Jersey, No. 3:19-cv-00595-AET-DEA	Nugent, Daniel, individually and on behalf of Brandon Nugent v. Aetna, Inc.; Aetna Health, Inc.; and Aetna Life Insurance Company	1/17/19	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, Middlesex County, NJ, No. MID-L-0724-19	Sanders, Clayton and Jaszimon Sanders v. Robert Suydam; Auchter Industrial VAC; John Does 1-10; and/or ABC Companies/Corporations 1-10; and Aetna Health Insurance, Inc.	1/21/19	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	5/9/19
U.S. District Court for the Eastern District of Kentucky, Northern Division, At Ashland, No. 0:19-cv-00010-HRW	Jordan, Keri v. Aetna Life Insurance Company; and Bon Secours Health System, Inc. Health Plan	1/29/19	Benefit Coverage Determination	Contract 19394.92	None	Closed - Settled	6/12/19

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:19-cv-00070-EJF	Daniel R. and Barbara M., individually and on behalf of I.M., a minor v. Aetna Health and Life Insurance Company; and the ProofPoint, Inc. and Wholly Owned Subsidiaries Health Plan 51-0414846	1/30/19	Benefit Coverage Determination	Contract 197000.00	None	Open	
Superior Court, Middlesex County, NJ, No. MID-DC-16909-18	Atlantic Plastic & Hand Surgery, P.A. v. Jessica Taveras and Alexis Rodriguez v. Aetna, Inc.	2/7/19	Benefit Coverage Determination	Contract 8565.92	None	Closed - Settled	8/20/19
U.S. District Court for the Middle District of Louisiana, No. 3:19-cv-00112-SDD-EWD	Wheeler, Tamra v. Aetna Life Insurance Company	2/20/19	Benefit Coverage Determination	Contract 13590.00	None	Open	
Superior Court, Bergen County, NJ, No. BER-DC-1867-19	Franklin Lakes Medical Imaging v. Thomas and Lea Pease v. Aetna Life Insurance Company	2/22/19	Benefit Coverage Determination	Contract 2700.00	None	Open	

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Morris County, NJ, No. MRS-DC-0533-19	Hackensack University Medical Center v. Ashwin Shah v. Aetna, Inc.	2/22/19	Benefit Coverage Determination	Contract 3135.80	None	Closed - Pretrial - Aetna Dismissed Voluntarily	4/3/19
Lima Municipal Court, Allen County, OH, No. 18CVF03376	Lima Memorial Health Systems v. Kenneth B. McLaughlin and Kimberly R. McLaughlin v. Aetna Insurance; and Aetna Inc.	2/22/19	Benefit Coverage Determination	Unspecified	None	Closed - Settled	7/19/19
1st Judicial District Court, Carson City, NV, No. 19OC000411B	Sarajena, Jonathan v. Renown Regional Medical Center; Aetna Health, Inc.; and Does I-V	2/28/19	Benefit Coverage Determination	Contract 22000.00	None	Closed - Settled	10/29/19
Superior Court, Mercer County, NJ, No. MER-SC-000140-19	Vallejo, Dunia C. Mendez and Jonathan T. Yazinski v. Aetna, Inc.	2/28/19	Benefit Coverage Determination	Contract 1198.00	None	Closed - Settled	4/3/19

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:19-cv-00153-BCW	Adam B. and A.B. v. Aetna Health and Life Insurance Company	3/5/19	Benefit Coverage Determination	Contract 31000.00	None	Open	
Court of Common Pleas, Philadelphia County, PA, No. 180702519	Thomas Jefferson University Hospitals, Inc. v. Felix and Tina Ezzio v. Aetna Health Insurance	3/5/19	Benefit Coverage Determination	Contract 20094.82	None	Open	
County Court, Adams County, CO, No. 2018C47977	BC Services Inc. v. Elizabeth Kerr v. Aetna Health Insurance Co.	3/11/19	Benefit Coverage Determination	Unspecified	None	Open	
County Court at Law 2, Fort Bend County, TX, No. 19-CCV--064560	Pennell, Kevin and Stephanie Pennell v. ADP TotalSource, Inc.; and Aetna Health Inc.	3/20/19	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed by Court Order	10/21/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Bridgeport, CT	Donne, Walter J. v. Aetna Health Insurance	3/25/19	Benefit Coverage Determination	Compensatory 4255.66	None	Closed - Settled	9/20/19
Small Claims Court, Mansfield, Tarrant County, TX, No. JP07-2019-SC00009412	Gray, Gregory v. Aetna Insuance via Robin Whitehead	3/26/19	Benefit Coverage Determination	Unspecified	None	Closed - Failure of Plaintiff to Prosecute	5/31/19
Circuit Court, Cook County, IL, No. 2019L003276	Maraist, Carolyn v. Aetna Inc.; Coventry Healthcare Inc.; Coventry Healthcare of Illinois, Inc.; and MHNet Behavioral Health Inc.	3/26/19	Benefit Coverage Determination	Compensatory 250000.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	5/31/19
U.S. District Court for the District of Utah, Central Division, No. 2:19-cv-00201-PMW	Neil W.; Stacey W.; and J.W. v. Oxford Health Insurance Company; United Behavioral Health; Aetna Health Insurance Company; and The ADP TotalSource, Inc. Health and Welfare Plan	3/26/19	Benefit Coverage Determination	Unspecified	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/20/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
20th Judicial Circuit Court, Lee County, FL, No. 19-CA-2045	Summerall, Cindy and Samuel Summeral v. Aetna Health, Inc.	4/9/19	Benefit Coverage Determination	Unspecified	None	Open	
District Court, Johnson County, KS, No. 19LA03292	Olathe Medical Center v. Kirk E. Lane v. Aetna Better Health of Kansas Inc.	4/18/19	Benefit Coverage Determination	Unspecified	None	Closed - Settled	11/19/19
U.S. District Court for the Southern District of Texas, Houston Division, No. 4:19-cv-01490	Emma E. v. Aetna Life Insurance Company; and ExxonMobil Medical Plan	4/24/19	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, Small Claims, Santa Clara County, CA, No. 19SC078605	Mimar, Tibet v. Aetna Better Health of California	4/29/19	Benefit Coverage Determination	Contract 2499.00	None	Closed - Settled	12/5/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Southern District of New York, No. 1:19-cv-04086-CM	Dello Russo, Laura v. Aetna Life Insurance Company; and Aetna Health Inc.	5/7/19	Benefit Coverage Determination	Compensatory 117510.00	None	Open	
U.S. District Court for the Northern District of California, No. 4:19-cv-02512-KAW	Kazda, Michala, on behalf of herself and all other similarly situated, v. Aetna Life Insurance Company	5/9/19	Class Action	Unspecified	None	Open	
Justice Court, Maricopa County, AZ, No. CC2019097047SC	Murray, Roy v. Aetna	5/15/19	Benefit Coverage Determination	Contract 2500.00	None	Closed - Settled	7/17/19
Circuit Court, Racine County, WI, No. 2018CV001768	Medical College of Wisconsin Inc. v. Lori L. Langenfeld v. Aetna Life Insurance Company	5/17/19	Benefit Coverage Determination	Unspecified	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court of the District of Columbia, Civil Division, Washington D.C., Case no. 2019SC2003610	Fackler, Erin v. Aetna Life Insurance Company	5/20/19	Benefit Coverage Determination	Compensatory 1252.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	9/19/19
U.S. District Court for the Northern District of Illinois, Eastern Division, No. 1:19-cv-03454	C.M. (Maraist) v. Aetna, Inc.; Coventry Healthcare Inc.; Coventry Healthcare of Illinois, Inc.; and MHNet Behavioral Health Inc.	5/22/19	Benefit Coverage Determination	Compensatory 250000.00	None	Open	
165th Judicial District Court, Harris County, TX, No. 2019-35634	Ainsworth, Christian v. Aetna Life Insurance Company; and Teachers Retirement System of Texas	5/23/19	Benefit Coverage Determination	Compensatory 244000.00	None	Open	
District Court, Bradford County, Commonwealth of Pennsylvania, No. CV-132-2019	Ragan, Jeff v. Glenn O. Hawbaker Inc.; Guthrie Clinic; and Aetna	5/23/19	Benefit Coverage Determination	Contract 492.80	None	Closed - Settled	12/12/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Small Claims, San Diego County, CA, No. 37-2019-00026470-SC-SC-CTL	Bragg, Yasbleidy Estella v. Aetna Life Insurance Company, Inc.	5/23/19	Benefit Coverage Determination	Unspecified	None	Closed - Settled	10/1/19
U.S. District Court for the District of Utah, Central Division, No. 2:19-cv-00365-EJF	William G.; and W.G. v. Aetna Health and Life Insurance Company; and Lockheed Martin Corporation Group Insurance Plan for Retired Employees	5/24/19	Benefit Coverage Determination	Compensatory 136000.00	None	Open	
1st District Court, Suffolk County, Ronkonkoma, NY, No. CV-000125-18CE	John T. Mather Hospital v. Teresa Fay v. Aetna Health Inc.	5/29/19	Benefit Coverage Determination	Contract 4256.42	None	Open	
Superior Court, Essex County, NJ, No. ESX-DC-2727-19	Short Hills Surgery Center v. Ransom Shannon v. Aetna Life Insurance Co.	5/31/19	Benefit Coverage Determination	Compensatory 9685.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
40th Judicial Circuit Court, Newton County, MO, No. 18NW-CV00414	Freeman Health System v. Kathryn A. McFarland v. Coventry Health and Life Insurance Company	6/11/19	Benefit Coverage Determination	Contract 28715.68	None	Closed - Settled	10/1/19
4th Judicial Circuit, County Court, Duval County, FL, No. 16-2019-SC-008061	University of Florida Jacksonville Physicians, Inc. v. David Samples v. Aetna Life Insurance Company	6/24/19	Benefit Coverage Determination	Unspecified	None	Open	
Commonwealth of Massachusetts, Commission Against Discrimination, No. 19SEM01895	Pangborn, Alexander v. Care Alternatives of Massachusetts, LLC d/b/a Ascend Hospice; Care One Management, LLC; and Aetna Life Insurance Company	6/28/19	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, Law Division, Special Civil Part, Small Claims, Burlington County, NJ, No. BUR-SC-0888-19	Schepps, Mark v. Aetna Life Insurance Company	7/8/19	Benefit Coverage Determination	Contract 960.00 Costs 42.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
284th Judicial District Court, Montgomery County, TX, No. 19-07-09448	Holick, Kimberly v. Aetna Life Insurance Company	7/11/19	Benefit Coverage Determination	Contract 1000000.00	None	Open	
Superior Court, Warren County, NJ, No. WRN-DC-1212-19	AHS Hospital Corp. d/b/a Hackettstown Medical Center and Morristown Medical Center v. John C. Malley and/or John Doe (1-10) v. Aetna Health Inc.	7/11/19	Benefit Coverage Determination	Contract 8357.43	None	Open	
Circuit Court, Greene County, MO, No. 1931-CC00849	MacPherson, Kenneth v. Aetna Life Insurance Company	7/15/19	Benefit Coverage Determination	Contract 108015.00	None	Open	
U.S. District Court for the District of Utah, Central Division, No. 2:19-cv-00500-DBP	Julian D.; and C.D. v. Aetna Life Insurance Company	7/16/19	Benefit Coverage Determination	Contract 88000.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Arizona, No. 2:19-cv-04751-SPL	Altman, Fiona v. Vivendi U.S. Retiree Benefits Program; and Aetna Life Insurance Company	7/18/19	Benefit Coverage Determination	Contract 66000.00	None	Open	
Circuit Court, Small Claims, Marion County, OR, No. 19SC32130	Weiherer, Daniel v. Aetna Life Insurance Company	7/25/19	Benefit Coverage Determination	Contract 560.00 Costs 165.00	None	Closed - Pretrial - Aetna Dismissed Voluntarily	10/21/19
Civil Court, Small Claims, Queens County, NY, No. 2552 SCQ 2019 1	Becker, Liza v. Aetna Health Inc.	7/26/19	Benefit Coverage Determination	Contract 5000.00	None	Closed - Settled	10/2/19
Judicial District Court, Small Claims, Lapeer County, MI, No. 19-01768-SC	Foster, Gary A. v. Aetna, Inc.	7/26/19	Benefit Coverage Determination	Contract 5870.00	None	Closed - Settled	10/21/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Northern District of Oklahoma, No. 4:19-cv-00409-GKF-FHM	Bragg-Sutton, John D. v. Aetna Life Insurance Company	7/26/19	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, Cowlitz County, WA, No. 19-2-00723-08	Randles, Jimmy v. Aetna Life Insurance; and USNR, LLC	7/29/19	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, Burlington County, NJ, No. BUR-L-1569-19	Folcher, Nikki v. Aetna Life Insurance Company	7/30/19	Benefit Coverage Determination	Contract 2464.90	None	Open	
District Court, Small Claims Division, Johnson County, KS, No. 19SC301	Atkins, Patrick V. v. Aetna	8/2/19	Benefit Coverage Determination	Contract 485.00 Costs 69.00	None	Closed - Settled	11/8/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the Central District of California, No. 2:19-cv-06840	Hendricks, Brian; and Andrew Sagalongos, on behalf of themselves and all others similarly situated v. Aetna Life Insurance Company	8/7/19	Class Action	Unspecified	None	Open	
U.S. District Court for the Eastern District of California, Sacramento Division, No. 2:19-cv-01560-MCE-CKD	Price, Mindy v. Aetna Life Insurance Company; and Costco Employee Benefits Program	8/12/19	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, Bergen County, NJ, No. BER-DC-4006-19	Hackensack University Medical Center v. Jenny Lozada v. Aetna a/k/a Aetna Health, Inc.; and John Does 1-10	8/16/19	Benefit Coverage Determination	Contract 182.00 Costs 50.00	None	Open	
U.S. District Court for the Southern District of Texas, Houston Division, No. 4:19-cv-03122	Marcoux, Karen v. Aetna Life Insurance Company	8/21/19	Benefit Coverage Determination	Contract 11550.00	None	Closed - Settled	12/12/19

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Civil Court of the City of New York, County of Richmond, Case no. CV-004963-19/RI	Shuk, Hoichi v. Aetna Inc.	8/26/19	Benefit Coverage Determination	Contract 1655.00	None	Open	
Justice of the Peace, Precinct 1, El Paso County, TX, No. 119-00161-CV	J.M., individually and as next friend of M.M. v. Aetna Life Insurance Company	8/28/19	Benefit Coverage Determination	Unspecified	None	Closed - Settled	12/2/19
U.S. District Court for the Eastern District of Pennsylvania, No. 2:19-cv-03902-AB	Molloy, Paul and Jacqueline Molloy, on behalf of themselves and all others similarly situated v. Aetna Life Insurance Company; and Aetna Inc.	8/28/19	Class Action	Unspecified	None	Open	
Superior Court, Ocean County, NJ, No. OCN-DC-7907-19	AHS Hospital Corp. d/b/a Morristown Medical Center v. Elizabeth G. Garruto v. Aetna Inc.	8/30/19	Benefit Coverage Determination	Contract 1873.31 Costs 57.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Bergen County, NJ, No. BER-L-6226-19	Zougras, Peter and Alexa Zougras v. Aetna Insurance Company	9/3/19	Benefit Coverage Determination	Contract 23984.01	None	Open	
U.S. District Court for the District of Utah, Central Division, No. 2:19-cv-00615-BSJ	John H.; and J.H. v. Beacon Health Options Inc.; Aetna Life Insurance Company; Dell Inc. Comprenensive Welfare Benefits Plan; and Quest Software Inc. Benefit Plan	9/3/19	Benefit Coverage Determination	Contract 85000.00	None	Open	
Superior Court, Small Claims, Los Angeles County, CA, No. 19STSC09983	Palaniappan, Ramasamy v. Aetna Life Insurance Company; and Stantec Consulting Services Inc.	9/5/19	Benefit Coverage Determination	Contract 5561.09	None	Closed - Settled	12/4/19
Superior Court, Passaic County, NJ, No. PAS-L-2872-19	Morel, Ana v. New Jersey Manufacturers Insurance Company; Aetna Health Insurance Company; and John Does 1-20	9/13/19	Benefit Coverage Determination	Unspecified	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Small Claims Division, Sacramento County, CA, No. 19SC03358	Cheruku, Suman Kumar; and Samantha Donthireddy v. Aetna Health and Life Insurance Company	9/18/19	Benefit Coverage Determination	Contract 387.70	None	Closed - Settled	11/7/19
U.S. District Court for the Eastern District of Pennsylvania, No. 5:19-cv-04391-EGS	Herzog, David v. Choice POS II Plan (BMCS Open Choice Plans); Aetna Life Insurance Company; and Perkiomen Valley School District	9/18/19	Benefit Coverage Determination	Unspecified	None	Open	
133rd Judicial District Court, Harris County, TX, No. 2019-68215	Wiggs, Kyle v. Aetna Life Insurance Company	9/19/19	Benefit Coverage Determination	Contract 33768.00	None	Open	
Superior Court, Bergen County, NJ, No. BER-DC-13283-19	Havriliak, M.D., Damian v. Romaine Medford v. Aetna Health Home Insurance	9/20/19	Benefit Coverage Determination	Unspecified	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:19-cv-00673-TC	David W.; and A.W. v. Aetna Life Insurance Company; and the Cox Enterprises Inc. Welfare Benefits Plan	9/23/19	Benefit Coverage Determination	Contract 35000.00	None	Open	
Superior Court, Somerset County, NJ, No. SOM-DC-4249-19	Gill, Gurinder Singh v. Aetna, Inc.	9/27/19	Benefit Coverage Determination	Contract 3615.00 Costs 407.00	None	Open	
Superior Court of California, County of Santa Clara, Case no. 19SC079991	Lee, Duke v. Aetna Life Insurance Company	10/2/19	Benefit Coverage Determination	Contract 1369.60	None	Closed - Settled	12/4/19
U.S. District Court for the District of Minnesota, No. 0:19-cv-02648-SRN-LIB	Mulugeta, Estela v. Aetna Insurance Company	10/3/19	Benefit Coverage Determination	Contract 10243.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Camden County, NJ, No. CAM-DC-8759-19	Butler, Richard v. Sklar Law, LLC; Andrew Sklar, Esquire v. Aetna; and Cigna	10/4/19	Benefit Coverage Determination	Contract 3705.00	None	Open	
U.S. District Court for the District of Connecticut, No. 3:19-cv-01579-VLB	Curtis, Dennis E., on his own behalf and on behalf of all others similarly situated v. Aetna Life Insurance Company	10/8/19	Class Action	Unspecified	None	Open	
Circuit Court, Williamson County, TN, No. 2019-534	Burch-Byers, Cathy Diane v. John Boykin Byers, III; and Aetna	10/11/19	Benefit Coverage Determination	Contract 12416.16	None	Open	
U.S. District Court for the District of Utah, Central Division, No. 2:19-cv-00858-DBP	Amy M.; and C.M. v. Aetna Health Inc.	11/1/19	Benefit Coverage Determination	Contract 153000.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, San Diego County, CA, No. _____	Makowski, Jr., Casimir J. v. Aetna; and Does 1-10	11/2/19	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, 3rd Judicial District, Palmer, AK, No. 3PA-19-1667 CI	Bassett, Randi J. v. Aetna, Inc. d/b/a Aetna Life Insurance Company and Aetna Resources LLC	11/5/19	Benefit Coverage Determination	Contract 100000.00	None	Open	
Superior Court, Hudson County, NJ, No. HUD-DC-12024-19	OB/GYN Women's Wellness, PC v. Safia Begum v. Aetna Inc. d/b/a Aetna Life Insurance Company; ABC Corp. 1-5; and John Does 1-5	11/8/19	Benefit Coverage Determination	Contract 15000.00	None	Open	
Superior Court, Los Angeles County, CA, No. 19STSC12730	Fisher, Sarah v. Aetna Life Insurance Company	11/14/19	Benefit Coverage Determination	Contract 10000.00	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
U.S. District Court for the District of Utah, Central Division, No. 2:19-cv-00928-EJF	Joe M.; and Christi M. v. Aetna; Geometry Global; WPP Group USA, Inc.; WPP Group USA, Inc. Benefits Plan	11/19/19	Benefit Coverage Determination	Contract 219550.00	None	Open	
Superior Court, Union County, NJ, No. UNN-L-4067-19	Alberti, Fabio v. Aetna Inc.	11/21/19	Benefit Coverage Determination	Contract 15623.33	None	Open	
U.S. District Court for the Central District of California	Sanchez, Tabitha v. ExxonMobil Medical Plan; and Does 1-10	11/21/19	Benefit Coverage Determination	Contract 170750.00	None	Open	
U.S. District Court for the District of Delaware, No. 19-2188	Goldstein, Paul R. v. Aetna Life Insurance Company; and Sanofi-Aventis U.S., LLC	11/25/19	Benefit Coverage Determination	Unspecified	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
17th Judicial Circuit Court, Broward County, FL, No. CACE-19-023180	Coleman, James v. Aetna Life Insurance Company	12/3/19	Benefit Coverage Determination	Unspecified	None	Open	
Civil Court, Small Claims, New York County, NY, No. 2507 SCNY 2019 1	Isaacson, Allen I. v. Aetna Life Insurance Company (No. 2507 SCNY 2019 1)	12/4/19	Benefit Coverage Determination	Unspecified	None	Open	
Civil Court of the City of Ney York, Case no. 2019031803317	Greenberg, Sanford H. v Aetna Health, Inc.	12/10/19	Benefit Coverage Determination	Contract 5000.00	None	Open	
U.S. District Court for the Northern District of California, No. 5:19-cv-08244-NC	Michael D. v. Aetna Life Insurance Company; The Avaya Inc. Medical Expense Plan for Salaried Employees; and Does 1-10	12/18/19	Benefit Coverage Determination	Unspecified	None	Open	

Table D - Aetna's Litigation for Lines of Business Other than Medicaid and Medicare

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Superior Court, Small Claims Division, Los Angeles County, CA, No. 191bsc03924	Klein, Pauline and Michael Wooten v. Aetna Life Insurance Co.	12/19/19	Benefit Coverage Determination	Unspecified	None	Open	
Superior Court, Small Claims Division, Los Angeles County, CA, No. 191bsc03945	Cunningham, Emily and Michael A. Wooten v. Aetna Life Insurance Co.	12/19/19	Benefit Coverage Determination	Unspecified	None	Open	

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Table E - CVS Health Litigation

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Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Supreme Court of State of NY	Barry Rozen v. CVS Caremark Corporation, et al.	05/07/2010	Non-coverage of medication	$1019.94	None awarded, reached confidential settlement	Closed	7/14/2010
Franklin County Municipal Court, Columbus Ohio	Robert Sammons v. Caremark	07/31/2012	Plaintiff alleges they were not reimbursed for medication	$260.00 + 3% annum	None awarded, settled for $332.00	Closed	8/31/2012
Ramsey County, MN District Court	Paula J. Morphew v. Caremark PCS Health, LLC, d/b/a CVS Caremark and Myron Frans, in his official capacity as Commissioner of Minnesota Management and Budget	3/2/18	Alleged limits on opioid medication constituted a breach of contract	Declaratory injunctive relief	None	Case resolved through a confidential settlement agreement and dismissed by plaintiff.	4/19
U.S. District Court (SDNY)	Rebecca Weinreb and David Weinreb v. Xerox Business Services, LLC Health and Welfare Plan; Conduent HR Consulting, LLC; and Caremark PCS Health LLC	1/3/18	Alleges non-coverage of fentanyl violates ERISA and discrimination laws	Declaratory injunctive and monetary relief	None	The district court granted defendants' motions to dismiss all claims. Plaintiffs have sought reconsideration of that decision and also filed an	N/A

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
						appeal to the Second Circuit. The reconsideration motion is fully briefed and awaiting a decision. The appeal in the Second Circuit has been stayed pending outcome of the reconsideration motion.	
Superior Court of New Jersey Chancery Division – Ocean County	Laurena Staub v. Caremark, LLC; Bollinger, Inc; Fairview Insurance Agency Associates; Brick Township Board of Education; John Does 1-10 (unknown individuals); Jane Does 1-10 (unknown individuals); and ABC Companies 1-10 (unknown entities)	9/23/16	Alleged limits on Imitrex and Zofran violated ERISA and state law and constituted a breach of contract and breach of implied covenant of good faith and fair dealing	Declaratory injunctive relief	None	Case resolved through a confidential settlement agreement and dismissed by plaintiff.	1/19

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
Albemarle County Court, VA	Taff, Laurence G. v. SilverScript Insurance Company	4/25/17	Non-coverage of medication	$5,000	None	Closed, judgment in favor of SilveScript Insurance Company	Closed
New Castle Court, DE	Christie, Dennis v. Silverscript Insurance Company, CVS Pharmacy	10/25/15	Plaintiff sued over copayments charged	$1,000	$314	Closed	Closed
Harris County Court, TX	Sarrami, Samira v. CaremarkPCS Health. LLC	4/10/17	Non-coverage of medication	Unspecified	None	Closed	2/24/16
Vigo Superior Court, Terre Haute, Indiana	Alberto Friedmann v. CVS Caremark Customer Care	8/28/2019	Plaintiff alleges lengthy time to receive prior authorization approval, which resulted in out of pocket medication cost.	$6,000	None awarded; settled for $500.	Closed	10/22/19

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Attachment G

Kentucky | Transforming Health Care | **Aetna**

Attachment G
Sanctions Tables

Table F - Aetna Better Health® of Kentucky Sanctions .....Att G-3

Table G - Aetna's Medicaid Sanctions in States Other than Kentucky .....Att G-29

Table H - Aetna's Medicare Sanctions.....Att G-57

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Table F - Aetna Better Health® of Kentucky Sanctions

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Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/7/2014	Other	WellCare and Coventry are set to be sued in federal court in KY for alleged violations of EMTALA and related laws/regulations, which generally require (1) a provider to perform a medical screening exam to anyone who presents to an ER to determine whether an emergency medical condition exists; and (2) a payor/MCO to cover those emergency services without regard to prior auth or to the provider's contractual relationship with that payor/MCO.	Notice to Cure	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/18/2015	Other	Aetna employee sent an unsecure email containing PHI to the Department of Insurance.	Notice to Cure	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/18/2015	Reporting – other data	State Report 15 did not reflect all the subcontractors the Plan utilizes.	Notice to Cure	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/18/2015	Reporting – other data	CoventryCares submitted a test file that failed six threshold edits for NPI and taxonomy codes.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/16/2015	Other	DMS received a complaint from a member stating violation of Privacy in her member mailing.	Notice to Cure	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/29/2015	Reporting – encounter data	CoventryCares Pharmacy Subcontractor (ESI) submitted an encounters file that caused the splitter to abnormally end with HP system.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/29/2015	Reporting – other data	Report clarification not received in a timely manner.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/11/2015	Reporting – other data	The Grievance and Appeals state report 13 did not include requests for disenrollment for cause sent to the Plan by the state.	Notice to Cure	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/17/2015	Other	Failure to meet pre-determined norms and/or goals of demonstrable or sustained improvement.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/24/2015	Network deficiency	Network Adequacy- Only had 93% out of the required 95% network adequacy for dermatologists in regions 7 and 2.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/31/2015	Reporting – encounter data	N/A	Sanction	$188,900.00	Paid

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/1/2016	Reporting – encounter data	Action plan requested to address Encounter Errors- Avesis 277U and 277UESC files.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/2/2016	Other	Provider Network file errors.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/8/2016	Claims processing accuracy	Denial of provider claims for CPT code 92626.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/9/2016	Claims processing timeliness	Delayed provider claims payment for The Kidney and Hypertension Center of Cincinnati.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/10/2016	Other	Action plan to address Avesis (vendor) provider manual hours of operation manual.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/11/2016	Other	Action Plan to address payments of diabetic supplies for dual eligible members billed under DME fee schedule.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/11/2016	Other	Action plan to address failure to credential and enroll provider within 90 days.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/21/2016	Other	Denial of cover services for Central KY Radiology.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/25/2016	Reporting – other data	Report 11 indicated 1 call out of 1,843 calls received a busy signal to the Behavioral Health Services Hotline.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/31/2016	Reporting – encounter data	N/A	Notice of Non-Compliance	$131,385.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/1/2016	Reporting – other data	Failure to submit TPL files in a timely manner.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/4/2016	Reporting – encounter data	N/A	Sanction	$144,250.00	Paid

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/4/2016	Other	Untimely response to grievance and appeals	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/4/2016	Other	Monitoring for subcontractors delegated vendor audit dates not listed.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/6/2016	Other	Providers complaints of untimely responses to Grievance and Appeals..	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/8/2016	Other	Education and training of Provider Relations Representatives.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/11/2016	Other	Four Grievances received as a result of member access issues.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/11/2016	Reporting – other data	Report 13 indicated there were no Member Access issues when we have dermatology access issues.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/30/2016	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$144,250.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/9/2016	Other	Untimely resolution to void a claim from provider/DMS	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/10/2016	Network deficiency	Lack of dermatologists	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/12/2016	Network deficiency	Network Adequacy and Proximity Report errors.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/23/2016	Other	Properly educating providers on MHNet transition.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/26/2016	Claims processing timeliness	N/A	CAP	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/26/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/31/2016	Reporting – encounter data	N/A	Sanction	$225,670.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/31/2016	Other	Unsecure email sent from subcontractor to State	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/31/2016	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$225,670.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/2/2016	Other	Unprotected email from subcontractor (Avesis) to DMS.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/7/2016	Reporting – encounter data	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/9/2016	Access standards	Result if IPRO audit; dental access and availability standards not met	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/9/2016	Claims processing accuracy	Claim that was sent to reconsideration rather than an appeal.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/9/2016	Claims processing accuracy	Failure to support provider on rejected claims.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/14/2016	Reporting – encounter data	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/21/2016	Reporting – other data	CAP- Plan submitted an empty 837I test file which could not be processed.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/23/2016	Other	IPRO findings for Dental (Avesis) Access and Availability survey.	CAP	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/29/2016	Network deficiency	Lack of dermatologists	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/29/2016	Other	Untimely Response to state inquiry	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/29/2016	Reporting – encounter data	N/A	Sanction	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/30/2016	Other	CAP - requested for untimely resolution to a void request from provider/DMS.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/30/2016	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$164,155.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/30/2016	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/8/2016	Other	Plan provided incomplete information for Program Integrity Audit	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/14/2016	Network deficiency	Network Adequacy deficiency in Dermatologist.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/14/2016	Other	Untimely responses to provider and DMS inquiries.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/15/2016	Other	Lack of ability to specifically identify SIU investigations originating from service verifications letters	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/15/2016	Other	Concern related to low SIU staff to case load ratio	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/15/2016	Other	Plan provided incomplete response to state inquiry	Letter of Concern	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/15/2016	Other	Plan response to DMS inquiry regarding TPL failed to specify timeframes in the Plan's processes.	Letter of Concern	N/A	Open
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/20/2016	Reporting – encounter data	N/A	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/20/2016	Other	Plan provided incomplete information to DMS request for information for CMS Program Integrity Audit.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/26/2016	Reporting – other data	Failure to response to multiple state requests	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/28/2016	Reporting – encounter data	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/28/2016	Reporting – encounter data	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/28/2016	Reporting – encounter data	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/28/2016	Reporting – encounter data	N/A	Sanction	$229,250.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/31/2016	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$229,250.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/3/2016	Reporting – encounter data	Encounter Void process failed to include complete and detailed information.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/3/2016	Other	TPL failed to specify timeframes in the Plan's processes.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/3/2016	Other	Subcontractor Provider representative failed to provide complete and detailed information.	Notice of Non-Compliance	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/3/2016	Other	Result of information provided at CMS focused review in 2016.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/3/2016	Other	Result of information provided at CMS focused review in 2016.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/9/2016	Reporting – other data	TPL Resource File errors, including missing fields, incorrect record length, etc.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/10/2016	Other	Untimely Response to state inquiry	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/10/2016	Reporting – encounter data	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/10/2016	Reporting – encounter data	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/17/2016	Other	DMS was contacted by a Provider regarding a claim that needs to void. Plan also failed to respond to request from DMS to outreach to the provider.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/24/2016	Other	Plan failed to respond to multiple requests from the DMS in required timeframes.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/24/2016	Other	Plan failure to respond to multiple requests from the DMS in required timeframes.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/25/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/25/2016	Other	Provider system issues related to system migration	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/29/2016	Claims processing accuracy	N/A	CAP	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/29/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/29/2016	Claims processing timeliness	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/29/2016	Other	Failure by plan staff to follow protocol for coordination between two state agencies	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/29/2016	Reporting – encounter data	N/A	Sanction	$26,381.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/31/2016	Other	Plan staff did not follow protocol regarding coordination with the DMS and Department of Community Based Services.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/31/2016	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$26,381.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/1/2016	Claims processing accuracy	N/A	Withhold and Forfeiture/CAP	$141,839.00	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/1/2016	Other	Failure to cooperate under Section 28.0, Provider Services (lack of response to provider inquiries)	Withhold and Forfeiture	$280,000.00	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/8/2016	Claims processing accuracy	N/A	Letter of concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/8/2016	Other	Provider system issues as a result of Migration from Coventry to Aetna.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/8/2016	Claims processing accuracy	Behavioral Health Providers regarding claim denials and payment issues as a result of Plan migration from Coventry to Aetna.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/9/2016	Claims processing accuracy	DMS was contacted by a provider regarding claim denials.	CAP	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/9/2016	Claims processing accuracy	Plan failure to void claims as communicated to DMS and the Provider.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/9/2016	Claims processing timeliness	Plan failure to void a claim timely for a Provider (White House Clinic).	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/12/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/16/2016	Claims processing accuracy	Plan has not paid provider correctly since 2013 for Bridge payments.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/19/2016	Claims processing accuracy	Claims: Withhold and Forfeiture- Failure to fully cooperate under section 28.0, Provider Services.	Sanction/Fine/Liquidated Damages	$280,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/23/2016	Claims processing timeliness	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/23/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/23/2016	Other	Plan did not meet contract requirements for Credentialing timeliness	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/23/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/23/2016	Reporting – other data	Report submitted containing insufficient information	Letter of concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/23/2016	Reporting – other data	Plan did not state which SIU provider site visit were announced vs unannounced	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/23/2016	Reporting – other data	Technical issue with TPL file submission	Letter of Concern	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/26/2016	Claims processing accuracy	DMS was contacted by a provider regarding claims that need to be voided.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/28/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/28/2016	Other	Plan response failed to provide complete and detailed information to differentiate which visits were announced and which were not announced for SFY 2016.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/29/2016	Other	Complaint to DMS regarding lack of responsiveness by the plan	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/29/2016	Reporting – encounter data	N/A	Sanction	$78,928.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/30/2016	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$78,928.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/3/2016	Other	Provider compliant to DMS that provider representative or other departments have been unresponsive to them.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/3/2016	Reporting – other data	TPL monthly resource file.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/4/2016	Reporting – other data	Report 15 being incomplete and not containing information of ongoing monitoring of all subcontractors.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/10/2016	Access standards	Behavioral Health providers not enrolled timely	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/10/2016	Other	Plan failed to collect change of ownership information from pharmacy provider	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/11/2016	Other	Lack of submission of information required for SFY 2016.	CAP	N/A	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/12/2016	Other	Aetna not submitting the information required in Appendix N. Program Integrity requirements V, reporting to Program Integrity for SFY 2016.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/13/2016	Financial – non claims	response to inquiry dated July 14, 2016 regarding Provider Payment Suspension Process.	Letter of Concern	N/A	Open
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/13/2016	Claims processing accuracy	Provider contacted DMS stating that they have not been paid since the conversion from CoventryCares to Aetna	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/13/2016	Claims processing accuracy	Provider notified DMS that they are still getting denials for CAS code 109 and CAS code 18.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/13/2016	Other	Untimely credentialing for two oral surgeons.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/13/2016	Claims processing accuracy	Plan has failed to respond to requests for resolution to PathGroup's issues regarding codes that need to be added for pathologist covered services.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/14/2016	Claims processing accuracy	Inpatient and outpatient claims denying since conversion from Coventry cares to Aetna.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/19/2016	Other	Provider complaint regarding lack of responsiveness to inquiries by the plan	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/19/2016	Other	Provider Payment Suspension Process.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/20/2016	Other	Plan failed to provide Garrard Pharmacists Group with concerning their change of ownership (CHOW) to HCA Pharmacy and medical equipment.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/21/2016	Claims processing timeliness	N/A	Letter of Concern/CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/21/2016	Claims processing timeliness	N/A	CAP	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/24/2016	Other	First received as LOC, then turned into CAP. BH providers are not enrolled timely which is a barrier to members needing these services.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/25/2016	Other	Subcontractor mistakenly terminated a provider	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/25/2016	Reporting – encounter data	N/A	Sanction	$272,624.22	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/25/2016	Other	Failure to respond timely to DMS regarding a provider issue.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/30/2016	Other	Plan vendor, Avesis, mistakenly termed a Provider.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/31/2016	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$272,624.22	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/3/2016	Reporting – encounter data	N/A	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/3/2016	Reporting – encounter data	N/A	Sanction	$363,761.50	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/7/2016	Financial – non claims	Provider charged for ER triage claims	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/7/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/9/2016	Claims processing timeliness	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/10/2016	Other	Audit/Review	Audit/Review	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/11/2016	Reporting – encounter data	Untimely submission of Encounter files	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/11/2016	Other	Due to LOC response did not provide an end date to which payment would be resolved.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/16/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/22/2016	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/22/2016	Claims processing accuracy	N/A	CAP	N/A	Open
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/28/2016	Claims processing accuracy	Due to Behavioral Health claims not being paid correctly.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/28/2016	Claims processing timeliness	Behavior Health claims not being paid.	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/30/2016	Other	Due to Provider being charged emergency triage payments after 9/1/16.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/30/2016	Claims processing timeliness	Due to non-emergency claims not paid to a Provider prior to 9/1/2016.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/30/2016	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$363,761.50	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/1/2016	Reporting - Encounter Data	N/A	Sanction	$450,174.91	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/2/2016	Claims processing timeliness	Regarding provider claims processing issues.	CAP	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/12/2016	Claims processing accuracy	N/A	Letter of Concern	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/12/2016	Claims processing timeliness	Outstanding provider claims.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/12/2016	Claims processing timeliness	Due to outstanding claims issues, credentialing issues, and unresponsiveness to provider issues.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/9/2017	Other	Audit/Review	Audit/Review	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/17/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$450,174.91	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/24/2017	Other	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	2/8/2017	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	2/16/2017	Claims processing timeliness	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	2/17/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$366,816.41	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/9/2017	Claims processing timeliness	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/13/2017	Other	Contract Requirements	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/15/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$399,264.62	Paid

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/16/2017	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/17/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$359,594.62	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/9/2017	Reporting – other data	Call Center Report	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/18/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$359,813.92	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/24/2017	Other	Fee Schedule Changes	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/8/2017	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/8/2017	Claims processing timeliness	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/23/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$375,080.94	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/27/2017	Other	Audit/Review	Sanction/Fine/Liquidated Damages	$25,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/17/2017	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/21/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$359,095.78	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/24/2017	Other	Fee Schedule Changes	Notice of Non-Compliance	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/24/2017	Other	Credentialing	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/26/2017	Other	Contract Requirements	Sanction/Fine/Liquidated Damages	$10,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/26/2017	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/9/2017	Claims processing timeliness	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/10/2017	Other	Untimely Response to Regulator	Sanction/Fine/Liquidated Damages	$1,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/14/2017	Claims processing timeliness	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/16/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$360,217.11	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/17/2017	Reporting – other data	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/18/2017	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/18/2017	Claims processing accuracy	N/A	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/13/2017	Other	Fee Schedule Changes	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/14/2017	Other	Credentialing	Notice of Non-Compliance	N/A	Closed

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/18/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$361,928.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/19/2017	Claims processing accuracy	N/A	Sanction/Fine/Liquidated Damages	$15,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/19/2017	Claims processing accuracy	N/A	Sanction/Fine/Liquidated Damages	$25,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/19/2017	Claims processing accuracy	N/A	Sanction/Fine/Liquidated Damages	$25,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/28/2017	Claims processing timeliness	N/A	Notice of Non-Compliance	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/19/2017	Other	Audit/Review	Audit/Review	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/20/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$373,469.17	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/17/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$370,928.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/18/2017	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$408,703.42	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/19/2017	Other	Contractual Requirements Not Met	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/20/2017	Other	Contractual Requirements Not Met	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/18/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$372,948.33	Paid

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/24/2018	Other	Contractual Requirements Not Met	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	2/16/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$462,165.10	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/16/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$333,699.07	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/27/2018	Other	Contractual Requirements Not Met	Sanction/Fine/Liquidated Damages	$5,000.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/20/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$307,342.14	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	5/18/2018	Reporting – other data	N/A		$419,408.50	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/15/2018	Reporting – encounter data	N/A		$369,905.25	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	6/21/2018	Other	Withhold Forfeiture	Due to legacy issues	$246,253.72	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	7/25/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$15,840.00	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	8/18/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$326,900.75	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/13/2018	Other	N/A	CAP		Open
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	9/14/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$395,405.18	Paid

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/20/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$574,889.58	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/26/2018	Reporting – encounter data	Identified encounters that are out of Compliance with coding guidelines	CAP	N/A	N/A
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	10/30/2018	Other	Subcontractor, Avesis	CAP	N/A	N/A
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	11/16/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$295,822.23	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	12/21/2018	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$359,577.44	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/15/2019	Reporting – encounter data	Duplicate Pharmacy Encounters	Notice of Non-Compliance	N/A	N/A
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	1/18/2019	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$317,383.21	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	2/15/2019	Reporting – encounter data	N/A	Sanction/Fine/Liquidated Damages	$309,936.37	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/6/2019	Other	Self-reported ransomware attack incident, involving Subcontractor, Equian, and their mailing vendor, Wolverine Solutions Group.	Notice of Non-Compliance	N/A	N/A
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	3/15/2019	Reporting – encounter data	N/A	Sanction	$308,272.01	Paid
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/2/2019	Other	The Department was notified that Aetna's Subcontractor, Avesis, has been withholding a $3.00 copayment on dental claims for children.	CAP	N/A	Closed
KY	Aetna Better Health of Kentucky Insurance Company/ Medicaid Managed Care Contract	4/19/2019	Reporting – encounter data	N/A	Sanction	$53,127.00	Paid

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	Kentucky - Department of Medicaid Services	Notice of Non-Compliance	3/1/2016	3/31/2016	March 2016 Encounter Penalties, 131,385	$131,385	Paid
KY	KY- Department for Medicaid Services	Notice of Non-Compliance	7/25/2018	7/25/2018	Untimely and Inaccurate Encounters Data for June.	$15,840	Paid
KY	Kentucky - Department of Medicaid Services	Sanction	12/1/2015	12/31/2015	December Encounters Penalties totaled $188,900	$188,900	Paid
KY	KY Department of Insurance	Sanction	10/15/2013	10/29/2013	In Q1 2013, health plan failed to be in compliance with paying 90% of clean claims in 30 days. In Q1 2013, health plan reported paying 81.32% in 30 days. Health plan has until 10/29/13 to advise DOI if Coventry plans to settle by paying fine.	$5,000	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	6/21/2018	6/21/2018	DMS forfeiture notice for failure to correct, under AE2017FTC-1- totaling $246,253.72. We believe the reason for this forfeiture is due to legacy issues and DMS acknowledges the Plan's current progress and improvement.	$246,253.72	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	6/15/2018	6/15/2018	Untimely and Inaccurate Encounters Data for May.	$369,905.25	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	5/18/2018	5/18/2018	Untimely and Inaccurate Encounters Data for April.	$419,408.50	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	4/20/2018	4/20/2018	Untimely and Inaccurate Encounters Data for March.	$307,342.14	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	3/16/2018	3/16/2018	Untimely and Inaccurate Encounters Data for February.	$333,699.07	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	2/16/2018	2/16/2018	Untimely and Inaccurate Encounters Data for January.	$462,165.10	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	1/18/2018	1/18/2018	Untimely and Inaccurate Encounters Data for December.	$372,948.33	Paid

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	12/18/2017	12/18/2017	Untimely and Inaccurate Encounters Data for November.	$408,703.42	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	11/17/2017	11/17/2017	Untimely and Inaccurate Encounters Data for October.	$370,928	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	10/20/2017	10/20/2017	Untimely and Inaccurate Encounters Data for September.	$373,469.17	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	9/19/2017	9/19/2017	AE2018FTC-2: The Division of Program Quality & Outcomes is penalizing Aetna Better Health of Kentucky under Section 40.5 Penalties for Failure to Correct- A Civil Money Penalties (13) a. and b. Upon review of your MCO's performance, the Department found that there were repeated contractual violations in which your MCO failed to correct in accordance with Section 28.1 Provider Services and Section 15.0 Management Information System. The Department continues to receive numerous complaints from behavioral providers regarding outstanding claims stemming from the migration from CoventryCares to Aetna Better Health, multiple system configuration issues, and as well as incorrect provider rates being loaded into the system from the following behavioral health providers: Phoenix Preferred Care, Alliance Counseling, Northkey, Lifeskills, Pennyroyal, Mountain Comprehensive, Lifeskills, Adanta, Alternative Behavioral Health Interventions (ABI), Parsons Counseling, Four Rivers, Behavioral Health, and River Valley Behavioral Health and Affiliates. Therefore, the Department shall withhold the amount of $15,000.00 of the monthly Capitation Payment next month. Action: AE2017NEC-1 Action: CAP Date Issued: 6/8/17	$15,000	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine/Liquidated Damages	9/19/2017	9/19/2017	AE2018FTC-3: The Division of Program Quality & Outcomes is penalizing Aetna Better Health of Kentucky under Section 40.5 Penalties for Failure to Correct- A Civil Money Penalties (13) a., b. and c. Upon review of your MCO's performance, the Department found that there were repeated contractual violations, which your MCO failed to correct in accordance with Section 28.1 Provider Services and Section 15.0 Management Information System. The Department continues to receive numerous complaints from behavioral health providers regarding outstanding claims stemming from the migration from CoventryCares to Aetna Better Health, multiple system configuration issues, and as well as incorrect provider rates being loaded into the system from the following behavioral health providers: Phoenix Preferred Care, Alliance Counseling, Northkey, Lifeskills, Pennyroyal, Mountain Comprehensive, Lifeskills, Adanta, Alternative Behavioral Health Interventions (ABI), Parsons Counseling, Four Rivers Behavioral Health, and River Valley Behavioral Health and Affiliates. Therefore, the Department shall withhold the amount of $25,000.00 of the monthly Capitation Payment next month. Action Action Date Issued AE2018CHR-1 CAP 7/26/17 AE2018CC-1 CAP 8/9/17	$25,000	Paid

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	KY- Department for Medicaid Services	Sanction/Fine/Liquidated Damages	9/19/2017	9/19/2017	AE2017FTC-4: The Division of Program Quality & Outcomes is penalizing Aetna Better Penalties for Failure to Correct- A Civil Money Penalties (13) a, b. and c. Health of Kentucky under Section 40.5 Upon review of your MCO's performance, the Department found that there were repeated contractual violations in which your MCO failed to correct in accordance with Section 28.1 Provider Services and Section 15.0 Management Information System. The Department continues to receive numerous complaints from regarding outstanding claims stemming from the migration from CoventryCares to Aetna Better Health. Therefore, the Department shall withhold the amount of $25,000.00 of the monthly Capitation Payment next month. Action Action Date Issued AE2018ECC-1 CAP 8/14/17 AE2018LWC-1 CAP 8/18/17 AE2018FHC-1 CAP 8/18/17	$25,000	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	9/18/2017	9/18/2017	Untimely and Inaccurate Encounters Data for August.	$361,928	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	8/16/2017	8/16/2017	Untimely and Inaccurate Encounters Data for July.	$360,217.11	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	8/10/2017	8/10/2017	Untimely Responses to Regulator: AE2018NEC-1: Based on your contract with Department for Medicaid Services (DMS) to provide managed care in accordance with Section 40.4 C, the following assessment applies: Penalty $1,000.00 Due Date 8/2/17 - Response Date 8/3/17 - Days Late 1 Assessment (Penalty Days Late) $1,000.00 For Failure of the Contractor to submit a response to a Corrective Action Letter (CAP) within (10) business days following the date of the written deficiency notice shall result in a $1000.00 per day penalty for each day until the response is received.	$1,000	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	7/26/2017	7/26/2017	AE2018FTC-1 - The Division of Program Quality & Outcomes is penalizing Aetna Better Health of Kentucky under Section 40.5 Penalties for Failure to Correct- A Civil Money Penalties (13) b. Upon review of your MCO's performance, the Department found that there were repeated contractual violations in which your MCO failed to correct which enabled the Department to monitor in accordance with Section 28.1 Provider Services and Section 15.0 Management Information System. Therefore, the Department shall withhold the amount of $10,000.00 of the monthly Capitation Payment.	$10,000	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	7/21/2017	7/21/2017	Untimely and Inaccurate Encounters Data for June.	$359,095.78	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	6/27/2017	6/27/2017	3 Year EQRO Failures: AE2017IPRO-FTC-1 Penalty- $25,000 penalty due to repeat findings from EQRO audit (for years 2015, 2016, 2017).	$25,000	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	6/23/2017	6/23/2017	Untimely and Inaccurate Encounters Data for May.	$375,080.94	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	5/18/2017	5/18/2017	Untimely and Inaccurate Encounters Data for April.	$359,813.92	Paid

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	4/17/2017	4/17/2017	Untimely and Inaccurate Encounters Data for March.	$359,594.62	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	3/15/2017	3/15/2017	Untimely and Inaccurate Encounters Data for February.	$399,264.62	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	2/17/2017	2/17/2017	Encounter Penalties for January 2017- for failure to Submit Encounters in Accordance with the Contract.	$366,816.41	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	1/17/2017	1/17/2017	Encounter Penalties for December 2016. for failure to Submit Encounters in Accordance with the Contract.	$450,174.91	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	11/1/2016	11/30/2016	Encounter Penalties for November 2016	$363,761.50	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	10/6/2016	7/25/2017	AE2016FTC-4- Withhold and Forfeiture- Under section 40.5 Penalties for Failure to correct Section B. The deficiency was not corrected within six (6) months from acceptance of the corrective action plan; therefore, the second half of the funds ($92,164.47) are forfeited. In addition a non-refundable $50,000 penalty was assessed for a total of $142,164 payable on the latter date of 7-25-2017.	$142,164	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	10/1/2016	10/31/2016	Encounter Penalties for October 2016	$272,624.22	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	9/1/2016	5/16/2017	AE2016FTC-4- Withhold and Forfeiture- Under section 40.5 Penalties for Failure to correct Section B. The deficiency was not corrected within three (3) months from acceptance of the corrective action plan; therefore, one-half of the funds ($92, 164.47) are forfeited.	$92,164.47	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	9/1/2016	9/19/2016	Claims: Withhold and Forfeiture- Failure to fully cooperate under section 28.0, Provider Services. 0.25% of monthly capitation payment (Approx. 280 K).	$280,000	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	9/1/2016	9/30/2016	Encounter Penalties for September 2016	$78,928	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	8/1/2016	8/31/2016	Encounter Penalties for August 2016	$26,381	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	7/1/2016	7/31/2016	Encounter Penalties for July 2016	$229,250	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	6/1/2016	6/30/2016	Encounter Penalties for June 2016	$164,155	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	5/1/2016	5/31/2016	Encounter Penalties for May 2016	$225,670	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	4/1/2016	4/30/2016	Encounter Penalties for April 2016	$144,250	Paid

Table F - Aetna Better Health of Kentucky Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	2/2/2016	2/29/2016	February encounters penalties totaled $134,135.	$134,135	Paid
KY	KY- Department for Medicaid Services	Sanction/Fine /Liquidated Damages	1/1/2016	1/31/2016	Encounter Penalties for January 2016 totaled $122K.	$122,320	Paid

Table G - Aetna's Medicaid Sanctions in States Other than Kentucky

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Table G - Aetna's Medicaid Sanctions in States Other than Kentucky

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Arizona	AZ - ADHS/DBHS	Sanction/Fine/Liquidated Damages	3/11/2016	5/11/2016	ADHS/DBHS issued a sanction for encounters pended over 120 days from the month of December 2015. The final sanction amounts is $13,635 for RBHA 37	$13,635	Paid
Arizona	AZ - ADHS/DBHS	Sanction/Fine/Liquidated Damages	3/11/2016	3/11/2016	ADHS/DBHS issued a sanction for encounters pended over 120 days from the month of December 2015. The final sanction amounts is $3,220 for RBHA 77	$3,220	Paid
Arizona	AZ - ADHS/DBHS	Sanction/Fine/Liquidated Damages	2/16/2016	4/18/2016	ADHS/DBHS issued a sanction for encounters pended over 120 days from the month of September 2015. The final sanction amounts is $25,525 for RBHA 37	$25,525	Paid
Arizona	AZ - ADHS/DBHS	Sanction/Fine/Liquidated Damages	2/16/2016	4/18/2016	ADHS/DBHS issued a sanction for encounters pended over 120 days from the month of September 2015. The final sanction amounts is $15,490 for RBHA 77	$15,490	Paid
Arizona	AZ - ADHS/DBHS	Sanction/Fine/Liquidated Damages	1/11/2016	1/11/2016	Regulatory Reporting -Data Integrity: October 2015 deliverables: • Inaccurate and incomplete submission of the GSA Integrated Care Performance Measures Report • Inaccurate and incomplete submission of the GSA Behavioral Health Performance Measures Report The sanction amount will include $1,000 for each inaccurate/incomplete submission. While sanctions were not assessed for deliverables submitted during the month of October 2015, ADHS is providing follow-up to the sanction intent notice issued on April 17, 2015, whereby final notice of a sanction amount and appeal rights are provided upon re-submission and approval of all sanctioned deliverables. The GSA Integrated Care Performance Measures Report was rejected by ADHS due to inaccuracy on April 17, 2015, resulting in a penalty of $1,000.00. The reporting template submitted by Mercy Maricopa, was incomplete as it was missing quarter one data and not all required performance measures were analyzed, as required. Additionally, Mercy Maricopa reportedly made subsequent updates to its internal database which resulted in a recalculation and restatement of previously submitted data. Mercy Maricopa resubmitted the report on April 24, 2015, and ADHS provided conditional acceptance pending additional clarification and resubmission by Mercy Maricopa. The repmi was resubmitted, reviewed, and accepted by ADHS on September 9, 2015. The GSA Behavioral Health Performance Measures Report was rejected by ADHS due to inaccuracy for the same reasons described above on April 15, 2015, resulting in a penalty of $1,000.00. Mercy Maricopa resubmitted the report and ADHS provided approval on April29, 2015.	$2,000	Paid

Table G - Aetna's Medicaid Sanctions in States Other than Kentucky

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Arizona	AZ - ADHS/DBHS	Sanction/Fine/Liquidated Damages	1/11/2016	3/11/2016	ADHS/DBHS issued a sanction for encounters pended over 120 days from the month of June 2015. The final sanction amounts is $32,230 for RBHA 37	$32,230	Paid
Arizona	AZ - ADHS/DBHS	Sanction/Fine/Liquidated Damages	1/11/2016	3/11/2016	ADHS/DBHS issued a sanction for encounters pended over 120 days from the month of June 2015. The final sanction amounts is $39, 760 for RBHA 77	$39,760	Paid
Arizona	AZ - ADHS/DBHS	Sanction	9/1/2015	9/30/2015	DBHS issued a sanction for excessive hold times for children in the emergency department.	$2,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	7/24/2015	7/24/2015	RBHA Supervisory Care Home Monthly Census Report (FY2015 M9)	$500	Paid
Arizona	AZ - ADHS/DBHS	Sanction	7/15/2015	7/15/2015	Grievance System Report (FY2015 M07)	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	7/2/2015	7/2/2015	Report of Each Use of Seclusion/Restraint Concerning Persons with Serious Mental Illness FY15M8	$3,500	Paid
Arizona	AZ - ADHS/DBHS	Sanction	6/23/2015	6/23/2015	Outpatient Commitment (COT) Monitoring Report (FY2015 M08)	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	6/2/2015	6/2/2015	Provider Notice: Appointment Availability and Timeliness Standards	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	6/2/2015	6/2/2015	Grievance System Report (FY2015 M06)	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	5/28/2015	5/28/2015	Encounters pended over 120 days	$1,605	Paid
Arizona	AZ - ADHS/DBHS	Sanction	5/28/2015	5/28/2015	Encounters pended over 120 days	$5,010	Paid

Table G - Aetna's Medicaid Sanctions in States Other than Kentucky

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Arizona	AZ - ADHS/DBHS	CAP	5/15/2015	7/1/2015	Appointment Standards and Timeliness of Services for Behavioral Health Providers: On May 15th, Mercy Maricopa received a Notice of Corrective Action regarding Appointment Standards and Timeliness of Services for Behavioral Health Providers. Per the notice, ADHS became aware of concerns regarding provider appointment availability via customer service complaints and quality of care concerns. Per the concerns/complaints, providers were not allowing members to schedule appointments for future dates and limiting members to same day appointments only. As a result, Mercy Maricopa placed Southwest Behavioral Health, on corrective action. On May 26th, Mercy Maricopa sent a provider notification prohibiting 100% of all open access scheduling practices, and requiring providers to allow scheduling of future appointments. On May 29th, Mercy Maricopa submitted a Corrective Action Plan and updated policy for ADHS review and approval. ADHS approved the CAP. The CAP activities require Mercy Maricopa submit a weekly "Secret Shopper Report" every Monday, a summary of interventions and follow-up activities every Wednesday, a monthly "Provider Relations Visit Reports", and implement the updated policy ADHS required to include explicit prohibitive language and all enforcement actions for a provider's failure to do so. ADHS provided technical assistance on June 18th, advising Mercy Maricopa's weekly submission of "Secret Shopper" results demonstrated the practice of 100% open scheduling continued within the network. To date, Mercy Maricopa has placed six (6) providers on CAPs and provided education and training to providers found to be non-compliant. Mercy Maricopa held an internal meeting with Network and Provider Relations and Systems of Care staff to identify and expedite implementation of internal action plans. The Quality Management Team was included to ensure ongoing investigation of access to care issues. As of July 1st, Mercy Maricopa received a Notice of Escalation from ADHS to inform the Corrective Action Plan is now a 30 Day Notice to Cure.	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	5/6/2015	5/6/2015	PCP Transition Log (FY2015 M06)	$500	Paid
Arizona	AZ - ADHS/DBHS	Sanction	4/23/2015	4/23/2015	Copies of Completed Internal and External audit reports and findings, completed fraud, waste and program abuse investigation reports and findings (FY2015 Q2)	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	4/17/2015	4/17/2015	Outpatient Commitment (COT) Monitoring Report (FY2015 M06)	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	4/15/2015	4/15/2015	Grievance System Report (FY2015 M05)	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	4/10/2015	4/10/2015	Corporate Compliance Ride-along Program (Data Validation Review Schedule) (FY2015 Q2)	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	4/3/2015	4/3/2015	Grievance System Report (FY2015 M04)	$3,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	3/30/2015	3/30/2015	Prior Authorization Data Report (FY2015 M04)	$1,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	3/30/2015	3/30/2015	Pharmacy Utilization report (FY2015 Q1)	$4,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	3/30/2015	3/30/2015	MM/UM Indicator Report (FY2015 Q1)	$500	Paid
Arizona	AZ - ADHS/DBHS	Sanction	3/16/2015	3/16/2015	Transportation Services	$100,000	Paid
Arizona	AZ - ADHS/DBHS	Sanction	2/27/2015	2/27/2015	Recipient and Provider Over and Under Utilization Report and Plan (FY2014 S2)	$3,000	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	4/24/2018	4/24/2018	Sanctionable Pended Encounters for Acute and ALTCS for September 2017.	$9,035	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	3/8/2018	3/8/2018	Encounters Sanctions for June 2017.	$4,005	Paid

Table G - Aetna's Medicaid Sanctions in States Other than Kentucky

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	7/25/2017	7/25/2017	December 2016 sanctions for encounters pended over 120 days.	$3,275	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	4/6/2017	4/6/2017	September 2016 sanctions for encounters pended over 120 days.	$8,075	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	11/23/2016	11/23/2016	CYE 13-14 Encounter Data Validation Audit	$2,826.18	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	5/20/2016	5/20/2016	Sanction for pended encounters from December 2015	$37,280	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	2/11/2016	2/11/2016	AHCCCS Acute and LTC sanctions for pending encounters over 120 days are in for Quarter ending September 30, 2015.	$7,250	Paid
Arizona	AZ - AHCCCS	Sanction	12/23/2015	12/23/2015	Final aged pended encounters for quarter ending June 2015	$8,510	Paid
Arizona	AZ - AHCCCS	Sanction	5/22/2015	5/22/2015	Final sanctions for pended encounters over 120 days for quarter ending December, 2014. Acute Sanction: $19, 170.00 ALTCS Sanction: $ 5,775.00 Total Sanction: $24,945.00	$24,945	Paid
Arizona	AZ - AHCCCS	Sanction	4/28/2015	4/28/2015	MCP is subject to sanction for failure to appropriately provide and adequately coordinate medically necessary transportation which prevented MCP members from timely receiving medically necessary health care services	$400,000	Paid
Arizona	AZ - AHCCCS	Sanction	4/24/2015	4/24/2015	Acute 2012 Data Validation Study results. Error rate above 5% are sanctionable. Error rates above 5%: A Match Timeliness Error Rate: 5.88% Sanction: $6,550.35 B Match Timeliness Error Rate: 9.8% Sanction: $3,759.12 Total ACUTE Sanction: $10,309.47	$10,309.47	Paid
Arizona	AZ - AHCCCS	Sanction	3/31/2015	8/7/2015	Final sanction for encounters pended over 120 days for Quarter Ending March 2015	$7,895	Paid
Arizona	AZ - AHCCCS	Sanction	2/25/2015	2/25/2015	Sanction for 3rd Quarter 2014 Encounters that were pended beyond 120 days	$1,210	Paid
Arizona	AZ - AHCCCS	Sanction	12/12/2014	12/12/2014	Sanction for pended encounters greater than 120 days	$3,275	Paid
Arizona	AZ - AHCCCS	Sanction	9/5/2014	9/5/2014	Sanction was received for pended encounters over 120 days for 1st Quarter 2014	$6,930	Paid

Table G - Aetna's Medicaid Sanctions in States Other than Kentucky

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Arizona	AZ - AHCCCS	Sanction	6/24/2014	6/24/2014	MCP Acute and ALTCS were sanctioned for pended encounters greater than 120 days for the 4th Quarter of 2013. Amount of $56,240.00.	$56,240	Paid
Arizona	AZ - AHCCCS	Sanction	4/10/2014	5/9/2014	This sanction is for the on-line encounter voids that were done in error. $25,000	$25,000	Paid
Arizona	AZ - AHCCCS	Sanction	12/20/2013	1/2/2014	AHCCCS has sanction MCP for Encounters Pended over 120 days in violation of contractual requirements for the quarter ending September 2013. They could have sanctioned MCP for $433,435, but have cut the sanction in 1/2 to $216,717. MCP is discussing with AHCCCS a possible mitigation/decrease in sanction amount.	$216,717	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	4/24/2018	4/24/2018	MMIC Encounter Sanctions for September 2017.	$7,725	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	3/8/2018	3/8/2018	June 2017 Final Encounter Sanctions.	$6,765	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	3/1/2018	3/1/2018	MMIC received sanctions for match timeliness area having an error rate of greater than 5% during the 2015 Data Validation Audit.	$1,207.30	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	11/16/2017	11/16/2017	Pended encounters for the quarter ending March 2017.	$840	Paid
Arizona	AZ - AHCCCS	Sanction/Fine/Liquidated Damages	7/25/2017	7/25/2017	December 2016 sanctions for encounters pended over 120 days.	$6,730	Paid
Arizona	AZ - DDD	Sanction/Fine/Liquidated Damages	3/19/2018	3/19/2018	DDD sanction for Sanctionable Encounters June 2017.	$835	Paid
Arizona	AZ - DDD	Sanction/Fine/Liquidated Damages	4/28/2017	4/28/2017	September 2016 sanctions for encounters pended over 120 days.	$945	Paid
Arizona	AZ - DDD	Sanction/Fine/Liquidated Damages	5/24/2016	5/24/2016	Encounters December 31, 2015 Sanctions	$8,455	Paid
Arizona	AZ - DDD	Sanction/Fine/Liquidated Damages	2/16/2016	2/16/2016	Pended encounters for the quarter ending September 30	$2,675	Paid
Arizona	AZ - DDD	Sanction/Fine/Liquidated Damages	1/4/2016	1/4/2016	Pended encounters for the quarter ending June 30, 2015	$2,025	Paid
Arizona	AZ - DDD	Sanction	8/26/2015	8/26/2015	Pended Encounters Sanction for Quarter Ending 3/31/2015	$860	Paid
Arizona	AZ - DDD	Sanction	5/7/2015	5/31/2015	CYE 12 The Division submitted the documents and any additional information you submitted on the preliminary findings and have rendered the following results and sanctions: For Study B NotEnc InClm the random sampling for your plan yielded 1 record that the explanations/documents were not accepted. For B Match Timeliness the random sampling for your plan yielded 1 record that was not accepted. The sanctions for these findings are as follows: Study B NotEnc InClm $ 10.91 B Match Timeliness $ 5.53 Total $ 16.44	$16.44	Paid
Arizona	AZ - DDD	Sanction	3/17/2015	3/17/2015	Sanction for pended encounters greater than 120 days for 3rd Quarter 2014	$640	Paid

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Arizona	AZ - DDD	Sanction	12/22/2014	12/22/2014	Sanction for pended encounters greater than 120 days for 2nd Quarter 2014	$840	Paid
Arizona	AZ - DDD	Sanction	9/5/2014	9/5/2014	Sanction for pended encounters over 120 days	$5,470	Paid
Arizona	AZ - DDD	Sanction	6/24/2014	6/24/2014	DDD sanctioned MCP Acute/ALTCS for pended encounter sanctions over the 120 day mark for 4th Quarter 2013 time frame. Amount was $6,325.00	$6,325	Paid
Arizona	AZ - DDD	Sanction	12/27/2013	12/27/2013	DDD has sanctioned MCP for over 120 day pended encounters that are in violation of the AHCCCS contractual requirements. DDD was sanctioned by AHCCCS, and it is a 100% pass-through to MCP. The sanction amount is $6,975.00.	$6,975	Paid
Arizona	Mercy Care Plan/ Acute and ALTCS Plan	7/17/2019	Other	CAP	Refocus of priorities to contractual requirements	N/A	Open
Arizona	Mercy Care/ACC	10/11/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$4,260	Paid
Arizona	Mercy Care/ACC	8/12/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$81,810	Paid
Arizona	Mercy Care/ALTCS	10/11/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$1,675	Paid
Arizona	Mercy Care/ALTCS	8/12/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$16,010	Paid
Arizona	Mercy Care/DDD	11/7/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$1,620	Paid
Arizona	Mercy Care/DDD	10/25/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$920	Paid
Arizona	Mercy Care/DDD	8/23/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$55,225	Paid
Arizona	Mercy Care/RBHA	10/11/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$16,975	Paid
Arizona	Mercy Care/RBHA	8/12/2019	Reporting – encounter data	Sanction	Performed root cause analysis and implemented required fixes	$3,910	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	6/22/2018	6/22/2018	Failure to Update Printed Provider Directories (LTC & MMA).	$9,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	6/18/2018	6/18/2018	Failure to Provide Transportation Services.	$2,500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	6/8/2018	6/8/2018	Long-term-Care Case Record Review Deficiencies (Submission 18). Case No.: 2018003050; AHCA File No.: 20960233	$31,500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	4/30/2018	4/30/2018	Liquidated Damages for Failure to Comply with Claims Processing Requirements (Incorrect Denials). Aetna has acknowledged that it was a global issue that affected six hundred forty-four (644) providers, twenty two thousand eight hundred and five (22,805) claims, and that four million, seven hundred seventeen thousand, three hundred and eight dollars ($4,717,308) had to be reprocessed. Aetna confirmed the issue spanned from February 2017 to October 2017 and that the affected claims were reprocessed and paid in January 2018. The Agency is assessing liquidated damages in the amount of $120,000 calculated at $10,000 per month pursuant to Section XIII. B.	$120,000	Paid

Table G - Aetna's Medicaid Sanctions in States Other than Kentucky

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	4/20/2018	4/20/2018	Liquidated Damages for Failure to File Accurate Reports (04 Long-term Care Reports).	$8,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	4/20/2018	4/20/2018	Liquidated Damages for Failure to Comply with Claims Processing Requirements (Incorrect Denials).	$6,500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	4/13/2018	4/13/2018	Liquidated Damages for Failure to File Accurate Reports and Failure to Submit Report Attestation (Provider Complaint Report).	$3,250	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	4/10/2018	4/10/2018	Liquidated Damages for Failure to File Accurate Reports (MPIP Data).	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	3/30/2018	3/30/2018	Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc. (Aetna) submitted a Provider Network Verification (PNV) file on March 1, 2018. The file titled SLCOV2018020301.dat did not follow the formatting protocol. An error occurred in the naming convention and as a result, the file failed to import successfully.	$250	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	3/16/2018	3/16/2018	Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc. (Aetna) submitted an Enrollee Complaints, Grievances and Appeals report to the Agency for Health Care Administration (Agency) on December 15, 2017 (November data) and January 16, 2018 (December data). The Agency's review of the reports identified the non-compliance issues described in Attachment A.	$1,250	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	3/15/2018	3/15/2018	Liquidated Damages for failure to Update Online Provider Directory (Dental Providers).	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	2/12/2018	2/12/2018	Liquidated Damages for Failure to File Accurate Reports (Q3 2017 Healthy Behaviors Report). Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc. (Aetna) submitted the Quarter 3 (Q3) 2017 Healthy Behaviors Report to the Agency on October 16, 2017. A review of the report identified that Aetna failed to include enrollees participating in the Prenatal and Post-Partum programs. The requested resubmittal also failed to include the number of females completing the programs, resulting in a third request for submission before the report was deemed accurate and complete.	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	2/9/2018	2/9/2018	Liquidated Damages for Failure to Comply with Enrollee Notice for Denials, Reductions, Terminations, or Suspensions of Services within the Timeframes Specified in the Contract (September 2017 DRTS). Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc. (Aetna) submitted a Denial, Reduction, Termination or Suspension of Services Report on September 21, 2017 (August Data). The Agency for Health Care Administration's (Agency) review of the report identified one (1) enrollee was not provided a Notice of Adverse Benefit Determination (NABD) within the timeframe as specified in the contract.	$2,500	Paid

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	1/26/2018	1/26/2018	Inaccurate report of our MPIP eligible provider submission. The Agency for Health Care Administration (Agency) required Aetna Better Health of Florida, Inc., (Aetna) to respond to an ad hoc request titled "Policy Transmittal 17-09 Ad Hoc Request for MMA Physician Incentive Program (MPIP) Provider Lists" due on March 8, 2017. A review of the MPIP provider list indicated that Aetna failed to include all eligible providers that met the MPIP qualifications in their submission.	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	1/19/2018	1/19/2018	Failure to Comply with Claims Processing Requirements (Medicare Part B Crossover Claims). Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health Florida (Aetna) has acknowledged that a configuration issue caused incorrect claim denials for Dialysis Medicare Part B Crossover claims. This was a global claims processing issue for the time period of February 2017 through October 2017. Aetna identified the issue in a claims complaint review in August 2017 (Attachment A), and is scheduled to complete reprocessing in January 2018.	$90,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	1/19/2018	1/19/2018	Failure to Comply with Claims Processing Requirements (Newborn Screening Claims). Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health Florida (Aetna) has acknowledged that a configuration issue caused incorrect claim denials for newborn screening claims billed by the Florida Department of Health, Bureau of Public Health Laboratories (Department). This resulted in $33,039.29 owed to the Department from January 2017 through October 2017. Aetna reprocessed the claims in October 2017.	$10,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	1/19/2018	1/19/2018	Failure to File Accurate Reports (Provider Complaint Report). Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc. (Aetna) submitted a Provider Complaint Report to the Agency for Health Care Administration (Agency) on August 15, 2017. A review of the report identified ten (1 0) non-claim complaints were not resolved within ninety (90) days, and nine (9) entries did not have the Provider's Medicaid ID listed.	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	1/12/2018	1/12/2018	Failure to File Accurate Reports as Specified in the Contract (Case Manager and Provider Training Report). On May 19, 2017, the Agency for Health Care Administration (Agency) notified Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc. (Aetna) via email of an ad-hoc report request using a provided template for Long-term Care Case Manager and Provider Training. The report was due to the Agency on June 20, 2017. A review of the submission found that Aetna had not verified mandatory training for any of the listed providers. After requesting remediation, the files for the months of July, September, October and November 2017, all contained errors and/or were incomplete.	$4,000	Paid

Table G - Aetna's Medicaid Sanctions in States Other than Kentucky

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	1/12/2018	1/12/2018	Failure to Timely Respond to an Agency or Ad-hoc Report (Long- term Care Enrollee Ad-Hoc Request). On August 29, 2017, the Agency for Health Care Administration {Agency) notified Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc. {Aetna) via email of a Long-term Care Enrollee Ad-Hoc Request due on September 11 , 2017. Aetna was granted two {2) extensions to submit the information. On November 2, 2017, the Agency requested that additional information be provided by 5:00 p.m. on November 13, 2017. The information was not submitted to the Agency until November 14, 2017, one {1) day after the due date.	$500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	12/8/2017	12/8/2017	Failure to Meet the Minimum Standards for CY 2016 Long-term Care (LTC) Performance Measures (PMs). The Agency is assessing liquidated damages in the amount of $20,700 pursuant to Attachment II, Exhibit 11-B, Section XIII.B.18-21.	$20,700	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	12/1/2017	12/1/2017	Failure to Timely Submit Complete and Accurate Quarterly Unaudited and Audited Annual Financial Statements. The Agency is assessing liquidated damages in the amount of $1,000 calculated at $500 per occurrence pursuant to Section XIII. B.	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	11/14/2017	11/14/2017	Failure to Submit a Provider Network File that Meets the Agency's Specifications. The plan incorrectly uploaded the weekly Provider Network File on the following date, November 9, 2017.	$250	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	10/20/2017	10/20/2017	The Agency for Health Care Administration (Agency) conducted a review of the Quarter One (Q1) and Quarter 2 (Q2) Claims Aging Reports submitted by Coventry Health Care of Florida. Aetna did not comply with the standards for timely processing nursing facility and hospice clean claims. The Agency is assessing liquidated damages in the amount of $20,000 calculated at $10,000 per standard and quarter pursuant to Section XIII.B.	$20,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	8/11/2017	8/11/2017	Liquidated damages of $1000 for untimely encounter submissions.	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	7/14/2017	7/14/2017	Failure to comply with claims processing as outlined in the contract.	$30,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	4/20/2017	4/20/2017	Liquidated damages of $1000 for untimely encounter submissions.	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	3/17/2017	3/28/2017	Medical Management: Failure to timely file a LTC Critical Incident Report as Specified in the Contract	$500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	3/13/2017	3/23/2017	Medical Management: The plan was assessed liquidated damages in the amount of $7,500 for failure to comply with enrollee notices for denials, reductions, terminations or suspension of services within the timeframes specified in the SMMC contract.	$7,500	Paid

Table G - Aetna's Medicaid Sanctions in States Other than Kentucky

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Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	2/20/2017	3/7/2017	Liquidated Damages for 2016 3rd quarter claims aging report - non-compliance with claims payment requirements for LTSS claims.	$30,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	2/1/2017	2/20/2017	Medical Management: Liquidated damages for failure to file an LTSS critical incident timely.	$500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	1/13/2017	1/31/2017	Medical Management: Liquidated damages for failure to timely file a critical incident report	$500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	1/13/2017	1/31/2017	Medical Management: Liquidated damages for LTSS case record review deficiencies - submission 13	$26,500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	11/18/2016	12/14/2016	Quality Measures: Liquidated damages for failure to meet the minimum standards for CY 2015 LTSS performance measures	$104,200	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	11/10/2016	11/29/2016	Quality Measures: Liquidated damages for failure to meet the minimum standards for CY 2015 HEDIS performance measures	$112,200	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	10/17/2016	11/3/2016	Medical Management: Liquidated damages for failure to facilitate transfers between health care settings	$7,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	6/21/2016	7/20/2016	Staffing Inadequacy: Health plan was assessed liquidated damages of $7,250.00 for failure to comply with staffing requirements.	$7,250	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	6/21/2016	7/20/2016	Medical Management: The health plan was assessed liquidated damages for failure to comply with enrollee notice for denials, reductions, terminations, or suspensions of service within the timeframes specified in the SMMC contract.	$25,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	6/7/2016	6/20/2016	Medical Management: Sanction for failure to provide continuity of care for behavioral health members.	$20,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	5/2/2016	5/30/2016	Regulatory Reporting - Timeliness: Health plan sanctioned by AHCA for failure to timely submit audited annual and quarterly unaudited financial statements.	$1,500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	2/12/2016	3/2/2016	Liquidated damages for failure to pay LTSS claims timely.	$50,000	Paid

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Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	2/5/2016	2/25/2016	Staffing Inadequacy: Liquidated damages for failure to comply with caseload staffing requirements.	$7,500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	12/30/2015	1/29/2016	Failure to File Accurate Financial Report	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	11/25/2015	12/24/2015	Failure to file accurate Achieved Savings Rebate Report for MMA & LTC	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	11/9/2015	12/1/2015	Failure to update online provider directory	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	8/28/2015	9/27/2015	FAILURE TO MEET THE MINIMUM STANDARDS FOR FFY 2013-2014 CHILD HEALTH CHECK-UP REPORTING	$50,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	8/21/2015	9/17/2015	Health plan was assessed $500 in liquidated damages for failure to timely file an amended marketing/public event report for a July 10, 2015 event.	$500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	8/21/2015	9/2/2015	Failure to timely file and amended marketing/public/educational events report - June 2015	$500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	6/3/2015	7/30/2015	The health plan was assessed liquidated damages for failure to meet the minimum standard for calendar year 2013 HEDIS performance measures.	$88,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	3/3/2015	3/27/2015	The health plan was assessed liquidated damages for the untimely filing of the LTC Case Management Monitoring and Evaluation report.	$500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	10/31/2014	11/18/2014	The health plan's behavioral health vendor Psychcare had a system issue that cause claims to be processed incorrectly. The health plan was assessed liquidated damages for failure to comply with claims process, $30,000 ($10,000 for July, August, Sept. 2014).	$30,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	8/11/2014	9/10/2014	Liquidated damages were assessed to the Florida health plan for failure to submit the "unable to locate" report timely.	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	6/6/2014	7/7/2014	The health plan was assessed liquidated damages in the amount of $247,500 for failure to comply with Marketing requirements.	$247,500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	5/9/2014	6/8/2014	PNV file submission failed to meet Agency specifications (5/8/14 submission)	$1,750	Paid

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Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	4/21/2014	5/6/2014	Liquidated damages for failure to achieve minimum standards for HEDIS performance measure groups and individual measures for the 2012 contract year.	$65,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	4/17/2014	5/17/2014	The health plan was assessed liquidated damages for submission of incorrect attestations for the 4/1/14 submission of the behavioral health 80/20 report. Damages were assessed to Coventry Health Care of Florida, Inc. and Coventry Health Plan of Florida, Inc. in the amount of $500.00 per plan.	$1,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	2/7/2014	3/14/2014	The health plan was assessed liquidated damages for failure to achieve the required 80% participation rate for CHCUP.	$50,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	3/5/2013	3/5/2013	Liquidated Damages - Child Health Check Up Corrective Action Plan (CHCUP CAP)	$2,500	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	2/19/2013	2/19/2013	Failure to achieve minimum performance measure standards established in the 2009-2012 Medicaid Health Plan Contract Performance Measure Groups: - Mental Health & Substance Abuse - Prenatal/Postpartum	$15,000	Paid
Florida	FL - AHCA	Sanction/Fine/Liquidated Damages	2/19/2013	2/19/2013	Failure to achieve minimum performance measure standards established in the 2009-2012 Medicaid Health Plan Contract for the Vista Health Plan.	$10,000	Paid
Florida	FL - AHCA	CAP	2/23/2012	3/4/2012	Hospital 60 day inpatient admission hold	$10,000	Paid
Florida	FL - AHCA	Sanction	2/19/2013	3/12/2013	2-19-13 notification of a fine for failure to achieve minimum performance measures related to HEDIS Preventative Care. The fine is $6,000 -- $2,000 for each measure we missed. The specific HEDIS areas of concern are: Cervical Cancer Screening (ccs) 42.7% Adults' Access to Preventive/Ambulatory Health Services (aap) 61.0% Annual Dental Visit (adv) 41.8% 10/18/13 - closing action due to health plan acquisition	$6,000	Paid
Florida	FL - AHCA - BMHC & HSD	CAP	2/17/2014	1/15/2015	The health Plan submitted a CAP to AHCA for failure to achieve the required 80% participation rate.	$25,000	Paid
Florida	FL - AHCA - BMHC & HSD	Sanction/Fine/Liquidated Damages	2/7/2014	3/10/2014	Coventry failed to achieve the required Federal 80% participation ratio. Coventry Health Care of Florida, and Coventry Health Plan of Florida were assessed $25,000 in liquidated damages.	$50,000	Paid
Florida		Sanction/Fine/Liquidated Damages	1/7/2015	1/31/2015	Failure to obtain approval of enrollee materials	$500	Paid

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Illinois	IL- HFS	Sanction/Fine/Liquidated Damages	10/17/2017	10/17/2017	Fine for encounter inaccuracy - below the 95% threshold at 94.39%.	$50,000	Paid
Illinois	IL- HFS	Sanction/Fine/Liquidated Damages	5/16/2017	5/16/2017	Medical Management: Pursuant to Article VII, Section 7.16.14, the Department is hereby providing Aetna written notice they are in direct violation of Section 5.1.2 failure to provide service under Service Package II of the ICP contract. Sanction is due to plan's failure to complete the process of requesting "closure of this member's waiver services."	$28,732.68	Paid
Louisiana	LA -DHH	Notice of Non-Compliance	6/25/2018	6/25/2018	Inaccurate Provider Directory- Correction of provider information due by July 10th.	$50,000	Paid
Louisiana	LA -DHH	Sanction/Fine/Liquidated Damages	12/19/2017	12/19/2017	Failure to Submit Financial Reports Timely. The 2017 third quarter financial reports were due to LDH on November 30, 2017, but Aetna did not submit these reports until December 8, 2017. Per Section 20.3 of the contract, failure to submit accurate standing and ad hoc reports carries a monetary penalty of $2,000 per calendar day each report is late or deemed incorrect. Because Aetna submitted the report eight days after the deadline, a penalty of $16,000 will be assessed.	$16,000	
Louisiana	LA -DHH	Notice of Non-Compliance	10/25/2017	10/25/2017	Regulatory Reporting - Data Integrity: By letter dated January 18, 2017, Aetna was notified that penalties would be levied should Aetna fail to submit accurate Specialized Behavioral Health Services (SBHS) quarterly network standing reports in the format prescribed by LDH to meet contract requirements. The attached monitoring feedback and requests for correction for SBHS network quarterly reports through 2017 Quarter 2 demonstrate that Aetna continued to submit inaccurate report data. Due to Aetna's failure to submit accurate reports according to the report format prescribed by LDH in accordance with Section 18.10 and the Table of Monetary Penalties in Section 20 of the contract, a penalty in the amount of $2,000 per calendar day for the 2017 Q2 Report 328 - Behavioral Health Provider Network Detail will be assessed for the period of April 1, 2017 through June 30, 2017 (91 days). The sum of $182,000 will be permanently retained from the 2% PMPM withhold amount to be released in November.	$182,000	Paid
Louisiana	LA -DHH	Notice of Non-Compliance	4/4/2016	12/15/2016	Failure to meet encounter data submission requirements.	$570,000	Paid
Louisiana	LA -DOI	Sanction	2/1/2014	2/19/2014	Received civil fine of $1,500.00 from DOI for failure to file biographical information on certain officers associated with the HMO application back in 2010. There was also a revised consent agreement.	$1,500	Paid
Louisiana		Sanction/Fine/Liquidated Damages	7/21/2017	7/21/2017	Regulatory Reporting - Data Integrity: Notice of Monetary Penalty issued because of Aetna's failure to submit accurate Specialized Behavioral Health Services reports as required by Aetna's contract with LDH. CAP updates from the plan to begin on 8/24 per email from LDH.	$44,000	Paid

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Michigan	MI Department of Community Health (MDCH) - Medicaid	Notice of Non-Compliance	6/11/2017	7/11/2017	State of Michigan, Department of Insurance and Financial Services, sent notice that contains allegations that Nations Insurance Agency Harper Woods failed to comply with certain requirements set forth in the Michigan Insurance Code. This Notice contains three parts. They are: Part A. Allegations that you have violated one or more provisions of the Code. Part B. The applicable law and possible penalties related to the violations allegedly committed. Part C. Explanation of procedures for you to follow in order to respond to this Notice as required by law. You are required to provide a written response to the allegations within the Notice by Tuesday, July 11,2017.	$1,000	Paid
Michigan		Sanction/Fine/Liquidated Damages	8/18/2017	8/18/2017	Provider Contract Filing Failure: There was a $1,000 fine imposed as a result of the Notice to Show Compliance-Enforcement Case #17-14736.	$1,000	Paid
Missouri	MO HealthNet	Sanction/Fine/Liquidated Damages	1/6/2017	1/6/2017	Credentialing: MO HealthNet conducted a review of 28 ABHMO providers credentialing files. This is the second response of this review (see Sanction rec'd 11/2016), finding 16 remaining applications not credentialed within the 60 business day timeframe.	$80,000	Paid
Missouri	MO HealthNet	Sanction/Fine/Liquidated Damages	11/10/2016	11/18/2016	Credentialing: MHD received complaints that ABH-Mo were not credentialing providers in a timely manner. As a result, MHD provided ABH-Mo with a spreadsheet of 20 providers and asked us to submit information regarding the credentialing of the providers in question. After reviewing the information provided, MHD notified ABH-Mo that we were not in compliance with the timeframes in our contract and as a result we are being fined $35,000. We are reviewing the information provided and researching other areas/requests from the State that could result in sanctions.	$35,000	Paid
Missouri	MO HealthNet	Sanction/Fine/Liquidated Damages	3/4/2016	5/5/2016	Delegation Oversight: Sanction of $16,300 for failure to notify and receive approval from the State for a subcontractor agreement with the vendor FirstSource. The sanction represents liquidated damages of $100 per day for 163 days and will be withheld from the May 5, 2016 monthly capitation payment.	$16,300	Paid
Missouri		Sanction/Fine/Liquidated Damages	6/1/2016	6/1/2016	Withhold due to reporting encounter data	$706,489	Paid
Missouri		Sanction/Fine/Liquidated Damages	3/1/2016	3/1/2016	Withhold due to reporting encounter data	$142,384	Paid
Missouri		Sanction/Fine/Liquidated Damages	3/1/2016	3/1/2016	Withhold due to reporting encounter data	$1,669,687	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	3/31/2017	3/31/2017	Encounters Sanctions: In March 2017, the State assessed a sanction of $6,322.32 for duplicate encounters. These amounts were withheld from the April 2017 capitation payment for failure to meet benchmarks established by State per category of service (COS). A total of $46,515.60 was incurred as sanctions for duplicate encounters.	$6,322.32	Paid

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New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	2/28/2017	2/28/2017	Encounters Withholds and Sanctions: In February 2017, the State assessed a total net withhold of $103,587 for failure to meet encounter requirements, along with a sanction of $2,002.96 for duplicate encounters. These amounts were withheld from the March 2017 capitation payment for failure to meet benchmarks established by State per category of service (COS). Underutilization is key contributing factor for gap to benchmark. Once status changes from withhold to sanction, on a monthly basis, Plan will submit Attestation of Underutilization to seek damage relief for as long as an underutilization issue exists. The May 2015, June 2015 and July 2015, for $10,716, $92,282 and $57,226, respectively, attestations were submitted; State response is pending. The August 2015 Attestation will be submitted at the end of March 2017. To date, State has withheld $1,166,943, of which $139,334 has been recouped through the submission of additional encounters, and $162,802 that was ready for final conversion to a sanction has been/is to be returned. $60,996 collected, and $101,806 is to be paid back to the plan in March 2017, leaving a current net withhold of $864,807. A total of $43,528 was incurred as sanctions for duplicate encounters.	$2,002.96	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	1/31/2017	1/31/2017	Encounters Sanctions: In January 2017, the State assessed a sanction of $4,996.36 for duplicate encounters. These amounts were withheld from the February 2017 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$4,996.36	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	12/30/2016	12/30/2016	Encounters Sanctions: In December 2016, the State assessed a sanction of $180.16 for duplicate encounters. These amounts were withheld from the January 2017 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$180.16	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	10/31/2016	10/31/2016	Encounters Sanctions: In December 2016, the State assessed a sanction of $72.94 for duplicate encounters. These amounts were withheld from the January 2017 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$72.94	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	9/30/2016	9/30/2016	Encounters Sanctions: In September 2016, the State assessed a sanction of $689.50 for duplicate encounters. These amounts were withheld from the October 2016 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$689.50	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	8/31/2016	8/31/2016	Encounters Sanctions: In August 2016, the State assessed a sanction of $55.10 for duplicate encounters. Also included is $20,576.00 received due to the capitated detail report. These amounts were withheld from the September 2016 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$20,631.10	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	5/31/2016	5/31/2016	Encounters Sanctions: In May 2016, the State assessed a sanction of $335.10 for duplicate encounters. These amounts were withheld from the June 2016 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$335.10	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	4/29/2016	4/29/2016	Encounters Sanctions: In April 2016, the State assessed a sanction of $6180.00 for duplicate encounters. These amounts were withheld from the May 2016 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$6,180	Paid

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New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	3/31/2016	3/31/2016	Encounters Sanctions: In March 2016, the State assessed a sanction of $133.48 for duplicate encounters. These amounts were withheld from the April 2016 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$133.48	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	2/29/2016	2/29/2016	Encounters Sanctions: In February 2016, the State assessed a sanction of $2378.02 for duplicate encounters. These amounts were withheld from the March 2016 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$2,378.02	Paid
New Jersey	NJ DMAHS	Sanction/Fine/Liquidated Damages	1/29/2016	1/29/2016	Encounters Sanctions: In January 2016, the State assessed a sanction of $2593.66 for duplicate encounters. These amounts were withheld from the February 2016 capitation payment for failure to meet benchmarks established by State per category of service (COS).	$2,593.66	Paid
New Jersey		Sanction/Fine/Liquidated Damages	3/1/2018	3/1/2018	Duplicate Encounters Submission for March.	$8,171	Paid
New Jersey		Sanction/Fine/Liquidated Damages	2/1/2018	2/1/2018	Duplicate Encounters Submission for February.	$2,354	Paid
New Jersey		Sanction/Fine/Liquidated Damages	10/1/2017	10/1/2017	Duplicate Encounters Submission	$404	Paid
New Jersey		Sanction/Fine/Liquidated Damages	8/1/2017	8/1/2017	Duplicate Encounters Submission	$1,057	Paid
New Jersey		Sanction/Fine/Liquidated Damages	7/1/2017	7/1/2017	Duplicate encounter submissions	$1,057	Paid
New Jersey		Sanction/Fine/Liquidated Damages	6/1/2017	6/1/2017	Duplicate encounter submissions	$7,882	Paid
New York	NY - DOH	Sanction	11/1/2015	11/30/2015	Capitation payments were made to the plan for members retro enrolled 10/2013 - 11/2015	$1,595,511	Paid
Ohio -OH Aetna Better Health of Ohio	OH-HSAG	Notice to Cure	9/1/2015	9/30/2015	Grievance and Appeal file submission was untimely	$10,000	Paid
Ohio -OH Aetna Better Health of Ohio	Ohio Department of Medicaid (ODM)	CAP	1/30/2018	1/30/2018	Failures within the Aetna Better Health of Ohio (Aetna) MyCare Ohio Care Management Program and with waiver incident reporting. Pursuant to Appendix N of the MCOP Provider Agreement, the Bureau of Managed Care Compliance and Oversight (BMCCO) is assessing a 10 point penalty against Aetna. This penalty brings Aetna's point total to 35, which is accompanied by a monetary penalty of $10,000 for the accumulated point total.	$10,000	Paid
Ohio -OH Aetna Better Health of Ohio	Ohio Department of Medicaid (ODM)	Notice of Non-Compliance	8/1/2017	8/1/2017	Network Adequacy: Failure to meet the provider panel requirements in the zip code(s) for which Aetna Better Health of Ohio holds a provider agreement. Plan received a revised letter on 8-3-2017 stating that they will be assessing a $2,000 fine.	$2,000	Paid
Ohio -OH Aetna Better Health of Ohio	Ohio Department of Medicaid (ODM)	Sanction	3/16/2015	2/29/2016	Ohio Department of Medicaid (ODM) issued a Notice of Noncompliance (NONC) on March 16, 2015 for plan's failure to timely mail all 2015 marketing materials to members passively and renewing enrolled for both Medicare and Medicaid effective January 1, 2015. The plan was assessed 5 points under ODM's compliance methodology bringing total points to 20 points. As a result, ABHO assessed a $5,000 fine under the progressive sanctions outlined in the state contract. Plan required to propose CAP on March 30, 2015.	$5,000	Paid

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Ohio -OH Aetna Better Health of Ohio	Ohio Department of Medicaid (ODM)	Sanction	3/6/2015	1/31/2016	Ohio Department of Medicaid (ODM) issued notice of noncompliance (NONC) for plan's failure to timely mail all required 2015 member marketing materials. The NONC required plan to submit a CAP by March 25, 2015. The plan submitted a CAP on March 24, 2015. The NONC imposes a 5 point penalty under ODM's progressive sanction methodology. This point assessment, combined with prior points, brings the plan to 20 pomts within a 12 month period. As a result of having points in the range of 16-25, the Plan is also assessed a $5,000 fine that must be paid by April 16, 2015.	$5,000	Paid
Ohio -OH Aetna Better Health of Ohio		Sanction/Fine/Liquidated Damages	5/10/2017	5/10/2017	Medical Management: Failure to meet care management requirements for the following four focus areas standards: Care Coordination, Transition of Care and Significant Events Follow-up, Person Centered Care, and Working toward Improved Outcomes. Request for reconsideration of remedial action under the CAS was approved in part with a reduced sanction of $5,000. CAP was accepted on 7-13-2017.	$5,000	Paid
Ohio -OH Aetna Better Health of Ohio		Sanction	12/29/2015	3/30/2016	Notice of Noncompliance from Ohio Department of Medicaid for failure to meet 30 second average speed to answer metric by 5 seconds in November 2015. Plan assessed 10 points and $20,000. Movement of nurse advice line to plan with dedicated Ohio staff during business hours.	$20,000	Paid
Ohio -OH Aetna Better Health of Ohio		Sanction	11/6/2015	3/30/2016	Notice of Noncompliance for submission of provider file that reflected noncompliance in provider panel requirements. $1,000 fine assessed. Plan requested technical assistance and improved QA process in producing complex files in manner that accurately reflects network.	$1,000	Paid
Ohio -OH Aetna Better Health of Ohio		Sanction	8/14/2015	11/15/2015	ODM conducted 2015 quarterly on site reviews/audits of samples of case management files in March, September and October 2015 to assess compliance with contract requirements for care management. This is being done with all Ohio Plans to shed light on the My Care Ohio program for the Ohio Department of Medicaid. One compliance action issued in regard to the first quarterly 2015 audit that occurred in March 2015. After request for reconsideration partially granted, plan assessed 20 points and $20,000 fine and state undertook reevaluation of scoring criteria for future audits.	$20,000	Paid
Ohio -OH Aetna Better Health of Ohio		Sanction	8/11/2015	6/30/2015	Notice of Noncompliance from Ohio Department of Medicaid for failure to meet 30 second average speed to answer metric by 4 seconds in June 2015. Plan assessed 5 points and $5,000 fine. Realignment of staff and Ohio call queues within corporate nurse advice call center	$5,000	Paid
Pennsylvania	HHSC	CAP	9/23/2014	10/3/2014	CAP/Fine -$1000 because Plan Pharmacy Encounters performance was 104% when the allowable variance is within 2% from the Standard Measure of 100% Fine paid, CAP pending acceptance	$1,000	Paid

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Pennsylvania	PA - DPW	Sanction/Fine/Liquidated Damages	12/5/2017	12/5/2017	The Department of Human Services (DHS) has reviewed your monthly claims processing report due November 6, 2017. In the Southwest Zone (SW), Aetna only adjudicated 98.4%. This percentage resulted in a sanction of $1,000 which was reduced to 333.00 due to low membership in this zone. In the Southeast Zone (SE), Aetna only adjudicated 98.8%. This percentage resulted in a sanction of $1,000.00. Also, Aetna only adjudicated 99.2% of Other than Inpatient clean claims within 45 days while the adjudication requirement for this timeframe is 100%. This percentage resulted in a sanction of $1,000.00. In the Leigh/Capital Zone (LC), Aetna only adjudicated 98.7%. This percentage resulted in a sanction of $1,000.00 which was reduced to $667.00 due to low membership in this zone. In the Northeast Zone (NE) Aetna only adjudicated 98.8%. This percentage resulted in a sanction of $1,000.00 which was reduced to $667.00 due to low membership in this zone. In the Northwest Zone (NW) Aetna only adjudicated 98.8%. This percentage resulted in a sanction of $1,000.00 which was reduced to $333.00 due to low membership in this zone. Sanctions calculated for this month totaled $ 4,000 as detailed above.	$4,000	Paid
Pennsylvania	PA - DPW	Sanction	10/1/2015	10/1/2015	Claim Timeliness Compliance	$2,000	Paid
Pennsylvania	PA - DPW	Sanction	9/2/2015	9/2/2015	Claim timeliness compliance	$1,333	Paid
Pennsylvania	PA - DPW	Sanction	1/28/2013	1/28/2013	On 01/28/2013, the Pennsylvania Department of Public Welfare assessed a fine for claims processed outside of contract requirements. In addition to the fees related to the claims processed outside of the contract requirements, the sanction was increased in both the Southeast and Lehigh Capital zone to $10,000 for each month lack of compliance occurs when timeliness requirements are missed in 7 out of 9 months.	$4,000	Paid
Pennsylvania		Sanction/Fine/Liquidated Damages	11/6/2017	11/6/2017	In the Northwest Zone (NW) Aetna only adjudicated 98.8% of Inpatient clean claims within 45 days while the adjudication requirement for this timeframe is 100%. This percentage resulted in a sanction of $1,000.00 which was reduced to $333.00 due to low membership in this zone.	$333	Paid
Pennsylvania		Sanction/Fine/Liquidated Damages	6/6/2017	6/6/2017	May 2017 Claims Processing Results. Found that not all regions were meeting the required percentages.	$7,667	Paid
Pennsylvania		Sanction/Fine/Liquidated Damages	5/3/2017	5/3/2017	November 2016 Claims Processing Results. Found that not all regions were meeting the required percentages.	$8,667	Paid
Pennsylvania		Sanction/Fine/Liquidated Damages	3/2/2017	3/2/2017	In the Northwest Zone (NW), Aetna only adjudicated 89.6% of Inpatient Clean claims within 30 days while the requirement for this timeframe is 90%. This percentage resulted in a sanction of $1,000 which was reduced to $333 due to the low membership in this zone.	$333	Paid
Pennsylvania		Sanction/Fine/Liquidated Damages	11/1/2016	11/30/2016	Claims Processing Timeliness	$10,666	Paid
Pennsylvania		Sanction/Fine/Liquidated Damages	10/1/2016	10/31/2016	Claims Processing Timeliness	$11,000	Paid
Texas	HHSC	Sanction/Fine/Liquidated Damages	4/16/2016	4/26/2016	Network Adequacy: Fine (CHIP Bexar)- $100.00 because GEO-Mapping mileage was 72.70% when standard is 75% for members in suburban counties within 5 miles of one pharmacy	$100	Paid
Texas	HHSC	CAP	4/16/2016	4/26/2016	Network Adequacy: CAP/Fine (STAR Bexar)- $100.00 because Geo-Mapping mileage was 65.50% when standard is 75% for members in suburban counties within 5 miles of one pharmacy	$100	Paid
Texas	HHSC	CAP	4/16/2016	4/26/2016	Regulatory Reporting - Data Integrity: CAP/Fine (STAR Bexar) -$1,000 because Frew Migrant Annual Report must be submitted on time, accurate and complete Report was incomplete (10 days)	$1,000	Paid

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Texas	HHSC	Sanction/Fine/Liquidated Damages	4/16/2016	4/26/2016	Fine (CHIP Bexar)- $250 because MCO Pharmacy encounters performance of 106% did not fall within the allowable 2% variance from the standard measure of 100%.	$250	Paid
Texas	HHSC	Sanction/Fine/Liquidated Damages	4/16/2016	4/26/2016	Fine (CHIP Tarrant)- $250 because MCO Pharmacy encounters performance of 105% did not fall within the allowable 2% variance from the standard measure of 100%.	$250	Paid
Texas	HHSC	Sanction/Fine/Liquidated Damages	4/16/2016	4/26/2016	Fine (STAR Bexar)- $250 because MCO Pharmacy encounters performance of 104% did not fall within the allowable 2% variance from the standard measure of 100%.	$250	Paid
Texas	HHSC	Sanction/Fine/Liquidated Damages	4/16/2016	4/26/2016	Fine (STAR Tarrant)- $250 because MCO Pharmacy encounters performance of 105% did not fall within the allowable 2% variance from the standard measure of 100%.	$250	Paid
Texas	HHSC	Sanction/Fine/Liquidated Damages	4/16/2016	4/26/2016	Fine (CHIP Bexar and Tarrant)- $5,000 because MCO Pharmacy encounter data must be submitted on time, accurate and complete. Pharmacy data was incomplete	$5,000	Paid
Texas	HHSC	CAP	4/16/2016	4/26/2016	CAP/Fine (STAR Bexar and Tarrant)- $5,000 because MCO Pharmacy encounter data must be submitted on time, accurate and complete. Pharmacy data was incomplete	$5,000	Paid
Texas	HHSC	CAP	12/16/2015	12/26/2015	CAP/Fine (CHIP Bexar and Tarrant) -$250.00 Encounter Data must be submitted on time Pharmacy encounters (not submitted)	$250	Paid
Texas	HHSC	CAP	12/16/2015	12/26/2015	CAP/Fine (CSTAR Bexar and Tarrant) -$250.00 Encounter Data must be submitted on time Pharmacy encounters (not submitted)	$250	Paid
Texas	HHSC	Sanction	1/16/2015	1/26/2015	Fine (STAR Bexar and Tarrant)-$300 because Frew Provider Recognition Report submitted 3 days late, inaccurate, and incomplete.	$300	Paid
Texas	HHSC	Sanction	1/16/2015	1/26/2015	Fine (STAR Bexar and Tarrant) -$1,200 because Frew Quarterly Monitoring Report was submitted 6 days late, inaccurate, and incomplete.	$1,200	Paid
Texas	HHSC	Sanction	1/16/2015	1/26/2015	Fine (STAR Bexar and Tarrant) -$4,000 Frew Quarterly Monitoring Report submitted 4 days late, inaccurate, and incomplete.	$4,000	Paid
Texas	HHSC	Sanction	9/29/2014	10/9/2014	Fine (STAR Bexar and Tarrant) -$1,300 because Frew Quarterly Monitoring Report submitted 13 days late, inaccurate, and incomplete.	$1,300	Paid
Texas	HHSC	CAP	9/23/2014	10/3/2014	CAP/Fine (STAR Tarrant) –$250 because Plan Pharmacy Encounters performance was 104% when the allowable variance is within 2% from the Standard Measure of 100%. Fine paid, CAP pending acceptance	$250	Paid
Texas	HHSC	Sanction	9/23/2014	10/3/2014	Fine (STAR Bexar and Tarrant) -$1,500 because Frew Medicaid Texas Health Steps (THSteps) Medical Checkups Report submitted 15 days late, inaccurate, and incomplete.	$1,500	Paid
Texas	HHSC	Sanction	9/3/2014	9/13/2014	Fine (STAR Bexar CHIP Bexar and Tarrant) -$200 each because Pharmacy Network Reports were submitted eight days late, inaccurate, or incomplete.	$200	Paid
Texas	HHSC	CAP	9/3/2014	9/13/2014	CAP/Fine -$600 because 73.68% of Member Hotline calls were answered within 30 seconds when 80% answer rate was required.	$600	Paid

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Texas	HHSC	CAP	9/3/2014	9/13/2014	CAP/Fine -$1,000 because Spanish section of plan website was not functional.	$1,000	Paid
Texas	HHSC	Sanction	9/3/2014	9/13/2014	Fine -$1,000 because Plan updated website without approval.	$1,000	Paid
Texas	HHSC	CAP	8/14/2014	8/24/2014	CAP/Fine -$10,000 for failure to provide notice of required coverage. Fine paid, CAP pending acceptance	$10,000	Paid
Texas	HHSC	CAP	8/14/2014	8/24/2014	CAP/Fine -$5,000 because CHIP Pharmacy Encounters performance was 103.00% when allowable variance is within 2% from the standard measure of 100%. Fine paid, CAP pending acceptance	$5,000	Paid
Texas	HHSC	CAP	8/14/2014	8/24/2014	CAP/Fine -$2,500 because STAR Pharmacy Encounters performance was 103.00% when allowable variance is within 2% from the Standard Measure of 100%. Fine paid, CAP pending acceptance	$2,500	Paid
Texas	HHSC	Sanction	8/14/2014	8/24/2014	Fine -$2,500 STAR Pharmacy Encounters performance was 103.00% when allowable variance is within 2% from the Standard Measure of 100%.	$2,500	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$8,800 because provider P92 files were submitted 88 days late, inaccurate or incomplete.	$8,800	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$8,800 because provider P94 files were submitted 88 days late, inaccurate or incomplete.	$8,800	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine –$850 because STAR Bexar Provider Termination reports were submitted 34 days late, inaccurate or incomplete. Fine paid and CAP pending acceptance	$850	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$750 because STAR Tarrant Provider Termination reports were submitted 30 days late, inaccurate or incomplete. Fine paid and CAP pending acceptance	$750	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$1,000 because Medical Encounter performance of 85% and did not fall within the allowable 2% variance from the standard measure of 100%. Fine paid and CAP pending acceptance	$1,000	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$250 because MCO Medical encounters performance of 91% did not fall within the allowable 2% variance from the standard measure of 100%. Fine paid, CAP pending acceptance	$250	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$3,600 because Vision Claim Summary Reports were submitted nine days late, inaccurate, or incomplete. Fine paid, CAP pending acceptance	$3,600	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$500 because Pharmacy Claims Summary Reports were submitted 20 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	$500	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$3,450 because CHIP Claims Summary Reports were submitted 69 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	$3,450	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP & Fine -$2,500 because Pharmacy Encounters performance was 104.00% when allowable variance was within 2% from the Standard Measure of 100%. Fine paid, CAP pending acceptance	$2,500	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine (STAR & CHIP) -$2,000 because Financial Statistical Reports were submitted 20 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	$2,000	Paid
Texas	HHSC	Sanction	8/17/2012	8/27/2012	Fine –$825 for non-compliance with contract performance measures for our Texas Medicaid risk business.	$825	Paid

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Texas	HHSC	Sanction	8/17/2012	8/27/2012	Fine (STAR Bexar, CHIP Bexar, STAR Tarrant, and CHIP Tarrant) -$200 each for answering CHIP Hotline calls within 30 seconds 78.63% of the time, instead of meeting the 80% performance standard.	$200	Paid
Texas	HHSC	Sanction	12/4/2014	12/14/2014	Fine -$200 because Frew Medicaid Texas Health Steps (THSteps) Medical Checkups Report considered 2 days late, inaccurate, and incomplete.	$200	Paid
Texas	HHSC	Sanction	12/4/2014	12/14/2014	Fine -$2,100 because Frew Annual Provider Training Report was considered 21 days late, inaccurate, and incomplete.	$2,100	Paid
Texas	HHSC	CAP	11/21/2014	12/1/2014	Disincentive/CAP -$136,230 for failure to achieve the required checkup participation rates for new members. CAP pending acceptance	$136,230	Paid
Texas	HHSC	Sanction	8/21/2014	8/31/2014	Fine -$40 because 75.55% of Member Hotline calls were answered within 30 seconds when required answer rate was 80%	$40	Paid
Texas	HHSC	Sanction	8/21/2014	8/31/2014	Fine -$25 because Provider Hotline Reports were submitted one day late, inaccurate, or incomplete.	$25	Paid
Texas	HHSC	Sanction	8/21/2014	8/31/2014	Fine -$50 because 95% of member appeals were resolved within 30 calendar days when the required resolution rate was 98%.	$50	Paid
Texas	HHSC	CAP	8/11/2014	8/21/2014	CAP/Fine -$525 because STAR Member Appeals Reports were submitted 21 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	$525	Paid
Texas	HHSC	CAP	8/11/2014	8/21/2014	CAP/Fine (STAR & CHIP) -$500 each for prohibited marketing practices. Fines paid, CAPs pending acceptance	$500	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$4,400 because Specialist Network Report was submitted 88 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	$4,400	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$325 because MC Provider Termination Report was submitted 13 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	$325	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$500 because STAR Acute Claims Summary Report was submitted five days late, inaccurate, or incomplete. Fine paid, CAP pending acceptance	$500	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine –S$4,350 because STAR Specialist Network Report was submitted 87 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	$4,350	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/ Fine -$600 because STAR Financial Statistical Reports were submitted six days late, inaccurate, or incomplete. Fine paid, CAP pending acceptance	$600	Paid
Texas	HHSC	CAP	6/2/2014	6/12/2014	CAP/Fine -$6,150 because Certificate of Insurance was submitted 123 days late, inaccurate or incomplete. Fine paid, CAP pending acceptance	$6,150	Paid
Texas	HHSC	Sanction	9/1/2011	9/11/2011	Fine –$1,000 for non-compliance with performance measures.	$1,000	Paid
Texas	HHSC	Sanction	9/1/2011	9/11/2011	Fine -$1,000 for a marketing violation.	$1,000	Paid

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Texas	TX - HHSC	Sanction/Fine/Liquidated Damages	5/24/2018	5/24/2018	A review of your reports for the third quarter of state fiscal year {SFY) 2017 found one material noncompliance issues. HHSC met with Aetna on February 26, 2018, to discuss its preliminary noncompliance findings. During the meeting, Aetna stated that they would confirm that the Pharmacy Reconciliation Report was in compliance for the STAR Kids program. HHSC sent that detail on September 27, 2017. Aetna failed to submit a revised Report. HHSC considered all additional mitigating factors submitted by Aetna. Aetna's final assessment amount for Quarter 3, SFY 2017 is $250.	$250	Paid
Texas	TX - HHSC	CAP	3/20/2017	3/20/2017	Encounter Reconciliation Report within a 2% variance.	$5,000	Paid
Texas	TX - HHSC	Sanction/Fine/Liquidated Damages	3/20/2017	3/20/2017	Delegation Oversight: Failed to perform an Administrative Service. Aetna Superior failed to submit copies of material subcontract(s) for Block Vision within 5 business days of execution.	$500	Paid
Texas	TX - HHSC	Sanction	6/3/2014	9/30/2014	Received notice of assessment of Liquidated Damages in the amount of $220,725.00. Health Plan is going to pay $38,400 and appeal the remainder. Appeal /Request for Clarification was submitted to HHSC on 6/5/14.	$38,400	Paid
Texas	TX - HHSC	Sanction	5/29/2013	7/5/2013	Q4 2012 (June-Aug)	$1,200	Paid
Texas	TX - HHSC	Sanction	5/29/2013	7/5/2013	Q4 2012 (June-Aug)	$1,000	Paid
Texas	TX - HHSC	Sanction	6/3/2014	12/31/2014	Received notice of assessment of Liquidated Damages in the amount of $64,100.00. Review of Aetna's responsibility determined Aetna is responsible for $11,650.00; CHRISTUS is appealing $35,400.00; some of which will be Aetna's responsibility if appeal fails.	$11,650	Paid
Texas	TX - HHSC	Sanction	6/3/2014	12/31/2014	Received notice of assessment of Liquidated Damages in the amount of $64,100.00. Review of Aetna's responsibility determined Aetna is responsible for $11,650.00; CHRISTUS is appealing $35,400.00; some of which will be Aetna's responsibility if appeal fails.	$11,650	Paid
Texas	TX - HHSC	CAP	6/10/2013	6/17/2013	Medical Encounter Submissions - 96% (985 standard)	$250	Paid
Texas	TX - HHSC	Sanction	6/10/2013	6/17/2013	Pharmacy Encounter submission - 92% (96% standard)	$250	Paid
Texas	TX - HHSC	CAP	6/3/2013	8/30/2013	Received CAP due to Encounter Report having a greater than 2% variance.	$750	Paid
Texas	TX - HHSC	Sanction	1/24/2013	6/17/2013	Pharmacy Encounter Submission 92% (98% standard)	$250	Paid
Texas	TX - HHSC	Sanction	6/3/2014	12/31/2014	Received notice of assessment of Liquidated Damages in the amount of $19,750.00. Review of Aetna's responsibility determined Aetna is responsible for $9,075.00.	$9,075	Paid
Texas	TX- HHSC	Sanction/Fine/Liquidated Damages	11/8/2017	11/8/2017	Invalid Member ID's on encounter submissions.	$8,000	Paid
Texas	TX- HHSC	Sanction/Fine/Liquidated Damages	11/8/2017	11/8/2017	G&A: Member complaints 98% resolved within 30 days didn't meet requirement. Actual performance was 89%. Liquidated damages of $25 for First Occurrence.	$25	Paid
Texas	TX- HHSC	Sanction/Fine/Liquidated Damages	6/2/2017	6/2/2017	A review of your reports for the fourth quarter of state fiscal year (SFY)2017 found thirteen material noncompliance issues. Encounter Data must be submitted on time. Pharmacy Encounters, Fifth Occurrence. HHSC is assessing liquidated damages against Aetna in the amount of $30,000.	$30,000	Paid

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Texas	TX- HHSC	Sanction/Fine/Liquidated Damages	6/2/2017	6/2/2017	A review of your reports for the fourth quarter of state fiscal year (SFY)2017 found thirteen material noncompliance issues. Member appeals 98% resolved within 30 days. Actual was 95.65%, second occurrence. HHSC is assessing liquidated damages against Aetna in the amount of $500.	$500	Paid
Texas		Sanction/Fine/Liquidated Damages	12/1/2016	12/1/2016	Claims Processing Timeliness	$2,000	Paid
Texas		Sanction/Fine/Liquidated Damages	12/1/2016	12/1/2016	Claims Processing Timeliness	$2,000	Paid
Texas		Sanction/Fine/Liquidated Damages	12/1/2016	12/1/2016	Reporting - Encounter Data	$2,000	Paid
Texas		Sanction/Fine/Liquidated Damages	12/1/2016	12/1/2016	Reporting - Encounter Data	$15,000	Paid
Texas		Sanction/Fine/Liquidated Damages	12/1/2016	12/1/2016	Reporting - Encounter Data	$15,000	Paid
Texas		Sanction/Fine/Liquidated Damages	8/1/2016	8/1/2016	G&A: 94% of member complaints were resolved within 30 calendar days when the required resolution rate was 98%	$50	Paid
Texas		Sanction/Fine/Liquidated Damages	8/1/2016	8/1/2016	Claims Processing Timeliness	$1,000	Paid
Texas		Sanction/Fine/Liquidated Damages	8/1/2016	8/1/2016	Claims Processing Timeliness	$1,000	Paid
Texas		Sanction/Fine/Liquidated Damages	8/1/2016	8/1/2016	Reporting - Encounter Data	$250	Paid
Texas		Sanction/Fine/Liquidated Damages	6/1/2016	6/1/2016	G&A: (Bexar CHIP) Claim Appeal - Timeliness: The plan failed to meet the minimum state performance measure of processing 98% of provider claim appeals within 30 days. Plan performance(s): 75%	$1,000	Paid
Texas		Sanction/Fine/Liquidated Damages	6/1/2016	6/1/2016	Reporting - Encounter Data	$15,000	Paid
Texas		Sanction/Fine/Liquidated Damages	6/1/2016	6/1/2016	Reporting - Encounter Data	$15,000	Paid
Texas		Sanction/Fine/Liquidated Damages	6/1/2016	6/1/2016	Reporting - Encounter Data	$250	Paid
Texas		Sanction/Fine/Liquidated Damages	6/1/2016	6/1/2016	Regulatory Reporting - Untimely: Plan failed to provide timely response to HHSC contractor, DK partners, during audit requests for finance review	$2,000	Paid
Virginia	VA-DMAS	Sanction/Fine/Liquidated Damages	6/1/2018	6/1/2018	Based on Aetna's April 2018 encounter submission, the Encounter Data Quality ("EDQ") report for April identified an area of violation. Further review revealed that Aetna has 163,105 encounters showing for Lag Days Critical Issues deviating from the established encounter submission schedule. Aetna will be issued one (1) point total for Aetna's inability to meet the timeliness (lag days) requirement for encounter submissions. Aetna has accumulated 25.0 points total to date. As described in Section 13.2.B of the Medallion 3. 0 Contract, remaining in Level 2 on the Compliance Deficiency Identification System requires a Financial Sanction in the amount of $5,000.	$5,000	Paid

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Virginia	VA-DMAS	Sanction/Fine/Liquidated Damages	4/30/2018	4/30/2018	Based on Aetna's March 2018 encounter submission, the Encounter Data Quality ("EDQ") report for March identified an area of violation. Further review revealed that Aetna has 15,764 encounters showing for Lag Days Critical Issues deviating from the established encounter submission schedule. Aetna shall submit a Corrective Action Plan ("CAP"). The CAP should be submitted to the Department no later than 30 calendar days from the date of this letter. Aetna will be issued two (2) points total. Since Aetna has accumulated 24.0 points total to date there will be a Financial Sanction in the amount of $5,000.	$5,000	Paid
Virginia	VA-DMAS	Sanction/Fine/Liquidated Damages	3/5/2018	3/5/2018	Aetna submitted the Foster Care Barrier Report for January 2018 deliverables to the Department. Upon review, it was discovered that these deliverables were either: 1) received past the submission deadline and/or 2) contained submission errors. All submissions received after the deadline (15th of the following month) incur an automatic ten (10) percent grading penalty for each day late. Submission errors also incur grading penalties as expressed in Section 13.2.C.IV.b of the Medallion 3. 0 Contract. Due to this penalty, Aetna received the following letter grade for this report: Foster Care Barrier Report: B. As a result of the error identified above, Aetna shall be issued a 0.5 point violation for the Foster Care Barrier Report pursuant to Section 13. 2. C. IV. b of the Medallion 3. 0 Contract. As Aetna is now in Level 3 on the Compliance Deficiency Identification System, a Financial Sanction in the amount of $10,000 will be assessed.	$10,000	Paid
Virginia	VA-DMAS	Sanction/Fine/Liquidated Damages	11/30/2017	11/30/2017	In reviewing the most recent EDQ Critical Issues End of Month Report dated November 20, 2017, Aetna has a remaining outstanding issue from the month of July 2017. Aetna shall be issued a one (1) point violation pursuant to Section 13.2.C.I of the Medallion 3.0 due to failure to correct July's 2017 I015 ESC code error by the deadline given by the Department. Aetna has accumulated 24.5 points total to date. As described in 13.2.B of the Medallion 3.0 contract, Level 2 on the Compliance Deficiency Identification System requires a Financial Sanction in the amount of $5,000.	$5,000	Paid
Virginia	VA-DMAS	Sanction/Fine/Liquidated Damages	11/30/2017	11/30/2017	Based on Aetna's October 2017 encounter submissions, the Encounter Data Quality ("EDQ") report for October identified a potential area of violation. Several pharmacy rebate critical issues were identified: I201, I202, I203, I204, I205, I206, and I210. As a result of the critical error identified above, Aetna shall be issued a one (1) point violation for October 2017 rebate issues pursuant to Section 13.2.C.I of the Medallion 3.0. Aetna has accumulated 24.5 points total to date. As described in 13.2.B of the Medallion 3.0 contract, Level 2 on the Compliance Deficiency Identification System requires a Financial Sanction in the amount of $5,000.	$5,000	Paid
Virginia	VA-DMAS	Sanction/Fine/Liquidated Damages	10/31/2017	10/31/2017	$5,000 sanction for encounter data accuracy.	$5,000	Paid

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Virginia	VA-DMAS	Sanction/Fine/Liquidated Damages	10/31/2017	10/31/2017	Based on Aetna's September 2017 encounter submissions, the Encounter Data Quality ("EDQ") report for September identified a potential area of violation. Several pharmacy rebate critical issues were identified: I201, I202, I203, I204, I205, I206, I207, I208, I209 and I210. Further review revealed that Aetna's September 2017 encounter submission had 298 encounters receiving one of the ESC codes listed above. Aetna has accumulated 22.5 points total to date. As described in 13.2.B of the Medallion 3.0 contract, reaching Level 2 on the Compliance Deficiency Identification System requires a Financial Sanction in the amount of $5,000.	$5,000	Paid
Virginia	VA-DMAS	Sanction/Fine/Liquidated Damages	9/29/2017	9/29/2017	Encounters: Aetna has now accumulated 15.5 points. As described in Section 13.2.B of the Medallion 3.0, Aetna is now in the Level 2 deficiency. Thus, The Department is issuing a Financial Sanction in the amount of $5,000 pursuant to Section 13.2.B of the Medallion 3.0. The referenced sanction amount shall be deducted from your monthly capitation payment. Generally, deductions shall be initiated within 3 0 calendar days from the end of the Comment Period.	$5,000	Paid
West Virginia	Bureau for Medical Services (BMS)	Audit/Review	2/20/2015	3/19/2015	CCWV's City of Charleston Business License Application due on 6/30/15 was submitted at the beginning of July. The state charged a small late fee of $7.39.	$7.39	Paid
West Virginia	WV Dept of Health and Human Resources, Bureau for Medical Services	CAP	3/4/2014	12/9/2014	BMS claims that as of 2/12/14, Scion, CCWV's Dental Vendor failed to meet its contractual obligation of claims payment timeliness for 249 network providers. The initial CAP included what BMS termed a Sanction. The Sanction was actually the interest penalty of $35.06 owed for the 249 late claims. This event occurred due to some issues around roll-out of the Dental Program which moved from FFS to the MCOs on 1/1/14. Changes to the structure of the program and reimbursement rates caused some administrative delays and delays with the LOA which stalled payment to the health plans and to the DBM. Coventry advanced the DBM monies to initiate payments. However, after that sum was depleted and BMS still had not released payment to the health plan, the subcontractor adjudicated claims but did not release 249 provider payments timely. Coventry's contract with BMS included a paragraph that indicated the plan is not responsible for timely payment when BMS is more than 15 days delinquent in their payment to the MCO. Therefore, on 3/19/14 CCWV requested a Document/Desk Review before working the CAP. 8/29/14 BMS responded and removed the Sanction portion of the action. They upheld the CAP. CAP submitted to BMS on 10/8/2014.	$35.06	Paid

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Table H- Aetna's Medicare Sanctions

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Table H - Aetna's Medicare Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	12/2019	Other	Failure to provide accurate communications	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2019	Other	Failure to have a state license in states in which the organization offers MA plans.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2019	Other	Failure to provide accurate communications	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	11/2019	Other	Failure to adhere to marketing requirements. Specifically, marketing for the 2020 plan year prior to October 1,2019; failing to include the material ID on the material; and failing to include required disclaimers on the material.	Notice of Non-Compliance	No	Closed
MI	Medicare/CMS	10/2019	Other	Failure to send out Integrated Denial Notices (IDN) to members using the current model as issued by CMS and MDHHS with the correct appeals process and ombudsman information.	Notice of Non-Compliance	No	Closed
MI	Medicare/CMS	05/2019	Other	Failure to meet the CMS standard for the disconnect percentage rate for the CMS Call Center metrics for Q1-2019	Notice of Non-Compliance	No	Closed
MI	Medicare/CMS	04/2019	Other	Failure to include correct information regarding eye exams, hearing aid, and transportation benefits in the CY 2019 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC)/Member Handbook	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2019	Other	Failure to accurately describe benefits and/or cost sharing information in Annual Notice of Change (ANOC) document(s) which prevents enrollees from making a fully informed health care choice.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2019	Other	Failure to meet administrative and management requirements - Low Star Ratings. CMS is requesting that your organization develop and implement a corrective action plan designed to ensure that it will achieve at least an “average” star rating. (1 Contract)	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	04/2019	Claims processing accuracy	Failure to meet the CMS’ requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2019	Other	Failure to adhere to the September 12, 2018 HPMS memo regarding the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) accuracy assessment	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2019	Other	Failure to meet the CMS standard for average hold time for the CMS Call Center Metrics for Q4-2018	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2019	Other	Inappropriate Marketing of the Open Enrollment Period	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	11/2018	Other	Failure to maintain accurate online Part C Provider Directory.	Warning Letter	No	Closed

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IL	Medicare/CMS	10/2018	Other	Failure to meet the Interpreter Availability call center standard during the 2018 Accuracy and Accessibility Study for Part C and/or Part D prospective enrollee beneficiary customer service phone lines	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2018	Other	CY2018 Monitoring of Marketed Comprehensive Formulary Errors	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2018	Other	Failure to Ensure Sales Agents are Licensed	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2018	Other	Failure to provide accurate information regarding premiums in a marketing piece.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2018	Reporting – other data	Failure to timely upload Actual Mail Dates for Contract Year 2018 Annual Notice of Change/Evidence of Coverage documents for Material ID(s): Y0001_2018_CB_S5768_186c126_ANOCEOC.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2018	Other	Failure to meet the CMS standard for average hold time during the first quarter (Q1) of 2018 for Part C and/or Part D current enrollee beneficiary customer service and/or pharmacy technical help desk phone lines	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2018	Claims processing accuracy	Failure to properly implement a formulary transition program consistent with Part D requirements, as indicated by the results of CMS' enhanced transition monitoring program, referred to as the Transition Monitoring Program Analysis (TMPA) project	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	02/2018	Reporting – other data	Failure to submit the correct formulary files (EGWP) by the filing deadline	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2018	Other	Failure to administer a formulary according to CMS requirements by making negative formulary changes to the EGWP base formulary without approval from CMS	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2018	Other	Failure to Submit Complete and Accurate Bid Submission - Total Beneficiary Cost	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2018	Claims processing accuracy	Failure to properly implement the required Transition Policy	Warning Letter	No	Closed
N/A	Medicare/CMS	02/2018	Claims processing accuracy	Failure to properly implement the required Transition Policy	Warning Letter with a Request for a Business Plan	No	Closed
MI	Medicare/CMS	01/2018	Reporting – other data	Failure to submit enrollment reconciliations	Notice of Non-Compliance	No	Closed
MI	Medicare/CMS	09/2017	Other	Failure to meet one or more call center timeliness standards during the second quarter (Q2) of 2017 for Part C and/or Part D current enrollee beneficiary customer service and/or pharmacy technical help desk phone lines.	Notice of Non-Compliance	No	Closed

Table H - Aetna's Medicare Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	05/2017	Reporting – other data	Failure to comply with the Part D Recovery Audit Contractor (RAC) program requirements concerning the timely resubmission of Prescription Drug Event (PDE) data prior to the 2009 reopening.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2017	Reporting – other data	Failure to comply with the Part D Recovery Audit Contractor (RAC) program requirements concerning the timely resubmission of Prescription Drug Event (PDE) data prior to the 2010 reopening.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2017	Reporting – other data	Failure to comply with the Part D Recovery Audit Contractor (RAC) program requirements concerning the timely resubmission of Prescription Drug Event (PDE) data prior to the 2011 reopening.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2017	Reporting – other data	Failure to comply with the Part D Recovery Audit Contractor (RAC) program requirements concerning the timely resubmission of Prescription Drug Event (PDE) data prior to the 2009 reopening	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2017	Reporting – other data	Failure to comply with the Part D Recovery Audit Contractor (RAC) program requirements concerning the timely resubmission of Prescription Drug Event (PDE) data prior to the 2011 reopening	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2017	Reporting – other data	Failure to comply with the Part D Recovery Audit Contractor (RAC) program requirements concerning the timely resubmission of Prescription Drug Event (PDE) data prior to the 2009 reopening	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2017	Other	Failure to ensure CY2017 Annual Notice of Change and/or Evidence of Coverage (ANOC/EOC) documents were accurately entered into HPMS according to CMS instructions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2017	Other	Failure to maintain accurate online Part C Provider Directory.	Notice of Non-Compliance	No	Closed
MI	Medicare/CMS	01/2017	Other	Failure meet one or more call center timeliness standards during the fourth quarter (Q4) of 2016 for Part C and/or Part D current enrollee beneficiary customer service and/or pharmacy technical help desk phone lines	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2016	Other	Failure to adhere to marketing requirements.	Notice of Non-Compliance	No	Closed
MI	Medicare/CMS	12/2016	Other	Failure to meet MMP Medicare network standards in the organization's approved service area.	Notice of Non-Compliance	No	Closed
MI	Medicare/CMS	08/2016	Other	Failure to meet one or more call center timeliness standards during the second quarter (Q2) of 2016 for Part C and/or Part D current enrollee beneficiary customer service and/or pharmacy technical help desk phone lines.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2016	Claims processing accuracy	Failure rate for the protected class drugs threshold exceeding 10% during the CY2015 TMPA monitoring.	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	04/2016	Reporting – other data	Failure to comply with the Part D Recovery Audit Contractor (RAC) program requirements concerning the timely resubmission of Prescription Drug Event (PDE) data prior to the 2007 reopening.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2016	Other	Failure to meet one or more call center timeliness standards during the first quarter (Q1) of 2016 for Part C and/or Part D current enrollee beneficiary customer service and/or pharmacy technical help desk phone lines.	Notice of Non-Compliance	No	Closed

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N/A	Medicare/CMS	02/2016	Other	Failure to comply with CMS CY2016 Bid Instructions (2 Contracts)	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	02/2016	Other	Failure to accurately display in formation on Medicare Plan Finder which resulted in a suppression.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2016	Reporting – other data	Failure to accurately display in formation on Medicare Plan Finder website which resulted in a suppression	Warning Letter	No	Closed
N/A	Medicare/CMS	02/2016	Other	Failure to meet the CMS Call Center Metrics for Q3-2015 for Part D Disconnect rate.	Notice of Non-Compliance	No	Closed
IL	Medicare/CMS	01/2016	Other	Failure to meet MMP Medicare network standards in the organization's approved service area.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2015	Other	Failure to Submit Complete and Accurate Bid Submission Meaningful Difference for CY2016	Notice of Non-Compliance	No	Closed
IL	Medicare/CMS	12/2015	Reporting – other data	Failure to Timely Submit 4Rx data to CMS	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2015	Other	Failure to meet administrative and management requirements - Low Star Ratings. CMS is requesting that your organization develop and implement a corrective action plan designed to ensure that it will achieve at least an "average" star rating .(1 Contract)	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	11/2015	Other	Failure to provide its enrollees with Medicare benefits in accordance with CMS requirements.	Civil Money Penalty (CMP)	$594,100.00	Closed
N/A	Medicare/CMS	11/2015	Other	Failure to comply with CMS' Coverage Determinations and Appeals Requirements for member notices	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2015	Other	Failure to Timely Update Online Provider Networks	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2015	Other	Failure to comply with the CY2015 Part D formulary submission and review requirements when the Plan did not submit PA/ST reviews as noted in the PA/ST stage 1 memo.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2015	Other	Failure to comply with CMS CY2015 Bid Instructions	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2015	Other	Failure to meet one or more call center timeliness standards during the second quarter (Q2) of 2015 for Part C and/or Part D current enrollee beneficiary customer service and/or pharmacy technical help desk phone lines for disconnect rate.	Notice of Non-Compliance	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	07/2015	Other	Failure to meet disconnect rate standards during the second quarter (Q2) of 2015 for Part C and/or Part D current enrollee beneficiary customer service and/or pharmacy technical help desk phone lines	Notice of Non-Compliance	No	Closed
IL	Medicare/CMS	07/2015	Reporting – other data	Failure to Report Medicare-Medicaid (MMP) Core and State Specific Measures as required	Warning Letter	No	Closed
NY	Medicare/CMS	06/2015	Other	Failure to meet the Interpreter availability standards	Notice of Non-Compliance	No	Closed
MI	Medicare/CMS	06/2015	Other	Failure to meet the Interpreter availability standards and TTY Information standards during the 2015 Accuracy and Accessibility Study for Part D prospective enrollee beneficiary customer service phone lines	Notice of Non-Compliance	No	Closed
MI	Medicare/CMS	05/2015	Other	Failure to comply with formulary crosswalk requirements whereby the sponsor assigns a proposed formulary to a particular CY2015 bid submission	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2015	Other	Failure to disseminate clear and accurate information regarding the number, mix, and distribution (addresses) of network pharmacies from which enrollees may obtain covered Part D drugs. Non-Network retail pharmacies were erroneously identified by Aetna as retail in	Civil Money Penalty, revised letter replaced 4/2/2015 version.	$1,000,000.00	Closed
N/A	Medicare/CMS	04/2015	Other	Failure to comply with CMS Marketing Requirements by failing to send certain post-enrollment materials in a timely manner to new members	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2015	Other	Failure to ensure timely receipt of the Part C Explanation of Benefits (EOB) to your Medicare enrollees	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2015	Other	Failure to send an Explanation of Benefits by the end of the month following the month in which the beneficiaries utilized their prescription drug benefits.	Notice of Non-Compliance	No	Closed
OH	Medicare/CMS	03/2015	Other	Failure to ensure timely receipt of the Evidence of Coverage (EOC)/Member Handbook documents to your current enrollees for Contract Year 2015. (CMS and the OH Dept. of Medicaid)	Notice of Non-Compliance	No	Closed
OH	Medicare/CMS	03/2015	Other	Failure to timely send the required 2015 marketing materials to members (CMS and the OH Dept. of Medicaid)	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2015	Other	Failure to update the Health Plan Management System (HPMS) with accurate information regarding the entities performing certain Part D functions on their behalf in contract year 2015	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2015	Reporting – other data	Failure to submit complete and accurate information about its pharmacy contracting arrangements in its application for a 2015 Part D contract.	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	02/2015	Other	Failure to comply with Part D regulatory requirements and follow CMS bid instructions for CY2015 Bid submission.	Ad-hoc Corrective Action Plan (CAP)	No	Closed

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N/A	Medicare/CMS	02/2015	Other	Failure to afford members access to retail pharmacies consistent with the Part D convenient access standard.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2015	Access standards	Failure to comply with the Part D program requirement that Part D sponsors permit the participation in their plan networks of any pharmacy that meets the plan's standard terms and conditions for participation.	Ad-hoc Corrective Action Plan (CAP); revised notice received.	No	Closed
N/A	Medicare/CMS	01/2015	Other	For requesting a plan correction of a bid after submission, failing one or more bid requirements or submitting an incomplete bid for CY2015.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2014	Claims processing accuracy	Failure to comply with Medicare Part D Requirements related to the coverage of Cialis in 2012 and/or 2013	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2014	Claims processing accuracy	Failure to comply with Medicare Part D Requirements related to the coverage of Cialis in 2012 and/or 2013	Warning Letter	No	Closed
N/A	Medicare/CMS	12/2014	Claims processing accuracy	Failure to comply with Medicare Part D Requirements related to the coverage of Cialis in 2012 and/or 2013	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2014	Claims processing accuracy	Failure to properly administer the Part D benefit plan	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2014	Claims processing accuracy	Failure to properly adjudicate Medicare Part D drug claims consistent with CMS requirements and the sponsors' CMS-approved plan benefit package (PBP) as determined by our Formulary Administration Analysis (FAA) monitoring initiative	Warning Letter	No	Closed
N/A	Medicare/CMS	09/2014	Claims processing accuracy	Failure to Process Non-Contracted Provider Claims Correctly	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2014	Other	Failure to accurately describe benefits and/or cost sharing information in the 2014 Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents; this determination was based on our review of your errata sheets. Failure to provide correct information prevents beneficiaries from making a fully informed health care choice.	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	07/2014	Reporting – other data	Failure to submit a MIPPA compliant State Medicaid Agency Contract for H2663 by the submission deadline of July 1, 2014 at 8:00 p.m. EDT	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2014	Reporting – other data	Failure to submit a MIPPA compliant State Medicaid Agency Contract for H1013 by the submission deadline of July 1, 2014 at 8:00 p.m. EDT	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2014	Other	Failure to submit a MIPPA compliant State Medicaid Agency Contract for H3959 by the submission deadline of July 1, 2014 at 8:00 p.m. EDT	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2014	Other	Failure to adhere to CMS requirements by not providing accurate information to beneficiaries as instructed by CMS	Notice of Non-Compliance	No	Closed

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N/A	Medicare/CMS	05/2014	Other	Failure to accurately describe benefits and/or cost sharing information in 2014 Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents; this determination was based on our review of your errata sheets. Failure to provide correct information prevents beneficiaries from making a fully informed health care choice	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	05/2014	Other	Failure to Conduct Outbound Enrollment Verification and Verification Calls to New Enrollees	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2014	Other	Failure to accurately describe benefits and/or cost sharing information in CY2014 Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents. Failure to provide correct information prevents beneficiaries from making a fully informed health care choice	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2014	Claims processing timeliness	Failure to comply with Medicare requirements related to Part D formulary and benefit administration, Part C and Part D coverage/organization determinations, appeals and grievances.	Civil Money Penalty (CMP)	$407,800.00	Closed
N/A	Medicare/CMS	04/2014	Claims processing timeliness	Failure to comply with Medicare requirements related to Part D formulary and benefit administration, Part C and Part D coverage/organization determinations, appeals and grievances.	Civil Money Penalty (CMP)	$101,500.00	Closed
N/A	Medicare/CMS	04/2014	Other	Failure to meet administrative and management requirements - Low Star Ratings. CMS is requesting that your organization develop and implement a corrective action plan designed to ensure that it will achieve at least an “average” star rating . (3 Contracts)	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	04/2014	Other	Failure to meet the administrative and management requirements that apply to stand-alone Medicare Prescription Drug Plan (PDP) sponsors	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	02/2014	Other	Failure to properly execute a transition program according to transition policy requirements as identified through CMS’ Transition Monitoring Program Analysis (TMPA) project	Warning Letter	No	Closed
N/A	Medicare/CMS	02/2014	Claims processing accuracy	Failure to properly execute a transition program according to transition policy requirements as identified through CMS’ CY2013 Transition Monitoring Program Analysis (TMPA) project	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	02/2014	Other	Failure to meet disconnect standards during the Fourth quarter (Q4) of 2013 for pharmacy technical help desk phone lines	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2014	Claims processing accuracy	Failure to comply with Medicare Part D program requirements concerning the proper administration of benefits to its plan members and the submission of correct claims payment information.	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	01/2014	Other	Failure to send the Low-Income Subsidy (LIS) Rider for arrival to members no later than September 30, 2013.	Notice of Non-Compliance	No	Closed

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N/A	Medicare/CMS	01/2014	Other	Failure to mail disenrollment due to Date of Death letters to members or their estates	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2013	Other	Failure to submit a complete and accurate final bid at the time of submission.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	11/2013	Claims processing accuracy	Failure to correctly process claims for Hydrochlorothiazide	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2013	Other	Failure to properly cancel enrollments for members who opted out of Part D auto facilitated enrollment	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2013	Other	Failure to provide accurate information in the Evidence of Coverage for SNP plans.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2013	Claims processing accuracy	Failure to process Part B vs Part D claims correctly.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2013	Other	Failure to conduct outbound enrollment and verification calls to new enrollees.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2013	Claims processing accuracy	Failure to accurately process coordination of benefits for prescription drugs, and for failing to assess appropriate copayments at point of sale	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2013	Claims processing accuracy	Failure to properly administer the Part D Benefit plan.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2013	Reporting – other data	Out of compliance with the survey requirements done by Acumen, L.L.C re Cialis. Aetna indicated "yes" in survey response that Cialis was prescribed for an indication other than Benign Prostatic Hyperplasia (BPH) or did not respond to survey.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2013	Claims processing accuracy	Failure to comply with Medicare Part D requirements related to the coverage of Cialis	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2013	Claims processing accuracy	Failure to meet the CMS' requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Warning Letter with a Request for a Business Plan	No	Closed

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N/A	Medicare/CMS	09/2013	Claims processing accuracy	Failure to meet the CMS' requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2013	Financial – non claims	Failure to adhere to agent/broker compensation rules. Aetna is currently failing to prorate renewal commissions and is also failing to use the calendar year as a basis for compensation.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2013	Other	Failure to provide accurate information in your Contract Year ("CY") 2013 Summary of Benefits ("SB") documents and your Evidence of Coverages (EOCs) to beneficiaries.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2013	Financial – non claims	Failure to adhere to agent/broker compensation rules.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2013	Other	Failure to Provide Accurate Information on CY 2013 Summary of Benefits document to beneficiaries.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2013	Other	Failure to provide accurate information in your Contract Year (CY) 2013 Summary of Benefits (SB) document to beneficiaries.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2013	Other	Failure to provide accurate CY2013 Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to your Medicare enrollees	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2013	Other	Failure to Adhere to the January 8, 2013, HPMS Memo Regarding Annual Notice of Change/Evidence of Coverage (ANOC/EOC) Accuracy Assessment.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2013	Financial – non claims	Failure to report correct DIR amounts	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2013	Claims processing accuracy	Failure to provide discounts under the Medicare Coverage Gap Discount Program	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2013	Claims processing accuracy	Incorrectly issuing refunds to low income subsidy (LIS) eligible beneficiaries	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2013	Claims processing accuracy	Inappropriately rejecting certain controlled substance claims for Medicare Part D payment at the point of sale between January 1 and January 2, 2013.	Notice of Non-Compliance	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	02/2013	Other	Failure to disseminate accurate plan information to State of Maine EGWP Members	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2013	Reporting – other data	Failure to adhere to the 90% upload requirement for scheduled marketing events during Q4 2012.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2013	Other	Notice of Intent to Impose Intermediate Sanctions (Suspension of Enrollment and Marketing) for all Standalone Prescription Drug Plan Contracts	Intermediate Sanctions CMS released SSIC from Intermediate Sanctions in January 2014 with a stipulation regarding low income Part D only beneficiaries. CMS continued to exclude SSIC from receiving automatic enrollment of low income subsidy (LIS) Part D only beneficiaries until February 2014	No	Closed
N/A	Medicare/CMS	12/2012	Claims processing accuracy	Failure to indicate Prior Auth on Formularies and Failure to Administer a CMS Approved Formulary	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	12/2012	Other	Inappropriate Prior Authorization (PA) Form Content	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure to meet Part D program requirement that Part D plan sponsors submit all required information for a future year's bids, including formularies that contain all or substantially all drugs from the classes of clinical concern.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure to provide Part D drug coverage to 4,592 beneficiaries.	Warning Letter	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure to Send Transition Fill Letters	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure to conduct outbound verification calls and issue verification letters timely.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure to administer the State of Hawaii Employer Group Waiver Plan (Hawaii EGWP) with the correct effective dates as required in the administration of its Medicare Prescription Drug Plan Sponsor contract	Notice of Non-Compliance	No	Closed

Table H - Aetna's Medicare Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	12/2012	Claims processing accuracy	Failure to meet the CMS' requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2012	Claims processing accuracy	Failure to properly calculate the true out-of-pocket (TrOOP) costs for 793 beneficiaries in 2011.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors.	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	12/2012	Other	Failure to comply with Medicare marketing requirements concerning accurate descriptions of benefits covered by your plans	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	11/2012	Other	Failure to issue the 2013 Annual Notice of Change (ANOCs) as required by CMS	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	11/2012	Claims processing accuracy	Failure to meet the CMS' requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	11/2012	Other	Inappropriate Marketing for a direct mail piece that had incorrect benefit information for prospective enrollees	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2012	Claims processing accuracy	Failure to provide discounts under the Medicare Coverage Gap Discount Program	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2012	Other	Failure to comply with Medicare marketing requirements concerning accuracy of benefits covered by your plans.	Notice of Non-Compliance	No	Closed

Table H - Aetna's Medicare Sanctions							
State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	10/2012	Access standards	Failure to meet Standard Time Frames for Organization Determinations	Warning Letter	No	Closed
N/A	Medicare/CMS	10/2012	Other	Failure to comply with CMS' requirement that Part D sponsors' final bid submissions must be complete and accurate at the time of submission. Aetna identified an error and requested a plan correction after Aetna had submitted its final contract year 2012 Part D bid submission information certifications	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2012	Claims processing accuracy	Failure to charge the correct cost-sharing	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	08/2012	Reporting – other data	Failure to complete the agent/broker compensation requirements timely	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2012	Reporting – other data	Failure to adhere to the 90% upload requirement for scheduled marketing events for 2012 Q2.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2012	Reporting – other data	Failure to adhere to the 90% upload requirement for scheduled marketing events for Q2 2012	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2012	Claims processing accuracy	Failure to comply with Part D requirements	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	05/2012	Other	Failure to achieve a Part C or D summary rating of at least three stars for at least three consecutive years. (3 Contracts)	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	05/2012	Reporting – other data	Failing to adhere to the 90% upload requirement for scheduled marketing events during Q4 2011	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2012	Reporting – other data	Failing to adhere to the 90% upload requirement for scheduled marketing events during Q4 2011	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2012	Reporting – other data	Failure to adhere to the 90% upload requirement for scheduled marketing events for 2011 Q4.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2012	Reporting – other data	Failure to complete the agent/broker compensation requirements timely.	Notice of Non-Compliance	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	05/2012	Financial – non claims	Failure to comply with Prompt Payment Requirements	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2012	Other	Failure to comply with Medicare Marketing Guidelines by not including physician street addresses and phone numbers in its 2012 provider directory (California Provider Missing Addresses)	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2012	Claims processing accuracy	Failure to update Low Income Subsidy (LIS) eligibility records, which resulted in LIS beneficiaries being charged incorrect cost sharing amounts for Part D drugs.	Warning Letter	No	Closed
N/A	Medicare/CMS	03/2012	Other	Failure to comply with Medicare requirements concerning the timely processing of beneficiary plan enrollment requests	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2012	Other	Failure to adhere to the CMS requirement that Part D sponsors' final contract year 2012 bid submissions and certifications are complete and accurate at the time of submission.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2012	Other	Failure to adhere to the CMS requirement that Part D sponsors' final contract year 2012 bid submissions and certifications are complete and accurate at the time of submission.	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	02/2012	Reporting – other data	Failure to comply with the contract year (CY) 2012 formulary submission deadline.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2012	Claims processing accuracy	Failure to Properly Administer Generic Copayments in 2010 and 2011. Low-income beneficiaries were incorrectly charged brand name drug copays instead of generic drug copays.	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	02/2012	Other	Failure to comply with Medicare marketing requirements concerning accuracy of benefits covered by your plans	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2012	Other	Failure to make a good faith effort to provide written notice of termination of a contracted provider at least 30 calendar days before the effective date	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2012	Claims processing accuracy	Payment of local sales tax charges on covered Part D prescription drug transactions within the state of Louisiana	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2012	Claims processing accuracy	Payment of local sales tax charges on covered Part D prescription drug transactions within the state of Louisiana	Notice of Non-Compliance	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	01/2012	Claims processing accuracy	Failure to submit corrected Prescription Drug Event data	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	01/2012	Claims processing accuracy	Failure to resubmit PDE Data timely 2010 plan year for Rebates	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	01/2012	Claims processing accuracy	Failure to resubmit PDE Data timely 2010 plan year for Rebates	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	12/2011	Reporting – other data	Failure to successfully submit 4Rx data for at least 99% of its contract year (CY) 2012 CMS-generated enrollments by the December 20, 2011 deadline	Warning Letter	No	Closed
N/A	Medicare/CMS	12/2011	Other	Failure to make a good faith effort to provide written notice of termination of a contracted provider at least 30 calendar days before the effective date.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2011	Other	Failure to comply with the Centers for Medicare & Medicaid Services" (CMS) requirement to use appropriate compendia as well as peer reviewed medical literature when making coverage determinations regarding medically accepted indications	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	12/2011	Other	Failure to issue required transition fill notices to beneficiaries	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	11/2011	Other	Failure to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors for 10 contracts	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	11/2011	Other	Failure to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	11/2011	Other	Failure to meet the administrative and management requirements for Medicare Advantage (MA) organizations its operations.	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	11/2011	Other	Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	11/2011	Other	Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors	Ad-hoc Corrective Action Plan (CAP)	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	11/2011	Other	Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors.	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	11/2011	Other	Failure to adhere to the CMS requirement that final bid submissions and final actuarial certifications be complete and accurate at the time of submission.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2011	Other	Failure to comply with Medicare Marketing requirements concerning appropriate file and use submissions and for readability of marketing materials.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2011	Claims processing accuracy	Failure to meet the CMS' requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Warning Letter	No	Closed
N/A	Medicare/CMS	09/2011	Other	Failure to electronically sign contract for CY 2012	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2011	Other	Failure to provide accurate enrollee information in Contract Year 2011 Evidence of Coverage (EOC) documents	Civil Money Penalty (CMP)	$20,000.00	Closed
N/A	Medicare/CMS	09/2011	Other	Failure to provide accurate beneficiary information in Contract Year 2011 Annual Notice of Change (ANOC) documents	Civil Money Penalty (CMP)	$20,000.00	Closed
N/A	Medicare/CMS	09/2011	Claims processing accuracy	Inappropriate Coverage of Part D Excluded Drugs - Benzodiazepines (i.e. Klonopin, Clonazepam, Diastat and Diazepam)	Warning Letter	No	Closed
N/A	Medicare/CMS	09/2011	Claims processing accuracy	Failure to apply the appropriate Cost Sharing to subsidy eligible individuals.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2011	Other	Failure to electronically sign contract for CY 2012	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2011	Other	Issuance of inaccurate Annual Notice of Change/Evidence of Coverage (ANOC/EOC) documents to your Medicare enrollees for the 2011 contract year.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2011	Other	Issuance of an inaccurate Annual Notice of Change/Evidence of Coverage for CY2011	Notice of Non-Compliance	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	08/2011	Other	Failure to provide accurate beneficiary information in Contract Year 2011 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2011	Other	Failure to be in compliance with Medicare Part D Late Enrollment Penalty (LEP) requirements.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2011	Other	Failure to issue required transition fill notices to beneficiaries	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2011	Other	Failure to meet the TTY Service call center standard during the 2011 Accuracy and Accessibility Study for Part D prospective enrollee beneficiary customer service phone lines	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2011	Other	Failure to meet the TTY Service call center standard during the 2011 Accuracy and Accessibility Study for Part D prospective enrollee beneficiary customer service phone lines	warning letter	No	Closed
N/A	Medicare/CMS	07/2011	Other	Failure to meet the TTY Service call center standard during the 2011 Accuracy and Accessibility Study for Part D prospective enrollee beneficiary customer service phone lines	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2011	Reporting – other data	Failure to meet CMS requirements in submitting 4Rx data (enrollment data consisting of 4 fields - Rx ID, Rx BIN, Rx PCN, and Rx Group) timely and successfully for CMS-generated enrollments.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2011	Other	Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	07/2011	Other	Failure, as indicated by its most recent low plan (or "star") rating, to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	07/2011	Other	Failure to meet the administrative and management requirements that apply to Medicare Advantage organizations (MAOs) and stand-alone Medicare Prescription Drug Plan (PDP) sponsors for 4 contracts.	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	06/2011	Other	Notice of Release of Intermediate Sanctions -Suspension of Marketing and Enrollment	Release Notice, and Corrective Action Plan	No	Closed
N/A	Medicare/CMS	06/2011	Other	Failure to comply with Part D Program contract requirements concerning Late Enrollment Penalty (LEP)	Warning Letter with a Request for a Business Plan	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	05/2011	Claims processing accuracy	Failure to meet the CMS' requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2011	Other	Failure to comply with LIS requirements 2007 through 2009	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	04/2011	Other	Failure with CMS requirements related to formulary crosswalks (i.e., the assignment of a proposed formulary to a particular bid submission) and bid and actuarial certifications for CY2011	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2011	Reporting – other data	Failure to submit the pricing data files and/or error(s) in the submitted pricing data.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2011	Other	Issuance of inaccurate 2011 low-income subsidy (LIS) Riders	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2011	Other	Failure to have effective systems in place to perform concurrent drug utilization review to prevent, among other things, the overutilization of prescription drug medications.	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	03/2011	Reporting – other data	Failure to transmit enrollments timely; Failure to transmit the correct application dates and failure to submit the correct election type.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2011	Other	Failure to be in compliance with Medicare Marketing Guidelines	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	02/2011	Other	Failure to comply with Medicare marketing requirements concerning accuracy of benefits covered by your plans.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2011	Other	Failure to update addresses in premium billing system	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2011	Other	Failure to update enrollment system timely	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2011	Other	Failure to provide accurate information to beneficiaries - 2010 Evidence of Coverage.	Civil Money Penalty (CMP)	$171,240.00	Closed

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N/A	Medicare/CMS	12/2010	Claims processing accuracy	Failure to reimburse subsidy-eligible individuals any excess premium or cost sharing paid by individual or organization.	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	12/2010	Other	Failure to follow Medicare Marketing Guidelines (MMG) for materials	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2010	Reporting – other data	Failure to provide CMS with the drug price information necessary to operate the Medicare Plan Finder (MPF) website.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2010	Other	Failure to provide CMS with the drug price information necessary to operate the Medicare Plan Finder (MPF) web site.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2010	Claims processing accuracy	Failure to implement appropriate point-of-sale edits on claims for drugs prescribed or dispensed by providers or entities who have been excluded from participation in Federal health care programs by the Department of Health and Human Services Office of the Inspector General (OIG).	Warning Letter	No	Closed
N/A	Medicare/CMS	12/2010	Reporting – other data	Failure to successfully submit 4Rx data for at least 99% of its contract year (CY) 2011 CMS-generated enrollments by the December 20, 2010 deadline.	Warning Letter	No	Closed
N/A	Medicare/CMS	12/2010	Reporting – other data	Failure to successfully submit 4Rx data for at least 99% of its contract year (CY) 2011 CMS-generated enrollments by the December 20, 2010 deadline	Warning Letter	No	Closed
N/A	Medicare/CMS	12/2010	Reporting – other data	Failure to successfully submit 4Rx data for at least 99% of its contract year (CY) 2011 CMS-generated enrollments by the December 20, 2010 deadline.	Warning Letter	No	Closed
N/A	Medicare/CMS	12/2010	Reporting – other data	Failure to upload one or more required pieces of translated marketing materials into the Health Plan Management System (HPMS) Marketing Review Module.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2010	Other	Failure to upload translated marketing materials in HPMS for CY2010	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2010	Other	Marketing Surveillance Notice of Noncompliance: Secret Shopping Deficiencies	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2010	Other	Failure to upload one or more required pieces of translated marketing materials into the Health Plan Management System (HPMS) Marketing Review Module	Notice of Non-Compliance	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	12/2010	Other	Failure to send timely non-renewal notices within the required timeframes and for incorrectly sending non-renewal letters to member who were not affected by a non-renewal.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2010	Other	Failure to provide accurate ANOC/EOC documents to Medicare enrollees for the 2010 contract year (CY).	Warning Letter	No	Closed
N/A	Medicare/CMS	12/2010	Other	Failure to provide accurate ANOC/EOC documents to Medicare enrollees for the 2010 contract year (CY).	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	12/2010	Other	Failure to provide accurate beneficiary information in Contract Year 2010 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents.	Civil Money Penalty (CMP)	$34,820.00	Closed
N/A	Medicare/CMS	10/2010	Reporting – other data	Failure to submit appropriate drug pricing for plan finder	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2010	Claims processing accuracy	Failure to meet the CMS' requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2010	Claims processing accuracy	Failure to meet the CMS requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2010	Claims processing accuracy	Failure to meet the CMS requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2010	Claims processing accuracy	Failure to meet the CMS requirement that Part D sponsors successfully complete automated true out-of-pocket (TrOOP) balance transfer (TBT) transactions in real-time for 100% of all transactions.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2010	Reporting – other data	Failure to provide requested documentation for Corrective Action Plan for CY2010	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	10/2010	Other	Failure to provide accurate beneficiary information in Contract Year 2010 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents	Civil Money Penalty (CMP)	$16,970.00	Closed
N/A	Medicare/CMS	10/2010	Other	Failure to download enrollments via the online enrollment center (OEC)	Notice of Non-Compliance	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	09/2010	Other	Failure to meet the TTY Service call center standard during the 2010 Accuracy and Accessibility Study for Part D prospective enrollee beneficiary customer service phone lines	Warning Letter	No	Closed
N/A	Medicare/CMS	09/2010	Claims processing accuracy	Failure to meet CMS' Low Income Subsidy(LIS) Beneficiary Compliance requirements	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2010	Other	Failure to meet the TTY Service call center standard during the 2010 Accuracy and Accessibility Study for Part D prospective enrollee beneficiary customer service phone lines	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2010	Claims processing accuracy	Failure to meet CMS' Low Income Subsidy(LIS) Beneficiary Compliance requirements	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2010	Other	Failure to meet the TTY Service call center standard during the 2010 Accuracy and Accessibility Study for Part D prospective enrollee beneficiary customer service phone lines	Warning Letter	No	Closed
N/A	Medicare/CMS	09/2010	Other	Failure to meet the TTY Service call center standard during the 2010 Accuracy and Accessibility Study for Part D prospective enrollee beneficiary customer service phone lines	Warning Letter	No	Closed
N/A	Medicare/CMS	09/2010	Claims processing accuracy	Incorrect adjustment of re-adjudicated claims	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2010	Claims processing accuracy	Failure to correctly adjudicate prescription drug claims	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	09/2010	Other	Failure to make a good faith effort to provide written notice of termination of a contracted provider at least 30 calendar days before the effective date.	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	08/2010	Reporting – other data	Failure to submit Best Available Evidence to Acumen	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2010	Other	Failure to enter correct Low Income Subsidy(LIS) information for Beneficiaries during CY2010.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2010	Other	Failure to meet Medicare Part D program website requirements.	Notice of Non-Compliance	No	Closed

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State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	08/2010	Other	Failure to meet Medicare Part D program website requirements.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2010	Reporting – other data	Failure to properly upload populated Annual Notice of Change/Evidence of Coverage templates into HPMS for the 2010 contract year.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2010	Other	Failure to handle undeliverable mail according to CMS program requirements	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2010	Other	Failure to notify beneficiaries of the disenrollment due to being out of area for CY2010	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	08/2010	Other	Failure to meet the administrative and management requirements for Medicare Advantage (MA) organizations its operations. In particular, the MA organizations plan rating scores during the last three contract years have established as a poor performer relative to other MAOs.	Warning Letter	No	Closed
N/A	Medicare/CMS	08/2010	Other	Sending of improper termination letters during 2010	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2010	Reporting – other data	Failure to submit Best Available Evidence to Acumen	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2010	Reporting – other data	Failure to submit Best Available Evidence to Acumen	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	07/2010	Reporting – other data	Failure to meet the requirements for submitting Risk Adjustment Data to CMS.	Ad-hoc Corrective Action Plan (CAP)	No	Closed
N/A	Medicare/CMS	06/2010	Other	Failure to timely notify CMS of a Compliance Issue related to inappropriate marketing material	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2010	Other	Failure to send out materials within the CMS required ten day turnaround	Warning Letter	No	Closed
N/A	Medicare/CMS	06/2010	Claims processing accuracy	Failure to coordinate benefits with State Pharmaceutical Assistance Programs (SPAPs)	Warning Letter	No	Closed

Table H - Aetna's Medicare Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	06/2010	Other	Inappropriate distribution of marketing material to Medicare enrollees in violation of Data Use Agreement with CMS.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2010	Other	Inappropriate disenrollment for failure to pay during 2010	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2010	Other	Failure to process enrollment requests timely	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2010	Other	Failure to Send Transition Fill Letters timely	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2010	Other	Failure to distribute combined enrollment notices timely	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2010	Other	Failure to distribute ID cards timely	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2010	Claims processing accuracy	Failure to charge correct cost share for LIS beneficiaries during 2009 and 2010	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	06/2010	Other	Failure to distribute marketing material appropriately	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2010	Other	Failure to distribute approved Marketing Materials	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2010	Other	Failure to ensure that sales agents meet certain qualifications.	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	05/2010	Other	Failure to ensure that all agents selling products on behalf of your organization meet CMS testing requirements and are State-licensed.	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	05/2010	Other	Privacy Breach	Notice of Non-Compliance	No	Closed

Table H - Aetna's Medicare Sanctions

State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	05/2010	Other	Failure to meet Medicare Benefits and Beneficiary Protection disclosure requirements for Medicare Advantage organizations.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2010	Other	Discrepancies in Social Security premium with hold during 2010	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2010	Other	Failure to process TRRs during CY2010	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	05/2010	Other	Failure to implement LEP attestations timely during CY2010	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2010	Other	Marketing Surveillance Notice of Noncompliance: Secret Shopping Deficiencies	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2010	Reporting – other data	Failure to submit Best Available Evidence to Acumen	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2010	Reporting – other data	Failure to meet (CMS) requirement for Part D sponsors to submit best available evidence (BAE) data.	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	04/2010	Other	Notice of Intent to Impose Intermediate Sanctions (Suspension of Enrollment and Marketing) For All Medicare Advantage/Prescription Drug Contracts and All Standalone Prescription Drug Plan Contracts	Intermediate Sanctions CMS released Aetna from Intermediate Sanctions in June 2011 with a stipulation regarding low income Part D only beneficiaries. CMS continued to exclude Aetna from receiving automatic enrollment of low income subsidy (LIS) Part D only beneficiaries until September 2012	No	Closed
N/A	Medicare/CMS	04/2010	Other	Failure to meet one or more call center timeliness standards during the third and/or fourth quarter of 2009 for current beneficiary customer service and/or pharmacy technical help desk phone lines	Warning Letter	No	Closed
N/A	Medicare/CMS	04/2010	Other	Marketing Surveillance Notice of Noncompliance: Secret Shopping Deficiencies	Warning Letter with a Request for a Business Plan	No	Closed

Table H - Aetna's Medicare Sanctions							
State	Contract/Program	Date of Action (month/year)	Category	Additional Category Specification (if applicable)	Description of Action Taken by Regulatory Body	Monetary Sanction (if applicable)	Final Disposition
N/A	Medicare/CMS	03/2010	Other	Failure to appropriately send Low Income Subsidy (LIS) Material Communications	Warning Letter with a Request for a Business Plan	No	Closed
N/A	Medicare/CMS	03/2010	Claims processing accuracy	Failure to update formulary to include protective class drugs	Notice of Non-Compliance	NO	Closed
N/A	Medicare/CMS	03/2010	Other	Failure to accurately distribute pharmacy directories	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	03/2010	Claims processing accuracy	Failure to charge correct cost share for LIS beneficiaries and those who reached catastrophic coverage	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2010	Other	Aetna customer service representatives (CSRs) continuing to provide inaccurate information to callers about plan premiums	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2010	Other	Failure to record in-bound telephone enrollments from December 23 through December 28, 2009	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2010	Other	Marketing Surveillance Notice of Noncompliance: Secret Shopping Deficiencies	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	02/2010	Other	Failure to report scheduled marketing events during Q4 2009	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2010	Claims processing timeliness	Failure to timely effectuate Independent Review entity (IRE) Appeal decisions	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2010	Claims processing accuracy	Failure to promptly effectuate payments	Notice of Non-Compliance	No	Closed
N/A	Medicare/CMS	01/2010	Other	Failure to meet the CMS' requirement that Part D sponsors exceed a 95% Low Income Subsidy (LIS) match rate between the sponsor's files and those of CMS.	Notice of Non-Compliance	No	Closed

Attachment H

Kentucky | Transforming Health Care | **Aetna**

Attachment H

B.2.c.(iii.) – SEC Filings: Pending or Recent Litigation Excerpts

2010 Aetna 10-K.....Att H-3

2011 Aetna 10-K.....Att H-11

2012 Aetna 10-K.....Att H-19

2013 Aetna 10-K.....Att H-29

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2015 Aetna 10-K.....Att H-47

2016 Aetna 10-K.....Att H-55

2017 Aetna 10-K.....Att H-63

2018 Aetna 10-Q Ending March 31.....Att H-69

2018 Aetna 10-Q Ending June 30.....Att H-77

2018 Aetna 10-Q Ending September 30.....Att H-85

2010 CVS Health 10-K .....Att H-93

2011 CVS Health 10-K .....Att H-101

2012 CVS Health 10-K .....Att H-109

2013 CVS Health 10-K .....Att H-117

2014 CVS Health 10-K .....Att H-125

2015 CVS Health 10-K .....Att H-133

2016 CVS Health 10-K .....Att H-143

2017 CVS Health 10-K .....Att H-151

Attachment H

B.2.c.(iii.) – SEC Filings: Pending or Recent Litigation Excerpts (cont.)

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2019 CVS Health 10-Q Ending March 31.....Att H-171

2019 CVS Health 10-Q Ending June 30.....Att H-181

2019 CVS Health 10-Q Ending September 30 .....Att H-191

2010 Aetna 10-K

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2010

or

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

For the transition period from _____ to _____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

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

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if smaller reporting company)

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

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2010) was $10.7 billion.

There were 384.5 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2011.

DOCUMENTS INCORPORATED BY REFERENCE

The 2010 Annual Report, Financial Report to Shareholders (the "Annual Report") is incorporated by reference in Parts I, II and IV to the extent described therein. The definitive proxy statement related to Aetna Inc.'s 2011 Annual Meeting of Shareholders, to be filed on or about April 11, 2011 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

Aetna Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2010

Unless the context otherwise requires, references to the terms "we," "our" or "us" used throughout this Annual Report on Form 10-K refer to Aetna Inc. (a Pennsylvania corporation) ("Aetna") and its subsidiaries (collectively, the "Company").

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while other arrangements are not subject to such a limit. At December 31, 2010, we do not believe that our future obligations under any of these agreements will be material to us.

- Separate Account assets - Certain Separate Account assets associated with the Large Case Pensions business represent funds maintained as a contractual requirement to fund specific pension annuities that we have guaranteed. Minimum contractual obligations underlying the guaranteed benefits in these Separate Accounts were $3.8 billion and $4.0 billion at December 31, 2010 and 2009, respectively. Refer to Note 2 beginning on page 57 for additional information on Separate Accounts. Contract holders assume all investment and mortality risk and are required to maintain Separate Account balances at or above a specified level. The level of required funds is a function of the risk underlying the Separate Accounts' investment strategy. If contract holders do not maintain the required level of Separate Account assets to meet the annuity guarantees, we would establish an additional liability. Contract holders' balances in the Separate Accounts at December 31, 2010 exceeded the value of the guaranteed benefit obligation. As a result, we were not required to maintain any additional liability for our related guarantees at December 31, 2010.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our premiums in the state compared to the premiums of other insurers. Certain states allow recoverability of assessments as offsets to premium taxes. Some states have similar laws relating to HMOs. The Pennsylvania Insurance Commissioner has placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and has petitioned a state court for liquidation. If Penn Treaty is declared insolvent and placed in liquidation, we and other insurers likely would be assessed over a period of years by guaranty associations for the payments the guaranty associations are required to make to Penn Treaty policyholders. We are currently unable to predict the ultimate outcome of, or reasonably estimate the loss or range of losses resulting from, this potential insolvency because we cannot predict when the state court will render a decision, the amount of the insolvency, if any, the amount and timing of associated guaranty association assessments or the amount or availability of potential offsets, such as premium tax offsets. It is reasonably possible that in future reporting periods we may record a liability and expense relating to Penn Treaty or other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While we have historically recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could jeopardize future recovery of these assessments.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment and the ultimate liability is not known at the balance sheet date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings
Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Other major health insurers are also the subject of similar litigation or have settled similar litigation. Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix").

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits

allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by a health plan member and by out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey under the caption *In re: Aetna UCR Litigation*, MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. Discovery is substantially complete in MDL 2020, several motions are pending, and briefing on class certification has been completed. The court has not set a trial date or a
timetable for deciding class certification or other pending motions. We intend to vigorously defend ourselves against the claims brought in these cases.

We also have received subpoenas and/or requests for documents and other information from, and have been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to our out-of-network benefit payment practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment practices.

CMS Actions
Effective April 21, 2010, CMS imposed intermediate sanctions on us, suspending the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone PDP contracts. The sanctions relate to our compliance with certain Medicare Part D requirements. The suspension does not affect our current Medicare enrollees who stay in their existing plans. CMS has granted us a limited waiver of these sanctions to allow us to continue to enroll eligible members into existing, contracted group Aetna Medicare Advantage Plans and Standalone PDPs through March 31, 2011. As a result of these sanctions, our 2011 Medicare membership was adversely affected because we did not participate in the 2010 open enrollment for individual 2011 Medicare plans which occurred between November 15, 2010 and December 31, 2010. We are cooperating fully with CMS on its review and are working to resolve the issues CMS has raised as soon as possible. If the CMS sanctions remain in effect or we fail to obtain extensions of the limited waiver through the end of those sanctions, our Medicare membership and operating results could be adversely affected.

CMS regularly audits our performance to determine our compliance with CMS's regulations, our contracts with CMS and the quality of services we provide to our Medicare members. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions and document their medical records. Medicare Advantage plans and PDPs receive increased premiums for members who have certain medical conditions identified with specific health condition codes. Federal regulators review and audit the providers' medical records and related health condition codes that determine the members' health status and the resulting premium payments to us. CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including two of Aetna's contracts for the 2007 contract year. Although these two audits are ongoing, we do not believe that they will have a material impact on our operating results, financial position or cash flows.

We believe that the OIG also is auditing risk adjustment data, and we expect CMS and the OIG to continue auditing risk adjustment data for the 2007 contract year and beyond. Aetna and other Medicare Advantage organizations have provided comments to CMS in response to CMS's December 2010 proposed RADV sampling and payment error calculation methodology by which CMS proposes to calculate and extrapolate RADV audit payment error rates for, and determine premium refunds payable by, Medicare Advantage plans. Our concerns with CMS's proposed methodology include the fact that the proposed methodology does not take into account the "error rate" in the original Medicare fee-for-service data that was used to develop the risk adjustment system and that retroactive audit and payment adjustments undermine the actuarial soundness of Medicare Advantage bids. CMS has indicated that it may make retroactive contract-level premium payment adjustments based on the results of these RADV audits, which could

occur as early as 2011. CMS's premium adjustments could be implemented prior to our, or other Medicare Advantage plans, having an opportunity to appeal the audit or payment error calculation results or methodology. We are unable to predict the ultimate outcome of CMS's final RADV audit methodology, other audits for the 2007 contract year or subsequent contract years, the amounts of any retroactive refunds of, or prospective adjustments to, premium payments made to us, or whether any audit findings would cause a change to our method of estimating future premium revenue in bid submissions to CMS for the current or future contract years or compromise premium assumptions made in our bids for prior contract years. Any premium refunds or adjustments resulting from regulatory audits, including those resulting from CMS's selection of its final RADV audit methodology, whether as a result of RADV or other audits by CMS or OIG or otherwise, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including employment litigation and claims of bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay medical and/or group insurance claims (including post-payment audit and collection practices), rescission of insurance coverage, improper disclosure of personal information, patent infringement and other intellectual property litigation and other litigation in our Health Care and Group Insurance businesses. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, various state insurance and health care regulatory authorities, state attorneys general, the Center for Consumer Information and Insurance Oversight, the Office of the Inspector General, the Office of Personnel Management, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, U.S. attorneys and other state and federal governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, in connection with their consideration of health care reform measures, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." There also continues to be heightened review by regulatory authorities of and increased litigation regarding the health care benefits industry's business and reporting practices, including premium rate increases, utilization management, complaint and grievance processing, information privacy, provider network structure (including the use of performance-based networks), delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices and claim payment practices (including payments to out-of-network providers). As a leading national health care benefits company, we regularly are the subject of such government actions. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds to members, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible loss of licensure or suspension from participation in government programs, including the actions taken by CMS that are described above under "CMS Actions."

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in a change in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. We are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

2011 Aetna 10-K

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2011

or

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

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

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

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). RYes £ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

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

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

(Do not check if smaller reporting company)

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

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2011) was $16.0 billion.

There were 350.4 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2012.

DOCUMENTS INCORPORATED BY REFERENCE

The 2011 Annual Report, Financial Report to Shareholders (the "Annual Report") is incorporated by reference in Parts I, II and IV to the extent described therein. The definitive proxy statement related to Aetna Inc.'s 2012 Annual Meeting of Shareholders, to be filed on or about April 9, 2012 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

Aetna Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2011

Unless the context otherwise requires, references to the terms "we", "our" or "us" used throughout this Annual Report on Form 10-K refer to Aetna Inc. (a Pennsylvania corporation) ("Aetna") and its subsidiaries (collectively, the "Company").

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one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and has petitioned a state court for liquidation. We cannot predict when a decision will be made, although we believe it is likely that the state court will rule within the next twelve months. If Penn Treaty is declared insolvent and placed in liquidation, we and other insurers likely would be assessed over a period of years by guaranty associations for the payments the guaranty associations are required to make to Penn Treaty policyholders. We are currently unable to predict the ultimate outcome of, or reasonably estimate the loss or range of losses resulting from, this potential insolvency because we cannot predict when the state court will render a decision, the amount of the insolvency, if any, the amount and timing of associated guaranty association assessments or the amount or availability of potential offsets, such as premium tax offsets. It is reasonably possible that in future reporting periods we may record a liability and expense relating to Penn Treaty or other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While we have historically recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment and the ultimate liability is not known at the balance sheet date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

Out-of-Network Benefit Proceedings

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation*, MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The physician plaintiffs have attempted to appeal the Florida District Court's ruling to the United States Court of Appeals for the Eleventh Circuit.

Discovery is substantially complete in MDL 2020, several motions are pending, and briefing on class certification has been completed. The court has not set a trial date or a timetable for deciding class certification. We intend to vigorously defend ourselves against the claims brought in these cases.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to our out-of-network benefit payment practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment practices.

CMS Actions

On June 13, 2011, the Centers for Medicare & Medicaid Services ("CMS") lifted the intermediate sanctions it had previously imposed on us that required us to suspend the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone Prescription Drug Plan ("PDP") contracts. The sanctions related to our compliance with certain Medicare Part D requirements. We have resumed marketing our Medicare Advantage and PDP products and have been enrolling beneficiaries with effective dates on and after July 1, 2011. CMS still is not assigning any new low income subsidy members to our PDPs at this time. However, low income subsidy members can make their own choice to enroll in Aetna products. As a result of these sanctions, our 2011 Medicare membership and operating results were adversely affected because we did not participate in the annual enrollment process for 2011. We continue to cooperate fully with CMS to address residual matters identified in connection with the sanction review.

CMS regularly audits our performance to determine our compliance with CMS's regulations, our contracts with CMS and the quality of services we provide to our Medicare members. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions and document their medical records. Medicare Advantage plans and PDPs receive increased premiums for members who have certain medical conditions identified with specific health condition codes. Federal regulators review and audit the providers' medical records and related health condition codes that determine the members' health status and the resulting premium payments to us. CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including two of Aetna's contracts for the 2007 contract year. Although these two audits are ongoing, we do not believe that they will have a material impact on our operating results, financial position or cash flows.

We believe that the Office of the Inspector General (the "OIG") also is auditing risk adjustment data, and we expect CMS and the OIG to continue auditing risk adjustment data for the 2007 contract year and beyond. Aetna and other Medicare Advantage organizations have provided comments to CMS in response to CMS's December 2010 proposed RADV sampling and payment error calculation methodology by which CMS proposes to calculate and extrapolate RADV audit payment error rates for, and determine premium refunds payable by, Medicare Advantage plans. Our concerns with CMS's proposed methodology include the fact that the proposed methodology does not take into account the "error rate" in the original Medicare fee-for-service data that was used to develop the risk adjustment system and that retroactive audit and payment adjustments undermine the actuarial soundness of Medicare Advantage bids. CMS has indicated that it may make retroactive contract-level premium payment adjustments based on the results of these RADV audits, which could occur during 2012. CMS's premium adjustments could be implemented prior to our, or other Medicare Advantage plans, having an opportunity to appeal the audit or payment error calculation results or methodology. We are unable to predict the ultimate outcome of CMS's final RADV audit methodology, other audits for the 2007 contract year or subsequent contract years, the amounts of any retroactive refunds of, or prospective adjustments to, premium payments made to us, or whether any audit findings would cause a change to our method of estimating future premium revenue in bid submissions to CMS for the current or future contract years or compromise premium assumptions made in our bids for prior contract years. Any premium refunds or adjustments resulting from regulatory audits, including those resulting from CMS's selection of its final RADV audit methodology, whether as a result of RADV or other audits by CMS or OIG or otherwise, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings
We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including employment litigation and claims of bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay medical and/or group insurance claims (including post-payment audit and collection practices), rescission of insurance coverage, improper disclosure of personal information, patent infringement and other intellectual property litigation and other litigation in our Health Care and Group Insurance businesses. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the Office of the Inspector General, the Office of Personnel Management, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state and federal governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." There also continues to be heightened review by regulatory authorities of and increased litigation regarding the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, complaint and grievance processing, information privacy, provider network structure (including the use of performance-based networks), delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices, sales practices, and claim payment practices (including payments to out-of-network providers and payments on life insurance policies). For example, New York is one of over 35 states that are investigating life insurers' claims payment and related escheat practices, and we have received requests for information from New York, Connecticut and Minnesota with respect to our life insurance claim payment and related escheat practices. As a leading national health and related benefits company, we regularly are the subject of such government actions. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries or states, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible loss of licensure or suspension or exclusion from participation in government programs, such as the intermediate sanctions previously imposed on us by CMS that are described above under "CMS Actions."

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in a change in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "CMS Actions" with respect to the two ongoing RADV audits for the 2007 contract year, we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

2012 Aetna 10-K

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2012

or

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

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

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

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). RYes £ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

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

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

(Do not check if smaller reporting company)

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

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2012) was $12.6 billion.

There were 328.0 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2013.

DOCUMENTS INCORPORATED BY REFERENCE

The 2012 Annual Report, Financial Report to Shareholders (the "Annual Report") is incorporated by reference in Parts I, II and IV to the extent described therein. The definitive proxy statement related to Aetna Inc.'s 2013 Annual Meeting of Shareholders, to be filed on or about April 5, 2013 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

Aetna Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2012

Unless the context otherwise requires, references to the terms "we", "our" or "us" used throughout this Annual Report on Form 10-K refer to Aetna Inc. (a Pennsylvania corporation) ("Aetna") and its subsidiaries (collectively, the "Company").

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succeed, the amount of the insolvency, if any, the amount and timing of associated guaranty association assessments or the amount or availability of potential offsets, such as premium tax offsets. It is reasonably possible that in future reporting periods we may record a liability and expense relating to Penn Treaty or other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While we have historically recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment and the ultimate liability is not known at the balance sheet date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

Out-of-Network Benefit Proceedings

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL No. 2020. Under the terms of the proposed nationwide settlement, we will be released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through the date the New Jersey District Court preliminarily approves the settlement. The settlement class period for health plan members begins on March 1, 2001, and the settlement class period for health care providers begins on June 3, 2003. The agreement contains no admission of wrongdoing. The medical associations are not parties to the settlement agreement.

Under the settlement agreement, we will pay $60 million, the substantial majority of which will be payable upon final court approval of the settlement, and pay up to an additional $60 million at the end of a claim submission and validation period that commences upon final court approval of the settlement. These payments will fund claims submitted by health plan members who are members of the plaintiff class and health care providers who are members of the plaintiff class. These payments also will fund the legal fees of plaintiffs' counsel and the costs of administering the settlement, in each case in amounts to be determined by the New Jersey District Court.

The proposed settlement is subject to preliminary and final court approval. Final court approval of the settlement is expected during 2013 but could be delayed by appeals or other proceedings. In addition, the Company has the right to terminate the settlement agreement if more than certain percentages of class members, or class members collectively holding specified dollar amounts of claims, elect to opt-out of the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income of approximately $78 million in the fourth quarter of 2012. The Company will pay for the settlement with available resources and expects the settlement payments to occur over the next twelve to twenty-four months. We intend to continue to vigorously defend ourselves against the claims brought in these cases by non-settling plaintiffs.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to our out-of-network benefit payment practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment practices.

CMS Actions

In June 2011, the Centers for Medicare & Medicaid Services ("CMS") lifted the intermediate sanctions it had previously imposed on us in April 2010 that required us to suspend the enrollment of and marketing to new members of all Aetna Medicare Advantage and Standalone Prescription Drug Plan ("PDP") contracts. The sanctions related to our compliance with certain Medicare Part D requirements. On September 27, 2012, CMS notified us that we were again eligible to receive assignments of low-income subsidy PDP members from CMS.

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions and document their medical records. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records and related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans. The Office of Inspector General (the "OIG") also is auditing risk adjustment data of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data.

In February 2012, CMS published a Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (the "Notice"). The Notice outlines the methodology that CMS will use to determine RADV audit premium refunds payable by Medicare Advantage plans for contract years 2011 and forward. Under that methodology, the RADV audit premium refund calculation will include an adjustment for the differences in documentation standards between the RADV audits and the risk adjustment model; however, the Notice provides limited information about that adjustment. In addition, CMS will project the error rate identified in the audit sample to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not make an adjustment for differences in documentation standards or project sample error rates to the entire contract. During 2013, CMS is expected to select Medicare Advantage contracts for contract year 2011 for audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the financial impact of the documentation standard adjustment, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect

of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in bid submissions to CMS for the current or future contract years or compromise premium assumptions made in our bids for prior contract years or the current contract year. Any premium refunds or adjustments resulting from regulatory audits, whether as a result of RADV or other audits by CMS, the OIG or otherwise, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including litigation related to the proposed acquisition of Coventry, employment litigation and claims of bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay medical and/or group insurance claims (including post-payment audit and collection practices), rescission of insurance coverage, improper disclosure of personal information, patent infringement and other intellectual property litigation and other litigation in our Health Care and Group Insurance businesses. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings."

There also continues to be heightened review by regulatory authorities of and increased litigation regarding the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including the use of performance-based networks and termination of provider contracts), delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices, sales practices, and claim payment practices (including payments to out-of-network providers and payments on life insurance policies). For example, New York is one of over 35 states that are investigating life insurers' claims payment and related escheat practices, and these investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, including New York, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices.

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible loss of licensure or suspension or exclusion from participation in government programs, such as the intermediate sanctions previously imposed on us by CMS that are described above under "CMS Actions."

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in a change in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. As a result, we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Other Obligations

We have operating leases for office space and certain computer and other equipment. Rental expenses for these items were $142 million, $133 million and $152 million in 2012, 2011 and 2010, respectively. The future net minimum payments under non-cancelable leases for 2013 through 2017 are estimated to be $123 million, $101 million, $59 million, $39 million and $30 million, respectively.

We also have funding obligations relating to equity limited partnership investments and commercial mortgage loans. The funding requirements for equity limited partnership investments and commercial mortgage loans for 2013 through 2017 are estimated to be $85 million, $55 million, $45 million, $27 million and $18 million, respectively.

19. Segment Information

Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment; it is added to our business segments in order to reconcile to our consolidated results. The Corporate Financing segment includes interest expense on our outstanding debt and the financing components of our pension and OPEB plan expense (the service cost components of this expense are allocated to our business segments).

2013 Aetna 10-K

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2013

or

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

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

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

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). RYes £ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

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

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

(Do not check if smaller reporting company)

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

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2013) was $23.0 billion.

There were 362.7 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2014.

DOCUMENTS INCORPORATED BY REFERENCE

The 2013 Annual Report, Financial Report to Shareholders (the "Annual Report") is incorporated by reference in Parts I, II and IV to the extent described therein. The definitive proxy statement related to Aetna Inc.'s 2014 Annual Meeting of Shareholders, to be filed on or about April 18, 2014 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

Aetna Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2013

Unless the context otherwise requires, references to the terms "we", "our" or "us" used throughout this Annual Report on Form 10-K refer to Aetna Inc. (a Pennsylvania corporation) ("Aetna") and its subsidiaries (collectively, the "Company").

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- Minimum Volume Commitments - In connection with the Coventry acquisition we assumed certain supplier agreements with minimum volume commitments which require us to make payments to the suppliers if the level of medical membership subject to the agreements falls below specified levels. The maximum potential amount of future payments we could be required to make over the remaining terms of the agreements, assuming the medical membership subject to the agreements is zero, is $233 million. Refer to Note 21 beginning on page 140 for additional information.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered as offsets to premium taxes. Some states have similar laws relating to HMOs. The Pennsylvania Insurance Commissioner (the "Commissioner") has placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. In May 2012, the state court denied the request and ordered the Commissioner to propose a rehabilitation plan. In September 2012, the state court finalized its opinion that Penn Treaty is not insolvent and remains in rehabilitation. The Commissioner has appealed the state court's decision and has filed a proposed rehabilitation plan with the state court. If the rehabilitation is not successful and Penn Treaty ultimately is placed in liquidation, we and other insurers likely would be assessed over a period of years by guaranty associations for the payments the guaranty associations are required to make to Penn Treaty policyholders. We are currently unable to predict the ultimate outcome of, or reasonably estimate the loss or range of losses resulting from, this potential insolvency because we cannot predict whether rehabilitation efforts will succeed, the amount of the insolvency, if any, the amount and timing of associated guaranty association assessments or the amount or availability of potential offsets, such as premium tax offsets. It is reasonably possible that in future reporting periods we may record a liability and expense relating to Penn Treaty or other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While we have historically recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment and the ultimate liability is not known at the balance sheet date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings
Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits

allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL No. 2020. Under the terms of the proposed nationwide settlement, we will be released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement class period for health plan members begins on March 1, 2001, and the settlement class period for health care providers begins on June 3, 2003. The agreement contains no admission of wrongdoing. The medical associations are not parties to the settlement agreement.

Under the settlement agreement, we will pay $60 million, the substantial majority of which will be payable upon final court approval of the settlement, and pay up to an additional $60 million at the end of a claim submission and validation period that commences upon final court approval of the settlement. These payments will fund claims submitted by health plan members who are members of the plaintiff class and health care providers who are members of the plaintiff class. These payments also will fund the legal fees of plaintiffs' counsel and the costs of administering the settlement, in each case in amounts to be determined by the New Jersey District Court.

The New Jersey District Court preliminarily approved the settlement on August 30, 2013. The proposed settlement remains subject to final court approval, and a final approval hearing is scheduled for March 2014. Final court approval of the settlement could be delayed by appeals or other proceedings. In addition, the Company has the right to terminate the settlement agreement if more than certain percentages of class members, or class members collectively holding specified dollar amounts of claims, elect to opt-out of the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of approximately $78 million in the fourth quarter of 2012. The Company will pay for the settlement with available resources and expects the settlement payments to occur over the next twelve to twenty-four months. We intend to continue to vigorously defend ourselves against the claims brought in these cases by non-settling plaintiffs.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

The Centers for Medicare & Medicaid Services ("CMS") regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions and document their medical

records. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans. The Office of Inspector General (the "OIG") also is auditing risk adjustment data of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data.

CMS is using a new audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the new methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the new methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. During 2013, CMS selected certain of our Medicare Advantage contracts for contract year 2011 for audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years or the current contract year. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV or other audits by CMS, the OIG or otherwise, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure of personal information, patent infringement and other intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly in our Medicaid business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and

entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings."

Over 35 states are investigating life insurers' claims payment and related escheat practices, and these investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $35.7 million ($55.0 million pretax). Given the legal and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of further changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be heightened review by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including the use of performance-based networks and termination of provider contracts), delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices, sales practices, and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible loss of licensure or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in a change in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Out-of-Network Benefit Proceedings" and "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Other Obligations

We have operating leases for office space and certain computer and other equipment. Rental expenses for these items were $170 million, $142 million and $133 million in 2013, 2012 and 2011, respectively. The future net minimum payments under non-cancelable leases for 2014 through 2018 are estimated to be $157 million, $116 million, $92 million, $64 million and $44 million, respectively.

2014 Aetna 10-K

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2014

or

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

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

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

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). RYes £ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

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

Large accelerated filer ☑ Accelerated filer £

Non-accelerated filer £ (Do not check if smaller reporting company) Smaller reporting company £

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

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2014) was $27.9 billion.

There were 348.7 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2015.

DOCUMENTS INCORPORATED BY REFERENCE

The 2014 Annual Report, Financial Report to Shareholders (the "Annual Report") is incorporated by reference in Parts I, II and IV to the extent described therein. The definitive proxy statement related to Aetna Inc.'s 2015 Annual Meeting of Shareholders, to be filed on or about April 3, 2015 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

have historically recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment and the ultimate liability is not known at the balance sheet date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

Out-of-Network Benefit Proceedings

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL No. 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement.

In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of approximately $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. We intend to vigorously defend ourselves against the claims brought by the plaintiffs. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $67.0 million ($103.0 million pretax).

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

The Centers for Medicare & Medicaid Services ("CMS") regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and PDPs for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing risk adjustment data of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. During 2013, CMS selected certain of our Medicare Advantage contracts for contract year 2011 for audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years or the current contract year. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial condition and cash flows.

Other Litigation and Regulatory Proceedings
We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of
performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, patent infringement and other intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly in our Medicaid business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings."

A significant number of states are investigating life insurers' claims payment and related escheat practices, and these investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $35.7 million ($55.0 million pretax). Given the legal and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of further changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), calculation of

minimum medical loss ratios, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in a change in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

Other Obligations

We have operating leases for office space and certain computer and other equipment. Rental expenses for these items were $177 million, $170 million and $142 million in 2014, 2013 and 2012, respectively. The future net minimum payments under non-cancelable leases for 2015 through 2019 are estimated to be $139 million, $103 million, $74 million, $56 million and $39 million, respectively.

We also have funding obligations relating to equity limited partnership investments and real estate partnerships. The funding requirements for equity limited partnership investments and real estate partnerships for 2015 through 2019 are estimated to be $132 million, $87 million, $55 million, $33 million and $22 million, respectively.

19. Segment Information

Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. The acquired Coventry operations are reflected in our Health Care segment on and after May 7, 2013. Our Corporate Financing segment is not a business segment; it is added to our business segments to reconcile to our consolidated results. The Corporate Financing segment includes interest expense on our outstanding debt and the financing components of our pension and OPEB plan expense (the service cost and prior service cost components of this expense are allocated to our business segments). Non-GAAP financial measures we disclose, such as operating earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

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2015 Aetna 10-K

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2015

or

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

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

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

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

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

Large accelerated filer ☑ Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if smaller reporting company) Smaller reporting company ☐

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

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2015) was $43.2 billion.

There were 349.6 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2016.

DOCUMENTS INCORPORATED BY REFERENCE

The 2015 Annual Report, Financial Report to Shareholders (the "Annual Report") is incorporated by reference in Parts I, II and IV to the extent described therein. The definitive proxy statement related to Aetna Inc.'s 2016 Annual Meeting of Shareholders, to be filed on or about April 8, 2016 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

Pennsylvania Insurance Commissioner (the "Commissioner") placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. In 2012, the state court denied the Commissioner's petition for liquidation. The Pennsylvania Supreme Court affirmed that ruling in July 2015. The state court's 2012 order directed the Commissioner to develop a plan of rehabilitation. The Commissioner filed an initial rehabilitation plan in April 2013, and filed amended plans in August 2014 and October 2014. The state court began a hearing in July 2015, which is schedule to continue in the spring of 2016, to consider the Commissioner's most recent proposed rehabilitation plan, which contemplates a partial liquidation of Penn Treaty. If Penn Treaty is placed in liquidation, we and other insurers likely would be assessed immediately or over a period of years by guaranty associations for the payments the guaranty associations are required to make to Penn Treaty policyholders. We are currently unable to predict the ultimate outcome of, or reasonably estimate the loss or range of losses resulting from, this potential insolvency because we cannot predict when or to what extent Penn Treaty ultimately will be declared insolvent, the amount of the insolvency, the amount and timing of associated future guaranty association assessments or the amount or availability of potential offsets, such as premium tax offsets. It is reasonably possible that during 2016 we may record a liability and expense relating to Penn Treaty and/or other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While we have historically recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment and the ultimate liability is not known at the balance sheet date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

Out-of-Network Benefit Proceedings

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District

Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $67.0 million ($103.0 million pretax).

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to vigorously defend ourselves against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

The Centers for Medicare & Medicaid Services ("CMS") regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to

validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing risk adjustment data of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for contract years 2011 and 2012 for audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years or the current contract year. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, patent infringement and other intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to vigorously defend ourselves against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly in our Medicaid business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the

investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings."

A significant number of states are investigating life insurers' claims payment and related escheat practices, and these investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $35.7 million ($55.0 million pretax). Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of further changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in a change in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above, and it is reasonably possible that their outcome could be material to us.

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2016 Aetna 10-K

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2016

or

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

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

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

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

Large accelerated filer ☑ Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if smaller reporting company) Smaller reporting company ☐

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

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2016) was $41.8 billion.

There were 351.7 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2017.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement related to Aetna Inc.'s 2017 Annual Meeting of Shareholders, to be filed on or about April 7, 2017 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

Terminated Acquisition of Humana and Related Matters
On February 14, 2017, Aetna and Molina entered into the APA Termination Agreement pursuant to which Aetna terminated the Molina APA, including all schedules and exhibits thereto, and all ancillary agreements contemplated thereby or entered pursuant thereto. Under the APA Termination Agreement, among other things, Aetna agreed to pay Molina in cash approximately 70% of Molina's transaction costs. We expect to pay Molina the applicable transaction costs during the first quarter of 2017.

In June 2016, we issued $13.0 billion of 2016 senior notes to partially fund the Humana Acquisition. In accordance with the terms of the 2016 senior notes, on February 14, 2017, we issued a notice of redemption for the entire $10.2 billion aggregate principal amount of the Special Mandatory Redemption Notes at a redemption price equal to 101% of the aggregate principal amount of those notes plus accrued and unpaid interest. We will redeem the Special Mandatory Redemption Notes on or about March 16, 2017. As a result of the redemption of the Special Mandatory Redemption Notes, in the first quarter of 2017, we will recognize on a pretax basis in our net income the entire approximately $420 million unamortized portion of the related cash flow hedge losses, debt issuance costs and debt issuance discounts and the entire approximately $100 million redemption premium paid on the Special Mandatory Redemption Notes upon such redemption.

Litigation and Regulatory Proceedings
Humana Acquisition - Department of Justice Litigation
On July 21, 2016, the DOJ and certain state attorneys general filed a civil complaint in the U.S. District Court for the District of Columbia (the "District Court") against us and Humana charging that the Humana Acquisition would violate Section 7 of the Clayton Antitrust Act, and seeking a permanent injunction to prevent Aetna from acquiring Humana. On January 23, 2017, the District Court granted the DOJ's request to enjoin the Humana Acquisition.

Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of

plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to defend ourselves vigorously against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing risk adjustment data of other companies, and we expect CMS and the OIG to continue auditing risk adjustment data.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years or the current contract year. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes,

marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, patent infringement and other intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings."

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $36 million ($55 million pretax). Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of further changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulation Proceedings", and it is reasonably possible that their outcome could be material to us.

Other Obligations

We have operating leases for office space and certain computer and other equipment. Rental expenses for these items were $167 million, $165 million and $177 million in 2016, 2015 and 2014, respectively. For 2017 through 2021, our future net minimum payments under non-cancelable leases and funding obligations relating to equity limited partnership investments, commercial mortgage loans and real estate partnerships were as following:

(Millions)	2017	2018	2019	2020	2021
Future net minimum payments under non-cancelable leases	$ 143	$ 121	$ 81	$ 47	$ 37
Funding requirements for equity limited partnership investments, commercial mortgage loans and real estate partnerships	177	127	94	56	37
Total	$ 320	$ 248	$ 175	$ 103	$ 74

18. Segment Information

Our operations are conducted in three business segments: Health Care, Group Insurance and Large Case Pensions. Our Corporate Financing segment is not a business segment; it is added to our business segments to reconcile to our consolidated results. The Corporate Financing segment includes interest expense on our outstanding debt and the financing components of our pension and OPEB plan expense (the prior service cost components of this expense are allocated to our business segments). Non-GAAP financial measures we disclose, such as operating earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

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2017 Aetna 10-K

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2017

or

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

For the transition period from _____ to_____

Commission file number 1-16095

Aetna Inc.

(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code	**(860) 273-0123**

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

Title of each class	Name of each exchange on which registered
Common Shares, $.01 par value	**New York Stock Exchange**

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

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

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

The aggregate market value of the outstanding common equity of the registrant held by non-affiliates as of the last business day of the registrant's most recently completed second fiscal quarter (June 30, 2017) was $49.2 billion.

There were 326.8 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at January 31, 2018.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement related to Aetna Inc.'s 2018 Annual Meeting of Shareholders, to be filed on or about April 6, 2018 (the "Proxy Statement"), is incorporated by reference in Parts III and IV to the extent described therein.

liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

Out-of-Network Benefit Proceedings

We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to defend ourselves vigorously against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other

litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing our risk adjustment-related data and that of other companies. We expect CMS and the OIG to continue these types of audits.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and Group Insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and Group Insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the U.S. Department of Justice, the Federal Trade Commission, U.S. attorneys and other state, federal and

international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $36 million ($55 million pretax). Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of further changes in our business practices, litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers and payments on life insurance policies).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

2018 Aetna 10-Q Ending March 31

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

FORM 10-Q

(Mark One)

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

For the quarterly period ended March 31, 2018

or

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

For the transition period from _____ to_____

Commission File Number: 1-16095

Aetna Inc.
(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code:	**(860) 273-0123**

Former name, former address and former fiscal year, if changed since last report: **N/A**

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter)
during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

☑ **Yes** ☐ **No**

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

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

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

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

There were 327.1 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at March 31, 2018.

13. Commitments and Contingencies

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner (the "Commissioner") placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, we recorded a discounted estimated liability and expense of $231 million pretax for our estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The undiscounted estimated liability was $347 million. The expense was recorded in operating expenses in our Consolidated Statements of Income, and the liability was recorded in accrued expenses and other current liabilities in our Consolidated Balance Sheets. We did not record an asset for expected premium tax offsets for our in force business at March 31, 2018 as the amount was not material. It is reasonably possible that in the future we may record a liability and expense relating to other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings
Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from

participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. We intend to defend ourselves vigorously against the plaintiffs' remaining claims.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

The Centers for Medicare & Medicaid Services ("CMS") regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing our risk adjustment-related data and that of other companies. We expect CMS and the OIG to continue these types of audits.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or

adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and divested group insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and divested group insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the DOJ, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding the CVS Health Transaction, our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. As a result of these changes, in the fourth quarter of 2013, we increased our estimated liability for unpaid life insurance claims with respect to insureds who passed away on or before December 31, 2013, and recorded in current and future benefits a charge of $36 million ($55 million pretax). Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur additional liability related to those practices, whether as a result of litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products,

student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

14. Segment Information

Effective for the first quarter of 2018, we realigned our business segments to correspond with changes to our management structure and internal management reporting, which reflect our evolving business strategy of helping our members live healthier lives. Refer to Note 1 for further discussion.

Non-GAAP financial measures we disclose, such as adjusted earnings and pre-tax adjusted earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. The chief executive officer assesses our consolidated results based on adjusted earnings and assesses business segment results based on pre-tax adjusted earnings because income taxes are recorded in our Corporate/Other category and are not allocated to our business operations.

Summarized financial information of our segment operations[1] for the three months ended March 31, 2018 and 2017 were as follows:

(Millions)	Health Care	Corporate/Other	Total Company
Three Months Ended March 31, 2018			
Revenue from external customers	**$ 14,995**	**$ 137**	**$ 15,132**
Pre-tax adjusted earnings (loss)[2]	**1,486**	**(48)**	**1,438**
Three Months Ended March 31, 2017			
Revenue from external customers	$ 14,688	$ 550	$ 15,238
Pre-tax adjusted earnings (loss)[2]	1,481	(30)	1,451

(1) Total assets by segment are not disclosed as this information is not reviewed by the chief executive officer.
(2) Pre-tax adjusted earnings (loss) excludes net realized capital gains or losses, amortization of other acquired intangible assets and the other items described in the reconciliation below.

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2018 Aetna 10-Q Ending June 30

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

FORM 10-Q

(Mark One)

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

For the quarterly period ended June 30, 2018

or

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

For the transition period from _____ to_____

Commission File Number: 1-16095

Aetna Inc.
(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code:	**(860) 273-0123**

Former name, former address and former fiscal year, if changed since last report: **N/A**

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter)
during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

☑ **Yes** ☐ **No**

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

Large accelerated filer ☑	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

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

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

There were 327.4 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at June 30, 2018.

14. Commitments and Contingencies

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner (the "Commissioner") placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, we recorded a discounted estimated liability and expense of $231 million pretax for our estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The undiscounted estimated liability was $347 million. The expense was recorded in operating expenses in our Consolidated Statements of Income, and the liability was recorded in accrued expenses and other current liabilities in our Consolidated Balance Sheets. We did not record an asset for expected premium tax offsets for our in force business at June 30, 2018 as the amount was not material. It is reasonably possible that in the future we may record a liability and expense relating to other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings
Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from

participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

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Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

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We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

The Centers for Medicare & Medicaid Services ("CMS") regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing our risk adjustment-related data and that of other companies. We expect CMS and the OIG to continue these types of audits.

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predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

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Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the DOJ, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding the CVS Health Transaction, our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

A significant number of states are investigating life insurers' claims payment and related escheat practices. These investigations have resulted in significant charges to earnings by other life insurers in connection with related settlements. We have received requests for information from a number of states, and certain of our subsidiaries are being audited, with respect to our life insurance claim payment and related escheat practices. In the fourth quarter of 2013, we made changes to our life insurance claim payment practices (including related escheatment practices) based on evolving industry practices and regulatory expectations and interpretations, including expanding our existing use of the Social Security Administration's Death Master File to identify additional potentially unclaimed death benefits and locate applicable beneficiaries. Given the judicial, legislative and regulatory uncertainty with respect to life insurance claim payment and related escheat practices, it is reasonably possible that we may incur liability related to those practices, whether as a result of litigation, government actions or otherwise, which could adversely affect our operating results and cash flows.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, our and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products,

student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

15. Segment Information

Effective for the first quarter of 2018, we realigned our business segments to correspond with changes to our management structure and internal management reporting which reflect our evolving business strategy of helping our members live healthier lives. Refer to Note 1 for further discussion.

Non-GAAP financial measures we disclose, such as adjusted earnings and pre-tax adjusted earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. The chief executive officer assesses our consolidated results based on adjusted earnings and assesses business segment results based on pre-tax adjusted earnings because income taxes are recorded in our Corporate/Other category and are not allocated to our business operations.

Summarized financial information of our segment operations[1] for the three and six months ended June 30, 2018 and 2017 were as follows:

(Millions)	Health Care	Corporate/Other	Total Company
Three Months Ended June 30, 2018			
Revenue from external customers	**$ 15,237**	**$ 141**	**$ 15,378**
Pre-tax adjusted earnings (loss)[2]	**1,602**	**(45)**	**1,557**
Three Months Ended June 30, 2017			
Revenue from external customers	$ 14,700	$ 561	$ 15,261
Pre-tax adjusted earnings (loss)[2]	1,774	(17)	1,757
Six Months Ended June 30, 2018			
Revenue from external customers	**$ 30,232**	**$ 278**	**$ 30,510**
Pre-tax adjusted earnings (loss)[2]	**3,088**	**(93)**	**2,995**
Six Months Ended June 30, 2017			
Revenue from external customers	$ 29,388	$ 1,111	$ 30,499
Pre-tax adjusted earnings (loss)[2]	3,255	(47)	3,208

(1) Total assets by segment are not disclosed as this information is not reviewed by the chief executive officer.
(2) Pre-tax adjusted earnings (loss) excludes net realized capital gains or losses, amortization of other acquired intangible assets and the other items described in the reconciliation below.

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2018 Aetna 10-Q Ending September 30

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

FORM 10-Q

(Mark One)

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

For the quarterly period ended September 30, 2018

or

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

For the transition period from _____ to_____

Commission File Number: 1-16095

Aetna Inc.
(Exact name of registrant as specified in its charter)

Pennsylvania (State or other jurisdiction of incorporation or organization)	**23-2229683** (I.R.S. Employer Identification No.)
151 Farmington Avenue, Hartford, CT (Address of principal executive offices)	**06156** (Zip Code)
Registrant's telephone number, including area code:	**(860) 273-0123**

Former name, former address and former fiscal year, if changed since last report: **N/A**

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

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

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

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

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

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

There were 327.4 million shares of the registrant's voting common stock with a par value of $.01 per share outstanding at September 30, 2018.

14. Commitments and Contingencies

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools
Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which we participate that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. Our assessments generally are based on a formula relating to our health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner (the "Commissioner") placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, we recorded a discounted estimated liability and expense of $231 million pretax for our estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The undiscounted estimated liability was $347 million. The expense was recorded in operating expenses in our Consolidated Statements of Income, and the liability was recorded in accrued expenses and other current liabilities in our Consolidated Balance Sheets. We did not record an asset for expected premium tax offsets for our in force business at September 30, 2018, as the amount was not material. It is reasonably possible that in the future we may record a liability and expense relating to other insolvencies which could have a material adverse effect on our operating results, financial position and cash flows. While historically we have ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which we do business are subject to assessments, including market stabilization and other risk-sharing pools, for which we are assessed charges based on incurred claims, demographic membership mix and other factors. We establish liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments we pay are dependent upon our experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, we believe we have adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings
Out-of-Network Benefit Proceedings
We are named as a defendant in several purported class actions and individual lawsuits arising out of our practices related to the payment of claims for services rendered to our members by health care providers with whom we do not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that we paid too little to our health plan members and/or providers for these services, among other reasons, because of our use of data provided by Ingenix, Inc., a subsidiary of one of our competitors ("Ingenix"). Other major health insurers are the subject of similar litigation or have settled similar litigation.

Various plaintiffs who are health care providers or medical associations seek to represent nationwide classes of out-of-network providers who provided services to our members during the period from 2001 to the present. Various plaintiffs who are members in our health plans seek to represent nationwide classes of our members who received services from out-of-network providers during the period from 2001 to the present. Taken together, these lawsuits allege that we violated state law, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Racketeer Influenced and Corrupt Organizations Act ("RICO") and federal antitrust laws, either acting alone or in concert with our competitors. The purported classes seek reimbursement of all unpaid benefits, recalculation and repayment of deductible and coinsurance amounts, unspecified damages and treble damages, statutory penalties, injunctive and declaratory relief, plus interest, costs and attorneys' fees, and seek to disqualify us from acting as a fiduciary of any benefit plan that is subject to ERISA. Individual lawsuits that generally contain similar allegations and seek similar relief have been brought by health plan members and out-of-network providers.

The first class action case was commenced on July 30, 2007. The federal Judicial Panel on Multi-District Litigation (the "MDL Panel") has consolidated these class action cases in the U.S. District Court for the District of New Jersey (the "New Jersey District Court") under the caption *In re: Aetna UCR Litigation,* MDL No. 2020 ("MDL 2020"). In addition, the MDL Panel has transferred the individual lawsuits to MDL 2020. On May 9, 2011, the New Jersey District Court dismissed the physician plaintiffs from MDL 2020 without prejudice. The New Jersey District Court's action followed a ruling by the United States District Court for the Southern District of Florida (the "Florida District Court") that the physician plaintiffs were enjoined from

participating in MDL 2020 due to a prior settlement and release. The United States Court of Appeals for the Eleventh Circuit has dismissed the physician plaintiffs' appeal of the Florida District Court's ruling.

On December 6, 2012, we entered into an agreement to settle MDL 2020. Under the terms of the proposed nationwide settlement, we would have been released from claims relating to our out-of-network reimbursement practices from the beginning of the applicable settlement class period through August 30, 2013. The settlement agreement did not contain an admission of wrongdoing. The medical associations were not parties to the settlement agreement.

Under the settlement agreement, we would have paid up to $120 million to fund claims submitted by health plan members and health care providers who were members of the settlement classes. These payments also would have funded the legal fees of plaintiffs' counsel and the costs of administering the settlement. In connection with the proposed settlement, the Company recorded an after-tax charge to net income attributable to Aetna of $78 million in the fourth quarter of 2012.

The settlement agreement provided us the right to terminate the agreement under certain conditions related to settlement class members who opted out of the settlement. Based on a report provided to the parties by the settlement administrator, the conditions permitting us to terminate the settlement agreement were satisfied. On March 13, 2014, we notified the New Jersey District Court and plaintiffs' counsel that we were terminating the settlement agreement. Various legal and factual developments since the date of the settlement agreement led us to believe terminating the settlement agreement was in our best interests. As a result of this termination, we released the reserve established in connection with the settlement agreement, net of amounts due to the settlement administrator, which reduced first quarter 2014 other general and administrative expenses by $103 million pretax.

On June 30, 2015, the New Jersey District Court granted in part our motion to dismiss the proceeding. The New Jersey District Court dismissed with prejudice the plaintiffs' RICO and federal antitrust claims; their ERISA claims that are based on our disclosures and our purported breach of fiduciary duties; and certain of their state law claims. The New Jersey District Court also dismissed with prejudice all claims asserted by several medical association plaintiffs. The plaintiffs' remaining claims are for ERISA benefits and breach of contract. On June 30, 2018, the New Jersey District Court denied the plaintiffs' request for class certification of the plaintiffs' remaining claims. On October 4, 2018, the lead plaintiffs informed the New Jersey District Court that they would voluntarily dismiss their claims with prejudice. The New Jersey District Court and the parties will address any claims that remain after these dismissals.

On October 28, 2016, we were named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to our out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in our individual Public Exchange products from 2014 through 2016. Coverage under our individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the arbitrator awarded the claimant hospitals approximately $150 million. We intend to continue to defend ourselves vigorously against the claimant hospitals' claims and to appeal the arbitrator's decision.

We also have received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and we are involved in other litigation regarding, our out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against us with respect to our out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits our performance to determine our compliance with CMS's regulations and our contracts with CMS and to assess the quality of services we provide to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to our and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. We collect claim and encounter data from providers and generally rely on providers to appropriately code their submissions to us and document their medical records, including the diagnosis data submitted to us with claims. CMS pays increased premiums to Medicare Advantage plans and prescription drug program plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to us. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require us to refund premium payments if our risk adjusted premiums are not properly supported by medical record data. The

Office of Inspector General (the "OIG") also is auditing our risk adjustment-related data and that of other companies. We expect CMS and the OIG to continue these types of audits.

CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. Historically, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase our exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of our Medicare Advantage contracts for various contract years for RADV audit. We are currently unable to predict which of our Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to us, the effect of any such refunds or adjustments on the actuarial soundness of our Medicare Advantage bids, or whether any RADV audit findings would cause a change to our method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in our bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of our minimum medical loss ratio rebates, methodology and/or reports, could be material and could adversely affect our operating results, financial position and cash flows.

Other Litigation and Regulatory Proceedings

We are involved in numerous other lawsuits arising, for the most part, in the ordinary course of our business operations, including claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits in our Health Care and divested group insurance businesses (including our post-payment audit and collection practices and reductions in payments to providers due to sequestration), provider network structure (including the use of performance-based networks and termination of provider contracts), provider directory accuracy, rescission of insurance coverage, improper disclosure of personal information, anticompetitive practices, intellectual property litigation, other legal proceedings in our Health Care and divested group insurance businesses and employment litigation. Some of these other lawsuits are or are purported to be class actions. We intend to defend ourselves vigorously against the claims brought in these matters.

Awards to us and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in our Commercial business, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to us being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect our operating results. We will continue to defend vigorously contract awards we receive.

In addition, our operations, current and past business practices, current and past contracts, and accounts and other books and records are subject to routine, regular and special investigations, audits, examinations and reviews by, and from time to time we receive subpoenas and other requests for information from, CMS, the U.S. Department of Health and Human Services, various state insurance and health care regulatory authorities, state attorneys general, treasurers and offices of inspector general, the Center for Consumer Information and Insurance Oversight, the OIG, the Office of Personnel Management, the U.S. Department of Labor, the U.S. Department of the Treasury, the U.S. Food and Drug Administration, committees, subcommittees and members of the U.S. Congress, the DOJ, the Federal Trade Commission, U.S. attorneys and other state, federal and international governmental authorities. These government actions include inquiries by, and testimony before, certain members, committees and subcommittees of the U.S. Congress regarding the CVS Health Transaction, our withdrawal from certain states' Public Exchanges for 2017, certain of our current and past business practices, including our overall claims processing and payment practices, our business practices with respect to our small group products, student health products or individual customers (such as market withdrawals, rating information, premium increases and medical benefit ratios), executive compensation matters and travel and entertainment expenses, as well as the investigations by, and subpoenas and requests from, attorneys general and others described above under "Out-of-Network Benefit Proceedings." We also have produced documents and information to the Civil Division of the DOJ in cooperation with a current investigation of our patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program.

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As a leading national health and related benefits company, we regularly are the subject of government actions of the types described above. These government actions may prevent or delay us from implementing planned premium rate increases and may result, and have resulted, in restrictions on our business, changes to or clarifications of our business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to us by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

Estimating the probable losses or a range of probable losses resulting from litigation, government actions and other legal proceedings is inherently difficult and requires an extensive degree of judgment, particularly where the matters involve indeterminate claims for monetary damages, involve claims for injunctive relief, may involve fines, penalties or punitive damages that are discretionary in amount, involve a large number of claimants or regulatory authorities, represent a change in regulatory policy, present novel legal theories, are in the early stages of the proceedings, are subject to appeal or could result in changes in business practices. In addition, because most legal proceedings are resolved over long periods of time, potential losses are subject to change due to, among other things, new developments, changes in litigation strategy, the outcome of intermediate procedural and substantive rulings and other parties' settlement posture and their evaluation of the strength or weakness of their case against us. Except as specifically noted above under "Other Litigation and Regulatory Proceedings," we are currently unable to predict the ultimate outcome of, or reasonably estimate the losses or a range of losses resulting from, the matters described above under "Litigation and Regulatory Proceedings", and it is reasonably possible that their outcome could be material to us.

15. Segment Information

Effective for the first quarter of 2018, we realigned our business segments to correspond with changes to our management structure and internal management reporting which reflect our evolving business strategy of helping our members live healthier lives. Refer to Note 1 for further discussion.

Non-GAAP financial measures we disclose, such as adjusted earnings and pre-tax adjusted earnings, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP. The chief executive officer assesses our consolidated results based on adjusted earnings and assesses business segment results based on pre-tax adjusted earnings because income taxes are recorded in our Corporate/Other category and are not allocated to our business operations.

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2010 CVS Health 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2010

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from to

Commission file number 001-01011

CVS CAREMARK CORPORATION

(Exact name of Registrant as specified in its charter)

Delaware **(State or other jurisdiction of incorporation or organization)**	**050494040** **(I.R.S. Employer Identification No.)**
One CVS Drive, Woonsocket, Rhode Island **(Address of principal executive offices)**	**02895** **(Zip Code)**

(401) 765-1500
(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share **Title of each class**	**New York Stock Exchange** **Name of each exchange on which registered**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒ Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $39,599,675,690 as of June 30, 2010, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 11, 2011, the registrant had 1,368,174,000 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

- Information contained on pages 20 through 80 and page 83 of our Annual Report to Stockholders for the fiscal year ended December 31, 2010 is incorporated by reference in our response to Items 7, 8 and 9 of Part II.
- Information contained in our Proxy Statement for the 2011 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

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Item 3. Legal Proceedings

I. Legal Proceedings

1. Caremark (the term "Caremark" being used herein to generally refer to any one or more pharmacy benefit management subsidiaries of the Company, as applicable) is a defendant in a qui tam lawsuit initially filed by a relator on behalf of various state and federal government agencies in Texas federal court in 1999. The case was unsealed in May 2005. The case seeks monetary damages and alleges that Caremark's processing of Medicaid and certain other government claims on behalf of its clients (which allegedly resulted in underpayments from our clients to the applicable government agencies) on one of Caremark's adjudication platforms violates applicable federal or state false claims acts and fraud statutes. The United States and the States of Texas, Tennessee, Florida, Arkansas, Louisiana and California intervened in the lawsuit, but Tennessee and Florida withdrew from the lawsuit in August 2006 and May 2007, respectively. The parties previously filed cross motions for partial summary judgment, and in August 2008, the court granted several of Caremark's motions and denied the motions filed by the plaintiffs. The court's rulings are favorable to Caremark and substantially limit the ability of the plaintiffs to assert false claims act allegations or statutory or common law theories of recovery based on Caremark's processing of Medicaid and other government reimbursement requests. The court's rulings are on appeal before the United States Court of Appeals for the Fifth Circuit. In April 2009, the State of Texas filed a purported civil enforcement action against Caremark for injunctive relief, damages and civil penalties in Travis County, Texas alleging that Caremark violated the Texas Medicaid Fraud Prevention Act and other state laws based on our processing of Texas Medicaid claims on behalf of PBM clients. The claims and issues raised in this lawsuit are related to the claims and issues pending in the federal qui tam lawsuit described above.

2. In December 2007, the Company received a document subpoena from the OIG, requesting information relating to the processing of Medicaid and other government agency claims on a different adjudication platform of Caremark. In October 2009 and October 2010, the Company received civil investigative demands from the Office of the Attorney General of the State of Texas requesting, respectively, information produced under this OIG subpoena and other information related to the processing of Medicaid claims. These civil investigative demands state that the Office of the Attorney General of the State of Texas is investigating allegations currently pending under seal relating to two of Caremark's adjudication platforms. The Company has been producing documents on a rolling basis in response to the requests for information contained in the OIG subpoena and in these civil investigative demands. The Company cannot predict with certainty the timing or outcome of any review of such information.

3. Caremark was named in a putative class action lawsuit filed in October 2003 in Alabama state court by John Lauriello, purportedly on behalf of participants in the 1999 settlement of various securities class action and derivative lawsuits against Caremark and others. Other defendants include insurance companies that provided coverage to Caremark with respect to the settled lawsuits. The Lauriello lawsuit seeks approximately $3.2 billion in compensatory damages plus other non-specified damages based on allegations that the amount of insurance coverage available for the settled lawsuits was misrepresented and suppressed. A similar lawsuit was filed in November 2003 by Frank McArthur, also in Alabama state court, naming as defendants Caremark, several insurance companies, attorneys and law firms involved in the 1999 settlement. This lawsuit was stayed as a later-filed class action, but McArthur was subsequently allowed to intervene in the Lauriello action. The attorneys and law firms named as defendants in McArthur's intervention pleadings have been dismissed from the case, and discovery on class certification and adequacy issues is underway.

4. Various lawsuits have been filed alleging that Caremark has violated applicable antitrust laws in establishing and maintaining retail pharmacy networks for client health plans. In August 2003, Bellevue Drug Co., Robert Schreiber, Inc. d/b/a Burns Pharmacy and Rehn-Huerbinger Drug Co. d/b/a Parkway Drugs #4, together with Pharmacy Freedom Fund and the National Community Pharmacists Association filed a putative class action against Caremark in Pennsylvania federal court, seeking treble damages and injunctive relief. This case was initially sent to arbitration based on the contract terms between the pharmacies and Caremark. In October 2003, two independent pharmacies, North Jackson Pharmacy, Inc.

and C&C, Inc. d/b/a Big C Discount Drugs, Inc., filed a putative class action complaint in Alabama federal court against Caremark and two PBM competitors, seeking treble damages and injunctive relief. The North Jackson Pharmacy case against two of the Caremark entities named as defendants was transferred to Illinois federal court, and the case against a separate Caremark entity was sent to arbitration based on contract terms between the pharmacies and Caremark. The Bellevue arbitration was then stayed by the parties pending developments in the North Jackson Pharmacy court case.

In August 2006, the Bellevue case and the North Jackson Pharmacy case were both transferred to Pennsylvania federal court by the Judicial Panel on Multidistrict Litigation for coordinated and consolidated proceedings with other cases before the panel, including cases against other PBMs. Caremark appealed the decision which vacated the order compelling arbitration and staying the proceedings in the Bellevue case and, following the appeal, the Court of Appeals reinstated the order compelling arbitration of the Bellevue case. Motions for class certification in the coordinated cases within the multidistrict litigation, including the North Jackson Pharmacy case, remain pending. The consolidated action is now known as the In Re Pharmacy Benefit Managers Antitrust Litigation.

5. Beginning in November 2008, the Company received and responded to several subpoenas from the DEA, Los Angeles Field Division, requesting sales data and other information regarding the Company's distribution of products containing pseudoephedrine ("PSE") at certain retail pharmacies and from one California distribution center. In September 2009, the United States Attorney's Office for the Central District of California ("USAO") and the DEA commenced discussions with the Company regarding whether, in late 2007 and 2008, the Company distributed PSE in violation of the Controlled Substances Act. In addition, the DEA issued an order to show cause against certain retail pharmacies and the Company's La Habra, California distribution center which could have resulted in administrative action against the Company's DEA registrations for these facilities. On October 13, 2010, the Company entered into a comprehensive resolution of this matter, resulting in the payment of $75 million in civil penalties for violations of the Controlled Substances Act and $2.6 million in criminal forfeiture relating to the sales of products containing PSE. The resolution included the entry of a non-prosecution agreement and civil settlement agreement with the USAO, the U.S. Attorney's Office for the District of Nevada and the DOJ, as well as a memorandum of agreement with the DEA that dismisses the above-referenced orders to show cause and contains certain ongoing compliance requirements for the Company.

6. In August 2009, the Company was notified by the FTC that it is conducting a non-public investigation under the FTCA into certain of the Company's business practices. In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies are conducting a multi-state investigation of the Company regarding issues similar to those being investigated by the FTC. At this time, 24 states, the District of Columbia, and the County of Los Angeles, are known to be participating in this multi-state investigation. The Company has been cooperating in these investigations, and continues to provide documents and other information as requested. The Company is not able to predict with certainty the timing or outcome of these investigations. However, it remains confident that its business practices and service offerings (which are designed to reduce health care costs and expand consumer choice) are being conducted in compliance with the antitrust laws.

7. In March 2009, the Company received a subpoena from the OIG requesting information concerning the Medicare Part D prescription drug plans of RxAmerica, the PBM subsidiary of Longs Drug Stores Corporation which was acquired by the Company in October 2008. The Company continues to respond to the request for information and has been producing responsive documents on a rolling basis. The Company cannot predict with certainty the timing or outcome of any review by the government of such information.

8. Since March 2009, the Company has been named in a series of putative collective and class action lawsuits filed in federal courts around the country, purportedly on behalf of current and former assistant store managers working in the Company's stores at various locations outside California. The lawsuits allege that the Company failed to pay overtime to assistant store managers as required under the Fair Labor Standards Act ("FLSA") and under certain state statutes. The lawsuits also seek other relief, including liquidated

damages, punitive damages, attorneys' fees, costs and injunctive relief arising out of the state and federal claims for overtime pay. Notice has been issued to over 13,000 current and former assistant store managers offering them the opportunity to "opt in" to certain of the FLSA collective actions and over 1,900 have elected to participate in these lawsuits. At this time, the Company is not able to predict the outcome of these cases, or the possible monetary exposure associated with the lawsuits. The Company's position, however, that the lawsuits are without merit and that the cases should not be certified as class or collective actions. The Company is vigorously defending these claims.

9. In January 2010, the Company received a subpoena from the OIG in connection with an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The subpoena requests retail pharmacy claims data for "dual eligible" customers (i.e., customers with both Medicaid and private insurance coverage), information concerning the Company's retail pharmacy claims processing systems, copies of pharmacy payor contracts and other documents and records. The Company has provided documents and other information in response to the subpoena and continues to engage in discussions with the government about the subject matter of the subpoena. The Company cannot predict with certainty the timing or outcome of any review by the government of such information.

10. In March 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to our pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise, The subpoena relates to an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The Company continues to respond to this request for information and has been producing responsive documents on a rolling basis. We cannot predict with certainty the timing or outcome of any reviews by the government of such information.

11. In November 2009, a securities class action lawsuit was filed in the United States District Court for the District of Rhode Island purportedly on behalf of purchasers of CVS Caremark Corporation stock between May 5, 2009 and November 4, 2009. The lawsuit names the Company and certain officers as defendants and includes allegations of securities fraud relating to public disclosures made by the Company concerning the PBM business and allegations of insider trading. In addition, a shareholder derivative lawsuit was filed in December 2009, in the same court against the directors and certain officers of the Company. A derivative lawsuit is a lawsuit filed by a shareholder purporting to assert claims on behalf of a corporation against directors and officers of the corporation. This lawsuit includes allegations of, among other things, securities fraud, insider trading and breach of fiduciary duties and further alleges that the Company was damaged by the purchase of stock at allegedly inflated prices under its share repurchase program. In January 2011, both lawsuits were transferred to the United States District Court for the District of New Hampshire. The Company believes these lawsuits are without merit and the Company plans to defend them vigorously.

12. The Company is also a party to other legal proceedings and inquiries arising in the normal course of its business, none of which is expected to be material to the Company. The Company can give no assurance, however, that our business, financial condition and results of operations will not be materially adversely affected, or that we will not be required to materially change our business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, as they may relate to our business or the pharmacy services or retail industry; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services or retail industry; (iv) institution of government enforcement actions against us; (v) adverse developments in any pending *qui tam* lawsuit against us, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against us; or (vi) adverse developments in other pending or future legal proceedings against us or affecting the pharmacy services or retail industry.

II. Environmental Matters

1. Item 103 of SEC Regulation S-K requires disclosure of certain environmental legal proceedings if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or

2011 CVS Health 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the fiscal year ended December 31, 2011

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the transition period from to

Commission file number 001-01011

CVS CAREMARK CORPORATION

(Exact name of Registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	**050494040** (I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island (Address of principal executive offices)	**02895** (Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share Title of each class	**New York Stock Exchange** Name of each exchange on which registered

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $50,513,379,248 as of June 30, 2011, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 10, 2012, the registrant had 1,302,378,570 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

- Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2011 is incorporated by reference in our response to Items 7, 8 and 9 of Part II.
- Information contained in our Proxy Statement for the 2012 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

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PART I

Item 1. Business

Overview

CVS Caremark Corporation ("CVS Caremark", the "Company", "we" or "us"), together with its subsidiaries, is the largest pharmacy health care provider in the United States, with integrated offerings across the entire spectrum of pharmacy care. CVS Caremark is uniquely positioned to deliver significant benefits to health plan sponsors through effective cost management solutions and innovative programs that engage plan members and promote healthier and more cost-effective behaviors. Our integrated pharmacy services model enhances our ability to offer plan members and consumers expanded choice, greater access and more personalized services to help them on their path to better health.

We effectively manage pharmaceutical costs and improve health care outcomes through our pharmacy benefit management ("PBM"), mail order and specialty pharmacy division, CVS Caremark ® Pharmacy Services; our approximately 7,300 CVS/pharmacy ® retail stores; our retail-based health clinic subsidiary, MinuteClinic ®; and our online retail pharmacy, CVS.com ®.

We currently have three reportable business segments: Pharmacy Services, Retail Pharmacy and Corporate.

Pharmacy Services Segment

The Pharmacy Services segment provides a full range of PBM services, as described more fully below, to our clients consisting primarily of employers, insurance companies, unions, government employee groups, managed care organizations and other sponsors of health benefit plans and individuals throughout the United States. In addition, through our SilverScript Insurance Company ("SilverScript"), Accendo Insurance Company ("Accendo") and Pennsylvania Life Insurance Company ("Pennsylvania Life") subsidiaries, we are a national provider of drug benefits to eligible beneficiaries under the Federal Government's Medicare Part D program. Currently, the Pharmacy Services business operates under the CVS Caremark ® Pharmacy Services, Caremark ®, CVS Caremark ®, CarePlus CVS/pharmacy ®, CarePlus™, RxAmerica ® and Accordant ® names. As of December 31, 2011, the Pharmacy Services segment operated 31 retail specialty pharmacy stores, 12 specialty mail order pharmacies and four mail service pharmacies located in 22 states, the District of Columbia and Puerto Rico.

Pharmacy Services Business Strategy - Our business strategy centers on providing innovative pharmaceutical solutions and quality client service in order to enhance clinical outcomes for our clients' health benefit plan members while assisting our clients and their plan members in better managing overall health care costs. We produce superior results for our clients and their plan members by leveraging our expertise in core PBM services, including: plan design and administration, formulary management, discounted drug purchase arrangements, Medicare Part D services, mail order and specialty pharmacy services, retail pharmacy network management services, prescription management systems, clinical services, disease management services and pharmacogenomics.

In addition, as a fully integrated pharmacy services company, we are able to offer our clients and their plan members a variety of programs and plan designs that benefit from our integrated information systems and the ability of our more than 25,000 pharmacists, nurse practitioners and physician assistants to interact personally with the many plan members who shop our stores every day. Through our multiple member touch points (retail stores, mail order and specialty pharmacies, retail clinics, call centers and proprietary websites), we seek to engage plan members in behaviors that lower cost and improve health care outcomes. Examples of these programs and services include: Maintenance Choice ®, a program where eligible client plan members can elect to fill their maintenance prescriptions at our retail pharmacy stores for the same price as mail order; Pharmacy Advisor ®, a program that uses our Consumer Engagement Engine ™ technology to facilitate face-to-face and telephone counseling by our pharmacists to help participating plan members with certain chronic diseases, such as diabetes and cardiovascular conditions, to identify gaps in care, adhere to their prescribed medications and manage their health conditions; compliance and persistency programs designed to ensure that patients take their medications in the proper manner; enhanced disease management programs that are targeted at managing chronic disease states; and an ExtraCare ® Health Card program which offers discounts to eligible plan members on certain over-the-counter health care products sold in our CVS/pharmacy stores. In addition, we are working with our clients to (i) decrease unnecessary and expensive emergency room visits by encouraging plan members to use MinuteClinic locations for everyday common ailments and (ii) create pilot programs that offer convenient and unique services available at MinuteClinic, such as injection training for specialty pharmacy services.

Item 3. Legal Proceedings

I. Legal Proceedings

1. Caremark (the term "Caremark" being used herein to generally refer to any one or more pharmacy benefit management subsidiaries of the Company, as applicable) is a defendant in a *qui tam* lawsuit initially filed by a relator on behalf of various state and federal government agencies in Texas federal court in 1999. The case was unsealed in May 2005. The case seeks monetary damages and alleges that Caremark's processing of Medicaid and certain other government claims on behalf of its clients (which allegedly resulted in underpayments from our clients to the applicable government agencies) on one of Caremark's adjudication platforms violates applicable federal or state false claims acts and fraud statutes. The United States and the States of Texas, Tennessee, Florida, Arkansas, Louisiana and California intervened in the lawsuit, but Tennessee and Florida withdrew from the lawsuit in August 2006 and May 2007, respectively. Thereafter, in 2008, the Company prevailed on several motions for partial summary judgment and, following an appellate ruling from the Fifth Circuit Court of Appeals in 2011 which affirmed in part and reversed in part these prior rulings, the claims asserted in the case against Caremark have been substantially narrowed. In April 2009, the State of Texas filed a purported civil enforcement action against Caremark for injunctive relief, damages and civil penalties in Travis County, Texas alleging that Caremark violated the Texas Medicaid Fraud Prevention Act and other state laws based on our processing of Texas Medicaid claims on behalf of PBM clients. In September 2011, the Company prevailed on a motion for partial summary judgment against the State of Texas and narrowed the remaining claims in the lawsuit. The claims and issues raised in this lawsuit are related to the claims and issues pending in the federal *qui tam* lawsuit described above.

2. In December 2007, the Company received a document subpoena from the OIG, requesting information relating to the processing of Medicaid and other government agency claims on a different adjudication platform of Caremark. In October 2009 and October 2010, the Company received civil investigative demands from the Office of the Attorney General of the State of Texas requesting, respectively, information produced under this OIG subpoena and other information related to the processing of Medicaid claims. These civil investigative demands state that the Office of the Attorney General of the State of Texas is investigating allegations currently pending under seal relating to two of Caremark's adjudication platforms. The Company has been producing documents on a rolling basis in response to the requests for information contained in the OIG subpoena and in these civil investigative demands. The Company cannot predict with certainty the timing or outcome of any review of such information.

3. Caremark was named in a putative class action lawsuit filed in October 2003 in Alabama state court by John Lauriello, purportedly on behalf of participants in the 1999 settlement of various securities class action and derivative lawsuits against Caremark and others. Other defendants include insurance companies that provided coverage to Caremark with respect to the settled lawsuits. The Lauriello lawsuit seeks approximately $3.2 billion in compensatory damages plus other non-specified damages based on allegations that the amount of insurance coverage available for the settled lawsuits was misrepresented and suppressed. A similar lawsuit was filed in November 2003 by Frank McArthur, also in Alabama state court, naming as defendants Caremark, several insurance companies, attorneys and law firms involved in the 1999 settlement. This lawsuit was stayed as a later-filed class action, but McArthur was subsequently allowed to intervene in the Lauriello action. The attorneys and law firms named as defendants in McArthur's intervention pleadings have been dismissed from the case, and discovery on class certification and adequacy issues is underway.

4. Various lawsuits have been filed alleging that Caremark has violated applicable antitrust laws in establishing and maintaining retail pharmacy networks for client health plans. In August 2003, Bellevue Drug Co., Robert Schreiber, Inc. d/b/a Burns Pharmacy and Rehn-Huerbinger Drug Co. d/b/a Parkway Drugs #4, together with Pharmacy Freedom Fund and the National Community Pharmacists Association filed a putative class action against Caremark in Pennsylvania federal court, seeking treble damages and injunctive relief. This case was initially sent to arbitration based on the contract terms between the pharmacies and Caremark. In October 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. d/b/a Big C Discount Drugs, Inc., filed a putative class action complaint in Alabama federal court against Caremark and two PBM competitors, seeking treble damages and injunctive relief. The North Jackson Pharmacy case against two of the Caremark entities named as defendants was transferred to Illinois federal court, and the case against a separate Caremark entity was sent to arbitration based on contract terms between the pharmacies and Caremark. The Bellevue arbitration was then stayed by the parties pending developments in the North Jackson Pharmacy court case.

In August 2006, the Bellevue case and the North Jackson Pharmacy case were both transferred to Pennsylvania federal court by the Judicial Panel on Multidistrict Litigation for coordinated and consolidated proceedings with other cases before the panel, including cases against other PBMs. Caremark appealed the decision which vacated the order compelling arbitration and staying the proceedings in the Bellevue case and, following the appeal, the Court of Appeals reinstated the order compelling arbitration of the Bellevue case. Motions for class certification in the coordinated cases within the multidistrict litigation, including the North Jackson Pharmacy case, remain pending. The consolidated action is now known as the In Re Pharmacy Benefit Managers Antitrust Litigation.

5. In August 2009, the Company was notified by the FTC that it was conducting a non-public investigation under the FTCA into certain of the Company's business practices. In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of the Company regarding issues similar to those being investigated by the FTC. At this time, 28 states, the District of Columbia, and the County of Los Angeles, are known to be participating in this multi-state investigation. On January 3, 2012, the FTC accepted for public comment, subject to final approval, a consent order. The proposed consent order would prohibit the Company from misrepresenting the price or cost of Medicare Part D prescription drugs, or other prices of costs associated with Medicare Part D prescription drug plans. The proposed order would also require the Company to pay $5 million in consumer redress, to be distributed to impacted RxAmerica Medicare Part D beneficiaries. The proposed order contains no allegations of antitrust law violations or anti-competitive behavior related to the Company's business practices or its products or service offerings. In addition, the Company has received a formal letter from the FTC closing all other aspects of the investigation. With respect to the multi-state investigation, the Company continues to cooperate in this investigation. The Company is not able to predict with certainty the timing or outcome of the multi-state investigation. However, it remains confident that its business practices and service offerings (which are designed to reduce health care costs and expand consumer choice) are being conducted in compliance with the antitrust laws.

6. In March 2009, the Company received a subpoena from the OIG requesting information concerning the Medicare Part D prescription drug plans of RxAmerica, the PBM subsidiary of Longs Drug Stores Corporation which was acquired by the Company in October 2008. The Company continues to respond to the request for information and has been producing responsive documents on a rolling basis. The Company cannot predict with certainty the timing or outcome of any review by the government of such information.

7. Since March 2009, the Company has been named in a series of putative collective and class action lawsuits filed in federal courts around the country, purportedly on behalf of current and former assistant store managers working in the Company's stores at various locations outside California. The lawsuits allege that the Company failed to pay overtime to assistant store managers as required under the Fair Labor Standards Act ("FLSA") and under certain state statutes. The lawsuits also seek other relief, including liquidated damages, punitive damages, attorneys' fees, costs and injunctive relief arising out of the state and federal claims for overtime pay. The Company has aggressively challenged both the merits of the lawsuits and the allegation that the cases should be certified as class or collective actions. In light of the cost and uncertainty involved in this litigation, however, the Company has reached an agreement with plaintiffs' counsel to settle the series of lawsuits. The court preliminarily approved the settlement in December 2011 and the Company anticipates that final court approval will be granted in the second quarter of 2012. The Company has established legal reserves related to these matters to fully cover the settlement payments.

8. In November 2009, a securities class action lawsuit was filed in the United States District Court for the District of Rhode Island purportedly on behalf of purchasers of CVS Caremark Corporation stock between May 5, 2009 and November 4, 2009. The lawsuit names the Company and certain officers as defendants and includes allegations of securities fraud relating to public disclosures made by the Company concerning the PBM business and allegations of insider trading. In addition, a shareholder derivative lawsuit was filed in December 2009 in the same court against the directors and certain officers of the Company. A derivative lawsuit is a lawsuit filed by a shareholder purporting to assert claims on behalf of a corporation against directors and officers of the corporation. This lawsuit includes allegations of, among other things, securities fraud, insider trading and breach of fiduciary duties and further alleges that the Company was damaged by the purchase of stock at allegedly inflated prices under its share repurchase program. In January 2011, both lawsuits were transferred to the United States District Court for the District of New Hampshire. The Company believes these lawsuits are without merit, and the Company plans to defend them vigorously. The Company received a subpoena dated February 28, 2011 from the SEC requesting, among other corporate records, information relating to public disclosures made by the Company in 2009 concerning its PBM and Medicare Part D businesses and information concerning ownership and transactions in the Company's securities by certain officers of the Company. The Company received a related subpoena dated September 20, 2011 from the SEC seeking, among other things, additional information concerning securities transactions by certain employees of the Company and public disclosures made by the Company during 2009. The Company is cooperating with these requests for information and is providing documents and other information to the SEC as requested.

2012 CVS Health 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the fiscal year ended December 31, 2012

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the transition period from to

Commission file number 001-01011

CVS CAREMARK CORPORATION

(Exact name of Registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	**050494040** (I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island (Address of principal executive offices)	**02895** (Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share Title of each class	**New York Stock Exchange** Name of each exchange on which registered

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $59,275,089,023 as of June 30, 2012, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 8, 2013, the registrant had 1,231,194,296 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

- Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2012 is incorporated by reference in our response to Items 7, 8 and 9 of Part II.
- Information contained in our Proxy Statement for the 2013 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

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Item 3. Legal Proceedings

I. Legal Proceedings

1. Caremark (the term "Caremark" being used herein to generally refer to any one or more pharmacy benefit management subsidiaries of the Company, as applicable) is a defendant in a *qui tam* lawsuit initially filed by a relator on behalf of various state and federal government agencies in Texas federal court in 1999. The case was unsealed in May 2005. The case seeks monetary damages and alleges that Caremark's processing of Medicaid and certain other government claims on behalf of its clients (which allegedly resulted in underpayments from our clients to the applicable government agencies) on one of Caremark's adjudication platforms violates applicable federal or state false claims acts and fraud statutes. The United States and the States of Texas, Tennessee, Florida, Arkansas, Louisiana and California intervened in the lawsuit, but Tennessee and Florida withdrew from the lawsuit in August 2006 and May 2007, respectively. Thereafter, in 2008, the Company prevailed on several motions for partial summary judgment and, following an appellate ruling from the Fifth Circuit Court of Appeals in 2011 which affirmed in part and reversed in part these prior rulings, the claims asserted in the case against Caremark have been substantially narrowed. In December 2007, the Company received a document subpoena from the OIG within the HHS, requesting information relating to the processing of Medicaid and other government agency claims on a different adjudication platform of Caremark. The Company has been providing documents and other information in response to this request for information. The Company has been conducting discussions with the DOJ and the OIG regarding a possible settlement of these legal matters.

2. In April 2009, the State of Texas filed a purported civil enforcement action against Caremark for injunctive relief, damages and civil penalties in Travis County, Texas alleging that Caremark violated the Texas Medicaid Fraud Prevention Act and other state laws based on its processing of Texas Medicaid claims on behalf of PBM clients on one of Caremark's adjudication platforms. In September 2011, the Company prevailed on a motion for partial summary judgment against the State of Texas and narrowed the remaining claims in the lawsuit. In October 2009 and October 2010, the Company received civil investigative demands from the Office of the Attorney General of the State of Texas requesting, respectively, information produced under the OIG subpoena described above and other information related to the processing of Medicaid claims. These civil investigative demands state that the Office of the Attorney General of the State of Texas is investigating allegations currently pending under seal relating to two other adjudication platforms of Caremark. In January 2012, the parties filed joint motions with the Texas federal and state courts requesting that the lawsuits with the State of Texas be abated so that the parties can focus on completing settlement documentation relating to Caremark's processing of Texas Medicaid claims.

3. Caremark was named in a putative class action lawsuit filed in October 2003 in Alabama state court by John Lauriello, purportedly on behalf of participants in the 1999 settlement of various securities class action and derivative lawsuits against Caremark and others. Other defendants include insurance companies that provided coverage to Caremark with respect to the settled lawsuits. The Lauriello lawsuit seeks approximately $3.2 billion in compensatory damages plus other non-specified damages based on allegations that the amount of insurance coverage available for the settled lawsuits was misrepresented and suppressed. A similar lawsuit was filed in November 2003 by Frank McArthur, also in Alabama state court, naming as defendants Caremark, several insurance companies, attorneys and law firms involved in the 1999 settlement. This lawsuit was stayed as a later-filed class action, but McArthur was subsequently allowed to intervene in the Lauriello action. Following the close of class discovery, the trial court entered an Order on August 15, 2012 that granted the plaintiffs' motion to certify a class pursuant to Alabama Rule of Civil Procedure 23(b)(3) but denied their request that the class also be certified pursuant to Rule 23(b)(1). In addition, the August 15, 2012 Order appointed class representatives and class counsel. The defendants have filed a notice of appeal with the Alabama Supreme Court and the plaintiffs have filed a notice of cross-appeal. The proceedings in the trial court are stayed by statute pending a decision on the appeal and cross-appeal by the Alabama Supreme Court.

4. Various lawsuits have been filed alleging that Caremark has violated applicable antitrust laws in establishing and maintaining retail pharmacy networks for client health plans. In August 2003, Bellevue Drug Co., Robert Schreiber, Inc. d/b/a Burns Pharmacy and Rehn-Huerbinger Drug Co. d/b/a Parkway Drugs #4, together with Pharmacy Freedom Fund and the National Community Pharmacists Association filed a putative class action against Caremark in Pennsylvania federal court, seeking treble damages and injunctive relief. This case was initially sent to arbitration based on the contract terms between the pharmacies and Caremark. In October 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. d/b/a Big C Discount Drugs, Inc., filed a putative class action complaint in Alabama federal court against Caremark and two PBM competitors, seeking treble damages and injunctive relief. The North Jackson Pharmacy case against two of the Caremark entities named as defendants was transferred to Illinois federal court, and the case against a separate Caremark entity was sent to arbitration based on contract terms between the pharmacies and Caremark. The Bellevue arbitration was then stayed by the parties pending developments in the North Jackson Pharmacy court case.

In August 2006, the Bellevue case and the North Jackson Pharmacy case were both transferred to Pennsylvania federal court by the Judicial Panel on Multidistrict Litigation for coordinated and consolidated proceedings with other cases before the panel, including cases against other PBMs. Caremark appealed the decision which vacated an order compelling arbitration and staying the proceedings in the Bellevue case and, following the appeal, the Court of Appeals reinstated the order compelling arbitration of the Bellevue case. Following remand, plaintiffs in the Bellevue case sought dismissal of their complaint to permit an immediate appeal of the reinstated order compelling arbitration and pursued an appeal to the Circuit Court of Appeals. In November 2012, the Circuit Court reversed the district court ruling and directed the parties to proceed in federal court. Motions for class certification in the coordinated cases within the multidistrict litigation, including the North Jackson Pharmacy case, remain pending. The consolidated action is now known as the In Re Pharmacy Benefit Managers Antitrust Litigation.

5. In November 2009, a securities class action lawsuit was filed in the United States District Court for the District of Rhode Island purportedly on behalf of purchasers of CVS Caremark Corporation stock between May 5, 2009 and November 4, 2009. The lawsuit names the Company and certain officers as defendants and includes allegations of securities fraud relating to public disclosures made by the Company concerning the PBM business and allegations of insider trading. In addition, a shareholder derivative lawsuit was filed in December 2009 in the same court against the directors and certain officers of the Company. A derivative lawsuit is a lawsuit filed by a shareholder purporting to assert claims on behalf of a corporation against directors and officers of the corporation. This lawsuit, which was stayed pending developments in the related securities class action, includes allegations of, among other things, securities fraud, insider trading and breach of fiduciary duties and further alleges that the Company was damaged by the purchase of stock at allegedly inflated prices under its share repurchase program. In January 2011, both lawsuits were transferred to the United States District Court for the District of New Hampshire. In June 2012, the court granted the Company's motion to dismiss the securities class action. The plaintiffs subsequently filed a notice of appeal of the Court's ruling on the motion to dismiss, and the appeal is pending. The derivative lawsuit will remain stayed pending the outcome of the appeal of the securities class action.

6. In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the FTC. Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company continues to cooperate in the multi-state investigation.

7. In March 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to our pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. The subpoena relates to an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The Company has been providing documents and other information in response to this request for information.

8. The Company received a subpoena from the SEC in February 2011 and has subsequently received additional subpoenas and other requests for information. The SEC's requests relate to, among other things, public disclosures made by the Company during 2009, transactions in the Company's securities by certain officers and employees of the Company during 2009 and the purchase accounting for the Longs Drug Stores acquisition. The Company has been providing documents and other information as requested by the SEC.

9. In January 2012, the United States District Court for the Eastern District of Pennsylvania unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that Caremark's processing of Medicare claims on behalf of one of its clients violated the federal false claims act. The United States, acting through the U.S. Attorney's Office in Philadelphia, Pennsylvania, declined to intervene in the lawsuit. Caremark filed a motion to dismiss the amended complaint and the DOJ filed a Statement of Interest with regard to Caremark's motion to dismiss. In December 2012, the court denied Caremark's motion to dismiss the amended complaint.

10. In January 2012, the Company received a subpoena from OIG requesting information about its Health Savings Pass program, a prescription drug discount program for uninsured or under insured individuals, in connection with an investigation of possible false or otherwise improper claims for payment involving HHS programs. In February 2012, the Company also received a civil investigative demand from the Office of the Attorney General of the State of Texas requesting a copy of information produced under this OIG subpoena and other information related to prescription drug claims submitted by our pharmacies to Texas Medicaid for reimbursement. The Company has been providing documents and other information in response to this request for information.

11. A purported shareholder derivative action was filed on behalf of nominal defendant CVS Caremark Corporation against certain of the Company's officers and members of its Board of Directors. The action was originally filed in June 2012 and, after the court granted leave to amend the original filing, an amended complaint was filed in November 2012. The amended complaint alleges a single claim for breach of fiduciary duty relating to the Company's alleged failure to properly implement internal regulatory controls to comply with the Controlled Substances Act and the Combat Methamphetamine Epidemic Act.

12. In November 2012, the Company received a subpoena from the OIG requesting information concerning automatic refill programs used by pharmacies to refill prescriptions for customers. The Company is cooperating and will be providing documents and other information in response to this request for information.

13. Effective January 15, 2013, CMS imposed intermediate sanctions on our SilverScript Medicare Part D PDP, consisting of immediate suspension of further plan enrollment and marketing activities. The sanctions relate to our compliance with certain Medicare Part D requirements and do not affect the enrollment status of our current PDP enrollees. CMS has granted a limited waiver of these sanctions to allow our PDP to continue to enroll eligible retirees of existing employer clients into our SilverScript plans and into employer group waiver plans to fulfill our commitments to implement and provide employer group waiver plan services. This limited waiver currently extends through April 30, 2013, and CMS has advised us that it will consider further extensions of the waiver on a rolling basis. At the beginning of the 2013 Medicare Part D plan year, the Company implemented an enrollment systems conversion process and other actions to consolidate our PDP plans. These consolidation efforts have impacted the enrollment and coverage determination services we provide to PDP enrollees. We are cooperating with CMS to address the service issues resulting from our plan consolidation efforts and to develop and implement a corrective action plan to resolve and remove the sanctions. We cannot predict how long the sanctions will remain in effect or the scope of corrective action or other remedial actions that CMS may require in order for the sanctions to be removed.

The Company is also a party to other legal proceedings and inquiries arising in the normal course of its business, none of which is expected to be material to the Company. We can give no assurance, however, that our business, financial condition and results of operations will not be materially adversely affected, or that we will not be required to materially change our business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in "Business — Government Regulation", as they may relate to our business, the pharmacy services, retail pharmacy or retail clinic industry or to the health care industry generally; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services, retail pharmacy or retail clinic industry or of the health care industry generally; (iv) institution of government enforcement actions against us; (v) adverse developments in any pending *qui tam* lawsuit against us, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against us; or (vi) adverse developments in other pending or future legal proceedings against us or affecting the pharmacy services, retail pharmacy or retail clinic industry or the health care industry generally.

II. Environmental Matters

1. Item 103 of SEC Regulation S-K requires disclosure of certain environmental legal proceedings if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. On January 24, 2013, the Company entered into Consent Orders with the State of Connecticut to resolve claims of alleged noncompliance with hazardous waste regulations by certain of the Company's stores in Connecticut. As part of this settlement, the company has agreed to pay $300,000 in civil penalties and $500,000 to fund supplemental environmental projects, and consented to injunctive provisions regarding future compliance with Connecticut waste laws.

Item 4. Mine Safety Disclosures

Not applicable.

2013 CVS Health 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2013
OR
☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from to
Commission file number 001-01011

CVS CAREMARK CORPORATION

(Exact name of Registrant as specified in its charter)

Delaware	**050494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Exchange Act: **None**
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒
The aggregate market value of the registrant's common stock held by non-affiliates was approximately $69,980,197,924 as of June 30, 2013, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 4, 2014, the registrant had 1,182,427,156 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

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Item 3. Legal Proceedings

I. Legal Proceedings

1. Caremark (the term "Caremark" being used herein to generally refer to any one or more PBM subsidiaries of the Company, as applicable) was a defendant in a *qui tam* lawsuit initially filed by a relator on behalf of various state and federal government agencies in Texas federal court in 1999. The case was unsealed in May 2005. The case sought monetary damages and alleged that Caremark's processing of Medicaid and certain other government claims on behalf of its clients (which allegedly resulted in underpayments from Caremark clients to the applicable government agencies) on one of Caremark's adjudication platforms violated applicable federal or state false claims acts and fraud statutes. The United States and the States of Texas, Tennessee, Florida, Arkansas, Louisiana and California intervened in the lawsuit, but Tennessee and Florida withdrew from the lawsuit in August 2006 and May 2007, respectively. Thereafter, in 2008, the Company prevailed on several motions for partial summary judgment and, following an appellate ruling from the Fifth Circuit Court of Appeals in 2011 that affirmed in part and reversed in part these prior rulings, the claims asserted in the case against Caremark were substantially narrowed. In December 2013, this case was dismissed following a settlement between the Company and the plaintiffs.

   In a related matter, in December 2007, the Company received a document subpoena from the Office of Inspector General ("OIG") within the U.S. Department of Health and Human Services ("HHS"), requesting information relating to the processing of Medicaid and other government agency claims on a different adjudication platform of Caremark. The Company has provided documents and other information in response to this request for information. The Company has been conducting discussions with the United States Department of Justice ("DOJ") and the OIG regarding a possible settlement of this legal matter.

2. Caremark was named in a putative class action lawsuit filed in October 2003 in Alabama state court by John Lauriello, purportedly on behalf of participants in the 1999 settlement of various securities class action and derivative lawsuits against Caremark and others. Other defendants include insurance companies that provided coverage to Caremark with respect to the settled lawsuits. The Lauriello lawsuit seeks approximately $3.2 billion in compensatory damages plus other non-specified damages based on allegations that the amount of insurance coverage available for the settled lawsuits was misrepresented and suppressed. A similar lawsuit was filed in November 2003 by Frank McArthur, also in Alabama state court, naming as defendants, among others, Caremark and several insurance companies involved in the 1999 settlement. This lawsuit was stayed as a later-filed class action, but McArthur was subsequently allowed to intervene in the Lauriello action. Following the close of class discovery, the trial court entered an Order on August 15, 2012 that granted the plaintiffs' motion to certify a class pursuant to Alabama Rule of Civil Procedures 23(b)(3) but denied their request that the class also be certified pursuant to Rule 23(b)(1). In addition, the August 15, 2012 Order appointed class representatives and class counsel. The defendants' appeal and plaintiffs' cross-appeal are pending before the Alabama Supreme Court. The proceedings in the trial court are stayed by statute pending a decision on the appeal and cross-appeal by the Alabama Supreme Court.

3. Various lawsuits have been filed alleging that Caremark has violated applicable antitrust laws in establishing and maintaining retail pharmacy networks for client health plans. In August 2003, Bellevue Drug Co., Robert Schreiber, Inc. d/b/a Burns Pharmacy and Rehn-Huerbinger Drug Co. d/b/a Parkway Drugs #4, together with Pharmacy Freedom Fund and the National Community Pharmacists Association filed a putative class action against Caremark in Pennsylvania federal court, seeking treble damages and injunctive relief. This case was initially sent to arbitration based on the contract terms between the pharmacies and Caremark. In October 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. d/b/a Big C Discount Drugs, Inc., filed a putative class action complaint in Alabama federal court against Caremark and two PBM competitors, seeking treble damages and injunctive relief. The North Jackson Pharmacy case against two of the Caremark entities named as defendants was transferred to Illinois federal court, and the case against a separate Caremark entity was sent to arbitration based on contract terms between the pharmacies and Caremark. The Bellevue arbitration was then stayed by the parties pending developments in the North Jackson Pharmacy court case.

   In August 2006, the Bellevue case and the North Jackson Pharmacy case were both transferred to Pennsylvania federal court by the Judicial Panel on Multidistrict Litigation for coordinated and consolidated proceedings with other cases before the panel, including cases against other PBMs. Caremark appealed the decision which vacated an order compelling arbitration and staying the proceedings in the Bellevue case and, following the appeal, the Court of Appeals reinstated the order compelling arbitration of the Bellevue case. Following remand, plaintiffs in the Bellevue case sought dismissal of their complaint to permit an immediate appeal of the reinstated order compelling arbitration and pursued an appeal to the Third Circuit Court of Appeals. In November 2012, the Third Circuit Court reversed the district court ruling and directed the parties to proceed in federal court. Motions for class certification in the coordinated cases within the multidistrict

litigation, including the North Jackson Pharmacy case, remain pending, and the court has permitted certain additional class discovery and briefing. The consolidated action is now known as the In Re Pharmacy Benefit Managers Antitrust Litigation.

4. In November 2009, a securities class action lawsuit was filed in the United States District Court for the District of Rhode Island purportedly on behalf of purchasers of CVS Caremark Corporation stock between May 5, 2009 and November 4, 2009. Plaintiffs subsequently amended the lawsuit to allege a class period beginning October 30, 2008. The lawsuit names the Company and certain officers as defendants and includes allegations of securities fraud relating to public disclosures made by the Company concerning the PBM business and allegations of insider trading. In addition, a shareholder derivative lawsuit was filed in December 2009 in the same court against the directors and certain officers of the Company. This lawsuit, which was stayed pending developments in the related securities class action, includes allegations of, among other things, securities fraud, insider trading and breach of fiduciary duties and further alleges that the Company was damaged by the purchase of stock at allegedly inflated prices under its share repurchase program. In January 2011, both lawsuits were transferred to the United States District Court for the District of New Hampshire. In June 2012, the court granted the Company's motion to dismiss the securities class action. The plaintiffs subsequently appealed the court's ruling on the motion to dismiss. In May 2013, the First Circuit Court of Appeals vacated the prior ruling and remanded the case to the district court for further proceedings. In December 2013, the district court denied the Company's renewed motion to dismiss the lawsuit. The derivative lawsuit will remain stayed until the Company answers the securities class action complaint.

5. In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the U.S. Federal Trade Commission ("FTC"). Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company has cooperated with the multi-state investigation.

6. In March 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to the Company's pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. The subpoena relates to an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The Company has provided documents and other information in response to this request for information.

7. The Company received a subpoena from the U.S. Securities and Exchange Commission ("SEC") in February 2011 and subsequently received additional subpoenas and other requests for information. The SEC's requests related to, among other things, public disclosures made by the Company during 2009, transactions in the Company's securities by certain officers and employees of the Company during 2009 and the purchase accounting for the Longs Drug Stores acquisition. The Company has provided the documents and other information requested by the SEC and has been cooperating with the SEC in this investigation. The Company has reached an agreement in principle with the staff of the Boston Regional Office of the SEC to settle certain allegations that, during the third and fourth quarters of 2009, the Company violated certain provisions of the Securities Act of 1933 and the Securities Exchange Act of 1934, including certain anti-fraud provisions of those statutes. The agreement in principle will be entered into by the Company on a "no admit or deny" basis, and the Company will not be restating its financial statements for any reporting period. The Company has agreed to pay a $20 million civil penalty when the settlement is finalized, and this amount has been fully reserved in the Company's financial statements. The Company will continue to cooperate with the SEC to document the settlement terms, and the settlement remains subject to approval by the Commission and federal court as required.

8. In January 2012, the United States District Court for the Eastern District of Pennsylvania unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that Caremark's processing of Medicare claims on behalf of one of its clients violated the federal false claims act. The United States, acting through the U.S. Attorney's Office in Philadelphia, Pennsylvania, declined to intervene in the lawsuit. Caremark filed a motion to dismiss the amended complaint and the DOJ filed a Statement of Interest with regard to Caremark's motion to dismiss. In December 2012, the court denied Caremark's motion to dismiss the amended complaint.

9. In January 2012, the Company received a subpoena from the OIG requesting information about its Health Savings Pass program, a prescription drug discount program for uninsured or underinsured individuals, in connection with an

investigation of possible false or otherwise improper claims for payment involving HHS programs. In February 2012, the Company also received a civil investigative demand from the Office of the Attorney General of the State of Texas requesting a copy of information produced under this OIG subpoena and other information related to prescription drug claims submitted by the Company's pharmacies to Texas Medicaid for reimbursement. The Company is providing documents and other information in response to these requests for information.

10. A purported shareholder derivative action was filed on behalf of nominal defendant CVS Caremark Corporation against certain of the Company's officers and members of its Board of Directors. The action, which alleged a single claim for breach of fiduciary duty relating to the Company's alleged failure to properly implement internal regulatory controls to comply with the Controlled Substances Act and the Combat Methamphetamine Epidemic Act, was originally filed in June 2012. In addition, an amended complaint was filed in November 2012 and a Supplemental Complaint was filed in April 2013. In October 2013, the court granted the Company's motion to dismiss and entered judgment dismissing the action, without prejudice. Following dismissal of the action, the same purported shareholder sent a letter to the Company's Board of Directors demanding that the Board investigate her allegations and pursue legal action against certain directors and officers of the Company. A committee of the Board of Directors is conducting a review and intends to respond to the letter as appropriate.

11. In November 2012, the Company received a subpoena from the OIG requesting information concerning automatic refill programs used by pharmacies to refill prescriptions for customers. The Company has been cooperating and providing documents and other information in response to this request for information.

The Company is also a party to other legal proceedings, inquiries and audits arising in the normal course of its business, none of which is expected to be material to the Company. We can give no assurance, however, that our business, financial condition and results of operations will not be materially adversely affected, or that we will not be required to materially change our business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations, including the laws and regulations described in "Business — Government Regulation", as they may relate to our business, the pharmacy services, retail pharmacy or retail clinic industry or to the health care industry generally; (iii) pending or future federal or state governmental investigations of our business or the pharmacy services, retail pharmacy or retail clinic industry or of the health care industry generally; (iv) institution of government enforcement actions against us; (v) adverse developments in any pending *qui tam* lawsuit against us, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against us; or (vi) adverse developments in other pending or future legal proceedings against us or affecting the pharmacy services, retail pharmacy or retail clinic industry or the health care industry generally.

II. Environmental Matters

Item 103 of SEC Regulation S-K requires disclosure of certain environmental legal proceedings if management reasonably believes that the proceedings involve potential monetary sanctions of $100,000 or more. On January 8, 2014, a Settlement Agreement was signed with the State of New Jersey to resolve claims of alleged noncompliance with hazardous and medical waste regulations in connection with certain of the Company's facilities in New Jersey. As part of this settlement, the Company has agreed to pay $132,000 in civil penalties to resolve these claims.

Item 4. Mine Safety Disclosures

Not applicable.

2014 CVS Health 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2014
OR
☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from to
Commission file number 001-01011

CVS HEALTH CORPORATION

(Exact name of Registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

Securities registered pursuant to Section 12(g) of the Exchange Act: **None**
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒
The aggregate market value of the registrant's common stock held by non-affiliates was approximately $87,242,957,318 as of June 30, 2014, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 3, 2015, the registrant had 1,125,252,739 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

- Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2014 are incorporated by reference in our response to Items 7, 8 and 9 of Part II.
- Information contained in our Proxy Statement for the 2015 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

The Company and most of its subsidiaries are subject to U.S. federal income tax as well as income tax of numerous state and local jurisdictions. The Internal Revenue Service ("IRS") is currently examining the Company's 2012, 2013 and 2014 consolidated U.S. federal income tax returns under its Compliance Assurance Process ("CAP") program. The CAP program is a voluntary program under which participating taxpayers work collaboratively with the IRS to identify and resolve potential tax issues through open, cooperative and transparent interaction prior to the filing of their federal income tax return.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2014, no examination has resulted in any proposed adjustments that would result in a material change to the Company's results of operations, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2009. The Company and its subsidiaries anticipate that a number of state and local income tax examinations will be concluded and statutes of limitation for open years will expire over the next twelve months, which may result in the utilization or reduction of the Company's reserve for uncertain tax positions of up to approximately $11 million . In addition, it is reasonably possible that the Company's unrecognized tax benefits could significantly change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company recognizes interest accrued related to unrecognized tax benefits and penalties in income tax expense. The Company recognized interest of approximately $6 million during the year ended December 31, 2014, and $4 million during each of the years ended December 31, 2013 and 2012. The Company had approximately $11 million and $10 million accrued for interest and penalties as of December 31, 2014 and 2013.

There are no material uncertain tax positions as of December 31, 2014 the ultimate deductibility of which is highly certain but for which there is uncertainty about the timing. If there were, any such items would impact deferred tax accounting only, not the annual effective income tax rate, and would accelerate the payment of cash to the taxing authority to a period earlier than expected.

The total amount of unrecognized tax benefits that, if recognized, would affect the effective income tax rate is approximately $170 million , after considering the federal benefit of state income taxes.

11 Commitments and Contingencies

Lease Guarantees

Between 1991 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, Marshalls, Kay-Bee Toys, Wilsons, This End Up and Footstar. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser has agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations.

As of December 31, 2014, the Company guaranteed approximately 72 such store leases (excluding the lease guarantees related to Linens 'n Things, which are discussed in Note 1), with the maximum remaining lease term extending through 2026. Management believes the ultimate disposition of any of the remaining guarantees will not have a material adverse effect on the Company's consolidated financial condition, results of operations or future cash flows.

Legal Matters

The Company is a party to legal proceedings, investigations and claims in the ordinary course of its business, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial position.

The Company's contingencies are subject to significant uncertainties, including, among other factors: (i) the procedural status of pending matters; (ii) whether class action status is sought and certified; (iii) whether asserted claims or allegations will survive dispositive motion practice; (iv) the extent of potential damages, fines or penalties, which are often unspecified or indeterminate; (v) the impact of discovery on the legal process; (vi) whether novel or unsettled legal theories are at issue; (vii) the settlement posture of the parties, and/or (viii) in the case of certain government agency investigations, whether a sealed *qui tam* lawsuit ("whistleblower" action) has been filed and whether the government agency makes a decision to intervene in the lawsuit following investigation.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters.

- In December 2007, the Company received a document subpoena from the Office of Inspector General ("OIG") within the U.S. Department of Health and Human Services, requesting information relating to the processing of Medicaid and certain other government agency claims on behalf of its clients (which allegedly resulted in underpayments from our pharmacy benefit management clients to the applicable government agencies) on one of the Company's adjudication platforms. In September 2014, the Company settled the OIG's claims, as well as related claims by the Department of Justice and private plaintiffs, without any admission of liability. The Company is in discussions with the OIG concerning other claim processing issues.

- Caremark (the term "Caremark" being used herein to generally refer to any one or more PBM subsidiaries of the Company, as applicable) was named in a putative class action lawsuit filed in October 2003 in Alabama state court by John Lauriello, purportedly on behalf of participants in the 1999 settlement of various securities class action and derivative lawsuits against Caremark and others. Other defendants include insurance companies that provided coverage to Caremark with respect to the settled lawsuits. The Lauriello lawsuit seeks approximately $3.2 billion in compensatory damages plus other non-specified damages based on allegations that the amount of insurance coverage available for the settled lawsuits was misrepresented and suppressed. A similar lawsuit was filed in November 2003 by Frank McArthur, also in Alabama state court, naming as defendants, among others, Caremark and several insurance companies involved in the 1999 settlement. This lawsuit was stayed as a later-filed class action, but McArthur was subsequently allowed to intervene in the Lauriello action. Following the close of class discovery, the trial court entered an Order on August 15, 2012 that granted the plaintiffs' motion to certify a class pursuant to Alabama Rule of Civil Procedures 23(b)(3) but denied their request that the class also be certified pursuant to Rule 23(b)(1). In addition, the August 15, 2012 Order appointed class representatives and class counsel. On September 12, 2014, the Alabama Supreme Court affirmed the trial court's August 15, 2012 Order. The Defendants timely filed an Application for Rehearing asking the Alabama Supreme Court to clarify or modify its September 12, 2014 decision. The proceedings in the trial court remain stayed pending resolution of the rehearing application.

- Various lawsuits have been filed alleging that Caremark has violated applicable antitrust laws in establishing and maintaining retail pharmacy networks for client health plans. In August 2003, Bellevue Drug Co., Robert Schreiber, Inc. d/b/a Burns Pharmacy and Rehn-Huerbinger Drug Co. d/b/a Parkway Drugs #4, together with Pharmacy Freedom Fund and the National Community Pharmacists Association filed a putative class action against Caremark in Pennsylvania federal court, seeking treble damages and injunctive relief. This case was initially sent to arbitration based on the contract terms between the pharmacies and Caremark. In October 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. d/b/a Big C Discount Drugs, Inc., filed a putative class action complaint in Alabama federal court against Caremark and two PBM competitors, seeking treble damages and injunctive relief. The North Jackson Pharmacy case against two of the Caremark entities named as defendants was transferred to Illinois federal court, and the case against a separate Caremark entity was sent to arbitration based on contract terms between the pharmacies and Caremark. The Bellevue arbitration was then stayed by the parties pending developments in the North Jackson Pharmacy court case.

  In August 2006, the Bellevue case and the North Jackson Pharmacy case were both transferred to Pennsylvania federal court by the Judicial Panel on Multidistrict Litigation for coordinated and consolidated proceedings with other cases before the panel, including cases against other PBMs. Motions for class certification in the coordinated cases within the multidistrict litigation, including the North Jackson Pharmacy case, remain pending, and the court has permitted certain additional class discovery and briefing. The consolidated action is now known as the In Re Pharmacy Benefit Managers Antitrust Litigation.

- In November 2009, a securities class action lawsuit was filed in the United States District Court for the District of Rhode Island by Richard Medoff, purportedly on behalf of purchasers of CVS Health Corporation stock between

May 5, 2009 and November 4, 2009. The lawsuit names the Company and certain officers as defendants and includes allegations of securities fraud relating to public disclosures made by the Company concerning the PBM business and allegations of insider trading. In addition, a shareholder derivative lawsuit was filed by Mark Wuotila in December 2009 in the same court against the directors and certain officers of the Company. This lawsuit, which has remained stayed pending developments in the related securities class action, includes allegations of, among other things, securities fraud, insider trading and breach of fiduciary duties and further alleges that the Company was damaged by the purchase of stock at allegedly inflated prices under its share repurchase program. In January 2011, both lawsuits were transferred to the United States District Court for the District of New Hampshire.

- In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the U.S. Federal Trade Commission ("FTC"). Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company has cooperated with the multi-state investigation.

- In March 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to the Company's pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. The subpoena relates to an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The Company has provided documents and other information in response to this request for information.

- In January 2012, the United States District Court for the Eastern District of Pennsylvania unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, Anthony Spay, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that Caremark's processing of Medicare claims on behalf of one of its clients violated the federal False Claims Act. The United States declined to intervene in the lawsuit. The case is proceeding.

- In November 2014, the U.S. District Court in the District of Massachusetts unsealed a *qui tam* lawsuit brought against the Company by a pharmacy auditor and a CVS pharmacist. The lawsuit, which was initially filed under seal in 2011, alleges that the Company violated the federal False Claims Act, as well as the false claims acts of several states, by overcharging state and federal governments in connection with prescription drugs available through the Company's Health Savings Pass program, a membership-based program that allows enrolled customers special pricing for typical 90-day supplies of various generic prescription drugs. The federal government, which issued a January 2012 OIG subpoena concerning the Health Savings Pass program, has declined to intervene in the case. The Company is now responding to the declined *qui tam* complaint. Separately, the Attorney General of the State of Texas has issued civil investigative demands and other requests in February 2012 and May 2014, and has continued its investigation concerning the Health Savings Pass program and claims for reimbursement from the Texas Medicaid program.

- On October 12, 2012, the Drug Enforcement Agency ("DEA") Administrator published its Final Decision and Order revoking the DEA license registrations for dispensing controlled substances at two of our retail pharmacy stores in Sanford , Florida. The license revocations for the two stores formally became effective on November 13, 2012. The Company has entered into discussions with the U.S. Attorney's Office for the Middle District of Florida concerning civil penalties for violations of the Controlled Substances Act arising from the circumstances underlying the action taken against the two Sanford, Florida stores. The Company is also undergoing several audits by the DEA and is in discussions with the DEA and the U.S. Attorney's Office in several locations. Whether agreements can be reached and on what terms is uncertain.

- In November 2012, the Company received a subpoena from the OIG requesting information concerning automatic refill programs used by pharmacies to refill prescriptions for customers. The Company has been cooperating and providing documents and other information in response to this request for information.

- In January 2014, the U.S. District Court in the Southern District of New York unsealed a *qui tam* action in which the Company is a defendant. The suit originally was filed under seal in 2011 by relator David Kester, a former employee of Novartis Pharmaceuticals Corp. ("Novartis"). The suit alleges that Novartis, the Company, and other specialty pharmacies violated the federal False Claims Act, as well as the false claims acts of several states, by using

pharmacists, nurses and other staff to recommend and increase the sales and market share for certain Novartis specialty drugs in exchange for patient referrals, rebates and discounts provided by Novartis. The federal government has intervened in the case as to some allegations against Novartis but has declined to intervene as to any of the allegations against the Company. The relator has continued to litigate the declined action against the Company and other specialty pharmacies.

- In March 2014, the Company received a subpoena from the United States Attorney's Office for the District of Rhode Island, requesting documents and information concerning bona fide service fees and rebates received from certain pharmaceutical manufacturers in connection with certain drugs utilized under Part D of the Medicare Program. The Company has been cooperating with the government and collecting documents in response to the subpoena.

The Company is also a party to other legal proceedings, government investigations, inquiries and audits arising in the normal course of its business, none of which is expected to be material to the Company. The Company can give no assurance, however, that its business, financial condition and results of operations will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to the Company's business, the pharmacy services, retail pharmacy or retail clinic industries or to the health care industry generally; (iii) pending or future federal or state governmental investigations of the Company's business or the pharmacy services, retail pharmacy or retail clinic industry or of the health care industry generally; (iv) pending or future government enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting the pharmacy services, retail pharmacy or retail clinic industry or the health care industry generally.

12 Segment Reporting

The Company currently has three reportable segments: Pharmacy Services, Retail Pharmacy and Corporate.

The Company evaluates its Pharmacy Services and Retail Pharmacy segment performance based on net revenue, gross profit and operating profit before the effect of certain intersegment activities and charges. The Company evaluates the performance of its Corporate Segment based on operating expenses before the effect of discontinued operations and certain intersegment activities and charges. See Note 1 for a description of the Pharmacy Services, Retail Pharmacy and Corporate segments and related significant accounting policies.

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2015 CVS Health 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2015
OR
☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from to
Commission file number 001-01011

CVS HEALTH CORPORATION
(Exact name of Registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $116,868,242,939 as of June 30, 2015, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 3, 2016, the registrant had 1,098,490,835 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

- Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2015 are incorporated by reference in our response to Items 7, 8 and 9 of Part II.
- Information contained in our Proxy Statement for the 2016 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

The Company and its subsidiaries are also currently under income tax examinations by a number of state and local tax authorities. As of December 31, 2015, no examination has resulted in any proposed adjustments that would result in a material change to the Company's results of operations, financial condition or liquidity.

Substantially all material state and local income tax matters have been concluded for fiscal years through 2010. Although certain state exams will be concluded and certain state statutes will lapse in 2016, the change in the balance of our uncertain tax positions will be immaterial. In addition, it is reasonably possible that the Company's unrecognized tax benefits could significantly change within the next twelve months due to the anticipated conclusion of various examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company recognizes interest accrued related to unrecognized tax benefits and penalties in income tax expense. The Company recognized interest of approximately $5 million during the year ended December 31, 2015, $6 million during the year ended December 31, 2014, and $4 million during the year ended December 31, 2013. The Company had approximately $16 million and $11 million accrued for interest and penalties as of December 31, 2015 and 2014, respectively.

There are no material uncertain tax positions as of December 31, 2015 the ultimate deductibility of which is highly certain but for which there is uncertainty about the timing. If there were, any such items would impact deferred tax accounting only, not the annual effective income tax rate, and would accelerate the payment of cash to the taxing authority to a period earlier than expected.

As of December 31, 2015, the total amount of unrecognized tax benefits that, if recognized, would affect the effective income tax rate is approximately $292 million , after considering the federal benefit of state income taxes.

12 Commitments and Contingencies

Lease Guarantees

Between 1991 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, Marshalls, Kay-Bee Toys, Wilsons, This End Up and Footstar. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser has agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations.

As of December 31, 2015, the Company guaranteed approximately 72 such store leases (excluding the lease guarantees related to Linens 'n Things, which are discussed in Note 1), with the maximum remaining lease term extending through 2026. Management believes the ultimate disposition of any of the remaining guarantees will not have a material adverse effect on the Company's consolidated financial condition, results of operations or future cash flows.

Legal Matters

The Company is a party to legal proceedings, investigations and claims in the ordinary course of its business, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial position.

The Company's contingencies are subject to significant uncertainties, including, among other factors: (i) the procedural status of pending matters; (ii) whether class action status is sought and certified; (iii) whether asserted claims or allegations will survive dispositive motion practice; (iv) the extent of potential damages, fines or penalties, which are often unspecified or indeterminate; (v) the impact of discovery on the legal process; (vi) whether novel or unsettled legal theories are at issue; (vii) the settlement posture of the parties, and/or (viii) in the case of certain government agency investigations, whether a sealed *qui tam* lawsuit ("whistleblower" action) has been filed and whether the government agency makes a decision to intervene in the lawsuit following investigation.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters.

- Caremark (the term "Caremark" being used herein to generally refer to any one or more PBM subsidiaries of the Company, as applicable) was named in a putative class action lawsuit filed in October 2003 in Alabama state court by John Lauriello, purportedly on behalf of participants in the 1999 settlement of various securities class action and derivative lawsuits against Caremark and others. Other defendants include insurance companies that provided coverage to Caremark with respect to the settled lawsuits. The Lauriello lawsuit seeks approximately $3.2 billion in compensatory damages plus other non-specified damages based on allegations that the amount of insurance coverage available for the settled lawsuits was misrepresented and suppressed. A similar lawsuit was filed in November 2003 by Frank McArthur, also in Alabama state court, naming as defendants, among others, Caremark and several insurance companies involved in the 1999 settlement. This lawsuit was stayed as a later-filed class action, but McArthur was subsequently allowed to intervene in the Lauriello action. Following the close of class discovery, the trial court entered an Order on August 15, 2012 that granted the plaintiffs' motion to certify a class pursuant to Alabama Rule of Civil Procedures 23(b)(3) but denied their request that the class also be certified pursuant to Rule 23(b)(1). In addition, the August 15, 2012 Order appointed class representatives and class counsel. On September 12, 2014, the Alabama Supreme Court affirmed the trial court's August 15, 2012 Order. In November 2015, the trial court ruled on the parties' motions for summary judgment. The Court granted in part and denied in part plaintiffs' motion for summary judgment and the Court denied Caremark's motion for summary judgment. The parties engaged in mediation in January 2016. The case is proceeding and trial is currently scheduled to begin on February 19, 2016.

- Beginning in August 2003, various lawsuits were filed by pharmacies alleging that Caremark and other PBMs were violating certain antitrust laws. In August 2003, Bellevue Drug Co., Robert Schreiber, Inc. d/b/a Burns Pharmacy and Rehn-Huerbinger Drug Co. d/b/a Parkway Drugs #4, together with Pharmacy Freedom Fund and the National Community Pharmacists Association filed a putative class action against Caremark in the United States District Court for the Eastern District of Pennsylvania, seeking treble damages and injunctive relief. This case was initially sent to arbitration based on the contract terms between the pharmacies and Caremark, but later returned to federal court, where it currently remains. In addition, in October 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. d/b/a Big C Discount Drugs, Inc., filed three separate putative class action complaints in the United States District Court for the Northern District of Alabama, all seeking treble damages and injunctive relief. One complaint named three Caremark entities as defendants, and the other two complaints named PBM competitors. The North Jackson Pharmacy case against two of the Caremark entities was transferred to the United States District Court for the Northern District of Illinois; the case against the third Caremark entity was sent to arbitration based on contract terms between the pharmacies and that entity. The arbitration was stayed at the parties' request and later closed by the American Arbitration Association.

  In August 2006, the Judicial Panel on Multidistrict Litigation issued an order transferring all related PBM antitrust cases, including the North Jackson Pharmacy cases, to the United States District Court for the Eastern District of Pennsylvania for coordinated and consolidated proceedings with the cases originally filed in that court, including the Bellevue matter. The consolidated action is now known as *In re Pharmacy Benefit Managers Antitrust Litigation* . A motion for class certification filed by the North Jackson Pharmacy plaintiffs against the Caremark defendants in August 2015 is currently pending. In the Bellevue matter, the parties are in the early stages of discovery.

- In February 2006, two substantially similar putative class action lawsuits were filed in the U.S. District Court for the Eastern District of Kentucky, and were consolidated and entitled Indiana State Dist. Council of Laborers & HOD Carriers Pension & Welfare Fund v. Omnicare, Inc., *et al.* , No. 2:06cv26. The consolidated complaint was filed against Omnicare, three of its officers and two of its directors and purported to be brought on behalf of all open-market purchasers of Omnicare common stock from August 3, 2005 through July 27, 2006, as well as all purchasers who bought shares of Omnicare common stock in Omnicare's public offering in December 2005. The complaint alleged violations of the Securities Exchange Act of 1934 and Section 11 of the Securities Act of 1933 and sought, among other things, compensatory damages and injunctive relief. After dismissals and appeals to the United States Court of Appeals for the Sixth Circuit, the United States Supreme Court remanded the case to the district court. In October 2015, the court granted plaintiffs' motion to file a third amended complaint. In December 2015, Omnicare filed a motion to dismiss plaintiffs' third amended complaint.

- In December 2007, the Company received a document subpoena from the Office of Inspector General ("OIG") within the U.S. Department of Health and Human Services, requesting information relating to the processing of Medicaid and certain other government agency claims on behalf of its clients (which allegedly resulted in underpayments from our

pharmacy benefit management clients to the applicable government agencies) on one of the Company's adjudication platforms. In September 2014, the Company settled the OIG's claims, as well as related claims by the Department of Justice and private plaintiffs, without any admission of liability. The Company is in discussions with the OIG concerning other claim processing issues.

- In November 2009, a securities class action lawsuit was filed in the United States District Court for the District of Rhode Island by Richard Medoff, purportedly on behalf of purchasers of CVS Health Corporation stock between May 5, 2009 and November 4, 2009. An amended complaint extended that time period back to October 30, 2008. The lawsuit names the Company and certain officers as defendants and includes allegations of securities fraud relating to public disclosures made by the Company concerning the PBM business and allegations of insider trading. In addition, a shareholder derivative lawsuit was filed by Mark Wuotila in December 2009 in the same court against the directors and certain officers of the Company. This lawsuit, which has remained stayed pending developments in the related securities class action, includes allegations of, among other things, securities fraud, insider trading and breach of fiduciary duties and further alleges that the Company was damaged by the purchase of stock at allegedly inflated prices under its share repurchase program. In January 2011, both lawsuits were transferred to the United States District Court for the District of New Hampshire. In August 2015, the Parties reached an agreement in principle to settle the Medoff action for $48 million . In September 2015, the Parties filed a joint stipulation seeking preliminary approval for this settlement. Preliminary approval was granted in November 2015 and the final approval hearing occurred in January 2016. The Company denies any wrongdoing, and agreed to a settlement to avoid the burden, uncertainty and distraction of litigation. The settlement will be funded by insurance proceeds. The Wuotila derivative matter remains pending.

- As part of a previously disclosed civil settlement agreement entered into by Omnicare with the U.S. Attorney's Office, for the District of Massachusetts in November 2009, Omnicare also entered into an amended and restated corporate integrity agreement ("CIA") with the OIG with a term of five years from November 2, 2009 with certain provisions continuing for a period after the term. In October 2015, Omnicare received a closure letter from the OIG. The Company is continuing discussions with the OIG around the CIA and its compliance program.

- In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the U.S. Federal Trade Commission ("FTC"). Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company has cooperated with the multi-state investigation.

- In March 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to the Company's pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. The subpoena relates to an investigation of possible false or otherwise improper claims for payment under the Medicare and Medicaid programs. The Company has provided documents and other information in response to this request for information.

- On October 29, 2010, a *qui tam* complaint entitled United States *et al., ex rel.* Banigan and Templin v. Organon USA, Inc., Omnicare, Inc. and PharMerica Corporation, Civil No. 07-12153-RWZ, that had been filed under seal with the U.S. District Court in Boston, Massachusetts, was ordered unsealed by the court. The complaint was brought by James Banigan and Richard Templin, former employees of Organon, as private party *qui tam* relators on behalf of the federal government and several state and local governments. The action alleges civil violations of the False Claims Act based on allegations that Organon and its affiliates paid Omnicare and several other long-term care pharmacies rebates, post-purchase discounts and other forms of remuneration in return for purchasing pharmaceuticals from Organon and taking steps to increase the purchase of Organon's drugs in violation of the Anti-Kickback Statute. The U.S. Department of Justice declined to intervene in this action. The court denied Omnicare's motion to dismiss in June 2012. Discovery is closed in this matter. The Company believes that the allegations are without merit.

- In January 2012, the United States District Court for the Eastern District of Pennsylvania unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, Anthony Spay, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that Caremark's processing of Medicare claims on behalf of one of its clients violated the federal False Claims Act. The United States declined to intervene in the lawsuit. In September

2015, the Court granted Caremark's motion for summary judgment in its entirety, and entered judgment in favor of Caremark and against Spay. In October 2015, Spay filed a notice of appeal in the United States Court of Appeals for the Third Circuit.

- In November 2012, the Company received a subpoena from the OIG requesting information concerning automatic refill programs used by pharmacies to refill prescriptions for customers. The Company has been cooperating and providing documents and other information in response to this request for information.

- In 2013, Omnicare received subpoenas seeking information regarding Omnicare's nationwide billing practices with regard to National Drug Code overrides and Omnicare's May 2008 acquisition of Pure Service Pharmacy. In 2014, Omnicare received subpoenas seeking information regarding Omnicare's Auto Label Verification system and Omnicare's per diem arrangements. Omnicare has produced documents and provided information in response to these subpoenas and continues to cooperate in the investigations.

- On March 22, 2013, a *qui tam* complaint entitled United States *et al. ex rel.* Susan Ruscher v. Omnicare, Inc. *et al.* , Civil No. 08-cv-3396, which had been filed under seal in the U.S. District Court for the Southern District of Texas, was unsealed by the court. The complaint was brought by Susan Ruscher as a private party *qui tam* relator on behalf of the federal government and several state governments alleging violations of the federal False Claims Act and analogous state laws based upon allegations that Omnicare's practices relating to customer collections violated the Anti-Kickback Statute. In September 2015, the court granted summary judgment dismissing all claims against Omnicare and denied relator's motion for summary judgment related to Omnicare's counterclaims and thereafter, in October 2015, the court entered a final judgment for Omnicare and stayed trial on the counterclaims pending an appeal from the relator. In October 2015, plaintiffs filed a notice of appeal in the United States Court of Appeals for the Fifth Circuit.

- In March 2014, the Company received a subpoena from the United States Attorney's Office for the District of Rhode Island, requesting documents and information concerning bona fide service fees and rebates received from pharmaceutical manufacturers in connection with certain drugs utilized under Part D of the Medicare Program, as well as the reporting of those fees and rebates to Part D plan sponsors. The Company has been cooperating with the government and providing documents and information in response to the subpoena.

- The U.S. Department of Justice, through the U.S. Attorney's Office for the Western District of Virginia, investigated whether Omnicare's activities in connection with the agreements it had with the manufacturer of the pharmaceutical Depakote violated the False Claims Act or the Anti-Kickback Statute. Omnicare cooperated with this investigation and believes that it has complied with applicable laws and regulations with respect to this matter. In connection with this matter, on December 22, 2014, the U.S. Department of Justice filed a civil complaint-in-intervention in two *qui tam* complaints, entitled United States, *et al., ex rel.* Spetter v. Abbott Laboratories, Inc., Omnicare, Inc., and PharMerica Corp., No. 1:07-cv-00006 and United States, *et al., ex rel.* McCoyd v. Abbott Laboratories, Omnicare, Inc., PharMerica Corp., and Miles White, No. 1:07-cv-00081, alleging civil violations of the False Claims Act in connection with the manufacturer agreements described above. In July 2015, the parties filed a Joint Motion to Stay the Litigation stating that the parties have reached a proposed resolution of the monetary terms of a potential settlement agreement. These financial terms are contingent on approval by authorized officials at the Department of Justice, negotiation of terms of a settlement agreement, approval and releases from the OIG, the National Association of Medicaid Fraud Control Units, and the Department of Justice, and coordination with discussions with the United States regarding other ongoing matters. While the Company believes that a final settlement will be reached, there can be no assurance that any final settlement agreement will be reached or as to the final terms of such settlement.

- In May 2015, the Company entered into a settlement agreement with the U.S. Attorney's Office for the Middle District of Florida, resolving alleged violations of the Controlled Substances Act ("CSA"). The Company paid a fine of $22 million in connection with the settlement. The Company is also undergoing several audits by the Drug Enforcement Agency ("DEA") Administrator and is in discussions with the DEA and the U.S. Attorney's Office in several locations concerning allegations that the Company has violated certain requirements of the CSA. Whether agreements can be reached and on what terms is uncertain.

- In May 2015, the Company received a subpoena from the OIG requesting information and documents concerning the Company's automatic refill programs, adherence outreach programs, and pharmacy customer incentives, particularly in connection with claims for reimbursement made to the Minnesota Medicaid program. The Company has been cooperating with the investigation and providing information in response to the subpoena.

- In July 2015, the U.S. District Court in the District of Massachusetts dismissed all claims alleged in a *qui tam* lawsuit that had been brought against the Company by a pharmacy auditor and a former CVS pharmacist. The lawsuit, which was initially filed under seal in 2011, alleged that the Company violated the federal False Claims Act, as well as the false claims acts of several states, by overcharging state and federal governments in connection with prescription drugs available through the Company's Health Savings Pass program, a membership-based program that allows enrolled customers special pricing for typical 90 -day supplies of various generic prescription drugs. The federal government had declined to intervene in the case. The plaintiffs are appealing the dismissal to the U.S. Court of Appeals for First Circuit.

- On July 27, 2015, a consolidated class action complaint was filed by plaintiffs naming Omnicare, the members of the Omnicare Board of Directors, CVS Health, CVS Pharmacy, Inc. and its merger subsidiary as defendants. The complaint alleged that the members of the Omnicare Board of Directors breached their fiduciary duties to Omnicare's stockholders during merger negotiations by entering into the merger agreement and approving the merger, and the CVS parties aided and abetted such breaches of fiduciary duties. In September 2015, the court granted plaintiffs' voluntary notice of dismissal of all allegations against the defendants.

- The Attorney General of the State of Texas issued civil investigative demands and other requests in February 2012, May 2014, and May 2015, and has continued its investigation concerning the Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program.

- In July and September 2015, two related putative class actions, Corcoran *et al* . v. CVS Health Corp., and Podgorny *et al* . v. CVS Health Corp., were filed against the Company in the United States District Court in the Northern District of California and the Northern District of Illinois, respectively. The two cases have been consolidated in United States District Court in the Northern District of California. The consolidated second amended complaint alleges that plaintiffs overpaid for prescriptions for generic drugs filled at CVS pharmacies. The plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states. The Company has moved to dismiss the second amended complaint.

- In September 2015, Omnicare was served with an administrative subpoena by the DEA. The subpoena seeks documents related to controlled substance policies, procedures, and practices at eight pharmacy locations from May 2012 to present. The Company has been cooperating and providing documents in response to this administrative subpoena.

- In October 2015, Omnicare received a Civil Investigative Demand from the United States Attorney's Office for the Southern District of New York requesting information and documents concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- In October 2015, the Company received from the U.S. Department of Justice a Civil Investigative Demand requesting documents and information in connection with a False Claims Act investigation concerning allegations that the Company submitted, or caused to be submitted, to the Medicare Part D program prescription drug event data that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- In November 2015, the United States District Court for the Eastern District of Pennsylvania unsealed a second amended *qui tam* complaint filed in September 2015, in an action captioned The United States of America et al. *ex rel.* Sally Schimelpfeinig and John Segura v. Dr. Reddy's Laboratories Limited *et al* . The U.S. Department of Justice declined to intervene in this action. The relators allege that the Company, Walgreens, Wal-Mart, and Dr. Reddy's Laboratories violated the federal and various state False Claims Acts by dispensing prescriptions in unit dose packaging supplied by Dr. Reddy's that was not compliant with the Consumer Product Safety Improvement Act and the Poison Preventive Packaging Act and thereby allegedly rendering the drugs misbranded under the Food, Drug & Cosmetic Act.

The Company is also a party to other legal proceedings, government investigations, inquiries and audits arising in the normal course of its business, none of which is expected to be material to the Company. The Company can give no assurance, however, that its business, financial condition and results of operations will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to the Company's

business, the pharmacy services, retail pharmacy, long-term care pharmacy or retail clinic industries or to the health care industry generally; (iii) pending or future federal or state governmental investigations of the Company's business or the pharmacy services, retail pharmacy, long-term care pharmacy or retail clinic industry or of the health care industry generally; (iv) pending or future government enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting the pharmacy services, retail pharmacy, long-term care pharmacy or retail clinic industry or the health care industry generally.

13 Segment Reporting

The Company currently has three reportable segments: Pharmacy Services, Retail/LTC and Corporate. The Retail/LTC Segment includes the operating results of the Company's Retail Pharmacy and LTC operating segments as the operations and economics characteristics are similar. The Company's segments maintain separate financial information for which operating results are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services and Retail/LTC segment performance based on net revenue, gross profit and operating profit before the effect of nonrecurring charges and certain intersegment activities. The Company evaluates the performance of its Corporate Segment based on operating expenses before the effect of discontinued operations, nonrecurring charges, and certain intersegment activities. See Note 1 for a description of the Pharmacy Services, Retail/LTC and Corporate segments and related significant accounting policies.

The following table is a reconciliation of the Company's business segments to the consolidated financial statements:

In millions	Pharmacy Services Segment [1][2]	Retail/LTC Segment [2]	Corporate Segment	Intersegment Eliminations [2]	Consolidated Totals
2015:					
Net revenues	$ 100,363	$ 72,007	$ —	$ (19,080)	$ 153,290
Gross profit	5,227	21,992	—	(691)	26,528
Operating profit [3]	3,989	7,130	(1,037)	(628)	9,454
Depreciation and amortization	654	1,336	102	—	2,092
Additions to property and equipment	359	1,883	125	—	2,367
2014:					
Net revenues	$ 88,440	$ 67,798	$ —	$ (16,871)	$ 139,367
Gross profit	4,771	21,277	—	(681)	25,367
Operating profit	3,514	6,762	(796)	(681)	8,799
Depreciation and amortization	630	1,205	96	—	1,931
Additions to property and equipment	308	1,745	83	—	2,136
2013:					
Net revenues	$ 76,208	$ 65,618	$ —	$ (15,065)	$ 126,761
Gross profit	4,237	20,112	—	(566)	23,783
Operating profit [4]	3,086	6,268	(751)	(566)	8,037
Depreciation and amortization	560	1,217	93	—	1,870
Additions to property and equipment	313	1,610	61	—	1,984

(1) Net revenues of the Pharmacy Services Segment include approximately $8.9 billion , $8.1 billion and $7.9 billion of Retail Co-Payments for 2015, 2014 and 2013, respectively. See Note 1 to the consolidated financial statements for additional information about Retail Co-Payments.

(2) Intersegment eliminations relate to intersegment revenue generating activities that occur between the Pharmacy Services Segment and the Retail/LTC Segment. These occur in the following ways: when members of Pharmacy Services Segment clients ("members") fill prescriptions at retail stores to purchase covered products, when members enrolled in programs such as Maintenance Choice ® elect to pick up maintenance prescriptions at a retail drugstore instead of receiving them through the mail, or when members have prescriptions filled at long-term care facilities. When these occur, both the Pharmacy Services and Retail/LTC segments record the revenues, gross profit and operating profit on a standalone basis.

(3) For the year ended December 31, 2015, the Corporate Segment operating loss includes $156 million of acquisition-related transaction and integration costs and a $90 million charge related to a legacy lawsuit challenging the 1999 legal settlement by MedPartners of various securities class actions and a related derivative claim.

(4) Consolidated operating profit for the year ended December 31, 2013 includes a $72 million gain on a legal settlement, of which, $11 million is included in the Pharmacy Services Segment and $61 million is included in the Retail/LTC Segment.

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2016 CVS Health 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2016
OR
☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from to
Commission file number 001-01011

CVS HEALTH CORPORATION
(Exact name of Registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $101,661,618,666 as of June 30, 2016, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 3, 2017, the registrant had 1,025,699,605 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

- Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2016 are incorporated by reference in our response to Items 7, 8 and 9 of Part II.
- Information contained in our Proxy Statement for the 2017 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

had approximately $30 million and $16 million accrued for interest and penalties as of December 31, 2016 and 2015, respectively.

There are no material uncertain tax positions as of December 31, 2016 the ultimate deductibility of which is highly certain but for which there is uncertainty about the timing. If there were, any such items would impact deferred tax accounting only, not the annual effective income tax rate, and would accelerate the payment of cash to the taxing authority to a period earlier than expected.

As of December 31, 2016, the total amount of unrecognized tax benefits that, if recognized, would affect the effective income tax rate is approximately $276 million , after considering the federal benefit of state income taxes.

11 Commitments and Contingencies

Lease Guarantees

Between 1991 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, Marshalls, Kay-Bee Toys, Wilsons, This End Up and Footstar. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of, the Company's guarantees remained in place, although each initial purchaser has agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations. As of December 31, 2016, the Company guaranteed approximately 87 such store leases (excluding the lease guarantees related to Linens 'n Things, which are discussed in Note 1 "Significant Accounting Policies"), with the maximum remaining lease term extending through 2047 .

In April 2016, the parent entity of Bob's Stores filed for Chapter 11 bankruptcy protection. As described above, the Company, through one or more of its affiliates, is alleged to have guaranteed certain of the Bob's Stores' leases (the "Bob's Leases"). On June 20, 2016, the bankruptcy court approved the sale of substantially all of the assets of Bob's Stores and certain other assets to a new entity ("Buyer"), which designated Buyer's affiliate Bob's Stores, LLC, a Delaware limited liability company ("New Bob's"), to acquire substantially all of the assets of Bob's Stores.

The Company, through its subsidiary, CVS Pharmacy, Inc., and New Bob's entered into an agreement in October 2016, pursuant to which, in exchange for an immaterial payment to be made by CVS Pharmacy, Inc., New Bob's agreed to accept the assignment of the Bob's Leases and to be bound by certain restrictions regarding renewals, extensions and modifications to the Bob's Leases. The Company believed these restrictions would potentially reduce the Company's exposure to liability under guarantees of the Bob's Leases in the future. The bankruptcy court approved the assignment of the Bob's Leases to New Bob's on November 7, 2016, and all of the Bob's Leases were assigned to New Bob's.

On February 5, 2017, New Bob's and certain of its affiliates (collectively, the "Debtors") filed for Chapter 11 bankruptcy protection. Certain documents filed in connection with the Debtors' bankruptcy case suggest that the Debtors may enter into an asset purchase agreement with Sports Direct Retail Ltd. ("Sports Direct"), for Sports Direct to serve as an initial bidder in an asset sale process to be conducted pursuant to Section 363 of the Bankruptcy Code. The Company will monitor the Debtors' bankruptcy proceedings.

Legal Matters

The Company is a party to legal proceedings, investigations and claims in the ordinary course of its business, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial position.

The Company's contingencies are subject to significant uncertainties, including, among other factors: (i) the procedural status of pending matters; (ii) whether class action status is sought and certified; (iii) whether asserted claims or allegations will survive dispositive motion practice; (iv) the extent of potential damages, fines or penalties, which are often unspecified or indeterminate; (v) the impact of discovery on the legal process; (vi) whether novel or unsettled legal theories are at issue; (vii) the settlement posture of the parties, and/or (viii) in the case of certain government agency investigations, whether a sealed

qui tam lawsuit ("whistleblower" action) has been filed and whether the government agency makes a decision to intervene in the lawsuit following investigation.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters.

- *In re Pharmacy Benefit Managers Antitrust Litigation* (U.S. District Court for the Eastern District of Pennsylvania) (consolidating *North Jackson Pharmacy, Inc.* et al *v. Caremark Rx Inc.* et al. (U.S. District Court for the Northern District of Alabama)). Beginning in August 2003, various lawsuits were filed by pharmacies alleging that various PBMs were violating certain antitrust laws. In October 2003, two independent pharmacies, North Jackson Pharmacy, Inc. and C&C, Inc. filed three putative class action complaints seeking treble damages and injunctive relief against Caremark (the term "Caremark" as used herein refers to one or more PBM subsidiaries of the Company, as applicable). In August 2006, the Judicial Panel on Multidistrict Litigation issued an order transferring all related PBM antitrust cases, including the North Jackson Pharmacy cases, to the United States District Court for the Eastern District of Pennsylvania for coordinated and consolidated proceedings with the cases originally filed in that court. The consolidated action is now known as *In re Pharmacy Benefit Managers Antitrust Litigation* . On January 18, 2017, the court denied the plaintiffs' motion for class certification filed against Caremark, denied a similar motion filed against another PBM, and decertified classes that had been previously certified against other PBMs.

- *Indiana State District Council of Laborers and HOD Carriers Pension and Welfare Fund v. Omnicare, Inc.* et al. (U.S. District Court for the Eastern District of Kentucky). In February 2006, two substantially similar putative class action lawsuits were filed and subsequently consolidated. The consolidated complaint was filed against Omnicare, three of its officers and two of its directors and purported to be brought on behalf of all open-market purchasers of Omnicare common stock from August 3, 2005 through July 27, 2006, as well as all purchasers who bought shares of Omnicare common stock in Omnicare's public offering in December 2005. The complaint alleged violations of the Securities Exchange Act of 1934 and Section 11 of the Securities Act of 1933 and sought, among other things, compensatory damages and injunctive relief. After dismissals and appeals to the United States Court of Appeals for the Sixth Circuit, the United States Supreme Court remanded the case to the district court. In October 2016, Omnicare filed an answer to plaintiffs' third amended complaint, and discovery commenced.

- *Claims Processing Matter.* In December 2007, the Company received a document subpoena from the Office of Inspector General ("OIG") within the U.S. Department of Health and Human Services, requesting information relating to the processing of Medicaid and certain other government agency claims on behalf of its clients (which allegedly resulted in underpayments from our pharmacy benefit management clients to the applicable government agencies) on one of the Company's adjudication platforms. In September 2014, the Company settled the OIG's claims, as well as related claims by the Department of Justice and private plaintiffs, without any admission of liability. The Company concluded its discussions with the OIG concerning other claim processing issues and resolved those additional matters on December 22, 2016 for the payment of an immaterial amount.

- *FTC and Multi-State Investigation.* In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the U.S. Federal Trade Commission ("FTC"). Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company has cooperated with the multi-state investigation.

- *United States* ex rel. *Jack Chin v. Walgreen Company* et al. (U.S. District Court for the Central District of California). In March 2010, the Company received a subpoena from the OIG requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to the Company's pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. In October 2016, the U.S. District Court for the Central District of California unsealed a *qui tam* complaint, filed in April 2009 against CVS Pharmacy and other retail pharmacies, alleging that the Company violated the federal False Claims Act, and the false claims acts of several states, by offering such programs. The federal government has declined intervention in the case.

- *United States* ex rel. *James Banigan and Richard Templin v. Organon USA Inc.* et al. (U.S. District Court for the District of Massachusetts). On October 29, 2010, the court unsealed a *qui tam* complaint, which had been under seal

since 2007, against Organon, Omnicare, Inc. and PharMerica Corporation. The suit was brought by two former employees of Organon, as relators on behalf of the federal government and several state and local governments. The action alleges civil violations of the federal False Claims Act based on allegations that Organon and its affiliates paid Omnicare and several other long-term care pharmacies rebates, post-purchase discounts and other forms of remuneration in return for purchasing pharmaceuticals from Organon and taking steps to increase the purchase of Organon's drugs in violation of the Anti-Kickback Statute. The U.S. Department of Justice declined to intervene in this action. The Company has tentatively agreed with the Department of Justice to resolve this matter for $23 million plus interest. These financial terms are contingent on approval by authorized officials at the Department of Justice, negotiation of terms of a settlement agreement, approval and releases from the OIG, the National Association of Medicaid Fraud Control Units, and the Department of Justice. While the Company believes that a final settlement will be reached, there can be no assurance that any final settlement agreement will be reached or as to the final terms of such settlement.

- *United States* ex rel. *Anthony R. Spay v. CVS Caremark Corporation* et al. (U.S. District Court for the Eastern District of Pennsylvania). In January 2012, the court unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, Anthony Spay, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that Caremark's processing of Medicare claims on behalf of one of its clients violated the federal False Claims Act. The United States declined to intervene in the lawsuit. In September 2015, the Court granted Caremark's motion for summary judgment in its entirety, and entered judgment in favor of Caremark and against Spay. In October 2015, Spay filed a notice of appeal in the United States Court of Appeals for the Third Circuit; that court heard oral arguments on the appeal in November 2016.

- *State of Texas* ex rel. *Myron Winkelman and Stephani Martinson* et al. *v. CVS Health Corporation* (Travis County District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands and has issued a series of subsequent requests for documents and information in connection with its investigation concerning the Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the court unsealed a first amended petition. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to Texas Medicaid by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the usual and customary price. The amended petition was unsealed following the Company's filing of *CVS Pharmacy, Inc. v. Charles Smith* et al. (Travis County District Court), a declaratory judgment action against the State of Texas in December 2016 seeking a declaration that the prices charged to members of the Health Savings Pass program do not constitute usual and customary prices under the Medicaid regulation.

- *California ReadyFill Subpoena.* In November 2012, the Company received a subpoena for documents from the OIG requesting information concerning automatic refill programs used by pharmacies to refill prescriptions for customers. The subpoena was issued in connection with an investigation conducted out of the U.S. Attorney's Office for the Central District of California. The Company produced documents and data.

- *Pure Services Subpoena.* In 2013, Omnicare received a subpoena seeking information regarding Omnicare's May 2008 acquisition of Pure Service Pharmacy. In 2016, Omnicare reached an agreement regarding financial terms to resolve, for $1.5 million plus interest, the subpoena regarding the acquisition of Pure Service Pharmacy. These financial terms are contingent on approval by authorized officials at the Department of Justice, negotiation of terms of a settlement agreement, approval and releases from the OIG, the National Association of Medicaid Fraud Control Units, and the Department of Justice. While the Company believes that a final settlement will be reached, there can be no assurance that any final settlement agreement will be reached or as to the final terms of such settlement.

- *Auto Label Subpoena.* In 2014, Omnicare received a subpoena seeking information regarding Omnicare's Auto Label Verification system. In 2016, Omnicare reached an agreement regarding financial terms to resolve, for $8 million plus interest, the subpoena regarding Omnicare's Auto Label Verification system. These financial terms are contingent on approval by authorized officials at the Department of Justice, negotiation of terms of a settlement agreement, approval and releases from the OIG, the National Association of Medicaid Fraud Control Units, and the Department of Justice. While the Company believes that a final settlement will be reached, there can be no assurance that any final settlement agreement will be reached or as to the final terms of such settlement.

- *Subpoena Concerning PBM Administrative Fees.* In March 2014, the Company received a subpoena from the United States Attorney's Office for the District of Rhode Island, requesting documents and information concerning bona fide service fees and rebates received from pharmaceutical manufacturers in connection with certain drugs utilized under

Part D of the Medicare Program, as well as the reporting of those fees and rebates to Part D plan sponsors. The Company has been cooperating with the government and providing documents and information in response to the subpoena.

- *ReadyFill Subpoena (Minnesota).* In May 2015, the Company received a subpoena from the OIG requesting information and documents concerning the Company's automatic refill programs, adherence outreach programs, and pharmacy customer incentives, particularly in connection with claims for reimbursement made to the Minnesota Medicaid program. The Company has been cooperating with the investigation and providing information in response to the subpoena.

- *Corcoran* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in United States District Court in the Northern District of California. Plaintiffs seek damages and injunctive relief on behalf of a class of consumers who purchased certain prescription drugs under the consumer protection statutes and common laws of certain states. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* (U.S. District Court for the District of Rhode Island) and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting as the pharmacy's usual and customary price the price available to members of the CVS Health Savings Pass program. The Company is defending these actions.

- *Omnicare DEA Subpoena.* In September 2015, Omnicare was served with an administrative subpoena by the U.S. Drug Enforcement Agency ("DEA"). The subpoena seeks documents related to controlled substance policies, procedures, and practices at eight pharmacy locations from May 2012 to the present. The Company has been cooperating and providing documents in response to this administrative subpoena.

- *Omnicare Cycle Fill CID.* In October 2015, Omnicare received a Civil Investigative Demand from the United States Attorney's Office for the Southern District of New York requesting information and documents concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *PBM Pricing CID.* In October 2015, the Company received from the U.S. Department of Justice a Civil Investigative Demand requesting documents and information in connection with a False Claims Act investigation concerning allegations that the Company submitted, or caused to be submitted, to the Medicare Part D program prescription drug event data that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *United States* ex rel. *Sally Schimelpfenig and John Segura v. Dr. Reddy's Laboratories Limited and Dr. Reddy's Laboratories, Inc.* (U.S. District Court for the Eastern District of Pennsylvania). In November 2015, the court unsealed a second amended *qui tam* complaint filed in September 2015. The U.S. Department of Justice declined to intervene in this action. The relators allege that the Company, Walgreens, Wal-Mart, and Dr. Reddy's Laboratories violated the federal and various state False Claims Acts by dispensing prescriptions in unit dose packaging supplied by Dr. Reddy's that was not compliant with the Consumer Product Safety Improvement Act and the Poison Preventive Packaging Act and thereby allegedly rendering the drugs misbranded under the Food, Drug & Cosmetic Act. The Company's motion to dismiss remains pending.

- *Barchock* et al. *v. CVS Health Corporation* et al. (U.S. District Court for the District of Rhode Island). In February 2016, an ERISA class action lawsuit was filed against the Company, the Benefit Plans Committee of the Company, and Galliard Capital Management, Inc., by Mary Barchock, Thomas Wasecko, and Stacy Weller, purportedly on behalf of the 401(k) Plan and the Employee Stock Ownership Plan of the Company (the "Plan"), and participants in the Plan. The complaint alleges that the defendants breached fiduciary duties owed to the plaintiffs and the Plan by investing too much of the Plan's Stable Value Fund in short-term money market funds and cash management accounts. The Company has moved to dismiss the plaintiffs' amended complaint.

- *State of California* ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined intervention in this case. The relator alleges that the Company submitted false

claims for payment to California Medicaid in connection with reimbursement for drugs available through the Health Savings Pass program as well as certain other generic drugs. The Company's motion to dismiss the complaint was denied.

- *DEA Matters.* In October 2016, the Company reached an agreement in principle with the U.S. Attorney's Office for the Eastern District of California to resolve alleged violations of the Controlled Substances Act ("CSA") for $5 million . The settlement is contingent on the negotiation of terms of a settlement agreement. The Company is also undergoing several audits by the DEA Administrator and is in discussions with the DEA and the U.S. Attorney's Office in several locations concerning allegations that the Company has violated certain requirements of the CSA.

- *State of Mississippi v. CVS Health Corporation* et al. (Chancery Court of Desoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to Mississippi Medicaid by not submitting as the pharmacy's usual and customary price the price available to members of the CVS Health Savings Pass program. The Company has responded to the complaint, filed a counterclaim, and moved to transfer the case to circuit court.

The Company is also a party to other legal proceedings, government investigations, inquiries and audits, and has received and is cooperating with subpoenas or similar process from various governmental agencies requesting information, all arising in the normal course of its business, none of which is expected to be material to the Company. The Company can give no assurance, however, that its business, financial condition and results of operations will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to the Company's business, the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industries or to the health care industry generally; (iii) pending or future federal or state governmental investigations of the Company's business or the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or of the health care industry generally; (iv) pending or future government enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or the health care industry generally.

12 Segment Reporting

The Company currently has three reportable segments: Pharmacy Services, Retail/LTC and Corporate. The Retail/LTC Segment includes the operating results of the Company's Retail Pharmacy and LTC/RxCrossroads operating segments as the operations and economics characteristics are similar. The Company's segments maintain separate financial information for which operating results are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services and Retail/LTC segments' performance based on net revenue, gross profit and operating profit before the effect of nonrecurring charges and gains and certain intersegment activities. The Company evaluates the performance of its Corporate Segment based on operating expenses before the effect of nonrecurring charges and gains and certain intersegment activities. The chief operating decision maker does not use total assets by segment to make decisions regarding resources, therefore the total asset disclosure by segment has not been included. See Note 1 "Significant Accounting Policies" for a description of the Pharmacy Services, Retail/LTC and Corporate segments and related significant accounting policies.

In 2016, approximately 11.2% of the Company's consolidated net revenues were from Aetna, a Pharmacy Services Segment client. In 2015 and 2014, no single customer accounted for 10% or more of the Company's consolidated net revenues. More than 99% of the Company's consolidated net revenues are earned and long-lived assets are located in the United States.

2017 CVS Health 10-K

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

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the fiscal year ended December 31, 2017

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the transition period from to

Commission file number 001-01011

CVS HEALTH CORPORATION
(Exact name of Registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500
(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (Do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $81,440,458,676 as of June 30, 2017, based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 9, 2018, the registrant had 1,014,532,157 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Filings made by companies with the Securities and Exchange Commission sometimes "incorporate information by reference." This means that the company is referring you to information that was previously filed or is to be filed with the SEC, and this information is considered to be part of the filing you are reading. The following materials are incorporated by reference into this Form 10-K:

Portions of our Annual Report to Stockholders for the fiscal year ended December 31, 2017 are incorporated by reference in our response to Items 7, 8 and 9 of Part II.

Information contained in our Proxy Statement for the 2018 Annual Meeting of Stockholders is incorporated by reference in our response to Items 10 through 14 of Part III.

examinations with the IRS for various years. An estimate of the range of the possible change cannot be made at this time.

The Company records interest expense related to unrecognized tax benefits and penalties in income tax expense. The Company accrued interest expense of approximately $11 million in 2017, $10 million in 2016 and $5 million in 2015. The Company had approximately $34 million and $30 million accrued for interest and penalties as of December 31, 2017 and 2016, respectively.

There are no material uncertain tax positions as of December 31, 2017 the ultimate deductibility of which is highly certain but for which there is uncertainty about the timing.

As of December 31, 2017, the total amount of unrecognized tax benefits that, if recognized, would affect the effective income tax rate is approximately $317 million, after considering the federal benefit of state income taxes.

12 Commitments and Contingencies

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores, Linens 'n Things, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the store's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser has agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries were to become insolvent and failed to make the required payments under a store lease, the Company could be required to satisfy these obligations. As of December 31, 2017, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Legal Matters

The Company is a party to legal proceedings, investigations and claims in the ordinary course of its business, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial position.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters.

- *Indiana State District Council of Laborers and HOD Carriers Pension and Welfare Fund v. Omnicare, Inc.,* et al. (U.S. District Court for the Eastern District of Kentucky). In February 2006, two substantially similar putative class action lawsuits were filed and subsequently consolidated. The consolidated complaint was filed against Omnicare, three of its officers and two of its directors and purported to be brought on behalf of all open-market purchasers of Omnicare common stock from August 3, 2005 through July 27, 2006, as well as all purchasers who bought shares of Omnicare common stock in Omnicare's public offering in December 2005. The complaint alleged violations of the Securities Exchange Act of 1934 and Section 11 of the Securities Act of 1933 and sought, among other things, compensatory damages and injunctive relief. After dismissals and appeals to the United States Court of Appeals for the Sixth Circuit, the United States Supreme Court remanded the case to the district court. In October 2016, Omnicare filed an answer to plaintiffs' third amended complaint, and

discovery commenced. In August 2017, the plaintiffs moved for class certification, which Omnicare has opposed.

- *FTC and Multi-State Investigation.* In March 2010, the Company learned that various State Attorneys General offices and certain other government agencies were conducting a multi-state investigation of certain of the Company's business practices similar to those being investigated at that time by the U.S. Federal Trade Commission ("FTC"). Twenty-eight states, the District of Columbia and the County of Los Angeles are known to be participating in this investigation. The prior FTC investigation, which commenced in August 2009, was officially concluded in May 2012 when the consent order entered into between the FTC and the Company became final. The Company has cooperated with the multi-state investigation.

- *United States* ex rel. *Jack Chin v. Walgreen Company,* et al. (U.S. District Court for the Central District of California). In March 2010, the Company received a subpoena from the U.S. Department of Health and Human Services, Office of the Inspector General requesting information about programs under which the Company has offered customers remuneration conditioned upon the transfer of prescriptions for drugs or medications to the Company's pharmacies in the form of gift cards, cash, non-prescription merchandise or discounts or coupons for non-prescription merchandise. In October 2016, the U.S. District Court for the Central District of California unsealed a *qui tam* complaint, filed in April 2009 against CVS Pharmacy and other retail pharmacies, alleging that the Company violated the federal False Claims Act, and the False Claims Acts of several states, by offering such programs. The complaint was served on the Company in January 2017. In December 2017, the same court unsealed a second *qui tam* complaint filed by the same relator in September 2017. The complaint is based on the same factual allegations but asserts a legal theory the Court did not permit him to add to the original case. The federal government has declined intervention in both cases. The Company is defending both lawsuits.

- *United States* ex rel. *Anthony R. Spay v. CVS Caremark Corporation,* et al. (U.S. District Court for the Eastern District of Pennsylvania). In January 2012, the court unsealed a first amended *qui tam* complaint filed in August 2011 by an individual relator, Anthony Spay, who is described in the complaint as having once been employed by a firm providing pharmacy prescription benefit audit and recovery services. The complaint seeks monetary damages and alleges that CVS Caremark's processing of Medicare claims on behalf of one of its clients violated the federal False Claims Act. The United States declined to intervene in the lawsuit. In September 2015, the Court granted CVS Caremark's motion for summary judgment in its entirety, and entered judgment in favor of CVS Caremark and against Spay. Spay appealed. In December 2017, the United States Court of Appeals for the Third Circuit affirmed the court's judgment in favor of CVS Caremark.

- *State of Texas* ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation,* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands and has issued a series of subsequent requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the court unsealed a first amended petition. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to Texas Medicaid by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the usual and customary price. The amended petition was unsealed following the Company's filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County District Court), a declaratory judgment action against the State of Texas in December 2016 seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the Medicaid regulation. The State of Texas is also pursuing temporary injunctive relief.

- *Subpoena Concerning PBM Administrative Fees.* In March 2014, the Company received a subpoena from the United States Attorney's Office for the District of Rhode Island, requesting documents and information concerning bona fide service fees and rebates received from pharmaceutical manufacturers in connection with certain drugs utilized under Medicare Part D, as well as the reporting of those fees and rebates to Part D plan

sponsors. The Company has been cooperating with the government and providing documents and information in response to the subpoena.

- *Corcoran* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in United States District Court in the Northern District of California. Plaintiffs seek damages and injunctive relief on behalf of a class of consumers who purchased certain prescription drugs under the consumer protection statutes and common laws of certain states. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the consumer case (Corcoran), the Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The plaintiffs have filed a notice of appeal to the Ninth Circuit. The Company continues to defend these actions.

- *Omnicare DEA Subpoena.* In September 2015, Omnicare was served with an administrative subpoena by the U.S. Drug Enforcement Administration ("DEA"). The subpoena seeks documents related to controlled substance policies, procedures, and practices at eight pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional pharmacy. The Company has been cooperating and providing documents in response to this administrative subpoena.

- *Omnicare Cycle Fill Civil Investigative Demand.* In October 2015, Omnicare received a Civil Investigative Demand from the United States Attorney's Office for the Southern District of New York requesting information and documents concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand. In July 2017, Omnicare also received a subpoena from the California Department of Insurance requesting documents on similar subject matter.

- *PBM Pricing Civil Investigative Demand.* In October 2015, the Company received from the U.S. Department of Justice (the "DOJ") a Civil Investigative Demand requesting documents and information in connection with a federal False Claims Act investigation concerning allegations that the Company submitted, or caused to be submitted, to the Medicare Part D program prescription drug event data that misrepresented true prices paid by the Company's PBM to pharmacies for drugs dispensed to Part D beneficiaries with prescription benefits administered by the Company's PBM. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *United States* ex rel. *Sally Schimelpfenig and John Segura v. Dr. Reddy's Laboratories Limited and Dr. Reddy's Laboratories, Inc.* (U.S. District Court for the Eastern District of Pennsylvania). In November 2015, the court unsealed a second amended *qui tam* complaint filed in September 2015. The DOJ declined to intervene in this action. The relators allege that the Company, Walgreens, Wal-Mart, and Dr. Reddy's Laboratories violated the federal and various state False Claims Acts by dispensing prescriptions in unit dose packaging supplied by Dr. Reddy's that was not compliant with the Consumer Product Safety Improvement Act and the Poison Preventive Packaging Act and thereby allegedly rendering the drugs misbranded under the Food, Drug and Cosmetic Act. In March 2017, the Court granted the Company's motion to dismiss with leave to file an amended complaint. In June 2017, the Company moved to dismiss relators' third amended complaint.

- *Barchock* et al. *v. CVS Health Corporation,* et al. (U.S. District Court for the District of Rhode Island). In February 2016, a class action lawsuit was filed against the Company, the Benefit Plans Committee of the Company, and Galliard Capital Management, Inc., by Mary Barchock, Thomas Wasecko, and Stacy Weller,

purportedly on behalf of the 401(k) Plan and the Employee Stock Ownership Plan of the Company (the "Plan"), and participants in the Plan. The complaint alleged that the defendants breached fiduciary duties owed to the plaintiffs and the Plan by investing too much of the Plan's Stable Value Fund in short-term money market funds and cash management accounts. The court recently granted the Company's motion to dismiss the plaintiffs' amended complaint. In May 2017, plaintiffs appealed that ruling in the United States Court of Appeals for the First Circuit.

- *State of California* ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined intervention in this case. The relator alleges that the Company submitted false claims for payment to California Medicaid in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer.

- *Retail DEA Matters.* The Company has been also undergoing several audits by the DEA Administrator and is in discussions with the DEA and the U.S. Attorney's Offices in several locations concerning allegations that the Company has violated certain requirements of the Controlled Substance Act.

- *National Opioid Litigation* . In December 2017, the United States Judicial Panel on Multidistrict Litigation ordered consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes, and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation is *In re National Prescription Opiate Litigation* (MDL No. 2804), pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes relevant federal court cases that name the Company, including actions filed by several counties in West Virginia; actions filed by several counties and cities in Michigan; actions filed by hospitals in Florida and Mississippi; and an action filed by the St. Croix Chippewa Indians of Wisconsin. Similar cases that name the Company in some capacity have been filed in state courts, including cases filed by Shelby County, Tennessee, *Shelby County (Tennessee) v. Purdue Pharma, L.P., et al.* (Shelby County Circuit Court, No. CT-004500-17), and several counties in West Virginia, *Brooke County (West Virginia) et al. v. Purdue Pharma, L.P., et al.* (Marshall County Circuit Court, Nos. 17-C-248 – 17-C-255). The Company is defending all such matters.

- *Cherokee Nation Opioid Litigation* . In April 2017, the Company was named as a defendant in an action filed on behalf of the Cherokee Nation in the District Court of Cherokee Nation (the "Cherokee Action") asserting various causes of action allegedly arising from the widespread abuse of opioids. In June 2017, the Company filed a motion to dismiss the Cherokee Action. The Cherokee Nation has since filed an amended petition in the Cherokee Action. Also in June 2017, the six defendants in the Cherokee Action collectively filed a complaint in the U.S. District Court for the Northern District of Oklahoma, *McKesson* , et al. *v. Hembree* , et al., seeking a declaration and preliminary injunction prohibiting the District Court of Cherokee Nation from exercising jurisdiction over the Cherokee Action. In January 2018, the U.S. District Court granted the preliminary injunction motion and issued an order enjoining the Cherokee Nation Attorney General and the judicial officers of the Cherokee Nation District Court from taking any action with respect to the Cherokee Action pending resolution of the federal court case.

- *State of Mississippi v. CVS Health Corporation,* et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to Mississippi Medicaid by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, filed a counterclaim, and moved to transfer the case to circuit court. The motion to transfer was granted, which the State has appealed, and the motion to dismiss remains pending.

- *Part B Insulin Products Civil Investigative Demand.* In December 2016, the Company received a Civil Investigative Demand from the U.S. Attorney's Office for the Northern District of New York, requesting documents and information in connection with a False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Medicare Part D rather than Part B. The Company has cooperated with the government and provided documents and information in response to the Civil Investigative Demand.

- *Cold Chain Logistics Civil Investigative Demand* . In September 2016, the Company received from the DOJ a Civil Investigative Demand in connection with an investigation as to whether the Company's handling of certain temperature-sensitive pharmaceuticals violates the federal Food, Drug and Cosmetic Act and the False Claims Act. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *Amburgey,* et al. *v. CaremarkPCS Health, L.L.C.* (U.S. District Court for the Central District of California). In March 2017, the Company was served with a complaint challenging the policies and procedures used by CVS Specialty pharmacies to ship temperature-sensitive medications. The case is similar to a matter already pending against the Company in the Superior Court of California (Los Angeles County), *Bertram v. Immunex Corp.* , et al., which was filed in October 2014. In November 2017, the plaintiffs voluntarily dismissed the *Amburgey* case without prejudice. The Company continues to defend the Bertram matter.

- *Barnett,* et al. v. *Novo Nordisk Inc* ., et al. and *Boss* , et al. v. *CVS Health Corporation* , et al., and *Christensen,* et al., v. *Novo Nordisk Inc.* et al., (all pending in the U.S. District Court for the District of New Jersey). These putative class actions were filed against the Company and other PBMs and manufacturers of insulin in March and April 2017. Plaintiffs in all cases allege that the PBMs and manufacturers have engaged in a conspiracy whereby the PBMs sell access to their formularies by demanding the highest rebates, which in turn causes increased list prices for insulin. The primary claims are antitrust claims, claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), violations of state unfair competition and consumer protection laws and in *Boss* , claims pursuant to the Employee Retirement Income Security Act ("ERISA"). In December 2017, the attorney appointed as interim lead counsel in *Barnet, Boss* and *Christensen* filed a consolidated amended class action complaint in a related action, *In re Insulin Pricing Litigation* , against only the drug manufacturers, and not against the PBMs.

- *Insulin Products Investigation.* In April 2017, the Company received a Civil Investigative Demand from the Attorney General of Washington, seeking documents and information regarding pricing and rebates for insulin products in connection with a pending investigation into unfair and deceptive acts or practice regarding insulin pricing. We have been notified by the Office of the Attorney General of Washington that information provided in response to the Civil Investigative Demand will be shared with the Attorneys General of California, Florida, Minnesota, New Mexico and the District of Columbia. In July 2017, the Company received a Civil Investigative Demand from the Attorney General of Minnesota, seeking documents and information regarding pricing and rebates for insulin and epinephrine products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin and epinephrine pricing.

- *Bewley,* et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed in May 2017 against the Company and other pharmacy benefit managers and manufacturers of glucagon kits (Bewley) and diabetes test strips (Prescott). Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws, and ERISA. These cases have both been transferred to the United States District Court for the District of New Jersey on defendants' motions. The Company is defending these lawsuits.

- *Klein* , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). In June 2017, a putative class action complaint was filed against the Company and other pharmacy benefit managers on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the pharmacy benefit managers are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPen through the process of negotiating increased rebates from EpiPen manufacturer, Mylan. The Company is defending this lawsuit.

- *Medicare Part D Civil Investigative Demand* . In May 2017, the United States Attorney's Office for the Southern District of New York issued a Civil Investigative Demand to the Company concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to the Civil Investigative Demand.

- *Shareholder Matters.* In August and September 2017, four complaints were filed by putative derivative plaintiffs against certain officers and directors of the Company. Three of those actions, *Sherman v. Merlo,* et al., *Feghali v. Merlo,* et al., and *Banchalter v. Merlo,* et al., were filed in the U.S. District Court for the District of Rhode Island. A fourth, *Boron v. Bracken,* et al., was filed in Rhode Island Superior Court. These matters assert a variety of causes of action, including breach of fiduciary duty, waste of corporate assets, unjust enrichment, civil conspiracy and violation of Section 14(a) of the Exchange Act, and are premised on the allegation that the defendants approved business plans that exposed the Company to various litigations and investigations. The three federal matters have been stayed pending resolution of certain of the underlying matters, and the Company has filed a motion to stay the state court action.

- *MSP Recovery Claims Series, LLC* , et al. v. *CVS Health Corporation* , et al. (U.S. District Court for the Western District of Texas). In September 2017, a putative class action complaint was filed against the company, Express Scripts, Inc., and the manufacturers of insulin on behalf of assignees of claims of Medicare Advantage Organizations. Plaintiffs assert that the PBMs and manufacturers have engaged in a conspiracy whereby the PBMs sell access to their formularies by demanding the highest rebates, which in turn causes increased list prices for insulin. The plaintiffs assert claims on behalf of two putative classes: (1) all Medicare C payors and (2) all Medicare D payors. The complaint asserts claims under RICO, and for common law fraud and unjust enrichment.

The Company is also a party to other legal proceedings, government investigations, inquiries and audits, and has received and is cooperating with subpoenas or similar process from various governmental agencies requesting information, all arising in the normal course of its business, none of which is expected to be material to the Company. The Company can give no assurance, however, that its business, financial condition and results of operations will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to the Company's business, the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industries or to the health care industry generally; (iii) pending or future federal or state governmental investigations of the Company's business or the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or of the health care industry generally; (iv) pending or future government enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting the pharmacy services, specialty pharmacy, retail pharmacy, long-term care pharmacy or retail clinic industry or the health care industry generally.

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2018 CVS Health 10-K

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

☑ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the fiscal year ended December 31, 2018

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**
For the transition period from _____ to_____
Commission file number 001-01011

CVSHealth

CVS HEALTH CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

(401) 765-1500

(Registrant's telephone number, including area code)

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

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	Name of each exchange on which registered

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

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

Large accelerated filer ☑ Accelerated filer ☐

Non-accelerated filer ☐ Smaller reporting company ☐

Emerging growth company ☐

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

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

The aggregate market value of the registrant's common stock held by non-affiliates was approximately $65,262,991,789 as of June 30, 2018 , based on the closing price of the common stock on the New York Stock Exchange. For purposes of this calculation, only executive officers and directors are deemed to be the affiliates of the registrant.

As of February 19, 2019 , the registrant had 1,297,082,165 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

The following materials are incorporated by reference into this Form 10-K:

Portions of the Annual Report to Stockholders for the fiscal year ended December 31, 2018 (the "Annual Report") are incorporated by reference in response to Items 1, 1A, 2 and 3 of Part I and Items 5, 6, 7, 7A, 8 and 9A of Part II, in each case to the extent described therein.

Information contained in the definitive proxy statement for CVS Health Corporation's 2019 Annual Meeting of Stockholders, to be filed on or about April 5, 2019 (the "Proxy Statement"), is incorporated by reference in response to Items 10 through 14 of Part III to the extent described therein.

to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of December 31, 2018, the Company guaranteed approximately 85 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. During the first quarter of 2017, Aetna recorded a discounted estimated liability and expense of $231 million pretax for its estimated share of future assessments by applicable life and health guaranty associations which reflects a 3.5% discount rate. The Company did not record an asset for expected premium tax offsets for its in force business at December 31, 2018, as the amount was not material. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's results of operations, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

The total guaranty fund assessments liability as of December 31, 2018 was $90 million and was recorded in accrued expenses on the consolidated balance sheet.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. The Company is defending itself against these claims.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The *Corcoran* plaintiffs have appealed the District Court's decision to the Ninth Circuit. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, moved for judgment on the pleadings, filed a counterclaim and moved the case to Mississippi Circuit Court. The Company's motion for judgment on the pleadings remains pending. The Company is defending itself against these claims.

Manufacturer's Rebate Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning manufacturer's rebates that the Company has negotiated.

Bewley, et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants' motions. The Company is defending itself against these claims.

Klein , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation* . The Company is defending itself against these claims.

In April 2017, the Company received a CID from the Attorney General of Washington requesting documents and information regarding pricing and rebates for insulin products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin pricing. The Office of the Attorney General of Washington has notified the Company that information provided in response to the Washington Attorney General's CID will be shared with the Attorneys General of California, Florida, Minnesota, New Mexico, the District of Columbia and Mississippi. In July 2017, the Company received a CID from the Attorney General of Minnesota requesting documents and information regarding pricing and rebates for insulin and epinephrine products in connection with a pending investigation into unfair and deceptive acts or practices regarding insulin and epinephrine pricing. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. Fewer than 100 similar cases that name the Company as a defendant in some capacity are pending in state courts. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). For several of these audits, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served Omnicare with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Company pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Company pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, Omnicare received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning Omnicare's cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, Omnicare also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the arbitrator awarded the claimant hospitals approximately $150 million . The Company is defending itself against the claimant hospitals' claims and has appealed the arbitrator's decision.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, attorneys general and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

CMS regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, HHS or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's results of operations, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's results of operations, cash flows or financial condition.

Other Legal and Regulatory Proceedings .

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and contracts with government customers in the Company's Commercial Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's results of operations. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, results of operations and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the

Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

17. Segment Reporting

The Company currently has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information for which results of operations are evaluated on a regular basis by the Company's chief operating decision maker in deciding how to allocate resources and in assessing performance.

The Company evaluates its Pharmacy Services, Retail/LTC and Health Care Benefits segments' performance based on operating income (loss) and operating income (loss) before the effect of (i) nonrecurring charges or gains and (ii) certain intersegment activities. The chief operating decision maker does not use total assets by segment to make decisions regarding resources. Therefore the total asset disclosure by segment has not been included. See Note 1 ''Significant Accounting Policies'' for a description of the Pharmacy Services, Retail/LTC, Health Care Benefits and Corporate/Other segments and related significant accounting policies.

In 2018 , 2017 and 2016 , approximately 9.8% , 12.3% and 11.7% , respectively, of the Company's consolidated revenues were from Aetna, a Pharmacy Services segment client. On November 28, 2018, the Company completed the Aetna Acquisition. Subsequent to the Aetna Acquisition, transactions with Aetna will continue to be reported within the Pharmacy Services segment, but are eliminated in the Company's consolidated financial statements.

Effective for the first quarter of 2019, the Company will realign the composition of its segments to correspond with changes to its operating model. As a result of this realignment, the Company's Silverscript PDP will move from the Pharmacy Services segment to the Health Care Benefits segment. In addition, the Company will move Aetna's mail order and specialty pharmacy operations from the Health Care Benefits segment to the Pharmacy Services segment.

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2019 CVS Health 10-Q Ending March 31

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

FORM 10-Q

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

For the quarterly period ended March 31, 2019
or

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

For the transition period from _____ to_____

Commission File Number: 001-01011

CVS HEALTH CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	*(Zip Code)*

(401) 765-1500
(Registrant's telephone number, including area code)

Former name, former address and former fiscal year, if changed since last report: **N/A**

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

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

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

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

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

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

There were 1,299,092,100 shares of the registrant's voting common stock with a par value of $0.01 per share outstanding at April 23, 2019.

related to Linens ‘n Things, which have been recorded as a liability on the unaudited condensed consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company’s assessments generally are based on a formula relating to the Company’s health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, “Penn Treaty”) in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company’s operating results, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company’s experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and estimable, the Company does not establish an accrued liability. None of the Company’s accruals for outstanding legal matters are material individually or in the aggregate to the Company’s financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company’s retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands (“CIDs”) to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies’

usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. The Company is defending itself against these claims.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. The *Corcoran* plaintiffs have appealed the District Court's decision to the Ninth Circuit. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Chancery Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi alleging that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. The Company has responded to the complaint, moved for judgment on the pleadings, filed a counterclaim and moved the case to Mississippi Circuit Court. The Company's motion for judgment on the pleadings remains pending. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

Bewley, et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants' motions. In April 2019, the named plaintiffs in both the *Bewley* and *Prescott* cases voluntarily dismissed all of their claims without prejudice, ending both cases.

Klein , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation* . The Company is defending itself against these claims.

The Company has received subpoenas, CIDs, and other requests for documents and information from, and is being investigated by, Attorneys General of several states regarding its PBM practices, including pricing and rebates. In addition, the Company received an inquiry from the U.S. Senate Committee on Finance regarding insulin pricing. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). In some instances, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served the Company with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Omnicare pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Omnicare pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with

respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the trial arbitrator awarded the claimant hospitals approximately $150 million . Aetna appealed the trial arbitrator's decision. On March 28, 2019, the appellate arbitrator reduced the award to approximately $86 million . The proceeding has ended. During the three months ended March 31, 2019, the Company recorded the reduction in the required reserve amount for this proceeding as a measurement period adjustment to its Aetna Acquisition accounting and recorded a reduction to goodwill.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

The United States Centers for Medicare & Medicaid Services ("CMS") regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, the United States Department of Health and Human Services or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the DOJ in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's operating results, cash flows or financial condition.

Shareholder Matters

In February and March 2019, two putative class action complaints were filed by putative plaintiffs against the Company and certain of its current and former officers. *Anarkat v. CVS Health Corp., et al.,* was filed in the U.S. District Court for the Southern District of New York, and *Labourers' Pension Fund of Central and Eastern Canada v. CVS Health Corp., et al.,* was filed in the Supreme Court of the State of New York, County of New York. The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit, which allegedly injured investors who acquired CVS Health securities between May 21, 2015 and February 20, 2019. The Company is defending itself against these claims.

Other Legal and Regulatory Proceedings .

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical malpractice, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

12. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information for the three months ended March 31, 2018 has been retrospectively adjusted to conform with the current period presentation. See the reconciliation of consolidated operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

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2019 CVS Health 10-Q Ending June 30

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

FORM 10-Q

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

For the quarterly period ended June 30, 2019
or

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

For the transition period from _____ to_____

Commission File Number: 001-01011

CVS HEALTH CORP ORATION
(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation)	(IRS Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(401) 765-1500**

Former name or former address, if changed since last report: **N/A**

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

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

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

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

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

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

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

There were 1,300,496,722 shares of the registrant's voting common stock with a par value of $0.01 per share outstanding at July 30, 2019 .

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11. Commitments and Contingencies

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of June 30, 2019 , the Company guaranteed approximately 79 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the unaudited condensed consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and one of its subsidiaries (collectively, "Penn Treaty") in rehabilitation, an intermediate action before insolvency, and subsequently petitioned a state court to convert the rehabilitation into a liquidation. Penn Treaty was placed in liquidation in March 2017. The Company has recorded a liability for its estimated share of future assessments by applicable life and health guaranty associations. It is reasonably possible that in the future the Company may record a liability and expense relating to other insolvencies which could have a material adverse effect on the Company's operating results, financial condition and cash flows. While historically the Company has ultimately recovered more than half of guaranty fund assessments through statutorily permitted premium tax offsets, significant increases in assessments could lead to legislative and/or regulatory actions that may limit future offsets.

HMOs in certain states in which the Company does business are subject to assessments, including market stabilization and other risk-sharing pools, for which the Company is assessed charges based on incurred claims, demographic membership mix and other factors. The Company establishes liabilities for these assessments based on applicable laws and regulations. In certain states, the ultimate assessments the Company pays are dependent upon the Company's experience relative to other entities subject to the assessment, and the ultimate liability is not known at the financial statement date. While the ultimate amount of the assessment is dependent upon the experience of all pool participants, the Company believes it has adequate reserves to cover such assessments.

Litigation and Regulatory Proceedings

The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. In June 2019, the Company and the Texas Attorney General commenced a civil jury trial in the *qui tam* action. Prior to the conclusion of that trial, the parties reached a settlement in principle on the remaining issues.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. In June 2019, the Ninth Circuit reversed the District Court's granting of summary judgment and reversed the District Court's narrowing of the requested class. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Circuit Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi, originally in the Chancery Court, but later transferred to the Circuit Court. The complaint alleged that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In June 2019, the Company's motion for judgment on the pleadings was granted in part and denied in part. Also in June 2019, the State of Mississippi's motion to dismiss the Company's counterclaim for declaratory relief was granted. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

Bewley, et al. v. *CVS Health Corporation* , et al. and *Prescott* , et al. v. *CVS Health Corporation* , et al. (both pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases allege that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims are made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases have been transferred to the U.S. District Court for the District of New Jersey on defendants' motions. In April 2019, the named plaintiffs in both the *Bewley* and *Prescott* cases voluntarily dismissed all of their claims without prejudice, ending both cases.

Klein , et al. v. *Prime Therapeutics* , et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation* . The Company is defending itself against these claims.

The Company has received subpoenas, CIDs, and other requests for documents and information from, and is being investigated by, Attorneys General of several states regarding its PBM practices, including pricing and rebates. In addition, the Company received an inquiry from the U.S. Senate Committee on Finance regarding insulin pricing. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). In some instances, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served the Company with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Omnicare pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Omnicare pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the trial arbitrator awarded the claimant hospitals approximately $150 million . Aetna appealed the trial arbitrator's decision. On March 28, 2019, the appellate arbitrator reduced the award to approximately $86 million . The proceeding has ended. During the six months ended June 30, 2019 , the Company recorded the reduction in the required reserve amount for this proceeding as a measurement period adjustment to its Aetna Acquisition accounting and recorded a reduction to goodwill.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

The United States Centers for Medicare & Medicaid Services ("CMS") regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be

selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange related or other audits by CMS, the OIG, the United States Department of Health and Human Services or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the United States Department of Justice (the "DOJ") in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. The consent decree remains subject to the court approval process under the Antitrust Procedures and Penalties Act, which could result in a revision in or delay in receiving approval of the consent decree. The approval process is for the limited purpose of determining whether the consent decree is in the public interest. The Company believes that the consent decree will not have a material impact on the Company's operating results, cash flows or financial condition.

Shareholder Matters

Between February and June 2019, five class action complaints were filed by putative plaintiffs against the Company and certain current and former officers and directors: *Anarkat v. CVS Health Corp., et al.,* Case No. 1:19-cv-01725 (S.D.N.Y.);
Labourers' Pension Fund of Central and Eastern Canada v. CVS Health Corp., et al., Case No. 651700/2019 (N.Y. Sup. Ct.);
City of Warren Police and Fire Retirement Sys.v. CVS Health Corp., et. al. , Case No. PC-2019-5658 (R.I. Super. Ct.); *Cambria Co. Employees Retirement Sys. v. CVS Health Corp., et al.* , Case No. 653223/2019 (N.Y. Sup. Ct.); and *Freundlich v. CVS Health Corp., et al* ., Case No. PC-2019-6685 (R.I. Super. Ct.). The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit, which allegedly injured investors who acquired CVS Health securities between May 21, 2015 and February 20, 2019. The *Freundlich* case also alleges that defendants misrepresented anticipated synergies of the Aetna Acquisition. The Company is defending itself against these claims.

Other Legal and Regulatory Proceedings .

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, all arising in the ordinary course of its businesses. These other legal proceedings include claims of or relating to bad faith, medical or professional malpractice, claims processing, dispensing, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or

delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

12. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (loss) (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information for the three and six months ended June 30, 2018 has been retrospectively adjusted to conform with the current period presentation. See the reconciliation of consolidated operating income (loss) (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income (loss) in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

2019 CVS Health 10-Q Ending September 30

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

FORM 10-Q

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

For the quarterly period ended September 30, 2019
or

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

For the transition period from _____ to_____

Commission File Number: 001-01011

CVS HEALTH CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	**05-0494040**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(401) 765-1500**

Former name, former address and former fiscal year, if changed since last report: **N/A**

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.01 per share	CVS	New York Stock Exchange

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

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

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

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

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

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

As of October 29, 2019, the registrant had 1,300,964,007 shares of common stock issued and outstanding.

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12. Commitments and Contingencies

Lease Guarantees

Between 1995 and 1997, the Company sold or spun off a number of subsidiaries, including Bob's Stores and Linens 'n Things, each of which subsequently filed for bankruptcy, and Marshalls. In many cases, when a former subsidiary leased a store, the Company provided a guarantee of the former subsidiary's lease obligations. When the subsidiaries were disposed of and accounted for as discontinued operations, the Company's guarantees remained in place, although each initial purchaser agreed to indemnify the Company for any lease obligations the Company was required to satisfy. If any of the purchasers or any of the former subsidiaries fail to make the required payments under a store lease, the Company could be required to satisfy those obligations. As of September 30, 2019, the Company guaranteed approximately 79 such store leases (excluding the lease guarantees related to Linens 'n Things, which have been recorded as a liability on the unaudited condensed consolidated balance sheet), with the maximum remaining lease term extending through 2029.

Guaranty Fund Assessments, Market Stabilization and Other Non-Voluntary Risk Sharing Pools

Under guaranty fund laws existing in all states, insurers doing business in those states can be assessed (in most states up to prescribed limits) for certain obligations of insolvent insurance companies to policyholders and claimants. The life and health insurance guaranty associations in which the Company participates that operate under these laws respond to insolvencies of long-term care insurers as well as health insurers. The Company's assessments generally are based on a formula relating to the Company's health care premiums in the state compared to the premiums of other insurers. Certain states allow assessments to be recovered over time as offsets to premium taxes. Some states have similar laws relating to HMOs and/or other payors such as not-for-profit consumer-governed health plans established under the ACA.

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The Company is a party to numerous legal proceedings, investigations, audits and claims arising, for the most part, in the ordinary course of its businesses, including the matters described below. The Company records accruals for outstanding legal matters when it believes it is probable that a loss will be incurred and the amount can be reasonably estimated. The Company evaluates, on a quarterly basis, developments in legal matters that could affect the amount of any accrual and developments that would make a loss contingency both probable and reasonably estimable. If a loss contingency is not both probable and reasonably estimable, the Company does not establish an accrued liability. None of the Company's accruals for outstanding legal matters are material individually or in the aggregate to the Company's financial condition.

Except as otherwise noted, the Company cannot predict with certainty the timing or outcome of the legal matters described below, and the Company is unable to reasonably estimate a possible loss or range of possible loss in excess of amounts already accrued for these matters. It is reasonably possible that the outcome of such legal matters could be material to the Company.

Usual and Customary Litigation

The Company is named as a defendant in a number of litigations that allege that the Company's retail stores overcharged for prescription drugs by not providing the correct usual and customary charge.

State of Texas ex rel. *Myron Winkelman and Stephani Martinson,* et al. *v. CVS Health Corporation* (Travis County Texas District Court). In February 2012, the Attorney General of the State of Texas issued Civil Investigative Demands ("CIDs") to the Company and subsequently has issued a series of requests for documents and information in connection with its investigation concerning the CVS Health Savings Pass program and other pricing practices with respect to claims for reimbursement from the Texas Medicaid program. In January 2017, the Travis County Court unsealed a first amended *qui tam* petition filed in April 2014. The government has intervened in this case. The amended petition alleges the Company violated the Texas Medicaid Fraud Prevention Act by submitting false claims for reimbursement to the Texas Medicaid program by, among other things, failing to use the price available to members of the CVS Health Savings Pass program as the pharmacies' usual and customary price. The amended petition was unsealed following the Company's December 2016 filing of *CVS Pharmacy, Inc. v. Charles Smith,* et al. (Travis County Texas District Court), a declaratory judgment action against the State of Texas seeking a declaration that the prices charged to members of the CVS Health Savings Pass program do not constitute usual and customary prices under the applicable Medicaid regulation. In March 2018, the Travis County Court denied the State of Texas's request for temporary injunctive relief. In June 2019, the Company and the Texas Attorney General commenced a civil jury trial in the *qui tam* action. Prior to the conclusion of that trial, the parties reached a settlement in principle on the remaining issues.

Corcoran et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of California) and *Podgorny* et al. *v. CVS Health Corporation* (U.S. District Court for the Northern District of Illinois). These putative class actions were filed against the Company in July and September 2015. The cases were consolidated in the U.S. District Court for the Northern District of California. Plaintiffs seek damages and injunctive relief under the consumer protection statutes and common laws of certain states on behalf of a class of consumers who purchased certain prescription drugs. Several third-party payors filed similar putative class actions on behalf of payors captioned *Sheet Metal Workers Local No. 20 Welfare and Benefit Fund v. CVS Health Corp.* and *Plumbers Welfare Fund, Local 130 v. CVS Health Corporation* (both pending in the U.S. District Court for the District of Rhode Island) in February and August 2016. In all of these cases the plaintiffs allege the Company overcharged for certain prescription drugs by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In the *Corcoran* case, the U.S. District Court granted summary judgment to CVS on plaintiffs' claims in their entirety and certified certain subclasses in September 2017. In June 2019, the U.S. Court of Appeals for the Ninth Circuit reversed the District Court's grant of summary judgment and reversed the District Court's narrowing of the requested class. The *Corcoran* case is now proceeding to a trial on a class basis. The *Sheet Metal Workers* plaintiffs have amended their complaint to assert a claim under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO") premised on an alleged conspiracy between the Company and other PBMs. The Company is defending itself against these claims.

State of California ex rel. *Matthew Omlansky v. CVS Caremark Corporation* (Superior Court of the State of California, County of Sacramento). In April 2016, the California Superior Court unsealed a first amended *qui tam* complaint filed in July 2013. The government has declined to intervene in this case. The relator alleges that the Company submitted false claims for payment to the California Medicaid program in connection with reimbursement for drugs available through the CVS Health Savings Pass program as well as certain other generic drugs. The case has been stayed pending the relator's appeal of the judgment against him in a similar case against another retailer. The Company is defending itself against these claims.

State of Mississippi v. CVS Health Corporation, et al. (Circuit Court of DeSoto County, Mississippi, Third Judicial District). In July 2016, the Company was served with a complaint filed on behalf of the State of Mississippi, originally in the Chancery Court, but later transferred to the Circuit Court. The complaint alleged that CVS retail pharmacies in Mississippi submitted false claims for reimbursement to the Mississippi Medicaid program by not submitting the price available to members of the CVS Health Savings Pass program as the pharmacy's usual and customary price. In June 2019, the Company's motion for judgment on the pleadings was granted in part and denied in part. Also in June 2019, the State of Mississippi's motion to dismiss the Company's counterclaim for declaratory relief was granted. The Company is defending itself against these claims.

PBM Litigation and Investigations

The Company is named as a defendant in a number of lawsuits and is subject to a number of investigations concerning its PBM practices.

Bewley, et al. v. *CVS Health Corporation*, et al. and *Prescott*, et al. v. *CVS Health Corporation*, et al. (both previously pending in the U.S. District Court for the Western District of Washington). These putative class actions were filed against the Company and other PBMs and manufacturers of glucagon kits (*Bewley*) and diabetes test strips (*Prescott*) in May 2017. Both cases alleged that, by contracting for rebates with the manufacturers of these diabetes products, the Company and other PBMs caused list prices for these products to increase, thereby harming certain consumers. The plaintiffs' primary claims were made under federal antitrust laws, RICO, state unfair competition and consumer protection laws and the federal Employee Retirement Income Security Act of 1974 ("ERISA"). Both of these cases were transferred to the U.S. District Court for the District of New Jersey on defendants' motions. In April 2019, the named plaintiffs in both the *Bewley* and *Prescott* cases voluntarily dismissed all of their claims without prejudice, ending both cases.

Klein, et al. v. *Prime Therapeutics*, et al. (U.S. District Court for the District of Minnesota). This putative class action was filed against the Company and other PBMs in June 2017 on behalf of ERISA plan members who purchased and paid for EpiPen or EpiPen Jr. Plaintiffs allege that the PBMs are ERISA fiduciaries to plan members and have violated ERISA by allegedly causing higher inflated prices for EpiPens through the process of negotiating increased rebates from EpiPen manufacturer Mylan. This case has been consolidated with a similar matter and is now proceeding as *In re EpiPen ERISA Litigation*. The Company is defending itself against these claims.

The Company has received subpoenas, CIDs, and other requests for documents and information from, and is being investigated by, Attorneys General of several states regarding its PBM practices, including pricing and rebates. In addition, the Company received an inquiry from the U.S. Senate Committee on Finance regarding insulin pricing. The Company has been providing documents and information in response to these subpoenas, CIDs and requests for information.

Controlled Substances Litigation, Audits and Subpoenas

In December 2017, the U.S. Judicial Panel on Multidistrict Litigation consolidated numerous cases filed against various defendants by plaintiffs such as counties, cities, hospitals, Indian tribes and third-party payors, alleging claims generally concerning the impacts of widespread opioid abuse. The consolidated multidistrict litigation captioned *In re National Prescription Opiate Litigation* (MDL No. 2804) is pending in the U.S. District Court for the Northern District of Ohio. This multidistrict litigation presumptively includes hundreds of relevant federal court cases that name the Company as a defendant. A significant number of similar cases that name the Company as a defendant in some capacity are pending in state courts. In addition, the Company has been named as a defendant in similar cases brought by certain state Attorneys General. The Company is defending itself against all such claims. Additionally, the Company has received subpoenas, CIDs and/or other requests for information regarding opioids from the Attorneys General and insurance and other regulators of several states. The Company has been cooperating with the government with respect to these subpoenas, CIDs and other requests for information.

The Company routinely is audited by the United States Drug Enforcement Administration ("DEA"). In some instances, the Company is in discussions with the DEA and U.S. Attorney's Offices concerning allegations that the Company violated certain requirements of the Controlled Substance Act.

In September 2015, the DEA served the Company with an administrative subpoena. The subpoena seeks documents related to controlled substance policies, procedures and practices at eight Omnicare pharmacy locations from May 2012 to the present. In September 2017, the DEA expanded the investigation to include an additional Omnicare pharmacy location. The Company has been cooperating with the government and providing documents and witnesses in response to this subpoena.

Prescription Processing Investigations

In October 2015, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning the Company's Omnicare pharmacies' cycle fill process for assisted living facilities. The Company has been cooperating with the government and providing documents and information in response to this CID. In July 2017, the Company also received a subpoena from the California Department of Insurance requesting documents concerning similar subject matter. The Company has been cooperating with the California Department of Insurance and providing documents and information in response to this subpoena.

In December 2016, the Company received a CID from the U.S. Attorney's Office for the Northern District of New York requesting documents and information in connection with a federal False Claims Act investigation concerning whether the Company's retail pharmacies improperly submitted certain insulin claims to Part D of the Medicare program rather than Part B of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to this CID.

In May 2017, the Company received a CID from the U.S. Attorney's Office for the Southern District of New York requesting documents and information concerning possible false claims submitted to Medicare in connection with reimbursements for prescription drugs under the Medicare Part D program. The Company has been cooperating with the government and providing documents and information in response to this CID.

Provider Proceedings

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the payment of claims for services rendered to its members by health care providers with whom the Company has a contract and with whom the Company does not have a contract ("out-of-network providers"). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits (including the Company's post payment audit and collection practices and reductions in payments to providers due to sequestration). Other major health insurers are the subject of similar litigation or have settled similar litigation.

On October 28, 2016, Aetna was named as a respondent in an arbitration proceeding that had commenced as a lawsuit in Florida state court on August 25, 2015. The arbitration proceeding was brought by hospitals owned by HCA Holdings, Inc. with respect to Aetna's out-of-network benefit payment and administration practices in Florida relating to services and care rendered to members in Aetna's individual Public Exchange products from 2014 through 2016. Coverage under Aetna's individual Public Exchange products in Florida was not available after December 31, 2016. On October 15, 2018, the trial arbitrator awarded the claimant hospitals approximately $150 million. Aetna appealed the trial arbitrator's decision. On March 28, 2019, the appellate arbitrator reduced the award to approximately $86 million. The proceeding has ended. During the nine months ended September 30, 2019, the Company recorded the reduction in the required reserve amount for this proceeding as a measurement period adjustment to its Aetna Acquisition accounting and recorded a reduction to goodwill.

The Company also has received subpoenas and/or requests for documents and other information from, and been investigated by, Attorneys General and other state and/or federal regulators, legislators and agencies relating to, and the Company is involved in other litigation regarding, its out-of-network benefit payment and administration practices. It is reasonably possible that others could initiate additional litigation or additional regulatory action against the Company with respect to its out-of-network benefit payment and/or administration practices.

CMS Actions

The United States Centers for Medicare & Medicaid Services ("CMS") regularly audits the Company's performance to determine its compliance with CMS's regulations and its contracts with CMS and to assess the quality of services it provides to Medicare beneficiaries. CMS uses various payment mechanisms to allocate and adjust premium payments to the Company's and other companies' Medicare plans by considering the applicable health status of Medicare members as supported by information prepared, maintained and provided by health care providers. The Company collects claim and encounter data from providers and generally relies on providers to appropriately code their submissions to the Company and document their medical records, including the diagnosis data submitted to the Company with claims. CMS pays increased premiums to Medicare Advantage plans and Medicare PDP plans for members who have certain medical conditions identified with specific diagnosis codes. Federal regulators review and audit the providers' medical records to determine whether those records support the related diagnosis codes that determine the members' health status and the resulting risk-adjusted premium payments to the Company. In that regard, CMS has instituted risk adjustment data validation ("RADV") audits of various Medicare Advantage plans, including certain of the Company's plans, to validate coding practices and supporting medical record documentation maintained by health care providers and the resulting risk adjusted premium payments to the plans. CMS may require the Company to refund premium payments if the Company's risk adjusted premiums are not properly supported by medical record data. The Office of Inspector General (the "OIG") also is auditing the Company's risk adjustment-related data and that of other companies. The Company expects CMS and the OIG to continue these types of audits.

In 2012, CMS revised its audit methodology for RADV audits to determine refunds payable by Medicare Advantage plans for contract year 2011 and forward. Under the revised methodology, among other things, CMS will project the error rate identified

in the audit sample of approximately 200 members to all risk adjusted premium payments made under the contract being audited. For contract years prior to 2011, CMS did not project sample error rates to the entire contract. As a result, the revised methodology may increase the Company's exposure to premium refunds to CMS based on incomplete medical records maintained by providers. Since 2013, CMS has selected certain of the Company's Medicare Advantage contracts for various contract years for RADV audit. The Company is currently unable to predict which of its Medicare Advantage contracts will be selected for future audit, the amounts of any retroactive refunds of, or prospective adjustments to, Medicare Advantage premium payments made to the Company, the effect of any such refunds or adjustments on the actuarial soundness of the Company's Medicare Advantage bids, or whether any RADV audit findings would require the Company to change its method of estimating future premium revenue in future bid submissions to CMS or compromise premium assumptions made in the Company's bids for prior contract years, the current contract year or future contract years. Any premium or fee refunds or adjustments resulting from regulatory audits, whether as a result of RADV, Public Exchange-related or other audits by CMS, the OIG, the United States Department of Health and Human Services or otherwise, including audits of the Company's minimum MLR rebates, methodology and/or reports, could be material and could adversely affect the Company's operating results, financial condition and/or cash flows.

Medicare CIDs

The Company has received CIDs from the Civil Division of the United States Department of Justice (the "DOJ") in connection with a current investigation of the Company's patient chart review processes in connection with risk adjustment data submissions under Parts C and D of the Medicare program. The Company has been cooperating with the government and providing documents and information in response to these CIDs.

Tunney Act Proceeding

On October 10, 2018, the Company and Aetna entered into a consent decree with the DOJ that allowed CVS Health's proposed acquisition of Aetna to proceed, provided Aetna agreed to sell its individual standalone Medicare Part D prescription drug plans. As permitted by the asset preservation stipulation and order dated October 25, 2018, CVS Health completed its acquisition of Aetna on November 28, 2018, and Aetna completed the sale of such plans on November 30, 2018. On September 4, 2019, the United States District Court for the District of Columbia (the "D.C. District Court") entered a final order that concluded the court approval process for the consent decree under the Antitrust Procedures and Penalties Act. The final order was issued without conditions. No further action is required by the D.C District Court, the DOJ or any other entity with regard to CVS Health's acquisition of Aetna.

Shareholder Matters

Between February and August 2019, six class action complaints were filed by putative plaintiffs against the Company and certain current and former officers and directors: *Anarkat v. CVS Health Corp., et al.,* Case No. 1:19-cv-00437 (U.S. District Court for the District of Rhode Island); *Labourers' Pension Fund of Central and Eastern Canada v. CVS Health Corp., et al.,* Case No. 651700/2019 (New York Supreme Court); *City of Warren Police and Fire Retirement Sys.v. CVS Health Corp., et. al.*, Case No. PC-2019-5658 (Rhode Island Superior Court); *Cambria Co. Employees Retirement Sys. v. CVS Health Corp., et al.*, Case No. 653223/2019 (New York Supreme Court); *Freundlich v. CVS Health Corp., et al*., Case No. PC-2019-6685 (Rhode Island Superior Court); and *Waterford Twp. Police & Fire Retirement Sys. v. CVS Health Corp., et al.,* Case No. 19-cv-00434 (U.S. District Court for the District of Rhode Island). The plaintiffs in these cases assert a variety of causes of action under federal securities laws that are premised on allegations that the defendants made certain omissions and misrepresentations relating to the performance of the Company's LTC business unit, which allegedly injured investors who acquired CVS Health securities between February 9, 2016 and February 20, 2019. The *Freundlich* case also alleges that defendants misrepresented anticipated synergies of the Aetna Acquisition. The Company is defending itself against these claims.

Other Legal and Regulatory Proceedings

The Company is also a party to other legal proceedings and is subject to government investigations, inquiries and audits and has received and is cooperating with the government in response to CIDs, subpoenas or similar process from various governmental agencies requesting information, arising, for the most part, in the ordinary course of its businesses. These other legal proceedings and government actions include claims of or relating to bad faith, medical or professional malpractice, claims processing, dispensing of medications, non-compliance with state and federal regulatory regimes, marketing misconduct, failure to timely or appropriately pay or administer claims and benefits, provider network structure (including the use of performance-based networks and termination of provider contracts), rescission of insurance coverage, improper disclosure or use of personal information, anticompetitive practices, general contractual matters, product liability, intellectual property litigation and

employment litigation. Some of these other legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Awards to the Company and others of certain government contracts, particularly Medicaid contracts and other contracts with government customers in the Company's Health Care Benefits segment, are subject to increasingly frequent protests by unsuccessful bidders. These protests may result in awards to the Company being reversed, delayed or modified. The loss or delay in implementation of any government contract could adversely affect the Company's operating results. The Company will continue to defend contract awards it receives.

There also continues to be a heightened level of review and/or audit by regulatory authorities and legislators of, and increased litigation regarding, the Company's and the rest of the health care and related benefits industry's business and reporting practices, including premium rate increases, utilization management, development and application of medical policies, complaint, grievance and appeal processing, information privacy, provider network structure (including provider network adequacy, the use of performance-based networks and termination of provider contracts), provider directory accuracy, calculation of minimum medical loss ratios and/or payment of related rebates, delegated arrangements, rescission of insurance coverage, limited benefit health products, student health products, pharmacy benefit management practices (including manufacturers' rebates, pricing, the use of narrow networks and the placement of drugs in formulary tiers), sales practices, customer service practices, vendor oversight and claim payment practices (including payments to out-of-network providers).

As a leading national health care company, the Company regularly is the subject of government actions of the types described above. These government actions may prevent or delay the Company from implementing planned premium rate increases and may result, and have resulted, in restrictions on the Company's businesses, changes to or clarifications of the Company's business practices, retroactive adjustments to premiums, refunds or other payments to members, beneficiaries, states or the federal government, withholding of premium payments to the Company by government agencies, assessments of damages, civil or criminal fines or penalties, or other sanctions, including the possible suspension or loss of licensure and/or suspension or exclusion from participation in government programs.

The Company can give no assurance, however, that its businesses, financial condition, operating results and/or cash flows will not be materially adversely affected, or that the Company will not be required to materially change its business practices, based on: (i) future enactment of new health care or other laws or regulations; (ii) the interpretation or application of existing laws or regulations as they may relate to one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iii) pending or future federal or state governmental investigations of one or more of the Company's businesses, one or more of the industries in which the Company competes and/or the health care industry generally; (iv) pending or future government audits, investigations or enforcement actions against the Company; (v) adverse developments in any pending *qui tam* lawsuit against the Company, whether sealed or unsealed, or in any future *qui tam* lawsuit that may be filed against the Company; or (vi) adverse developments in pending or future legal proceedings against the Company or affecting one or more of the industries in which the Company competes and/or the health care industry generally.

13. Segment Reporting

The Company has three operating segments, Pharmacy Services, Retail/LTC and Health Care Benefits, as well as a Corporate/Other segment. The Company's segments maintain separate financial information, and the CODM evaluates the segments' operating results on a regular basis in deciding how to allocate resources among the segments and in assessing segment performance. The CODM evaluates the performance of the Company's segments based on adjusted operating income. Effective for the first quarter of 2019, adjusted operating income is defined as operating income (GAAP measure) excluding the impact of amortization of intangible assets and other items, if any, that neither relate to the ordinary course of the Company's business nor reflect the Company's underlying business performance. Segment financial information for the three and nine months ended September 30, 2018 has been retrospectively adjusted to conform with the current period presentation. See the reconciliation of consolidated operating income (GAAP measure) to adjusted operating income below for further context regarding the items excluded from operating income in determining adjusted operating income. The Company uses adjusted operating income as its principal measure of segment performance as it enhances the Company's ability to compare past financial performance with current performance and analyze underlying business performance and trends. Non-GAAP financial measures the Company discloses, such as consolidated adjusted operating income, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

Attachment I

Kentucky | Transforming Health Care | **Aetna**

Jonathan E. Copley, JD

Chief Executive Officer (CEO)

Jonathan ("Jon") E. Copley, JD, is a fifth-generation Kentuckian and the only managed care organization (MCO) CEO in Kentucky that has MCO, provider, and Cabinet for Health & Family Services leadership experience in Kentucky. During his 13 years of Medicaid experience and his 16 years of health care industry experience, Jon has been a member of the leadership team for three MCOs in the state and led two of them. Jon currently serves as the CEO of Aetna Better Health of Kentucky (ABHKY) where he is responsible for delivering on all state contractual requirements of the more than $1 billion Medicaid health plan with nearly 220,000 members. Additionally, he provides direction and oversight to more than 200 directly reporting staff. Under his leadership, ABHKY has achieved the top health plan rating in Kentucky by National Committee for Quality Assurance (NCQA) along with an accreditation status of Commendable. Prior to joining ABHKY, Jon held executive-level positions for a number of other health plans including Aetna Better Health of Missouri, Nebraska, and Oklahoma, CareSource, and Centene. Prior to his experience working at health plans, Jon served in senior leadership roles in both the private and public sector, including corporate counsel and external affairs director of the Bluegrass Regional Mental Health Board and acting undersecretary and chief administrative officer as well as the executive director and chief contract and procurement officer in the Commonwealth of Kentucky's Cabinet for Health and Family Services. Most recently, Jon was appointed as Chairman of the Kentucky Chamber of Commerce's Opioid Task Force and is a longtime member of the Kentucky Bar Association and the University of Kentucky Fellows Society. He earned his Juris Doctor from the University of Kentucky, College of Law in Lexington, Kentucky and undergraduate degree from Campbellsville University in Campbellsville, Kentucky.

Experience

Aetna Inc., a CVS Health Company 2015 – Present

Chief Executive Officer, Aetna Better Health of Kentucky, Louisville, KY (2017 – Present)

- Accountable for local market performance and the P&L responsibility for the $1B+ Medicaid health plan with approximately 211,000 members and more than 200 direct reports
- Responsible for executive leadership and the overall direction and strategy for the health plan, including financial stability, operational performance, and compliance with all policies and contractual requirements
- Attained state contract renewal for 2018 and 2019 that was explicitly at risk of non-renewal
- Delivered financial results in line with operating plan for each of the 7 quarters to date
- Reduced corrective actions plans with the State from 15 to 0 in less than one year
- Decreased formal provider issues, including a reduction from 36 to 0 with key provider group (Kentucky Hospital Association), moving from the least preferred payer to one of the most preferred
- Earned the State's top NCQA Health Plan Rating overall and a 'Commendable' accreditation status
- Received an Aetna ABX (Achieving Business Excellence) Quarterly Distinction Award
- Led multiple key segment-wide change initiatives, including the creation of a provider experience model
- Kentucky plan achieved highest increases year-over-year in positive results in annual employee engagement survey
- Named to Kentucky Chamber of Commerce Board of Directors

Jonathan E. Copley, JD

- Membership: 211,000; population: Temporary Assistance for Needy Families (TANF), Children's Health Insurance Program (CHIP), Affordable Care Act (ACA), and Supplemental Security Income (SSI)

Chief Executive Officer, Aetna Better Health of Oklahoma, Oklahoma City, Oklahoma (2017)

- Engaged with Medicaid segment Business Development team in the first quarter of 2017 to provide local health plan leadership for development activities and Oklahoma Sooner Health+ RFP process
- Named as proposed health plan CEO and local accountable party for potential contract with the Oklahoma Health Care Authority
- Responsible for executive leadership and the overall direction and strategy for the health plan, including financial stability, operational performance, and compliance with all policies and contractual requirements
- Led Aetna's oral presentation to the State reviewers, resulting in the top score amongst bidders

Acting Chief Executive Officer, Aetna Better Health of Missouri, St. Louis, MO (2016 – 2017)

- Assumed local leadership of the 280,000-member health plan in November of 2016 following unexpected negative RFP result and departure of CEO and CMO
- Maintained staff engagement and delivered on State contractual requirements through April 30, 2017 and during the run-out period into 2018
- Implemented what Aetna Humana Resources described as best practice in a multi-pronged collaborative process across Aetna to retain top talent within the company (100+ team members were re-deployed)
- Responsible for executive leadership and the overall direction and strategy for the health plan, including financial stability, operational performance, and compliance with all policies and contractual requirements
- Membership: 280,000
- Population: TANF, CHIP, and children in foster care

Chief Executive Officer, Aetna Better Health of Nebraska, Omaha, NE (2015 – 2016)

- Joined Aetna at the end of September 2015 to lead 105,000+ member health plan with accountability for local market performance, including the P&L responsibility for $500M+ and nearly 100 directly reporting staff
- Produced financial results in 2016 more than 150% ahead of the annual plan operating margin target
- Drove continuous improvement in the Medical Management department with the best results in the plan's five-year history
- Achieved both a commendable rating from NCQA and a perfect score on annual EQRO review
- Successfully wound down operations at the end of 2016 after negative RFP outcome and oversaw the run-out period into 2018
- Led CEO team, Community of Practice, for nearly 15 months with most engagement in years
- Responsible for executive leadership and the overall direction and strategy for the health plan, including financial stability, operational performance, and compliance with all policies and contractual requirements
- Membership: 105,000
- Population: Aged, Blind, and Disabled, SSI, TANF, CHIP, and children in foster care

CareSource Kentucky, Louisville, KY 2013 – 2015

CareSource Management Group, Dayton, OH

Corporate Vice President and Executive Director, Kentucky Market

- Accounted for local market performance and the P&L of a more than $700 million Medicaid health plan with more than 115,000 members and the Just4Me Qualified Health Plan (QHP) product launched on January 1, 2015
- Acted as liaison between CareSource and strategic alliance partner, Humana
- Directed and led more than 50 Kentucky-based operations, clinical, and regulatory staff, in addition to dozens of corporate dual-reporting staff
- Advanced strong and effective relationships with Kentucky providers, regulators, advocates, trade associations, and community leaders
- Began development of Medicare Advantage product and sales operations for the 2015-2016 launch
- Managed the successful startup of the Medicaid health plan in Q1 of 2013 and Just4Me QHP in Q1 of 2015
- Developed and led the marketing and organic growth of the Medicaid plan from 15,000 to 95,000 members in one year
- Exceeded financial revenue and margin targets in each of the first 11 quarters of Medicaid plan operation
- Achieved the highest employee engagement ratings within CareSource, considerably surpassing national averages
- Established positive relationships with both providers and members in start-up, as evidenced in CAHPS® survey results

Kentucky Spirit Health Plan, Lexington, KY 2012 – 2013

Centene Corporation, St. Louis, MO

Director of Plan Operations and Director of External Affairs and Marketing

- Reported to plan president and CEO; led development and execution of short- and long-term strategic objectives throughout the plan, including continued start-up activities and potential wind-down actions
- Integrated complex business, technical, and clinical processes across the organization
- Managed external and legislative affairs efforts and supervised marketing and communications activities and staff
- Using Baldridge quality standards, worked with each department in developing methods to quantify outcomes and generate opportunities for savings and growth
- Directed medical cost management initiatives across all functional areas; advanced business excellence initiatives
- Provided consultation to Regulatory, Finance, and Provider Contracting staff
- Advanced from directing plan operations to additional responsibilities for external affairs, marketing, communications, business excellence, and project management within six months
- Selected to lead marketplace exploration and development in Kentucky

Bluegrass Regional Mental Health Board, Lexington, KY 2008 – 2012

Corporate Counsel, Executive Operations Liaison, and External Affairs Director

- Administered all legal affairs for the Bluegrass region's community mental health services, intellectual and developmental disabilities services, and substance abuse services spanning 17 counties
- Oversaw corporate law, labor and employment, workers' compensation, and insurance defense functions

Jonathan E. Copley, JD

- Managed local, state, and federal government relations and regulatory affairs
- Performed administrative risk analysis, resolved problems, and ensured corporate compliance
- Developed and analyzed public policies and mitigated risk
- Orchestrated external affairs and alliances with all levels of government, nonprofit agencies, educational institutions, and advocacy groups
- Acted as chief counsel to president and CEO and board of directors on all legal analysis, government affairs, and public relations
- Served as liaison between three companies and several departments within each company, communicating and resolving administrative operations issues
- Represented president and CEO in her absence, including at a statewide trade organization meeting and Kentucky Mental Health Coalition
- Led the development and implementation of a central triage center for serious mental health crises, which was the first in the State of Kentucky and included serving as liaison between community partners, police officers, and judges to ensure regulatory compliance and local support
- Improved communication and transparency between hospitals by leading efforts to strengthen collaboration with UK HealthCare and implementing uniform processes and standards
- Played key role in facilitating smooth transition to new Medicaid managed care process; negotiated more profitable, cost-effective contracts than many other health care providers throughout State

Kentucky Cabinet for Health and Family Services, Frankfort, KY 2004 – 2008

Acting Undersecretary and Chief Administrative Officer (2006 – 2008)

- Directed daily administrative and fiscal operations, which included 11,000 state and contract staff and a $6.8 billion annual budget
- Led all services related to technology, human resources, procurement, budgeting, accounting, contracts, grants, and facilities management
- Controlled a $64 million budget and supervised more than 500 staff
- Orchestrated the year-long effort to build the cabinet's state biennial budget

Director and Chief Contract and Procurement Officer (2004 – 2008)

- Contributed to merger and subsequent reorganization of the Cabinet for Health Services and the Cabinet for Families and Children
- Supervised up to 50 staff and controlled a $4 million annual budget; served as acting chief administrative officer at Oakwood in 2005
- Appeared monthly before Kentucky Legislature's Government Contract Review Committee
- Championed development of new agency and system to centrally manage cabinet's contracting, procurement, and grants acquisition services
- Accelerated processes by 20%, improved efficiency, and reduced costs by millions of dollars through better managing and combining contracts
- Directed administrative aspect of Medicaid modernization, including coordinating procurement and negotiations of pharmacy, information systems, and disease management contracts totaling more than $200 million

Education

- Juris Doctor, University of Kentucky College of Law, 2003
- Bachelor of Science, Business Marketing and Marketing Management (Honors), Campbellsville University, 1998

Licensures and Certifications

Member, Kentucky Bar Association; licensed to practice law in Kentucky (License # 89798)

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Paige E. Mankovich, Esq.

Acting Chief Operating Officer

Paige E. Mankovich, Esq. is an executive with unparalleled business acumen and success in the areas government affairs and compliance. She is a native Kentuckian with two years of health care industry experience and two years of managed Medicaid experience. Her expertise includes strategic and tactical planning, cross-functional leadership, risk analysis and mitigation, business intelligence, and regulatory compliance. In her role as chief operations officer for Aetna Better Health of Kentucky, Paige is an analytical professional possessing a record of achievement optimizing efficiencies and controlling costs, improving operations, ensuring compliance, and resolving issues. She is responsible for employees in Enrollee Services, Community Development, Operations Management, the Project Management Office, Network Operations, Provider Relations, Contracting, Informatics, and Grievances and Appeals. Prior to joining Aetna, Paige served as the Corporate Counsel for Compliance and Government Affairs for Kentucky Employers' Mutual Insurance, where she facilitated the procurement program by providing counsel on the entire procurement process from drafting the RFP to award of contract and served as liaison to the state and national trade associations. Her educational background includes a Juris Doctorate from the University of Kentucky College of Law and a Bachelor of Science in Accounting from the University of Kentucky where she graduated Magna Cum Laude.

Experience

Aetna Better Health of Kentucky, a CVS Health Company 2017 – Present

Acting Chief Operating Officer (2019 – Present)

- Serve as a key member of the leadership team in the Kentucky Medicaid managed care plan. Oversee operations for 211,000-member statewide Medicaid managed care organization that generates 1 billion in annual revenue. Provides strategic and tactical leadership to network management, claims, provider services, grievances and appeals, enrollee services, reporting, and implementation of new programs
- Develops, monitors and reviews performance reports and service performance trends and recommends specific actions or remedies as necessary
- Develops and maintains strong collaborative relationships within operations as well as with medical management, quality, and compliance
- Develops, trains, evaluates, and coaches staff to provide cost effective claim processing and claim and customer service while ensuring that quality standards are met
- Responsible for implementing ABX (Achieving Business Excellence) techniques and optimization tools

*Chief of Staff/Director of Strategic Planning (*2018 – 2019)

- Reports directly to the Kentucky Medicaid health plan CEO and serve on the executive leadership team of the $1B+ Medicaid health plan with 211,000 members, having overseen the reduction of the number of open issues on the Kentucky Hospital Association log from 35 to 0, the reduction of state corrective actions from 15 to 0, and achievement of an National Committee for Quality Assurance commendable health plan rating and best in class consumer satisfaction
- Acts as CEO's designee in his absence with Kentucky Department for Medicaid Services, the Kentucky Hospital Association, Kentucky Association of Health plans, legislators, state advisory councils, provider groups, and other external stakeholders

Paige Mankovich, Esq.

- Provides strategic counsel to the CEO regarding health plan operations, working across all internal departments both at the health plan and national level to develop and implement best practices in health services and plan operations
- Advises health plan CEO, CFO, COO, and CMO on end-to-end strategic initiatives
- Leads, develops, executes, and assesses strategic initiatives within Kentucky Medicaid market and Aetna Medicaid organization segment

*Plan Compliance Officer (*2017 – 2018)

- Led, implemented, and maintained compliance program, including risk assessments, monitoring, and maintaining effective compliance policies and procedures
- Independently managed multiple highly complex regulatory interactions, including drafting regulatory correspondence, responding to regulatory inquiries, and negotiating resolution of regulatory matters
- Built and maintained positive, productive relationships with internal and external constituents at the most senior and regulatory organizational levels; drove decision-making and influenced ethical and compliant outcomes necessary to accomplish goals

Kentucky Employers' Mutual Insurance 2014 – 2017

Corporate Counsel for Compliance and Government Affairs (March 2016 – October 2017)

- Facilitated procurement program by providing counsel on the entire procurement process from drafting the RFP to award of contract
- Reviewed, analyzed, and drafted legislation and responses to pending legislation and regulatory amendments, and advised internal business units of potential changes
- Served as liaison to the state and national trade association

Associate Corporate Counsel (May 2014 – March 2016)

- Managed litigated workers compensation claims and directed outside counsel
- Advised claims unit on investigative techniques, recent court decisions, and compensability decisions

Philips Parker Orberson & Arnett, P.L.C. 2012 – 2014

Associate Counsel

Represented insureds in litigation practice

Education

- Juris Doctorate, University of Kentucky College of Law, 2012
- Bachelor of Science in Accounting, University of Kentucky, 2009

Licensures and Certifications

Kentucky Law License (License#: 95190)

Lisa M. Chandler

Chief Financial Officer (CFO)

Lisa Chandler is an experienced executive leader with 28 years of health care industry experience and 9 years of managed Medicaid experience. Her expertise includes oversight of statutory reporting, audits, financial reporting, budget/forecasting, dividend calculations, broker payment processing, federal/state filings, and collaborating with all operational areas. In her role as chief financial officer for Aetna Better Health of Kentucky, Lisa is responsible for oversight of all financial reporting and analysis aspects of the Medicaid health plan. Prior to joining Aetna, Lisa served as the controller for Coventry of Missouri, which was acquired by Aetna and is now part of the CVS Health organization, where she oversaw statutory reporting, audits, financial reporting, budget/forecasting, and accounts payable. Her educational background includes a Bachelor of Science in Accountancy with a minor in Psychology from the University of Missouri-Columbia.

Experience

Aetna Inc., a CVS Health Company 2011 – Present

Chief Financial Officer, Aetna Better Health of Kentucky, Louisville, KY (2011 – Present)

- Responsible for oversight of all financial reporting and analysis aspects of the Medicaid health plan
- May include but not limited to financial reporting (GAAP and statutory), audit, budgeting/forecasting, rate setting, state reporting per our contractual obligations, provider contracting, medical expense trend review, and waiver program

Group Health Plan, Inc., a Coventry Corporation, St. Louis, MO 1999 – 2011

Controller (2006 – 2011)

- Oversaw statutory reporting, audits, financial reporting, budget/forecasting, dividend calculations, broker payment processing, 1099s, accounts payable, treasury functions, federal/state filings, employee commission payments, Medicare bid support, and interaction with all departments of the company to ensure financial stability

Accounting Manager (2001 – 2006)

- Oversaw statutory reporting, financial reporting, audits, treasury functions, accounts payable, capitation, 1099s, broker payment processing, implementations of new products or new groups, and other duties as assigned

Senior Accountant (1999 – 2001)

- Responsible for cash reconciliations, financial reporting, audits, accounts payable, and other duties as assigned

Coventry Corporation, Nashville, TN 1996 – 1999

Project Supervisor – Financial Systems

- Responsible for the complete implementation and maintenance of the financial system including general ledger, accounts payable, asset management, and purchase order over five geographic locations

Lisa M. Chandler

Group Health Plan, Inc., a Coventry Corporation, St. Louis, MO 1992 – 1996

Financial Analyst (1995 – 1996)

- Responsible for all analysis related to pharmacy, provider contracts, administrative costs, and health center expenses; assisted with the budget process

Accounting Analyst (1994 – 1995)

- Coordinated the preparation and analysis of the monthly financial statements, the annual audit, and quarterly reporting to the parent company; prepared Department of Insurance filings; served as the financial system administrator; assisted with the implementation of the claims/capitation and pharmacy system; responsible for completing forms 5500 and 1099s; supervised the accounting support specialist; communicated with all levels of management

Staff Accountant (1992 – 1994)

- Prepared journal entries and completed balance sheet and expense account analysis; maintained the asset management system; completed audit schedules

Education

Bachelor of Science in Accountancy with a minor in Psychology, University of Missouri, 1991

LaRhanda Trammell, MPA-CRJ, MBA-HCM, HCAFA

Chief Compliance Officer

LaRhanda Trammell is a native Kentuckian and knowledgeable compliance executive with 16 years of health care industry experience and 5 years of managed Medicaid experience. Her expertise includes public and private health care operations specifically through the field of auditing, investigations and compliance, and program integrity. In her role as chief compliance officer for Aetna Better Health of Kentucky, LaRhanda is responsible for ensuring that the plan is conducting all their business in full compliance with all state and national laws and regulations that pertain to the health care industry. Prior to joining Aetna, LaRhanda served as the associate director of program integrity for Passport Health Plan, where she managed and directed the Program Integrity (PI) department and developed and implemented internal controls that promoted the prevention of health care fraud, waste, and financial abuse. Her educational background includes a Master of Public Affairs, a Master of Business Administration with a specialization in Health Care Management, and a Bachelor of Science in Business Administration all from Indiana Wesleyan University. LaRhanda is also an adjunct instructor of Healthcare Administration at Indiana Wesleyan University.

Experience

Aetna Inc., a CVS Health Company 2018 – Present

Chief Compliance Officer, Aetna Better Health of Kentucky, Louisville, KY (2011 – Present)

- Ensures the company is conducting its business in full compliance with all national and international laws and regulations that pertain to its industry, as well as professional standards, accepted business practices, and internal standards
- Prepares schedules and timetables for the inspection of management practices
- Develops and implements strategies necessary for minimizing risk of non-compliance
- Responsible for day-to-day operations, planning, and activities of the compliance program
- Responsible for establishing and implementing an effective compliance program to prevent illegal, unethical, or improper conduct
- Maintains a relationship with the state regulators to ensure compliance with Aetna's contract
- Maintains a relationship with other governmental agencies to ensure policies and procedures are abided

Passport Health Plan/Evolent Health, LLC 2016 – 2018

Associate Director, Program Integrity

- Managed and directed the PI department and related responsibilities
- Developed and implemented internal controls that promote the prevention of health care fraud, waste, and financial abuse as well as adherence to applicable federal, state, and local laws and program requirements
- Developed and conducted the annual review of PI-related policies and procedures
- Completed an annual PI risk assessment and developed and implemented of an annual program integrity workplan focused to address areas of risk/concern and opportunities for improvement
- Developed and implemented tools and resources necessary to carry out PI-related responsibilities
- Generated routine and periodic internal and external reports on PI activities, trends, and recoupments
- Established, monitored, analyzed, and regularly reported metrics for PI and compliance activities
- Provided effective direction, supervision, consultation, and training to PI personnel
- Managed a team of 5 and completed timely evaluations for subordinates

LaRhanda D. Trammell, MPA-CRJ, MBA-HCM, HCAFA

- Met regularly with PI department personnel and Executive Leadership team
- Addressed areas of concerns timely and conduct disciplinary action in accordance with Human Resources policies and procedures as appropriate
- Assured Department resources are adequate and available to conduct department responsibilities
- Worked closely with department agencies such as Office of Inspector General, Department of Medicaid Services Program Integrity, Medicaid Fraud Control Unit, Federal Bureau of Investigation (FBI), and the Attorney General office regarding cases referred for fraudulent activity

Passport Health Plan/Evolent Health, LLC 2015 – 2016
Program Integrity Auditor

- Collaborated with providers to develop corrective actions, including repayment of identified recoveries through fraud, waste, and abuse allegations
- Responsible for drafting audit/investigative reports summarizing evidence and audit activities and reporting findings accordingly
- Reviewed medical records/documentation to make determination on proper coding (CPT and ICD-10)
- Made referrals of findings to clients, regulators, and/or law enforcement as directed by the Director of National Program Integrity, Kentucky
- Participated in communication and training sessions for providers when necessary
- Served as Passport's representative during formal proceedings when necessary
- Traveled to provider offices and facilities for conducting the audit

Louisville Metro Government 2014 – 2015
Internal Auditor

- Reviewed scope of review in conjunction with the audit manager
- Conducted audit testing of specified area and identify reportable issues and dimension of risk
- Communicated findings to senior management and drafted comprehensive reports of audit areas
- Established risk-based audit programs
- Traveled to departmental locations within Metro Government for conducting reviews/audits

Humana Insurance Company 2004 – 2011
Lead Special Investigator Analyst (July 2011 – May 2014)

- Identified/investigated cases related to potential fraud waste and abuse by providers
- Employed an analytical strategy to provider proactive and reactive investigative data support in all conventional and complex fraudulent claim scenarios
- Worked closely with legal departments, law enforcements agencies, Department of Insurance, FBI, Office of Attorney General, and Office of Inspector General while maintaining and communicating with other insurance companies using SIRIS and other government tracking websites
- Instructed and led special investigative assistants with the direction of work

Grievance and Appeal Specialist (Medicare) (March 2008 – July 2011)

- Assisted Medicare members in resolving issues regarding claims, complaints, and other complex problems that need resolution
- Created and maintained proactive communication with other departments to ensure a positive ongoing relationship
- Collected, analyzed, and interpreted trend information to address and resolve non-routine business-related concerns

Information Specialist (November 2006 – March 2008)

- Reviewed and evaluated data with statistical, financial, or clinical emphasis, and racked data trends
- Scrutinized information and provided sophisticated solutions to address issues with supervisors
- Created and maintained proactive communication with other departments to ensure a positive ongoing relationship

Billing Specialist (August 2004 – November 2006)

- Managed accounts (CI/CAS and MTV) of large and small groups in Texas, completing audits and basic enrollment tasks
- Worked with benefit administrators to ensure timely premium payments and group account reconciliation

Education

- Master of Public Affairs with a specialization in Criminal Justice, Indiana Wesleyan University, 2016
- Master of Business Administration with a specialization in Health Care Management, Indiana Wesleyan University, 2014
- Bachelor of Science in Business Administration, Indiana Wesleyan University, 2012
- Associate of Science in Business, Indiana Wesleyan University, 2010

Licensures and Certifications

Health Care Anti-Fraud Associate (HCAFA) Certification, American Health Insurance Plans (AHIP), 2013

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David M. Hiestand, MD, PhD, FACCP, FAAP

Vice President and Chief Medical Officer for Aetna Medicaid

Dr. David Hiestand, MD, PhD, is Vice President and Chief Medical Officer for Aetna Medicaid. In this role he oversees corporate medical management and clinical strategy for all health plans owned and administered by Aetna Medicaid. Dr. Hiestand has had a 20-year career in health care, including six years with Aetna, where he most recently served as the Regional Medical Director for the Midwest Region. He also served as the Chief Medical Officer for Aetna Better Health of Kentucky. He previously worked in both academic and private practice Pulmonary, Critical Care, and Sleep Medicine. He obtained a BA in philosophy from Centre College in Danville, Kentucky and a PhD in Medicinal Chemistry and Pharmaceutics from the University of Kentucky. He completed medical school, residency, and fellowship at the University of Kentucky and is board certified in Internal Medicine, Pulmonary, Critical Care, Sleep Medicine, and Pediatrics. He also has training in Hyperbaric Medicine. His academic interests included quality assurance and improvement and health information technology. Prior to joining Coventry/Aetna, he served as a Medical Director for Express Scripts.

Experience

Aetna Inc., a CVS Health Company 2017 – Present

VP, CMO Aetna Medicaid (2019 – present)

- Responsible for oversight of Clinical Operations, Quality and Pharmacy Operations for Medicaid segment and Medicare-Medicaid integrated plans

Interim Chief Medical Officer, (2019)

Regional Medical Director – Great Plains (2018 – 2019)

- Responsible for clinical oversight of Great Plains Region
- Chair of Utilization Management Steering Committee
- Physician Chair of National Pharmacy and Therapeutics Committee

Senior Medical Director (2017 – 2018)

- Responsible for segment oversight of utilization management
  - Chair of Utilization Management Steering Committee
  - Physician Chair of National Pharmacy and Therapeutics Committee
- Clinical coach for Chief Medical Officers in the Great Plains Region

Aetna Better Health of Kentucky 2013 – 2019

Chief Medical Officer (2016 – 2017, July 2019 – present)

- Development of strategic approaches to optimize company performance
  - Identification and analysis of medical cost drivers and trends
  - Evaluation of provider network for enhancement and expansion
  - Direct clinical aspects of value based solutions opportunities
- Management of Health Services Team
  - Oversight of medical directors, nurse case and utilization review managers, and non-clinical staff – 7 direct reports and approximately 160 FTEs supervised
  - Lead quality improvement projects and collaborate with quality team
- Clinical liaison to Department of Medicaid Services
  - Represent health plan in State meetings and special projects

David Hiestand, MD, PhD, FACCP, FAAP

- Chair of Quality Management / Utilization Management, Pharmacy and Therapeutics, and Credentialing Committees
- Supervised successful migration to Aetna Medicaid Health Services Model

Interim Chief Medical Officer (2015 – 2016)

Medical Director (2013 – 2016)

- Utilization management
  - Prior authorization and concurrent review using InterQual and MCG criteria sets
  - Pharmacy prior authorization
  - Appeals with focus on pulmonary, critical care, and sleep cases
- Case management
  - Medical director leadership to member restriction (lock-in) program
  - Implemented cross-functional team to address members with Hepatitis C requiring medical therapy
  - Medical director leadership to co-morbid case management team, focusing on members with multiple conditions.
- Quality and Safety
  - Identification and review of quality of care and safety concerns within provider network

Express Scripts 2012 – 2013

Associate Medical Director

- Utilization management in pharmacy and home health services.

University of Louisville, Louisville, KY 2010 – 2013

Assistant Professor of Medicine, Division of Pulmonary, Critical Care, & Sleep Disorders

- Obtained competitive grant from Cystic Fibrosis Foundation to improve quality and process activities for the adult CF program
- Managed clinical operations for Sleep Disorders Center including staff, budget, and operations
- Directed Fellowship Program in Sleep Medicine
- Served on Pharmacy and Therapeutics committee for Jewish Hospital
- Facilitated implementation of Intensivist program for Jewish Hospital Intensive Care Units

Kentuckiana Pulmonary Associates 2007 – 2010

Private Practice Pulmonary, Critical Care, Sleep Physician

University of Kentucky

Part-time Instructor, Department of Pediatrics (2002 – 2005)

Assistant Professor of Medicine, Division of Pulmonary, Critical Care, & Sleep Medicine (2005 – 2007)

- Developed and led ICU Quality Assurance and Improvement Committee with reduction in Health Care Associated Conditions and improvement in standard practices and procedures resulting in improved ICU LOS and cost
- Provided clinical consultative support to enterprise-wide electronic health record implementation
  - Developed order sets for physician order entry
- Designed rule-based clinical decision support tools
  - Led curriculum development and managed educational programs for Fellowship in Pulmonary, Critical Care, and Sleep Medicine

Education

- B.A. in Philosophy - Centre College, Danville, Kentucky, 1989
- Ph.D. in Pharmaceutical Sciences: Medicinal Chemistry & Therapeutics – University of Kentucky College of Pharmacy, 1994
- M.D. (with distinction) – University of Kentucky College of Medicine, 1998
- Residency in Internal Medicine and Pediatrics – University of Kentucky, 1998 – 2002
- Fellowship in Pulmonary, Critical Care, & Sleep Medicine - University of Kentucky, 2002 – 2005
- Primary Training in Hyperbaric Medicine – Undersea and Hyperbaric Medical Society, 2008
- Physician in Management Series – American Association for Physician Leadership, 2015

Licensures and Certifications

- Kentucky Board of Medical Licensure (KY 34902), 1999
- Indiana Board of Medical Licensure (IN 01064503A), 2007
- Michigan Board of Medical Licensure (MI 4301102285), 2013
- Kansas Board of Healing Arts (KS 04-41016), 2018
- American Board of Internal Medicine (212666), 2002, Ongoing MOC through 2022
- American Board of Pediatrics (075678), 2002, Ongoing MOC through 2024
- American Board of Internal Medicine, Subspecialty in Pulmonary Medicine, 2004, Ongoing MOC through 2024
- American Board of Internal Medicine, Certificate in Critical Care Medicine, 2005, Ongoing MOC through 2026
- American Board of Sleep Medicine, Diplomat (lifetime), 2006
- American Board of Internal Medicine, Certificate in Sleep Medicine, 2007, Ongoing MOC through 2027
- Undersea and Hyperbaric Medicine Training Program – Basic training certificate, 2008
- Advanced Cardiac Life Support, Provider – recertified 2013

Professional Membership and Activity

- Member, American Academy of Pediatrics
- Member, American College of Chest Physicians
- Member, American Thoracic Society
- Member, Society of Critical Care Medicine
- Member, American Academy of Sleep Medicine
- Member, Southern Society of Clinical Investigation
- Member, American Association for Physician Leadership

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April Cox, PharmD

Pharmacy Director

April Cox, PharmD, is a native Kentuckian and skilled pharmacist professional with 12 years of health care industry experience and 7 years of managed Medicaid experience. Her expertise includes clinical guidance development, pharmacy trend analysis, vendor oversight, CLIA-waived testing, and formulary management. In her role as pharmacy director for Aetna Better Health of Kentucky, Dr. Cox is responsible for developing savings strategies targeting pharmaceutical interventions, maintaining an accurate formulary, and developing pharmacy clinical authorization guidelines. Prior to joining Aetna, she served as clinical pharmacist for Humana, where she reviewed claims for fraud, waste, and abuse such as TIRF medications, those that required therapeutic monitoring, and those exceeding $20,000 in cost. Her educational background includes a Doctor of Pharmacy from the University of Kentucky and a Bachelor of Science in Chemistry from Western Kentucky University.

Experience

Aetna Better Health of Kentucky, a CVS Health Company 2017 – Present
Pharmacy Director/Clinical Pharmacy Manager

- Develops and promotes strategies and policies that enhance quality of pharmaceutical care in a cost-effective manner; supports innovative, quality-focused, and efficient pharmacy services; and ensures that all pharmacy-related activities are compliant with all regulations, contracts, and statutes
- Maintains policies and procedures to comply with IPRO, EQRO, and NCQA standards
- Maintains accurate formulary, prior authorization, and supportive documentation postings
- Develops savings strategies targeting pharmaceutical interventions
- Provides monthly operating report for pharmacy-specific financial trends and utilization relating to retail pharmacy and specialty pharmacy
- Develops pharmacy clinical authorization guidelines
- Performs drug utilization review program activities in compliance with state and Centers for Medicare & Medicaid Services regulations
- Acts as liaison between managed care plan and pharmacy benefit manager and conducts vendor oversight
- Assists clinical case management and other interdisciplinary teams in care plans, identifies high-risk members for outreach, and addresses member pharmacy-related issues at point of sale
- Advisor to the local Pharmacy and Therapeutics Committee

Humana 2015 – 2017
Clinical Pharmacist

- Provided clinical review of specialty and high-cost drugs for appropriate utilization to identify fraudulent claim submission
- Review medications that are part of REMS and treatment for rare disease states
- Review medications that require therapeutic monitoring
- Review medications exceeding $20,000
- Review member waste and abuse cases for overutilization
- Assisted in formulary management of compounds

April Cox, PharmD

Passport Health Plan 2014 – 2015
Consultant Outreach Pharmacist

- Provided direct provider, pharmacy, and member education regarding Passport Health Plan formulary and prior authorization program
- Participated in Pharmacy and Therapeutics Committee
- Traveled to regions 1, 2, 4, 7, and 8 to provide consulting services for expanded Medicaid population
- Consulted for Passport Health Plan Pharmacy lock-in re-evaluation initiative
- Formulary management
- Composed provider communications for outreach

Coventry Health Care (Acquired by Aetna, Inc.) 2013
Clinical Pharmacist, Special Investigations Unit

- Provided clinical pharmaceutical information to Special Investigations Unit investigators and coordinators to assist in building cases as it relates to fraud, waste, and abuse of prescriptions and medical billing for Commercial, Medicare, and Medicaid plans
- Served clinical liaison for HEAT drug cases
- Identified patterns of fraud, waste, and abuse involving high-dollar prescription medications
- Identified patterns of fraud, waste, and abuse between pharmacies, prescribers, and members where all parties are benefiting financially
- Provided professional clinical data that supports scheme patterns and opposes good faith prescribing habits
- Provide professional clinical data that supports or opposes members' clinical diagnosis
- Provide professional clinical data that supports or opposes prescribers' dosages of prescription medications
- Verified that dosages were clinically appropriate
- Specifically looked at controlled substance profiles of members

Walgreens Pharmacy 2009 – 2013
Pharmacy Manager

- Directed a staff of 1-2 staff pharmacists and 5-8 technicians and oversaw all business operations for the Pharmacy department
- Ensured pharmacy operations are compliant with state and federal laws
- Developed procedures to manage inventory in a cost-effective manner
- Implemented policies to execute company promotions
- Supervised staff pharmacists and technicians
- Provided immunization services
- Performed health testing (blood pressure, blood glucose, A1C, and cholesterol)
- Performed drug utilization reviews and medication therapy management through outcomes
- Processed and troubleshoot third party claims
- Provided superior customer and counseling services

Walgreens Pharmacy 2008 – 2009
Staff Pharmacist

- Provided support to the pharmacy manager and completed drug utilization reviews
- Provided immunization services
- Performed drug utilization reviews
- Dispensed prescription medications
- Processed third party claims

- Provided superior customer and counseling services
- Performed medicinal compounding
- Assisted patients in selecting over-the-counter preparations

Education

- Doctor of Pharmacy, University of Kentucky, 2008
- Bachelor of Science in Chemistry, Western Kentucky University at Bowling Green, 2004

Licensures and Certifications

- Kentucky Pharmacy License (License #014115)
- American Pharmacist Association MTM Certification
- American Pharmacist Association Immunization Certification

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Jerry W. Caudill, DMD, FAGD, MAGD, CDC, FPFA, FICD, FACD

Dental Director/Associate National Dental Director

Jerry W. Caudill, DMD, is a skilled and competent dental professional with 37 years of health care industry experience and 7 years of managed Medicaid experience. His expertise includes general dentistry practice, tele-dentistry, dental consulting, vendor oversight, and program planning for dentistry. In his role as dental director for Aetna Better Health of Kentucky, Dr. Caudill is responsible for developing savings strategies targeting dental interventions, providing leadership to the dental department staff, and developing dental-related guidelines. Prior to joining Aetna, he served as the Kentucky State Dental Director for Avēsis Incorporated, where he runs the statewide operations for the administration of Medicaid dental benefits for over 1.1 million recipients. His educational background includes a Doctor of Dental Medicine from the University of Kentucky and an Associate of Applied Science from Morehead State University. Dr. Caudill has served as the President of the North Carolina Academy of General Dentistry from 2012-2013 and is a current member of the American Association of Dental Consultants, American Dental Association, Kentucky Dental Association, Academy of General Dentistry, Kentucky Academy of General Dentistry, International Association for Orthodontics, Louisville Dental Society, Pierre Fauchard Academy, International College of Dentists, American College of Dentists, Council of Interstate Testing Agencies, and American Dental Education Association. He has been inducted as a Fellow in the following entities: Fellow of the Pierre Fauchard Academy (FPFA), Fellow of the International College of Dentists (FICD), and a Fellow of the American College of Dentists (FACD).

Experience

Aetna Better Health of Kentucky, a CVS Health Company 2019 – Present
Dental Director/Associate National Dental Director

- Develops and promotes strategies and policies that enhance quality of dental care in a cost-effective manner
- Support innovative, quality-focused, and efficient dental services and ensures that all dental related activities are compliant with all regulations, contracts, and statutes
- Maintains policies and procedures for the Dental department
- Provides operating reports for dental specific financial trends and utilization
- Develops dental clinical authorization guidelines
- Acts as liaison between managed care plan and dental benefit manager and conducts vendor oversight
- Provides leadership for the Dental department staff

Avēsis Incorporated, a Guardian Company 2013 – Present
Kentucky State Dental Director (2013 – Present)

- Administered the Kentucky Medicaid dental benefits for over 1.1. million Medicaid members

Dental Claims Consultant (2012 –2013)

The Premier Dental Group 2009 – 2013
Dental Claims Consultant

Private Practice 2002 – 2013
General Dentist (North Carolina)

Jerry W. Caudill, DMD, FAGD, MAGD, CDC, CTCP, FPFA, FICD, FACD

Castle Dental Centers 1998 – 2002
Regional Clinical Director (120 offices in multiple states)
Regional Dental Director (120 offices in multiple states)
National Dental Director (120 offices in multiple states)

Private Practice 1990 – 1997
Dental Director (Dubai, United Arab Emirates)

Private Practice 1982 – 1989
General Dentist

Education

- Doctor of Dental Medicine, University of Kentucky College of Dentistry, Lexington, Kentucky, 1982
- Associate of Applied Science in Electronics, Morehead State University, 1971

Licensures and Certifications

- Kentucky Dental License
- Certified Telemedicine Clinical Presenter and Technology Professional, 2019
- Certified Dental Consultant, 2016
- Fellow of the Pierre Fauchard Academy, 2017
- Fellow of the International College of Dentists, 2017
- Fellow of the American College of Dentists, 2018

Sarah Bowling, LPCC

Behavioral Health and Care Management Director

Sarah Bowling is a Licensed Professional Clinical Counselor (LPCC) with more than 10 years of experience developing and implementing best practice approaches and introducing innovations to better improve outcomes. In her role as Behavioral Health and Care Management Director for Aetna Better Health of Kentucky, Sarah is responsible for supervising care management services for over 200,000 members across Kentucky and ensuring the best practice approaches are utilized to promote better health outcomes. Prior to joining Aetna, Sarah provided direct care behavioral health and care management services to some of the Commonwealth's most vulnerable populations both at The Brook Hospital and Home of the Innocents. She ensured evidenced based practices were used and implemented process improvements related to safety and discharge planning. Her educational background includes a Bachelor of Arts in Communication and a Master in Rehabilitation Counseling. Additionally, Sarah maintains her independent behavioral health license as an LPCC.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2016 – Present

Behavioral Health and Care Management Director (Louisville, KY, 2020 – Present)

- Accountable for meeting the financial, operational, and quality objectives of the unit
- Works closely with functional area managers to ensure consistency in clinical interventions
- Communicates strategic plan and specific tactics to meet plan
- Identifies opportunities to implement best practice approaches and introduce innovations to better improve outcomes
- Participates in the recruitment and hiring process for staff
- Assesses developmental needs and collaborates with others to identify and implement action plans that support the development of high performing teams
- Evaluates and interprets data and identifies areas of improvement
- Works effectively with government agencies to deliver great health plan care to members

Manager, Clinical Health Services (2019 – 2019)

- Supervise the following Care Management Teams: Behavioral Health Discharge Follow-up, Homeless Initiative, Care Management Associates, and the Start Strong Reentry Program
- Complete monthly audits of staff and member files
- Improved the outreach process for Behavioral Health Discharge Follow-up, correlating to improved HEDIS Outcomes
- Prepare charts and documentation for NCQA Audits
- Lead interdisciplinary treatment team rounds to discuss and problem solve complex cases
- Conduct educational staff trainings on various behavioral health topics
- Participate in Social Determinants of Health and Adverse Childhood Experiences Workgroups

Supervisor, Clinical Health Services (2018 – 2019)

- Supervised the following Care Management Teams: Behavioral Health Discharge Follow-up, Homeless Initiative, Care Management Associates, and the Start Strong Reentry Program
- Completed monthly audits of staff and member files
- Completed ABX Yellow Belt Training
- Lead interdisciplinary treatment team rounds to discuss and problem solve complex cases
- Participated in Social Determinants of Health and Adverse Childhood Experiences Workgroups

Clinical Case Manager, Behavioral Health (2016 – 2018)

Sarah Bowling, LPCC

- Successfully case managed and maintained a full case load
- Completed multiple face-to-face visits, resulting in success stories
- Developed all CM Staff Training on the Outreach Process
- Participated in an Opioid Workgroup related to improving outcomes for members

The Brook Hospital Dupont 2011 – Present
Clinical Therapist

- Maintained caseload of assigned patients – completing assessments, developing treatment plans, completing crisis safety plans, and discharge planning
- Facilitated individual, group, and family sessions
- Participated in multi-disciplinary treatment teams
- Participated in work groups to improve patient safety, as well as treatment process plans

Home of the Innocents 2009 – 2011
Clinical Specialist

- Maintained caseload of assigned patients – completing assessments, developing treatment plans, completing crisis safety plans, and discharge planning
- Facilitated individual, group, and family sessions
- Participated in multi-disciplinary treatment teams
- Participated in work groups to improve patient safety, as well as treatment process plans

Education

- Master of Rehabilitation Counseling, University of Kentucky, Lexington, Kentucky, December 2009
- Bachelor of Arts: Communication, University of Kentucky, Lexington, Kentucky, May 2008

Licensures and Certifications

- Kentucky Licensed Professional Clinical Counselor (#103036)

Stacey Kleinman, MBA

Provider Network Director

Stacey Kleinman is a fourth-generation Kentuckian and experienced informatics and reporting professional with 12 years of health care industry experience and 3 years of managed Medicaid experience. Her broad expertise includes executive level reporting, process documentation, project management, actuarial analysis and reporting, data analytics, and financial modeling. In her role as the provider network director for Aetna Better Health of Kentucky, Stacey is responsible for leading the production department for all provider-related information. Prior to serving in that role, Stacey held the positions of lead business consultant and manager of informatics for Aetna. Her educational background includes a Master of Business Administration from Bellarmine University in Louisville and a Bachelor and Associate of Science in Business Administration from Sullivan University in Louisville.

Experience

Aetna Better Health of Kentucky, a CVS Health Company 2017 – Present

Provider Network Director/Director of Network Operations

- Leads production department of 13 associates for all provider-related information.
- Created Book of Standard Operating Procedures for the Operations department
- Serves as the health plan representative for weekly information technology touchpoint meetings and CSRA meetings
- Attends and contributes to ABX touchpoints, SAI meetings, Quality Management Oversight Committee, Kentucky CAP workgroups, DMS daily meetings, encounter touchpoints, meetings at the state for operational items, leadership meetings, and daily Kentucky operations touchpoints with segment partners

Lead Business Consultant (October 2017 – May 2018)

- Reported directly to chief executive officer of Aetna Better Health of Kentucky
- Facilitated daily Kentucky health plan meetings with key leaders from all segments

Manager of Informatics (July 2017 – May 2017)

- Led team of four associates in producing ad hoc reporting
- Established a process for how all associates requested data from the Informatics department to streamline requests and reduce turnaround times
- Had associates work together to produce template queries so others on the team could field questions about how others pulled data if needed
- Tested new issue tracking system post-implementation and responsible for keeping the system in sync as updates were made

Humana, Inc. 2008 – 2017

Senior Products Actuarial Compliance Project Manager (May 2016 – July 2017)

- Dedicated support resource for Compliance Actuarial team
- Created an annual schedule with over 1,000 tasks by utilizing Microsoft Project
- Provided weekly status dashboards to indicate prioritization of deliverables and competing priorities
- Ensured project schedule execution by creation of meetings to gather stakeholders in order to drive conversations and process
- Maintained relationships between teams by partnering with other project managers and utilizing issue identification processes to mitigate and/or communicate downstream effects

Stacey Z. Kleinman, MBA

- Worked as a conduit between actuaries and external data suppliers to obtain achievable requirements needed to populate service level agreements which are representative of final products requested
- Utilized SharePoint to track and keep record of attestations, professional requirements, Centers for Medicare & Medicaid Services (CMS) releases, major milestones, trainings, instructions, and all other compliance materials
- Coordinated daily meetings with all parties internal and external to senior products actuarial for the CMS desk review process for Humana Medicare bids
- Strategized to create a workflow process, which allows the actuarial directors to review at any point in time the status of their tools
- Compiled the annual budget and reporting of the budget throughout the year for the Senior Products Actuarial department
- Submitted requests to accounts payable system for contractor payments (over $3 million per year)
- Reviewed annual lessons learned and understand impact on existing controls to provide recommendations for tasks to be added, changed, or deleted from project schedule or process documentation

Market & Business Operations Management Strategic Consultant (May 2015 – May 2016)

- Provided data analytics of Humana One business (ACA) representing over $1.2 billion of claims
- Delivered key findings to internal partners from data analytics produced on monthly basis
- Key responsibilities: creation of ad hoc reporting to support research efforts and analysis for RGI rules, served as a resource to the team for all things, and created a summary level reporting package
- Worked with senior leadership to create strategic plans then tracked and measured performance

Senior Products Actuarial Quality Assurance Process Manager (November 2013 – May 2015)

- Led a team of four
- Established partnership with Internal Audit and relationship with Finance on the budget process
- Supported models/tools (Bid Model, QFM, MACRS, SCT, SAM, MaRS, MACTAPT, BIDE) by providing compliant templates to owners
- Supported report (town hall, stop loss template, cap tables) documentation in MAAIDS by providing standard document templates to report owners
- Reviewed state documentation and facilitated automation of quality assurance process
- Instituted best practices in project/process planning, validation, regression testing, and documentation

Senior Products Actuarial Financial Reporting Process Manager (May 2013 – November 2013)

- Led a team of four
- Served as a liaison between Senior Products Actuarial and Corporate Finance
- Trained at town hall to business consultant ownership on the team
- Provided documentation on how to compile information for Worksheet 1 Section 6 on the bid
- Worked with Pricing Actuaries and Corporate Finance to obtain additional financial information needed from an acquisition company
- Effectively integrated information into the current process and coordinated answers to questions
- Provided guidance to reconcile all data pulls accurately and how to document methods

Senior Products Actuarial Financial Reporting Process Business Consultant (October 2012 – May 2013)

- Led a team of two
- Served as liaison between Senior Products Actuarial and Finance
- Produced the related parties 2012 base file and substantiation for 2014 bids
- Worked with TSG groups on segmentation and BIDE upgrades for current year

- Produced town hall presentation to encompass budget, actuals, and projections
- Collaborated with Corporate Finance on how to tie back from tools used during bid season

Commercial Financial Ops West Central Region Consultant (May 2011 – October 2012)

- Corporate contact for Colorado, Kansas/Missouri, Dallas, and Houston commercial finance markets.
- Responsible for the monthly close process including trending, restatements, icemakers, Vitality Biometrics entries, ASO reserves review, and Fin Gap review
- Reviewed quarterly financial narratives, trend template report, market trend by category report, and the top groups report
- Responsible for quarterly price trending, quarterly legal entity flux analysis, and the annual premium budget process
- Chosen to facilitate admin project analysis for PPNO review by Humana chief financial officer
- Member of Fin Ops Commercial Career Development and Mentor Committees

Financial Operations Data Quality and Production Support Financial Analyst (February 2008 – May 2011)

- Point of contact for IFM audit monthly reconciliation and responsible for discussion during monthly close
- Assisted team members in correcting outages from reconciliation
- Performed reconciliation in testing environment when new projects are started to ensure data integrity

Education

- Master of Business Administration from Bellarmine University, 2015
- Bachelor of Science in Business Administration from Sullivan University, 2007
- Associate of Science in Business Administration from Sullivan University, 2006

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Donna G. Hall, RN

Quality Improvement Director

Donna G. Hall is an accomplished quality management professional and registered nurse holding a vision for outcomes with more than 20 years of progressive health care industry experience and 12 years of managed Medicaid experience. She is positioned to deliver leadership excellence, innovative operational efficiency, and quality outcomes. Her expertise includes quality improvement, prevention and wellness, and member-centric quality outcomes. In her role as the director of quality management for Aetna Better Health of Kentucky, Donna is responsible for developing and implementing the quality assessment and performance improvement (QAPI) programs and policies in addition to running the department's operations. Under Donna's leadership, ABHKY achieved a 'Commendable' rating under the National Committee for Quality Assurance (NCQA) accreditation. Prior to joining Aetna, Donna served as the quality and training specialist for SHPS, Kentucky's fee-for-service program. Her educational background includes an Associate of Science degree in Business Administration from Sullivan College in Louisville, Kentucky, an Associate of Science degree (Nursing) from Excelsior College, and a Bachelor of Arts in Health Care Management from Southern New Hampshire University with an expected completion date in 2020.

Experience

Aetna Inc., a CVS Health Company 2012 – Present

Director, Quality Management, Aetna Better Health of Kentucky (August 2013 – Present)

- Project planning and oversight of Healthcare Effectiveness Data and Information Set (HEDIS) project, performance, and improvement
- Project implementation and oversight of NCQA accreditation process (initial and renewal)
- Key participant in value-based savings arrangements and proposals with providers
- Maintain compliance with State required performance improvement projects by analyzing encounter data, HEDIS interventions, and implementation of interventions
- Develop, implement, and monitor quality policies and procedures, ensuring state contract requirements are captured
- Support and organize yearly audits for EQRO, medical record documentation, and HEDIS

Manager, Quality Management, Aetna Better Health of Kentucky (November 2013 – August 2013)

- Managed project implementation and was responsible for oversight of NCQA accreditation process
- Collaborated with Health Services and Operations to ensure compliance with all NCQA standards
- Maintained compliance with state-required performance improvement projects by analyzing encounter data, HEDIS interventions, and implementation of interventions
- Monitored and reported quality metrics monthly, quarterly, and annually to plan executives and DMS
- Developed and supported communication activities for providers and members for satisfaction surveys, newsletters, clinical practice guidelines, and health plan performance
- Served as committee lead for Quality Management/Utilization Management (QM/UM), Executive Quality Improvement, Delegation and Oversight, Policy and Procedure, Quality Member Access, and Credentialing Committees

Donna G. Hall, RN

Clinical Trainer/Auditor, Aetna Better Health of Kentucky (December 2012 – November 2013)

- Medical review audits of criteria application for Concurrent Review, Retro-review, and Appeals staff

Quality Improvement Nurse Consultant, Aetna Better Health of Kentucky (March 2012 – December 2012)

Ensured compliance with accreditation and regulatory standards; quality of care investigations

Texas Medicaid and Healthcare Partnership 2012 – 2012
Utilization Management Clinical Reviewer (January 2012 – March 2012)

Home health prior authorization/telework temporary contract worker

SHPS (Carewise) 2008 – 2011
Quality and Training Specialist (January 2008 – December 2011)

- Assigned to Kentucky and Texas Medicaid contracts
- Designed and implemented quality program for new department implementation (Texas Medicaid)
- Monitored phone lines (Centers for Medicare & Medicaid Services supervisor) for service-level goals
- Compiled trending reports and monthly employee scorecards
- Implemented ultrasound review process, saving the State of Texas $4.1 million annually

Various Nursing Positions 1999 – 2002
Nurse (June 1999 – April 2002)

- Performed direct care; followed specific state regulated documentation guidelines
- Experience includes long-term care, medical/surgical, allergy and asthma, and wound care

Education

- Bachelor of Arts, Health Care Management, Southern New Hampshire University (in progress; expected completion date: 2020)
- Associate of Science in Nursing, Excelsior College, 2012
- Diploma of Practical Nursing, Spencerian College, 2000
- Associate of Science, Business Administration, Sullivan College, 1997

Licensures and Certifications

Registered Nurse, State of Kentucky (License Number: 1133705)

Jennifer R. Nachreiner, MPH, RD

Population Health Management Director

Jennifer R. Nachreiner is an experienced professional with 11 years of health care industry experience and 2 years of managed Medicaid experience. Her expertise includes population health management, health promotion and wellness, and member engagement. In her role as the population health management director for Aetna Better Health of Kentucky, Jennifer is responsible for monitoring health plan utilization to identify trends for targeted intervention to address the continuum of risk in the Kentucky Medicaid population. Prior to serving in that role, Jennifer held several positions within Aetna including account manager, wellness account consultant, and registered dietician/health coach. Her educational background includes a Master of Public Health from the Gillings School of Global Public Health at University of North Carolina, Chapel Hill, and a Bachelor of Science in Dietetics from the University of Cincinnati where she graduated with Magna Cum Laude honors. Jennifer is also a registered dietitian, a certified worksite wellness program manager, and a licensed insurance agent for life, health, and disability.

Experience

Aetna Better Health of Kentucky, a CVS Health Company 2019 – Present
Population Health Management Director

- Monitors health plan utilization to identify trends and areas of need for targeted intervention development and delivery to address the continuum of risk within the Kentucky Medicaid population
- Engages internal and external stakeholders including community-based organizations, value-based providers, and the Department of Public Health to address priority conditions within Aetna membership and the State of Kentucky at large
- Supports provider practice transformation through integration of health plan analytics and systems with provider workflows, processes, and goals to enhance collaborative efforts toward improving enrollee outcomes
- Aligns resources and care coordination with hospital systems or behavioral health providers to improve integration of the care delivery system

Aetna Inc., a CVS Health Company 2011 – 2019
Account Manager (2015 –2019)

- Monitored medical plan utilization and trends to develop programming and benefits strategy that aligns with customer needs
- Improved member engagement through education and targeted messaging
- Worked in tandem with medical director, Pharmacy team, Case Management, Disease Management, and Behavioral Health to ensure members are receiving the right tools at the right time to make the most informed decisions about their health
- Maintained balance between resolving daily client issues while also focusing on long-term strategic client goals

Wellness Account Consultant (*2014 – 2015)*

- Leveraged Aetna population health management tools for targeted growth of new business and retention of existing business
- Provided recommendations for the identification and implementation of programs that improve quality, increase efficiency, and drive cost savings

Jennifer R. Nachreiner, MPH, RD

- Managed relationships with community partners and vendors to best support plan sponsor goals and address member gaps in care
- Delivered internal and external training on wellness programs by preparing and presenting materials related to population health management

Registered Dietician – Health Coach (2011 – 2014)

- Collaborated with multiple departments to plan, develop, implement, and continually evaluate first onsite population health management program for Active Health Management, an Aetna subsidiary
- Provided in-person wellness coaching for nutrition, physical activity, stress management, and tobacco cessation
- Enhanced the continuum of care experience by evaluating members for referral into appropriate clinical programs (case management, disease management, behavioral health, lifestyle coaching)
- Developed education material and presented to member population to improve health outcomes and promote member tools
- Served as liaison for health plan by promoting internal and external vendor integration via member education and by driving referrals to plan resources

American Academy of Pediatrics 2011 – 2014
Guest Speaker, EPIC Program

- Presented obesity treatment standard of care information to local physicians' offices and staff
- Improved presence of registered dietitians in the community setting for the treatment and primary prevention of pediatric obesity through Evaluation, Treatment and Prevention of Pediatric Obesity in Community Settings program

University of North Carolina, Chapel Hill 2010 – 2012
Project Manager

- Accountable for oversight of all phases of a multi-site randomized clinical trial for diabetes management
- Planned and developed a technology-driven intervention for prevention of type 2 diabetes in high-risk groups
- Coordinated resources and study supplies including development of protocol and manuals of procedures and regulatory documents such as IRB consent and assent forms
- Collaborated with Information department to develop multi-layered website for study subjects and research staff

Education

- Master of Public Health, Gillings School of Global Public Health, University of North Carolina, Chapel Hill, 2010
- Bachelor of Science in Dietetics, University of Cincinnati, Magna Cum Laude Honors, 2009

Licensures and Certifications

- Registered Dietitian, Academy of Nutrition and Dietetics (2009 – present) (License #1001018)
- Certified Worksite Wellness Program Manager, Chapman Institute (2014)
- Certificate of Training in Adult Weight Management (2010)
- Licensed Life, Health & Disability Insurance Agent (2014 – present) (License # 707571 PA)

Christina L. Bowlin

Provider Services Manager

Christina L. Bowlin is an experienced network development executive with 15 years of health care industry experience and 6 years of managed Medicaid experience. Her expertise includes provider relations, credentialing, provider billing, and process improvement. In her role as the provider relations director for Aetna Better Health of Kentucky, Christina is responsible for overseeing the day-to-day operations of staff members, education, service, reimbursement, and management of existing provider networks, supporting the recruitment of providers, the delivery of provider data, and ensuring all contractual metrics are met and/or exceeded. Prior to joining Aetna, Christina served as the director of managed care for Norton Healthcare, where she managed the day-to-day operations of contract analysts that modeled and built contracts, led Joint Operating Committee (JOC) meetings with payers, concentrated on revenue cycle performance, and provided price transparency through the price estimations service line. Her educational background includes a Bachelor of Science in Business Management from Indiana Wesleyan University.

Experience

Aetna Better Health of Kentucky 2018 – Present
Provider Relations Director

- Oversees day-to-day operations of ten Provider Network staff members to ensure development, education, service, reimbursement, and management of existing provider networks; supports recruitment, delivery of provider data, and ensuring all contractual metrics are met and/or exceeded
  - Optimizes interactions with assigned providers and internal business partners to establish and maintain productive, professional relationships and partners on the development of business strategy and programs to support the operational plans
  - Collaborates cross-functionally to ensure resolution of escalated issues or projects for assigned provider systems and monitors performance and adherence to scorecards and payout schedules based on established quality, growth, and clinical measures
  - Educates internal and external parties as needed to ensure compliance with contract policies and parameters, plan design, compensation process, technology, performance measurement techniques, policies, and procedures
  - Meets with key providers periodically to ensure service levels are meeting expectations
  - Manages the development of agenda, validates materials, and facilitates external provider meetings
  - Acts as subject matter expert resource for other team members
  - Collaborates with the population health position in identifying improved outcome opportunities
- Oversees day-to-day operations of two Value-based Contracting staff members
  - Accountable for designing conceptual models, initiative planning, and negotiating high value/risk contracts with the most complex and challenging providers
  - Negotiates and executes contracts with the most complex market/region/national, largest group/system or highest value/volume of spend providers with significant financial implications
  - Evaluates, helps formulate, and implements the provider network strategic plans to achieve contracting targets and manage medical costs through effective provider contracting to meet state contract and product requirements

Christina L. Bowlin

Norton Healthcare, Louisville, KY 2017 – 2018
Director, Managed Care

- Managed the day-to-day operations of six contract analysts that modeled and built contracts within Harvest and Epic; led JOC meetings with payers; concentrated on revenue cycle performance and provided price transparency through price estimations service line
- Led the negotiation, management, and financial performance of payer contracts
- Oversaw financial analysis, reporting, and forecasting for contract negotiation and reconciliation
- Mediated and resolved escalated disputes with payer strategy and operation team representatives through JOC meeting
- Represented health system issues at the Kentucky Hospital Association (KHA) meetings with managed Medicaid payer plans
- Provided education, leadership, and collaboration with various internal departments to improve overall performance
- Utilized knowledge of hospital, ancillary, and professional billing, payment methodology, and national guidelines to help improve revenue cycle operations

KentuckyOne Health, Louisville, KY 2016 – 2017
Director, Revenue Cycle and Denials

- Managed two nurse auditors and one government payer enrollment staff
- Maximized the collection of payment and reimbursement from payer sources by assessing operational and clinical processes and procedures
- Created and implemented action plans and subsequent policy and procedure changes to improve and avoid denials
- Mediated and resolved escalated disputes with payer strategy and operations team representatives through JOC meetings with payer representatives
- Represented health system issues at KHA meetings with managed Medicaid payer plans
- Provided leadership and collaboration with patient financial departments such as Revenue Integrity, Denial Management, Billing, Patient Access, and Coding to address areas of opportunity for the health system
- Utilized knowledge of hospital, ancillary, professional billing, payment methodology, and national guidelines to improve revenue cycle operations
- Oversaw revenue activities and organize strategies to increase profitability to meet financial objectives for the organization

CareSource, Louisville, KY 2014 – 2016
Manager, Health Partnership

- Managed nine provider engagement staff to support Medicaid, Medicare, and Qualified Health Plan provider networks
- Ensured adherence to network operations, customer service standards, research, and quality expectations
- Developed and approved communications to ensure timely information provided on an ongoing basis to providers
- Ensured network compliance with all regulatory requirements and company-mandated policies and procedures
- Tracked, reported, and analyzed productivity regarding network performance
- Ensured appropriate policies, procedures, and provider relation functions in place to support NCQA accreditation, HEDIS, and annual state Medicaid IPRO audit processes
- Acted as the lead payer representative at KHA meetings

ZirMed, Louisville, KY 2013 – 2014
Enterprise Implementation Consultant

- Acted as primary customer contact for ZirMed solution for issues during implementation
- Developed agenda and plans for any customer discussions regarding ZirMed setup
- Led ZirMed solution training for customers
- Assisted with pre-go-live review and go-live timeline based on direction from project manager
- Provided onsite or remote go-live support
- Proactively and independently identified opportunities for cycle time and departmental improvement

Baptist Medical Associates, Inc., Louisville, KY 2012 – 2013
Revenue Cycle and Credentialing Supervisor

- Managed day-to-day operations of three enrollment specialists
- Managed the credentialing process of payer enrollment and hospital/facility privileges for 200+ providers at 85 primary care/specialty locations, two hospitals, and one surgery center
- Worked closely with Managed Care team to ensure plan participation and accurate fee reimbursement
- Managed the enrollment process for EFT and ERAs with multiple clearinghouses
- Maintained PCI compliance with merchant vendor (Elavon) for credit card processing
- Manually prepared financial scorecards for self-managed practice locations that utilized own practice management software such as Greenway and Mosaic
- Reviewed, calculated, and approved RMS billing fees for payment
- Reviewed denials and claim reimbursement for stigmatic issues and addressed with the appropriate billing contact
- Conducted annual HIPAA training classes for all revenue cycle employees
- Created ad hoc reports from practice management systems as needed to support operations and management
- Monitored missing charges report, billing error logs, held claims report; worked directly with the practices and Enrollment team to resolve any charge and reimbursement delays
- Reviewed and approved refund requests to payers and patients
- Conducted provider orientations to gather all necessary documents and signatures for provider enrollment
- Participated in weekly implementation meetings to ensure proper and timely onboarding of all new providers

Bluegrass Family Health/SIHO/Baptist Health Network, Louisville, KY 2010 – 2012
Provider Relations Representative

- Conducted onsite meetings with participating providers and educated appropriate staff members regarding policies and requirements
- Served as a liaison between the Baptist Health Network and participating providers regarding initiatives, policies and procedures. and other plan requirements
- Entered all participating provider demographics, contract terms, and fee schedules into the Diamond Database
- Negotiated contract terms with new providers interested in participating with the PPO network
- Addressed and resolved provider complaints and claims issues

Amerihealth Mercy (Passport Health Plans), Louisville, KY 2009 – 2010
Provider Relations Representative

- Conducted onsite meetings with 326 participating specialist providers consistent with established servicing guidelines and educated appropriate staff members regarding policies and requirements
- Served as a liaison between PHP and participating providers regarding PHP initiatives, policies and procedures, and other plan requirements
- Guaranteed PHP and provider contract compliance

Christina L. Bowlin

- Facilitated the contracting and credentialing process with participating providers within PHP guidelines
- Addressed and resolved provider complaints and issues assigned to a work queue in EXP

Baptist Community Health Services, Louisville, KY 2005 – 2009

Credentialing Coordinator

- Responsible for all levels of credentialing for 200+ providers at 60+ locations throughout the state
- Initiated and maintained working relationships with all existing and incoming providers within the Baptist network
- Created credentialing policies and procedures for both internal and external users
- Served on Implementation team alongside the Managed Care team for the purpose of payor contract negotiations and credentialing
- Solely responsible for the evaluation and completion of all Medicare compliance regulations of new property/building leases and new providers

Billing Office Team Lead

- Leadership role of 20 FTE in department responsible for the billing and collections of all Medicare, Medicaid, and Commercial insurance carriers, both primary and secondary
- Created and implemented departmental policies and procedures and the use of an error corrections log for ten provider locations through tracking cause and effect of denied claims
- Worked closely with upper level management to identify and rectify major discrepancies in billing office workflow and excessive A/R
- Performed all departmental and system training for both existing and new employees
- Effectively participated in the cleanup efforts of the McKesson and Systoc billing systems to improve A/R

Claims Specialist

- Billed and collected on all Medicare, Medicaid, managed care organization, and commercial insurance plans
- Audited charges and patient information to ensure maximum and timely reimbursement
- Reviewed claim pre-submission via web-based application to assure accuracy

Education

Bachelor of Business Management, Indiana Wesleyan University, 2012

Scott Hunt, MA

Utilization Management Director

Scott Hunt is an accomplished and energetic leader in utilization management settings. He utilizes the training and skills he developed to continue the betterment of membership, staff, and company. In his role as the director of utilization management for Aetna, Scott oversees prior authorization, concurrent review and retrospective review, operational tasks involving claims, appeals, provider relations, and contracting issues, and implementing process changes. Prior to joining Aetna, Scott served as the assistant nurse manager for Norton Audubon Hospital. His educational background includes a Master of Arts in Leadership and Health System Administration, a Bachelor of Science in Nursing, an Associate of Nursing all from Excelsior College of Nursing in Albany, New York, a Master of Science in Fire Science and Executive Leadership, and a Bachelor of Science in Fire Science from Ashwood University.

Experience

Aetna Inc., a CVS Health Company 2012 – Present
Director, Clinical Health Services/Utilization Management, Aetna Better Health of Kentucky

- Oversight of prior authorization, concurrent review, and retrospective review
- Operational tasks involving claims, appeals, provider relations, and contracting issues
- Writing and implementing the yearly departmental budget
- Implementing process changes
- Updating policies and procedures
- Human resource activity such as staff development, hiring, and termination
- Addressing state regulatory issues

Norton Audubon Hospital, Louisville, KY 2010 – 2012
Assistant Nurse Manager, Emergency Department

- Emergent care of patients
- Daily operations and oversight of staff
- Assisted in budget development
- Assisted in policies and procedures
- Supplied ordering for department

Baptist Hospital East, Louisville, KY 2009 – 2010
Emergency Room Nurse, Preceptor, Team Leader

- Emergent care of patients
- Daily operations and oversight of the staff
- Assisted in budget development
- Assisted in policies and procedures
- Served as preceptor to new students and new employees
- Served as team lead

Jewish Hospital, Louisville, KY 2008 – 2009
Emergency Room Nurse, Preceptor, Team Leader

- Emergent care of patients
- Daily operations and oversight of staff
- Assisted in budget development
- Assisted in policies and procedures

Scott Hunt, MA

Town of Clarksville, IN 1999 – 2008
Firefighter, Paramedic, Emergency Medical Services (EMS) Director

- Firefighting duties as well as emergent care of patients
- Daily operations and oversight of EMS staff
- Developed budget for EMS division of the department
- Addressed any State compliance concerns and any regulatory issues

Education

- Master of Arts in Leadership and Health System Administration, Excelsior College, Albany, New York, 2018
- Bachelor of Science in Nursing, Excelsior College of Nursing, 2009
- Associate of Nursing, Excelsior College of Nursing, 2008
- Master of Science in Fire Science and Executive Leadership, Ashwood University, 2006
- Bachelor of Science in Fire Science, Ashwood University, 2004

Licensures and Certifications

- Licensed Registered Nurse, Kentucky (License # 1118552)
- Licensed Registered Nurse, Indiana (License #28181198A)

Paula A. Fellows, LPN

Enrollee and Provider Grievance and Appeal Coordinator

Paula A. Fellows is a team-oriented and experienced professional with 33 years of health care industry experience and 10 years of managed Medicaid experience. Her expertise includes many leadership roles in the nursing arena. Paula has focused most of her work on improving health outcomes of the members. In her role as an enrollee and provider grievance and appeal coordinator for Aetna, Paula manages the staff and the daily activities that deal directly with the grievances and appeals that come to the company. She is also responsible for resolution and response for any DMS/State complaints in relation to the Appeals department. Prior to joining Aetna, Paula served as the nurse reviewer for SHPS. Her educational background includes an associate degree in licensed practical nursing from Galen Health Institute for Nursing in Louisville, Kentucky.

Experience

Aetna Inc., a CVS Health Company 2012 – Present

Manager, Grievances and Appeals/Enrollee and Provider Grievance & Appeal Coordinator (Present)

- Manage the team's daily productivity and resources; communicates productivity expectations, and balances workload to achieve customer satisfaction through prompt/accurate handling of customer concerns
- Manages a team of clinical and non-clinical personnel to ensure Aetna's policies and procedures and regulatory and accreditation requirements are in compliance
- Manages the staff to performance measures and standards for quality service and cost-effectiveness and coaches the team/individuals to take appropriate action
- Assists the team in collaborating with others to identify and implement action plans that support the development of high-performing teams and individuals
- Ensures work of the team meets federal and state requirements and quality measures with respect to letter content and turnaround time for appeals and complaints handling
- Training of clinical and non-clinical staff
- Responsible for resolution and response for any DMS/State complaints in relation to the Appeals department
- Responsible for fiscal budget for the department
- White Belt certification (Achieving Business Excellence)

Manager, Retroactive Review/Referrals, Aetna Better Health of Kentucky (2013 – 2014)

- Oversee the daily operations of department to ensure compliance of guidelines set forth by the company
- Process review and retro-review requests from providers related to retro-eligibility or claims error process in a timely manner
- Coordinate staffing to ensure all retro cases are completed within National Committee for Quality Assurance (NCQA) guidelines
- Responsible for resolving issues daily in 4 claims queues
- Responsible for reviewing clinical documentation for all appeals and submitting to medical director for review
- Respond to critical emails from provider representatives, claims, and other staff regarding claims issues, authorization, or data entry errors

Paula A. Fellows, LPN

- Responsible for daily reports and special projects assigned by the director and vice president of health services
- Resolves member, provider, and staff issues and concerns
- Assists in the writing and review of policy and procedures
- Assists other staff members in other departments with claims or authorization issues
- Assists the Appeals department as the only nurse to process appeal requests along with other manager related duties daily

Concurrent Review/Retroactive Review Nurse, Aetna Better Health of Kentucky (2012 – 2013)

- Reviewed retro-review requests from providers related to retro-eligibility or claims error process in a timely manner
- Coordinated staffing to ensure all retro cases are completed within NCQA and contractual guidelines
- Resolved issues daily in 4 claims queues
- Reviewed clinical documentation for all appeals and submitting to medical for review
- Respond to critical emails from provider representatives, claims, and other staff regarding claims issues, authorization, or data entry errors
- Responsible for daily reports and special projects assigned by the director and vice president of health services
- Resolved member, provider, and staff issues and concerns
- Assisted in the writing and review of policy and procedures
- Assisted other staff members in other departments with claims or authorization issues

Carewise Health, Louisville, KY 2010 – 2011
Nurse Reviewer

- Responded to fax and call center phone requests for home health/durable medical equipment (DME) for Texas Medicaid clients
- Approved or denied requests according to Texas Medicaid policies or criteria and sent letters
- Performed other related research, administrative tasks, and special projects, as assigned
- Contacted providers for verification of requests or education
- Department point of contact for those more complex cases that needed to be referred to medical director review for consideration of approval or denial

Advanced ENT and Allergy, New Albany, IN 2010 – 2010
Allergy Technician/LPN

- Performed allergy testing and education for all patients
- Gave injections to patients
- Made allergy and food serum or drops
- Performed phone triages with patients
- Assisted physicians with in-office procedures as needed

Humana Inc., Louisville, KY 1997 – 2010
Government Inquiry Representative, Humana Military Healthcare Services (2000 – 2010)

- Department point of contact for all debt collection issues for active duty and retired military personnel and their families
- Researched TRICARE policy and educated providers and beneficiaries on claims processing
- Researched, coordinated and/or responded to inquiries/issues from TRICARE Management Activity or congressional offices in relation to claims that processed and paid the provider incorrectly
- Ensured that all government-required reports are submitted to the government in a timely manner
- Performed in-depth research on TRICARE manuals and contractual issues

- Performed other related research, administrative tasks, and special projects, as assigned
- Assisted with billing and enrollment issues and contact proper department for assistance
- Reviewed marketing and beneficiary education materials for clarity, accuracy, and appropriateness

Disabilities Coordinator, Humana Military Healthcare Services (1997 – 2000)

- Responded to inquiries for approval of durable medical equipment and other medical services under the program for persons with disabilities for managed care
- Drafted approval or denial letters for requested services
- Audited correspondence/approval letters for accuracy
- Negotiated DME pricing with several network providers
- Performed extensive claims research and follow-up on claims
- Worked with all levels within the organization to facilitate, coordinate, and direct resolution to problems identified in correspondence

Eye Care Institute, Louisville, KY 1994 – 1997

Team Leader

- Served as the supervisor for front office staff; responsible for surgery scheduling for more than 6 physicians
- Obtained authorization for surgeries from insurance companies
- Scheduled all preadmission testing
- Educated patients and family on what to expect regarding their surgery
- Trained front office and back office employees
- Assisted physician with office surgeries as needed
- Researched coordinator for two active eye research studies

Education

Practical Nursing Program, Galen Health Institute for Nursing, Louisville, Kentucky, 1995

Licensures and Certifications

Licensed Practical Nurse, Kentucky (License #2032493/Indiana License #27041025A)

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Patrice L. McGhee, DPA

Director of Social Determinants of Health

Patrice L. McGhee is a Kentucky native and a knowledgeable community development professional with 11 years of health care industry experience and 3 years of managed Medicaid experience. Her expertise includes grant budget and management, policy and procedure development, and strategic planning. In her role as director of social determinants of health (SDOH) for Aetna Better Health of Kentucky, Patrice is responsible for coordinating all SDOH activities and other outreach innovations and activities for the plan. Prior to joining Aetna, Patrice served as the director of community partnerships and programs for Freestore Foodbank, where she administered a $60M Feeding America Account, sourced new funding streams, and ensured compliance with federal regulations in a tristate region of Ohio, Kentucky, and Indiana. Her educational background includes a Doctor of Public Administration from Capella University, a Master of Science in Justice Administration from University of Louisville, and a Bachelor of Arts in Criminal Justice from Kentucky State University.

Experience

Aetna Better Health of Kentucky, a CVS Health Company 2017 – Present

Manager, Community Development/Director of Social Determinants of Health

- Provides oversight for a team of 7 direct reports; apportions a $2M complex budget, reconciles expenditures, and partners with Finance department to forecast, guide the business marketing and advertising strategic plan, and ensure adherence to the state contract for all 8 Medicaid regions throughout the state of Kentucky. In Q1 of 2019, created a reconciliation process that eliminated month-end meetings and 100% report accuracy.
- Leads open enrollment campaigns: the Q4 2018 Eating Dinner Together Member Appreciation Campaign offered 32 statewide events and served 260+ members during a 2-month period; it was the first strategic open enrollment campaign since the health plan entered the market in 2011.
- Serves as the plan SDOH and health equity researcher and presents at conferences as a subject matter expert; most recent presentation in Q4 at the Kentucky Rural Health Association Conference on food insecurity.
- Drives SDOH and outreach innovation and education; develops branded measurable health literacy programs; in Q1 2019 developed Getting on T.R.A.C.K, a customized curriculum for transitioning fosters. In Q1 2018, created a data collection process that tracks outreach activities, providing metrics on resource distribution (40% directly to community members) and staff time (65% increase in member face-to-face interaction).
- Conducts statewide SDOH, health equity, and statistical research to fashion the 2019 #KnowToGrow Campaign, an internal campaign focused on understanding the member's demographic makeup, health risks, and social determinant needs. The campaign will guide the development of new products and community investments.
- Fosters relationships with 2,000+ community partner network; identifies and deploys staff to participate in community activities and events; 30% of one-time sponsorships have increased to year-round partnerships to include a 65% increase in ongoing member contact through health literacy programming.

Patrice L. McGhee, DPA

Freestore Foodbank, Cincinnati, OH 2016
Director of Community Partnerships and Programs

- Managed a team of 10 direct reports; administered a $60M Feeding America account, sourced new funding streams, and ensured compliance with federal regulations in a Tri-state region of Ohio, Kentucky, and Indiana.
- Spearheaded program evaluations (PE); conducted a PE to assess food distribution, factoring client usage as an indicator for program augmentation; results supported the 50 by 50 strategic plan. In addition, led the implementation of the Mobile Market program in partnership with Tri-health Health Systems.
- Fostered relationships with 200+ community partners and supervised the food bank accreditation process.

Commission for Children with Special Health Care Needs, Louisville, KY 2015 – 2016
KIPDA Region – Executive Advisor/Director (political appointment)

- Managed a team of 30 direct reports; governed a $2M budget, guided Title-V, Part C Early Intervention Point of Entry operations and served as a chief executive responsible for decisions affecting workflow of 12 offices and 162 staff
- Developed policies and procedure, metrics and ensured adherence to federal and state regulations; met quarterly compliance indicators favorably within 10% of goal
- Analyzed metrics, drafted quantitative reports, and reported findings to legislators and key stakeholders
- Directed facilities project from introductory to completion; project culminated ahead of schedule and under budget; occupied June 1, 2015

University of Phoenix, Louisville, KY 2013 – 2015
Adjunct Professor (part-time)
Taught approved undergraduate curriculum in liberal studies department; developed lessons based on professional experiences, graded assignments, reported grades, and mentored students; fostered an environment of critical thinking; offered instruction using various educational tools which included traditional lectures, real-world discussions, and writing assessments

Kentuckiana Regional Planning and Development Agency, Louisville, KY 2007 – 2015
Senior Program Manager/Planner

- Supervised tasks of 2 staff; appropriated $325k state budget and ensured compliance with Kentucky Administrative Regulations for the Kentucky Caregiver Program; increased program enrollment by 80% within the first year of program control and 10-25% growth every subsequent year; program growth helped exceed annual expenditure of 85% by 10% per annum and streamlining operations decreased wait-time for services
- Developed KCP policies and procedures (P&P), trained key stakeholders on P&Ps, and coordinated annual caregiver conferences
- Provided State Health Insurance Planning for Medicare recipients, Children's Health Insurance Program, and Dual Eligible Special Needs Plans
- Wrote Scope of Work for provider contracts, conducted annual audits, and reported finding and composed corrective action plans
- Composed mini-grant RFP and provided oversight of grantee contracts; 10 grants awarded for 2 years, expanding supportive services by 50%; applied for government grants; 75% of independent and joint grant bids were awarded

Education

- Doctor of Public Administration, Capella University, 2015
- Master of Science, Justice Administration, University of Louisville, 2006
- Bachelor of Arts, Criminal Justice, Kentucky State University, 2002

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Catherine Easley

Chief of Staff

Catherine Easley is a native Kentuckian with over 10 years of strategic communications and project management experience, 3 focused specifically on Kentucky Medicaid. Her expertise includes working with diverse constituencies to develop and implement innovative and creative campaigns that engage stakeholders. In her role as Chief of Staff for Aetna Better Health of Kentucky, Catherine provides strategic counsel to the CEO regarding health plan operations, working across all internal departments both at the health plan and national level to develop and implement best practices in health services and plan operations. Prior to joining Aetna, Catherine worked in various positions in state and federal government where she managed communication efforts among multiple internal and external stakeholders, beneficiaries, legislators, media, and the general public. Her educational background includes a Bachelor of Arts in Political Science and Communications from Wake Forest University.

Experience

Aetna Better Health of Kentucky 2019 – Present
Chief of Staff

- Reports directly to the Kentucky Medicaid health plan CEO and serve on the executive leadership team of the $1B+ Medicaid health plan with 217,000 members.
- Acts as CEO's designee in his absence with Kentucky Department for Medicaid Services, the Kentucky Hospital Association, Kentucky Association of Health plans, legislators, state advisory councils, provider groups, and other external stakeholders.
- Provides strategic counsel to the CEO regarding health plan operations, working across all internal departments both at the health plan and national level to develop and implement best practices in health services and plan operations.
- Works collaboratively to identify internal and external communication gaps and opportunities and leads comprehensive communications efforts to address each.
- Develops, executes, and assesses strategic initiatives within Kentucky Medicaid market and Aetna Medicaid organization segment.

Anthem, Kentucky Medicaid 2019
Community Outreach and Marketing Manager

- Lead the creation of a strategic plan for all community outreach, engagement, collaboration, and marketing efforts.
- Work with internal and external stakeholders to promote objectives in innovative and creative ways to engage the public; ensure the message is distributed and received across diverse channels.
- Direct outreach planning and activities to achieve key partnership objectives.

Kentucky Cabinet for Health and Family Services 2017 – 2019
Executive Advisor to the Secretary

- Lead the development and implementation of a strategic communications plan to promote and educate the public about the Cabinet's health programs.
- Responsible for project management among various stakeholders and vendors involved in external communications and programs that support communications strategy, vision and message.
- Plan education and outreach activities to engage all stakeholders, gather feedback, inform them of changes before implementation, and ensure they are prepared to help facilitate a successful transition.

Catherine Easley

Office of the Governor, Kentucky 2015 – 2017
Deputy Chief of Staff for External Affairs

- Develop close working relationship with third party groups focused on economic development, education, healthcare, regulatory reform, energy, and agriculture.
- Coordinating cross-agency, cross-cabinet efforts aimed at improving how Kentucky serves its children, families, and most vulnerable citizens.

Various Congressional Offices 2011 – 2015
Communications Director

- Develop and implement Member's short and long-term communications strategy targeting district, state, regional, national, and social media outlets.
- Responsible for all messaging, earned media, and online visibility, as well as other communications activities including coalition building, third-party advocacy, and community outreach.
- Produce high quality internal and external communications content, including writing and distributing press releases, media advisories, editorials, newsletters, surveys, and other public statements.

U.S. Consumer Product Safety Commission, Office of Commissioner Anne M. Northup 2009 – 2010
Press Secretary

- Manage all public relations and developed aggressive communications plan.
- Increase commissioner's outreach efforts through relationship building.

Education

- Bachelor of Arts in Political Science with a Minor in Communications, Wake Forest University, 2006

Attachment J

Kentucky | Transforming Health Care | **Aetna**

Attachment J
C.4 – Financial Security Obligations

Aetna 2018 Risk Based Capital Report ..... Att J-3

Capital Support Letter ..... Att J-7

CVS Five-Year Credit Agreement 2017 ..... Att J-11

CVS Credit Agreement Amendment No. 3 Five-Year 2017 ..... Att J-177

CVS Five-Year Credit Agreement 2018 ..... Att J-219

CVS Credit Agreement Amendment No. 1 Five-Year 2018 ..... Att J-337

CVS Five-Year Credit Agreement 2019 ..... Att J-379

CVS 364-Day Credit Agreement 2019 ..... Att J-497

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Aetna 2018 Risk Based Capital Report

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RISK BASED CAPITAL FOR THE YEAR 2018 OF THE Aetna Better Health of Kentucky Insurance Company

COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL

	Abbreviation	(1) Amount
(1) Total Adjusted Capital, Post Tax		326,498,199
(2) Company Action Level=200% of Authorized Control Level	CAL	70,522,162
(3) Regulatory Action Level=150% of Authorized Control Level	RAL	52,891,622
(4) Authorized Control Level=100% of Authorized Control Level	ACL	35,261,081
(5) Mandatory Control Level=70% of Authorized Control Level	MCL	24,682,757
(6) Level of Action, if Any		NONE
THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY ON THE INDICATED LINE		
Total Adjusted Capital on Line 14 of the Five-Year Historical Data Page		326,498,199
Authorized Control Level Risk-Based Capital on Line 15 of the Five-Year Historical Data Page		35,261,081

TREND TEST

	Annual Statement Source	(1) Amount	(2) Result
(7) Total Revenue	Page 4, Line 8	1,121,827,068	
(8) Underwriting Deductions	Page 4, Line 23	1,052,700,986	
(9) Combined Ratio	Line (8)/Line (7)	93.838	
(10) RBC Ratio	Line(1)/Line (4)	925.945	
(11) Trend Test Result	If Line (10) is between 200% and 300% and Line (9) > 105%, then "Yes", otherwise "No"		NO
(12) Level of Action, if any, including Trend Test		NONE	

Capital Support Letter

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January 22, 2020

Aetna Better Health of Kentucky Insurance Company

Ladies and Gentlemen:

This letter confirms that Aetna Health Holdings, LLC ("AHH") will provide financial support to Aetna Better Health of Kentucky Insurance Company dba Aetna Better Health of Kentucky (the "Company") sufficient for it to satisfy capital requirements and to remain in good standing with the Commonwealth of Kentucky.

AHH is currently an indirect parent of the Company and any financial support to the Company will first be made to Coventry Health and Life Insurance Company ("CHL"), the direct parent of the Company, for as long as CHL remains the direct parent of the Company. CHL will provide any such financial support received from AHH to the Company in the form of capital contributions to meet Commonwealth requirements.

This shall remain in effect from the date of this letter, through and including December 31, 2024. This term will be extended, if necessary, to support the capital requirements of the Company.

In addition, the undersigned represent that AHH (or one or more of its affiliates) has the ability to provide the necessary financial support to the Company to the extent and when deemed necessary by the Company and that there are no restrictions on AHH (or one or more of its affiliates) to provide such support.

Very Truly Yours,

Edward C. Lee
President and Secretary
Aetna Health Holdings, LLC

*Any financial support to the Company will be initiated by its indirect parent, AHH, and provided to CHL, the Company's direct parent. CHL will then provide such financial support to the Company in the form of capital contributions to meet Commonwealth of Kentucky's capital requirements.

CVS Five-Year Credit Agreement 2017

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Exhibit 10.2

EXECUTION VERSION

BNY MELLON

FIVE YEAR CREDIT AGREEMENT

by and among

CVS HEALTH CORPORATION,

THE LENDERS PARTY HERETO,

BARCLAYS BANK PLC and JPMORGAN CHASE BANK, N.A.,
as Co-Syndication Agents,

BANK OF AMERICA, N.A., GOLDMAN SACHS BANK USA, and
WELLS FARGO BANK, N.A.,
as Co-Documentation Agents,

and

THE BANK OF NEW YORK MELLON,
as Administrative Agent

Dated as of May 17, 2018

THE BANK OF NEW YORK MELLON,
GOLDMAN SACHS BANK USA,
MERRILL LYNCH, PIERCE, FENNER & SMITH INCORPORATED,
and
WELLS FARGO SECURITIES, LLC,
as Joint Lead Arrangers

THE BANK OF NEW YORK MELLON,
BARCLAYS BANK PLC, GOLDMAN SACHS BANK USA,
JPMORGAN CHASE BANK, N.A.,
MERRILL LYNCH, PIERCE, FENNER & SMITH INCORPORATED,
and
WELLS FARGO SECURITIES, LLC,
as Joint Bookrunners

Prepared by:
Bryan Cave Leighton Paisner LLP
1290 Avenue of the Americas
New York, New York 10104-3300

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Exhibit	H	Form of Competitive Bid
Exhibit	I	Form of Competitive Bid Accept/Reject Letter
Exhibit	J	Form of Letter of Credit Request
Exhibit	K	Form of Commitment Increase Supplement

FIVE YEAR CREDIT AGREEMENT, dated as of May 17, 2018, by and among ***CVS HEALTH CORPORATION***, a Delaware corporation (the ***"Borrower"***), the lenders party hereto from time to time (each a ***"Lender"*** and, collectively, the ***"Lenders"***), ***BARCLAYS BANK PLC*** (***"Barclays")*** and ***JPMORGAN CHASE BANK, N.A***., (***"JPMC"***), as co-syndication agents (in such capacity, each a ***"Co-Syndication Agent"*** and, collectively, the ***"Co-Syndication Agents"***), ***BANK OF AMERICA, N.A. ("BofA"), GOLDMAN SACHS BANK USA ("GS"),*** and ***WELLS FARGO BANK, N.A***. (***"Wells Fargo")***, as co-documentation agents (in such capacity, each a "***Co-Documentation Agent***" and, collectively, the "***Co-Documentation Agents***"), and ***THE BANK OF NEW YORK MELLON*** (***"BNY Mellon"***), as administrative agent for the Lenders (in such capacity, together with its successors and assigns, the "***Administrative Agent***").

1. *DEFINITIONS AND PRINCIPLES OF CONSTRUCTION*

1.1 *Definitions*

When used in any Loan Document (as defined below), each of the following terms shall have the meaning ascribed thereto unless the context otherwise specifically requires:

"ABR Advances": the Revolving Credit Loans (or any portions thereof) at such time as they (or such portions) are made or are being maintained at a rate of interest based upon the Alternate Base Rate.

"Accumulated Funding Deficiency": as defined in Section 304 of ERISA.

"Acquisition": with respect to any Person, the purchase or other acquisition by such Person, by any means whatsoever, of (a) stock of, or other equity securities of, any other Person if, immediately thereafter, such other Person would be either a consolidated subsidiary of such Person or otherwise under the control of such Person, or (b) any business, going concern or division or segment thereof, or all or substantially all of the assets thereof; *provided* that no redemption, retirement, purchase or acquisition by any Person of the stock or other equity securities of such Person shall be deemed to constitute an Acquisition.

"Acquisition Agreement": that certain Agreement and Plan of Merger, dated as of December 3, 2017, by and among the Borrower, Merger Sub and Aetna, as amended, amended and restated, supplemented or otherwise modified from time to time.

"Acquisition Closing Date": the date of the consummation of the Aetna Acquisition.

"Acquisition Indebtedness": unsecured indebtedness in an aggregate principal amount not exceeding $49,000,000,000, issued or borrowed by the Borrower for the purpose of financing the Aetna Acquisition (including all of the transaction costs, fees, commissions and expenses in connection therewith) and which is redeemable or prepayable if the Aetna Acquisition is not consummated.

"Administrative Agent": as defined in the preamble.

"***Administrative Agent's Office***": the Administrative Agent's address and, as appropriate, account as set forth in Section 11.2, or such other address or account as the Administrative Agent may from time to time notify to the Borrower and the Lenders.

"Administrative Questionnaire": an Administrative Questionnaire in a form supplied by the Administrative Agent.

"Aetna": Aetna Inc., a Pennsylvania corporation.

"Aetna Acquisition": the acquisition by the Borrower, through Merger Sub, of all of the equity interests in Aetna pursuant to the Acquisition Agreement.

"Aetna Existing Indebtedness": as defined in Section 8.1.

"Affected Advance": as defined in Section 3.8(b).

"Affiliate": with respect to any Person at any time and from time to time, any other Person (other than a wholly-owned subsidiary of such Person) which, at such time (a) controls such Person, (b) is controlled by such Person or (c) is under common control with such Person. The term "control", as used in this definition with respect to any Person, means the power, whether direct or indirect through one or more intermediaries, to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting securities or other interests, by contract or otherwise.

"Agents and Arrangers": collectively, the Administrative Agent, the Co-Syndication Agents, the Co-Documentation Agents, the Joint Lead Arrangers, and the Joint Bookrunners.

"Aggregate Commitment Amount": at any time, the sum of the Commitment Amounts of the Lenders at such time under this Agreement. The Aggregate Commitment Amount on the Effective Date is $2,000,000,000.

"Aggregate Credit Exposure": at any time, the sum at such time of (a) the aggregate Committed Credit Exposure of the Lenders at such time and (b) the aggregate outstanding principal balance of all Competitive Bid Loans at such time.

"Aggregate Letter of Credit Commitment": at any time, the sum of the Letter of Credit Commitments of the Issuers at such time. The Aggregate Letter of Credit Commitment on the Effective Date is $150,000,000.

"Agreement": this Five Year Credit Agreement, as the same may be amended, amended and restated, supplemented or otherwise modified from time to time.

"Alternate Base Rate": for any day, a rate per annum equal to the greatest of (i) the BNY Mellon Rate in effect on such day; (ii) the sum of (a) 1/2 of 1% per annum and (b) the Federal Funds Effective Rate in effect on such day; and (iii) the sum of (a) 1% per annum and (b) the One Month LIBOR Rate in effect on such day. The Alternate Base Rate shall change as and when the

greatest of the foregoing rates shall change. Any change in the Alternate Base Rate shall become effective as of the opening of business on the day specified in the public announcement of such change.

"Anti-Corruption Laws": all laws, rules, and regulations of any jurisdiction applicable to the Borrower or the Subsidiaries from time to time concerning or relating to bribery or corruption.

"Applicable Margin": (i) with respect to the unpaid principal balance of ABR Advances, the applicable percentage set forth below in the column entitled "ABR Advances", (ii) with respect to the unpaid principal balance of Eurodollar Advances, the applicable percentage set forth below in the column entitled "Eurodollar Advances", (iii) with respect to the Facility Fee, the applicable percentage set forth below in the column entitled "Facility Fee", (iv) with respect to the Letter of Credit Participation Fee payable in respect of standby Letters of Credit, the applicable percentage set forth below in the column entitled "Participation Fee - Standby", and (v) with respect to the Letter of Credit Participation Fee payable in respect of commercial Letters of Credit, the applicable percentage set forth below in the column entitled "Participation Fee - Commercial", in each case opposite the applicable Pricing Level:

Pricing Level	**ABR Advances**	**Eurodollar Advances**	**Facility Fee**	**Participation Fee - Standby**	**Participation Fee – Commercial**
Pricing Level I	0.000%	0.805%	0.070%	0.805%	0.4025%
Pricing Level II	0.000%	0.915%	0.085%	0.915%	0.4575%
Pricing Level III	0.025%	1.025%	0.100%	1.025%	0.5125%
Pricing Level IV	0.125%	1.125%	0.125%	1.125%	0.5625%
Pricing Level V	0.200%	1.200%	0.175%	1.200%	0.6000%
Pricing Level VI	0.375%	1.375%	0.250%	1.375%	0.6875%

Decreases in the Applicable Margin resulting from a change in Pricing Level shall become effective upon the delivery by the Borrower to the Administrative Agent of a notice pursuant to Section 7.7(d). Increases in the Applicable Margin resulting from a change in Pricing Level shall become effective on the effective date of any downgrade or withdrawal in the rating by Moody's or S&P of the senior unsecured long term debt rating of the Borrower.

"Approved Fund": any Person (other than a natural person) that is (or will be) engaged in making, purchasing, holding or otherwise investing in commercial loans and similar extensions of credit in the ordinary course of its business that is administered or managed by (a) a Lender, (b) an Affiliate of a Lender or (c) an entity or an Affiliate of an entity that administers or manages a Lender.

"Assignment and Assumption": an assignment and assumption entered into by a Lender and an assignee (with the consent of any party whose consent is required by

Section 11.7(b)), and accepted by the Administrative Agent, substantially in the form of Exhibit E or any other form approved by the Administrative Agent.

"***Authorized Officer***": means those officers of the Borrower or any Subsidiary whose signatures and incumbency shall have been certified in writing to the Administrative Agent.

"Bail-In Action": the exercise of any Write-Down and Conversion Powers by the applicable EEA Resolution Authority in respect of any liability of an EEA Financial Institution.

"Bail-In Legislation": with respect to any EEA Member Country implementing Article 55 of Directive 2014/59/EU of the European Parliament and of the Council of the European Union, the implementing law for such EEA Member Country from time to time which is described in the EU Bail-In Legislation Schedule.

"Barclays": as defined in the preamble.

"Benefit Plan": as defined in Section 11.23(d).

"BNY Mellon": as defined in the preamble.

"BNY Mellon Rate": a rate of interest per annum equal to the rate of interest publicly announced in New York City by BNY Mellon from time to time as its prime commercial lending rate, such rate to be adjusted automatically (without notice) on the effective date of any change in such publicly announced rate.

"BofA": as defined in the preamble.

"Borrower": as defined in the preamble.

"Borrower Materials": as defined in Section 7.7.

"Borrowing Date": (i) in respect of Revolving Credit Loans, any Domestic Business Day or Eurodollar Business Day, as the case may be, on which the Lenders shall make Revolving Credit Loans pursuant to a Borrowing Request or pursuant to a Mandatory Borrowing, (ii) in respect of Competitive Bid Loans, any Domestic Business Day on which a Lender shall make a Competitive Bid Loan pursuant to a Competitive Bid Request, (iii) in respect of Swing Line Loans, any Domestic Business Day on which the Swing Line Lender shall make a Swing Line Loan pursuant to a Borrowing Request and (iv) in respect of Letters of Credit, any Domestic Business Day on which an Issuer shall issue a Letter of Credit pursuant to a Letter of Credit Request.

"Borrowing Request": a request for Revolving Credit Loans or Swing Line Loans substantially in the form of Exhibit C.

"Change of Control": any of the following:

(i) any Person or group (as such term is used in Section 13(d)(3) of the Securities Exchange Act of 1934, as amended), (a) shall have or acquire beneficial ownership of securities having 35% or more of the ordinary voting power of the Borrower or (b) shall possess,

directly or indirectly, the power to direct or cause the direction of the management and policies of the Borrower, whether through the ownership of voting securities, by contract or otherwise; or

(ii) the Continuing Directors shall cease for any reason to constitute a majority of the board of directors of the Borrower then in office.

"Co-Documentation Agent" and ***"Co-Documentation Agents"***: as defined in the preamble.

"Co-Syndication Agent" and ***"Co-Syndication Agents"***: as defined in the preamble.

"Commercial Letter of Credit Commitment": at any time with respect to any Issuer, the commitment of such Issuer to issue commercial Letters of Credit in accordance with the terms hereof in an aggregate outstanding face amount not exceeding the lesser of (a) the amount set forth adjacent to such Issuer's name under the heading "Commercial Letter of Credit Commitment" in Exhibit A at such time or, if not listed on Exhibit A, the "Commercial Letter of Credit Commitment" which such Issuer shall have assumed from another Issuer in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7, or (b) 25% of the Aggregate Commitment Amount as in effect at such time.

"Commercial Letter of Credit Exposure": at any time in respect of any Issuer, an amount equal to such Issuer's Letter of Credit Exposure in respect of commercial Letters of Credit.

"Commitment": in respect of any Lender, such Lender's undertaking to make Revolving Credit Loans, subject to the terms and conditions hereof, in an aggregate outstanding principal amount not to exceed the Commitment Amount of such Lender.

"Commitment Amount": at any time and with respect to any Lender, the amount set forth adjacent to such Lender's name under the heading "Commitment Amount" in Exhibit A at such time or, in the event that such Lender is not listed on Exhibit A, the "Commitment Amount" which such Lender shall have assumed from another Lender in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7.

"Commitment Increase Supplement": a Commitment Increase Supplement substantially in the form of Exhibit K.

"Commitment Percentage": at any time and with respect to any Lender, a fraction the numerator of which is such Lender's Commitment Amount at such time, and the denominator of which is the Aggregate Commitment Amount at such time; *provided* that in the event the Commitments shall have expired or otherwise terminated or been terminated, then Commitment Percentage shall be determined immediately prior thereto.

"Commitment Period": the period commencing on the Effective Date and ending on the Commitment Termination Date or on such earlier date as all of the Commitments shall have been terminated in accordance with the terms hereof.

"Commitment Termination Date": the earlier of (i) May 17, 2023 (subject to extension as provided in Section 2.12) and (ii) the date on which the Loans shall become due and payable, whether by acceleration, notice of intention to prepay or otherwise.

"Committed Credit Exposure": with respect to any Lender at any time, the sum at such time of (a) the outstanding principal balance of such Lender's Revolving Credit Loans, (b) the Swing Line Exposure of such Lender and (c) the Letter of Credit Exposure of such Lender.

"Compensatory Interest Payment": as defined in Section 3.4(c).

"Competitive Bid": an offer by a Lender, substantially in the form of Exhibit H, to make one or more Competitive Bid Loans.

"Competitive Bid Accept/Reject Letter": a notification made by the Borrower pursuant to Section 2.4(d) substantially in the form of Exhibit I.

"Competitive Bid Loan": as defined in Section 2.4(a).

"Competitive Bid Rate": as to any Competitive Bid made by a Lender pursuant to Section 2.4(b), the fixed rate of interest (which shall be expressed in the form of a decimal to no more than four decimal places) offered by such Lender with respect thereto.

"Competitive Bid Request": a request by the Borrower, substantially in the form of Exhibit F, for Competitive Bids.

"Competitive Interest Period": as to any Competitive Bid Loan, the period commencing on the date of such Competitive Bid Loan and ending on the date requested in the Competitive Bid Request with respect thereto, which shall not be earlier than 3 days after the date of such Competitive Bid Loan or later than 180 days after the date of such Competitive Bid Loan; *provided* that if any Competitive Interest Period would end on a day other than a Domestic Business Day, such Competitive Interest Period shall be extended to the next succeeding Domestic Business Day, unless such next succeeding Domestic Business Day would be a date on or after the Commitment Termination Date, in which case such Competitive Interest Period shall end on the next preceding Domestic Business Day. Interest shall accrue from and including the first day of a Competitive Interest Period to but excluding the last day of such Competitive Interest Period.

"Consolidated": the Borrower and the Subsidiaries on a consolidated basis in accordance with GAAP.

"Contingent Obligation": as to any Person (the "***secondary obligor***"), any obligation of such secondary obligor (a) guaranteeing or in effect guaranteeing any return on any investment made by another Person, or (b) guaranteeing or in effect guaranteeing any Indebtedness, lease, dividend or other obligation ("***primary obligation***") of any other Person (the "***primary obligor***") in any manner, whether directly or indirectly, including any obligation of such secondary obligor, whether or not contingent, (i) to purchase any such primary obligation or any Property constituting direct or indirect security therefor, (ii) to advance or supply funds (A) for the purchase or payment of any such primary obligation or (B) to maintain working capital or equity capital of

the primary obligor or otherwise to maintain the net worth or solvency of the primary obligor, (iii) to purchase Property, securities or services primarily for the purpose of assuring the beneficiary of any such primary obligation of the ability of the primary obligor to make payment of such primary obligation, (iv) otherwise to assure or hold harmless the beneficiary of such primary obligation against loss in respect thereof, and (v) in respect of the Indebtedness of any partnership in which such secondary obligor is a general partner, except to the extent that such Indebtedness of such partnership is nonrecourse to such secondary obligor and its separate Property; *provided* that the term "***Contingent Obligation***" shall not include the indorsement of instruments for deposit or collection in the ordinary course of business.

"Continuing Director": any member of the board of directors of the Borrower (i) who is a member of that board of directors on the Effective Date, (ii) who was nominated for election by the board of directors a majority of whom were directors on the Effective Date or (iii) whose election or nomination for election was approved by one or more of such directors.

"Control Person": as defined in Section 3.6.

"Convert", ***"Conversion"*** and ***"Converted"***: each, a reference to a conversion pursuant to Section 3.3 of one Type of Revolving Credit Loan into the other Type of Revolving Credit Loan.

"Costs": as defined in Section 3.6.

"Credit Exposure": with respect to any Lender at any time, the sum at such time of (a) the Committed Credit Exposure of such Lender at such time and (b) the outstanding principal balance of all Competitive Bid Loans of such Lender at such time.

"Credit Parties": the Administrative Agent, the Swing Line Lender, the Issuers and the Lenders.

"CVS Bridge Facility": if entered into by the Borrower, the Borrower's senior unsecured 364-day term loan facility for loans in an aggregate principal amount not to exceed $4,000,000,000, the proceeds of which will be used to fund, in part, the Aetna Acquisition, including paying all related fees, commissions and expenses.

"***CVS Bridge Facility Commitment Letter***": the commitment letter, dated as of December 3, 2017 (together with all exhibits, schedules and annexes thereto), among the Borrower, Barclays, GS, Goldman Sachs Lending Partners LLC, BofA and ML, the other Persons party thereto and any other Persons that may become parties thereto, relating to the CVS Bridge Facility, as supplemented by the Joinder to Bridge Facility Commitment Letter, dated December 15, 2017, as amended by the Acknowledgment and Agreement, dated the date hereof, and as may be further amended, amended and restated, supplemented or otherwise modified from time to time.

"Default": any of the events specified in Section 9.1, whether or not any requirement for the giving of notice, the lapse of time, or both, or any other condition, has been satisfied.

"Defaulting Lender": any Lender, as reasonably determined by the Administrative Agent, that has (a) failed to fund any portion of its Loans or participations in Letters of Credit or Swing Line Loans within two Domestic Business Days of the date required to be funded by it hereunder, unless such Lender notifies the Administrative Agent and the Borrower in writing that such failure is the result of such Lender's determination that one or more conditions precedent to funding (each of which conditions precedent, together with any applicable default, shall be specifically identified in such writing) has not been satisfied, (b) notified the Borrower or any Credit Party in writing that it does not intend to comply with any of its funding obligations under this Agreement or has made a public statement to the effect that it does not intend to comply with its funding obligations under this Agreement or generally under other agreements in which it commits to extend credit, unless such writing or public statement relates to such Lender's obligation to fund a Loan hereunder and states that such position is based on such Lender's determination that a condition precedent to funding (which condition precedent, together with any applicable default, shall be specifically identified in such writing or public statement) cannot be satisfied, (c) failed, two Domestic Business Days after written request by the Administrative Agent (based on the reasonable belief that it may not fulfill its funding obligation), to confirm that it will comply with the terms of this Agreement relating to its obligations to fund prospective Loans and participations in then outstanding Letters of Credit and Swing Line Loans; *provided* that such Lender shall cease to be a Defaulting Lender under this clause (c) upon receipt by the Administrative Agent of such confirmation, (d) otherwise failed to pay over to the Administrative Agent or any other Lender any other amount required to be paid by it hereunder within two Domestic Business Days of the date when due, unless the subject of a good faith dispute, or (e) (i) becomes or is insolvent or has a parent company that has become or is insolvent, (ii) becomes the subject of a bankruptcy or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment or has a parent company that has become the subject of a bankruptcy or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment, or (iii) becomes, or has a parent company that becomes, the subject of a Bail-in Action, *provided* that a Lender shall not qualify as a Defaulting Lender solely as a result of the acquisition or maintenance of an ownership interest in such Lender or its parent company, or of the exercise of control over such Lender or any Person controlling such Lender, by a Governmental Authority or instrumentality thereof so long as such ownership interest does not result in or provide such Lender with immunity from the jurisdiction of courts within the United States of America or from the enforcement of judgments or writs of attachment on its assets or permit such Lender (or such Governmental Authority) to reject, repudiate, disavow or disaffirm any agreements made by such Lender.

"Disposition": with respect to any Person, any sale, assignment, transfer or other disposition by such Person by any means, of:

(a) the stock of, or other equity interests of, any other Person,

(b) any business, operating entity, division or segment thereof, or

(c) any other Property of such Person, other than (i) the sale of inventory (other than in connection with bulk transfers), (ii) the disposition of equipment and (iii) the sale of cash investments.

"***Disqualified Institutions***": those Persons that are (a) competitors of the Borrower or its Subsidiaries or Aetna or its subsidiaries, identified in writing by the Borrower to the Administrative Agent from time to time (it being understood that, notwithstanding anything herein to the contrary, in no event shall a supplement apply retroactively to disqualify any Person that has previously acquired an assignment or participation interest hereunder that is otherwise an Eligible Assignee, but upon the effectiveness of such designation, any such Person may not acquire any additional Commitments, Advances or participations), (b) such other Persons identified in writing by the Borrower to the Administrative Agent prior to the Effective Date and (c) Affiliates of the Persons identified pursuant to clause (a) or (b) that are either clearly identifiable by name or identified in writing by the Borrower to the Administrative Agent.

"Dividend Restrictions": as defined in Section 8.7.

"Dollar" *or* ***"$"***: lawful currency of the United States of America.

"Domestic Business Day": any day other than a Saturday, Sunday or a day which in New York City is a legal holiday or a day on which banking institutions are authorized or required by law or other governmental action to close.

"EEA Financial Institution": (a) any credit institution or investment firm established in any EEA Member Country which is subject to the supervision of an EEA Resolution Authority, (b) any entity established in an EEA Member Country which is a parent of an institution described in clause (a) of this definition, or (c) any financial institution established in an EEA Member Country which is a subsidiary of an institution described in clause (a) or (b) of this definition and is subject to consolidated supervision with its parent.

"EEA Member Country": any of the member states of the European Union, Iceland, Liechtenstein, and Norway.

"EEA Resolution Authority": any public administrative authority or any person entrusted with public administrative authority of any EEA Member Country (including any delegee) having responsibility for the resolution of any EEA Financial Institution.

"Effective Date": as defined in Section 5.

"Eligible Assignee": a Person that is a permitted assignee under Section 11.7(b) that has received the consent of each party whose consent is required under Section 11.7(b).

"Employee Benefit Plan": an employee benefit plan, within the meaning of Section 3(3) of ERISA, maintained, sponsored or contributed to by the Borrower, any Subsidiary or any ERISA Affiliate.

"Environmental Laws": all laws, rules, regulations, codes, ordinances, orders, decrees, judgments, injunctions, notices or binding agreements issued, promulgated or entered into by any Governmental Authority, relating in any way to the environment, preservation or reclamation of natural resources, the management, release or threatened release of any Hazardous Material or to health and safety matters.

"Environmental Liability": as to any Person, any statutory, common law or equitable liability, contingent or otherwise (including any liability for damages, costs of environmental investigation, sampling or remediation, fines, penalties or indemnities), of such Person directly or indirectly resulting from or based upon (i) violation of any Environmental Law, (ii) the generation, use, handling, transportation, storage, treatment, discharge or disposal of any Hazardous Materials, (iii) exposure to any Hazardous Materials, (iv) the release or threatened release of any Hazardous Materials into the environment or (v) any contract, agreement or other consensual arrangement pursuant to which liability is assumed or imposed with respect to any of the foregoing.

"ERISA": the Employee Retirement Income Security Act of 1974, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"ERISA Affiliate": when used with respect to an Employee Benefit Plan, ERISA, the PBGC or a provision of the Internal Revenue Code pertaining to employee benefit plans, any Person that is a member of any group of organizations within the meaning of Sections 414(b) or (c) of the Internal Revenue Code or, solely with respect to the applicable provisions of the Internal Revenue Code, Section 414(m) or (o) of the Internal Revenue Code, of which the Borrower or any Subsidiary is a member.

"ERISA Event": (a) any "reportable event", as defined in Section 4043 of ERISA with respect to a Pension Plan (other than an event for which the 30-day notice period is waived); (b) the determination that any Pension Plan is considered an at-risk plan or a plan in endangered or critical status within the meaning of Sections 430, 431 or 432 of the Internal Revenue Code or Sections 303, 304 or 305 of ERISA; (c) the filing pursuant to the Internal Revenue Code or ERISA of an application for a waiver of the minimum funding standard with respect to any Pension Plan; (d) the incurrence by the Borrower, any Subsidiary or an ERISA Affiliate of any liability under Title IV of ERISA with respect to the termination of any Pension Plan, other than for PBGC premiums due but not delinquent under Section 4007 of ERISA, upon the Borrower, any Subsidiary or an ERISA Affiliate; (e) the receipt by the Borrower, any Subsidiary or an ERISA Affiliate from the PBGC or a plan administrator of any notice relating to an intention to terminate any Pension Plan or to appoint a trustee to administer any Pension Plan; (f) the incurrence by the Borrower, any Subsidiary or an ERISA Affiliate of any liability with respect to the withdrawal or partial withdrawal from any Pension Plan or Multiemployer Plan; (g) any limits under Section 436 of the Internal Revenue Code become applicable; or (h) any failure to make any payment required by Section 430(j) of the Internal Revenue Code.

"EU Bail-In Legislation Schedule": the EU Bail-In Legislation Schedule published by the Loan Market Association (or any successor person), as in effect from time to time.

"Eurodollar Advance": a portion of the Revolving Credit Loans selected by the Borrower to bear interest during a Eurodollar Interest Period selected by the Borrower at a rate per annum based upon a Eurodollar Rate determined with reference to such Eurodollar Interest Period, all pursuant to and in accordance with Section 2.1 or Section 3.3.

"Eurodollar Business Day": any Domestic Business Day, other than a Domestic Business Day on which banks are not open for dealings in Dollar deposits in the interbank eurodollar market.

"Eurodollar Interest Period": the period commencing on any Eurodollar Business Day selected by the Borrower in accordance with Section 2.3 or Section 3.3 and ending one, two, three or six months thereafter, as selected by the Borrower in accordance with either such Sections, subject to the following:

(i) if any Eurodollar Interest Period would otherwise end on a day which is not a Eurodollar Business Day, such Eurodollar Interest Period shall be extended to the immediately succeeding Eurodollar Business Day unless the result of such extension would be to carry the end of such Eurodollar Interest Period into another calendar month, in which event such Eurodollar Interest Period shall end on the Eurodollar Business Day immediately preceding such day; and

(ii) if any Eurodollar Interest Period shall begin on the last Eurodollar Business Day of a calendar month (or on a day for which there is no numerically corresponding day in the calendar month at the end of such Eurodollar Interest Period), such Eurodollar Interest Period shall end on the last Eurodollar Business Day of such latter calendar month.

"Eurodollar Rate": with respect to any Eurodollar Advance for any Eurodollar Interest Period, (a) the LIBO Rate for such Eurodollar Interest Period, multiplied by (b) the Statutory Reserve Rate.

"Event of Default": any of the events specified in Section 9.1, *provided* that any requirement for the giving of notice, the lapse of time, or both, or any other condition has been satisfied.

"Excluded Taxes": with respect to the Administrative Agent, any Lender, any Issuer or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, (a) Taxes imposed on or measured by its net income (however denominated), and franchise Taxes, in each case, (i) imposed on it by the jurisdiction (or any political subdivision thereof) under the laws of which it is organized or in which its principal office is located or, in the case of any Lender, in which its applicable lending office is located, or (ii) that are Other Connection Taxes, (b) any branch profits Taxes imposed by the United States of America or that are Other Connection Taxes, (c) in the case of a Lender (other than an assignee pursuant to a request by the Borrower under Section 3.13), any withholding Tax that (i) is imposed on amounts payable to such Lender at the time such Lender becomes a party hereto (or designates a new lending office), except to the extent that such Lender (or its assignor, if any) was entitled, at the time of designation of a new lending office (or assignment), to receive additional amounts from the Borrower with respect to such withholding

Tax pursuant to Section 3.10, or (ii) is attributable to such Lender's failure or inability (other than as a result of a Regulatory Change, except for a Regulatory Change relating to the implementation of FATCA) to comply with Section 3.10 and (d) any Taxes imposed under FATCA.

"Existing Commitment Termination Date": as defined in Section 2.12(a).

"Existing 2014 Credit Agreement": the Second Amended and Restated Credit Agreement, dated as of July 24, 2014, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and BNY Mellon, as administrative agent, as amended by Amendment No. 1 to Second Amended and Restated Credit Agreement, dated as of December 15, 2017, and as further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 2015 Credit Agreement": the Credit Agreement, dated as of July 1, 2015, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and BNY Mellon, as administrative agent, as amended by Amendment No. 1 to Credit Agreement, dated as of December 15, 2017, and Amendment No. 2 to Credit Agreement, dated as of the date hereof, and as the same may be further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 2017 Credit Agreement": the Five Year Credit Agreement, dated as of May 18, 2017, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and BNY Mellon, as administrative agent, as amended by Amendment No. 1 to Five Year Credit Agreement, dated as of December 15, 2017, and Amendment No. 2 to Five Year Credit Agreement, dated as of the date hereof, and as the same may be further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 364-Day Credit Agreement": the 364-Day Credit Agreement, dated as of May 17, 2018, by and among the Borrower, the lenders party thereto from time to time, BofA, GS and Wells Fargo, as co-syndication agents, Barclays and JPMC, as co-documentation agents, and BNY Mellon, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing Term Loan Agreement": the Term Loan Agreement, dated as of December 15, 2017, by and among the Borrower, the lenders party thereto from time to time, GS and BofA, as co-syndication agents, and Barclays, as administrative agent, as amended by Amendment No. 1 to Term Loan Agreement, dated as of the date hereof, and as the same may be further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Expiration Date": the first date, occurring on or after the date the Commitments shall have terminated or been terminated in accordance herewith, upon which there shall be no Loans, Reimbursement Obligations or Letters of Credit outstanding.

"Extension Date": as defined in Section 2.12(a).

"Extension Request": as defined in Section 2.12(a).

"Facility Fee": as defined in Section 3.11.

"FATCA": Sections 1471 through 1474 of the Internal Revenue Code, as of the date of this Agreement (or any amended or successor version that is substantively comparable and not materially more onerous to comply with), any current or future regulations or official interpretations thereof, any agreements entered into pursuant to Section 1471(b)(1) of the Internal Revenue Code, any applicable intergovernmental agreements with respect thereto, and any treaty, law, regulations, or other official guidance enacted in any other jurisdiction relating to such intergovernmental agreement.

"Federal Funds Effective Rate": for any day, the rate calculated by the Federal Reserve Bank of New York based on such day's (or, if such day is not a Domestic Business Day, the immediately preceding Domestic Business Day) federal funds transactions by depository institutions (as determined in such manner as the Federal Reserve Bank of New York shall set forth on its public website from time to time) and published on the next succeeding Domestic Business Day by the Federal Reserve Bank of New York as the federal funds effective rate, or, if such rate is not so published for any day which is a Domestic Business Day, the average of the quotations for such day on such transactions received by the Administrative Agent from three Federal funds brokers of recognized standing selected by the Administrative Agent, *provided* that if the "Federal Funds Effective Rate" would otherwise be less than zero, the "Federal Funds Effective Rate" shall be deemed to be zero for purposes of this Agreement.

"Fees": as defined in Section 3.2(a).

"Financial Statements": as defined in Section 4.13.

"Foreign Lender": any Lender or any Issuer that is not a United States person within the meaning of Section 7701(a)(30) of the Internal Revenue Code.

"GAAP": generally accepted accounting principles set forth in the opinions and pronouncements of the Accounting Principles Board and the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board or such other principles as may be approved by a significant segment of the accounting profession, which are applicable to the circumstances as of the date of determination, consistently applied; *provided*, *however*, that the accounting for operating leases and financing or capital leases under GAAP as in effect on the Effective Date (including, without limitation, Accounting Standards Codification 840) shall apply for determining compliance with the provisions of this Agreement.

"***Governmental Authority"***: any foreign, federal, state, municipal or other government, or any department, commission, board, bureau, agency, public authority or instrumentality thereof, or any court, arbitrator, regulatory body or central bank (including any supra-national bodies such as the European Union or the European Central Bank).

"GS": as defined in the preamble.

"***Hazardous Materials"***: all ignitable, explosive, reactive, corrosive or radioactive substances or wastes and all hazardous or toxic materials, substances, chemicals, wastes or other pollutants, including but not limited to petroleum or petroleum distillates, asbestos or asbestos containing materials, polychlorinated biphenyls, radon gas, toxic mold, infectious or medical wastes, hazardous biological agents, hazardous pharmaceutical substances and all other materials, substances, chemicals, wastes, contaminants or pollutants of any nature that are now or hereafter regulated pursuant to any Environmental Law, or are now or hereafter defined, listed or classified as a hazardous or toxic material, substance, chemical, waste, contaminant or pollutant in any Environmental Law.

"Highest Lawful Rate": as to any Lender, the maximum rate of interest, if any, which at any time or from time to time may be contracted for, taken, charged or received on the Loans or the Notes or which may be owing to such Lender pursuant to this Agreement under the laws applicable to such Lender and this Agreement.

"Impacted Interest Period": has the meaning assigned to it in the definition of *"LIBO Rate"*.

"Increasing Lender": as defined in Section 2.6(d).

"Indebtedness": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) indebtedness with respect to any conditional sale or other title retention agreement, (d) indebtedness arising under acceptance facilities and the amount available to be drawn under all letters of credit (excluding for purposes of Section 8.1 and Section 8.9 letters of credit obtained in the ordinary course of business by the Borrower or any Subsidiary) issued for the account of such Person and, without duplication, all drafts drawn thereunder to the extent such Person shall not have reimbursed the issuer thereof in respect of such issuer's payment of such drafts, (e) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, (f) all indebtedness described in (a) - (e) above secured by any Lien on any Property owned by such Person even though such Person shall not have assumed or otherwise become liable for the payment thereof (other than carriers', warehousemen's, mechanics', repairmen's or other like non-consensual Liens arising in the ordinary course of business), and (g) Contingent Obligations in respect of any indebtedness described in items (a) - (f) above; *provided* that, for purposes of this definition, Indebtedness shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"Indemnified Amount": as defined in Section 11.10(b).

"***Indemnified Liabilities"***: as defined in Section 11.5.

"Indemnified Person": as defined in Section 11.10(a).

"Indemnified Taxes": Taxes other than Excluded Taxes and Other Taxes.

"Information": as defined in Section 11.14(b).

***"Insurance Subsidiary"*:** any Subsidiary subject to regulation by the commissioner of insurance, the commissioner of health or any equivalent Governmental Authority in any applicable jurisdiction.

"Intangible Assets": at any date, the value, as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP, of: (i) all trade names, trademarks, licenses, patents, copyrights, service marks, goodwill and other like intangibles, (ii) organizational and development costs, (iii) deferred charges (other than prepaid items, such as insurance, taxes, interest, commissions, rents, pensions, compensation and similar items and tangible assets being amortized), and (iv) unamortized debt discount and expense, less unamortized premium.

"Intercompany Debt": (i) Indebtedness of the Borrower to one or more of the Subsidiaries of the Borrower and (ii) Indebtedness of one or more of the Subsidiaries of the Borrower to the Borrower or any one or more of the other Subsidiaries of the Borrower.

"Intercompany Disposition": a Disposition by the Borrower or any of the Subsidiaries of the Borrower to the Borrower or to any of the other Subsidiaries of the Borrower.

"Interest Payment Date": (i) as to any ABR Advance, the last day of each March, June, September and December, commencing on the first of such days to occur after such ABR Advance is made or any Eurodollar Advance is converted to an ABR Advance, (ii) as to any Swing Line Loan, the day on which the outstanding principal balance of such Swing Line Loan shall become due and payable in accordance with Section 2.2(a), (iii) as to any Eurodollar Advance in respect of which the Borrower has selected a Eurodollar Interest Period of one, two or three months, the last day of such Eurodollar Interest Period, (iv) as to any Competitive Bid Loan in respect of which the Borrower has selected a Competitive Interest Period of 90 days or less, the last day of such Competitive Interest Period and (v) as to any Eurodollar Advance or Competitive Bid Loan in respect of which the Borrower has selected an Interest Period greater than three months or 90 days, as the case may be, the last day of the third month or the 90th day, as the case may be, of such Interest Period and the last day of such Interest Period.

"Interest Period": a Eurodollar Interest Period, a Swing Line Interest Period or a Competitive Interest Period, as the case may be.

"Internal Revenue Code": the Internal Revenue Code of 1986, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"Interpolated Rate": in relation to determining the applicable LIBO Screen Rate, the rate which results from interpolating on a linear basis between:

(a) the LIBO Screen Rate for the longest period (for which the LIBO Screen Rate is available) which is shorter than the Impacted Interest Period of the applicable Eurodollar Advance; and

(b) the LIBO Screen Rate for the shortest period (for which that LIBO Screen Rate is available) which is longer than the Impacted Interest Period of such Eurodollar Advance,

each as of approximately 11:00 a.m. (London, England time) two Eurodollar Business Days prior to the commencement of such Interest Period; *provided* that in the event either of the two foregoing LIBO Screen Rates is not available at such time, then the *"Interpolated Rate"* with respect to such Eurodollar Advance for such Interest Period shall be the average of rates at which Dollar deposits of $5,000,000 and for a maturity comparable to such Interest Period are offered to major banks in the London interbank market by the principal London office of the Administrative Agent in immediately available funds in the London interbank market at approximately 11:00 a.m., London time, two Eurodollar Business Days prior to the commencement of such Interest Period.

"issue" *or* ***"issuance"***: when used with respect to a Letter of Credit, shall be deemed to include any increase in the amount of such Letter of Credit.

"Issuers": BNY Mellon, Barclays, BofA, GS, JPMC and Wells Fargo; each an ***"Issuer"***.

"Joint Bookrunners": BNY Mellon, ML, Barclays, GS, JPMC and WFS.

"Joint Lead Arrangers": BNY Mellon, GS, ML and WFS.

"JPMC": as defined in the preamble.

"Lender" and ***"Lenders"***: as defined in the preamble; such term to also include the Swing Line Lender and each Issuer where the context hereof requires or permits such inclusion.

"Letter of Credit" and ***"Letters of Credit"***: as defined in Section 2.8(a).

"Letter of Credit Application": an application and agreement for the issuance or amendment of a Letter of Credit in the form from time to time in use by the applicable Issuer.

"Letter of Credit Commitment": at any time with respect to any Issuer, the commitment of such Issuer to issue Letters of Credit (which, for the avoidance of doubt, shall include all standby letters of credit and all commercial letters of credit issued by such Issuer) in accordance with the terms hereof in an aggregate outstanding face amount not exceeding the lesser of (a) the amount set forth adjacent to such Issuer's name under the heading "Letter of Credit Commitment" in Exhibit A at such time or, if not listed on Exhibit A, the "Letter of Credit

Commitment" which such Issuer shall have assumed from another Issuer in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7, or (b) the amount equal to the Aggregate Commitment Amount as in effect at such time multiplied by a percentage equal to a fraction, the numerator of which is one and the denominator of which is six.

"Letter of Credit Exposure": at any time, (a) in respect of all Lenders, the sum, without duplication, of (i) the maximum aggregate amount which may be drawn under all unexpired Letters of Credit at such time (whether or not the conditions for drawing thereunder have or may be satisfied), (ii) the aggregate amount, at such time, of all unpaid drafts (which have not been dishonored) drawn under all Letters of Credit, and (iii) the aggregate unpaid principal amount of the Reimbursement Obligations at such time, (b) in respect of any Lender, an amount equal to such Lender's Commitment Percentage at such time multiplied by the amount determined under clause (a) of this definition, and (c) in respect of any Issuer, the amount determined under clause (a) of this definition in respect of a Letter of Credit issued by such Issuer.

"Letter of Credit Participation Fee": as defined in Section 3.12.

"Letter of Credit Request": a request substantially in the form of Exhibit J.

"LIBO Rate": with respect to any Eurodollar Advance for any Eurodollar Interest Period, the rate per annum equal to the ICE Benchmark Administration Limited LIBOR Rate (or such successor thereto if the ICE Benchmark Administration Limited is no longer making such a rate available) appearing on the applicable Bloomberg screen (or other commercially available source as designated by the Administrative Agent from time to time for purposes of providing quotations of interest rates applicable to Dollar deposits in the London interbank market) at approximately 11:00 a.m., London time, two (2) Eurodollar Business Days prior to the commencement of such Eurodollar Interest Period, as the rate for Dollar deposits with a maturity comparable to such Eurodollar Interest Period (in each case, the ***"LIBO Screen Rate"***); *provided* that (i) if the LIBO Screen Rate shall be less than zero, the LIBO Rate shall be deemed to be zero for the purposes of this Agreement, and (ii) if the LIBO Screen Rate shall not be available at such time for such Eurodollar Interest Period (an ***"Impacted Interest Period"***) then the LIBO Rate shall be the Interpolated Rate, *provided* that if any Interpolated Rate shall be less than zero, such Interpolated Rate shall be deemed to be zero for purposes of this Agreement.

"LIBO Screen Rate": has the meaning assigned to it in the definition of *"LIBO Rate"*.

"Lien": any mortgage, pledge, hypothecation, assignment, lien, deposit arrangement, charge, encumbrance or other security arrangement or security interest of any kind, or the interest of a vendor or lessor under any conditional sale agreement, capital lease or other title retention agreement; *provided*, that in no event shall an operating lease be deemed to constitute a Lien.

"Loan": a Revolving Credit Loan, a Competitive Bid Loan or a Swing Line Loan, as the case may be.

"Loan Documents": this Agreement and, upon the execution and delivery thereof, the Notes, if any, and the Reimbursement Agreements, if any.

"Loans": the Revolving Credit Loans, the Competitive Bid Loans and the Swing Line Loans.

"Mandatory Borrowing": as defined in Section 2.2(b).

"Margin Stock": any "margin stock", as said term is defined in Regulation U of the Board of Governors of the Federal Reserve System, as the same may be amended or supplemented from time to time.

"Material Adverse": with respect to any change or effect, a material adverse change in, or effect on, as the case may be, (i) the financial condition, operations, business, or Property of the Borrower and the Subsidiaries taken as a whole, (ii) the ability of the Borrower to perform its obligations under the Loan Documents, or (iii) the ability of the Administrative Agent, any Issuer or any Lender to enforce the Loan Documents.

"Merger Sub": Hudson Merger Sub Corp., a Pennsylvania corporation and a wholly owned Subsidiary of the Borrower.

"ML": Merrill Lynch, Pierce, Fenner & Smith Incorporated.

"Moody's": Moody's Investors Service, Inc., or any successor thereto.

"Multiemployer Plan": a Pension Plan which is a multiemployer plan as defined in Section 4001(a)(3) of ERISA.

"Negotiated Rate": with respect to each Swing Line Loan, the rate per annum agreed to in writing by the Borrower and the Swing Line Lender as the interest rate which such Swing Line Loan shall bear.

"Net Tangible Assets": at any date, the total assets as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP, less, without duplication (i) all current liabilities (due within one year) as shown on such balance sheet and (ii) Intangible Assets and liabilities relating thereto.

"Net Tangible Assets Test": as defined in Section 8.1.

"New Lender": as defined in Section 2.6(d).

"Non-Extending Lender": as defined in Section 2.12(b).

"Note": with respect to each Lender that has requested one in accordance with Section 2.11, a promissory note evidencing such Lender's Loans payable to the order of such Lender (or, if required by such Lender, to such Lender and its registered assigns), substantially in the form of Exhibit B.

"One Month LIBOR Rate": with respect to any ABR Advance for any day, the rate per annum equal to the ICE Benchmark Administration Limited LIBOR Rate (or such successor thereto if the ICE Benchmark Administration Limited is no longer making such a rate available) appearing on the applicable Bloomberg screen (or other commercially available source as designated by the Administrative Agent from time to time for purposes of providing quotations of interest rates applicable to Dollar deposits in the London interbank market) at approximately 11:00 a.m., London time, on such day (or, if such day is not a Eurodollar Business Day, the immediately preceding Eurodollar Business Day), as the rate for Dollar deposits with a maturity of approximately one month (in each case, the ***"One Month Screen Rate"***), *provided* that (a) in the event the *"One Month LIBOR Rate"* is not otherwise available, then the *"One Month LIBOR Rate"* with respect to such ABR Advance shall be the rate at which Dollar deposits of $5,000,000 and for a maturity of approximately one month are offered by the principal London office of the Administrative Agent in immediately available funds in the London interbank market at approximately 11:00 a.m., London time, on such day (or, if such day is not a Eurodollar Business Day, the immediately preceding Eurodollar Business Day), and (b) in the event that the *"One Month LIBOR Rate"* would otherwise be less than zero, such *"One Month LIBOR Rate"* shall be deemed to be zero for purposes of this Agreement.

"One Month Screen Rate": has the meaning assigned to it in the definition of *"One Month LIBOR Rate"*.

"Other Connection Taxes": with respect to the Administrative Agent, any Lender, any Issuer or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, Taxes imposed as a result of a present or former connection between such recipient and the jurisdiction imposing such Tax (other than connections arising from such recipient having executed, delivered, become a party to, performed its obligations under, received payments under, received or perfected a security interest under, engaged in any other transaction pursuant to, enforced any Loan Document, or sold or assigned an interest in any Loan or Loan Document).

"Other Taxes": all present or future stamp, court or documentary Taxes or any other excise or property Taxes, charges or similar levies arising from any payment made hereunder or under any other Loan Document or from the execution, delivery or enforcement of, or otherwise with respect to, this Agreement or any other Loan Document, except any such Taxes that are Other Connection Taxes imposed with respect to an assignment (other than an assignment made pursuant to Section 3.13).

"Participant": as defined in Section 11.7(d).

"Participant Register": as defined in Section 11.7(d).

"Patriot Act": as defined in Section 11.20.

"PBGC": the Pension Benefit Guaranty Corporation established pursuant to Subtitle A of Title IV of ERISA, or any Governmental Authority succeeding to the functions thereof.

"Pension Plan": at any time, any Employee Benefit Plan (including a Multiemployer Plan) subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, the funding requirements of which are, or at any time within the six years immediately preceding the time in question were, in whole or in part, the responsibility of the Borrower, any Subsidiary or an ERISA Affiliate.

"Person": any individual, firm, partnership, limited liability company, joint venture, corporation, association, business trust, joint stock company, unincorporated association, trust, Governmental Authority or any other entity, whether acting in an individual, fiduciary, or other capacity, and for the purpose of the definition of "ERISA Affiliate", a trade or business.

"Platform": as defined in Section 7.7.

"Pricing Level": Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV, Pricing Level V or Pricing Level VI, as the case may be.

"Pricing Level I": any time when the senior unsecured long term debt rating of the Borrower by (x) S&P is A or higher or (y) Moody's is A2 or higher.

"Pricing Level II": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is A- or higher or (y) Moody's is A3 or higher and (ii) Pricing Level I does not apply.

"Pricing Level III": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB+ or higher or (y) Moody's is Baa1 or higher and (ii) neither Pricing Level I nor Pricing Level II applies.

"Pricing Level IV": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB or higher or (y) Moody's is Baa2 or higher and (ii) none of Pricing Level I, Pricing Level II or Pricing Level III applies.

"Pricing Level V": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB- or higher or (y) Moody's is Baa3 or higher and (ii) none of Pricing Level I, Pricing Level II, Pricing Level III or Pricing Level IV applies.

"Pricing Level VI": any time when none of Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV or Pricing Level V applies.

Notwithstanding each definition of Pricing Level set forth above, if at any time the senior unsecured long term debt ratings of the Borrower by S&P and Moody's differ by more than one equivalent rating level, then the applicable Pricing Level shall be determined based upon the lower such rating adjusted upwards to the next higher rating level.

"Proceeding": as defined in Section 11.10(d).

"Prohibited Transaction": a transaction that is prohibited under Section 4975 of the Internal Revenue Code or Section 406 of ERISA and not exempt under Section 4975 of the Internal Revenue Code, Section 408 of ERISA or any applicable administrative exemptions.

"Property": in respect of any Person, all types of real, personal or mixed property and all types of tangible or intangible property owned or leased by such Person.

"PTE": as defined in Section 11.23(d).

"Regulatory Change": the occurrence, after the date hereof, of any of the following: (a) the adoption or taking effect of any law, rule, regulation or treaty, (b) any change in any law, rule, regulation or treaty or in the administration, implementation, interpretation or application thereof by any Governmental Authority or (c) the making or issuance of any request, guideline or directive (whether or not having the force of law) by any Governmental Authority; *provided* that, notwithstanding anything herein to the contrary, (i) the Dodd-Frank Wall Street Reform and Consumer Protection Act and all requests, rules, guidelines or directives thereunder or issued in connection therewith and (ii) all requests, rules, guidelines or directives promulgated by the Bank for International Settlements, the Basel Committee on Banking Supervision (or any successor or similar authority) or the United States or foreign regulatory authorities, in each case, pursuant to Basel III, in the case of each of clauses (i) and (ii), shall be deemed to be a "Regulatory Change", regardless of the date enacted, adopted or issued, but only if any such requirements are generally applicable to (and for which reimbursement is generally being sought by the Lenders in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this definition), as determined by the Lenders in their respective reasonable discretion.

"Register": as defined in Section 11.7(c).

"Reimbursement Agreement": as defined in Section 2.8(b).

"Reimbursement Obligations": all obligations and liabilities of the Borrower due and to become due (a) under the Reimbursement Agreements and (b) hereunder in respect of Letters of Credit.

"Related Parties": with respect to any specified Person, such Person's Affiliates and the respective directors, officers, employees, agents and advisors of such Person and such Person's Affiliates.

"Replaced Lender": as defined in Section 3.13.

"Replacement Lender": as defined in Section 3.13.

"Required Lenders": (a) at any time prior to the Commitment Termination Date or such earlier date as all of the Commitments shall have terminated or been terminated in accordance herewith, Lenders having Commitment Amounts greater than 50% of the Aggregate Commitment Amount, and (b) at all other times, Lenders having Credit Exposure greater than 50% of the Aggregate Credit Exposure.

"Restricted Payment": with respect to any Person, any of the following, whether direct or indirect: (a) the declaration or payment by such Person of any dividend or distribution on any class of stock of such Person, other than a dividend payable solely in shares of that class of stock to the holders of such class, (b) the declaration or payment by such Person of any distribution on any other type or class of equity interest or equity investment in such Person, and (c) any redemption, retirement, purchase or acquisition of, or sinking fund or other similar payment in respect of, any class of stock of, or other type or class of equity interest or equity investment in, such Person.

"Restrictive Agreement": as defined in Section 8.7.

"Revolving Credit Loan" and ***"Revolving Credit Loans"***: as defined in Section 2.1(a).

"Sanctioned Country": at any time, a country or territory which is the subject or target of any Sanctions.

"Sanctioned Person": at any time, (a) any Person listed in any Sanctions-related list of designated Persons maintained by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State, (b) any Person operating, organized or resident in a Sanctioned Country or (c) any Person controlled by any such Person.

"Sanctions": economic or financial sanctions or trade embargoes imposed, administered or enforced from time to time by the U.S. government, including those administered by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State.

"S&P": Standard & Poor's Financial Services LLC, a subsidiary of S&P Global Inc., and any successor thereto.

"Screen Rate": either the LIBO Screen Rate or the One Month Screen Rate.

"Special Counsel": such counsel as the Administrative Agent may engage from time to time.

"Statutory Reserve Rate": a fraction (expressed as a decimal), the numerator of which is the number one and the denominator of which is the number one minus the aggregate of the maximum reserve percentages (including any marginal, special, emergency or supplemental reserves) expressed as a decimal established by the Board of Governors of the Federal Reserve System to which the Administrative Agent is subject for eurocurrency funding (currently referred to as "Eurocurrency liabilities" in Regulation D of the Board of Governors of the Federal Reserve System, as amended). Such reserve percentages shall include those imposed pursuant to said Regulation D. Eurodollar Loans shall be deemed to constitute eurocurrency funding and to be subject to such reserve requirements without benefit of or credit for proration, exemptions or offsets that may be available from time to time to any Lender under said Regulation D or any comparable regulation. The Statutory Reserve Rate shall be adjusted automatically on and as of the effective date of any change in any reserve percentage.

"Subsidiary": at any time and from time to time, any corporation, partnership, limited liability company, joint venture or other business entity of which the Borrower and/or any Subsidiary of the Borrower, directly or indirectly at such time, either (a) in respect of a corporation, owns or controls more than 50% of the outstanding stock having ordinary voting power to elect a majority of the board of directors or similar managing body, irrespective of whether a class or classes shall or might have voting power by reason of the happening of any contingency, or (b) in respect of a partnership, limited liability company, joint venture or other business entity, is entitled to share in more than 50% of the profits and losses, however determined.

"Swing Line Commitment": the commitment of the Swing Line Lender to make Swing Line Loans in accordance with the terms hereof in an aggregate outstanding principal amount not exceeding $100,000,000 (or, if less, the Aggregate Commitment Amount) at any time, as the same may be reduced pursuant to Section 2.6.

"Swing Line Commitment Period": the period from the Effective Date to, but excluding, the Swing Line Termination Date.

"Swing Line Exposure": at any time, in respect of any Lender, an amount equal to the aggregate principal balance of such Lender's Swing Line Participation Amount.

"Swing Line Interest Period": as to any Swing Line Loan, the period commencing on the date of such Swing Line Loan and ending on the date set forth by the Borrower in the Borrowing Request with respect to such Swing Line Loan; *provided* that the last day of any Swing Line Interest Period shall not be earlier than one day after the date of such Swing Line Loan or later than 7 days after the date of such Swing Line Loan and in no event later than the Swing Line Termination Date; *provided further* that if any Swing Line Interest Period would end on a day other than a Domestic Business Day, such Swing Line Interest Period shall be extended to the next succeeding Domestic Business Day. Interest shall accrue from and including the first day of a Swing Line Interest Period to but excluding the last day of such Swing Line Interest Period.

"Swing Line Lender": BNY Mellon.

"Swing Line Loan" and ***"Swing Line Loans"***: as defined in Section 2.2(a).

"Swing Line Maturity Date": as defined in Section 2.2(a).

"Swing Line Participation Amount": as defined in Section 2.2(c).

"Swing Line Termination Date": the date which is 7 Domestic Business Days prior to the Commitment Termination Date.

"Taxes": all present or future taxes, levies, imposts, duties, deductions, withholdings, assessments, fees or other charges imposed by any Governmental Authority, including any interest, additions to tax or penalties applicable thereto.

"Termination Event": with respect to any Pension Plan, (a) an ERISA Event, (b) the termination of a Pension Plan under Section 4041(c) of ERISA, or the filing of a notice of intent to

terminate a Pension Plan under Section 4041(c) of ERISA, or the treatment of a Pension Plan amendment as a termination under Section 4041(e) of ERISA (except an amendment made after such Pension Plan satisfies the requirement for a standard termination under Section 4041(b) of ERISA), (c) the institution of proceedings by the PBGC to terminate a Pension Plan under Section 4042 of ERISA, or (d) the appointment of a trustee to administer any Pension Plan under Section 4042 of ERISA.

"Threshold Amount": prior to the later of (x) the termination or other expiration of the CVS Bridge Facility Commitment Letter in accordance with its terms and (y) the termination or other expiration of the CVS Bridge Facility if it is entered into, $250,000,000, and at all other times $200,000,000.

"Total Capitalization": at any date, the sum of the Borrower's Consolidated Indebtedness and shareholders' equity on such date, determined in accordance with GAAP.

"Type": with respect to any Revolving Credit Loan, the characteristic of such Loan as an ABR Advance or a Eurodollar Advance, each of which constitutes a Type of Revolving Credit Loan.

"Unqualified Amount": as defined in Section 3.4(c).

"Upstream Dividends": as defined in Section 8.7(a).

"U.S. Lender": as defined in Section 3.10(f).

"United States Tax Compliance Certificate": as defined in Section 3.10(f)(iii).

"Wells Fargo": as defined in the preamble.

"***WFS***": Wells Fargo Securities, LLC.

"Write-Down and Conversion Powers": with respect to any EEA Resolution Authority, the write-down and conversion powers of such EEA Resolution Authority from time to time under the Bail-In Legislation for the applicable EEA Member Country, which write-down and conversion powers are described in the EU Bail-In Legislation Schedule.

1.2 ***Principles of Construction***

(a) All capitalized terms defined in this Agreement shall have the meanings given to such capitalized terms herein when used in the other Loan Documents or in any certificate, opinion or other document made or delivered pursuant hereto or thereto, unless otherwise expressly provided therein.

(b) Unless otherwise expressly provided herein, the word *"fiscal"* when used herein shall refer to the relevant fiscal period of the Borrower. As used in the Loan Documents and in any certificate, opinion or other document made or delivered pursuant thereto, accounting terms not defined in Section 1.1, and accounting terms partly defined in Section 1.1, to the extent

not defined, shall have the respective meanings given to them under GAAP as in effect from time to time; *provided* that, if the Borrower notifies the Administrative Agent that the Borrower requests an amendment to any provision hereof to eliminate the effect of any change occurring after the date hereof in GAAP or in the application thereof on the operation of such provision (or if the Administrative Agent notifies the Borrower that the Required Lenders request an amendment to any provision hereof for such purpose), regardless of whether any such notice is given before or after such change in GAAP or in the application thereof, then such provision shall be interpreted on the basis of, and any accounting term related thereto shall have the respective meaning given to it under, GAAP as in effect and applied immediately before such change shall have become effective until such notice shall have been withdrawn or such provision amended in accordance herewith.

(c) The words *"hereof"*, *"herein"*, *"hereto"* and *"hereunder"* and similar words when used in each Loan Document shall refer to such Loan Document as a whole and not to any particular provision of such Loan Document, and Section, schedule and exhibit references contained therein shall refer to Sections thereof or schedules or exhibits thereto unless otherwise expressly provided therein.

(d) All references herein to a time of day shall mean the then applicable time in New York, New York, unless otherwise expressly provided herein.

(e) Section headings have been inserted in the Loan Documents for convenience only and shall not be construed to be a part thereof. Unless the context otherwise requires, words in the singular number include the plural, and words in the plural include the singular.

(f) Whenever in any Loan Document or in any certificate or other document made or delivered pursuant thereto, the terms thereof require that a Person sign or execute the same or refer to the same as having been so signed or executed, such terms shall mean that the same shall be, or was, duly signed or executed by (i) in respect of any Person that is a corporation, any duly authorized officer thereof, and (ii) in respect of any other Person (other than an individual), any analogous counterpart thereof.

(g) The words *"include"* and *"including"*, when used in each Loan Document, shall mean that the same shall be included *"without limitation"*, unless otherwise specifically provided.

(h) All references to "knowledge" or "awareness" of the Borrower or any Subsidiary means the actual knowledge of an Authorized Officer of the Borrower or such Subsidiary.

2. *AMOUNT AND TERMS OF LOANS*

2.1 *Revolving Credit Loans*

(a) Subject to the terms and conditions hereof, each Lender severally (and not jointly) agrees to make loans in Dollars under this Agreement (each a ***"Revolving Credit Loan"***

and, collectively with each other Revolving Credit Loan of such Lender and/or with each Revolving Credit Loan of each other Lender, the ***"Revolving Credit Loans"***) to the Borrower from time to time during the Commitment Period, during which period the Borrower may borrow, prepay and reborrow in accordance with the provisions hereof. Immediately after making each Revolving Credit Loan and after giving effect to all Swing Line Loans and Competitive Bid Loans repaid and all Reimbursement Obligations paid on the same date, the Aggregate Credit Exposure will not exceed the Aggregate Commitment Amount. With respect to each Lender, at the time of the making of any Revolving Credit Loan, the sum of (I) the principal amount of such Lender's Revolving Credit Loan constituting a part of the Revolving Credit Loans to be made, (II) the aggregate principal balance of all other Revolving Credit Loans (exclusive of Revolving Credit Loans which are repaid with the proceeds of, and simultaneously with the incidence of, the Revolving Credit Loans to be made) then outstanding from such Lender and (III) the product of (A) such Lender's Commitment Percentage and (B) the sum of (1) the aggregate principal balance of all Swing Line Loans (exclusive of Swing Line Loans which are repaid with the proceeds of, and simultaneously with the incurrence of, the Revolving Credit Loans to be made) then outstanding and (2) the Letter of Credit Exposure of all Lenders, will not exceed the Commitment of such Lender at such time. At the option of the Borrower, indicated in a Borrowing Request, Revolving Credit Loans may be made as ABR Advances or Eurodollar Advances.

(b) The aggregate outstanding principal balance of all Revolving Credit Loans shall be due and payable on the Commitment Termination Date or on such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6.

2.2 ***Swing Line Loans***

(a) Subject to the terms and conditions hereof, the Swing Line Lender agrees to make loans in Dollars under this Agreement (each a ***"Swing Line Loan"*** and, collectively, the ***"Swing Line Loans"***) to the Borrower from time to time during the Swing Line Commitment Period. Swing Line Loans (i) may be repaid and reborrowed in accordance with the provisions hereof, (ii) shall not, immediately after giving effect thereto, result in the Aggregate Credit Exposure exceeding the Aggregate Commitment Amount, and (iii) shall not, immediately after giving effect thereto, result in the aggregate outstanding principal balance of all Swing Line Loans exceeding the Swing Line Commitment. The Swing Line Lender shall not be obligated to make any Swing Line Loan at a time when any Lender is a Defaulting Lender unless the Swing Line Lender has entered into arrangements satisfactory to it and the Borrower to eliminate the Swing Line Lender's risk with respect to such Defaulting Lender's participation in such Swing Line Loan. The Swing Line Lender will not make a Swing Line Loan if the Administrative Agent or any Lender, by notice to the Swing Line Lender and the Borrower no later than one Domestic Business Day prior to the Borrowing Date with respect to such Swing Line Loan, shall have determined that the conditions set forth in Section 6 have not been satisfied or waived and such conditions remain unsatisfied as of the requested time of the making of such Loan. Each Swing Line Loan shall be due and payable on the day (the ***"Swing Line Maturity Date"***) being the earliest of the last day of the Swing Line Interest Period applicable thereto, the date on which the Swing Line Commitment shall have been terminated in accordance with Section 2.6, and the date on which the Loans shall become due and payable pursuant to the provisions hereof,

whether by acceleration or otherwise. Each Swing Line Loan shall bear interest at the Negotiated Rate applicable thereto. The Swing Line Lender shall disburse the proceeds of Swing Line Loans at its office designated in Section 11.2 by crediting such proceeds to an account of the Borrower maintained with the Swing Line Lender.

(b) On any Domestic Business Day, the Swing Line Lender may, in its sole discretion, give notice to the Lenders and the Borrower that such outstanding Swing Line Loan shall be funded with a borrowing of Revolving Credit Loans (*provided* that such notice shall be deemed to have been automatically given upon the occurrence of a Default or an Event of Default under Section 9.1(h), (i) or (j)), in which case a borrowing of Revolving Credit Loans made as ABR Advances (each such borrowing, a ***"Mandatory Borrowing"***) shall be made by all Lenders *pro rata* based on each such Lender's Commitment Percentage on the Domestic Business Day immediately succeeding the giving of such notice. The proceeds of each Mandatory Borrowing shall be remitted directly to the Swing Line Lender to repay such outstanding Swing Line Loan. Each Lender irrevocably agrees to make a Revolving Credit Loan pursuant to each Mandatory Borrowing in the amount and in the manner specified in the preceding sentence and on the date specified in writing by the Swing Line Lender notwithstanding: (i) whether the amount of such Mandatory Borrowing complies with the minimum amount for Loans otherwise required hereunder, (ii) whether any condition specified in Section 6 is then unsatisfied, (iii) whether a Default then exists, (iv) the Borrowing Date of such Mandatory Borrowing, (v) the aggregate principal amount of all Loans then outstanding, (vi) the Aggregate Credit Exposure at such time and (vii) the amount of the Commitments at such time.

(c) Upon each receipt by a Lender of a notice from the Administrative Agent, such Lender shall purchase unconditionally, irrevocably, and severally (and not jointly) from the Swing Line Lender a participation in the outstanding Swing Line Loans (including accrued interest thereon) in an amount equal to the product of its Commitment Percentage and the outstanding balance of the Swing Line Loans (each, a ***"Swing Line Participation Amount"***). Each Lender shall also be liable for an amount equal to the product of its Commitment Percentage and any amounts paid by the Borrower pursuant to this Section 2.2 that are subsequently rescinded or avoided, or must otherwise be restored or returned. Such liabilities shall be unconditional and without regard to the occurrence of any Default or the compliance by the Borrower with any of its obligations under the Loan Documents.

(d) In furtherance of Section 2.2(c), upon each receipt by a Lender of a notice from the Administrative Agent, such Lender shall promptly make available to the Administrative Agent for the account of the Swing Line Lender its Swing Line Participation Amount at the office of the Administrative Agent specified in Section 11.2, in Dollars and in immediately available funds. The Administrative Agent shall deliver the payments made by each Lender pursuant to the immediately preceding sentence to the Swing Line Lender promptly upon receipt thereof in like funds as received. Each Lender hereby indemnifies and agrees to hold harmless the Administrative Agent and the Swing Line Lender from and against any and all losses, liabilities (including liabilities for penalties), actions, suits, judgments, demands, costs and expenses resulting from any failure on the part of such Lender to pay, or from any delay in paying, the Administrative Agent any amount such Lender is required by notice from the

Administrative Agent to pay in accordance with this Section 2.2 (except in respect of losses, liabilities or other obligations suffered by the Administrative Agent or the Swing Line Lender, as the case may be, resulting from the gross negligence or willful misconduct of the Administrative Agent or the Swing Line Lender, as the case may be), and such Lender shall pay interest to the Administrative Agent for the account of the Swing Line Lender from the date such amount was due until paid in full, on the unpaid portion thereof, at a rate of interest per annum, whether before or after judgment, equal to (i) from the date such amount was due until the third day therefrom, the Federal Funds Effective Rate, and (ii) thereafter, the Federal Funds Effective Rate *plus* 2%, payable upon demand by the Swing Line Lender. The Administrative Agent shall distribute such interest payments to the Swing Line Lender upon receipt thereof in like funds as received.

(e) Whenever the Administrative Agent is reimbursed by the Borrower for the account of the Swing Line Lender for any payment in connection with Swing Line Loans and such payment relates to an amount previously paid by a Lender pursuant to this Section 2.2, the Administrative Agent will promptly remit such payment to such Lender.

2.3 ***Notice of Borrowing Revolving Credit Loans and Swing Line Loans***

The Borrower agrees to notify the Administrative Agent (and with respect to a Swing Line Loan, the Swing Line Lender), which notification shall be irrevocable, no later than (a) 2:00 P.M., on the proposed Borrowing Date in the case of Swing Line Loans, (b) 12:00 Noon on the proposed Borrowing Date in the case of Revolving Credit Loans to consist of ABR Advances and (c) 12:00 Noon at least three Eurodollar Business Days prior to the proposed Borrowing Date in the case of Revolving Credit Loans to consist of Eurodollar Advances. Each such notice shall specify (i) the aggregate amount requested to be borrowed under the Commitments or the Swing Line Commitment, (ii) the proposed Borrowing Date, (iii) whether a borrowing of Revolving Credit Loans is to be made as an ABR Advance, one or more Eurodollar Advances, or both, and the amount of each thereof, (iv) the Eurodollar Interest Period for each such Eurodollar Advance and (v) the Swing Line Interest Period for, and the amount of, each Swing Line Loan. Each such notice shall be promptly confirmed by delivery to the Administrative Agent (and, with respect to a Swing Line Loan, the Swing Line Lender) of a Borrowing Request. Each Eurodollar Advance to be made on a Borrowing Date, when aggregated with all amounts to be Converted to Eurodollar Advances on such date and having the same Interest Period as such Eurodollar Advance, shall equal no less than $10,000,000, or an integral multiple of $1,000,000 in excess thereof. Each ABR Advance made on each Borrowing Date shall equal no less than $5,000,000 or an integral multiple of $500,000 in excess thereof. Each Swing Line Loan made on each Borrowing Date shall equal no less than $1,000,000 or an integral multiple of $500,000 in excess thereof. The Administrative Agent shall promptly notify each Lender (by telephone or otherwise, such notification to be confirmed by fax, email or other writing) of each such Borrowing Request. Subject to its receipt of each such notice from the Administrative Agent and subject to the terms and conditions hereof, (A) each Lender shall make immediately available funds available to the Administrative Agent at the address therefor set forth in Section 11.2 not later than 1:00 P.M. on each Borrowing Date in an amount equal to such Lender's Commitment Percentage of the Revolving Credit Loans requested by the Borrower on such Borrowing Date and/or (B) the Swing Line Lender shall make immediately

available funds available to the Borrower on such Borrowing Date in an amount equal to the Swing Line Loan requested by the Borrower.

2.4 ***Competitive Bid Loans and Procedure***

(a) Subject to the terms and conditions hereof, the Borrower may request competitive bid loans in Dollars under this Agreement (each a ***"Competitive Bid Loan"***) during the Commitment Period. In order to request Competitive Bids, the Borrower shall deliver by hand, fax or email to the Administrative Agent a duly completed and executed Competitive Bid Request not later than 12:00 Noon, one Domestic Business Day before the proposed Borrowing Date therefor. A Competitive Bid Request that does not conform substantially to the format of Exhibit F may be rejected by the Administrative Agent in the Administrative Agent's reasonable discretion, and the Administrative Agent shall promptly notify the Borrower of such rejection by fax or email and by telephone. Each Competitive Bid Request shall specify (x) the proposed Borrowing Date for the Competitive Bid Loans then being requested (which shall be a Domestic Business Day) and the aggregate principal amount thereof and (y) the Competitive Interest Period or Competitive Interest Periods (which shall not exceed ten different Interest Periods in a single Competitive Bid Request), with respect thereto (which may not end after the Domestic Business Day immediately preceding the Commitment Termination Date). Promptly after its receipt of each Competitive Bid Request that is not rejected as aforesaid, the Administrative Agent shall invite by fax or email (substantially in the form of Exhibit G) the Lenders (other than any Defaulting Lender) to bid, on the terms and conditions of this Agreement, to make Competitive Bid Loans pursuant to such Competitive Bid Request.

(b) Each Lender (other than any Defaulting Lender), in its sole and absolute discretion, may make one or more Competitive Bids to the Borrower responsive to a Competitive Bid Request. Each Competitive Bid by a Lender must be received by the Administrative Agent not later than 10:00 A.M. on the proposed Borrowing Date for the relevant Competitive Bid Loan. Multiple bids will be accepted by the Administrative Agent. Bids to make Competitive Bid Loans that, in the reasonable judgment of the Administrative Agent, do not conform to the Bids solicited by the related Competitive Bid Request shall be rejected by the Administrative Agent. Competitive Bids that do not conform substantially to the format of Exhibit H may be rejected by the Administrative Agent after conferring with, and upon the instruction of, the Borrower, and the Administrative Agent shall notify the Lender making such nonconforming bid of such rejection as soon as practicable. Each Competitive Bid shall be irrevocable and shall specify (x) the principal amount (which (1) shall be in a minimum principal amount of $10,000,000 or an integral multiple of $1,000,000 in excess thereof, and (2) may equal the entire principal amount requested by the Borrower) of the Competitive Bid Loan or Competitive Bid Loans that the Lender is willing to make to the Borrower, (y) the Competitive Bid Rate or Competitive Bid Rates at which the Lender is prepared to make such Competitive Bid Loan or Competitive Bid Loans, and (z) the Competitive Interest Period with respect to each such Competitive Bid Loan and the last day thereof. If any Lender shall elect not to make a Competitive Bid, such Lender shall so notify the Administrative Agent by fax or email not later than 10:00 A.M. on the proposed Borrowing Date therefor, *provided* that the failure by any Lender to give any such notice shall not obligate such Lender to make any Competitive Bid Loan in connection with the relevant Competitive Bid Request.

(c) With respect to each Competitive Bid Request, the Administrative Agent shall (i) notify the Borrower by fax or email by 11:00 A.M. on the proposed Borrowing Date with respect thereto of each Competitive Bid made, the Competitive Bid Rate applicable thereto and the identity of the Lender that made such Competitive Bid, and (ii) send a list of all Competitive Bids to the Borrower for its records as soon as practicable after completion of the bidding process. Each notice and list sent by the Administrative Agent pursuant to this Section 2.4(c) shall list the Competitive Bids in ascending yield order.

(d) The Borrower may in its sole and absolute discretion, subject only to the provisions of this Section 2.4(d), accept or reject any Competitive Bid made in accordance with the procedures set forth in this Section 2.4, and the Borrower shall notify the Administrative Agent by telephone, confirmed by fax or email in the form of a duly completed and executed Competitive Bid Accept/Reject Letter, whether and to what extent it has decided to accept or reject any or all of such Competitive Bids not later than 12:00 Noon on the proposed Borrowing Date therefor; *provided* that the failure by the Borrower to give such notice shall be deemed to be a rejection of all such Competitive Bids. In connection with each acceptance of one or more Competitive Bids by the Borrower:

(1) the Borrower shall not accept a Competitive Bid of a given tenor made at a particular Competitive Bid Rate if the Borrower has decided to reject a Competitive Bid having the same tenor made at a lower Competitive Bid Rate unless the acceptance of such Competitive Bid made at a lower Competitive Bid Rate would subject the Borrower to any requirement to withhold any taxes or deduct any amount from any amounts payable under the Loan Documents, in which case the Borrower may reject such Competitive Bid made at a lower Competitive Bid Rate,

(2) the aggregate amount of the Competitive Bids accepted by the Borrower shall not exceed the principal amount specified in the Competitive Bid Request therefor,

(3) if the Borrower shall desire to accept a Competitive Bid made at a particular Competitive Bid Rate, it must accept all other Competitive Bids at such Competitive Bid Rate, except for any such Competitive Bid the acceptance of which would subject the Borrower to any requirement to withhold any taxes or deduct any amount from any amounts payable under the Loan Documents; *provided* that if the acceptance of all such other Competitive Bids would cause the aggregate amount of all such accepted Competitive Bids to exceed the amount requested, then such acceptance shall be made pro rata in accordance with the amount of each such Competitive Bid at such Competitive Bid Rate,

(4) except pursuant to clause (3) above, no Competitive Bid shall be accepted unless the Competitive Bid Loan with respect thereto shall be in a minimum principal amount of $10,000,000 or an integral multiple of $1,000,000 in excess thereof, and

(5) no Competitive Bid shall be accepted and no Competitive Bid Loan shall be made, if immediately after giving effect thereto, the Aggregate Credit Exposure would exceed the Aggregate Commitment Amount.

(e) The Administrative Agent shall promptly fax or email to each bidding Lender (with a copy to the Borrower) a Competitive Bid Accept/Reject Letter advising such Lender whether its Competitive Bid has been accepted (and if accepted, in what amount and at what Competitive Bid Rate), and each successful bidder so notified will thereupon become bound, subject to the applicable conditions hereof, to make the Competitive Bid Loan in respect of which each of its Competitive Bids has been accepted by making immediately available funds available to the Administrative Agent at its address set forth in Section 11.2 not later than 1:00 P.M. on the Borrowing Date for such Competitive Bid Loan in the amount thereof.

(f) Anything herein to the contrary notwithstanding, if the Administrative Agent shall elect to submit a Competitive Bid in its capacity as a Lender, it shall submit such bid directly to the Borrower not later than 9:30 A.M. on the relevant proposed Borrowing Date.

(g) All notices required by this Section 2.4 shall be given in accordance with Section 11.2.

(h) Each Competitive Bid Loan shall be due and payable on the last day of the Interest Period applicable thereto or on such earlier date upon which the Loans shall become due and payable pursuant to the provisions hereof, whether by acceleration or otherwise.

2.5 ***Use of Proceeds***

The Borrower agrees that the proceeds of the Loans and Letters of Credit shall be used solely for its general corporate purposes, but not inconsistent with this Section 2.5. Notwithstanding anything to the contrary contained in any Loan Document, the Borrower further agrees that no part of the proceeds of any Loan or Letter of Credit will be used, directly or indirectly, and whether immediately, incidentally or ultimately (i) for a purpose which violates any law, rule or regulation of any Governmental Authority, including the provisions of Regulations U or X of the Board of Governors of the Federal Reserve System, as amended, or any provision of this Agreement, including, without limitation, the provisions of Section 4.9 or (ii) to make a loan to any director or executive officer of the Borrower or any Subsidiary.

2.6 ***Termination, Reduction or Increase of Commitments***

(a) *Termination on Commitment Termination Date*. Unless previously terminated, the Commitments and the Letter of Credit Commitment shall terminate on the Commitment Termination Date and the Swing Line Commitment shall terminate on the Swing Line Termination Date.

(b) *Voluntary Termination or Reductions*. At the Borrower's option in its sole and absolute discretion and upon at least one Domestic Business Day's prior irrevocable notice to the Administrative Agent, the Borrower may (i) terminate the Commitments, the Swing Line Commitment and the Letter of Credit Commitment, at any time, or (ii) permanently reduce the

Aggregate Commitment Amount, the Swing Line Commitment or the Letter of Credit Commitment, in part at any time and from time to time; *provided* that (1) each such partial reduction shall be in an amount equal to at least $5,000,000 or an integral multiple of $1,000,000 in excess thereof and (2) immediately after giving effect to each such reduction, (A) the Aggregate Commitment Amount shall equal or exceed the Aggregate Credit Exposure, (B) the Swing Line Commitment shall equal or exceed the aggregate outstanding principal balance of all Swing Line Loans and (C) the Letter of Credit Commitment shall equal or exceed the Letter of Credit Exposure of all Lenders; *provided*, *further* that, notwithstanding the foregoing, a notice of termination of the Commitments, the Swing Line Commitment and the Letter of Credit Commitment delivered by the Borrower may state that such notice is conditioned upon the effectiveness of other credit facilities or transactions (such notice to specify the proposed effective date), in which case such notice may be revoked by the Borrower (by notice to the Administrative Agent on or prior to such specified effective date) if such condition is not satisfied and the Borrower shall indemnify the Lenders in accordance with Section 3.5, if applicable.

(c) *In General*. Each reduction of the Aggregate Commitment Amount shall be made by reducing each Lender's Commitment Amount by an amount equal to the product of such Lender's Commitment Percentage and the amount of such reduction.

(d) *Increase in Aggregate Commitment Amount.* The Borrower may at any time and from time to time prior to the 90th day prior to the then-applicable Commitment Termination Date, at its sole cost and expense, request any one or more of the Lenders having a Commitment to increase its Commitment Amount (the decision to increase the Commitment Amount of a Lender to be within the sole and absolute discretion of such Lender), or any Eligible Assignee to provide a new Commitment, by submitting to the Administrative Agent a Commitment Increase Supplement, duly executed and delivered by the Borrower and each such Lender or Eligible Assignee, as the case may be. Upon receipt of any such Commitment Increase Supplement, the Administrative Agent, the Swing Line Lender and each Issuer shall promptly execute and deliver such Commitment Increase Supplement and the Administrative Agent shall deliver a copy thereof to the Borrower and each such Lender or Eligible Assignee, as the case may be. Upon execution and delivery of such Commitment Increase Supplement by the Administrative Agent, the Swing Line Lender and each Issuer, (i) in the case of each such Lender (an ***"Increasing Lender"***), its Commitment Amount shall be increased to the amount set forth in such Commitment Increase Supplement, and (ii) in the case of each such Eligible Assignee (a ***"New Lender"***), such New Lender shall become a party hereto and have the rights and obligations of a Lender under the Loan Documents and its Commitment shall be as set forth in such Commitment Increase Supplement; *provided* that:

(1) immediately after giving effect thereto, the sum of all increases in the Aggregate Commitment Amount made pursuant to this Section 2.6(d) shall not exceed $250,000,000;

(2) each such increase of the Aggregate Commitment Amount shall be in an amount not less than $25,000,000 or such amount plus an integral multiple of

$5,000,000; *provided* that an increase may be in a lesser amount if such increase is an increase of the entire remaining amount available under clause (1) above;

(3) no Default shall have occurred or be continuing on the effective date of the increase;

(4) the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on the effective date of such increase (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such effective date), except those which are expressly specified to be made as of an earlier date;

(5) in the case of each New Lender, the Commitment Amount assumed by such New Lender shall not be less than $25,000,000;

(6) if Revolving Credit Loans would be outstanding immediately after giving effect to any such increase, then simultaneously with such increase (A) each such Increasing Lender, each such New Lender and each other Lender shall be deemed to have entered into a master assignment and assumption, in form and substance substantially similar to Exhibit E, pursuant to which each such other Lender shall have assigned to each such Increasing Lender and each such New Lender a portion of its Revolving Credit Loans necessary to reflect proportionately the Commitments as increased in accordance with this Section 2.6(d), and (B) in connection with such assignment, each such Increasing Lender and each such New Lender shall pay to the Administrative Agent, for the account of each such other Lender, such amount as shall be necessary to reflect the assignment to it of such Revolving Credit Loans, and in connection with such master assignment each such other Lender may treat the assignment of Eurodollar Advances as a prepayment of such Eurodollar Advances for purposes of Section 3.5;

(7) each such New Lender shall have delivered to the Administrative Agent an Administrative Questionnaire and to the Administrative Agent and the Borrower all forms, if any, that are required to be delivered by such New Lender pursuant to Section 3.10; and

(8) the Administrative Agent shall have received such other certificates, resolutions and opinions as the Administrative Agent shall have reasonably requested.

2.7 ***Prepayments of Loans***

(a) *Voluntary Prepayments*. The Borrower may prepay Revolving Credit Loans, Competitive Bid Loans and Swing Line Loans, in whole or in part, without premium or penalty, but subject to Section 3.5, at any time and from time to time, by notifying the Administrative Agent at least two Eurodollar Business Days, in the case of a prepayment of Eurodollar Advances, two Domestic Business Days, in the case of a prepayment of Competitive

Bid Loans, or one Domestic Business Day, in the case of a prepayment of Swing Line Loans or ABR Advances, prior to the proposed prepayment date specifying (i) the Loans to be prepaid, (ii) the amount to be prepaid, and (iii) the date of prepayment. Upon receipt of each such notice, the Administrative Agent shall promptly notify each Lender thereof. Each such notice given by the Borrower pursuant to this Section 2.7 shall be irrevocable, *provided* that, if a notice of prepayment is given in connection with a conditional notice of termination of the Commitments, the Swing Line Commitment and the Letter of Credit Commitment as contemplated by Section 2.6, then such notice of prepayment may be revoked if such notice of termination is revoked in accordance with Section 2.6, and the Borrower shall indemnify the Lenders in accordance with Section 3.5. Each partial prepayment under this Section 2.7 shall be (A) in the case of Eurodollar Advances, in a minimum amount of $5,000,000 or an integral multiple of $1,000,000 in excess thereof or the entire remaining amount of Eurodollar Advances, (B) in the case of ABR Advances, in a minimum amount of $1,000,000 or an integral multiple of $100,000 in excess thereof or the entire remaining amount of ABR Advances, (C) in the case of Swing Line Loans, in a minimum amount of $500,000 or an integral multiple of $100,000 in excess thereof or the entire remaining amount of Swing Line Loans, and (D) in the case of Competitive Bid Loans, in a minimum amount of $5,000,000 or an integral multiple of $1,000,000 in excess thereof or the entire remaining amount of Competitive Bid Loans.

(b) *In General*. Simultaneously with each prepayment hereunder, the Borrower shall prepay all accrued and unpaid interest on the amount prepaid through the date of prepayment and indemnify the Lenders in accordance with Section 3.5, if applicable.

2.8 ***Letter of Credit Sub-facility***

(a) Subject to the terms and conditions hereof and the payment by the Borrower to each Issuer of such fees as the Borrower and such Issuer shall have agreed in writing, each Issuer severally (and not jointly) agrees, in reliance on the agreement of the other Lenders set forth in Section 2.9, to issue standby or commercial letters of credit (each a ***"Letter of Credit"*** and, collectively, the ***"Letters of Credit"***) during the Commitment Period for the account of the Borrower; *provided* that immediately after the issuance of each Letter of Credit (i) the Letter of Credit Exposure of all Lenders shall not exceed the Aggregate Letter of Credit Commitment, (ii) the Aggregate Credit Exposure shall not exceed the Aggregate Commitment Amount, (iii) the Letter of Credit Exposure of such Issuer shall not exceed the Letter of Credit Commitment of such Issuer, and (iv) the Commercial Letter of Credit Exposure of such Issuer shall not exceed the Commercial Letter of Credit Commitment of such Issuer. Each Letter of Credit shall have an expiration date which shall be not later than, in the case of standby Letters of Credit, the earlier to occur of one year from the date of issuance thereof or 5 days prior to the Commitment Termination Date and, in the case of commercial Letters of Credit, the earlier to occur of 180 days from the date of issuance thereof or 5 days prior to the Commitment Termination Date. No Letter of Credit shall be issued if the Administrative Agent, or any Lender by notice to the Administrative Agent, and the proposed Issuer shall have determined, no later than 3:00 P.M. one Domestic Business Day prior to the requested date of issuance of such Letter of Credit, that the conditions set forth in Section 6 have not been satisfied or waived.

(b) Each Letter of Credit shall be issued at the request of the Borrower in support of an obligation of the Borrower or any Subsidiary in favor of a beneficiary who has requested the issuance of such Letter of Credit. The Borrower shall give the Administrative Agent a Letter of Credit Request for the issuance of each Letter of Credit by 12:00 Noon at least two Domestic Business Days prior to the requested date of issuance. Such Letter of Credit Request shall specify (i) whether such Letter of Credit is a standby or commercial Letter of Credit, (ii) the beneficiary of such Letter of Credit and the obligations of the Borrower or the Subsidiary in respect of which such Letter of Credit is to be issued, (iii) the Borrower's proposal as to the conditions under which a drawing may be made under such Letter of Credit and the documentation to be required in respect thereof, (iv) the maximum amount to be available under such Letter of Credit, (v) the requested date of issuance, and (vi) the name of the proposed Issuer thereof. Upon receipt of such Letter of Credit Request from the Borrower, the Administrative Agent shall promptly notify the applicable Issuer and each Lender thereof. Such Issuer shall, on the proposed date of issuance and subject to the terms and conditions of this Agreement, issue the requested Letter of Credit; *provided* that in the event such Issuer fails to issue such Letter of Credit or is a Defaulting Lender, any other Issuer may (in its sole and absolute discretion, and notwithstanding that its Letter of Credit Exposure may exceed its Letter of Credit Commitment, but with (x) the consent of the Borrower and (y) notice to the Administrative Agent) issue such Letter of Credit otherwise in accordance with the terms hereof; *provided further* that immediately after the issuance thereof (A) the Letter of Credit Exposure of all Lenders shall not exceed the Aggregate Letter of Credit Commitment, and (B) the Aggregate Credit Exposure shall not exceed the Aggregate Commitment Amount. Each Letter of Credit shall be in form and substance reasonably satisfactory to the Issuer thereof, with such provisions with respect to the conditions under which a drawing may be made thereunder and the documentation required in respect of such drawing as such Issuer shall reasonably require. Each Letter of Credit shall be used solely for the purposes described therein. Each Letter of Credit Request and each Letter of Credit shall be subject to the standard terms and conditions for letters of credit of the Issuer thereof (each as amended, supplemented or replaced from time to time, a ***"Reimbursement Agreement"***) executed by the Borrower and delivered to such Issuer.

(c) Each payment by an Issuer of a draft drawn under a Letter of Credit issued thereby shall give rise to the obligation of the Borrower to promptly (and in any event within one Domestic Business Day) reimburse such Issuer for the amount thereof. Such Issuer shall promptly notify the Borrower of such payment by such Issuer of a draft drawn under a Letter of Credit. In lieu of such notice, if the Borrower has not made reimbursement prior to the end of the Domestic Business Day following the day during which such Issuer made such payment of such draft, the Borrower hereby authorizes such Issuer to deduct the amount of any such reimbursement from such account(s) as the Borrower may from time to time designate in writing to such Issuer, upon which such Issuer shall apply the amount of such deduction to such reimbursement. If all or any portion of any Reimbursement Obligation in respect of a Letter of Credit shall not be paid on the date that the Issuer thereof shall have made payment of a draft drawn under such Letter of Credit, the amount of such Reimbursement Obligation shall bear interest, at a rate per annum equal to the Alternate Base Rate *plus* the Applicable Margin applicable to ABR Advances, from the date such Issuer made such payment of such draft until the end of the Domestic Business Day following the day during which such Issuer made such payment of such draft (whether at the stated maturity thereof, by acceleration or otherwise), and

from and after such Domestic Business Day (whether at the stated maturity thereof, by acceleration or otherwise), such Reimbursement Obligation shall bear interest, payable upon demand, at a rate per annum equal to the Alternate Base Rate *plus* the Applicable Margin applicable to ABR Advances *plus* 2%, from such due date until paid in full (whether before or after the entry of a judgment thereon).

(d) In the event of any conflict between the terms hereof and the terms of any Reimbursement Agreement or Letter of Credit Application, the terms hereof shall control.

2.9 ***Letter of Credit Participation***

(a) Each Lender hereby unconditionally and irrevocably, severally (and not jointly) takes an undivided participating interest in the obligations of each Issuer under and in connection with each Letter of Credit issued thereby in an amount equal to such Lender's Commitment Percentage (as in effect from time to time) of the amount of such Letter of Credit. Each Lender shall be liable to each Issuer for its Commitment Percentage of the unreimbursed amount of any draft drawn and honored under each Letter of Credit issued thereby. Each Lender shall also be liable for an amount equal to the product of its Commitment Percentage and any amounts paid by the Borrower pursuant to Section 2.8 that are subsequently rescinded or avoided, or must otherwise be restored or returned. Such liabilities shall be unconditional and without regard to the occurrence of any Default or the compliance by the Borrower with any of its obligations under the Loan Documents.

(b) Each Issuer shall promptly notify the Administrative Agent, and the Administrative Agent shall promptly notify each Lender (which notice shall be promptly confirmed in writing), of the date and the amount of each draft paid under each Letter of Credit issued by such Issuer with respect to which full reimbursement payment shall not have been made by the Borrower as provided in Section 2.8(c), and forthwith upon receipt of such notice, such Lender shall promptly make available to the Administrative Agent for the account of such Issuer its Commitment Percentage of the amount of such unreimbursed draft at the office of the Administrative Agent specified in Section 11.2 in Dollars and in immediately available funds. The Administrative Agent shall distribute the payments made by each Lender pursuant to the immediately preceding sentence to such Issuer promptly upon receipt thereof in like funds as received. Each Lender shall indemnify and hold harmless the Administrative Agent and each Issuer from and against any and all losses, liabilities (including liabilities for penalties), actions, suits, judgments, demands, costs and expenses (including, without limitation, reasonable attorneys' fees and expenses) resulting from any failure on the part of such Lender to provide, or from any delay in providing, the Administrative Agent with such Lender's Commitment Percentage of the amount of any payment made by such Issuer under a Letter of Credit issued by such Issuer in accordance with this clause (b) (except in respect of losses, liabilities or other obligations suffered by the Administrative Agent or such Issuer, as the case may be, resulting from the gross negligence or willful misconduct of the Administrative Agent or such Issuer, as the case may be). If a Lender does not make available to the Administrative Agent when due an amount equal to such Lender's Commitment Percentage of any unreimbursed payment made by an Issuer under a Letter of Credit issued thereby, such Lender shall be required to pay interest to the Administrative Agent for the account of such Issuer on the unpaid portion of such amount at

a rate of interest per annum equal to (i) from the date such Lender should have made such amount available until the third day therefrom, the Federal Funds Effective Rate, and (ii) thereafter, the Federal Funds Effective Rate *plus* 2%, in each case payable upon demand by such Issuer. The Administrative Agent shall distribute such interest payments to such Issuer upon receipt thereof in like funds as received.

(c) Whenever the Administrative Agent is reimbursed by the Borrower, for the account of an Issuer, for any payment under a Letter of Credit issued thereby and such payment relates to an amount previously paid by a Lender in respect of its Commitment Percentage of the amount of such payment under such Letter of Credit, the Administrative Agent (or such Issuer, if such payment by a Lender was paid by the Administrative Agent to such Issuer) will promptly pay over such payment to such Lender.

2.10 ***Absolute Obligation with respect to Letter of Credit Payments***

The Borrower's obligation to reimburse the Administrative Agent for the account of an Issuer for each payment under or in respect of each Letter of Credit issued thereby shall be absolute and unconditional under any and all circumstances and irrespective of any set-off, counterclaim or defense to payment which the Borrower may have or have had against the beneficiary of such Letter of Credit, the Administrative Agent, such Issuer, the Swing Line Lender, any Lender or any other Person, including, without limitation, any defense based on the failure of any drawing to conform to the terms of such Letter of Credit, any drawing document proving to be forged, fraudulent or invalid, or the legality, validity, regularity or enforceability of such Letter of Credit; *provided* that, with respect to any Letter of Credit, the foregoing shall not relieve the Issuer thereof of any liability it may have to the Borrower for any actual damages sustained by the Borrower arising from a wrongful payment (or failure to pay) under such Letter of Credit made as a result of such Issuer's gross negligence or willful misconduct.

2.11 ***Notes***

Any Lender may request that the Loans made by it be evidenced by a Note. In such event, the Borrower shall prepare, execute and deliver to such Lender a Note payable to such Person or, if requested by such Person, such Person and its registered assigns.

2.12 ***Extension of Commitment Termination Date***

(a) *Request for Extension*. The Borrower may, in its sole and absolute discretion, by notice to the Administrative Agent (which shall promptly notify the Lenders) not more than 90 days and not less than 30 days prior to each of the first, second, third, fourth and fifth anniversary of the Effective Date (each such anniversary date, an ***"Extension Date"***), request (each, an ***"Extension Request"***) that the Lenders extend the Commitment Termination Date then in effect (the ***"Existing Commitment Termination Date"***) for an additional one-year period, *provided* that the Borrower may only effect one such extension of the Commitment Termination Date. Each Lender, acting in its sole discretion, shall, by notice to the Borrower and the Administrative Agent given not later than the 20th day (or such later day as shall be acceptable to the Borrower) following the date of the Borrower's notice, advise the Borrower and the Administrative Agent whether or not such Lender agrees to such extension; *provided* that

any Lender (which includes each Issuer and the Swing Line Lender) that does not so advise the Borrower and the Administrative Agent shall be deemed to have rejected such Extension Request. The election of any Lender to agree to such extension shall not obligate any other Lender to so agree.

(b) *Replacement of Non-Extending Lenders*. The Borrower shall have the right at any time on or prior to the relevant Extension Date to replace any Lender which has not consented to the Extension Request (each, a ***"Non-Extending Lender"***) pursuant to Section 3.13.

(c) *Conditions to Effectiveness of Extension*. Notwithstanding anything in this Agreement to the contrary, the extension of the Existing Commitment Termination Date on any Extension Date shall not be effective unless, immediately before and after giving effect to such extension on such Extension Date: (i) no Default shall have occurred and be continuing on such Extension Date and the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on such Extension Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such Extension Date), except those which are expressly specified to be made as of an earlier date, and the Administrative Agent shall have received a certificate, in form and substance reasonably satisfactory to the Administrative Agent, to such effect from the chief financial officer of the Borrower (or such other financial officer reasonably acceptable to the Administrative Agent), and (ii) the Administrative Agent shall have received such other certificates, resolutions and opinions as the Administrative Agent may reasonably request.

(d) *Effectiveness of Extension*. If (and only if) the conditions specified in Section 2.12(c) shall have been satisfied or waived with respect to the extension of the Existing Commitment Termination Date on the applicable Extension Date, then, effective as of such Extension Date, the Commitment Termination Date, with respect to the Commitment of each Lender that has agreed to so extend its Commitment and of each Replacement Lender that has assumed a Commitment of a Non-Extending Lender in connection with such Extension Request, shall be extended to the date falling one year after the Existing Commitment Termination Date (or, if such date is not a Domestic Business Day, the immediately preceding Domestic Business Day), and each such Replacement Lender shall thereupon become a "Lender" for all purposes of this Agreement. Notwithstanding anything herein to the contrary, (i) with respect to any portion of the Commitment of any Non-Extending Lender that has not been fully assumed by one or more Replacement Lenders, the Commitment Termination Date for such Lender with respect to such non-assumed portion of its Commitment shall remain unchanged, and (ii) with respect to any Loans of such Lender that have not been purchased by one or more Replacement Lenders, the applicable maturity date with respect to such non-purchased Loans shall remain unchanged and shall be repayable by the Borrower on such applicable maturity date without there being any requirement that any such repayment be shared with other Lenders. In addition, on the Extension Date, the Borrower agrees to pay all accrued and unpaid interest, fees and other amounts then due under this Agreement from the Borrower to each Lender consenting to the Extension Request, each Non-Extending Lender and each Replacement Lender. Solely for the purpose of calculating break funding payments under Section 3.5, the assignment by any

Non-Extending Lender of any Eurodollar Advance prior to the last day of the Interest Period applicable thereto in accordance with this Section 2.12 shall be deemed to constitute a prepayment by the Borrower of such Eurodollar Advance.

2.13 ***Defaulting Lenders***

Notwithstanding any provision of this Agreement to the contrary, if any Lender becomes a Defaulting Lender, then the following provisions shall apply for so long as such Lender is a Defaulting Lender:

(a) Facility Fees shall cease to accrue, and shall not be payable, on the unfunded portion of the Commitment of such Defaulting Lender pursuant to Section 3.11;

(b) the Commitment and Credit Exposure of such Defaulting Lender shall not be included in determining whether all Lenders or the Required Lenders have taken or may take any action hereunder (including any consent to any amendment or waiver pursuant to Section 11.1); *provided* that any waiver, amendment or modification with respect to the following shall require the consent of such Defaulting Lender: (i) any waiver, amendment or modification requiring the consent of all Lenders or each affected Lender which affects such Defaulting Lender differently than other affected Lenders, (ii) any waiver, amendment or modification increasing the Commitment of such Defaulting Lender, (iii) any waiver, amendment or modification extending the Commitment Period with respect to such Defaulting Lender, (iv) any waiver, amendment or modification reducing the principal amount owed under the Loan Documents to such Defaulting Lender (other than by payment thereof), or (v) any waiver, amendment or modification extending the final maturity of sums owed to such Defaulting Lender, or (vi) a modification of this Section 2.13(b);

(c) if any Swing Line Exposure or Letter of Credit Exposure exists at the time a Lender becomes a Defaulting Lender then:

(1) all or any part of such Defaulting Lender's Swing Line Exposure and Letter of Credit Exposure shall be reallocated among the non-Defaulting Lenders in accordance with their respective Commitment Percentages but only to the extent that (A) the sum of all non-Defaulting Lenders' Committed Credit Exposures plus, without duplication, the amount of such Defaulting Lender's Swing Line Exposure and Letter of Credit Exposure reallocated to such non-Defaulting Lenders, does not exceed the total of all non-Defaulting Lenders' Commitments and (B) with respect to each non-Defaulting Lender, the sum of such non-Defaulting Lender's Committed Credit Exposure plus, without duplication, the amount of such Defaulting Lender's Swing Line Exposure and Letter of Credit Exposure reallocated to such non-Defaulting Lender, does not exceed such non-Defaulting Lender's Commitment;

(2) if the reallocation described in clause (1) above cannot, or can only partially, be effected, the Borrower shall within one Domestic Business Day following notice by the Administrative Agent (A) first, prepay such Swing Line Exposure and (B) second, cash collateralize such Defaulting Lender's Letter of Credit Exposure (after giving effect to any partial reallocation pursuant to clause (1) above) in a manner

satisfactory to the Administrative Agent and the Issuers for so long as such Letter of Credit Exposure is outstanding;

(3) if the Borrower cash collateralizes any portion of such Defaulting Lender's Letter of Credit Exposure pursuant to this Section 2.13(c), the Borrower shall not be required to pay any Letter of Credit Participation Fees to such Defaulting Lender pursuant to Section 3.12 with respect to such Defaulting Lender's Letter of Credit Exposure during the period such Defaulting Lender's Letter of Credit Exposure is cash collateralized; and

(4) if the Swing Line Exposure or Letter of Credit Exposure of such Defaulting Lender is reallocated pursuant to this Section 2.13(c), then the fees payable to the Lenders pursuant to Section 3.11 and Section 3.12 shall be adjusted to give effect to such reallocation, and the Administrative Agent shall promptly notify the Lenders of any reallocation described in this Section 2.13(c);

(d) so long as any Lender is a Defaulting Lender, the Swing Line Lender shall not be required to fund any Swing Line Loan and no Issuer shall be required to issue, amend, extend or increase any Letter of Credit, unless it is satisfied that the related exposure will be 100% covered by the Commitments of the non-Defaulting Lenders and/or cash collateral will be provided by the Borrower in accordance with Section 2.13(c), and participating interests in any such newly issued or increased Letter of Credit or newly made Swing Line Loan shall be allocated among non-Defaulting Lenders in a manner consistent with Section 2.13(c)(1) (and Defaulting Lenders shall not participate therein);

(e) any amount payable to such Defaulting Lender hereunder (whether on account of principal, interest, fees or otherwise and including any amount that would otherwise be payable to such Defaulting Lender pursuant to Section 11.9 but excluding Section 3.13) shall, in lieu of being distributed to such Defaulting Lender, be retained by the Administrative Agent in a segregated account and, subject to any applicable requirements of law, be applied at such time or times as may be determined by the Administrative Agent (i) first, to the payment of any amounts owing by such Defaulting Lender to the Administrative Agent hereunder, (ii) second, pro rata, to the payment of any amounts owing by such Defaulting Lender to the Issuers and the Swing Line Lender hereunder, (iii) third, if so determined by the Administrative Agent or requested by any Issuer or the Swing Line Lender, held in such account as cash collateral for future funding obligations of the Defaulting Lender in respect of any existing or future participating interest in any Swing Line Loan or Letter of Credit, (iv) fourth, to the funding of any Revolving Credit Loan (including any Mandatory Borrowing) in respect of which such Defaulting Lender has failed to fund its portion thereof as required by this Agreement, as determined by the Administrative Agent, (v) fifth, if so determined by the Administrative Agent and the Borrower, held in such account as cash collateral for future funding obligations of the Defaulting Lender in respect of any Revolving Credit Loans (including any Mandatory Borrowings) under this Agreement, (vi) sixth, to the payment of any amounts owing to the Lenders, the Issuers or the Swing Line Lender as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by any Lender, any Issuer or the Swing Line Lender against such Defaulting Lender as a result of such Defaulting Lender's breach of its

obligations under this Agreement, (vii) seventh, to the payment of any amounts owing to the Borrower as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by the Borrower against such Defaulting Lender as a result of such Defaulting Lender's breach of its obligations under this Agreement, and (viii) eighth, to such Defaulting Lender or as otherwise directed by a court of competent jurisdiction; *provided* that if such payment is (x) a prepayment of the principal amount of any Revolving Credit Loan (including any Mandatory Borrowing) or Reimbursement Obligations in respect of drawings under Letters of Credit paid by an Issuer with respect to which a Defaulting Lender has funded its participation obligations and (y) made at a time when the conditions set forth in Section 6 are satisfied or waived, such payment shall be applied solely to prepay the Revolving Credit Loans (including Mandatory Borrowings) of, and Reimbursement Obligations owed to, all non-Defaulting Lenders pro rata prior to being applied to the prepayment of any Loans, or Reimbursement Obligations owed to, any Defaulting Lender;

(f) the Borrower shall have the right at any time during which a Lender is a Defaulting Lender to replace such Defaulting Lender pursuant to Section 3.13; and

(g) subject to Section 11.22, no reallocation pursuant to Section 2.13(c) shall constitute a waiver or release of any claim of any party hereunder against a Defaulting Lender arising from a Lender having become a Defaulting Lender, including any claim of a non-Defaulting Lender as a result of such non-Defaulting Lender's increased exposure following such reallocation.

3. *PROCEEDS, PAYMENTS, CONVERSIONS, INTEREST, YIELD PROTECTION AND FEES*

3.1 *Disbursement of the Proceeds of the Loans*

The Administrative Agent shall disburse the proceeds of the Loans (other than the Swing Line Loans) at its office specified in Section 11.2 by crediting to the Borrower's general deposit account with the Administrative Agent the funds received from each Lender. Unless the Administrative Agent shall have received prior notice from a Lender (by telephone or otherwise, such notice to be confirmed by fax, email or other writing) that such Lender will not make available to the Administrative Agent such Lender's Commitment Percentage of the Revolving Credit Loans, or the amount of any Competitive Bid Loan, to be made by it on a Borrowing Date, the Administrative Agent may assume that such Lender has made such amount available to the Administrative Agent on such Borrowing Date in accordance with this Section 3.1, *provided* that, in the case of a Revolving Credit Loan, such Lender received notice thereof from the Administrative Agent in accordance with the terms hereof, and the Administrative Agent may, in reliance upon such assumption, make available to the Borrower on such Borrowing Date a corresponding amount. If and to the extent that such Lender shall not have so made such amount available to the Administrative Agent, such Lender and the Borrower severally agree to pay to the Administrative Agent, forthwith on demand, such corresponding amount (to the extent not previously paid by the other), together with interest thereon for each day from the date such amount is made available to the Borrower until the date such amount is paid to the Administrative Agent, at a rate per annum equal to, in the case of the Borrower, the applicable interest rate set forth in Section 3.4(a) and, in

the case of such Lender, the Federal Funds Effective Rate from the date such payment is due until the third day after such date and, thereafter, at the Federal Funds Effective Rate *plus* 2%. Any such payment by the Borrower shall be without prejudice to its rights against such Lender. If such Lender shall pay to the Administrative Agent such corresponding amount, such amount so paid shall constitute such Lender's Loan as part of such Loans for purposes of this Agreement, which Loan shall be deemed to have been made by such Lender on the Borrowing Date applicable to such Loans.

3.2 ***Payments***

(a) Each payment, including each prepayment, of principal and interest on the Loans and of the Facility Fee and the Letter of Credit Participation Fee (collectively, together with all of the other fees to be paid to the Administrative Agent, the Lenders, the Issuers and the Swing Line Lender in connection with the Loan Documents, the ***"Fees"***), and of all of the other amounts to be paid to the Administrative Agent and the Lenders in connection with the Loan Documents (other than amounts payable to a Lender under Section 3.5, Section 3.6, Section 3.10, Section 11.5 and Section 11.10) shall be made by the Borrower to the Administrative Agent at its office specified in Section 11.2 without setoff, deduction or counterclaim in funds immediately available in New York by 3:00 P.M. on the due date for such payment. The failure of the Borrower to make any such payment by such time shall not constitute a default hereunder, *provided* that such payment is made on such due date, but any such payment made after 3:00 P.M. on such due date shall be deemed to have been made on the next Domestic Business Day or Eurodollar Business Day, as the case may be, for the purpose of calculating interest on amounts outstanding on the Loans. If the Borrower has not made any such payment prior to 3:00 P.M., the Borrower hereby authorizes the Administrative Agent to deduct the amount of any such payment from such account(s) as the Borrower may from time to time designate in writing to the Administrative Agent, upon which the Administrative Agent shall apply the amount of such deduction to such payment. Promptly upon receipt thereof by the Administrative Agent, each payment of principal and interest on the: (i) Revolving Credit Loans shall be remitted by the Administrative Agent in like funds as received to each Lender (a) first, pro rata according to the amount of interest which is then due and payable to the Lenders, and (b) second, pro rata according to the amount of principal which is then due and payable to the Lenders, (ii) Competitive Bid Loans shall be remitted by the Administrative Agent in like funds as received to each applicable Lender and (iii) Swing Line Loans shall be remitted by the Administrative Agent in like funds as received to the Swing Line Lender. Each payment of the Facility Fee and the Letter of Credit Participation Fee payable to the Lenders shall be promptly transmitted by the Administrative Agent in like funds as received to each Lender pro rata according to such Lender's Commitment Amount or, if the Commitments shall have terminated or been terminated, according to the outstanding principal amount of such Lender's Revolving Credit Loans.

(b) If any payment hereunder or under the Loans shall be due and payable on a day which is not a Domestic Business Day or a Eurodollar Business Day, as the case may be, the due date thereof (except as otherwise provided in the definition of Eurodollar Interest Period or Competitive Interest Period) shall be extended to the next Domestic Business Day or Eurodollar Business Day, as the case may be, and (except with respect to payments in respect of

the Facility Fee and the Letter of Credit Participation Fee) interest shall be payable at the applicable rate specified herein during such extension.

3.3 ***Conversions; Other Matters***

(a) The Borrower may elect at any time and from time to time to Convert one or more Eurodollar Advances to an ABR Advance by giving the Administrative Agent at least one Domestic Business Day's prior irrevocable notice of such election, specifying the amount to be so Converted. In addition, the Borrower may elect at any time and from time to time to Convert an ABR Advance to any one or more new Eurodollar Advances or to Convert any one or more existing Eurodollar Advances to any one or more new Eurodollar Advances by giving the Administrative Agent no later than 10:00 A.M. at least two Eurodollar Business Days' prior irrevocable notice of such election, specifying the amount to be so Converted and the initial Interest Period relating thereto; *provided* that any Conversion of an ABR Advance to an Eurodollar Advance shall only be made on a Eurodollar Business Day; *provided, further* that, notwithstanding the foregoing, a notice of Conversion delivered by the Borrower may state that such notice is conditioned upon the effectiveness of other credit facilities or transactions (such notice to specify the proposed effective date), in which case such notice may be revoked by the Borrower (by notice to the Administrative Agent prior to the day specified for such Conversion in such notice of Conversion) if such condition is not satisfied and the Borrower shall indemnify the Lenders in accordance with Section 3.5, if applicable. The Administrative Agent shall promptly provide the Lenders with notice of each such election. Each Conversion of Loans shall be made pro rata according to the outstanding principal amount of the Loans of each Lender. ABR Advances and Eurodollar Advances may be Converted pursuant to this Section 3.3 in whole or in part; *provided* that the amount to be Converted to each Eurodollar Advance, when aggregated with any Eurodollar Advance to be made on such date in accordance with Section 2.1 and having the same Interest Period as such first Eurodollar Advance, shall equal no less than $10,000,000 or an integral multiple of $1,000,000 in excess thereof or the entire remaining amount of the Eurodollar Advances.

(b) Notwithstanding anything in this Agreement to the contrary, the Borrower shall not have the right to elect to Convert any existing ABR Advance to a Eurodollar Advance or to Convert any existing Eurodollar Advance to a new Eurodollar Advance if (i) a Default or an Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) shall then exist, or (ii) any other Event of Default shall then exist and the Administrative Agent shall have notified the Borrower at the request of the Required Lenders that no ABR Advance or Eurodollar Advance may be Converted to a new Eurodollar Advance. In such event, such ABR Advance shall be automatically continued as an ABR Advance or such Eurodollar Advance shall be automatically Converted to an ABR Advance on the last day of the Interest Period applicable to such Eurodollar Advance. The foregoing shall not affect any other rights or remedies that the Administrative Agent or any Lender may have under this Agreement or any other Loan Document.

(c) Each Conversion shall be effected by each Lender by applying the proceeds of each new ABR Advance or Eurodollar Advance, as the case may be, to the existing

ABR Advance or Eurodollar Advance (or portion thereof) being Converted (it being understood that such Conversion shall not constitute a borrowing for purposes of Section 4 or Section 6).

(d) Notwithstanding any other provision of any Loan Document:

(1) if the Borrower shall have failed to elect a Eurodollar Advance under Section 2.3 or this Section 3.3, as the case may be, in connection with any borrowing of new Revolving Credit Loans or expiration of an Interest Period with respect to any existing Eurodollar Advance, the amount of the Revolving Credit Loans subject to such borrowing or such existing Eurodollar Advance shall thereafter be an ABR Advance until such time, if any, as the Borrower shall elect a new Eurodollar Advance pursuant to this Section 3.3,

(2) the Borrower shall not be permitted to select a Eurodollar Advance the Interest Period in respect of which ends later than the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6, and

(3) the Borrower shall not be permitted to have more than 15 Eurodollar Advances and Competitive Bid Loans, in the aggregate, outstanding at any one time; it being understood and agreed that each borrowing of Eurodollar Advances or Competitive Bid Loans pursuant to a single Borrowing Request or Competitive Bid Request, as the case may be, shall constitute the making of one Eurodollar Advance or Competitive Bid Loan for the purpose of calculating such limitation.

3.4 ***Interest Rates and Payment Dates***

(a) *Prior to Maturity*. Except as otherwise provided in Section 3.4(b) and Section 3.4(c), the Loans shall bear interest on the unpaid principal balance thereof at the applicable interest rate or rates per annum set forth below:

LOANS	RATE
Revolving Credit Loans constituting ABR Advances	Alternate Base Rate *plus* the Applicable Margin.
Revolving Credit Loans constituting Eurodollar Advances	Eurodollar Rate applicable thereto *plus* the Applicable Margin.
Competitive Bid Loans	Fixed rate of interest applicable thereto accepted by the Borrower pursuant to Section 2.4(d).
Swing Line Loans	Negotiated Rate applicable thereto as provided in Section 2.2(a).

(b) *Late Payment Rate*. Any payment of principal or interest on the Loans, Fees or other amounts payable by the Borrower under the Loan Documents not paid on the date when due and payable shall, after the occurrence and during the continuance of an Event of Default pursuant to Section 9.1(a), 9.1(b), 9.1(h), 9.1(i) or 9.1(j), bear interest, in the case of principal or interest on a Loan, at the applicable interest rate on such Loan *plus* 2% per annum and, in the case of any Fees or other amounts, at the Alternate Base Rate *plus* the Applicable Margin *plus* 2% per annum, in each case from the due date thereof until the date such payment is made (whether before or after the entry of any judgment thereon).

(c) *Highest Lawful Rate*. Notwithstanding anything to the contrary contained in this Agreement, at no time shall the interest rate payable to any Lender on any of its Loans, together with the Fees and all other amounts payable hereunder to such Lender to the extent the same constitute or are deemed to constitute interest, exceed the Highest Lawful Rate. If in respect of any period during the term of this Agreement, any amount paid to any Lender hereunder, to the extent the same shall (but for the provisions of this Section 3.4) constitute or be deemed to constitute interest, would exceed the maximum amount of interest permitted by the Highest Lawful Rate during such period (such amount being hereinafter referred to as an ***"Unqualified Amount"***), then (i) such Unqualified Amount shall be applied or shall be deemed to have been applied as a prepayment of the Loans of such Lender, and (ii) if, in any subsequent period during the term of this Agreement, all amounts payable hereunder to such Lender in respect of such period which constitute or shall be deemed to constitute interest shall be less than the maximum amount of interest permitted by the Highest Lawful Rate during such period, then the Borrower shall pay to such Lender in respect of such period an amount (each a ***"Compensatory Interest Payment"***) equal to the lesser of (x) a sum which, when added to all such amounts, would equal the maximum amount of interest permitted by the Highest Lawful Rate during such period, and (y) an amount equal to the aggregate sum of all Unqualified Amounts *less* all other Compensatory Interest Payments.

(d) *General*. Interest shall be payable in arrears on each Interest Payment Date, on the Commitment Termination Date, to the extent provided in Section 2.7(b), upon each prepayment of the Loans and, to the extent provided in Section 2.12(d), on the Extension Date. Any change in the interest rate on the Loans resulting from an increase or a decrease in the Alternate Base Rate or any reserve requirement shall become effective as of the opening of business on the day on which such change shall become effective. The Administrative Agent shall, as soon as practicable, notify the Borrower and the Lenders of the effective date and the amount of each change in the BNY Mellon Rate, but any failure to so notify shall not in any manner affect the obligation of the Borrower to pay interest on the Loans in the amounts and on the dates set forth herein. Each determination by the Administrative Agent of the Alternate Base Rate, the Eurodollar Rate and the Competitive Bid Rate pursuant to this Agreement shall be conclusive and binding on the Borrower absent manifest error. The Borrower acknowledges that to the extent interest payable on the Loans is based on the Alternate Base Rate, such rate is only one of the bases for computing interest on loans made by the Lenders, and by basing interest payable on ABR Advances on the Alternate Base Rate, the Lenders have not committed to charge, and the Borrower has not in any way bargained for, interest based on a lower or the lowest rate at which the Lenders may now or in the future make extensions of credit to other Persons. All interest (other than interest calculated with reference to the BNY Mellon Rate) shall

be calculated on the basis of a 360-day year for the actual number of days elapsed, and all interest determined with reference to the BNY Mellon Rate shall be calculated on the basis of a 365/366-day year for the actual number of days elapsed.

(e) *No Warranty.* The Administrative Agent does not warrant or accept responsibility for, and shall not have any liability with respect to, the administration, submission or any other matter related to the rates in the definition of "LIBO Rate" and "One Month LIBOR Rate"; *provided* that the foregoing shall not apply to any liability arising out of the bad faith, willful misconduct or gross negligence of the Administrative Agent.

3.5 ***Indemnification for Loss***

Notwithstanding anything contained herein to the contrary, if: (i) the Borrower shall fail to borrow a Eurodollar Advance or if the Borrower shall fail to Convert all or any portion of any Revolving Credit Loan constituting an ABR Advance to a Eurodollar Advance after it shall have given notice to do so in which it shall have requested a Eurodollar Advance pursuant to Section 2.3 or Section 3.3, as the case may be, (ii) the Borrower shall fail to borrow a Competitive Bid Loan after it shall have accepted any offer with respect thereto in accordance with Section 2.4 or a Swing Line Loan after it shall have agreed to a Negotiated Rate with respect thereto in accordance with Section 2.2(a), (iii) a Eurodollar Advance, Competitive Bid Loan or Swing Line Loan shall be terminated for any reason prior to the last day of the Interest Period applicable thereto (other than the termination of a Swing Line Loan resulting from a Mandatory Borrowing at a time when no Default shall exist), (iv) any repayment or prepayment of the principal amount of a Eurodollar Advance, Competitive Bid Loan or Swing Line Loan is made for any reason on a date which is prior to the last day of the Interest Period applicable thereto (other than the repayment or prepayment of a Swing Line Loan resulting from a Mandatory Borrowing at a time when no Default shall exist), (v) the Borrower shall have revoked a notice of prepayment or notice of termination of the Commitments, the Swing Line Commitment and the Letter of Credit Commitment that was conditioned upon the effectiveness of other credit facilities or transactions pursuant to Section 2.6 or Section 2.7, or (vi) a Eurodollar Advance is assigned other than on the last day of the Interest Period applicable thereto as a result of an increase in the Aggregate Commitment Amount pursuant to Section 2.6(d) or a replacement of a Lender pursuant to clause (x) or (z) of Section 3.13, then the Borrower agrees to indemnify each Lender against, and to pay on demand directly to such Lender the amount (calculated by such Lender using any method chosen by such Lender which is customarily used by such Lender for such purpose for borrowers similar to the Borrower) equal to any loss or expense suffered by such Lender as a result of such failure to borrow or Convert, or such termination, repayment, prepayment or revocation, including any loss, cost or expense suffered by such Lender in liquidating or employing deposits acquired to fund or maintain the funding of such Eurodollar Advance, Competitive Bid Loan or Swing Line Loan, as the case may be, or redeploying funds prepaid or repaid, in amounts which correspond to such Eurodollar Advance, Competitive Bid Loan or Swing Line Loan, as the case may be, and any reasonable internal processing charge customarily charged by such Lender in connection therewith for borrowers similar to the Borrower.

3.6 ***Reimbursement for Costs, Etc.***

If at any time or from time to time there shall occur a Regulatory Change and any Issuer or any Lender shall have reasonably determined that such Regulatory Change (i) shall have had or will thereafter have the effect of reducing (A) the rate of return on such Issuer's or such Lender's capital or liquidity or the capital or liquidity of any Person directly or indirectly owning or controlling such Issuer or such Lender (each a ***"Control Person"***), or (B) the asset value (for capital or liquidity purposes) to such Issuer, such Lender or such Control Person, as applicable, of the Reimbursement Obligations, or any participation therein, or the Loans, or any participation therein, in any case to a level below that which such Issuer, such Lender or such Control Person could have achieved or would thereafter be able to achieve but for such Regulatory Change (after taking into account such Issuer's, such Lender's or such Control Person's policies regarding capital or liquidity), (ii) will impose, modify or deem applicable any reserve, asset, special deposit or special assessment requirements on deposits obtained in the interbank eurodollar market in connection with the Loan Documents (excluding, with respect to any Eurodollar Advance, any such requirement which is included in the determination of the rate applicable thereto), or (iii) will subject such Issuer, such Lender or such Control Person, as applicable, to any tax (documentary, stamp or otherwise) with respect to this Agreement, any Note, any Reimbursement Agreement or any other Loan Document (except, in the case of clause (iii) above, for any Indemnified Taxes, Excluded Taxes or Other Taxes), then, in each such case, within ten days after demand by such Issuer or such Lender, as applicable, the Borrower shall pay directly to such Issuer, such Lender or such Control Person, as the case may be, such additional amount or amounts as shall be sufficient to compensate such Issuer, such Lender or such Control Person, as the case may be, for any such reduction, reserve or other requirement, tax, loss, cost or expense (excluding general administrative and overhead costs) (collectively, ***"Costs"***) attributable to such Issuer's, such Lender's or such Control Person's compliance during the term hereof with such Regulatory Change, but only if such Costs are generally applicable to (and for which reimbursement is generally being sought by such Issuer, such Lender or such Control Person, as applicable, in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this Section 3.6), as determined by such Issuer or such Lender, as applicable, in its reasonable discretion. Each Issuer and each Lender may make multiple requests for compensation under this Section 3.6.

Notwithstanding the foregoing, the Borrower will not be required to compensate any Lender for any Costs under this Section 3.6 arising prior to 45 days preceding the date of demand, unless the applicable Regulatory Change giving rise to such Costs is imposed retroactively. In the case of retroactivity, such notice shall be provided to the Borrower not later than 45 days from the date that such Lender learned of such Regulatory Change. The Borrower's obligation to compensate such Lender shall be contingent upon the provision of such timely notice (but any failure by such Lender to provide such timely notice shall not affect the Borrower's obligations with respect to (i) Costs incurred from the date as of which such Regulatory Change became effective to the date that is 45 days after the date such Lender reasonably should have learned of such Regulatory Change and (ii) Costs incurred following the provision of such notice).

3.7 ***Illegality of Funding***

Notwithstanding any other provision hereof, if any Lender shall reasonably determine that any law, regulation, treaty or directive, or any change therein or in the interpretation or application thereof, shall make it unlawful for such Lender to make or maintain any Eurodollar Advance as contemplated by this Agreement, such Lender shall promptly notify the Borrower and the Administrative Agent thereof, and (a) the commitment of such Lender to make such Eurodollar Advances or Convert ABR Advances to such Eurodollar Advances shall forthwith be suspended, (b) such Lender shall fund its portion of each requested Eurodollar Advance as an ABR Advance and (c) such Lender's Loans then outstanding as such Eurodollar Advances, if any, shall be Converted automatically to an ABR Advance on the last day of the then current Interest Period applicable thereto or at such earlier time as may be required. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7 and such Lender shall have obtained actual knowledge that it is once again legal for such Lender to make or maintain Eurodollar Advances, such Lender shall promptly notify the Administrative Agent and the Borrower thereof and, upon receipt of such notice by each of the Administrative Agent and the Borrower, such Lender's commitment to make or maintain Eurodollar Advances shall be reinstated. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7, such suspension shall not otherwise affect such Lender's Commitment.

3.8 ***Option to Fund; Substituted Interest Rate***

(a) Each Lender has indicated that, if the Borrower requests a Swing Line Loan, a Eurodollar Advance or a Competitive Bid Loan, such Lender may wish to purchase one or more deposits in order to fund or maintain its funding of its Commitment Percentage of such Eurodollar Advance or its Swing Line Loan or Competitive Bid Loan during the Interest Period with respect thereto; it being understood that the provisions of this Agreement relating to such funding are included only for the purpose of determining the rate of interest to be paid in respect of such Swing Line Loan, Eurodollar Advance or Competitive Bid Loan and any amounts owing under Section 3.5 and Section 3.6. The Swing Line Lender and each Lender shall be entitled to fund and maintain its funding of all or any part of each Swing Line Loan, Eurodollar Advance and Competitive Bid Loan in any manner it sees fit, but all such determinations hereunder shall be made as if such Lender had actually funded and maintained its Commitment Percentage of each Eurodollar Advance or its Swing Line Loan or Competitive Bid Loan, as the case may be, during the applicable Interest Period through the purchase of deposits in an amount equal to the amount of its Commitment Percentage of such Eurodollar Advance or the amount of such Swing Line Loan or Competitive Bid Loan, as the case may be, and having a maturity corresponding to such Interest Period. Each Lender may fund its Loans from or for the account of any branch or office of such Lender as such Lender may choose from time to time, subject to Section 3.10.

(b) In the event that (i) the Administrative Agent shall have determined in good faith (which determination shall be conclusive and binding upon the Borrower) that Dollar deposits are not being offered to banks in the London interbank eurodollar market for the applicable amount and Interest Period or if by reason of circumstances affecting the interbank eurodollar market adequate and reasonable means do not exist for ascertaining the Eurodollar Rate applicable pursuant to Section 2.3 or Section 3.3, or (ii) the Required Lenders shall have

notified the Administrative Agent that they have in good faith determined (which determination shall be conclusive and binding on the Borrower) that the applicable Eurodollar Rate will not adequately and fairly reflect the cost to such Lenders of maintaining or funding loans bearing interest based on such Eurodollar Rate with respect to any portion of the Revolving Credit Loans that the Borrower has requested be made as Eurodollar Advances or any Eurodollar Advance that will result from the requested Conversion of any portion of the Revolving Credit Loans into Eurodollar Advances (each, an ***"Affected Advance"***), the Administrative Agent shall promptly notify the Borrower and the Lenders (by telephone or otherwise, to be promptly confirmed in writing) of such determination on or, to the extent practicable, prior to the requested Borrowing Date or Conversion date for such Affected Advances. If the Administrative Agent shall give such notice, (A) any Affected Advances shall be made as ABR Advances, (B) the Revolving Credit Loans (or any portion thereof) that were to have been Converted to Affected Advances shall be Converted to or continued as ABR Advances, and (C) any outstanding Affected Advances shall be Converted, on the last day of the then current Interest Period with respect thereto, to ABR Advances. Until any notice under clauses (i) or (ii), as the case may be, of this Section 3.8(b) has been withdrawn by the Administrative Agent (by notice to the Borrower) promptly upon either (x) the Administrative Agent having determined that such circumstances affecting the relevant market no longer exist and that adequate and reasonable means do exist for determining the Eurodollar Rate pursuant to Section 2.3 or Section 3.3, or (y) the Administrative Agent having been notified by the Required Lenders that circumstances no longer render the Loans (or any portion thereof) Affected Advances, no further Eurodollar Advances shall be required to be made by the Lenders nor shall the Borrower have the right to Convert all or any portion of the Revolving Credit Loans to Eurodollar Advances.

(c) In the event that the Administrative Agent shall have determined in good faith (which determination shall be conclusive and binding upon the Borrower absent manifest error) that by reason of circumstances affecting the interbank Eurodollar market adequate and reasonable means do not exist for ascertaining the One Month LIBOR Rate, the Administrative Agent shall promptly notify the Borrower and the Lenders (by telephone or otherwise, to be promptly confirmed in writing) of such determination. If the Administrative Agent shall give such notice, the Alternate Base Rate shall be determined without giving effect to clause (iii) thereof until such time, if any, as such notice shall have been withdrawn by the Administrative Agent (by notice to the Borrower) promptly upon the Administrative Agent having determined that such circumstances affecting the relevant market no longer exist and that adequate and reasonable means do exist for determining the One Month LIBOR Rate.

(d) If at any time the Administrative Agent shall have determined in good faith (which determination shall be conclusive and binding upon the Borrower absent manifest error) that (i) the circumstances under clause (i) of Section 3.8(b) or under Section 3.8(c) have arisen and such circumstances are unlikely to be temporary, or (ii) the circumstances set forth in clause (i) of this Section 3.8(d) have not arisen but the supervisor for the administrator of either Screen Rate or a Governmental Authority having jurisdiction over the Administrative Agent has made a public statement identifying a specific date after which such Screen Rate shall no longer be used for determining interest rates for loans, or (iii)(x) with respect to Eurodollar Advances, the LIBOR Rate is no longer a widely recognized benchmark rate for newly originated loans in the U.S. syndicated loan market in the applicable currency or (y) with respect to ABR Advances,

the One Month LIBOR Rate is no longer a widely recognized benchmark rate for newly originated loans in the U.S. syndicated loan market in the applicable currency, then the Administrative Agent and the Borrower shall endeavor to establish an alternate rate of interest to the LIBO Rate and the One Month LIBOR Rate that gives due consideration to the then prevailing market convention for determining rates of interest for syndicated loans in the United States at such time, and shall enter into a mutually acceptable amendment to this Agreement to reflect such alternate rates of interest and such other related changes to this Agreement as may be applicable (but, for the avoidance of doubt, such related changes shall not include a reduction of the Applicable Margin); *provided* that, if any such alternate rate of interest shall be less than zero, such rate shall be deemed to be zero for the purposes of this Agreement; *provided, further*, that after the occurrence of the circumstances described in clause (i), (ii) or (iii) above, the Borrower may revoke any pending request for a borrowing, Conversion or continuation of Eurodollar Advances (to the extent of the affected Eurodollar Advance or Interest Period). Notwithstanding anything to the contrary in Section 11.1, such amendment shall become effective without any further action or consent of any other party to this Agreement (other than the Borrower, whose prior written consent for such amendment shall be required) so long as the Administrative Agent shall not have received, within five (5) Domestic Business Days of the date any notice of such alternate rates of interest is provided to the Lenders, a written notice from the Required Lenders stating that such Lenders object to such amendment (it being understood that, if the Required Lenders object to any such amendment, the Administrative Agent and the Borrower shall be permitted to continue to establish alternate rates of interest and provide one or more additional notices hereunder until an amendment pursuant to this Section 3.8(d) has become effective).

3.9 *Certificates of Payment and Reimbursement*

Each Issuer and each Lender agrees, in connection with any request by it for payment or reimbursement pursuant to Section 3.5 or Section 3.6, to provide the Borrower with a certificate, signed by an officer of such Issuer or such Lender, as the case may be, setting forth a description in reasonable detail of any such payment or reimbursement and the applicable Section of this Agreement pursuant to and in accordance with which such request is made. Each determination by such Issuer and such Lender of such payment or reimbursement shall be conclusive absent manifest error.

3.10 *Taxes; Net Payments*

(a) *Payments Free of Taxes*. Any and all payments by or on account of any obligation of the Borrower hereunder or under any other Loan Document shall be made free and clear of and without reduction or withholding for any Indemnified Taxes or Other Taxes, *provided* that if the Borrower shall be required by applicable law to deduct any Indemnified Taxes (including any Other Taxes) from such payments, then (i) the sum payable shall be increased as necessary so that after making all required deductions (including deductions applicable to additional sums payable under this Section 3.10) the Administrative Agent, the applicable Lender or the applicable Issuer, as the case may be, receives an amount equal to the sum it would have received had no such deductions for Indemnified Taxes or Other Taxes been

made, (ii) the Borrower shall make such deductions and (iii) the Borrower shall timely pay the full amount deducted to the relevant Governmental Authority in accordance with applicable law.

(b) *Payment of Other Taxes by the Borrower*. Without limiting the provisions of paragraph (a) above, the Borrower shall timely pay any Other Taxes to the relevant Governmental Authority in accordance with applicable law.

(c) *Indemnification by the Borrower*. The Borrower shall indemnify the Administrative Agent, each Lender and each Issuer, within 30 days after demand therefor, for the full amount of any Indemnified Taxes imposed on or with respect to any payment made by or on account of any obligation of the Borrower under any Loan Document or Other Taxes (including Indemnified Taxes or Other Taxes imposed or asserted on or attributable to amounts payable under this Section 3.10) paid by the Administrative Agent, such Lender or such Issuer, as the case may be, and, without duplication, any penalties, interest and reasonable expenses arising therefrom or with respect thereto, whether or not such Indemnified Taxes or Other Taxes were correctly or legally imposed or asserted by the relevant Governmental Authority. A certificate as to the amount of such payment or liability delivered to the Borrower by such Lender or such Issuer (with a copy to the Administrative Agent), or by the Administrative Agent on its own behalf or on behalf of such Lender or such Issuer, shall be conclusive absent manifest error. After any Lender or any Issuer (as the case may be) learns of the imposition of any Indemnified Taxes or Other Taxes, such Lender or such Issuer (as the case may be) will as soon as reasonably practicable notify the Borrower thereof; *provided* that the failure to provide Borrower with such notice shall not release the Borrower from its indemnification obligations under this Section 3.10.

(d) *Evidence of Payments*. As soon as practicable after any payment of Indemnified Taxes or Other Taxes by the Borrower to a Governmental Authority, the Borrower shall deliver to the Administrative Agent the original or a certified copy of a receipt issued by such Governmental Authority evidencing such payment, a copy of the return reporting such payment or other evidence of such payment reasonably satisfactory to the Administrative Agent.

(e) *Indemnification by the Lenders*. Each Lender shall severally indemnify the Administrative Agent, within 10 days after demand therefor, for (i) any Indemnified Taxes attributable to such Lender (but only to the extent that the Borrower has not already indemnified the Administrative Agent for such Indemnified Taxes and without limiting the obligation of the Borrower to do so), (ii) any Taxes attributable to such Lender's failure to comply with the provisions of Section 11.7(d) relating to the maintenance of a Participant Register, and (iii) any Excluded Taxes attributable to such Lender, in each case, that are payable or paid by the Administrative Agent in connection with any Loan Document, and any reasonable expenses arising therefrom or with respect thereto, whether or not such Taxes were correctly or legally imposed or asserted by the relevant Governmental Authority. A certificate as to the amount of such payment or liability delivered to any Lender by the Administrative Agent shall be conclusive absent manifest error. Each Lender hereby authorizes the Administrative Agent to set off and apply any and all amounts at any time owing to such Lender under any Loan Document or otherwise payable by the Administrative Agent to the Lender from any other source against any amount due to the Administrative Agent under this paragraph (e).

(f) *Status of Lenders*. Any Lender that is entitled to an exemption from or reduction of withholding Tax under the law of the jurisdiction in which the Borrower is resident for Tax purposes, or any treaty to which such jurisdiction is a party, with respect to payments hereunder or under any other Loan Document shall deliver to the Borrower (with a copy to the Administrative Agent), at the time or times prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent, such properly completed and executed documentation prescribed by applicable law as will permit such payments to be made without withholding or at a reduced rate of withholding. In addition, any Lender, if requested by the Borrower or the Administrative Agent, shall deliver such other documentation prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent as will enable the Borrower or the Administrative Agent to determine whether or not such Lender is subject to backup withholding or information reporting requirements.

Without limiting the generality of the foregoing, any Foreign Lender shall deliver to the Borrower and the Administrative Agent (in such number of copies as shall be requested by the recipient) on or prior to the date on which such Foreign Lender becomes a Lender under this Agreement (and from time to time thereafter (i) if such Foreign Lender shall determine that any applicable form or certification has expired or will then expire or has or will then become obsolete or incorrect or that an event has occurred that requires or will then require a change in the most recent form or certification previously delivered by it to the Borrower and the Administrative Agent and (ii) upon the request of the Borrower or the Administrative Agent, but only if such Foreign Lender is legally entitled to do so), whichever of the following is applicable:

(i) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E claiming eligibility for benefits of an income Tax treaty to which the United States of America is a party,

(ii) duly completed copies of Internal Revenue Service Form W-8ECI,

(iii) in the case of a Foreign Lender claiming the benefits of the exemption for portfolio interest under Section 881(c) of the Internal Revenue Code, (x) a certificate (a ***"United States Tax Compliance Certificate"***) to the effect that such Foreign Lender is not (A) a "bank" within the meaning of Section 881(c)(3)(A) of the Internal Revenue Code, (B) a "10 percent shareholder" of the Borrower within the meaning of Section 881(c)(3)(B) of the Internal Revenue Code, (C) a "controlled foreign corporation" described in Section 881(c)(3)(C) of the Internal Revenue Code nor (D) engaged in the conduct of a trade or business within the United States to which the interest payment is effectively connected and (y) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E,

(iv) to the extent a Foreign Lender is not the beneficial owner (for example, where the Foreign Lender is a partnership or participating Lender granting a typical participation), a complete and executed Internal Revenue Service Form W-8IMY, accompanied by a Form W-8ECI, Form W-8BEN, Form W-8BEN-E, a United States Tax Compliance Certificate, Internal Revenue Service Form W-9 and/or other certification documents from each beneficial owner, as applicable; *provided* that, if the Foreign Lender is a partnership (and not a participating Lender) and one or more partners of such Foreign Lender are claiming the portfolio

interest exemption, such Foreign Lender shall provide a United States Tax Compliance Certificate, on behalf of such beneficial owner(s) in lieu of requiring each beneficial owner to provide its own certificate, or

(v) any other form prescribed by applicable law as a basis for claiming exemption from or a reduction in United States Federal withholding Tax duly completed together with such supplementary documentation as may be prescribed by applicable law to permit the Borrower to determine the withholding or deduction required to be made.

If a payment made to a Lender under any Loan Document would be subject to U.S. federal withholding Tax imposed by FATCA if such Lender were to fail to comply with the applicable reporting requirements of FATCA (including those contained in Section 1471(b) or 1472(b) of the Internal Revenue Code, as applicable), such Lender shall deliver to the Borrower and the Administrative Agent at the time or times prescribed by law and at such time or times reasonably requested by the Borrower or the Administrative Agent such documentation prescribed by applicable law (including as prescribed by Section 1471(b)(3)(C) of the Internal Revenue Code) and such additional documentation reasonably requested by the Borrower or the Administrative Agent as may be necessary for the Borrower and the Administrative Agent to comply with their obligations under FATCA and to determine that such Lender has complied with such Lender's obligations under FATCA or to determine the amount to deduct and withhold from such payment. Solely for purposes of this clause, "FATCA" shall include any amendments made to FATCA after the date of this Agreement.

Without limiting the foregoing, upon request of the Administrative Agent or the Borrower, each Lender and each Issuer that is a "United States person" within the meaning of Section 7701(a)(30) of the Internal Revenue Code that lends to the Borrower (each, a ***"U.S. Lender"***) shall deliver to the Administrative Agent and the Borrower two duly signed, properly completed copies of Internal Revenue Service Form W-9 on or prior to the Effective Date (or on or prior to the date it becomes a party to this Agreement), certifying that such U.S. Lender is entitled to an exemption from United States backup withholding, or any successor form.

(g) *Treatment of Certain Refunds*. If the Administrative Agent, a Lender or an Issuer determines, in its sole discretion exercised in good faith, that it has received a refund of any Taxes or Other Taxes as to which it has been indemnified by the Borrower or with respect to which the Borrower has paid additional amounts pursuant to this Section 3.10, it shall pay to the Borrower an amount equal to such refund (but only to the extent of indemnity payments made, or additional amounts paid, by the Borrower under this Section 3.10 with respect to the Taxes or Other Taxes giving rise to such refund), net of all reasonable and documented out-of-pocket expenses of the Administrative Agent, such Lender or such Issuer, as the case may be, and without interest (other than any interest paid by the relevant Governmental Authority with respect to such refund), *provided* that the Borrower, upon the request of the Administrative Agent, such Lender or such Issuer, agrees to repay the amount paid over to the Borrower (plus any penalties, interest or other charges imposed by the relevant Governmental Authority) to the Administrative Agent, such Lender or such Issuer in the event the Administrative Agent, such Lender or such Issuer is required to repay such refund or Tax credit to such Governmental Authority. This paragraph shall not be construed to require the Administrative Agent, any

Lender or any Issuer to make available its Tax returns (or any other information relating to its Taxes that it deems confidential) to the Borrower or any other Person.

(h) *Designation of a Different Lending Office*. If any Lender requests compensation under Section 3.6, or requires the Borrower to pay any additional amount to any Lender or any Governmental Authority for the account of any Lender pursuant to this Section 3.10, then such Lender shall use reasonable efforts to designate a different lending office for funding or booking its Loans hereunder or to assign its rights and obligations hereunder to another of its offices, branches or affiliates, if, in the judgment of such Lender, such designation or assignment (i) would eliminate or reduce amounts payable pursuant to Section 3.6 or this Section 3.10, as the case may be, in the future and (ii) would not subject such Lender to any unreimbursed cost or expense and would not otherwise be disadvantageous to such Lender. The Borrower hereby agrees to pay all reasonable and documented out-of-pocket costs and expenses incurred by any Lender in connection with any such designation or assignment.

(i) *Survival*. Each party's obligations under this Section 3.10 shall survive the resignation or replacement of the Administrative Agent or any assignment of rights by, or the replacement of, a Lender, the termination of the Commitments and the repayment, satisfaction or discharge of all obligations under any Loan Document.

3.11 ***Facility Fees***

The Borrower agrees to pay to the Administrative Agent for the account of each Lender a fee (the ***"Facility Fee"***) during the period commencing on the Effective Date and ending on the Expiration Date, payable quarterly in arrears on the last day of each March, June, September and December of each year, commencing on the last day of the calendar quarter during which the Facility Fee shall commence to accrue, and on the Expiration Date, at a rate per annum equal to the Applicable Margin of (a) prior to the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6, the Commitment Amount of such Lender (whether used or unused), and (b) thereafter, the sum of (i) the outstanding principal balance of all Revolving Credit Loans of such Lender, (ii) such Lender's Swing Line Exposure and (iii) such Lender's Letter of Credit Exposure. Notwithstanding anything to the contrary contained in this Section 3.11, on and after the Commitment Termination Date, the Facility Fee shall be payable upon demand. In addition, upon each reduction of the Aggregate Commitment Amount, the Borrower shall pay the Facility Fee accrued on the amount of such reduction through the date of such reduction. The Facility Fee shall be computed on the basis of a 360-day year for the actual number of days elapsed.

3.12 ***Letter of Credit Participation Fee***

The Borrower agrees to pay to the Administrative Agent for the pro rata account of each Lender a fee (the ***"Letter of Credit Participation Fee"***) with respect to the Letters of Credit during the period commencing on the Effective Date and ending on the Commitment Termination Date or, if later, the date when the Letter of Credit Exposure of all Lenders is $0, payable quarterly in arrears on the last day of each March, June, September and December of each year, commencing on the last day of the calendar quarter in which the Effective Date shall have occurred, and on the last date of such period, at a rate per annum equal to (i) in the case of standby Letters of Credit, the

Applicable Margin of the average daily aggregate amount which may be drawn under all standby Letters of Credit during such period (whether or not the conditions for drawing thereunder have or may be satisfied) multiplied by such Lender's Commitment Percentage, and (ii) in the case of commercial Letters of Credit, the Applicable Margin of the average daily aggregate amount which may be drawn under all commercial Letters of Credit during such period (whether or not the conditions for drawing thereunder have or may be satisfied) multiplied by such Lender's Commitment Percentage. The Letter of Credit Participation Fee shall be computed on the basis of a 360-day year for the actual number of days elapsed.

3.13 ***Replacement of Lender***

If (x) the Borrower is obligated to pay to any Lender any amount under Section 3.6 or Section 3.10, the Borrower shall have the right within 90 days thereafter, (y) any Lender shall be a Defaulting Lender, the Borrower shall have the right at any time during which such Lender shall remain a Defaulting Lender, or (z) any Lender shall have not consented to an Extension Request, the Borrower shall have the right at any time on the relevant Extension Date, in each case in accordance with the requirements of Section 11.7(b) and only if no Default shall exist, to replace such Lender (the ***"Replaced Lender"***) with one or more Eligible Assignees (each a ***"Replacement Lender"***); *provided* that (i) at the time of any replacement pursuant to this Section 3.13, the Replacement Lender shall enter into one or more Assignment and Assumptions pursuant to Section 11.7(b) (with the processing and recordation fee referred to in Section 11.7(b) payable pursuant to said Section 11.7(b) to be paid by the Replacement Lender) pursuant to which the Replacement Lender shall acquire the Commitment, the outstanding Loans, the Swing Line Exposure and the Letter of Credit Exposure of the Replaced Lender and, in connection therewith, shall pay the following: (a) to the Replaced Lender, an amount equal to the sum of (A) an amount equal to the principal of, and all accrued and unpaid interest on, all outstanding Loans and Swing Line Participation Amounts of the Replaced Lender, (B) an amount equal to all drawings on all Letters of Credit that have been funded by (and not reimbursed to) such Replaced Lender, together with all then unpaid interest with respect thereto at such time, and (C) an amount equal to all accrued, but unpaid, fees owing to the Replaced Lender, (b) to each Issuer, an amount equal to such Replaced Lender's Commitment Percentage of all drawings on Letters of Credit issued by such Issuer (which at such time remain unpaid drawings) to the extent such amount was not funded by such Replaced Lender, (c) to the Swing Line Lender, an amount equal to such Replaced Lender's Commitment Percentage of any Mandatory Borrowing to the extent such amount was not funded by such Replaced Lender, and (d) to the Administrative Agent an amount equal to all amounts owed by such Replaced Lender to the Administrative Agent under this Agreement, including, without limitation, an amount equal to the principal of, and all accrued and unpaid interest on, all outstanding Loans of the Replaced Lender, a corresponding amount of which was made available by the Administrative Agent to the Borrower pursuant to Section 3.1 and which has not been repaid to the Administrative Agent by such Replaced Lender or the Borrower, and (ii) all obligations of the Borrower owing to the Replaced Lender (other than those specifically described in clause (i) above in respect of which the assignment purchase price has been, or is concurrently being, paid) shall be paid in full to such Replaced Lender concurrently with such replacement. Upon the execution of the respective Assignment and Assumptions and the payment of amounts referred to in clauses (i) and (ii) of this Section 3.13, the Replacement Lender shall become a Lender hereunder and the Replaced Lender shall cease to constitute a Lender hereunder, except with respect to indemnification provisions

under this Agreement that are intended to survive the termination of the Commitments and the repayment of the Loans which may be applicable to any such Replaced Lender prior to the date of its replacement. Solely for the purpose of calculating break funding payments under Section 3.5, the assignment by any Replaced Lender of any Eurodollar Advance prior to the last day of the Interest Period applicable thereto pursuant to clause (x) or (z) of this Section 3.13 shall be deemed to constitute a prepayment by the Borrower of such Eurodollar Advance.

4. *REPRESENTATIONS AND WARRANTIES*

In order to induce the Administrative Agent, the Lenders and the Issuers to enter into this Agreement, the Lenders to make the Loans and the Issuers to issue Letters of Credit, the Borrower hereby makes the following representations and warranties to the Administrative Agent, the Lenders and the Issuers:

4.1 *Existence and Power*

Each of the Borrower and the Subsidiaries is duly organized, validly existing and (to the extent applicable in such jurisdiction) in good standing under the laws of the jurisdiction of its incorporation or formation (except, in the case of the Subsidiaries, where the failure to be in such good standing could not reasonably be expected to have a Material Adverse effect), has all requisite corporate power and authority to own its Property and to carry on its business as now conducted, and is qualified to do business as a foreign corporation and is in good standing in each jurisdiction in which it owns or leases real Property or in which the nature of its business requires it to be so qualified (except those jurisdictions where the failure to be so qualified or to be in good standing could not reasonably be expected to have a Material Adverse effect).

4.2 *Authority; EEA Financial Institution*

The Borrower has full corporate power and authority to enter into, execute, deliver and perform the terms of the Loan Documents, all of which have been duly authorized by all proper and necessary corporate action and are not in contravention of any applicable law or the terms of its Certificate of Incorporation and By-Laws. No consent or approval of, or other action by, shareholders of the Borrower, any Governmental Authority, or any other Person (which has not already been obtained) is required to authorize in respect of the Borrower, or is required in connection with, the execution, delivery and performance by the Borrower of the Loan Documents or is required as a condition to the enforceability of the Loan Documents against the Borrower. The Borrower is not an EEA Financial Institution.

4.3 *Binding Agreement*

The Loan Documents constitute the valid and legally binding obligations of the Borrower, enforceable against the Borrower in accordance with their respective terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by equitable principles relating to the availability of specific performance as a remedy.

4.4 ***Litigation***

As of the Effective Date, there are no actions, suits, arbitration proceedings or claims (whether purportedly on behalf of the Borrower, any Subsidiary or otherwise) pending or, to the knowledge of the Borrower, threatened against the Borrower or any Subsidiary or any of their respective Properties, or maintained by the Borrower or any Subsidiary, at law or in equity, before any Governmental Authority which could reasonably be expected to have a Material Adverse effect. There are no proceedings pending or, to the knowledge of the Borrower, threatened against the Borrower or any Subsidiary (a) which call into question the validity or enforceability of any Loan Document, or otherwise seek to invalidate, any Loan Document, or (b) which might, individually or in the aggregate, materially and adversely affect any of the transactions contemplated by any Loan Document.

4.5 ***No Conflicting Agreements***

(a) Neither the Borrower nor any Subsidiary is in default under any agreement to which it is a party or by which it or any of its Property is bound the effect of which could reasonably be expected to have a Material Adverse effect. No notice to, or filing with, any Governmental Authority is required for the due execution, delivery and performance by the Borrower of the Loan Documents.

(b) No provision of any existing material mortgage, material indenture, material contract or material agreement or of any existing statute, rule, regulation, judgment, decree or order binding on the Borrower or any Subsidiary (other than any Insurance Subsidiary in the case of clause (i) and clause (ii) below) or affecting the Property of the Borrower or such Subsidiary (i) conflicts with any Loan Document, (ii) requires any consent which has not already been obtained with respect to any Loan Document, or (iii) would in any way prevent the execution, delivery or performance by the Borrower of the terms of any Loan Document. Neither the execution and delivery, nor the performance, by the Borrower of the terms of each Loan Document will constitute a default under, or result in the creation or imposition of, or obligation to create, any Lien upon the Property of the Borrower or any Subsidiary (other than any Insurance Subsidiary) pursuant to the terms of any such mortgage, indenture, contract or agreement.

4.6 ***Taxes***

The Borrower and each Subsidiary has filed or caused to be filed all tax returns, and has paid, or has made adequate provision for the payment of, all taxes shown to be due and payable on said returns or in any assessments made against them, the failure of which to file or pay could reasonably be expected to have a Material Adverse effect, and no tax Liens (other than Liens permitted under Section 8.2) have been filed against the Borrower or any Subsidiary and no claims are being asserted with respect to such taxes which are required by GAAP to be reflected in the Financial Statements and are not so reflected, except for taxes which have been assessed but which are not yet due and payable. The charges, accruals and reserves on the books of the Borrower and each Subsidiary with respect to all federal, state, local and other taxes are considered by the management of the Borrower to be adequate, and the Borrower knows of no unpaid assessment which (a) could reasonably be expected to have a Material Adverse effect, or (b) is or might be due

and payable against it or any Subsidiary or any Property of the Borrower or any Subsidiary, except such thereof as are being contested in good faith and by appropriate proceedings diligently conducted, and for which adequate reserves have been set aside in accordance with GAAP or which have been assessed but are not yet due and payable.

4.7 ***Compliance with Applicable Laws; Filings***

Neither the Borrower nor any Subsidiary is in default with respect to any judgment, order, writ, injunction, decree or decision of any Governmental Authority which default could reasonably be expected to have a Material Adverse effect. The Borrower and each Subsidiary is complying with all applicable statutes, rules and regulations of all Governmental Authorities, a violation of which could reasonably be expected to have a Material Adverse effect. The Borrower and each Subsidiary has filed or caused to be filed with all Governmental Authorities all reports, applications, documents, instruments and information required to be filed pursuant to all applicable laws, rules, regulations and requests which, if not so filed, could reasonably be expected to have a Material Adverse effect.

4.8 ***Governmental Regulations***

The Borrower is not subject to regulation under the Investment Company Act of 1940, as amended.

4.9 ***Federal Reserve Regulations; Use of Proceeds***

The Borrower is not engaged principally, or as one of its important activities, in the business of extending credit for the purpose of purchasing or carrying any Margin Stock. No part of the proceeds of the Loans or the Letters of Credit has been or will be used, directly or indirectly, and whether immediately, incidentally or ultimately, for a purpose which violates the provisions of Regulations T, U or X of the Board of Governors of the Federal Reserve System, as amended. Anything in this Agreement to the contrary notwithstanding, neither any Issuer nor any Lender shall be obligated to extend credit to or on behalf of the Borrower in violation of any limitation or prohibition provided by any applicable law, regulation or statute, including said Regulation U. Following application of the proceeds of each Loan and the issuance of each Letter of Credit, not more than 25% (or such greater or lesser percentage as is provided in the exclusions from the definition of "Indirectly Secured" contained in said Regulation U as in effect at the time of the making of such Loan or issuance of such Letter of Credit) of the value of the assets of the Borrower and the Subsidiaries on a Consolidated basis that are subject to Section 8.2 will be Margin Stock. In addition, no part of the proceeds of any Loan or Letter of Credit will be used, whether directly or indirectly, and whether immediately, incidentally or ultimately, to make a loan to any director or executive officer of the Borrower or any Subsidiary.

4.10 ***No Misrepresentation***

No representation or warranty contained in any Loan Document and no certificate or written report furnished by the Borrower to the Administrative Agent or any Lender pursuant to any Loan Document contains, as of its date, a misstatement of a material fact, or omits to state, as of its date, a material fact required to be stated in order to make the statements therein contained, when

taken as a whole, not materially misleading (*provided* that any representation, warranty, statement or written report that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such date) in the light of the circumstances under which made (after giving effect to all supplements and updates with respect thereto) (it being understood that the Borrower makes no representation or warranty hereunder with respect to any projections, other forward looking information, industry information or general economic information); *provided*, that at any time that the representations set forth in this Section 4.10 (if any) are made on or prior to the Acquisition Closing Date, with respect to any such information (if any) relating to Aetna and its subsidiaries (and its and their respective businesses) such representations are made to the best of the Borrower's knowledge.

4.11 ***Plans***

The Borrower, each Subsidiary and each ERISA Affiliate have complied with the material requirements of Section 515 of ERISA with respect to each Pension Plan which is a Multiemployer Plan, except where the failure to so comply could not reasonably be expected to have a Material Adverse effect. The Borrower, each Subsidiary and each ERISA Affiliate has, as of the date hereof, made all contributions or payments to or under each Pension Plan required by law or the terms of such Pension Plan or any contract or agreement, except where the failure to make such contributions or payments could not reasonably be expected to have a Material Adverse effect. No liability to the PBGC has been, or is reasonably expected by the Borrower, any Subsidiary or any ERISA Affiliate to be, incurred by the Borrower, any Subsidiary or any ERISA Affiliate that could reasonably be expected to have a Material Adverse effect. Liability, as referred to in this Section 4.11, includes any joint and several liability, but excludes any current or, to the extent it represents future liability in the ordinary course, any future liability for premiums under Section 4007 of ERISA.

4.12 ***Environmental Matters***

Neither the Borrower nor any Subsidiary (a) has received written notice or otherwise learned of any claim, demand, action, event, condition, report or investigation indicating or concerning any potential or actual liability which individually or in the aggregate could reasonably be expected to have a Material Adverse effect, arising in connection with (i) any non-compliance with or violation of the requirements of any applicable Environmental Law, or (ii) the release or threatened release of any Hazardous Material, (b) to the best knowledge of the Borrower, has any threatened or actual liability in connection with the release or threatened release of any Hazardous Material into the environment which individually or in the aggregate could reasonably be expected to have a Material Adverse effect, (c) has received notice of any federal or state investigation evaluating whether any remedial action is needed to respond to a release or threatened release of any Hazardous Material into the environment for which the Borrower or any Subsidiary is or would be liable, which liability would reasonably be expected to have a Material Adverse effect, or (d) has received notice that the Borrower or any Subsidiary is or may be liable to any Person under the Comprehensive Environmental Response, Compensation and Liability Act, as amended, 42 U.S.C. Section 9601 et seq., or any analogous state law, which liability would reasonably be expected to have a Material Adverse effect. The Borrower and each Subsidiary is in compliance with the financial responsibility requirements of federal and state Environmental Laws to the extent

applicable, including those contained in 40 C.F.R., parts 264 and 265, subpart H, and any analogous state law, except in those cases in which the failure so to comply would not reasonably be expected to have a Material Adverse effect.

4.13 *Financial Statements*

The Borrower has heretofore delivered to the Lenders through the Administrative Agent copies of the audited Consolidated Balance Sheet of the Borrower and its Subsidiaries as of December 31, 2017, and the related Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for the fiscal year then ended. The financial statements referred to immediately above, including all related notes and schedules, are herein referred to collectively as the ***"Financial Statements"***. The Financial Statements fairly present, in all material respects, the Consolidated financial condition and results of the operations of the Borrower and the Subsidiaries as of the dates and for the periods indicated therein and, except as noted therein, have been prepared in conformity with GAAP as then in effect. Neither the Borrower nor any of the Subsidiaries has any material obligation or liability of any kind (whether fixed, accrued, contingent, unmatured or otherwise) which, in accordance with GAAP as then in effect, should have been disclosed in the Financial Statements and was not. During the period from January 1, 2018 to and including the Effective Date, there was no Material Adverse change, including as a result of any change in law, in the Consolidated financial condition, operations, business or Property of the Borrower and the Subsidiaries taken as a whole.

4.14 *Anti-Corruption Laws and Sanctions*

The Borrower has implemented and maintains in effect policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions, and the Borrower, the Subsidiaries and their respective officers and employees and, to the knowledge of the Borrower, its directors are in compliance with Anti-Corruption Laws and applicable Sanctions in all material respects. None of (a) the Borrower, any Subsidiary or, to the knowledge of the Borrower or such Subsidiary, any of their respective directors, officers or employees, or (b) to the knowledge of the Borrower, any agent of the Borrower or any Subsidiary that will act in any capacity in connection with or benefit from the credit facility established hereby, is a Sanctioned Person. No Loan or Letter of Credit, use of proceeds or other transaction contemplated by this Agreement will violate Anti-Corruption Laws or applicable Sanctions.

5. *CONDITIONS TO EFFECTIVENESS*

This Agreement shall become effective on and as of the date (the ***"Effective Date"***) that the following conditions shall have been satisfied or waived in accordance with Section 11.1:

5.1 *Agreement*

The Administrative Agent shall have received counterparts of this Agreement executed by the Borrower, the Administrative Agent, each Issuer, the Swing Line Lender and each Lender.

5.2 ***Notes***

The Administrative Agent shall have received a Note, executed by the Borrower, for each Lender that shall have given at least three Domestic Business Days' prior written notice of its request for a Note.

5.3 ***Corporate Action***

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Secretary or an Assistant Secretary of the Borrower (i) attaching a true and complete copy of the resolutions of its Board of Directors and of all documents evidencing all other necessary corporate action taken by the Borrower to authorize this Agreement, the other Loan Documents and the transactions contemplated hereby and thereby, (ii) attaching a true and complete copy of its Certificate of Incorporation and By-Laws, (iii) setting forth the incumbency of the officer or officers of the Borrower who may sign this Agreement and the other Loan Documents, and any other certificates, requests, notices or other documents required hereunder or thereunder, and (iv) attaching a certificate of good standing of the Secretary of State of the State of Delaware.

5.4 ***Opinion of Counsel to the Borrower***

The Administrative Agent shall have received (a) an opinion of Thomas Moffatt, assistant general counsel of the Borrower, dated the Effective Date, in the form of Exhibit D-1, and (b) an opinion of Shearman & Sterling LLP, special counsel to the Borrower, dated the Effective Date, in the form of Exhibit D-2.

5.5 ***Termination of Existing 2014 Credit Agreement***

After giving effect to the application of the proceeds of the Loans on the Effective Date, the Indebtedness under the Existing 2014 Credit Agreement shall have been fully repaid, the commitments under the Existing 2014 Credit Agreement shall have been canceled or terminated, and the Administrative Agent shall have received reasonably satisfactory evidence thereof. In order to facilitate the termination of the commitments under the Existing 2014 Credit Agreement, the Borrower hereby gives notice that the Borrower wishes to terminate the commitments under the Existing 2014 Credit Agreement, effective as of the Effective Date. Each Lender that is a party to the Existing 2014 Credit Agreement, by its execution hereof, waives any requirement of prior notice set forth therein as a condition to the right of the Borrower to terminate the commitments thereunder.

5.6 ***No Default and Representations and Warranties***

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Senior Vice President and Treasurer of the Borrower certifying that there exists no Default and that the representations and warranties contained in this Agreement are true and correct in all material respects (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on the Effective Date), except those which are expressly specified to be made as of an earlier date.

5.7 ***Fees***

The Administrative Agent shall have received all fees and other amounts due and payable to it on the Effective Date, including the upfront fees payable to the Lenders, in respect of this Agreement.

5.8 ***Due Diligence; "Know Your Customer"***

Each Lender shall have received such documents and information as it may have requested in order to comply with "know-your-customer" and other applicable Sanctions, anti-terrorism, anti-money laundering and similar rules and regulations and related policies, to the extent the Borrower shall have received written requests therefor at least ten (10) Domestic Business Days prior to the Effective Date.

6. *CONDITIONS OF LENDING - ALL LOANS AND LETTERS OF CREDIT*

The obligation of each Lender on any Borrowing Date to make each Revolving Credit Loan (other than a Revolving Credit Loan constituting a Mandatory Borrowing), the Swing Line Lender to make each Swing Line Loan, each Issuer to issue each Letter of Credit and each Lender to make a Competitive Bid Loan are subject to the fulfillment (or waiver in accordance with Section 11.1) of the following conditions precedent:

6.1 ***Compliance***

On each Borrowing Date, and after giving effect to the Loans to be made or the Letters of Credit to be issued on such Borrowing Date, (a) there shall exist no Default, and (b) the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on such Borrowing Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such Borrowing Date), except those which are expressly specified to be made as of an earlier date.

6.2 ***Requests***

The Administrative Agent shall have timely received from the Borrower on or before such Borrowing Date, as applicable, a duly executed Borrowing Request (together with, in the case of a request for a Swing Line Loan, a duly executed agreement as to the Negotiated Rate with respect to such Swing Line Loan), Letter of Credit Request (together with a duly executed Reimbursement Agreement with respect to the Letter(s) of Credit requested thereby) and/or Competitive Bid Request (together with a duly executed Competitive Bid Accept/Reject Letter).

7. *AFFIRMATIVE COVENANTS*

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the

Reimbursement Obligations, the Fees and all other sums payable under the Loan Documents (other than contingent obligations for which no claim has been made), the Borrower will:

7.1 ***Legal Existence***

Except as may otherwise be permitted by Section 8.3 and Section 8.4, maintain, and cause each Subsidiary to maintain, its corporate existence in good standing in the jurisdiction of its incorporation or formation and in each other jurisdiction in which the failure so to do could reasonably be expected to have a Material Adverse effect, except that the corporate existence of Subsidiaries may be terminated if (i) such Subsidiaries operate closing or discontinued operations or (ii) if the Borrower determines in good faith that such termination is in the best interests of the Borrower and is not materially disadvantageous to the Lenders.

7.2 ***Taxes***

Pay and discharge when due, and cause each Subsidiary so to do, all taxes, assessments, governmental charges, license fees and levies upon or with respect to the Borrower and such Subsidiary, and upon the income, profits and Property thereof unless, and only to the extent, that either (i)(a) such taxes, assessments, governmental charges, license fees and levies shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Subsidiary, and (b) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor, or (ii) the failure to pay or discharge such taxes, assessments, governmental charges, license fees and levies could not reasonably be expected to have a Material Adverse effect.

7.3 ***Insurance***

Keep, and cause each Subsidiary to keep, insurance with responsible insurance companies (and/or a plan of self-insurance) in such amounts and against such risks as is usually carried by the Borrower or such Subsidiary.

7.4 ***Performance of Obligations***

Pay and discharge when due, and cause each Subsidiary so to do, all lawful Indebtedness, obligations and claims for labor, materials and supplies or otherwise which, if unpaid, could reasonably be expected to (a) have a Material Adverse effect, or (b) become a Lien on the Property of the Borrower or any Subsidiary, except those Liens permitted under Section 8.2, *provided* that neither the Borrower nor such Subsidiary shall be required to pay or discharge or cause to be paid or discharged any such Indebtedness, obligation or claim so long as (i) the validity thereof shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Subsidiary, and (ii) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor.

7.5 ***Condition of Property***

Except for ordinary wear and tear, at all times, maintain, protect and keep in good repair, working order and condition, all material Property necessary for the operation of its business

(other than Property which is replaced with similar Property) as then being operated, and cause each Subsidiary so to do.

7.6 ***Observance of Legal Requirements***

(a) Observe and comply in all material respects, and cause each Subsidiary so to do, with all laws, ordinances, orders, judgments, rules, regulations, certifications, franchises, permits, licenses, directions and requirements of all Governmental Authorities, which now or at any time hereafter may be applicable to it or to such Subsidiary, a violation of which could reasonably be expected to have a Material Adverse effect.

(b) Maintain in effect and enforce policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions.

7.7 ***Financial Statements and Other Information***

Maintain, and cause each Subsidiary to maintain, a standard system of accounting in accordance with GAAP, and furnish to the Administrative Agent for distribution to the Lenders:

(a) As soon as available and, in any event, within 90 days after the close of each fiscal year, a copy of (x) the Borrower's 10-K in respect of such fiscal year, and (y) (i) the Borrower's Consolidated Balance Sheet as of the end of such fiscal year, and (ii) the related Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows, as of and through the end of such fiscal year, setting forth in each case in comparative form the corresponding figures in respect of the previous fiscal year, all in reasonable detail, and accompanied by a report of the Borrower's auditors, which report shall state that (A) such auditors audited such financial statements, (B) such audit was made in accordance with generally accepted auditing standards in effect at the time and provides a reasonable basis for such opinion, and (C) said financial statements have been prepared in accordance with GAAP;

(b) As soon as available, and in any event within 45 days after the end of each of the first three fiscal quarters of each fiscal year, a copy of (x) the Borrower's 10-Q in respect of such fiscal quarter, and (y) (i) the Borrower's condensed Consolidated Balance Sheet as of the end of such quarter and (ii) the related condensed Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for (A) such quarter and (B) the period from the beginning of the then current fiscal year to the end of such quarter, in each case in comparable form with the prior fiscal year, all in reasonable detail and prepared in accordance with GAAP (without footnotes and subject to year-end adjustments);

(c) Simultaneously with the delivery of the financial statements required by clauses (a) and (b) above, a certificate of the Chief Financial Officer or the Senior Vice President and Treasurer of the Borrower certifying that no Default shall have occurred or be continuing or, if so, specifying in such certificate all such Defaults, and setting forth computations in reasonable detail demonstrating compliance with Section 8.1 and Section 8.9.

(d) Prompt notice upon the Borrower becoming aware of any change in the applicability of a Pricing Level;

(e) As soon as practicable after becoming available, copies of all regular or periodic reports (including current reports on Form 8-K) which the Borrower or any Subsidiary may now or hereafter be required to file with or deliver to the U.S. Securities and Exchange Commission, or any other Governmental Authority succeeding to the functions thereof;

(f) Prompt written notice of: (i) any citation, summons, subpoena, order to show cause or other order naming the Borrower or any Subsidiary a party to any proceeding before any Governmental Authority which could reasonably be expected to have a Material Adverse effect, and include with such notice a copy of such citation, summons, subpoena, order to show cause or other order, (ii) any lapse or other termination of any license, permit, franchise or other authorization issued to the Borrower or any Subsidiary by any Governmental Authority, (iii) any refusal by any Governmental Authority to renew or extend any license, permit, franchise or other authorization, and (iv) any dispute between the Borrower or any Subsidiary and any Governmental Authority, which lapse, termination, refusal or dispute, referred to in clause (ii), (iii) or (iv) above, could reasonably be expected to have a Material Adverse effect;

(g) Prompt written notice of the occurrence of (i) each Default, (ii) each Event of Default and (iii) each Material Adverse change;

(h) As soon as practicable following receipt thereof, copies of any audit reports delivered in connection with the statements referred to in Section 7.7(a);

(i) From time to time, such other information regarding the financial position or business of the Borrower and the Subsidiaries as the Administrative Agent, at the reasonable request of any Lender, may reasonably request; and

(j) Prompt written notice of such other information with documentation required by bank regulatory authorities under applicable "know your customer" and anti-money laundering laws, rules and regulations (including, without limitation, the Patriot Act), as from time to time may be reasonably requested by the Administrative Agent or by any Issuer or any Lender (through the Administrative Agent).

Information required to be delivered pursuant to (x) this Section 7.7 shall be deemed to have been delivered if such information shall have been posted by the Administrative Agent on a Debtdomain, IntraLinks, Syndtrak or similar electronic system (the ***"Platform"***) to which each Lender and each Issuer has been granted access and (y) clauses (a), (b) and (e) of this Section 7.7 shall be deemed delivered to the Administrative Agent, the Issuers and the Lenders when available on the Borrower's website at http://www.cvshealth.com or the website of the U.S. Securities and Exchange Commission at http://www.sec.gov. Information delivered pursuant to this Section 7.7 may also be delivered by electronic communications pursuant to procedures approved by the Administrative Agent.

The Borrower hereby acknowledges that the Administrative Agent and/or the Joint Lead Arrangers and Joint Bookrunners will make available to the Lenders materials and/or

information provided by or on behalf of the Borrower hereunder (collectively, ***"Borrower Materials"***) by posting the Borrower Materials on the Platform.

7.8 ***Records***

Upon reasonable notice and during normal business hours and, if no Event of Default has occurred and is continuing, not more than once in each fiscal year, permit representatives of the Administrative Agent and each Lender to visit the offices of the Borrower and each Subsidiary, to examine the books and records (other than tax returns and work papers related to tax returns) thereof and auditors' reports relating thereto, to discuss the affairs of the Borrower and each Subsidiary with the respective officers thereof, and to meet and discuss the affairs of the Borrower and each Subsidiary with the Borrower's auditors.

7.9 ***Authorizations***

Maintain and cause each Subsidiary to maintain, in full force and effect, all copyrights, patents, trademarks, trade names, franchises, licenses, permits, applications, reports, and other authorizations and rights, which, if not so maintained, would individually or in the aggregate have a Material Adverse effect.

8. ***NEGATIVE COVENANTS***

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the Reimbursement Obligations, the Fees and all other sums payable under the Loan Documents (other than contingent obligations for which no claim has been made), the Borrower will not:

8.1 ***Subsidiary Indebtedness***

Permit the Indebtedness of all Subsidiaries (excluding Indebtedness under capital leases incurred in connection with a sale leaseback transaction) to exceed (on a combined basis) 15% of Net Tangible Assets (the ***"Net Tangible Assets Test"***); *provided* that, on and following the Acquisition Closing Date until such time as the Borrower is in compliance with the Net Tangible Assets Test (without giving effect to clause (x) below), (x) any Indebtedness of Aetna and its Subsidiaries existing as of the Acquisition Closing Date (but excluding any increase, refinancing or replacement thereof, in each case on and following the Acquisition Closing Date, (the ***"Aetna Existing Indebtedness"***)) shall not be included as Indebtedness for purposes of this Section 8.1 and (y) the Indebtedness of all Subsidiaries (excluding the Aetna Existing Indebtedness and other Indebtedness under capital leases incurred in connection with a sale leaseback transaction) shall not at any time exceed $900,000,000 in the aggregate.

8.2 ***Liens***

Create, incur, assume or suffer to exist any Lien against or on any Property now owned or hereafter acquired by the Borrower or any of the Subsidiaries, or permit any of the Subsidiaries so to do, except any one or more of the following types of Liens: (a) Liens in connection with workers' compensation, unemployment insurance or other social security

obligations (which phrase shall not be construed to refer to ERISA or the minimum funding obligations under Section 412 of the Internal Revenue Code), (b) Liens to secure the performance of bids, tenders, letters of credit, contracts (other than contracts for the payment of Indebtedness), leases, statutory obligations, surety, customs, appeal, performance and payment bonds and other obligations of like nature, or to qualify to do business, maintain insurance or obtain other benefits, in each such case arising in the ordinary course of business, (c) mechanics', workmen's, carriers', warehousemen's, materialmen's, landlords' or other like Liens arising in the ordinary course of business with respect to obligations which are not due or which are being contested in good faith and by appropriate proceedings diligently conducted, (d) Liens for taxes, assessments, fees or governmental charges the payment of which is not required under Section 7.2 or Section 7.4, (e) easements, rights of way, restrictions, leases of Property to others, easements for installations of public utilities, title imperfections and restrictions, zoning ordinances and other similar encumbrances affecting Property which in the aggregate do not materially impair its use for the operation of the business of the Borrower or such Subsidiary, (f) Liens on Property of the Subsidiaries under capital leases and Liens on Property (including on the capital stock or other equity interests) of the Subsidiaries acquired (whether as a result of purchase, capital lease, merger or other acquisition) and either existing on such Property when acquired, or created contemporaneously with or within 12 months of such acquisition to secure the payment or financing of the purchase price of such Property (including the construction, development, substantial repair, alteration or improvement thereof), and any renewals thereof, *provided* that such Liens attach only to the Property so purchased or acquired (including any such construction, development, substantial repair, alteration or improvement thereof) and *provided further* that the Indebtedness secured by such Liens is permitted by Section 8.1, (g) statutory Liens in favor of lessors arising in connection with Property leased to the Borrower or any of the Subsidiaries, (h) Liens of attachments, judgments or awards against the Borrower or any of the Subsidiaries with respect to which an appeal or proceeding for review shall be pending or a stay of execution or bond shall have been obtained, or which are otherwise being contested in good faith and by appropriate proceedings diligently conducted, and in respect of which adequate reserves shall have been established in accordance with GAAP on the books of the Borrower or such Subsidiary, (i) Liens securing Indebtedness of a Subsidiary to the Borrower or another Subsidiary, (j) Liens (other than Liens permitted by any of the foregoing clauses) arising in the ordinary course of its business which do not secure Indebtedness and do not, in the aggregate, materially detract from the value of the business of the Borrower and its Subsidiaries, taken as a whole, (k) Liens in favor of the United States of America, or any state thereof, to secure partial, progress, advance or other payments pursuant to any contract or provisions of any statute, and (l) additional Liens securing Indebtedness of the Borrower and the Subsidiaries in an aggregate outstanding Consolidated principal amount not exceeding 15% of Net Tangible Assets.

8.3 ***Dispositions***

Make any Disposition, or permit any of its Subsidiaries so to do, of all or substantially all of the assets of the Borrower and the Subsidiaries on a Consolidated basis.

8.4 ***Merger or Consolidation, Etc.***

Consolidate with, be acquired by, or merge into or with any Person unless (x) immediately after giving effect thereto no Default shall or would exist and (y) either (i) the Borrower or (ii) a corporation organized and existing under the laws of one of the States of the United States of America shall be the survivor of such consolidation or merger, *provided* that if the Borrower is not the survivor, the corporation which is the survivor shall expressly assume, pursuant to an instrument executed and delivered to the Administrative Agent, and in form and substance reasonably satisfactory to the Administrative Agent, all obligations of the Borrower under the Loan Documents and the Administrative Agent shall have received such documents, opinions and certificates as it shall have reasonably requested in connection therewith.

8.5 ***Acquisitions***

Make any Acquisition, or permit any of the Subsidiaries so to do, except any one or more of the following: (a) Acquisitions by the Borrower or any of the Subsidiaries in connection with Intercompany Dispositions not prohibited by Section 8.3, (b) the Aetna Acquisition, and (c) Acquisitions by the Borrower or any of the Subsidiaries, *provided* that immediately before and after giving effect to each such Acquisition made pursuant to this clause (c), no Event of Default shall or would exist.

8.6 ***Restricted Payments***

Make any Restricted Payment or permit any of the Subsidiaries so to do, except any one or more of the following Restricted Payments: (a) any direct or indirect Subsidiary may make dividends or other distributions to the Borrower or to any other direct or indirect Subsidiary or otherwise ratably with respect to its stock or other equity interests, and (b) the Borrower may make Restricted Payments, *provided* that, in the case of this clause (b), immediately before and after giving effect thereto, no Event of Default shall or would exist.

8.7 ***Limitation on Upstream Dividends by Subsidiaries***

Permit or cause any of the Subsidiaries (other than any Insurance Subsidiary) to enter into or agree, or otherwise be or become subject, to any agreement, contract or other arrangement (other than this Agreement and the other Loan Documents) with any Person (each a ***"Restrictive Agreement"***) pursuant to the terms of which (a) such Subsidiary is or would be prohibited from declaring or paying any cash dividends on any class of its stock owned directly or indirectly by the Borrower or any of the other Subsidiaries or from making any other distribution on account of any class of any such stock (herein referred to as ***"Upstream Dividends"***), or (b) the declaration or payment of Upstream Dividends by a Subsidiary to the Borrower or another Subsidiary, on an annual or cumulative basis, is or would be otherwise limited or restricted (***"Dividend Restrictions"***). Notwithstanding the foregoing, nothing in this Section 8.7 shall prohibit:

(a) Dividend Restrictions set forth in any Restrictive Agreement in effect on the date hereof and any extensions, refinancings, renewals or replacements thereof; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no

less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(b) Dividend Restrictions existing with respect to any Person acquired by the Borrower or any Subsidiary and existing at the time of such acquisition, which Dividend Restrictions are not applicable to any Person or the property or assets of any Person other than such Person or its property or assets acquired, and any extensions, refinancings, renewals or replacements of any of the foregoing; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(c) Dividend Restrictions consisting of customary net worth, leverage and other financial covenants, customary covenants regarding the merger of or sale of stock or assets of a Subsidiary, customary restrictions on transactions with affiliates, and customary subordination provisions governing Indebtedness owed to the Borrower or any Subsidiary, in each case contained in, or required by, any agreement governing Indebtedness incurred by a Subsidiary in accordance with Section 8.1; or

(d) Dividend Restrictions contained in any other credit agreement so long as such Dividend Restrictions are no more restrictive than those contained in this Agreement (including Dividend Restrictions contained in the Existing 364-Day Credit Agreement, the Existing 2015 Credit Agreement, the Existing 2017 Credit Agreement, the Existing Term Loan Agreement and the CVS Bridge Facility).

8.8 ***Limitation on Negative Pledges***

Enter into any agreement (other than (i) this Agreement, (ii) any other credit agreement that is substantially similar to this Agreement, (iii) purchase money financings or capital leases permitted by this Agreement (*provided* that any prohibition or limitation therein shall only be effective against the assets financed thereby), (iv) customary restrictions and conditions contained in agreements relating to the Disposition of a Subsidiary, property or assets pending such Disposition, *provided* such restrictions and conditions apply only to such Subsidiary, property or assets, (v) restrictions and conditions contained in documentation relating to a Subsidiary in existence on and as of the Effective Date, (vi) restrictions and conditions contained in documentation relating to a Subsidiary acquired after the Effective Date, *provided* that such restriction or condition (x) existed at the time such Person became a Subsidiary and was not created in contemplation of or in connection with such Person becoming a Subsidiary and (y) applies only to such Subsidiary, and (vii) customary provisions in joint venture agreements, leases, licenses and other contracts restricting or conditioning the assignment or encumbrance thereof, including, without limitation, licenses and sublicenses of patents, trademarks, copyrights and similar intellectual property rights) or permit any Subsidiary (other than any Insurance Subsidiary) so to do, which prohibits or limits the ability of the Borrower or such Subsidiary to create, incur, assume or suffer to exist any Lien upon any of its Property or revenues, whether now owned or hereafter acquired, to secure the obligations of the Borrower hereunder.

8.9 ***Ratio of Consolidated Indebtedness to Total Capitalization***

Permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.60:1.00; *provided* that (a) from the Acquisition Closing Date through and including the fiscal quarter ending September 30, 2019, the Borrower will not permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.65:1.00, and (b) until the earliest of (x) the occurrence of the Acquisition Closing Date, (y) the date that is 30 days following the termination of the Acquisition Agreement in accordance with its terms and (z) August 31, 2019, solely for purposes of calculating compliance with this Section 8.9, Consolidated Indebtedness and Total Capitalization shall each be calculated exclusive of any Acquisition Indebtedness.

9. ***DEFAULT***

9.1 ***Events of Default***

The following shall each constitute an ***"Event of Default"*** hereunder:

(a) The failure of the Borrower to make any payment of principal on any Loan or any reimbursement payment in respect of any Letter of Credit when due and payable; or

(b) The failure of the Borrower to make any payment of interest on any Loan or of any Fee on any date when due and payable and such default shall continue unremedied for a period of 5 Domestic Business Days after the same shall be due and payable; or

(c) The failure of the Borrower to observe or perform any covenant or agreement contained in Section 2.5, Section 7.1, or in Section 8; or

(d) The failure of the Borrower to observe or perform any other covenant or agreement contained in this Agreement, and such failure shall have continued unremedied for a period of 30 days after the Borrower shall have become aware of such failure; or

(e) [Reserved]; or

(f) Any representation or warranty of the Borrower (or of any of its officers on its behalf) made in any Loan Document, or made in any certificate or report or other document (other than an opinion of counsel) delivered on or after the date hereof in connection with any such Loan Document shall in any such case prove to have been incorrect or misleading (whether because of misstatement or omission) in any material respect when made; or

(g) (i) Obligations in an aggregate Consolidated amount in excess of the Threshold Amount of the Borrower (other than its obligations hereunder and under the Notes) and the Subsidiaries, whether as principal, guarantor, surety or other obligor, for the payment of any Indebtedness or any net liability under interest rate swap, collar, exchange or cap agreements, (A) shall become or shall be declared to be due and payable prior to the expressed maturity thereof, or (B) shall not be paid when due or within any grace period for the payment

thereof, or (ii) any holder of any such obligations shall have the right to declare the Indebtedness evidenced thereby due and payable prior to its stated maturity; or

(h) An involuntary proceeding shall be commenced or an involuntary petition shall be filed seeking (i) liquidation, reorganization or other relief in respect of the Borrower or any Subsidiary or its debts, or of a substantial part of its assets, under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect or (ii) the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Subsidiary or for a substantial part of its assets, and, in any such case, such proceeding or petition shall continue undismissed for 60 days or an order or decree approving or ordering any of the foregoing shall be entered; or

(i) The Borrower or any Subsidiary shall (i) voluntarily commence any proceeding or file any petition seeking liquidation, reorganization or other relief under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect, (ii) consent to the institution of, or fail to contest in a timely and appropriate manner, any proceeding or petition described in clause (h) of this Section 9.1, (iii) apply for or consent to the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Subsidiary or for a substantial part of its assets, (iv) file an answer admitting the material allegations of a petition filed against it in any such proceeding, (v) make a general assignment for the benefit of creditors or (vi) take any action for the purpose of effecting any of the foregoing; or

(j) The Borrower or any Subsidiary shall (i) generally not be paying its debts as such debts become due or (ii) admit in writing its inability to pay its debts as they become due; or

(k) Judgments or decrees in an aggregate Consolidated amount in excess of the Threshold Amount against the Borrower and the Subsidiaries shall remain unpaid, unstayed on appeal, undischarged, unbonded or undismissed for a period of 60 days during which execution shall not be effectively stayed, or any action shall be legally taken by a judgment creditor to attach or levy upon any assets of the Borrower or any Subsidiary to enforce any such judgment; or

(l) After the Effective Date a Change of Control shall occur; or

(m) (i) Any Termination Event shall occur (x) with respect to any Pension Plan (other than a Multiemployer Plan) or (y) with respect to any other retirement plan subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, which plan, during the five year period prior to such Termination Event, was the responsibility in whole or in part of the Borrower, any Subsidiary or any ERISA Affiliate; *provided* that this clause (y) shall only apply if, in connection with such Termination Event, it is reasonably likely that liability in an aggregate Consolidated amount in excess of the Threshold Amount will be imposed upon the Borrower; (ii) the failure to satisfy the minimum funding standards under Section 302 of ERISA or Section 412 of the Internal Revenue Code in an aggregate Consolidated amount in excess of the Threshold Amount shall exist with respect to any Pension Plan for which the Borrower has responsibility (other than that portion of a Multiemployer Plan's Accumulated Funding Deficiency to the

extent such Accumulated Funding Deficiency is attributable to employers other than Borrower); (iii) any Person shall engage in a Prohibited Transaction involving any Employee Benefit Plan in respect of which it is reasonably likely that liability in an aggregate Consolidated amount in excess of the Threshold Amount will be imposed upon the Borrower; (iv) the Borrower shall fail to pay when due an amount which is payable by it to the PBGC or to a Pension Plan (including a Multiemployer Plan) under Title IV of ERISA; (v) the imposition on the Borrower of any tax under Section 4980(B)(a) of the Internal Revenue Code; or (vi) the assessment of a civil penalty on the Borrower with respect to any Employee Benefit Plan under Section 502(c) of ERISA; in each case, to the extent such event or condition would have a Material Adverse effect. In determining the Consolidated amount for any purpose pursuant to this Section 9.1(m), the liabilities, funding amounts, taxes and penalties referenced in the foregoing clauses of this Section 9.1(m) shall include those of the Subsidiaries and ERISA Affiliates of the Borrower to the extent the Borrower is obligated to pay any such liabilities, funding amounts, taxes and penalties.

9.2 ***Remedies***

(a) Upon the occurrence of an Event of Default or at any time thereafter during the continuance of an Event of Default, the Administrative Agent, at the written request of the Required Lenders, shall notify the Borrower that the Commitments, the Swing Line Commitment and the Letter of Credit Commitment have been terminated and/or that all of the Loans, the Notes and the Reimbursement Obligations and all accrued and unpaid interest on any thereof and all other amounts owing under the Loan Documents have been declared immediately due and payable, *provided* that upon the occurrence of an Event of Default under Section 9.1(h), (i) or (j) with respect to the Borrower, the Commitments, the Swing Line Commitment and the Letter of Credit Commitment shall automatically terminate and all of the Loans, the Notes and the Reimbursement Obligations and all accrued and unpaid interest on any thereof and all other amounts owing under the Loan Documents shall become immediately due and payable without declaration or notice to the Borrower. To the fullest extent not prohibited by law, except for the notice provided for in the preceding sentence, the Borrower expressly waives any presentment, demand, protest, notice of protest or other notice of any kind in connection with the Loan Documents and its obligations thereunder. To the fullest extent not prohibited by law, the Borrower further expressly waives and covenants not to assert any appraisement, valuation, stay, extension, redemption or similar law, now or at any time hereafter in force which might delay, prevent or otherwise impede the performance or enforcement of the Loan Documents.

(b) In the event that the Commitments, the Swing Line Commitment and the Letter of Credit Commitment shall have been terminated or all of the Loans, the Notes and the Reimbursement Obligations shall have become or been declared to be due and payable pursuant to the provisions of this Section 9.2, (i) the Borrower shall forthwith deposit an amount equal to the Letter of Credit Exposure in a cash collateral account with and under the exclusive control of the Administrative Agent, and (ii) the Administrative Agent, the Issuers and the Lenders agree, among themselves, that any funds received from or on behalf of the Borrower under any Loan Document by any Issuer or any Lender (except funds received by any Issuer or any Lender as a result of a purchase from such Issuer or such Lender, as the case may be, pursuant to the provisions of Section 11.9(b)) shall be remitted to the Administrative Agent, and shall be applied

by the Administrative Agent in payment of the Loans, the Reimbursement Obligations and the other obligations of the Borrower under the Loan Documents in the following manner and order: (1) first, to the payment or reimbursement of the Administrative Agent, the Issuers and the Lenders, in that order, for any fees, expenses or amounts (other than the principal of and interest on the Reimbursement Obligations) due from the Borrower pursuant to the provisions of Section 11.5 and the Reimbursement Agreements, (2) second, to the payment of the Fees, (3) third, to the payment of any other fees, expenses or amounts (other than the principal of and interest on the Loans and the Notes and the Reimbursement Obligations) payable by the Borrower to the Administrative Agent, any Issuer or any of the Lenders under the Loan Documents, (4) fourth, to the payment, pro rata according to the outstanding principal balance of the Loans and the Letter of Credit Exposure of each Lender, of interest due on the Loans and the Reimbursement Obligations, (5) fifth, to the payment, pro rata according to the sum of (A) the aggregate outstanding principal balance of the Loans of each Lender *plus* (B) the aggregate outstanding balance of the Reimbursement Obligations of each Lender, of the aggregate outstanding principal balance of the Loans and the aggregate outstanding balance of the Reimbursement Obligations, and (6) sixth, any remaining funds shall be paid to whosoever shall be entitled thereto or as a court of competent jurisdiction shall direct.

(c) In the event that the Loans and the Notes and the Reimbursement Obligations shall have been declared due and payable pursuant to the provisions of this Section 9.2, the Administrative Agent upon the written request of the Required Lenders, shall proceed to enforce the Reimbursement Obligations and the rights of the holders of the Loans and the Notes by suit in equity, action at law and/or other appropriate proceedings, whether for payment or the specific performance of any covenant or agreement contained in the Loan Documents. In the event that the Administrative Agent shall fail or refuse so to proceed, each Issuer and each Lender shall be entitled to take such action as the Required Lenders shall deem appropriate to enforce its rights under the Loan Documents.

10. *AGENT*

10.1 *Appointment and Authority*

Each Credit Party hereby irrevocably appoints BNY Mellon to act on its behalf as the Administrative Agent hereunder and under the other Loan Documents and authorizes the Administrative Agent to take such actions on its behalf and to exercise such powers as are delegated to the Administrative Agent by the terms hereof or thereof, together with such actions and powers as are reasonably incidental thereto. The provisions of this Section 10 (other than Section 10.6) are solely for the benefit of the Administrative Agent and the Credit Parties and the Borrower shall have no rights as a third party beneficiary or otherwise of any of such provisions.

10.2 *Rights as a Lender*

The Person serving as the Administrative Agent hereunder shall have the same rights and powers in its capacity as a Lender (which includes Issuer) as any other Lender and may exercise the same as though it were not the Administrative Agent and the term “Lender” or “Lenders” shall, unless otherwise expressly indicated or unless the context otherwise requires, include the Person serving as the Administrative Agent hereunder in its individual capacity.

Such Person and its Affiliates may accept deposits from, lend money to, act as the financial advisor or in any other advisory capacity for and generally engage in any kind of business with the Borrower, any of its Subsidiaries or any other Affiliate thereof as if such Person were not the Administrative Agent hereunder and without any duty to account therefor to the Lenders.

10.3 ***Exculpatory Provisions***

(a) The Administrative Agent shall not have any duties or obligations except those expressly set forth herein and in the other Loan Documents. Without limiting the generality of the foregoing, the Administrative Agent:

(1) shall not be subject to any fiduciary or other implied duties, regardless of whether a Default has occurred and is continuing;

(2) shall not have any duty to take any discretionary action or exercise any discretionary powers, except discretionary rights and powers expressly contemplated hereby or by the other Loan Documents that the Administrative Agent is required to exercise as directed in writing by the Required Lenders (or such other number or percentage of the Lenders as shall be expressly provided for herein or in the other Loan Documents); *provided* that the Administrative Agent shall not be required to take any action that, in its opinion or the opinion of its counsel, may expose the Administrative Agent to liability or that is contrary to any Loan Document or applicable law; and

(3) shall not, except as expressly set forth herein and in the other Loan Documents, have any duty to disclose, and shall not be liable for the failure to disclose, any information relating to the Borrower, any of its Subsidiaries or any Affiliate thereof that is communicated to or obtained by the Person serving as the Administrative Agent or any of its Affiliates in any capacity.

(b) The Administrative Agent shall not be liable for any action taken or not taken by it (i) with the consent or at the request of the Required Lenders (or such other number or percentage of the Lenders as shall be necessary, or as the Administrative Agent shall believe in good faith shall be necessary, under the circumstances as provided in Section 11.1 and Section 9) or (ii) in the absence of its own gross negligence or willful misconduct. The Administrative Agent shall be deemed not to have knowledge of any Default unless and until notice describing such Default is given to the Administrative Agent by the Borrower, a Lender or an Issuer.

(c) The Administrative Agent shall not be responsible for or have any duty to ascertain or inquire into (i) any statement, warranty or representation made in or in connection with this Agreement or any other Loan Document, (ii) the contents of any certificate, report or other document delivered hereunder or thereunder or in connection herewith or therewith, (iii) the performance or observance of any of the covenants, agreements or other terms or conditions set forth herein or therein or the occurrence of any Default, (iv) the validity, enforceability, effectiveness or genuineness of this Agreement, any other Loan Document or any other agreement, instrument or document or (v) the satisfaction of any condition set forth in Section 5

or Section 6 or elsewhere herein, other than to confirm receipt of items expressly required to be delivered to the Administrative Agent.

10.4 ***Reliance by Administrative Agent***

The Administrative Agent shall be entitled to rely upon, and shall not incur any liability for relying upon, any notice, request, certificate, consent, statement, instrument, document or other writing (including any electronic message, internet or intranet website posting or other distribution) believed by it to be genuine and to have been signed, sent or otherwise authenticated by the proper Person. The Administrative Agent also may rely upon any statement made to it orally or by telephone and believed by it to have been made by the proper Person, and shall not incur any liability for relying thereon. In determining compliance with any condition hereunder to the making of a Loan or the issuance of a Letter of Credit, that by its terms must be fulfilled to the satisfaction of a Lender or an Issuer, the Administrative Agent may presume that such condition is satisfactory to such Lender or such Issuer unless the Administrative Agent shall have received notice to the contrary from such Lender or such Issuer prior to the making of such Loan or the issuance of such Letter of Credit. The Administrative Agent may consult with legal counsel (who may be counsel for the Borrower), independent public accounting firms and other experts selected by it, and shall not be liable for any action taken or not taken by it in accordance with the advice of any such counsel, accounting firm or experts.

10.5 ***Delegation of Duties***

The Administrative Agent may perform any and all of its duties and exercise its rights and powers hereunder or under any other Loan Document by or through any one or more sub-agents appointed by the Administrative Agent. The Administrative Agent and any such sub-agent may perform any and all of its duties and exercise its rights and powers by or through their respective Related Parties. The exculpatory provisions of this Section 10 shall apply to any such sub-agent and to the Related Parties of the Administrative Agent and any such sub-agent, and shall apply to their respective activities in connection with the syndication of the credit facilities provided for herein as well as activities as the Administrative Agent.

10.6 ***Resignation of Administrative Agent***

The Administrative Agent may at any time give notice of its resignation to the Credit Parties and the Borrower. Upon receipt of any such notice of resignation, the Required Lenders shall have the right, subject to, so long as no Event of Default has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed), to appoint a successor, which shall be a bank with an office in New York, New York, or an Affiliate of any such bank with an office in New York, New York. If no such successor shall have been so appointed by the Required Lenders and shall have accepted such appointment within 30 days after the retiring Administrative Agent gives notice of its resignation, then the retiring Administrative Agent may on behalf of the Credit Parties, appoint a successor Administrative Agent meeting the qualifications set forth above, subject to, so long as no Default has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed); *provided* that if the Administrative Agent shall notify the Borrower and the

Credit Parties that no qualifying Person has accepted such appointment, then such resignation shall nonetheless become effective in accordance with such notice and (a) the retiring Administrative Agent shall be discharged from its duties and obligations hereunder and under the other Loan Documents and (b) all payments, communications and determinations provided to be made by, to or through the Administrative Agent shall instead be made by or to each Credit Party directly, until such time as the Required Lenders appoint a successor Administrative Agent as provided for above in this Section. Upon the acceptance of a successor's appointment as Administrative Agent hereunder, such successor shall succeed to and become vested with all of the rights, powers, privileges and duties of the retiring (or retired) Administrative Agent, and the retiring Administrative Agent shall be discharged from all of its duties and obligations hereunder or under the other Loan Documents (if not already discharged therefrom as provided above in this Section). The fees payable by the Borrower to a successor Administrative Agent shall be the same as those payable to its predecessor unless otherwise agreed between the Borrower and such successor. After the retiring Administrative Agent's resignation hereunder and under the other Loan Documents, the provisions of this Section 10 and Section 11.5 shall continue in effect for the benefit of such retiring Administrative Agent, its sub-agents and their respective Related Parties in respect of any actions taken or omitted to be taken by any of them while the retiring Administrative Agent was acting as Administrative Agent.

10.7 *Non-Reliance on Administrative Agent and Other Credit Parties*

Each Credit Party acknowledges that it has, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it has deemed appropriate, made its own credit analysis and decision to enter into this Agreement. Each Credit Party also acknowledges that it will, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it shall from time to time deem appropriate, continue to make its own decisions in taking or not taking action under or based upon this Agreement, any other Loan Document or any related agreement or any document furnished hereunder or thereunder.

10.8 *No Other Duties, etc.*

Anything herein to the contrary notwithstanding, none of the Joint Bookrunners, the Joint Lead Arrangers, the Co-Documentation Agents or the Co-Syndication Agents listed on the cover page hereof shall have any powers, duties or responsibilities under this Agreement or any of the other Loan Documents, except in its capacity, as applicable, as the Administrative Agent, a Lender or an Issuer.

11. *OTHER PROVISIONS*

11.1 *Amendments, Waivers, Etc.*

With the written consent of the Required Lenders, the Administrative Agent and the Borrower may, from time to time, enter into written amendments, supplements or modifications of the Loan Documents (which, for the avoidance of doubt, shall require the prior written consent of

the Borrower) and, with the written consent of the Required Lenders and the Borrower, the Administrative Agent on behalf of the Lenders may execute and deliver to any such parties a written instrument waiving or consenting to the departure from, on such terms and conditions as the Administrative Agent may specify in such instrument (which terms and conditions shall have been agreed to by the Borrower), any of the requirements of the Loan Documents or any Default and its consequences, *provided* that no such amendment, supplement, modification, waiver or consent shall (i) increase the Commitment Amount of any Lender without the consent of such Lender (*provided* that no waiver of a Default shall be deemed to constitute such an increase), (ii) extend the Commitment Period without the consent of each Lender directly affected thereby, (iii) reduce the amount, or extend the time of payment, of the Fees without the consent of each Lender directly affected thereby, (iv) reduce the rate, or extend the time of payment of, interest on any Revolving Credit Loan, any Note or any Reimbursement Obligation (other than the applicability of any post-default increase in such rate of interest) without the consent of each Lender directly affected thereby, (v) reduce the amount of, or extend the time of payment of, any payment of any Reimbursement Obligation or principal on any Revolving Credit Loan or any Note without the consent of each Lender directly affected thereby, (vi) decrease or forgive the principal amount of any Revolving Credit Loan, any Note or any Reimbursement Obligation without the consent of each Lender directly affected thereby, (vii) consent to any assignment or delegation by the Borrower of any of its rights or obligations under any Loan Document without the consent of each Lender, (viii) change the provisions of this Section 11.1 without the consent of each Lender, (ix) change the definition of Required Lenders without the consent of each Lender, (x) change the several nature of the obligations of the Lenders without the consent of each Lender, (xi) change the sharing provisions among Lenders without the consent of each Lender directly affected thereby, or (xii) extend the expiration date of a Letter of Credit beyond the Commitment Termination Date without the consent of each Lender. Notwithstanding the foregoing, in addition to the receipt of the prior written consents of the Borrower and the Required Lenders, no such amendment, supplement, modification, waiver or consent shall (A) amend, modify or waive any provision of Section 10 or otherwise change any of the rights or obligations of the Administrative Agent, any Issuer or the Swing Line Lender under any Loan Document without the written consent of the Administrative Agent, such Issuer or the Swing Line Lender, as the case may be, (B) change the Letter of Credit Commitment, change the amount or the time of payment of any Letter of Credit or any commission or fee payable to the Issuer thereof in connection therewith, or change any other term or provision which relates to the Letter of Credit Commitment of such Issuer or the Letters of Credit issued thereby without the written consent of such Issuer, (C) change the Swing Line Commitment, change the amount or the time of payment of the Swing Line Loans or interest thereon or change any other term or provision which relates to the Swing Line Commitment or the Swing Line Loans without the written consent of the Swing Line Lender or (D) change the amount or the time of payment of any Competitive Bid Loan or interest thereon without the written consent of the Lender holding such Competitive Bid Loan. Any such amendment, supplement, modification, waiver or consent shall apply equally to each of the Lenders and shall be binding upon the parties to the applicable Loan Document, the Lenders, the Issuers, the Administrative Agent and all future holders of the Loans, the Notes and the Reimbursement Obligations. In the case of any waiver, the Borrower, the Lenders, the Issuers and the Administrative Agent shall be restored to their former position and rights under the Loan Documents, but any Default waived shall not extend to any subsequent or other Default, or impair any right consequent thereon. Notwithstanding anything to the contrary in this Section 11.1, if the Administrative Agent and the Borrower shall have jointly identified an

obvious error, ambiguity, defect, inconsistency, omission or any error or omission of a technical nature, in each case, in any provision of the Loan Documents, then the Administrative Agent and the Borrower shall be permitted to amend such provision, and, in each case, such amendment shall become effective without any further action or consent of any party to any Loan Document (other than the Administrative Agent and the Borrower) if the same (x) does not adversely affect the rights of any Lender or (y) is not objected to in writing by the Required Lenders to the Administrative Agent within five Domestic Business Days following receipt of notice thereof. Any amendment, waiver or consent effected in accordance with this Section 11.1 shall be binding upon each Person that is at the time thereof a Lender and each Person that subsequently becomes a Lender.

11.2 ***Notices***

(a) *Notices Generally.* Except in the case of notices and other communications expressly permitted to be given by telephone, all notices and other communications provided for herein shall be in writing and shall be delivered by hand or overnight courier service, mailed by certified or registered mail or sent by facsimile or email, as follows:

If to the Borrower:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Carol A. DeNale
Senior Vice President and Treasurer – Treasury Department
Facsimile: (401) 770-5768
Telephone: (401) 770-4407
Email: carol.denale@cvshealth.com

with a copy, in the case of a notice of Default, to:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Tom Moffatt
Vice President, Assistant Secretary and Assistant General Counsel – Corporate Services
Facsimile: (401) 216-3758
Telephone: (401) 770-5409
Email: thomas.moffatt@cvshealth.com

with a copy (in the case of a notice of Default and which shall not constitute notice under this Agreement or any other Loan Document for any purpose) to:

Shearman & Sterling LLP
599 Lexington Avenue
New York, New York 10022
Attention: Gus M. Atiyah
Facsimile: (646) 848-5227
Telephone: (212) 848-5227
Email: gus.atiyah@shearman.com

If to the Administrative Agent or the Swing Line Lender:

in the case of each Borrowing Request, each notice of prepayment under Section 2.7, each Letter of Credit Request, each Competitive Bid Request, each Competitive Bid, and each Competitive Bid Accept/Reject Letter:

BNY Mellon
Administrator/ Issuer Services
Client Services Delivery Loan Processing COE
Loan Administration
6023 Airport Road
Oriskany, New York 13424
Attention: Daizon Camp
Facsimile: (315) 765-4533
Telephone: (315) 765-4145
Email: afasyndications@bnymellon.com

and in all other cases:

The Bank of New York Mellon
101 Barclay Street
14th Floor West
New York, New York 10286
Attention: H. Stephen Griffith
Facsimile: (212) 815-3749
Telephone: (212) 815-2214
Email: stephen.griffith@bnymellon.com

and

The Bank of New York Mellon
500 Grant Street
Pittsburgh, Pennsylvania 15219
Attention: Clifford Mull
Facsimile: (412) 234-8087
Telephone: (412) 234-1346
Email: clifford.mull@bnymellon.com

If to any Lender or any Issuer: to it at its address (or facsimile number or email address) set forth in its Administrative Questionnaire.

(b) *Electronic Communications*. Notices and other communications to the Credit Parties hereunder may be delivered or furnished by electronic communication (including email and internet or intranet websites) pursuant to procedures approved by the Administrative Agent; *provided* that the foregoing shall not apply to notices to any Credit Party pursuant to Section 2 or Section 3.3 if such Credit Party has notified the Administrative Agent that it is incapable of receiving notices under such Sections by electronic communication. The Administrative Agent or the Borrower may, in its discretion, agree to accept notices and other communications to it hereunder by electronic communications pursuant to procedures approved by it; *provided* that approval of such procedures may be limited to particular notices or communications.

Unless the Administrative Agent otherwise prescribes, (i) notices and other communications sent to an email address shall be deemed received upon the sender's receipt of an acknowledgement from the intended recipient (such as by the "return receipt requested" or "read requested" function, as available, return email or other written acknowledgement); *provided* that if such notice or other communication is not sent during the normal business hours of the recipient, such notice or communication shall be deemed to have been sent at the opening of business on the next Domestic Business Day for the recipient, and (ii) notices or communications posted to an internet or intranet website shall be deemed received upon the deemed receipt by the intended recipient at its email address as described in the foregoing clause (i) of notification that such notice or communication is available and identifying the website address therefor.

(c) *Change of Address*. Any party hereto may change its address, facsimile number or email address for notices and other communications hereunder by notice to the other parties hereto (or, in the case of any Lender or any Issuer, by notice to the Administrative Agent and the Borrower). All notices and other communications given to any party hereto in accordance with the provisions of this Agreement shall be deemed to have been given on the date of receipt; *provided* that any such notice or communication that is not received on a Domestic Business Day during the normal business hours of the recipient shall be deemed received at the opening of business on the next Domestic Business Day.

11.3 ***No Waiver; Cumulative Remedies***

No failure to exercise and no delay in exercising, on the part of the Administrative Agent, any Lender or any Issuer, any right, remedy, power or privilege under any Loan Document shall operate as a waiver thereof, nor shall any single or partial exercise of any right, remedy, power or privilege under any Loan Document preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege. The rights, remedies, powers and privileges under the Loan Documents are cumulative and not exclusive of any rights, remedies, powers and privileges provided by law.

11.4 ***Survival of Representations and Warranties***

All representations and warranties made in the Loan Documents and in any document, certificate or statement delivered pursuant thereto or in connection therewith shall survive the execution and delivery of the Loan Documents.

11.5 ***Payment of Expenses; Indemnified Liabilities***

(a) The Borrower agrees, as soon as practicable following presentation of a statement or invoice therefor setting forth in reasonable detail the items thereof, and whether any Loan is made or Letter of Credit is issued, (a) to pay or reimburse the Administrative Agent and its Affiliates for all their reasonable and documented out-of-pocket costs and expenses actually incurred in connection with the development, syndication, preparation and execution of, and any amendment, waiver, consent, supplement or modification to, the Loan Documents, any documents prepared in connection therewith and the consummation of the transactions contemplated thereby, whether such Loan Documents or any such amendment, waiver, consent, supplement or modification to the Loan Documents or any documents prepared in connection therewith are executed and whether the transactions contemplated thereby are consummated, including the reasonable and documented out-of-pocket fees and disbursements of Special Counsel, (b) to pay, indemnify, and hold the Administrative Agent, the Lenders and the Issuers harmless from any and all recording and filing fees and any and all liabilities and penalties with respect to, or resulting from any delay (other than penalties to the extent attributable to the negligence of the Administrative Agent, the Lenders or the Issuers, as the case may be, in failing to pay such fees, liabilities or penalties when due) which may be payable or determined to be payable in connection with the execution and delivery of, or consummation of any of the transactions contemplated by, or any amendment, supplement or modification of, or any waiver or consent under or in respect of, the Loan Documents or any documents prepared in connection therewith, and (c) to pay, reimburse, indemnify and hold each Indemnified Person harmless from and against any and all other liabilities, obligations, claims, losses, damages, penalties, actions, judgments, suits, costs, expenses and disbursements of any kind or nature whatsoever (including the reasonable and documented out-of-pocket fees and disbursements of one counsel (but excluding the allocated cost of internal counsel) representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a single local counsel for each applicable jurisdiction (which may include a single counsel acting in multiple jurisdictions) (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Person))) actually incurred with respect to the enforcement, performance of, and preservation of rights under, the Loan Documents (all the foregoing, collectively, the ***"Indemnified Liabilities"***) and, if and to the extent that the foregoing indemnity may be unenforceable for any reason, the Borrower agrees to make the maximum payment permitted under applicable law. Notwithstanding anything to the contrary contained in this Section 11.5, the foregoing payment, indemnification and reimbursement obligations will not, as to any Person

identified in this Section 11.5, apply to any losses, claims, damages, liabilities and related expenses to the extent arising (A) from the willful misconduct, gross negligence, fraud or bad faith of such Person, (B) from a material breach of the obligations hereunder of such Person, (C) out of or in connection with Section 11.22, or (D) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by any such Person against any such other Person (other than the Administrative Agent, in its capacity as such), in each case under clauses (A) and (B), to the extent determined by a final and non-appealable judgment of a court of competent jurisdiction. The agreements in this Section 11.5 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

(b) Notwithstanding the above, the Borrower shall have no liability under this Section 11.5 to indemnify or hold harmless any Indemnified Person for any losses, claims, damages, liabilities and related expenses relating to income or withholding Taxes or any Tax in lieu of such Taxes. Notwithstanding the foregoing, any amounts claimed by an Indemnified Person under Section 11.10 shall not be available to be claimed by such Indemnified Person under this Section 11.5, it being understood and agreed that the rights of an Indemnified Person under this Section 11.5 and Section 11.10 shall not be duplicative.

11.6 ***Lending Offices***

Each Lender shall have the right at any time and from time to time to transfer any Loan to a different office of such Lender, subject to Section 3.10.

11.7 ***Successors and Assigns***

(a) *Successors and Assigns Generally*. The provisions of this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns permitted hereby, except that the Borrower may not assign or otherwise transfer any of its rights or obligations hereunder without the prior written consent of the Administrative Agent and each Lender and no Lender may assign or otherwise transfer any of its rights or obligations hereunder except (i) to an assignee in accordance with the provisions of paragraph (b) of this Section 11.7, (ii) by way of participation in accordance with the provisions of paragraph (d) of this Section 11.7 or (iii) by way of pledge or assignment of a security interest subject to the restrictions of paragraph (f) of this Section 11.7 (and any other attempted assignment or transfer by any party hereto shall be null and void). Nothing in this Agreement, expressed or implied, shall be construed to confer upon any Person (other than the parties hereto, their respective successors and assigns permitted hereby, the Participants to the extent provided in paragraph (d) of this Section 11.7 and, to the extent expressly contemplated hereby, the Related Parties of each Credit Party) any legal or equitable right, remedy or claim under or by reason of this Agreement.

(b) *Assignments by Lenders*. Any Lender may at any time assign to one or more assignees all or a portion of its rights and obligations under this Agreement (including all or a portion of its Commitment and the Loans and obligations in respect of its Letter of Credit

Exposure and Swing Line Exposure at the time owing to it); *provided* that any such assignment shall be subject to the following conditions:

(1) *Minimum Amounts*.

(A) in the case of an assignment of the entire remaining amount of the assigning Lender's Commitment Amount or Swing Line Commitment and the Loans and obligations in respect of its Letter of Credit Exposure and Swing Line Exposure at the time owing to it or in the case of an assignment to a Lender, an Affiliate of a Lender or an Approved Fund, no minimum amount need be assigned; and

(B) in any case not described in paragraph (b)(1)(A) of this Section 11.7, the Commitment Amount or Swing Line Commitment (which for this purpose includes the Loans of the assigning Lender outstanding thereunder and obligations in respect of its Letter of Credit Exposure and Swing Line Exposure at the time owing to it thereunder) or, if the Commitment or Swing Line Commitment of the assigning Lender is not then in effect, the principal outstanding balance of the Loans and the Letter of Credit Exposure and Swing Line Exposure of the assigning Lender subject to each such assignment (determined as of the date the Assignment and Assumption with respect to such assignment is delivered to the Administrative Agent or, if a "Trade Date" is specified in the Assignment and Assumption, as of such "Trade Date") shall not be less than $5,000,000, unless each of the Administrative Agent and, so long as no Event of Default has occurred and is continuing, the Borrower otherwise consents (each such consent not to be unreasonably withheld or delayed).

(2) *Proportionate Amounts*. Each partial assignment shall be made as an assignment of a proportionate part of all the assigning Lender's rights and obligations under this Agreement with respect to the Loans, Letter of Credit Exposure and Swing Line Exposure or the Commitment assigned, except that this clause (2) shall not prohibit any Lender from assigning all or a portion of its rights and obligations in respect of Competitive Bid Loans on a non-pro rata basis.

(3) *Required Consents*. No consent shall be required for any assignment except to the extent required by paragraph (b)(1)(B) of this Section 11.7 and, in addition:

(A) the consent of the Borrower (such consent not to be unreasonably withheld or delayed) shall be required unless (x) an Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) has occurred and is continuing at the time of such assignment or (y) such assignment is to a Lender, an Affiliate of a Lender or an Approved Fund;

(B) the consent of the Administrative Agent (such consent not to be unreasonably withheld, conditioned or delayed) shall be required for assignments in respect of an unfunded or revolving facility hereunder if such assignment is to a Person that is not a Lender with a Commitment in respect of such facility, an Affiliate of such Lender or an Approved Fund with respect to such Lender; and

(C) the consent of each Issuer (such consent not to be unreasonably withheld, conditioned or delayed) shall be required for any assignment that increases the obligation of the assignee to participate in exposure under one or more Letters of Credit (whether or not then outstanding) and the Swing Line Lender (such consent not to be unreasonably withheld or delayed) shall be required for any assignment in respect of the revolving facility hereunder.

(4) *Assignment and Assumption*. The parties to each assignment shall execute and deliver to the Administrative Agent an Assignment and Assumption, together with a processing and recordation fee of $4,500 ($7,500 in the case of an assignment by a Defaulting Lender) (which fee may be waived or reduced in the sole discretion of the Administrative Agent), and the assignee, if it is not a Lender, shall deliver to the Administrative Agent an Administrative Questionnaire.

(5) *No Assignment to Certain Parties*. No such assignment shall be made to (A) the Borrower, any of its Subsidiaries or any of their respective Affiliates, (B) any Defaulting Lender or any of its Subsidiaries or any Person who, upon becoming a Lender hereunder, would constitute any of the foregoing Persons described in this clause (B), or (C) any Disqualified Institution.

(6) *No Assignment to Natural Persons*. No such assignment shall be made to a natural person.

Subject to acceptance and recording thereof by the Administrative Agent pursuant to paragraph (c) of this Section 11.7, from and after the effective date specified in each Assignment and Assumption, the assignee thereunder shall be a party to this Agreement and, to the extent of the interest assigned by such Assignment and Assumption, have the rights and obligations of a Lender under this Agreement, and the assigning Lender thereunder shall, to the extent of the interest assigned by such Assignment and Assumption, be released from its obligations under this Agreement (and, in the case of an Assignment and Assumption covering all of the assigning Lender's rights and obligations under this Agreement, such Lender shall cease to be a party hereto) but shall continue to be entitled to the benefits of Section 3.6, Section 3.7, and Section 11.10 with respect to facts and circumstances occurring prior to the effective date of such assignment. Any assignment or transfer by a Lender of rights or obligations under this Agreement that does not comply with this paragraph shall be treated for purposes of this Agreement as a sale by such Lender of a participation in such rights and obligations in accordance with paragraph (d) of this Section 11.7.

(c) *Register*. The Administrative Agent, acting solely for this purpose as an agent of the Borrower, shall maintain at one of its offices in New York, New York a copy of each Assignment and Assumption delivered to it and a register for the recordation of the names and addresses of the Lenders, and the Commitments of, and principal amounts (and stated interest) of the Loans owing to, each Lender pursuant to the terms hereof from time to time (the ***"Register"***). The entries in the Register shall be conclusive absent manifest error, and the Borrower, the Administrative Agent, the Issuers and the Lenders may treat each Person whose name is recorded in the Register pursuant to the terms hereof as a Lender hereunder for all

purposes of this Agreement, notwithstanding notice to the contrary. The Register shall be available for inspection by the Borrower, any Issuer and any Lender (but only, in the case of an Issuer or a Lender, at the Administrative Agent's Office and with respect to any entry relating to such Lender's Commitments, Advances and other obligations pursuant to the terms hereof or such Issuer's Letter of Credit Commitments or other obligations pursuant to the terms hereof, as applicable) at any reasonable time and from time to time upon reasonable prior notice.

(d) *Participations*. Any Lender may at any time, without the consent of, or notice to, the Borrower or the Administrative Agent, sell participations to any Person (other than a natural person, the Borrower, any of its Subsidiaries or any of their respective Affiliates) (each, a ***"Participant"***) in all or a portion of such Lender's rights and/or obligations under this Agreement (including all or a portion of its Commitment, Letter of Credit Exposure, Swing Line Exposure and/or the Loans, Letter of Credit Exposure or Swing Line Exposure owing to it); *provided* that (i) all of such Lender's obligations under this Agreement and the other Loan Documents shall remain in all respects unchanged, (ii) such Lender shall remain solely responsible to the other parties hereto for the performance of such obligations and (iii) the Borrower, the Administrative Agent and each Credit Party shall continue to deal solely and directly with such Lender in connection with such Lender's rights and obligations under this Agreement. Any agreement or instrument pursuant to which a Lender sells such a participation shall provide that such Lender shall retain the sole right to enforce this Agreement and to approve any amendment, modification or waiver of any provision of this Agreement; *provided* that such agreement or instrument may provide that such Lender will not, without the consent of the Participant, agree to any amendment, modification or waiver which requires the consent of all Lenders or all affected Lenders that directly affects such Participant. Subject to paragraph (e) of this Section 11.7, the Borrower agrees that each Participant shall be entitled to the benefits of Section 3.5, Section 3.6, Section 3.7 and Section 3.10 to the same extent as if it were a Lender and had acquired its interest by assignment pursuant to paragraph (b) of this Section 11.7. To the extent permitted by law, each Participant also shall be entitled to the benefits of Section 11.9(a) as though it were a Lender, *provided* that such Participant agrees to be subject to Section 11.9(b) as though it were a Lender. Each Lender that sells a participation with respect to a Commitment or Loan shall, solely for the purposes of complying with the rules regarding registered form in the Internal Revenue Code, act as a non-fiduciary agent of the Borrower, maintaining a register on which it enters the name and address of each Participant and the principal amounts (and related interest amounts) of each Participant's interest in the Commitment and/or Loan (each a ***"Participant Register"***), and the entries in such Participant Register shall be conclusive, absent manifest error, and such Lender shall treat each Person whose name is recorded in the Participant Register as the owner of such participation for all purposes of this Agreement notwithstanding any notice to the contrary. No Lender shall be required to disclose the existence of, or any of the information contained in, any Participant Register maintained by it to the Borrower or any other Person unless requested in writing by the Borrower, and only to the Internal Revenue Service to the extent such disclosure is required in order to comply with the rules requiring registered form pursuant to the Internal Revenue Code.

(e) *Limitations upon Participant Rights*. A Participant shall not be entitled to receive any greater payment under Section 3.6, Section 3.7 or Section 3.10 than the applicable Lender would have been entitled to receive with respect to the participation sold to such

Participant, unless the sale of the participation to such Participant is made with the Borrower's prior written consent. A Participant shall not be entitled to the benefits of Section 3.10 unless the Borrower is notified of the participation sold to such Participant and such Participant agrees, for the benefit of the Borrower, to comply with Section 3.10(f) as though it were a Lender.

(f) *Certain Pledges*. Any Lender may at any time pledge or assign a security interest in all or any portion of its rights under this Agreement to secure obligations of such Lender, including any pledge or assignment to secure obligations to a Federal Reserve Bank or other central bank having jurisdiction over such Lender; *provided* that no such pledge or assignment shall release such Lender from any of its obligations hereunder or substitute any such pledgee or assignee for such Lender as a party hereto.

11.8 ***Counterparts; Electronic Execution of Assignments***

(a) *Counterparts*. Each of the Loan Documents (other than the Notes) may be executed on any number of separate counterparts and all of said counterparts taken together shall be deemed to constitute one and the same agreement. It shall not be necessary in making proof of any Loan Document to produce or account for more than one counterpart signed by the party to be charged. A set of the copies of this Agreement signed by all of the parties hereto shall be lodged with each of the Borrower and the Administrative Agent. Delivery of an executed counterpart of a signature page of any Loan Document by fax or other electronic means (e.g., ".pdf" or ".tif") shall be effective as delivery of a manually executed counterpart of such Loan Document.

(b) *Electronic Execution of Assignments*. The words "execution," "signed," "signature," and words of like import in any Assignment and Assumption shall be deemed to include electronic signatures or the keeping of records in electronic form, each of which shall be of the same legal effect, validity or enforceability as a manually executed signature or the use of a paper-based recordkeeping system, as the case may be, to the extent and as provided for in any applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, the New York State Electronic Signatures and Records Act, or any other similar state laws based on the Uniform Electronic Transactions Act.

11.9 ***Set-off and Sharing of Payments***

(a) In addition to any rights and remedies of the Lenders and the Issuers provided by law, after the occurrence and during the continuance of an Event of Default under Section 9.1(a) or Section 9.1(b) or upon the acceleration of the Loans, each Lender and each Issuer shall have the right, without prior notice to the Borrower, any such notice being expressly waived by the Borrower, to set-off and apply against any indebtedness or other liability, whether matured or unmatured, of the Borrower to such Lender or such Issuer arising under the Loan Documents, any amount owing from such Lender or such Issuer to the Borrower. To the extent permitted by applicable law, the aforesaid right of set-off may be exercised by such Lender or such Issuer against the Borrower or against any trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors, receiver, or execution, judgment or attachment creditor of the Borrower, or against anyone else claiming through or against the Borrower or such trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors,

receivers, or execution, judgment or attachment creditor, notwithstanding the fact that such right of set-off shall not have been exercised by such Lender or such Issuer prior to the making, filing or issuance of, service upon such Lender or such Issuer of, or notice to such Lender or such Issuer of, any petition, assignment for the benefit of creditors, appointment or application for the appointment of a receiver, or issuance of execution, subpoena, order or warrant. Each Lender and each Issuer agree promptly to notify the Borrower and the Administrative Agent after each such set-off and application made by such Lender or such Issuer, *provided* that the failure to give such notice shall not affect the validity of such set-off and application.

(b) If any Lender or any Issuer shall obtain any payment (whether voluntary, involuntary, through the exercise of any right of set-off, or otherwise) on account of its Loans or its Notes or the Reimbursement Obligations in excess of its pro rata share (in accordance with the outstanding principal balance of all Loans or the Reimbursement Obligations) of payments then due and payable on account of the Loans and Notes received by all the Lenders or the Reimbursement Obligations received by all Issuers, such Lender or such Issuer, as the case may be, shall forthwith purchase, without recourse, for cash, from the other Lenders or Issuers, as the case may be, such participations in their Loans and Notes or the Reimbursement Obligations as shall be necessary to cause such purchasing Lender or Issuer to share the excess payment with each of them according to their pro rata share (in accordance with the outstanding principal balance of all Loans and the Reimbursement Obligations); *provided* that if all or any portion of such excess payment is thereafter recovered from such purchasing Lender or Issuer, such purchase from each Lender or Issuer shall be rescinded and each such Lender and Issuer shall repay to the purchasing Lender or Issuer the purchase price to the extent of such recovery, together with an amount equal to such Lender's or Issuer's pro rata share (according to the proportion of (i) the amount of such Lender's or Issuer's required repayment to (ii) the total amount so recovered from the purchasing Lender or Issuer) of any interest or other amount paid or payable by the purchasing Lender or Issuer in respect of the total amount so recovered. The Borrower agrees, to the fullest extent permitted by law, that any Lender or Issuer so purchasing a participation from another Lender or Issuer pursuant to this Section 11.9 may exercise such rights to payment (including the right of set-off) with respect to such participation as fully as if such Lender or Issuer were the direct creditor of the Borrower in the amount of such participation.

11.10 ***Indemnity***

(a) The Borrower shall indemnify each Credit Party and each Related Party thereof (each such Person being called an ***"Indemnified Person"***) against, and hold each Indemnified Person harmless from, any and all losses, claims, damages, liabilities and related expenses, including the reasonable and documented out-of-pocket fees and disbursements of one counsel (but excluding the allocated cost of internal counsel) representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction (which may include a single counsel acting in multiple jurisdictions) (and, if reasonably necessary, one specialty counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a

single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Person)), actually incurred by any Indemnified Person arising out of, in connection with, or as a result of (i) the execution or delivery of any Loan Document or any agreement or instrument contemplated thereby, the performance by the parties to the Loan Documents of their respective obligations thereunder or the consummation of the transactions contemplated hereby or any other transactions contemplated thereby, (ii) any Loan or Letter of Credit or the use of the proceeds thereof, (iii) any actual or alleged presence or release of Hazardous Materials in, on, under or from any property owned or operated by the Borrower or any of the Subsidiaries, or any Environmental Liability related in any way to the Borrower or any of the Subsidiaries or (iv) any actual or prospective claim, litigation, investigation or proceeding relating to any of the foregoing, whether based on statute, contract, tort or any other theory and regardless of whether any Indemnified Person is a party thereto. Notwithstanding anything to the contrary contained in this Section 11.10(a), the foregoing indemnity will not, as to any Indemnified Person, apply to any losses, claims, damages, liabilities and related expenses to the extent arising (A) from the willful misconduct, gross negligence, fraud or bad faith of such Indemnified Person, (B) from a material breach of the obligations hereunder of such Indemnified Person, (C) out of or in connection with Section 11.22, or (D) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by an Indemnified Person against any other Indemnified Person (other than the Administrative Agent, in its capacity as such), in each case under clauses (A) and (B), to the extent determined by a final and non-appealable judgment of a court of competent jurisdiction.

(b) To the extent that the Borrower fails to pay as soon as practicable any amount required to be paid by it to the Administrative Agent under subsection (a) of this Section 11.10 (the ***"Indemnified Amount"***), each Lender severally agrees to pay to the Administrative Agent an amount equal to the product of such unpaid amount *multiplied by* (i) at any time when no Loans are outstanding, its Commitment Percentage, and (ii) at any time when Loans are outstanding (x) if the Commitments then exist, its Commitment Percentage or (y) if the Commitments have been terminated or otherwise no longer exist, the percentage equal to the fraction, (A) the numerator of which is the sum of such Lender's Credit Exposure and (B) the denominator of which is the sum of the Aggregate Credit Exposure (in each case determined as of the time that the applicable Indemnified Amount is sought), *provided* that the Indemnified Amount was payable to the Administrative Agent in its capacity as such.

(c) The obligations of the Borrower and the Lenders under this Section 11.10 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

(d) If any settlement of any investigation, litigation or proceeding to which the indemnity in this Section 11.10 applies (any of the foregoing, a ***"Proceeding"***) is instituted or threatened against any Indemnified Person (or its Related Parties) in respect of which indemnity may be sought hereunder, the Borrower shall be entitled to assume the defense thereof with counsel selected by the Borrower (which counsel shall be reasonably satisfactory to such Indemnified Person) and after notice from the Borrower to such Indemnified Person of the Borrower's election so to assume the defense thereof, the Borrower will not be liable to such

Indemnified Person hereunder for any legal or other expenses subsequently incurred by such Indemnified Person in connection with the defense thereof, other than reasonable costs of investigation and such other expenses as have been approved in advance; *provided*, that (i) if counsel for such Indemnified Person determines in good faith that there is a conflict that requires separate representation for the Borrower and such Indemnified Person or that there may be legal defenses available to such Indemnified Person which are different from or in addition to those available to the Borrower or (ii) the Borrower fails to assume or proceed in a timely and reasonable manner with the defense of such action or fails to employ counsel reasonably satisfactory to such Indemnified Person in any such action, then in either such event, (A) such Indemnified Person shall be entitled to one primary counsel and, if necessary, one local counsel to represent such Indemnified Person and all other Indemnified Persons similarly situated (such counsels selected by the Administrative Agent), (B) the Borrower shall not, or shall not any longer, be entitled to assume the defense thereof on behalf of such Indemnified Person and (C) such Indemnified Person shall be entitled to indemnification for the expenses (including fees and expenses of such counsel) to the extent provided in this Section 11.10. Notwithstanding the foregoing, the Borrower shall not be liable for any settlement, compromise or consent to the entry of any judgment in any action or Proceeding effected without the Borrower's prior written consent (which consent shall not be unreasonably withheld or delayed, it being understood and agreed that the withholding or delaying of the Borrower's consent in connection with a settlement, compromise or consent to the entry of any judgment in any action or proceeding which does not include an unconditional release of the Borrower and the Subsidiaries from all liability or claims that are the subject matter of such Proceeding or which includes a statement as to any admission of fault by or on behalf of the Borrower or any Subsidiary shall not be deemed unreasonable), but if settled with the Borrower's prior written consent or if there is a final judgment for the plaintiff in any such Proceeding, the Borrower agrees to indemnify and hold harmless each Indemnified Person from and against any and all losses, claims, damages, liabilities and expenses by reason of such settlement, compromise or consent to the entry of any judgment in any action or Proceeding in accordance with this Section 11.10. The Borrower shall not, without the prior written consent of an Indemnified Person, effect any settlement of any pending or threatened Proceeding against such Indemnified Person in respect of which indemnity could have been sought hereunder by such Indemnified Person unless such settlement (x) includes an unconditional release of such Indemnified Person from all liability or claims that are the subject matter of such Proceeding and (y) does not include any statement as to any admission of fault by or on behalf of such Indemnified Person.

(e) Notwithstanding any provision in this Agreement to the contrary, none of the Borrower, the Administrative Agent, the Lenders or any Affiliate of any of the foregoing will be responsible or liable to any Person or entity, on any theory of liability, for any indirect, special, punitive or consequential damages that may be alleged as a result of the transactions contemplated hereby or by the other Loan Documents or any use or intended use of the proceeds of the Loans; *provided* that nothing in this clause (e) shall limit the Borrower's indemnity obligations set forth in this Agreement with respect to any indirect, punitive or consequential damages included in any third party claim in connection with which an Indemnified Person is entitled to indemnification hereunder. In addition to, and without limiting the immediately foregoing sentence, and to the extent permitted by applicable law, the Borrower shall not assert, and hereby waives, any claim against any Indemnified Person, on any theory of liability, for

special, indirect, consequential or punitive damages (as opposed to direct and actual damages) arising out of, in connection with, or as a result of, any Loan Document or any agreement, instrument or other document contemplated thereby, the transactions contemplated hereby or any Loan or any Letter of Credit or the use of the proceeds thereof.

(f) Notwithstanding the above, the Borrower shall have no liability under this Section 11.10 to indemnify or hold harmless any Indemnified Person for any losses, claims, damages, liabilities and related expenses relating to income or withholding Taxes or any Tax in lieu of such Taxes. Notwithstanding the foregoing, any amounts claimed by an Indemnified Person under Section 11.5 shall not be available to be claimed by such Indemnified Person under this Section 11.10, it being understood and agreed that the rights of an Indemnified Person under this Section 11.10 and Section 11.5 shall not be duplicative.

11.11 ***Governing Law***

The Loan Documents and the rights and obligations of the parties thereto shall be governed by, and construed and interpreted in accordance with, the laws of the State of New York.

11.12 ***Severability***

Every provision of the Loan Documents is intended to be severable, and if any term or provision thereof shall be invalid, illegal or unenforceable for any reason, the validity, legality and enforceability of the remaining provisions thereof shall not be affected or impaired thereby, and any invalidity, illegality or unenforceability in any jurisdiction shall not affect the validity, legality or enforceability of any such term or provision in any other jurisdiction.

11.13 ***Integration***

All exhibits to the Loan Documents shall be deemed to be a part thereof. Each Loan Document embodies the entire agreement and understanding between or among the parties thereto with respect to the subject matter thereof and supersedes all prior agreements and understandings between or among the parties thereto with respect to the subject matter thereof.

11.14 ***Treatment of Certain Information***

(a) Each Credit Party agrees to maintain the confidentiality of the Information (as defined below), except that Information may be disclosed (i) to its Affiliates and to its and its Affiliates' respective partners, directors, officers, employees, agents, advisors and other representatives (it being understood that the Persons to whom such disclosure is made will be informed of the confidential nature of such Information and instructed to keep such Information confidential); *provided* that each Credit Party shall be responsible for its controlled Affiliates' compliance in keeping Information confidential, (ii) to the extent requested by any regulatory authority purporting to have jurisdiction over it (including any self-regulatory authority, such as the National Association of Insurance Commissioners) (in which case such Person agrees (except with respect to any audit or examination conducted by bank accountants or any governmental regulatory authority exercising examination or regulatory authority) to inform the Borrower promptly thereof prior to such disclosure to the extent practicable and not prohibited by law),

(iii) to the extent required by applicable laws or regulations or by any subpoena or similar legal process (in which case such Person agrees to (except with respect to any audit or examination conducted by bank accountants or any governmental regulatory authority exercising examination or regulatory authority) to inform the Borrower promptly thereof prior to such disclosure to the extent practicable and not prohibited by law), (iv) to any other party hereto, (v) in connection with the exercise of any remedies hereunder or under any other Loan Document or any action or proceeding relating to this Agreement or any other Loan Document or the enforcement of rights hereunder or thereunder, (vi) subject to an agreement containing provisions substantially the same as those of this Section 11.14, to (A) any assignee of or Participant in, or any prospective assignee of or Participant in, any of its rights or obligations under this Agreement or (B) any actual or prospective counterparty (or its advisors) to any swap or derivative transaction relating to the Borrower and its obligations, (vii) to Gold Sheets and other similar bank trade publications, such information to consist of deal terms and other information customarily found in such publications, (viii) with the prior written consent of the Borrower or (ix) to the extent such Information (1) becomes publicly available other than as a result of a breach of this Section 11.14 or (2) becomes available to the Administrative Agent, any Credit Party or any of their respective Affiliates on a non-confidential basis from a source other than the Borrower not known to such Credit Party to be prohibited from disclosing such Information.

(b) For purposes of this Section 11.14, ***"Information"*** means all information received from the Borrower or any of its Subsidiaries relating to the Borrower or any of its Subsidiaries or any of their respective businesses, other than any such information that is available to the Administrative Agent or any other Credit Party on a non-confidential basis prior to disclosure by the Borrower or any of its Subsidiaries.

11.15 ***Acknowledgments***

The Borrower acknowledges that (a) it has been advised by counsel in the negotiation, execution and delivery of the Loan Documents, (b) by virtue of the Loan Documents, the relationship among the Administrative Agent, the Issuers and the Lenders, on the one hand, and the Borrower, on the other hand, is solely that of debtor and creditor, and (c) by virtue of the Loan Documents, no joint venture exists among the Lenders or among the Borrower and the Lenders.

11.16 ***Consent to Jurisdiction***

Each of the parties hereto irrevocably submits to the exclusive jurisdiction of any New York State or Federal Court sitting in the City of New York, Borough of Manhattan, over any suit, action, claim, counterclaim or proceeding arising out of or relating to the Loan Documents. Each of the parties hereto irrevocably waives, to the fullest extent permitted by law, any objection which it may now or hereafter have to the laying of the venue of any such suit, action, claim, counterclaim or proceeding brought in such a court and any claim that any such suit, action, claim, counterclaim or proceeding brought in such a court has been brought in an inconvenient forum. Each of the parties hereto agrees that a final judgment in any such suit, action, claim, counterclaim or proceeding brought in such a court, after all appropriate appeals, shall be conclusive and binding upon it.

11.17 ***Service of Process***

Each of the parties hereto agrees that process may be served against it in any suit, action or proceeding referred to in Section 11.16 by sending the same by first class mail, return receipt requested or by overnight courier service, with receipt acknowledged, to the address of such party set forth or referred to in Section 11.2. Each of the parties hereto agrees that any such service (i) shall be deemed in every respect effective service of process upon it in any such suit, action, or proceeding, and (ii) shall to the fullest extent enforceable by law, be taken and held to be valid personal service upon and personal delivery to it.

11.18 ***No Limitation on Service or Suit***

Nothing in the Loan Documents or any modification, waiver, or amendment thereto shall affect the right of the Administrative Agent, any Issuer or any Lender to serve process in any manner permitted by law or limit the right of the Administrative Agent, any Issuer or any Lender to bring proceedings against the Borrower in the courts of any jurisdiction or jurisdictions.

11.19 ***WAIVER OF TRIAL BY JURY***

EACH OF THE CREDIT PARTIES AND THE BORROWER KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION ARISING OUT OF, UNDER OR IN CONNECTION WITH THE LOAN DOCUMENTS OR THE TRANSACTIONS CONTEMPLATED THEREBY. FURTHER, THE BORROWER HEREBY CERTIFIES THAT NO REPRESENTATIVE OR AGENT OF ANY OF THE CREDIT PARTIES, OR COUNSEL TO ANY OF THE CREDIT PARTIES, HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT ANY OF THE CREDIT PARTIES WOULD NOT, IN THE EVENT OF SUCH LITIGATION, SEEK TO ENFORCE THIS WAIVER OF RIGHT TO JURY TRIAL PROVISION. THE BORROWER ACKNOWLEDGES THAT THE CREDIT PARTIES HAVE BEEN INDUCED TO ENTER INTO THIS AGREEMENT BY, *INTER ALIA*, THE PROVISIONS OF THIS SECTION 11.19.

11.20 ***Patriot Act Notice***

Each Lender and the Administrative Agent (for itself and not on behalf of any Lender) hereby notifies the Borrower that pursuant to the requirements of the USA PATRIOT Act (Title III of Pub. L. 107-56 (signed into law October 26, 2001), as amended from time to time) (the ***"Patriot Act"***), it is required to obtain, verify and record information that identifies the Borrower, which information includes the name and address of the Borrower and other information that will allow such Lender or the Administrative Agent, as applicable, to identify the Borrower in accordance with the Patriot Act.

11.21 ***No Fiduciary Duty***

The Borrower agrees that in connection with all aspects of the transactions contemplated hereby and any communications in connection therewith, the Borrower and its Subsidiaries, on the one hand, and the Credit Parties, the Joint Lead Arrangers and Joint

Bookrunners named on the cover page hereof, and their respective Affiliates, on the other hand, will have a business relationship that does not create, by implication or otherwise, any fiduciary duty on the part of the Credit Parties or such Joint Lead Arrangers and Joint Bookrunners, or their respective Affiliates, and no such duty will be deemed to have arisen in connection with any such transactions or communications.

11.22 ***Acknowledgement and Consent to Bail-In of EEA Financial Institutions***

Notwithstanding anything to the contrary in any Loan Document or in any other agreement, arrangement or understanding among any such parties, each party hereto acknowledges that any liability of any Lender or Issuer that is an EEA Financial Institution arising under any Loan Document, to the extent such liability is unsecured, may be subject to the Write-Down and Conversion Powers of an EEA Resolution Authority and agrees and consents to, and acknowledges and agrees to be bound by:

(a) the application of any Write-Down and Conversion Powers by an EEA Resolution Authority to any such liabilities arising hereunder which may be payable to it by any Lender or Issuer that is an EEA Financial Institution; and

(b) the effects of any Bail-in Action on any such liability, including, if applicable:

(i) a reduction in full or in part or cancellation of any such liability;

(ii) a conversion of all, or a portion of, such liability into shares or other instruments of ownership in such EEA Financial Institution, its parent undertaking, or a bridge institution that may be issued to it or otherwise conferred on it, and that such shares or other instruments of ownership will be accepted by it in lieu of any rights with respect to any such liability under this Agreement or any other Loan Document; or

(iii) the variation of the terms of such liability in connection with the exercise of the Write-Down and Conversion Powers of any EEA Resolution Authority.

11.23 ***Certain ERISA Matters***

(a) Each Lender (x) represents and warrants, as of the date such Person became a Lender party hereto, to, and (y) covenants, from the date such Person became a Lender party hereto to the date such Person ceases being a Lender party hereto, for the benefit of, the Agents and Arrangers and their respective Affiliates, and not, for the avoidance of doubt, to or for the benefit of the Borrower or any other Credit Party, that at least one of the following is and will be true:

(i) such Lender is not using “plan assets” (within the meaning of 29 CFR §2510.3-101, as modified by Section 3(42) of ERISA) of one or more Benefit Plans in connection with the Loans or the Commitments,

(ii) the transaction exemption set forth in one or more PTEs, such as PTE 84-14 (a class exemption for certain transactions determined by independent qualified

professional asset managers), PTE 95-60 (a class exemption for certain transactions involving insurance company general accounts), PTE 90-1 (a class exemption for certain transactions involving insurance company pooled separate accounts), PTE 91-38 (a class exemption for certain transactions involving bank collective investment funds) or PTE 96-23 (a class exemption for certain transactions determined by in-house asset managers), is applicable with respect to such Lender's entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement,

(iii) (A) such Lender is an investment fund managed by a "Qualified Professional Asset Manager" (within the meaning of Part VI of PTE 84-14), (B) such Qualified Professional Asset Manager made the investment decision on behalf of such Lender to enter into, participate in, administer and perform the Loans, the Commitments and this Agreement, (C) the entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement satisfies the requirements of sub-sections (b) through (g) of Part I of PTE 84-14 and (D) to the best knowledge of such Lender, the requirements of subsection (a) of Part I of PTE 84-14 are satisfied with respect to such Lender's entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement, or

(iv) such other representation, warranty and covenant as may be agreed in writing between the Administrative Agent, in its sole discretion, and such Lender.

(b) In addition, unless sub-clause (i) in the immediately preceding clause (a) is true with respect to a Lender or such Lender has not provided another representation, warranty and covenant as provided in sub-clause (iv) in the immediately preceding clause (a), such Lender further (x) represents and warrants, as of the date such Person became a Lender party hereto, to, and (y) covenants, from the date such Person became a Lender party hereto to the date such Person ceases being a Lender party hereto, for the benefit of, the Agents and Arrangers and their respective Affiliates, and not, for the avoidance of doubt, to or for the benefit of the Borrower or any other Credit Party, that:

(i) none of the Agents and Arrangers or any of their respective Affiliates is a fiduciary with respect to the assets of such Lender (including in connection with the reservation or exercise of any rights by any such Person under this Agreement, any Loan Document or any documents related hereto or thereto),

(ii) the Person making the investment decision on behalf of such Lender with respect to the entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement is independent (within the meaning of 29 CFR § 2510.3-21) and is a bank, an insurance carrier, an investment adviser, a broker-dealer or other Person that holds, or has under management or control, total assets of at least $50 million, in each case as described in 29 CFR § 2510.3-21(c)(1)(i)(A)-(E),

(iii) the Person making the investment decision on behalf of such Lender with respect to the entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement is capable of evaluating investment risks independently, both in general and with regard to particular transactions and investment strategies (including in respect of the obligations),

(iv) the Person making the investment decision on behalf of such Lender

with respect to the entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement is a fiduciary under ERISA or the Internal Revenue Code, or both, with respect to the Loans, the Commitments and this Agreement and is responsible for exercising independent judgment in evaluating the transactions hereunder, and

(v) no fee or other compensation is being paid directly to any of the Agents and Arrangers or any of their respective Affiliates for investment advice (as opposed to other services) in connection with the Loans, the Commitments or this Agreement.

(c) The Agents and Arrangers hereby inform the Lenders that each such Person is not undertaking to provide impartial investment advice, or to give advice in a fiduciary capacity, in connection with the transactions contemplated hereby, and that such Person has a financial interest in the transactions contemplated hereby in that such Person or an Affiliate thereof (i) may receive interest or other payments with respect to the Loans, the Commitments and this Agreement, (ii) may recognize a gain if it extended the Loans or the Commitments for an amount less than the amount being paid for an interest in the Loans or the Commitments by such Lender or (iii) may receive fees or other payments in connection with the transactions contemplated hereby, the Loan Documents or otherwise, including structuring fees, commitment fees, arrangement fees, facility fees, upfront fees, underwriting fees, ticking fees, agency fees, administrative agent or collateral agent fees, utilization fees, minimum usage fees, letter of credit fees, fronting fees, deal-away or alternate transaction fees, amendment fees, processing fees, term out premiums, banker's acceptance fees, breakage or other early termination fees or fees similar to the foregoing.

(d) For purposes of this Section 11.23, the following defined terms when used herein have the following meanings:

"Benefit Plan" means any of (a) an "employee benefit plan" (as defined in ERISA) that is subject to Title I of ERISA, (b) a "plan" as defined in Section 4975 of the Internal Revenue Code or (c) any Person whose assets include (for purposes of ERISA Section 3(42) or otherwise for purposes of Title I of ERISA or Section 4975 of the Internal Revenue Code) the assets of any such "employee benefit plan" or "plan".

"PTE" means a prohibited transaction class exemption issued by the U.S. Department of Labor, as any such exemption may be amended from time to time.

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AS EVIDENCE of the agreement by the parties hereto to the terms and conditions herein contained, each such party has caused this Agreement to be executed on its behalf.

CVS HEALTH CORPORATION

By: /s/ Carol A. DeNale
Name: Carol A. DeNale
Title: Senior Vice President and Treasurer

CVS Health Corporation 2018 Five Year Credit Agreement

THE BANK OF NEW YORK MELLON,
as the Administrative Agent, an Issuer, the Swing
Line Lender and a Lender

By: /s/ Clifford A. Mull
Name: Clifford A. Mull
Title: Director

CVS Health Corporation 2018 Five Year Credit Agreement

BANK OF AMERICA, N.A.,
as an Issuer and a Lender

By: /s/ Carlos J. Medina
Name: Carlos J. Medina
Title: Director

CVS Health Corporation 2018 Five Year Credit Agreement

WELLS FARGO BANK, N.A.,
as an Issuer and a Lender

By: /s/ Christopher M. Johnson
Name: Christopher M. Johnson
Title: Director

CVS Health Corporation 2018 Five Year Credit Agreement

BARCLAYS BANK PLC,
as an Issuer and a Lender

By: /s/ Ritam Bhalla
Name: Ritam Bhalla
Title: Director

CVS Health Corporation 2018 Five Year Credit Agreement

JPMORGAN CHASE BANK, N.A.,
as an Issuer and a Lender

By: /s/ Vanessa Chiu
Name: Vanessa Chiu
Title: Executive Director

CVS Health Corporation 2018 Five Year Credit Agreement

GOLDMAN SACHS BANK USA,
as an Issuer and a Lender

By: /s/ Annie Carr
Name: Annie Carr
Title: Authorized Signatory

CVS Health Corporation 2018 Five Year Credit Agreement

MIZUHO BANK, LTD.,
as a Lender

By: /s/ Tracy Rahn
Name: Tracy Rahn
Title: Authorized Signatory

CVS Health Corporation 2018 Five Year Credit Agreement

SUNTRUST BANK,
as a Lender

By: /s/ Johnetta Bush
Name: Johnetta Bush
Title: Director

CVS Health Corporation 2018 Five Year Credit Agreement

U.S. BANK NATIONAL ASSOCIATION,
as a Lender

By: /s/ Joyce P. Dorsett
Name: Joyce P. Dorsett
Title: Senior Vice President

CVS Health Corporation 2018 Five Year Credit Agreement

MUFG BANK, LTD.,
as a Lender

By: /s/ Kevin Wood
Name: Kevin Wood
Title: Director

CVS Health Corporation 2018 Five Year Credit Agreement

ROYAL BANK OF CANADA,
as a Lender

By: /s/ Gordon MacArthur
Name: Gordon MacArthur
Title: Authorized Signatory

CVS Health Corporation 2018 Five Year Credit Agreement

CITIBANK, N.A.,
as a Lender

By: /s/ Alejandro Romero
Name: Alejandro Romero
Title: Vice President

CVS Health Corporation 2018 Five Year Credit Agreement

KEYBANK NATIONAL ASSOCIATION,
as a Lender

By: /s/ Marianne T. Meil
Name: Marianne T. Meil
Title: Senior Vice President

CVS Health Corporation 2018 Five Year Credit Agreement

FIFTH THIRD BANK,
as a Lender

By: /s/ Todd S.Robinson
Name: Todd S.Robinson
Title: VP

CVS Health Corporation 2018 Five Year Credit Agreement

SUMITOMO MITSUI BANKING CORPORATION,
as a Lender

By: /s/ James D. Weinstein
Name: James D. Weinstein
Title: Managing Director

CVS Health Corporation 2018 Five Year Credit Agreement

PNC BANK, NATIONAL ASSOCIATION,
as a Lender

By: /s/ William P. Herold
Name: William P. Herold
Title: Vice President

CVS Health Corporation 2018 Five Year Credit Agreement

SANTANDER BANK, N.A.,
as a Lender

By: /s/ Andres Barbosa
Name: Andres Barbosa
Title: Executive Director

By: /s/ Gonzalo Acha
Name: Gonzalo Acha
Title: Managing Director

CVS Health Corporation 2018 Five Year Credit Agreement

CREDIT SUISSE AG, CAYMAN ISLANDS BRANCH, as a Lender

By: /s/ William O'Daly
Name: William O'Daly
Title: Authorized Signatory

By: /s/ Lingzi Huang
Name: Lingzi Huang
Title: Authorized Signatory

CVS Health Corporation 2018 Five Year Credit Agreement

INDUSTRIAL AND COMMERCIAL BANK OF CHINA LIMITED, NEW YORK BRANCH,
as a Lender

By: /s/ Pinyen Shih
Name: Pinyen Shih
Title: Executive Director

By: /s/ Yu Wang
Name: Yu Wang
Title: Assistant Vice President

CVS Health Corporation 2018 Five Year Credit Agreement

TD BANK, N.A.,
as a Lender

By: /s/ Uk-Sun Kim
Name: Uk-Sun Kim
Title: Senior Vice President

CVS Health Corporation 2018 Five Year Credit Agreement

BANK OF CHINA, NEW YORK BRANCH,
as a Lender

By: /s/ Raymond Qiao
Name: Raymond Qiao
Title: Executive Vice President

CVS Health Corporation 2018 Five Year Credit Agreement

[BANK],
as a Lender

By: _____
Name:
Title:

CVS Health Corporation 2018 Five Year Credit Agreement

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT A

LIST OF COMMITMENTS

Lender	Commitment Amount	Letter of Credit Commitment	Commercial Letter of Credit Commitment
The Bank of New York Mellon	$140,000,000	$25,000,000	$25,000,000
Barclays Bank PLC	$140,000,000	$25,000,000	$0
Bank of America, N.A.	$140,000,000	$25,000,000	$25,000,000
Goldman Sachs Bank USA	$140,000,000	$25,000,000	$0
JPMorgan Chase Bank, N.A.	$140,000,000	$25,000,000	$25,000,000
Wells Fargo Bank, N.A.	$140,000,000	$25,000,000	$25,000,000
Mizuho Bank, Ltd.	$102,000,000		
SunTrust Bank	$102,000,000		
U.S. Bank National Association	$102,000,000		
MUFG Bank, Ltd.	$102,000,000		
Royal Bank of Canada	$102,000,000		
Citibank, N.A.	$102,000,000		
Fifth Third Bank	$70,000,000		
PNC Bank, National Association	$70,000,000		
Santander Bank, N.A.	$70,000,000		
Credit Suisse AG, Cayman Islands Branch	$70,000,000		
Sumitomo Mitsui Banking Corporation	$70,000,000		
KeyBank National Association	$49,500,000		
TD Bank, N.A.	$49,500,000		

Bank of China, New York Branch	$49,500,000		
Industrial and Commercial Bank of China Limited, New York Branch	$49,500,000		
TOTAL	**$2,000,000,000**	**$150,000,000**	**$100,000,000**

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2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT B

FORM OF NOTE

[_____], 2018
New York, New York

FOR VALUE RECEIVED, the undersigned, CVS HEALTH CORPORATION, a Delaware corporation (the "Borrower"), hereby promises to pay to the order of _____ (the "Lender") the outstanding principal balance of the Lender's Loans, together with interest thereon, at the rate or rates, in the amounts and at the time or times set forth in the Five Year Credit Agreement (as the same may be amended, amended and restated, supplemented or otherwise modified from time to time, the "Credit Agreement"), dated as of May 17, 2018, by and among the Borrower, the Lenders party thereto from time to time and The Bank of New York Mellon, as administrative agent (in such capacity, together with its successors and assigns, the "Administrative Agent"), in each case at the office of the Administrative Agent located at 225 Liberty Street, New York, New York, or at such other place as the Administrative Agent may specify from time to time, in lawful money of the United States of America in immediately available funds.

Capitalized terms used herein that are not otherwise defined herein shall have the respective meanings ascribed thereto in the Credit Agreement.

The Loans evidenced by this Note are prepayable in the amounts, and on the dates, set forth in the Credit Agreement. This Note is one of the Notes under the Credit Agreement, and is subject to, and shall be construed in accordance with, the provisions thereof, and is entitled to the benefits set forth in the Loan Documents.

The Lender is hereby authorized to record on the schedule annexed hereto, and any continuation sheets which the Lender may attach thereto (a) the date and amount of each Revolving Credit Loan, Competitive Bid Loan and Swing Line Loan made by the Lender, (b) the Interest Period for each Revolving Credit Loan (Eurodollar Advance only), Competitive Bid Loan and Swing Line Loan made by the Lender, (c) the Type of each Revolving Credit Loan made by the Lender as one or more ABR Advances, one or more Eurodollar Advances, or a combination thereof, (d) the Eurodollar Rate applicable to each Revolving Credit Loan (Eurodollar Advance only), the Competitive Bid Rate applicable to each Competitive Bid Loan and the Negotiated Rate applicable to each Swing Line Loan, in each case made by the Lender and (e) the date and amount of each Conversion of each Revolving Credit Loan made by the Lender, and each payment or prepayment of principal of each Loan made by the Lender. The failure to so record or any error in so recording shall not affect the obligation of the Borrower to repay the Loans, together with interest thereon, as provided in the Credit Agreement.

Except as specifically otherwise provided in the Credit Agreement, the Borrower hereby waives presentment, demand, notice of dishonor, protest, notice of protest and all other demands, protests and notices in connection with the execution, delivery, performance, collection and

enforcement of this Note.

This Note is being delivered in, is intended to be performed in, shall be construed and interpreted in accordance with, and shall be governed by the laws of, the State of New York.

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This Note may only be amended by an instrument in writing executed pursuant to the provisions of Section 11.1 of the Credit Agreement.

CVS HEALTH CORPORATION

By: _____
Name: _____
Title: _____

CVS Health Corporation 2018 Five Year Credit Agreement
Note

SCHEDULE TO NOTE

Date of Loan	Type (Revolving Credit, Swing Line or Competitive Bid) and Amount of Loan	Interest Period (If other than an ABR Advance)	Type of Revolving Credit Loan (ABR or Eurodollar)	Interest Rate	Date and Amount of Conversion of Revolving Credit Loan	Date and Amount of Principal Payment or Prepayment	Notation Made by

CVS Health Corporation 2018 Five Year Credit Agreement
Note

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT C

FORM OF BORROWING REQUEST

[Date]

The Bank of New York Mellon, as Administrative Agent
Administrator/ Issuer Services
Client Services Delivery Loan Processing COE
Loan Administration
6023 Airport Road
Oriskany, New York 13424
Attention: Daizon Camp
Facsimile: (315) 765-4533
Telephone:(315) 765-4145
Email: afasyndications@bnymellon.com

Re: Five Year Credit Agreement, dated as of May 17, 2018, by and among CVS Health Corporation, a Delaware corporation (the "Borrower"), the Lenders party thereto from time to time and The Bank of New York Mellon, as Administrative Agent (as amended, amended and restated, supplemented or otherwise modified from time to time, the "Credit Agreement")

Capitalized terms used herein that are not otherwise defined herein shall have the respective meanings ascribed thereto in the Credit Agreement.

Pursuant to Section 2.3 of the Credit Agreement, the Borrower hereby gives notice of its intention to borrow Revolving Credit Loans in the aggregate principal amount of $_____ on _____, and/or a Swing Line Loan in the principal amount of $_____ on _____, which borrowing shall consist of the following:

Revolving Credit Loans (ABR Advance or Eurodollar Advance) or Swing Line Loan	Principal Amount	Interest Period (Other than for ABR Advance)

The Borrower hereby certifies that on the Borrowing Date(s) set forth above, and after giving effect to the Loans requested hereby:

There shall exist no Default.

The representations and warranties contained in the Credit Agreement shall be true and correct in all material respects (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such Borrowing Date), except those which are expressly specified to be made as of an earlier date which representations and warranties shall be true and correct in all material respects or in all respects, as the case may be, as of such earlier date.

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CVS Health Corporation 2018 Five Year Credit Agreement
Borrowing Request

IN EVIDENCE of the foregoing, the undersigned has caused this Borrowing Request to be duly executed on its behalf.

CVS HEALTH CORPORATION

By: _____
Name: _____
Title: _____

CVS Health Corporation 2018 Five Year Credit Agreement
Borrowing Request

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT D-1

FORM OF OPINION OF COUNSEL TO THE BORROWER

May 17, 2018

The Lenders and the Administrative Agent referred to below
c/o The Bank of New York Mellon,
as Administrative Agent
225 Liberty Street
New York, New York 10286

Ladies and Gentlemen:

I am an assistant general counsel of CVS Health Corporation, a Delaware corporation (the "Borrower"), and have acted as such in connection with the Five Year Credit Agreement, dated as of the date hereof (the "Credit Agreement"), by and among the Borrower, the lenders party thereto (the "Lenders") and The Bank of New York Mellon, as administrative agent (in such capacity, the "Administrative Agent"). Capitalized terms not otherwise defined herein shall have the meanings assigned to them in the Credit Agreement.

I have examined originals or copies, certified or otherwise identified to my satisfaction, of such documents, corporate records, certificates of public officials and other instruments and have conducted such other investigations of fact and law as I have deemed necessary or advisable for purposes of this opinion. In rendering my opinions set forth below, I have assumed (i) the due authorization, execution and delivery by all parties thereto (other than the Borrower) of the Credit Agreement, (ii) the genuineness of all signatures, (iii) the legal capacity of natural persons, (iv) the authenticity of all documents submitted to me as originals, and (v) the conformity to original documents of all documents submitted to me as copies.

Based upon the foregoing, I am of the opinion that:

1. The Borrower is a corporation duly incorporated, validly existing and in good standing under the laws of the State of Delaware. The Borrower has all requisite corporate power and authority to own its Property and to carry on its business as now conducted.

2. The Borrower is qualified to do business as a foreign corporation and is in good standing in each jurisdiction in which it owns or leases real Property or in which the nature of its business requires it to be so qualified (except those jurisdictions where the failure to be so qualified or to be in good standing could not reasonably be expected to have a Material Adverse effect).

3. The execution, delivery and performance by the Borrower of the Credit Agreement and the Note, dated the date hereof (the "Note"), are within the Borrower's corporate powers and have been duly authorized by all necessary corporate action on the part of the Borrower.

4. The execution, delivery and performance by the Borrower of the Credit Agreement and the Note do not require any action or approval on the part of the shareholders of the Borrower or any action by or in respect of, or filing with, any governmental body, agency or official under United States federal law or the Delaware General Corporation Law, and do not contravene, or constitute a default under, any provision of (i) United States federal law or the Delaware General Corporation Law, (ii) the Certificate of Incorporation or the bylaws of the Borrower, or (iii) any existing material mortgage, material indenture, material contract or material agreement, in each case binding on the Borrower or any Subsidiary (other than any Insurance Subsidiary) or affecting the Property of the Borrower or any Subsidiary (other than any Insurance Subsidiary).

5. The Credit Agreement and the Note delivered by the Borrower on the date hereof have been duly executed and delivered by the Borrower.

6. The Borrower is not an "investment company" (as such term is defined in the United States Investment Company Act of 1940, as amended).

7. To the best of my knowledge, there are no actions, suits, arbitration proceedings or claims (whether purportedly on behalf of the Borrower, any Subsidiary or otherwise) pending or threatened against the Borrower or any Subsidiary or any of their respective Properties, or maintained by the Borrower or any Subsidiary, at law or in equity, before any Governmental Authority which could reasonably be expected to have a Material Adverse effect. To the best of my knowledge, there are no proceedings pending or threatened against the Borrower or any Subsidiary which call into question the validity or enforceability of, or otherwise seek to invalidate, any Loan Document.

8. To the best of my knowledge, the Borrower is not in default under any agreement to which it is a party or by which it or any of its Property is bound the effect of which could reasonably be expected to have a Material Adverse effect.

9. To the best of my knowledge, no provision of any judgment, decree or order, in each case binding on the Borrower or any Subsidiary (other than any Insurance Subsidiary) or affecting the Property of the Borrower or any Subsidiary (other than any Insurance Subsidiary) conflicts with, or requires any consent which has not already been obtained under, or would in any way prevent the execution, delivery or performance by the Borrower of the terms of, any Loan Document.

I am a member of the bar of the Commonwealth of Massachusetts and the foregoing opinion is limited to the laws of the Commonwealth of Massachusetts, the federal law of the United States of America and the Delaware General Corporation Law.

This opinion is rendered solely to you in connection with the above matter. This opinion may not be relied upon by you for any other purpose or relied upon by any other person without my prior written consent.

Very truly yours,

Thomas S. Moffatt
Vice President, Assistant Corporate Secretary and
Assistant General Counsel,
CVS Health Corporation

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT D-2

FORM OF OPINION OF SPECIAL COUNSEL TO THE BORROWER

May 17, 2018

To the Persons listed in Schedule A

CVS Health Corporation

Ladies and Gentlemen:

We have acted as counsel to CVS Health Corporation, a Delaware corporation (the "Company"), in connection with the preparation, execution and delivery of the Five Year Credit Agreement, dated as of the date hereof (the "Credit Agreement"), among the Company, the lenders party thereto (the "Lenders") and The Bank of New York Mellon, as administrative agent (in such capacity, the "Administrative Agent"). This opinion is furnished to you pursuant to Section 5.4(b) of the Credit Agreement. Unless otherwise defined herein, terms defined in the Credit Agreement are used herein as therein defined.

In that connection, we have reviewed an original or a copy of the Credit Agreement.

We have also reviewed originals or copies of such other documents as we have deemed necessary as a basis for the opinions expressed below.

In our review of the Credit Agreement and other documents, we have assumed:

(A) The genuineness of all signatures.

(B) The authenticity of the originals of the documents submitted to us.

(C) The conformity to authentic originals of any documents submitted to us as copies.

(D) As to matters of fact, the truthfulness of the representations made in the Credit Agreement.

(E) That the Credit Agreement is the legal, valid and binding obligation of each party thereto, other than the Company, enforceable against each such party in accordance with its terms.

(F) That:

(1) The Company is an entity duly organized, validly existing and in good standing under the laws of the State of Delaware.

(2) The Company has full power to execute, deliver and perform, and has duly executed and delivered, the Credit Agreement.

(3) The execution, delivery and performance by the Company of the Credit Agreement have been duly authorized by all necessary action (corporate or otherwise) and do not:

(a) contravene its certificate of incorporation or by-laws;

(b) except with respect to Generally Applicable Law, violate any law, rule or regulation applicable to it; or

(c) result in any conflict with or breach of any agreement or document binding on it.

(4) Except with respect to Generally Applicable Law, no authorization, approval or other action by, and no notice to or filing with, any governmental authority or regulatory body or any other third party is required for the due execution, delivery or performance by the Company of the Credit Agreement or, if any such authorization, approval, action, notice or filing is required, it has been duly obtained, taken, given or made and is in full force and effect.

We have not independently established the validity of the foregoing assumptions.

"Generally Applicable Law" means the federal law of the United States of America, and the law of the State of New York (including the rules or regulations promulgated thereunder or pursuant thereto), that a New York lawyer exercising customary professional diligence would reasonably be expected to recognize as being applicable to the Company, the Credit Agreement or the transactions governed by the Credit Agreement. Without limiting the generality of the foregoing definition of Generally Applicable Law, the term "Generally Applicable Law" does not include the Commodity Exchange Act, as amended, and the rules and regulations thereunder and does not include any law, rule or regulation that is applicable to the Company, the Credit Agreement or such transactions solely because such law, rule or regulation is part of a regulatory regime applicable to any party to the Credit Agreement or any of its affiliates due to the specific assets or business of such party or such affiliate.

Based upon the foregoing and upon such other investigation as we have deemed necessary and subject to the qualifications set forth below, we are of the opinion that:

1. The execution and delivery by the Company of the Credit Agreement do not, and the performance by the Company of its obligations thereunder and the borrowings and issuances of letters of credit thereunder will not, result in a violation of Generally Applicable Law.

2. No authorization, approval or other action by, and no notice to or filing with, any United States federal or New York governmental authority or regulatory body,

is required for the due execution, delivery or performance by the Company of the Credit Agreement.

3. The Credit Agreement is the legal, valid and binding obligation of the Company, enforceable against the Company in accordance with its terms.

Our opinions expressed above are subject to the following qualifications:

(a) Our opinion in paragraph 3 is subject to the effect of any applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting creditors' rights generally (including without limitation all laws relating to fraudulent transfers).

(b) Our opinion in paragraph 3 is subject to the effect of general principles of equity, including without limitation concepts of materiality, reasonableness, good faith and fair dealing (regardless of whether considered in a proceeding in equity or at law).

(c) We express no opinion with respect to Section 11.9 of the Credit Agreement to the extent that such Section (or such similar provisions) permit set-off to be made without notice.

(d) We express no opinion with respect to the enforceability of indemnification provisions, or of release or exculpation provisions, contained in the Credit Agreement to the extent that enforcement thereof is contrary to public policy regarding the indemnification against or release or exculpation of criminal violations, intentional harm or violations of securities laws or acts of gross negligence or willful misconduct.

(e) We express no opinion with respect to Section 11.16 of the Credit Agreement to the extent that such Section (i) contains a waiver of any objections based on inappropriate venue or forum non conveniens in any Federal courts of the United States, (ii) implies that a Federal court of the United States has subject matter jurisdiction, or (iii) purports to grant any court exclusive jurisdiction.

(f) We express no opinion with respect to the effect of Section 11.22 of the Credit Agreement or any Bail-In Action.

(g) Our opinions are limited to Generally Applicable Law and we do not express any opinion herein concerning any other law.

A copy of this opinion letter may be delivered by any of you to any person that becomes a Lender in accordance with the provisions of the Credit Agreement. Any such person may rely on the opinions expressed above as if this opinion letter were addressed and delivered to such person on the date hereof.

This opinion letter is rendered to you in connection with the transactions contemplated by the Credit Agreement. This opinion letter may not be relied upon by you or any person entitled to rely on this opinion pursuant to the preceding paragraph for any other purpose without our prior written consent.

[SIGNATURE PAGE IMMEDIATELY FOLLOWS]

This opinion letter speaks only as of the date hereof. We expressly disclaim any responsibility to advise you of any development or circumstance of any kind, including any change of law or fact that may occur after the date of this opinion letter that might affect the opinions expressed herein.

Very truly yours,

GMA/BZ/AN
RHR

SCHEDULE A

The Bank of New York Mellon, as Administrative Agent

The Lenders party to the Credit Agreement (referred to in the foregoing opinion letter) on the date hereof

CVS Health Corporation 2018 Five Year Credit Agreement
Opinion of Counsel

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT E

FORM OF ASSIGNMENT AND ASSUMPTION

This Assignment and Assumption (the "Assignment and Assumption") is dated as of the Effective Date set forth below and is entered into by and between [the][each][1] Assignor identified in item 1 below ([the][each, an] "Assignor") and [the][each][2] Assignee identified in item 2 below ([the][each, an] "Assignee"). [It is understood and agreed that the rights and obligations of [the Assignors][the Assignees][3] hereunder are several and not joint.][4] Capitalized terms used but not defined herein shall have the meanings given to them in the Credit Agreement identified below (the "Credit Agreement"), receipt of a copy of which is hereby acknowledged by [the][each] Assignee. The Standard Terms and Conditions set forth in Annex 1 attached hereto are hereby agreed to and incorporated herein by reference and made a part of this Assignment and Assumption as if set forth herein in full.

For an agreed consideration, [the][each] Assignor hereby irrevocably sells and assigns to [the Assignee][the respective Assignees], and [the][each] Assignee hereby irrevocably purchases and assumes from [the Assignor][the respective Assignors], subject to and in accordance with the Standard Terms and Conditions and the Credit Agreement, as of the Effective Date inserted by the Administrative Agent as contemplated below (i) all of [the Assignor's][the respective Assignors'] rights and obligations in [its capacity as a Lender][their respective capacities as Lenders] under the Credit Agreement and any other documents or instruments delivered pursuant thereto to the extent related to the amount and percentage interest identified below of all of such outstanding rights and obligations of [the Assignor][the respective Assignors] under the respective facilities identified below (including, without limitation, any Letters of Credit and Swing Line Loans [, and any Competitive Bid Loans,][5] included in such facilities) and (ii) to the extent permitted to be assigned under applicable law, all claims, suits, causes of action and any other right of [the Assignor (in its capacity as a Lender)][the respective Assignors (in their respective capacities as Lenders)] against any Person, whether known or unknown, arising under or in connection with the Credit Agreement, any other documents or instruments delivered pursuant thereto or the loan transactions governed thereby or in any way based on or related to any of the foregoing, including, but not limited to, contract claims, tort claims, malpractice claims, statutory claims and all other claims at law or in equity related to the rights and obligations sold and assigned pursuant to clause (i) above (the rights and obligations sold and assigned by [the][any] Assignor to [the][any]

[1] For bracketed language here and elsewhere in this form relating to the Assignor(s), if the assignment is from a single Assignor, choose the first bracketed language. If the assignment is from multiple Assignors, choose the second bracketed language.

[2] For bracketed language here and elsewhere in this form relating to the Assignee(s), if the assignment is to a single Assignee, choose the first bracketed language. If the assignment is to multiple Assignees, choose the second bracketed language.

[3] Select as appropriate.

[4] Include bracketed language if there are either multiple Assignors or multiple Assignees.

[5] Include or exclude, as applicable.

Assignee pursuant to clauses (i) and (ii) above being referred to herein collectively as [the][an] "Assigned Interest"). Each such sale and assignment is without recourse to [the][any] Assignor and, except as expressly provided in this Assignment and Assumption, without representation or warranty by [the][any] Assignor.

1. Assignor[s]: _____

_____

Assignor [is] [is not][6] a Defaulting Lender.

2. Assignee[s]: _____

_____

[for each Assignee, indicate [Affiliate][Approved Fund] of [*identify Lender*]

3. Borrower: CVS Health Corporation, a Delaware corporation.

4. Administrative Agent: The Bank of New York Mellon, as the administrative agent under the Credit Agreement.

5. Credit Agreement: The Five Year Credit Agreement, dated as of May 17, 2018, among the Borrower, the Lenders party thereto from time to time and the Administrative Agent, as from time to time amended, amended and restated, supplemented or otherwise modified.

6. Assigned Interest[s]:

Assignor[s][7]	Assignee[s][8]	Aggregate Amount of Commitment/Revolving Credit Loans for all Lenders[9]	Amount of Commitment/Revolving Credit Loans Assigned[8]	Percentage Assigned of Commitment/ Revolving Credit Loans[10]	CUSIP Number (if applicable)
		$_____	$_____	_____%	
		$_____	$_____	_____%	
		$_____	$_____	_____%	

[6] Delete inapplicable item.
[7] List each Assignor, as appropriate.
[8] List each Assignee, as appropriate.
[9] Amount to be adjusted by the counterparties to take into account any payments or prepayments made between the Trade Date and the Effective Date.
[10] Set forth, to at least 9 decimals, as a percentage of the Commitment/Revolving Credit Loans of all Lenders thereunder.

Assignor[s][11]	Assignee[s][12]	Amount and Competitive Interest Period of each outstanding Competitive Bid Loan of Assignor[13]	Amount of each Competitive Bid Loan Assigned by Assignor to Assignee[8]	CUSIP Number (if applicable)
		$_____ Competitive Interest Period beginning _____ and ending _____	$_____	
		$_____ Competitive Interest Period beginning _____ and ending _____	$_____	
		$_____ Competitive Interest Period beginning _____ and ending _____	$_____	

[7. Trade Date: _____ ___, 20__][14]

[11] List each Assignor, as appropriate.
[12] List each Assignee, as appropriate.
[13] Amount to be adjusted by the counterparties to take into account any payments or prepayments made between the Trade Date and the Effective Date.
[14] To be completed if the Assignor(s) and the Assignee(s) intend that the minimum assignment amount is to be determined as of the Trade Date.

Effective Date:_____ _____, 20___ [TO BE INSERTED BY ADMINISTRATIVE AGENT AND WHICH SHALL BE THE EFFECTIVE DATE OF RECORDATION OF TRANSFER IN THE REGISTER THEREFOR.]

The terms set forth in this Assignment and Assumption are hereby agreed to:

ASSIGNOR[S][15]

[NAME OF ASSIGNOR]

By: _____
Title:_____

[NAME OF ASSIGNOR]

By: _____
Title:_____

ASSIGNEE[S][16]

[NAME OF ASSIGNEE]

By: _____
Title:_____

[NAME OF ASSIGNEE]

By: _____
Title:_____

[15] Add additional signature blocks as needed.
[16] Add additional signature blocks as needed.

[Consented to and][17] Accepted:

THE BANK OF NEW YORK MELLON, as Administrative Agent,
an Issuer and Swing Line Lender

By: _____
Title: _____

[Consented to:][18]

CVS HEALTH CORPORATION

By: _____
Title: _____

[17] To be added only if the consent of the Administrative Agent is required by the terms of the Credit Agreement.
[18] To be added only if the consent of the Borrower and/or other parties (e.g. Swing Line Lender, any Issuer) is required by the terms of the Credit Agreement.

STANDARD TERMS AND CONDITIONS FOR
ASSIGNMENT AND ASSUMPTION

1. Representations and Warranties

1.1 Assignor[s]. [The][Each] Assignor (a) represents and warrants that (i) it is the legal and beneficial owner of [the][the relevant] Assigned Interest, (ii) [the][such] Assigned Interest is free and clear of any lien, encumbrance or other adverse claim, (iii) it has full power and authority, and has taken all action necessary, to execute and deliver this Assignment and Assumption and to consummate the transactions contemplated hereby and (iv) it is [not][19] a Defaulting Lender; and (b) assumes no responsibility with respect to (i) any statements, warranties or representations made in or in connection with the Credit Agreement or any other Loan Document, (ii) the execution, legality, validity, enforceability, genuineness, sufficiency or value of the Loan Documents or any collateral thereunder, (iii) the financial condition of the Borrower, any of its Subsidiaries or Affiliates or any other Person obligated in respect of any Loan Document or (iv) the performance or observance by the Borrower, any of its Subsidiaries or Affiliates or any other Person of any of their respective obligations under any Loan Document.

1.2 Assignee[s]. [The][Each] Assignee (a) represents and warrants that (i) it has full power and authority, and has taken all action necessary, to execute and deliver this Assignment and Assumption and to consummate the transactions contemplated hereby and to become a Lender under the Credit Agreement, (ii) it meets all the requirements to be an assignee under Section 11.7(b)(3), (5) and (6) of the Credit Agreement (subject to such consents, if any, as may be required under Section 11.7(b)(3) of the Credit Agreement), (iii) from and after the Effective Date, it shall be bound by the provisions of the Credit Agreement as a Lender thereunder and, to the extent of [the][the relevant] Assigned Interest, shall have the obligations of a Lender thereunder, (iv) it is sophisticated with respect to decisions to acquire assets of the type represented by the Assigned Interest and either it, or the Person exercising discretion in making its decision to acquire the Assigned Interest, is experienced in acquiring assets of such type, (v) it has received a copy of the Credit Agreement, and has received or has been accorded the opportunity to receive copies of the most recent financial statements delivered pursuant to Section 7.7 thereof, as applicable, and such other documents and information as it deems appropriate to make its own credit analysis and decision to enter into this Assignment and Assumption and to purchase [the][such] Assigned Interest, (vi) it has, independently and without reliance upon the Administrative Agent or any other Lender and based on such documents and information as it has deemed appropriate, made its own credit analysis and decision to enter into this Assignment and Assumption and to purchase [the][such] Assigned Interest, (vii) it has delivered to the Borrower and the Administrative Agent any documentation required to be delivered by it pursuant to Section 3.10(f) of the Credit Agreement, duly completed and executed by [the][such] Assignee, and (viii) ASSIGNEE HAS EXAMINED THE LIST OF DISQUALIFIED INSTITUTIONS (IF ANY) AND (I) REPRESENTS AND WARRANTS THAT (A) IT IS NOT IDENTIFIED ON SUCH LIST AND (B) IT IS NOT AN AFFILIATE OF ANY INSTITUTION IDENTIFIED ON SUCH LIST AND (II) ACKNOWLEDGES THAT CERTAIN TRANSACTIONS WITH DISQUALIFIED INSTITUTIONS SHALL BE SUBJECT

[19] Delete if inapplicable or remove brackets.

TO SECTION 11.7 OF THE CREDIT AGREEMENT; and (b) agrees that (i) it will, independently and without reliance on the Administrative Agent, [the][any] Assignor or any other Lender, and based on such documents and information as it shall deem appropriate at the time, continue to make its own credit decisions in taking or not taking action under the Loan Documents, and (ii) it will perform in accordance with their terms all of the obligations which by the terms of the Loan Documents are required to be performed by it as a Lender.

2. Payments. From and after the Effective Date, the Administrative Agent shall make all payments in respect of the Assigned Interest (including payments of principal, interest, fees and other amounts) to the Assignee whether such amounts have accrued prior to or on or after the Effective Date. The Assignor and the Assignee shall make all appropriate adjustments in payments by the Administrative Agent for periods prior to the Effective Date or with respect to the making of this assignment directly between themselves.

3. General Provisions. This Assignment and Assumption shall be binding upon, and inure to the benefit of, the parties hereto and their respective successors and assigns. This Assignment and Assumption may be executed in any number of counterparts, which together shall constitute one instrument. Delivery of an executed counterpart of a signature page of this Assignment and Assumption by telecopy or other electronic means (e.g., ".pdf" or ".tif") shall be effective as delivery of a manually executed counterpart of this Assignment and Assumption. This Assignment and Assumption and the rights and obligations of the parties hereto shall be governed by, and construed and interpreted in accordance with, the laws of the State of New York.

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT F

FORM OF COMPETITIVE BID REQUEST

[Date]

The Bank of New York Mellon, as Administrative Agent
Administrator/ Issuer Services
Client Services Delivery Loan Processing COE
Loan Administration
6023 Airport Road
Oriskany, New York 13424
Attention: Daizon Camp
Facsimile: (315) 765-4533
Telephone:(315) 765-4145
Email: afasyndications@bnymellon.com

Re: Five Year Credit Agreement, dated as of May 17, 2018, by and among CVS Health Corporation, a Delaware corporation (the "Borrower"), the Lenders party thereto from time to time and The Bank of New York Mellon, as Administrative Agent (as amended, amended and restated, supplemented or otherwise modified from time to time, the "Credit Agreement")

Capitalized terms used herein that are not otherwise defined herein shall have the respective meanings ascribed thereto in the Credit Agreement.

Pursuant to Section 2.4 of the Credit Agreement, the Borrower hereby gives notice of its request to borrow Competitive Bid Loans in the aggregate principal amount of $_____ on _____ (which is a Domestic Business Day), which borrowing shall consist of the following:

Principal Amount	Competitive Interest Period

The Borrower hereby certifies that on the Borrowing Date set forth above, and after giving effect to the Competitive Bid Loans requested hereby:

(a) There shall exist no Default.

(b) The representations and warranties contained in the Credit Agreement shall be true and correct in all material respects (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects, except those which are expressly specified to be made as of an earlier date which representations and warranties shall be true and correct in all material respects or in all respects, as the case may be, as of such earlier date.

[REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY]

IN EVIDENCE of the foregoing, the undersigned has caused this Competitive Bid Request to be duly executed on its behalf.

CVS HEALTH CORPORATION

By: _____
Name: _____
Title: _____

CVS Health Corporation 2018 Five Year Credit Agreement
Competitive Bid Request

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT G

FORM OF INVITATION TO BID

[Date]

To the Lenders party
from time to time to the
Credit Agreement referred to below

Re: Five Year Credit Agreement, dated as of May 17, 2018, by and among CVS Health Corporation, a Delaware corporation (the "Borrower"), the Lenders party thereto from time to time and The Bank of New York Mellon, as Administrative Agent (as amended, amended and restated, supplemented or otherwise modified from time to time, the "Credit Agreement")

Capitalized terms used herein that are not otherwise defined herein shall have the respective meanings ascribed thereto in the Credit Agreement.

Pursuant to a Competitive Bid Request, the Borrower gave notice of its request to borrow Competitive Bid Loans in the aggregate principal amount of $_____ on _____ (which shall be a Domestic Business Day), which borrowing would consist of the following:

Principal Amount	Competitive Interest Period

The Lenders are hereby invited to bid, pursuant to the terms and conditions of the Credit Agreement, on such requested Competitive Bid Loans.

[REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY]

IN EVIDENCE of the foregoing, the undersigned has caused this Invitation to Bid to be duly executed on its behalf.

THE BANK OF NEW YORK MELLON,
as Administrative Agent

By: _____
Name: _____
Title: _____

CVS Health Corporation 2018 Five Year Credit Agreement
Invitation to Bid

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT H

FORM OF COMPETITIVE BID

[Date]

The Bank of New York Mellon, as Administrative Agent
Administrator/ Issuer Services
Client Services Delivery Loan Processing COE
Loan Administration
6023 Airport Road
Oriskany, New York 13424
Attention: Daizon Camp
Facsimile: (315) 765-4533
Telephone:(315) 765-4145
Email: afasyndications@bnymellon.com

Re: Five Year Credit Agreement, dated as of May 17, 2018, by and among CVS Health Corporation, a Delaware corporation (the "Borrower"), the Lenders party thereto from time to time and The Bank of New York Mellon, as Administrative Agent (as amended, amended and restated, supplemented or otherwise modified from time to time, the "Credit Agreement")

Capitalized terms used herein that are not otherwise defined herein shall have the respective meanings ascribed thereto in the Credit Agreement.

In response to a Competitive Bid Request dated _____, the undersigned Lender hereby offers to make Competitive Bid Loan(s) in the aggregate principal amount of $_____ on _____ (which shall be a Domestic Business Day), which borrowing would consist of the following:

Principal Amount	Competitive Interest Period	Competitive Bid Rate

[REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY]

IN EVIDENCE of the foregoing, the undersigned has caused this Competitive Bid to be duly executed on its behalf.

[LENDER]

By: _____
Name: _____
Title: _____

CVS Health Corporation 2018 Five Year Credit Agreement
Competitive Bid

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT I

FORM OF COMPETITIVE BID ACCEPT/REJECT LETTER

[Date]

The Bank of New York Mellon, as Administrative Agent
Administrator/ Issuer Services
Client Services Delivery Loan Processing COE
Loan Administration
6023 Airport Road
Oriskany, New York 13424
Attention: Daizon Camp
Facsimile: (315) 765-4533
Telephone:(315) 765-4145
Email: afasyndications@bnymellon.com

Re: Five Year Credit Agreement, dated as of May 17, 2018, by and among CVS Health Corporation, a Delaware corporation (the "Borrower"), the Lenders party thereto from time to time and The Bank of New York Mellon, as Administrative Agent (as amended, amended and restated, supplemented or otherwise modified from time to time, the "Credit Agreement")

Capitalized terms used herein that are not otherwise defined herein shall have the respective meanings ascribed thereto in the Credit Agreement.

Pursuant to Section 2.4(d) of the Credit Agreement, the Borrower hereby gives notice of its acceptance of the following Competitive Bids:

Lender	Principal Amount	Competitive Interest Period	Competitive Bid Rate

and its rejection of all other Competitive Bids, in each case made pursuant to the Competitive Bid Request, dated _____.

[REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY]

IN EVIDENCE of the foregoing, the undersigned has caused this Competitive Bid Accept/Reject Letter to be duly executed on its behalf.

CVS HEALTH CORPORATION

By: _____
Name: _____
Title: _____

CVS Health Corporation 2018 Five Year Credit Agreement
Competitive Bid Accept/Reject Letter

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT J

FORM OF LETTER OF CREDIT REQUEST

[Date]

The Bank of New York Mellon, as Administrative Agent
Administrator/ Issuer Services
Client Services Delivery Loan Processing COE
Loan Administration
6023 Airport Road
Oriskany, New York 13424
Attention: Daizon Camp
Facsimile: (315) 765-4533
Telephone:(315) 765-4145
Email: afasyndications@bnymellon.com

Re: Five Year Credit Agreement, dated as of May 17, 2018, by and among CVS Health Corporation, a Delaware corporation (the "Borrower"), the Lenders party thereto from time to time and The Bank of New York Mellon, as Administrative Agent (as amended, amended and restated, supplemented or otherwise modified from time to time, the "Credit Agreement")

Capitalized terms used herein that are not otherwise defined herein shall have the respective meanings ascribed thereto in the Credit Agreement.

Pursuant to Section 2.8(b) of the Credit Agreement, the Borrower hereby gives notice of its request for the issuance by [_____] (the "Issuer")[20] of a [standby][commercial][21] Letter of Credit in support of an obligation of [the Borrower][Name of Subsidiary] for the benefit of _____ on _____ in connection with _____ in the maximum amount of $_____. A drawing may be made under such Letter of Credit under the following conditions: _____.

The Borrower hereby certifies that on the above requested date of issuance of such Letter of Credit, and after giving effect to the issuance of such Letter of Credit:

(a) There shall exist no Default.

(b) The representations and warranties contained in the Credit Agreement shall be true and correct in all material respects (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and

[20] Insert name of Issuer
[21] Barclays Bank PLC not an Issuer of commercial Letters of Credit

correct (after giving effect to any qualification therein) in all respects, except those which are expressly specified to be made as of an earlier date which representations and warranties shall be true and correct in all material respects or in all respects, as the case may be, as of such earlier date.

(c) After giving effect to the Letter of Credit requested hereby (i) the Letter of Credit Exposure of all Lenders shall not exceed the Aggregate Letter of Credit Commitment, (ii) the Aggregate Credit Exposure shall not exceed the Aggregate Commitment Amount, (iii) the Letter of Credit Exposure of the Issuer shall not exceed the Letter of Credit Commitment of the Issuer, and (iv) the Commercial Letter of Credit Exposure of the Issuer shall not exceed the Commercial Letter of Credit Commitment of the Issuer.

[REMAINDER OF THIS PAGE IS LEFT BLANK INTENTIONALLY]

CVS Health Corporation 2018 Five Year Credit Agreement
Letter of Credit Request

IN EVIDENCE of the foregoing, the undersigned has caused this Letter of Credit Request to be duly executed on its behalf.

CVS HEALTH CORPORATION

By: _____
Name: _____
Title: _____

CVS Health Corporation 2018 Five Year Credit Agreement
Letter of Credit Request

2018 FIVE YEAR CREDIT AGREEMENT

EXHIBIT K

FORM OF COMMITMENT INCREASE SUPPLEMENT

COMMITMENT INCREASE SUPPLEMENT, dated as of _____, 20__ to the Five Year Credit Agreement, dated as of May 17, 2018, by and among CVS Health Corporation, a Delaware corporation (the "Borrower"), the Lenders party thereto from time to time and The Bank of New York Mellon, as Administrative Agent (as amended, amended and restated, supplemented or otherwise modified from time to time, the "Credit Agreement"). Capitalized terms used herein that are defined in the Credit Agreement shall have the meanings therein defined.

1. Pursuant to Section 2.6(d) of the Credit Agreement, the Borrower hereby proposes to increase (the "Increase") the Aggregate Commitment Amount from $_____ to $_____.

2. Each of the following Lenders (each an "Increasing Lender") has been invited by the Borrower, and has agreed, subject to the terms hereof, to increase its Commitment Amount as follows:

Name of Lender	Commitment Amount (after giving effect to the Increase)
	$_____
	$_____
	$_____

3. Each of the following Persons (each a "New Lender") has been invited by the Borrower, and has agreed, subject to the terms hereof, to become a "Lender" under the Credit Agreement with a Commitment Amount in the amount set forth below:

Name of New Lender	Commitment Amount
	$_____
	$_____
	$_____

4. The Borrower hereby represents and warrants to the Administrative Agent, each Lender and each New Lender that immediately before and after giving effect to the Increase, no Default exists or would exist and that the representations and warranties contained in the Credit Agreement are true and correct in all material respects (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language are true and correct (after giving effect to any qualification therein) in all respects with the same effect

as though such representations and warranties had been made on the effective date of the Increase, except those which are expressly specified to be made as of an earlier date which representations and warranties were true and correct in all material respects or in all respects, as the case may be, as of such earlier date.

5. Pursuant to Section 2.6(d) of the Credit Agreement, by execution and delivery of this Commitment Increase Supplement, together with the satisfaction of all of the requirements set forth in such Section 2.6(d) (the date of such satisfaction being the "Increase Effective Date"), (i) each of the Increasing Lenders shall have, on and as of the Increase Effective Date of the Increase, a Commitment Amount equal to the amount set forth above next to its name, and (ii) each of the New Lenders as of the Increase Effective Date shall be deemed to be a "Lender" under, and as such term is defined in, the Credit Agreement, and shall have a Commitment Amount equal to the amount set forth above next to its name.

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IN EVIDENCE of the foregoing, each of the undersigned has caused this Commitment Increase Supplement to be duly executed on its behalf.

CVS HEALTH CORPORATION

By: _____
Name: _____
Title: _____

THE BANK OF NEW YORK MELLON, as Administrative Agent

By: _____
Name: _____
Title: _____

[INCREASING LENDER]

By: _____
Name: _____
Title: _____

[NEW LENDER]

By: _____
Name: _____
Title: _____

CVS Credit Agreement Amendment No. 3 Five-Year 2017

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Exhibit 10.4

EXECUTION VERSION

AMENDMENT NO. 3 TO FIVE YEAR CREDIT AGREEMENT

AMENDMENT NO. 3 (this "Amendment"), dated as of May 16, 2019, is entered into among CVS Health Corporation, a Delaware corporation (the "Borrower"), The Bank of New York Mellon, as Administrative Agent, and the Lenders party hereto (the "Consenting Lenders"). Except as otherwise provided herein, capitalized terms used herein which are not defined herein shall have the meanings set forth in the Credit Agreement (as defined below).

WHEREAS, the Borrower, the Lenders and the Administrative Agent entered into that certain Five Year Credit Agreement, dated as of May 18, 2017 (as amended, amended and restated, supplemented or otherwise modified from time to time prior to the date hereof, the "Credit Agreement"); and

WHEREAS, the Borrower has requested that the Lenders amend the Credit Agreement as set forth below.

NOW, THEREFORE, in consideration of the covenants, conditions and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, and pursuant to Section 11.1 of the Credit Agreement, the parties hereto hereby agree as follows:

1. Amendments. The Credit Agreement is hereby amended as follows:

(a) Section 1.1 of the Credit Agreement is hereby amended by adding the following new definitions in the appropriate alphabetical order:

"***Acquisition Debt***": any Indebtedness incurred by the Borrower or any of its Subsidiaries for the purpose of financing, in whole or in part, a Material Acquisition and any related transactions or series of related transactions (including for the purpose of refinancing or replacing all or a portion of any pre-existing Indebtedness of the Person(s) or assets to be acquired), which Indebtedness is redeemable or prepayable if such Material Acquisition is not consummated.

"Amendment No. 3 Effective Date": May 16, 2019.

"***Equity Interests***": shares of capital stock, partnership interests, membership interests, beneficial interests or other ownership interests, whether voting or nonvoting, in, or interests in the income or profits of, a Person, and any warrants, options or other rights entitling the holder thereof to purchase or acquire any of the foregoing.

"Existing 2019 Credit Agreement": the Five Year Credit Agreement, dated as of May 16, 2019, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, GS and Wells Fargo, as co-documentation agents, and BofA, as administrative agent, as amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Indebtedness for Borrowed Money": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, and (d) Contingent Obligations in respect of any indebtedness described in items (a) - (c) above; *provided* that, for purposes of this definition, Indebtedness for Borrowed Money shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"***LIBOR Successor Rate***": as defined in Section 3.8(c).

"***LIBOR Successor Rate Conforming Changes***": as defined in Section 3.8(c).

"***Material Acquisition***": any acquisition of (a) Equity Interests in any Person if, after giving effect thereto, such Person will become a Subsidiary or (b) assets comprising all or substantially all the assets of (or all or substantially all the assets constituting a business unit, division, product line or line of business of) any Person; provided that the aggregate consideration therefor (including Indebtedness assumed in connection therewith, all obligations in respect of the deferred purchase price therefor (including obligations under any purchase price adjustment but excluding earn-out or similar payments) and all other consideration payable in connection therewith (including payment obligations in respect of noncompetition agreements or other arrangements representing acquisition consideration)) equals or exceeds $500,000,000.

"***Material Subsidiary***": a Subsidiary of the Borrower with respect to which (i) the Borrower's and its other Subsidiaries' investments in, and advances to, such Subsidiary exceed ten percent (10%) of the total assets of the Borrower and its Subsidiaries Consolidated as of the end of the most recently completed fiscal year, (ii) the Borrower's and its other Subsidiaries' proportionate share of the total assets (after intercompany eliminations) of such Subsidiary exceeds 10 percent (10%) of the total assets of the Borrower and its Subsidiaries Consolidated as of the end of the most recently completed fiscal year, or (iii) the Borrower's and its other Subsidiaries' equity in the income from continuing operations before income taxes of such Subsidiary exclusive of amounts attributable to any non-controlling interests exceeds ten percent (10%) of such income of the Borrower and its Subsidiaries Consolidated for the most recently completed fiscal year.

"***Scheduled Unavailability Date***": as defined in Section 3.8(c)(ii).

"***SEC Reports***": the Borrower's 2018 Annual Report on Form 10-K, the Borrower's quarterly report on Form 10-Q for the quarterly period ending March 31, 2019, and any 8-K filings made by the Borrower subsequent to March 31, 2019 and prior to the Amendment No. 3 Effective Date.

(b) Section 1.1 of the Credit Agreement is hereby further amended by amending and restating the following definitions in their entirety to read as follows:

"Existing 2018 Credit Agreement": the Five Year Credit Agreement, dated as of May 17, 2018, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA, GS and Wells Fargo, as co-documentation agents, and BNY Mellon, as administrative agent, as amended by Amendment No. 1 to Five Year Credit Agreement, dated as of May 16, 2019, and as the same may be further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 364-Day Credit Agreement": the 364-Day Credit Agreement, dated as of May 16, 2019, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, GS and Wells Fargo, as co-documentation agents, and BofA, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"GAAP": subject to Section 1.2(b), generally accepted accounting principles set forth in the opinions and pronouncements of the Accounting Principles Board and the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board or such other principles as may be approved by a significant segment of the accounting profession, which are applicable to the circumstances as of the date of determination, consistently applied.

"Indebtedness": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) indebtedness with respect to any conditional sale or other title retention agreement, (d) indebtedness arising under acceptance facilities and the amount available to be drawn under all letters of credit (excluding for purposes of Section 8.9 letters of credit obtained in the ordinary course of business by the Borrower or any Subsidiary) issued for the account of such Person and, without duplication, all drafts drawn thereunder to the extent such Person shall not have reimbursed the issuer thereof in respect of such issuer's payment of such drafts, (e) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, (f) all indebtedness described in (a) - (e) above secured by any Lien on any Property owned by such Person even though such Person shall not have assumed or otherwise become liable for the payment thereof (other than carriers', warehousemen's, mechanics', repairmen's or other like non-consensual Liens arising in the ordinary course of business), and (g) Contingent Obligations in respect of any indebtedness described in items (a) - (f) above; *provided* that, for purposes of this definition, Indebtedness shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"***Threshold Amount***": $300,000,000.

(c) Section 1.1 of the Credit Agreement is hereby amended by deleting the following definitions set forth therein: "Acquisition," "Acquisition Indebtedness," "Amendment No. 2 Effective Date," "CVS Bridge Facility," "CVS

Bridge Facility Commitment Letter," "Existing 2015 Credit Agreement" and "Restricted Payment".

(d) Section 1.2 of the Credit Agreement is hereby amended by amending and restating clause (b) thereof in its entirety as follows:

"(b) Unless otherwise expressly provided herein, the word "fiscal" when used herein shall refer to the relevant fiscal period of the Borrower. As used in the Loan Documents and in any certificate, opinion or other document made or delivered pursuant thereto, accounting terms not defined in Section 1.1, and accounting terms partly defined in Section 1.1, to the extent not defined, shall have the respective meanings given to them under GAAP as in effect from time to time; provided that, if the Borrower notifies the Administrative Agent that the Borrower requests an amendment to any provision hereof to eliminate the effect of any change occurring after the date hereof in GAAP or in the application thereof on the operation of such provision (or if the Administrative Agent notifies the Borrower that the Required Lenders request an amendment to any provision hereof for such purpose), regardless of whether any such notice is given before or after such change in GAAP or in the application thereof, then such provision shall be interpreted on the basis of, and any accounting term related thereto shall have the respective meaning given to it under, GAAP as in effect and applied immediately before such change shall have become effective until such notice shall have been withdrawn or such provision amended in accordance herewith. Any lease that is characterized as an operating lease in accordance with GAAP after the Borrower's adoption of ASC 842 (regardless of the date on which such lease has been entered into) shall not be a capital or finance lease, and any such lease shall be, for all purposes of this Agreement, treated as though it were reflected on the Borrower's consolidated financial statements in the same manner as an operating lease would have been reflected prior to Borrower's adoption of ASC 842."

(e) Section 2.5 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"The Borrower agrees that the proceeds of the Loans and Letters of Credit shall be used solely for its general corporate purposes, but not inconsistent with this Section 2.5 or any other provision of this Agreement, including, without limitation, the provisions of Section 4.9, and not in contravention of any applicable law, rule or regulation."

(f) Section 3.8 of the Credit Agreement is hereby amended by adding a new Section 3.8(c) immediately following Section 3.8(b) thereof as follows:

"(c) Notwithstanding anything to the contrary in this Agreement or any other Loan Documents, if the Administrative Agent and the Borrower determine that:

(i) adequate and reasonable means do not exist for ascertaining LIBOR for any requested Interest Period and such circumstances are unlikely to be temporary, because the LIBOR Screen Rate is not available or published on a current basis and such circumstances are unlikely to be temporary; or

(ii) the applicable supervisor or administrator of the LIBO Screen Rate or a Governmental Authority having jurisdiction over the Administrative Agent has made a public statement identifying a specific date after which LIBOR or the LIBO Screen Rate shall no longer be made available, or used for determining the interest rate of loans in the U.S. syndicated loan market denominated in Dollars (such specific date, the "Scheduled Unavailability Date"), or

(iii) syndicated loans currently being executed, or that include language similar to that contained in this Section 3.8(c), are generally being executed or amended (as applicable) to incorporate or adopt a new benchmark interest rate to replace LIBOR,

then, reasonably promptly after such determination by the Administrative Agent and the Borrower, the Administrative Agent and the Borrower may amend this Agreement to replace LIBOR with an alternate benchmark rate (including any mathematical or other adjustments to the benchmark (if any) incorporated therein), giving due consideration to any evolving or then existing convention for similar Dollar denominated syndicated credit facilities for such alternative benchmarks (any such proposed rate, a "LIBOR Successor Rate"), together with any proposed LIBOR Successor Rate Conforming Changes (as defined below) and any such amendment shall become effective at 5:00 p.m. on the fifth Domestic Business Day after the Administrative Agent shall have posted such proposed amendment to all Lenders and the Borrower unless, prior to such time, Lenders comprising the Required Lenders have delivered to the Administrative Agent written notice that such Required Lenders do not accept such amendment with each such notice stating that such Lender objects to such amendment (which such notice shall note with specificity the particular provisions of the amendment to which such Lender objects, it being understood that the Required Lenders need not specify identical objectionable provisions of the amendment in order to constitute effective notice). Such LIBOR Successor Rate shall be applied in a manner consistent with market practice; provided that to the extent such market practice is not administratively feasible for the Administrative Agent, such LIBOR Successor Rate shall be applied in a manner as otherwise reasonably determined by the Administrative Agent.

If no LIBOR Successor Rate has been determined and the circumstances under clause (i) above exist or the Scheduled Unavailability

Date has occurred (as applicable), the Administrative Agent will promptly so notify the Borrower and each Lender. Thereafter, (x) the obligation of the Lenders to make or maintain Eurodollar Advances shall be suspended, (to the extent of the affected Eurodollar Advances or Eurodollar Interest Periods), and (y) the One Month LIBOR Rate component shall no longer be utilized in determining the Alternate Base Rate. Upon receipt of such notice, the Borrower may revoke any pending request for a borrowing of, Conversion to or continuation of Eurodollar Advances (to the extent of the affected Eurodollar Advances or Eurodollar Interest Periods) or, failing that, will be deemed to have Converted such request into a request for a borrowing of ABR Advances (subject to the foregoing clause (y)) in the amount specified therein.

Notwithstanding anything else herein, any definition of LIBOR Successor Rate shall provide that in no event shall such LIBOR Successor Rate be less than zero for purposes of this Agreement.

For purposes hereof, "LIBOR Successor Rate Conforming Changes" means, with respect to any proposed LIBOR Successor Rate, any conforming changes to the definitions of Alternate Base Rate, Eurodollar Interest Period and One Month LIBOR Rate, timing and frequency of determining rates and making payments of interest and other administrative matters as may be appropriate, in the discretion of the Administrative Agent in consultation with the Borrower, to reflect the adoption of such LIBOR Successor Rate and to permit the administration thereof by the Administrative Agent in a manner substantially consistent with market practice (or, if the Administrative Agent determines that adoption of any portion of such market practice is not administratively feasible or that no market practice for the administration of such LIBOR Successor Rate exists, in such other manner of administration as the Administrative Agent determines is reasonably necessary in connection with the administration of this Agreement)."

(g) Section 4.1 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"The Borrower is duly organized, validly existing and in good standing under the laws of the jurisdiction of its incorporation, has all requisite corporate power and authority to own its Property and to carry on its business as now conducted, and is qualified to do business as a foreign corporation and is in good standing in each jurisdiction in which it owns or leases real Property or in which the nature of its business requires it to be so qualified (except those jurisdictions where the failure to be so qualified or to be in good standing could not reasonably be expected to have a Material Adverse effect)."

(h) Section 4.2 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"The Borrower has full corporate power and authority to enter into, execute, deliver and perform the terms of the Loan Documents, all of which have been duly authorized by all proper and necessary corporate action and are not in contravention of: (i) except as could not reasonably be expected to have a Material Adverse effect, any applicable law or (ii) the terms of its Certificate of Incorporation and By-Laws. No consent or approval of, or other action by, shareholders of the Borrower, any Governmental Authority, or any other Person (which has not already been obtained) is required to authorize in respect of the Borrower, or is required in connection with, the execution, delivery and performance by the Borrower of the Loan Documents or is required as a condition to the enforceability of the Loan Documents against the Borrower. The Borrower is not an EEA Financial Institution."

(i) Section 4.3 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"The Loan Documents constitute the valid and legally binding obligations of the Borrower, enforceable against the Borrower in accordance with their respective terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by equitable principles relating to the availability of specific performance as a remedy."

(j) Section 4.4 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"As of the Amendment No. 3 Effective Date, there are no actions, suits, arbitration proceedings or claims (whether purportedly on behalf of the Borrower, any Material Subsidiary or otherwise) pending or, to the knowledge of the Borrower, threatened against the Borrower or any Material Subsidiary or any of their respective Properties, or maintained by the Borrower or any Material Subsidiary, at law or in equity, before any Governmental Authority which have not been disclosed in the SEC Reports that could reasonably be expected to have a Material Adverse effect. There are no proceedings pending or, to the knowledge of the Borrower, threatened against the Borrower or any Material Subsidiary (a) which call into question the validity or enforceability of any Loan Document, or otherwise seek to invalidate, any Loan Document, or (b) which might, individually or in the aggregate, materially and adversely affect any of the transactions contemplated by any Loan Document."

(k) Section 4.5(a) of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(l) Section 4.5(b) of the Credit Agreement is hereby amended and restated in its entirety as follows:

"(b) No provision of any existing material mortgage, material indenture, material contract or material agreement or of any existing statute, rule, regulation, judgment, decree or order binding on the Borrower or affecting the Property of the Borrower (i) conflicts with any Loan Document, (ii) requires any consent which has not already been obtained with respect to any Loan Document, or (iii) would in any way prevent the execution, delivery or performance by the Borrower of the terms of any Loan Document, except in the case of provisions of any existing material mortgage, material indenture, material contract or material agreement, as could not reasonably be expected to have a Material Adverse effect. Neither the execution and delivery, nor the performance, by the Borrower of the terms of each Loan Document will constitute a default under, or result in the creation or imposition of, or obligation to create, any Lien upon the Property of the Borrower pursuant to the terms of any such mortgage, indenture, contract or agreement."

(m) Each of Section 4.6 and Section 4.7 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(n) Section 4.8 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"The Borrower is not required to be registered as an "investment company" under the Investment Company Act of 1940, as amended."

(o) Section 4.9 of the Credit Agreement is hereby amended by deleting the last sentence thereof.

(p) Each of Section 4.11 and Section 4.12 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(q) Section 7.1 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Except as may otherwise be permitted by Section 8.3 and Section 8.4, maintain, and cause each Material Subsidiary to maintain, its corporate existence in good standing in the jurisdiction of its incorporation or formation and in each other jurisdiction in which the failure so to do could reasonably be expected to have a Material Adverse effect, except that the corporate existence of Material Subsidiaries may be terminated if (i) such Material Subsidiaries operate closing or discontinued operations or (ii) if the Borrower determines in good faith that such termination is in the best

interests of the Borrower and is not materially disadvantageous to the Lenders."

(r) Section 7.2 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Pay and discharge when due, and cause each Material Subsidiary so to do, all taxes, assessments, governmental charges, license fees and levies upon or with respect to the Borrower and such Material Subsidiary, and upon the income, profits and Property thereof unless, and only to the extent, that either (i)(a) such taxes, assessments, governmental charges, license fees and levies shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Material Subsidiary, and (b) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor, or (ii) the failure to pay or discharge such taxes, assessments, governmental charges, license fees and levies could not reasonably be expected to have a Material Adverse effect."

(s) Each of Section 7.3, Section 7.4 and Section 7.5 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(t) Section 7.6(a) of the Credit Agreement is hereby amended and restated in its entirety as follows:

"(a) Observe and comply in all material respects, and cause each Material Subsidiary so to do, with all laws, ordinances, orders, judgments, rules, regulations, certifications, franchises, permits, licenses, directions and requirements of all Governmental Authorities, which now or at any time hereafter may be applicable to it or to such Material Subsidiary, except (i) where a violation of which could not reasonably be expected to have a Material Adverse effect, or (ii) to the extent that such noncompliance is being contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Material Subsidiary."

(u) Section 7.7 of the Credit Agreement is hereby amended by (i) deleting each of clause (f) and clause (h) thereof and replacing each of such clause with "[Reserved]", and (ii) amending an restating each of clause (c) and clause (g) thereof in its entirety as follows:

"(c) Simultaneously with the delivery of the financial statements required by clauses (a) and (b) above, a certificate of the Chief Financial Officer or the Senior Vice President and Treasurer of the Borrower certifying that no Default shall have occurred or be continuing or, if so, specifying in such certificate all such Defaults, and setting forth computations in reasonable detail demonstrating compliance with Section 8.9."

"(g) Prompt written notice of the occurrence of (i) each Default and (ii) each Event of Default;"

(v) Section 7.8 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Upon reasonable notice and during normal business hours after an Event of Default has occurred and is continuing, permit representatives of the Administrative Agent and each Lender to visit the offices of the Borrower and each Material Subsidiary, to examine the books and records (other than tax returns and work papers related to tax returns) thereof and auditors' reports relating thereto, to discuss the affairs of the Borrower and each Material Subsidiary with the respective officers thereof, and to meet and discuss the affairs of the Borrower and each Material Subsidiary with the Borrower's auditors, except for information covered by an attorney-client or other legal privilege or to the extent the inspection would reasonably be expected to result in a violation or other breach of any third party confidentiality agreement."

(w) Section 7.9 of the Credit Agreement is hereby deleted in its entirety.

(x) Section 8.1 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(y) Section 8.2 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Create, incur, assume or suffer to exist any Lien against or on any Property now owned or hereafter acquired by the Borrower or any of the Subsidiaries, or permit any of the Subsidiaries so to do, except any one or more of the following types of Liens: (a) Liens in connection with workers' compensation, unemployment insurance or other social security obligations (which phrase shall not be construed to refer to ERISA or the minimum funding obligations under Section 412 of the Internal Revenue Code), (b) Liens to secure the performance of bids, tenders, letters of credit, contracts (other than contracts for the payment of Indebtedness), leases, statutory obligations, surety, customs, appeal, performance and payment bonds and other obligations of like nature, or to qualify to do business, maintain insurance or obtain other benefits, in each such case arising in the ordinary course of business, (c) mechanics', workmen's, carriers', warehousemen's, materialmen's, landlords' or other like Liens arising in the ordinary course of business with respect to obligations which are not due or which are being contested in good faith and by appropriate proceedings diligently conducted, (d) Liens for taxes, assessments, fees or governmental charges the payment of which is not required under Section 7.2, (e) easements, rights of way, restrictions, leases of Property to others, easements for installations of public utilities, title imperfections and restrictions, zoning ordinances and

other similar encumbrances affecting Property which in the aggregate do not materially impair its use for the operation of the business of the Borrower or such Subsidiary, (f) Liens on Property of the Subsidiaries under capital leases and Liens on Property (including on the capital stock or other equity interests) of the Subsidiaries acquired (whether as a result of purchase, capital lease, merger or other acquisition) and either existing on such Property when acquired, or created contemporaneously with or within 12 months of such acquisition to secure the payment or financing of the purchase price of such Property (including the construction, development, substantial repair, alteration or improvement thereof), and any renewals thereof, *provided* that such Liens attach only to the Property so purchased or acquired (including any such construction, development, substantial repair, alteration or improvement thereof) and *provided further* that the Indebtedness secured by such Liens is not otherwise prohibited hereunder, (g) statutory Liens in favor of lessors arising in connection with Property leased to the Borrower or any of the Subsidiaries, (h) Liens of attachments, judgments or awards against the Borrower or any of the Subsidiaries with respect to which an appeal or proceeding for review shall be pending or a stay of execution or bond shall have been obtained, or which are otherwise being contested in good faith and by appropriate proceedings diligently conducted, and in respect of which adequate reserves shall have been established in accordance with GAAP on the books of the Borrower or such Subsidiary, (i) Liens securing Indebtedness of a Subsidiary to the Borrower or another Subsidiary, (j) Liens (other than Liens permitted by any of the foregoing clauses) arising in the ordinary course of its business which do not secure Indebtedness and do not, in the aggregate, materially detract from the value of the business of the Borrower and its Subsidiaries, taken as a whole, (k) Liens in favor of the United States of America, or any state thereof, to secure partial, progress, advance or other payments pursuant to any contract or provisions of any statute, and (l) additional Liens securing Indebtedness of the Borrower and the Subsidiaries in an aggregate outstanding Consolidated principal amount not exceeding 15% of Net Tangible Assets."

(z) Section 8.3 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Make any Disposition (including by way of limited liability company division), or permit any of its Subsidiaries so to do, of all or substantially all of the assets of the Borrower and the Subsidiaries on a Consolidated basis; provided that (a) any Subsidiary may make Dispositions to the Borrower, and (b) so long as no Default or Event of Default exists prior to or after giving effect thereto, (i) the Borrower may dispose of all or substantially all of its assets to a wholly-owned domestic Subsidiary that assumes all of the obligations of the Borrower under this Agreement and (ii) any Subsidiary may dispose of all or substantially all of

its assets to another Subsidiary, provided that if such Subsidiary is a wholly-owned Subsidiary, the transferee shall be a wholly-owned Subsidiary."

(aa) Each of Section 8.5 and Section 8.6 of the Credit Agreement is hereby deleted in its entirety and each replaced by "[Reserved]."

(bb) Section 8.7 of the Credit Agreement is hereby amended by (i) adding the words "and the other Loan Documents" immediately after the words "other than this Agreement" in the first paragraph thereof, and (ii) amending an restating each of Clauses (c) and (d) thereof in its entirety as follows:

"(c) Dividend Restrictions consisting of customary net worth, leverage and other financial covenants, customary covenants regarding the merger of or sale of stock or assets of a Subsidiary, customary restrictions on transactions with affiliates, and customary subordination provisions governing Indebtedness owed to the Borrower or any Subsidiary, in each case contained in, or required by, any agreement governing Indebtedness incurred by a Subsidiary in accordance with the terms of this Agreement; or

(d) Dividend Restrictions contained in any other credit agreement so long as such Dividend Restrictions are no more restrictive than those contained in this Agreement (including Dividend Restrictions contained in the Existing 364-Day Credit Agreement, the Existing 2018 Credit Agreement, the Existing 2019 Credit Agreement and the Existing Term Loan Agreement."

(cc) Section 8.8 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(dd) Section 8.9 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.60:1.00; *provided* that from the Amendment No. 3 Effective Date through and including the fiscal quarter ending September 30, 2019, the Borrower will not permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.65:1.00; *provided further* that (i) subsequent to the fiscal quarter ending March 31, 2020, upon the consummation of any Material Acquisition and the written election of the Borrower to the Administrative Agent no later than thirty days following the consummation of such Material Acquisition, the maximum permitted ratio of Consolidated Indebtedness to Total Capitalization shall be increased by 0.05:1.00 above the otherwise-applicable maximum permitted ratio of Consolidated Indebtedness to Total Capitalization with respect to the last day of the fiscal quarter during which such Material Acquisition shall have been consummated and the last day of each of the immediately following three

consecutive fiscal quarters, and (ii) between the signing of the definitive agreement (or offer documentation, as applicable) for a Material Acquisition and the earlier of (x) the closing of such Material Acquisition and (y) thirty (30) days following the termination of such definitive agreement (or offer documentation, as applicable) for such Material Acquisition, any Acquisition Debt incurred to finance such Material Acquisition shall be excluded for purposes of calculation the ratio of Consolidated Indebtedness to Total Capitalization hereunder. The Borrower shall only be permitted to make an election pursuant to the last proviso of the preceding sentence twice during the term of this Agreement, and there shall be at least two consecutive fiscal quarters between such elections during which time no increase to the maximum permitted ratio of Consolidated Indebtedness to Total Capitalization shall be in effect."

(ee) Section 9.1 of the Credit Agreement is hereby amended by amending and restating each of clause (g), clause (h), clause (i), clause (j), clause (k) and clause (m) thereof in its entirety as follows:

"(g) (i) Obligations in an aggregate Consolidated amount in excess of the Threshold Amount of the Borrower (other than its obligations hereunder and under the Notes) and the Material Subsidiaries, whether as principal, guarantor, surety or other obligor, for the payment of any Indebtedness for Borrowed Money or any net liability under interest rate swap, collar, exchange or cap agreements, (A) shall become or shall be declared to be due and payable prior to the expressed maturity thereof, or (B) shall not be paid when due or within any grace period for the payment thereof, or (ii) any holder of any such obligations shall have the right to declare the Indebtedness for Borrowed Money evidenced thereby due and payable prior to its stated maturity; or"

"(h) An involuntary proceeding shall be commenced or an involuntary petition shall be filed seeking (i) liquidation, reorganization or other relief in respect of the Borrower or any Material Subsidiary or its debts, or of a substantial part of its assets, under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect or (ii) the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Material Subsidiary or for a substantial part of its assets, and, in any such case, such proceeding or petition shall continue undismissed for 60 days or an order or decree approving or ordering any of the foregoing shall be entered; or"

"(i) The Borrower or any Material Subsidiary shall (i) voluntarily commence any proceeding or file any petition seeking liquidation, reorganization or other relief under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect, (ii) consent to the institution of, or fail to contest in a timely and appropriate manner, any proceeding or petition described in clause (h) of

this Section 9.1, (iii) apply for or consent to the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Material Subsidiary or for a substantial part of its assets, (iv) file an answer admitting the material allegations of a petition filed against it in any such proceeding, (v) make a general assignment for the benefit of creditors or (vi) take any action for the purpose of effecting any of the foregoing; or"

"(j) The Borrower or any Material Subsidiary shall (i) generally not be paying its debts as such debts become due or (ii) admit in writing its inability to pay its debts as they become due; or"

"(k) Judgments or decrees in an aggregate Consolidated amount in excess of the Threshold Amount (to the extent not covered by independent third-party insurance or captive insurance as to which the insurer does not dispute coverage) against the Borrower and the Material Subsidiaries shall remain unpaid, unstayed on appeal, undischarged, unbonded or undismissed for a period of 60 days during which execution shall not be effectively stayed, or any action shall be legally taken by a judgment creditor to attach or levy upon any assets of the Borrower or any Material Subsidiary to enforce any such judgment; or"

"(m) Solely to the extent as would have a Material Adverse effect: (i) any Termination Event shall occur (x) with respect to any Pension Plan (other than a Multiemployer Plan) or (y) with respect to any other retirement plan subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, which plan, during the five year period prior to such Termination Event, was the responsibility in whole or in part of the Borrower, any Material Subsidiary or any ERISA Affiliate; (ii) the failure to satisfy the minimum funding standards under Section 302 of ERISA or Section 412 of the Internal Revenue Code shall exist with respect to any Pension Plan for which the Borrower has responsibility (other than that portion of a Multiemployer Plan's Accumulated Funding Deficiency to the extent such Accumulated Funding Deficiency is attributable to employers other than Borrower); (iii) any Person shall engage in a Prohibited Transaction involving any Employee Benefit Plan in respect of which it is reasonably likely that liability will be imposed upon the Borrower; (iv) the Borrower shall fail to pay when due an amount which is payable by it to the PBGC or to a Pension Plan (including a Multiemployer Plan) under Title IV of ERISA; (v) the imposition on the Borrower of any tax under Section 4980(B)(a) of the Internal Revenue Code; or (vi) the assessment of a civil penalty on the Borrower with respect to any Employee Benefit Plan under Section 502(c) of ERISA. In determining the Consolidated amount for any purpose pursuant to this Section 9.1(m), the liabilities, funding amounts, taxes and penalties referenced in the foregoing clauses of this Section 9.1(m) shall include those of the Material Subsidiaries and ERISA Affiliates

of the Borrower to the extent the Borrower is obligated to pay any such liabilities, funding amounts, taxes and penalties."

(ff) Section 11.2(a) of the Credit Agreement is hereby amended and restated in its entirety as follows:

"(a) *Notices Generally.* Except in the case of notices and other communications expressly permitted to be given by telephone, all notices and other communications provided for herein shall be in writing and shall be delivered by hand or overnight courier service, mailed by certified or registered mail or sent by facsimile or email, as follows:

If to the Borrower:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Carol A. DeNale
Senior Vice President and Treasurer –Treasury Department
Facsimile: (401) 770-5768
Telephone: (401) 770-4407
Email: carol.denale@cvshealth.com

with a copy, in the case of a notice of Default or Event of Default, to:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Tom Moffatt
Vice President, Assistant Secretary and Assistant General Counsel –
Corporate Services
Facsimile: (401) 216-3758
Telephone: (401) 770-5409
Email: thomas.moffatt@cvshealth.com

with a copy (in the case of a notice of Default or Event of Default and which shall not constitute notice under this Agreement or any other Loan Document for any purpose) to:

Shearman & Sterling LLP
599 Lexington Avenue
New York, New York 10022
Attention: Gus M. Atiyah
Facsimile: (646) 848-5227
Telephone: (212) 848-5227
Email: gus.atiyah@shearman.com

If to the Administrative Agent, the Swing Line Lender and the Issuer:

in the case of each Borrowing Request, each notice of prepayment under Section 2.7, each Letter of Credit Request, each Competitive Bid Request, each Competitive Bid, and each Competitive Bid Accept/Reject Letter:

The Bank of New York Mellon
Administrator/ Issuer Services
Client Services Delivery Loan Processing COE
Loan Administration
6023 Airport Road
Oriskany, New York 13424
Attention: Crystal Keyser
Facsimile: (315) 765-4533
Telephone: (315) 801-2437
Email: afasyndications@bnymellon.com

and in all other cases:

The Bank of New York Mellon
3300 PGA Blvd
Palm Beach Gardens, FL 33410
Attention: Johna Fidanza
Telephone: (561) 868-7434
Email: johna.fidanza@bnymellon.com

and

The Bank of New York Mellon
500 Grant Street
Pittsburgh, Pennsylvania 15219
Attention: Clifford Mull
Facsimile: (412) 234-8087
Telephone: (412) 234-1346
Email: clifford.mull@bnymellon.com

If to any Lender or any other Issuer: to it at its address (or facsimile number or email address) set forth in its Administrative Questionnaire."

2. Condition Precedent. This Amendment shall become effective on and as of the date hereof (the "***Amendment No. 3 Effective Date***") upon the receipt by the Administrative Agent of counterparts of this Amendment executed by the Borrower and the Consenting Lenders constituting Required Lenders. Upon satisfaction of the condition precedent set forth in this Section 2, the Administrative Agent shall provide the Borrower and the Lenders with written confirmation that this Amendment has become effective.

3. Representations and Warranties.

(a) The Borrower hereby represents and warrants as follows:

(i) The Borrower has taken all necessary corporate action to authorize the execution, delivery and performance of this Amendment.

(ii) This Amendment has been duly executed and delivered by the Borrower and constitutes the valid and legally binding obligations of the Borrower, enforceable against the Borrower in accordance with its terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by equitable principles relating to the availability of specific performance as a remedy.

(iii) No consent or approval of, or other action by, shareholders of the Borrower, any Governmental Authority, or any other Person (which has not already been obtained) is required to authorize in respect of the Borrower, or is required in connection with, the execution, delivery, and performance by the Borrower of this Amendment or is required as a condition to the enforceability of this Amendment against the Borrower.

(b) The Borrower represents and warrants to the Lenders that (i) the representations and warranties of the Borrower set forth in Section 4 of the Credit Agreement (as amended by this Amendment) are true and correct in all material respects on the date hereof (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language is true and correct (after giving effect to any qualification therein) in all respects on the date hereof), except to the extent that such representations and warranties expressly relate to an earlier date, in which case such representations and warranties were true and correct in all material respects or, if qualified as to "materiality", "Material Adverse" or similar language, in all respects, on such earlier date and (ii) no Default exists on the date hereof.

4. Miscellaneous.

(a) Except as expressly amended hereby, the Credit Agreement and the other Loan Documents shall remain in full force and effect.

(b) On and after the Amendment No. 3 Effective Date, each reference in the Credit Agreement to "this Agreement", "hereunder", "hereof" or words of like import referring to the Credit Agreement, and each reference in the other Loan Documents to "the Credit Agreement", "thereunder", "thereof" or words of like import referring to the Credit Agreement, shall mean and be a reference to the Credit Agreement as modified hereby. This Amendment shall constitute a Loan Document.

(c) This Amendment may be executed on any number of separate counterparts and all of said counterparts taken together shall be deemed to constitute one and the same agreement. It shall not be necessary in making proof of this Amendment to produce or account for more than one counterpart signed by the party to be charged. A set of the copies of this Amendment signed by all of the parties hereto shall be lodged with each of the Borrower and the Administrative

Agent. Delivery of an executed counterpart of a signature page of this Amendment by fax or other electronic means (e.g., ".pdf" or ".tif") shall be effective as delivery of a manually executed counterpart of this Amendment.

(d) This Amendment and the rights and obligations of the parties hereto shall be governed by, and construed and interpreted in accordance with, the laws of the State of New York.

[signature pages follow]

The parties have caused this Amendment to be duly executed as of the date first written above.

CVS HEALTH CORPORATION

By: /s/ CAROL A. DENALE
Name: Carol A. DeNale
Title: Senior Vice President and Treasurer

[Amendment No. 3 to the 2017 Five Year Credit Agreement]

THE BANK OF NEW YORK MELLON,
as Administrative Agent and a Lender

By: /s/ CLIFFORD A. MULL
Name: Clifford A. Mull
Title: Director

[Amendment No. 3 to the 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

BANK OF AMERICA, N.A.

By: /s/ DARREN MERTEN
Name: Darren Merten
Title: Vice President

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

Wells Fargo Bank, National Association

By: /s/ JORDAN HARRIS
Name: Jordan Harris
Title: Director

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

BARCLAYS BANK PLC

By: /s/ RITAM BHALLA
Name: Ritam Bhalla
Title: Director

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

JPMORGAN CHASE BANK, N.A.

By: /s/ VANESSA CHIU
Name: Vanessa Chiu
Title: Executive Director

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

Goldman Sachs Bank USA

By: /s/ ANNIE CARR
Name: Annie Car
Title: Authorized Signatory

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

MIZUHO BANK, LTD.

By: /s/ TRACY RAHN
Name: Tracy Rahn
Title: Authorized Signatory

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

SunTrust Bank, as a Lender

By: /s/ STEVE CURRAN
Name: Steve Curran
Title: Director

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

U.S. BANK NATIONAL ASSOCIATION

By: /s/ JOYCE P. DORSETT
Name: Joyce P. Dorsett
Title: Senior Vice President

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

MUFG BANK, LTD.

By: /s/ JACK LONKER
Name: Jack Lonker
Title: Director

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

ROYAL BANK OF CANADA

By: /s/ GORDON MACARTHUR
Name: Gordon MacArthur
Title: Authorized Signatory

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

KeyBank National Association

By: /s/ MARIANNE T. MEIL
Name: Marianne T. Meil
Title: Senior Vice President

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

FIFTH THIRD BANK

By: /s/ TODD S. ROBINSON
Name: Todd S. Robinson
Title: VP

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

Sumitomo Mitsui Banking Corporation

By: /s/ MICHAEL MAGUIRE
Name: Michael Maguire
Title: Executive Director

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

PNC BANK, NATIONAL ASSOCIATION, as a Lender

By: /s/ WILLIAM P. HEROLD
Name: William P. Herold
Title: Vice President

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

SANTANDER BANK, N.A.

By: /s/ XAVIER RUIZ SENA
Name: Xavier Ruiz Sena
Title: Managing Director

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

Industrial and Commercial Bank of China Limited,
New York Branch

By: /s/ HSIWEI CHEN
Name: Hsiwei Chen
Title: Director

By: /s/ PINYEN SHIH
Name: Pinyen Shih
Title: Executive Director

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

TD BANK, N.A.

By: /s/ UK-SUN KIM
Name: Uk-Sun Kim
Title: Senior Vice President

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

Bank of China, New York Branch

By: /s/ RAYMOND QIAO
Name: Raymond Qiao
Title: Executive Vice President

[Amendment No. 3 to 2017 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 3 to the Credit Agreement.

BANK OF HAWAII

By: /s/ RYAN KITAMURA
Name: Ryan Kitamura
Title: Vice President

[Amendment No. 3 to 2017 Five Year Credit Agreement]

CVS Five-Year Credit Agreement 2018

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Exhibit 10.2

EXECUTION VERSION

BNY MELLON

FIVE YEAR CREDIT AGREEMENT

by and among

CVS HEALTH CORPORATION,

THE LENDERS PARTY HERETO,

BARCLAYS BANK PLC and JPMORGAN CHASE BANK, N.A.,
as Co-Syndication Agents,

BANK OF AMERICA, N.A., and WELLS FARGO BANK, N.A.,
as Co-Documentation Agents,

and

THE BANK OF NEW YORK MELLON,
as Administrative Agent

Dated as of May 18, 2017

THE BANK OF NEW YORK MELLON,
MERRILL LYNCH, PIERCE, FENNER & SMITH INCORPORATED
and
WELLS FARGO SECURITIES, LLC,
as Joint Lead Arrangers

THE BANK OF NEW YORK MELLON,
MERRILL LYNCH, PIERCE, FENNER & SMITH INCORPORATED,
BARCLAYS BANK PLC, JPMORGAN CHASE BANK, N.A.,
and
WELLS FARGO SECURITIES, LLC,
as Joint Bookrunners

Prepared by:
Bryan Cave LLP
1290 Avenue of the Americas
New York, New York 10104-3300

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FIVE YEAR CREDIT AGREEMENT, dated as of May 18, 2017, by and among ***CVS HEALTH CORPORATION***, a Delaware corporation (the ***"Borrower"***), the lenders party hereto from time to time (each a ***"Lender"*** and, collectively, the ***"Lenders"***), ***BARCLAYS BANK PLC*** (***"Barclays")*** and ***JPMORGAN CHASE BANK, N.A.***, (***"JPMC"***) as co-syndication agents (in such capacity, each a ***"Co-Syndication Agent"*** and, collectively, the ***"Co-Syndication Agents"***), ***BANK OF AMERICA, N.A.*** ***("BofA"***) and ***WELLS FARGO BANK, N.A***. (***"Wells Fargo")***, as co-documentation agents (in such capacity, each a *"**Co-Documentation Agent**"* and, collectively, the *"**Co-Documentation Agents**"*), and ***THE BANK OF NEW YORK MELLON*** (***"BNY Mellon"***), as administrative agent for the Lenders (in such capacity, the *"**Administrative Agent**"*).

1. *DEFINITIONS AND PRINCIPLES OF CONSTRUCTION*

1.1 *Definitions*

When used in any Loan Document (as defined below), each of the following terms shall have the meaning ascribed thereto unless the context otherwise specifically requires:

"ABR Advances": the Revolving Credit Loans (or any portions thereof) at such time as they (or such portions) are made or are being maintained at a rate of interest based upon the Alternate Base Rate.

"Accumulated Funding Deficiency": as defined in Section 304 of ERISA.

"Acquisition": with respect to any Person, the purchase or other acquisition by such Person, by any means whatsoever, of (a) stock of, or other equity securities of, any other Person if, immediately thereafter, such other Person would be either a consolidated subsidiary of such Person or otherwise under the control of such Person, or (b) any business, going concern or division or segment thereof, or all or substantially all of the assets thereof; *provided* that no redemption, retirement, purchase or acquisition by any Person of the stock or other equity securities of such Person shall be deemed to constitute an Acquisition.

"Administrative Agent": as defined in the preamble.

"Administrative Questionnaire": an Administrative Questionnaire in a form supplied by the Administrative Agent.

"Affected Advance": as defined in Section 3.8(b).

"Affiliate": with respect to any Person at any time and from time to time, any other Person (other than a wholly-owned subsidiary of such Person) which, at such time (a) controls such Person, (b) is controlled by such Person or (c) is under common control with such Person. The term "control", as used in this definition with respect to any Person, means the power, whether direct or indirect through one or more intermediaries, to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting securities or other interests, by contract or otherwise.

"Aggregate Commitment Amount": at any time, the sum of the Commitment Amounts of the Lenders at such time under this Agreement. The Aggregate Commitment Amount on the Effective Date is $1,000,000,000.

"Aggregate Credit Exposure": at any time, the sum at such time of (a) the aggregate Committed Credit Exposure of the Lenders at such time and (b) the aggregate outstanding principal balance of all Competitive Bid Loans at such time.

"Aggregate Letter of Credit Commitment": at any time, the sum of the Letter of Credit Commitments of the Issuers at such time. The Aggregate Letter of Credit Commitment on the Effective Date is $150,000,000.

"Agreement": this Five Year Credit Agreement, as the same may be amended, amended and restated, supplemented or otherwise modified from time to time.

"Alternate Base Rate": for any day, a rate per annum equal to the greatest of (i) the BNY Mellon Rate in effect on such day; (ii) the sum of (a) 1/2 of 1% per annum and (b) the Federal Funds Effective Rate in effect on such day; and (iii) the sum of (a) 1% per annum and (b) the One Month LIBOR Rate in effect on such day. The Alternate Base Rate shall change as and when the greatest of the foregoing rates shall change. Any change in the Alternate Base Rate shall become effective as of the opening of business on the day specified in the public announcement of such change.

"Anti-Corruption Laws": all laws, rules, and regulations of any jurisdiction applicable to the Borrower or the Subsidiaries from time to time concerning or relating to bribery or corruption.

"Applicable Margin": (i) with respect to the unpaid principal balance of ABR Advances, the applicable percentage set forth below in the column entitled "ABR Advances", (ii) with respect to the unpaid principal balance of Eurodollar Advances, the applicable percentage set forth below in the column entitled "Eurodollar Advances", (iii) with respect to the Facility Fee, the applicable percentage set forth below in the column entitled "Facility Fee", (iv) with respect to the Letter of Credit Participation Fee payable in respect of standby Letters of Credit, the applicable percentage set forth below in the column entitled "Participation Fee - Standby", and (v) with respect to the Letter of Credit Participation Fee payable in respect of commercial Letters of Credit, the applicable percentage set forth below in the column entitled "Participation Fee - Commercial", in each case opposite the applicable Pricing Level:

Pricing Level	ABR Advances	Eurodollar Advances	Facility Fee	Participation Fee - Standby	Participation Fee – Commercial
Pricing Level I	0.000%	0.805%	0.070%	0.805%	0.4025%
Pricing Level II	0.000%	0.915%	0.085%	0.915%	0.4575%
Pricing Level III	0.025%	1.025%	0.100%	1.025%	0.5125%
Pricing Level IV	0.125%	1.125%	0.125%	1.125%	0.5625%
Pricing Level V	0.325%	1.325%	0.175%	1.325%	0.6625%
Pricing Level VI	0.500%	1.500%	0.250%	1.500%	0.7500%

Decreases in the Applicable Margin resulting from a change in Pricing Level shall become effective upon the delivery by the Borrower to the Administrative Agent of a notice pursuant to Section 7.7(d). Increases in the Applicable Margin resulting from a change in Pricing Level shall become effective on the effective date of any downgrade or withdrawal in the rating by Moody's or S&P of the senior unsecured long term debt rating of the Borrower.

"Approved Fund": any Person (other than a natural person) that is (or will be) engaged in making, purchasing, holding or otherwise investing in commercial loans and similar extensions of credit in the ordinary course of its business that is administered or managed by (a) a

Lender, (b) an Affiliate of a Lender or (c) an entity or an Affiliate of an entity that administers or manages a Lender.

"Assignment and Assumption": an assignment and assumption entered into by a Lender and an assignee (with the consent of any party whose consent is required by Section 11.7(b)), and accepted by the Administrative Agent, in substantially the form of Exhibit E or any other form approved by the Administrative Agent.

"Bail-In Action": the exercise of any Write-Down and Conversion Powers by the applicable EEA Resolution Authority in respect of any liability of an EEA Financial Institution.

"Bail-In Legislation": with respect to any EEA Member Country implementing Article 55 of Directive 2014/59/EU of the European Parliament and of the Council of the European Union, the implementing law for such EEA Member Country from time to time which is described in the EU Bail-In Legislation Schedule.

"Barclays": as defined in the preamble.

"BNY Mellon": as defined in the preamble.

"BNY Mellon Rate": a rate of interest per annum equal to the rate of interest publicly announced in New York City by BNY Mellon from time to time as its prime commercial lending rate, such rate to be adjusted automatically (without notice) on the effective date of any change in such publicly announced rate.

"BofA": as defined in the preamble.

"Borrower": as defined in the preamble.

"Borrower Materials": as defined in Section 7.7.

"Borrowing Date": (i) in respect of Revolving Credit Loans, any Domestic Business Day or Eurodollar Business Day, as the case may be, on which the Lenders shall make Revolving Credit Loans pursuant to a Borrowing Request or pursuant to a Mandatory Borrowing, (ii) in respect of Competitive Bid Loans, any Domestic Business Day on which a Lender shall make a Competitive Bid Loan pursuant to a Competitive Bid Request, (iii) in respect of Swing Line Loans, any Domestic Business Day on which the Swing Line Lender shall make a Swing Line Loan pursuant to a Borrowing Request and (iv) in respect of Letters of Credit, any Domestic Business Day on which an Issuer shall issue a Letter of Credit pursuant to a Letter of Credit Request.

"Borrowing Request": a request for Revolving Credit Loans or Swing Line Loans in the form of Exhibit C.

"Change of Control": any of the following:

(i) any Person or group (as such term is used in Section 13(d)(3) of the Securities Exchange Act of 1934, as amended), (a) shall have or acquire beneficial ownership of securities having 35% or more of the ordinary voting power of the Borrower or (b) shall possess, directly or indirectly, the power to direct or cause the direction of the management and policies of the Borrower, whether through the ownership of voting securities, by contract or otherwise; or

(ii) the Continuing Directors shall cease for any reason to constitute a majority of the board of directors of the Borrower then in office.

"Co-Documentation Agent" and ***"Co-Documentation Agents"***: as defined in the preamble.

"Co-Syndication Agent" and ***"Co-Syndication Agents"***: as defined in the preamble.

"Commercial Letter of Credit Commitment": at any time with respect to any Issuer, the commitment of such Issuer to issue commercial Letters of Credit in accordance with the terms hereof in an aggregate outstanding face amount not exceeding the lesser of (a) the amount set forth adjacent to such Issuer's name under the heading "Commercial Letter of Credit Commitment" in Exhibit A at such time or, if not listed on Exhibit A, the "Commercial Letter of Credit Commitment" which such Issuer shall have assumed from another Issuer in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7, or (b) 25% of the Aggregate Commitment Amount as in effect at such time.

"Commercial Letter of Credit Exposure": at any time in respect of any Issuer, an amount equal to such Issuer's Letter of Credit Exposure in respect of commercial Letters of Credit.

"Commitment": in respect of any Lender, such Lender's undertaking to make Revolving Credit Loans, subject to the terms and conditions hereof, in an aggregate outstanding principal amount not to exceed the Commitment Amount of such Lender.

"Commitment Amount": at any time and with respect to any Lender, the amount set forth adjacent to such Lender's name under the heading "Commitment Amount" in Exhibit A at such time or, in the event that such Lender is not listed on Exhibit A, the "Commitment Amount" which such Lender shall have assumed from another Lender in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7.

"Commitment Increase Supplement": a Commitment Increase Supplement substantially in the form of Exhibit K.

"Commitment Percentage": at any time and with respect to any Lender, a fraction the numerator of which is such Lender's Commitment Amount at such time, and the denominator of which is the Aggregate Commitment Amount at such time, provided that in the event the Commitments shall have expired or otherwise terminated or been terminated, then Commitment Percentage shall be determined immediately prior thereto.

"Commitment Period": the period commencing on the Effective Date and ending on the Commitment Termination Date, or on such earlier date as all of the Commitments shall have been terminated in accordance with the terms hereof.

"Commitment Termination Date": the earlier of (i) May 18, 2022 (subject to extension as provided in Section 2.12) and (ii) the date on which the Loans shall become due and payable, whether by acceleration, notice of intention to prepay or otherwise.

"Committed Credit Exposure": with respect to any Lender at any time, the sum at such time of (a) the outstanding principal balance of such Lender's Revolving Credit Loans, (b) the Swing Line Exposure of such Lender and (c) the Letter of Credit Exposure of such Lender.

"Compensatory Interest Payment": as defined in Section 3.4(c).

"Competitive Bid": an offer by a Lender, in the form of Exhibit H, to make one or more Competitive Bid Loans.

"Competitive Bid Accept/Reject Letter": a notification made by the Borrower pursuant to Section 2.4(d) in the form of Exhibit I.

"Competitive Bid Loan": as defined in Section 2.4(a).

"Competitive Bid Rate": as to any Competitive Bid made by a Lender pursuant to Section 2.4(b), the fixed rate of interest (which shall be expressed in the form of a decimal to no more than four decimal places) offered by such Lender with respect thereto.

"Competitive Bid Request": a request by the Borrower, in the form of Exhibit F, for Competitive Bids.

"Competitive Interest Period": as to any Competitive Bid Loan, the period commencing on the date of such Competitive Bid Loan and ending on the date requested in the Competitive Bid Request with respect thereto, which shall not be earlier than 3 days after the date of such Competitive Bid Loan or later than 180 days after the date of such Competitive Bid Loan; *provided* that if any Competitive Interest Period would end on a day other than a Domestic Business Day, such Competitive Interest Period shall be extended to the next succeeding Domestic Business Day, unless such next succeeding Domestic Business Day would be a date on or after the Commitment Termination Date, in which case such Competitive Interest Period shall end on the next preceding Domestic Business Day. Interest shall accrue from and including the first day of a Competitive Interest Period to but excluding the last day of such Competitive Interest Period.

"Consolidated": the Borrower and the Subsidiaries on a consolidated basis in accordance with GAAP.

"Contingent Obligation": as to any Person (the "secondary obligor"), any obligation of such secondary obligor (a) guaranteeing or in effect guaranteeing any return on any investment made by another Person, or (b) guaranteeing or in effect guaranteeing any Indebtedness, lease, dividend or other obligation ("primary obligation") of any other Person (the "primary obligor") in any manner, whether directly or indirectly, including any obligation of such secondary obligor, whether or not contingent, (i) to purchase any such primary obligation or any Property constituting direct or indirect security therefor, (ii) to advance or supply funds (A) for the purchase or payment of any such primary obligation or (B) to maintain working capital or equity capital of the primary obligor or otherwise to maintain the net worth or solvency of the primary obligor, (iii) to purchase Property, securities or services primarily for the purpose of assuring the beneficiary of any such primary obligation of the ability of the primary obligor to make payment of such primary obligation, (iv) otherwise to assure or hold harmless the beneficiary of such primary obligation against loss in respect thereof, and (v) in respect of the Indebtedness of any partnership in which such secondary obligor is a general partner, except to the extent that such Indebtedness of such partnership is nonrecourse to such secondary obligor and its separate Property; *provided* that the term "Contingent Obligation" shall not include the indorsement of instruments for deposit or collection in the ordinary course of business.

"Continuing Director": any member of the board of directors of the Borrower (i) who is a member of that board of directors on the Effective Date, (ii) who was nominated for election by the board of directors a majority of whom were directors on the Effective Date or (iii) whose election or nomination for election was approved by one or more of such directors.

"Control Person": as defined in Section 3.6.

"Convert", ***"Conversion"*** and ***"Converted"***: each, a reference to a conversion pursuant to Section 3.3 of one Type of Revolving Credit Loan into the other Type of Revolving Credit Loan.

"Costs": as defined in Section 3.6.

"Co-Syndication Agent" and ***"Co-Syndication Agents"***: as defined in the preamble.

"Credit Exposure": with respect to any Lender at any time, the sum at such time of (a) the Committed Credit Exposure of such Lender at such time and (b) the outstanding principal balance of all Competitive Bid Loans of such Lender at such time.

"Credit Parties": the Administrative Agent, the Swing Line Lender, the Issuers and the Lenders.

"Default": any of the events specified in Section 9.1, whether or not any requirement for the giving of notice, the lapse of time, or both, or any other condition, has been satisfied.

"Defaulting Lender": any Lender, as reasonably determined by the Administrative Agent, that has (a) failed to fund any portion of its Loans or participations in Letters of Credit or Swing Line Loans within two Domestic Business Days of the date required to be funded by it hereunder, unless such Lender notifies the Administrative Agent and the Borrower in writing that such failure is the result of such Lender's determination that one or more conditions precedent to funding (each of which conditions precedent, together with any applicable default, shall be specifically identified in such writing) has not been satisfied, (b) notified the Borrower or any Credit Party in writing that it does not intend to comply with any of its funding obligations under this Agreement or has made a public statement to the effect that it does not intend to comply with its funding obligations under this Agreement or generally under other agreements in which it commits to extend credit, unless such writing or public statement relates to such Lender's obligation to fund a Loan hereunder and states that such position is based on such Lender's determination that a condition precedent to funding (which condition precedent, together with any applicable default, shall be specifically identified in such writing or public statement) cannot be satisfied, (c) failed, two Domestic Business Days after written request by the Administrative Agent (based on the reasonable belief that it may not fulfill its funding obligation), to confirm that it will comply with the terms of this Agreement relating to its obligations to fund prospective Loans and participations in then outstanding Letters of Credit and Swing Line Loans; *provided* that such Lender shall cease to be a Defaulting Lender under this clause (c) upon receipt by the Administrative Agent of such confirmation, (d) otherwise failed to pay over to the Administrative Agent or any other Lender any other amount required to be paid by it hereunder within two Domestic Business Days of the date when due, unless the subject of a good faith dispute, or (e) (i) becomes or is insolvent or has a parent company that has become or is insolvent, (ii) becomes the subject of a bankruptcy or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment or has a parent company that has become the subject of a bankruptcy or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment, or (iii) becomes, or has a parent company that becomes, the subject of a Bail-in Action, *provided* that a Lender shall not qualify as a Defaulting Lender solely as a result of the acquisition or maintenance of an ownership interest in such Lender or its parent company, or of the exercise of control over such Lender or any Person controlling such Lender, by a Governmental Authority or instrumentality thereof so long as such ownership interest does not result in or provide such Lender with immunity from the jurisdiction of courts within the United States of America or from the enforcement of judgments or

writs of attachment on its assets or permit such Lender (or such Governmental Authority) to reject, repudiate, disavow or disaffirm any agreements made by such Lender.

"Disposition": with respect to any Person, any sale, assignment, transfer or other disposition by such Person by any means, of:

(a) the stock of, or other equity interests of, any other Person,

(b) any business, operating entity, division or segment thereof, or

(c) any other Property of such Person, other than (i) the sale of inventory (other than in connection with bulk transfers), (ii) the disposition of equipment and (iii) the sale of cash investments.

"Dividend Restrictions": as defined in Section 8.7.

"Dollar" *or* ***"$"***: lawful currency of the United States of America.

"Domestic Business Day": any day other than a Saturday, Sunday or a day which in New York City is a legal holiday or a day on which banking institutions are authorized or required by law or other governmental action to close.

"EEA Financial Institution": (a) any credit institution or investment firm established in any EEA Member Country which is subject to the supervision of an EEA Resolution Authority, (b) any entity established in an EEA Member Country which is a parent of an institution described in clause (a) of this definition, or (c) any financial institution established in an EEA Member Country which is a subsidiary of an institution described in clause (a) or (b) of this definition and is subject to consolidated supervision with its parent.

"EEA Member Country": any of the member states of the European Union, Iceland, Liechtenstein, and Norway.

"EEA Resolution Authority": any public administrative authority or any person entrusted with public administrative authority of any EEA Member Country (including any delegee) having responsibility for the resolution of any EEA Financial Institution.

"Effective Date": as defined in Section 5.

"Eligible Assignee": a Person that is a permitted assignee under Section 11.7(b) that has received the consent of each party whose consent is required under Section 11.7(b).

"Employee Benefit Plan": an employee benefit plan, within the meaning of Section 3(3) of ERISA, maintained, sponsored or contributed to by the Borrower, any Subsidiary or any ERISA Affiliate.

"Environmental Laws": all laws, rules, regulations, codes, ordinances, orders, decrees, judgments, injunctions, notices or binding agreements issued, promulgated or entered into by any Governmental Authority, relating in any way to the environment, preservation or

reclamation of natural resources, the management, release or threatened release of any Hazardous Material or to health and safety matters.

"Environmental Liability": as to any Person, any statutory, common law or equitable liability, contingent or otherwise (including any liability for damages, costs of environmental investigation, sampling or remediation, fines, penalties or indemnities), of such Person directly or indirectly resulting from or based upon (i) violation of any Environmental Law, (ii) the generation, use, handling, transportation, storage, treatment, discharge or disposal of any Hazardous Materials, (iii) exposure to any Hazardous Materials, (iv) the release or threatened release of any Hazardous Materials into the environment or (v) any contract, agreement or other consensual arrangement pursuant to which liability is assumed or imposed with respect to any of the foregoing.

"ERISA": the Employee Retirement Income Security Act of 1974, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"ERISA Affiliate": when used with respect to an Employee Benefit Plan, ERISA, the PBGC or a provision of the Internal Revenue Code pertaining to employee benefit plans, any Person that is a member of any group of organizations within the meaning of Sections 414(b) or (c) of the Internal Revenue Code or, solely with respect to the applicable provisions of the Internal Revenue Code, Sections 414(m) or (o) of the Internal Revenue Code, of which the Borrower or any Subsidiary is a member.

"ERISA Event": (a) any "reportable event", as defined in Section 4043 of ERISA with respect to a Pension Plan (other than an event for which the 30-day notice period is waived); (b) the determination that any Pension Plan is considered an at-risk plan or a plan in endangered or critical status within the meaning of Sections 430, 431 or 432 of the Internal Revenue Code or Sections 303, 304 or 305 of ERISA; (c) the filing pursuant to the Internal Revenue Code or ERISA of an application for a waiver of the minimum funding standard with respect to any Pension Plan; (d) the incurrence by the Borrower, any Subsidiary or an ERISA Affiliate of any liability under Title IV of ERISA with respect to the termination of any Pension Plan, other than for PBGC premiums due but not delinquent under Section 4007 of ERISA, upon the Borrower, any Subsidiary or an ERISA Affiliate; (e) the receipt by the Borrower, any Subsidiary or an ERISA Affiliate from the PBGC or a plan administrator of any notice relating to an intention to terminate any Pension Plan or to appoint a trustee to administer any Pension Plan; (f) the incurrence by the Borrower, any Subsidiary or an ERISA Affiliate of any liability with respect to the withdrawal or partial withdrawal from any Pension Plan or Multiemployer Plan; (g) any limits under Section 436 of the Internal Revenue Code become applicable; or (h) any failure to make any payment required by Section 430(j) of the Internal Revenue Code.

"EU Bail-In Legislation Schedule": the EU Bail-In Legislation Schedule published by the Loan Market Association (or any successor person), as in effect from time to time.

"Eurodollar Advance": a portion of the Revolving Credit Loans selected by the Borrower to bear interest during a Eurodollar Interest Period selected by the Borrower at a rate per

annum based upon a Eurodollar Rate determined with reference to such Eurodollar Interest Period, all pursuant to and in accordance with Section 2.1 or Section 3.3.

"Eurodollar Business Day": any Domestic Business Day, other than a Domestic Business Day on which banks are not open for dealings in Dollar deposits in the interbank eurodollar market.

"Eurodollar Interest Period": the period commencing on any Eurodollar Business Day selected by the Borrower in accordance with Section 2.3 or Section 3.3 and ending one, two, three or six months thereafter, as selected by the Borrower in accordance with either such Sections, subject to the following:

(i) if any Eurodollar Interest Period would otherwise end on a day which is not a Eurodollar Business Day, such Eurodollar Interest Period shall be extended to the immediately succeeding Eurodollar Business Day unless the result of such extension would be to carry the end of such Eurodollar Interest Period into another calendar month, in which event such Eurodollar Interest Period shall end on the Eurodollar Business Day immediately preceding such day; and

(ii) if any Eurodollar Interest Period shall begin on the last Eurodollar Business Day of a calendar month (or on a day for which there is no numerically corresponding day in the calendar month at the end of such Eurodollar Interest Period), such Eurodollar Interest Period shall end on the last Eurodollar Business Day of such latter calendar month.

"Eurodollar Rate": with respect to any Eurodollar Advance or any ABR Advance, to the extent such ABR Advance is based on the Eurodollar Rate, for any Interest Period, an interest rate per annum equal to (a) the LIBO Rate for such Interest Period multiplied by (b) the Statutory Reserve Rate.

"Event of Default": any of the events specified in Section 9.1, *provided* that any requirement for the giving of notice, the lapse of time, or both, or any other condition has been satisfied.

"Excluded Taxes": with respect to the Administrative Agent, any Lender, any Issuer or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, (a) Taxes imposed on or measured by its net income (however denominated), and franchise Taxes, in each case, (i) imposed on it by the jurisdiction (or any political subdivision thereof) under the laws of which it is organized or in which its principal office is located or, in the case of any Lender, in which its applicable lending office is located, or (ii) that are Other Connection Taxes, (b) any branch profits Taxes imposed by the United States of America or that are Other Connection Taxes, (c) in the case of a Lender (other than an assignee pursuant to a request by the Borrower under Section 3.13), any withholding Tax that (i) is imposed on amounts payable to such Lender at the time such Lender becomes a party hereto (or designates a new lending office), except to the extent that such Lender (or its assignor, if any) was entitled, at the time of designation of a new lending office (or assignment), to receive additional amounts from the Borrower with respect to such withholding Tax pursuant to Section 3.10, or (ii) is attributable to such Lender's failure or inability (other

than as a result of a Regulatory Change, except for a Regulatory Change relating to the implementation of FATCA) to comply with Section 3.10 and (d) any Taxes imposed under FATCA.

"*Existing Commitment Termination Date*": as defined in Section 2.12(a).

"*Existing 2013 Credit Agreement*": the Credit Agreement, dated as of May 23, 2013, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and BNY Mellon, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"*Existing 2014 Credit Agreement*": the Second Amended and Restated Credit Agreement, dated as of July 24, 2014, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and BNY Mellon, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"*Existing 2015 Credit Agreement*": the Credit Agreement, dated as of July 1, 2015, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and BNY Mellon, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"*Existing 364-Day Credit Agreement*": the Credit Agreement, dated as of May 18, 2017, by and among the Borrower, the lenders party thereto from time to time, BofA and Wells Fargo, as co-syndication agents, Barclays and JPMC, as co-documentation agents, and BNY Mellon, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"*Expiration Date*": the first date, occurring on or after the date the Commitments shall have terminated or been terminated in accordance herewith, upon which there shall be no Loans, Reimbursement Obligations or Letters of Credit outstanding.

"*Extension Date*": as defined in Section 2.12(a).

"*Extension Request*": as defined in Section 2.12(a).

"*Facility Fee*": as defined in Section 3.11.

"*FATCA*": Sections 1471 through 1474 of the Internal Revenue Code, as of the date of this Agreement (or any amended or successor version that is substantively comparable and not materially more onerous to comply with), any current or future regulations or official interpretations thereof, any agreements entered into pursuant to Section 1471(b)(1) of the Internal Revenue Code, any applicable intergovernmental agreements with respect thereto, and any treaty, law, regulations, or other official guidance enacted in any other jurisdiction relating to such intergovernmental agreement.

"Federal Funds Effective Rate": for any day, the rate calculated by the Federal Reserve Bank of New York based on such day's (or, if such day is not a Domestic Business Day, the immediately preceding Domestic Business Day) federal funds transactions by depository institutions (as determined in such manner as the Federal Reserve Bank of New York shall set forth on its public website from time to time) and published on the next succeeding Domestic Business Day by the Federal Reserve Bank of New York as the federal funds effective rate, or, if such rate is not so published for any day which is a Domestic Business Day, the average of the quotations for such day on such transactions received by the Administrative Agent from three Federal funds brokers of recognized standing selected by the Administrative Agent.

"Fees": as defined in Section 3.2(a).

"Financial Statements": as defined in Section 4.13.

"Foreign Lender": any Lender or any Issuer that is not a United States person within the meaning of Section 7701(a)(30) of the Internal Revenue Code.

"GAAP": generally accepted accounting principles set forth in the opinions and pronouncements of the Accounting Principles Board and the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board or such other principles as may be approved by a significant segment of the accounting profession, which are applicable to the circumstances as of the date of determination, consistently applied; *provided*, *however*, that the accounting for operating leases and financing or capital leases under GAAP as in effect on the Effective Date (including, without limitation, Accounting Standards Codification 840) shall apply for determining compliance with the provisions of this Agreement.

"Governmental Authority": any foreign, federal, state, municipal or other government, or any department, commission, board, bureau, agency, public authority or instrumentality thereof, or any court, arbitrator, regulatory body or central bank (including any supra-national bodies such as the European Union or the European Central Bank).

"Hazardous Materials": all ignitable, explosive, reactive, corrosive or radioactive substances or wastes and all hazardous or toxic materials, substances, chemicals, wastes or other pollutants, including but not limited to petroleum or petroleum distillates, asbestos or asbestos containing materials, polychlorinated biphenyls, radon gas, toxic mold, infectious or medical wastes, hazardous biological agents, hazardous pharmaceutical substances and all other materials, substances, chemicals, wastes, contaminants or pollutants of any nature that are now or hereafter regulated pursuant to any Environmental Law, or are now or hereafter defined, listed or classified as a hazardous or toxic material, substance, chemical, waste, contaminant or pollutant in any Environmental Law.

"Highest Lawful Rate": as to any Lender, the maximum rate of interest, if any, which at any time or from time to time may be contracted for, taken, charged or received on the Loans or the Notes or which may be owing to such Lender pursuant to this Agreement under the laws applicable to such Lender and this Agreement.

"Impacted Interest Period": has the meaning assigned to it in the definition of *"LIBO Rate"*.

"Increasing Lender": as defined in Section 2.6(d).

"Indebtedness": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) indebtedness with respect to any conditional sale or other title retention agreement, (d) indebtedness arising under acceptance facilities and the amount available to be drawn under all letters of credit (excluding for purposes of Section 8.1 and Section 8.9 letters of credit obtained in the ordinary course of business by the Borrower or any Subsidiary) issued for the account of such Person and, without duplication, all drafts drawn thereunder to the extent such Person shall not have reimbursed the issuer thereof in respect of such issuer's payment of such drafts, (e) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, (f) all indebtedness described in (a) - (e) above secured by any Lien on any Property owned by such Person even though such Person shall not have assumed or otherwise become liable for the payment thereof (other than carriers', warehousemen's, mechanics', repairmen's or other like non-consensual Liens arising in the ordinary course of business), and (g) Contingent Obligations in respect of any indebtedness described in items (a) - (f) above; *provided* that, for purposes of this definition, Indebtedness shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"Indemnified Amount": as defined in Section 11.10(b).

"Indemnified Liabilities": as defined in Section 11.5.

"Indemnified Person": as defined in Section 11.10(a).

"Indemnified Taxes": Taxes other than Excluded Taxes and Other Taxes.

"Information": as defined in Section 11.14(b).

"Intangible Assets": at any date, the value, as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP, of: (i) all trade names, trademarks, licenses, patents, copyrights, service marks, goodwill and other like intangibles, (ii) organizational and development costs, (iii) deferred charges (other than prepaid items, such as insurance, taxes, interest, commissions, rents, pensions, compensation and similar items and tangible assets being amortized), and (iv) unamortized debt discount and expense, less unamortized premium.

"Intercompany Debt": (i) Indebtedness of the Borrower to one or more of the Subsidiaries of the Borrower and (ii) Indebtedness of one or more of the Subsidiaries of the Borrower to the Borrower or any one or more of the other Subsidiaries of the Borrower.

"Intercompany Disposition": a Disposition by the Borrower or any of the Subsidiaries of the Borrower to the Borrower or to any of the other Subsidiaries of the Borrower.

"Interest Payment Date": (i) as to any ABR Advance, the last day of each March, June, September and December, commencing on the first of such days to occur after such ABR Advance is made or any Eurodollar Advance is converted to an ABR Advance, (ii) as to any Swing Line Loan, the day on which the outstanding principal balance of such Swing Line Loan shall become due and payable in accordance with Section 2.2(a), (iii) as to any Eurodollar Advance in respect of which the Borrower has selected a Eurodollar Interest Period of one, two or three months, the last day of such Eurodollar Interest Period, (iv) as to any Competitive Bid Loan in respect of which the Borrower has selected a Competitive Interest Period of 90 days or less, the last day of such Competitive Interest Period and (v) as to any Eurodollar Advance or Competitive Bid Loan in respect of which the Borrower has selected an Interest Period greater than three months or 90 days, as the case may be, the last day of the third month or the 90th day, as the case may be, of such Interest Period and the last day of such Interest Period.

"Interest Period": a Eurodollar Interest Period, a Swing Line Interest Period or a Competitive Interest Period, as the case may be.

"Internal Revenue Code": the Internal Revenue Code of 1986, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"Interpolated Rate": in relation to determining the applicable LIBO Screen Rate, the rate which results from interpolating on a linear basis between:

(a) the LIBO Screen Rate for the longest period (for which the LIBO Screen Rate is available) which is shorter than the Impacted Interest Period of the applicable Eurodollar Advance; and

(b) the LIBO Screen Rate for the shortest period (for which that LIBO Screen Rate is available) which is longer than the Impacted Interest Period of such Eurodollar Advance,

each as of approximately 11:00 a.m. (London, England time) two Business Days prior to the commencement of such Interest Period; *provided* that in the event either of the two foregoing LIBO Screen Rates is not available at such time, then the *"Interpolated Rate"* with respect to such Eurodollar Advance for such Interest Period shall be the average of rates at which Dollar deposits of $5,000,000 and for a maturity comparable to such Interest Period are offered to major banks in the London interbank market by the principal London office of the Administrative Agent in immediately available funds in the London interbank market at approximately 11:00 a.m., London time, two Eurodollar Business Days prior to the commencement of such Interest Period.

"issue" *or* ***"issuance"***: when used with respect to a Letter of Credit, shall be deemed to include any increase in the amount of such Letter of Credit.

"Issuers": BNY Mellon, Barclays, BofA, JPMC and Wells Fargo; each an ***"Issuer"***.

"Joint Bookrunners": BNY Mellon, ML, Barclays, JPMC and WFS.

"Joint Lead Arrangers": BNY Mellon, ML and WFS.

"JPMC": as defined in the preamble.

"Lender" and ***"Lenders"***: as defined in the preamble; such term to also include the Swing Line Lender and each Issuer where the context hereof requires or permits such inclusion.

"Letter of Credit" and ***"Letters of Credit"***: as defined in Section 2.8(a).

"Letter of Credit Application": an application and agreement for the issuance or amendment of a Letter of Credit in the form from time to time in use by the applicable Issuer.

"Letter of Credit Commitment": at any time with respect to any Issuer, the commitment of such Issuer to issue Letters of Credit (which, for the avoidance of doubt, shall include all standby letters of credit and all commercial letters of credit issued by such Issuer) in accordance with the terms hereof in an aggregate outstanding face amount not exceeding the lesser of (a) the amount set forth adjacent to such Issuer's name under the heading "Letter of Credit Commitment" in Exhibit A at such time or, if not listed on Exhibit A, the "Letter of Credit Commitment" which such Issuer shall have assumed from another Issuer in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7, or (b) 20% of the Aggregate Commitment Amount as in effect at such time.

"Letter of Credit Exposure": at any time, (a) in respect of all Lenders, the sum, without duplication, of (i) the maximum aggregate amount which may be drawn under all unexpired Letters of Credit at such time (whether or not the conditions for drawing thereunder have or may be satisfied), (ii) the aggregate amount, at such time, of all unpaid drafts (which have not been dishonored) drawn under all Letters of Credit, and (iii) the aggregate unpaid principal amount of the Reimbursement Obligations at such time, (b) in respect of any Lender, an amount equal to such Lender's Commitment Percentage at such time multiplied by the amount determined under clause (a) of this definition, and (c) in respect of any Issuer, the amount determined under clause (a) of this definition in respect of a Letter of Credit issued by such Issuer.

"Letter of Credit Participation Fee": as defined in Section 3.12.

"Letter of Credit Request": a request in the form of Exhibit J.

"LIBO Rate": with respect to any Eurodollar Advance for any Interest Period, the rate per annum equal to the ICE Benchmark Administration Limited LIBOR Rate (or such successor thereto if the ICE Benchmark Administration Limited is no longer making such a rate available) appearing on the applicable Bloomberg screen (or other commercially available source as designated by the Administrative Agent from time to time for purposes of providing quotations of interest rates applicable to Dollar deposits in the London interbank market) at approximately 11:00 a.m., London time, two (2) Eurodollar Business Days prior to the commencement of such Interest Period, as the rate for Dollar deposits with a maturity comparable to such Interest Period (in each case, the ***"LIBO Screen Rate"***); *provided* that (i) if

the LIBO Screen Rate shall be less than zero, the LIBO Rate shall be deemed to be zero for the purposes of this Agreement, and (ii) if the LIBO Screen Rate shall not be available at such time for such Interest Period (an ***"Impacted Interest Period"***) then the LIBO Rate shall be the Interpolated Rate, *provided* that if any Interpolated Rate shall be less than zero, such Interpolated Rate shall be deemed to be zero for purposes of this Agreement.

"LIBO Screen Rate": has the meaning assigned to it in the definition of *"LIBO Rate"*.

"Lien": any mortgage, pledge, hypothecation, assignment, lien, deposit arrangement, charge, encumbrance or other security arrangement or security interest of any kind, or the interest of a vendor or lessor under any conditional sale agreement, capital lease or other title retention agreement.

"Loan": a Revolving Credit Loan, a Competitive Bid Loan or a Swing Line Loan, as the case may be.

"Loan Documents": this Agreement and, upon the execution and delivery thereof, the Notes, if any, and the Reimbursement Agreements, if any.

"Loans": the Revolving Credit Loans, the Competitive Bid Loans and the Swing Line Loans.

"Mandatory Borrowing": as defined in Section 2.2(b).

"Margin Stock": any "margin stock", as said term is defined in Regulation U of the Board of Governors of the Federal Reserve System, as the same may be amended or supplemented from time to time.

"Material Adverse": with respect to any change or effect, a material adverse change in, or effect on, as the case may be, (i) the financial condition, operations, business, or Property of the Borrower and the Subsidiaries taken as a whole, (ii) the ability of the Borrower to perform its obligations under the Loan Documents, or (iii) the ability of the Administrative Agent, any Issuer or any Lender to enforce the Loan Documents.

"ML": Merrill Lynch, Pierce, Fenner & Smith Incorporated.

"Moody's": Moody's Investors Service, Inc., or any successor thereto.

"Multiemployer Plan": a Pension Plan which is a multiemployer plan as defined in Section 4001(a)(3) of ERISA.

"Negotiated Rate": with respect to each Swing Line Loan, the rate per annum agreed to in writing by the Borrower and the Swing Line Lender as the interest rate which such Swing Line Loan shall bear.

"Net Tangible Assets": at any date, the total assets as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP,

less, without duplication (i) all current liabilities (due within one year) as shown on such balance sheet and (ii) Intangible Assets and liabilities relating thereto.

"New Lender": as defined in Section 2.6(d).

"Non-Extending Lender": as defined in Section 2.12(b).

"Note": with respect to each Lender that has requested one in accordance with Section 2.11, a promissory note evidencing such Lender's Loans payable to the order of such Lender (or, if required by such Lender, to such Lender and its registered assigns), substantially in the form of Exhibit B.

"One Month LIBOR Rate": with respect to any ABR Advance for any day, the rate per annum equal to the ICE Benchmark Administration Limited LIBOR Rate (or such successor thereto if the ICE Benchmark Administration Limited is no longer making such a rate available) appearing on the applicable Bloomberg screen (or other commercially available source as designated by the Administrative Agent from time to time for purposes of providing quotations of interest rates applicable to Dollar deposits in the London interbank market) at approximately 11:00 a.m., London time, on such day (or, if such date is not a Eurodollar Business Day, the immediately preceding Eurodollar Business Day), as the rate for Dollar deposits with a maturity of approximately one month, *provided* that (a) in the event the *"One Month LIBOR Rate"* is not otherwise available, then the *"One Month LIBOR Rate"* with respect to such ABR Advance shall be the rate at which Dollar deposits of $5,000,000 and for a maturity of approximately one month are offered by the principal London office of the Administrative Agent in immediately available funds in the London interbank market at approximately 11:00 a.m., London time, on such day, and (b) in the event that the *"One Month LIBOR Rate"* would otherwise be less than zero, such *"One Month LIBOR Rate"* shall be deemed to be zero for purposes of this Agreement.

"Other Connection Taxes": with respect to the Administrative Agent, any Lender, any Issuer or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, Taxes imposed as a result of a present or former connection between such recipient and the jurisdiction imposing such Tax (other than connections arising from such recipient having executed, delivered, become a party to, performed its obligations under, received payments under, received or perfected a security interest under, engaged in any other transaction pursuant to, enforced any Loan Document, or sold or assigned an interest in any Loan or Loan Document).

"Other Taxes": all present or future stamp, court or documentary Taxes or any other excise or property Taxes, charges or similar levies arising from any payment made hereunder or under any other Loan Document or from the execution, delivery or enforcement of, or otherwise with respect to, this Agreement or any other Loan Document, except any such Taxes that are Other Connection Taxes imposed with respect to an assignment (other than an assignment made pursuant to Section 3.13).

"Participant": as defined in Section 11.7(d).

"Participant Register": as defined in Section 11.7(d).

"Patriot Act": as defined in Section 11.20.

"PBGC": the Pension Benefit Guaranty Corporation established pursuant to Subtitle A of Title IV of ERISA, or any Governmental Authority succeeding to the functions thereof.

"Pension Plan": at any time, any Employee Benefit Plan (including a Multiemployer Plan) subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, the funding requirements of which are, or at any time within the six years immediately preceding the time in question were, in whole or in part, the responsibility of the Borrower, any Subsidiary or an ERISA Affiliate.

"Person": any individual, firm, partnership, limited liability company, joint venture, corporation, association, business trust, joint stock company, unincorporated association, trust, Governmental Authority or any other entity, whether acting in an individual, fiduciary, or other capacity, and for the purpose of the definition of "ERISA Affiliate", a trade or business.

"Platform": as defined in Section 7.7.

"Pricing Level": Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV, Pricing Level V or Pricing Level VI, as the case may be.

"Pricing Level I": any time when the senior unsecured long term debt rating of the Borrower by (x) S&P is A or higher or (y) Moody's is A2 or higher.

"Pricing Level II": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is A- or higher or (y) Moody's is A3 or higher and (ii) Pricing Level I does not apply.

"Pricing Level III": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB+ or higher or (y) Moody's is Baa1 or higher and (ii) neither Pricing Level I nor Pricing Level II applies.

"Pricing Level IV": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB or higher or (y) Moody's is Baa2 or higher and (ii) none of Pricing Level I, Pricing Level II or Pricing Level III applies.

"Pricing Level V": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB- or higher or (y) Moody's is Baa3 or higher and (ii) none of Pricing Level I, Pricing Level II, Pricing Level III or Pricing Level IV applies.

"Pricing Level VI": any time when none of Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV or Pricing Level V applies.

Notwithstanding each definition of Pricing Level set forth above, if at any time the senior unsecured long term debt ratings of the Borrower by S&P and Moody's differ by more than one equivalent rating level, then the applicable Pricing Level shall be determined based upon the lower such rating adjusted upwards to the next higher rating level.

"Proceeding": as defined in Section 11.10(a).

"Prohibited Transaction": a transaction that is prohibited under Section 4975 of the Internal Revenue Code or Section 406 of ERISA and not exempt under Section 4975 of the Internal Revenue Code, Section 408 of ERISA or any applicable administrative exemptions.

"Property": in respect of any Person, all types of real, personal or mixed property and all types of tangible or intangible property owned or leased by such Person.

"Regulatory Change": the occurrence, after the date hereof, of any of the following: (a) the adoption or taking effect of any law, rule, regulation or treaty, (b) any change in any law, rule, regulation or treaty or in the administration, implementation, interpretation or application thereof by any Governmental Authority or (c) the making or issuance of any request, guideline or directive (whether or not having the force of law) by any Governmental Authority; *provided* that, notwithstanding anything herein to the contrary, (i) the Dodd-Frank Wall Street Reform and Consumer Protection Act and all requests, rules, guidelines or directives thereunder or issued in connection therewith and (ii) all requests, rules, guidelines or directives promulgated by the Bank for International Settlements, the Basel Committee on Banking Supervision (or any successor or similar authority) or the United States or foreign regulatory authorities, in each case, pursuant to Basel III, in the case of each of clauses (i) and (ii), shall be deemed to be a "Regulatory Change", regardless of the date enacted, adopted or issued, but only if any such requirements are generally applicable to (and for which reimbursement is generally being sought by the Lenders in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this definition), as determined by the Lenders in their respective reasonable discretion.

"Register": as defined in Section 11.7(c).

"Reimbursement Agreement": as defined in Section 2.8(b).

"Reimbursement Obligations": all obligations and liabilities of the Borrower due and to become due (a) under the Reimbursement Agreements and (b) hereunder in respect of Letters of Credit.

"Related Parties": with respect to any specified Person, such Person's Affiliates and the respective directors, officers, employees, agents and advisors of such Person and such Person's Affiliates.

"Replaced Lender": as defined in Section 3.13.

"Replacement Lender": as defined in Section 3.13.

"Required Lenders": (a) at any time prior to the Commitment Termination Date or such earlier date as all of the Commitments shall have terminated or been terminated in accordance herewith, Lenders having Commitment Amounts equal to or more than 51% of the Aggregate Commitment Amount, and (b) at all other times, Lenders having Credit Exposure equal to or more than 51% of the Aggregate Credit Exposure.

"Restricted Payment": with respect to any Person, any of the following, whether direct or indirect: (a) the declaration or payment by such Person of any dividend or distribution on any class of stock of such Person, other than a dividend payable solely in shares of that class of stock to the holders of such class, (b) the declaration or payment by such Person of any distribution on any other type or class of equity interest or equity investment in such Person, and (c) any redemption, retirement, purchase or acquisition of, or sinking fund or other similar payment in respect of, any class of stock of, or other type or class of equity interest or equity investment in, such Person.

"Restrictive Agreement": as defined in Section 8.7.

"Revolving Credit Loan" and ***"Revolving Credit Loans"***: as defined in Section 2.1(a).

"Sanctioned Country": at any time, a country or territory which is the subject or target of any Sanctions.

"Sanctioned Person": at any time, (a) any Person listed in any Sanctions-related list of designated Persons maintained by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State, (b) any Person operating, organized or resident in a Sanctioned Country or (c) any Person controlled by any such Person.

"Sanctions": economic or financial sanctions or trade embargoes imposed, administered or enforced from time to time by the U.S. government, including those administered by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State.

"S&P": Standard & Poor's Ratings Services, a subsidiary of McGraw Hill Financial, Inc., or any successor thereto.

"Special Counsel": such counsel as the Administrative Agent may engage from time to time.

"Statutory Reserve Rate": a fraction (expressed as a decimal), the numerator of which is the number one and the denominator of which is the number one minus the aggregate of the maximum reserve percentages (including any marginal, special, emergency or supplemental reserves) expressed as a decimal established by the Board of Governors of the Federal Reserve System to which the Administrative Agent is subject for eurocurrency funding (currently referred to as "Eurocurrency liabilities" in Regulation D of the Board of Governors of the Federal Reserve System, as amended). Such reserve percentages shall include those imposed pursuant to said Regulation D. Eurodollar Loans shall be deemed to constitute eurocurrency funding and to be subject to such reserve requirements without benefit of or credit for proration, exemptions or offsets that may be available from time to time to any Lender under said Regulation D or any comparable regulation. The Statutory Reserve Rate shall be adjusted automatically on and as of the effective date of any change in any reserve percentage.

"Subsidiary": at any time and from time to time, any corporation, partnership, limited liability company, joint venture or other business entity of which the Borrower and/or any

Subsidiary of the Borrower, directly or indirectly at such time, either (a) in respect of a corporation, owns or controls more than 50% of the outstanding stock having ordinary voting power to elect a majority of the board of directors or similar managing body, irrespective of whether a class or classes shall or might have voting power by reason of the happening of any contingency, or (b) in respect of a partnership, limited liability company, joint venture or other business entity, is entitled to share in more than 50% of the profits and losses, however determined.

"Swing Line Commitment": the commitment of the Swing Line Lender to make Swing Line Loans in accordance with the terms hereof in an aggregate outstanding principal amount not exceeding $100,000,000 (or, if less, the Aggregate Commitment Amount) at any time, as the same may be reduced pursuant to Section 2.6.

"Swing Line Commitment Period": the period from the Effective Date to, but excluding, the Swing Line Termination Date.

"Swing Line Exposure": at any time, in respect of any Lender, an amount equal to the aggregate principal balance of such Lender's Swing Line Participation Amount.

"Swing Line Interest Period": as to any Swing Line Loan, the period commencing on the date of such Swing Line Loan and ending on the date set forth by the Borrower in the Borrowing Request with respect to such Swing Line Loan; *provided* that the last day of any Swing Line Interest Period shall not be earlier than one day after the date of such Swing Line Loan or later than 7 days after the date of such Swing Line Loan and in no event later than the Swing Line Termination Date; *provided further* that if any Swing Line Interest Period would end on a day other than a Domestic Business Day, such Swing Line Interest Period shall be extended to the next succeeding Domestic Business Day. Interest shall accrue from and including the first day of a Swing Line Interest Period to but excluding the last day of such Swing Line Interest Period.

"Swing Line Lender": BNY Mellon.

"Swing Line Loan" and ***"Swing Line Loans"***: as defined in Section 2.2(a).

"Swing Line Maturity Date": as defined in Section 2.2(a).

"Swing Line Participation Amount": as defined in Section 2.2(c).

"Swing Line Termination Date": the date which is 7 Domestic Business Days prior to the Commitment Termination Date.

"Taxes": all present or future taxes, levies, imposts, duties, deductions, withholdings, assessments, fees or other charges imposed by any Governmental Authority, including any interest, additions to tax or penalties applicable thereto.

"Termination Event": with respect to any Pension Plan, (a) an ERISA Event, (b) the termination of a Pension Plan under Section 4041(c) of ERISA, or the filing of a notice of intent to terminate a Pension Plan under Section 4041(c) of ERISA, or the treatment of a Pension Plan amendment as a termination under Section 4041(e) of ERISA (except an amendment made after such Pension Plan satisfies the requirement for a standard termination under Section 4041(b) of

ERISA), (c) the institution of proceedings by the PBGC to terminate a Pension Plan under Section 4042 of ERISA, or (d) the appointment of a trustee to administer any Pension Plan under Section 4042 of ERISA.

"Total Capitalization": at any date, the sum of the Borrower's Consolidated Indebtedness and shareholders' equity on such date, determined in accordance with GAAP.

"Type": with respect to any Revolving Credit Loan, the characteristic of such Loan as an ABR Advance or a Eurodollar Advance, each of which constitutes a Type of Revolving Credit Loan.

"Unqualified Amount": as defined in Section 3.4(c).

"Upstream Dividends": as defined in Section 8.7(a).

"U.S. Lender": as defined in Section 3.10(f).

"United States Tax Compliance Certificate": as defined in Section 3.10(f)(iii).

"Wells Fargo": as defined in the preamble.

"***WFS***": Wells Fargo Securities, LLC.

"Write-Down and Conversion Powers": with respect to any EEA Resolution Authority, the write-down and conversion powers of such EEA Resolution Authority from time to time under the Bail-In Legislation for the applicable EEA Member Country, which write-down and conversion powers are described in the EU Bail-In Legislation Schedule.

1.2 ***Principles of Construction***

(a) All capitalized terms defined in this Agreement shall have the meanings given to such capitalized terms herein when used in the other Loan Documents or in any certificate, opinion or other document made or delivered pursuant hereto or thereto, unless otherwise expressly provided therein.

(b) Unless otherwise expressly provided herein, the word *"fiscal"* when used herein shall refer to the relevant fiscal period of the Borrower. As used in the Loan Documents and in any certificate, opinion or other document made or delivered pursuant thereto, accounting terms not defined in Section 1.1, and accounting terms partly defined in Section 1.1, to the extent not defined, shall have the respective meanings given to them under GAAP as in effect from time to time; *provided* that, if the Borrower notifies the Administrative Agent that the Borrower requests an amendment to any provision hereof to eliminate the effect of any change occurring after the date hereof in GAAP or in the application thereof on the operation of such provision (or if the Administrative Agent notifies the Borrower that the Required Lenders request an amendment to any provision hereof for such purpose), regardless of whether any such notice is given before or after such change in GAAP or in the application thereof, then such provision shall be interpreted on the basis of, and any accounting term related thereto shall have the respective meaning given to it under, GAAP as in effect and applied immediately before such

change shall have become effective until such notice shall have been withdrawn or such provision amended in accordance herewith.

(c) The words *"hereof"*, *"herein"*, *"hereto"* and *"hereunder"* and similar words when used in each Loan Document shall refer to such Loan Document as a whole and not to any particular provision of such Loan Document, and Section, schedule and exhibit references contained therein shall refer to Sections thereof or schedules or exhibits thereto unless otherwise expressly provided therein.

(d) All references herein to a time of day shall mean the then applicable time in New York, New York, unless otherwise expressly provided herein.

(e) Section headings have been inserted in the Loan Documents for convenience only and shall not be construed to be a part thereof. Unless the context otherwise requires, words in the singular number include the plural, and words in the plural include the singular.

(f) Whenever in any Loan Document or in any certificate or other document made or delivered pursuant thereto, the terms thereof require that a Person sign or execute the same or refer to the same as having been so signed or executed, such terms shall mean that the same shall be, or was, duly signed or executed by (i) in respect of any Person that is a corporation, any duly authorized officer thereof, and (ii) in respect of any other Person (other than an individual), any analogous counterpart thereof.

(g) The words *"include"* and *"including"*, when used in each Loan Document, shall mean that the same shall be included *"without limitation"*, unless otherwise specifically provided.

2. *AMOUNT AND TERMS OF LOANS*

2.1 *Revolving Credit Loans*

(a) Subject to the terms and conditions hereof, each Lender severally (and not jointly) agrees to make loans in Dollars under this Agreement (each a ***"Revolving Credit Loan"*** and, collectively with each other Revolving Credit Loan of such Lender and/or with each Revolving Credit Loan of each other Lender, the ***"Revolving Credit Loans"***) to the Borrower from time to time during the Commitment Period, during which period the Borrower may borrow, prepay and reborrow in accordance with the provisions hereof. Immediately after making each Revolving Credit Loan and after giving effect to all Swing Line Loans and Competitive Bid Loans repaid and all Reimbursement Obligations paid on the same date, the Aggregate Credit Exposure will not exceed the Aggregate Commitment Amount. With respect to each Lender, at the time of the making of any Revolving Credit Loan, the sum of (I) the principal amount of such Lender's Revolving Credit Loan constituting a part of the Revolving Credit Loans to be made, (II) the aggregate principal balance of all other Revolving Credit Loans (exclusive of Revolving Credit Loans

which are repaid with the proceeds of, and simultaneously with the incidence of, the Revolving Credit Loans to be made) then outstanding from such Lender and (III) the product of (A) such Lender's Commitment Percentage and (B) the sum of (1) the aggregate principal balance of all Swing Line Loans (exclusive of Swing Line Loans which are repaid with the proceeds of, and simultaneously with the incurrence of, the Revolving Credit Loans to be made) then outstanding and (2) the Letter of Credit Exposure of all Lenders, will not exceed the Commitment of such Lender at such time. At the option of the Borrower, indicated in a Borrowing Request, Revolving Credit Loans may be made as ABR Advances or Eurodollar Advances.

(b) The aggregate outstanding principal balance of all Revolving Credit Loans shall be due and payable on the Commitment Termination Date or on such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6.

2.2 ***Swing Line Loans***

(a) Subject to the terms and conditions hereof, the Swing Line Lender agrees to make loans in Dollars under this Agreement (each a ***"Swing Line Loan"*** and, collectively, the ***"Swing Line Loans"***) to the Borrower from time to time during the Swing Line Commitment Period. Swing Line Loans (i) may be repaid and reborrowed in accordance with the provisions hereof, (ii) shall not, immediately after giving effect thereto, result in the Aggregate Credit Exposure exceeding the Aggregate Commitment Amount, and (iii) shall not, immediately after giving effect thereto, result in the aggregate outstanding principal balance of all Swing Line Loans exceeding the Swing Line Commitment. The Swing Line Lender shall not be obligated to make any Swing Line Loan at a time when any Lender is a Defaulting Lender unless the Swing Line Lender has entered into arrangements satisfactory to it and the Borrower to eliminate the Swing Line Lender's risk with respect to such Defaulting Lender's participation in such Swing Line Loan. The Swing Line Lender will not make a Swing Line Loan if the Administrative Agent, or any Lender by notice to the Swing Line Lender and the Borrower no later than one Domestic Business Day prior to the Borrowing Date with respect to such Swing Line Loan, shall have determined that the conditions set forth in Section 6 have not been satisfied or waived and such conditions remain unsatisfied as of the requested time of the making of such Loan. Each Swing Line Loan shall be due and payable on the day (the ***"Swing Line Maturity Date"***) being the earliest of the last day of the Swing Line Interest Period applicable thereto, the date on which the Swing Line Commitment shall have been terminated in accordance with Section 2.6, and the date on which the Loans shall become due and payable pursuant to the provisions hereof, whether by acceleration or otherwise. Each Swing Line Loan shall bear interest at the Negotiated Rate applicable thereto. The Swing Line Lender shall disburse the proceeds of Swing Line Loans at its office designated in Section 11.2 by crediting such proceeds to an account of the Borrower maintained with the Swing Line Lender.

(b) On any Domestic Business Day, the Swing Line Lender may, in its sole discretion, give notice to the Lenders and the Borrower that such outstanding Swing Line Loan shall be funded with a borrowing of Revolving Credit Loans (*provided* that such notice shall be deemed to have been automatically given upon the occurrence of a Default or an Event of Default under Section 9.1(h), (i) or (j)), in which case a borrowing of Revolving Credit Loans made as ABR Advances (each such borrowing, a ***"Mandatory Borrowing"***) shall be made by all Lenders *pro rata* based on each such Lender's Commitment Percentage on the Domestic Business Day immediately succeeding the giving of such notice. The proceeds of each Mandatory Borrowing shall be remitted directly to the Swing Line Lender to repay such outstanding Swing Line Loan. Each Lender irrevocably agrees to make a Revolving Credit Loan

pursuant to each Mandatory Borrowing in the amount and in the manner specified in the preceding sentence and on the date specified in writing by the Swing Line Lender notwithstanding: (i) whether the amount of such Mandatory Borrowing complies with the minimum amount for Loans otherwise required hereunder, (ii) whether any condition specified in Section 6 is then unsatisfied, (iii) whether a Default then exists, (iv) the Borrowing Date of such Mandatory Borrowing, (v) the aggregate principal amount of all Loans then outstanding, (vi) the Aggregate Credit Exposure at such time and (vii) the amount of the Commitments at such time.

(c) Upon each receipt by a Lender of notice from the Administrative Agent, such Lender shall purchase unconditionally, irrevocably, and severally (and not jointly) from the Swing Line Lender a participation in the outstanding Swing Line Loans (including accrued interest thereon) in an amount equal to the product of its Commitment Percentage and the outstanding balance of the Swing Line Loans (each, a ***"Swing Line Participation Amount"***). Each Lender shall also be liable for an amount equal to the product of its Commitment Percentage and any amounts paid by the Borrower pursuant to this Section 2.2 that are subsequently rescinded or avoided, or must otherwise be restored or returned. Such liabilities shall be unconditional and without regard to the occurrence of any Default or the compliance by the Borrower with any of its obligations under the Loan Documents.

(d) In furtherance of Section 2.2(c), upon each receipt by a Lender of notice from the Administrative Agent, such Lender shall promptly make available to the Administrative Agent for the account of the Swing Line Lender its Swing Line Participation Amount at the office of the Administrative Agent specified in Section 11.2, in Dollars and in immediately available funds. The Administrative Agent shall deliver the payments made by each Lender pursuant to the immediately preceding sentence to the Swing Line Lender promptly upon receipt thereof in like funds as received. Each Lender hereby indemnifies and agrees to hold harmless the Administrative Agent and the Swing Line Lender from and against any and all losses, liabilities (including liabilities for penalties), actions, suits, judgments, demands, costs and expenses resulting from any failure on the part of such Lender to pay, or from any delay in paying, the Administrative Agent any amount such Lender is required by notice from the Administrative Agent to pay in accordance with this Section 2.2 (except in respect of losses, liabilities or other obligations suffered by the Administrative Agent or the Swing Line Lender, as the case may be, resulting from the gross negligence or willful misconduct of the Administrative Agent or the Swing Line Lender, as the case may be), and such Lender shall pay interest to the Administrative Agent for the account of the Swing Line Lender from the date such amount was due until paid in full, on the unpaid portion thereof, at a rate of interest per annum, whether before or after judgment, equal to (i) from the date such amount was due until the third day therefrom, the Federal Funds Effective Rate (but not less than 0.0%), and (ii) thereafter, the Federal Funds Effective Rate (but not less than 0.0%) *plus* 2%, payable upon demand by the Swing Line Lender. The Administrative Agent shall distribute such interest payments to the Swing Line Lender upon receipt thereof in like funds as received.

(e) Whenever the Administrative Agent is reimbursed by the Borrower for the account of the Swing Line Lender for any payment in connection with Swing Line Loans and such payment relates to an amount previously paid by a Lender pursuant to this Section 2.2, the Administrative Agent will promptly remit such payment to such Lender.

2.3 ***Notice of Borrowing Revolving Credit Loans and Swing Line Loans***

The Borrower agrees to notify the Administrative Agent (and with respect to a Swing Line Loan, the Swing Line Lender), which notification shall be irrevocable, no later than (a) 2:00 P.M., on the proposed Borrowing Date in the case of Swing Line Loans, (b) 12:00 Noon on the proposed Borrowing Date in the case of Revolving Credit Loans to consist of ABR Advances and (c) 12:00 Noon at least three Eurodollar Business Days prior to the proposed Borrowing Date in the case of Revolving Credit Loans to consist of Eurodollar Advances. Each such notice shall specify (i) the aggregate amount requested to be borrowed under the Commitments or the Swing Line Commitment, (ii) the proposed Borrowing Date, (iii) whether a borrowing of Revolving Credit Loans is to be made as an ABR Advance, one or more Eurodollar Advances, or both, and the amount of each thereof, (iv) the Eurodollar Interest Period for each such Eurodollar Advance and (v) the Swing Line Interest Period for, and the amount of, each Swing Line Loan. Each such notice shall be promptly confirmed by delivery to the Administrative Agent (and, with respect to a Swing Line Loan, the Swing Line Lender) of a Borrowing Request. Each Eurodollar Advance to be made on a Borrowing Date, when aggregated with all amounts to be Converted to Eurodollar Advances on such date and having the same Interest Period as such Eurodollar Advance, shall equal no less than $10,000,000, or an integral multiple of $1,000,000 in excess thereof. Each ABR Advance made on each Borrowing Date shall equal no less than $5,000,000 or an integral multiple of $500,000 in excess thereof. Each Swing Line Loan made on each Borrowing Date shall equal no less than $1,000,000 or an integral multiple of $500,000 in excess thereof. The Administrative Agent shall promptly notify each Lender (by telephone or otherwise, such notification to be confirmed by fax, email or other writing) of each such Borrowing Request. Subject to its receipt of each such notice from the Administrative Agent and subject to the terms and conditions hereof, (A) each Lender shall make immediately available funds available to the Administrative Agent at the address therefor set forth in Section 11.2 not later than 1:00 P.M. on each Borrowing Date in an amount equal to such Lender's Commitment Percentage of the Revolving Credit Loans requested by the Borrower on such Borrowing Date and/or (B) the Swing Line Lender shall make immediately available funds available to the Borrower on such Borrowing Date in an amount equal to the Swing Line Loan requested by the Borrower.

2.4 ***Competitive Bid Loans and Procedure***

(a) Subject to the terms and conditions hereof, the Borrower may request competitive bid loans in Dollars under this Agreement (each a ***"Competitive Bid Loan"***) during the Commitment Period. In order to request Competitive Bids, the Borrower shall deliver by hand, fax or email to the Administrative Agent a duly completed and executed Competitive Bid Request not later than 12:00 Noon, one Domestic Business Day before the proposed Borrowing Date therefor. A Competitive Bid Request that does not conform substantially to the format of Exhibit F may be rejected by the Administrative Agent in the Administrative Agent's reasonable discretion, and the Administrative Agent shall promptly notify the Borrower of such rejection by fax or email and by telephone. Each Competitive Bid Request shall specify (x) the proposed Borrowing Date for the Competitive Bid Loans then being requested (which shall be a Domestic Business Day) and the aggregate principal amount thereof and (y) the Competitive Interest Period or Competitive Interest Periods (which shall not exceed ten different Interest Periods in a single Competitive Bid Request), with respect thereto (which may not end after the Domestic

Business Day immediately preceding the Commitment Termination Date). Promptly after its receipt of each Competitive Bid Request that is not rejected as aforesaid, the Administrative Agent shall invite by fax or email (in the form of Exhibit G) the Lenders (other than any Defaulting Lender) to bid, on the terms and conditions of this Agreement, to make Competitive Bid Loans pursuant to such Competitive Bid Request.

(b) Each Lender (other than any Defaulting Lender), in its sole and absolute discretion, may make one or more Competitive Bids to the Borrower responsive to a Competitive Bid Request. Each Competitive Bid by a Lender must be received by the Administrative Agent not later than 10:00 A.M. on the proposed Borrowing Date for the relevant Competitive Bid Loan. Multiple bids will be accepted by the Administrative Agent. Bids to make Competitive Bid Loans that, in the reasonable judgment of the Administrative Agent, do not conform to the Bids solicited by the related Competitive Bid Request shall be rejected by the Administrative Agent. Bids to make Competitive Bid Loans that do not conform substantially to the format of Exhibit H may be rejected by the Administrative Agent after conferring with, and upon the instruction of, the Borrower, and the Administrative Agent shall notify the Lender making such nonconforming bid of such rejection as soon as practicable. Each Competitive Bid shall be irrevocable and shall specify (x) the principal amount (which (1) shall be in a minimum principal amount of $10,000,000 or an integral multiple of $1,000,000 in excess thereof, and (2) may equal the entire principal amount requested by the Borrower) of the Competitive Bid Loan or Competitive Bid Loans that the Lender is willing to make to the Borrower, (y) the Competitive Bid Rate or Rates at which the Lender is prepared to make such Competitive Bid Loan or Competitive Bid Loans, and (z) the Competitive Interest Period with respect to each such Competitive Bid Loan and the last day thereof. If any Lender shall elect not to make a Competitive Bid, such Lender shall so notify the Administrative Agent by fax or email not later than 10:00 A.M. on the proposed Borrowing Date therefor, *provided* that the failure by any Lender to give any such notice shall not obligate such Lender to make any Competitive Bid Loan in connection with the relevant Competitive Bid Request.

(c) With respect to each Competitive Bid Request, the Administrative Agent shall (i) notify the Borrower by fax or email by 11:00 A.M. on the proposed Borrowing Date with respect thereto of each Competitive Bid made, the Competitive Bid Rate applicable thereto and the identity of the Lender that made such Competitive Bid, and (ii) send a list of all Competitive Bids to the Borrower for its records as soon as practicable after completion of the bidding process. Each notice and list sent by the Administrative Agent pursuant to this Section 2.4(c) shall list the Competitive Bids in ascending yield order.

(d) The Borrower may in its sole and absolute discretion, subject only to the provisions of this Section 2.4(d), accept or reject any Competitive Bid made in accordance with the procedures set forth in this Section 2.4, and the Borrower shall notify the Administrative Agent by telephone, confirmed by fax or email in the form of a duly completed and executed Competitive Bid Accept/Reject Letter, whether and to what extent it has decided to accept or reject any or all of such Competitive Bids not later than 12:00 Noon on the proposed Borrowing Date therefor; *provided* that the failure by the Borrower to give such notice shall be deemed to be a rejection of all such Competitive Bids. In connection with each acceptance of one or more Competitive Bids by the Borrower:

(1) the Borrower shall not accept a Competitive Bid of a given tenor made at a particular Competitive Bid Rate if the Borrower has decided to reject a Competitive Bid having the same tenor made at a lower Competitive Bid Rate unless the acceptance of such lower Competitive Bid would subject the Borrower to any requirement to withhold any taxes or deduct any amount from any amounts payable under the Loan Documents, in which case the Borrower may reject such lower Competitive Bid,

(2) the aggregate amount of the Competitive Bids accepted by the Borrower shall not exceed the principal amount specified in the Competitive Bid Request therefor,

(3) if the Borrower shall desire to accept a Competitive Bid made at a particular Competitive Bid Rate, it must accept all other Competitive Bids at such Competitive Bid Rate, except for any such Competitive Bid the acceptance of which would subject the Borrower to any requirement to withhold any taxes or deduct any amount from any amounts payable under the Loan Documents; *provided* that if the acceptance of all such other Competitive Bids would cause the aggregate amount of all such accepted Competitive Bids to exceed the amount requested, then such acceptance shall be made pro rata in accordance with the amount of each such Competitive Bid at such Competitive Bid Rate,

(4) except pursuant to clause (3) above, no Competitive Bid shall be accepted unless the Competitive Bid Loan with respect thereto shall be in a minimum principal amount of $10,000,000 or an integral multiple of $1,000,000 in excess thereof, and

(5) no Competitive Bid shall be accepted and no Competitive Bid Loan shall be made, if immediately after giving effect thereto, the Aggregate Credit Exposure would exceed the Aggregate Commitment Amount.

(e) The Administrative Agent shall promptly fax or email to each bidding Lender (with a copy to the Borrower) a Competitive Bid Accept/Reject Letter advising such Lender whether its Competitive Bid has been accepted (and if accepted, in what amount and at what Competitive Bid Rate), and each successful bidder so notified will thereupon become bound, subject to the other applicable conditions hereof, to make the Competitive Bid Loan in respect of which each of its Competitive Bids has been accepted by making immediately available funds available to the Administrative Agent at its address set forth in Section 11.2 not later than 1:00 P.M. on the Borrowing Date for such Competitive Bid Loan in the amount thereof.

(f) Anything herein to the contrary notwithstanding, if the Administrative Agent shall elect to submit a Competitive Bid in its capacity as a Lender, it shall submit such bid directly to the Borrower not later than 9:30 A.M. on the relevant proposed Borrowing Date.

(g) All notices required by this Section 2.4 shall be given in accordance with Section 11.2.

(h) Each Competitive Bid Loan shall be due and payable on the last day of the Interest Period applicable thereto or on such earlier date upon which the Loans shall become due and payable pursuant to the provisions hereof, whether by acceleration or otherwise.

2.5 ***Use of Proceeds***

The Borrower agrees that the proceeds of the Loans and Letters of Credit shall be used solely for its general corporate purposes, but not inconsistent with this Section 2.5. Notwithstanding anything to the contrary contained in any Loan Document, the Borrower further agrees that no part of the proceeds of any Loan or Letter of Credit will be used, directly or indirectly, and whether immediately, incidentally or ultimately (i) for a purpose which violates any law, rule or regulation of any Governmental Authority, including the provisions of Regulations U or X of the Board of Governors of the Federal Reserve System, as amended, or any provision of this Agreement, including, without limitation, the provisions of Section 4.9 or (ii) to make a loan to any director or executive officer of the Borrower or any Subsidiary.

2.6 ***Termination, Reduction or Increase of Commitments***

(a) *Termination on Commitment Termination Date*. Unless previously terminated, the Commitments and the Letter of Credit Commitment shall terminate on the Commitment Termination Date and the Swing Line Commitment shall terminate on the Swing Line Termination Date.

(b) *Voluntary Termination or Reductions*. At the Borrower's option and upon at least one Domestic Business Day's prior irrevocable notice to the Administrative Agent, the Borrower may (i) terminate the Commitments, the Swing Line Commitment and the Letter of Credit Commitment, at any time, or (ii) permanently reduce the Aggregate Commitment Amount, the Swing Line Commitment or the Letter of Credit Commitment, in part at any time and from time to time, *provided* that (1) each such partial reduction shall be in an amount equal to at least $5,000,000 or an integral multiple of $1,000,000 in excess thereof, and (2) immediately after giving effect to each such reduction, (A) the Aggregate Commitment Amount shall equal or exceed the Aggregate Credit Exposure, (B) the Swing Line Commitment shall equal or exceed the aggregate outstanding principal balance of all Swing Line Loans and (C) the Letter of Credit Commitment shall equal or exceed the Letter of Credit Exposure of all Lenders, and *provided*, *further* that, notwithstanding the foregoing, a notice of termination of the Commitments, the Swing Line Commitment and the Letter of Credit Commitment delivered by the Borrower may state that such notice is conditioned upon the effectiveness of other credit facilities (such notice to specify the proposed effective date), in which case such notice may be revoked by the Borrower (by notice to the Administrative Agent on or prior to such specified effective date) if such condition is not satisfied and the Borrower shall indemnify the Lenders in accordance with Section 3.5, if applicable.

(c) *In General*. Each reduction of the Aggregate Commitment Amount shall be made by reducing each Lender's Commitment Amount by an amount equal to the product of such Lender's Commitment Percentage and the amount of such reduction.

(d) *Increase in Aggregate Commitment Amount.* The Borrower may at any time and from time to time prior to the 90th day prior to the then-applicable Commitment Termination Date, at its sole cost and expense, request any one or more of the Lenders having a Commitment to increase its Commitment Amount (the decision to increase the Commitment Amount of a Lender to be within the sole and absolute discretion of such Lender), or any other Eligible Assignee reasonably satisfactory to the Administrative Agent, the Swing Line Lender and each Issuer to provide a new Commitment, by submitting to the Administrative Agent a Commitment Increase Supplement, duly executed by the Borrower and each such Lender or other Eligible Assignee, as the case may be. Upon receipt of any such Commitment Increase Supplement, the Administrative Agent, the Swing Line Lender and each Issuer shall promptly execute such Commitment Increase Supplement and the Administrative Agent shall deliver a copy thereof to the Borrower and each such Lender or other Eligible Assignee, as the case may be. Upon execution and delivery of such Commitment Increase Supplement by the Administrative Agent, the Swing Line Lender and each Issuer, (i) in the case of each such Lender (an ***"Increasing Lender"***), its Commitment Amount shall be increased to the amount set forth in such Commitment Increase Supplement, and (ii) in the case of each such other Eligible Assignee (a ***"New Lender"***), such New Lender shall become a party hereto and have the rights and obligations of a Lender under the Loan Documents and its Commitment shall be as set forth in such Commitment Increase Supplement; *provided* that:

(1) immediately after giving effect thereto, the sum of all increases in the Aggregate Commitment Amount made pursuant to this Section 2.6(d) shall not exceed $250,000,000;

(2) each such increase of the Aggregate Commitment Amount shall be in an amount not less than $25,000,000 or such amount plus an integral multiple of $5,000,000;

(3) no Default shall have occurred or be continuing on the effective date of the increase;

(4) the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on the effective date of such increase (provided that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such effective date), except those which are expressly specified to be made as of an earlier date;

(5) in the case of each New Lender, the Commitment Amount assumed by such New Lender shall not be less than $25,000,000;

(6) if Revolving Credit Loans would be outstanding immediately after giving effect to any such increase, then simultaneously with such increase (A) each such Increasing Lender, each such New Lender and each other Lender shall be deemed to have entered into a master assignment and assumption, in form and substance substantially similar to Exhibit E, pursuant to which each such other Lender shall have assigned to

each such Increasing Lender and each such New Lender a portion of its Revolving Credit Loans necessary to reflect proportionately the Commitments as increased in accordance with this Section 2.6(d), and (B) in connection with such assignment, each such Increasing Lender and each such New Lender shall pay to the Administrative Agent, for the account of each such other Lender, such amount as shall be necessary to reflect the assignment to it of Revolving Credit Loans, and in connection with such master assignment each such other Lender may treat the assignment of Eurodollar Advances as a prepayment of such Eurodollar Advances for purposes of Section 3.5;

(7) each such New Lender shall have delivered to the Administrative Agent an Administrative Questionnaire and to the Administrative Agent and the Borrower all forms, if any, that are required to be delivered by such New Lender pursuant to Section 3.10; and

(8) the Administrative Agent shall have received such other certificates, resolutions and opinions as the Administrative Agent shall have reasonably requested.

2.7 ***Prepayments of Loans***

(a) *Voluntary Prepayments*. The Borrower may prepay Revolving Credit Loans, Competitive Bid Loans and Swing Line Loans, in whole or in part, without premium or penalty, but subject to Section 3.5 at any time and from time to time, by notifying the Administrative Agent, which notification shall be irrevocable, at least two Eurodollar Business Days, in the case of a prepayment of Eurodollar Advances, two Domestic Business Days, in the case of a prepayment of Competitive Bid Loans, or one Domestic Business Day, in the case of a prepayment of Swing Line Loans or ABR Advances, prior to the proposed prepayment date specifying (i) the Loans to be prepaid, (ii) the amount to be prepaid, and (iii) the date of prepayment. Upon receipt of each such notice, the Administrative Agent shall promptly notify each Lender thereof. Each such notice given by the Borrower pursuant to this Section 2.7 shall be irrevocable, *provided* that, if a notice of prepayment is given in connection with a conditional notice of termination of the Commitments, the Swing Line Commitment and the Letter of Credit Commitment as contemplated by Section 2.6, then such notice of prepayment may be revoked if such notice of termination is revoked in accordance with Section 2.6, and the Borrower shall indemnify the Lenders in accordance with Section 3.5. Each partial prepayment under this Section 2.7 shall be (A) in the case of Eurodollar Advances, in a minimum amount of $5,000,000 or an integral multiple of $1,000,000 in excess thereof, (B) in the case of ABR Advances, in a minimum amount of $1,000,000 or an integral multiple of $100,000 in excess thereof, (C) in the case of Swing Line Loans, in a minimum amount of $500,000 or an integral multiple of $100,000 in excess thereof, and (D) in the case of Competitive Bid Loans, in a minimum amount of $5,000,000 or an integral multiple of $1,000,000 in excess thereof.

(b) *In General*. Simultaneously with each prepayment hereunder, the Borrower shall prepay all accrued interest on the amount prepaid through the date of prepayment and indemnify the Lenders in accordance with Section 3.5, if applicable.

2.8 ***Letter of Credit Sub-facility***

(a) Subject to the terms and conditions hereof and the payment by the Borrower to each Issuer of such fees as the Borrower and such Issuer shall have agreed in writing, each Issuer severally (and not jointly) agrees, in reliance on the agreement of the other Lenders set forth in Section 2.9, to issue standby or commercial letters of credit (each a ***"Letter of Credit"*** and, collectively, the ***"Letters of Credit"***) during the Commitment Period for the account of the Borrower; *provided* that immediately after the issuance of each Letter of Credit (i) the Letter of Credit Exposure of all Lenders shall not exceed the Aggregate Letter of Credit Commitment, (ii) the Aggregate Credit Exposure shall not exceed the Aggregate Commitment Amount, (iii) the Letter of Credit Exposure of such Issuer shall not exceed the Letter of Credit Commitment of such Issuer, and (iv) the Commercial Letter of Credit Exposure of such Issuer shall not exceed the Commercial Letter of Credit Commitment of such Issuer. Each Letter of Credit shall have an expiration date which shall be not later than, in the case of standby Letters of Credit, the earlier to occur of one year from the date of issuance thereof or 5 days prior to the Commitment Termination Date and, in the case of commercial Letters of Credit, the earlier to occur of 180 days from the date of issuance thereof or 5 days prior to the Commitment Termination Date. No Letter of Credit shall be issued if the Administrative Agent, or any Lender by notice to the Administrative Agent and the proposed Issuer no later than 3:00 P.M. one Domestic Business Day prior to the requested date of issuance of such Letter of Credit, shall have determined that the conditions set forth in Section 6 have not been satisfied or waived.

(b) Each Letter of Credit shall be issued at the request of the Borrower in support of an obligation of the Borrower or any Subsidiary in favor of a beneficiary who has requested the issuance of such Letter of Credit. The Borrower shall give the Administrative Agent a Letter of Credit Request for the issuance of each Letter of Credit by 12:00 Noon at least two Domestic Business Days prior to the requested date of issuance. Such Letter of Credit Request shall specify (i) whether such Letter of Credit is a standby or commercial Letter of Credit, (ii) the beneficiary of such Letter of Credit and the obligations of the Borrower or the Subsidiary in respect of which such Letter of Credit is to be issued, (iii) the Borrower's proposal as to the conditions under which a drawing may be made under such Letter of Credit and the documentation to be required in respect thereof, (iv) the maximum amount to be available under such Letter of Credit, (v) the requested date of issuance, and (vi) the name of the proposed Issuer thereof. Upon receipt of such Letter of Credit Request from the Borrower, the Administrative Agent shall promptly notify the applicable Issuer and each Lender thereof. Such Issuer shall, on the proposed date of issuance and subject to the other terms and conditions of this Agreement, issue the requested Letter of Credit; *provided* that in the event such Issuer fails to issue such Letter of Credit or is a Defaulting Lender, any other Issuer may (in its sole and absolute discretion, and notwithstanding that its Letter of Credit Exposure may exceed its Letter of Credit Commitment, but with (x) the consent of the Borrower and (y) notice to the Administrative Agent) issue such Letter of Credit otherwise in accordance with the terms hereof; *provided further* that immediately after the issuance thereof (A) the Letter of Credit Exposure of all Lenders shall not exceed the Aggregate Letter of Credit Commitment, and (B) the Aggregate Credit Exposure shall not exceed the Aggregate Commitment Amount. Each

Letter of Credit shall be in form and substance reasonably satisfactory to the Issuer thereof, with such provisions with respect to the conditions under which a drawing may be made thereunder and the documentation required in respect of such drawing as such Issuer shall reasonably require. Each Letter of Credit shall be used solely for the purposes described therein. Each Letter of Credit Request and each Letter of Credit shall be subject to the standard terms and conditions for letters of credit of the Issuer thereof (each as amended, supplemented or replaced from time to time, a ***"Reimbursement Agreement"***) executed by the Borrower and delivered to such Issuer.

(c) Each payment by an Issuer of a draft drawn under a Letter of Credit issued thereby shall give rise to the obligation of the Borrower to promptly (and in any event within one Domestic Business Day) reimburse such Issuer for the amount thereof. Such Issuer shall promptly notify the Borrower of such payment by such Issuer of a draft drawn under a Letter of Credit. In lieu of such notice, if the Borrower has not made reimbursement prior to the end of the Domestic Business Day following the day during which such Issuer made such payment of such draft, the Borrower hereby authorizes such Issuer to deduct the amount of any such reimbursement from such account(s) as the Borrower may from time to time designate in writing to such Issuer, upon which such Issuer shall apply the amount of such deduction to such reimbursement. If all or any portion of any Reimbursement Obligation in respect of a Letter of Credit shall not be paid on the date that the Issuer thereof shall have made payment of a draft drawn under such Letter of Credit, the amount of such Reimbursement Obligation shall bear interest, at a rate per annum equal to the Alternate Base Rate *plus* the Applicable Margin applicable to ABR Advances, from the date such Issuer made such payment of such draft until the end of the Domestic Business Day following the day during which such Issuer made such payment of such draft (whether at the stated maturity thereof, by acceleration or otherwise), and from and after such Domestic Business Day (whether at the stated maturity thereof, by acceleration or otherwise), such Reimbursement Obligation shall bear interest, payable upon demand, at a rate per annum equal to the Alternate Base Rate *plus* the Applicable Margin applicable to ABR Advances *plus* 2%, from such due date until paid in full (whether before or after the entry of a judgment thereon).

(d) In the event of any conflict between the terms hereof and the terms of any Reimbursement Agreement or Letter of Credit Application, the terms hereof shall control.

2.9 ***Letter of Credit Participation***

(a) Each Lender hereby unconditionally and irrevocably, severally (and not jointly) takes an undivided participating interest in the obligations of each Issuer under and in connection with each Letter of Credit issued thereby in an amount equal to such Lender's Commitment Percentage (as in effect from time to time) of the amount of such Letter of Credit. Each Lender shall be liable to each Issuer for its Commitment Percentage of the unreimbursed amount of any draft drawn and honored under each Letter of Credit issued thereby. Each Lender shall also be liable for an amount equal to the product of its Commitment Percentage and any amounts paid by the Borrower pursuant to Section 2.8 that are subsequently rescinded or avoided, or must otherwise be restored or returned. Such liabilities shall be unconditional and without regard to the occurrence of any Default or the compliance by the Borrower with any of its obligations under the Loan Documents.

(b) Each Issuer shall promptly notify the Administrative Agent, and the Administrative Agent shall promptly notify each Lender (which notice shall be promptly confirmed in writing), of the date and the amount of each draft paid under each Letter of Credit

issued by such Issuer with respect to which full reimbursement payment shall not have been made by the Borrower as provided in Section 2.8(c), and forthwith upon receipt of such notice, such Lender shall promptly make available to the Administrative Agent for the account of such Issuer its Commitment Percentage of the amount of such unreimbursed draft at the office of the Administrative Agent specified in Section 11.2 in Dollars and in immediately available funds. The Administrative Agent shall distribute the payments made by each Lender pursuant to the immediately preceding sentence to such Issuer promptly upon receipt thereof in like funds as received. Each Lender shall indemnify and hold harmless the Administrative Agent and each Issuer from and against any and all losses, liabilities (including liabilities for penalties), actions, suits, judgments, demands, costs and expenses (including, without limitation, reasonable attorneys' fees and expenses) resulting from any failure on the part of such Lender to provide, or from any delay in providing, the Administrative Agent with such Lender's Commitment Percentage of the amount of any payment made by such Issuer under a Letter of Credit issued by such Issuer in accordance with this clause (b) (except in respect of losses, liabilities or other obligations suffered by the Administrative Agent or such Issuer, as the case may be, resulting from the gross negligence or willful misconduct of the Administrative Agent or such Issuer, as the case may be). If a Lender does not make available to the Administrative Agent when due an amount equal to such Lender's Commitment Percentage of any unreimbursed payment made by an Issuer under a Letter of Credit issued thereby, such Lender shall be required to pay interest to the Administrative Agent for the account of such Issuer on the unpaid portion of such amount at a rate of interest per annum equal to (i) from the date such Lender should have made such amount available until the third day therefrom, the Federal Funds Effective Rate, and (ii) thereafter, the Federal Funds Effective Rate *plus* 2%, in each case payable upon demand by such Issuer. The Administrative Agent shall distribute such interest payments to such Issuer upon receipt thereof in like funds as received.

(c) Whenever the Administrative Agent is reimbursed by the Borrower, for the account of an Issuer, for any payment under a Letter of Credit issued thereby and such payment relates to an amount previously paid by a Lender in respect of its Commitment Percentage of the amount of such payment under such Letter of Credit, the Administrative Agent (or such Issuer, if such payment by a Lender was paid by the Administrative Agent to such Issuer) will promptly pay over such payment to such Lender.

2.10 *Absolute Obligation with respect to Letter of Credit Payments*

The Borrower's obligation to reimburse the Administrative Agent for the account of an Issuer for each payment under or in respect of each Letter of Credit issued thereby shall be absolute and unconditional under any and all circumstances and irrespective of any set-off, counterclaim or defense to payment which the Borrower may have or have had against the beneficiary of such Letter of Credit, the Administrative Agent, such Issuer, the Swing Line Lender, any Lender or any other Person, including, without limitation, any defense based on the failure of any drawing to conform to the terms of such Letter of Credit, any drawing document proving to be forged, fraudulent or invalid, or the legality, validity, regularity or enforceability of such Letter of Credit, *provided* that, with respect to any Letter of Credit, the foregoing shall not relieve the Issuer thereof of any liability it may have to the Borrower for any actual damages sustained by the Borrower arising from a wrongful payment (or failure to pay) under such Letter of Credit made as a result of such Issuer's gross negligence or willful misconduct.

2.11 ***Notes***

Any Lender may request that the Loans made by it be evidenced by a Note. In such event, the Borrower shall prepare, execute and deliver to such Lender a Note payable to such Person or, if requested by such Person, such Person and its registered assigns. Thereafter, all Loans evidenced by such Note and interest thereon shall at all times (including after assignment pursuant to Section 11.7) be represented by a Note in like form payable to the payee named therein and its registered assigns.

2.12 ***Extension of Commitment Termination Date***

(a) *Request for Extension*. The Borrower may, by notice to the Administrative Agent (which shall promptly notify the Lenders) not more than 90 days and not less than 30 days prior to each of the first, second, third, fourth and fifth anniversary of the Effective Date (each such anniversary date, an ***"Extension Date"***), request (each, an ***"Extension Request"***) that the Lenders extend the Commitment Termination Date then in effect (the ***"Existing Commitment Termination Date"***) for an additional one year period, *provided* that the Borrower may only effect one such extension of the Commitment Termination Date. Each Lender, acting in its sole discretion, shall, by notice to the Borrower and the Administrative Agent given not later than the 20th day (or such later day as shall be acceptable to the Borrower) following the date of the Borrower's notice, advise the Borrower and the Administrative Agent whether or not such Lender agrees to such extension; *provided* that any Lender (which includes each Issuer and the Swing Line Lender) that does not so advise the Borrower and the Administrative Agent shall be deemed to have rejected such Extension Request. The election of any Lender to agree to such extension shall not obligate any other Lender to so agree.

(b) *Replacement of Non-Extending Lenders*. The Borrower shall have the right at any time on or prior to the relevant Extension Date to replace any Lender which has not consented to the Extension Request (each, a ***"Non-Extending Lender"***) pursuant to Section 3.13.

(c) *Conditions to Effectiveness of Extension*. Notwithstanding anything in this Agreement to the contrary, the extension of the Existing Commitment Termination Date on any Extension Date shall not be effective unless, immediately before and after giving effect to such extension on such Extension Date: (i) no Default shall have occurred and be continuing on such Extension Date and the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on such Extension Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such Extension Date), except those which are expressly specified to be made as of an earlier date, and the Administrative Agent shall have received a certificate, in form and substance reasonably satisfactory to the Administrative Agent, to such effect from the chief financial officer of the Borrower (or such other financial officer reasonably acceptable to the Administrative Agent), and (ii) the Administrative Agent shall have received such other certificates, resolutions and opinions as the Administrative Agent may reasonably request.

(d) *Effectiveness of Extension*. If (and only if) the conditions specified in Section 2.12(c) have been satisfied or waived with respect to the extension of the Existing Commitment Termination Date on the applicable Extension Date, then, effective as of such Extension Date, the Commitment Termination Date, with respect to the Commitment of each Lender that has agreed to so extend its Commitment and of each Replacement Lender that has assumed a Commitment of a Non-Extending Lender in connection with such Extension Request, shall be extended to the date falling one year after the Existing Commitment Termination Date (or, if such date is not a Domestic Business Day, the immediately preceding Domestic Business Day), and each such Replacement Lender shall thereupon become a "Lender" for all purposes of this Agreement. Notwithstanding anything herein to the contrary, (i) with respect to any portion of the Commitment of any Non-Extending Lender that has not been fully assumed by one or more Replacement Lenders, the Commitment Termination Date for such Lender with respect to such non-assumed portion of its Commitment shall remain unchanged, and (ii) with respect to any Loans of such Lender that have not been purchased by one or more Replacement Lenders, the applicable maturity date with respect to such non-purchased Loans shall remain unchanged and shall be repayable by the Borrower on such applicable maturity date without there being any requirement that any such repayment be shared with other Lenders. In addition, on the Extension Date, the Borrower agrees to pay all accrued and unpaid interest, fees and other amounts then due under this Agreement from the Borrower to each Lender consenting to the Extension Request, each Non-Extending Lender and each Replacement Lender. Solely for the purpose of calculating break funding payments under Section 3.5, the assignment by any Non-Extending Lender of any Eurodollar Advance prior to the last day of the Interest Period applicable thereto in accordance with this Section 2.12 shall be deemed to constitute a prepayment by the Borrower of such Eurodollar Advance.

2.13 ***Defaulting Lenders***

Notwithstanding any provision of this Agreement to the contrary, if any Lender becomes a Defaulting Lender, then the following provisions shall apply for so long as such Lender is a Defaulting Lender:

(a) Facility Fees shall cease to accrue on the unfunded portion of the Commitment of such Defaulting Lender pursuant to Section 3.11;

(b) the Commitment and Committed Credit Exposure of such Defaulting Lender shall not be included in determining whether all Lenders or the Required Lenders have taken or may take any action hereunder (including any consent to any amendment or waiver pursuant to Section 11.1); *provided* that any waiver, amendment or modification with respect to the following shall require the consent of such Defaulting Lender: (i) any waiver, amendment or modification requiring the consent of all Lenders or each affected Lender which affects such Defaulting Lender differently than other affected Lenders, (ii) any waiver, amendment or modification increasing the Commitment of such Defaulting Lender, (iii) any waiver, amendment or modification extending the Commitment Period with respect to such Defaulting Lender, (iv) any waiver, amendment or modification reducing the principal amount owed under the Loan Documents to such Defaulting Lender (other than by payment thereof), or (v) any waiver, amendment or modification extending the final maturity of sums owed to such Defaulting Lender, or (vi) a modification of this Section 2.13(b);

(c) if any Swing Line Exposure or Letter of Credit Exposure exists at the time a Lender becomes a Defaulting Lender then:

(1) all or any part of such Defaulting Lender's Swing Line Exposure and Letter of Credit Exposure shall be reallocated among the non-Defaulting Lenders in accordance with their respective Commitment Percentages but only to the extent that (A) the sum of all non-Defaulting Lenders' Committed Credit Exposures plus, without duplication, the amount of such Defaulting Lender's Swing Line Exposure and Letter of Credit Exposure reallocated to such non-Defaulting Lenders, does not exceed the total of all non-Defaulting Lenders' Commitments and (B) with respect to each non-Defaulting Lender, the sum of such non-Defaulting Lender's Committed Credit Exposure plus, without duplication, the amount of such Defaulting Lender's Swing Line Exposure and Letter of Credit Exposure reallocated to such non-Defaulting Lender, does not exceed such non-Defaulting Lender's Commitment;

(2) if the reallocation described in clause (1) above cannot, or can only partially, be effected, the Borrower shall within one Domestic Business Day following notice by the Administrative Agent (A) first, prepay such Swing Line Exposure and (B) second, cash collateralize such Defaulting Lender's Letter of Credit Exposure (after giving effect to any partial reallocation pursuant to clause (1) above) in a manner satisfactory to the Administrative Agent and the Issuers for so long as such Letter of Credit Exposure is outstanding;

(3) if the Borrower cash collateralizes any portion of such Defaulting Lender's Letter of Credit Exposure pursuant to this Section 2.13(c), the Borrower shall not be required to pay any Letter of Credit Participation Fees to such Defaulting Lender pursuant to Section 3.12 with respect to such Defaulting Lender's Letter of Credit Exposure during the period such Defaulting Lender's Letter of Credit Exposure is cash collateralized; and

(4) if the Swing Line Exposure or Letter of Credit Exposure of such Defaulting Lender is reallocated pursuant to this Section 2.13(c), then the fees payable to the Lenders pursuant to Section 3.11 and Section 3.12 shall be adjusted to give effect to such reallocation, and the Administrative Agent shall promptly notify the Lenders of any reallocation described in this Section 2.13(c);

(d) so long as any Lender is a Defaulting Lender, the Swing Line Lender shall not be required to fund any Swing Line Loan and no Issuer shall be required to issue, amend, extend or increase any Letter of Credit, unless it is satisfied that the related exposure will be 100% covered by the Commitments of the non-Defaulting Lenders and/or cash collateral will be provided by the Borrower in accordance with Section 2.13(c), and participating interests in any such newly issued or increased Letter of Credit or newly made Swing Line Loan shall be allocated among non-Defaulting Lenders in a manner consistent with Section 2.13(c)(1) (and Defaulting Lenders shall not participate therein);

(e) any amount payable to such Defaulting Lender hereunder (whether on account of principal, interest, fees or otherwise and including any amount that would otherwise

be payable to such Defaulting Lender pursuant to Section 11.9 but excluding Section 3.13) shall, in lieu of being distributed to such Defaulting Lender, be retained by the Administrative Agent in a segregated account and, subject to any applicable requirements of law, be applied at such time or times as may be determined by the Administrative Agent (i) first, to the payment of any amounts owing by such Defaulting Lender to the Administrative Agent hereunder, (ii) second, pro rata, to the payment of any amounts owing by such Defaulting Lender to the Issuers and the Swing Line Lender hereunder, (iii) third, if so determined by the Administrative Agent or requested by any Issuer or the Swing Line Lender, held in such account as cash collateral for future funding obligations of the Defaulting Lender in respect of any existing or future participating interest in any Swing Line Loan or Letter of Credit, (iv) fourth, to the funding of any Revolving Credit Loan (including any Mandatory Borrowing) in respect of which such Defaulting Lender has failed to fund its portion thereof as required by this Agreement, as determined by the Administrative Agent, (v) fifth, if so determined by the Administrative Agent and the Borrower, held in such account as cash collateral for future funding obligations of the Defaulting Lender in respect of any Revolving Credit Loans (including any Mandatory Borrowings) under this Agreement, (vi) sixth, to the payment of any amounts owing to the Lenders, the Issuers or the Swing Line Lender as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by any Lender, any Issuer or the Swing Line Lender against such Defaulting Lender as a result of such Defaulting Lender's breach of its obligations under this Agreement, (vii) seventh, to the payment of any amounts owing to the Borrower as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by the Borrower against such Defaulting Lender as a result of such Defaulting Lender's breach of its obligations under this Agreement, and (viii) eighth, to such Defaulting Lender or as otherwise directed by a court of competent jurisdiction; *provided* that if such payment is (x) a prepayment of the principal amount of any Revolving Credit Loan (including any Mandatory Borrowing) or Reimbursement Obligations in respect of drawings under Letters of Credit paid by an Issuer with respect to which a Defaulting Lender has funded its participation obligations and (y) made at a time when the conditions set forth in Section 6 are satisfied or waived, such payment shall be applied solely to prepay the Revolving Credit Loans (including Mandatory Borrowings) of, and Reimbursement Obligations owed to, all non-Defaulting Lenders pro rata prior to being applied to the prepayment of any Loans, or Reimbursement Obligations owed to, any Defaulting Lender;

(f) The Borrower shall have the right at any time during which a Lender is a Defaulting Lender to replace such Defaulting Lender pursuant to Section 3.13; and

(g) Subject to Section 11.22, no reallocation pursuant to Section 2.13(c) shall constitute a waiver or release of any claim of any party hereunder against a Defaulting Lender arising from a Lender having become a Defaulting Lender, including any claim of a non-Defaulting Lender as a result of such non-Defaulting Lender's increased exposure following such reallocation.

3. *PROCEEDS, PAYMENTS, CONVERSIONS, INTEREST, YIELD PROTECTION AND FEES*

3.1 *Disbursement of the Proceeds of the Loans*

The Administrative Agent shall disburse the proceeds of the Loans (other than the Swing Line Loans) at its office specified in Section 11.2 by crediting to the Borrower's general deposit account with the Administrative Agent the funds received from each Lender. Unless the Administrative Agent shall have received prior notice from a Lender (by telephone or otherwise, such notice to be confirmed by fax, email or other writing) that such Lender will not make available to the Administrative Agent such Lender's Commitment Percentage of the Revolving Credit Loans, or the amount of any Competitive Bid Loan, to be made by it on a Borrowing Date, the Administrative Agent may assume that such Lender has made such amount available to the Administrative Agent on such Borrowing Date in accordance with this Section 3.1, *provided* that, in the case of a Revolving Credit Loan, such Lender received notice thereof from the Administrative Agent in accordance with the terms hereof, and the Administrative Agent may, in reliance upon such assumption, make available to the Borrower on such Borrowing Date a corresponding amount. If and to the extent such Lender shall not have so made such amount available to the Administrative Agent, such Lender and the Borrower severally agree to pay to the Administrative Agent, forthwith on demand, such corresponding amount (to the extent not previously paid by the other), together with interest thereon for each day from the date such amount is made available to the Borrower until the date such amount is paid to the Administrative Agent, at a rate per annum equal to, in the case of the Borrower, the applicable interest rate set forth in Section 3.4(a) and, in the case of such Lender, the Federal Funds Effective Rate (but not less than 0.0%) from the date such payment is due until the third day after such date and, thereafter, at the Federal Funds Effective Rate (but not less than 0.0%) *plus* 2%. Any such payment by the Borrower shall be without prejudice to its rights against such Lender. If such Lender shall pay to the Administrative Agent such corresponding amount, such amount so paid shall constitute such Lender's Loan as part of such Loans for purposes of this Agreement, which Loan shall be deemed to have been made by such Lender on the Borrowing Date applicable to such Loans.

3.2 *Payments*

(a) Each payment, including each prepayment, of principal and interest on the Loans and of the Facility Fee and the Letter of Credit Participation Fee (collectively, together with all of the other fees to be paid to the Administrative Agent, the Lenders, the Issuers and the Swing Line Lender in connection with the Loan Documents, the ***"Fees"***), and of all of the other amounts to be paid to the Administrative Agent and the Lenders in connection with the Loan Documents (other than amounts payable to a Lender under Section 3.5, Section 3.6, Section 3.10, Section 11.5 and Section 11.10) shall be made by the Borrower to the Administrative Agent at its office specified in Section 11.2 without setoff, deduction or counterclaim in funds immediately available in New York by 3:00 P.M. on the due date for such payment. The failure of the Borrower to make any such payment by such time shall not constitute a default hereunder, *provided* that such payment is made on such due date, but any such payment made after 3:00 P.M. on such due date shall be deemed to have been made on the next Domestic Business Day or Eurodollar Business Day, as the case may be, for the purpose of calculating interest on amounts outstanding on the Loans. If the Borrower has not made any such payment prior to 3:00 P.M.,

the Borrower hereby authorizes the Administrative Agent to deduct the amount of any such payment from such account(s) as the Borrower may from time to time designate in writing to the Administrative Agent, upon which the Administrative Agent shall apply the amount of such deduction to such payment. Promptly upon receipt thereof by the Administrative Agent, each payment of principal and interest on the: (i) Revolving Credit Loans shall be remitted by the Administrative Agent in like funds as received to each Lender (a) first, pro rata according to the amount of interest which is then due and payable to the Lenders, and (b) second, pro rata according to the amount of principal which is then due and payable to the Lenders, (ii) Competitive Bid Loans shall be remitted by the Administrative Agent in like funds as received to each applicable Lender and (iii) Swing Line Loans shall be remitted by the Administrative Agent in like funds as received to the Swing Line Lender. Each payment of the Facility Fee and the Letter of Credit Participation Fee payable to the Lenders shall be promptly transmitted by the Administrative Agent in like funds as received to each Lender pro rata according to such Lender's Commitment Amount or, if the Commitments shall have terminated or been terminated, according to the outstanding principal amount of such Lender's Revolving Credit Loans.

(b) If any payment hereunder or under the Loans shall be due and payable on a day which is not a Domestic Business Day or a Eurodollar Business Day, as the case may be, the due date thereof (except as otherwise provided in the definition of Eurodollar Interest Period or Competitive Interest Period) shall be extended to the next Domestic Business Day or Eurodollar Business Day, as the case may be,, and (except with respect to payments in respect of the Facility Fee and the Letter of Credit Participation Fee) interest shall be payable at the applicable rate specified herein during such extension.

3.3 ***Conversions; Other Matters***

(a) The Borrower may elect at any time and from time to time to Convert one or more Eurodollar Advances to an ABR Advance by giving the Administrative Agent at least one Domestic Business Day's prior irrevocable notice of such election, specifying the amount to be so Converted. In addition, the Borrower may elect at any time and from time to time to Convert an ABR Advance to any one or more new Eurodollar Advances or to Convert any one or more existing Eurodollar Advances to any one or more new Eurodollar Advances by giving the Administrative Agent no later than 10:00 A.M. at least two Eurodollar Business Days' prior irrevocable notice of such election, specifying the amount to be so Converted and the initial Interest Period relating thereto, *provided* that any Conversion of an ABR Advance to an Eurodollar Advance shall only be made on a Eurodollar Business Day. The Administrative Agent shall promptly provide the Lenders with notice of each such election. Each Conversion of Loans shall be made pro rata according to the outstanding principal amount of the Loans of each Lender. ABR Advances and Eurodollar Advances may be Converted pursuant to this Section 3.3 in whole or in part, *provided* that the amount to be Converted to each Eurodollar Advance, when aggregated with any Eurodollar Advance to be made on such date in accordance with Section 2.1 and having the same Interest Period as such first Eurodollar Advance, shall equal no less than $10,000,000 or an integral multiple of $1,000,000 in excess thereof.

(b) Notwithstanding anything in this Agreement to the contrary, the Borrower shall not have the right to elect to Convert any existing ABR Advance to a Eurodollar Advance or to Convert any existing Eurodollar Advance to a new Eurodollar Advance if (i) a Default or

Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) shall then exist, or (ii) any other Event of Default shall then exist and the Administrative Agent shall have notified the Borrower at the request of the Required Lenders that no ABR Advance or Eurodollar Advance may be Converted to a new Eurodollar Advance. In such event, such ABR Advance shall be automatically continued as an ABR Advance or such Eurodollar Advance shall be automatically Converted to an ABR Advance on the last day of the Interest Period applicable to such Eurodollar Advance. The foregoing shall not affect any other rights or remedies that the Administrative Agent or any Lender may have under this Agreement or any other Loan Document.

(c) Each Conversion shall be effected by each Lender by applying the proceeds of each new ABR Advance or Eurodollar Advance, as the case may be, to the existing ABR Advance or Eurodollar Advance (or portion thereof) being Converted (it being understood that such Conversion shall not constitute a borrowing for purposes of Section 4 or Section 6).

(d) Notwithstanding any other provision of any Loan Document:

(1) if the Borrower shall have failed to elect a Eurodollar Advance under Section 2.3 or this Section 3.3, as the case may be, in connection with any borrowing of new Revolving Credit Loans or expiration of an Interest Period with respect to any existing Eurodollar Advance, the amount of the Revolving Credit Loans subject to such borrowing or such existing Eurodollar Advance shall thereafter be an ABR Advance until such time, if any, as the Borrower shall elect a new Eurodollar Advance pursuant to this Section 3.3,

(2) the Borrower shall not be permitted to select a Eurodollar Advance the Interest Period in respect of which ends later than the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6, and

(3) the Borrower shall not be permitted to have more than 15 Eurodollar Advances and Competitive Bid Loans, in the aggregate, outstanding at any one time; it being understood and agreed that each borrowing of Eurodollar Advances or Competitive Bid Loans pursuant to a single Borrowing Request or Competitive Bid Request, as the case may be, shall constitute the making of one Eurodollar Advance or Competitive Bid Loan for the purpose of calculating such limitation.

3.4 ***Interest Rates and Payment Dates***

(a) *Prior to Maturity*. Except as otherwise provided in Section 3.4(b) and Section 3.4(c), the Loans shall bear interest on the unpaid principal balance thereof at the applicable interest rate or rates per annum set forth below:

LOANS	**RATE**
Revolving Credit Loans constituting ABR Advances	Alternate Base Rate *plus* the Applicable Margin.
Revolving Credit Loans constituting Eurodollar Advances	Eurodollar Rate applicable thereto *plus* the Applicable Margin.
Competitive Bid Loans	Fixed rate of interest applicable thereto accepted by the Borrower pursuant to Section 2.4(d).

Swing Line Loans	Negotiated Rate applicable thereto as provided in Section 2.2(a).

(b) *After Maturity, Late Payment Rate*. After maturity, whether by acceleration, notice of intention to prepay or otherwise, the outstanding principal balance of each Loan shall bear interest at the applicable interest rate on such Loan *plus* 2% per annum until paid (whether before or after the entry of any judgment thereon). Any payment of principal or interest on the Loans, Fees or other amounts payable by the Borrower under the Loan Documents not paid on the date when due and payable shall bear interest, in the case of principal or interest on a Loan, at the applicable interest rate on such Loan *plus* 2% per annum and, in the case of any Fees or other amounts, at the Alternate Base Rate *plus* the Applicable Margin *plus* 2% per annum, in each case from the due date thereof until the date such payment is made (whether before or after the entry of any judgment thereon).

(c) *Highest Lawful Rate*. Notwithstanding anything to the contrary contained in this Agreement, at no time shall the interest rate payable to any Lender on any of its Loans, together with the Fees and all other amounts payable hereunder to such Lender to the extent the same constitute or are deemed to constitute interest, exceed the Highest Lawful Rate. If in respect of any period during the term of this Agreement, any amount paid to any Lender hereunder, to the extent the same shall (but for the provisions of this Section 3.4) constitute or be deemed to constitute interest, would exceed the maximum amount of interest permitted by the Highest Lawful Rate during such period (such amount being hereinafter referred to as an ***"Unqualified Amount"***), then (i) such Unqualified Amount shall be applied or shall be deemed to have been applied as a prepayment of the Loans of such Lender, and (ii) if, in any subsequent period during the term of this Agreement, all amounts payable hereunder to such Lender in respect of such period which constitute or shall be deemed to constitute interest shall be less than the maximum amount of interest permitted by the Highest Lawful Rate during such period, then the Borrower shall pay to such Lender in respect of such period an amount (each a ***"Compensatory Interest Payment"***) equal to the lesser of (x) a sum which, when added to all such amounts, would equal the maximum amount of interest permitted by the Highest Lawful Rate during such period, and (y) an amount equal to the aggregate sum of all Unqualified Amounts *less* all other Compensatory Interest Payments.

(d) *General*. Interest shall be payable in arrears on each Interest Payment Date, on the Commitment Termination Date, to the extent provided in Section 2.7(b), upon each prepayment of the Loans and, to the extent provided in Section 2.12(d), on the Extension Date. Any change in the interest rate on the Loans resulting from an increase or a decrease in the Alternate Base Rate or any reserve requirement shall become effective as of the opening of

business on the day on which such change shall become effective. The Administrative Agent shall, as soon as practicable, notify the Borrower and the Lenders of the effective date and the amount of each change in the BNY Mellon Rate, but any failure to so notify shall not in any manner affect the obligation of the Borrower to pay interest on the Loans in the amounts and on the dates set forth herein. Each determination by the Administrative Agent of the Alternate Base Rate, the Eurodollar Rate and the Competitive Bid Rate pursuant to this Agreement shall be conclusive and binding on the Borrower absent manifest error. The Borrower acknowledges that to the extent interest payable on the Loans is based on the Alternate Base Rate, such rate is only one of the bases for computing interest on loans made by the Lenders, and by basing interest payable on ABR Advances on the Alternate Base Rate, the Lenders have not committed to charge, and the Borrower has not in any way bargained for, interest based on a lower or the lowest rate at which the Lenders may now or in the future make extensions of credit to other Persons. All interest (other than interest calculated with reference to the BNY Mellon Rate) shall be calculated on the basis of a 360-day year for the actual number of days elapsed, and all interest determined with reference to the BNY Mellon Rate shall be calculated on the basis of a 365/366-day year for the actual number of days elapsed.

3.5 *Indemnification for Loss*

Notwithstanding anything contained herein to the contrary, if: (i) the Borrower shall fail to borrow a Eurodollar Advance or if the Borrower shall fail to Convert all or any portion of any Revolving Credit Loan constituting an ABR Advance to a Eurodollar Advance after it shall have given notice to do so in which it shall have requested a Eurodollar Advance pursuant to Section 2.3 or Section 3.3, as the case may be, (ii) the Borrower shall fail to borrow a Competitive Bid Loan after it shall have accepted any offer with respect thereto in accordance with Section 2.4 or a Swing Line Loan after it shall have agreed to a Negotiated Rate with respect thereto in accordance with Section 2.2(a), (iii) a Eurodollar Advance, Competitive Bid Loan or Swing Line Loan shall be terminated for any reason prior to the last day of the Interest Period applicable thereto (other than the termination of a Swing Line Loan resulting from a Mandatory Borrowing at a time when no Default shall exist), (iv) any repayment or prepayment of the principal amount of a Eurodollar Advance, Competitive Bid Loan or Swing Line Loan is made for any reason on a date which is prior to the last day of the Interest Period applicable thereto (other than the repayment or prepayment of a Swing Line Loan resulting from a Mandatory Borrowing at a time when no Default shall exist), (v) the Borrower shall have revoked a notice of prepayment or notice of termination of the Commitments, the Swing Line Commitment and the Letter of Credit Commitment that was conditioned upon the effectiveness of other credit facilities pursuant to Section 2.6 or Section 2.7, or (vi) a Eurodollar Advance is assigned other than on the last day of the Interest Period applicable thereto as a result of an increase in the Aggregate Commitment Amount pursuant to Section 2.6(d) or a replacement of a Lender pursuant to clause (x) or (z) of Section 3.13, then the Borrower agrees to indemnify each Lender against, and to pay on demand directly to such Lender the amount (calculated by such Lender using any method chosen by such Lender which is customarily used by such Lender for such purpose for borrowers similar to the Borrower) equal to any loss or expense suffered by such Lender as a result of such failure to borrow or Convert, or such termination, repayment, prepayment or revocation, including any loss, cost or expense suffered by such Lender in liquidating or employing deposits acquired to fund or maintain the funding of such Eurodollar Advance, Competitive Bid Loan or Swing Line Loan, as the case may be, or redeploying funds prepaid or repaid, in amounts which correspond to such Eurodollar Advance, Competitive Bid Loan

or Swing Line Loan, as the case may be, and any reasonable internal processing charge customarily charged by such Lender in connection therewith for borrowers similar to the Borrower.

3.6 ***Reimbursement for Costs, Etc.***

If at any time or from time to time there shall occur a Regulatory Change and any Issuer or any Lender shall have reasonably determined that such Regulatory Change (i) shall have had or will thereafter have the effect of reducing (A) the rate of return on such Issuer's or such Lender's capital or liquidity or the capital or liquidity of any Person directly or indirectly owning or controlling such Issuer or such Lender (each a ***"Control Person"***), or (B) the asset value (for capital or liquidity purposes) to such Issuer, such Lender or such Control Person, as applicable, of the Reimbursement Obligations, or any participation therein, or the Loans, or any participation therein, in any case to a level below that which such Issuer, such Lender or such Control Person could have achieved or would thereafter be able to achieve but for such Regulatory Change (after taking into account such Issuer's, such Lender's or such Control Person's policies regarding capital or liquidity), (ii) will impose, modify or deem applicable any reserve, asset, special deposit or special assessment requirements on deposits obtained in the interbank eurodollar market in connection with the Loan Documents (excluding, with respect to any Eurodollar Advance, any such requirement which is included in the determination of the rate applicable thereto), or (iii) will subject such Issuer, such Lender or such Control Person, as applicable, to any tax (documentary, stamp or otherwise) with respect to this Agreement, any Note, any Reimbursement Agreement or any other Loan Document (except, in the case of clause (iii) above, for any Indemnified Taxes, Excluded Taxes or Other Taxes) then, in each such case, within ten days after demand by such Issuer or such Lender, as applicable, the Borrower shall pay directly to such Issuer, such Lender or such Control Person, as the case may be, such additional amount or amounts as shall be sufficient to compensate such Issuer, such Lender or such Control Person, as the case may be, for any such reduction, reserve or other requirement, tax, loss, cost or expense (excluding general administrative and overhead costs) (collectively, ***"Costs"***) attributable to such Issuer's, such Lender's or such Control Person's compliance during the term hereof with such Regulatory Change, but only if such Costs are generally applicable to (and for which reimbursement is generally being sought by such Issuer, such Lender or such Control Person, as applicable, in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this Section 3.6), as determined by such Issuer or such Lender, as applicable, in its reasonable discretion. Each Issuer and each Lender may make multiple requests for compensation under this Section 3.6.

Notwithstanding the foregoing, the Borrower will not be required to compensate any Lender for any Costs under this Section 3.6 arising prior to 45 days preceding the date of demand, unless the applicable Regulatory Change giving rise to such Costs is imposed retroactively. In the case of retroactivity, such notice shall be provided to the Borrower not later than 45 days from the date that such Lender learned of such Regulatory Change. The Borrower's obligation to compensate such Lender shall be contingent upon the provision of such timely notice (but any failure by such Lender to provide such timely notice shall not affect the Borrower's obligations with respect to (i) Costs incurred from the date as of which such Regulatory Change became effective to the date that is 45 days after the date such Lender reasonably should have learned of such Regulatory Change and (ii) Costs incurred following the provision of such notice).

3.7 *Illegality of Funding*

Notwithstanding any other provision hereof, if any Lender shall reasonably determine that any law, regulation, treaty or directive, or any change therein or in the interpretation or application thereof, shall make it unlawful for such Lender to make or maintain any Eurodollar Advance as contemplated by this Agreement, such Lender shall promptly notify the Borrower and the Administrative Agent thereof, and (a) the commitment of such Lender to make such Eurodollar Advances or Convert ABR Advances to such Eurodollar Advances shall forthwith be suspended, (b) such Lender shall fund its portion of each requested Eurodollar Advance as an ABR Advance and (c) such Lender's Loans then outstanding as such Eurodollar Advances, if any, shall be Converted automatically to an ABR Advance on the last day of the then current Interest Period applicable thereto or at such earlier time as may be required. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7 and such Lender shall have obtained actual knowledge that it is once again legal for such Lender to make or maintain Eurodollar Advances, such Lender shall promptly notify the Administrative Agent and the Borrower thereof and, upon receipt of such notice by each of the Administrative Agent and the Borrower, such Lender's commitment to make or maintain Eurodollar Advances shall be reinstated. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7, such suspension shall not otherwise affect such Lender's Commitment.

3.8 *Option to Fund; Substituted Interest Rate*

(a) Each Lender has indicated that, if the Borrower requests a Swing Line Loan, a Eurodollar Advance or a Competitive Bid Loan, such Lender may wish to purchase one or more deposits in order to fund or maintain its funding of its Commitment Percentage of such Eurodollar Advance or its Swing Line Loan or Competitive Bid Loan during the Interest Period with respect thereto; it being understood that the provisions of this Agreement relating to such funding are included only for the purpose of determining the rate of interest to be paid in respect of such Swing Line Loan, Eurodollar Advance or Competitive Bid Loan and any amounts owing under Section 3.5 and Section 3.6. The Swing Line Lender and each Lender shall be entitled to fund and maintain its funding of all or any part of each Swing Line Loan, Eurodollar Advance and Competitive Bid Loan in any manner it sees fit, but all such determinations hereunder shall be made as if such Lender had actually funded and maintained its Commitment Percentage of each Eurodollar Advance or its Swing Line Loan or Competitive Bid Loan, as the case may be, during the applicable Interest Period through the purchase of deposits in an amount equal to the amount of its Commitment Percentage of such Eurodollar Advance or the amount of such Swing Line Loan or Competitive Bid Loan, as the case may be, and having a maturity corresponding to such Interest Period. Each Lender may fund its Loans from or for the account of any branch or office of such Lender as such Lender may choose from time to time, subject to Section 3.10.

(b) In the event that (i) the Administrative Agent shall have determined in good faith (which determination shall be conclusive and binding upon the Borrower) that Dollar deposits are not being offered to banks in the London interbank eurodollar market for the applicable amount and Interest Period or if by reason of circumstances affecting the interbank eurodollar market adequate and reasonable means do not exist for ascertaining the Eurodollar Rate applicable pursuant to Section 2.3 or Section 3.3, or (ii) the Required Lenders shall have notified the Administrative Agent that they have in good faith determined (which determination

shall be conclusive and binding on the Borrower) that the applicable Eurodollar Rate will not adequately and fairly reflect the cost to such Lenders of maintaining or funding loans bearing interest based on such Eurodollar Rate with respect to any portion of the Revolving Credit Loans that the Borrower has requested be made as Eurodollar Advances or any Eurodollar Advance that will result from the requested Conversion of any portion of the Revolving Credit Loans into Eurodollar Advances (each, an ***"Affected Advance"***), the Administrative Agent shall promptly notify the Borrower and the Lenders (by telephone or otherwise, to be promptly confirmed in writing) of such determination on or, to the extent practicable, prior to the requested Borrowing Date or Conversion date for such Affected Advances. If the Administrative Agent shall give such notice, (A) any Affected Advances shall be made as ABR Advances, (B) the Revolving Credit Loans (or any portion thereof) that were to have been Converted to Affected Advances shall be Converted to or continued as ABR Advances, and (C) any outstanding Affected Advances shall be Converted, on the last day of the then current Interest Period with respect thereto, to ABR Advances. Until any notice under clauses (i) or (ii), as the case may be, of this Section 3.8(b) has been withdrawn by the Administrative Agent (by notice to the Borrower) promptly upon either (x) the Administrative Agent having determined that such circumstances affecting the relevant market no longer exist and that adequate and reasonable means do exist for determining the Eurodollar Rate pursuant to Section 2.3 or Section 3.3, or (y) the Administrative Agent having been notified by the Required Lenders that circumstances no longer render the Loans (or any portion thereof) Affected Advances, no further Eurodollar Advances shall be required to be made by the Lenders nor shall the Borrower have the right to Convert all or any portion of the Revolving Credit Loans to Eurodollar Advances.

3.9 *Certificates of Payment and Reimbursement*

Each Issuer and each Lender agrees, in connection with any request by it for payment or reimbursement pursuant to Section 3.5 or Section 3.6, to provide the Borrower with a certificate, signed by an officer of such Issuer or such Lender, as the case may be, setting forth a description in reasonable detail of any such payment or reimbursement and the applicable Section of this Agreement pursuant to and in accordance with which such request is made. Each determination by such Issuer and such Lender of such payment or reimbursement shall be conclusive absent manifest error.

3.10 *Taxes; Net Payments*

(a) *Payments Free of Taxes*. Any and all payments by or on account of any obligation of the Borrower hereunder or under any other Loan Document shall be made free and clear of and without reduction or withholding for any Indemnified Taxes or Other Taxes, *provided* that if the Borrower shall be required by applicable law to deduct any Indemnified Taxes (including any Other Taxes) from such payments, then (i) the sum payable shall be increased as necessary so that after making all required deductions (including deductions applicable to additional sums payable under this Section 3.10) the Administrative Agent, the applicable Lender or the applicable Issuer, as the case may be, receives an amount equal to the sum it would have received had no such deductions for Indemnified Taxes or Other Taxes been made, (ii) the Borrower shall make such deductions and (iii) the Borrower shall timely pay the full amount deducted to the relevant Governmental Authority in accordance with applicable law.

(b) *Payment of Other Taxes by the Borrower*. Without limiting the provisions of paragraph (a) above, the Borrower shall timely pay any Other Taxes to the relevant Governmental Authority in accordance with applicable law.

(c) *Indemnification by the Borrower*. The Borrower shall indemnify the Administrative Agent, each Lender and each Issuer, within 30 days after demand therefor, for the full amount of any Indemnified Taxes imposed on or with respect to any payment made by or on account of any obligation of the Borrower under any Loan Document or Other Taxes (including Indemnified Taxes or Other Taxes imposed or asserted on or attributable to amounts payable under this Section 3.10) paid by the Administrative Agent, such Lender or such Issuer, as the case may be, and, without duplication, any penalties, interest and reasonable expenses arising therefrom or with respect thereto, whether or not such Indemnified Taxes or Other Taxes were correctly or legally imposed or asserted by the relevant Governmental Authority. A certificate as to the amount of such payment or liability delivered to the Borrower by such Lender or such Issuer (with a copy to the Administrative Agent), or by the Administrative Agent on its own behalf or on behalf of such Lender or such Issuer, shall be conclusive absent manifest error. After any Lender or any Issuer (as the case may be) learns of the imposition of any Indemnified Taxes or Other Taxes, such Lender or such Issuer (as the case may be) will as soon as reasonably practicable notify the Borrower thereof; *provided* that the failure to provide Borrower with such notice shall not release the Borrower from its indemnification obligations under this Section 3.10.

(d) *Evidence of Payments*. As soon as practicable after any payment of Indemnified Taxes or Other Taxes by the Borrower to a Governmental Authority, the Borrower shall deliver to the Administrative Agent the original or a certified copy of a receipt issued by such Governmental Authority evidencing such payment, a copy of the return reporting such payment or other evidence of such payment reasonably satisfactory to the Administrative Agent.

(e) *Indemnification by the Lenders*. Each Lender shall severally indemnify the Administrative Agent, within 10 days after demand therefor, for (i) any Indemnified Taxes attributable to such Lender (but only to the extent that the Borrower has not already indemnified the Administrative Agent for such Indemnified Taxes and without limiting the obligation of the Borrower to do so), (ii) any Taxes attributable to such Lender's failure to comply with the provisions of Section 11.7(d) relating to the maintenance of a Participant Register, and (iii) any Excluded Taxes attributable to such Lender, in each case, that are payable or paid by the Administrative Agent in connection with any Loan Document, and any reasonable expenses arising therefrom or with respect thereto, whether or not such Taxes were correctly or legally imposed or asserted by the relevant Governmental Authority. A certificate as to the amount of such payment or liability delivered to any Lender by the Administrative Agent shall be conclusive absent manifest error. Each Lender hereby authorizes the Administrative Agent to set off and apply any and all amounts at any time owing to such Lender under any Loan Document or otherwise payable by the Administrative Agent to the Lender from any other source against any amount due to the Administrative Agent under this paragraph (e).

(f) *Status of Lenders*. Any Lender that is entitled to an exemption from or reduction of withholding Tax under the law of the jurisdiction in which the Borrower is resident for Tax purposes, or any treaty to which such jurisdiction is a party, with respect to payments

hereunder or under any other Loan Document shall deliver to the Borrower (with a copy to the Administrative Agent), at the time or times prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent, such properly completed and executed documentation prescribed by applicable law as will permit such payments to be made without withholding or at a reduced rate of withholding. In addition, any Lender, if requested by the Borrower or the Administrative Agent, shall deliver such other documentation prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent as will enable the Borrower or the Administrative Agent to determine whether or not such Lender is subject to backup withholding or information reporting requirements.

Without limiting the generality of the foregoing, any Foreign Lender shall deliver to the Borrower and the Administrative Agent (in such number of copies as shall be requested by the recipient) on or prior to the date on which such Foreign Lender becomes a Lender under this Agreement (and from time to time thereafter (i) if such Foreign Lender shall determine that any applicable form or certification has expired or will then expire or has or will then become obsolete or incorrect or that an event has occurred that requires or will then require a change in the most recent form or certification previously delivered by it to the Borrower and the Administrative Agent and (ii) upon the request of the Borrower or the Administrative Agent, but only if such Foreign Lender is legally entitled to do so), whichever of the following is applicable:

(i) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E claiming eligibility for benefits of an income Tax treaty to which the United States of America is a party,

(ii) duly completed copies of Internal Revenue Service Form W-8ECI,

(iii) in the case of a Foreign Lender claiming the benefits of the exemption for portfolio interest under Section 881(c) of the Internal Revenue Code, (x) a certificate (a ***"United States Tax Compliance Certificate"***) to the effect that such Foreign Lender is not (A) a "bank" within the meaning of Section 881(c)(3)(A) of the Internal Revenue Code, (B) a "10 percent shareholder" of the Borrower within the meaning of Section 881(c)(3)(B) of the Internal Revenue Code, (C) a "controlled foreign corporation" described in Section 881(c)(3)(C) of the Internal Revenue Code nor (D) engaged in the conduct of a trade or business within the United States to which the interest payment is effectively connected and (y) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E,

(iv) to the extent a Foreign Lender is not the beneficial owner (for example, where the Foreign Lender is a partnership or participating Lender granting a typical participation), a complete and executed Internal Revenue Service Form W-8IMY, accompanied by a Form W-8ECI, Form W-8BEN, Form W-8BEN-E, a United States Tax Compliance Certificate, Internal Revenue Service Form W-9 and/or other certification documents from each beneficial owner, as applicable; *provided* that, if the Foreign Lender is a partnership (and not a participating Lender) and one or more partners of such Foreign Lender are claiming the portfolio interest exemption, such Foreign Lender shall provide a United States Tax Compliance Certificate, on behalf of such beneficial owner(s) in lieu of requiring each beneficial owner to provide its own certificate, or

(v) any other form prescribed by applicable law as a basis for claiming exemption from or a reduction in United States Federal withholding Tax duly completed together with such supplementary documentation as may be prescribed by applicable law to permit the Borrower to determine the withholding or deduction required to be made.

If a payment made to a Lender under any Loan Document would be subject to U.S. federal withholding Tax imposed by FATCA if such Lender were to fail to comply with the applicable reporting requirements of FATCA (including those contained in Section 1471(b) or 1472(b) of the Internal Revenue Code, as applicable), such Lender shall deliver to the Borrower and the Administrative Agent at the time or times prescribed by law and at such time or times reasonably requested by the Borrower or the Administrative Agent such documentation prescribed by applicable law (including as prescribed by Section 1471(b)(3)(C) of the Internal Revenue Code) and such additional documentation reasonably requested by the Borrower or the Administrative Agent as may be necessary for the Borrower and the Administrative Agent to comply with their obligations under FATCA and to determine that such Lender has complied with such Lender's obligations under FATCA or to determine the amount to deduct and withhold from such payment. Solely for purposes of this clause, "FATCA" shall include any amendments made to FATCA after the date of this Agreement.

Without limiting the foregoing, upon request of the Administrative Agent or the Borrower, each Lender and each Issuer that is a "United States person" within the meaning of Section 7701(a)(30) of the Internal Revenue Code that lends to the Borrower (each, a ***"U.S. Lender"***) shall deliver to the Administrative Agent and the Borrower two duly signed, properly completed copies of Internal Revenue Service Form W-9 on or prior to the Effective Date (or on or prior to the date it becomes a party to this Agreement), certifying that such U.S. Lender is entitled to an exemption from United States backup withholding, or any successor form.

(g) *Treatment of Certain Refunds*. If the Administrative Agent, a Lender or an Issuer determines, in its sole discretion exercised in good faith, that it has received a refund of any Taxes or Other Taxes as to which it has been indemnified by the Borrower or with respect to which the Borrower has paid additional amounts pursuant to this Section 3.10, it shall pay to the Borrower an amount equal to such refund (but only to the extent of indemnity payments made, or additional amounts paid, by the Borrower under this Section 3.10 with respect to the Taxes or Other Taxes giving rise to such refund), net of all reasonable and documented out-of-pocket expenses of the Administrative Agent, such Lender or such Issuer, as the case may be, and without interest (other than any interest paid by the relevant Governmental Authority with respect to such refund), *provided* that the Borrower, upon the request of the Administrative Agent, such Lender or such Issuer, agrees to repay the amount paid over to the Borrower (plus any penalties, interest or other charges imposed by the relevant Governmental Authority) to the Administrative Agent, such Lender or such Issuer in the event the Administrative Agent, such Lender or such Issuer is required to repay such refund or Tax credit to such Governmental Authority. This paragraph shall not be construed to require the Administrative Agent, any Lender or any Issuer to make available its Tax returns (or any other information relating to its Taxes that it deems confidential) to the Borrower or any other Person.

(h) *Designation of a Different Lending Office*. If any Lender requests compensation under Section 3.6, or requires the Borrower to pay any additional amount to any

Lender or any Governmental Authority for the account of any Lender pursuant to this Section 3.10, then such Lender shall use reasonable efforts to designate a different lending office for funding or booking its Loans hereunder or to assign its rights and obligations hereunder to another of its offices, branches or affiliates, if, in the judgment of such Lender, such designation or assignment (i) would eliminate or reduce amounts payable pursuant to Section 3.6 or this Section 3.10, as the case may be, in the future and (ii) would not subject such Lender to any unreimbursed cost or expense and would not otherwise be disadvantageous to such Lender. The Borrower hereby agrees to pay all reasonable and documented out-of-pocket costs and expenses incurred by any Lender in connection with any such designation or assignment.

(i) *Survival*. Each party's obligations under this Section 3.10 shall survive the resignation or replacement of the Administrative Agent or any assignment of rights by, or the replacement of, a Lender, the termination of the Commitments and the repayment, satisfaction or discharge of all obligations under any Loan Document.

3.11 ***Facility Fees***

The Borrower agrees to pay to the Administrative Agent for the account of each Lender a fee (the ***"Facility Fee"***) during the period commencing on the Effective Date and ending on the Expiration Date, payable quarterly in arrears on the last day of each March, June, September and December of each year, commencing on the last day of the calendar quarter during which the Facility Fee shall commence to accrue, and on the Expiration Date, at a rate per annum equal to the Applicable Margin of (a) prior to the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6, the Commitment Amount of such Lender (whether used or unused), and (b) thereafter, the sum of (i) the outstanding principal balance of all Revolving Credit Loans of such Lender, (ii) such Lender's Swing Line Exposure and (iii) such Lender's Letter of Credit Exposure. Notwithstanding anything to the contrary contained in this Section 3.11, on and after the Commitment Termination Date, the Facility Fee shall be payable upon demand. In addition, upon each reduction of the Aggregate Commitment Amount, the Borrower shall pay the Facility Fee accrued on the amount of such reduction through the date of such reduction. The Facility Fee shall be computed on the basis of a 360-day year for the actual number of days elapsed.

3.12 ***Letter of Credit Participation Fee***

The Borrower agrees to pay to the Administrative Agent for the pro rata account of each Lender a fee (the ***"Letter of Credit Participation Fee"***) with respect to the Letters of Credit during the period commencing on the Effective Date and ending on the Commitment Termination Date or, if later, the date when the Letter of Credit Exposure of all Lenders is $0, payable quarterly in arrears on the last day of each March, June, September and December of each year, commencing on the last day of the calendar quarter in which the Effective Date shall have occurred, and on the last date of such period, at a rate per annum equal to (i) in the case of standby Letters of Credit, the Applicable Margin of the average daily aggregate amount which may be drawn under all standby Letters of Credit during such period (whether or not the

conditions for drawing thereunder have or may be satisfied) multiplied by such Lender's Commitment Percentage, and (ii) in the case of commercial Letters of Credit, the Applicable Margin of the average daily aggregate amount which may be drawn under all commercial Letters of Credit during such period (whether or not the conditions for drawing thereunder have or may be satisfied) multiplied by such Lender's Commitment Percentage. The Letter of Credit Participation Fee shall be computed on the basis of a 360-day year for the actual number of days elapsed.

3.13 *Replacement of Lender*

If (x) the Borrower is obligated to pay to any Lender any amount under Section 3.6 or Section 3.10, the Borrower shall have the right within 90 days thereafter, (y) any Lender shall be a Defaulting Lender, the Borrower shall have the right at any time during which such Lender shall remain a Defaulting Lender, or (z) any Lender shall have not consented to an Extension Request, the Borrower shall have the right at any time on the relevant Extension Date, in each case in accordance with the requirements of Section 11.7(b) and only if no Default shall exist, to replace such Lender (the ***"Replaced Lender"***) with one or more Eligible Assignees (each a ***"Replacement Lender"***), reasonably acceptable to the Administrative Agent, the Swing Line Lender and each Issuer, *provided* that (i) at the time of any replacement pursuant to this Section 3.13, the Replacement Lender shall enter into one or more Assignment and Assumptions pursuant to Section 11.7(b) (with the processing and recordation fee referred to in Section 11.7(b) payable pursuant to said Section 11.7(b) to be paid by the Replacement Lender) pursuant to which the Replacement Lender shall acquire the Commitment, the outstanding Loans, the Swing Line Exposure and the Letter of Credit Exposure of the Replaced Lender and, in connection therewith, shall pay the following: (a) to the Replaced Lender, an amount equal to the sum of (A) an amount equal to the principal of, and all accrued interest on, all outstanding Loans and Swing Line Participation Amounts of the Replaced Lender, (B) an amount equal to all drawings on all Letters of Credit that have been funded by (and not reimbursed to) such Replaced Lender, together with all then unpaid interest with respect thereto at such time, and (C) an amount equal to all accrued, but unpaid, fees owing to the Replaced Lender, (b) to each Issuer, an amount equal to such Replaced Lender's Commitment Percentage of all drawings on Letters of Credit issued by such Issuer (which at such time remain unpaid drawings) to the extent such amount was not funded by such Replaced Lender, (c) to the Swing Line Lender, an amount equal to such Replaced Lender's Commitment Percentage of any Mandatory Borrowing to the extent such amount was not funded by such Replaced Lender, and (d) to the Administrative Agent an amount equal to all amounts owed by such Replaced Lender to the Administrative Agent under this Agreement, including, without limitation, an amount equal to the principal of, and all accrued interest on, all outstanding Loans of the Replaced Lender, a corresponding amount of which was made available by the Administrative Agent to the Borrower pursuant to Section 3.1 and which has not been repaid to the Administrative Agent by such Replaced Lender or the Borrower, and (ii) all obligations of the Borrower owing to the Replaced Lender (other than those specifically described in clause (i) above in respect of which the assignment purchase price has been, or is concurrently being, paid) shall be paid in full to such Replaced Lender concurrently with such replacement. Upon the execution of the respective Assignment and Assumptions and the payment of amounts referred to in clauses (i) and (ii) of this Section 3.13, the Replacement Lender shall become a Lender hereunder and the Replaced Lender shall cease to constitute a Lender hereunder, except with respect to indemnification provisions under this Agreement that are intended to survive the termination of the Commitments and the repayment of the Loans which may be applicable to any such Replaced Lender prior to the date of its replacement. Solely for the purpose of calculating break funding payments under Section 3.5, the assignment by any Replaced Lender of any Eurodollar Advance prior to the last day of the

Interest Period applicable thereto pursuant to clause (x) or (z) of this Section 3.13 shall be deemed to constitute a prepayment by the Borrower of such Eurodollar Advance.

4. *REPRESENTATIONS AND WARRANTIES*

In order to induce the Administrative Agent, the Lenders and the Issuers to enter into this Agreement, the Lenders to make the Loans and the Issuers to issue Letters of Credit, the Borrower hereby makes the following representations and warranties to the Administrative Agent, the Lenders and the Issuers:

4.1 *Existence and Power*

Each of the Borrower and the Subsidiaries is duly organized, validly existing and in good standing under the laws of the jurisdiction of its incorporation or formation (except, in the case of the Subsidiaries, where the failure to be in such good standing could not reasonably be expected to have a Material Adverse effect), has all requisite corporate power and authority to own its Property and to carry on its business as now conducted, and is qualified to do business as a foreign corporation and is in good standing in each jurisdiction in which it owns or leases real Property or in which the nature of its business requires it to be so qualified (except those jurisdictions where the failure to be so qualified or to be in good standing could not reasonably be expected to have a Material Adverse effect).

4.2 *Authority; EEA Financial Institution*

The Borrower has full corporate power and authority to enter into, execute, deliver and perform the terms of the Loan Documents, all of which have been duly authorized by all proper and necessary corporate action and are not in contravention of any applicable law or the terms of its Certificate of Incorporation and By-Laws. No consent or approval of, or other action by, shareholders of the Borrower, any Governmental Authority, or any other Person (which has not already been obtained) is required to authorize in respect of the Borrower, or is required in connection with, the execution, delivery, and performance by the Borrower of the Loan Documents or is required as a condition to the enforceability of the Loan Documents against the Borrower. The Borrower is not an EEA Financial Institution.

4.3 *Binding Agreement*

The Loan Documents constitute the valid and legally binding obligations of the Borrower, enforceable in accordance with their respective terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by equitable principles relating to the availability of specific performance as a remedy.

4.4 *Litigation*

As of the Effective Date, there are no actions, suits, arbitration proceedings or claims (whether purportedly on behalf of the Borrower, any Subsidiary or otherwise) pending or, to the knowledge of the Borrower, threatened against the Borrower or any Subsidiary or any of their respective Properties, or maintained by the Borrower or any Subsidiary, at law or in equity,

before any Governmental Authority which could reasonably be expected to have a Material Adverse effect. There are no proceedings pending or, to the knowledge of the Borrower, threatened against the Borrower or any Subsidiary (a) which call into question the validity or enforceability of any Loan Document, or otherwise seek to invalidate, any Loan Document, or (b) which might, individually or in the aggregate, materially and adversely affect any of the transactions contemplated by any Loan Document.

4.5 ***No Conflicting Agreements***

(a) Neither the Borrower nor any Subsidiary is in default under any agreement to which it is a party or by which it or any of its Property is bound the effect of which could reasonably be expected to have a Material Adverse effect. No notice to, or filing with, any Governmental Authority is required for the due execution, delivery and performance by the Borrower of the Loan Documents.

(b) No provision of any existing material mortgage, material indenture, material contract or material agreement or of any existing statute, rule, regulation, judgment, decree or order binding on the Borrower or any Subsidiary or affecting the Property of the Borrower or any Subsidiary conflicts with, or requires any consent which has not already been obtained under, or would in any way prevent the execution, delivery or performance, by the Borrower of the terms of, any Loan Document. Neither the execution and delivery, nor the performance, by the Borrower of the terms of each Loan Document will constitute a default under, or result in the creation or imposition of, or obligation to create, any Lien upon the Property of the Borrower or any Subsidiary pursuant to the terms of any such mortgage, indenture, contract or agreement.

4.6 ***Taxes***

The Borrower and each Subsidiary has filed or caused to be filed all tax returns, and has paid, or has made adequate provision for the payment of, all taxes shown to be due and payable on said returns or in any assessments made against them, the failure of which to file or pay could reasonably be expected to have a Material Adverse effect, and no tax Liens (other than Liens permitted under Section 8.2) have been filed against the Borrower or any Subsidiary and no claims are being asserted with respect to such taxes which are required by GAAP to be reflected in the Financial Statements and are not so reflected, except for taxes which have been assessed but which are not yet due and payable. The charges, accruals and reserves on the books of the Borrower and each Subsidiary with respect to all federal, state, local and other taxes are considered by the management of the Borrower to be adequate, and the Borrower knows of no unpaid assessment which (a) could reasonably be expected to have a Material Adverse effect, or (b) is or might be due and payable against it or any Subsidiary or any Property of the Borrower or any Subsidiary, except such thereof as are being contested in good faith and by appropriate proceedings diligently conducted, and for which adequate reserves have been set aside in accordance with GAAP or which have been assessed but are not yet due and payable.

4.7 ***Compliance with Applicable Laws; Filings***

Neither the Borrower nor any Subsidiary is in default with respect to any judgment, order, writ, injunction, decree or decision of any Governmental Authority which default could reasonably be expected to have a Material Adverse effect. The Borrower and each Subsidiary is complying with all applicable statutes, rules and regulations of all Governmental Authorities, a violation of which could reasonably be expected to have a Material Adverse effect. The Borrower and each Subsidiary has filed or caused to be filed with all Governmental Authorities all reports, applications, documents, instruments and information required to be filed pursuant to all applicable laws, rules, regulations and requests which, if not so filed, could reasonably be expected to have a Material Adverse effect.

4.8 ***Governmental Regulations***

The Borrower is not subject to regulation under the Investment Company Act of 1940, as amended.

4.9 ***Federal Reserve Regulations; Use of Proceeds***

The Borrower is not engaged principally, or as one of its important activities, in the business of extending credit for the purpose of purchasing or carrying any Margin Stock. No part of the proceeds of the Loans or the Letters of Credit has been or will be used, directly or indirectly, and whether immediately, incidentally or ultimately, for a purpose which violates the provisions of Regulations T, U or X of the Board of Governors of the Federal Reserve System, as amended. Anything in this Agreement to the contrary notwithstanding, neither any Issuer nor any Lender shall be obligated to extend credit to or on behalf of the Borrower in violation of any limitation or prohibition provided by any applicable law, regulation or statute, including said Regulation U. Following application of the proceeds of each Loan and the issuance of each Letter of Credit, not more than 25% (or such greater or lesser percentage as is provided in the exclusions from the definition of "Indirectly Secured" contained in said Regulation U as in effect at the time of the making of such Loan or issuance of such Letter of Credit) of the value of the assets of the Borrower and the Subsidiaries on a Consolidated basis that are subject to Section 8.2 will be Margin Stock. In addition, no part of the proceeds of any Loan or Letter of Credit will be used, whether directly or indirectly, and whether immediately, incidentally or ultimately, to make a loan to any director or executive officer of the Borrower or any Subsidiary.

4.10 ***No Misrepresentation***

No representation or warranty contained in any Loan Document and no certificate or written report furnished by the Borrower to the Administrative Agent or any Lender pursuant to any Loan Document contains, as of its date, a misstatement of a material fact, or omits to state, as of its date, a material fact required to be stated in order to make the statements therein contained, when taken as a whole, not materially misleading (*provided* that any representation, warranty, statement or written report that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such date) in the light of the circumstances under which made (after giving effect to all supplements and updates with

respect thereto) (it being understood that the Borrower makes no representation or warranty hereunder with respect to any projections or other forward looking information).

4.11 ***Plans***

The Borrower, each Subsidiary and each ERISA Affiliate have complied with the material requirements of Section 515 of ERISA with respect to each Pension Plan which is a Multiemployer Plan, except where the failure to so comply could not reasonably be expected to have a Material Adverse effect. The Borrower, each Subsidiary and each ERISA Affiliate has, as of the date hereof, made all contributions or payments to or under each Pension Plan required by law or the terms of such Pension Plan or any contract or agreement, except where the failure to make such contributions or payments could not reasonably be expected to have a Material Adverse effect. No liability to the PBGC has been, or is reasonably expected by the Borrower, any Subsidiary or any ERISA Affiliate to be, incurred by the Borrower, any Subsidiary or any ERISA Affiliate that could reasonably be expected to have a Material Adverse effect. Liability, as referred to in this Section 4.11, includes any joint and several liability, but excludes any current or, to the extent it represents future liability in the ordinary course, any future liability for premiums under Section 4007 of ERISA.

4.12 ***Environmental Matters***

Neither the Borrower nor any Subsidiary (a) has received written notice or otherwise learned of any claim, demand, action, event, condition, report or investigation indicating or concerning any potential or actual liability which individually or in the aggregate could reasonably be expected to have a Material Adverse effect, arising in connection with (i) any non-compliance with or violation of the requirements of any applicable Environmental Law, or (ii) the release or threatened release of any Hazardous Material, (b) to the best knowledge of the Borrower, has any threatened or actual liability in connection with the release or threatened release of any Hazardous Material into the environment which individually or in the aggregate could reasonably be expected to have a Material Adverse effect, (c) has received notice of any federal or state investigation evaluating whether any remedial action is needed to respond to a release or threatened release of any Hazardous Material into the environment for which the Borrower or any Subsidiary is or would be liable, which liability would reasonably be expected to have a Material Adverse effect, or (d) has received notice that the Borrower or any Subsidiary is or may be liable to any Person under the Comprehensive Environmental Response, Compensation and Liability Act, as amended, 42 U.S.C. Section 9601 et seq., or any analogous state law, which liability would reasonably be expected to have a Material Adverse effect. The Borrower and each Subsidiary is in compliance with the financial responsibility requirements of federal and state Environmental Laws to the extent applicable, including those contained in 40 C.F.R., parts 264 and 265, subpart H, and any analogous state law, except in those cases in which the failure so to comply would not reasonably be expected to have a Material Adverse effect.

4.13 ***Financial Statements***

The Borrower has heretofore delivered to the Lenders through the Administrative Agent copies of the audited Consolidated Balance Sheet of the Borrower and its Subsidiaries as of December 31, 2016, and the related Consolidated Statements of Income,

Comprehensive Income, Shareholders' Equity and Cash Flows for the fiscal year then ended. The financial statements referred to immediately above, including all related notes and schedules, are herein referred to collectively as the ***"Financial Statements"***. The Financial Statements fairly present, in all material respects, the Consolidated financial condition and results of the operations of the Borrower and the Subsidiaries as of the dates and for the periods indicated therein and, except as noted therein, have been prepared in conformity with GAAP as then in effect. Neither the Borrower nor any of the Subsidiaries has any material obligation or liability of any kind (whether fixed, accrued, contingent, unmatured or otherwise) which, in accordance with GAAP as then in effect, should have been disclosed in the Financial Statements and was not. During the period from January 1, 2017 to and including the Effective Date, there was no Material Adverse change, including as a result of any change in law, in the Consolidated financial condition, operations, business or Property of the Borrower and the Subsidiaries taken as a whole.

4.14 *Anti-Corruption Laws and Sanctions*

The Borrower has implemented and maintains in effect policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions, and the Borrower, the Subsidiaries and their respective officers and employees and, to the knowledge of the Borrower, its directors are in compliance with Anti-Corruption Laws and applicable Sanctions in all material respects. None of (a) the Borrower, any Subsidiary or, to the knowledge of the Borrower or such Subsidiary, any of their respective directors, officers or employees, or (b) to the knowledge of the Borrower, any agent of the Borrower or any Subsidiary that will act in any capacity in connection with or benefit from the credit facility established hereby, is a Sanctioned Person. No Loan or Letter of Credit, use of proceeds or other transaction contemplated by this Agreement will violate Anti-Corruption Laws or applicable Sanctions.

5. *CONDITIONS TO EFFECTIVENESS*

This Agreement shall become effective on and as of the date (the ***"Effective Date"***) that the following conditions shall have been satisfied:

5.1 *Agreement*

The Administrative Agent shall have received counterparts of this Agreement executed by the Borrower, the Administrative Agent, each Issuer and each Lender.

5.2 *Notes*

The Administrative Agent shall have received a Note, executed by the Borrower, for each Lender that shall have given at least three Domestic Business Days' prior written notice of its request for a Note.

5.3 *Corporate Action*

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Secretary or an Assistant Secretary of the Borrower (i) attaching a true and complete copy of the resolutions of its Board of Directors and of all documents evidencing all other necessary

corporate action (in form and substance reasonably satisfactory to the Administrative Agent) taken by the Borrower to authorize this Agreement, the other Loan Documents and the transactions contemplated hereby and thereby, (ii) attaching a true and complete copy of its Certificate of Incorporation and By-Laws, (iii) setting forth the incumbency of the officer or officers of the Borrower who may sign this Agreement and the Loan Documents, and any other certificates, requests, notices or other documents required hereunder or thereunder, and (iv) attaching a certificate of good standing of the Secretary of State of the State of Delaware.

5.4 ***Opinion of Counsel to the Borrower***

The Administrative Agent shall have received (a) an opinion of Thomas Moffatt, assistant general counsel of the Borrower, dated the Effective Date, in the form of Exhibit D-1, and (b) an opinion of Shearman & Sterling LLP, special counsel to the Borrower, dated the Effective Date, in the form of Exhibit D-2.

5.5 ***Termination of Existing 2013 Credit Agreement***

After giving effect to the application of the proceeds of the Loans on the Effective Date, the Indebtedness under the Existing 2013 Credit Agreement shall have been fully repaid, the commitments under the Existing 2013 Credit Agreement shall have been canceled or terminated, and the Administrative Agent shall have received reasonably satisfactory evidence thereof. In order to facilitate the termination of the commitments under the Existing 2013 Credit Agreement, the Borrower hereby gives notice that the Borrower wishes to terminate the commitments under the Existing 2013 Credit Agreement, effective as of the Effective Date. Each Lender that is a party to the Existing 2013 Credit Agreement, by its execution hereof, waives any requirement of prior notice set forth therein as a condition to the right of the Borrower to terminate the commitments thereunder.

5.6 ***No Default and Representations and Warranties***

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Senior Vice President and Treasurer of the Borrower certifying that there exists no Default and that the representations and warranties contained in this Agreement are true and correct in all material respects (provided that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on the Effective Date).

5.7 ***Fees***

The Administrative Agent shall have received all fees and other amounts due and payable to it on the Effective Date, including the upfront fees payable to the Lenders, in respect of this Agreement.

5.8 ***Due Diligence; "Know Your Customer"***

Each Lender shall have received such documents and information as it may have requested in order to comply with "know-your-customer" and other applicable Sanctions, anti-terrorism, anti-money laundering and similar rules and regulations and related policies, to the

extent the Borrower shall have received written requests therefor at least ten (10) Domestic Business Days prior to the Effective Date.

6. *CONDITIONS OF LENDING - ALL LOANS AND LETTERS OF CREDIT*

The obligation of each Lender on any Borrowing Date to make each Revolving Credit Loan (other than a Revolving Credit Loan constituting a Mandatory Borrowing), the Swing Line Lender to make each Swing Line Loan, each Issuer to issue each Letter of Credit and each Lender to make a Competitive Bid Loan are subject to the fulfillment of the following conditions precedent:

6.1 *Compliance*

On each Borrowing Date, and after giving effect to the Loans to be made or the Letters of Credit to be issued on such Borrowing Date, (a) there shall exist no Default, and (b) the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on such Borrowing Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such Borrowing Date), except those which are expressly specified to be made as of an earlier date.

6.2 *Requests*

The Administrative Agent shall have timely received from the Borrower on or before such Borrowing Date, as applicable, a duly executed Borrowing Request (together with, in the case of a request for a Swing Line Loan, a duly executed agreement as to the Negotiated Rate with respect to such Swing Line Loan), Letter of Credit Request (together with a duly executed Reimbursement Agreement with respect to the Letter(s) of Credit requested thereby) and/or Competitive Bid Request (together with a duly executed Competitive Bid Accept/Reject Letter).

7. *AFFIRMATIVE COVENANTS*

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the Reimbursement Obligations, the Fees and all other sums payable under the Loan Documents (other than contingent obligations for which no claim has been made), the Borrower will:

7.1 *Legal Existence*

Except as may otherwise be permitted by Section 8.3 and Section 8.4, maintain, and cause each Subsidiary to maintain, its corporate existence in good standing in the jurisdiction of its incorporation or formation and in each other jurisdiction in which the failure so to do could reasonably be expected to have a Material Adverse effect, except that the corporate existence of Subsidiaries may be terminated if (i) such Subsidiaries operate closing or discontinued operations or (ii) if the Borrower determines in good faith that such termination is in the best interests of the Borrower and is not materially disadvantageous to the Lenders.

7.2 ***Taxes***

Pay and discharge when due, and cause each Subsidiary so to do, all taxes, assessments, governmental charges, license fees and levies upon or with respect to the Borrower and such Subsidiary, and upon the income, profits and Property thereof unless, and only to the extent, that either (i)(a) such taxes, assessments, governmental charges, license fees and levies shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Subsidiary, and (b) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor, or (ii) the failure to pay or discharge such taxes, assessments, governmental charges, license fees and levies could not reasonably be expected to have a Material Adverse effect.

7.3 ***Insurance***

Keep, and cause each Subsidiary to keep, insurance with responsible insurance companies in such amounts and against such risks as is usually carried by the Borrower or such Subsidiary.

7.4 ***Performance of Obligations***

Pay and discharge when due, and cause each Subsidiary so to do, all lawful Indebtedness, obligations and claims for labor, materials and supplies or otherwise which, if unpaid, could reasonably be expected to (a) have a Material Adverse effect, or (b) become a Lien on the Property of the Borrower or any Subsidiary, except those Liens permitted under Section 8.2, *provided* that neither the Borrower nor such Subsidiary shall be required to pay or discharge or cause to be paid or discharged any such Indebtedness, obligation or claim so long as (i) the validity thereof shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Subsidiary, and (ii) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor.

7.5 ***Condition of Property***

Except for ordinary wear and tear, at all times, maintain, protect and keep in good repair, working order and condition, all material Property necessary for the operation of its business (other than Property which is replaced with similar Property) as then being operated, and cause each Subsidiary so to do.

7.6 ***Observance of Legal Requirements***

(a) Observe and comply in all material respects, and cause each Subsidiary so to do, with all laws, ordinances, orders, judgments, rules, regulations, certifications, franchises, permits, licenses, directions and requirements of all Governmental Authorities, which now or at any time hereafter may be applicable to it or to such Subsidiary, a violation of which could reasonably be expected to have a Material Adverse effect; and

(b) Maintain in effect and enforce policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions.

7.7 ***Financial Statements and Other Information***

Maintain, and cause each Subsidiary to maintain, a standard system of accounting in accordance with GAAP, and furnish to the Administrative Agent for distribution to the Lenders:

(a) As soon as available and, in any event, within 90 days after the close of each fiscal year, a copy of (x) the Borrower's 10-K in respect of such fiscal year, and (y) (i) the Borrower's Consolidated Balance Sheet as of the end of such fiscal year, and (ii) the related Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows, as of and through the end of such fiscal year, setting forth in each case in comparative form the corresponding figures in respect of the previous fiscal year, all in reasonable detail, and accompanied by a report of the Borrower's auditors, which report shall state that (A) such auditors audited such financial statements, (B) such audit was made in accordance with generally accepted auditing standards in effect at the time and provides a reasonable basis for such opinion, and (C) said financial statements have been prepared in accordance with GAAP;

(b) As soon as available, and in any event within 45 days after the end of each of the first three fiscal quarters of each fiscal year, a copy of (x) the Borrower's 10-Q in respect of such fiscal quarter, and (y) (i) the Borrower's condensed Consolidated Balance Sheet as of the end of such quarter and (ii) the related condensed Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for (A) such quarter and (B) the period from the beginning of the then current fiscal year to the end of such quarter, in each case in comparable form with the prior fiscal year, all in reasonable detail and prepared in accordance with GAAP (without footnotes and subject to year-end adjustments);

(c) Simultaneously with the delivery of the financial statements required by clauses (a) and (b) above, a certificate of the Chief Financial Officer or the Senior Vice President and Treasurer of the Borrower certifying that no Default shall have occurred or be continuing or, if so, specifying in such certificate all such Defaults, and setting forth computations in reasonable detail demonstrating compliance with Section 8.1 and Section 8.9.

(d) Prompt notice upon the Borrower becoming aware of any change in the applicability of a Pricing Level;

(e) As soon as practicable after becoming available, copies of all regular or periodic reports (including current reports on Form 8-K) which the Borrower or any Subsidiary may now or hereafter be required to file with or deliver to the U.S. Securities and Exchange Commission, or any other Governmental Authority succeeding to the functions thereof;

(f) Prompt written notice of: (i) any citation, summons, subpoena, order to show cause or other order naming the Borrower or any Subsidiary a party to any proceeding before any Governmental Authority which could reasonably be expected to have a Material Adverse effect, and include with such notice a copy of such citation, summons, subpoena, order to show cause or other order, (ii) any lapse or other termination of any license, permit, franchise or other authorization issued to the Borrower or any Subsidiary by any Governmental Authority, (iii) any refusal by any Governmental Authority to renew or extend any license, permit, franchise or other authorization, and (iv) any dispute between the Borrower or any Subsidiary and any

Governmental Authority, which lapse, termination, refusal or dispute, referred to in clause (ii), (iii) or (iv) above, could reasonably be expected to have a Material Adverse effect;

(g) Prompt written notice of the occurrence of (i) each Default, (ii) each Event of Default and (iii) each Material Adverse change;

(h) As soon as practicable following receipt thereof, copies of any audit reports delivered in connection with the statements referred to in Section 7.7(a);

(i) From time to time, such other information regarding the financial position or business of the Borrower and the Subsidiaries as the Administrative Agent, at the request of any Lender, may reasonably request; and

(j) Prompt written notice of such other information with documentation required by bank regulatory authorities under applicable "know your customer" and anti-money laundering laws, rules and regulations (including, without limitation, the Patriot Act), as from time to time may be reasonably requested by the Administrative Agent, any Issuer or any Lender.

Information required to be delivered pursuant to (x) this Section 7.7 shall be deemed to have been delivered if such information shall have been posted by the Administrative Agent on a Debtdomain, IntraLinks, Syndtrak or similar electronic system (the ***"Platform"***) to which each Lender and each Issuer has been granted access and (y) clauses (a), (b) and (e) of this Section 7.7 shall be deemed delivered to the Administrative Agent, the Issuers and the Lenders when available on the Borrower's website at http://www.cvshealth.com or the website of the U.S. Securities and Exchange Commission at http://www.sec.gov. Information delivered pursuant to this Section 7.7 may also be delivered by electronic communications pursuant to procedures approved by the Administrative Agent.

The Borrower hereby acknowledges that the Administrative Agent and/or the Joint Lead Arrangers and Joint Bookrunners will make available to the Lenders materials and/or information provided by or on behalf of the Borrower hereunder (collectively, ***"Borrower Materials"***) by posting the Borrower Materials on the Platform.

7.8 ***Records***

Upon reasonable notice and during normal business hours and, if no Event of Default has occurred and is continuing, not more than once in each fiscal year, permit representatives of the Administrative Agent and each Lender to visit the offices of the Borrower and each Subsidiary, to examine the books and records (other than tax returns and work papers related to tax returns) thereof and auditors' reports relating thereto, to discuss the affairs of the Borrower and each Subsidiary with the respective officers thereof, and to meet and discuss the affairs of the Borrower and each Subsidiary with the Borrower's auditors.

7.9 ***Authorizations***

Maintain and cause each Subsidiary to maintain, in full force and effect, all copyrights, patents, trademarks, trade names, franchises, licenses, permits, applications, reports, and

other authorizations and rights, which, if not so maintained, would individually or in the aggregate have a Material Adverse effect.

8. *NEGATIVE COVENANTS*

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the Reimbursement Obligations, the Fees and all other sums payable under the Loan Documents (other than contingent obligations for which no claim has been made), the Borrower will not:

8.1 *Subsidiary Indebtedness*

Permit the Indebtedness of all Subsidiaries (excluding Indebtedness under capital leases incurred in connection with a sale leaseback transaction) to exceed (on a combined basis) 15% of Net Tangible Assets.

8.2 *Liens*

Create, incur, assume or suffer to exist any Lien against or on any Property now owned or hereafter acquired by the Borrower or any of the Subsidiaries, or permit any of the Subsidiaries so to do, except any one or more of the following types of Liens: (a) Liens in connection with workers' compensation, unemployment insurance or other social security obligations (which phrase shall not be construed to refer to ERISA or the minimum funding obligations under Section 412 of the Internal Revenue Code), (b) Liens to secure the performance of bids, tenders, letters of credit, contracts (other than contracts for the payment of Indebtedness), leases, statutory obligations, surety, customs, appeal, performance and payment bonds and other obligations of like nature, or to qualify to do business, maintain insurance or obtain other benefits, in each such case arising in the ordinary course of business, (c) mechanics', workmen's, carriers', warehousemen's, materialmen's, landlords' or other like Liens arising in the ordinary course of business with respect to obligations which are not due or which are being contested in good faith and by appropriate proceedings diligently conducted, (d) Liens for taxes, assessments, fees or governmental charges the payment of which is not required under Section 7.2 or Section 7.4, (e) easements, rights of way, restrictions, leases of Property to others, easements for installations of public utilities, title imperfections and restrictions, zoning ordinances and other similar encumbrances affecting Property which in the aggregate do not materially impair its use for the operation of the business of the Borrower or such Subsidiary, (f) Liens on Property of the Subsidiaries under capital leases and Liens on Property (including on the capital stock or other equity interests) of the Subsidiaries acquired (whether as a result of purchase, capital lease, merger or other acquisition) and either existing on such Property when acquired, or created contemporaneously with or within 12 months of such acquisition to secure the payment or financing of the purchase price of such Property (including the construction, development, substantial repair, alteration or improvement thereof), and any renewals thereof, *provided* that such Liens attach only to the Property so purchased or acquired (including any such construction, development, substantial repair, alteration or improvement thereof) and *provided further* that the Indebtedness secured by such Liens is permitted by Section 8.1, (g) statutory Liens in favor of lessors arising in connection with Property leased to the Borrower or any of the Subsidiaries, (h) Liens of attachments, judgments or awards against the Borrower or any of the Subsidiaries with respect to which an appeal or

proceeding for review shall be pending or a stay of execution or bond shall have been obtained, or which are otherwise being contested in good faith and by appropriate proceedings diligently conducted, and in respect of which adequate reserves shall have been established in accordance with GAAP on the books of the Borrower or such Subsidiary, (i) Liens securing Indebtedness of a Subsidiary to the Borrower or another Subsidiary, (j) Liens (other than Liens permitted by any of the foregoing clauses) arising in the ordinary course of its business which do not secure Indebtedness and do not, in the aggregate, materially detract from the value of the business of the Borrower and its Subsidiaries, taken as a whole, (k) Liens in favor of the United States of America, or any state thereof, to secure partial, progress, advance or other payments pursuant to any contract or provisions of any statute, and (l) additional Liens securing Indebtedness of the Borrower and the Subsidiaries in an aggregate outstanding Consolidated principal amount not exceeding 15% of Net Tangible Assets.

8.3 ***Dispositions***

Make any Disposition, or permit any of its Subsidiaries so to do, of all or substantially all of the assets of the Borrower and the Subsidiaries on a Consolidated basis.

8.4 ***Merger or Consolidation, Etc.***

Consolidate with, be acquired by, or merge into or with any Person unless (x) immediately after giving effect thereto no Default shall or would exist and (y) either (i) the Borrower or (ii) a corporation organized and existing under the laws of one of the States of the United States of America shall be the survivor of such consolidation or merger, *provided* that if the Borrower is not the survivor, the corporation which is the survivor shall expressly assume, pursuant to an instrument executed and delivered to the Administrative Agent, and in form and substance reasonably satisfactory to the Administrative Agent, all obligations of the Borrower under the Loan Documents and the Administrative Agent shall have received such documents, opinions and certificates as it shall have reasonably requested in connection therewith.

8.5 ***Acquisitions***

Make any Acquisition, or permit any of the Subsidiaries so to do, except any one or more of the following: (a) Acquisitions by the Borrower or any of the Subsidiaries in connection with Intercompany Dispositions not prohibited by Section 8.3, and (b) Acquisitions by the Borrower or any of the Subsidiaries, *provided* that immediately before and after giving effect to each such Acquisition no Event of Default shall or would exist.

8.6 ***Restricted Payments***

Make any Restricted Payment or permit any of the Subsidiaries so to do, except any one or more of the following Restricted Payments: (a) any direct or indirect Subsidiary may make dividends or other distributions to the Borrower or to any other direct or indirect Subsidiary or otherwise ratably with respect to its stock or other equity interests, and (b) the Borrower may make Restricted Payments, *provided* that, in the case of this clause (b), immediately before and after giving effect thereto, no Event of Default shall or would exist.

8.7 ***Limitation on Upstream Dividends by Subsidiaries***

Permit or cause any of the Subsidiaries to enter into or agree, or otherwise be or become subject, to any agreement, contract or other arrangement (other than this Agreement) with any Person (each a ***"Restrictive Agreement"***) pursuant to the terms of which (a) such Subsidiary is or would be prohibited from declaring or paying any cash dividends on any class of its stock owned directly or indirectly by the Borrower or any of the other Subsidiaries or from making any other distribution on account of any class of any such stock (herein referred to as ***"Upstream Dividends"***), or (b) the declaration or payment of Upstream Dividends by a Subsidiary to the Borrower or another Subsidiary, on an annual or cumulative basis, is or would be otherwise limited or restricted (***"Dividend Restrictions"***). Notwithstanding the foregoing, nothing in this Section 8.7 shall prohibit:

(a) Dividend Restrictions set forth in any Restrictive Agreement in effect on the date hereof and any extensions, refinancings, renewals or replacements thereof; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(b) Dividend Restrictions existing with respect to any Person acquired by the Borrower or any Subsidiary and existing at the time of such acquisition, which Dividend Restrictions are not applicable to any Person or the property or assets of any Person other than such Person or its property or assets acquired, and any extensions, refinancings, renewals or replacements of any of the foregoing; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(c) Dividend Restrictions consisting of customary net worth, leverage and other financial covenants, customary covenants regarding the merger of or sale of stock or assets of a Subsidiary, customary restrictions on transactions with affiliates, and customary subordination provisions governing Indebtedness owed to the Borrower or any Subsidiary, in each case contained in, or required by, any agreement governing Indebtedness incurred by a Subsidiary in accordance with Section 8.1; or

(d) Dividend Restrictions contained in any other credit agreement so long as such Dividend Restrictions are no more restrictive than those contained in this Agreement (including Dividend Restrictions contained in the Existing 364-Day Credit Agreement, the Existing 2014 Credit Agreement and the Existing 2015 Credit Agreement).

8.8 ***Limitation on Negative Pledges***

Enter into any agreement (other than (i) this Agreement, (ii) any other credit agreement that is substantially similar to this Agreement, (iii) purchase money financings or capital leases permitted by this Agreement (provided that any prohibition or limitation therein shall only be effective against the assets financed thereby), (iv) customary restrictions and conditions contained in agreements relating to the Disposition of a Subsidiary, property or assets pending such Disposition,

provided such restrictions and conditions apply only to such Subsidiary, property or assets, (v) restrictions and conditions contained in documentation relating to a Subsidiary acquired after the Effective Date, *provided* that such restriction or condition (x) existed at the time such Person became a Subsidiary and was not created in contemplation of or in connection with such Person becoming a Subsidiary and (y) applies only to such Subsidiary, and (vi) customary provisions in joint venture agreements, leases, licenses and other contracts restricting or conditioning the assignment or encumbrance thereof, including, without limitation, licenses and sublicenses of patents, trademarks, copyrights and similar intellectually property rights) or permit any Subsidiary so to do, which prohibits or limits the ability of the Borrower or such Subsidiary to create, incur, assume or suffer to exist any Lien upon any of its Property or revenues, whether now owned or hereafter acquired, to secure the obligations of the Borrower hereunder.

8.9 *Ratio of Consolidated Indebtedness to Total Capitalization*

Permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.6 : 1.0.

9. *DEFAULT*

9.1 *Events of Default*

The following shall each constitute an ***"Event of Default"*** hereunder:

(a) The failure of the Borrower to make any payment of principal on any Loan or any reimbursement payment in respect of any Letter of Credit when due and payable; or

(b) The failure of the Borrower to make any payment of interest on any Loan or of any Fee on any date when due and payable and such default shall continue unremedied for a period of 5 Domestic Business Days after the same shall be due and payable; or

(c) The failure of the Borrower to observe or perform any covenant or agreement contained in Section 2.5, Section 7.1, or in Section 8; or

(d) The failure of the Borrower to observe or perform any other covenant or agreement contained in this Agreement, and such failure shall have continued unremedied for a period of 30 days after the Borrower shall have become aware of such failure; or

(e) [Reserved]; or

(f) Any representation or warranty of the Borrower (or of any of its officers on its behalf) made in any Loan Document, or made in any certificate or report or other document (other than an opinion of counsel) delivered on or after the date hereof in connection with any such Loan Document shall in any such case prove to have been incorrect or misleading (whether because of misstatement or omission) in any material respect when made; or

(g) (i) Obligations in an aggregate Consolidated amount in excess of $125,000,000 of the Borrower (other than its obligations hereunder and under the Notes) and the Subsidiaries, whether as principal, guarantor, surety or other obligor, for the payment of any

Indebtedness or any net liability under interest rate swap, collar, exchange or cap agreements, (A) shall become or shall be declared to be due and payable prior to the expressed maturity thereof, or (B) shall not be paid when due or within any grace period for the payment thereof, or (ii) any holder of any such obligations shall have the right to declare the Indebtedness evidenced thereby due and payable prior to its stated maturity; or

(h) An involuntary proceeding shall be commenced or an involuntary petition shall be filed seeking (i) liquidation, reorganization or other relief in respect of the Borrower or any Subsidiary or its debts, or of a substantial part of its assets, under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect or (ii) the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Subsidiary or for a substantial part of its assets, and, in any such case, such proceeding or petition shall continue undismissed for 60 days or an order or decree approving or ordering any of the foregoing shall be entered; or

(i) The Borrower or any Subsidiary shall (i) voluntarily commence any proceeding or file any petition seeking liquidation, reorganization or other relief under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect, (ii) consent to the institution of, or fail to contest in a timely and appropriate manner, any proceeding or petition described in clause (h) of this Section 9.1, (iii) apply for or consent to the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Subsidiary or for a substantial part of its assets, (iv) file an answer admitting the material allegations of a petition filed against it in any such proceeding, (v) make a general assignment for the benefit of creditors or (vi) take any action for the purpose of effecting any of the foregoing; or

(j) The Borrower or any Subsidiary shall (i) generally not be paying its debts as such debts become due or (ii) admit in writing its inability to pay its debts as they become due; or

(k) Judgments or decrees in an aggregate Consolidated amount in excess of $125,000,000 against the Borrower and the Subsidiaries shall remain unpaid, unstayed on appeal, undischarged, unbonded or undismissed for a period of 60 days during which execution shall not be effectively stayed, or any action shall be legally taken by a judgment creditor to attach or levy upon any assets of the Borrower or any Subsidiary to enforce any such judgment; or

(l) After the Effective Date a Change of Control shall occur; or

(m) (i) Any Termination Event shall occur (x) with respect to any Pension Plan (other than a Multiemployer Plan) or (y) with respect to any other retirement plan subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, which plan, during the five year period prior to such Termination Event, was the responsibility in whole or in part of the Borrower, any Subsidiary or any ERISA Affiliate, provided that this clause (y) shall only apply if, in connection with such Termination Event, it is reasonably likely that liability in an aggregate Consolidated amount in excess of $125,000,000 will be imposed upon the Borrower; (ii) the failure to satisfy the minimum funding standards under Section 302 of ERISA or Section 412 of the Internal Revenue Code in an aggregate Consolidated amount in excess of $125,000,000 shall

exist with respect to any Pension Plan for which the Borrower has responsibility (other than that portion of a Multiemployer Plan's Accumulated Funding Deficiency to the extent such Accumulated Funding Deficiency is attributable to employers other than Borrower); (iii) any Person shall engage in a Prohibited Transaction involving any Employee Benefit Plan in respect of which it is reasonably likely that liability in an aggregate Consolidated amount in excess of $125,000,000 will be imposed upon the Borrower; (iv) the Borrower shall fail to pay when due an amount which is payable by it to the PBGC or to a Pension Plan (including a Multiemployer Plan) under Title IV of ERISA; (v) the imposition on the Borrower of any tax under Section 4980(B)(a) of the Internal Revenue Code; or (vi) the assessment of a civil penalty on the Borrower with respect to any Employee Benefit Plan under Section 502(c) of ERISA; in each case, to the extent such event or condition would have a Material Adverse effect. In determining the Consolidated amount for any purpose pursuant to this Section 9.1(m), the liabilities, funding amounts, taxes and penalties referenced in the foregoing clauses of this Section 9.1(m) shall include those of the Subsidiaries and ERISA Affiliates of the Borrower to the extent the Borrower is obligated to pay any such liabilities, funding amounts, taxes and penalties.

9.2 ***Remedies***

(a) Upon the occurrence of an Event of Default or at any time thereafter during the continuance of an Event of Default, the Administrative Agent, at the written request of the Required Lenders, shall notify the Borrower that the Commitments, the Swing Line Commitment and the Letter of Credit Commitment have been terminated and/or that all of the Loans, the Notes and the Reimbursement Obligations and all accrued and unpaid interest on any thereof and all other amounts owing under the Loan Documents have been declared immediately due and payable, *provided* that upon the occurrence of an Event of Default under Section 9.1(h), (i) or (j) with respect to the Borrower, the Commitments, the Swing Line Commitment and the Letter of Credit Commitment shall automatically terminate and all of the Loans, the Notes and the Reimbursement Obligations and all accrued and unpaid interest on any thereof and all other amounts owing under the Loan Documents shall become immediately due and payable without declaration or notice to the Borrower. To the fullest extent not prohibited by law, except for the notice provided for in the preceding sentence, the Borrower expressly waives any presentment, demand, protest, notice of protest or other notice of any kind in connection with the Loan Documents and its obligations thereunder. To the fullest extent not prohibited by law, the Borrower further expressly waives and covenants not to assert any appraisement, valuation, stay, extension, redemption or similar law, now or at any time hereafter in force which might delay, prevent or otherwise impede the performance or enforcement of the Loan Documents.

(b) In the event that the Commitments, the Swing Line Commitment and the Letter of Credit Commitment shall have been terminated or all of the Loans, the Notes and the Reimbursement Obligations shall have become or been declared to be due and payable pursuant to the provisions of this Section 9.2, (i) the Borrower shall forthwith deposit an amount equal to the Letter of Credit Exposure in a cash collateral account with and under the exclusive control of the Administrative Agent, and (ii) the Administrative Agent, the Issuers and the Lenders agree, among themselves, that any funds received from or on behalf of the Borrower under any Loan Document by any Issuer or any Lender (except funds received by any Issuer or any Lender as a result of a purchase from such Issuer or such Lender, as the case may be, pursuant to the provisions of Section 11.9(b)) shall be remitted to the Administrative Agent, and shall be applied

by the Administrative Agent in payment of the Loans, the Reimbursement Obligations and the other obligations of the Borrower under the Loan Documents in the following manner and order: (1) first, to the payment or reimbursement of the Administrative Agent, the Issuers and the Lenders, in that order, for any fees, expenses or amounts (other than the principal of and interest on the Reimbursement Obligations) due from the Borrower pursuant to the provisions of Section 11.5 and the Reimbursement Agreements, (2) second, to the payment of the Fees, (3) third, to the payment of any other fees, expenses or amounts (other than the principal of and interest on the Loans and the Notes and the Reimbursement Obligations) payable by the Borrower to the Administrative Agent, any Issuer or any of the Lenders under the Loan Documents, (4) fourth, to the payment, pro rata according to the outstanding principal balance of the Loans and the Letter of Credit Exposure of each Lender, of interest due on the Loans and the Reimbursement Obligations, (5) fifth, to the payment, pro rata according to the sum of (A) the aggregate outstanding principal balance of the Loans of each Lender *plus* (B) the aggregate outstanding balance of the Reimbursement Obligations of each Lender, of the aggregate outstanding principal balance of the Loans and the aggregate outstanding balance of the Reimbursement Obligations, and (6) sixth, any remaining funds shall be paid to whosoever shall be entitled thereto or as a court of competent jurisdiction shall direct.

(c) In the event that the Loans and the Notes and the Reimbursement Obligations shall have been declared due and payable pursuant to the provisions of this Section 9.2, the Administrative Agent upon the written request of the Required Lenders, shall proceed to enforce the Reimbursement Obligations and the rights of the holders of the Loans and the Notes by suit in equity, action at law and/or other appropriate proceedings, whether for payment or the specific performance of any covenant or agreement contained in the Loan Documents. In the event that the Administrative Agent shall fail or refuse so to proceed, each Issuer and each Lender shall be entitled to take such action as the Required Lenders shall deem appropriate to enforce its rights under the Loan Documents.

10. *AGENT*

10.1 *Appointment and Authority*

Each Credit Party hereby irrevocably appoints BNY Mellon to act on its behalf as the Administrative Agent hereunder and under the other Loan Documents and authorizes the Administrative Agent to take such actions on its behalf and to exercise such powers as are delegated to the Administrative Agent by the terms hereof or thereof, together with such actions and powers as are reasonably incidental thereto. The provisions of this Section 10 (other than Section 10.6) are solely for the benefit of the Administrative Agent and the Credit Parties and the Borrower shall have no rights as a third party beneficiary or otherwise of any of such provisions.

10.2 *Rights as a Lender*

The Person serving as the Administrative Agent hereunder shall have the same rights and powers in its capacity as a Lender (which includes Issuer) as any other Lender and may exercise the same as though it were not the Administrative Agent and the term “Lender” or “Lenders” shall, unless otherwise expressly indicated or unless the context otherwise requires, include the Person serving as the Administrative Agent hereunder in its individual capacity.

Such Person and its Affiliates may accept deposits from, lend money to, act as the financial advisor or in any other advisory capacity for and generally engage in any kind of business with the Borrower, any of its Subsidiaries or any other Affiliate thereof as if such Person were not the Administrative Agent hereunder and without any duty to account therefor to the Lenders.

10.3 ***Exculpatory Provisions***

(a) The Administrative Agent shall not have any duties or obligations except those expressly set forth herein and in the other Loan Documents. Without limiting the generality of the foregoing, the Administrative Agent:

(1) shall not be subject to any fiduciary or other implied duties, regardless of whether a Default has occurred and is continuing;

(2) shall not have any duty to take any discretionary action or exercise any discretionary powers, except discretionary rights and powers expressly contemplated hereby or by the other Loan Documents that the Administrative Agent is required to exercise as directed in writing by the Required Lenders (or such other number or percentage of the Lenders as shall be expressly provided for herein or in the other Loan Documents); provided that the Administrative Agent shall not be required to take any action that, in its opinion or the opinion of its counsel, may expose the Administrative Agent to liability or that is contrary to any Loan Document or applicable law; and

(3) shall not, except as expressly set forth herein and in the other Loan Documents, have any duty to disclose, and shall not be liable for the failure to disclose, any information relating to the Borrower, any of its Subsidiaries or any Affiliate thereof that is communicated to or obtained by the Person serving as the Administrative Agent or any of its Affiliates in any capacity.

(b) The Administrative Agent shall not be liable for any action taken or not taken by it (i) with the consent or at the request of the Required Lenders (or such other number or percentage of the Lenders as shall be necessary, or as the Administrative Agent shall believe in good faith shall be necessary, under the circumstances as provided in Section 11.1 and Section 9) or (ii) in the absence of its own gross negligence or willful misconduct. The Administrative Agent shall be deemed not to have knowledge of any Default unless and until notice describing such Default is given to the Administrative Agent by the Borrower, a Lender or an Issuer.

(c) The Administrative Agent shall not be responsible for or have any duty to ascertain or inquire into (i) any statement, warranty or representation made in or in connection with this Agreement or any other Loan Document, (ii) the contents of any certificate, report or other document delivered hereunder or thereunder or in connection herewith or therewith, (iii) the performance or observance of any of the covenants, agreements or other terms or conditions set forth herein or therein or the occurrence of any Default, (iv) the validity, enforceability, effectiveness or genuineness of this Agreement, any other Loan Document or any other agreement, instrument or document or (v) the satisfaction of any condition set forth in Section 5 or

Section 6 or elsewhere herein, other than to confirm receipt of items expressly required to be delivered to the Administrative Agent.

10.4 ***Reliance by Administrative Agent***

The Administrative Agent shall be entitled to rely upon, and shall not incur any liability for relying upon, any notice, request, certificate, consent, statement, instrument, document or other writing (including any electronic message, internet or intranet website posting or other distribution) believed by it to be genuine and to have been signed, sent or otherwise authenticated by the proper Person. The Administrative Agent also may rely upon any statement made to it orally or by telephone and believed by it to have been made by the proper Person, and shall not incur any liability for relying thereon. In determining compliance with any condition hereunder to the making of a Loan or the issuance of a Letter of Credit, that by its terms must be fulfilled to the satisfaction of a Lender or an Issuer, the Administrative Agent may presume that such condition is satisfactory to such Lender or such Issuer unless the Administrative Agent shall have received notice to the contrary from such Lender or such Issuer prior to the making of such Loan or the issuance of such Letter of Credit. The Administrative Agent may consult with legal counsel (who may be counsel for the Borrower), independent public accounting firms and other experts selected by it, and shall not be liable for any action taken or not taken by it in accordance with the advice of any such counsel, accounting firm or experts.

10.5 ***Delegation of Duties***

The Administrative Agent may perform any and all of its duties and exercise its rights and powers hereunder or under any other Loan Document by or through any one or more sub-agents appointed by the Administrative Agent. The Administrative Agent and any such sub-agent may perform any and all of its duties and exercise its rights and powers by or through their respective Related Parties. The exculpatory provisions of this Section 10 shall apply to any such sub-agent and to the Related Parties of the Administrative Agent and any such sub-agent, and shall apply to their respective activities in connection with the syndication of the credit facilities provided for herein as well as activities as the Administrative Agent.

10.6 ***Resignation of Administrative Agent***

The Administrative Agent may at any time give notice of its resignation to the Credit Parties and the Borrower. Upon receipt of any such notice of resignation, the Required Lenders shall have the right, subject to, so long as no Default has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed), to appoint a successor, which shall be a bank with an office in New York, New York, or an Affiliate of any such bank with an office in New York, New York. If no such successor shall have been so appointed by the Required Lenders and shall have accepted such appointment within 30 days after the retiring Administrative Agent gives notice of its resignation, then the retiring Administrative Agent may on behalf of the Credit Parties, appoint a successor Administrative Agent meeting the qualifications set forth above, subject to, so long as no Default has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed); *provided* that if the Administrative Agent shall notify the Borrower and the Credit Parties that no qualifying Person has accepted such appointment, then such resignation shall

nonetheless become effective in accordance with such notice and (a) the retiring Administrative Agent shall be discharged from its duties and obligations hereunder and under the other Loan Documents and (b) all payments, communications and determinations provided to be made by, to or through the Administrative Agent shall instead be made by or to each Credit Party directly, until such time as the Required Lenders appoint a successor Administrative Agent as provided for above in this paragraph. Upon the acceptance of a successor's appointment as Administrative Agent hereunder, such successor shall succeed to and become vested with all of the rights, powers, privileges and duties of the retiring (or retired) Administrative Agent, and the retiring Administrative Agent shall be discharged from all of its duties and obligations hereunder or under the other Loan Documents (if not already discharged therefrom as provided above in this paragraph). The fees payable by the Borrower to a successor Administrative Agent shall be the same as those payable to its predecessor unless otherwise agreed between the Borrower and such successor. After the retiring Administrative Agent's resignation hereunder and under the other Loan Documents, the provisions of this Section 10 and Section 11.5 shall continue in effect for the benefit of such retiring Administrative Agent, its sub-agents and their respective Related Parties in respect of any actions taken or omitted to be taken by any of them while the retiring Administrative Agent was acting as Administrative Agent.

10.7 *Non-Reliance on Administrative Agent and Other Credit Parties*

Each Credit Party acknowledges that it has, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it has deemed appropriate, made its own credit analysis and decision to enter into this Agreement. Each Credit Party also acknowledges that it will, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it shall from time to time deem appropriate, continue to make its own decisions in taking or not taking action under or based upon this Agreement, any other Loan Document or any related agreement or any document furnished hereunder or thereunder.

10.8 *No Other Duties, etc.*

Anything herein to the contrary notwithstanding, none of the Joint Bookrunners, the Joint Lead Arrangers, the Co-Documentation Agents or the Co-Syndication Agents listed on the cover page hereof shall have any powers, duties or responsibilities under this Agreement or any of the other Loan Documents, except in its capacity, as applicable, as the Administrative Agent, a Lender or an Issuer.

11. *OTHER PROVISIONS*

11.1 *Amendments, Waivers, Etc.*

With the written consent of the Required Lenders, the Administrative Agent and the Borrower may, from time to time, enter into written amendments, supplements or modifications of the Loan Documents (which, for the avoidance of doubt, shall require the prior written consent of the Borrower) and, with the written consent of the Required Lenders and the Borrower, the Administrative Agent on behalf of the Lenders may execute and deliver to any such parties a written

instrument waiving or consenting to the departure from, on such terms and conditions as the Administrative Agent may specify in such instrument, any of the requirements of the Loan Documents or any Default and its consequences, *provided* that no such amendment, supplement, modification, waiver or consent shall (i) increase the Commitment Amount of any Lender without the consent of such Lender (*provided* that no waiver of a Default shall be deemed to constitute such an increase), (ii) extend the Commitment Period without the consent of each Lender directly affected thereby, (iii) reduce the amount, or extend the time of payment, of the Fees without the consent of each Lender directly affected thereby, (iv) reduce the rate, or extend the time of payment of, interest on any Revolving Credit Loan, any Note or any Reimbursement Obligation (other than the applicability of any post-default increase in such rate of interest) without the consent of each Lender directly affected thereby, (v) reduce the amount of, or extend the time of payment of, any payment of any Reimbursement Obligation or principal on any Revolving Credit Loan or any Note without the consent of each Lender directly affected thereby, (vi) decrease or forgive the principal amount of any Revolving Credit Loan, any Note or any Reimbursement Obligation without the consent of each Lender directly affected thereby, (vii) consent to any assignment or delegation by the Borrower of any of its rights or obligations under any Loan Document without the consent of each Lender, (viii) change the provisions of this Section 11.1 without the consent of each Lender, (ix) change the definition of Required Lenders without the consent of each Lender, (x) change the several nature of the obligations of the Lenders without the consent of each Lender, (xi) change the sharing provisions among Lenders without the consent of each Lender directly affected thereby, or (xii) extend the expiration date of a Letter of Credit beyond the Commitment Termination Date without the consent of each Lender. Notwithstanding the foregoing, in addition to the receipt of the prior written consents of the Borrower and the Required Lenders, no such amendment, supplement, modification, waiver or consent shall (A) amend, modify or waive any provision of Section 10 or otherwise change any of the rights or obligations of the Administrative Agent, any Issuer or the Swing Line Lender under any Loan Document without the written consent of the Administrative Agent, such Issuer or the Swing Line Lender, as the case may be, (B) change the Letter of Credit Commitment, change the amount or the time of payment of any Letter of Credit or any commission or fee payable to the Issuer thereof in connection therewith, or change any other term or provision which relates to the Letter of Credit Commitment of such Issuer or the Letters of Credit issued thereby without the written consent of such Issuer, (C) change the Swing Line Commitment, change the amount or the time of payment of the Swing Line Loans or interest thereon or change any other term or provision which relates to the Swing Line Commitment or the Swing Line Loans without the written consent of the Swing Line Lender or (D) change the amount or the time of payment of any Competitive Bid Loan or interest thereon without the written consent of the Lender holding such Competitive Bid Loan. Any such amendment, supplement, modification, waiver or consent shall apply equally to each of the Lenders and shall be binding upon the parties to the applicable Loan Document, the Lenders, the Issuers, the Administrative Agent and all future holders of the Loans, the Notes and the Reimbursement Obligations. In the case of any waiver, the Borrower, the Lenders, the Issuers and the Administrative Agent shall be restored to their former position and rights under the Loan Documents, but any Default waived shall not extend to any subsequent or other Default, or impair any right consequent thereon.

11.2 ***Notices***

(a) *Notices Generally.* Except in the case of notices and other communications expressly permitted to be given by telephone, all notices and other

communications provided for herein shall be in writing and shall be delivered by hand or overnight courier service, mailed by certified or registered mail or sent by facsimile or email, as follows:

If to the Borrower:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Carol A. DeNale
Senior Vice President and Treasurer – Treasury Department
Facsimile: (401) 770-5768
Telephone: (401) 770-4407
Email: carol.denale@cvshealth.com

with a copy, in the case of a notice of Default, to:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Tom Moffatt
Vice President, Assistant Secretary and Assistant General Counsel – Corporate Services
Facsimile: (401) 216-3758
Telephone: (401) 770-5409
Email: thomas.moffatt@cvshealth.com

with a copy (in the case of a notice of Default and which shall not constitute notice under this Agreement or any other Loan Document for any purpose) to:

Shearman & Sterling LLP
599 Lexington Avenue
New York, New York 10022
Attention: Gus M. Atiyah
Facsimile: (646) 848-5227
Telephone: (212) 848-5227
Email: gus.atiyah@shearman.com

If to the Administrative Agent or the Swing Line Lender:

in the case of each Borrowing Request, each notice of prepayment under Section 2.7, each Letter of Credit Request, each Competitive Bid Request, each Competitive Bid, and each Competitive Bid Accept/Reject Letter:

BNY Mellon
Administrator/ Issuer Services
Client Services Delivery Loan Processing COE
Loan Administration
6023 Airport Road
Oriskany, New York 13424
Attention: Lauren La Comb
Facsimile: (315) 765-4533
Telephone: (315) 765-4145
Email: afasyndications@bnymellon.com

and in all other cases:

The Bank of New York Mellon
101 Barclay Street
14th Floor West
New York, New York 10286
Attention: H. Stephen Griffith
Facsimile: (212) 815-3749
Telephone: (212) 815-2214
Email: stephen.griffith@bnymellon.com

and

The Bank of New York Mellon
500 Grant Street
Pittsburgh, Pennsylvania 15219
Attention: Clifford Mull
Facsimile: (412) 234-8087
Telephone: (412) 234-1346
Email: clifford.mull@bnymellon.com

If to any Lender or any Issuer: to it at its address (or facsimile number or email address) set forth in its Administrative Questionnaire.

(b) *Electronic Communications*. Notices and other communications to the Credit Parties hereunder may be delivered or furnished by electronic communication (including email and internet or intranet websites) pursuant to procedures approved by the Administrative Agent; *provided* that the foregoing shall not apply to notices to any Credit Party pursuant to Section 2 or Section 3.3 if such Credit Party has notified the Administrative Agent that it is incapable of receiving notices under such Sections by electronic communication. The Administrative Agent or the Borrower may, in its discretion, agree to accept notices and other communications to it hereunder by electronic communications pursuant to procedures approved by it; *provided* that approval of such procedures may be limited to particular notices or communications.

Unless the Administrative Agent otherwise prescribes, (i) notices and other communications sent to an email address shall be deemed received upon the sender's receipt of an acknowledgement from the intended recipient (such as by the "return receipt requested" or "read requested" function, as available, return email or other written acknowledgement); *provided* that if such notice or other communication is not sent during the normal business hours of the recipient, such notice or communication shall be deemed to have been sent at the opening of business on the next Domestic Business Day for the recipient, and (ii) notices or communications posted to an internet or intranet website shall be deemed received upon the deemed receipt by the intended recipient at its email address as described in the foregoing clause (i) of notification that such notice or communication is available and identifying the website address therefor.

(c) *Change of Address*. Any party hereto may change its address, facsimile number or email address for notices and other communications hereunder by notice to the other parties hereto (or, in the case of any Lender or any Issuer, by notice to the Administrative Agent and the Borrower). All notices and other communications given to any party hereto in accordance with the provisions of this Agreement shall be deemed to have been given on the date of receipt; *provided* that any such notice or communication that is not received on a Domestic Business Day during the normal business hours of the recipient shall be deemed received at the opening of business on the next Domestic Business Day.

11.3 *No Waiver; Cumulative Remedies*

No failure to exercise and no delay in exercising, on the part of the Administrative Agent, any Lender or any Issuer, any right, remedy, power or privilege under any Loan Document shall operate as a waiver thereof, nor shall any single or partial exercise of any right, remedy, power or privilege under any Loan Document preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege. The rights, remedies, powers and privileges under the Loan Documents are cumulative and not exclusive of any rights, remedies, powers and privileges provided by law.

11.4 *Survival of Representations and Warranties*

All representations and warranties made in the Loan Documents and in any document, certificate or statement delivered pursuant thereto or in connection therewith shall survive the execution and delivery of the Loan Documents.

11.5 *Payment of Expenses; Indemnified Liabilities*

The Borrower agrees, as soon as practicable following presentation of a statement or invoice therefor setting forth in reasonable detail the items thereof, and whether any Loan is made or Letter of Credit is issued, (a) to pay or reimburse the Administrative Agent and its Affiliates for all their reasonable and documented out-of-pocket costs and expenses actually incurred in connection with the development, syndication, preparation and execution of, and any amendment, waiver, consent, supplement or modification to, the Loan Documents, any documents prepared in connection therewith and the consummation of the transactions contemplated thereby, whether such Loan Documents or any such amendment, waiver, consent, supplement or modification to the Loan Documents or any documents prepared in connection therewith are executed and whether the

transactions contemplated thereby are consummated, including the reasonable and documented out-of-pocket fees and disbursements of Special Counsel, (b) to pay, indemnify, and hold the Administrative Agent, the Lenders and the Issuers harmless from any and all recording and filing fees and any and all liabilities and penalties with respect to, or resulting from any delay (other than penalties to the extent attributable to the negligence of the Administrative Agent, the Lenders or the Issuers, as the case may be, in failing to pay such fees, liabilities or penalties when due) which may be payable or determined to be payable in connection with the execution and delivery of, or consummation of any of the transactions contemplated by, or any amendment, supplement or modification of, or any waiver or consent under or in respect of, the Loan Documents or any documents prepared in connection therewith, and (c) to pay, reimburse, indemnify and hold each Indemnified Person harmless from and against any and all other liabilities, obligations, claims, losses, damages, penalties, actions, judgments, suits, costs, expenses and disbursements of any kind or nature whatsoever (including the reasonable and documented out-of-pocket fees and disbursements of one counsel representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Person))) actually incurred with respect to the enforcement, performance of, and preservation of rights under, the Loan Documents (all the foregoing, collectively, the ***"Indemnified Liabilities"***) and, if and to the extent that the foregoing indemnity may be unenforceable for any reason, the Borrower agrees to make the maximum payment permitted under applicable law. Notwithstanding anything to the contrary contained in this Section 11.5, the foregoing payment, indemnification and reimbursement obligations will not, as to any Person identified in this Section 11.5, apply to any losses, claims, damages, liabilities and related expenses to the extent arising (A) from the willful misconduct, gross negligence, fraud or bad faith of such Person, (B) from a material breach of the obligations hereunder of such Person, (C) out of or in connection with Section 11.22, or (D) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by any such Person against any such other Person (other than the Administrative Agent, in its capacity as such), in each case under clauses (A) through (D), to the extent determined by a final and non-appealable judgment of a court of competent jurisdiction. The agreements in this Section 11.5 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

11.6 *Lending Offices*

Each Lender shall have the right at any time and from time to time to transfer any Loan to a different office of such Lender, subject to Section 3.10.

11.7 *Successors and Assigns*

(a) *Successors and Assigns Generally*. The provisions of this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors

and assigns permitted hereby, except that the Borrower may not assign or otherwise transfer any of its rights or obligations hereunder without the prior written consent of the Administrative Agent and each Lender and no Lender may assign or otherwise transfer any of its rights or obligations hereunder except (i) to an assignee in accordance with the provisions of paragraph (b) of this Section 11.7, (ii) by way of participation in accordance with the provisions of paragraph (d) of this Section 11.7 or (iii) by way of pledge or assignment of a security interest subject to the restrictions of paragraph (f) of this Section 11.7 (and any other attempted assignment or transfer by any party hereto shall be null and void). Nothing in this Agreement, expressed or implied, shall be construed to confer upon any Person (other than the parties hereto, their respective successors and assigns permitted hereby, the Participants to the extent provided in paragraph (d) of this Section 11.7 and, to the extent expressly contemplated hereby, the Related Parties of each Credit Party) any legal or equitable right, remedy or claim under or by reason of this Agreement.

(b) *Assignments by Lenders*. Any Lender may at any time assign to one or more assignees all or a portion of its rights and obligations under this Agreement (including all or a portion of its Commitment and the Loans and obligations in respect of its Letter of Credit Exposure and Swing Line Exposure at the time owing to it); *provided* that any such assignment shall be subject to the following conditions:

(1) *Minimum Amounts*.

(A) in the case of an assignment of the entire remaining amount of the assigning Lender's Commitment Amount or Swing Line Commitment and the Loans and obligations in respect of its Letter of Credit Exposure and Swing Line Exposure at the time owing to it or in the case of an assignment to a Lender, an Affiliate of a Lender or an Approved Fund, no minimum amount need be assigned; and

(B) in any case not described in paragraph (b)(1)(A) of this Section 11.7, the Commitment Amount or Swing Line Commitment (which for this purpose includes the Loans of the assigning Lender outstanding thereunder and obligations in respect of its Letter of Credit Exposure and Swing Line Exposure at the time owing to it thereunder) or, if the Commitment or Swing Line Commitment of the assigning Lender is not then in effect, the principal outstanding balance of the Loans and the Letter of Credit Exposure and Swing Line Exposure of the assigning Lender subject to each such assignment (determined as of the date the Assignment and Assumption with respect to such assignment is delivered to the Administrative Agent or, if a "Trade Date" is specified in the Assignment and Assumption, as of such "Trade Date") shall not be less than $5,000,000, unless each of the Administrative Agent and, so long as no Event of Default has occurred and is continuing, the Borrower otherwise consents (each such consent not to be unreasonably withheld or delayed).

(2) *Proportionate Amounts*. Each partial assignment shall be made as an assignment of a proportionate part of all the assigning Lender's rights and obligations under this Agreement with respect to the Loans, Letter of Credit Exposure and Swing Line Exposure or the Commitment assigned, except that this clause (2) shall not prohibit any Lender from assigning all or a portion of its rights and obligations in respect of Competitive Bid Loans on a non-pro rata basis.

(3) *Required Consents*. No consent shall be required for any assignment except to the extent required by paragraph (b)(1)(B) of this Section 11.7 and, in addition:

(A) the consent of the Borrower (such consent not to be unreasonably withheld or delayed) shall be required unless (x) an Event of Default has occurred and is continuing at the time of such assignment or (y) such assignment is to a Lender, an Affiliate of a Lender or an Approved Fund;

(B) the consent of the Administrative Agent (such consent not to be unreasonably withheld or delayed) shall be required for assignments in respect of an unfunded or revolving facility hereunder if such assignment is to a Person that is not a Lender with a Commitment in respect of such facility, an Affiliate of such Lender or an Approved Fund with respect to such Lender; and

(C) the consent of each Issuer (such consent not to be unreasonably withheld or delayed) shall be required for any assignment that increases the obligation of the assignee to participate in exposure under one or more Letters of Credit (whether or not then outstanding) and the Swing Line Lender (such consent not to be unreasonably withheld or delayed) shall be required for any assignment in respect of the revolving facility hereunder.

(4) *Assignment and Assumption*. The parties to each assignment shall execute and deliver to the Administrative Agent an Assignment and Assumption, together with a processing and recordation fee of $4,500 ($7,500 in the case of an assignment by a Defaulting Lender) (which fee may be waived or reduced in the sole discretion of the Administrative Agent), and the assignee, if it is not a Lender, shall deliver to the Administrative Agent an Administrative Questionnaire.

(5) *No Assignment to Certain Parties*. No such assignment shall be made to the Borrower, any of its Subsidiaries or any of their respective Affiliates.

(6) *No Assignment to Natural Persons*. No such assignment shall be made to a natural person.

Subject to acceptance and recording thereof by the Administrative Agent pursuant to paragraph (c) of this Section 11.7, from and after the effective date specified in each Assignment and Assumption, the assignee thereunder shall be a party to this Agreement and, to the extent of the interest assigned by such Assignment and Assumption, have the rights and obligations of a Lender under this Agreement, and the assigning Lender thereunder shall, to the extent of the interest assigned by such Assignment and Assumption, be released from its obligations under this Agreement (and, in the case of an Assignment and Assumption covering all of the assigning Lender's rights and obligations under this Agreement, such Lender shall cease to be a party hereto) but shall continue to be entitled to the benefits of Section 3.6, Section 3.7, and Section 11.10 with respect to facts and circumstances occurring prior to the effective date of such assignment. Any assignment or transfer by a Lender of rights or obligations under this Agreement that does not comply with this paragraph shall be treated for purposes of this Agreement as a sale by such Lender

of a participation in such rights and obligations in accordance with paragraph (d) of this Section 11.7.

(c) *Register*. The Administrative Agent, acting solely for this purpose as an agent of the Borrower, shall maintain at one of its offices in New York, New York a copy of each Assignment and Assumption delivered to it and a register for the recordation of the names and addresses of the Lenders, and the Commitments of, and principal amounts (and stated interest) of the Loans owing to, each Lender pursuant to the terms hereof from time to time (the ***"Register"***). The entries in the Register shall be conclusive, and the Borrower, the Administrative Agent, the Issuers and the Lenders may treat each Person whose name is recorded in the Register pursuant to the terms hereof as a Lender hereunder for all purposes of this Agreement, notwithstanding notice to the contrary. The Register shall be available for inspection by the Borrower, any Issuer and any Lender at any reasonable time and from time to time upon reasonable prior notice.

(d) *Participations*. Any Lender may at any time, without the consent of, or notice to, the Borrower or the Administrative Agent, sell participations to any Person (other than a natural person, the Borrower, any of its Subsidiaries or any of their respective Affiliates) (each, a ***"Participant"***) in all or a portion of such Lender's rights and/or obligations under this Agreement (including all or a portion of its Commitment, Letter of Credit Exposure, Swing Line Exposure and/or the Loans, Letter of Credit Exposure or Swing Line Exposure owing to it); *provided* that (i) such Lender's obligations under this Agreement shall remain unchanged, (ii) such Lender shall remain solely responsible to the other parties hereto for the performance of such obligations and (iii) the Borrower, the Administrative Agent and each Credit Party shall continue to deal solely and directly with such Lender in connection with such Lender's rights and obligations under this Agreement. Any agreement or instrument pursuant to which a Lender sells such a participation shall provide that such Lender shall retain the sole right to enforce this Agreement and to approve any amendment, modification or waiver of any provision of this Agreement; *provided* that such agreement or instrument may provide that such Lender will not, without the consent of the Participant, agree to any amendment, modification or waiver which requires the consent of all Lenders or all affected Lenders that directly affects such Participant. Subject to paragraph (e) of this Section 11.7, the Borrower agrees that each Participant shall be entitled to the benefits of Section 3.5, Section 3.6, Section 3.7 and Section 3.10 to the same extent as if it were a Lender and had acquired its interest by assignment pursuant to paragraph (b) of this Section 11.7. To the extent permitted by law, each Participant also shall be entitled to the benefits of Section 11.9(a) as though it were a Lender, *provided* that such Participant agrees to be subject to Section 11.9(b) as though it were a Lender. Each Lender that sells a participation with respect to a Commitment or Loan shall, solely for the purposes of complying with the rules regarding registered form in the Internal Revenue Code, act as a non-fiduciary agent of the Borrower, maintaining a register on which it enters the name and address of each Participant and the principal amounts (and related interest amounts) of each Participant's interest in the Commitment and/or Loan (each a ***"Participant Register"***), and the entries in such Participant Register shall be conclusive, absent manifest error, and such Lender shall treat each Person whose name is recorded in the Participant Register as the owner of such participation for all purposes of this Agreement notwithstanding any notice to the contrary. No Lender shall be required to disclose the existence of, or any of the information contained in, any Participant Register maintained by it to the Borrower or any other Person unless requested in writing by the

Borrower, and only to the Internal Revenue Service to the extent such disclosure is required in order to comply with the rules requiring registered form pursuant to the Internal Revenue Code.

(e) *Limitations upon Participant Rights*. A Participant shall not be entitled to receive any greater payment under Section 3.6, Section 3.7 or Section 3.10 than the applicable Lender would have been entitled to receive with respect to the participation sold to such Participant, unless the sale of the participation to such Participant is made with the Borrower's prior written consent. A Participant shall not be entitled to the benefits of Section 3.10 unless the Borrower is notified of the participation sold to such Participant and such Participant agrees, for the benefit of the Borrower, to comply with Section 3.10(f) as though it were a Lender.

(f) *Certain Pledges*. Any Lender may at any time pledge or assign a security interest in all or any portion of its rights under this Agreement to secure obligations of such Lender, including any pledge or assignment to secure obligations to a Federal Reserve Bank or other central bank having jurisdiction over such Lender; *provided* that no such pledge or assignment shall release such Lender from any of its obligations hereunder or substitute any such pledgee or assignee for such Lender as a party hereto.

11.8 ***Counterparts; Electronic Execution of Assignments***

(a) *Counterparts*. Each of the Loan Documents (other than the Notes) may be executed on any number of separate counterparts and all of said counterparts taken together shall be deemed to constitute one and the same agreement. It shall not be necessary in making proof of any Loan Document to produce or account for more than one counterpart signed by the party to be charged. A set of the copies of this Agreement signed by all of the parties hereto shall be lodged with each of the Borrower and the Administrative Agent. Delivery of an executed counterpart of a signature page of any Loan Document by fax or other electronic means (e.g., ".pdf" or ".tif") shall be effective as delivery of a manually executed counterpart of such Loan Document.

(b) *Electronic Execution of Assignments*. The words "execution," "signed," "signature," and words of like import in any Assignment and Assumption shall be deemed to include electronic signatures or the keeping of records in electronic form, each of which shall be of the same legal effect, validity or enforceability as a manually executed signature or the use of a paper-based recordkeeping system, as the case may be, to the extent and as provided for in any applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, the New York State Electronic Signatures and Records Act, or any other similar state laws based on the Uniform Electronic Transactions Act.

11.9 ***Set-off and Sharing of Payments***

(a) In addition to any rights and remedies of the Lenders and the Issuers provided by law, upon the occurrence of an Event of Default under Section 9.1(a) or Section 9.1(b) or upon the acceleration of the Loans, each Lender and each Issuer shall have the right, without prior notice to the Borrower, any such notice being expressly waived by the Borrower, to set-off and apply against any indebtedness or other liability, whether matured or unmatured, of the Borrower to such Lender or such Issuer arising under the Loan Documents, any amount

owing from such Lender or such Issuer to the Borrower. To the extent permitted by applicable law, the aforesaid right of set-off may be exercised by such Lender or such Issuer against the Borrower or against any trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors, receiver, or execution, judgment or attachment creditor of the Borrower, or against anyone else claiming through or against the Borrower or such trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors, receivers, or execution, judgment or attachment creditor, notwithstanding the fact that such right of set-off shall not have been exercised by such Lender or such Issuer prior to the making, filing or issuance of, service upon such Lender or such Issuer of, or notice to such Lender or such Issuer of, any petition, assignment for the benefit of creditors, appointment or application for the appointment of a receiver, or issuance of execution, subpoena, order or warrant. Each Lender and each Issuer agree promptly to notify the Borrower and the Administrative Agent after each such set-off and application made by such Lender or such Issuer, *provided* that the failure to give such notice shall not affect the validity of such set-off and application.

(b) If any Lender or any Issuer shall obtain any payment (whether voluntary, involuntary, through the exercise of any right of set-off, or otherwise) on account of its Loans or its Notes or the Reimbursement Obligations in excess of its pro rata share (in accordance with the outstanding principal balance of all Loans or the Reimbursement Obligations) of payments then due and payable on account of the Loans and Notes received by all the Lenders or the Reimbursement Obligations received by all Issuers, such Lender or such Issuer, as the case may be, shall forthwith purchase, without recourse, for cash, from the other Lenders or Issuers, as the case may be, such participations in their Loans and Notes or the Reimbursement Obligations as shall be necessary to cause such purchasing Lender or Issuer to share the excess payment with each of them according to their pro rata share (in accordance with the outstanding principal balance of all Loans and the Reimbursement Obligations); *provided* that if all or any portion of such excess payment is thereafter recovered from such purchasing Lender or Issuer, such purchase from each Lender or Issuer shall be rescinded and each such Lender and Issuer shall repay to the purchasing Lender or Issuer the purchase price to the extent of such recovery, together with an amount equal to such Lender's or Issuer's pro rata share (according to the proportion of (i) the amount of such Lender's or Issuer's required repayment to (ii) the total amount so recovered from the purchasing Lender or Issuer) of any interest or other amount paid or payable by the purchasing Lender or Issuer in respect of the total amount so recovered. The Borrower agrees, to the fullest extent permitted by law, that any Lender or Issuer so purchasing a participation from another Lender or Issuer pursuant to this Section 11.9 may exercise such rights to payment (including the right of set-off) with respect to such participation as fully as if such Lender or Issuer were the direct creditor of the Borrower in the amount of such participation.

11.10 ***Indemnity***

(a) The Borrower shall indemnify each Credit Party and each Related Party thereof (each such Person being called an ***"Indemnified Person"***) against, and hold each Indemnified Person harmless from, any and all losses, claims, damages, liabilities and related expenses, including the reasonable and documented out-of-pocket fees and disbursements of one counsel representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty

counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Person)), actually incurred by any Indemnified Person arising out of, in connection with, or as a result of (i) the execution or delivery of any Loan Document or any agreement or instrument contemplated thereby, the performance by the parties to the Loan Documents of their respective obligations thereunder or the consummation of the transactions contemplated hereby or any other transactions contemplated thereby, (ii) any Loan or Letter of Credit or the use of the proceeds thereof, (iii) any actual or alleged presence or release of Hazardous Materials in, on, under or from any property owned or operated by the Borrower or any of the Subsidiaries, or any Environmental Liability related in any way to the Borrower or any of the Subsidiaries or (iv) any actual or prospective claim, litigation, investigation or proceeding relating to any of the foregoing, whether based on statute, contract, tort or any other theory and regardless of whether any Indemnified Person is a party thereto. Notwithstanding anything to the contrary contained in this Section 11.10(a), the foregoing indemnity will not, as to any Indemnified Person, apply to any losses, claims, damages, liabilities and related expenses to the extent arising (A) from the willful misconduct, gross negligence, fraud or bad faith of such Indemnified Person, (B) from a material breach of the obligations hereunder of such Indemnified Person, (C) out of or in connection with Section 11.22, or (D) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by an Indemnified Person against any other Indemnified Person (other than the Administrative Agent, in its capacity as such), in each case under clauses (A) through (D), to the extent determined by a final and non-appealable judgment of a court of competent jurisdiction. The Borrower shall not be liable for any settlement of any investigation, litigation or proceeding to which the indemnity in this Section 11.10(a) applies (any of the foregoing, a ***"Proceeding"***) effected without the Borrower's prior written consent (which consent shall not be unreasonably withheld or delayed, it being understood and agreed that the withholding or delaying of the Borrower's consent in connection with a settlement which does not include an unconditional release of the Borrower and the Subsidiaries from all liability or claims that are the subject matter of such Proceeding or which includes a statement as to any admission of fault by or on behalf of the Borrower or any Subsidiary shall not be deemed unreasonable), but if settled with the Borrower's prior written consent or if there is a final judgment for the plaintiff in any such Proceeding, the Borrower agrees to indemnify and hold harmless each Indemnified Person from and against any and all losses, claims, damages, liabilities and expenses by reason of such settlement or judgment in accordance with this Section 11.10(a). The Borrower shall not, without the prior written consent of an Indemnified Person, effect any settlement of any pending or threatened Proceeding against such Indemnified Person in respect of which indemnity could have been sought hereunder by such Indemnified Person unless such settlement (x) includes an unconditional release of such Indemnified Person from all liability or claims that are the subject matter of such Proceeding and (y) does not include any statement as to any admission of fault by or on behalf of such Indemnified Person. Notwithstanding the above, the Borrower shall have no liability under clause (i) of this Section 11.10(a) to indemnify or hold harmless any Indemnified Person for any losses, claims,

damages, liabilities and related expenses relating to income or withholding Taxes or any Tax in lieu of such Taxes.

(b) To the extent that the Borrower fails to pay as soon as practicable any amount required to be paid by it to the Administrative Agent under subsection (a) of this Section 11.10 (the ***"Indemnified Amount"***), each Lender severally agrees to pay to the Administrative Agent an amount equal to the product of such unpaid amount *multiplied by* (i) at any time when no Loans are outstanding, its Commitment Percentage, and (ii) at any time when Loans are outstanding (x) if the Commitments then exist, its Commitment Percentage or (y) if the Commitments have been terminated or otherwise no longer exist, the percentage equal to the fraction, (A) the numerator of which is the sum of such Lender's Credit Exposure and (B) the denominator of which is the sum of the Aggregate Credit Exposure (in each case determined as of the time that the applicable Indemnified Amount is sought), *provided* that the Indemnified Amount was payable to the Administrative Agent in its capacity as such.

(c) The obligations of the Borrower and the Lenders under this Section 11.10 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

(d) To the extent permitted by applicable law, the Borrower shall not assert, and hereby waives, any claim against any Indemnified Person, on any theory of liability, for special, indirect, consequential or punitive damages (as opposed to direct and actual damages) arising out of, in connection with, or as a result of, any Loan Document or any agreement, instrument or other document contemplated thereby, the transactions contemplated hereby or any Loan or any Letter of Credit or the use of the proceeds thereof.

11.11 ***Governing Law***

The Loan Documents and the rights and obligations of the parties thereto shall be governed by, and construed and interpreted in accordance with, the laws of the State of New York.

11.12 ***Severability***

Every provision of the Loan Documents is intended to be severable, and if any term or provision thereof shall be invalid, illegal or unenforceable for any reason, the validity, legality and enforceability of the remaining provisions thereof shall not be affected or impaired thereby, and any invalidity, illegality or unenforceability in any jurisdiction shall not affect the validity, legality or enforceability of any such term or provision in any other jurisdiction.

11.13 ***Integration***

All exhibits to the Loan Documents shall be deemed to be a part thereof. Each Loan Document embodies the entire agreement and understanding between or among the parties thereto with respect to the subject matter thereof and supersedes all prior agreements and understandings between or among the parties thereto with respect to the subject matter thereof.

11.14 ***Treatment of Certain Information***

(a) Each Credit Party agrees to maintain the confidentiality of the Information (as defined below), except that Information may be disclosed (i) to its Affiliates and to its and its Affiliates' respective partners, directors, officers, employees, agents, advisors and other representatives (it being understood that the Persons to whom such disclosure is made will be informed of the confidential nature of such Information and instructed to keep such Information confidential), (ii) to the extent requested by any regulatory authority purporting to have jurisdiction over it (including any self-regulatory authority, such as the National Association of Insurance Commissioners), (iii) to the extent required by applicable laws or regulations or by any subpoena or similar legal process, (iv) to any other party hereto, (v) in connection with the exercise of any remedies hereunder or under any other Loan Document or any action or proceeding relating to this Agreement or any other Loan Document or the enforcement of rights hereunder or thereunder, (vi) subject to an agreement containing provisions substantially the same as those of this Section 11.14, to (A) any assignee of or Participant in, or any prospective assignee of or Participant in, any of its rights or obligations under this Agreement or (B) any actual or prospective counterparty (or its advisors) to any swap or derivative transaction relating to the Borrower and its obligations, (vii) to Gold Sheets and other similar bank trade publications, such information to consist of deal terms and other information customarily found in such publications, (viii) with the consent of the Borrower or (ix) to the extent such Information (1) becomes publicly available other than as a result of a breach of this Section 11.14 or (2) becomes available to the Administrative Agent, any Credit Party or any of their respective Affiliates on a non-confidential basis from a source other than the Borrower not known to such Credit Party to be prohibited from disclosing such Information.

(b) For purposes of this Section 11.14, ***"Information"*** means all information received from the Borrower or any of its Subsidiaries relating to the Borrower or any of its Subsidiaries or any of their respective businesses, other than any such information that is available to the Administrative Agent or any other Credit Party on a non-confidential basis prior to disclosure by the Borrower or any of its Subsidiaries.

11.15 ***Acknowledgments***

The Borrower acknowledges that (a) it has been advised by counsel in the negotiation, execution and delivery of the Loan Documents, (b) by virtue of the Loan Documents, the relationship among the Administrative Agent, the Issuers and the Lenders, on the one hand, and the Borrower, on the other hand, is solely that of debtor and creditor, and (c) by virtue of the Loan Documents, no joint venture exists among the Lenders or among the Borrower and the Lenders.

11.16 ***Consent to Jurisdiction***

The Borrower irrevocably submits to the exclusive jurisdiction of any New York State or Federal Court sitting in the City of New York, Borough of Manhattan, over any suit, action or proceeding arising out of or relating to the Loan Documents. The Borrower irrevocably waives, to the fullest extent permitted by law, any objection which it may now or hereafter have to the laying of the venue of any such suit, action or proceeding brought in such a court and any claim that any such suit, action or proceeding brought in such a court has been

brought in an inconvenient forum. The Borrower agrees that a final judgment in any such suit, action or proceeding brought in such a court, after all appropriate appeals, shall be conclusive and binding upon it.

11.17 ***Service of Process***

The Borrower agrees that process may be served against it in any suit, action or proceeding referred to in Section 11.16 by sending the same by first class mail, return receipt requested or by overnight courier service, with receipt acknowledged, to the address of the Borrower set forth or referred to in Section 11.2. The Borrower agrees that any such service (i) shall be deemed in every respect effective service of process upon it in any such suit, action, or proceeding, and (ii) shall to the fullest extent enforceable by law, be taken and held to be valid personal service upon and personal delivery to it.

11.18 ***No Limitation on Service or Suit***

Nothing in the Loan Documents or any modification, waiver, or amendment thereto shall affect the right of the Administrative Agent, any Issuer or any Lender to serve process in any manner permitted by law or limit the right of the Administrative Agent, any Issuer or any Lender to bring proceedings against the Borrower in the courts of any jurisdiction or jurisdictions.

11.19 ***WAIVER OF TRIAL BY JURY***

EACH OF THE CREDIT PARTIES AND THE BORROWER KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION ARISING OUT OF, UNDER OR IN CONNECTION WITH THE LOAN DOCUMENTS OR THE TRANSACTIONS CONTEMPLATED THEREBY. FURTHER, THE BORROWER HEREBY CERTIFIES THAT NO REPRESENTATIVE OR AGENT OF ANY OF THE CREDIT PARTIES, OR COUNSEL TO ANY OF THE CREDIT PARTIES, HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT ANY OF THE CREDIT PARTIES WOULD NOT, IN THE EVENT OF SUCH LITIGATION, SEEK TO ENFORCE THIS WAIVER OF RIGHT TO JURY TRIAL PROVISION. THE BORROWER ACKNOWLEDGES THAT THE CREDIT PARTIES HAVE BEEN INDUCED TO ENTER INTO THIS AGREEMENT BY, *INTER ALIA*, THE PROVISIONS OF THIS SECTION 11.19.

11.20 ***Patriot Act Notice***

Each Lender and the Administrative Agent (for itself and not on behalf of any Lender) hereby notifies the Borrower that pursuant to the requirements of the USA PATRIOT Act (Title III of Pub. L. 107-56 (signed into law October 26, 2001), as amended from time to time) (the ***"Patriot Act"***), it is required to obtain, verify and record information that identifies the Borrower, which information includes the name and address of the Borrower and other information that will allow such Lender or the Administrative Agent, as applicable, to identify the Borrower in accordance with the Patriot Act.

11.21 ***No Fiduciary Duty***

The Borrower agrees that in connection with all aspects of the transactions contemplated hereby and any communications in connection therewith, the Borrower and its Subsidiaries, on the one hand, and the Credit Parties, the Joint Lead Arrangers and Joint Bookrunners named on the cover page hereof, and their respective Affiliates, on the other hand, will have a business relationship that does not create, by implication or otherwise, any fiduciary duty on the part of the Credit Parties or such Joint Lead Arrangers and Joint Bookrunners, or their respective Affiliates, and no such duty will be deemed to have arisen in connection with any such transactions or communications.

11.22 ***Acknowledgement and Consent to Bail-In of EEA Financial Institutions***

Notwithstanding anything to the contrary in any Loan Document or in any other agreement, arrangement or understanding among any such parties, each party hereto acknowledges that any liability of any Lender or Issuer that is an EEA Financial Institution arising under any Loan Document, to the extent such liability is unsecured, may be subject to the Write-Down and Conversion Powers of an EEA Resolution Authority and agrees and consents to, and acknowledges and agrees to be bound by:

(a) the application of any Write-Down and Conversion Powers by an EEA Resolution Authority to any such liabilities arising hereunder which may be payable to it by any Lender or Issuer that is an EEA Financial Institution; and

(b) the effects of any Bail-in Action on any such liability, including, if applicable:

(i) a reduction in full or in part or cancellation of any such liability;

(ii) a conversion of all, or a portion of, such liability into shares or other instruments of ownership in such EEA Financial Institution, its parent undertaking, or a bridge institution that may be issued to it or otherwise conferred on it, and that such shares or other instruments of ownership will be accepted by it in lieu of any rights with respect to any such liability under this Agreement or any other Loan Document; or

(iii) the variation of the terms of such liability in connection with the exercise of the Write-Down and Conversion Powers of any EEA Resolution Authority.

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AS EVIDENCE of the agreement by the parties hereto to the terms and conditions herein contained, each such party has caused this Agreement to be executed on its behalf.

CVS HEALTH CORPORATION

By: /s/ Carol A. DeNale
Name: Carol A. DeNale
Title: Senior Vice President and Treasurer

CVS Health Corporation 2017 Five Year Credit Agreement

THE BANK OF NEW YORK MELLON,
as the Administrative Agent, an Issuer, the
Swing Line Lender and a Lender

By: /s/ Clifford A. Mull
Name: Clifford A. Mull
Title: First Vice President

CVS Health Corporation 2017 Five Year Credit Agreement

BANK OF AMERICA, N.A.,
as a Co-Documentation Agent, an Issuer and a Lender

By: /s/ Carlos Medina
Name: Carlos Medina
Title: Director

CVS Health Corporation 2017 Five Year Credit Agreement

WELLS FARGO BANK, N.A.,
as a Co-Documentation Agent, an Issuer and a Lender

By: /s/ Christopher M. Johnson
Name: Christopher M. Johnson
Title: Vice President

CVS Health Corporation 2017 Five Year Credit Agreement

BARCLAYS BANK PLC,
as a Co-Syndication Agent, an Issuer and a Lender

By: /s/ Ritam Bhalla
Name: Ritam Bhalla
Title: Director

CVS Health Corporation 2017 Five Year Credit Agreement

JPMORGAN CHASE BANK, N.A.,
as a Co-Syndication Agent, an Issuer and a Lender

By: /s/ Robert D. Bryant
Name: Robert D. Bryant
Title: Executive Director

CVS Health Corporation 2017 Five Year Credit Agreement

MIZUHO BANK, LTD., as a Lender

By: /s/ Tracy Rahn
Name: Tracy Rahn
Title: Authorized Signatory

CVS Health Corporation 2017 Five Year Credit Agreement

SUNTRUST BANK, as a Lender

By: /s/ Johnetta Bush
Name: Johnetta Bush
Title: Director

CVS Health Corporation 2017 Five Year Credit Agreement

GOLDMAN SACHS BANK USA, as a Lender

By: /s/ Annie Carr
Name: Annie Carr
Title: Authorized Signatory

CVS Health Corporation 2017 Five Year Credit Agreement

U.S. BANK NATIONAL ASSOCIATION, as a Lender

By: /s/ Joyce P. Dorsett
Name: Joyce P. Dorsett
Title: Vice President

CVS Health Corporation 2017 Five Year Credit Agreement

THE BANK OF TOKYO-MITSUBISHI UFJ, LTD., as a Lender

By: /s/ Brian McNany
Name: Brian McNany
Title: Director

CVS Health Corporation 2017 Five Year Credit Agreement

ROYAL BANK OF CANADA, as a Lender

By: /s/ Gordon MacArthur
Name: Gordon MacArthur
Title: Authorized Signatory

CVS Health Corporation 2017 Five Year Credit Agreement

KEYBANK NATIONAL ASSOCIATION, as a Lender

By: /s/ Marianne T. Meil
Name: Marianne T. Meil
Title: Senior Vice President

CVS Health Corporation 2017 Five Year Credit Agreement

FIFTH THIRD BANK, as a Lender

By: /s/ Todd S. Robinson
Name: Todd S. Robinson
Title: VP

CVS Health Corporation 2017 Five Year Credit Agreement

PNC BANK, NATIONAL ASSOCIATION, as a Lender

By: /s/ Michael A. Richards
Name: Michael A. Richards
Title: Senior Vice President

CVS Health Corporation 2017 Five Year Credit Agreement

SANTANDER BANK N.A., as a Lender

By: /s/ Andres Barbosa
Name: Andres Barbosa
Title: Executive Director

CVS Health Corporation 2017 Five Year Credit Agreement

INDUSTRIAL AND COMMERCIAL BANK OF CHINA LIMITED, NEW YORK BRANCH, as a Lender

By: /s/ Hsiwei Chen
Name: Hsiwei Chen
Title: VP

By: /s/ Pinyen Shih
Name: Pinyen Shih
Title: Executive Director

CVS Health Corporation 2017 Five Year Credit Agreement

TD BANK, N.A., as a Lender

By: /s/ Uk-Sun Kim
Name: Uk-Sun Kim
Title: Senior Vice President

CVS Health Corporation 2017 Five Year Credit Agreement

SUMITOMO MITSUI BANKING CORPORATION, as a Lender

By: /s/ James Weinstein
Name: James Weinstein
Title: Managing Director

CVS Health Corporation 2017 Five Year Credit Agreement

BANK OF CHINA, NEW YORK BRANCH,
as a Lender

By: /s/ Raymond Qiao
Name: Raymond Qiao
Title: Managing Director

CVS Health Corporation 2017 Five Year Credit Agreement

BANK OF HAWAII, as a Lender

By: /s/ John McKenna
Name: John McKenna
Title: Senior Vice President

CVS Health Corporation 2017 Five Year Credit Agreement

Commitment Increase Supplement

CVS Credit Agreement Amendment No. 1 Five-Year 2018

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Exhibit 10.3

EXECUTION VERSION

AMENDMENT NO. 1 TO FIVE YEAR CREDIT AGREEMENT

AMENDMENT NO. 1 (this "Amendment"), dated as of May 16, 2019, is entered into among CVS Health Corporation, a Delaware corporation (the "Borrower"), The Bank of New York Mellon, as Administrative Agent, and the Lenders party hereto (the "Consenting Lenders"). Except as otherwise provided herein, capitalized terms used herein which are not defined herein shall have the meanings set forth in the Credit Agreement (as defined below).

WHEREAS, the Borrower, the Lenders and the Administrative Agent entered into that certain Five Year Credit Agreement, dated as of May 17, 2018 (as amended, amended and restated, supplemented or otherwise modified from time to time prior to the date hereof, the "Credit Agreement"); and

WHEREAS, the Borrower has requested that the Lenders amend the Credit Agreement as set forth below.

NOW, THEREFORE, in consideration of the covenants, conditions and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, and pursuant to Section 11.1 of the Credit Agreement, the parties hereto hereby agree as follows:

1. Amendments. The Credit Agreement is hereby amended as follows:

(a) Section 1.1 of the Credit Agreement is hereby amended by adding the following new definitions in the appropriate alphabetical order:

"***Acquisition Debt***": any Indebtedness incurred by the Borrower or any of its Subsidiaries for the purpose of financing, in whole or in part, a Material Acquisition and any related transactions or series of related transactions (including for the purpose of refinancing or replacing all or a portion of any pre-existing Indebtedness of the Person(s) or assets to be acquired), which Indebtedness is redeemable or prepayable if such Material Acquisition is not consummated.

"Amendment No. 1 Effective Date": May 16, 2019.

"***Equity Interests***": shares of capital stock, partnership interests, membership interests, beneficial interests or other ownership interests, whether voting or nonvoting, in, or interests in the income or profits of, a Person, and any warrants, options or other rights entitling the holder thereof to purchase or acquire any of the foregoing.

"Existing 2019 Credit Agreement": the Five Year Credit Agreement, dated as of May 16, 2019, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, GS and Wells Fargo, as co-documentation agents, and BofA, as administrative agent, as amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Indebtedness for Borrowed Money": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, and (d) Contingent Obligations in respect of any indebtedness described in items (a) - (c) above; *provided* that, for purposes of this definition, Indebtedness for Borrowed Money shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"***LIBOR Successor Rate***": as defined in Section 3.8(d).

"***LIBOR Successor Rate Conforming Changes***": as defined in Section 3.8(d).

"***Material Acquisition***": any acquisition of (a) Equity Interests in any Person if, after giving effect thereto, such Person will become a Subsidiary or (b) assets comprising all or substantially all the assets of (or all or substantially all the assets constituting a business unit, division, product line or line of business of) any Person; provided that the aggregate consideration therefor (including Indebtedness assumed in connection therewith, all obligations in respect of the deferred purchase price therefor (including obligations under any purchase price adjustment but excluding earn-out or similar payments) and all other consideration payable in connection therewith (including payment obligations in respect of noncompetition agreements or other arrangements representing acquisition consideration)) equals or exceeds $500,000,000.

"***Material Subsidiary***": a Subsidiary of the Borrower with respect to which (i) the Borrower's and its other Subsidiaries' investments in, and advances to, such Subsidiary exceed ten percent (10%) of the total assets of the Borrower and its Subsidiaries Consolidated as of the end of the most recently completed fiscal year, (ii) the Borrower's and its other Subsidiaries' proportionate share of the total assets (after intercompany eliminations) of such Subsidiary exceeds 10 percent (10%) of the total assets of the Borrower and its Subsidiaries Consolidated as of the end of the most recently completed fiscal year, or (iii) the Borrower's and its other Subsidiaries' equity in the income from continuing operations before income taxes of such Subsidiary exclusive of amounts attributable to any non-controlling interests exceeds ten percent (10%) of such income of the Borrower and its Subsidiaries Consolidated for the most recently completed fiscal year.

"***Scheduled Unavailability Date***": as defined in Section 3.8(d)(ii).

"***SEC Reports***": the Borrower's 2018 Annual Report on Form 10-K, the Borrower's quarterly report on Form 10-Q for the quarterly period ending March 31, 2019, and any 8-K filings made by the Borrower subsequent to March 31, 2019 and prior to the Amendment No. 1 Effective Date.

(b) Section 1.1 of the Credit Agreement is hereby further amended by amending and restating the following definitions in their entirety to read as follows:

"Existing 2017 Credit Agreement": the Five Year Credit Agreement, dated as of May 18, 2017, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and BNY Mellon, as administrative agent, as amended by Amendment No. 1 to Five Year Credit Agreement, dated as of December 15, 2017, Amendment No. 2 to Five Year Credit Agreement, dated as of May 17, 2018, Amendment No. 3 to Five Year Credit Agreement, dated as of May 16, 2019, and as the same may be further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 364-Day Credit Agreement": the 364-Day Credit Agreement, dated as of May 16, 2019, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, GS and Wells Fargo, as co-documentation agents, and BofA, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"GAAP": subject to Section 1.2(b), generally accepted accounting principles set forth in the opinions and pronouncements of the Accounting Principles Board and the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board or such other principles as may be approved by a significant segment of the accounting profession, which are applicable to the circumstances as of the date of determination, consistently applied.

"Indebtedness": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) indebtedness with respect to any conditional sale or other title retention agreement, (d) indebtedness arising under acceptance facilities and the amount available to be drawn under all letters of credit (excluding for purposes of Section 8.9 letters of credit obtained in the ordinary course of business by the Borrower or any Subsidiary) issued for the account of such Person and, without duplication, all drafts drawn thereunder to the extent such Person shall not have reimbursed the issuer thereof in respect of such issuer's payment of such drafts, (e) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, (f) all indebtedness described in (a) - (e) above secured by any Lien on any Property owned by such Person even though such Person shall not have assumed or otherwise become liable for the payment thereof (other than carriers', warehousemen's, mechanics', repairmen's or other like non-consensual Liens arising in the ordinary course of business), and (g) Contingent Obligations in respect of any indebtedness described in items (a) - (f) above; *provided* that, for purposes of this definition, Indebtedness shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"***Threshold Amount***": $300,000,000.

(c) Section 1.1 of the Credit Agreement is hereby amended by deleting the following definitions set forth therein: "Acquisition," "Acquisition Indebtedness," "Aetna Existing Indebtedness," "CVS Bridge Facility," "CVS Bridge Facility Commitment Letter," "Existing 2015 Credit Agreement," "Net Tangible Assets Test," and "Restricted Payment".

(d) Section 1.2 of the Credit Agreement is hereby amended by amending and restating clause (b) thereof in its entirety as follows:

"(b) Unless otherwise expressly provided herein, the word "fiscal" when used herein shall refer to the relevant fiscal period of the Borrower. As used in the Loan Documents and in any certificate, opinion or other document made or delivered pursuant thereto, accounting terms not defined in Section 1.1, and accounting terms partly defined in Section 1.1, to the extent not defined, shall have the respective meanings given to them under GAAP as in effect from time to time; provided that, if the Borrower notifies the Administrative Agent that the Borrower requests an amendment to any provision hereof to eliminate the effect of any change occurring after the date hereof in GAAP or in the application thereof on the operation of such provision (or if the Administrative Agent notifies the Borrower that the Required Lenders request an amendment to any provision hereof for such purpose), regardless of whether any such notice is given before or after such change in GAAP or in the application thereof, then such provision shall be interpreted on the basis of, and any accounting term related thereto shall have the respective meaning given to it under, GAAP as in effect and applied immediately before such change shall have become effective until such notice shall have been withdrawn or such provision amended in accordance herewith. Any lease that is characterized as an operating lease in accordance with GAAP after the Borrower's adoption of ASC 842 (regardless of the date on which such lease has been entered into) shall not be a capital or finance lease, and any such lease shall be, for all purposes of this Agreement, treated as though it were reflected on the Borrower's consolidated financial statements in the same manner as an operating lease would have been reflected prior to Borrower's adoption of ASC 842."

(e) Section 2.5 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"The Borrower agrees that the proceeds of the Loans and Letters of Credit shall be used solely for its general corporate purposes, but not inconsistent with this Section 2.5 or any other provision of this Agreement, including, without limitation, the provisions of Section 4.9, and not in contravention of any applicable law, rule or regulation."

(f) Section 3.8(d) of the Credit Agreement is hereby amended and restated in its entirety as follows:

"(d) Notwithstanding anything to the contrary in this Agreement or any other Loan Documents, if the Administrative Agent and the Borrower determine that:

(i) adequate and reasonable means do not exist for ascertaining LIBOR for any requested Interest Period and such circumstances are unlikely to be temporary, because the LIBOR Screen Rate is not available or published on a current basis and such circumstances are unlikely to be temporary; or

(ii) the applicable supervisor or administrator of the LIBO Screen Rate or a Governmental Authority having jurisdiction over the Administrative Agent has made a public statement identifying a specific date after which LIBOR or the LIBO Screen Rate shall no longer be made available, or used for determining the interest rate of loans in the U.S. syndicated loan market denominated in Dollars (such specific date, the "Scheduled Unavailability Date"), or

(iii) syndicated loans currently being executed, or that include language similar to that contained in this Section 3.8(d), are generally being executed or amended (as applicable) to incorporate or adopt a new benchmark interest rate to replace LIBOR,

then, reasonably promptly after such determination by the Administrative Agent and the Borrower, the Administrative Agent and the Borrower may amend this Agreement to replace LIBOR with an alternate benchmark rate (including any mathematical or other adjustments to the benchmark (if any) incorporated therein), giving due consideration to any evolving or then existing convention for similar Dollar denominated syndicated credit facilities for such alternative benchmarks (any such proposed rate, a "LIBOR Successor Rate"), together with any proposed LIBOR Successor Rate Conforming Changes (as defined below) and any such amendment shall become effective at 5:00 p.m. on the fifth Domestic Business Day after the Administrative Agent shall have posted such proposed amendment to all Lenders and the Borrower unless, prior to such time, Lenders comprising the Required Lenders have delivered to the Administrative Agent written notice that such Required Lenders do not accept such amendment with each such notice stating that such Lender objects to such amendment (which such notice shall note with specificity the particular provisions of the amendment to which such Lender objects, it being understood that the Required Lenders need not specify identical objectionable provisions of the amendment in order to constitute effective

notice). Such LIBOR Successor Rate shall be applied in a manner consistent with market practice; provided that to the extent such market practice is not administratively feasible for the Administrative Agent, such LIBOR Successor Rate shall be applied in a manner as otherwise reasonably determined by the Administrative Agent.

If no LIBOR Successor Rate has been determined and the circumstances under clause (i) above exist or the Scheduled Unavailability Date has occurred (as applicable), the Administrative Agent will promptly so notify the Borrower and each Lender. Thereafter, (x) the obligation of the Lenders to make or maintain Eurodollar Advances shall be suspended, (to the extent of the affected Eurodollar Advances or Eurodollar Interest Periods), and (y) the One Month LIBOR Rate component shall no longer be utilized in determining the Alternate Base Rate. Upon receipt of such notice, the Borrower may revoke any pending request for a borrowing of, Conversion to or continuation of Eurodollar Advances (to the extent of the affected Eurodollar Advances or Eurodollar Interest Periods) or, failing that, will be deemed to have Converted such request into a request for a borrowing of ABR Advances (subject to the foregoing clause (y)) in the amount specified therein.

Notwithstanding anything else herein, any definition of LIBOR Successor Rate shall provide that in no event shall such LIBOR Successor Rate be less than zero for purposes of this Agreement.

For purposes hereof, "LIBOR Successor Rate Conforming Changes" means, with respect to any proposed LIBOR Successor Rate, any conforming changes to the definitions of Alternate Base Rate, Eurodollar Interest Period and One Month LIBOR Rate, timing and frequency of determining rates and making payments of interest and other administrative matters as may be appropriate, in the discretion of the Administrative Agent in consultation with the Borrower, to reflect the adoption of such LIBOR Successor Rate and to permit the administration thereof by the Administrative Agent in a manner substantially consistent with market practice (or, if the Administrative Agent determines that adoption of any portion of such market practice is not administratively feasible or that no market practice for the administration of such LIBOR Successor Rate exists, in such other manner of administration as the Administrative Agent determines is reasonably necessary in connection with the administration of this Agreement)."

(g) Section 4.1 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"The Borrower is duly organized, validly existing and in good standing under the laws of the jurisdiction of its incorporation, has all requisite corporate power and authority to own its Property and to carry on

its business as now conducted, and is qualified to do business as a foreign corporation and is in good standing in each jurisdiction in which it owns or leases real Property or in which the nature of its business requires it to be so qualified (except those jurisdictions where the failure to be so qualified or to be in good standing could not reasonably be expected to have a Material Adverse effect)."

(h) Section 4.2 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"The Borrower has full corporate power and authority to enter into, execute, deliver and perform the terms of the Loan Documents, all of which have been duly authorized by all proper and necessary corporate action and are not in contravention of: (i) except as could not reasonably be expected to have a Material Adverse effect, any applicable law or (ii) the terms of its Certificate of Incorporation and By-Laws. No consent or approval of, or other action by, shareholders of the Borrower, any Governmental Authority, or any other Person (which has not already been obtained) is required to authorize in respect of the Borrower, or is required in connection with, the execution, delivery and performance by the Borrower of the Loan Documents or is required as a condition to the enforceability of the Loan Documents against the Borrower. The Borrower is not an EEA Financial Institution."

(i) Section 4.4 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"As of the Amendment No. 1 Effective Date, there are no actions, suits, arbitration proceedings or claims (whether purportedly on behalf of the Borrower, any Material Subsidiary or otherwise) pending or, to the knowledge of the Borrower, threatened against the Borrower or any Material Subsidiary or any of their respective Properties, or maintained by the Borrower or any Material Subsidiary, at law or in equity, before any Governmental Authority which have not been disclosed in the SEC Reports that could reasonably be expected to have a Material Adverse effect. There are no proceedings pending or, to the knowledge of the Borrower, threatened against the Borrower or any Material Subsidiary (a) which call into question the validity or enforceability of any Loan Document, or otherwise seek to invalidate, any Loan Document, or (b) which might, individually or in the aggregate, materially and adversely affect any of the transactions contemplated by any Loan Document."

(j) Section 4.5(a) of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(k) Section 4.5(b) of the Credit Agreement is hereby amended and restated in its entirety as follows:

"(b) No provision of any existing material mortgage, material indenture, material contract or material agreement or of any existing statute, rule, regulation, judgment, decree or order binding on the Borrower or affecting the Property of the Borrower (i) conflicts with any Loan Document, (ii) requires any consent which has not already been obtained with respect to any Loan Document, or (iii) would in any way prevent the execution, delivery or performance by the Borrower of the terms of any Loan Document, except in the case of provisions of any existing material mortgage, material indenture, material contract or material agreement, as could not reasonably be expected to have a Material Adverse effect. Neither the execution and delivery, nor the performance, by the Borrower of the terms of each Loan Document will constitute a default under, or result in the creation or imposition of, or obligation to create, any Lien upon the Property of the Borrower pursuant to the terms of any such mortgage, indenture, contract or agreement."

(l) Each of Section 4.6 and Section 4.7 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(m) Section 4.8 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"The Borrower is not required to be registered as an "investment company" under the Investment Company Act of 1940, as amended."

(n) Section 4.9 of the Credit Agreement is hereby amended by deleting the last sentence thereof.

(o) Each of Section 4.11 and Section 4.12 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(p) Section 7.1 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Except as may otherwise be permitted by Section 8.3 and Section 8.4, maintain, and cause each Material Subsidiary to maintain, its corporate existence in good standing in the jurisdiction of its incorporation or formation and in each other jurisdiction in which the failure so to do could reasonably be expected to have a Material Adverse effect, except that the corporate existence of Material Subsidiaries may be terminated if (i) such Material Subsidiaries operate closing or discontinued operations or (ii) if the Borrower determines in good faith that such termination is in the best interests of the Borrower and is not materially disadvantageous to the Lenders."

(q) Section 7.2 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Pay and discharge when due, and cause each Material Subsidiary so to do, all taxes, assessments, governmental charges, license fees and levies upon or with respect to the Borrower and such Material Subsidiary, and upon the income, profits and Property thereof unless, and only to the extent, that either (i)(a) such taxes, assessments, governmental charges, license fees and levies shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Material Subsidiary, and (b) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor, or (ii) the failure to pay or discharge such taxes, assessments, governmental charges, license fees and levies could not reasonably be expected to have a Material Adverse effect."

(r) Each of Section 7.3, Section 7.4 and Section 7.5 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(s) Section 7.6(a) of the Credit Agreement is hereby amended and restated in its entirety as follows:

"(a) Observe and comply in all material respects, and cause each Material Subsidiary so to do, with all laws, ordinances, orders, judgments, rules, regulations, certifications, franchises, permits, licenses, directions and requirements of all Governmental Authorities, which now or at any time hereafter may be applicable to it or to such Material Subsidiary, except (i) where a violation of which could not reasonably be expected to have a Material Adverse effect, or (ii) to the extent that such noncompliance is being contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Material Subsidiary."

(t) Section 7.7 of the Credit Agreement is hereby amended by (i) deleting each of clause (f) and clause (h) thereof and replacing each of such clause with "[Reserved]", and (ii) amending an restating each of clause (c) and clause (g) thereof in its entirety as follows:

"(c) Simultaneously with the delivery of the financial statements required by clauses (a) and (b) above, a certificate of the Chief Financial Officer or the Senior Vice President and Treasurer of the Borrower certifying that no Default shall have occurred or be continuing or, if so, specifying in such certificate all such Defaults, and setting forth computations in reasonable detail demonstrating compliance with Section 8.9."

"(g) Prompt written notice of the occurrence of (i) each Default and (ii) each Event of Default;"

(u) Section 7.8 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Upon reasonable notice and during normal business hours after an Event of Default has occurred and is continuing, permit representatives of the Administrative Agent and each Lender to visit the offices of the Borrower and each Material Subsidiary, to examine the books and records (other than tax returns and work papers related to tax returns) thereof and auditors' reports relating thereto, to discuss the affairs of the Borrower and each Material Subsidiary with the respective officers thereof, and to meet and discuss the affairs of the Borrower and each Material Subsidiary with the Borrower's auditors, except for information covered by an attorney-client or other legal privilege or to the extent the inspection would reasonably be expected to result in a violation or other breach of any third party confidentiality agreement."

(v) Section 7.9 of the Credit Agreement is hereby deleted in its entirety.

(w) Section 8.1 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(x) Section 8.2 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Create, incur, assume or suffer to exist any Lien against or on any Property now owned or hereafter acquired by the Borrower or any of the Subsidiaries, or permit any of the Subsidiaries so to do, except any one or more of the following types of Liens: (a) Liens in connection with workers' compensation, unemployment insurance or other social security obligations (which phrase shall not be construed to refer to ERISA or the minimum funding obligations under Section 412 of the Internal Revenue Code), (b) Liens to secure the performance of bids, tenders, letters of credit, contracts (other than contracts for the payment of Indebtedness), leases, statutory obligations, surety, customs, appeal, performance and payment bonds and other obligations of like nature, or to qualify to do business, maintain insurance or obtain other benefits, in each such case arising in the ordinary course of business, (c) mechanics', workmen's, carriers', warehousemen's, materialmen's, landlords' or other like Liens arising in the ordinary course of business with respect to obligations which are not due or which are being contested in good faith and by appropriate proceedings diligently conducted, (d) Liens for taxes, assessments, fees or governmental charges the payment of which is not required under Section 7.2, (e) easements, rights of way, restrictions, leases of Property to others, easements for installations of public utilities, title imperfections and restrictions, zoning ordinances and other similar encumbrances affecting Property which in the aggregate do not materially impair its use for the

operation of the business of the Borrower or such Subsidiary, (f) Liens on Property of the Subsidiaries under capital leases and Liens on Property (including on the capital stock or other equity interests) of the Subsidiaries acquired (whether as a result of purchase, capital lease, merger or other acquisition) and either existing on such Property when acquired, or created contemporaneously with or within 12 months of such acquisition to secure the payment or financing of the purchase price of such Property (including the construction, development, substantial repair, alteration or improvement thereof), and any renewals thereof, *provided* that such Liens attach only to the Property so purchased or acquired (including any such construction, development, substantial repair, alteration or improvement thereof) and *provided further* that the Indebtedness secured by such Liens is not otherwise prohibited hereunder, (g) statutory Liens in favor of lessors arising in connection with Property leased to the Borrower or any of the Subsidiaries, (h) Liens of attachments, judgments or awards against the Borrower or any of the Subsidiaries with respect to which an appeal or proceeding for review shall be pending or a stay of execution or bond shall have been obtained, or which are otherwise being contested in good faith and by appropriate proceedings diligently conducted, and in respect of which adequate reserves shall have been established in accordance with GAAP on the books of the Borrower or such Subsidiary, (i) Liens securing Indebtedness of a Subsidiary to the Borrower or another Subsidiary, (j) Liens (other than Liens permitted by any of the foregoing clauses) arising in the ordinary course of its business which do not secure Indebtedness and do not, in the aggregate, materially detract from the value of the business of the Borrower and its Subsidiaries, taken as a whole, (k) Liens in favor of the United States of America, or any state thereof, to secure partial, progress, advance or other payments pursuant to any contract or provisions of any statute, and (l) additional Liens securing Indebtedness of the Borrower and the Subsidiaries in an aggregate outstanding Consolidated principal amount not exceeding 15% of Net Tangible Assets."

(y) Section 8.3 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Make any Disposition (including by way of limited liability company division), or permit any of its Subsidiaries so to do, of all or substantially all of the assets of the Borrower and the Subsidiaries on a Consolidated basis; provided that (a) any Subsidiary may make Dispositions to the Borrower, and (b) so long as no Default or Event of Default exists prior to or after giving effect thereto, (i) the Borrower may dispose of all or substantially all of its assets to a wholly-owned domestic Subsidiary that assumes all of the obligations of the Borrower under this Agreement and (ii) any Subsidiary may dispose of all or substantially all of its assets to another Subsidiary, provided that if such Subsidiary is a

wholly-owned Subsidiary, the transferee shall be a wholly-owned Subsidiary."

(z) Each of Section 8.5 and Section 8.6 of the Credit Agreement is hereby deleted in its entirety and each replaced by "[Reserved]."

(aa) Clauses (c) and (d) of Section 8.7 of the Credit Agreement are hereby amended and restated in their entirety as follows:

"(c) Dividend Restrictions consisting of customary net worth, leverage and other financial covenants, customary covenants regarding the merger of or sale of stock or assets of a Subsidiary, customary restrictions on transactions with affiliates, and customary subordination provisions governing Indebtedness owed to the Borrower or any Subsidiary, in each case contained in, or required by, any agreement governing Indebtedness incurred by a Subsidiary in accordance with the terms of this Agreement; or

(d) Dividend Restrictions contained in any other credit agreement so long as such Dividend Restrictions are no more restrictive than those contained in this Agreement (including Dividend Restrictions contained in the Existing 364-Day Credit Agreement, the Existing 2017 Credit Agreement, the Existing 2019 Credit Agreement and the Existing Term Loan Agreement."

(bb) Section 8.8 of the Credit Agreement is hereby deleted in its entirety and replaced by "[Reserved]."

(cc) Section 8.9 of the Credit Agreement is hereby amended and restated in its entirety as follows:

"Permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.60:1.00; *provided* that from the Amendment No. 1 Effective Date through and including the fiscal quarter ending September 30, 2019, the Borrower will not permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.65:1.00; *provided further* that (i) subsequent to the fiscal quarter ending March 31, 2020, upon the consummation of any Material Acquisition and the written election of the Borrower to the Administrative Agent no later than thirty days following the consummation of such Material Acquisition, the maximum permitted ratio of Consolidated Indebtedness to Total Capitalization shall be increased by 0.05:1.00 above the otherwise-applicable maximum permitted ratio of Consolidated Indebtedness to Total Capitalization with respect to the last day of the fiscal quarter during which such Material Acquisition shall have been consummated and the last day of each of the immediately following three consecutive fiscal quarters, and (ii) between

the signing of the definitive agreement (or offer documentation, as applicable) for a Material Acquisition and the earlier of (x) the closing of such Material Acquisition and (y) thirty (30) days following the termination of such definitive agreement (or offer documentation, as applicable) for such Material Acquisition, any Acquisition Debt incurred to finance such Material Acquisition shall be excluded for purposes of calculation the ratio of Consolidated Indebtedness to Total Capitalization hereunder. The Borrower shall only be permitted to make an election pursuant to the last proviso of the preceding sentence twice during the term of this Agreement, and there shall be at least two consecutive fiscal quarters between such elections during which time no increase to the maximum permitted ratio of Consolidated Indebtedness to Total Capitalization shall be in effect."

(dd) Section 9.1 of the Credit Agreement is hereby amended by amending and restating each of clause (g), clause (h), clause (i), clause (j), clause (k) and clause (m) thereof in its entirety as follows:

"(g) (i) Obligations in an aggregate Consolidated amount in excess of the Threshold Amount of the Borrower (other than its obligations hereunder and under the Notes) and the Material Subsidiaries, whether as principal, guarantor, surety or other obligor, for the payment of any Indebtedness for Borrowed Money or any net liability under interest rate swap, collar, exchange or cap agreements, (A) shall become or shall be declared to be due and payable prior to the expressed maturity thereof, or (B) shall not be paid when due or within any grace period for the payment thereof, or (ii) any holder of any such obligations shall have the right to declare the Indebtedness for Borrowed Money evidenced thereby due and payable prior to its stated maturity; or"

"(h) An involuntary proceeding shall be commenced or an involuntary petition shall be filed seeking (i) liquidation, reorganization or other relief in respect of the Borrower or any Material Subsidiary or its debts, or of a substantial part of its assets, under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect or (ii) the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Material Subsidiary or for a substantial part of its assets, and, in any such case, such proceeding or petition shall continue undismissed for 60 days or an order or decree approving or ordering any of the foregoing shall be entered; or"

"(i) The Borrower or any Material Subsidiary shall (i) voluntarily commence any proceeding or file any petition seeking liquidation, reorganization or other relief under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect, (ii) consent to the institution of, or fail to contest in a

timely and appropriate manner, any proceeding or petition described in clause (h) of this Section 9.1, (iii) apply for or consent to the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Material Subsidiary or for a substantial part of its assets, (iv) file an answer admitting the material allegations of a petition filed against it in any such proceeding, (v) make a general assignment for the benefit of creditors or (vi) take any action for the purpose of effecting any of the foregoing; or"

"(j) The Borrower or any Material Subsidiary shall (i) generally not be paying its debts as such debts become due or (ii) admit in writing its inability to pay its debts as they become due; or"

"(k) Judgments or decrees in an aggregate Consolidated amount in excess of the Threshold Amount (to the extent not covered by independent third-party insurance or captive insurance as to which the insurer does not dispute coverage) against the Borrower and the Material Subsidiaries shall remain unpaid, unstayed on appeal, undischarged, unbonded or undismissed for a period of 60 days during which execution shall not be effectively stayed, or any action shall be legally taken by a judgment creditor to attach or levy upon any assets of the Borrower or any Material Subsidiary to enforce any such judgment; or"

"(m) Solely to the extent as would have a Material Adverse effect: (i) any Termination Event shall occur (x) with respect to any Pension Plan (other than a Multiemployer Plan) or (y) with respect to any other retirement plan subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, which plan, during the five year period prior to such Termination Event, was the responsibility in whole or in part of the Borrower, any Material Subsidiary or any ERISA Affiliate; (ii) the failure to satisfy the minimum funding standards under Section 302 of ERISA or Section 412 of the Internal Revenue Code shall exist with respect to any Pension Plan for which the Borrower has responsibility (other than that portion of a Multiemployer Plan's Accumulated Funding Deficiency to the extent such Accumulated Funding Deficiency is attributable to employers other than Borrower); (iii) any Person shall engage in a Prohibited Transaction involving any Employee Benefit Plan in respect of which it is reasonably likely that liability will be imposed upon the Borrower; (iv) the Borrower shall fail to pay when due an amount which is payable by it to the PBGC or to a Pension Plan (including a Multiemployer Plan) under Title IV of ERISA; (v) the imposition on the Borrower of any tax under Section 4980(B)(a) of the Internal Revenue Code; or (vi) the assessment of a civil penalty on the Borrower with respect to any Employee Benefit Plan under Section 502(c) of ERISA. In determining the Consolidated amount for any purpose pursuant to this Section 9.1(m), the liabilities, funding amounts, taxes and penalties referenced in the foregoing clauses of this Section 9.1(m) shall include those of the Material Subsidiaries and

ERISA Affiliates of the Borrower to the extent the Borrower is obligated to pay any such liabilities, funding amounts, taxes and penalties."

(ee) Section 11.2(a) of the Credit Agreement is hereby amended and restated in its entirety as follows:

"(a) *Notices Generally.* Except in the case of notices and other communications expressly permitted to be given by telephone, all notices and other communications provided for herein shall be in writing and shall be delivered by hand or overnight courier service, mailed by certified or registered mail or sent by facsimile or email, as follows:

If to the Borrower:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Carol A. DeNale
Senior Vice President and Treasurer –Treasury Department
Facsimile: (401) 770-5768
Telephone: (401) 770-4407
Email: carol.denale@cvshealth.com

with a copy, in the case of a notice of Default or Event of Default, to:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Tom Moffatt
Vice President, Assistant Secretary and Assistant General Counsel – Corporate Services
Facsimile: (401) 216-3758
Telephone: (401) 770-5409
Email: thomas.moffatt@cvshealth.com

with a copy (in the case of a notice of Default or Event of Default and which shall not constitute notice under this Agreement or any other Loan Document for any purpose) to:

Shearman & Sterling LLP
599 Lexington Avenue
New York, New York 10022
Attention: Gus M. Atiyah
Facsimile: (646) 848-5227
Telephone: (212) 848-5227
Email: gus.atiyah@shearman.com

If to the Administrative Agent, the Swing Line Lender and the Issuer:

in the case of each Borrowing Request, each notice of prepayment under Section 2.7, each Letter of Credit Request, each Competitive Bid Request, each Competitive Bid, and each Competitive Bid Accept/Reject Letter:

The Bank of New York Mellon
Administrator/ Issuer Services
Client Services Delivery Loan Processing COE
Loan Administration
6023 Airport Road
Oriskany, New York 13424
Attention: Crystal Keyser
Facsimile: (315) 765-4533
Telephone: (315) 801-2437
Email: afasyndications@bnymellon.com

and in all other cases:

The Bank of New York Mellon
3300 PGA Blvd
Palm Beach Gardens, FL 33410
Attention: Johna Fidanza
Telephone: (561) 868-7434
Email: johna.fidanza@bnymellon.com

and

The Bank of New York Mellon
500 Grant Street
Pittsburgh, Pennsylvania 15219
Attention: Clifford Mull
Facsimile: (412) 234-8087
Telephone: (412) 234-1346
Email: clifford.mull@bnymellon.com

If to any Lender or any other Issuer: to it at its address (or facsimile number or email address) set forth in its Administrative Questionnaire."

2. Condition Precedent. This Amendment shall become effective on and as of the date hereof (the "***Amendment No. 1 Effective Date***") upon the receipt by the Administrative Agent of counterparts of this Amendment executed by the Borrower and the Consenting Lenders constituting Required Lenders. Upon satisfaction of the condition precedent set forth in this Section 2, the Administrative Agent shall provide the Borrower and the Lenders with written confirmation that this Amendment has become effective.

3. Representations and Warranties.

(a) The Borrower hereby represents and warrants as follows:

(i) The Borrower has taken all necessary corporate action to authorize the execution, delivery and performance of this Amendment.

(ii) This Amendment has been duly executed and delivered by the Borrower and constitutes the valid and legally binding obligations of the Borrower, enforceable against the Borrower in accordance with its terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by equitable principles relating to the availability of specific performance as a remedy.

(iii) No consent or approval of, or other action by, shareholders of the Borrower, any Governmental Authority, or any other Person (which has not already been obtained) is required to authorize in respect of the Borrower, or is required in connection with, the execution, delivery, and performance by the Borrower of this Amendment or is required as a condition to the enforceability of this Amendment against the Borrower.

(b) The Borrower represents and warrants to the Lenders that (i) the representations and warranties of the Borrower set forth in Section 4 of the Credit Agreement (as amended by this Amendment) are true and correct in all material respects on the date hereof (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language is true and correct (after giving effect to any qualification therein) in all respects on the date hereof), except to the extent that such representations and warranties expressly relate to an earlier date, in which case such representations and warranties were true and correct in all material respects or, if qualified as to "materiality", "Material Adverse" or similar language, in all respects, on such earlier date and (ii) no Default exists on the date hereof.

4. Miscellaneous.

(a) Except as expressly amended hereby, the Credit Agreement and the other Loan Documents shall remain in full force and effect.

(b) On and after the Amendment No. 1 Effective Date, each reference in the Credit Agreement to "this Agreement", "hereunder", "hereof" or words of like import referring to the Credit Agreement, and each reference in the other Loan Documents to "the Credit Agreement", "thereunder", "thereof" or words of like import referring to the Credit Agreement, shall mean and be a reference to the Credit Agreement as modified hereby. This Amendment shall constitute a Loan Document.

(c) This Amendment may be executed on any number of separate counterparts and all of said counterparts taken together shall be deemed to constitute one and the same agreement. It shall not be necessary in making proof of this Amendment to produce or account for more than one counterpart signed by the party to be charged. A set of the copies of this Amendment signed by all of the parties hereto shall be lodged with each of the Borrower and the

Administrative Agent. Delivery of an executed counterpart of a signature page of this Amendment by fax or other electronic means (e.g., ".pdf" or ".tif") shall be effective as delivery of a manually executed counterpart of this Amendment.

(d) This Amendment and the rights and obligations of the parties hereto shall be governed by, and construed and interpreted in accordance with, the laws of the State of New York.

[signature pages follow]

The parties have caused this Amendment to be duly executed as of the date first written above.

CVS HEALTH CORPORATION

By: /s/ CAROL A. DENALE
Name: Carol A. DeNale
Title: Senior Vice President and Treasurer

[Amendment No. 1 to the 2018 Five Year Credit Agreement]

THE BANK OF NEW YORK MELLON,
as Administrative Agent and a Lender

By: /s/ CLIFFORD A. MULL
Name: Clifford A. Mull
Title: Director

[Amendment No. 1 to the 2018 Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

BANK OF AMERICA, N.A.

By: /s/ DARREN MERTEN
Name: Darren Merten
Title: Vice President

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

Wells Fargo Bank, National Association

By: /s/ JORDAN HARRIS
Name: Jordan Harris
Title: Director

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

BARCLAYS BANK PLC

By: /s/ RITAM BHALLA
Name: Ritam Bhalla
Title: Director

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

JPMORGAN CHASE BANK, N.A.

By: /s/ VANESSA CHIU
Name: Vanessa Chiu
Title: Executive Director

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

Goldman Sachs Bank USA

By: /s/ ANNIE CARR
Name: Annie Carr
Title: Authorized Signatory

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

MIZUHO BANK, LTD.

By: /s/ TRACY RAHN
Name: Tracy Rahn
Title: Authorized Signatory

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

Sun Trust Bank, as a Lender

By: /s/ STEVE CURRAN
Name: Steve Curran
Title: Director

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

U.S. BANK NATIONAL ASSOCIATION

By: /s/ JOYCE P. DORSETT
Name: Joyce P. Dorsett
Title: Senior Vice President

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

MUFG BANK, LTD.

By: /s/ JACK LONKER
Name: Jack Lonker
Title: Director

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

ROYAL BANK OF CANADA

By: /s/ GORDON MACARTHUR
Name: Gordon MacArthur
Title: Authorized Signatory

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

CITIBANK, N.A., as a Lender

By: /s/ ALEJANDRO E. ROMERO
Name: Alejandro E. Romero
Title: Vice President

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

KeyBank National Association

By: /s/ MARIANNE T. MEIL
Name: Marianne T. Meil
Title: Senior Vice President

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

FIFTH THIRD BANK

By: /s/ TODD S. ROBINSON
Name: Todd S. Robinson
Title: VP

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

Sumitomo Mitsui Banking Corporation

By: /s/ MICHAEL MAGUIRE
Name: Michael Maguire
Title: Executive Director

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

PNC BANK, NATIONAL ASSOCIATION, as a Lender

By: /s/ WILLIAM P. HEROLD
Name: William P. Herold
Title: Vice President

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

SANTANDER BANK, N.A.

By: /s/ XAVIER RUIZ SENA
Name: Xavier Ruiz Sena
Title: Manging Director

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

CREDIT SUISSE AG, CAYMAN ISALNDS BRANCH

By: /s/ WILLIAM O'DALY
Name: William O'Daly
Title: Authorized Signatory

By: /s/ ANDREW GRIFFIN
Name: Andrew Griffin
Title: Authorized Signatory

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

Industrial and Commercial Bank of China Limited,
New York Branch

By: /s/ HSIWEI CHEN
Name: Hsiwei Chen
Title: Director

By: /s/ PINYEN SHIH
Name: Pinyen Shih
Title: Executive Director

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

TD BANK, N.A.

By: /s/ UK-SUN KIM
Name: Uk-Sun Kim
Title: Senior Vice President

[Amendment No. 1 to Five Year Credit Agreement]

The undersigned Lender hereby consents to Amendment No. 1 to the Credit Agreement.

Bank of China, New York Branch

By: /s/ RAYMOND QIAO
Name: Raymond Qiao
Title: Executive Vice President

[Amendment No. 1 to Five Year Credit Agreement]

CVS Five-Year Credit Agreement 2019

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Exhibit 10.2
EXECUTION VERSION

FIVE YEAR CREDIT AGREEMENT

by and among

CVS HEALTH CORPORATION,

THE LENDERS PARTY HERETO,

BARCLAYS BANK PLC and JPMORGAN CHASE BANK, N.A.,
as Co-Syndication Agents,

GOLDMAN SACHS BANK USA, and
WELLS FARGO BANK, NATIONAL ASSOCIATION,
as Co-Documentation Agents,

and

BANK OF AMERICA, N.A.,
as Administrative Agent

Dated as of May 16, 2019

BOFA SECURITIES, INC.,
BARCLAYS BANK PLC, GOLDMAN SACHS BANK USA,
JPMORGAN CHASE BANK, N.A.,
and
WELLS FARGO SECURITIES, LLC,
as Joint Lead Arrangers and Joint Bookrunners

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FIVE YEAR CREDIT AGREEMENT, dated as of May 16, 2019, by and among ***CVS HEALTH CORPORATION***, a Delaware corporation (the ***"Borrower"***), the lenders party hereto from time to time (each a ***"Lender"*** and, collectively, the ***"Lenders"***), ***BARCLAYS BANK PLC*** (***"Barclays")*** and ***JPMORGAN CHASE BANK, N.A.***, (***"JPMC"***), as co-syndication agents (in such capacity, each a ***"Co-Syndication Agent"*** and, collectively, the ***"Co-Syndication Agents"***), ***GOLDMAN SACHS BANK USA*** (**"*GS*"**), and ***WELLS FARGO BANK, NATIONAL ASSOCIATION*** (***"Wells Fargo")***, as co-documentation agents (in such capacity, each a "***Co-Documentation Agent***" and, collectively, the "***Co-Documentation Agents***"), and ***BANK OF AMERICA, N.A.***, as administrative agent for the Lenders (in such capacity, together with its successors and assigns, the "***Administrative Agent***").

1. DEFINITIONS AND PRINCIPLES OF CONSTRUCTION

1.1 Definitions

When used in any Loan Document (as defined below), each of the following terms shall have the meaning ascribed thereto unless the context otherwise specifically requires:

"ABR Advances": the Revolving Credit Loans (or any portions thereof) at such time as they (or such portions) are made or are being maintained at a rate of interest based upon the Alternate Base Rate.

"***Acquisition Debt***": any Indebtedness incurred by the Borrower or any of its Subsidiaries for the purpose of financing, in whole or in part, a Material Acquisition and any related transactions or series of related transactions (including for the purpose of refinancing or replacing all or a portion of any pre-existing Indebtedness of the Person(s) or assets to be acquired), which Indebtedness is redeemable or prepayable if such Material Acquisition is not consummated.

"Accumulated Funding Deficiency": as defined in Section 304 of ERISA.

"Administrative Agent": as defined in the preamble.

"***Administrative Agent's Office***": the Administrative Agent's address and, as appropriate, account as set forth in Section 11.2, or such other address or account as the Administrative Agent may from time to time notify to the Borrower and the Lenders.

"Administrative Questionnaire": an Administrative Questionnaire in a form supplied by the Administrative Agent.

"Affected Advance": as defined in Section 3.8(b).

"Affiliate": with respect to any Person at any time and from time to time, any other Person (other than a wholly-owned subsidiary of such Person) which, at such time (a) controls such Person, (b) is controlled by such Person or (c) is under common control with such Person. The term "control", as used in this definition with respect to any Person, means the power, whether direct or indirect through one or more intermediaries, to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting securities or other interests, by contract or otherwise.

"Agent Parties": as defined in Section 11.2(d).

"Aggregate Commitment Amount": at any time, the sum of the Commitment Amounts of the Lenders at such time under this Agreement. The Aggregate Commitment Amount on the Effective Date is $2,000,000,000.

"Aggregate Credit Exposure": at any time, the sum at such time of (a) the aggregate Committed Credit Exposure of the Lenders at such time and (b) the aggregate outstanding principal balance of all Competitive Bid Loans at such time.

"Aggregate Letter of Credit Commitment": at any time, the sum of the Letter of Credit Commitments of the Issuers at such time. The Aggregate Letter of Credit Commitment on the Effective Date is $250,000,000.

"Agreement": this Five Year Credit Agreement, as the same may be amended, amended and restated, supplemented or otherwise modified from time to time.

"Alternate Base Rate": for any day, a fluctuating rate per annum equal to the highest of (a) the Federal Funds Effective Rate plus 1/2 of 1% (b) the rate of interest in effect for such day as publicly announced from time to time by Bank of America as its "prime rate", and (c) the One Month LIBOR Rate in effect on such day plus 1.00%. The "prime rate" is a rate set by BofA based upon various factors including BofA's costs and desired return, general economic conditions and other factors, and is used as a reference point for pricing some loans, which may be priced at, above, or below such announced rate. Any change in such prime rate announced by BofA shall take effect at the opening of business on the day specified in the public announcement of such change. If the Alternate Base Rate is being used as an alternate rate of interest pursuant to Section 3.8 hereof, then the Alternate Base Rate shall be the greater of clauses (a) and (b) above and shall be determined without reference to clause (c) above.

"Anti-Corruption Laws": all laws, rules, and regulations of any jurisdiction applicable to the Borrower or the Subsidiaries from time to time concerning or relating to bribery or corruption.

"Applicable Margin": (i) with respect to the unpaid principal balance of ABR Advances, the applicable percentage set forth below in the column entitled "ABR Advances", (ii) with respect to the unpaid principal balance of Eurodollar Advances and Swing Line Loans bearing interest at the LIBOR Daily Floating Rate, the applicable percentage set forth below in the column entitled "Eurodollar Advances/Swing Line Loans", (iii) with respect to the Facility Fee, the applicable percentage set forth below in the column entitled "Facility Fee", (iv) with respect to the Letter of Credit Participation Fee payable in respect of standby Letters of Credit, the applicable percentage set forth below in the column entitled "Participation Fee - Standby", and (v) with respect to the Letter of Credit Participation Fee payable in respect of commercial Letters of Credit, the applicable percentage set forth below in the column entitled "Participation Fee - Commercial", in each case opposite the applicable Pricing Level:

Pricing Level	**ABR Advances**	**Eurodollar Advances/ Swing Line Loans**	**Facility Fee**	**Participation Fee - Standby**	**Participation Fee – Commercial**
Pricing Level I	0.000%	0.685%	0.065%	0.685%	0.3425%
Pricing Level II	0.000%	0.795%	0.080%	0.795%	0.3975%
Pricing Level III	0.000%	0.910%	0.090%	0.910%	0.4550%
Pricing Level IV	0.015%	1.015%	0.110%	1.015%	0.5075%
Pricing Level V	0.125%	1.125%	0.125%	1.125%	0.5625%
Pricing Level VI	0.275%	1.275%	0.225%	1.275%	0.6375%

Decreases in the Applicable Margin resulting from a change in Pricing Level shall become effective upon the delivery by the Borrower to the Administrative Agent of a notice pursuant to Section 7.7(d). Increases in the Applicable Margin resulting from a change in Pricing Level shall become effective on the effective date of any downgrade or withdrawal in the rating by Moody's or S&P of the senior unsecured long term debt rating of the Borrower.

"Approved Fund": any Person (other than a natural person) that is (or will be) engaged in making, purchasing, holding or otherwise investing in commercial loans and similar extensions of credit in the ordinary course of its business that is administered or managed by (a) a Lender, (b) an Affiliate of a Lender or (c) an entity or an Affiliate of an entity that administers or manages a Lender.

"Assignment and Assumption": an assignment and assumption entered into by a Lender and an assignee (with the consent of any party whose consent is required by Section 11.7(b)), and accepted by the Administrative Agent, substantially in the form of Exhibit E or any other form (including electronic documentation generated by use of an electronic platform) approved by the Administrative Agent.

"***Authorized Officer***": the chief executive officer, president, chief financial officer, treasurer, assistant treasurer or controller of the Borrower, solely for purposes of the delivery of incumbency certificates pursuant to Section 5.1, the secretary or any assistant secretary of the Borrower and, solely for purposes of notices given to Sections 2.3 and 3.3, any other officer or employee of the Borrower so designated by any of the foregoing officers in a notice to the Administrative Agent. Any document delivered hereunder that is signed by an Authorized Officer shall be conclusively presumed to have been authorized by all necessary corporate, partnership and/or other action on the part of the Borrower and such Authorized Officer shall be conclusively presumed to have acted on behalf of the Borrower.

"Bail-In Action": the exercise of any Write-Down and Conversion Powers by the applicable EEA Resolution Authority in respect of any liability of an EEA Financial Institution.

"Bail-In Legislation": with respect to any EEA Member Country implementing Article 55 of Directive 2014/59/EU of the European Parliament and of the Council of the European Union, the implementing law for such EEA Member Country from time to time which is described in the EU Bail-In Legislation Schedule.

"Barclays": as defined in the preamble.

"BAS": BofA Securities, Inc.

"***Beneficial Ownership Certification***": a certification regarding beneficial ownership required by the Beneficial Ownership Regulation.

"***Beneficial Ownership Regulation***": 31 C.F.R. § 1010.230.

"Benefit Plan": as defined in Section 11.23(c).

"BofA": means Bank of America, N.A. and its successors.

"Borrower": as defined in the preamble.

"Borrower Materials": as defined in Section 7.7.

"Borrowing Date": (i) in respect of Revolving Credit Loans, any Domestic Business Day or Eurodollar Business Day, as the case may be, on which the Lenders shall make Revolving Credit Loans pursuant to a Borrowing Request or pursuant to a Mandatory Borrowing, (ii) in respect of Competitive Bid Loans, any Domestic Business Day on which a Lender shall make a Competitive Bid Loan pursuant to a Competitive Bid Request, (iii) in respect of Swing Line Loans, any Domestic Business Day on which the Swing Line Lender shall make a Swing Line Loan pursuant to a Borrowing Request and (iv) in respect of Letters of Credit, any Domestic Business Day on which an Issuer shall issue a Letter of Credit pursuant to a Letter of Credit Request.

"Borrowing Request": a request for Revolving Credit Loans or Swing Line Loans substantially in the form of Exhibit C or such other form as may be approved by the Administrative Agent, including any form on an electronic platform or electronic transmission system as shall be approved by the Administrative Agent, appropriately completed and signed by an Authorized Officer of the Borrower.

"Change of Control": any of the following:

(i) any Person or group (as such term is used in Section 13(d)(3) of the Securities Exchange Act of 1934, as amended), (a) shall have or acquire beneficial ownership of securities having 35% or more of the ordinary voting power of the Borrower or (b) shall possess, directly or indirectly, the power to direct or cause the direction of the management and policies of the Borrower, whether through the ownership of voting securities, by contract or otherwise; or

(ii) the Continuing Directors shall cease for any reason to constitute a majority of the board of directors of the Borrower then in office.

"Co-Documentation Agent" and ***"Co-Documentation Agents"***: as defined in the preamble.

"Co-Syndication Agent" and ***"Co-Syndication Agents"***: as defined in the preamble.

"Commercial Letter of Credit Commitment": at any time with respect to any Issuer, the commitment of such Issuer to issue commercial Letters of Credit in accordance with the terms hereof in an aggregate outstanding face amount not exceeding the lesser of (a) the amount set forth adjacent to such Issuer's name under the heading "Commercial Letter of Credit Commitment" in Exhibit A at such time or, if not listed on Exhibit A, the "Commercial Letter of Credit Commitment" which such Issuer shall have assumed from another Issuer in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7, or (b) 7.5% of the Aggregate Commitment Amount as in effect at such time.

"Commercial Letter of Credit Exposure": at any time in respect of any Issuer, an amount equal to such Issuer's Letter of Credit Exposure in respect of commercial Letters of Credit.

"Commitment": in respect of any Lender, such Lender's undertaking to make Revolving Credit Loans, subject to the terms and conditions hereof, in an aggregate outstanding principal amount not to exceed the Commitment Amount of such Lender.

"Commitment Amount": at any time and with respect to any Lender, the amount set forth adjacent to such Lender's name under the heading "Commitment Amount" in Exhibit A at such time or, in the event that such Lender is not listed on Exhibit A, the "Commitment Amount" which such Lender shall have assumed from another Lender in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7.

"Commitment Increase Supplement": a Commitment Increase Supplement substantially in the form of Exhibit K.

"Commitment Percentage": at any time and with respect to any Lender, a fraction (expressed as a percentage carried out to the ninth decimal place) the numerator of which is such Lender's Commitment Amount at such time, and the denominator of which is the Aggregate Commitment Amount at such time; *provided* that in the event the Commitments shall have expired or otherwise terminated or been terminated, then Commitment Percentage shall be determined immediately prior thereto.

"Commitment Period": the period commencing on the Effective Date and ending on the Commitment Termination Date or on such earlier date as all of the Commitments shall have been terminated in accordance with the terms hereof.

"Commitment Termination Date": the earlier of (i) May 16, 2024 (subject to extension as provided in Section 2.12) and (ii) the date on which the Loans shall become due and payable, whether by acceleration, notice of intention to prepay or otherwise.

"Committed Credit Exposure": with respect to any Lender at any time, the sum at such time of (a) the outstanding principal balance of such Lender's Revolving Credit Loans, (b) the Swing Line Exposure of such Lender and (c) the Letter of Credit Exposure of such Lender.

"Compensatory Interest Payment": as defined in Section 3.4(c).

"Competitive Bid": an offer by a Lender, substantially in the form of Exhibit H, to make one or more Competitive Bid Loans.

"Competitive Bid Accept/Reject Letter": a notification made by the Borrower pursuant to Section 2.4(d) substantially in the form of Exhibit I.

"Competitive Bid Loan": as defined in Section 2.4(a).

"Competitive Bid Rate": as to any Competitive Bid made by a Lender pursuant to Section 2.4(b), the fixed rate of interest (which shall be expressed in the form of a decimal to no more than four decimal places) offered by such Lender with respect thereto.

"Competitive Bid Request": a request by the Borrower, substantially in the form of Exhibit F, for Competitive Bids.

"Competitive Interest Period": as to any Competitive Bid Loan, the period commencing on the date of such Competitive Bid Loan and ending on the date requested in the Competitive Bid Request with respect thereto, which shall not be earlier than 3 days after the date of such Competitive Bid Loan or later than 180 days after the date of such Competitive Bid Loan; *provided* that if any Competitive Interest Period would end on a day other than a Domestic Business Day, such Competitive Interest Period shall be extended to the next succeeding Domestic Business Day, unless such next succeeding Domestic Business Day would be a date on or after the Commitment Termination Date, in which case such Competitive Interest Period shall end on the next preceding Domestic Business Day. Interest shall accrue from and including the first day of a Competitive Interest Period to but excluding the last day of such Competitive Interest Period.

"Consolidated": the Borrower and the Subsidiaries on a consolidated basis in accordance with GAAP.

"Contingent Obligation": as to any Person (the *"**secondary obligor**"*), any obligation of such secondary obligor (a) guaranteeing or in effect guaranteeing any return on any investment made by another Person, or (b) guaranteeing or in effect guaranteeing any Indebtedness, lease, dividend or other obligation (*"**primary obligation**"*) of any other Person (the *"**primary obligor**"*) in any manner, whether directly or indirectly, including any obligation of such secondary obligor, whether or not contingent, (i) to purchase any such primary obligation or any Property constituting direct or indirect security therefor, (ii) to advance or supply funds (A) for the purchase or payment of any such primary obligation or (B) to maintain working capital or equity capital of the primary obligor or otherwise to maintain the net worth or solvency of the primary obligor, (iii) to purchase Property, securities or services primarily for the purpose of assuring the beneficiary of any such primary obligation of the ability of the primary obligor to make payment of such primary obligation, (iv) otherwise to assure or hold harmless the beneficiary of such primary obligation against loss in respect thereof, and (v) in respect of the Indebtedness of any partnership in which such secondary obligor is a general partner, except to the extent that such Indebtedness of such partnership is nonrecourse to such secondary obligor and its separate Property; *provided* that the term *"**Contingent Obligation**"* shall not include the indorsement of instruments for deposit or collection in the ordinary course of business.

"Continuing Director": any member of the board of directors of the Borrower (i) who is a member of that board of directors on the Effective Date, (ii) who was nominated for election by the board of directors a majority of whom were directors on the Effective Date or (iii) whose election or nomination for election was approved by one or more of such directors.

"Control Person": as defined in Section 3.6.

"Convert", ***"Conversion"*** and ***"Converted"***: each, a reference to a conversion pursuant to Section 3.3 of one Type of Revolving Credit Loan into the other Type of Revolving Credit Loan.

"Costs": as defined in Section 3.6.

"Credit Exposure": with respect to any Lender at any time, the sum at such time of (a) the Committed Credit Exposure of such Lender at such time and (b) the outstanding principal balance of all Competitive Bid Loans of such Lender at such time.

"Credit Parties": the Administrative Agent, the Swing Line Lender, the Issuers and the Lenders.

"Default": any of the events specified in Section 9.1, whether or not any requirement for the giving of notice, the lapse of time, or both, or any other condition, has been satisfied.

"*Defaulting Lender*": any Lender, as reasonably determined by the Administrative Agent, that has (a) failed to fund any portion of its Loans or participations in Letters of Credit or Swing Line Loans within two Domestic Business Days of the date required to be funded by it hereunder, unless such Lender notifies the Administrative Agent and the Borrower in writing that such failure is the result of such Lender's determination that one or more conditions precedent to funding (each of which conditions precedent, together with any applicable default, shall be specifically identified in such writing) has not been satisfied,
(b) notified the Borrower or any Credit Party in writing that it does not intend to comply with any of its funding obligations under this Agreement or has made a public statement to the effect that it does not intend to comply with its funding obligations under this Agreement or generally under other agreements in which it commits to extend credit, unless such writing or public statement relates to such Lender's obligation to fund a Loan hereunder and states that such position is based on such Lender's determination that a condition precedent to funding (which condition precedent, together with any applicable default, shall be specifically identified in such writing or public statement) cannot be satisfied, (c) failed, two Domestic Business Days

after written request by the Administrative Agent (based on the reasonable belief that it may not fulfill its funding obligation), to confirm that it will comply with the terms of this Agreement relating to its obligations to fund prospective Loans and participations in then outstanding Letters of Credit and Swing Line Loans; *provided* that such Lender shall cease to be a Defaulting Lender under this clause (c) upon receipt by the Administrative Agent of such confirmation, (d) otherwise failed to pay over to the Administrative Agent or any other Lender any other amount required to be paid by it hereunder within two Domestic Business Days of the date when due, unless the subject of a good faith dispute, or (e) (i) becomes or is insolvent or has a parent company that has become or is insolvent, (ii) becomes the subject of a bankruptcy or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment or has a parent company that has become the subject of a bankruptcy or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment, or (iii) becomes, or has a parent company that becomes, the subject of a Bail-in Action, *provided* that a Lender shall not qualify as a Defaulting Lender solely as a result of the acquisition or maintenance of an ownership interest in such Lender or its parent company, or of the exercise of control over such Lender or any Person controlling such Lender, by a Governmental Authority or instrumentality thereof so long as such ownership interest does not result in or provide such Lender with immunity from the jurisdiction of courts within the United States of America or from the enforcement of judgments or writs of attachment on its assets or permit such Lender (or such Governmental Authority) to reject, repudiate, disavow or disaffirm any agreements made by such Lender.

"Disposition": with respect to any Person, any sale, assignment, transfer or other disposition by such Person by any means, of:

(a) the stock of, or other equity interests of, any other Person,

(b) any business, operating entity, division or segment thereof, or

(c) any other Property of such Person, other than (i) the sale of inventory (other than in connection with bulk transfers), (ii) the disposition of equipment and (iii) the sale of cash investments.

"***Disqualified Institutions***": those Persons that are (a) competitors of the Borrower or its Subsidiaries, identified in writing by the Borrower to the Administrative Agent and the Lenders from time to time (by posting such notice to the Platform) not less than one (1) Domestic Business Day prior to the date of determination (it being understood that, notwithstanding anything herein to the contrary, in no event shall a supplement apply retroactively to disqualify any Person that has previously acquired an assignment or participation interest hereunder that is otherwise an Eligible Assignee, but upon the effectiveness of such designation, any such Person may not acquire any additional Commitments, Advances or participations), (b) such other Persons identified in writing by the Borrower to the Administrative Agent prior to the Effective Date and (c) Affiliates of the Persons identified pursuant to clause (a) or (b) that are either clearly identifiable by name or identified in writing by the Borrower to the Administrative Agent; provided that "Disqualified Institutions" shall exclude any Person that the Borrower has designated as no longer being a "Disqualified Institution" by written notice delivered to the Administrative Agent and the Lenders from time to time.

"Dividend Restrictions": as defined in Section 8.7.

"Dollar" *or* ***"$"***: lawful currency of the United States of America.

"Domestic Business Day": any day other than a Saturday, Sunday or a day which in New York City is a legal holiday or a day on which banking institutions are authorized or required by law or other governmental action to close.

"EEA Financial Institution": (a) any credit institution or investment firm established in any EEA Member Country which is subject to the supervision of an EEA Resolution Authority, (b) any entity established in an EEA Member Country which is a parent of an institution described in clause (a) of this definition, or (c) any financial institution established in an EEA Member Country which is a subsidiary of an institution described in clause (a) or (b) of this definition and is subject to consolidated supervision with its parent.

"EEA Member Country": any of the member states of the European Union, Iceland, Liechtenstein, and Norway.

"EEA Resolution Authority": any public administrative authority or any person entrusted with public administrative authority of any EEA Member Country (including any delegee) having responsibility for the resolution of any EEA Financial Institution.

"Effective Date": as defined in Section 5.

"*Eligible Assignee*": a Person that is a permitted assignee under Section 11.7(b) that has received the consent of each party whose consent is required under Section 11.7(b). For the avoidance of doubt, any Disqualified Institution is subject to Section 11.7(h).

"Employee Benefit Plan": an employee benefit plan, within the meaning of Section 3(3) of ERISA, maintained, sponsored or contributed to by the Borrower, any Subsidiary or any ERISA Affiliate.

"Environmental Laws": all laws, rules, regulations, codes, ordinances, orders, decrees, judgments, injunctions, notices or binding agreements issued, promulgated or entered into by any Governmental Authority, relating in any way to the environment, preservation or reclamation of natural resources, the management, release or threatened release of any Hazardous Material or to health and safety matters.

"Environmental Liability": as to any Person, any statutory, common law or equitable liability, contingent or otherwise (including any liability for damages, costs of environmental investigation, sampling or remediation, fines, penalties or indemnities), of such Person directly or indirectly resulting from or based upon (i) violation of any Environmental Law, (ii) the generation, use, handling, transportation, storage, treatment, discharge or disposal of any Hazardous Materials, (iii) exposure to any Hazardous Materials, (iv) the release or threatened release of any Hazardous Materials into the environment or (v) any contract, agreement or other consensual arrangement pursuant to which liability is assumed or imposed with respect to any of the foregoing.

"***Equity Interests***": shares of capital stock, partnership interests, membership interests, beneficial interests or other ownership interests, whether voting or nonvoting, in, or interests in the income or profits of, a Person, and any warrants, options or other rights entitling the holder thereof to purchase or acquire any of the foregoing.

"ERISA": the Employee Retirement Income Security Act of 1974, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"ERISA Affiliate": when used with respect to an Employee Benefit Plan, ERISA, the PBGC or a provision of the Internal Revenue Code pertaining to employee benefit plans, any Person that is a member

of any group of organizations within the meaning of Sections 414(b) or (c) of the Internal Revenue Code or, solely with respect to the applicable provisions of the Internal Revenue Code, Section 414(m) or (o) of the Internal Revenue Code, of which the Borrower or any Subsidiary is a member.

"*ERISA Event*": (a) any "reportable event", as defined in Section 4043 of ERISA with respect to a Pension Plan (other than an event for which the 30-day notice period is waived); (b) the determination that any Pension Plan is considered an at-risk plan or a plan in endangered or critical status within the meaning of Sections 430, 431 or 432 of the Internal Revenue Code or Sections 303, 304 or 305 of ERISA; (c) the filing pursuant to the Internal Revenue Code or ERISA of an application for a waiver of the minimum funding standard with respect to any Pension Plan; (d) the incurrence by the Borrower, any Subsidiary or an ERISA Affiliate of any liability under Title IV of ERISA with respect to the termination of any Pension Plan, other than for PBGC premiums due but not delinquent under Section 4007 of ERISA, upon the Borrower, any Subsidiary or an ERISA Affiliate; (e) the receipt by the Borrower, any Subsidiary or an ERISA Affiliate from the PBGC or a plan administrator of any notice relating to an intention to terminate any Pension Plan or to appoint a trustee to administer any Pension Plan; (f) the incurrence by the Borrower, any Subsidiary or an ERISA Affiliate of any liability with respect to the withdrawal or partial withdrawal from any Pension Plan or Multiemployer Plan; (g) any limits under Section 436 of the Internal Revenue Code become applicable; or (h) any failure to make any payment required by Section 430(j) of the Internal Revenue Code.

"EU Bail-In Legislation Schedule": the EU Bail-In Legislation Schedule published by the Loan Market Association (or any successor person), as in effect from time to time.

"Eurodollar Advance": a portion of the Revolving Credit Loans selected by the Borrower to bear interest during a Eurodollar Interest Period selected by the Borrower at a rate per annum based upon a Eurodollar Rate determined with reference to such Eurodollar Interest Period, all pursuant to and in accordance with Section 2.1 or Section 3.3.

"Eurodollar Business Day": any Domestic Business Day, other than a Domestic Business Day on which banks are not open for dealings in Dollar deposits in the interbank eurodollar market.

"Eurodollar Interest Period": the period commencing on any Eurodollar Business Day selected by the Borrower in accordance with Section 2.3 or Section 3.3 and ending one, two, three or six months thereafter, as selected by the Borrower in accordance with either such Sections, subject to the following:

(i) if any Eurodollar Interest Period would otherwise end on a day which is not a Eurodollar Business Day, such Eurodollar Interest Period shall be extended to the immediately succeeding Eurodollar Business Day unless the result of such extension would be to carry the end of such Eurodollar Interest Period into another calendar month, in which event such Eurodollar Interest Period shall end on the Eurodollar Business Day immediately preceding such day; and

(ii) if any Eurodollar Interest Period shall begin on the last Eurodollar Business Day of a calendar month (or on a day for which there is no numerically corresponding day in the calendar month at the end of such Eurodollar Interest Period), such Eurodollar Interest Period shall end on the last Eurodollar Business Day of such latter calendar month.

"Eurodollar Rate": with respect to any Eurodollar Advance for any Eurodollar Interest Period, (a) the LIBO Rate for such Eurodollar Interest Period, multiplied by (b) the Statutory Reserve Rate.

"Event of Default": any of the events specified in Section 9.1, *provided* that any requirement for the giving of notice, the lapse of time, or both, or any other condition has been satisfied.

"Excluded Taxes": with respect to the Administrative Agent, any Lender, any Issuer or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, (a) Taxes imposed on or measured by its net income (however denominated) or overall gross receipts, and franchise Taxes, in each case, (i) imposed on it by the jurisdiction (or any political subdivision thereof) under the laws of which it is organized or in which its principal office is located or, in the case of any Lender, in which its applicable lending office is located, or (ii) that are Other Connection Taxes, (b) any branch profits Taxes imposed by the United States of America or that are Other Connection Taxes, (c) in the case of a Lender (other than an assignee pursuant to a request by the Borrower under Section 3.13), any withholding Tax that is imposed on amounts payable to such Lender at the time such Lender becomes a party hereto (or designates a new lending office), except to the extent that such Lender (or its assignor, if any) was entitled, at the time of designation of a new lending office (or assignment), to receive additional amounts from the Borrower with respect to such withholding Tax pursuant to Section 3.10, (d) any Tax attributable to such recipient's failure or inability (other than as a result of a Regulatory Change, except for a Regulatory Change relating to the implementation of FATCA) to comply with Section 3.10(f) and (e) any Taxes imposed under FATCA.

"Existing Commitment Termination Date": as defined in Section 2.12(a).

"Existing 2015 Credit Agreement": the Credit Agreement, dated as of July 1, 2015, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and The Bank of New York Mellon, as administrative agent, as amended by Amendment No. 1 to Credit Agreement, dated as of December 15, 2017, and Amendment No. 2 to Credit Agreement, dated as of May 17, 2018.

"Existing 2017 Credit Agreement": the Five Year Credit Agreement, dated as of May 18, 2017, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and The Bank of New York Mellon, as administrative agent, as amended by Amendment No. 1 to Five Year Credit Agreement, dated as of December 15, 2017, Amendment No. 2 to Five Year Credit Agreement, dated as of May 17, 2018 Amendment No. 3 to Five Year Credit Agreement, dated as of May 16, 2019, and as the same may be further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 2018 Credit Agreement": the Five Year Credit Agreement, dated as of May 17, 2018, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA, GS and Wells Fargo, as co-documentation agents, and The Bank of New York Mellon, as administrative agent, as amended by Amendment No. 1 to Five Year Credit Agreement dated as of May 16, 2019 and as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 364-Day Credit Agreement": the 364-Day Credit Agreement, dated as of May 16, 2019, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, GS and Wells Fargo, as co-documentation agents, and BofA, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing Term Loan Agreement": the Term Loan Agreement, dated as of December 15, 2017, by and among the Borrower, the lenders party thereto from time to time, GS and BofA, as co-syndication agents, and Barclays, as administrative agent, as amended by Amendment No. 1 to Term Loan Agreement, dated as of May 17, 2018, and as the same may be further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Expiration Date": the first date, occurring on or after the date the Commitments shall have terminated or been terminated in accordance herewith, upon which there shall be no Loans, Reimbursement Obligations or Letters of Credit outstanding.

"Extension Date": as defined in Section 2.12(a).

"Extension Request": as defined in Section 2.12(a).

"Facility Fee": as defined in Section 3.11.

"FATCA": Sections 1471 through 1474 of the Internal Revenue Code, as of the date of this Agreement (or any amended or successor version that is substantively comparable and not materially more onerous to comply with), any current or future regulations or official interpretations thereof, any agreements entered into pursuant to Section 1471(b)(1) of the Internal Revenue Code, any applicable intergovernmental agreements with respect thereto, and any treaty, law, regulations, or other official guidance enacted in any other jurisdiction relating to such intergovernmental agreement.

"Federal Funds Effective Rate": for any day, the rate per annum equal to the weighted average of the rates on overnight Federal funds transactions with members of the Federal Reserve System, as published by the Federal Reserve Bank of New York on the Domestic Business Day next succeeding such day; provided that (a) if such day is not a Domestic Business Day, the Federal Funds Effective Rate for such day shall be such rate on such transactions on the next preceding Domestic Business Day as so published on the next succeeding Domestic Business Day, and (b) if no such rate is so published on such next succeeding Domestic Business Day, the Federal Funds Effective Rate for such day shall be the average rate (rounded upward, if necessary, to a whole multiple of 1/100 of 1%) charged to BofA on such day on such transactions as reasonably determined by the Administrative Agent; *provided* that if the "Federal Funds Effective Rate" would otherwise be less than zero, the "Federal Funds Effective Rate" shall be deemed to be zero for purposes of this Agreement.

"Fees": as defined in Section 3.2(a).

"Financial Statements": as defined in Section 4.13.

"Foreign Lender": any Lender or any Issuer that is not a United States person within the meaning of Section 7701(a)(30) of the Internal Revenue Code.

"GAAP": subject to Section 1.2(b), generally accepted accounting principles set forth in the opinions and pronouncements of the Accounting Principles Board and the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board or such other principles as may be approved by a significant segment of the accounting profession, which are applicable to the circumstances as of the date of determination, consistently applied.

"***Governmental Authority"***: any foreign, federal, state, municipal or other government, or any department, commission, board, bureau, agency, public authority or instrumentality thereof, or any court, arbitrator, regulatory body or central bank (including any supra-national bodies such as the European Union or the European Central Bank).

"GS": as defined in the preamble.

"***Hazardous Materials"***: all ignitable, explosive, reactive, corrosive or radioactive substances or wastes and all hazardous or toxic materials, substances, chemicals, wastes or other pollutants, including but

not limited to petroleum or petroleum distillates, asbestos or asbestos containing materials, polychlorinated biphenyls, radon gas, toxic mold, infectious or medical wastes, hazardous biological agents, hazardous pharmaceutical substances and all other materials, substances, chemicals, wastes, contaminants or pollutants of any nature that are now or hereafter regulated pursuant to any Environmental Law, or are now or hereafter defined, listed or classified as a hazardous or toxic material, substance, chemical, waste, contaminant or pollutant in any Environmental Law.

"Highest Lawful Rate": as to any Lender, the maximum rate of interest, if any, which at any time or from time to time may be contracted for, taken, charged or received on the Loans or the Notes or which may be owing to such Lender pursuant to this Agreement under the laws applicable to such Lender and this Agreement.

"Increasing Lender": as defined in Section 2.6(d).

"Indebtedness": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) indebtedness with respect to any conditional sale or other title retention agreement, (d) indebtedness arising under acceptance facilities and the amount available to be drawn under all letters of credit (excluding for purposes of Section 8.9 letters of credit obtained in the ordinary course of business by the Borrower or any Subsidiary) issued for the account of such Person and, without duplication, all drafts drawn thereunder to the extent such Person shall not have reimbursed the issuer thereof in respect of such issuer's payment of such drafts, (e) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, (f) all indebtedness described in (a) - (e) above secured by any Lien on any Property owned by such Person even though such Person shall not have assumed or otherwise become liable for the payment thereof (other than carriers', warehousemen's, mechanics', repairmen's or other like non-consensual Liens arising in the ordinary course of business), and (g) Contingent Obligations in respect of any indebtedness described in items (a) - (f) above; *provided* that, for purposes of this definition, Indebtedness shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"Indebtedness for Borrowed Money": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, and (d) Contingent Obligations in respect of any indebtedness described in items (a) - (c) above; *provided* that, for purposes of this definition, Indebtedness for Borrowed Money shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"Indemnified Amount": as defined in Section 11.10(b).

"***Indemnified Liabilities"***: as defined in Section 11.5(a).

"Indemnified Person": as defined in Section 11.10(a).

"Indemnified Taxes": Taxes other than Excluded Taxes and Other Taxes.

"Information": as defined in Section 11.14(b).

"Insurance Subsidiary": any Subsidiary subject to regulation by the commissioner of insurance, the commissioner of health or any equivalent Governmental Authority in any applicable jurisdiction.

"Intangible Assets": at any date, the value, as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP, of: (i) all trade names, trademarks, licenses, patents, copyrights, service marks, goodwill and other like intangibles, (ii) organizational and development costs, (iii) deferred charges (other than prepaid items, such as insurance, taxes, interest, commissions, rents, pensions, compensation and similar items and tangible assets being amortized), and (iv) unamortized debt discount and expense, less unamortized premium.

"Intercompany Debt": (i) Indebtedness of the Borrower to one or more of the Subsidiaries of the Borrower and (ii) Indebtedness of one or more of the Subsidiaries of the Borrower to the Borrower or any one or more of the other Subsidiaries of the Borrower.

"Intercompany Disposition": a Disposition by the Borrower or any of the Subsidiaries of the Borrower to the Borrower or to any of the other Subsidiaries of the Borrower.

"Interest Payment Date": (i) as to any ABR Advance, the last day of each March, June, September and December, commencing on the first of such days to occur after such ABR Advance is made or any Eurodollar Advance is converted to an ABR Advance, (ii) as to any Swing Line Loan, the day on which the outstanding principal balance of such Swing Line Loan shall become due and payable in accordance with Section 2.2(a), (iii) as to any Eurodollar Advance in respect of which the Borrower has selected a Eurodollar Interest Period of one, two or three months, the last day of such Eurodollar Interest Period, (iv) as to any Competitive Bid Loan in respect of which the Borrower has selected a Competitive Interest Period of 90 days or less, the last day of such Competitive Interest Period and (v) as to any Eurodollar Advance or Competitive Bid Loan in respect of which the Borrower has selected an Interest Period greater than three months or 90 days, as the case may be, the last day of the third month or the 90th day, as the case may be, of such Interest Period and the last day of such Interest Period.

"Interest Period": a Eurodollar Interest Period or a Competitive Interest Period, as the case may be.

"Internal Revenue Code": the Internal Revenue Code of 1986, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"issue" *or* ***"issuance"***: when used with respect to a Letter of Credit, shall be deemed to include any increase in the amount of such Letter of Credit.

"Issuers": Barclays, BofA, GS, JPMC and Wells Fargo; each an ***"Issuer"***.

"Joint Lead Arrangers": BAS, Barclays, GS, JPMC and WFS.

"JPMC": as defined in the preamble.

"Lender" and ***"Lenders"***: as defined in the preamble; such term to also include the Swing Line Lender and each Issuer where the context hereof requires or permits such inclusion.

"Letter of Credit" and ***"Letters of Credit"***: as defined in Section 2.8(a).

"Letter of Credit Application": an application and agreement for the issuance or amendment of a Letter of Credit in the form from time to time in use by the applicable Issuer.

"Letter of Credit Commitment": at any time with respect to any Issuer, the commitment of such Issuer to issue Letters of Credit (which, for the avoidance of doubt, shall include all standby letters of credit and all commercial letters of credit issued by such Issuer) in accordance with the terms hereof in an aggregate outstanding face amount not exceeding the lesser of (a) the amount set forth adjacent to such Issuer's name under the heading "Letter of Credit Commitment" in Exhibit A at such time or, if not listed on Exhibit A, the "Letter of Credit Commitment" which such Issuer shall have assumed from another Issuer in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7, and (b) the amount equal to the Aggregate Commitment Amount as in effect at such time multiplied by a percentage equal to a fraction, the numerator of which is one and the denominator of which is five.

"Letter of Credit Exposure": at any time, (a) in respect of all Lenders, the sum, without duplication, of (i) the maximum aggregate amount which may be drawn under all unexpired Letters of Credit at such time (whether or not the conditions for drawing thereunder have or may be satisfied), (ii) the aggregate amount, at such time, of all unpaid drafts (which have not been dishonored) drawn under all Letters of Credit, and (iii) the aggregate unpaid principal amount of the Reimbursement Obligations at such time, (b) in respect of any Lender, an amount equal to such Lender's Commitment Percentage at such time multiplied by the amount determined under clause (a) of this definition, and (c) in respect of any Issuer, the amount determined under clause (a) of this definition in respect of a Letter of Credit issued by such Issuer.

"Letter of Credit Participation Fee": as defined in Section 3.12.

"Letter of Credit Request": a request substantially in the form of Exhibit J.

"LIBO Rate": for any Eurodollar Interest Period with respect to a Eurodollar Rate Loan, the rate per annum equal to the London Interbank Offered Rate as administered by ICE Benchmark Administration (or any other Person that takes over the administration of such rate for Dollars for a period equal in length to such Interest Period) ("LIBOR") as published on the applicable Bloomberg screen page (or such other commercially available source providing such quotations as may be designated by the Administrative Agent from time to time) at approximately 11:00 a.m., London time, two Eurodollar Business Days prior to the commencement of such Eurodollar Interest Period, for Dollar deposits (for delivery on the first day of such Eurodollar Interest Period) with a term equivalent to such Eurodollar Interest Period; *provided* that if the LIBO Rate shall be less than zero, the LIBO Rate shall be deemed to be zero for the purposes of this Agreement.

"LIBO Screen Rate": the LIBOR quote on the applicable screen page the Administrative Agent designates to determine LIBOR (or such other commercially available source providing such quotations as may be designated by the Administrative Agent from time to time).

"***LIBOR***" as defined in the definition of LIBO Rate.

"***LIBOR Daily Floating Rate***": a fluctuating rate of interest, which can change on each Domestic Business Day, equal to LIBOR, or a comparable or successor rate which rate is approved by the Administrative Agent, as published on the applicable Bloomberg screen page (or such other commercially available source providing such quotations as may be designated by the Swing Line Lender from time to time) at or about 11:00 a.m., London time, two Eurodollar Business Days prior to the date in question, for Dollar deposits with a term equivalent to a one month term beginning on that date, as adjusted from time to time in the Swing Line Lender's sole discretion for reserve requirements, deposit insurance assessment

rates and other regulatory costs; provided that: (i) to the extent a comparable or successor rate is approved by the Swing Line Lender in connection herewith, the approved rate shall be applied in a manner consistent with market practice; provided, further that to the extent such market practice is not administratively feasible for the Swing Line Lender, such approved rate shall be applied in a manner as otherwise reasonably determined by the Swing Line Lender, (ii) if the LIBOR Daily Floating Rate shall be less than zero, such rate shall be deemed zero for purposes of this Agreement and (iii) if such rate is not available at such time for any reason, then the rate will be determined by such alternate method as reasonably selected by the Swing Line Lender.

"***LIBOR Successor Rate***": as defined in Section 3.8(d).

"***LIBOR Successor Rate Conforming Changes***": as defined in Section 3.8(d).

"Lien": any mortgage, pledge, hypothecation, assignment, lien, deposit arrangement, charge, encumbrance or other security arrangement or security interest of any kind, or the interest of a vendor or lessor under any conditional sale agreement, capital lease or other title retention agreement; *provided*, that in no event shall an operating lease be deemed to constitute a Lien.

"Loan": a Revolving Credit Loan, a Competitive Bid Loan or a Swing Line Loan, as the case may be.

"Loan Documents": this Agreement and, upon the execution and delivery thereof, the Notes, if any, and the Reimbursement Agreements, if any.

"Loans": the Revolving Credit Loans, the Competitive Bid Loans and the Swing Line Loans.

"Mandatory Borrowing": as defined in Section 2.2(b).

"Margin Stock": any "margin stock", as said term is defined in Regulation U of the Board of Governors of the Federal Reserve System, as the same may be amended or supplemented from time to time.

"***Material Acquisition***": any acquisition of (a) Equity Interests in any Person if, after giving effect thereto, such Person will become a Subsidiary or (b) assets comprising all or substantially all the assets of (or all or substantially all the assets constituting a business unit, division, product line or line of business of) any Person; provided that the aggregate consideration therefor (including Indebtedness assumed in connection therewith, all obligations in respect of the deferred purchase price therefor (including obligations under any purchase price adjustment but excluding earn-out or similar payments) and all other consideration payable in connection therewith (including payment obligations in respect of noncompetition agreements or other arrangements representing acquisition consideration)) equals or exceeds $500,000,000.

"Material Adverse": with respect to any change or effect, a material adverse change in, or effect on, as the case may be, (i) the financial condition, operations, business, or Property of the Borrower and the Subsidiaries taken as a whole, (ii) the ability of the Borrower to perform its obligations under the Loan Documents, or (iii) the ability of the Administrative Agent, any Issuer or any Lender to enforce the Loan Documents.

"***Material Subsidiary***": a Subsidiary of the Borrower with respect to which (i) the Borrower's and its other Subsidiaries' investments in, and advances to, such Subsidiary exceed ten percent (10%) of the total assets of the Borrower and its Subsidiaries Consolidated as of the end of the most recently completed fiscal year, (ii) the Borrower's and its other Subsidiaries' proportionate share of the total assets (after intercompany eliminations) of such Subsidiary exceeds 10 percent (10%) of the total assets of the Borrower

and its Subsidiaries Consolidated as of the end of the most recently completed fiscal year, or (iii) the Borrower's and its other Subsidiaries' equity in the income from continuing operations before income taxes of such Subsidiary exclusive of amounts attributable to any non-controlling interests exceeds ten percent (10%) of such income of the Borrower and its Subsidiaries Consolidated for the most recently completed fiscal year.

"Moody's": Moody's Investors Service, Inc., or any successor thereto.

"Multiemployer Plan": a Pension Plan which is a multiemployer plan as defined in Section 4001(a)(3) of ERISA.

"***Negotiated Rate***": with respect to each Swing Line Loan, the rate per annum agreed to in writing by the Borrower and the Swing Line Lender as the interest rate which such Swing Line Loan shall bear.

"Net Tangible Assets": at any date, the total assets as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP, less, without duplication (i) all current liabilities (due within one year) as shown on such balance sheet and (ii) Intangible Assets and liabilities relating thereto.

"New Lender": as defined in Section 2.6(d).

"Non-Extending Lender": as defined in Section 2.12(b).

"Note": with respect to each Lender that has requested one in accordance with Section 2.11, a promissory note evidencing such Lender's Loans payable to such Lender (or, if required by such Lender, to such Lender and its registered assigns), substantially in the form of Exhibit B.

"One Month LIBOR Rate": for any interest calculation with respect to an ABR Advance on any date, the rate per annum equal to LIBOR, at or about 11:00 a.m., London time determined two Eurodollar Business Days prior to such date for Dollar deposits with a term of one month commencing that day, *provided* that in the event that the *"One Month LIBOR Rate"* would otherwise be less than zero, such *"One Month LIBOR Rate"* shall be deemed to be zero for purposes of this Agreement.

"***Other Connection Taxes***": with respect to the Administrative Agent, any Lender, any Issuer or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, Taxes imposed as a result of a present or former connection between such recipient and the jurisdiction imposing such Tax (other than connections arising from such recipient having executed, delivered, become a party to, performed its obligations under, received payments under, received or perfected a security interest under, engaged in any other transaction pursuant to, enforced any Loan Document, or sold or assigned an interest in any Loan or Loan Document).

"Other Taxes": all present or future stamp, court or documentary Taxes or any other excise or property Taxes, charges or similar levies arising from any payment made hereunder or under any other Loan Document or from the execution, delivery or enforcement of, or otherwise with respect to, this Agreement or any other Loan Document, except any such Taxes that are Other Connection Taxes imposed with respect to an assignment (other than an assignment made pursuant to Section 3.13).

"Participant": as defined in Section 11.7(d).

"Participant Register": as defined in Section 11.7(d).

"Patriot Act": as defined in Section 11.20.

"PBGC": the Pension Benefit Guaranty Corporation established pursuant to Subtitle A of Title IV of ERISA, or any Governmental Authority succeeding to the functions thereof.

"Pension Plan": at any time, any Employee Benefit Plan (including a Multiemployer Plan) subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, the funding requirements of which are, or at any time within the six years immediately preceding the time in question were, in whole or in part, the responsibility of the Borrower, any Subsidiary or an ERISA Affiliate.

"Person": any individual, firm, partnership, limited liability company, joint venture, corporation, association, business trust, joint stock company, unincorporated association, trust, Governmental Authority or any other entity, whether acting in an individual, fiduciary, or other capacity, and for the purpose of the definition of "ERISA Affiliate", a trade or business.

"Plan of Reorganization": as defined in Section 11.7(h)(iii).

"Platform": as defined in Section 7.7.

"Pricing Level": Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV, Pricing Level V or Pricing Level VI, as the case may be.

"Pricing Level I": any time when the senior unsecured long term debt rating of the Borrower by (x) S&P is A or higher or (y) Moody's is A2 or higher.

"Pricing Level II": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is A- or higher or (y) Moody's is A3 or higher and (ii) Pricing Level I does not apply.

"Pricing Level III": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB+ or higher or (y) Moody's is Baa1 or higher and (ii) neither Pricing Level I nor Pricing Level II applies.

"Pricing Level IV": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB or higher or (y) Moody's is Baa2 or higher and (ii) none of Pricing Level I, Pricing Level II or Pricing Level III applies.

"Pricing Level V": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB- or higher or (y) Moody's is Baa3 or higher and (ii) none of Pricing Level I, Pricing Level II, Pricing Level III or Pricing Level IV applies.

"Pricing Level VI": any time when none of Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV or Pricing Level V applies.

Notwithstanding each definition of Pricing Level set forth above, if at any time the senior unsecured long term debt ratings of the Borrower by S&P and Moody's differ by more than one equivalent rating level, then the applicable Pricing Level shall be determined based upon the lower such rating adjusted upwards to the next higher rating level.

"Proceeding": as defined in Section 11.10(d).

"*Prohibited Transaction*": a transaction that is prohibited under Section 4975 of the Internal Revenue Code or Section 406 of ERISA and not exempt under Section 4975 of the Internal Revenue Code, Section 408 of ERISA or any applicable administrative exemptions.

"Property": in respect of any Person, all types of real, personal or mixed property and all types of tangible or intangible property owned or leased by such Person.

"PTE": as defined in Section 11.23(c).

"Regulatory Change": the occurrence, after the date hereof, of any of the following: (a) the adoption or taking effect of any law, rule, regulation or treaty, (b) any change in any law, rule, regulation or treaty or in the administration, implementation, interpretation or application thereof by any Governmental Authority or (c) the making or issuance of any request, guideline or directive (whether or not having the force of law) by any Governmental Authority; *provided* that, notwithstanding anything herein to the contrary, (i) the Dodd-Frank Wall Street Reform and Consumer Protection Act and all requests, rules, guidelines or directives thereunder or issued in connection therewith and (ii) all requests, rules, guidelines or directives promulgated by the Bank for International Settlements, the Basel Committee on Banking Supervision (or any successor or similar authority) or the United States or foreign regulatory authorities, in each case, pursuant to Basel III, in the case of each of clauses (i) and (ii), shall be deemed to be a "Regulatory Change", regardless of the date enacted, adopted or issued, but only if any such requirements are generally applicable to (and for which reimbursement is generally being sought by the Lenders in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this definition), as determined by the Lenders in their respective reasonable discretion.

"Register": as defined in Section 11.7(c).

"Reimbursement Agreement": as defined in Section 2.8(b) and, as the context requires, shall include the Letter of Credit Application related to the applicable Letter of Credit.

"Reimbursement Obligations": all obligations and liabilities of the Borrower due and to become due (a) under the Reimbursement Agreements and (b) hereunder in respect of Letters of Credit.

"Related Parties": with respect to any specified Person, such Person's Affiliates and the respective directors, officers, employees, agents and advisors of such Person and such Person's Affiliates.

"Replaced Lender": as defined in Section 3.13.

"Replacement Lender": as defined in Section 3.13.

"Required Lenders": (a) at any time prior to the Commitment Termination Date or such earlier date as all of the Commitments shall have terminated or been terminated in accordance herewith, Lenders having Commitment Amounts greater than 50% of the Aggregate Commitment Amount, and (b) at all other times, Lenders having Credit Exposure greater than 50% of the Aggregate Credit Exposure.

"Restrictive Agreement": as defined in Section 8.7.

"Revolving Credit Loan" and ***"Revolving Credit Loans"***: as defined in Section 2.1(a).

"S&P": Standard & Poor's Financial Services LLC, a subsidiary of S&P Global Inc., or any successor thereto.

"Sanctioned Country": at any time, a country or territory which is the subject or target of any Sanctions.

"Sanctioned Person": at any time, (a) any Person listed in any Sanctions-related list of designated Persons maintained by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State, (b) any Person operating, organized or resident in a Sanctioned Country or (c) any Person controlled by any such Person.

"Sanctions": economic or financial sanctions or trade embargoes imposed, administered or enforced from time to time by the U.S. government, including those administered by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State.

"***Scheduled Unavailability Date***": as defined in Section 3.8(d)(ii).

"***SEC Reports***": the Borrower's 2018 Annual Report on Form 10-K, the Borrower's quarterly report on Form 10-Q for the quarterly period ending March 31, 2019, and any 8-K filings made by the Borrower subsequent to March 31, 2019 and prior to the Effective Date.

"Special Counsel": such counsel as the Administrative Agent may engage from time to time.

"Statutory Reserve Rate": a fraction (expressed as a decimal), the numerator of which is the number one and the denominator of which is the number one minus the aggregate of the maximum reserve percentages (including any marginal, special, emergency or supplemental reserves) expressed as a decimal established by the Board of Governors of the Federal Reserve System to which the Administrative Agent is subject for eurocurrency funding (currently referred to as "Eurocurrency liabilities" in Regulation D of the Board of Governors of the Federal Reserve System, as amended). Such reserve percentages shall include those imposed pursuant to said Regulation D. Eurodollar Loans shall be deemed to constitute eurocurrency funding and to be subject to such reserve requirements without benefit of or credit for proration, exemptions or offsets that may be available from time to time to any Lender under said Regulation D or any comparable regulation. The Statutory Reserve Rate shall be adjusted automatically on and as of the effective date of any change in any reserve percentage.

"Subsidiary": at any time and from time to time, any corporation, partnership, limited liability company, joint venture or other business entity of which the Borrower and/or any Subsidiary of the Borrower, directly or indirectly at such time, either (a) in respect of a corporation, owns or controls more than 50% of the outstanding stock having ordinary voting power to elect a majority of the board of directors or similar managing body, irrespective of whether a class or classes shall or might have voting power by reason of the happening of any contingency, or (b) in respect of a partnership, limited liability company, joint venture or other business entity, is entitled to share in more than 50% of the profits and losses, however determined.

"Swing Line Commitment": the commitment of the Swing Line Lender to make Swing Line Loans in accordance with the terms hereof in an aggregate outstanding principal amount not exceeding $100,000,000 (or, if less, the Aggregate Commitment Amount) at any time, as the same may be reduced pursuant to Section 2.6.

"Swing Line Commitment Period": the period from the Effective Date to, but excluding, the Swing Line Termination Date.

"Swing Line Exposure": at any time, in respect of any Lender, an amount equal to the aggregate principal balance of such Lender's Swing Line Participation Amount.

"Swing Line Lender": BofA.

"Swing Line Loan" and ***"Swing Line Loans"***: as defined in Section 2.2(a).

"Swing Line Maturity Date": as defined in Section 2.2(a).

"Swing Line Participation Amount": as defined in Section 2.2(c).

"Swing Line Termination Date": the date which is 7 Domestic Business Days prior to the Commitment Termination Date.

"Taxes": all present or future taxes, levies, imposts, duties, deductions, withholdings, assessments, fees or other charges in the nature of a tax imposed by any Governmental Authority, including any interest, additions to tax or penalties applicable thereto.

"Termination Event": with respect to any Pension Plan, (a) an ERISA Event, (b) the termination of a Pension Plan under Section 4041(c) of ERISA, or the filing of a notice of intent to terminate a Pension Plan under Section 4041(c) of ERISA, or the treatment of a Pension Plan amendment as a termination under Section 4041(e) of ERISA (except an amendment made after such Pension Plan satisfies the requirement for a standard termination under Section 4041(b) of ERISA), (c) the institution of proceedings by the PBGC to terminate a Pension Plan under Section 4042 of ERISA, or (d) the appointment of a trustee to administer any Pension Plan under Section 4042 of ERISA.

"Threshold Amount": $300,000,000.

"Total Capitalization": at any date, the sum of the Borrower's Consolidated Indebtedness and shareholders' equity on such date, determined in accordance with GAAP.

"Type": with respect to any Revolving Credit Loan, the characteristic of such Loan as an ABR Advance or a Eurodollar Advance, each of which constitutes a Type of Revolving Credit Loan.

"Unqualified Amount": as defined in Section 3.4(c).

"Upstream Dividends": as defined in Section 8.7.

"U.S. Lender": as defined in Section 3.10(f).

"United States Tax Compliance Certificate": as defined in Section 3.10(f)(iii).

"Wells Fargo": as defined in the preamble.

"***WFS***": Wells Fargo Securities, LLC.

"Write-Down and Conversion Powers": with respect to any EEA Resolution Authority, the write-down and conversion powers of such EEA Resolution Authority from time to time under the Bail-In Legislation for the applicable EEA Member Country, which write-down and conversion powers are described in the EU Bail-In Legislation Schedule.

1.2 Principles of Construction

(a) All capitalized terms defined in this Agreement shall have the meanings given to such capitalized terms herein when used in the other Loan Documents or in any certificate, opinion

or other document made or delivered pursuant hereto or thereto, unless otherwise expressly provided therein.

(b) Unless otherwise expressly provided herein, the word *"fiscal"* when used herein shall refer to the relevant fiscal period of the Borrower. As used in the Loan Documents and in any certificate, opinion or other document made or delivered pursuant thereto, accounting terms not defined in Section 1.1, and accounting terms partly defined in Section 1.1, to the extent not defined, shall have the respective meanings given to them under GAAP as in effect from time to time; *provided* that, if the Borrower notifies the Administrative Agent that the Borrower requests an amendment to any provision hereof to eliminate the effect of any change occurring after the date hereof in GAAP or in the application thereof on the operation of such provision (or if the Administrative Agent notifies the Borrower that the Required Lenders request an amendment to any provision hereof for such purpose), regardless of whether any such notice is given before or after such change in GAAP or in the application thereof, then such provision shall be interpreted on the basis of, and any accounting term related thereto shall have the respective meaning given to it under, GAAP as in effect and applied immediately before such change shall have become effective until such notice shall have been withdrawn or such provision amended in accordance herewith. Any lease that is characterized as an operating lease in accordance with GAAP after the Borrower's adoption of ASC 842 (regardless of the date on which such lease has been entered into) shall not be a capital or finance lease, and any such lease shall be, for all purposes of this Agreement, treated as though it were reflected on the Borrower's consolidated financial statements in the same manner as an operating lease would have been reflected prior to Borrower's adoption of ASC 842.

(c) The words *"hereof"*, *"herein"*, *"hereto"* and *"hereunder"* and similar words when used in each Loan Document shall refer to such Loan Document as a whole and not to any particular provision of such Loan Document, and Section, schedule and exhibit references contained therein shall refer to Sections thereof or schedules or exhibits thereto unless otherwise expressly provided therein.

(d) All references herein to a time of day shall mean the then applicable time in New York, New York, unless otherwise expressly provided herein.

(e) Section headings have been inserted in the Loan Documents for convenience only and shall not be construed to be a part thereof. Unless the context otherwise requires, words in the singular number include the plural, and words in the plural include the singular.

(f) Whenever in any Loan Document or in any certificate or other document made or delivered pursuant thereto, the terms thereof require that a Person sign or execute the same or refer to the same as having been so signed or executed, such terms shall mean that the same shall be, or was, duly signed or executed by (i) in respect of any Person that is a corporation, any duly authorized officer thereof, and (ii) in respect of any other Person (other than an individual), any analogous counterpart thereof.

(g) The words *"include"* and *"including"*, when used in each Loan Document, shall mean that the same shall be included *"without limitation"*, unless otherwise specifically provided.

(h) All references to "knowledge" or "awareness" of the Borrower or any Subsidiary means the actual knowledge of an Authorized Officer of the Borrower or such Subsidiary.

2. AMOUNT AND TERMS OF LOANS

2.1 Revolving Credit Loans

(a) Subject to the terms and conditions hereof, each Lender severally (and not jointly) agrees to make loans in Dollars under this Agreement (each a ***"Revolving Credit Loan"*** and, collectively with each other Revolving Credit Loan of such Lender and/or with each Revolving Credit Loan of each other Lender, the ***"Revolving Credit Loans"***) to the Borrower from time to time during the Commitment Period, during which period the Borrower may borrow, prepay and reborrow in accordance with the provisions hereof. Immediately after making each Revolving Credit Loan and after giving effect to all Swing Line Loans and Competitive Bid Loans repaid and all Reimbursement Obligations paid on the same date, the Aggregate Credit Exposure will not exceed the Aggregate Commitment Amount. With respect to each Lender, at the time of the making of any Revolving Credit Loan, the sum of (I) the principal amount of such Lender's Revolving Credit Loan constituting a part of the Revolving Credit Loans to be made, (II) the aggregate principal balance of all other Revolving Credit Loans (exclusive of Revolving Credit Loans which are repaid with the proceeds of, and simultaneously with the incidence of, the Revolving Credit Loans to be made) then outstanding from such Lender and (III) the product of (A) such Lender's Commitment Percentage and (B) the sum of (1) the aggregate principal balance of all Swing Line Loans (exclusive of Swing Line Loans which are repaid with the proceeds of, and simultaneously with the incurrence of, the Revolving Credit Loans to be made) then outstanding and (2) the Letter of Credit Exposure of all Lenders, will not exceed the Commitment of such Lender at such time. At the option of the Borrower, indicated in a Borrowing Request, Revolving Credit Loans may be made as ABR Advances or Eurodollar Advances.

(b) The aggregate outstanding principal balance of all Revolving Credit Loans shall be due and payable on the Commitment Termination Date or on such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6.

2.2 Swing Line Loans

(a) Subject to the terms and conditions hereof and in reliance upon the agreements of the other Lenders set forth in this Section 2.2, the Swing Line Lender agrees to make loans in Dollars under this Agreement (each a ***"Swing Line Loan"*** and, collectively, the ***"Swing Line Loans"***) to the Borrower from time to time during the Swing Line Commitment Period. Swing Line Loans (i) may be repaid and reborrowed in accordance with the provisions hereof, (ii) shall not, immediately after giving effect thereto, result in the Aggregate Credit Exposure exceeding the Aggregate Commitment Amount, and (iii) shall not, immediately after giving effect thereto, result in the aggregate outstanding principal balance of all Swing Line Loans exceeding the Swing Line Commitment. The Swing Line Lender shall not be obligated to make any Swing Line Loan at a time when any Lender is a Defaulting Lender unless the Swing Line Lender has entered into arrangements satisfactory to it and the Borrower to eliminate the Swing Line Lender's risk with respect to such Defaulting Lender's participation in such Swing Line Loan. The Swing Line Lender will not make a Swing Line Loan if the Administrative Agent or any Lender, by notice to the Swing Line Lender and the Borrower no later than one Domestic Business Day prior to the Borrowing Date with respect to such Swing Line Loan, shall have determined that the conditions set forth in Section 6 have not been satisfied or waived and such conditions remain unsatisfied as of the requested time of the making of such Loan. Each Swing Line Loan shall be due and payable on the day (the ***"Swing Line Maturity Date"***) being the earliest of the tenth Domestic Business Day after such Swing Line Loan is made, the date on which the Swing Line Commitment shall have been terminated in accordance with Section 2.6, and the date on which the Loans shall become due and

payable pursuant to the provisions hereof, whether by acceleration or otherwise. Each Swing Line Loan shall bear interest at the Negotiated Rate (or, if the Negotiated Rate is not available, the LIBOR Daily Floating Rate *plus* the Applicable Margin). The Swing Line Lender shall disburse the proceeds of Swing Line Loans at its office designated in Section 11.2 by crediting such proceeds to an account of the Borrower maintained with the Swing Line Lender.

(b) On any Domestic Business Day, the Swing Line Lender may, in its sole discretion, give notice to the Lenders and the Borrower that such outstanding Swing Line Loan shall be funded with a borrowing of Revolving Credit Loans (*provided* that such notice shall be deemed to have been automatically given upon the occurrence of a Default or an Event of Default under Section 9.1(h), (i) or (j)), in which case a borrowing of Revolving Credit Loans made as ABR Advances (each such borrowing, a ***"Mandatory Borrowing"***) shall be made by all Lenders *pro rata* based on each such Lender's Commitment Percentage on the Domestic Business Day immediately succeeding the giving of such notice. The proceeds of each Mandatory Borrowing shall be remitted directly to the Swing Line Lender to repay such outstanding Swing Line Loan. Each Lender irrevocably agrees to make a Revolving Credit Loan pursuant to each Mandatory Borrowing in the amount and in the manner specified in the preceding sentence and on the date specified in writing by the Swing Line Lender notwithstanding: (i) whether the amount of such Mandatory Borrowing complies with the minimum amount for Loans otherwise required hereunder, (ii) whether any condition specified in Section 6 is then unsatisfied, (iii) whether a Default then exists, (iv) the Borrowing Date of such Mandatory Borrowing, (v) the aggregate principal amount of all Loans then outstanding, (vi) the Aggregate Credit Exposure at such time and (vii) the amount of the Commitments at such time.

(c) Upon each receipt by a Lender of a notice from the Administrative Agent, such Lender shall purchase unconditionally, irrevocably, and severally (and not jointly) from the Swing Line Lender a participation in the outstanding Swing Line Loans (including accrued interest thereon) in an amount equal to the product of its Commitment Percentage and the outstanding balance of the Swing Line Loans (each, a ***"Swing Line Participation Amount"***). Each Lender shall also be liable for an amount equal to the product of its Commitment Percentage and any amounts paid by the Borrower pursuant to this Section 2.2 that are subsequently rescinded or avoided, or must otherwise be restored or returned. Such liabilities shall be unconditional and without regard to the occurrence of any Default or the compliance by the Borrower with any of its obligations under the Loan Documents.

(d) In furtherance of Section 2.2(c), upon each receipt by a Lender of a notice from the Administrative Agent, such Lender shall promptly make available to the Administrative Agent for the account of the Swing Line Lender its Swing Line Participation Amount at the office of the Administrative Agent specified in Section 11.2, in Dollars and in immediately available funds. The Administrative Agent shall deliver the payments made by each Lender pursuant to the immediately preceding sentence to the Swing Line Lender promptly upon receipt thereof in like funds as received. Each Lender hereby indemnifies and agrees to hold harmless the Administrative Agent and the Swing Line Lender from and against any and all losses, liabilities (including liabilities for penalties), actions, suits, judgments, demands, costs and expenses resulting from any failure on the part of such Lender to pay, or from any delay in paying, the Administrative Agent any amount such Lender is required by notice from the Administrative Agent to pay in accordance with this Section 2.2 (except in respect of losses, liabilities or other obligations suffered by the Administrative Agent or the Swing Line Lender, as the case may be, resulting from the gross negligence or willful misconduct of the Administrative Agent or the Swing Line Lender, as the case may be), and such Lender shall pay interest to the Administrative Agent for the account of the Swing Line Lender from the date such amount was due until paid in full, on the unpaid portion thereof, at a rate of

interest per annum, whether before or after judgment, equal to (i) from the date such amount was due until the third day therefrom, the Federal Funds Effective Rate, and (ii) thereafter, the Federal Funds Effective Rate *plus* 2%, payable upon demand by the Swing Line Lender. The Administrative Agent shall distribute such interest payments to the Swing Line Lender upon receipt thereof in like funds as received.

(e) Whenever the Administrative Agent is reimbursed by the Borrower for the account of the Swing Line Lender for any payment in connection with Swing Line Loans and such payment relates to an amount previously paid by a Lender pursuant to this Section 2.2, the Administrative Agent will promptly remit such payment to such Lender.

2.3 Notice of Borrowing Revolving Credit Loans and Swing Line Loans

The Borrower agrees to notify the Administrative Agent (and with respect to a Swing Line Loan, the Swing Line Lender), which notification shall be irrevocable, no later than (a) 2:00 P.M., on the proposed Borrowing Date in the case of Swing Line Loans, (b) 12:00 Noon on the proposed Borrowing Date in the case of Revolving Credit Loans to consist of ABR Advances and (c) 12:00 Noon at least three Eurodollar Business Days prior to the proposed Borrowing Date in the case of Revolving Credit Loans to consist of Eurodollar Advances. Each such notice shall specify (i) the aggregate amount requested to be borrowed under the Commitments or the Swing Line Commitment, (ii) the proposed Borrowing Date, (iii) whether a borrowing of Revolving Credit Loans is to be made as an ABR Advance, one or more Eurodollar Advances, or both, and the amount of each thereof, (iv) the Eurodollar Interest Period for each such Eurodollar Advance and (v) the amount of each Swing Line Loan. Each such notice shall be promptly confirmed by delivery to the Administrative Agent (and, with respect to a Swing Line Loan, the Swing Line Lender) of a Borrowing Request. Each Eurodollar Advance to be made on a Borrowing Date, when aggregated with all amounts to be Converted to Eurodollar Advances on such date and having the same Interest Period as such Eurodollar Advance, shall equal no less than $10,000,000, or an integral multiple of $1,000,000 in excess thereof. Each ABR Advance made on each Borrowing Date shall equal no less than $5,000,000 or an integral multiple of $500,000 in excess thereof. Each Swing Line Loan made on each Borrowing Date shall equal no less than $1,000,000 or an integral multiple of $500,000 in excess thereof. The Administrative Agent shall promptly notify each Lender (by telephone or otherwise, such notification to be confirmed by fax, email or other writing) of each such Borrowing Request. Subject to its receipt of each such notice from the Administrative Agent and subject to the terms and conditions hereof, (A) each Lender shall make immediately available funds available to the Administrative Agent at the address therefor set forth in Section 11.2 not later than 1:00 P.M. on each Borrowing Date in an amount equal to such Lender's Commitment Percentage of the Revolving Credit Loans requested by the Borrower on such Borrowing Date and/or (B) the Swing Line Lender shall make immediately available funds available to the Borrower on such Borrowing Date in an amount equal to the Swing Line Loan requested by the Borrower.

2.4 Competitive Bid Loans and Procedure

(a) Subject to the terms and conditions hereof, the Borrower may request competitive bid loans in Dollars under this Agreement (each a ***"Competitive Bid Loan"***) during the Commitment Period. In order to request Competitive Bids, the Borrower shall deliver by hand, fax or email to the Administrative Agent a duly completed and executed Competitive Bid Request not later than 12:00 Noon, one Domestic Business Day before the proposed Borrowing Date therefor. A Competitive Bid Request that does not conform substantially to the format of Exhibit F may be rejected by the Administrative Agent in the Administrative Agent's reasonable discretion, and the Administrative Agent shall promptly notify the Borrower of such rejection by fax or email and by telephone. Each Competitive Bid Request shall specify (x) the proposed Borrowing Date for the Competitive Bid Loans then being requested (which shall be a Domestic Business Day) and the

aggregate principal amount thereof and (y) the Competitive Interest Period or Competitive Interest Periods (which shall not exceed ten different Interest Periods in a single Competitive Bid Request), with respect thereto (which may not end after the Domestic Business Day immediately preceding the Commitment Termination Date). Promptly after its receipt of each Competitive Bid Request that is not rejected as aforesaid, the Administrative Agent shall invite by fax or email (substantially in the form of Exhibit G) the Lenders (other than any Defaulting Lender) to bid, on the terms and conditions of this Agreement, to make Competitive Bid Loans pursuant to such Competitive Bid Request.

(b) Each Lender (other than any Defaulting Lender), in its sole and absolute discretion, may make one or more Competitive Bids to the Borrower responsive to a Competitive Bid Request. Each Competitive Bid by a Lender must be received by the Administrative Agent not later than 10:00 A.M. on the proposed Borrowing Date for the relevant Competitive Bid Loan. Multiple bids will be accepted by the Administrative Agent. Bids to make Competitive Bid Loans that, in the reasonable judgment of the Administrative Agent, do not conform to the Competitive Bids solicited by the related Competitive Bid Request shall be rejected by the Administrative Agent. Competitive Bids that do not conform substantially to the format of Exhibit H may be rejected by the Administrative Agent after conferring with, and upon the instruction of, the Borrower, and the Administrative Agent shall notify the Lender making such nonconforming bid of such rejection as soon as practicable. Each Competitive Bid shall be irrevocable and shall specify (x) the principal amount (which (1) shall be in a minimum principal amount of $10,000,000 or an integral multiple of $1,000,000 in excess thereof, and (2) may equal the entire principal amount requested by the Borrower) of the Competitive Bid Loan or Competitive Bid Loans that the Lender is willing to make to the Borrower, (y) the Competitive Bid Rate or Competitive Bid Rates at which the Lender is prepared to make such Competitive Bid Loan or Competitive Bid Loans, and (z) the Competitive Interest Period with respect to each such Competitive Bid Loan and the last day thereof. If any Lender shall elect not to make a Competitive Bid, such Lender shall so notify the Administrative Agent by fax or email not later than 10:00 A.M. on the proposed Borrowing Date therefor, *provided* that the failure by any Lender to give any such notice shall not obligate such Lender to make any Competitive Bid Loan in connection with the relevant Competitive Bid Request.

(c) With respect to each Competitive Bid Request, the Administrative Agent shall (i) notify the Borrower by fax or email by 11:00 A.M. on the proposed Borrowing Date with respect thereto of each Competitive Bid made, the Competitive Bid Rate applicable thereto and the identity of the Lender that made such Competitive Bid, and (ii) send a list of all Competitive Bids to the Borrower for its records as soon as practicable after completion of the bidding process. Each notice and list sent by the Administrative Agent pursuant to this Section 2.4(c) shall list the Competitive Bids in ascending yield order.

(d) The Borrower may in its sole and absolute discretion, subject only to the provisions of this Section 2.4(d), accept or reject any Competitive Bid made in accordance with the procedures set forth in this Section 2.4, and the Borrower shall notify the Administrative Agent by telephone, confirmed by fax or email in the form of a duly completed and executed Competitive Bid Accept/Reject Letter, whether and to what extent it has decided to accept or reject any or all of such Competitive Bids not later than 12:00 Noon on the proposed Borrowing Date therefor; *provided* that the failure by the Borrower to give such notice shall be deemed to be a rejection of all such Competitive Bids. In connection with each acceptance of one or more Competitive Bids by the Borrower:

(1) the Borrower shall not accept a Competitive Bid of a given tenor made at a particular Competitive Bid Rate if the Borrower has decided to reject a Competitive Bid

having the same tenor made at a lower Competitive Bid Rate unless the acceptance of such Competitive Bid made at a lower Competitive Bid Rate would subject the Borrower to any requirement to withhold any taxes or deduct any amount from any amounts payable under the Loan Documents, in which case the Borrower may reject such Competitive Bid made at a lower Competitive Bid Rate,

(2) the aggregate amount of the Competitive Bids accepted by the Borrower shall not exceed the principal amount specified in the Competitive Bid Request therefor,

(3) if the Borrower shall desire to accept a Competitive Bid made at a particular Competitive Bid Rate, it must accept all other Competitive Bids at such Competitive Bid Rate, except for any such Competitive Bid the acceptance of which would subject the Borrower to any requirement to withhold any taxes or deduct any amount from any amounts payable under the Loan Documents; *provided* that if the acceptance of all such other Competitive Bids would cause the aggregate amount of all such accepted Competitive Bids to exceed the amount requested, then such acceptance shall be made pro rata in accordance with the amount of each such Competitive Bid at such Competitive Bid Rate,

(4) except pursuant to clause (3) above, no Competitive Bid shall be accepted unless the Competitive Bid Loan with respect thereto shall be in a minimum principal amount of $10,000,000 or an integral multiple of $1,000,000 in excess thereof, and

(5) no Competitive Bid shall be accepted and no Competitive Bid Loan shall be made, if immediately after giving effect thereto, the Aggregate Credit Exposure would exceed the Aggregate Commitment Amount.

(e) The Administrative Agent shall promptly fax or email to each bidding Lender (with a copy to the Borrower) a Competitive Bid Accept/Reject Letter advising such Lender whether its Competitive Bid has been accepted (and if accepted, in what amount and at what Competitive Bid Rate), and each successful bidder so notified will thereupon become bound, subject to the applicable conditions hereof, to make the Competitive Bid Loan in respect of which each of its Competitive Bids has been accepted by making immediately available funds available to the Administrative Agent at its address set forth in Section 11.2 not later than 1:00 P.M. on the Borrowing Date for such Competitive Bid Loan in the amount thereof.

(f) Anything herein to the contrary notwithstanding, if the Administrative Agent shall elect to submit a Competitive Bid in its capacity as a Lender, it shall submit such bid directly to the Borrower not later than 9:30 A.M. on the relevant proposed Borrowing Date.

(g) All notices required by this Section 2.4 shall be given in accordance with Section 11.2.

(h) Each Competitive Bid Loan shall be due and payable on the last day of the Interest Period applicable thereto or on such earlier date upon which the Loans shall become due and payable pursuant to the provisions hereof, whether by acceleration or otherwise.

2.5 Use of Proceeds

The Borrower agrees that the proceeds of the Loans and Letters of Credit shall be used solely for its general corporate purposes, but not inconsistent with this Section 2.5 or any other provision of this

Agreement, including, without limitation, the provisions of Section 4.9, and not in contravention of any applicable law, rule or regulation.

2.6 Termination, Reduction or Increase of Commitments

(a) Termination on Commitment Termination Date. Unless previously terminated, the Commitments and the Letter of Credit Commitment shall terminate on the Commitment Termination Date and the Swing Line Commitment shall terminate on the Swing Line Termination Date.

(b) Voluntary Termination or Reductions. At the Borrower's option in its sole and absolute discretion and upon at least one Domestic Business Day's prior irrevocable notice to the Administrative Agent, the Borrower may (i) terminate the Commitments, the Swing Line Commitment and the Letter of Credit Commitment, at any time, or (ii) permanently reduce the Aggregate Commitment Amount, the Swing Line Commitment or the Letter of Credit Commitment, in part at any time and from time to time; *provided* that (1) each such partial reduction shall be in an amount equal to at least $5,000,000 or an integral multiple of $1,000,000 in excess thereof and (2) immediately after giving effect to each such reduction, (A) the Aggregate Commitment Amount shall equal or exceed the Aggregate Credit Exposure, (B) the Swing Line Commitment shall equal or exceed the aggregate outstanding principal balance of all Swing Line Loans and (C) the Letter of Credit Commitment shall equal or exceed the Letter of Credit Exposure of all Lenders; *provided*, *further* that, notwithstanding the foregoing, a notice of termination of the Commitments, the Swing Line Commitment and the Letter of Credit Commitment delivered by the Borrower may state that such notice is conditioned upon the effectiveness of other credit facilities or transactions (such notice to specify the proposed effective date), in which case such notice may be revoked by the Borrower (by notice to the Administrative Agent on or prior to such specified effective date) if such condition is not satisfied and the Borrower shall indemnify the Lenders in accordance with Section 3.5, if applicable.

(c) In General. Each reduction of the Aggregate Commitment Amount shall be made by reducing each Lender's Commitment Amount by an amount equal to the product of such Lender's Commitment Percentage and the amount of such reduction.

(d) Increase in Aggregate Commitment Amount. The Borrower may at any time and from time to time prior to the 90th day prior to the then-applicable Commitment Termination Date, at its sole cost and expense, request any one or more of the Lenders having a Commitment to increase its Commitment Amount (the decision to increase the Commitment Amount of a Lender to be within the sole and absolute discretion of such Lender), or any Eligible Assignee to provide a new Commitment, by submitting to the Administrative Agent a Commitment Increase Supplement, duly executed and delivered by the Borrower and each such Lender or Eligible Assignee, as the case may be. Upon receipt of any such Commitment Increase Supplement, the Administrative Agent, the Swing Line Lender and each Issuer shall promptly execute and deliver such Commitment Increase Supplement and the Administrative Agent shall deliver a copy thereof to the Borrower and each such Lender or Eligible Assignee, as the case may be. Upon execution and delivery of such Commitment Increase Supplement by the Administrative Agent, the Swing Line Lender and each Issuer, (i) in the case of each such Lender (an **"*Increasing Lender*"**), its Commitment Amount shall be increased to the amount set forth in such Commitment Increase Supplement, and (ii) in the case of each such Eligible Assignee (a **"*New Lender*"**), such New Lender shall become a party hereto and have the rights and obligations of a Lender under the Loan Documents and its Commitment shall be as set forth in such Commitment Increase Supplement; *provided* that:

(1) immediately after giving effect thereto, the sum of all increases in the Aggregate Commitment Amount made pursuant to this Section 2.6(d) shall not exceed $500,000,000;

(2) each such increase of the Aggregate Commitment Amount shall be in an amount not less than $25,000,000 or such amount plus an integral multiple of $5,000,000; *provided* that an increase may be in a lesser amount if such increase is an increase of the entire remaining amount available under clause (1) above;

(3) no Default shall have occurred or be continuing on the effective date of the increase;

(4) the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on the effective date of such increase (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such effective date), except those which are expressly specified to be made as of an earlier date;

(5) in the case of each New Lender, the Commitment Amount assumed by such New Lender shall not be less than $25,000,000;

(6) if Revolving Credit Loans would be outstanding immediately after giving effect to any such increase, then simultaneously with such increase (A) each such Increasing Lender, each such New Lender and each other Lender shall be deemed to have entered into a master assignment and assumption, in form and substance substantially similar to Exhibit E, pursuant to which each such other Lender shall have assigned to each such Increasing Lender and each such New Lender a portion of its Revolving Credit Loans necessary to reflect proportionately the Commitments as increased in accordance with this Section 2.6(d), and (B) in connection with such assignment, each such Increasing Lender and each such New Lender shall pay to the Administrative Agent, for the account of each such other Lender, such amount as shall be necessary to reflect the assignment to it of such Revolving Credit Loans, and in connection with such master assignment each such other Lender may treat the assignment of Eurodollar Advances as a prepayment of such Eurodollar Advances for purposes of Section 3.5;

(7) each such New Lender shall have delivered to the Administrative Agent an Administrative Questionnaire and to the Administrative Agent and the Borrower all forms, if any, that are required to be delivered by such New Lender pursuant to Section 3.10;

(8) at least five Domestic Business Days prior to the effectiveness of such increase, if the Borrower qualifies as a "legal entity customer" under the Beneficial Ownership Regulation, it shall have delivered, to each Lender that so requests, a Beneficial Ownership Certification; and

(9) the Administrative Agent shall have received such other customary certificates, resolutions and opinions as the Administrative Agent shall have reasonably requested.

2.7 Prepayments of Loans

(a) Voluntary Prepayments. The Borrower may prepay Revolving Credit Loans, Competitive Bid Loans and Swing Line Loans, in whole or in part, without premium or penalty, but subject to Section 3.5, at any time and from time to time, by notifying the Administrative Agent (which notice shall be in a form reasonably acceptable to the Administrative Agent) at least two Eurodollar Business Days, in the case of a prepayment of Eurodollar Advances, two Domestic Business Days, in the case of a prepayment of Competitive Bid Loans, or one Domestic Business Day, in the case of a prepayment of Swing Line Loans or ABR Advances, prior to the proposed prepayment date specifying (i) the Loans to be prepaid, (ii) the amount to be prepaid, and (iii) the date of prepayment. Upon receipt of each such notice, the Administrative Agent shall promptly notify each Lender thereof. Each such notice given by the Borrower pursuant to this Section 2.7 shall be irrevocable, *provided* that, if a notice of prepayment is given in connection with a conditional notice of termination of the Commitments, the Swing Line Commitment and the Letter of Credit Commitment as contemplated by Section 2.6, then such notice of prepayment may be revoked if such notice of termination is revoked in accordance with Section 2.6, and the Borrower shall indemnify the Lenders in accordance with Section 3.5. Each partial prepayment under this Section 2.7 shall be (A) in the case of Eurodollar Advances, in a minimum amount of $5,000,000 or an integral multiple of $1,000,000 in excess thereof or the entire remaining amount of Eurodollar Advances, (B) in the case of ABR Advances, in a minimum amount of $1,000,000 or an integral multiple of $100,000 in excess thereof or the entire remaining amount of ABR Advances, (C) in the case of Swing Line Loans, in a minimum amount of $500,000 or an integral multiple of $100,000 in excess thereof or the entire remaining amount of Swing Line Loans, and (D) in the case of Competitive Bid Loans, in a minimum amount of $5,000,000 or an integral multiple of $1,000,000 in excess thereof or the entire remaining amount of Competitive Bid Loans.

(b) In General. Simultaneously with each prepayment hereunder, the Borrower shall prepay all accrued and unpaid interest on the amount prepaid through the date of prepayment and indemnify the Lenders in accordance with Section 3.5, if applicable.

2.8 Letter of Credit Sub-facility-

(a) Subject to the terms and conditions hereof and the payment by the Borrower to each Issuer of such fees as the Borrower and such Issuer shall have agreed in writing, each Issuer severally (and not jointly) agrees, in reliance on the agreement of the other Lenders set forth in Section 2.9, to issue standby or commercial letters of credit (each a ***"Letter of Credit"*** and, collectively, the ***"Letters of Credit"***) during the Commitment Period for the account of the Borrower; *provided* that immediately after the issuance of each Letter of Credit (i) the Letter of Credit Exposure of all Lenders shall not exceed the Aggregate Letter of Credit Commitment, (ii) the Aggregate Credit Exposure shall not exceed the Aggregate Commitment Amount, (iii) the Letter of Credit Exposure of such Issuer shall not exceed the Letter of Credit Commitment of such Issuer, and (iv) the Commercial Letter of Credit Exposure of such Issuer shall not exceed the Commercial Letter of Credit Commitment of such Issuer. Each Letter of Credit shall have an expiration date which shall be not later than, in the case of standby Letters of Credit, the earlier to occur of one year from the date of issuance thereof or 5 days prior to the Commitment Termination Date and, in the case of commercial Letters of Credit, the earlier to occur of 180 days from the date of issuance thereof or 5 days prior to the Commitment Termination Date. No Letter of Credit shall be issued if the Administrative Agent, or any Lender by notice to the Administrative Agent, and the proposed Issuer shall have determined, no later than 3:00 P.M. one Domestic Business Day prior to the requested date of issuance of such Letter of Credit, that the conditions set forth in Section 6 have not been satisfied or waived.

(b) Each Letter of Credit shall be issued at the request of the Borrower in support of an obligation of the Borrower or any Subsidiary in favor of a beneficiary who has requested the issuance of such Letter of Credit. The Borrower shall give the Administrative Agent a Letter of Credit Request for the issuance of each Letter of Credit by 12:00 Noon at least two Domestic Business Days prior to the requested date of issuance. Such Letter of Credit Request shall specify (i) whether such Letter of Credit is a standby or commercial Letter of Credit, (ii) the beneficiary of such Letter of Credit and the obligations of the Borrower or the Subsidiary in respect of which such Letter of Credit is to be issued, (iii) the Borrower's proposal as to the conditions under which a drawing may be made under such Letter of Credit and the documentation to be required in respect thereof, (iv) the maximum amount to be available under such Letter of Credit, (v) the requested date of issuance, and (vi) the name of the proposed Issuer thereof. Upon receipt of such Letter of Credit Request from the Borrower, the Administrative Agent shall promptly notify the applicable Issuer and each Lender thereof. Such Issuer shall, on the proposed date of issuance and subject to the terms and conditions of this Agreement, issue the requested Letter of Credit; *provided* that in the event such Issuer fails to issue such Letter of Credit or is a Defaulting Lender, any other Issuer may (in its sole and absolute discretion, and notwithstanding that its Letter of Credit Exposure may exceed its Letter of Credit Commitment, but with (x) the consent of the Borrower and (y) notice to the Administrative Agent) issue such Letter of Credit otherwise in accordance with the terms hereof; *provided further* that immediately after the issuance thereof (A) the Letter of Credit Exposure of all Lenders shall not exceed the Aggregate Letter of Credit Commitment, and (B) the Aggregate Credit Exposure shall not exceed the Aggregate Commitment Amount. Each Letter of Credit shall be in form and substance reasonably satisfactory to the Issuer thereof, with such provisions with respect to the conditions under which a drawing may be made thereunder and the documentation required in respect of such drawing as such Issuer shall reasonably require. Each Letter of Credit shall be used solely for the purposes described therein. Each Letter of Credit Request and each Letter of Credit shall be subject to the standard terms and conditions for letters of credit of the Issuer thereof (each as amended, supplemented or replaced from time to time, a ***"Reimbursement Agreement"***) executed by the Borrower and delivered to such Issuer.

(c) Each payment by an Issuer of a drawing under a Letter of Credit issued thereby shall give rise to the obligation of the Borrower to promptly (and in any event within one Domestic Business Day) reimburse such Issuer for the amount thereof (together with any interest). Such Issuer shall promptly notify the Borrower of such payment by such Issuer of a drawing under a Letter of Credit. In lieu of such notice, if the Borrower has not made reimbursement prior to the end of the Domestic Business Day following the day during which such Issuer made such payment of such drawing, the Borrower hereby authorizes such Issuer to deduct the amount of any such reimbursement from such account(s) as the Borrower may from time to time designate in writing to such Issuer, upon which such Issuer shall apply the amount of such deduction to such reimbursement. If all or any portion of any Reimbursement Obligation in respect of a Letter of Credit shall not be paid on the date that the Issuer thereof shall have made payment of a drawing under such Letter of Credit, the amount of such Reimbursement Obligation shall bear interest, at a rate per annum equal to the Alternate Base Rate *plus* the Applicable Margin applicable to ABR Advances, from the date such Issuer made such payment of such drawing until the end of the Domestic Business Day following the day during which such Issuer made such payment of such drawing (whether at the stated maturity thereof, by acceleration or otherwise), and from and after such Domestic Business Day (whether at the stated maturity thereof, by acceleration or otherwise), such Reimbursement Obligation shall bear interest, payable upon demand, at a rate per annum equal to the Alternate Base Rate *plus* the Applicable Margin applicable to ABR Advances *plus* 2%, from such due date until paid in full (whether before or after the entry of a judgment thereon).

(d) In the event of any conflict between the terms hereof and the terms of any Reimbursement Agreement or Letter of Credit Application, the terms hereof shall control.

2.9 Letter of Credit Participation

(a) Each Lender hereby unconditionally and irrevocably, severally (and not jointly) takes an undivided participating interest in the obligations of each Issuer under and in connection with each Letter of Credit issued thereby in an amount equal to such Lender's Commitment Percentage (as in effect from time to time) of the amount of such Letter of Credit. Each Lender shall be liable to each Issuer for its Commitment Percentage of the unreimbursed amount of any drawing honored under each Letter of Credit issued thereby. Each Lender shall also be liable for an amount equal to the product of its Commitment Percentage and any amounts paid by the Borrower pursuant to Section 2.8 that are subsequently rescinded or avoided, or must otherwise be restored or returned. Such liabilities shall be unconditional and without regard to the occurrence of any Default or the compliance by the Borrower with any of its obligations under the Loan Documents.

(b) Each Issuer shall promptly notify the Administrative Agent, and the Administrative Agent shall promptly notify each Lender (which notice shall be promptly confirmed in writing), of the date and the amount of each drawing paid under each Letter of Credit issued by such Issuer with respect to which full reimbursement payment shall not have been made by the Borrower as provided in Section 2.8(c), and forthwith upon receipt of such notice, such Lender shall promptly make available to the Administrative Agent for the account of such Issuer its Commitment Percentage of the amount of such unreimbursed drawing at the office of the Administrative Agent specified in Section 11.2 in Dollars and in immediately available funds. The Administrative Agent shall distribute the payments made by each Lender pursuant to the immediately preceding sentence to such Issuer promptly upon receipt thereof in like funds as received. Each Lender shall indemnify and hold harmless the Administrative Agent and each Issuer from and against any and all losses, liabilities (including liabilities for penalties), actions, suits, judgments, demands, costs and expenses (including, without limitation, reasonable attorneys' fees and expenses) resulting from any failure on the part of such Lender to provide, or from any delay in providing, the Administrative Agent with such Lender's Commitment Percentage of the amount of any payment made by such Issuer under a Letter of Credit issued by such Issuer in accordance with this clause (b) (except in respect of losses, liabilities or other obligations suffered by the Administrative Agent or such Issuer, as the case may be, resulting from the gross negligence or willful misconduct of the Administrative Agent or such Issuer, as the case may be). If a Lender does not make available to the Administrative Agent when due an amount equal to such Lender's Commitment Percentage of any unreimbursed payment made by an Issuer under a Letter of Credit issued thereby, such Lender shall be required to pay interest to the Administrative Agent for the account of such Issuer on the unpaid portion of such amount at a rate of interest per annum equal to (i) from the date such Lender should have made such amount available until the third day therefrom, the Federal Funds Effective Rate, and (ii) thereafter, the Federal Funds Effective Rate *plus* 2%, in each case payable upon demand by such Issuer. The Administrative Agent shall distribute such interest payments to such Issuer upon receipt thereof in like funds as received.

(c) Whenever the Administrative Agent is reimbursed by the Borrower, for the account of an Issuer, for any payment under a Letter of Credit issued thereby and such payment relates to an amount previously paid by a Lender in respect of its Commitment Percentage of the amount of such payment under such Letter of Credit, the Administrative Agent (or such Issuer, if such payment by a Lender was paid by the Administrative Agent to such Issuer) will promptly pay over such payment to such Lender.

2.10 Absolute Obligation with respect to Letter of Credit Payments

The Borrower's obligation to reimburse the Administrative Agent for the account of an Issuer for each payment under or in respect of each Letter of Credit issued thereby shall be absolute and unconditional under any and all circumstances and irrespective of any set-off, counterclaim or defense to payment which the Borrower may have or have had against the beneficiary of such Letter of Credit, the Administrative Agent, such Issuer, the Swing Line Lender, any Lender or any other Person, including, without limitation, any defense based on the failure of any drawing to conform to the terms of such Letter of Credit, any drawing document proving to be forged, fraudulent or invalid, or the legality, validity, regularity or enforceability of such Letter of Credit; *provided* that, with respect to any Letter of Credit, the foregoing shall not relieve the Issuer thereof of any liability it may have to the Borrower for any actual damages sustained by the Borrower arising from a wrongful payment (or failure to pay) under such Letter of Credit made as a result of such Issuer's gross negligence or willful misconduct.

2.11 Notes

Any Lender may request that the Loans made by it be evidenced by a Note. In such event, the Borrower shall prepare, execute and deliver to such Lender a Note payable to such Person or, if requested by such Person, such Person and its registered assigns.

2.12 Extension of Commitment Termination Date

(a) Request for Extension. The Borrower may, in its sole and absolute discretion, by notice to the Administrative Agent (which shall promptly notify the Lenders) not more than 90 days and not less than 30 days prior to each of the first, second, third, fourth and fifth anniversary of the Effective Date (each such anniversary date, an "***Extension Date***"), request (each, an "***Extension Request***") that the Lenders extend the Commitment Termination Date then in effect (the "***Existing Commitment Termination Date***") for an additional one-year period, *provided* that the Borrower may only effect one such extension of the Commitment Termination Date. Each Lender, acting in its sole discretion, shall, by notice to the Borrower and the Administrative Agent given not later than the 20th day (or such later day as shall be acceptable to the Borrower) following the date of the Borrower's notice, advise the Borrower and the Administrative Agent whether or not such Lender agrees to such extension; *provided* that any Lender (which includes each Issuer and the Swing Line Lender) that does not so advise the Borrower and the Administrative Agent shall be deemed to have rejected such Extension Request. The election of any Lender to agree to such extension shall not obligate any other Lender to so agree.

(b) Replacement of Non-Extending Lenders. The Borrower shall have the right at any time on or prior to the relevant Extension Date to replace any Lender which has not consented to the Extension Request (each, a ***"Non-Extending Lender"***) pursuant to Section 3.13.

(c) Conditions to Effectiveness of Extension. Notwithstanding anything in this Agreement to the contrary, the extension of the Existing Commitment Termination Date on any Extension Date shall not be effective unless, immediately before and after giving effect to such extension on such Extension Date: (i) no Default shall have occurred and be continuing on such Extension Date and the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on such Extension Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such Extension Date), except those which are expressly specified to be made as of an earlier date, and the Administrative Agent

shall have received a certificate, in form and substance reasonably satisfactory to the Administrative Agent, to such effect from the chief financial officer of the Borrower (or such other financial officer reasonably acceptable to the Administrative Agent), and (ii) the Administrative Agent shall have received such other customary certificates, resolutions and opinions as the Administrative Agent may reasonably request.

(d) Effectiveness of Extension. If (and only if) the conditions specified in Section 2.12(c) shall have been satisfied or waived with respect to the extension of the Existing Commitment Termination Date on the applicable Extension Date, then, effective as of such Extension Date, the Commitment Termination Date, with respect to the Commitment of each Lender that has agreed to so extend its Commitment and of each Replacement Lender that has assumed a Commitment of a Non-Extending Lender in connection with such Extension Request, shall be extended to the date falling one year after the Existing Commitment Termination Date (or, if such date is not a Domestic Business Day, the immediately preceding Domestic Business Day), and each such Replacement Lender shall thereupon become a "Lender" for all purposes of this Agreement. Notwithstanding anything herein to the contrary, (i) with respect to any portion of the Commitment of any Non-Extending Lender that has not been fully assumed by one or more Replacement Lenders, the Commitment Termination Date for such Lender with respect to such non-assumed portion of its Commitment shall remain unchanged, and (ii) with respect to any Loans of such Lender that have not been purchased by one or more Replacement Lenders, the applicable maturity date with respect to such non-purchased Loans shall remain unchanged and shall be repayable by the Borrower on such applicable maturity date without there being any requirement that any such repayment be shared with other Lenders. In addition, on the Extension Date, the Borrower agrees to pay all accrued and unpaid interest, fees and other amounts then due under this Agreement from the Borrower to each Lender consenting to the Extension Request, each Non-Extending Lender and each Replacement Lender. Solely for the purpose of calculating break funding payments under Section 3.5, the assignment by any Non-Extending Lender of any Eurodollar Advance prior to the last day of the Interest Period applicable thereto in accordance with this Section 2.12 shall be deemed to constitute a prepayment by the Borrower of such Eurodollar Advance.

2.13 Defaulting Lenders

Notwithstanding any provision of this Agreement to the contrary, if any Lender becomes a Defaulting Lender, then the following provisions shall apply for so long as such Lender is a Defaulting Lender:

(a) Facility Fees shall cease to accrue, and shall not be payable, on the unfunded portion of the Commitment of such Defaulting Lender pursuant to Section 3.11;

(b) the Commitment and Credit Exposure of such Defaulting Lender shall not be included in determining whether all Lenders or the Required Lenders have taken or may take any action hereunder (including any consent to any amendment or waiver pursuant to Section 11.1); *provided* that any waiver, amendment or modification with respect to the following shall require the consent of such Defaulting Lender: (i) any waiver, amendment or modification requiring the consent of all Lenders or each affected Lender which affects such Defaulting Lender in a manner that is materially adverse in comparison to the other affected Lenders, (ii) any waiver, amendment or modification increasing the Commitment of such Defaulting Lender, (iii) any waiver, amendment or modification extending the Commitment Period with respect to such Defaulting Lender, (iv) any waiver, amendment or modification reducing the principal amount owed under the Loan Documents to such Defaulting Lender (other than by payment thereof), or (v) any waiver,

amendment or modification extending the final maturity of sums owed to such Defaulting Lender, or (vi) a modification of this Section 2.13(b);

(c) if any Swing Line Exposure or Letter of Credit Exposure exists at the time a Lender becomes a Defaulting Lender then:

(1) all or any part of such Defaulting Lender's Swing Line Exposure and Letter of Credit Exposure shall be reallocated among the non-Defaulting Lenders in accordance with their respective Commitment Percentages but only to the extent that (A) the sum of all non-Defaulting Lenders' Committed Credit Exposures plus, without duplication, the amount of such Defaulting Lender's Swing Line Exposure and Letter of Credit Exposure reallocated to such non-Defaulting Lenders, does not exceed the total of all non-Defaulting Lenders' Commitments and (B) with respect to each non-Defaulting Lender, the sum of such non-Defaulting Lender's Committed Credit Exposure plus, without duplication, the amount of such Defaulting Lender's Swing Line Exposure and Letter of Credit Exposure reallocated to such non-Defaulting Lender, does not exceed such non-Defaulting Lender's Commitment;

(2) if the reallocation described in clause (1) above cannot, or can only partially, be effected, the Borrower shall within one Domestic Business Day following notice by the Administrative Agent (A) first, prepay such Swing Line Exposure and (B) second, cash collateralize such Defaulting Lender's Letter of Credit Exposure (after giving effect to any partial reallocation pursuant to clause (1) above) in a manner reasonably satisfactory to the Administrative Agent and the Issuers for so long as such Letter of Credit Exposure is outstanding;

(3) if the Borrower cash collateralizes any portion of such Defaulting Lender's Letter of Credit Exposure pursuant to this Section 2.13(c), the Borrower shall not be required to pay any Letter of Credit Participation Fees to such Defaulting Lender pursuant to Section 3.12 with respect to such Defaulting Lender's Letter of Credit Exposure during the period such Defaulting Lender's Letter of Credit Exposure is cash collateralized; and

(4) if the Swing Line Exposure or Letter of Credit Exposure of such Defaulting Lender is reallocated pursuant to this Section 2.13(c), then the fees payable to the Lenders pursuant to Section 3.11 and Section 3.12 shall be adjusted to give effect to such reallocation, and the Administrative Agent shall promptly notify the Lenders of any reallocation described in this Section 2.13(c);

(d) so long as any Lender is a Defaulting Lender, the Swing Line Lender shall not be required to fund any Swing Line Loan and no Issuer shall be required to issue, amend, extend or increase any Letter of Credit, unless it is satisfied that the related exposure will be 100% covered by the Commitments of the non-Defaulting Lenders and/or cash collateral will be provided by the Borrower in accordance with Section 2.13(c), and participating interests in any such newly issued or increased Letter of Credit or newly made Swing Line Loan shall be allocated among non-Defaulting Lenders in a manner consistent with Section 2.13(c)(1) (and Defaulting Lenders shall not participate therein);

(e) any amount payable to such Defaulting Lender hereunder (whether on account of principal, interest, fees or otherwise and including any amount that would otherwise be payable to such Defaulting Lender pursuant to Section 11.9 but excluding Section 3.13 and other than any amount constituting Facilities Fees or Letter of Credit Participation Fees which are not payable to

such Defaulting Lender in accordance with Sections 2.13(a) and 2.13(c)(3)) shall, in lieu of being distributed to such Defaulting Lender, be retained by the Administrative Agent in a segregated account and, subject to any applicable requirements of law, be applied at such time or times as may be determined by the Administrative Agent (i) first, to the payment of any amounts owing by such Defaulting Lender to the Administrative Agent hereunder, (ii) second, pro rata, to the payment of any amounts owing by such Defaulting Lender to the Issuers and the Swing Line Lender hereunder, (iii) third, if so determined by the Administrative Agent or requested by any Issuer or the Swing Line Lender, held in such account as cash collateral for future funding obligations of the Defaulting Lender in respect of any existing or future participating interest in any Swing Line Loan or Letter of Credit, (iv) fourth, to the funding of any Revolving Credit Loan (including any Mandatory Borrowing) in respect of which such Defaulting Lender has failed to fund its portion thereof as required by this Agreement, as determined by the Administrative Agent, (v) fifth, if so determined by the Administrative Agent and the Borrower, held in such account as cash collateral for future funding obligations of the Defaulting Lender in respect of any Revolving Credit Loans (including any Mandatory Borrowings) under this Agreement, (vi) sixth, to the payment of any amounts owing to the Lenders, the Issuers or the Swing Line Lender as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by any Lender, any Issuer or the Swing Line Lender against such Defaulting Lender as a result of such Defaulting Lender's breach of its obligations under this Agreement, (vii) seventh, to the payment of any amounts owing to the Borrower as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by the Borrower against such Defaulting Lender as a result of such Defaulting Lender's breach of its obligations under this Agreement, and (viii) eighth, to such Defaulting Lender or as otherwise directed by a court of competent jurisdiction; *provided* that if such payment is (x) a prepayment of the principal amount of any Revolving Credit Loan (including any Mandatory Borrowing) or Reimbursement Obligations in respect of drawings under Letters of Credit paid by an Issuer with respect to which a Defaulting Lender has funded its participation obligations and (y) made at a time when the conditions set forth in Section 6 are satisfied or waived, such payment shall be applied solely to prepay the Revolving Credit Loans (including Mandatory Borrowings) of, and Reimbursement Obligations owed to, all non-Defaulting Lenders pro rata prior to being applied to the prepayment of any Loans, or Reimbursement Obligations owed to, any Defaulting Lender;

(f) the Borrower shall have the right at any time during which a Lender is a Defaulting Lender to replace such Defaulting Lender pursuant to Section 3.13; and

(g) subject to Section 11.22, no reallocation pursuant to Section 2.13(c) shall constitute a waiver or release of any claim of any party hereunder against a Defaulting Lender arising from a Lender having become a Defaulting Lender, including any claim of a non-Defaulting Lender as a result of such non-Defaulting Lender's increased exposure following such reallocation.

3. PROCEEDS, PAYMENTS, CONVERSIONS, INTEREST, YIELD PROTECTION AND FEES

3.1 Disbursement of the Proceeds of the Loans

The Administrative Agent shall disburse the proceeds of the Loans (other than the Swing Line Loans) at its office specified in Section 11.2 by crediting to the Borrower's general deposit account with the Administrative Agent the funds received from each Lender. Unless the Administrative Agent shall have received prior notice from a Lender (by telephone or otherwise, such notice to be confirmed by fax, email or other writing) that such Lender will not make available to the Administrative Agent such Lender's Commitment Percentage of the Revolving Credit Loans, or the amount of any Competitive Bid Loan, to be

made by it on a Borrowing Date, the Administrative Agent may assume that such Lender has made such amount available to the Administrative Agent on such Borrowing Date in accordance with this Section 3.1, *provided* that, in the case of a Revolving Credit Loan, such Lender received notice thereof from the Administrative Agent in accordance with the terms hereof, and the Administrative Agent may, in reliance upon such assumption, make available to the Borrower on such Borrowing Date a corresponding amount. If and to the extent that such Lender shall not have so made such amount available to the Administrative Agent, such Lender and the Borrower severally agree to pay to the Administrative Agent, forthwith on demand, such corresponding amount (to the extent not previously paid by the other), together with interest thereon for each day from the date such amount is made available to the Borrower until the date such amount is paid to the Administrative Agent, at a rate per annum equal to, in the case of the Borrower, the applicable interest rate set forth in Section 3.4(a) and, in the case of such Lender, the Federal Funds Effective Rate from the date such payment is due until the third day after such date and, thereafter, at the Federal Funds Effective Rate *plus* 2%. Any such payment by the Borrower shall be without prejudice to its rights against such Lender. If such Lender shall pay to the Administrative Agent such corresponding amount, such amount so paid shall constitute such Lender's Loan as part of such Loans for purposes of this Agreement, which Loan shall be deemed to have been made by such Lender on the Borrowing Date applicable to such Loans.

3.2 Payments

(a) Each payment, including each prepayment, of principal and interest on the Loans and of the Facility Fee and the Letter of Credit Participation Fee (collectively, together with all of the other fees to be paid to the Administrative Agent, the Lenders, the Issuers and the Swing Line Lender in connection with the Loan Documents, the ***"Fees"***), and of all of the other amounts to be paid to the Administrative Agent and the Lenders in connection with the Loan Documents (other than amounts payable to a Lender under Section 3.5, Section 3.6, Section 3.10, Section 11.5 and Section 11.10) shall be made by the Borrower to the Administrative Agent at its office specified in Section 11.2 without condition, recoupment, defense, setoff, deduction or counterclaim in funds immediately available in New York by 3:00 P.M. on the due date for such payment. The failure of the Borrower to make any such payment by such time shall not constitute a default hereunder, *provided* that such payment is made on such due date, but any such payment made after 3:00 P.M. on such due date shall be deemed to have been made on the next Domestic Business Day or Eurodollar Business Day, as the case may be, for the purpose of calculating interest on amounts outstanding on the Loans. If the Borrower has not made any such payment prior to 3:00 P.M., the Borrower hereby authorizes the Administrative Agent to deduct the amount of any such payment from such account(s) as the Borrower may from time to time designate in writing to the Administrative Agent, upon which the Administrative Agent shall apply the amount of such deduction to such payment. Promptly upon receipt thereof by the Administrative Agent, each payment of principal and interest on the: (i) Revolving Credit Loans shall be remitted by the Administrative Agent in like funds as received to each Lender (a) first, pro rata according to the amount of interest which is then due and payable to the Lenders, and (b) second, pro rata according to the amount of principal which is then due and payable to the Lenders, (ii) Competitive Bid Loans shall be remitted by the Administrative Agent in like funds as received to each applicable Lender and (iii) Swing Line Loans shall be remitted by the Administrative Agent in like funds as received to the Swing Line Lender. Each payment of the Facility Fee and the Letter of Credit Participation Fee payable to the Lenders shall be promptly transmitted by the Administrative Agent in like funds as received to each Lender pro rata according to such Lender's Commitment Amount or, if the Commitments shall have terminated or been terminated, according to the outstanding principal amount of such Lender's Revolving Credit Loans.

(b) If any payment hereunder or under the Loans shall be due and payable on a day which is not a Domestic Business Day or a Eurodollar Business Day, as the case may be, the due date thereof (except as otherwise provided in the definition of Eurodollar Interest Period or Competitive Interest Period) shall be extended to the next Domestic Business Day or Eurodollar Business Day, as the case may be, and (except with respect to payments in respect of the Facility Fee and the Letter of Credit Participation Fee) interest shall be payable at the applicable rate specified herein during such extension.

3.3 Conversions; Other Matters

(a) The Borrower may elect at any time and from time to time to Convert one or more Eurodollar Advances to an ABR Advance by giving the Administrative Agent at least one Domestic Business Day's prior irrevocable notice of such election (in the form of a Borrowing Request), specifying the amount to be so Converted. In addition, the Borrower may elect at any time and from time to time to Convert an ABR Advance to any one or more new Eurodollar Advances or to Convert any one or more existing Eurodollar Advances to any one or more new Eurodollar Advances by giving the Administrative Agent no later than 10:00 A.M. at least two Eurodollar Business Days' prior irrevocable notice of such election (in the form of a Borrowing Request), specifying the amount to be so Converted and the initial Interest Period relating thereto; *provided* that any Conversion of an ABR Advance to an Eurodollar Advance shall only be made on a Eurodollar Business Day; *provided*, *further* that, notwithstanding the foregoing, a Borrowing Request for a Conversion delivered by the Borrower may state that such Borrowing Request is conditioned upon the effectiveness of other credit facilities or transactions (such Borrowing Request to specify the proposed effective date), in which case such Borrowing Request may be revoked by the Borrower (by notice to the Administrative Agent prior to the day specified for such Conversion in such Borrowing Request) if such condition is not satisfied and the Borrower shall indemnify the Lenders in accordance with Section 3.5, if applicable. The Administrative Agent shall promptly provide the Lenders with notice of each such election. Each Conversion of Loans shall be made pro rata according to the outstanding principal amount of the Loans of each Lender. ABR Advances and Eurodollar Advances may be Converted pursuant to this Section 3.3 in whole or in part; *provided* that the amount to be Converted to each Eurodollar Advance, when aggregated with any Eurodollar Advance to be made on such date in accordance with Section 2.1 and having the same Interest Period as such first Eurodollar Advance, shall equal no less than $10,000,000 or an integral multiple of $1,000,000 in excess thereof or the entire remaining amount of the Eurodollar Advances.

(b) Notwithstanding anything in this Agreement to the contrary, the Borrower shall not have the right to elect to Convert any existing ABR Advance to a Eurodollar Advance or to Convert any existing Eurodollar Advance to a new Eurodollar Advance if (i) a Default or an Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) shall then exist, or (ii) any other Event of Default shall then exist and the Administrative Agent shall have notified the Borrower at the request of the Required Lenders that no ABR Advance or Eurodollar Advance may be Converted to a new Eurodollar Advance. In such event, such ABR Advance shall be automatically continued as an ABR Advance or such Eurodollar Advance shall be automatically Converted to an ABR Advance on the last day of the Interest Period applicable to such Eurodollar Advance. The foregoing shall not affect any other rights or remedies that the Administrative Agent or any Lender may have under this Agreement or any other Loan Document.

(c) Each Conversion shall be effected by each Lender by applying the proceeds of each new ABR Advance or Eurodollar Advance, as the case may be, to the existing ABR Advance

or Eurodollar Advance (or portion thereof) being Converted (it being understood that such Conversion shall not constitute a borrowing for purposes of Section 4 or Section 6).

(d) Notwithstanding any other provision of any Loan Document:

(1) if the Borrower shall have failed to elect a Eurodollar Advance under Section 2.3 or this Section 3.3, as the case may be, in connection with any borrowing of new Revolving Credit Loans or expiration of an Interest Period with respect to any existing Eurodollar Advance, the amount of the Revolving Credit Loans subject to such borrowing or such existing Eurodollar Advance shall thereafter be an ABR Advance until such time, if any, as the Borrower shall elect a new Eurodollar Advance pursuant to this Section 3.3,

(2) the Borrower shall not be permitted to select a Eurodollar Advance the Interest Period in respect of which ends later than the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6, and

(3) the Borrower shall not be permitted to have more than (x) 15 Eurodollar Advances and (y) 15 Competitive Bid Loans outstanding at any one time; it being understood and agreed that each borrowing of Eurodollar Advances or Competitive Bid Loans pursuant to a single Borrowing Request or Competitive Bid Request, as the case may be, shall constitute the making of one Eurodollar Advance or Competitive Bid Loan for the purpose of calculating such limitation.

3.4 Interest Rates and Payment Dates

(a) *Prior to Maturity*. Except as otherwise provided in Section 3.4(b) and Section 3.4(c), the Loans shall bear interest on the unpaid principal balance thereof at the applicable interest rate or rates per annum set forth below:

LOANS	RATE
Revolving Credit Loans constituting ABR Advances	Alternate Base Rate *plus* the Applicable Margin.
Revolving Credit Loans constituting Eurodollar Advances	Eurodollar Rate applicable thereto *plus* the Applicable Margin.
Competitive Bid Loans	Fixed rate of interest applicable thereto accepted by the Borrower pursuant to Section 2.4(d).
Swing Line Loans	Negotiated Rate applicable thereto as provided in Section 2.2(a) (or if not available, the LIBOR Daily Floating Rate *plus* the Applicable Margin).

(b) Late Payment Rate. Any payment of principal or interest on the Loans, Fees or other amounts payable by the Borrower under the Loan Documents not paid on the date when due and payable shall, after the occurrence and during the continuance of an Event of Default pursuant to Section 9.1(a), 9.1(b), 9.1(h), 9.1(i) or 9.1(j), bear interest, in the case of principal or interest on a Loan, at the applicable interest rate on such Loan *plus* 2% per annum and, in the case of any Fees

or other amounts, at the Alternate Base Rate *plus* the Applicable Margin *plus* 2% per annum, in each case from the due date thereof until the date such payment is made (whether before or after the entry of any judgment thereon).

(c) Highest Lawful Rate. Notwithstanding anything to the contrary contained in this Agreement, at no time shall the interest rate payable to any Lender on any of its Loans, together with the Fees and all other amounts payable hereunder to such Lender to the extent the same constitute or are deemed to constitute interest, exceed the Highest Lawful Rate. If in respect of any period during the term of this Agreement, any amount paid to any Lender hereunder, to the extent the same shall (but for the provisions of this Section 3.4) constitute or be deemed to constitute interest, would exceed the maximum amount of interest permitted by the Highest Lawful Rate during such period (such amount being hereinafter referred to as an ***"Unqualified Amount"***), then (i) such Unqualified Amount shall be applied or shall be deemed to have been applied as a prepayment of the Loans of such Lender, and (ii) if, in any subsequent period during the term of this Agreement, all amounts payable hereunder to such Lender in respect of such period which constitute or shall be deemed to constitute interest shall be less than the maximum amount of interest permitted by the Highest Lawful Rate during such period, then the Borrower shall pay to such Lender in respect of such period an amount (each a ***"Compensatory Interest Payment"***) equal to the lesser of (x) a sum which, when added to all such amounts, would equal the maximum amount of interest permitted by the Highest Lawful Rate during such period, and (y) an amount equal to the aggregate sum of all Unqualified Amounts *less* all other Compensatory Interest Payments.

(d) General. Interest shall be payable in arrears on each Interest Payment Date, on the Commitment Termination Date, to the extent provided in Section 2.7(b), upon each prepayment of the Loans and, to the extent provided in Section 2.12(d), on the Extension Date. Any change in the interest rate on the Loans resulting from an increase or a decrease in the Alternate Base Rate or any reserve requirement shall become effective as of the opening of business on the day on which such change shall become effective. Each determination by the Administrative Agent of the Alternate Base Rate, the Eurodollar Rate and the Competitive Bid Rate pursuant to this Agreement shall be conclusive and binding on the Borrower absent manifest error. The Borrower acknowledges that to the extent interest payable on the Loans is based on the Alternate Base Rate, such rate is only one of the bases for computing interest on loans made by the Lenders, and by basing interest payable on ABR Advances on the Alternate Base Rate, the Lenders have not committed to charge, and the Borrower has not in any way bargained for, interest based on a lower or the lowest rate at which the Lenders may now or in the future make extensions of credit to other Persons. All interest (other than interest calculated with reference to the Alternate Base Rate) shall be calculated on the basis of a 360-day year for the actual number of days elapsed, and all interest determined with reference to the Alternate Base Rate shall be calculated on the basis of a 365/366-day year for the actual number of days elapsed.

(e) No Warranty. The Administrative Agent does not warrant or accept responsibility for, and shall not have any liability with respect to, the administration, submission or any other matter related to the rates in the definition of "LIBO Rate", "Eurodollar Rate", "One Month LIBOR Rate", "LIBOR Successor Rate" and "LIBOR Successor Rate Conforming Changes"; *provided* that the foregoing shall not apply to any liability arising out of the bad faith, willful misconduct or gross negligence of the Administrative Agent.

3.5 Indemnification for Loss

Notwithstanding anything contained herein to the contrary, if: (i) the Borrower shall fail to borrow a Eurodollar Advance or if the Borrower shall fail to Convert all or any portion of any Revolving Credit

Loan constituting an ABR Advance to a Eurodollar Advance after it shall have given notice to do so in which it shall have requested a Eurodollar Advance pursuant to Section 2.3 or Section 3.3, as the case may be, (ii) the Borrower shall fail to borrow a Competitive Bid Loan after it shall have accepted any offer with respect thereto in accordance with Section 2.4, (iii) a Eurodollar Advance or Competitive Bid Loan shall be terminated for any reason prior to the last day of the Interest Period applicable thereto, (iv) any repayment or prepayment of the principal amount of a Eurodollar Advance or Competitive Bid Loan is made for any reason on a date which is prior to the last day of the Interest Period applicable thereto, (v) the Borrower shall have revoked a notice of prepayment or notice of termination of the Commitments and the Letter of Credit Commitment that was conditioned upon the effectiveness of other credit facilities or transactions pursuant to Section 2.6 or Section 2.7, or (vi) a Eurodollar Advance is assigned other than on the last day of the Interest Period applicable thereto as a result of an increase in the Aggregate Commitment Amount pursuant to Section 2.6(d) or a replacement of a Lender pursuant to clause (x) or (z) of Section 3.13, then the Borrower agrees to indemnify each Lender against, and to pay on demand directly to such Lender the amount (calculated by such Lender using any method chosen by such Lender which is customarily used by such Lender for such purpose for borrowers similar to the Borrower) equal to any loss or expense suffered by such Lender as a result of such failure to borrow or Convert, or such termination, repayment, prepayment or revocation, including any loss, cost or expense suffered by such Lender in liquidating or employing deposits acquired to fund or maintain the funding of such Eurodollar Advance or Competitive Bid Loan, as the case may be, or redeploying funds prepaid or repaid, in amounts which correspond to such Eurodollar Advance or Competitive Bid Loan, as the case may be, and any reasonable internal processing charge customarily charged by such Lender in connection therewith for borrowers similar to the Borrower.

3.6 Reimbursement for Costs, Etc.

If at any time or from time to time there shall occur a Regulatory Change and any Issuer or any Lender shall have reasonably determined that such Regulatory Change (i) shall have had or will thereafter have the effect of reducing (A) the rate of return on such Issuer's or such Lender's capital or liquidity or the capital or liquidity of any Person directly or indirectly owning or controlling such Issuer or such Lender (each a ***"Control Person"***), or (B) the asset value (for capital or liquidity purposes) to such Issuer, such Lender or such Control Person, as applicable, of the Reimbursement Obligations, or any participation therein, or the Loans, or any participation therein, in any case to a level below that which such Issuer, such Lender or such Control Person could have achieved or would thereafter be able to achieve but for such Regulatory Change (after taking into account such Issuer's, such Lender's or such Control Person's policies regarding capital or liquidity), (ii) will impose, modify or deem applicable any reserve, asset, special deposit or special assessment requirements on deposits obtained in the interbank Eurodollar market in connection with the Loan Documents (excluding, with respect to any Eurodollar Advance, any such requirement which is included in the determination of the rate applicable thereto), or (iii) will subject such Issuer, such Lender or such Control Person, as applicable, to any tax (documentary, stamp or otherwise) with respect to this Agreement, any Note, any Reimbursement Agreement or any other Loan Document (except, in the case of clause (iii) above, for any Indemnified Taxes, Excluded Taxes or Other Taxes), then, in each such case, within ten days after demand by such Issuer or such Lender, as applicable, the Borrower shall pay directly to such Issuer, such Lender or such Control Person, as the case may be, such additional amount or amounts as shall be sufficient to compensate such Issuer, such Lender or such Control Person, as the case may be, for any such reduction, reserve or other requirement, tax, loss, cost or expense (excluding general administrative and overhead costs) (collectively, ***"Costs"***) attributable to such Issuer's, such Lender's or such Control Person's compliance during the term hereof with such Regulatory Change, but only if such Costs are generally applicable to (and for which reimbursement is generally being sought by such Issuer, such Lender or such Control Person, as applicable, in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this Section 3.6), as determined by such Issuer or such Lender, as applicable, in its

reasonable discretion. Each Issuer and each Lender may make multiple requests for compensation under this Section 3.6.

Notwithstanding the foregoing, the Borrower will not be required to compensate any Issuer or any Lender for any Costs under this Section 3.6 arising prior to 45 days preceding the date of demand, unless the applicable Regulatory Change giving rise to such Costs is imposed retroactively. In the case of retroactivity, such notice shall be provided to the Borrower not later than 45 days from the date that such Issuer or such Lender learned of such Regulatory Change. The Borrower's obligation to compensate such Issuer or such Lender shall be contingent upon the provision of such timely notice (but any failure by such Issuer or such Lender to provide such timely notice shall not affect the Borrower's obligations with respect to (i) Costs incurred from the date as of which such Regulatory Change became effective to the date that is 45 days after the date such Issuer or such Lender reasonably should have learned of such Regulatory Change and (ii) Costs incurred following the provision of such notice).

3.7 Illegality of Funding

Notwithstanding any other provision hereof, if any Lender shall reasonably determine that any law, regulation, treaty or directive, or any change therein or in the interpretation or application thereof, shall make it unlawful for such Lender to make or maintain any Eurodollar Advance as contemplated by this Agreement or to determine or charge interest rates based upon LIBOR, such Lender shall promptly notify the Borrower and the Administrative Agent thereof, and (a) the commitment of such Lender to make such Eurodollar Advances or Convert ABR Advances to such Eurodollar Advances shall forthwith be suspended, (b) such Lender shall fund its portion of each requested Eurodollar Advance as an ABR Advance, (c) such Lender's Loans then outstanding as such Eurodollar Advances, if any, shall be Converted automatically to an ABR Advance on the last day of the then current Interest Period applicable thereto or at such earlier time as may be required and (d) if such notice asserts the illegality of such Lender making or maintaining ABR Advances the interest rate on which is determined by reference to One Month LIBOR Rate, the interest rate on which ABR Advances of such Lender shall, if necessary to avoid such illegality, be determined by the Administrative Agent without reference to the One Month LIBOR Rate component of the Alternate Base Rate. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7 and such Lender shall have obtained actual knowledge that it is once again legal for such Lender to make or maintain Eurodollar Advances, such Lender shall promptly notify the Administrative Agent and the Borrower thereof and, upon receipt of such notice by each of the Administrative Agent and the Borrower, such Lender's commitment to make or maintain Eurodollar Advances shall be reinstated. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7, such suspension shall not otherwise affect such Lender's Commitment.

3.8 Option to Fund; Substituted Interest Rate

(a) Each Lender has indicated that, if the Borrower requests a Eurodollar Advance or a Competitive Bid Loan, such Lender may wish to purchase one or more deposits in order to fund or maintain its funding of its Commitment Percentage of such Eurodollar Advance or Competitive Bid Loan during the Interest Period with respect thereto; it being understood that the provisions of this Agreement relating to such funding are included only for the purpose of determining the rate of interest to be paid in respect of such Eurodollar Advance or Competitive Bid Loan and any amounts owing under Section 3.5 and Section 3.6. Each Lender shall be entitled to fund and maintain its funding of all or any part of each Eurodollar Advance and Competitive Bid Loan in any manner it sees fit, but all such determinations hereunder shall be made as if such Lender had actually funded and maintained its Commitment Percentage of each Eurodollar Advance or Competitive Bid Loan, as the case may be, during the applicable Interest Period through the purchase of deposits in an amount equal to the amount of its Commitment Percentage of such

Eurodollar Advance or Competitive Bid Loan, as the case may be, and having a maturity corresponding to such Interest Period. Each Lender may fund its Loans from or for the account of any branch or office of such Lender as such Lender may choose from time to time, subject to Section 3.10.

(b) In the event that (i) the Administrative Agent shall have determined in good faith (which determination shall be conclusive and binding upon the Borrower) that Dollar deposits are not being offered to banks in the London interbank Eurodollar market for the applicable amount and Interest Period or if by reason of circumstances affecting the interbank Eurodollar market adequate and reasonable means do not exist for ascertaining the Eurodollar Rate applicable pursuant to Section 2.3 or Section 3.3, or (ii) the Required Lenders shall have notified the Administrative Agent that they have in good faith determined (which determination shall be conclusive and binding on the Borrower) that the applicable Eurodollar Rate will not adequately and fairly reflect the cost to such Lenders of maintaining or funding loans bearing interest based on such Eurodollar Rate with respect to any portion of the Revolving Credit Loans that the Borrower has requested be made as Eurodollar Advances or any Eurodollar Advance that will result from the requested Conversion of any portion of the Revolving Credit Loans into Eurodollar Advances (each, an ***"Affected Advance"***), the Administrative Agent shall promptly notify the Borrower and the Lenders (by telephone or otherwise, to be promptly confirmed in writing) of such determination on or, to the extent practicable, prior to the requested Borrowing Date or Conversion date for such Affected Advances. If the Administrative Agent shall give such notice, (A) any Affected Advances shall be made as ABR Advances, (B) the Revolving Credit Loans (or any portion thereof) that were to have been Converted to Affected Advances shall be Converted to or continued as ABR Advances, and (C) any outstanding Affected Advances shall be Converted, on the last day of the then current Interest Period with respect thereto, to ABR Advances. Until any notice under clauses (i) or (ii), as the case may be, of this Section 3.8(b) has been withdrawn by the Administrative Agent (by notice to the Borrower) promptly upon either (x) the Administrative Agent having determined that such circumstances affecting the relevant market no longer exist and that adequate and reasonable means do exist for determining the Eurodollar Rate pursuant to Section 2.3 or Section 3.3, or (y) the Administrative Agent having been notified by the Required Lenders that circumstances no longer render the Loans (or any portion thereof) Affected Advances, no further Eurodollar Advances shall be required to be made by the Lenders nor shall the Borrower have the right to Convert all or any portion of the Revolving Credit Loans to Eurodollar Advances.

(c) In the event that the Administrative Agent shall have determined in good faith (which determination shall be conclusive and binding upon the Borrower absent manifest error) that by reason of circumstances affecting the interbank Eurodollar market adequate and reasonable means do not exist for ascertaining the One Month LIBOR Rate, the Administrative Agent shall promptly notify the Borrower and the Lenders (by telephone or otherwise, to be promptly confirmed in writing) of such determination. If the Administrative Agent shall give such notice, the Alternate Base Rate shall be determined without giving effect to clause (iii) thereof until such time, if any, as such notice shall have been withdrawn by the Administrative Agent (by notice to the Borrower) promptly upon the Administrative Agent having determined that such circumstances affecting the relevant market no longer exist and that adequate and reasonable means do exist for determining the One Month LIBOR Rate.

(d) Notwithstanding anything to the contrary in this Agreement or any other Loan Documents, if the Administrative Agent and the Borrower determine that:

(i) adequate and reasonable means do not exist for ascertaining LIBOR for any requested Interest Period and such circumstances are unlikely to be temporary, because

the LIBOR Screen Rate is not available or published on a current basis and such circumstances are unlikely to be temporary; or

(ii) the applicable supervisor or administrator of the LIBO Screen Rate or a Governmental Authority having jurisdiction over the Administrative Agent has made a public statement identifying a specific date after which LIBOR or the LIBO Screen Rate shall no longer be made available, or used for determining the interest rate of loans in the U.S. syndicated loan market denominated in Dollars (such specific date, the "Scheduled Unavailability Date"), or

(iii) syndicated loans currently being executed, or that include language similar to that contained in this Section 3.8(d), are generally being executed or amended (as applicable) to incorporate or adopt a new benchmark interest rate to replace LIBOR,

then, reasonably promptly after such determination by the Administrative Agent and the Borrower, the Administrative Agent and the Borrower may amend this Agreement to replace LIBOR with an alternate benchmark rate (including any mathematical or other adjustments to the benchmark (if any) incorporated therein), giving due consideration to any evolving or then existing convention for similar Dollar denominated syndicated credit facilities for such alternative benchmarks (any such proposed rate, a "***LIBOR Successor Rate***"), together with any proposed LIBOR Successor Rate Conforming Changes (as defined below) and any such amendment shall become effective at 5:00 p.m. on the fifth Domestic Business Day after the Administrative Agent shall have posted such proposed amendment to all Lenders and the Borrower unless, prior to such time, Lenders comprising the Required Lenders have delivered to the Administrative Agent written notice that such Required Lenders do not accept such amendment with each such notice stating that such Lender objects to such amendment (which such notice shall note with specificity the particular provisions of the amendment to which such Lender objects, it being understood that the Required Lenders need not specify identical objectionable provisions of the amendment in order to constitute effective notice). Such LIBOR Successor Rate shall be applied in a manner consistent with market practice; provided that to the extent such market practice is not administratively feasible for the Administrative Agent, such LIBOR Successor Rate shall be applied in a manner as otherwise reasonably determined by the Administrative Agent.

If no LIBOR Successor Rate has been determined and the circumstances under clause (i) above exist or the Scheduled Unavailability Date has occurred (as applicable), the Administrative Agent will promptly so notify the Borrower and each Lender. Thereafter, (x) the obligation of the Lenders to make or maintain Eurodollar Advances shall be suspended, (to the extent of the affected Eurodollar Advances or Eurodollar Interest Periods), and (y) the One Month LIBOR Rate component shall no longer be utilized in determining the Alternate Base Rate. Upon receipt of such notice, the Borrower may revoke any pending request for a borrowing of, Conversion to or continuation of Eurodollar Advances (to the extent of the affected Eurodollar Advances or Eurodollar Interest Periods) or, failing that, will be deemed to have Converted such request into a request for a borrowing of ABR Advances (subject to the foregoing clause (y)) in the amount specified therein.

Notwithstanding anything else herein, any definition of LIBOR Successor Rate shall provide that in no event shall such LIBOR Successor Rate be less than zero for purposes of this Agreement.

For purposes hereof, "***LIBOR Successor Rate Conforming Changes***" means, with respect to any proposed LIBOR Successor Rate, any conforming changes to the definitions of Alternate

Base Rate, Eurodollar Interest Period and One Month LIBOR Rate, timing and frequency of determining rates and making payments of interest and other administrative matters as may be appropriate, in the discretion of the Administrative Agent in consultation with the Borrower, to reflect the adoption of such LIBOR Successor Rate and to permit the administration thereof by the Administrative Agent in a manner substantially consistent with market practice (or, if the Administrative Agent determines that adoption of any portion of such market practice is not administratively feasible or that no market practice for the administration of such LIBOR Successor Rate exists, in such other manner of administration as the Administrative Agent determines is reasonably necessary in connection with the administration of this Agreement).

3.9 Certificates of Payment and Reimbursement

Each Issuer and each Lender agrees, in connection with any request by it for payment or reimbursement pursuant to Section 3.5, Section 3.6 or Section 3.10, to provide the Borrower with a certificate, signed by an officer of such Issuer or such Lender, as the case may be, setting forth a description in reasonable detail of any such payment or reimbursement and the applicable Section of this Agreement pursuant to and in accordance with which such request is made. Each determination by such Issuer and such Lender of such payment or reimbursement shall be conclusive absent manifest error.

3.10 Taxes; Net Payments

(a) Payments Free of Taxes. Any and all payments by or on account of any obligation of the Borrower hereunder or under any other Loan Document shall be made free and clear of and without reduction or withholding for any Indemnified Taxes or Other Taxes, *provided* that if the Borrower shall be required by applicable law to deduct any Indemnified Taxes (including any Other Taxes) from such payments, then (i) the sum payable shall be increased as necessary so that after making all required deductions (including deductions applicable to additional sums payable under this Section 3.10) the Administrative Agent, the applicable Lender or the applicable Issuer, as the case may be, receives an amount equal to the sum it would have received had no such deductions for Indemnified Taxes or Other Taxes been made, (ii) the Borrower shall make such deductions and (iii) the Borrower shall timely pay the full amount deducted to the relevant Governmental Authority in accordance with applicable law.

(b) Payment of Other Taxes by the Borrower. Without limiting the provisions of paragraph (a) above, the Borrower shall timely pay any Other Taxes to the relevant Governmental Authority in accordance with applicable law.

(c) Indemnification by the Borrower. The Borrower shall indemnify the Administrative Agent, each Lender and each Issuer, within 30 days after demand therefor, for the full amount of any Indemnified Taxes imposed on or with respect to any payment made by or on account of any obligation of the Borrower under any Loan Document or Other Taxes (including Indemnified Taxes or Other Taxes imposed or asserted on or attributable to amounts payable under this Section 3.10) paid by the Administrative Agent, such Lender or such Issuer, as the case may be, and, without duplication, any penalties, interest and reasonable and documented out-of-pocket expenses arising therefrom or with respect thereto (other than any penalties that result from the gross negligence, bad faith or willful misconduct of the Administrative Agent, such Lender or such Issuer, as applicable, as determined by a final and non-appealable judgment of a court of competent jurisdiction); *provided* that if the Borrower reasonably believes that such Taxes were not correctly or legally asserted, the Administrative Agent, such Lender or such Issuer, as applicable, will cooperate with the Borrower to obtain a refund of such Taxes so long as such efforts would not result in any additional costs or expenses not reimbursed by the Borrower and such cooperation

would not, in the judgment of such Lender or such Issuer, as applicable, be materially disadvantageous to it. A certificate as to the amount of such payment or liability that complies with Section 3.9 and is delivered to the Borrower by such Lender or such Issuer (with a copy to the Administrative Agent), or by the Administrative Agent on its own behalf or on behalf of such Lender or such Issuer, shall be conclusive absent manifest error. After any Lender or any Issuer (as the case may be) learns of the imposition of any Indemnified Taxes or Other Taxes, such Lender or such Issuer (as the case may be) will as soon as reasonably practicable notify the Borrower thereof; *provided* that the failure to provide Borrower with such notice shall not release the Borrower from its indemnification obligations under this Section 3.10. Notwithstanding anything to the contrary contained in this Section 3.10, the Borrower shall not be required to indemnify the Administrative Agent or any Lender or Issuer pursuant to this Section 3.10 for any additional costs, such as penalties or interest, to the extent that such costs resulted from a failure of the Administrative Agent or such Lender or Issuer to notify the Borrower of such possible indemnification claim within 180 days after the Administrative Agent or such Lender or Issuer receives notice from the applicable taxing authority of the tax giving rise to such indemnification claim.

(d) Evidence of Payments. As soon as practicable after any payment of Indemnified Taxes or Other Taxes by the Borrower to a Governmental Authority, the Borrower shall deliver to the Administrative Agent the original or a certified copy of a receipt issued by such Governmental Authority evidencing such payment, a copy of the return reporting such payment or other evidence of such payment reasonably satisfactory to the Administrative Agent.

(e) Indemnification by the Lenders. Each Lender shall severally indemnify the Administrative Agent, within 10 days after demand therefor, for (i) any Indemnified Taxes attributable to such Lender (but only to the extent that the Borrower has not already indemnified the Administrative Agent for such Indemnified Taxes and without limiting the obligation of the Borrower to do so), (ii) any Taxes attributable to such Lender's failure to comply with the provisions of Section 11.7(d) relating to the maintenance of a Participant Register, and (iii) any Excluded Taxes attributable to such Lender, in each case, that are payable or paid by the Administrative Agent in connection with any Loan Document, and any reasonable expenses arising therefrom or with respect thereto, whether or not such Taxes were correctly or legally imposed or asserted by the relevant Governmental Authority. A certificate as to the amount of such payment or liability delivered to any Lender by the Administrative Agent shall be conclusive absent manifest error. Each Lender hereby authorizes the Administrative Agent to set off and apply any and all amounts at any time owing to such Lender under any Loan Document or otherwise payable by the Administrative Agent to the Lender from any other source against any amount due to the Administrative Agent under this paragraph (e).

(f) Status of Lenders. Any Lender that is entitled to an exemption from or reduction of withholding Tax under the law of the jurisdiction in which the Borrower is resident for Tax purposes, or any treaty to which such jurisdiction is a party, with respect to payments hereunder or under any other Loan Document shall deliver to the Borrower (with a copy to the Administrative Agent), at the time or times prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent, such properly completed and executed documentation prescribed by applicable law as will permit such payments to be made without withholding or at a reduced rate of withholding. In addition, any Lender, if requested by the Borrower or the Administrative Agent, shall deliver such other documentation prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent as will enable the Borrower or the Administrative Agent to determine whether or not such Lender is subject to backup withholding or information reporting requirements.

Without limiting the generality of the foregoing, any Foreign Lender shall deliver to the Borrower and the Administrative Agent (in such number of copies as shall be requested by the recipient) on or prior to the date on which such Foreign Lender becomes a Lender under this Agreement (and from time to time thereafter (i) if such Foreign Lender shall determine that any applicable form or certification has expired or will then expire or has or will then become obsolete or incorrect or that an event has occurred that requires or will then require a change in the most recent form or certification previously delivered by it to the Borrower and the Administrative Agent and (ii) upon the request of the Borrower or the Administrative Agent, but only if such Foreign Lender is legally entitled to do so), whichever of the following is applicable:

(i) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E claiming eligibility for benefits of an income Tax treaty to which the United States of America is a party,

(ii) duly completed copies of Internal Revenue Service Form W-8ECI,

(iii) in the case of a Foreign Lender claiming the benefits of the exemption for portfolio interest under Section 881(c) of the Internal Revenue Code, (x) a certificate (a ***"United States Tax Compliance Certificate"***) to the effect that such Foreign Lender is not (A) a "bank" within the meaning of Section 881(c)(3)(A) of the Internal Revenue Code, (B) a "10 percent shareholder" of the Borrower within the meaning of Section 881(c)(3)(B) of the Internal Revenue Code, (C) a "controlled foreign corporation" described in Section 881(c)(3)(C) of the Internal Revenue Code nor (D) engaged in the conduct of a trade or business within the United States to which the interest payment is effectively connected and (y) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E,

(iv) to the extent a Foreign Lender is not the beneficial owner (for example, where the Foreign Lender is a partnership or participating Lender granting a typical participation), a complete and executed Internal Revenue Service Form W-8IMY, accompanied by a Form W-8ECI, Form W-8BEN, Form W-8BEN-E, a United States Tax Compliance Certificate, Internal Revenue Service Form W-9 and/or other certification documents from each beneficial owner, as applicable; *provided* that, if the Foreign Lender is a partnership (and not a participating Lender) and one or more partners of such Foreign Lender are claiming the portfolio interest exemption, such Foreign Lender shall provide a United States Tax Compliance Certificate, on behalf of such beneficial owner(s) in lieu of requiring each beneficial owner to provide its own certificate, or

(v) any other form prescribed by applicable law as a basis for claiming exemption from or a reduction in United States Federal withholding Tax duly completed together with such supplementary documentation as may be prescribed by applicable law to permit the Borrower to determine the withholding or deduction required to be made.

If a payment made to a Lender under any Loan Document would be subject to U.S. federal withholding Tax imposed by FATCA if such Lender were to fail to comply with the applicable reporting requirements of FATCA (including those contained in Section 1471(b) or 1472(b) of the Internal Revenue Code, as applicable), such Lender shall deliver to the Borrower and the Administrative Agent at the time or times prescribed by law and at such time or times reasonably requested by the Borrower or the Administrative Agent such documentation prescribed by applicable law (including as prescribed by Section 1471(b)(3)(C) of the Internal Revenue Code) and such additional documentation reasonably requested by the Borrower or the Administrative

Agent as may be necessary for the Borrower and the Administrative Agent to comply with their obligations under FATCA and to determine that such Lender has complied with such Lender's obligations under FATCA or to determine the amount to deduct and withhold from such payment. Solely for purposes of this clause, "FATCA" shall include any amendments made to FATCA after the date of this Agreement.

Without limiting the foregoing, upon request of the Administrative Agent or the Borrower, each Lender and each Issuer that is a "United States person" within the meaning of Section 7701(a)(30) of the Internal Revenue Code that lends to the Borrower (each, a ***"U.S. Lender"***) shall deliver to the Administrative Agent and the Borrower two duly signed, properly completed copies of Internal Revenue Service Form W-9 on or prior to the Effective Date (or on or prior to the date it becomes a party to this Agreement), certifying that such U.S. Lender is entitled to an exemption from United States backup withholding, or any successor form.

(g) Treatment of Certain Refunds. If the Administrative Agent, a Lender or an Issuer determines, in its sole discretion exercised in good faith, that it has received a refund of any Taxes or Other Taxes as to which it has been indemnified by the Borrower or with respect to which the Borrower has paid additional amounts pursuant to this Section 3.10, it shall pay to the Borrower an amount equal to such refund (but only to the extent of indemnity payments made, or additional amounts paid, by the Borrower under this Section 3.10 with respect to the Taxes or Other Taxes giving rise to such refund), net of all reasonable and documented out-of-pocket expenses of the Administrative Agent, such Lender or such Issuer, as the case may be, and without interest (other than any interest paid by the relevant Governmental Authority with respect to such refund), *provided* that the Borrower, upon the request of the Administrative Agent, such Lender or such Issuer, agrees to repay the amount paid over to the Borrower (plus any penalties, interest or other charges imposed by the relevant Governmental Authority) to the Administrative Agent, such Lender or such Issuer in the event the Administrative Agent, such Lender or such Issuer is required to repay such refund or Tax credit to such Governmental Authority. This paragraph shall not be construed to require the Administrative Agent, any Lender or any Issuer to make available its Tax returns (or any other information relating to its Taxes that it deems confidential) to the Borrower or any other Person.

(h) Designation of a Different Lending Office. If any Lender requests compensation under Section 3.6, or requires the Borrower to pay any additional amount to any Lender or any Governmental Authority for the account of any Lender pursuant to this Section 3.10, then such Lender shall use reasonable efforts to designate a different lending office for funding or booking its Loans hereunder or to assign its rights and obligations hereunder to another of its offices, branches or affiliates, if such designation or assignment (i) would eliminate or reduce amounts payable pursuant to Section 3.6 or this Section 3.10, as the case may be, in the future and (ii) in the judgment of such Lender, would not subject such Lender to any unreimbursed cost or expense and would not otherwise be disadvantageous to such Lender. The Borrower hereby agrees to pay all reasonable and documented out-of-pocket costs and expenses incurred by any Lender in connection with any such designation or assignment.

(i) *Survival*. Each party's obligations under this Section 3.10 shall survive the resignation or replacement of the Administrative Agent or any assignment of rights by, or the replacement of, a Lender, the termination of the Commitments and the repayment, satisfaction or discharge of all obligations under any Loan Document.

3.11 Facility Fees

The Borrower agrees to pay to the Administrative Agent for the account of each Lender a fee (the ***"Facility Fee"***) during the period commencing on the Effective Date and ending on the Expiration Date, payable quarterly in arrears on the last day of each March, June, September and December of each year, commencing on the last day of the calendar quarter during which the Facility Fee shall commence to accrue, and on the Expiration Date, at a rate per annum equal to the Applicable Margin of (a) prior to the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6, the Commitment Amount of such Lender (whether used or unused), and (b) thereafter, the sum of (i) the outstanding principal balance of all Revolving Credit Loans of such Lender, (ii) such Lender's Swing Line Exposure and (iii) such Lender's Letter of Credit Exposure. Notwithstanding anything to the contrary contained in this Section 3.11, on and after the Commitment Termination Date, the Facility Fee shall be payable upon demand. In addition, upon each reduction of the Aggregate Commitment Amount, the Borrower shall pay the Facility Fee accrued on the amount of such reduction through the date of such reduction. The Facility Fee shall be computed on the basis of a 360-day year for the actual number of days elapsed.

3.12 Letter of Credit Participation Fee

The Borrower agrees to pay to the Administrative Agent for the pro rata account of each Lender a fee (the ***"Letter of Credit Participation Fee"***) with respect to the Letters of Credit during the period commencing on the Effective Date and ending on the Commitment Termination Date or, if later, the date when the Letter of Credit Exposure of all Lenders is $0, payable quarterly in arrears on the last day of each March, June, September and December of each year, commencing on the last day of the calendar quarter in which the Effective Date shall have occurred, and on the last date of such period, at a rate per annum equal to (i) in the case of standby Letters of Credit, the Applicable Margin of the average daily aggregate amount which may be drawn under all standby Letters of Credit during such period (whether or not the conditions for drawing thereunder have or may be satisfied) multiplied by such Lender's Commitment Percentage, and (ii) in the case of commercial Letters of Credit, the Applicable Margin of the average daily aggregate amount which may be drawn under all commercial Letters of Credit during such period (whether or not the conditions for drawing thereunder have or may be satisfied) multiplied by such Lender's Commitment Percentage. The Letter of Credit Participation Fee shall be computed on the basis of a 360-day year for the actual number of days elapsed.

3.13 Replacement of Lender

If (x) the Borrower is obligated to pay to any Lender any amount under Section 3.6 or Section 3.10, the Borrower shall have the right within 90 days thereafter, (y) any Lender shall be a Defaulting Lender, the Borrower shall have the right at any time during which such Lender shall remain a Defaulting Lender, or (z) any Lender shall have not consented to an Extension Request, the Borrower shall have the right at any time on the relevant Extension Date, in each case in accordance with the requirements of Section 11.7(b) and only if no Default shall exist, to replace such Lender (the ***"Replaced Lender"***) with one or more Eligible Assignees (each a ***"Replacement Lender"***); *provided* that (i) at the time of any replacement pursuant to this Section 3.13, the Replacement Lender shall enter into one or more Assignment and Assumptions pursuant to Section 11.7(b) (with the processing and recordation fee referred to in Section 11.7(b) payable pursuant to said Section 11.7(b) to be paid by the Replacement Lender) pursuant to which the Replacement Lender shall acquire the Commitment, the outstanding Loans, the Swing Line Exposure and the Letter of Credit Exposure of the Replaced Lender and, in connection therewith, shall pay the following: (a) to the Replaced Lender, an amount equal to the sum of (A) an amount equal to the principal of, and all accrued and unpaid interest on, all outstanding Loans and Swing Line Participation Amounts of the Replaced Lender, (B) an amount equal to all drawings on all Letters of Credit that have been funded by

(and not reimbursed to) such Replaced Lender, together with all then unpaid interest with respect thereto at such time, and (C) an amount equal to all accrued, but unpaid, fees owing to the Replaced Lender, (b) to each Issuer, an amount equal to such Replaced Lender's Commitment Percentage of all drawings on Letters of Credit issued by such Issuer (which at such time remain unpaid drawings) to the extent such amount was not funded by such Replaced Lender, (c) to the Swing Line Lender, an amount equal to such Replaced Lender's Commitment Percentage of any Mandatory Borrowing to the extent such amount was not funded by such Replaced Lender, and (d) to the Administrative Agent an amount equal to all amounts owed by such Replaced Lender to the Administrative Agent under this Agreement, including, without limitation, an amount equal to the principal of, and all accrued and unpaid interest on, all outstanding Loans of the Replaced Lender, a corresponding amount of which was made available by the Administrative Agent to the Borrower pursuant to Section 3.1 and which has not been repaid to the Administrative Agent by such Replaced Lender or the Borrower, and (ii) all obligations of the Borrower owing to the Replaced Lender (other than those specifically described in clause (i) above in respect of which the assignment purchase price has been, or is concurrently being, paid) shall be paid in full to such Replaced Lender concurrently with such replacement. Upon the execution and delivery of the respective Assignment and Assumptions and the payment of amounts referred to in clauses (i) and (ii) of this Section 3.13, the Replacement Lender shall become a Lender hereunder and the Replaced Lender shall cease to constitute a Lender hereunder, except with respect to indemnification provisions under this Agreement that are intended to survive the termination of the Commitments and the repayment of the Loans which may be applicable to any such Replaced Lender prior to the date of its replacement. Solely for the purpose of calculating break funding payments under Section 3.5, the assignment by any Replaced Lender of any Eurodollar Advance prior to the last day of the Interest Period applicable thereto pursuant to clause (x) or (z) of this Section 3.13 shall be deemed to constitute a prepayment by the Borrower of such Eurodollar Advance.

4. REPRESENTATIONS AND WARRANTIES

In order to induce the Administrative Agent, the Lenders and the Issuers to enter into this Agreement, the Lenders to make the Loans and the Issuers to issue Letters of Credit, the Borrower hereby makes the following representations and warranties to the Administrative Agent, the Lenders and the Issuers:

4.1 Existence and Power

The Borrower is duly organized, validly existing and in good standing under the laws of the jurisdiction of its incorporation, has all requisite corporate power and authority to own its Property and to carry on its business as now conducted, and is qualified to do business as a foreign corporation and is in good standing in each jurisdiction in which it owns or leases real Property or in which the nature of its business requires it to be so qualified (except those jurisdictions where the failure to be so qualified or to be in good standing could not reasonably be expected to have a Material Adverse effect).

4.2 Authority; EEA Financial Institution

The Borrower has full corporate power and authority to enter into, execute, deliver and perform the terms of the Loan Documents, all of which have been duly authorized by all proper and necessary corporate action and are not in contravention of: (i) except as could not reasonably be expected to have a Material Adverse effect, any applicable law or (ii) the terms of its Certificate of Incorporation and By-Laws. No consent or approval of, or other action by, shareholders of the Borrower, any Governmental Authority, or any other Person (which has not already been obtained) is required to authorize in respect of the Borrower, or is required in connection with, the execution, delivery and performance by the Borrower of the Loan Documents or is required as a condition to the enforceability of the Loan Documents against the Borrower. The Borrower is not an EEA Financial Institution.

4.3 Binding Agreement

The Loan Documents constitute the valid and legally binding obligations of the Borrower, enforceable against the Borrower in accordance with their respective terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally and by equitable principles relating to the availability of specific performance as a remedy.

4.4 Litigation

As of the Effective Date, there are no actions, suits, arbitration proceedings or claims (whether purportedly on behalf of the Borrower, any Material Subsidiary or otherwise) pending or, to the knowledge of the Borrower, threatened against the Borrower or any Material Subsidiary or any of their respective Properties, or maintained by the Borrower or any Material Subsidiary, at law or in equity, before any Governmental Authority which have not been disclosed in the SEC Reports that could reasonably be expected to have a Material Adverse effect. There are no proceedings pending or, to the knowledge of the Borrower, threatened against the Borrower or any Material Subsidiary (a) which call into question the validity or enforceability of any Loan Document, or otherwise seek to invalidate, any Loan Document, or (b) which might, individually or in the aggregate, materially and adversely affect any of the transactions contemplated by any Loan Document.

4.5 No Conflicting Agreements

(a) [Reserved].

(b) No provision of any existing material mortgage, material indenture, material contract or material agreement or of any existing statute, rule, regulation, judgment, decree or order binding on the Borrower or affecting the Property of the Borrower (i) conflicts with any Loan Document, (ii) requires any consent which has not already been obtained with respect to any Loan Document, or (iii) would in any way prevent the execution, delivery or performance by the Borrower of the terms of any Loan Document, except in the case of provisions of any existing material mortgage, material indenture, material contract or material agreement, as could not reasonably be expected to have a Material Adverse effect. Neither the execution and delivery, nor the performance, by the Borrower of the terms of each Loan Document will constitute a default under, or result in the creation or imposition of, or obligation to create, any Lien upon the Property of the Borrower pursuant to the terms of any such mortgage, indenture, contract or agreement.

4.6 [Reserved]

4.7 [Reserved]

4.8 Governmental Regulations

The Borrower is not required to be registered as an "investment company" under the Investment Company Act of 1940, as amended.

4.9 Federal Reserve Regulations; Use of Proceeds

The Borrower is not engaged principally, or as one of its important activities, in the business of extending credit for the purpose of purchasing or carrying any Margin Stock. No part of the proceeds of the Loans or the Letters of Credit has been or will be used, directly or indirectly, and whether immediately,

incidentally or ultimately, for a purpose which violates the provisions of Regulations T, U or X of the Board of Governors of the Federal Reserve System, as amended. Anything in this Agreement to the contrary notwithstanding, neither any Issuer nor any Lender shall be obligated to extend credit to or on behalf of the Borrower in violation of any limitation or prohibition provided by any applicable law, regulation or statute, including said Regulation U. Following application of the proceeds of each Loan and the issuance of each Letter of Credit, not more than 25% (or such greater or lesser percentage as is provided in the exclusions from the definition of "Indirectly Secured" contained in said Regulation U as in effect at the time of the making of such Loan or issuance of such Letter of Credit) of the value of the assets of the Borrower and the Subsidiaries on a Consolidated basis that are subject to Section 8.2 will be Margin Stock.

4.10 No Misrepresentation

No representation or warranty contained in any Loan Document and no certificate or written report furnished by the Borrower to the Administrative Agent or any Lender pursuant to any Loan Document contains, as of its date, a misstatement of a material fact, or omits to state, as of its date, a material fact required to be stated in order to make the statements therein contained, when taken as a whole, not materially misleading (*provided* that any representation, warranty, statement or written report that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such date) in the light of the circumstances under which made (after giving effect to all supplements and updates with respect thereto) (it being understood that the Borrower makes no representation or warranty hereunder with respect to any projections, other forward looking information, industry information or general economic information). As of the Effective Date, the information included in any Beneficial Ownership Certification of the Borrower, if applicable, is true and correct in all respects.

4.11 [Reserved]

4.12 [Reserved]

4.13 Financial Statements

The Borrower has heretofore delivered to the Lenders through the Administrative Agent copies of the audited Consolidated Balance Sheet of the Borrower and its Subsidiaries as of December 31, 2018, and the related Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for the fiscal year then ended. The financial statements referred to immediately above, including all related notes and schedules, are herein referred to collectively as the ***"Financial Statements"***. The Financial Statements fairly present, in all material respects, the Consolidated financial condition and results of the operations of the Borrower and the Subsidiaries as of the dates and for the periods indicated therein and, except as noted therein, have been prepared in conformity with GAAP as then in effect. Neither the Borrower nor any of the Subsidiaries has any material obligation or liability of any kind (whether fixed, accrued, contingent, unmatured or otherwise) which, in accordance with GAAP as then in effect, should have been disclosed in the Financial Statements and was not. During the period from January 1, 2019 to and including the Effective Date, there was no Material Adverse change, including as a result of any change in law, in the Consolidated financial condition, operations, business or Property of the Borrower and the Subsidiaries taken as a whole that was not disclosed in the SEC Reports.

4.14 Anti-Corruption Laws and Sanctions

The Borrower has implemented and maintains in effect policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions, and the Borrower, the Subsidiaries and their

respective officers and employees and, to the knowledge of the Borrower, its directors are in compliance with Anti-Corruption Laws and applicable Sanctions in all material respects. None of (a) the Borrower, any Subsidiary or, to the knowledge of the Borrower or such Subsidiary, any of their respective directors, officers or employees, or (b) to the knowledge of the Borrower, any agent of the Borrower or any Subsidiary that will act in any capacity in connection with or benefit from the credit facility established hereby, is a Sanctioned Person. No Loan or Letter of Credit, use of proceeds or other transaction contemplated by this Agreement will violate Anti-Corruption Laws or applicable Sanctions.

5. CONDITIONS TO EFFECTIVENESS

This Agreement shall become effective on and as of the date (the ***"Effective Date"***) that the following conditions shall have been satisfied or waived in accordance with Section 11.1:

5.1 Agreement

The Administrative Agent shall have received counterparts of this Agreement executed by the Borrower, the Administrative Agent, each Issuer, the Swing Line Lender and each Lender.

5.2 Notes

The Administrative Agent shall have received a Note, executed and delivered by the Borrower, for each Lender that shall have given at least three Domestic Business Days' prior written notice of its request for a Note.

5.3 Corporate Action

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Secretary or an Assistant Secretary of the Borrower (i) attaching a true and complete copy of the resolutions of its Board of Directors and of all documents evidencing all other necessary corporate action taken by the Borrower to authorize this Agreement, the other Loan Documents and the transactions contemplated hereby and thereby, (ii) attaching a true and complete copy of its Certificate of Incorporation and By-Laws, (iii) setting forth the incumbency of the officer or officers of the Borrower who may sign this Agreement and the other Loan Documents, and any other certificates, requests, notices or other documents required hereunder or thereunder, and (iv) attaching a certificate of good standing of the Secretary of State of the State of Delaware.

5.4 Opinion of Counsel to the Borrower

The Administrative Agent shall have received (a) an opinion of Thomas Moffatt, assistant general counsel of the Borrower, dated the Effective Date, in the form of Exhibit D-1, and (b) an opinion of Shearman & Sterling LLP, special counsel to the Borrower, dated the Effective Date, in the form of Exhibit D-2.

5.5 Termination of Existing 2015 Credit Agreement

After giving effect to the application of the proceeds of the Loans on the Effective Date, the Indebtedness under the Existing 2015 Credit Agreement shall have been fully repaid, the commitments under the Existing 2015 Credit Agreement shall have been canceled or terminated, and the Administrative Agent shall have received reasonably satisfactory evidence thereof. In order to facilitate the termination of the commitments under the Existing 2015 Credit Agreement, the Borrower hereby gives notice that the Borrower wishes to terminate the commitments under the Existing 2015 Credit Agreement, effective as of

the Effective Date. Each Lender that is a party to the Existing 2015 Credit Agreement, by its execution hereof, waives any requirement of prior notice set forth therein as a condition to the right of the Borrower to terminate the commitments thereunder.

5.6 No Default and Representations and Warranties

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Senior Vice President and Treasurer of the Borrower certifying that there exists no Default and that the representations and warranties contained in this Agreement are true and correct in all material respects (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on the Effective Date), except those which are expressly specified to be made as of an earlier date.

5.7 Fees

The Administrative Agent shall have received all fees and other amounts due and payable to it on the Effective Date, including the upfront fees payable to the Lenders, in respect of this Agreement.

5.8 Due Diligence; "Know Your Customer"

(a) Each Lender shall have received such documents and information as it may have requested in order to comply with "know-your-customer" and other applicable Sanctions, anti-terrorism, anti-money laundering and similar rules and regulations and related policies, to the extent the Borrower shall have received written requests therefor at least ten (10) Domestic Business Days prior to the Effective Date, and (b) at least five Domestic Business Days prior to the Effective Date, if the Borrower qualifies as a "legal entity customer" under the Beneficial Ownership Regulation, it shall have delivered to each Lender that so requests a Beneficial Ownership Certification.

Without limiting the generality of the provisions of Section 10.4, for purposes of determining compliance with the conditions specified in this Section 5, each Lender that has signed this Agreement shall be deemed to have consented to, approved or accepted or to be satisfied with, each document or other matter required thereunder to be consented to or approved by or acceptable or satisfactory to a Lender unless the Administrative Agent shall have received notice from such Lender prior to the proposed Effective Date specifying its objection thereto.

6. CONDITIONS OF LENDING - ALL LOANS AND LETTERS OF CREDIT-

The obligation of each Lender on any Borrowing Date to make each Revolving Credit Loan (other than a Revolving Credit Loan constituting a Mandatory Borrowing), the Swing Line Lender to make each Swing Line Loan, each Issuer to issue each Letter of Credit and each Lender to make a Competitive Bid Loan are subject to the fulfillment (or waiver in accordance with Section 11.1) of the following conditions precedent:

6.1 Compliance

On each Borrowing Date, and after giving effect to the Loans to be made or the Letters of Credit to be issued on such Borrowing Date, (a) there shall exist no Default, and (b) the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on such Borrowing Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language

shall be true and correct (after giving effect to any qualification therein) in all respects on such Borrowing Date), except those which are expressly specified to be made as of an earlier date.

6.2 Requests

The Administrative Agent shall have timely received from the Borrower on or before such Borrowing Date, as applicable, a duly executed Borrowing Request (together with, in the case of a request for a Swing Line Loan that will bear interest at the Negotiated Rate, a duly executed agreement as to the Negotiated Rate with respect to such Swing Line Loan), Letter of Credit Request (together with a duly executed Reimbursement Agreement with respect to the Letter(s) of Credit requested thereby) and/or Competitive Bid Request (together with a duly executed Competitive Bid Accept/Reject Letter).

7. AFFIRMATIVE COVENANTS

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the Reimbursement Obligations, the Fees and all other sums payable under the Loan Documents (other than contingent obligations for which no claim has been made), the Borrower will:

7.1 Legal Existence

Except as may otherwise be permitted by Section 8.3 and Section 8.4, maintain, and cause each Material Subsidiary to maintain, its corporate existence in good standing in the jurisdiction of its incorporation or formation and in each other jurisdiction in which the failure so to do could reasonably be expected to have a Material Adverse effect, except that the corporate existence of Material Subsidiaries may be terminated if (i) such Material Subsidiaries operate closing or discontinued operations or (ii) if the Borrower determines in good faith that such termination is in the best interests of the Borrower and is not materially disadvantageous to the Lenders.

7.2 Taxes

Pay and discharge when due, and cause each Material Subsidiary so to do, all taxes, assessments, governmental charges, license fees and levies upon or with respect to the Borrower and such Material Subsidiary, and upon the income, profits and Property thereof unless, and only to the extent, that either (i)(a) such taxes, assessments, governmental charges, license fees and levies shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Material Subsidiary, and (b) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor, or (ii) the failure to pay or discharge such taxes, assessments, governmental charges, license fees and levies could not reasonably be expected to have a Material Adverse effect.

7.3 [Reserved]

7.4 [Reserved]

7.5 [Reserved]

7.6 Observance of Legal Requirements

(a) Observe and comply in all material respects, and cause each Material Subsidiary so to do, with all laws, ordinances, orders, judgments, rules, regulations, certifications, franchises, permits, licenses, directions and requirements of all Governmental Authorities, which now or at

any time hereafter may be applicable to it or to such Material Subsidiary, except (i) where a violation of which could not reasonably be expected to have a Material Adverse effect, or (ii) to the extent that such noncompliance is being contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Material Subsidiary.

(b) Maintain in effect and enforce policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions.

7.7 Financial Statements and Other Information

Maintain, and cause each Subsidiary to maintain, a standard system of accounting in accordance with GAAP, and furnish to the Administrative Agent for distribution to the Lenders:

(a) As soon as available and, in any event, within 90 days after the close of each fiscal year, a copy of (x) the Borrower's 10-K in respect of such fiscal year, and (y) (i) the Borrower's Consolidated Balance Sheet as of the end of such fiscal year, and (ii) the related Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows, as of and through the end of such fiscal year, setting forth in each case in comparative form the corresponding figures in respect of the previous fiscal year, all in reasonable detail, and accompanied by a report of the Borrower's auditors, which report shall state that (A) such auditors audited such financial statements, (B) such audit was made in accordance with generally accepted auditing standards in effect at the time and provides a reasonable basis for such opinion, and (C) said financial statements have been prepared in accordance with GAAP;

(b) As soon as available, and in any event within 45 days after the end of each of the first three fiscal quarters of each fiscal year, a copy of (x) the Borrower's 10-Q in respect of such fiscal quarter, and (y) (i) the Borrower's condensed Consolidated Balance Sheet as of the end of such quarter and (ii) the related condensed Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for (A) such quarter and (B) the period from the beginning of the then current fiscal year to the end of such quarter, in each case in comparable form with the prior fiscal year, all in reasonable detail and prepared in accordance with GAAP (without footnotes and subject to year-end adjustments);

(c) Simultaneously with the delivery of the financial statements required by clauses (a) and (b) above, a certificate of the Chief Financial Officer or the Senior Vice President and Treasurer of the Borrower certifying that no Default shall have occurred or be continuing or, if so, specifying in such certificate all such Defaults, and setting forth computations in reasonable detail demonstrating compliance with Section 8.9.

(d) Prompt notice upon the Borrower becoming aware of any change in the applicability of a Pricing Level;

(e) As soon as practicable after becoming available, copies of all regular or periodic reports (including current reports on Form 8-K) which the Borrower or any Subsidiary may now or hereafter be required to file with or deliver to the U.S. Securities and Exchange Commission, or any other Governmental Authority succeeding to the functions thereof;

(f) **[reserved]**;

(g) Prompt written notice of the occurrence of (i) each Default and (ii) each Event of Default;

(h) **[reserved]**;

(i) From time to time, such other information regarding the financial position or business of the Borrower and the Subsidiaries as the Administrative Agent, at the reasonable request of any Lender, may reasonably request; and

(j) Prompt written notice of such other information with documentation required by bank regulatory authorities under applicable "know your customer" and anti-money laundering laws, rules and regulations (including, without limitation, the Patriot Act and the Beneficial Ownership Regulation), as from time to time may be reasonably requested by the Administrative Agent or by any Issuer or any Lender (through the Administrative Agent).

Information required to be delivered pursuant to (x) this Section 7.7 shall be deemed to have been delivered if such information shall have been posted by the Administrative Agent on a Debtdomain, IntraLinks, Syndtrak or similar electronic system (the ***"Platform"***) to which each Lender and each Issuer has been granted access and (y) clauses (a), (b) and (e) of this Section 7.7 shall be deemed delivered to the Administrative Agent, the Issuers and the Lenders when available on the Borrower's website at http://www.cvshealth.com or the website of the U.S. Securities and Exchange Commission at http://www.sec.gov. Information delivered pursuant to this Section 7.7 may also be delivered by electronic communications pursuant to procedures approved by the Administrative Agent.

The Borrower hereby acknowledges that the Administrative Agent and/or the Joint Lead Arrangers will make available to the Lenders materials and/or information provided by or on behalf of the Borrower hereunder (collectively, "***Borrower Materials***") by posting the Borrower Materials on the Platform.

7.8 Records

Upon reasonable notice and during normal business hours after an Event of Default has occurred and is continuing, permit representatives of the Administrative Agent and each Lender to visit the offices of the Borrower and each Material Subsidiary, to examine the books and records (other than tax returns and work papers related to tax returns) thereof and auditors' reports relating thereto, to discuss the affairs of the Borrower and each Material Subsidiary with the respective officers thereof, and to meet and discuss the affairs of the Borrower and each Material Subsidiary with the Borrower's auditors, except for information covered by an attorney-client or other legal privilege or to the extent the inspection would reasonably be expected to result in a violation or other breach of any third party confidentiality agreement.

8. NEGATIVE COVENANTS

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the Reimbursement Obligations, the Fees and all other sums payable under the Loan Documents (other than contingent obligations for which no claim has been made), the Borrower will not:

8.1 [Reserved]

8.2 Liens

Create, incur, assume or suffer to exist any Lien against or on any Property now owned or hereafter acquired by the Borrower or any of the Subsidiaries, or permit any of the Subsidiaries so to do, except any one or more of the following types of Liens: (a) Liens in connection with workers' compensation, unemployment insurance or other social security obligations (which phrase shall not be construed to refer to ERISA or the minimum funding obligations under Section 412 of the Internal Revenue Code), (b) Liens to secure the performance of bids, tenders, letters of credit, contracts (other than contracts for the payment of Indebtedness), leases, statutory obligations, surety, customs, appeal, performance and payment bonds and other obligations of like nature, or to qualify to do business, maintain insurance or obtain other benefits, in each such case arising in the ordinary course of business, (c) mechanics', workmen's, carriers', warehousemen's, materialmen's, landlords' or other like Liens arising in the ordinary course of business with respect to obligations which are not due or which are being contested in good faith and by appropriate proceedings diligently conducted, (d) Liens for taxes, assessments, fees or governmental charges the payment of which is not required under Section 7.2, (e) easements, rights of way, restrictions, leases of Property to others, easements for installations of public utilities, title imperfections and restrictions, zoning ordinances and other similar encumbrances affecting Property which in the aggregate do not materially impair its use for the operation of the business of the Borrower or such Subsidiary, (f) Liens on Property of the Subsidiaries under capital leases and Liens on Property (including on the capital stock or other equity interests) of the Subsidiaries acquired (whether as a result of purchase, capital lease, merger or other acquisition) and either existing on such Property when acquired, or created contemporaneously with or within 12 months of such acquisition to secure the payment or financing of the purchase price of such Property (including the construction, development, substantial repair, alteration or improvement thereof), and any renewals thereof, *provided* that such Liens attach only to the Property so purchased or acquired (including any such construction, development, substantial repair, alteration or improvement thereof) and *provided further* that the Indebtedness secured by such Liens is not otherwise prohibited hereunder, (g) statutory Liens in favor of lessors arising in connection with Property leased to the Borrower or any of the Subsidiaries, (h) Liens of attachments, judgments or awards against the Borrower or any of the Subsidiaries with respect to which an appeal or proceeding for review shall be pending or a stay of execution or bond shall have been obtained, or which are otherwise being contested in good faith and by appropriate proceedings diligently conducted, and in respect of which adequate reserves shall have been established in accordance with GAAP on the books of the Borrower or such Subsidiary, (i) Liens securing Indebtedness of a Subsidiary to the Borrower or another Subsidiary, (j) Liens (other than Liens permitted by any of the foregoing clauses) arising in the ordinary course of its business which do not secure Indebtedness and do not, in the aggregate, materially detract from the value of the business of the Borrower and its Subsidiaries, taken as a whole, (k) Liens in favor of the United States of America, or any state thereof, to secure partial, progress, advance or other payments pursuant to any contract or provisions of any statute, and (l) additional Liens securing Indebtedness of the Borrower and the Subsidiaries in an aggregate outstanding Consolidated principal amount not exceeding 15% of Net Tangible Assets.

8.3 Dispositions

Make any Disposition (including by way of limited liability company division), or permit any of its Subsidiaries so to do, of all or substantially all of the assets of the Borrower and the Subsidiaries on a Consolidated basis; provided that (a) any Subsidiary may make Dispositions to the Borrower, and (b) so long as no Default or Event of Default exists prior to or after giving effect thereto, (i) the Borrower may dispose of all or substantially all of its assets to a wholly-owned domestic Subsidiary that assumes all of the obligations of the Borrower under this Agreement and (ii) any Subsidiary may dispose of all or

substantially all of its assets to another Subsidiary, provided that if such Subsidiary is a wholly-owned Subsidiary, the transferee shall be a wholly-owned Subsidiary.

8.4 Merger or Consolidation, Etc.

Consolidate with, be acquired by, or merge into or with any Person unless (x) immediately after giving effect thereto no Default shall or would exist and (y) either (i) the Borrower or (ii) a corporation organized and existing under the laws of one of the States of the United States of America shall be the survivor of such consolidation or merger, *provided* that if the Borrower is not the survivor, the corporation which is the survivor shall expressly assume, pursuant to an instrument executed and delivered to the Administrative Agent, and in form and substance reasonably satisfactory to the Administrative Agent, all obligations of the Borrower under the Loan Documents and the Administrative Agent shall have received such documents, opinions and certificates as it shall have reasonably requested in connection therewith.

8.5 [Reserved]

8.6 [Reserved]

8.7 Limitation on Upstream Dividends by Subsidiaries

Permit or cause any of the Subsidiaries (other than any Insurance Subsidiary) to enter into or agree, or otherwise be or become subject, to any agreement, contract or other arrangement (other than this Agreement and the other Loan Documents) with any Person (each a ***"Restrictive Agreement"***) pursuant to the terms of which (a) such Subsidiary is or would be prohibited from declaring or paying any cash dividends on any class of its stock owned directly or indirectly by the Borrower or any of the other Subsidiaries or from making any other distribution on account of any class of any such stock (herein referred to as ***"Upstream Dividends"***), or (b) the declaration or payment of Upstream Dividends by a Subsidiary to the Borrower or another Subsidiary, on an annual or cumulative basis, is or would be otherwise limited or restricted (***"Dividend Restrictions"***). Notwithstanding the foregoing, nothing in this Section 8.7 shall prohibit:

(a) Dividend Restrictions set forth in any Restrictive Agreement in effect on the date hereof and any extensions, refinancings, renewals or replacements thereof; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(b) Dividend Restrictions existing with respect to any Person acquired by the Borrower or any Subsidiary and existing at the time of such acquisition, which Dividend Restrictions are not applicable to any Person or the property or assets of any Person other than such Person or its property or assets acquired, and any extensions, refinancings, renewals or replacements of any of the foregoing; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(c) Dividend Restrictions consisting of customary net worth, leverage and other financial covenants, customary covenants regarding the merger of or sale of stock or assets of a Subsidiary, customary restrictions on transactions with affiliates, and customary subordination provisions governing Indebtedness owed to the Borrower or any Subsidiary, in each case contained

in, or required by, any agreement governing Indebtedness incurred by a Subsidiary in accordance with the terms of this Agreement; or

(d) Dividend Restrictions contained in any other credit agreement so long as such Dividend Restrictions are no more restrictive than those contained in this Agreement (including Dividend Restrictions contained in the Existing 364-Day Credit Agreement, the Existing 2017 Credit Agreement, the Existing 2018 Credit Agreement and the Existing Term Loan Agreement.

8.8 [Reserved]

8.9 Ratio of Consolidated Indebtedness to Total Capitalization

Permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.60:1.00; *provided* that from the Effective Date through and including the fiscal quarter ending September 30, 2019, the Borrower will not permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.65:1.00; *provided further* that (i) subsequent to the fiscal quarter ending March 31, 2020, upon the consummation of any Material Acquisition and the written election of the Borrower to the Administrative Agent no later than thirty days following the consummation of such Material Acquisition, the maximum permitted ratio of Consolidated Indebtedness to Total Capitalization shall be increased by 0.05:1.00 above the otherwise-applicable maximum permitted ratio of Consolidated Indebtedness to Total Capitalization with respect to the last day of the fiscal quarter during which such Material Acquisition shall have been consummated and the last day of each of the immediately following three consecutive fiscal quarters, and (ii) between the signing of the definitive agreement (or offer documentation, as applicable) for a Material Acquisition and the earlier of (x) the closing of such Material Acquisition and (y) thirty days following the termination of such definitive agreement (or offer documentation, as applicable) for such Material Acquisition, any Acquisition Debt incurred to finance such Material Acquisition shall be excluded for purposes of calculation the ratio of Consolidated Indebtedness to Total Capitalization hereunder. The Borrower shall only be permitted to make an election pursuant to the last proviso of the preceding sentence twice during the term of this Agreement, and there shall be at least two consecutive fiscal quarters between such elections during which time no increase to the maximum permitted ratio of Consolidated Indebtedness to Total Capitalization shall be in effect.

9. DEFAULT

9.1 Events of Default

The following shall each constitute an ***"Event of Default"*** hereunder:

(a) The failure of the Borrower to make any payment of principal on any Loan or any reimbursement payment in respect of any Letter of Credit when due and payable; or

(b) The failure of the Borrower to make any payment of interest on any Loan or of any Fee on any date when due and payable and such default shall continue unremedied for a period of 5 Domestic Business Days after the same shall be due and payable; or

(c) The failure of the Borrower to observe or perform any covenant or agreement contained in Section 2.5, Section 7.1, or in Section 8; or

(d) The failure of the Borrower to observe or perform any other covenant or agreement contained in this Agreement, and such failure shall have continued unremedied for a period of 30 days after the Borrower shall have become aware of such failure; or

(e) [Reserved]; or

(f) Any representation or warranty of the Borrower (or of any of its officers on its behalf) made in any Loan Document, or made in any certificate or report or other document (other than an opinion of counsel) delivered on or after the date hereof in connection with any such Loan Document shall in any such case prove to have been incorrect or misleading (whether because of misstatement or omission) in any material respect when made; or

(g) (i) Obligations in an aggregate Consolidated amount in excess of the Threshold Amount of the Borrower (other than its obligations hereunder and under the Notes) and the Material Subsidiaries, whether as principal, guarantor, surety or other obligor, for the payment of any Indebtedness for Borrowed Money or any net liability under interest rate swap, collar, exchange or cap agreements, (A) shall become or shall be declared to be due and payable prior to the expressed maturity thereof, or (B) shall not be paid when due or within any grace period for the payment thereof, or (ii) any holder of any such obligations shall have the right to declare the Indebtedness for Borrowed Money evidenced thereby due and payable prior to its stated maturity; or

(h) An involuntary proceeding shall be commenced or an involuntary petition shall be filed seeking (i) liquidation, reorganization or other relief in respect of the Borrower or any Material Subsidiary or its debts, or of a substantial part of its assets, under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect or (ii) the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Material Subsidiary or for a substantial part of its assets, and, in any such case, such proceeding or petition shall continue undismissed for 60 days or an order or decree approving or ordering any of the foregoing shall be entered; or

(i) The Borrower or any Material Subsidiary shall (i) voluntarily commence any proceeding or file any petition seeking liquidation, reorganization or other relief under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect, (ii) consent to the institution of, or fail to contest in a timely and appropriate manner, any proceeding or petition described in clause (h) of this Section 9.1, (iii) apply for or consent to the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Material Subsidiary or for a substantial part of its assets, (iv) file an answer admitting the material allegations of a petition filed against it in any such proceeding, (v) make a general assignment for the benefit of creditors or (vi) take any action for the purpose of effecting any of the foregoing; or

(j) The Borrower or any Material Subsidiary shall (i) generally not be paying its debts as such debts become due or (ii) admit in writing its inability to pay its debts as they become due; or

(k) Judgments or decrees in an aggregate Consolidated amount in excess of the Threshold Amount (to the extent not covered by independent third-party insurance or captive insurance as to which the insurer does not dispute coverage) against the Borrower and the Material Subsidiaries shall remain unpaid, unstayed on appeal, undischarged, unbonded or undismissed for a period of 60 days during which execution shall not be effectively stayed, or any action shall be

legally taken by a judgment creditor to attach or levy upon any assets of the Borrower or any Material Subsidiary to enforce any such judgment; or

(l) After the Effective Date a Change of Control shall occur; or

(m) Solely to the extent as would have a Material Adverse effect: (i) any Termination Event shall occur (x) with respect to any Pension Plan (other than a Multiemployer Plan) or (y) with respect to any other retirement plan subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, which plan, during the five year period prior to such Termination Event, was the responsibility in whole or in part of the Borrower, any Material Subsidiary or any ERISA Affiliate; (ii) the failure to satisfy the minimum funding standards under Section 302 of ERISA or Section 412 of the Internal Revenue Code shall exist with respect to any Pension Plan for which the Borrower has responsibility (other than that portion of a Multiemployer Plan's Accumulated Funding Deficiency to the extent such Accumulated Funding Deficiency is attributable to employers other than Borrower); (iii) any Person shall engage in a Prohibited Transaction involving any Employee Benefit Plan in respect of which it is reasonably likely that liability will be imposed upon the Borrower; (iv) the Borrower shall fail to pay when due an amount which is payable by it to the PBGC or to a Pension Plan (including a Multiemployer Plan) under Title IV of ERISA; (v) the imposition on the Borrower of any tax under Section 4980(B)(a) of the Internal Revenue Code; or (vi) the assessment of a civil penalty on the Borrower with respect to any Employee Benefit Plan under Section 502(c) of ERISA. In determining the Consolidated amount for any purpose pursuant to this Section 9.1(m), the liabilities, funding amounts, taxes and penalties referenced in the foregoing clauses of this Section 9.1(m) shall include those of the Material Subsidiaries and ERISA Affiliates of the Borrower to the extent the Borrower is obligated to pay any such liabilities, funding amounts, taxes and penalties.

9.2 Remedies

(a) Upon the occurrence of an Event of Default or at any time thereafter during the continuance of an Event of Default, the Administrative Agent, at the written request of the Required Lenders, shall notify the Borrower that the Commitments, the Swing Line Commitment and the Letter of Credit Commitment have been terminated and/or that all of the Loans, the Notes and the Reimbursement Obligations and all accrued and unpaid interest on any thereof and all other amounts owing under the Loan Documents have been declared immediately due and payable, *provided* that upon the occurrence of an Event of Default under Section 9.1(h), (i) or (j) with respect to the Borrower, the Commitments, the Swing Line Commitment and the Letter of Credit Commitment shall automatically terminate and all of the Loans, the Notes and the Reimbursement Obligations and all accrued and unpaid interest on any thereof and all other amounts owing under the Loan Documents shall become immediately due and payable without declaration or notice to the Borrower. To the fullest extent not prohibited by law, except for the notice provided for in the preceding sentence, the Borrower expressly waives any presentment, demand, protest, notice of protest or other notice of any kind in connection with the Loan Documents and its obligations thereunder. To the fullest extent not prohibited by law, the Borrower further expressly waives and covenants not to assert any appraisement, valuation, stay, extension, redemption or similar law, now or at any time hereafter in force which might delay, prevent or otherwise impede the performance or enforcement of the Loan Documents.

(b) In the event that the Commitments, the Swing Line Commitment and the Letter of Credit Commitment shall have been terminated or all of the Loans, the Notes and the Reimbursement Obligations shall have become or been declared to be due and payable pursuant to the provisions of this Section 9.2, (i) the Borrower shall forthwith deposit an amount equal to the

Letter of Credit Exposure in a cash collateral account with and under the exclusive control of the Administrative Agent, and (ii) the Administrative Agent, the Issuers and the Lenders agree, among themselves, that any funds received from or on behalf of the Borrower under any Loan Document by any Issuer or any Lender (except funds received by any Issuer or any Lender as a result of a purchase from such Issuer or such Lender, as the case may be, pursuant to the provisions of Section 11.9(b)) shall be remitted to the Administrative Agent, and shall be applied by the Administrative Agent in payment of the Loans, the Reimbursement Obligations and the other obligations of the Borrower under the Loan Documents in the following manner and order: (1) first, to the payment or reimbursement of the Administrative Agent, the Issuers and the Lenders, in that order, for any fees, expenses or amounts (other than the principal of and interest on the Reimbursement Obligations) due from the Borrower pursuant to the provisions of Section 11.5 and the Reimbursement Agreements, (2) second, to the payment of the Fees, (3) third, to the payment of any other fees, expenses or amounts (other than the principal of and interest on the Loans and the Notes and the Reimbursement Obligations) payable by the Borrower to the Administrative Agent, any Issuer or any of the Lenders under the Loan Documents, (4) fourth, to the payment, pro rata according to the outstanding principal balance of the Loans and the Letter of Credit Exposure of each Lender, of interest due on the Loans and the Reimbursement Obligations, (5) fifth, to the payment, pro rata according to the sum of (A) the aggregate outstanding principal balance of the Loans of each Lender *plus* (B) the aggregate outstanding balance of the Reimbursement Obligations of each Lender, of the aggregate outstanding principal balance of the Loans and the aggregate outstanding balance of the Reimbursement Obligations, and (6) sixth, any remaining funds shall be paid to whosoever shall be entitled thereto or as a court of competent jurisdiction shall direct.

(c) In the event that the Loans and the Notes and the Reimbursement Obligations shall have been declared due and payable pursuant to the provisions of this Section 9.2, the Administrative Agent upon the written request of the Required Lenders, shall proceed to enforce the Reimbursement Obligations and the rights of the holders of the Loans and the Notes by suit in equity, action at law and/or other appropriate proceedings, whether for payment or the specific performance of any covenant or agreement contained in the Loan Documents. In the event that the Administrative Agent shall fail or refuse so to proceed, each Issuer and each Lender shall be entitled to take such action as the Required Lenders shall deem appropriate to enforce its rights under the Loan Documents.

10. AGENT

10.1 Appointment and Authority

Each Credit Party hereby irrevocably appoints BofA to act on its behalf as the Administrative Agent hereunder and under the other Loan Documents and authorizes the Administrative Agent to take such actions on its behalf and to exercise such powers as are delegated to the Administrative Agent by the terms hereof or thereof, together with such actions and powers as are reasonably incidental thereto. The provisions of this Section 10 (other than Section 10.6) are solely for the benefit of the Administrative Agent and the Credit Parties and the Borrower shall have no rights as a third party beneficiary or otherwise of any of such provisions.

10.2 Rights as a Lender

The Person serving as the Administrative Agent hereunder shall have the same rights and powers in its capacity as a Lender (which includes Issuer) as any other Lender and may exercise the same as though it were not the Administrative Agent and the term “Lender” or “Lenders” shall, unless otherwise expressly indicated or unless the context otherwise requires, include the Person serving as the Administrative Agent

hereunder in its individual capacity. Such Person and its Affiliates may accept deposits from, lend money to, own securities of, act as the financial advisor or in any other advisory capacity for and generally engage in any kind of business with, the Borrower, any of its Subsidiaries or any other Affiliate thereof as if such Person were not the Administrative Agent hereunder and without any duty to account therefor to the Lenders.

10.3 Exculpatory Provisions

(a) The Administrative Agent shall not have any duties or obligations except those expressly set forth herein and in the other Loan Documents. Without limiting the generality of the foregoing, the Administrative Agent:

(1) shall not be subject to any fiduciary or other implied duties, regardless of whether a Default has occurred and is continuing;

(2) shall not have any duty to take any discretionary action or exercise any discretionary powers, except discretionary rights and powers expressly contemplated hereby or by the other Loan Documents that the Administrative Agent is required to exercise as directed in writing by the Required Lenders (or such other number or percentage of the Lenders as shall be expressly provided for herein or in the other Loan Documents); *provided* that the Administrative Agent shall not be required to take any action that, in its opinion or the opinion of its counsel, may expose the Administrative Agent to liability or that is contrary to any Loan Document or applicable law; and

(3) shall not, except as expressly set forth herein and in the other Loan Documents, have any duty to disclose, and shall not be liable for the failure to disclose, any information relating to the Borrower, any of its Subsidiaries or any Affiliate thereof that is communicated to or obtained by the Person serving as the Administrative Agent or any of its Affiliates in any capacity.

(b) The Administrative Agent shall not be liable for any action taken or not taken by it (i) with the consent or at the request of the Required Lenders (or such other number or percentage of the Lenders as shall be necessary, or as the Administrative Agent shall believe in good faith shall be necessary, under the circumstances as provided in Section 11.1 and Section 9) or (ii) in the absence of its own gross negligence or willful misconduct. The Administrative Agent shall be deemed not to have knowledge of any Default unless and until written notice describing such Default is given to the Administrative Agent by the Borrower, a Lender or an Issuer.

(c) The Administrative Agent shall not be responsible for or have any duty to ascertain or inquire into (i) any statement, warranty or representation made in or in connection with this Agreement or any other Loan Document, (ii) the contents of any certificate, report or other document delivered hereunder or thereunder or in connection herewith or therewith, (iii) the performance or observance of any of the covenants, agreements or other terms or conditions set forth herein or therein or the occurrence of any Default, (iv) the validity, enforceability, effectiveness or genuineness of this Agreement, any other Loan Document or any other agreement, instrument or document or (v) the satisfaction of any condition set forth in Section 5 or Section 6 or elsewhere herein, other than to confirm receipt of items expressly required to be delivered to the Administrative Agent.

(d) The Administrative Agent shall not be responsible or have any liability for, or have any duty to ascertain, inquire into, monitor or enforce, compliance with the provisions of this

Agreement relating to Disqualified Institutions. Without limiting the generality of the foregoing, the Administrative Agent shall not (x) be obligated to ascertain, monitor or inquire as to whether any Lender or prospective Lender is a Disqualified Institution or (y) have any liability with respect to or arising out of any assignment of Loans, or disclosure of confidential information, to any Disqualified Institution.

10.4 Reliance by Administrative Agent

The Administrative Agent shall be entitled to rely upon, and shall not incur any liability for relying upon, any notice, request, certificate, consent, statement, instrument, document or other writing (including any electronic message, internet or intranet website posting or other distribution) believed by it to be genuine and to have been signed, sent or otherwise authenticated by the proper Person. The Administrative Agent also may rely upon any statement made to it orally or by telephone and believed by it to have been made by the proper Person, and shall not incur any liability for relying thereon. In determining compliance with any condition hereunder to the making of a Loan or the issuance of a Letter of Credit that by its terms must be fulfilled to the satisfaction of a Lender or an Issuer, the Administrative Agent may presume that such condition is satisfactory to such Lender or such Issuer unless the Administrative Agent shall have received notice to the contrary from such Lender or such Issuer prior to the making of such Loan or the issuance of such Letter of Credit. The Administrative Agent may consult with legal counsel (who may be counsel for the Borrower), independent public accounting firms and other experts selected by it and shall not be liable for any action taken or not taken by it in accordance with the advice of any such counsel, accounting firm or experts.

10.5 Delegation of Duties

The Administrative Agent may perform any and all of its duties and exercise its rights and powers hereunder or under any other Loan Document by or through any one or more sub-agents appointed by the Administrative Agent. The Administrative Agent and any such sub-agent may perform any and all of its duties and exercise its rights and powers by or through their respective Related Parties. The exculpatory provisions of this Section 10 shall apply to any such sub-agent and to the Related Parties of the Administrative Agent and any such sub-agent, and shall apply to their respective activities in connection with the syndication of the credit facilities provided for herein as well as activities as the Administrative Agent.

10.6 Resignation of Administrative Agent

(a) The Administrative Agent may at any time give notice of its resignation to the Credit Parties and the Borrower. Upon receipt of any such notice of resignation, the Required Lenders shall have the right, subject to, so long as no Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed), to appoint a successor, which shall be a bank with an office in New York, New York, or an Affiliate of any such bank with an office in New York, New York. If no such successor shall have been so appointed by the Required Lenders and shall have accepted such appointment within 30 days after the retiring Administrative Agent gives notice of its resignation, then the retiring Administrative Agent may on behalf of the Credit Parties, appoint a successor Administrative Agent meeting the qualifications set forth above, subject to, so long as no Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed); *provided* that if the Administrative Agent shall notify the Borrower and the Credit Parties that no qualifying Person has accepted such appointment, then such resignation shall nonetheless become effective in accordance

with such notice and (a) the retiring Administrative Agent shall be discharged from its duties and obligations hereunder and under the other Loan Documents and (b) all payments, communications and determinations provided to be made by, to or through the Administrative Agent shall instead be made by or to each Credit Party directly, until such time as the Required Lenders appoint a successor Administrative Agent as provided for above in this Section. Upon the acceptance of a successor's appointment as Administrative Agent hereunder, such successor shall succeed to and become vested with all of the rights, powers, privileges and duties of the retiring (or retired) Administrative Agent, and the retiring Administrative Agent shall be discharged from all of its duties and obligations hereunder or under the other Loan Documents (if not already discharged therefrom as provided above in this Section). The fees payable by the Borrower to a successor Administrative Agent shall be the same as those payable to its predecessor unless otherwise agreed in writing between the Borrower and such successor. After the retiring Administrative Agent's resignation hereunder and under the other Loan Documents, the provisions of this Section 10 and Section 11.5 shall continue in effect for the benefit of such retiring Administrative Agent, its sub-agents and their respective Related Parties in respect of any actions taken or omitted to be taken by any of them while the retiring Administrative Agent was acting as Administrative Agent.

(b) Any resignation by BofA as Administrative Agent pursuant to this Section 10.6 shall also constitute its resignation as an Issuer and Swing Line Lender. If BofA resigns as an Issuer, it shall, pending the issuance of letters of credit in substitution of the outstanding Letters of Credit in accordance with clause (iii) of the last sentence of this Section 10.6(b) and the return and cancellation of such outstanding Letters of Credit, retain all the rights, powers, privileges and duties of an Issuer hereunder with respect to all Letters of Credit outstanding as of the effective date of its resignation as an Issuer and all Reimbursement Obligations with respect thereto, including the right to require the Lenders to make ABR Advances or fund risk participations pursuant to Section 2.9. If BofA resigns as Swing Line Lender, it shall retain all the rights of the Swing Line Lender provided for hereunder with respect to Swing Line Loans made by it and outstanding as of the effective date of such resignation, including the right to require the Lenders to make ABR Advances or fund risk participations in outstanding Swing Line Loans pursuant to Section 2.2. Upon the appointment by the Borrower of a successor Issuer or Swing Line Lender hereunder (which successor shall in all cases be a Lender other than a Defaulting Lender), (i) such successor shall succeed to and become vested with all of the rights, powers, privileges and duties of the retiring Issuer or Swing Line Lender, as applicable, (ii) the retiring Issuer and Swing Line Lender shall be discharged from all of their respective duties and obligations hereunder or under the other Loan Documents (other than with respect to outstanding Swing Line Loans made by it and outstanding Letters of Credit issued by it), and (iii) the successor Issuer shall issue letters of credit in substitution for the Letters of Credit, if any, outstanding at the time of such succession or make other arrangements satisfactory to BofA and the Borrower to effectively assume the obligations of BofA with respect to such Letters of Credit.

10.7 Non-Reliance on Administrative Agent and Other Credit Parties-

Each Credit Party acknowledges that it has, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it has deemed appropriate, made its own credit analysis and decision to enter into this Agreement. Each Credit Party also acknowledges that it will, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it shall from time to time deem appropriate, continue to make its own decisions in taking or not taking action under or based upon this Agreement, any other Loan Document or any related agreement or any document furnished hereunder or thereunder.

10.8 No Other Duties, etc.

Anything herein to the contrary notwithstanding, none of the Joint Lead Arrangers, the Co-Documentation Agents or the Co-Syndication Agents listed on the cover page hereof shall have any powers, duties or responsibilities under this Agreement or any of the other Loan Documents, except in its capacity, as applicable, as the Administrative Agent, a Lender or an Issuer.

11. OTHER PROVISIONS

11.1 Amendments, Waivers, Etc.

With the written consent of the Required Lenders, the Administrative Agent and the Borrower may, from time to time, enter into written amendments, supplements or modifications of the Loan Documents (which, for the avoidance of doubt, shall require the prior written consent of the Borrower) and, with the written consent of the Required Lenders and the Borrower, the Administrative Agent on behalf of the Lenders may execute and deliver to any such parties a written instrument waiving or consenting to the departure from, on such terms and conditions as the Administrative Agent may specify in such instrument (which terms and conditions shall have been agreed to by the Borrower), any of the requirements of the Loan Documents or any Default or any Event of Default and its consequences, *provided* that no such amendment, supplement, modification, waiver or consent shall (i) increase the Commitment Amount of any Lender without the consent of such Lender (*provided* that no waiver of a Default or Event of Default shall be deemed to constitute such an increase), (ii) extend the Commitment Period without the consent of each Lender directly affected thereby, (iii) reduce the amount, or extend the time of payment, of the Fees without the consent of each Lender directly affected thereby, (iv) reduce the rate, or extend the time of payment of, interest on any Revolving Credit Loan, any Note or any Reimbursement Obligation (other than the applicability of any post-default increase in such rate of interest) without the consent of each Lender directly affected thereby, (v) reduce the amount of, or extend the time of payment of, any payment of any Reimbursement Obligation or principal on any Revolving Credit Loan or any Note without the consent of each Lender directly affected thereby, (vi) decrease or forgive the principal amount of any Revolving Credit Loan, any Note or any Reimbursement Obligation without the consent of each Lender directly affected thereby, (vii) consent to any assignment or delegation by the Borrower of any of its rights or obligations under any Loan Document without the consent of each Lender, (viii) change the provisions of this Section 11.1 without the consent of each Lender, (ix) change the definition of Required Lenders without the consent of each Lender, (x) change the several nature of the obligations of the Lenders without the consent of each Lender, (xi) change the sharing provisions among Lenders without the consent of each Lender directly affected thereby, or (xii) extend the expiration date of a Letter of Credit beyond the Commitment Termination Date without the consent of each Lender. Notwithstanding the foregoing, in addition to the receipt of the prior written consents of the Borrower and the Required Lenders, no such amendment, supplement, modification, waiver or consent shall (A) amend, modify or waive any provision of Section 10 or otherwise change any of the rights or obligations of the Administrative Agent, any Issuer or the Swing Line Lender under any Loan Document without the written consent of the Administrative Agent, such Issuer or the Swing Line Lender, as the case may be, (B) change the Letter of Credit Commitment, change the amount or the time of payment of any Letter of Credit or any commission or fee payable to the Issuer thereof in connection therewith, or change any other term or provision which relates to the Letter of Credit Commitment of such Issuer or the Letters of Credit issued thereby without the written consent of such Issuer, (C) change the Swing Line Commitment, change the amount or the time of payment of the Swing Line Loans or interest thereon or change any other term or provision which relates to the Swing Line Commitment or the Swing Line Loans without the written consent of the Swing Line Lender or (D) change the amount or the time of payment of any Competitive Bid Loan or interest thereon without the written consent of the Lender holding such Competitive Bid Loan. Any such amendment, supplement, modification, waiver or consent shall apply equally to each of the Lenders and shall be binding upon the

parties to the applicable Loan Document, the Lenders, the Issuers, the Administrative Agent and all future holders of the Loans, the Notes and the Reimbursement Obligations. In the case of any waiver, the Borrower, the Lenders, the Issuers and the Administrative Agent shall be restored to their former position and rights under the Loan Documents, but any Default or Event of Default waived shall not extend to any subsequent or other Default or Event of Default, or impair any right consequent thereon. Notwithstanding anything to the contrary in this Section 11.1, (1) the Administrative Agent and the Borrower may make amendments contemplated by Section 3.8(d) without the consent of any other Person party hereto and (2) if the Administrative Agent and the Borrower shall have jointly identified an obvious error, ambiguity, defect, inconsistency, omission or any error or omission of a technical nature, in each case, in any provision of the Loan Documents, then the Administrative Agent and the Borrower shall be permitted to amend such provision, and, in each case, such amendment shall become effective without any further action or consent of any party to any Loan Document (other than the Administrative Agent and the Borrower) if the same (x) does not adversely affect the rights of any Lender or (y) is not objected to in writing by the Required Lenders to the Administrative Agent within five Domestic Business Days following receipt of notice thereof. Any amendment, waiver or consent effected in accordance with this Section 11.1 shall be binding upon each Person that is at the time thereof a Lender and each Person that subsequently becomes a Lender.

11.2 Notices

(a) Notices Generally. Except in the case of notices and other communications expressly permitted to be given by telephone, all notices and other communications provided for herein shall be in writing and shall be delivered by hand or overnight courier service, mailed by certified or registered mail or sent by facsimile or email, as follows:

If to the Borrower:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Carol A. DeNale
Senior Vice President and Treasurer – Treasury Department
Facsimile: (401) 770-5768
Telephone: (401) 770-4407
Email: carol.denale@cvshealth.com

with a copy, in the case of a notice of Default or Event of Default, to:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Tom Moffatt
Vice President, Assistant Secretary and Assistant General Counsel – Corporate Services
Facsimile: (401) 216-3758
Telephone: (401) 770-5409
Email: thomas.moffatt@cvshealth.com

with a copy (in the case of a notice of Default or Event of Default and which shall not constitute notice under this Agreement or any other Loan Document for any purpose) to:

Shearman & Sterling LLP

599 Lexington Avenue
New York, New York 10022
Attention: Gus M. Atiyah
Facsimile: (646) 848-5227
Telephone: (212) 848-5227
Email: gus.atiyah@shearman.com

If to the Administrative Agent, BofA as an Issuer or the Swing Line Lender:

in the case of each Borrowing Request, each notice of prepayment under Section 2.7, each Letter of Credit Request, each Competitive Bid Request, each Competitive Bid, and each Competitive Bid Accept/Reject Letter:

Bank of America, N.A., as Administrative Agent
900 W. Trade St., 6th Floor
NC1-026-06-03
Charlotte, NC 28255
Attention: Carl Dormenyo
Tel: 980-387-3981
Facsimile: 704-683-9310
Email: carl.dormenyo@baml.com

Remittance Instructions- US Dollars:
Bank of America, N.A.
New York, NY
ABA# 026009593
Account No.: 1366072250600
Account Name: Wire Clearing Acct for Syn Loans-LIQ
Ref: CVS HEALTH CORPORATION

in the case of each Letter of Credit Request:

Bank of America, N.A.
Trade Operations
1 Fleet Way
Mail Code: PA6-580-02-30
Scranton, Pa. 18507
Attention: Trade Operations
Tel: 570-496-9619
Facsimile: 800-755-8740
Email: tradeclientserviceteamus@baml.com

Remittance Instructions:

Bank of America, N.A.
New York, NY
ABA #: 026-009-593
Account #: 04535-883980
Attn: Scranton Standby
Ref: CVS HEALTH CORPORATION

and in all other cases:

Bank of America, N.A., as Administrative Agent
900 W. Trade St., 6th Floor
NC1-026-06-03
Charlotte, NC 28255
Attention: Kyle Harding
Tel: 980-275-6132
Facsimile: 704-719-5215
Email: kyle.d.harding@baml.com

If to any Lender or any other Issuer: to it at its address (or facsimile number or email address) set forth in its Administrative Questionnaire.

(b) *Electronic Communications*. Notices and other communications to the Credit Parties hereunder may be delivered or furnished by electronic communication (including email, FpML messaging and internet or intranet websites) pursuant to procedures approved by the Administrative Agent; *provided* that the foregoing shall not apply to notices to any Credit Party pursuant to Section 2 or Section 3.3 if such Credit Party has notified the Administrative Agent that it is incapable of receiving notices under such Sections by electronic communication. The Administrative Agent or the Borrower may, in its discretion, agree to accept notices and other communications to it hereunder by electronic communications pursuant to procedures approved by it; *provided* that approval of such procedures may be limited to particular notices or communications.

Unless the Administrative Agent otherwise prescribes, (i) notices and other communications sent to an email address shall be deemed received upon the sender's receipt of an acknowledgement from the intended recipient (such as by the "return receipt requested" or "read requested" function, as available, return email or other written acknowledgement); *provided* that if such notice or other communication is not sent during the normal business hours of the recipient, such notice or communication shall be deemed to have been sent at the opening of business on the next Domestic Business Day for the recipient, and (ii) notices or communications posted to an internet or intranet website shall be deemed received upon the deemed receipt by the intended recipient at its email address as described in the foregoing clause (i) of notification that such notice or communication is available and identifying the website address therefor.

(c) *Change of Address.* Any party hereto may change its address, facsimile number or email address for notices and other communications hereunder by notice to the other parties hereto (or, in the case of any Lender or any Issuer, by notice to the Administrative Agent and the Borrower). Subject to the second paragraph of this Section 11.2(b), all notices and other communications given to any party hereto in accordance with the provisions of this Agreement shall be deemed to have been given on the date of receipt; *provided* that any such notice or communication that is not received on a Domestic Business Day during the normal business hours of the recipient shall be deemed received at the opening of business on the next Domestic Business Day.

(d) *The Platform.* THE PLATFORM IS PROVIDED "AS IS" AND "AS AVAILABLE." THE AGENT PARTIES (AS DEFINED BELOW) DO NOT WARRANT THE ACCURACY OR COMPLETENESS OF THE BORROWER MATERIALS OR THE ADEQUACY OF THE PLATFORM, AND EXPRESSLY DISCLAIM LIABILITY FOR ERRORS IN OR OMISSIONS FROM THE BORROWER MATERIALS. NO WARRANTY OF

ANY KIND, EXPRESS, IMPLIED OR STATUTORY, INCLUDING ANY WARRANTY OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, NON-INFRINGEMENT OF THIRD PARTY RIGHTS OR FREEDOM FROM VIRUSES OR OTHER CODE DEFECTS, IS MADE BY ANY AGENT PARTY IN CONNECTION WITH THE BORROWER MATERIALS OR THE PLATFORM. In no event shall the Administrative Agent or any of its Related Parties (collectively, the "Agent Parties") have any liability to the Borrower, any Lender, any Issuer or any other Person for losses, claims, damages, liabilities or expenses of any kind (whether in tort, contract or otherwise) arising out of the Borrower's or the Administrative Agent's transmission of Borrower Materials or notices through the Platform, any other electronic platform or electronic messaging service, or through the Internet.

11.3 No Waiver; Cumulative Remedies

No failure to exercise and no delay in exercising, on the part of the Administrative Agent, any Lender or any Issuer, any right, remedy, power or privilege under any Loan Document shall operate as a waiver thereof, nor shall any single or partial exercise of any right, remedy, power or privilege under any Loan Document preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege. The rights, remedies, powers and privileges under the Loan Documents are cumulative and not exclusive of any rights, remedies, powers and privileges provided by law.

11.4 Survival of Representations and Warranties

All representations and warranties made in the Loan Documents and in any document, certificate or statement delivered pursuant thereto or in connection therewith shall survive the execution and delivery of the Loan Documents.

11.5 Payment of Expenses; Indemnified Liabilities

(a) The Borrower agrees, as soon as practicable following presentation of a statement or invoice therefor setting forth in reasonable detail the items thereof, and whether any Loan is made or Letter of Credit is issued, (a) to pay or reimburse the Administrative Agent and its Affiliates for all their reasonable and documented out-of-pocket costs and expenses actually incurred in connection with the development, syndication, preparation and execution of, and any amendment, waiver, consent, supplement or modification to, the Loan Documents, any documents prepared in connection therewith and the consummation of the transactions contemplated thereby, whether such Loan Documents or any such amendment, waiver, consent, supplement or modification to the Loan Documents or any documents prepared in connection therewith are executed and whether the transactions contemplated thereby are consummated, including the reasonable and documented out-of-pocket fees and disbursements of Special Counsel, (b) to pay, indemnify, and hold the Administrative Agent, the Lenders and the Issuers harmless from any and all recording and filing fees and any and all liabilities and penalties with respect to, or resulting from any delay (other than penalties to the extent attributable to the negligence of the Administrative Agent, the Lenders or the Issuers, as the case may be, in failing to pay such fees, liabilities or penalties when due) which may be payable or determined to be payable in connection with the execution and delivery of, or consummation of any of the transactions contemplated by, or any amendment, supplement or modification of, or any waiver or consent under or in respect of, the Loan Documents or any documents prepared in connection therewith, and (c) to pay, reimburse, indemnify and hold each Indemnified Person harmless from and against any and all other liabilities, obligations, claims, losses, damages, penalties, actions, judgments, suits, costs, expenses and disbursements of any kind or nature whatsoever (including the reasonable and documented out-of-pocket fees and disbursements of one counsel (but excluding the allocated cost of internal counsel)

representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a single local counsel for each applicable jurisdiction (which may include a single counsel acting in multiple jurisdictions) (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Person))) actually incurred with respect to the enforcement, performance of, and preservation of rights under, the Loan Documents (all the foregoing, collectively, the ***"Indemnified Liabilities"***) and, if and to the extent that the foregoing indemnity may be unenforceable for any reason, the Borrower agrees to make the maximum payment permitted under applicable law. Notwithstanding anything to the contrary contained in this Section 11.5, the foregoing payment, indemnification and reimbursement obligations will not, as to any Person identified in this Section 11.5, apply to any losses, claims, damages, liabilities and related expenses to the extent arising (A) from the willful misconduct, gross negligence, fraud or bad faith of such Person, (B) from a material breach of the obligations hereunder of such Person, (C) out of or in connection with Section 11.22, or (D) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by any such Person against any such other Person (other than the Administrative Agent, Joint Lead Arranger, Issuer or Swing Line Lender, in each case, in its capacity as such), in each case under clauses (A) and (B), to the extent determined by a final and non-appealable judgment of a court of competent jurisdiction. The agreements in this Section 11.5 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

(b) Notwithstanding the above, the Borrower shall have no liability under this Section 11.5 to indemnify or hold harmless any Indemnified Person for any losses, claims, damages, liabilities and related expenses relating to income or withholding Taxes or any Tax in lieu of such Taxes. Notwithstanding the foregoing, any amounts claimed by an Indemnified Person under Section 11.10 shall not be available to be claimed by such Indemnified Person under this Section 11.5, it being understood and agreed that the rights of an Indemnified Person under this Section 11.5 and Section 11.10 shall not be duplicative.

11.6 Lending Offices

Each Lender shall have the right at any time and from time to time to transfer any Loan to a different office of such Lender, subject to Section 3.10.

11.7 Successors and Assigns

(a) Successors and Assigns Generally. The provisions of this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns permitted hereby, except that the Borrower may not assign or otherwise transfer any of its rights or obligations hereunder without the prior written consent of the Administrative Agent and each Lender and no Lender may assign or otherwise transfer any of its rights or obligations hereunder except (i) to an assignee in accordance with the provisions of paragraph (b) of this Section 11.7, (ii) by way of participation in accordance with the provisions of paragraph (d) of this Section 11.7 or (iii) by way of pledge or assignment of a security interest subject to the restrictions of paragraph (f) of this Section 11.7 (and any other attempted assignment or transfer by any party hereto shall be null and void). Nothing in this Agreement, expressed or implied, shall be construed

to confer upon any Person (other than the parties hereto, their respective successors and assigns permitted hereby, the Participants to the extent provided in paragraph (d) of this Section 11.7 and, to the extent expressly contemplated hereby, the Related Parties of each Credit Party) any legal or equitable right, remedy or claim under or by reason of this Agreement.

(b) Assignments by Lenders. Any Lender may at any time assign to one or more assignees all or a portion of its rights and obligations under this Agreement (including all or a portion of its Commitment and the Loans and obligations in respect of its Letter of Credit Exposure and Swing Line Exposure at the time owing to it); *provided* that any such assignment shall be subject to the following conditions:

(1) Minimum Amounts.

(A) in the case of an assignment of the entire remaining amount of the assigning Lender's Commitment Amount or Swing Line Commitment and the Loans and obligations in respect of its Letter of Credit Exposure and Swing Line Exposure at the time owing to it or in the case of an assignment to a Lender, an Affiliate of a Lender or an Approved Fund, no minimum amount need be assigned; and

(B) in any case not described in paragraph (b)(1)(A) of this Section 11.7, the Commitment Amount or Swing Line Commitment (which for this purpose includes the Loans of the assigning Lender outstanding thereunder and obligations in respect of its Letter of Credit Exposure and Swing Line Exposure at the time owing to it thereunder) or, if the Commitment or Swing Line Commitment of the assigning Lender is not then in effect, the principal outstanding balance of the Loans and the Letter of Credit Exposure and Swing Line Exposure of the assigning Lender subject to each such assignment (determined as of the date the Assignment and Assumption with respect to such assignment is delivered to the Administrative Agent or, if a "Trade Date" is specified in the Assignment and Assumption, as of such "Trade Date") shall not be less than $5,000,000, unless each of the Administrative Agent and, so long as no Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) has occurred and is continuing, the Borrower otherwise consents (each such consent not to be unreasonably withheld or delayed).

(2) Proportionate Amounts. Each partial assignment shall be made as an assignment of a proportionate part of all the assigning Lender's rights and obligations under this Agreement with respect to the Loans, Letter of Credit Exposure and Swing Line Exposure or the Commitment assigned, except that this clause (2) shall not prohibit any Lender from assigning all or a portion of its rights and obligations in respect of Competitive Bid Loans on a non-pro rata basis.

(3) Required Consents. No consent shall be required for any assignment except to the extent required by paragraph (b)(1)(B) of this Section 11.7 and, in addition:

(A) the consent of the Borrower (such consent not to be unreasonably withheld or delayed) shall be required unless (x) an Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) has occurred and is continuing at the time of such assignment or (y) such assignment is to a Lender, an Affiliate of a Lender or an Approved Fund (it being understood that it

shall not be deemed unreasonable for the Borrower to withhold consent to any assignment if it reasonably believes that such assignment would result in the Borrower incurring increased costs pursuant to Section 3.6 or Section 3.10);

(B) the consent of the Administrative Agent (such consent not to be unreasonably withheld, conditioned or delayed) shall be required for assignments in respect of an unfunded or revolving facility hereunder if such assignment is to a Person that is not a Lender with a Commitment in respect of such facility, an Affiliate of such Lender or an Approved Fund with respect to such Lender; and

(C) the consent of each Issuer (such consent not to be unreasonably withheld, conditioned or delayed) shall be required for any assignment that increases the obligation of the assignee to participate in exposure under one or more Letters of Credit (whether or not then outstanding) and the Swing Line Lender (such consent not to be unreasonably withheld or delayed) shall be required for any assignment in respect of the revolving facility hereunder.

(4) Assignment and Assumption. The parties to each assignment shall execute and deliver to the Administrative Agent an Assignment and Assumption, together with a processing and recordation fee of $4,500 ($7,500 in the case of an assignment by a Defaulting Lender) (which fee shall be paid by the assignor or the assignee and may be waived or reduced in the sole discretion of the Administrative Agent), and the assignee, if it is not a Lender, shall deliver to the Administrative Agent an Administrative Questionnaire.

(5) No Assignment to Certain Parties. No such assignment shall be made to (A) the Borrower, any of its Subsidiaries or any of their respective Affiliates, or (B) any Defaulting Lender or any of its Subsidiaries or any Person who, upon becoming a Lender hereunder, would constitute any of the foregoing Persons described in this clause (B).

(6) No Assignment to Natural Persons. No such assignment shall be made to a natural person (or a holding company, investment vehicle or trust for, or owned and operated by or for the primary benefit of a natural person).

(7) Certain Additional Payments. In connection with any assignment of rights and obligations of any Defaulting Lender hereunder, no such assignment shall be effective unless and until, in addition to the other conditions thereto set forth herein, the parties to the assignment shall make such additional payments to the Administrative Agent in an aggregate amount sufficient, upon distribution thereof as appropriate (which may be outright payment, purchases by the assignee of participations or subparticipations, or other compensating actions, including funding, with the consent of the Borrower and the Administrative Agent, the applicable pro rata share of Loans previously requested but not funded by the Defaulting Lender, to each of which the applicable assignee and assignor hereby irrevocably consent), to (x) pay and satisfy in full all payment liabilities then owed by such Defaulting Lender to the Administrative Agent, any Issuer or any Lender hereunder (and interest accrued thereon) and (y) acquire (and fund as appropriate) its full pro rata share of all Loans and participations in Letters of Credit and Swing Line Loans in accordance with its Commitment Percentage. Notwithstanding the foregoing, in the event that any assignment of rights and obligations of any Defaulting Lender hereunder shall become effective under applicable law without compliance with the provisions of this

clause (7), then the assignee of such interest shall be deemed to be a Defaulting Lender for all purposes of this Agreement until such compliance occurs.

Subject to acceptance and recording thereof by the Administrative Agent pursuant to paragraph (c) of this Section 11.7, from and after the effective date specified in each Assignment and Assumption, the assignee thereunder shall be a party to this Agreement and, to the extent of the interest assigned by such Assignment and Assumption, have the rights and obligations of a Lender under this Agreement, and the assigning Lender thereunder shall, to the extent of the interest assigned by such Assignment and Assumption, be released from its obligations under this Agreement (and, in the case of an Assignment and Assumption covering all of the assigning Lender's rights and obligations under this Agreement, such Lender shall cease to be a party hereto) but shall continue to be entitled to the benefits of Section 3.6, Section 3.7, and Section 11.10 with respect to facts and circumstances occurring prior to the effective date of such assignment. Any assignment or transfer by a Lender of rights or obligations under this Agreement that does not comply with this paragraph shall be treated for purposes of this Agreement as a sale by such Lender of a participation in such rights and obligations in accordance with paragraph (d) of this Section 11.7.

(c) Register. The Administrative Agent, acting solely for this purpose as an agent of the Borrower, shall maintain at one of its offices in the United States of America a copy of each Assignment and Assumption delivered to it and a register for the recordation of the names and addresses of the Lenders, and the Commitments of, and principal amounts (and stated interest) of the Loans owing to, each Lender pursuant to the terms hereof from time to time (the ***"Register"***). The entries in the Register shall be conclusive absent manifest error, and the Borrower, the Administrative Agent, the Issuers and the Lenders shall treat each Person whose name is recorded in the Register pursuant to the terms hereof as a Lender hereunder for all purposes of this Agreement, notwithstanding notice to the contrary. The Register shall be available for inspection by the Borrower, any Issuer and any Lender (but only, in the case of an Issuer or a Lender, at the Administrative Agent's Office and with respect to any entry relating to such Lender's Commitments, Advances and other obligations pursuant to the terms hereof or such Issuer's Letter of Credit Commitments and other obligations pursuant to the terms hereof, as applicable) at any reasonable time and from time to time upon reasonable prior notice.

(d) Participations. Any Lender may at any time, without the consent of, or notice to, the Borrower or the Administrative Agent, sell participations to any Person (other than a natural person (or a holding company, investment vehicle or trust for, or owned and operated by or for the primary benefit of a natural person), the Borrower, any of its Subsidiaries or any of their respective Affiliates) (each, a **"*Participant*"**) in all or a portion of such Lender's rights and/or obligations under this Agreement (including all or a portion of its Commitment, Letter of Credit Exposure, Swing Line Exposure and/or the Loans, Letter of Credit Exposure or Swing Line Exposure owing to it); *provided* that (i) all of such Lender's obligations under this Agreement and the other Loan Documents shall remain in all respects unchanged, (ii) such Lender shall remain solely responsible to the other parties hereto for the performance of such obligations and (iii) the Borrower, the Administrative Agent and each Credit Party shall continue to deal solely and directly with such Lender in connection with such Lender's rights and obligations under this Agreement. Any agreement or instrument pursuant to which a Lender sells such a participation shall provide that such Lender shall retain the sole right to enforce this Agreement and to approve any amendment, modification or waiver of any provision of this Agreement; *provided* that such agreement or instrument may provide that such Lender will not, without the consent of the Participant, agree to any amendment, modification or waiver which requires the consent of all Lenders or all affected Lenders that directly affects such Participant. Subject to paragraph (e) of this Section 11.7, the

Borrower agrees that each Participant shall be entitled to the benefits of Section 3.5, Section 3.6, Section 3.7 and Section 3.10 to the same extent as if it were a Lender and had acquired its interest by assignment pursuant to paragraph (b) of this Section 11.7. To the extent permitted by law, each Participant also shall be entitled to the benefits of Section 11.9(a) as though it were a Lender, *provided* that such Participant agrees to be subject to Section 11.9(b) as though it were a Lender. Each Lender that sells a participation with respect to a Commitment or Loan shall, solely for the purposes of complying with the rules regarding registered form in the Internal Revenue Code, act as a non-fiduciary agent of the Borrower, maintaining a register on which it enters the name and address of each Participant and the principal amounts (and stated interest amounts) of each Participant's interest in the Commitment and/or Loan (each a "***Participant Register***"), and the entries in such Participant Register shall be conclusive, absent manifest error, and such Lender shall treat each Person whose name is recorded in the Participant Register as the owner of such participation for all purposes of this Agreement notwithstanding any notice to the contrary. No Lender shall be required to disclose the existence of, or any of the information contained in, any Participant Register maintained by it to the Borrower or any other Person unless requested in writing by the Borrower, and only to the Internal Revenue Service to the extent such disclosure is required in order to comply with the rules requiring registered form pursuant to the Internal Revenue Code.

(e) Limitations upon Participant Rights. A Participant shall not be entitled to receive any greater payment under Section 3.6, Section 3.7 or Section 3.10 than the applicable Lender would have been entitled to receive with respect to the participation sold to such Participant, unless the sale of the participation to such Participant is made with the Borrower's prior written consent. A Participant shall not be entitled to the benefits of Section 3.10 unless the Borrower is notified of the participation sold to such Participant and such Participant agrees, for the benefit of the Borrower, to comply with Section 3.10(f) as though it were a Lender.

(f) Certain Pledges. Any Lender may at any time pledge or assign a security interest in all or any portion of its rights under this Agreement to secure obligations of such Lender, including any pledge or assignment to secure obligations to a Federal Reserve Bank or other central bank having jurisdiction over such Lender; *provided* that no such pledge or assignment shall release such Lender from any of its obligations hereunder or substitute any such pledgee or assignee for such Lender as a party hereto.

(g) Resignation as Issuer or Swing Line Lender after Assignment. Notwithstanding anything to the contrary contained herein, if at any time any Issuer or the Swing Line Lender assigns all of its Commitment and Loans pursuant to clause (b) above, such Issuer or Swing Line Lender may, (i) upon 30 days' notice to the Administrative Agent, the Borrower and the Lenders, resign as an Issuer and/or (ii) upon 30 days' notice to the Borrower, resign as Swing Line Lender. In the event of any such resignation as an Issuer or Swing Line Lender, the Borrower shall be entitled to appoint from among the Lenders a successor Issuer or Swing Line Lender hereunder; provided, however, that no failure by the Borrower to appoint any such successor shall affect the resignation of the applicable Issuer or Swing Line Lender as an Issuer or Swing Line Lender, as the case may be. If the applicable Issuer resigns as an Issuer, it shall retain all the rights, powers, privileges and duties of an Issuer hereunder with respect to all Letters of Credit issued by it and outstanding as of the effective date of its resignation as an Issuer and all Reimbursement Obligations with respect thereto (including the right to require the Lenders to make ABR Advances or fund risk participations in pursuant to Section 2.9). If the Swing Line Lender resigns as Swing Line Lender, it shall retain all the rights of the Swing Line Lender provided for hereunder with respect to Swing Line Loans made by it and outstanding as of the effective date of such resignation, including the right to require the Lenders to make ABR Advances or fund risk participations in outstanding

Swing Line Loans pursuant to Section 2.2. Upon the appointment of a successor Issuer and/or Swing Line Lender, (x) such successor shall succeed to and become vested with all of the rights, powers, privileges and duties of the retiring Issuer or Swing Line Lender, as the case may be, and (y) the successor Issuer shall issue letters of credit in substitution for the Letters of Credit, if any, outstanding at the time of such succession or make other arrangements satisfactory to the applicable retiring Issuer and the Borrower to effectively assume the obligations of the applicable retiring Issuer with respect to such Letters of Credit.

(h) Disqualified Institutions. (i) No assignment shall be made to any Person that was a Disqualified Institution as of the date (the "Trade Date") on which the applicable Lender entered into a binding agreement to sell and assign all or a portion of its rights and obligations under this Agreement to such Person (unless the Borrower has consented to such assignment in writing as otherwise contemplated by this Section 11.7, in which case such Person will not be considered a Disqualified Institution for the purpose of such assignment). For the avoidance of doubt, with respect to any assignee that becomes a Disqualified Institution after the applicable Trade Date (including as a result of the delivery of a notice pursuant to, and/or the expiration of the notice period referred to in, the definition of "Disqualified Institution"), (x) such assignee shall not retroactively be disqualified from becoming a Lender and (y) the execution and delivery by the Borrower of an Assignment and Assumption with respect to such assignee will not by itself result in such assignee no longer being considered a Disqualified Institution. Any assignment in violation of this clause (h)(i) shall not be void, but the other provisions of this clause (h) shall apply.

(ii) If any assignment is made to any Disqualified Institution without the Borrower's prior consent in violation of clause (i) above, or if any Person becomes a Disqualified Institution after the applicable Trade Date, the Borrower may, at its sole expense and effort, upon notice to the applicable Disqualified Institution and the Administrative Agent, (A) terminate any Commitment of such Disqualified Institution and repay all obligations of the Borrower owing to such Disqualified Institution in connection with such Commitment, and/or (B) require such Disqualified Institution to assign and delegate, without recourse (in accordance with and subject to the restrictions contained in this Section 11.7), all of its interest, rights and obligations under this Agreement and the other Loan Documents to an Eligible Assignee that shall assume such obligations at the lesser of (x) the principal amount thereof and (y) the amount that such Disqualified Institution paid to acquire such interests, rights and obligations, in each case plus accrued interest, accrued fees and all other amounts (other than principal amounts) payable to it hereunder and other the other Loan Documents.

(iii) Notwithstanding anything to the contrary contained in this Agreement, Disqualified Institutions (A) will not (x) have the right to receive information, reports or other materials provided to Lenders by the Borrower, the Administrative Agent or any other Lender, (y) attend or participate in meetings attended by the Lenders and the Administrative Agent, or (z) access any electronic site established for the Lenders or confidential communications from counsel to or financial advisors of the Administrative Agent or the Lenders and (B) (x) for purposes of any consent to any amendment, waiver or modification of, or any action under, and for the purpose of any direction to the Administrative Agent or any Lender to undertake any action (or refrain from taking any action) under this Agreement or any other Loan Document, each Disqualified Institution will be deemed to have consented in the same proportion as the Lenders that are not Disqualified Institutions consented to such matter, and (y) for purposes of voting on any

plan of reorganization or plan of liquidation pursuant to any bankruptcy or insolvency laws ("Plan of Reorganization"), each Disqualified Institution party hereto hereby agrees (1) not to vote on such Plan of Reorganization, (2) if such Disqualified Institution does vote on such Plan of Reorganization notwithstanding the restriction in the foregoing clause (1), such vote will be deemed not to be in good faith and shall be "designated" pursuant to Section 1126(e) of the United States Bankruptcy Code (or any similar provision in any other bankruptcy or insolvency laws), and such vote shall not be counted in determining whether the applicable class has accepted or rejected such Plan of Reorganization in accordance with Section 1126(c) of the United States Bankruptcy Code (or any similar provision in any other bankruptcy or insolvency laws) and (3) not to contest any request by any party for a determination by the bankruptcy court (or other applicable court of competent jurisdiction) effectuating the foregoing clause (2).

11.8 Counterparts; Electronic Execution of Assignments

(a) Counterparts. Each of the Loan Documents (other than the Notes) may be executed on any number of separate counterparts and all of said counterparts taken together shall be deemed to constitute one and the same agreement. It shall not be necessary in making proof of any Loan Document to produce or account for more than one counterpart signed by the party to be charged. A set of the copies of this Agreement signed by all of the parties hereto shall be lodged with each of the Borrower and the Administrative Agent. Delivery of an executed counterpart of a signature page of any Loan Document by fax or other electronic means (e.g., ".pdf" or ".tif") shall be effective as delivery of a manually executed counterpart of such Loan Document.

(b) Electronic Execution of Assignments and Certain Other Documents. The words "execution," "execute", "signed," "signature," and words of like import in or related to any document to be signed in connection with this Agreement and the transactions contemplated hereby (including without limitation Assignment and Assumptions, amendments or other modifications, Borrowing Requests, waivers and consents) shall be deemed to include electronic signatures, the electronic matching of assignment terms and contract formations on electronic platforms approved by the Administrative Agent, or the keeping of records in electronic form, each of which shall be of the same legal effect, validity or enforceability as a manually executed signature or the use of a paper-based recordkeeping system, as the case may be, to the extent and as provided for in any applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, the New York State Electronic Signatures and Records Act, or any other similar state laws based on the Uniform Electronic Transactions Act; provided that notwithstanding anything contained herein to the contrary the Administrative Agent is under no obligation to agree to accept electronic signatures in any form or in any format unless expressly agreed to by the Administrative Agent pursuant to procedures approved by it (it being acknowledged that the Administrative Agent will accept ".pdf" signatures).

11.9 Set-off and Sharing of Payments-

(a) In addition to any rights and remedies of the Lenders and the Issuers provided by law, after the occurrence and during the continuance of an Event of Default under Section 9.1(a) or Section 9.1(b) or upon the acceleration of the Loans, each Lender and each Issuer shall have the right, without prior notice to the Borrower, any such notice being expressly waived by the Borrower, to set-off and apply against any indebtedness or other liability, whether matured or unmatured, of the Borrower to such Lender or such Issuer arising under the Loan Documents, any amount owing from such Lender or such Issuer to the Borrower. To the extent permitted by applicable law, the aforesaid right of set-off may be exercised by such Lender or such Issuer against

the Borrower or against any trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors, receiver, or execution, judgment or attachment creditor of the Borrower, or against anyone else claiming through or against the Borrower or such trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors, receivers, or execution, judgment or attachment creditor, notwithstanding the fact that such right of set-off shall not have been exercised by such Lender or such Issuer prior to the making, filing or issuance of, service upon such Lender or such Issuer of, or notice to such Lender or such Issuer of, any petition, assignment for the benefit of creditors, appointment or application for the appointment of a receiver, or issuance of execution, subpoena, order or warrant. Each Lender and each Issuer agree promptly to notify the Borrower and the Administrative Agent after each such set-off and application made by such Lender or such Issuer, *provided* that the failure to give such notice shall not affect the validity of such set-off and application.

(b) If any Lender or any Issuer shall obtain any payment (whether voluntary, involuntary, through the exercise of any right of set-off, or otherwise) on account of its Loans or its Notes or the Reimbursement Obligations in excess of its pro rata share (in accordance with the outstanding principal balance of all Loans or the Reimbursement Obligations) of payments then due and payable on account of the Loans and Notes received by all the Lenders or the Reimbursement Obligations received by all Issuers, such Lender or such Issuer, as the case may be, shall forthwith purchase, without recourse, for cash, from the other Lenders or Issuers, as the case may be, such participations in their Loans and Notes or the Reimbursement Obligations as shall be necessary to cause such purchasing Lender or Issuer to share the excess payment with each of them according to their pro rata share (in accordance with the outstanding principal balance of all Loans and the Reimbursement Obligations); *provided* that if all or any portion of such excess payment is thereafter recovered from such purchasing Lender or Issuer, such purchase from each Lender or Issuer shall be rescinded and each such Lender and Issuer shall repay to the purchasing Lender or Issuer the purchase price to the extent of such recovery, together with an amount equal to such Lender's or Issuer's pro rata share (according to the proportion of (i) the amount of such Lender's or Issuer's required repayment to (ii) the total amount so recovered from the purchasing Lender or Issuer) of any interest or other amount paid or payable by the purchasing Lender or Issuer in respect of the total amount so recovered. The Borrower agrees, to the fullest extent permitted by law, that any Lender or Issuer so purchasing a participation from another Lender or Issuer pursuant to this Section 11.9 may exercise such rights to payment (including the right of set-off) with respect to such participation as fully as if such Lender or Issuer were the direct creditor of the Borrower in the amount of such participation. The provisions of this Section 11.9 shall not be construed to apply to (A) any payment made by or on behalf of the Borrower pursuant to and in accordance with the express terms of this Agreement (including the application of funds arising from the existence of a Defaulting Lender or Disqualified Institution), (y) the application of cash collateral as provided herein, or (z) any payment obtained by a Lender as consideration for the assignment of or sale of a participation in any of its Loans or subparticipations in Reimbursement Obligations or Swing Line Loans to any assignee or participant, other than an assignment to the Borrower or any Subsidiary thereof (as to which the provisions of this Section 11.9 shall apply).

11.10 Indemnity

(a) The Borrower shall indemnify each Credit Party and each Related Party thereof (each such Person being called an "***Indemnified Person***") against, and hold each Indemnified Person harmless from, any and all losses, claims, damages, liabilities and related expenses, including the reasonable and documented out-of-pocket fees and disbursements of one counsel (but excluding the allocated cost of internal counsel) representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction

(which may include a single counsel acting in multiple jurisdictions) (and, if reasonably necessary, one specialty counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Person)), actually incurred by any Indemnified Person arising out of, in connection with, or as a result of (i) the execution or delivery of any Loan Document or any agreement or instrument contemplated thereby, the performance by the parties to the Loan Documents of their respective obligations thereunder or the consummation of the transactions contemplated hereby or any other transactions contemplated thereby, (ii) any Loan or Letter of Credit or the use of the proceeds thereof, (iii) any actual or alleged presence or release of Hazardous Materials in, on, under or from any property owned or operated by the Borrower or any of the Subsidiaries, or any Environmental Liability related in any way to the Borrower or any of the Subsidiaries or (iv) any actual or prospective claim, litigation, investigation or proceeding relating to any of the foregoing, whether based on statute, contract, tort or any other theory and regardless of whether any Indemnified Person is a party thereto. Notwithstanding anything to the contrary contained in this Section 11.10(a), the foregoing indemnity will not, as to any Indemnified Person, apply to any losses, claims, damages, liabilities and related expenses to the extent arising (A) from the willful misconduct, gross negligence, fraud or bad faith of such Indemnified Person, (B) from a material breach of the obligations hereunder of such Indemnified Person, (C) out of or in connection with Section 11.22, or (D) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by an Indemnified Person against any other Indemnified Person (other than the Administrative Agent, a Joint Lead Arranger, Issuer or Swing Line Lender, in each case in its capacity as such), in each case under clauses (A) and (B), to the extent determined by a final and non-appealable judgment of a court of competent jurisdiction.

(b) To the extent that the Borrower fails to pay as soon as practicable any amount required to be paid by it to the Administrative Agent under subsection (a) of this Section 11.10 (the ***"Indemnified Amount"***), each Lender severally agrees to pay to the Administrative Agent an amount equal to the product of such unpaid amount *multiplied by* (i) at any time when no Loans are outstanding, its Commitment Percentage, and (ii) at any time when Loans are outstanding (x) if the Commitments then exist, its Commitment Percentage or (y) if the Commitments have been terminated or otherwise no longer exist, the percentage equal to the fraction, (A) the numerator of which is the sum of such Lender's Credit Exposure and (B) the denominator of which is the sum of the Aggregate Credit Exposure (in each case determined as of the time that the applicable Indemnified Amount is sought), *provided* that the Indemnified Amount was payable to the Administrative Agent in its capacity as such.

(c) The obligations of the Borrower and the Lenders under this Section 11.10 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

(d) If any settlement of any investigation, litigation or proceeding to which the indemnity in this Section 11.10 applies (any of the foregoing, a ***"Proceeding"***) is instituted or threatened against any Indemnified Person (or its Related Parties) in respect of which indemnity may be sought hereunder, unless an Event of Default under Section 9.1(a), 9.1(h), 9.1(i) or 9.1(j) exists, the Borrower shall be entitled to assume the defense thereof with counsel selected by the Borrower (which counsel shall be reasonably satisfactory to such Indemnified Person) and after

notice from the Borrower to such Indemnified Person of the Borrower's election so to assume the defense thereof, the Borrower will not be liable to such Indemnified Person hereunder for any legal or other expenses subsequently incurred by such Indemnified Person in connection with the defense thereof, other than reasonable and documented out-of-pocket costs of investigation and such other reasonable and documented out-of-pocket expenses as have been approved in advance; *provided*, that (i) if counsel for such Indemnified Person determines in good faith that there is a conflict that requires separate representation for the Borrower and such Indemnified Person or that there may be legal defenses available to such Indemnified Person which are different from or in addition to those available to the Borrower or (ii) the Borrower fails to assume or proceed in a timely and reasonable manner with the defense of such action or fails to employ counsel reasonably satisfactory to such Indemnified Person in any such action, then in either such event, (A) such Indemnified Person shall be entitled to one primary counsel and, if necessary, one local counsel to represent such Indemnified Person and all other Indemnified Persons similarly situated (such counsels selected by the Administrative Agent), (B) the Borrower shall not, or shall not any longer, be entitled to assume the defense thereof on behalf of such Indemnified Person and (C) such Indemnified Person shall be entitled to indemnification for the expenses (including fees and expenses of such counsel) to the extent provided in this Section 11.10. Notwithstanding the foregoing, the Borrower shall not be liable for any settlement, compromise or consent to the entry of any judgment in any action or Proceeding effected without the Borrower's prior written consent (which consent shall not be unreasonably withheld, conditioned or delayed, it being understood and agreed that the withholding, conditioning or delaying of the Borrower's consent in connection with a settlement, compromise or consent to the entry of any judgment in any action or proceeding which does not include an unconditional release of the Borrower and the Subsidiaries from all liability or claims that are the subject matter of such Proceeding or which includes a statement as to any admission of fault by or on behalf of the Borrower or any Subsidiary shall not be deemed unreasonable), but if settled with the Borrower's prior written consent or if there is a final judgment for the plaintiff in any such Proceeding, the Borrower agrees to indemnify and hold harmless each Indemnified Person from and against any and all losses, claims, damages, liabilities and expenses by reason of such settlement, compromise or consent to the entry of any judgment in any action or Proceeding in accordance with this Section 11.10. The Borrower shall not, without the prior written consent of an Indemnified Person, effect any settlement of any pending or threatened Proceeding against such Indemnified Person in respect of which indemnity could have been sought hereunder by such Indemnified Person unless such settlement (x) includes an unconditional release of such Indemnified Person from all liability or claims that are the subject matter of such Proceeding, (y) does not include any statement as to any admission of fault by or on behalf of such Indemnified Person and (z) contains customary confidentiality provisions with respect to the terms of such settlement.

(e) Notwithstanding any provision in this Agreement to the contrary, none of the Borrower, the Administrative Agent, the Lenders or any Affiliate of any of the foregoing will be responsible or liable to any Person or entity, on any theory of liability, for any indirect, special, punitive or consequential damages that may be alleged as a result of the transactions contemplated hereby or by the other Loan Documents or any use or intended use of the proceeds of the Loans; *provided* that nothing in this clause (e) shall limit the Borrower's indemnity obligations set forth in this Agreement with respect to any indirect, punitive or consequential damages included in any third party claim in connection with which an Indemnified Person is entitled to indemnification hereunder. In addition to, and without limiting the immediately foregoing sentence, and to the extent permitted by applicable law, the Borrower shall not assert, and hereby waives, any claim against any Indemnified Person, on any theory of liability, for special, indirect, consequential or punitive damages (as opposed to direct and actual damages) arising out of, in connection with, or as a result of, any Loan Document or any agreement, instrument or other document contemplated

thereby, the transactions contemplated hereby or any Loan or any Letter of Credit or the use of the proceeds thereof.

(f) Notwithstanding the above, the Borrower shall have no liability under this Section 11.10 to indemnify or hold harmless any Indemnified Person for any losses, claims, damages, liabilities and related expenses relating to income or withholding Taxes or any Tax in lieu of such Taxes. Notwithstanding the foregoing, any amounts claimed by an Indemnified Person under Section 11.5 shall not be available to be claimed by such Indemnified Person under this Section 11.10, it being understood and agreed that the rights of an Indemnified Person under this Section 11.10 and Section 11.5 shall not be duplicative.

11.11 Governing Law

The Loan Documents and the rights and obligations of the parties thereto shall be governed by, and construed and interpreted in accordance with, the laws of the State of New York.

11.12 Severability

Every provision of the Loan Documents is intended to be severable, and if any term or provision thereof shall be invalid, illegal or unenforceable for any reason, the validity, legality and enforceability of the remaining provisions thereof shall not be affected or impaired thereby, and any invalidity, illegality or unenforceability in any jurisdiction shall not affect the validity, legality or enforceability of any such term or provision in any other jurisdiction.

11.13 Integration

All exhibits to the Loan Documents shall be deemed to be a part thereof. Each Loan Document embodies the entire agreement and understanding between or among the parties thereto with respect to the subject matter thereof and supersedes all prior agreements and understandings between or among the parties thereto with respect to the subject matter thereof.

11.14 Treatment of Certain Information

(a) Each Credit Party agrees to maintain the confidentiality of the Information (as defined below), except that Information may be disclosed (i) to its Affiliates and to its and its Affiliates' respective partners, directors, officers, employees, agents, advisors and other representatives (it being understood that the Persons to whom such disclosure is made will be informed of the confidential nature of such Information and instructed to keep such Information confidential); *provided* that each Credit Party shall be responsible for its controlled Affiliates' compliance in keeping Information confidential, (ii) to the extent requested by any regulatory authority purporting to have jurisdiction over it (including any self-regulatory authority, such as the National Association of Insurance Commissioners) (in which case such Person agrees (except with respect to any audit or examination conducted by bank accountants or any governmental regulatory authority exercising examination or regulatory authority) to inform the Borrower promptly thereof prior to such disclosure to the extent practicable and not prohibited by law), (iii) to the extent required by applicable laws or regulations or by any subpoena or similar legal process (in which case such Person agrees to (except with respect to any audit or examination conducted by bank accountants or any governmental regulatory authority exercising examination or regulatory authority) to inform the Borrower promptly thereof prior to such disclosure to the extent practicable and not prohibited by law), (iv) to any other party hereto, (v) in connection with the exercise of any remedies hereunder or under any other Loan Document or any action or proceeding relating to this

Agreement or any other Loan Document or the enforcement of rights hereunder or thereunder, (vi) subject to an agreement containing provisions substantially the same as those of this Section 11.14, to (A) any assignee of or Participant in, or any prospective assignee of or Participant in, any of its rights or obligations under this Agreement or (B) any actual or prospective counterparty (or its advisors) to any swap or derivative transaction relating to the Borrower and its obligations, (vii) to Gold Sheets and other similar bank trade publications, such information to consist of deal terms and other information customarily found in such publications, (viii) with the prior written consent of the Borrower, (ix) to the extent such Information (1) becomes publicly available other than as a result of a breach of this Section 11.14 or a breach of any other confidentiality obligation owing by such Credit Party to the Borrower or (2) becomes available to the Administrative Agent, any Credit Party or any of their respective Affiliates on a non-confidential basis from a source other than the Borrower not known to such Credit Party to be prohibited from disclosing such Information, and (x) on a confidential basis to (i) any rating agency in connection with rating the Borrower or its Subsidiaries or the credit facilities provided hereunder or (ii) the CUSIP Service Bureau or any similar agency in connection with the application, issuance, publishing and monitoring of CUSIP numbers of other market identifiers with respect to the credit facilities provided hereunder. In addition, the Administrative Agent and the Lenders may disclose the existence of this Agreement and information about this Agreement to market data collectors, similar service providers to the lending industry and service providers to the Administrative Agent and the Lenders in connection with the administration of this Agreement, the other Loan Documents, and the Commitments.

(b) For purposes of this Section 11.14, ***"Information"*** means all information received from the Borrower or any of its Subsidiaries relating to the Borrower or any of its Subsidiaries or any of their respective businesses, other than any such information that is available to the Administrative Agent or any other Credit Party on a non-confidential basis prior to disclosure by the Borrower or any of its Subsidiaries.

11.15 Acknowledgments

The Borrower acknowledges that (a) it has been advised by counsel in the negotiation, execution and delivery of the Loan Documents, (b) by virtue of the Loan Documents, the relationship among the Administrative Agent, the Issuers and the Lenders, on the one hand, and the Borrower, on the other hand, is solely that of debtor and creditor, and (c) by virtue of the Loan Documents, no joint venture exists among the Lenders or among the Borrower and the Lenders.

11.16 Consent to Jurisdiction

Each of the parties hereto irrevocably submits to the exclusive jurisdiction of any New York State or Federal Court sitting in the City of New York, Borough of Manhattan, over any suit, action, claim, counterclaim or proceeding arising out of or relating to the Loan Documents. EACH OF THE PARTIES HERETO IRREVOCABLY WAIVES, TO THE FULLEST EXTENT PERMITTED BY LAW, ANY OBJECTION WHICH IT MAY NOW OR HEREAFTER HAVE TO THE LAYING OF THE VENUE OF ANY SUCH SUIT, ACTION, CLAIM, COUNTERCLAIM OR PROCEEDING BROUGHT IN SUCH A COURT AND ANY CLAIM THAT ANY SUCH SUIT, ACTION, CLAIM, COUNTERCLAIM OR PROCEEDING BROUGHT IN SUCH A COURT HAS BEEN BROUGHT IN AN INCONVENIENT FORUM.Each of the parties hereto agrees that a final judgment in any such suit, action, claim, counterclaim or proceeding brought in such a court, after all appropriate appeals, shall be conclusive and binding upon it.

11.17 Service of Process

Each of the parties hereto agrees that process may be served against it in any suit, action or proceeding referred to in Section 11.16 by sending the same by first class mail, return receipt requested or by overnight courier service, with receipt acknowledged, to the address of such party set forth or referred to in Section 11.2. Each of the parties hereto agrees that any such service (i) shall be deemed in every respect effective service of process upon it in any such suit, action, or proceeding, and (ii) shall to the fullest extent enforceable by law, be taken and held to be valid personal service upon and personal delivery to it.

11.18 No Limitation on Service or Suit

Nothing in the Loan Documents or any modification, waiver, or amendment thereto shall affect the right of the Administrative Agent, any Issuer or any Lender to serve process in any manner permitted by law or limit the right of the Administrative Agent, any Issuer or any Lender to bring proceedings against the Borrower in the courts of any jurisdiction or jurisdictions.

11.19 WAIVER OF TRIAL BY JURY

EACH OF THE CREDIT PARTIES AND THE BORROWER KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION ARISING OUT OF, UNDER OR IN CONNECTION WITH THE LOAN DOCUMENTS OR THE TRANSACTIONS CONTEMPLATED THEREBY. FURTHER, THE BORROWER HEREBY CERTIFIES THAT NO REPRESENTATIVE OR AGENT OF ANY OF THE CREDIT PARTIES, OR COUNSEL TO ANY OF THE CREDIT PARTIES, HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT ANY OF THE CREDIT PARTIES WOULD NOT, IN THE EVENT OF SUCH LITIGATION, SEEK TO ENFORCE THIS WAIVER OF RIGHT TO JURY TRIAL PROVISION. THE BORROWER ACKNOWLEDGES THAT THE CREDIT PARTIES HAVE BEEN INDUCED TO ENTER INTO THIS AGREEMENT BY, *INTER ALIA*, THE PROVISIONS OF THIS SECTION 11.19.

11.20 Patriot Act Notice

Each Lender and the Administrative Agent (for itself and not on behalf of any Lender) hereby notifies the Borrower that pursuant to the requirements of the USA PATRIOT Act (Title III of Pub. L. 107-56 (signed into law October 26, 2001), as amended from time to time) (the ***"Patriot Act"***), it is required to obtain, verify and record information that identifies the Borrower, which information includes the name and address of the Borrower and other information that will allow such Lender or the Administrative Agent, as applicable, to identify the Borrower in accordance with the Patriot Act.

11.21 No Fiduciary Duty

The Borrower agrees that in connection with all aspects of the transactions contemplated hereby and any communications in connection therewith, the Borrower and its Subsidiaries, on the one hand, and the Credit Parties, the Joint Lead Arrangers named on the cover page hereof, and their respective Affiliates, on the other hand, will have a business relationship that does not create, by implication or otherwise, any fiduciary duty on the part of the Credit Parties or such Joint Lead Arrangers, or their respective Affiliates, and no such duty will be deemed to have arisen in connection with any such transactions or communications.

11.22 Acknowledgement and Consent to Bail-In of EEA Financial Institutions

Notwithstanding anything to the contrary in any Loan Document or in any other agreement, arrangement or understanding among any such parties, each party hereto acknowledges that any liability of any Lender or Issuer that is an EEA Financial Institution arising under any Loan Document, to the extent such liability is unsecured, may be subject to the Write-Down and Conversion Powers of an EEA Resolution Authority and agrees and consents to, and acknowledges and agrees to be bound by:

(a) the application of any Write-Down and Conversion Powers by an EEA Resolution Authority to any such liabilities arising hereunder which may be payable to it by any Lender or Issuer that is an EEA Financial Institution; and

(b) the effects of any Bail-in Action on any such liability, including, if applicable:

(i) a reduction in full or in part or cancellation of any such liability;

(ii) a conversion of all, or a portion of, such liability into shares or other instruments of ownership in such EEA Financial Institution, its parent entity, or a bridge institution that may be issued to it or otherwise conferred on it, and that such shares or other instruments of ownership will be accepted by it in lieu of any rights with respect to any such liability under this Agreement or any other Loan Document; or

(iii) the variation of the terms of such liability in connection with the exercise of the Write-Down and Conversion Powers of any EEA Resolution Authority.

11.23 Certain ERISA Matters

(a) Each Lender (x) represents and warrants, as of the date such Person became a Lender party hereto, to, and (y) covenants, from the date such Person became a Lender party hereto to the date such Person ceases being a Lender party hereto, for the benefit of, the Administrative Agent and the Joint Lead Arrangers and not, for the avoidance of doubt, to or for the benefit of the Borrower, that at least one of the following is and will be true:

(i) such Lender is not using "plan assets" (within the meaning of Section 3(42) of ERISA or otherwise) of one or more Benefit Plans with respect to such Lender's entrance into, participation in, administration of and performance of the Loans, the Letters of Credit, the Commitments or this Agreement,

(ii) the transaction exemption set forth in one or more PTEs, such as PTE 84-14 (a class exemption for certain transactions determined by independent qualified professional asset managers), PTE 95-60 (a class exemption for certain transactions involving insurance company general accounts), PTE 90-1 (a class exemption for certain transactions involving insurance company pooled separate accounts), PTE 91-38 (a class exemption for certain transactions involving bank collective investment funds) or PTE 96-23 (a class exemption for certain transactions determined by in-house asset managers), is applicable with respect to such Lender's entrance into, participation in, administration of and performance of the Loans, the Letters of Credit, the Commitments and this Agreement,

(iii) (A) such Lender is an investment fund managed by a "Qualified Professional Asset Manager" (within the meaning of Part VI of PTE 84-14), (B) such Qualified Professional Asset Manager made the investment decision on behalf of such

Lender to enter into, participate in, administer and perform the Loans, the Letters of Credit, the Commitments and this Agreement, (C) the entrance into, participation in, administration of and performance of the Loans, the Letters of Credit, the Commitments and this Agreement satisfies the requirements of sub-sections (b) through (g) of Part I of PTE 84-14 and (D) to the best knowledge of such Lender, the requirements of subsection (a) of Part I of PTE 84-14 are satisfied with respect to such Lender's entrance into, participation in, administration of and performance of the Loans, the Letters of Credit, the Commitments and this Agreement, or

(iv) such other representation, warranty and covenant as may be agreed in writing between the Administrative Agent, in its sole discretion, and such Lender.

(b) In addition, unless either (1) sub-clause (i) in the immediately preceding clause (a) is true with respect to a Lender or (2) a Lender has provided another representation, warranty and covenant in accordance with sub-clause (iv) in the immediately preceding clause (a), such Lender further (x) represents and warrants, as of the date such Person became a Lender party hereto, to, and (y) covenants, from the date such Person became a Lender party hereto to the date such Person ceases being a Lender party hereto, for the benefit of, the Agents and the Joint Lead Arrangers and not, for the avoidance of doubt, to or for the benefit of the Borrower, that the Administrative Agent is not a fiduciary with respect to the assets of such Lender involved in such Lender's entrance into, participation in, administration of and performance of the Loans, the Letters of Credit, the Commitments and this Agreement (including in connection with the reservation or exercise of any rights by the Administrative Agent under this Agreement, any Loan Document or any documents related hereto or thereto).

(c) For purposes of this Section 11.23, the following defined terms when used herein have the following meanings:

"Benefit Plan" means any of (a) an "employee benefit plan" (as defined in ERISA) that is subject to Title I of ERISA, (b) a "plan" as defined in Section 4975 of the Internal Revenue Code or (c) any Person whose assets include (for purposes of ERISA Section 3(42) or otherwise for purposes of Title I of ERISA or Section 4975 of the Internal Revenue Code) the assets of any such "employee benefit plan" or "plan".

"PTE" means a prohibited transaction class exemption issued by the U.S. Department of Labor, as any such exemption may be amended from time to time.

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AS EVIDENCE of the agreement by the parties hereto to the terms and conditions herein contained, each such party has caused this Agreement to be executed on its behalf.

CVS HEALTH CORPORATION

By: /s/ CAROL A. DENALE
Name: Carol A. DeNale
Title: Senior Vice President and Treasurer

BANK OF AMERICA, N.A., as
Administrative Agent,

By: /s/ KYLE D HARDING
Name: Kyle D Harding
Title: AVP

BANK OF AMERICA, N.A., as an Issuer, the
Swing Line Lender and a Lender

By: /s/ DARREN MERTEN
Name: Darren Merten
Title: Vice President

BARCLAYS BANK PLC, as an Issuer and a Lender

By: /s/ RITAM BHALLA
Name: Ritam Bhalla
Title: Director

GOLDMAN SACHS BANK USA, as an Issuer
and a Lender

By: /s/ ANNIE CARR
Name: Annie Carr
Title: Authorized Signatory

JPMORGAN CHASE BANK, N. A., as an
Issuer and a Lender

By: /s/ VANESSA CHIU
Name: Vanessa Chiu
Title: Executive Director

WELLS FARGO BANK, NATIONAL ASSOCIATION, as an Issuer and a Lender

By: /s/ JORDAN HARRIS
Name: Jordan Harris
Title: Director

CVS HEALTH CORPORATION
FIVE YEAR CREDIT AGREEMENT

CITIBANK, N.A., as a Lender

By: /s/ ALEJANDRO E. ROMERO
Name: Alejandro E. Romero
Title: Vice President

MIZUHO BANK, LTD., as a Lender

By: /s/ TRACY RAHN
Name: Tracy Rahn
Title: Authorized Signatory

MUFG BANK, LTD., as a Lender

By: /s/ JACK LONKER
Name: Jack Lonker
Title: Director

ROYAL BANK OF CANADA, as a Lender

By: /s/ GORDON MACARTHUR
Name: Gordon MacArthur
Title: Authorized Signatory

SUNTRUST BANK, as a Lender

By: /s/ STEVE CURRAN
Name: Steve Curran
Title: Director

U.S. BANK NATIONAL ASSOCIATION, as
a Lender

By: /s/ JOYCE P. DORSETT
Name: Joyce P. Dorsett
Title: Senior Vice President

CREDIT SUISSE AG, CAYMAN ISLANDS BRANCH, as a Lender

By: /s/ WILLIAM O'DALY
Name: William O'Daly
Title: Authorized Signatory

By: /s/ ANDREW GRIFFIN
Name: Andrew Griffin
Title: Authorized Signatory

FIFTH THIRD BANK, as a Lender

By: /s/ TODD S. ROBINSON
Name: Todd S. Robinson
Title: VP

PNC BANK, NATIONAL ASSOCIATION,
as a Lender

By: /s/ MICHAEL RICHARDS
Name: Michael Richards
Title: SVP, Managing Director

SANTANDER BANK N.A., as a Lender

By: /s/ XAVIER RUIZ SENA
Name: Xavier Ruiz Sena
Title: Managing Director

SUMITOMO MITSUI BANKING CORPORATION, as a Lender

By: /s/ MICHAEL MAGUIRE
Name: Michael Maguire
Title: Executive Director

BANK OF CHINA, NEW YORK BRANCH,
as a Lender

By: /s/ RAYMOND QIAO
Name: Raymond Qiao
Title: Vice Executive President

INDUSTRIAL AND COMMERCIAL BANK OF CHINA LIMITED, NEW YORK BRANCH, as a Lender

By: /s/ HSIWEI CHEN
Name: Hsiwei Chen
Title: Director

By: /s/ PINYEN SHIH
Name: Pinyen Shih
Title: Executive Director

KEYBANK NATIONAL ASSOCIATION, as
a Lender

By: /s/ MARIANNE T. MEIL
Name: Marianne T. Meil
Title: Senior Vice President

TD BANK, N.A., as a Lender

By: /s/ UK-SUN KIM
Name: Uk-Sun Kim
Title: Senior Vice President

THE BANK OF NEW YORK MELLON, as a Lender

By: /s/ CLIFFORD A. MULL
Name: Clifford A. Mull
Title: Director

CVS 364-Day Credit Agreement 2019

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Exhibit 10.1
EXECUTION VERSION

364-DAY CREDIT AGREEMENT

by and among

CVS HEALTH CORPORATION,

THE LENDERS PARTY HERETO,

GOLDMAN SACHS BANK USA, and
WELLS FARGO BANK, NATIONAL ASSOCIATION,
as Co-Syndication Agents,

BARCLAYS BANK PLC and JPMORGAN CHASE BANK, N.A.,
as Co-Documentation Agents,

and

BANK OF AMERICA, N.A.,
as Administrative Agent

Dated as of May 16, 2019

BOFA SECURITIES, INC.,
BARCLAYS BANK PLC, GOLDMAN SACHS BANK USA,
JPMORGAN CHASE BANK, N.A.,
and
WELLS FARGO SECURITIES, LLC,
as Joint Lead Arrangers and Joint Bookrunners

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EXHIBITS

Exhibit A List of Commitments
Exhibit B Form of Note
Exhibit C Form of Borrowing Request
Exhibit D 1 Form of Opinion of Counsel to the Borrower
Exhibit D 2 Form of Opinion of Special Counsel to the Borrower
Exhibit E Form of Assignment and Assumption
Exhibit F Form of Competitive Bid Request
Exhibit G Form of Invitation to Bid
Exhibit H Form of Competitive Bid
Exhibit I Form of Competitive Bid Accept/Reject Letter
Exhibit J [reserved]
Exhibit K Form of Commitment Increase Supplement

364-DAY CREDIT AGREEMENT, dated as of May 16, 2019, by and among ***CVS HEALTH CORPORATION***, a Delaware corporation (the ***"Borrower"***), the lenders party hereto from time to time (each a ***"Lender"*** and, collectively, the ***"Lenders"***), ***GOLDMAN SACHS BANK USA*** **("*GS*"),** and ***WELLS FARGO BANK, NATIONAL ASSOCIATION*** (***"Wells Fargo")***, as co-syndication agents (in such capacity, each a ***"Co-Syndication Agent"*** and, collectively, the ***"Co-Syndication Agents"***), ***BARCLAYS BANK PLC*** (***"Barclays")*** and ***JPMORGAN CHASE BANK, N.A.***, (***"JPMC"***), as co-documentation agents (in such capacity, each a "***Co-Documentation Agent***" and, collectively, the "***Co-Documentation Agents***"), and ***BANK OF AMERICA, N.A.***, as administrative agent for the Lenders (in such capacity, together with its successors and assigns, the "***Administrative Agent***").

1. DEFINITIONS AND PRINCIPLES OF CONSTRUCTION

1.1 Definitions

When used in any Loan Document (as defined below), each of the following terms shall have the meaning ascribed thereto unless the context otherwise specifically requires:

"ABR Advances": the Revolving Credit Loans (or any portions thereof) at such time as they (or such portions) are made or are being maintained at a rate of interest based upon the Alternate Base Rate.

"***Acquisition Debt***": any Indebtedness incurred by the Borrower or any of its Subsidiaries for the purpose of financing, in whole or in part, a Material Acquisition and any related transactions or series of related transactions (including for the purpose of refinancing or replacing all or a portion of any pre-existing Indebtedness of the Person(s) or assets to be acquired), which Indebtedness is redeemable or prepayable if such Material Acquisition is not consummated.

"Accumulated Funding Deficiency": as defined in Section 304 of ERISA.

"Administrative Agent": as defined in the preamble.

"***Administrative Agent's Office***": the Administrative Agent's address and, as appropriate, account as set forth in Section 11.2, or such other address or account as the Administrative Agent may from time to time notify to the Borrower and the Lenders.

"Administrative Questionnaire": an Administrative Questionnaire in a form supplied by the Administrative Agent.

"Affected Advance": as defined in Section 3.8(b).

"Affiliate": with respect to any Person at any time and from time to time, any other Person (other than a wholly-owned subsidiary of such Person) which, at such time (a) controls such Person, (b) is controlled by such Person or (c) is under common control with such Person. The term "control", as used in this definition with respect to any Person, means the power, whether direct or indirect through one or more intermediaries, to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting securities or other interests, by contract or otherwise.

"Agent Parties": as defined in Section 11.2(d).

"Aggregate Commitment Amount": at any time, the sum of the Commitment Amounts of the Lenders at such time under this Agreement. The Aggregate Commitment Amount on the Effective Date is $1,000,000,000.

"Aggregate Credit Exposure": at any time, the sum at such time of (a) the aggregate Committed Credit Exposure of the Lenders at such time and (b) the aggregate outstanding principal balance of all Competitive Bid Loans at such time.

"Agreement": this 364-Day Credit Agreement, as the same may be amended, amended and restated, supplemented or otherwise modified from time to time.

"Alternate Base Rate": for any day, a fluctuating rate per annum equal to the highest of (a) the Federal Funds Effective Rate plus 1/2 of 1% (b) the rate of interest in effect for such day as publicly announced from time to time by Bank of America as its "prime rate", and (c) the One Month LIBOR Rate in effect on such day plus 1.00%. The "prime rate" is a rate set by BofA based upon various factors including BofA's costs and desired return, general economic conditions and other factors, and is used as a reference point for pricing some loans, which may be priced at, above, or below such announced rate. Any change in such prime rate announced by BofA shall take effect at the opening of business on the day specified in the public announcement of such change. If the Alternate Base Rate is being used as an alternate rate of interest pursuant to Section 3.8 hereof, then the Alternate Base Rate shall be the greater of clauses (a) and (b) above and shall be determined without reference to clause (c) above.

"Anti-Corruption Laws": all laws, rules, and regulations of any jurisdiction applicable to the Borrower or the Subsidiaries from time to time concerning or relating to bribery or corruption.

"Applicable Margin": (i) with respect to the unpaid principal balance of ABR Advances, the applicable percentage set forth below in the column entitled "ABR Advances", (ii) with respect to the unpaid principal balance of Eurodollar Advances, the applicable percentage set forth below in the column entitled "Eurodollar Advances", and (iii) with respect to the Facility Fee, the applicable percentage set forth below in the column entitled "Facility Fee", in each case opposite the applicable Pricing Level:

Pricing Level	**ABR Advances**	**Eurodollar Advances**	**Facility Fee**
Pricing Level I	0.000%	0.700%	0.050%
Pricing Level II	0.000%	0.815%	0.060%
Pricing Level III	0.000%	0.930%	0.070%
Pricing Level IV	0.035%	1.035%	0.090%
Pricing Level V	0.140%	1.140%	0.110%
Pricing Level VI	0.350%	1.350%	0.150%

Decreases in the Applicable Margin resulting from a change in Pricing Level shall become effective upon the delivery by the Borrower to the Administrative Agent of a notice pursuant to Section 7.7(d). Increases in the Applicable Margin resulting from a change in Pricing Level shall become effective on the effective date of any downgrade or withdrawal in the rating by Moody's or S&P of the senior unsecured long term debt rating of the Borrower.

"Approved Fund": any Person (other than a natural person) that is (or will be) engaged in making, purchasing, holding or otherwise investing in commercial loans and similar extensions of credit in the ordinary course of its business that is administered or managed by (a) a Lender, (b) an Affiliate of a Lender or (c) an entity or an Affiliate of an entity that administers or manages a Lender.

"Assignment and Assumption": an assignment and assumption entered into by a Lender and an assignee (with the consent of any party whose consent is required by Section 11.7(b)), and accepted by the Administrative Agent, substantially in the form of Exhibit E or any other form (including electronic documentation generated by use of an electronic platform) approved by the Administrative Agent.

"***Authorized Officer***": the chief executive officer, president, chief financial officer, treasurer, assistant treasurer or controller of the Borrower, solely for purposes of the delivery of incumbency certificates pursuant to Section 5.1, the secretary or any assistant secretary of the Borrower and, solely for purposes of notices given to Sections 2.3 and 3.3, any other officer or employee of the Borrower so designated by any of the foregoing officers in a notice to the Administrative Agent. Any document delivered hereunder that is signed by an Authorized Officer shall be conclusively presumed to have been authorized by all necessary corporate, partnership and/or other action on the part of the Borrower and such Authorized Officer shall be conclusively presumed to have acted on behalf of the Borrower.

"Bail-In Action": the exercise of any Write-Down and Conversion Powers by the applicable EEA Resolution Authority in respect of any liability of an EEA Financial Institution.

"Bail-In Legislation": with respect to any EEA Member Country implementing Article 55 of Directive 2014/59/EU of the European Parliament and of the Council of the European Union, the implementing law for such EEA Member Country from time to time which is described in the EU Bail-In Legislation Schedule.

"Barclays": as defined in the preamble.

"BAS": BofA Securities, Inc.

"***Beneficial Ownership Certification***": a certification regarding beneficial ownership required by the Beneficial Ownership Regulation.

"***Beneficial Ownership Regulation***": 31 C.F.R. § 1010.230.

"Benefit Plan": as defined in Section 11.23(c).

"BofA": means Bank of America, N.A. and its successors.

"Borrower": as defined in the preamble.

"Borrower Materials": as defined in Section 7.7.

"Borrowing Date": (i) in respect of Revolving Credit Loans, any Domestic Business Day or Eurodollar Business Day, as the case may be, on which the Lenders shall make Revolving Credit Loans pursuant to a Borrowing Request, and (ii) in respect of Competitive Bid Loans, any Domestic Business Day on which a Lender shall make a Competitive Bid Loan pursuant to a Competitive Bid Request.

"Borrowing Request": a request for Revolving Credit Loans substantially in the form of Exhibit C or such other form as may be approved by the Administrative Agent, including any form on an electronic platform or electronic transmission system as shall be approved by the Administrative Agent, appropriately completed and signed by an Authorized Officer of the Borrower.

"Change of Control": any of the following:

(i) any Person or group (as such term is used in Section 13(d)(3) of the Securities Exchange Act of 1934, as amended), (a) shall have or acquire beneficial ownership of securities having 35% or more of the ordinary voting power of the Borrower or (b) shall possess, directly or indirectly, the power to direct or cause the direction of the management and policies of the Borrower, whether through the ownership of voting securities, by contract or otherwise; or

(ii) the Continuing Directors shall cease for any reason to constitute a majority of the board of directors of the Borrower then in office.

"***Co-Documentation Agent***" and "Co-Documentation Agents": as defined in the preamble.

"***Co-Syndication Agent***" and "Co-Syndication Agents": as defined in the preamble.

"Commitment": in respect of any Lender, such Lender's undertaking to make Revolving Credit Loans, subject to the terms and conditions hereof, in an aggregate outstanding principal amount not to exceed the Commitment Amount of such Lender.

"Commitment Amount": at any time and with respect to any Lender, the amount set forth adjacent to such Lender's name under the heading "Commitment Amount" in Exhibit A at such time or, in the event that such Lender is not listed on Exhibit A, the "Commitment Amount" which such Lender shall have assumed from another Lender in accordance with Section 11.7 on or prior to such time, as the same may be adjusted from time to time pursuant to Section 2.6 and Section 11.7.

"Commitment Increase Supplement": a Commitment Increase Supplement substantially in the form of Exhibit K.

"Commitment Percentage": at any time and with respect to any Lender, a fraction (expressed as a percentage carried out to the ninth decimal place) the numerator of which is such Lender's Commitment Amount at such time, and the denominator of which is the Aggregate Commitment Amount at such time; *provided* that in the event the Commitments shall have expired or otherwise terminated or been terminated, then Commitment Percentage shall be determined immediately prior thereto.

"Commitment Period": the period commencing on the Effective Date and ending on the Commitment Termination Date or on such earlier date as all of the Commitments shall have been terminated in accordance with the terms hereof.

"Commitment Termination Date": the earlier of (i) May 14, 2020 (subject to extension as provided in Section 2.12) and (ii) the date on which the Loans shall become due and payable, whether by acceleration, notice of intention to prepay or otherwise.

"Committed Credit Exposure": with respect to any Lender at any time, the sum at such time of the outstanding principal balance of such Lender's Revolving Credit Loans.

"Compensatory Interest Payment": as defined in Section 3.4(c).

"Competitive Bid": an offer by a Lender, substantially in the form of Exhibit H, to make one or more Competitive Bid Loans.

"Competitive Bid Accept/Reject Letter": a notification made by the Borrower pursuant to Section 2.4(d) substantially in the form of Exhibit I.

"Competitive Bid Loan": as defined in Section 2.4(a).

"Competitive Bid Rate": as to any Competitive Bid made by a Lender pursuant to Section 2.4(b), the fixed rate of interest (which shall be expressed in the form of a decimal to no more than four decimal places) offered by such Lender with respect thereto.

"Competitive Bid Request": a request by the Borrower, substantially in the form of Exhibit F, for Competitive Bids.

"Competitive Interest Period": as to any Competitive Bid Loan, the period commencing on the date of such Competitive Bid Loan and ending on the date requested in the Competitive Bid Request with respect thereto, which shall not be earlier than 3 days after the date of such Competitive Bid Loan or later than 180 days after the date of such Competitive Bid Loan; *provided* that if any Competitive Interest Period would end on a day other than a Domestic Business Day, such Competitive Interest Period shall be extended to the next succeeding Domestic Business Day, unless such next succeeding Domestic Business Day would be a date on or after the Commitment Termination Date, in which case such Competitive Interest Period shall end on the next preceding Domestic Business Day. Interest shall accrue from and including the first day of a Competitive Interest Period to but excluding the last day of such Competitive Interest Period.

"Consolidated": the Borrower and the Subsidiaries on a consolidated basis in accordance with GAAP.

"Contingent Obligation": as to any Person (the *"**secondary obligor**"*), any obligation of such secondary obligor (a) guaranteeing or in effect guaranteeing any return on any investment made by another Person, or (b) guaranteeing or in effect guaranteeing any Indebtedness, lease, dividend or other obligation (*"**primary obligation**"*) of any other Person (the *"**primary obligor**"*) in any manner, whether directly or indirectly, including any obligation of such secondary obligor, whether or not contingent, (i) to purchase any such primary obligation or any Property constituting direct or indirect security therefor, (ii) to advance or supply funds (A) for the purchase or payment of any such primary obligation or (B) to maintain working capital or equity capital of the primary obligor or otherwise to maintain the net worth or solvency of the primary obligor, (iii) to purchase Property, securities or services primarily for the purpose of assuring the beneficiary of any such primary obligation of the ability of the primary obligor to make payment of such primary obligation, (iv) otherwise to assure or hold harmless the beneficiary of such primary obligation against loss in respect thereof, and (v) in respect of the Indebtedness of any partnership in which such secondary obligor is a general partner, except to the extent that such Indebtedness of such partnership is nonrecourse to such secondary obligor and its separate Property; *provided* that the term *"**Contingent Obligation**"* shall not include the indorsement of instruments for deposit or collection in the ordinary course of business.

"Continuing Director": any member of the board of directors of the Borrower (i) who is a member of that board of directors on the Effective Date, (ii) who was nominated for election by the board of directors a majority of whom were directors on the Effective Date or (iii) whose election or nomination for election was approved by one or more of such directors.

"Control Person": as defined in Section 3.6.

"Convert", ***"Conversion"*** and ***"Converted"***: each, a reference to a conversion pursuant to Section 3.3 of one Type of Revolving Credit Loan into the other Type of Revolving Credit Loan.

"Costs": as defined in Section 3.6.

"Credit Exposure": with respect to any Lender at any time, the sum at such time of (a) the Committed Credit Exposure of such Lender at such time and (b) the outstanding principal balance of all Competitive Bid Loans of such Lender at such time.

"Credit Parties": the Administrative Agent and the Lenders.

"Default": any of the events specified in Section 9.1, whether or not any requirement for the giving of notice, the lapse of time, or both, or any other condition, has been satisfied.

"***Defaulting Lender***": any Lender, as reasonably determined by the Administrative Agent, that has (a) failed to fund any portion of its Loans within two Domestic Business Days of the date required to be funded by it hereunder, unless such Lender notifies the Administrative Agent and the Borrower in writing that such failure is the result of such Lender's determination that one or more conditions precedent to funding (each of which conditions precedent, together with any applicable default, shall be specifically identified in such writing) has not been satisfied, (b) notified the Borrower or any Credit Party in writing that it does not intend to comply with any of its funding obligations under this Agreement or has made a public statement to the effect that it does not intend to comply with its funding obligations under this Agreement or generally under other agreements in which it commits to extend credit, unless such writing or public statement relates to such Lender's obligation to fund a Loan hereunder and states that such position is based on such Lender's determination that a condition precedent to funding (which condition precedent, together with any applicable default, shall be specifically identified in such writing or public statement) cannot be satisfied, (c) failed, two Domestic Business Days after written request by the Administrative Agent (based on the reasonable belief that it may not fulfill its funding obligation), to confirm that it will comply with the terms of this Agreement relating to its obligations to fund prospective Loans; *provided* that such Lender shall cease to be a Defaulting Lender under this clause (c) upon receipt by the Administrative Agent of such confirmation, (d) otherwise failed to pay over to the Administrative Agent or any other Lender any other amount required to be paid by it hereunder within two Domestic Business Days of the date when due, unless the subject of a good faith dispute, or (e) (i) becomes or is insolvent or has a parent company that has become or is insolvent, (ii) becomes the subject of a bankruptcy or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment or has a parent company that has become the subject of a bankruptcy or insolvency proceeding, or has had a receiver, interim receiver, receiver and manager, administrator, liquidator, conservator, trustee or custodian appointed for it, or has taken any action in furtherance of, or indicating its consent to, approval of or acquiescence in any such proceeding or appointment, or (iii) becomes, or has a parent company that becomes, the subject of a Bail-in Action, *provided* that a Lender shall not qualify as a Defaulting Lender solely as a result of the acquisition or maintenance of an ownership interest in such Lender or its parent company, or of the exercise of control over such Lender or any Person controlling such Lender, by a Governmental Authority or instrumentality thereof so long as such ownership interest does not result in or provide such Lender with immunity from the jurisdiction of courts within the United States of America or from the enforcement of judgments or writs of attachment on its assets or permit such Lender (or such Governmental Authority) to reject, repudiate, disavow or disaffirm any agreements made by such Lender.

"Disposition": with respect to any Person, any sale, assignment, transfer or other disposition by such Person by any means, of:

(a) the stock of, or other equity interests of, any other Person,

(b) any business, operating entity, division or segment thereof, or

(c) any other Property of such Person, other than (i) the sale of inventory (other than in connection with bulk transfers), (ii) the disposition of equipment and (iii) the sale of cash investments.

"***Disqualified Institutions***": those Persons that are (a) competitors of the Borrower or its Subsidiaries, identified in writing by the Borrower to the Administrative Agent and the Lenders from time to time (by posting such notice to the Platform) not less than one (1) Domestic Business Day prior to the date of determination (it being understood that, notwithstanding anything herein to the contrary, in no event shall a supplement apply retroactively to disqualify any Person that has previously acquired an assignment or participation interest hereunder that is otherwise an Eligible Assignee, but upon the effectiveness of such designation, any such Person may not acquire any additional Commitments, Advances or participations), (b) such other Persons identified in writing by the Borrower to the Administrative Agent prior to the Effective Date and (c) Affiliates of the Persons identified pursuant to clause (a) or (b) that are either clearly identifiable by name or identified in writing by the Borrower to the Administrative Agent; provided that "Disqualified Institutions" shall exclude any Person that the Borrower has designated as no longer being a "Disqualified Institution" by written notice delivered to the Administrative Agent and the Lenders from time to time.

"Dividend Restrictions": as defined in Section 8.7.

"Dollar" *or* ***"$"***: lawful currency of the United States of America.

"Domestic Business Day": any day other than a Saturday, Sunday or a day which in New York City is a legal holiday or a day on which banking institutions are authorized or required by law or other governmental action to close.

"EEA Financial Institution": (a) any credit institution or investment firm established in any EEA Member Country which is subject to the supervision of an EEA Resolution Authority, (b) any entity established in an EEA Member Country which is a parent of an institution described in clause (a) of this definition, or (c) any financial institution established in an EEA Member Country which is a subsidiary of an institution described in clause (a) or (b) of this definition and is subject to consolidated supervision with its parent.

"EEA Member Country": any of the member states of the European Union, Iceland, Liechtenstein, and Norway.

"EEA Resolution Authority": any public administrative authority or any person entrusted with public administrative authority of any EEA Member Country (including any delegee) having responsibility for the resolution of any EEA Financial Institution.

"Effective Date": as defined in Section 5.

"***Eligible Assignee***": a Person that is a permitted assignee under Section 11.7(b) that has received the consent of each party whose consent is required under Section 11.7(b). For the avoidance of doubt, any Disqualified Institution is subject to Section 11.7(g).

"Employee Benefit Plan": an employee benefit plan, within the meaning of Section 3(3) of ERISA, maintained, sponsored or contributed to by the Borrower, any Subsidiary or any ERISA Affiliate.

"Environmental Laws": all laws, rules, regulations, codes, ordinances, orders, decrees, judgments, injunctions, notices or binding agreements issued, promulgated or entered into by any Governmental

Authority, relating in any way to the environment, preservation or reclamation of natural resources, the management, release or threatened release of any Hazardous Material or to health and safety matters.

"Environmental Liability": as to any Person, any statutory, common law or equitable liability, contingent or otherwise (including any liability for damages, costs of environmental investigation, sampling or remediation, fines, penalties or indemnities), of such Person directly or indirectly resulting from or based upon (i) violation of any Environmental Law, (ii) the generation, use, handling, transportation, storage, treatment, discharge or disposal of any Hazardous Materials, (iii) exposure to any Hazardous Materials, (iv) the release or threatened release of any Hazardous Materials into the environment or (v) any contract, agreement or other consensual arrangement pursuant to which liability is assumed or imposed with respect to any of the foregoing.

"*Equity Interests*": shares of capital stock, partnership interests, membership interests, beneficial interests or other ownership interests, whether voting or nonvoting, in, or interests in the income or profits of, a Person, and any warrants, options or other rights entitling the holder thereof to purchase or acquire any of the foregoing.

"ERISA": the Employee Retirement Income Security Act of 1974, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"ERISA Affiliate": when used with respect to an Employee Benefit Plan, ERISA, the PBGC or a provision of the Internal Revenue Code pertaining to employee benefit plans, any Person that is a member of any group of organizations within the meaning of Sections 414(b) or (c) of the Internal Revenue Code or, solely with respect to the applicable provisions of the Internal Revenue Code, Section 414(m) or (o) of the Internal Revenue Code, of which the Borrower or any Subsidiary is a member.

"*ERISA Event*": (a) any "reportable event", as defined in Section 4043 of ERISA with respect to a Pension Plan (other than an event for which the 30-day notice period is waived); (b) the determination that any Pension Plan is considered an at-risk plan or a plan in endangered or critical status within the meaning of Sections 430, 431 or 432 of the Internal Revenue Code or Sections 303, 304 or 305 of ERISA; (c) the filing pursuant to the Internal Revenue Code or ERISA of an application for a waiver of the minimum funding standard with respect to any Pension Plan; (d) the incurrence by the Borrower, any Subsidiary or an ERISA Affiliate of any liability under Title IV of ERISA with respect to the termination of any Pension Plan, other than for PBGC premiums due but not delinquent under Section 4007 of ERISA, upon the Borrower, any Subsidiary or an ERISA Affiliate; (e) the receipt by the Borrower, any Subsidiary or an ERISA Affiliate from the PBGC or a plan administrator of any notice relating to an intention to terminate any Pension Plan or to appoint a trustee to administer any Pension Plan; (f) the incurrence by the Borrower, any Subsidiary or an ERISA Affiliate of any liability with respect to the withdrawal or partial withdrawal from any Pension Plan or Multiemployer Plan; (g) any limits under Section 436 of the Internal Revenue Code become applicable; or (h) any failure to make any payment required by Section 430(j) of the Internal Revenue Code.

"EU Bail-In Legislation Schedule": the EU Bail-In Legislation Schedule published by the Loan Market Association (or any successor person), as in effect from time to time.

"Eurodollar Advance": a portion of the Revolving Credit Loans selected by the Borrower to bear interest during a Eurodollar Interest Period selected by the Borrower at a rate per annum based upon a Eurodollar Rate determined with reference to such Eurodollar Interest Period, all pursuant to and in accordance with Section 2.1 or Section 3.3.

"Eurodollar Business Day": any Domestic Business Day, other than a Domestic Business Day on which banks are not open for dealings in Dollar deposits in the interbank eurodollar market.

"Eurodollar Interest Period": the period commencing on any Eurodollar Business Day selected by the Borrower in accordance with Section 2.3 or Section 3.3 and ending one, two, three or six months thereafter, as selected by the Borrower in accordance with either such Sections, subject to the following:

(i) if any Eurodollar Interest Period would otherwise end on a day which is not a Eurodollar Business Day, such Eurodollar Interest Period shall be extended to the immediately succeeding Eurodollar Business Day unless the result of such extension would be to carry the end of such Eurodollar Interest Period into another calendar month, in which event such Eurodollar Interest Period shall end on the Eurodollar Business Day immediately preceding such day; and

(ii) if any Eurodollar Interest Period shall begin on the last Eurodollar Business Day of a calendar month (or on a day for which there is no numerically corresponding day in the calendar month at the end of such Eurodollar Interest Period), such Eurodollar Interest Period shall end on the last Eurodollar Business Day of such latter calendar month.

"***Eurodollar Rate***": with respect to any Eurodollar Advance for any Eurodollar Interest Period, (a) the LIBO Rate for such Eurodollar Interest Period, multiplied by (b) the Statutory Reserve Rate.

"Event of Default": any of the events specified in Section 9.1, *provided* that any requirement for the giving of notice, the lapse of time, or both, or any other condition has been satisfied.

"Excluded Taxes": with respect to the Administrative Agent, any Lender or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, (a) Taxes imposed on or measured by its net income (however denominated) or overall gross receipts, and franchise Taxes, in each case, (i) imposed on it by the jurisdiction (or any political subdivision thereof) under the laws of which it is organized or in which its principal office is located or, in the case of any Lender, in which its applicable lending office is located, or (ii) that are Other Connection Taxes, (b) any branch profits Taxes imposed by the United States of America or that are Other Connection Taxes, (c) in the case of a Lender (other than an assignee pursuant to a request by the Borrower under Section 3.13), any withholding Tax that is imposed on amounts payable to such Lender at the time such Lender becomes a party hereto (or designates a new lending office), except to the extent that such Lender (or its assignor, if any) was entitled, at the time of designation of a new lending office (or assignment), to receive additional amounts from the Borrower with respect to such withholding Tax pursuant to Section 3.10, (d) any Tax attributable to such recipient's failure or inability (other than as a result of a Regulatory Change, except for a Regulatory Change relating to the implementation of FATCA) to comply with Section 3.10(f) and (e) any Taxes imposed under FATCA.

"***Existing Commitment Termination Date***": as defined in Section 2.12(a).

"Existing 2017 Credit Agreement": the Five Year Credit Agreement, dated as of May 18, 2017, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA and Wells Fargo, as co-documentation agents, and The Bank of New York Mellon, as administrative agent, as amended by Amendment No. 1 to Five Year Credit Agreement, dated as of December 15, 2017, Amendment No. 2 to Five Year Credit Agreement, dated as of May 17, 2018, Amendment No. 3 to Five Year Credit Agreement, dated as of May 16, 2019, and as the same may be further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 2018 Credit Agreement": the Five Year Credit Agreement, dated as of May 17, 2018, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, BofA, GS and Wells Fargo, as co-documentation agents, and The Bank of New York Mellon, as administrative agent, as amended by Amendment No. 1 to Five Year Credit Agreement dated as of May 16, 2019, and as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing 2019 Credit Agreement": the Five Year Credit Agreement, dated as of May 16, 2019, by and among the Borrower, the lenders party thereto from time to time, Barclays and JPMC, as co-syndication agents, GS and Wells Fargo, as co-documentation agents, and BofA, as administrative agent, as the same may be amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Existing Term Loan Agreement": the Term Loan Agreement, dated as of December 15, 2017, by and among the Borrower, the lenders party thereto from time to time, GS and BofA, as co-syndication agents, and Barclays, as administrative agent, as amended by Amendment No. 1 to Term Loan Agreement, dated as of May 17, 2018, and as the same may be further amended, amended and restated, supplemented, replaced or otherwise modified from time to time.

"Expiration Date": the first date, occurring on or after the date the Commitments shall have terminated or been terminated in accordance herewith, upon which there shall be no Loans outstanding.

"Extension Date": as defined in Section 2.12(a).

"Extension Request": as defined in Section 2.12(a).

"Facility Fee": as defined in Section 3.11.

"FATCA": Sections 1471 through 1474 of the Internal Revenue Code, as of the date of this Agreement (or any amended or successor version that is substantively comparable and not materially more onerous to comply with), any current or future regulations or official interpretations thereof, any agreements entered into pursuant to Section 1471(b)(1) of the Internal Revenue Code, any applicable intergovernmental agreements with respect thereto, and any treaty, law, regulations, or other official guidance enacted in any other jurisdiction relating to such intergovernmental agreement.

"Federal Funds Effective Rate": for any day, the rate per annum equal to the weighted average of the rates on overnight Federal funds transactions with members of the Federal Reserve System, as published by the Federal Reserve Bank of New York on the Domestic Business Day next succeeding such day; provided that (a) if such day is not a Domestic Business Day, the Federal Funds Effective Rate for such day shall be such rate on such transactions on the next preceding Domestic Business Day as so published on the next succeeding Domestic Business Day, and (b) if no such rate is so published on such next succeeding Domestic Business Day, the Federal Funds Effective Rate for such day shall be the average rate (rounded upward, if necessary, to a whole multiple of 1/100 of 1%) charged to BofA on such day on such transactions as reasonably determined by the Administrative Agent; *provided* that if the "Federal Funds Effective Rate" would otherwise be less than zero, the "Federal Funds Effective Rate" shall be deemed to be zero for purposes of this Agreement.

"Fees": as defined in Section 3.2(a).

"Financial Statements": as defined in Section 4.13.

"Foreign Lender": any Lender that is not a United States person within the meaning of Section 7701(a)(30) of the Internal Revenue Code.

"GAAP": subject to Section 1.2(b), generally accepted accounting principles set forth in the opinions and pronouncements of the Accounting Principles Board and the American Institute of Certified Public Accountants and statements and pronouncements of the Financial Accounting Standards Board or such other principles as may be approved by a significant segment of the accounting profession, which are applicable to the circumstances as of the date of determination, consistently applied.

"Governmental Authority": any foreign, federal, state, municipal or other government, or any department, commission, board, bureau, agency, public authority or instrumentality thereof, or any court, arbitrator, regulatory body or central bank (including any supra-national bodies such as the European Union or the European Central Bank).

"GS": as defined in the preamble.

"Hazardous Materials": all ignitable, explosive, reactive, corrosive or radioactive substances or wastes and all hazardous or toxic materials, substances, chemicals, wastes or other pollutants, including but not limited to petroleum or petroleum distillates, asbestos or asbestos containing materials, polychlorinated biphenyls, radon gas, toxic mold, infectious or medical wastes, hazardous biological agents, hazardous pharmaceutical substances and all other materials, substances, chemicals, wastes, contaminants or pollutants of any nature that are now or hereafter regulated pursuant to any Environmental Law, or are now or hereafter defined, listed or classified as a hazardous or toxic material, substance, chemical, waste, contaminant or pollutant in any Environmental Law.

"Highest Lawful Rate": as to any Lender, the maximum rate of interest, if any, which at any time or from time to time may be contracted for, taken, charged or received on the Loans or the Notes or which may be owing to such Lender pursuant to this Agreement under the laws applicable to such Lender and this Agreement.

"Increasing Lender": as defined in Section 2.6(d).

"Indebtedness": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) indebtedness with respect to any conditional sale or other title retention agreement, (d) indebtedness arising under acceptance facilities and the amount available to be drawn under all letters of credit (excluding for purposes of Section 8.9 letters of credit obtained in the ordinary course of business by the Borrower or any Subsidiary) issued for the account of such Person and, without duplication, all drafts drawn thereunder to the extent such Person shall not have reimbursed the issuer thereof in respect of such issuer's payment of such drafts, (e) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, (f) all indebtedness described in (a) - (e) above secured by any Lien on any Property owned by such Person even though such Person shall not have assumed or otherwise become liable for the payment thereof (other than carriers', warehousemen's, mechanics', repairmen's or other like non-consensual Liens arising in the ordinary course of business), and (g) Contingent Obligations in respect of any indebtedness described in items (a) - (f) above; *provided* that, for purposes of this definition, Indebtedness shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"Indebtedness for Borrowed Money": as to any Person at a particular time, all items of such Person which constitute, without duplication, (a) indebtedness for borrowed money or the deferred purchase price of Property (other than trade payables and accrued expenses incurred in the ordinary course of business), (b) indebtedness evidenced by notes, bonds, debentures or similar instruments, (c) that portion of any obligation of such Person, as lessee, which in accordance with GAAP is required to be capitalized on a balance sheet of such Person, and (d) Contingent Obligations in respect of any indebtedness described in items (a) - (c) above; *provided* that, for purposes of this definition, Indebtedness for Borrowed Money shall not include Intercompany Debt and obligations in respect of interest rate caps, collars, exchanges, swaps or other, similar agreements.

"Indemnified Amount": as defined in Section 11.10(b).

"Indemnified Liabilities": as defined in Section 11.5(a).

"Indemnified Person": as defined in Section 11.10(a).

"Indemnified Taxes": Taxes other than Excluded Taxes and Other Taxes.

"Information": as defined in Section 11.14(b).

"Insurance Subsidiary": any Subsidiary subject to regulation by the commissioner of insurance, the commissioner of health or any equivalent Governmental Authority in any applicable jurisdiction.

"Intangible Assets": at any date, the value, as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP, of: (i) all trade names, trademarks, licenses, patents, copyrights, service marks, goodwill and other like intangibles, (ii) organizational and development costs, (iii) deferred charges (other than prepaid items, such as insurance, taxes, interest, commissions, rents, pensions, compensation and similar items and tangible assets being amortized), and (iv) unamortized debt discount and expense, less unamortized premium.

"Intercompany Debt": (i) Indebtedness of the Borrower to one or more of the Subsidiaries of the Borrower and (ii) Indebtedness of one or more of the Subsidiaries of the Borrower to the Borrower or any one or more of the other Subsidiaries of the Borrower.

"Intercompany Disposition": a Disposition by the Borrower or any of the Subsidiaries of the Borrower to the Borrower or to any of the other Subsidiaries of the Borrower.

"Interest Payment Date": (i) as to any ABR Advance, the last day of each March, June, September and December, commencing on the first of such days to occur after such ABR Advance is made or any Eurodollar Advance is converted to an ABR Advance, (ii) as to any Eurodollar Advance in respect of which the Borrower has selected a Eurodollar Interest Period of one, two or three months, the last day of such Eurodollar Interest Period, (iii) as to any Competitive Bid Loan in respect of which the Borrower has selected a Competitive Interest Period of 90 days or less, the last day of such Competitive Interest Period and (iv) as to any Eurodollar Advance or Competitive Bid Loan in respect of which the Borrower has selected an Interest Period greater than three months or 90 days, as the case may be, the last day of the third month or the 90th day, as the case may be, of such Interest Period and the last day of such Interest Period.

"Interest Period": a Eurodollar Interest Period or a Competitive Interest Period, as the case may be.

"Internal Revenue Code": the Internal Revenue Code of 1986, as amended from time to time, or any successor thereto, and the rules and regulations issued thereunder, as from time to time in effect.

"Joint Lead Arrangers": BAS, Barclays, GS, JPMC and WFS.

"JPMC": as defined in the preamble.

"Lender" and ***"Lenders"***: as defined in the preamble.

"LIBO Rate": for any Eurodollar Interest Period with respect to a Eurodollar Rate Loan, the rate per annum equal to the London Interbank Offered Rate as administered by ICE Benchmark Administration (or any other Person that takes over the administration of such rate for Dollars for a period equal in length to such Interest Period) ("LIBOR") as published on the applicable Bloomberg screen page (or such other commercially available source providing such quotations as may be designated by the Administrative Agent from time to time) at approximately 11:00 a.m., London time, two Eurodollar Business Days prior to the commencement of such Eurodollar Interest Period, for Dollar deposits (for delivery on the first day of such Eurodollar Interest Period) with a term equivalent to such Eurodollar Interest Period; *provided* that if the LIBO Rate shall be less than zero, the LIBO Rate shall be deemed to be zero for the purposes of this Agreement.

"LIBO Screen Rate": the LIBOR quote on the applicable screen page the Administrative Agent designates to determine LIBOR (or such other commercially available source providing such quotations as may be designated by the Administrative Agent from time to time).

"***LIBOR***" as defined in the definition of LIBO Rate.

"***LIBOR Successor Rate***": as defined in Section 3.8(d).

"***LIBOR Successor Rate Conforming Changes***": as defined in Section 3.8(d).

"Lien": any mortgage, pledge, hypothecation, assignment, lien, deposit arrangement, charge, encumbrance or other security arrangement or security interest of any kind, or the interest of a vendor or lessor under any conditional sale agreement, capital lease or other title retention agreement; *provided*, that in no event shall an operating lease be deemed to constitute a Lien.

"Loan": a Revolving Credit Loan or a Competitive Bid Loan, as the case may be.

"Loan Documents": this Agreement and, upon the execution and delivery thereof, the Notes, if any.

"Loans": the Revolving Credit Loans and the Competitive Bid Loans.

"Margin Stock": any "margin stock", as said term is defined in Regulation U of the Board of Governors of the Federal Reserve System, as the same may be amended or supplemented from time to time.

"***Material Acquisition***": any acquisition of (a) Equity Interests in any Person if, after giving effect thereto, such Person will become a Subsidiary or (b) assets comprising all or substantially all the assets of (or all or substantially all the assets constituting a business unit, division, product line or line of business of) any Person; provided that the aggregate consideration therefor (including Indebtedness assumed in connection therewith, all obligations in respect of the deferred purchase price therefor (including obligations under any purchase price adjustment but excluding earn-out or similar payments) and all other

consideration payable in connection therewith (including payment obligations in respect of noncompetition agreements or other arrangements representing acquisition consideration)) equals or exceeds $500,000,000.

"Material Adverse": with respect to any change or effect, a material adverse change in, or effect on, as the case may be, (i) the financial condition, operations, business, or Property of the Borrower and the Subsidiaries taken as a whole, (ii) the ability of the Borrower to perform its obligations under the Loan Documents, or (iii) the ability of the Administrative Agent or any Lender to enforce the Loan Documents.

"***Material Subsidiary***": a Subsidiary of the Borrower with respect to which (i) the Borrower's and its other Subsidiaries' investments in, and advances to, such Subsidiary exceed ten percent (10%) of the total assets of the Borrower and its Subsidiaries Consolidated as of the end of the most recently completed fiscal year, (ii) the Borrower's and its other Subsidiaries' proportionate share of the total assets (after intercompany eliminations) of such Subsidiary exceeds 10 percent (10%) of the total assets of the Borrower and its Subsidiaries Consolidated as of the end of the most recently completed fiscal year, or (iii) the Borrower's and its other Subsidiaries' equity in the income from continuing operations before income taxes of such Subsidiary exclusive of amounts attributable to any non-controlling interests exceeds ten percent (10%) of such income of the Borrower and its Subsidiaries Consolidated for the most recently completed fiscal year.

"Moody's": Moody's Investors Service, Inc., or any successor thereto.

"Multiemployer Plan": a Pension Plan which is a multiemployer plan as defined in Section 4001(a)(3) of ERISA.

"Net Tangible Assets": at any date, the total assets as shown on the most recent Consolidated balance sheet of the Borrower and the Subsidiaries as at the end of the fiscal quarter ending not more than 135 days prior to such date, prepared in accordance with GAAP, less, without duplication (i) all current liabilities (due within one year) as shown on such balance sheet and (ii) Intangible Assets and liabilities relating thereto.

"New Lender": as defined in Section 2.6(d).

"Non-Extending Lender": as defined in Section 2.12(b).

"Note": with respect to each Lender that has requested one in accordance with Section 2.11, a promissory note evidencing such Lender's Loans payable to such Lender (or, if required by such Lender, to such Lender and its registered assigns), substantially in the form of Exhibit B.

"One Month LIBOR Rate": for any interest calculation with respect to an ABR Advance on any date, the rate per annum equal to LIBOR, at or about 11:00 a.m., London time determined two Eurodollar Business Days prior to such date for Dollar deposits with a term of one month commencing that day, *provided* that in the event that the *"One Month LIBOR Rate"* would otherwise be less than zero, such *"One Month LIBOR Rate"* shall be deemed to be zero for purposes of this Agreement.

"***Other Connection Taxes***": with respect to the Administrative Agent, any Lender, or any other recipient of any payment to be made by or on account of any obligation of the Borrower hereunder or any other Loan Document, Taxes imposed as a result of a present or former connection between such recipient and the jurisdiction imposing such Tax (other than connections arising from such recipient having executed, delivered, become a party to, performed its obligations under, received payments under, received or perfected a security interest under, engaged in any other transaction pursuant to, enforced any Loan Document, or sold or assigned an interest in any Loan or Loan Document).

"Other Taxes": all present or future stamp, court or documentary Taxes or any other excise or property Taxes, charges or similar levies arising from any payment made hereunder or under any other Loan Document or from the execution, delivery or enforcement of, or otherwise with respect to, this Agreement or any other Loan Document, except any such Taxes that are Other Connection Taxes imposed with respect to an assignment (other than an assignment made pursuant to Section 3.13).

"Participant": as defined in Section 11.7(d).

"Participant Register": as defined in Section 11.7(d).

"Patriot Act": as defined in Section 11.20.

"PBGC": the Pension Benefit Guaranty Corporation established pursuant to Subtitle A of Title IV of ERISA, or any Governmental Authority succeeding to the functions thereof.

"Pension Plan": at any time, any Employee Benefit Plan (including a Multiemployer Plan) subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, the funding requirements of which are, or at any time within the six years immediately preceding the time in question were, in whole or in part, the responsibility of the Borrower, any Subsidiary or an ERISA Affiliate.

"Person": any individual, firm, partnership, limited liability company, joint venture, corporation, association, business trust, joint stock company, unincorporated association, trust, Governmental Authority or any other entity, whether acting in an individual, fiduciary, or other capacity, and for the purpose of the definition of "ERISA Affiliate", a trade or business.

"Plan of Reorganization": as defined in Section 11.7(g)(iii).

"Platform": as defined in Section 7.7.

"Pricing Level": Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV, Pricing Level V or Pricing Level VI, as the case may be.

"Pricing Level I": any time when the senior unsecured long term debt rating of the Borrower by (x) S&P is A or higher or (y) Moody's is A2 or higher.

"Pricing Level II": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is A- or higher or (y) Moody's is A3 or higher and (ii) Pricing Level I does not apply.

"Pricing Level III": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB+ or higher or (y) Moody's is Baa1 or higher and (ii) neither Pricing Level I nor Pricing Level II applies.

"Pricing Level IV": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB or higher or (y) Moody's is Baa2 or higher and (ii) none of Pricing Level I, Pricing Level II or Pricing Level III applies.

"Pricing Level V": any time when (i) the senior unsecured long term debt rating of the Borrower by (x) S&P is BBB- or higher or (y) Moody's is Baa3 or higher and (ii) none of Pricing Level I, Pricing Level II, Pricing Level III or Pricing Level IV applies.

"Pricing Level VI": any time when none of Pricing Level I, Pricing Level II, Pricing Level III, Pricing Level IV or Pricing Level V applies.

Notwithstanding each definition of Pricing Level set forth above, if at any time the senior unsecured long term debt ratings of the Borrower by S&P and Moody's differ by more than one equivalent rating level, then the applicable Pricing Level shall be determined based upon the lower such rating adjusted upwards to the next higher rating level.

"Proceeding": as defined in Section 11.10(d).

"*Prohibited Transaction"*: a transaction that is prohibited under Section 4975 of the Internal Revenue Code or Section 406 of ERISA and not exempt under Section 4975 of the Internal Revenue Code, Section 408 of ERISA or any applicable administrative exemptions.

"Property": in respect of any Person, all types of real, personal or mixed property and all types of tangible or intangible property owned or leased by such Person.

"PTE": as defined in Section 11.23(c).

"Regulatory Change": the occurrence, after the date hereof, of any of the following: (a) the adoption or taking effect of any law, rule, regulation or treaty, (b) any change in any law, rule, regulation or treaty or in the administration, implementation, interpretation or application thereof by any Governmental Authority or (c) the making or issuance of any request, guideline or directive (whether or not having the force of law) by any Governmental Authority; *provided* that, notwithstanding anything herein to the contrary, (i) the Dodd-Frank Wall Street Reform and Consumer Protection Act and all requests, rules, guidelines or directives thereunder or issued in connection therewith and (ii) all requests, rules, guidelines or directives promulgated by the Bank for International Settlements, the Basel Committee on Banking Supervision (or any successor or similar authority) or the United States or foreign regulatory authorities, in each case, pursuant to Basel III, in the case of each of clauses (i) and (ii), shall be deemed to be a "Regulatory Change", regardless of the date enacted, adopted or issued, but only if any such requirements are generally applicable to (and for which reimbursement is generally being sought by the Lenders in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this definition), as determined by the Lenders in their respective reasonable discretion.

"Register": as defined in Section 11.7(c).

"Related Parties": with respect to any specified Person, such Person's Affiliates and the respective directors, officers, employees, agents and advisors of such Person and such Person's Affiliates.

"Replaced Lender": as defined in Section 3.13.

"Replacement Lender": as defined in Section 3.13.

"Required Lenders": (a) at any time prior to the Commitment Termination Date or such earlier date as all of the Commitments shall have terminated or been terminated in accordance herewith, Lenders having Commitment Amounts greater than 50% of the Aggregate Commitment Amount, and (b) at all other times, Lenders having Credit Exposure greater than 50% of the Aggregate Credit Exposure.

"Restrictive Agreement": as defined in Section 8.7.

"***Revolving Credit Loan***" and "Revolving Credit Loans": as defined in Section 2.1(a).

"S&P": Standard & Poor's Financial Services LLC, a subsidiary of S&P Global Inc., or any successor thereto.

"Sanctioned Country": at any time, a country or territory which is the subject or target of any Sanctions.

"Sanctioned Person": at any time, (a) any Person listed in any Sanctions-related list of designated Persons maintained by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State, (b) any Person operating, organized or resident in a Sanctioned Country or (c) any Person controlled by any such Person.

"Sanctions": economic or financial sanctions or trade embargoes imposed, administered or enforced from time to time by the U.S. government, including those administered by the Office of Foreign Assets Control of the U.S. Department of the Treasury or the U.S. Department of State.

"***Scheduled Unavailability Date***": as defined in Section 3.8(d)(ii).

"***SEC Reports***": the Borrower's 2018 Annual Report on Form 10-K, the Borrower's quarterly report on Form 10-Q for the quarterly period ending March 31, 2019, and any 8-K filings made by the Borrower subsequent to March 31, 2019 and prior to the Effective Date.

"Special Counsel": such counsel as the Administrative Agent may engage from time to time.

"Statutory Reserve Rate": a fraction (expressed as a decimal), the numerator of which is the number one and the denominator of which is the number one minus the aggregate of the maximum reserve percentages (including any marginal, special, emergency or supplemental reserves) expressed as a decimal established by the Board of Governors of the Federal Reserve System to which the Administrative Agent is subject for eurocurrency funding (currently referred to as "Eurocurrency liabilities" in Regulation D of the Board of Governors of the Federal Reserve System, as amended). Such reserve percentages shall include those imposed pursuant to said Regulation D. Eurodollar Loans shall be deemed to constitute eurocurrency funding and to be subject to such reserve requirements without benefit of or credit for proration, exemptions or offsets that may be available from time to time to any Lender under said Regulation D or any comparable regulation. The Statutory Reserve Rate shall be adjusted automatically on and as of the effective date of any change in any reserve percentage.

"Subsidiary": at any time and from time to time, any corporation, partnership, limited liability company, joint venture or other business entity of which the Borrower and/or any Subsidiary of the Borrower, directly or indirectly at such time, either (a) in respect of a corporation, owns or controls more than 50% of the outstanding stock having ordinary voting power to elect a majority of the board of directors or similar managing body, irrespective of whether a class or classes shall or might have voting power by reason of the happening of any contingency, or (b) in respect of a partnership, limited liability company, joint venture or other business entity, is entitled to share in more than 50% of the profits and losses, however determined.

"Taxes": all present or future taxes, levies, imposts, duties, deductions, withholdings, assessments, fees or other charges in the nature of a tax imposed by any Governmental Authority, including any interest, additions to tax or penalties applicable thereto.

"Termination Event": with respect to any Pension Plan, (a) an ERISA Event, (b) the termination of a Pension Plan under Section 4041(c) of ERISA, or the filing of a notice of intent to terminate a Pension Plan under Section 4041(c) of ERISA, or the treatment of a Pension Plan amendment as a termination under Section 4041(e) of ERISA (except an amendment made after such Pension Plan satisfies the requirement for a standard termination under Section 4041(b) of ERISA), (c) the institution of proceedings by the PBGC to terminate a Pension Plan under Section 4042 of ERISA, or (d) the appointment of a trustee to administer any Pension Plan under Section 4042 of ERISA.

"Threshold Amount": $300,000,000.

"Total Capitalization": at any date, the sum of the Borrower's Consolidated Indebtedness and shareholders' equity on such date, determined in accordance with GAAP.

"Type": with respect to any Revolving Credit Loan, the characteristic of such Loan as an ABR Advance or a Eurodollar Advance, each of which constitutes a Type of Revolving Credit Loan.

"Unqualified Amount": as defined in Section 3.4(c).

"Upstream Dividends": as defined in Section 8.7.

"U.S. Lender": as defined in Section 3.10(f).

"***United States Tax Compliance Certificate***": as defined in Section 3.10(f)(iii).

"Wells Fargo": as defined in the preamble.

"***WFS***": Wells Fargo Securities, LLC.

"Write-Down and Conversion Powers": with respect to any EEA Resolution Authority, the write-down and conversion powers of such EEA Resolution Authority from time to time under the Bail-In Legislation for the applicable EEA Member Country, which write-down and conversion powers are described in the EU Bail-In Legislation Schedule.

1.2 Principles of Construction

(a) All capitalized terms defined in this Agreement shall have the meanings given to such capitalized terms herein when used in the other Loan Documents or in any certificate, opinion or other document made or delivered pursuant hereto or thereto, unless otherwise expressly provided therein.

(b) Unless otherwise expressly provided herein, the word *"fiscal"* when used herein shall refer to the relevant fiscal period of the Borrower. As used in the Loan Documents and in any certificate, opinion or other document made or delivered pursuant thereto, accounting terms not defined in Section 1.1, and accounting terms partly defined in Section 1.1, to the extent not defined, shall have the respective meanings given to them under GAAP as in effect from time to time; *provided* that, if the Borrower notifies the Administrative Agent that the Borrower requests an amendment to any provision hereof to eliminate the effect of any change occurring after the date hereof in GAAP or in the application thereof on the operation of such provision (or if the Administrative Agent notifies the Borrower that the Required Lenders request an amendment to any provision hereof for such purpose), regardless of whether any such notice is given before or after such change in GAAP or in the application thereof, then such provision shall be interpreted

on the basis of, and any accounting term related thereto shall have the respective meaning given to it under, GAAP as in effect and applied immediately before such change shall have become effective until such notice shall have been withdrawn or such provision amended in accordance herewith. Any lease that is characterized as an operating lease in accordance with GAAP after the Borrower's adoption of ASC 842 (regardless of the date on which such lease has been entered into) shall not be a capital or finance lease, and any such lease shall be, for all purposes of this Agreement, treated as though it were reflected on the Borrower's consolidated financial statements in the same manner as an operating lease would have been reflected prior to Borrower's adoption of ASC 842.

(c) The words *"hereof"*, *"herein"*, *"hereto"* and *"hereunder"* and similar words when used in each Loan Document shall refer to such Loan Document as a whole and not to any particular provision of such Loan Document, and Section, schedule and exhibit references contained therein shall refer to Sections thereof or schedules or exhibits thereto unless otherwise expressly provided therein.

(d) All references herein to a time of day shall mean the then applicable time in New York, New York, unless otherwise expressly provided herein.

(e) Section headings have been inserted in the Loan Documents for convenience only and shall not be construed to be a part thereof. Unless the context otherwise requires, words in the singular number include the plural, and words in the plural include the singular.

(f) Whenever in any Loan Document or in any certificate or other document made or delivered pursuant thereto, the terms thereof require that a Person sign or execute the same or refer to the same as having been so signed or executed, such terms shall mean that the same shall be, or was, duly signed or executed by (i) in respect of any Person that is a corporation, any duly authorized officer thereof, and (ii) in respect of any other Person (other than an individual), any analogous counterpart thereof.

(g) The words *"include"* and *"including"*, when used in each Loan Document, shall mean that the same shall be included *"without limitation"*, unless otherwise specifically provided.

(h) All references to "knowledge" or "awareness" of the Borrower or any Subsidiary means the actual knowledge of an Authorized Officer of the Borrower or such Subsidiary.

2. AMOUNT AND TERMS OF LOANS

2.1 Revolving Credit Loans

(a) Subject to the terms and conditions hereof, each Lender severally (and not jointly) agrees to make loans in Dollars under this Agreement (each a ***"Revolving Credit Loan"*** and, collectively with each other Revolving Credit Loan of such Lender and/or with each Revolving Credit Loan of each other Lender, the ***"Revolving Credit Loans"***) to the Borrower from time to time during the Commitment Period, during which period the Borrower may borrow, prepay and reborrow in accordance with the provisions hereof. Immediately after making each Revolving Credit Loan and after giving effect to all Competitive Bid Loans repaid on the same date, the Aggregate Credit Exposure will not exceed the Aggregate Commitment Amount. With respect to each Lender, at the time of the making of any Revolving Credit Loan, the sum of (I) the principal amount of such Lender's Revolving Credit Loan constituting a part of the Revolving Credit Loans to be made and (II) the aggregate principal balance of all other Revolving Credit Loans (exclusive

of Revolving Credit Loans which are repaid with the proceeds of, and simultaneously with the incidence of, the Revolving Credit Loans to be made) then outstanding from such Lender, will not exceed the Commitment of such Lender at such time. At the option of the Borrower, indicated in a Borrowing Request, Revolving Credit Loans may be made as ABR Advances or Eurodollar Advances.

(b) The aggregate outstanding principal balance of all Revolving Credit Loans shall be due and payable on the Commitment Termination Date (subject to Section 2.2) or on such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6.

2.2 Term-out Option

The Borrower may, in its sole and absolute discretion, upon not less than 10 days' (and not more than 60 days') notice to the Administrative Agent, elect to convert all of the Loans outstanding on the Commitment Termination Date in effect at such time into "term loans" in which case the outstanding Loans shall not be due on the Commitment Termination Date and shall instead be due and payable on the first anniversary of the Commitment Termination Date, with the effect that, notwithstanding anything to the contrary in this Agreement or in any other Loan Document, all references in this Agreement and each other Loan Document to the Commitment Termination Date (other than as set forth in this Section 2.2 or Section 2.1) shall thereafter be deemed to refer to the date that is the first anniversary of the Commitment Termination Date; *provided* that (a) the Borrower shall have delivered an officer's certificate on the Commitment Termination Date certifying that the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on the Commitment Termination Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on the Commitment Termination Date), except those which are expressly specified to be made as of an earlier date, (b) no Default shall have occurred and be continuing, and (c) the Borrower shall have paid to the Administrative Agent for the account of the Lenders a fee in the amount equal to (i) 0.75% multiplied by (ii) the aggregate outstanding principal amount of all Loans so converted. All Loans converted into "term loans" pursuant to this Section 2.2 shall continue to constitute Loans under this Agreement and the other Loan Documents except that the Borrower may not reborrow such Loans pursuant to Section 2.1 after all or any portion of such Loans have been prepaid pursuant to Section 2.7 and no new Loans may be borrowed on or after the Commitment Termination Date.

2.3 Notice of Borrowing Revolving Credit Loans

The Borrower agrees to notify the Administrative Agent, which notification shall be irrevocable, no later than (a) 12:00 Noon on the proposed Borrowing Date in the case of Revolving Credit Loans to consist of ABR Advances and (b) 12:00 Noon at least three Eurodollar Business Days prior to the proposed Borrowing Date in the case of Revolving Credit Loans to consist of Eurodollar Advances. Each such notice shall specify (i) the aggregate amount requested to be borrowed under the Commitments, (ii) the proposed Borrowing Date, (iii) whether a borrowing of Revolving Credit Loans is to be made as an ABR Advance, one or more Eurodollar Advances, or both, and the amount of each thereof, and (iv) the Eurodollar Interest Period for each such Eurodollar Advance. Each such notice shall be promptly confirmed by delivery to the Administrative Agent of a Borrowing Request. Each Eurodollar Advance to be made on a Borrowing Date, when aggregated with all amounts to be Converted to Eurodollar Advances on such date and having the same Interest Period as such Eurodollar Advance, shall equal no less than $10,000,000, or an integral multiple of $1,000,000 in excess thereof. Each ABR Advance made on each Borrowing Date shall equal no less than $5,000,000 or an integral multiple of $500,000 in excess thereof. The Administrative Agent

shall promptly notify each Lender (by telephone or otherwise, such notification to be confirmed by fax, email or other writing) of each such Borrowing Request. Subject to its receipt of each such notice from the Administrative Agent and subject to the terms and conditions hereof, each Lender shall make immediately available funds available to the Administrative Agent at the address therefor set forth in Section 11.2 not later than 1:00 P.M. on each Borrowing Date in an amount equal to such Lender's Commitment Percentage of the Revolving Credit Loans requested by the Borrower on such Borrowing Date.

2.4 Competitive Bid Loans and Procedure

(a) Subject to the terms and conditions hereof, the Borrower may request competitive bid loans in Dollars under this Agreement (each a "***Competitive Bid Loan***") during the Commitment Period. In order to request Competitive Bids, the Borrower shall deliver by hand, fax or email to the Administrative Agent a duly completed and executed Competitive Bid Request not later than 12:00 Noon, one Domestic Business Day before the proposed Borrowing Date therefor. A Competitive Bid Request that does not conform substantially to the format of Exhibit F may be rejected by the Administrative Agent in the Administrative Agent's reasonable discretion, and the Administrative Agent shall promptly notify the Borrower of such rejection by fax or email and by telephone. Each Competitive Bid Request shall specify (x) the proposed Borrowing Date for the Competitive Bid Loans then being requested (which shall be a Domestic Business Day) and the aggregate principal amount thereof and (y) the Competitive Interest Period or Competitive Interest Periods (which shall not exceed ten different Interest Periods in a single Competitive Bid Request), with respect thereto (which may not end after the Domestic Business Day immediately preceding the Commitment Termination Date). Promptly after its receipt of each Competitive Bid Request that is not rejected as aforesaid, the Administrative Agent shall invite by fax or email (substantially in the form of Exhibit G) the Lenders (other than any Defaulting Lender) to bid, on the terms and conditions of this Agreement, to make Competitive Bid Loans pursuant to such Competitive Bid Request.

(b) Each Lender (other than any Defaulting Lender), in its sole and absolute discretion, may make one or more Competitive Bids to the Borrower responsive to a Competitive Bid Request. Each Competitive Bid by a Lender must be received by the Administrative Agent not later than 10:00 A.M. on the proposed Borrowing Date for the relevant Competitive Bid Loan. Multiple bids will be accepted by the Administrative Agent. Bids to make Competitive Bid Loans that, in the reasonable judgment of the Administrative Agent, do not conform to the Competitive Bids solicited by the related Competitive Bid Request shall be rejected by the Administrative Agent. Competitive Bids that do not conform substantially to the format of Exhibit H may be rejected by the Administrative Agent after conferring with, and upon the instruction of, the Borrower, and the Administrative Agent shall notify the Lender making such nonconforming bid of such rejection as soon as practicable. Each Competitive Bid shall be irrevocable and shall specify (x) the principal amount (which (1) shall be in a minimum principal amount of $10,000,000 or an integral multiple of $1,000,000 in excess thereof, and (2) may equal the entire principal amount requested by the Borrower) of the Competitive Bid Loan or Competitive Bid Loans that the Lender is willing to make to the Borrower, (y) the Competitive Bid Rate or Competitive Bid Rates at which the Lender is prepared to make such Competitive Bid Loan or Competitive Bid Loans, and (z) the Competitive Interest Period with respect to each such Competitive Bid Loan and the last day thereof. If any Lender shall elect not to make a Competitive Bid, such Lender shall so notify the Administrative Agent by fax or email not later than 10:00 A.M. on the proposed Borrowing Date therefor, *provided* that the failure by any Lender to give any such notice shall not obligate such Lender to make any Competitive Bid Loan in connection with the relevant Competitive Bid Request.

(c) With respect to each Competitive Bid Request, the Administrative Agent shall (i) notify the Borrower by fax or email by 11:00 A.M. on the proposed Borrowing Date with respect thereto of each Competitive Bid made, the Competitive Bid Rate applicable thereto and the identity of the Lender that made such Competitive Bid, and (ii) send a list of all Competitive Bids to the Borrower for its records as soon as practicable after completion of the bidding process. Each notice and list sent by the Administrative Agent pursuant to this Section 2.4(c) shall list the Competitive Bids in ascending yield order.

(d) The Borrower may in its sole and absolute discretion, subject only to the provisions of this Section 2.4(d), accept or reject any Competitive Bid made in accordance with the procedures set forth in this Section 2.4, and the Borrower shall notify the Administrative Agent by telephone, confirmed by fax or email in the form of a duly completed and executed Competitive Bid Accept/Reject Letter, whether and to what extent it has decided to accept or reject any or all of such Competitive Bids not later than 12:00 Noon on the proposed Borrowing Date therefor; *provided* that the failure by the Borrower to give such notice shall be deemed to be a rejection of all such Competitive Bids. In connection with each acceptance of one or more Competitive Bids by the Borrower:

(1) the Borrower shall not accept a Competitive Bid of a given tenor made at a particular Competitive Bid Rate if the Borrower has decided to reject a Competitive Bid having the same tenor made at a lower Competitive Bid Rate unless the acceptance of such Competitive Bid made at a lower Competitive Bid Rate would subject the Borrower to any requirement to withhold any taxes or deduct any amount from any amounts payable under the Loan Documents, in which case the Borrower may reject such Competitive Bid made at a lower Competitive Bid Rate,

(2) the aggregate amount of the Competitive Bids accepted by the Borrower shall not exceed the principal amount specified in the Competitive Bid Request therefor,

(3) if the Borrower shall desire to accept a Competitive Bid made at a particular Competitive Bid Rate, it must accept all other Competitive Bids at such Competitive Bid Rate, except for any such Competitive Bid the acceptance of which would subject the Borrower to any requirement to withhold any taxes or deduct any amount from any amounts payable under the Loan Documents; *provided* that if the acceptance of all such other Competitive Bids would cause the aggregate amount of all such accepted Competitive Bids to exceed the amount requested, then such acceptance shall be made pro rata in accordance with the amount of each such Competitive Bid at such Competitive Bid Rate,

(4) except pursuant to clause (3) above, no Competitive Bid shall be accepted unless the Competitive Bid Loan with respect thereto shall be in a minimum principal amount of $10,000,000 or an integral multiple of $1,000,000 in excess thereof, and

(5) no Competitive Bid shall be accepted and no Competitive Bid Loan shall be made, if immediately after giving effect thereto, the Aggregate Credit Exposure would exceed the Aggregate Commitment Amount.

(e) The Administrative Agent shall promptly fax or email to each bidding Lender (with a copy to the Borrower) a Competitive Bid Accept/Reject Letter advising such Lender whether its Competitive Bid has been accepted (and if accepted, in what amount and at what Competitive Bid Rate), and each successful bidder so notified will thereupon become bound, subject to the applicable conditions hereof, to make the Competitive Bid Loan in respect of which each of its Competitive Bids has been accepted by making immediately available funds available to the Administrative Agent at its address set forth in Section 11.2 not later than 1:00 P.M. on the Borrowing Date for such Competitive Bid Loan in the amount thereof.

(f) Anything herein to the contrary notwithstanding, if the Administrative Agent shall elect to submit a Competitive Bid in its capacity as a Lender, it shall submit such bid directly to the Borrower not later than 9:30 A.M. on the relevant proposed Borrowing Date.

(g) All notices required by this Section 2.4 shall be given in accordance with Section 11.2.

(h) Each Competitive Bid Loan shall be due and payable on the last day of the Interest Period applicable thereto or on such earlier date upon which the Loans shall become due and payable pursuant to the provisions hereof, whether by acceleration or otherwise.

2.5 Use of Proceeds

The Borrower agrees that the proceeds of the Loans shall be used solely for its general corporate purposes, but not inconsistent with this Section 2.5 or any other provision of this Agreement, including, without limitation, the provisions of Section 4.9, and not in contravention of any applicable law, rule or regulation.

2.6 Termination, Reduction or Increase of Commitments

(a) Termination on Commitment Termination Date. Unless previously terminated, the Commitments shall terminate on the Commitment Termination Date.

(b) Voluntary Termination or Reductions. At the Borrower's option in its sole and absolute discretion and upon at least one Domestic Business Day's prior irrevocable notice to the Administrative Agent, the Borrower may (i) terminate the Commitments at any time, or (ii) permanently reduce the Aggregate Commitment Amount in part at any time and from time to time; *provided* that (1) each such partial reduction shall be in an amount equal to at least $5,000,000 or an integral multiple of $1,000,000 in excess thereof, and (2) immediately after giving effect to each such reduction, the Aggregate Commitment Amount shall equal or exceed the Aggregate Credit Exposure; *provided*, *further* that, notwithstanding the foregoing, a notice of termination of the Commitments delivered by the Borrower may state that such notice is conditioned upon the effectiveness of other credit facilities or transactions (such notice to specify the proposed effective date), in which case such notice may be revoked by the Borrower (by notice to the Administrative Agent on or prior to such specified effective date) if such condition is not satisfied and the Borrower shall indemnify the Lenders in accordance with Section 3.5, if applicable.

(c) In General. Each reduction of the Aggregate Commitment Amount shall be made by reducing each Lender's Commitment Amount by an amount equal to the product of such Lender's Commitment Percentage and the amount of such reduction.

(d) Increase in Aggregate Commitment Amount. The Borrower may at any time and from time to time prior to the 90th day prior to the then-applicable Commitment Termination Date, at its sole cost and expense, request any one or more of the Lenders having a Commitment to increase its Commitment Amount (the decision to increase the Commitment Amount of a Lender to be within the sole and absolute discretion of such Lender), or any Eligible Assignee to provide a new Commitment, by submitting to the Administrative Agent a Commitment Increase Supplement, duly executed and delivered by the Borrower and each such Lender or Eligible Assignee, as the case may be. Upon receipt of any such Commitment Increase Supplement, the Administrative Agent shall promptly execute and deliver such Commitment Increase Supplement and the Administrative Agent shall deliver a copy thereof to the Borrower and each such Lender or Eligible Assignee, as the case may be. Upon execution and delivery of such Commitment Increase Supplement by the Administrative Agent, (i) in the case of each such Lender (an **"*Increasing Lender*"**), its Commitment Amount shall be increased to the amount set forth in such Commitment Increase Supplement, and (ii) in the case of each such Eligible Assignee (a **"*New Lender*"**), such New Lender shall become a party hereto and have the rights and obligations of a Lender under the Loan Documents and its Commitment shall be as set forth in such Commitment Increase Supplement; *provided* that:

(1) immediately after giving effect thereto, the sum of all increases in the Aggregate Commitment Amount made pursuant to this Section 2.6(d) shall not exceed $500,000,000;

(2) each such increase of the Aggregate Commitment Amount shall be in an amount not less than $25,000,000 or such amount plus an integral multiple of $5,000,000; *provided* that an increase may be in a lesser amount if such increase is an increase of the entire remaining amount available under clause (1) above;

(3) no Default shall have occurred or be continuing on the effective date of the increase;

(4) the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on the effective date of such increase (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such effective date), except those which are expressly specified to be made as of an earlier date;

(5) in the case of each New Lender, the Commitment Amount assumed by such New Lender shall not be less than $25,000,000;

(6) if Revolving Credit Loans would be outstanding immediately after giving effect to any such increase, then simultaneously with such increase (A) each such Increasing Lender, each such New Lender and each other Lender shall be deemed to have entered into a master assignment and assumption, in form and substance substantially similar to Exhibit E, pursuant to which each such other Lender shall have assigned to each such Increasing Lender and each such New Lender a portion of its Revolving Credit Loans necessary to reflect proportionately the Commitments as increased in accordance with this Section 2.6(d), and (B) in connection with such assignment, each such Increasing Lender and each such New Lender shall pay to the Administrative Agent, for the account of each such other

Lender, such amount as shall be necessary to reflect the assignment to it of such Revolving Credit Loans, and in connection with such master assignment each such other Lender may treat the assignment of Eurodollar Advances as a prepayment of such Eurodollar Advances for purposes of Section 3.5;

(7) each such New Lender shall have delivered to the Administrative Agent an Administrative Questionnaire and to the Administrative Agent and the Borrower all forms, if any, that are required to be delivered by such New Lender pursuant to Section 3.10;

(8) at least five Domestic Business Days prior to the effectiveness of such increase, if the Borrower qualifies as a "legal entity customer" under the Beneficial Ownership Regulation, it shall have delivered, to each Lender that so requests, a Beneficial Ownership Certification; and

(9) the Administrative Agent shall have received such other customary certificates, resolutions and opinions as the Administrative Agent shall have reasonably requested.

2.7 Prepayments of Loans.

(a) Voluntary Prepayments. The Borrower may prepay Revolving Credit Loans and Competitive Bid Loans, in whole or in part, without premium or penalty, but subject to Section 3.5, at any time and from time to time, by notifying the Administrative Agent (which notice shall be in a form reasonably acceptable to the Administrative Agent) at least two Eurodollar Business Days, in the case of a prepayment of Eurodollar Advances, two Domestic Business Days, in the case of a prepayment of Competitive Bid Loans, or one Domestic Business Day, in the case of a prepayment of ABR Advances, prior to the proposed prepayment date specifying (i) the Loans to be prepaid, (ii) the amount to be prepaid, and (iii) the date of prepayment. Upon receipt of each such notice, the Administrative Agent shall promptly notify each Lender thereof. Each such notice given by the Borrower pursuant to this Section 2.7 shall be irrevocable, *provided* that, if a notice of prepayment is given in connection with a conditional notice of termination of the Commitments as contemplated by Section 2.6, then such notice of prepayment may be revoked if such notice of termination is revoked in accordance with Section 2.6, and the Borrower shall indemnify the Lenders in accordance with Section 3.5. Each partial prepayment under this Section 2.7 shall be (A) in the case of Eurodollar Advances, in a minimum amount of $5,000,000 or an integral multiple of $1,000,000 in excess thereof or the entire remaining amount of Eurodollar Advances, (B) in the case of ABR Advances, in a minimum amount of $1,000,000 or an integral multiple of $100,000 in excess thereof or the entire remaining amount of ABR Advances, and (C) in the case of Competitive Bid Loans, in a minimum amount of $5,000,000 or an integral multiple of $1,000,000 in excess thereof or the entire remaining amount of Competitive Bid Loans.

(b) In General. Simultaneously with each prepayment hereunder, the Borrower shall prepay all accrued and unpaid interest on the amount prepaid through the date of prepayment and indemnify the Lenders in accordance with Section 3.5, if applicable.

2.8 Reserved

2.9 Reserved

2.10 Reserved

2.11 Notes

Any Lender may request that the Loans made by it be evidenced by a Note. In such event, the Borrower shall prepare, execute and deliver to such Lender a Note payable to such Person or, if requested by such Person, such Person and its registered assigns

2.12 Extension of Commitment Termination Date

(a) Request for Extension. The Borrower may, in its sole and absolute discretion, by notice to the Administrative Agent (which shall promptly notify the Lenders) not more than 60 days and not less than 30 days prior to the Commitment Termination Date (the "***Extension Date***") request (an **"*Extension Request*"**) that the Lenders extend the Commitment Termination Date then in effect (the **"*Existing Commitment Termination Date*"**) for an additional 364-day period. Each Lender, acting in its sole discretion, shall, by notice to the Borrower and the Administrative Agent given not later than the 20th day (or such later day as shall be acceptable to the Borrower) following the date of the Borrower's notice, advise the Borrower and the Administrative Agent whether or not such Lender agrees to such extension; *provided* that any Lender that does not so advise the Borrower and the Administrative Agent shall be deemed to have rejected such Extension Request. The election of any Lender to agree to such extension shall not obligate any other Lender to so agree.

(b) Replacement of Non-Extending Lenders. The Borrower shall have the right at any time on or prior to the relevant Extension Date to replace any Lender which has not consented to the Extension Request (each, a ***"Non-Extending Lender"***) pursuant to Section 3.13.

(c) Conditions to Effectiveness of Extension. Notwithstanding anything in this Agreement to the contrary, the extension of the Existing Commitment Termination Date on any Extension Date shall not be effective unless, immediately before and after giving effect to such extension on such Extension Date: (i) no Default shall have occurred and be continuing on such Extension Date and the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on such Extension Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such Extension Date), except those which are expressly specified to be made as of an earlier date, and the Administrative Agent shall have received a certificate, in form and substance reasonably satisfactory to the Administrative Agent, to such effect from the chief financial officer of the Borrower (or such other financial officer reasonably acceptable to the Administrative Agent), and (ii) the Administrative Agent shall have received such other customary certificates, resolutions and opinions as the Administrative Agent may reasonably request.

(d) Effectiveness of Extension. If (and only if) the conditions specified in Section 2.12(c) shall have been satisfied or waived with respect to the extension of the Existing Commitment Termination Date on the applicable Extension Date, then, effective as of such Extension Date, the Commitment Termination Date, with respect to the Commitment of each Lender that has agreed to so extend its Commitment and of each Replacement Lender that has assumed a Commitment of a Non-Extending Lender in connection with such Extension Request, shall be extended to the date falling 364-days after the Existing Commitment Termination Date (or, if such date is not a Domestic Business Day, the immediately preceding Domestic Business Day), and each such Replacement Lender shall thereupon become a "Lender" for all purposes of this Agreement. Notwithstanding anything herein to the contrary, (i) with respect to any portion of the

Commitment of any Non-Extending Lender that has not been fully assumed by one or more Replacement Lenders, the Commitment Termination Date for such Lender with respect to such non-assumed portion of its Commitment shall remain unchanged, and (ii) with respect to any Loans of such Lender that have not been purchased by one or more Replacement Lenders, the applicable maturity date with respect to such non-purchased Loans shall remain unchanged and shall be repayable by the Borrower on such applicable maturity date without there being any requirement that any such repayment be shared with other Lenders. In addition, on the Extension Date, the Borrower agrees to pay all accrued and unpaid interest, fees and other amounts then due under this Agreement from the Borrower to each Lender consenting to the Extension Request, each Non-Extending Lender and each Replacement Lender. Solely for the purpose of calculating break funding payments under Section 3.5, the assignment by any Non-Extending Lender of any Eurodollar Advance prior to the last day of the Interest Period applicable thereto in accordance with this Section 2.12 shall be deemed to constitute a prepayment by the Borrower of such Eurodollar Advance.

2.13 Defaulting Lenders

Notwithstanding any provision of this Agreement to the contrary, if any Lender becomes a Defaulting Lender, then the following provisions shall apply for so long as such Lender is a Defaulting Lender:

(a) Facility Fees shall cease to accrue, and shall not be payable, on the unfunded portion of the Commitment of such Defaulting Lender pursuant to Section 3.11;

(b) the Commitment and Credit Exposure of such Defaulting Lender shall not be included in determining whether all Lenders or the Required Lenders have taken or may take any action hereunder (including any consent to any amendment or waiver pursuant to Section 11.1); *provided* that any waiver, amendment or modification with respect to the following shall require the consent of such Defaulting Lender: (i) any waiver, amendment or modification requiring the consent of all Lenders or each affected Lender which affects such Defaulting Lender in a manner that is materially adverse in comparison to the other affected Lenders, (ii) any waiver, amendment or modification increasing the Commitment of such Defaulting Lender, (iii) any waiver, amendment or modification extending the Commitment Period with respect to such Defaulting Lender, (iv) any waiver, amendment or modification reducing the principal amount owed under the Loan Documents to such Defaulting Lender (other than by payment thereof), or (v) any waiver, amendment or modification extending the final maturity of sums owed to such Defaulting Lender, or (vi) a modification of this Section 2.13(b);

(c) [reserved];

(d) [reserved];

(e) any amount payable to such Defaulting Lender hereunder (whether on account of principal, interest, fees or otherwise and including any amount that would otherwise be payable to such Defaulting Lender pursuant to Section 11.9 but excluding Section 3.13 and other than any amount constituting Facilities Fees which are not payable to such Defaulting Lender in accordance with Section 2.13(a)) shall, in lieu of being distributed to such Defaulting Lender, be retained by the Administrative Agent in a segregated account and, subject to any applicable requirements of law, be applied at such time or times as may be determined by the Administrative Agent (i) first, to the payment of any amounts owing by such Defaulting Lender to the Administrative Agent hereunder, (ii) second, to the funding of any Revolving Credit Loan in respect of which such

Defaulting Lender has failed to fund its portion thereof as required by this Agreement, as determined by the Administrative Agent, (iii) third, if so determined by the Administrative Agent and the Borrower, held in such account as cash collateral for future funding obligations of the Defaulting Lender in respect of any Revolving Credit Loans under this Agreement, (iv) fourth, to the payment of any amounts owing to the Lenders as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by any Lender against such Defaulting Lender as a result of such Defaulting Lender's breach of its obligations under this Agreement, (v) fifth, to the payment of any amounts owing to the Borrower as a result of any final and non-appealable judgment of a court of competent jurisdiction obtained by the Borrower against such Defaulting Lender as a result of such Defaulting Lender's breach of its obligations under this Agreement, and (vi) sixth, to such Defaulting Lender or as otherwise directed by a court of competent jurisdiction; *provided* that if such payment is (x) a prepayment of the principal amount of any Revolving Credit Loan and (y) made at a time when the conditions set forth in Section 6 are satisfied or waived, such payment shall be applied solely to prepay the Revolving Credit Loans of all non-Defaulting Lenders pro rata prior to being applied to the prepayment of any Loans owed to any Defaulting Lender; and

(f) the Borrower shall have the right at any time during which a Lender is a Defaulting Lender to replace such Defaulting Lender pursuant to Section 3.13.

3. PROCEEDS, PAYMENTS, CONVERSIONS, INTEREST, YIELD PROTECTION AND FEES

3.1 Disbursement of the Proceeds of the Loans

The Administrative Agent shall disburse the proceeds of the Loans at its office specified in Section 11.2 by crediting to the Borrower's general deposit account with the Administrative Agent the funds received from each Lender. Unless the Administrative Agent shall have received prior notice from a Lender (by telephone or otherwise, such notice to be confirmed by fax, email or other writing) that such Lender will not make available to the Administrative Agent such Lender's Commitment Percentage of the Revolving Credit Loans, or the amount of any Competitive Bid Loan, to be made by it on a Borrowing Date, the Administrative Agent may assume that such Lender has made such amount available to the Administrative Agent on such Borrowing Date in accordance with this Section 3.1, *provided* that, in the case of a Revolving Credit Loan, such Lender received notice thereof from the Administrative Agent in accordance with the terms hereof, and the Administrative Agent may, in reliance upon such assumption, make available to the Borrower on such Borrowing Date a corresponding amount. If and to the extent that such Lender shall not have so made such amount available to the Administrative Agent, such Lender and the Borrower severally agree to pay to the Administrative Agent, forthwith on demand, such corresponding amount (to the extent not previously paid by the other), together with interest thereon for each day from the date such amount is made available to the Borrower until the date such amount is paid to the Administrative Agent, at a rate per annum equal to, in the case of the Borrower, the applicable interest rate set forth in Section 3.4(a) and, in the case of such Lender, the Federal Funds Effective Rate from the date such payment is due until the third day after such date and, thereafter, at the Federal Funds Effective Rate *plus* 2%. Any such payment by the Borrower shall be without prejudice to its rights against such Lender. If such Lender shall pay to the Administrative Agent such corresponding amount, such amount so paid shall constitute such Lender's Loan as part of such Loans for purposes of this Agreement, which Loan shall be deemed to have been made by such Lender on the Borrowing Date applicable to such Loans.

3.2 Payments.

(a) Each payment, including each prepayment, of principal and interest on the Loans and of the Facility Fee (collectively, together with all of the other fees to be paid to the Administrative Agent and the Lenders in connection with the Loan Documents, the ***"Fees"***), and of all of the other amounts to be paid to the Administrative Agent and the Lenders in connection with the Loan Documents (other than amounts payable to a Lender under Section 3.5, Section 3.6, Section 3.10, Section 11.5 and Section 11.10) shall be made by the Borrower to the Administrative Agent at its office specified in Section 11.2 without condition, recoupment, defense, setoff, deduction or counterclaim in funds immediately available in New York by 3:00 P.M. on the due date for such payment. The failure of the Borrower to make any such payment by such time shall not constitute a default hereunder, *provided* that such payment is made on such due date, but any such payment made after 3:00 P.M. on such due date shall be deemed to have been made on the next Domestic Business Day or Eurodollar Business Day, as the case may be, for the purpose of calculating interest on amounts outstanding on the Loans. If the Borrower has not made any such payment prior to 3:00 P.M., the Borrower hereby authorizes the Administrative Agent to deduct the amount of any such payment from such account(s) as the Borrower may from time to time designate in writing to the Administrative Agent, upon which the Administrative Agent shall apply the amount of such deduction to such payment. Promptly upon receipt thereof by the Administrative Agent, each payment of principal and interest on the: (i) Revolving Credit Loans shall be remitted by the Administrative Agent in like funds as received to each Lender (a) first, pro rata according to the amount of interest which is then due and payable to the Lenders, and (b) second, pro rata according to the amount of principal which is then due and payable to the Lenders and (ii) Competitive Bid Loans shall be remitted by the Administrative Agent in like funds as received to each applicable Lender. Each payment of the Facility Fee payable to the Lenders shall be promptly transmitted by the Administrative Agent in like funds as received to each Lender pro rata according to such Lender's Commitment Amount or, if the Commitments shall have terminated or been terminated, according to the outstanding principal amount of such Lender's Revolving Credit Loans.

(b) If any payment hereunder or under the Loans shall be due and payable on a day which is not a Domestic Business Day or a Eurodollar Business Day, as the case may be, the due date thereof (except as otherwise provided in the definition of Eurodollar Interest Period or Competitive Interest Period) shall be extended to the next Domestic Business Day or Eurodollar Business Day, as the case may be, and (except with respect to payments in respect of the Facility Fee) interest shall be payable at the applicable rate specified herein during such extension.

3.3 Conversions; Other Matters.

(a) The Borrower may elect at any time and from time to time to Convert one or more Eurodollar Advances to an ABR Advance by giving the Administrative Agent at least one Domestic Business Day's prior irrevocable notice of such election (in the form of a Borrowing Request), specifying the amount to be so Converted. In addition, the Borrower may elect at any time and from time to time to Convert an ABR Advance to any one or more new Eurodollar Advances or to Convert any one or more existing Eurodollar Advances to any one or more new Eurodollar Advances by giving the Administrative Agent no later than 10:00 A.M. at least two Eurodollar Business Days' prior irrevocable notice of such election (in the form of a Borrowing Request), specifying the amount to be so Converted and the initial Interest Period relating thereto; *provided* that any Conversion of an ABR Advance to an Eurodollar Advance shall only be made on a Eurodollar Business Day; *provided*, *further* that, notwithstanding the foregoing, a Borrowing Request for a Conversion delivered by the Borrower may state that such Borrowing Request is conditioned upon the effectiveness of other credit facilities or transactions (such Borrowing Request to specify the proposed effective date), in which case such Borrowing Request may be

revoked by the Borrower (by notice to the Administrative Agent prior to the day specified for such Conversion in such Borrowing Request) if such condition is not satisfied and the Borrower shall indemnify the Lenders in accordance with Section 3.5, if applicable. The Administrative Agent shall promptly provide the Lenders with notice of each such election. Each Conversion of Loans shall be made pro rata according to the outstanding principal amount of the Loans of each Lender. ABR Advances and Eurodollar Advances may be Converted pursuant to this Section 3.3 in whole or in part; *provided* that the amount to be Converted to each Eurodollar Advance, when aggregated with any Eurodollar Advance to be made on such date in accordance with Section 2.1 and having the same Interest Period as such first Eurodollar Advance, shall equal no less than $10,000,000 or an integral multiple of $1,000,000 in excess thereof or the entire remaining amount of the Eurodollar Advances.

(b) Notwithstanding anything in this Agreement to the contrary, the Borrower shall not have the right to elect to Convert any existing ABR Advance to a Eurodollar Advance or to Convert any existing Eurodollar Advance to a new Eurodollar Advance if (i) a Default or an Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) shall then exist, or (ii) any other Event of Default shall then exist and the Administrative Agent shall have notified the Borrower at the request of the Required Lenders that no ABR Advance or Eurodollar Advance may be Converted to a new Eurodollar Advance. In such event, such ABR Advance shall be automatically continued as an ABR Advance or such Eurodollar Advance shall be automatically Converted to an ABR Advance on the last day of the Interest Period applicable to such Eurodollar Advance. The foregoing shall not affect any other rights or remedies that the Administrative Agent or any Lender may have under this Agreement or any other Loan Document.

(c) Each Conversion shall be effected by each Lender by applying the proceeds of each new ABR Advance or Eurodollar Advance, as the case may be, to the existing ABR Advance or Eurodollar Advance (or portion thereof) being Converted (it being understood that such Conversion shall not constitute a borrowing for purposes of Section 4 or Section 6).

(d) Notwithstanding any other provision of any Loan Document:

(1) if the Borrower shall have failed to elect a Eurodollar Advance under Section 2.3 or this Section 3.3, as the case may be, in connection with any borrowing of new Revolving Credit Loans or expiration of an Interest Period with respect to any existing Eurodollar Advance, the amount of the Revolving Credit Loans subject to such borrowing or such existing Eurodollar Advance shall thereafter be an ABR Advance until such time, if any, as the Borrower shall elect a new Eurodollar Advance pursuant to this Section 3.3,

(2) the Borrower shall not be permitted to select a Eurodollar Advance the Interest Period in respect of which ends later than the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6, and

(3) the Borrower shall not be permitted to have more than (x) 15 Eurodollar Advances and (y) 15 Competitive Bid Loans outstanding at any one time; it being understood and agreed that each borrowing of Eurodollar Advances or Competitive Bid Loans pursuant to a single Borrowing Request or Competitive Bid Request, as the case may be, shall constitute the making of one Eurodollar Advance or Competitive Bid Loan for the purpose of calculating such limitation.

3.4 Interest Rates and Payment Dates.

(a) Prior to Maturity. Except as otherwise provided in Section 3.4(b) and Section 3.4(c), the Loans shall bear interest on the unpaid principal balance thereof at the applicable interest rate or rates per annum set forth below:

LOANS	RATE
Revolving Credit Loans constituting ABR Advances	Alternate Base Rate *plus* the Applicable Margin.
Revolving Credit Loans constituting Eurodollar Advances	Eurodollar Rate applicable thereto *plus* the Applicable Margin.
Competitive Bid Loans	Fixed rate of interest applicable thereto accepted by the Borrower pursuant to Section 2.4(d).

(b) Late Payment Rate. Any payment of principal or interest on the Loans, Fees or other amounts payable by the Borrower under the Loan Documents not paid on the date when due and payable shall, after the occurrence and during the continuance of an Event of Default pursuant to Section 9.1(a), 9.1(b), 9.1(h), 9.1(i) or 9.1(j), bear interest, in the case of principal or interest on a Loan, at the applicable interest rate on such Loan *plus* 2% per annum and, in the case of any Fees or other amounts, at the Alternate Base Rate *plus* the Applicable Margin *plus* 2% per annum, in each case from the due date thereof until the date such payment is made (whether before or after the entry of any judgment thereon).

(c) Highest Lawful Rate. Notwithstanding anything to the contrary contained in this Agreement, at no time shall the interest rate payable to any Lender on any of its Loans, together with the Fees and all other amounts payable hereunder to such Lender to the extent the same constitute or are deemed to constitute interest, exceed the Highest Lawful Rate. If in respect of any period during the term of this Agreement, any amount paid to any Lender hereunder, to the extent the same shall (but for the provisions of this Section 3.4) constitute or be deemed to constitute interest, would exceed the maximum amount of interest permitted by the Highest Lawful Rate during such period (such amount being hereinafter referred to as an ***"Unqualified Amount"***), then (i) such Unqualified Amount shall be applied or shall be deemed to have been applied as a prepayment of the Loans of such Lender, and (ii) if, in any subsequent period during the term of this Agreement, all amounts payable hereunder to such Lender in respect of such period which constitute or shall be deemed to constitute interest shall be less than the maximum amount of interest permitted by the Highest Lawful Rate during such period, then the Borrower shall pay to such Lender in respect of such period an amount (each a ***"Compensatory Interest Payment"***) equal to the lesser of (x) a sum which, when added to all such amounts, would equal the maximum amount of interest permitted by the Highest Lawful Rate during such period, and (y) an amount equal to the aggregate sum of all Unqualified Amounts *less* all other Compensatory Interest Payments.

(d) General. Interest shall be payable in arrears on each Interest Payment Date, on the Commitment Termination Date, to the extent provided in Section 2.7(b), upon each prepayment of the Loans and, to the extent provided in Section 2.12(d), on the Extension Date. Any change in the interest rate on the Loans resulting from an increase or a decrease in the Alternate Base Rate or any reserve requirement shall become effective as of the opening of business on the day on which

such change shall become effective. Each determination by the Administrative Agent of the Alternate Base Rate, the Eurodollar Rate and the Competitive Bid Rate pursuant to this Agreement shall be conclusive and binding on the Borrower absent manifest error. The Borrower acknowledges that to the extent interest payable on the Loans is based on the Alternate Base Rate, such rate is only one of the bases for computing interest on loans made by the Lenders, and by basing interest payable on ABR Advances on the Alternate Base Rate, the Lenders have not committed to charge, and the Borrower has not in any way bargained for, interest based on a lower or the lowest rate at which the Lenders may now or in the future make extensions of credit to other Persons. All interest (other than interest calculated with reference to the Alternate Base Rate) shall be calculated on the basis of a 360-day year for the actual number of days elapsed, and all interest determined with reference to the Alternate Base Rate shall be calculated on the basis of a 365/366-day year for the actual number of days elapsed.

(e) No Warranty. The Administrative Agent does not warrant or accept responsibility for, and shall not have any liability with respect to, the administration, submission or any other matter related to the rates in the definition of "LIBO Rate", "Eurodollar Rate", "One Month LIBOR Rate", "LIBOR Successor Rate" and "LIBOR Successor Rate Conforming Changes"; *provided* that the foregoing shall not apply to any liability arising out of the bad faith, willful misconduct or gross negligence of the Administrative Agent.

3.5 Indemnification for Loss

Notwithstanding anything contained herein to the contrary, if: (i) the Borrower shall fail to borrow a Eurodollar Advance or if the Borrower shall fail to Convert all or any portion of any Revolving Credit Loan constituting an ABR Advance to a Eurodollar Advance after it shall have given notice to do so in which it shall have requested a Eurodollar Advance pursuant to Section 2.3 or Section 3.3, as the case may be, (ii) the Borrower shall fail to borrow a Competitive Bid Loan after it shall have accepted any offer with respect thereto in accordance with Section 2.4, (iii) a Eurodollar Advance or Competitive Bid Loan shall be terminated for any reason prior to the last day of the Interest Period applicable thereto, (iv) any repayment or prepayment of the principal amount of a Eurodollar Advance or Competitive Bid Loan is made for any reason on a date which is prior to the last day of the Interest Period applicable thereto, (v) the Borrower shall have revoked a notice of prepayment or notice of termination of the Commitments that was conditioned upon the effectiveness of other credit facilities or transactions pursuant to Section 2.6 or Section 2.7, or (vi) a Eurodollar Advance is assigned other than on the last day of the Interest Period applicable thereto as a result of an increase in the Aggregate Commitment Amount pursuant to Section 2.6(d) or a replacement of a Lender pursuant to clause (x) or (z) of Section 3.13, then the Borrower agrees to indemnify each Lender against, and to pay on demand directly to such Lender the amount (calculated by such Lender using any method chosen by such Lender which is customarily used by such Lender for such purpose for borrowers similar to the Borrower) equal to any loss or expense suffered by such Lender as a result of such failure to borrow or Convert, or such termination, repayment, prepayment or revocation, including any loss, cost or expense suffered by such Lender in liquidating or employing deposits acquired to fund or maintain the funding of such Eurodollar Advance or Competitive Bid Loan, as the case may be, or redeploying funds prepaid or repaid, in amounts which correspond to such Eurodollar Advance or Competitive Bid Loan, as the case may be, and any reasonable internal processing charge customarily charged by such Lender in connection therewith for borrowers similar to the Borrower.

3.6 Reimbursement for Costs, Etc.

If at any time or from time to time there shall occur a Regulatory Change and any Lender shall have reasonably determined that such Regulatory Change (i) shall have had or will thereafter have the effect of reducing (A) the rate of return on such Lender's capital or liquidity or the capital or liquidity of any

Person directly or indirectly owning or controlling such Lender (each a ***"Control Person"***), or (B) the asset value (for capital or liquidity purposes) to such Lender or such Control Person, as applicable, of the Loans, or any participation therein, in any case to a level below that which such Lender or such Control Person could have achieved or would thereafter be able to achieve but for such Regulatory Change (after taking into account such Lender's or such Control Person's policies regarding capital or liquidity), (ii) will impose, modify or deem applicable any reserve, asset, special deposit or special assessment requirements on deposits obtained in the interbank Eurodollar market in connection with the Loan Documents (excluding, with respect to any Eurodollar Advance, any such requirement which is included in the determination of the rate applicable thereto), or (iii) will subject such Lender or such Control Person, as applicable, to any tax (documentary, stamp or otherwise) with respect to this Agreement, any Note, or any other Loan Document (except, in the case of clause (iii) above, for any Indemnified Taxes, Excluded Taxes or Other Taxes), then, in each such case, within ten days after demand by such Lender, the Borrower shall pay directly to such Lender or such Control Person, as the case may be, such additional amount or amounts as shall be sufficient to compensate such Lender or such Control Person, as the case may be, for any such reduction, reserve or other requirement, tax, loss, cost or expense (excluding general administrative and overhead costs) (collectively, ***"Costs"***) attributable to such Lender's or such Control Person's compliance during the term hereof with such Regulatory Change, but only if such Costs are generally applicable to (and for which reimbursement is generally being sought by such Lender or such Control Person, as applicable, in respect of) credit transactions similar to this transaction from similarly situated borrowers (which are parties to credit or loan documentation containing a provision similar to this Section 3.6), as determined by such Lender, in its reasonable discretion. Each Lender may make multiple requests for compensation under this Section 3.6.

Notwithstanding the foregoing, the Borrower will not be required to compensate any Lender for any Costs under this Section 3.6 arising prior to 45 days preceding the date of demand, unless the applicable Regulatory Change giving rise to such Costs is imposed retroactively. In the case of retroactivity, such notice shall be provided to the Borrower not later than 45 days from the date that such Lender learned of such Regulatory Change. The Borrower's obligation to compensate such Lender shall be contingent upon the provision of such timely notice (but any failure by such Lender to provide such timely notice shall not affect the Borrower's obligations with respect to (i) Costs incurred from the date as of which such Regulatory Change became effective to the date that is 45 days after the date such Lender reasonably should have learned of such Regulatory Change and (ii) Costs incurred following the provision of such notice).

3.7 Illegality of Funding

Notwithstanding any other provision hereof, if any Lender shall reasonably determine that any law, regulation, treaty or directive, or any change therein or in the interpretation or application thereof, shall make it unlawful for such Lender to make or maintain any Eurodollar Advance as contemplated by this Agreement or to determine or charge interest rates based upon LIBOR, such Lender shall promptly notify the Borrower and the Administrative Agent thereof, and (a) the commitment of such Lender to make such Eurodollar Advances or Convert ABR Advances to such Eurodollar Advances shall forthwith be suspended, (b) such Lender shall fund its portion of each requested Eurodollar Advance as an ABR Advance, (c) such Lender's Loans then outstanding as such Eurodollar Advances, if any, shall be Converted automatically to an ABR Advance on the last day of the then current Interest Period applicable thereto or at such earlier time as may be required and (d) if such notice asserts the illegality of such Lender making or maintaining ABR Advances the interest rate on which is determined by reference to One Month LIBOR Rate, the interest rate on which ABR Advances of such Lender shall, if necessary to avoid such illegality, be determined by the Administrative Agent without reference to the One Month LIBOR Rate component of the Alternate Base Rate. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7 and such Lender shall have obtained actual knowledge that it is once again legal for such Lender to make or maintain Eurodollar Advances, such Lender shall promptly notify the Administrative Agent and

the Borrower thereof and, upon receipt of such notice by each of the Administrative Agent and the Borrower, such Lender's commitment to make or maintain Eurodollar Advances shall be reinstated. If the commitment of any Lender with respect to Eurodollar Advances is suspended pursuant to this Section 3.7, such suspension shall not otherwise affect such Lender's Commitment.

3.8 Option to Fund; Substituted Interest Rate.

(a) Each Lender has indicated that, if the Borrower requests a Eurodollar Advance or a Competitive Bid Loan, such Lender may wish to purchase one or more deposits in order to fund or maintain its funding of its Commitment Percentage of such Eurodollar Advance or Competitive Bid Loan during the Interest Period with respect thereto; it being understood that the provisions of this Agreement relating to such funding are included only for the purpose of determining the rate of interest to be paid in respect of such Eurodollar Advance or Competitive Bid Loan and any amounts owing under Section 3.5 and Section 3.6. Each Lender shall be entitled to fund and maintain its funding of all or any part of each Eurodollar Advance and Competitive Bid Loan in any manner it sees fit, but all such determinations hereunder shall be made as if such Lender had actually funded and maintained its Commitment Percentage of each Eurodollar Advance or Competitive Bid Loan, as the case may be, during the applicable Interest Period through the purchase of deposits in an amount equal to the amount of its Commitment Percentage of such Eurodollar Advance or Competitive Bid Loan, as the case may be, and having a maturity corresponding to such Interest Period. Each Lender may fund its Loans from or for the account of any branch or office of such Lender as such Lender may choose from time to time, subject to Section 3.10.

(b) In the event that (i) the Administrative Agent shall have determined in good faith (which determination shall be conclusive and binding upon the Borrower) that Dollar deposits are not being offered to banks in the London interbank Eurodollar market for the applicable amount and Interest Period or if by reason of circumstances affecting the interbank Eurodollar market adequate and reasonable means do not exist for ascertaining the Eurodollar Rate applicable pursuant to Section 2.3 or Section 3.3, or (ii) the Required Lenders shall have notified the Administrative Agent that they have in good faith determined (which determination shall be conclusive and binding on the Borrower) that the applicable Eurodollar Rate will not adequately and fairly reflect the cost to such Lenders of maintaining or funding loans bearing interest based on such Eurodollar Rate with respect to any portion of the Revolving Credit Loans that the Borrower has requested be made as Eurodollar Advances or any Eurodollar Advance that will result from the requested Conversion of any portion of the Revolving Credit Loans into Eurodollar Advances (each, an ***"Affected Advance"***), the Administrative Agent shall promptly notify the Borrower and the Lenders (by telephone or otherwise, to be promptly confirmed in writing) of such determination on or, to the extent practicable, prior to the requested Borrowing Date or Conversion date for such Affected Advances. If the Administrative Agent shall give such notice, (A) any Affected Advances shall be made as ABR Advances, (B) the Revolving Credit Loans (or any portion thereof) that were to have been Converted to Affected Advances shall be Converted to or continued as ABR Advances, and (C) any outstanding Affected Advances shall be Converted, on the last day of the then current Interest Period with respect thereto, to ABR Advances. Until any notice under clauses (i) or (ii), as the case may be, of this Section 3.8(b) has been withdrawn by the Administrative Agent (by notice to the Borrower) promptly upon either (x) the Administrative Agent having determined that such circumstances affecting the relevant market no longer exist and that adequate and reasonable means do exist for determining the Eurodollar Rate pursuant to Section 2.3 or Section 3.3, or (y) the Administrative Agent having been notified by the Required Lenders that circumstances no longer render the Loans (or any portion thereof) Affected Advances,

no further Eurodollar Advances shall be required to be made by the Lenders nor shall the Borrower have the right to Convert all or any portion of the Revolving Credit Loans to Eurodollar Advances.

(c) In the event that the Administrative Agent shall have determined in good faith (which determination shall be conclusive and binding upon the Borrower absent manifest error) that by reason of circumstances affecting the interbank Eurodollar market adequate and reasonable means do not exist for ascertaining the One Month LIBOR Rate, the Administrative Agent shall promptly notify the Borrower and the Lenders (by telephone or otherwise, to be promptly confirmed in writing) of such determination. If the Administrative Agent shall give such notice, the Alternate Base Rate shall be determined without giving effect to clause (iii) thereof until such time, if any, as such notice shall have been withdrawn by the Administrative Agent (by notice to the Borrower) promptly upon the Administrative Agent having determined that such circumstances affecting the relevant market no longer exist and that adequate and reasonable means do exist for determining the One Month LIBOR Rate.

(d) Notwithstanding anything to the contrary in this Agreement or any other Loan Documents, if the Administrative Agent and the Borrower determine that:

(i) adequate and reasonable means do not exist for ascertaining LIBOR for any requested Interest Period and such circumstances are unlikely to be temporary, because the LIBOR Screen Rate is not available or published on a current basis and such circumstances are unlikely to be temporary; or

(ii) the applicable supervisor or administrator of the LIBO Screen Rate or a Governmental Authority having jurisdiction over the Administrative Agent has made a public statement identifying a specific date after which LIBOR or the LIBO Screen Rate shall no longer be made available, or used for determining the interest rate of loans in the U.S. syndicated loan market denominated in Dollars (such specific date, the "Scheduled Unavailability Date"), or

(iii) syndicated loans currently being executed, or that include language similar to that contained in this Section 3.8(d), are generally being executed or amended (as applicable) to incorporate or adopt a new benchmark interest rate to replace LIBOR,

then, reasonably promptly after such determination by the Administrative Agent and the Borrower, the Administrative Agent and the Borrower may amend this Agreement to replace LIBOR with an alternate benchmark rate (including any mathematical or other adjustments to the benchmark (if any) incorporated therein), giving due consideration to any evolving or then existing convention for similar Dollar denominated syndicated credit facilities for such alternative benchmarks (any such proposed rate, a "***LIBOR Successor Rate***"), together with any proposed LIBOR Successor Rate Conforming Changes (as defined below) and any such amendment shall become effective at 5:00 p.m. on the fifth Domestic Business Day after the Administrative Agent shall have posted such proposed amendment to all Lenders and the Borrower unless, prior to such time, Lenders comprising the Required Lenders have delivered to the Administrative Agent written notice that such Required Lenders do not accept such amendment with each such notice stating that such Lender objects to such amendment (which such notice shall note with specificity the particular provisions of the amendment to which such Lender objects, it being understood that the Required Lenders need not specify identical objectionable provisions of the amendment in order to constitute effective notice). Such LIBOR Successor Rate shall be applied in a manner consistent with market practice; provided that to the extent such market practice is not administratively feasible for the

Administrative Agent, such LIBOR Successor Rate shall be applied in a manner as otherwise reasonably determined by the Administrative Agent.

If no LIBOR Successor Rate has been determined and the circumstances under clause (i) above exist or the Scheduled Unavailability Date has occurred (as applicable), the Administrative Agent will promptly so notify the Borrower and each Lender. Thereafter, (x) the obligation of the Lenders to make or maintain Eurodollar Advances shall be suspended, (to the extent of the affected Eurodollar Advances or Eurodollar Interest Periods), and (y) the One Month LIBOR Rate component shall no longer be utilized in determining the Alternate Base Rate. Upon receipt of such notice, the Borrower may revoke any pending request for a borrowing of, Conversion to or continuation of Eurodollar Advances (to the extent of the affected Eurodollar Advances or Eurodollar Interest Periods) or, failing that, will be deemed to have Converted such request into a request for a borrowing of ABR Advances (subject to the foregoing clause (y)) in the amount specified therein.

Notwithstanding anything else herein, any definition of LIBOR Successor Rate shall provide that in no event shall such LIBOR Successor Rate be less than zero for purposes of this Agreement.

For purposes hereof, "***LIBOR Successor Rate Conforming Changes***" means, with respect to any proposed LIBOR Successor Rate, any conforming changes to the definitions of Alternate Base Rate, Eurodollar Interest Period and One Month LIBOR Rate, timing and frequency of determining rates and making payments of interest and other administrative matters as may be appropriate, in the discretion of the Administrative Agent in consultation with the Borrower, to reflect the adoption of such LIBOR Successor Rate and to permit the administration thereof by the Administrative Agent in a manner substantially consistent with market practice (or, if the Administrative Agent determines that adoption of any portion of such market practice is not administratively feasible or that no market practice for the administration of such LIBOR Successor Rate exists, in such other manner of administration as the Administrative Agent determines is reasonably necessary in connection with the administration of this Agreement).

3.9 Certificates of Payment and Reimbursement

Each Lender agrees, in connection with any request by it for payment or reimbursement pursuant to Section 3.5, Section 3.6 or Section 3.10, to provide the Borrower with a certificate, signed by an officer of such Lender, as the case may be, setting forth a description in reasonable detail of any such payment or reimbursement and the applicable Section of this Agreement pursuant to and in accordance with which such request is made. Each determination by such Lender of such payment or reimbursement shall be conclusive absent manifest error.

3.10 Taxes; Net Payments

(a) Payments Free of Taxes. Any and all payments by or on account of any obligation of the Borrower hereunder or under any other Loan Document shall be made free and clear of and without reduction or withholding for any Indemnified Taxes or Other Taxes, *provided* that if the Borrower shall be required by applicable law to deduct any Indemnified Taxes (including any Other Taxes) from such payments, then (i) the sum payable shall be increased as necessary so that after making all required deductions (including deductions applicable to additional sums payable under this Section 3.10) the Administrative Agent or the applicable Lender, as the case may be, receives an amount equal to the sum it would have received had no such deductions for Indemnified Taxes or Other Taxes been made, (ii) the Borrower shall make such deductions and (iii) the Borrower

shall timely pay the full amount deducted to the relevant Governmental Authority in accordance with applicable law.

(b) Payment of Other Taxes by the Borrower. Without limiting the provisions of paragraph (a) above, the Borrower shall timely pay any Other Taxes to the relevant Governmental Authority in accordance with applicable law.

(c) Indemnification by the Borrower. The Borrower shall indemnify the Administrative Agent and each Lender within 30 days after demand therefor, for the full amount of any Indemnified Taxes imposed on or with respect to any payment made by or on account of any obligation of the Borrower under any Loan Document or Other Taxes (including Indemnified Taxes or Other Taxes imposed or asserted on or attributable to amounts payable under this Section 3.10) paid by the Administrative Agent or such Lender, as the case may be, and, without duplication, any penalties, interest and reasonable and documented out-of-pocket expenses arising therefrom or with respect thereto (other than any penalties that result from the gross negligence, bad faith or willful misconduct of the Administrative Agent or such Lender, as applicable, as determined by a final and non-appealable judgment of a court of competent jurisdiction); *provided* that if the Borrower reasonably believes that such Taxes were not correctly or legally asserted, the Administrative Agent or such Lender, as applicable, will cooperate with the Borrower to obtain a refund of such Taxes so long as such efforts would not result in any additional costs or expenses not reimbursed by the Borrower and such cooperation would not, in the judgment of such Lender, be materially disadvantageous to it. A certificate as to the amount of such payment or liability that complies with Section 3.9 and is delivered to the Borrower by such Lender (with a copy to the Administrative Agent), or by the Administrative Agent on its own behalf or on behalf of such Lender shall be conclusive absent manifest error. After any Lender learns of the imposition of any Indemnified Taxes or Other Taxes, such Lender will as soon as reasonably practicable notify the Borrower thereof; *provided* that the failure to provide Borrower with such notice shall not release the Borrower from its indemnification obligations under this Section 3.10. Notwithstanding anything to the contrary contained in this Section 3.10, the Borrower shall not be required to indemnify the Administrative Agent or any Lender pursuant to this Section 3.10 for any additional costs, such as penalties or interest, to the extent that such costs resulted from a failure of the Administrative Agent or such Lender to notify the Borrower of such possible indemnification claim within 180 days after the Administrative Agent or such Lender receives notice from the applicable taxing authority of the tax giving rise to such indemnification claim.

(d) Evidence of Payments. As soon as practicable after any payment of Indemnified Taxes or Other Taxes by the Borrower to a Governmental Authority, the Borrower shall deliver to the Administrative Agent the original or a certified copy of a receipt issued by such Governmental Authority evidencing such payment, a copy of the return reporting such payment or other evidence of such payment reasonably satisfactory to the Administrative Agent.

(e) Indemnification by the Lenders. Each Lender shall severally indemnify the Administrative Agent, within 10 days after demand therefor, for (i) any Indemnified Taxes attributable to such Lender (but only to the extent that the Borrower has not already indemnified the Administrative Agent for such Indemnified Taxes and without limiting the obligation of the Borrower to do so), (ii) any Taxes attributable to such Lender's failure to comply with the provisions of Section 11.7(d) relating to the maintenance of a Participant Register, and (iii) any Excluded Taxes attributable to such Lender, in each case, that are payable or paid by the Administrative Agent in connection with any Loan Document, and any reasonable expenses arising therefrom or with respect thereto, whether or not such Taxes were correctly or legally imposed or asserted by the relevant Governmental Authority. A certificate as to the amount of such payment

or liability delivered to any Lender by the Administrative Agent shall be conclusive absent manifest error. Each Lender hereby authorizes the Administrative Agent to set off and apply any and all amounts at any time owing to such Lender under any Loan Document or otherwise payable by the Administrative Agent to the Lender from any other source against any amount due to the Administrative Agent under this paragraph (e).

(f) Status of Lenders. Any Lender that is entitled to an exemption from or reduction of withholding Tax under the law of the jurisdiction in which the Borrower is resident for Tax purposes, or any treaty to which such jurisdiction is a party, with respect to payments hereunder or under any other Loan Document shall deliver to the Borrower (with a copy to the Administrative Agent), at the time or times prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent, such properly completed and executed documentation prescribed by applicable law as will permit such payments to be made without withholding or at a reduced rate of withholding. In addition, any Lender, if requested by the Borrower or the Administrative Agent, shall deliver such other documentation prescribed by applicable law or reasonably requested by the Borrower or the Administrative Agent as will enable the Borrower or the Administrative Agent to determine whether or not such Lender is subject to backup withholding or information reporting requirements.

Without limiting the generality of the foregoing, any Foreign Lender shall deliver to the Borrower and the Administrative Agent (in such number of copies as shall be requested by the recipient) on or prior to the date on which such Foreign Lender becomes a Lender under this Agreement (and from time to time thereafter (i) if such Foreign Lender shall determine that any applicable form or certification has expired or will then expire or has or will then become obsolete or incorrect or that an event has occurred that requires or will then require a change in the most recent form or certification previously delivered by it to the Borrower and the Administrative Agent and (ii) upon the request of the Borrower or the Administrative Agent, but only if such Foreign Lender is legally entitled to do so), whichever of the following is applicable:

(i) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E claiming eligibility for benefits of an income Tax treaty to which the United States of America is a party,

(ii) duly completed copies of Internal Revenue Service Form W-8ECI,

(iii) in the case of a Foreign Lender claiming the benefits of the exemption for portfolio interest under Section 881(c) of the Internal Revenue Code, (x) a certificate (a ***"United States Tax Compliance Certificate"***) to the effect that such Foreign Lender is not (A) a "bank" within the meaning of Section 881(c)(3)(A) of the Internal Revenue Code, (B) a "10 percent shareholder" of the Borrower within the meaning of Section 881(c)(3)(B) of the Internal Revenue Code, (C) a "controlled foreign corporation" described in Section 881(c)(3)(C) of the Internal Revenue Code nor (D) engaged in the conduct of a trade or business within the United States to which the interest payment is effectively connected and (y) duly completed copies of Internal Revenue Service Form W-8BEN or Form W-8BEN-E,

(iv) to the extent a Foreign Lender is not the beneficial owner (for example, where the Foreign Lender is a partnership or participating Lender granting a typical participation), a complete and executed Internal Revenue Service Form W-8IMY, accompanied by a Form W-8ECI, Form W-8BEN, Form W-8BEN-E, a United States Tax Compliance Certificate, Internal Revenue Service Form W-9 and/or other certification

documents from each beneficial owner, as applicable; *provided* that, if the Foreign Lender is a partnership (and not a participating Lender) and one or more partners of such Foreign Lender are claiming the portfolio interest exemption, such Foreign Lender shall provide a United States Tax Compliance Certificate, on behalf of such beneficial owner(s) in lieu of requiring each beneficial owner to provide its own certificate, or

(v) any other form prescribed by applicable law as a basis for claiming exemption from or a reduction in United States Federal withholding Tax duly completed together with such supplementary documentation as may be prescribed by applicable law to permit the Borrower to determine the withholding or deduction required to be made.

If a payment made to a Lender under any Loan Document would be subject to U.S. federal withholding Tax imposed by FATCA if such Lender were to fail to comply with the applicable reporting requirements of FATCA (including those contained in Section 1471(b) or 1472(b) of the Internal Revenue Code, as applicable), such Lender shall deliver to the Borrower and the Administrative Agent at the time or times prescribed by law and at such time or times reasonably requested by the Borrower or the Administrative Agent such documentation prescribed by applicable law (including as prescribed by Section 1471(b)(3)(C) of the Internal Revenue Code) and such additional documentation reasonably requested by the Borrower or the Administrative Agent as may be necessary for the Borrower and the Administrative Agent to comply with their obligations under FATCA and to determine that such Lender has complied with such Lender's obligations under FATCA or to determine the amount to deduct and withhold from such payment. Solely for purposes of this clause, "FATCA" shall include any amendments made to FATCA after the date of this Agreement.

Without limiting the foregoing, upon request of the Administrative Agent or the Borrower, each Lender that is a "United States person" within the meaning of Section 7701(a)(30) of the Internal Revenue Code that lends to the Borrower (each, a ***"U.S. Lender"***) shall deliver to the Administrative Agent and the Borrower two duly signed, properly completed copies of Internal Revenue Service Form W-9 on or prior to the Effective Date (or on or prior to the date it becomes a party to this Agreement), certifying that such U.S. Lender is entitled to an exemption from United States backup withholding, or any successor form.

(g) Treatment of Certain Refunds. If the Administrative Agent or a Lender determines, in its sole discretion exercised in good faith, that it has received a refund of any Taxes or Other Taxes as to which it has been indemnified by the Borrower or with respect to which the Borrower has paid additional amounts pursuant to this Section 3.10, it shall pay to the Borrower an amount equal to such refund (but only to the extent of indemnity payments made, or additional amounts paid, by the Borrower under this Section 3.10 with respect to the Taxes or Other Taxes giving rise to such refund), net of all reasonable and documented out-of-pocket expenses of the Administrative Agent or such Lender, as the case may be, and without interest (other than any interest paid by the relevant Governmental Authority with respect to such refund), *provided* that the Borrower, upon the request of the Administrative Agent or such Lender, agrees to repay the amount paid over to the Borrower (plus any penalties, interest or other charges imposed by the relevant Governmental Authority) to the Administrative Agent or such Lender in the event the Administrative Agent or such Lender is required to repay such refund or Tax credit to such Governmental Authority. This paragraph shall not be construed to require the Administrative Agent or any Lender to make available its Tax returns (or any other information relating to its Taxes that it deems confidential) to the Borrower or any other Person.

(h) Designation of a Different Lending Office. If any Lender requests compensation under Section 3.6, or requires the Borrower to pay any additional amount to any Lender or any Governmental Authority for the account of any Lender pursuant to this Section 3.10, then such Lender shall use reasonable efforts to designate a different lending office for funding or booking its Loans hereunder or to assign its rights and obligations hereunder to another of its offices, branches or affiliates, if such designation or assignment (i) would eliminate or reduce amounts payable pursuant to Section 3.6 or this Section 3.10, as the case may be, in the future and (ii) in the judgment of such Lender, would not subject such Lender to any unreimbursed cost or expense and would not otherwise be disadvantageous to such Lender. The Borrower hereby agrees to pay all reasonable and documented out-of-pocket costs and expenses incurred by any Lender in connection with any such designation or assignment.

(i) Survival. Each party's obligations under this Section 3.10 shall survive the resignation or replacement of the Administrative Agent or any assignment of rights by, or the replacement of, a Lender, the termination of the Commitments and the repayment, satisfaction or discharge of all obligations under any Loan Document.

3.11 Facility Fees

The Borrower agrees to pay to the Administrative Agent for the account of each Lender a fee (the ***"Facility Fee"***) during the period commencing on the Effective Date and ending on the Expiration Date, payable quarterly in arrears on the last day of each March, June, September and December of each year, commencing on the last day of the calendar quarter during which the Facility Fee shall commence to accrue, and on the Expiration Date, at a rate per annum equal to the Applicable Margin of (a) prior to the Commitment Termination Date or such earlier date upon which all of the Commitments shall have been terminated in accordance with Section 2.6, the Commitment Amount of such Lender (whether used or unused), and (b) thereafter, the sum of the outstanding principal balance of all Revolving Credit Loans of such Lender. Notwithstanding anything to the contrary contained in this Section 3.11, on and after the Commitment Termination Date, the Facility Fee shall be payable upon demand. In addition, upon each reduction of the Aggregate Commitment Amount, the Borrower shall pay the Facility Fee accrued on the amount of such reduction through the date of such reduction. The Facility Fee shall be computed on the basis of a 360-day year for the actual number of days elapsed.

3.12 Reserved

3.13 Replacement of Lender

If (x) the Borrower is obligated to pay to any Lender any amount under Section 3.6 or Section 3.10, the Borrower shall have the right within 90 days thereafter, (y) any Lender shall be a Defaulting Lender, the Borrower shall have the right at any time during which such Lender shall remain a Defaulting Lender, or (z) any Lender shall have not consented to an Extension Request, the Borrower shall have the right at any time on the relevant Extension Date, in each case in accordance with the requirements of Section 11.7(b) and only if no Default shall exist, to replace such Lender (the ***"Replaced Lender"***) with one or more Eligible Assignees (each a ***"Replacement Lender"***); *provided* that (i) at the time of any replacement pursuant to this Section 3.13, the Replacement Lender shall enter into one or more Assignment and Assumptions pursuant to Section 11.7(b) (with the processing and recordation fee referred to in Section 11.7(b) payable pursuant to said Section 11.7(b) to be paid by the Replacement Lender) pursuant to which the Replacement Lender shall acquire the Commitment and the outstanding Loans of the Replaced Lender and, in connection therewith, shall pay the following: (a) to the Replaced Lender, an amount equal to the sum of (A) the principal of, and all accrued and unpaid interest on, all outstanding Loans of the Replaced Lender and (B) an amount equal to all accrued, but unpaid, fees owing to the Replaced Lender, and (b) to

the Administrative Agent an amount equal to all amounts owed by such Replaced Lender to the Administrative Agent under this Agreement, including, without limitation, an amount equal to the principal of, and all accrued and unpaid interest on, all outstanding Loans of the Replaced Lender, a corresponding amount of which was made available by the Administrative Agent to the Borrower pursuant to Section 3.1 and which has not been repaid to the Administrative Agent by such Replaced Lender or the Borrower, and (ii) all obligations of the Borrower owing to the Replaced Lender (other than those specifically described in clause (i) above in respect of which the assignment purchase price has been, or is concurrently being, paid) shall be paid in full to such Replaced Lender concurrently with such replacement. Upon the execution and delivery of the respective Assignment and Assumptions and the payment of amounts referred to in clauses (i) and (ii) of this Section 3.13, the Replacement Lender shall become a Lender hereunder and the Replaced Lender shall cease to constitute a Lender hereunder, except with respect to indemnification provisions under this Agreement that are intended to survive the termination of the Commitments and the repayment of the Loans which may be applicable to any such Replaced Lender prior to the date of its replacement. Solely for the purpose of calculating break funding payments under Section 3.5, the assignment by any Replaced Lender of any Eurodollar Advance prior to the last day of the Interest Period applicable thereto pursuant to clause (x) or (z) of this Section 3.13 shall be deemed to constitute a prepayment by the Borrower of such Eurodollar Advance.

4. REPRESENTATIONS AND WARRANTIES

In order to induce the Administrative Agent and the Lenders to enter into this Agreement, and the Lenders to make the Loans, the Borrower hereby makes the following representations and warranties to the Administrative Agent and the Lenders:

4.1 Existence and Power

The Borrower is duly organized, validly existing and in good standing under the laws of the jurisdiction of its incorporation, has all requisite corporate power and authority to own its Property and to carry on its business as now conducted, and is qualified to do business as a foreign corporation and is in good standing in each jurisdiction in which it owns or leases real Property or in which the nature of its business requires it to be so qualified (except those jurisdictions where the failure to be so qualified or to be in good standing could not reasonably be expected to have a Material Adverse effect).

4.2 Authority; EEA Financial Institution

The Borrower has full corporate power and authority to enter into, execute, deliver and perform the terms of the Loan Documents, all of which have been duly authorized by all proper and necessary corporate action and are not in contravention of: (i) except as could not reasonably be expected to have a Material Adverse effect, any applicable law or (ii) the terms of its Certificate of Incorporation and By-Laws. No consent or approval of, or other action by, shareholders of the Borrower, any Governmental Authority, or any other Person (which has not already been obtained) is required to authorize in respect of the Borrower, or is required in connection with, the execution, delivery and performance by the Borrower of the Loan Documents or is required as a condition to the enforceability of the Loan Documents against the Borrower. The Borrower is not an EEA Financial Institution.

4.3 Binding Agreement

The Loan Documents constitute the valid and legally binding obligations of the Borrower, enforceable against the Borrower in accordance with their respective terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting

the enforcement of creditors' rights generally and by equitable principles relating to the availability of specific performance as a remedy.

4.4 Litigation

As of the Effective Date, there are no actions, suits, arbitration proceedings or claims (whether purportedly on behalf of the Borrower, any Material Subsidiary or otherwise) pending or, to the knowledge of the Borrower, threatened against the Borrower or any Material Subsidiary or any of their respective Properties, or maintained by the Borrower or any Material Subsidiary, at law or in equity, before any Governmental Authority which have not been disclosed in the SEC Reports that could reasonably be expected to have a Material Adverse effect. There are no proceedings pending or, to the knowledge of the Borrower, threatened against the Borrower or any Material Subsidiary (a) which call into question the validity or enforceability of any Loan Document, or otherwise seek to invalidate, any Loan Document, or (b) which might, individually or in the aggregate, materially and adversely affect any of the transactions contemplated by any Loan Document.

4.5 No Conflicting Agreements.

(a) [Reserved].

(b) No provision of any existing material mortgage, material indenture, material contract or material agreement or of any existing statute, rule, regulation, judgment, decree or order binding on the Borrower or affecting the Property of the Borrower (i) conflicts with any Loan Document, (ii) requires any consent which has not already been obtained with respect to any Loan Document, or (iii) would in any way prevent the execution, delivery or performance by the Borrower of the terms of any Loan Document, except in the case of provisions of any existing material mortgage, material indenture, material contract or material agreement, as could not reasonably be expected to have a Material Adverse effect. Neither the execution and delivery, nor the performance, by the Borrower of the terms of each Loan Document will constitute a default under, or result in the creation or imposition of, or obligation to create, any Lien upon the Property of the Borrower pursuant to the terms of any such mortgage, indenture, contract or agreement.

4.6 [Reserved]

4.7 [Reserved]

4.8 Governmental Regulations

The Borrower is not required to be registered as an "investment company" under the Investment Company Act of 1940, as amended.

4.9 Federal Reserve Regulations; Use of Proceeds

The Borrower is not engaged principally, or as one of its important activities, in the business of extending credit for the purpose of purchasing or carrying any Margin Stock. No part of the proceeds of the Loans has been or will be used, directly or indirectly, and whether immediately, incidentally or ultimately, for a purpose which violates the provisions of Regulations T, U or X of the Board of Governors of the Federal Reserve System, as amended. Anything in this Agreement to the contrary notwithstanding, no Lender shall be obligated to extend credit to or on behalf of the Borrower in violation of any limitation or prohibition provided by any applicable law, regulation or statute, including said Regulation U. Following application of the proceeds of each Loan, not more than 25% (or such greater or lesser percentage as is

provided in the exclusions from the definition of "Indirectly Secured" contained in said Regulation U as in effect at the time of the making of such Loan) of the value of the assets of the Borrower and the Subsidiaries on a Consolidated basis that are subject to Section 8.2 will be Margin Stock.

4.10 No Misrepresentation

No representation or warranty contained in any Loan Document and no certificate or written report furnished by the Borrower to the Administrative Agent or any Lender pursuant to any Loan Document contains, as of its date, a misstatement of a material fact, or omits to state, as of its date, a material fact required to be stated in order to make the statements therein contained, when taken as a whole, not materially misleading (*provided* that any representation, warranty, statement or written report that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such date) in the light of the circumstances under which made (after giving effect to all supplements and updates with respect thereto) (it being understood that the Borrower makes no representation or warranty hereunder with respect to any projections, other forward looking information, industry information or general economic information). As of the Effective Date, the information included in any Beneficial Ownership Certification of the Borrower, if applicable, is true and correct in all respects.

4.11 [Reserved]

4.12 [Reserved]

4.13 Financial Statements

The Borrower has heretofore delivered to the Lenders through the Administrative Agent copies of the audited Consolidated Balance Sheet of the Borrower and its Subsidiaries as of December 31, 2018, and the related Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for the fiscal year then ended. The financial statements referred to immediately above, including all related notes and schedules, are herein referred to collectively as the ***"Financial Statements"***. The Financial Statements fairly present, in all material respects, the Consolidated financial condition and results of the operations of the Borrower and the Subsidiaries as of the dates and for the periods indicated therein and, except as noted therein, have been prepared in conformity with GAAP as then in effect. Neither the Borrower nor any of the Subsidiaries has any material obligation or liability of any kind (whether fixed, accrued, contingent, unmatured or otherwise) which, in accordance with GAAP as then in effect, should have been disclosed in the Financial Statements and was not. During the period from January 1, 2019 to and including the Effective Date, there was no Material Adverse change, including as a result of any change in law, in the Consolidated financial condition, operations, business or Property of the Borrower and the Subsidiaries taken as a whole that was not disclosed in the SEC Reports.

4.14 Anti-Corruption Laws and Sanctions

The Borrower has implemented and maintains in effect policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions, and the Borrower, the Subsidiaries and their respective officers and employees and, to the knowledge of the Borrower, its directors are in compliance with Anti-Corruption Laws and applicable Sanctions in all material respects. None of (a) the Borrower, any Subsidiary or, to the knowledge of the Borrower or such Subsidiary, any of their respective directors, officers or employees, or (b) to the knowledge of the Borrower, any agent of the Borrower or any Subsidiary that will act in any capacity in connection with or benefit from the credit facility established hereby, is a

Sanctioned Person. No Loan, use of proceeds or other transaction contemplated by this Agreement will violate Anti-Corruption Laws or applicable Sanctions.

5. CONDITIONS TO EFFECTIVENESS

This Agreement shall become effective on and as of the date (the ***"Effective Date"***) that the following conditions shall have been satisfied or waived in accordance with Section 11.1:

5.1 Agreement

The Administrative Agent shall have received counterparts of this Agreement executed by the Borrower, the Administrative Agent and each Lender.

5.2 Notes

The Administrative Agent shall have received a Note, executed and delivered by the Borrower, for each Lender that shall have given at least three Domestic Business Days' prior written notice of its request for a Note.

5.3 Corporate Action

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Secretary or an Assistant Secretary of the Borrower (i) attaching a true and complete copy of the resolutions of its Board of Directors and of all documents evidencing all other necessary corporate action taken by the Borrower to authorize this Agreement, the other Loan Documents and the transactions contemplated hereby and thereby, (ii) attaching a true and complete copy of its Certificate of Incorporation and By-Laws, (iii) setting forth the incumbency of the officer or officers of the Borrower who may sign this Agreement and the other Loan Documents, and any other certificates, requests, notices or other documents required hereunder or thereunder, and (iv) attaching a certificate of good standing of the Secretary of State of the State of Delaware.

5.4 Opinion of Counsel to the Borrower

The Administrative Agent shall have received (a) an opinion of Thomas Moffatt, assistant general counsel of the Borrower, dated the Effective Date, in the form of Exhibit D-1, and (b) an opinion of Shearman & Sterling LLP, special counsel to the Borrower, dated the Effective Date, in the form of Exhibit D-2.

5.5 No Default and Representations and Warranties

The Administrative Agent shall have received a certificate, dated the Effective Date, of the Senior Vice President and Treasurer of the Borrower certifying that there exists no Default and that the representations and warranties contained in this Agreement are true and correct in all material respects (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on the Effective Date), except those which are expressly specified to be made as of an earlier date.

5.6 Fees

The Administrative Agent shall have received all fees and other amounts due and payable to it on the Effective Date in respect of this Agreement.

5.7 Due Diligence; "Know Your Customer"

(a) Each Lender shall have received such documents and information as it may have requested in order to comply with "know-your-customer" and other applicable Sanctions, anti-terrorism, anti-money laundering and similar rules and regulations and related policies, to the extent the Borrower shall have received written requests therefor at least ten (10) Domestic Business Days prior to the Effective Date, and (b) at least five Domestic Business Days prior to the Effective Date, if the Borrower qualifies as a "legal entity customer" under the Beneficial Ownership Regulation, it shall have delivered to each Lender that so requests a Beneficial Ownership Certification.

Without limiting the generality of the provisions of Section 10.4, for purposes of determining compliance with the conditions specified in this Section 5, each Lender that has signed this Agreement shall be deemed to have consented to, approved or accepted or to be satisfied with, each document or other matter required thereunder to be consented to or approved by or acceptable or satisfactory to a Lender unless the Administrative Agent shall have received notice from such Lender prior to the proposed Effective Date specifying its objection thereto..

6. CONDITIONS OF LENDING - ALL LOANS

The obligation of each Lender on any Borrowing Date to make each Revolving Credit Loan and each Lender to make a Competitive Bid Loan are subject to the fulfillment (or waiver in accordance with Section 11.1) of the following conditions precedent:

6.1 Compliance

On each Borrowing Date, and after giving effect to the Loans to be made on such Borrowing Date, (a) there shall exist no Default, and (b) the representations and warranties contained in this Agreement shall be true and correct in all material respects with the same effect as though such representations and warranties had been made on such Borrowing Date (*provided* that any representation and warranty that is qualified as to "materiality", "Material Adverse" or similar language shall be true and correct (after giving effect to any qualification therein) in all respects on such Borrowing Date), except those which are expressly specified to be made as of an earlier date.

6.2 Requests

The Administrative Agent shall have timely received from the Borrower on or before such Borrowing Date, as applicable, a duly executed Borrowing Request and/or Competitive Bid Request (together with a duly executed Competitive Bid Accept/Reject Letter).

7. AFFIRMATIVE COVENANTS

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the Fees and all other sums payable under the Loan Documents (other than contingent obligations for which no claim has been made), the Borrower will:

7.1 Legal Existence

Except as may otherwise be permitted by Section 8.3 and Section 8.4, maintain, and cause each Material Subsidiary to maintain, its corporate existence in good standing in the jurisdiction of its incorporation or formation and in each other jurisdiction in which the failure so to do could reasonably be

expected to have a Material Adverse effect, except that the corporate existence of Material Subsidiaries may be terminated if (i) such Material Subsidiaries operate closing or discontinued operations or (ii) if the Borrower determines in good faith that such termination is in the best interests of the Borrower and is not materially disadvantageous to the Lenders.

7.2 Taxes

Pay and discharge when due, and cause each Material Subsidiary so to do, all taxes, assessments, governmental charges, license fees and levies upon or with respect to the Borrower and such Material Subsidiary, and upon the income, profits and Property thereof unless, and only to the extent, that either (i)(a) such taxes, assessments, governmental charges, license fees and levies shall be contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Material Subsidiary, and (b) such reserve or other appropriate provision as shall be required by GAAP shall have been made therefor, or (ii) the failure to pay or discharge such taxes, assessments, governmental charges, license fees and levies could not reasonably be expected to have a Material Adverse effect.

7.3 [Reserved]

7.4 [Reserved]

7.5 [Reserved]

7.6 Observance of Legal Requirements..

(a) Observe and comply in all material respects, and cause each Material Subsidiary so to do, with all laws, ordinances, orders, judgments, rules, regulations, certifications, franchises, permits, licenses, directions and requirements of all Governmental Authorities, which now or at any time hereafter may be applicable to it or to such Material Subsidiary, except (i) where a violation of which could not reasonably be expected to have a Material Adverse effect, or (ii) to the extent that such noncompliance is being contested in good faith and by appropriate proceedings diligently conducted by the Borrower or such Material Subsidiary.

(b) Maintain in effect and enforce policies and procedures designed to ensure compliance by the Borrower, the Subsidiaries and their respective directors, officers, employees and agents with Anti-Corruption Laws and applicable Sanctions.

7.7 Financial Statements and Other Information

Maintain, and cause each Subsidiary to maintain, a standard system of accounting in accordance with GAAP, and furnish to the Administrative Agent for distribution to the Lenders:

(a) As soon as available and, in any event, within 90 days after the close of each fiscal year, a copy of (x) the Borrower's 10-K in respect of such fiscal year, and (y) (i) the Borrower's Consolidated Balance Sheet as of the end of such fiscal year, and (ii) the related Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows, as of and through the end of such fiscal year, setting forth in each case in comparative form the corresponding figures in respect of the previous fiscal year, all in reasonable detail, and accompanied by a report of the Borrower's auditors, which report shall state that (A) such auditors audited such financial statements, (B) such audit was made in accordance with generally accepted auditing standards in effect at the time and provides a reasonable basis for such opinion, and (C) said financial statements have been prepared in accordance with GAAP;

(b) As soon as available, and in any event within 45 days after the end of each of the first three fiscal quarters of each fiscal year, a copy of (x) the Borrower's 10-Q in respect of such fiscal quarter, and (y) (i) the Borrower's condensed Consolidated Balance Sheet as of the end of such quarter and (ii) the related condensed Consolidated Statements of Income, Comprehensive Income, Shareholders' Equity and Cash Flows for (A) such quarter and (B) the period from the beginning of the then current fiscal year to the end of such quarter, in each case in comparable form with the prior fiscal year, all in reasonable detail and prepared in accordance with GAAP (without footnotes and subject to year-end adjustments);

(c) Simultaneously with the delivery of the financial statements required by clauses (a) and (b) above, a certificate of the Chief Financial Officer or the Senior Vice President and Treasurer of the Borrower certifying that no Default shall have occurred or be continuing or, if so, specifying in such certificate all such Defaults, and setting forth computations in reasonable detail demonstrating compliance with Section 8.9.

(d) Prompt notice upon the Borrower becoming aware of any change in the applicability of a Pricing Level;

(e) As soon as practicable after becoming available, copies of all regular or periodic reports (including current reports on Form 8-K) which the Borrower or any Subsidiary may now or hereafter be required to file with or deliver to the U.S. Securities and Exchange Commission, or any other Governmental Authority succeeding to the functions thereof;

(f) **[reserved]**;

(g) Prompt written notice of the occurrence of (i) each Default and (ii) each Event of Default;

(h) **[reserved]**;

(i) From time to time, such other information regarding the financial position or business of the Borrower and the Subsidiaries as the Administrative Agent, at the reasonable request of any Lender, may reasonably request; and

(j) Prompt written notice of such other information with documentation required by bank regulatory authorities under applicable "know your customer" and anti-money laundering laws, rules and regulations (including, without limitation, the Patriot Act and the Beneficial Ownership Regulation), as from time to time may be reasonably requested by the Administrative Agent or any Lender (through the Administrative Agent).

Information required to be delivered pursuant to (x) this Section 7.7 shall be deemed to have been delivered if such information shall have been posted by the Administrative Agent on a Debtdomain, IntraLinks, Syndtrak or similar electronic system (the ***"Platform"***) to which each Lender has been granted access and (y) clauses (a), (b) and (e) of this Section 7.7 shall be deemed delivered to the Administrative Agent and the Lenders when available on the Borrower's website at http://www.cvshealth.com or the website of the U.S. Securities and Exchange Commission at http://www.sec.gov. Information delivered pursuant to this Section 7.7 may also be delivered by electronic communications pursuant to procedures approved by the Administrative Agent.

The Borrower hereby acknowledges that the Administrative Agent and/or the Joint Lead Arrangers will make available to the Lenders materials and/or information provided by or on behalf of the Borrower hereunder (collectively, "***Borrower Materials***") by posting the Borrower Materials on the Platform.

7.8 Records

Upon reasonable notice and during normal business hours after an Event of Default has occurred and is continuing, permit representatives of the Administrative Agent and each Lender to visit the offices of the Borrower and each Material Subsidiary, to examine the books and records (other than tax returns and work papers related to tax returns) thereof and auditors' reports relating thereto, to discuss the affairs of the Borrower and each Material Subsidiary with the respective officers thereof, and to meet and discuss the affairs of the Borrower and each Material Subsidiary with the Borrower's auditors, except for information covered by an attorney-client or other legal privilege or to the extent the inspection would reasonably be expected to result in a violation or other breach of any third party confidentiality agreement.

8. NEGATIVE COVENANTS

The Borrower covenants and agrees that on and after the Effective Date and until the later to occur of (a) the Commitment Termination Date and (b) the payment in full of the Loans, the Fees and all other sums payable under the Loan Documents (other than contingent obligations for which no claim has been made), the Borrower will not:

8.1 [Reserved]

8.2 Liens

Create, incur, assume or suffer to exist any Lien against or on any Property now owned or hereafter acquired by the Borrower or any of the Subsidiaries, or permit any of the Subsidiaries so to do, except any one or more of the following types of Liens: (a) Liens in connection with workers' compensation, unemployment insurance or other social security obligations (which phrase shall not be construed to refer to ERISA or the minimum funding obligations under Section 412 of the Internal Revenue Code), (b) Liens to secure the performance of bids, tenders, letters of credit, contracts (other than contracts for the payment of Indebtedness), leases, statutory obligations, surety, customs, appeal, performance and payment bonds and other obligations of like nature, or to qualify to do business, maintain insurance or obtain other benefits, in each such case arising in the ordinary course of business, (c) mechanics', workmen's, carriers', warehousemen's, materialmen's, landlords' or other like Liens arising in the ordinary course of business with respect to obligations which are not due or which are being contested in good faith and by appropriate proceedings diligently conducted, (d) Liens for taxes, assessments, fees or governmental charges the payment of which is not required under Section 7.2, (e) easements, rights of way, restrictions, leases of Property to others, easements for installations of public utilities, title imperfections and restrictions, zoning ordinances and other similar encumbrances affecting Property which in the aggregate do not materially impair its use for the operation of the business of the Borrower or such Subsidiary, (f) Liens on Property of the Subsidiaries under capital leases and Liens on Property (including on the capital stock or other equity interests) of the Subsidiaries acquired (whether as a result of purchase, capital lease, merger or other acquisition) and either existing on such Property when acquired, or created contemporaneously with or within 12 months of such acquisition to secure the payment or financing of the purchase price of such Property (including the construction, development, substantial repair, alteration or improvement thereof), and any renewals thereof, *provided* that such Liens attach only to the Property so purchased or acquired (including any such construction, development, substantial repair, alteration or improvement thereof) and *provided further* that the Indebtedness secured by such Liens is not otherwise prohibited hereunder, (g) statutory Liens in favor of lessors arising in connection with Property leased to the Borrower or any of the

Subsidiaries, (h) Liens of attachments, judgments or awards against the Borrower or any of the Subsidiaries with respect to which an appeal or proceeding for review shall be pending or a stay of execution or bond shall have been obtained, or which are otherwise being contested in good faith and by appropriate proceedings diligently conducted, and in respect of which adequate reserves shall have been established in accordance with GAAP on the books of the Borrower or such Subsidiary, (i) Liens securing Indebtedness of a Subsidiary to the Borrower or another Subsidiary, (j) Liens (other than Liens permitted by any of the foregoing clauses) arising in the ordinary course of its business which do not secure Indebtedness and do not, in the aggregate, materially detract from the value of the business of the Borrower and its Subsidiaries, taken as a whole, (k) Liens in favor of the United States of America, or any state thereof, to secure partial, progress, advance or other payments pursuant to any contract or provisions of any statute, and (l) additional Liens securing Indebtedness of the Borrower and the Subsidiaries in an aggregate outstanding Consolidated principal amount not exceeding 15% of Net Tangible Assets.

8.3 Dispositions

Make any Disposition (including by way of limited liability company division), or permit any of its Subsidiaries so to do, of all or substantially all of the assets of the Borrower and the Subsidiaries on a Consolidated basis; provided that (a) any Subsidiary may make Dispositions to the Borrower, and (b) so long as no Default or Event of Default exists prior to or after giving effect thereto, (i) the Borrower may dispose of all or substantially all of its assets to a wholly-owned domestic Subsidiary that assumes all of the obligations of the Borrower under this Agreement and (ii) any Subsidiary may dispose of all or substantially all of its assets to another Subsidiary, provided that if such Subsidiary is a wholly-owned Subsidiary, the transferee shall be a wholly-owned Subsidiary.

8.4 Merger or Consolidation, Etc.

Consolidate with, be acquired by, or merge into or with any Person unless (x) immediately after giving effect thereto no Default shall or would exist and (y) either (i) the Borrower or (ii) a corporation organized and existing under the laws of one of the States of the United States of America shall be the survivor of such consolidation or merger, *provided* that if the Borrower is not the survivor, the corporation which is the survivor shall expressly assume, pursuant to an instrument executed and delivered to the Administrative Agent, and in form and substance reasonably satisfactory to the Administrative Agent, all obligations of the Borrower under the Loan Documents and the Administrative Agent shall have received such documents, opinions and certificates as it shall have reasonably requested in connection therewith.

8.5 [Reserved]

8.6 [Reserved]

8.7 Limitation on Upstream Dividends by Subsidiaries

Permit or cause any of the Subsidiaries (other than any Insurance Subsidiary) to enter into or agree, or otherwise be or become subject, to any agreement, contract or other arrangement (other than this Agreement and the other Loan Documents) with any Person (each a ***"Restrictive Agreement"***) pursuant to the terms of which (a) such Subsidiary is or would be prohibited from declaring or paying any cash dividends on any class of its stock owned directly or indirectly by the Borrower or any of the other Subsidiaries or from making any other distribution on account of any class of any such stock (herein referred to as ***"Upstream Dividends"***), or (b) the declaration or payment of Upstream Dividends by a Subsidiary to the Borrower or another Subsidiary, on an annual or cumulative basis, is or would be otherwise limited or restricted (***"Dividend Restrictions"***). Notwithstanding the foregoing, nothing in this Section 8.7 shall prohibit:

(a) Dividend Restrictions set forth in any Restrictive Agreement in effect on the date hereof and any extensions, refinancings, renewals or replacements thereof; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(b) Dividend Restrictions existing with respect to any Person acquired by the Borrower or any Subsidiary and existing at the time of such acquisition, which Dividend Restrictions are not applicable to any Person or the property or assets of any Person other than such Person or its property or assets acquired, and any extensions, refinancings, renewals or replacements of any of the foregoing; *provided* that the Dividend Restrictions in any such extensions, refinancings, renewals or replacements are no less favorable in any material respect to the Lenders than those Dividend Restrictions that are then in effect and that are being extended, refinanced, renewed or replaced;

(c) Dividend Restrictions consisting of customary net worth, leverage and other financial covenants, customary covenants regarding the merger of or sale of stock or assets of a Subsidiary, customary restrictions on transactions with affiliates, and customary subordination provisions governing Indebtedness owed to the Borrower or any Subsidiary, in each case contained in, or required by, any agreement governing Indebtedness incurred by a Subsidiary in accordance with the terms of this Agreement; or

(d) Dividend Restrictions contained in any other credit agreement so long as such Dividend Restrictions are no more restrictive than those contained in this Agreement (including Dividend Restrictions contained in the Existing 2017 Credit Agreement, the Existing 2018 Credit Agreement, the Existing 2019 Credit Agreement and the Existing Term Loan Agreement.

8.8 [Reserved]

8.9 Ratio of Consolidated Indebtedness to Total Capitalization

Permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.60:1.00; *provided* that from the Effective Date through and including the fiscal quarter ending September 30, 2019, the Borrower will not permit its ratio of Consolidated Indebtedness to Total Capitalization at the end of any fiscal quarter to exceed 0.65:1.00; *provided further* that (i) subsequent to the fiscal quarter ending March 31, 2020, upon the consummation of any Material Acquisition and the written election of the Borrower to the Administrative Agent no later than thirty days following the consummation of such Material Acquisition, the maximum permitted ratio of Consolidated Indebtedness to Total Capitalization shall be increased by 0.05:1.00 above the otherwise-applicable maximum permitted ratio of Consolidated Indebtedness to Total Capitalization with respect to the last day of the fiscal quarter during which such Material Acquisition shall have been consummated and the last day of each of the immediately following three consecutive fiscal quarters, and (ii) between the signing of the definitive agreement (or offer documentation, as applicable) for a Material Acquisition and the earlier of (x) the closing of such Material Acquisition and (y) thirty days following the termination of such definitive agreement (or offer documentation, as applicable) for such Material Acquisition, any Acquisition Debt incurred to finance such Material Acquisition shall be excluded for purposes of calculation the ratio of Consolidated Indebtedness to Total Capitalization hereunder. The Borrower shall only be permitted to make an election pursuant to the last proviso of the preceding sentence twice during the term of this Agreement, and there shall be at least two consecutive fiscal quarters between such elections during which time no increase to the maximum permitted ratio of Consolidated Indebtedness to Total Capitalization shall be in effect.

9. DEFAULT

9.1 Events of Default

The following shall each constitute an ***"Event of Default"*** hereunder:

(a) The failure of the Borrower to make any payment of principal on any Loan when due and payable; or

(b) The failure of the Borrower to make any payment of interest on any Loan or of any Fee on any date when due and payable and such default shall continue unremedied for a period of 5 Domestic Business Days after the same shall be due and payable; or

(c) The failure of the Borrower to observe or perform any covenant or agreement contained in Section 2.5, Section 7.1, or in Section 8; or

(d) The failure of the Borrower to observe or perform any other covenant or agreement contained in this Agreement, and such failure shall have continued unremedied for a period of 30 days after the Borrower shall have become aware of such failure; or

(e) [Reserved]; or

(f) Any representation or warranty of the Borrower (or of any of its officers on its behalf) made in any Loan Document, or made in any certificate or report or other document (other than an opinion of counsel) delivered on or after the date hereof in connection with any such Loan Document shall in any such case prove to have been incorrect or misleading (whether because of misstatement or omission) in any material respect when made; or

(g) (i) Obligations in an aggregate Consolidated amount in excess of the Threshold Amount of the Borrower (other than its obligations hereunder and under the Notes) and the Material Subsidiaries, whether as principal, guarantor, surety or other obligor, for the payment of any Indebtedness for Borrowed Money or any net liability under interest rate swap, collar, exchange or cap agreements, (A) shall become or shall be declared to be due and payable prior to the expressed maturity thereof, or (B) shall not be paid when due or within any grace period for the payment thereof, or (ii) any holder of any such obligations shall have the right to declare the Indebtedness for Borrowed Money evidenced thereby due and payable prior to its stated maturity; or

(h) An involuntary proceeding shall be commenced or an involuntary petition shall be filed seeking (i) liquidation, reorganization or other relief in respect of the Borrower or any Material Subsidiary or its debts, or of a substantial part of its assets, under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect or (ii) the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Material Subsidiary or for a substantial part of its assets, and, in any such case, such proceeding or petition shall continue undismissed for 60 days or an order or decree approving or ordering any of the foregoing shall be entered; or

(i) The Borrower or any Material Subsidiary shall (i) voluntarily commence any proceeding or file any petition seeking liquidation, reorganization or other relief under any federal, state or foreign bankruptcy, insolvency, receivership or similar law now or hereafter in effect, (ii) consent to the institution of, or fail to contest in a timely and appropriate manner, any proceeding

or petition described in clause (h) of this Section 9.1, (iii) apply for or consent to the appointment of a receiver, trustee, custodian, sequestrator, conservator or similar official for the Borrower or any Material Subsidiary or for a substantial part of its assets, (iv) file an answer admitting the material allegations of a petition filed against it in any such proceeding, (v) make a general assignment for the benefit of creditors or (vi) take any action for the purpose of effecting any of the foregoing; or

(j) The Borrower or any Material Subsidiary shall (i) generally not be paying its debts as such debts become due or (ii) admit in writing its inability to pay its debts as they become due; or

(k) Judgments or decrees in an aggregate Consolidated amount in excess of the Threshold Amount (to the extent not covered by independent third-party insurance or captive insurance as to which the insurer does not dispute coverage) against the Borrower and the Material Subsidiaries shall remain unpaid, unstayed on appeal, undischarged, unbonded or undismissed for a period of 60 days during which execution shall not be effectively stayed, or any action shall be legally taken by a judgment creditor to attach or levy upon any assets of the Borrower or any Material Subsidiary to enforce any such judgment; or

(l) After the Effective Date a Change of Control shall occur; or

(m) Solely to the extent as would have a Material Adverse effect: (i) any Termination Event shall occur (x) with respect to any Pension Plan (other than a Multiemployer Plan) or (y) with respect to any other retirement plan subject to Section 302 of ERISA or Section 412 of the Internal Revenue Code, which plan, during the five year period prior to such Termination Event, was the responsibility in whole or in part of the Borrower, any Material Subsidiary or any ERISA Affiliate; (ii) the failure to satisfy the minimum funding standards under Section 302 of ERISA or Section 412 of the Internal Revenue Code shall exist with respect to any Pension Plan for which the Borrower has responsibility (other than that portion of a Multiemployer Plan's Accumulated Funding Deficiency to the extent such Accumulated Funding Deficiency is attributable to employers other than Borrower); (iii) any Person shall engage in a Prohibited Transaction involving any Employee Benefit Plan in respect of which it is reasonably likely that liability will be imposed upon the Borrower; (iv) the Borrower shall fail to pay when due an amount which is payable by it to the PBGC or to a Pension Plan (including a Multiemployer Plan) under Title IV of ERISA; (v) the imposition on the Borrower of any tax under Section 4980(B)(a) of the Internal Revenue Code; or (vi) the assessment of a civil penalty on the Borrower with respect to any Employee Benefit Plan under Section 502(c) of ERISA. In determining the Consolidated amount for any purpose pursuant to this Section 9.1(m), the liabilities, funding amounts, taxes and penalties referenced in the foregoing clauses of this Section 9.1(m) shall include those of the Material Subsidiaries and ERISA Affiliates of the Borrower to the extent the Borrower is obligated to pay any such liabilities, funding amounts, taxes and penalties.

9.2 Remedies.

(a) Upon the occurrence of an Event of Default or at any time thereafter during the continuance of an Event of Default, the Administrative Agent, at the written request of the Required Lenders, shall notify the Borrower that the Commitments have been terminated and/or that all of the Loans, the Notes and all accrued and unpaid interest on any thereof and all other amounts owing under the Loan Documents have been declared immediately due and payable, *provided* that upon the occurrence of an Event of Default under Section 9.1(h), (i) or (j) with respect to the Borrower, the Commitments shall automatically terminate and all of the Loans, the Notes and all accrued and

unpaid interest on any thereof and all other amounts owing under the Loan Documents shall become immediately due and payable without declaration or notice to the Borrower. To the fullest extent not prohibited by law, except for the notice provided for in the preceding sentence, the Borrower expressly waives any presentment, demand, protest, notice of protest or other notice of any kind in connection with the Loan Documents and its obligations thereunder. To the fullest extent not prohibited by law, the Borrower further expressly waives and covenants not to assert any appraisement, valuation, stay, extension, redemption or similar law, now or at any time hereafter in force which might delay, prevent or otherwise impede the performance or enforcement of the Loan Documents.

(b) In the event that the Commitments shall have been terminated or all of the Loans and the Notes shall have become or been declared to be due and payable pursuant to the provisions of this Section 9.2, the Administrative Agent and the Lenders agree, among themselves, that any funds received from or on behalf of the Borrower under any Loan Document by any Lender (except funds received by any Lender as a result of a purchase from such Lender pursuant to the provisions of Section 11.9(b)) shall be remitted to the Administrative Agent, and shall be applied by the Administrative Agent in payment of the Loans and the other obligations of the Borrower under the Loan Documents in the following manner and order: (1) first, to the payment or reimbursement of the Administrative Agent and the Lenders, in that order, for any fees, expenses or amounts due from the Borrower pursuant to the provisions of Section 11.5, (2) second, to the payment of the Fees, (3) third, to the payment of any other fees, expenses or amounts (other than the principal of and interest on the Loans and the Notes) payable by the Borrower to the Administrative Agent or any of the Lenders under the Loan Documents, (4) fourth, to the payment, pro rata according to the outstanding principal balance of the Loans of each Lender, of interest due on the Loans, (5) fifth, to the payment, pro rata according to the sum of the aggregate outstanding principal balance of the Loans of each Lender of the aggregate outstanding principal balance of the Loans, and (6) sixth, any remaining funds shall be paid to whosoever shall be entitled thereto or as a court of competent jurisdiction shall direct.

(c) In the event that the Loans and the Notes shall have been declared due and payable pursuant to the provisions of this Section 9.2, the Administrative Agent upon the written request of the Required Lenders, shall proceed to enforce the rights of the holders of the Loans and the Notes by suit in equity, action at law and/or other appropriate proceedings, whether for payment or the specific performance of any covenant or agreement contained in the Loan Documents. In the event that the Administrative Agent shall fail or refuse so to proceed, each Lender shall be entitled to take such action as the Required Lenders shall deem appropriate to enforce its rights under the Loan Documents.

10. AGENT

10.1 Appointment and Authority.

Each Credit Party hereby irrevocably appoints BofA to act on its behalf as the Administrative Agent hereunder and under the other Loan Documents and authorizes the Administrative Agent to take such actions on its behalf and to exercise such powers as are delegated to the Administrative Agent by the terms hereof or thereof, together with such actions and powers as are reasonably incidental thereto. The provisions of this Section 10 (other than Section 10.6) are solely for the benefit of the Administrative Agent and the Credit Parties and the Borrower shall have no rights as a third party beneficiary or otherwise of any of such provisions.

10.2 Rights as a Lender

The Person serving as the Administrative Agent hereunder shall have the same rights and powers in its capacity as a Lender as any other Lender and may exercise the same as though it were not the Administrative Agent and the term "Lender" or "Lenders" shall, unless otherwise expressly indicated or unless the context otherwise requires, include the Person serving as the Administrative Agent hereunder in its individual capacity. Such Person and its Affiliates may accept deposits from, lend money to, own securities of, act as the financial advisor or in any other advisory capacity for and generally engage in any kind of business with, the Borrower, any of its Subsidiaries or any other Affiliate thereof as if such Person were not the Administrative Agent hereunder and without any duty to account therefor to the Lenders.

10.3 Exculpatory Provisions

(a) The Administrative Agent shall not have any duties or obligations except those expressly set forth herein and in the other Loan Documents. Without limiting the generality of the foregoing, the Administrative Agent:

(1) shall not be subject to any fiduciary or other implied duties, regardless of whether a Default has occurred and is continuing;

(2) shall not have any duty to take any discretionary action or exercise any discretionary powers, except discretionary rights and powers expressly contemplated hereby or by the other Loan Documents that the Administrative Agent is required to exercise as directed in writing by the Required Lenders (or such other number or percentage of the Lenders as shall be expressly provided for herein or in the other Loan Documents); *provided* that the Administrative Agent shall not be required to take any action that, in its opinion or the opinion of its counsel, may expose the Administrative Agent to liability or that is contrary to any Loan Document or applicable law; and

(3) shall not, except as expressly set forth herein and in the other Loan Documents, have any duty to disclose, and shall not be liable for the failure to disclose, any information relating to the Borrower, any of its Subsidiaries or any Affiliate thereof that is communicated to or obtained by the Person serving as the Administrative Agent or any of its Affiliates in any capacity.

(b) The Administrative Agent shall not be liable for any action taken or not taken by it (i) with the consent or at the request of the Required Lenders (or such other number or percentage of the Lenders as shall be necessary, or as the Administrative Agent shall believe in good faith shall be necessary, under the circumstances as provided in Section 11.1 and Section 9) or (ii) in the absence of its own gross negligence or willful misconduct. The Administrative Agent shall be deemed not to have knowledge of any Default unless and until written notice describing such Default is given to the Administrative Agent by the Borrower or a Lender.

(c) The Administrative Agent shall not be responsible for or have any duty to ascertain or inquire into (i) any statement, warranty or representation made in or in connection with this Agreement or any other Loan Document, (ii) the contents of any certificate, report or other document delivered hereunder or thereunder or in connection herewith or therewith, (iii) the performance or observance of any of the covenants, agreements or other terms or conditions set forth herein or therein or the occurrence of any Default, (iv) the validity, enforceability, effectiveness or genuineness of this Agreement, any other Loan Document or any other agreement,

instrument or document or (v) the satisfaction of any condition set forth in Section 5 or Section 6 or elsewhere herein, other than to confirm receipt of items expressly required to be delivered to the Administrative Agent.

(d) The Administrative Agent shall not be responsible or have any liability for, or have any duty to ascertain, inquire into, monitor or enforce, compliance with the provisions of this Agreement relating to Disqualified Institutions. Without limiting the generality of the foregoing, the Administrative Agent shall not (x) be obligated to ascertain, monitor or inquire as to whether any Lender or prospective Lender is a Disqualified Institution or (y) have any liability with respect to or arising out of any assignment of Loans, or disclosure of confidential information, to any Disqualified Institution.

10.4 Reliance by Administrative Agent

The Administrative Agent shall be entitled to rely upon, and shall not incur any liability for relying upon, any notice, request, certificate, consent, statement, instrument, document or other writing (including any electronic message, internet or intranet website posting or other distribution) believed by it to be genuine and to have been signed, sent or otherwise authenticated by the proper Person. The Administrative Agent also may rely upon any statement made to it orally or by telephone and believed by it to have been made by the proper Person, and shall not incur any liability for relying thereon. In determining compliance with any condition hereunder to the making of a Loan that by its terms must be fulfilled to the satisfaction of a Lender, the Administrative Agent may presume that such condition is satisfactory to such Lender unless the Administrative Agent shall have received notice to the contrary from such Lender prior to the making of such Loan. The Administrative Agent may consult with legal counsel (who may be counsel for the Borrower), independent public accounting firms and other experts selected by it and shall not be liable for any action taken or not taken by it in accordance with the advice of any such counsel, accounting firm or experts.

10.5 Delegation of Duties

The Administrative Agent may perform any and all of its duties and exercise its rights and powers hereunder or under any other Loan Document by or through any one or more sub-agents appointed by the Administrative Agent. The Administrative Agent and any such sub-agent may perform any and all of its duties and exercise its rights and powers by or through their respective Related Parties. The exculpatory provisions of this Section 10 shall apply to any such sub-agent and to the Related Parties of the Administrative Agent and any such sub-agent, and shall apply to their respective activities in connection with the syndication of the credit facilities provided for herein as well as activities as the Administrative Agent.

10.6 Resignation of Administrative Agent

The Administrative Agent may at any time give notice of its resignation to the Credit Parties and the Borrower. Upon receipt of any such notice of resignation, the Required Lenders shall have the right, subject to, so long as no Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed), to appoint a successor, which shall be a bank with an office in New York, New York, or an Affiliate of any such bank with an office in New York, New York. If no such successor shall have been so appointed by the Required Lenders and shall have accepted such appointment within 30 days after the retiring Administrative Agent gives notice of its resignation, then the retiring Administrative Agent may on behalf of the Credit Parties, appoint a successor Administrative Agent meeting the qualifications set forth above, subject to, so long as no Event of Default under Section 9.1(a),

Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) has occurred and is continuing, the consent of the Borrower (such consent not to be unreasonably withheld or delayed); *provided* that if the Administrative Agent shall notify the Borrower and the Credit Parties that no qualifying Person has accepted such appointment, then such resignation shall nonetheless become effective in accordance with such notice and (a) the retiring Administrative Agent shall be discharged from its duties and obligations hereunder and under the other Loan Documents and (b) all payments, communications and determinations provided to be made by, to or through the Administrative Agent shall instead be made by or to each Credit Party directly, until such time as the Required Lenders appoint a successor Administrative Agent as provided for above in this Section. Upon the acceptance of a successor's appointment as Administrative Agent hereunder, such successor shall succeed to and become vested with all of the rights, powers, privileges and duties of the retiring (or retired) Administrative Agent, and the retiring Administrative Agent shall be discharged from all of its duties and obligations hereunder or under the other Loan Documents (if not already discharged therefrom as provided above in this Section). The fees payable by the Borrower to a successor Administrative Agent shall be the same as those payable to its predecessor unless otherwise agreed in writing between the Borrower and such successor. After the retiring Administrative Agent's resignation hereunder and under the other Loan Documents, the provisions of this Section 10 and Section 11.5 shall continue in effect for the benefit of such retiring Administrative Agent, its sub-agents and their respective Related Parties in respect of any actions taken or omitted to be taken by any of them while the retiring Administrative Agent was acting as Administrative Agent.

10.7 Non-Reliance on Administrative Agent and Other Credit Parties

Each Credit Party acknowledges that it has, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it has deemed appropriate, made its own credit analysis and decision to enter into this Agreement. Each Credit Party also acknowledges that it will, independently and without reliance upon the Administrative Agent or any other Credit Party or any of their Related Parties and based on such documents and information as it shall from time to time deem appropriate, continue to make its own decisions in taking or not taking action under or based upon this Agreement, any other Loan Document or any related agreement or any document furnished hereunder or thereunder.

10.8 No Other Duties, etc.

Anything herein to the contrary notwithstanding, none of the Joint Lead Arrangers, the Co-Documentation Agents or the Co-Syndication Agents listed on the cover page hereof shall have any powers, duties or responsibilities under this Agreement or any of the other Loan Documents, except in its capacity, as applicable, as the Administrative Agent or a Lender.

11. OTHER PROVISIONS

11.1 Amendments, Waivers, Etc.

With the written consent of the Required Lenders, the Administrative Agent and the Borrower may, from time to time, enter into written amendments, supplements or modifications of the Loan Documents (which, for the avoidance of doubt, shall require the prior written consent of the Borrower) and, with the written consent of the Required Lenders and the Borrower, the Administrative Agent on behalf of the Lenders may execute and deliver to any such parties a written instrument waiving or consenting to the departure from, on such terms and conditions as the Administrative Agent may specify in such instrument (which terms and conditions shall have been agreed to by the Borrower), any of the requirements of the Loan Documents or any Default or any Event of Default and its consequences, *provided* that no such amendment, supplement, modification, waiver or consent shall (i) increase the Commitment Amount of

any Lender without the consent of such Lender (*provided* that no waiver of a Default or Event of Default shall be deemed to constitute such an increase), (ii) extend the Commitment Period without the consent of each Lender directly affected thereby, (iii) reduce the amount, or extend the time of payment, of the Fees without the consent of each Lender directly affected thereby, (iv) reduce the rate, or extend the time of payment of, interest on any Revolving Credit Loan or any Note (other than the applicability of any post-default increase in such rate of interest) without the consent of each Lender directly affected thereby, (v) reduce the amount of, or extend the time of payment of, any payment of any principal on any Revolving Credit Loan or any Note without the consent of each Lender directly affected thereby, (vi) decrease or forgive the principal amount of any Revolving Credit Loan or any Note without the consent of each Lender directly affected thereby, (vii) consent to any assignment or delegation by the Borrower of any of its rights or obligations under any Loan Document without the consent of each Lender, (viii) change the provisions of this Section 11.1 without the consent of each Lender, (ix) change the definition of Required Lenders without the consent of each Lender, (x) change the several nature of the obligations of the Lenders without the consent of each Lender, or (xi) change the sharing provisions among Lenders without the consent of each Lender directly affected thereby. Notwithstanding the foregoing, in addition to the receipt of the prior written consents of the Borrower and the Required Lenders, no such amendment, supplement, modification, waiver or consent shall (A) amend, modify or waive any provision of Section 10 or otherwise change any of the rights or obligations of the Administrative Agent under any Loan Document without the written consent of the Administrative Agent or (B) change the amount or the time of payment of any Competitive Bid Loan or interest thereon without the written consent of the Lender holding such Competitive Bid Loan. Any such amendment, supplement, modification, waiver or consent shall apply equally to each of the Lenders and shall be binding upon the parties to the applicable Loan Document, the Lenders, the Administrative Agent and all future holders of the Loans and the Notes. In the case of any waiver, the Borrower, the Lenders and the Administrative Agent shall be restored to their former position and rights under the Loan Documents, but any Default or Event of Default waived shall not extend to any subsequent or other Default or Event of Default, or impair any right consequent thereon. Notwithstanding anything to the contrary in this Section 11.1, (1) the Administrative Agent and the Borrower may make amendments contemplated by Section 3.8(d) without the consent of any other Person party hereto and (2) if the Administrative Agent and the Borrower shall have jointly identified an obvious error, ambiguity, defect, inconsistency, omission or any error or omission of a technical nature, in each case, in any provision of the Loan Documents, then the Administrative Agent and the Borrower shall be permitted to amend such provision, and, in each case, such amendment shall become effective without any further action or consent of any party to any Loan Document (other than the Administrative Agent and the Borrower) if the same (x) does not adversely affect the rights of any Lender or (y) is not objected to in writing by the Required Lenders to the Administrative Agent within five Domestic Business Days following receipt of notice thereof. Any amendment, waiver or consent effected in accordance with this Section 11.1 shall be binding upon each Person that is at the time thereof a Lender and each Person that subsequently becomes a Lender.

11.2 Notices

(a) Notices Generally. Except in the case of notices and other communications expressly permitted to be given by telephone, all notices and other communications provided for herein shall be in writing and shall be delivered by hand or overnight courier service, mailed by certified or registered mail or sent by facsimile or email, as follows:

If to the Borrower:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Carol A. DeNale

Senior Vice President and Treasurer – Treasury Department
Facsimile: (401) 770-5768
Telephone: (401) 770-4407

Email: carol.denale@cvshealth.com

with a copy, in the case of a notice of Default or Event of Default, to:

CVS Health Corporation
1 CVS Drive
Woonsocket, Rhode Island 02895
Attention: Tom Moffatt
Vice President, Assistant Secretary
and Assistant General Counsel – Corporate Services
Facsimile: (401) 216-3758
Telephone: (401) 770-5409
Email: thomas.moffatt@cvshealth.com

with a copy (in the case of a notice of Default or Event of Default and which shall not constitute notice under this Agreement or any other Loan Document for any purpose) to:

Shearman & Sterling LLP
599 Lexington Avenue
New York, New York 10022
Attention: Gus M. Atiyah
Facsimile: (646) 848-5227
Telephone: (212) 848-5227
Email: gus.atiyah@shearman.com

If to the Administrative Agent:

in the case of each Borrowing Request, each notice of prepayment under Section 2.7, each Competitive Bid Request, each Competitive Bid, and each Competitive Bid Accept/Reject Letter:

Bank of America, N.A., as Administrative Agent
900 W. Trade St., 6th Floor
NC1-026-06-03
Charlotte, NC 28255
Attention: Carl Dormenyo
Tel: 980-387-3981
Facsimile: 704-683-9310
Email: carl.dormenyo@baml.com

Remittance Instructions- US Dollars:
Bank of America, N.A.
New York, NY
ABA# 026009593
Account No.: 1366072250600
Account Name: Wire Clearing Acct for Syn Loans-LIQ
Ref: CVS HEALTH CORPORATION

and in all other cases:

Bank of America, N.A., as Administrative Agent
900 W. Trade St., 6th Floor
NC1-026-06-03
Charlotte, NC 28255
Attention: Kyle Harding
Tel: 980-275-6132
Facsimile: 704-719-5215
Email: kyle.d.harding@baml.com

If to any Lender: to it at its address (or facsimile number or email address) set forth in its Administrative Questionnaire.

(b) Electronic Communications. Notices and other communications to the Credit Parties hereunder may be delivered or furnished by electronic communication (including email, FpML messaging and internet or intranet websites) pursuant to procedures approved by the Administrative Agent; *provided* that the foregoing shall not apply to notices to any Credit Party pursuant to Section 2 or Section 3.3 if such Credit Party has notified the Administrative Agent that it is incapable of receiving notices under such Sections by electronic communication. The Administrative Agent or the Borrower may, in its discretion, agree to accept notices and other communications to it hereunder by electronic communications pursuant to procedures approved by it; *provided* that approval of such procedures may be limited to particular notices or communications.

Unless the Administrative Agent otherwise prescribes, (i) notices and other communications sent to an email address shall be deemed received upon the sender's receipt of an acknowledgement from the intended recipient (such as by the "return receipt requested" or "read requested" function, as available, return email or other written acknowledgement); *provided* that if such notice or other communication is not sent during the normal business hours of the recipient, such notice or communication shall be deemed to have been sent at the opening of business on the next Domestic Business Day for the recipient, and (ii) notices or communications posted to an internet or intranet website shall be deemed received upon the deemed receipt by the intended recipient at its email address as described in the foregoing clause (i) of notification that such notice or communication is available and identifying the website address therefor.

(c) Change of Address. Any party hereto may change its address, facsimile number or email address for notices and other communications hereunder by notice to the other parties hereto (or, in the case of any Lender, by notice to the Administrative Agent and the Borrower). Subject to the second paragraph of this Section 11.2(b), all notices and other communications given to any party hereto in accordance with the provisions of this Agreement shall be deemed to have been given on the date of receipt; *provided* that any such notice or communication that is not received on a Domestic Business Day during the normal business hours of the recipient shall be deemed received at the opening of business on the next Domestic Business Day.

(d) The Platform. THE PLATFORM IS PROVIDED "AS IS" AND "AS AVAILABLE." THE AGENT PARTIES (AS DEFINED BELOW) DO NOT WARRANT THE ACCURACY OR COMPLETENESS OF THE BORROWER MATERIALS OR THE ADEQUACY OF THE PLATFORM, AND EXPRESSLY DISCLAIM LIABILITY FOR ERRORS IN OR OMISSIONS FROM THE BORROWER MATERIALS. NO WARRANTY OF ANY KIND, EXPRESS, IMPLIED OR STATUTORY, INCLUDING ANY WARRANTY OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, NON-INFRINGEMENT OF THIRD PARTY RIGHTS OR FREEDOM FROM VIRUSES OR OTHER CODE DEFECTS,

IS MADE BY ANY AGENT PARTY IN CONNECTION WITH THE BORROWER MATERIALS OR THE PLATFORM. In no event shall the Administrative Agent or any of its Related Parties (collectively, the "Agent Parties") have any liability to the Borrower, any Lender or any other Person for losses, claims, damages, liabilities or expenses of any kind (whether in tort, contract or otherwise) arising out of the Borrower's or the Administrative Agent's transmission of Borrower Materials or notices through the Platform, any other electronic platform or electronic messaging service, or through the Internet

11.3 No Waiver; Cumulative Remedies

No failure to exercise and no delay in exercising, on the part of the Administrative Agent or any Lender, any right, remedy, power or privilege under any Loan Document shall operate as a waiver thereof, nor shall any single or partial exercise of any right, remedy, power or privilege under any Loan Document preclude any other or further exercise thereof or the exercise of any other right, remedy, power or privilege. The rights, remedies, powers and privileges under the Loan Documents are cumulative and not exclusive of any rights, remedies, powers and privileges provided by law.

11.4 Survival of Representations and Warranties

All representations and warranties made in the Loan Documents and in any document, certificate or statement delivered pursuant thereto or in connection therewith shall survive the execution and delivery of the Loan Documents.

11.5 Payment of Expenses; Indemnified Liabilities

(a) The Borrower agrees, as soon as practicable following presentation of a statement or invoice therefor setting forth in reasonable detail the items thereof, and whether any Loan is made, (a) to pay or reimburse the Administrative Agent and its Affiliates for all their reasonable and documented out-of-pocket costs and expenses actually incurred in connection with the development, syndication, preparation and execution of, and any amendment, waiver, consent, supplement or modification to, the Loan Documents, any documents prepared in connection therewith and the consummation of the transactions contemplated thereby, whether such Loan Documents or any such amendment, waiver, consent, supplement or modification to the Loan Documents or any documents prepared in connection therewith are executed and whether the transactions contemplated thereby are consummated, including the reasonable and documented out-of-pocket fees and disbursements of Special Counsel, (b) to pay, indemnify, and hold the Administrative Agent and the Lenders harmless from any and all recording and filing fees and any and all liabilities and penalties with respect to, or resulting from any delay (other than penalties to the extent attributable to the negligence of the Administrative Agent or the Lenders, as the case may be, in failing to pay such fees, liabilities or penalties when due) which may be payable or determined to be payable in connection with the execution and delivery of, or consummation of any of the transactions contemplated by, or any amendment, supplement or modification of, or any waiver or consent under or in respect of, the Loan Documents or any documents prepared in connection therewith, and (c) to pay, reimburse, indemnify and hold each Indemnified Person harmless from and against any and all other liabilities, obligations, claims, losses, damages, penalties, actions, judgments, suits, costs, expenses and disbursements of any kind or nature whatsoever (including the reasonable and documented out-of-pocket fees and disbursements of one counsel (but excluding the allocated cost of internal counsel) representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or

perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a single local counsel for each applicable jurisdiction (which may include a single counsel acting in multiple jurisdictions) (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Person))) actually incurred with respect to the enforcement, performance of, and preservation of rights under, the Loan Documents (all the foregoing, collectively, the ***"Indemnified Liabilities"***) and, if and to the extent that the foregoing indemnity may be unenforceable for any reason, the Borrower agrees to make the maximum payment permitted under applicable law. Notwithstanding anything to the contrary contained in this Section 11.5, the foregoing payment, indemnification and reimbursement obligations will not, as to any Person identified in this Section 11.5, apply to any losses, claims, damages, liabilities and related expenses to the extent arising (A) from the willful misconduct, gross negligence, fraud or bad faith of such Person, (B) from a material breach of the obligations hereunder of such Person, (C) out of or in connection with Section 11.22, or (D) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by any such Person against any such other Person (other than the Administrative Agent or Joint Lead Arranger, in each case, in its capacity as such), in each case under clauses (A) and (B), to the extent determined by a final and non-appealable judgment of a court of competent jurisdiction. The agreements in this Section 11.5 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

(b) Notwithstanding the above, the Borrower shall have no liability under this Section 11.5 to indemnify or hold harmless any Indemnified Person for any losses, claims, damages, liabilities and related expenses relating to income or withholding Taxes or any Tax in lieu of such Taxes. Notwithstanding the foregoing, any amounts claimed by an Indemnified Person under Section 11.10 shall not be available to be claimed by such Indemnified Person under this Section 11.5, it being understood and agreed that the rights of an Indemnified Person under this Section 11.5 and Section 11.10 shall not be duplicative.

11.6 Lending Offices

Each Lender shall have the right at any time and from time to time to transfer any Loan to a different office of such Lender, subject to Section 3.10.

11.7 Successors and Assigns.

(a) Successors and Assigns Generally. The provisions of this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns permitted hereby, except that the Borrower may not assign or otherwise transfer any of its rights or obligations hereunder without the prior written consent of the Administrative Agent and each Lender and no Lender may assign or otherwise transfer any of its rights or obligations hereunder except (i) to an assignee in accordance with the provisions of paragraph (b) of this Section 11.7, (ii) by way of participation in accordance with the provisions of paragraph (d) of this Section 11.7 or (iii) by way of pledge or assignment of a security interest subject to the restrictions of paragraph (f) of this Section 11.7 (and any other attempted assignment or transfer by any party hereto shall be null and void). Nothing in this Agreement, expressed or implied, shall be construed to confer upon any Person (other than the parties hereto, their respective successors and assigns permitted hereby, the Participants to the extent provided in paragraph (d) of this Section 11.7 and, to the extent expressly contemplated hereby, the Related Parties of each Credit Party) any legal or equitable right, remedy or claim under or by reason of this Agreement.

(b) Assignments by Lenders. Any Lender may at any time assign to one or more assignees all or a portion of its rights and obligations under this Agreement (including all or a portion of its Commitment and the Loans at the time owing to it); *provided* that any such assignment shall be subject to the following conditions:

(1) Minimum Amounts.

(A) in the case of an assignment of the entire remaining amount of the assigning Lender's Commitment Amount and the Loans at the time owing to it or in the case of an assignment to a Lender, an Affiliate of a Lender or an Approved Fund, no minimum amount need be assigned; and

(B) in any case not described in paragraph (b)(1)(A) of this Section 11.7, the Commitment Amount (which for this purpose includes the Loans of the assigning Lender outstanding thereunder) or, if the Commitment of the assigning Lender is not then in effect, the principal outstanding balance of the Loans of the assigning Lender subject to each such assignment (determined as of the date the Assignment and Assumption with respect to such assignment is delivered to the Administrative Agent or, if a "Trade Date" is specified in the Assignment and Assumption, as of such "Trade Date") shall not be less than $5,000,000, unless each of the Administrative Agent and, so long as no Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) has occurred and is continuing, the Borrower otherwise consents (each such consent not to be unreasonably withheld or delayed).

(2) Proportionate Amounts. Each partial assignment shall be made as an assignment of a proportionate part of all the assigning Lender's rights and obligations under this Agreement with respect to the Loans or the Commitment assigned, except that this clause (2) shall not prohibit any Lender from assigning all or a portion of its rights and obligations in respect of Competitive Bid Loans on a non-pro rata basis.

(3) Required Consents. No consent shall be required for any assignment except to the extent required by paragraph (b)(1)(B) of this Section 11.7 and, in addition:

(A) the consent of the Borrower (such consent not to be unreasonably withheld or delayed) shall be required unless (x) an Event of Default under Section 9.1(a), Section 9.1(b), Section 9.1(h), Section 9.1(i) or Section 9.1(j) has occurred and is continuing at the time of such assignment or (y) such assignment is to a Lender, an Affiliate of a Lender or an Approved Fund (it being understood that it shall not be deemed unreasonable for the Borrower to withhold consent to any assignment if it reasonably believes that such assignment would result in the Borrower incurring increased costs pursuant to Section 3.6 or Section 3.10); and

(B) the consent of the Administrative Agent (such consent not to be unreasonably withheld, conditioned or delayed) shall be required for assignments in respect of an unfunded or revolving facility hereunder if such assignment is to a Person that is not a Lender with a Commitment in respect of such facility, an Affiliate of such Lender or an Approved Fund with respect to such Lender.

(4) Assignment and Assumption. The parties to each assignment shall execute and deliver to the Administrative Agent an Assignment and Assumption, together with a processing and recordation fee of $4,500 ($7,500 in the case of an assignment by a Defaulting Lender) (which fee shall be paid by the assignor or the assignee and may be waived or reduced in the sole discretion of the Administrative Agent), and the assignee, if it is not a Lender, shall deliver to the Administrative Agent an Administrative Questionnaire.

(5) No Assignment to Certain Parties. No such assignment shall be made to (A) the Borrower, any of its Subsidiaries or any of their respective Affiliates or (B) any Defaulting Lender or any of its Subsidiaries or any Person who, upon becoming a Lender hereunder, would constitute any of the foregoing Persons described in this clause (B).

(6) No Assignment to Natural Persons. No such assignment shall be made to a natural person (or a holding company, investment vehicle or trust for, or owned and operated by or for the primary benefit of a natural person).

(7) Certain Additional Payments. In connection with any assignment of rights and obligations of any Defaulting Lender hereunder, no such assignment shall be effective unless and until, in addition to the other conditions thereto set forth herein, the parties to the assignment shall make such additional payments to the Administrative Agent in an aggregate amount sufficient, upon distribution thereof as appropriate (which may be outright payment, purchases by the assignee of participations or subparticipations, or other compensating actions, including funding, with the consent of the Borrower and the Administrative Agent, the applicable pro rata share of Loans previously requested but not funded by the Defaulting Lender, to each of which the applicable assignee and assignor hereby irrevocably consent), to (x) pay and satisfy in full all payment liabilities then owed by such Defaulting Lender to the Administrative Agent or any Lender hereunder (and interest accrued thereon) and (y) acquire (and fund as appropriate) its full pro rata share of all Loans in accordance with its Commitment Percentage. Notwithstanding the foregoing, in the event that any assignment of rights and obligations of any Defaulting Lender hereunder shall become effective under applicable law without compliance with the provisions of this clause (7), then the assignee of such interest shall be deemed to be a Defaulting Lender for all purposes of this Agreement until such compliance occurs

Subject to acceptance and recording thereof by the Administrative Agent pursuant to paragraph (c) of this Section 11.7, from and after the effective date specified in each Assignment and Assumption, the assignee thereunder shall be a party to this Agreement and, to the extent of the interest assigned by such Assignment and Assumption, have the rights and obligations of a Lender under this Agreement, and the assigning Lender thereunder shall, to the extent of the interest assigned by such Assignment and Assumption, be released from its obligations under this

Agreement (and, in the case of an Assignment and Assumption covering all of the assigning Lender's rights and obligations under this Agreement, such Lender shall cease to be a party hereto) but shall continue to be entitled to the benefits of Section 3.6, Section 3.7, and Section 11.10 with respect to facts and circumstances occurring prior to the effective date of such assignment. Any assignment or transfer by a Lender of rights or obligations under this Agreement that does not comply with this paragraph shall be treated for purposes of this Agreement as a sale by such Lender of a participation in such rights and obligations in accordance with paragraph (d) of this Section 11.7.

(c) Register. The Administrative Agent, acting solely for this purpose as an agent of the Borrower, shall maintain at one of its offices in the United States of America a copy of each Assignment and Assumption delivered to it and a register for the recordation of the names and addresses of the Lenders, and the Commitments of, and principal amounts (and stated interest) of the Loans owing to, each Lender pursuant to the terms hereof from time to time (the ***"Register"***). The entries in the Register shall be conclusive absent manifest error, and the Borrower, the Administrative Agent and the Lenders shall treat each Person whose name is recorded in the Register pursuant to the terms hereof as a Lender hereunder for all purposes of this Agreement, notwithstanding notice to the contrary. The Register shall be available for inspection by the Borrower and any Lender (but only, in the case of a Lender, at the Administrative Agent's Office and with respect to any entry relating to such Lender's Commitments, Advances and other obligations pursuant to the terms hereof) at any reasonable time and from time to time upon reasonable prior notice.

(d) Participations. Any Lender may at any time, without the consent of, or notice to, the Borrower or the Administrative Agent, sell participations to any Person (other than a natural person (or a holding company, investment vehicle or trust for, or owned and operated by or for the primary benefit of a natural person), the Borrower, any of its Subsidiaries or any of their respective Affiliates) (each, a **"*Participant*"**) in all or a portion of such Lender's rights and/or obligations under this Agreement (including all or a portion of its Commitment and/or the Loans owing to it); *provided* that (i) all of such Lender's obligations under this Agreement and the other Loan Documents shall remain in all respects unchanged, (ii) such Lender shall remain solely responsible to the other parties hereto for the performance of such obligations and (iii) the Borrower, the Administrative Agent and each Credit Party shall continue to deal solely and directly with such Lender in connection with such Lender's rights and obligations under this Agreement. Any agreement or instrument pursuant to which a Lender sells such a participation shall provide that such Lender shall retain the sole right to enforce this Agreement and to approve any amendment, modification or waiver of any provision of this Agreement; *provided* that such agreement or instrument may provide that such Lender will not, without the consent of the Participant, agree to any amendment, modification or waiver which requires the consent of all Lenders or all affected Lenders that directly affects such Participant. Subject to paragraph (e) of this Section 11.7, the Borrower agrees that each Participant shall be entitled to the benefits of Section 3.5, Section 3.6, Section 3.7 and Section 3.10 to the same extent as if it were a Lender and had acquired its interest by assignment pursuant to paragraph (b) of this Section 11.7. To the extent permitted by law, each Participant also shall be entitled to the benefits of Section 11.9(a) as though it were a Lender, *provided* that such Participant agrees to be subject to Section 11.9(b) as though it were a Lender. Each Lender that sells a participation with respect to a Commitment or Loan shall, solely for the purposes of complying with the rules regarding registered form in the Internal Revenue Code, act as a non-fiduciary agent of the Borrower, maintaining a register on which it enters the name and address of each Participant and the principal amounts (and stated interest amounts) of each Participant's interest in the Commitment and/or Loan (each a **"*Participant Register*"**), and the entries in such Participant Register shall be conclusive, absent manifest error, and such Lender shall

treat each Person whose name is recorded in the Participant Register as the owner of such participation for all purposes of this Agreement notwithstanding any notice to the contrary. No Lender shall be required to disclose the existence of, or any of the information contained in, any Participant Register maintained by it to the Borrower or any other Person unless requested in writing by the Borrower, and only to the Internal Revenue Service to the extent such disclosure is required in order to comply with the rules requiring registered form pursuant to the Internal Revenue Code.

(e) Limitations upon Participant Rights. A Participant shall not be entitled to receive any greater payment under Section 3.6, Section 3.7 or Section 3.10 than the applicable Lender would have been entitled to receive with respect to the participation sold to such Participant, unless the sale of the participation to such Participant is made with the Borrower's prior written consent. A Participant shall not be entitled to the benefits of Section 3.10 unless the Borrower is notified of the participation sold to such Participant and such Participant agrees, for the benefit of the Borrower, to comply with Section 3.10(f) as though it were a Lender.

(f) Certain Pledges. Any Lender may at any time pledge or assign a security interest in all or any portion of its rights under this Agreement to secure obligations of such Lender, including any pledge or assignment to secure obligations to a Federal Reserve Bank or other central bank having jurisdiction over such Lender; *provided* that no such pledge or assignment shall release such Lender from any of its obligations hereunder or substitute any such pledgee or assignee for such Lender as a party hereto.

(g) Disqualified Institutions.

(i) No assignment shall be made to any Person that was a Disqualified Institution as of the date (the "Trade Date") on which the applicable Lender entered into a binding agreement to sell and assign all or a portion of its rights and obligations under this Agreement to such Person (unless the Borrower has consented to such assignment in writing as otherwise contemplated by this Section 11.7, in which case such Person will not be considered a Disqualified Institution for the purpose of such assignment). For the avoidance of doubt, with respect to any assignee that becomes a Disqualified Institution after the applicable Trade Date (including as a result of the delivery of a notice pursuant to, and/or the expiration of the notice period referred to in, the definition of "Disqualified Institution"), (x) such assignee shall not retroactively be disqualified from becoming a Lender and (y) the execution and delivery by the Borrower of an Assignment and Assumption with respect to such assignee will not by itself result in such assignee no longer being considered a Disqualified Institution. Any assignment in violation of this clause (g)(i) shall not be void, but the other provisions of this clause (g) shall apply.

(ii) If any assignment is made to any Disqualified Institution without the Borrower's prior consent in violation of clause (i) above, or if any Person becomes a Disqualified Institution after the applicable Trade Date, the Borrower may, at its sole expense and effort, upon notice to the applicable Disqualified Institution and the Administrative Agent, (A) terminate any Commitment of such Disqualified Institution and repay all obligations of the Borrower owing to such Disqualified Institution in connection with such Commitment, and/or (B) require such Disqualified Institution to assign and delegate, without recourse (in accordance with and subject to the restrictions contained in this Section 11.7), all of its interest, rights and obligations under this Agreement and the other Loan Documents to an Eligible Assignee that shall assume such obligations at the lesser of (x) the principal amount thereof and (y) the amount that such Disqualified

Institution paid to acquire such interests, rights and obligations, in each case plus accrued interest, accrued fees and all other amounts (other than principal amounts) payable to it hereunder and other the other Loan Documents.

(iii) Notwithstanding anything to the contrary contained in this Agreement, Disqualified Institutions (A) will not (x) have the right to receive information, reports or other materials provided to Lenders by the Borrower, the Administrative Agent or any other Lender, (y) attend or participate in meetings attended by the Lenders and the Administrative Agent, or (z) access any electronic site established for the Lenders or confidential communications from counsel to or financial advisors of the Administrative Agent or the Lenders and (B) (x) for purposes of any consent to any amendment, waiver or modification of, or any action under, and for the purpose of any direction to the Administrative Agent or any Lender to undertake any action (or refrain from taking any action) under this Agreement or any other Loan Document, each Disqualified Institution will be deemed to have consented in the same proportion as the Lenders that are not Disqualified Institutions consented to such matter, and (y) for purposes of voting on any plan of reorganization or plan of liquidation pursuant to any bankruptcy or insolvency laws ("Plan of Reorganization"), each Disqualified Institution party hereto hereby agrees (1) not to vote on such Plan of Reorganization, (2) if such Disqualified Institution does vote on such Plan of Reorganization notwithstanding the restriction in the foregoing clause (1), such vote will be deemed not to be in good faith and shall be "designated" pursuant to Section 1126(e) of the United States Bankruptcy Code (or any similar provision in any other bankruptcy or insolvency laws), and such vote shall not be counted in determining whether the applicable class has accepted or rejected such Plan of Reorganization in accordance with Section 1126(c) of the United States Bankruptcy Code (or any similar provision in any other bankruptcy or insolvency laws) and (3) not to contest any request by any party for a determination by the bankruptcy court (or other applicable court of competent jurisdiction) effectuating the foregoing clause (2).

11.8 Counterparts; Electronic Execution of Assignments.

(a) Counterparts. Each of the Loan Documents (other than the Notes) may be executed on any number of separate counterparts and all of said counterparts taken together shall be deemed to constitute one and the same agreement. It shall not be necessary in making proof of any Loan Document to produce or account for more than one counterpart signed by the party to be charged. A set of the copies of this Agreement signed by all of the parties hereto shall be lodged with each of the Borrower and the Administrative Agent. Delivery of an executed counterpart of a signature page of any Loan Document by fax or other electronic means (e.g., ".pdf" or ".tif") shall be effective as delivery of a manually executed counterpart of such Loan Document.

(b) Electronic Execution of Assignments and Certain Other Documents. The words "execution," "execute", "signed," "signature," and words of like import in or related to any document to be signed in connection with this Agreement and the transactions contemplated hereby (including without limitation Assignment and Assumptions, amendments or other modifications, Borrowing Requests, waivers and consents) shall be deemed to include electronic signatures, the electronic matching of assignment terms and contract formations on electronic platforms approved by the Administrative Agent, or the keeping of records in electronic form, each of which shall be of the same legal effect, validity or enforceability as a manually executed signature or the use of a paper-based recordkeeping system, as the case may be, to the extent and as provided for in any applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, the New York State Electronic Signatures and Records Act, or any other similar state laws based

on the Uniform Electronic Transactions Act; provided that notwithstanding anything contained herein to the contrary the Administrative Agent is under no obligation to agree to accept electronic signatures in any form or in any format unless expressly agreed to by the Administrative Agent pursuant to procedures approved by it (it being acknowledged that the Administrative Agent will accept ".pdf" signatures).

11.9 Set-off and Sharing of Payments-.

(a) In addition to any rights and remedies of the Lenders provided by law, after the occurrence and during the continuance of an Event of Default under Section 9.1(a) or Section 9.1(b) or upon the acceleration of the Loans, each Lender shall have the right, without prior notice to the Borrower, any such notice being expressly waived by the Borrower, to set-off and apply against any indebtedness or other liability, whether matured or unmatured, of the Borrower to such Lender arising under the Loan Documents, any amount owing from such Lender to the Borrower. To the extent permitted by applicable law, the aforesaid right of set-off may be exercised by such Lender against the Borrower or against any trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors, receiver, or execution, judgment or attachment creditor of the Borrower, or against anyone else claiming through or against the Borrower or such trustee in bankruptcy, custodian, debtor in possession, assignee for the benefit of creditors, receivers, or execution, judgment or attachment creditor, notwithstanding the fact that such right of set-off shall not have been exercised by such Lender prior to the making, filing or issuance of, service upon such Lender of, or notice to such Lender of, any petition, assignment for the benefit of creditors, appointment or application for the appointment of a receiver, or issuance of execution, subpoena, order or warrant. Each Lender agrees promptly to notify the Borrower and the Administrative Agent after each such set-off and application made by such Lender, *provided* that the failure to give such notice shall not affect the validity of such set-off and application.

(b) If any Lender shall obtain any payment (whether voluntary, involuntary, through the exercise of any right of set-off, or otherwise) on account of its Loans or its Notes in excess of its pro rata share (in accordance with the outstanding principal balance of all Loans) of payments then due and payable on account of the Loans and Notes received by all the Lenders, such Lender shall forthwith purchase, without recourse, for cash, from the other Lenders such participations in their Loans and Notes as shall be necessary to cause such purchasing Lender to share the excess payment with each of them according to their pro rata share (in accordance with the outstanding principal balance of all Loans); *provided* that if all or any portion of such excess payment is thereafter recovered from such purchasing Lender, such purchase from each Lender shall be rescinded and each such Lender shall repay to the purchasing Lender the purchase price to the extent of such recovery, together with an amount equal to such Lender's pro rata share (according to the proportion of (i) the amount of such Lender's required repayment to (ii) the total amount so recovered from the purchasing Lender) of any interest or other amount paid or payable by the purchasing Lender in respect of the total amount so recovered. The Borrower agrees, to the fullest extent permitted by law, that any Lender so purchasing a participation from another Lender pursuant to this Section 11.9 may exercise such rights to payment (including the right of set-off) with respect to such participation as fully as if such Lender were the direct creditor of the Borrower in the amount of such participation. The provisions of this Section 11.9 shall not be construed to apply to any payment made by or on behalf of the Borrower pursuant to and in accordance with the express terms of this Agreement (including the application of funds arising from the existence of a Defaulting Lender or Disqualified Institution).

11.10 Indemnity.

(a) The Borrower shall indemnify each Credit Party and each Related Party thereof (each such Person being called an "***Indemnified Person***") against, and hold each Indemnified Person harmless from, any and all losses, claims, damages, liabilities and related expenses, including the reasonable and documented out-of-pocket fees and disbursements of one counsel (but excluding the allocated cost of internal counsel) representing all of the Indemnified Persons, taken as a whole, and, if reasonably necessary, of a single local counsel for each applicable jurisdiction (which may include a single counsel acting in multiple jurisdictions) (and, if reasonably necessary, one specialty counsel for each applicable specialty), representing all of the Indemnified Persons, taken as a whole (and, in the case of any actual or perceived conflict of interest where the Indemnified Person affected by such conflict notifies the Borrower of the existence of such conflict and thereafter retains its own counsel, of another firm of counsel (and, if reasonably necessary, a single local counsel for each applicable jurisdiction (and, if reasonably necessary, one specialty counsel for each applicable specialty), for each such affected Indemnified Person)), actually incurred by any Indemnified Person arising out of, in connection with, or as a result of (i) the execution or delivery of any Loan Document or any agreement or instrument contemplated thereby, the performance by the parties to the Loan Documents of their respective obligations thereunder or the consummation of the transactions contemplated hereby or any other transactions contemplated thereby, (ii) any Loan or the use of the proceeds thereof, (iii) any actual or alleged presence or release of Hazardous Materials in, on, under or from any property owned or operated by the Borrower or any of the Subsidiaries, or any Environmental Liability related in any way to the Borrower or any of the Subsidiaries or (iv) any actual or prospective claim, litigation, investigation or proceeding relating to any of the foregoing, whether based on statute, contract, tort or any other theory and regardless of whether any Indemnified Person is a party thereto. Notwithstanding anything to the contrary contained in this Section 11.10(a), the foregoing indemnity will not, as to any Indemnified Person, apply to any losses, claims, damages, liabilities and related expenses to the extent arising (A) from the willful misconduct, gross negligence, fraud or bad faith of such Indemnified Person, (B) from a material breach of the obligations hereunder of such Indemnified Person, (C) out of or in connection with Section 11.22, or (D) out of or in connection with any claim, litigation, investigation or proceeding that does not involve an act or omission of the Borrower or any of its Affiliates and that is brought by an Indemnified Person against any other Indemnified Person (other than the Administrative Agent or a Joint Lead Arranger, in each case in its capacity as such), in each case under clauses (A) and (B), to the extent determined by a final and non-appealable judgment of a court of competent jurisdiction.

(b) To the extent that the Borrower fails to pay as soon as practicable any amount required to be paid by it to the Administrative Agent under subsection (a) of this Section 11.10 (the ***"Indemnified Amount"***), each Lender severally agrees to pay to the Administrative Agent an amount equal to the product of such unpaid amount *multiplied by* (i) at any time when no Loans are outstanding, its Commitment Percentage, and (ii) at any time when Loans are outstanding (x) if the Commitments then exist, its Commitment Percentage or (y) if the Commitments have been terminated or otherwise no longer exist, the percentage equal to the fraction, (A) the numerator of which is the sum of such Lender's Credit Exposure and (B) the denominator of which is the sum of the Aggregate Credit Exposure (in each case determined as of the time that the applicable Indemnified Amount is sought), *provided* that the Indemnified Amount was payable to the Administrative Agent in its capacity as such.

(c) The obligations of the Borrower and the Lenders under this Section 11.10 shall survive the termination of the Commitments and the payment of the Loans and the Notes and all other amounts payable under the Loan Documents.

(d) If any settlement of any investigation, litigation or proceeding to which the indemnity in this Section 11.10 applies (any of the foregoing, a ***"Proceeding"***) is instituted or threatened against any Indemnified Person (or its Related Parties) in respect of which indemnity may be sought hereunder, unless an Event of Default under Section 9.1(a), 9.1(h), 9.1(i) or 9.1(j) exists, the Borrower shall be entitled to assume the defense thereof with counsel selected by the Borrower (which counsel shall be reasonably satisfactory to such Indemnified Person) and after notice from the Borrower to such Indemnified Person of the Borrower's election so to assume the defense thereof, the Borrower will not be liable to such Indemnified Person hereunder for any legal or other expenses subsequently incurred by such Indemnified Person in connection with the defense thereof, other than reasonable and documented out-of-pocket costs of investigation and such other reasonable and documented out-of-pocket expenses as have been approved in advance; *provided*, that (i) if counsel for such Indemnified Person determines in good faith that there is a conflict that requires separate representation for the Borrower and such Indemnified Person or that there may be legal defenses available to such Indemnified Person which are different from or in addition to those available to the Borrower or (ii) the Borrower fails to assume or proceed in a timely and reasonable manner with the defense of such action or fails to employ counsel reasonably satisfactory to such Indemnified Person in any such action, then in either such event, (A) such Indemnified Person shall be entitled to one primary counsel and, if necessary, one local counsel to represent such Indemnified Person and all other Indemnified Persons similarly situated (such counsels selected by the Administrative Agent), (B) the Borrower shall not, or shall not any longer, be entitled to assume the defense thereof on behalf of such Indemnified Person and (C) such Indemnified Person shall be entitled to indemnification for the expenses (including fees and expenses of such counsel) to the extent provided in this Section 11.10. Notwithstanding the foregoing, the Borrower shall not be liable for any settlement, compromise or consent to the entry of any judgment in any action or Proceeding effected without the Borrower's prior written consent (which consent shall not be unreasonably withheld, conditioned or delayed, it being understood and agreed that the withholding, conditioning or delaying of the Borrower's consent in connection with a settlement, compromise or consent to the entry of any judgment in any action or proceeding which does not include an unconditional release of the Borrower and the Subsidiaries from all liability or claims that are the subject matter of such Proceeding or which includes a statement as to any admission of fault by or on behalf of the Borrower or any Subsidiary shall not be deemed unreasonable), but if settled with the Borrower's prior written consent or if there is a final judgment for the plaintiff in any such Proceeding, the Borrower agrees to indemnify and hold harmless each Indemnified Person from and against any and all losses, claims, damages, liabilities and expenses by reason of such settlement, compromise or consent to the entry of any judgment in any action or Proceeding in accordance with this Section 11.10. The Borrower shall not, without the prior written consent of an Indemnified Person, effect any settlement of any pending or threatened Proceeding against such Indemnified Person in respect of which indemnity could have been sought hereunder by such Indemnified Person unless such settlement (x) includes an unconditional release of such Indemnified Person from all liability or claims that are the subject matter of such Proceeding, (y) does not include any statement as to any admission of fault by or on behalf of such Indemnified Person and (z) contains customary confidentiality provisions with respect to the terms of such settlement.

(e) Notwithstanding any provision in this Agreement to the contrary, none of the Borrower, the Administrative Agent, the Lenders or any Affiliate of any of the foregoing will be responsible or liable to any Person or entity, on any theory of liability, for any indirect, special, punitive or consequential damages that may be alleged as a result of the transactions contemplated hereby or by the other Loan Documents or any use or intended use of the proceeds of the Loans; *provided* that nothing in this clause (e) shall limit the Borrower's indemnity obligations set forth in this Agreement with respect to any indirect, punitive or consequential damages included in any

third party claim in connection with which an Indemnified Person is entitled to indemnification hereunder. In addition to, and without limiting the immediately foregoing sentence, and to the extent permitted by applicable law, the Borrower shall not assert, and hereby waives, any claim against any Indemnified Person, on any theory of liability, for special, indirect, consequential or punitive damages (as opposed to direct and actual damages) arising out of, in connection with, or as a result of, any Loan Document or any agreement, instrument or other document contemplated thereby, the transactions contemplated hereby or any Loan or the use of the proceeds thereof.

(f) Notwithstanding the above, the Borrower shall have no liability under this Section 11.10 to indemnify or hold harmless any Indemnified Person for any losses, claims, damages, liabilities and related expenses relating to income or withholding Taxes or any Tax in lieu of such Taxes. Notwithstanding the foregoing, any amounts claimed by an Indemnified Person under Section 11.5 shall not be available to be claimed by such Indemnified Person under this Section 11.10, it being understood and agreed that the rights of an Indemnified Person under this Section 11.10 and Section 11.5 shall not be duplicative.

11.11 Governing Law

The Loan Documents and the rights and obligations of the parties thereto shall be governed by, and construed and interpreted in accordance with, the laws of the State of New York.

11.12 Severability

Every provision of the Loan Documents is intended to be severable, and if any term or provision thereof shall be invalid, illegal or unenforceable for any reason, the validity, legality and enforceability of the remaining provisions thereof shall not be affected or impaired thereby, and any invalidity, illegality or unenforceability in any jurisdiction shall not affect the validity, legality or enforceability of any such term or provision in any other jurisdiction.

11.13 Integration

All exhibits to the Loan Documents shall be deemed to be a part thereof. Each Loan Document embodies the entire agreement and understanding between or among the parties thereto with respect to the subject matter thereof and supersedes all prior agreements and understandings between or among the parties thereto with respect to the subject matter thereof.

11.14 Treatment of Certain Information

(a) Each Credit Party agrees to maintain the confidentiality of the Information (as defined below), except that Information may be disclosed (i) to its Affiliates and to its and its Affiliates' respective partners, directors, officers, employees, agents, advisors and other representatives (it being understood that the Persons to whom such disclosure is made will be informed of the confidential nature of such Information and instructed to keep such Information confidential); *provided* that each Credit Party shall be responsible for its controlled Affiliates' compliance in keeping Information confidential, (ii) to the extent requested by any regulatory authority purporting to have jurisdiction over it (including any self-regulatory authority, such as the National Association of Insurance Commissioners) (in which case such Person agrees (except with respect to any audit or examination conducted by bank accountants or any governmental regulatory authority exercising examination or regulatory authority) to inform the Borrower promptly thereof prior to such disclosure to the extent practicable and not prohibited by law), (iii) to the extent required by applicable laws or regulations or by any subpoena or similar legal process

(in which case such Person agrees to (except with respect to any audit or examination conducted by bank accountants or any governmental regulatory authority exercising examination or regulatory authority) to inform the Borrower promptly thereof prior to such disclosure to the extent practicable and not prohibited by law), (iv) to any other party hereto, (v) in connection with the exercise of any remedies hereunder or under any other Loan Document or any action or proceeding relating to this Agreement or any other Loan Document or the enforcement of rights hereunder or thereunder, (vi) subject to an agreement containing provisions substantially the same as those of this Section 11.14, to (A) any assignee of or Participant in, or any prospective assignee of or Participant in, any of its rights or obligations under this Agreement or (B) any actual or prospective counterparty (or its advisors) to any swap or derivative transaction relating to the Borrower and its obligations, (vii) to Gold Sheets and other similar bank trade publications, such information to consist of deal terms and other information customarily found in such publications, (viii) with the prior written consent of the Borrower, (ix) to the extent such Information (1) becomes publicly available other than as a result of a breach of this Section 11.14 or a breach of any other confidentiality obligation owing by such Credit Party to the Borrower or (2) becomes available to the Administrative Agent, any Credit Party or any of their respective Affiliates on a non-confidential basis from a source other than the Borrower not known to such Credit Party to be prohibited from disclosing such Information, and (x) on a confidential basis to (i) any rating agency in connection with rating the Borrower or its Subsidiaries or the credit facilities provided hereunder or (ii) the CUSIP Service Bureau or any similar agency in connection with the application, issuance, publishing and monitoring of CUSIP numbers of other market identifiers with respect to the credit facilities provided hereunder. In addition, the Administrative Agent and the Lenders may disclose the existence of this Agreement and information about this Agreement to market data collectors, similar service providers to the lending industry and service providers to the Administrative Agent and the Lenders in connection with the administration of this Agreement, the other Loan Documents, and the Commitments.

(b) For purposes of this Section 11.14, ***"Information"*** means all information received from the Borrower or any of its Subsidiaries relating to the Borrower or any of its Subsidiaries or any of their respective businesses, other than any such information that is available to the Administrative Agent or any other Credit Party on a non-confidential basis prior to disclosure by the Borrower or any of its Subsidiaries.

11.15 Acknowledgments

The Borrower acknowledges that (a) it has been advised by counsel in the negotiation, execution and delivery of the Loan Documents, (b) by virtue of the Loan Documents, the relationship among the Administrative Agent and the Lenders, on the one hand, and the Borrower, on the other hand, is solely that of debtor and creditor, and (c) by virtue of the Loan Documents, no joint venture exists among the Lenders or among the Borrower and the Lenders.

11.16 Consent to Jurisdiction

Each of the parties hereto irrevocably submits to the exclusive jurisdiction of any New York State or Federal Court sitting in the City of New York, Borough of Manhattan, over any suit, action, claim, counterclaim or proceeding arising out of or relating to the Loan Documents. EACH OF THE PARTIES HERETO IRREVOCABLY WAIVES, TO THE FULLEST EXTENT PERMITTED BY LAW, ANY OBJECTION WHICH IT MAY NOW OR HEREAFTER HAVE TO THE LAYING OF THE VENUE OF ANY SUCH SUIT, ACTION, CLAIM, COUNTERCLAIM OR PROCEEDING BROUGHT IN SUCH A COURT AND ANY CLAIM THAT ANY SUCH SUIT, ACTION, CLAIM, COUNTERCLAIM OR PROCEEDING BROUGHT IN SUCH A COURT HAS BEEN BROUGHT IN AN INCONVENIENT FORUM.. Each of the parties hereto agrees that a final judgment in any such suit, action, claim,

counterclaim or proceeding brought in such a court, after all appropriate appeals, shall be conclusive and binding upon it.

11.17 Service of Process

Each of the parties hereto agrees that process may be served against it in any suit, action or proceeding referred to in Section 11.16 by sending the same by first class mail, return receipt requested or by overnight courier service, with receipt acknowledged, to the address of such party set forth or referred to in Section 11.2. Each of the parties hereto agrees that any such service (i) shall be deemed in every respect effective service of process upon it in any such suit, action, or proceeding, and (ii) shall to the fullest extent enforceable by law, be taken and held to be valid personal service upon and personal delivery to it.

11.18 No Limitation on Service or Suit

Nothing in the Loan Documents or any modification, waiver, or amendment thereto shall affect the right of the Administrative Agent or any Lender to serve process in any manner permitted by law or limit the right of the Administrative Agent or any Lender to bring proceedings against the Borrower in the courts of any jurisdiction or jurisdictions.

11.19 WAIVER OF TRIAL BY JURY

EACH OF THE CREDIT PARTIES AND THE BORROWER KNOWINGLY, VOLUNTARILY AND INTENTIONALLY WAIVES ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN RESPECT OF ANY LITIGATION ARISING OUT OF, UNDER OR IN CONNECTION WITH THE LOAN DOCUMENTS OR THE TRANSACTIONS CONTEMPLATED THEREBY. FURTHER, THE BORROWER HEREBY CERTIFIES THAT NO REPRESENTATIVE OR AGENT OF ANY OF THE CREDIT PARTIES, OR COUNSEL TO ANY OF THE CREDIT PARTIES, HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT ANY OF THE CREDIT PARTIES WOULD NOT, IN THE EVENT OF SUCH LITIGATION, SEEK TO ENFORCE THIS WAIVER OF RIGHT TO JURY TRIAL PROVISION. THE BORROWER ACKNOWLEDGES THAT THE CREDIT PARTIES HAVE BEEN INDUCED TO ENTER INTO THIS AGREEMENT BY, *INTER ALIA*, THE PROVISIONS OF THIS SECTION 11.19.

11.20 Patriot Act Notice

Each Lender and the Administrative Agent (for itself and not on behalf of any Lender) hereby notifies the Borrower that pursuant to the requirements of the USA PATRIOT Act (Title III of Pub. L. 107-56 (signed into law October 26, 2001), as amended from time to time) (the ***"Patriot Act"***), it is required to obtain, verify and record information that identifies the Borrower, which information includes the name and address of the Borrower and other information that will allow such Lender or the Administrative Agent, as applicable, to identify the Borrower in accordance with the Patriot Act.

11.21 No Fiduciary Duty

The Borrower agrees that in connection with all aspects of the transactions contemplated hereby and any communications in connection therewith, the Borrower and its Subsidiaries, on the one hand, and the Credit Parties, the Joint Lead Arrangers named on the cover page hereof, and their respective Affiliates, on the other hand, will have a business relationship that does not create, by implication or otherwise, any fiduciary duty on the part of the Credit Parties or such Joint Lead Arrangers, or their respective Affiliates, and no such duty will be deemed to have arisen in connection with any such transactions or communications.

11.22 Acknowledgement and Consent to Bail-In of EEA Financial Institutions

Notwithstanding anything to the contrary in any Loan Document or in any other agreement, arrangement or understanding among any such parties, each party hereto acknowledges that any liability of any Lender that is an EEA Financial Institution arising under any Loan Document, to the extent such liability is unsecured, may be subject to the Write-Down and Conversion Powers of an EEA Resolution Authority and agrees and consents to, and acknowledges and agrees to be bound by:

(a) the application of any Write-Down and Conversion Powers by an EEA Resolution Authority to any such liabilities arising hereunder which may be payable to it by any Lender that is an EEA Financial Institution; and

(b) the effects of any Bail-in Action on any such liability, including, if applicable:

(i) a reduction in full or in part or cancellation of any such liability;

(ii) a conversion of all, or a portion of, such liability into shares or other instruments of ownership in such EEA Financial Institution, its parent entity, or a bridge institution that may be issued to it or otherwise conferred on it, and that such shares or other instruments of ownership will be accepted by it in lieu of any rights with respect to any such liability under this Agreement or any other Loan Document; or

(iii) the variation of the terms of such liability in connection with the exercise of the Write-Down and Conversion Powers of any EEA Resolution Authority.

11.23 Certain ERISA Matters

(a) Each Lender (x) represents and warrants, as of the date such Person became a Lender party hereto, to, and (y) covenants, from the date such Person became a Lender party hereto to the date such Person ceases being a Lender party hereto, for the benefit of, the Administrative Agent and the Joint Lead Arrangers and not, for the avoidance of doubt, to or for the benefit of the Borrower, that at least one of the following is and will be true:

(i) such Lender is not using "plan assets" (within the meaning of Section 3(42) of ERISA or otherwise) of one or more Benefit Plans with respect to such Lender's entrance into, participation in, administration of and performance of the Loans, the Commitments or this Agreement,

(ii) the transaction exemption set forth in one or more PTEs, such as PTE 84-14 (a class exemption for certain transactions determined by independent qualified professional asset managers), PTE 95-60 (a class exemption for certain transactions involving insurance company general accounts), PTE 90-1 (a class exemption for certain transactions involving insurance company pooled separate accounts), PTE 91-38 (a class exemption for certain transactions involving bank collective investment funds) or PTE 96-23 (a class exemption for certain transactions determined by in-house asset managers), is applicable with respect to such Lender's entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement,

(iii) (iii) (A) such Lender is an investment fund managed by a "Qualified Professional Asset Manager" (within the meaning of Part VI of PTE 84-14), (B) such

Qualified Professional Asset Manager made the investment decision on behalf of such Lender to enter into, participate in, administer and perform the Loans, the Commitments and this Agreement, (C) the entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement satisfies the requirements of sub-sections (b) through (g) of Part I of PTE 84-14 and (D) to the best knowledge of such Lender, the requirements of subsection (a) of Part I of PTE 84-14 are satisfied with respect to such Lender's entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement, or

(iv) such other representation, warranty and covenant as may be agreed in writing between the Administrative Agent, in its sole discretion, and such Lender.

(b) In addition, unless either (1) sub-clause (i) in the immediately preceding clause (a) is true with respect to a Lender or (2) a Lender has provided another representation, warranty and covenant in accordance with sub-clause (iv) in the immediately preceding clause (a), such Lender further (x) represents and warrants, as of the date such Person became a Lender party hereto, to, and (y) covenants, from the date such Person became a Lender party hereto to the date such Person ceases being a Lender party hereto, for the benefit of, the Agents and the Joint Lead Arrangers and not, for the avoidance of doubt, to or for the benefit of the Borrower, that the Administrative Agent is not a fiduciary with respect to the assets of such Lender involved in such Lender's entrance into, participation in, administration of and performance of the Loans, the Commitments and this Agreement (including in connection with the reservation or exercise of any rights by the Administrative Agent under this Agreement, any Loan Document or any documents related hereto or thereto).

(c) For purposes of this Section 11.23, the following defined terms when used herein have the following meanings:

"Benefit Plan" means any of (a) an "employee benefit plan" (as defined in ERISA) that is subject to Title I of ERISA, (b) a "plan" as defined in Section 4975 of the Internal Revenue Code or (c) any Person whose assets include (for purposes of ERISA Section 3(42) or otherwise for purposes of Title I of ERISA or Section 4975 of the Internal Revenue Code) the assets of any such "employee benefit plan" or "plan".

"PTE" means a prohibited transaction class exemption issued by the U.S. Department of Labor, as any such exemption may be amended from time to time.

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AS EVIDENCE of the agreement by the parties hereto to the terms and conditions herein contained, each such party has caused this Agreement to be executed on its behalf.

CVS HEALTH CORPORATION

By: /s/ CAROL A. DENALE
Name: Carol A. DeNale
Title: Senior Vice President and Treasurer

BANK OF AMERICA, N.A., as Administrative Agent

By: /s/ KYLE D HARDING
Name: Kyle D Harding
Title: AVP

CVS HEALTH CORPORATION
364-DAY CREDIT AGREEMENT

BANK OF AMERICA, N.A., as a Lender

By: /s/ DARREN MERTEN
Name: Darren Merten
Title: Vice President

BARCLAYS BANK PLC, as a Lender

By: /s/ RITAM BHALLA
Name: Ritam Bhalla
Title: Director

GOLDMAN SACHS BANK USA, as a Lender

By: /s/ ANNIE CARR
Name: Annie Carr
Title: Authorized Signatory

JPMORGAN CHASE BANK, N.A., as a Lender

By: /s/ VANESSA CHIU
Name: Vanessa Chiu
Title: Executive Director

WELLS FARGO BANK, NATIONAL ASSOCIATION, as a Lender

By: /s/ JORDAN HARRIS
Name: Jordan Harris
Title: Director

CITIBANK, N.A., as a Lender

By: /s/ ALEJANDRO E. ROMERO
Name: Alejandro E. Romero
Title: Vice President

MIZUHO BANK, LTD., as a Lender

By: /s/ TRACY RAHN
Name: Tracy Rahn
Title: Authorized Signatory

MUFG BANK, LTD., as a Lender

By: /s/ JACK LONKER
Name: Jack Lonker
Title: Director

ROYAL BANK OF CANADA, as a Lender

By: /s/ GORDON MACARTHUR
Name: Gordon MacArthur
Title: Authorized Signatory

SUNTRUST BANK, as a Lender

By: /s/ STEVE CURRAN
Name: Steve Curran
Title: Director

U.S. BANK NATIONAL ASSOCIATION, as
a Lender

By: /s/ JOYCE P. DORSETT
Name: Joyce P. Dorsett
Title: Senior Vice President

CREDIT SUISSE AG, CAYMAN ISLANDS BRANCH, as a Lender

By: /s/ WILLIAM O'DALY
Name: William O'Daly
Title: Authorized Signatory

By: /s/ ANDREW GRIFFIN
Name: Andrew Griffin
Title: Authorized Signatory

FIFTH THIRD BANK, as a Lender

By: /s/ TODD S. ROBINSON
Name: Todd S. Robinson
Title: VP

PNC BANK, NATIONAL ASSOCIATION,
as a Lender

By: /s/ MICHAEL RICHARDS
Name: Michael Richards
Title: SVP, Managing Director

BANCO SANTANDER, S.A., NEW YORK BRANCH, as a Lender

By: /s/ RITA WALZ-CUCCIOLI
Name: Rita Walz-Cuccioli
Title: Executive Director
Banco Santander S.A., New York Branch

By: /s/ TERENCE CORCORAN
Name: Terence Corcoran
Title: Executive Director
Banco Santander S.A., New York Branch

SUMITOMO MITSUI BANKING CORPORATION, as a Lender

By: /s/ MICHAEL MAGUIRE
Name: Michael Maguire
Title: Executive Director

BANK OF CHINA, NEW YORK BRANCH, as a Lender

By: /s/ RAYMOND QIAO
Name: Raymond Qiao
Title: Executive Vice President

INDUSTRIAL AND COMMERCIAL BANK OF CHINA LIMITED, NEW YORK BRANCH, as a Lender

By: /s/ HSIWEI CHEN
Name: Hsiwei Chen
Title: Director

By: /s/ PINYEN SHIH
Name: Pinyen Shih
Title: Executive Director

KEYBANK NATIONAL ASSOCIATION, as
a Lender

By: /s/ MARIANNE T. MEIL
Name: Marianne T. Meil
Title: Senior Vice President

TD BANK, N.A., as a Lender

By: /s/ UK-SUN KIM
Name: Uk-Sun Kim
Title: Senior Vice President

CVS HEALTH CORPORATION
364-DAY CREDIT AGREEMENT

THE BANK OF NEW YORK MELLON, as a Lender

By: /s/ CLIFFORD A. MULL
Name: Clifford A. Mull
Title: Director

CVS HEALTH CORPORATION
364-DAY CREDIT AGREEMENT

Attachment K

Kentucky | Transforming Health Care | **Aetna**

Attachment K
C.7 – Encounter Data

Encounter Data Submission Policy ..... Att K-3

Encounter and Health Plan Roles and Responsibilities Policy ..... Att K-9

Data Transfer to Encounter Management System Policy ..... Att K-15

Encounter Inventory Management Policy ..... Att K-23

Correction of Encounter Data in EMS ..... Att K-29

Encounter Financial Completeness ..... Att K-35

Processing of Encounter Response File Information
from Regulatory Agencies ..... Att K-41

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Encounter Data Submission Policy

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PURPOSE:

The purpose of this policy is to define the process for the submission of encounter data and supplemental data to the designated agency, in accordance with Health Insurance Portability and Accountability Act (HIPAA) standards and Regulatory requirements, for the purpose of rate setting, quality management, risk adjustment and other mandated requirements. Medicaid Encounters will cooperate with Regulator or designated entities in conducting encounter data quality assessments.

STATEMENT OF OBJECTIVE:

The objective is to submit complete encounter data in an accurate and timely manner.

DEFINITIONS:

Claim	Provider submitted record, representing an episode of care provided, utilizing the approved form(s) and correct coding.
Correct Coding	Process used to validate coding of claims as submitted by providers.
Edits	Regulator's responses to encounter submission that need to be resolved and/or reviewed by the Encounter Unit. Responses may be rejects or informational only.
Encounter Management System	Aetna Medicaid Administrator LLC's (AMA's) internally developed, proprietary encounter processing system or a third party vendor supported encounter management system.
Encounter	A record of health care services provided to a recipient, submitted by the provider / Health Plan to the payer / Regulatory agency.
Health Insurance Portability and Accountability Act (HIPAA)- Compliant File Format	A data format and transaction standard for submitting medical related information.
Regulator	A State, Federal agency or fiscal intermediary that administers Medicaid or Medicare Encounter data.
Scrubs	Pre-export processes used to update and/or hold data that would cause known issues on submission to the State.

Third Party Vendor	A vendor who has an arrangement with a Health Plan to provide delegated services and submits their claims and supplemental encounter data to the Encounter Unit for submission to the Regulatory agency.

LEGAL/CONTRACT REFERENCE:

- Regulatory requirements
- Third-party vendor contracts
- Requests for proposals (RFP)
- Health Plan contracts with State/ Federal Medicaid agencies

FOCUS/DISPOSITION:

Under the direction of the Encounters Management Team, the Encounter Unit is responsible for the complete, accurate, timely submission and re-submission, of encounter data through the encounter management system, to the appropriate agency according to the regulator's submission requirements.

The Encounter Unit maintains responsibility for process oversight/control and reporting to internal and external sources as required.

A manual or scheduled export process is initiated in the encounter management system, creating HIPAA- compliant files according to pre-defined parameters. The files are submitted to the appropriate Regulatory agency and archived in accordance with records retention guidelines.

The Encounter Unit reviews, approves and communicates file format encounter changes from the Regulator or Health Plan to Information Technology (IT).

OPERATING PROTOCOL:

Systems

- Claims processing system
- Encounter management system(s)

Measurements

- Encounter unit transmission of 100% of eligible claims or supplemental data

- Achieve 100%, plus/minus 5%, encounter acceptance of finalized claims and dollars paid in the claims processing system, unless otherwise defined in the Regulator's contract
- Achieve the timeliness metric as defined in the Regulator's contract

Reporting

- End to End Financial Reconciliation Report
- Transfer Validation Report (included within End to End Report)
- Weekly File Tracker
- Encounter Error Reports
- Monthly Compliance Report
- Regulator specific reports

INTER-/INTRADEPENDENCIES:

Internal

- Claims
- Configuration Solutions Reimbursement Analysis (CSRA)
- Enrollment Services
- Finance
- Health Plan affiliates
- Health Plan Reimbursement Administration (HPRA)
- Information Technology (IT)
- Provider Data Services (PDS)

External

- Centers for Medicare & Medicaid Services (CMS)
- State Medicaid agency or fiscal intermediary
- Third-party vendors
- Vendor supported encounter management system

Aetna Medicaid Administrators LLC

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Gina Conflitti, MD, MBA
Chief Medical Officer

Reviewed and revised: 11/2010
Reviewed and revised: 02/2011
Reviewed and revised: 03/2012
Reviewed and revised: 10/2012
Reviewed and revised: 10/2013
Reviewed and revised: 10/2014
Reviewed and revised: 02/2016
Reviewed and revised: 02/2017
Reviewed and revised: 03/2017
Reviewed and revised: 08/2017
Reviewed and revised: 01/2018
Reviewed and revised: 02/2018
Reviewed and revised: 01/2019

Encounter and Health Plan Roles and Responsibilities Policy

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PURPOSE:

The purpose of this policy is to clearly define roles and responsibilities for the end-to-end encounter process.

STATEMENT OF OBJECTIVE:

The objective of this policy is to delineate responsibilities and accountabilities between each Medicaid Encounters functional area and Health Plan personnel

DEFINITION:

Encounter	A record of health care services provided to an eligible Medicaid or Medicare recipient, submitted by the Health Plan or designee to the applicable Regulatory agency.
Edits	State responses to encounter submission that need to be resolved and/or reviewed by the Encounters Unit. Responses may be rejects or informational only.
Rate Setting	The process for determining a payment amount that a State reimburses to a Health Plan for the provision of a service. States typically pay managed care organizations for risk-based managed care services through fixed periodic payments for a defined package of benefits. These capitation payments are typically made on a Per Member Per Month (PMPM) basis.
Regulator	A State, Federal agency or fiscal intermediary that administers Medicaid or Medicare Encounter data.
Risk Adjustment	An actuarial tool used to calibrate State payments to Health plans or other stakeholders based on the relative health of the at-risk populations. It combines medical and pharmacy claims based on both diagnosis codes and National Drug Codes (NDC) to identify members with chronic conditions.
Scrubs	Pre-export processes used to update and/or hold data that would cause known errors on submission to the State.
Third Party Vendor	A vendor who has an arrangement with a Health Plan to provide delegated services and submits their claims data to the Encounters unit for submission to the Regulatory agency.

LEGAL/CONTRACT REFERENCE:

- Regulatory requirements
- Third-party vendor contracts
- Requests for proposals (RFP)
- Health Plan contracts with State/Federal Medicaid agencies and/or providers
- State specific Companion Guides and/or Provider and Claims manuals
- Health Insurance Portability and Accountability Act (HIPAA) 837 (I, P, D) Implementation Guides
- National Council for Prescription Drug Program (NCPDP) D.0/D.2/Post Adjudication History (PAH) Implementation Guides

FOCUS/DISPOSITION:

Responsibilities:

Under the direction of the Medicaid Encounters director, encounter management personnel have designated responsibility for:

- Encounter data submissions based on regulator schedule
- Reconciliation and monitoring of encounter inventory
- Research and resolution of internal scrubs and external edits (with the exception of member and provider related errors)
- Encounter Tactical Reporting
- Participate in meetings with the Health Plan to review encounter performance and resolve issues
- Participate in risk adjustment and rate setting activities as needed
- Interacts with State's technical intermediaries and State Information Technology (IT) departments on an ongoing basis
- Implementation of Regulator's encounter file format changes
- Internal quality monitoring of encounter corrections and submissions
- Development and management of Encounter policies and desktop procedures

Under the direction of the Health Plan Operation lead, Health Plan personnel have designated responsibility for:

- Encounter financial completeness evaluations with coordination from Health Plan Finance and Centralized Encounter Unit

- Coordination with the Centralized Encounters Unit for resolution of issues to meet contractual standards and avoid penalties
- Research and resolution of member and provider related scrubs and edits
- Management of Third Party Vendor Relations (contract, quality, corrective action plan, utilization monitoring)
- Coordination of risk adjustment and rate setting activities with responsible parties as needed
- Management of State reporting (claim lag and spend data) and coordinating with appropriate functional areas
- Management of State requests (questionnaires and audits)
- Representation and participation in all State and Third Party Vendor encounter calls
- Communicating operational updates from State or internal meetings that may impact claims or encounters

OPERATING PROTOCOL:

Systems

- Claims processing system
- Encounter management system(s)
- Actuarial Services Reporting Database (ASDB)

Measurements

- Meet Timeliness and Accuracy requirements as defined in the Regulator's contract
- Meet financial completeness metrics as defined in the Regulator's contract
- Adherence to State financial reporting requirements as defined in the Regulator's contract
- Meet Risk and Rate setting timeliness as defined in the Regulator's contract

Reporting

- State provided Encounter Utilization / Financial Completion Reports
- Encounters End-To-End Financial Reconciliation Report
- Health Plan Financial Claim Lag / Spend Report

INTER-/INTRADEPENDENCIES:

Internal

- Actuarial Services
- Configuration Solutions Reimbursement Analysis (CSRA)
- Enrollment Services
- Health Plan affiliates
- Informatics / Business Information Services (BIS)
- Information Technology (IT)
- Medicaid Encounter Unit management and staff
- Provider Data Services (PDS)

External

- Centers for Medicare & Medicaid Services (CMS)
- External Auditing Agencies
- State Medicaid agency or fiscal intermediary
- Third-party vendors

Aetna Medicaid Administrators LLC

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Gina Conflitti, MD, MBA
Chief Medical Officer

Reviewed and revised: 11/2017
Reviewed and revised: 01/2018
Reviewed and revised: 01/2019

Proprietary

Data Transfer to Encounter Management System Policy

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PURPOSE:

The purpose of this policy is to define the process of centralizing finalized claims data for Medicaid and Medicare Health Plans; confirming timely, complete and accurate representation of the Health Plan member's utilization is reported, including third party vendors.

STATEMENT OF OBJECTIVE:

The objective of this policy is to track and monitor the accuracy in which encounter data is brought into the encounter management system, in order to demonstrate encounters are complete, accurate and submitted in a timely manner, in accordance with the Regulator's contract and internal policies.

DEFINITION:

Adjudicate	Progression of claims going through the payment process.
Claim	Provider submitted record, representing an episode of care provided, utilizing the approved form(s) and correct coding.
Correct coding	Process used to validate coding of claims as submitted by providers.
Denied claim	The decision not to pay for services submitted for payment or reimbursement.
Encounter	A record of health care services provided to a recipient, submitted by the provider / Health Plan to the payer / Regulatory agency.
Encounter Management System	Aetna Medicaid Administrator LLC's (AMA's) internally developed, proprietary encounter processing system or a third party vendor supported encounter management system.
File Translator	Software used to translate 837 Claim files into formats that can be loaded into Aetna's backend databases or exported to outside vendors requiring this data.
Regulator	A State, Federal agency or fiscal intermediary that administers Medicaid or Medicare Encounter data.
State/Federal/ Health Insurance Portability and Accountability Act (HIPAA) Edits	Edits or responses to submitted encounters which indicate that the record was accepted or the reason why it was rejected.
Validator	A third-party software product that is used to validate 837 Claim files insuring that the files meet minimum HIPAA standard for the transaction sets based on Industry Implementation Guides.

Third-Party Vendor	A vendor who has an arrangement with a Health Plan to provide delegated services and submits claims data to the Encounter Unit for submission to the Regulatory agency.

LEGAL/CONTRACT REFERENCE:

- Regulatory requirements
- Third-party vendor contracts
- Requests for proposals (RFP)
- Health Plan contracts with State/Federal Medicaid agencies and/or providers
- State specific Companion Guides and/or Provider and Claims manuals
- HIPAA 837 (I, P, D) Implementation Guides
- NCPDP D.0/D.2/PAH Implementation Guides

FOCUS/DISPOSITION:

Under the direction of the Encounters Management Team, the Encounter Unit, utilizing the claims processing system and the encounter management system, is responsible for collection and transfer of adjudicated claims in accordance with RFPs, internal policies/procedures, and other binding agreements/regulations.

Third-party vendors are responsible for collection and accurate adjudication of specific claims data, timely transmission of the data in an agreed upon format, in accordance with RFPs, internal policies/procedures and other binding agreements/regulations.

Transfer of claims data from the processing system to the encounter management system occurs through a manual or scheduled process where claims in a paid, denied or reversed status are imported into the encounter management system according to plan specifications.

The Encounter Unit initiates the transfer of third-party vendor data via EDI files into the encounter management system. Files are validated for HIPAA compliance and translated prior to being written to the system data tables. Files that contain unacceptable data, either whole files or individual records, in accordance with the agreements with third-party vendors, are rejected and returned to the vendors.
Standard tracking and reconciliation reports are used to validate 100% of eligible claims that are imported into the encounter management system for submission.

OPERATING PROTOCOL:

Systems

- Encounter management system(s)
- Claims processing system

Measurements

- Encounter unit transfer rate of 100% of eligible claims

Reporting

- Transfer Validation Report (included within End to End Report)
- Weekly File Tracker
- End to End Financial Reconciliation Report:
  - Transfer Validation Report

INTER/INTRA-DEPENDENCIES:

Internal

- Claims
- Enrollment Services
- Health Plan Operations
- Information Technology (IT)
- Provider Data Services (PDS)
- Shared Services Operations

External

- Third party encounter management system
- Third party vendors

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Reviewed and revised: 11/2010
Reviewed and revised: 10/2011
Reviewed and revised: 10/2012
Reviewed and revised: 10/2013
Reviewed and revised: 10/2014
Reviewed and revised: 02/2016
Reviewed and revised: 02/2017
Reviewed and revised: 03/2017
Reviewed and revised: 01/2018
Reviewed and revised: 06/2018
Reviewed and revised: 01/2019

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Encounter Inventory Management Policy

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PURPOSE:

The purpose of the Encounter Inventory Management policy is to confirm proper inventory control for complete, timely and accurate encounter submissions.

STATEMENT OF OBJECTIVE:

The objective of this policy is to maintain accountability for the control of the encounter inventory to provide timely and accurate encounter submissions.

DEFINITIONS:

Claim	Provider submitted record, representing an episode of care provided, utilizing the approved form(s) and correct coding.
Encounter	A record of health care services provided to a recipient, submitted by the provider / Health Plan to the payer / Regulatory agency.
Encounter Management System	Aetna Medicaid Administrators LLC's (AMA's) internally developed, proprietary encounter processing system or a third party vendor supported encounter management system.
Regulator	A State, Federal agency or fiscal intermediary that administers Medicaid or Medicare Encounter data.
Third Party Vendor	A vendor who has an arrangement with a Health Plan to provide delegated services and submits claims data to the Encounter Unit for submission to the Regulatory agency.

LEGAL/CONTRACT REFERENCE:

- Regulatory requirements
- Third-party vendor contracts
- Requests for proposals (RFP)
- Health Plan contracts with State/Federal Medicaid agencies and/or providers
- State specific Companion Guides and/or Provider and Claims manuals
- Health Insurance Portability and Accountability Act (HIPAA) 837 (I, P, D) Implementation Guides
- National Council for Prescription Drug Program (NCPDP) D.0/D.2/ Post Adjudication History (PAH) Implementation Guides

FOCUS/DISPOSITION:

Under the direction of the Encounters director, Encounter management personnel are responsible for managing the encounter inventory using the following controls:

- Encounter reports are reviewed weekly by Encounter management and project managers
- Compliance Dashboard generated and reviewed monthly by Encounter management, project managers, and staff
- Weekly meetings are held with Encounter management and the plan specific teams to discuss aging of encounter inventory
- Weekly or bi-monthly meetings are held with the Medicaid Health Plans to discuss aging of encounter inventory

OPERATING PROTOCOL:

Systems

- Claims processing system
- Encounter management system(s)

Measurement

- Meet Timeliness and Accuracy requirements as defined in the Regulator's contract

Reporting

- Encounter correction work distribution reports
- Encounter Error reports
- End to End Financial Reconciliation report
- Weekly File Tracker
- Monthly Compliance Report
- Weekly Progress Tracker
- Regulator/Plan reports
- Scheduled and Ad Hoc Processing queries

INTER-/INTRADEPENDENCIES:

Internal

- Claims Analysts
- Configuration Solutions Reimbursement Analysis (CSRA)
- Data and Production Management (DPM)

- Encounters
- Enrollment Services
- Health Plan Finance
- Health Plan Operations
- Health Plan Provider Services
- Information Technology (IT)
- Provider Data Services (PDS)

External

- Centers for Medicare & Medicaid Services (CMS)
- State Medicaid Agency or Fiscal Intermediary
- Third-party vendors

Aetna Medicaid Administrators LLC

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Reviewed and revised: 04/2013
Reviewed and revised: 02/2014
Reviewed and revised: 02/2015
Reviewed and revised: 02/2016
Reviewed and revised: 02/2017
Reviewed and revised: 03/2017
Reviewed and revised: 01/2018
Reviewed and revised: 01/2019

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Correction of Encounter Data in EMS

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PURPOSE:

The purpose of this policy is to document the correction activities that occur within or outside of the encounter management system(s).

STATEMENT OF OBJECTIVE:

The objectives are to define the process of correction, modification, and/or re-formatting of non-compliant encounter records, in accordance with the Regulator's accuracy and timeliness requirements.

DEFINITION:

Claim	Provider submitted record, representing an episode of care provided, utilizing the approved form(s) and correct coding.
Correct coding	Process used to validate coding of claims as submitted by providers.
Encounter	A record of health care services provided to a recipient, submitted by the provider / Health Plan to the payer / Regulatory agency.
Encounter Management System	Aetna Medicaid Administrator LLC's (AMA's) internally developed, proprietary encounter processing system or a third party vendor supported encounter management system.
Regulator	A State, Federal agency or fiscal intermediary that administers Medicaid or Medicare Encounter data.
Third-Party Vendor	A vendor who has an arrangement with a Health Plan to provide delegated services and submits claims data to the Encounter Unit for submission to the Regulatory agency.

LEGAL/CONTRACT REFERENCE:

- Regulatory requirements
- Third-party vendor contracts
- Requests for proposals (RFP)
- Health Plan contracts

FOCUS/DISPOSITION:

Under the direction of the Encounter Management Team, the Encounter Unit is responsible for correction of encounter data, including from the claim system and coordinating the correction of third party vendor errors.

The Encounter Unit researches errors and validates encounter data to resolve edits. Internal edits are worked prior to encounter submission to make certain accuracy requirements are met. Errors received from the State are worked and resubmitted in accordance with State requirements.

Third-party vendors' encounter data is validated (for Health Insurance Portability and Accountability Act [HIPAA] compliance), and imported into the encounter management system. Errors are communicated to third-party vendors for resolution.

OPERATING PROTOCOL:

Systems

- Encounter management system(s)
- Claims processing system
- Regulator's encounter processing systems

Measurements

- Achieve 100%, plus/minus 5%, encounter acceptance of finalized claims and dollars paid in the claims processing system, unless otherwise defined in the Regulator's contract
- Achieve the timeliness metric as defined in the Regulator's contract

Reporting

- Encounter Error Reports
  - Third Party Encounter Error Report
  - Provider Error Report
  - Member Error Report
- Encounter Correction Analyst work distribution reports

INTER/INTRA-DEPENDENCIES:

Internal

- Centralized or Health Plan Enrollment
- Claims
- Configuration Solutions Reimbursement Analysis (CSRA)
- Health Plan Provider Services
- Information Technology (IT)
- Provider Data Services (PDS)

External

- Centers for Medicare & Medicaid Services (CMS)
- State's Medicaid Agency or Fiscal Intermediary
- Third party vendors
- Vendor supported encounter management system

Aetna Medicaid Administrators LLC

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Reviewed and revised: 12/20/2007
Reviewed and revised: 01/08/2008
Reviewed and revised: 02/28/2011
Reviewed and revised: 03/2012
Reviewed and revised: 10/2012
Reviewed and revised: 10/2013
Reviewed and revised: 10/2014
Reviewed and revised: 02/2016
Reviewed and revised: 02/2017
Reviewed and revised: 01/2018
Reviewed and revised: 06/2018
Reviewed and revised: 01/2019

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Encounter Financial Completeness

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PURPOSE:

The purpose of the Encounter Financial Completeness policy is to verify reconciliation and evaluation of the overall financial completeness of encounter data submitted to the Regulator.

STATEMENT OF OBJECTIVE:

The objective of this policy is to maintain accountability and identify parties responsible for addressing reconciliation of paid claims data with the encounter acceptance rate.

DEFINITIONS:

Claim	Provider submitted record, representing an episode of care provided, utilizing the approved form(s) and correct coding
Encounter	A record of health care services provided to a recipient, submitted by the provider / Health Plan to the payer / Regulatory agency.
Encounter Management System	Aetna Medicaid Administrator LLC's (AMA's) internally developed, proprietary encounter processing system or a third party vendor supported encounter management system.
Regulator	A State, Federal agency or fiscal intermediary that administers Medicaid or Medicare Encounter data.
Third Party Vendor	A vendor who has an arrangement with a Health Plan to provide delegated services and submits claims data to the Encounter Unit for submission to the Regulatory agency.

LEGAL/CONTRACT REFERENCE:

- Regulatory requirements
- Third-party vendor contracts
- Requests for proposals (RFP)
- Health Plan contracts with State/ Federal Medicaid agencies and/or providers
- State specific Companion Guides and/or Provider and Claims manuals
- Health Insurance Portability and Accountability Act (HIPAA) 837 (I, P, D) Implementation Guides
- National Council for Prescription Drug Program (NCPD)D.0/D.2/ Post Adjudication History (PAH) Implementation Guides

FOCUS/DISPOSITION:

Under the direction of Aetna Medicaid, Aetna Medicare, and Health Plan Finance, on an ongoing basis Health Plan Operations and Encounter Management personnel are responsible to review and monitor financial acceptance rates for risk adjustment and rate setting for fiscal and/or calendar year periods.

OPERATING PROTOCOL:

Systems

- Claims processing system
- Encounter management system(s)
- Actuarial Services Data Base (ASDB)
- Vendor Claim Detail / History Reports / Plan Audit Tables

Measurement

- Meet Timeliness and Accuracy requirements as defined in the Regulator's contract
- Achieve 100%, plus/minus 5%, encounter acceptance of finalized claims and dollars paid in the claims processing system

Reporting

- End To End Financial Reconciliation Report
- Health Plan Financial reports
- Fit gap analysis reports

INTER-/INTRADEPENDENCIES:

Internal

- Claims analysts
- Configuration Solutions Reimbursement Analysis (CSRA)
- Enrollment Services
- Finance
- Health Plan affiliates
- Information Technology (IT)
- Informatics and Risk Adjustment
- Provider Data Services (PDS)

External

- Centers for Medicare & Medicaid Services (CMS)
- State Medicaid agency or fiscal intermediary
- Third party vendors

Aetna Medicaid Administrators LLC

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Reviewed and revised: 02/2013
Reviewed and revised: 03/2014
Reviewed and revised: 03/2015
Reviewed and revised: 02/2016
Reviewed and revised: 02/2017
Reviewed and revised: 03/2017
Reviewed and revised: 01/2018
Reviewed and revised: 01/2019

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Processing of Encounter Response File Information from Regulatory Agencies

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PURPOSE:

The purpose of this policy is to define the processing of encounter response file information received from regulatory agencies that are imported into the Encounter management systems.

STATEMENT OF OBJECTIVE:

The objective is to update the encounter status, monitor/report encounter submission results, and identify encounter issues based on file information received from the regulatory agencies.

DEFINITION:

Encounter	A record of health care services provided to a recipient, submitted by the provider / Health Plan to the payer / Regulatory agency.
Encounter Management System	Aetna Medicaid Administrator LLC's (AMA's) internally developed proprietary encounter processing system or a third party vendor supported encounter management system.
Regulator	A State, Federal agency or fiscal intermediary that administers Medicaid or Medicare Encounter data.
State/Federal/ Health Insurance Portability and Accountability Act (HIPAA) files	General or specific information returned on a remit file(s) detailing accepted encounters or why an encounter was not accepted.
Third-Party Vendor	A vendor who has an arrangement with a Health Plan to provide delegated services and submit claims data to the Encounter Unit for submission to the Regulatory agency.

LEGAL/CONTRACT REFERENCE:

- Regulatory requirements
- Third party vendor contracts
- Requests for proposals (RFP)
- Health Plan contracts

FOCUS/DISPOSITION:

The appropriate State, agency, or designee, is responsible for the transmission, via secure electronic transmission, of remittance information for all submitted encounters on Health Insurance Portability and Accountability Act (HIPAA) compliant remittance file formats and/or proprietary information

files as defined by the Regulatory agency.

Under the direction of the Encounter Management Team, the Encounter Unit is responsible for the transfer of encounter file information into the Encounter management system, including third party vendors.

The Encounter Unit monitors, tracks, and reconciles the encounter data received in the file(s), and provides reports to the appropriate internal/external parties.

OPERATING PROTOCOL:

Systems

- Claims processing system
- Encounter management system(s)

Measurements

- Achieve 100%, plus/minus 5%, encounter acceptance of finalized claims and dollars paid in the claims processing system, unless otherwise defined in the regulator's contract
- Achieve the timeliness metric as defined in the regulator's contract

Reporting

- Weekly Progress Tracker
- Encounter Error Reports
- Weekly File Tracker
- End to End Financial Reconciliation Report

INTER-/INTRADEPENDENCIES:

Internal

- Health Plans
- Information Technology (IT)

External

- Centers for Medicare & Medicaid Services (CMS)
- State Medicaid agency or fiscal intermediary

- Vendor supported encounter management system
- Third party vendors

Aetna Medicaid Administrators LLC

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Reviewed and revised: 12/2007
Reviewed and revised: 03/2011
Reviewed and revised: 03/2012
Reviewed and revised: 10/2013
Reviewed and revised: 10/2014
Reviewed and revised: 02/2016
Reviewed and revised: 02/2017
Reviewed and revised: 03/2017
Reviewed and revised: 01/2018
Reviewed: 01/2019

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Attachment L

Kentucky | Transforming Health Care | **Aetna**

Attachment L

C.9 - Aetna Better Health® of Kentucky VBS Care Collaboration

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ABHKY VBS Care Collaboration

JENNIFER NACHREINER

aetna®

05/10/2019

Care Collaboration

Goals

- Establish new forum to address ongoing, nearly universal challenges
- Determined collaboratively by stakeholders based on utilization and cost

Initial Planning

- Facilitated by Population Health team, decisions made by stakeholders
- Stakeholders include clinical and quality teams at both plan and provider
- Level of involvement and collaboration determined by stakeholders
- Workflow analysis and evaluation planning

Ongoing Action

- Monthly conversations – monitor progress and address issues in real-time
- Modify approach as needed
- Include UM/CM/Rx team as appropriate

Coordinated effort between health plan and VBS groups to best support and manage high and emerging risk members through frequent touch-points and utilization review.

Purpose of Care Collaboration

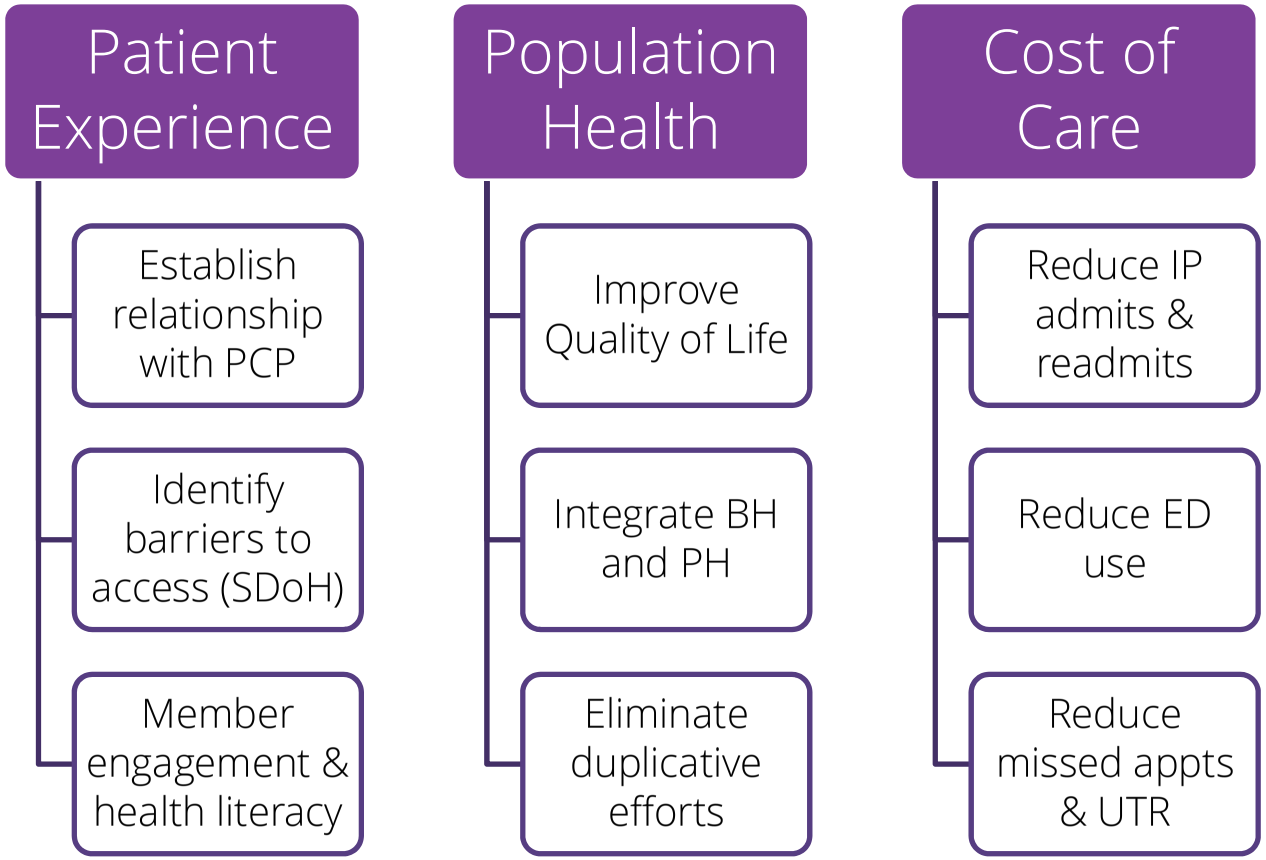

Opportunities

Identify Cohort for Collaboration

- IP admissions and ED frequency
- High cost with no PCP recent visit
- ED visits with low severity
- Diagnosis and claim spend/utilization
- Multiple HEDIS gaps
- Risk adjustment members

Aetna Health Plan Resources

- Key Performance Indicator Reports
- Consolidated CORE Reports - utilization
- HEDIS Dashboard and Gaps
- CareUnify Leverage
- Daily PA Files

Medicaid (ABD) member (23 y/o male) - BH

Assigned PCP	Chris Combs	Most Recent Visit 08/18
ED Visits	45 (5 low severity)	Most Recent Visit 02/19
Admits (R12)	0	
Conditions	Schizoaffective Disorder, Bipolar, Depression, Anxiety	
Rx Count	25	
Total spend (med + Rx)	$34,638	
Current Engagement	CM outreach 2.19 for ER and Homeless	

General Risk: Medium

Inpatient Risk: Medium

ED Risk: High

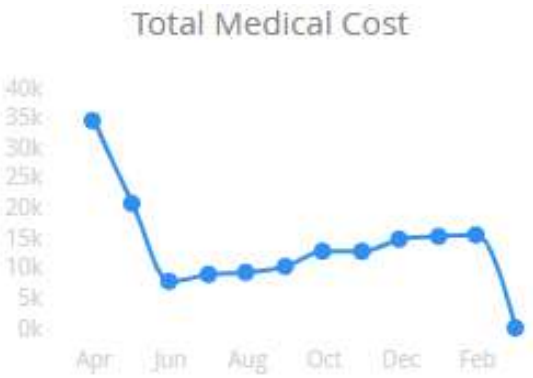

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Data sources: CORE report 2/1/18-1/31/19, Predictive Pathways Modeling report, and CareUnify

Medicaid (exp) member (52 y/o male) - PH

Assigned PCP	Sara Miller	Most Recent Visit 11/18
ED Visits (R12)	2	Most Recent 08/18
Admits (R12)	3	Most Recent 05/19
Conditions	CKD, DM, COPD, HTN, hyperlipidemia	
Rx Script Count	116	
Total spend (med + Rx)	$88,437	
Current Engagement	UM referred, sent to KY1 for OR	

General Risk: High

Inpatient Risk: High

ED Risk: High

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Data sources: CORE report 2/1/18-1/31/19, Predictive Pathways Modeling report, and CareUnify

Clinical Collaboration Analysis – ED

All Active collaborations

Utilization metrics specific to members discussed during the clinical collaborations

Percent change	3 month: - 35.9%
	6 month: - 26.2%
	9 month: - 24.7%
	12 month: - 4.2%

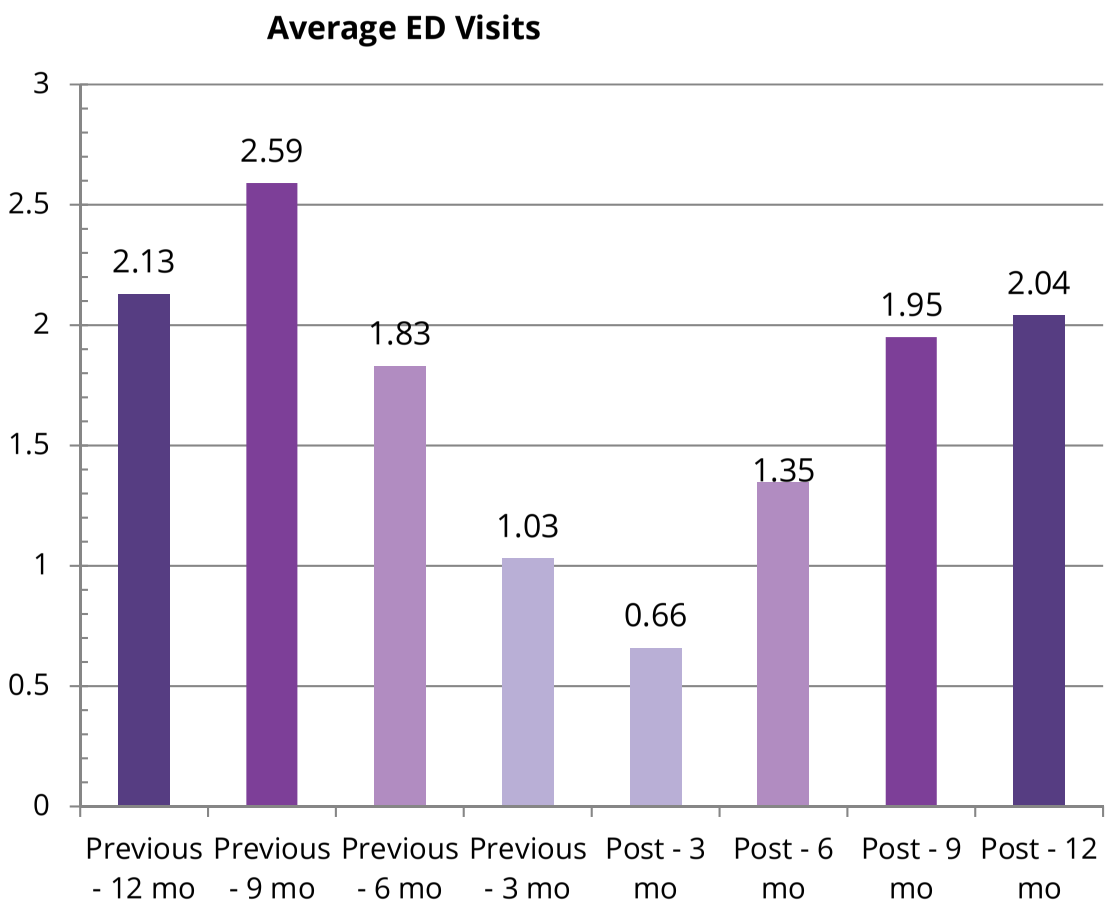

Data source: Quick Base Outcomes Tracker

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Clinical Collaboration Analysis – IP

All Active collaborations

Utilization metrics specific to members discussed during the clinical collaborations

Percent change	3 month: - 43.5%
	6 month: - 24.3%
	9 month: - 16.1%
	12 month: - 17.1%

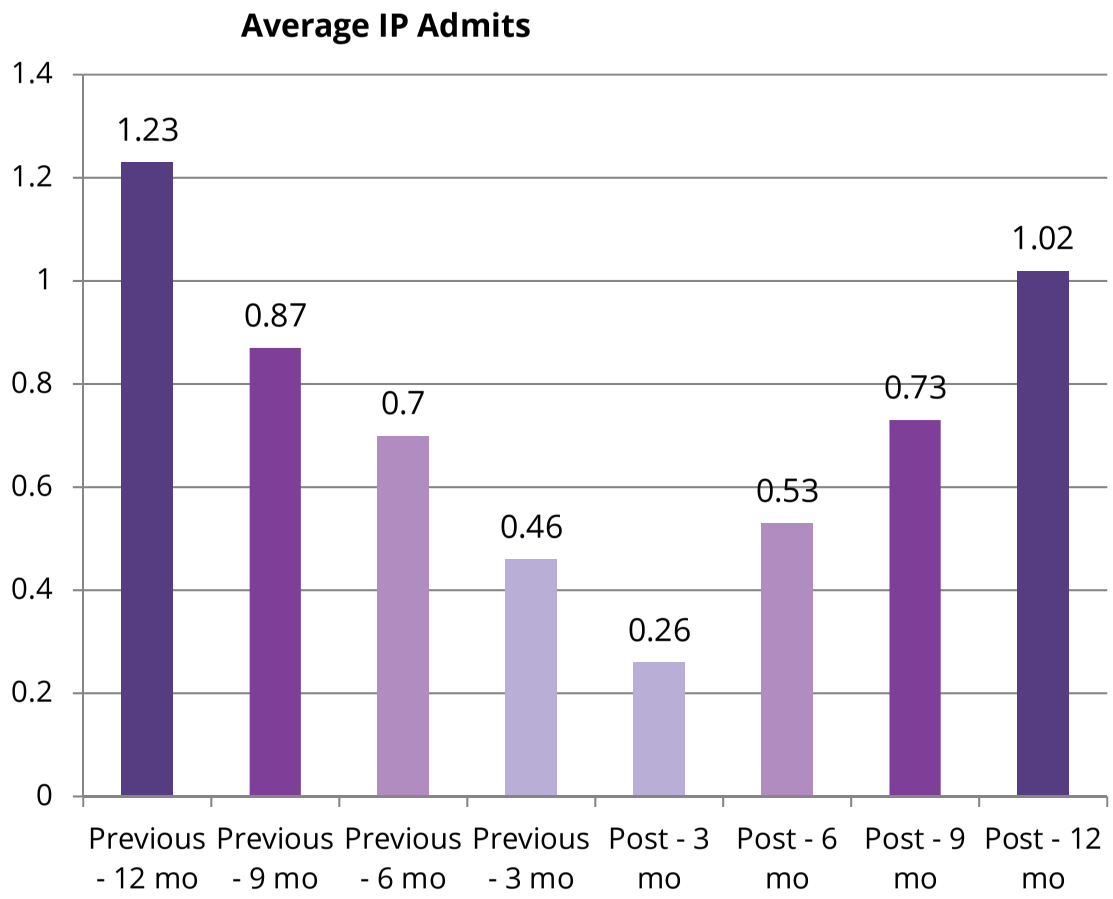

Data source: Quick Base Outcomes Tracker

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Clinical Collaboration Analysis – Readmissions

All Active collaborations

Utilization metrics specific to members discussed during the clinical collaborations

Percent change	3 month: - 25.0%
	6 month: - 7.7%
	9 month: 0.0%
	12 month: 47.6%

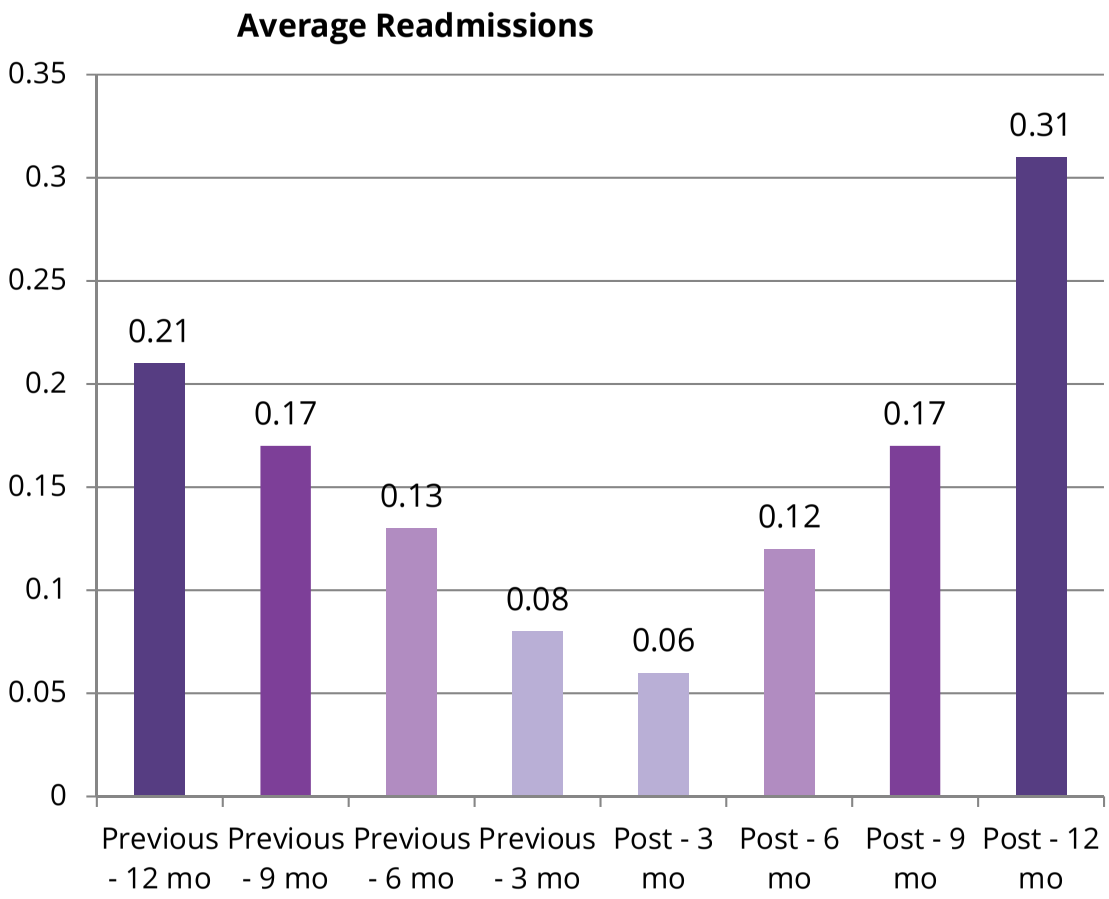

Data source: Quick Base Outcomes Tracker

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Questions

- How do we integrate into current workflows?
- How do we ensure no follow up by ABHKY for members that are being co-managed by VBS group?
- Who from ABHKY needs to be involved in CC calls?
- Can we prioritize risk adjustment members?
- Which VBS groups to target for engagement (Ky1, St E, Baptist)

Attachment M

Kentucky | Transforming Health Care | **Aetna**

Attachment M
C.12 – Enrollee Services

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Welcome Letter .....Att M-7

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Enrollee ID Card

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Aetna Better Health® of Kentucky

Aetna Better Health® of Kentucky

Name Last Name, First Name, MI
Member ID# 00000000000

DOB 00/00/0000 **Sex** X

PCP Last Name, First Name
PCP Phone 000-000-0000

Effective Date 00/00/0000

RXBIN: 610591 **RXPCN:** ADV **RXGRP:** RX8831

Pharmacist Use Only: **1-855-319-6290**

aetnabetterhealth.com/kentucky

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

MEKYMED1B

Att M-5

Aetna Better Health of Kentucky
9900 Corporate Campus Drive, Suite 1000, Louisville, KY 40223

Member Services: **1-855-300-5528**, (TTY **711**), TDD **1-800-627-4702**
24-Hour Nurse Line: **1-855-620-3924**
Behavioral Health: **1-888-604-6106**

In case of an emergency go to the nearest emergency room or call 911.

Provider Numbers
Eligibility: **1-855-300-5528**
Authorization: **1-888-725-4969**

Send claims to:
Aetna Better Health of Kentucky
P.O. Box 65195
Phoenix, AZ 85082-5195

Payer EDI: 128KY

KYMEDB1

Welcome Letter

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Aetna Better Health of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, Kentucky 40223

Forward Services Requested

<Name>
<Address>
<City, State Zip Code>

<Date>

Aetna Better Health® of Kentucky

Your new health plan and member ID card

Dear member:

Welcome to Aetna Better Health of Kentucky, your new Kentucky HEALTH plan.

Attached is your new member ID card. Keep it with you in case you need it.

Your member handbook will arrive separately. You can learn more about your benefit plan by reading your member handbook.

Questions? You can visit **aetnabetterhealth.com/kentucky** or call **1-855-300-5528**, (TDD **1-800-627-4702**, TTY: **711**), weekdays, 7 a.m. to 7 p.m. ET.

Thank you for being an Aetna Better Health of Kentucky member. We look forward to working together to make a healthier Kentucky. It all starts with you.

Sincerely,

Member Services

AETNA BETTER HEALTH® OF KENTUCKY

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator
4500 East Cotton Center Boulevard
Phoenix, AZ 85040
Telephone: **1-888-234-7358 (TTY 711)**
Email: MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل **1-800-385-4104** (للصم والبكم: **711**).

SERBO-CROATIAN: OBAVEŠTENJE: Ako govorite srpski, usluge jezičke pomoći dostupne su vam besplatno. Pozovite broj na poleđini vaše identifikacione kartice ili broj **1-800-385-4104** (TTY – telefon za osobe sa oštećenim govorom ili sluhom: **711**).

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または**1-800-385-4104** (TTY: **711**)までご連絡ください。

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

PENN DUTCH: Geb Acht: Wann du Deitsch Pennsilfaanisch Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf die Nummer uff, ass hinne uff dei ID card iss, odder ruf **1-800-385-4104** (TTY: **711**).

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नम्बर वा **1-800-385-4104** (TTY**: 711**) मा फोन गर्नुहोस्।

OROMO (CUSHITE): Hubadhu: yoo Oromoo dubbatta ta'ee, gargaarsa tajaajiiloota afaanii, kaffaalttii bilisaa ni jiraa siif. Lakkoofsa bilbiilaa ID kee duuba irraa jiruun yookiin **1-800-385-4104** (TTY: **711**).

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

KIRUNDI (BANTU): ICITONDERWA: Namba uvuga Ikirundi, serivisi zigufasha kugusigurira ururimi, ku buntu, ziraboneka ushobora kuzironswa. Hamagara inomero iri inyuma ku gakarata k'akarangamuntu kawe canke iyi nomero **1-800-385-4104** (Ufise ubumuga bwo kutumva neza ifashishe (TTY): **711**).

Aetna Better Health® of Kentucky Enrollee Handbook

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Aetna Better Health® of Kentucky

January 2020

AetnaBetterHealth.com/Kentucky

86.07.318.1-KY

Important phone numbers for members

Member Services **1-855-300-5528**
(TDD: **1-800-627-4702**, TTY: 711)

24-Hour Informed Health Line **1-855-620-3924**

Transportation **1-888-941-7433**

Kentucky Medicaid Member Services **1-800-635-2570**

Behavioral Health Crisis Hotline **1-888-604-6106**
(TDD: **1-866-200-3269**, TTY: 711)
Available 24/7

Mailing address

9900 Corporate Campus Drive
Suite 1000
Louisville, KY 40223

Download our Mobile App

- For iPhone go to the Apple Store
- For Android go to the Google Play Store

Personal information

_____
My member ID number

_____
My primary care provider (PCP)

_____
My PCP's phone number

AetnaBetterHealth.com/Kentucky

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Welcome to Aetna Better Health of Kentucky

Welcome and thank you for choosing Aetna Better Health of Kentucky. Your choice of our health plan is an important one for you and your family.

We have a strong network of doctors, hospitals and other health care providers. They offer a wide range of services to meet your health care needs and those of your family.

It's important that you understand how to use our services and your benefits. This Member Handbook has information you need to know about your benefits. Please take the time to read it carefully. You can also download a copy from our website at **AetnaBetterHealth.com/Kentucky**.

Our Member Services Department is always ready to answer your questions. Call **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

As a lifelong Kentuckian, your health and the health of all Kentuckians is a personal priority of mine. We look forward to serving you and your family.

Sincerely,

Jonathan Copley
Chief Executive Officer

We're here to help create a healthier Kentucky, with healthier communities, families and people. And it all starts with you.

Your checklist for success

- ❏ Update your address and email.
- ❏ Keep your ID card on you and provide it to all doctors and pharmacies you visit.
- ❏ Update your PCP by calling us.
- ❏ Call your PCP to schedule your checkups and screenings.
- ❏ Know when to call your PCP and when to use the emergency room (see pages 21–23).
- ❏ Gain new skills. You can get help with education and training.
- ❏ Recertify for Medicaid benefits each year – the state will contact you.
- ❏ Read this handbook to learn more about topics like covered services and limits, copays, and things like how to file an appeal.

My questions for follow-up:

How Managed Care Works

Managed Care Organizations (MCOs) like Aetna Better Health of Kentucky help you get high quality medical care. We have a network of doctors, specialists, pharmacists and other providers available to meet your health care needs. We offer bonus benefits and services designed to assist you in your healthcare journey. Whether you need preventive care or guidance managing a chronic medical condition, we want to help you achieve your best health.

Aetna Better Health manages your covered Medicaid benefits by:

- Working with your Primary Care Provider (PCP) to decide what care you need
- Explaining information in this handbook when there is a question about coverage
- Providing palliative hospice services along with other health services and medication for members under age 19 who have been diagnosed with a serious illness

Providing you with quality service

Aetna Better Health serves members statewide. We're one of the largest managed care health plans in Kentucky. Our strong partnerships with health care providers and other community organizations help to give you complete and quality care.

Aetna Better Health has demonstrated our commitment to the highest standards and earned an accreditation status of Commendable by the National Committee. The rating is based on clinical quality, member satisfaction and NCQA survey results. To find out more about Quality Matters, visit **AetnaBetterHealth.com/Kentucky**.

Affirmative statement

Aetna Better Health employees make clinical decisions regarding health care based on the most appropriate care and service available. We don't reward providers or other employees for any denials of service. We also don't encourage nor reward clinical decisions that result in decreased services.

In addition, Aetna Better Health does not use incentives to encourage barriers to care and service. We prohibit any employee or representative of Aetna Better Health from making decisions regarding hiring, promotions, or termination of providers or other individuals based upon the likelihood or perceived likelihood that the individual or group will support or tend to support the denial of benefits.

Eligibility

Only the Department for Community Based Services (DCBS) may approve your eligibility for Medicaid. For questions about your eligibility, please call your local DCBS office at **1-855-306-8959**. You may also use **benefind.ky.gov**, the Assistance and Support Programs for Kentuckians website, to find out if you qualify for programs like Medicaid or the Kentucky Children's Health Insurance Program (KCHIP).

Enrollment

DCBS provides Aetna Better Health with the name, address, age and sex of each member enrolled in this plan. Your effective date is on your Aetna Better Health Member ID card.

Changes in enrollment

You must notify us if you have any of the following changes:

- You have a baby
- A covered family member passes away
- A covered family member moves out of your home
- Your family size changes in any way
- You move
- You get other health insurance

If any of the above apply to you, you must:

- Call your local DCBS office at **1-855-306-8959**.
- Call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.
- If you also have Medicare, call your local Social Security Administration office.

If you move away from our service area, we'll help you get services until you are disenrolled.

Births

Once your baby is born, you must obtain a Medicaid ID number for your baby.

We want to be sure your baby doesn't have problems getting care. It's very important that you call your local Department for Community Based Services (DCBS) office to report your baby's birth and get the baby's Medicaid ID number. Your baby's provider(s) won't be paid until your baby receives her/his Medicaid ID number.

Babies born to mothers enrolled in Aetna Better Health should be automatically enrolled in Aetna Better Health. Please call your local Department for Community Based Services and Aetna Better Health at **1-855-300-5528** (TTY users dial **711**; TDD users dial **1-800-627-4702**) to report your baby's birth.

Special programs

There are special programs available to help you. They're the Lock-In program and the Supplemental Security Income Assistance program. They're described below.

Lock-In program

The Lock-In program is an approved Medicaid Program designed to give support to members who need assistance in managing health care needs. The Lock-In program helps members manage their medical care. This program doesn't stop a member from getting the care they need. Instead, members get coordinated care when they use one doctor, one pharmacy and one hospital.

Member claims data is reviewed to identify members who have visited multiple providers, hospital emergency departments, and/or pharmacies.

Aetna Better Health can enroll the member with one or more providers that will support the member's establishment of a medical home and healthful prescription habits.

Someone who is in the Lock-In Program may only have access to one of each of these:

- One (1) primary care provider
- One (1) pharmacy
- One (1) hospital

Members will be locked in to designated providers for a period of 24 months. Aetna Better Health will monitor the claims and pharmacy use of Lock-In members at least annually after the initial 24 month lock-in period.

If the member switches health plans, their lock-in assignment will follow them to their new health plan.

Members determined by Aetna Better Health to be enrolled in the Lock-In program will be provided with written notice of his/her enrollment in the Lock-In program.

Enrollment in the Lock-In program will be effective within 60 days from the date the member is provided written notice. A member will have the right to appeal his/her enrollment in the Lock-In program by providing additional information as to why his/her enrollment is inappropriate. See page 49 for more information on appeal rights.

Supplemental Security Income (SSI) application assistance

SSI is a monthly cash benefit that you may get if you're disabled and you qualify. This government program is for adults and children. You don't have to have any work history to qualify.

Adults may qualify for SSI if they:

- Have a medical condition that needs ongoing care
- Have a medical condition that prevents them from working

Children may qualify for SSI if they:

- Have a medical condition that needs ongoing care
- Have problems talking, hearing or understanding words
- Are using a wheelchair or walker or need other medical equipment
- Are in a Special Education program

Aetna Better Health has partnered with HumanArc to help our members apply for SSI benefits. If you think you or your child may qualify, call HumanArc at **1-888-447-8908**. HumanArc will help you complete your application.

How to Use This Handbook

This member handbook explains how Aetna Better Health of Kentucky works and how to help keep you and your family healthy. It tells you how to get health care or emergency care when you need it and gives you information about going to your primary care provider (PCP). Your PCP is the provider you will go to for most of your health care needs. Your handbook also tells you what benefits are covered by Medicaid and explains bonus benefits you get as an Aetna Better Health member. It includes important contact information and websites that will be helpful resources, too.

Help from Member Services

Member Services can answer questions about health care benefits, ID cards and Primary Care Providers (PCPs). You can also call them to get help with some health care problems. Just call **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**). Someone is there to answer your call Monday through Friday, 7 AM to 7 PM ET. Our Member Services team is here to help make sure each member is treated fairly and able to exercise their rights.

Auxiliary Aids and Services

Member web portal

This member website is your go-to resource for managing your plan. It will help you use your Aetna Better Health benefits and services so you can get and stay healthy. You can:

- **Access health plan details** - change your doctor, find forms or get member ID cards
- **Get personalized health information** - answer questions about your health and get the tips and tools you'll need to meet your health goals, like quitting smoking and weight management
- **Research prescription drugs** - find a pharmacy, see how much a drug costs or ask for a drug not covered by your plan
- **Get instant access to authorization approvals** - see the status of requests for prior authorization (if you are unable to access the web portal, we can mail these to you upon request)
- **Get instant access to claims details** - see the status of your claim from start to finish
- **Find support** - get in touch with a nurse or learn more about the disease management and wellness programs that will help you stay on track with goals

Sign up today. It's easy.

To learn more about these tools, you can visit Aetna Better Health at **AetnaBetterHealth.com/Kentucky**.

To create your account, go to **AetnaBetterHealth.com/Kentucky/login** and select Member Portal. And when you're ready to sign up, just select 'register online.'

You will need your health plan member ID and a current email address to create an account.

Information about your providers

If you want to learn more about our providers, you can locate the information on our website at **AetnaBetterHealth.com/Kentucky**. Click on the 'Find a Provider' ribbon on the top right-hand side of the page. From there you can search by type of doctor and/or location. The online provider directory gives the provider's name, address, telephone numbers, professional credentials, specialty and board certification status. For more information, you can also visit **www.healthgrades.com**. This site gives more information about providers, such as which medical school they attended and where they did their residency training. If you need help or do not have internet access, please call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

Learn more about your pharmacy benefits

Get details about your pharmacy benefits and services. This information will help you make the best decisions about your care. You can call Member Services, or just sign into your secure member portal. You'll get access to:

- Find in-network pharmacies
- Help asking for a drug not covered by your plan
- Look up drug interactions, side effects and risks
- Determine financial responsibility for a drug
- Find out if generic substitutes are available
- Access health plan details - anytime, anywhere

Our goal is to make it easier for you to use your benefits. We've built the member portal to be your go-to resource for managing your plan. You can change your doctor or get a new member ID card. You can also find out how and when to get referrals or authorizations for services, and we'll also tell you about their costs. To talk to us about your health plan, just call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**).

Mobile app

Get your health care information when you want it with the Aetna Better Health Mobile App. You can get instant access to the tools you need to stay connected with your health care. Download your free mobile app today in the iTunes App Store or Google's Play Store.

With our mobile app, you can:

- Find a provider
- View a mobile version of your ID card
- See your medical and prescription claims
- View your medications
- Update your profile information
- View your handbook

- Request a new ID card be sent to you
- See your care plan (if you have one)
- Build a support circle of friends and providers
- Check out health resources
- Ask to change your Primary Care Provider (PCP)
- Send questions to Member Services

Informed Health Line

The 24-hour Informed Health Line gives you access to medical information and advice at no cost to you. It's available 24 hours a day, 7 days a week. Just call **1-855-620-3924** to speak to a nurse. You can also connect with a nurse through the member portal.

Informed Health Line services include:

- Toll-free calls to a registered nurse any time. Translation services are available, if needed.
- Ask questions online and receive a response within 24 hours.
- Get help and advice for acute and chronic conditions.
- Find out more about a medical test or procedure.
- Get help preparing for a doctor's visit.

You may be eligible for a smartphone at NO COST

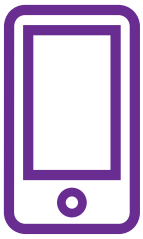

Now you can stay connected with those who care about you.

You may be eligible for a new phone and/or a data package, including:

- Android smartphone
- Voice minutes
- Data packages
- Unlimited text messaging
- Unlimited calls to Aetna Better Health

To learn more or see if you're eligible go to **AetnaBetterHealth.com/Kentucky/members/benefits/cellphone** or call us at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**).

Website information

You can get up-to-date information about your Aetna Better Health plan on our website at **AetnaBetterHealth.com/Kentucky**. You can visit our website to get information about the services we provide, our provider network, frequently asked questions, contact phone numbers and email addresses. Need help? Just call **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**).

We're always here to help

For help getting started or to sign up over the phone, you can call Member Services at **1-855-300-5528** (**TDD: 1-800-627-4702** or **TTY: 711**).

Your Health Plan ID Card

Aetna Better Health Member ID card

When you join Aetna Better Health, each eligible family member receives their own Aetna Better Health Member ID card. This Member ID card tells the provider you are an Aetna Better Health member. The first date you may get care from Aetna Better Health is on your Member ID card. You may also have to show a picture ID to prove you are the person whose name is on the Member ID card.

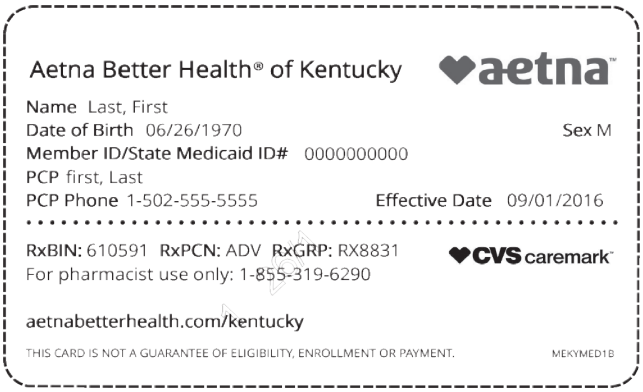

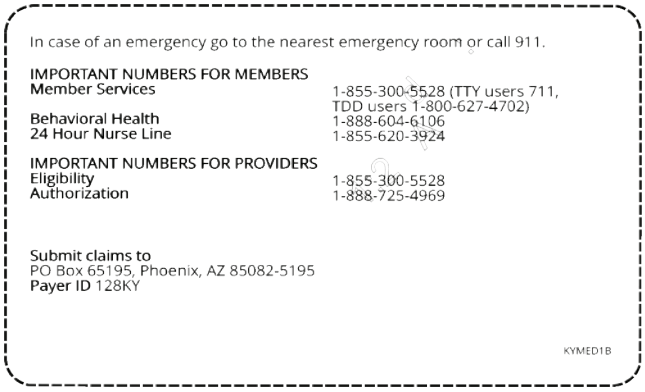

Information included on the Aetna Better Health Member ID card includes but is not limited to:

- Your name
- Your Member ID/State Medicaid ID number
- Your date of birth
- Effective date
- Your Primary Care Provider (PCP) (if you have one)
- Your PCP's office phone number (if you have one)

If you do not have a Member ID card, call Member Services at **1-855-300-5528** (**TTY:** users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET. You may also view your Member ID card on the mobile app. If you lose your Member ID card or if it is stolen, please call Member Services.

Member Rights and Responsibilities

Your Medicaid rights

As a Medicaid member, you are entitled to the following rights:

- Receive information on beneficiary and plan information.
- Be treated with respect and with due consideration for your dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of your medical records and request that they be amended or corrected.

Disenrollment

You may ask to stop your membership with Aetna Better Health for any reason if it's within 90 days of your first enrollment or reenrollment. You may ask to stop your Aetna Better Health membership for cause after the first 90 days. You may have cause if:

- Your PCP is no longer in our network
- You can't access a qualified provider to treat your medical condition
- You experience poor quality of care
- You have lack of access to covered services

You must send a written request for disenrollment. You must give a reason you're asking to be disenrolled. You should send your request to Kentucky Department for Medicaid Services. The address is:

Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6E-C
Frankfort, KY 40621

You will be disenrolled if you or your family members are no longer eligible as determined by DCBS.

Your Medicaid responsibilities

- To give the best information you can so that Medicaid and your providers can take care of you and your family
- To follow your provider's instructions and care plans
- To call your provider first when you need medical care
- To go to providers who take your Medicaid card
- To show your latest Medicaid card every time you get medical services
- To make sure that you only see Kentucky Medicaid providers
- To keep all appointments and be on time
- To cancel an appointment if you cannot be there on time
- To pay your copays
- To follow the rules of your provider's office or clinic. If you or others do not follow the rules, your provider can ask you to leave
- To ask your provider questions if you do not understand something about your medical care
- To tell the truth about yourself and your medical problems
- To report suspected fraud and abuse
- To understand your rights and responsibilities as a Kentucky Medicaid member

Quality Member Access Committee (QMAC)

We need your help! Did you know that you, our member, can help decide how your health care services are provided? The QMAC is a group of members that can and do make a difference in the services and materials provided by Aetna Better Health.

The QMAC is looking for members to offer a point of view, insight, concern and solutions directly to us. We appreciate your voice and time! QMAC members are reimbursed for travel and provided lunch. If a member cannot attend in person, a member can attend by phone. As part of the QMAC you can:

- Be part of the solution
- Have the opportunity to better understand why decisions are made
- Understand how those changes will directly affect your family and others just like you
- Share your experiences as a member of Aetna Better Health
- Be a part of an environment that requests and respects consumer input

Please consider becoming a member of the QMAC. We want your help. For more information about the QMAC or to get the meeting call-in number, please call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

Member satisfaction survey

Aetna Better Health conducts member satisfaction surveys at least once a year. You may receive this confidential survey by mail sometime this year. Please help us learn your opinions by filling it out. If you'd like a copy of the results, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET. Your responses to this survey will not affect your Medicaid eligibility.

Our Member Services team is here to help make sure each member is treated fairly and able to exercise their rights.

Your medical records

Aetna Better Health keeps your personal and health information safe and private. We are required by law to give you the Notice of Privacy Practices. This notice explains your rights about the privacy of your personal information and how we may use and share your personal information. Changes to this notice apply to the information that we have about you. This also applies to any information that we may get or have in the future. Our privacy policy also makes sure our staff is trained on privacy and security policies, which include oral protection of your personal information. You may request a copy at any time.

Aetna Better Health and your providers make sure all your records are kept safe and private. We limit access to your personal information to only those who need it. We have proper protection for entry to our buildings and computer systems. Our Privacy Office also makes sure our staff is trained on our privacy and security policies.

To give the best service, we may use and share your personal information for treatment, payment and operations. We may limit the information Aetna Better Health shares about you as the law requires. For example, HIV/AIDS, substance use, family planning and genetic information may be further protected by law. Our privacy policies always follow the strictest laws.

In the provider's office, your records are labeled with your name and stored in a safe area so unauthorized individuals can't see your information. If your medical information is on a computer, a special password is needed to see that information.

Your medical record can't be sent to anyone without your written permission, unless required by law. When you ask your provider's office to transfer records, they'll give you a release form to sign. It's their responsibility to give this information to you. If you have problems getting your records or having them sent to another provider, please contact Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET. They'll assist you in getting your records within 10 working days of your request.

You have a right to review your medical records. You may also ask that they be updated or corrected. If you'd like a free copy of your medical or personal records maintained by Aetna Better Health, you may call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET. You can also ask for a blank form to fill out and send with a letter to Aetna Better Health. When Aetna Better Health receives your written request, we'll send you the requested records within 30 days. We'll let you know in writing if it will take longer. It should never take more than 60 days from the date of your written request.

Part 1 – First Things You Should Know

What is benefind?

benefind is a website, **benefind.ky.gov**, where you can apply for benefits like:

- Supplemental Nutrition Assistance Program (SNAP) – helps you buy healthy foods for you and your family
- Medicaid – helps cover medical care costs
- Kentucky Transitional Assistance Program (KTAP) – helps pay for basic needs like rent, utilities, and other household expenses

Checking benefit eligibility - You can use benefind to check if you may be eligible to receive benefits if:

- You are unsure if you qualify for benefits
- You are new to Kentucky's public assistance program
- You have never received benefits before

Simply select the benefits you would like to see if you qualify for and answer questions about yourself and your household.

How to Choose Your PCP

Primary Care Provider (PCP)

Your Primary Care Provider (PCP) is your health care provider who takes care of all your main health care needs. You can choose your PCP. Your PCP will see you for well care check-ups and medical problems. Your PCP is your medical home. A medical home helps make sure that the right medical care is available when you need it.

Get to know your PCP. It helps ensure that you get medical care from someone who knows you and from someone who you feel comfortable with. Your PCP is your medical home. Your PCP takes care of all your main health care needs. Your PCP will learn about your health to prevent or detect future illness.

PCPs help keep you healthy by:

- Teaching you how to stay healthy
- Treating a health problem before it becomes serious
- Keeping immunizations up to date
- Providing care when you are sick

All members must select a PCP except:

- Pregnant women
- Children who are disabled or in foster care
- Dual-eligible members (those who have both Medicaid and Medicare)
- Adults who are under state guardianship

You will receive a printed directory of PCPs when you first enroll with us and you can also access the online Provider Directory at **AetnaBetterHealth.com/Kentucky** at any time.

If you have not chosen or been assigned a PCP, you may go to any PCP in the Aetna Better Health network to receive care. Once you have chosen a PCP, this is who you should receive your care from.

Your PCP's name is on your member ID card. If you don't choose a PCP, we will choose one for you.

How to Change Your PCP

To change your PCP, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET. or you can request the change through the Member Portal on our website at **AetnaBetterHealth.com/Kentucky**. If the member is a child, the member's parent or guardian may change the PCP. Lock-In members should ask to speak to the Lock-In Case Management Department. Please refer to page 9 for more information on the Lock-In program.

If you choose a PCP who is not taking new patients, you will have to choose another PCP. If your family doctor is not part of Aetna Better Health's network, you'll have to choose someone else. (You can also ask if your family doctor would like to join our plan.) There are benefits to keeping your PCP. The better they get to know you, the better they can treat you. But there is no limit to the number of times you can change your PCP.

In some cases, your PCP may ask that you be removed from his or her practice. If this happens, you'll get a new PCP. Some reasons your PCP may ask for this change may be that:

- You and your PCP do not get along
- Your PCP cannot meet your medical needs
- You miss appointments

Aetna Better Health may also decide to change your PCP. We will notify you if this happens. We will also notify you if your PCP is no longer in our network. In this case, we will help you select a new PCP.

It's very important to show up for your scheduled appointments. If you can't go to your appointment, cancel the appointment at least 24-hours before the appointment. See page 41 for more information about getting rides to your appointments.

If your PCP is not in his or her office when you need care, just ask to see another provider in the group. There may be a provider on call that you could see.

If you have a serious condition or chronic illness, you may ask to have a specialist as your PCP. Specialists may act as PCPs for members with special needs. However, the specialist must agree

to be your PCP. Call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET, to make this request.

How to Get Regular Health Care

You should get your care from your PCP, who is your medical home. Exceptions include these situations:

- Your PCP wants you to get care that is out of Aetna Better Health's provider network and Aetna Better Health pre-authorizes the service.
- You receive family planning services.
- You are seeking care for a foster child.
- You have an emergency.
- You are seeking behavioral health services.
- You are seeking direct access services such as those described in this handbook.

Care or supplies must be medically needed to be covered. Aetna Better Health reviews generally accepted standards of care to see if care meets these standards.

Call your PCP to make an appointment for a checkup

As soon as you get your Aetna Better Health Member ID card, make an appointment with your PCP for a checkup (even if you are not sick). This way, your PCP can get to know you and help you manage your health better.

Children should also see their PCP for well child checkups, shots and screenings as soon as possible. For well child checkups, shots and screenings, try to call your PCP two or three weeks ahead to get an appointment.

When you or someone in your family is sick and needs medical care, call your PCP. Your PCP can help arrange plans with other providers when you need special care.

Call your PCP even if it is after office hours

If you need care after hours:

- Call the PCP's office to find out how to get care after hours. If it is not an emergency, leave a message.
- If you still cannot reach your PCP, call our 24-Hours Nurse Line at **1-855-620-3924** (**TTY: 711**).

Your PCP's phone number is on your Aetna Better Health Member ID card. You can change your PCP at any time by calling us at **1-855-300-5528** (**TTY: 711** or **TDD: 1-800-627-4702**).

24-hour care

The office of your Primary Care Provider (PCP) is your medical home. Your PCP is the one who takes care of all of your main health needs. You can call your PCP 24 hours a day, 7 days a week, including weekends and holidays. For routine and urgent care, you should always call your PCP first.

In an emergency, call 911 or go to the closest emergency room. You may also call the 24-Hour Informed Health Line at **1-855-620-3924** (TTY users dial **711**, TDD users dial **1-800-627-4702**).

24-hour Informed Health Line

We encourage you to work with your PCP for all your health care needs. But, if you have a medical question and are not sure what to do, call our 24 hour Informed Health Line at **1-855-620-3924** (TTY users dial **711**, TDD users dial **1-800-627-4702**). The nurses can help answer your health questions. They can tell you what to do when you need health care, such as call your PCP for an appointment, go to an urgent care, or go to the emergency room. You can find the Informed Health Line number on the back of your Aetna Better Health Member ID card.

Access and availability standards

You should be able to see your health care provider within the timeframes below for the following situations. Please let us know if you have problems seeing your health care provider within these timeframes.

Provider or service	Availability
Routine, preventive care appointments	Within 30 days
Specialty care	Within 30 days for routine care; within 48 hours for urgent care
Non-urgent sick care appointments	Within 72 hours
Urgent care appointment	Within 48 hours
Behavioral Health Services	Within 10 business days for initial visit and for routine follow-up care Within 6 hours for a non-life threatening emergency Within 48 hours for urgent services
Emergency visit	Immediately
General dentist services	Within 3 weeks for regular appointments; within 48 hours for urgent care
General vision, lab and x-ray services	Within 30 days of regular appointments; within 48 hours for urgent care
Initial prenatal visit for newly enrolled pregnant women in first trimester	Within 14 days
Initial prenatal visit for newly enrolled pregnant women in second trimester	Within 7 days
Initial prenatal visit for newly enrolled pregnant women in third trimester	Within 3 days
Initial prenatal visit for newly enrolled pregnant women with high-risk pregnancies	Within 3 days
After hours care (answering service; on-call MDs)	24 hours a day; 7 days a week
Waiting room time	45 minutes*

*does not apply to emergency room wait times

How to Get Specialty Care

Referrals

Aetna Better Health does not require a referral from your PCP or OB/GYN before you see another Aetna Better Health provider unless you are a Lock-In member. Your PCP is your medical home and should coordinate your care. You should call your PCP to tell him/her you are going to the other provider. Lock-In members must have a referral to see any provider except the one that they are already assigned.

You can obtain a listing of your local specialists by calling Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET. You can also find a provider on the mobile app.

Out-of-Network Providers

Providers not in our network

If your PCP wants you to see a provider who is not in Aetna Better Health's provider network, he or she must send us a written request. You may go to a provider not in our network only if:

- The care is needed
- There are no Aetna Better Health providers to give the care
- Aetna Better Health has approved the care

We have the right to choose where you can get services when there is not an Aetna Better Health provider available to give the care you need. The provider not in our network who plans to give you care should request prior authorization to provide services. Call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET, with any questions.

In the case of an emergency, you may see any provider. Additionally, you may see any provider for a child in foster care or for family planning services.

Member notification of provider terminations

Aetna Better Health will be solely responsible for notifying members that a provider or provider group is no longer a participating provider. We'll notify members prior to the effective date of the termination. When Aetna Better Health is provided advance notice of the termination, we'll mail members notice at least 30 days in advance.

When we don't receive advance notice, we'll mail members notice within fifteen (15) days of learning the provider is terminating. Members have 10 days to choose a provider or one will be chosen for them.

Emergencies

What is an emergency?

An emergency is a sudden injury or serious illness that if not treated right away, could cause death or permanent harm. If you're pregnant, it could mean harm to your health and the health of your baby. You don't have to go to an Aetna Better Health participating provider in an emergency, and you do not need a prior authorization for emergency services.

Some examples of an emergency are:

Trouble breathing	Poisoning
Broken bones	Severe or unusual bleeding
Convulsions, seizures or loss of consciousness	Severe burns
Chest pain	Suicidal or homicidal feelings
Deep knife wounds or gunshot wounds	Fever in newborn (less than 3 months old)
Pregnancy-related problems	Serious head, neck or back injury
Any vaginal bleeding in pregnancy	Severe abdominal pain
Signs of a stroke (including loss of vision, sudden numbness, weakness, slurred speech or confusion)	Signs of a heart attack (including chest pain)

If possible, call your PCP or the 24-hour Informed Health Line at **1-855-620-3924** (TTY users dial **711**, TDD users dial **1-800-627-4702**). If you cannot call, go to the nearest hospital emergency room or call 911. If you're admitted to a hospital that isn't in Aetna Better Health's network, you may be transferred to a hospital in our network when your condition is stable if authorized by Aetna Better Health.

If you must stay in the hospital after an emergency, the provider must call Aetna Better Health within 24 hours. If that day is on a weekend or legal holiday, the provider must call by the end of the next working day.

Show your Aetna Better Health Member ID card to the providers and ask them to file the claims with Aetna Better Health.

You should always follow up with your PCP after going to urgent care or to the ER.

Out of service area

If you're outside of our service area and need medical treatment, you're only covered for an emergency when seen at an emergency room. Outside of our service area means outside the Commonwealth of Kentucky. If you see a provider who is out of our service area and is not signed up with Medicaid, you may have to pay the bill. The provider must be willing to bill Aetna, get a Kentucky Medicaid ID number and call Aetna to approve care. If you're away from home and need to see a doctor, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

Post-stabilization care

This is medically needed care after an emergency condition is stable. Aetna Better Health doesn't require prior authorization for post-stabilization care.

Follow-up care

After an emergency, be sure to get any follow-up care from your PCP. Do not go back to the emergency room for this care.

Emergency services

Always carry your Aetna Better Health Member ID card. Know where to find your closest hospital emergency room. There is a list of hospitals with emergency services in your Provider Directory or call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**). If you see a provider who is out of our service area and is not signed up with Medicaid, you may have to pay the bill. The provider must be willing to bill Aetna, get a Kentucky Medicaid ID number and call Aetna to approve care. Monday through Friday, 7 AM to 7 PM ET. You can also find a list online at **AetnaBetterHealth.com/Kentucky**.

Urgent Care

Urgent care is medically needed care for an unexpected illness or injury. If possible, call your PCP. If you're unable to receive urgent care from your PCP, you may need to get care at an urgent care center. If you have a true emergency, go to the hospital emergency room.

If you need help deciding if you have a care need that is urgent, please call our 24-hour Informed Health Line at **1-855-620-3924** (TTY users dial **711**, TDD users dial **1-800-627-4702**). The nurse can help you decide whether to get care at an urgent care center or wait for an appointment with your provider.

If your PCP's office is closed, you might need to go to urgent care for your health care needs. Urgent care is for injuries or illnesses requiring immediate care, but not serious enough to go to the emergency room.

Some examples when you might need urgent care:

Accidents and falls	Sprains and strains
Moderate back problems	Breathing difficulties (i.e., mild to moderate asthma)
Urinary tract infections	Bleeding/cuts - not bleeding a lot but requiring stitches
Eye irritation and redness	Diagnostic services, including X-rays and laboratory tests
Skin rashes and infections	Fever or flu
Vomiting, diarrhea or dehydration	Severe sore throat or cough
Minor broken bones (such as fingers or toes)	

We Want You to Stay Healthy

Routine screening and testing

Everyone has different health needs. We want to work with our members to help them reach their health goals. That's why Aetna Better Health offers information to help our members stay healthy. We are focused on making sure our members get the health care they need, and we want you to feel empowered to manage your own health.

Aetna Better Health provides benefits for no cost routine screening and testing to help you stay healthy. Members age 20 and older should have regular health exams. These exams include

screenings for cholesterol levels, high blood pressure, diabetes, obesity and physical activity as well as your risk for heart disease and cancer. Providers should give guidance about the screenings and follow the Centers for Disease Control and Prevention (CDC) guidelines.

Managing medical conditions

When you have a condition, your health care provider will work with you to set up a treatment plan. The plan will likely include several actions. For example, it might include medications, changes to what you eat or exercise. It might also include ways to find emotional support.

Asthma

Aetna Better Health can help you get care if you have asthma. Some people have bad asthma problems and a lot of trouble breathing. Some people have fewer asthma problems and less trouble breathing. Everyone with asthma needs care from a doctor.

We have a disease management program for members with asthma. If you have asthma, tell us and your doctor. If you learn you have asthma from your doctor, tell us. We will work with you to see if you are low risk or high risk for problems.

If you are low risk, we will give you information to help you take care of yourself.

If you are high risk, a case manager will call you to talk about your care. Here are some things the case manager will talk about with you:

- Taking care of your asthma at home
- Why taking your medicine is important
- What causes asthma attacks
- Why you need to do what your doctor tells you
- Ways to change your habits so you feel better

It is important to know as much as you can about your asthma. If you want to learn more about Aetna Better Health's disease management program for asthma, call Member Services at **1-855-300-5528** (**TTY: 711** or **TDD: 1-800-627-4702**). Ask to talk to a care manager.

Diabetes

Aetna Better Health can help you get care if you have diabetes. People with diabetes have too much sugar in their blood. If they do not get treatment or care, they could have major health problems such as heart disease and blindness.

Some people might have pre-diabetes. HealthRunsDEEP (HRD) is a community education class for people who may be at risk of pre-diabetes. If you are overweight, obese, don't eat a properly balanced diet and/or are inactive, HRD is for you! HRD covers:

- How to eat balanced meals
- Monitoring progress (food tracking)
- How to incorporate activity into your day
- Various other techniques to keep you on track and reduce your risk of diabetes

Aetna members that participate in the HealthRunsDeep program will also have access to virtual diabetes support.

Other people have mild diabetes. They take care of it by exercising and eating healthy foods. Other people have more serious diabetes. They have to take shots of a hormone called insulin. Insulin helps your body's cells use food the right way. Everyone with diabetes needs care from a doctor.

We have a disease management program for members with diabetes. Tell us and your doctor if you have diabetes. Call us if your doctor tells you that you have diabetes. We will work with you to see if you are low risk or high risk for problems.

If you are low risk, we will give you information to help you care for yourself. Also, we will work with your doctor to get you the right care.

If you are high risk, a case manager will call you to see if you need more help.

We will teach you about diabetes and help you take care of yourself. You will learn:

- How to take care of your diabetes
- How to watch your blood sugar
- Why you need to take your medicine
- How to take good care of your feet
- Why you need to do what your doctor tells you
- How to learn healthy habits so you feel better

It is important to learn as much as you can about your diabetes. If you want to learn more about Aetna Better Health's disease management program for diabetes, call Member Services at **1-855-300-5528** (**TTY: 711** or **TDD: 1-800-627-4702**). Ask to talk to a care manager.

Congestive Heart Failure (CHF)

Aetna Better Health can help you get care if you have Congestive Heart Failure (CHF). CHF is not a disease. It is a condition that happens when the heart cannot pump enough blood for your body. We have a disease management program for members with CHF.

Everyone with CHF needs care from a doctor. If you do not get care, your heart could get weaker and you will feel very sick. You may even have to go to the hospital.

Many people live very well with CHF. To live well, you must see a doctor regularly and do what the doctor tells you. We will work with you and your doctor to get you the right treatment.

Most people with CHF fit in one of four groups:

- **Group one:** A person may not have signs of CHF or heart damage. He or she may have other problems such as high blood pressure, diabetes or blocked blood vessels in the heart. We will teach you ways to live healthier if you are part of this group. This will help you be less likely to get CHF.
- **Group two:** A person's heart has been damaged. The heart is not as healthy as it could be. But the person does not show symptoms of heart failure. Maybe the person has had a heart attack or an infection in the heart. Maybe the heart valves are not working correctly. Your doctor may give you medicine called ACE inhibitors or beta blockers if you are part of this group.
- **Group three:** A person's heart may be damaged, like in group two. The person shows signs of heart failure. We will teach you about having healthier habits if you are part of this group. You will learn about exercise and eating healthy food. Also, your doctor may give you medicine for your CHF.
- **Group four:** This is the most serious group. A person's heart may be getting weaker. It may not be able to pump blood to the body very well. Your doctor may refer you to a heart doctor, or you may have to go to the hospital if you are part of group four.

It is important to learn as much as you can about your CHF. If you want to learn more about Aetna Better Health's disease management program for CHF, call Member Services at **1-855-300-5528** (**TTY: 711** or **TDD: 1-800-627-4702**). Ask to talk to a care manager.

Chronic Obstructive Pulmonary Disease (COPD)

Aetna Better Health can help you get care if you have COPD. COPD stands for chronic obstructive pulmonary disease, which is a lung disease. A lot of people can live well with COPD. We can help you live well too.

COPD happens slowly over time. People often will not know there is a problem. COPD makes people's lungs not work as well as they used to. Some people have worse COPD than others. That is why everyone gets different kinds of treatment. We will work with you and your doctor to find the best treatment for you.

We have a disease management program for members with COPD. Tell us and your doctor if you have lung disease. Call us if your doctor tells you that you have lung disease. We will see if you are low risk or high risk for problems with COPD.

If you are high risk, a care manager will call you to see if you need more help. The care manager will talk to you about not smoking and your treatment. Some people need oxygen, medicines or other care.

It is important to learn as much as you can about your COPD.

If you want to learn more about Aetna Better Health's disease management program for COPD, call Member Services at **1-855-300-5528** (**TTY: 711** or **TDD: 1-800-627-4702**). Ask to talk to a care manager.

Cancer-related checkups

Depending on age and sex, screenings may look for cancer of the:

- Lymph nodes
- Ovaries
- Testes
- Oral cavity
- Skin
- Thyroid

Breast cancer

Yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health. Breast exams should be done by your provider as part of your regular health exams.

- Every three years for women between ages 20 and 30
- Every year for women age 40 and older

Breast self-exams should begin at age 20. Women should know how their breasts normally feel and they should report any changes to their provider.

If you or someone in your family has had breast cancer, you're at risk. Women who are at risk should talk to their providers about getting their first mammography before they turn 40 years old. They may also ask about more tests (for example, breast ultrasound or MRI) or tests more often.

Colon and rectal cancer

Beginning at age 50, both men and women should follow one of these schedules:

- Yearly fecal occult blood test (FOBT)* or fecal immunochemical test (FIT)
- Flexible sigmoidoscopy every five years
- Yearly FOBT* or FIT, plus flexible sigmoidoscopy every five years**
- Double-contrast barium enema every five years
- Colonoscopy every 10 years

* For FOBT, the take-home multiple sample method should be used.

** The combination of yearly FOBT or FIT or flexible sigmoidoscopy every five years is preferred over only one of these options. Members should have a colonoscopy if any of these tests are positive.

If members have any of the following risk factors, they should talk to their providers about starting colorectal cancer screening earlier:

- A personal history of colorectal cancer or adenomatous polyps
- A strong family history of colorectal cancer or polyps in a parent, sibling, or child, under age 60, or in two relatives of any age
- A personal history of chronic inflammatory bowel disease
- A family history of an hereditary colorectal cancer syndrome (familial adenomatous polyposis or hereditary non-polyposis colon cancer)

Cervical cancer

All women should have cervical cancer screenings about three years after they start having sex (no later than 21 years old). Women should have screenings every year with a regular Pap test (or every two years using the newer liquid-based Pap test).

Beginning at age 30, women with three normal Pap test results in a row may get screened every two to three years. Women over age 30 may get screened every three years (but not more often) with either the standard or liquid-based Pap test, plus the HPV DNA test. Women at risk should be screened every year. Risks include diethylstilbestrol (DES) exposure before birth or HIV infection. A risk could also be a weakened immune system due to organ transplant, chemotherapy or chronic steroid use.

Women, 70 years of age or older, with three or more normal Pap tests in a row and no abnormal Pap test results in the last 10 years may stop having cervical cancer screening. Women with a history of cervical cancer, DES exposure before birth, HIV infection or a weakened immune system should be screened as long as they're healthy.

Women with a total hysterectomy (removal of the uterus and cervix) may also stop having cervical cancer screening, unless the surgery was done as a treatment for cervical cancer or pre-cancer.

Women who have had a hysterectomy without removal of the cervix should continue to follow the guidelines above.

Endometrial (uterine) cancer

The American Cancer Society recommends that all women in menopause should know about the risks and symptoms of endometrial or uterine cancer. Women should report any sudden bleeding or spotting to their providers. Beginning at age 35, women with or at high risk for hereditary non-polyposis colon cancer (HNPCC) should be offered screening for endometrial cancer with endometrial biopsy each year.

Prostate cancer

Beginning at age 50, men who are expected to survive 10 years should be offered the prostate-specific antigen (PSA) blood test. They should also be offered a digital rectal examination (DRE) each year. Men at high risk, such as African-American men, should begin testing at age 45. Men with relatives (parent, sibling, and child) who got cancer at an early age may also be at risk. Men at even higher risk could begin testing at age 40. Depending on the results of this test, you might not need testing again until age 45.

All men should be given information about finding and treating prostate cancer early. This can help them make an informed decision about testing. Men who ask their provider to make the decision for them should be tested. Providers shouldn't discourage men from being tested. Providers must offer testing and should encourage men to be tested.

Medical Technology Committee

Aetna Better Health has a group of health care providers and health specialists that review new and existing drugs and technology. The group recommends what will and will not be covered. This is done by a review of research and clinical guidelines. It's also done by looking at what other doctors are doing. Our doctors will work with your doctor to get you the care you need. We explain information in this handbook when there's a question about coverage. Looking at new methods allows us to make sure you have access to current, safe and effective health care.

Part 2 – Your Benefits and Plan Procedures

Services Covered by Aetna Better Health of Kentucky

What are my benefits?

The following is an overview of services that we cover and the copayments that may apply. Copayments, also called Copays, refer to the dollar amount you, as the member, may be responsible for paying when you receive certain services such as office visits, supplies or prescriptions.

Benefit	Copay	Limits
Inpatient Medical Hospitalization		
Acute Inpatient Hospital Services	$50	Per admission
Inpatient Physician/Surgeon Services	$0	Cosmetic surgery is not covered (except for post-mastectomy reconstructive surgery)
Transplant	$0	No limit
Emergency Services		
Emergency Room (ER)	$0; $8	$8 for non-emergency use of the ER
Emergency Ambulance (ground or air)	$0	No limit
Ambulatory Patient Services		
Physician Office Services	$3	No limit

Outpatient Hospital/ Ambulatory Surgical Center	$4	Cosmetic surgery is not covered (except for post-mastectomy reconstructive surgery)
Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC) & Primary Care Center (PCC)	$3	Per visit
Dental Services (adults)	$3 $0 for children	Per visit
Home Health Care	$0	No limit
Vision Services (adults)	$3	1 eye exam per year
Vision Services (children)	$0	1 eye exam per year
Urgent Care	$3	Per visit
Radiation Therapy	$0	No limit
Chemotherapy	$0	No limit
Family Planning	$0	No limit
Podiatry	$3	No limit
Maternity and Newborn Care		
Prenatal and Postnatal Care	$0	No limit
Maternity Services	$0	No limit
Prescription Drugs		
Prescription Drugs	$1 Generic; $4 Brand Name – no generic	No limit
Rehabilitative and Habilitative Services and Devices		
Skilled Nursing and Rehabilitation	$0	No limit
Chiropractic Services	$3	Per visit 26 visits per 12-month period
Durable Medical Equipment	$4	Per item
Hearing Aids/Audiometric Services	$0	Limited to children under 21
Orthotic/Prosthetic Devices	$4	Per item
Physical/Occupational/ Speech Therapy	$3	Per visit; 20 visits per therapy per year; No copay for children
Private Duty Nursing	$0	2,000 hours per year (outpatient only)

Laboratory, Diagnostic and Radiology Services		
Laboratory, Diagnostic, and Radiology Services (outpatient)	$3	Per visit per service
Pediatric Services		
Autism Spectrum Disorders	$0	Up to age 21
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Special Services	$0	Limited to medically necessary services and must be prior authorized
Commission for Children with Special Health Care Needs	$0	Limited to children who meet the eligibility criteria of the Kentucky Commission for Children with Special Health Care Needs
Specialized Children's Services Clinics	$0	Services limited to children under age 18 and must be performed by specialized clinics
Targeted Case Management: Severe emotional disability (SED) Children	$0	Limited to children who meet Kentucky's statutory definition of SED
First Steps Services	$0	Services are available to children from birth through age two who have developmental delays or diagnosed physical or mental conditions associated with developmental delay
Mental Health and Substance Use Disorder Services		
Targeted Case Management	$0	No limit
Inpatient Mental Health/ Substance Use Services	$50	Per admission
Outpatient Mental Health/ Substance Use Services	$3	Per visit
Psychiatric residential treatment facilities (PRTFs)	$0	Services for residents ages 6 to 21
Preventive Services and Chronic Disease Management		
Smoking/Tobacco Cessation	$0	No limit
Allergy Services	$0	No limit

Wellness services (Immunizations and other preventive health services such as annual check-ups, pap smears, blood pressure screenings, etc.)	$0	No limit
Other		
Non-Emergency Transportation	$0	No limit
Family Planning	$0	No limit
Hospice	$0	No limit
Second Opinion	$0	No limit
TeleHealth	$0	No limit
Renal Dialysis/Hemodialysis (outpatient)	$0	No limit

Notes:

- All benefits provided must be medically necessary.
- Copays apply to all members unless exempt.
- Copays are limited to no more than 5% of your family's total income each calendar quarter (every 3 months).

Population Health Management

At Aetna Better Health of Kentucky, we understand that your needs are special to you. Our goal is to help you stay healthy and to make sure you stay involved in your healthcare. Our Population Health Management program helps our members find the right care at the right time. This is for both physical health and mental health. We can help with housing, food, transportation and other daily needs. Our Population Health Management program focuses on the following four key areas:

- Our **Flu Vaccine** program provides education on the importance of flu vaccine in order to keep our members healthy.
- Our **Be Healthy** program provides education and care management support for members with diabetes.
- Our **Lock-In** program provides care management that support and assists members with finding a medical home (PCP).
- Our **Aetna Cares** program provides care management support and education for members who have heart failure, depression, asthma or COPD.

If you are interested in any of the above or have questions about any of these programs, just call member services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET. Ask to speak to a care manager or look for us online at **AetnaBetterHealth.com/Kentucky**.

Care Management and Disease Management

Managing chronic illness can sometimes be difficult. Knowing who to contact, what test results mean, or how to get needed services can be hard. Aetna Better Health of Kentucky's team of Care and Disease Managers are here to help our members, as well as their families, primary care providers and caregivers. We can help with changes and provide information so patients and caregivers are better prepared and informed about health care decisions and goals.

If you have a chronic condition, such as low back pain, sickle cell anemia, hemophilia, HIV/AIDS, multiple sclerosis or other conditions such as high-risk pregnancy or neonatal concerns, a history of health problems, or problems following our rules for getting health care, we want to work with you and your PCP to meet your health care needs. Our Care and Disease Management Teams can also offer assistance to quit smoking. Aetna Better Health has special programs for foster care children. To learn more about these programs, call member service at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**).

The goal of care management is to help you reach your best level of wellness and fitness. Your care manager can help you find the right providers and services.

Aetna Better Health has special programs for our members with asthma, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), depression and coronary artery disease (CAD). These programs help you care for yourself through education, health coaching and special care. Care and Disease Management help you get the best care in the best way.

The Disease and Care Management team provides the following services:

- Aetna Better Health nurses and other health care staff will work with you to understand how you can best manage your condition.
- We'll help you regularly assess your health care status, book doctor appointments and connect you with community resources.
- You'll receive informational newsletters which provide updates on your condition.
- Education and informational materials will be provided to you to help you understand and manage the medications your provider has ordered.
- Information about events such as health fairs.

To make sure our records are up to date, our Care Management team will call new members to complete a health risk assessment.

If you would like to get Care Management or Disease Management services, or have any questions about these programs, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET. Ask to speak to a care manager or look for us online at **AetnaBetterHealth.com/Kentucky**.

If you don't want Care Management or Disease Management services, you can tell us by calling Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

Women's health care services

OB/GYNs provide health care services for women. This care is for the female reproductive system.

Covered services

- A gynecological exam each year for female members, age 13 or older, that includes: a breast exam, a pelvic exam and an annual pap smear (if indicated)
- Screening mammograms using the following schedule:
  - One baseline screening for ages 35-39
  - One mammogram annually for ages 40 and over
- Prenatal care
- Aetna Better Health recommends pregnant women be HIV tested
- Services to treat any medical condition that may complicate the pregnancy
- Services for pregnancy and postpartum care
- If a newborn and mother, or only the newborn, is released from the hospital less than 48 hours after the day of delivery, at least 1 follow-up visit is covered when within 48 hours after discharge
- Hysterectomy, when medically needed
- Prostheses needed after a complete or partial removal of a breast for any medical reason
- Reconstructive breast surgery performed along with, or after, a full or partial mastectomy. Inpatient hospital care is covered for at least 48 hours after a radical or modified radical mastectomy
- Inpatient hospital care is covered for 24-hours after a total mastectomy or a partial mastectomy with lymph node dissection

Inpatient hospital care for lengths mentioned above can be less if you and your provider agree on the shorter stay.

Mastectomy services

Your health care provider will work with you to decide the services best for you. This may include:

- All stages of rebuilding the breast on which the mastectomy was performed
- Surgery and rebuilding of the other breast so they look the same
- Prostheses and treatment of physical problems of the mastectomy, including lymphedema

Utilization Management (UM) program

The Aetna Better Health Utilization Management (UM) program ensures that you receive quality services that are medically necessary, meet professionally recognized standards of care, and are provided in the most effective and medically appropriate setting. Our program provides a system for prospective, concurrent, and retrospective review of services and treatments provided.

Our Quality Management/Utilization Management Committee (QM/UM) is comprised of Aetna Better Health participating providers, medical directors and management staff. Our QM/UM oversees the UM program. A doctor provides daily oversight of the UM program.

Behavioral health care

Behavioral health care services are to treat a member's mental health. This includes alcohol and substance use services. Covered services include:

- Community Mental Health Center services
- Inpatient behavioral health services
- Substance Use Rehabilitation and Residential services
- Outpatient behavioral health services
- Partial Hospitalization Program services
- Intensive Outpatient Program services
- In-home behavioral health services
- Psychiatric Residential Treatment Facility services
- Court-ordered acute inpatient psychiatric services for members under age 21 and over age 65
- Peer Support Services
- Pharmacy services

Everyone should have the opportunity to be as healthy as possible. This includes your mental health. We have on-line tools in the member portal section that you can use to get information on wellness such as identifying depression, avoiding at-risk drinking, smoking cessation and healthy habits. Our tools are also available in print.

If you need behavioral health services, you can choose your own behavioral health providers. Your PCP may refer you for behavioral health services. You can find information on in-network behavioral health providers by visiting our website **AetnaBetterHealth.com/Kentucky**. Click on the 'Find a Provider' ribbon on the top right-hand side of the page. From there you can search by type of behavioral health provider and/or location. The online provider directory gives the provider's name, address, telephone numbers, professional credentials, specialty and board certification status. Aetna Better Health of Kentucky can also help you find behavioral health providers and make appointments by calling member services at **1-855-300-5528**.

Some behavioral health care is covered only when it has been pre-authorized (unless it is an emergency). Please make sure your provider checks the prior authorization list before providing you a behavioral health service. Inpatient care you get is reviewed during your stay. Your care will be covered as long as it's medically needed. If it's decided that all or part of your stay is not needed, the provider will be told that coverage will end.

If you miss a scheduled behavioral health appointment, your provider will contact you within 24 hours to reschedule the appointment. If you are receiving inpatient behavioral health services, before you leave your provider will schedule an outpatient follow-up appointment to occur within 7 days of your discharge.

In the case of a behavioral health emergency, you should call the Behavioral Health Crisis Hotline at **1-888-604-6106** (TTY dial **711**, TDD dial **1-866-200-3269**). It is open 24 hours a day, 7 days a week, 365 days a year. They can help you get the care you need.

Member liability

Federal law states that certain members may be responsible to pay for part of their care. This is called "member liability." Members who:

- Receive non-institutional hospice
- Live in a Psychiatric Residential Treatment Facility (PRTF) or a behavioral health or psychiatric hospital and are under age 21 or over age 64

The amount of member liability is based on the member's income. Members with low income may have to pay $0. Other members with higher incomes may have to pay more. The Department for Community Based Services (DCBS) calculates the member's liability. Your DCBS case worker can help you better understand this process. We'll send you a notice before we apply member liability.

Adult immunizations

Aetna Better Health covers certain Adult Immunizations at your local, participating health department or pharmacy. To find out if these and other vaccines are available, please contact your provider or Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**).

Dental care

Aetna Better Health covers basic dental services for adults and children under the age of 21. Children living in Kentucky must get a dental exam before they start kindergarten. Aetna Better Health contracts with Avesis to provide dental, oral surgery or orthodontic services for our members.

Eye care and eyeglasses

Aetna Better Health covers certain vision services for members. Children living in Kentucky must get an eye exam before they start kindergarten. Children are eligible for eyeglasses once a year with a prescription. As a bonus benefits, adults can get a free pair of eyeglasses every two years. Aetna Better Health contracts with Avesis to provide vision and eye care services for our members.

Call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET, to find out how to get care. You may also look in your Provider Directory or online at **AetnaBetterHealth.com/Kentucky** under Find a Provider.

Radiology and cardiology services

Aetna Better Health contracts with eviCore to provide radiology benefit management for our members. It's necessary for your provider to get prior authorization from eviCore to perform the following outpatient non-emergency diagnostic tests:

- MRI - Magnetic Resonance Imaging
- PET - Positron Emission Tomography
- CT - Computed Tomography
- CCTA - Coronary Computed Tomography Angiography
- Stress echo cardiogram
- Nuclear Cardiology
- MUGA - Multiple Gated Acquisition Scan
- Obstetric Ultrasounds

Your provider doesn't need to prior authorize the following non-emergency advanced diagnostic tests:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency room radiology services

Once the diagnostic test is approved, eviCore will contact you directly to help you select a facility/location and schedule your appointment. If you're unable to speak with a radiology representative, you'll receive a letter through the mail with the facility name and location. Your provider will give you an order for the test to present at the time of your appointment.

Family planning services and supplies

Family planning services includes birth control counseling and supplies. Aetna Better Health covers family planning for members of child-bearing age. You don't need to ask your PCP before getting this care. Appointments for counseling and medical services shall be available as soon as possible within a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Any care you receive is kept private. If you don't want to talk to your PCP about family planning, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET. We can help you choose a family planning provider and assist with scheduling. You may get family planning services and supplies from an Aetna Better Health provider or a provider not in our network.

Non-covered pharmacy services

The following items aren't covered by Aetna Better Health benefits:

- Medications that aren't effective or are not safe
- Medication used for weight loss or weight gain
- Medications used to promote fertility
- Cosmetics or products used for hair growth
- Medications used for treatment of sexual dysfunction
- Experimental medications that have no proven medical benefits

Tobacco cessation

If you're a smoker, have a history of smoking, or use other types of tobacco, we want to work with you to help you stop. Aetna Better Health has a program that is designed to help you if you're ready to quit smoking. This service is provided over the phone. You can get help in the form of patches, gum or medications. Nicotine Replacement Therapy (NRT) is available to you with a prescription from your primary care provider. If you would like assistance with smoking cessation please call at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET and ask for Care Management.

The Commonwealth of Kentucky also has a free program. Always talk to your doctor before starting any new program. For more information on this free program, call Quitnow Kentucky at **1-800-QUIT-NOW** (**1-800-784-8669**).

High-risk prenatal services

Aetna Better Health provides care management for high-risk members who are pregnant. The PCP or OB/GYN and Aetna Better Health work together to decide if a member needs these extra services.

The following are additional covered services for pregnant women:

- Diet review and counseling by a registered dietitian
- Coordination of community resources (childbirth and parenting classes)
- Breast pumps
- Obtaining long-term care services
- Follow-up to be sure a member gets needed care
- Guidance and support
- Blood glucose meters
- Testing for HIV

Long-term care is often called nursing home services. If you need long-term care services for more than 30 days, Aetna Better Health will work with the Cabinet for Health and Family Services to disenroll you from managed care and make sure you get the services you need.

Outpatient services

Outpatient services include:

- Preventive care
- Medical tests
- Care to help you heal

You should tell your PCP when you receive outpatient services. You can get the care at hospital outpatient departments, clinics, health centers or doctors' offices in Aetna Better Health's Provider Network. You can find the list online at **AetnaBetterHealth.com/Kentucky**.

Inpatient hospital care

When you don't have an emergency, we must authorize your stay BEFORE you go to the hospital. You must go to a hospital that is an Aetna Better Health participating provider unless authorized by us to go to a hospital not in our network. You'll be under the care of your PCP or other doctor to whom your PCP has sent you.

Provider services

We cover care that's given by an Aetna Better Health provider when it's medically necessary. You may receive the care in the provider's office, a hospital, a clinic, or any other place needed to treat an illness, injury or disease. You may also receive family planning, maternity care, EPSDT well-child screenings or other preventive care. Regular health exams are covered for adults.

Prescription drugs

Aetna Better Health covers prescription medications that are on our preferred drug list also called a formulary. Take your prescription and Aetna Better Health Member ID card to a network pharmacy. If you have Medicare or other insurance, you must show that ID card as well. Aetna Better Health doesn't pay for drugs that haven't been approved by the Federal Drug Administration (FDA). You can find out if your medicines are on the Preferred Drug List in one of two ways:

- Call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.
- Go online to our website at **AetnaBetterHealth.com/Kentucky/members/pharmacy** to see the list of covered drugs.

Prescription exceptions request

If your medicine isn't on our drug list, ask your provider if there's one on the drug list you can use. If not, your provider must ask us for a prescription exception. We'll decide after review and if necessary, after talking with your provider, if the drug on the drug list will not work for your medical condition. If your provider doesn't ask for the exception, Aetna Better Health may not pay for it.

We'll review the medical exception request within 24 hours. If we're unable to meet this deadline, the pharmacist may give you a three-day supply of the drug, except for opioid pain medicine. If we don't approve your medical exception, we'll tell you in writing. We'll also tell you how to start the complaint/appeal process.

Over-the-counter medicines

Sometimes your provider may want you to take over-the-counter (OTC) medicines. Like other drugs, your doctor must give you a prescription for over-the-counter medicines to take to the pharmacy. You can find out if your over-the-counter medicines are covered on the Preferred Drug List in one of two ways:

- Call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.
- Go online to our website at **AetnaBetterHealth.com/Kentucky/members/pharmacy** to see the list of covered over-the-counter drugs.

Prior authorization

Aetna Better Health must approve some medicines before we cover them. We do this through prior authorization.

If your medicine requires prior authorization, you can:

- Ask your provider for a similar drug that does not require prior authorization
- Ask your provider to contact Aetna Better Health to start the prior authorization process. Your provider will know how to do this

We will review your provider's request within 24 hours. Your pharmacist may give you a three-day temporary supply of the medicine (except for opioid pain medicine) while your provider tries to get it approved.

We'll tell you in writing if we don't approve the request. We'll also tell you how to start the complaint/appeal process.

Step therapy (ST)

Some drugs aren't approved unless another drug has been tried first. ST coverage requires that a trial of another drug be used before a requested drug is covered.

Quantity limits

Some drugs have limits to the number of doses you may get. This is called a quantity limit. The Food and Drug Administration (FDA) decides safe dose limits. For a partial list of the services we cover and to see what approvals are required, you can call Aetna Better Health's Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**).

The pharmacist will fill your prescription according to FDA safe dosing limits. He/she will do this even if your provider wrote the prescription for more than the recommended FDA safe dosing limits. The pharmacist won't give you more medicine if your provider doesn't get it prior authorized. The pharmacist will ask your provider to call us first.

Brand-name drugs instead of generic alternatives

Aetna Better Health pays for generic drugs, when available. If your provider wants you to have a brand-name drug when the generic drug is on our Preferred Drug List, he/she must ask us for a prior authorization. We'll review the request. If we do not approve the request for a brand-name drug, we'll tell you in writing. We will also tell you how to start the complaint/appeal process.

Medicines that are not on our drug list when enrolled

If your drugs aren't on our drug list when you're enrolled with Aetna Better Health, you may take your medicine for 30 days after you enroll with us. Your provider should change your medicine to one on our preferred drug list or submit a prior authorization. If we do not prior authorize the exception, we'll tell you in writing. We will also tell you how to start the complaint/appeal process.

Changes to our drug list

Aetna Better Health may need to make changes to our drug list from time to time. If you're taking a medicine that will be removed from our drug list, we'll tell you in writing at least 30 days before it is removed. You can also access our updated drug list online at **AetnaBetterHealth.com/Kentucky/members/pharmacy**.

Second medical opinions

You may need a second opinion for an illness, surgery or treatment that your PCP says you need. You can call your PCP or Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET, for help getting a second opinion.

There is no cost to you for second opinions administered by our providers or providers not in our network. All second opinions by providers not in our network require prior authorization from Aetna Better Health.

Translation or interpreter services

If your primary language is not English or you have a hearing impairment, we'll help you get interpreter services. This service is free. Tell your doctor that you need a spoken language translator or sign language help and he or she will contact us.

If you need to contact us about your benefits and your primary language isn't English, we'll contact our language line service, which will translate for you. If you have a hearing impairment, you may use either TTY or TDD services (TTY users dial **711**, TDD users dial **1-800-627-4702**). We'll work with our members who are deaf to determine their preferred method of interpretation and give priority to meeting those requests.

How to get transportation

- **Emergency transportation:** Call 911 or the closest ambulance service.
- **Non-emergency transportation:** Kentucky Medicaid will pay to take some members to get medical services covered by Kentucky Medicaid. If you need a ride, you must talk to the transportation broker in your county to schedule a trip.

Each county in Kentucky has a transportation broker. You can only use the transportation broker for a ride if you can't use your own car or don't have one. If you can't use your car, you have to get a note for the transportation broker that explains why you can't use your car. If you need a ride from a transportation broker and you or someone in your household has a car, you can:

- Get a doctor's note that says you can't drive
- Get a note from your mechanic if your car doesn't run
- Get a note from the boss or school official if your car is needed for someone else's work or school
- Get a copy of the registration if your car is junked
- Kentucky Medicaid doesn't cover rides to pick up prescriptions

For a list of transportation brokers and their contact information, please visit **www.chfs.ky.gov/dms/** or call Kentucky Medicaid at **1-800-635-2570**. For more information about transportation services, call the Kentucky Transportation Cabinet at **1-888-941-7433**.

The hours of operation are Monday through Friday, 8 AM to 4:30 PM ET and Saturday 8 AM to 1 PM ET. If you need a ride, you have to call 72 hours before the time that you need the ride. If you have to cancel an appointment, call your broker as soon as possible.

You should always try to go to a medical facility that is close to you. If you need medical care from someone outside your service area, you have to get a note from your PCP. The note has to say why it is important for you to travel outside your area. (Your area is your county and the counties next to it).

If you're in a wheelchair, or if you can walk but get disoriented, you may choose a transportation company that can meet these special needs. Contact your broker to see what special needs companies are available. You have to get a note from your PCP. The note has to say why that type of transportation is needed.

Please note: KCHIP III children do not get non-emergency transportation.

Benefits you can get from Aetna Better Health of Kentucky

Bonus benefits and services

We provide free services to you. These benefits are only for Aetna Better Health members. Below is a list of the benefits and services.

No-cost bonus benefits and services	
Eyeglasses for children & adults	Opioid lockbox for qualifying members
Meal delivery for qualifying members	Second chance support services such as job fairs and employment opportunities
Virtual diabetes support	24-hour Informed Health Line
Support services to assist with transportation, housing, food and education	Periodontal Care for pregnant women
Hearing aids & exams for children and adults	Aetna Better Choices Programs
CVS Weight Management Program	Aetna Better Health Mobile App

Aetna Better Choices Programs overview

Cribs for Moms program

You can earn a special gift for seeing your doctor regularly during your pregnancy. When you find out you are pregnant, call Member Services at **1-855-300-5528** and ask to speak with a care manager. Aetna Better Health offers a free portable crib incentive for pregnant members at 37 weeks of pregnancy if you meet the following:

- If you're a new member, you must visit your doctor within 42 days of enrolling with our plan
- Attend 7 or more obstetrical provider visits during pregnancy

Ask your obstetrical provider to complete the Cribs for Moms program form and return it to your care manager.

Promise Rewards program

You can earn a Promise Rewards special gift after your baby is born. You will earn a free diaper bag and a $10 gift card if you complete the following:

- Complete your post-partum visit. This visit must be within 21–56 days after your baby is born.
- Ask your obstetrical provider to complete the Promise Rewards form and return it to Aetna Better Health.

For additional details or questions, call member services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

Sign up for Text4baby

This free text service sends you health tips and reminders throughout your pregnancy. For additional details or questions, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

Aetna Better Choices to Health Incentive Program

Members can earn gift cards after completing the following checkups:

- $10 gift card for completing a lead screening test for children prior to their 2nd birthday
- $10 gift card for completing a diabetic retinal exam for adults 18–75 years old
- $10 gift card for completing spirometry testing for members 42 years or older with COPD
- $20 gift card for completing a follow-up visit with a behavioral health practitioner within 7 days of discharge after a hospitalization for mental illness (6 years of age or older)

For additional details or questions, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

Health education

Members receive health education from Aetna Better Health through:

- This member handbook
- Member newsletter
- Website **AetnaBetterHealth.com/Kentuck**y
- Care managers and social workers

Outreach program

Our Outreach Team works with community-based organizations, such as schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chambers of commerce, faith-based groups and other appropriate organizations to engage, educate and empower our members. Our Outreach Team provides community education on topics such as nutrition, chronic disease management, transitions, access to resources and provides assistance to members and the entire community.

Services NOT Covered (if you get a bill)

If Aetna Better Health denies a procedure, service or prescription, you or your PCP may request an appeal. You do this by sending a request to Aetna Better Health's Appeals department.

See page 49, "Appeals and grievances," for more information.

The following services are not covered by Kentucky Medicaid:

- Any laboratory service performed by a provider without a current certification under the Clinical Laboratory Improvement Amendment applies to all facilities and individual providers of any laboratory services
- Cosmetic procedures or services performed only to improve appearance
- Hysterectomy procedures performed only to sterilize (prevent pregnancy)
- Medical or surgical treatment of infertility (reverse sterilization, in vitro fertilization, etc.)
- Induced abortion for a reason other than the mother's life is in danger, or in the case of rape or incest
- Paternity testing
- Personal services or comfort items
- Post-mortem services

- Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental
- Sex change services
- Sterilization of a mentally incompetent or institutionalized member
- Services that a member isn't required to pay and no other person is legally responsible to pay

How our Providers are Paid

Filing claims

If you obtain services from an Aetna Better Health provider or another Medicaid provider, your claims will be filed for you by the provider. Medicaid providers are not allowed to bill you for Medicaid services. If you see a provider who is out of our service area and is not signed up with Medicaid, you may have to pay the bill. For more info, see the "Out of Service Area" section on page 22.

If you receive a bill for Medicaid services, please contact Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

We will pay for medically necessary, authorized health care you have paid for, up to the amount allowed by Medicaid. We must receive all claims within 365 days after the date of service.

Incomplete claim forms, including Pharmacy Reimbursement Claim Forms will not be processed.

Plan Member Copayments

Copay

Copay is the amount of money a member has to pay when he/she receives a service from a health care provider. Please see "What are my benefits?" starting on page 29 for copay amounts.

Limits on copays

There is a limit on the total amount of copays you will have to pay. You will not have to pay more than 5% of your family's income each quarter of the year. The first quarter of the year is January through March; the second quarter is April through June; the third quarter is July through September; and the fourth quarter is October through December.

We keep track of the copays you pay. When you reach the limit, you will not have to pay any more copays for the remainder of the quarter. If you pay a copay after your family has reached the maximum out-of-pocket amount, your provider will refund the copay to you.

If you have Medicare and Medicare pays for the service, you have no Medicaid copay.

Copayment exceptions

All Medicaid members are required to pay the copays outlined below except for the following exempt individuals and services:

- Foster children
- Children enrolled in Medicaid
- Pregnant women (includes 60-day period after pregnancy ends)
- Kentucky Medicaid beneficiaries who have reached their cost sharing limit for the quarter (5% of the family's total income per quarter)
- Individuals receiving hospice care
- Emergency services
- Some family planning services
- Preventive services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a federal benefit for children from birth up to age 21, who are eligible for Medicaid or the Kentucky Children's Health Insurance Program (KCHIP).

Under the EPSDT program, children are checked for medical problems early and on a regular basis. These well-child checkups are available by your provider or local health department. Scheduled well-child checkups protect your child's health and future. The program identifies health problems before they become serious.

If your child needs additional services, we may cover them. EPSDT special services covers medically necessary services not normally covered by Medicaid. This may include medical supplies and special equipment; dental services not normally covered; allergy serum and shots; and behavioral health services not normally covered. These EPSDT Special Services require prior authorization. Your provider will ask for this prior authorization.

KCHIP III children are not eligible for EPSDT special services or for help with non-emergency transportation.

Children should get checkups regularly, at the ages listed below.

Ages recommended for well-child checkups	
3–5 days after birth	12 months
By 1 month	15 months
2 months	18 months
4 months	24 months
6 months	30 months
9 months	1 time per year between ages 3 and 20

Sick visits don't take the place of routine screening visits.

Children need shots that help their bodies fight disease. Each shot fights a different disease. Children must have a record of these shots in order to begin school. You may be required to give this information when you enroll your children in school.

Children should get each shot at the ages given in the chart below. Some shots need to be given more than once.

Immunization chart (shots)

Age	Shot
Shortly after birth	Hepatitis B, #1
Between 1 and 2 months	Hepatitis B, #2
2 months	Diphtheria, Tetanus, acellular Pertussis (DTaP), #1 H. influenzae type B (Hib), #1 - Inactivated Poliovirus (IPV), #1 - Pneumococcal Conjugate (PCV13), #1 - Rotavirus, #1
4 months	Diphtheria, Tetanus, acellular Pertussis (DTaP), #2 H. influenzae type B (Hib), #2 - Inactivated Poliovirus (IPV), #2 - Pneumococcal Conjugate (PCV13), #2 - Rotavirus, #2
6 months	Diphtheria, Tetanus, acellular Pertussis (DTaP), #3 Pneumococcal Conjugate (PCV13), #3
Between 6 and 18 months	Hepatitis B, #3 Rotavirus, if needed Inactivated Poliovirus (IPV), #3
Between 6 and 36 months	Influenza (Flu) – annually after 6 months of age
Between 12 and 15 months	H. influenzae type B (Hib), #3 - Measles, Mumps & Rubella (MMR), #1 - Pneumococcal Conjugate (PCV13), #4 - Varicella (Chickenpox), #1
Between 12 and 23 months	Hepatitis A #1 and Hepatitis A #2
Between 15 and 18 months	Diphtheria, Tetanus, acellular Pertussis (DTaP), #4
After 2 years of age for certain high-risk groups	Pneumococcal Polysaccharide (PPV)
4 to 6 years	Diphtheria, Tetanus, acellular Pertussis (DTaP), #5 Inactivated Poliovirus (IPV), #4 - Measles, Mumps, Rubella (MMR), #2
11 to 18 years	Varicella (Chickenpox), #2 Tetanus, Diptheria, acellular Pertussis (Tdap) Meningococcal Conjugate, #1
9 to 18 years	Human Papillomavirus (HPV), 2 or 3 dose series

For other guidelines, see the Centers for Disease Control (CDC) Guidelines for Immunization at **www.cdc.gov/vaccines/schedules/hcp/index.html**.

Benefits offered by the State

Most Medicaid services will be provided by Aetna Better Health of Kentucky. Some services will still be provided by Kentucky Medicaid. You will use your Medicaid ID card for these services. These services are:

- **First Steps** - A program that helps children with developmental disabilities from birth to age 3 and their families, by offering services through a variety of community agencies. Call **877-417-8377** or **877-41-STEPS** for more information.
- **HANDS (Health Access Nurturing and Development Services)** - This is a voluntary home visitation program for new and expectant parents. Contact your local health department for information and to learn about resources.
- **Non-emergency medical transportation** - If you cannot find a way to get to your health care appointment, you may be able to get a ride from a transportation company. Call **1-888-941-7433** for help or see **http://chfs.ky.gov/dms/trans.htm** for a list of transportation brokers or companies and how to contact them.
- **Services for children at school** - These services are for children from 3 to 21 years of age, who are eligible under the Individuals with Disabilities Education Act (IDEA) and have an Individual Education Plan (IEP). These services include speech therapy, occupational therapy, physical therapy and behavioral (mental) health services. Call **502-564-9444** for more information.

Direct access services

Direct access to care means you can get the covered services below from any Aetna Better Health provider of your choice without needing a referral.

- Primary care vision services, including one pair of eyeglasses for adults every two years; also includes getting glasses fitted
- Primary care dental and oral surgery services and evaluations
- Family planning
- Maternity care for members under 18 years of age
- Immunizations for members 19 and over at pharmacy or health department
- Sexually transmitted disease screening, evaluation and treatment are available from your PCP or public health departments
- Tuberculosis screening, evaluation and treatment
- Testing for HIV, HIV-related conditions and other communicable diseases
- Chiropractic services
- Women's health specialists

For members with special health care needs, direct access to a specialist is not restricted.

Prior Authorization and Timeframes

Prior authorization

Aetna Better Health must approve some health care services and supplies before you get them. This is called prior authorization. Aetna Better Health follows nationally recognized guidelines for the care your provider suggests.

These guidelines are used to make prior authorization decisions. Some services that need prior authorization are listed below. Your provider can get a full listing of services that need prior authorization on the Aetna Better Health provider portal. This list may change from time to time. Call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET, to request the most current list.

Prior authorization list

Your provider must check if a prior authorization is required before providing you a service. Some items that require prior authorization are:

- All inpatient services, including psychiatric, skilled nursing facilities and rehabilitation
- All physical health services provided in the home
- All services administered by providers not in our network (except an emergency; care for a child in foster care; and family planning)
- Purchase of durable medical equipment, prosthetics and supplies costing more than $500
- Durable medical equipment rentals
- Dental anesthesia (in an outpatient facility)
- Transplant services, including transplant evaluation*
- Some behavioral health and substance use services (not emergencies)
- All enterals and metabolic foods
- Some vision services
- Some dental services
- Chiropractic visits after the first 12
- Some radiology services (CT scans, MRIs, PET scans)
- Cardiology services
- Most surgical procedures
- Pain management services
- Physical therapy

*An Aetna Better Health network provider may not be in the transplant network. Please work with your Aetna Better Health transplant case manager to choose a provider.

The following table lists the timeframes used when we make our decision on the prior authorization.

Type of Decision	Decision	Initial Notification	Notification Method
Urgent prior authorization	2 business days from receipt of request*	2 business days from receipt of request	Oral and/or written, dependent on type of notification
Non-urgent prior authorization	2 business days from receipt of request*	2 business days from receipt of request	Oral and/or written, dependent on type of notification

*The timeframes for decisions and notification may be extended if additional information is needed to process the request.

If we need more information to make a decision, we'll request it from your provider within the timeframes in the above table. The provider has 14 days to submit the additional information for prior authorization requests. We will also notify our members of requests for more information on the date we request it from the provider.

- If the provider sends the additional information within 14 days, we will approve or deny the service and notify our member, member's PCP and requesting provider according to the timeframes in the table above.
- If we don't receive the requested information within 14 days, we will approve or deny the service based upon the available information and notify the member, member's PCP and requesting provider according to the timeframes above.

Appeals and Grievances

Please be sure to read this section. It's important that you know how to tell us if you're unhappy. The steps to follow are below.

Complaints (Grievances)

You can file a complaint at any time if you're not happy with our service. Filing a complaint means you're letting us know about services with which you're not happy. You can call or write us at any time. Our phone number is **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**). Our hours are from 7 AM to 7 PM ET. We're open Monday through Friday.

If you want to write to us about your problem, your letter should include:

- Your name
- Your member ID number
- Your mailing address and phone number
- A description of what you're upset about and how you'd like us to fix it

You can also have someone else act on your behalf. This person is your authorized representative. This person may be:

- Your provider
- Your legal guardian
- Relative
- Friend
- An attorney
- Other person

You have to give written permission to the person that allows them to file a complaint for you. Mail your letter to us at the address below.

Complaint and Appeal Department
Aetna Better Health
Attn: Complaint and Appeal Department
9900 Corporate Campus Drive
Suite 1000
Louisville, KY 40223

You can also call us at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

We'll send you a letter letting you know we got your complaint within 5 working days.

We'll send you a letter to let you know what we did about your problem within 30 calendar days of the date we get your letter or call.

We'll never punish or discriminate against you or your provider, or take any negative action against either of you in any way for filing any kind of appeal or complaint.

Appeals

If Aetna Better Health makes a decision you don't agree with, you can file an appeal. If you file an appeal, it means you want us to review a decision we made about your care. Call us or mail us your appeal. If you want to call, our phone number is **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**). We're open Monday through Friday, 7 AM to 7 PM ET. You can also mail your appeal to us at the address below.

You have to get your letter to us or call us within 60 calendar days of the day you got our denial letter. Mail your letter to the address below:

Aetna Better Health
Attn: Aetna Better Health
Attn: Complaint and Appeal Department
9900 Corporate Campus Drive
Suite 1000
Louisville, KY 40223

If you call us to tell us about your appeal, we'll also need you to send in a written appeal. When you call, we can send you a form to fill out. You can fill out the form or just write us a letter. When we send you the form, we'll also include a postage-paid envelope for you to use. You must send us your letter or form within 10 calendar days from the date on the letter that comes with the form.

In your letter, be sure to tell us any details you want us to consider in your appeal review, including why you think we should change our decision. Your letter must also include:

- Your name, phone number, member ID number and mailing address
- Your doctor's name
- The date of the service you want
- Any information or documents you have that might help change our mind within a reasonable time period. We will tell you in the letter acknowledging your appeal what that time frame will be.
- At any point before or during the appeal process, if you or your representative want to see the case file, medical records or any other documents and records, you may request a copy free of charge.

You can do the appeal, or you can ask someone to do it for you. You can choose anyone you want, including a friend, your doctor, a legal guardian, a relative or an attorney. If you pick a person to do the appeal for you, that person is your Authorized Representative. You must write us a note with the name of the person who will speak for you. Be sure to sign it. You can also fill out a consent form to let the person you chose speak for you as your Representative. We'll send you the form. Just call us at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

After we get your appeal, we'll send you a letter within 5 working days to let you know we got it. In the letter, we'll tell you how you can participate in a meeting to talk about your appeal. The letter will have the date of an appeal meeting. This is when we'll go over your case. When you send us your letter, let us know if you want to come to the appeal meeting. You can attend in person or by phone. At least one person who wasn't involved in the first decision to deny the service will look over the appeal. If your appeal is about something medical, a doctor who is licensed will also look at your case. The doctor that looks at the case will have an understanding of the kind of care you need. If your appeal isn't about something medical, it's called an administrative appeal. A committee that includes at least one doctor will look at the case during a meeting.

In most cases, we'll make a decision about your appeal within 30 calendar days from the date we get it. We may need 14 more days to finish your case. We only take extra time if it'll make things better for you. We'll send you a letter at least two days before your appeal is due to be finished to let you know if we need the extra time.

You can file a complaint if you don't agree with us using the extra time. You can also ask us to hold your appeal for 14 more days if you need time to give us more details.

Expedited (faster) appeals

There's a fast appeal process called an expedited appeal. You can ask for an expedited appeal if your life or health could be harmed by us taking the normal time to finish your appeal. Call us at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET, to let us know if you need an expedited appeal. You do not have to submit your request for an expedited appeal in writing. If your expedited appeal request meets the guidelines, we'll make a decision within 72 hours from when we got your request. After you let us know you want an expedited appeal, if you find that you have more information you want to send us for the appeal review, you have 24-hours to get it to us. If your request to expedite the appeal isn't approved, we'll call you to let you know. Then we'll process your appeal just like a normal appeal. We'll send you a decision on the case within 30 calendar days. You may ask for another 14 calendar days to give us more information. Aetna Better Health may also need more information. We'll send you a notice if there's a delay that you didn't request.

We'll never punish or discriminate against you or your provider or take any negative action against either of you in any way for filing any kind of appeal or complaint. If you're unable to file a written appeal or complaint on your own, you may call Member Services. We'll take the information and complete the complaint or appeal for you. Member Services can provide free copies of information about your complaint or appeal.

If we change our decision after reviewing your appeal or expedited appeal, we will approve your request within 72 hours of the decision.

Provider appeals

Your provider also has the right to appeal and request further review of a decision they don't agree with. These rights and procedures are determined by state law and policies set by the Kentucky Department of Medicaid Services. Please see our website at **AetnaBetterHealth.com/Kentucky** or contact Member Services for further information.

If you don't agree with our decision on your appeal, you can ask the state to look at your case by writing them a letter. This is a State Fair Hearing. The state's rules say you must wait for your appeal to be finished before you can have a State Fair Hearing.

Your benefits during the appeal or State Fair Hearing process

When you ask for an appeal, you can continue to receive your benefits. If you want to continue to receive your benefits, you must let us know by calling Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET or sending us a letter. We have to receive your letter within 10 days of the date on the decision letter we sent you before your appeal. You can also continue your benefits during a State Fair Hearing. If you want to continue your benefits, you must let us know by calling Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET or sending us a letter. You need to let us know within 10 days of the date on the decision letter we send you at the end of your appeal.

You can request that we continue your benefits if:

- You write or call us to ask for an extension of your benefits
- Your appeal is about a service we stopped (temporarily or permanently) or a service that was authorized before, but has now been reduced in amount
- An authorized provider ordered the service
- The authorization period hasn't expired for the service

Aetna Better Health
Attention: Complaint and Appeal Department
9900 Corporate Campus Drive
Suite 1000
Louisville, KY 40223

If you need more information about the types of services covered or the need for approval on services, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

At the State Fair Hearing, if the hearings officer doesn't agree with your claim and still denies your request, you may have to pay for continued services. You won't have to pay until the State Fair Hearing decision is final.

We'll never punish or discriminate against you or your provider, or take any negative action against you because you filed any kind of appeal, State Fair Hearing or complaint.

State Fair Hearing

To qualify for a State Fair Hearing, your letter should:

- Be mailed or filed within 120 days from the date on the most recent appeals determination letter we sent you
- Explain why you need a State Fair Hearing
- Give the date of service and kind of service we denied
- Include a copy of the last appeal decision letter you got from us

A state employee called a hearings officer is in charge of your State Fair Hearing. The hearings officer will send you a letter with the date and time for your hearing. The letter will also explain the hearing process. If you do not want to speak or are unable to speak for yourself, you can choose someone to speak for you at the hearing.

If you filled out a consent form for the appeal, they'll be able to speak for you. If you didn't, you can still call us to get one for the State Fair Hearing.

To request a State Fair Hearing, you should send your letter to the address below.

Kentucky Department for Medicaid Services Division of Program Quality and Outcomes
Attention: State Fair Hearings
275 East Main Street, 6C-C
Frankfort, KY 40621-0001

You can request the State Fair Hearing or you can ask someone to do it for you. You can choose anyone you want, including a friend, your doctor, a legal guardian, a relative or an attorney to speak for you. If you pick a person to do the State Fair Hearing for you, that person is your Authorized Representative. If you didn't already do so during the appeal, you must fill out a consent form to let someone else speak for you.

Part 3 – Other

Advance Directives

You have the right to make decisions about your medical care. An advance directive documents your health care decisions when you cannot speak for yourself. It tells your provider what future health care wishes you have if you are too sick to tell anyone yourself. This is the only time the advance directive is used. Your provider has the responsibility to discuss Advance Medical Directives with you at the first medical appointment and document that discussion in your medical record.

Advance directives can include a living will or durable power of attorney for health care. Your advance directive is included in your medical records. You should tell your provider if you have certain moral and/or religious beliefs that would stop you from making advance directives.

Your doctor or other health care provider should write down your objections to making advance directives and make this a part of your medical records.

Members should do the following when preparing an advance directive:

- Sign and date your advance directive
- Obtain signatures of two (2) witnesses, in accordance with state law
- Give a copy of the advance directive to your doctor so it can be put in your medical record
- Keep a copy for yourself
- Take a copy with you when going to the hospital or ER

Aetna Better Health will tell you within 90 days if rules about advance directives change. You, or your authorized representative, may file a complaint if your advance directive is not followed.

You may send your complaint to the:

Director, Division of Health Care Cabinet for Health and Family Services
275 East Main Street, 5 E-A
Frankfort, KY 40621-0001

or

Inspector General
Cabinet for Health and Family Services
275 East Main Street, 5 E-A
Frankfort, KY 40621-0001

Fraud, Waste and Abuse

Member fraud and abuse

Medicaid fraud can be:

- Lying or holding back information when you sign up to be a member of Kentucky Medicaid or KCHIP
- Letting someone else use your Aetna Better Health Member ID card
- Not telling the Social Security Administration (SSA) or the Department for Community Based Services (DCBS) about changes in income and family status
- Not telling Kentucky Medicaid that you have other insurance

Medicaid abuse can be:

- Too many emergency room visits for conditions that are not emergencies
- Using pain medicines that you do not need
- Getting prescriptions that you do not need

If you commit Medicaid fraud, you:

- Must pay back any money Medicaid paid for you to get services
- Could be prosecuted for a crime and go to jail
- Could lose your Kentucky Medicaid benefits for up to a year

Provider fraud

Providers can commit fraud many different ways. Provider fraud, like member fraud, takes money from those who need it. Because of this fraud, there is less money to treat members who need medical help. You can help stop provider fraud.

Keep a record of:

- Medical services you get
- When and where the service takes place
- Name of the person who takes care of you
- Any other services ordered by the provider

Some examples of provider fraud are:

- Billing for services that you did not get
- Making an appointment for a return office visit when you do not need one
- Taking X-rays, doing blood work, etc. that you do not need

- Billing for services that someone else in the office actually performed (charging you too much for those services)
- Billing for more time than the service took
- Adding extra names to your bill (for example, a family member) and billing for those
- Taking money from another provider to refer you to him/her

Reporting Medicaid fraud

If you think someone has committed Medicaid fraud or abuse, call Medicaid's Fraud and Abuse Hotline at **1-800-372-2970**. Everything you say is private.

Third Party Liability (TPL)

We need to know if you have other health insurance along with Medicaid. Contact Aetna Better Health of Kentucky if you have other insurance coverage or lose insurance coverage from another plan. Call Aetna Better Health of Kentucky's Member Services Department at **1-855-300-5528**.

When you have other health insurance, your provider should always bill that health insurance first. Medicaid always pays last. This is called Third Party Liability (TPL). If Aetna Better Health of Kentucky pays the bill when you have other health insurance, your other health insurance will have to pay the money back. If you file a lawsuit or otherwise recover expenses from any other source, you or your attorney must notify Aetna Better Health of Kentucky. For questions about TPL, call **1-855-300-5528**.

Examples of other insurance are:

- Personal health insurance
- Veteran's coverage
- Worker's compensation
- Auto insurance to cover injury due to an auto accident
- Recover expenses from a lawsuit or from any other source due to an injury, disease or disability
- Insurance that pays you if you have cancer, heart disease and other disabilities
- Student health insurance policies
- Sports health insurance policies
- Medicare

Reporting accidents

You must also report if you get hurt at your job or have an accident. Call Aetna Better Health's Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.

Important Phone Numbers and Web Sites

Agency	Web Address
benefind	**1-844-407-8398** **https://benefind.ky.gov/**
Department for Medicaid Services (DMS)	**1-800-635-2570** **https://chfs.ky.gov/ agencies/dms/Pages/default.aspx**
Kentucky Attorney General Office of Medicaid Fraud and Abuse	**https://ag.ky.gov/about/branches/OMFA**
Department for Medicaid Services (DMS) Fraud and Abuse	**1-800-372-2970** **https://chfs.ky.gov/agencies/dms/dpi/Pages/fraud-abuse.aspx**
Kentucky Department for Community Based Services (DCBS)	**1-855-306-8959** **Fax: 502-573-2007** **https://prdweb.chfs.ky.gov/Office_Phone/index.aspx**
Kentucky Children's Health Insurance Plan (KCHIP)	**1-877-524-4718** **1-800-662-5397 en Espanol** **https:// kidshealth.ky.gov/Pages/index.aspx**
Social Security	**1-800-772-1213** **http://www.ssa.gov**
Office of the Medicaid Ombudsman	**1-800-372-2973** **Or TTY 1-800-627-4702** **https://chfs.ky.gov/agencies/os/omb/Pages/default.aspx**
Child and Adult Abuse	**1-800-752-6200**
National Domestic Violence Hotline	**1-800-799-SAFE (7233)**

Medicaid Managed Care Ombudsman Program

The Cabinet for Health and Family Services Ombudsman Program

The Ombudsman Program ensures people who use various public services are treated fairly. The Office of the Ombudsman answers questions, looks into complaints and works to settle them. For more information or to get help, please contact the Office of the Ombudsman at **1-800-372-2973** or **1-800-627-4702** (**TTY**). You can also write to the Ombudsman at the address below:

The Office of the Ombudsman
Cabinet for Health and Family Services
275 E. Main St., 1E-B
Frankfort, KY 40621

Health Insurance Portability and Accountability Act (HIPAA)

Your health information is personal. HIPAA rules give you the right to control your personal health information (PHI). Any health information that can be used to identify you is protected health information.

Anyone who takes part in your medical care can see your PHI. Everyone who handles your health information is legally required to protect the privacy of your PHI. Anyone who uses your PHI in a wrong way is responsible for that.

PHI can be legally used in certain ways. A provider who is treating you can see your PHI as a part of your care and treatment.

You can decide to let people use your PHI if you think it is necessary. If you decide to let someone else use your PHI, you need to write a detailed letter stating that person is allowed to use it. A person has to have a written statement to ask for your PHI, even if that person is a spouse or a family member.

Where do I send questions?

If you have questions about HIPAA and your PHI, please contact the Aetna Better Health of Kentucky Privacy Officer, in writing.

The address is:

Aetna Better Health of Kentucky
Attn: Privacy Officer
9900 Corporate Campus Dr., Suite 1000
Louisville, KY 40223

Complaints:

If you think your PHI has been used incorrectly, you can make a complaint.

The address is:

The Secretary of Health and Human Services
Room 615F
200 Independence Ave., SW
Washington, D.C. 20201

You can call the U.S. Department of Health and Human Services at **877-696-6775**. You can also call the United States Office of Civil Rights at **1-866-OCR-PRIV** (**866-627-7748**) or **866-788-4989** (**TTY**).

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice was effective as of February 1, 2016.

What do we mean when we use the words "health information"[1]

We use the words "health information" when we mean information that identifies you. Examples include:

- Your name
- Your date of birth
- Health care you received
- Amounts paid for your care

How we use and share your health information

Help take care of you: We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical tests. We may also remind you of appointments. We may share your health information with other people who give you care. This could be doctors or drug stores. If you're no longer with our plan, with your permission, we can give your health information to your new doctor.

Family and friends: We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an accident, we may need to talk with one of these people. If you don't want us to give out your health information, call us.

If you're under eighteen and don't want us to give your health information to your parents, call us. We can help in some cases if allowed by state law.

For payment: We may give your health information to others who pay for your care. Your doctor must give us a claim form that includes your health information. We may also use your health information to look at the care your doctor gives you. We can also check your use of health services.

Health care operations: We may use your health information to help us do our job.

For example, we may use your health information for:

- Health promotion
- Care management
- Quality improvement
- Fraud prevention
- Disease prevention
- Legal matters

A Care Manager may work with your doctor. They may tell you about programs or places that can help you with your health problem. When you call us with questions we need to look at your health information to give you answers.

Sharing with other businesses

We may share your health information with other businesses. We do this for the reasons we explained above. For example, you may have transportation covered in your plan. We may share your health information with them to help you get to the doctor's office. We'll tell them if you are in a motorized wheelchair, so they send a van instead of a car to pick you up.

[1] For purposes of this notice, "Aetna" and the pronouns "we," "us" and "our" refer to all the HMO and licensed insurer subsidiaries of Aetna Inc. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

Other reasons we might share your health information

We also may share your health information for these reasons:

- **Public safety** - To help with things like child abuse, threats to public health.
- **Research** - To researchers, after care is taken to protect your information.
- **Business partners** - To people that provide services to us, they promise to keep your information safe.
- **Industry regulation** - To state and federal agencies, they check us to make sure we are doing a good job.
- **Law enforcement** - To federal, state and local enforcement people.
- **Legal actions** - To courts for a lawsuit or legal matter.

Reasons that we'll need your written okay

Except for what we explained above, we'll ask for your okay before using or sharing your health information. For example, we'll get your okay:

- For marketing reasons that have nothing to do with your health plan.
- Before sharing any psychotherapy notes.
- For the sale of your health information.
- For other reasons as required by law.

You can cancel your okay at any time. To cancel your okay, write to us. We can't use or share your genetic information when we make the decision to provide you health care insurance.

What are your rights?

You have the right to look at your health information.

- You can ask us for a copy.
- You can ask for your medical records. Call your doctor's office or the place where you were treated.

You have the right to ask us to change your health information.

- You can ask us to change your health information if you think it's not right.
- If we don't agree with the change you asked for, ask us to file a written statement of disagreement.

You have the right to get a list of people or groups that we have shared your health information with.

- You have the right to ask for a private way to be in touch with you.
- If you think the way we keep in touch with you is not private enough, call us.
- We will do our best to be in touch with you in a way that is more private.

You have the right to ask for special care in how we use or share your health information.

- We may use or share your health information in the ways we describe in this notice.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- We don't have to agree but we'll think about it carefully.

You have the right to know if your health information was shared without your okay.

- We'll tell you if we do this in a letter.

Call us toll free at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**) to:

- Ask us to do any of the things above.
- Ask us for a paper copy of this notice.
- Ask us any questions about the notice.

You also have the right to send us a complaint. If you think your rights were violated, write to us at:

Aetna Better Health
Attention: Complaint and Appeal Department
9900 Corporate Campus Drive
Suite 1000
Louisville, KY 40223

You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address.

If you're unhappy and tell the Office of Civil Rights, you will not lose plan membership or health care services. We won't use your complaint against you. We'll never punish or discriminate against you or your provider, or take any negative action against you because you filed any kind of appeal, State Fair Hearing, or complaint.

Protecting your information

We protect your health information with specific procedures, such as:

- Administrative. We have rules that tell us how to use your health information no matter what form it is in–written, oral, or electronic.
- Physical. Your health information is locked up and is kept in safe areas. We protect entry to our computers and buildings. This helps us to block unauthorized entry.
- Technical. Access to your health information is "role-based." This allows only those who need to do their job and give care to you to have access.

We follow all state and federal laws for the protection of your health information.

If we change this notice

By law, we must keep your health information private. We must follow what we say in this notice.

We also have the right to change this notice. If we change this notice, the changes apply to all of your information we have or will get in the future. You can get a copy of the most recent notice on our web site at **AetnaBetterHealth.com/Kentucky**.

Discrimination is Against the Law

Aetna Better Heath of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna Better Heath of Kentucky] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna Better Heath of Kentucky provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Aetna Better Heath of Kentucky also provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the EEO/Civil Rights Compliance Branch.

If you believe that **Aetna Better Heath of Kentucky** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

EEO/Civil Rights Compliance Branch

Cabinet for Health and Family Services
Office of Human Resource Management
275 E. Main St, Mail Stop 5C-D
Frankfort, KY 40621
Telephone: **1-502-564-7770**
Fax: **1-502-564-3129**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the EEO/Civil Rights Compliance Branch is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F
HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al [1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711).]

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 [1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711).]

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1- 855-300- 5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711) (رقم هاتف الصم والبكم)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711) 번으로 전화해 주십시오.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711)

ध्यान दिनुहोस्: तपाइंले नेपाली बोल्नुहुन्छ भने तपाइंको निमित्त भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् (टिटिवाइ: 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, Ni argama. Bilbilaa 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570; 1-800-635-2570 (**TTY:** 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (телетайп: **TTY:**711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona- 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (TTY-711) Telefon za osobe sa oštećenim governor ili sluhom: 1- 855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-855-300-5528; 1-855-690-7784; 1-855-852-7005; 1-800-578-0603; 1-877-389-9457; 1-800-635-2570 (**TTY:** 711)まで、お電話に てご連絡ください。

Key Words/Definitions

- **Appeal** - An appeal is a complaint you make when you want us to change a decision we made about your care.
- **Child** - A member who is age younger than 19.
- **Complaint** - A complaint is when you write or call to complain about a provider, the plan and/or a service. A complaint is also known as a grievance.
- **Copayment** - An amount of money to be paid by a member for a provider visit, service or drug prescription. Also called a copay.
- **Covered services** - The medical care, services, or supplies paid for by Aetna Better Health. This care is described in this handbook.
- **Dual eligible** - This means a member is eligible for both Medicare and Medicaid benefits.
- **Durable Medical Equipment** - This describes any equipment that provides a medical benefit and serves a medical purpose, is prescribed by your provider, and can be used in the home. It includes such items as: wheelchairs, hospital beds, bedside commodes, canes, crutches, walkers, portable oxygen, monitors, nebulizers, bili blankets and/or bili lights.
- **Early Periodic Screening, Diagnosis, and Treatment (EPSDT)** - This program is for preventive health care and well-child checkups for children under the age of 21. EPSDT well-child checkups include screenings, shots and referrals, as needed.
- **Emergency Medical Condition** - Serious symptoms that are severe enough (including pain) that someone without medical training (a prudent layperson) knowing an average amount about health and medicine, could expect that if you didn't get immediate medical care any of the following may happen:
  - The health of the person (or, if a pregnant woman, the health of the woman or her unborn child) would be placed in serious danger
  - Serious injury to bodily functions
  - Serious injury to any bodily organ or part
- With respect to a pregnant woman having contractions:
  - There's inadequate time to safely transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or unborn child

- **Emergency Medical Transportation** - Call 911 in the case of an emergency.
- **Emergency Room Care** - Care provided in the emergency room when you have an injury, sudden illness or an illness that quickly gets worse.
- **Emergency Services** - This includes all tests, labs or services that occur during care received in the Emergency Room.
- **Excluded Services** - Health care services that are not covered by Aetna Better Health of Kentucky.
- **Family planning care** - This program offers information on birth control methods. This helps you plan your family size.
- **Grievance** - A grievance is when you write or call to complain about a provider, the plan and/or a service. A grievance is also known as a complaint.
- **Habilitation Services and Devices** - Services or therapy that help a person with disabilities keep, learn or improve skills and functioning for daily living. These services can be delivered in either inpatient or outpatient settings.
- **Health Insurance** - A program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly and people with disabilities.
- **Home Health Care** - Health care services in your home.
- **Hospice Services** - Services that provide comfort and support for persons in the last stages of a terminal illness and their families.
- **Hospitalizations** - Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.
- **Hospital Outpatient Care** - Care in a hospital that usually doesn't require an overnight stay.
- **Medical home** - A health care provider that is in charge of a medical team who cares for a member's health. This team manages all areas of preventive, acute and chronic needs of a member. A medical home can help a member take an active role in the decisions about their health and well-being.
- **Medically needed/medically necessary** - Services or supplies to diagnose, treat, correct, or prevent a member's illness or injury. Aetna Better Health must agree the care meets all of the following:
  - Care is correct for the symptoms, diagnosis and treatment of the condition
  - Follows standards of good medical practice
  - Not be solely for the convenience of the member, PCP, hospital, other health care provider or caregiver
  - Correct supply or level of service that can be safely and effectively provided, for members in the hospital, it also means their symptoms can't be diagnosed or treated safely outside the hospital
  - Must meet national standards, if applicable
- **Member** - Any person who is eligible for Medicaid managed care services in Kentucky and has Aetna Better Health coverage.
- **Member Services Department** - This department can answer questions about your Aetna Better Health benefits. Member Services can be reached at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 AM to 7 PM ET.
- **Network** - A complete list of all health care providers actively participating with Aetna Better Health. The provider directory is created from this list.
- **Non-participating provider** - A doctor, hospital or other licensed facility or health care provider, who hasn't signed a contract with Aetna Better Health, to give services to members.

- **Physician services** - Health care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.
- **Plan** - A benefit your employer, union or other group sponsor provides to you to pay for your health care services.
- **Post stabilization care** - Medically needed care after an emergency condition becomes stable.
- **Participating provider** - A doctor, hospital or other licensed facility or health care provider, who has signed a contract with Aetna Better Health, agreeing to give services to members.
- **Preauthorization** - Your health care provider must ask Aetna Better Health to approve certain services before he/she gives you the care. Also called prior authorization.
- **Premium** - The amount you pay for your health insurance every month.
- **Prescription drug coverage** - Health insurance or plan that helps pay for prescription drugs and medications.
- **Prescription drugs** - Drugs and medications that, by law, require a prescription.
- **Primary Care Provider (PCP)** - Your PCP is your medical home. The Aetna Better Health provider you select for your primary health care is your PCP. Your PCP arranges for most of the care you need. PCPs specialize in general practice, family practice, internal medicine or pediatrics. Female members age 13 or older may select an OB/GYN for their PCP to arrange for most care they need.
- **Provider** - A physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides health care services to patients.
- **Provider directory** - The list of providers in the Aetna Better Health network that give care to our members. This list does change. The most up-to-date list may be found on our website at **AetnaBetterHealth.com/Kentucky** or the mobile app.
- **Prudent layperson** - This is a person who does not have medical training.
- **Rehabilitation services and devices** - Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt or disabled. These services may include physical and occupational therapy, speech language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
- **Service area** - The places in Kentucky where the plan is an option as a managed care provider for Kentucky Medicaid.
- **Skilled nursing care** - Services from licensed nurses in your home or in a nursing home.
- **Specialist** - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
- **Step Therapy (ST)** - Some drugs aren't approved unless another drug has been tried first. ST coverage requires that a trial of another drug be used before a requested drug is covered.
- **24-Hour Informed Health Line** - Can answer specific health questions or give advice on what to do when you need health care, such as calling your PCP, making an appointment or going to the emergency room. The 24-hour Informed Health Line is available 24 hours a day, 7 days a week at **1-855- 620-3924** (TTY users dial **711**, TDD users dial **1-800-627-4702**).
- **Welcome kit** - The packet mailed to you upon enrollment that includes your Member Handbook, Primary Care Provider Directory, Notice of Privacy Practices, and other helpful information.
- **Urgent Care** - This is medically needed care for an unexpected illness or injury that you need sooner than a routine visit with your PCP.
- **You/Your** - Refers to you, the member.

AetnaBetterHealth.com/Kentucky

Aetna Better Health® of Kentucky PCP Directory

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Healthy happens together

Primary Care Provider (PCP) Directory

aetna™

AetnaBetterHealth.com/Kentucky

Aetna Better Health® of Kentucky

86.05.329.1-KY

How to use this provider directory

Primary care providers (PCP) directory

How to find a provider in your area

This directory is arranged by provider type, county and city. Look for the county and city you live in (or one near you) and find a provider close to where you live.

If you would like more information about a provider, you may contact the:

- Provider's office
- American Board of Medical Specialties (ABMS) **abms.org**
- American Medical Association **ama-assn.org**

To request a hard copy of the Specialist and Hospital directory, call Member Service at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**).

For the most up-to-date information about Aetna Better Health of Kentucky network providers in your area, visit **AetnaBetterHealth.com/Kentucky** or call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**).

Welcome to Aetna Better Health of Kentucky

Aetna Better Health of Kentucky is a managed care organization (MCO) that offers quality health care you and your family deserve.

As a member of Aetna Better Health of Kentucky, you have benefits, such as:

- Your choice of a family primary care provider (PCP) from the Aetna Better Health of Kentucky network
- A variety of hospitals and providers in your community
- 24-Hour Informed Health Line
- Disease management programs

Your member ID card
Each Aetna Better Health of Kentucky member gets a Member ID card with his/her PCP listed. This card also has other important phone numbers. Keep it with you at all times. Please show your Member ID card at every health care visit.

Check this directory
Please be sure the PCP you select is part of our network. We work closely with our providers to take care of your health and medical needs.

Contact your PCP before getting care
You should contact your PCP when you need health care. There are some services that you may get without going to your PCP first. Check your Member Handbook for more information on these services.

Because new providers join our network all the time, this book may not be up-to-date. If a provider is not listed, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**). They have the most up-to-date information. They can also answer any questions you may have about Aetna Better Health of Kentucky.

Changing your PCP
If you want to change your PCP, call Member Services at **1-855-300-5528** (TTY users dial **711**, TDD users dial **1-800-627-4702**), Monday through Friday, 7 a.m. to 7 p.m. ET or you can request the change through the Member Portal on our website at **AetnaBetterHealth.com/Kentucky**. If the member is a child, the member's parent or guardian may change the PCP.

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AETNA BETTER HEALTH® OF KENTUCKY

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator
4500 East Cotton Center Boulevard
Phoenix, AZ 85040
Telephone: **1-888-234-7358 (TTY 711)**
Email: MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل **1-800-385-4104** (للصم والبكم: **711**).

SERBO-CROATIAN: OBAVEŠTENJE: Ako govorite srpski, usluge jezičke pomoći dostupne su vam besplatno. Pozovite broj na poleđini vaše identifikacione kartice ili broj **1-800-385-4104** (TTY – telefon za osobe sa oštećenim govorom ili sluhom: **711**).

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または**1-800-385-4104** (TTY: **711**)までご連絡ください。

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

PENN DUTCH: Geb Acht: Wann du Deitsch Pennsilfaanisch Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf die Nummer uff, ass hinne uff dei ID card iss, odder ruf **1-800-385-4104** (TTY: **711**).

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नम्बर वा **1-800-385-4104** (TTY**: 711**) मा फोन गर्नुहोस्।

OROMO (CUSHITE): Hubadhu: yoo Oromoo dubbatta ta'ee, gargaarsa tajaajiiloota afaanii, kaffaalttii bilisaa ni jiraa siif. Lakkoofsa bilbiilaa ID kee duuba irraa jiruun yookiin **1-800-385-4104** (TTY: **711**).

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

KIRUNDI (BANTU): ICITONDERWA: Namba uvuga Ikirundi, serivisi zigufasha kugusigurira ururimi, ku buntu, ziraboneka ushobora kuzironswa. Hamagara inomero iri inyuma ku gakarata k'akarangamuntu kawe canke iyi nomero **1-800-385-4104** (Ufise ubumuga bwo kutumva neza ifashishe (TTY): **711**).

Primary Care Physicians

Providers Listed by County, Specialty, Provider Name.

KENTUCKY

ADAIR

FAMILY MEDICINE

BOBORODEA, VIOREL
803 Burkesville St
Columbia, KY 42728
(270) 318-3399

BURTON MARTHA A
805 Burkesville St
Columbia, KY 42728
(270) 384-0233

CORNELIUS, JESSICA M
322 General John Adair Dr
Columbia, KY 42728
(270) 384-2751

CORNELIUS, JESSICA M
526 Indian Dr
Columbia, KY 42728
(270) 384-2571

CORNELIUS, JESSICA M
870 Indian Dr
Columbia, KY 42728
(270) 384-0077

GILES, CHARLES STEPHEN
3066 Campbellsville Rd
Columbia, KY 42728
(270) 384-6451

GILES, CHARLES STEPHEN
901 Westlake Dr
Columbia, KY 42728
(270) 651-4444

HAYCRAFT, AMANDA S
1463 Campbellsville Rd
Columbia, KY 42728
(270) 384-9934

KITECK, CLINTON S
310 Jamestown St
Columbia, KY 42728
(270) 384-4764

KITECK, CLINTON S
901 Westlake Dr
Columbia, KY 42728
(270) 651-4444

KITECK, CLINTON S
902 Westlake Dr Ste 101
Columbia, KY 42728
(270) 384-0451

MOONEY, MELANIE L
901 Westlake Dr
Columbia, KY 42728
(270) 651-4444

OZOR, MARTIN C
901 Westlake Dr
Columbia, KY 42728
(270) 651-4444

PARTIN, GARY L
1597 Bliss Rd
Columbia, KY 42728
(270) 634-0151

PARTIN, GARY L
363 Office Park Dr
Columbia, KY 42728
(270) 384-3939

SEELEY, MARTHA L
901 Westlake Dr
Columbia, KY 42728
(270) 651-4444

SHIPP, ROBERT S
1463 Campbellsville Rd
Columbia, KY 42728
(270) 384-9934

TUCKER, SUMMER R
187 Will Walker Rd
Columbia, KY 42728
(270) 789-1112

WALLER, CHARLES L
901 Westlake Dr
Columbia, KY 42728
(800) 377-8721

WILSON, JARED K
901 Westlake Dr
Columbia, KY 42728
(270) 651-4444

GENERAL PRACTICE

TODD, LISA A
197 Will Walker Rd
Columbia, KY 42728
(270) 384-9981

INTERNAL MEDICINE

BRILL, BRIAN C
901 Westlake Dr
Columbia, KY 42728
(270) 651-4444

DENE, MARY LOU
1463 Campbellsville Rd
Columbia, KY 42728
(270) 384-9934

SIADY, JESUS C
901 Westlake Dr
Columbia, KY 42728
(270) 651-4444

WEIDLER, DONALD JOHN
1463 Campbellsville Rd
Columbia, KY 42728
(270) 384-9934

WEIDLER, DONALD JOHN
901 Westlake Dr
Columbia, KY 42728
(270) 651-4444

PEDIATRICS

HESSON, DAVID
187 Will Walker Rd
Columbia, KY 42728
(270) 789-1112

MARTIN, MATTHEW S
187 Will Walker Rd
Columbia, KY 42728
(270) 789-1112

STYER, THOMAS B
901 Westlake Dr
Columbia, KY 42728
(800) 377-8721

ALLEN

FAMILY MEDICINE

MANION, KENNY J
113 E Public Sq
Scottsville, KY 42164
(270) 843-5662

INTERNAL MEDICINE

ABDUL'WAHEED, MOHAMMAD A
466 Burnley Rd
Scottsville, KY 42164
(270) 622-9636

SCHWENDER, FRANK T
466 Burnley Rd
Scottsville, KY 42164
(270) 622-9636

ANDERSON

FAMILY MEDICINE

ELLIS, JUSTINA M
512 Saffell St
Lawrenceburg, KY 40342
(502) 839-1231

PEDIATRICS

DICKINSON, JEREMY T
1100 Glensboro Rd Parkview Ctr Ste 6
Lawrenceburg, KY 40342
(859) 236-1080

GRAVES, MATTHEW A
1100 Glensboro Rd Parkview Ctr Ste 6
Lawrenceburg, KY 40342
(859) 236-1080

MUNDAY MIRANDA L
1100 Glensboro Rd Parkview Center Ste 6
Lawrenceburg, KY 40342
(859) 236-1080

STEIN, DOUGLAS A
1100 Glensboro Rd Parkview Center Ste 6
Lawrenceburg, KY 40342
(859) 236-1080

WIGLESWORTH, JOSHUA S
1100 Glensboro Rd Parkview Ctr Ste 6
Lawrenceburg, KY 40342
(859) 236-1080

Primary Care Providers

BALLARD

FAMILY MEDICINE

BRAZZELL, JOHN W
120 N 4th St
Barlow, KY 42024
(270) 334-3131

WIGGINS, JOSEPH D
120N 4th St
Barlow, KY 42024
(270) 334-3131

INTERNAL MEDICINE

ALLEN, HENRY W
120 N 4th St
Barlow, KY 42024
(270) 334-3131

BUTLER, DANNY N
134 Phillips Dr
Wickliffe, KY 42087
(270) 443-2900

BARREN

FAMILY MEDICINE

BALE, PHILLIP WICKENDEN
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

BROOKS, LINDSEY KAY
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

CAMPBELL, JASON H
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

CAMPBELL, JASON H
303 Professional Park Dr
Glasgow, KY 42141
(270) 629-3772

CAMPBELL, JASON H
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

CLEMENTS, JAMES
1330 N Race St
Glasgow, KY 42141
(270) 261-5065

CLEMENTS, JAMES
400 N Dixie Hwy
Cave City, KY 42127
(270) 773-2600

CLOUSE, RICHARD M
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

CLOUSE, RICHARD M
310 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-4263

CLOUSE, RICHARD M
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

COLEMAN, AMY ELIZABETH
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

CREWS, JAMES P
207 N Dixie Hwy
Cave City, KY 42127
(270) 773-3736

DOTSON, LESLEY A
1325 N Race St
Glasgow, KY 42141
(606) 298-3412

DUNN, PAUL D
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

FLANNERY, ANTHONY WEBSTER
1008 Glenview Dr Ste A
Glasgow, KY 42141
(270) 651-8185

FLANNERY, ANTHONY WEBSTER
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

FLANNERY, ANTHONY WEBSTER
310 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-4263

FLANNERY, ANTHONY WEBSTER
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

GILSON, IAN S
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

GILSON, IAN S
310 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-4263

GILSON, IAN S
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

HOUSE, STEVEN A
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

KISER, AMELIA R
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

KITECK, CLINTON S
1301 N Race St
Glasgow, KY 42141
(270) 651-4444

KITECK, CLINTON S
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

MALLORY, BRAD M
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

MALLORY, BRAD M
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

MANION, KENNY J
411 S L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-7796

MILLER, MELENDA K
1301 N Race St
Glasgow, KY 42141
(270) 651-4444

MILLER, MELENDA K
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

NEUHAUS, LINSEY L
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

NEUHAUS, LINSEY L
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

SEELEY, MARTHA L
220 N Race St
Glasgow, KY 42141

SMALL, KAREN MARSH
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

SMALL, KAREN MARSH
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

WILLIAMS, ROGER T
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

WILLIAMS, ROGER T
1330 N Race St
Glasgow, KY 42141
(270) 261-5065

WILLIAMS, ROGER T
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

WILLIAMS, ROGER T
400 N Dixie Hwy
Cave City, KY 42127
(270) 773-2600

WRIGHT, R BRENT
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

ZELLER, STEVEN ROBERT
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

GENERAL PRACTICE

TURNER, CHARLES A
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

TURNER, CHARLES A
1330 N Race St
Glasgow, KY 42141
(270) 261-5065

TURNER, CHARLES A
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

INTERNAL MEDICINE

ABDUL'WAHEED, MOHAMMAD A
1004 Glenview Dr
Glasgow, KY 42141
(270) 782-0151

ALI, AMJAD M
1301 N Race St
Glasgow, KY 42141
(270) 651-4444

CAMPBELL, ALISON S
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

CAMPBELL, ALISON S
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

CLEMMONS, ANTON M
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

DICKINSON, LEWIS G
1004 Glenview Dr
Glasgow, KY 42141
(270) 651-9611

ELSALLABI, OSAMA S
1301 N Race St
Glasgow, KY 42141
(270) 651-4444

GERMAN, DAVID C
1301 N Race St
Glasgow, KY 42141
(270) 651-4560

GERMAN, DAVID C
211 Professional Park Dr
Glasgow, KY 42141
(270) 651-8325

GERMAN, DAVID C
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

MADDOX DAVID A
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

MATNEY, ASHLEY R
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

MEJIA, JUAN CARLOS
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

MODI, YASHPAL
1301 N Race St
Glasgow, KY 42141
(270) 651-4444

NORRIS, ASHLEY ANN
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

PATEL, NIRAJ I
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

PINGLETON, DAWN E
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

PORTER, JOSHUA M
1301 N Race St
Glasgow, KY 42141
(270) 651-4444

ROMAIN, MCLEAN JOHNSON
1301 N Race St
Glasgow, KY 42141
(270) 651-4797

WALKER, MICHAEL BRYAN
312 N L Rogers Wells Blvd
Glasgow, KY 42141
(270) 651-1111

PEDIATRICS

BROOKS, HAZEL LYNNETTE
303 Professional Drive
Glasgow, KY 42141
(270) 651-9696

DONNELLY, STACY
301 Professional Park Dr
Glasgow, KY 42141
(270) 651-9696

MOSS, SANDRA DOTSON
290 Old Jackson Hwy 31 E Loop
Glasgow, KY 42141
(270) 678-5740

WARREN, DONNA M
303 Professional Drive
Glasgow, KY 42141
(270) 651-9696

BATH

FAMILY MEDICINE

BAKER, PHILLIP B
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

BANKS, AARON P
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

BURROWS, CRAIG H
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

FAGBEMI, RUTH I
17 Miller Dr
Owingsville, KY 40360
(606) 674-3033

MOORE, CAROLYN A
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

MURPHY, KRISTEN
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

SMITH, CLIFFORD C
521 E High St
Owingsville, KY 40360
(859) 404-7686

WOMACK, GLENN R
602 Main St
Sharpsburg, KY 40374
(606) 247-5006

GENERAL PRACTICE

COX, MELISSA L
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

ELAM, TYLER J
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

INTERNAL MEDICINE

HALL, RICHARD A
44 Water St
Owingsville, KY 40360
(606) 674-6776

KASSIS, TAUFIK K
17 Miller Dr
Owingsville, KY 40360
(606) 674-3033

WEAVER, ANTHONY
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

PEDIATRICS

HENLY, NANCY J
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

SIKORSKA, MIROSLAWA E
632 Slate Ave
Owingsville, KY 40360
(606) 674-6386

BELL

FAMILY MEDICINE

BREEDING, VAN S
100 College Rd Ste 131-132
Middlesboro, KY 40965
(606) 654-9450

Primary Care Providers

ELIAN, MAYADA
3504 Cumberland Ave
Middlesboro, KY 40965
(606) 248-0737

FREDERICH, JEFFREY L
850 Riverview Ave
Pineville, KY 40977
(606) 337-8104

FUGATE, SHAWN S
302 S Walnut St
Pineville, KY 40977
(606) 337-2252

FUGATE, SHAWN S
313 S Cherry St
Pineville, KY 40977
(606) 654-3338

GAMBRELL, CHADWICK E
100 College Rd Ste 131-132
Middlesboro, KY 40965
(606) 654-9450

GAMBRELL, CHADWICK E
251 S Pine St
Pineville, KY 40977
(606) 337-3500

HORTILLOSA, MARIA A
2032 Cumberland Ave
Middlesboro, KY 40965
(606) 248-4833

HORTILLOSA, MARIA A
3513 Cumberland Ave
Middlesboro, KY 40965
(606) 248-5187

LUCAS, ELIZABETH S
251 S Pine St
Pineville, KY 40977
(606) 337-3500

SLONE, BRITTANY J
2317 Cumberland Ave
Middlesboro, KY 40965
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Lexington, KY 40513
(859) 219-2851

YARBRO, MARINA T
1736 Alexandria Dr Ste 125
Lexington, KY 40504
(859) 278-8772

YARBRO, MARINA T
2628 Wilhite Ct
Lexington, KY 40503
(859) 721-1972

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1113 Centre Pkwy
Lexington, KY 40517
(859) 381-3774

YOUNG, THOMAS L
122 Arceme Ave
Lexington, KY 40505
(859) 381-3750

YOUNG, THOMAS L
135 E Maxwell St Ste 200
Lexington, KY 40508
(859) 323-6211

YOUNG, THOMAS L
161 Bruce St
Lexington, KY 40507
(859) 252-2598

YOUNG, THOMAS L
1640 Bryan Station Rd Ste 1
Lexington, KY 40505
(859) 288-2425

YOUNG, THOMAS L
1736 Alexandria Dr Ste 125
Lexington, KY 40504
(859) 288-2425

YOUNG, THOMAS L
2101 Saint Mathilda Dr
Lexington, KY 40502
(859) 381-3273

YOUNG, THOMAS L
218 Mandalay Rd
Lexington, KY 40504
(859) 381-3346

YOUNG, THOMAS L
2333 Alumni Park Plz Ste 200
Lexington, KY 40517
(859) 257-7900

YOUNG, THOMAS L
2400 Greatstone Pt
Lexington, KY 40504
(859) 257-9800

YOUNG, THOMAS L
551 Parkside Dr
Lexington, KY 40505
(859) 381-3012

YOUNG, THOMAS L
555 E Fifth St
Lexington, KY 40508
(859) 381-3172

YOUNG, THOMAS L
650 Newtown Pike
Lexington, KY 40508
(859) 288-2392

YOUNG, THOMAS L
707 Howard St
Lexington, KY 40508
(859) 288-2425

FLEMING

FAMILY MEDICINE

BOYD MICHAEL ALAN
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Flemingsburg, KY 41041
(606) 849-3374

INTERNAL MEDICINE

APPLEGATE AMANDA MAE
932 Elizaville Ave
Flemingsburg, KY 41041
(606) 849-3374

FLOYD

FAMILY MEDICINE

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1279 Old Abbott Mountain Rd
Prestonsburg, KY 41653
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ARNETT, CHARLES F
5000 KY Route 321
Prestonsburg, KY 41653

ARNETT, SCOTT B
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Harold, KY 41635
(606) 478-8787

ARNETT, SCOTT B
400 University Dr Ste 211
Prestonsburg, KY 41653
(606) 889-6367

ARNETT, SCOTT B
5000 KY Route 321
Prestonsburg, KY 41653

ARNETT, SCOTT B
5000 KY Route 321 Ste 4102
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(606) 889-6185

BAILEY, CHRISTOPHER M
121 Oak Ridge Ct Ste A
Prestonsburg, KY 41653
(606) 506-5114

BAILEY, CHRISTOPHER M
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(606) 478-8787

BAILEY, CHRISTOPHER M
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Prestonsburg, KY 41653
(606) 886-1173

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BOWMAN, CLAYTON V
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BURCHETT, BLAKE
4851 KY Route 321
Prestonsburg, KY 41653
(606) 886-1173

BURCHETT, BLAKE
5000 KY Route 321
Prestonsburg, KY 41653

BURCHETT, BLAKE
535 N Lake Dr
Prestonsburg, KY 41653
(606) 886-8466

CASTLE, JASON
24 Left Penhook Rd
Harold, KY 41635
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CASTLE, JASON
5000 KY Route 321
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COLLINS, BRANDI LEMASTER
5000 KY Route 321
Prestonsburg, KY 41653

DOTSON, LESLEY A
7629 KY Route 979
Grethel, KY 41631
(606) 886-8546

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GOBLE, MICHAEL D
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Harold, KY 41635
(606) 478-4600

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5000 KY Route 321
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HALL, DEBRA K
5000 KY Route 321 Ste 4102
Prestonsburg, KY 41653
(606) 889-6185

HALL, DEBRA K
723 S Lake Dr
Prestonsburg, KY 41653
(606) 886-8175

HALL, MARY A
9788 KY Route 122 Ste 2
Mc Dowell, KY 41647
(606) 377-2492

HARDISON, ROBERT D
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Prestonsburg, KY 41653
(606) 886-8511

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11087 Main St
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(606) 285-3690

HARLOW, BRITTANY L
12579 Main St Ste 101
Martin, KY 41649
(606) 285-0681

HARLOW, BRITTANY L
2662 King Kelly Coleman Highway
Wayland, KY 41666
(606) 358-4211

HARLOW, BRITTANY L
30 KY Route 306
Bypro, KY 41612
(606) 452-1700

HARLOW, BRITTANY L
9350 US Highway 23 S Ste 3
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(606) 285-9989

HARLOW, BRITTANY L
9879 KY Route 122
Mc Dowell, KY 41647
(606) 377-3462

HESS, JONATHAN A
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Prestonsburg, KY 41653
(606) 886-7600

HESS, ROBERT A
5000 KY Route 321
Prestonsburg, KY 41653
(606) 886-8511

HOWARD, KELLY E
5000 KY Route 321 Ste 3141
Prestonsburg, KY 41653
(606) 886-7517

JOHNSON, KEVIN B
121 Oak Ridge Ct Ste A
Prestonsburg, KY 41653
(606) 506-5114

JOHNSON, LARRY C
104 S Front Ave
Prestonsburg, KY 41653
(606) 886-4346

JURICH, NICHOLAS
1279 Old Abbott Mountain Rd
Prestonsburg, KY 41653
(606) 886-1260

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KUMMANT, EILEEN M
11203 Main St
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KUMMANT, EILEEN M
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(606) 478-3636

KUMMANT, EILEEN M
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LYONS, JONATHAN M
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MARSHALL, KASSI M
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(606) 285-0681

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Mc Dowell, KY 41647
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MAZUMDER, MOHAMMED
92 Pickett Ln
Prestonsburg, KY 41653
(606) 874-0012

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Prestonsburg, KY 41653
(606) 886-7517

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Martin, KY 41649
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MUTISO, ANDREW
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Prestonsburg, KY 41653
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OQUINN, ANGELA M
12579 Main St Ste 101
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(606) 285-0681

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PARKER, CARMAN A
286 US Highway 23 N
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1709 KY Route 321
Prestonsburg, KY 41653
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PARSONS, JEREMY C
23 Willow Dr
Auxier, KY 41602
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(606) 889-6367

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Prestonsburg, KY 41653

PARSONS, JEREMY C
5000 KY Route 321 Ste 4102
Prestonsburg, KY 41653
(606) 889-6185

PARSONS, JEREMY C
7629 KY Route 979
Grethel, KY 41631
(606) 587-2200

POTTER, JEFFERY S
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Harold, KY 41635
(606) 478-8787

POTTER, JEFFERY S
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(606) 886-0224

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5000 KY Route 321
Prestonsburg, KY 41653

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Prestonsburg, KY 41653

SHY, STEPHEN C
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1279 Old Abbott Mountain Rd
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(606) 886-1260

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Prestonsburg, KY 41653

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WATTS, JANEY L
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Harold, KY 41635
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WATTS, JANEY L
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23 Willow Dr
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KOUSA, LOEY J
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Primary Care Providers

INTERNAL MEDICINE

ALIKER, DENIS O
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CARUSO, MARK P
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Prestonsburg, KY 41653

EMERICK, ROBERT S
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(606) 886-7600

MANNAN, MOHAMMAD YAHYA
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Prestonsburg, KY 41653
(606) 889-9994

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Prestonsburg, KY 41653
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Martin, KY 41649
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PRATER, JEFFERY W
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PREVATT, OPAL
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Bypro, KY 41612
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REDDY, SUJATHA S
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Prestonsburg, KY 41653
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STUMBO, ANTHONY C
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STUMBO, ANTHONY C
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Prestonsburg, KY 41653
(606) 886-7645

STUMBO, ANTHONY C
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93 Pickett Ln
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(606) 874-0009

WEBB, SONJA T
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PEDIATRICS

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JAAFAR, MAZEN
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MILLS, TIFFANY MICHELLE
5000 KY Route 321 Ste 4102
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(606) 889-6185

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Prestonsburg, KY 41653
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Prestonsburg, KY 41653

FRANKLIN

FAMILY MEDICINE

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AMJAD, SOBIA
103 Diagnostic Dr Ste A
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ARVIN, JON A
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ASHBURN, WILLIAM T
226 W Main St
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ASHER, LAURA G
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BAILEY, BETSY E
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BAILEY, CHRISTOPHER M
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BANKS, ADRIAN C
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BARCELONA, RAMON L
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BATES, RODNEY K
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(502) 227-4379

BAUMANN, ERIC
226 W Main St
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(502) 227-4379

BELANGER, JOHN S
226 W Main St
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(502) 227-4379

BIRCH, MORGAN W
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BREEDING, VAN S
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(502) 227-4379

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(502) 227-4379

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(502) 227-4379

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COOPER, ROBERT
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CRANSTOUN, LANDI M
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DAVIS, HUNTER W
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Frankfort, KY 40601
(502) 227-4379

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DILLON, STEPHANIE L
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DUNAWAY, MICHAEL D
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DUNCAN, BRENT H
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EUBANK, RACHEL R
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(502) 227-4379

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226 W Main St
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Frankfort, KY 40601
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FARLEY III , FRANK D
593 E Main St
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FLETCHER-JONES, CRYSTAL MOORE
226 W Main St
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(502) 227-4379

FOWLES, THOMAS
101 Kings Daughters Dr Ste B
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(859) 466-8951

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226 W Main St
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GOBLE, MICHAEL D
226 W Main St
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(502) 227-4379

GRABENSTEIN, THOMAS G
226 W Main St
Frankfort, KY 40601
(502) 227-4379

GRAVES, KEVIN A
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(502) 227-4379

GRAY, JENNIFER
226 W Main St
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(502) 227-4379

GRAY, NINA C
226 W Main St
Frankfort, KY 40601
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GREEN, HEATHER CROMIE
226 W Main St
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GRINBERG, SVETLANA
226 W Main St
Frankfort, KY 40601
(502) 227-4379

GROOMS, BRYAN D
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(502) 227-4379

GROSSER, TIMOTHY T
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(502) 227-4379

GUTTMAN, NANCY E
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HADLEY JENIFER L
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(502) 227-4379

HAGER, JAMES R
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(502) 227-4379

HALL, LUTHER DANIEL
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HAMILTON, THOMAS E
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HAMILTON, THOMAS E
4 HMB Cir
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(502) 227-4379

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(502) 227-4379

HOLMES, GREGORY
226 W Main St
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(502) 227-4379

HOSKINS ROBERT C
226 W Main St
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(502) 227-4379

HOWARD, KELLY E
226 W Main St
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(502) 227-4379

HUANG, ANNA K
226 W Main St
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(502) 227-4379

HUME, TIMOTHY DALE
226 W Main St
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(502) 227-4379

JAMES, NAREN N
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(502) 227-4379

JANARDAN, SOUMYA G
226 W Main St
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JOHNSON, BEVERLY C
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JOHNSON, KEVIN B
226 W Main St
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(502) 227-4379

JOHNSON, LARRY C
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KING, NATALIE M
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LALREMSIAMI, BABIE
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LANE, ARTINA
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LOY, ERIC E
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2420 Argillite Rd Ste B
Flatwoods, KY 41139
(606) 836-3900

LAWENTMANN, MAGGIE
US 23 at Indianola Ave
South Shore, KY 41175
(606) 932-3150

LOBACH, AUGUSTINUS J
1629 Ashland Rd Ste 2
Greenup, KY 41144
(606) 473-0687

LOBACH, AUGUSTINUS J
2420 Argillite Rd Ste B
Flatwoods, KY 41139
(606) 836-3900

MCCOY, LORI D
2420 Argillite Rd Ste B
Flatwoods, KY 41139
(606) 836-3900

ODUKOYA, OLUSEGUN A
2420 Argillite Rd
Flatwoods, KY 41139
(606) 836-3900

STEVENSON, GRANT L
142 Depot Dr
South Shore, KY 41175
(606) 932-2271

UNDERWOOD, ZACHARY D
2420 Argillite Rd Ste B
Flatwoods, KY 41139
(606) 836-3900

GENERAL PRACTICE

HUDSON, GREGORY
137 State Route 3117
South Shore, KY 41175
(606) 932-2079

PEDIATRICS

YMALAY, CHITO T
908 Powell Ln Ste 101
Flatwoods, KY 41139
(606) 836-0263

HANCOCK

FAMILY MEDICINE

KING, BRADLEY S
185 State Route 271 S
Lewisport, KY 42351
(270) 927-9991

VINCENT, WILLIAM K
1520 4th St
Lewisport, KY 42351
(270) 922-8492

GENERAL PRACTICE

TIU, JAIME B
1520 4th St
Lewisport, KY 42351
(270) 844-8232

INTERNAL MEDICINE

MOOLANI, MASHESH K
185 State Route 271 S
Lewisport, KY 42351
(270) 927-9991

HARDIN

FAMILY MEDICINE

CORNELIUS, JESSICA M
100 Country Club Rd
Vine Grove, KY 40175
(844) 435-0900

CORNELIUS, JESSICA M
100 Trojan Way
Radcliff, KY 40160
(844) 435-0900

CORNELIUS, JESSICA M
10471 Leitchfield Rd
Cecilia, KY 42724
(844) 435-0900

CORNELIUS, JESSICA M
110 W A Jenkins Rd
Elizabethtown, KY 42701
(844) 435-0900

CORNELIUS, JESSICA M
129 College St
Glendale, KY 42740
(844) 435-0900

CORNELIUS, JESSICA M
151 Horseshoe Bend Rd
Sonora, KY 42776
(844) 435-0900

INGRAM, THOMAS G
2412 Ring Rd Ste 200
Elizabethtown, KY 42701
(270) 765-5926

KHAN, BUSHRA BURKI
1230 Woodland Dr Ste 114
Elizabethtown, KY 42701
(502) 549-3100

MOVANIA, JAWED M
1117 Woodland Dr
Elizabethtown, KY 42701
(270) 769-2363

MOVANIA, JAWED M
1321 Ring Rd Ste 107
Elizabethtown, KY 42701
(270) 986-7373

MOVANIA, JAWED M
225 Saint John Rd
Elizabethtown, KY 42701
(270) 769-3315

MOVANIA, JAWED M
3909 S Wilson Rd
Radcliff, KY 40160
(270) 351-9444

MOVANIA, JAWED M
599 Rogersville Rd
Radcliff, KY 40160
(270) 351-2999

MOVANIA, JAWED M
700 W Lincoln Trail Blvd
Radcliff, KY 40160
(270) 351-3192

MOVANIA, JAWED M
913 North Dixie Skilled Nursing Facility
Elizabethtown, KY 42701
(270) 737-1212

NASIR, MUJAHID
1311 Ring Rd Ste 101
Elizabethtown, KY 42701
(270) 900-4555

NASIR, MUJAHID
1321 Ring Rd Ste 107
Elizabethtown, KY 42701
(270) 986-7373

NASIR, MUJAHID
700 W Lincoln Trail Blvd
Radcliff, KY 40160
(270) 351-3192

ZOELLER, DAVID J
1239 Woodland Dr
Elizabethtown, KY 42701
(270) 765-4535

GENERAL PRACTICE

SMITH, DEBRA A
599 Rogersville Rd
Radcliff, KY 40160
(502) 709-0430

SMITH, GREGORY D
2412 Ring Rd Ste 200
Elizabethtown, KY 42701
(270) 765-5926

Primary Care Providers

INTERNAL MEDICINE

AHMED, AYAZ
1321 Ring Rd Ste 107
Elizabethtown, KY 42701
(270) 986-7373

AHMED, AYAZ
700 W Lincoln Trail Blvd
Radcliff, KY 40160
(270) 351-3192

AHMED, SYED ZULFIQAR
1009 N Dixie Ave
Elizabethtown, KY 42701
(270) 737-0678

ARCE, JAVIER J
914 N Dixie Ave Ste 203
Elizabethtown, KY 42701
(270) 765-3303

BLAND, VIVIAN H
914 N Dixie Ave Ste 306
Elizabethtown, KY 42701
(270) 769-1559

EKLUND, BRIAN M
914 N Dixie Ave Ste 304
Elizabethtown, KY 42701
(270) 769-1049

FAHEEM, AMJAD M
800 W Lincoln Trail Blvd Ste 102
Radcliff, KY 40160
(270) 351-3515

FAHEEM, AMJAD M
914 N Dixie Ave Ste 302
Elizabethtown, KY 42701
(270) 769-0892

GODFREY, CHRIS J
914 N Dixie Ave Ste 304
Elizabethtown, KY 42701
(270) 769-1049

GODFREY, JOHN A
914 N Dixie Ave Ste 304
Elizabethtown, KY 42701
(270) 769-1049

GODFREY, WILLIAM J
914 N Dixie Ave Ste 304
Elizabethtown, KY 42701
(270) 769-1049

QUADRI, SYED R
1311 Ring Rd Ste 105
Elizabethtown, KY 42701
(270) 769-0892

QUADRI, SYED R
1321 Ring Rd Ste 107
Elizabethtown, KY 42701
(270) 986-7373

QUADRI, SYED R
700 W Lincoln Trail Blvd
Radcliff, KY 40160
(270) 351-3192

QUADRI, SYED R
800 W Lincoln Trail Blvd Ste 102
Radcliff, KY 40160
(270) 351-3515

PEDIATRICS

BALDWIN, KATHERINE H
100 Country Club Rd
Vine Grove, KY 40175
(844) 435-0900

BALDWIN, KATHERINE H
100 Trojan Way
Radcliff, KY 40160
(844) 435-0900

BALDWIN, KATHERINE H
10471 Leitchfield Rd
Cecilia, KY 42724
(844) 435-0900

BALDWIN, KATHERINE H
110 W A Jenkins Rd
Elizabethtown, KY 42701
(844) 435-0900

BALDWIN, KATHERINE H
129 College St
Glendale, KY 42740
(844) 435-0900

BALDWIN, KATHERINE H
151 Horseshoe Bend Rd
Sonora, KY 42776
(844) 435-0900

BALDWIN, KATHERINE H
275 Rineyville School Rd
Rineyville, KY 40162
(844) 435-0900

BALL, MARQUITA H
111 Helmwood Plaza Dr
Elizabethtown, KY 42701
(270) 737-4808

BROWNING, RAMONA
103 Financial Pl Ste 100
Elizabethtown, KY 42701
(270) 769-0110

CAMMACK, VERONICA H
111 Helmwood Plaza Dr
Elizabethtown, KY 42701
(270) 737-4808

COLE, ALEXIS M
1301 Ring Rd
Elizabethtown, KY 42701
(270) 765-2107

FLYNN, MELISSA B
111 Helmwood Plaza Dr
Elizabethtown, KY 42701
(270) 737-4808

IRWIN, MEREDITH K
1301 Ring Rd
Elizabethtown, KY 42701
(270) 765-2107

METRY, REBECCA
1301 Ring Rd
Elizabethtown, KY 42701
(270) 765-2107

NEEL, DONALD R
1301 Ring Rd
Elizabethtown, KY 42701
(270) 765-2107

NESSLE, CHARLES N
1301 Ring Rd
Elizabethtown, KY 42701
(270) 765-2107

NGUYEN, HY K
750 W Lincoln Trail Blvd Ste 101
Radcliff, KY 40160
(270) 351-1850

NOORJAHAN, ALI
103 Financial Pl Ste 100
Elizabethtown, KY 42701
(270) 769-0110

PEARMAN, LEIGH A
111 Helmwood Plaza Dr
Elizabethtown, KY 42701
(270) 737-4808

POPE, MELISA M
1301 Ring Rd
Elizabethtown, KY 42701
(270) 765-2107

PRICE, CARA G
1301 Ring Rd
Elizabethtown, KY 42701
(270) 765-2107

SAIFULLAH, YASIR
103 Financial Pl Ste 100
Elizabethtown, KY 42701
(270) 769-0110

SOTIROPOULOS, CHRISTINA M
1301 Ring Rd
Elizabethtown, KY 42701
(270) 765-2107

HARLAN

FAMILY MEDICINE

ATKINS, ROBERT R
103 E Central St
Harlan, KY 40831
(606) 573-9440

BREEDING, VAN S
132 Village Center Rd
Harlan, KY 40831
(606) 573-7771

BREEDING, VAN S
1620 E Main St
Cumberland, KY 40823
(606) 589-6113

COLTON, SHARON M
209 E Mound St
Harlan, KY 40831
(606) 573-1975

DUNN, ANNA L
37 Ball Park Rd
Harlan, KY 40831
(606) 573-4520

GAMBRELL, CHADWICK E
132 Village Center Rd
Harlan, KY 40831
(606) 573-7771

GRINBERG, SVETLANA
132 Village Center Rd
Harlan, KY 40831
(606) 573-7771

GRINBERG, SVETLANA
1620 E Main St
Cumberland, KY 40823
(606) 589-6113

HATTON, JONATHAN
1620 E Main St
Cumberland, KY 40823
(606) 589-6113

JACOBS-POPE, ROBIN
18880 N US Highway 119
Cumberland, KY 40823
(606) 589-0130

JACOBS-POPE, ROBIN
37 Ball Park Rd
Harlan, KY 40831
(606) 573-4520

LUCAS, ELIZABETH S
132 Village Center Rd
Harlan, KY 40831
(606) 573-7771

INTERNAL MEDICINE

BALL, PATRICK E
37 Ball Park Rd
Harlan, KY 40831
(606) 573-4520

COPE, ANYA K
101 Chad St
Evarts, KY 40828
(606) 837-2108

COPE, ANYA K
209 E Mound St
Harlan, KY 40831
(606) 573-1975

DAHHAN, ABDUL K
120 Professional Ln Ste 101
Harlan, KY 40831
(606) 573-1085

MARLOWE, STANLEY D
18880 N US Highway 119
Cumberland, KY 40823
(606) 589-0130

MARLOWE, STANLEY D
37 Ball Park Rd
Harlan, KY 40831
(606) 573-4520

SHAW, JANE
37 Ball Park Rd
Harlan, KY 40831
(606) 573-4520

PEDIATRICS

ALLEN, AMBER L
132 Village Center Rd
Harlan, KY 40831
(606) 573-7771

CORP, FRANCISCO F
132 Village Center Rd
Harlan, KY 40831
(606) 573-7771

HAAS, MARJORIE
37 Ball Park Rd
Harlan, KY 40831
(606) 573-4520

SIDHU, GUASHARAN K
29 Eula Gray St
Harlan, KY 40831
(606) 573-9690

SMITH, CARL E
120 Professional Ln Ste 201
Harlan, KY 40831
(606) 573-3032

VACCARO, PAUL G
132 Village Center Rd
Harlan, KY 40831
(606) 573-7771

VACCARO, PAUL G
1620 E Main St
Cumberland, KY 40823
(606) 589-6113

HARRISON

FAMILY MEDICINE

COOPER, JOHN GREGORY
1210 KY Hwy 36 E Ste 2C
Cynthiana, KY 41031
(859) 234-6000

DAMRON, MICHAEL S
805 US Highway 27 S
Cynthiana, KY 41031
(859) 234-9222

MOSES, STEPHEN A
430 E Pleasant St Ste 1
Cynthiana, KY 41031
(859) 234-3282

GENERAL PRACTICE

GAINEY MICHAEL SHANE
1210 KY Highway 36 E Ste 1A
Cynthiana, KY 41031
(859) 234-5555

GAINEY MICHAEL SHANE
439 E Pleasant St
Cynthiana, KY 41031
(859) 234-4494

GAINEY MICHAEL SHANE
805 US Highway 27 S
Cynthiana, KY 41031
(859) 234-9222

WRIGHT, ARDY C
430 E Pleasant St Ste 1
Cynthiana, KY 41031
(859) 234-3282

INTERNAL MEDICINE

BESSON, STEPHEN
1210 KY Highway 36 E Ste 2A
Cynthiana, KY 41031
(859) 289-6311

BESSON, STEPHEN
1210 KY Highway 36 E Unit 1
Cynthiana, KY 41031
(859) 235-3634

CALDER, JAMES O
1210 KY Highway 36 E Ste 2A
Cynthiana, KY 41031
(859) 289-6311

DANNEMAN, WILLIAM G
1210 KY Highway 36 E Unit 1
Cynthiana, KY 41031
(859) 234-1707

DANNEMAN, WILLIAM G
805 US Highway 27 S
Cynthiana, KY 41031
(859) 234-9222

LEWIS, DWIGHT E
1210 KY Highway 36 E Unit 1
Cynthiana, KY 41031
(859) 235-3634

MCKEMIE JR , WILLIAM F
1210 KY Highway 36 E Unit 1
Cynthiana, KY 41031
(859) 235-3634

HART

FAMILY MEDICINE

CLEMENTS, JAMES
950 Main St
Munfordville, KY 42765
(270) 524-1201

GHAFFAR, MUTEEB
117 W South St
Munfordville, KY 42765
(270) 524-7231

HEWITT, ALELEA
117 W South St
Munfordville, KY 42765
(270) 524-7231

JONES, SHERRY G
117 W South St
Munfordville, KY 42765
(270) 524-7231

MIDDLETON, JAMES W
117 W South St
Munfordville, KY 42765
(270) 524-7231

SHAH, FORAM A
207 E Main St
Horse Cave, KY 42749
(270) 786-2372

INTERNAL MEDICINE

CHANI, SWARANJIT K
1134 Main St
Munfordville, KY 42765
(719) 277-7545

CHANI, SWARANJIT K
1501 S Dixie St
Horse Cave, KY 42749
(270) 745-1100

CHANI, SWARANJIT K
207 E Main St
Horse Cave, KY 42749
(270) 786-2372

PANDEYA, VIRAG
950 Main St
Munfordville, KY 42765
(270) 524-1201

Primary Care Providers

PEDIATRICS

HEMMER, ANN M
117 W South St
Munfordville, KY 42765
(270) 524-7231

MIDDLETON EVELYN S
117 W South St
Munfordville, KY 42765
(270) 524-7231

HENDERSON

FAMILY MEDICINE

CHAPPELL, BRANDON A
1305 N Elm St
Henderson, KY 42420
(270) 827-7700

CHAPPELL, BRANDON A
471 Klutey Park Plaza Dr
Henderson, KY 42420
(270) 830-8032

CHAPPELL, BRANDON A
471 Letcher St
Henderson, KY 42420
(270) 831-7950

CHUMLEY, CHRISTINA C
110 2nd St
Henderson, KY 42420
(270) 827-7380

CHUMLEY, CHRISTINA C
2000 N Elm St Ste 1A
Henderson, KY 42420
(270) 869-0401

CHUMLEY, CHRISTINA C
471 Klutey Park Plaza Dr
Henderson, KY 42420
(270) 830-6100

CRUMP, WILLIAM J
472 Klutey Park Plaza Dr Ste B
Henderson, KY 42420
(270) 826-5522

FUTRELL, CHARLES H
1015 N Elm St
Henderson, KY 42420
(270) 826-8009

FUTRELL, CHARLES H
110 3rd St Ste 250
Henderson, KY 42420
(270) 826-0135

FUTRELL, CHARLES H
471 Klutey Park Plaza Dr
Henderson, KY 42420
(270) 830-6100

FUTRELL, CHARLES H
471 Letcher St
Henderson, KY 42420
(270) 831-7950

KANG SMITH , JUNG W
340 Starlite Dr
Henderson, KY 42420
(270) 844-8027

KHERA, AMNEET K
1997 Barrett Ct
Henderson, KY 42420
(270) 827-8662

KHERA, AMNEET K
471 Klutey Park Plaza Dr
Henderson, KY 42420
(270) 830-6100

KITCHENS, JOSHUA S
1413 N Elm St Ste 201
Henderson, KY 42420
(270) 827-8662

KITCHENS, JOSHUA S
471 Letcher St
Henderson, KY 42420
(270) 831-7950

LEE, JOHN R
1997 Barrett Ct
Henderson, KY 42420
(270) 827-8662

MADDOX, BRIAN C
110 2nd St
Henderson, KY 42420
(270) 827-7380

MADDOX, BRIAN C
1997 Barrett Ct
Henderson, KY 42420
(270) 827-8662

MADDOX, BRIAN C
411 Letcher St
Henderson, KY 42420
(270) 831-7950

MADDOX, BRIAN C
471 Klutey Park Plaza Dr
Henderson, KY 42420
(270) 830-8032

MCCLELLAN JR , JOHN W
1015 N Elm St
Henderson, KY 42420
(270) 826-8009

MOORE, PAUL E
110 3rd St Ste 250
Henderson, KY 42420
(270) 826-0135

MOORE, PAUL E
1305 N Elm St
Henderson, KY 42420
(270) 827-7700

MOORE, PAUL E
471 Klutey Park Plaza Dr
Henderson, KY 42420
(270) 830-6100

MOORE, PAUL E
471 Letcher St
Henderson, KY 42420
(270) 831-7950

MOSLEY, CASIE
1200 Barrett Blvd
Henderson, KY 42420
(270) 844-8600

MOSLEY, JONATHAN M
1200 Barrett Blvd
Henderson, KY 42420
(270) 844-8600

NEWBERRY, DENNIS
110 3rd St Ste 370
Henderson, KY 42420
(270) 869-8376

NEWBERRY, DENNIS
1305 N Elm St
Henderson, KY 42420
(270) 827-7700

NGUYEN, NHAN H
1015 N Elm St
Henderson, KY 42420
(270) 826-8009

NGUYEN, NHAN H
1305 N Elm St
Henderson, KY 42420
(270) 827-7700

PHELPS, NATHANIEL C
471 Letcher St
Henderson, KY 42420
(270) 831-7950

RIGHTMYER, GERALD R
1015 N Elm St
Henderson, KY 42420
(270) 826-8009

RIGHTMYER, GERALD R
319 8th St Ste 1
Henderson, KY 42420
(270) 827-5657

RIGHTMYER, GERALD R
471 Klutey Park Plaza Dr
Henderson, KY 42420
(270) 830-6100

SANDOVAL, ARMANDO C
1015 N Elm St
Henderson, KY 42420
(270) 826-8009

SANDOVAL, ARMANDO C
1413 N Elm St Ste 101
Henderson, KY 42420
(270) 827-9803

SHOCKLEY, ALBEN B
1200 Barrett Blvd
Henderson, KY 42420
(270) 844-8600

TACKETT, MARK A
1200 Barrett Blvd
Henderson, KY 42420
(270) 844-8600

WATKINS, DAVID A
1015 N Elm St
Henderson, KY 42420
(270) 826-8009

WELLINGTON, BRIAN D
1413 N Elm St Ste 106
Henderson, KY 42420
(270) 827-0064

WELLINGTON, BRIAN D
340 Starlite Dr
Henderson, KY 42420
(270) 844-8027

WILDER, THEARON P
1413 N Elm St Ste 201
Henderson, KY 42420
(270) 827-8662

WRIGHT, GARAH E
1015 N Elm St
Henderson, KY 42420
(270) 826-8009

WRIGHT, GARAH E
1413 N Elm St Ste 106
Henderson, KY 42420
(270) 827-0064

WRIGHT, GARAH E
340 Starlite Dr
Henderson, KY 42420
(270) 844-8027

INTERNAL MEDICINE

EKSTROM, KATHRYN M
340 Starlite Dr
Henderson, KY 42420
(270) 844-8027

HOPPER, REBECCA D
340 Starlite Dr
Henderson, KY 42420
(270) 844-8027

MADDELA, ZENAIDA A
1015 N Elm St
Henderson, KY 42420
(270) 826-8009

WATKINS, SCOTT A
1015 N Elm St
Henderson, KY 42420
(270) 826-8009

WATKINS, SCOTT A
1413 N Elm St Ste 106
Henderson, KY 42420
(270) 827-0064

WATKINS, SCOTT A
340 Starlite Dr
Henderson, KY 42420
(270) 844-8027

WHITE, WILLIAM A
340 Starlite Dr
Henderson, KY 42420
(270) 844-8027

YOUSEF, BASSAM
110 3rd St Ste 370A
Henderson, KY 42420
(270) 869-8376

PEDIATRICS

CRICK, LARRY GEORGE
110 3rd St Ste 180
Henderson, KY 42420
(270) 827-3573

CRICK, LARRY GEORGE
1305 N Elm St
Henderson, KY 42420
(270) 827-7700

ERVIN, ERIC D
110 3rd St Ste 180
Henderson, KY 42420
(270) 827-3573

FARMER, RACHEL E
1035 N Elm St
Henderson, KY 42420
(270) 827-4596

HENRY

FAMILY MEDICINE

DAVE, KAMLESH
151 E Broadway St Ste A
Eminence, KY 40019
(502) 593-0083

GARDNER, KENNETH A
150 Fairview Ct
Eminence, KY 40019
(502) 845-5672

JONES, DAVID A
150 Fairview Ct
Eminence, KY 40019
(502) 845-5672

LORENZO, JOSE T
75 Park Rd
New Castle, KY 40050
(502) 772-5034

SIDDIQUI, ARIFA
75 Park Rd
New Castle, KY 40050
(502) 772-5034

GENERAL PRACTICE

BRIONES, FE N
75 Park Rd
New Castle, KY 40050
(502) 772-5034

INTERNAL MEDICINE

MADDOX DAVID A
150 Fairview Ct
Eminence, KY 40019
(502) 845-5672

PEDIATRICS

ENRIQUEZ, MARIETTA E
75 Park Rd
New Castle, KY 40050
(502) 772-5034

HICKMAN

FAMILY MEDICINE

SMITH, BRUCE C
308 S Washington St Ste 200
Clinton, KY 42031
(270) 653-0220

GENERAL PRACTICE

BENIGNO, DAISY M
106 W Clay St
Clinton, KY 42031
(270) 653-6277

HOPKINS

FAMILY MEDICINE

ABOOD, ADEL A
200 Clinic Dr
Madisonville, KY 42431
(270) 825-6680

BERRY, RONALD A
444 S Main St
Madisonville, KY 42431
(270) 821-4444

BOWLES, JAMES M
800 Hospital Dr
Madisonville, KY 42431
(270) 326-4216

CRUMP, WILLIAM J
800 Hospital Dr
Madisonville, KY 42431
(270) 326-4216

DAUGHTERY, ALISSA H
510 Ruby Dr
Madisonville, KY 42431
(270) 399-7900

FAZENBAKER STACEY B
240 Ayer Pkwy
Madisonville, KY 42431
(270) 825-8345

FRALISH, BILL K
800 Hospital Dr
Madisonville, KY 42431
(270) 326-4216

FRALISH, BILL K
900 Hospital Dr
Madisonville, KY 42431
(270) 825-5100

GALLOWAY, ABRAHAM S
510 Ruby Dr
Madisonville, KY 42431
(270) 399-7900

GILKEY, SANDRA SUE
5758 Nortonville Rd
Nortonville, KY 42442
(270) 669-9028

HANKE, FORREST A
1756 E Center St
Madisonville, KY 42431
(270) 821-3300

HANKE, FORREST A
800 Hospital Dr
Madisonville, KY 42431
(270) 326-4216

HARGROVE, KENNETH R
800 Hospital Dr
Madisonville, KY 42431
(270) 326-4216

HARGROVE, KENNETH R
900 Hospital Dr
Madisonville, KY 42431
(270) 527-0000

HOLDER, JAMES ANTHONY
230 Madison Square Dr Ste C
Madisonville, KY 42431
(270) 821-6262

JEAN, SAMANTHA
200 Clinic Dr
Madisonville, KY 42431
(270) 825-6680

JOHNSON, BEVERLY C
444 S Main St
Madisonville, KY 42431
(270) 821-4444

JOHNSON, BEVERLY C
510 Ruby Dr
Madisonville, KY 42431
(270) 399-7900

Primary Care Providers

JONES, JAYNA R
2100 N Main St
Madisonville, KY 42431
(270) 927-8585

JONES, JAYNA R
230 Madison Square Dr Ste C
Madisonville, KY 42431
(270) 821-6262

JONES, KENT E
1756 E Center St
Madisonville, KY 42431
(270) 821-3300

JONES, KENT E
800 Hospital Dr
Madisonville, KY 42431
(270) 326-4216

JONES, MICHAEL B
230 Madison Square Dr Ste C
Madisonville, KY 42431
(270) 821-6262

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732 Highway 36
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(606) 768-2191

MURPHY, LOGAN
732 Highway 36
Frenchburg, KY 40322
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RUCKER, DREAMA D
732 Highway 36
Frenchburg, KY 40322
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GENERAL PRACTICE

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Primary Care Providers

MERCER

FAMILY MEDICINE

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CRASE, CHARLES E
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Harrodsburg, KY 40330
(859) 734-5770

DARTT, RICHARD M
106 Commercial Dr
Harrodsburg, KY 40330
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(859) 733-5864

FULLER, RENEE C
1509 Louisville Rd
Harrodsburg, KY 40330
(859) 734-5770

LORAH, JAY A
464 Linden Ave
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(859) 733-4817

MAIDEN, COURTNEY D
464 Linden Ave
Harrodsburg, KY 40330
(859) 239-2471

MAIDEN, COURTNEY D
466 Linden Ave Ste A
Harrodsburg, KY 40330

MAIDEN, COURTNEY D
470 Linden Ave Ste 5
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RICHARD, JOHN W
853 Lexington Rd
Harrodsburg, KY 40330
(513) 672-3300

STILTNER, LYNETTA L
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STILTNER, LYNETTA L
470 Linden Ave Ste 5
Harrodsburg, KY 40330
(859) 733-5864

WHELAN, JESSICA
464 Linden Ave
Harrodsburg, KY 40330
(859) 733-4817

GENERAL PRACTICE

MIRICH, RODNEY L
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Harrodsburg, KY 40330
(859) 734-5770

INTERNAL MEDICINE

GOODSTEIN, RICHARD S
464 Linden Ave
Harrodsburg, KY 40330
(859) 733-4817

SHAHZAD, MOHAMMAD F
464 Linden Ave
Harrodsburg, KY 40330
(859) 733-4817

PEDIATRICS

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464 Linden Ave
Harrodsburg, KY 40330
(859) 239-2471

JOHNSON, PAMELA
466 Linden Ave
Harrodsburg, KY 40330
(859) 734-5123

JOHNSON, PAMELA
466 Linden Ave Ste B
Harrodsburg, KY 40330
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JOHNSON, PAMELA
470 Linden Ave Ste 5
Harrodsburg, KY 40330
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METCALFE

FAMILY MEDICINE

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1701 W Stockton St
Edmonton, KY 42129
(270) 432-4800

MONROE

FAMILY MEDICINE

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415 Capp Harlan Rd
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(270) 487-9231

BEAN, JERRY NEAL
901 N Main St
Tompkinsville, KY 42167
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(270) 487-9231

CARTER, WILLIAM M
604 N Main St
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(270) 407-5150

CARTER, WILLIAM M
606 N Main St
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HUME, TIMOTHY DALE
710 N Main St
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AVULA, PRAVIN N
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(270) 725-4515

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102 Rhodes St
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415 Capp Harlan Rd
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529 Capp Harlan Rd
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(270) 725-4515

WEIDLER, DONALD JOHN
801 N Main St
Tompkinsville, KY 42167
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MONTGOMERY

FAMILY MEDICINE

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125 Foxglove Dr Ste D
Mount Sterling, KY 40353
(859) 498-3333

HUMPHREY, RONALD L
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Mount Sterling, KY 40353
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40 S Bank St
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(859) 498-2815

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RODDEN, ANN
227 Falcon Dr Ste G03
Mount Sterling, KY 40353
(859) 498-7345

RODDEN, ANN
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INTERNAL MEDICINE

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ROBERTS, LONNIE WILLIAM
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PEDIATRICS

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401 Commerce Cir
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MORGAN

FAMILY MEDICINE

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HOLT, DANIEL
476 Liberty Rd
West Liberty, KY 41472
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KELLER, KELLI
1084 Highway 7 Ste 2
West Liberty, KY 41472
(606) 743-3065

INTERNAL MEDICINE

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West Liberty, KY 41472
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SHAIKH, NADEEM A
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MUHLENBERG

FAMILY MEDICINE

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CHAPPELL, KRISTY L
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HOLT, TERRY DON
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PRUNTY, MARSHALL E
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SAXON, DAVID B
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ZELLER, STEVEN ROBERT
480 Hopkinsville St
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(207) 338-5777

ZELLER, STEVEN ROBERT
504 Hopkinsville St
Greenville, KY 42345
(270) 338-6488

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BRASHEAR, JAMES S
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Central City, KY 42330
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LEWIS, BRACKEN C
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(270) 377-2626

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(207) 338-5777

DAVIS, DEANDRA D
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(270) 338-6488

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504 Hopkinsville St
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(270) 338-6488

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WHITTEN-HOSKINS, ELIZA J
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Greenville, KY 42345
(270) 338-6488

NELSON

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(844) 435-0900

CORNELIUS, JESSICA M
130 Wilson Creek Rd
Boston, KY 40107
(844) 435-0900

CORNELIUS, JESSICA M
260 Arnold Ln
Bloomfield, KY 40008
(844) 435-0900

CORNELIUS, JESSICA M
489 High St
New Haven, KY 40051
(844) 435-0900

SOSNIN JR, BARRY B
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INTERNAL MEDICINE

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PEDIATRICS

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KHOURY, HABIB MICHAEL
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(502) 349-6641

SAIFULLAH, YASIR
118 Patriot Dr Ste 204
Bardstown, KY 40004
(502) 337-6125

NICHOLAS

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Carlisle, KY 40311
(502) 868-5617

COOPER, GEOFFREY J
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MOORE, NATHAN L
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(502) 868-5617

PRESTON, HENRY R
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Carlisle, KY 40311
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YOUNG, CHESTER RAY
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Carlisle, KY 40311
(502) 868-5617

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VILLAFLOR, OSIAS M
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INTERNAL MEDICINE

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(859) 289-6311

CALDER, JAMES O
245 East Main St
Carlisle, KY 40311
(859) 289-6311

MCKEMIE JR , WILLIAM F
254 E Main St
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(859) 289-6311

OHIO

FAMILY MEDICINE

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Beaver Dam, KY 42320
(270) 274-4771

DURHAM, BRUCE
1211 Old Main St
Hartford, KY 42347
(270) 298-7411

DURHAM, BRUCE
20 E McMurtry Ave
Hartford, KY 42347
(270) 298-5404

GARRETT, HEATHER N
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LUCENO, GILBERT R
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(270) 298-7411

LUCENO, GILBERT R
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(270) 298-5404

MILLS, STEVEN R
1215 Old Main St
Hartford, KY 42347
(270) 298-5404

MILLS, STEVEN R
1313 N Main St
Beaver Dam, KY 42320
(270) 504-1300

MILLS, STEVEN R
44 W Main St
Fordsville, KY 42343
(270) 276-9953

MIRANDA, CHRISTEL D
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(270) 298-7411

MIRANDA, CHRISTEL D
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Hartford, KY 42347
(270) 298-5404

MIRANDA, CHRISTEL D
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Fordsville, KY 42343
(270) 276-9953

MUTCHLER, BRADFORD E
1219 N Main St Ste 101
Beaver Dam, KY 42320
(270) 274-0638

ROWLAND, ANDERSON R
20 E McMurtry Ave
Hartford, KY 42347
(270) 298-5404

WONG, CHARLES W
20 E McMurtry Ave
Hartford, KY 42347
(270) 298-5404

GENERAL PRACTICE

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(270) 298-5404

GREGORY, DONALD K
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1215 Old Main St
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(270) 298-5404

WESTERFIELD PHELPS, BAILEY
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Beaver Dam, KY 42320
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INTERNAL MEDICINE

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Hartford, KY 42347
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OLDHAM

FAMILY MEDICINE

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CHUBINIDZE, OMARI
1306 Old Taylor Trl
Goshen, KY 40026
(502) 244-5252

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La Grange, KY 40031
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GIBSON, RICHARD J
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(502) 241-8611

GILBERTS, ALLISON B
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(502) 225-6920

GOURIEUX, ERIC D
1230 Market St Ste B
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(502) 225-6920

HAQUE, AHRAR
1230 Market St Ste B
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(502) 225-6920

JOLLY, STEPHANIE
1230 Market St Ste B
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(502) 225-6920

PATTON, STEVEN
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(502) 225-6920

TREESE, DAVID T
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(502) 225-6900

TUCKER, ALISON A
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(502) 225-6900

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ZAHORIK, KARI J
1230 Market St Ste B
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GENERAL PRACTICE

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INTERNAL MEDICINE

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JETT, KATHERINE H
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PEDIATRICS

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(502) 225-6920

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(502) 225-6920

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(502) 394-6555

NESSLE, CHARLES N
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(502) 394-6555

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(502) 225-6900

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(502) 225-6920

OWEN

FAMILY MEDICINE

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(859) 655-6100

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GENERAL PRACTICE

MARTIN, ELMER
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(859) 655-6100

PEDIATRICS

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(859) 567-1591

PENDLETON

FAMILY MEDICINE

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Butler, KY 41006
(859) 654-2283

OSBORNE LEWIS , REBECCA L
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(859) 654-2283

SCHACK, BRIAN W
79 Country Club Dr
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(859) 654-2283

SHARP II, THOMAS L
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(859) 654-2283

PERRY

FAMILY MEDICINE

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750 Morton Blvd
Hazard, KY 41701
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CHANEY, GEORGE R
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Hazard, KY 41701
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Hazard, KY 41701
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Hazard, KY 41701
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KINGERY, JOSEPH EAGLE
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Hazard, KY 41701
(606) 439-1559

KUDRIMOTI, ARCHANA M
750 Morton Blvd
Hazard, KY 41701
(606) 439-1559

MARSHALL, KASSI M
115 Rockwood Ln
Hazard, KY 41701
(606) 436-5761

MUHA, BRETT
210 Black Gold Blvd
Hazard, KY 41701
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SIKORSKA, MIROSLAWA E
222 Medical Cir
Morehead, KY 40351
(606) 783-6524

SIKORSKA, MIROSLAWA E
234 Medical Cir Ste 1
Morehead, KY 40351
(606) 780-5330

SIKORSKA, MIROSLAWA E
316 W 2nd St
Morehead, KY 40351
(606) 784-3771

RUSSELL

FAMILY MEDICINE

COOPER, LEANN D
124 Dowell Rd
Russell Springs, KY 42642
(270) 866-2440

COOPER, LEANN D
153 Dowell Rd
Russell Springs, KY 42642
(270) 866-4141

GIBSON, MILES K
153 Dowell Rd
Russell Springs, KY 42642
(270) 866-2440

GIBSON, MILES K
92 J T Pettey Dr Ste 600
Russell Springs, KY 42642
(270) 866-7066

HURLEY, JONAS N
153 Dowell Rd
Russell Springs, KY 42642
(270) 866-2440

JONES, STEPHANIE R
153 Dowell Rd
Russell Springs, KY 42642
(270) 866-2440

KILGALLIN, JOHN D
153 Dowell Rd
Russell Springs, KY 42642
(270) 866-2440

KITECK, CLINTON S
2465 Lakeway Dr
Russell Springs, KY 42642
(270) 858-3636

INTERNAL MEDICINE

BERTRAM JR , ROBERT L
153 Dowell Rd
Russell Springs, KY 42642
(270) 866-2440

BERTRAM JR , ROBERT L
92 Joe T Petty Dr Ste 400
Russell Springs, KY 42642
(859) 901-0012

DOLEN, STEFANIE T
124 Dowell Rd Ste 103
Russell Springs, KY 42642
(270) 866-3161

PEDIATRICS

VON GRUENIGEN, HOLLY D
404 Steve Dr
Russell Springs, KY 42642
(270) 866-3161

SCOTT

FAMILY MEDICINE

CRAIG CEDRIC
3501 Main St
Stamping Ground, KY 40379
(502) 535-5686

DAVIS, WILLIAM S
205 Champion Way
Georgetown, KY 40324
(502) 570-2725

FOWLES, THOMAS
111 Osbourne Way Ste 1
Georgetown, KY 40324
(502) 570-0007

GAGNON, DAVID PHILIP
205 Champion Way
Georgetown, KY 40324
(502) 570-2725

LANE, AMANDA E
1138 Lexington Rd Ste 130
Georgetown, KY 40324
(502) 867-0222

LANE, AMANDA E
1502 Oxford Dr Ste 100
Georgetown, KY 40324
(502) 570-3875

PRESTON, HENRY R
1502 Oxford Dr Ste 100
Georgetown, KY 40324
(502) 868-5617

RABIEE, ABDOLREZA
111 Osbourne Way Ste 1
Georgetown, KY 40324
(502) 570-0007

RAO, PADMA G
1150 Lexington Rd Ste 102
Georgetown, KY 40324
(502) 863-4485

REINHART, TODD D
1138 Lexington Rd Ste 130
Georgetown, KY 40324
(615) 415-8048

REINHART, TODD D
1138 Lexington Rd Ste 230
Georgetown, KY 40324
(502) 867-0222

REINHART, TODD D
1502 Oxford Dr Ste 100
Georgetown, KY 40324
(502) 868-5617

SODA, NAWAR
111 Osbourne Way Ste 1
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(502) 570-0007

WECHMAN, RAYMOND
1138 Lexington Rd Ste 130
Georgetown, KY 40324
(615) 415-8048

WECHMAN, RAYMOND
1502 Oxford Dr Ste 100
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(502) 868-5617

YOUNG, YAVARACE
205 Champion Way Ste 10
Georgetown, KY 40324
(502) 570-2725

ZIBELL, SCOTT H
205 Champion Way
Georgetown, KY 40324
(502) 570-2725

INTERNAL MEDICINE

BALBAUGH, ANDREW P
1138 Lexington Rd Ste 230
Georgetown, KY 40324
(502) 867-0222

BIRDWHISTELL, MATTHEW C
1138 Lexington Rd Ste 290
Georgetown, KY 40324
(502) 863-0721

JOHNSON, ERIN Y
1138 Lexington Rd Ste 230
Georgetown, KY 40324
(502) 867-0222

TAYLOR, KENT EDWARD
1140 Lexington Rd Ste 105
Georgetown, KY 40324
(502) 868-5617

TAYLOR, KENT EDWARD
1140 Lexington Rd Ste 202
Georgetown, KY 40324
(502) 868-5603

PEDIATRICS

ANGLIN, CAITLYN R
1162 Lexington Rd
Georgetown, KY 40324
(502) 863-6426

HAMBRICK, HORACE
1162 Lexington Rd
Georgetown, KY 40324
(502) 863-6426

OLIVER, JENNIFER S
1162 Lexington Rd
Georgetown, KY 40324
(502) 863-6426

QUACKENBUSH, ANN NICOLE
1162 Lexington Rd
Georgetown, KY 40324
(502) 863-6426

RIEBEL, JENNIFER S
1162 Lexington Rd
Georgetown, KY 40324
(502) 863-6426

SIMON MICHAEL W
205 Champion Way
Georgetown, KY 40324
(502) 570-2725

SWEIGART, LACEY B
1162 Lexington Rd
Georgetown, KY 40324
(502) 863-6426

YARBRO, MARINA T
205 Champion Way Ste 10
Georgetown, KY 40324
(502) 570-2725

SHELBY

FAMILY MEDICINE

ALLEN, LETICIA K
60 Mack Walters Rd
Shelbyville, KY 40065
(502) 633-4622

BETZ, DONNA L
130 Stonecrest Rd Ste 106
Shelbyville, KY 40065
(502) 647-1000

EMERIC, EDGAR
101 Stonecrest Rd Ste 1
Shelbyville, KY 40065
(502) 633-2233

GARDNER, KENNETH A
515 Hospital Dr Ste 1
Shelbyville, KY 40065
(502) 633-3525

GIBSON, RICHARD J
150 Frankfort Rd Ste 103
Shelbyville, KY 40065
(502) 844-2888

JONES, DAVID A
515 Hospital Dr Ste 1
Shelbyville, KY 40065
(502) 633-3525

KASARANENI, YAMUNA
101 Stonecrest Rd Ste 1
Shelbyville, KY 40065
(502) 633-2233

KEHRER, MEREDITH LEA
130 Stonecrest Rd Ste 106
Shelbyville, KY 40065
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MASSEY, BROOK THOMAS
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Shelbyville, KY 40065
(502) 633-2233

SMITH, JAMES R
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(502) 633-3525

WALDRIDGE II, RONALD EDWIN
60 Mack Walters Rd
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(502) 633-4622

WALLACE, DAVID WAYNE
515 Hospital Dr Ste 1
Shelbyville, KY 40065
(502) 633-3525

GENERAL PRACTICE

SAMES, EDWARD L
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INTERNAL MEDICINE

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PEDIATRICS

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30 Main St
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(502) 226-3937

GRIFFITH, CHARLES HENRY
77 Mack Walters Rd Ste 300
Shelbyville, KY 40065
(502) 226-3937

HAWKINS, SARAH
150 Frankfort Rd Ste 101
Shelbyville, KY 40065
(502) 647-5468

IRWIN, MEREDITH K
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Shelbyville, KY 40065
(502) 647-5468

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720 Hospital Dr Ste 2
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(502) 647-5468

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Shelbyville, KY 40065
(502) 647-5468

NEEL, DONALD R
150 Frankfort Rd Ste 101
Shelbyville, KY 40065
(502) 647-5468

NESSLE, CHARLES N
150 Frankfort Rd Ste 101
Shelbyville, KY 40065
(502) 647-5468

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71 Mack Walters Rd
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SOTIROPOULOS, CHRISTINA M
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SIMPSON

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ADAMS JOHN V
119 Memorial Dr
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BHATT, OMKAR N
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(270) 781-6477

BROOKS, LINDSEY KAY
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(270) 781-6477

CLEMENTS, JAMES
1112 S Main St
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(270) 586-1969

Primary Care Providers

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121 Memorial Dr
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(270) 482-0101

CLEMENTS, JAMES
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(270) 781-6477

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FRASER, AMBREEN
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(270) 781-6477

GEARLDS, AMY
1112 S Main St
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(270) 586-1969

GRACE, MEDHAT
1112 S Main St
Franklin, KY 42134
(270) 586-1969

HARRIGAN, WILLIAM
1112 S Main St
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(270) 586-1969

HARRIGAN, WILLIAM
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LOSEKAMP, CRAIG A
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(270) 781-6477

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(270) 781-5111

REDDY, KARUNA G
1100 Brookhaven Rd Ste 103
Franklin, KY 42134
(270) 598-9595

REDDY, KARUNA G
1112 S Main St
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(270) 586-1969

REDDY, KARUNA G
208 S Main St
Franklin, KY 42134
(270) 781-6477

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1020 S Main St
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RUBEEN, SHAFIA
1030 Brookhaven Rd
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(270) 745-1467

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WESLEY, ROBERT T
208 S Main St
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208 S Main St
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GENERAL PRACTICE

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(270) 598-4949

PERSAD, SAM
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Franklin, KY 42134
(270) 586-7053

RIBEYRE, RICHARD P
1100 Brookhaven Rd
Franklin, KY 42134
(270) 598-4800

INTERNAL MEDICINE

AVULA, PRAVIN N
208 S Main St
Franklin, KY 42134
(270) 781-6477

GOVER, JOHN D
1112 S Main St
Franklin, KY 42134
(270) 586-1969

HANSBROUGH , JAMES R
1112 S Main St
Franklin, KY 42134
(270) 586-1969

HENDRIX, WAYNE
1112 S Main St
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(270) 586-1969

HENDRIX, WAYNE
208 S Main St
Franklin, KY 42134
(270) 781-6477

PANDEYA, VIRAG
1112 S Main St
Franklin, KY 42134
(270) 586-1969

SPENCER

FAMILY MEDICINE

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311 Reasor Ave
Taylorsville, KY 40071
(502) 744-4401

MOISE, FRITZ
311 Reasor Ave
Taylorsville, KY 40071
(502) 477-9356

SIDDIQUI, ARIFA
311 Reasor Ave
Taylorsville, KY 40071
(502) 744-4401

WELLS, MICHAEL
870 Taylorsville Rd
Taylorsville, KY 40071
(502) 477-8888

GENERAL PRACTICE

BRIONES, FE N
311 Reasor Ave
Taylorsville, KY 40071
(502) 477-9356

INTERNAL MEDICINE

NARCISSE, CRYSTAL D
311 Reasor Ave
Taylorsville, KY 40071
(502) 477-9356

PEDIATRICS

ENRIQUEZ, MARIETTA E
311 Reasor Ave
Taylorsville, KY 40071
(502) 744-4401

TAYLOR

FAMILY MEDICINE

BROOKS, BOBBY J
127 Kingswood Dr
Campbellsville, KY 42718
(270) 403-8385

DIXON, JEROME A
150 W Bear Track Rd
Campbellsville, KY 42718
(270) 465-8133

FROGGE, KELLEE D
67 Kingswood Dr
Campbellsville, KY 42718
(270) 849-2379

GRAVES, KEVIN A
150 W Bear Track Rd
Campbellsville, KY 42718
(270) 465-8133

SEELEY, MARTHA L
67 Kingswood Dr
Campbellsville, KY 42718
(270) 849-2379

STEPHENS CASSANDRA
1003 Greensburg Rd
Campbellsville, KY 42718
(270) 465-0060

SZTENDERA, LORA D
407 E 1st St
Campbellsville, KY 42718
(270) 465-4841

TUCKER, SUMMER R
105 Greenbriar Dr Ste B
Campbellsville, KY 42718
(270) 465-0191

TUCKER, SUMMER R
125 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

TUCKER, SUMMER R
150 W Bear Track Rd
Campbellsville, KY 42718
(270) 465-8133

GENERAL PRACTICE

FELTNER, WILLIAM D
1866 Old Lebanon Rd
Campbellsville, KY 42718
(270) 465-3588

INTERNAL MEDICINE

EADE JOEL D
1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-6116

EADE JOEL D
67 Kingswood Dr
Campbellsville, KY 42718
(270) 465-2116

HINTON, STEPHEN S
1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-6116

NELSON, TROY M
150 W Bear Track Rd
Campbellsville, KY 42718
(270) 465-8133

SMITH, WILLIAM
67 Kingswood Dr
Campbellsville, KY 42718
(270) 849-2379

PEDIATRICS

ARNOLD, DANIEL M
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

BAUM, CRAIG S
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

BODEANU, DAN GEORGE
307 E Broadway St
Campbellsville, KY 42718
(270) 789-4788

BROTHERS, KYLE BERTRAM
1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-1112

DAUK, KELLY L
1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-1112

FELTON, HEATHER M
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

GREWAL HARINDER S
101 W Bear Track Rd
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(270) 849-2488

GRIFFIN, SARAH JEANNE
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

HANCOCK, MELISSA SUBLETT
1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-1112

HAVLIN, KEVIN M
73 Kingswood Dr
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(270) 789-1112

HESSON, DAVID
111 Kingswood Dr
Campbellsville, KY 42718
(270) 789-5822

HESSON, DAVID
125 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

HESSON, DAVID
2705 Hodgenville Rd
Campbellsville, KY 42718
(270) 849-5731

HESSON, DAVID
300 Ingram Ave
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(270) 849-3656

HESSON, DAVID
522 N Hoskins Ave
Campbellsville, KY 42718
(270) 849-2379

HESSON, DAVID
67 Kingswood Dr
Campbellsville, KY 42718
(270) 465-2116

HESSON, DAVID
95 Kingswood Dr
Campbellsville, KY 42718
(270) 789-3812

HONAKER, JOSHUA T
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

JONES, VERONNIE FAYE
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

KRAUSE, ANDREA LYNN
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KURBASIC, MIRZADA PASIC
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Campbellsville, KY 42718
(270) 789-1112

MARTIN, ELAINE DRAKE
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(270) 789-1112

MARTIN, MATTHEW S
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(270) 789-1112

MARTIN, MATTHEW S
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(270) 465-2116

MITCHELL, JULIA L
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

MORRIS, MARIAN E
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

NOTA, MARIA F
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

PATEL, PRADIP D
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(270) 789-1112

PENDLETON, AMBER L
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

Primary Care Providers

PFITZER, LISA JOAN
73 Kingswood Dr
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(270) 789-1112

PURCELL, KENDALL E
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

SAYAT, JONATHAN G
73 Kingswood Dr
Campbellsville, KY 42718
(270) 789-1112

SCHOLTZ, ANA L
1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-1112

SCHWENK, KLINT M
1700 Old Lebanon Rd
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(270) 789-1112

STIFF, JENNIFER H
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(270) 789-1112

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1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-1112

TAULBEE, REBECCA L
1700 Old Lebanon Rd
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(270) 789-1112

THERIOT, JUDITH ANN
1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-1112

THOMPSON, JENNIFER E
1700 Old Lebanon Rd
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(270) 789-1112

WASSER, LAWRENCE JAY
1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-1112

ZAFAR, NAGMA
1700 Old Lebanon Rd
Campbellsville, KY 42718
(270) 789-1112

TODD

FAMILY MEDICINE

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10220 Dixie Beeline Hwy
Guthrie, KY 42234
(270) 483-2525

GRABENSTEIN, THOMAS G
810 S Main St
Elkton, KY 42220
(270) 265-5600

JOHNSON, BEVERLY C
10220 Dixie Beeline Hwy
Guthrie, KY 42234
(270) 220-0340

INTERNAL MEDICINE

MAJMUDAR, MANOJ H
713 W Main St
Elkton, KY 42220
(270) 265-5353

SHAH, PRAKASH N
207 E Main St
Elkton, KY 42220
(270) 265-2574

TRIGG

FAMILY MEDICINE

ANDERSON WILLIAM B
245 Main St
Cadiz, KY 42211
(270) 522-6634

BRAZIL, JAMES A
250 Main St Ste B
Cadiz, KY 42211
(270) 522-3444

GODWIN, SHEA A
250 Main St Ste D
Cadiz, KY 42211
(270) 522-6963

INTERNAL MEDICINE

CHRISTOPHER JULIE C
254 Main St
Cadiz, KY 42211
(270) 522-0898

UNION

FAMILY MEDICINE

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4604 US Highway 60 W
Morganfield, KY 42437
(270) 389-5000

CLAPP, WILLIAM H
1284 US Highway 60 W
Morganfield, KY 42437
(270) 389-2323

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Morganfield, KY 42437
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ROOF, MICHAEL A
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WALLACE, DEBRA J
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WARREN

FAMILY MEDICINE

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ADAMS JOHN V
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(270) 843-3376

ALLEN, JOSEPH RICHARD
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BALE, PHILLIP WICKENDEN
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1225 Fairway St
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(270) 781-3910

BELILES, CHASE A
201 Park St
Bowling Green, KY 42101
(270) 782-4260

BELILES, CHASE A
2724 Nashville Rd
Bowling Green, KY 42101
(270) 780-0560

BELILES, CHASE A
5575 Scottsville Rd
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(270) 781-6477

BELILES, CHASE A
5796 Nashville Rd
Bowling Green, KY 42101
(270) 781-6477

BELILES, CHASE A
990 Wilkinson Trce
Bowling Green, KY 42103
(270) 781-4043

BENNETT, ASHLEY JILL
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(270) 782-4260

BHATT, OMKAR N
201 Park St
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(270) 782-4260

BHATT, OMKAR N
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(270) 781-6477

BHATT, OMKAR N
5796 Nashville Rd
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BROOKS, LINDSEY KAY
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BROOKS, LINDSEY KAY
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(270) 781-3910

CLEMENTS, JAMES
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(270) 781-5111

CLEMENTS, JAMES
1402 Andrea St
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(270) 781-0167

CLEMENTS, JAMES
1681 Normal Dr
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(270) 745-2273

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201 Park St
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(270) 843-3376

CLEMENTS, JAMES
2724 Nashville Rd
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CLEMENTS, JAMES
350 Park St
Bowling Green, KY 42101
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CLEMENTS, JAMES
5575 Scottsville Rd
Bowling Green, KY 42104
(270) 781-6477

CLEMENTS, JAMES
5796 Nashville Rd
Bowling Green, KY 42101
(270) 781-6477

CLEMENTS, JAMES
990 Wilkinson Trce
Bowling Green, KY 42103
(270) 781-4043

DEW, KEVIN D
2508 Scottsville Rd Ste 104
Bowling Green, KY 42104
(815) 713-2600

DOUGLAS, JAMES T
1777 Ashley Cir
Bowling Green, KY 42104
(270) 651-4797

FRASER, AMBREEN
5575 Scottsville Rd
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(270) 781-6477

FRASER, AMBREEN
5796 Nashville Rd
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(270) 781-6477

GEARLDS, AMY
1225 Fairway St
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(270) 781-3910

GEARLDS, AMY
1681 Normal Dr
Bowling Green, KY 42101
(270) 781-5111

GEARLDS, AMY
201 Park St
Bowling Green, KY 42101
(270) 782-4260

GEARLDS, AMY
201 Park St Ste 20A
Bowling Green, KY 42101
(270) 781-4043

GEARLDS, AMY
2724 Nashville Rd
Bowling Green, KY 42101
(270) 781-3910

GIBSON, JANE C
201 Park St
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(270) 843-3376

GIBSON, JANE C
350 Park St
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(270) 781-5111

GILLIAM, KATHERINE H
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GRAY, JENNIFER
225 Natchez Trace Ave
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(270) 783-3573

GRAY, JENNIFER
615 7th Ave
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(270) 783-3573

GRAY, JENNIFER
825 4th Ave
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HARRIGAN, WILLIAM
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HARRIGAN, WILLIAM
5575 Scottsville Rd
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(270) 781-6477

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HARRIS, FRANK R
201 Park St
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HARRIS, FRANK R
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Bowling Green, KY 42101
(270) 781-4043

LANG, MICHAEL
250 Park St
Bowling Green, KY 42101
(270) 745-1000

LANG, MICHAEL
291 New Towne Rd
Bowling Green, KY 42103
(270) 796-3500

LOSEKAMP, CRAIG A
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LOSEKAMP, CRAIG A
5575 Scottsville Rd
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(270) 781-6477

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(270) 781-3910

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MANION, KENNY J
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MASTRONARDI, DIEGO G
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(270) 782-4260

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Primary Care Providers

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(270) 781-6477

NAPIER, DAVID CRAIG
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5796 Nashville Rd
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(270) 781-6477

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PURVIS, JEFFREY
5796 Nashville Rd
Bowling Green, KY 42101
(270) 781-6477

RAPP, JESSICA M
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(270) 781-6477

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(270) 745-1000

RUBEEN, SHAFIA
291 New Towne Rd
Bowling Green, KY 42103
(270) 796-3500

STILTNER, LYNETTA L
1777 Ashley Cir
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(270) 781-4090

UDDIN, FAIZ M
2435 Nashville Rd Ste 109
Bowling Green, KY 42101
(270) 745-1100

WESLEY, ROBERT T
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5575 Scottsville Rd
Bowling Green, KY 42104
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WESLEY, ROBERT T
5796 Nashville Rd
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(270) 746-9400

EMBRY III, KENNETH E
165 Natchez Trace Ave Ste 205
Bowling Green, KY 42103
(270) 282-2024

ENGLAND-WRIGHT, LORI A
225 Natchez Trace Ave
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(270) 783-3573

ENGLAND-WRIGHT, LORI A
825 4th Ave
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(270) 526-2145

HALL, MICHAEL P
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(270) 781-4090

HSIEH, STANLEY H Y
1402 Andrea St
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(270) 781-0167

TURNER, CHARLES A
201 Park St
Bowling Green, KY 42101
(270) 843-3376

INTERNAL MEDICINE

ABDUL'WAHEED, MOHAMMAD A
825 2nd Ave Ste B1
Bowling Green, KY 42101
(270) 782-0151

ALVAREZ-PICHARDO ELAINE MABEL
291 New Towne Rd
Bowling Green, KY 42103
(270) 796-3500

ALVAREZ-PICHARDO ELAINE MABEL
825 2nd Ave Ste B3
Bowling Green, KY 42101
(270) 901-0629

AVULA, PRAVIN N
201 Park St
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(270) 782-4260

AVULA, PRAVIN N
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(270) 781-6477

AVULA, PRAVIN N
5796 Nashville Rd
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(270) 781-6477

CHHABRA, SHALINI
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Bowling Green, KY 42101
(270) 782-4260

DESAI, RIMA
291 New Towne Rd
Bowling Green, KY 42103
(270) 796-3500

DUNHAM, GEORGE T
615 7th Ave
Bowling Green, KY 42101
(270) 783-3573

GOVER, JOHN D
201 Park St
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(270) 843-3376

HENDRIX, WAYNE
201 Park St
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(270) 782-4260

HENDRIX, WAYNE
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(270) 781-6477

HENDRIX, WAYNE
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(270) 781-6477

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(270) 781-0167

HSIEH, ANSON
201 Park St
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JAIN, MANISHA
427 US 31W Bypass
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(270) 796-8800

JARVIS, JAMES O
1777 Ashley Cir
Bowling Green, KY 42104
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KAUL, SANJAY
291 New Towne Rd
Bowling Green, KY 42103
(270) 796-3500

KELLY KEVIN M
1777 Ashley Cir
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KESRI, SAM R
5993 Scottsville Rd
Bowling Green, KY 42104
(270) 842-5850

KHOUKAZ, MAYA K
291 New Towne Rd
Bowling Green, KY 42103
(270) 796-3500

KHOUKAZ, MAYA K
825 2nd Ave Ste B3
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(270) 901-0629

KNIERY PAUL A
615 7th Ave
Bowling Green, KY 42101
(270) 846-4800

LONG, TIMOTHY R
1801 Ashley Cir Ste 535
Bowling Green, KY 42104
(270) 793-3357

MAYFIELD, SARAH AUGUSTA
615 7th Ave
Bowling Green, KY 42101
(270) 846-4800

PANDEYA, VIRAG
201 Park St
Bowling Green, KY 42101
(270) 782-4260

QADIR, AHMED S
250 Park St Ste 6B
Bowling Green, KY 42101
(270) 745-1467

SAHETYA, GUL K
427 US 31W Byp
Bowling Green, KY 42101
(270) 796-8800

SAHETYA, KALIDAS G
427 US 31W Bypass
Bowling Green, KY 42101
(270) 796-8800

SCHWENDER, FRANK T
825 2nd Ave Ste B1
Bowling Green, KY 42101
(270) 782-0151

SINGH, KAMAL P
201 Park St
Bowling Green, KY 42101
(270) 782-4260

SINGH, KUSHAL P
201 Park St
Bowling Green, KY 42101
(270) 782-4260

SUN, HUIFANG FAITH
201 Park St
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(270) 782-4260

SUN, HUIFANG FAITH
990 Wilkinson Trce
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(270) 781-4043

TRAVIS, WILLIAM J
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Bowling Green, KY 42101
(270) 782-4260

WELCH, RICHARD D
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PEDIATRICS

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(270) 782-8700

BITTERLING, JEFFREY L
201 Park St
Bowling Green, KY 42101
(270) 782-4260

BLACKERBY, JEFFRIES L
1211 Ashley Cir
Bowling Green, KY 42104
(270) 782-8700

CHERRY, TIFFANI M
201 Park St
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(270) 843-3376

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2724 Nashville Rd
Bowling Green, KY 42101
(270) 781-3910

FRASER, ZAHID G
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(270) 782-8700

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201 Park St
Bowling Green, KY 42101
(270) 782-4260

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(270) 783-3573

HARRELL, WILLIAM B
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Bowling Green, KY 42101
(270) 783-3573

HARRELL, WILLIAM B
825 4th Ave
Bowling Green, KY 42101
(270) 526-2145

KRIES KELLY E
615 7th Ave
Bowling Green, KY 42101
(270) 846-4800

MILES, CASEY L
615 7th Ave
Bowling Green, KY 42101
(270) 846-4800

SHEKAR, SUMAN
291 New Towne Rd
Bowling Green, KY 42103
(270) 796-3500

SHEKAR, SUMAN
825 2nd Ave Ste B3
Bowling Green, KY 42101
(270) 901-0629

SMITH, JOHN
1211 Ashley Cir
Bowling Green, KY 42104
(270) 782-8700

SMITH, JOHN C
1211 Ashley Cir
Bowling Green, KY 42104
(270) 782-8700

SMITH, JOHN C
201 Park St
Bowling Green, KY 42101
(270) 782-4260

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VOAKES, JOHN E
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Primary Care Providers

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(270) 783-3573

WITCHER, LORI D
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(270) 783-3573

WITCHER, LORI D
825 4th Ave
Bowling Green, KY 42101
(270) 526-2145

WASHINGTON

FAMILY MEDICINE

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280 Lincoln Dr
Springfield, KY 40069
(859) 336-9801

FULLER, RENEE C
280 Lincoln Dr
Springfield, KY 40069
(859) 336-9801

SPALDING, STEFANIE
79 Bobolink Dr
Springfield, KY 40069
(859) 366-0771

STAFFORD, WILLIAM C
280 Lincoln Dr
Springfield, KY 40069
(859) 336-9801

TAYLOR, DAWN C
445 Lincoln Dr
Springfield, KY 40069
(859) 336-7731

WELLS, BRIAN F
101 W Grundy Ave
Springfield, KY 40069
(615) 516-3283

INTERNAL MEDICINE

BROWN, JULIA KEELING
219 W Main St
Springfield, KY 40069
(859) 336-7795

HADDAD, IMAD A
805 Bardstown Rd Ste 12
Springfield, KY 40069
(859) 481-7113

KIRK III , WILLIAM D
79 Bobolink Dr
Springfield, KY 40069
(859) 336-3365

WAYNE

FAMILY MEDICINE

CORNELIUS, JESSICA M
1080 S Main St
Monticello, KY 42633
(270) 858-6644

EATON, MATTHEW T
1 S Creek Dr Ste 102
Monticello, KY 42633
(606) 348-3365

JONES, SHERRY G
160 Cave St
Monticello, KY 42633
(270) 858-6644

SEXTON, SHAWNA M
166 Hospital St
Monticello, KY 42633
(606) 348-9343

INTERNAL MEDICINE

BROWN, JOSEPH CLAY
1215 N Main St Ste 2
Monticello, KY 42633
(606) 348-3365

WEBSTER

FAMILY MEDICINE

COLE, KELLY L
1355 US Highway 41A S
Dixon, KY 42409
(270) 631-2412

CRUMP, WILLIAM J
215 E Main St
Providence, KY 42450
(270) 667-7017

CRUMP, WILLIAM J
9086 State Route 132 W
Clay, KY 42404
(270) 664-2526

LINBERRY, TRISTAN K
215 E Main St
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(270) 667-7017

WHITLEY

FAMILY MEDICINE

ASHBURN, WILLIAM T
140 Bryan Blvd
Corbin, KY 40701
(606) 523-2005

BAILEY SR , RICHARD W
686 S Highway 25 W
Williamsburg, KY 40769
(606) 549-5052

BIRD, RUSSELL J
1 Trillium Way
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CARTER, RICHARD A
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COONEY, PAUL A
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COOPER, ROBERT
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(800) 986-2186

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15139 N US 25 E
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(606) 280-7772

DEVERS, DUSTIN
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14949 N US Highway 25 E Ste 4
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(502) 253-4900

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(606) 526-8122

JAMES, SEAN W
14949 N US Highway 25 E Ste 4
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(606) 528-0305

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LEWIS, JONATHAN A
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(606) 528-5527

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ONG, FRANCIS B
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PERRY, KELVIN D
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Corbin, KY 40701
(606) 528-0848

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121 Bishop St
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(606) 528-2124

PERRY, TRUMAN
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THOMAS, TOSHA N
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DURHAM, WILLIAM R
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(606) 523-3038

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GAMMON, DAVID A
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(606) 258-0701

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MORTON, STEVEN E
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PEDIATRICS

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(606) 528-9700

WOLFE

FAMILY MEDICINE

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Campton, KY 41301
(606) 668-6932

Primary Care Providers

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FUGATE, BRITTANY
202 Plummer St
Campton, KY 41301
(606) 668-7385

HAMILTON, DERRICK J
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(606) 668-7385

SANTOS, EDWIN M
31 Main St Ste 1
Campton, KY 41301
(606) 668-9076

PEDIATRICS

MENDOZA, EDGAR ALLAN D
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(606) 668-7385

PLUMB-MOORE, KIMERLI
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Campton, KY 41301
(606) 668-7385

SMOOT, SUNSHINE M
202 Plummer St
Campton, KY 41301
(606) 668-7385

WOODFORD

FAMILY MEDICINE

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159 Frankfort St
Versailles, KY 40383
(859) 879-6440

GAGNON, DAVID PHILIP
159 Frankfort St
Versailles, KY 40383
(859) 879-6440

JUSTICE, TONYA S
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Versailles, KY 40383
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RABIEE, ABDOLREZA
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Lexington, KY 40383
(859) 523-5310

SODA, NAWAR
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Aetna Better Health® of Kentucky Clear the Smoke Brochure

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Att M-271

Clear the air of second-hand smoke

Second-hand smoke causes about 3,000 deaths each year. This is just in people who don't smoke. *Second-hand smoke always has risks. There are risks even if people are around it for a short time. Children are exposed to more second-hand smoke than adults who don't smoke.

**Source – National Institutes of Health*

This is general health information and should not replace the advice or care you get from your provider. Always ask your provider about your own health care needs.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

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Aetna Better Health® of Kentucky
9900 Corporate Campus Drive
Suite 1000
Louisville, Kentucky 40223

Behavioral Health Services
1-888-604-6106
(TTY/TDD **1-800-627-4702**)
aetnabetterhealth.com/kentucky

KY-19-01-01 AEMC00190 FK4.7

Living Well

Clear the air of second-hand smoke

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KY Clear The Smoke Brochure.indd 1

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Att M-272

Children and teens with ongoing health conditions are more at risk for bad effects from second-hand smoke. They should be protected from it.

The best thing parents can do for their children is quit smoking. If you are a child with an ongoing condition, you should never start smoking.

Parents and teens with ongoing conditions should do the following:

- Don't allow anyone to smoke around you or your children.
- Teach your children to know about the dangers of smoking.
- Don't let children smoke.
- Don't start smoking.
- Don't allow smoking in your home or car.
- Don't keep ashtrays in the house.
- Ask people not to smoke when you visit them.
- Avoid places where smoking is allowed.
- Sit in non-smoking sections. Sit as far as possible from smoking areas.
- Be sure your child's day care center is smoke-free.

Our disease management program helps people live well.

Our program helps people manage ongoing conditions, so they can live well. To learn more, call our Behavioral Health line **at 1-855-300-5528**.

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The following tips help break the habit. Use them yourself or share them with your parents if you are a teenager.

- Take care of yourself. Be sure to eat well, get plenty of sleep, drink water and get some exercise (check with your provider about exercise first).
- Get Help. There are many groups that help people quit smoking:
  - The American Lung Association offers online support at **www.ffsonline.org**
  - Nicotine Anonymous offers a 12-step program. You can find a meeting by calling **415-750-0328**.
  - Visit smokefree.gov at **www.smokefree.gov** or call **1-800-QUITNOW**.
- Use a quitting aid. Many people find nicotine substitutes to be helpful. You can buy the patch, gum or inhalers at any drug store. Ask your provider if a quitting aid would be right for you.
- Avoid stress and situations that used to make you smoke. Think about the times and places you smoked the most before you quit. Stay away from them, if possible.
- If you slip, don't let it bring you down. Pick yourself up and start over again. Don't use it as an excuse to start smoking again. Many people try to quit two or three times before, they make it.

Sources: National Institutes of Health, **Smokefree.gov.**

If you think you need Care Management or Disease Management services, or have any questions about these services, just call us at **1-855-300-5528** (TTY users dial 711, TDD users dial **1-800-627-4702**), Monday through Friday, 7 a.m. to 7 p.m. ET. Ask to speak to a care manager.

Aetna Better Health® of Kentucky Metabolic Brochure

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Key screenings for metabolic syndrome

Body Mass Index Screening: People with schizophrenia or bipolar disorder

Cholesterol Screening: Lipid profile for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications

Blood Pressure Screening: People with schizophrenia or bipolar disorder

Screening for Tobacco Use: Follow up for people with serious mental illness

Diabetes Screening: People with schizophrenia or bipolar disorder who are using antipsychotic medications.

Att M-275

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ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-410**4 (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

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KY-19-01-04 AEMC00195 FK3.6

KY Metabolic Brochure.indd 1

Metabolic Syndrome and Cardiovascular Risk Screening

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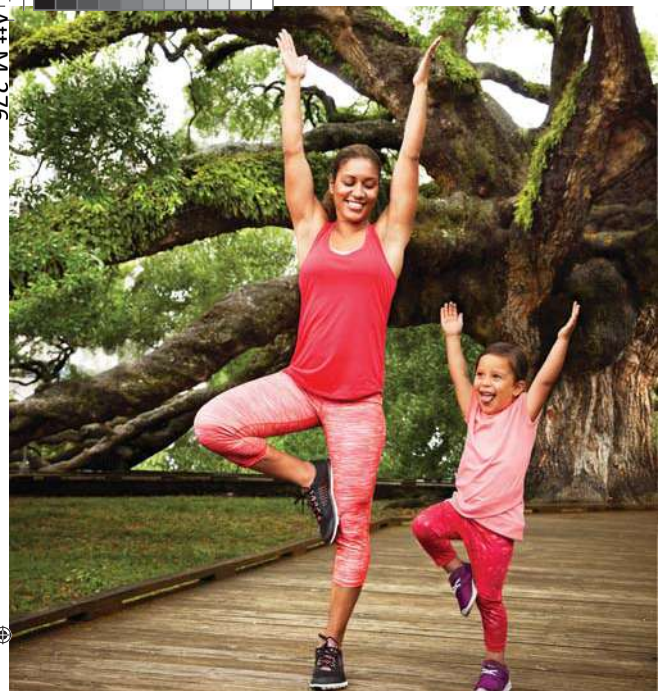

Did you know?

- It's common that some of the most effective medications for mental illness are associated with weight gain
- Physical side effects of medications combined with mental health problems and unhealthy lifestyle behaviors leads to a life expectancy 25 years less than the average person
- Nutritional and metabolic diseases, and possibly obesity-related cancers are more prevalent among people with serious mental illness compared to the general population
- There's sufficient evidence that people with serious mental illness are less likely to receive standard levels of care for most of their diseases.

Tips for Lowering Blood Pressure

- Decrease sodium (salt) intake to less than 2300 mg per day
- Increase potassium by eating more fruits and vegetables
- Lower carbohydrate intake, specifically refined sugars found in sweetened beverages, crackers, chips, and bread
- Eat more fatty fish such as salmon, sardines, mackerel, or halibut to increase the amount of omega-3 fatty acids

Tips for losing weight

- Consume less sugared drinks and add more water and unsweetened tea
- Increase physical activity and strive for 10,000 steps per day
- Increase fruit and vegetable intake and lower processed foods
- Strive for 7-9 hours of quality sleep per night to help lower cortisol levels

Tips for quitting Tobacco

- Consider using Nicotine Replacement Therapy (NRT)
- Enlist the support of friends, family, coworkers and let them know of plans to quit
- Set a quit date and plan for it by cleaning the inside of the car, all clothes/jackets, carpet, and furniture
- Establish a new routine around regular smoking times such as going for a walk, exercising, meditation, or reading

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Aetna Better Health® of Kentucky Men's Health Brochure

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Aetna Better Health® of Kentucky

Keeping you healthy

We want you to know about all the ways we can help to keep you healthy. Included are health screenings that are free to you as a member of Aetna Better Health.

Att M-279

If you have questions about health screenings for men, you should talk with your PCP. If you have questions about your benefits, call Member Services at **1-855-300-5528**.

This is general health information and should not replace the advice or care you get from your provider. Always ask your provider about your own health care needs.

To receive a translated copy of this document, call Member Services at **1-855-300-5528**.

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number
on the back of your ID card or 1-800-385-4104 (TTY: 711).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al
1-800-385-4104 (TTY: 711).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 1-800-385-4104 (TTY: 711)。

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KY-18-10-07 AEMC00194 FK6.5

Staying healthy: A guide for men

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KY Mens Health 11x17 2019.indd 1
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General checkups
You should see your primary care provider (PCP) yearly for a checkup. The screenings in this brochure can be done or scheduled during that visit. Think of your PCP as your medical home—the place to get your needed medical care. You and your PCP work as partners in a medical home to make sure you stay healthy and get the care you need. Your PCP is listed on your Aetna Better Health of Kentucky ID card.

Tobacco
Stopping the use of tobacco is the best thing you can do for your health. Smoking causes heart and lung problems. It can lead to cancer, asthma and strokes. If you need help quitting, talk to your PCP.

Prostate health
The prostate gland is a small gland near your bladder. It is part of the reproductive system. It makes the fluid that carries sperm out of the body. Sometimes the prostate will get bigger as a man gets older. This can make it harder to empty your bladder. There may be other symptoms too. Your PCP may want to do a screening test for prostate cancer. Talk to your PCP if you have questions about your prostate health.

Diabetes and High Blood Pressure
Diabetes is a condition that occurs when the body can't use a type of sugar called glucose. If untreated, the level of glucose in the body gets and stays too high. High blood pressure or hypertension occurs when your blood pressure repeatedly exceeds 140 over 90 mmHg - a systolic pressure above 140 with a diastolic pressure above 90. Many people have one or both of these conditions and don't know it. They may not have any symptoms. These conditions may lead to serious problems like heart, kidney or eye problems, strokes and even death. Be sure to get your blood pressure checked. Talk to your PCP about checking for diabetes. It can keep you healthier now and in the future.

Activity
Staying active helps keep you healthy. Walking, mowing the lawn, dancing and riding a bike are just a few examples of types of good physical activity. Try to be active for 30 minutes or more 3 or more days every week.

Diet
Eating a healthy diet is important. Try eating fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products. Include lean meats, poultry, fish, beans, eggs, and nuts. Avoid foods high in fat, salt, and added sugars. For more information about healthy eating for parents, families, teens and kids, go to **aetnabetterhealth.com/kentucky**.

STDs
If you are sexually active, you could get a sexually transmitted disease (STD). An STD is an infection that can make you and your partner very sick. There are several kinds of STDs. Some have signs you can see or feel, but some do not. You can give an STD to someone or get it and not even know it. If you have unprotected sex, or if you have more than one partner, you are at higher risk of getting an STD.

See your PCP if you think you may have an STD or if you have been exposed to one. Your PCP may do tests based on your sexual history, signs and symptoms. Talk to your PCP about this at your yearly checkup and whenever you think you might have an STD.

Heart Disease
The heart is made up of many parts. The parts work together to pump blood to all areas of your body. Heart disease can make it hard for your heart to function. Problems can include irregular heartbeats, build-up of plaque and narrowing of the heart vessels. This may lead to chest pain and possibly a heart attack.

You are at more risk for heart disease if you:
- Have high blood pressure
- Smoke
- Are overweight
- Have high cholesterol
- Are physically inactive
- Have diabetes

Colorectal cancer
This type of cancer can be prevented. You can lower risk by:
- Having less than three alcoholic drinks per day
- Quitting smoking
- Staying at the right weight
- Exercising
- There are three types of colon cancer screenings:
- Fecal occult blood testing (every year)
- Sigmoidoscopy (every five years)
- Colonoscopy (every ten years)

Flu
The flu can be very serious. It can even cause death. Getting a flu shot every year at any age can protect you. If you have ongoing health problems, ask your provider about getting a flu shot. An annual flu shot is suggested every year for everyone age six months and older.

Healthy male preventive measures

16-39	40-49	50-65	65+	Age appropriate preventive measure*
✓	✓	✓	✓	STD screening for sexually active men who are at risk for contracting an STD
		✓	✓	Lung cancer screening if you are age 55- 74, in good health and have a current or past history of smoking. Talk with your doctor to see if you need to be screened.
	✓	✓	✓	Prostate screening Screening is a personal choice and should be discussed with your PCP
	✓	✓	✓	Routine cholesterol screening beginning at age 45
✓	✓	✓	✓	Routine blood pressure screening every year
✓	✓	✓	✓	Diabetes screening if cholesterol level is elevated
		✓	✓	Colorectal cancer screening starting at age 50: • Flexible sigmoidoscopy (every 5 years) or • Colonoscopy (every 10 years) or • Double-contrast barium enema (every 5 years) or • CT Colonography (every 5 years In addition, members should get a stool test every year or stool DNA test every 3 years.
		✓	✓	Glaucoma screening for ages 60 and above
✓	✓	✓	✓	Seasonal Influenza (flu) vaccine every year
			✓	Pneumonia vaccine
✓	✓	✓		Tetanus/Diptheria booster every 10 years
		✓	✓	Zoster (shingles) – one dose vaccine on or after age 60

* Aetna Better Health of Kentucky follows the recommendations of the American Cancer Society and the United States Preventive Task Force.

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Attachment N

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Attachment N
C.15 – Letters of Support

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HOUSING AUTHORITY OF BOWLING GREEN
247 DOUBLE SPRINGS ROAD
BOWLING GREEN, KENTUCKY 42101
Telephone 270-843-6071 Fax 270-781-7091

Commissioner Steckel
275 E. Main Street
Frankfort, Kentucky 40601

June 20, 2019

Greetings Commissioner Steckel,

I am writing to speak about the wonderful partnership The Housing Authority of Bowling Green Kentucky has with Aetna Better Health. Amy Coleman, a representative of Aetna has been a great asset to our organization. She assists with keeping our residents updated on the many things Aetna Better Health does that can assist them with a healthier lifestyle. Aetna Better Health also assisted in a sponsorship of our annual Education, Information, and Job Fair. The fair was held on April 26th at our education facility, 31 vendors were in attendance and 103 individuals graced our doors. We still have individuals who are making connections from the fair. We just had one this week who gained employment after his time with our Reach Higher Welfare to Work Program was done.

Renea Covington

Renea Covington
Community Initiatives Director
270-467-7144 Office

5/7/19

To Whom It May Concern:

My name is Laura Whitehouse and I am the Family Resource Coordinator for Burns and Tamarack Elementary Schools in Daviess County. I am fortunate enough to work with a fantastic Community Outreach Coordinator with Aetna.

Gwen Ochoa and I started a partnership the beginning of this school year in August 2018. We started our collaboration partnership when I asked her to be a part of my Advisory Council-which is a group of influential community members, school administrators, and parents of children at the Elementary School who assist the Family Resource Coordinator with the program standards and budget. Gwen was nominated to the Advisory Council Chair in September 2018 and since then has lead all the council meetings.

The partnership that Gwen has provided to both elementary schools is crucial to the development and implementation of new programs. In November and December of 2018 Gwen and I partnered with her Nutrition and crockpot class. We had several participants and each gained invaluable knowledge to cook healthier food and save money.

This summer Gwen and I are again collaborating in my Summer Programs of home visits. Gwen will be providing Aetna backpacks in addition to small summer items; sunglasses, sunscreen, etc while I am providing a Summer calendar and books to promote a healthy, happy and educational summer.

Aetna and Gwen have assisted so much not only in the lives of the children and families of the schools I serve, she is an invaluable member to our school community.

Sincerely,

Laura Whitehouse
4514 Goetz Drive
Owensboro, KY 42301
Family Resource Coordinator-Burns and Tamarack Elementary

LETTER OF SUPPORT and USE OF NAME CONSENT

AETNA BETTER HEALTH OF KENTUCKY INC., ("Aetna"), a Kentucky corporation, is pursuing Medicaid Managed Care opportunities in connection with the Kentucky Cabinet for Health and Family Services (CHFS) Department for Medicaid Services (DMS).

CPESN USA is a clinically integrated network of community-based pharmacies that currently exists in 43 states, Kentucky being one. Pharmacies in CPESN Kentucky have been working with Aetna for the past six months on a program designed to bring some aspects of care management into the local community via community pharmacies who are committed to a different level of care and service for their patients.

Pharmacies in CPESN Kentucky commit to ongoing participation in our network and with Aetna Better Health of Kentucky on this pharmacy care management program ("the Program"). CPESN Kentucky also grants permission to Aetna to reference CPESN by name in any bids, proposals, or state contract applications that may be developed in pursuit of this opportunity. Our signatures below are evidence of our intent to continue participation in the network and work with Aetna to advance value based reimbursement models.

Through the Program, CPESN pharmacies work with high risk, medically complex Aetna members who have a strong need for medication use supports, care planning, and follow up. Regular reviews by the pharmacy of the entire drug regimen and patient goals, as well as social factors and health concerns that may be keeping the patient from achieving those goals, are integrated with Aetna Care Management activities. In the six months since the program began, CPESN pharmacies have worked with Aetna members who have diabetes, asthma, COPD, hypertension, heart disease, depression, bipolar disorder, and substance use disorder. They have identified social determinants of health in multiple areas, including food insecurity, housing instability, lack of access to transportation, and interpersonal violence and have referred those challenges to Aetna Care Management for assistance. Additionally, Aetna members reported a very high rate of satisfaction with the program, and both CPESN pharmacies and Aetna Care Managers have multiple stories of problems resolved and progress to better health outcomes because of the Program. CPESN Kentucky looks forward to more opportunities to collaborate with Aetna in the new managed care contract term that begins in 2020.

Finally, CPESN consents to the use of our name and other identifying and/or descriptive information about us in any bids, proposals, or state contract applications Aetna may develop in all formats, including, but not limited to, electronic media.

CPESN Kentucky: Lead Network Facilitator, David Figg

Signature: _____ Date: June 26, 2019

FAMILY ENRICHMENT CENTER

1133 ADAMS STREET, BOWLING GREEN, KY 42101
PHONE (270) 781-6714 • FAX (270) 842-5831

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Funded By:

- Prevent Child Abuse Kentucky
- Cabinet for Health & Family Services
- Kappa Delta Sorority
- WHAS Crusade for Children
- United Way of Southern Kentucky

May 7, 2019

Lynn Hulsey
Family Enrichment Center
Director of Development
1133 Adams Street
Bowling Green, KY 42101

On behalf of Family Enrichment Center I would like to extend this letter of thanks for all the support we receive from Aetna, and Amy Coleman.

Family Enrichment Center's mission is to empower families and prevent child abuse by providing education, social support, crisis intervention, and a safe environment for parents and their children; to promote healthy family functioning through assistance and treatment of the entire family; and to increase public awareness, knowledge and sensitivity toward child abuse and neglect so that full community support and involvement may be enlisted to eliminate this serious social problem.

Aetna is a strong supporter of the work we do here at Family Enrichment Center and our work to help families be great so their children grow up safe, happy and healthy. For the past two years Aetna has been heavily involved in our Buckets of Hope program which has reached thousands of children and their parents with information regarding health and wellness, as well as helped us raise money for continued service provision. Not only Buckets of Hope, but other community activities have received personal and monetary support from Aetna, for which we are extremely grateful and wouldn't be able to provide free child abuse prevention services without partnerships like this. More than the sponsorships, is the support provided by staff and their concern for the work we do to keep children safe and healthy in our community.

From all of us at Family Enrichment Center, we appreciate Aetna and your support of our mission.

Sincerely,

Lynn Hulsey

Lynn Hulsey
Director of Programs
Family Enrichment Center

Empowering Families and Preventing Child Abuse
www.FamilyEnrichmentCenter.com

Commissioner Steckel
275 E. Main St.
Frankfort, KY 40601

June 14, 2019

Dear Commissioner Steckel,

I am pleased to offer my perspective on the difference Aetna Better Health of Kentucky makes in our community through its investment in the Food Literacy Project at Oxmoor Farm.

Thanks to Aetna's generosity and support through a Truck Farm sponsorship in 2018, the Food Literacy Project achieved life-changing results as youth transformed their communities through food, farming and the land. Since 2006, the Food Literacy Project has been working to create a healthy and equitable community where people and places thrive. Over 40,000 youth and families have explored fresh, wholesome foods, cultivating healthy lifestyles. Truck Farm helps us reach even more people in the region.

Aetna's 2018 investment enabled Truck Farm to bring the "field-to-fork" experience into neighborhoods and schools so that participants could connect through planting, harvesting, cooking, and tasting fresh vegetables right from the mobile learning garden.

Due to your generosity, over 3,440 youth, families, caregivers, and community members increased their knowledge about healthy eating, gardening, and healthy lifestyles through Truck Farm programming.

Each participant who encountered Truck Farm had the opportunity to use their senses on a "tasting tour" of the seasonal vegetables growing right in the bed of the truck. Community members enjoyed chives and lavender in spring, fresh tomatillos and sweet peppers in summer, kale in early fall, and broccoli in late fall. Not only did participants experience tasting these vegetables, but they also helped plant them. Youth who tasted broccoli in fall reaped the rewards sewn by those who planted in summer.

Truck Farm allows the Food Literacy Project to bring the farm to the community; we drove hundreds of miles in 2018 with nearly 50 stops at locations including Hawthorne Elementary School, Iroquois Park, Americana Community Center, Whitney Young Job Corps, and Beechmont Community Center. One highlight for Truck Farm in 2018 was a visit to the Episcopal Church Home senior community, where residents learned about container gardening and seasonality in preparation for planting their own garden beds at the homes. Our farm-based educators helped residents plan and plant their new garden beds so that seniors can enjoy the outdoors, participate in physical activity, and experience smells, sounds, and flavors that evoke their pasts.

Another 2018 highlight was Truck Farm's weekly visits to Jefferson County Public Schools Summer Food Service Program sites. At these sites, JCPS provides free, nutritionally-balanced meals to children and teens to help prevent the nutritional summer slide. While these meals typically consist of packaged, nonperishable items, Truck Farm followed along behind the JCPS Bus Stop Cafes to teach youth and their families about growing and cooking fresh vegetables. We saw many returning faces each week as youth helped us plant, harvest, and prepare fresh vegetables for community members to taste, supporting healthy lifestyles and inspiring curiosity and connection to the land.

Truck Farm accomplishes more than connecting youth with fresh vegetables; it moves youth to transform their communities into vibrant places. One teenager who encountered Truck Farm in her community was inspired to apply to work in our Youth Community Agriculture

Program (YCAP), a summer employment opportunity for underserved teens. Christina "Kale" (her farm name) completed the full seven weeks of the summer program, experiencing the rigor and rewards of farming and developing her public speaking and leadership skills. After the program, she said she is excited to stay involved in her community.

Over 84% of the students the Food Literacy Project serves qualify for free or reduced school lunch and many live in neighborhoods that face high poverty rates and significant health disparities, due in large part to the limited availability of fresh vegetables. As the only farm-based, food education program available in the Louisville area, the Food Literacy Project engages youth and families most at risk for inadequate food access, poor nutrition and ill health.

Aetna's generous Truck Farm sponsorship led to significant changes in knowledge, attitudes, and nutritious behaviors, and increased access to fresh vegetables and nutrition education. After participating in our Field-to-Fork program, 69% of students reported planning to eat more vegetables; 89% tasted a new vegetable as part of their experience. Moreover, teens like Christina "Kale" who are employed through our Youth Community Agriculture Program (YCAP) frequently serve as Truck Farm ambassadors throughout the community; in addition to improved knowledge and attitudes about food and nutrition, they report significant increases in their ability to listen, speak publicly, and work as part of a team.

Thanks to Aetna Better Health of Kentucky, the Food Literacy Project provides life-changing experiences for Louisville residents. We are proud to work alongside them to improve community health and look forward to continued partnership with Aetna.

Gratefully,

Carol Gundersen

Carol Gundersen
Executive Director

HOTEL INC

Helping Others Through Extending Love In the Name of Christ

PO Box 1688, 1005 Boatlanding Road, Bowling Green KY 42102 www.hotelincbg.com 270-782-1263

May 2, 2019

Aetna Better Health
9900 Corporate Campus Drive, Ste: 1000
Louisville KY 40223

To Whom it May Concern;

We are so grateful for the commitment to community that Aetna Better Health provides. This year we are honored to have Aetna as a sponsor with events in support of our Homeless & Housing Dept. Each quarter we are celebrating milestones that people experiencing homelessness have conquered during that quarter. The first quarter of 2019, 21 program participants were honored with a dinner, small gift and opportunity to share their journey. This summer we will also host a family bbq to celebrate individuals and families that have obtained and maintained their housing this past year.
Aetna's belief in a better and healthy community for all people and supporting individual accomplishments is empowering to the person and a celebration of community engagement with neighbors.

Thank you so much!

Sincerely,

Rhondell Miller

Rhondell Miller
Executive Director
director@hotelincbg.com

June 6, 2019

Carol Steckel, Commissioner
Department of Medicaid Services
275 E. Main St.
Frankfort, KY 40601

Dear Commissioner Steckel:

It is my pleasure to write a letter of support for Aetna Better Health of Kentucky in pursuit of a procurement as a Medicaid provider.

Aetna has been a corporate member of Kentucky Nonprofit Network, the state association of nonprofits, since 2012. Over the years, they have invested in a number of important KNN initiatives that support and strengthen Kentucky's nonprofit sector, such as:

- our More Than Charity data initiative highlighting the size, scope and economic importance of nonprofits – these data resources are critical to nonprofit efforts to education local, state and federal decision-makers on the vital role Kentucky's nonprofits play as employers (employing one in eleven Kentuckians) and economic engines (generating over $27 billion in annual economic activity);
- sponsored our annual Kentucky Nonprofit Day at the Capitol event – the annual opportunity for nonprofits to connect with legislators and speak with a unified voice on issues that impact their operating environment and ability to serve Kentuckians, which has been a critical opportunity to advocate for improved nonprofit laws and repeal of sales tax on nonprofit fundraising;
- sponsored an online grant proposal writing course to help nonprofits improve their skills to generate needed grant revenue – as the demand for

Kentucky Nonprofit Network, Inc., PO Box 24362, Lexington, KY 40524
T: 859.963.3203 F: 859.534.3310 www.kynonprofits.org

services increases and resources are shrinking, skills like this are vital for many nonprofits.

Aetna has made important investments in helping to create a more effective nonprofit sector in Kentucky. Their support has helped KNN provide valuable professional development for nonprofit executives and strengthened nonprofit efforts to better share their stories of impact and value. Both are important to creating an environment where the work and expertise of nonprofits is valued.

Nonprofits are essential to the kind of quality of life wanted for all Kentuckians and KNN is appreciative of Aetna's commitment to partnership with us and these vital organizations. We look forward to future opportunities that will help Aetna continue to partner with nonprofits to support members, their families and communities across Kentucky.

KNN supports Aetna's efforts to be selected as a Medicaid Managed Care Organization.

Sincerely,

Danielle Clore

Danielle Clore
CEO

1716 Scherm Road
Owensboro, KY 42301
270-926-7273

437 First Street
Henderson, KY 42420
270-826-7273

May 3, 2019

To Whom it may concern:

I am writing on behalf of New Beginnings Sexual Assault Support Services in Owensboro, KY. I wanted to express how much the partnership with Aetna has affected those that we serve.

When Ms. Gwendolyn Ochoa first reached out to me a few years ago, I was very impressed with her desire to help sexual assault survivors. She wanted to be a part of our events but also sat through one of our Board of Directors training so she could gain insight on how we operate and the services we provide. I knew then that she was committed to our mission and truly cared about helping those during their most critical time of need.

With our limited funding, Gwen stepped up and provided teddy bears for our young sexual abuse survivors. What most would think is a simple stuffed animal, our families know that it's so much more. That little bear brings their child comfort and joy in a scary situation. Their eyes light up when our advocate hands it over to them. It not only helps our families, but our advocates too knowing they can bring some sense of calm to the child.

But Aetna didn't stop with the bears. They went on to be a sponsor for our largest fundraiser. The proceeds from this event help our clinical and outreach programs do more work in marginalized communities. Through this outreach we have been able to engage more with the Latino and Burmese communities providing education and translation services for those seeking therapy. We also started trainings that aid our community in working with the LGBTQ populations. And most recently, we started a group for survivors that brought many males to our agency seeking help for childhood sexual abuse issues. More than once we heard from survivors that we were the first ones they told about their abuse. Some of which happened more than 30 years ago. Our ability to expand and reach more people has only been possible through partnerships with businesses like Aetna. I truly believe they care about families and being a steward of service to the community they are involved with.

Again, thank you Aetna for your support. We truly can say our program has flourished because of your commitment to making it possible.

Sincerely

Karla Ward
Executive Director
New Beginnings Sexual Assault Support Services, Inc.

Helping men, women, & children rise above sexual victimization.

www.nbowensboro.org

Our Lady of Bellefonte Hospital

June 14, 2019

Commissioner Steckel
275 East Main St.
Frankfort, KY. 40601

Dear Commissioner Steckel

I am delighted for the chance to express how grateful Our Lady of Bellefonte Hospital and Bon Secours Mercy Health is that we have had the opportunity to partner with Aetna Better Health of Kentucky over the past several years. The coverage that Aetna Better Health of Kentucky provides has been instrumental in ensuring that those who are most vulnerable within our communities are able to receive the preventative and emergent care that they need to live happier and more fulfilling lives.

Additionally, we have been grateful for their participation and support of our area health coalition, "Healthy Choices Communities". We appreciate the robust participation of their Community Outreach Representative, MaryBeth Lacy, in our local area Community health needs assessment process, workgroups and events addressing substance abuse disorder and access to health care for our patients, clients and the community in regards to looking at our gaps and to help us figure out how to help an individual connect with the correct agency, organization or service to meet the individual's needs. Supporting us in our effort to meet the needs of our most at risk population is invaluable and is very important to have as a resource along with support in the work that we do in the community. It is through this collaborative work that engages a variety of stakeholders within our community that we can truly make an impact and move the needle.

It is clearly evident that Aetna Better Health of Kentucky cares about the community as a whole and the kindness and support they show is deeply appreciated. Our Lady of Bellefonte Hospital and Bon Secours Mercy Health is looking forward to many more years of partnership with Aetna Better Health of Kentucky. The kindness and support Marybeth has shown for our mission is deeply appreciated, and is a vital part to making a difference in our community.

With that being said, please accept our sincere recommendation for Aetna Better Health of Kentucky in pursuit of being a Medicaid provider.

Sincerely,

Joseph Mazzawi
Vice President of Mission
Bon Secours Kentucky Health System and Our Lady of Bellefonte Hospital

1000 St. Christopher Drive
Ashland, KY 41101
p: 606.833.3333

Provider Health Link of KY
2628 Titleist Rd
Louisville KY, 40242

Jun 13th, 2019

Commissioner of Medicaid Services
275 E. Main Street
Frankfort, KY 40601

Dear Commissioner:

On behalf of Provider Health Link of KY we are writing a letter of support for Aetna Better Health of Kentucky in pursuit of the Kentucky Medicaid Managed Care program.

Aetna Better Health of Kentucky provides managed care services targeted to government-sponsored health care programs including Medicaid, Medicare, Prescription Drug Plans, and the Health Insurance Exchanges. Aetna offers a variety of health plans for families, children, and the aged, blind and disabled.

Provider Health Link manages the service fund contract between Big Sandy PHO and Aetna Better Health of Kentucky. We take great pride in assisting Big Sandy PHO with issues surrounding credentialing, physician loads, billing and a variety of other service fund related issues. Big Sandy PHO's physician membership includes both primary care and specialty practices and covers approximately 3,500 Aetna members in Southeastern Kentucky. Aetna provides reports monthly that help Provider Health Link effectively manage BSPHO's service fund agreement.

Aetna along with Provider Health Link has worked diligently to improve quality scores in all of BSPHO's provider practices. During our monthly meetings we discuss quality initiatives such as Care Gap and HEDIS scores. This shows Aetna's commitment to not only quality, but also the overall well-being of BSPHO's members.

Provider Health Link would like to extend their full support for Aetna's bid submission. We look forward to working with Aetna to continue to improve the health of Big Sandy PHO's members.

Sincerely,

Christopher Cessna
Manager
Provider Health Link
606-682-2836

LCDHD
Lake Cumberland District Health Department
A Healthy Today for a Brighter Tomorrow

Russell County Health Department

211 Fruit of The Loom Drive • PO Box 378
Jamestown, Kentucky 42629
Phone: 270-343-2181 • Fax: 270-974-4084

To Whom it may Concern:

I would like to take this opportunity to acknowledge my wonderful Aetna Better Health of Kentucky Community Outreach Coordinator, Amy Coleman and the wonderful work she does in our community. She is an active member of our Russell County Community Health and Wellness Coalition, where we can count on her as we work together in moving forward in making our community a better place to work, play and live.

She represents Aetna well with her outgoing personality and willingness to participate in any task at hand. The Russell County Community Health and Wellness Coalition is involved in many health focused projects, and Amy is willing to work with all community events, from Health Fairs to Longest Day of Play and 5-K's to provide information and education that Aetna Better Health of Kentucky has to offer. She is a great educator with our community as she can communicate with all levels of socioeconomic backgrounds.

Again, on behalf of our coalition member and myself, we are convinced we have a community partner who truly has a passion for the health of all she services and consider it a great honor to have her and the company she represent as our friend, mentor and community partner that just doesn't come to meeting but is truly committed to being a part of the solution for a better Russell County. If this letter is not convincing, just take a look at the below picture and see the evidence of how numerus community partners such as Aetna, is coming together to improve the overall health of communities one person at a time.

Respectfully,
Mrs. Shirley Roberson Daulton
Policy and Promotion Program, LCDHD

Lake Cumberland District Health Department
A Healthy Today for a Brighter Tomorrow

Russell County Health Department

211 Fruit of The Loom Drive • PO Box 378
Jamestown, Kentucky 42629
Phone: 270-343-2181 • Fax: 270-974-4084

Russell County Community
Health and Wellness Coalition

MISSION OF ECHO

ECHO is a volunteer based organization dedicated to preventing and reducing the incidence and impact of child abuse by providing education, advocacy, and support services to the children and families of Metro Louisville and surrounding areas.

June 13, 2019

RE: Safe Zone Overview

In the re-establishment of the Safe Zone Family room, ECHO's strategic plan is to have the space fully functional by the end of 2019. In the past few months to help support the initiative, ECHO received community support and sponsorship from Aetna to renovate the space and make it more functional for kids between the age 5-12+ years of age. This support was invaluable of providing a safe place for children while parents are handling family issues at the Family Courthouse. We are most appreciative of the funding, but more importantly the partnership with Aetna and the potential opportunity for Aetna employees to volunteer at the Safe Zone Family room.

ECHO has established a Safe Zone coordinator that will help assist with recruiting volunteers, training, and maintaining the space with supervised adults. ECHO has tentatively scheduled a volunteer training in February to reach out the community for support. Volunteers will participate in a 2-hour training, Darkness to Light, to understand what child abuse is and how to recognize, how to respond to a child disclosure about abuse, and the proper way to report child abuse. In the effort to recruit volunteers for the space, ECHO has met with the Family Court Judges to help further express the need, posts will be made on ECHO's Facebook page, and will be reaching out to social organizations.

The Safe Zone's hours of operation will be Tuesday, Wednesday, and Thursday from 9am-12pm, with the hopes of having extended hours in the summer. Each day will comprise of two volunteers in the room to help supervise the kids. Only social workers, deputy sheriffs, attorneys, CASA volunteers or family court support workers can admit a child into the Safe Zone. On the average, ECHO will be providing services for 10-15 children per month in the Safe Zone.

Since the Open House of the Safe Zone in October, ECHO has provided services to an average of 2-3 children per week. The vision of the Safe Zone is to communicate with more court workers, such as CPS to help them understand the availability of service to the children, so they do not have to witness any family court issues. "Volunteering with ECHO and seeing the transformation of space for children has truly been an eye-opening experience to the number of children & families that are affected by some type of trauma. I'm excited to dedicate my time to the Safe Zone in order to help children and families in our community". (Michelle Ecken, Safe Zone Coordinator)

ECHO looks forward to continuing to build partnerships with Family Courthouse, Aetna, and the community to help provide support services to the children and families in our community.

June 14, 2019

Adam Meier
Secretary
Cabinet for Health and Family Services
275 E. Main St. 5W-A
Frankfort, KY 40621

Dear Secretary Meier:

Please let this serve as a letter of support for Aetna Better Health as the Commonwealth considers its MCO partners for the Medicaid program for 2020. Aetna has been a solid and stable business partner of ours for many years, and we believe will be a good partner for Kentucky.

St. Elizabeth has worked closely with Aetna Better Health since the start of the KY managed Medicaid program, and we have come to trust them as a partner in care interested in both the bottom line and the improved health of their members. In the past several years, we have jointly developed new 'pay-for performance' programs that provide payments that are direct results of the quality care we are providing to our patients.

We strongly believe Aetna Better Health's strategy aligns with our mission to improve the health of our patients, and we would encourage you to consider their bid for the Kentucky Medicaid program.

If I can answer any questions, I would be happy to. Please feel free to contact me directly at 859-360-9235.

Sincerely,

William Banks
VP, Managed Care

better together | www.stelizabeth.com

ST. ELIZABETH | COVINGTON
1500 James Simpson, Jr. Way
Covington, KY 41011
P: 859.655.8800

ST. ELIZABETH | FALMOUTH
512 South Maple Avenue
Falmouth, KY 41040
P: 859.572.3500

ST. ELIZABETH | FT. THOMAS
85 North Grand Avenue
Ft. Thomas, KY 41075
P: 859.572.3100

ST. ELIZABETH | EDGEWOOD
1 Medical Village Drive
Edgewood, KY 41017
P: 859.301.2000

ST. ELIZABETH | FLORENCE
7380 Turfway Road
Florence, KY 41042
P: 859.212.5200

ST. ELIZABETH | GRANT
238 Barnes Road
Williamstown, KY 41097
P: 859.824.8240

The Kings Center

(Faith United, Inc. Board of Directors)
202 East 3rd Street, Frankfort, KY 40601
Phone: (502) 227-8010 Fax: (502) 227-8025
Email: kingscenter@fewpb.net
Web Site: www.kingscenter.org

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Serving the physical, emotional, academic, and spiritual needs of Frankfort's children and families through a caring presence in the community

June 18, 2019

Commissioner Carol H. Steckel, MPH
Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street
Frankfort, KY 40601

Dear Commissioner Steckel:

I welcome the opportunity to express the sincere appreciation of the entire Faith United, Inc. Board of Directors for our partnership with Aetna Better Health in providing programming for The Kings Center over the last couple of years. The Butterfly Metamorphosis Program, sponsored by Aetna last year and continuing this year, is one of our most successful programs. This program introduces our youth to the broader concept of transformation and changes that occur throughout the cycle of life and opens doors for discussions of the transformations they will experience as they mature. Moreover, Metamorphosis engages our youth in the three targeted areas of Kings Center programming: development of positive life skills, improvement of grades and academic skills, and awareness of good health and fitness practices.

As a community-based organization, the Kings Center is committed to offering value-based programming that engages children in a variety of experiences that not only nurture their curiosity and talents, but also help them become more disciplined in decisions that impact their health, academics, and emotional well-being. As a non-profit organization that relies heavily on volunteers and donors, we could not provide programming that helps us pursue our mission without the generous and caring support of community partners like Aetna Better Health. We value their commitment to public health and their willingness to work with community organizations to spread positive messages which will have a lasting impact.

Sincerely,

Sheila Mason Burton, Board Chair
Faith United, Inc.

United Way of Franklin County

May 7, 2019

Dear Aetna Partners,

In 2018, we were the recipients of 400 sleeping bags to help our chronically homeless clients who were living on the streets or in a night-by-night shelter. Because of this, we were able to help countless people who might otherwise have frozen to death on the streets. These acts of kindness are exactly what organizations like Welcome House need in order to keep our doors open and to serve the people we encounter to the best of our abilities. Without partners like you, Welcome House would not be half as successful in providing life-saving services to the most vulnerable populations.

Thanks to donors like Aetna, Welcome House was able to serve over 1,600 clients last year. Your contribution supports the continuum of services and affordable housing with the goal of ending homelessness. By providing housing for people with low, fixed incomes and those working for low wages, households are stabilized and have a better chance at maintaining a job and long-term housing.

We look forward to working with Aetna in the future. If you have any questions, or would like to visit us for a tour, please contact Sara Kahmann at skahmann@welcomehouseky.org or Kelly Rose at krose@welcomehouseky.org.

Once again, thank you for your donation and support of Welcome House!

Sincerely,

Kelly Rose

Director of Marketing & Development

For more information on any of the above information, contact Kelly Rose at 859.431.8717 or email krose@welcomehouseky.org.

859.431.8717 859.431.6297
205 W Pike St. | Covington, KY 41011
WelcomeHouseKY.org

Attachment O

Kentucky | Transforming Health Care | **Aetna**

Attachment O
C.17 – Provider Services

Provider Website Sample Screenshots ..... Att O-3

Proposed Credentialing Policy and Procedure ..... Att O-19

Aetna Better Health® of Kentucky Committee Minutes Policy ..... Att O-23

Aetna Better Health® of Kentucky Confidentiality and Disclosure of Credentialing, Recredentialing Peer Review Information Policy ..... Att O-27

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Provider Website Sample Screenshots

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Overview of the ABHKY Website:

www.aetnabetterhealth.com/kentucky

aetna®

AETNA BETTER HEALTH® OF KENTUCKY

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- Behavioral Health
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For providers

To find the name and contact information for your Network Relations Representative, simply click the link below!

Who is my Network Relations Consultant?

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  - Credentialing Criteria
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- Provider Manual
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- Risk Adjustment
- Provider Portal
- Quality Matters
- Resources
- Practice Guidelines

Join our network

Become a network provider
There are many great reasons for providers to join Aetna Better Health of Kentucky:

- Our Provider Relations staff works hard to understand your business issues and meet your needs
- You benefit from ongoing support and training opportunities
- Your claims are processed in a timely, efficient manner
- You receive competitive compensation
- You have access to advanced technology that can enhance patient care

To join the Aetna Better Health of Kentucky networks, please contact Provider Relations at **1-855-454-0061** or by email at KYProviderRelations@aetna.com .

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Credentialing criteria

Learn more about the qualifications that must be met for participation in our network

- Application Requirements for Primary Care and Specialty Care +
- Facility Site Review +
- Application Requirements for Ancillary/Facility Providers +
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Formulary drug list

The formulary is a list of drugs chosen by Aetna Better Health of Kentucky and a team of doctors and pharmacists. Drugs on this list are generally covered under the plan as long as they are medically necessary. Members must fill their prescriptions at an Aetna Better Health of Kentucky network pharmacy and follow other plan rules.

Please review the formulary for any restrictions or recommendations regarding prescription drugs before prescribing a medication to an Aetna Better Health of Kentucky patient.

You can download the **formulary** . You can also view a list of this month's formulary updates.

You now have the ability to search for drugs using our new **Formulary Search Tool**. Searches can be performed by drug name or by drug class. The tool will provide formulary status, generic alternatives and if there are any clinical edits (Prior Authorization, Quantity Limits, Age Limits etc).

Common Preferred Drug List (PDL)

Drug Recall - Immediate Action Needed

Auvi-QR (epinephrine) auto-injector

- Over-the-counter drugs +
- Pharmacy authorization guidelines +
- Pharmacy prior authorization forms A - L +
- Pharmacy prior authorization forms M - Z +
- Electronic Prior Authorization (ePA) +
- Formulary Updates +
- Specialty medications +
- Step therapy & quantity limits +

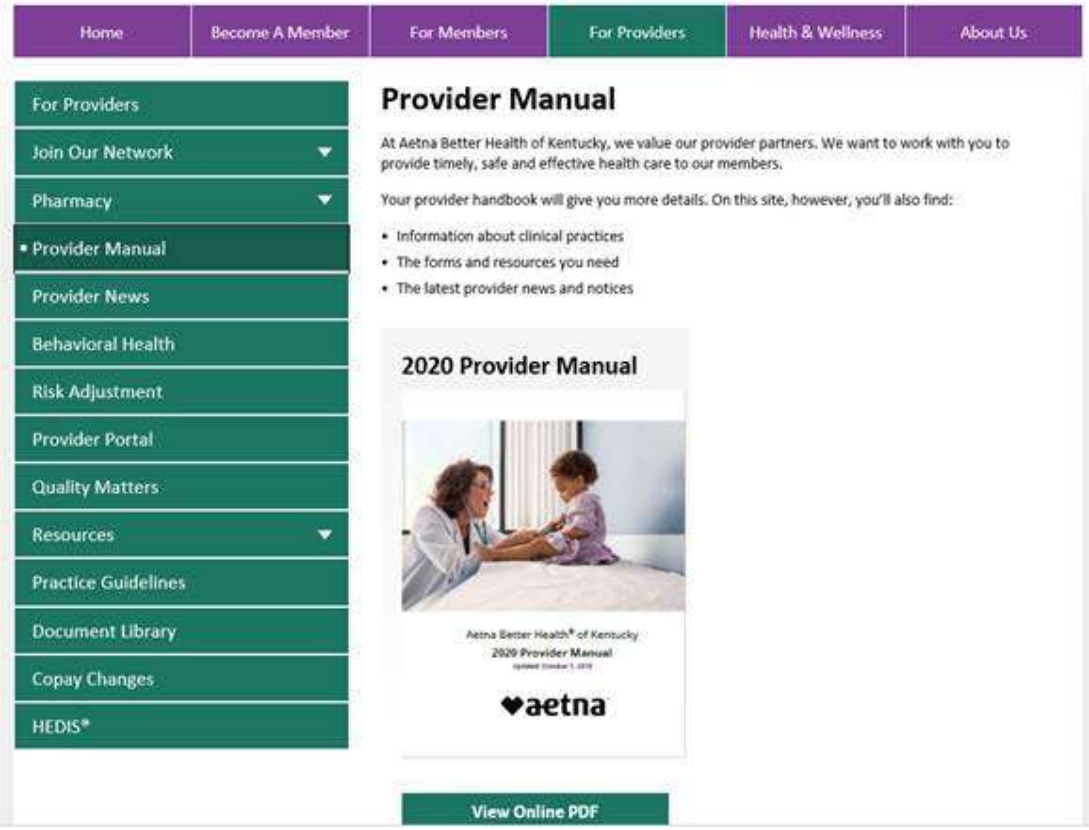
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At Aetna Better Health of Kentucky, we value our provider partners. We want to work with you to provide timely, safe and effective health care to our members.
Your provider handbook will give you more details. On this site, however, you'll also find:
• Information about clinical practices
• The forms and resources you need
• The latest provider news and notices
2020 Provider Manual
Aetna Better Health® of Kentucky
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Provider news

We publish a provider newsletter. Here you can view current and past issues.

- Aetna Better Health Newsletters +
- Past Coventry Newsletters +
- 2019 Fax Blast +
- 2018 Fax Blast +
- 2017 Fax Blast +
- 2016 Fax Blast +
- DMS Program Fact Sheets +
- Medically Frail Webinar Registration +

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Behavioral health

Aetna Better Health of Kentucky covers behavioral health services. These services include specialized behavioral health services provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, mental health clinics, and mental health rehabilitation service providers (public or private). We also cover inpatient hospital services for acute medical detoxification.

Aetna Better Health of Kentucky is committed to having an integrated care model that looks at all that affects a person – physical, emotional, lifestyle, beliefs and values. We treat behavioral and physical health together.

We work with members and providers to focus on prevention and wellness:

- Screening for issues that could lead to illness and treating them early with whole-person approach
- Providing classes and services with providers and others to help members learn to better manage their own care

Basic behavorial health +

Specialized behavorial health +

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Risk Adjustment

Member Acuity and Risk Adjustment

Aetna Better Health Kentucky's members have a broad distribution of health status, ranging from good health to multiple chronic illnesses. Collectively, the sickest members of any health plan require the most attention and care; they also drive the highest cost of care. To address this, Kentucky Medicaid funds Medicaid Managed Care plans based on a complex calculation that includes members' degree of morbidity (referred to as **acuity**) through the State's Risk Adjustment Payment Model. In this model, the more a plan's members have certain chronic conditions, the higher the Risk Score the State assigns to the plan. Accurate Risk Scoring requires that members with these conditions have all of their chronic conditions documented in claims. Reporting on member acuity starts and ends with the provider.

Diagnosis Coding in Claims

Encounters are electronic documents created in the claims process and reported to the State of Kentucky, showing each service provided to members. The **diagnosis codes** in each encounter drive the calculation of each plan's Risk Score. Each time a member with a chronic condition has that condition addressed at a visit, the diagnosis should appear on the claim. It is critical that providers document all chronic illness diagnosis codes on every applicable claim. Evaluation of the codes and subsequent Risk Adjustment analysis is done by the State on a bi-annual basis. Thus, providers should include the diagnosis code on every patient claim at every visit when it was addressed to ensure that the diagnosis is captured and utilized in the most current encounter analysis.

Acute Visits

Members with chronic conditions who may not have seen their provider for periodic checkups may still present for episodic or acute conditions. These visits are opportunities to address their chronic conditions. If your member visits you for an episodic or acute condition and a chronic condition is currently present and addressed during the visit, the chronic condition diagnosis should be coded and included on the claim.

For example, a member with type 2 diabetes presents to the office with bronchitis. During the visit, along with treatment of bronchitis, you also provide reminders on the management of diabetes and the risk of elevated blood-glucose levels related to the acute bronchitis. The claim should include both the diagnosis of acute bronchitis and the diagnosis of diabetes.

Our Partnership

Aetna Better Health of Kentucky is your partner in caring for all of our members, including our highest acuity members. We offer Integrated Care Management and our Quality program mails visit reminders and calls members, all in an effort to get them the care that they need.

Aetna Better Health of Kentucky thanks you for your continued commitment to assisting our members.

- 1. Document every page +
- 2. Capture each diagnosis +
- 3. Be specific +
- 4. Add assessment and treatment plans +
- 5. Ask about past conditions +
- 6. Be thorough +
- 7. Close gaps in care +
- 8. Sign on the dotted line +
- 9. Use all tools available +
- 10. When in doubt, document +

aetna™

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Provider portal

Our enhanced, secure and user-friendly web portal is now available. This HIPAA-compliant portal is available 24 hours a day. And it supports the functions and access to information that you need to take care of your patients. Popular features include:

- *Single sign-on* – One log-in and password allows you to move smoothly through various systems.
- *Mobile interface* – Enjoy the additional convenience of access through your mobile device.
- *Personalized content and services* – After log-in, you will find a landing page customized for you.
- *Real-time data access* – View updates as soon as they are posted.
- *Better tracking* – Know immediately the status of each claim submission and medical PA request.
- *eReferrals* – Go paperless. Refer patients to registered specialists electronically and communicate securely with the provider.
- *Auto-Auths* – Depending on the auth type and service location, it is possible to receive an auto-approval on your request.
- *Detailed summaries* – Find easy access to details about denied PA requests or claims.
- *Enhanced information* – Analyze, track and improve services and processes.

Sign up today. It's easy.

Provider groups must first register a principal user known as the "Provider Representative." Once registered, the "Provider Representative" can add authorized users within each entity or practice.

To get started, you can register online. Or you can contact our Provider Services department to sign up over the phone. You can also submit your registration via fax. Just download the form (see link below) or request a copy from Provider Services. Remember, internet access with a valid e-mail is required for registration.

Secure Provider Web Portal - Log in

Provider Portal Registration Form

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Quality matters

The scope of the Quality Improvement program (QI) is comprehensive, addressing the quality and safety of clinical care and services provided to our members, including physical health, behavioral health, dental and vision care. The QI program actively initiates, monitors and evaluates standards of health care practice, the infrastructure essential to the delivery of clinical quality of care and services to members. Aetna Better Health of Kentucky maintains a companywide commitment to quality and industry best practices and/or standards as set forth by state and federal regulators, as well as accrediting organizations.

The Quality Improvement Program Description provides the framework for Aetna Better Health of Kentucky to continually monitor, evaluate and improve the quality of care, safety and services provided to all members, employers, practitioners/providers and external/ internal customers. The program provides an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services.

Aetna Better Health of Kentucky has many ongoing quality improvement activities to fulfill the scope of the QI Program. The full detail of major activities including time frames for completion, responsible parties, and planned monitoring and evaluation is included in the QI Work Plan. The QI Program consists of the following elements:

- QI Program Description Summary
- Annual QI Program Evaluation
- Policies & Procedures
- Annual QI Workplan
- Quality Improvement Activities
- QI Committee Structure

Member satisfaction survey +

HEDIS results +

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Resources

In this section, you'll find a number of resources to assist you in serving our Aetna Better Health of Kentucky members. Remember, you can always find more information in our provider manual.

Visit our **document library** for provider forms, provider notices and other helpful provider materials.

Search Medicaid ID

DMS has created a provider directory that will enable providers to verify that an Ordering, Referring or Prescribing physician is a Kentucky Medicaid provider. Please use the link below to search for a provider's Medicaid ID:

https://prdweb.chfs.ky.gov/ProviderDirectory/PDSearch.aspx

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Practice guidelines

Aetna Better Health's Clinical Practice Guidelines (CPG's) and Preventive Health Guidelines (PHG's) are based on nationally recognized recommendations and peer reviewed medical literature.

Clinical Practice Guidelines -

Aetna Better Health adopts evidence-based clinical practice guidelines (CPGs) from nationally-recognized sources. CPGs are tools that help practitioners make decisions about appropriate health care for specific clinical circumstances. The Aetna National Guideline Committee reviews CPGs every two years or more frequently if national guidelines change within the two-year period.

CPGs are provided for informational purposes only and are not meant to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgement regarding the appropriate treatment of a patient in any given case.

Formally ac PDF Opens In New Window sed using the following link:

Clinical Practice Guidelines

Preventive Service Guidelines +

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Document library

For your convenience, we have compiled the most frequently used documents in one location. This collection of files and forms is available to you from our health plans. Here you will supporting documentation to help you provide superior service to our members. If you wish, you may view, print, or store these files below for your future reference.

- Provider Document Library +
- Universal DMS Forms +
- 2016 Provider Forums +
- Provider Education +
- Provider Forms +
- Behavioral Health +
- Lock-In +
- Member Incentives +

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Copay changes

Dear Aetna Better Health Partners:

On January 1, 2019, copays will be as follows. Please click here to learn more.

If you have any questions or concerns, simply contact your Network Relations Consultant.

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HEDIS®

Healthcare Effectiveness Data and Information Set (HEDIS®)

What is HEDIS®?

HEDIS® is a performance measurement tool that is coordinated and administered by NCQA (National Committee for Quality Assurance) and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring health plan performance. HEDIS® performance measures are utilized by more than 90 percent of American health plans to compare how well a plan performs in multiple areas including: Quality of care, Access to care, and Member satisfaction with both the health plan and its providers.

Why is HEDIS® important?

Health plans use HEDIS® results to measure performance, pinpoint quality initiatives, and deliver educational programs for members and providers. HEDIS® helps to ensure that health plans are offering quality preventive care and services to members.

Value of HEDIS® to providers

HEDIS® can help you to direct efficient and effective management of your patients' care by allowing you to continually monitor patient health, prevent further complications, and identify additional issues that may develop.

HEDIS® providers education and helpful materials

At Aetna Better Health of Kentucky, our goal is to improve access to quality health care for our members. We provide a broad network of providers and community organizations in order to achieve improved health outcomes.

HEDIS® provider education +

HEDIS® supplemental data submission process +

HEDIS Scores +

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Proposed Credentialing Policy and Procedure

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Desktop: Credentialing Process

Aetna Better Health of Kentucky
Health Plan Operations

Credentialing

Introduction

The following is a proposed process for coordinating with the state CVO.

Players: State CVO, Provider, Health Plan Contracting and Health Plan Network Operations

Process Initiation: Process is initiated with either notification from a provider the desire to contract with ABHKY or the receipt of a verified credentialing packet from state CVO.

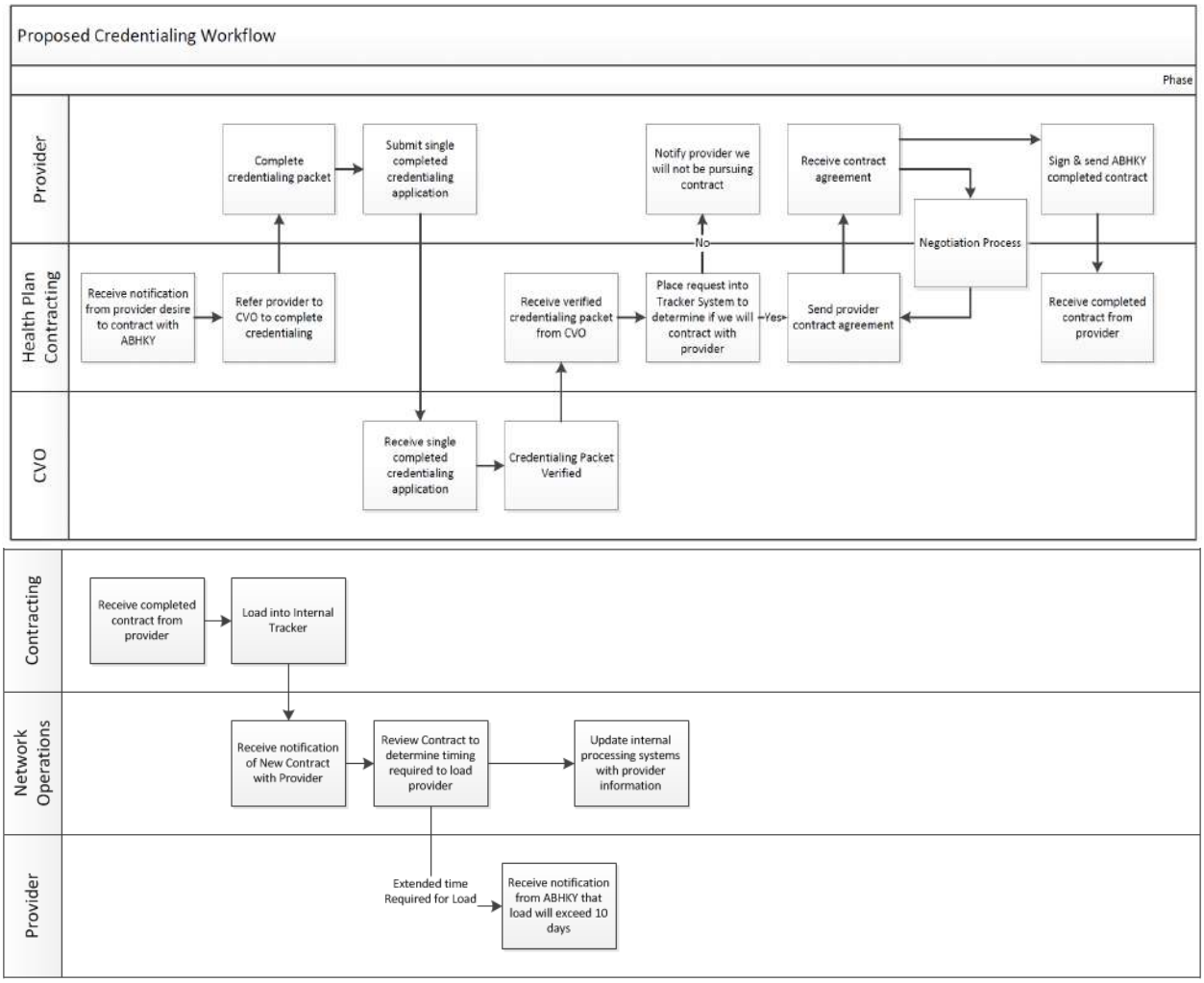

Step	Action
1.	ABHKY receives notification from provider desire to contract. ABHKY refers provider to CVO to complete credentialing.
2.	ABHKY receives verified credentialing packet from CVO.
3.	Network Contracting places request into Tracker System to determine if we will contract with provider. A. If no, notify provider we will not be pursuing a contract B. If yes, send provider contract agreement and begin negotiation process.
4.	Once negotiation process is complete, Network Contracting signs & places ABHKY completed contract into Tracker System to be loaded.
5.	Network Operations receives notification of New Contract with Provider in Tracker System.
6.	Network Operations reviews contract to determine timing required to load provider. A. If less than 10 days, proceed with loading provider B. If more than 10 days, notify provider loading will exceed 10 days but no more than 25 days.
7.	Network Operations completes updating of internal processing systems with provider information.
8.	Network Relations notifies provider system load is complete.

Aetna Better Health® of Kentucky
Committee Minutes Policy

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AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Committee Minutes	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 02
Subsection:		Effective Date:	11/01/2017
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Credentialing and re-credentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna's QM 02 Committee Minutes policy (QM 02) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and re-credentialing of practitioners and providers. This policy amendment documents Aetna Better Health's acceptance of QM 02 and defines those practices used in conjunction with this policy to comply with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.

DEFINITIONS:

External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354 and performs external quality review and other related activities as set forth in federal regulations.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

LEGAL/CONTRACT REFERENCE:

-
- NCQA Standards and Guidelines for the Accreditation of Health Plans: 2018
- NCQA Standards and Guidelines for the Accreditation of Health Plans: 2017

POLICY LANGUAGE AMENDMENT:[1]

Credentialing minutes are maintained by Aetna Health Management and are made available to Aetna Better Health upon request to meet requests from the Aetna Better Health accreditation agencies, state regulators, CMS and/or an EQRO and to the extent required by law as determined by the appropriate regional general counsel.

Aetna Better Health

Jonathan E. Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

[1]NCQA HP 2018 CR2

Aetna Better Health® of Kentucky
Confidentiality and Disclosure of Credentialing, Recredentialing Peer Review Information Policy

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AETNA BETTER HEALTH® of Kentucky
Policy

Policy Name:	Confidentiality and Disclosure of Credentialing, Recredentialing Peer Review Information	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 04
Subsection:		Effective Date:	05/01/2017
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Credentialing and recredentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna's QM 04 Confidentiality and Disclosure of Credentialing, Recredentialing Peer Review Information policy (QM 04) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and recredentialing of practitioners and providers. This policy amendment documents Aetna Better Health's acceptance of QM 04 and defines those practices used in conjunction with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.

DEFINITIONS:

External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review and other related activities as set forth in federal regulations.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

LEGAL/CONTRACT REFERENCE:

- National Committee for Quality Assurance Standards and Guidelines for the Accreditation of Health Plans: 2017 and 2018

POLICY LANGUAGE AMENDMENT:[1]

Practitioner and provider peer review files maintained by Aetna Health Management are made available to Aetna Better Health upon request to meet requests from the Aetna Better Health Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an EQRO and to the extent required by law as determined by the appropriate regional general counsel. The Aetna Better Health Quality Management department is responsible for monitoring the activities performed on behalf of Aetna Better Health by Aetna Health Management and preparing summary reports of peer review decisions for the Aetna Better Health Quality Management/Utilization Management Committee.

Aetna Better Health

Jonathan E. Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

[1] NCQA HP 2017 CR1 A11; NCQA HP 2018 CR1 A11

Aetna Better Health® of Kentucky
Assessment Credentialing of Organizational Providers Policy

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AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Assessment/Credentialing of Organizational Providers	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 51
Subsection:		Effective Date:	10/01/2016
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Credentialing and re-credentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna's QM 51 Assessment/Credentialing of Organizational Providers policy (QM 51) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and recredentialing of practitioners and providers. This policy amendment documents Aetna Better Health's acceptance of QM 51 and defines those practices used in conjunction with this policy to comply with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.[1]

DEFINITIONS:

External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review and other related activities as set forth in federal regulations.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

LEGAL/CONTRACT REFERENCE:

- Kentucky Medicaid Managed Care Contract, Section 28.2 Provider Credentialing and Recredentialing Appendix J: Credentialing Process
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans: 201

[1] NCQA HP 2017 CR7

AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Assessment/Credentialing of Organizational Providers	Page:	2 of 2
Department:	Credentialing	Policy Number:	QM 51
Subsection:		Effective Date:	10/01/2016
Applies to:	■ Medicaid Health Plans		

POLICY LANGUAGE AMENDMENT:

Provider credentialing and recredentialing files maintained by Aetna Health Management are made available to Aetna Better Health upon request to meet requests from the Aetna Better Health Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an EQRO and to the extent required by law as determined by the appropriate regional general counsel. The Aetna Better Health Quality Management department is responsible for monitoring the activities performed on behalf of Aetna Better Health by Aetna Health Management and preparing summary reports of credentialing and recredentialing decisions for the Aetna Better Health Quality Management/Utilization Management Committee.

If a provider's credentials are terminated Aetna Better Health coordinates with Aetna Health Management to notify appropriate regulatory boards or agencies. If appropriate, law enforcement is also notified.

Aetna Better Health

Jonathan E. Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

Aetna Better Health® of Kentucky
Practitioner Credentialing, Recredentialing Policy

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AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Practitioner Credentialing, Recredentialing	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 54
Subsection:		Effective Date:	10/01/2016
Applies to:	■ Kentucky Medicaid Managed Care ■ Kentucky HEALTH		

PURPOSE:

Credentialing and re-credentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna's QM 54 Practitioner Credentialing, Recredentialing policy (QM 54) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and recredentialing of practitioners and providers. This policy amendment documents Aetna Better Health's acceptance of QM 54 and defines those practices used in conjunction with this policy to comply with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.[1]

DEFINITIONS:

External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review and other related activities as set forth in federal regulations.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

LEGAL/CONTRACT REFERENCE:

- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- Kentucky Medicaid Managed Care Contract, Section 28.2 Provider Credentialing and Recredentialing, Appendix J: Credentialing Process

[1] NCQA HP 2017 CR1, CR3, CR4 & CR5; NCQA HP 2018 [E] CR1, [R] CR3, [R] CR4 & [E] CR5

POLICY LANGUAGE AMENDMENT:

Practitioner credentialing and recredentialing files maintained by Aetna Health Management are made available to Aetna Better Health upon request to meet requests from the Aetna Better Health Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an EQRO and to the extent required by law as determined by the appropriate regional general counsel. The Aetna Better Health Quality Management department is responsible for monitoring the activities performed on behalf of Aetna Better Health by Aetna Health Management and preparing summary reports of credentialing and recredentialing decisions for the Aetna Better Health Quality Management/Utilization Management Committee.

The Contractor shall complete the Credentialing or Recredentialing of a Provider within ninety (90) calendar days of receipt of all relative information from the Provider or within forty-five (45) days if the Provider is providing substance use disorder services[2]

If a practitioner's credentials are terminated Aetna Better Health coordinates with Aetna Health Management to notify appropriate regulatory boards or agencies. If appropriate, law enforcement is also notified.

Aetna Better Health

Jonathan E. Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

Reviewed and revised: 10/2017
Reviewed and revised: 12/2018

[2] Kentucky Medicaid Managed Care Contract, Section 28.2

Aetna Better Health® of Kentucky
Practitioner Application Policy

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AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Practitioner Application	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 56
Subsection:		Effective Date:	05/01/2017
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Credentialing and recredentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna's QM 56 Practitioner Application policy (QM 56) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and recredentialing of practitioners and providers.[1] This policy amendment documents Aetna Better Health's acceptance of QM 56 and defines those practices used in conjunction with this policy to comply with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.

DEFINITIONS:

External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review and other related activities as set forth in federal regulations.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

LEGAL/CONTRACT REFERENCE:

- National Committee for Quality Assurance Standards and Guidelines for the Accreditation of Health Plans: 2017 and 2018

[1] NCQA HP 2017 CR1, CR3 and CR6; NCQA HP 2017 CR1, CR3 and CR5

AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Practitioner Application	Page:	2 of 2
Department:	Credentialing	Policy Number:	QM 56
Subsection:		Effective Date:	05/01/2017
Applies to:	■ Medicaid Health Plans		

POLICY LANGUAGE AMENDMENT:

Practitioner and provider credentialing and recredentialing files maintained by Aetna Health Management are made available to Aetna Better Health upon request to meet requests from the Aetna Better Health Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an EQRO and to the extent required by law as determined by the appropriate regional general counsel. The Aetna Better Health Quality Management department is responsible for monitoring the activities performed on behalf of Aetna Better Health by Aetna Health Management and preparing summary reports of credentialing and recredentialing decisions for the Aetna Better Health Quality Management/Utilization Management Committee.

Aetna Better Health

Jonathan E. Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

Aetna Better Health® of Kentucky
Delegated Credentialing/Recredentialing Policy

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AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Delegated Credentialing/Recredentialing	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 59
Subsection:		Effective Date:	10/01/2016
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Credentialing and re-credentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna's QM 59 Delegated Credentialing/Recredentialing policy (QM 59) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and recredentialing of practitioners and providers. This policy amendment documents Aetna Better Health's acceptance of QM 59 and defines those practices used in conjunction with this policy to comply with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.[1]

DEFINITIONS:

External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review and other related activities as set forth in federal regulations.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

LEGAL/CONTRACT REFERENCE:

- Kentucky Medicaid Managed Care Contract, Section 4.2, 4.3, 28.2; Appendix J. Credentialing Process
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans: 2018

[1] NCQA HP 2017 CR8

POLICY LANGUAGE AMENDMENT:

Although all or part of a function may be delegated after approval by state regulators, Aetna Better Health is accountable for the quality of care and services performed for members and the decisions made on its behalf. Aetna Better Health is also accountable for confirming that the delegated organization performs the delegated function appropriately and in compliance with applicable standards and requirements.

Audit reports of delegated activities and corrective action plans, if applicable, are submitted to the appropriate committee (e.g., Quality Management/Utilization Management Committee, Delegation Subcommittee) for oversight review and approval and then to the Quality Management Oversight Committee.

Delegation oversight files maintained by Aetna Health Management are made available to Aetna Better Health upon request to meet requests from the Aetna Better Health Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an EQRO and to the extent required by law as determined by the appropriate regional general counsel. The Aetna Better Health Provider Relations department is responsible for monitoring the activities performed on behalf of Aetna Better Health by Aetna Health Management and preparing summary reports of delegation decisions to the Aetna Better Health Quality Management Oversight Committee.

Aetna Better Health

Jonathan E. Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

Aetna Better Health® of Kentucky
Practitioner Participation and Peer Review Policy

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AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Practitioner Participation and Peer Review	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 62
Subsection:		Effective Date:	07/01/2017
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Credentialing and re-credentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna's QM 62 Practitioner Participation and Peer Review policy (QM 62) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and recredentialing of practitioners and providers. This policy amendment documents Aetna Better Health's acceptance of QM 62 and defines those practices used in conjunction with this policy to comply with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.[1]

DEFINITIONS:

External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review and other related activities as set forth in federal regulations.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

LEGAL/CONTRACT REFERENCE:

- Kentucky Medicaid Managed Care Contract
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans: 2018

[1] NCQA HP 2017 CR1 A, CR3, CR5 and CR6

AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Practitioner Participation and Peer Review	Page:	2 of 2
Department:	Credentialing	Policy Number:	QM 62
Subsection:		Effective Date:	07/01/2017
Applies to:	■ Medicaid Health Plans		

POLICY LANGUAGE AMENDMENT:

Aetna Better Health reviews and investigates potential quality of care concerns (PQoC) as outlined in QM 63 Review of Potential Quality of Care Concerns Policy. As noted in QM 63, upon review of PQoC issues, the chief medical officer (CMO) makes a determination regarding appropriate actions and may forward the issue to the Aetna Credentialing and Performance Committee and/or the Aetna Better Health Quality Management/Utilization Management Committee for peer review.

Practitioner and provider peer review files maintained by Aetna Health Management are made available to Aetna Better Health upon request to meet requests from the Aetna Better Health Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an EQRO) and to the extent required by law as determined by the appropriate regional general counsel. The Aetna Better Health Provider Relations department is responsible for monitoring the activities performed on behalf of Aetna Better Health by Aetna Health Management and preparing summary reports of peer review decisions for the Aetna Better Health Quality Management/ Utilization Management Committee.

Aetna Better Health

Jonathan E Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

Aetna Better Health® of Kentucky
Medical Director Credentialing, Recredentialing and Peer Review Policy

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AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Medical Director Credentialing, Recredentialing and Peer Review	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 70
Subsection:		Effective Date:	07/01/2017
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Credentialing and re-credentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna's QM 70 Medical Director Credentialing, Recredentialing and Peer Review policy (QM 70) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for credentialing and recredentialing. This policy amendment documents Aetna Better Health's acceptance of QM 70 and defines those practices used in conjunction with this policy to comply with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.

DEFINITIONS:

Chief Medical Officer (CMO)	An Aetna Better Health full-time physician (thirty-two [32] hours/week) with an active unencumbered license, in accordance with state laws and regulations, who serves as the medical director to oversee medical management and provision of core benefits and services to members. The CMO oversees the Quality Assessment and Performance Improvement (QAPI) activities and chairs the Quality Management/Utilization Management Committee (i.e., QAPI committee).
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review and other related activities as set forth in federal regulations.
Medical Director	A physician directly employed or under contract to Aetna or Aetna Better Health who is responsible for providing clinical expertise and business direction promoting the delivery of high quality, constituent responsive and cost effective health care.

LEGAL/CONTRACT REFERENCE:

- Kentucky Medicaid Managed Care contract

- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans: 2018

POLICY LANGUAGE AMENDMENT:

QM 70 applies to all Aetna Better Health medical directors including the chief medical officer. Chief medical officer and medical director credentialing and recredentialing files maintained by Aetna Health Management are made available to Aetna Better Health upon request to meet requests from the Aetna Better Health Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an EQRO and to the extent required by law as determined by the appropriate regional general counsel. The Aetna Better Health Provider Relations department is responsible for monitoring the activities performed on behalf of Aetna Better Health by Aetna Health Management and preparing summary reports of credentialing and recredentialing decisions for the Aetna Better Health Quality Management/Utilization Management Committee.

Aetna Better Health

Jonathan E. Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

Aetna Better Health® of Kentucky
Credentialing Policy and Procedure Development Amendment Policy

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AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Credentialing Policy and Procedure Development Amendment	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 75
Subsection:		Effective Date:	06/01/2016
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Credentialing and re-credentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna's QM 75 Credentialing Policy and Procedure Development policy (QM 75) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and re-credentialing of practitioners and providers. This policy amendment documents Aetna Better Health's acceptance of QM 75 and defines those practices used in conjunction with this policy to comply with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.

DEFINITIONS:

External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review and other related activities as set forth in federal regulations.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

LEGAL/CONTRACT REFERENCE:

- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans: 2018
- Kentucky Mediciad Managed Care Contract, Section 28.2 Provider Credentialing and Recredentialing; Appendix J: Credentialing Process

AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Credentialing Policy and Procedure Development Amendment	Page:	2 of 2
Department:	Credentialing	Policy Number:	QM 75
Subsection:		Effective Date:	06/01/2016
Applies to:	■ Medicaid Health Plans		

POLICY LANGUAGE AMENDMENT:[1]

Credentialing policies are maintained by Aetna Health Management and are made available to Aetna Better Health for adoption. Aetna Better Health demonstrates adoption of Aetna Health Management credentialing policies through the implementation and approval of Aetna Better Health policy amendments. Credentialing criteria required by Aetna Better Health for regulatory and/or contractual purposes that are not defined in the Aetna Health Management national policies or state amendments are to be outlined in Aetna Better Health policy amendments.

The Health Operations Policy Process (HOPP) noted in Aetna Health Management policy QM 75 Credentialing Policy and Procedure Development is not applicable to Aetna Better Health's program.

Aetna Better Health

Jonathan E. Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

[1] NCQA HP 2017 CR1 A1

Aetna Better Health® of Kentucky
Reporting Sanctions: NPDB and State Licensing Authorities Policy

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AETNA BETTER HEALTH® of Kentucky
Policy Amendment

Policy Name:	Reporting Sanctions: NPDB and State Licensing Authorities	Page:	1 of 2
Department:	Credentialing	Policy Number:	QM 78
Subsection:		Effective Date:	05/01/2016
Applies to:	■ Medicaid Health Plans		

PURPOSE:

Credentialing and recredentialing activities are performed on behalf of Aetna Better Health by affiliate organization Aetna Health Management. Aetna Better Health and Aetna Health Management are affiliates under common ownership of Aetna Inc. Aetna Better Health utilizes Aetna Health Management to perform credentialing activities. This arrangement is outlined in the Intercompany Master Credentialing Agreement.

Aetna Better Health has adopted Aetna Health Management's QM 78 Reporting Sanctions: National Practitioner Data Bank (NPDB), and State Licensing Authorities policy (QM 78) and process that follow National Committee for Quality Assurance (NCQA) standards and guidelines for the credentialing and recredentialing of practitioners and providers. This policy amendment documents Aetna Better Health's acceptance of QM 78 and defines those practices used in conjunction with this policy to comply with state and Centers for Medicare & Medicaid Services (CMS) regulatory and legislative requirements.

DEFINITIONS:

External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and/or performs external quality review and other related activities as set forth in federal regulations.
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

LEGAL/CONTRACT REFERENCE:

- Kentucky Medicaid Managed Care contract, Section 28.2 Provider Credentialing and Recredentialing and Appendix J: Credentialing Process
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans: 2017 and 2018

POLICY LANGUAGE AMENDMENT:

Provider credentialing and recredentialing files maintained by Aetna Health Management are made available to Aetna Better Health upon request to meet requests from the Aetna Better Health Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an EQRO and to the extent required by law as determined by the appropriate regional general counsel. The Aetna Better Health Quality Management department is responsible for monitoring the activities performed on behalf of Aetna Better Health by Aetna Health Management and preparing summary reports of credentialing and recredentialing decisions for the Aetna Better Health Quality Management/Utilization Management Committee.

If a practitioner's or provider's credentials are terminated, Aetna Better Health coordinates with Aetna Health Management to notify appropriate regulatory boards or agencies. If appropriate, law enforcement is also notified.[1]

Aetna Better Health

Jon Copley
Chief Executive Officer

Lisa D. Baird
Chief Operating Officer

[1] NCQA HP 2017 CR 6 A1-2; NCQA HP 2018 CR 6 A1 -2

Attachment P

Kentucky | Transforming Health Care | **Aetna**

Attachment P
C.18 – Provider Network

Medicaid National Provider Agreement ..... Att P-3

Medicaid Provider Agreement ..... Att P-27

Medicaid Hospital Agreement ..... Att P-43

Medicaid Facility Agreement ..... Att P-61

Provider Network Listing ..... Att P-79

Provider Counts by Provider Type Summary ..... Att P-81

Geographic Access Report ..... Att P-83

Sample Network Monitoring Tool –
2018 Raw Data PATS Survey Workbook ..... Att P-459

Sample Network Monitoring Tool –
PATS Survey Access Tool ..... Att P-465

Sample Network Monitoring Tool – SCA Report ..... Att P-483

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Medicaid National Provider Agreement

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NATIONAL PROVIDER AGREEMENT

Aetna Medicaid Administrators LLC, on behalf of itself and its Affiliates ("Company"), and **_____,** on behalf of itself and any and all of its Group Providers ("Provider"), are entering into this National Provider Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes and incorporates this **Cover/Signature Page**, the **General Terms and Conditions** and **Definitions** that follow, and attachments specific to the Medicaid Product Category, including the **Medicaid Product Addendum** and the state-specific or other attachments listed on the **Medicaid Attachment – Table of Contents** that immediately follows (collectively, the "Agreement").

EFFECTIVE DATE: [DATE] (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Provider agrees that he/she has read and understood this Agreement, has had the opportunity to review it with an attorney of Provider's choice, and is authorized to bind Provider, including all Group Providers, to the terms of the Agreement.

PROVIDER	**COMPANY**
By:_____	**By:**_____
Printed Name:_____	**Printed Name:**_____
Title:_____	**Title:**_____
FEDERAL TAX I.D. NUMBER:_____	
NPI NUMBER:_____	

As required by Section 8.7 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Provider:	**Company:**
_____	**Aetna Better Health**
_____	**Attn: Network Management**
_____	**4500 E. Cotton Center Blvd**
_____	**Phoenix, AZ 85040**

With additional notice from Provider to be sent to:

the Affiliates and addresses listed on Exhibit A – Affiliate Listing.

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MEDICAID ATTACHMENT – TABLE OF CONTENTS

Exhibit A – Affiliate Listing

Exhibit B – Service and Rate Schedule (Medicaid Products)
Exhibit B-1 [State #1]-Specific Service and Rate Schedule
Exhibit B-2 [State #2]-Specific Service and Rate Schedule
[Etc.]
[Delete State-Specific Schedules if Only a National Service and Rate Schedule]

Exhibit C – State Compliance Addenda (Medicaid Products)
Exhibit C-1 [Insert Name of State #1 RCA Document]
Exhibit C-2 [Insert Name of State #2 RCA Document]
[Etc.]

Exhibit D – Performance Guarantees (Medicaid Products)
Exhibit D-1 [State #1]-Specific Performance Guarantee
Exhibit D-2 [State #2]-Specific Performance Guarantee
[Etc.]
[Delete State-Specific Guarantees if Only a National Performance Guarantee]

Exhibit E – Value-Based Solutions Addendum - [Insert name of VBS Addenda, if any; add state-specific VBS addenda, if any (i.e. E-1, E-2, etc.)]

Exhibit F – [Other]

[Exhibits D-F only insert as applicable]

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GENERAL TERMS AND CONDITIONS

1.0 PROVIDER OBLIGATIONS

1.1 **General Obligations**. Provider agrees that it and all Group Providers will:

(a) provide Covered Services (including, but not limited to, any related facilities, equipment, personnel and./or other resources necessary to provide the Covered Services), to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Provider represents that neither it nor any Group Provider has been excluded from participation in any Federal or state funded health program, or has a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Provider understands that no Group Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Group Providers in all Individual Sites and Provider locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Provider's services to be made directly to Provider instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Provider further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Provider agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act ("ACA") (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Provider will not accept any referral from persons or entities that have a financial interest in Provider, or make any referrals to persons or entities in which Provider has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (a) material litigation brought against Provider or a Group Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Provider renders to Members; (b) claims against Provider or a Group Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (c) change in the ownership or management of Provider; and (d) material change in services provided by Provider or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Provider or a Group Provider related to those services.

1.2 **Provider, Group Provider and Individual Site Contacts and Service Information**. Provider agrees that it has provided Company with contact information, including, but not limited to, a list of Group Providers (including a list of Group Providers at each Individual Site and Provider location), that is complete and accurate as of the Effective Date. Provider will notify Company within ten (10) business days of all changes to (a) such list/information: (b) the services Provider and/or Group Providers provide at each Individual Site/location; and (c) any contact and/or billing information for Provider and Group Providers. Notwithstanding the previous sentence, Provider must notify Company at least ninety (90) days in advance in the event that any Individual Site/location is being opened, acquired, sold, merged and/or closed. Provider understands that failure to keep all such contact and service information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's requirements for updating information and the actions it may take if Provider fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Provider.

1.3 **Compliance with Company Policies**. Provider agrees to comply with Company Policies, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Provider's administration or rates under this Agreement, Company will send Provider at least ninety (90) days advance written notice of the Policy change. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. If Provider objects to a Policy change that will have a significant impact on Provider's administration or operations or will create a material adverse financial impact for Provider, it shall, within sixty (60) days of Company's notification, provide Company with written notice, specifying the basis for its concern; in such event, the Parties will negotiate, in good faith, an appropriate amendment, if any, to this Agreement. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment**. Subject to Applicable Law, Provider agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Group Providers for services rendered, and that it will require all Group Providers to look solely to Provider for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Provider and Group Providers, containing all information needed to process the claims, within one hundred and twenty (120) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Provider's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) to notify Company of any underpayment, or payment or claim denial dispute, within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any

overpayment. In the event of Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Provider acquires or takes operational responsibility for another Participating Provider (e.g., practice, facility or ancillary provider), the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider until the earlier of such time as: (i) Company and Provider negotiate and implement new mutually agreeable rates for that Participating Provider under this Agreement; or (ii) Company terminates that Participating Provider's network participation with at least one hundred and eighty (180) days prior written notice to Provider and the Participating Provider.

[OR – NETWORK MANAGER NEEDS TO DETERMINE IN ADVANCE OF SENDING AGREEMENT WHICH VERSION OF 1.4 (h) IS ADVANTAGEOUS TO COMPANY]

in the event that Provider acquires or takes operational responsibility for another Participating Provider (e.g., practice, facility or ancillary provider), the terms and rates of this Agreement will automatically govern with respect to such new provider, unless the Parties reach mutual agreement on other rates.

1.5 **Member Billing**. Provider agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Provider's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

1.6 **Utilization Management**. Provider agrees that it shall be subject to utilization management (including prospective, concurrent and retrospective review) and that payment for Provider services may be adjusted or denied for the inefficient delivery of services.

1.7 **Precertification and Referrals**. Provider agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan. For the purpose of pre-service testing, Provider agrees to directly provide testing or accept test results and examinations performed outside Provider, provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the delivery of services. For those Members who require services under a specialty program (e.g., transplant services), Provider agrees to work with Company in transferring the Member's care to a specialty program Provider, as the case may be.

1.8 **Third Party Premium Payments.** Provider agrees that it will not, either directly or indirectly, or through or in conjunction with any third party, pay for or otherwise reimburse Members (through monetary currency, gift cards, credits and/or other items of value) for all or a part of the cost of health coverage.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Provider; (ii) provide Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Provider with a means to check Member eligibility; and (iv) include Provider in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Providers through its provider websites or other commonly accepted media.

2.2 **Claims Payment**. Subject to Applicable Law, the terms of each applicable **Product Addendum(a) and Service and Rate Schedule(s)**, and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees:

(a) when it is the Payer, to pay Provider for Covered Services rendered to Members; and
(b) when it is not the Payer, to notify the Payer to forward payment to Provider for Covered Services,

within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim. While Company may service or process payment for claims on behalf of Payers who are not Affiliates (e.g., self-funded plan sponsors), Provider acknowledges that Company has no legal or other responsibility for the payment of those claims. However, Company will use commercially reasonable efforts to assist Provider, as appropriate, in collecting payments from Payers.

3.0 NETWORK PARTICIPATION

Provider agrees that it and Group Providers (in all Individual Sites and locations) will participate in the Product Categories checked on the signature sheet to this Agreement. Company has the right, upon ninety (90) days written notice to Provider, to:

(a) add Product Categories (e.g., Medicare or a new Product Category not existing as of the Effective Date); and
(b) add types of Plans (e.g., PPO, HMO) and/or specialty programs (e.g., disease management or women's health) in any Product Category;

Company will notify Provider of the rates that will apply for any addition and will, as necessary, send Provider a new or revised **Product Addendum** and **Service and Rate Schedule**.

Provider can decline any addition by notifying Company in writing, within thirty (30) days of receiving Company's notice. A variation of an existing Product Category, Plan type or specialty program at existing terms and rates will not be considered "an addition" under this section.

Company is not required to designate or include Provider, any specific Group Provider(s) or any specific Individual Site/Provider location(s) as a preferred provider or Participating Provider in any specific Product Category, Plan (or Plan variation) or specialty program. Company may operate networks in which Provider is not included, whether for specific Payers/customers or otherwise. In certain situations, Provider may treat a Member of a Plan or Product Category in which Provider does not participate (e.g., a Member traveling out of area, emergency services). In those situations, Company may apply rates and terms (e.g., no balance billing) that Provider has accepted under this Agreement for Covered Services provided to those Members. Not all Product Categories and Plan types are available in all geographic locations.

4.0 CONFIDENTIALITY

Company and Provider agree that Provider's medical records do not belong to Company. Company and Provider agree that the information contained in the claims Provider submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) to governmental authorities having jurisdiction; (b) in the case of Company's disclosure, to

Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (c) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Provider will keep the rates and the development of rates and other terms of this Agreement confidential. However, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Group Providers**. Company may terminate the participation of one or more Group Providers, Individual Sites or locations by providing Provider with at least ninety (90) days written notice prior to the date of termination.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Provider or any Group Provider (including, but not limited to, any Individual Site or location), with written notice to Provider, due to: (a) Provider's or the applicable Group Provider's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Provider for the benefit of creditors; (c) Provider's or the applicable Group Provider's indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to fraud or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Provider to an entity not acceptable to Company; (f) any false statement or material omission of Provider or a Group Provider in a network participation application and/or related materials; or (g) a determination by Company that Provider's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in (a)-(f) above. Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Provider agrees to provide services, at Company's discretion, to: (a) any Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. In addition, Provider agrees to facilitate the transfer of care for any Members then receiving services under this Agreement to another Participating Provider. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Provider will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Relationship**. Company and Provider are independent contractors, and not employees, agents or representatives of each other. Company and Provider will each be solely liable for its own activities and those of its employees and other agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not

limited to, reasonable attorneys' fees) arising out of Provider's and/or Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless Provider and Group Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Provider agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Provider will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent.

6.3 **Interference with Contractual Relations**. Provider will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Provider will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between Provider and a Member, or a party designated by a Member, that is determined by Provider to be necessary or appropriate for the diagnosis and care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution**. Company will provide an internal mechanism under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association. **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator(s) must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law and/or an applicable **State Compliance Addendum**, this Agreement will be governed in all respects by the laws of the state where Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Insurance**. Company agrees to procure and maintain such policies of general and other insurance, and/or maintain an appropriate program of self-insurance, as shall be necessary to insure Company and its employees against any claim(s) for damages arising in connection with the performance of Company's obligations under this Agreement. Provider agrees to procure and maintain such policies of general and professional liability and other insurance at minimum levels required by state law, or in the absence of state law specifying a minimum limit, an amount customarily maintained by similarly situated providers of similar services in the state(s) or region(s) in which Provider operates. Such insurance coverage shall cover the acts and omissions of Provider and Group Providers.

8.4 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.5 **Assignment**. Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

8.6 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency, governmental authority or applicable accreditation agency. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice to Provider by letter, newsletter, or electronic or other commonly accepted media, to comply with Applicable Law.

8.7 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.8 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity, that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Provider, applicable accreditation agency/organization requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Group Provider. A health care provider who is employed by or contracted with Provider or who otherwise bills for services under this Agreement, whether on a regular or on call basis. Group Provider includes all of the persons and entities that provide services to Members in any of Provider's practice arrangements, Individual Sites, or locations and under any of its tax identification numbers, unless specifically excluded, as explained in the Agreement.

Individual Sites. Individual Provider facilities and/or centers that are owned and/or operated by Provider (and including employed and/or contracted personnel providing services at such sites).

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Provider, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Provider serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Provider participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

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MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include Medicaid Products, as defined below.

1. **Definitions**.

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. Medicaid Product(s). Those publicly funded or subsidized managed-care programs for Medicaid, Children's Health Insurance Program (CHIP), and/or other low-income or otherwise qualified individuals that are operated and/or administered by Company, as set forth in **Exhibit B – Service and Rate Schedule (Medicaid Products)**, which may include without limitation managed long-term services and supports (a/k/a MLTSS) programs and any integrated or D-SNP Medicare-Medicaid plans (a/k/a MMPs or dual-eligible plans).

   c. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in **Exhibit B – Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in **Exhibit C – State Compliance Addendum (Medicaid Products)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other

authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Product Addendum**. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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EXHIBIT A

AFFILIATE LISTING

[Insert Affiliate Listing Chart]

EXHIBIT B

SERVICE AND RATE SCHEDULE (MEDICAID PRODUCTS)

1.0 DEFINITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Medicare Allowable Payment (Inpatient Services) is defined as the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Administrative Contractor (MAC) would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and Aetna payment and processing guidelines. The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a MAC for both overpayments and underpayments.

C. Medicare Physician Fee Schedule (MFS) is defined as a fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within sixty (60) days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Company payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

2.0 TERMS AND CONDITIONS

A. Medicare-Medicaid Plans. Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether CMS and other applicable Government Sponsors regard that service as a Medicare Covered Service or a Medicaid Covered Service when and as provided by a particular provider, and by a Member's benefit limits under each program. For Covered Services that are Medicare Covered Services when and as provided by Provider (inclusive of Member copayment or coinsurance), Company shall compensate Provider at the Medicare Allowable rate. For Covered Services that are *only* covered under Medicaid when and as provided by Provider (such as, but not limited to, long-term care and home and community based waiver services), Company shall compensate Provider at the AMMFS rate. When a service is covered under *both* Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination-of-benefit principles, and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

B. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (*e.g.*, Merit-Based Incentive Payment System (MIPS), Alternate Payment Models (APM)).

[Insert any other National Service and Rate Terms]

EXHIBIT B-[1]

[STATE #1]-Specific Service and Rate Schedule

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following Medicaid Product(s):

A. The Medicaid and/or CHIP Plans offered by Company within **[State #1]**.

B. The integrated or D-SNP Medicare-Medicaid Plans (a/k/a MMPs or dual-eligible plans) offered by Company within **[State #1]**.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider's actual billed charges, whichever is less:

Medicaid and/or CHIP Plans:	Aetna Medicaid Market Fee Schedule
Medicare-Medicaid Plans:	Medicare Allowable Payment or Medicare Physician Fee Schedule (as applicable)

[or alternative compensation amounts/terms to be negotiated with Provider on a case-by-case basis]

[Insert any other State-specific Service and Rate Terms]

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EXHIBIT C

STATE COMPLIANCE ADDENDUM (MEDICAID PRODUCTS)

The Parties acknowledge that each State Compliance Addenda that follows shall apply to the extent that (i) Company offers Medicaid Products in such State and (ii) Provider and/or Group Providers provide services or items in such State.

[Insert if Provider reasonably objects to applicability of certain language in the RCAs due to nature of Provider's services (ask legal if not sure if reasonable)→]

[Notwithstanding the foregoing, the Parties agree that certain provisions in the State Compliance Addenda are applicable to certain providers of health care services and to the extent that Provider and/or Group Providers provide different kinds of services, certain of the provisions may not reasonably apply to Provider.]

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EXHIBIT C-[1]

[Insert Name of State #1 RCA Document]

EXHIBIT D

PERFORMANCE GUARANTEES (MEDICAID PRODUCTS)

[Insert any National Performance Guarantees]

EXHIBIT D-[1]

[State #1]-Specific Performance Guarantee

[Insert any State-Specific Performance Guarantees]

EXHIBIT E

VALUE-BASED SOLUTIONS ADDENDUM

[Insert name of VBS Addenda, if any; add state-specific VBS addenda (E-1, E-2, etc.), if any]

EXHIBIT F

[ADD OTHER EXHIBITS, IF ANY]

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Medicaid Provider Agreement

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PROVIDER AGREEMENT

Aetna Better Health of _____, on behalf of itself and its Affiliates ("Company"), and **[INSERT PROVIDER NAME],** on behalf of itself and any and all of its Group Providers and locations ("Provider"), are entering into this Provider Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page and the **General Terms and Conditions** that follow. It also includes and incorporates one or more of the following **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, **Product Addendum(a)**, or other attachments (collectively, the "Agreement"), as checked below:

	AGREEMENT PARTS
✓	This Cover & Signature Page
✓	General Terms and Conditions
✓	Medicaid Product Addendum
✓	Service and Rate Schedule (Medicaid Products)
✓	State Compliance Addendum (Medicaid Products)
	[Other] (Indian Health Care Provider Addendum, etc.)

EFFECTIVE DATE: [DATE] (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Provider agrees that it has read and understood this Agreement, has had the opportunity to review it with an attorney of its choice, and is authorized to bind Provider, including all Group Providers and Provider locations, to the terms of the Agreement.

PROVIDER

By:_____

Printed Name:_____

Title:_____

COMPANY

By:_____

Printed Name:_____

Title:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

As required by Section 8.7 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Provider:

_____

_____

Company:

Aetna Better Health

Attn: Network Management

_____ **4500 E. Cotton Center Blvd**

_____ **Phoenix, AZ 85040**

[*If applicable add:* With additional notice from Provider to be sent to:]
Aetna Better Health of State Name
[ADDRESS]

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GENERAL TERMS AND CONDITIONS

1.0 PROVIDER OBLIGATIONS

1.1 **General Obligations**. Provider agrees that it and all Group Providers will:

(a) provide Covered Services to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Provider represents that neither it nor any Group Provider has been excluded from participation in any Federal or state funded health program, or have a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Provider understands that no Group Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Group Providers in all Provider locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Provider's services to be made directly to Provider instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Provider further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Provider agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act ("ACA") (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Provider will not accept any referral from persons or entities that have a financial interest in Provider, or make any referrals to persons or entities in which Provider has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (a) material litigation brought against Provider or a Group Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Provider renders to Members; (b) claims against Provider or a Group Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (c) change in the ownership or management of Provider; and (d) material change in services provided by Provider or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Provider or a Group Provider related to those services.

1.2 **Provider and Group Provider Contact and Service Information**. Provider agrees that it has provided Company with contact information, including, but not limited to, a list of Group Providers and Provider locations, that is complete and accurate as of the Effective Date. Provider will notify Company within ten (10) business days of all changes to the list of Group Providers, the services it/they provide and all contact and billing information for Provider and Group Providers. Provider understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's requirements for updating information and the actions it may take if Provider fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Provider.

1.3 **Compliance with Company Policies**. Provider agrees to comply with Company Policies, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Provider's administration or rates under this Agreement, Company will send Provider at least ninety (90) days advance written notice of the Policy change. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment**. Subject to Applicable Law, Provider agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Group Providers for services rendered, and that it will require all Group Providers to look solely to Provider for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Provider and Group Providers, containing all information needed to process the claims, within one hundred and twenty (120) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Provider's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) to notify Company of any underpayment, or payment or claim denial dispute, within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Provider acquires or takes operational responsibility for another Participating Provider practice, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider until the earlier of such time as: (a) Company and Provider negotiate and implement new mutually agreeable rates for that Participating Provider under this Agreement; or (b) Company terminates that Participating Provider's network participation with at least one hundred and eighty (180) days prior written notice to Provider and the Participating Provider.

1.5 **Member Billing**. Provider agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Provider's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Provider; (ii) provide Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Provider with a means to check Member eligibility; and (iv) include Provider in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Providers through its provider websites or other commonly accepted media.

2.2 **Claims Payment**. Subject to Applicable Law, the terms of each applicable **Product Addendum(a) and Service and Rate Schedule(s)**, and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees:

(a) when it is the Payer, to pay Provider for Covered Services rendered to Members; and

(b) when it is not the Payer, to notify the Payer to forward payment to Provider for Covered Services,

within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim. While Company may service or process payment for claims on behalf of Payers who are not Affiliates (e.g., self-funded plan sponsors), Provider

acknowledges that Company has no legal or other responsibility for the payment of those claims. However, Company will use commercially reasonable efforts to assist Provider, as appropriate, in collecting payments from Payers.

3.0 NETWORK PARTICIPATION

Provider agrees that it and Group Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company has the right, upon ninety (90) days written notice to Provider, to:

(a) add Product Categories (e.g., Medicare or a new Product Category not existing as of the Effective Date); and

(b) add types of Plans (e.g., PPO, HMO) and/or specialty programs (e.g., disease management or women's health) in any Product Category;

Company will notify Provider of the rates that will apply for any addition and will, as necessary, send Provider a new or revised **Product Addendum** and **Service and Rate Schedule**.

Provider can decline any addition by notifying Company in writing, within thirty (30) days of receiving Company's notice. A variation of an existing Product Category, Plan type or specialty program at existing terms and rates will not be considered "an addition" under this section.

Company is not required to designate or include Provider, any specific Group Provider(s) or any specific Provider location(s) as a preferred provider or Participating Provider in any specific Product Category, Plan (or Plan variation) or specialty program. Company may operate networks in which Provider is not included, whether for specific Payers/customers or otherwise. In certain situations, Provider may treat a Member of a Plan or Product Category in which Provider does not participate (e.g., a Member traveling out of area, emergency services). In those situations, Company may apply rates and terms (e.g., no balance billing) that Provider has accepted under this Agreement for Covered Services provided to those Members. Not all Product Categories and Plan types are available in all geographic locations.

4.0 CONFIDENTIALITY

Company and Provider agree that Provider's medical records do not belong to Company. Company and Provider agree that the information contained in the claims Provider submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (i) to governmental authorities having jurisdiction; (ii) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (iii) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Provider will keep the rates and the development of rates and other terms of this Agreement confidential. However, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Group Providers**. Company may terminate the participation of one or more individual Group Providers or locations by providing Group with at least ninety (90) days written notice prior to the date of termination.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Provider or any Group Provider or location, with written notice to Provider, due to: (a) Provider's or the applicable Group Provider's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Provider for the benefit of creditors; (c) Provider's or the applicable Group Provider's indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to fraud or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Provider to an entity not acceptable to Company; (f) any false statement or material omission of Provider or a Group Provider in a network participation application and/or related materials; or (g) a determination by Company that Provider's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in (a)-(f) above. Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Provider agrees to provide services, at Company's discretion, to: (a) any Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Provider will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Relationship**. Company and Provider are independent contractors, and not employees, agents or representatives of each other. Company and Provider will each be solely liable for its own activities and those of its employees and other agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Provider's and/or Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless Provider and Group Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Provider agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Provider will not use

Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent.

6.3 **Interference with Contractual Relations**. Provider will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Provider will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (i) any communication between Provider and a Member, or a party designated by a Member, that is determined by Provider to be necessary or appropriate for the diagnosis and care of the Member; or (ii) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution and Mediation**. Company will provide an internal mechanism under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any

subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.4 **Assignment**. Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

8.5 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Additionally, Company may amend this Agreement, upon at least ninety (90) days prior written notice to Provider. If Provider is not willing to accept an Amendment that is not required by Applicable Law, it may terminate the Agreement, with at least sixty (60) days written notice to Company in advance of the effective date of the Amendment.

8.6 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.7 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

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APPENDIX 1 - DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Provider, applicable accreditation agency/organization requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Group Provider. A health care provider who is employed by or contracted with Provider or who otherwise bills for services under this Agreement, whether on a regular or on call basis. Group Provider includes all of the persons and entities that provide services to Members in any of Provider's practice arrangements or locations and under any of its tax identification numbers, unless specifically excluded, as explained in the Agreement.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Provider, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Provider serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Provider participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include Medicaid Products, as defined below.

1. **Definitions**.

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. Medicaid Product(s). Those publicly funded or subsidized managed-care programs for Medicaid, Children's Health Insurance Program (CHIP), and/or other low-income or otherwise qualified individuals that are operated and/or administered by Company, as set forth in the **Service and Rate Schedule (Medicaid Products)**, which may include without limitation managed long-term services and supports (a/k/a MLTSS) programs and any integrated or D-SNP Medicare-Medicaid plans (a/k/a MMPs or dual-eligible plans).

   c. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Product)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Product Addendum**. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following Medicaid Product(s):

A. The Medicaid and/or CHIP Plans offered by Company within the State.

B. The integrated or D-SNP Medicare-Medicaid Plans (a/k/a MMPs or dual-eligible plans) offered by Company within the State.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider's actual billed charges, whichever is less:

Medicaid and/or CHIP Plans:	Aetna Medicaid Market Fee Schedule
Medicare-Medicaid Plans:	Medicare Allowable Payment or Medicare Physician Fee Schedule (as applicable)

[or alternative compensation amounts/terms to be negotiated with Provider on a case-by-case basis]

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Medicare Allowable Payment (Inpatient Services) is defined as the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Administrative Contractor (MAC) would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and Aetna payment and processing guidelines. The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a MAC for both overpayments and underpayments.

C. Medicare Physician Fee Schedule (MFS) is defined as a fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within sixty (60) days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Company payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

D. Medicare-Medicaid Plans. Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether CMS and other applicable Government Sponsors regard that service as a Medicare Covered Service or a Medicaid Covered Service when and as provided by a particular provider, and by a Member's benefit limits under each program. For Covered Services that are Medicare Covered Services when and as provided by Provider (inclusive of Member copayment or coinsurance), Company shall

compensate Provider at the Medicare Allowable rate. For Covered Services that are *only* covered under Medicaid when and as provided by Provider (such as, but not limited to, long-term care and home and community based waiver services), Company shall compensate Provider at the AMMFS rate. When a service is covered under *both* Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination-of-benefit principles, and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

E. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (*e.g.*, Merit-Based Incentive Payment System (MIPS), Alternate Payment Models (APM)).

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Medicaid Hospital Agreement

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HOSPITAL AGREEMENT

Aetna Better Health of _____, on behalf of itself and its Affiliates ("Company"), and **[INSERT HOSPITAL NAME],** on behalf of itself and any and all of its Hospital Providers and locations ("Hospital" or "Provider"), are entering into this Hospital Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page and the **General Terms and Conditions** that follow. It also includes and incorporates one or more of the following **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, **Product Addendum(a)**, or other attachments (collectively, the "Agreement"), as checked below:

	AGREEMENT PARTS
✓	This Cover & Signature Page
✓	General Terms and Conditions
✓	Medicaid Product Addendum
✓	Service and Rate Schedule (Medicaid Products)
✓	State Compliance Addendum (Medicaid Products)
	[Other] (Indian Health Care Provider Addendum, etc.)

EFFECTIVE DATE: [DATE] (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Hospital agrees that he/she has read and understood this Agreement, has had the opportunity to review it with an attorney of Hospital's choice, and is authorized to bind Hospital, including all Hospital Providers and Hospital locations, to the terms of the Agreement.

HOSPITAL

By:_____

Printed Name:_____

Title:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

COMPANY

By:_____

Printed Name:_____

Title:_____

As required by Section 8.7 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Hospital:

_____

_____

Company:

Aetna Better Health

Attn: Network Management

_____ **4500 E. Cotton Center Blvd**

_____ **Phoenix, AZ 85040**

[*If applicable add:* With additional notice from Hospital to be sent to:]
Aetna Better Health of State Name
[ADDRESS]

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GENERAL TERMS AND CONDITIONS

1.0 HOSPITAL OBLIGATIONS

1.1 **General Obligations**. Hospital agrees that it and all Hospital Providers will:

(a) provide Covered Services, including any related facilities, equipment, personnel and/or other resources necessary to provide the Covered Services, to Members according to generally accepted standards of care in the applicable geographic area;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law and conduct all credentialing, privileging, and re-appointment in accordance with Applicable Law and its medical staff by-laws, regulations, and policies;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Hospital represents that neither it nor any Hospital Provider has been excluded from participation in any Federal or state funded health program, or have a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements; Hospital understands that no Hospital Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Hospital locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Hospital's services to be made directly to Hospital instead of to the Member, unless the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Hospital further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Hospital agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act ("ACA") (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Hospital will not accept any referral from persons or entities that have a financial interest in Hospital, or make any referrals to persons or entities in which Hospital has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (a) material litigation brought against Hospital or a Hospital Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Hospital renders to Members; (b) claims against Hospital or a Hospital Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks, that could reasonably have a material impact on Hospital's ability to provide services to Members or to participate in Medicare or Medicaid programs; (c) investigation or action taken by The Joint Commission (TJC) and/or other applicable accrediting organization that could adversely affect Hospital's accreditation status; (d) change in the ownership or management of Hospital; (e) material change in services provided by Hospital (e.g., a significant decrease in medical staff or the closure of a service unit or a material decrease in beds or emergency services departments) or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Hospital or a Hospital Provider related to those services;

(n) mutually commit, together with Company, to the promotion of Member safety and clinical quality, including the prevention of potentially avoidable serious adverse events. Hospital agrees to comply with Company's Patient Safety Events and related policies, and any successor policies, including, but not limited to, notification to applicable reporting agencies; root cause analysis; corrective action; and the waiver of directly related charges for certain events. Hospital agrees to publically report patient safety and quality information at least annually, to one or more external reporting entities, including but not limited to: CMS Quality Reporting Program; TJC; Leapfrog Hospital Survey; and March of Dimes 39-Week Initiative.

1.2 **Hospital Contact and Service Information**. Hospital agrees that it has provided Company with contact information that is complete and accurate as of the Effective Date. Hospital will notify Company within ten (10) business days of all changes to the list of Hospital Providers, the services it/they provide and all contact and billing information for Hospital and Hospital Providers. Hospital understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's requirements for updating information and the actions it may take if Hospital fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Hospital.

1.3 **Compliance with Company Policies**. Hospital agrees to comply with Company Policies of which Hospital knows or reasonably should have known, including, but not limited to, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Hospital's administration or rates under this Agreement, Company will send Hospital at least ninety (90) days advance written notice of the Policy change. Hospital understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. If Hospital objects to a Policy change that will have a significant impact on Hospital's administration or operations or will create a material adverse financial impact for Hospital, it shall, within sixty (60) days of Company's notification, provide Company with written notice, specifying the basis for its concern; in such event, the Parties will negotiate, in good faith, an appropriate amendment, if any, to this Agreement. Hospital is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment**. Subject to Applicable Law, Hospital agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Hospital Providers for services rendered, and that it will require all Hospital Providers to look solely to Hospital for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Hospital and Hospital Providers, containing all information needed to process the claims, within one hundred and twenty (120) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Hospital provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Hospital's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) to notify Company of any underpayment, or payment or claim denial dispute within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Hospital's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Hospital acquires or takes operational responsibility for another Participating Provider practice, hospital or other facility, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider until the earlier of such time as: (a) Company and Hospital negotiate and implement new mutually agreeable rates for that Participating Provider under this Agreement; or (b) Company terminates that Participating Provider's network participation with at least one hundred and eighty (180) days prior written notice to Hospital and the Participating Provider.

1.5 **Member Billing**. Hospital agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Hospital's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

1.6 **Utilization Management**. Hospital agrees that it shall be subject to utilization management (including prospective, concurrent and retrospective review) and that payment for Hospital services may be adjusted or denied for the inefficient delivery of services related to admissions, or length of stay. To facilitate timely and accurate concurrent utilization management, Hospital and Company will cooperate as necessary to facilitate on-site and/or concurrent telephonic utilization management at Hospital.

1.7 **Precertification and Referrals**. Except when a Member requires emergency services, Hospital agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Hospital services. Hospital will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions. Hospital agrees to provide notice of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For the purpose of pre-admission testing, Hospital agrees to directly provide testing or

accept test results and examinations performed outside Hospital, provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the admission. For those Members who require services under a specialty program, Hospital agrees to work with Company in transferring the Member's care to a specialty program Hospital, as the case may be.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Hospital, (ii) provide Hospital with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Hospital with a means to check Member eligibility; and (iv) include Hospital in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Hospital of periodic updates to its Policies as required by this Agreement and make current Policies available to Hospital through its provider websites or other commonly accepted media.

2.2 **Claims Payment**. Subject to Applicable Law, the terms of each applicable **Product Addendum(a) and Service and Rate Schedule(s)**, and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees:

(a) when it is the Payer, to pay Hospital for Covered Services rendered to Members; and

(b) when it is not the Payer, to notify the Payer to forward payment to Hospital for Covered Services,

within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim. While Company may service or process payment for claims on behalf of Payers who are not Affiliates (e.g., self-funded plan sponsors), Hospital acknowledges that Company has no legal or other responsibility for the payment of those claims. However, Company will use commercially reasonable efforts to assist Hospital, as appropriate, in collecting payments from Payers.

3.0 NETWORK PARTICIPATION

Hospital agrees that it and Hospital Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company has the right, upon ninety (90) days written notice to Hospital, to:

(a) add Product Categories (e.g., Medicare or a new Product Category not existing as of the Effective Date); and

(b) add types of Plans (e.g., PPO, HMO) and/or specialty programs (e.g., disease management or women's health) in any Product Category;

Company will notify Hospital of the rates that will apply for any addition and will, as necessary, send Hospital a new or revised **Product Addendum** and **Service and Rate Schedule**.

Hospital can decline any addition by notifying Company in writing, within thirty (30) days of receiving Company's notice. A variation of an existing Product Category, Plan type or specialty program at existing terms and rates will not be considered "an addition" under this section.

Company is not required to designate or include Hospital, any specific Hospital Provider(s) or any specific Hospital location(s) as a preferred provider or Participating Provider in any specific Product Category, Plan (or Plan variation) or specialty program. Company may operate networks in which Hospital is not included, whether for specific Payers/customers or otherwise. In certain situations, Hospital may treat a Member of a Plan or Product Category in which Hospital does not participate (e.g., a Member traveling out of area, emergency services). In those situations, Company may apply rates and terms (e.g., no balance billing) that Hospital has accepted under this Agreement for Covered Services provided to those Members. Not all Product Categories and Plan types are available in all geographic locations.

4.0 CONFIDENTIALITY

Company and Hospital agree that medical records do not belong to Company. Company and Hospital agree that the information contained in the claims Hospital submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (i) to governmental authorities having jurisdiction; (ii) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (iii) in the case of Hospital/Hospital Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Hospital will keep the rates and the development of rates and other terms of this Agreement confidential. However, Hospital, through its staff, is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which Hospital is paid. In addition, Hospital and Hospital Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Hospitals, Facilities or Locations**. Company may terminate the participation of one or more of Hospital's individual hospitals, facilities or locations: (a) without cause, by providing Hospital with at least one hundred and eighty (180) days written notice prior to the date of termination; or (b) for breach, as specified below, without affecting the participation of other hospitals/facilities/locations.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Hospital or any Hospital Provider or location, with written notice to Hospital, due to: (a) Hospital's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) the bankruptcy or receivership of Hospital, or an assignment by Hospital for the benefit of creditors; (c) the exclusion, debarment or suspension of Hospital or a Hospital Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (d) change of control of Hospital to an entity not acceptable to Company; (e) the revocation or suspension of Hospital's accreditation by TJC or any other applicable accrediting agency; or (f) a determination by Company that Hospital's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Hospital will provide immediate notice to Company of any of the events described in (a)-(e) above. Hospital may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under

this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Hospital agrees to provide services, at Company's discretion, to: (a) any Member under Hospital's care who, at the time of the effective date of termination, is a registered bed patient at Hospital, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Hospital will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Relationship**. Company and Hospital are independent contractors, and not employees, agents or representatives of each other. Company and Hospital will each be solely liable for its own activities and those of its employees and other agents, and neither Company nor Hospital will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Hospital acknowledges that all Member care and related decisions are the responsibility of Hospital and/or Hospital Providers and that Policies do not dictate or control Hospital's and/or Hospital Providers' clinical decisions with respect to the care of Members. Hospital agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Hospital's and/or Hospital Providers' provision of care to Members. Company agrees to indemnify and hold harmless Hospital and Hospital Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Hospital agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Hospital will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent, which consent shall not be unreasonably withheld.

6.3 **Interference with Contractual Relations**. Hospital will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Hospital will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (i) any communication between Hospital and a Member, or a party designated by a Member determined by Hospital to be necessary or appropriate for the diagnosis and care of the Member; or (ii) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution and Mediation**. Company will provide an internal mechanism under which Hospital can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Hospital will

exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND HOSPITAL UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Hospital is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in

any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Insurance**. Company agrees to procure and maintain such policies of general and other insurance, and/or maintain an appropriate program of self-insurance, as shall be necessary to insure Company and its employees against any claim or claims for damages arising directly or indirectly in connection with the performance of any service by Company under this Agreement. Hospital agrees to procure and maintain such policies of general and professional liability and other insurance or a comparable program of self-insurance at minimum levels as required by state law, or in the absence of a state law specifying a minimum limit, an amount customarily maintained by hospitals in the state or region in which the Hospital operates. Such insurance coverage shall cover the acts and omissions of Hospital as well as those of Hospital's agents and employees.

8.4 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.5 **Assignment**. Hospital may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Hospital participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Hospital.

8.6 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency, governmental authority or applicable accreditation agency. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice, by letter, newsletter, electronic mail or other media, to Hospital to comply with Applicable Law, or any order or directive of any governmental agency.

8.7 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.8 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

APPENDIX 1 - DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Hospital, applicable accreditation agency or organization (e.g., TJC) requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Hospital Provider. Any physician or other health care provider employed by Hospital or who, through a contract or arrangement with Hospital, provides those services to Members that are described in the professional component section of the applicable **Service and Rate Schedule**.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Hospital, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Hospital serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria, Provider Manuals, clinical policy bulletins, credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, Institutes of Excellence™, complaint and appeals, and other policies and procedures (as modified from time to time) that are made available to Hospital electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Hospital participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include Medicaid Products, as defined below.

1. **Definitions**.

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. Medicaid Product(s). Those publicly funded or subsidized managed-care programs for Medicaid, Children's Health Insurance Program (CHIP), and/or other low-income or otherwise qualified individuals that are operated and/or administered by Company, as set forth in the **Service and Rate Schedule (Medicaid Products)**, which may include without limitation managed long-term services and supports (a/k/a MLTSS) programs and any integrated or D-SNP Medicare-Medicaid plans (a/k/a MMPs or dual-eligible plans).

   c. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Product)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Product Addendum**. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following Medicaid Product(s):

A. The Medicaid and/or CHIP Plans offered by Company within the State.

B. The integrated or D-SNP Medicare-Medicaid Plans (a/k/a MMPs or dual-eligible plans) offered by Company within the State.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider's actual billed charges, whichever is less:

Medicaid and/or CHIP Plans:	Aetna Medicaid Market Fee Schedule
Medicare-Medicaid Plans:	Medicare Allowable Payment or Medicare Physician Fee Schedule (as applicable)

[or alternative compensation amounts/terms to be negotiated with Provider on a case-by-case basis]

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Medicare Allowable Payment (Inpatient Services) is defined as the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Administrative Contractor (MAC) would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and Aetna payment and processing guidelines. The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a MAC for both overpayments and underpayments.

C. Medicare Physician Fee Schedule (MFS) is defined as a fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within sixty (60) days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Company payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

D. Medicare-Medicaid Plans. Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether CMS and other applicable Government Sponsors regard that service as a Medicare Covered Service or a Medicaid Covered Service when and as provided by a particular provider, and by a Member's benefit limits under each program. For Covered Services that are Medicare Covered

Services when and as provided by Provider (inclusive of Member copayment or coinsurance), Company shall compensate Provider at the Medicare Allowable rate. For Covered Services that are *only* covered under Medicaid when and as provided by Provider (such as, but not limited to, long-term care and home and community based waiver services), Company shall compensate Provider at the AMMFS rate. When a service is covered under *both* Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination-of-benefit principles, and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

E. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (*e.g.*, Merit-Based Incentive Payment System (MIPS), Alternate Payment Models (APM)).

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Medicaid Facility Agreement

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FACILITY AGREEMENT

Aetna Better Health of _____, on behalf of itself and its Affiliates ("Company"), and **[INSERT FACILITY NAME],** on behalf of itself and any and all of its Facility Providers and locations ("Facility" or "Provider"), are entering into this Facility Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page and the **General Terms and Conditions** that follow. It also includes and incorporates one or more of the following **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, **Product Addendum(a)**, or other attachments (collectively, the "Agreement"), as checked below:

	AGREEMENT PARTS
✓	This Cover & Signature Page
✓	General Terms and Conditions
✓	Medicaid Product Addendum
✓	Service and Rate Schedule (Medicaid Products)
✓	State Compliance Addendum (Medicaid Products)
	[Other] (Indian Health Care Provider Addendum, etc.)

EFFECTIVE DATE: [DATE] (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Facility agrees that he/she has read and understood this Agreement, has had the opportunity to review it with an attorney of Facility's choice, and is authorized to bind Facility, including all Facility Providers and Facility locations, to the terms of the Agreement.

FACILITY

By:_____

Printed Name:_____

Title:_____

COMPANY

By:_____

Printed Name:_____

Title:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

As required by Section 8.7 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Hospital:

_____

_____

_____

Company:

Aetna Better Health

Attn: Network Management

4500 E. Cotton Center Blvd

_____ **Phoenix, AZ 85040**

If applicable add: **With additional notice from Hospital to be sent to:]**

Aetna Better Health of State Name

[ADDRESS]

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GENERAL TERMS AND CONDITIONS

1.0 FACILITY OBLIGATIONS

1.1 **General Obligations**. Facility agrees that it and all Facility Providers will:

(a) provide Covered Services, including any related facilities, equipment, personnel and/or other resources necessary to provide the Covered Services, to Members according to generally accepted standards of care in the applicable geographic area;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law and conduct all credentialing, privileging, and re-appointment in accordance with Applicable Law and its medical staff by-laws, regulations, and policies;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Facility represents that neither it nor any Facility Provider has been excluded from participation in any Federal or state funded health program, or have a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Facility understands that no Facility Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Facility Providers in all Facility locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Facility's services to be made directly to Facility instead of to the Member, unless the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Facility further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Facility agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act ("ACA") (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Facility will not accept any referral from persons or entities that have a financial interest in Facility, or make any referrals to persons or entities in which Facility has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (a) material litigation brought against Facility or a Facility Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Facility renders to Members; (b) claims against Facility or a Facility Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks, that could reasonably have a material impact on Facility's ability to provide services to Members or to participate in Medicare or Medicaid programs; (c) investigation or action taken by The Joint Commission (TJC) and/or other applicable accrediting organization that could adversely affect Facility's accreditation status; (d) change in the ownership or management of Facility; (e) material change in services provided by Facility (e.g., a significant decrease in medical staff or the closure of a service unit or a material decrease in beds or emergency services departments) or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Facility or a Facility Provider related to those services;

(n) mutually commit, together with Company, to the promotion of Member safety and clinical quality, including the prevention of potentially avoidable serious adverse events. Facility agrees to comply with Company's Patient Safety Events and related policies, and any successor policies, including, but not limited to, notification to applicable reporting agencies; root cause analysis; corrective action; and the waiver of directly related charges for certain events. Facility agrees to publically report patient safety and quality information at least annually, to one or more external reporting entities, including but not limited to: CMS Quality Reporting Program; TJC; Leapfrog Facility Survey; and March of Dimes 39-Week Initiative.

1.2 **Facility Contact and Service Information**. Facility agrees that it has provided Company with contact information that is complete and accurate as of the Effective Date. Facility will notify Company within ten (10) business days of all changes to the list of Facility Providers, the services it/they provide and all contact and billing information for Facility and Facility Providers. Facility understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's requirements for updating information and the actions it may take if Facility fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Facility.

1.3 **Compliance with Company Policies**. Facility agrees to comply with Company Policies of which Facility knows or reasonably should have known, including, but not limited to, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Facility's administration or rates under this Agreement, Company will send Facility at least ninety (90) days advance written notice of the Policy change. Facility understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. If Facility objects to a Policy change that will have a significant impact on Facility's administration or operations or will create a material adverse financial impact for Facility, it shall, within sixty (60) days of Company's notification, provide Company with written notice, specifying the basis for its concern; in such event, the Parties will negotiate, in good faith, an appropriate amendment, if any, to this Agreement. Facility is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment**. Subject to Applicable Law, Facility agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Facility Providers for services rendered, and that it will require all Facility Providers to look solely to Facility for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Facility and Facility Providers, containing all information needed to process the claims, within one hundred and twenty (120) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Facility provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Facility's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) to notify Company of any underpayment, or payment or claim denial dispute within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Facility's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Facility acquires or takes operational responsibility for another Participating Provider practice or other facility, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider until the earlier of such time as: (a) Company and Facility negotiate and implement new mutually agreeable rates for that Participating Provider under this Agreement; or (b) Company terminates that Participating Provider's network participation with at least one hundred and eighty (180) days prior written notice to Facility and the Participating Provider.

1.5 **Member Billing**. Facility agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Facility's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

1.6 **Utilization Management**. Facility agrees that it shall be subject to utilization management (including prospective, concurrent and retrospective review) and that payment for Facility services may be adjusted or denied for the inefficient delivery of services related to admissions, or length of stay. To facilitate timely and accurate concurrent utilization management, Facility and Company will cooperate as necessary to facilitate on-site and/or concurrent telephonic utilization management at Facility.

1.7 **Precertification and Referrals**. Except when a Member requires emergency services, Facility agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Facility services. Facility will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions. Facility agrees to provide notice of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such

services. For the purpose of pre-admission testing, Facility agrees to directly provide testing or accept test results and examinations performed outside Facility, provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the admission. For those Members who require services under a specialty program, Facility agrees to work with Company in transferring the Member's care to a specialty program Facility, as the case may be.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Facility, (ii) provide Facility with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Facility with a means to check Member eligibility; and (iv) include Facility in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Facility of periodic updates to its Policies as required by this Agreement and make current Policies available to Facility through its provider websites or other commonly accepted media.

2.2 **Claims Payment**. Subject to Applicable Law, the terms of each applicable **Product Addendum(a) and Service and Rate Schedule(s)**, and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees:

(a) when it is the Payer, to pay Facility for Covered Services rendered to Members; and
(b) when it is not the Payer, to notify the Payer to forward payment to Facility for Covered Services,

within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim. While Company may service or process payment for claims on behalf of Payers who are not Affiliates (e.g., self-funded plan sponsors), Facility acknowledges that Company has no legal or other responsibility for the payment of those claims. However, Company will use commercially reasonable efforts to assist Facility, as appropriate, in collecting payments from Payers.

3.0 NETWORK PARTICIPATION

Facility agrees that it and Facility Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company has the right, upon ninety (90) days written notice to Facility, to:

(a) add Product Categories (e.g., Medicare or a new Product Category not existing as of the Effective Date); and
(b) add types of Plans (e.g., PPO, HMO) and/or specialty programs (e.g., disease management or women's health) in any Product Category;

Company will notify Facility of the rates that will apply for any addition and will, as necessary, send Facility a new or revised **Product Addendum** and **Service and Rate Schedule**.

Facility can decline any addition by notifying Company in writing, within thirty (30) days of receiving Company's notice. A variation of an existing Product Category, Plan type or specialty program at existing terms and rates will not be considered "an addition" under this section.

Company is not required to designate or include Facility, any specific Facility Provider(s) or any specific Facility location(s) as a preferred provider or Participating Provider in any specific Product Category, Plan (or Plan variation)

or specialty program. Company may operate networks in which Facility is not included, whether for specific Payers/customers or otherwise. In certain situations, Facility may treat a Member of a Plan or Product Category in which Facility does not participate (e.g., a Member traveling out of area, emergency services). In those situations, Company may apply rates and terms (e.g., no balance billing) that Facility has accepted under this Agreement for Covered Services provided to those Members. Not all Product Categories and Plan types are available in all geographic locations.

4.0 CONFIDENTIALITY

Company and Facility agree that medical records do not belong to Company. Company and Facility agree that the information contained in the claims Facility submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (i) to governmental authorities having jurisdiction; (ii) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (iii) in the case of Facility/Facility Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Facility will keep the rates and the development of rates and other terms of this Agreement confidential. However, Facility, through its staff, is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which Facility is paid. In addition, Facility and Facility Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Facilities or Locations**. Company may terminate the participation of one or more of Facility's individual facilities or locations: (a) without cause, by providing Facility with at least one hundred and eighty (180) days written notice prior to the date of termination; or (b) for breach, as specified below, without affecting the participation of other facilities/locations.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Facility or any Facility Provider or location, with written notice to Facility, due to: (a) Facility's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) the bankruptcy or receivership of Facility, or an assignment by Facility for the benefit of creditors; (c) the exclusion, debarment or suspension of Facility or a Facility Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (d) change of control of Facility to an entity not acceptable to Company; (e) the revocation or suspension of Facility's accreditation by TJC or any other applicable accrediting agency; or (f) a determination by Company that Facility's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Facility will provide immediate notice to Company of any of the events described in (a)-(e) above. Facility may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Facility agrees to provide services, at Company's discretion, to: (a) any Member under Facility's care who, at the time of the effective date of termination, is a registered bed patient at Facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable

Service and Rate Schedule will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Facility will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Relationship**. Company and Facility are independent contractors, and not employees, agents or representatives of each other. Company and Facility will each be solely liable for its own activities and those of its employees and other agents, and neither Company nor Facility will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Facility acknowledges that all Member care and related decisions are the responsibility of Facility and/or Facility Providers and that Policies do not dictate or control Facility's and/or Facility Providers' clinical decisions with respect to the care of Members. Facility agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Facility's and/or Facility Providers' provision of care to Members. Company agrees to indemnify and hold harmless Facility and Facility Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Facility agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Facility will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent, which consent shall not be unreasonably withheld.

6.3 **Interference with Contractual Relations**. Facility will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Facility will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (i) any communication between Facility and a Member, or a party designated by a Member determined by Facility to be necessary or appropriate for the diagnosis and care of the Member; or (ii) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution and Mediation**. Company will provide an internal mechanism under which Facility can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Facility will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND FACILITY UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR**

INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT. The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Facility is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Insurance**. Company agrees to procure and maintain such policies of general and other insurance, and/or maintain an appropriate program of self-insurance, as shall be necessary to insure Company and its employees against any claim or claims for damages arising directly or indirectly in connection with the performance of any service by Company under this Agreement. Facility agrees to procure and maintain such policies of general and professional liability and other insurance or a comparable program of self-insurance at minimum levels as required by state law, or in the absence of a state law specifying a minimum limit, an amount customarily maintained by facilities in the state or region in which the Facility operates. Such insurance coverage shall cover the acts and omissions of Facility as well as those of Facility's agents and employees.

8.4 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.5 **Assignment**. Facility may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Facility participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Facility.

8.6 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency, governmental authority or applicable accreditation agency. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice, by letter, newsletter, electronic mail or other media, to Facility to comply with Applicable Law, or any order or directive of any governmental agency.

8.7 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.8 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

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APPENDIX 1 - DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Facility, applicable accreditation agency or organization (e.g., TJC, Committee on Accreditation of Rehabilitation Facilities ("CARF"), American Association for Accreditation of Ambulatory Surgery Facilities ("AAAASF"), American Osteopathic Association's Healthcare Facilities Accreditation Program ("HFAP")) requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Facility Provider. Any physician or other health care provider employed by Facility or who, through a contract or arrangement with Facility, provides those services to Members that are described in the professional component section of the applicable **Service and Rate Schedule**.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Facility, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Facility serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria, Provider Manuals, clinical policy bulletins, credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, Institutes of Excellence™, complaint and appeals, and other policies and procedures (as modified from time to time) that are made available to Facility electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Facility participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include Medicaid Products, as defined below.

1. **Definitions.**

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. Medicaid Product(s). Those publicly funded or subsidized managed-care programs for Medicaid, Children's Health Insurance Program (CHIP), and/or other low-income or otherwise qualified individuals that are operated and/or administered by Company, as set forth in the **Service and Rate Schedule (Medicaid Products)**, which may include without limitation managed long-term services and supports (a/k/a MLTSS) programs and any integrated or D-SNP Medicare-Medicaid plans (a/k/a MMPs or dual-eligible plans).

   c. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Product)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Product Addendum**. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following Medicaid Product(s):

A. The Medicaid and/or CHIP Plans offered by Company within the State.

B. The integrated or D-SNP Medicare-Medicaid Plans (a/k/a MMPs or dual-eligible plans) offered by Company within the State.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider's actual billed charges, whichever is less:

Medicaid and/or CHIP Plans:	Aetna Medicaid Market Fee Schedule
Medicare-Medicaid Plans:	Medicare Allowable Payment or Medicare Physician Fee Schedule (as applicable)

[or alternative compensation amounts/terms to be negotiated with Provider on a case-by-case basis]

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Medicare Allowable Payment (Inpatient Services) is defined as the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Administrative Contractor (MAC) would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and Aetna payment and processing guidelines. The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a MAC for both overpayments and underpayments.

C. Medicare Physician Fee Schedule (MFS) is defined as a fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within sixty (60) days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Company payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

D. Medicare-Medicaid Plans. Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether CMS and other applicable Government Sponsors regard that service as a Medicare Covered Service or a Medicaid Covered Service when and as provided by a particular provider, and by a Member's benefit limits under each program. For Covered Services that are Medicare Covered Services when and as provided by Provider (inclusive of Member copayment or coinsurance), Company shall compensate Provider at the Medicare Allowable rate. For Covered Services that are *only* covered under Medicaid

when and as provided by Provider (such as, but not limited to, long-term care and home and community based waiver services), Company shall compensate Provider at the AMMFS rate. When a service is covered under *both* Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination-of-benefit principles, and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

E. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (*e.g.*, Merit-Based Incentive Payment System (MIPS), Alternate Payment Models (APM)).

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Provider Network Listing

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Provider Counts by Provider Type Summary

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Geographic Access Report

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Kentucky Medicaid - Based on Miles/Minutes

Region Code	Provider Type	Provider Type Description	Population	December 2019 Mlies Adequacy	Minutes Adequacy
01	a	Hospitals and Ambulatory Surgery Centers	Rural	100.0%	100.0%
02	a	Hospitals and Ambulatory Surgery Centers	Urban	100.0%	100.0%
02	a	Hospitals and Ambulatory Surgery Centers	Rural	100.0%	100.0%
03	a	Hospitals and Ambulatory Surgery Centers	Urban	100.0%	100.0%
03	a	Hospitals and Ambulatory Surgery Centers	Rural	100.0%	100.0%
04	a	Hospitals and Ambulatory Surgery Centers	Urban	100.0%	100.0%
04	a	Hospitals and Ambulatory Surgery Centers	Rural	100.0%	100.0%
05	a	Hospitals and Ambulatory Surgery Centers	Urban	100.0%	100.0%
05	a	Hospitals and Ambulatory Surgery Centers	Rural	100.0%	100.0%
06	a	Hospitals and Ambulatory Surgery Centers	Urban	100.0%	100.0%
07	a	Hospitals and Ambulatory Surgery Centers	Urban	100.0%	100.0%
07	a	Hospitals and Ambulatory Surgery Centers	Rural	100.0%	100.0%
08	a	Hospitals and Ambulatory Surgery Centers	Rural	100.0%	100.0%
01	b	Physicians, APRN, PA and Family Planning Providers	Rural	100.0%	100.0%
02	b	Physicians, APRN, PA and Family Planning Providers	Urban	100.0%	100.0%
02	b	Physicians, APRN, PA and Family Planning Providers	Rural	100.0%	100.0%
03	b	Physicians, APRN, PA and Family Planning Providers	Urban	100.0%	100.0%
03	b	Physicians, APRN, PA and Family Planning Providers	Rural	100.0%	100.0%
04	b	Physicians, APRN, PA and Family Planning Providers	Urban	100.0%	100.0%
04	b	Physicians, APRN, PA and Family Planning Providers	Rural	100.0%	100.0%
05	b	Physicians, APRN, PA and Family Planning Providers	Urban	100.0%	100.0%
05	b	Physicians, APRN, PA and Family Planning Providers	Rural	100.0%	100.0%
06	b	Physicians, APRN, PA and Family Planning Providers	Urban	100.0%	100.0%
07	b	Physicians, APRN, PA and Family Planning Providers	Urban	100.0%	100.0%
07	b	Physicians, APRN, PA and Family Planning Providers	Rural	100.0%	100.0%
08	b	Physicians, APRN, PA and Family Planning Providers	Rural	100.0%	100.0%
01	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Rural	100.0%	100.0%
02	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Urban	100.0%	95.2%
02	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Rural	100.0%	100.0%
03	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Urban	100.0%	100.0%
03	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Rural	100.0%	100.0%
04	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Urban	100.0%	100.0%
04	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Rural	100.0%	100.0%
05	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Urban	100.0%	100.0%
05	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Rural	100.0%	100.0%
06	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Urban	100.0%	100.0%
07	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Urban	100.0%	99.9%
07	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Rural	100.0%	100.0%
08	c	Free Standing Birthing Ctrs Primary Care Ctrs LHD, HHA, FQHC, RHC and Private Dute Nursing Agencies	Rural	100.0%	100.0%
01	d	Behavioral Health and Substance Abuse Providers	Rural	100.0%	100.0%
02	d	Behavioral Health and Substance Abuse Providers	Urban	100.0%	100.0%
02	d	Behavioral Health and Substance Abuse Providers	Rural	100.0%	100.0%
03	d	Behavioral Health and Substance Abuse Providers	Urban	100.0%	100.0%
03	d	Behavioral Health and Substance Abuse Providers	Rural	100.0%	100.0%
04	d	Behavioral Health and Substance Abuse Providers	Urban	100.0%	100.0%
04	d	Behavioral Health and Substance Abuse Providers	Rural	100.0%	100.0%
05	d	Behavioral Health and Substance Abuse Providers	Urban	100.0%	100.0%
05	d	Behavioral Health and Substance Abuse Providers	Rural	100.0%	100.0%
06	d	Behavioral Health and Substance Abuse Providers	Urban	100.0%	100.0%
07	d	Behavioral Health and Substance Abuse Providers	Urban	100.0%	100.0%
07	d	Behavioral Health and Substance Abuse Providers	Rural	100.0%	100.0%
08	d	Behavioral Health and Substance Abuse Providers	Rural	100.0%	100.0%
01	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Rural	100.0%	100.0%
02	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Urban	100.0%	100.0%
02	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Rural	100.0%	100.0%
03	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Urban	100.0%	100.0%
03	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Rural	100.0%	100.0%
04	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Urban	100.0%	100.0%
04	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Rural	100.0%	100.0%
05	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Urban	100.0%	100.0%
05	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Rural	100.0%	100.0%
06	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Urban	100.0%	100.0%
07	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Urban	100.0%	100.0%
07	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Rural	100.0%	100.0%
08	e	Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists	Rural	100.0%	100.0%
01	f	Physical Therapists, Occupational Therapists and Chiropractors	Rural	100.0%	100.0%
02	f	Physical Therapists, Occupational Therapists and Chiropractors	Urban	100.0%	100.0%
02	f	Physical Therapists, Occupational Therapists and Chiropractors	Rural	100.0%	100.0%
03	f	Physical Therapists, Occupational Therapists and Chiropractors	Urban	100.0%	100.0%
03	f	Physical Therapists, Occupational Therapists and Chiropractors	Rural	100.0%	100.0%
04	f	Physical Therapists, Occupational Therapists and Chiropractors	Urban	100.0%	100.0%
04	f	Physical Therapists, Occupational Therapists and Chiropractors	Rural	100.0%	100.0%
05	f	Physical Therapists, Occupational Therapists and Chiropractors	Urban	100.0%	100.0%
05	f	Physical Therapists, Occupational Therapists and Chiropractors	Rural	100.0%	100.0%
06	f	Physical Therapists, Occupational Therapists and Chiropractors	Urban	100.0%	100.0%
07	f	Physical Therapists, Occupational Therapists and Chiropractors	Urban	100.0%	100.0%
07	f	Physical Therapists, Occupational Therapists and Chiropractors	Rural	100.0%	100.0%
08	f	Physical Therapists, Occupational Therapists and Chiropractors	Rural	100.0%	100.0%
01	g	Dentists	Rural	100.0%	100.0%
02	g	Dentists	Urban	100.0%	100.0%
02	g	Dentists	Rural	100.0%	100.0%
03	g	Dentists	Urban	100.0%	100.0%
03	g	Dentists	Rural	100.0%	100.0%

04	g	Dentists	Urban	100.0%	100.0%
04	g	Dentists	Rural	100.0%	100.0%
05	g	Dentists	Urban	100.0%	100.0%
05	g	Dentists	Rural	100.0%	100.0%
06	g	Dentists	Urban	100.0%	100.0%
07	g	Dentists	Urban	100.0%	100.0%
07	g	Dentists	Rural	100.0%	100.0%
08	g	Dentists	Rural	100.0%	100.0%
01	h	Pharmacies and Durable Medical Equipment Suppliers	Rural	100.0%	100.0%
02	h	Pharmacies and Durable Medical Equipment Suppliers	Urban	100.0%	100.0%
02	h	Pharmacies and Durable Medical Equipment Suppliers	Rural	100.0%	100.0%
03	h	Pharmacies and Durable Medical Equipment Suppliers	Urban	100.0%	100.0%
03	h	Pharmacies and Durable Medical Equipment Suppliers	Rural	100.0%	100.0%
04	h	Pharmacies and Durable Medical Equipment Suppliers	Urban	100.0%	100.0%
04	h	Pharmacies and Durable Medical Equipment Suppliers	Rural	100.0%	100.0%
05	h	Pharmacies and Durable Medical Equipment Suppliers	Urban	100.0%	100.0%
05	h	Pharmacies and Durable Medical Equipment Suppliers	Rural	100.0%	100.0%
06	h	Pharmacies and Durable Medical Equipment Suppliers	Urban	100.0%	100.0%
07	h	Pharmacies and Durable Medical Equipment Suppliers	Urban	100.0%	100.0%
07	h	Pharmacies and Durable Medical Equipment Suppliers	Rural	100.0%	100.0%
08	h	Pharmacies and Durable Medical Equipment Suppliers	Rural	100.0%	100.0%
01	i	Podiatrists	Rural	100.0%	100.0%
02	i	Podiatrists	Urban	99.9%	99.3%
02	i	Podiatrists	Rural	100.0%	100.0%
03	i	Podiatrists	Urban	100.0%	100.0%
03	i	Podiatrists	Rural	100.0%	100.0%
04	i	Podiatrists	Urban	100.0%	100.0%
04	i	Podiatrists	Rural	100.0%	100.0%
05	i	Podiatrists	Urban	100.0%	100.0%
05	i	Podiatrists	Rural	100.0%	100.0%
06	i	Podiatrists	Urban	100.0%	100.0%
07	i	Podiatrists	Urban	100.0%	100.0%
07	i	Podiatrists	Rural	100.0%	100.0%
08	i	Podiatrists	Rural	100.0%	100.0%
01	j	Renal Dialysis Clinics	Rural	100.0%	100.0%
02	j	Renal Dialysis Clinics	Urban	100.0%	99.9%
02	j	Renal Dialysis Clinics	Rural	100.0%	100.0%
03	j	Renal Dialysis Clinics	Urban	99.9%	99.9%
03	j	Renal Dialysis Clinics	Rural	100.0%	100.0%
04	j	Renal Dialysis Clinics	Urban	100.0%	99.9%
04	j	Renal Dialysis Clinics	Rural	100.0%	100.0%
05	j	Renal Dialysis Clinics	Urban	100.0%	100.0%
05	j	Renal Dialysis Clinics	Rural	100.0%	100.0%
06	j	Renal Dialysis Clinics	Urban	100.0%	100.0%
07	j	Renal Dialysis Clinics	Urban	100.0%	100.0%
07	j	Renal Dialysis Clinics	Rural	100.0%	100.0%
08	j	Renal Dialysis Clinics	Rural	100.0%	99.3%
01	k	Transportation Providers	Rural	100.0%	100.0%
02	k	Transportation Providers	Urban	100.0%	100.0%
02	k	Transportation Providers	Rural	100.0%	100.0%
03	k	Transportation Providers	Urban	99.7%	96.6%
03	k	Transportation Providers	Rural	100.0%	100.0%
04	k	Transportation Providers	Urban	100.0%	100.0%
04	k	Transportation Providers	Rural	100.0%	100.0%
05	k	Transportation Providers	Urban	100.0%	100.0%
05	k	Transportation Providers	Rural	100.0%	100.0%
06	k	Transportation Providers	Urban	100.0%	100.0%
07	k	Transportation Providers	Urban	100.0%	100.0%
07	k	Transportation Providers	Rural	100.0%	100.0%
08	k	Transportation Providers	Rural	100.0%	100.0%
01	l	Laboratory and Radiology Providers	Rural	100.0%	100.0%
02	l	Laboratory and Radiology Providers	Urban	100.0%	100.0%
02	l	Laboratory and Radiology Providers	Rural	100.0%	100.0%
03	l	Laboratory and Radiology Providers	Urban	100.0%	100.0%
03	l	Laboratory and Radiology Providers	Rural	100.0%	100.0%
04	l	Laboratory and Radiology Providers	Urban	100.0%	100.0%
04	l	Laboratory and Radiology Providers	Rural	100.0%	100.0%
05	l	Laboratory and Radiology Providers	Urban	100.0%	100.0%
05	l	Laboratory and Radiology Providers	Rural	100.0%	100.0%
06	l	Laboratory and Radiology Providers	Urban	100.0%	100.0%
07	l	Laboratory and Radiology Providers	Urban	100.0%	100.0%
07	l	Laboratory and Radiology Providers	Rural	100.0%	100.0%
08	l	Laboratory and Radiology Providers	Rural	100.0%	100.0%
01	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Rural	100.0%	100.0%
02	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Urban	100.0%	100.0%
02	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Rural	100.0%	100.0%
03	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Urban	98.3%	97.4%
03	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Rural	100.0%	100.0%
04	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Urban	100.0%	100.0%
04	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Rural	100.0%	100.0%
05	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Urban	99.9%	99.7%
05	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Rural	100.0%	100.0%
06	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Urban	96.0%	92.3%
07	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Urban	99.2%	92.6%
07	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Rural	100.0%	100.0%
08	m	Individual and Clinics Providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Special	Rural	100.0%	100.0%

Provider Locations

January 23, 2020

Region 1 Hospitals and Ambulatory Surgery Centers

Total Providers: 9

a All providers

Interstates

US Highways

State Highways

12.93 miles

Region 1 Hospitals and Ambulatory Surgery Centers

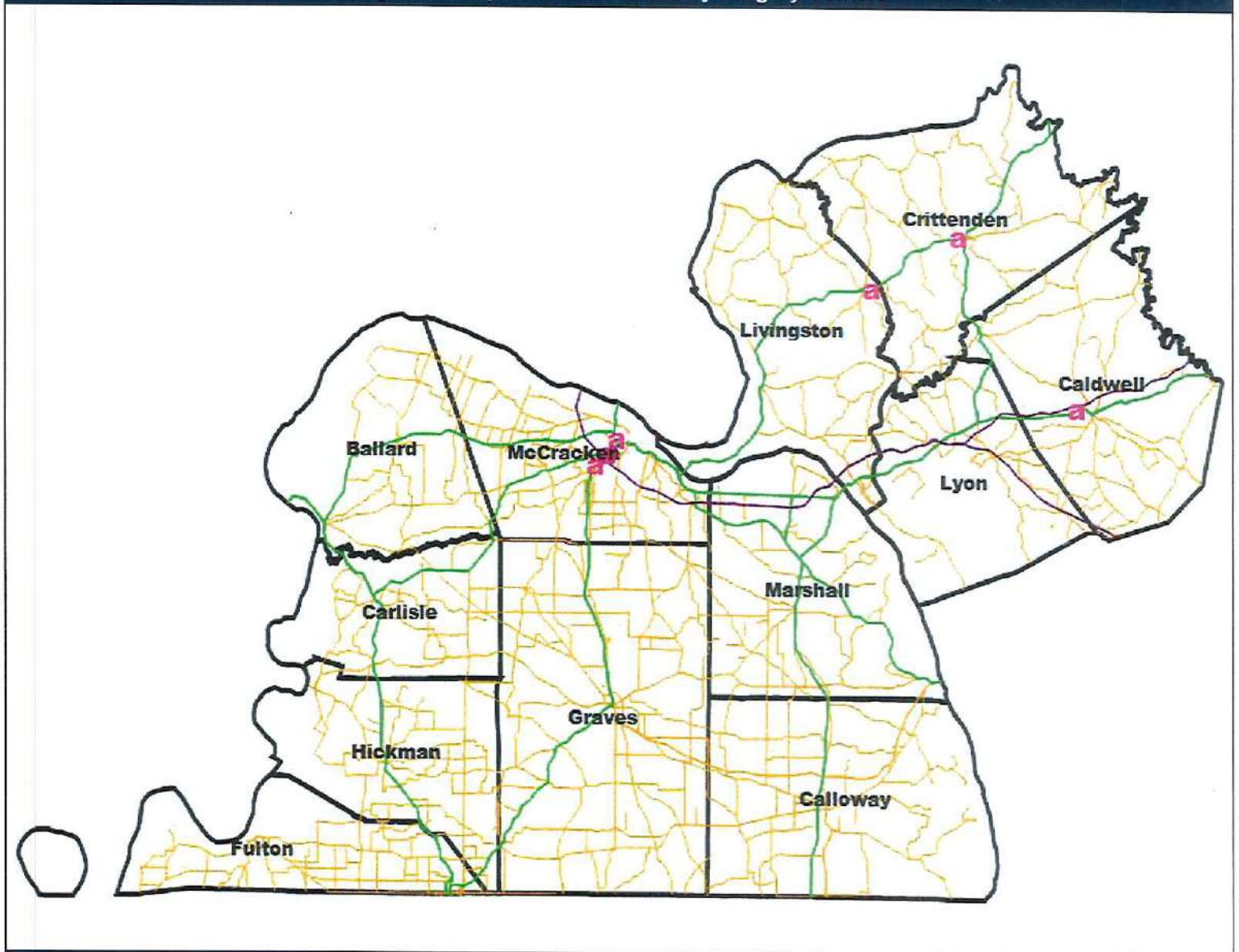

9 providers at 8 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 miles

Overall Access[1]

11,338 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

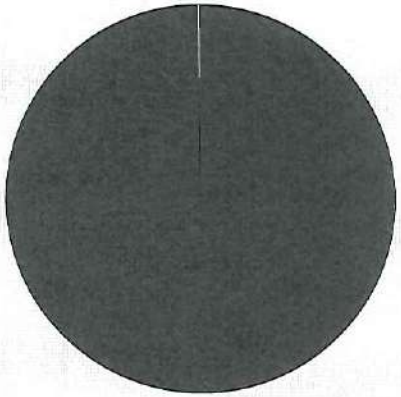

Times

	Average
Distance to 1st closest provider	18.8 miles
Distance to 2nd closest provider	23.6 miles
Distance to 3rd closest provider	25.1 miles
Distance to 4th closest provider	25.9 miles
Distance to 5th closest provider	27.1 miles

Access Standard Comparison

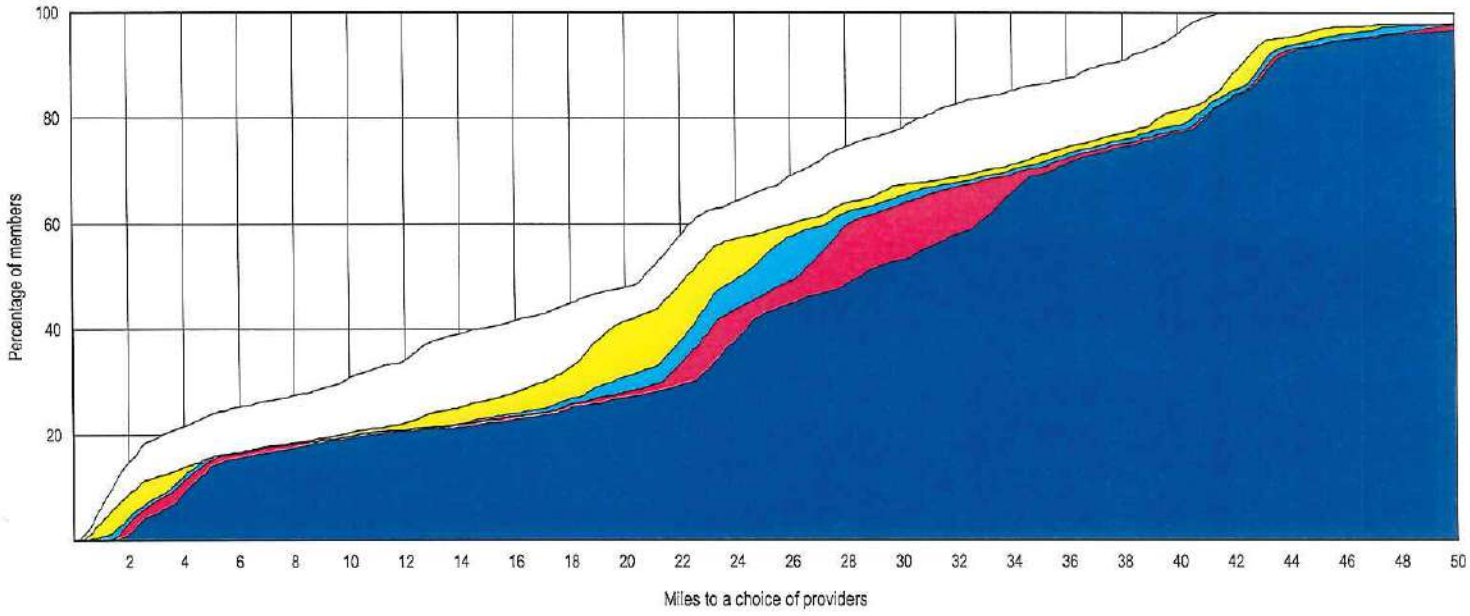

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Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
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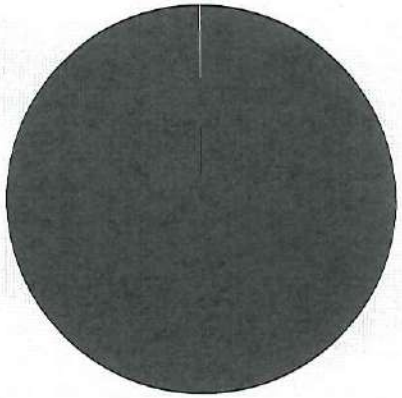

Times

	Average
Time to 1st closest provider	20.4 mins
Time to 2nd closest provider	25.7 mins
Time to 3rd closest provider	27.3 mins
Time to 4th closest provider	28.2 mins
Time to 5th closest provider	29.5 mins

Access Standard Comparison

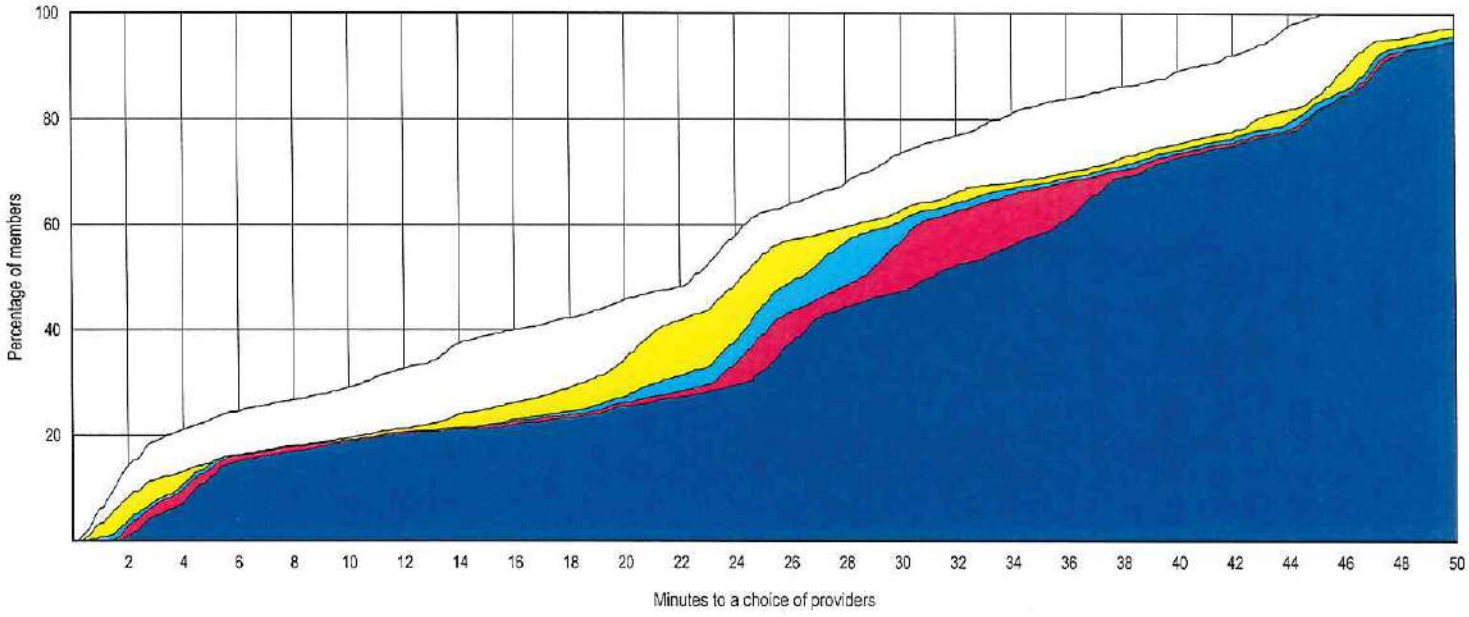

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Provider Locations

January 23, 2020

Region 2 Hospitals and Ambulatory Surgery Centers

Total Providers: 11

a All providers

Interstates

US Highways

State Highways

15.14 miles

Region 2 Hospitals and Ambulatory Surgery Centers

11 providers at 10 locations

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Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 miles

Overall Access[1]

16,143 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

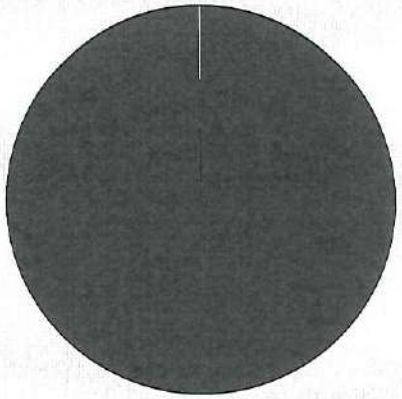

Distances

	Average
Distance to 1st closest provider	11.2 miles
Distance to 2nd closest provider	18.0 miles
Distance to 3rd closest provider	21.5 miles
Distance to 4th closest provider	22.4 miles
Distance to 5th closest provider	23.5 miles

Access Standard Comparison

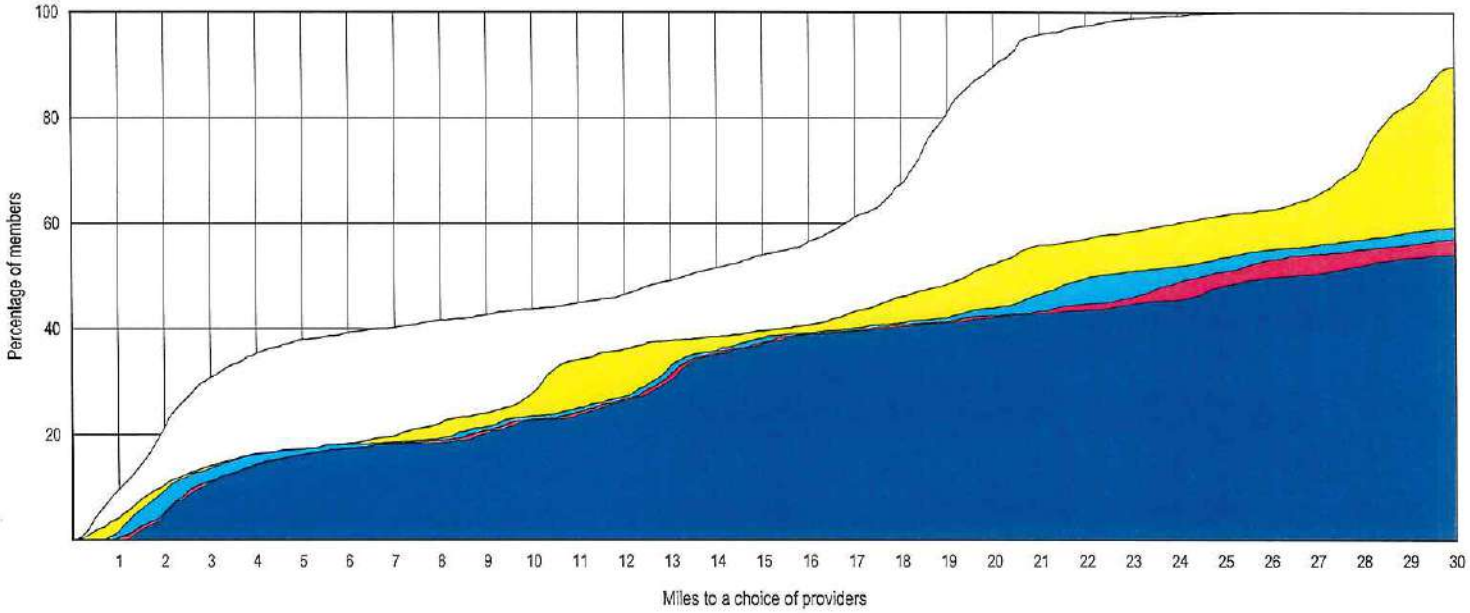

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 minutes

Overall Access[1]

16,143 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

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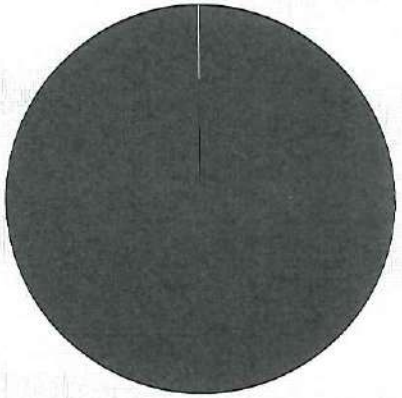

Times

	Average
Time to 1st closest provider	12.2 mins
Time to 2nd closest provider	19.9 mins
Time to 3rd closest provider	23.8 mins
Time to 4th closest provider	25.1 mins
Time to 5th closest provider	26.4 mins

Access Standard Comparison

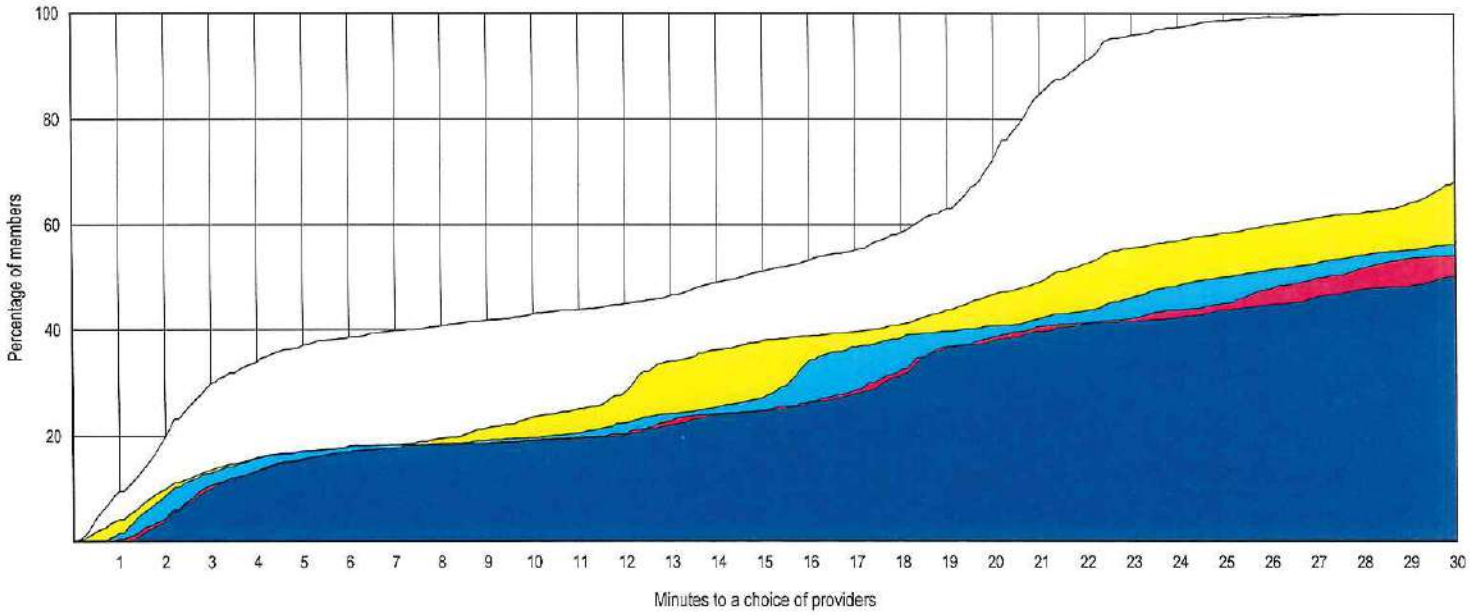

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 miles

Overall Access[1]

9,636 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

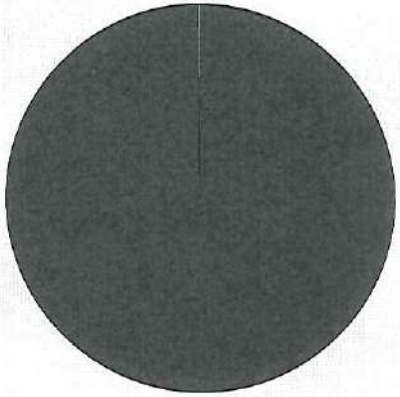

Distances

	Average
Distance to 1st closest provider	8.2 miles
Distance to 2nd closest provider	17.7 miles
Distance to 3rd closest provider	25.5 miles
Distance to 4th closest provider	30.7 miles
Distance to 5th closest provider	33.8 miles

Access Standard Comparison

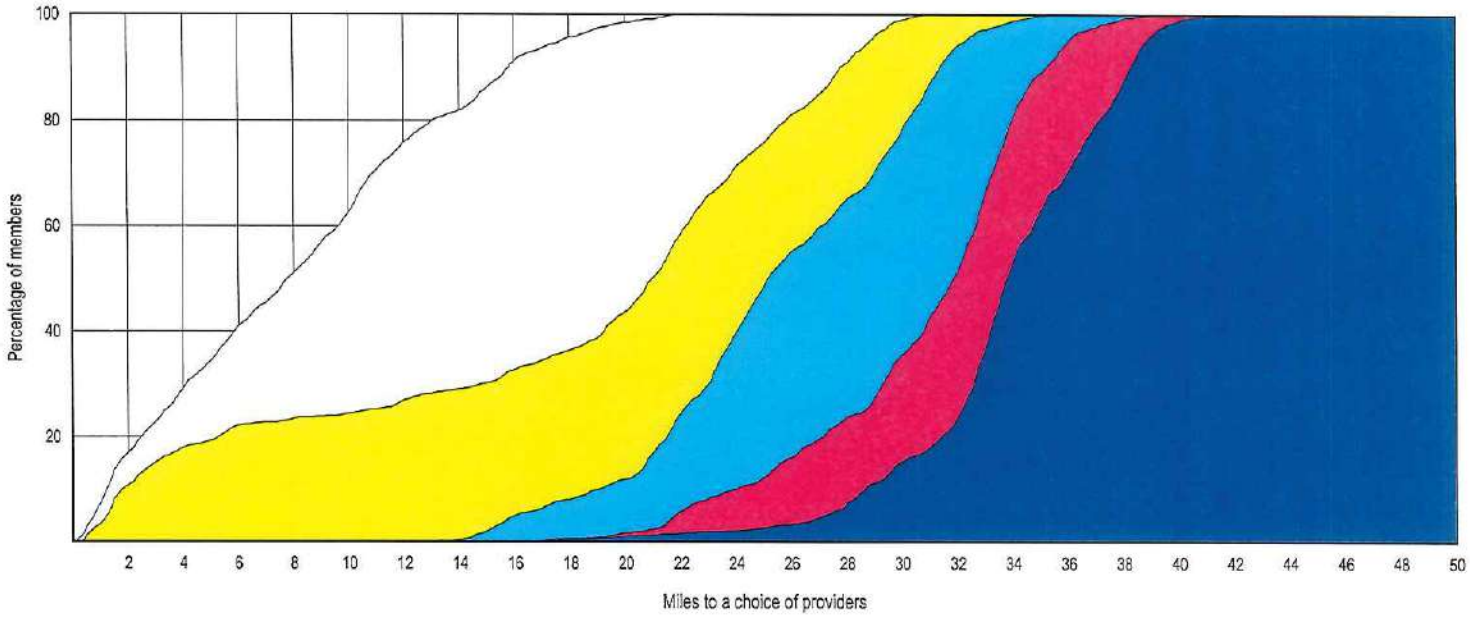

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 minutes

Overall Access[1]

9,636 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

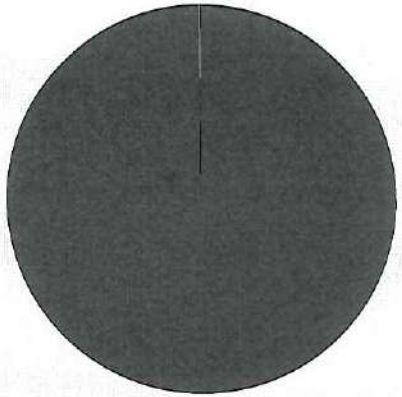

Times

	Average
Time to 1st closest provider	8.9 mins
Time to 2nd closest provider	19.3 mins
Time to 3rd closest provider	27.8 mins
Time to 4th closest provider	33.7 mins
Time to 5th closest provider	37.1 mins

Access Standard Comparison

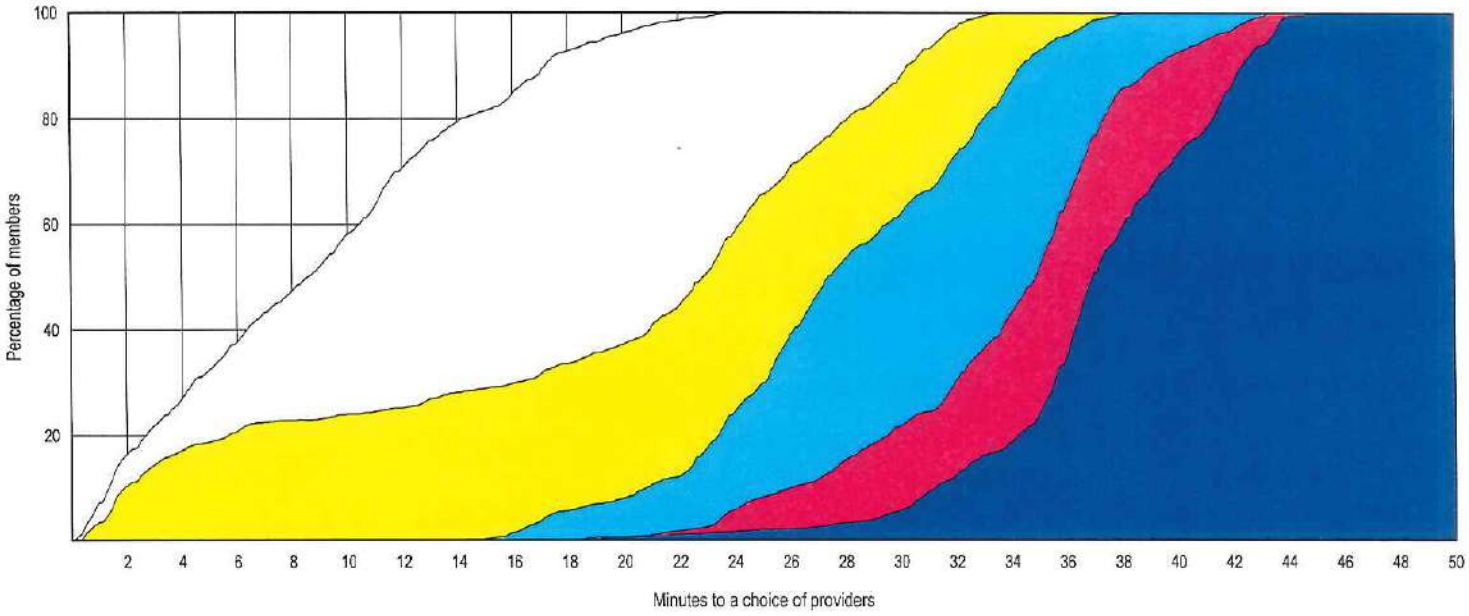

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Provider Locations

January 23, 2020

Region 3 Hospitals and Ambulatory Surgery Centers

Total Providers: 23

a All providers

Interstates

US Highways

State Highways

15.97 miles

Region 3 Hospitals and Ambulatory Surgery Centers

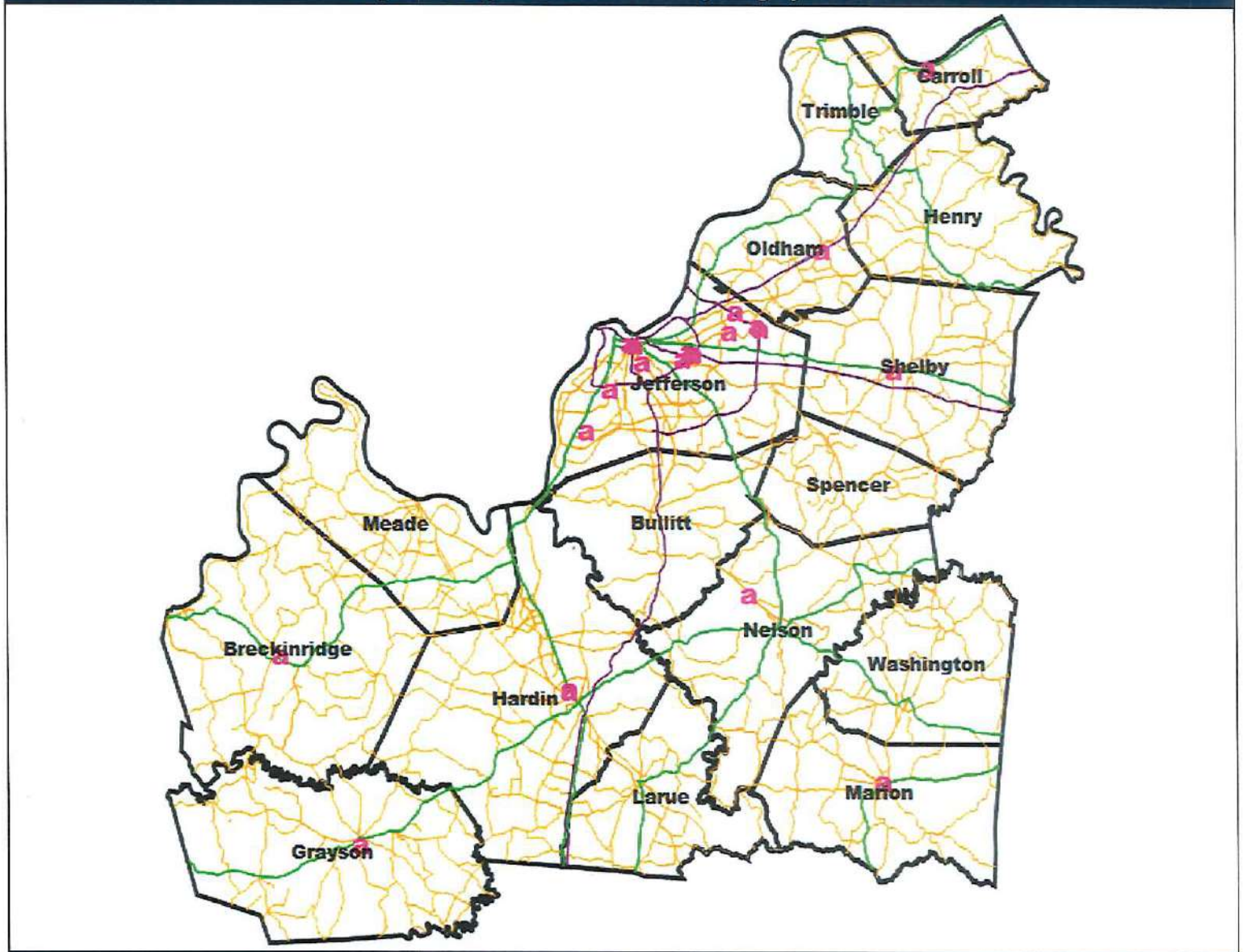

23 providers at 23 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 miles

Overall Access[1]

18,130 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

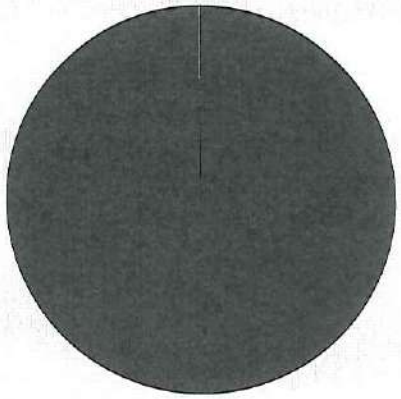

Distances

	Average
Distance to 1st closest provider	5.2 miles
Distance to 2nd closest provider	7.5 miles
Distance to 3rd closest provider	10.0 miles
Distance to 4th closest provider	10.7 miles
Distance to 5th closest provider	11.7 miles

Access Standard Comparison

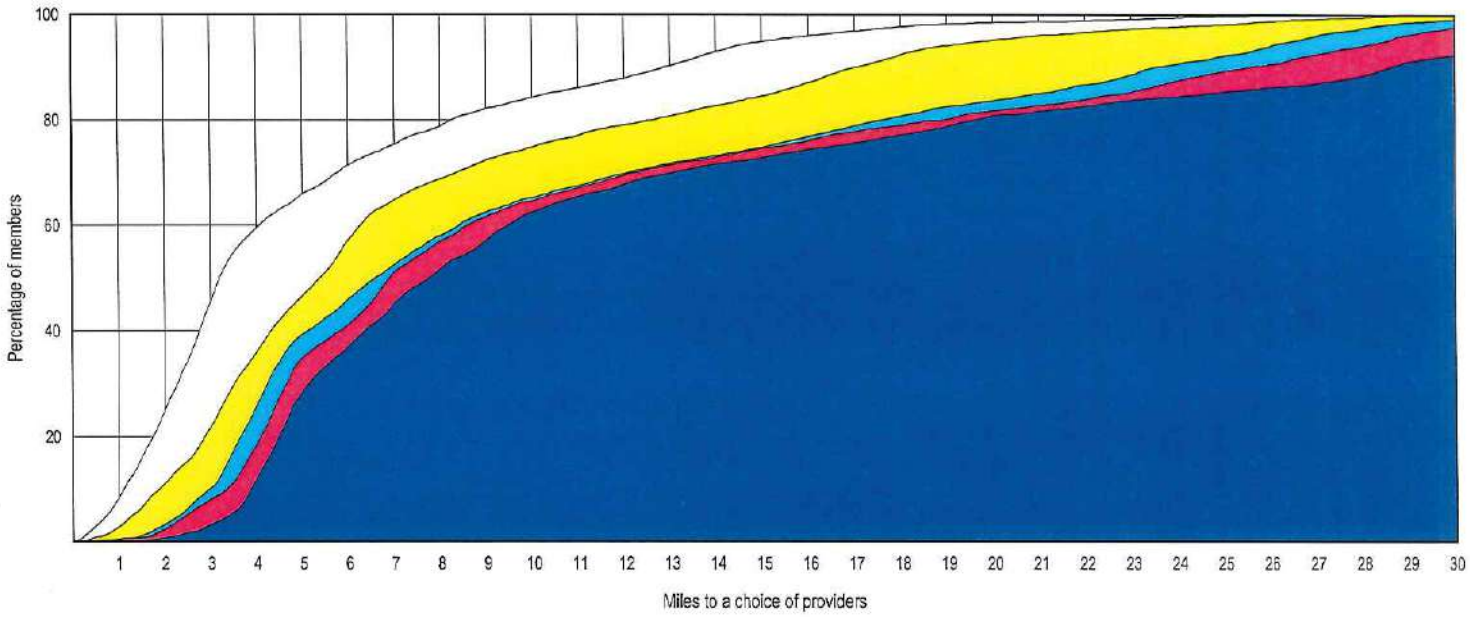

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Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 minutes

Overall Access[1]

18,130 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 18,124 (99.9%) Members with access
- 3 (0.1%) Members without access
- 3 (0.0%) Members excluded

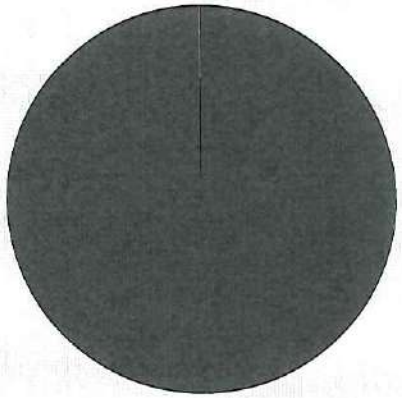

Times

	Average
Time to 1st closest provider	6.7 mins
Time to 2nd closest provider	9.7 mins
Time to 3rd closest provider	12.7 mins
Time to 4th closest provider	13.6 mins
Time to 5th closest provider	15.0 mins

Access Standard Comparison

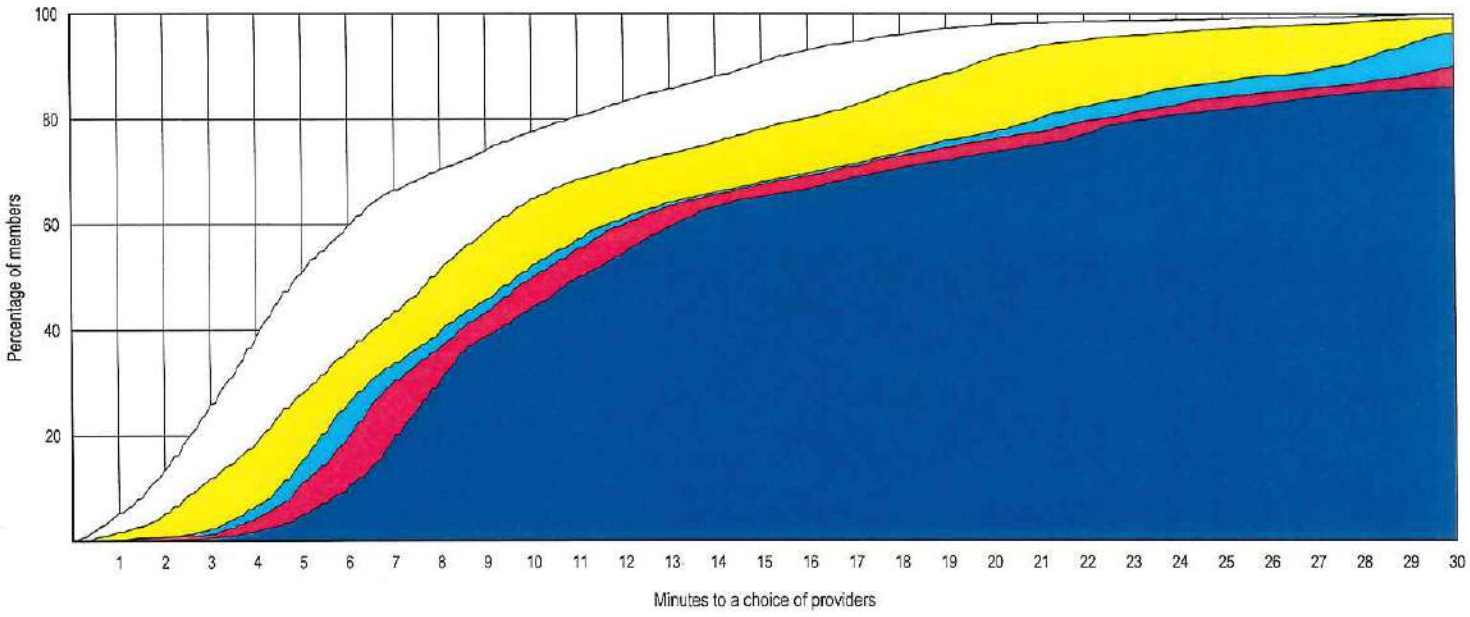

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Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 miles

Overall Access[1]

1,901 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

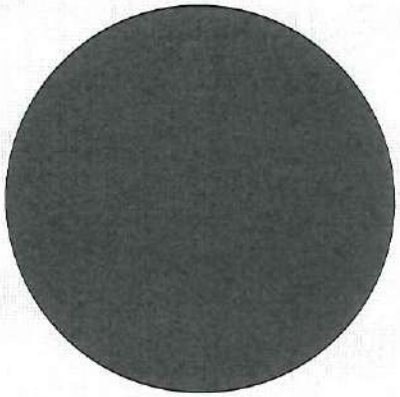

Distances

	Average
Distance to 1st closest provider	8.8 miles
Distance to 2nd closest provider	21.9 miles
Distance to 3rd closest provider	28.0 miles
Distance to 4th closest provider	30.9 miles
Distance to 5th closest provider	33.2 miles

Access Standard Comparison

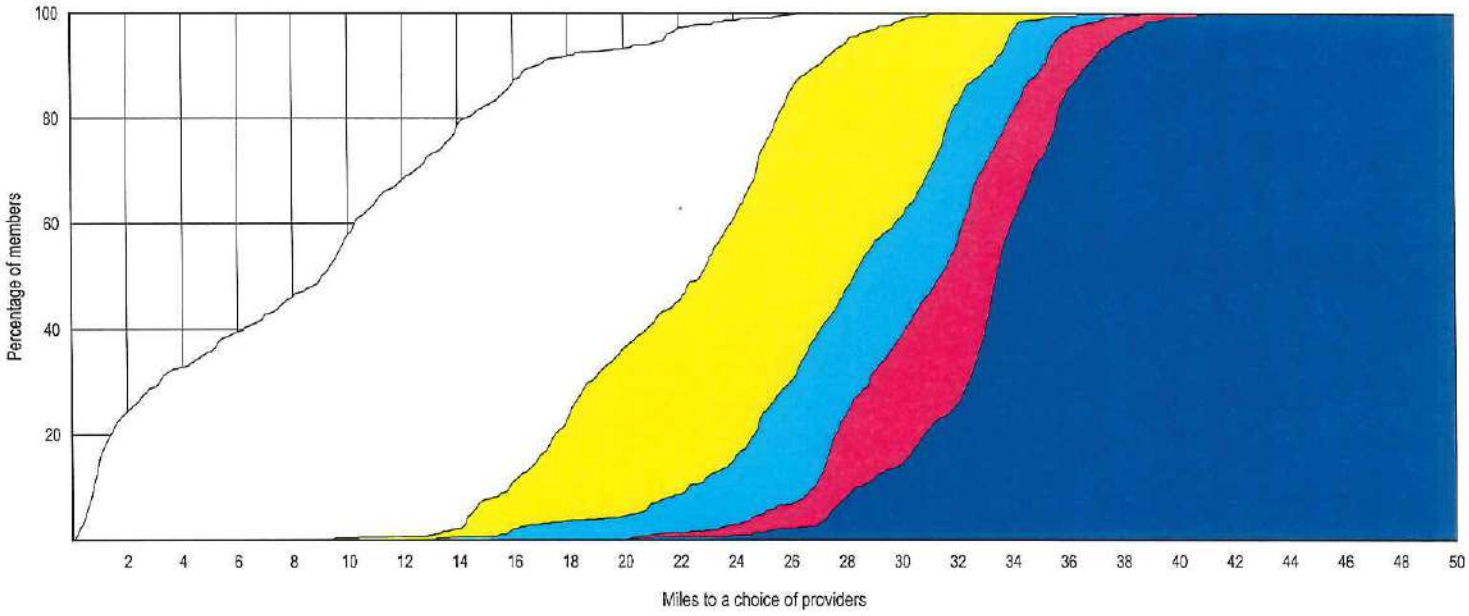

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
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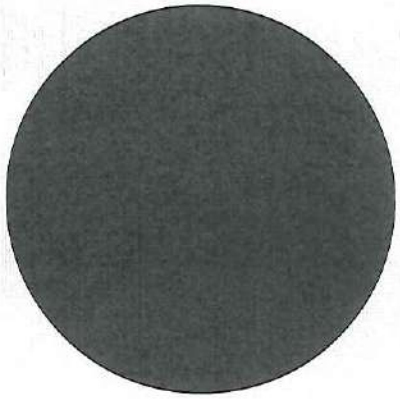

Times

	Average
Time to 1st closest provider	9.5 mins
Time to 2nd closest provider	23.8 mins
Time to 3rd closest provider	30.5 mins
Time to 4th closest provider	33.7 mins
Time to 5th closest provider	36.2 mins

Access Standard Comparison

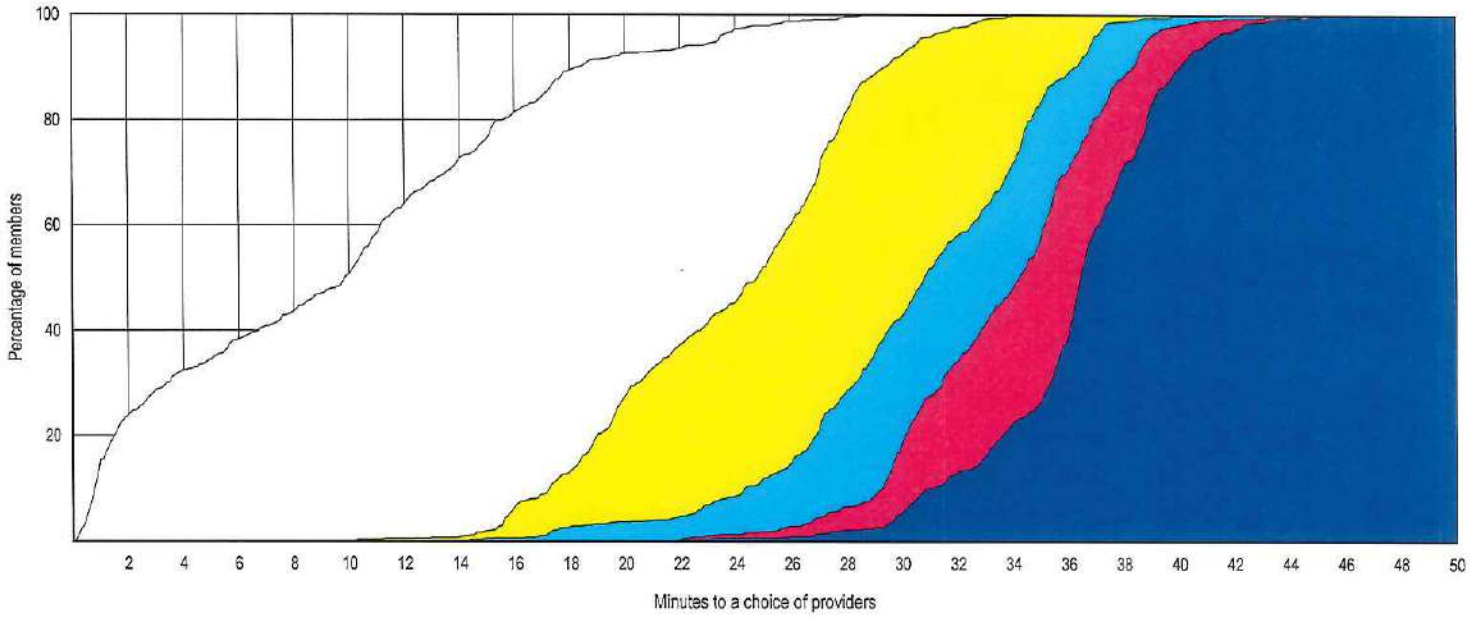

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Provider Locations

January 23, 2020

Region 4 Hospitals and Ambulatory Surgery Centers

Total Providers: 17

a All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Hospitals and Ambulatory Surgery Centers

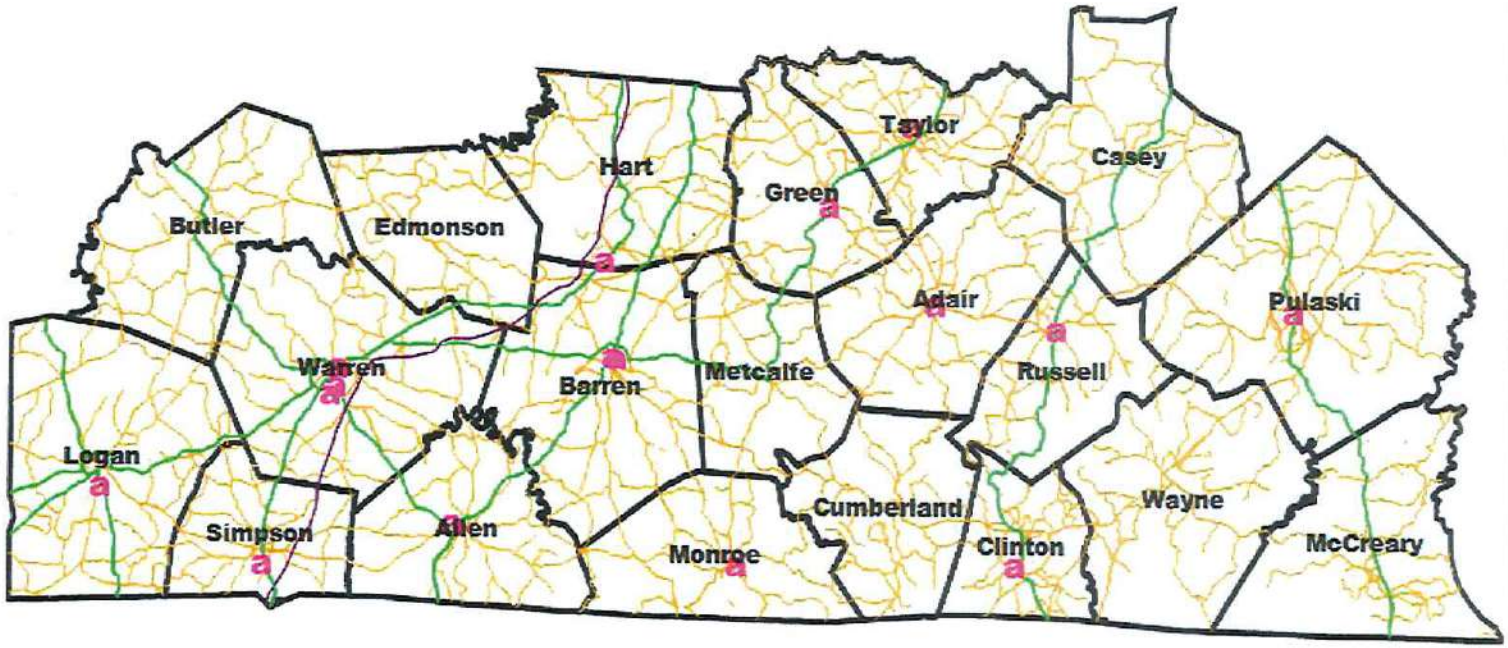

17 providers at 16 locations

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Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 miles

Overall Access[1]

7,413 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

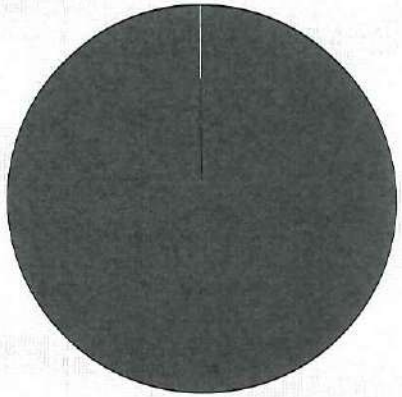

Distances

	Average
Distance to 1st closest provider	5.2 miles
Distance to 2nd closest provider	8.5 miles
Distance to 3rd closest provider	9.7 miles
Distance to 4th closest provider	22.6 miles
Distance to 5th closest provider	25.5 miles

Access Standard Comparison

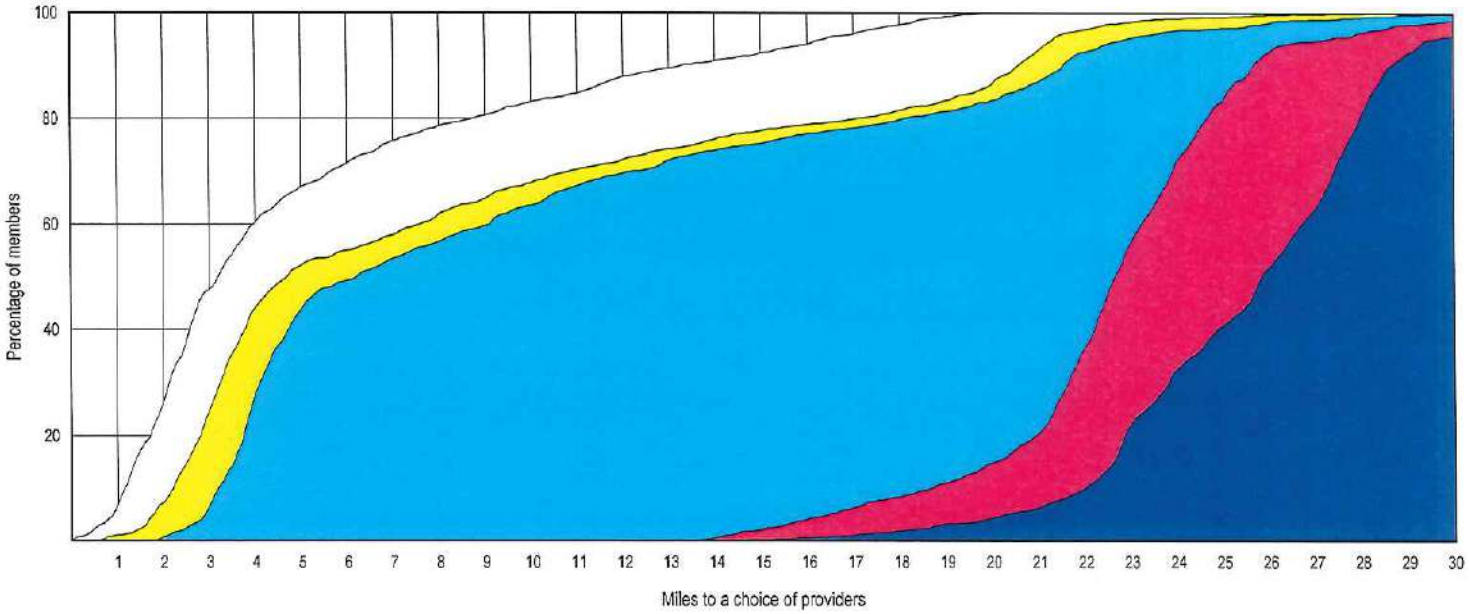

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 minutes

Overall Access[1]

7,413 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

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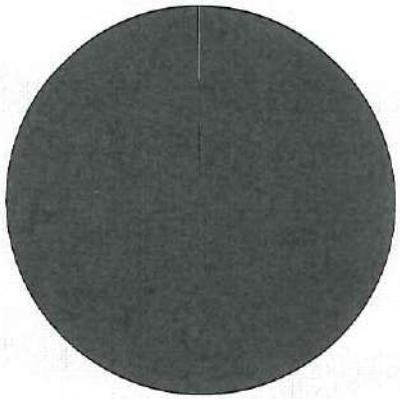

Times

	Average
Time to 1st closest provider	5.7 mins
Time to 2nd closest provider	9.2 mins
Time to 3rd closest provider	10.5 mins
Time to 4th closest provider	24.6 mins
Time to 5th closest provider	27.8 mins

Access Standard Comparison

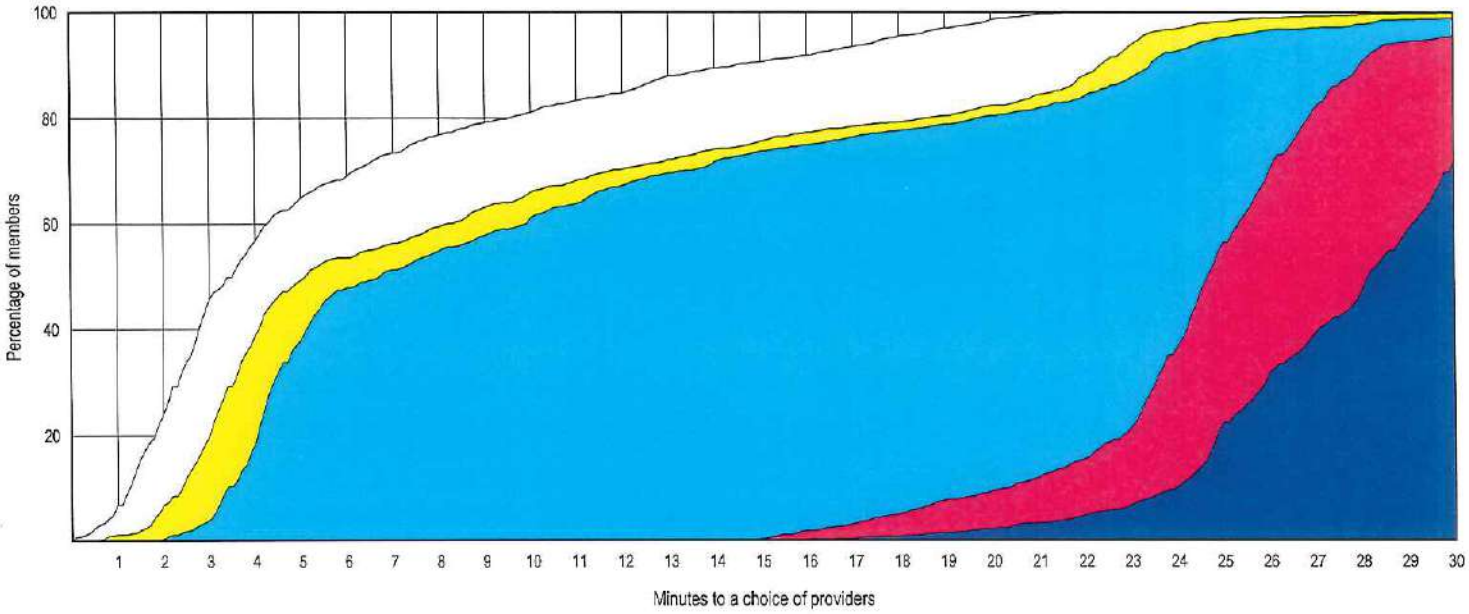

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Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 miles

Overall Access[1]

28,324 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

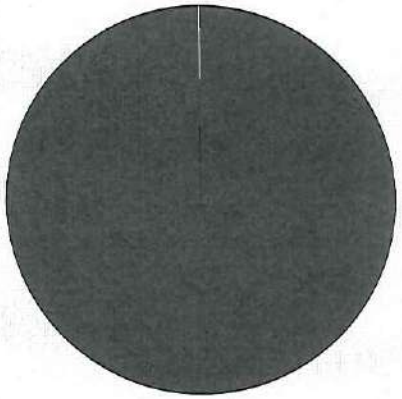

Distances

	Average
Distance to 1st closest provider	10.9 miles
Distance to 2nd closest provider	17.4 miles
Distance to 3rd closest provider	23.6 miles
Distance to 4th closest provider	27.1 miles
Distance to 5th closest provider	30.6 miles

Access Standard Comparison

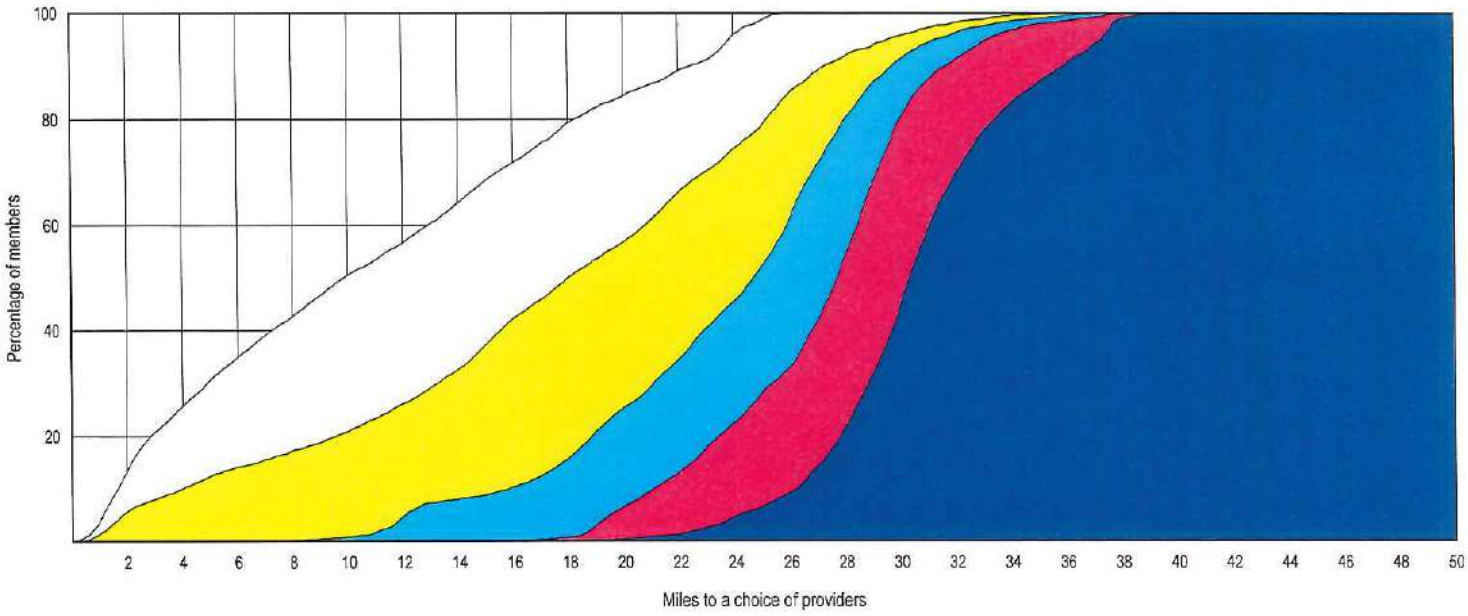

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Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 minutes

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163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

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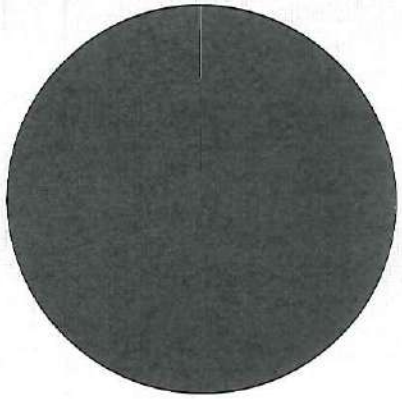

Times

	Average
Time to 1st closest provider	11.9 mins
Time to 2nd closest provider	18.9 mins
Time to 3rd closest provider	25.7 mins
Time to 4th closest provider	29.5 mins
Time to 5th closest provider	33.3 mins

Access Standard Comparison

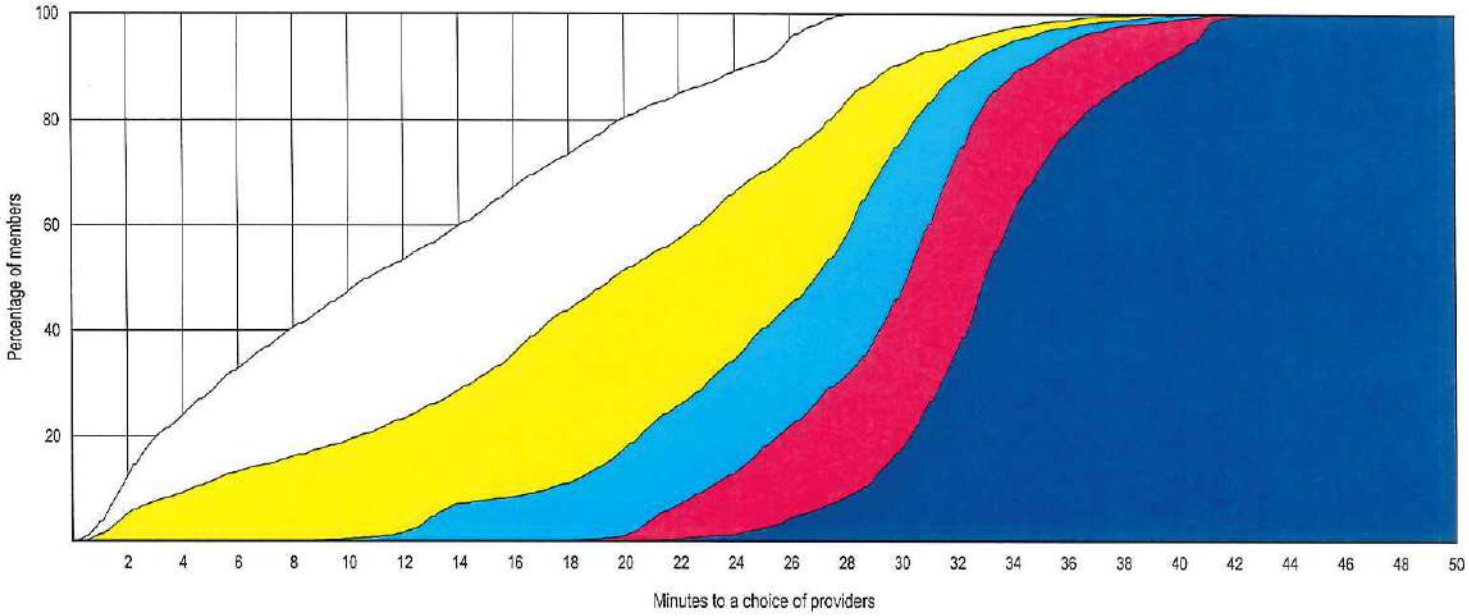

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Provider Locations

January 23, 2020

Region 5 Hospitals and Ambulatory Surgery Centers

Total Providers: 30

a All providers

Interstates

US Highways

State Highways

17.44 miles

Region 5 Hospitals and Ambulatory Surgery Centers

30 providers at 27 locations

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Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 miles

Overall Access[1]

22,712 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

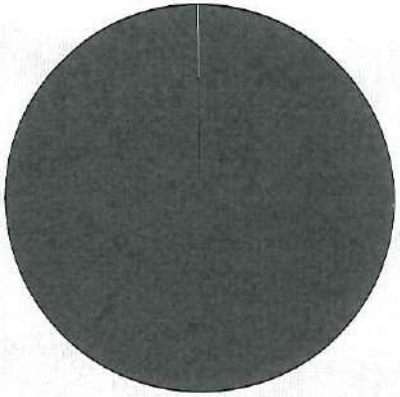

Distances

	Average
Distance to 1st closest provider	3.6 miles
Distance to 2nd closest provider	6.9 miles
Distance to 3rd closest provider	7.6 miles
Distance to 4th closest provider	8.4 miles
Distance to 5th closest provider	9.2 miles

Access Standard Comparison

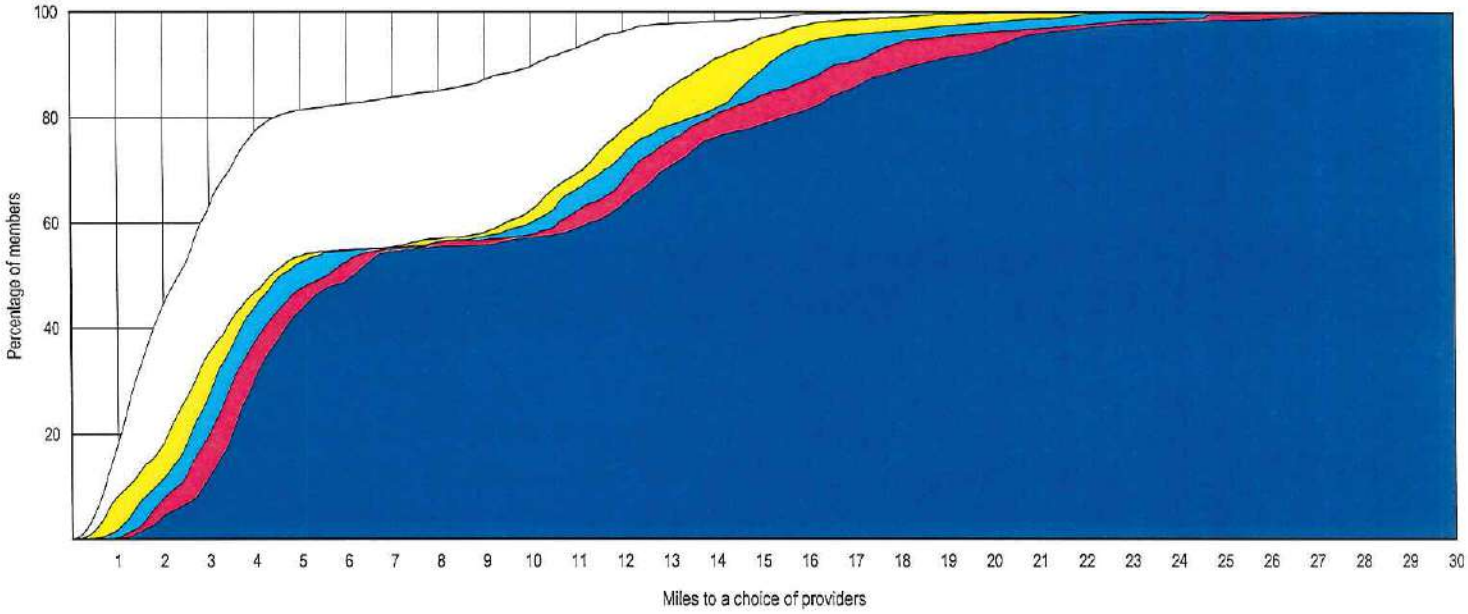

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 minutes

Overall Access[1]

22,712 Members
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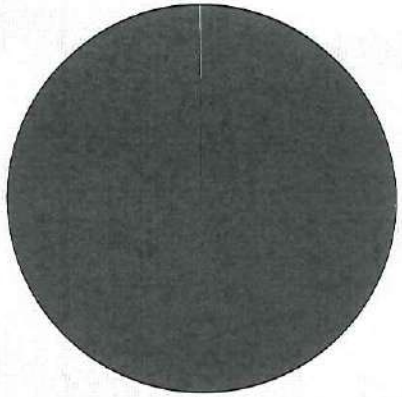

Times

	Average
Time to 1st closest provider	4.7 mins
Time to 2nd closest provider	8.7 mins
Time to 3rd closest provider	10.0 mins
Time to 4th closest provider	11.0 mins
Time to 5th closest provider	12.2 mins

Access Standard Comparison

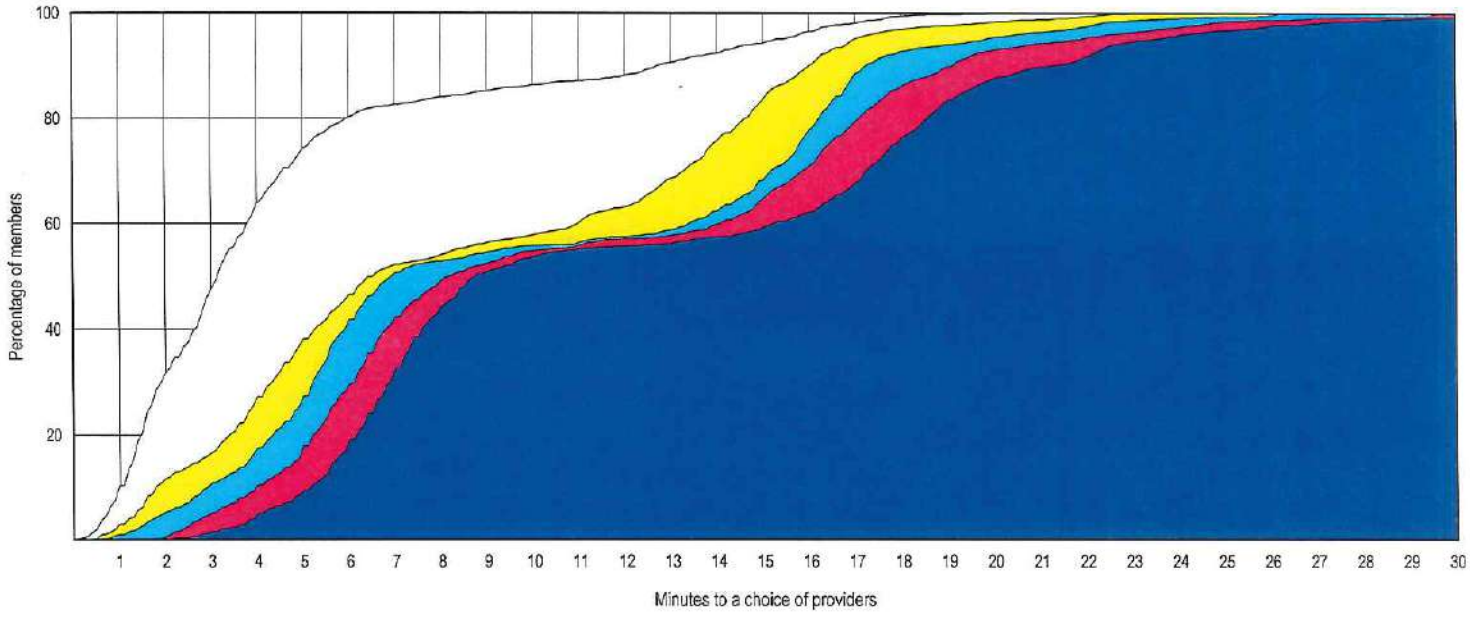

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Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 miles

Overall Access[1]

23,127 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

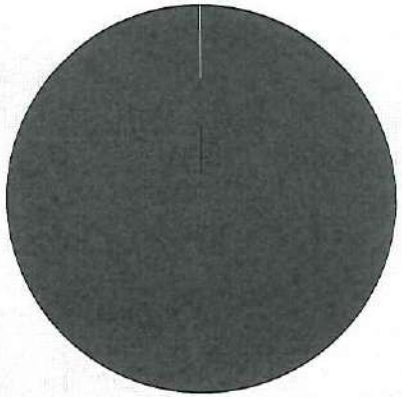

Distances

	Average
Distance to 1st closest provider	8.5 miles
Distance to 2nd closest provider	16.9 miles
Distance to 3rd closest provider	22.0 miles
Distance to 4th closest provider	24.6 miles
Distance to 5th closest provider	27.1 miles

Access Standard Comparison

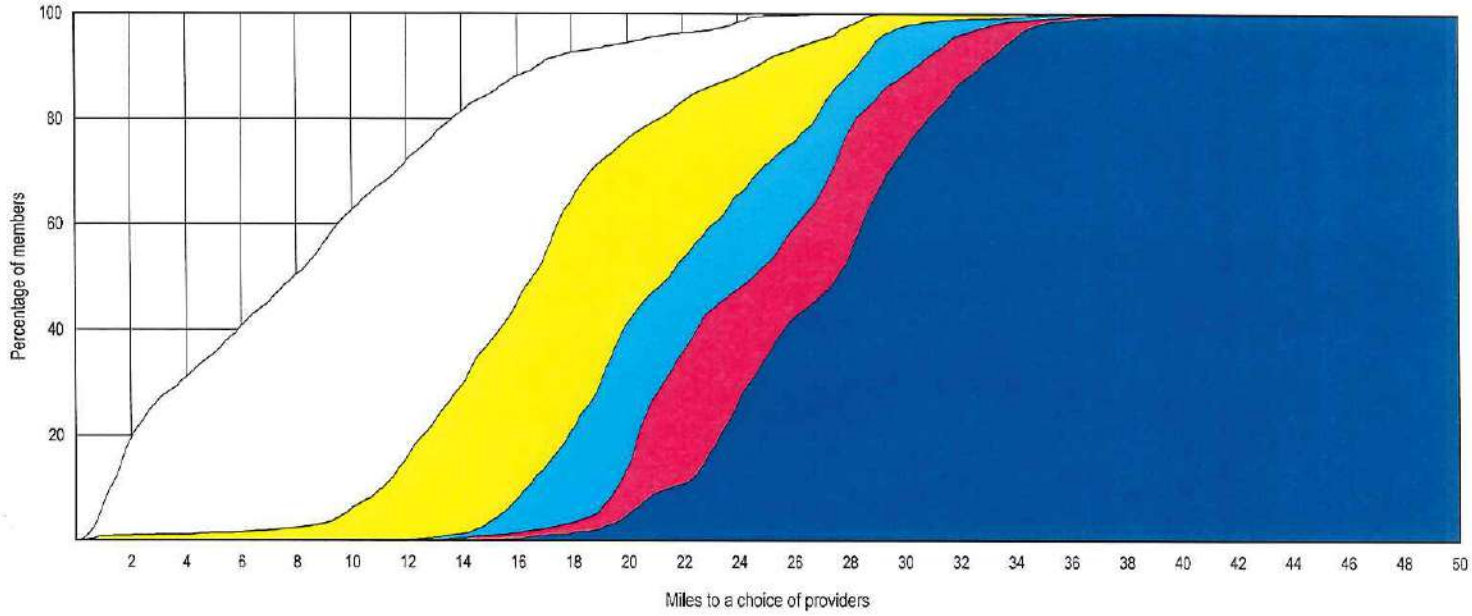

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Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

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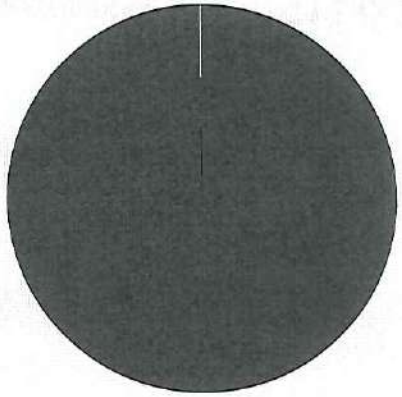

Times

	Average
Time to 1st closest provider	9.2 mins
Time to 2nd closest provider	18.4 mins
Time to 3rd closest provider	24.2 mins
Time to 4th closest provider	27.1 mins
Time to 5th closest provider	30.0 mins

Access Standard Comparison

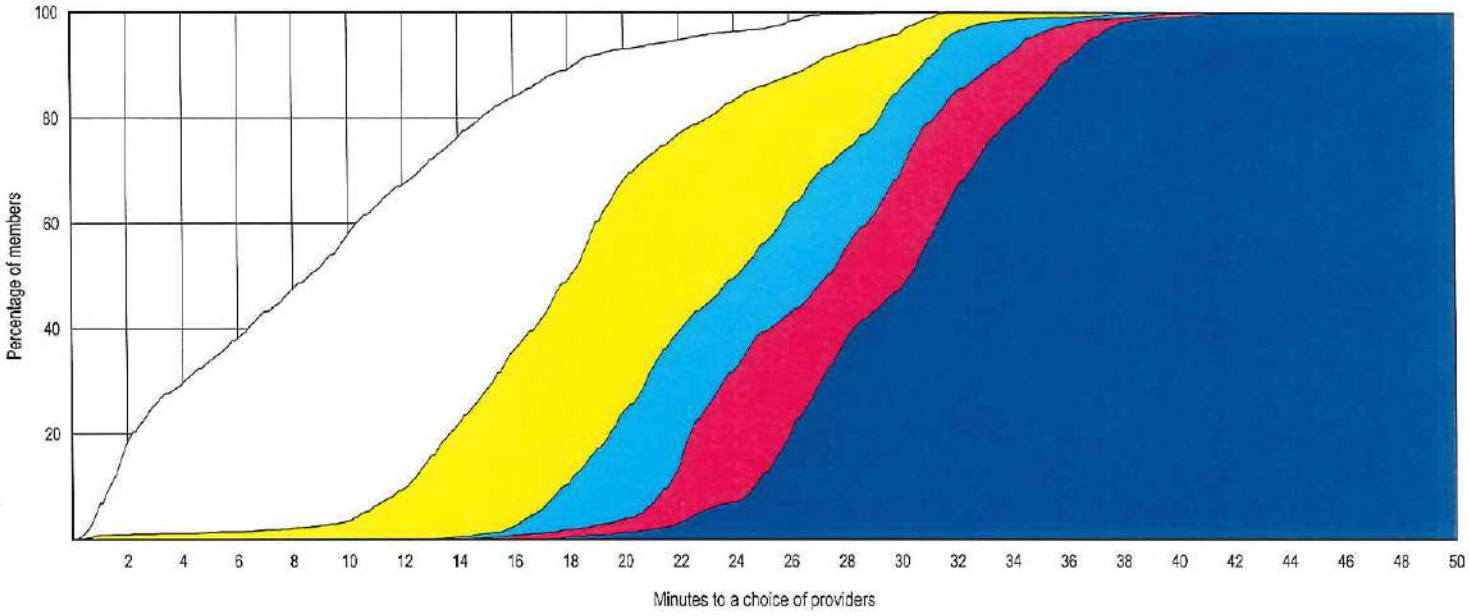

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Provider Locations

January 23, 2020

Region 6 Hospitals and Ambulatory Surgery Centers

Total Providers: 12

a All providers

Interstates

US Highways

State Highways

7.48 miles

Region 6 Hospitals and Ambulatory Surgery Centers

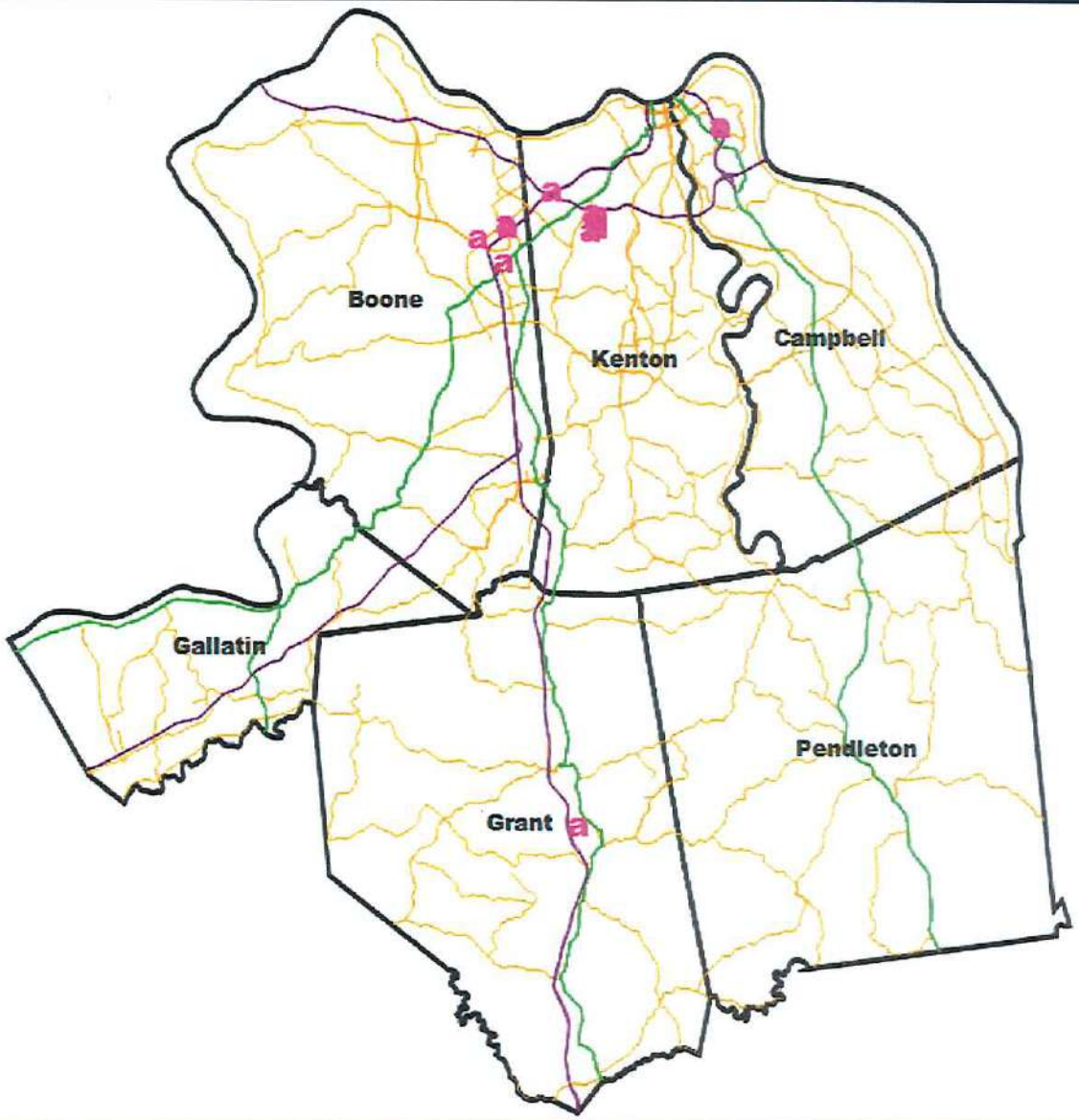

12 providers at 13 locations

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Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 miles

Overall Access[1]

22,413 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

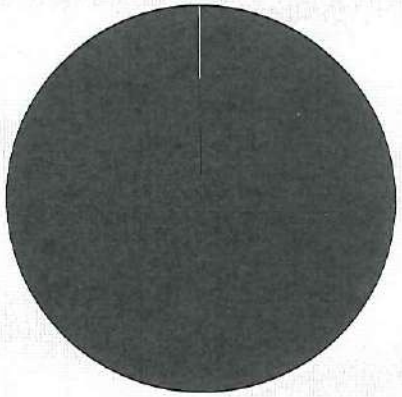

Distances

	Average
Distance to 1st closest provider	5.2 miles
Distance to 2nd closest provider	5.6 miles
Distance to 3rd closest provider	7.2 miles
Distance to 4th closest provider	8.1 miles
Distance to 5th closest provider	9.0 miles

Access Standard Comparison

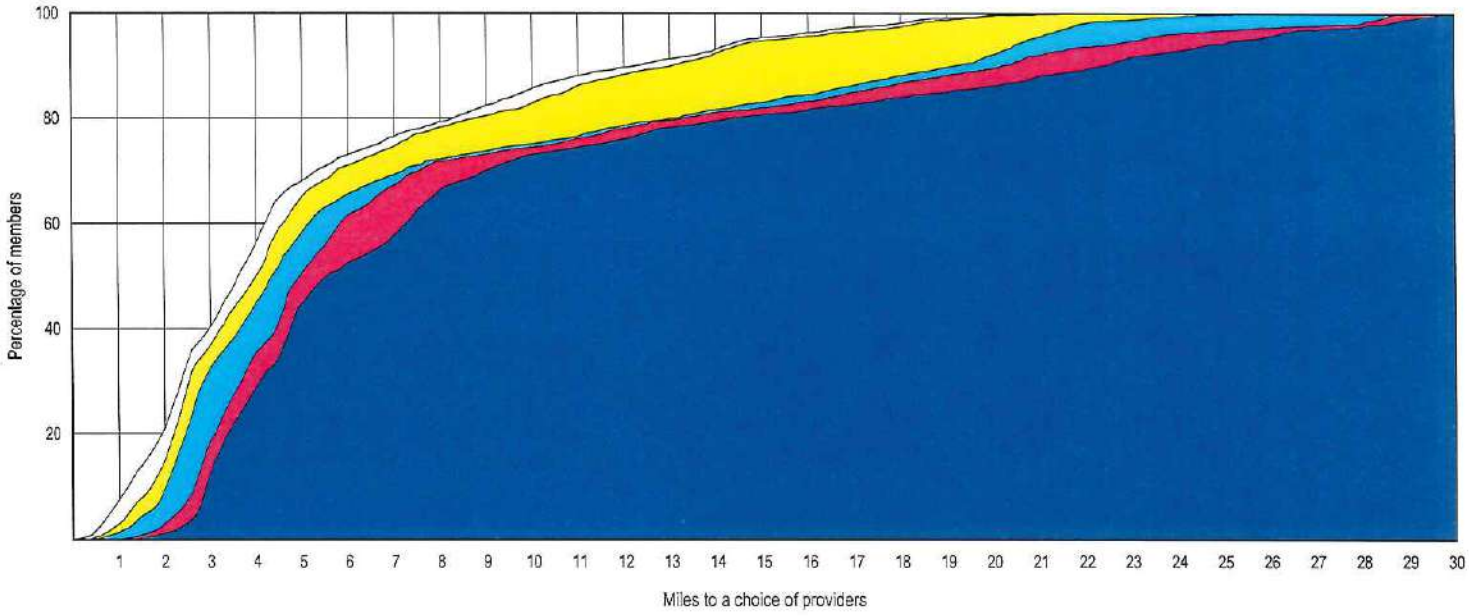

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Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 minutes

Overall Access[1]

22,413 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

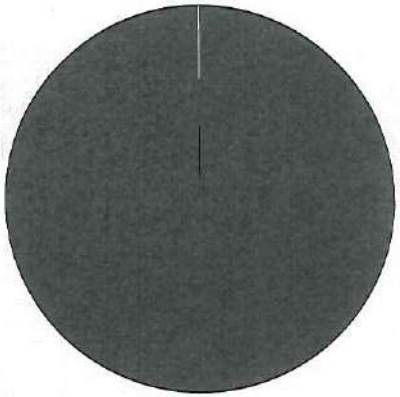

Times

	Average
Time to 1st closest provider	6.3 mins
Time to 2nd closest provider	6.8 mins
Time to 3rd closest provider	8.8 mins
Time to 4th closest provider	10.1 mins
Time to 5th closest provider	11.3 mins

Access Standard Comparison

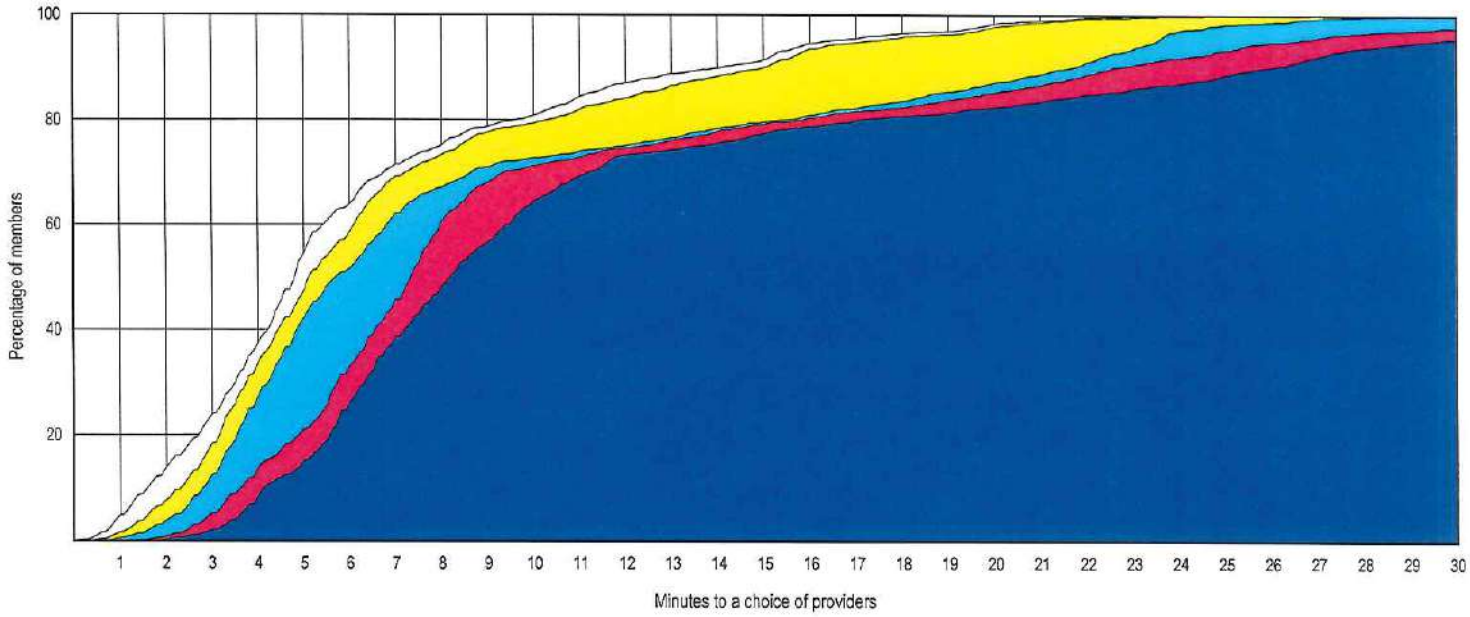

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Provider Locations

January 23, 2020

Region 7 Hospitals and Ambulatory Surgery Centers

Total Providers: 7

a All providers

Interstates

US Highways

State Highways

12.36 miles

Region 7 Hospitals and Ambulatory Surgery Centers

7 providers at 7 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 miles

Overall Access[1]

2,907 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

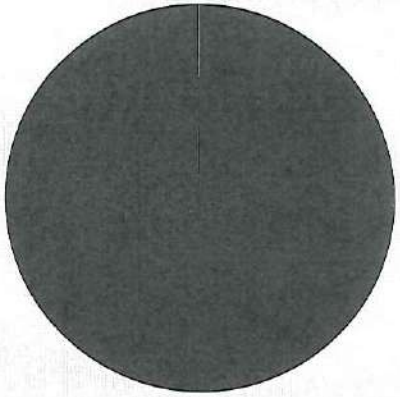

Distances

	Average
Distance to 1st closest provider	10.0 miles
Distance to 2nd closest provider	18.5 miles
Distance to 3rd closest provider	24.7 miles
Distance to 4th closest provider	29.1 miles
Distance to 5th closest provider	34.5 miles

Access Standard Comparison

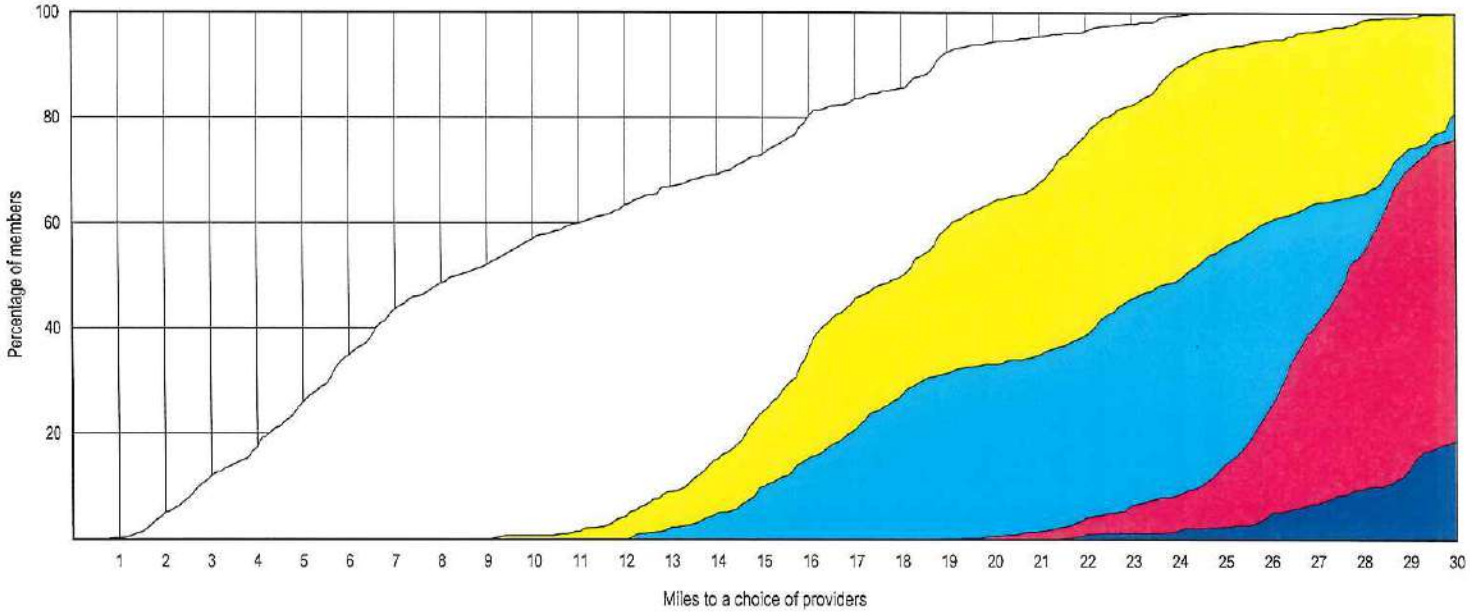

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 30 minutes

Overall Access[1]

2,907 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

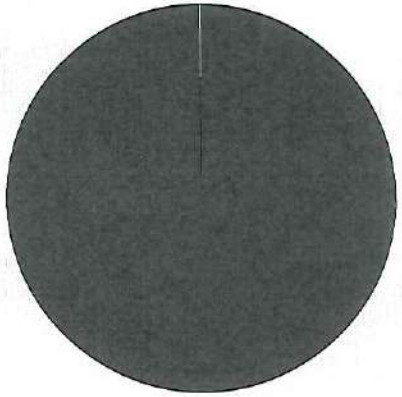

Times

	Average
Time to 1st closest provider	11.5 mins
Time to 2nd closest provider	20.8 mins
Time to 3rd closest provider	27.2 mins
Time to 4th closest provider	32.3 mins
Time to 5th closest provider	38.3 mins

Access Standard Comparison

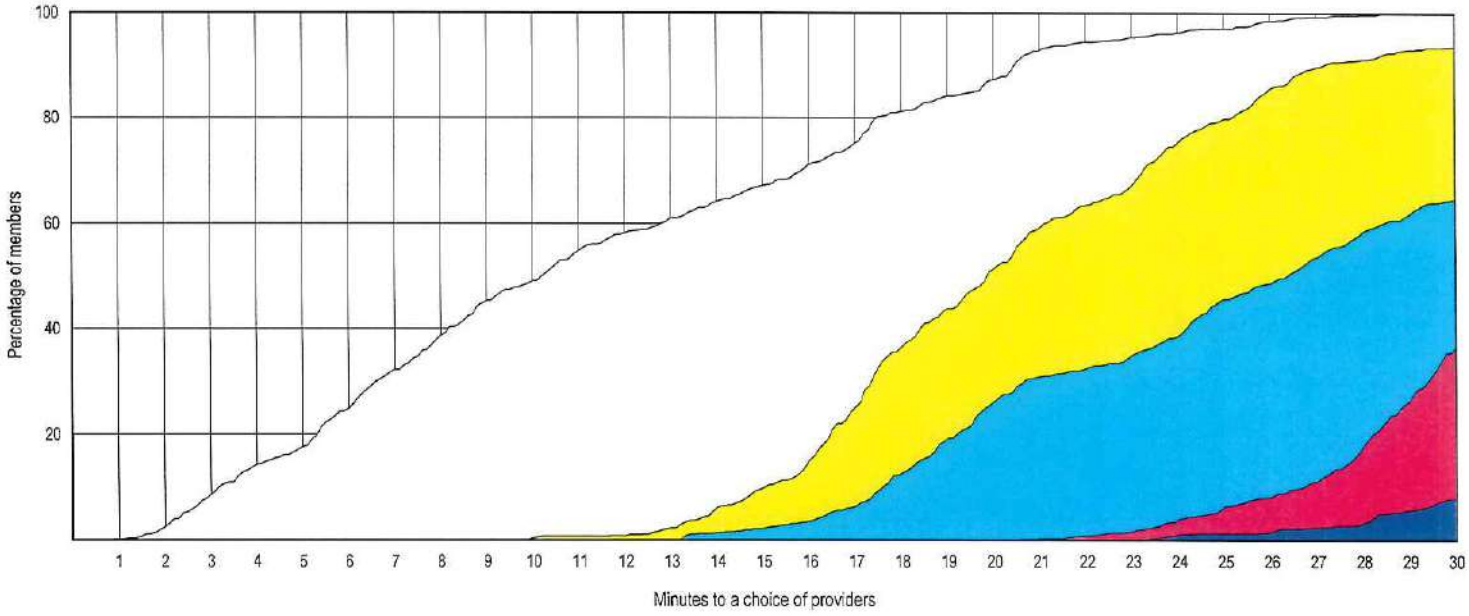

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Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 miles

Overall Access[1]

10,408 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

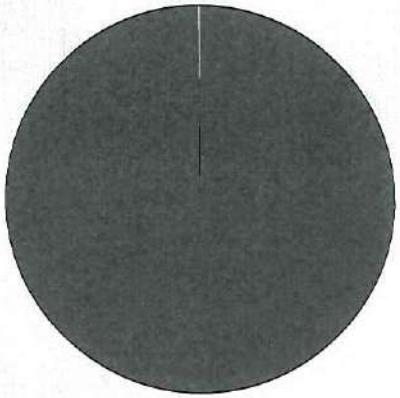

Distances

	Average
Distance to 1st closest provider	11.3 miles
Distance to 2nd closest provider	18.5 miles
Distance to 3rd closest provider	24.8 miles
Distance to 4th closest provider	26.6 miles
Distance to 5th closest provider	31.5 miles

Access Standard Comparison

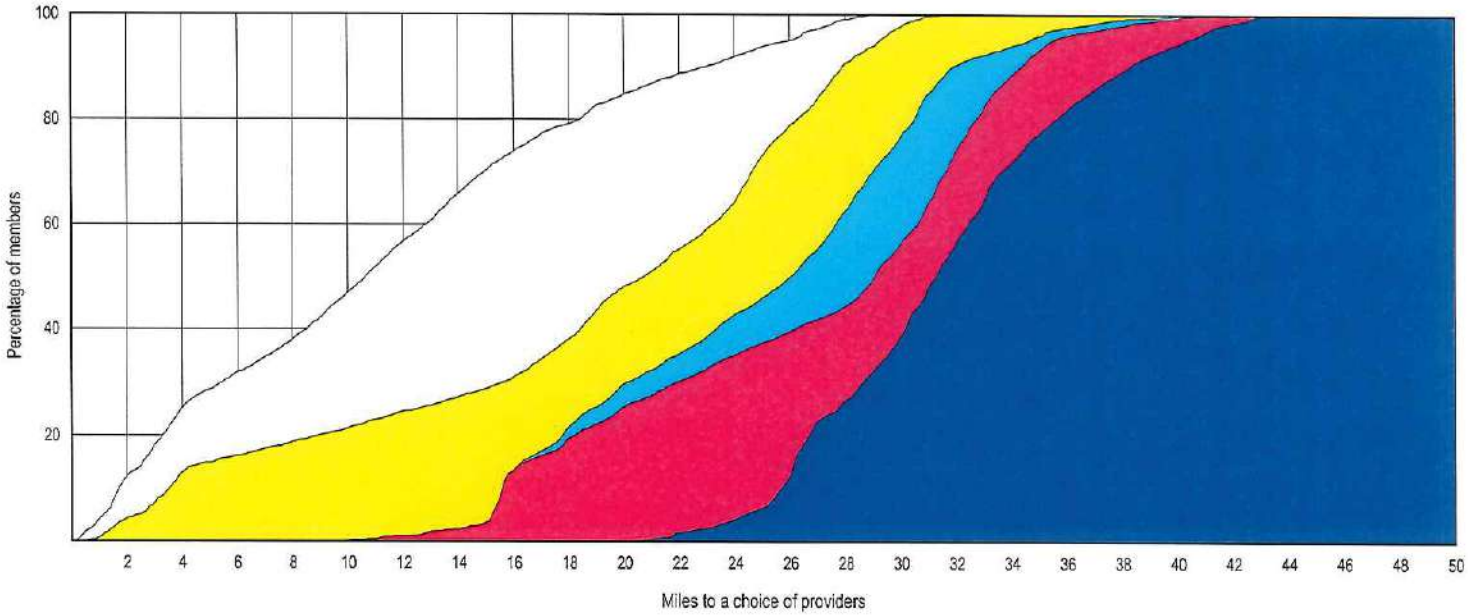

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 minutes

Member / Provider Groups
Region 7 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 minutes

Overall Access[1]

10,408 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

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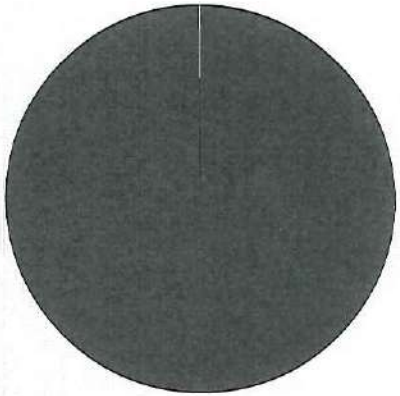

Times

	Average
Time to 1st closest provider	12.4 mins
Time to 2nd closest provider	20.3 mins
Time to 3rd closest provider	27.0 mins
Time to 4th closest provider	29.1 mins
Time to 5th closest provider	34.5 mins

Access Standard Comparison

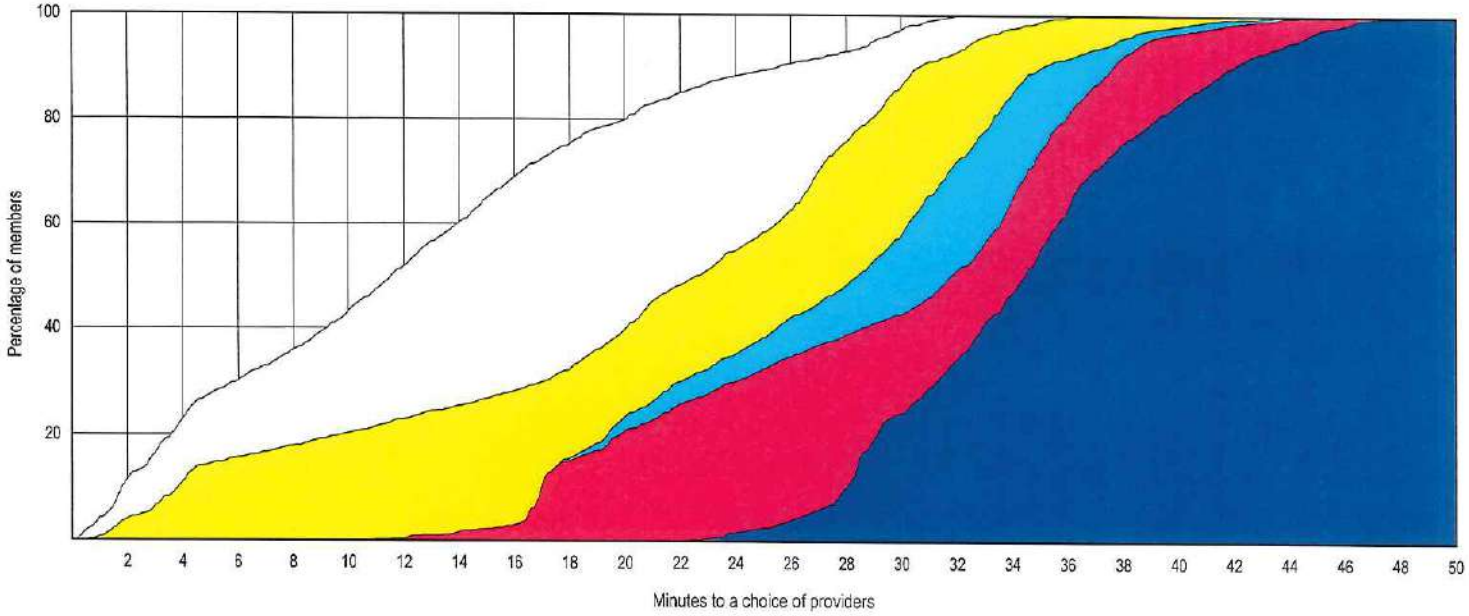

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Provider Locations

January 23, 2020

Region 8 Hospitals and Ambulatory Surgery Centers

Total Providers: 17

a All providers

Interstates

US Highways

State Highways

16.38 miles

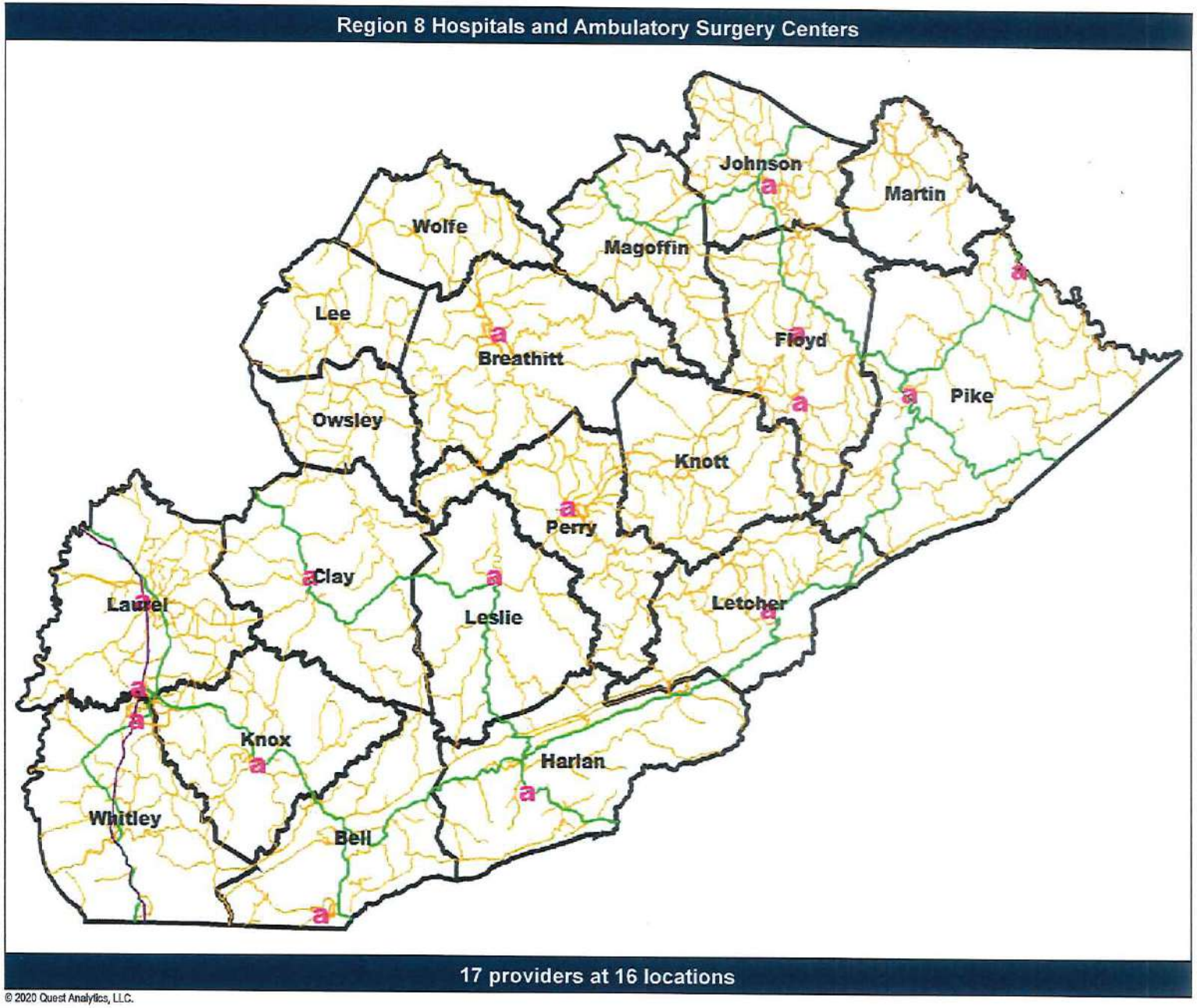

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 miles

Overall Access[1]

31,600 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

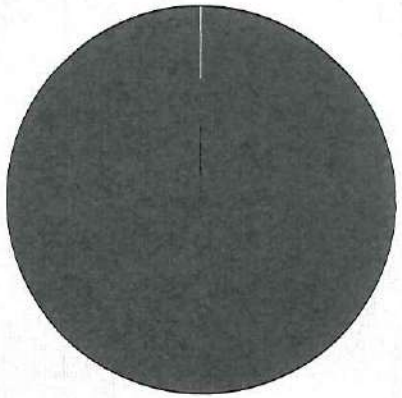

Times

	Average
Distance to 1st closest provider	9.3 miles
Distance to 2nd closest provider	15.9 miles
Distance to 3rd closest provider	19.6 miles
Distance to 4th closest provider	23.1 miles
Distance to 5th closest provider	26.3 miles

Access Standard Comparison

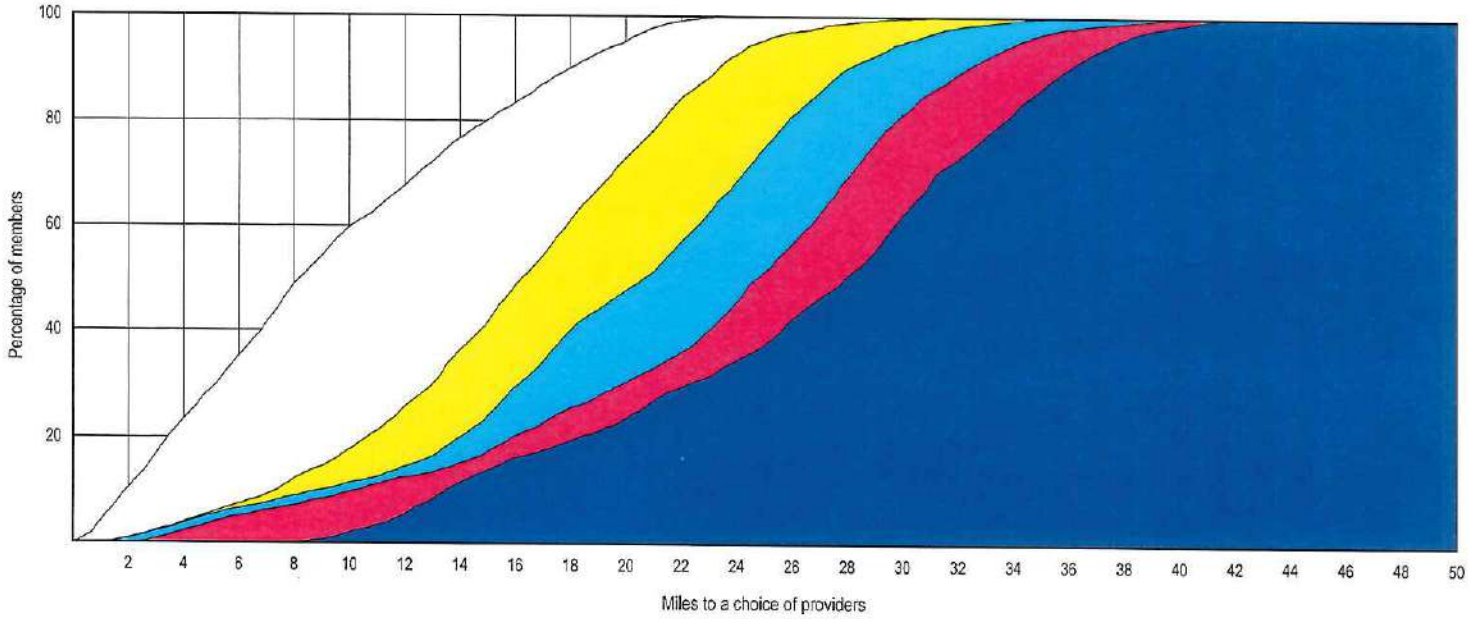

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Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Hospitals and Ambulatory Surgery Centers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Hospitals and Ambulatory Surgery Centers) provider in 50 minutes

Overall Access[1]

31,600 Members
163 providers at 177 locations (Hospitals and Ambulatory Surgery Centers)

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- 15 (0.0%) Members excluded

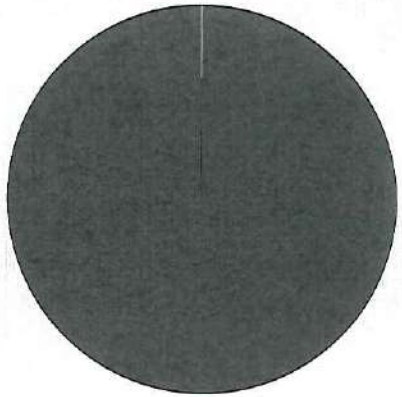

Times

	Average
Time to 1st closest provider	10.1 mins
Time to 2nd closest provider	17.3 mins
Time to 3rd closest provider	21.4 mins
Time to 4th closest provider	25.1 mins
Time to 5th closest provider	28.7 mins

Access Standard Comparison

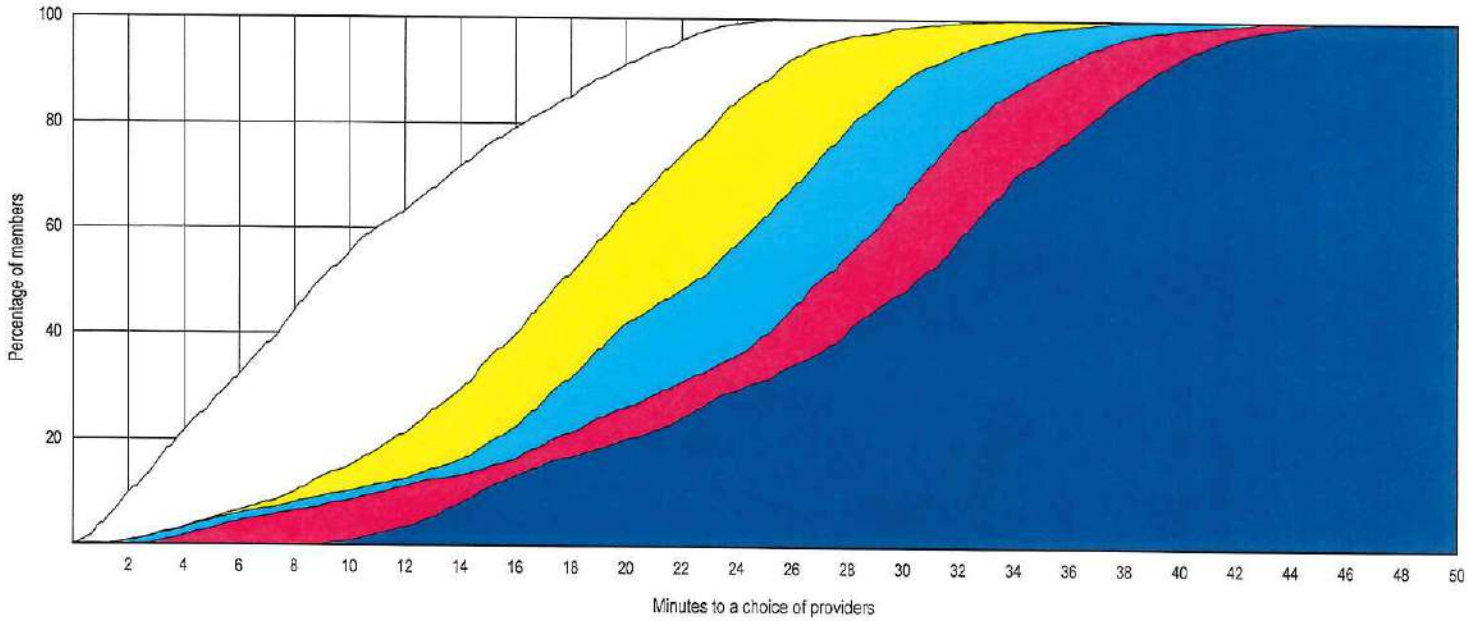

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Provider Locations

January 23, 2020

Region 1 Physicians, APRN, PA, and Family Planning Providers

Total Providers: 1,464

b All providers

Interstates

US Highways

State Highways

12.93 miles

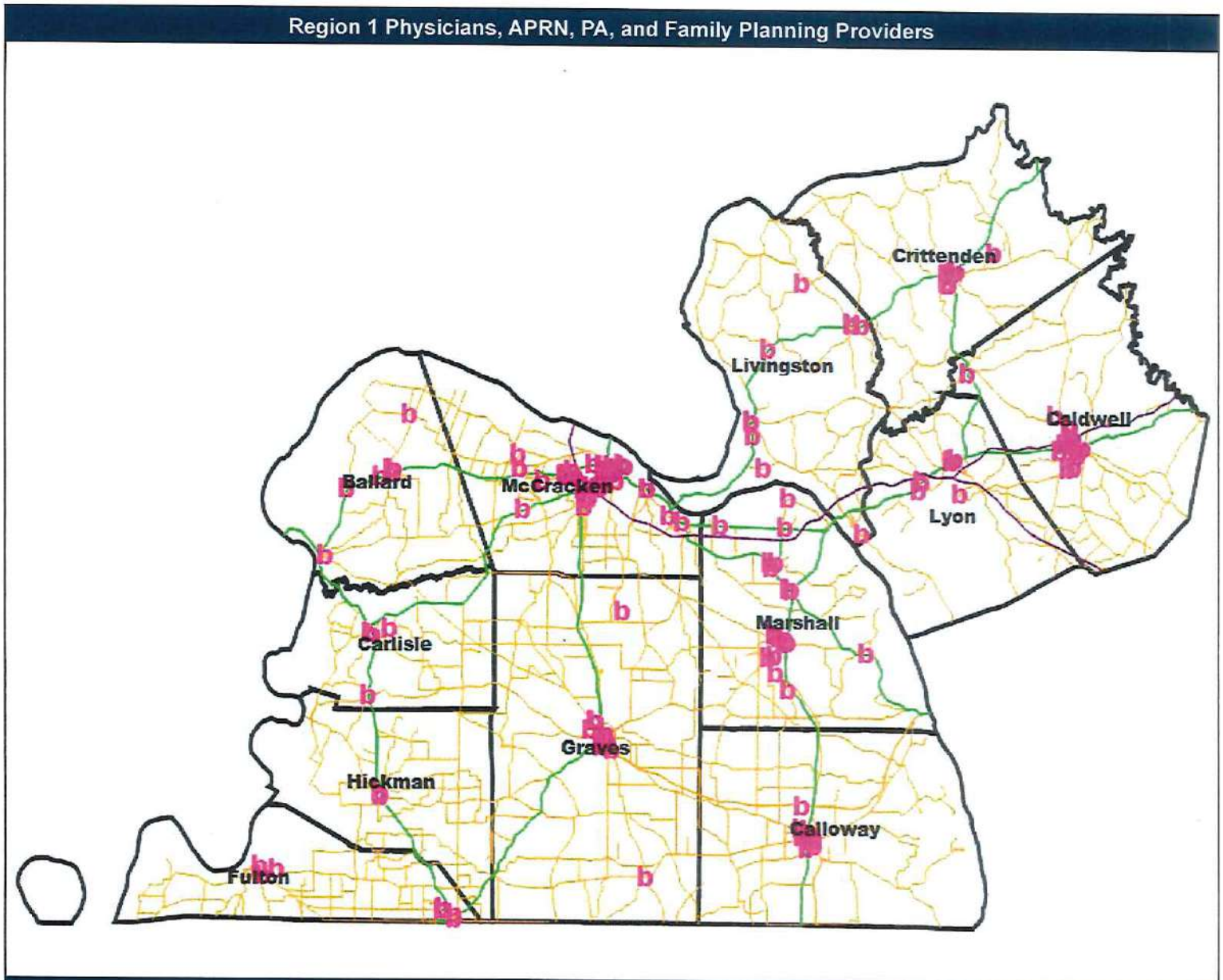

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Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 miles

Overall Access[1]

11,338 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

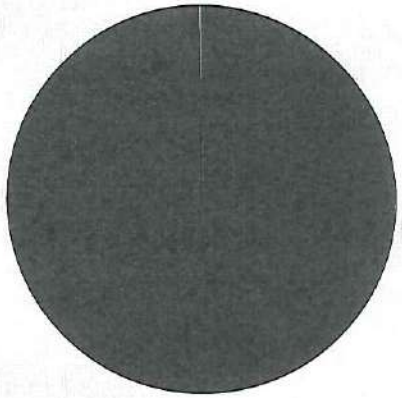

Times

	Average
Distance to 1st closest provider	2.8 miles
Distance to 2nd closest provider	3.3 miles
Distance to 3rd closest provider	3.5 miles
Distance to 4th closest provider	3.7 miles
Distance to 5th closest provider	3.8 miles

Access Standard Comparison

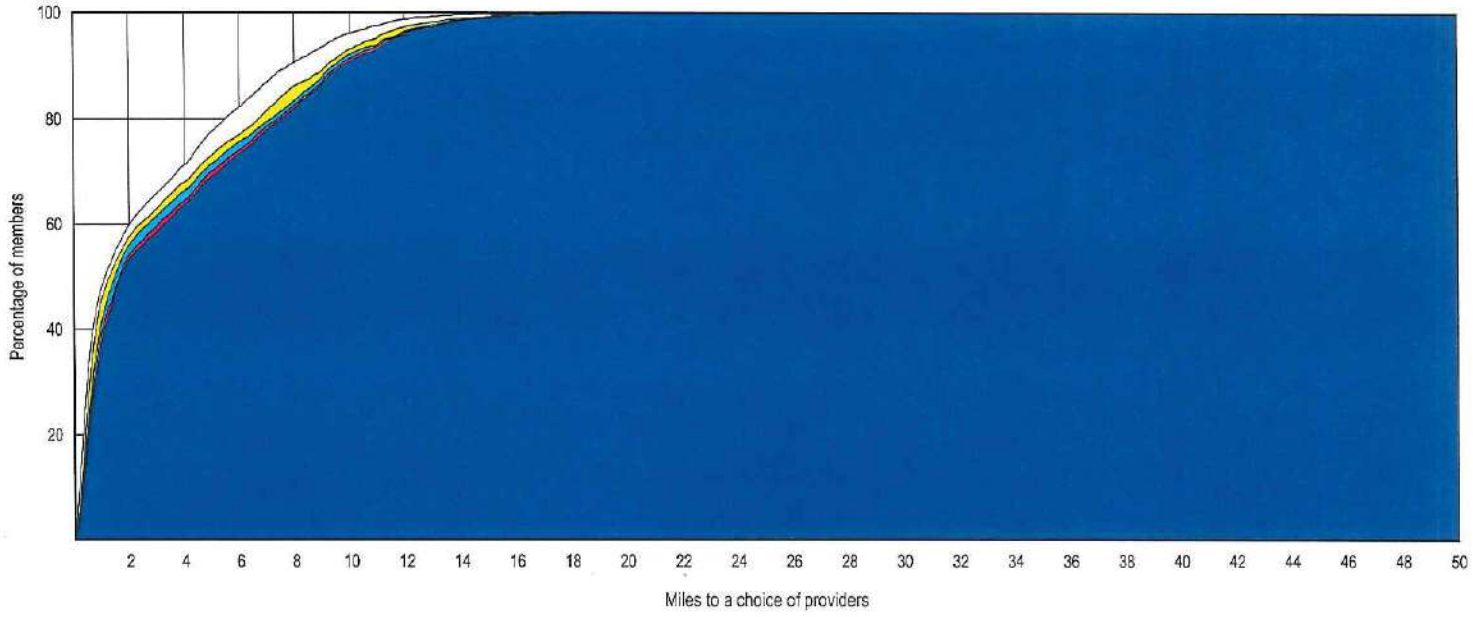

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 minutes

Overall Access[1]

11,338 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

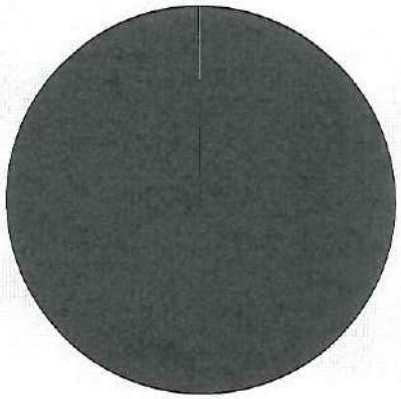

Times

	Average
Time to 1st closest provider	3.0 mins
Time to 2nd closest provider	3.6 mins
Time to 3rd closest provider	3.8 mins
Time to 4th closest provider	4.0 mins
Time to 5th closest provider	4.1 mins

Access Standard Comparison

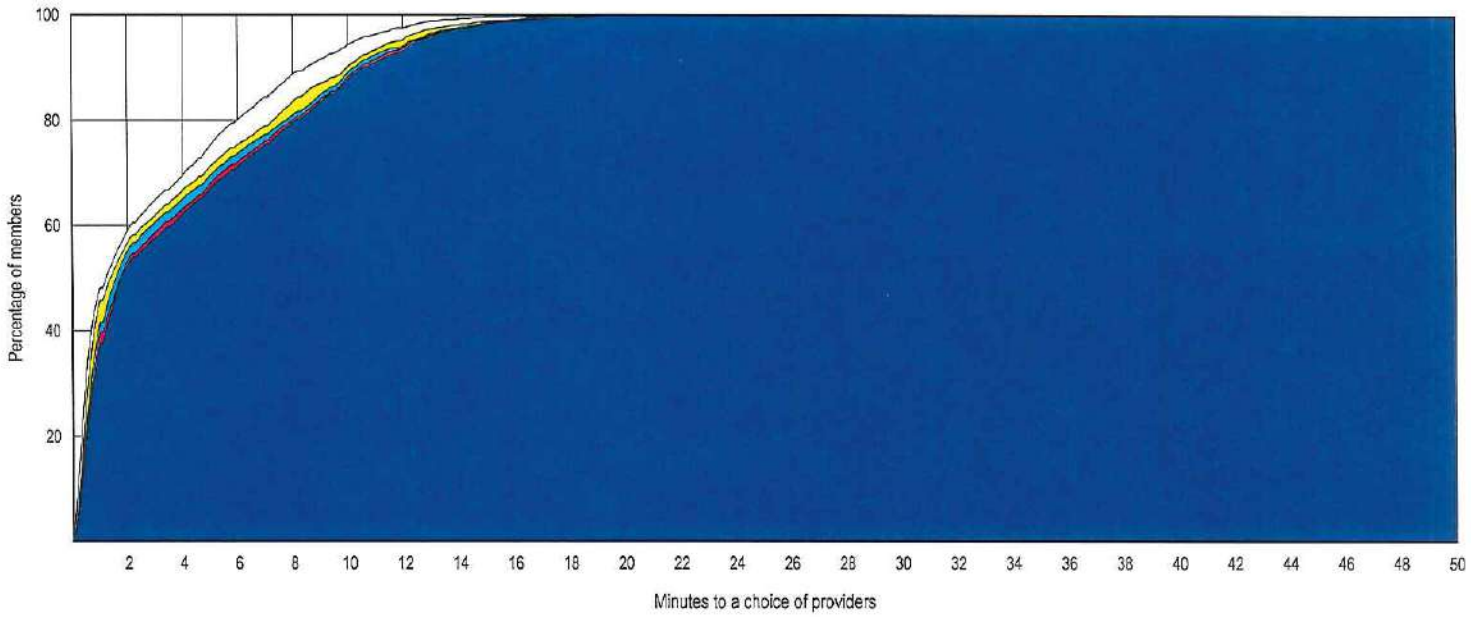

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Provider Locations

January 23, 2020

Region 2 Physicians, APRN, PA, and Family Planning Providers

Total Providers: 2,008

b All providers

Interstates

US Highways

State Highways

15.14 miles

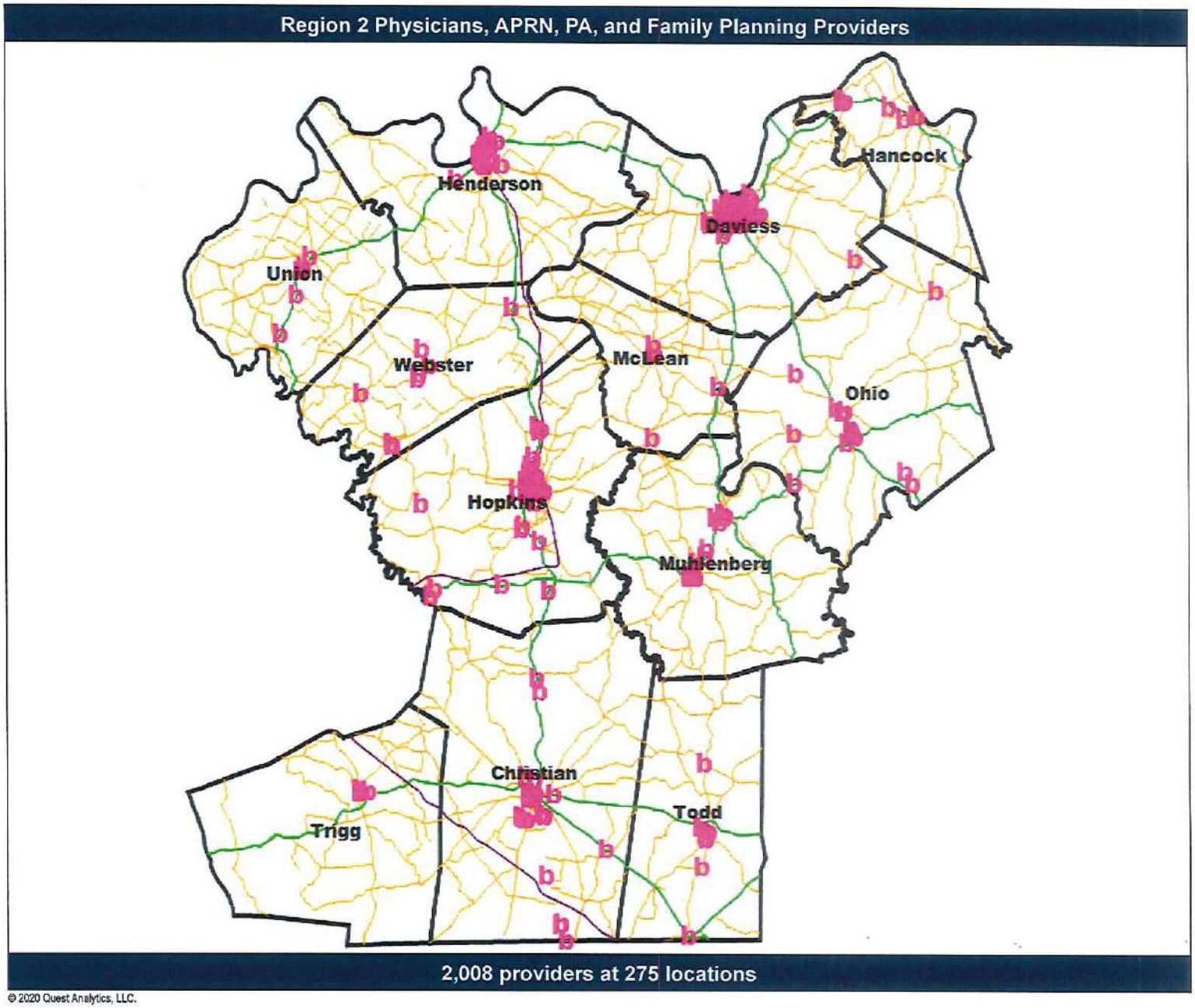

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 miles

Overall Access[1]

16,143 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

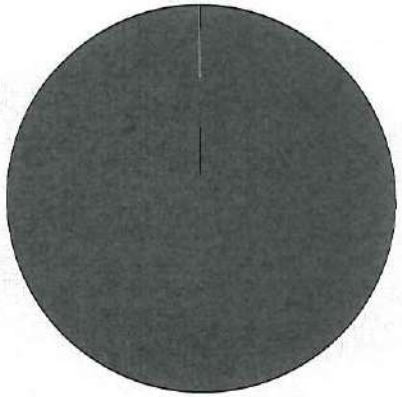

Distances

	Average
Distance to 1st closest provider	2.1 miles
Distance to 2nd closest provider	2.3 miles
Distance to 3rd closest provider	2.5 miles
Distance to 4th closest provider	2.7 miles
Distance to 5th closest provider	2.8 miles

Access Standard Comparison

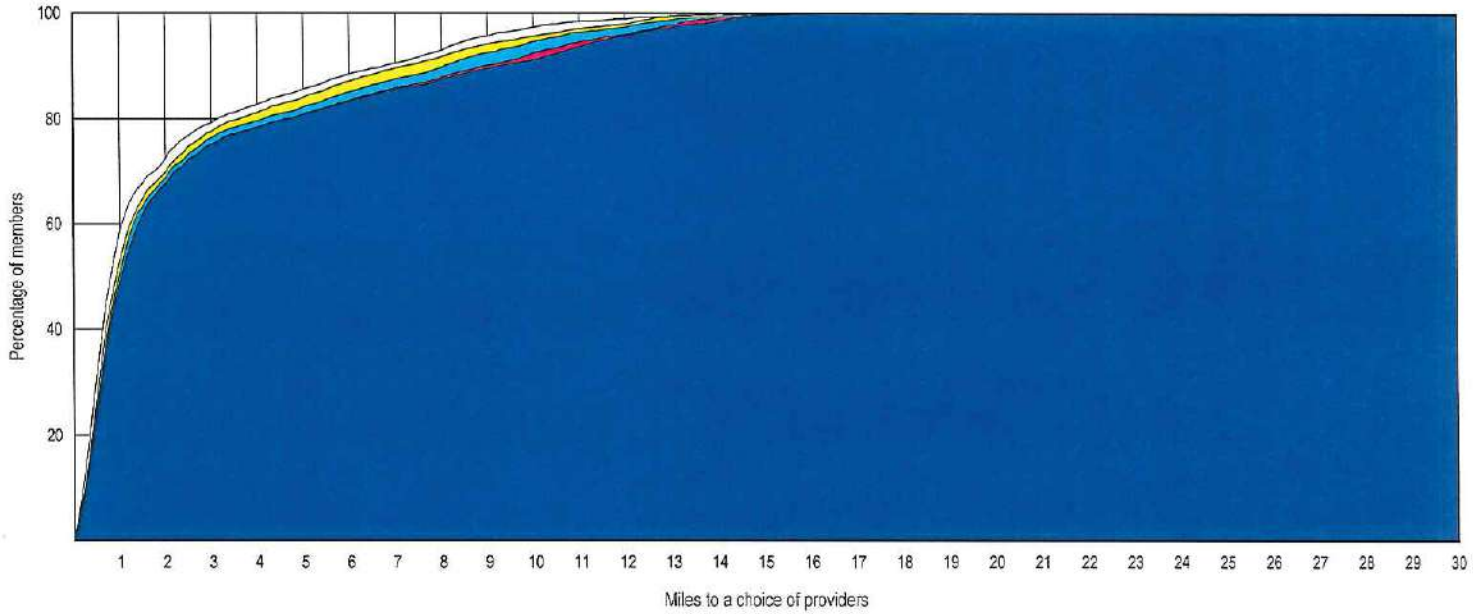

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Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 minutes

Overall Access[1]

16,143 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

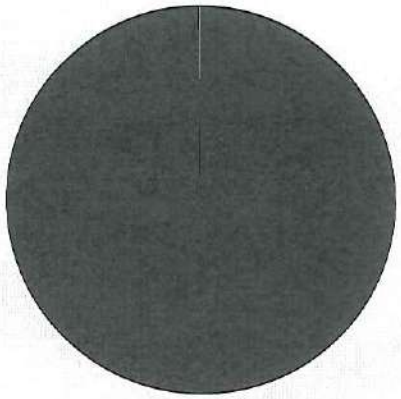

Times

	Average
Time to 1st closest provider	2.3 mins
Time to 2nd closest provider	2.5 mins
Time to 3rd closest provider	2.7 mins
Time to 4th closest provider	2.9 mins
Time to 5th closest provider	3.0 mins

Access Standard Comparison

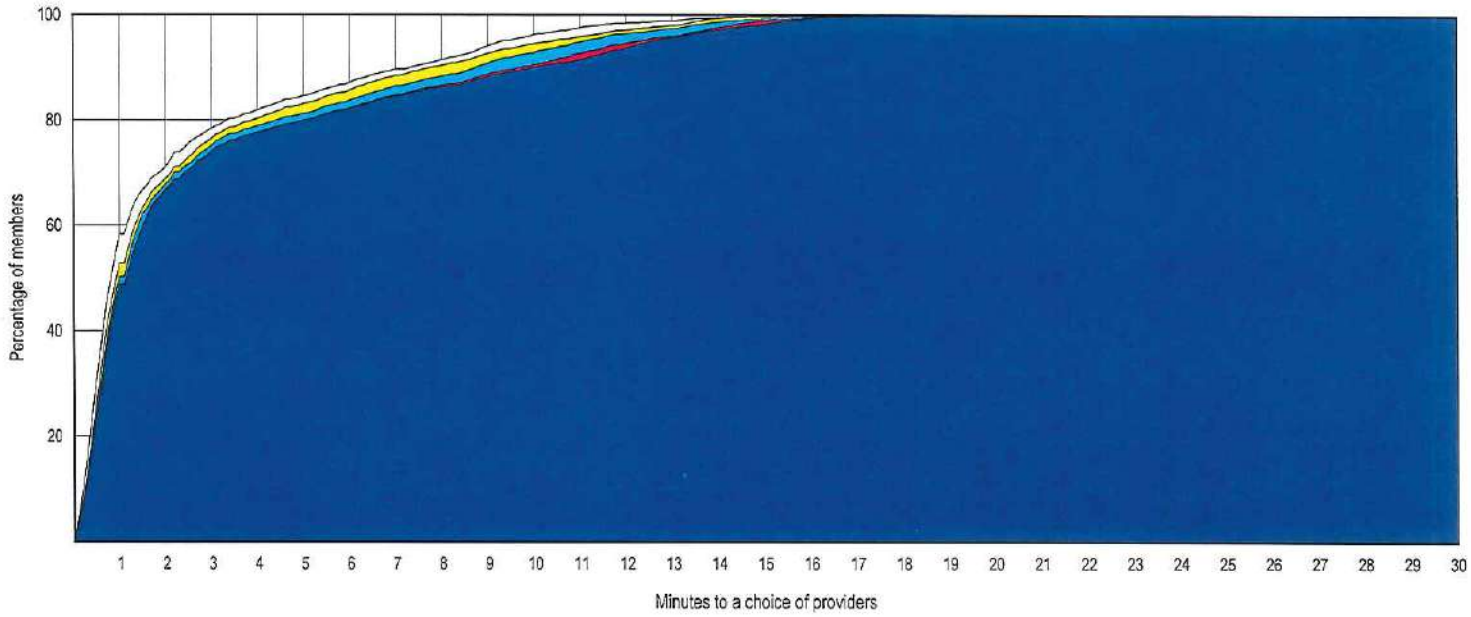

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 miles

Overall Access[1]

9,636 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

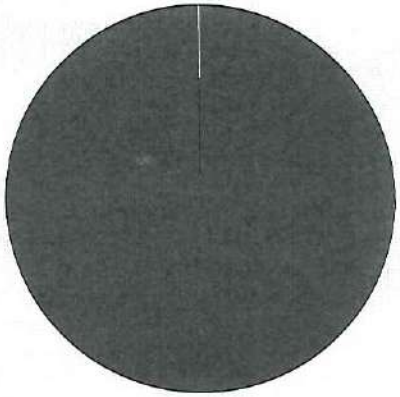

Distances

	Average
Distance to 1st closest provider	2.7 miles
Distance to 2nd closest provider	3.3 miles
Distance to 3rd closest provider	3.7 miles
Distance to 4th closest provider	4.1 miles
Distance to 5th closest provider	4.2 miles

Access Standard Comparison

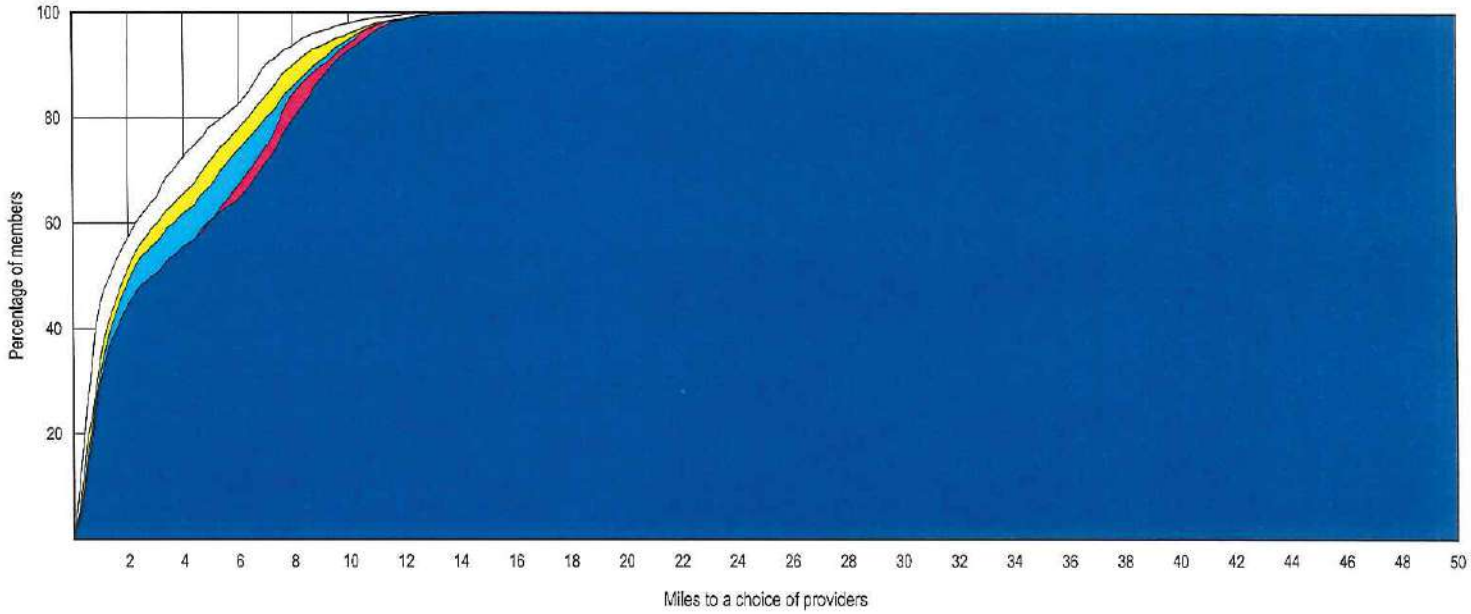

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 minutes

Overall Access[1]

9,636 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

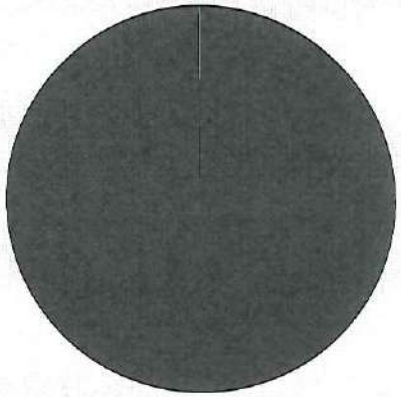

Times

	Average
Time to 1st closest provider	2.9 mins
Time to 2nd closest provider	3.6 mins
Time to 3rd closest provider	3.9 mins
Time to 4th closest provider	4.4 mins
Time to 5th closest provider	4.6 mins

Access Standard Comparison

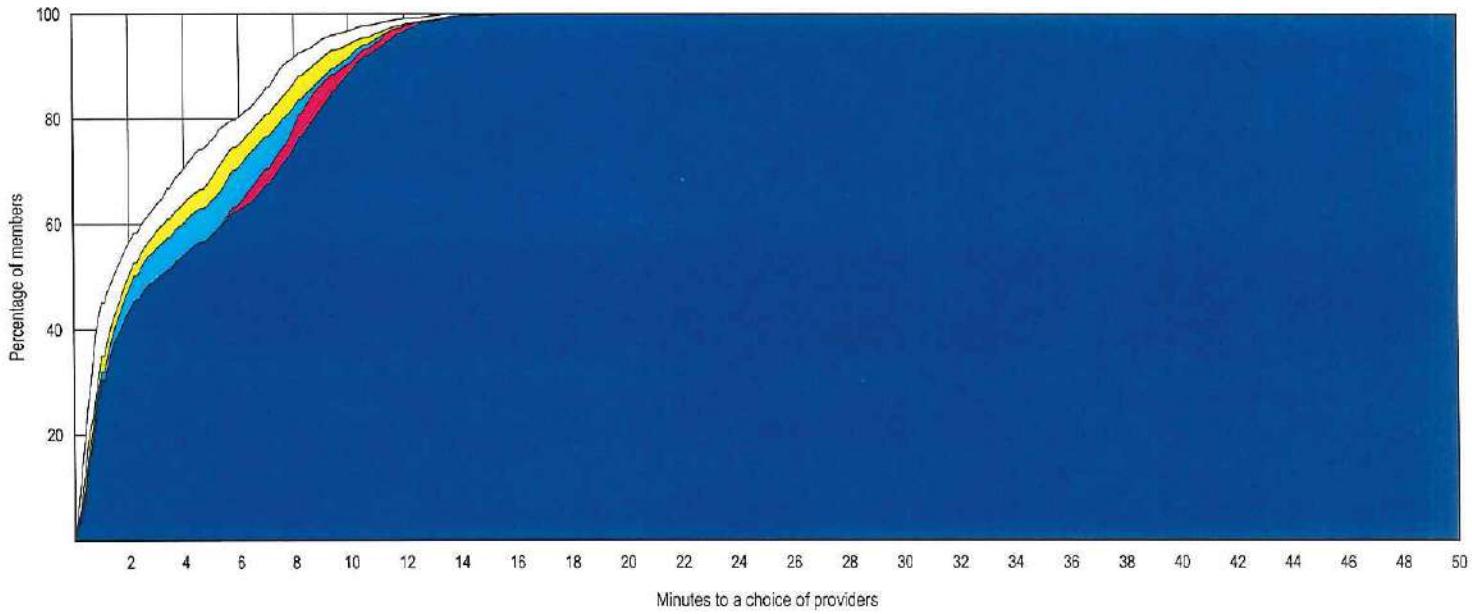

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Provider Locations

January 23, 2020

Region 3 Physicians, APRN, PA, and Family Planning Providers

Total Providers: 5,966

b All providers

Interstates

US Highways

State Highways

15.97 miles

Region 3 Physicians, APRN, PA, and Family Planning Providers

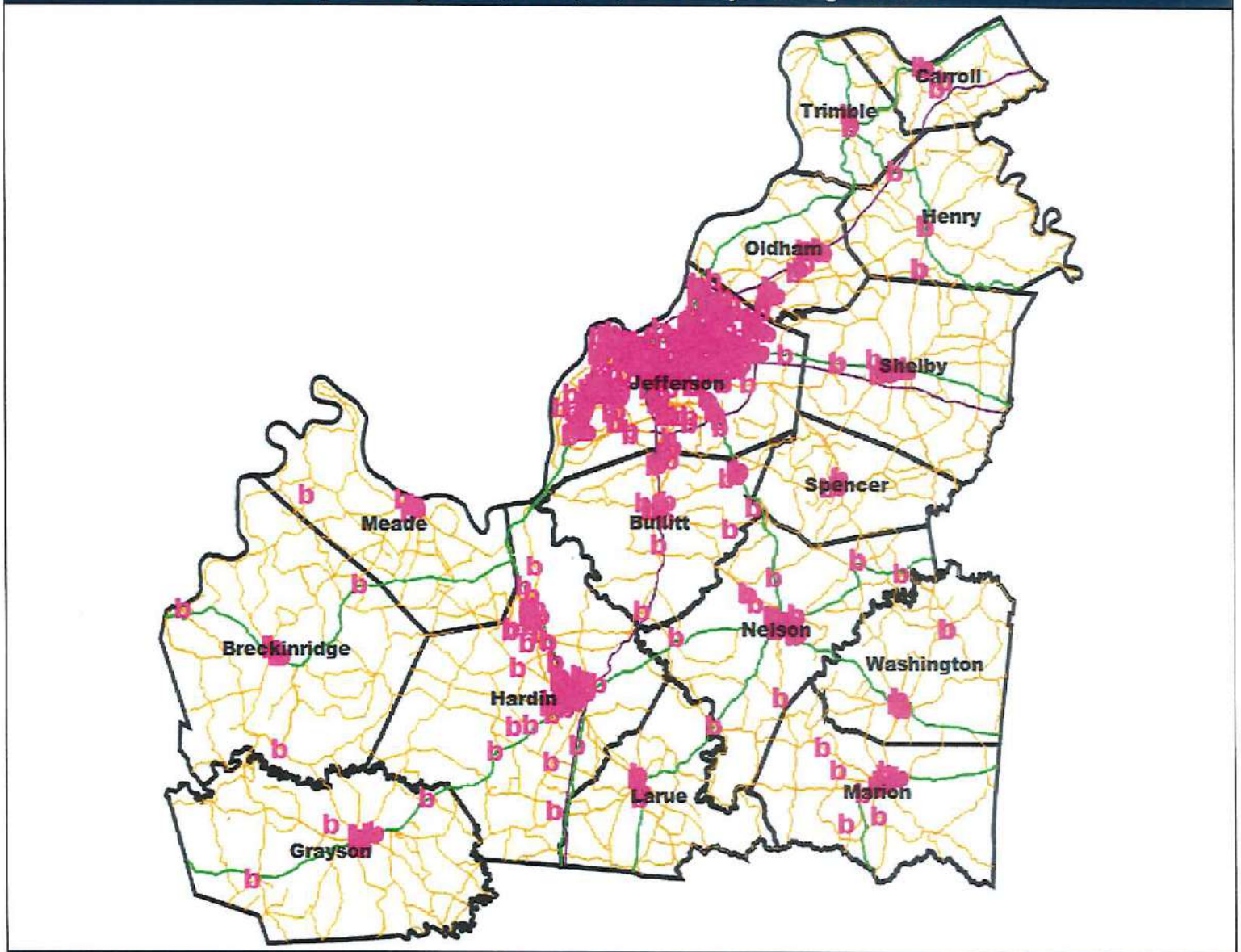

5,966 providers at 806 locations

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Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 miles

Overall Access[1]

18,130 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

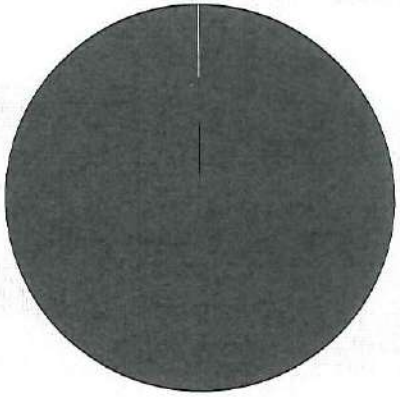

Distances

	Average
Distance to 1st closest provider	1.2 miles
Distance to 2nd closest provider	1.3 miles
Distance to 3rd closest provider	1.4 miles
Distance to 4th closest provider	1.4 miles
Distance to 5th closest provider	1.4 miles

Access Standard Comparison

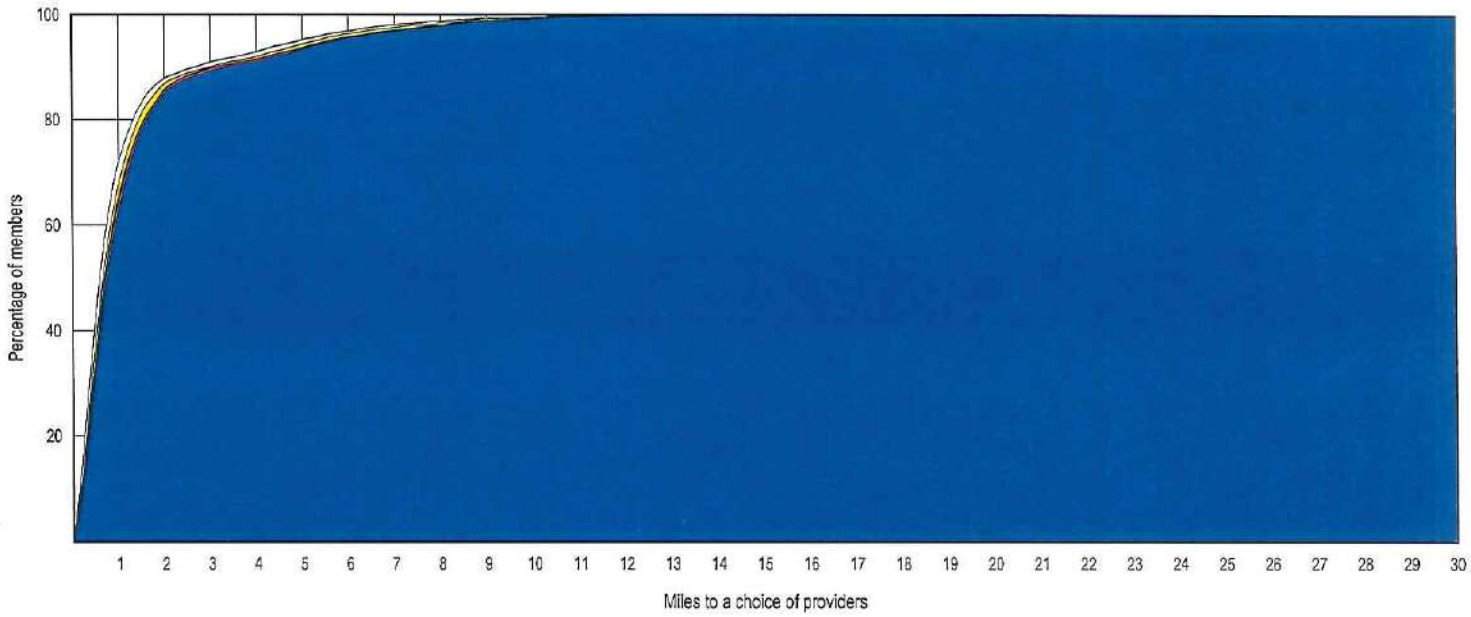

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 minutes

Overall Access[1]

18,130 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

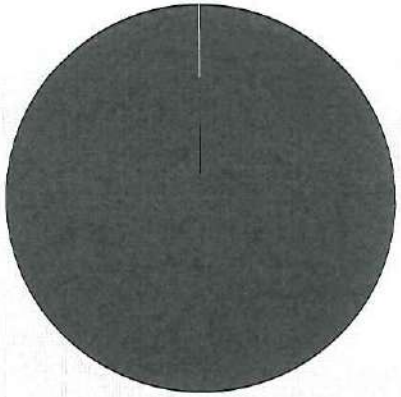

Times

	Average
Time to 1st closest provider	1.4 mins
Time to 2nd closest provider	1.6 mins
Time to 3rd closest provider	1.7 mins
Time to 4th closest provider	1.7 mins
Time to 5th closest provider	1.8 mins

Access Standard Comparison

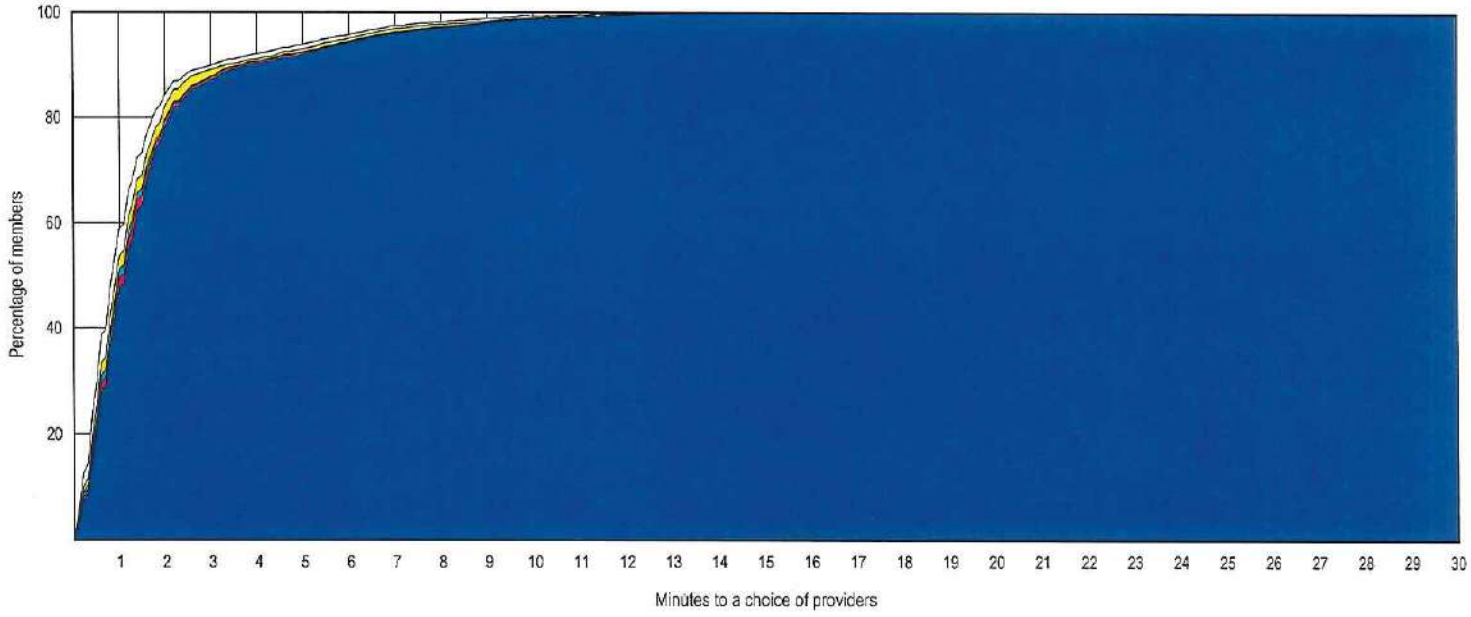

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Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 miles

Overall Access[1]

1,901 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

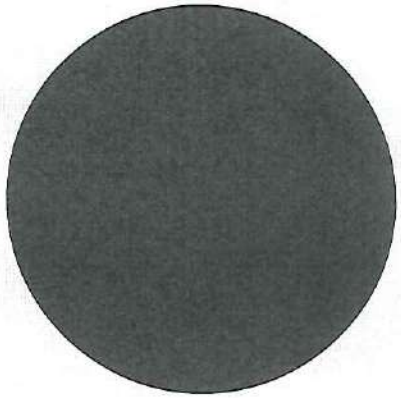

Distances

	Average
Distance to 1st closest provider	3.6 miles
Distance to 2nd closest provider	4.4 miles
Distance to 3rd closest provider	4.4 miles
Distance to 4th closest provider	4.4 miles
Distance to 5th closest provider	5.5 miles

Access Standard Comparison

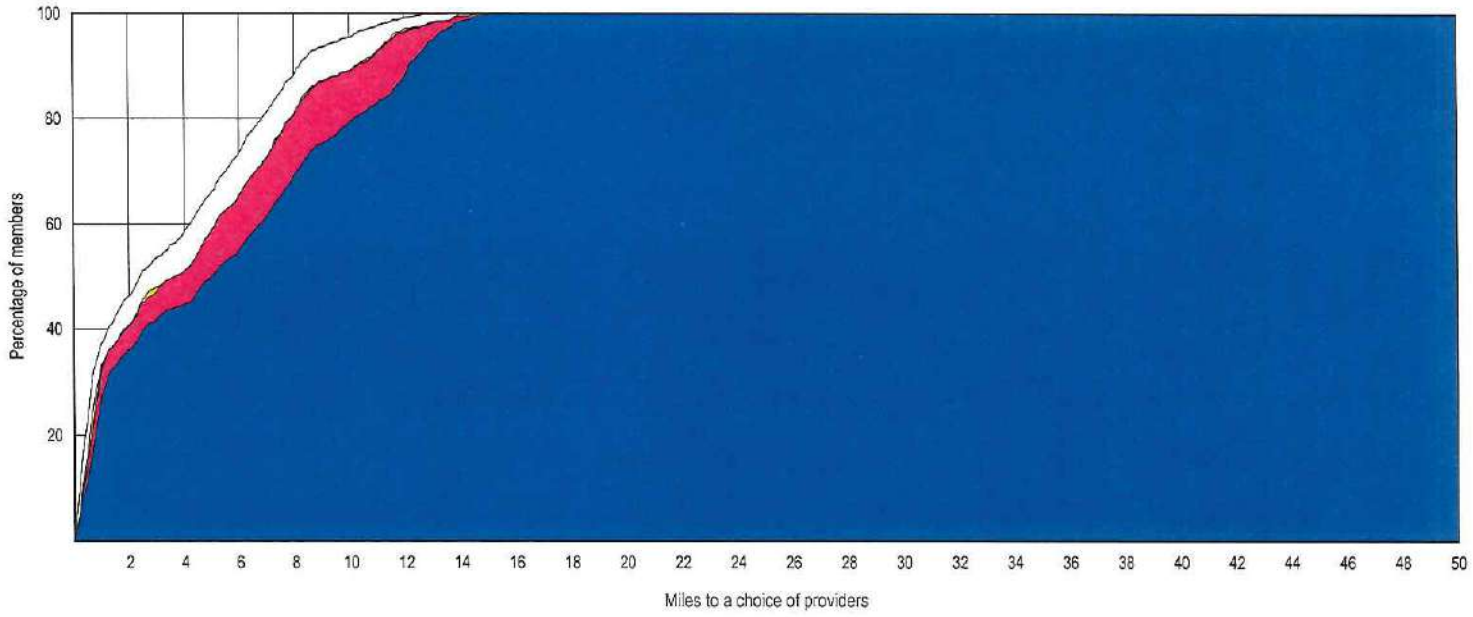

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 minutes

Overall Access[1]

1,901 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

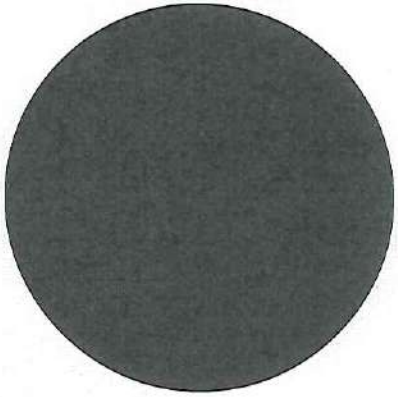

Times

	Average
Time to 1st closest provider	3.9 mins
Time to 2nd closest provider	4.7 mins
Time to 3rd closest provider	4.8 mins
Time to 4th closest provider	4.8 mins
Time to 5th closest provider	6.0 mins

Access Standard Comparison

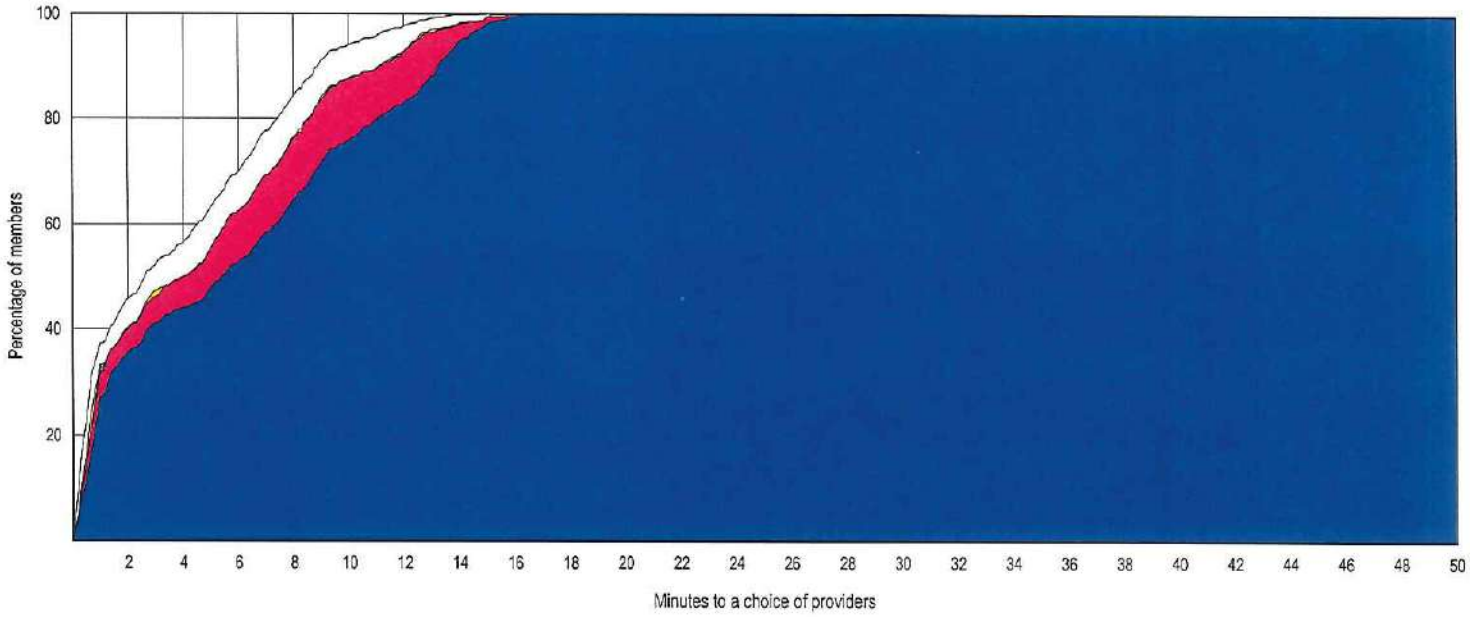

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Provider Locations

January 23, 2020

Region 4 Physicians, APRN, PA, and Family Planning Providers

Total Providers: 2,705

b All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Physicians, APRN, PA, and Family Planning Providers

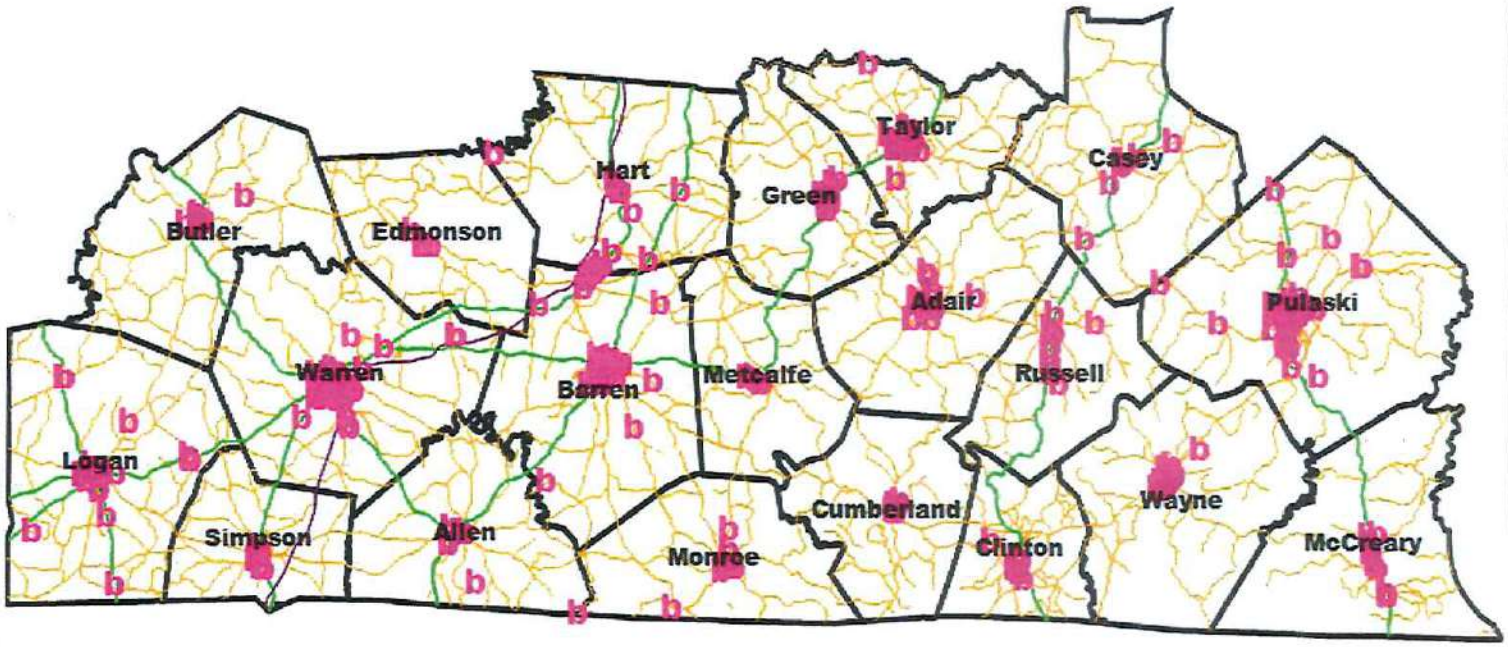

2,705 providers at 498 locations

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Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 miles

Overall Access[1]

7,413 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

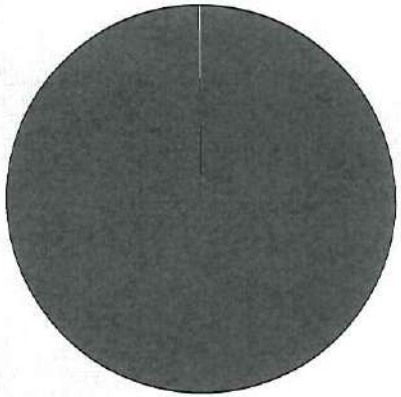

Distances

	Average
Distance to 1st closest provider	2.2 miles
Distance to 2nd closest provider	2.3 miles
Distance to 3rd closest provider	2.4 miles
Distance to 4th closest provider	2.5 miles
Distance to 5th closest provider	2.5 miles

Access Standard Comparison

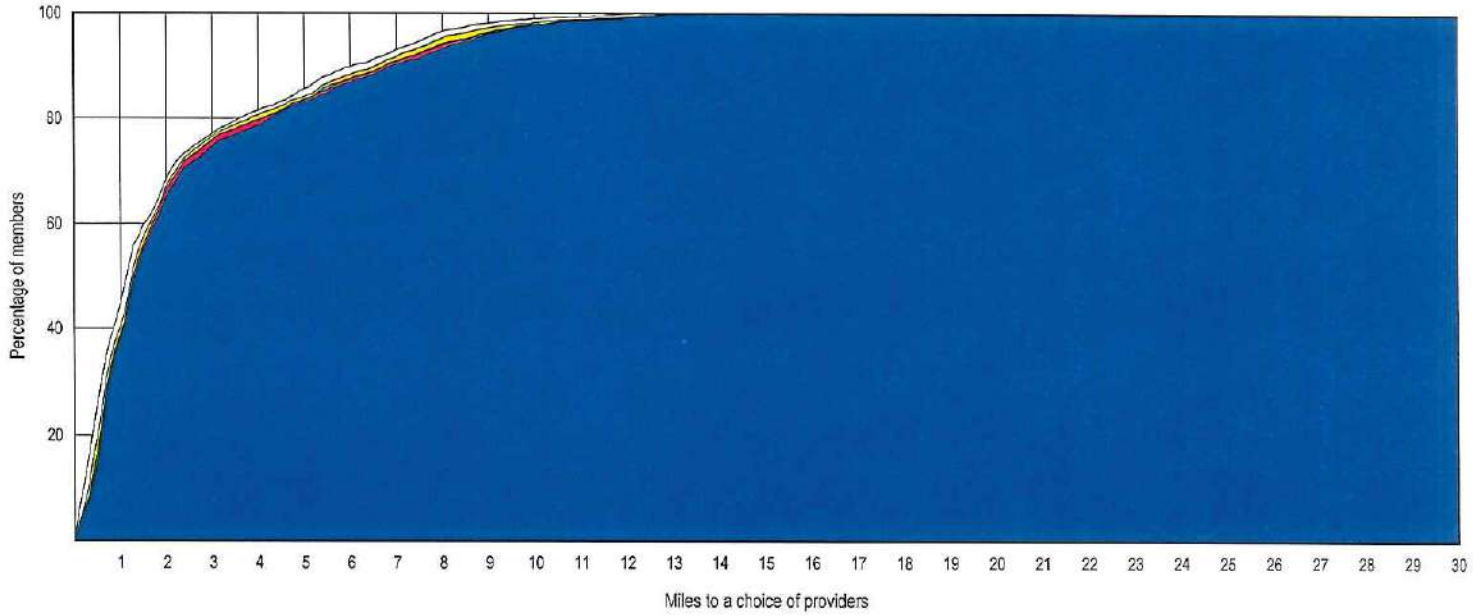

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
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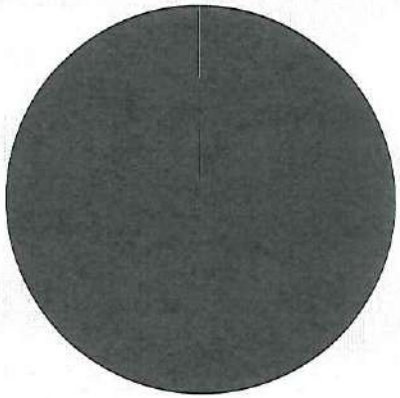

Times

	Average
Time to 1st closest provider	2.3 mins
Time to 2nd closest provider	2.5 mins
Time to 3rd closest provider	2.6 mins
Time to 4th closest provider	2.6 mins
Time to 5th closest provider	2.7 mins

Access Standard Comparison

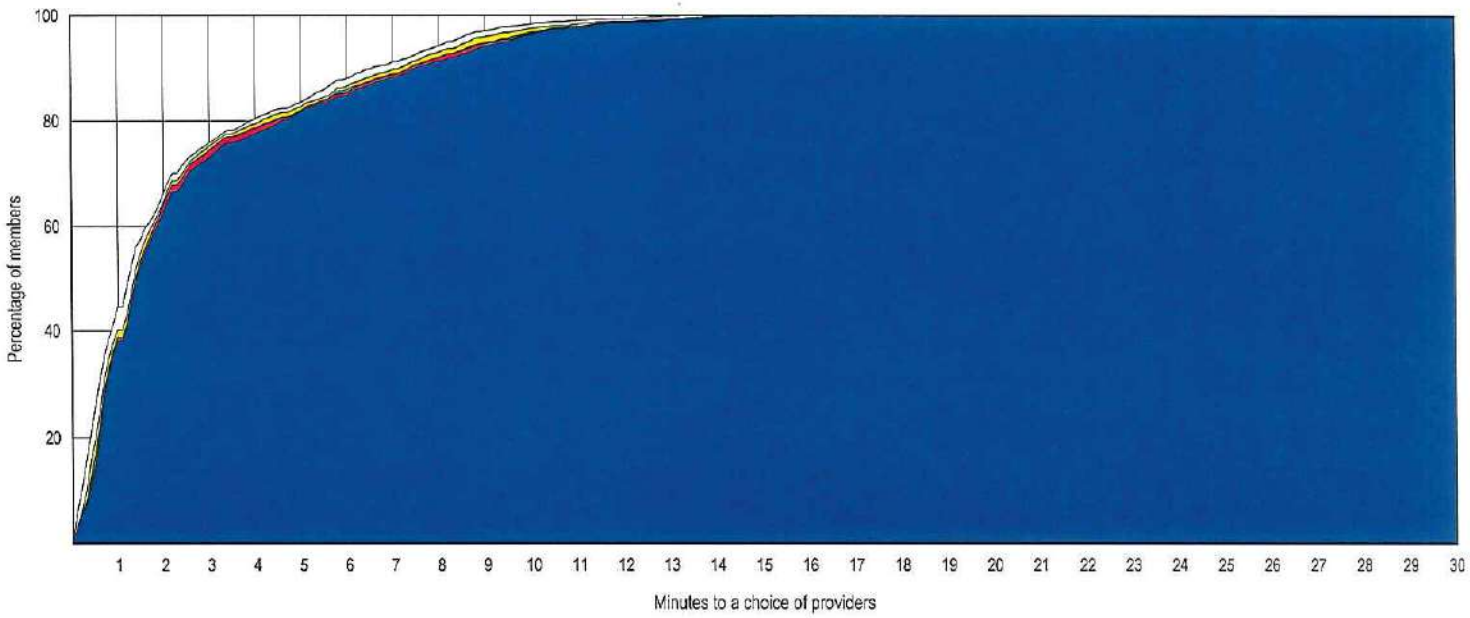

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Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 miles

Overall Access[1]

28,324 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

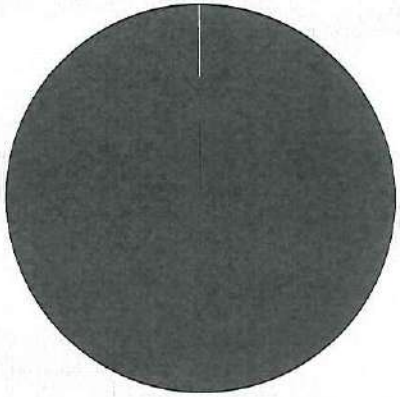

Distances

	Average
Distance to 1st closest provider	3.3 miles
Distance to 2nd closest provider	3.7 miles
Distance to 3rd closest provider	3.8 miles
Distance to 4th closest provider	3.9 miles
Distance to 5th closest provider	4.0 miles

Access Standard Comparison

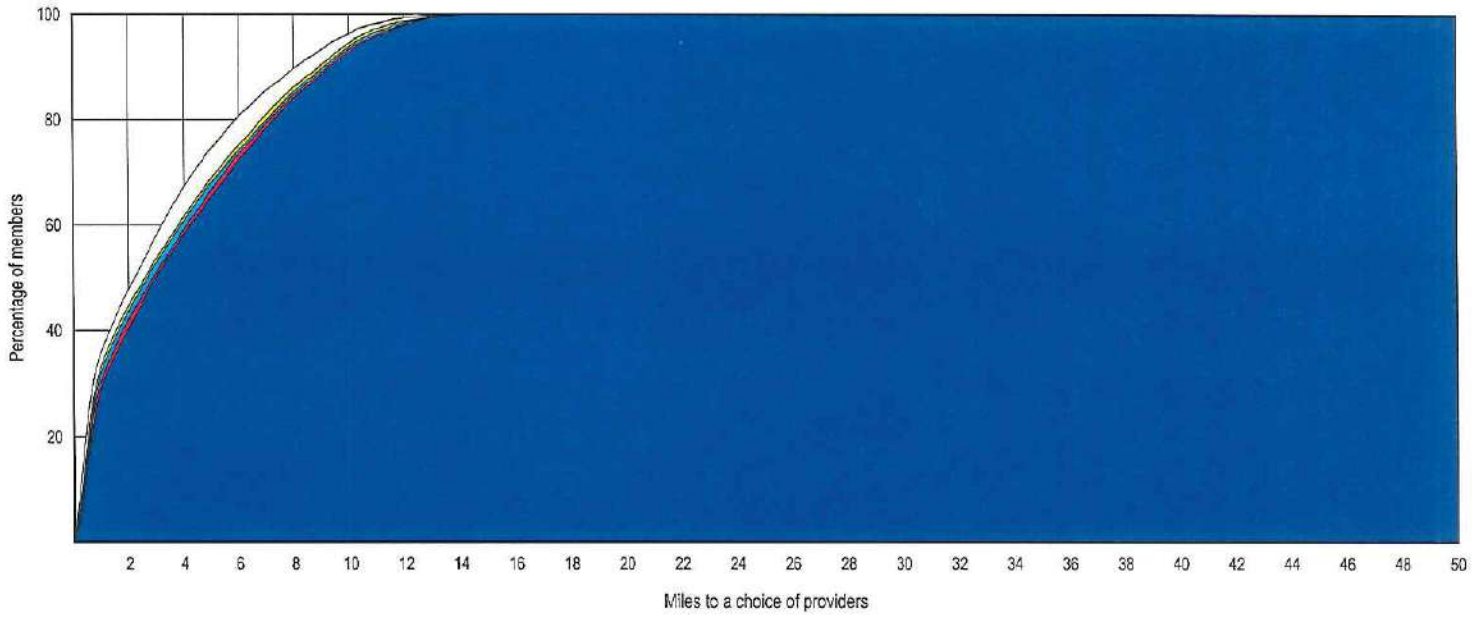

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Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 minutes

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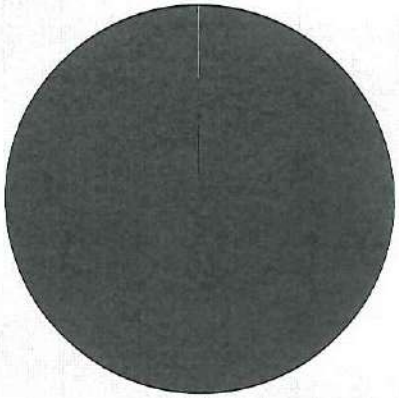

Times

	Average
Time to 1st closest provider	3.5 mins
Time to 2nd closest provider	4.0 mins
Time to 3rd closest provider	4.1 mins
Time to 4th closest provider	4.2 mins
Time to 5th closest provider	4.4 mins

Access Standard Comparison

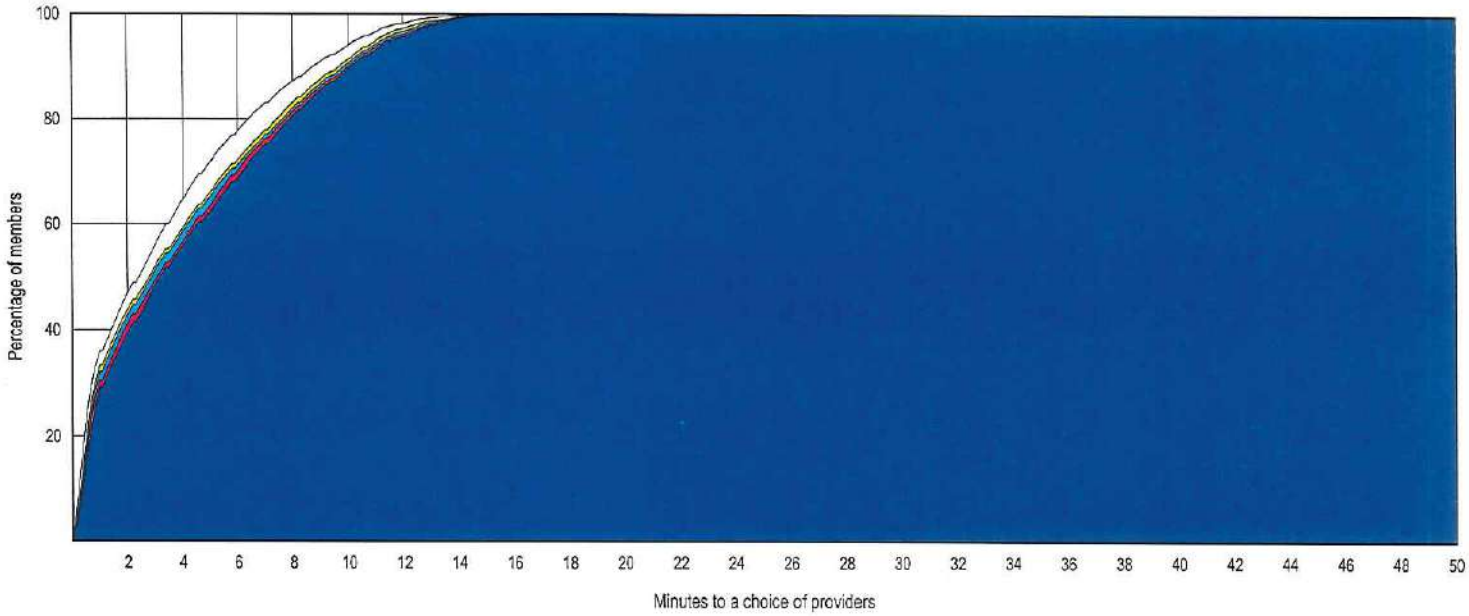

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Provider Locations

January 23, 2020

Region 5 Physicians, APRN, PA, and Family Planning Providers

Total Providers: 5,004

b All providers

Interstates

US Highways

State Highways

17.44 miles

Region 5 Physicians, APRN, PA, and Family Planning Providers

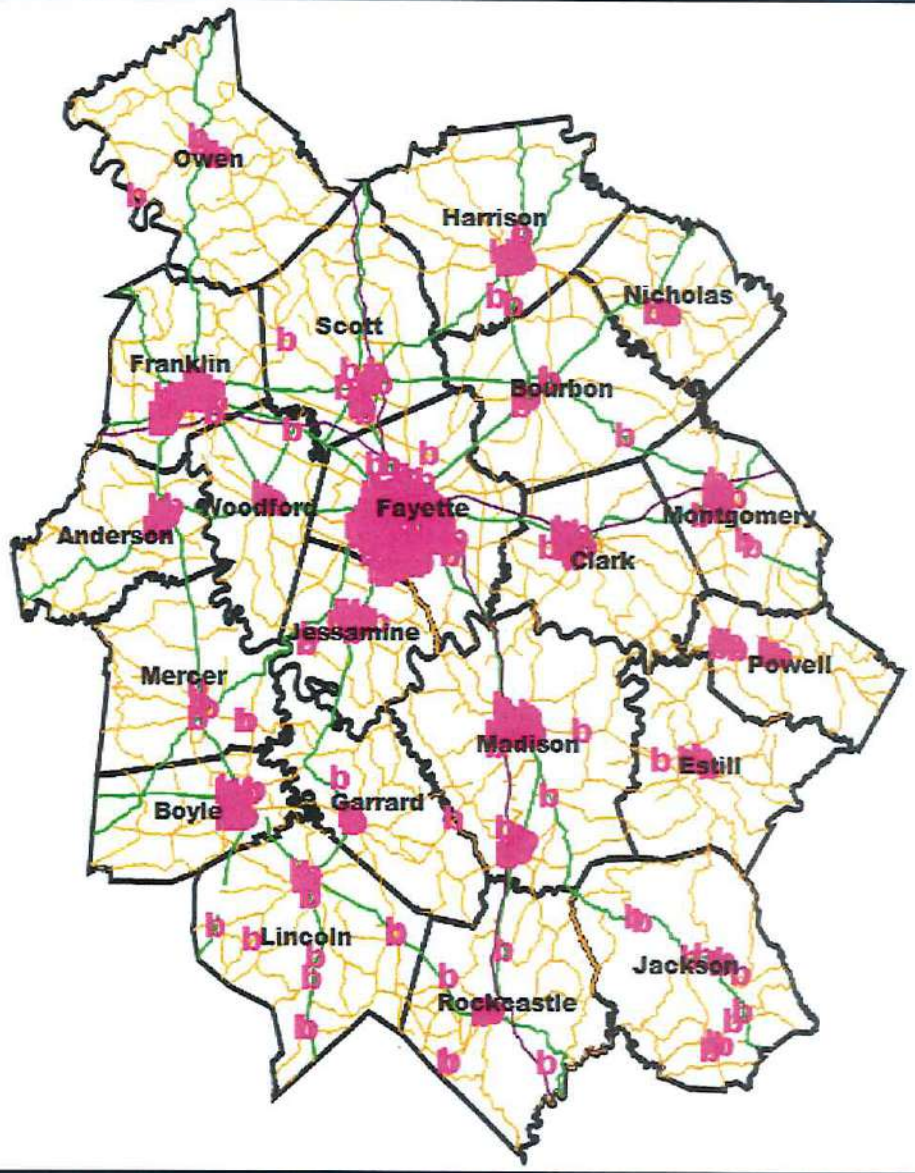

5,004 providers at 724 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 miles

Overall Access[1]

22,712 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

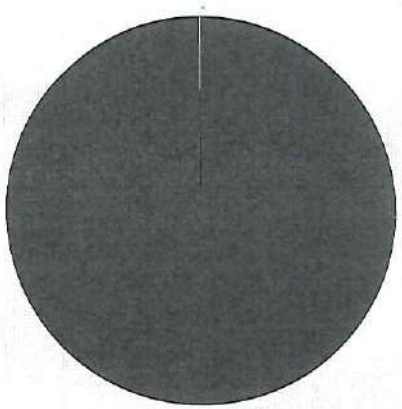

Distances

	Average
Distance to 1st closest provider	1.0 mile
Distance to 2nd closest provider	1.2 miles
Distance to 3rd closest provider	1.3 miles
Distance to 4th closest provider	1.3 miles
Distance to 5th closest provider	1.4 miles

Access Standard Comparison

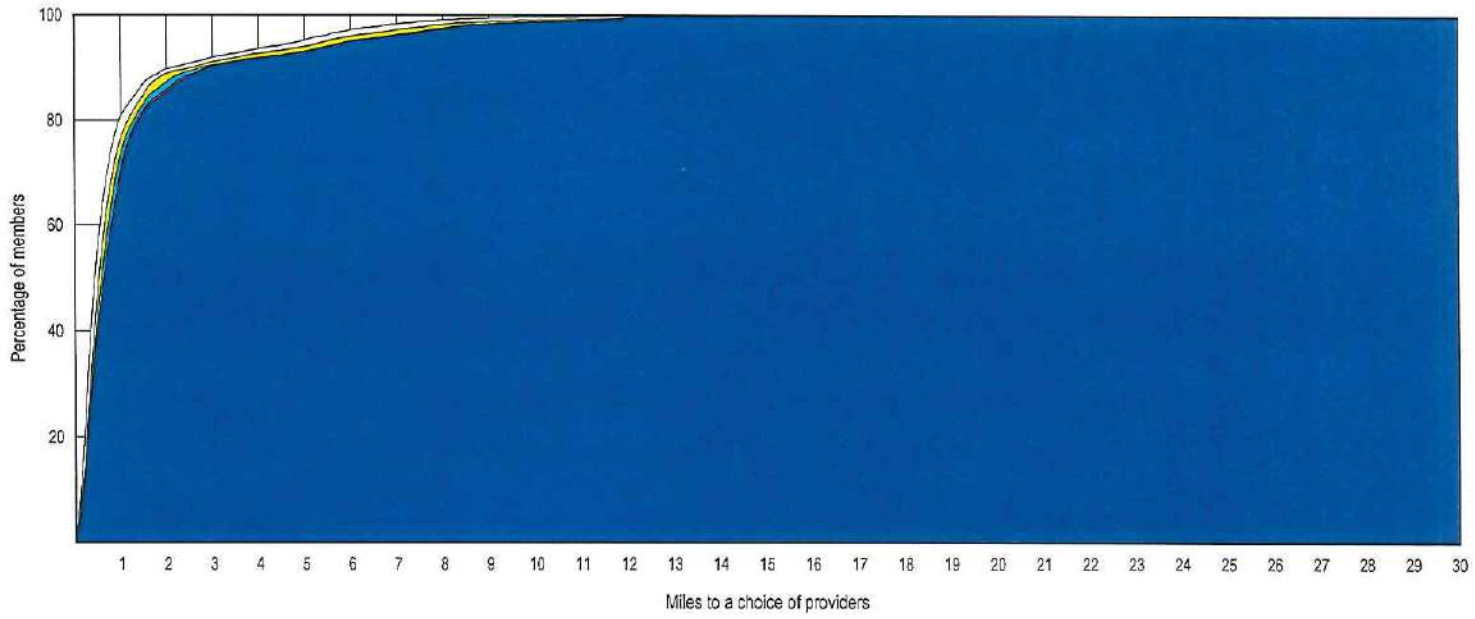

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Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 minutes

Overall Access[1]

22,712 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

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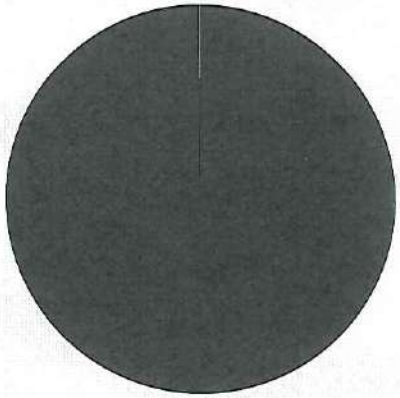

Times

	Average
Time to 1st closest provider	1.2 mins
Time to 2nd closest provider	1.4 mins
Time to 3rd closest provider	1.5 mins
Time to 4th closest provider	1.6 mins
Time to 5th closest provider	1.6 mins

Access Standard Comparison

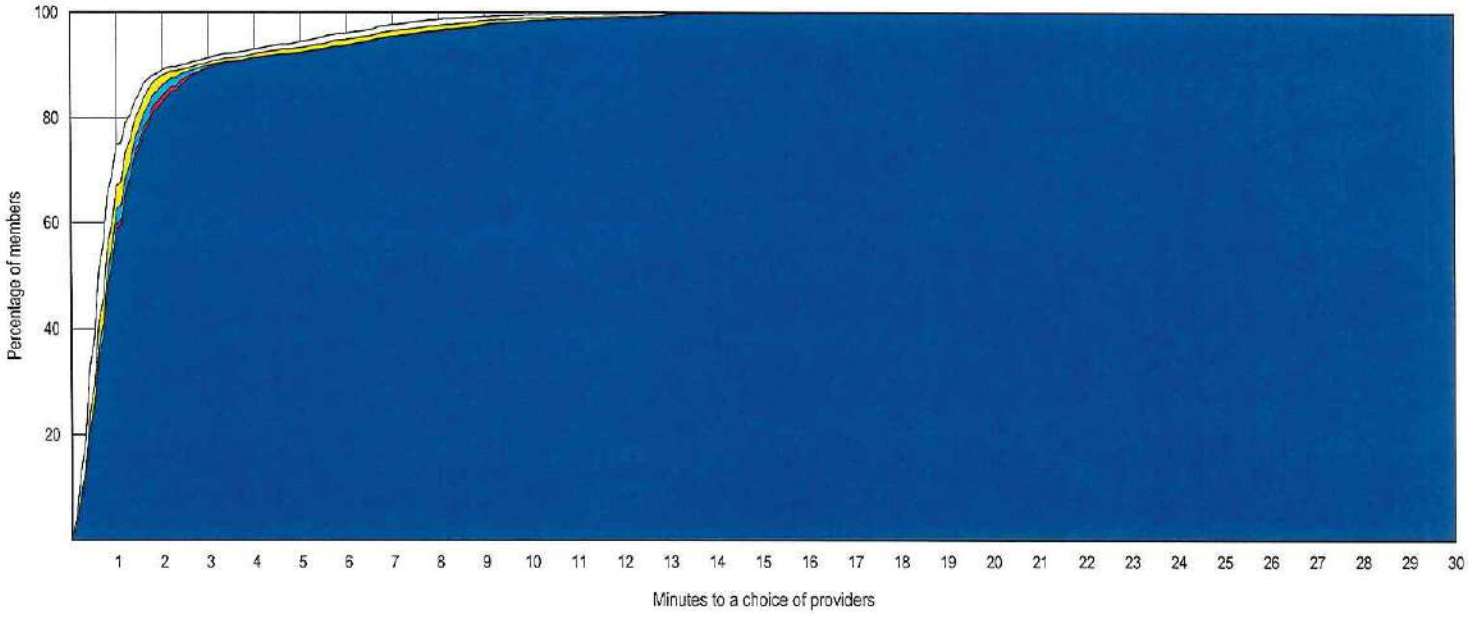

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 miles

Overall Access[1]

23,127 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

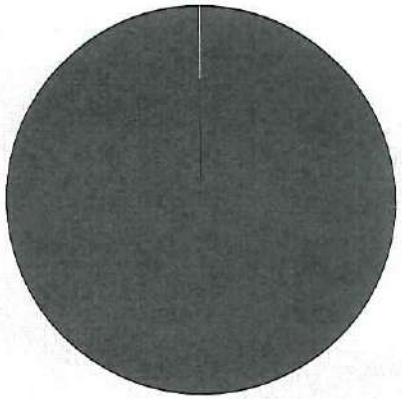

Distances

	Average
Distance to 1st closest provider	2.5 miles
Distance to 2nd closest provider	2.7 miles
Distance to 3rd closest provider	2.9 miles
Distance to 4th closest provider	3.0 miles
Distance to 5th closest provider	3.0 miles

Access Standard Comparison

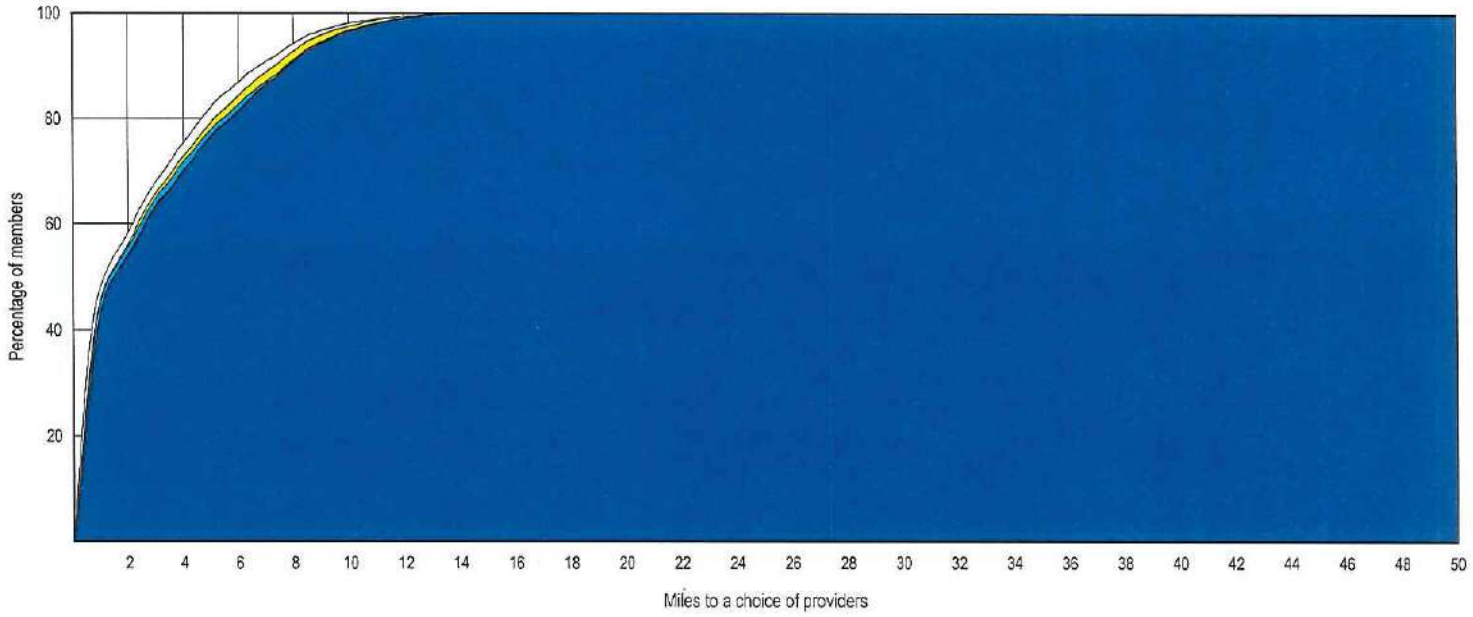

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 minutes

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23,127 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

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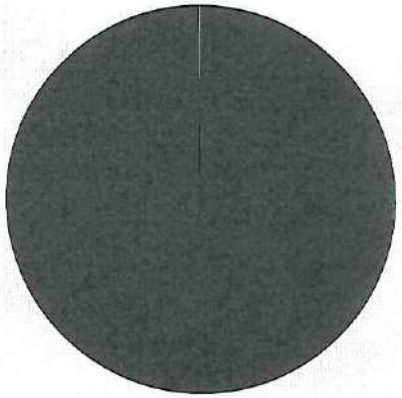

Times

	Average
Time to 1st closest provider	2.7 mins
Time to 2nd closest provider	2.9 mins
Time to 3rd closest provider	3.1 mins
Time to 4th closest provider	3.2 mins
Time to 5th closest provider	3.3 mins

Access Standard Comparison

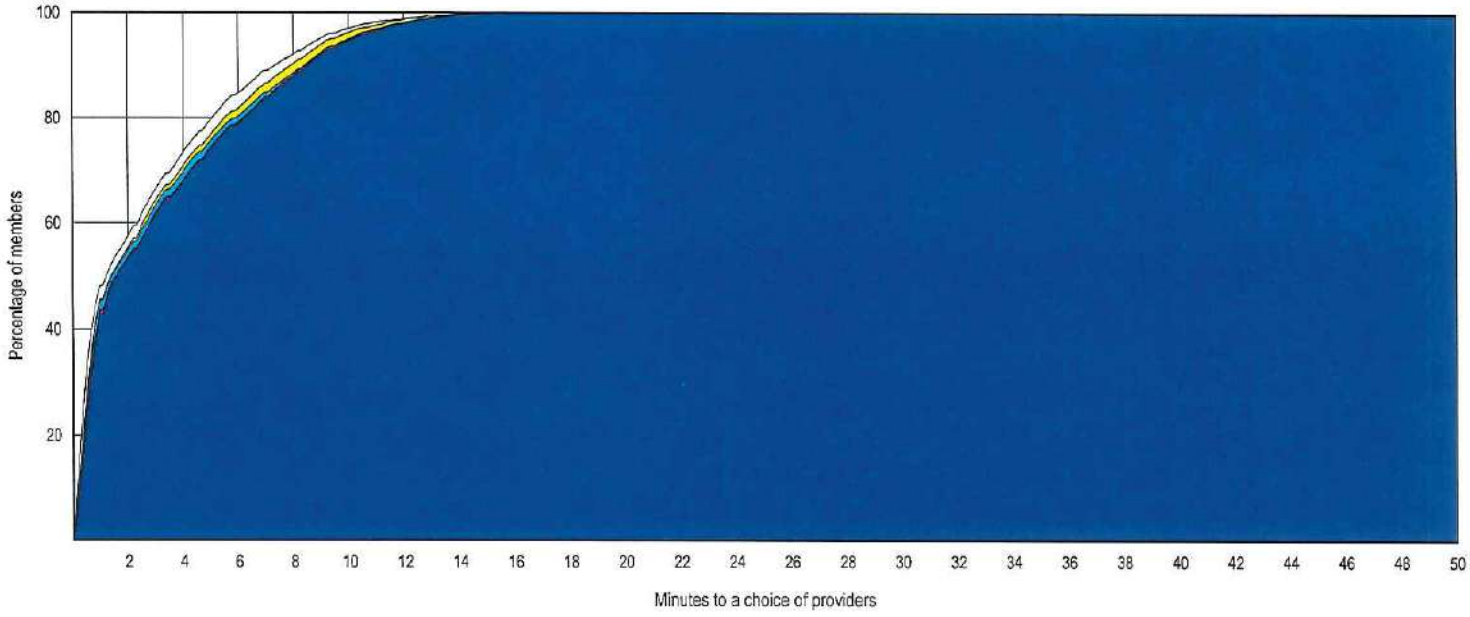

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Provider Locations

January 23, 2020

Region 6 Physicians, APRN, PA, and Family Planning Providers

Total Providers: 1,830

b All providers

Interstates

US Highways

State Highways

7.48 miles

Region 6 Physicians, APRN, PA, and Family Planning Providers

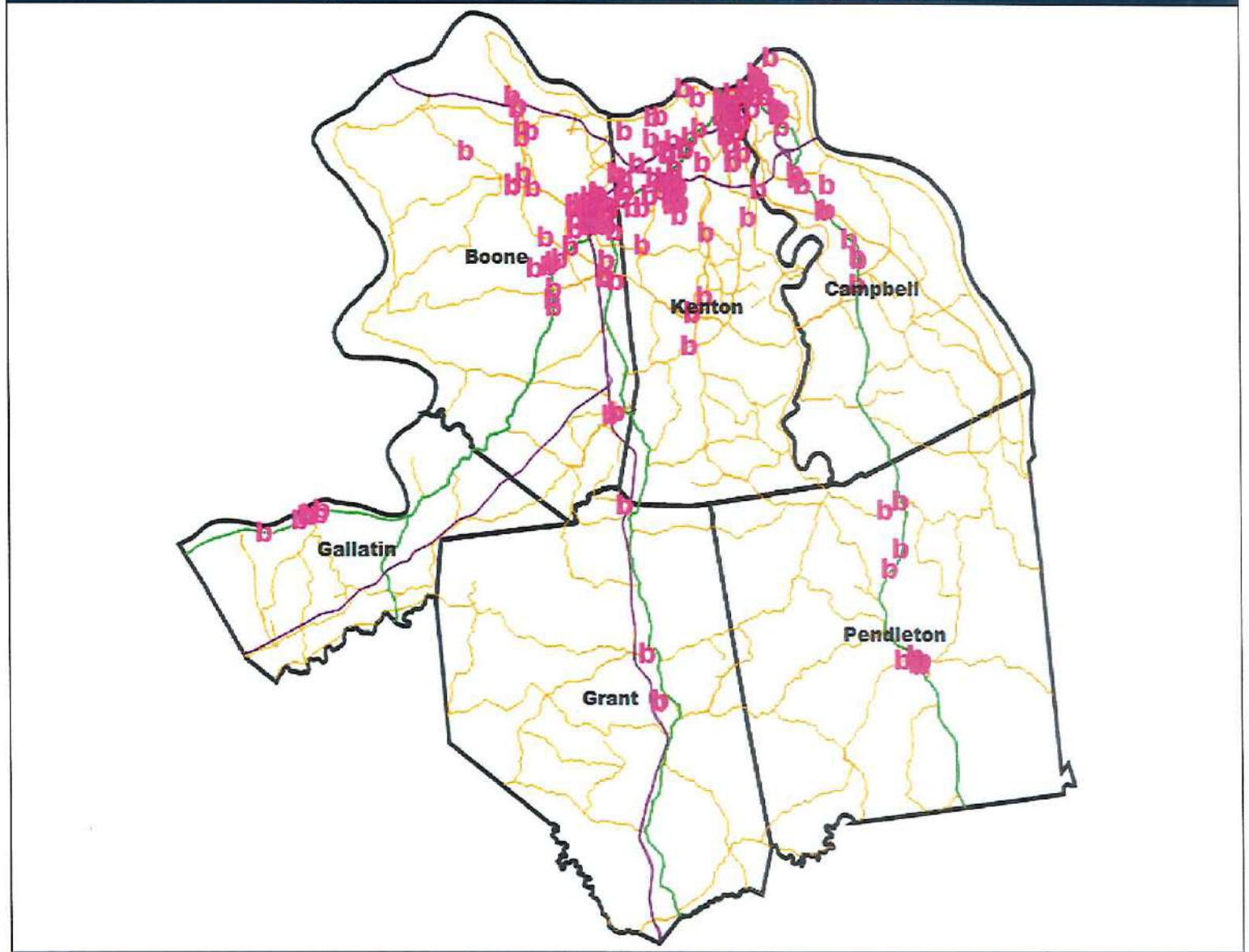

1,830 providers at 209 locations

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Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 miles

Overall Access[1]

22,413 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

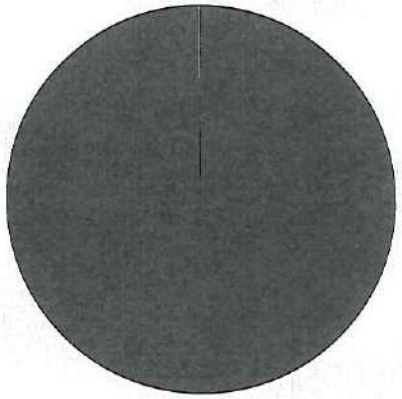

Distances

	Average
Distance to 1st closest provider	1.4 miles
Distance to 2nd closest provider	1.5 miles
Distance to 3rd closest provider	1.6 miles
Distance to 4th closest provider	1.6 miles
Distance to 5th closest provider	1.6 miles

Access Standard Comparison

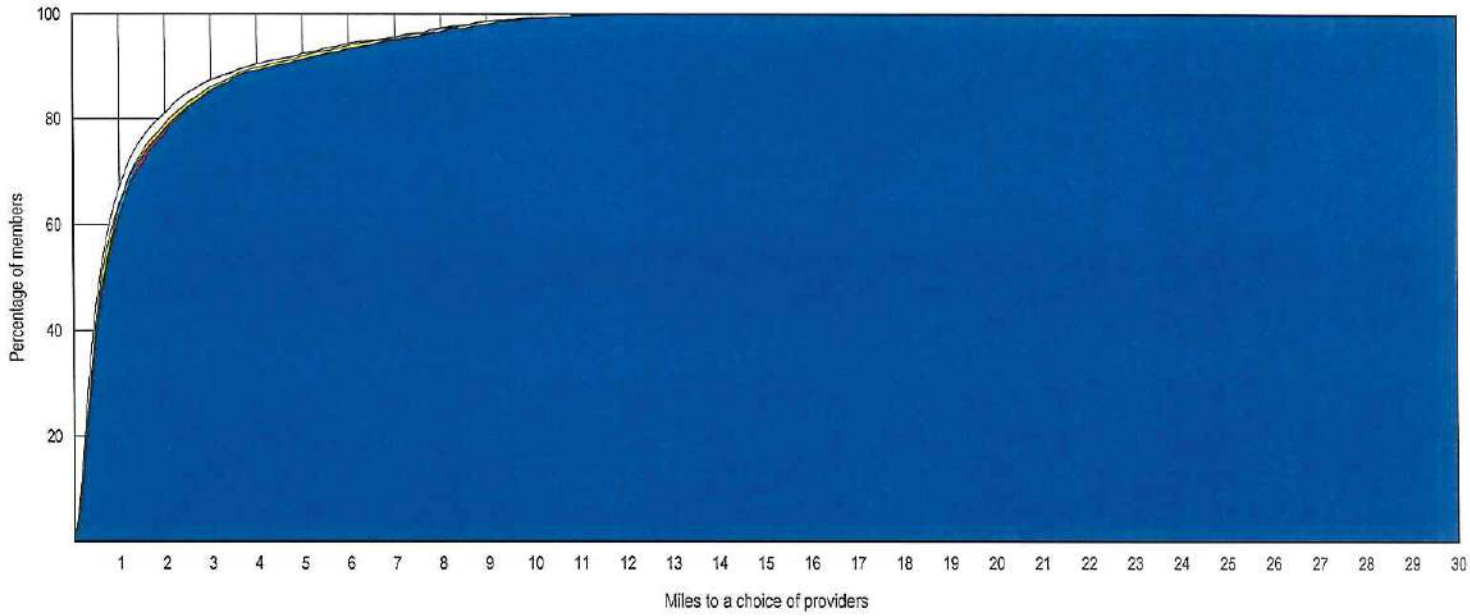

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

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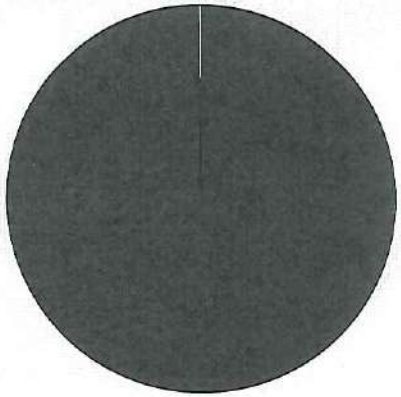

Times

	Average
Time to 1st closest provider	1.6 mins
Time to 2nd closest provider	1.8 mins
Time to 3rd closest provider	1.8 mins
Time to 4th closest provider	1.9 mins
Time to 5th closest provider	1.9 mins

Access Standard Comparison

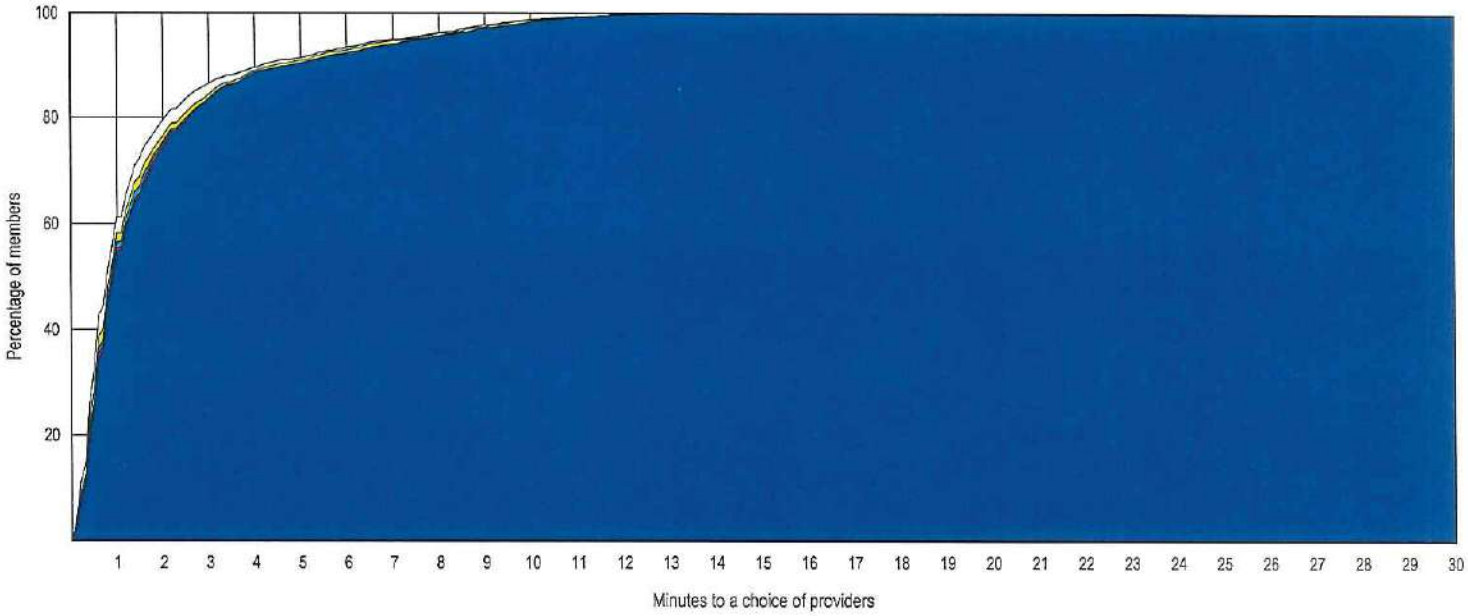

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Provider Locations

January 23, 2020

Region 7 Physicians, APRN, PA, and Family Planning Providers

Total Providers: 1,510

b All providers

Interstates

US Highways

State Highways

12.36 miles

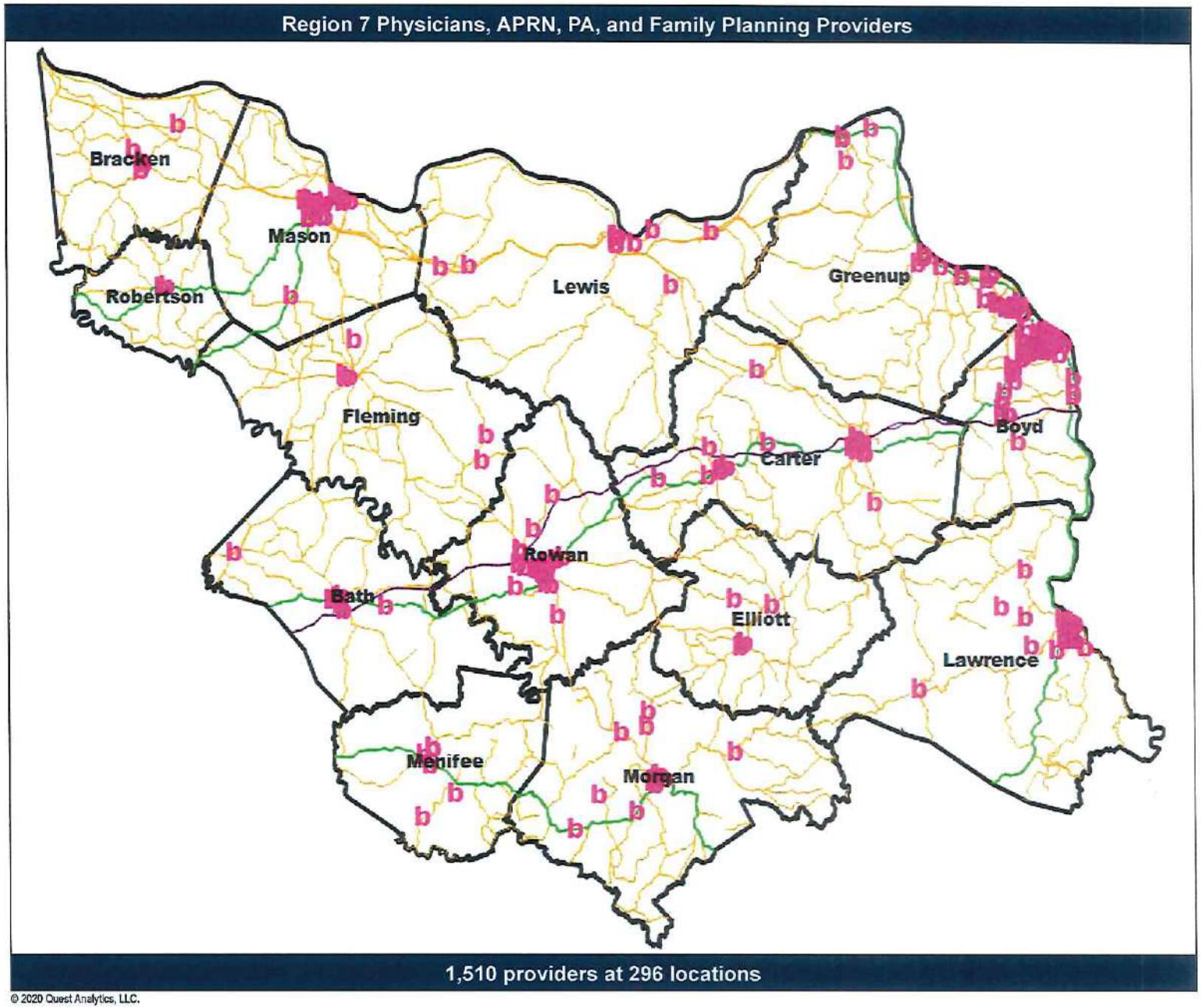

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 miles

Overall Access[1]

2,907 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

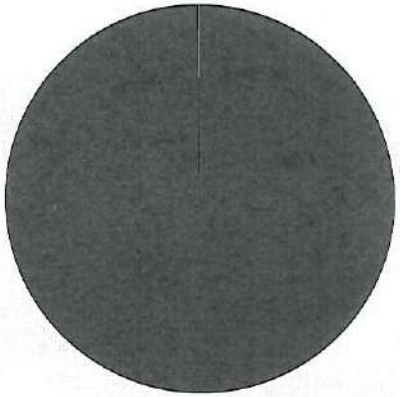

Distances

	Average
Distance to 1st closest provider	2.3 miles
Distance to 2nd closest provider	2.5 miles
Distance to 3rd closest provider	2.7 miles
Distance to 4th closest provider	3.1 miles
Distance to 5th closest provider	3.5 miles

Access Standard Comparison

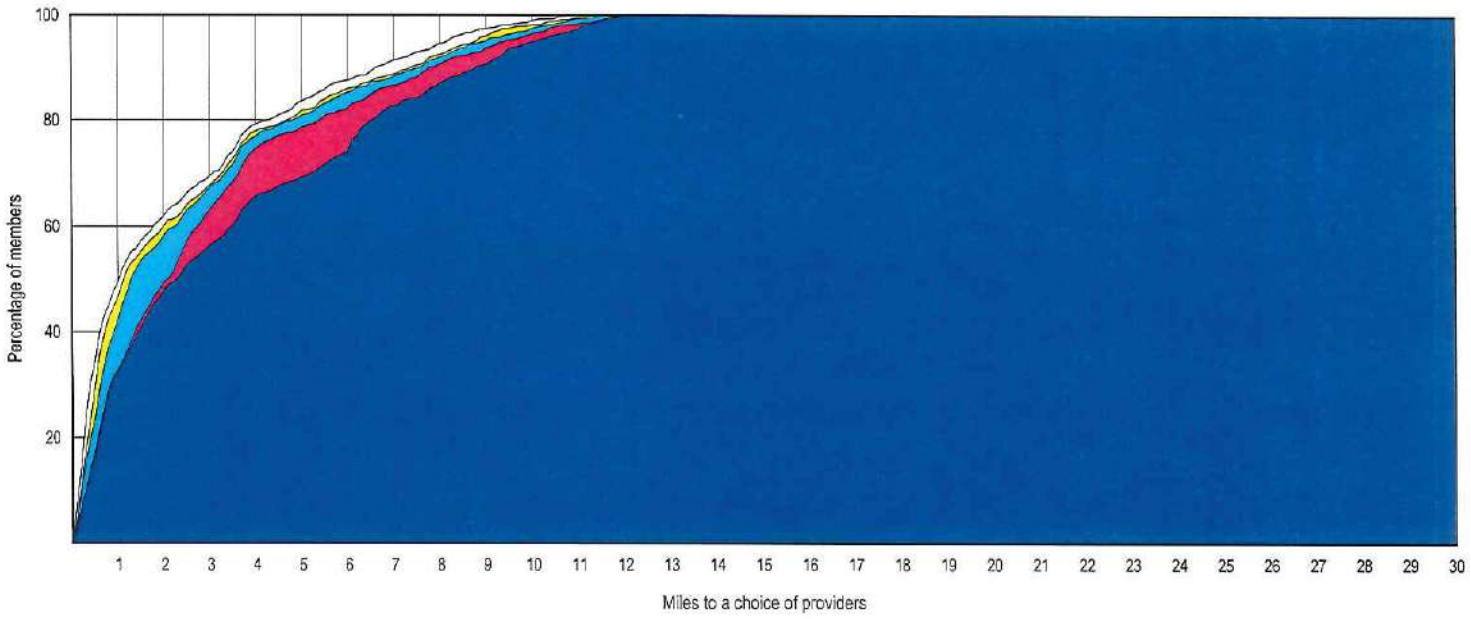

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 miles

Overall Access[1]

10,408 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

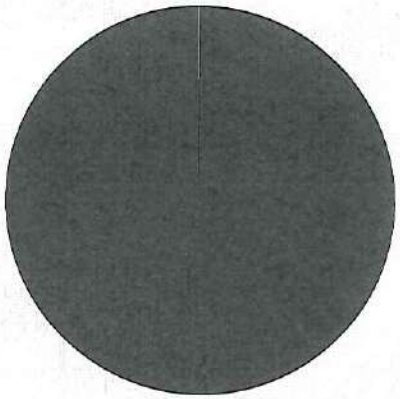

Distances

	Average
Distance to 1st closest provider	3.2 miles
Distance to 2nd closest provider	4.0 miles
Distance to 3rd closest provider	4.3 miles
Distance to 4th closest provider	4.5 miles
Distance to 5th closest provider	4.7 miles

Access Standard Comparison

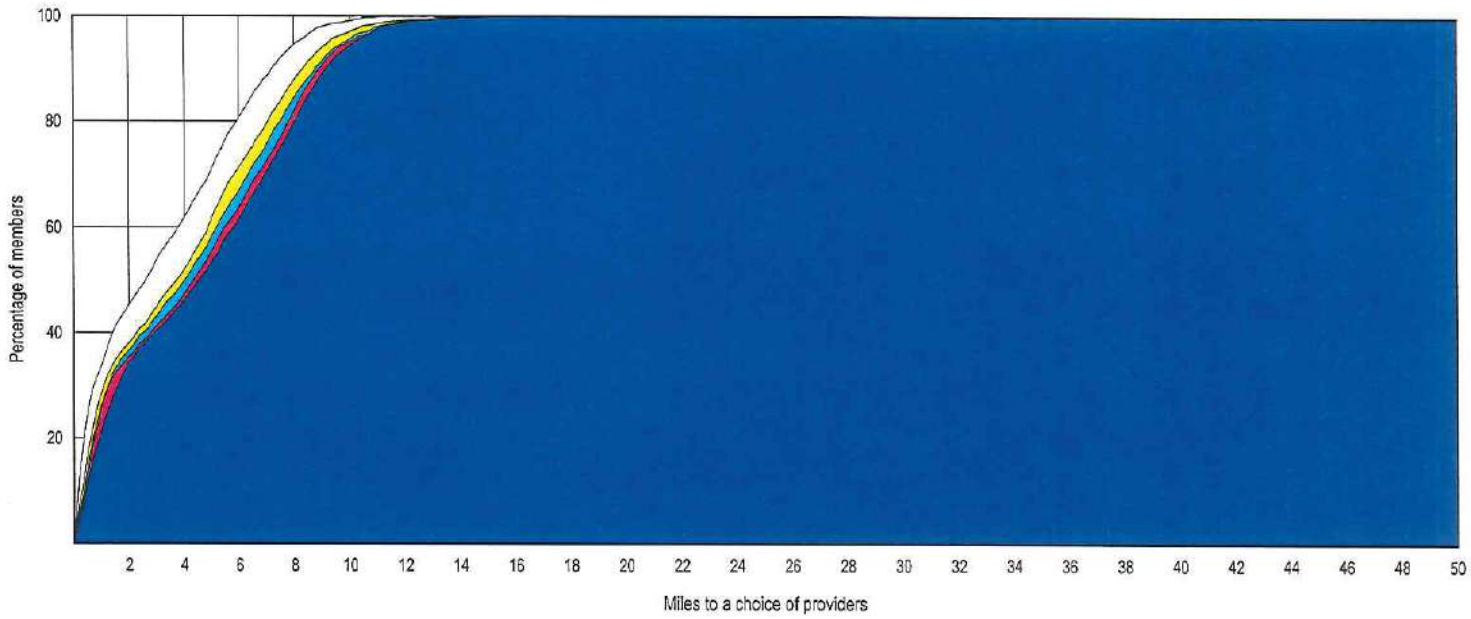

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Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 30 minutes

Overall Access[1]

2,907 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

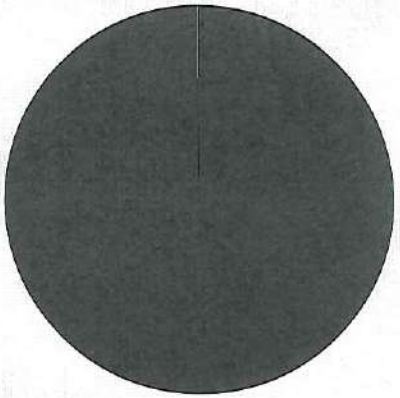

Times

	Average
Time to 1st closest provider	2.5 mins
Time to 2nd closest provider	2.8 mins
Time to 3rd closest provider	2.9 mins
Time to 4th closest provider	3.3 mins
Time to 5th closest provider	3.9 mins

Access Standard Comparison

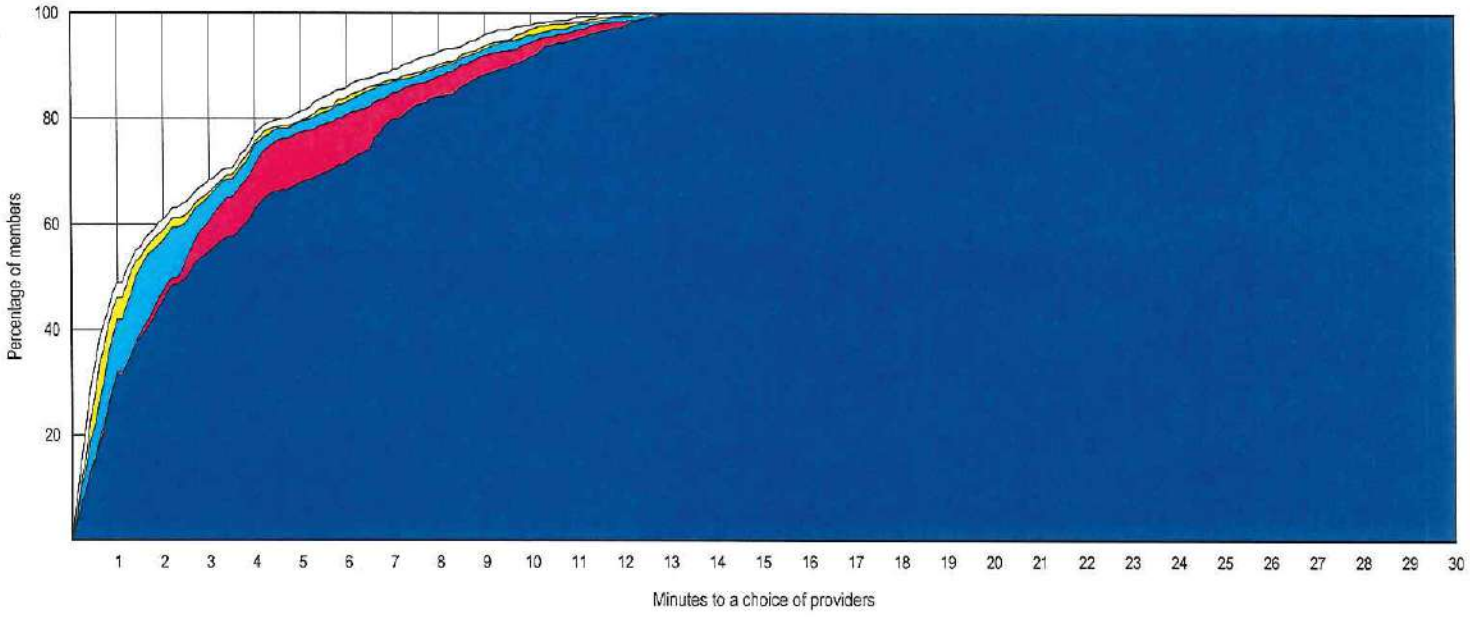

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Provider Locations

January 23, 2020

Region 8 Physicians, APRN, PA, and Family Planning Providers

Total Providers: 2,871

b All providers

Interstates

US Highways

State Highways

16.38 miles

Region 8 Physicians, APRN, PA, and Family Planning Providers

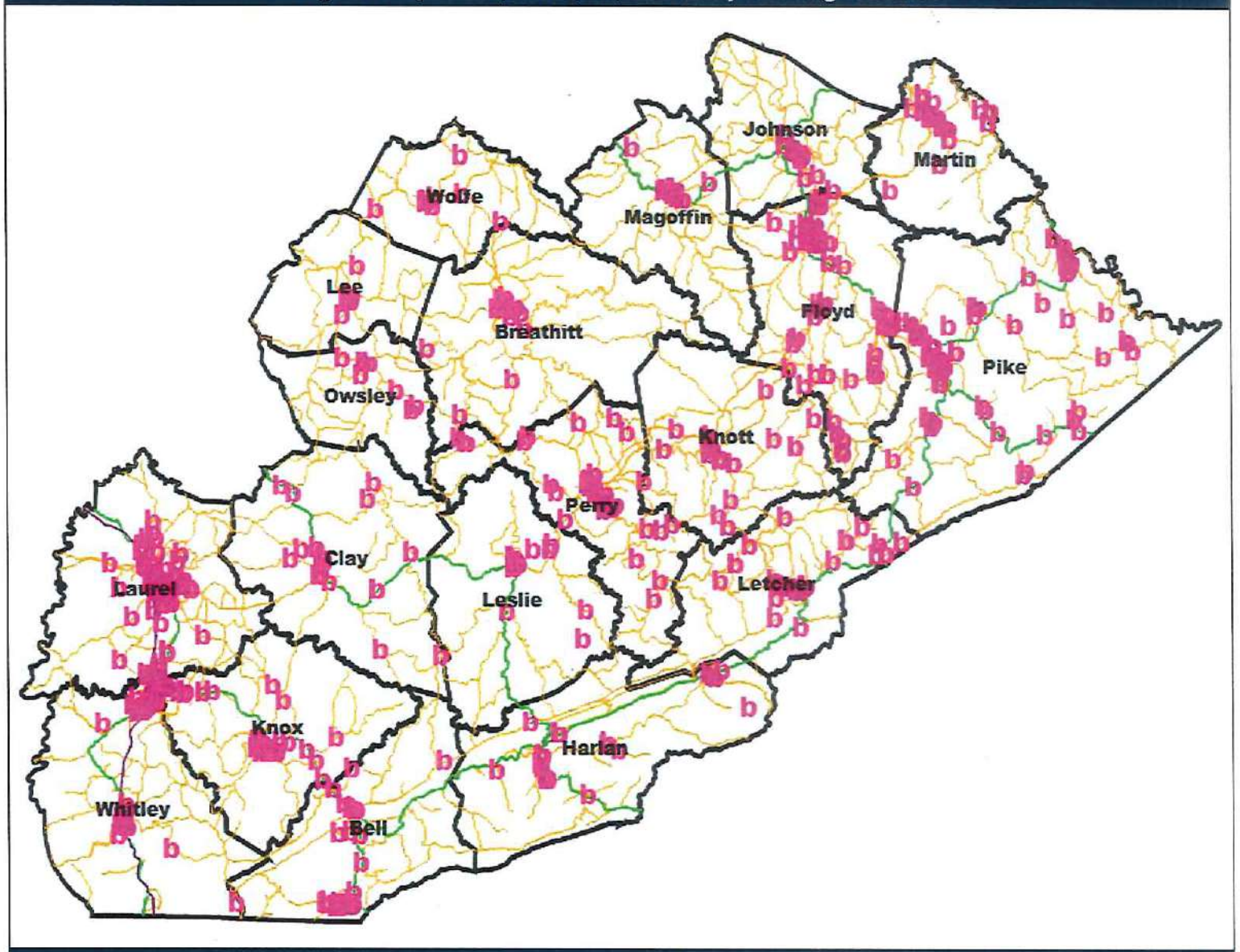

2,871 providers at 672 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 minutes

Member / Provider Groups
Region 7 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 minutes

Overall Access[1]

10,408 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

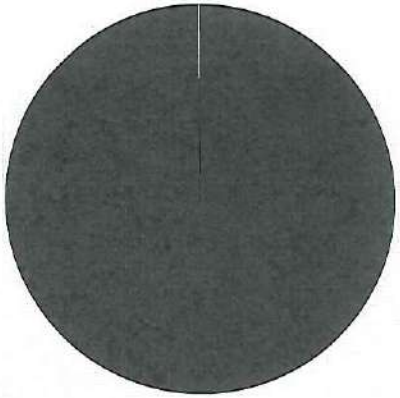

Times

	Average
Time to 1st closest provider	3.5 mins
Time to 2nd closest provider	4.3 mins
Time to 3rd closest provider	4.6 mins
Time to 4th closest provider	4.9 mins
Time to 5th closest provider	5.1 mins

Access Standard Comparison

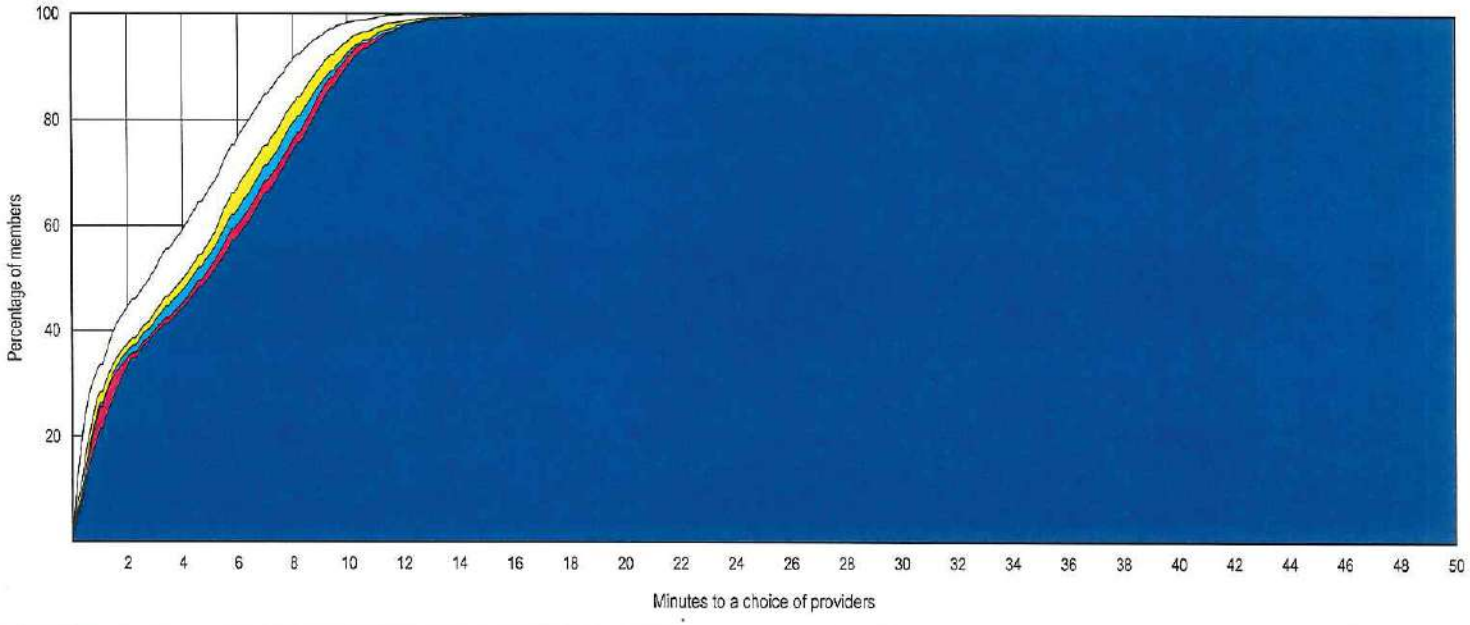

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Physicians, APRN, PA, and Family Planning Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Physicians, APRN, PA, and Family Planning Providers) provider in 50 minutes

Overall Access[1]

31,600 Members
25,100 providers at 4,936 locations (Physicians, APRN, PA, and Family Planning Providers)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

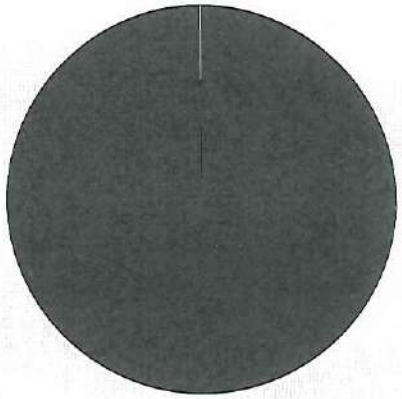

Times

	Average
Time to 1st closest provider	2.7 mins
Time to 2nd closest provider	3.0 mins
Time to 3rd closest provider	3.3 mins
Time to 4th closest provider	3.5 mins
Time to 5th closest provider	3.8 mins

Access Standard Comparison

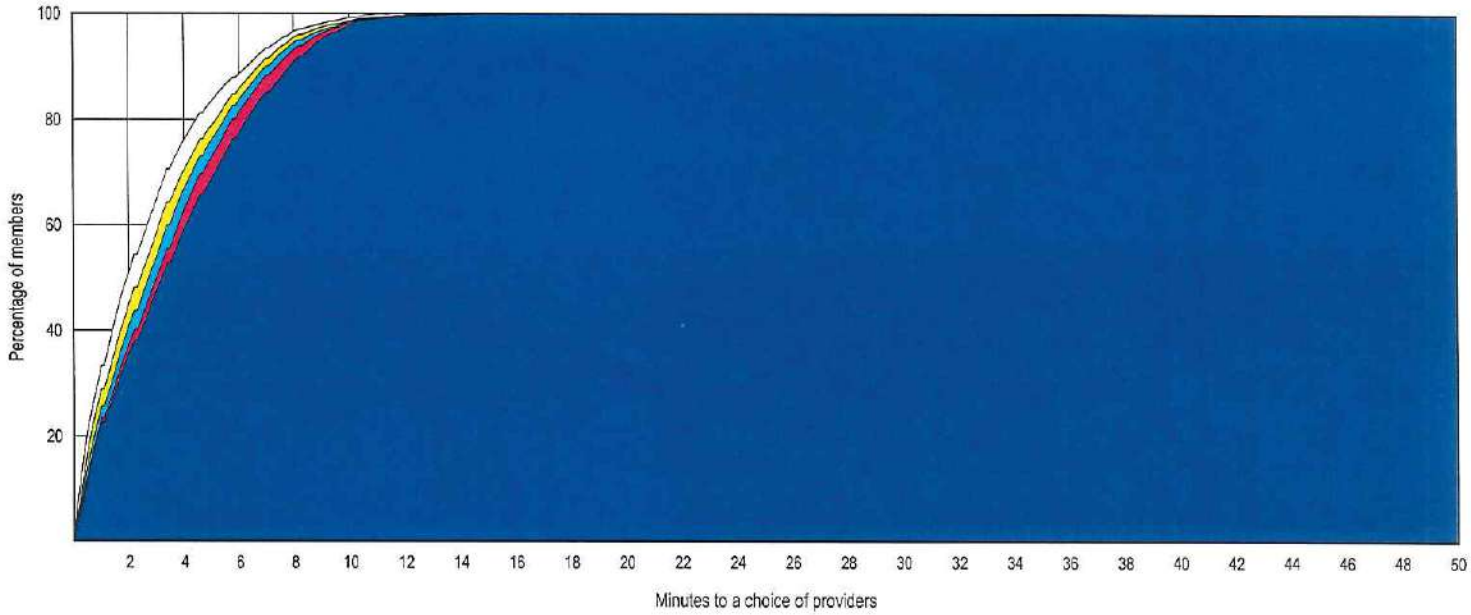

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Provider Locations

January 23, 2020

Region 1 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Total Providers: 16

c All providers

Interstates

US Highways

State Highways

12.93 miles

Region 1 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

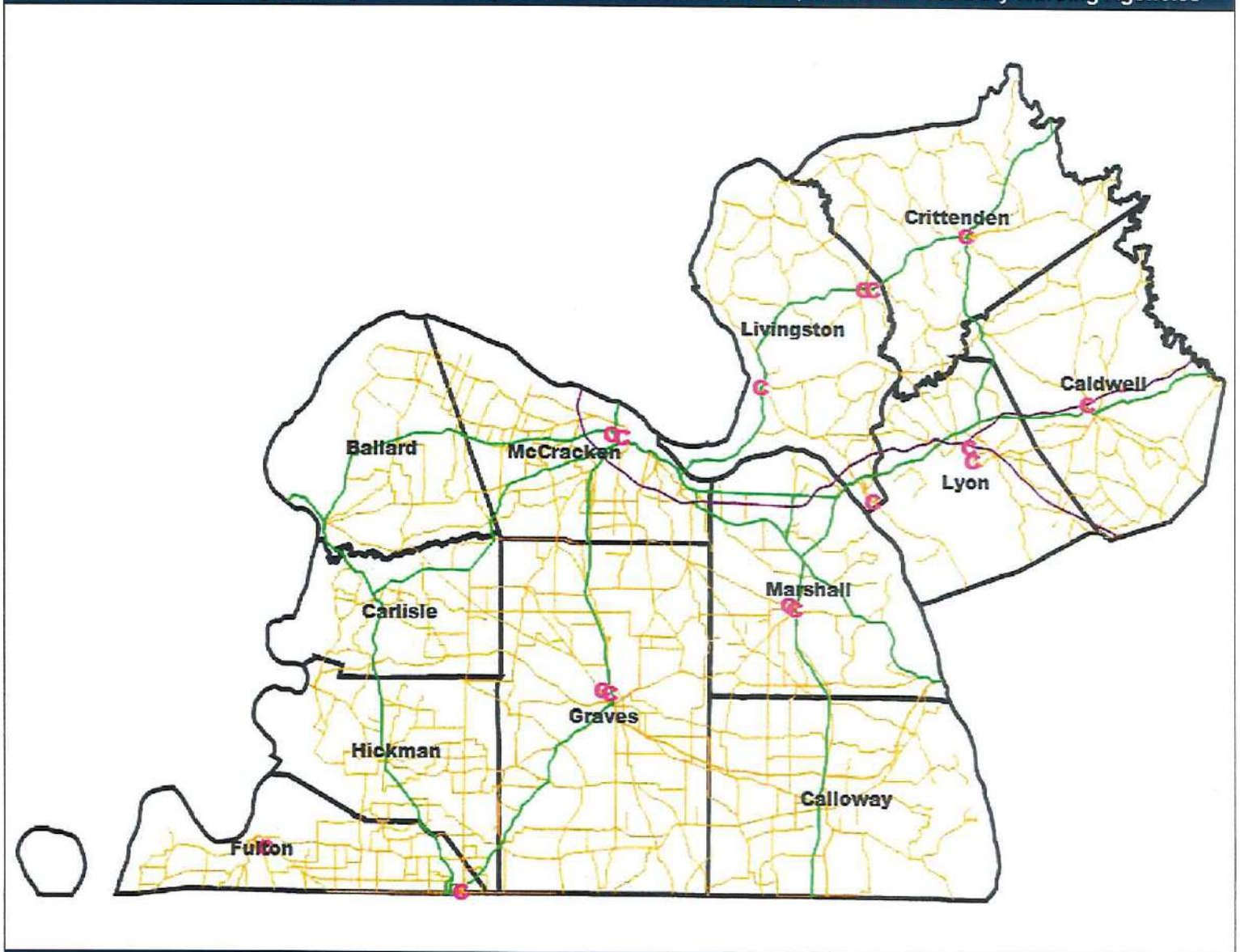

16 providers at 17 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 miles

Overall Access[1]

11,338 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

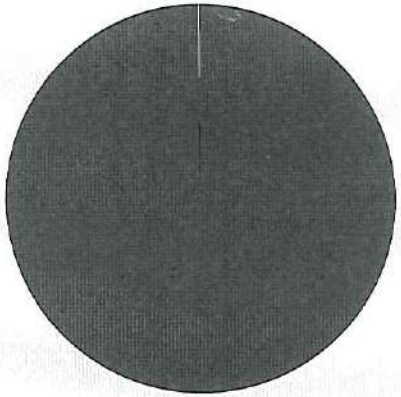

Times

	Average
Distance to 1st closest provider	8.5 miles
Distance to 2nd closest provider	10.7 miles
Distance to 3rd closest provider	16.5 miles
Distance to 4th closest provider	21.3 miles
Distance to 5th closest provider	24.2 miles

Access Standard Comparison

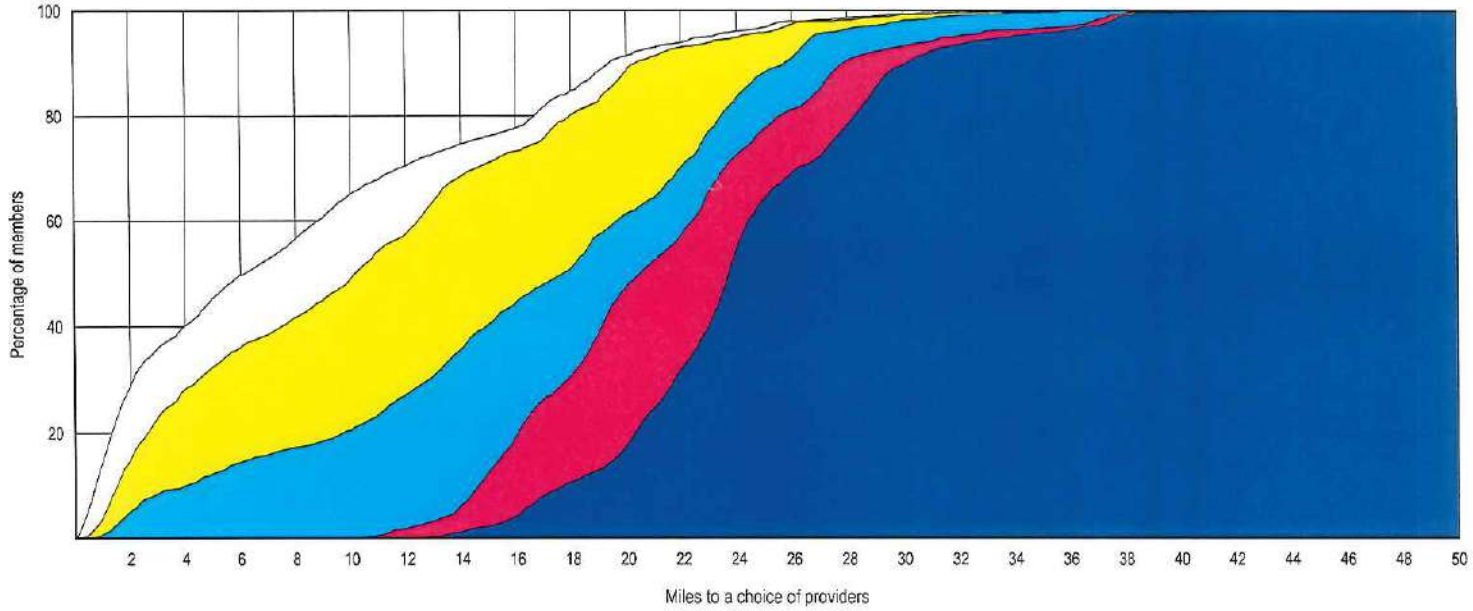

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 minutes

Overall Access[1]

11,338 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

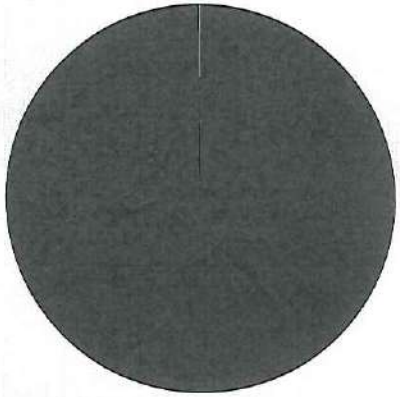

Times

	Average
Time to 1st closest provider	9.3 mins
Time to 2nd closest provider	11.6 mins
Time to 3rd closest provider	18.0 mins
Time to 4th closest provider	23.2 mins
Time to 5th closest provider	26.4 mins

Access Standard Comparison

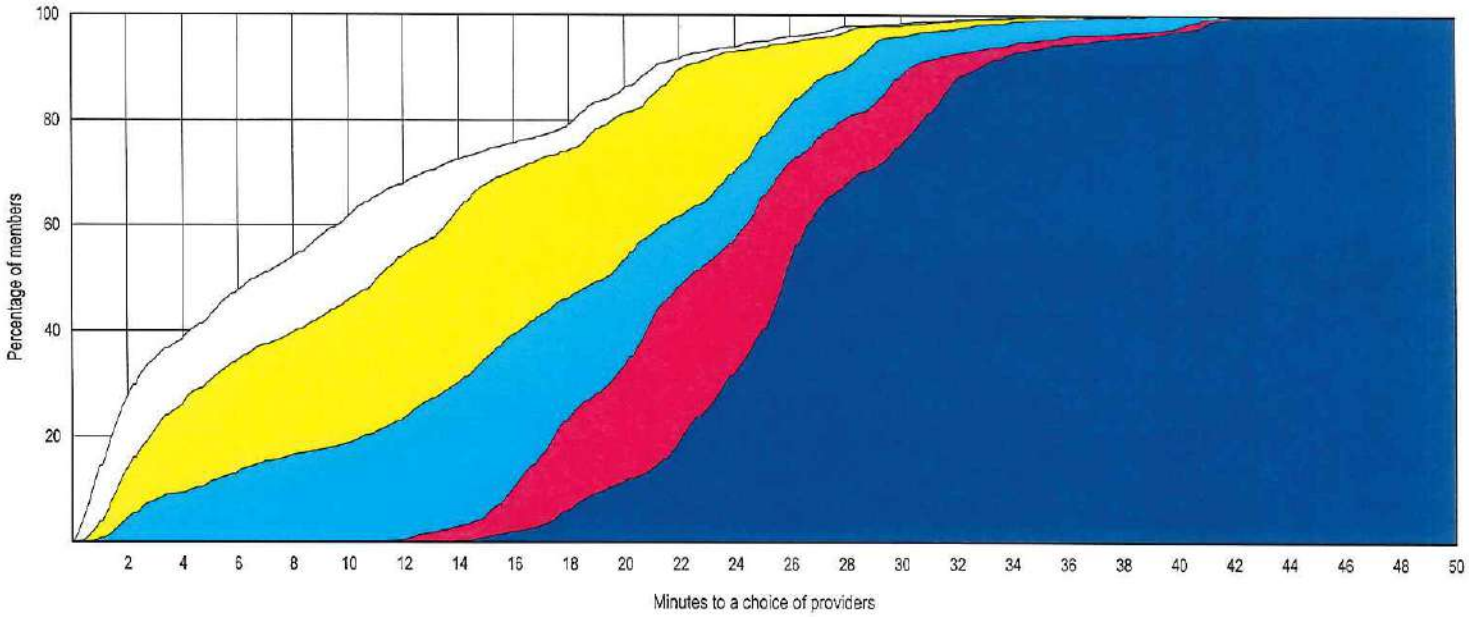

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Provider Locations

January 23, 2020

Region 2 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Total Providers: 28

c All providers

Interstates

US Highways

State Highways

15.14 miles

Region 2 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

28 providers at 31 locations

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Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 miles

Overall Access[1]

16,143 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

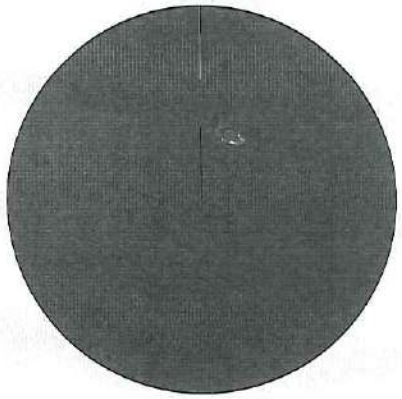

Distances

	Average
Distance to 1st closest provider	8.5 miles
Distance to 2nd closest provider	10.7 miles
Distance to 3rd closest provider	11.9 miles
Distance to 4th closest provider	12.4 miles
Distance to 5th closest provider	16.3 miles

Access Standard Comparison

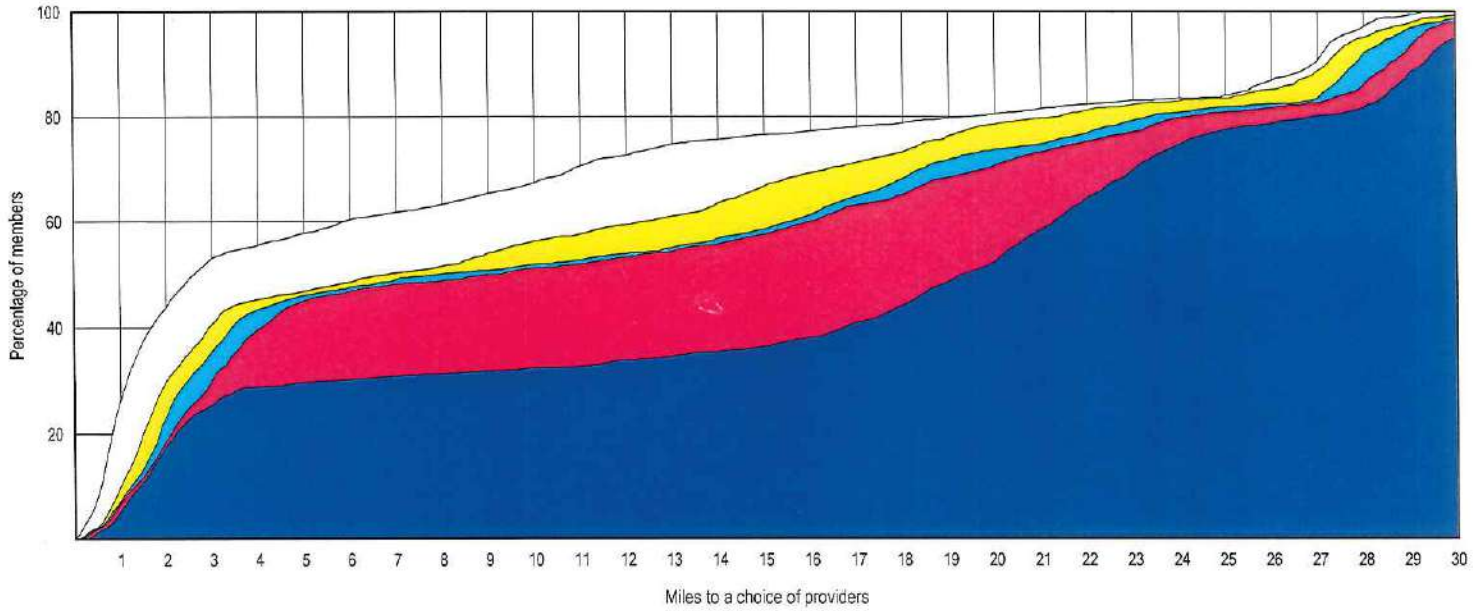

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 minutes

Overall Access[1]

16,143 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 15,375 (95.2%) Members with access
- 767 (4.8%) Members without access
- 1 (0.0%) Members excluded

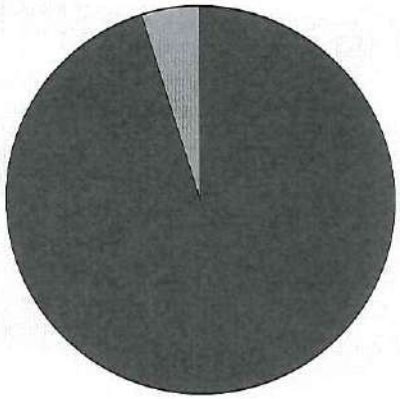

Times

	Average
Time to 1st closest provider	9.2 mins
Time to 2nd closest provider	11.6 mins
Time to 3rd closest provider	12.9 mins
Time to 4th closest provider	13.5 mins
Time to 5th closest provider	17.8 mins

Access Standard Comparison

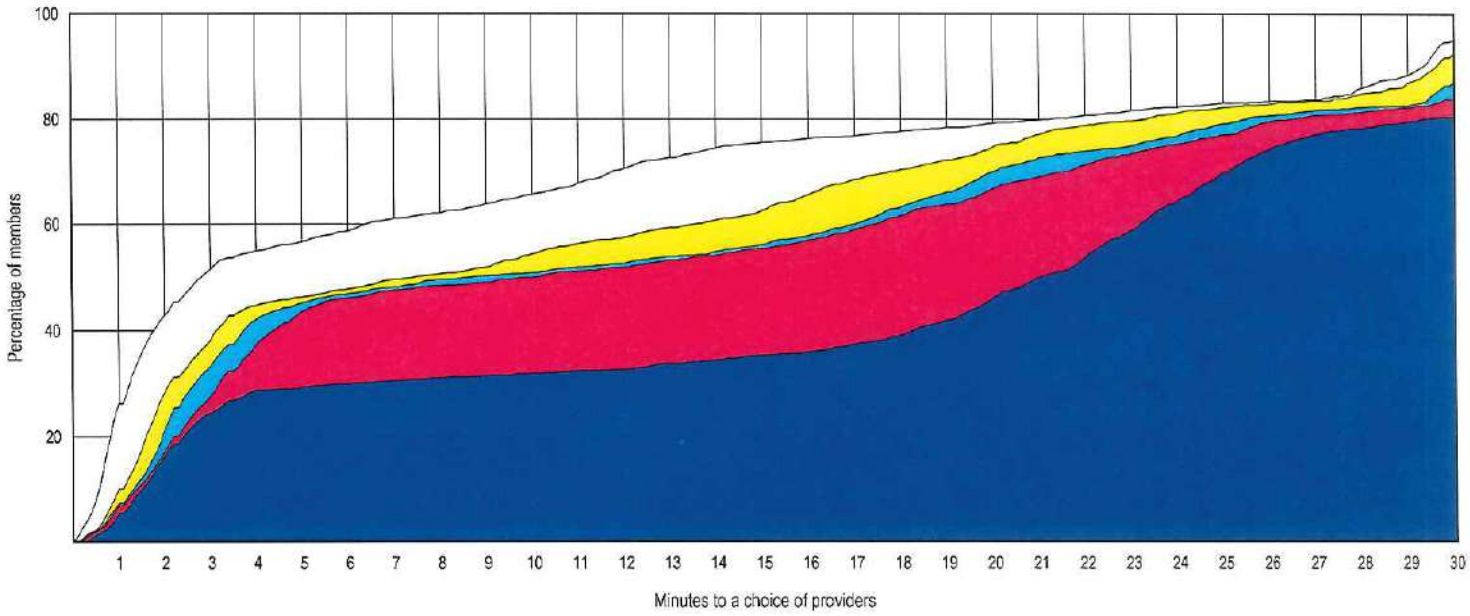

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 miles

Overall Access[1]

9,636 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

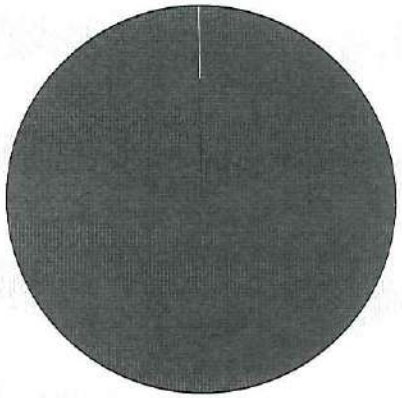

Distances

	Average
Distance to 1st closest provider	5.9 miles
Distance to 2nd closest provider	12.1 miles
Distance to 3rd closest provider	15.7 miles
Distance to 4th closest provider	18.3 miles
Distance to 5th closest provider	19.9 miles

Access Standard Comparison

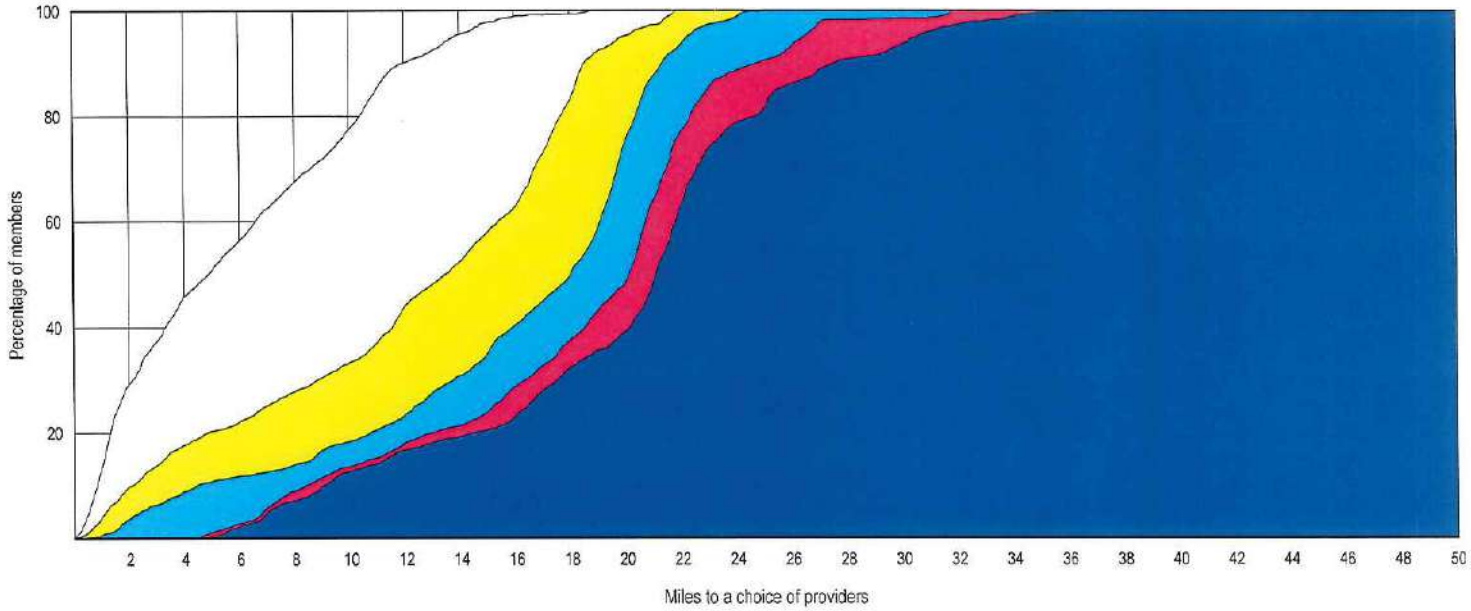

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Access Overview

January 23, 2020

Access Analysis

Region 2 Rural - 1 in 50 minutes

Member / Provider Groups

Region 2 Rural Members

Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph

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

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

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:

1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 minutes

Overall Access[1]

9,636 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

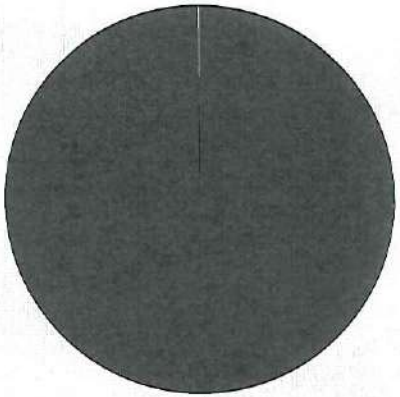

Times

	Average
Time to 1st closest provider	6.3 mins
Time to 2nd closest provider	13.1 mins
Time to 3rd closest provider	17.1 mins
Time to 4th closest provider	20.0 mins
Time to 5th closest provider	21.7 mins

Access Standard Comparison

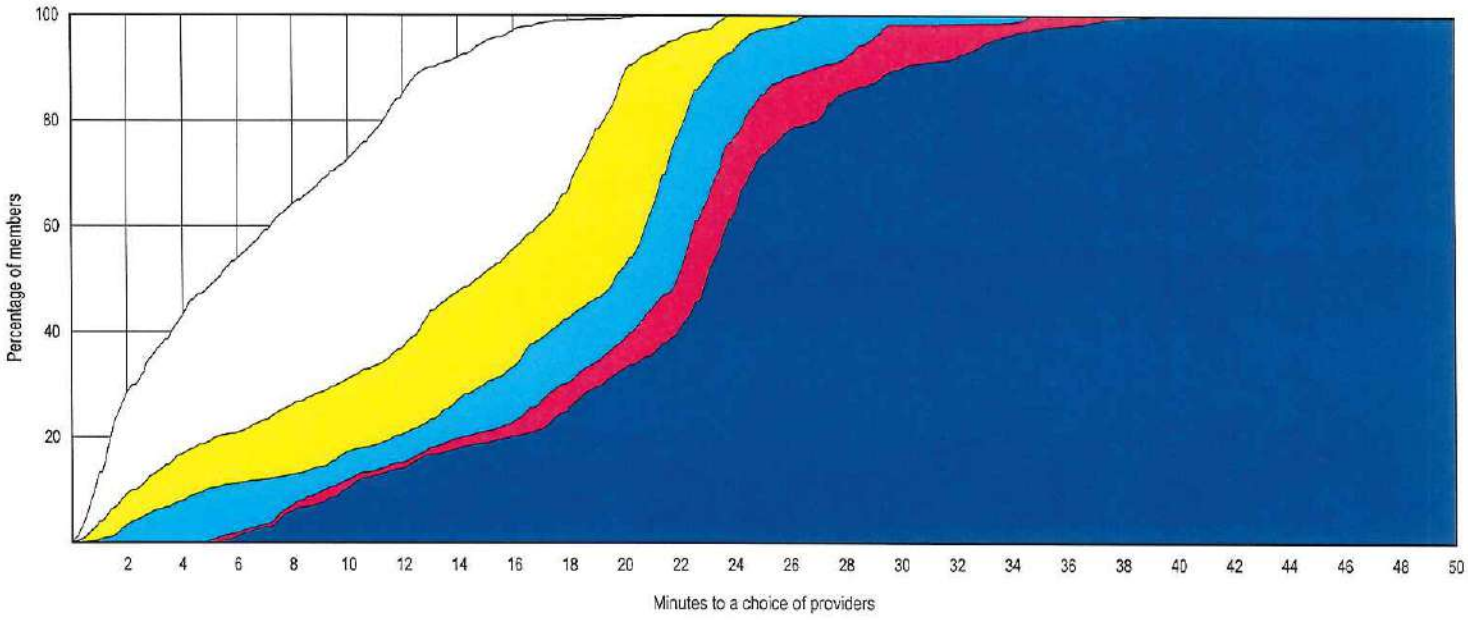

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Provider Locations

January 23, 2020

Region 3 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Total Providers: 27

c All providers

Interstates

US Highways

State Highways

15.97 miles

Region 3 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

27 providers at 30 locations

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Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 miles

Overall Access[1]

18,130 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

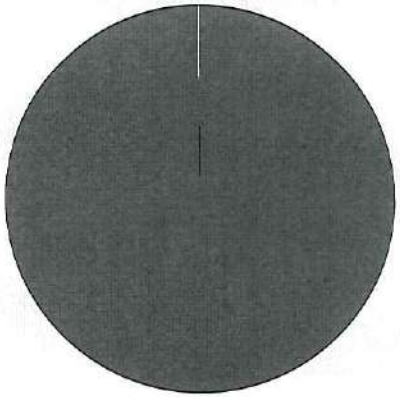

Distances

	Average
Distance to 1st closest provider	4.9 miles
Distance to 2nd closest provider	8.1 miles
Distance to 3rd closest provider	9.5 miles
Distance to 4th closest provider	10.9 miles
Distance to 5th closest provider	12.3 miles

Access Standard Comparison

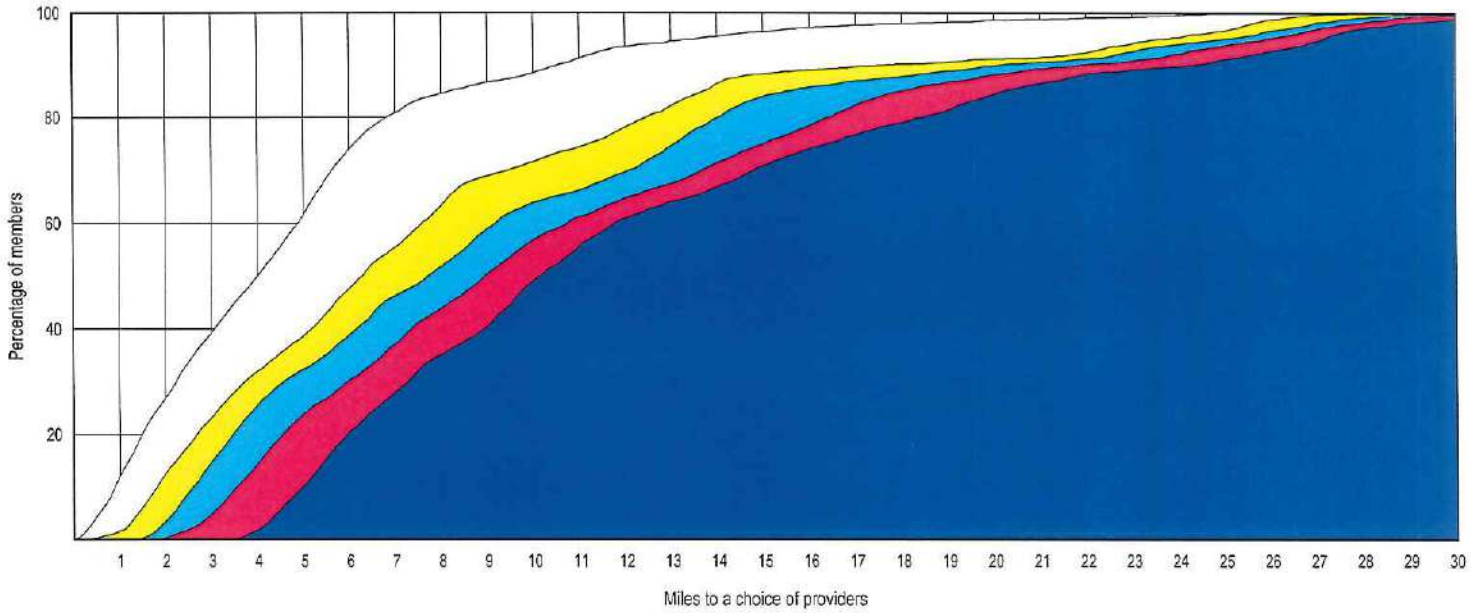

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis

Region 3 Urban - 1 in 30 minutes

Member / Provider Groups

Region 3 Urban Members

Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph

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

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

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:

1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 minutes

Overall Access[1]

18,130 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 18,124 (99.9%) Members with access
- 3 (0.1%) Members without access
- 3 (0.0%) Members excluded

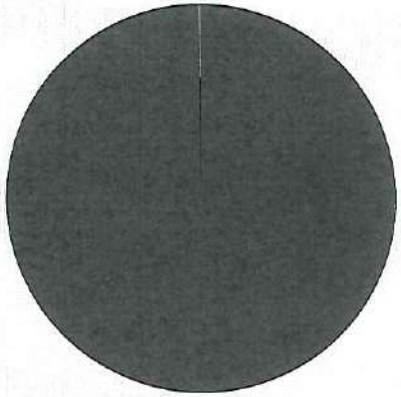

Times

	Average
Time to 1st closest provider	6.5 mins
Time to 2nd closest provider	10.5 mins
Time to 3rd closest provider	12.4 mins
Time to 4th closest provider	14.2 mins
Time to 5th closest provider	16.1 mins

Access Standard Comparison

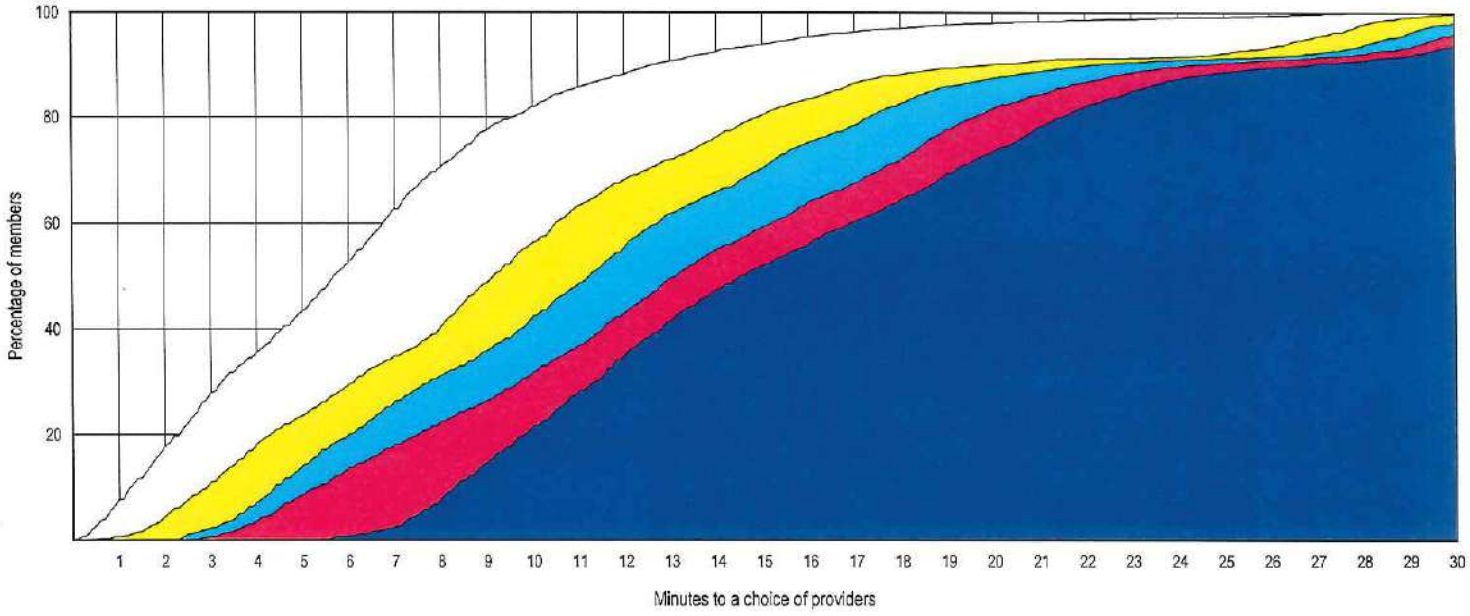

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Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 miles

Overall Access[1]

1,901 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

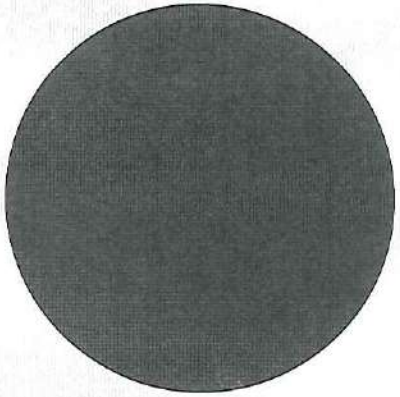

Distances

	Average
Distance to 1st closest provider	6.8 miles
Distance to 2nd closest provider	8.8 miles
Distance to 3rd closest provider	14.5 miles
Distance to 4th closest provider	18.3 miles
Distance to 5th closest provider	20.6 miles

Access Standard Comparison

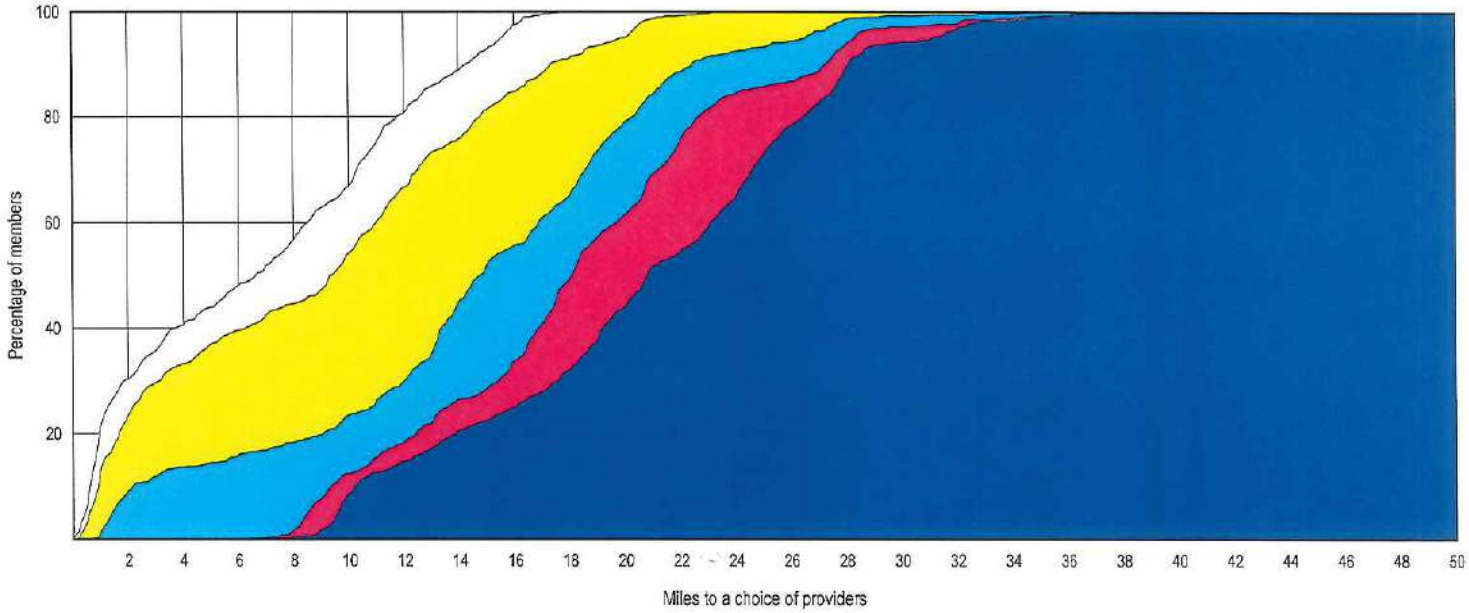

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Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 minutes

Overall Access[1]

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297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 1,901 (100.0%) Members with access
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- 0 (0.0%) Members excluded

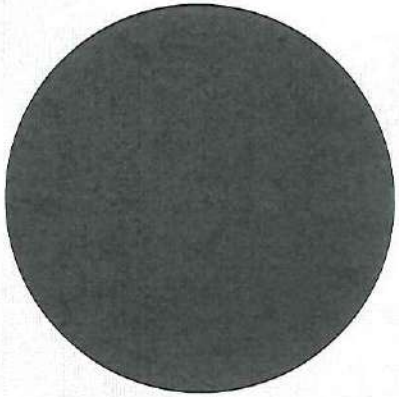

Times

	Average
Time to 1st closest provider	7.3 mins
Time to 2nd closest provider	9.6 mins
Time to 3rd closest provider	15.8 mins
Time to 4th closest provider	19.9 mins
Time to 5th closest provider	22.5 mins

Access Standard Comparison

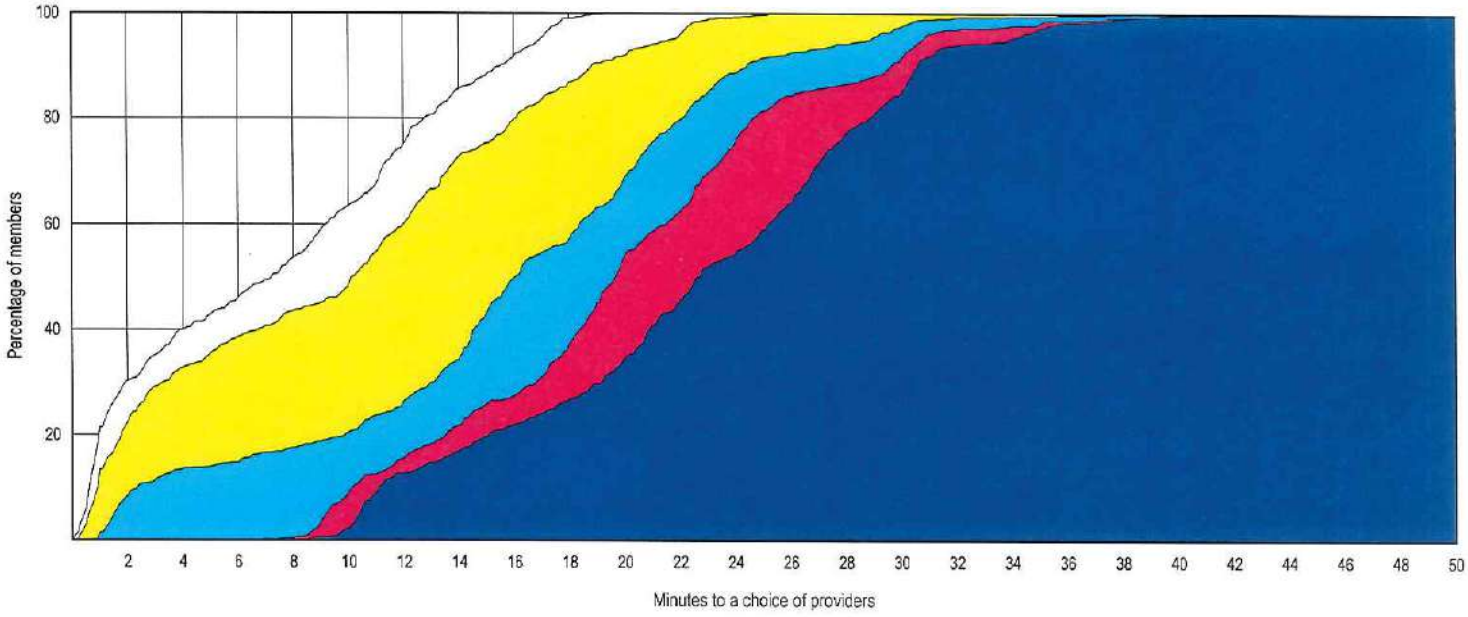

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Provider Locations

January 23, 2020

Region 4 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Total Providers: 40

c All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

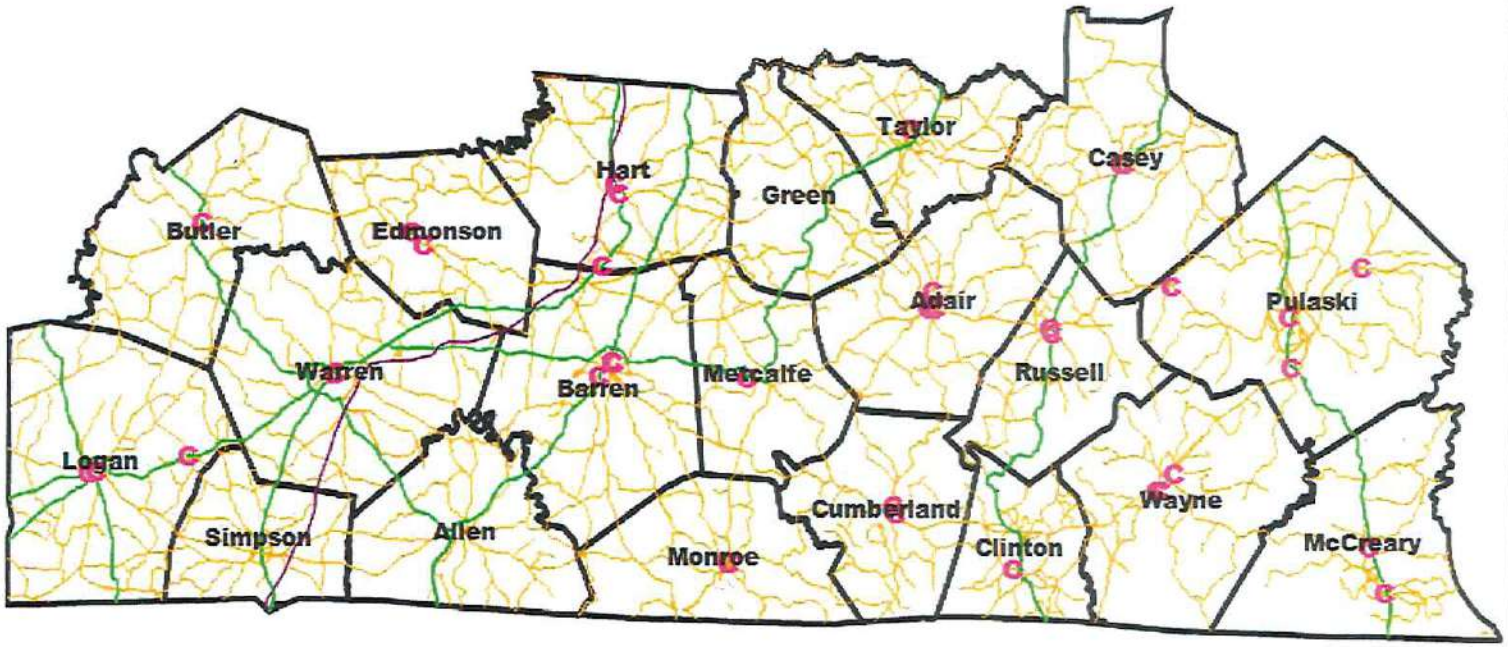

40 providers at 40 locations

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Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 miles

Overall Access[1]

7,413 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

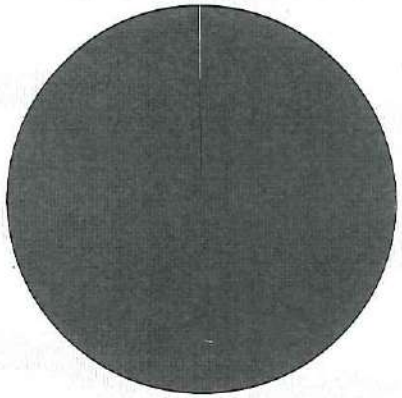

Distances

	Average
Distance to 1st closest provider	6.6 miles
Distance to 2nd closest provider	7.9 miles
Distance to 3rd closest provider	18.8 miles
Distance to 4th closest provider	22.1 miles
Distance to 5th closest provider	23.7 miles

Access Standard Comparison

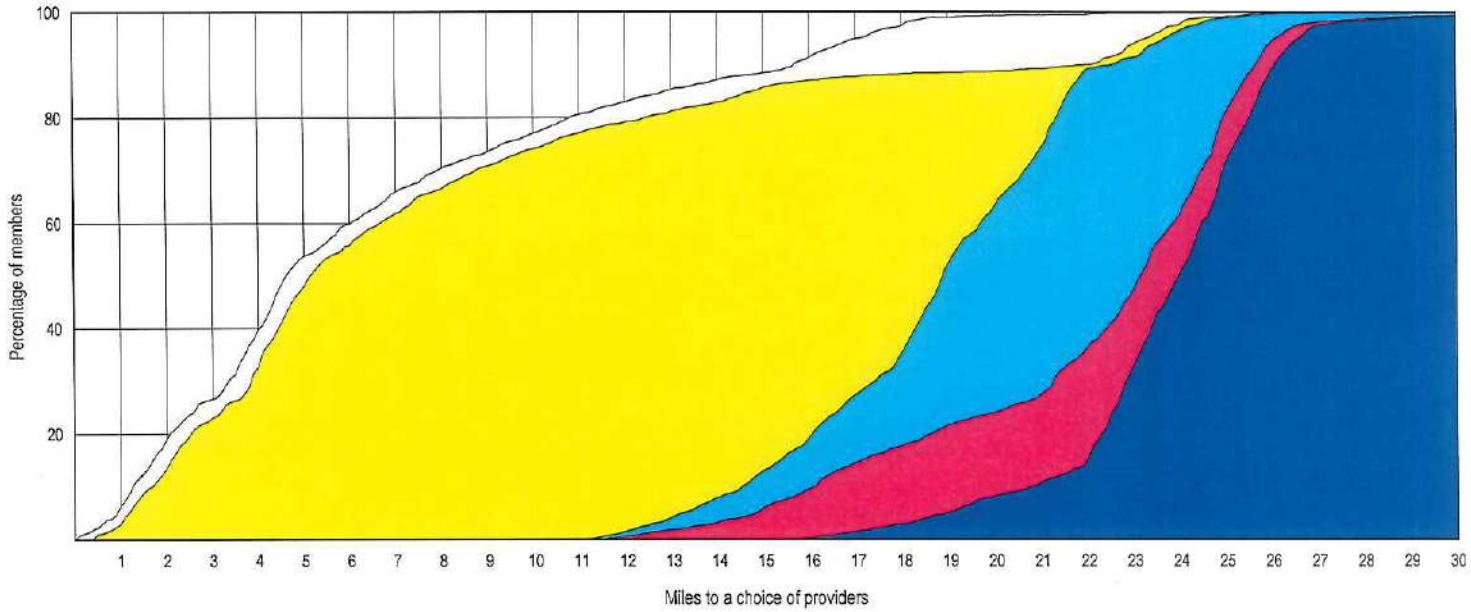

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Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 minutes

Overall Access[1]

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297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 7,409 (99.9%) Members with access
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- 4 (0.1%) Members excluded

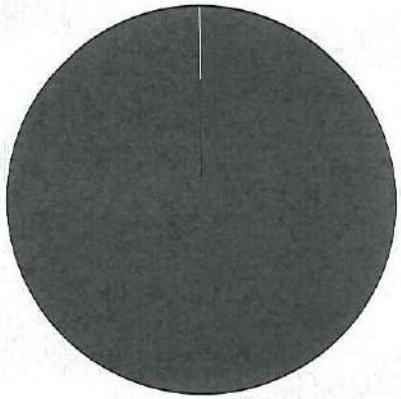

Times

	Average
Time to 1st closest provider	7.1 mins
Time to 2nd closest provider	8.5 mins
Time to 3rd closest provider	20.5 mins
Time to 4th closest provider	24.1 mins
Time to 5th closest provider	25.9 mins

Access Standard Comparison

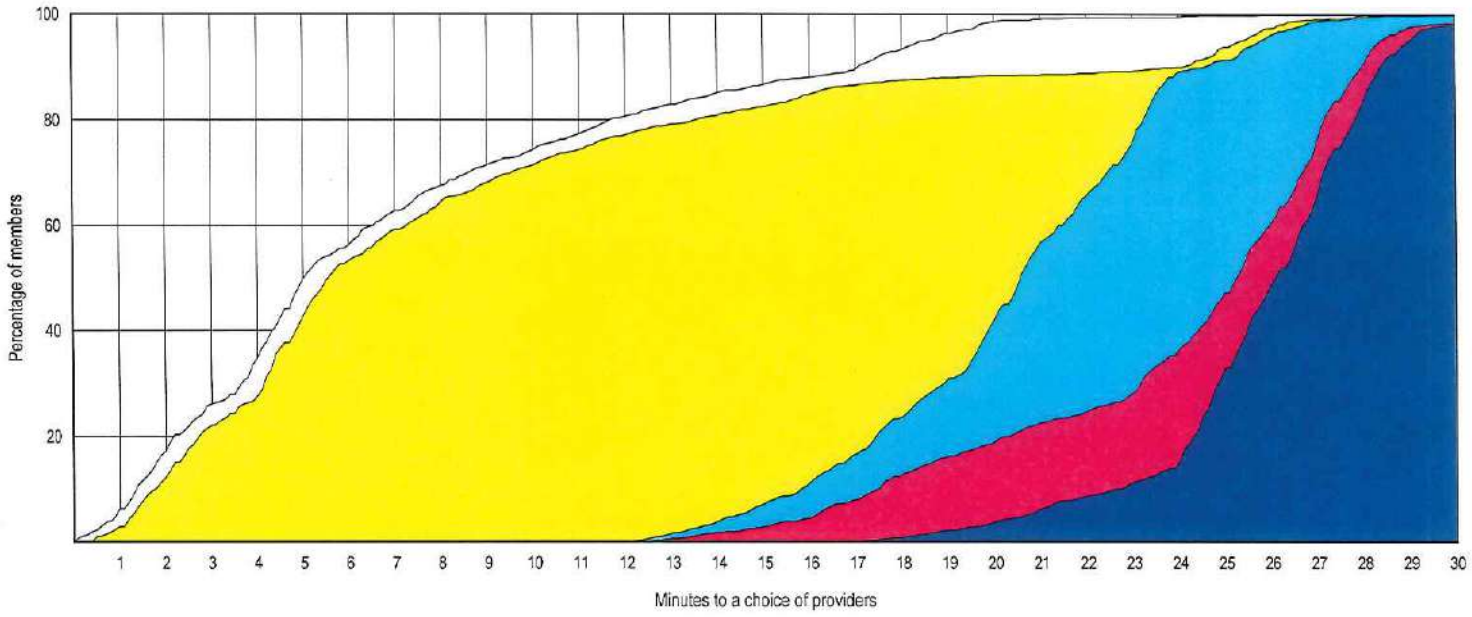

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Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 miles

Overall Access[1]

28,324 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

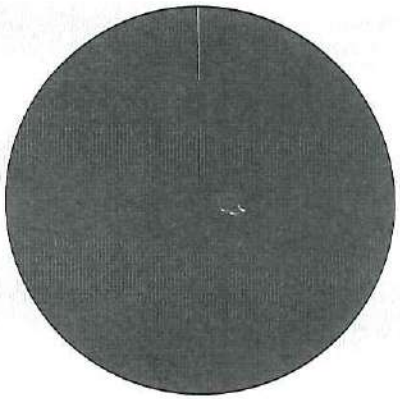

Distances

	Average
Distance to 1st closest provider	6.2 miles
Distance to 2nd closest provider	9.6 miles
Distance to 3rd closest provider	13.5 miles
Distance to 4th closest provider	17.5 miles
Distance to 5th closest provider	19.5 miles

Access Standard Comparison

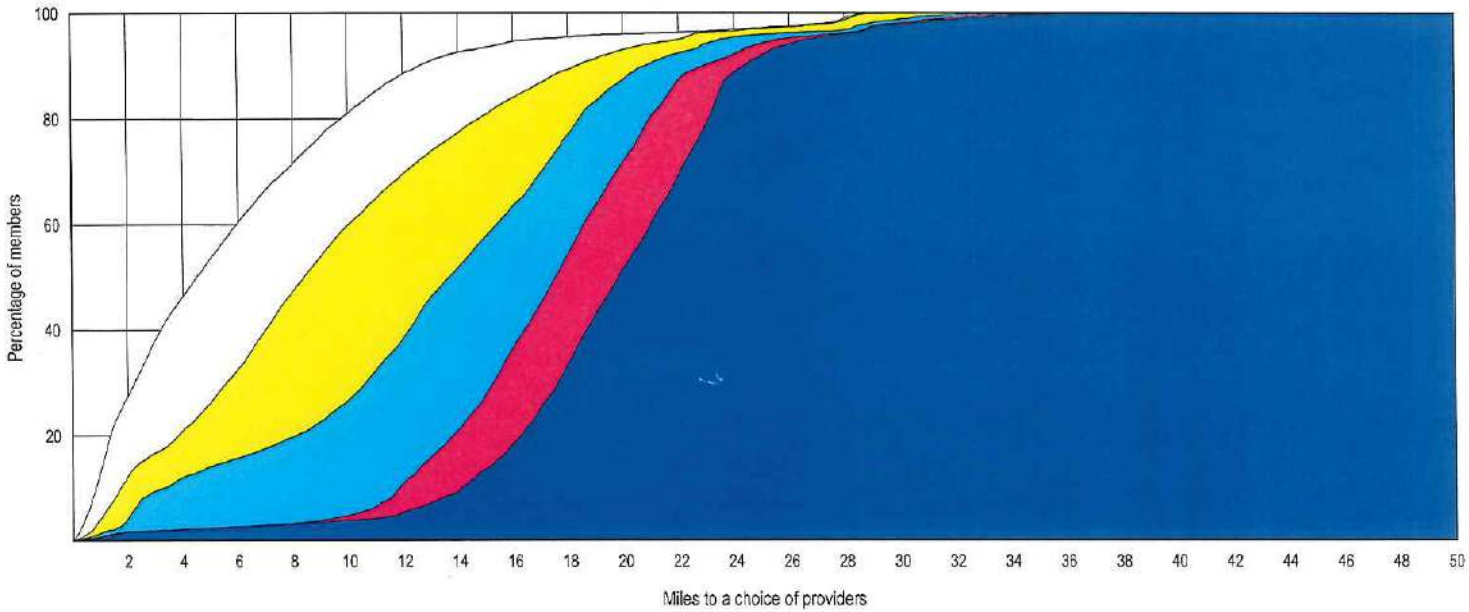

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Access Overview

January 23, 2020

Access Analysis

Region 4 Rural - 1 in 50 minutes

Member / Provider Groups

Region 4 Rural Members

Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph

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

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

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:

1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 minutes

Overall Access[1]

28,324 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

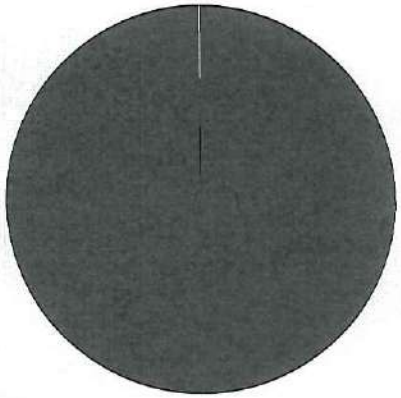

Times

	Average
Time to 1st closest provider	6.7 mins
Time to 2nd closest provider	10.4 mins
Time to 3rd closest provider	14.7 mins
Time to 4th closest provider	19.1 mins
Time to 5th closest provider	21.3 mins

Access Standard Comparison

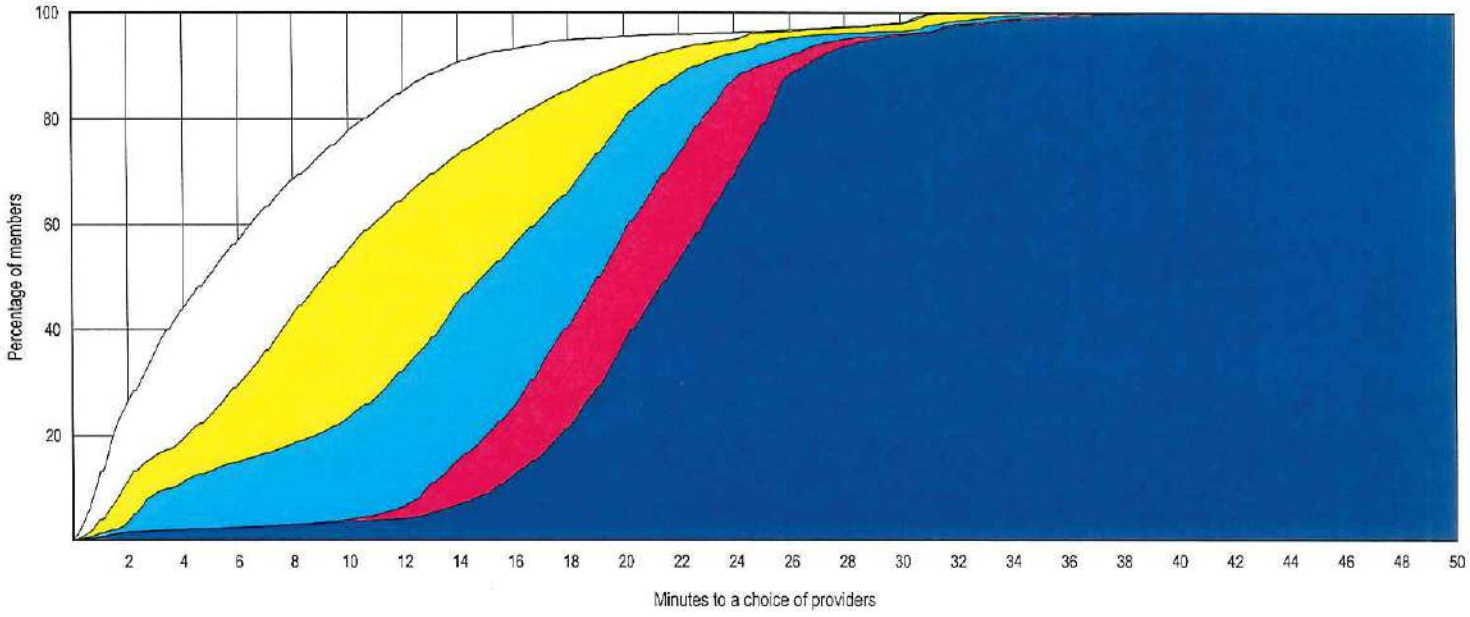

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Provider Locations

January 23, 2020

Region 5 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Total Providers: 48

c All providers

Interstates

US Highways

State Highways

17.44 miles

Region 5 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

48 providers at 47 locations

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Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 miles

Overall Access[1]

22,712 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

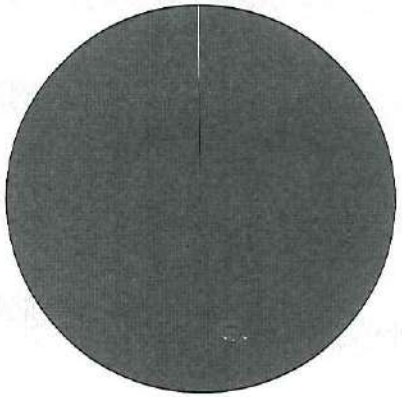

Distances

	Average
Distance to 1st closest provider	5.9 miles
Distance to 2nd closest provider	7.1 miles
Distance to 3rd closest provider	8.6 miles
Distance to 4th closest provider	9.3 miles
Distance to 5th closest provider	10.0 miles

Access Standard Comparison

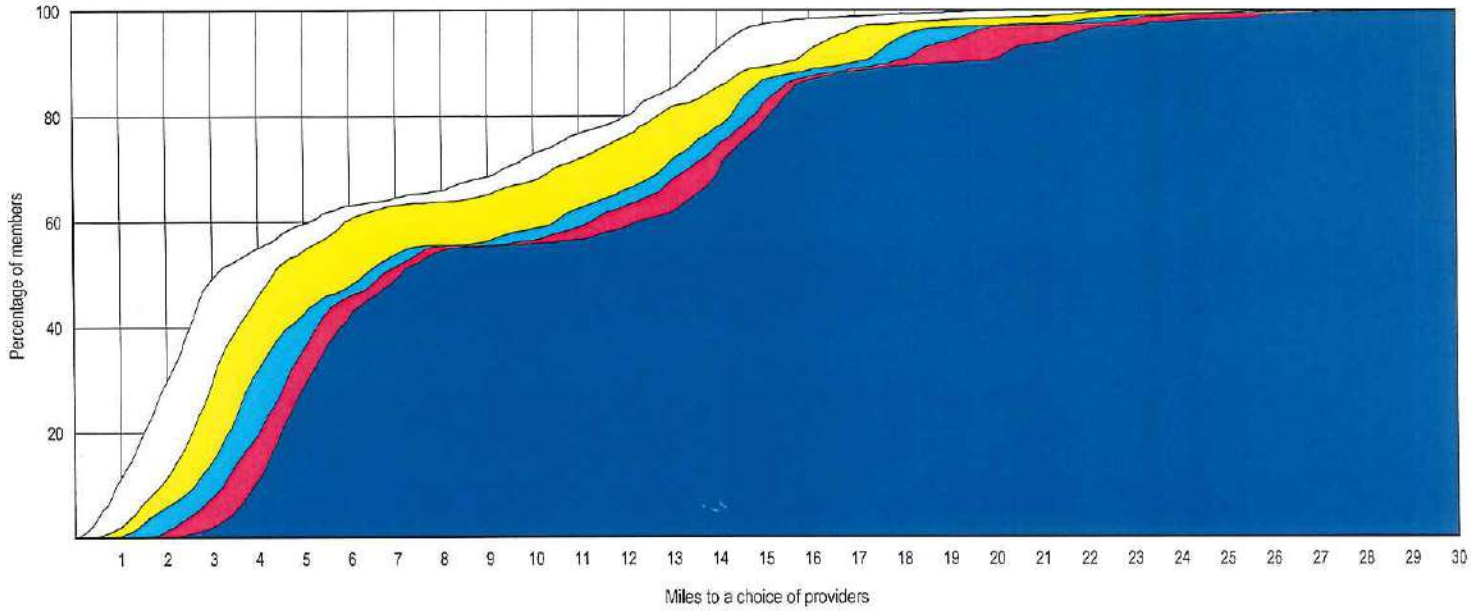

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Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 minutes

Overall Access[1]

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297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

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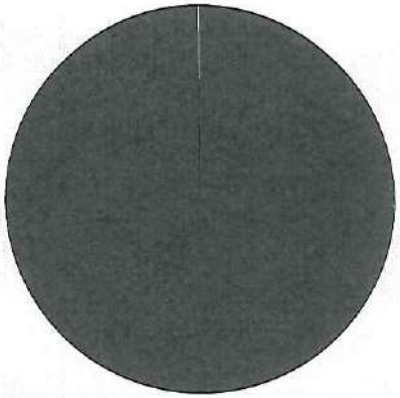

Times

	Average
Time to 1st closest provider	7.1 mins
Time to 2nd closest provider	9.1 mins
Time to 3rd closest provider	11.1 mins
Time to 4th closest provider	12.2 mins
Time to 5th closest provider	13.3 mins

Access Standard Comparison

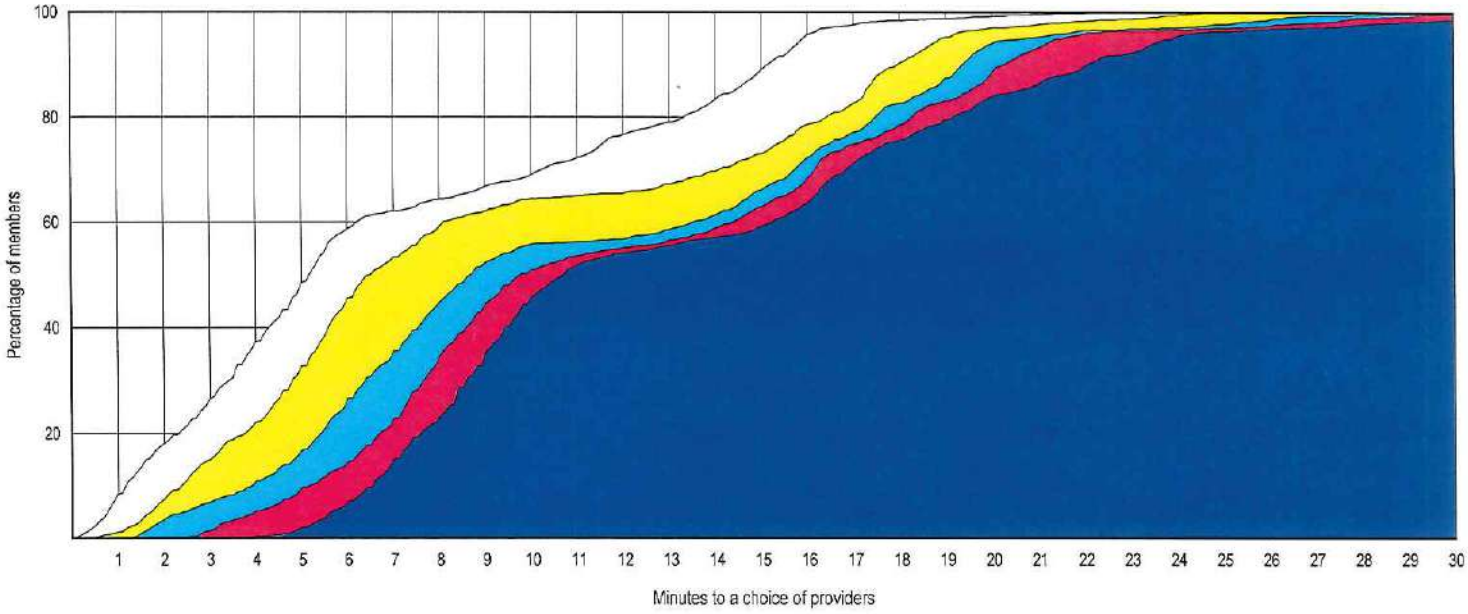

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Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 miles

Overall Access[1]

23,127 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

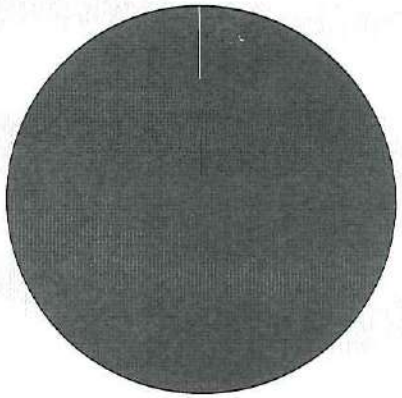

Distances

	Average
Distance to 1st closest provider	4.8 miles
Distance to 2nd closest provider	10.0 miles
Distance to 3rd closest provider	13.2 miles
Distance to 4th closest provider	15.4 miles
Distance to 5th closest provider	17.2 miles

Access Standard Comparison

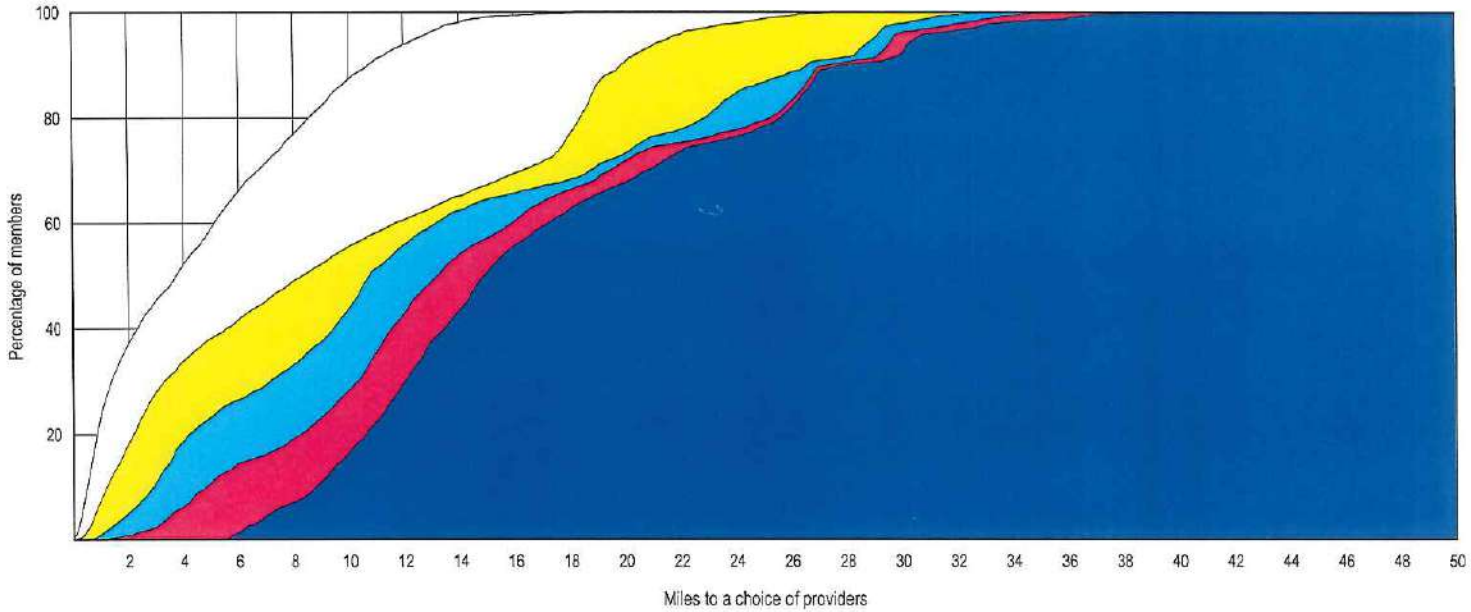

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Access Overview

January 23, 2020

Access Analysis

Region 5 Rural - 1 in 50 minutes

Member / Provider Groups

Region 5 Rural Members

Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph

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

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

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:

1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 minutes

Overall Access[1]

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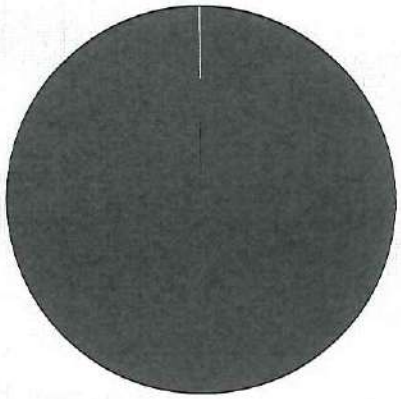

Times

	Average
Time to 1st closest provider	5.2 mins
Time to 2nd closest provider	10.8 mins
Time to 3rd closest provider	14.3 mins
Time to 4th closest provider	16.8 mins
Time to 5th closest provider	18.8 mins

Access Standard Comparison

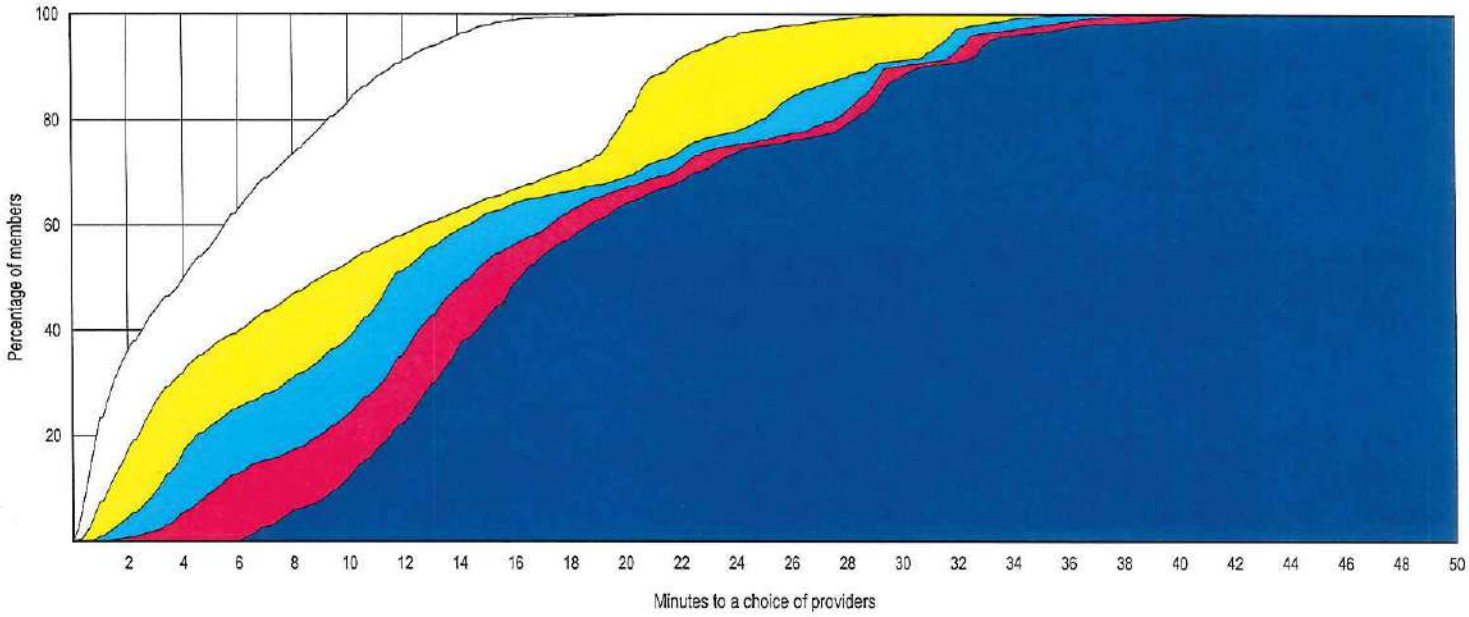

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Provider Locations

January 23, 2020

Region 6 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Total Providers: 4

c All providers

Interstates

US Highways

State Highways

7.48 miles

Region 6 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

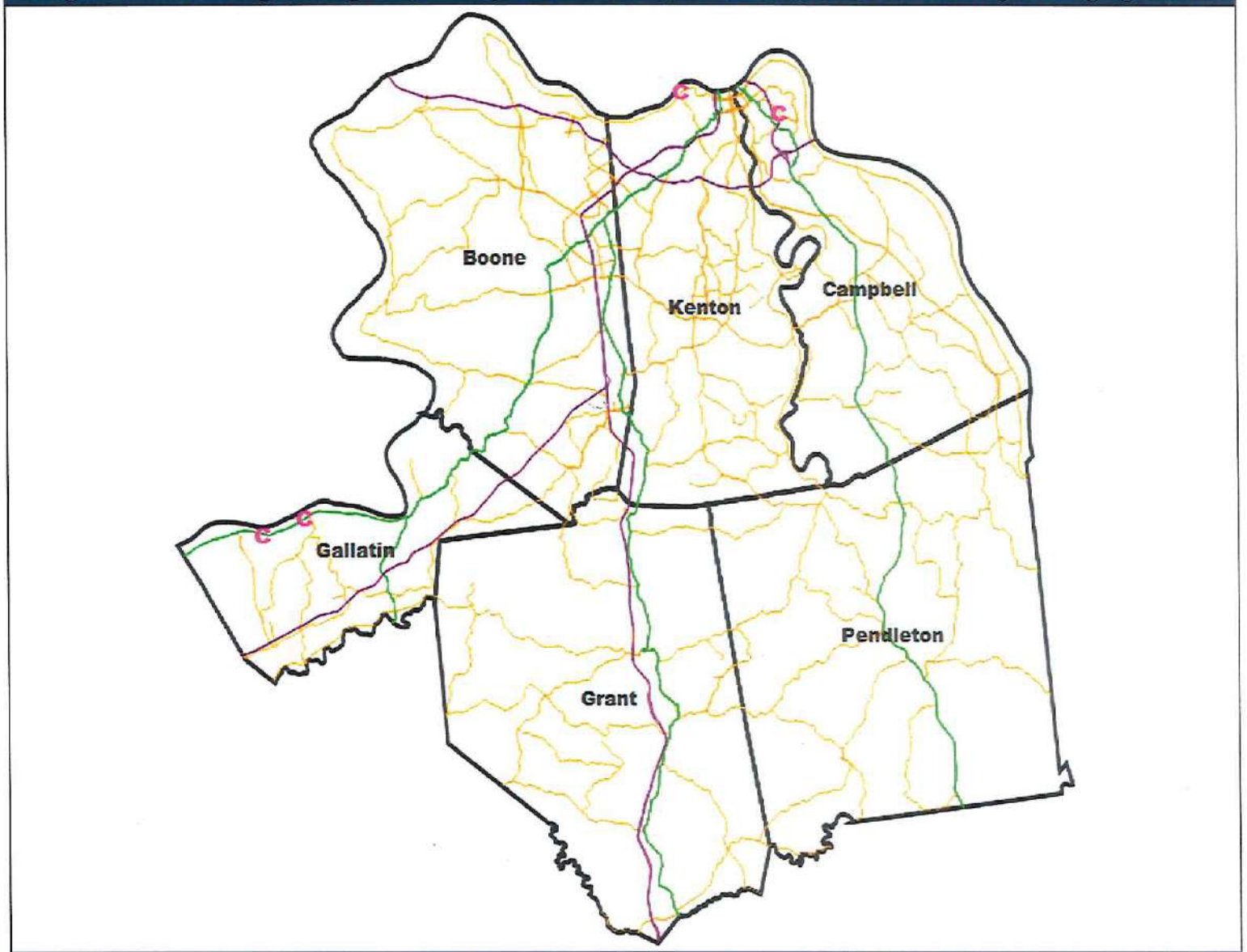

4 providers at 4 locations

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Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 miles

Overall Access[1]

22,413 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

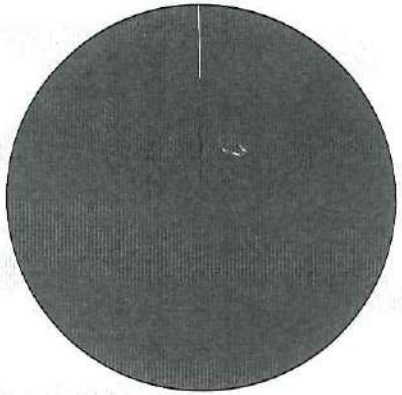

Distances

	Average
Distance to 1st closest provider	9.3 miles
Distance to 2nd closest provider	12.4 miles
Distance to 3rd closest provider	14.4 miles
Distance to 4th closest provider	22.0 miles
Distance to 5th closest provider	23.9 miles

Access Standard Comparison

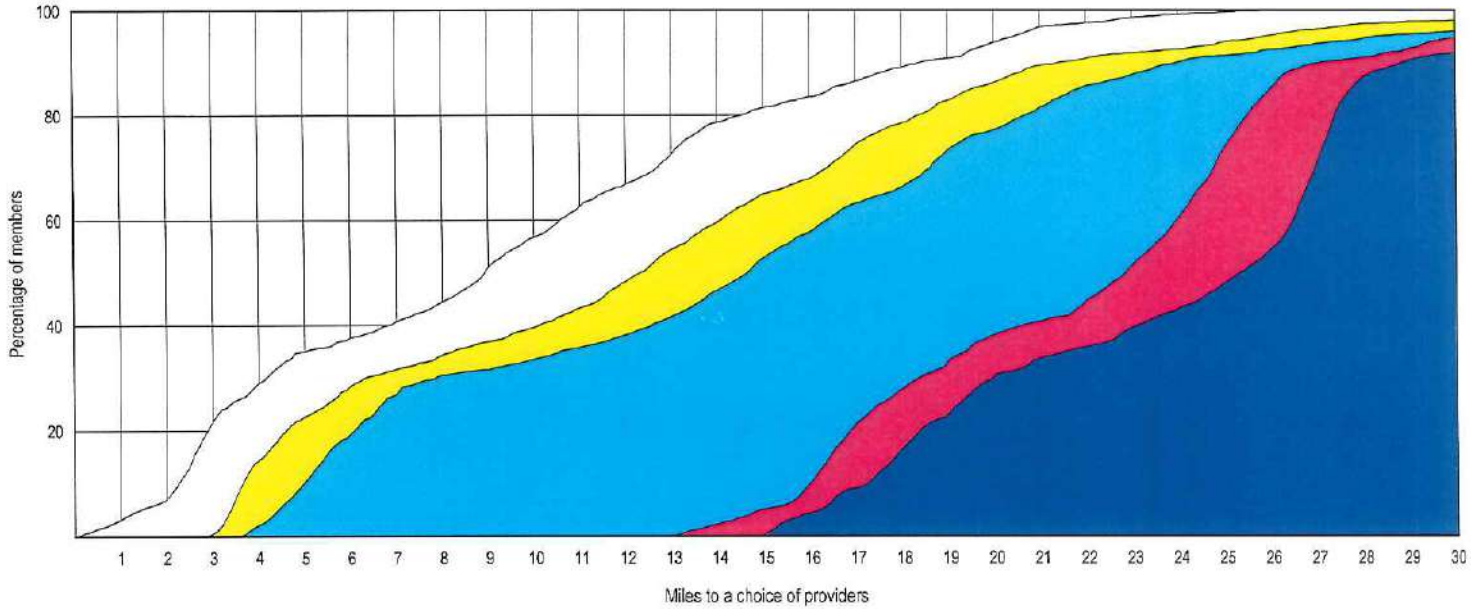

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 minutes

Overall Access[1]

22,413 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

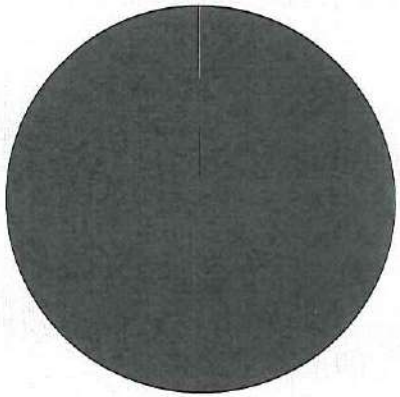

Times

	Average
Time to 1st closest provider	12.3 mins
Time to 2nd closest provider	15.9 mins
Time to 3rd closest provider	20.1 mins
Time to 4th closest provider	27.5 mins
Time to 5th closest provider	29.6 mins

Access Standard Comparison

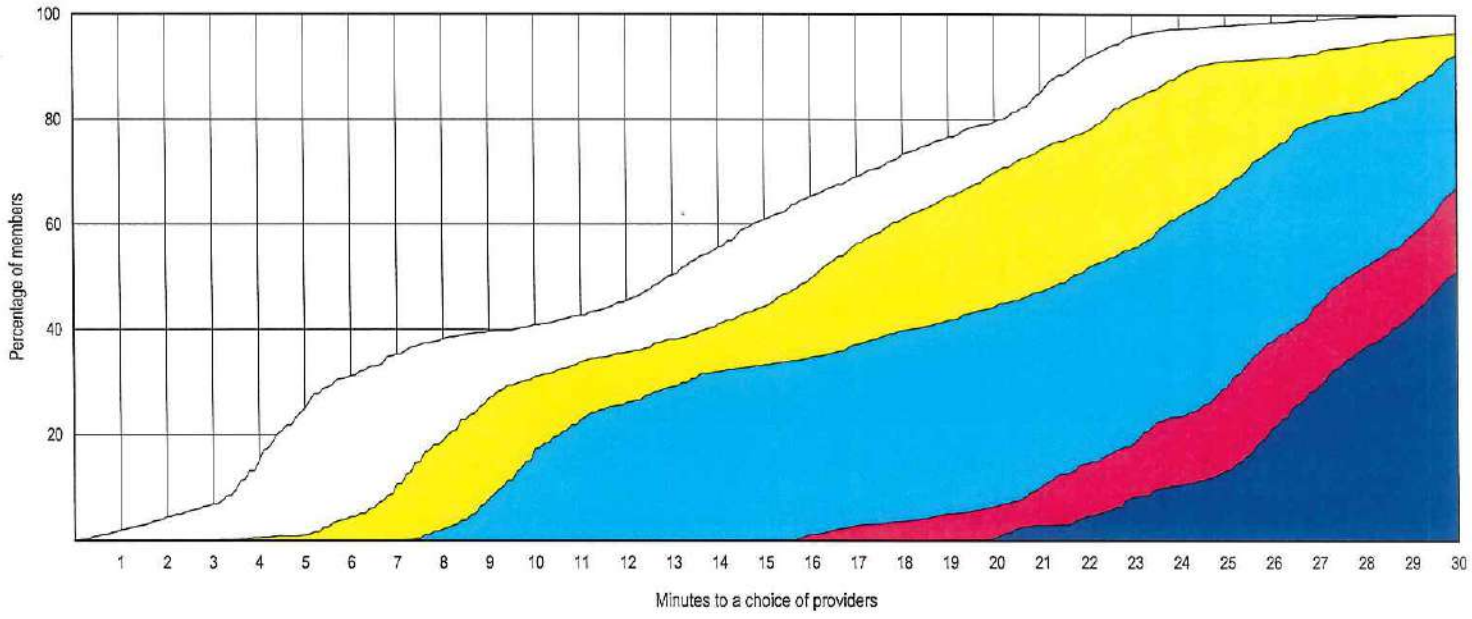

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Provider Locations

January 23, 2020

Region 7 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Total Providers: 18

c All providers

Interstates

US Highways

State Highways

12.36 miles

Region 7 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

18 providers at 17 locations

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Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 miles

Overall Access[1]

2,907 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

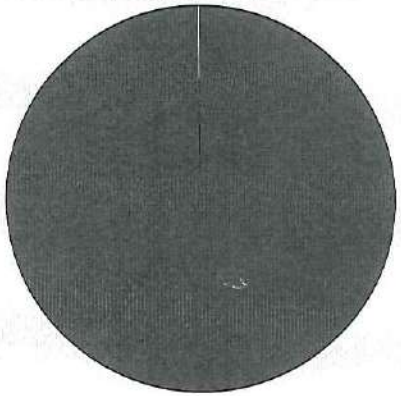

Distances

	Average
Distance to 1st closest provider	8.1 miles
Distance to 2nd closest provider	10.7 miles
Distance to 3rd closest provider	14.5 miles
Distance to 4th closest provider	16.2 miles
Distance to 5th closest provider	18.7 miles

Access Standard Comparison

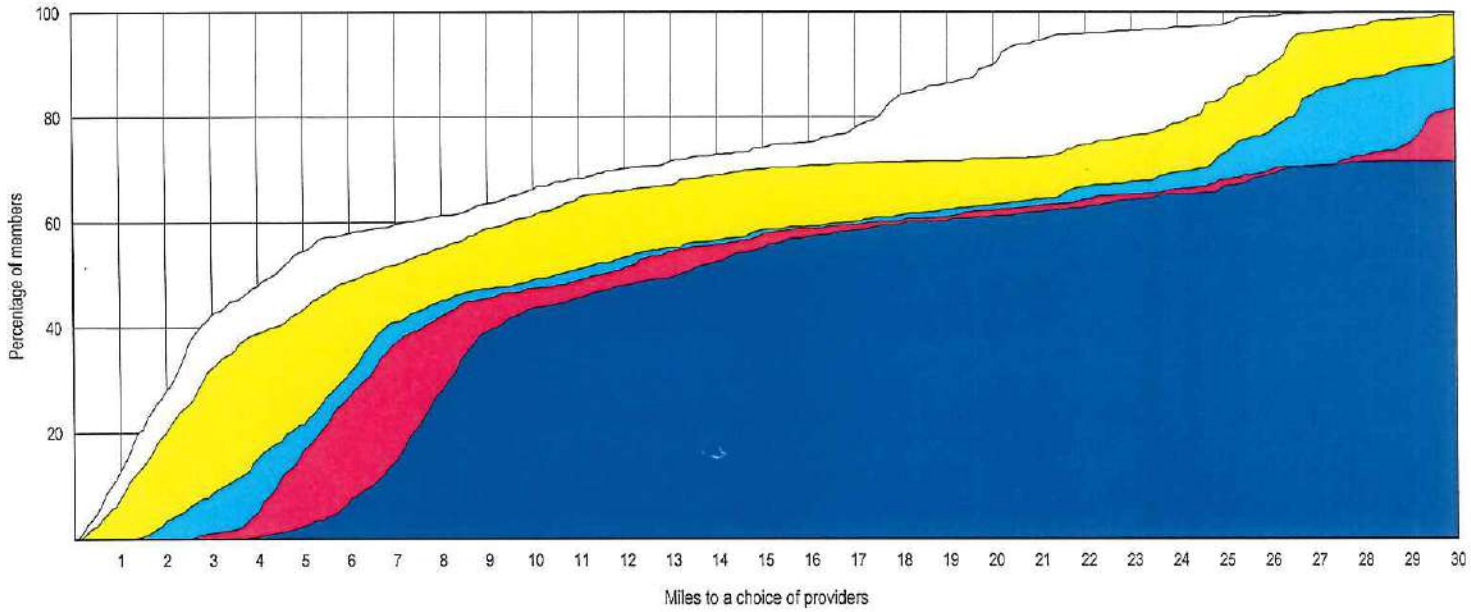

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Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 30 minutes

Overall Access[1]

2,907 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 2,902 (99.8%) Members with access
- 3 (0.1%) Members without access
- 2 (0.1%) Members excluded

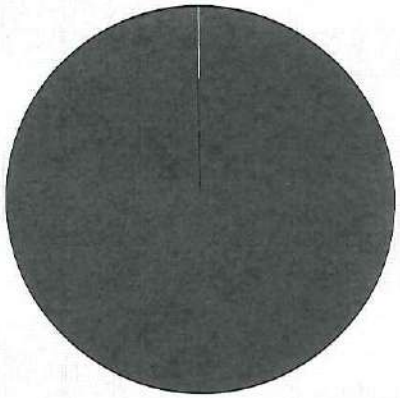

Times

	Average
Time to 1st closest provider	8.9 mins
Time to 2nd closest provider	11.8 mins
Time to 3rd closest provider	16.0 mins
Time to 4th closest provider	18.0 mins
Time to 5th closest provider	20.8 mins

Access Standard Comparison

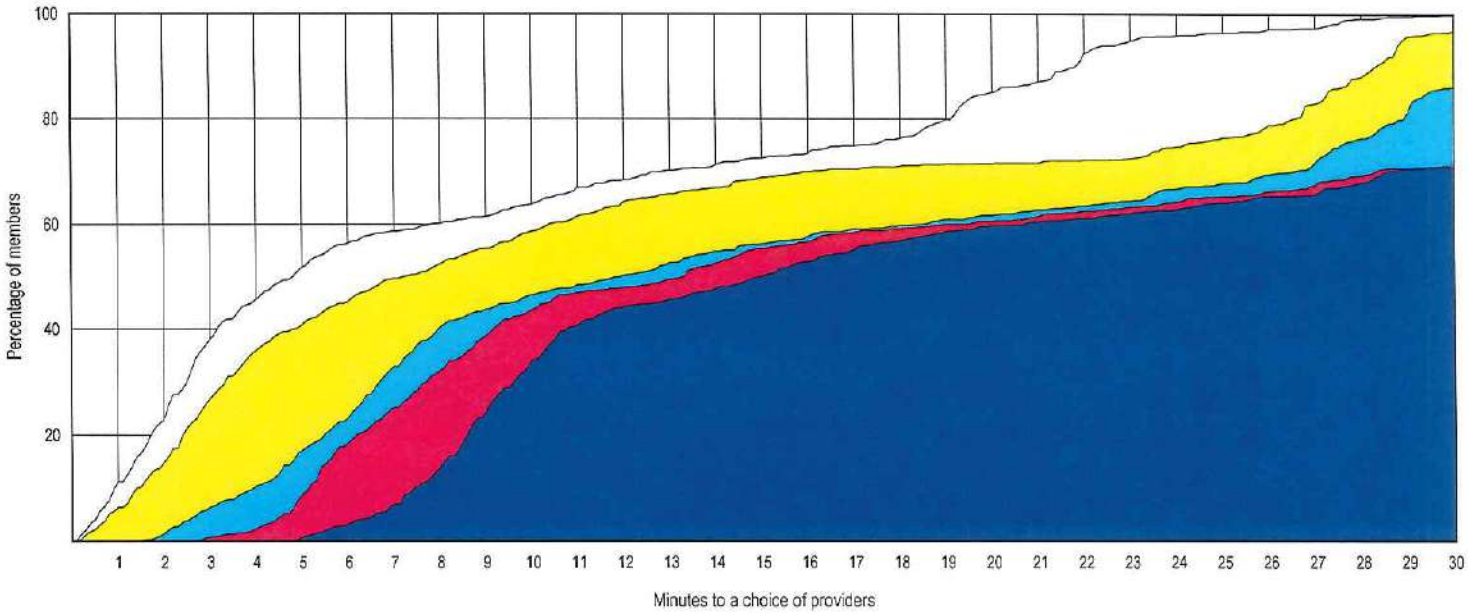

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 miles

Overall Access[1]

10,408 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

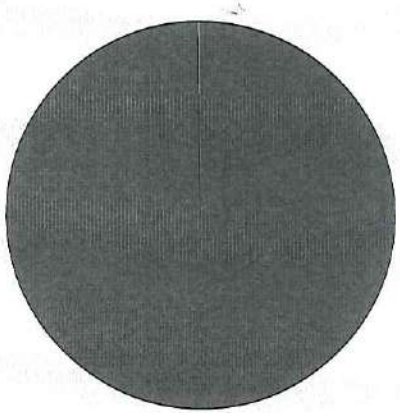

Distances

	Average
Distance to 1st closest provider	7.9 miles
Distance to 2nd closest provider	14.1 miles
Distance to 3rd closest provider	19.0 miles
Distance to 4th closest provider	21.0 miles
Distance to 5th closest provider	24.9 miles

Access Standard Comparison

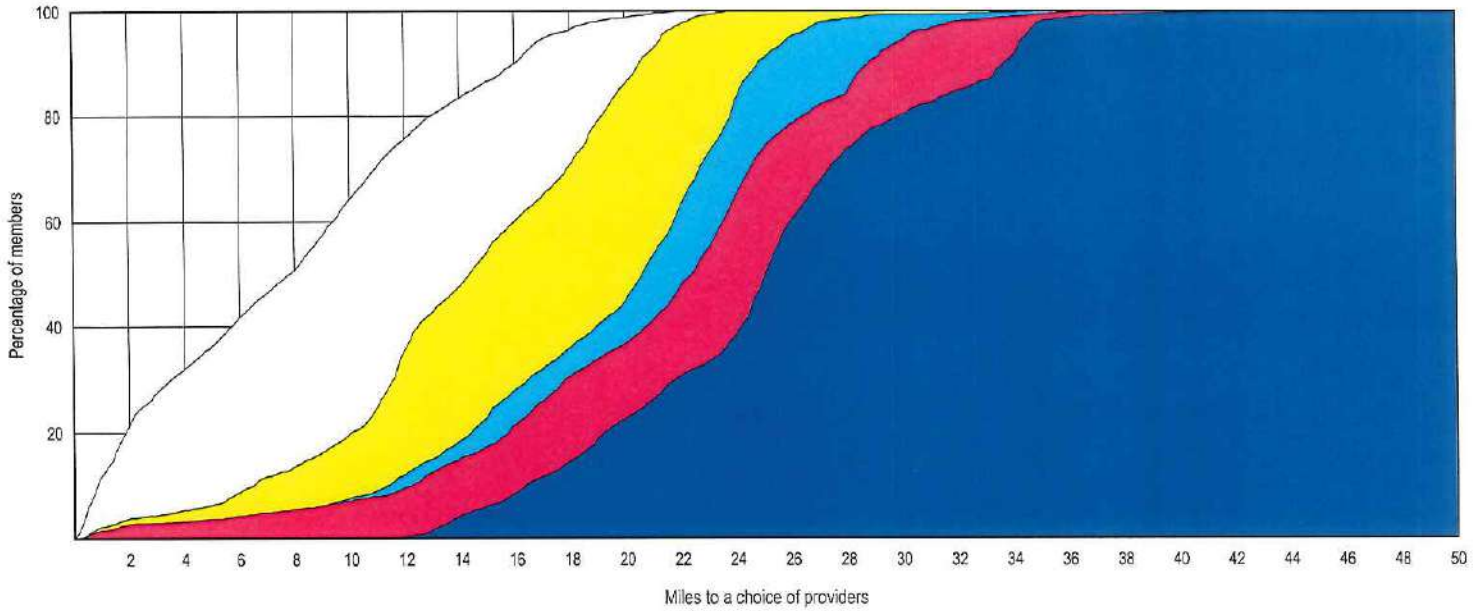

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis

Region 7 Rural - 1 in 50 minutes

Member / Provider Groups

Region 7 Rural Members

Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph

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

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

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:

1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 minutes

Overall Access[1]

10,408 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

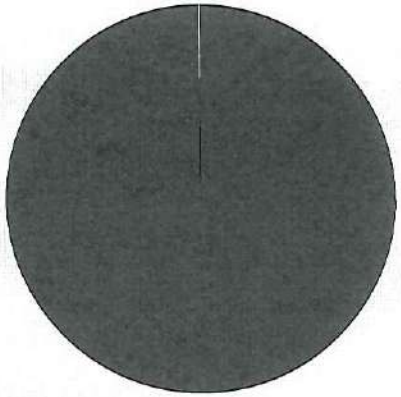

Times

	Average
Time to 1st closest provider	8.6 mins
Time to 2nd closest provider	15.3 mins
Time to 3rd closest provider	20.7 mins
Time to 4th closest provider	22.9 mins
Time to 5th closest provider	27.2 mins

Access Standard Comparison

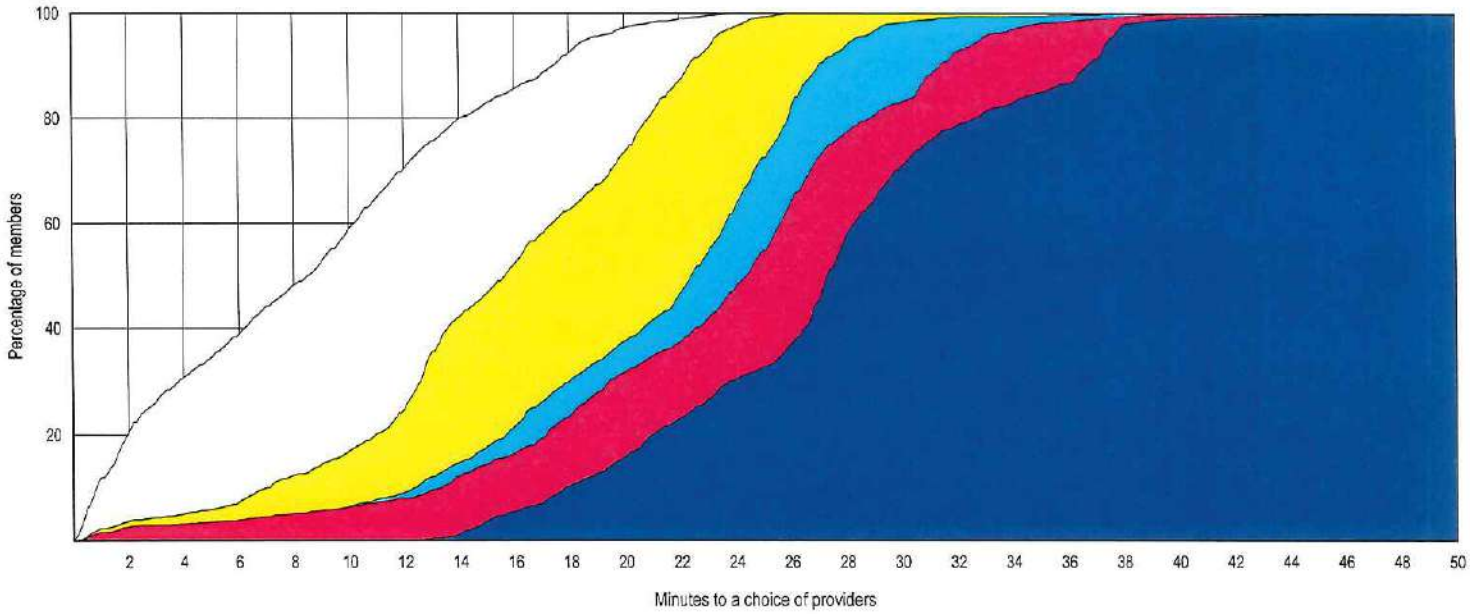

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Provider Locations

January 23, 2020

Region 8 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Total Providers: 100

c All providers

Interstates

US Highways

State Highways

16.38 miles

Region 8 Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

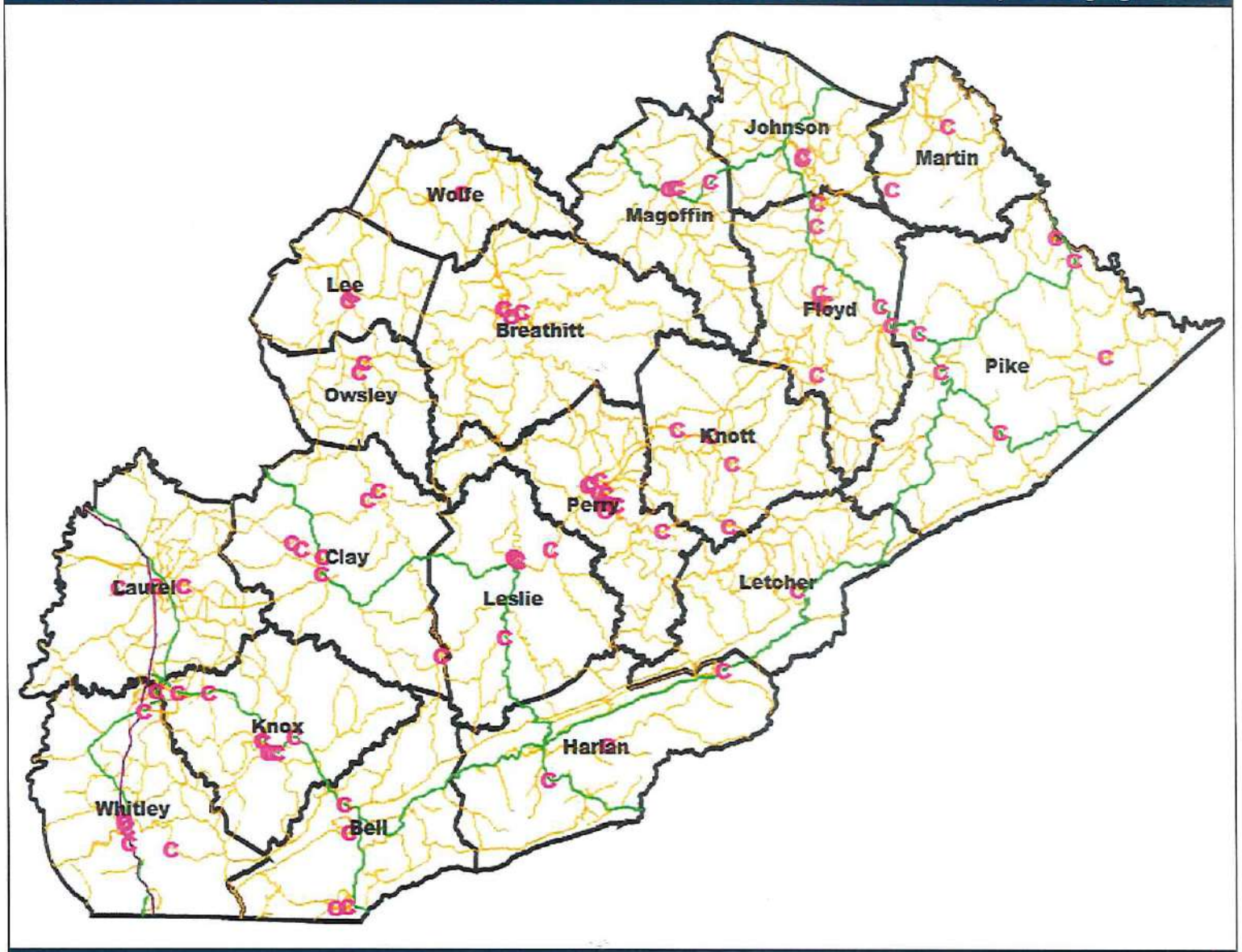

100 providers at 90 locations

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Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 miles

Overall Access[1]

31,600 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

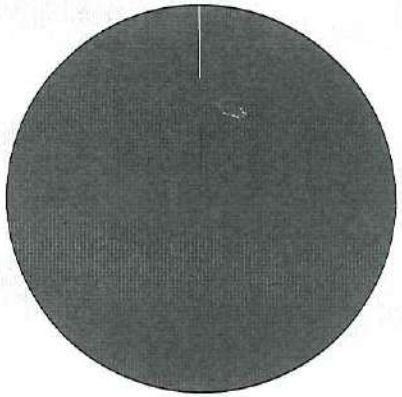

Times

	Average
Distance to 1st closest provider	4.9 miles
Distance to 2nd closest provider	6.9 miles
Distance to 3rd closest provider	8.5 miles
Distance to 4th closest provider	10.0 miles
Distance to 5th closest provider	11.6 miles

Access Standard Comparison

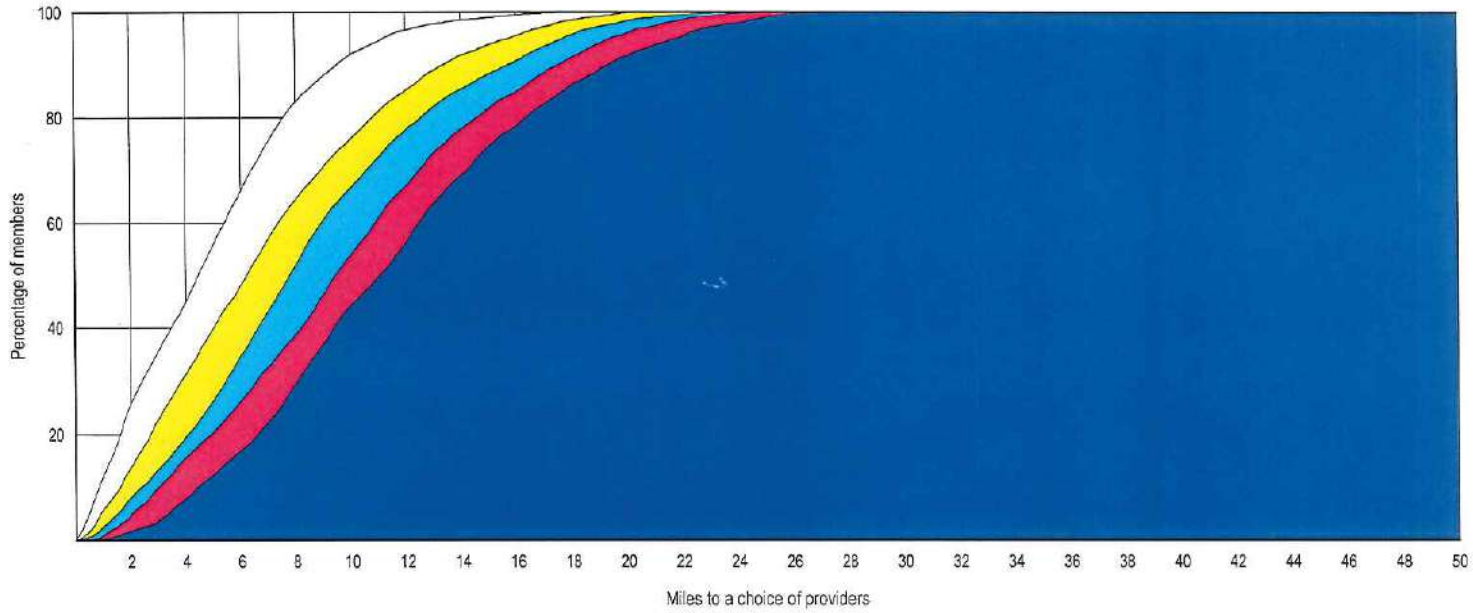

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Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies) provider in 50 minutes

Overall Access[1]

31,600 Members
297 providers at 297 locations (Freestanding Birthing Ctrs, Primary Care Ctrs, LHD, HHA, FQHC, RHC & Private Duty Nursing Agencies)

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- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

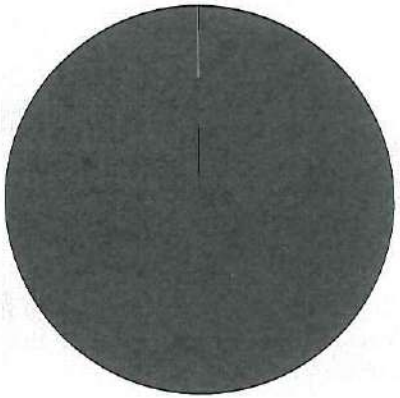

Times

	Average
Time to 1st closest provider	5.3 mins
Time to 2nd closest provider	7.5 mins
Time to 3rd closest provider	9.2 mins
Time to 4th closest provider	10.8 mins
Time to 5th closest provider	12.6 mins

Access Standard Comparison

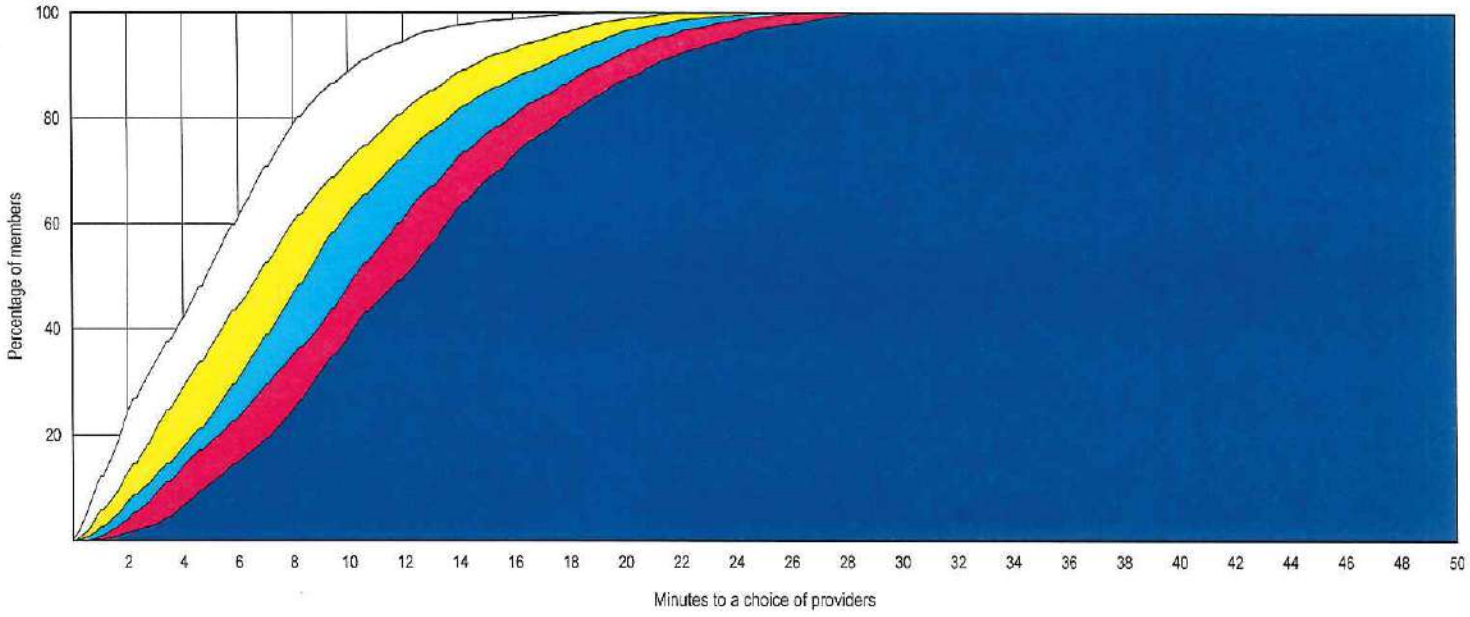

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Provider Locations

January 23, 2020

Region 1 Behavioral Health and Substance Abuse Providers

Total Providers: 149

d All providers

Interstates

US Highways

State Highways

12.93 miles

Region 1 Behavioral Health and Substance Abuse Providers

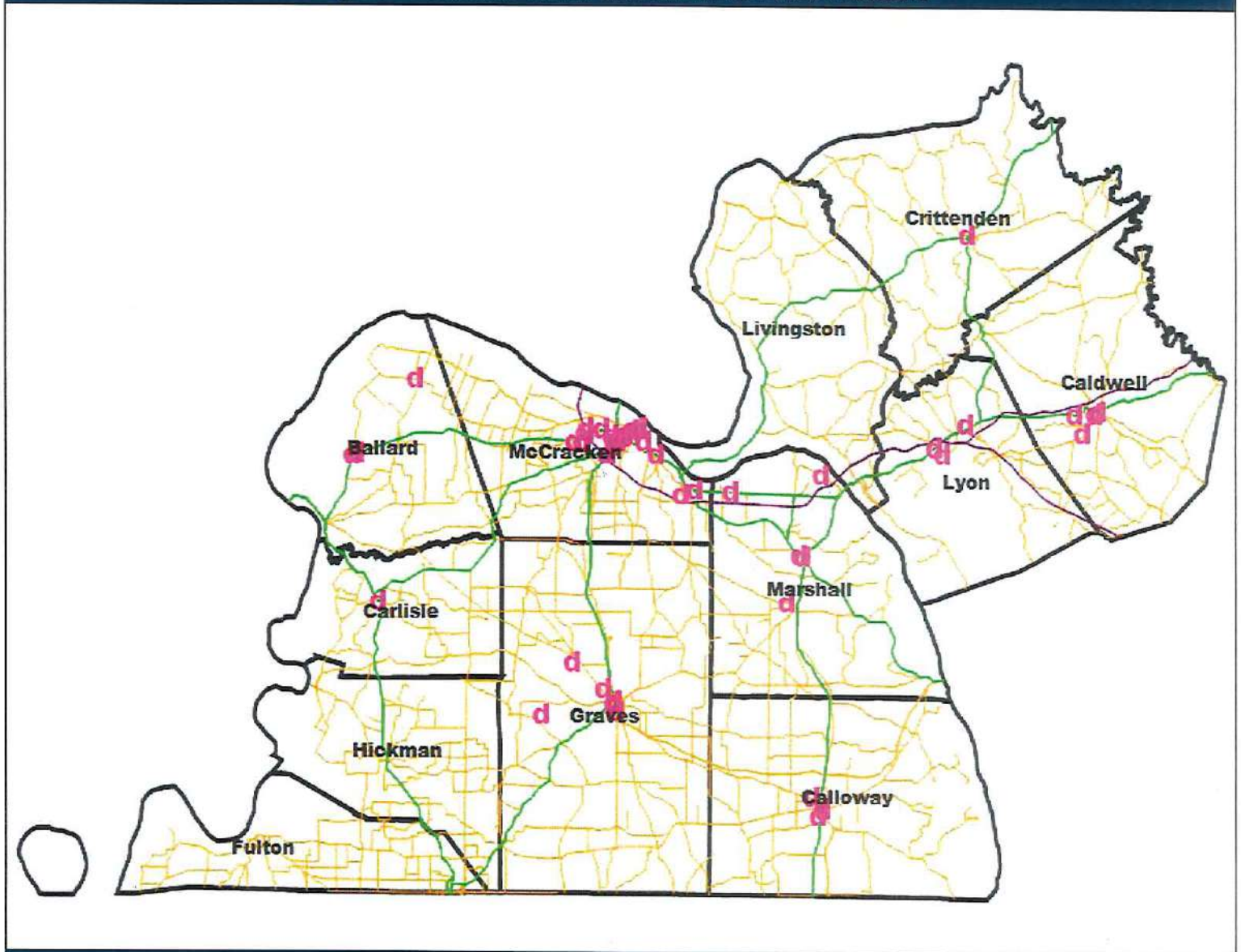

149 providers at 58 locations

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Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 miles

Overall Access[1]

11,338 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

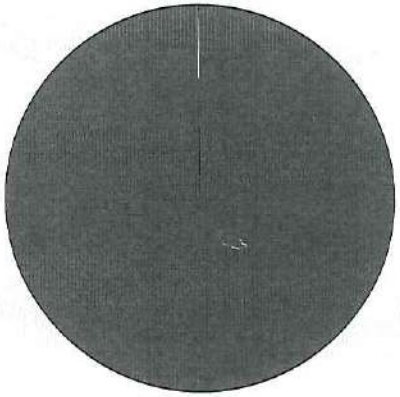

Times

	Average
Distance to 1st closest provider	5.4 miles
Distance to 2nd closest provider	6.3 miles
Distance to 3rd closest provider	6.9 miles
Distance to 4th closest provider	7.5 miles
Distance to 5th closest provider	7.8 miles

Access Standard Comparison

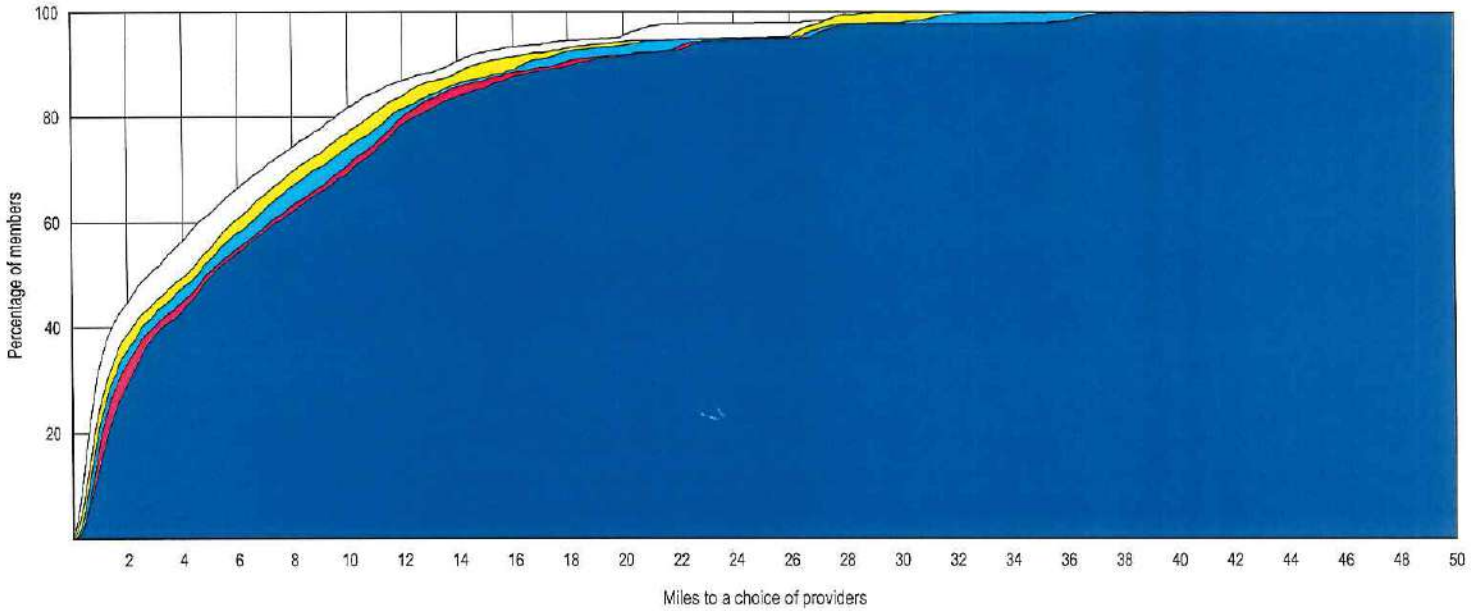

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 minutes

Overall Access[1]

11,338 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

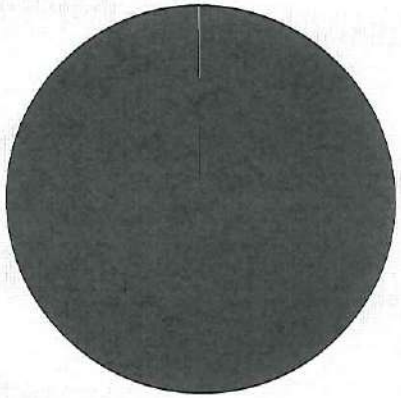

Times

	Average
Time to 1st closest provider	5.8 mins
Time to 2nd closest provider	6.9 mins
Time to 3rd closest provider	7.5 mins
Time to 4th closest provider	8.2 mins
Time to 5th closest provider	8.5 mins

Access Standard Comparison

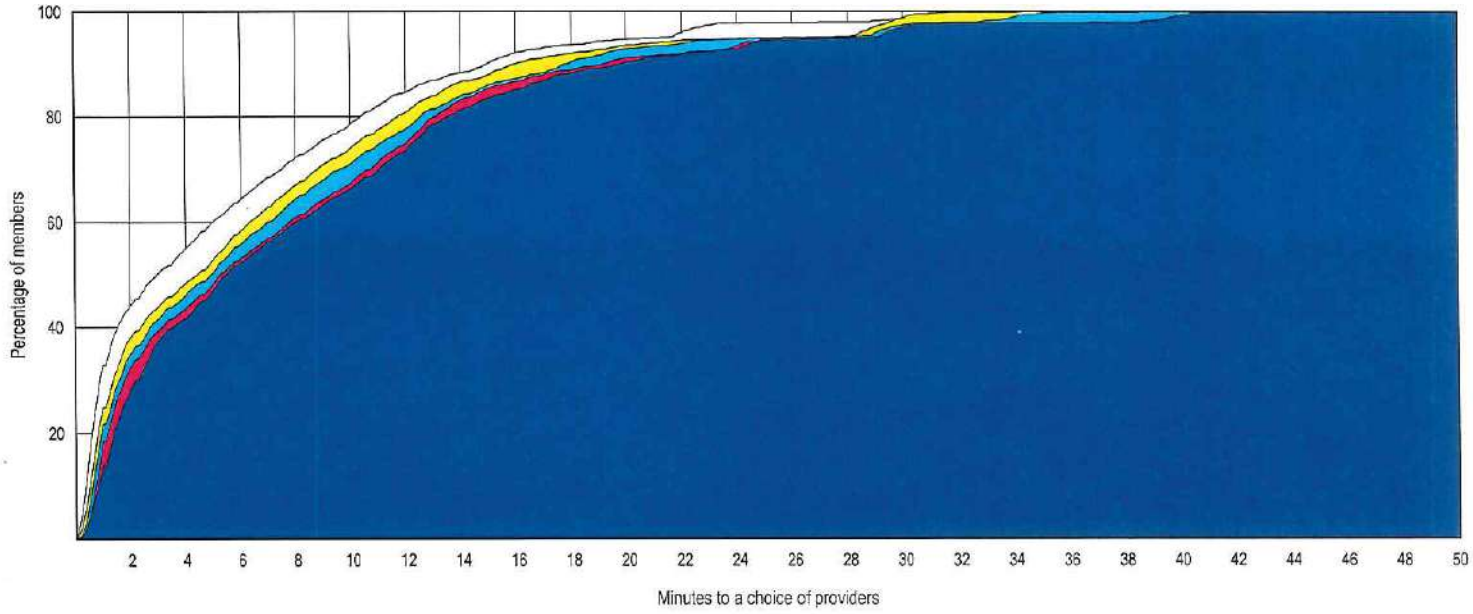

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Provider Locations

January 23, 2020

Region 2 Behavioral Health and Substance Abuse Providers

Total Providers: 222

d All providers

Interstates

US Highways

State Highways

15.14 miles

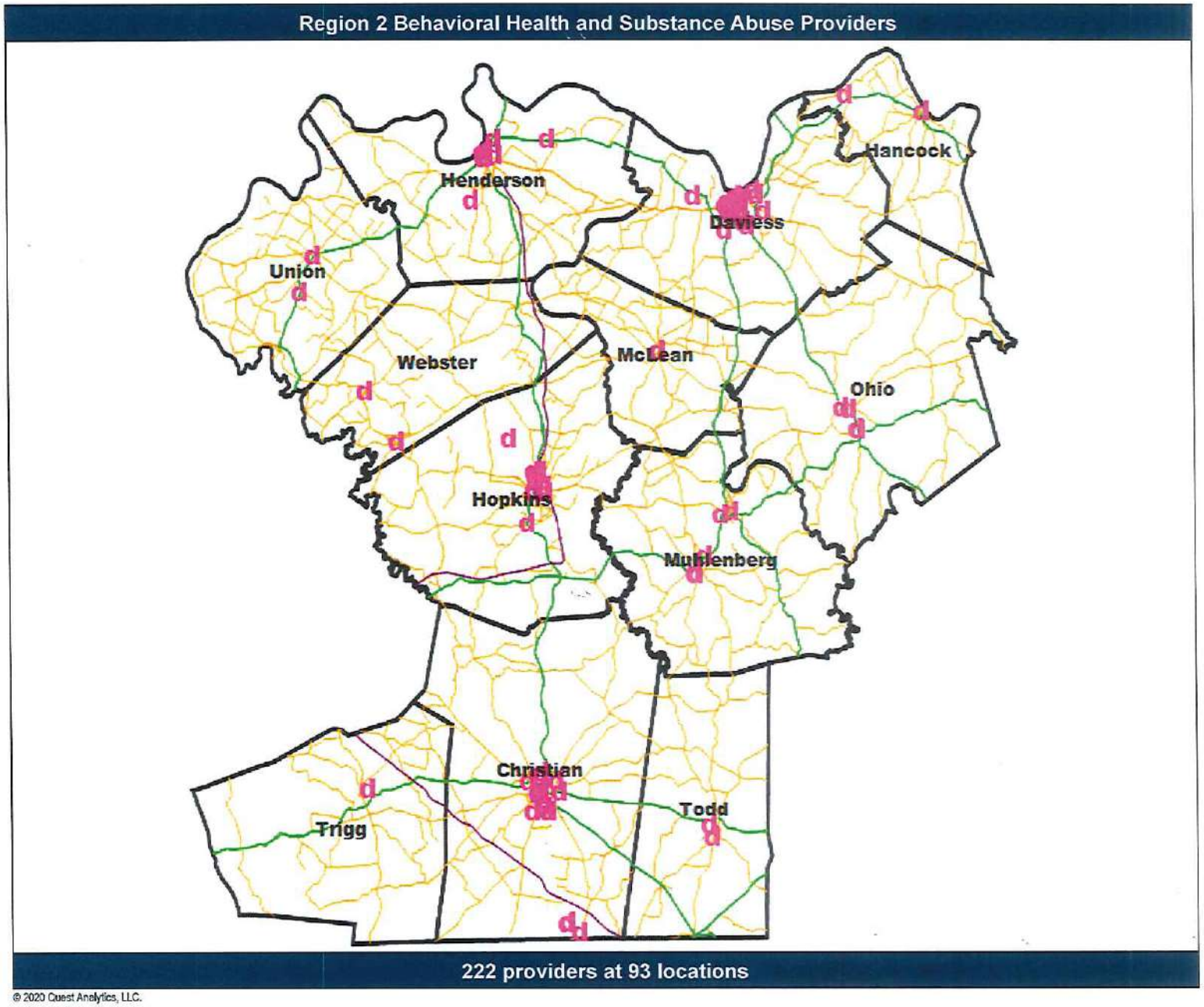

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 miles

Overall Access[1]

16,143 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

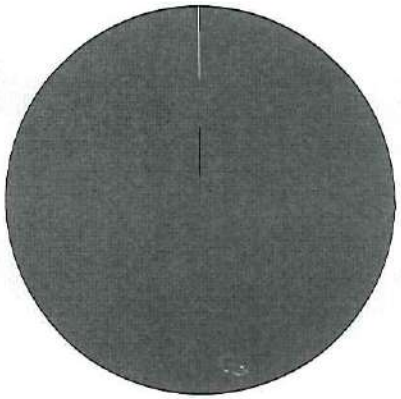

Distances

	Average
Distance to 1st closest provider	2.9 miles
Distance to 2nd closest provider	3.4 miles
Distance to 3rd closest provider	4.2 miles
Distance to 4th closest provider	4.4 miles
Distance to 5th closest provider	4.6 miles

Access Standard Comparison

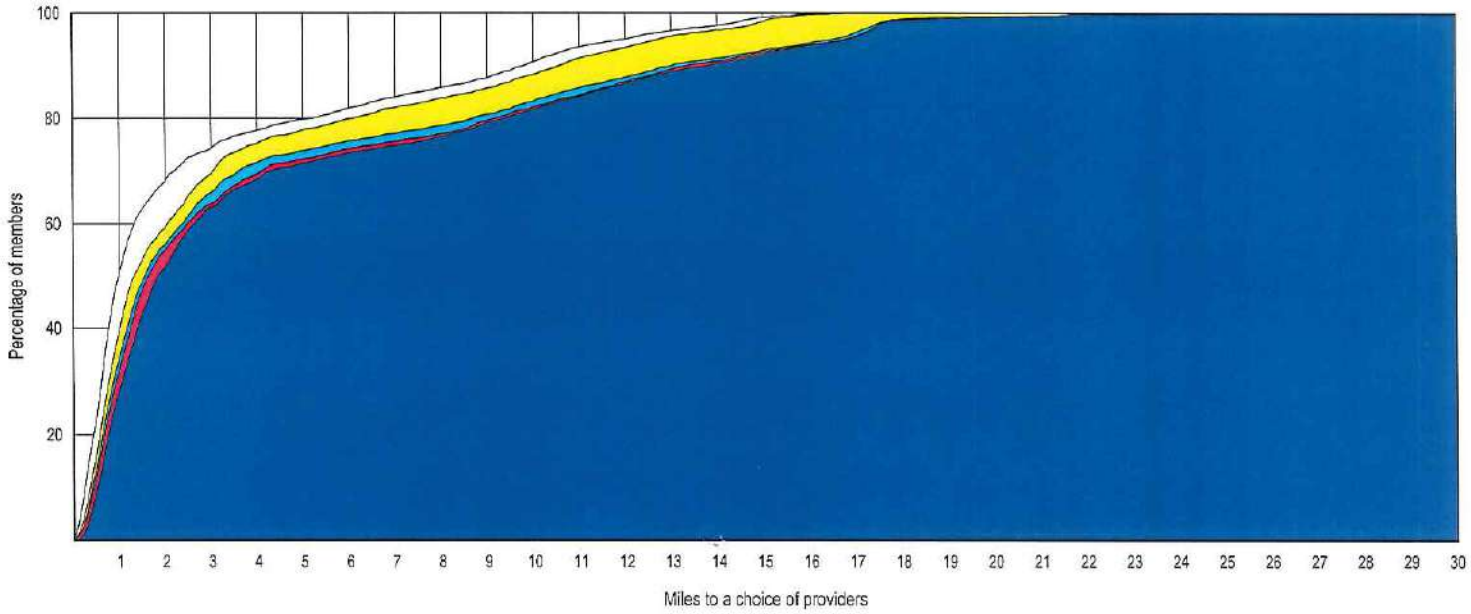

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Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 minutes

Overall Access[1]

16,143 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

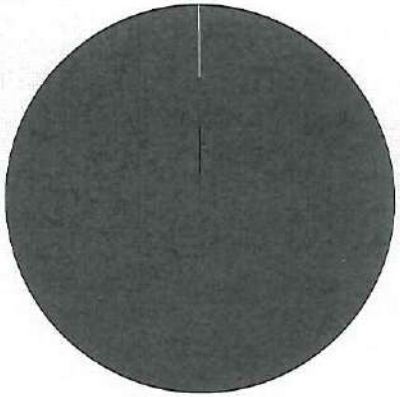

Times

	Average
Time to 1st closest provider	3.1 mins
Time to 2nd closest provider	3.6 mins
Time to 3rd closest provider	4.6 mins
Time to 4th closest provider	4.8 mins
Time to 5th closest provider	5.0 mins

Access Standard Comparison

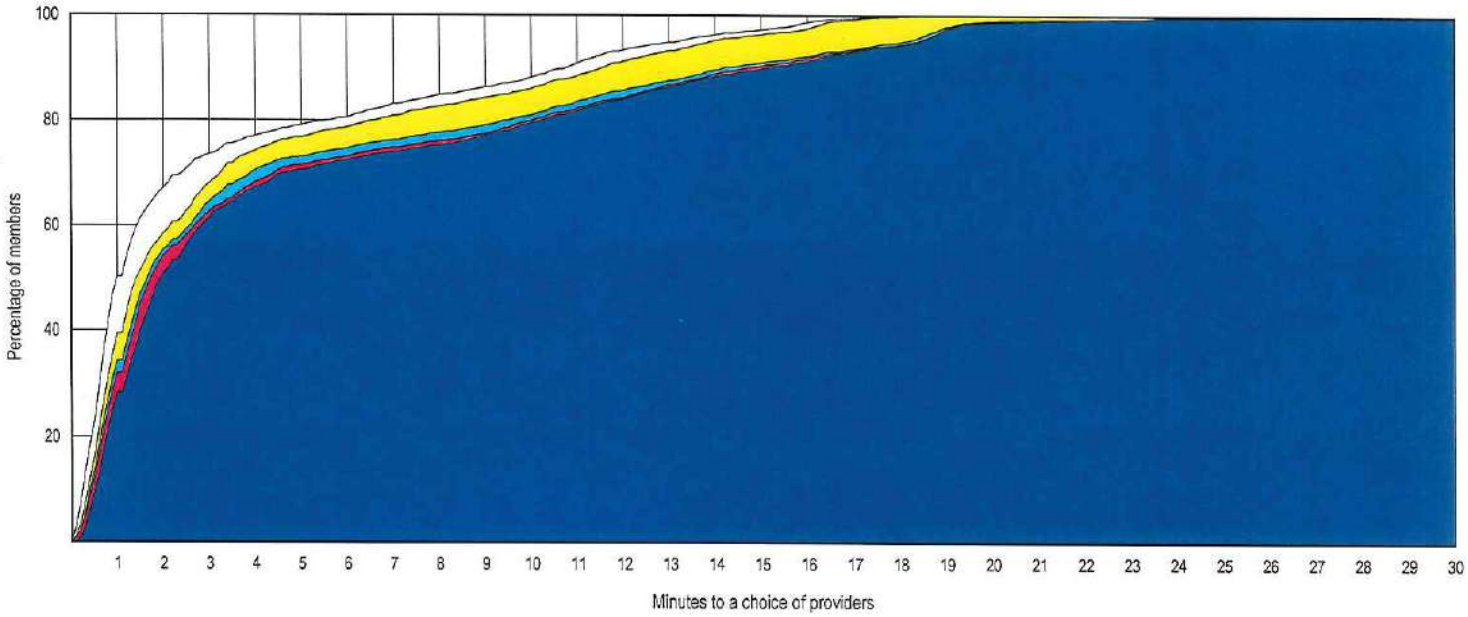

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 miles

Overall Access[1]

9,636 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

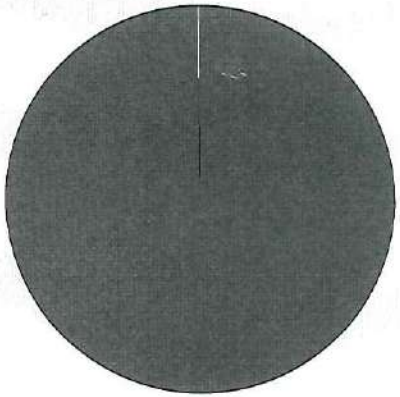

Distances

	Average
Distance to 1st closest provider	5.2 miles
Distance to 2nd closest provider	5.6 miles
Distance to 3rd closest provider	6.2 miles
Distance to 4th closest provider	7.4 miles
Distance to 5th closest provider	8.6 miles

Access Standard Comparison

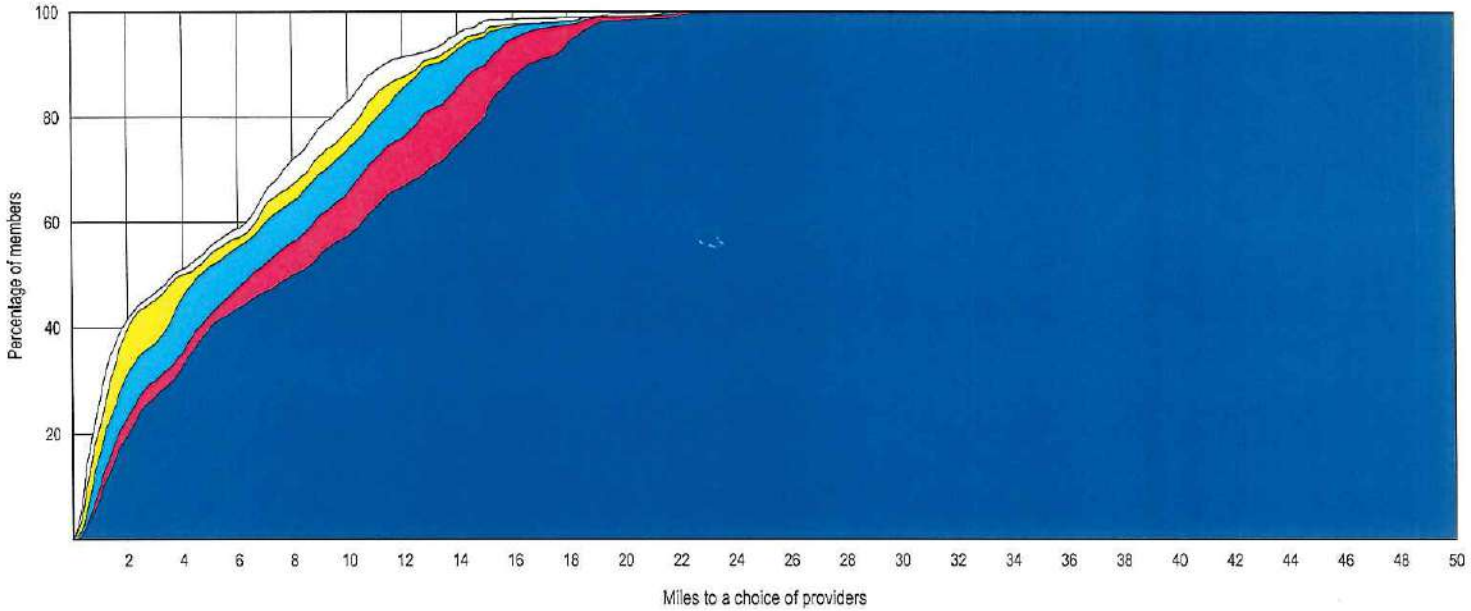

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 minutes

Overall Access[1]

9,636 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

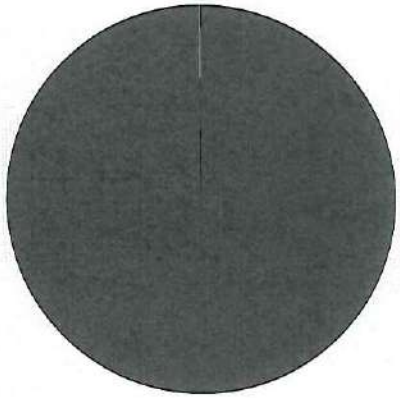

Times

	Average
Time to 1st closest provider	5.6 mins
Time to 2nd closest provider	6.1 mins
Time to 3rd closest provider	6.7 mins
Time to 4th closest provider	8.0 mins
Time to 5th closest provider	9.3 mins

Access Standard Comparison

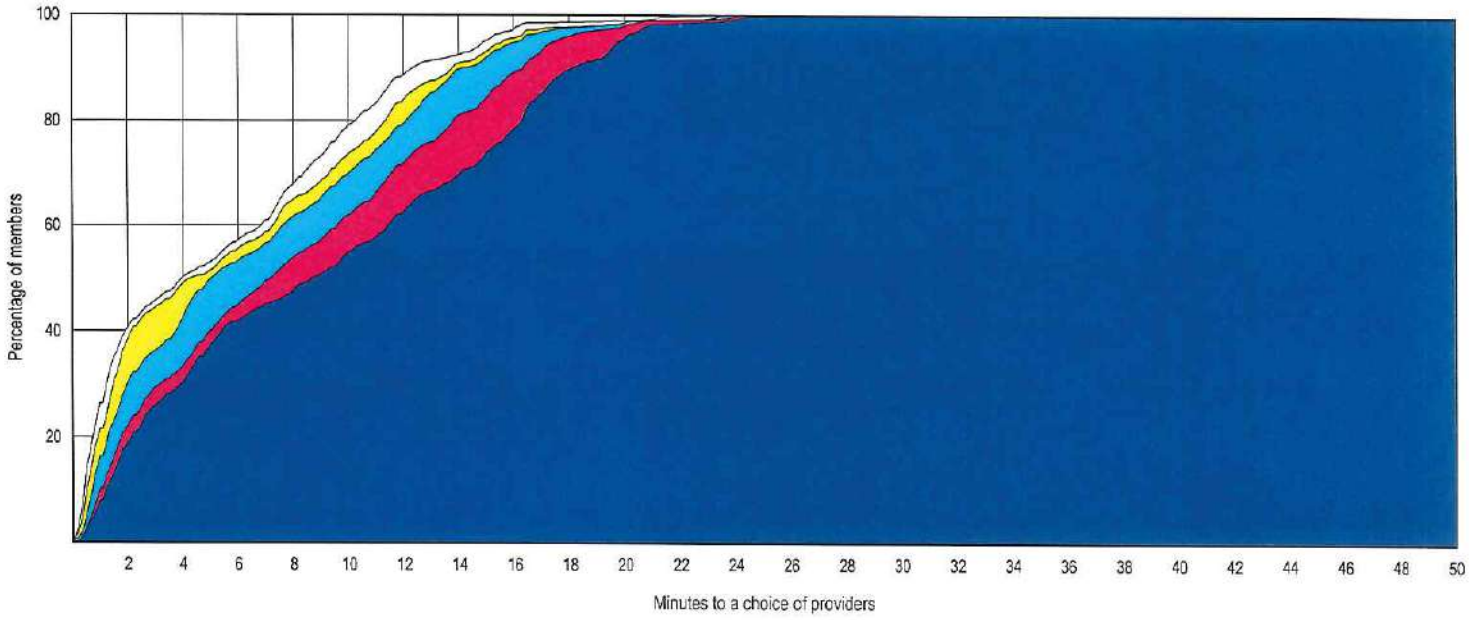

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Provider Locations

January 23, 2020

Region 3 Behavioral Health and Substance Abuse Providers

Total Providers: 742

d All providers

Interstates

US Highways

State Highways

15.97 miles

Region 3 Behavioral Health and Substance Abuse Providers

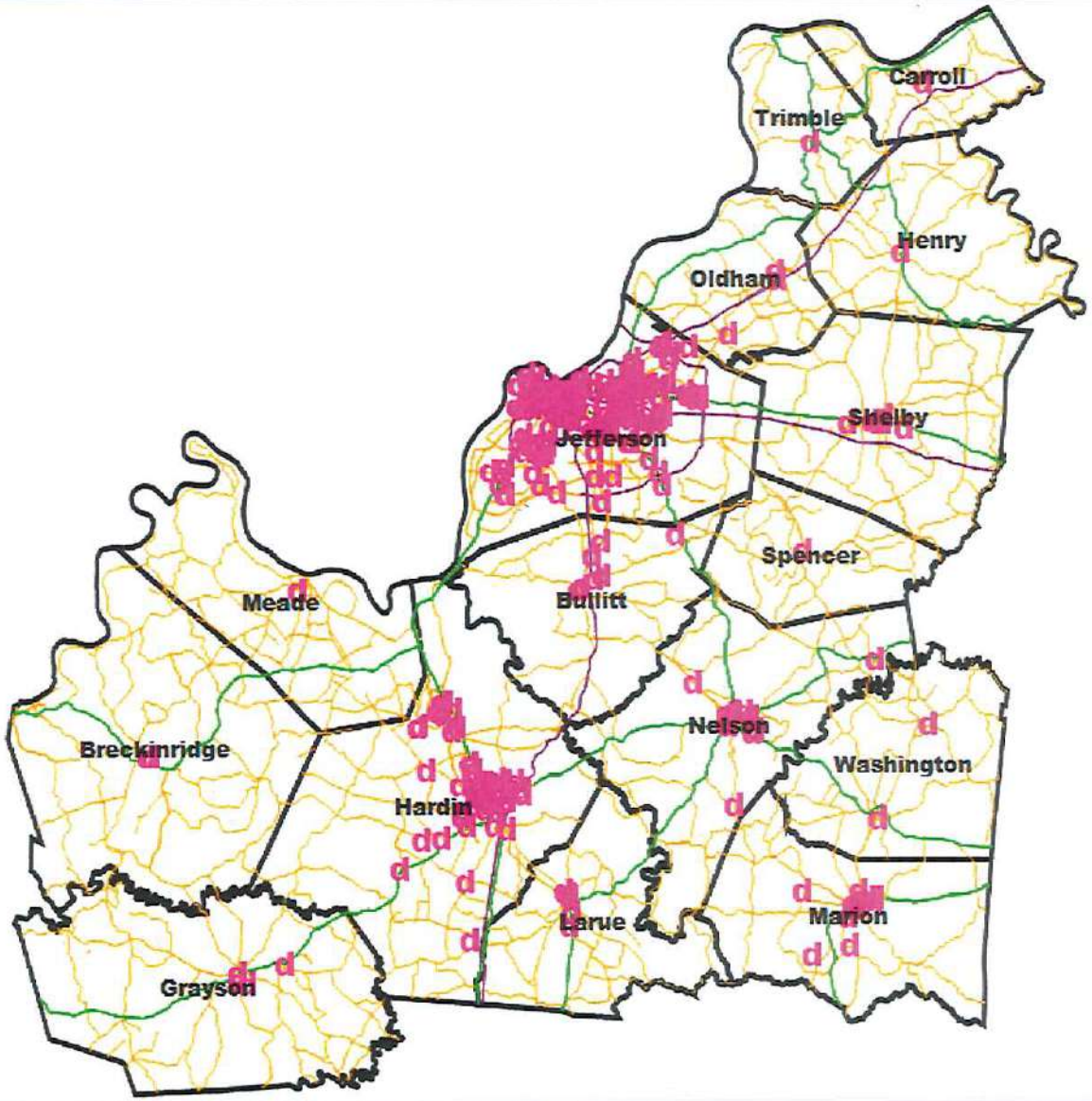

742 providers at 311 locations

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Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 miles

Overall Access[1]

18,130 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

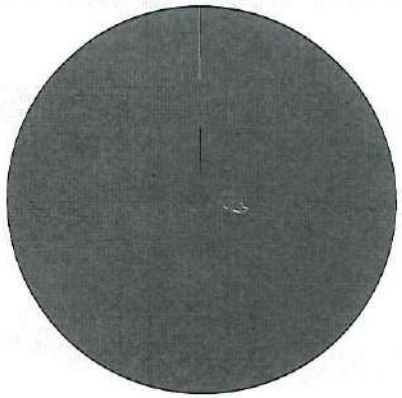

Distances

	Average
Distance to 1st closest provider	1.7 miles
Distance to 2nd closest provider	2.1 miles
Distance to 3rd closest provider	2.5 miles
Distance to 4th closest provider	2.8 miles
Distance to 5th closest provider	2.9 miles

Access Standard Comparison

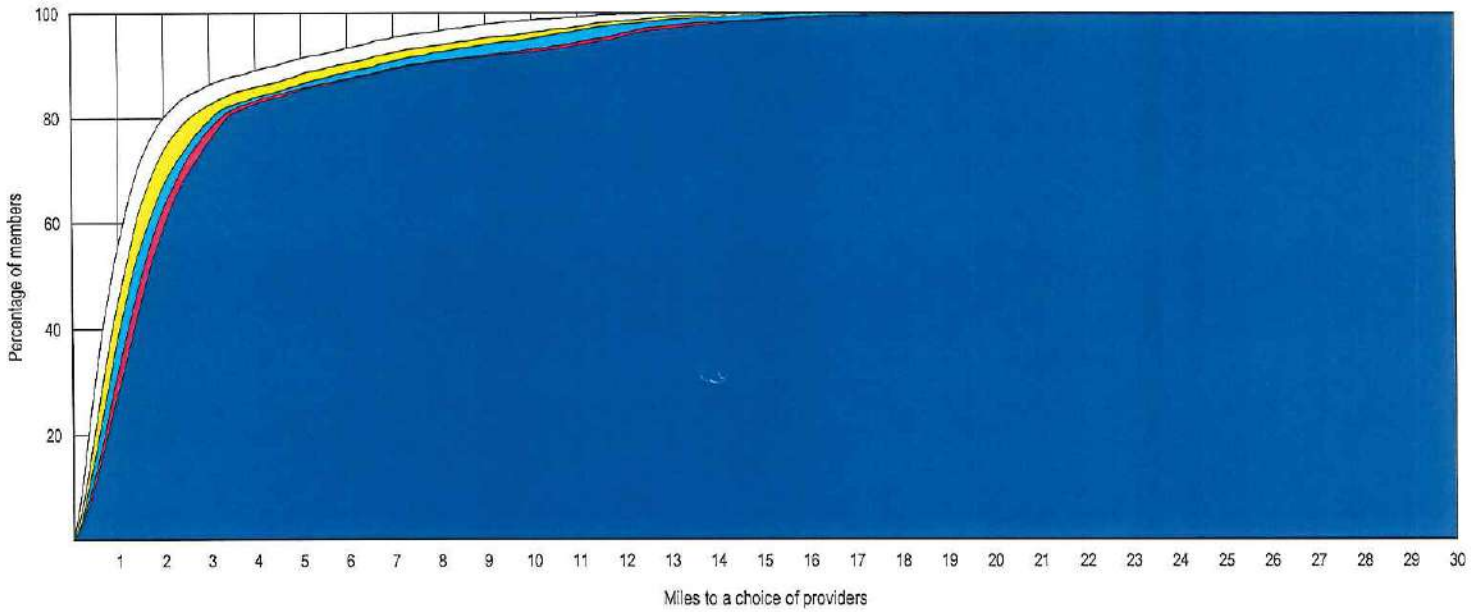

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 minutes

Overall Access[1]

18,130 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 18,127 (99.9%) Members with access
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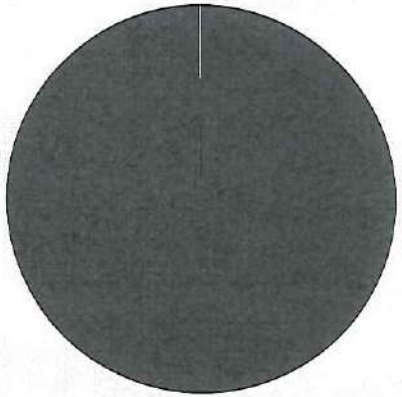

Times

	Average
Time to 1st closest provider	2.1 mins
Time to 2nd closest provider	2.6 mins
Time to 3rd closest provider	3.0 mins
Time to 4th closest provider	3.4 mins
Time to 5th closest provider	3.6 mins

Access Standard Comparison

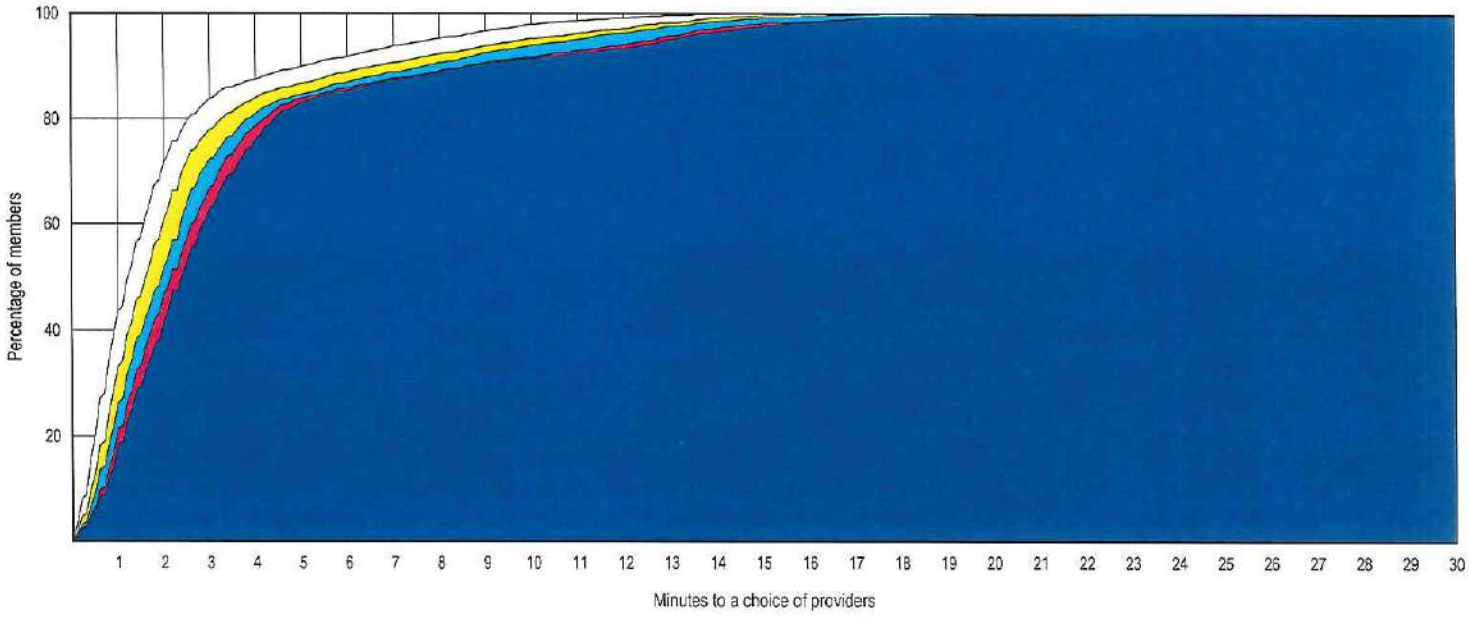

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Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 miles

Overall Access[1]

1,901 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

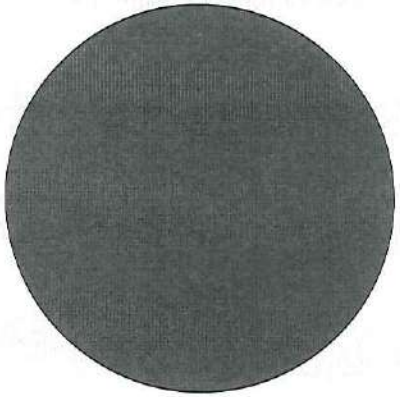

Distances

	Average
Distance to 1st closest provider	6.0 miles
Distance to 2nd closest provider	6.5 miles
Distance to 3rd closest provider	8.1 miles
Distance to 4th closest provider	8.9 miles
Distance to 5th closest provider	9.0 miles

Access Standard Comparison

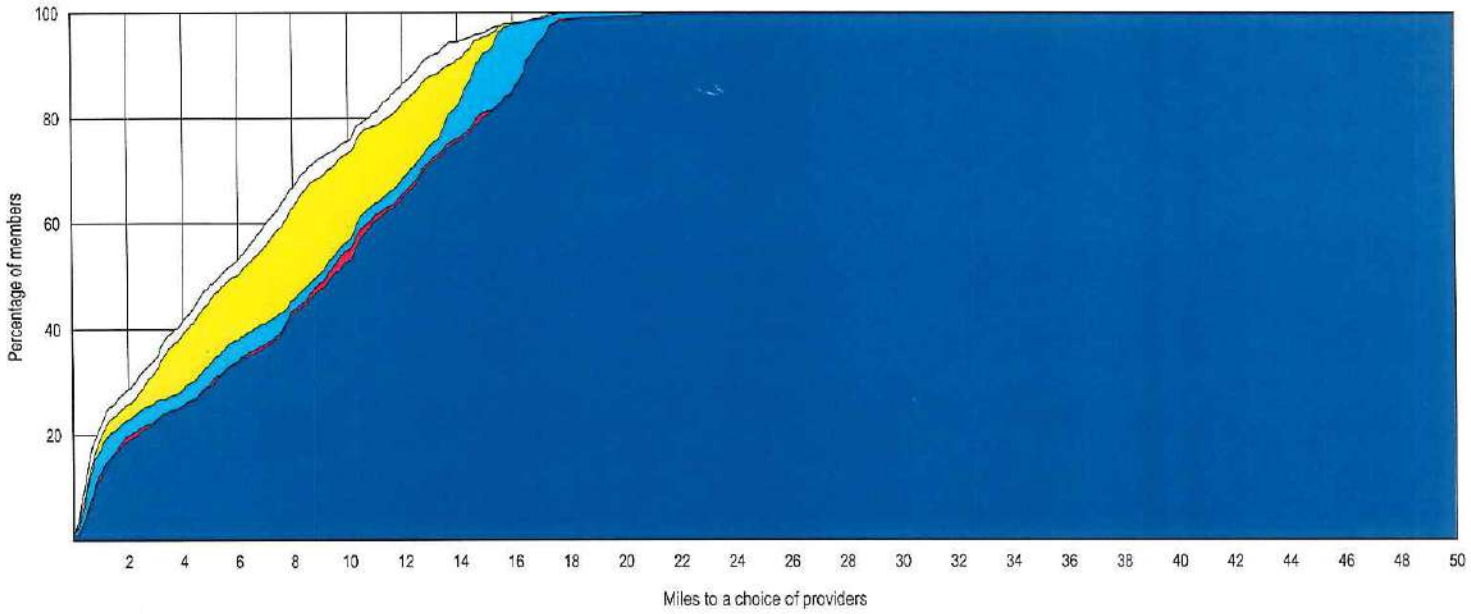

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 minutes

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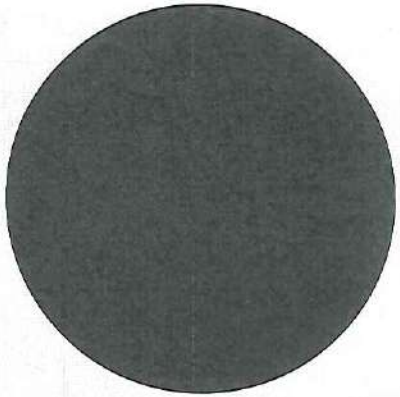

Times

	Average
Time to 1st closest provider	6.5 mins
Time to 2nd closest provider	7.0 mins
Time to 3rd closest provider	8.8 mins
Time to 4th closest provider	9.7 mins
Time to 5th closest provider	9.8 mins

Access Standard Comparison

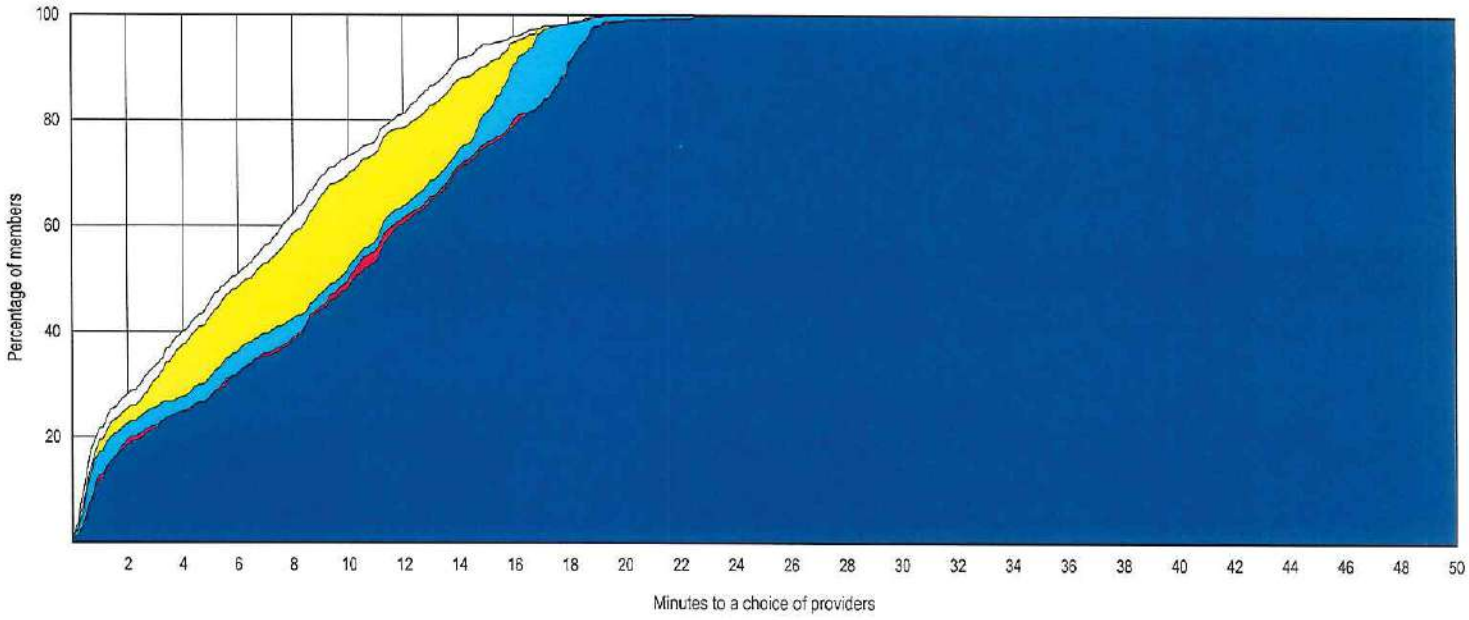

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Provider Locations

January 23, 2020

Region 4 Behavioral Health and Substance Abuse Providers

Total Providers: 373

d All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Behavioral Health and Substance Abuse Providers

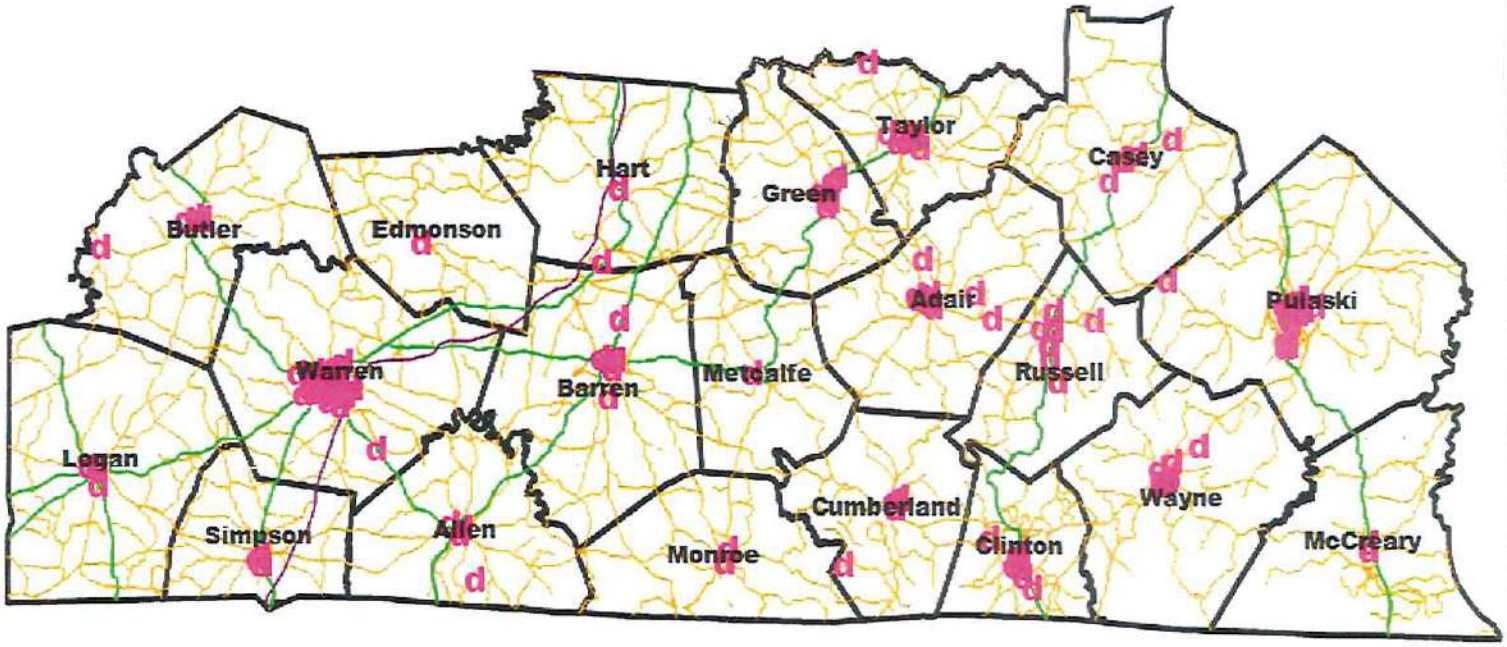

373 providers at 195 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 miles

Overall Access[1]

7,413 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

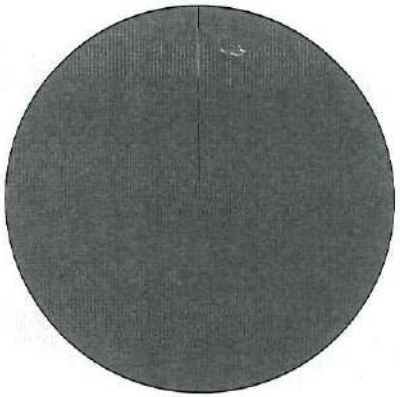

Distances

	Average
Distance to 1st closest provider	3.0 miles
Distance to 2nd closest provider	3.2 miles
Distance to 3rd closest provider	3.3 miles
Distance to 4th closest provider	3.4 miles
Distance to 5th closest provider	3.4 miles

Access Standard Comparison

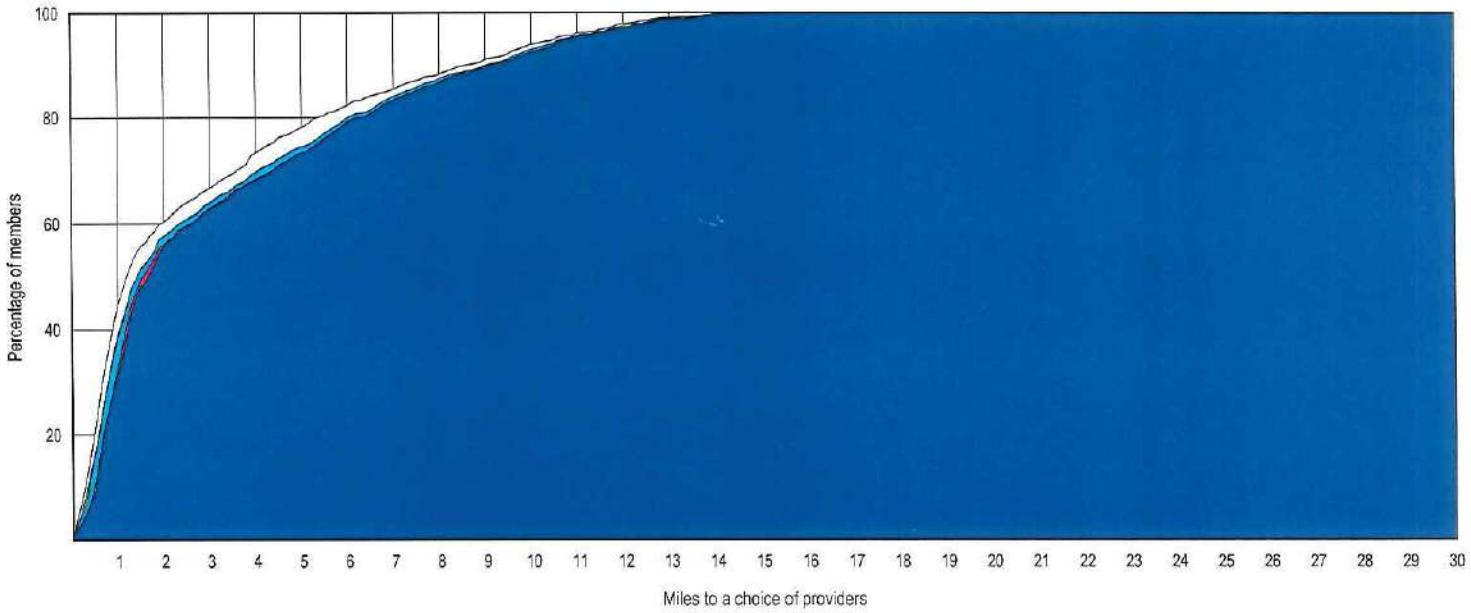

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 minutes

Overall Access[1]

7,413 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

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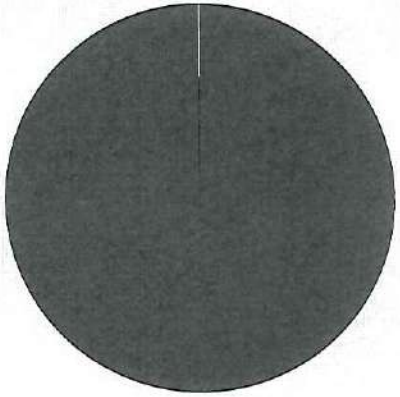

Times

	Average
Time to 1st closest provider	3.2 mins
Time to 2nd closest provider	3.5 mins
Time to 3rd closest provider	3.5 mins
Time to 4th closest provider	3.7 mins
Time to 5th closest provider	3.7 mins

Access Standard Comparison

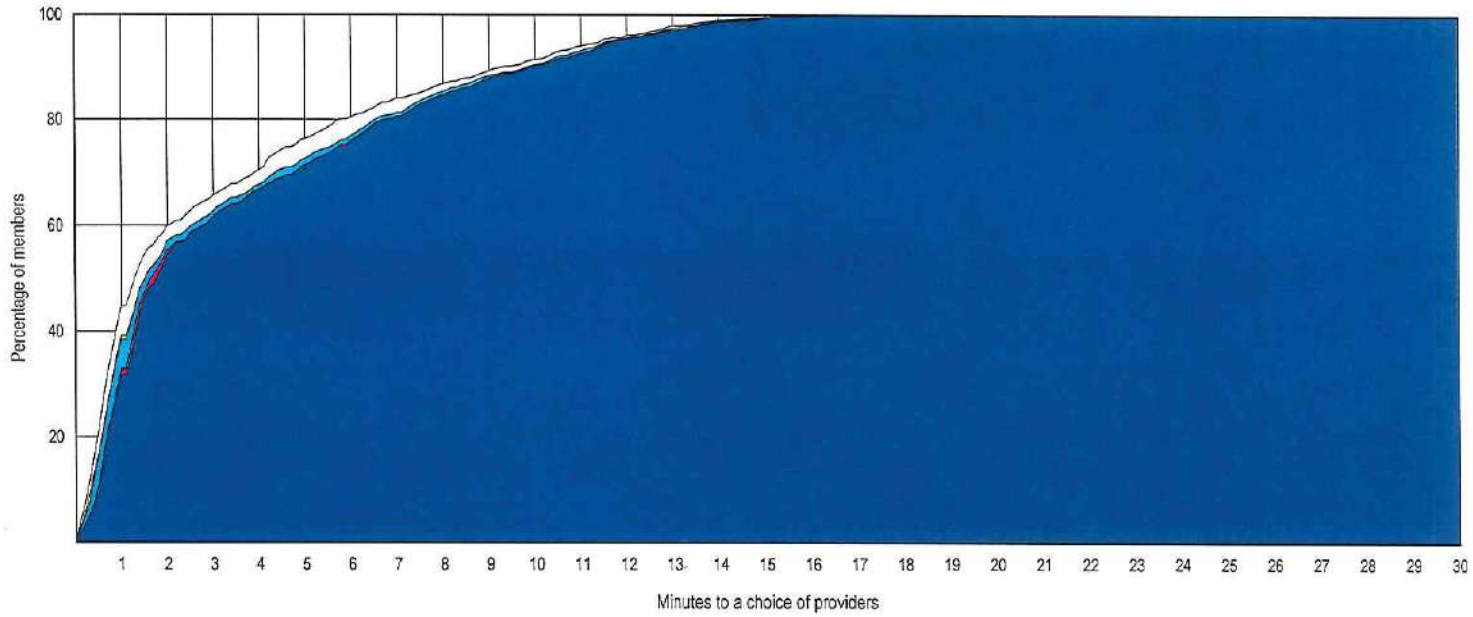

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 miles

Overall Access[1]

28,324 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

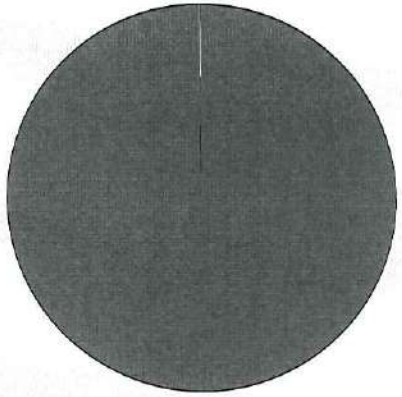

Distances

	Average
Distance to 1st closest provider	4.5 miles
Distance to 2nd closest provider	4.9 miles
Distance to 3rd closest provider	5.1 miles
Distance to 4th closest provider	5.3 miles
Distance to 5th closest provider	5.5 miles

Access Standard Comparison

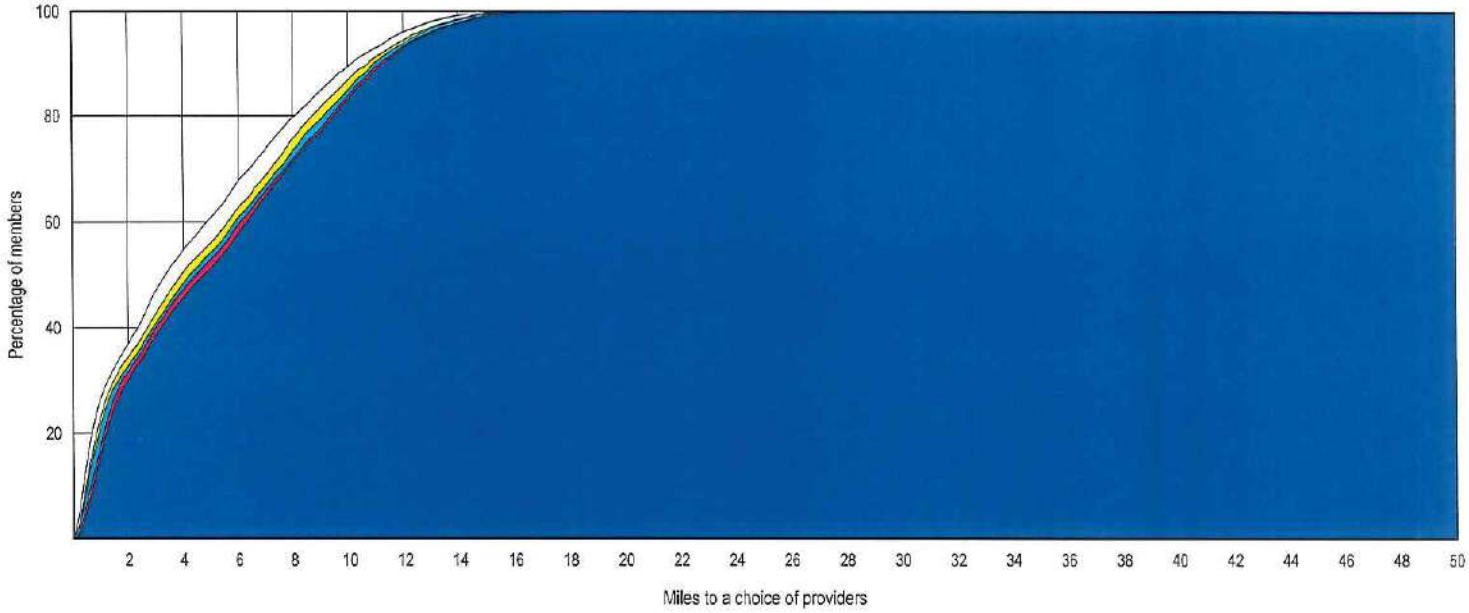

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 minutes

Overall Access[1]

28,324 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

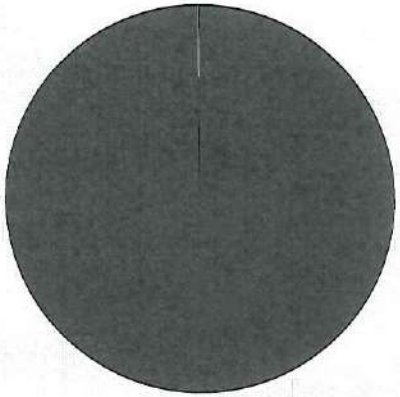

Times

	Average
Time to 1st closest provider	4.8 mins
Time to 2nd closest provider	5.3 mins
Time to 3rd closest provider	5.6 mins
Time to 4th closest provider	5.8 mins
Time to 5th closest provider	5.9 mins

Access Standard Comparison

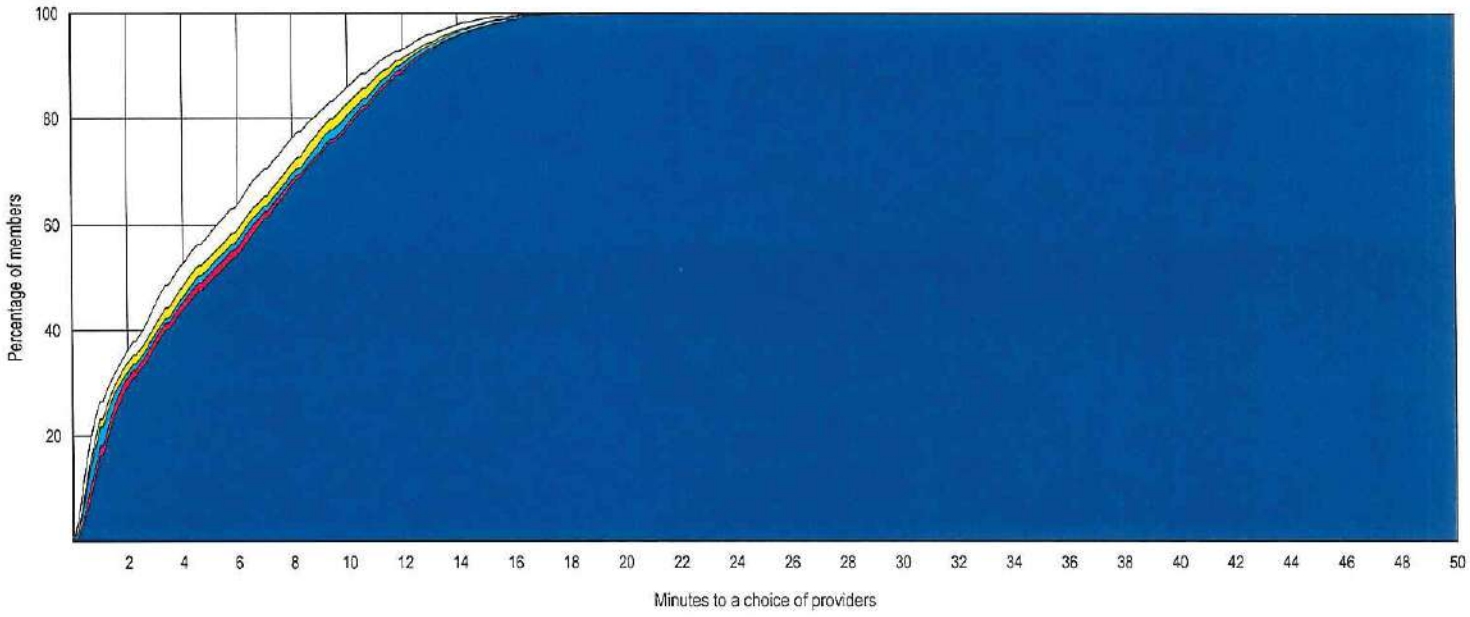

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Provider Locations

January 23, 2020

Region 5 Behavioral Health and Substance Abuse Providers

Total Providers: 586

d All providers

Interstates

US Highways

State Highways

17.44 miles

Region 5 Behavioral Health and Substance Abuse Providers

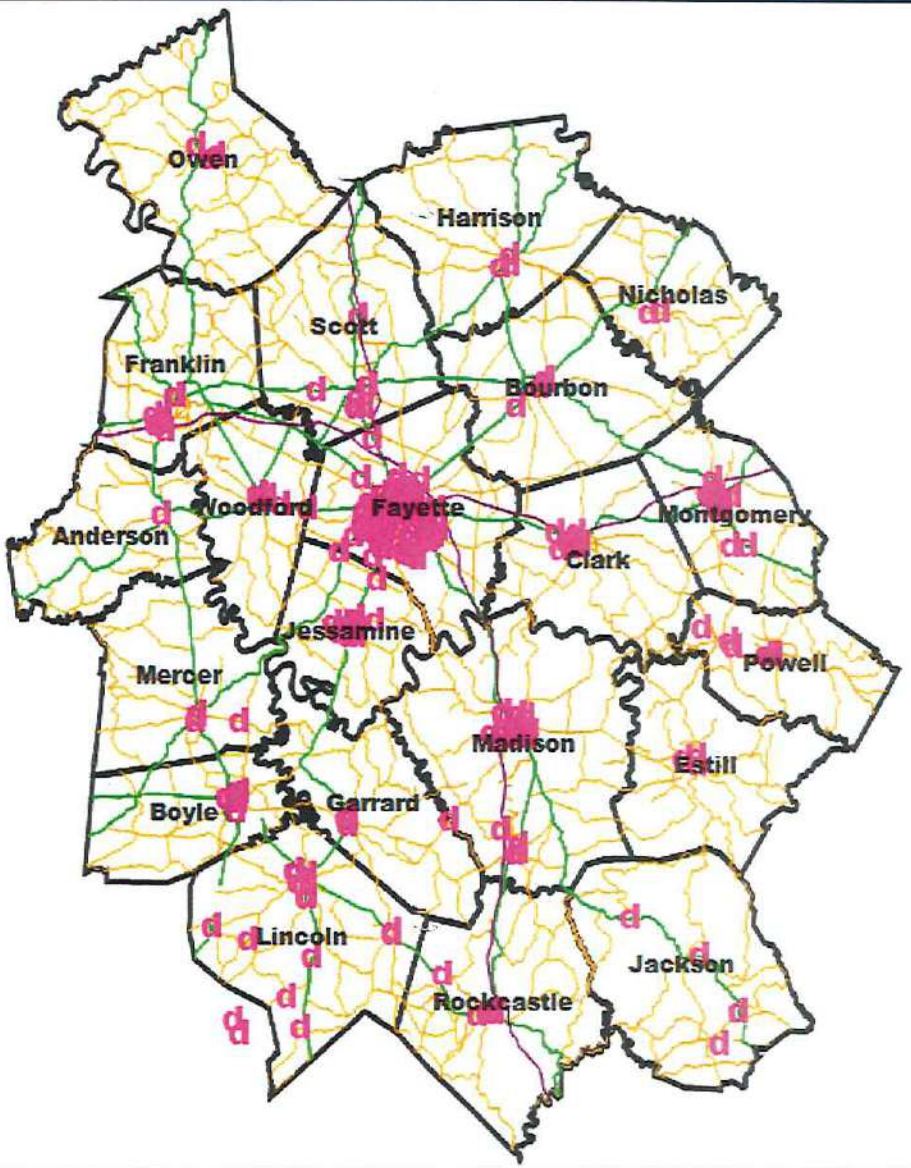

586 providers at 271 locations

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Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 miles

Overall Access[1]

22,712 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

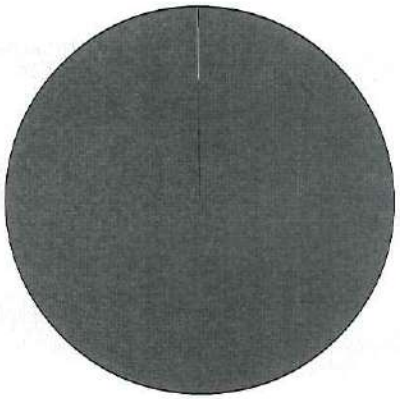

Distances

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

Access Standard Comparison

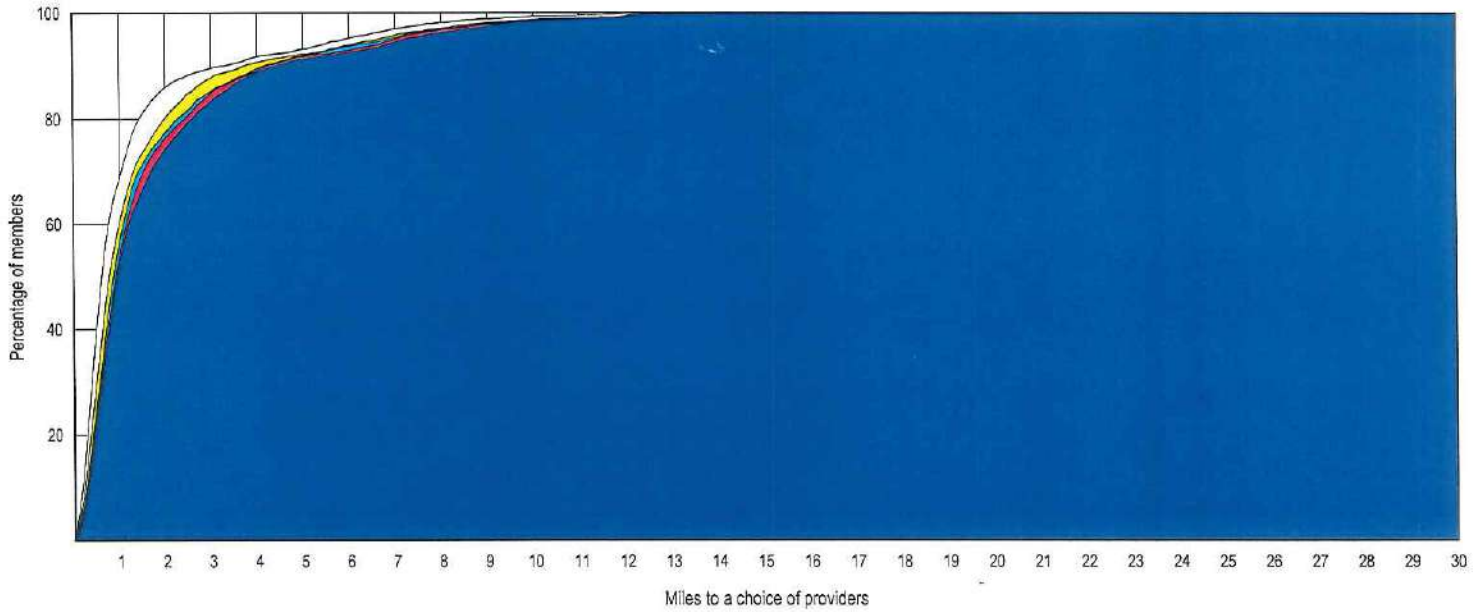

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 minutes

Overall Access[1]

22,712 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 22,696 (99.9%) Members with access
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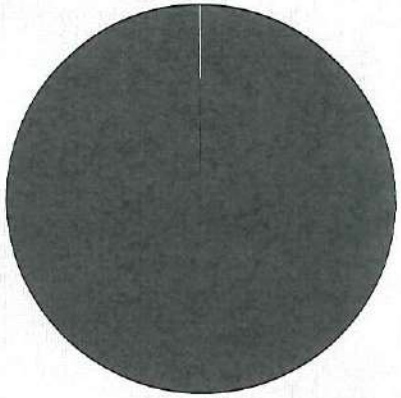

Times

	Average
Time to 1st closest provider	1.6 mins
Time to 2nd closest provider	1.9 mins
Time to 3rd closest provider	2.1 mins
Time to 4th closest provider	2.2 mins
Time to 5th closest provider	2.3 mins

Access Standard Comparison

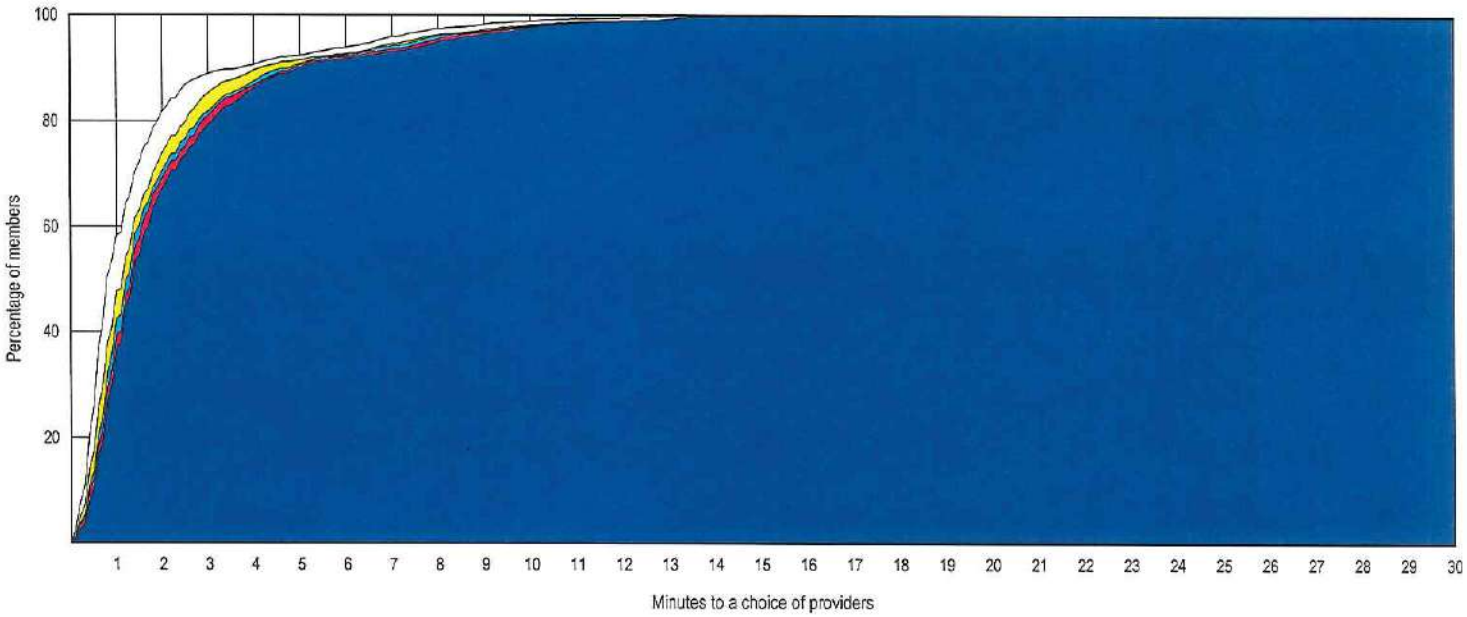

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Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 miles

Overall Access[1]

23,127 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

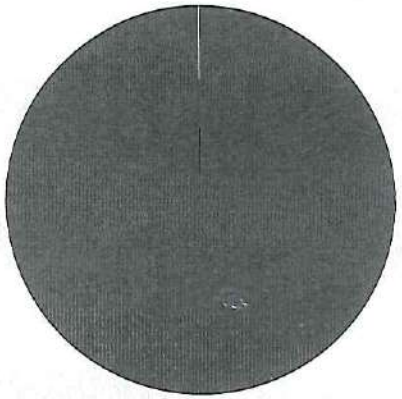

Distances

	Average
Distance to 1st closest provider	3.3 miles
Distance to 2nd closest provider	3.4 miles
Distance to 3rd closest provider	3.7 miles
Distance to 4th closest provider	4.2 miles
Distance to 5th closest provider	4.5 miles

Access Standard Comparison

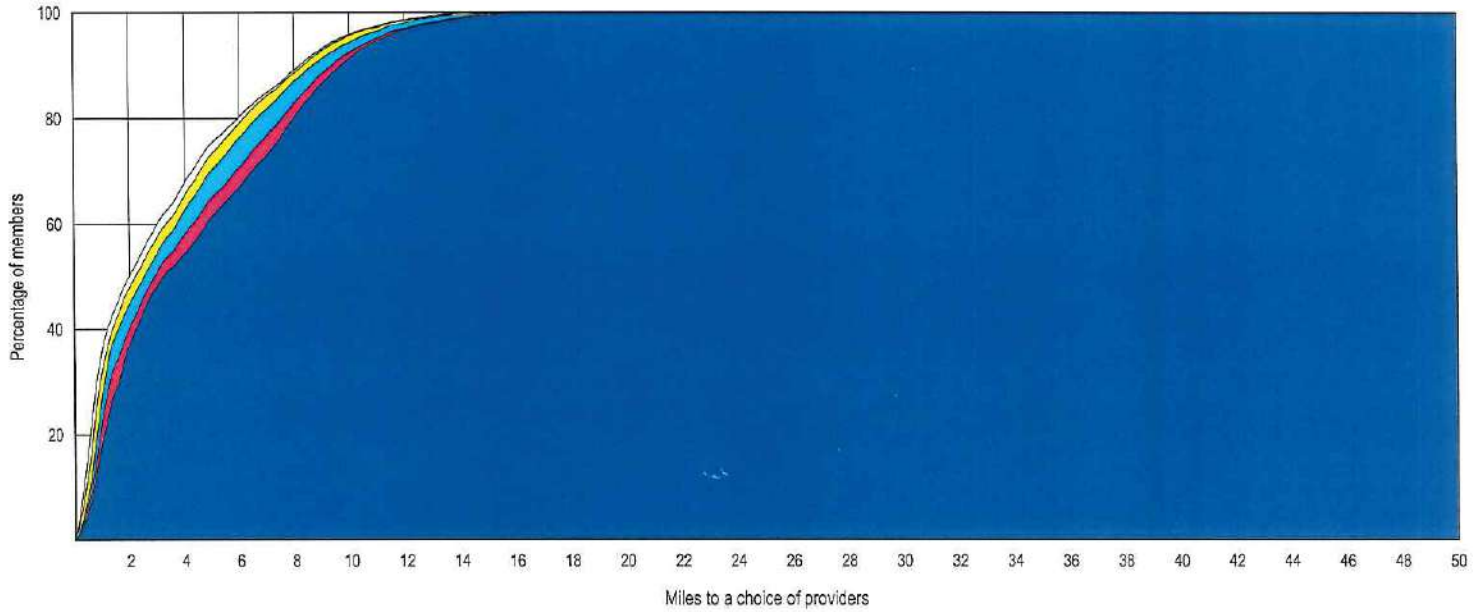

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 minutes

Overall Access[1]

23,127 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

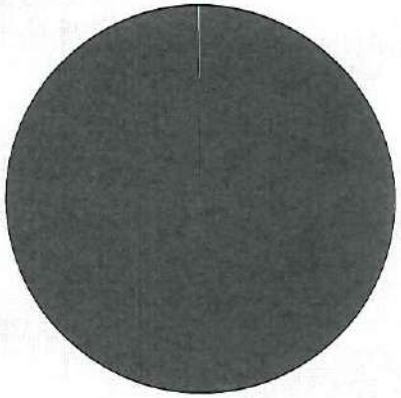

Times

	Average
Time to 1st closest provider	3.5 mins
Time to 2nd closest provider	3.7 mins
Time to 3rd closest provider	4.0 mins
Time to 4th closest provider	4.5 mins
Time to 5th closest provider	4.9 mins

Access Standard Comparison

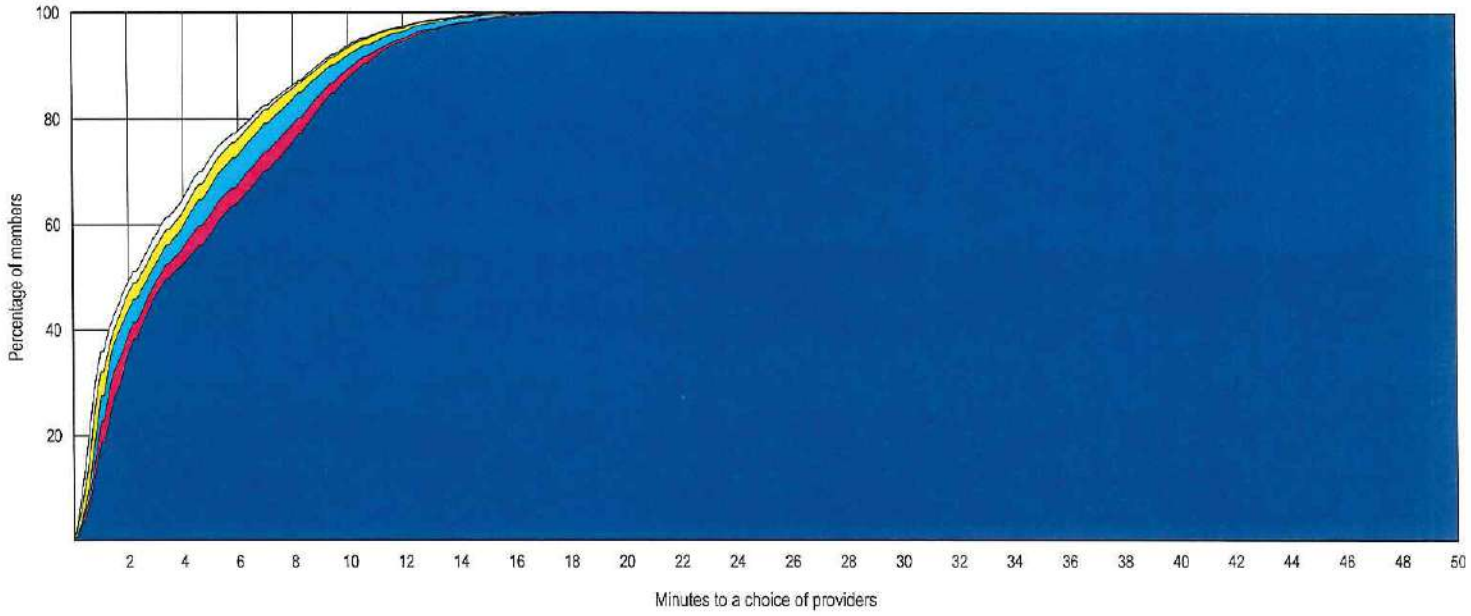

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Provider Locations

January 23, 2020

Region 6 Behavioral Health and Substance Abuse Providers

Total Providers: 199

d All providers

Interstates

US Highways

State Highways

7.48 miles

Region 6 Behavioral Health and Substance Abuse Providers

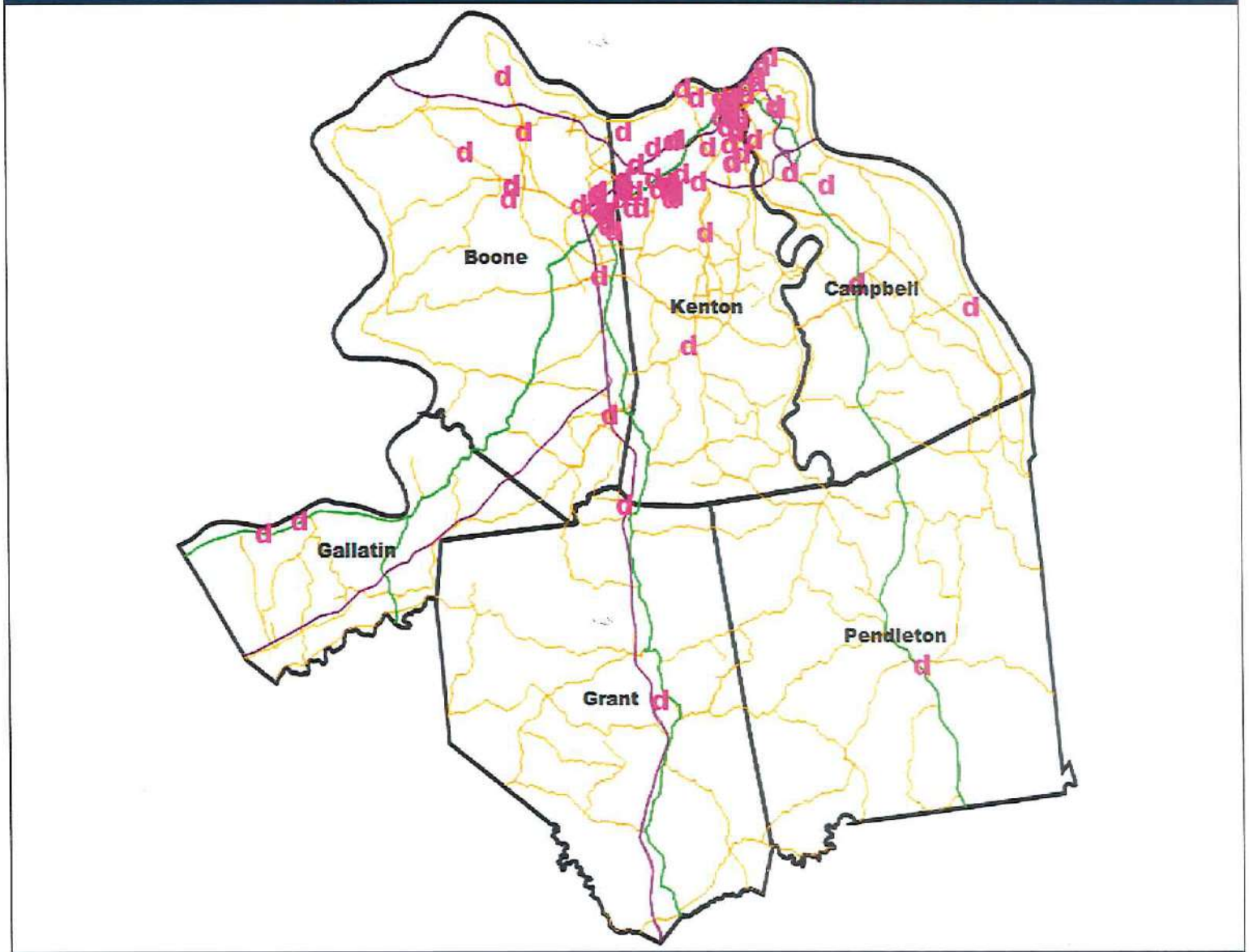

199 providers at 85 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 miles

Overall Access[1]

22,413 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

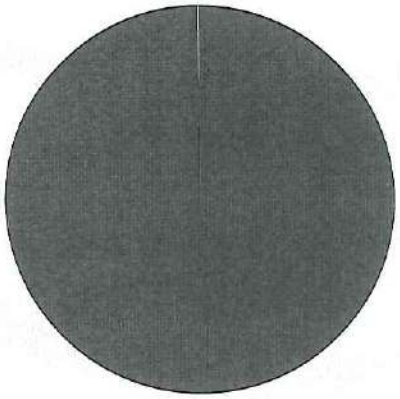

Distances

	Average
Distance to 1st closest provider	1.9 miles
Distance to 2nd closest provider	2.1 miles
Distance to 3rd closest provider	2.3 miles
Distance to 4th closest provider	2.5 miles
Distance to 5th closest provider	2.6 miles

Access Standard Comparison

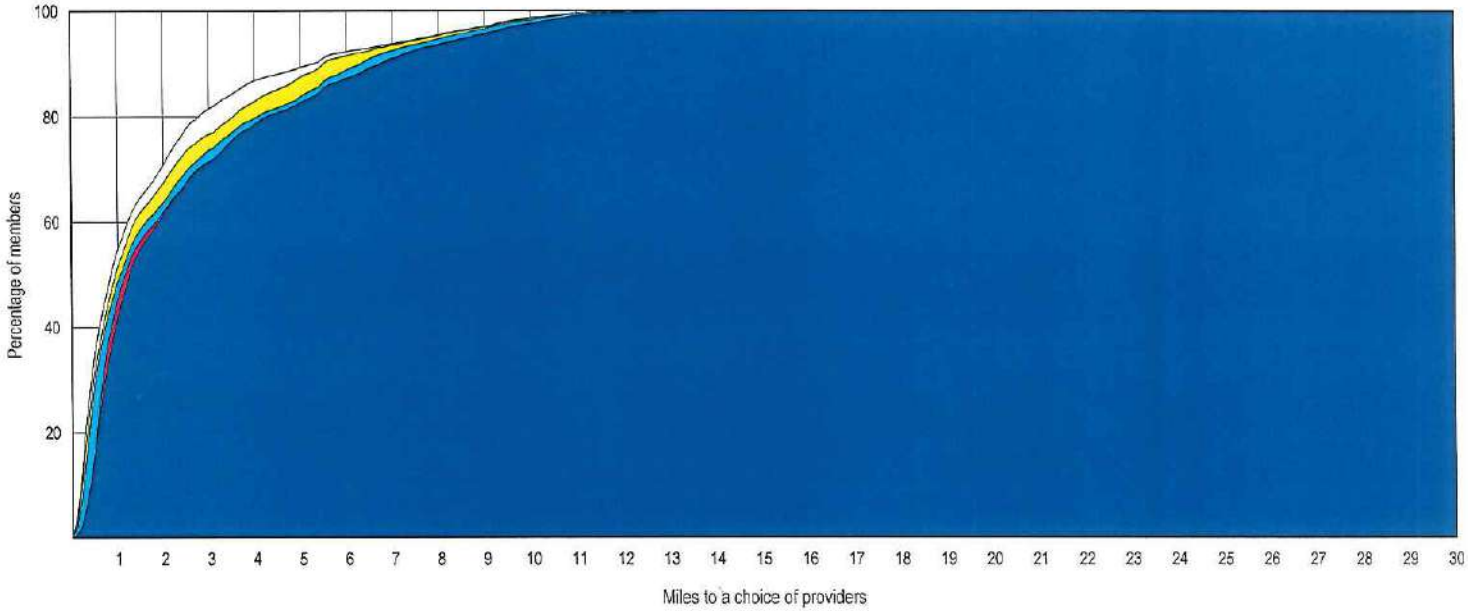

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 minutes

Overall Access[1]

22,413 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

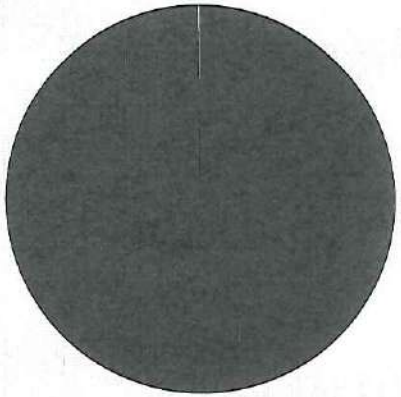

Times

	Average
Time to 1st closest provider	2.2 mins
Time to 2nd closest provider	2.4 mins
Time to 3rd closest provider	2.7 mins
Time to 4th closest provider	2.9 mins
Time to 5th closest provider	3.0 mins

Access Standard Comparison

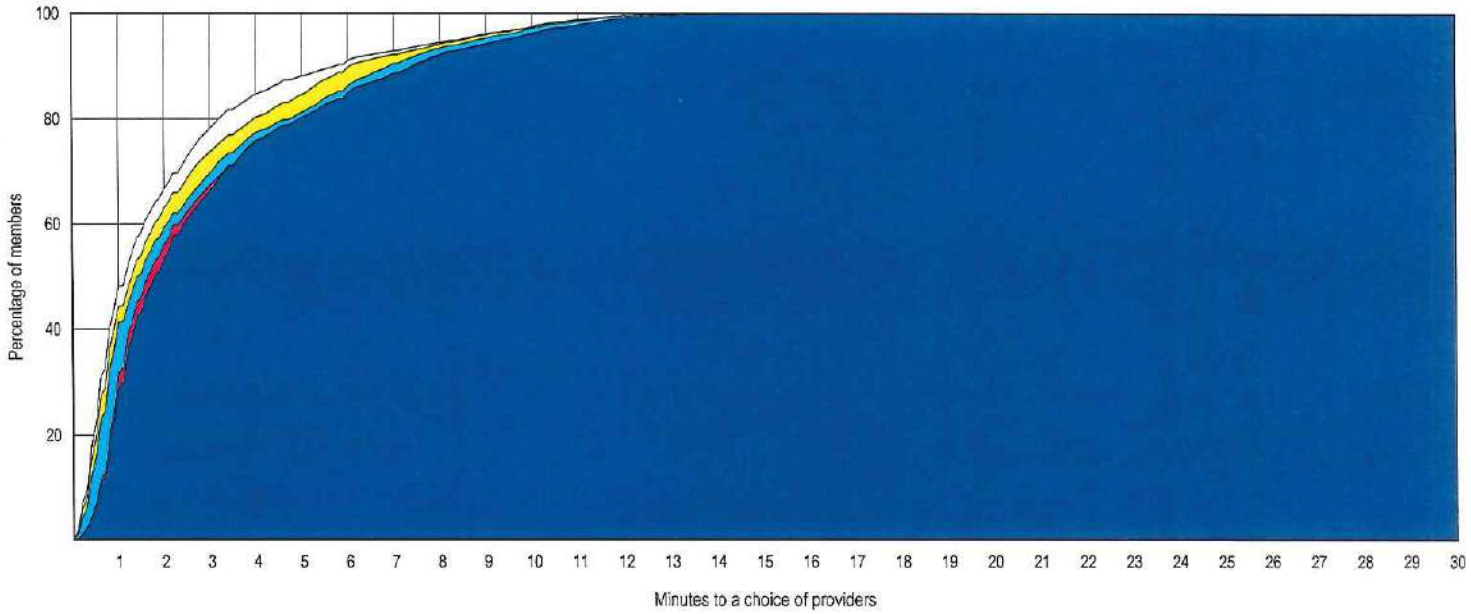

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Provider Locations

January 23, 2020

Region 7 Behavioral Health and Substance Abuse Providers

Total Providers: 234

d All providers

Interstates

US Highways

State Highways

12.36 miles

Region 7 Behavioral Health and Substance Abuse Providers

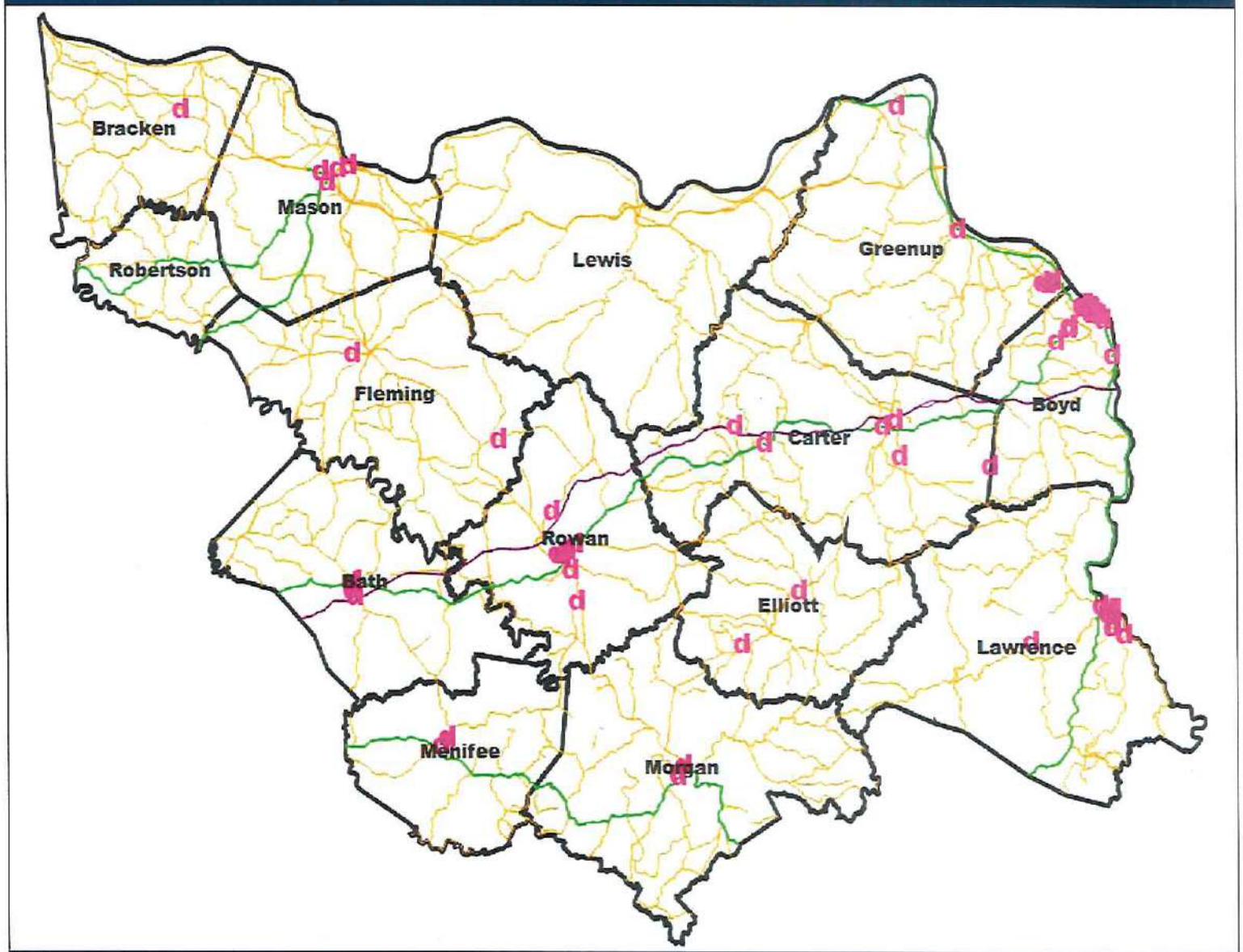

234 providers at 84 locations

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Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 miles

Overall Access[1]

2,907 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

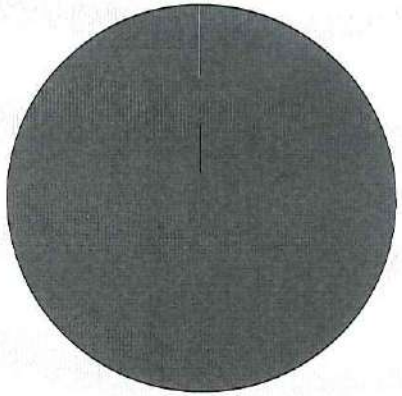

Distances

	Average
Distance to 1st closest provider	4.1 miles
Distance to 2nd closest provider	6.6 miles
Distance to 3rd closest provider	6.7 miles
Distance to 4th closest provider	6.9 miles
Distance to 5th closest provider	7.0 miles

Access Standard Comparison

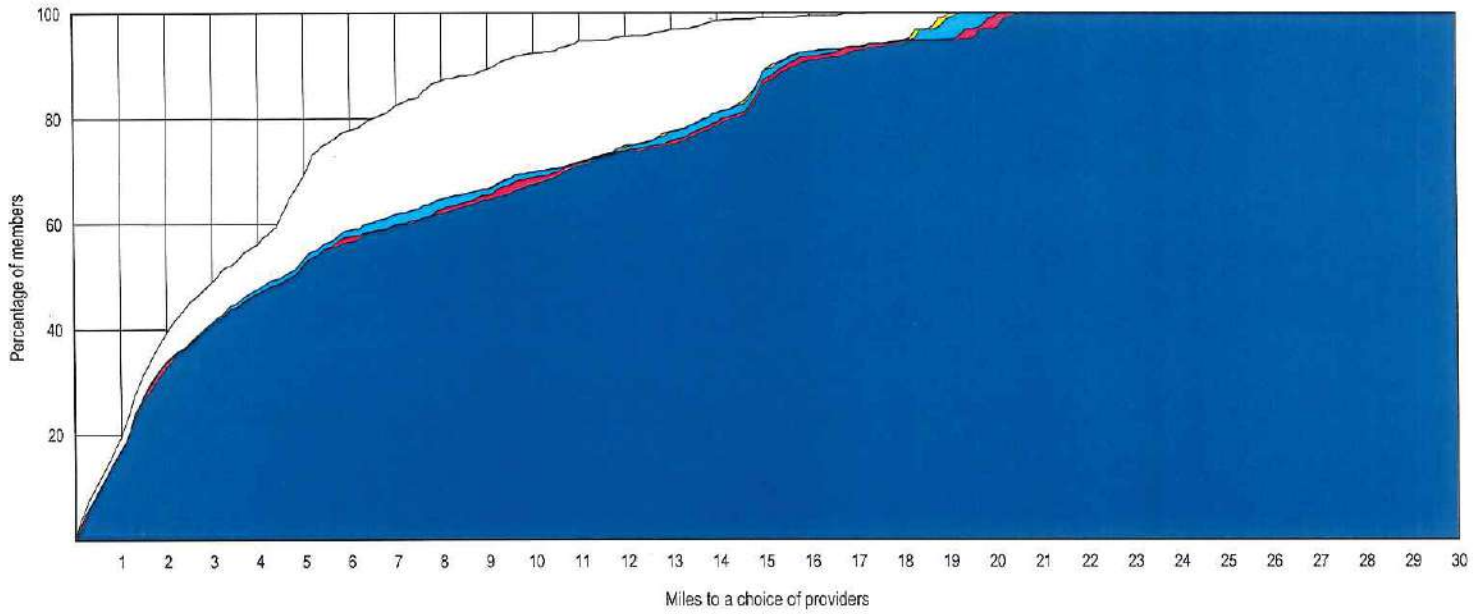

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 30 minutes

Overall Access[1]

2,907 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

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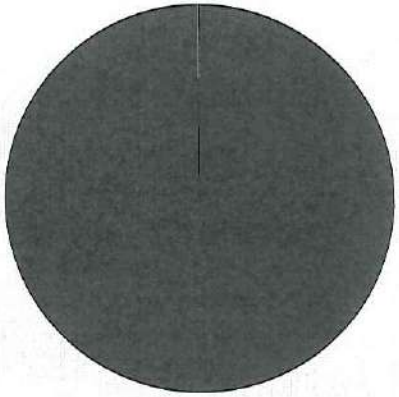

Times

	Average
Time to 1st closest provider	4.4 mins
Time to 2nd closest provider	7.2 mins
Time to 3rd closest provider	7.3 mins
Time to 4th closest provider	7.5 mins
Time to 5th closest provider	7.6 mins

Access Standard Comparison

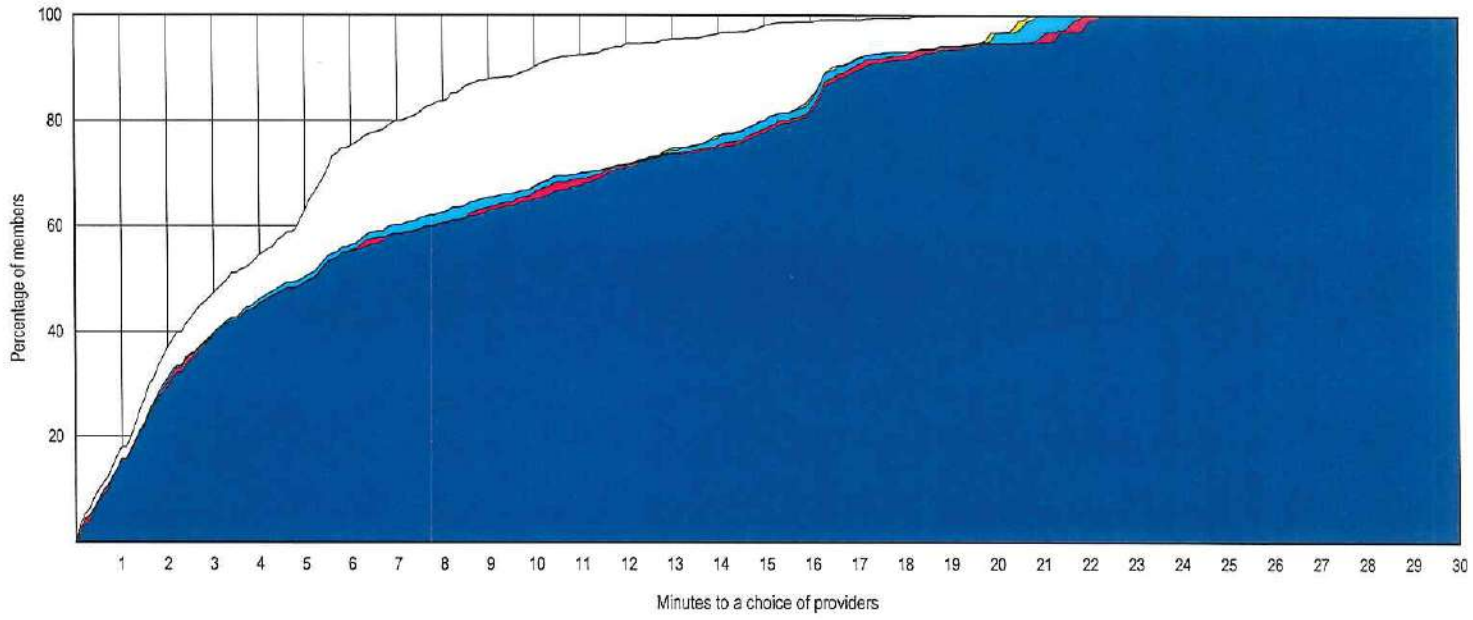

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Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 miles

Overall Access[1]

10,408 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

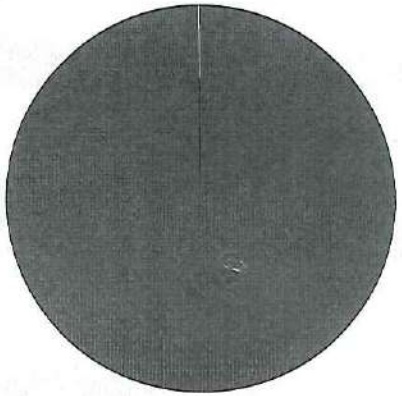

Distances

	Average
Distance to 1st closest provider	6.7 miles
Distance to 2nd closest provider	8.0 miles
Distance to 3rd closest provider	8.2 miles
Distance to 4th closest provider	8.4 miles
Distance to 5th closest provider	8.8 miles

Access Standard Comparison

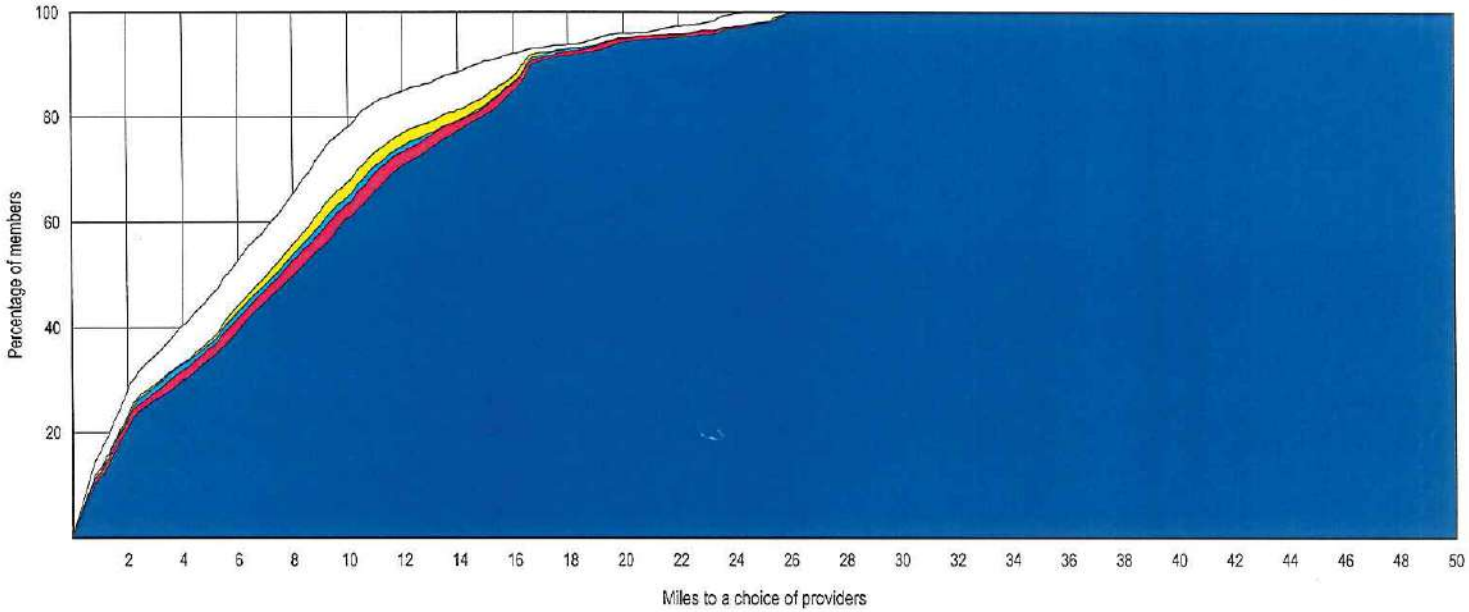

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Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 minutes

Member / Provider Groups
Region 7 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 minutes

Overall Access[1]

10,408 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

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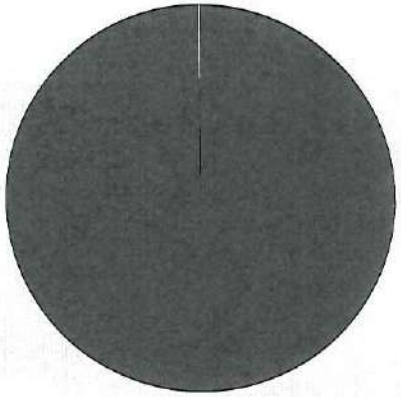

Times

	Average
Time to 1st closest provider	7.2 mins
Time to 2nd closest provider	8.7 mins
Time to 3rd closest provider	8.9 mins
Time to 4th closest provider	9.1 mins
Time to 5th closest provider	9.6 mins

Access Standard Comparison

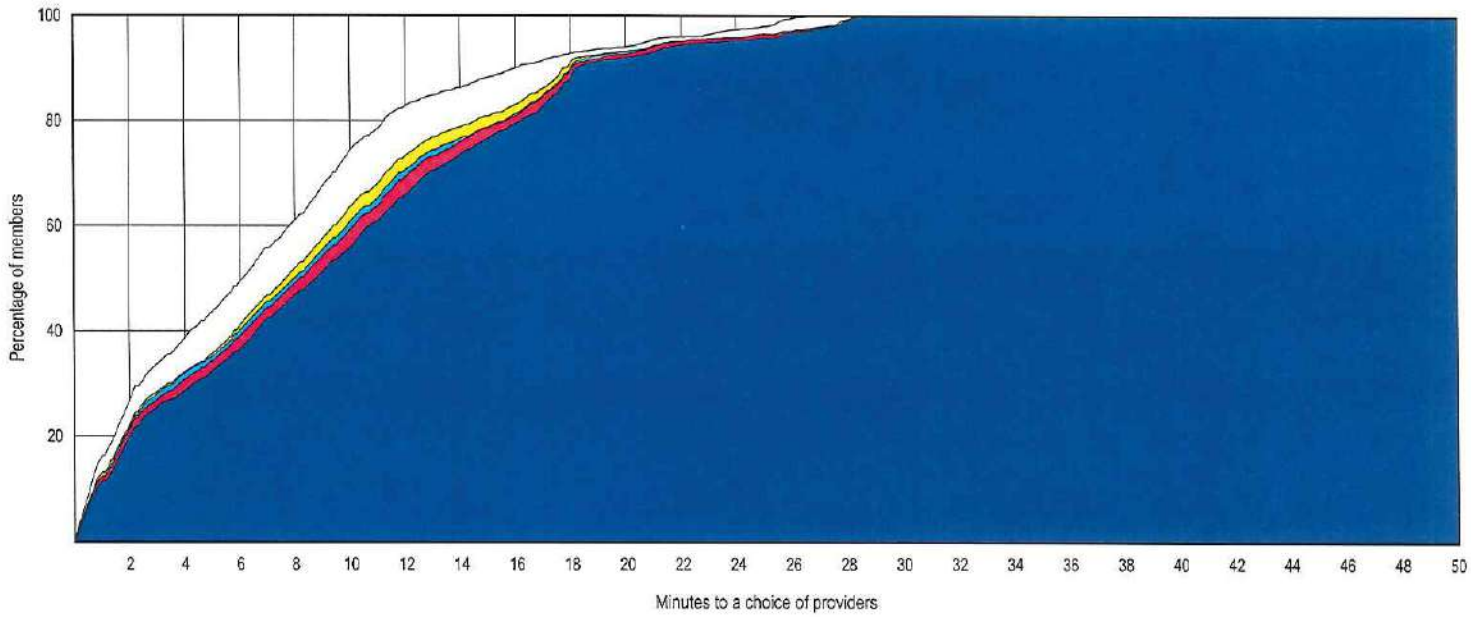

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Provider Locations

January 23, 2020

Region 8 Behavioral Health and Substance Abuse Providers

Total Providers: 355

d All providers

Interstates

US Highways

State Highways

16.38 miles

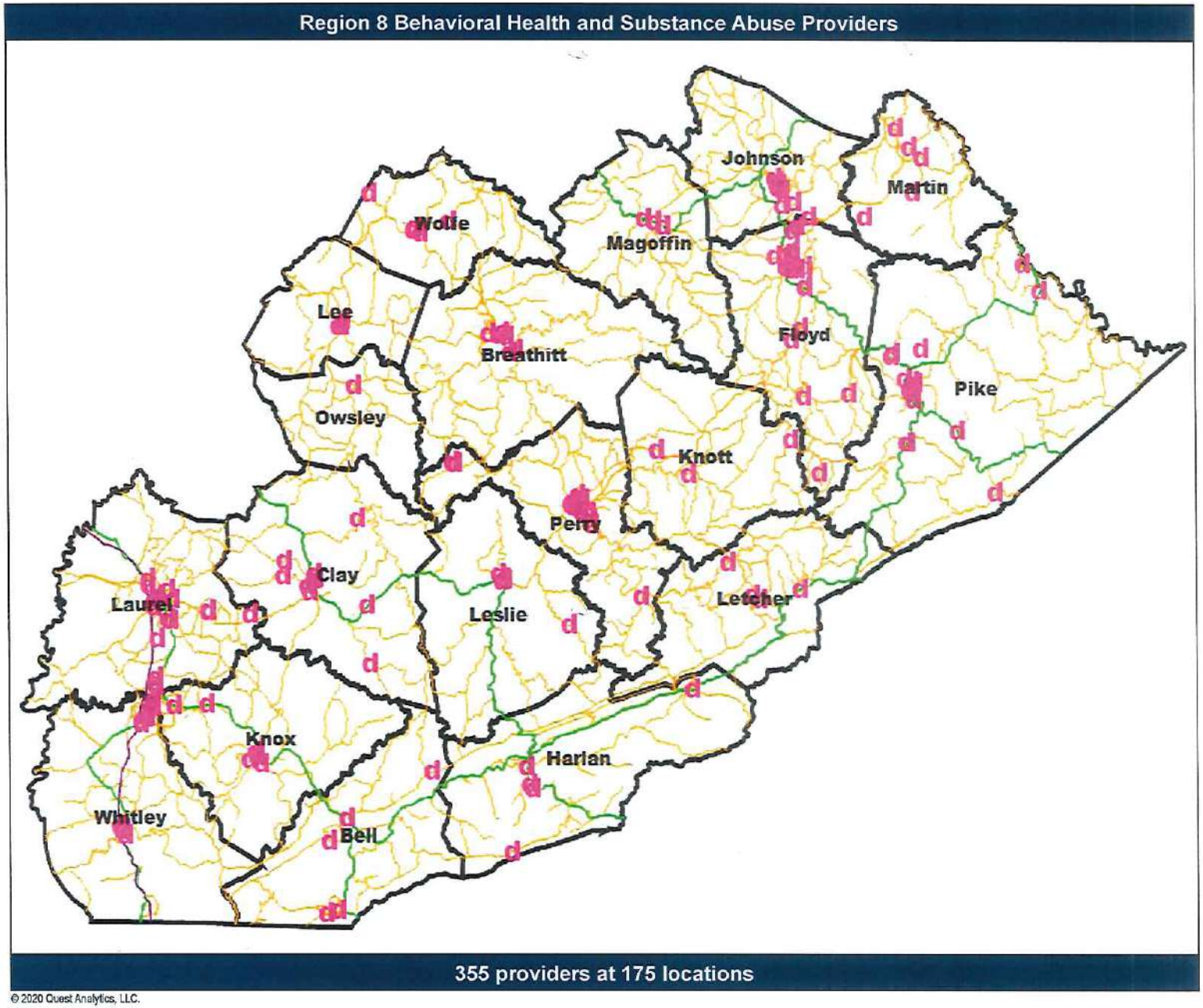

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Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 miles

Overall Access[1]

31,600 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

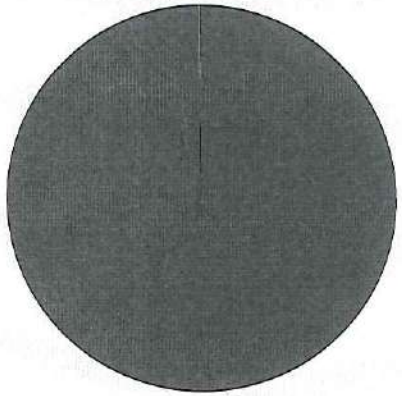

Times

	Average
Distance to 1st closest provider	4.2 miles
Distance to 2nd closest provider	4.8 miles
Distance to 3rd closest provider	5.0 miles
Distance to 4th closest provider	5.3 miles
Distance to 5th closest provider	5.5 miles

Access Standard Comparison

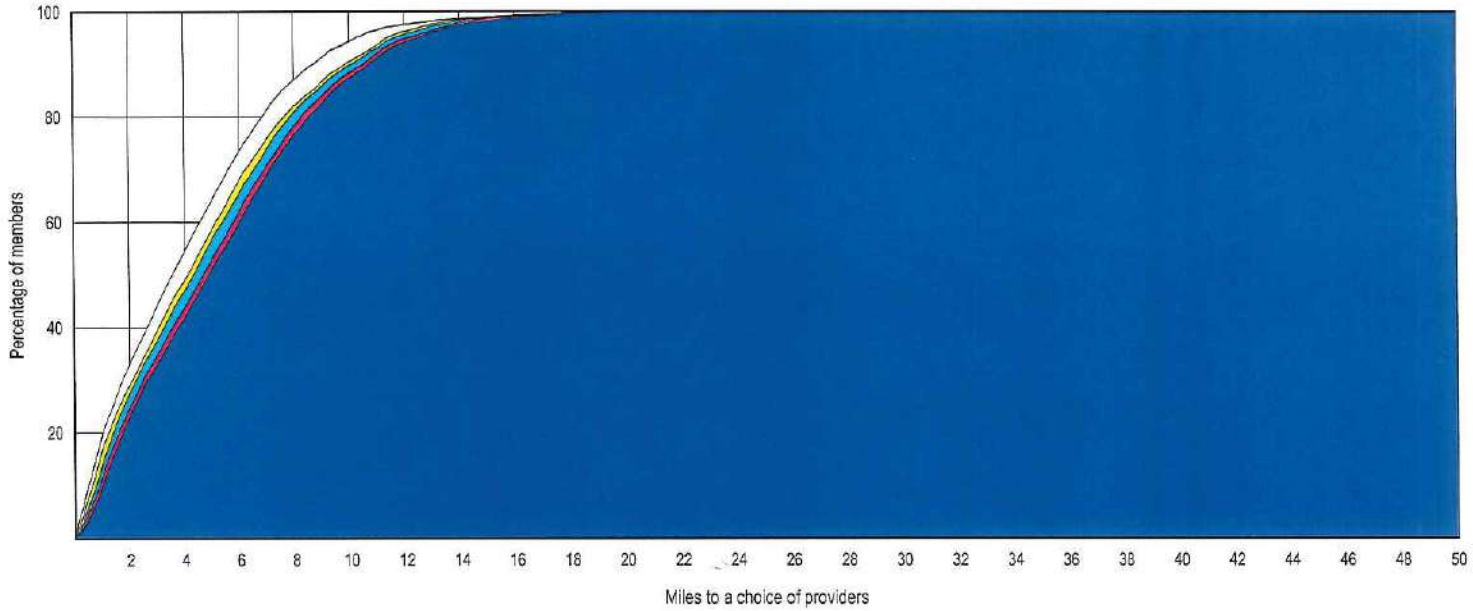

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Behavioral Health and Substance Abuse Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Behavioral Health and Substance Abuse Providers) provider in 50 minutes

Overall Access[1]

31,600 Members
2,547 providers at 1,351 locations (Behavioral Health and Substance Abuse Providers)

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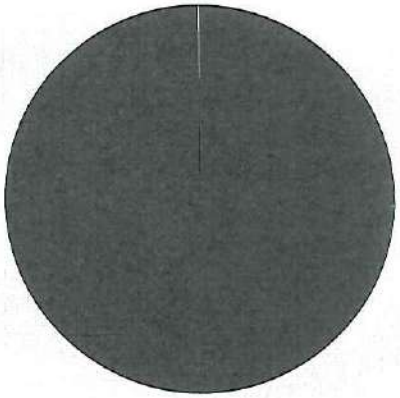

Times

	Average
Time to 1st closest provider	4.6 mins
Time to 2nd closest provider	5.2 mins
Time to 3rd closest provider	5.4 mins
Time to 4th closest provider	5.7 mins
Time to 5th closest provider	5.9 mins

Access Standard Comparison

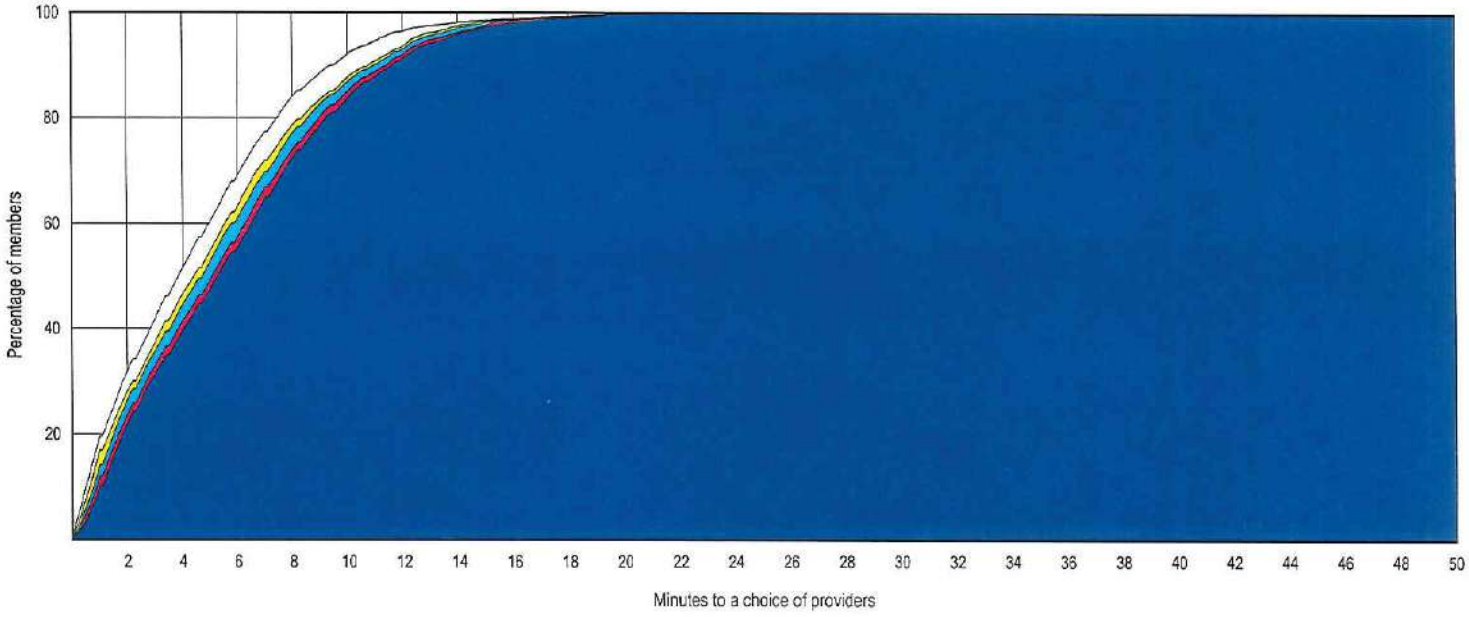

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Provider Locations

January 23, 2020

Region 1 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Total Providers: 14

e All providers

Interstates

US Highways

State Highways

12.93 miles

Region 1 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

14 providers at 16 locations

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Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 miles

Overall Access[1]

11,338 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

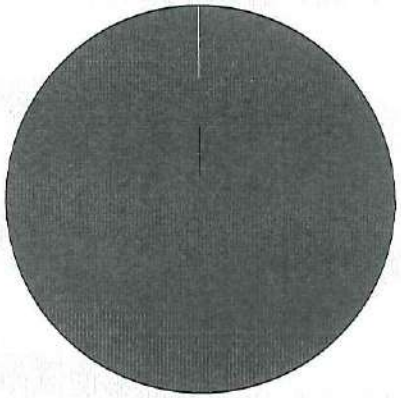

Times

	Average
Distance to 1st closest provider	7.3 miles
Distance to 2nd closest provider	9.5 miles
Distance to 3rd closest provider	15.7 miles
Distance to 4th closest provider	17.8 miles
Distance to 5th closest provider	19.3 miles

Access Standard Comparison

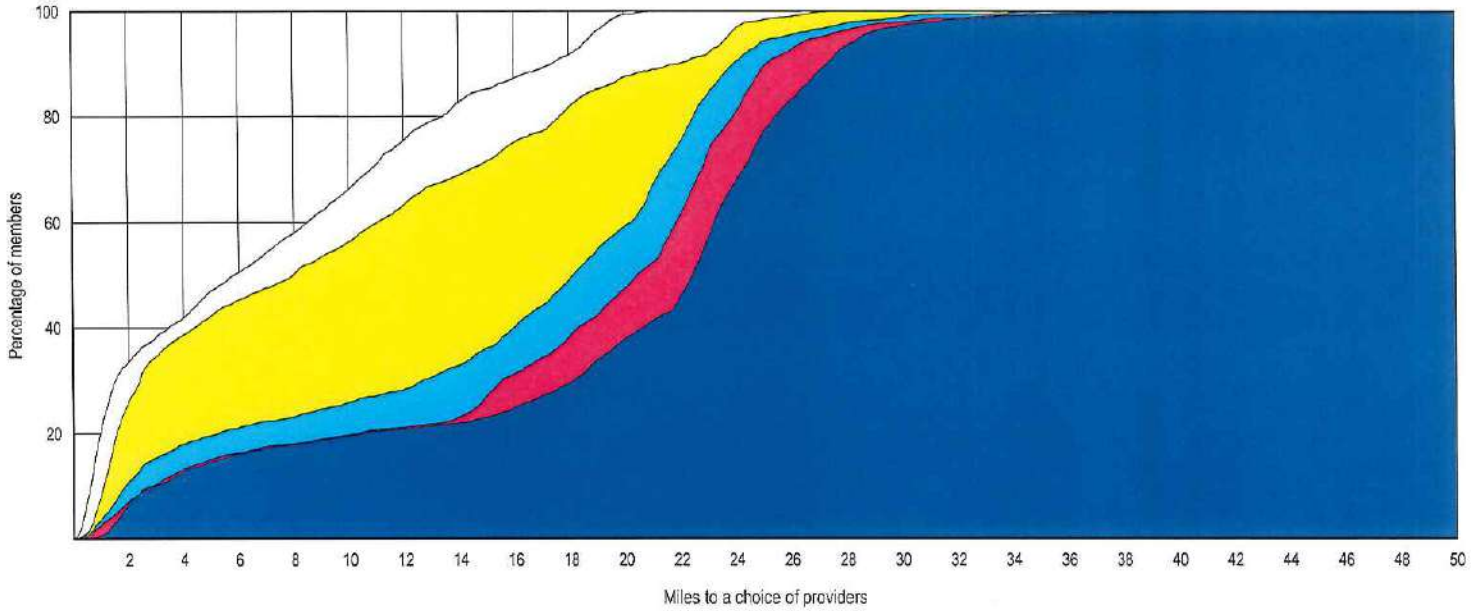

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis

Region 1 Rural - 1 in 50 minutes

Member / Provider Groups

Region 1 Rural Members

Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph

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

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

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:

1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 minutes

Overall Access[1]

11,338 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

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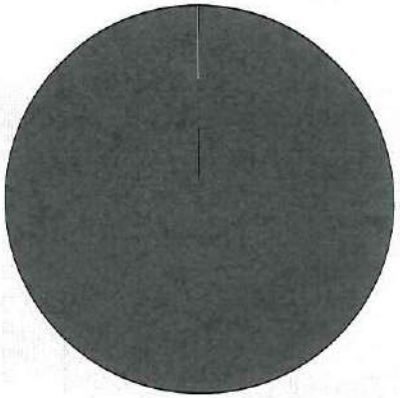

Times

	Average
Time to 1st closest provider	7.9 mins
Time to 2nd closest provider	10.4 mins
Time to 3rd closest provider	17.1 mins
Time to 4th closest provider	19.4 mins
Time to 5th closest provider	21.0 mins

Access Standard Comparison

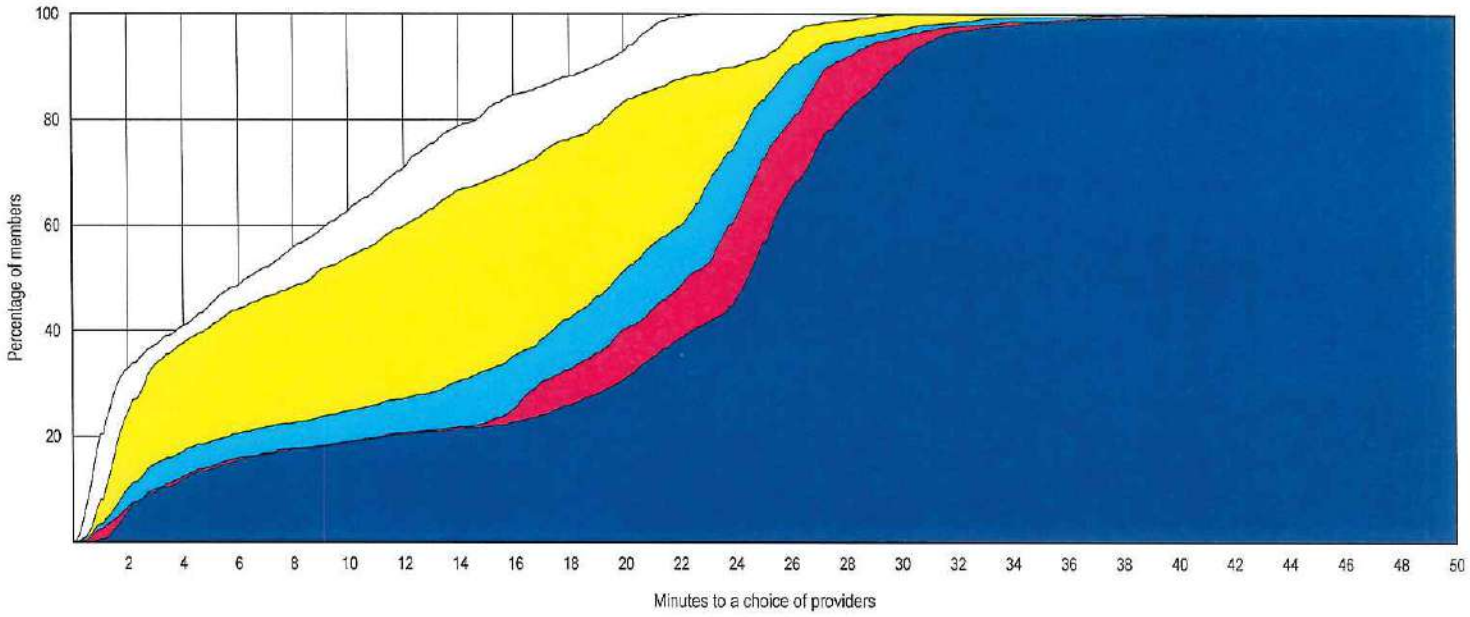

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Provider Locations

January 23, 2020

Region 2 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Total Providers: 48

e All providers

Interstates

US Highways

State Highways

15.14 miles

Region 2 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

48 providers at 28 locations

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Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 miles

Overall Access[1]

16,143 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

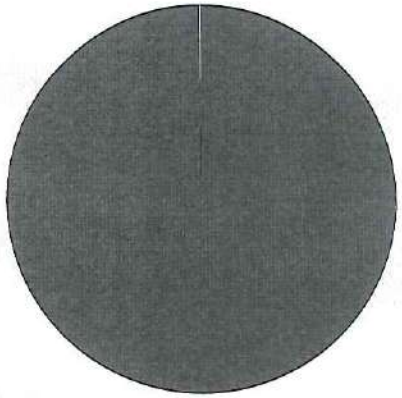

Distances

	Average
Distance to 1st closest provider	4.6 miles
Distance to 2nd closest provider	6.3 miles
Distance to 3rd closest provider	6.9 miles
Distance to 4th closest provider	7.2 miles
Distance to 5th closest provider	9.1 miles

Access Standard Comparison

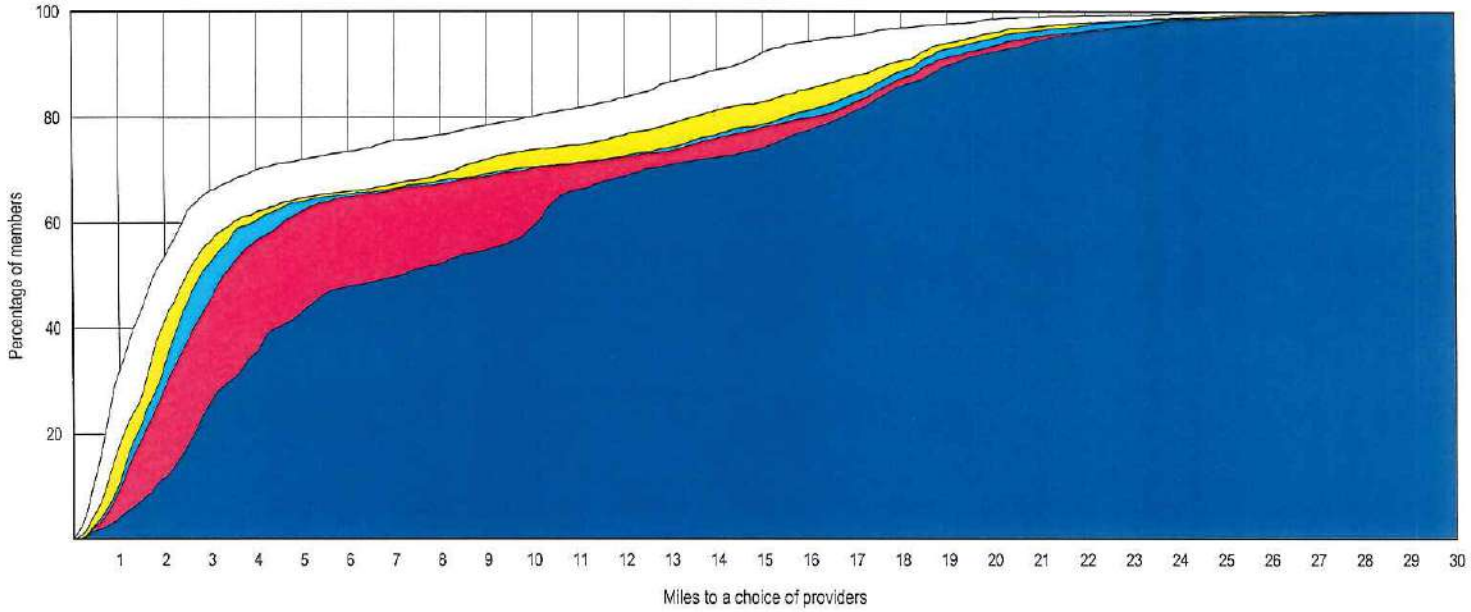

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 minutes

Overall Access[1]

16,143 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

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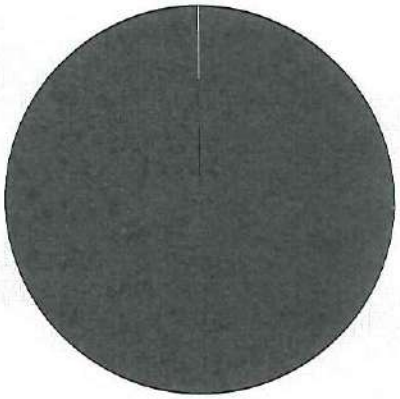

Times

	Average
Time to 1st closest provider	5.0 mins
Time to 2nd closest provider	6.8 mins
Time to 3rd closest provider	7.5 mins
Time to 4th closest provider	7.8 mins
Time to 5th closest provider	9.9 mins

Access Standard Comparison

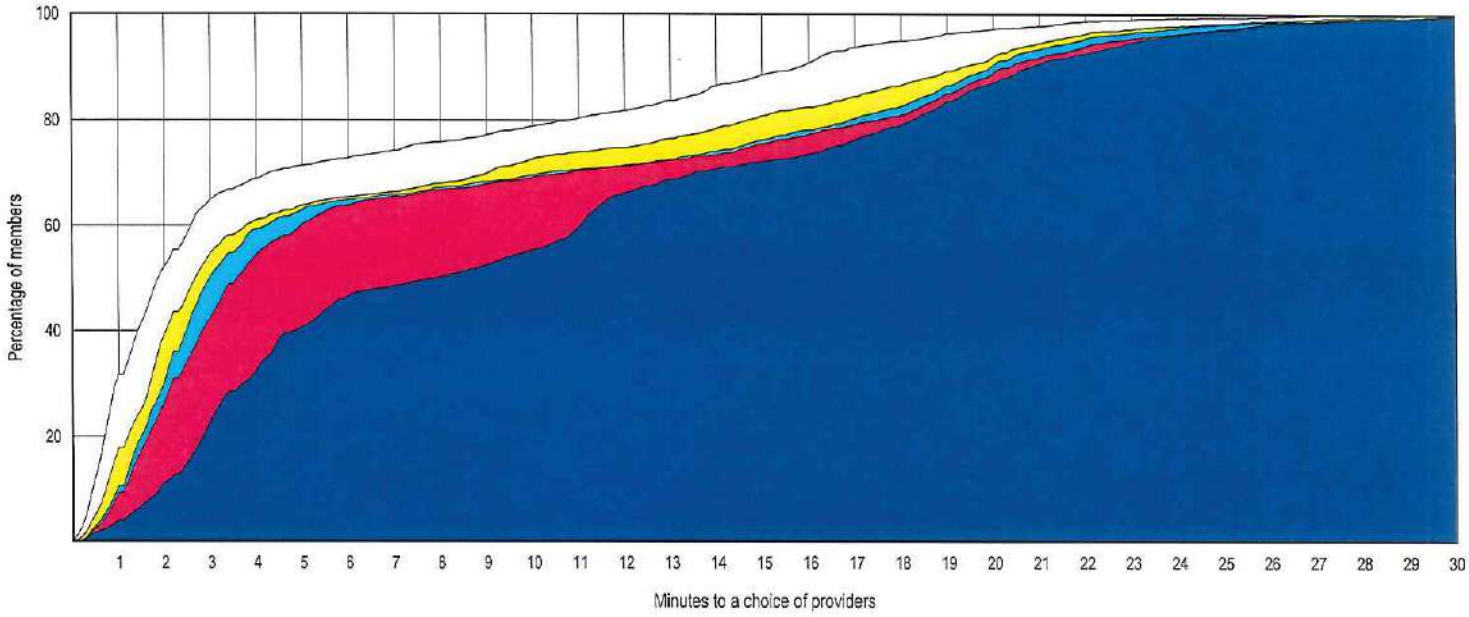

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 miles

Overall Access[1]

9,636 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

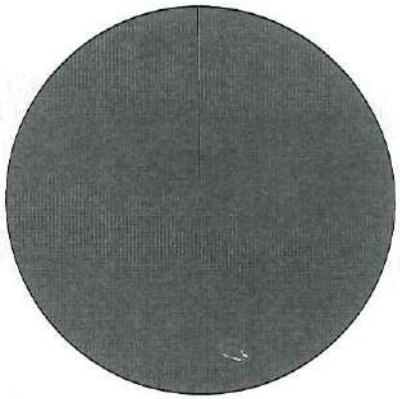

Distances

	Average
Distance to 1st closest provider	10.4 miles
Distance to 2nd closest provider	12.2 miles
Distance to 3rd closest provider	13.3 miles
Distance to 4th closest provider	17.4 miles
Distance to 5th closest provider	17.9 miles

Access Standard Comparison

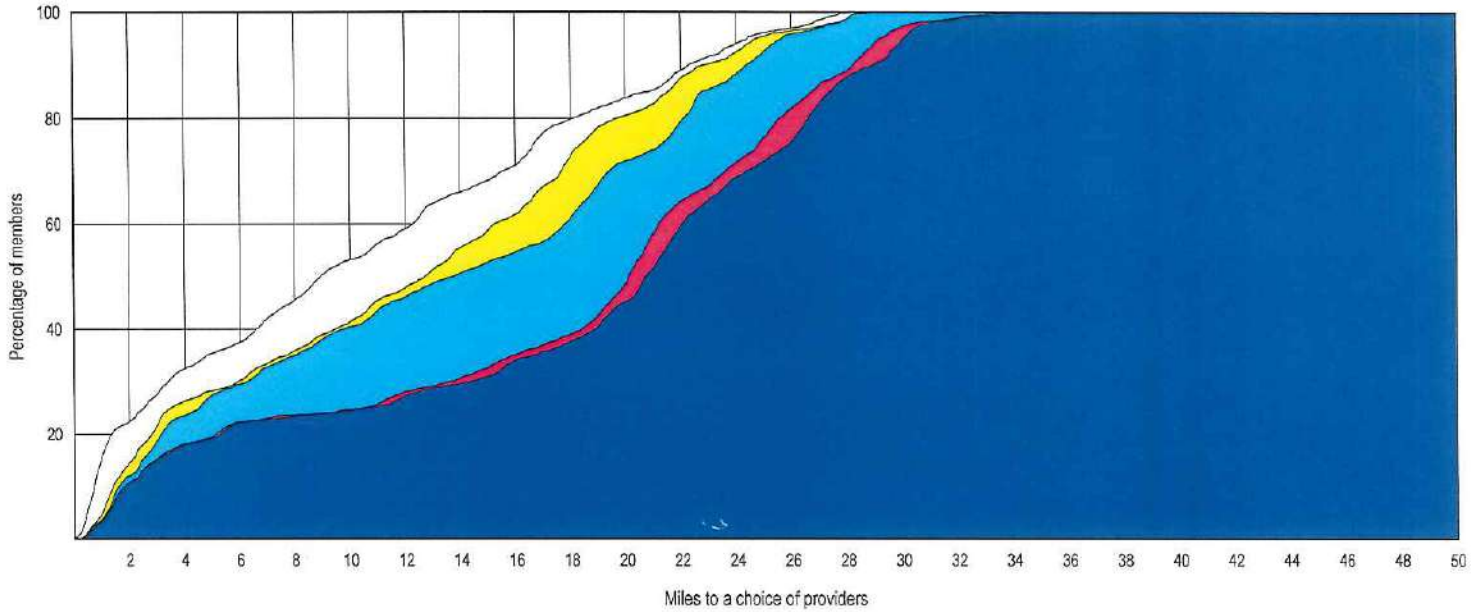

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 minutes

Overall Access[1]

9,636 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 9,628 (99.9%) Members with access
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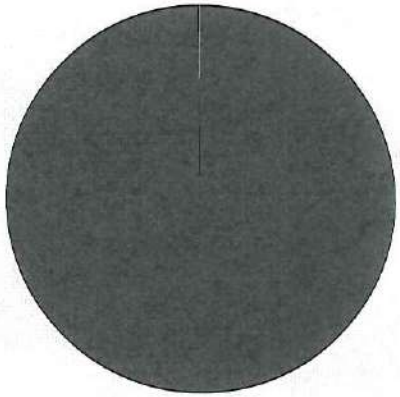

Times

	Average
Time to 1st closest provider	11.3 mins
Time to 2nd closest provider	13.3 mins
Time to 3rd closest provider	14.5 mins
Time to 4th closest provider	18.9 mins
Time to 5th closest provider	19.5 mins

Access Standard Comparison

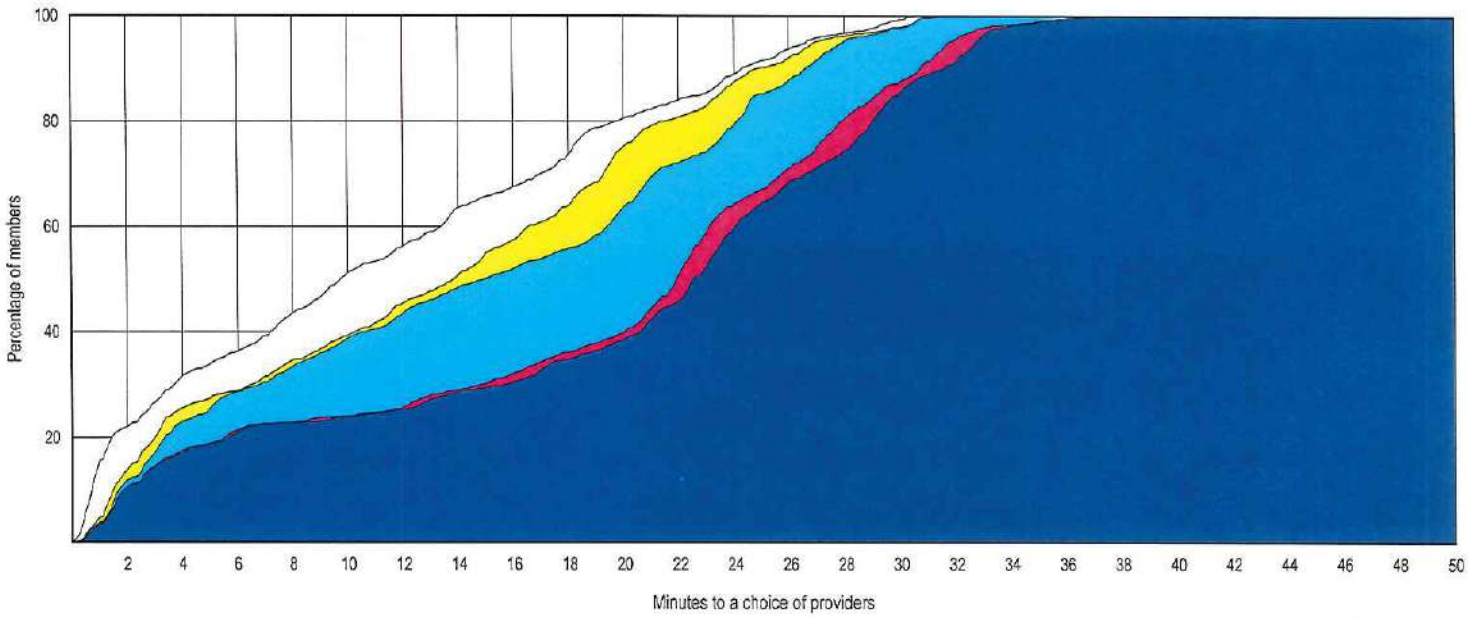

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Provider Locations

January 23, 2020

Region 3 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Total Providers: 168

e All providers

Interstates

US Highways

State Highways

15.97 miles

Region 3 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

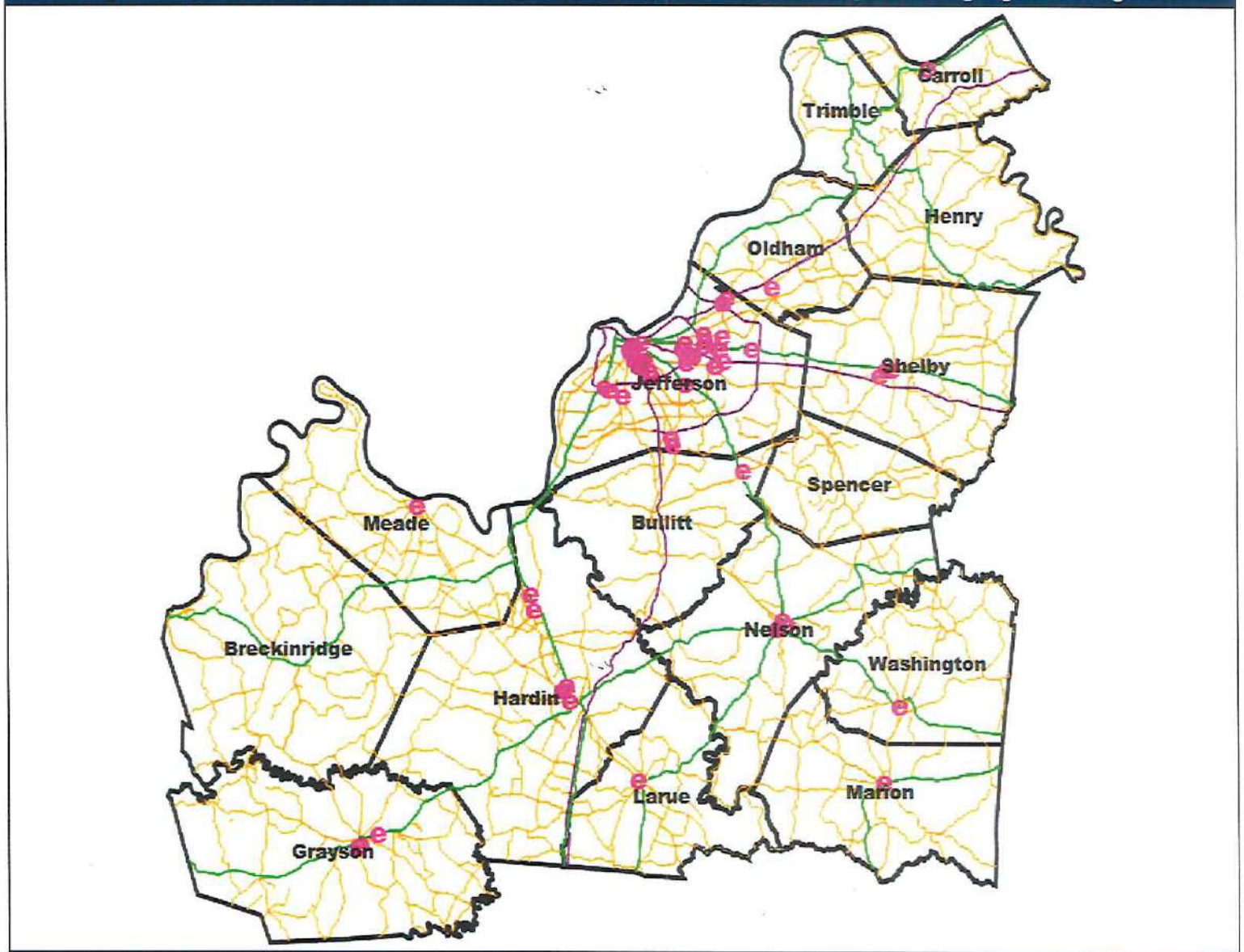

168 providers at 75 locations

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Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 miles

Overall Access[1]

18,130 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

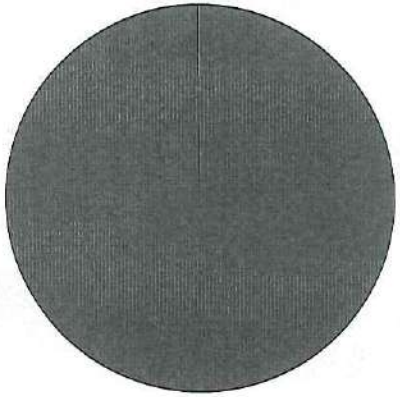

Distances

	Average
Distance to 1st closest provider	3.6 miles
Distance to 2nd closest provider	4.1 miles
Distance to 3rd closest provider	4.5 miles
Distance to 4th closest provider	5.0 miles
Distance to 5th closest provider	5.3 miles

Access Standard Comparison

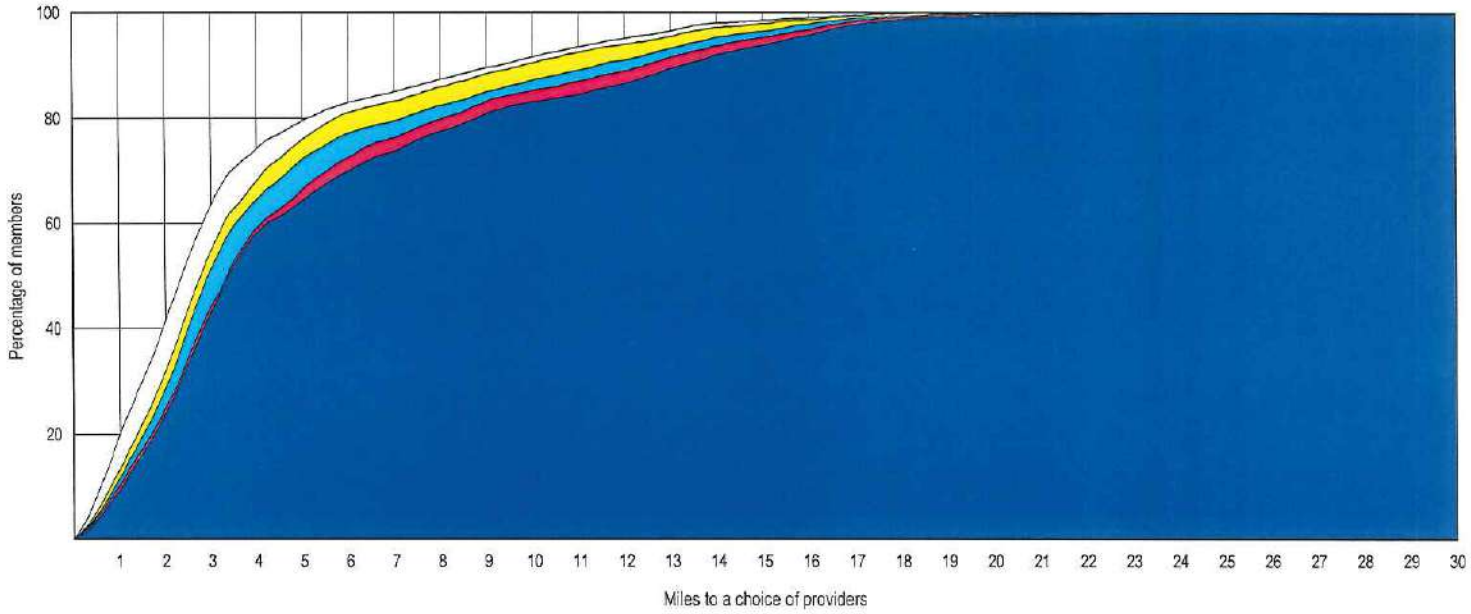

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Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 minutes

Overall Access[1]

18,130 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

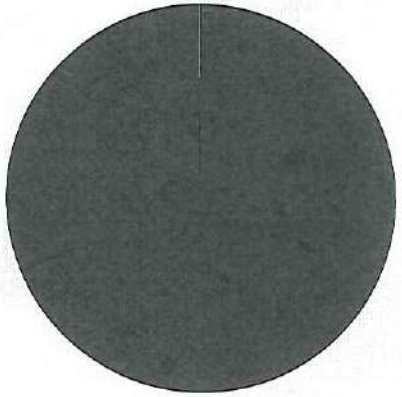

Times

	Average
Time to 1st closest provider	4.6 mins
Time to 2nd closest provider	5.4 mins
Time to 3rd closest provider	5.9 mins
Time to 4th closest provider	6.6 mins
Time to 5th closest provider	7.0 mins

Access Standard Comparison

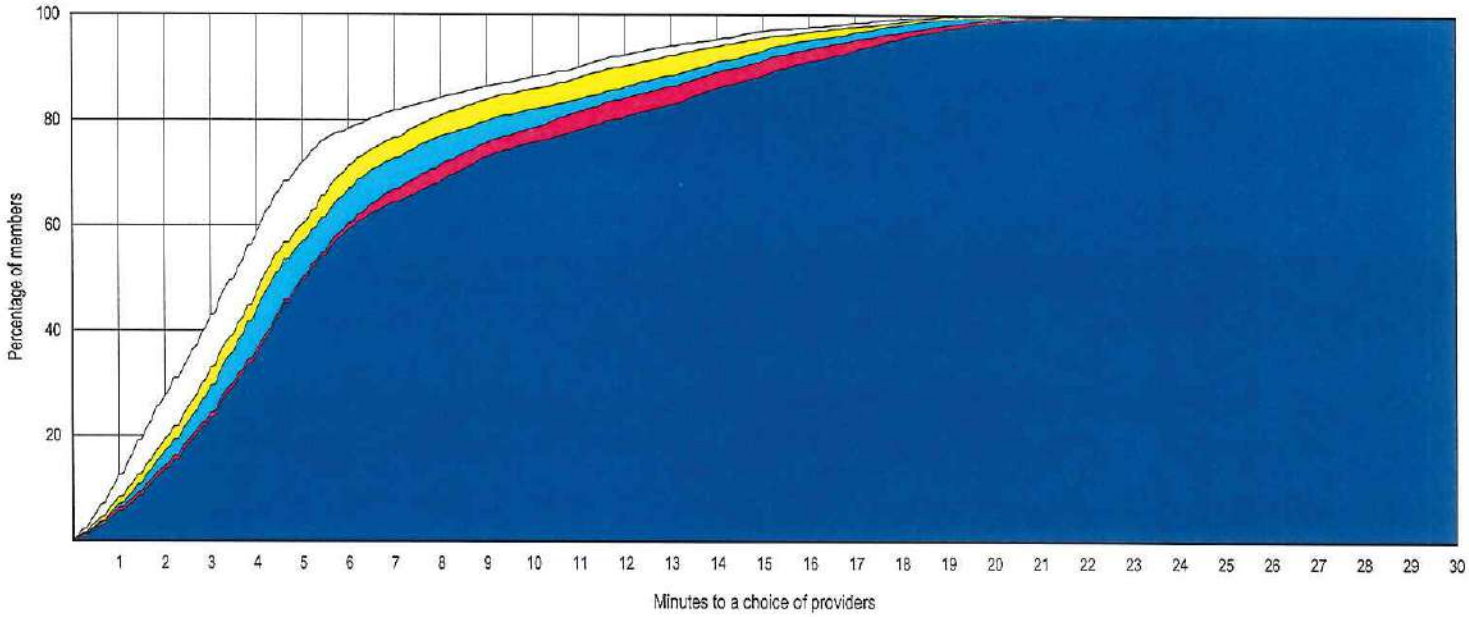

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 miles

Overall Access[1]

1,901 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

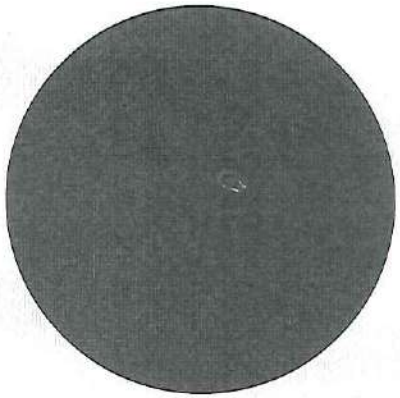

Distances

	Average
Distance to 1st closest provider	9.5 miles
Distance to 2nd closest provider	11.0 miles
Distance to 3rd closest provider	11.6 miles
Distance to 4th closest provider	13.3 miles
Distance to 5th closest provider	13.8 miles

Access Standard Comparison

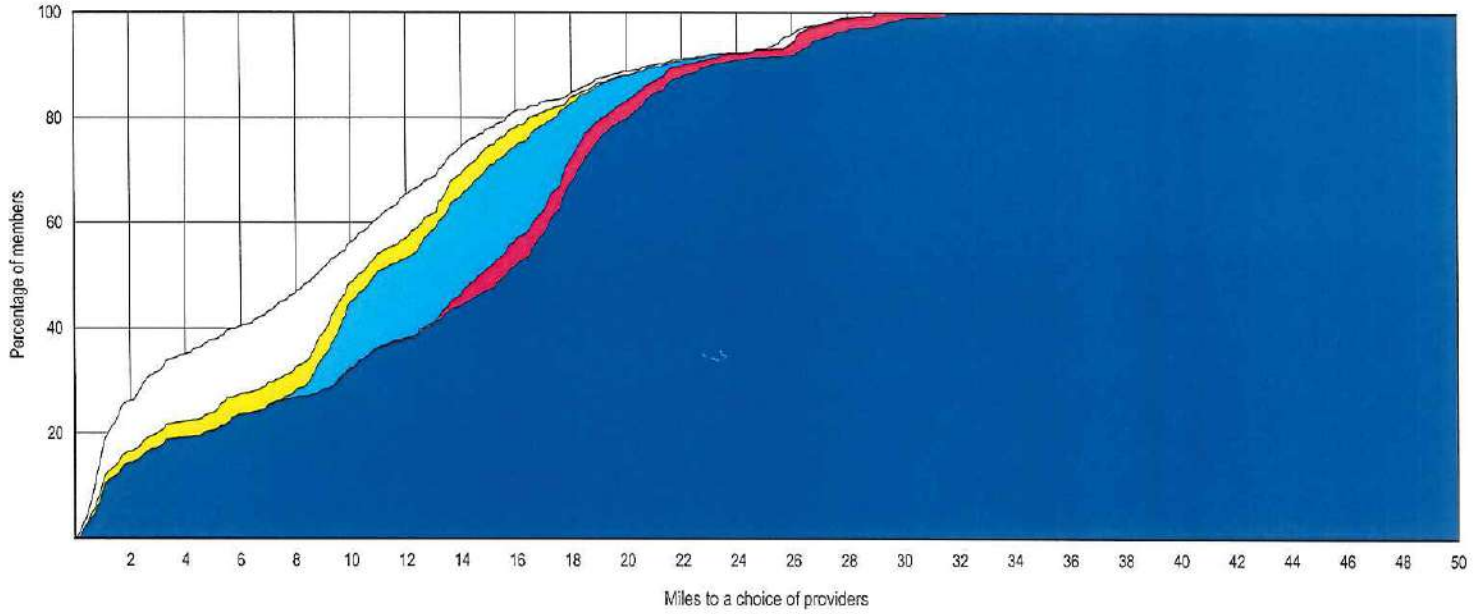

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 minutes

Overall Access[1]

1,901 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

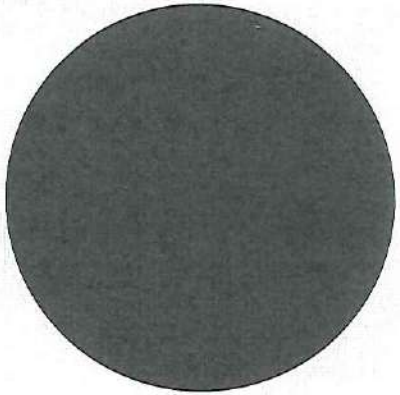

Times

	Average
Time to 1st closest provider	10.3 mins
Time to 2nd closest provider	12.0 mins
Time to 3rd closest provider	12.7 mins
Time to 4th closest provider	14.4 mins
Time to 5th closest provider	15.1 mins

Access Standard Comparison

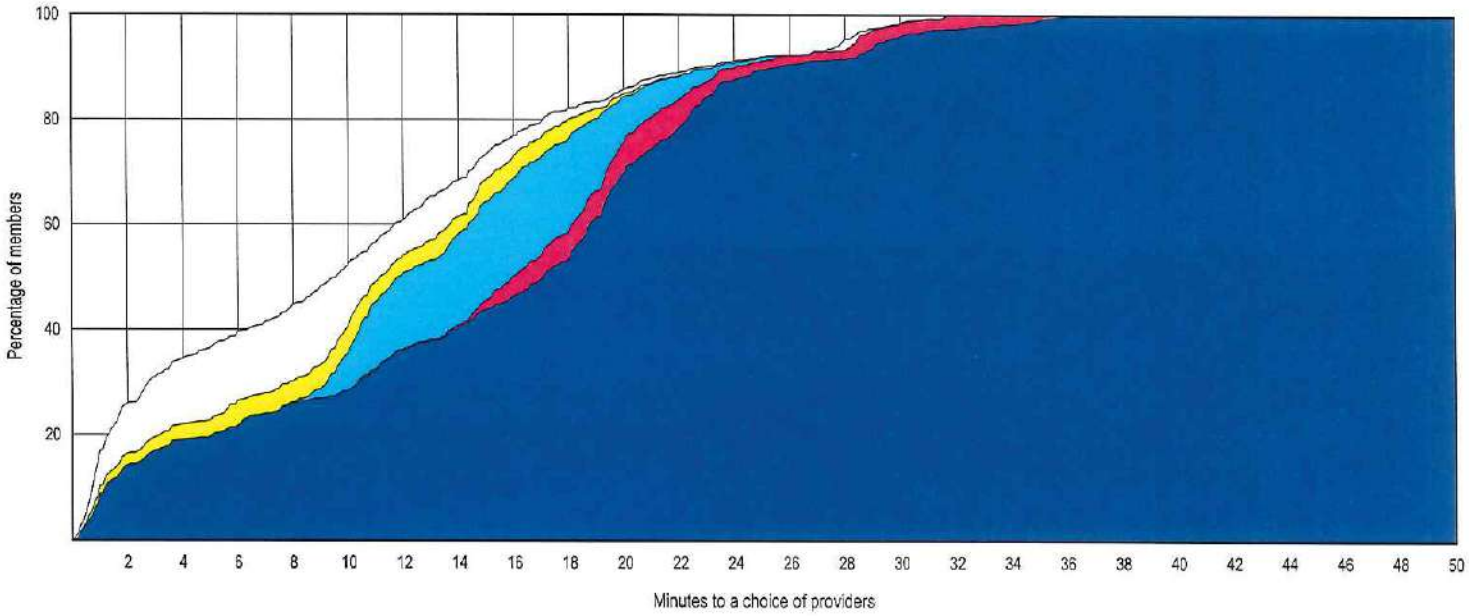

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Provider Locations

January 23, 2020

Region 4 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Total Providers: 58

e All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

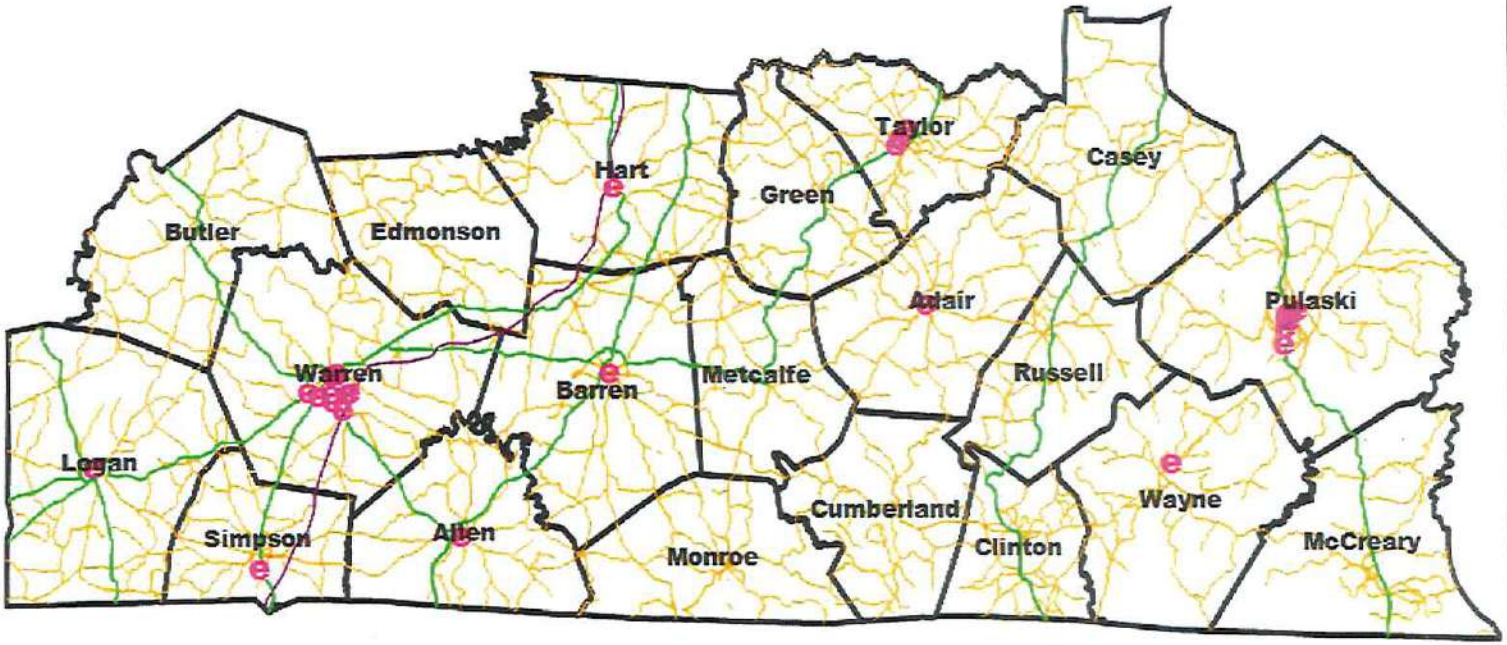

58 providers at 32 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 miles

Overall Access[1]

7,413 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

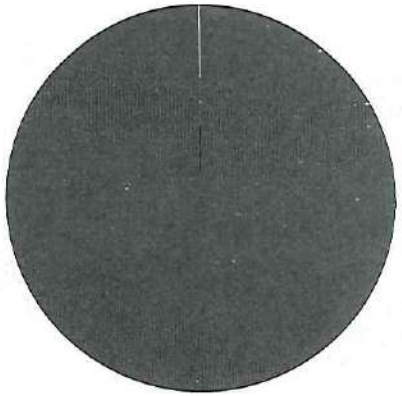

Distances

	Average
Distance to 1st closest provider	4.6 miles
Distance to 2nd closest provider	5.0 miles
Distance to 3rd closest provider	5.1 miles
Distance to 4th closest provider	5.2 miles
Distance to 5th closest provider	5.3 miles

Access Standard Comparison

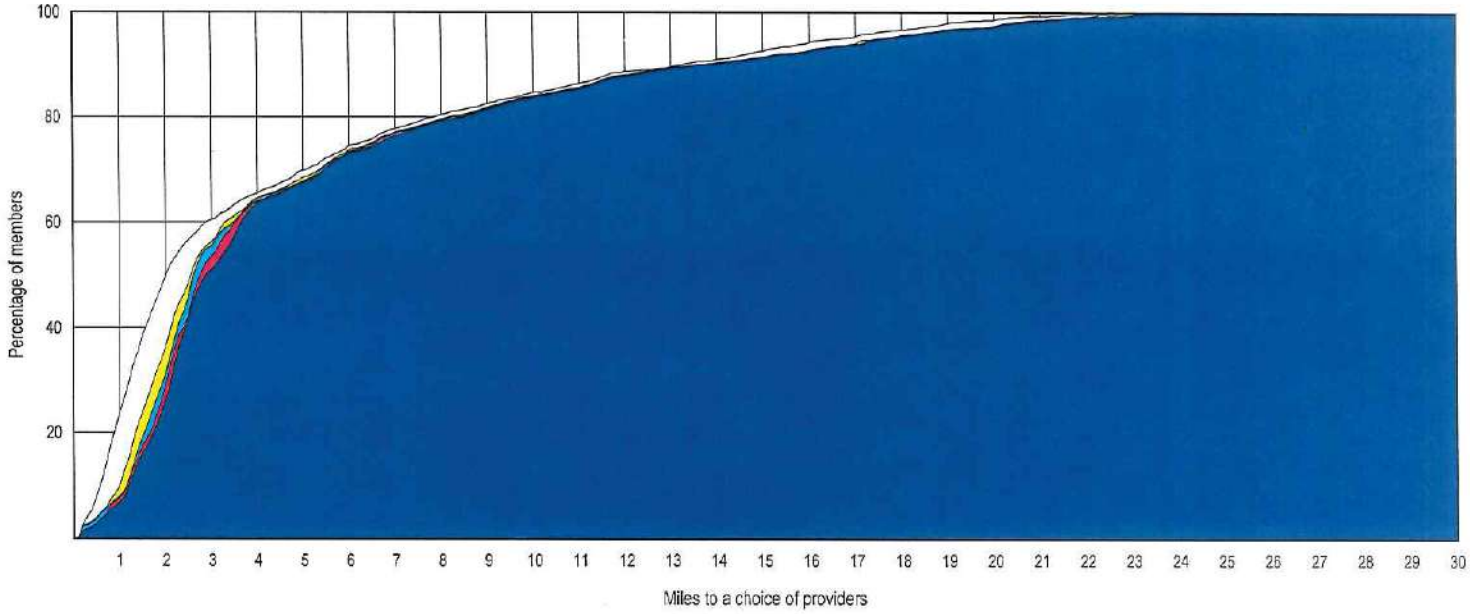

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 minutes

Overall Access[1]

7,413 Members
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- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

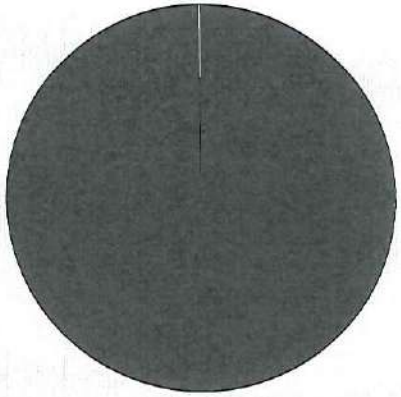

Times

	Average
Time to 1st closest provider	4.9 mins
Time to 2nd closest provider	5.4 mins
Time to 3rd closest provider	5.5 mins
Time to 4th closest provider	5.6 mins
Time to 5th closest provider	5.7 mins

Access Standard Comparison

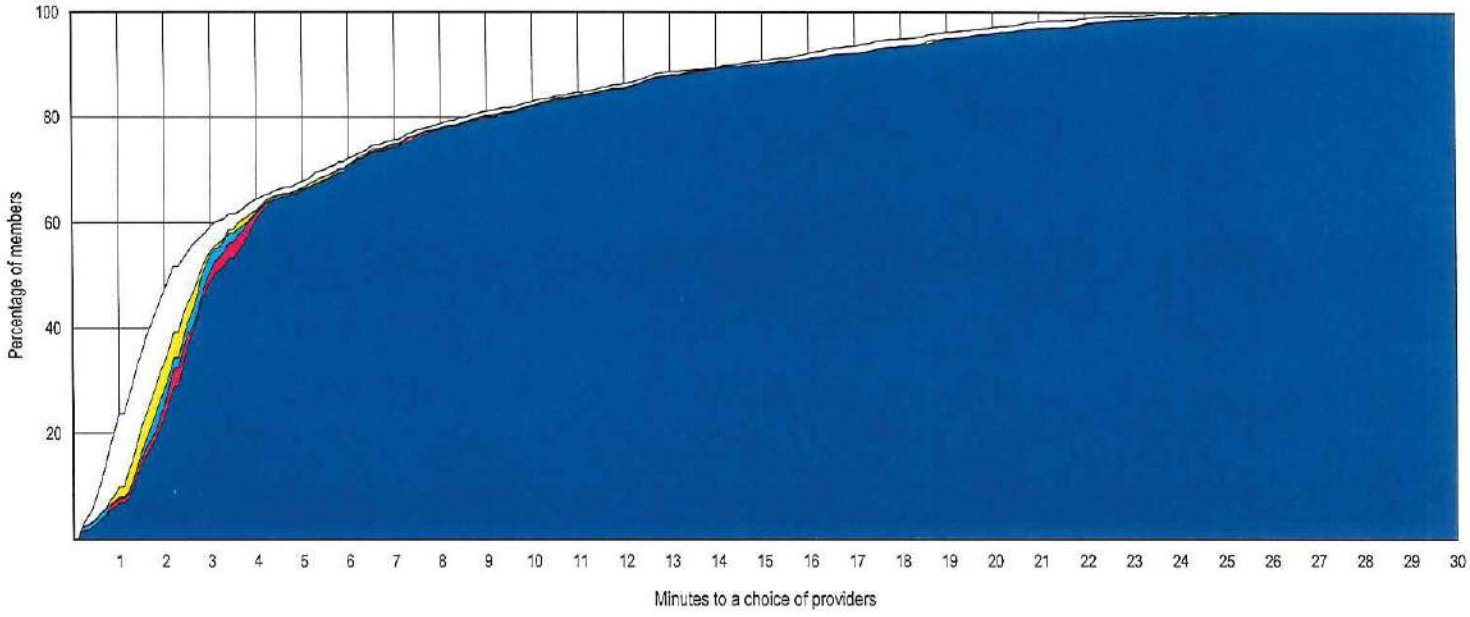

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 miles

Overall Access[1]

28,324 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

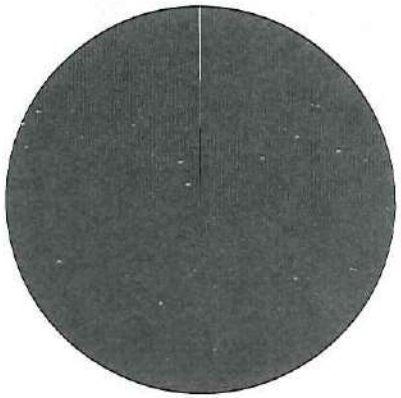

Distances

	Average
Distance to 1st closest provider	12.3 miles
Distance to 2nd closest provider	17.0 miles
Distance to 3rd closest provider	20.8 miles
Distance to 4th closest provider	22.8 miles
Distance to 5th closest provider	23.2 miles

Access Standard Comparison

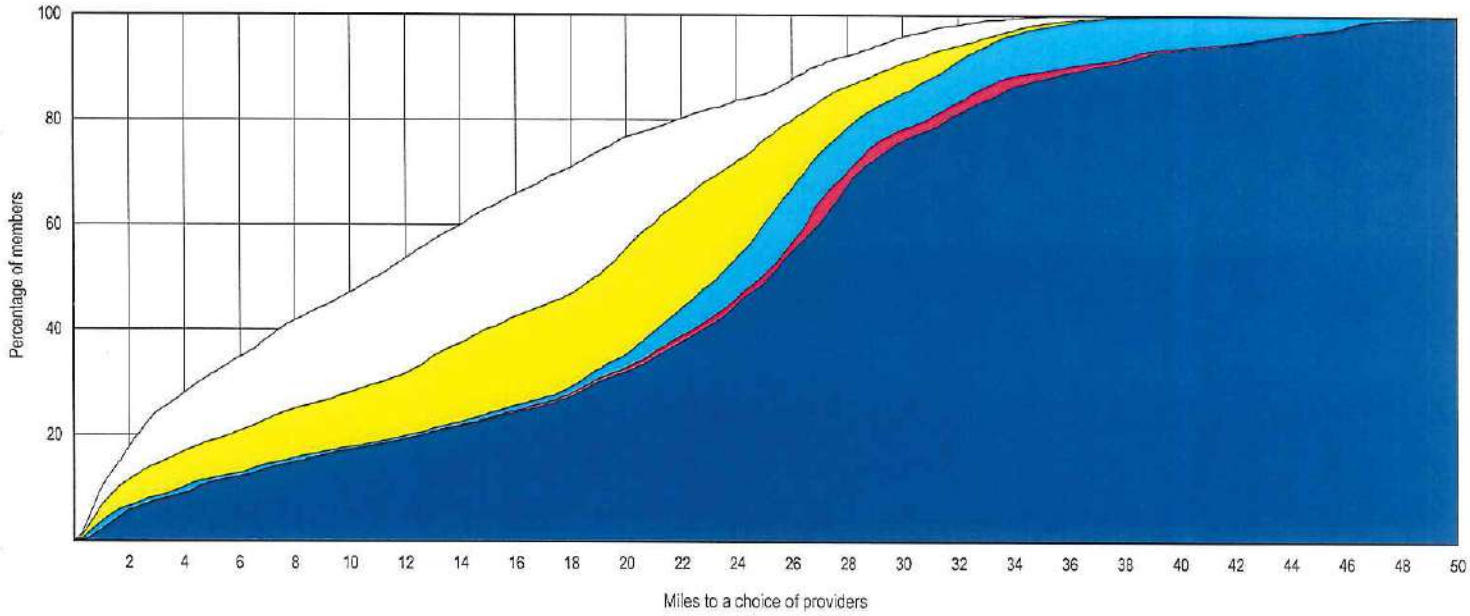

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 minutes

Overall Access[1]

28,324 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

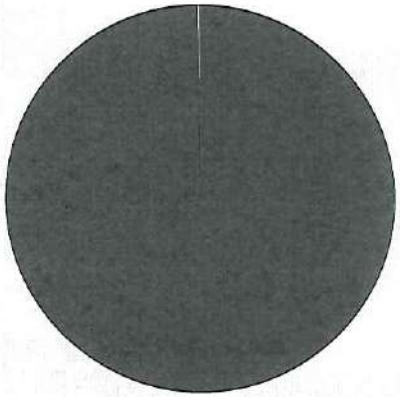

Times

	Average
Time to 1st closest provider	13.4 mins
Time to 2nd closest provider	18.5 mins
Time to 3rd closest provider	22.7 mins
Time to 4th closest provider	24.8 mins
Time to 5th closest provider	25.2 mins

Access Standard Comparison

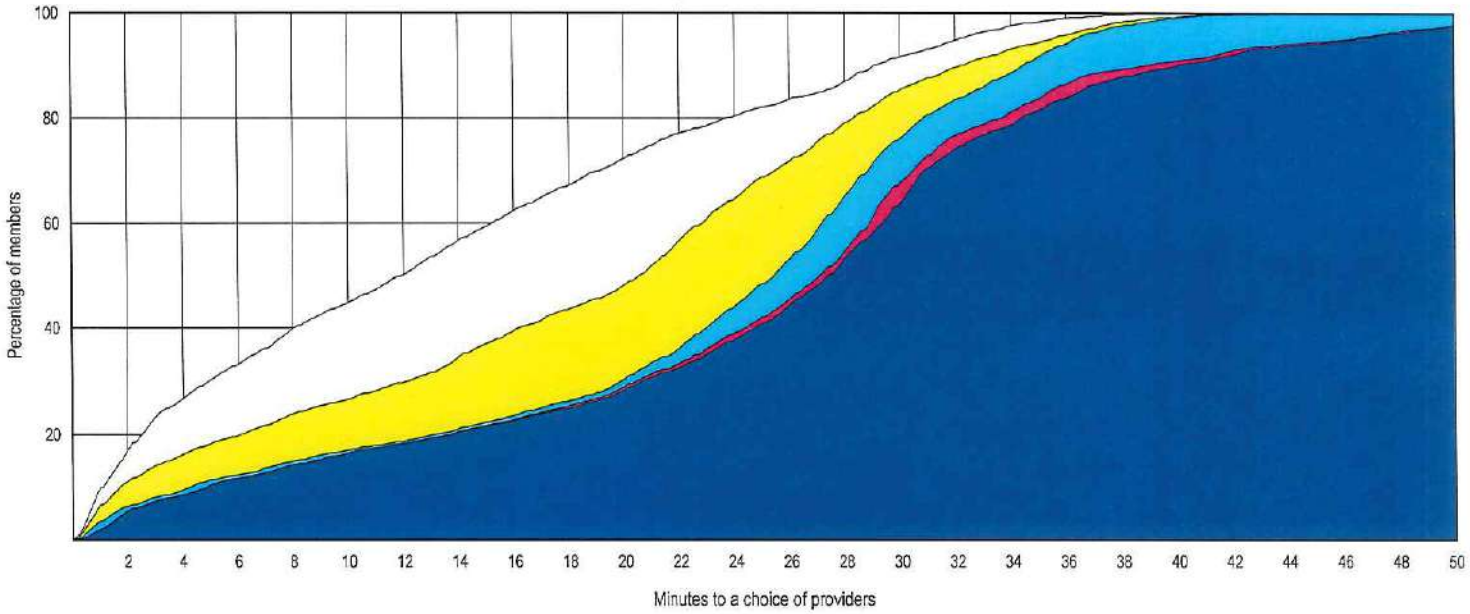

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Provider Locations

January 23, 2020

Region 5 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Total Providers: 80

e All providers

Interstates

US Highways

State Highways

17.44 miles

Region 5 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

80 providers at 54 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 miles

Overall Access[1]

22,712 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

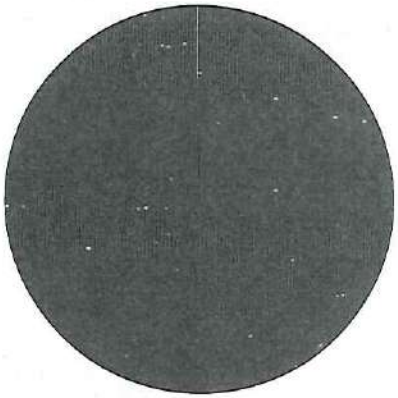

Distances

	Average
Distance to 1st closest provider	2.4 miles
Distance to 2nd closest provider	2.8 miles
Distance to 3rd closest provider	3.8 miles
Distance to 4th closest provider	5.1 miles
Distance to 5th closest provider	5.8 miles

Access Standard Comparison

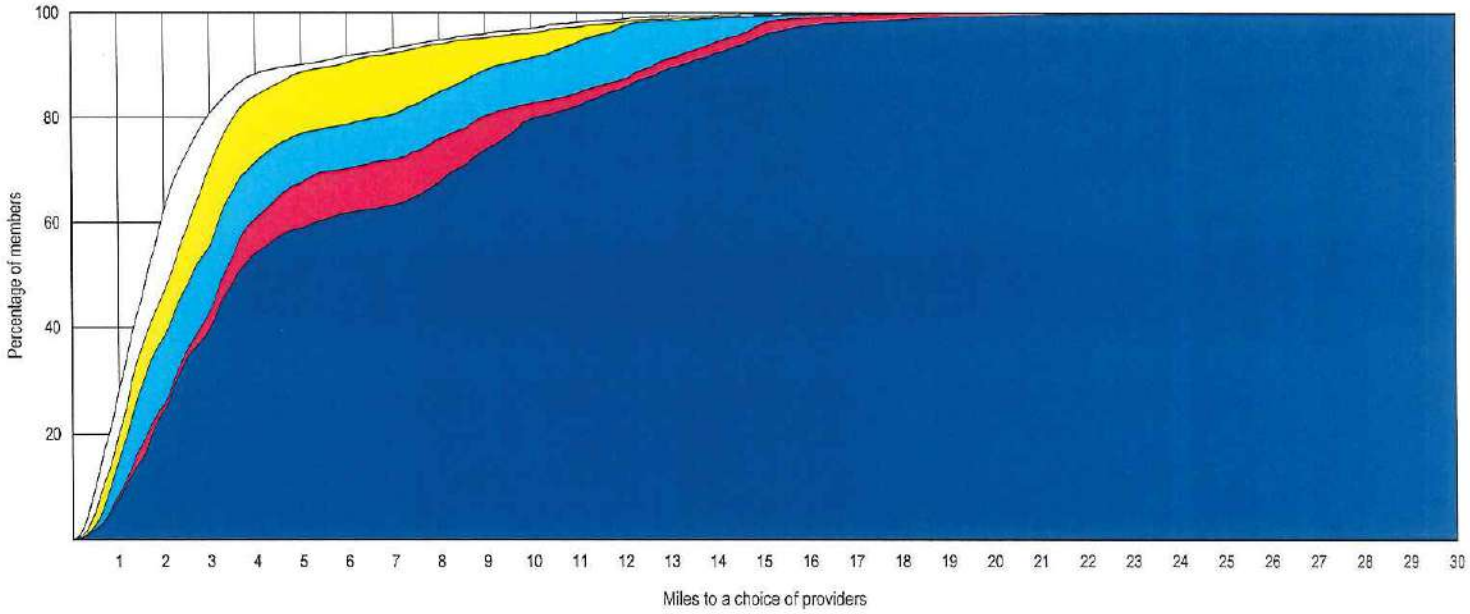

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Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

1 The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 minutes

Overall Access[1]

22,712 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

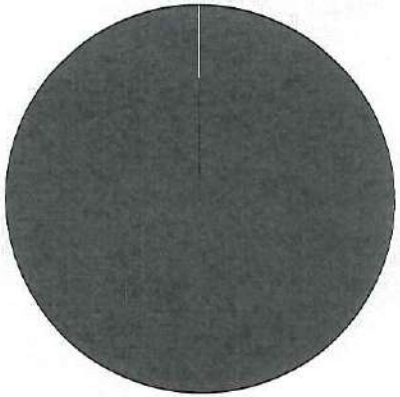

Times

	Average
Time to 1st closest provider	3.1 mins
Time to 2nd closest provider	3.7 mins
Time to 3rd closest provider	4.8 mins
Time to 4th closest provider	6.2 mins
Time to 5th closest provider	7.1 mins

Access Standard Comparison

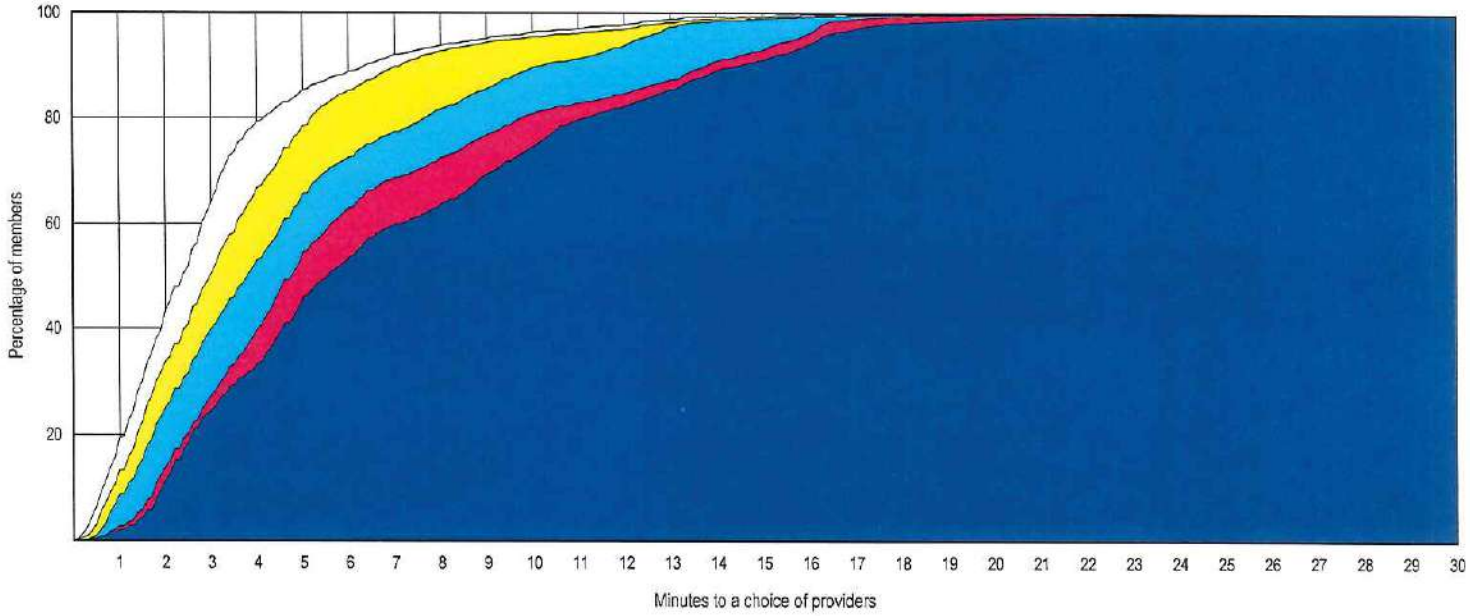

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 miles

Overall Access[1]

23,127 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

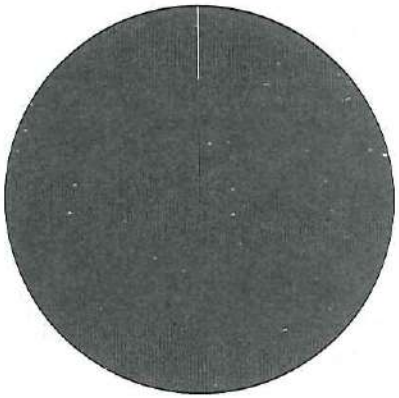

Distances

	Average
Distance to 1st closest provider	7.9 miles
Distance to 2nd closest provider	11.4 miles
Distance to 3rd closest provider	12.9 miles
Distance to 4th closest provider	14.9 miles
Distance to 5th closest provider	17.9 miles

Access Standard Comparison

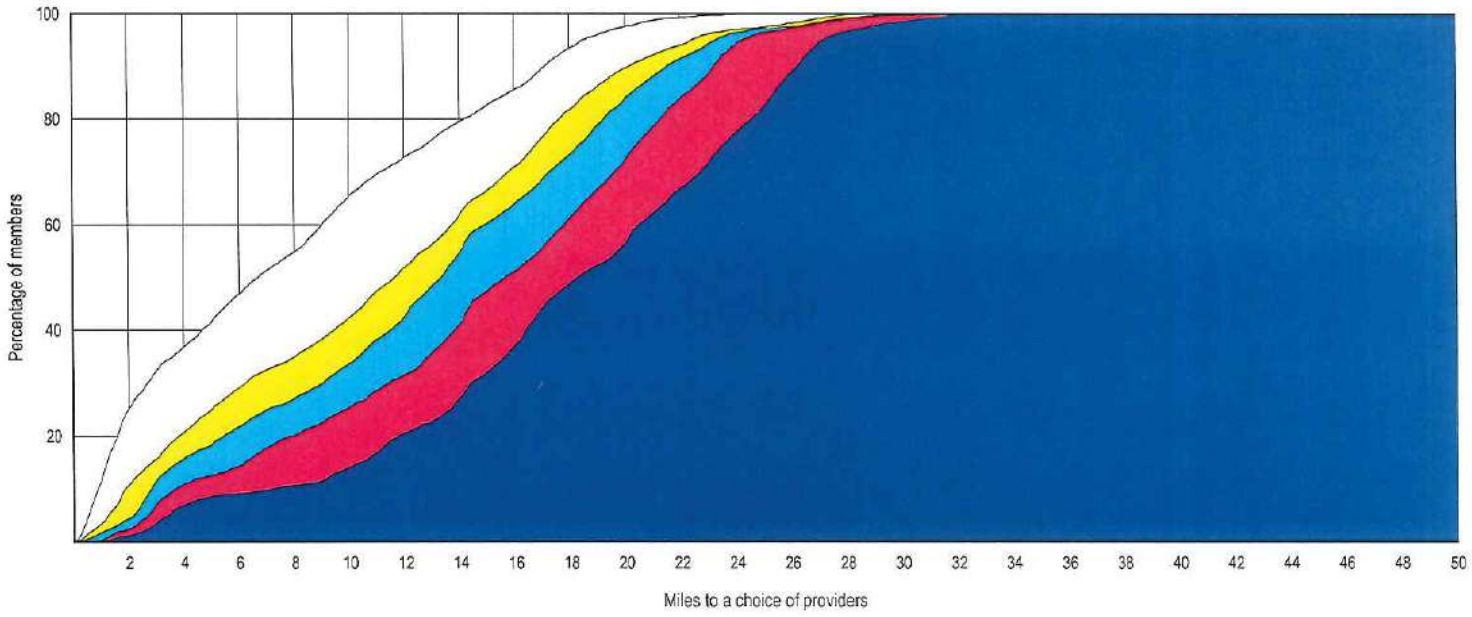

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 minutes

Overall Access[1]

23,127 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

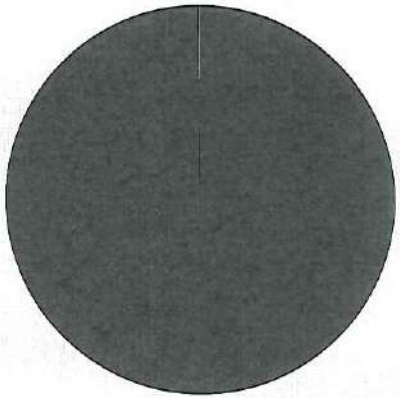

Times

	Average
Time to 1st closest provider	8.6 mins
Time to 2nd closest provider	12.4 mins
Time to 3rd closest provider	14.1 mins
Time to 4th closest provider	16.3 mins
Time to 5th closest provider	19.4 mins

Access Standard Comparison

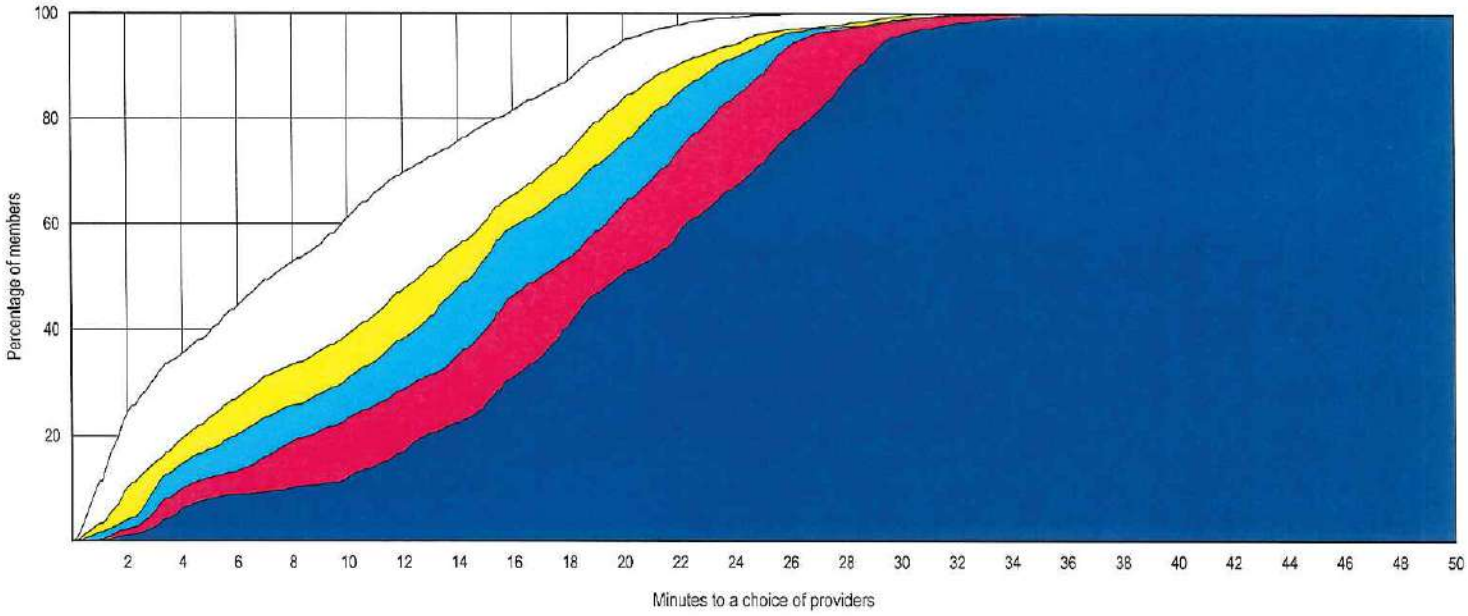

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Provider Locations

January 23, 2020

Region 6 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Total Providers: 38

e All providers

Interstates

US Highways

State Highways

7.48 miles

Region 6 Behavioral Health and Substance Abuse Providers

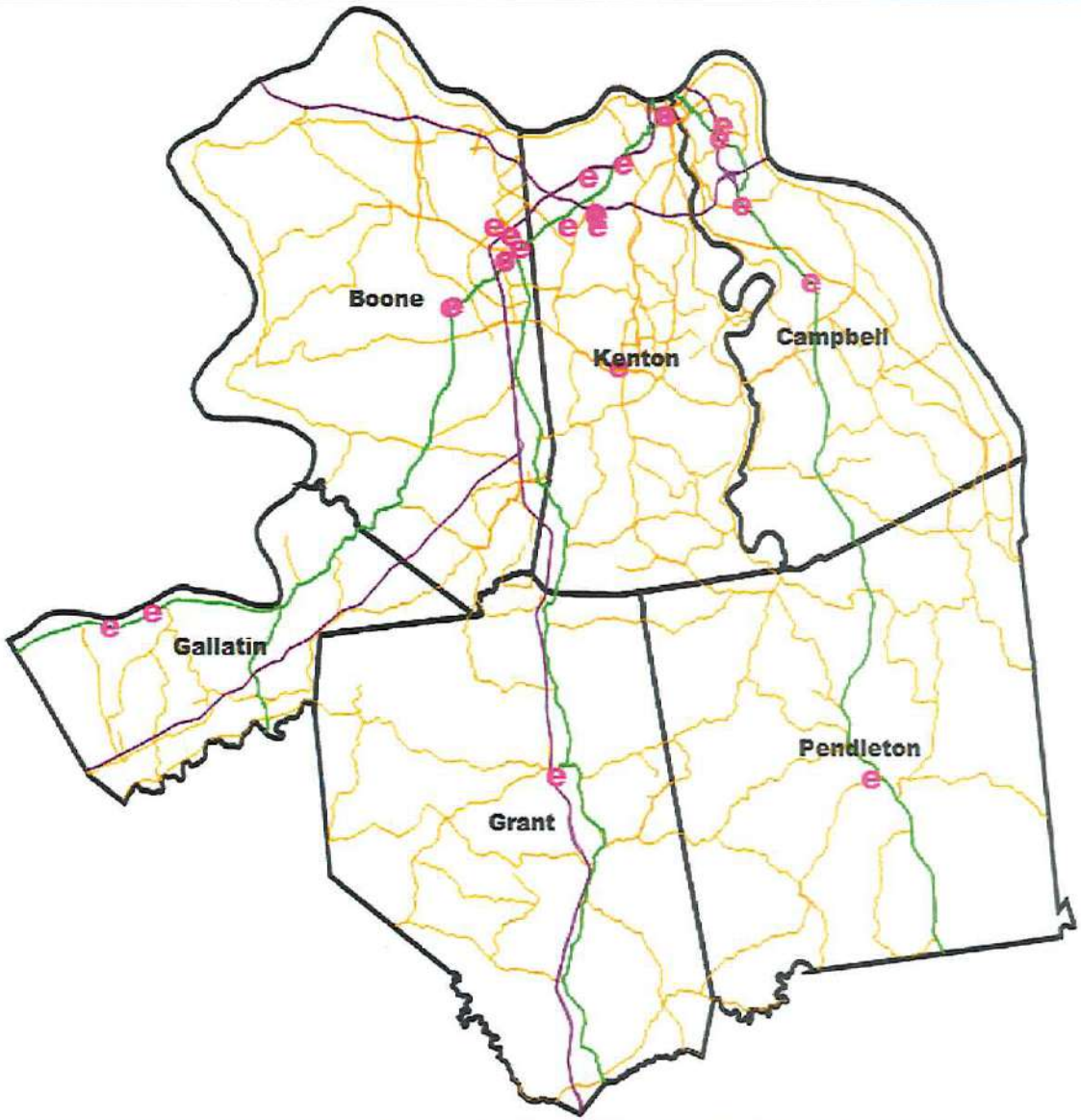

38 providers at 25 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 miles

Overall Access[1]

22,413 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

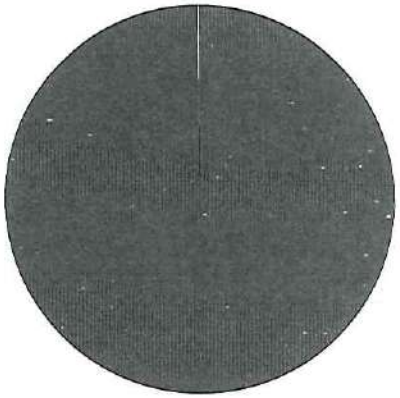

Distances

	Average
Distance to 1st closest provider	3.3 miles
Distance to 2nd closest provider	4.3 miles
Distance to 3rd closest provider	5.5 miles
Distance to 4th closest provider	6.3 miles
Distance to 5th closest provider	6.7 miles

Access Standard Comparison

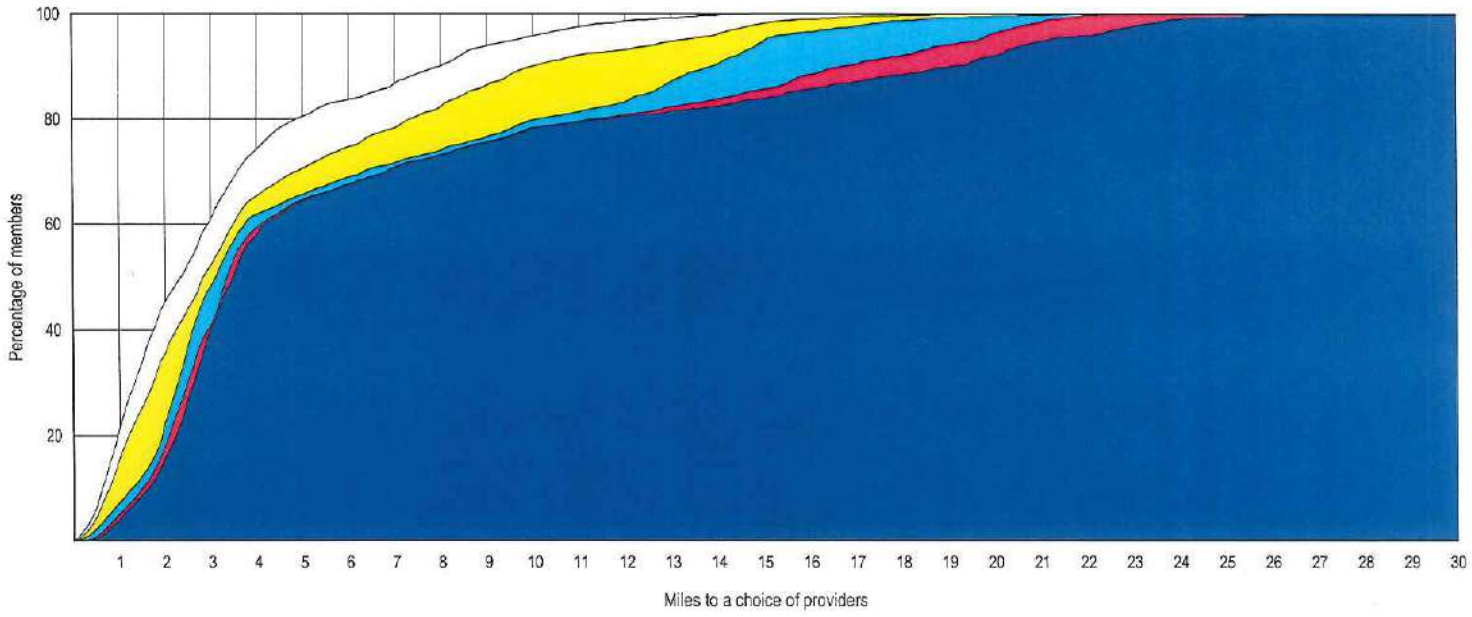

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Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 minutes

Overall Access[1]

22,413 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

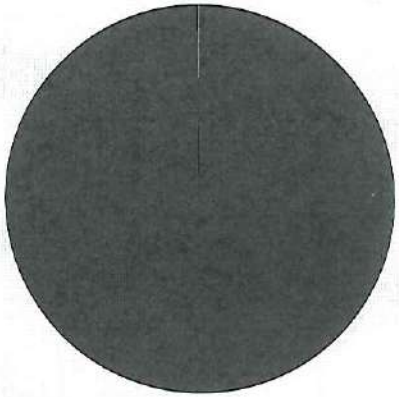

Times

	Average
Time to 1st closest provider	4.0 mins
Time to 2nd closest provider	5.2 mins
Time to 3rd closest provider	6.6 mins
Time to 4th closest provider	7.4 mins
Time to 5th closest provider	7.9 mins

Access Standard Comparison

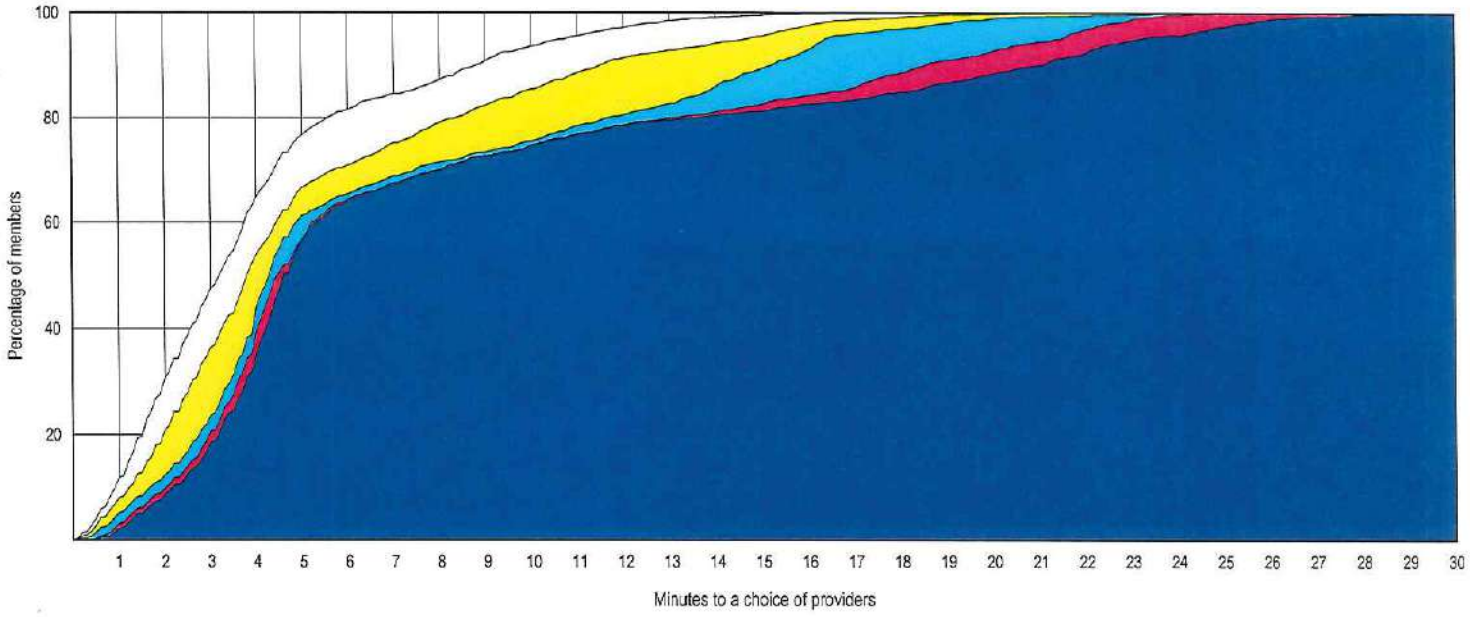

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Provider Locations

January 23, 2020

Region 7 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Total Providers: 16

e All providers

Interstates

US Highways

State Highways

12.36 miles

Region 7 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

16 providers at 12 locations

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Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 miles

Overall Access[1]

2,907 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

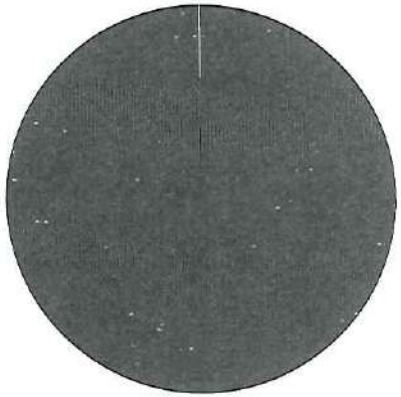

Distances

	Average
Distance to 1st closest provider	8.7 miles
Distance to 2nd closest provider	9.7 miles
Distance to 3rd closest provider	12.3 miles
Distance to 4th closest provider	13.2 miles
Distance to 5th closest provider	18.5 miles

Access Standard Comparison

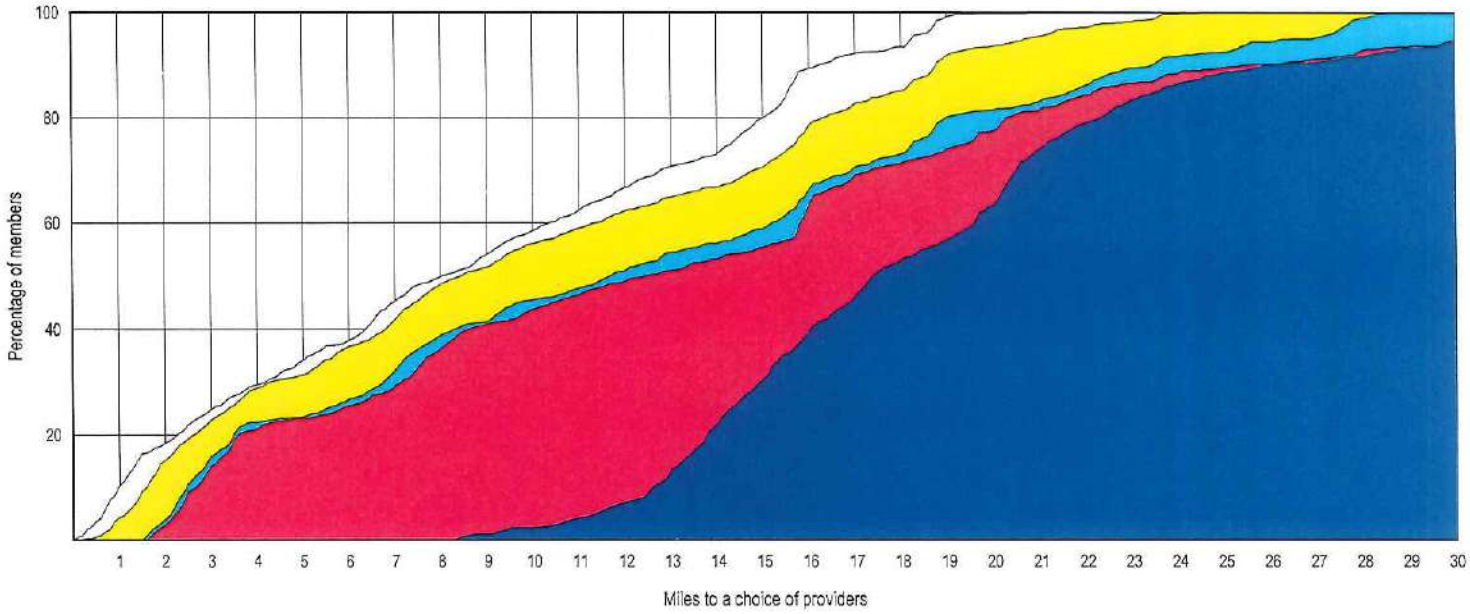

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Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 30 minutes

Overall Access[1]

2,907 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

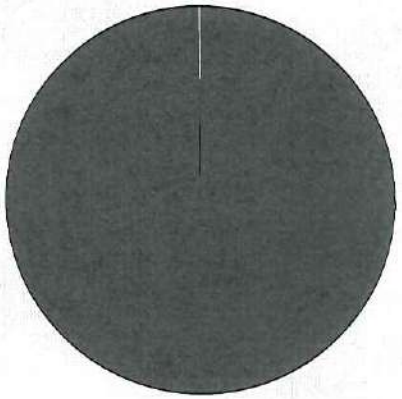

Times

	Average
Time to 1st closest provider	9.6 mins
Time to 2nd closest provider	10.6 mins
Time to 3rd closest provider	13.7 mins
Time to 4th closest provider	14.9 mins
Time to 5th closest provider	20.8 mins

Access Standard Comparison

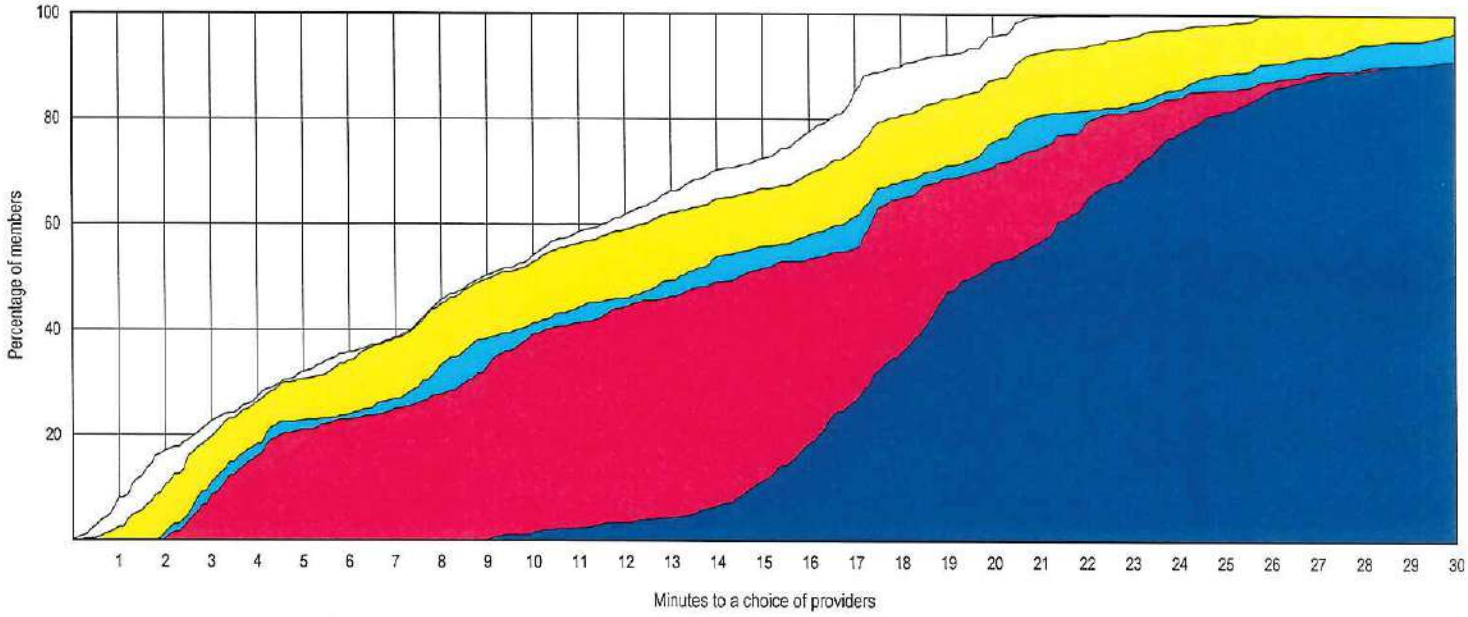

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 miles

Overall Access[1]

10,408 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

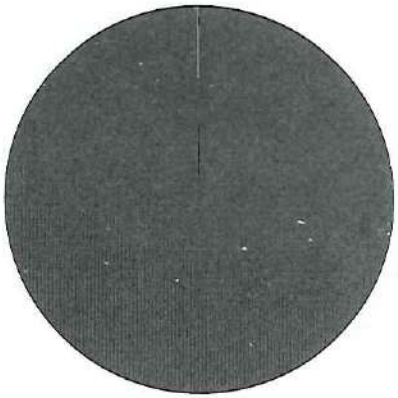

Distances

	Average
Distance to 1st closest provider	11.0 miles
Distance to 2nd closest provider	13.4 miles
Distance to 3rd closest provider	15.2 miles
Distance to 4th closest provider	19.3 miles
Distance to 5th closest provider	21.5 miles

Access Standard Comparison

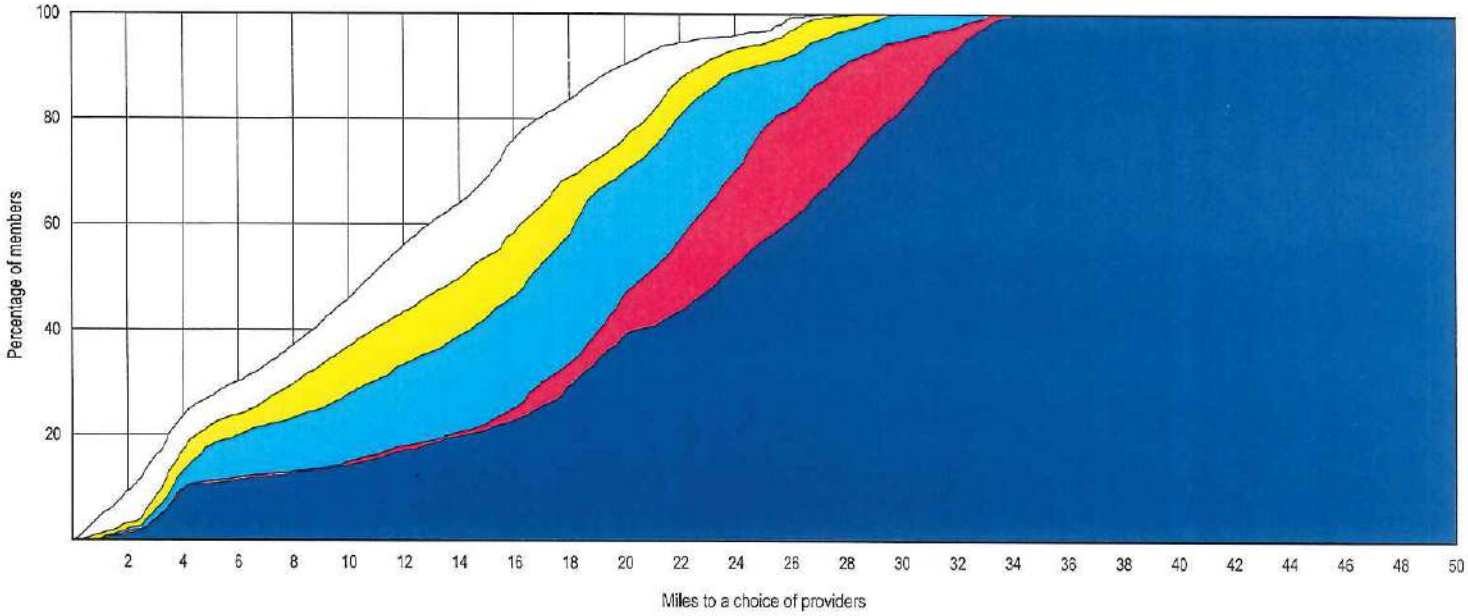

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 minutes

Member / Provider Groups
Region 7 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 minutes

Overall Access[1]

10,408 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

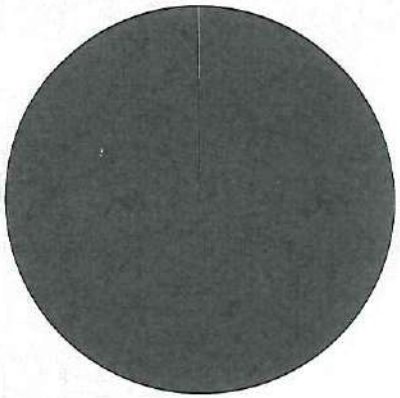

Times

	Average
Time to 1st closest provider	11.9 mins
Time to 2nd closest provider	14.6 mins
Time to 3rd closest provider	16.6 mins
Time to 4th closest provider	21.1 mins
Time to 5th closest provider	23.4 mins

Access Standard Comparison

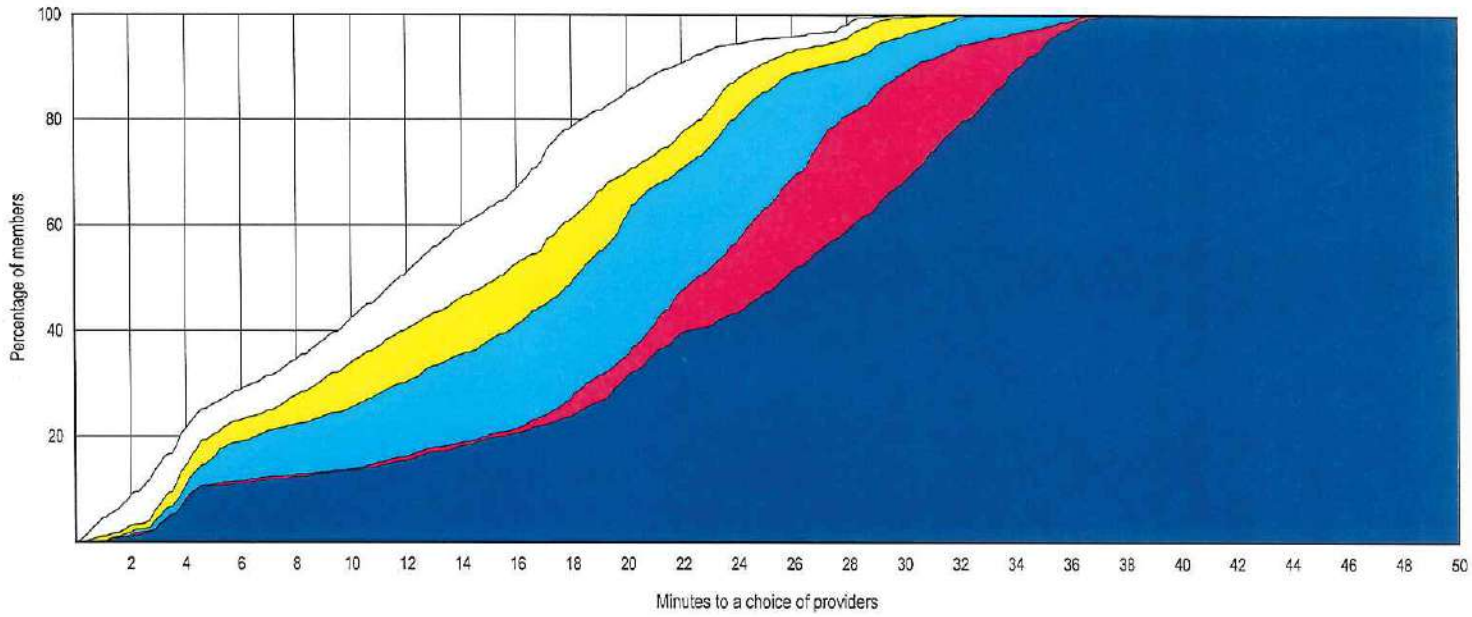

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Provider Locations

January 23, 2020

Region 8 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Total Providers: 39

e All providers

Interstates

US Highways

State Highways

16.38 miles

Region 8 Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

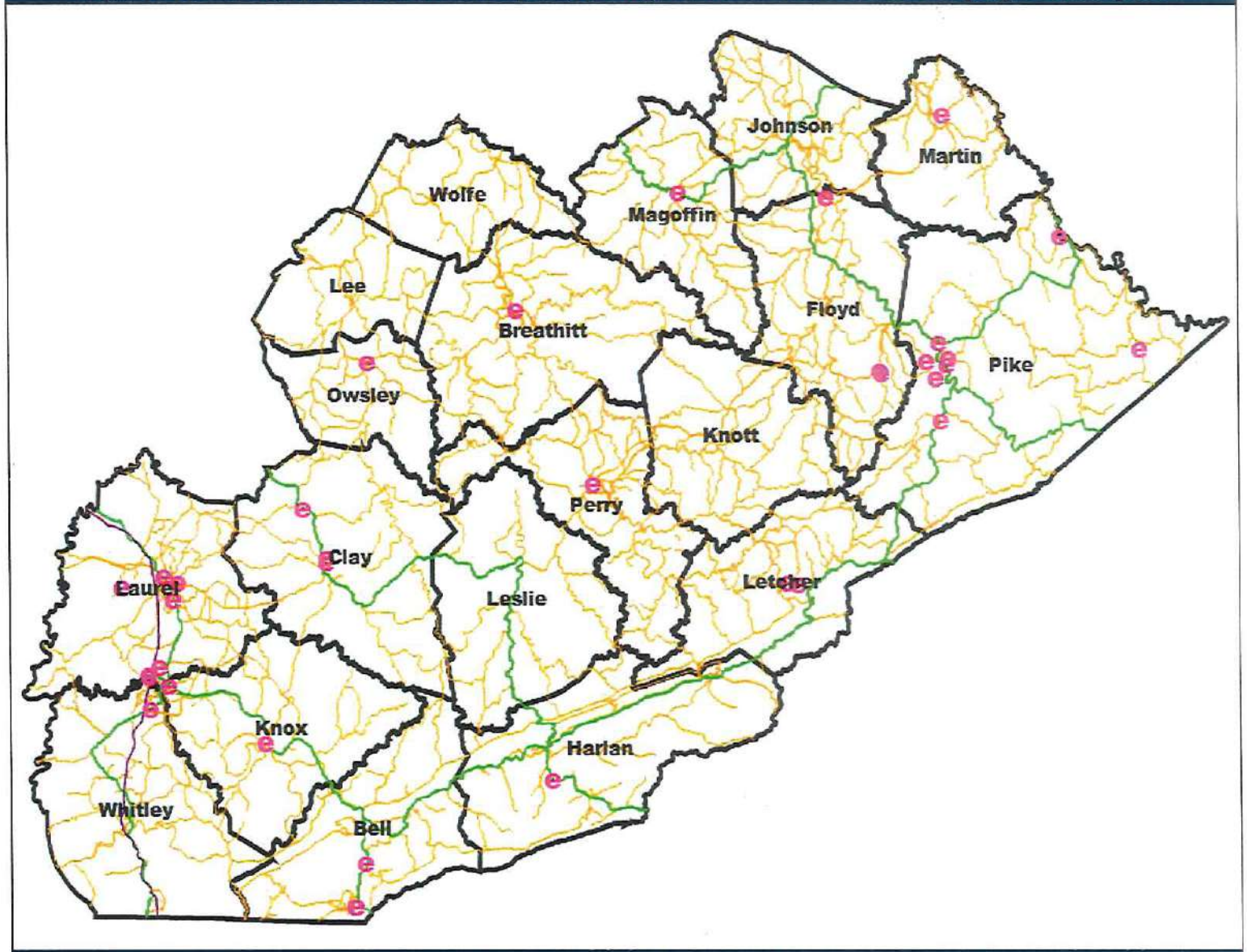

39 providers at 35 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 miles

Overall Access[1]

31,600 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

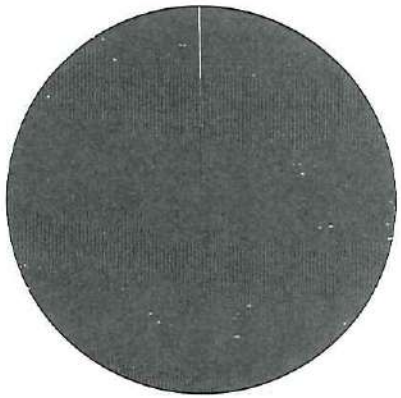

Times

	Average
Distance to 1st closest provider	7.3 miles
Distance to 2nd closest provider	9.9 miles
Distance to 3rd closest provider	11.2 miles
Distance to 4th closest provider	11.7 miles
Distance to 5th closest provider	12.4 miles

Access Standard Comparison

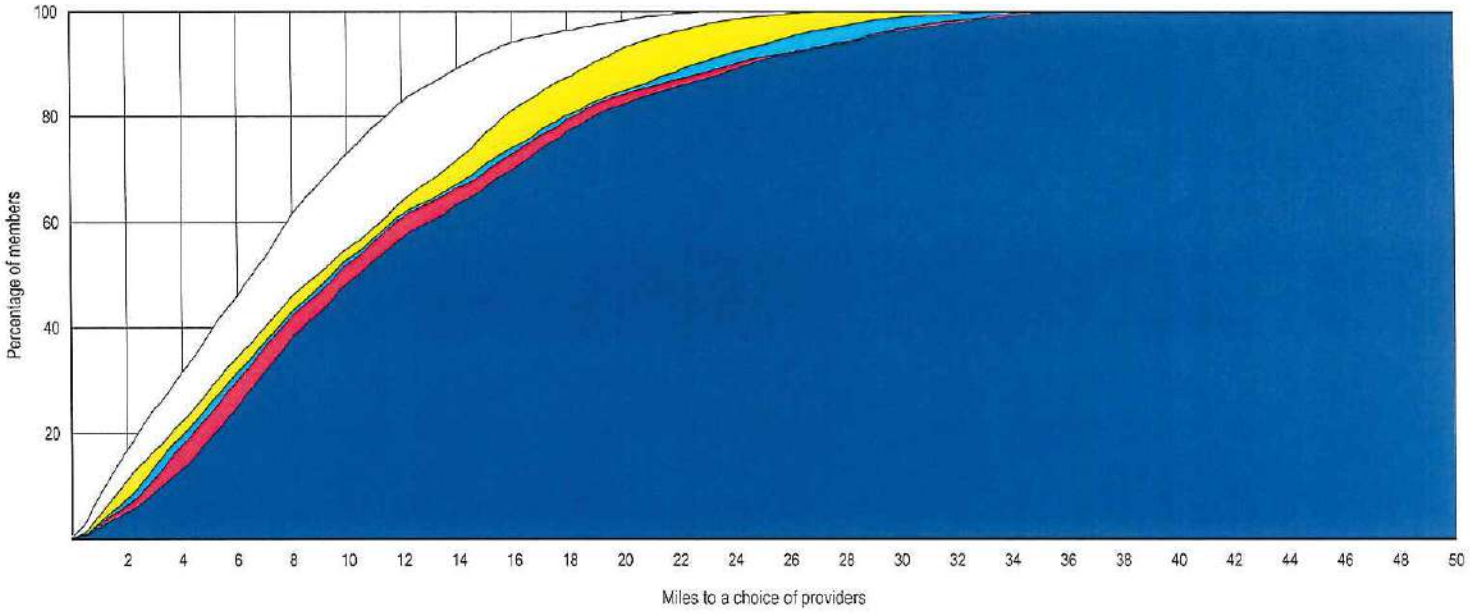

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists) provider in 50 minutes

Overall Access[1]

31,600 Members
477 providers at 340 locations (Opticians, Optometrists, Audiologists, Hearing Aid Vendors and Speech Language Pathologists)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

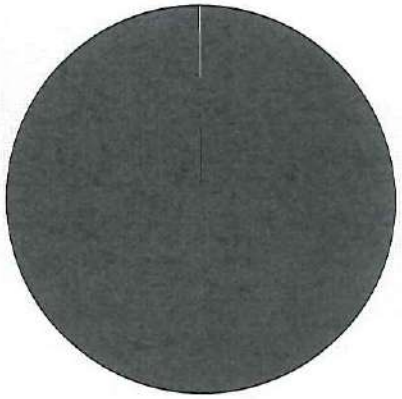

Times

	Average
Time to 1st closest provider	7.9 mins
Time to 2nd closest provider	10.7 mins
Time to 3rd closest provider	12.1 mins
Time to 4th closest provider	12.7 mins
Time to 5th closest provider	13.5 mins

Access Standard Comparison

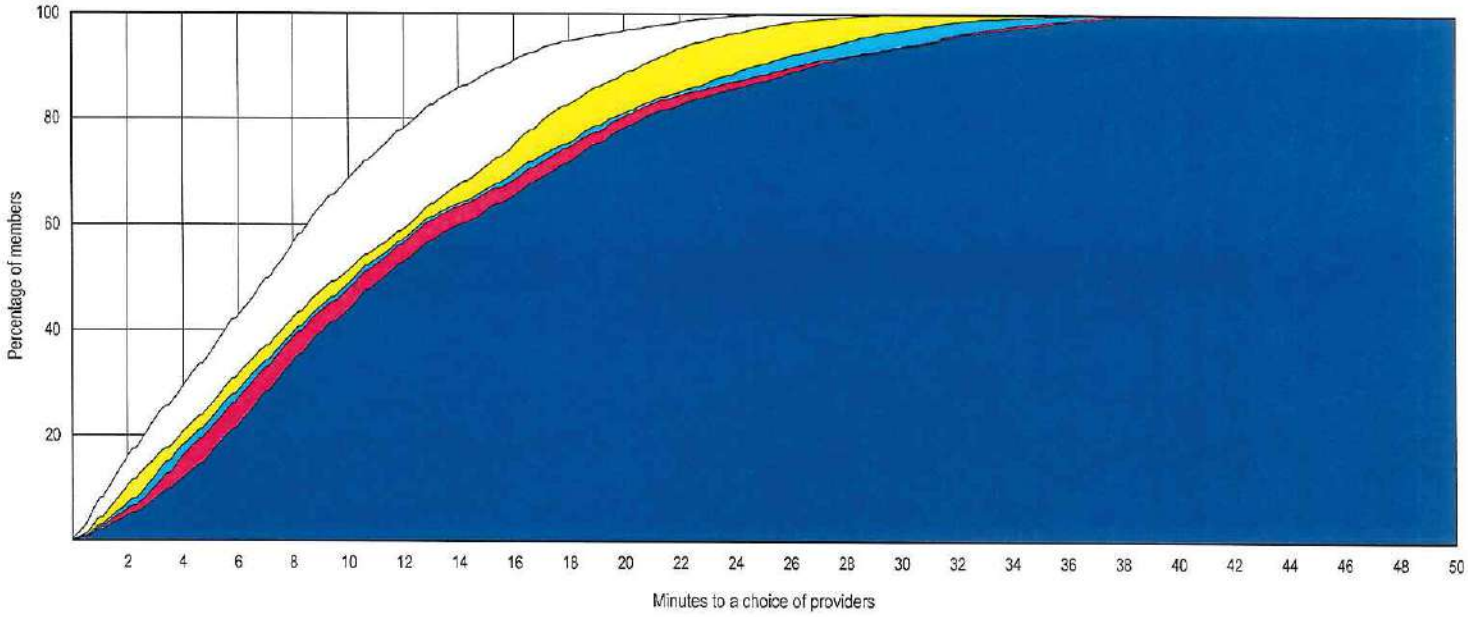

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Provider Locations

January 23, 2020

Region 1 Physical Therapists, Occupational Therapists and Chiropractors

Total Providers: 33

All providers

Interstates

US Highways

State Highways

12.93 miles

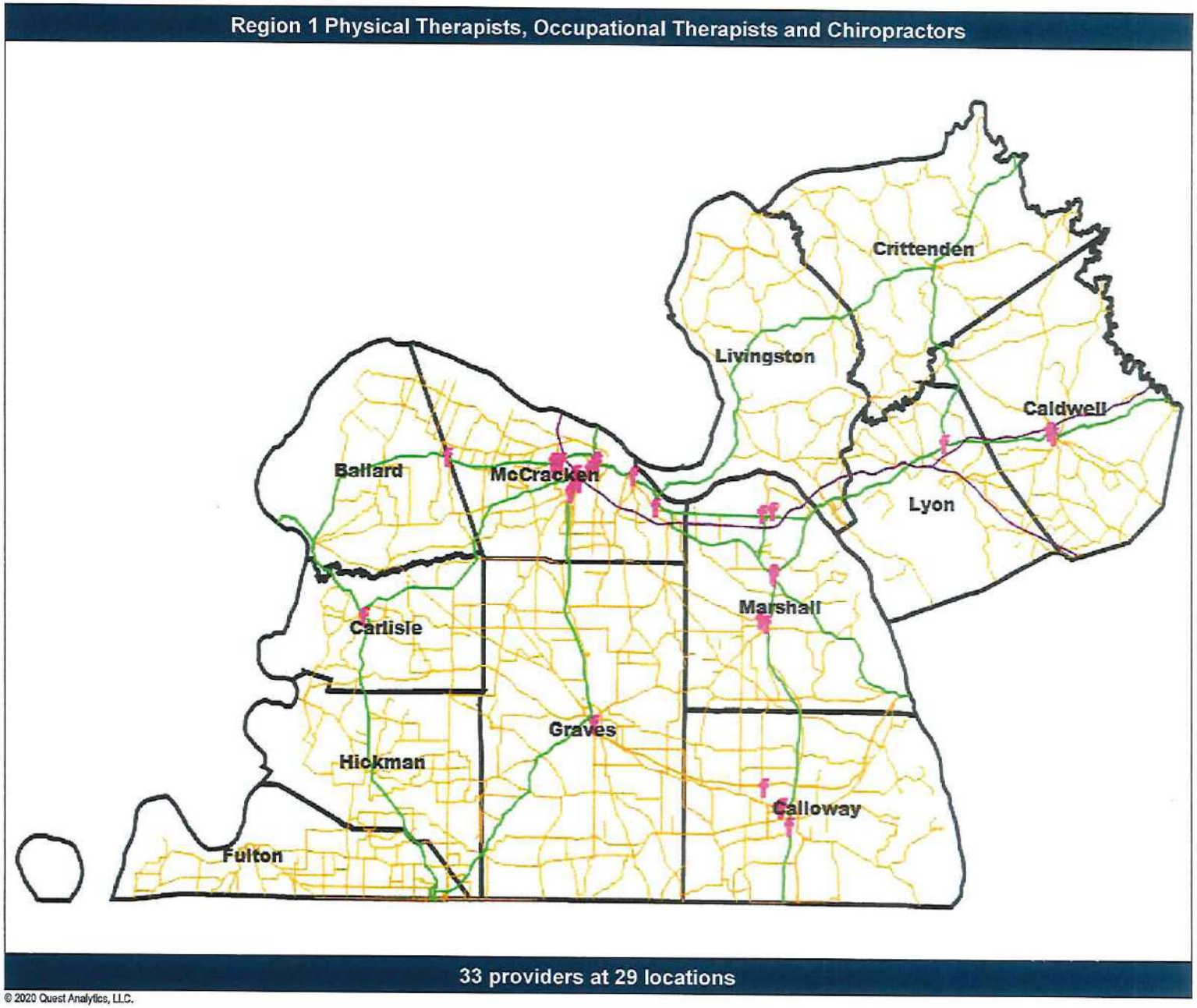

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 miles

Overall Access[1]

11,338 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

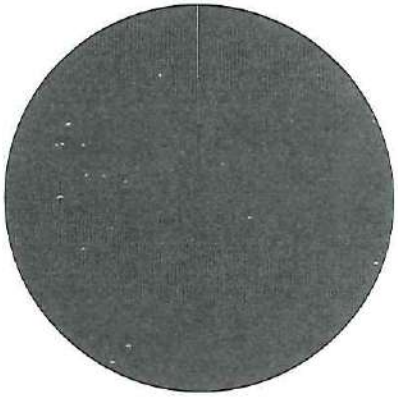

Times

	Average
Distance to 1st closest provider	6.4 miles
Distance to 2nd closest provider	10.0 miles
Distance to 3rd closest provider	11.1 miles
Distance to 4th closest provider	13.0 miles
Distance to 5th closest provider	14.2 miles

Access Standard Comparison

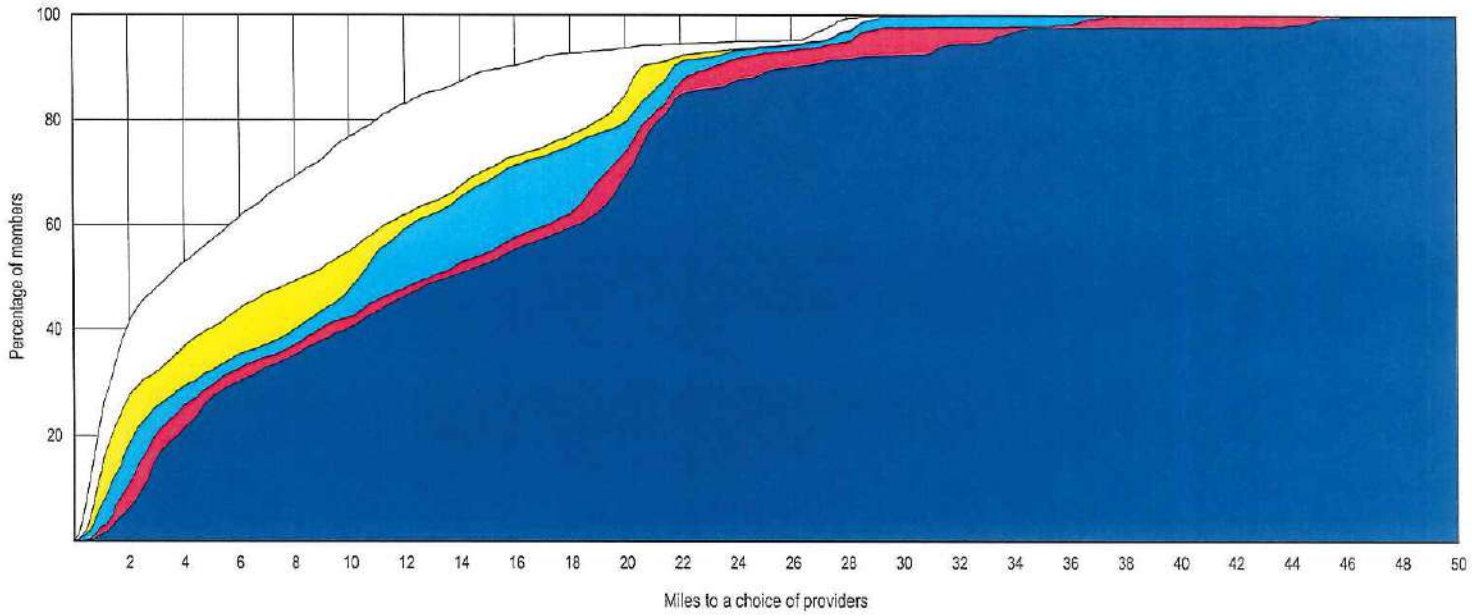

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 minutes

Overall Access[1]

11,338 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

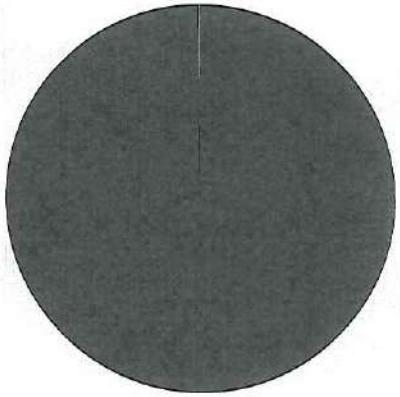

Times

	Average
Time to 1st closest provider	6.9 mins
Time to 2nd closest provider	10.8 mins
Time to 3rd closest provider	12.1 mins
Time to 4th closest provider	14.1 mins
Time to 5th closest provider	15.5 mins

Access Standard Comparison

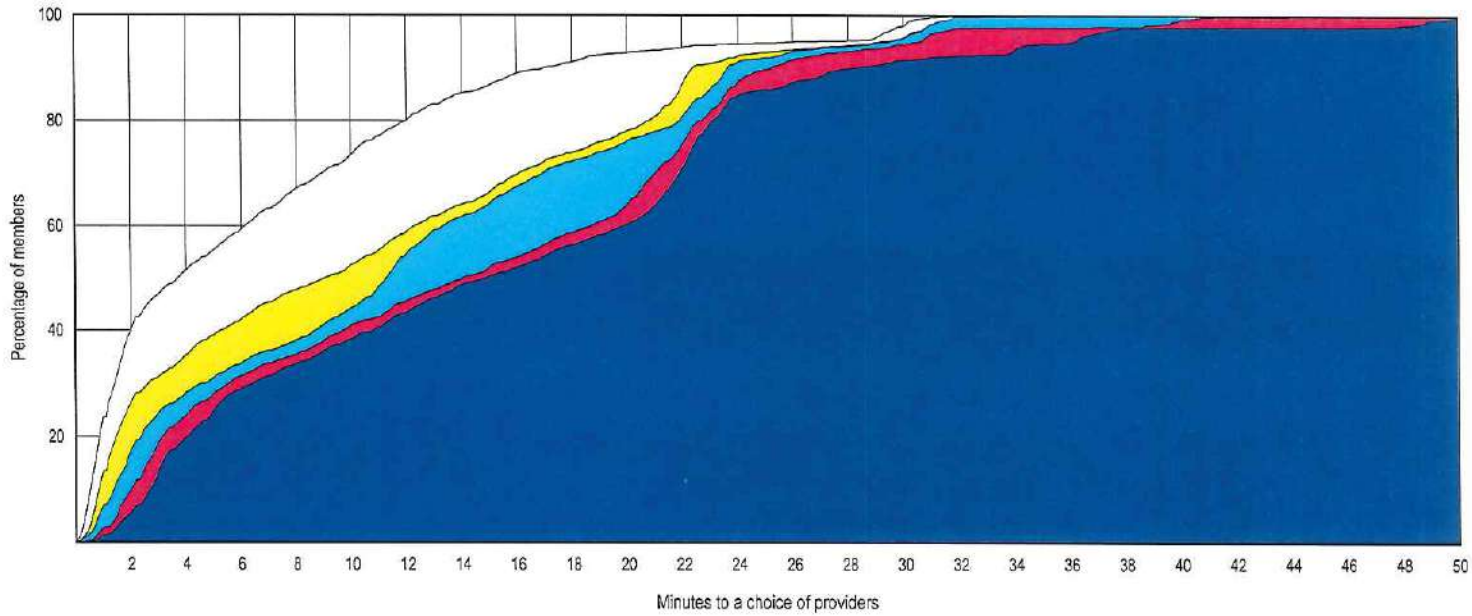

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Provider Locations

January 23, 2020

Region 2 Physical Therapists, Occupational Therapists and Chiropractors

Total Providers: 136

f All providers

Interstates

US Highways

State Highways

15.14 miles

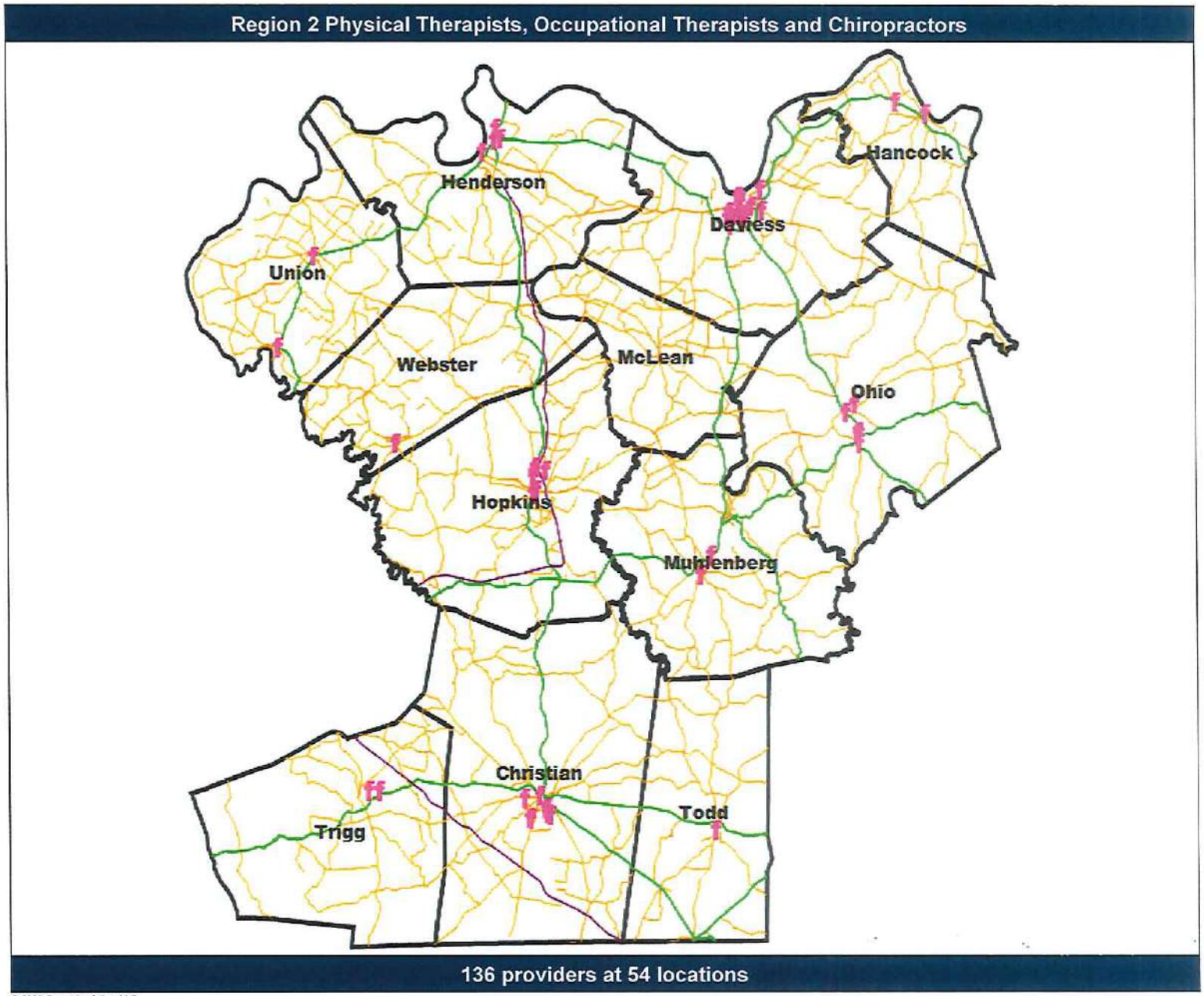

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 miles

Overall Access[1]

16,143 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

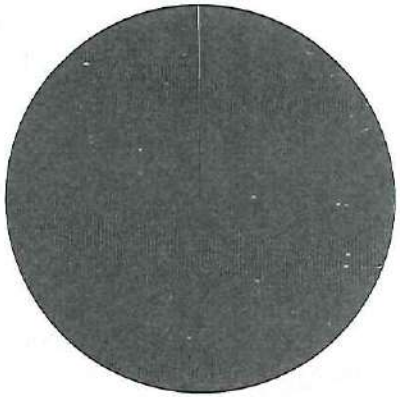

Distances

	Average
Distance to 1st closest provider	4.4 miles
Distance to 2nd closest provider	5.0 miles
Distance to 3rd closest provider	5.3 miles
Distance to 4th closest provider	6.5 miles
Distance to 5th closest provider	6.7 miles

Access Standard Comparison

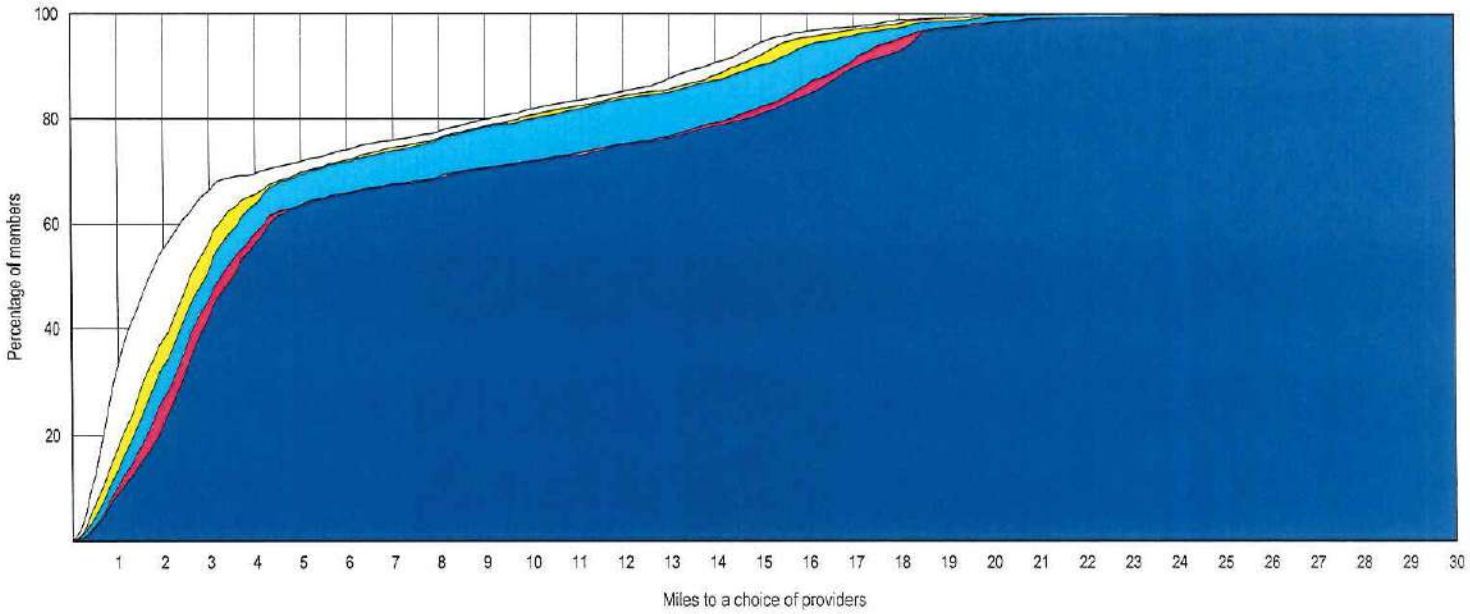

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 minutes

Overall Access[1]

16,143 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

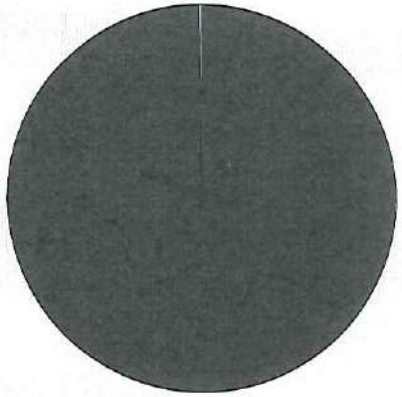

Times

	Average
Time to 1st closest provider	4.7 mins
Time to 2nd closest provider	5.4 mins
Time to 3rd closest provider	5.7 mins
Time to 4th closest provider	7.1 mins
Time to 5th closest provider	7.3 mins

Access Standard Comparison

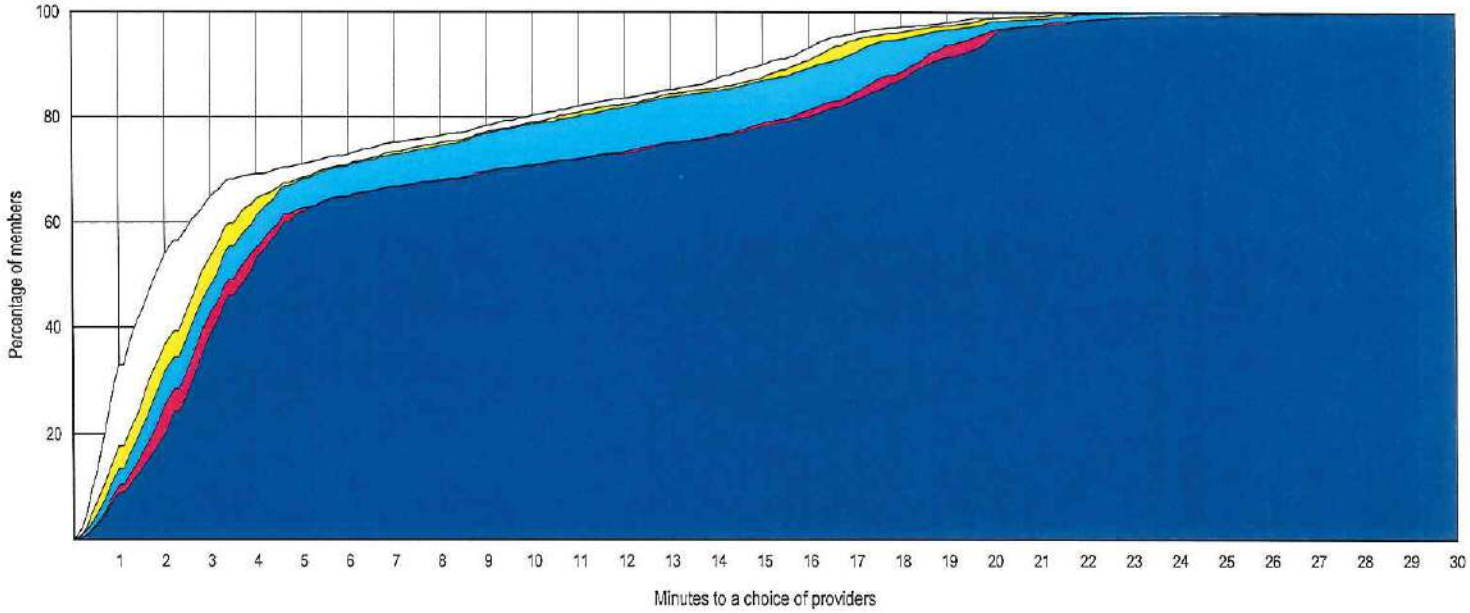

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 miles

Overall Access[1]

9,636 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

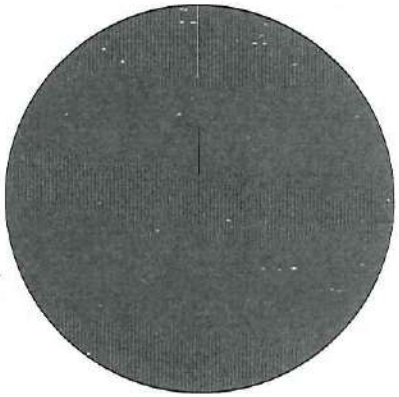

Distances

	Average
Distance to 1st closest provider	5.7 miles
Distance to 2nd closest provider	7.2 miles
Distance to 3rd closest provider	10.4 miles
Distance to 4th closest provider	11.7 miles
Distance to 5th closest provider	11.8 miles

Access Standard Comparison

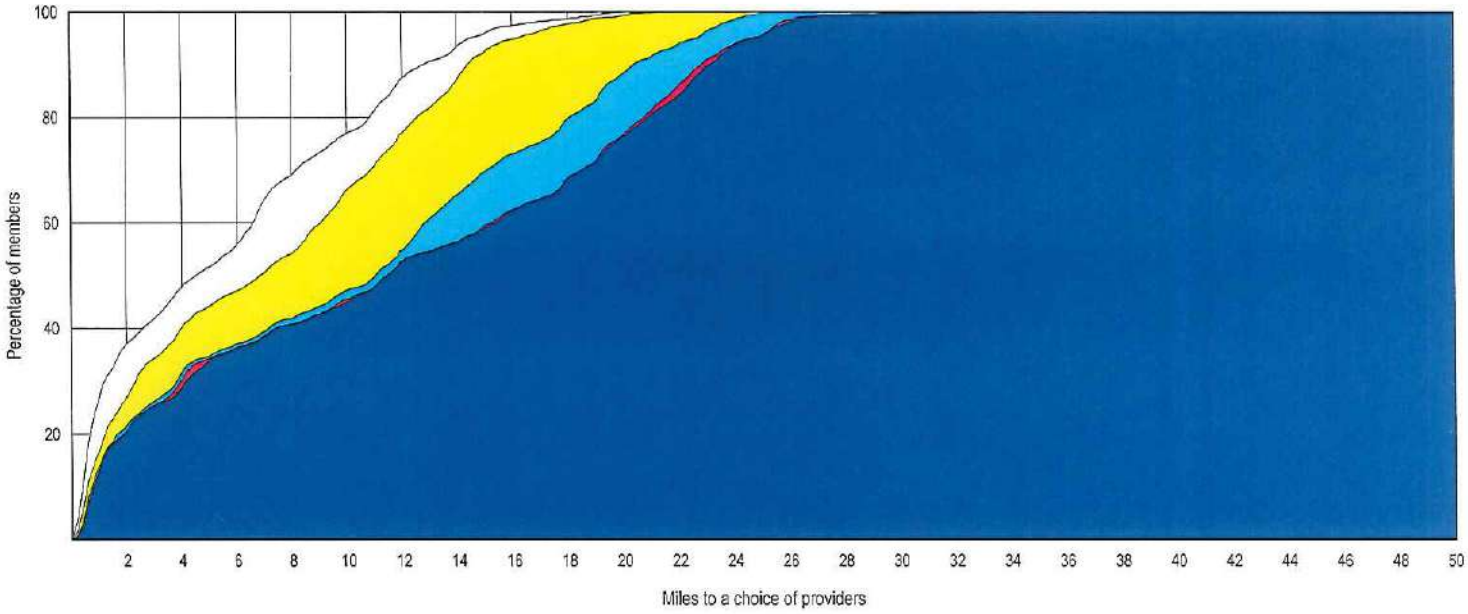

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 minutes

Overall Access[1]

9,636 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

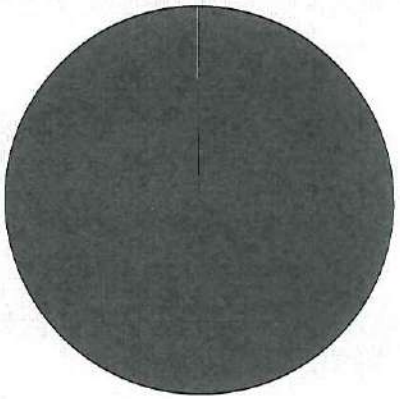

Times

	Average
Time to 1st closest provider	6.2 mins
Time to 2nd closest provider	7.8 mins
Time to 3rd closest provider	11.3 mins
Time to 4th closest provider	12.7 mins
Time to 5th closest provider	12.8 mins

Access Standard Comparison

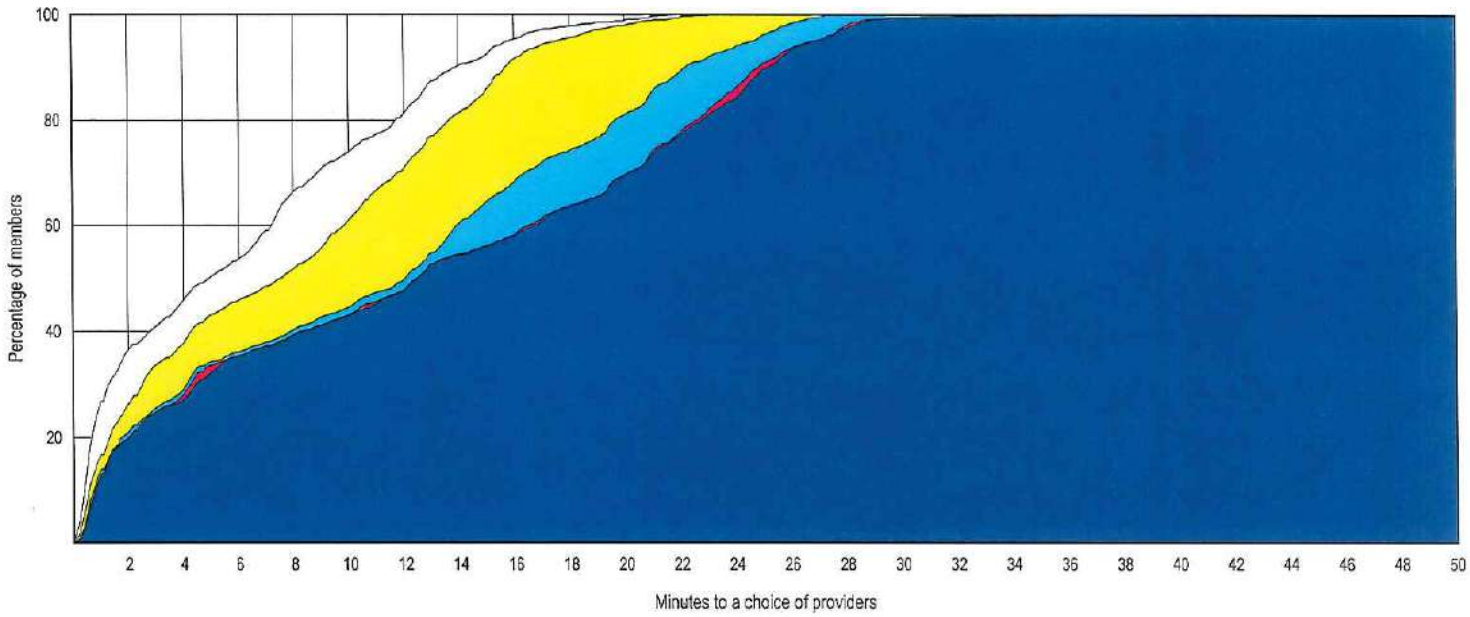

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Provider Locations

January 23, 2020

Region 3 Physical Therapists, Occupational Therapists and Chiropractors

Total Providers: 360

All providers

Interstates

US Highways

State Highways

15.97 miles

Region 3 Physical Therapists, Occupational Therapists and Chiropractors

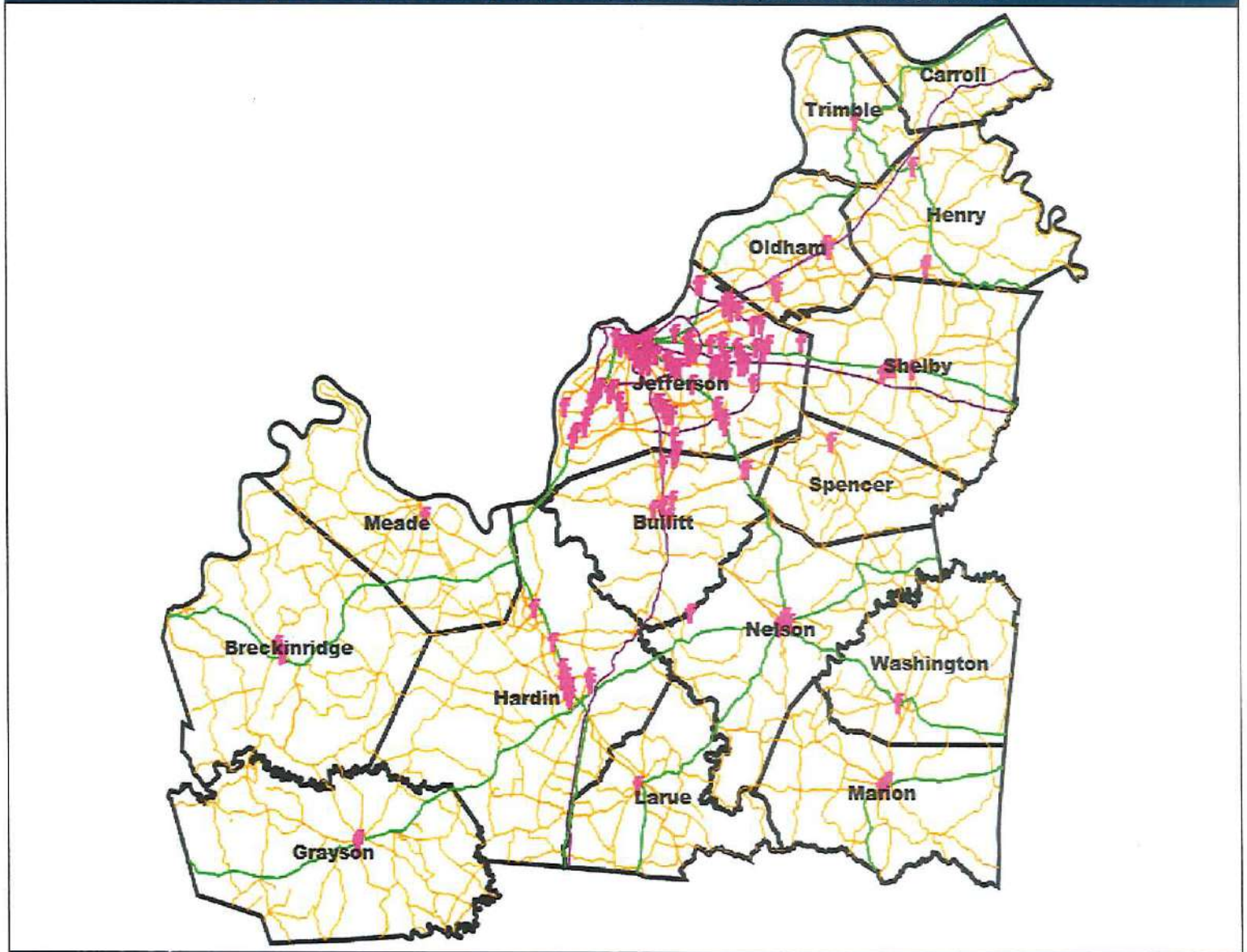

360 providers at 160 locations

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Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 miles

Overall Access[1]

18,130 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

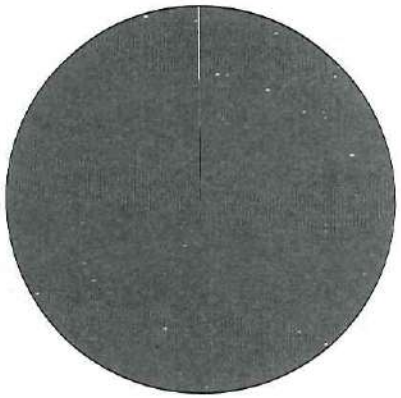

Distances

	Average
Distance to 1st closest provider	2.1 miles
Distance to 2nd closest provider	2.8 miles
Distance to 3rd closest provider	3.2 miles
Distance to 4th closest provider	3.3 miles
Distance to 5th closest provider	3.5 miles

Access Standard Comparison

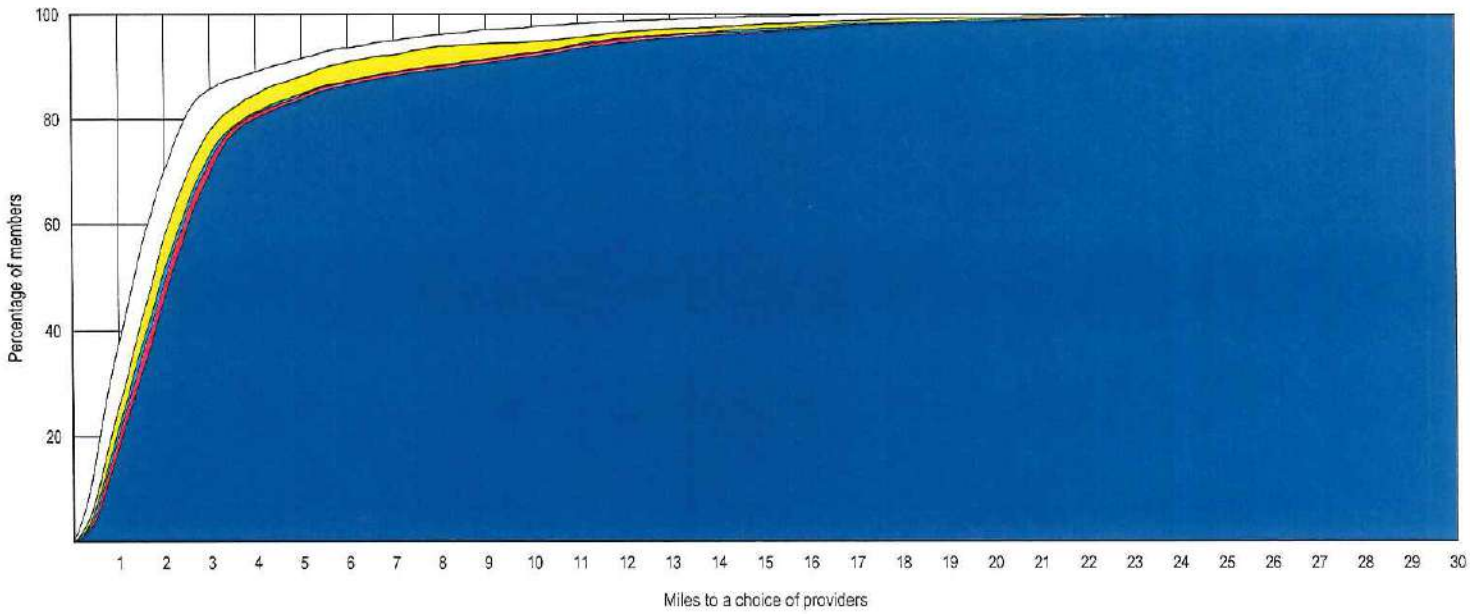

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 minutes

Overall Access[1]

18,130 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

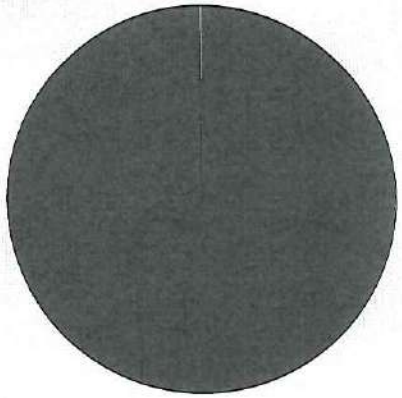

Times

	Average
Time to 1st closest provider	2.7 mins
Time to 2nd closest provider	3.5 mins
Time to 3rd closest provider	4.0 mins
Time to 4th closest provider	4.2 mins
Time to 5th closest provider	4.4 mins

Access Standard Comparison

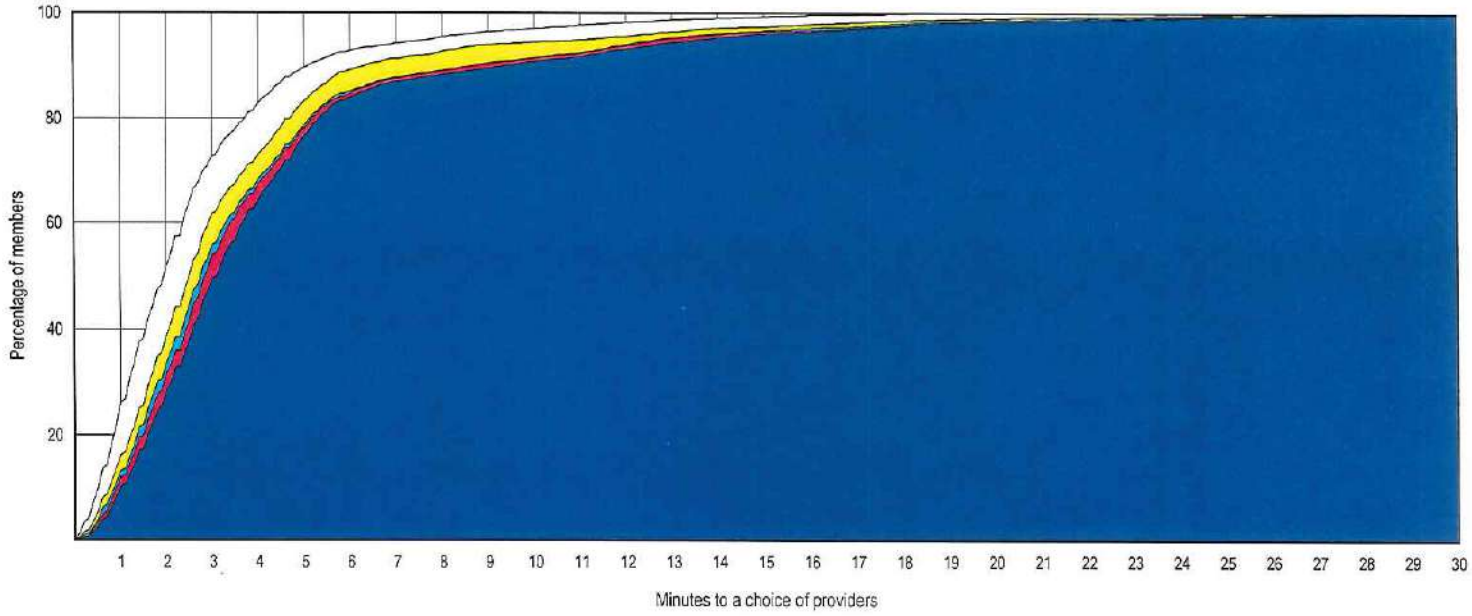

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 miles

Overall Access[1]

1,901 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

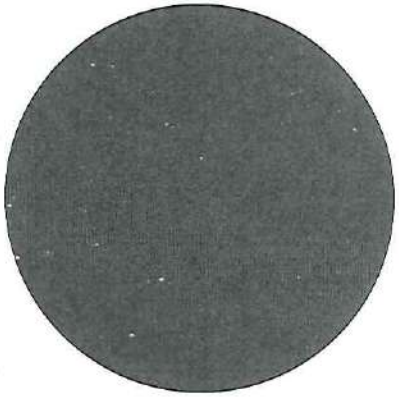

Distances

	Average
Distance to 1st closest provider	8.8 miles
Distance to 2nd closest provider	9.0 miles
Distance to 3rd closest provider	9.8 miles
Distance to 4th closest provider	9.9 miles
Distance to 5th closest provider	11.8 miles

Access Standard Comparison

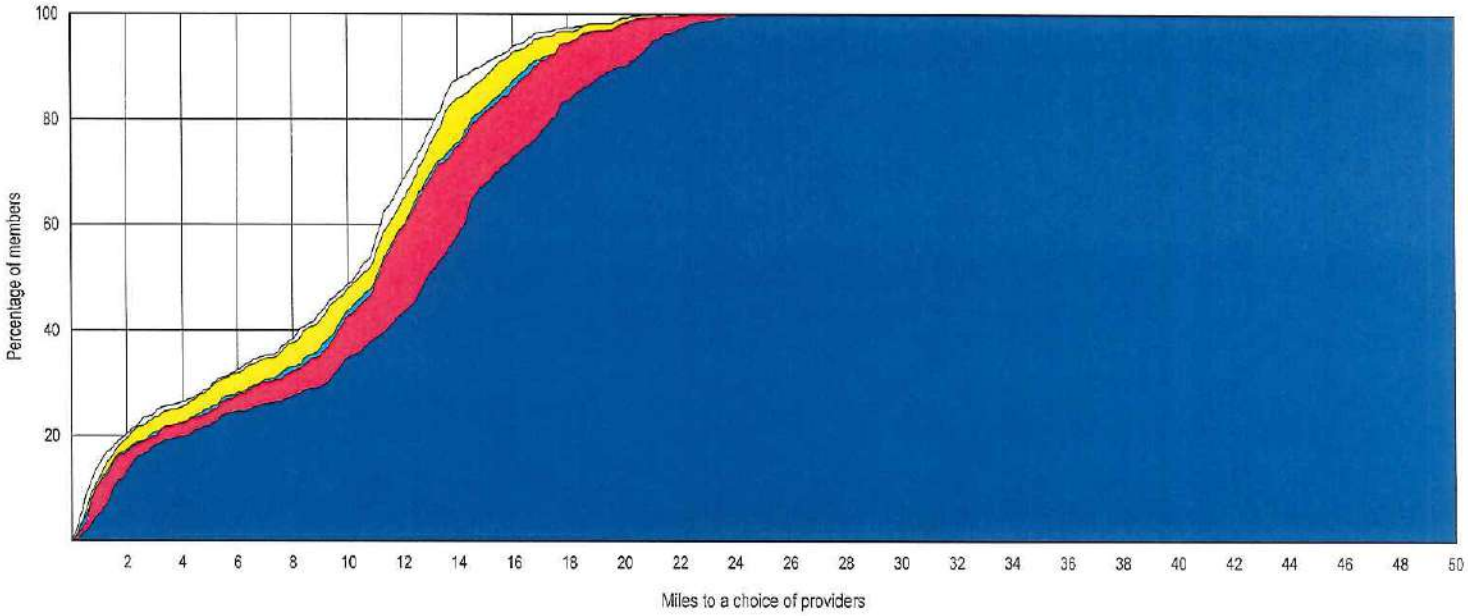

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 minutes

Overall Access[1]

1,901 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

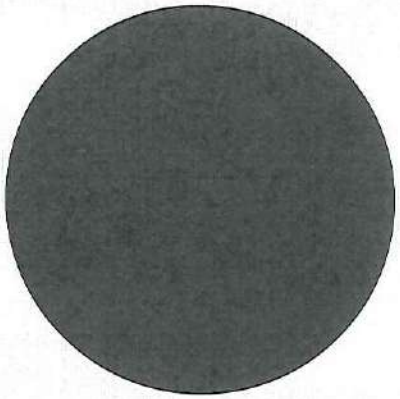

Times

	Average
Time to 1st closest provider	9.5 mins
Time to 2nd closest provider	9.8 mins
Time to 3rd closest provider	10.7 mins
Time to 4th closest provider	10.8 mins
Time to 5th closest provider	12.8 mins

Access Standard Comparison

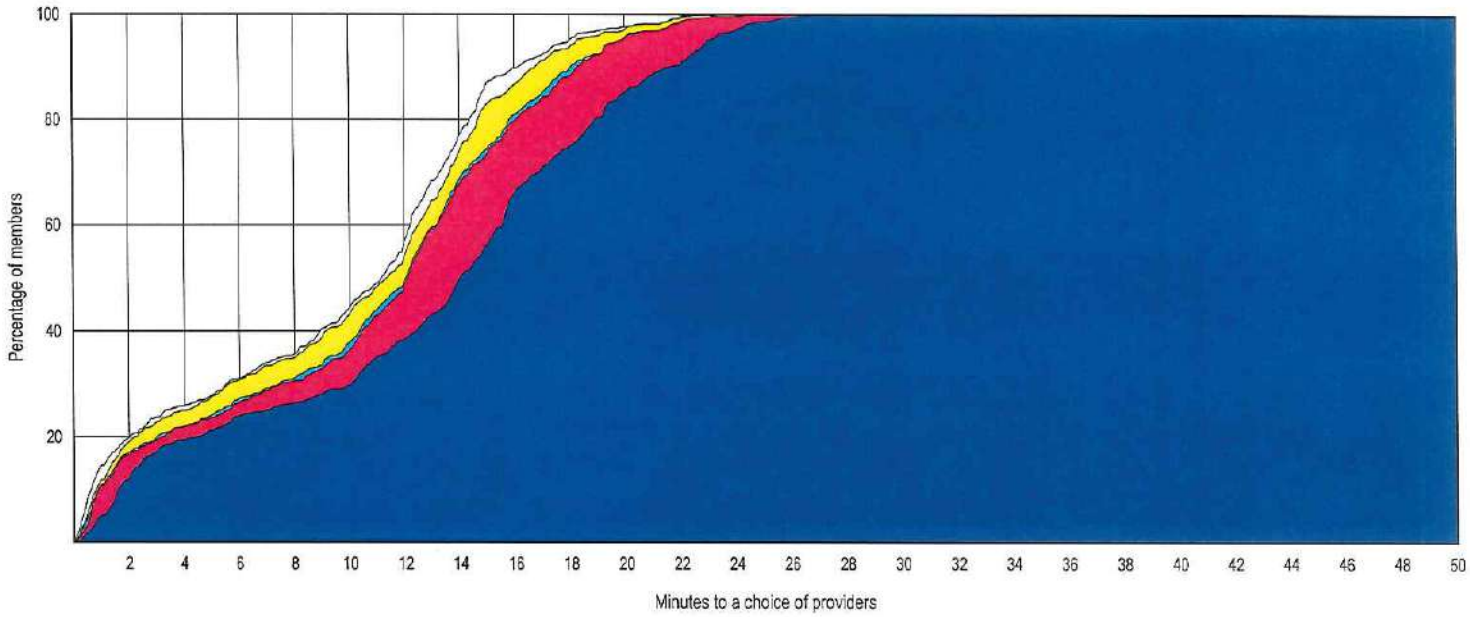

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Provider Locations

January 23, 2020

Region 4 Physical Therapists, Occupational Therapists and Chiropractors

Total Providers: 174

All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Physical Therapists, Occupational Therapists and Chiropractors

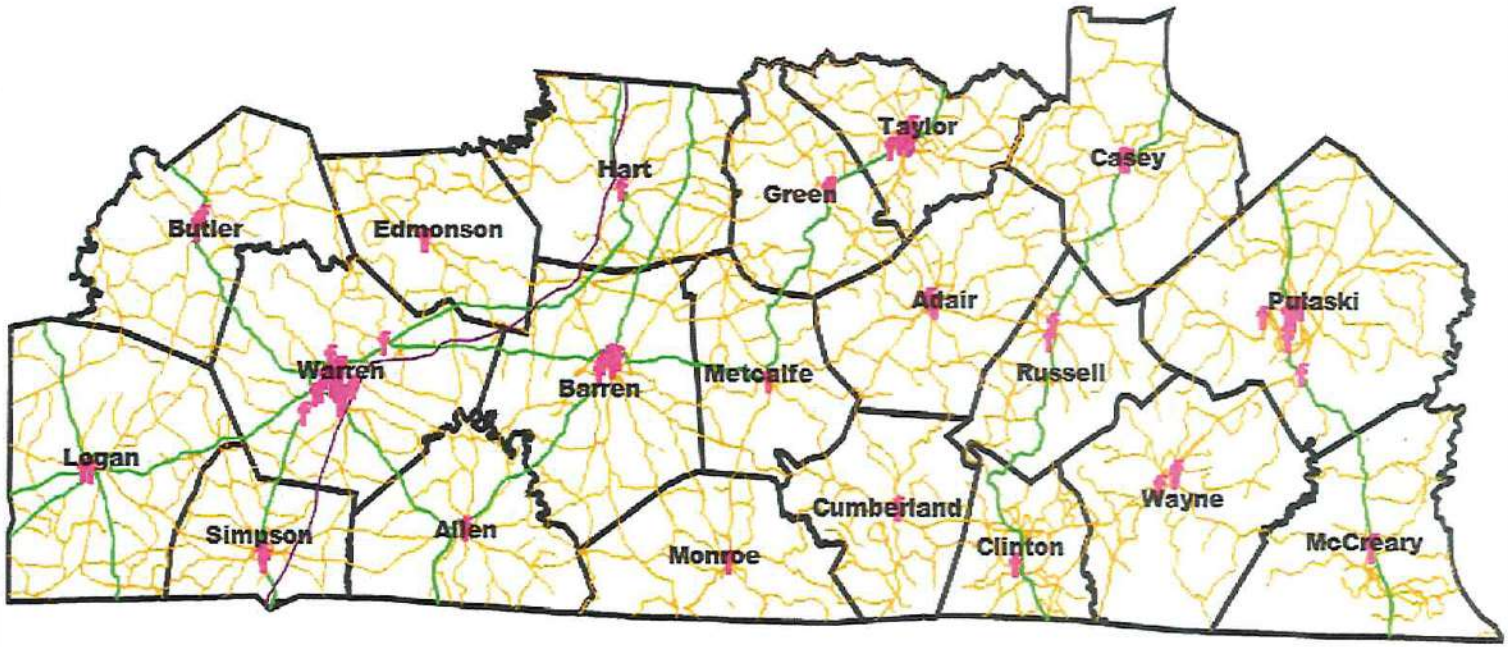

174 providers at 82 locations

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Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 miles

Overall Access[1]

7,413 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

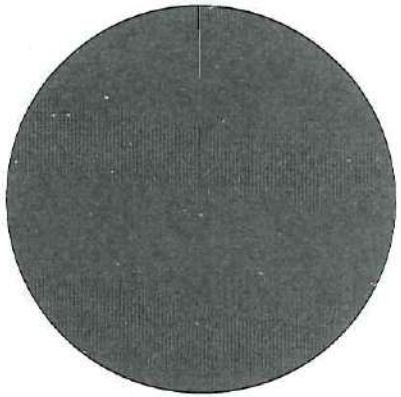

Distances

	Average
Distance to 1st closest provider	3.0 miles
Distance to 2nd closest provider	3.2 miles
Distance to 3rd closest provider	3.3 miles
Distance to 4th closest provider	3.3 miles
Distance to 5th closest provider	3.3 miles

Access Standard Comparison

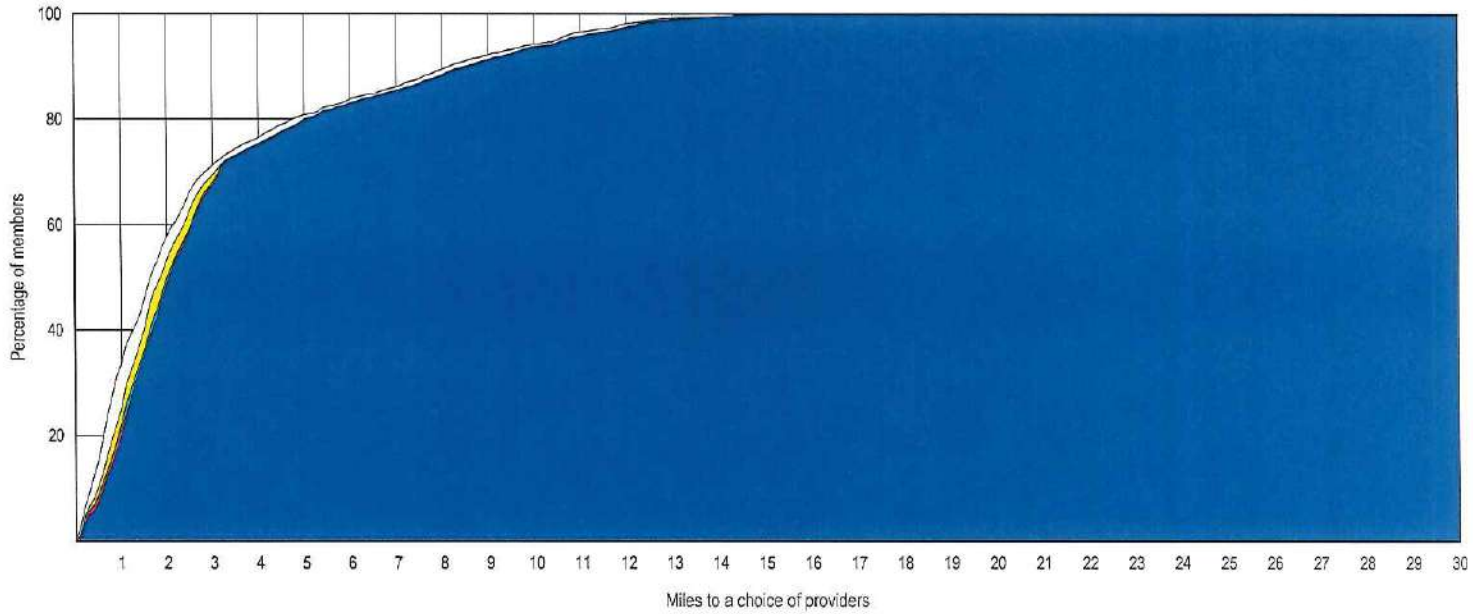

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Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 minutes

Overall Access[1]

7,413 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

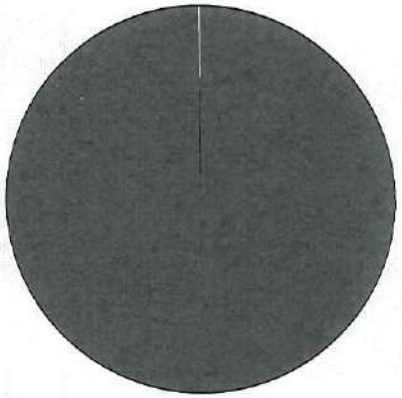

Times

	Average
Time to 1st closest provider	3.2 mins
Time to 2nd closest provider	3.4 mins
Time to 3rd closest provider	3.5 mins
Time to 4th closest provider	3.5 mins
Time to 5th closest provider	3.6 mins

Access Standard Comparison

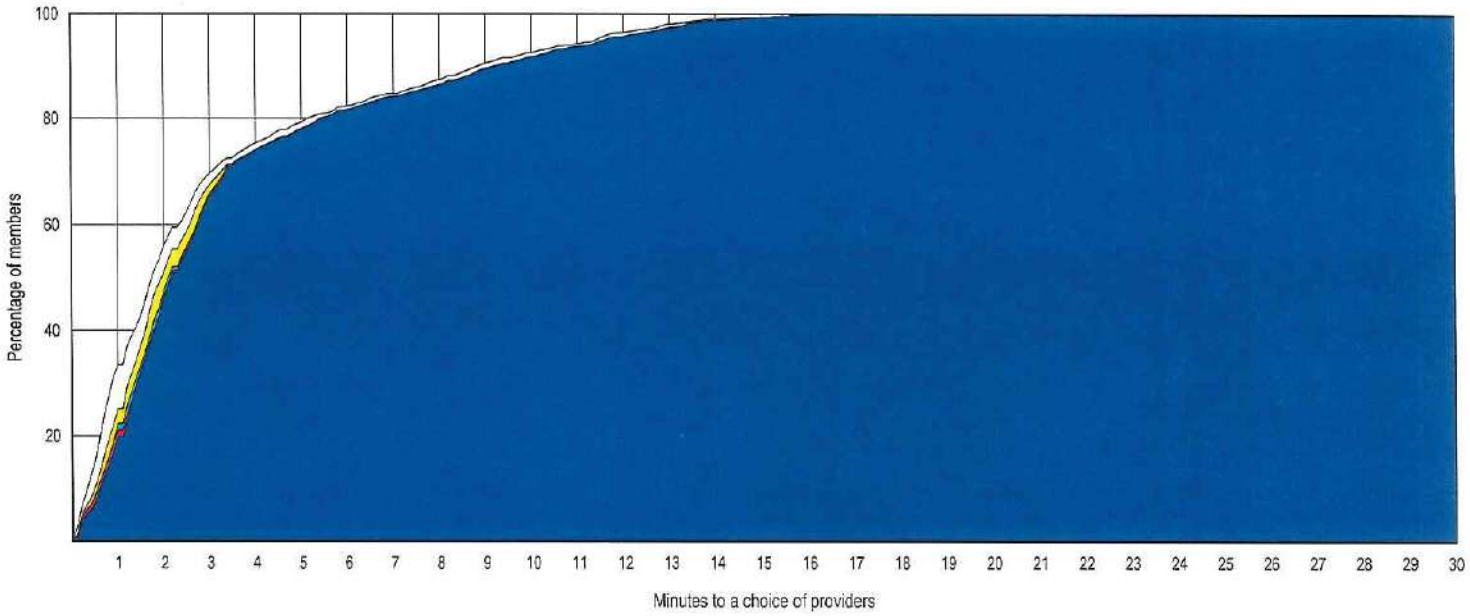

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 miles

Overall Access[1]

28,324 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

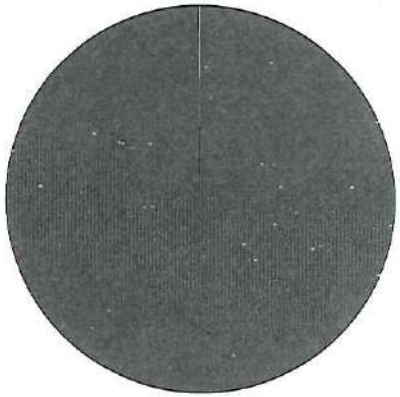

Distances

	Average
Distance to 1st closest provider	5.4 miles
Distance to 2nd closest provider	7.3 miles
Distance to 3rd closest provider	8.9 miles
Distance to 4th closest provider	12.3 miles
Distance to 5th closest provider	13.3 miles

Access Standard Comparison

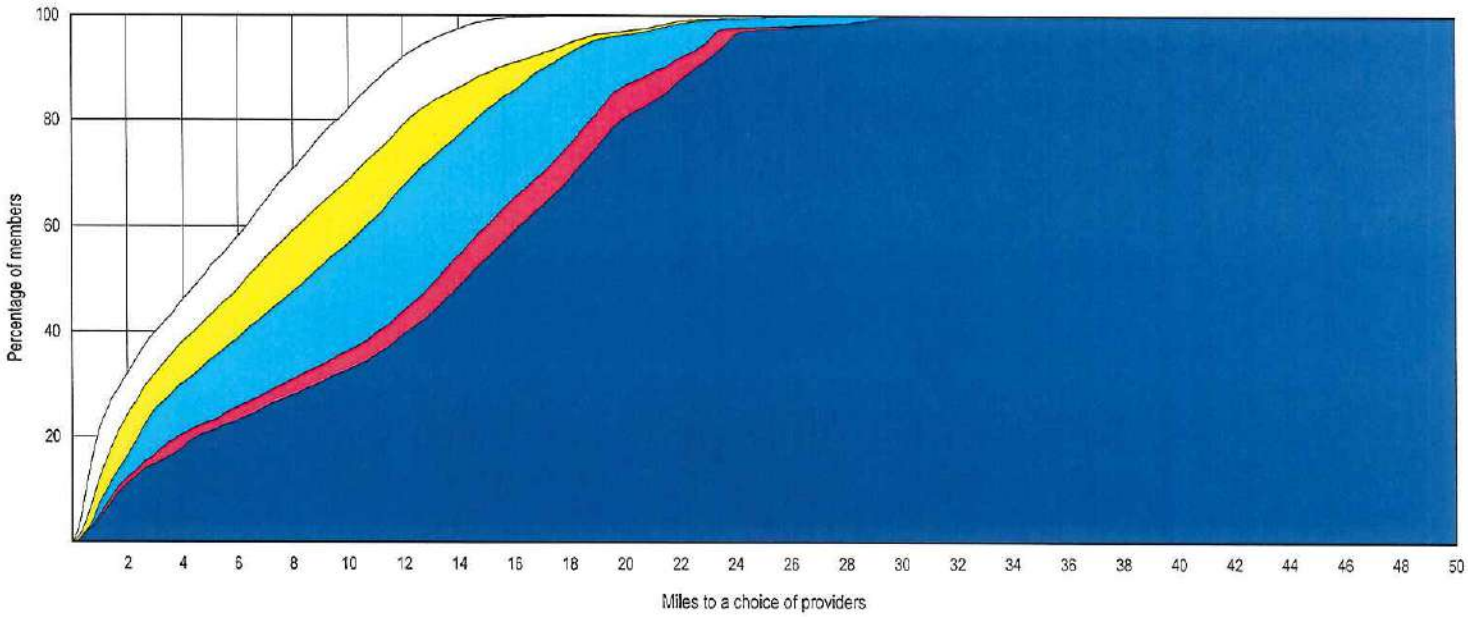

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 minutes

Overall Access[1]

28,324 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

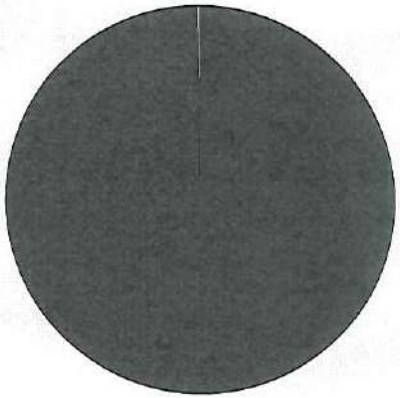

Times

	Average
Time to 1st closest provider	5.9 mins
Time to 2nd closest provider	8.0 mins
Time to 3rd closest provider	9.7 mins
Time to 4th closest provider	13.4 mins
Time to 5th closest provider	14.4 mins

Access Standard Comparison

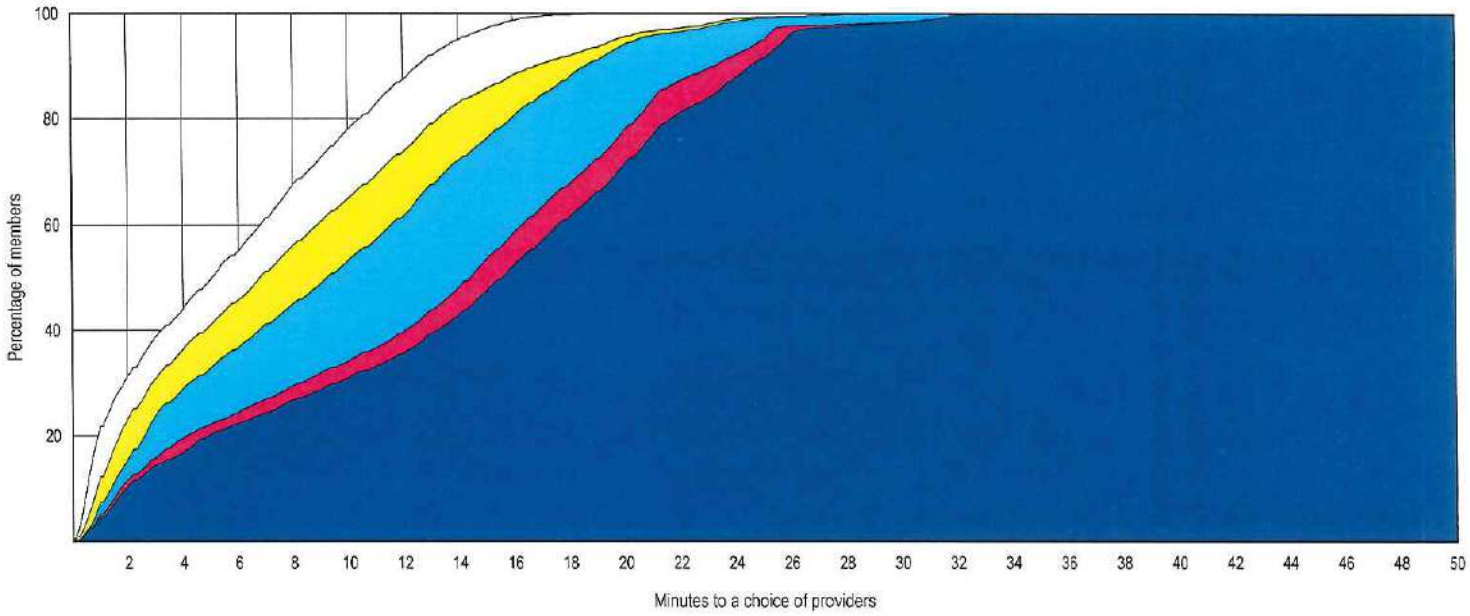

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Provider Locations

January 23, 2020

Region 5 Physical Therapists, Occupational Therapists and Chiropractors

Total Providers: 285

All providers

Interstetes

US Highways

State Highways

17.44 miles

Region 5 Physical Therapists, Occupational Therapists and Chiropractors

285 providers at 135 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 miles

Overall Access[1]

22,712 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

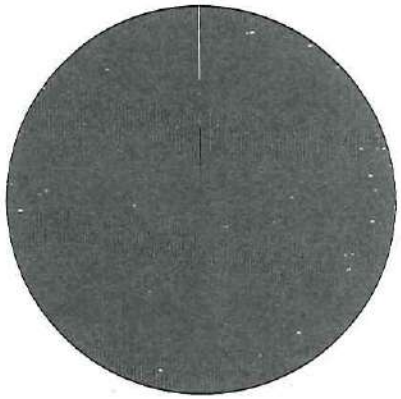

Distances

	Average
Distance to 1st closest provider	2.0 miles
Distance to 2nd closest provider	2.2 miles
Distance to 3rd closest provider	2.4 miles
Distance to 4th closest provider	2.5 miles
Distance to 5th closest provider	2.9 miles

Access Standard Comparison

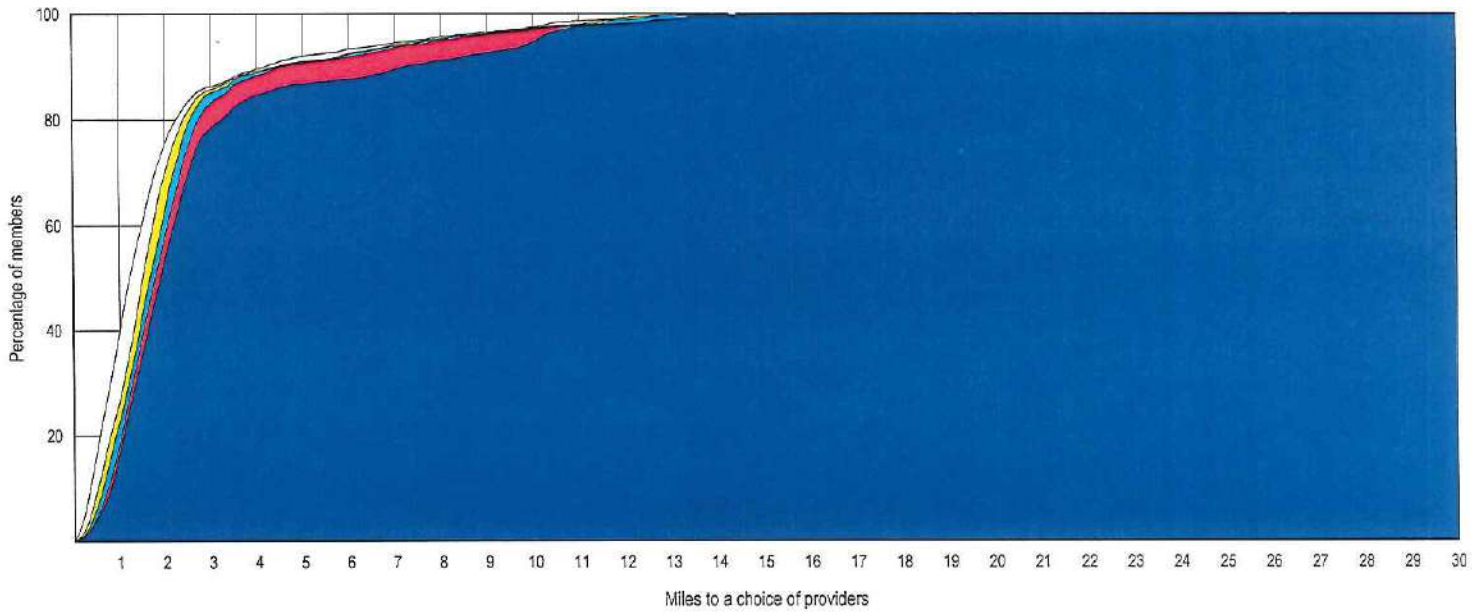

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 minutes

Overall Access[1]

22,712 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

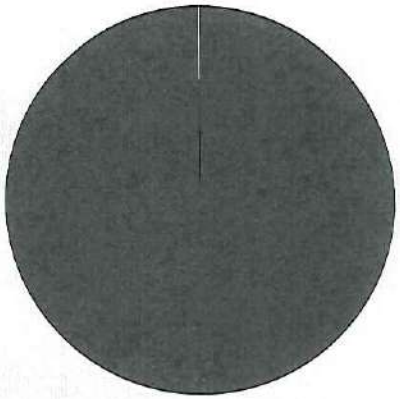

Times

	Average
Time to 1st closest provider	2.5 mins
Time to 2nd closest provider	2.8 mins
Time to 3rd closest provider	3.0 mins
Time to 4th closest provider	3.1 mins
Time to 5th closest provider	3.5 mins

Access Standard Comparison

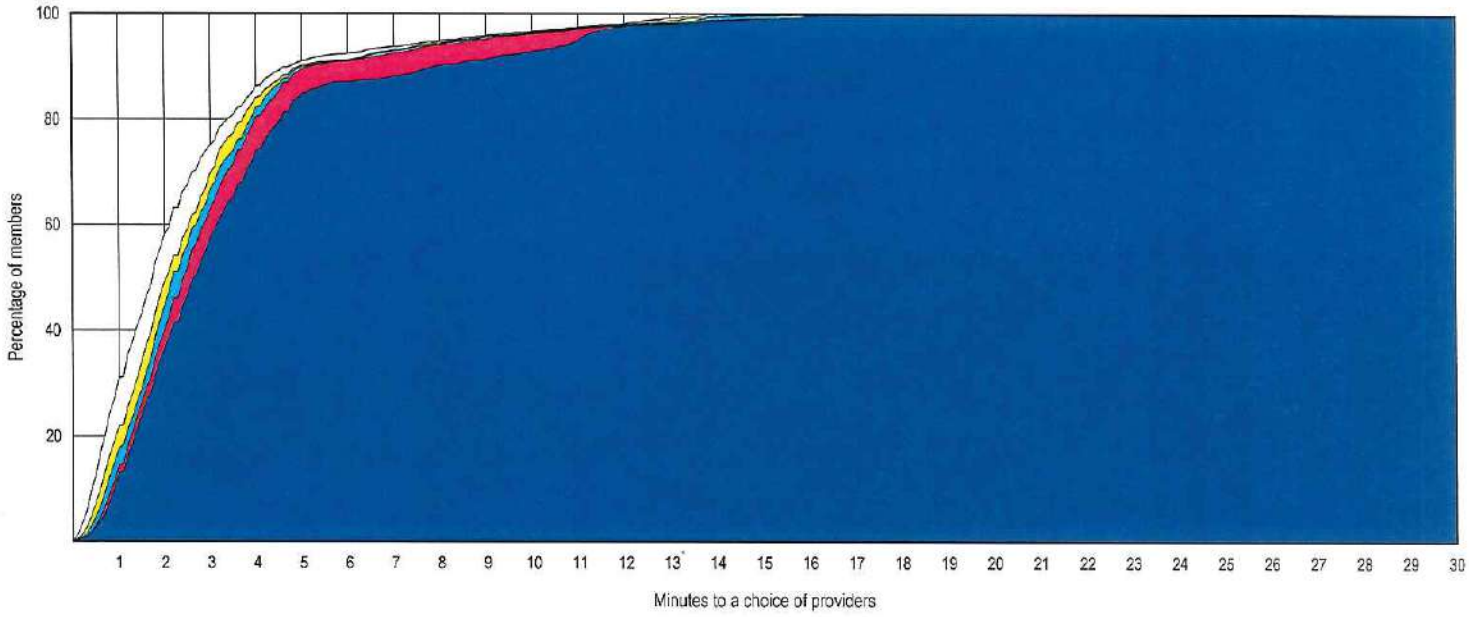

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Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 miles

Overall Access[1]

23,127 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

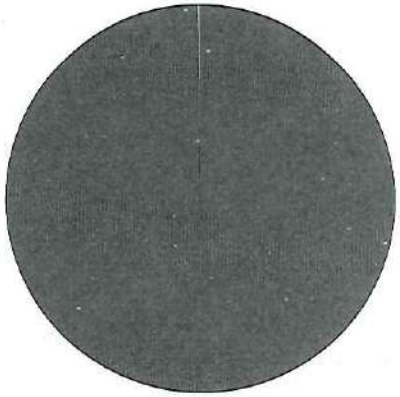

Distances

	Average
Distance to 1st closest provider	4.7 miles
Distance to 2nd closest provider	5.6 miles
Distance to 3rd closest provider	6.8 miles
Distance to 4th closest provider	7.7 miles
Distance to 5th closest provider	8.7 miles

Access Standard Comparison

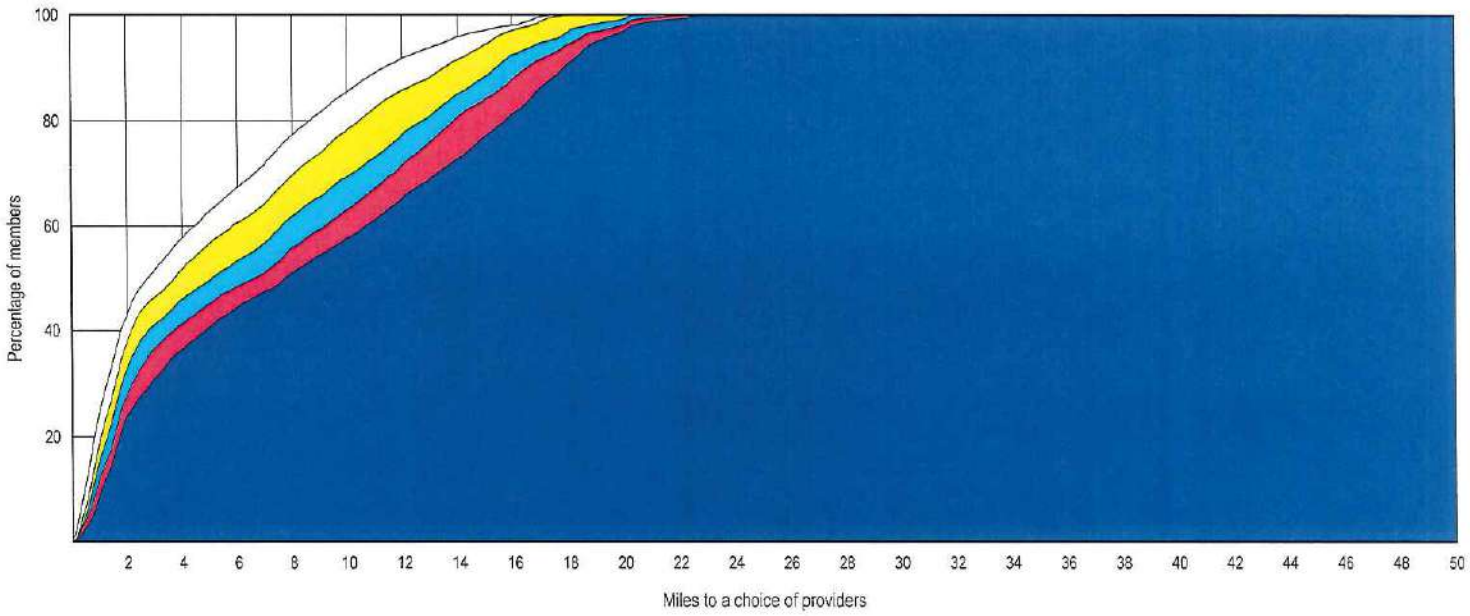

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 minutes

Overall Access[1]

23,127 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

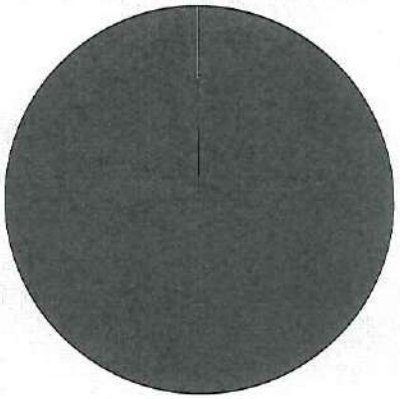

Times

	Average
Time to 1st closest provider	5.0 mins
Time to 2nd closest provider	6.0 mins
Time to 3rd closest provider	7.3 mins
Time to 4th closest provider	8.3 mins
Time to 5th closest provider	9.4 mins

Access Standard Comparison

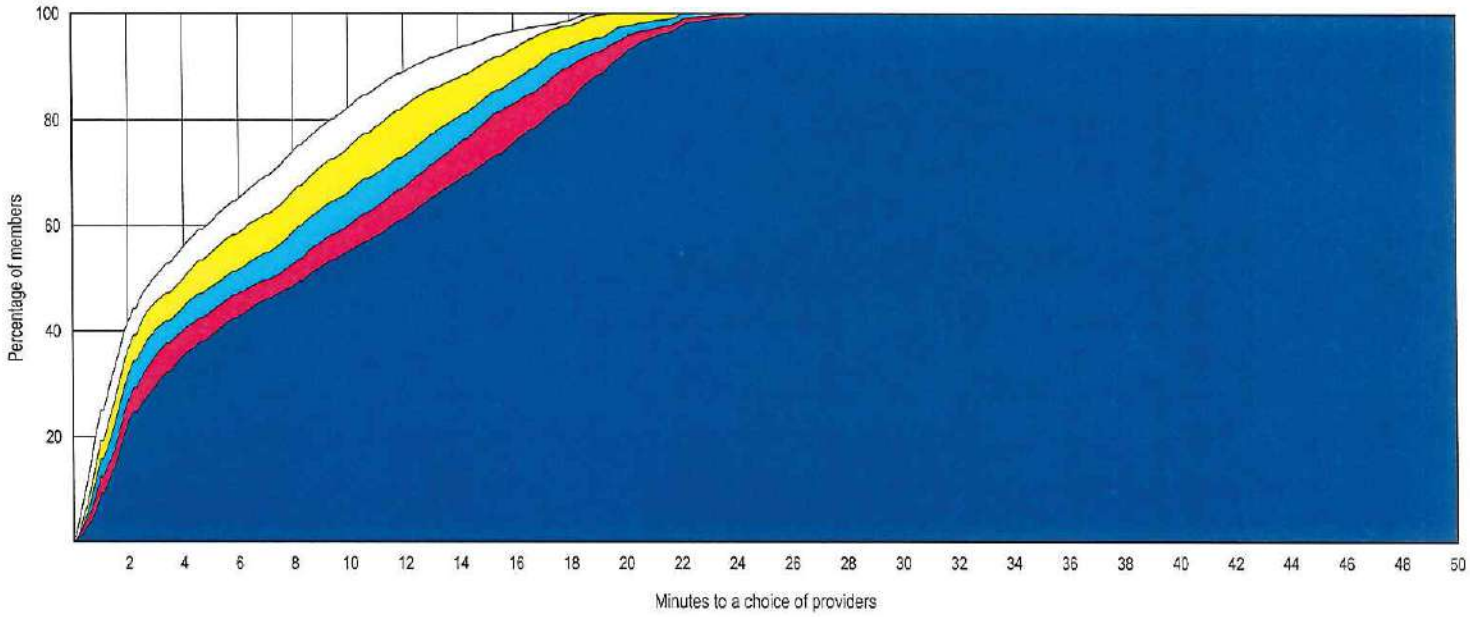

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Provider Locations

January 23, 2020

Region 6 Physical Therapists, Occupational Therapists and Chiropractors

Total Providers: 63

f All providers

Interstates

US Highways

State Highways

7.48 miles

Region 6 Physical Therapists, Occupational Therapists and Chiropractors

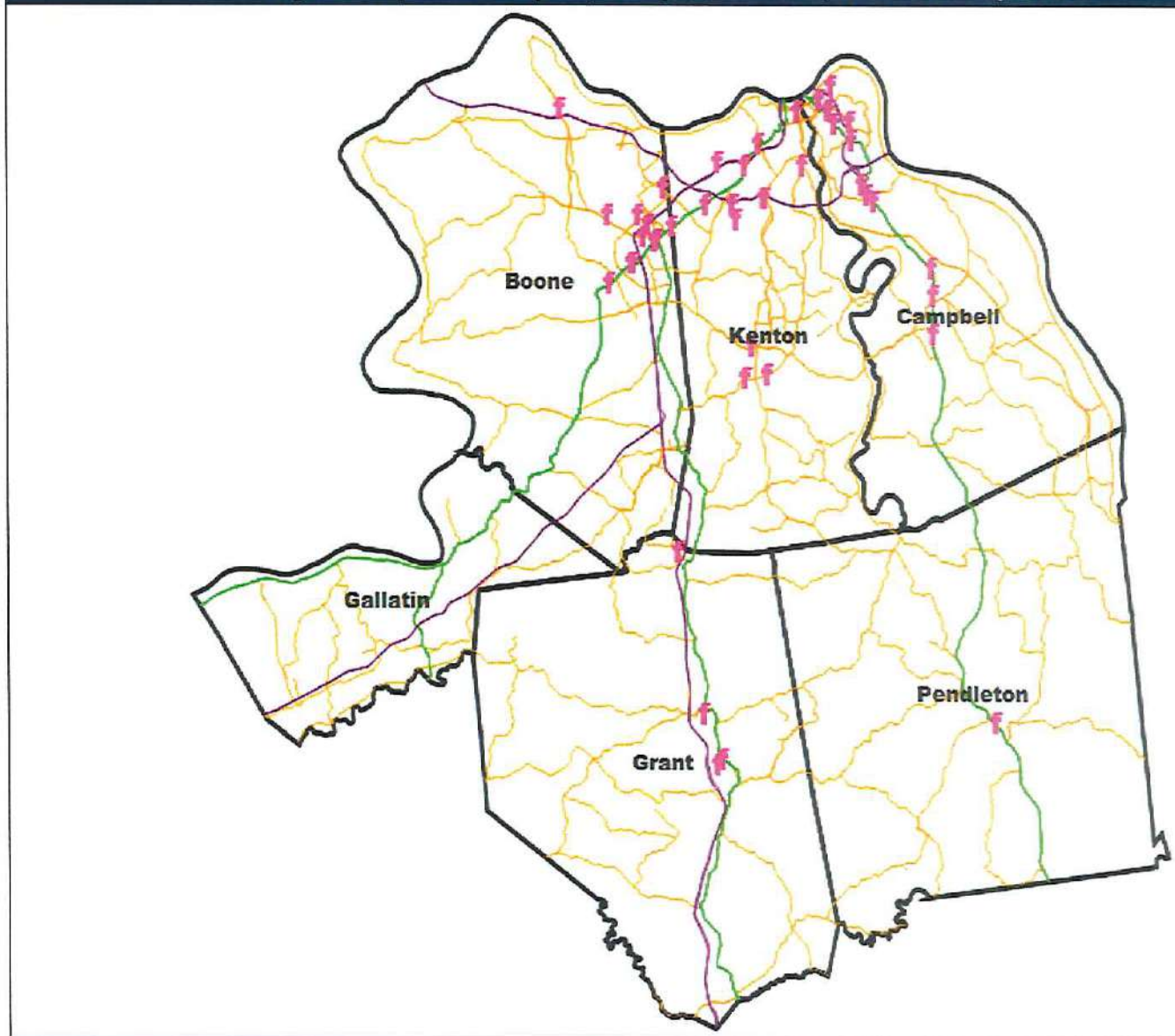

63 providers at 45 locations

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Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 miles

Overall Access[1]

22,413 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

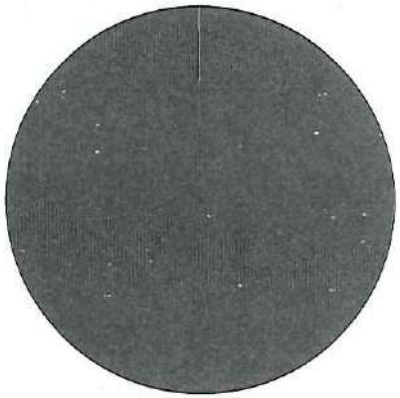

Distances

	Average
Distance to 1st closest provider	2.5 miles
Distance to 2nd closest provider	3.8 miles
Distance to 3rd closest provider	4.2 miles
Distance to 4th closest provider	4.5 miles
Distance to 5th closest provider	4.9 miles

Access Standard Comparison

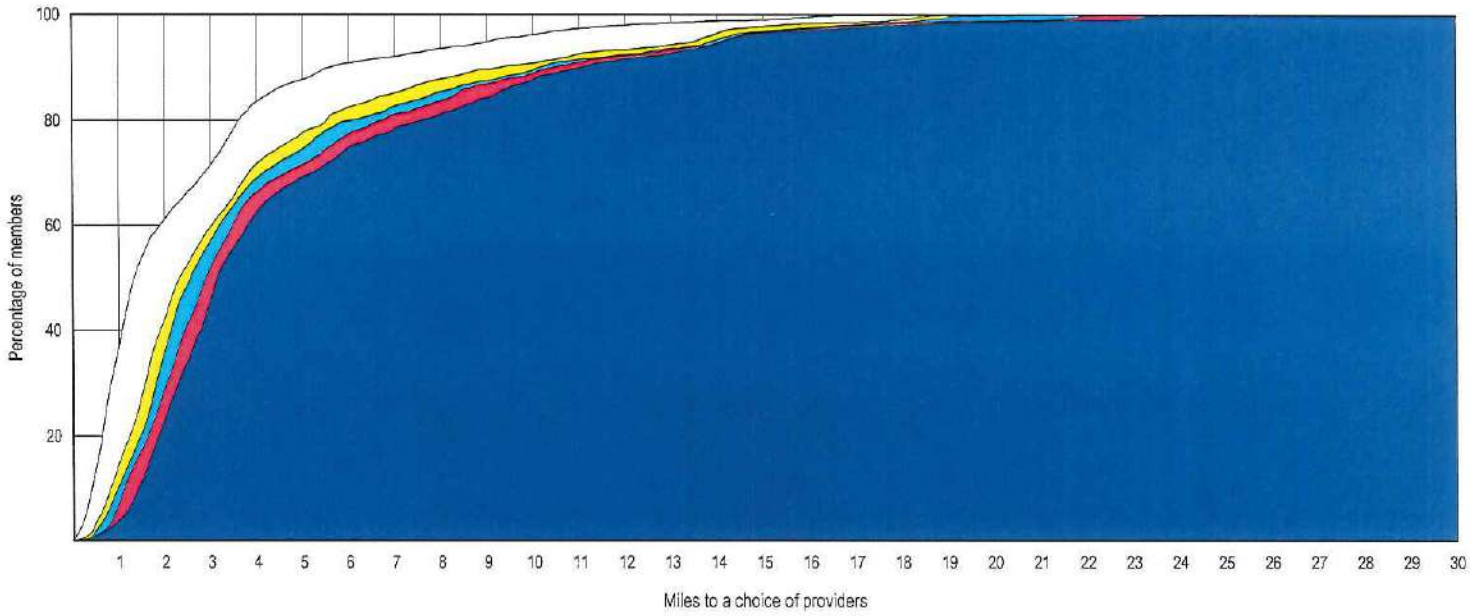

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 minutes

Overall Access[1]

22,413 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

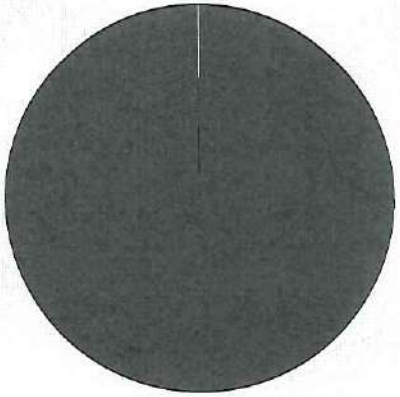

Times

	Average
Time to 1st closest provider	3.0 mins
Time to 2nd closest provider	4.6 mins
Time to 3rd closest provider	5.1 mins
Time to 4th closest provider	5.5 mins
Time to 5th closest provider	6.1 mins

Access Standard Comparison

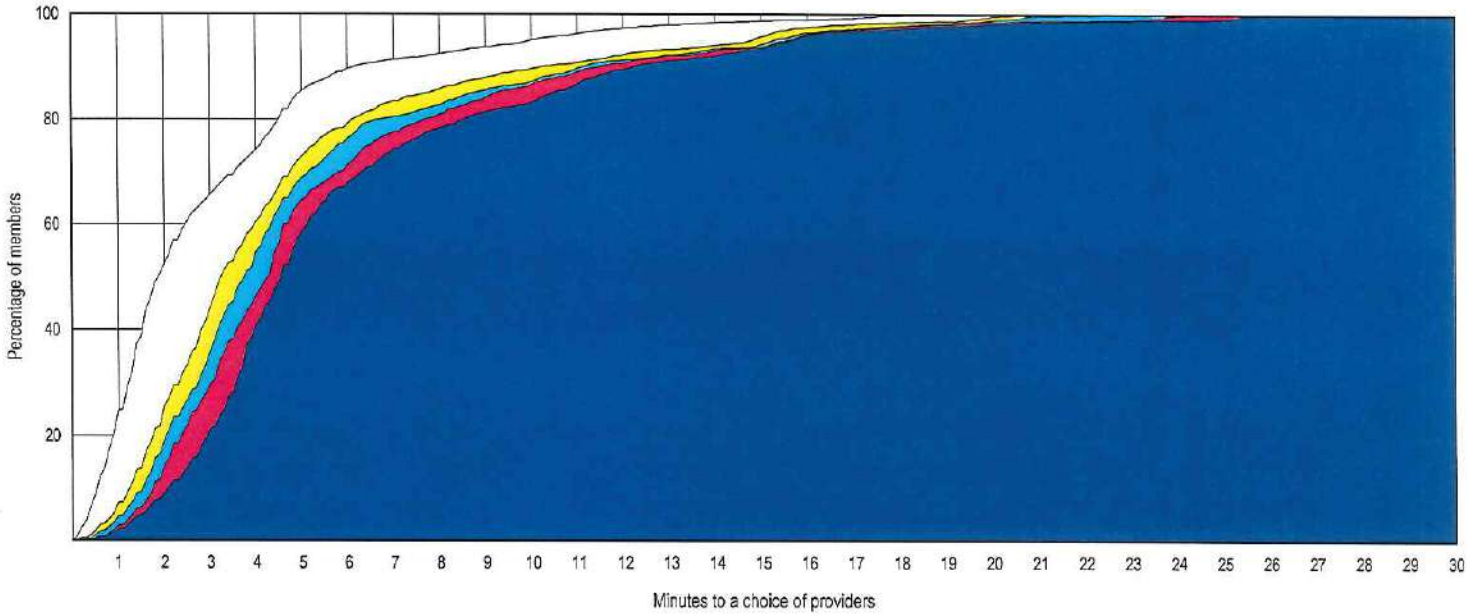

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Provider Locations

January 23, 2020

Region 7 Physical Therapists, Occupational Therapists and Chiropractors

Total Providers: 16

f All providers

Interstates

US Highways

State Highways

12.36 miles

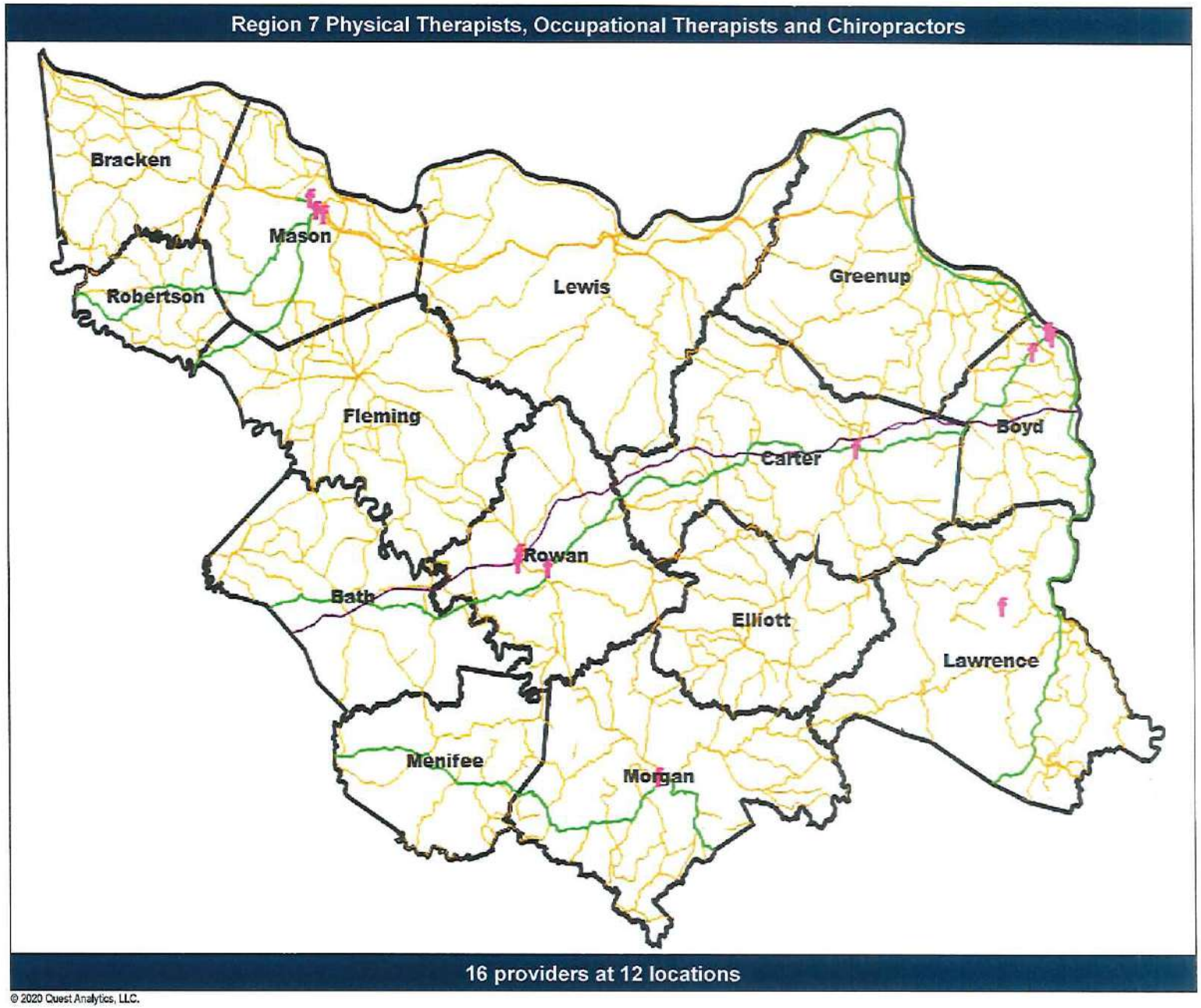

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 miles

Overall Access[1]

2,907 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

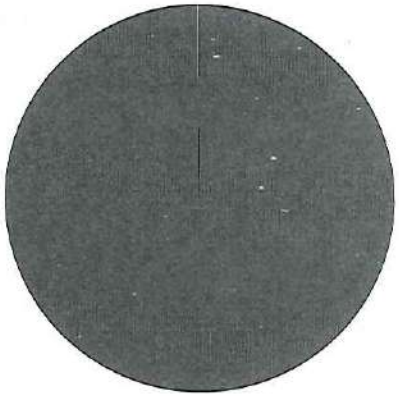

Distances

	Average
Distance to 1st closest provider	6.8 miles
Distance to 2nd closest provider	8.2 miles
Distance to 3rd closest provider	8.5 miles
Distance to 4th closest provider	8.9 miles
Distance to 5th closest provider	9.2 miles

Access Standard Comparison

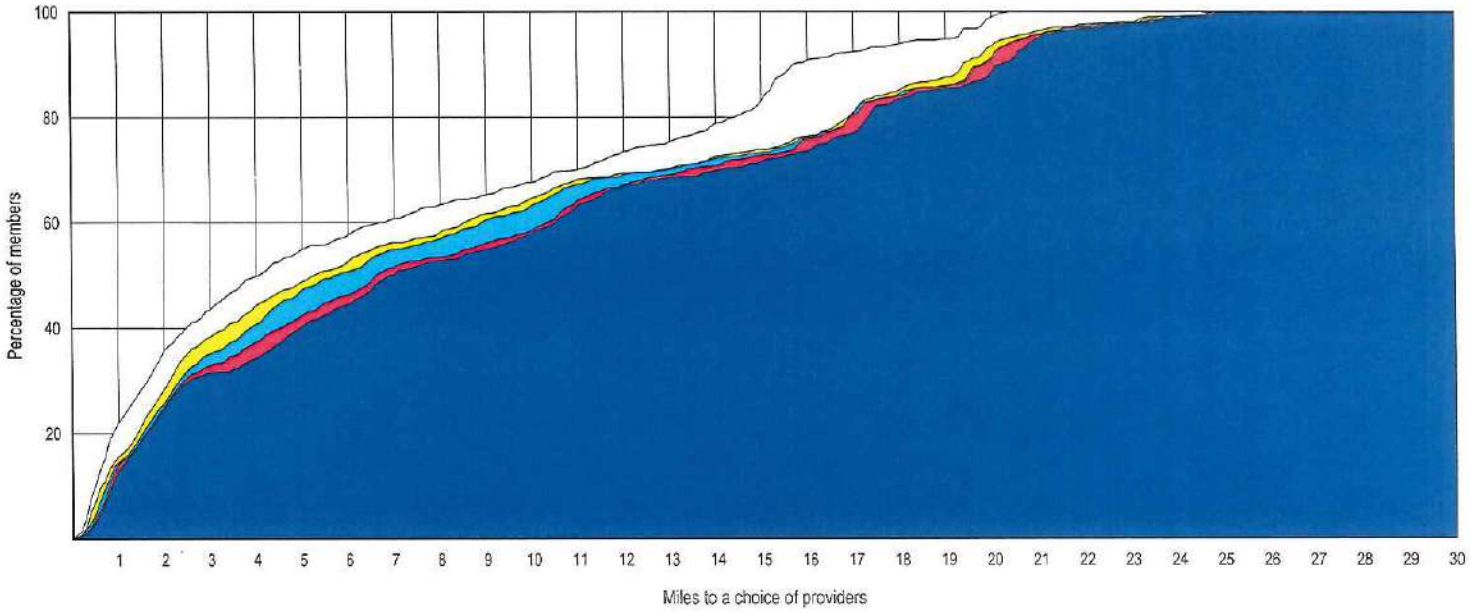

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 30 minutes

Overall Access[1]

2,907 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

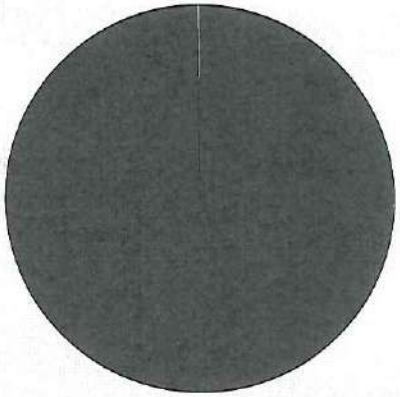

Times

	Average
Time to 1st closest provider	7.5 mins
Time to 2nd closest provider	8.9 mins
Time to 3rd closest provider	9.2 mins
Time to 4th closest provider	9.7 mins
Time to 5th closest provider	10.0 mins

Access Standard Comparison

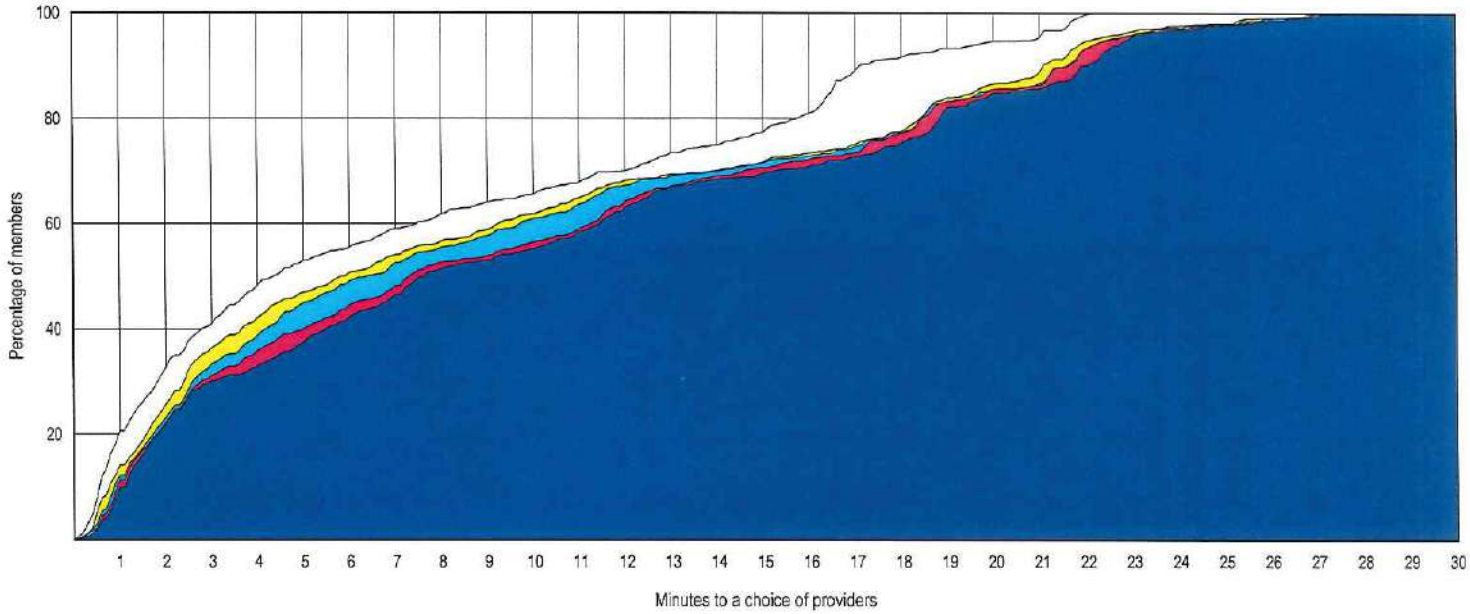

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Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 miles

Overall Access[1]

10,408 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

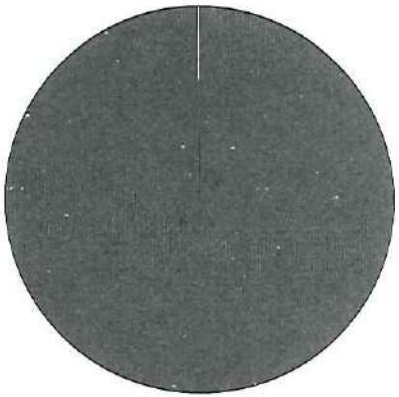

Distances

	Average
Distance to 1st closest provider	9.1 miles
Distance to 2nd closest provider	10.8 miles
Distance to 3rd closest provider	12.1 miles
Distance to 4th closest provider	13.6 miles
Distance to 5th closest provider	14.2 miles

Access Standard Comparison

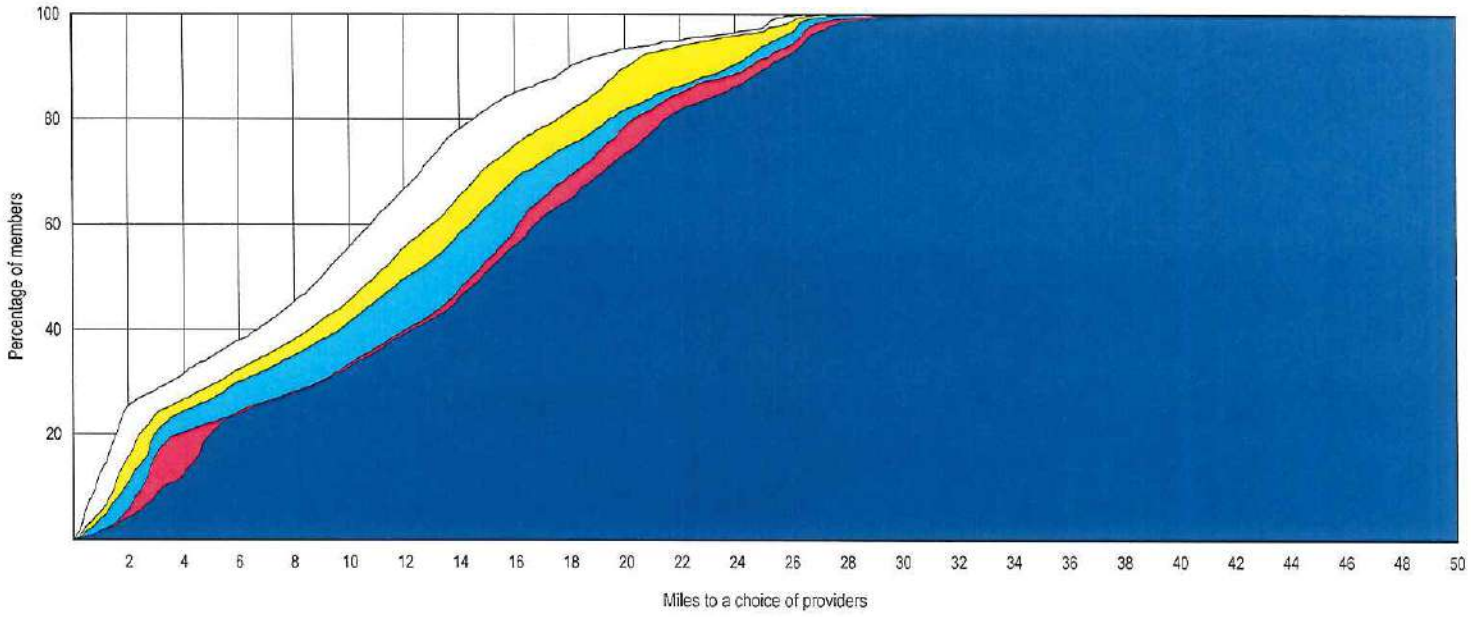

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis

Region 7 Rural - 1 in 50 minutes

Member / Provider Groups

Region 7 Rural Members

Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph

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

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

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:

1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 minutes

Overall Access[1]

10,408 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

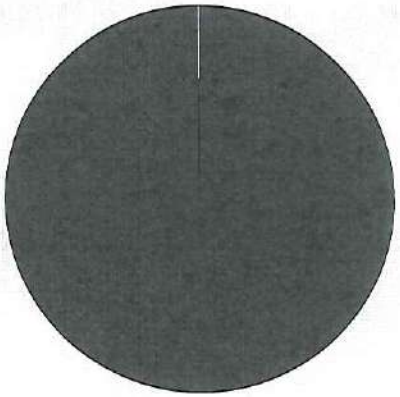

Times

	Average
Time to 1st closest provider	9.8 mins
Time to 2nd closest provider	11.7 mins
Time to 3rd closest provider	13.1 mins
Time to 4th closest provider	14.7 mins
Time to 5th closest provider	15.5 mins

Access Standard Comparison

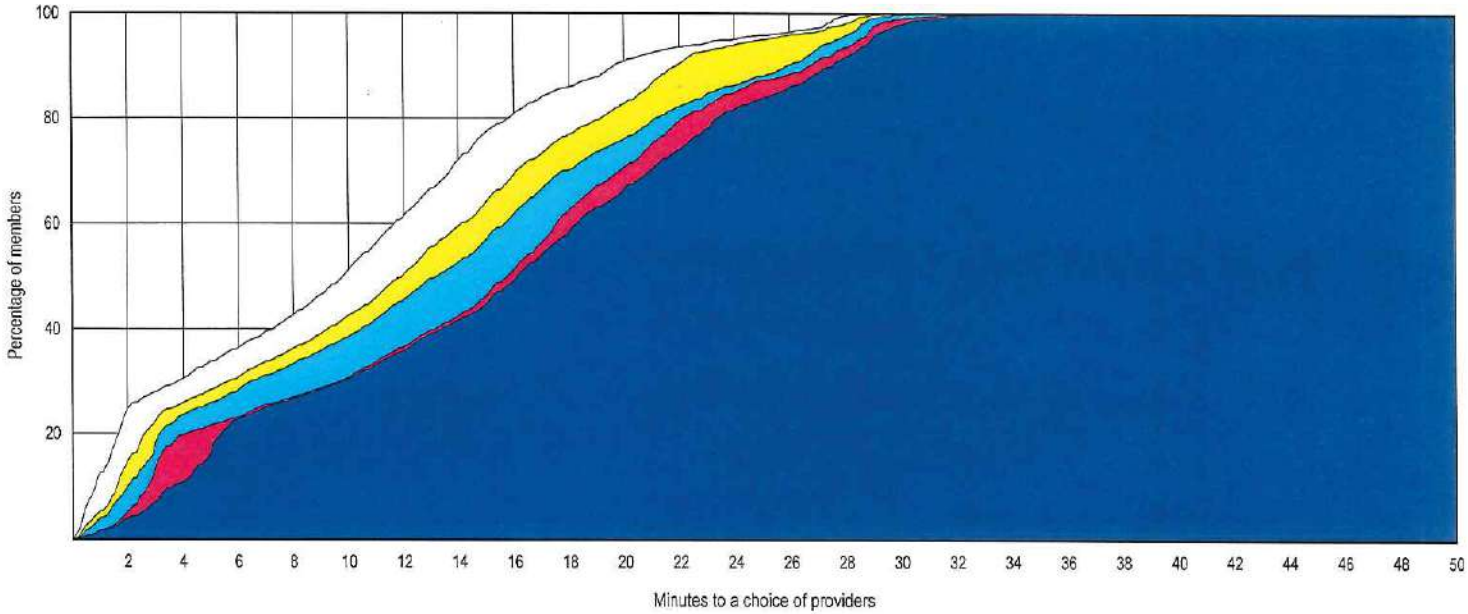

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Provider Locations

January 23, 2020

Region 8 Physical Therapists, Occupational Therapists and Chiropractors

Total Providers: 39

f All providers

Interstates

US Highways

State Highways

16.38 miles

Region 8 Physical Therapists, Occupational Therapists and Chiropractors

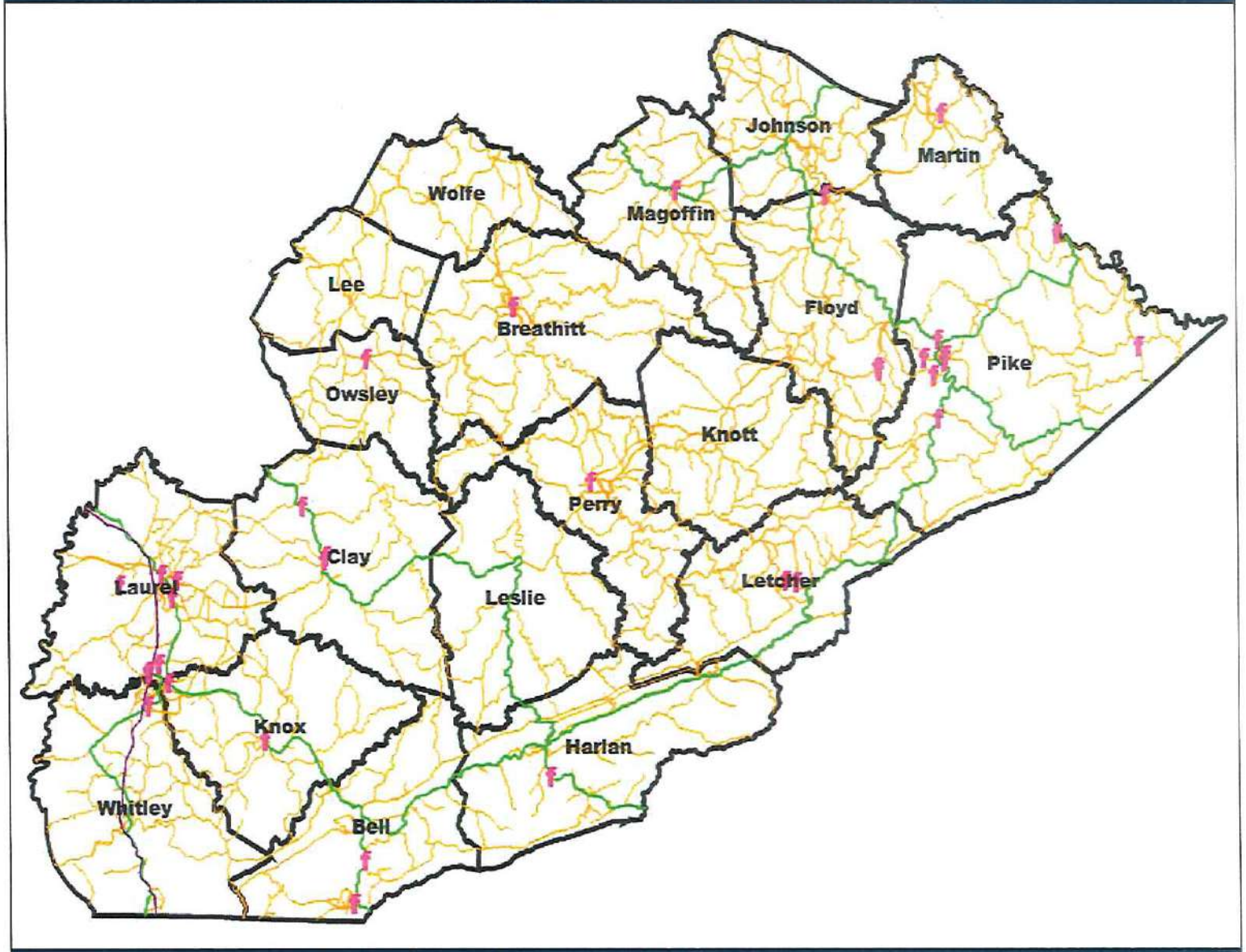

39 providers at 35 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 miles

Overall Access[1]

31,600 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

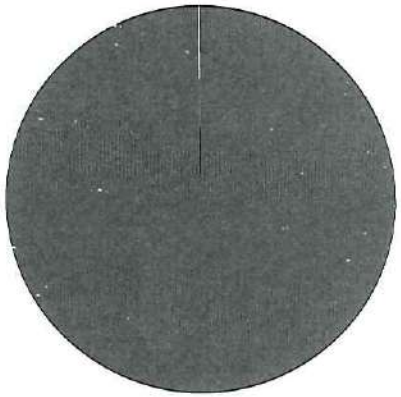

Times

	Average
Distance to 1st closest provider	5.9 miles
Distance to 2nd closest provider	7.7 miles
Distance to 3rd closest provider	9.3 miles
Distance to 4th closest provider	10.5 miles
Distance to 5th closest provider	11.5 miles

Access Standard Comparison

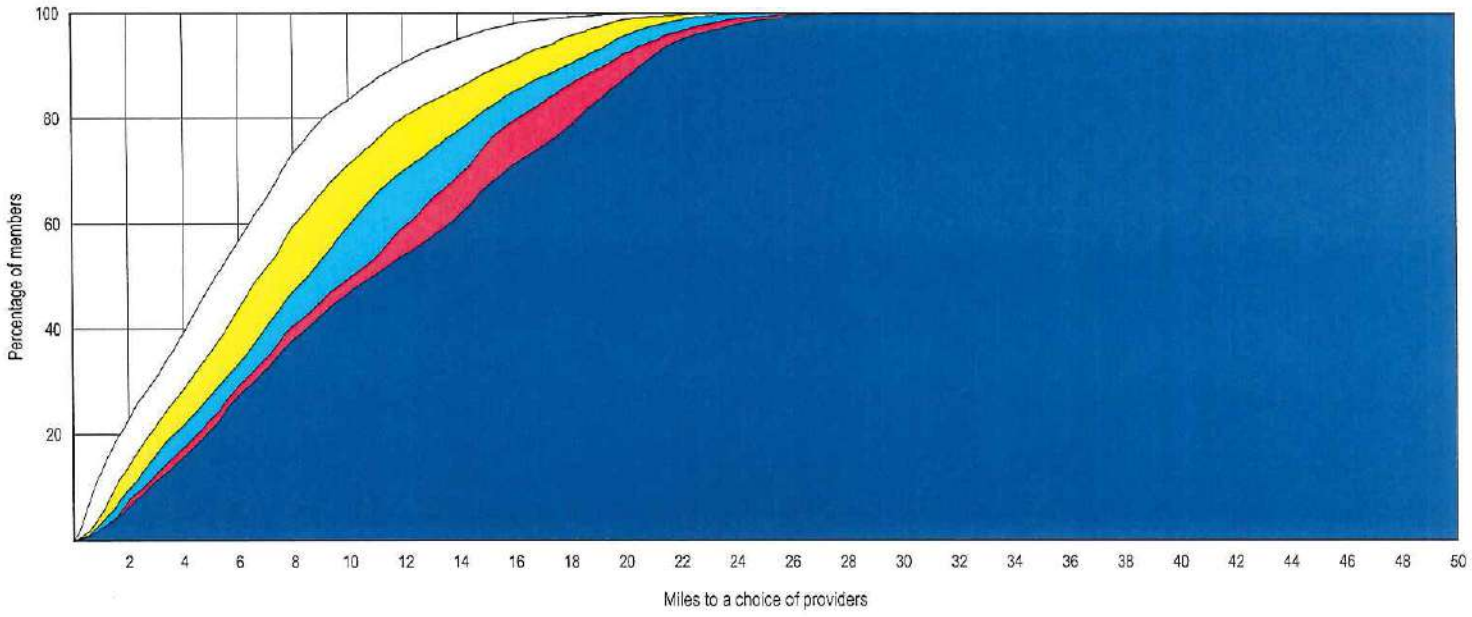

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Physical Therapists, Occupational Therapists and Chiropractors

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Physical Therapists, Occupational Therapists and Chiropractors) provider in 50 minutes

Overall Access[1]

31,600 Members
1,134 providers at 622 locations (Physical Therapists, Occupational Therapists and Chiropractors)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

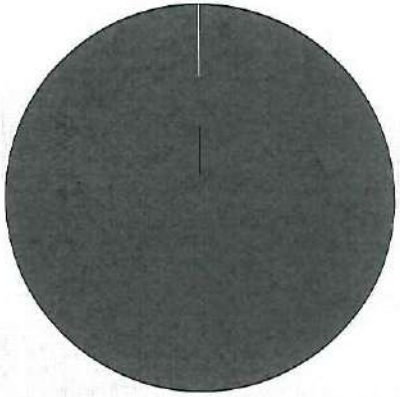

Times

	Average
Time to 1st closest provider	6.3 mins
Time to 2nd closest provider	8.4 mins
Time to 3rd closest provider	10.1 mins
Time to 4th closest provider	11.5 mins
Time to 5th closest provider	12.5 mins

Access Standard Comparison

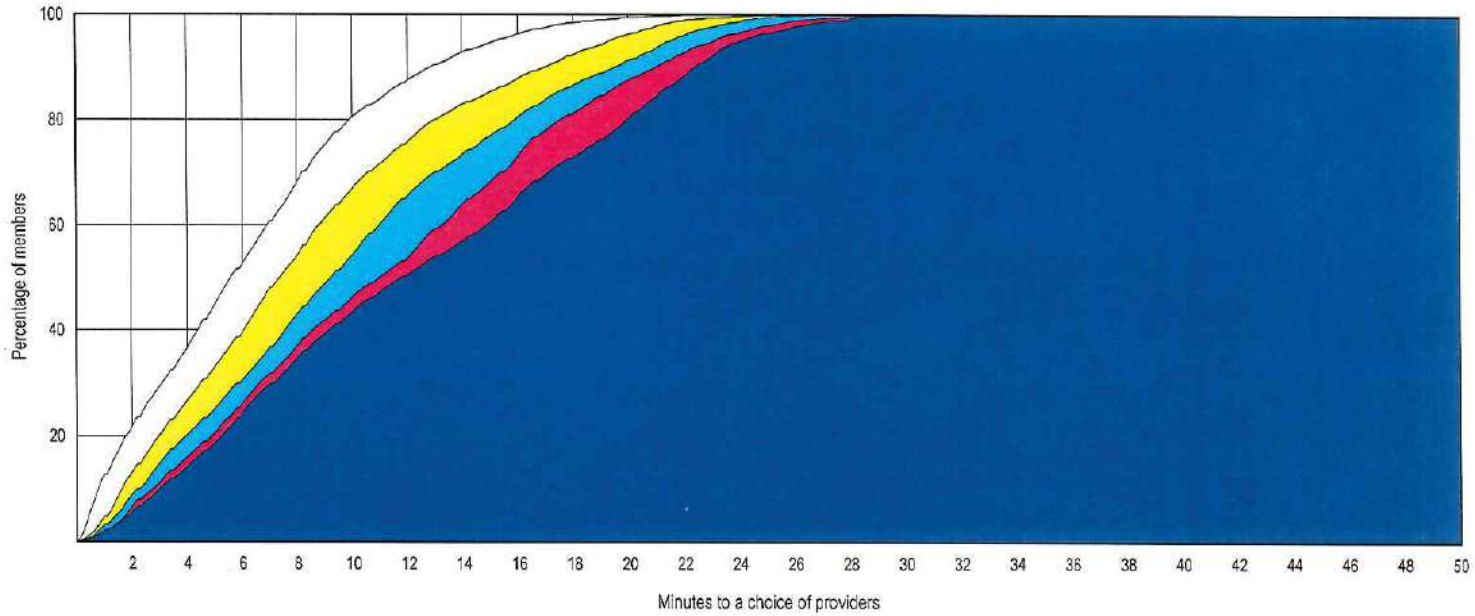

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Access Overview

January 15, 2020

Created for...
KY Medicaid Analysis

Created by...
Avesis

Access Analysis
ABHKY Medicaid Dental - by specialty

Member / Provider Groups
ABHKY Medicaid Membership (ABHKY Medicaid Service Area)
General Dentists - 271

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest

[1] The Access Standard is defined as (ABHKY Medicaid Membership (ABHKY Medicaid Service Area)) members accessing:
1 (General Dentists - 271) provider in 50 miles

Overall Access[1]

205,638 Members
786 providers at 1,029 locations (General Dentists - 271)

- 205,638 (100.0%) Members with access
- 0 (0.0%) Members without access

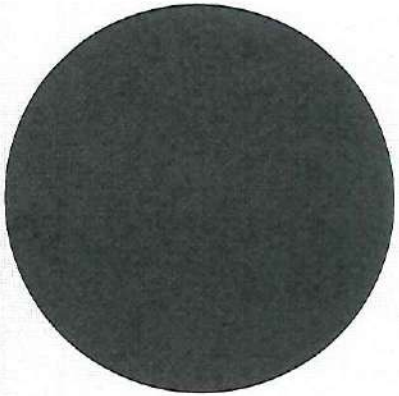

Times

	Average
Distance to 1st closest provider	3.7 miles
Distance to 2nd closest provider	4.5 miles
Distance to 3rd closest provider	5.4 miles

Access Standard Comparison

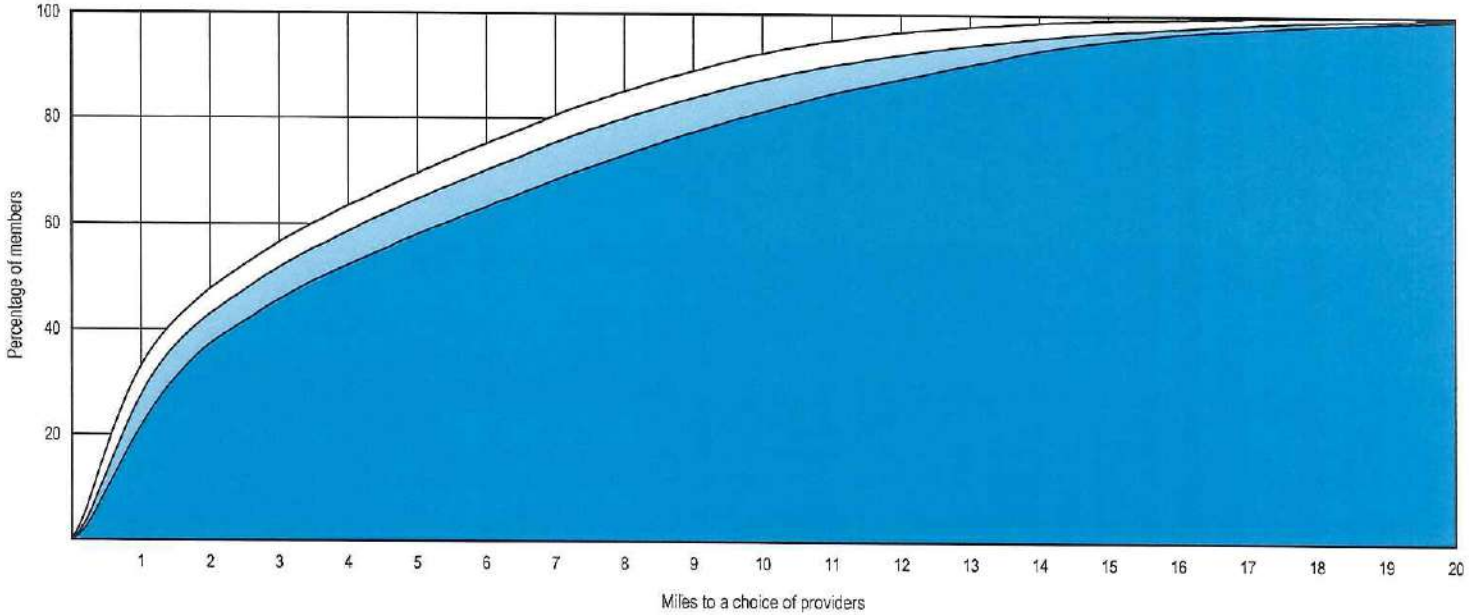

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Provider Locations

January 23, 2020

Region 1 Pharmacies and Durable Medical Equipment Suppliers

Total Providers: 30

h All providers

Interstates

US Highways

State Highways

12.93 miles

Region 1 Pharmacies and Durable Medical Equipment Suppliers

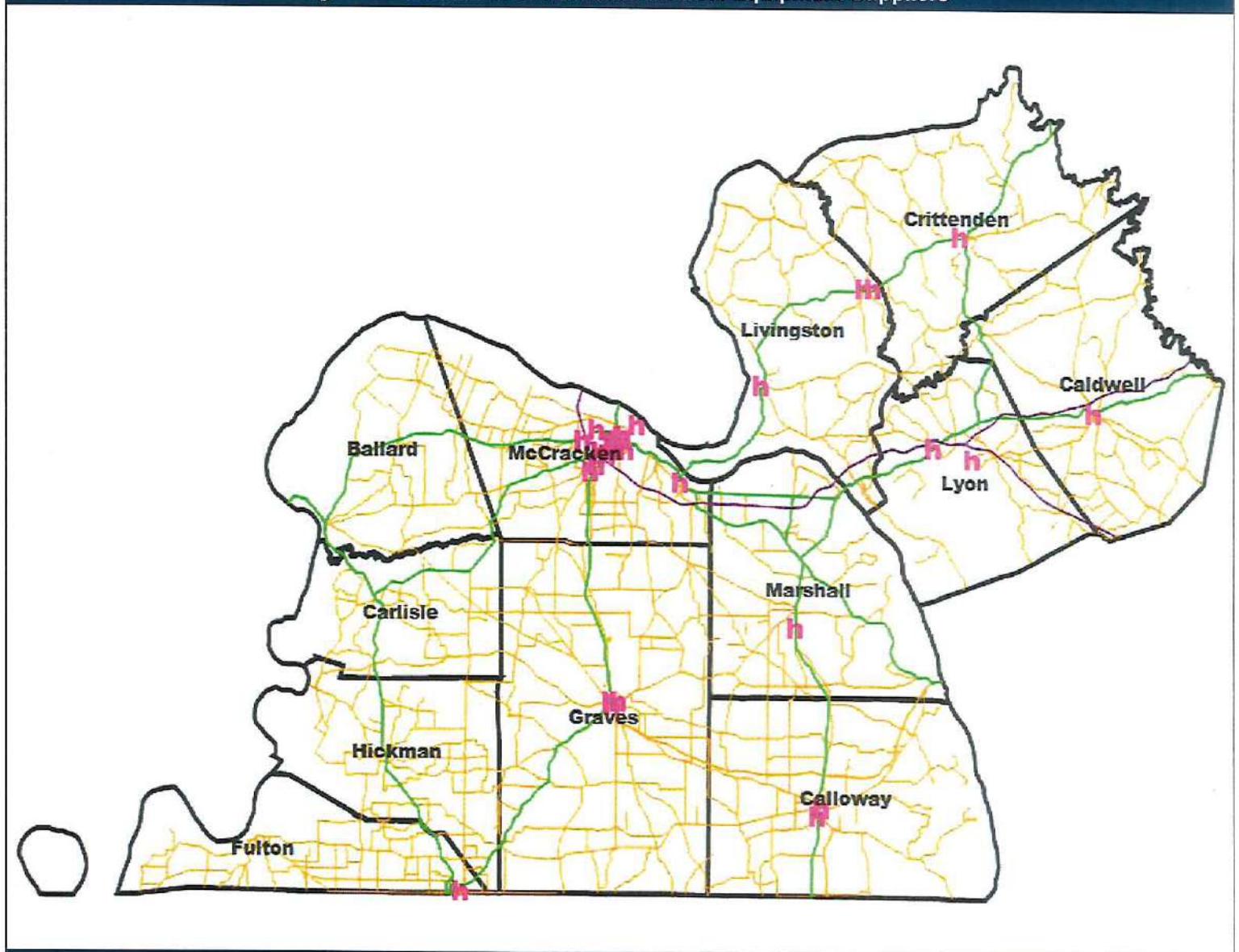

30 providers at 29 locations

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Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 miles

Overall Access[1]

11,338 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

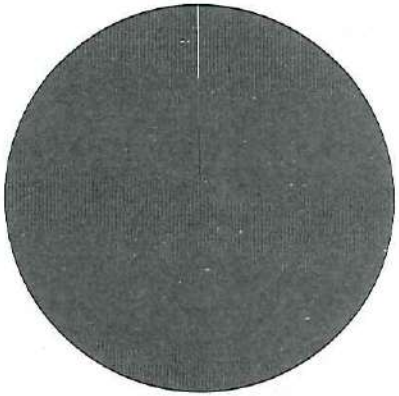

Times

	Average
Distance to 1st closest provider	5.8 miles
Distance to 2nd closest provider	9.4 miles
Distance to 3rd closest provider	10.2 miles
Distance to 4th closest provider	13.9 miles
Distance to 5th closest provider	17.9 miles

Access Standard Comparison

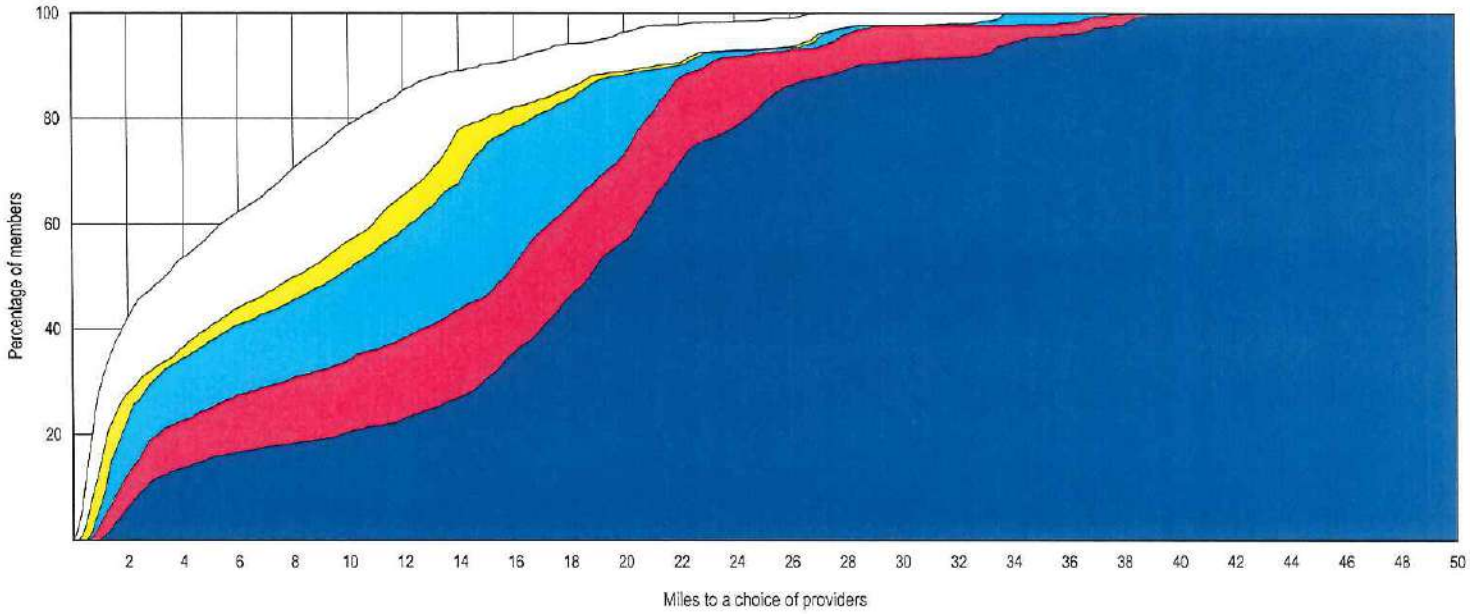

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Access Overview

January 24, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 minutes

Overall Access[1]

11,338 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 11,334 (99.9%) Members with access
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- 4 (0.0%) Members excluded

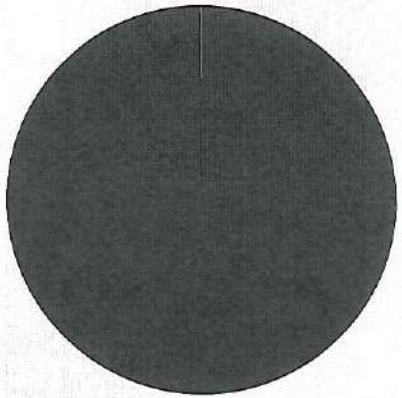

Times

	Average
Time to 1st closest provider	6.3 mins
Time to 2nd closest provider	10.2 mins
Time to 3rd closest provider	11.1 mins
Time to 4th closest provider	15.1 mins
Time to 5th closest provider	19.5 mins

Access Standard Comparison

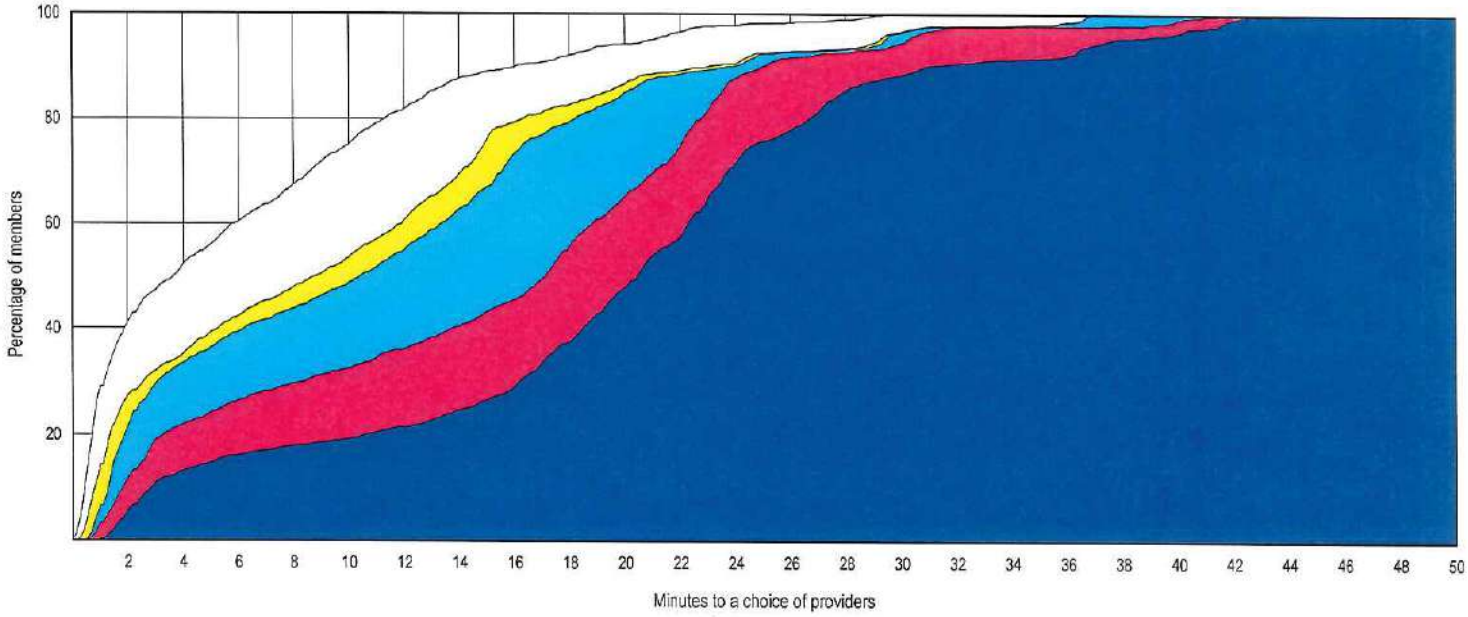

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Provider Locations

January 23, 2020

Region 2 Pharmacies and Durable Medical Equipment Suppliers

Total Providers: 34

h All providers

Interstates

US Highways

State Highways

15.14 miles

Region 2 Pharmacies and Durable Medical Equipment Suppliers

34 providers at 31 locations

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Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 30 miles

Overall Access[1]

16,143 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

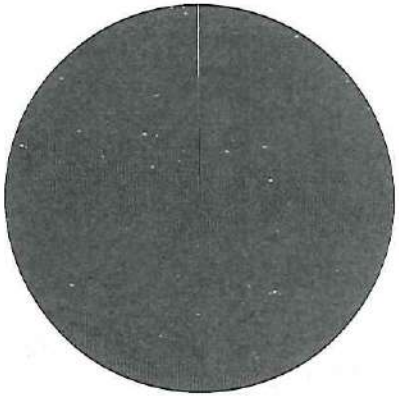

Distances

	Average
Distance to 1st closest provider	5.4 miles
Distance to 2nd closest provider	6.4 miles
Distance to 3rd closest provider	6.9 miles
Distance to 4th closest provider	9.2 miles
Distance to 5th closest provider	15.1 miles

Access Standard Comparison

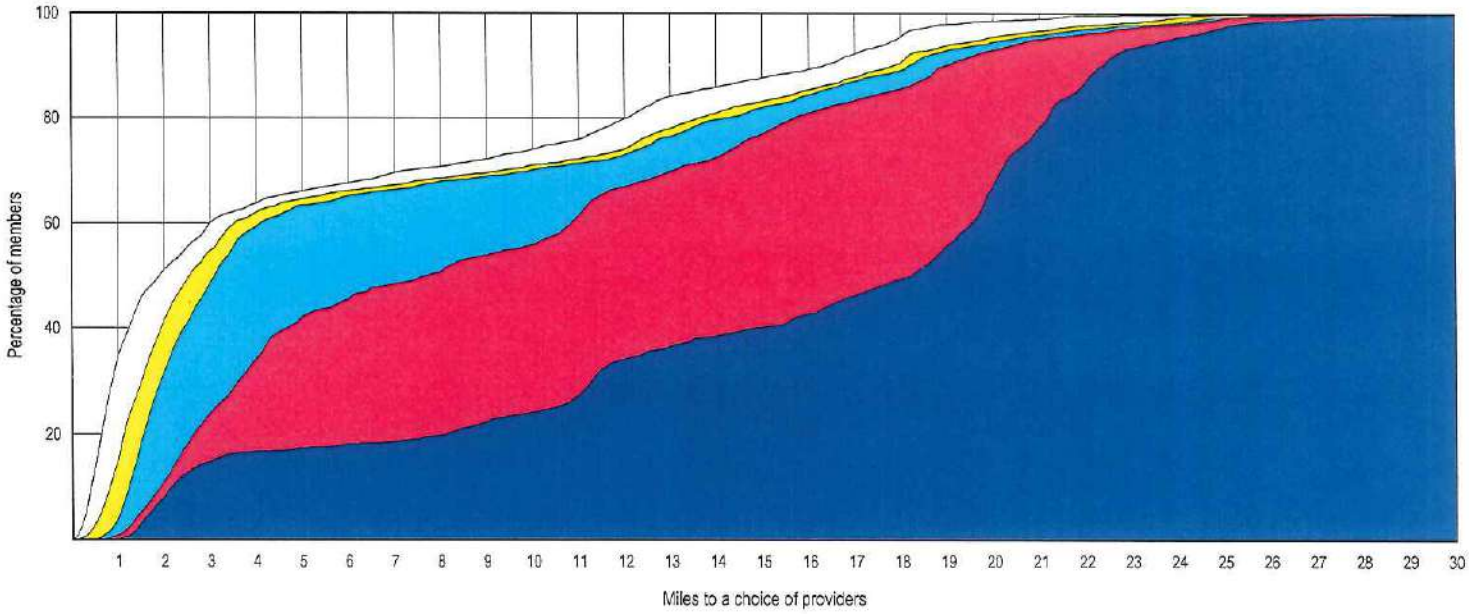

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Access Overview

January 24, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 30 minutes

Overall Access[1]

16,143 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

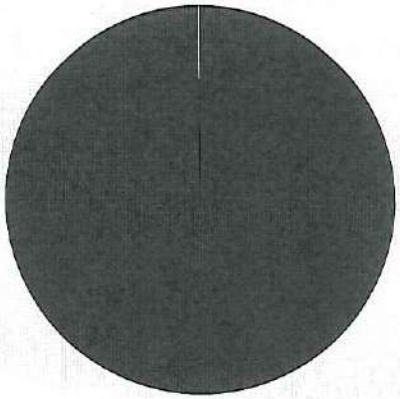

Times

	Average
Time to 1st closest provider	5.9 mins
Time to 2nd closest provider	6.9 mins
Time to 3rd closest provider	7.5 mins
Time to 4th closest provider	10.2 mins
Time to 5th closest provider	16.7 mins

Access Standard Comparison

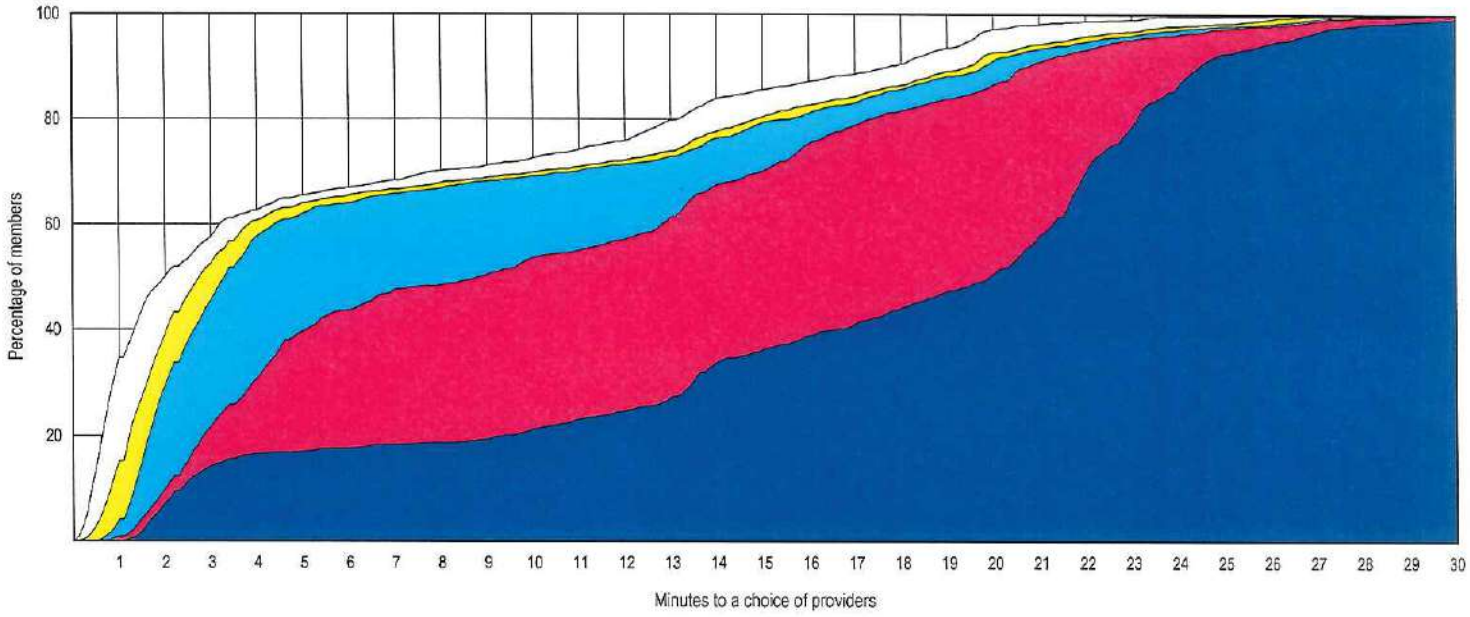

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 miles

Overall Access[1]

9,636 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

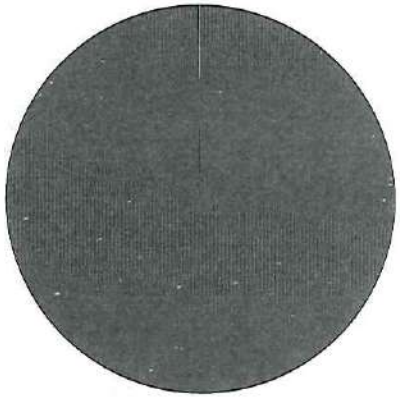

Distances

	Average
Distance to 1st closest provider	5.3 miles
Distance to 2nd closest provider	9.9 miles
Distance to 3rd closest provider	13.0 miles
Distance to 4th closest provider	15.5 miles
Distance to 5th closest provider	17.3 miles

Access Standard Comparison

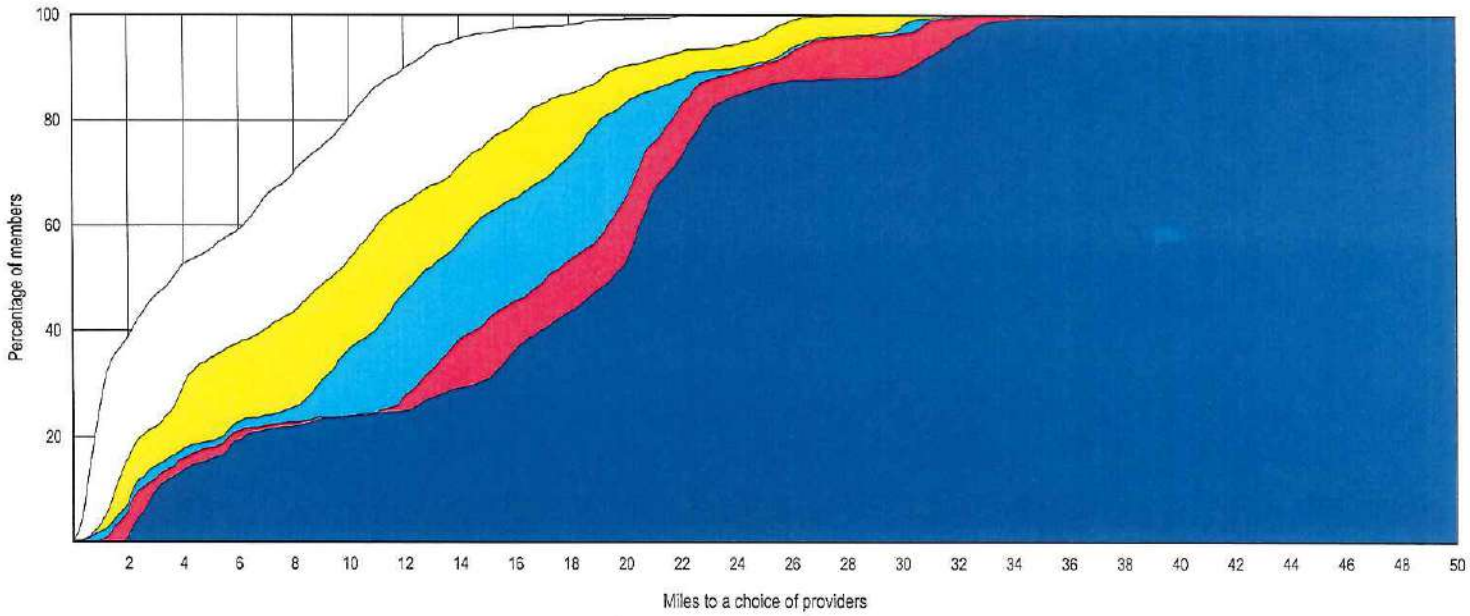

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 minutes

Overall Access[1]

9,636 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

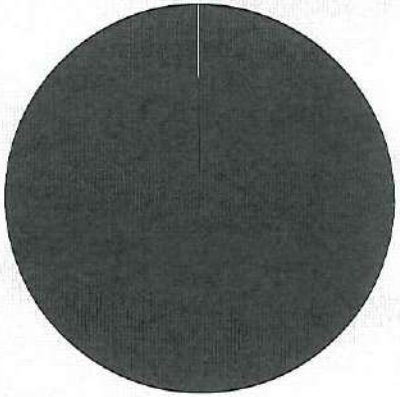

Times

	Average
Time to 1st closest provider	5.8 mins
Time to 2nd closest provider	10.8 mins
Time to 3rd closest provider	14.2 mins
Time to 4th closest provider	16.9 mins
Time to 5th closest provider	18.9 mins

Access Standard Comparison

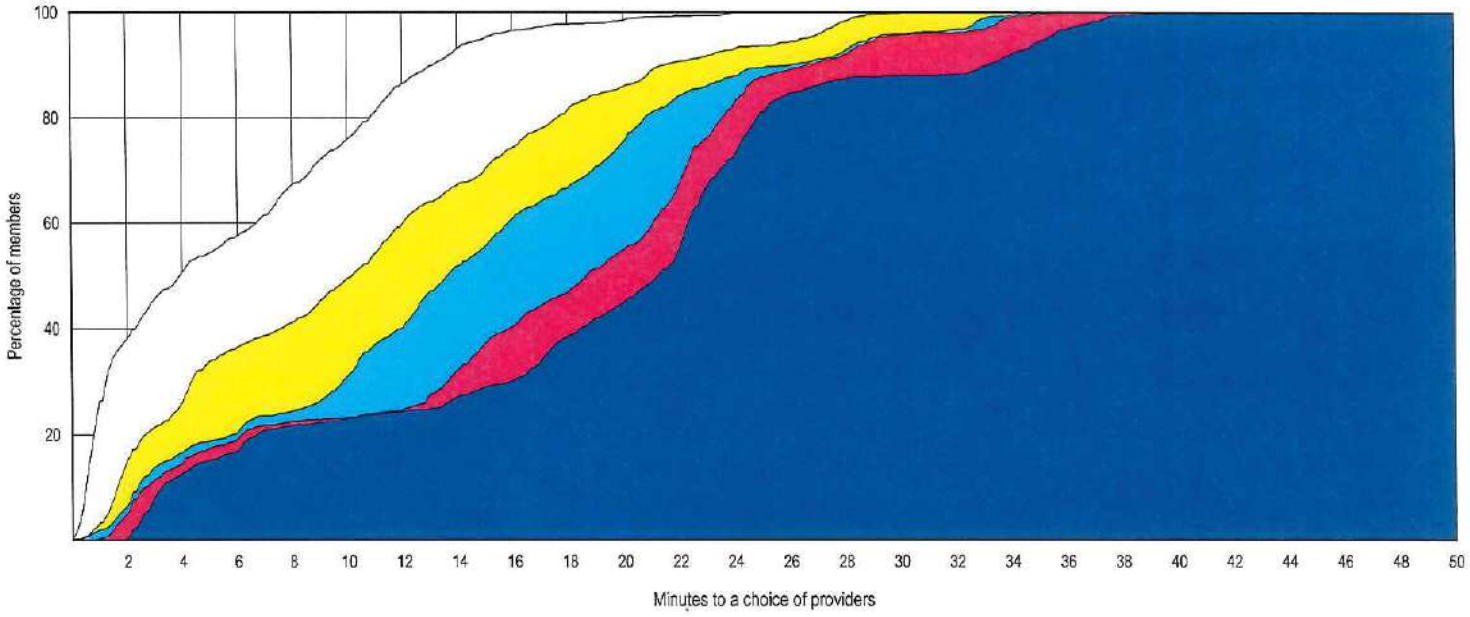

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Provider Locations

January 23, 2020

Region 3 Pharmacies and Durable Medical Equipment Suppliers

Total Providers: 58

h All providers

Interstates

US Highways

State Highways

15.97 miles

Region 3 Pharmacies and Durable Medical Equipment Suppliers

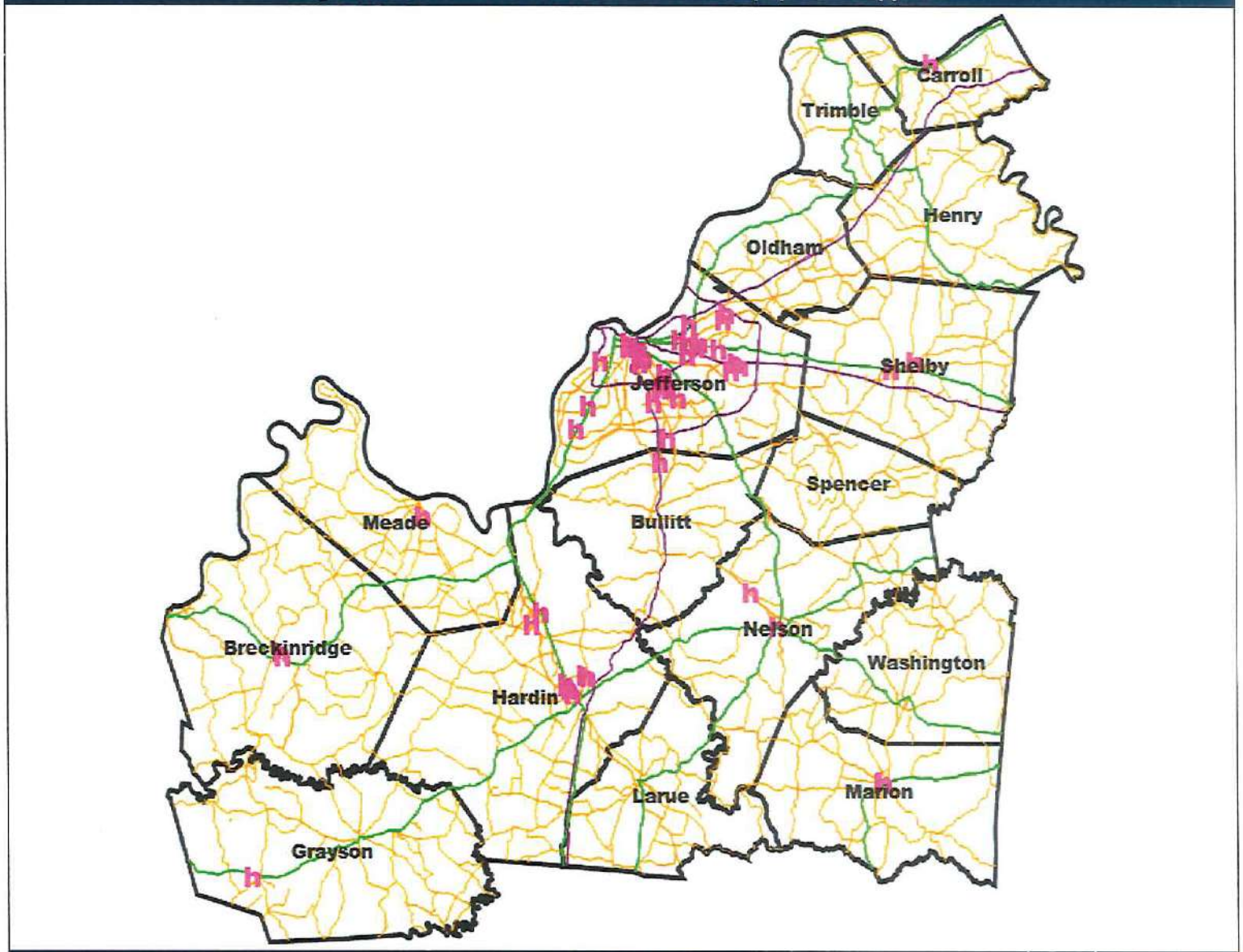

58 providers at 53 locations

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Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 30 miles

Overall Access[1]

18,130 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

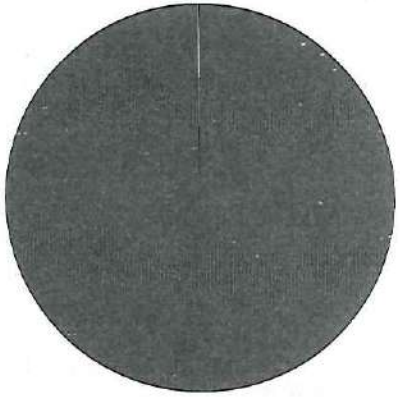

Distances

	Average
Distance to 1st closest provider	3.6 miles
Distance to 2nd closest provider	4.9 miles
Distance to 3rd closest provider	6.9 miles
Distance to 4th closest provider	7.4 miles
Distance to 5th closest provider	7.8 miles

Access Standard Comparison

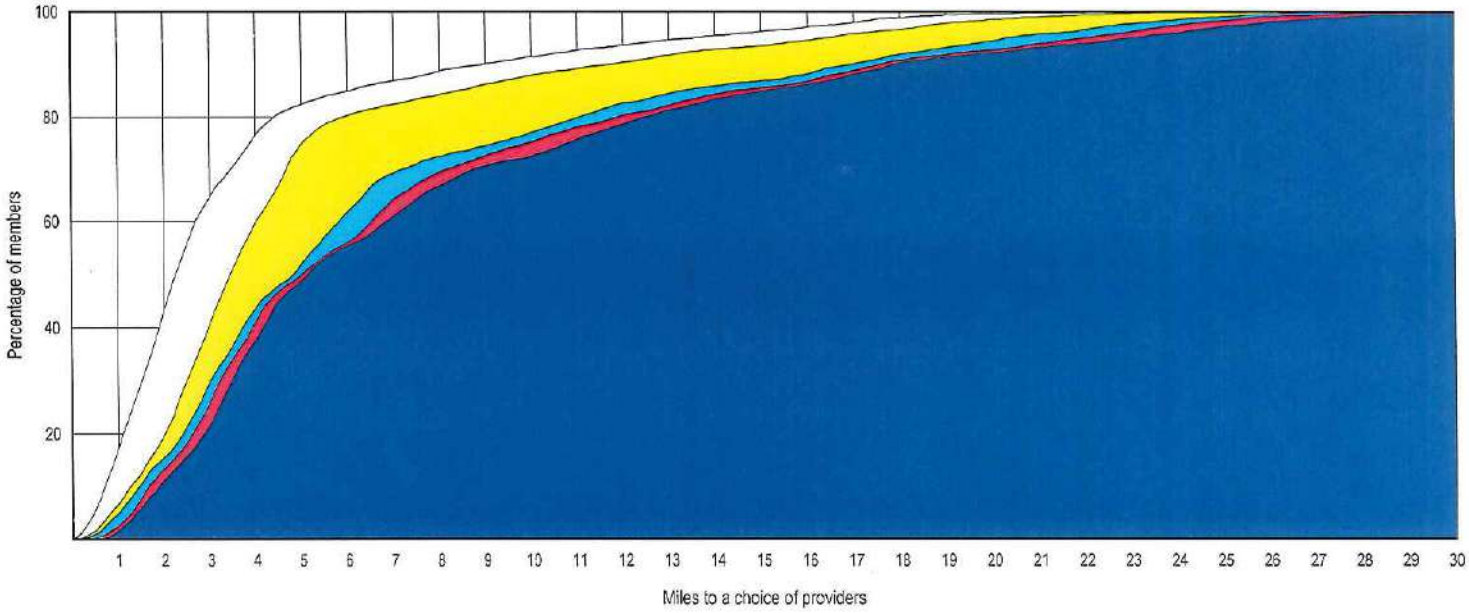

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Access Overview

January 24, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 30 minutes

Overall Access[1]

18,130 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

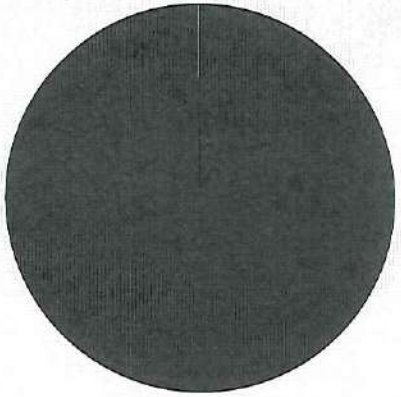

Times

	Average
Time to 1st closest provider	4.5 mins
Time to 2nd closest provider	6.3 mins
Time to 3rd closest provider	8.6 mins
Time to 4th closest provider	9.3 mins
Time to 5th closest provider	9.9 mins

Access Standard Comparison

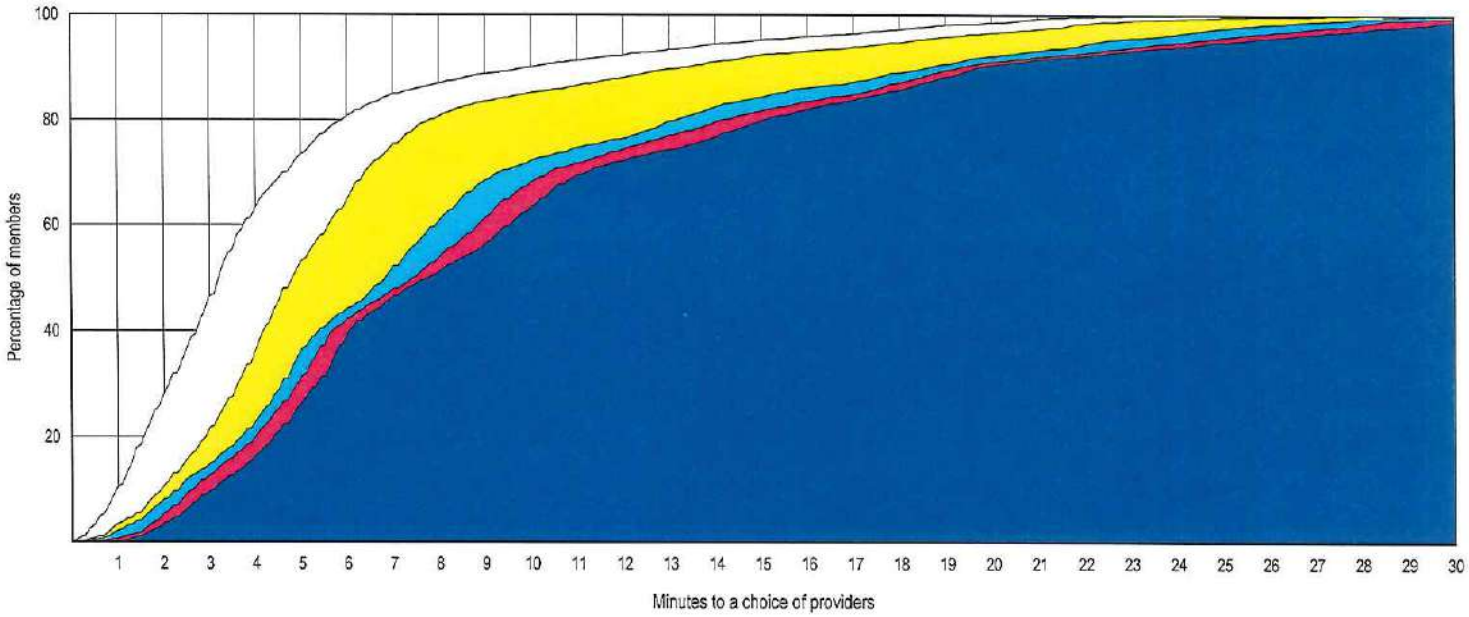

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 miles

Overall Access[1]

1,901 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

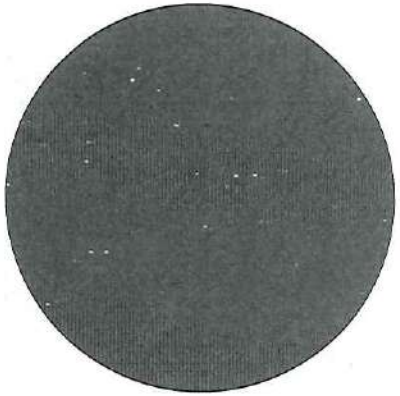

Distances

	Average
Distance to 1st closest provider	9.6 miles
Distance to 2nd closest provider	14.8 miles
Distance to 3rd closest provider	20.8 miles
Distance to 4th closest provider	24.7 miles
Distance to 5th closest provider	26.2 miles

Access Standard Comparison

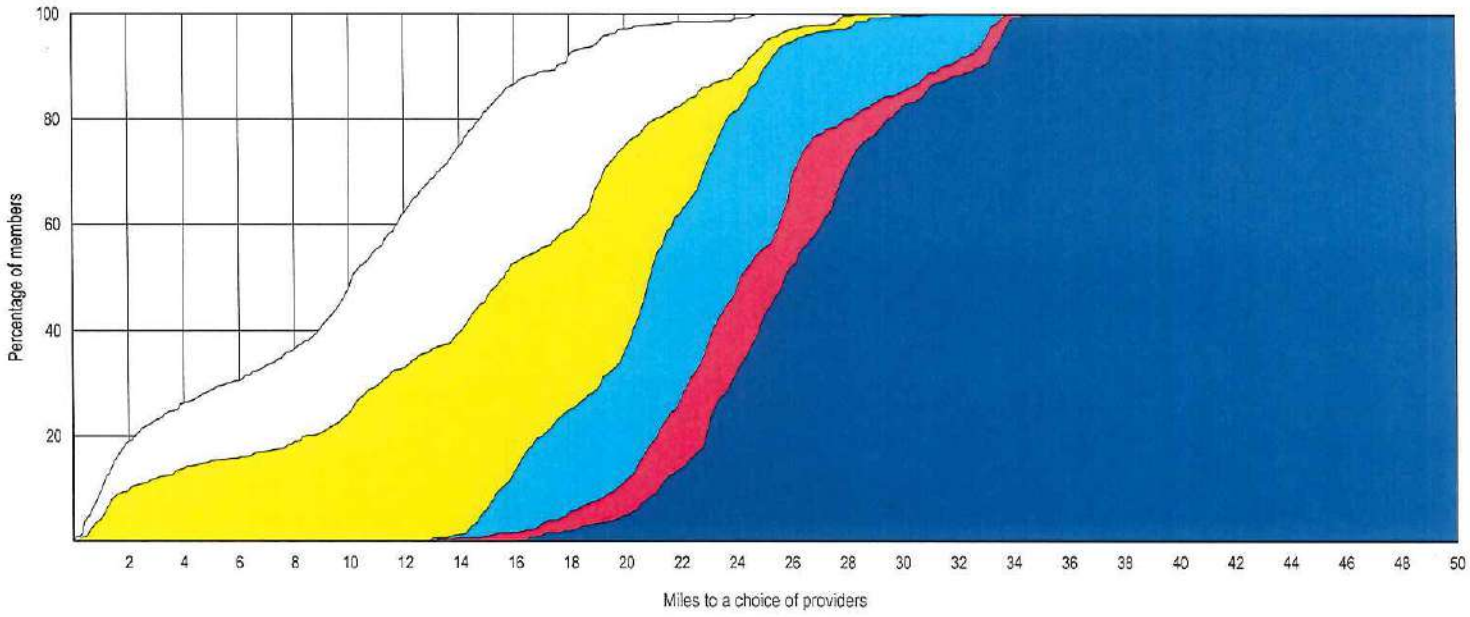

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Access Overview

January 24, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 minutes

Overall Access[1]

1,901 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

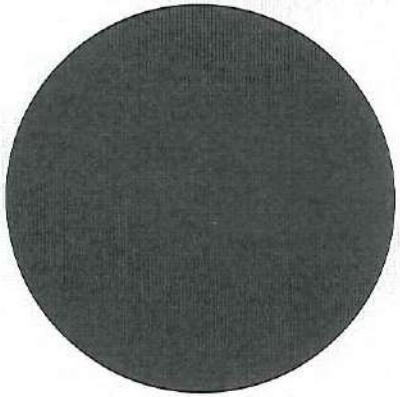

Times

	Average
Time to 1st closest provider	10.5 mins
Time to 2nd closest provider	16.1 mins
Time to 3rd closest provider	22.6 mins
Time to 4th closest provider	27.0 mins
Time to 5th closest provider	28.7 mins

Access Standard Comparison

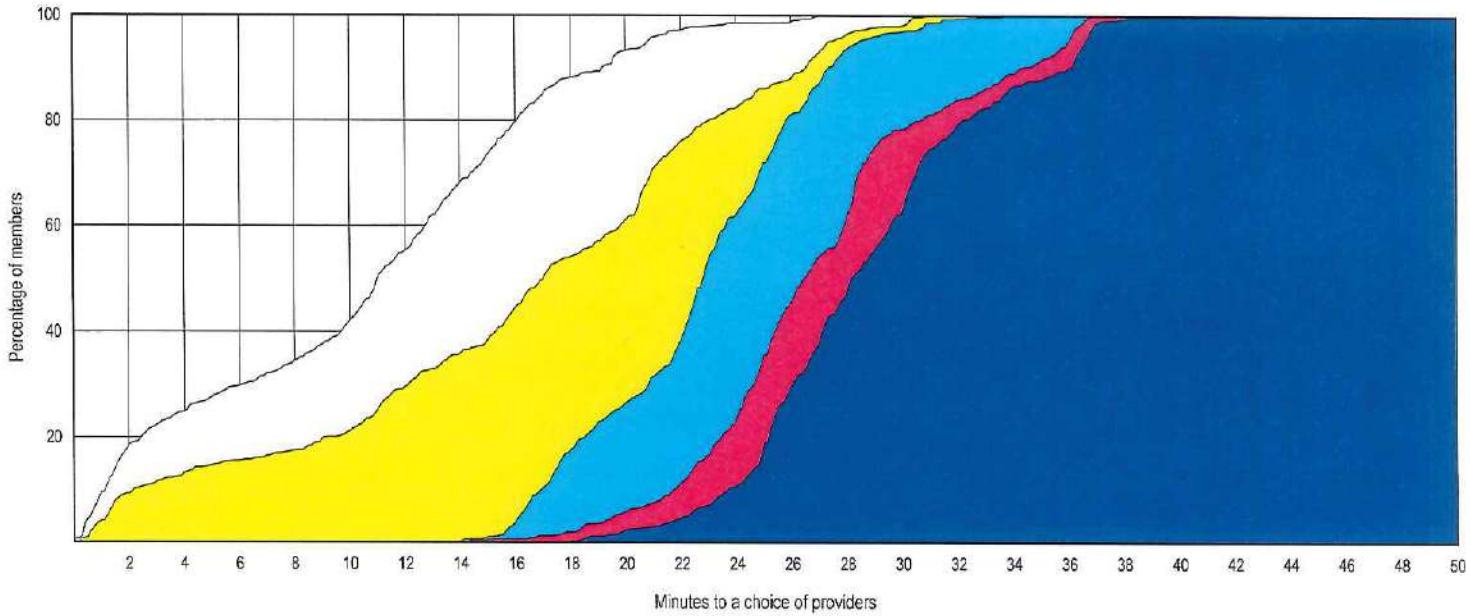

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Provider Locations

January 23, 2020

Region 4 Pharmacies and Durable Medical Equipment Suppliers

Total Providers: 70

h All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Pharmacies and Durable Medical Equipment Suppliers

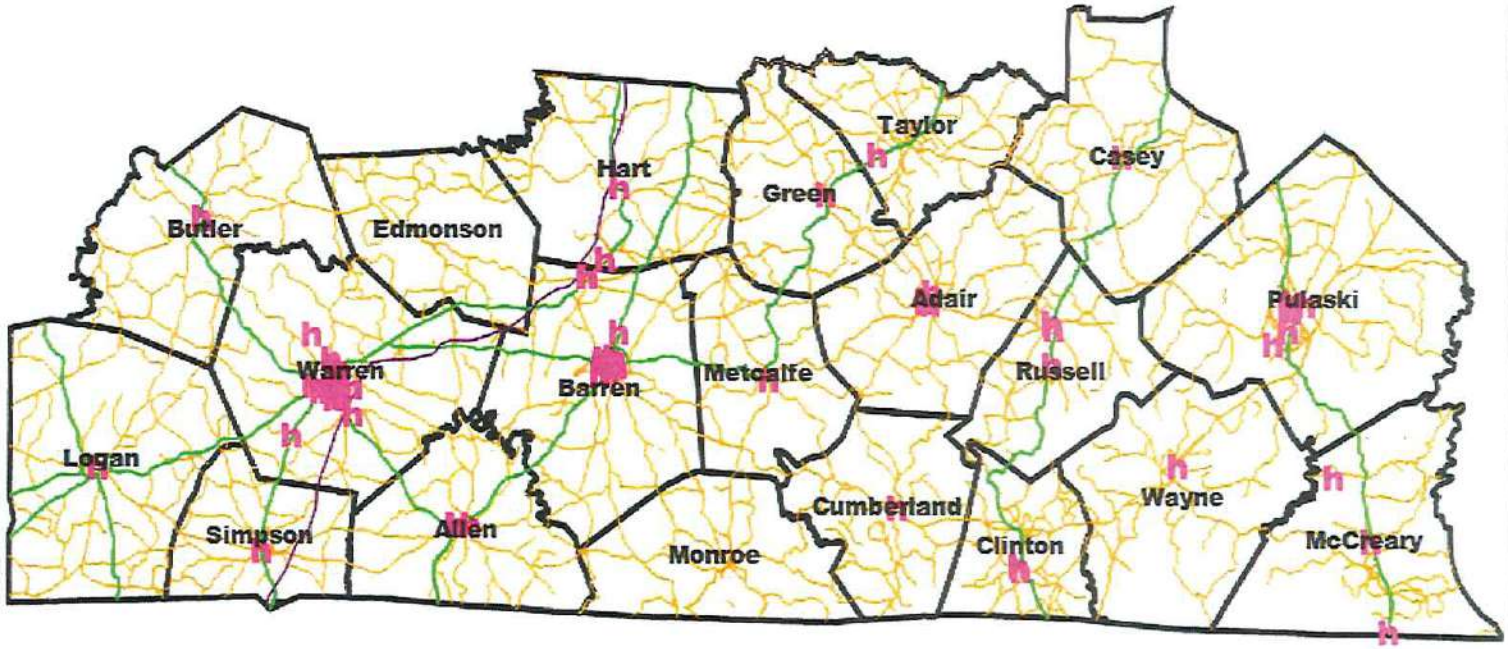

70 providers at 71 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 30 miles

Overall Access[1]

7,413 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

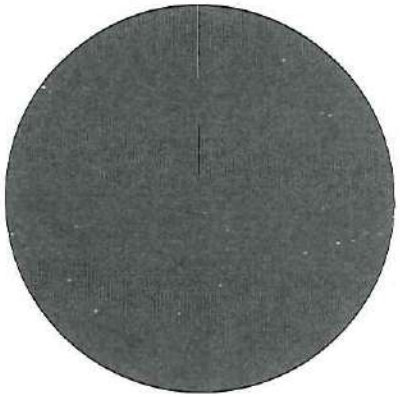

Distances

	Average
Distance to 1st closest provider	4.0 miles
Distance to 2nd closest provider	6.3 miles
Distance to 3rd closest provider	7.4 miles
Distance to 4th closest provider	7.8 miles
Distance to 5th closest provider	8.0 miles

Access Standard Comparison

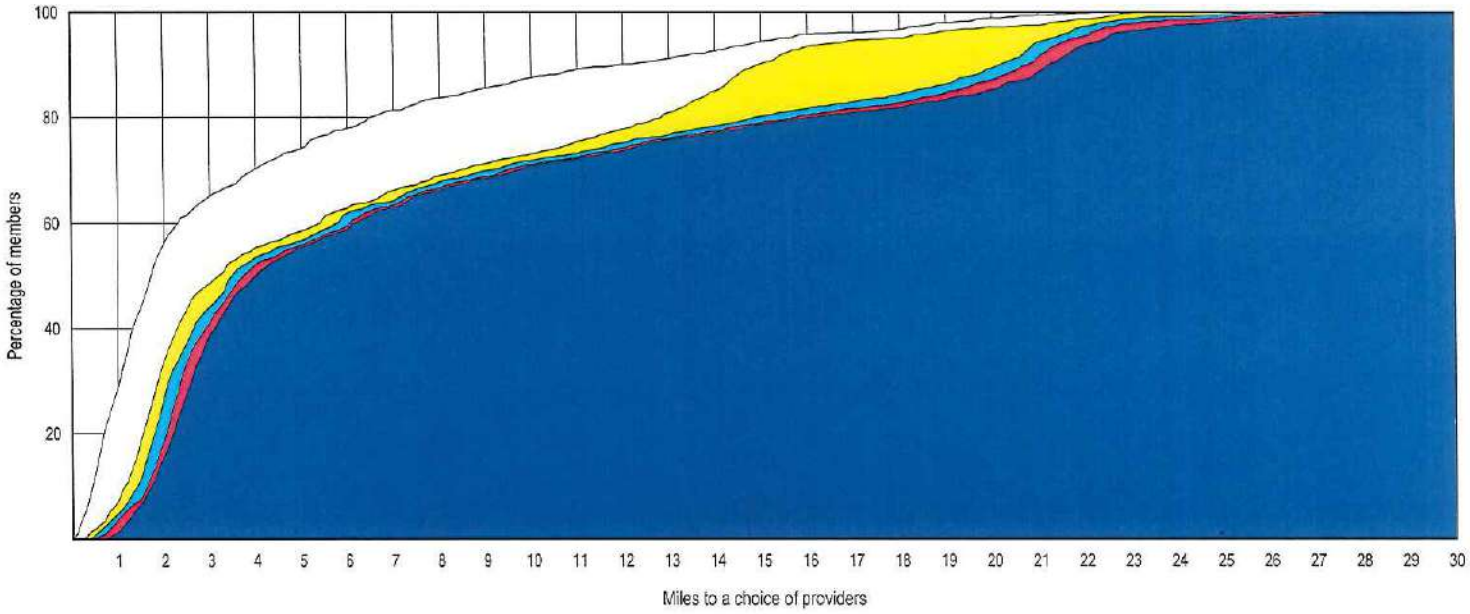

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 30 minutes

Overall Access[1]

7,413 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

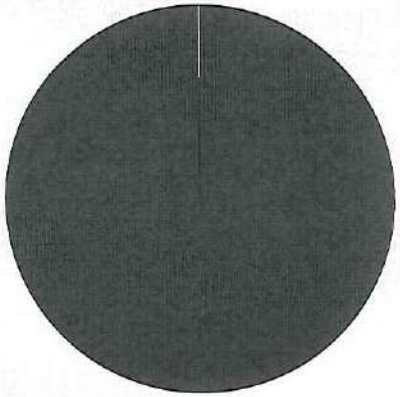

Times

	Average
Time to 1st closest provider	4.3 mins
Time to 2nd closest provider	6.8 mins
Time to 3rd closest provider	8.0 mins
Time to 4th closest provider	8.4 mins
Time to 5th closest provider	8.7 mins

Access Standard Comparison

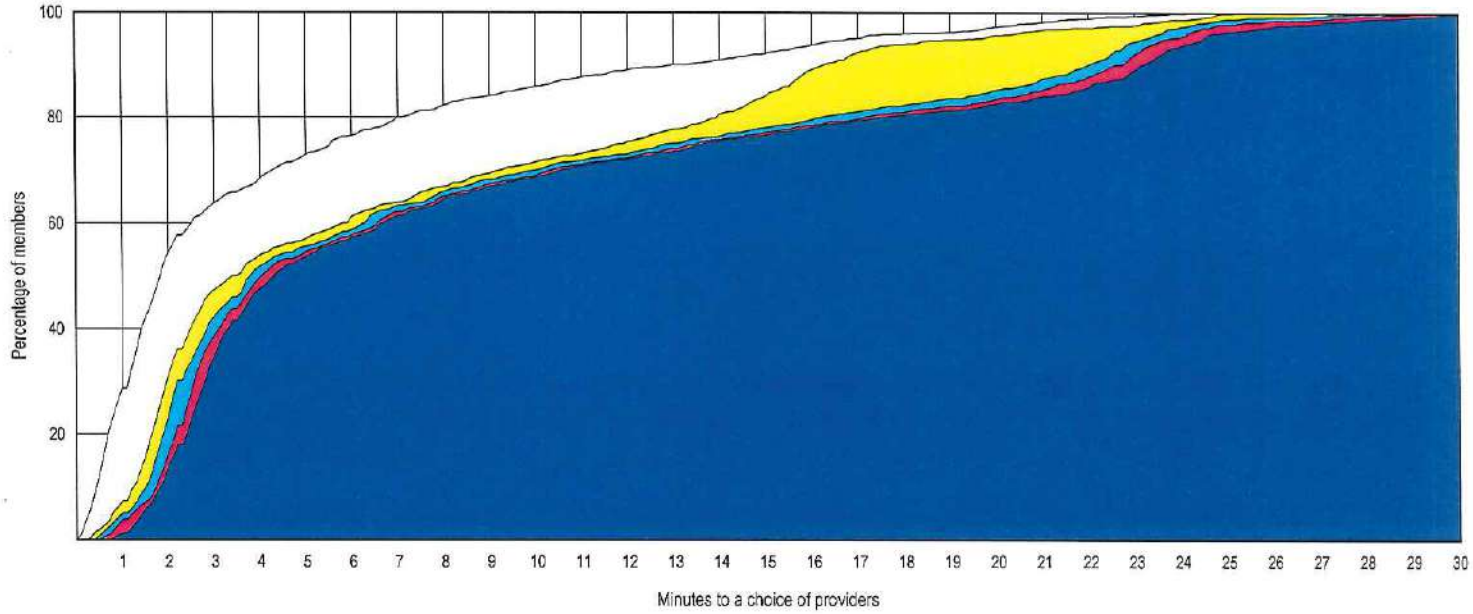

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Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 miles

Overall Access[1]

28,324 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

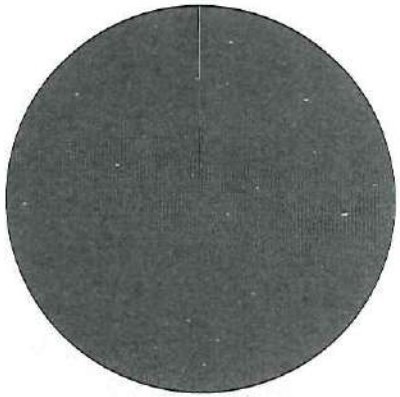

Distances

	Average
Distance to 1st closest provider	5.7 miles
Distance to 2nd closest provider	9.4 miles
Distance to 3rd closest provider	12.1 miles
Distance to 4th closest provider	14.3 miles
Distance to 5th closest provider	16.7 miles

Access Standard Comparison

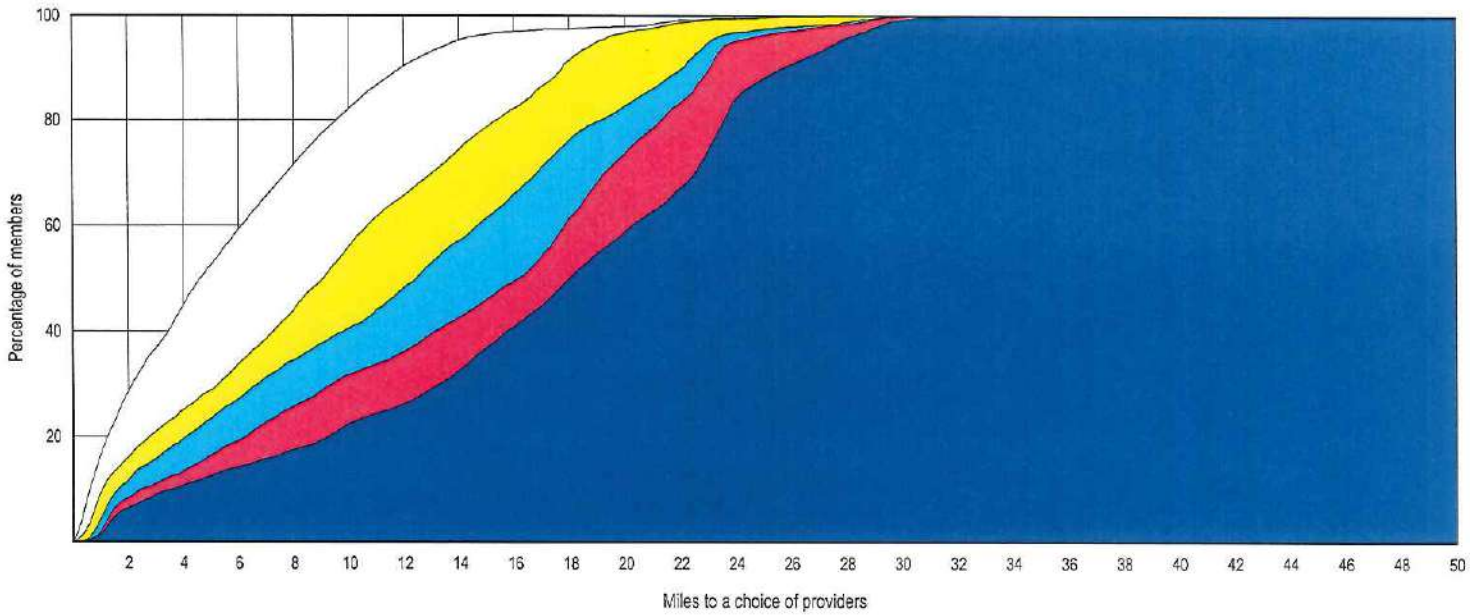

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
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[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 minutes

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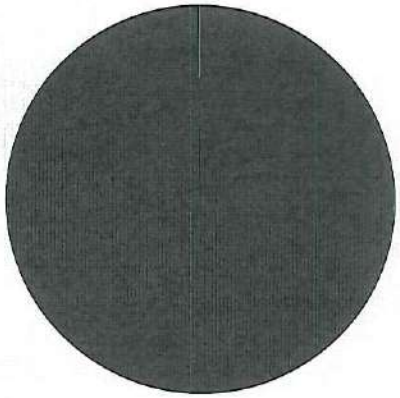

Times

	Average
Time to 1st closest provider	6.2 mins
Time to 2nd closest provider	10.2 mins
Time to 3rd closest provider	13.2 mins
Time to 4th closest provider	15.6 mins
Time to 5th closest provider	18.2 mins

Access Standard Comparison

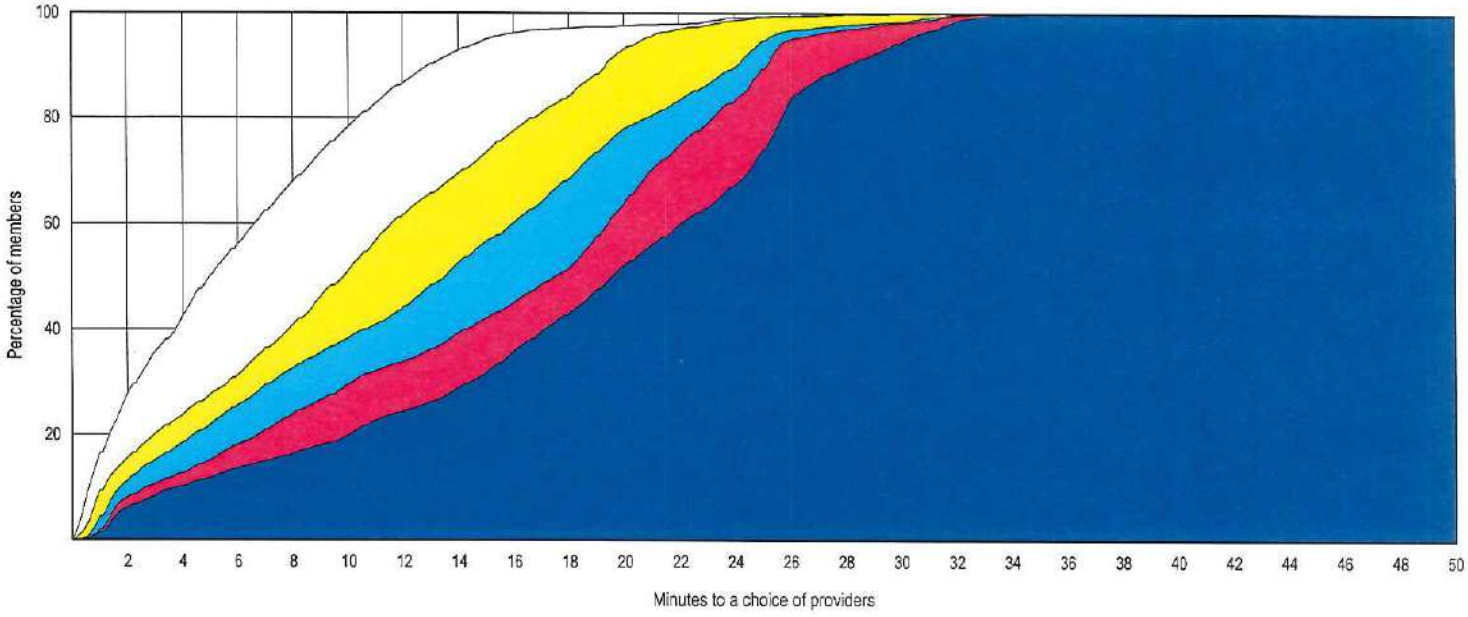

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Provider Locations

January 23, 2020

Region 5 Pharmacies and Durable Medical Equipment Suppliers

Total Providers: 71

h All providers

Interstates

US Highways

State Highways

17.44 miles

Region 5 Pharmacies and Durable Medical Equipment Suppliers

71 providers at 69 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 30 miles

Overall Access[1]

22,712 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

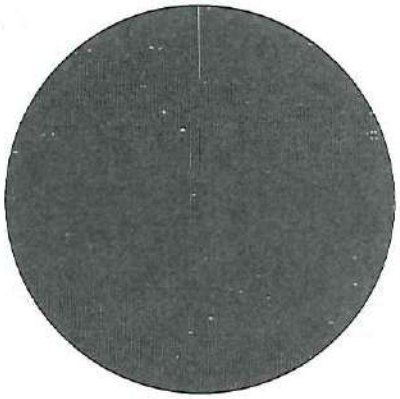

Distances

	Average
Distance to 1st closest provider	2.8 miles
Distance to 2nd closest provider	4.0 miles
Distance to 3rd closest provider	5.8 miles
Distance to 4th closest provider	6.3 miles
Distance to 5th closest provider	7.1 miles

Access Standard Comparison

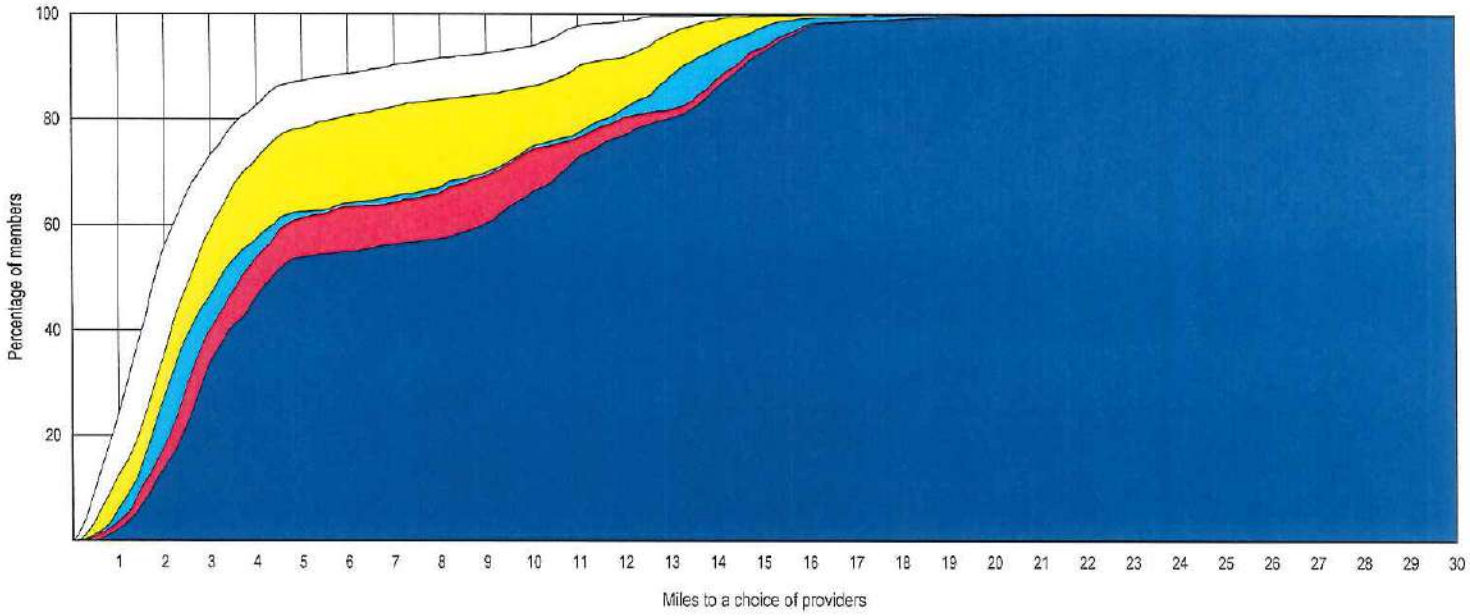

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Access Overview

January 24, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
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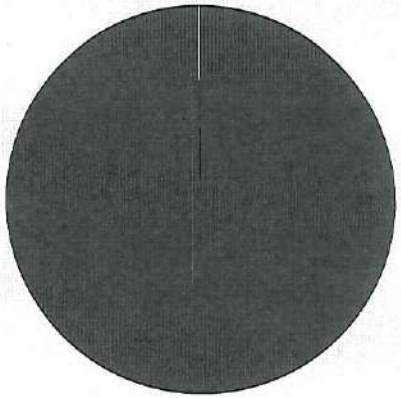

Times

	Average
Time to 1st closest provider	3.4 mins
Time to 2nd closest provider	4.8 mins
Time to 3rd closest provider	6.8 mins
Time to 4th closest provider	7.5 mins
Time to 5th closest provider	8.8 mins

Access Standard Comparison

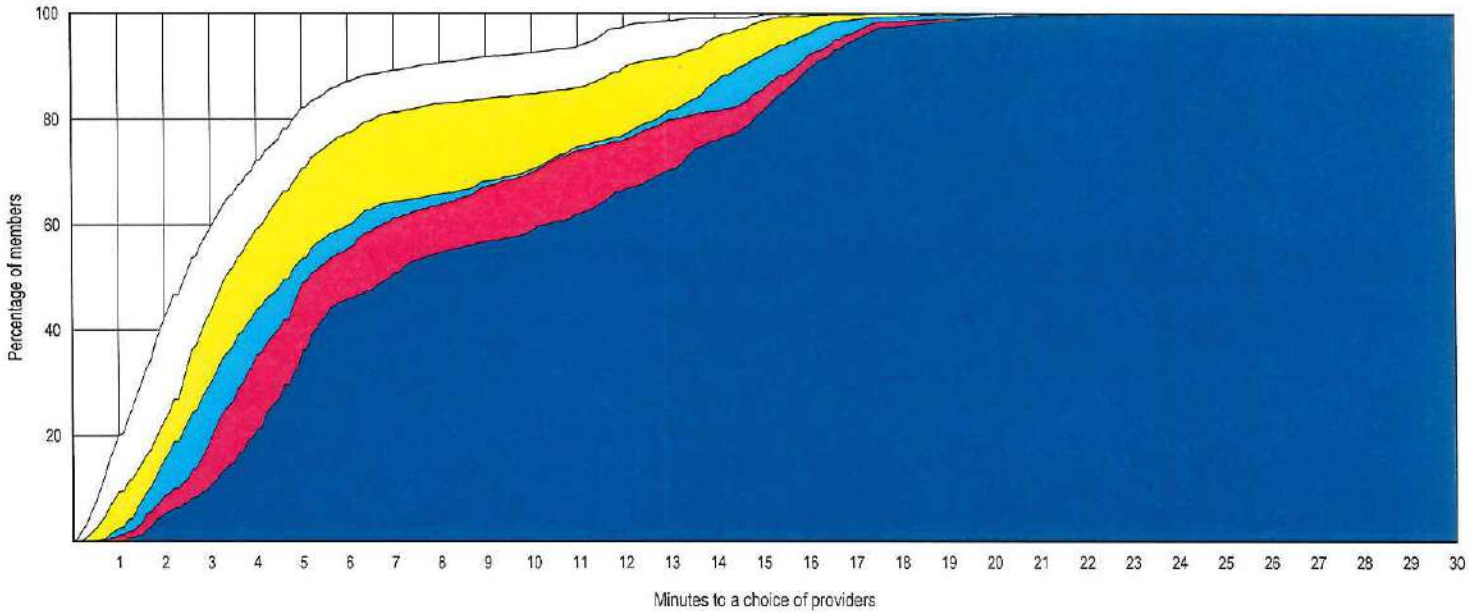

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 miles

Overall Access[1]

23,127 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

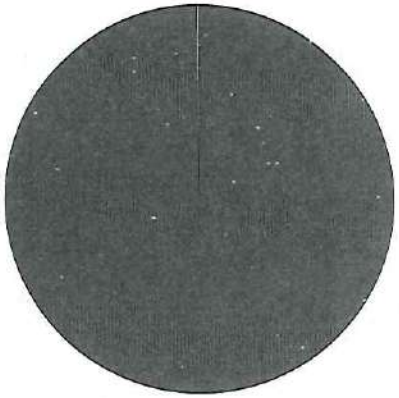

Distances

	Average
Distance to 1st closest provider	5.1 miles
Distance to 2nd closest provider	7.7 miles
Distance to 3rd closest provider	9.5 miles
Distance to 4th closest provider	11.4 miles
Distance to 5th closest provider	13.5 miles

Access Standard Comparison

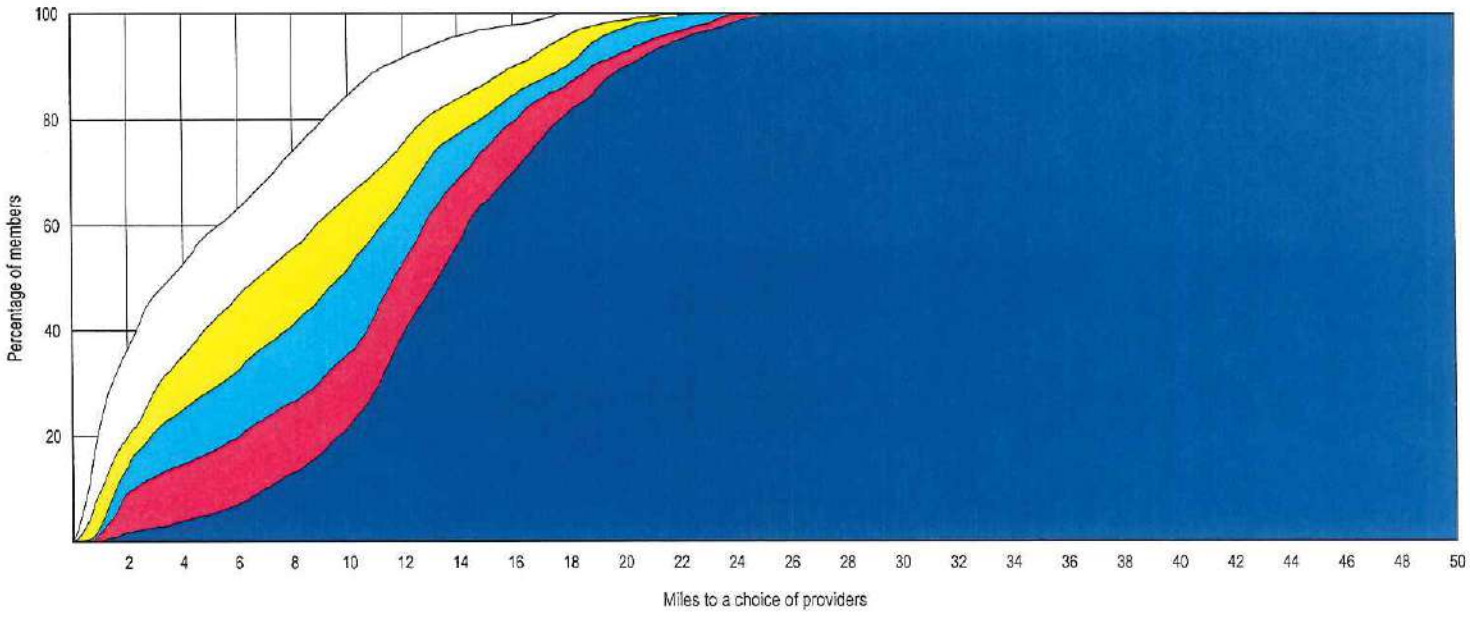

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Access Overview

January 24, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

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23,127 Members
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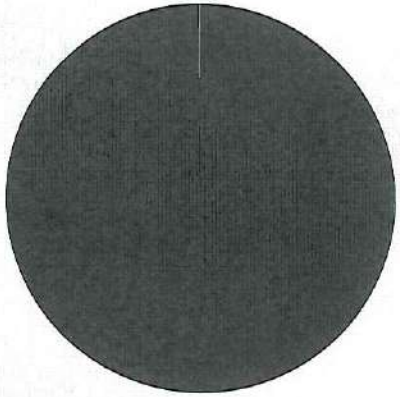

Times

	Average
Time to 1st closest provider	5.5 mins
Time to 2nd closest provider	8.4 mins
Time to 3rd closest provider	10.3 mins
Time to 4th closest provider	12.4 mins
Time to 5th closest provider	14.7 mins

Access Standard Comparison

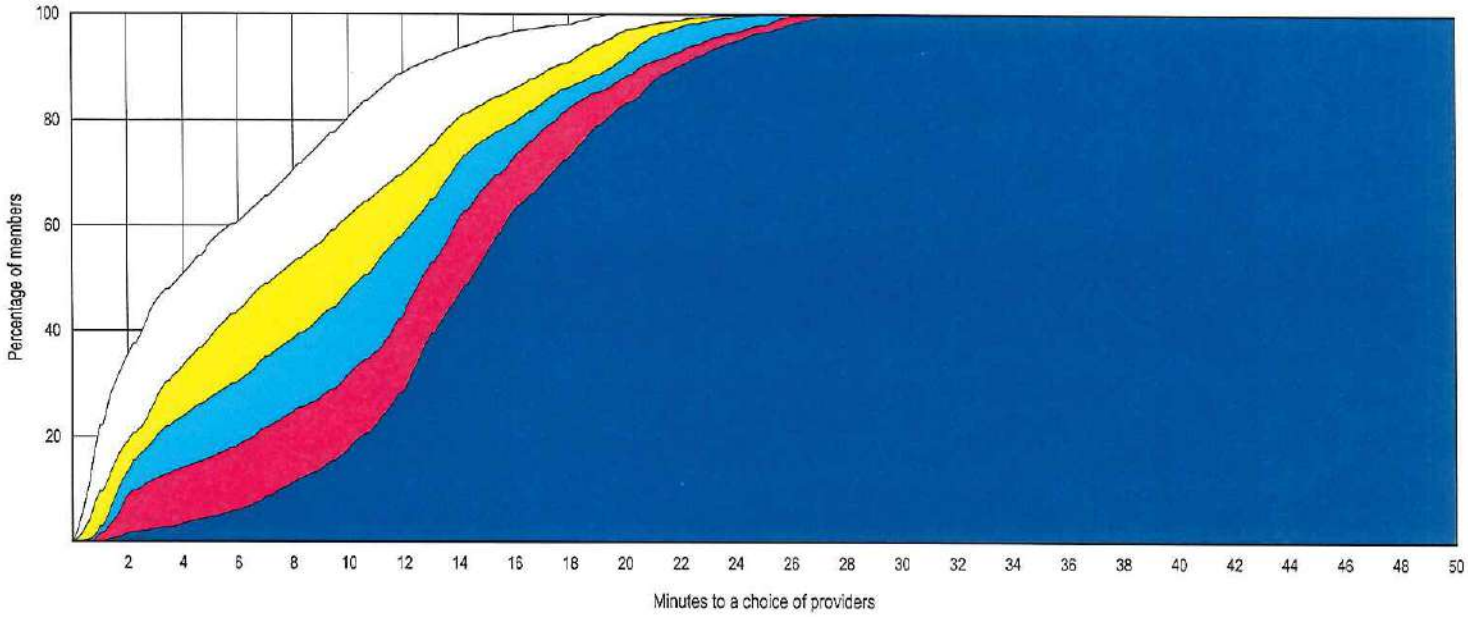

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Provider Locations

January 23, 2020

Region 6 Pharmacies and Durable Medical Equipment Suppliers

Total Providers: 24

h All providers

Interstates

US Highways

State Highways

7.48 miles

Region 6 Pharmacies and Durable Medical Equipment Suppliers

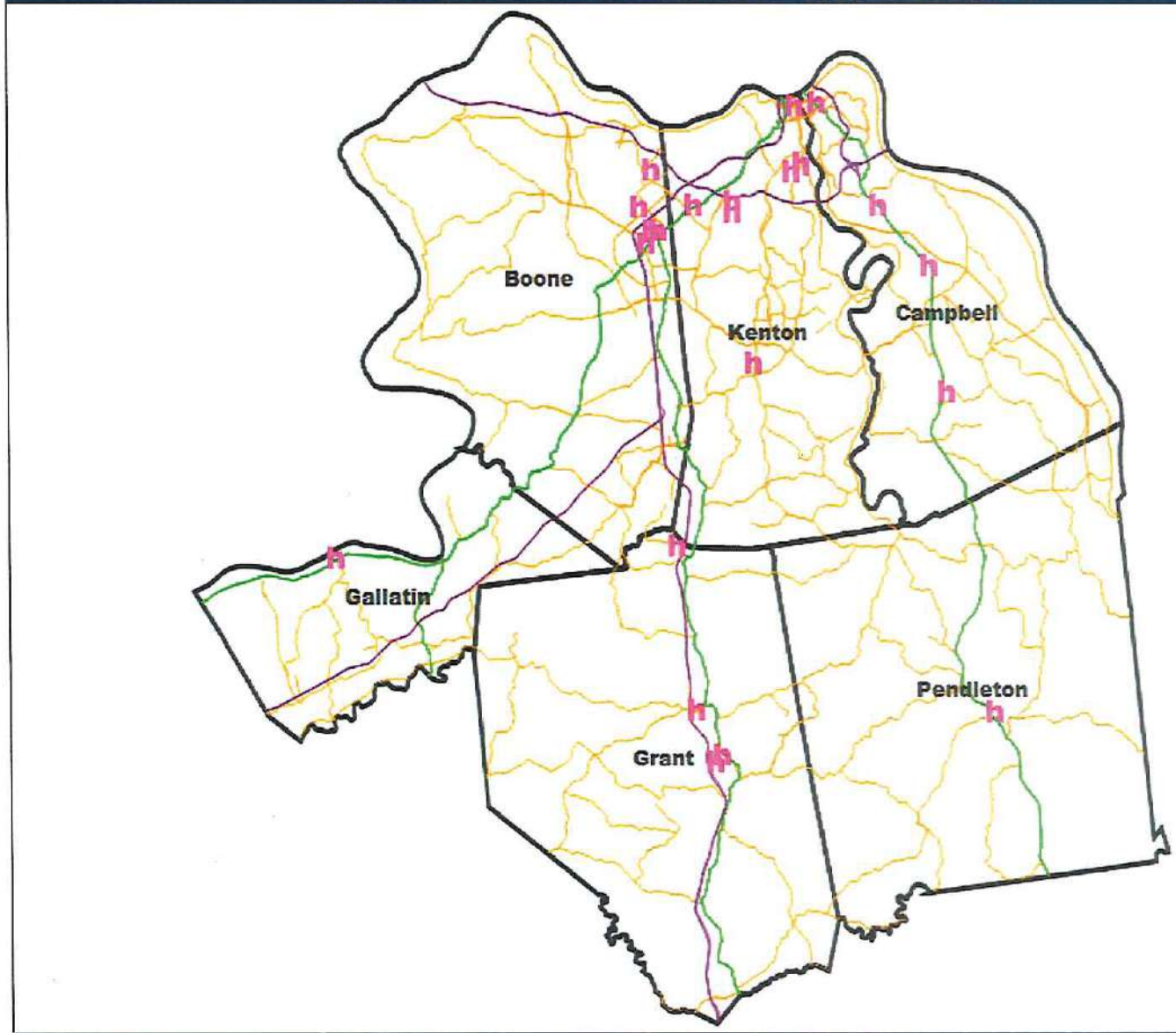

24 providers at 23 locations

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Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 30 miles

Overall Access[1]

22,413 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

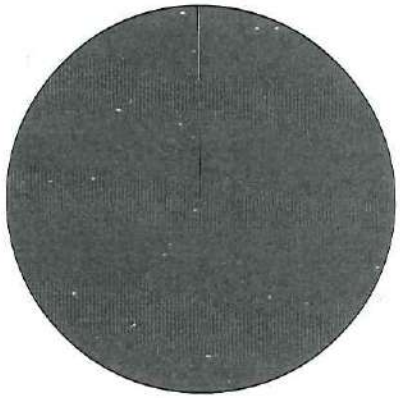

Distances

	Average
Distance to 1st closest provider	2.8 miles
Distance to 2nd closest provider	4.0 miles
Distance to 3rd closest provider	5.1 miles
Distance to 4th closest provider	5.7 miles
Distance to 5th closest provider	6.6 miles

Access Standard Comparison

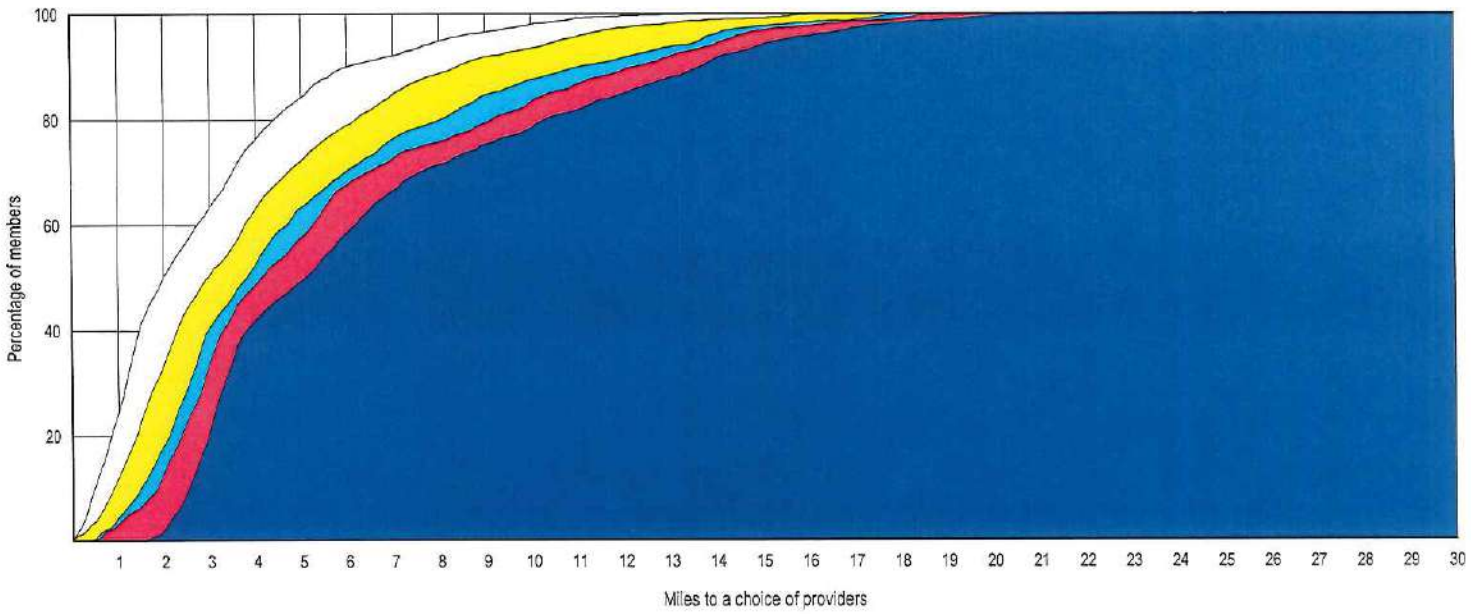

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
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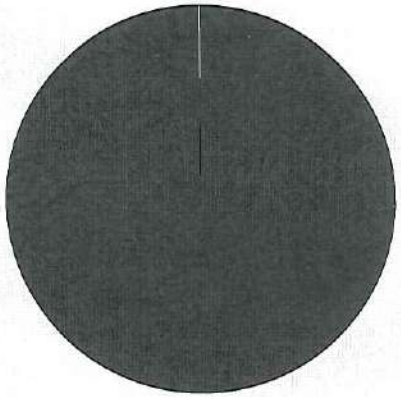

Times

	Average
Time to 1st closest provider	3.5 mins
Time to 2nd closest provider	4.8 mins
Time to 3rd closest provider	6.1 mins
Time to 4th closest provider	6.8 mins
Time to 5th closest provider	7.9 mins

Access Standard Comparison

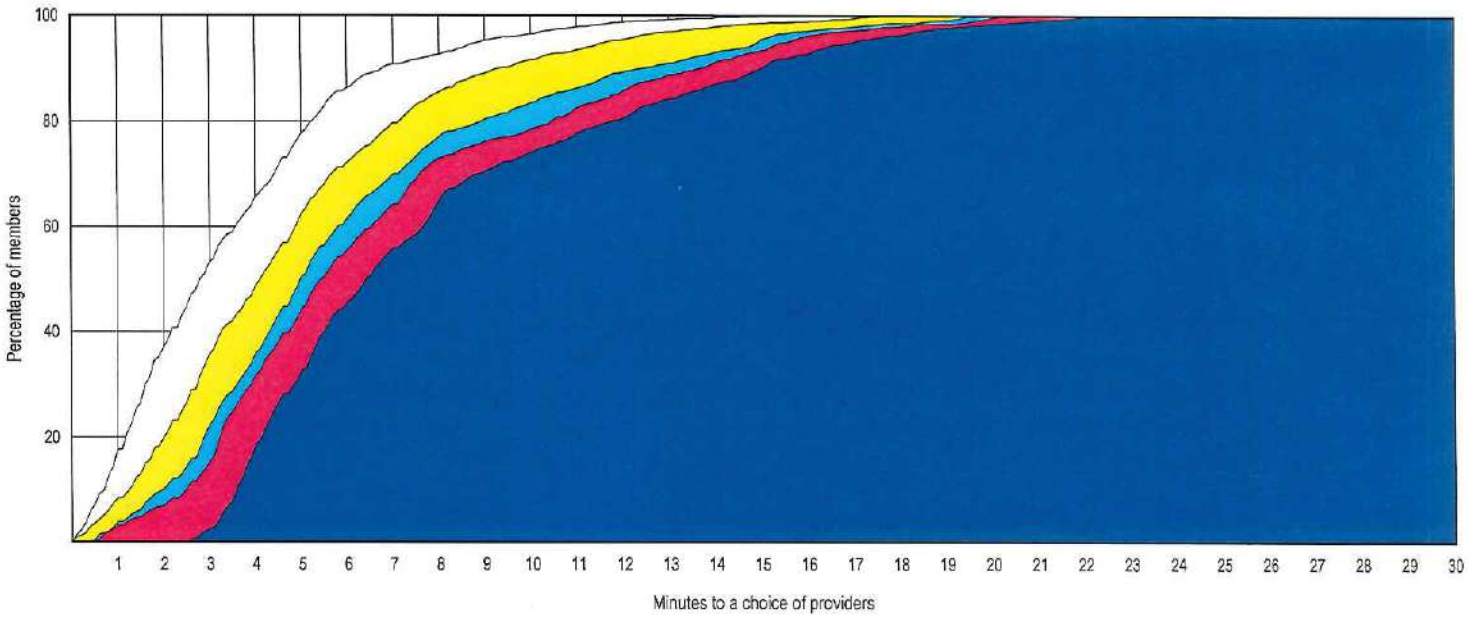

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Provider Locations

January 23, 2020

Region 7 Pharmacies and Durable Medical Equipment Suppliers

Total Providers: 43

h All providers

Interstates

US Highways

State Highways

12.36 miles

Region 7 Pharmacies and Durable Medical Equipment Suppliers

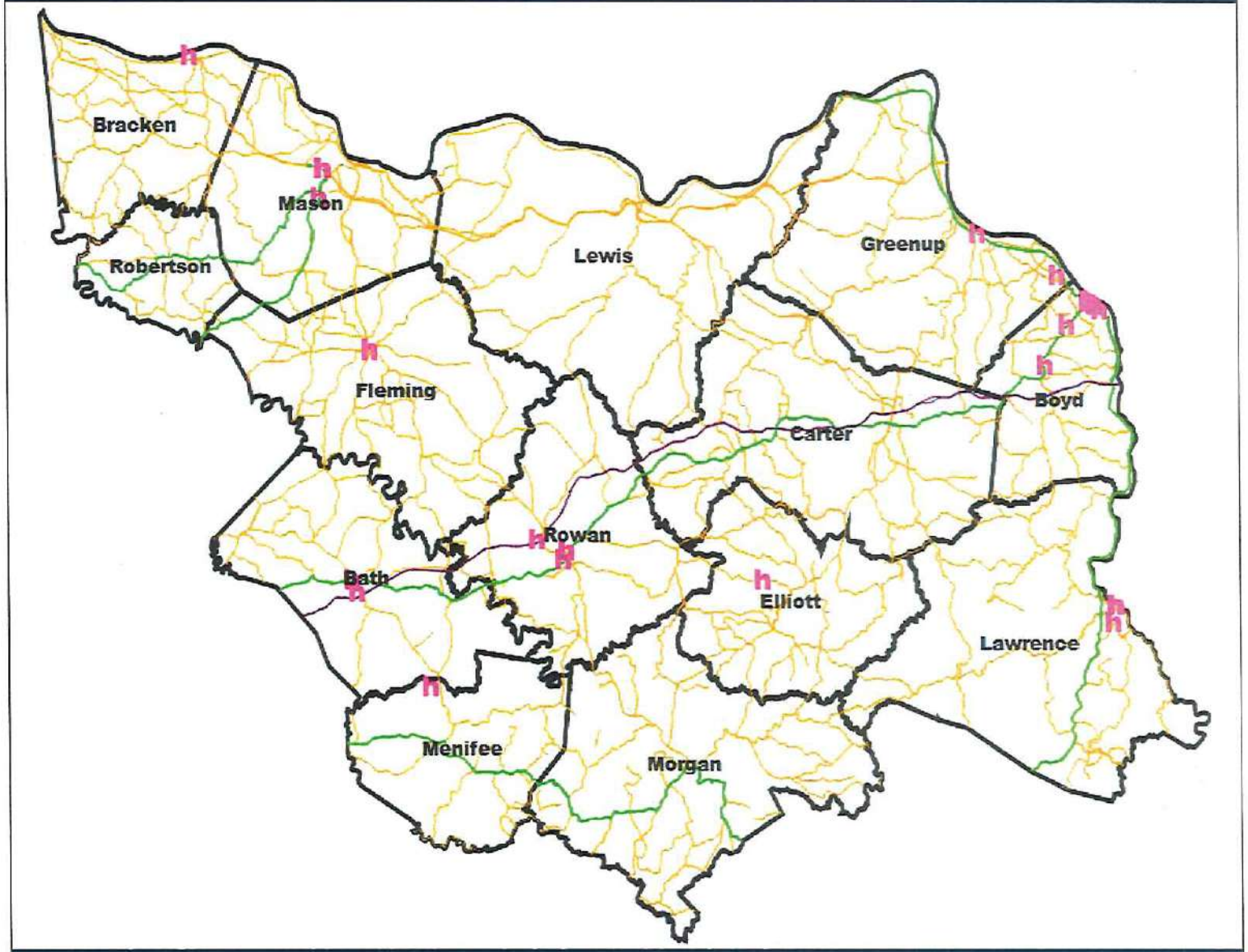

43 providers at 26 locations

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Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 30 miles

Overall Access[1]

2,907 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

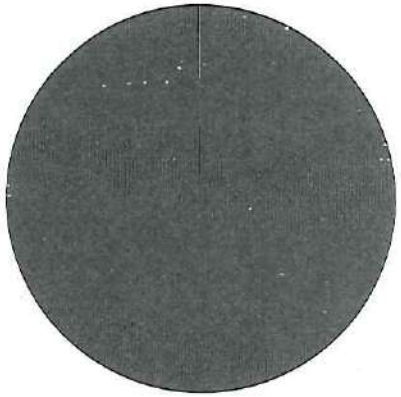

Distances

	Average
Distance to 1st closest provider	5.0 miles
Distance to 2nd closest provider	7.8 miles
Distance to 3rd closest provider	9.2 miles
Distance to 4th closest provider	10.1 miles
Distance to 5th closest provider	11.5 miles

Access Standard Comparison

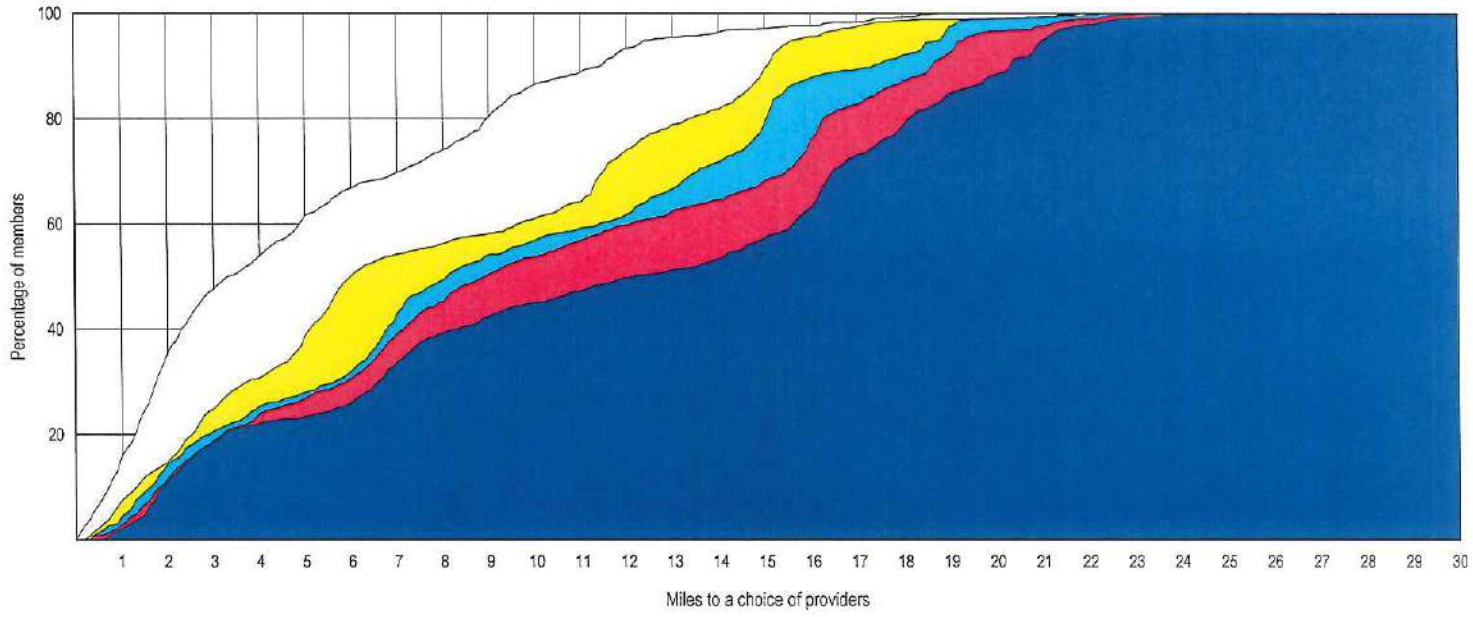

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

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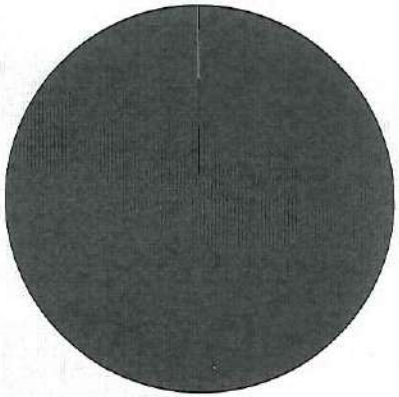

Times

	Average
Time to 1st closest provider	5.5 mins
Time to 2nd closest provider	8.6 mins
Time to 3rd closest provider	10.2 mins
Time to 4th closest provider	11.2 mins
Time to 5th closest provider	12.9 mins

Access Standard Comparison

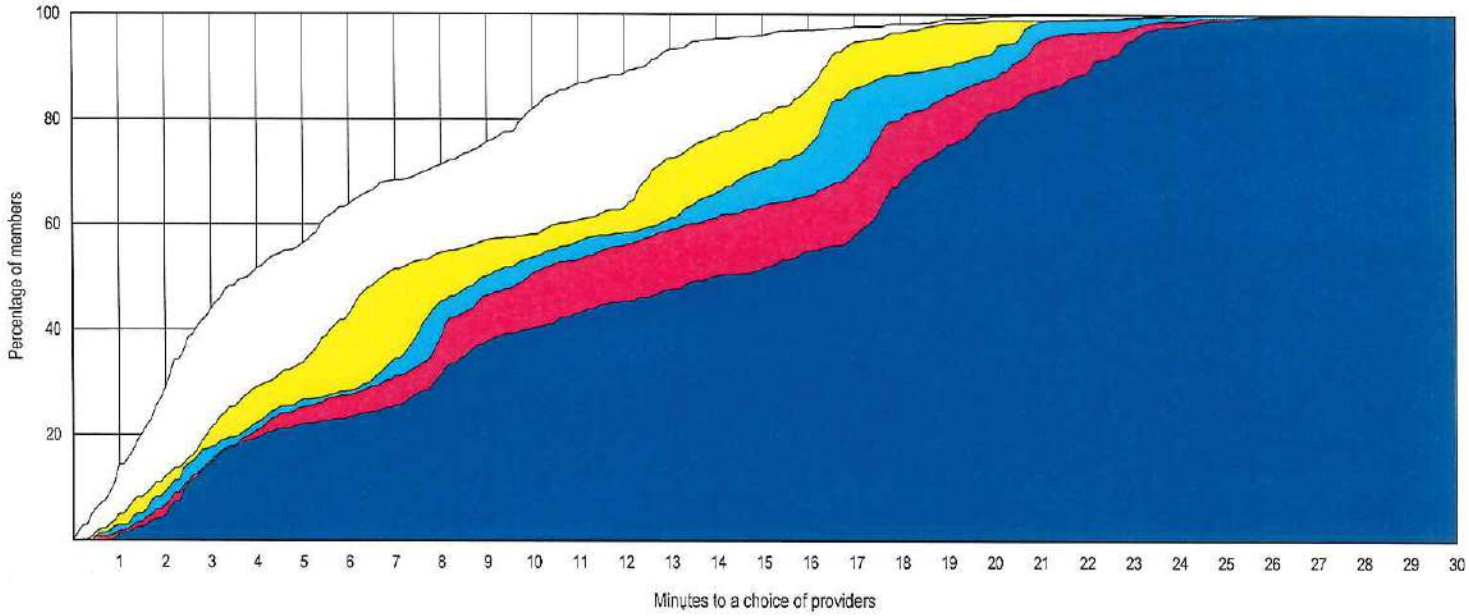

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Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 miles

Overall Access[1]

10,408 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

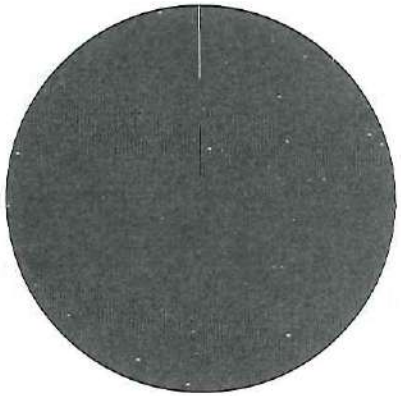

Distances

	Average
Distance to 1st closest provider	8.9 miles
Distance to 2nd closest provider	10.7 miles
Distance to 3rd closest provider	12.9 miles
Distance to 4th closest provider	14.9 miles
Distance to 5th closest provider	15.4 miles

Access Standard Comparison

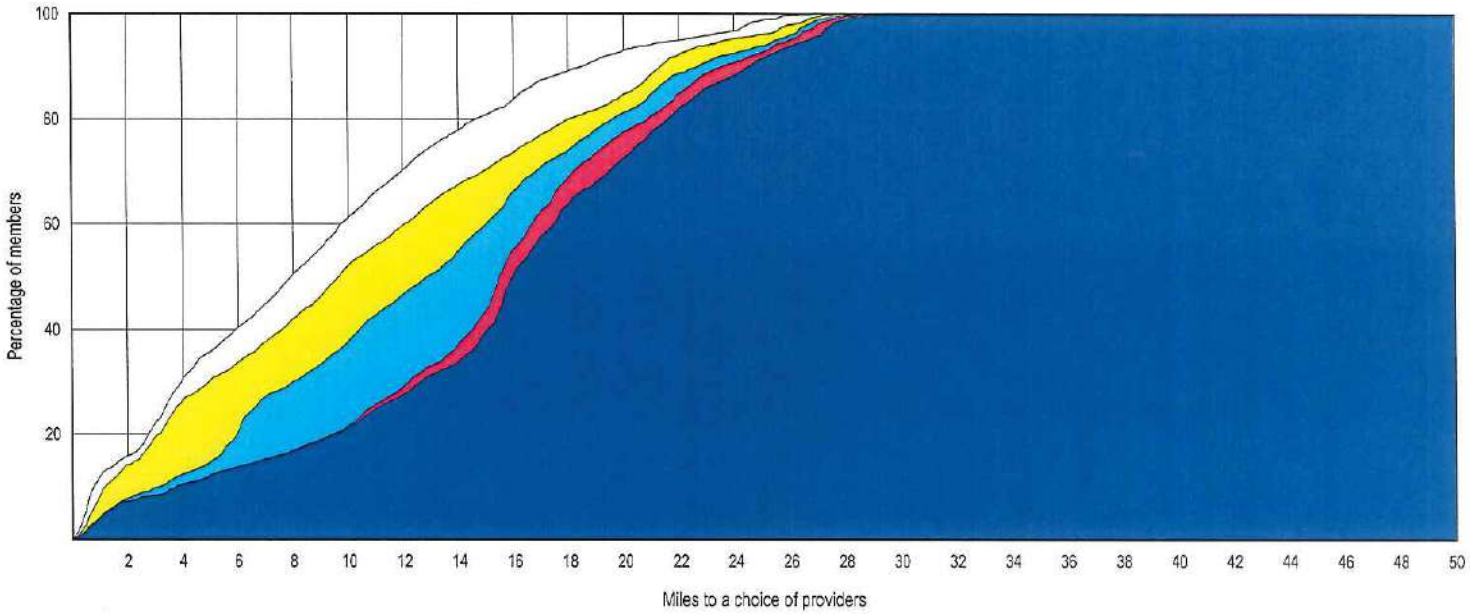

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 7 Rural - 1 in 50 minutes

Member / Provider Groups
Region 7 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
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- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

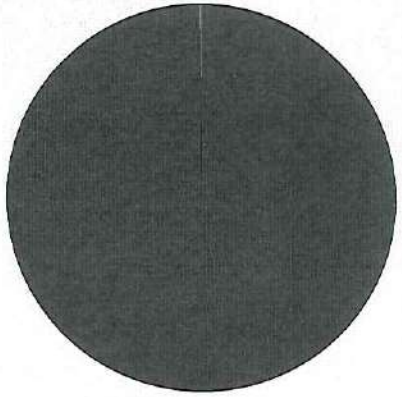

Times

	Average
Time to 1st closest provider	9.7 mins
Time to 2nd closest provider	11.6 mins
Time to 3rd closest provider	14.0 mins
Time to 4th closest provider	16.2 mins
Time to 5th closest provider	16.9 mins

Access Standard Comparison

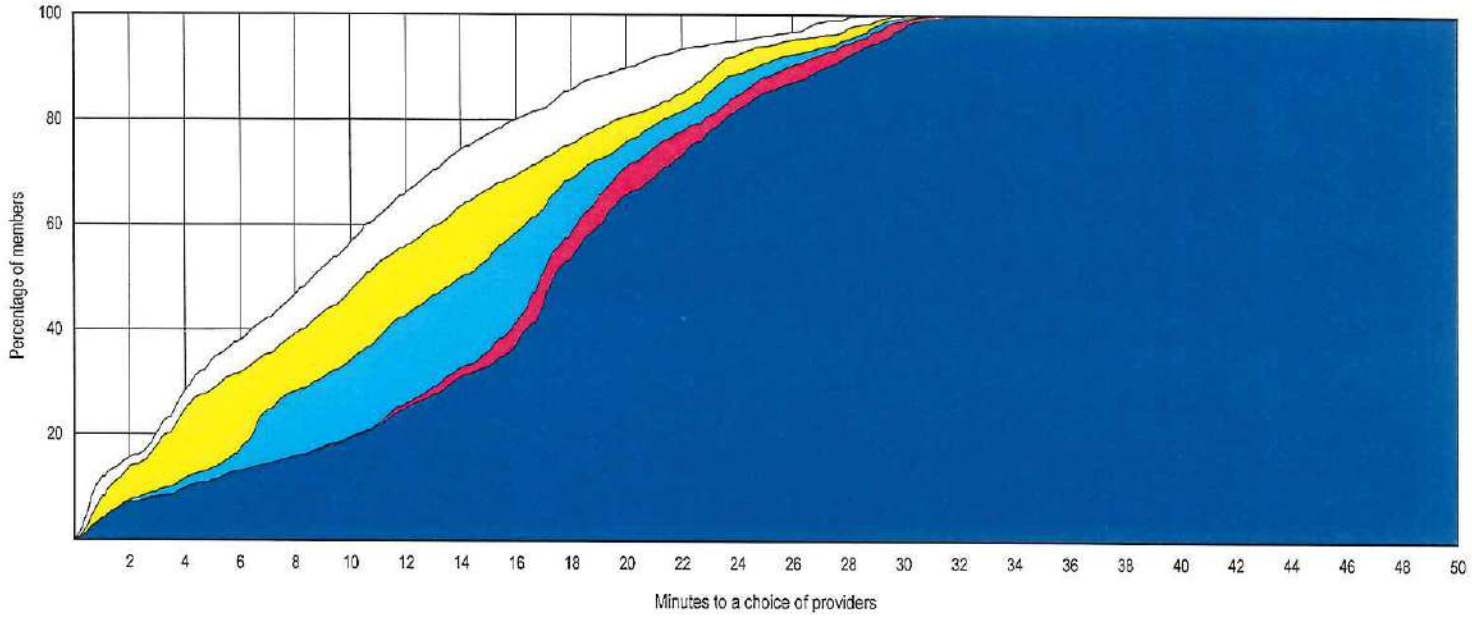

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Provider Locations

January 23, 2020

Region 8 Pharmacies and Durable Medical Equipment Suppliers

Total Providers: 72

h All providers

Interstates

US Highways

State Highways

16.38 miles

Region 8 Pharmacies and Durable Medical Equipment Suppliers

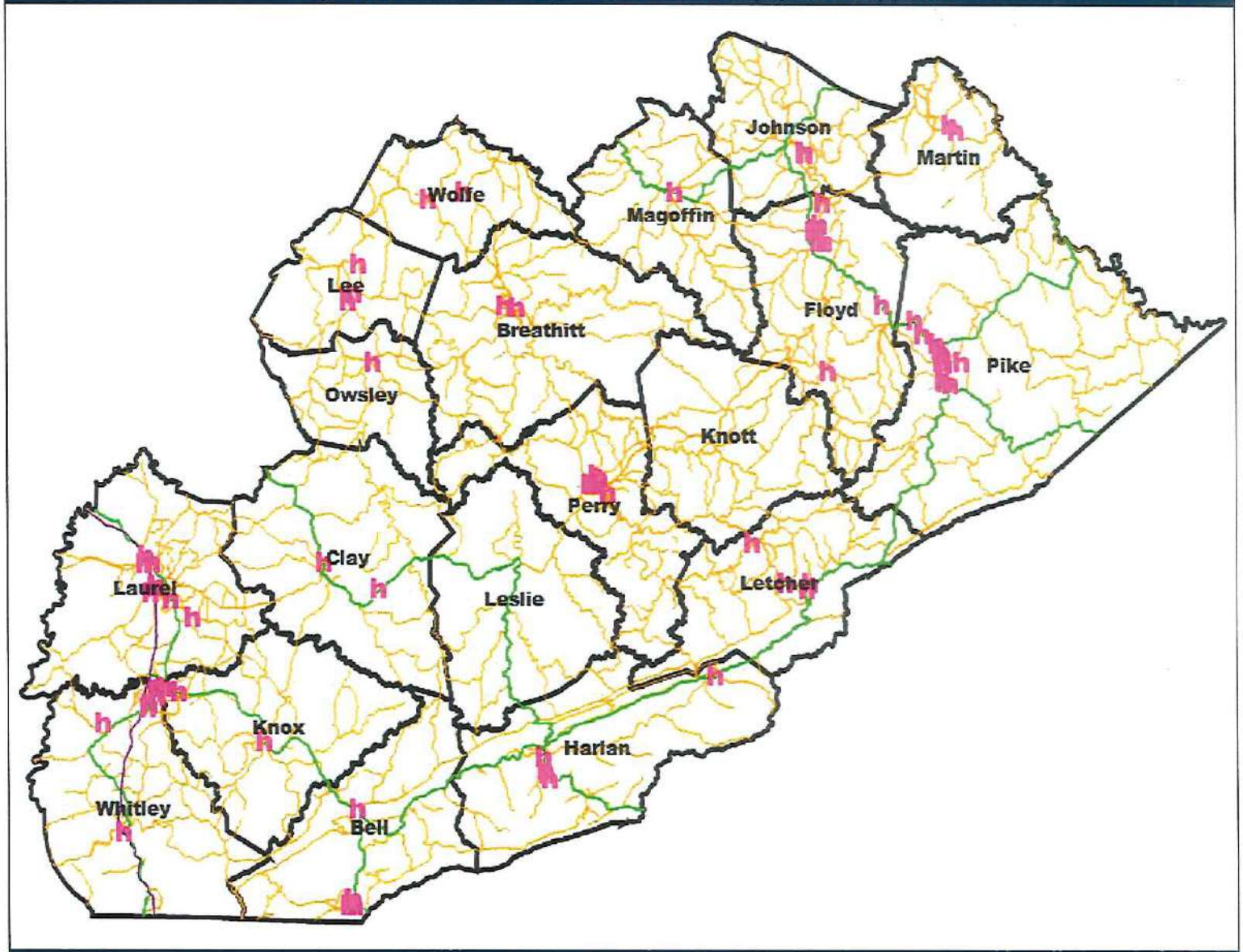

72 providers at 79 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 miles

Overall Access[1]

31,600 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

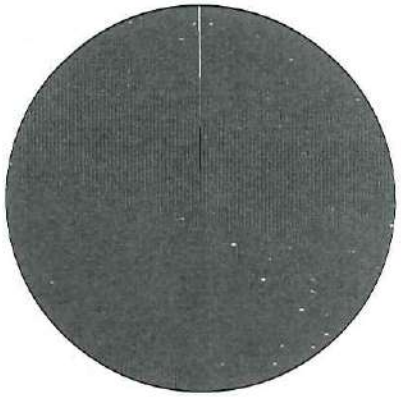

Times

	Average
Distance to 1st closest provider	6.0 miles
Distance to 2nd closest provider	8.5 miles
Distance to 3rd closest provider	10.0 miles
Distance to 4th closest provider	11.3 miles
Distance to 5th closest provider	12.3 miles

Access Standard Comparison

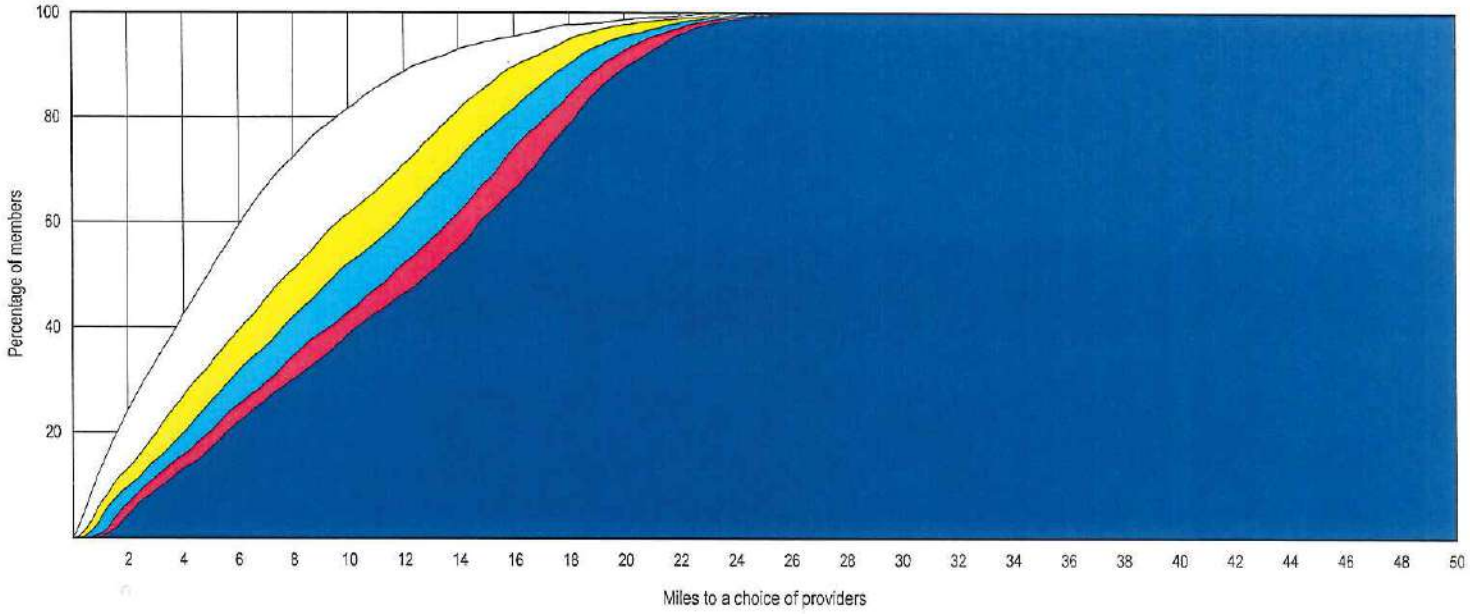

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Access Overview

January 24, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Pharmacies and Durable Medical Equipment Suppliers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Pharmacies and Durable Medical Equipment Suppliers) provider in 50 minutes

Overall Access[1]

31,600 Members
506 providers at 566 locations (Pharmacies and Durable Medical Equipment Suppliers)

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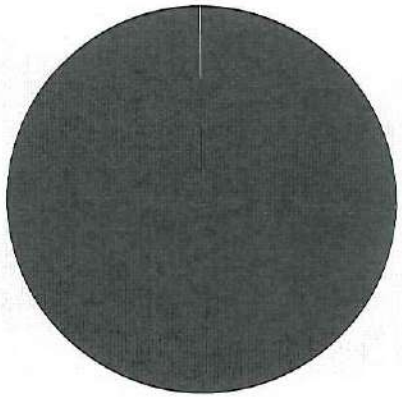

Times

	Average
Time to 1st closest provider	6.5 mins
Time to 2nd closest provider	9.3 mins
Time to 3rd closest provider	10.8 mins
Time to 4th closest provider	12.3 mins
Time to 5th closest provider	13.4 mins

Access Standard Comparison

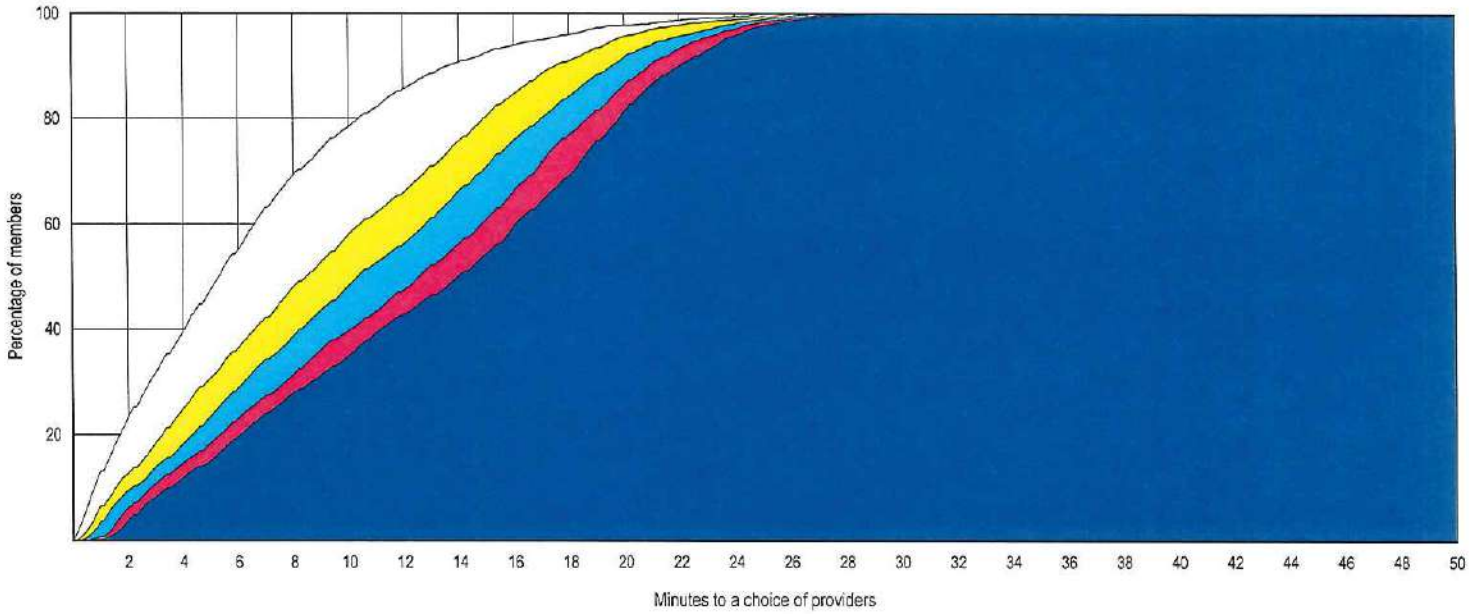

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Provider Locations

January 23, 2020

Region 1 Podiatrists

Total Providers: 4

i All providers

Interstates

US Highways

State Highways

12.93 miles

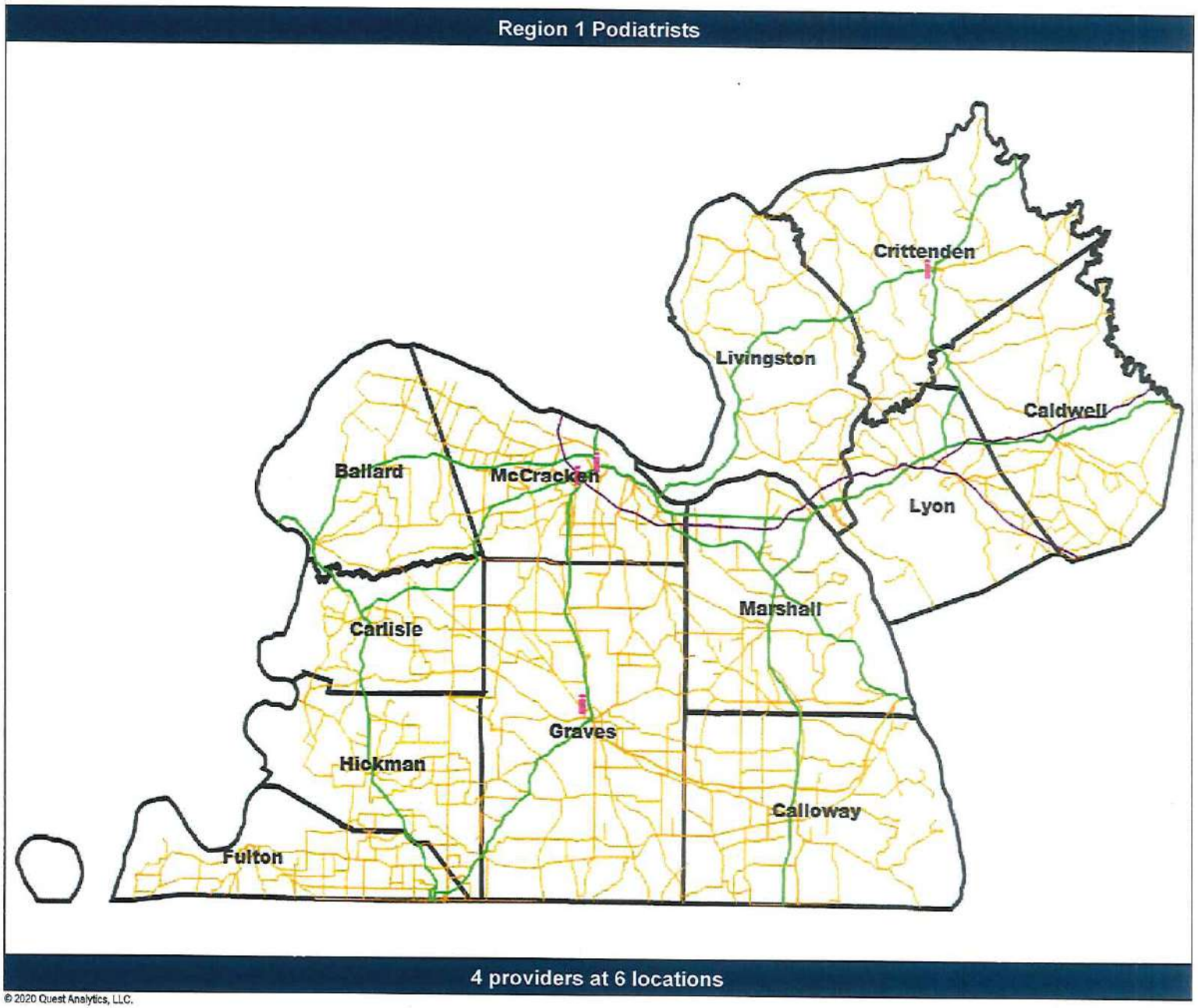

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Podiatrists) provider in 50 miles

Overall Access[1]

11,338 Members
169 providers at 209 locations (Podiatrists)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

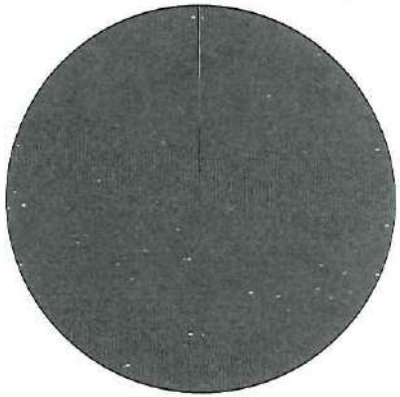

Times

		Average
Distance to 1st closest provider	15.5 miles	
Distance to 2nd closest provider	17.3 miles	
Distance to 3rd closest provider	17.8 miles	
Distance to 4th closest provider	26.8 miles	
Distance to 5th closest provider	31.6 miles	

Access Standard Comparison

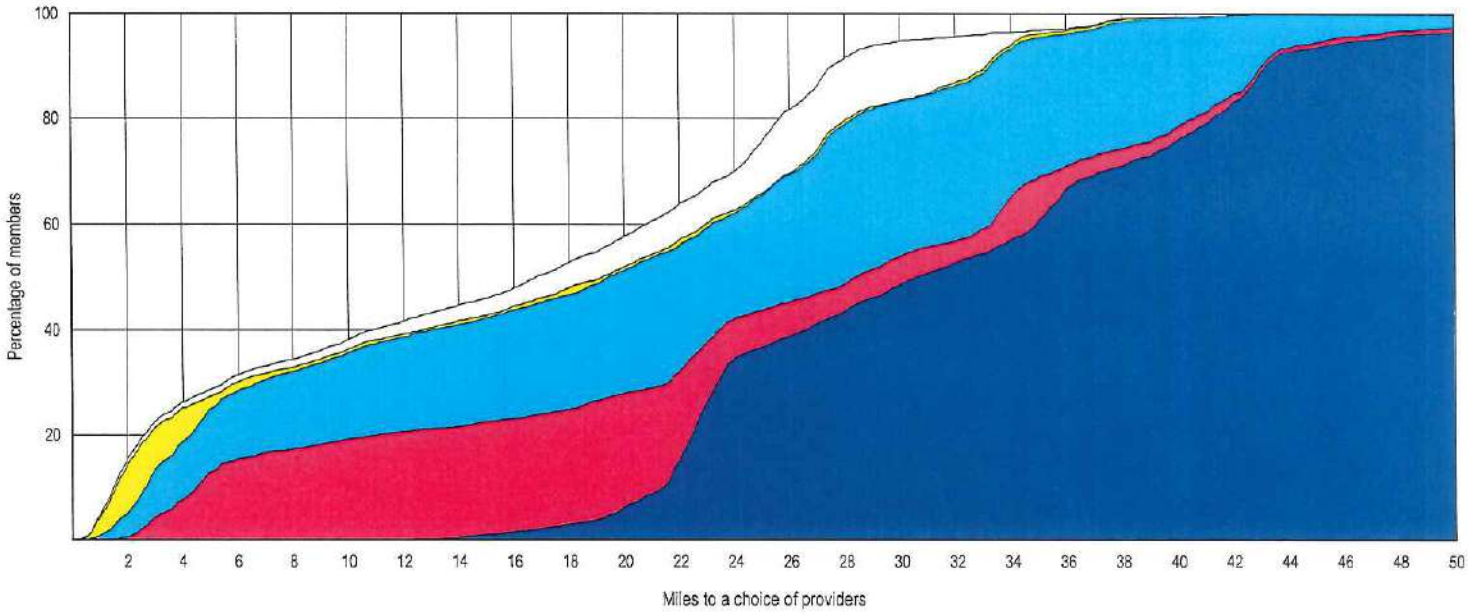

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Access Overview

January 24, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Podiatrists) provider in 50 minutes

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11,338 Members
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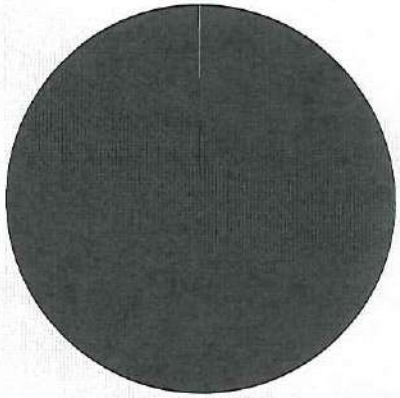

Times

	Average
Time to 1st closest provider	16.9 mins
Time to 2nd closest provider	18.8 mins
Time to 3rd closest provider	19.3 mins
Time to 4th closest provider	29.2 mins
Time to 5th closest provider	34.5 mins

Access Standard Comparison

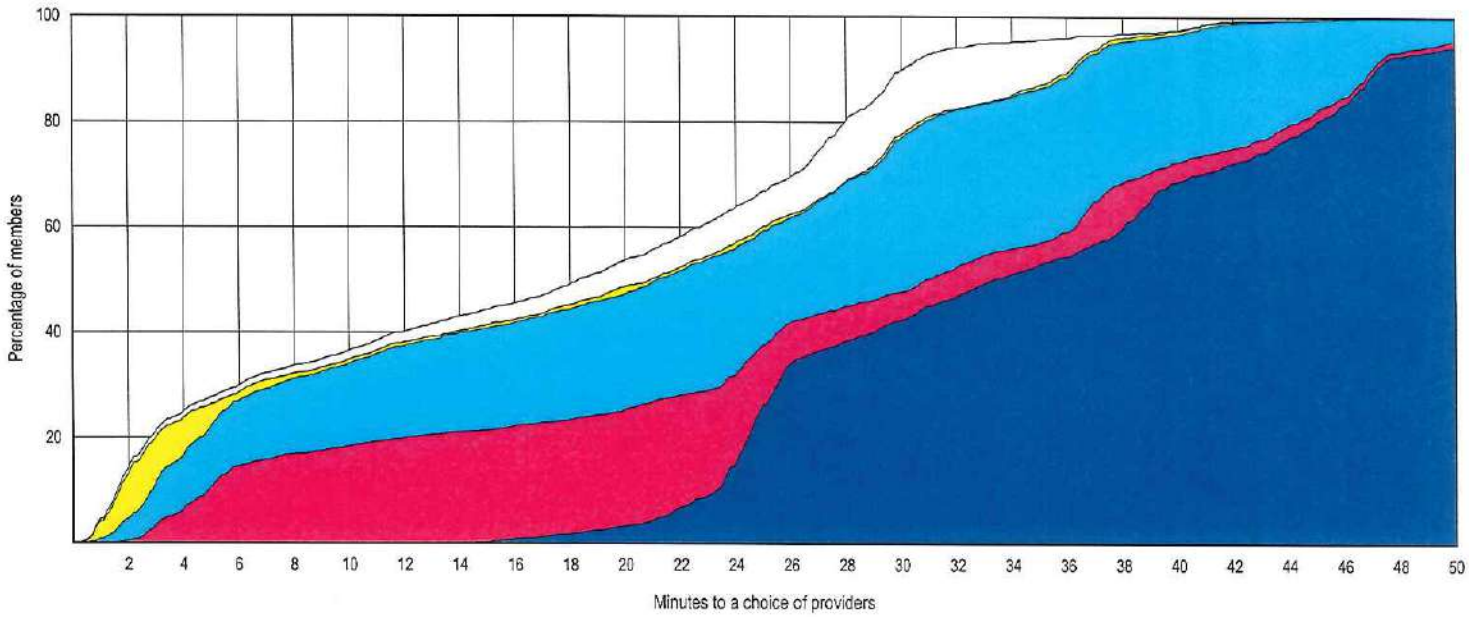

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Provider Locations

January 23, 2020

Region 2 Podiatrists

Total Providers: 8

i All providers

Interstates

US Highways

State Highways

15.14 miles

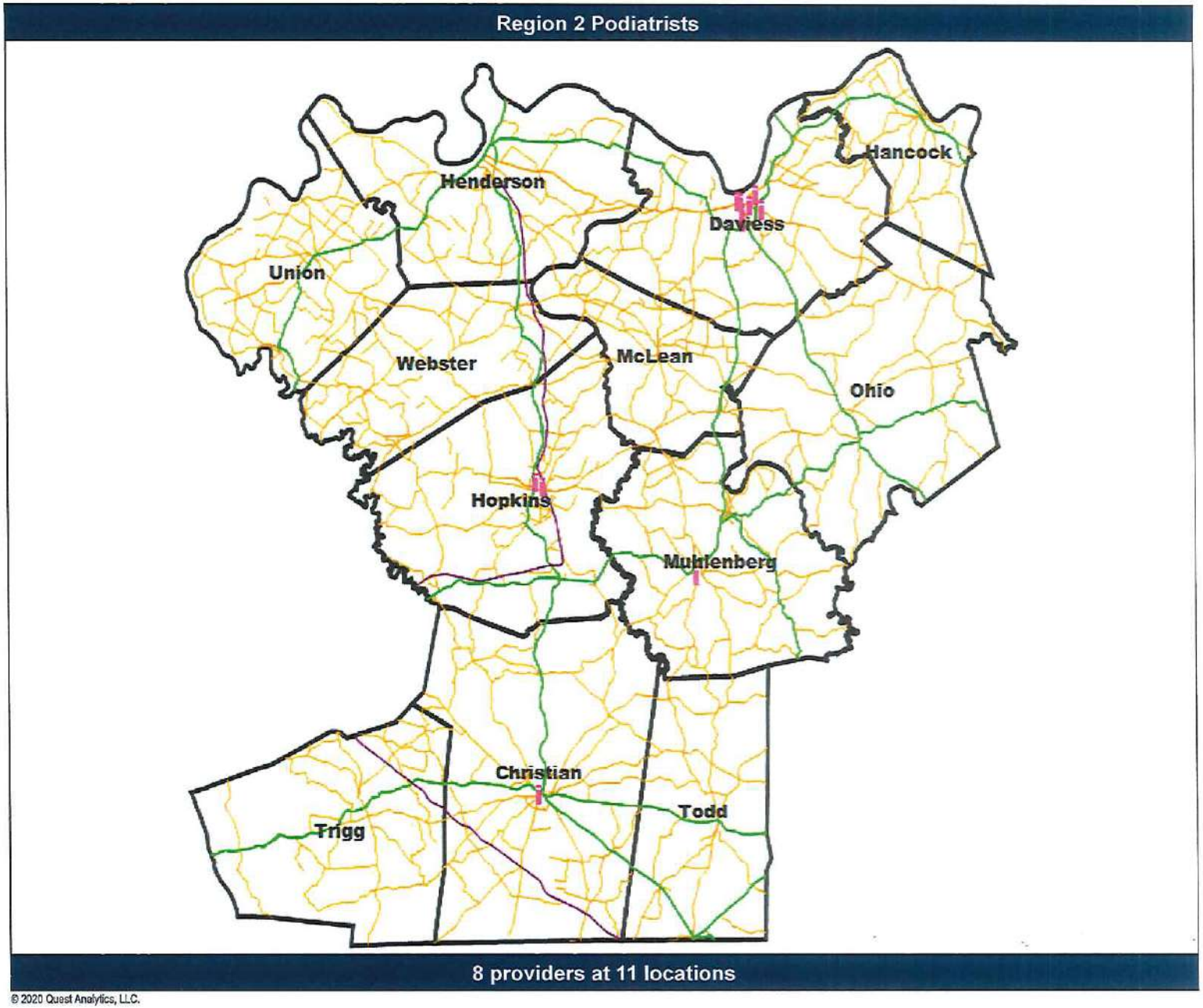

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Podiatrists) provider in 30 miles

Overall Access[1]

16,143 Members
169 providers at 209 locations (Podiatrists)

- 16,127 (99.9%) Members with access
- 15 (0.1%) Members without access
- 1 (0.0%) Members excluded

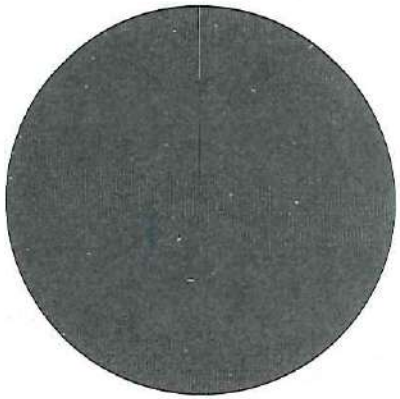

Distances

	Average
Distance to 1st closest provider	8.3 miles
Distance to 2nd closest provider	20.7 miles
Distance to 3rd closest provider	21.3 miles
Distance to 4th closest provider	22.0 miles
Distance to 5th closest provider	24.7 miles

Access Standard Comparison

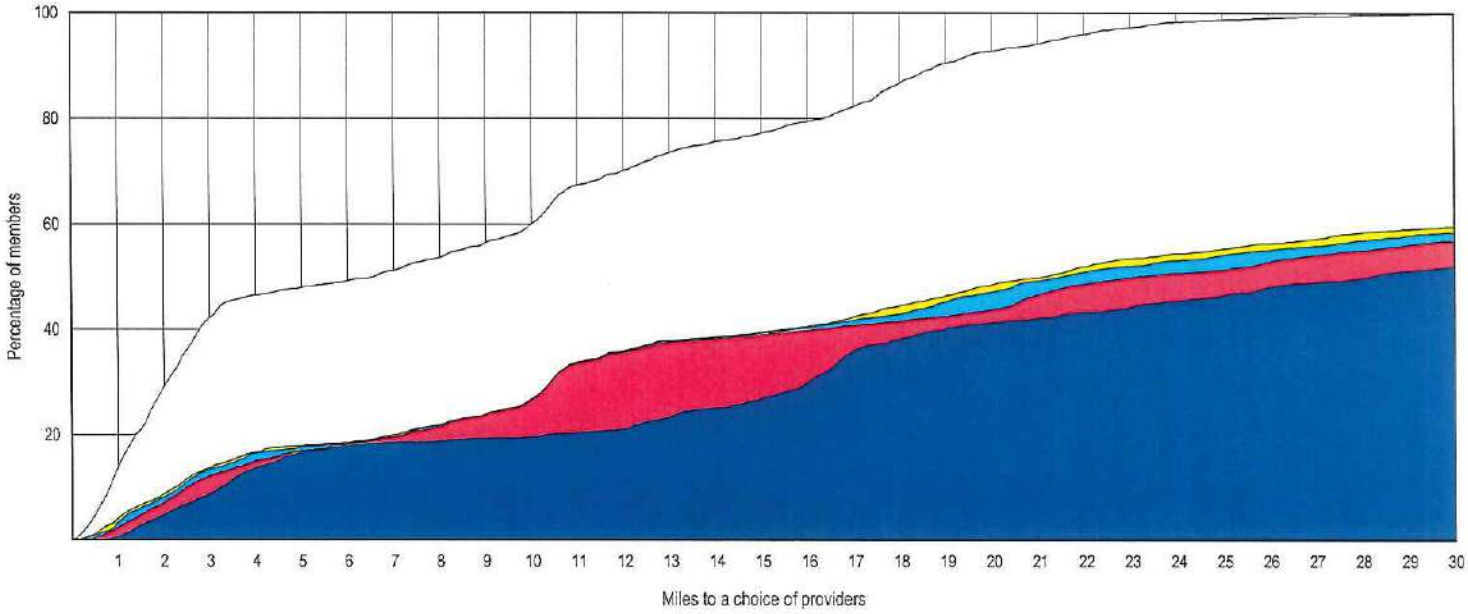

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Podiatrists) provider in 30 minutes

Overall Access[1]

16,143 Members
169 providers at 209 locations (Podiatrists)

- 16,034 (99.3%) Members with access
- 108 (0.7%) Members without access
- 1 (0.0%) Members excluded

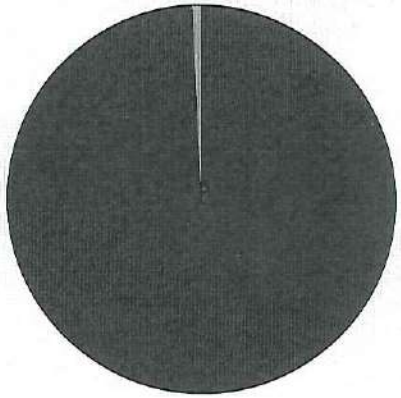

Times

	Average
Time to 1st closest provider	9.2 mins
Time to 2nd closest provider	22.8 mins
Time to 3rd closest provider	23.5 mins
Time to 4th closest provider	24.2 mins
Time to 5th closest provider	27.1 mins

Access Standard Comparison

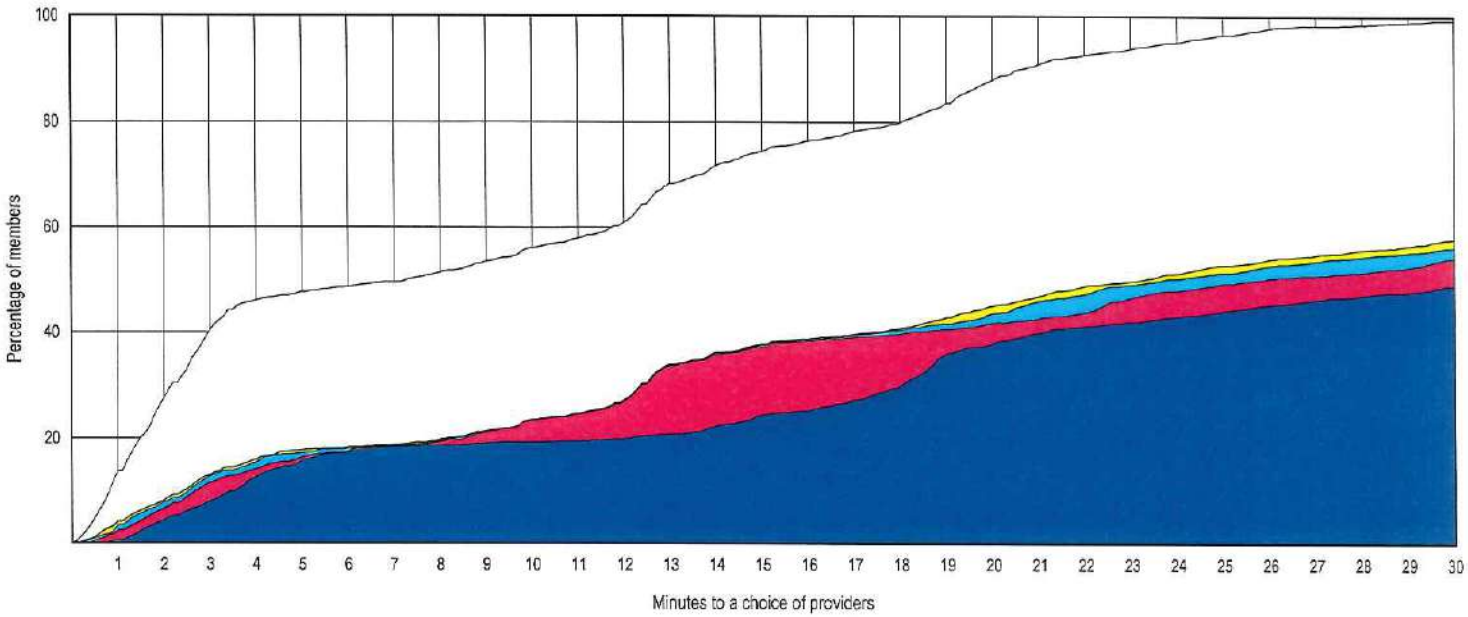

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Podiatrists) provider in 50 miles

Overall Access[1]

9,636 Members
169 providers at 209 locations (Podiatrists)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

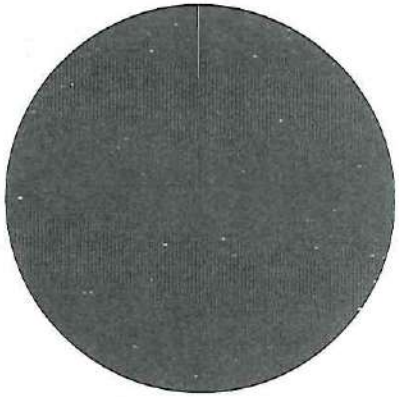

Distances

	Average
Distance to 1st closest provider	14.4 miles
Distance to 2nd closest provider	19.4 miles
Distance to 3rd closest provider	20.6 miles
Distance to 4th closest provider	27.4 miles
Distance to 5th closest provider	32.5 miles

Access Standard Comparison

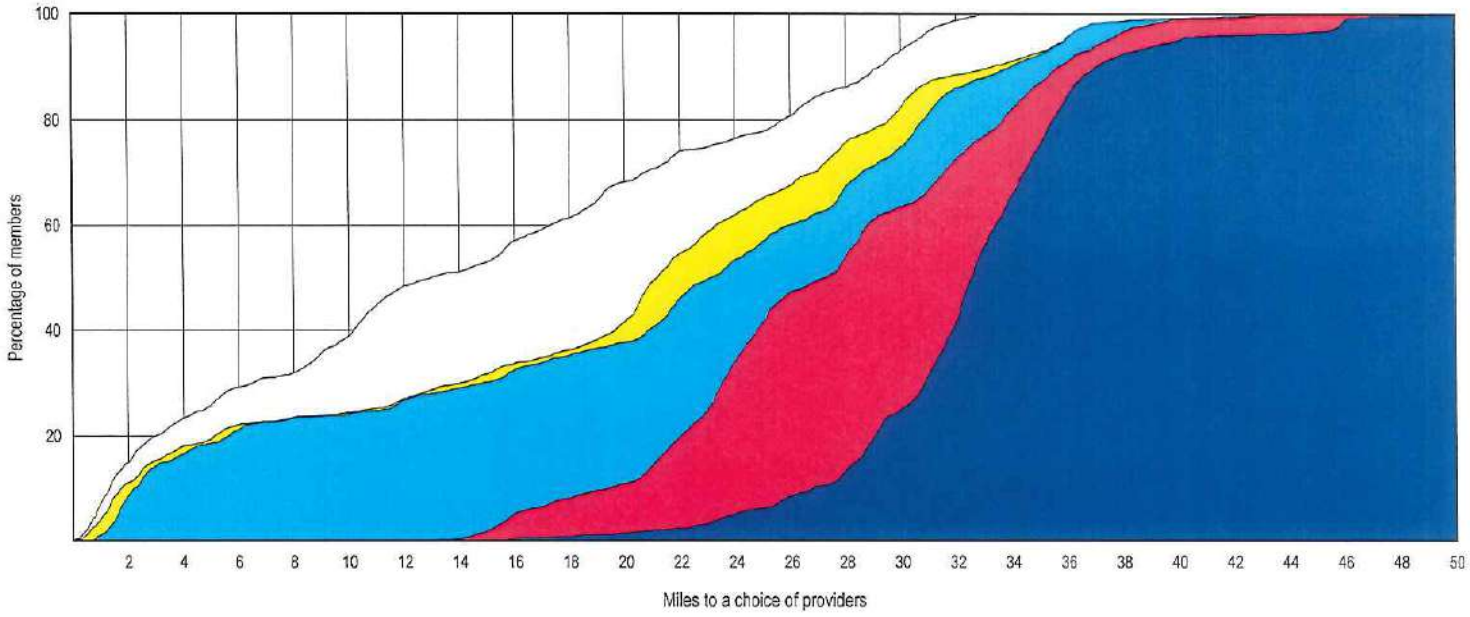

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Podiatrists) provider in 50 minutes

Overall Access[1]

9,636 Members
169 providers at 209 locations (Podiatrists)

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- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

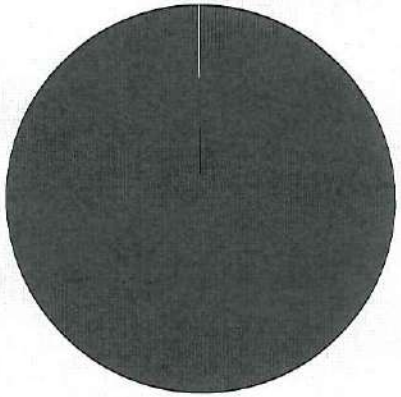

Times

	Average
Time to 1st closest provider	15.7 mins
Time to 2nd closest provider	21.4 mins
Time to 3rd closest provider	22.7 mins
Time to 4th closest provider	30.2 mins
Time to 5th closest provider	35.9 mins

Access Standard Comparison

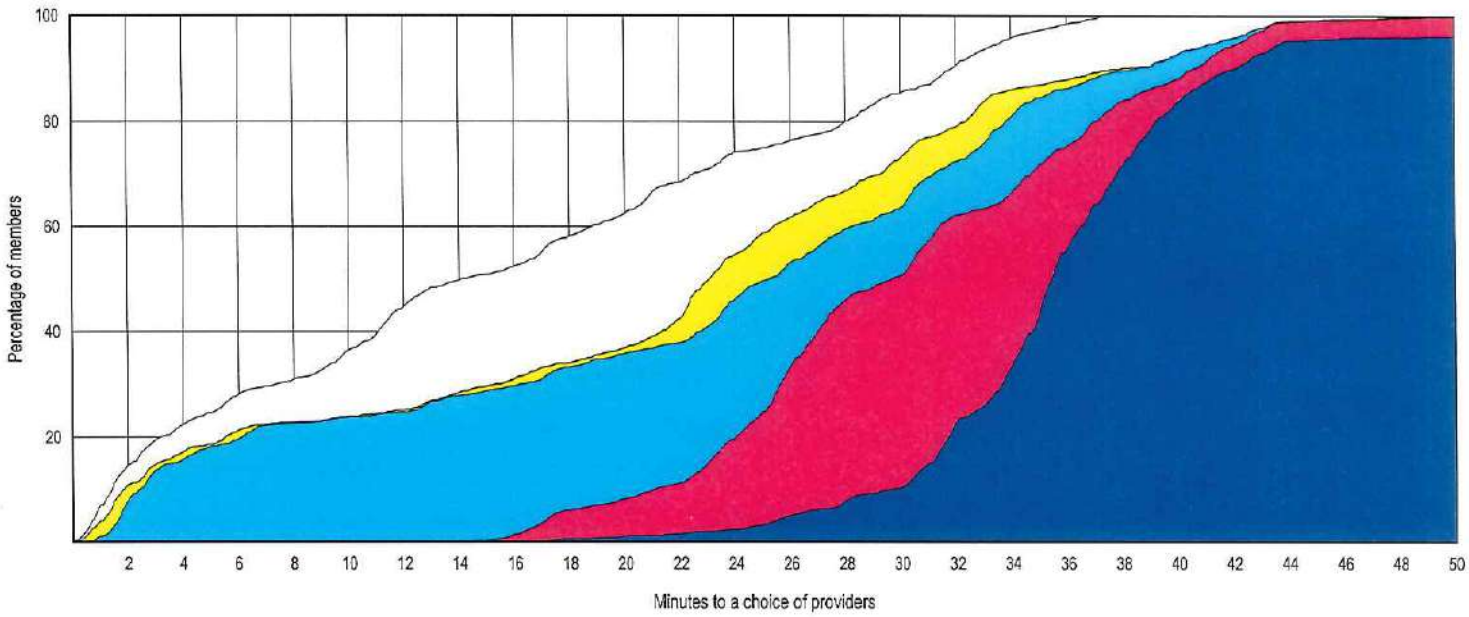

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Provider Locations

January 23, 2020

Region 3 Podiatrists

Total Providers: 52

i All providers

Interstates

US Highways

State Highways

15.97 miles

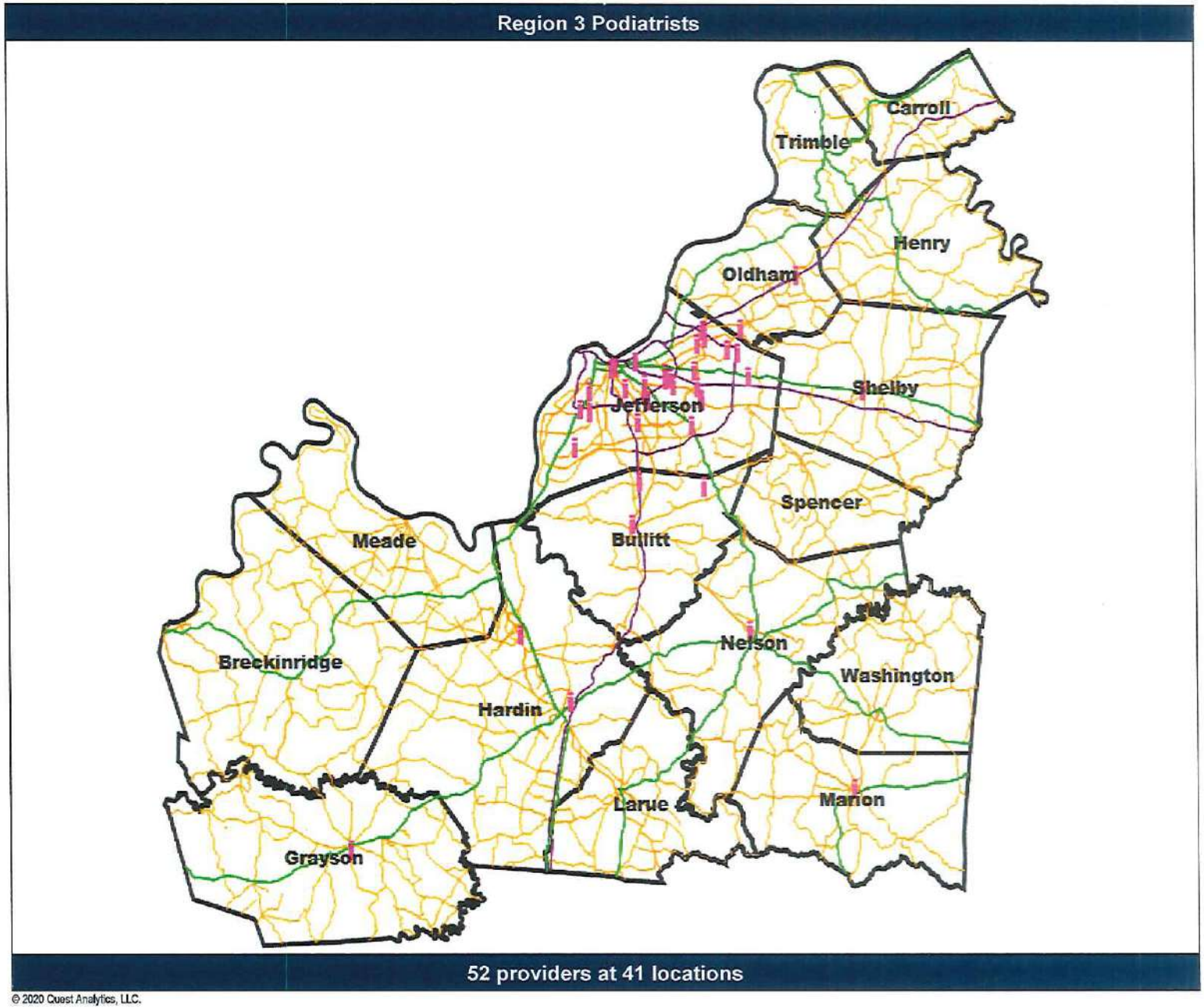

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Podiatrists) provider in 30 miles

Overall Access[1]

18,130 Members
169 providers at 209 locations (Podiatrists)

- 18,127 (99.9%) Members with access
- 0 (0.0%) Members without access
- 3 (0.0%) Members excluded

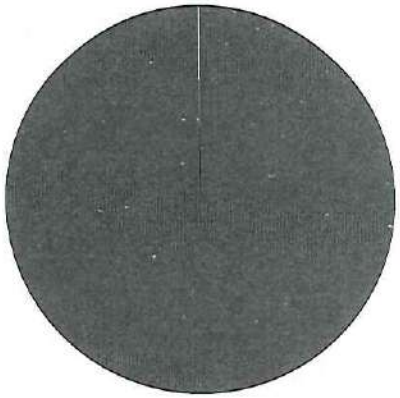

Distances

	Average
Distance to 1st closest provider	3.5 miles
Distance to 2nd closest provider	4.7 miles
Distance to 3rd closest provider	5.8 miles
Distance to 4th closest provider	6.2 miles
Distance to 5th closest provider	6.5 miles

Access Standard Comparison

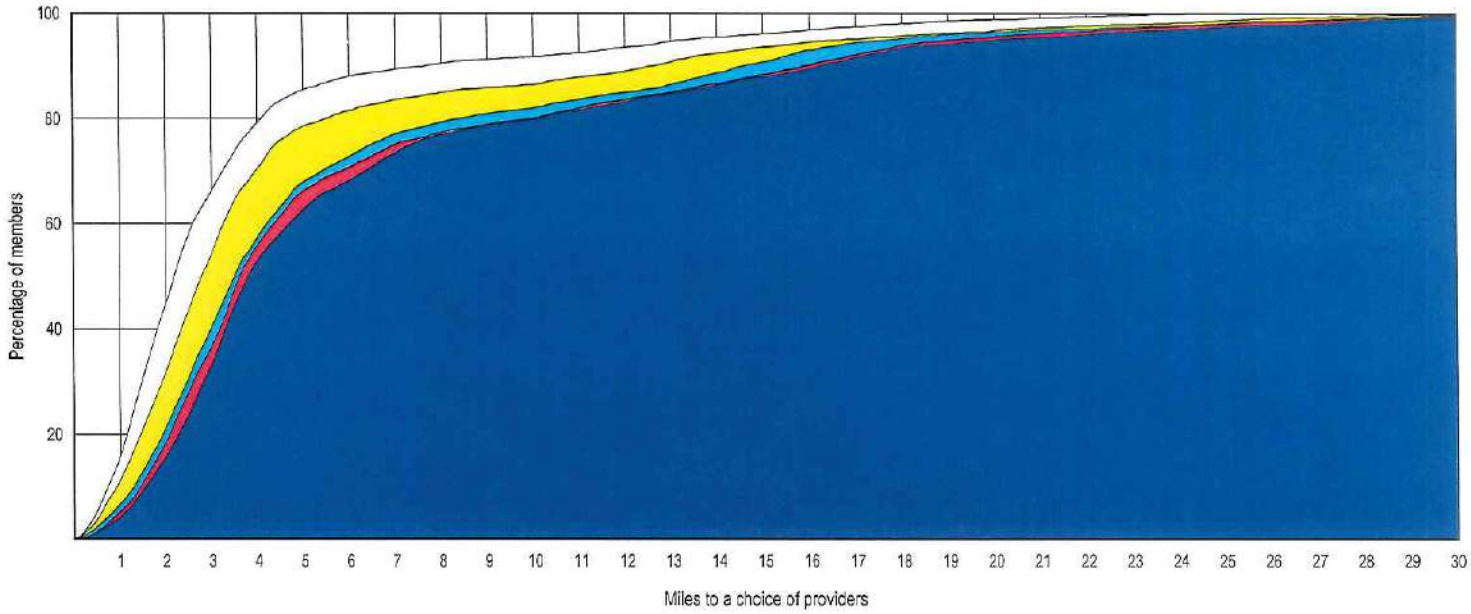

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Podiatrists) provider in 30 minutes

Overall Access[1]

18,130 Members
169 providers at 209 locations (Podiatrists)

- 18,121 (99.9%) Members with access
- 6 (0.1%) Members without access
- 3 (0.0%) Members excluded

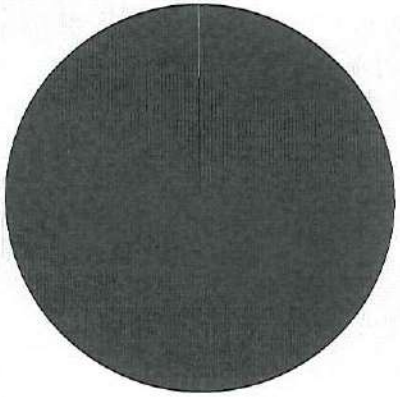

Times

	Average
Time to 1st closest provider	4.3 mins
Time to 2nd closest provider	5.7 mins
Time to 3rd closest provider	7.0 mins
Time to 4th closest provider	7.6 mins
Time to 5th closest provider	7.9 mins

Access Standard Comparison

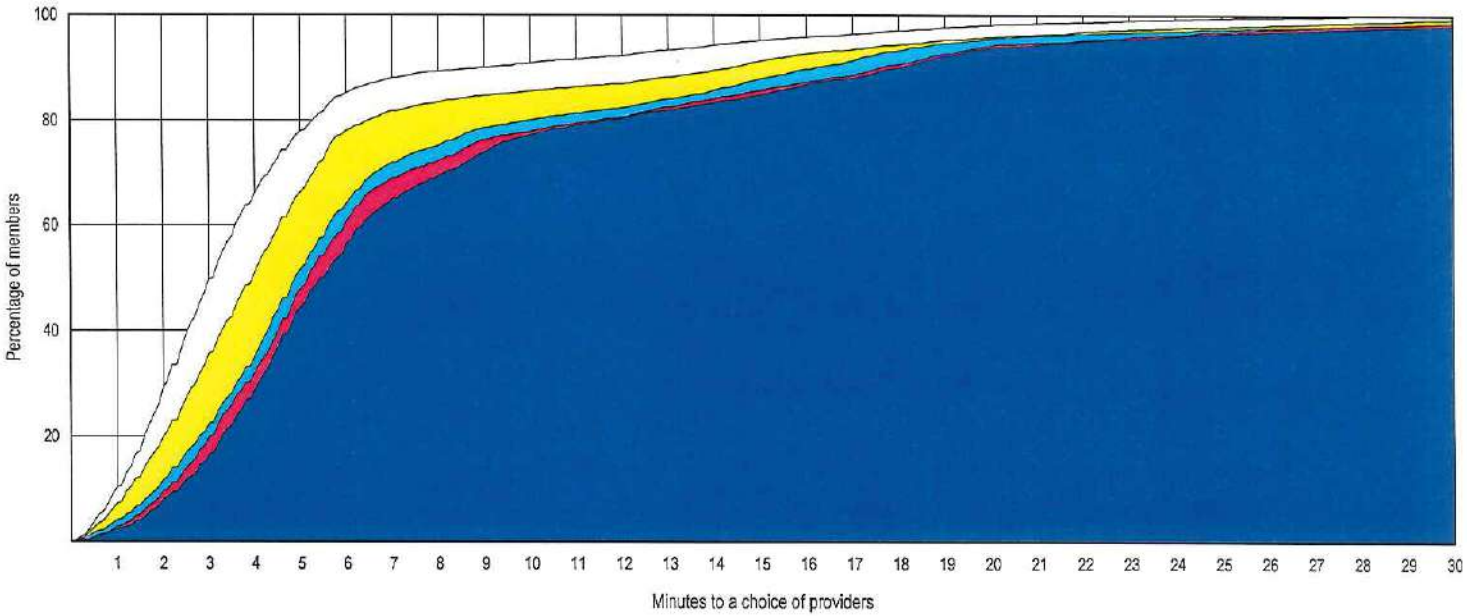

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Podiatrists) provider in 50 miles

Overall Access[1]

1,901 Members
169 providers at 209 locations (Podiatrists)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

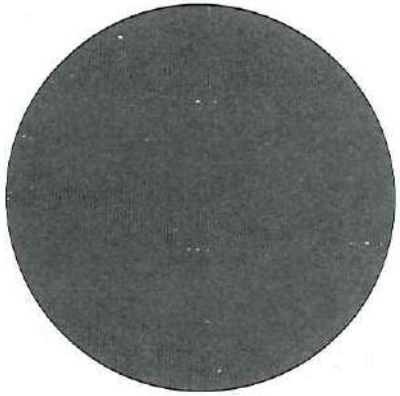

Distances

	Average
Distance to 1st closest provider	13.4 miles
Distance to 2nd closest provider	18.5 miles
Distance to 3rd closest provider	19.6 miles
Distance to 4th closest provider	28.1 miles
Distance to 5th closest provider	28.7 miles

Access Standard Comparison

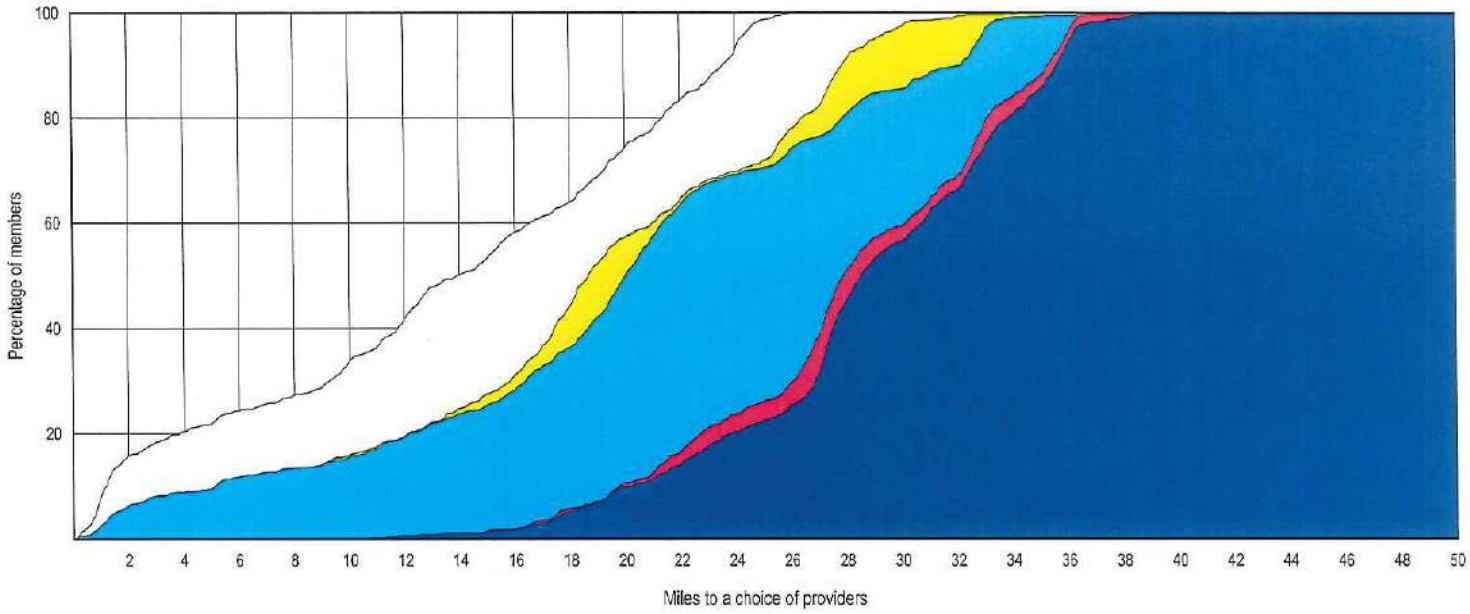

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Podiatrists) provider in 50 minutes

Overall Access[1]

1,901 Members
169 providers at 209 locations (Podiatrists)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

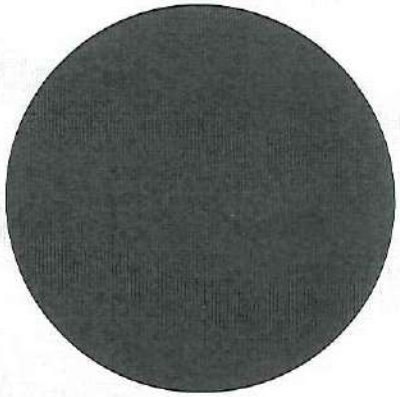

Times

	Average
Time to 1st closest provider	14.6 mins
Time to 2nd closest provider	20.1 mins
Time to 3rd closest provider	21.3 mins
Time to 4th closest provider	30.7 mins
Time to 5th closest provider	31.3 mins

Access Standard Comparison

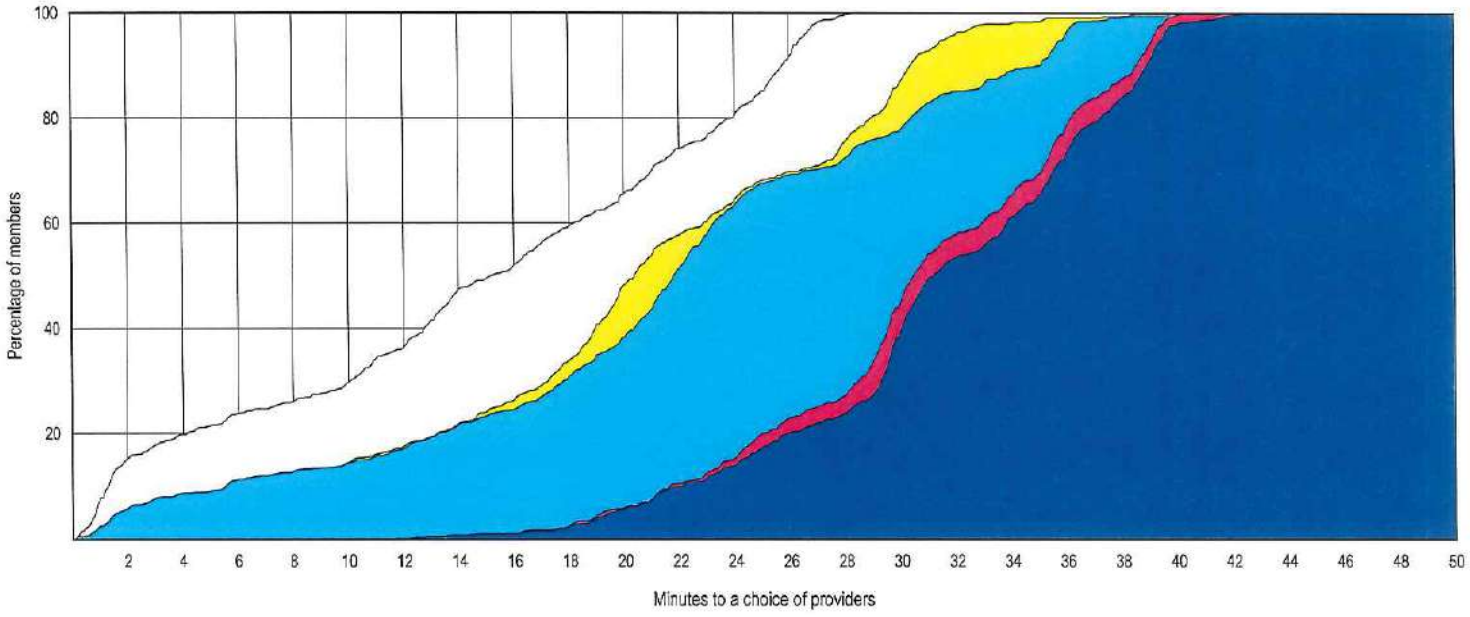

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Provider Locations

January 23, 2020

Region 4 Podiatrists

Total Providers: 16

All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Podiatrists

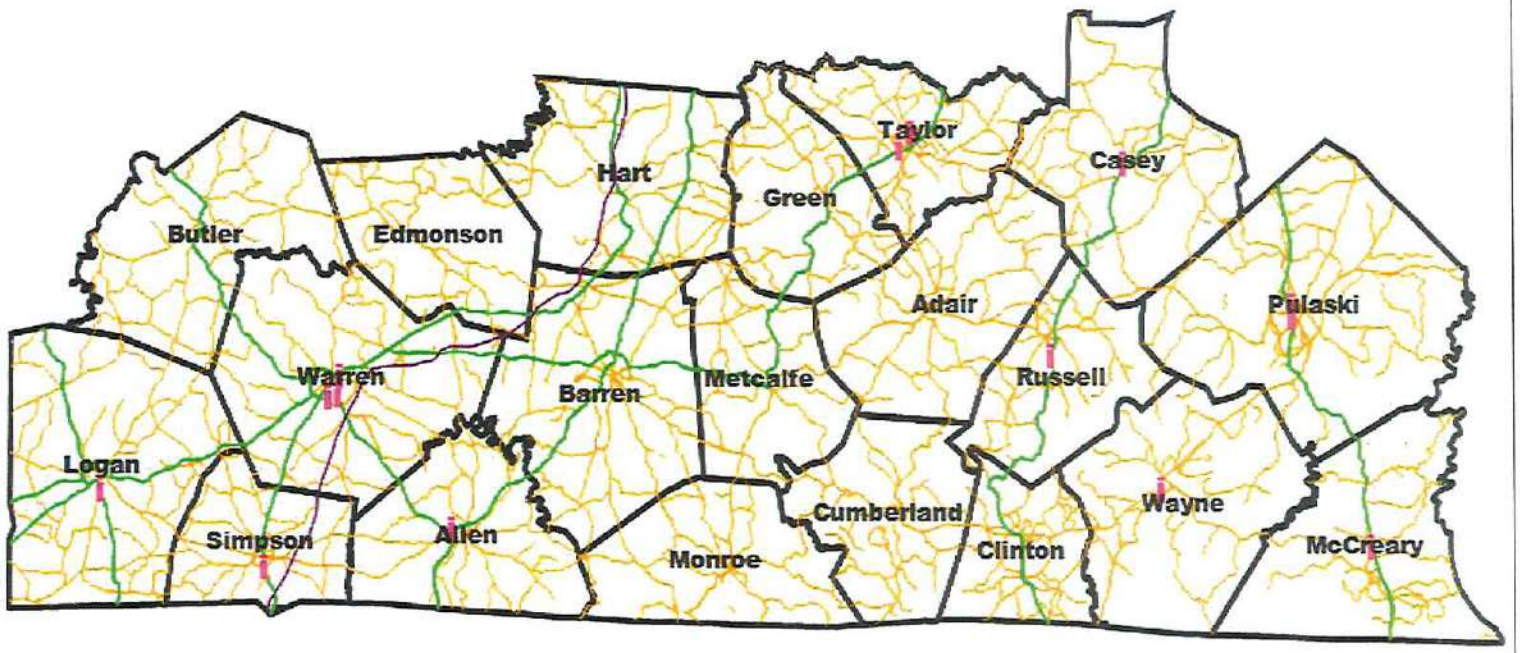

16 providers at 16 locations

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Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Podiatrists) provider in 30 miles

Overall Access[1]

7,413 Members
169 providers at 209 locations (Podiatrists)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

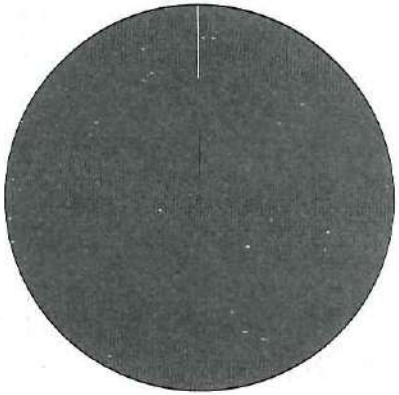

Distances

	Average
Distance to 1st closest provider	5.4 miles
Distance to 2nd closest provider	5.4 miles
Distance to 3rd closest provider	8.2 miles
Distance to 4th closest provider	8.7 miles
Distance to 5th closest provider	9.2 miles

Access Standard Comparison

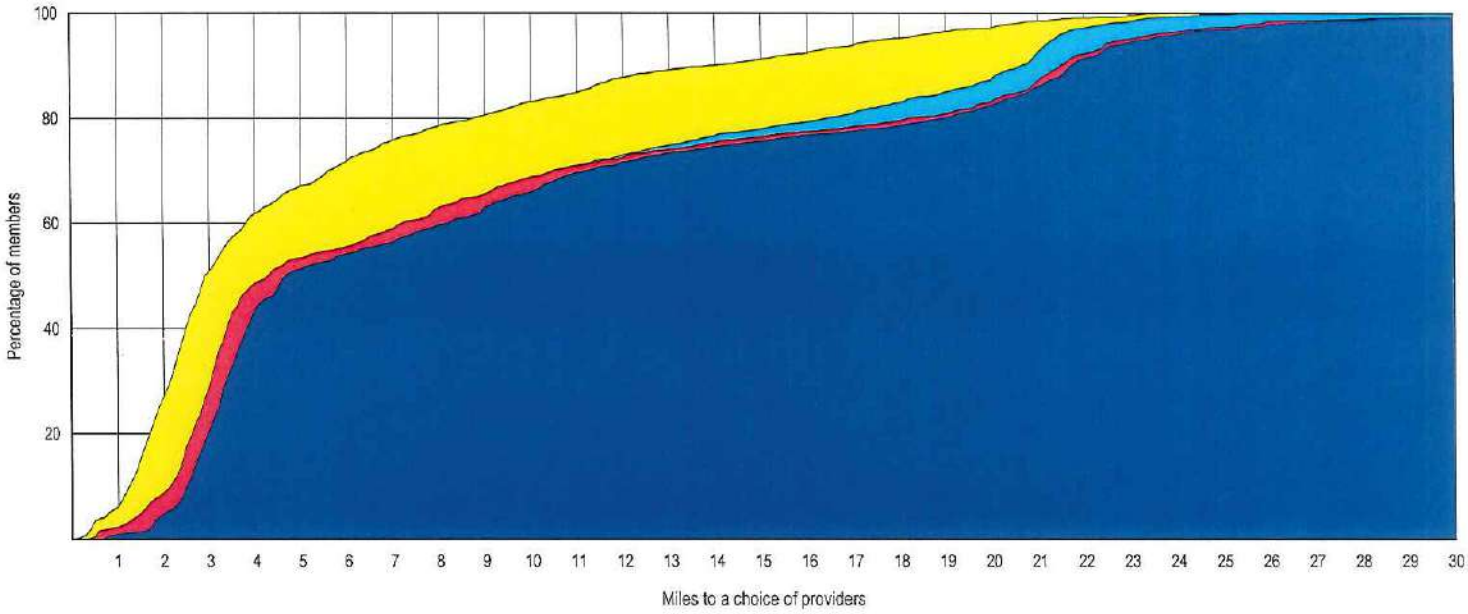

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
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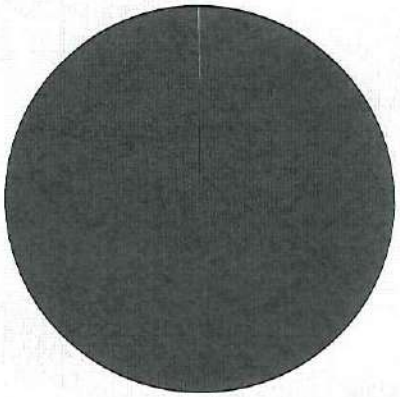

Times

	Average
Time to 1st closest provider	5.8 mins
Time to 2nd closest provider	5.8 mins
Time to 3rd closest provider	8.9 mins
Time to 4th closest provider	9.4 mins
Time to 5th closest provider	10.0 mins

Access Standard Comparison

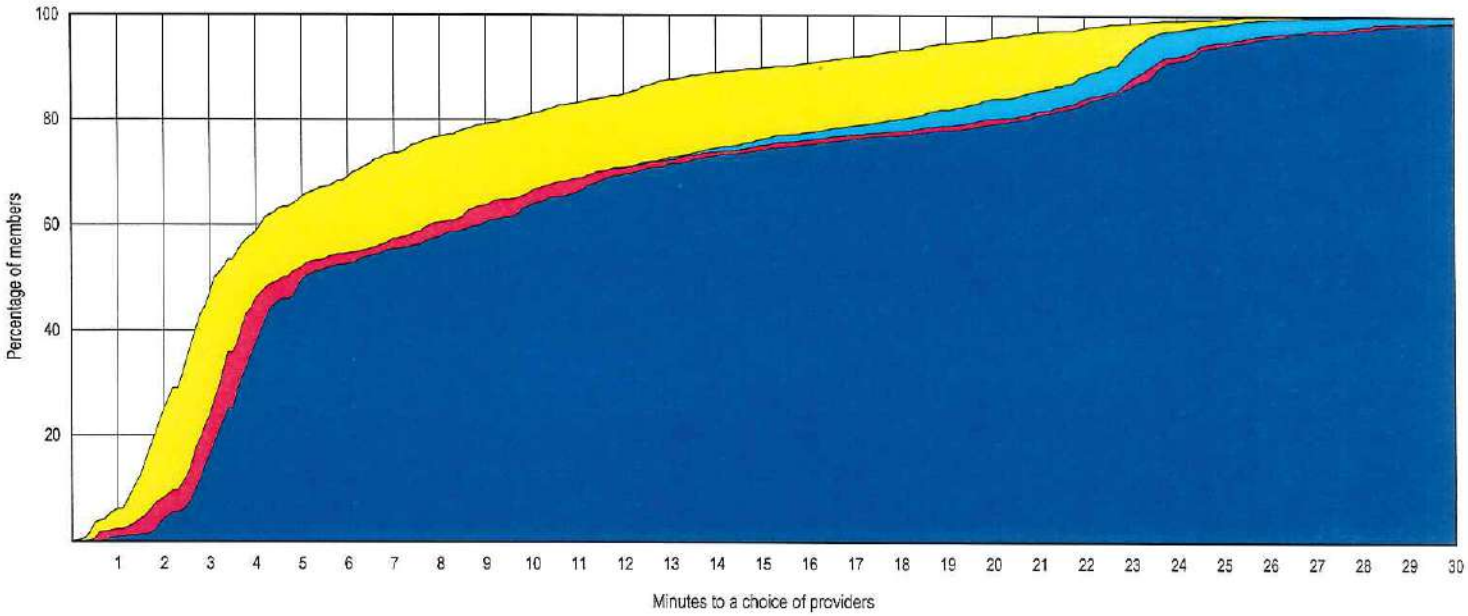

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Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Podiatrists) provider in 50 miles

Overall Access[1]

28,324 Members
169 providers at 209 locations (Podiatrists)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

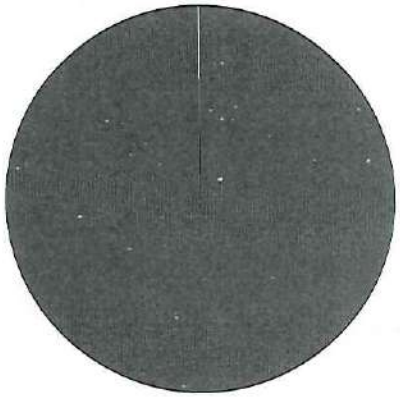

Distances

	Average
Distance to 1st closest provider	13.3 miles
Distance to 2nd closest provider	15.9 miles
Distance to 3rd closest provider	20.6 miles
Distance to 4th closest provider	24.1 miles
Distance to 5th closest provider	25.9 miles

Access Standard Comparison

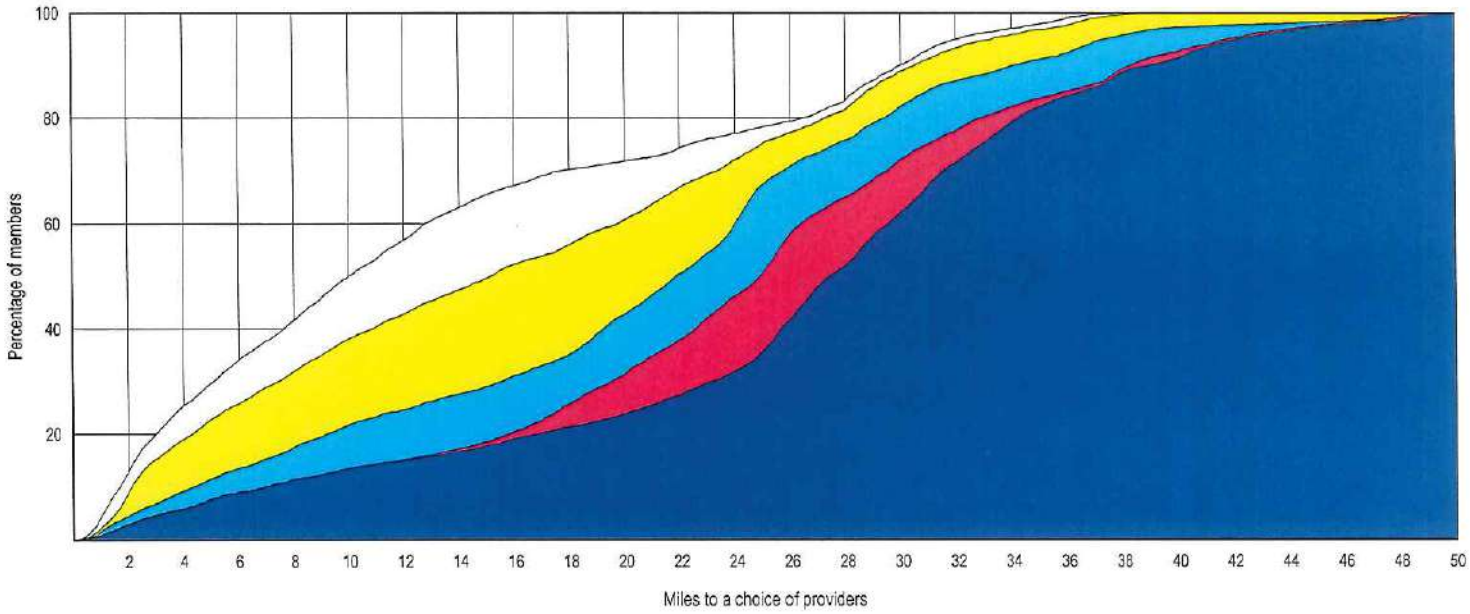

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Access Overview

January 24, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
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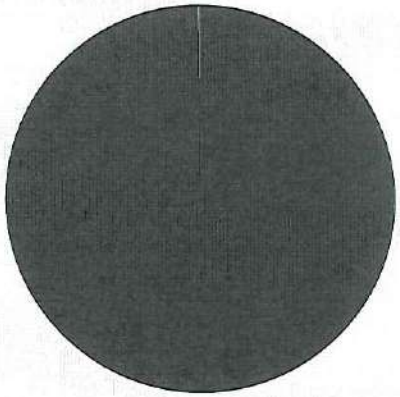

Times

	Average
Time to 1st closest provider	14.5 mins
Time to 2nd closest provider	17.3 mins
Time to 3rd closest provider	22.4 mins
Time to 4th closest provider	26.2 mins
Time to 5th closest provider	28.2 mins

Access Standard Comparison

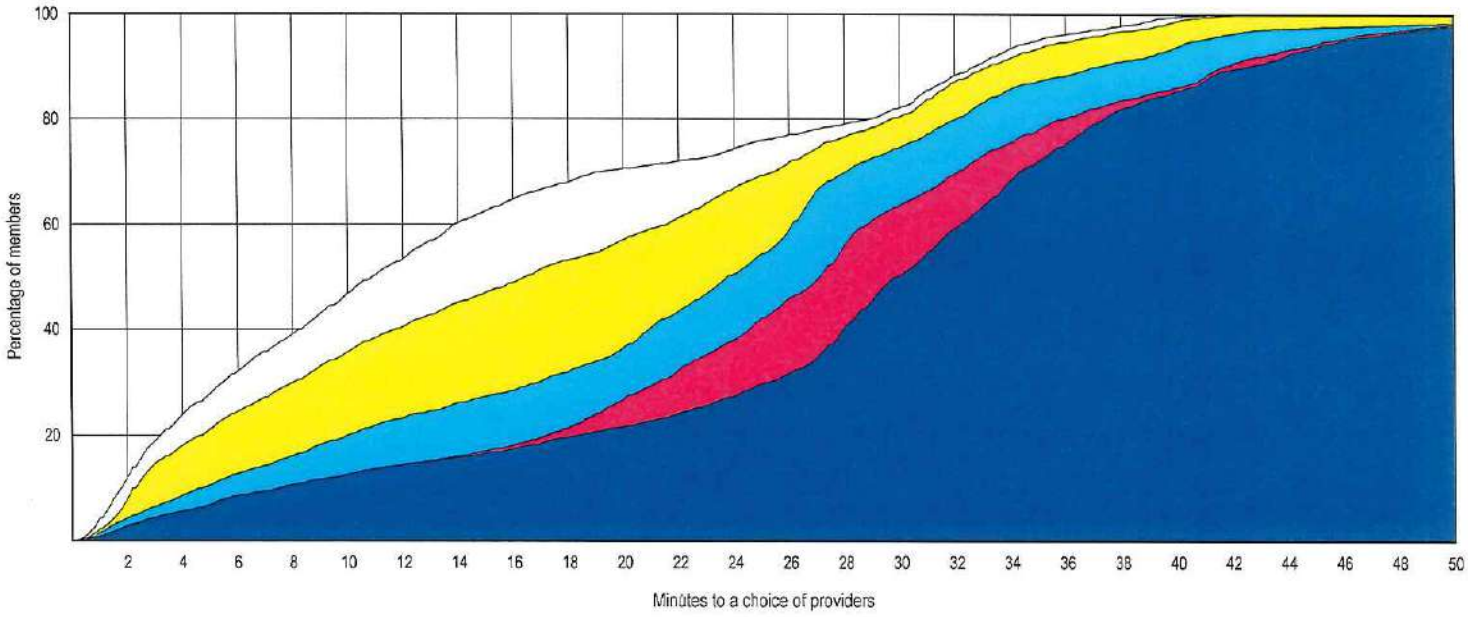

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Provider Locations

January 23, 2020

Region 5 Podiatrists

Total Providers: 35

i All providers

Interstates

US Highways

State Highways

17.44 miles

Region 5 Podiatrists

35 providers at 34 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Podiatrists) provider in 30 miles

Overall Access[1]

22,712 Members
169 providers at 209 locations (Podiatrists)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

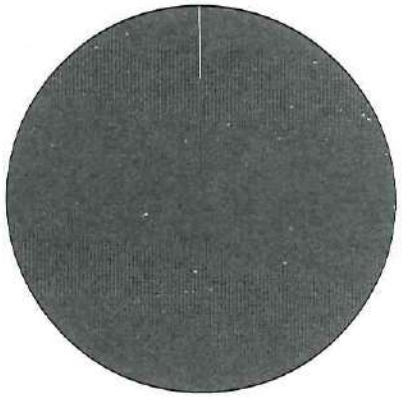

Distances

	Average
Distance to 1st closest provider	4.4 miles
Distance to 2nd closest provider	5.5 miles
Distance to 3rd closest provider	6.0 miles
Distance to 4th closest provider	8.1 miles
Distance to 5th closest provider	8.2 miles

Access Standard Comparison

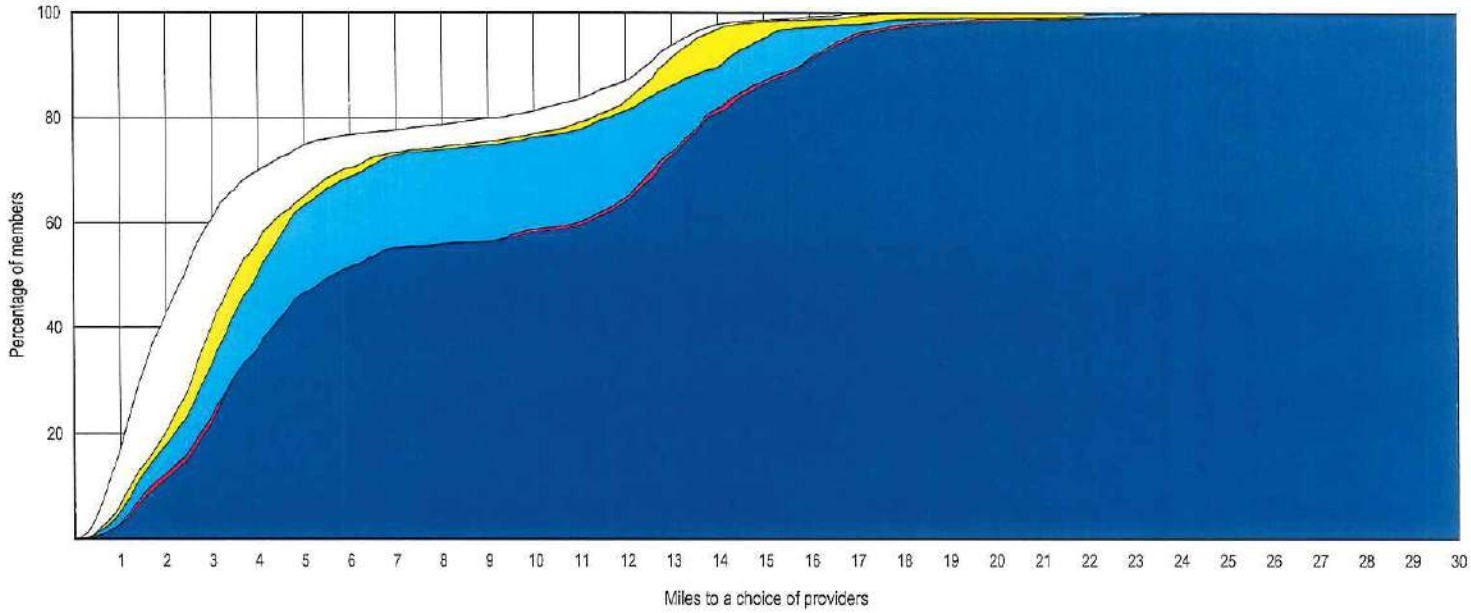

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
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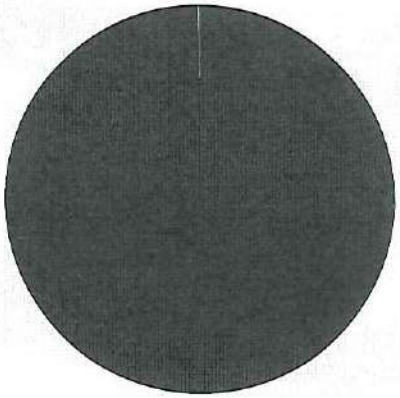

Times

	Average
Time to 1st closest provider	5.7 mins
Time to 2nd closest provider	7.1 mins
Time to 3rd closest provider	7.6 mins
Time to 4th closest provider	10.3 mins
Time to 5th closest provider	10.4 mins

Access Standard Comparison

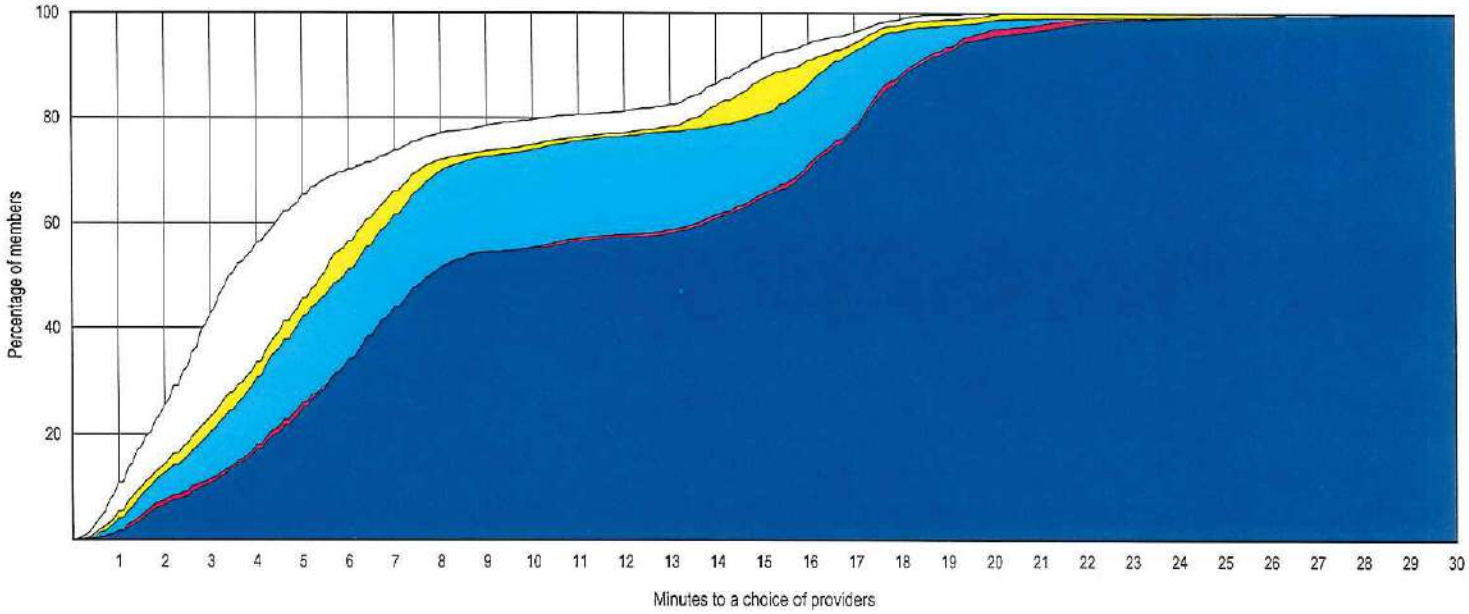

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Podiatrists) provider in 50 miles

Overall Access[1]

23,127 Members
169 providers at 209 locations (Podiatrists)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

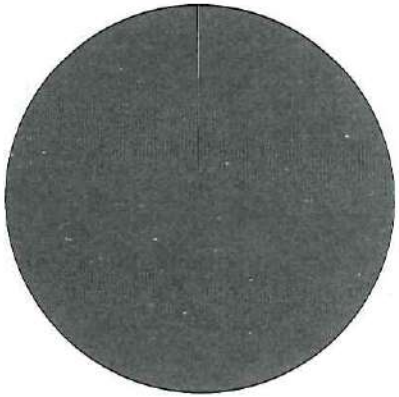

Distances

	Average
Distance to 1st closest provider	7.8 miles
Distance to 2nd closest provider	9.3 miles
Distance to 3rd closest provider	11.6 miles
Distance to 4th closest provider	12.6 miles
Distance to 5th closest provider	13.7 miles

Access Standard Comparison

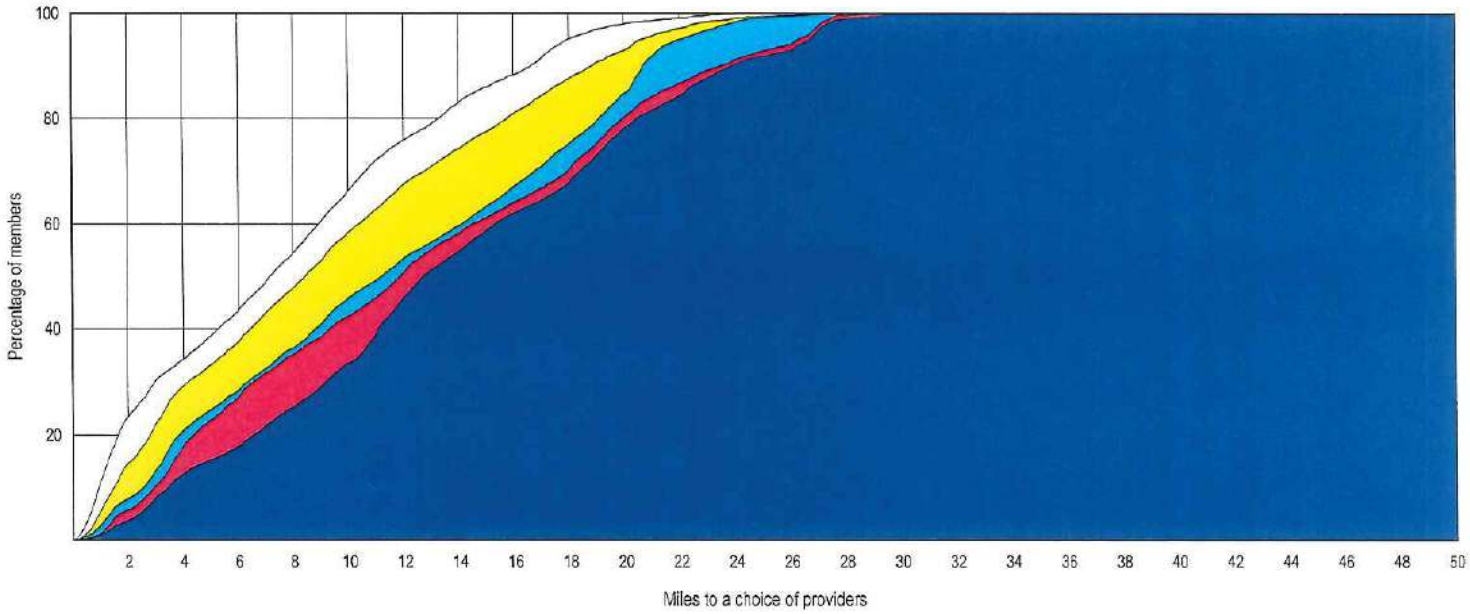

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Podiatrists

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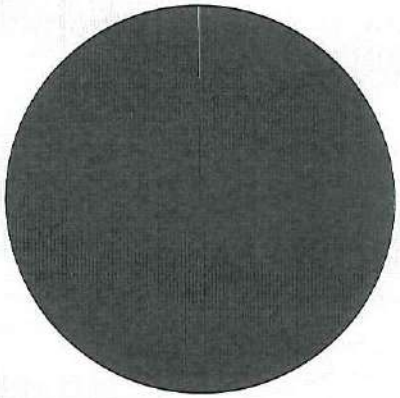

Times

	Average
Time to 1st closest provider	8.5 mins
Time to 2nd closest provider	10.1 mins
Time to 3rd closest provider	12.6 mins
Time to 4th closest provider	13.7 mins
Time to 5th closest provider	14.9 mins

Access Standard Comparison

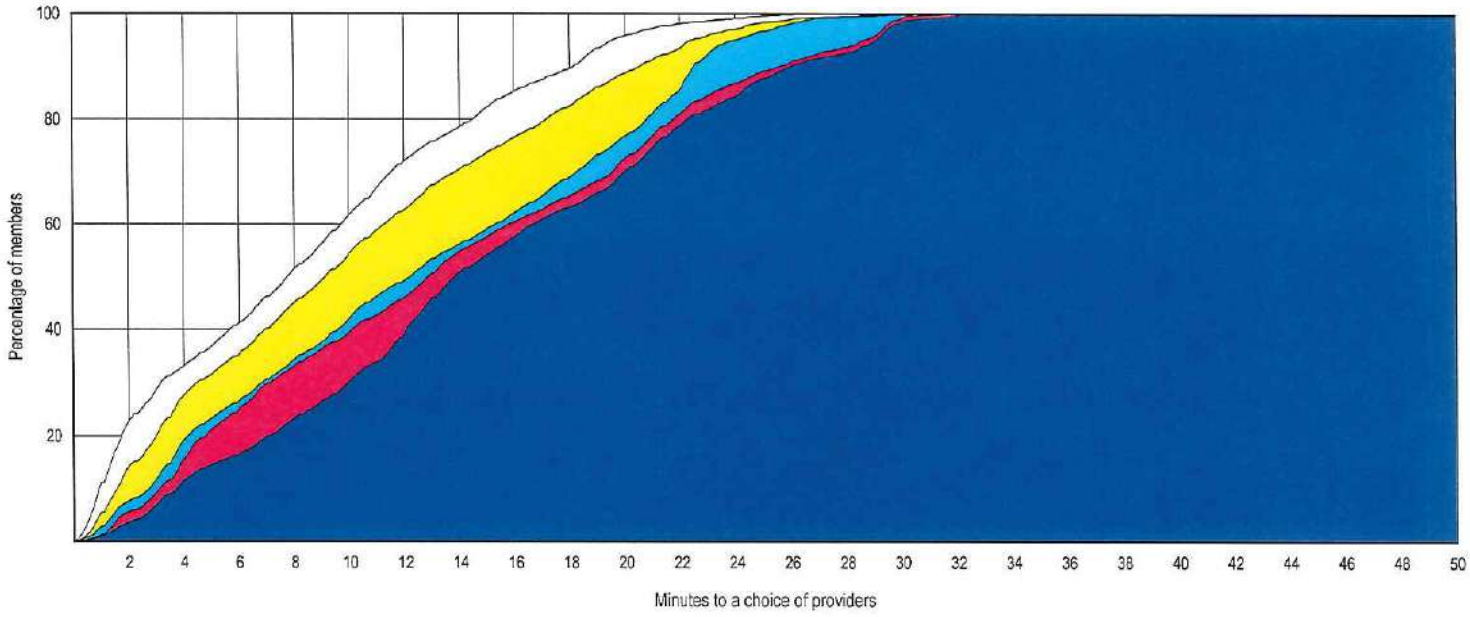

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Provider Locations

January 23, 2020

Region 6 Podiatrists

Total Providers: 22

i All providers

Interstates

US Highways

State Highways

7.48 miles

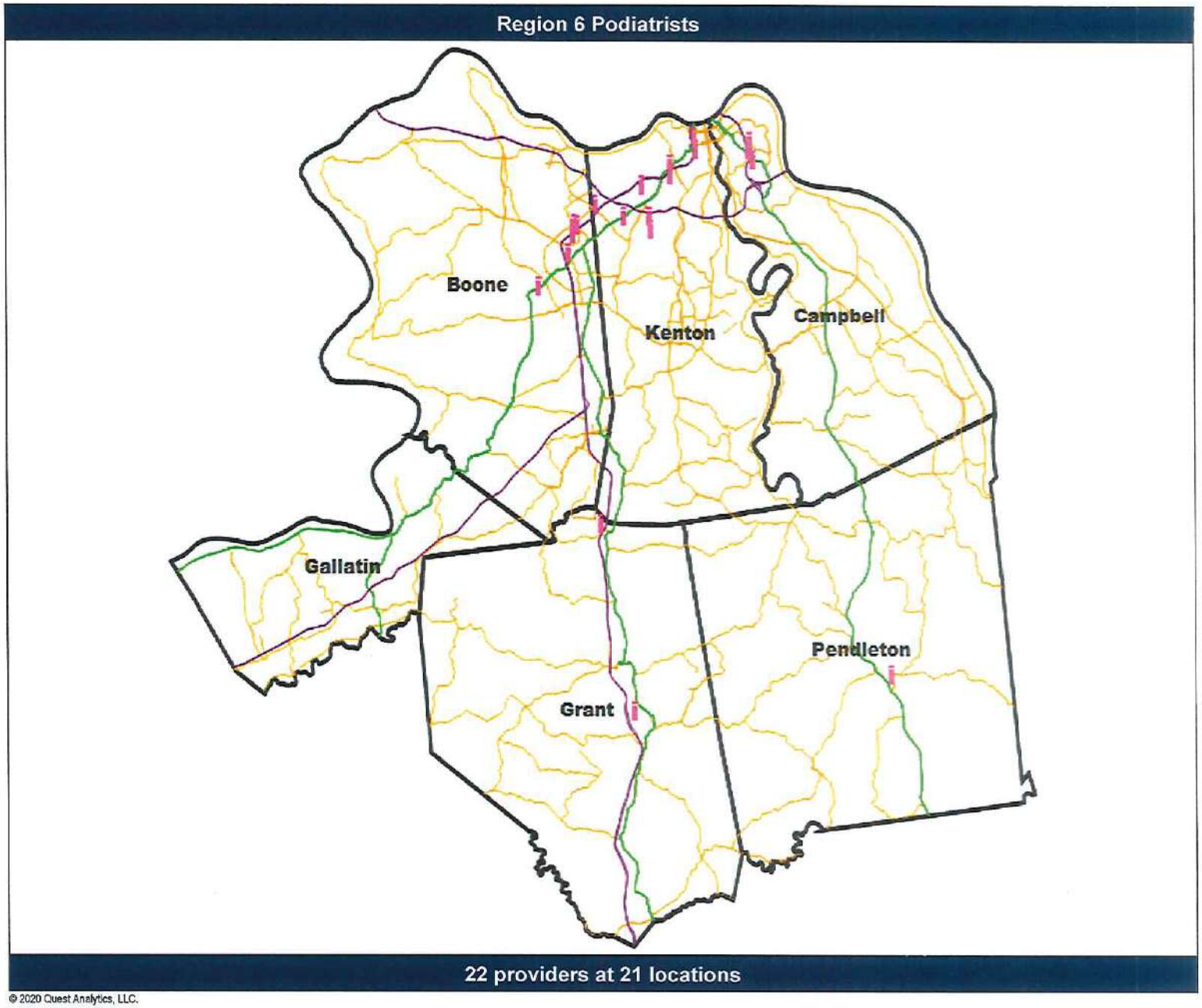

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
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Overall Access[1]

22,413 Members
169 providers at 209 locations (Podiatrists)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

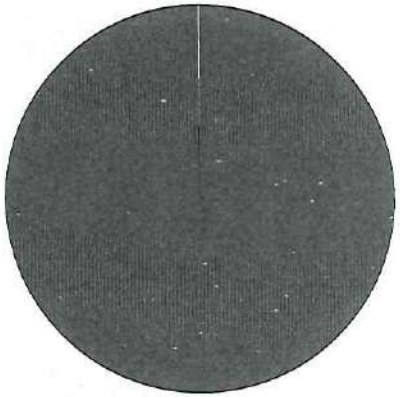

Distances

	Average
Distance to 1st closest provider	3.7 miles
Distance to 2nd closest provider	4.5 miles
Distance to 3rd closest provider	4.6 miles
Distance to 4th closest provider	4.8 miles
Distance to 5th closest provider	4.9 miles

Access Standard Comparison

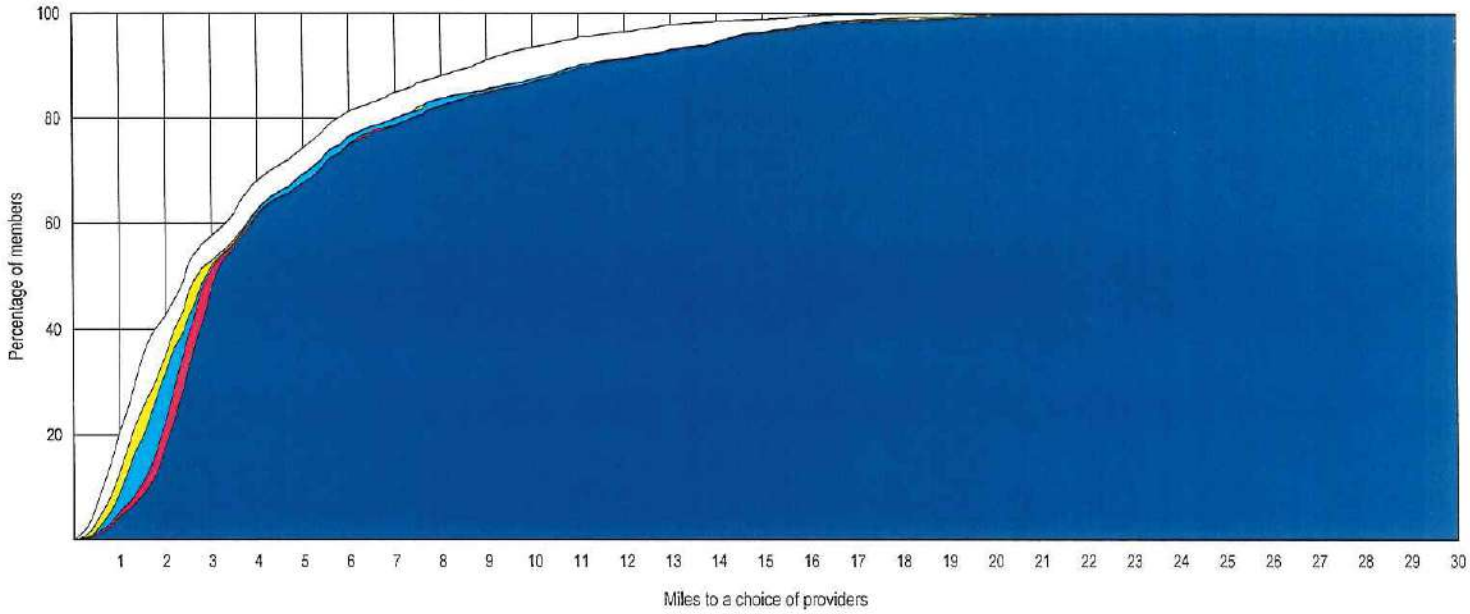

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Podiatrists

Comparison Graph
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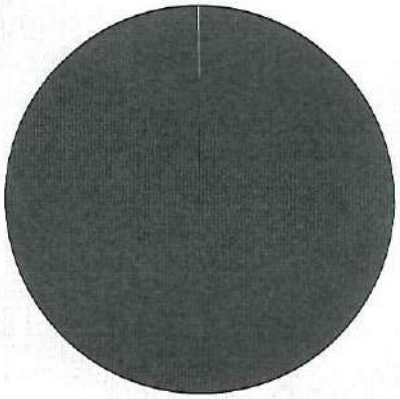

Times

	Average
Time to 1st closest provider	4.5 mins
Time to 2nd closest provider	5.5 mins
Time to 3rd closest provider	5.7 mins
Time to 4th closest provider	6.1 mins
Time to 5th closest provider	6.3 mins

Access Standard Comparison

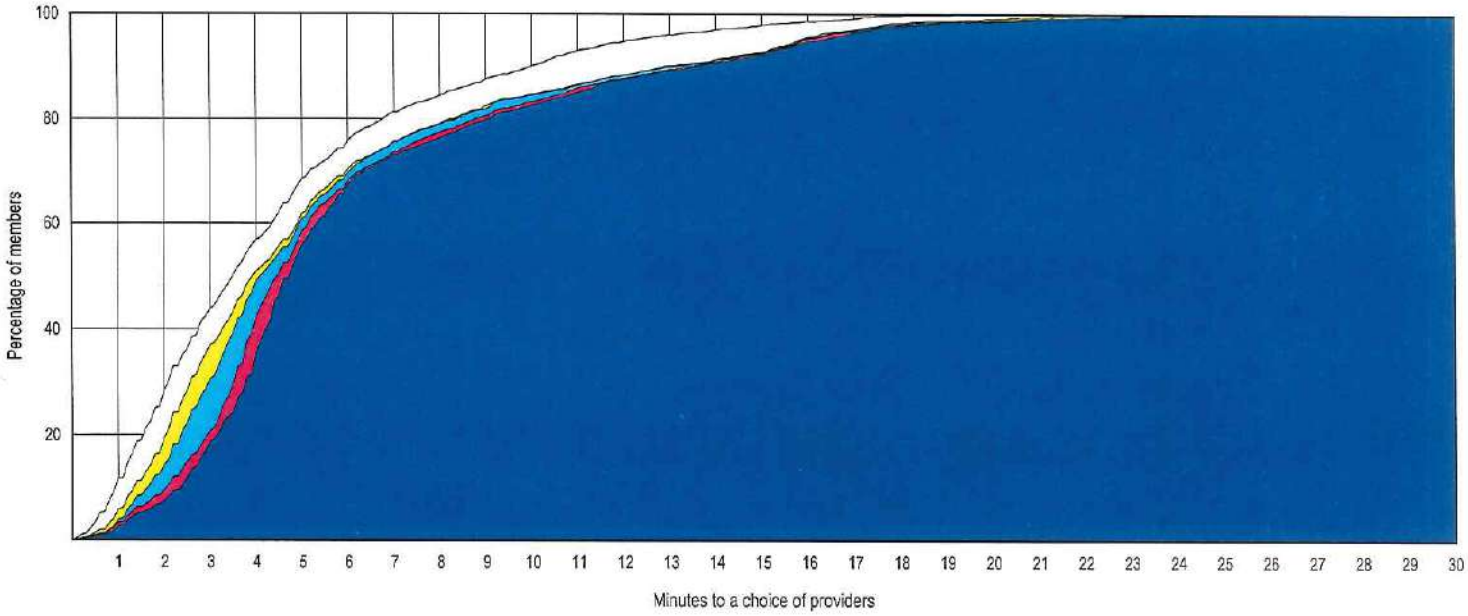

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Provider Locations

January 23, 2020

Region 7 Podiatrists

Total Providers: 4

i All providers

Interstates

US Highways

State Highways

12.36 miles

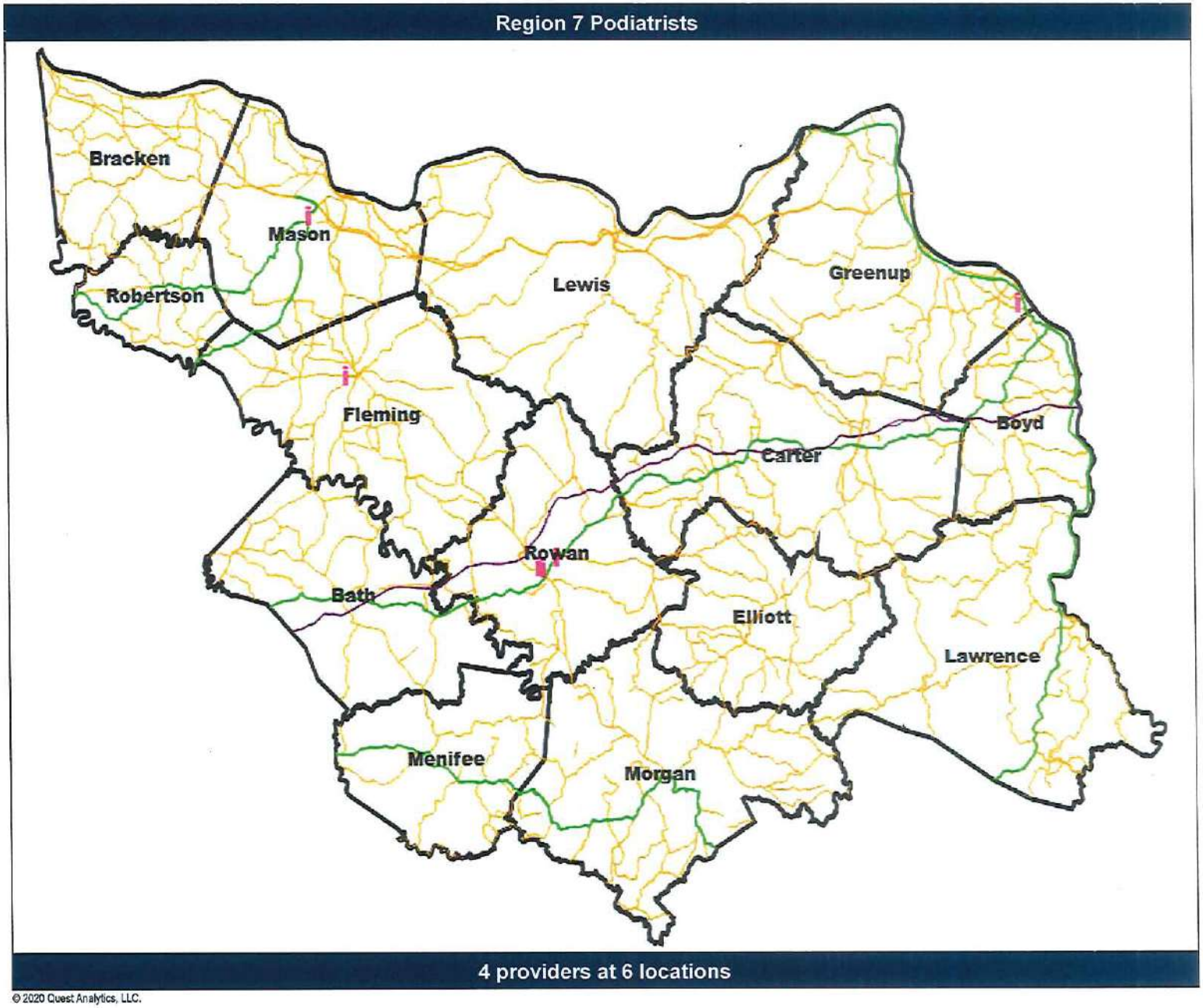

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Podiatrists) provider in 30 miles

Overall Access[1]

2,907 Members
169 providers at 209 locations (Podiatrists)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

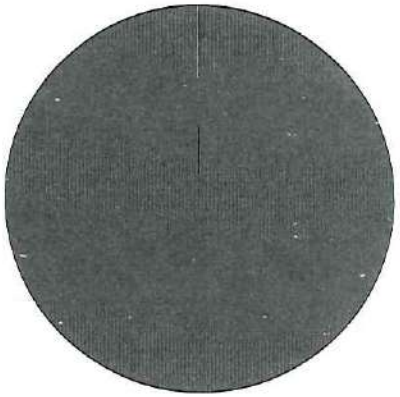

Distances

	Average
Distance to 1st closest provider	9.3 miles
Distance to 2nd closest provider	19.1 miles
Distance to 3rd closest provider	24.3 miles
Distance to 4th closest provider	32.1 miles
Distance to 5th closest provider	40.0 miles

Access Standard Comparison

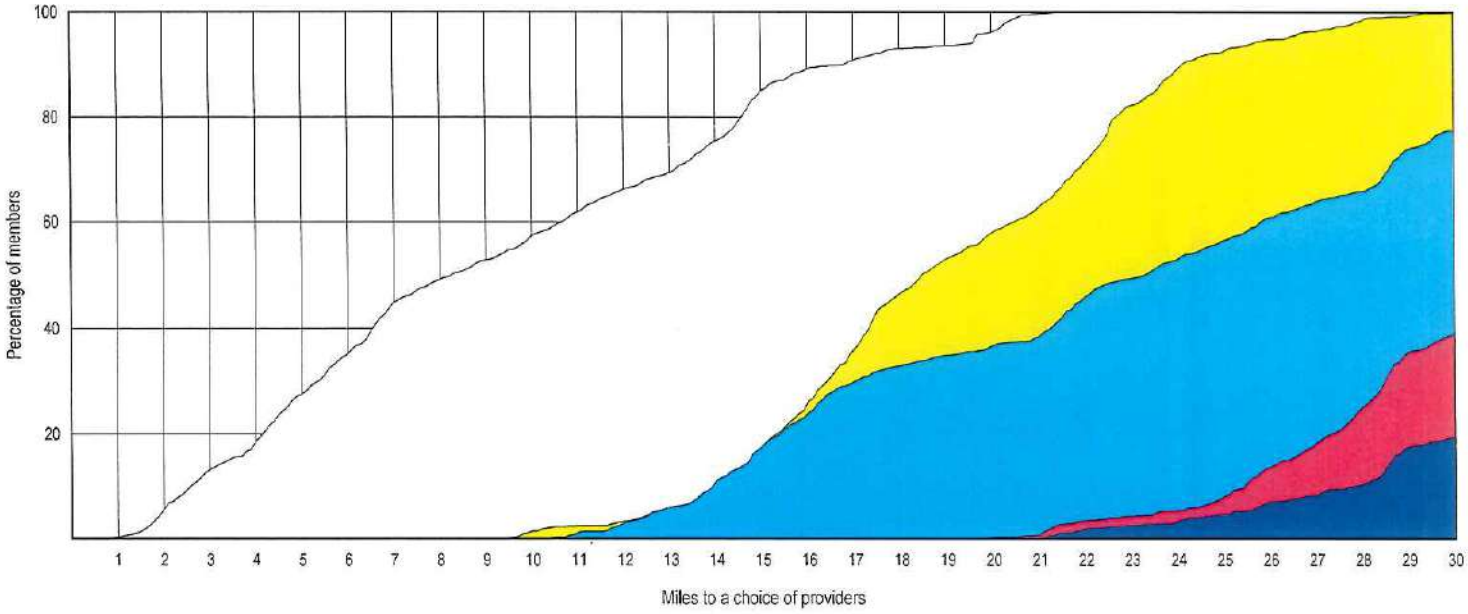

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
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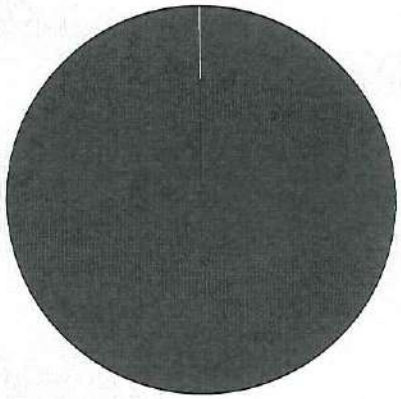

Times

	Average
Time to 1st closest provider	10.7 mins
Time to 2nd closest provider	21.4 mins
Time to 3rd closest provider	26.8 mins
Time to 4th closest provider	35.7 mins
Time to 5th closest provider	44.4 mins

Access Standard Comparison

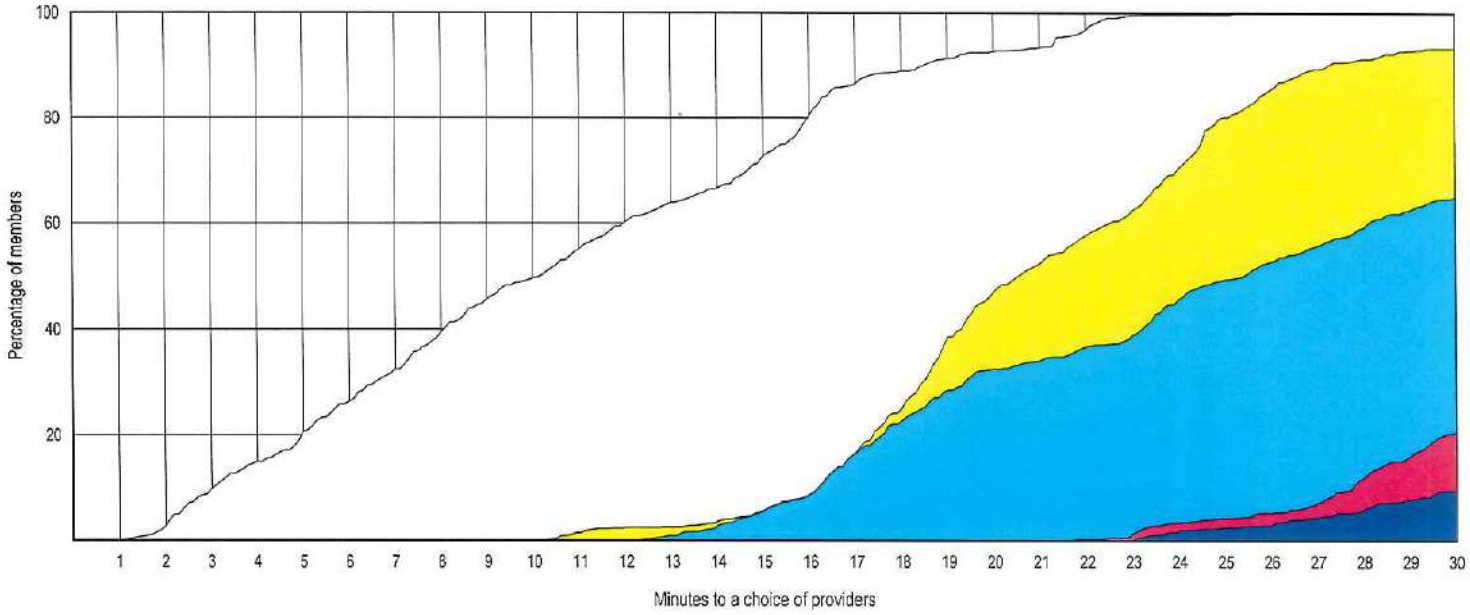

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Podiatrists) provider in 50 miles

Overall Access[1]

10,408 Members
169 providers at 209 locations (Podiatrists)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

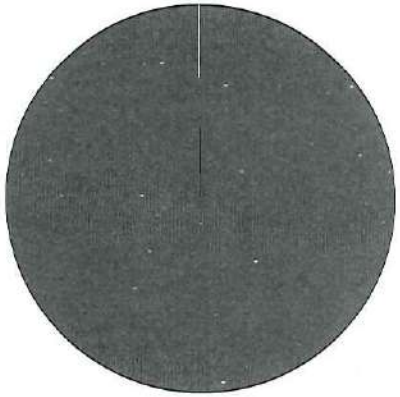

Distances

	Average
Distance to 1st closest provider	12.7 miles
Distance to 2nd closest provider	17.6 miles
Distance to 3rd closest provider	22.3 miles
Distance to 4th closest provider	28.4 miles
Distance to 5th closest provider	30.4 miles

Access Standard Comparison

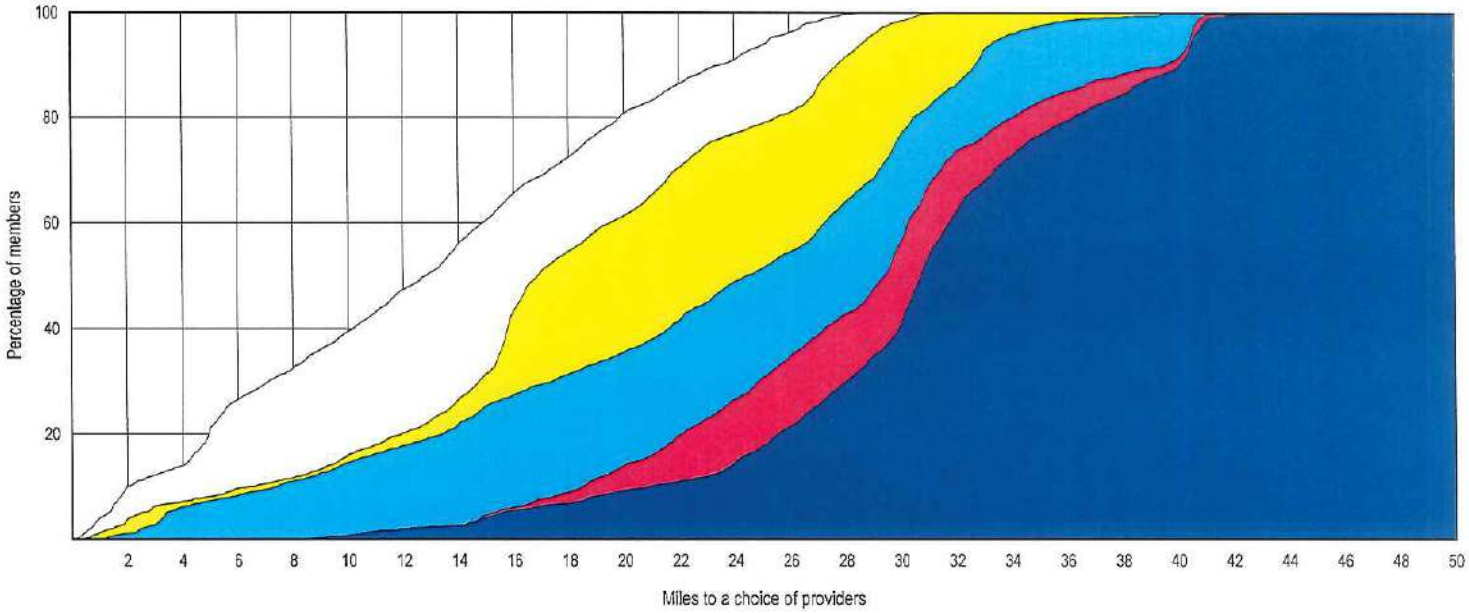

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 7 Rural - 1 in 50 minutes

Member / Provider Groups
Region 7 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
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169 providers at 209 locations (Podiatrists)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

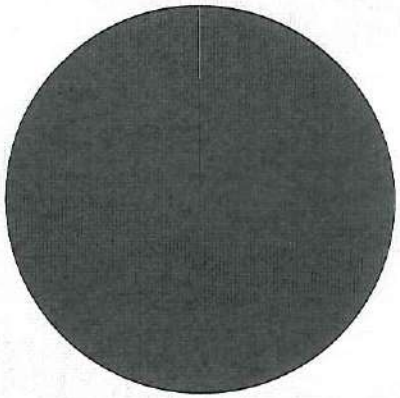

Times

	Average
Time to 1st closest provider	14.0 mins
Time to 2nd closest provider	19.3 mins
Time to 3rd closest provider	24.3 mins
Time to 4th closest provider	31.0 mins
Time to 5th closest provider	33.1 mins

Access Standard Comparison

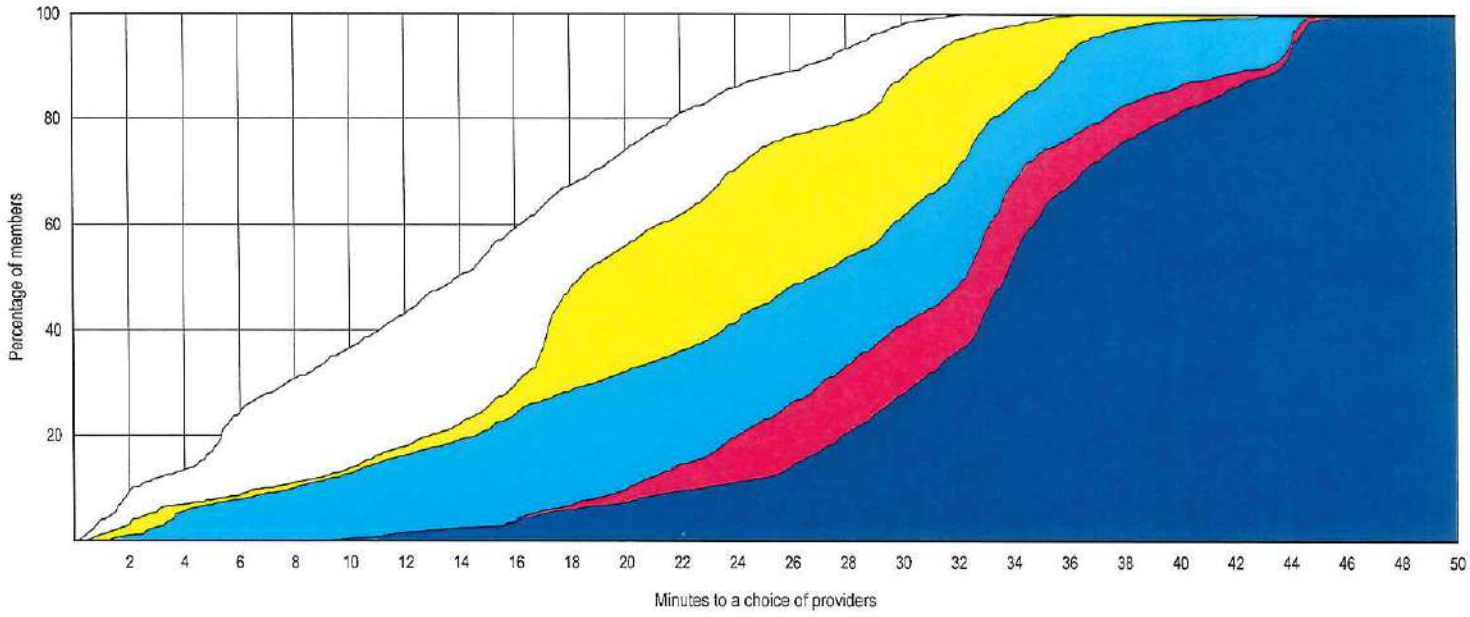

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Provider Locations

January 23, 2020

Region 8 Podiatrists

Total Providers: 23

i All providers

Interstates

US Highways

State Highways

16.38 miles

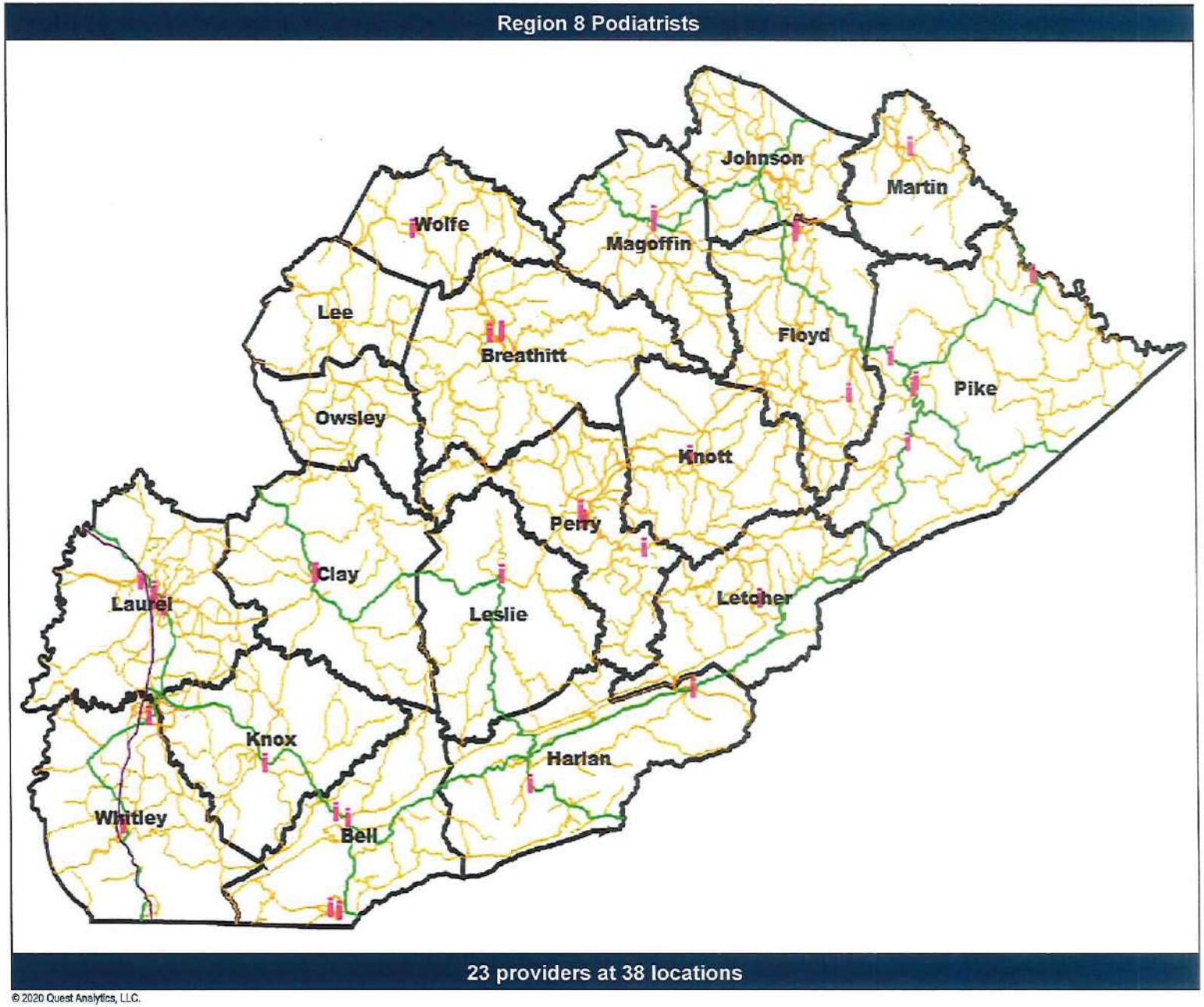

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Podiatrists) provider in 50 miles

Overall Access[1]

31,600 Members
169 providers at 209 locations (Podiatrists)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

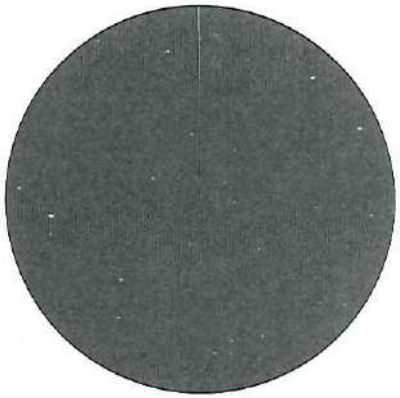

Times

	Average
Distance to 1st closest provider	7.1 miles
Distance to 2nd closest provider	9.9 miles
Distance to 3rd closest provider	11.6 miles
Distance to 4th closest provider	12.8 miles
Distance to 5th closest provider	15.5 miles

Access Standard Comparison

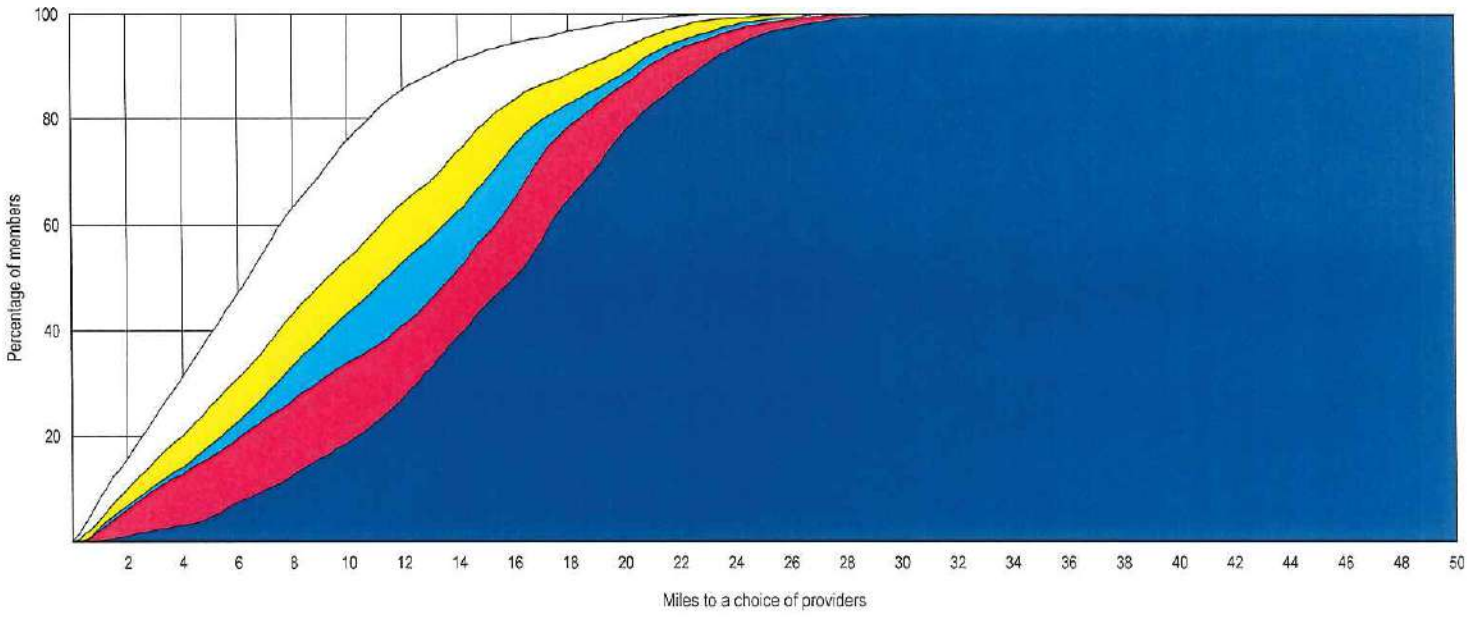

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Podiatrists

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Podiatrists) provider in 50 minutes

Overall Access[1]

31,600 Members
169 providers at 209 locations (Podiatrists)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

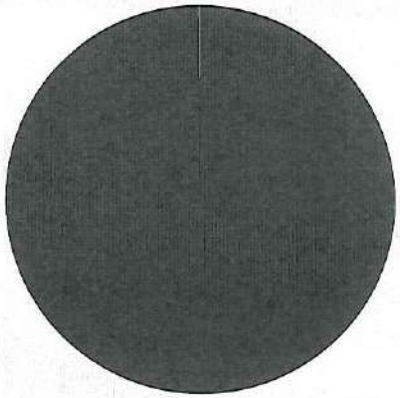

Times

	Average
Time to 1st closest provider	7.6 mins
Time to 2nd closest provider	10.7 mins
Time to 3rd closest provider	12.6 mins
Time to 4th closest provider	14.0 mins
Time to 5th closest provider	16.9 mins

Access Standard Comparison

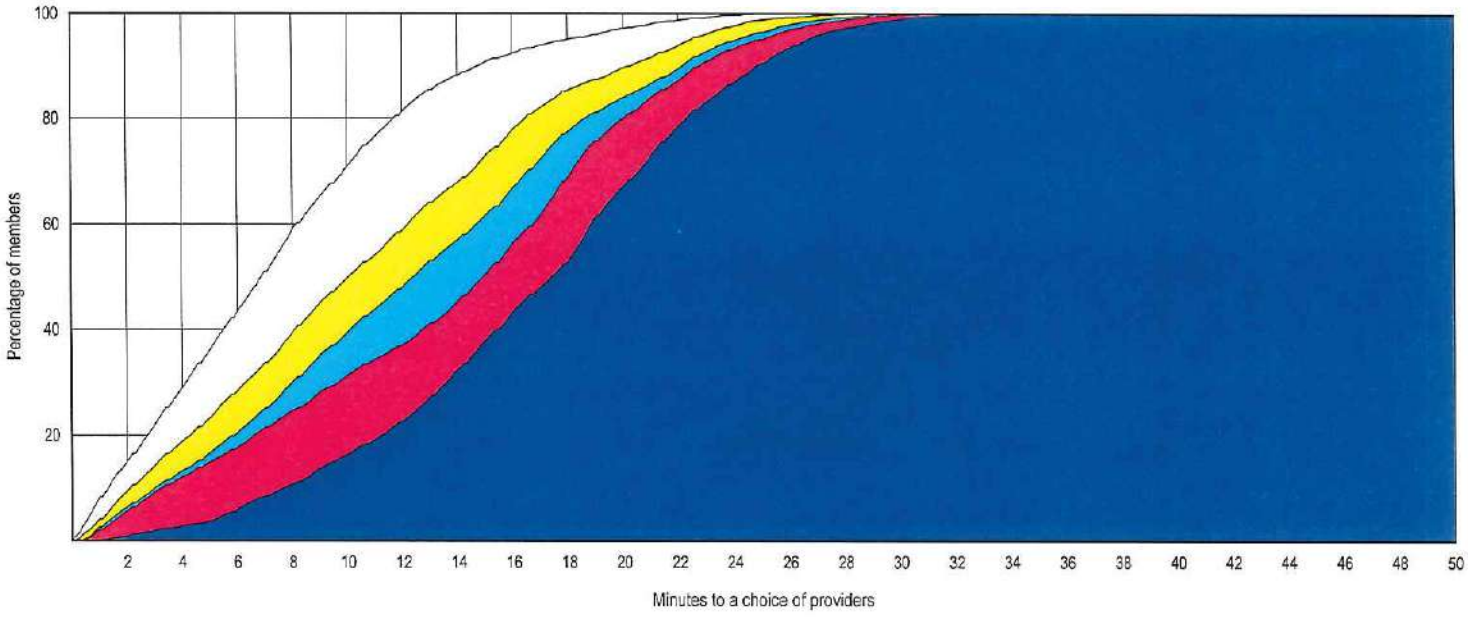

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Provider Locations

January 23, 2020

Region 1 Renal Dialysis Clinics

Total Providers: 6

j All providers

Interstates

US Highways

State Highways

12.93 miles

Region 1 Renal Dialysis Clinics

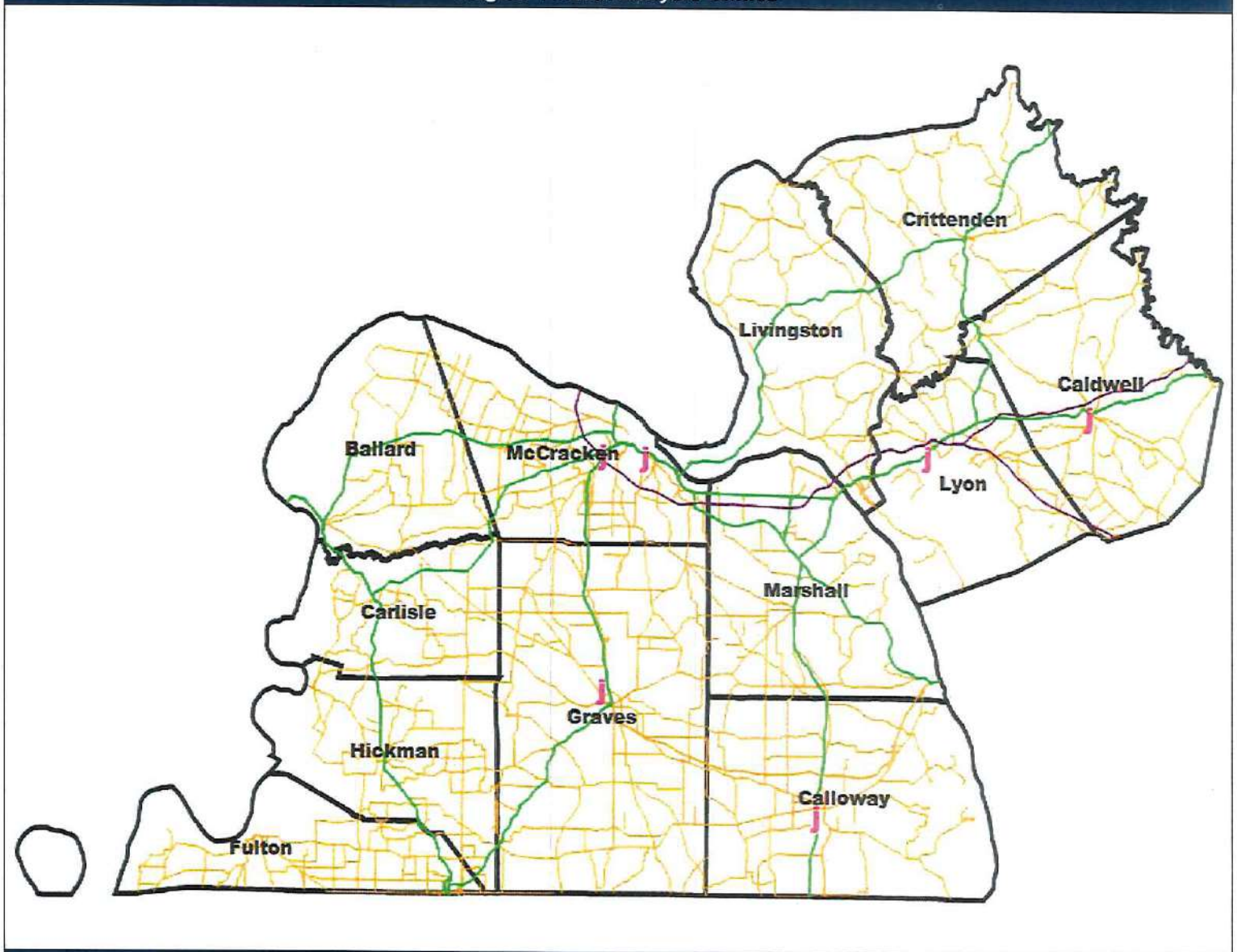

6 providers at 6 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 miles

Overall Access[1]

11,338 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

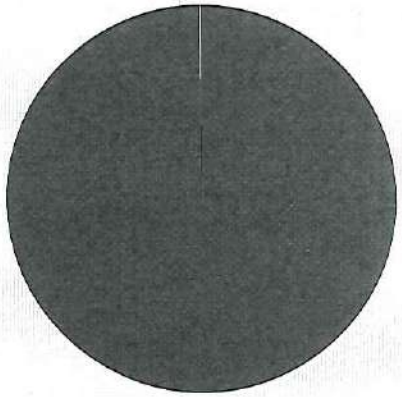

Times

	Average
Distance to 1st closest provider	9.4 miles
Distance to 2nd closest provider	20.1 miles
Distance to 3rd closest provider	27.8 miles
Distance to 4th closest provider	33.0 miles
Distance to 5th closest provider	42.8 miles

Access Standard Comparison

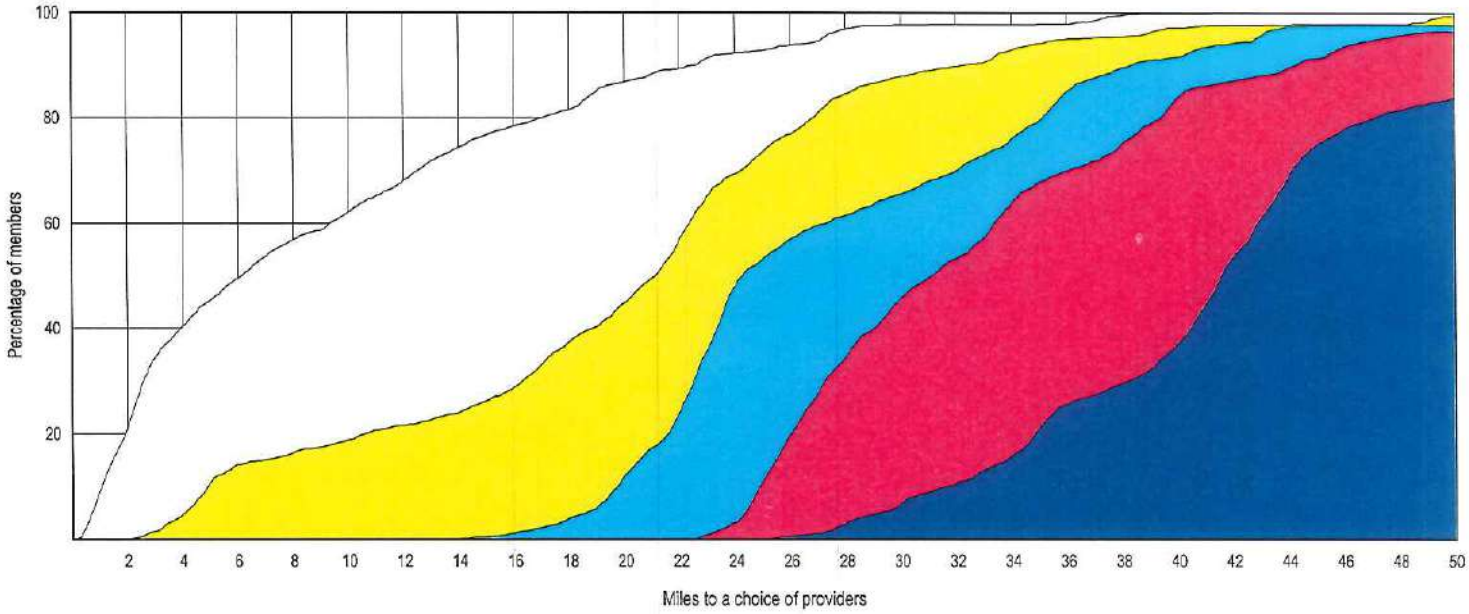

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 minutes

Overall Access[1]

11,338 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

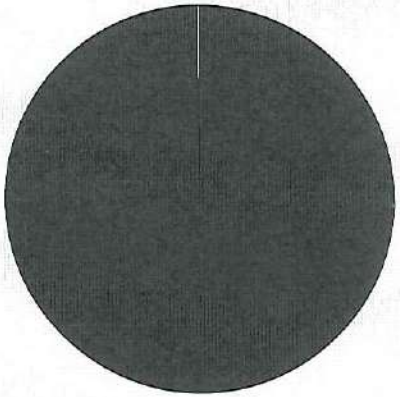

Times

	Average
Time to 1st closest provider	10.2 mins
Time to 2nd closest provider	21.9 mins
Time to 3rd closest provider	30.2 mins
Time to 4th closest provider	36.0 mins
Time to 5th closest provider	46.6 mins

Access Standard Comparison

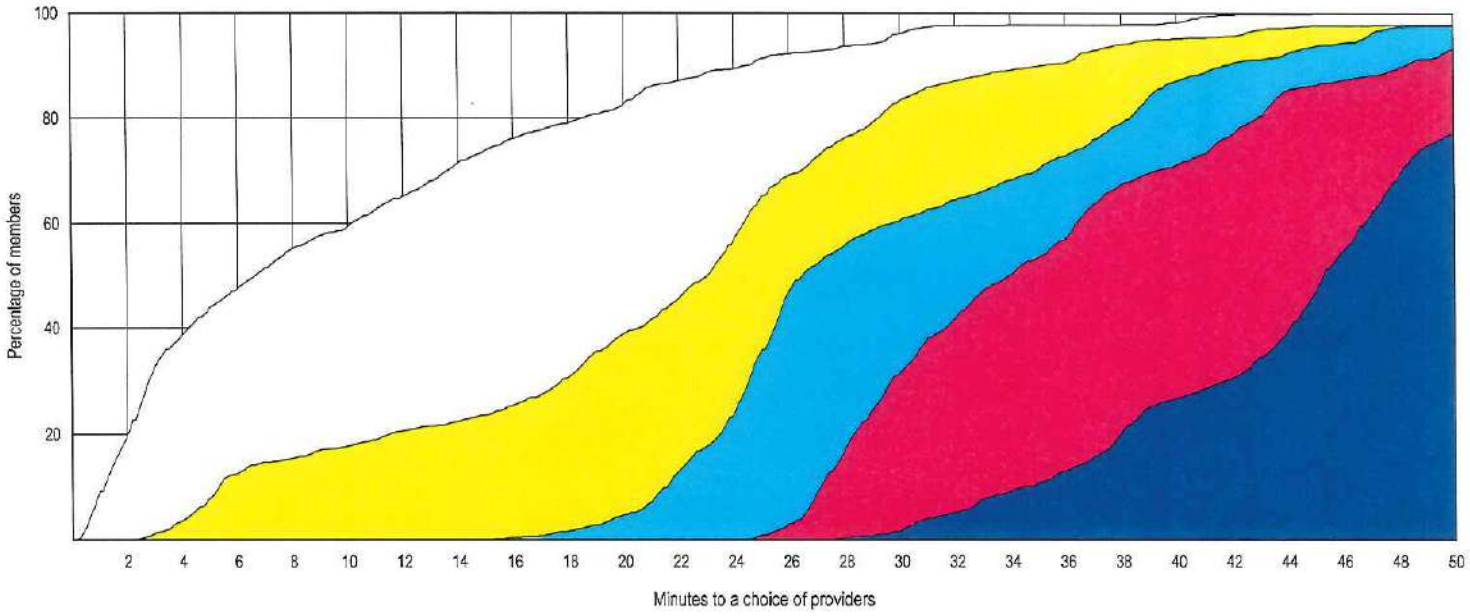

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Provider Locations

January 23, 2020

Region 2 Renal Dialysis Clinics

Total Providers: 10

All providers

Interstates

US Highways

State Highways

15.14 miles

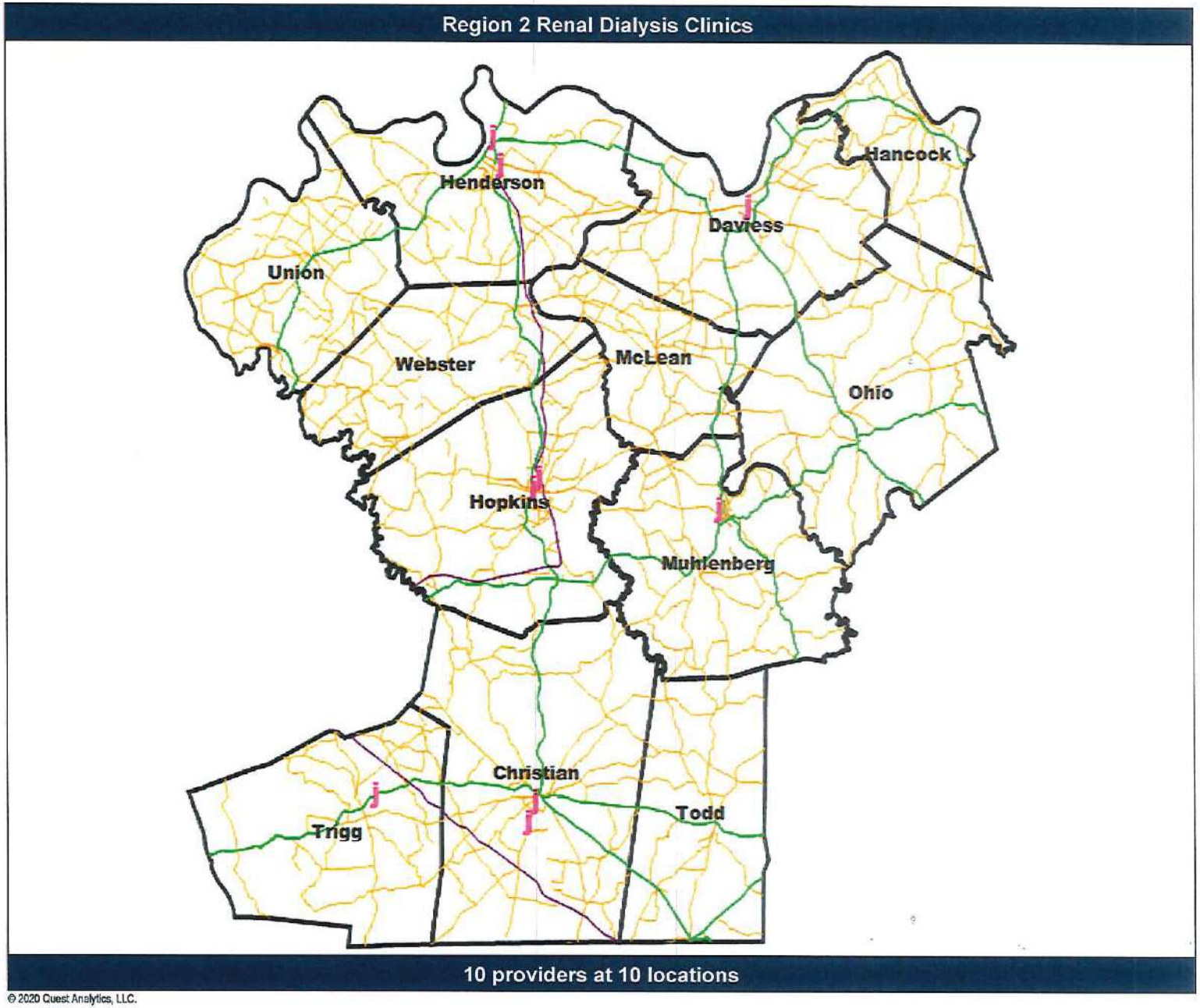

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 miles

Overall Access[1]

16,143 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 16,141 (99.9%) Members with access
- 1 (0.1%) Members without access
- 1 (0.0%) Members excluded

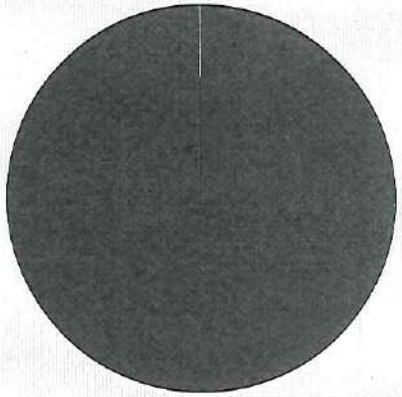

Distances

	Average
Distance to 1st closest provider	6.0 miles
Distance to 2nd closest provider	13.2 miles
Distance to 3rd closest provider	19.4 miles
Distance to 4th closest provider	27.2 miles
Distance to 5th closest provider	35.8 miles

Access Standard Comparison

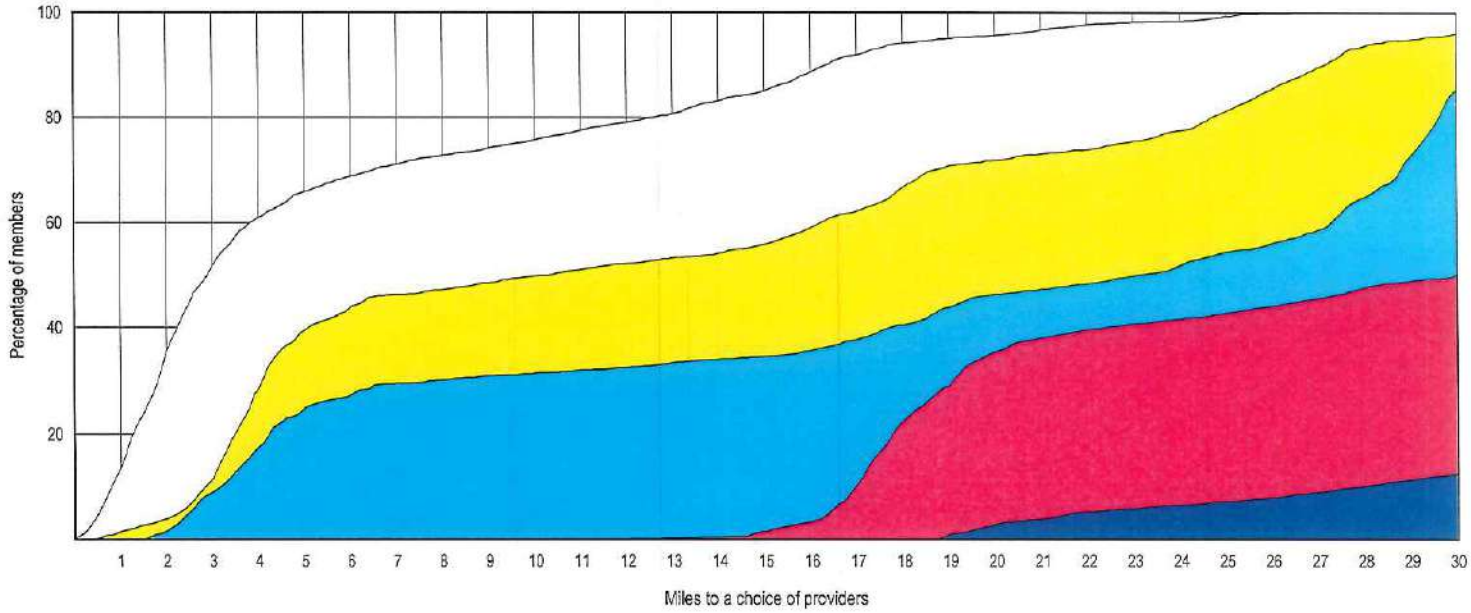

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 minutes

Overall Access[1]

16,143 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 16,131 (99.9%) Members with access
- 11 (0.1%) Members without access
- 1 (0.0%) Members excluded

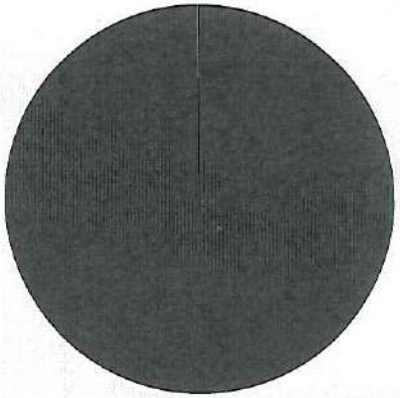

Times

	Average
Time to 1st closest provider	6.5 mins
Time to 2nd closest provider	14.4 mins
Time to 3rd closest provider	21.1 mins
Time to 4th closest provider	29.6 mins
Time to 5th closest provider	39.0 mins

Access Standard Comparison

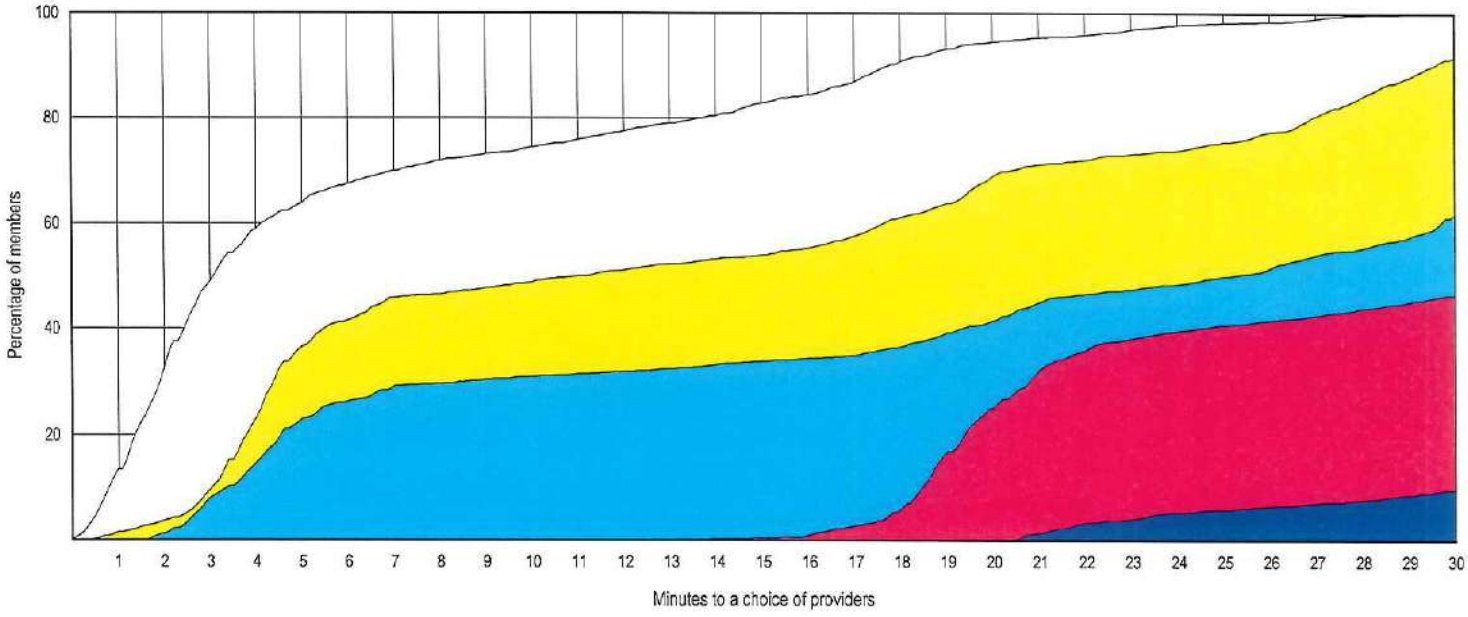

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 miles

Overall Access[1]

9,636 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

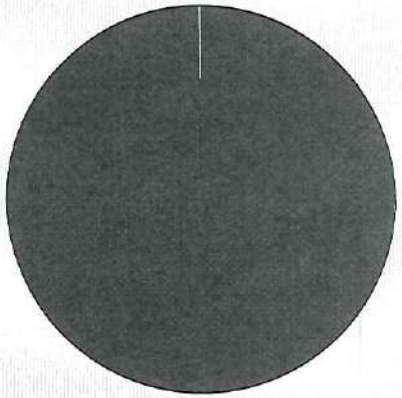

Distances

	Average
Distance to 1st closest provider	13.9 miles
Distance to 2nd closest provider	20.0 miles
Distance to 3rd closest provider	27.2 miles
Distance to 4th closest provider	34.4 miles
Distance to 5th closest provider	37.0 miles

Access Standard Comparison

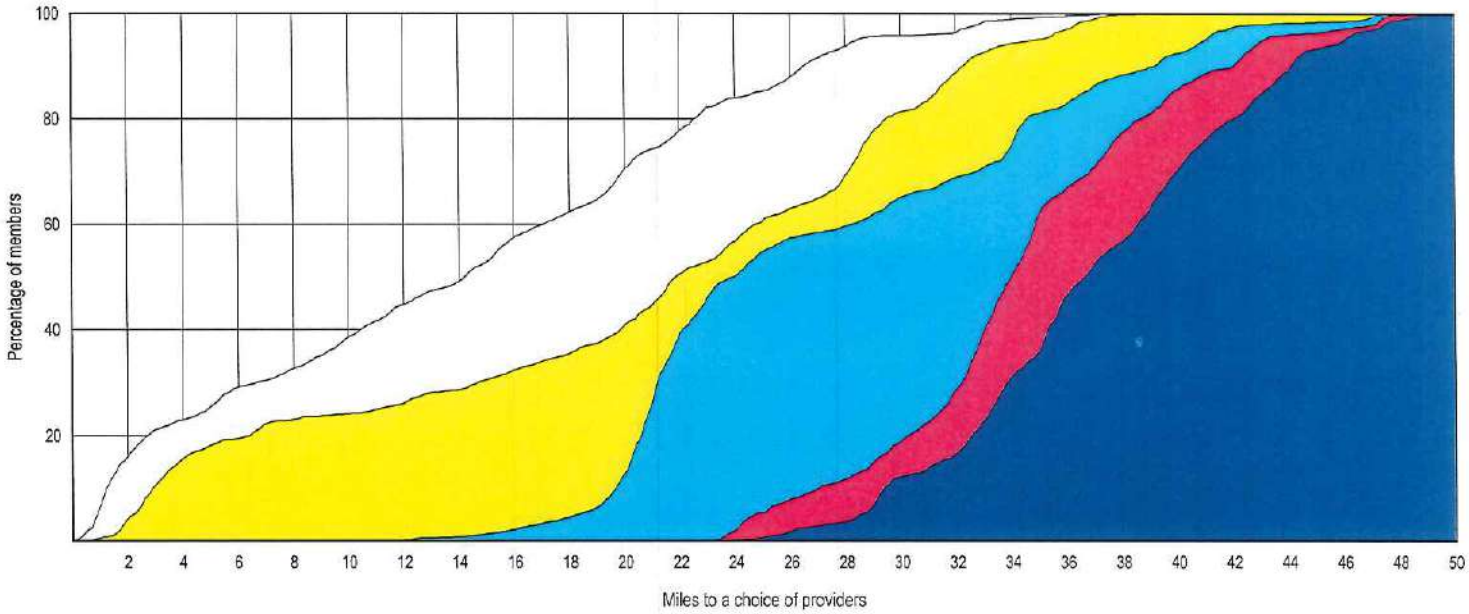

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Access Overview

January 24, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 minutes

Overall Access[1]

9,636 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

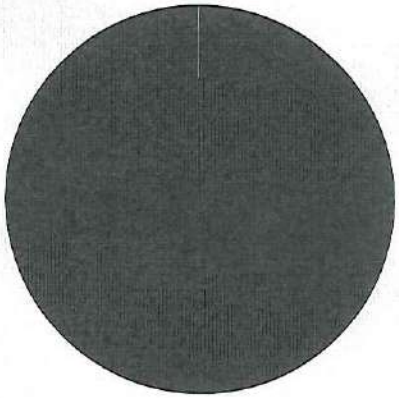

Times

	Average
Time to 1st closest provider	15.1 mins
Time to 2nd closest provider	21.8 mins
Time to 3rd closest provider	29.6 mins
Time to 4th closest provider	37.5 mins
Time to 5th closest provider	40.4 mins

Access Standard Comparison

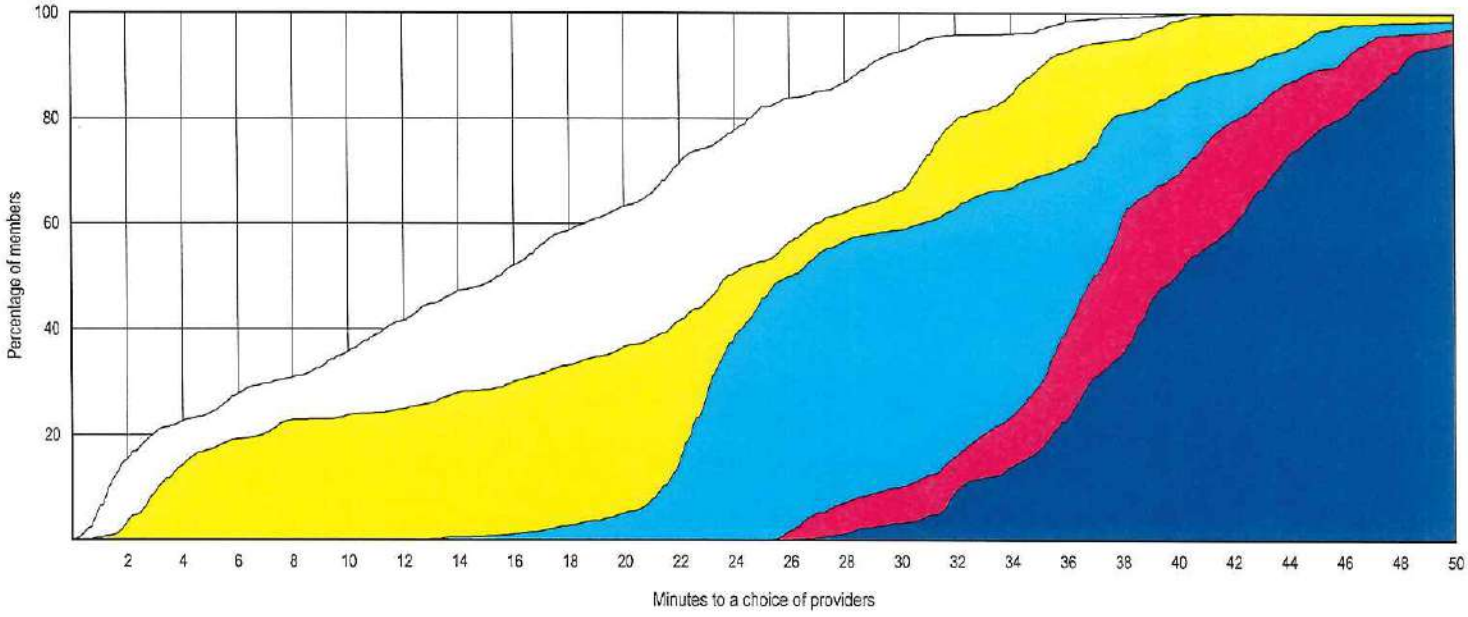

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Provider Locations

January 23, 2020

Region 3 Renal Dialysis Clinics

Total Providers: 30

j All providers

Interstates

US Highways

State Highways

15.97 miles

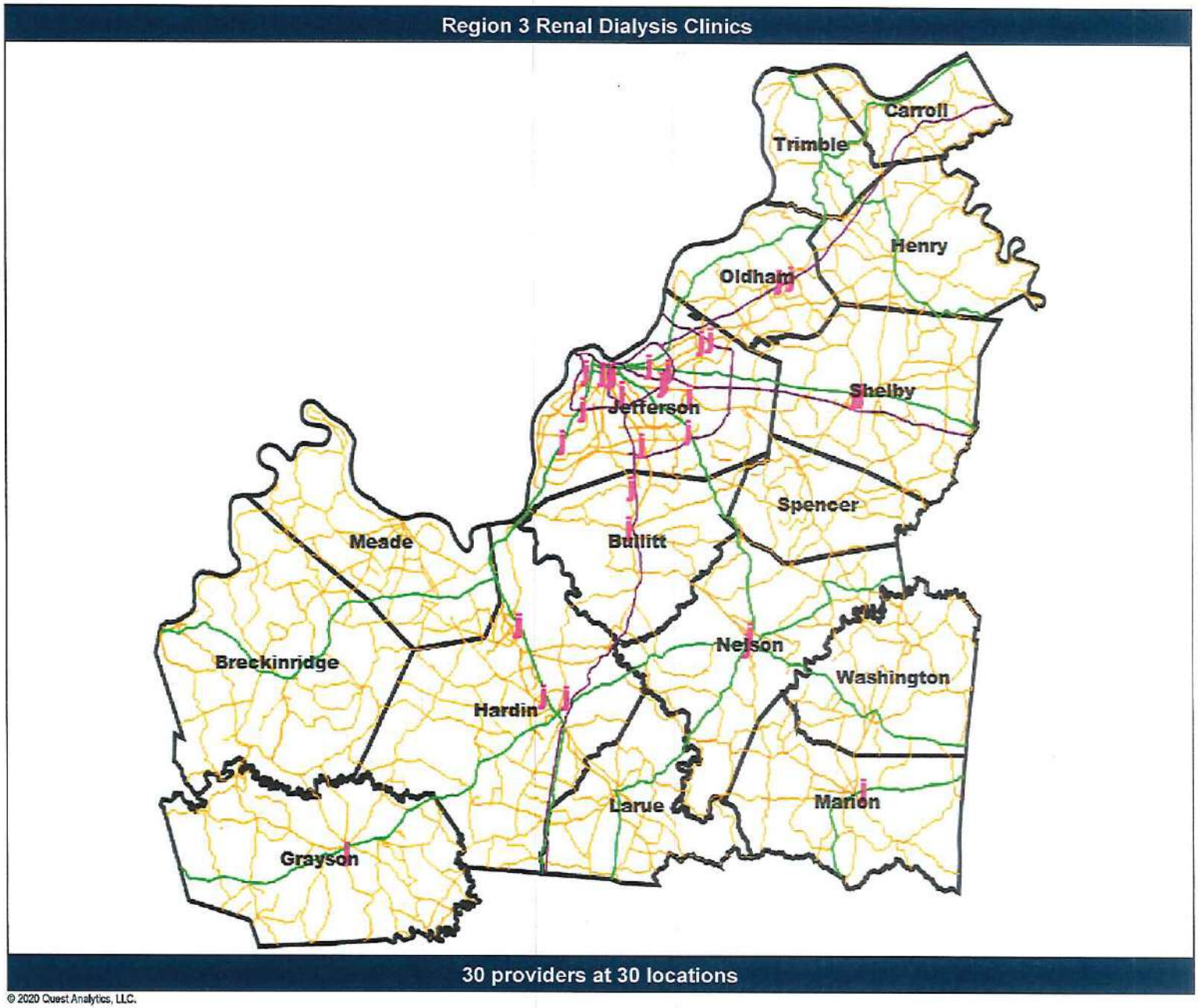

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 miles

Overall Access[1]

18,130 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 18,115 (99.9%) Members with access
- 12 (0.1%) Members without access
- 3 (0.0%) Members excluded

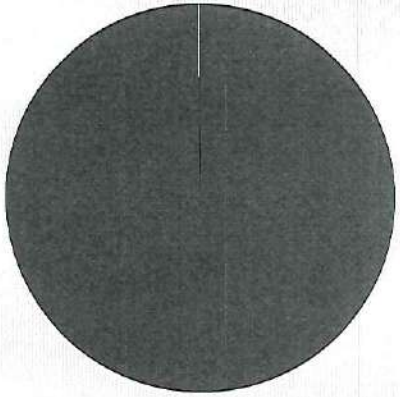

Distances

	Average
Distance to 1st closest provider	3.7 miles
Distance to 2nd closest provider	5.3 miles
Distance to 3rd closest provider	8.2 miles
Distance to 4th closest provider	9.2 miles
Distance to 5th closest provider	10.9 miles

Access Standard Comparison

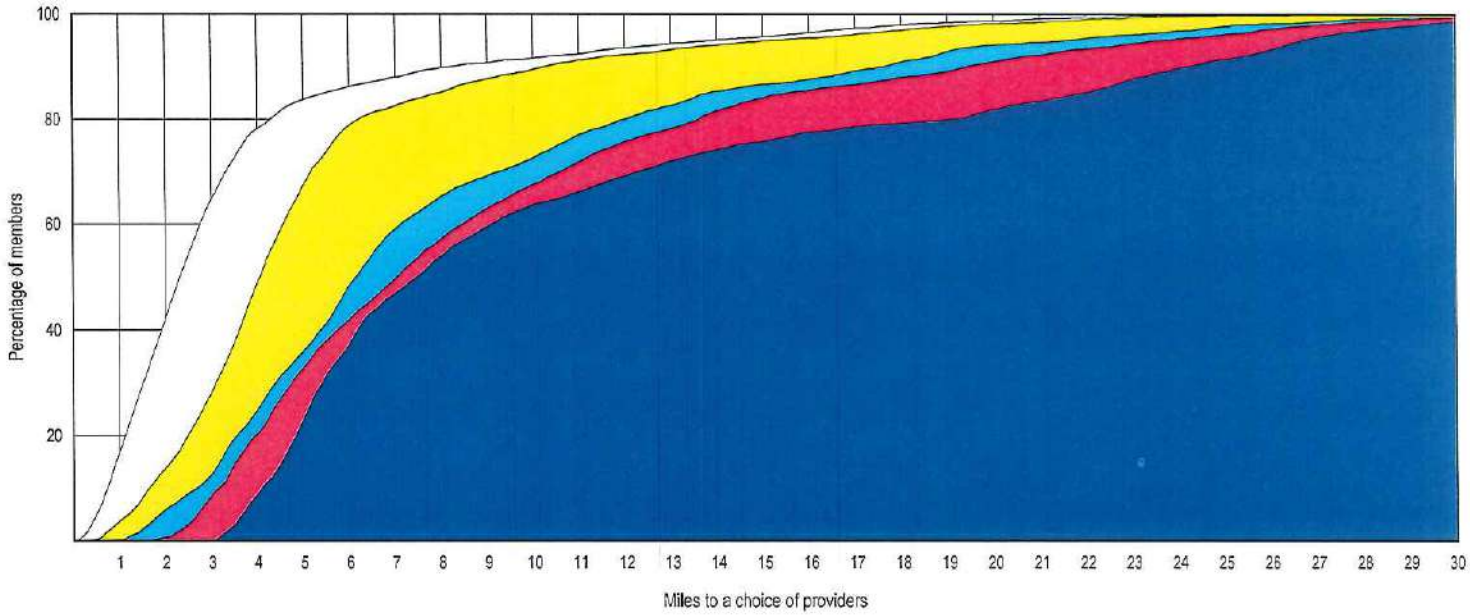

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Access Overview

January 24, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 minutes

Overall Access[1]

18,130 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 18,101 (99.8%) Members with access
- 26 (0.1%) Members without access
- 3 (0.0%) Members excluded

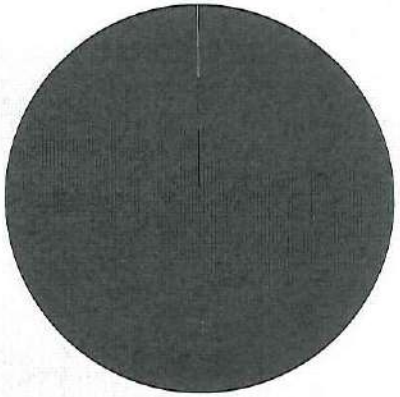

Times

	Average
Time to 1st closest provider	4.6 mins
Time to 2nd closest provider	6.7 mins
Time to 3rd closest provider	10.3 mins
Time to 4th closest provider	11.8 mins
Time to 5th closest provider	13.9 mins

Access Standard Comparison

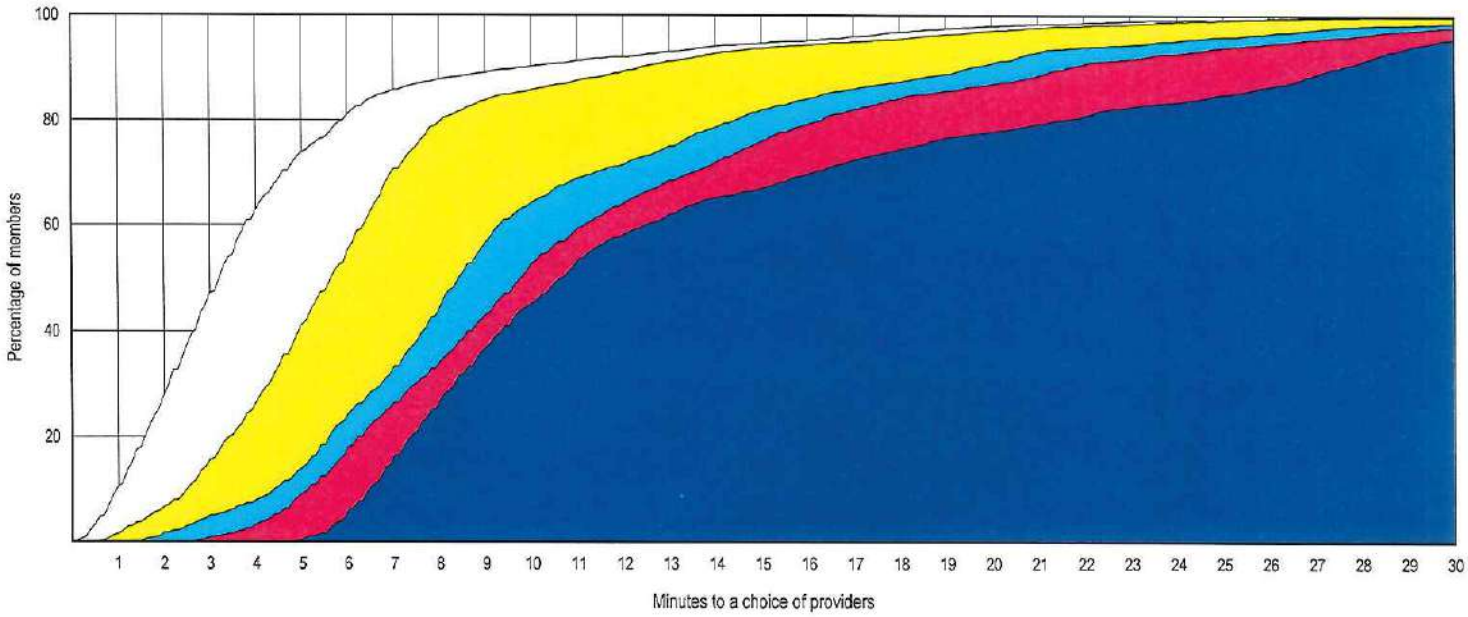

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Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 miles

Overall Access[1]

1,901 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

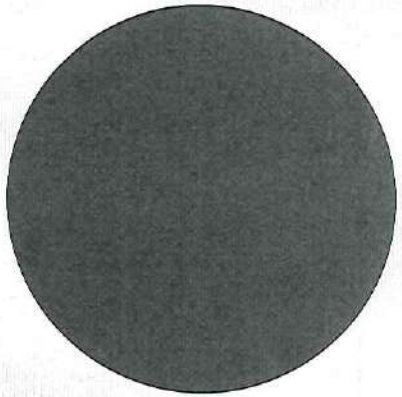

Distances

	Average
Distance to 1st closest provider	15.4 miles
Distance to 2nd closest provider	26.7 miles
Distance to 3rd closest provider	28.6 miles
Distance to 4th closest provider	31.6 miles
Distance to 5th closest provider	33.3 miles

Access Standard Comparison

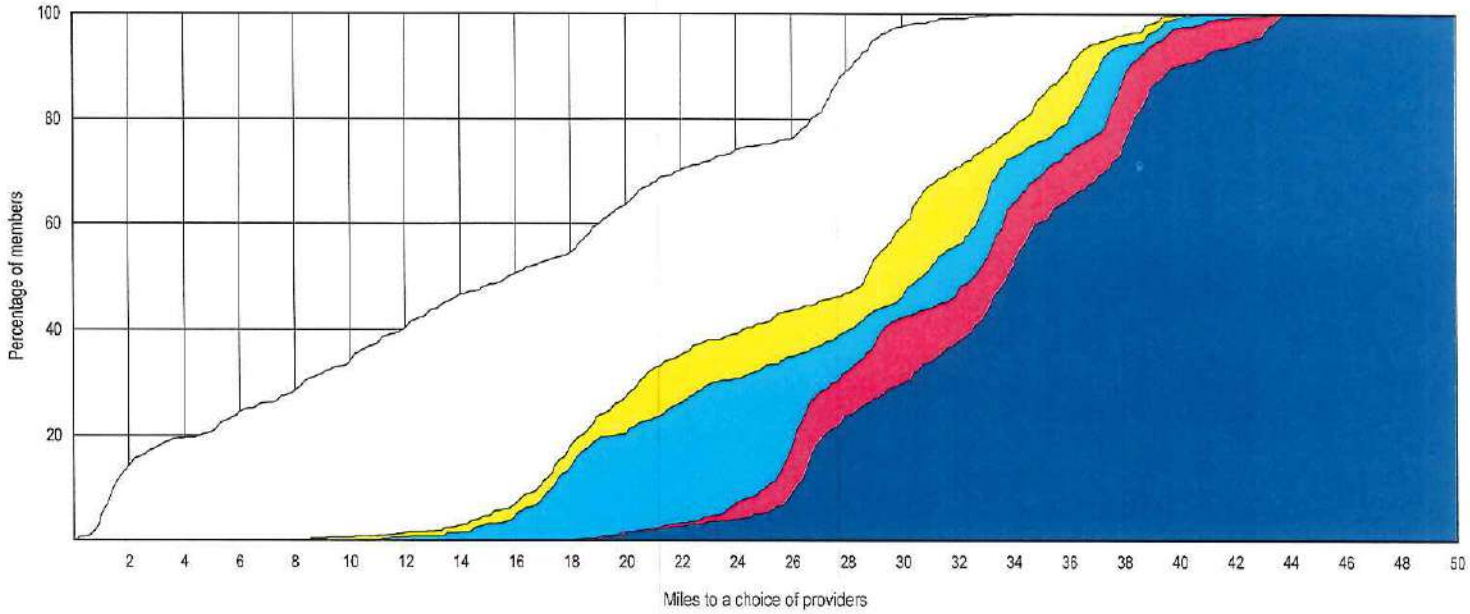

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 minutes

Overall Access[1]

1,901 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

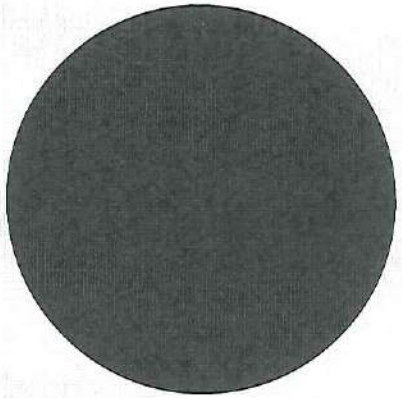

Times

	Average
Time to 1st closest provider	16.9 mins
Time to 2nd closest provider	29.3 mins
Time to 3rd closest provider	31.5 mins
Time to 4th closest provider	35.1 mins
Time to 5th closest provider	36.9 mins

Access Standard Comparison

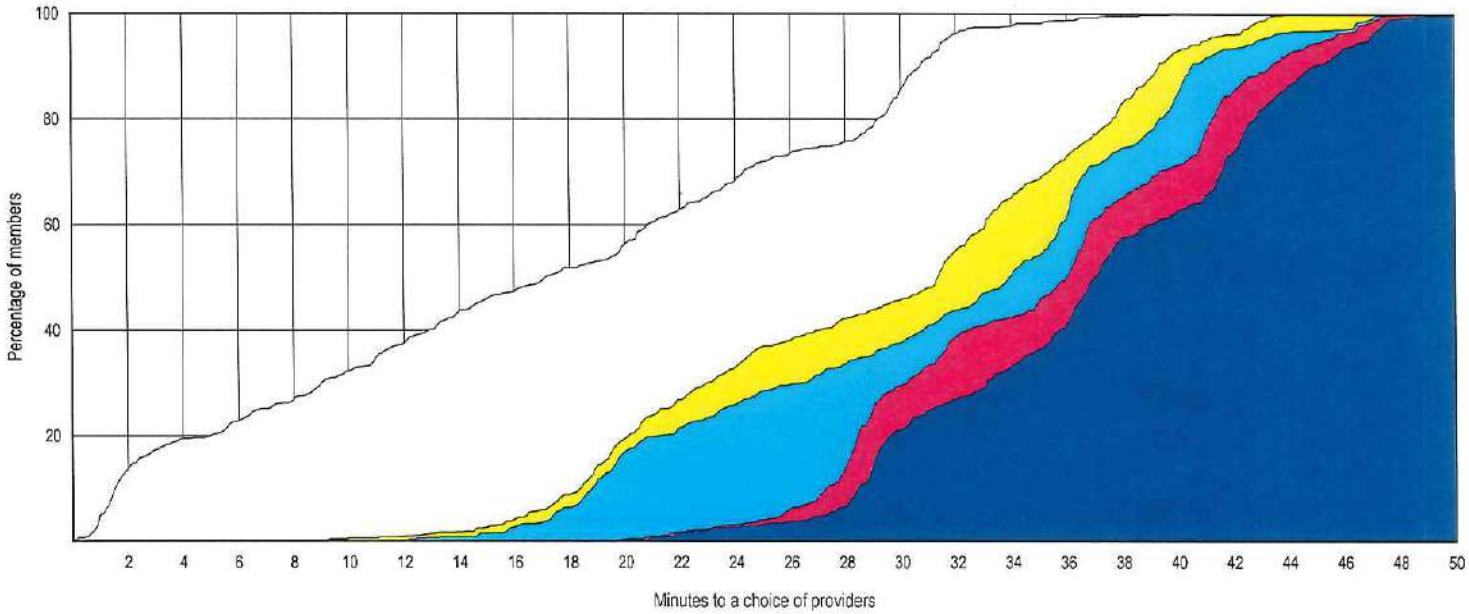

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Provider Locations

January 23, 2020

Region 4 Renal Dialysis Clinics

Total Providers: 9

j All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Renal Dialysis Clinics

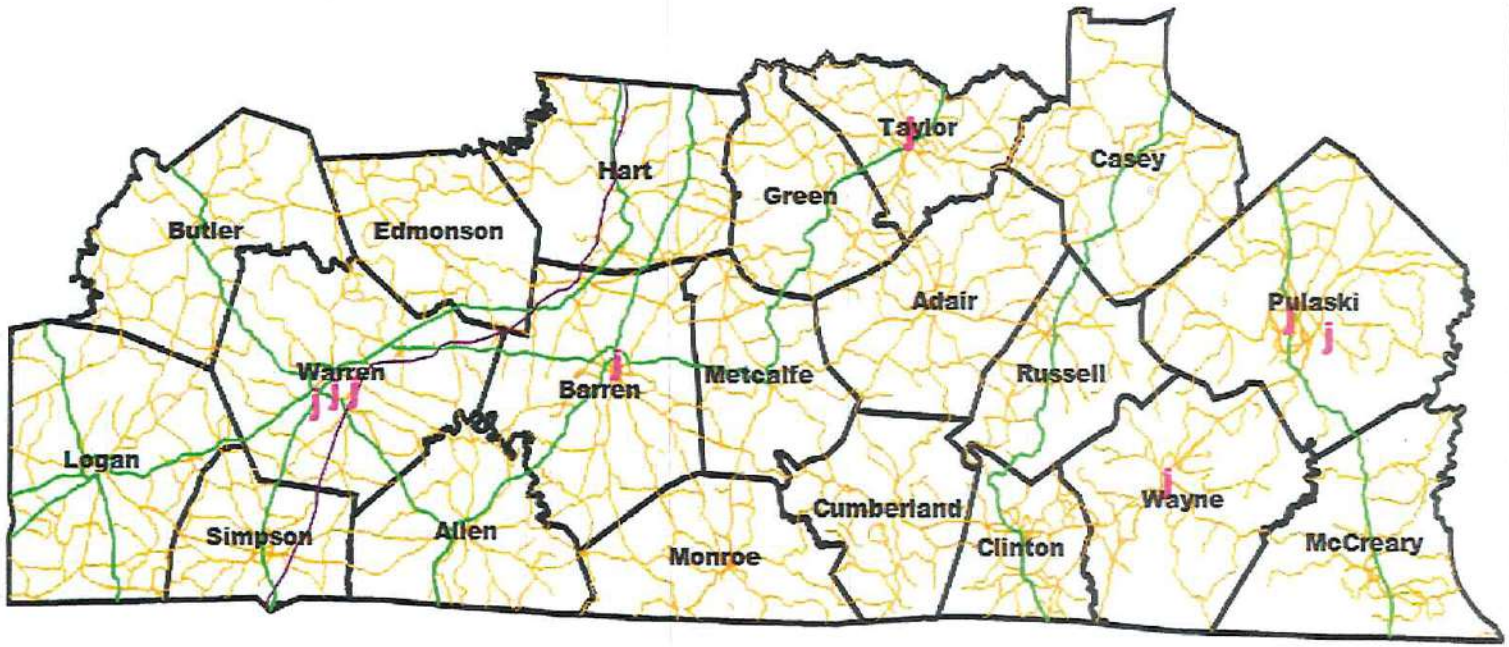

9 providers at 9 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 miles

Overall Access[1]

7,413 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

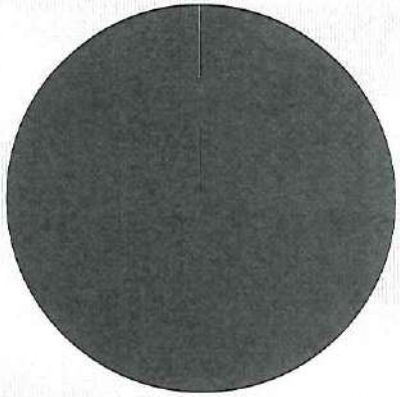

Distances

	Average
Distance to 1st closest provider	7.5 miles
Distance to 2nd closest provider	9.3 miles
Distance to 3rd closest provider	11.0 miles
Distance to 4th closest provider	33.1 miles
Distance to 5th closest provider	39.4 miles

Access Standard Comparison

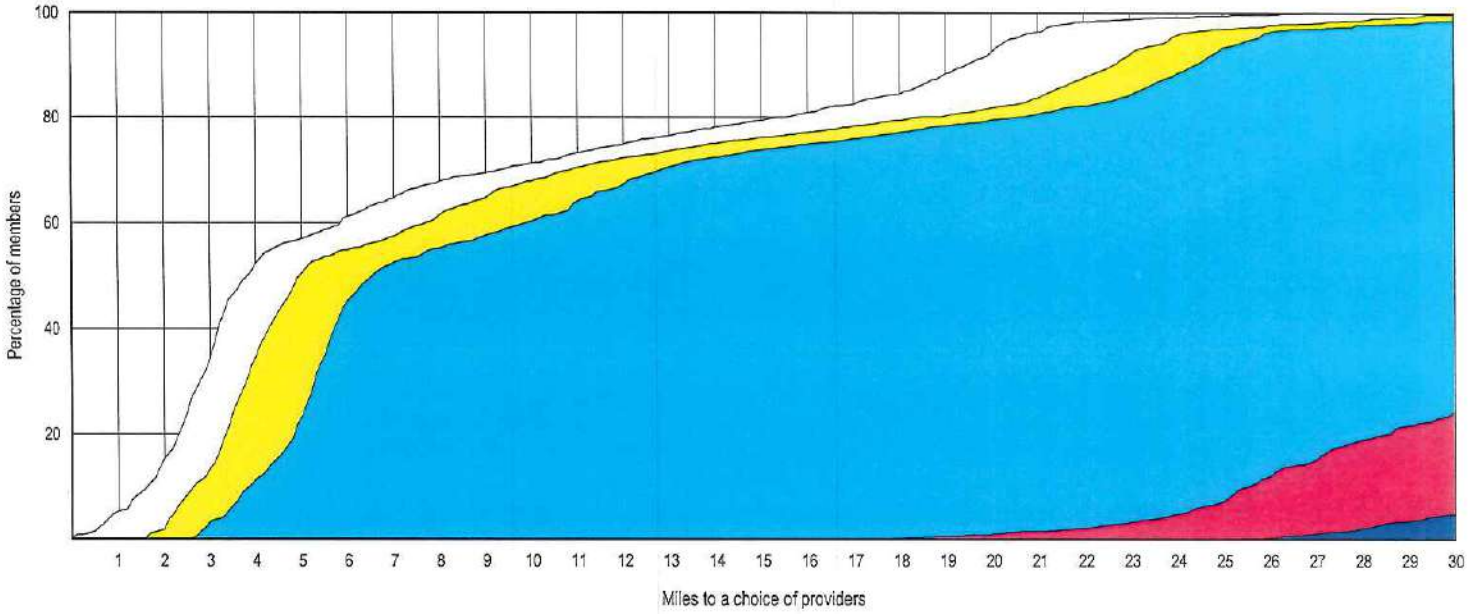

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Access Overview

January 24, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 minutes

Overall Access[1]

7,413 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 7,405 (99.9%) Members with access
- 4 (0.1%) Members without access
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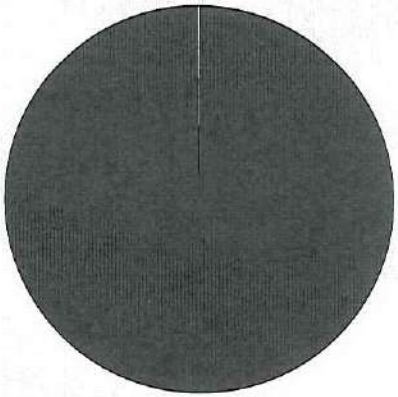

Times

	Average
Time to 1st closest provider	8.2 mins
Time to 2nd closest provider	10.1 mins
Time to 3rd closest provider	12.0 mins
Time to 4th closest provider	36.0 mins
Time to 5th closest provider	43.0 mins

Access Standard Comparison

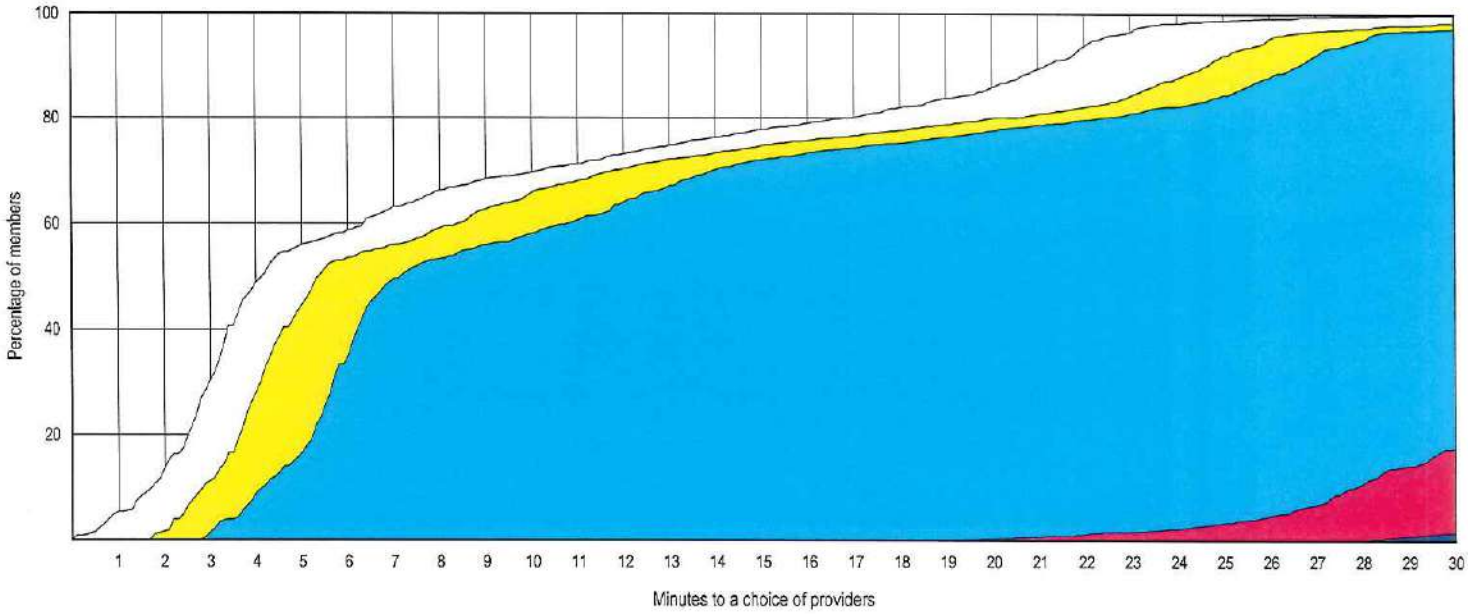

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Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 miles

Overall Access[1]

28,324 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

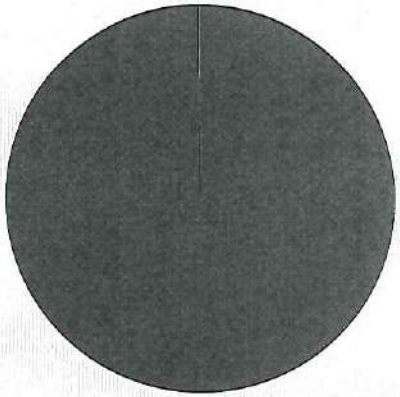

Distances

	Average
Distance to 1st closest provider	15.8 miles
Distance to 2nd closest provider	24.9 miles
Distance to 3rd closest provider	30.8 miles
Distance to 4th closest provider	41.8 miles
Distance to 5th closest provider	46.3 miles

Access Standard Comparison

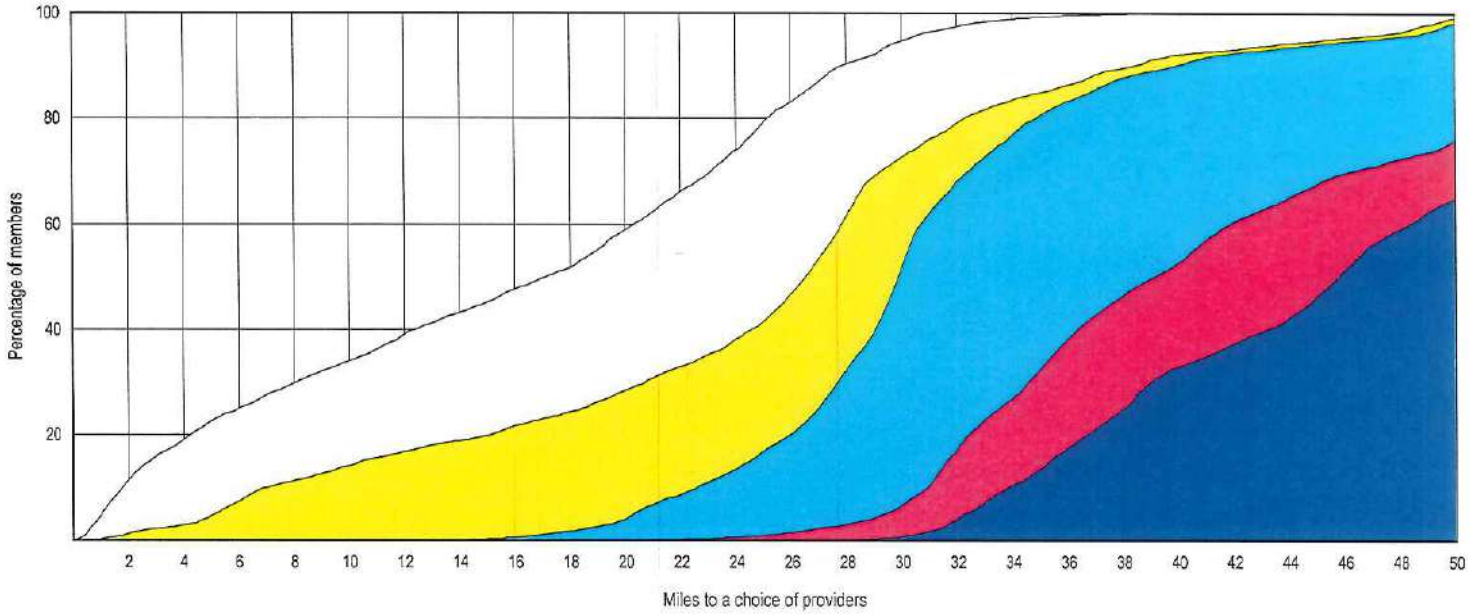

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 minutes

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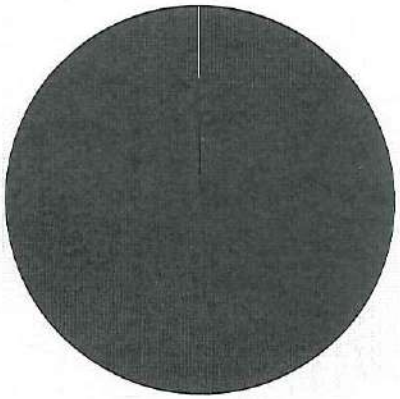

Times

	Average
Time to 1st closest provider	17.2 mins
Time to 2nd closest provider	27.1 mins
Time to 3rd closest provider	33.6 mins
Time to 4th closest provider	45.6 mins
Time to 5th closest provider	50.4 mins

Access Standard Comparison

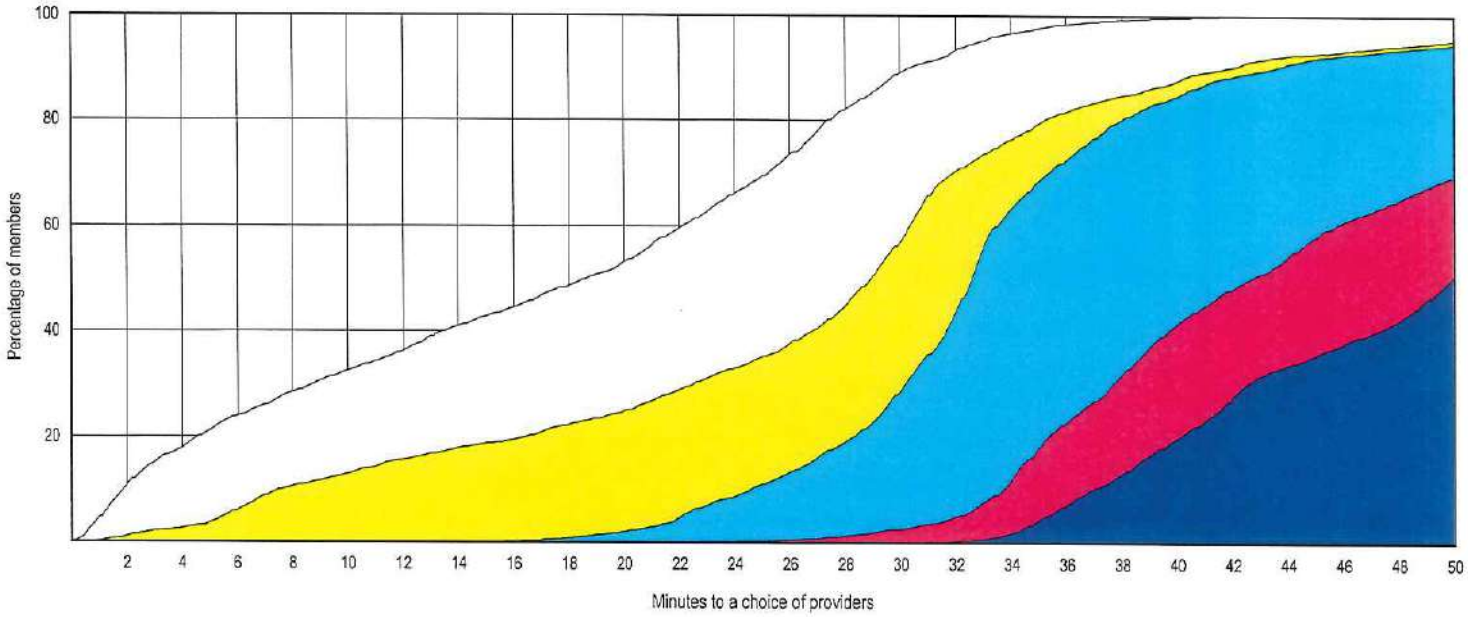

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Provider Locations

January 23, 2020

Region 5 Renal Dialysis Clinics

Total Providers: 17

j All providers

Interstates

US Highways

State Highways

17.44 miles

Region 5 Renal Dialysis Clinics

17 providers at 17 locations

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Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 miles

Overall Access[1]

22,712 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

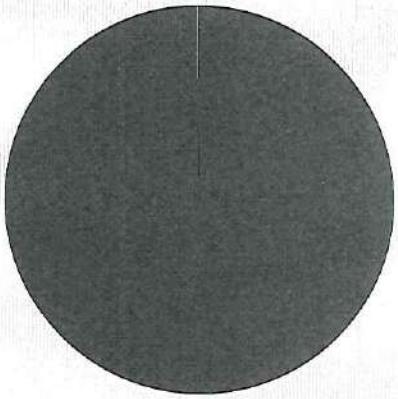

Distances

	Average
Distance to 1st closest provider	2.8 miles
Distance to 2nd closest provider	7.5 miles
Distance to 3rd closest provider	9.1 miles
Distance to 4th closest provider	10.4 miles
Distance to 5th closest provider	11.4 miles

Access Standard Comparison

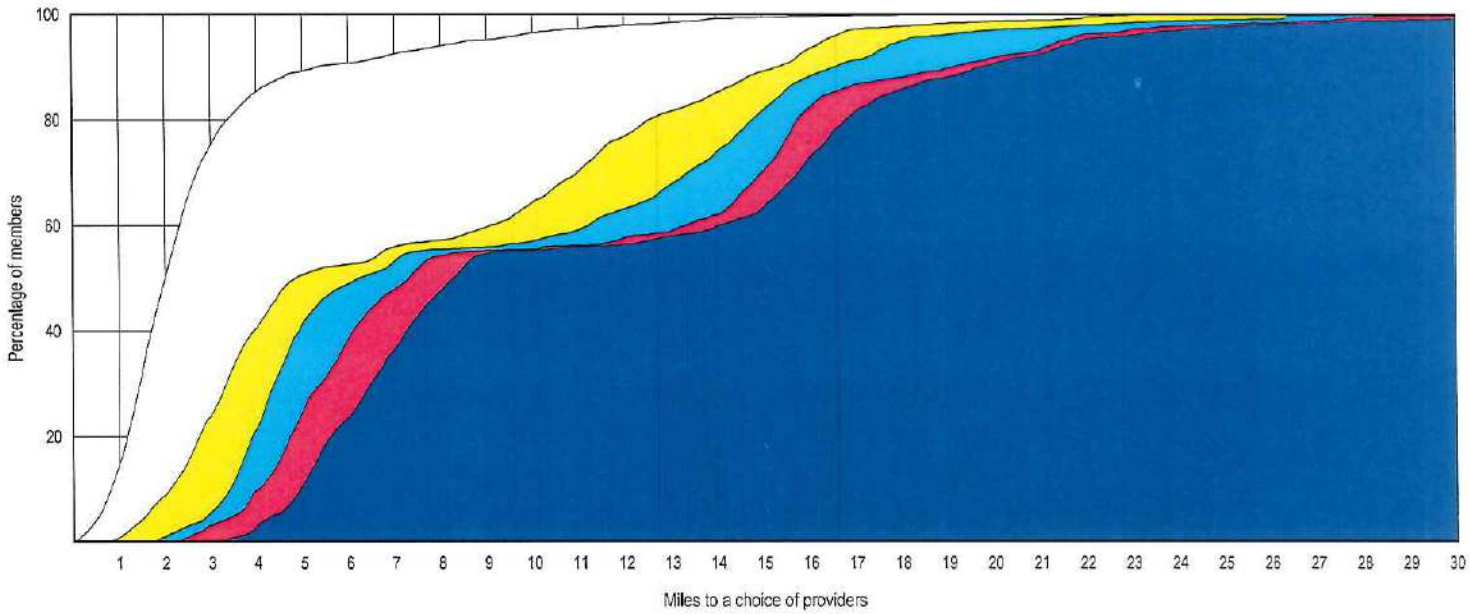

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
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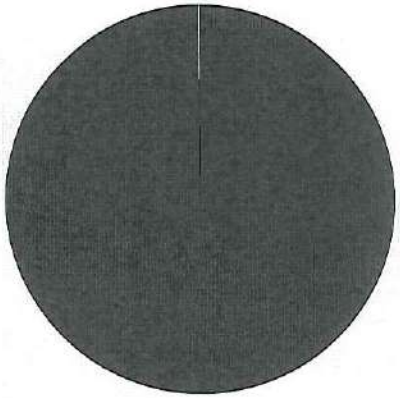

Times

	Average
Time to 1st closest provider	3.4 mins
Time to 2nd closest provider	9.1 mins
Time to 3rd closest provider	11.6 mins
Time to 4th closest provider	13.2 mins
Time to 5th closest provider	14.3 mins

Access Standard Comparison

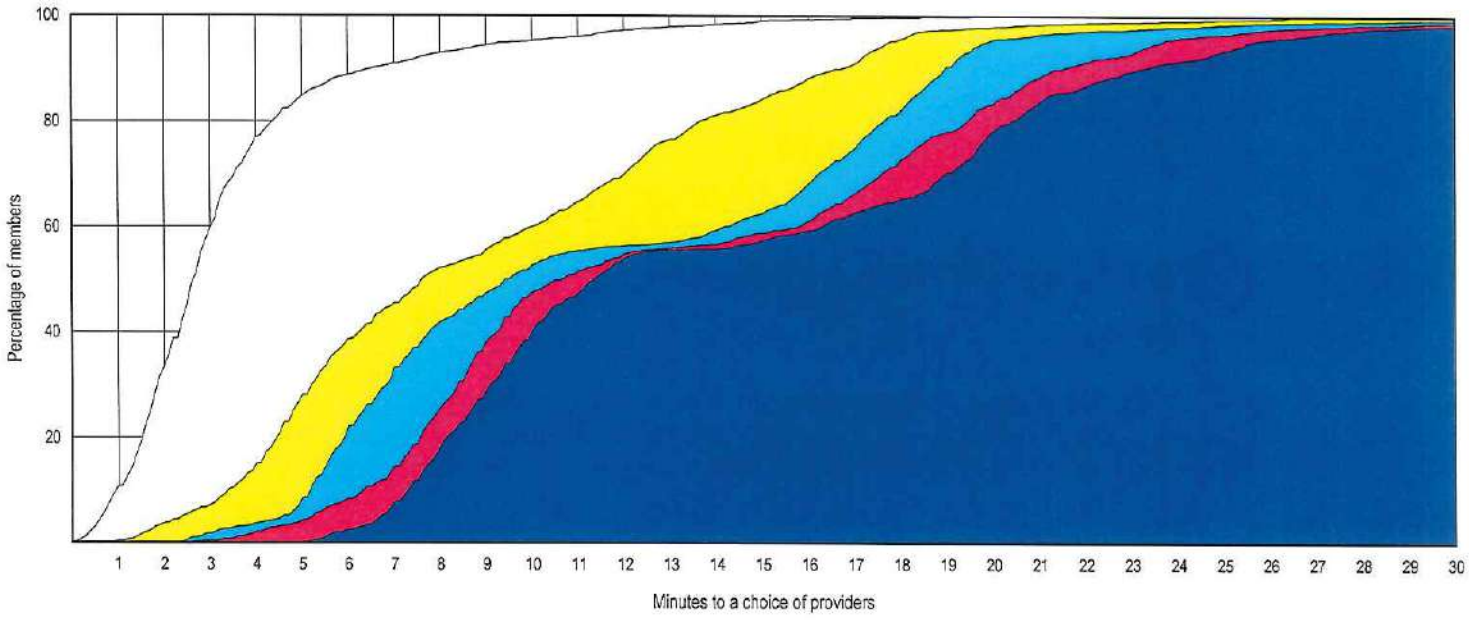

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 miles

Overall Access[1]

23,127 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

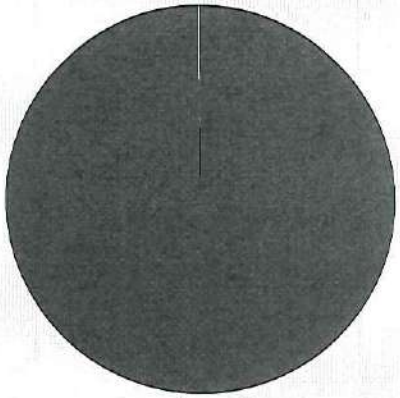

Distances

	Average
Distance to 1st closest provider	11.3 miles
Distance to 2nd closest provider	20.3 miles
Distance to 3rd closest provider	25.6 miles
Distance to 4th closest provider	28.5 miles
Distance to 5th closest provider	30.4 miles

Access Standard Comparison

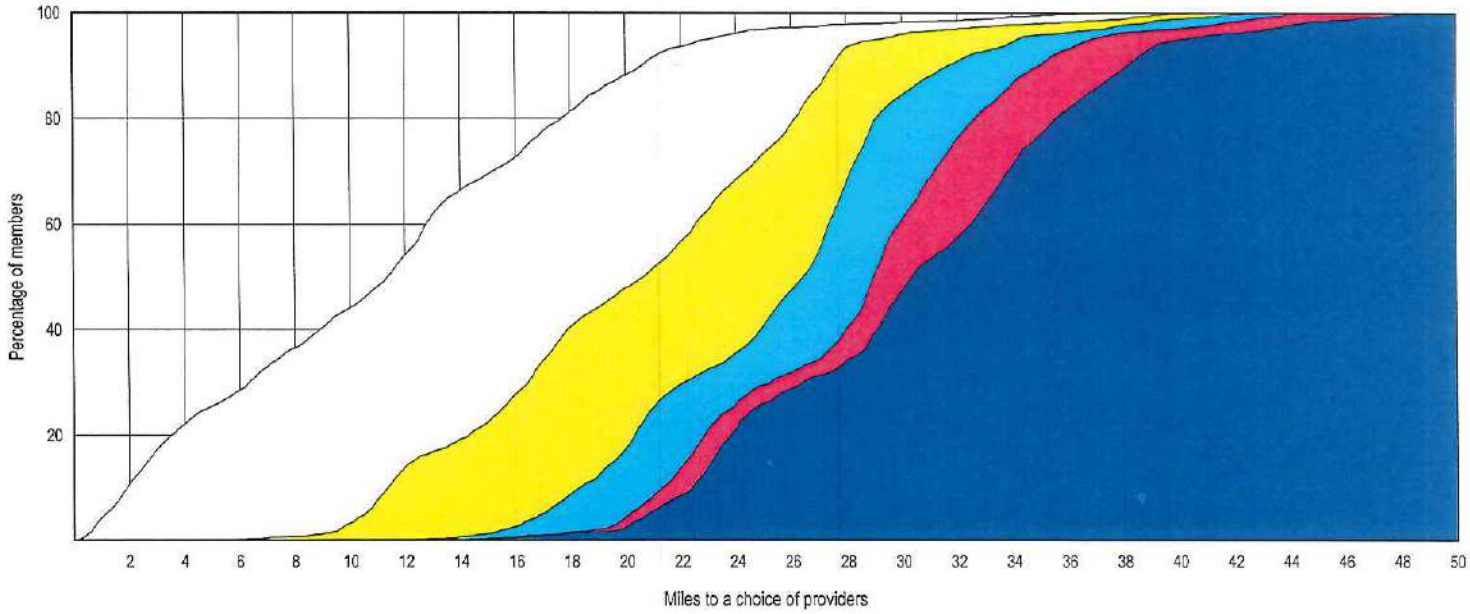

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

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97 providers at 97 locations (Renal Dialysis Clinics)

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- 9 (0.0%) Members excluded

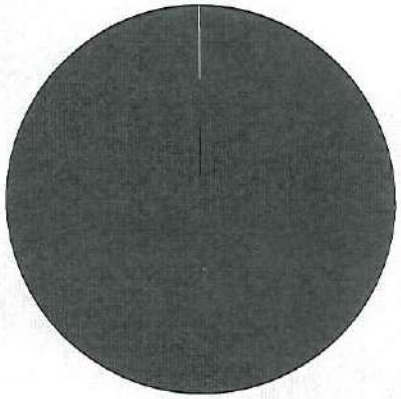

Times

	Average
Time to 1st closest provider	12.3 mins
Time to 2nd closest provider	22.1 mins
Time to 3rd closest provider	27.9 mins
Time to 4th closest provider	31.2 mins
Time to 5th closest provider	33.3 mins

Access Standard Comparison

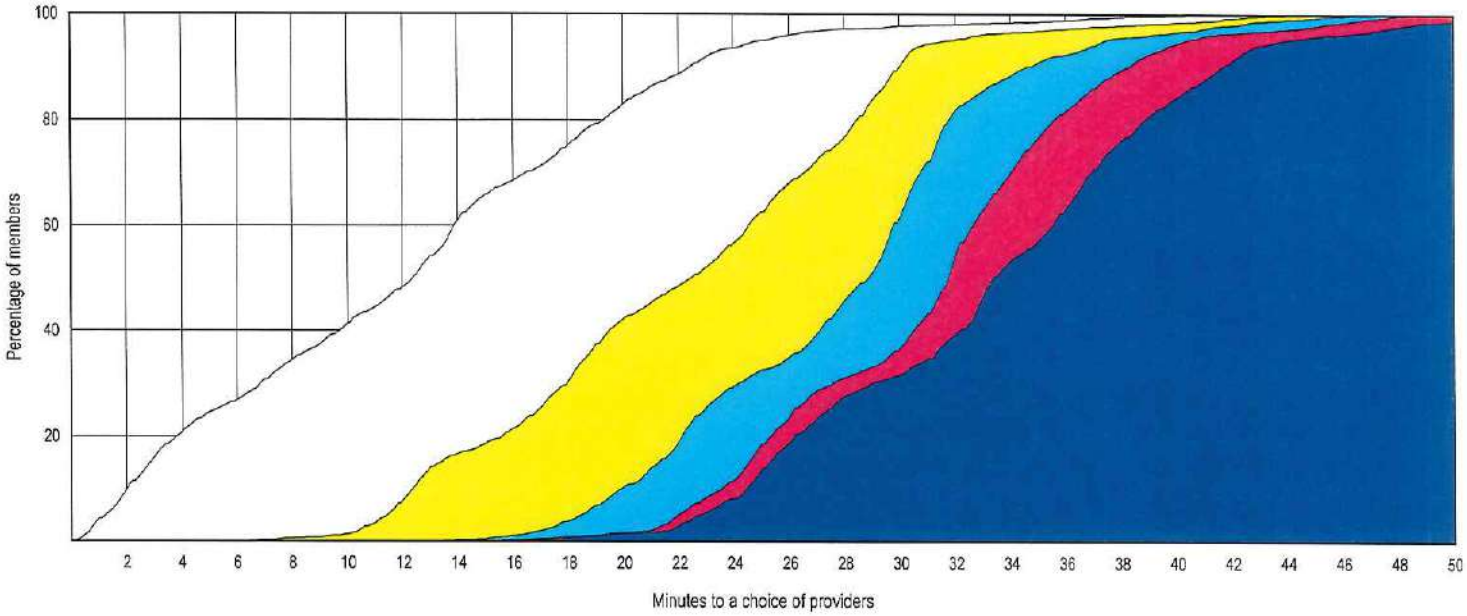

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Provider Locations

January 23, 2020

Region 6 Renal Dialysis Clinics

Total Providers: 8

j All providers

Interstates

US Highways

State Highways

7.48 miles

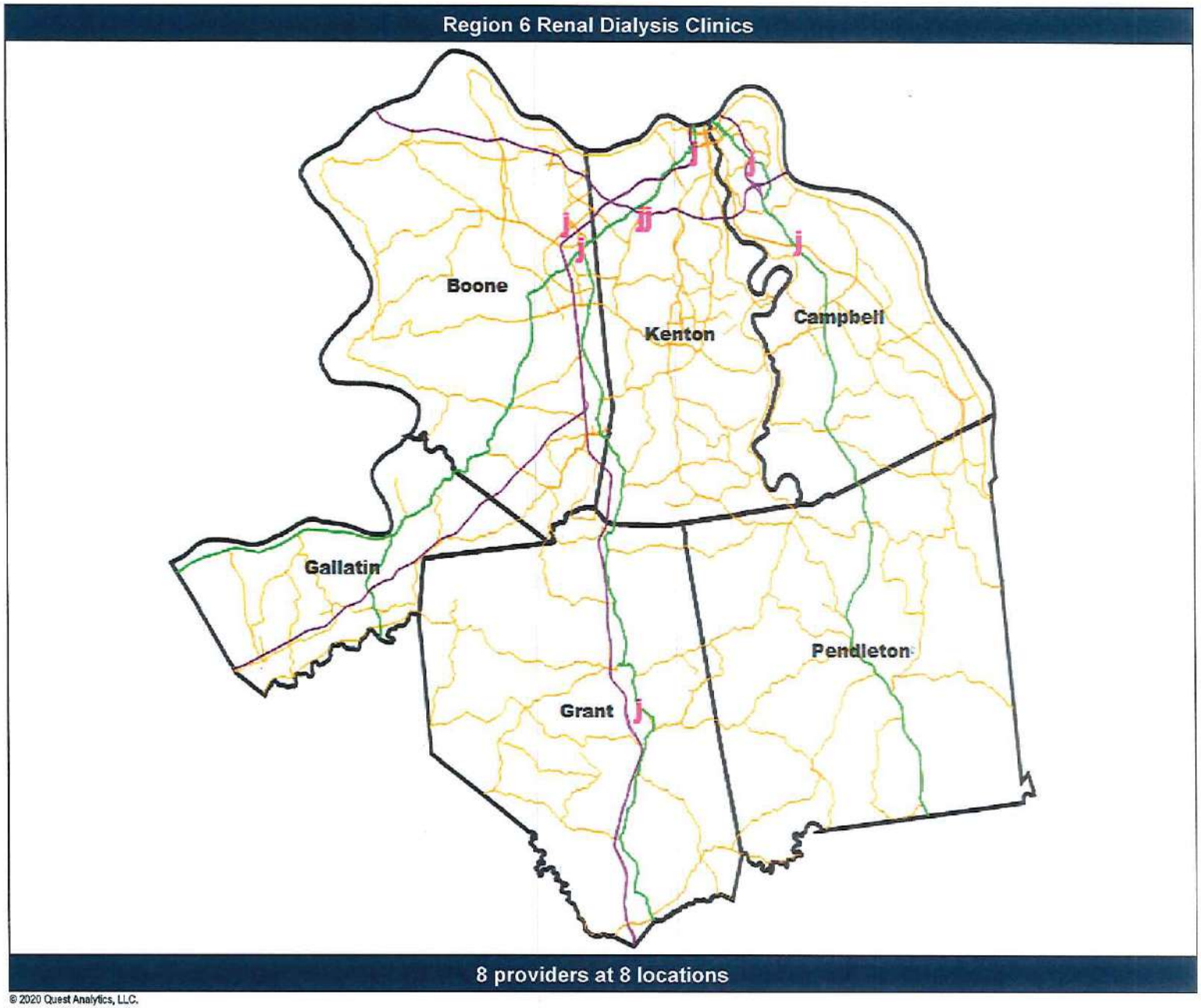

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 miles

Overall Access[1]

22,413 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

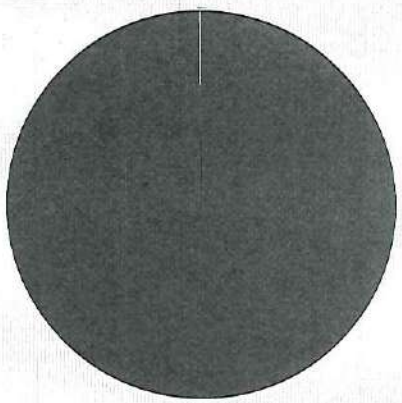

Distances

	Average
Distance to 1st closest provider	4.9 miles
Distance to 2nd closest provider	8.2 miles
Distance to 3rd closest provider	10.4 miles
Distance to 4th closest provider	11.1 miles
Distance to 5th closest provider	13.5 miles

Access Standard Comparison

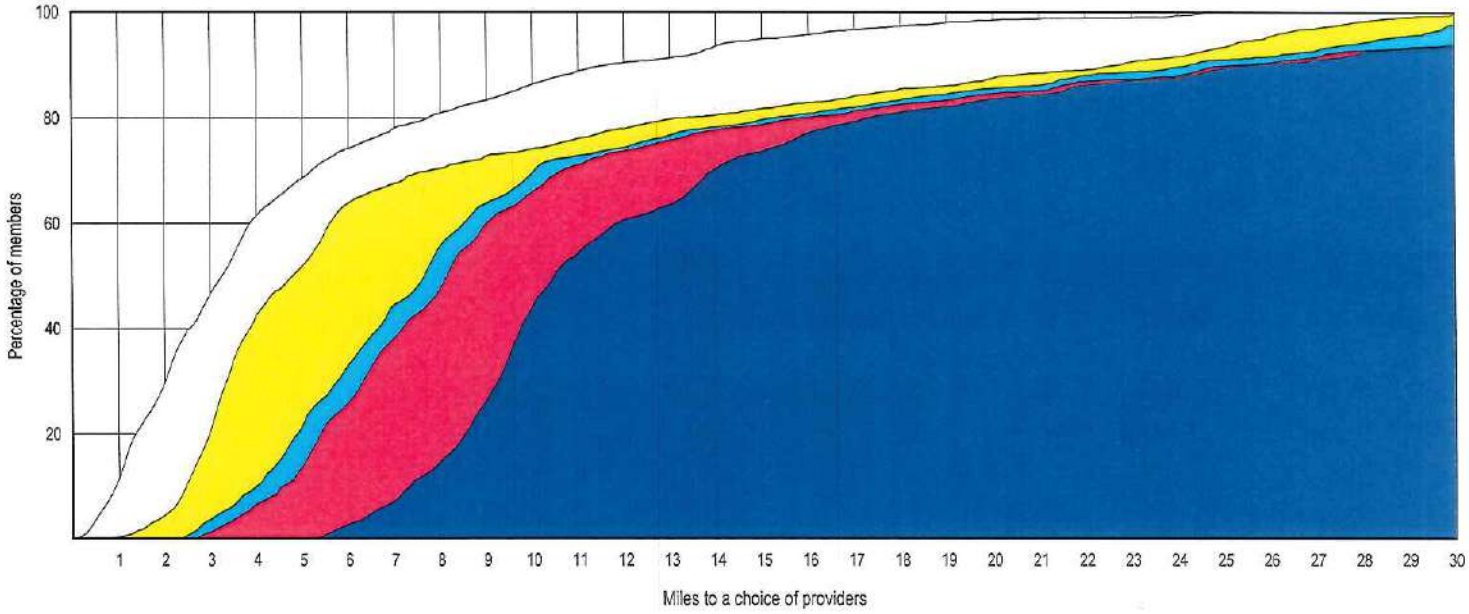

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 minutes

Overall Access[1]

22,413 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 22,405 (99.9%) Members with access
- 1 (0.1%) Members without access
- 7 (0.0%) Members excluded

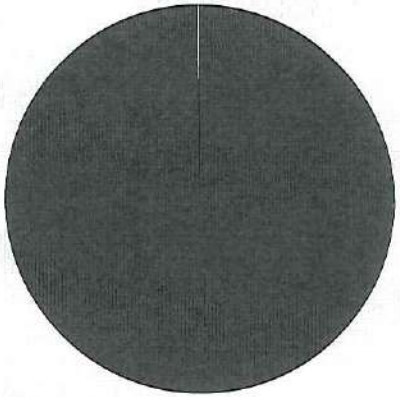

Times

	Average
Time to 1st closest provider	6.1 mins
Time to 2nd closest provider	10.5 mins
Time to 3rd closest provider	13.1 mins
Time to 4th closest provider	14.2 mins
Time to 5th closest provider	17.2 mins

Access Standard Comparison

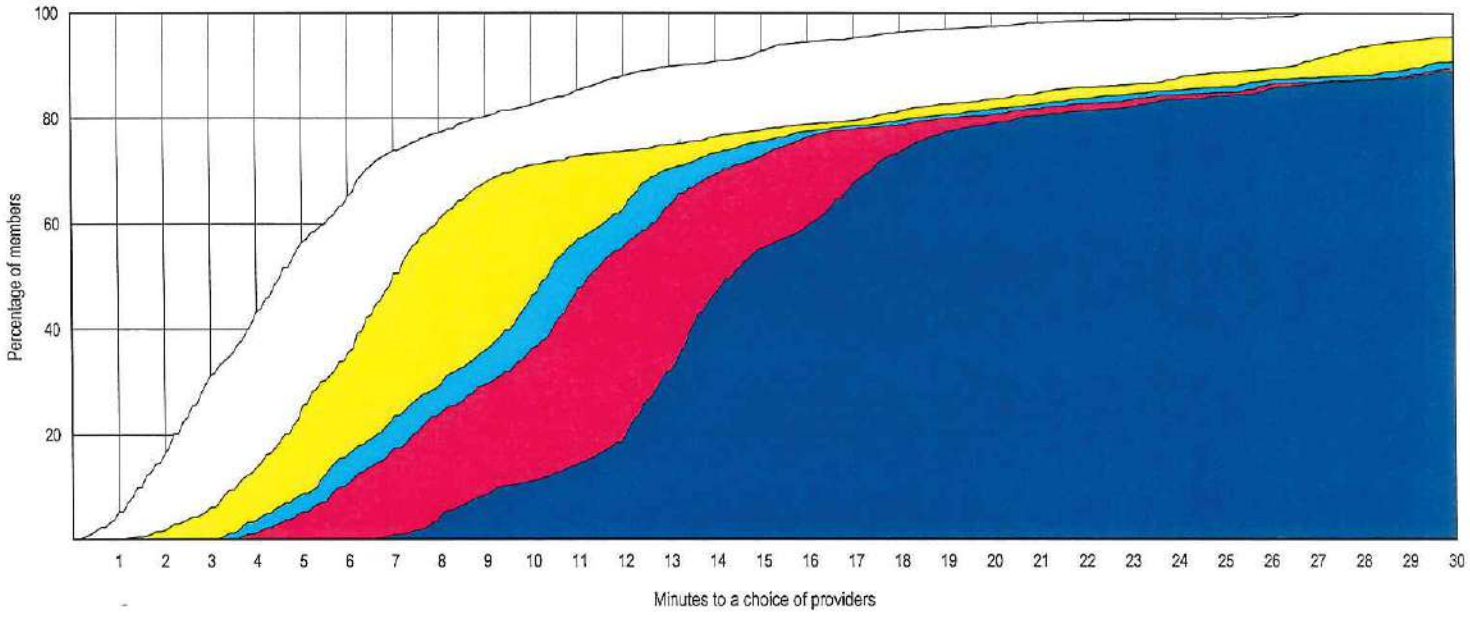

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Provider Locations

January 23, 2020

Region 7 Renal Dialysis Clinics

Total Providers: 7

All providers

Interstates

US Highways

State Highways

12.36 miles

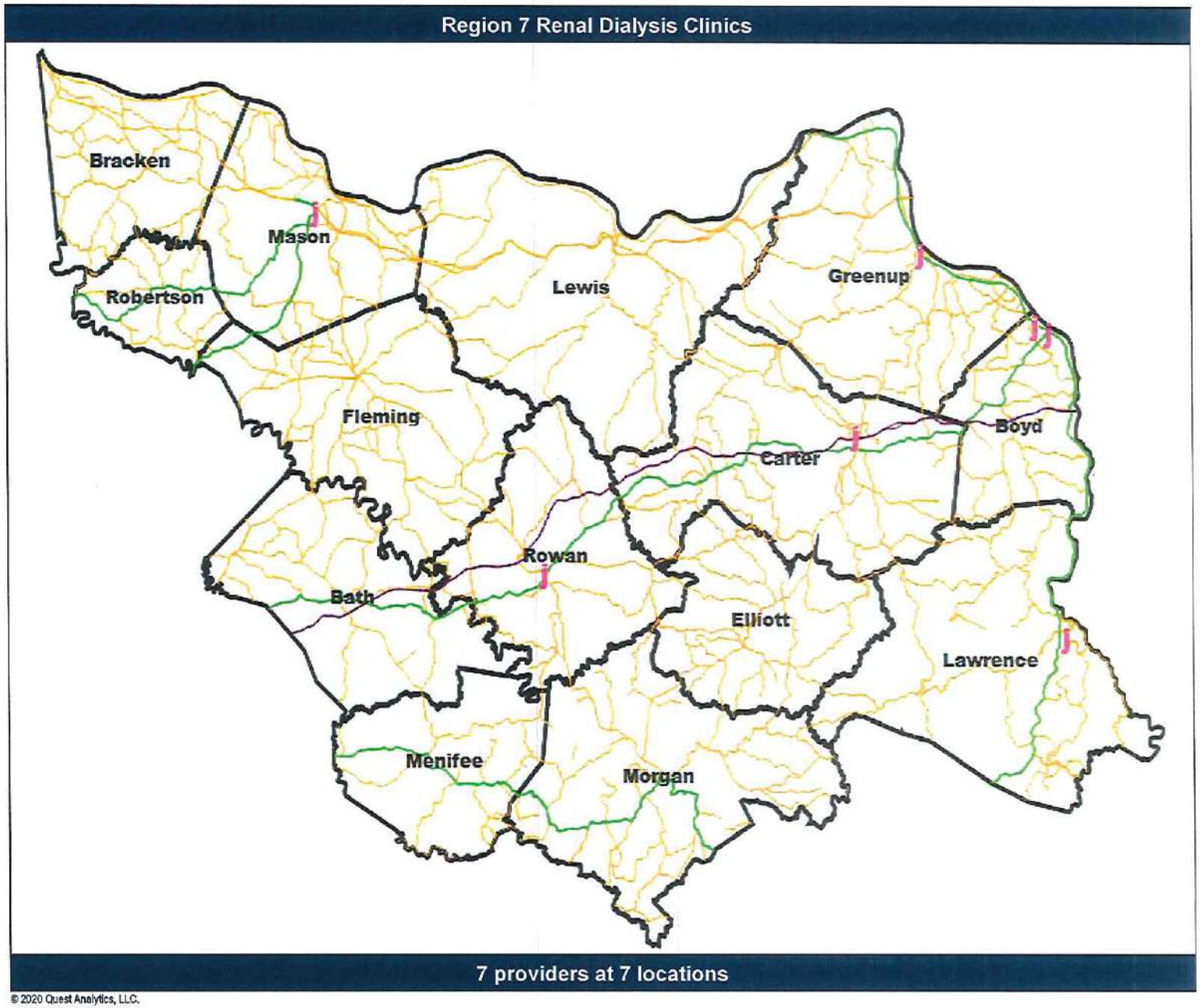

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 miles

Overall Access[1]

2,907 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

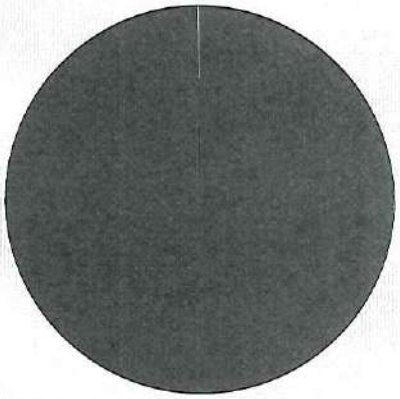

Distances

	Average
Distance to 1st closest provider	9.8 miles
Distance to 2nd closest provider	15.4 miles
Distance to 3rd closest provider	22.0 miles
Distance to 4th closest provider	26.9 miles
Distance to 5th closest provider	34.5 miles

Access Standard Comparison

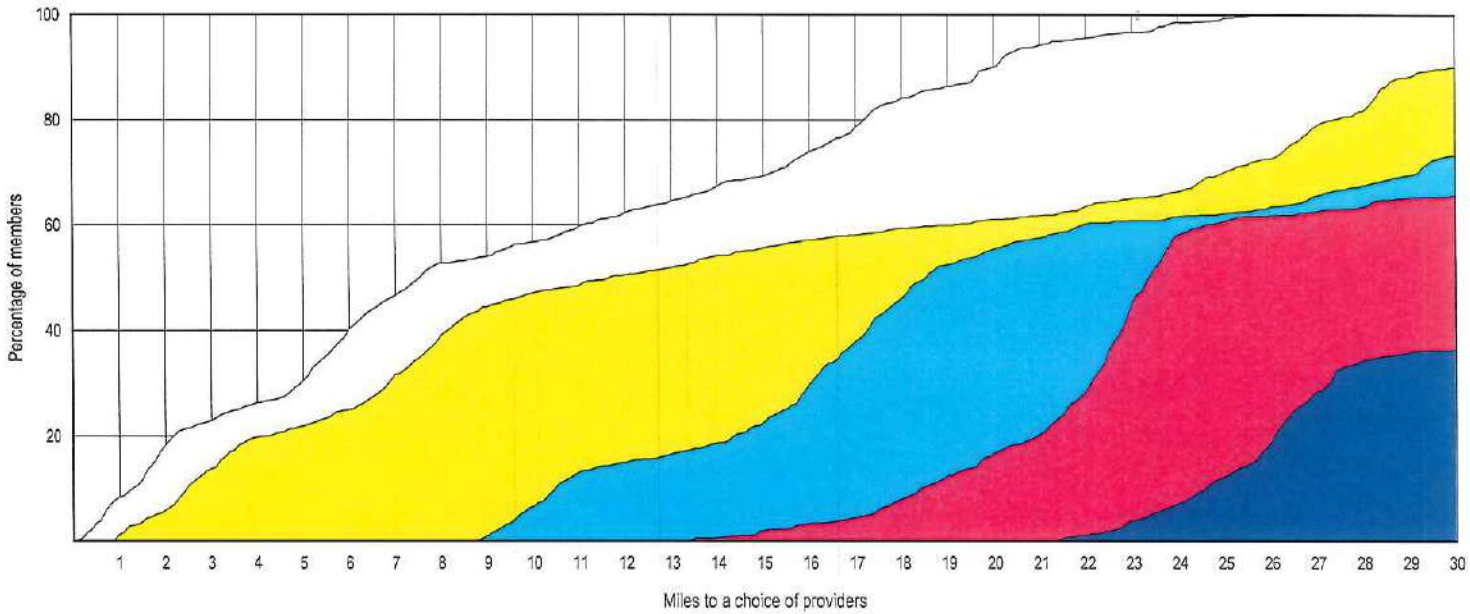

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Access Overview

January 24, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Renal Dialysis Clinics) provider in 30 minutes

Overall Access[1]

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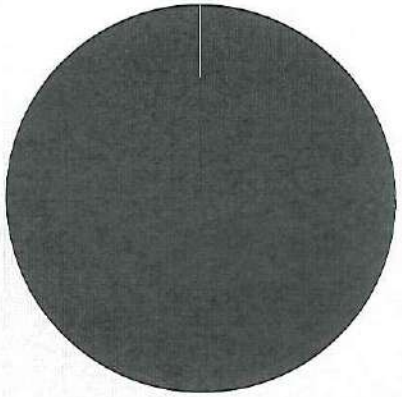

Times

	Average
Time to 1st closest provider	10.9 mins
Time to 2nd closest provider	17.2 mins
Time to 3rd closest provider	24.9 mins
Time to 4th closest provider	30.5 mins
Time to 5th closest provider	39.1 mins

Access Standard Comparison

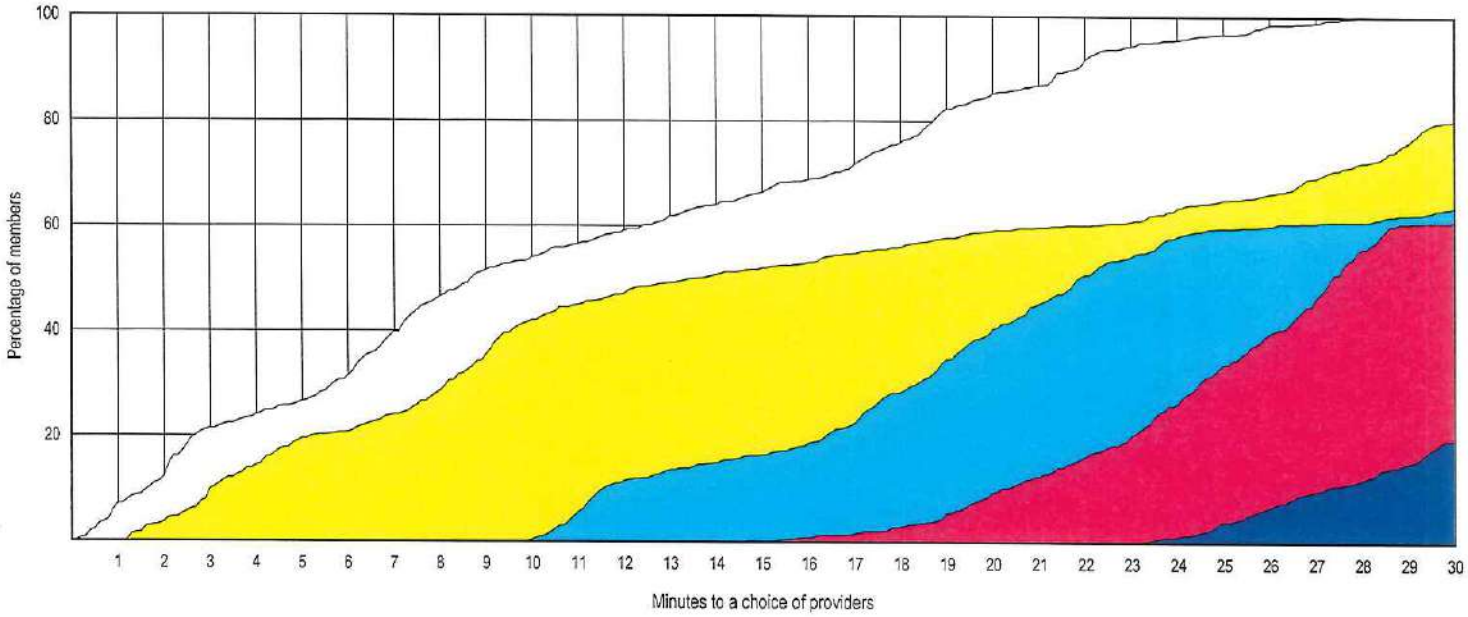

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 miles

Overall Access[1]

10,408 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

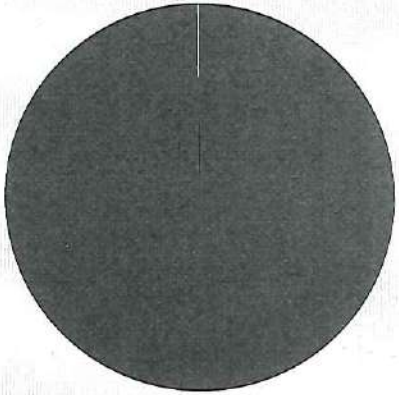

Distances

	Average
Distance to 1st closest provider	12.2 miles
Distance to 2nd closest provider	28.4 miles
Distance to 3rd closest provider	33.3 miles
Distance to 4th closest provider	36.4 miles
Distance to 5th closest provider	39.8 miles

Access Standard Comparison

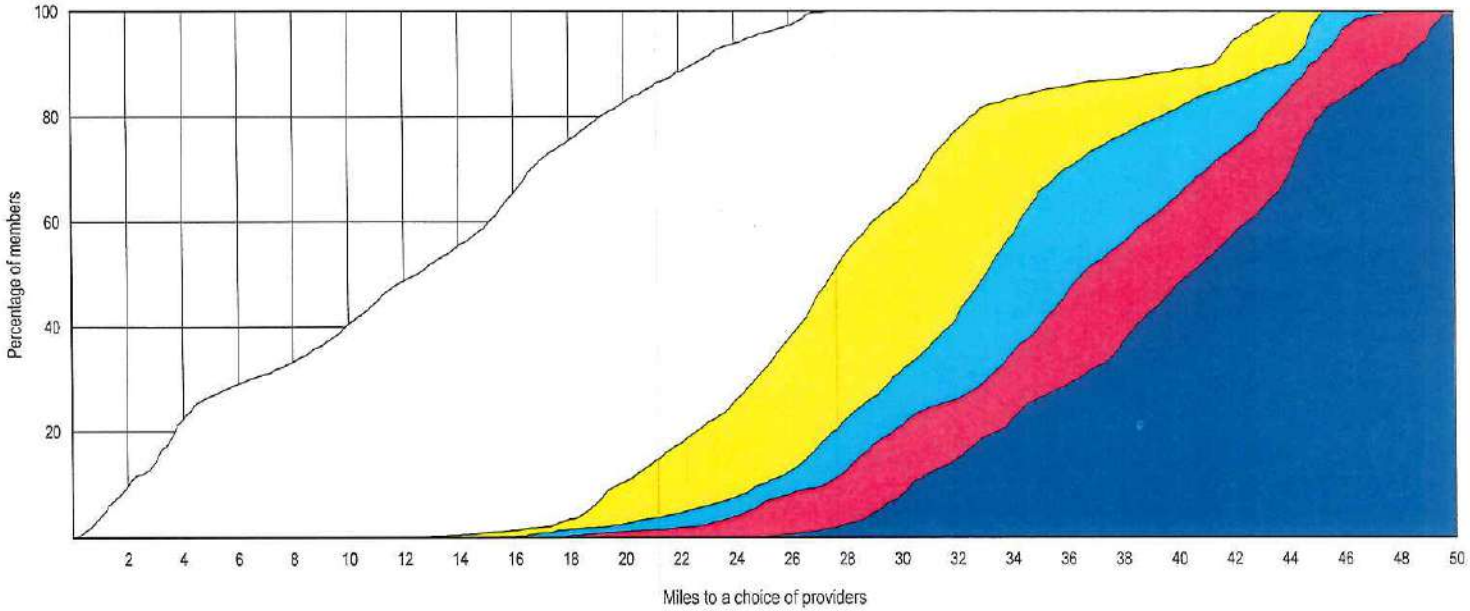

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 7 Rural - 1 in 50 minutes

Member / Provider Groups
Region 7 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 minutes

Overall Access[1]

10,408 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

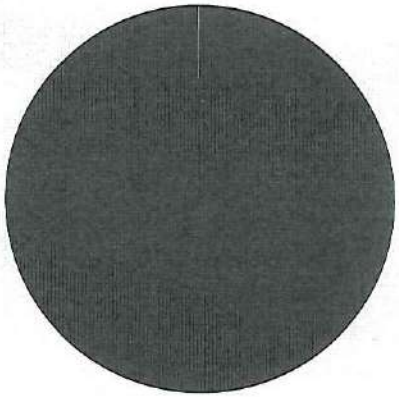

Times

	Average
Time to 1st closest provider	13.3 mins
Time to 2nd closest provider	31.1 mins
Time to 3rd closest provider	36.6 mins
Time to 4th closest provider	40.0 mins
Time to 5th closest provider	43.9 mins

Access Standard Comparison

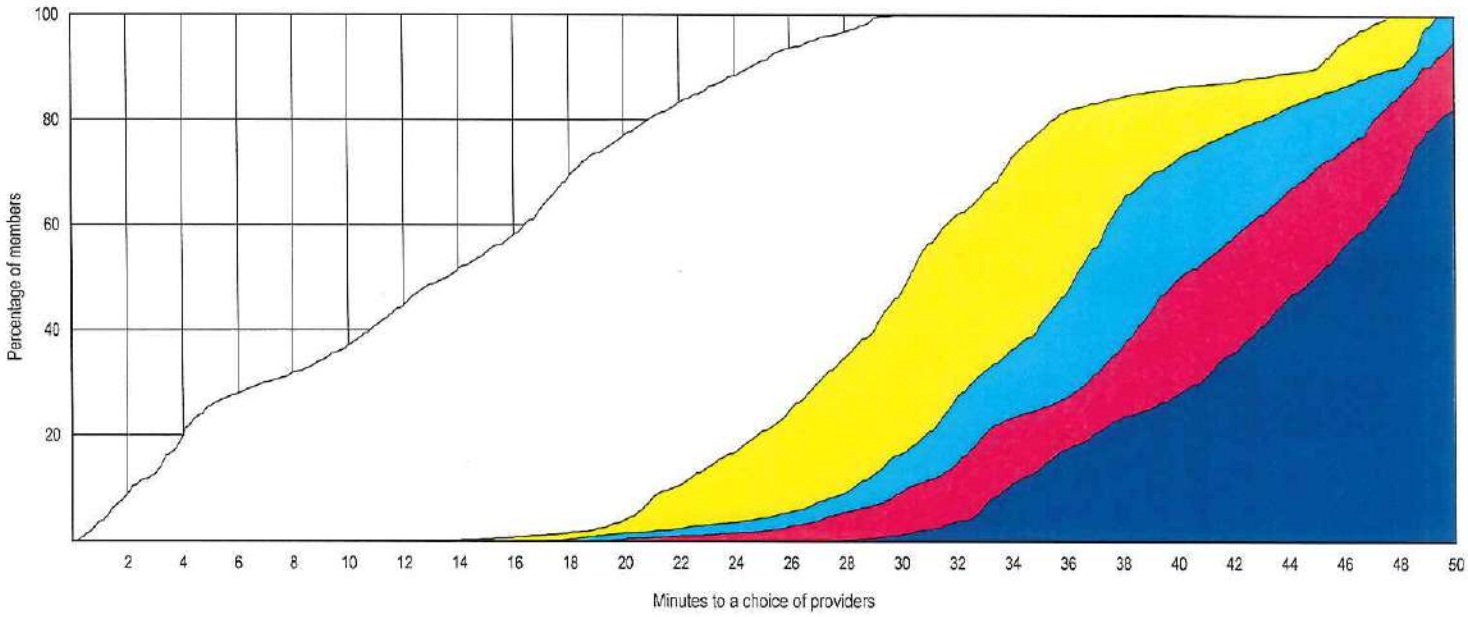

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Provider Locations

January 23, 2020

Region 8 Renal Dialysis Clinics

Total Providers: 10

j All providers

Interstates

US Highways

State Highways

16.38 miles

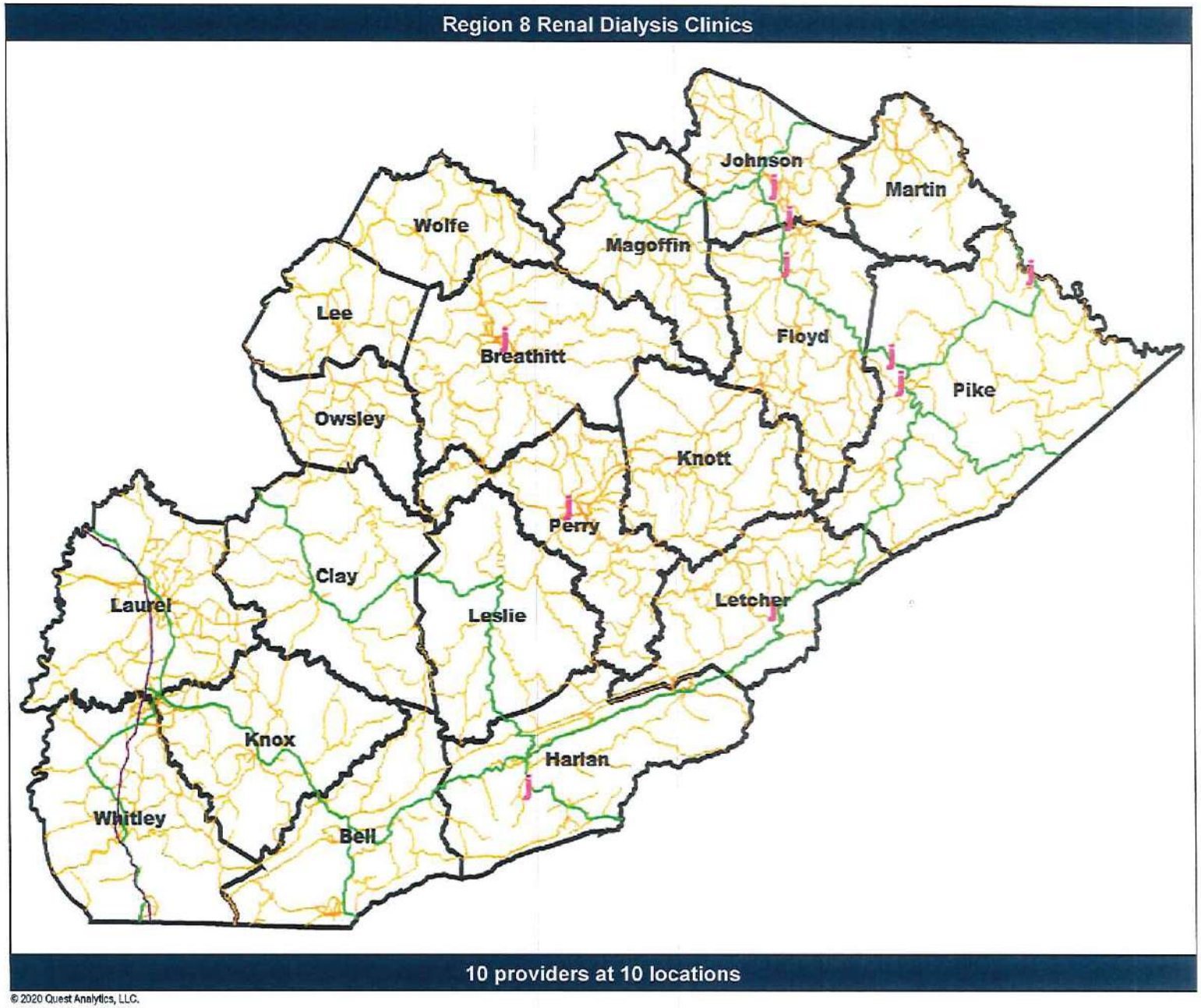

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Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 miles

Overall Access[1]

31,600 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

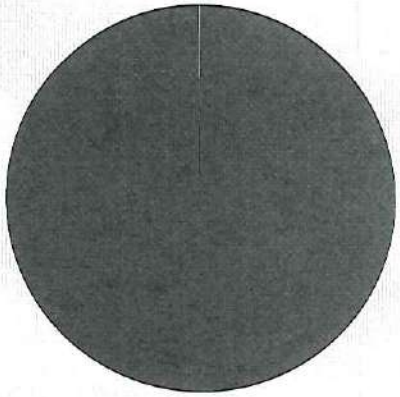

Times

	Average
Distance to 1st closest provider	19.9 miles
Distance to 2nd closest provider	26.5 miles
Distance to 3rd closest provider	32.5 miles
Distance to 4th closest provider	38.2 miles
Distance to 5th closest provider	42.6 miles

Access Standard Comparison

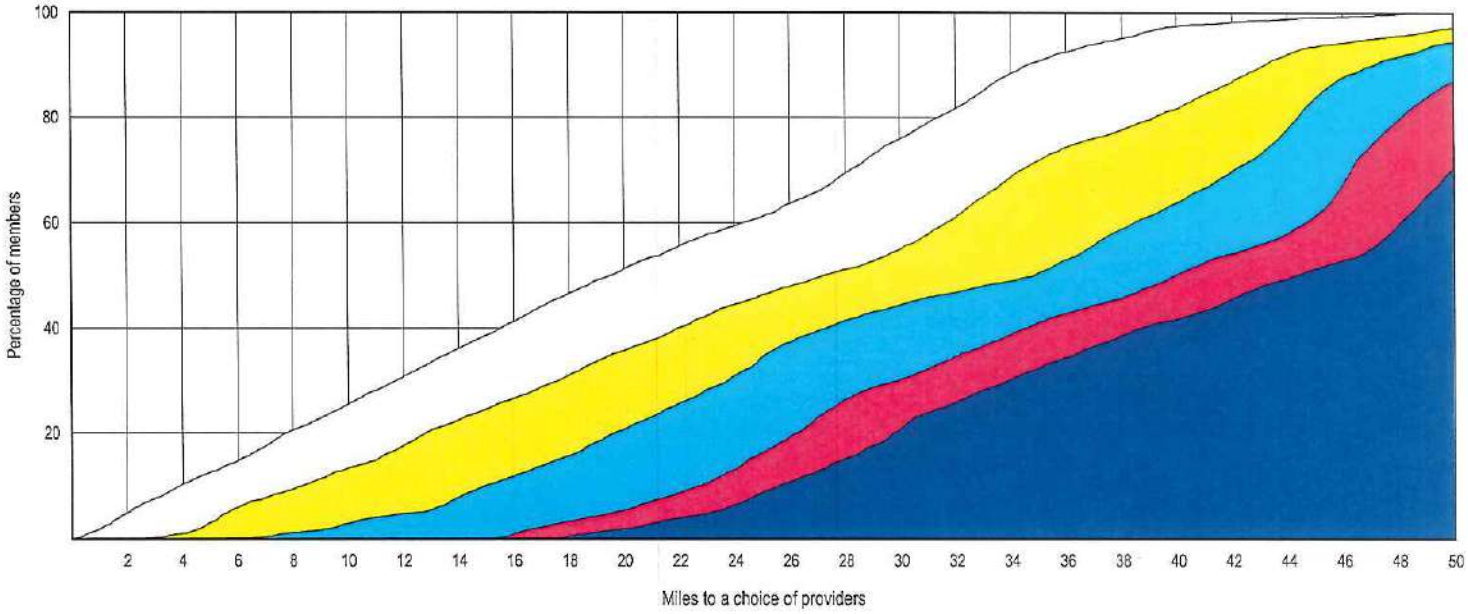

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Renal Dialysis Clinics

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Renal Dialysis Clinics) provider in 50 minutes

Overall Access[1]

31,600 Members
97 providers at 97 locations (Renal Dialysis Clinics)

- 31,365 (99.3%) Members with access
- 220 (0.7%) Members without access
- 15 (0.0%) Members excluded

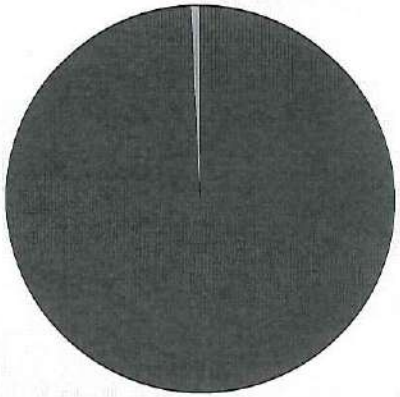

Times

	Average
Time to 1st closest provider	21.7 mins
Time to 2nd closest provider	28.9 mins
Time to 3rd closest provider	35.5 mins
Time to 4th closest provider	41.7 mins
Time to 5th closest provider	46.4 mins

Access Standard Comparison

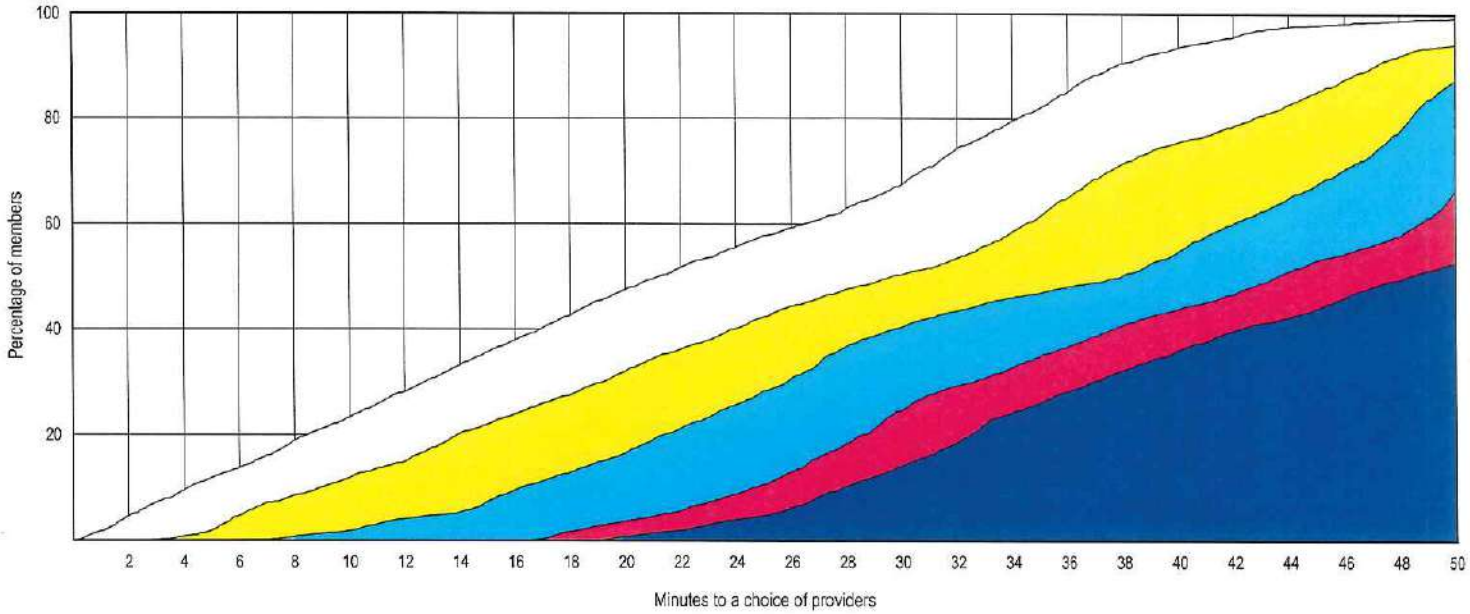

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Provider Locations

January 23, 2020

Region 1 Transportation Providers

Total Providers: 12

k All providers

Interstates

US Highways

State Highways

12.93 miles

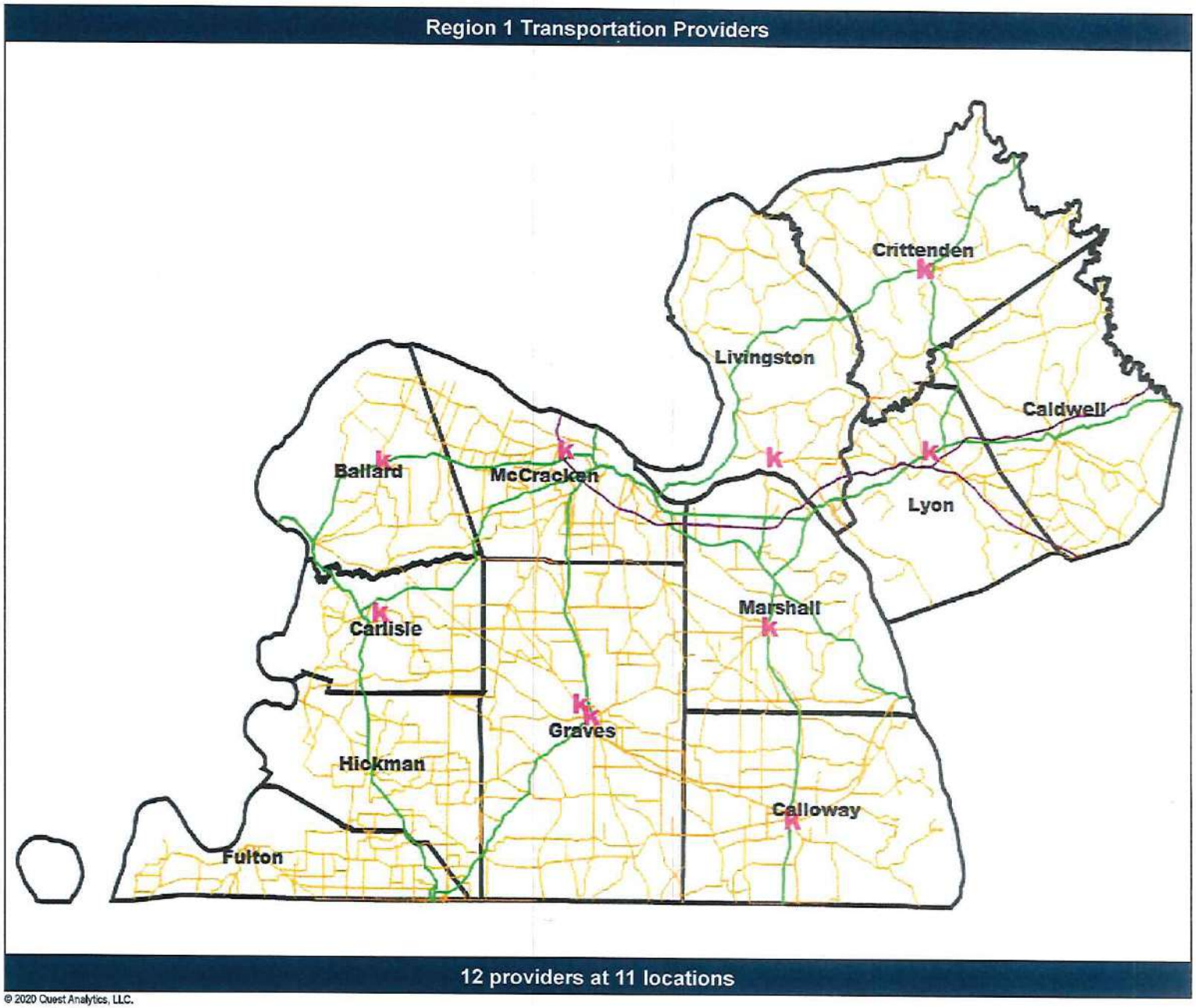

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 miles

Overall Access[1]

11,338 Members
163 providers at 158 locations (Transportation Providers)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

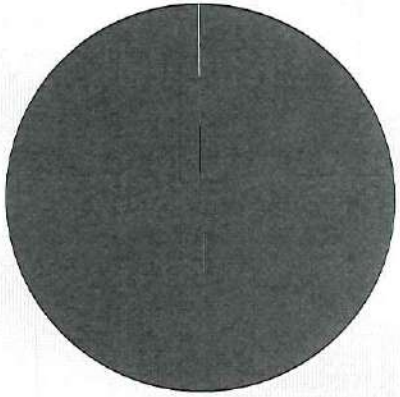

Times

	Average
Distance to 1st closest provider	7.3 miles
Distance to 2nd closest provider	14.7 miles
Distance to 3rd closest provider	20.9 miles
Distance to 4th closest provider	23.9 miles
Distance to 5th closest provider	25.8 miles

Access Standard Comparison

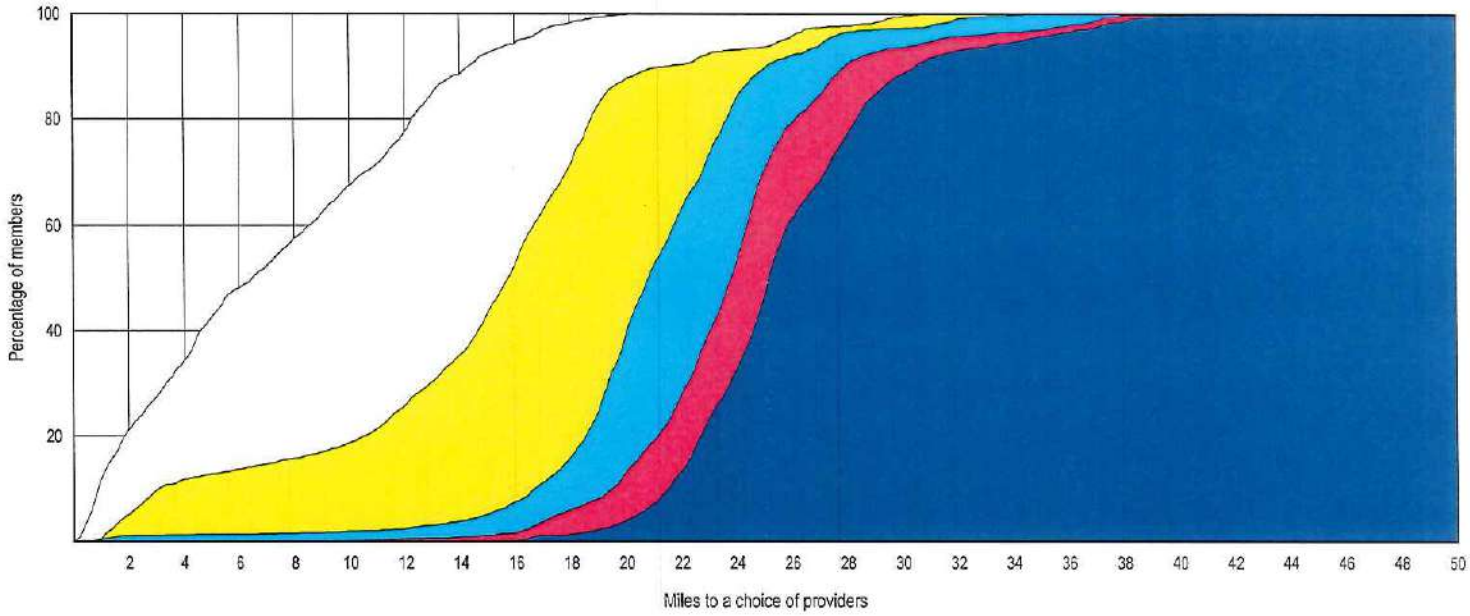

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 minutes

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- 4 (0.0%) Members excluded

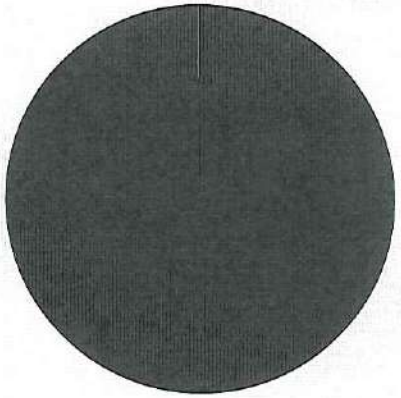

Times

	Average
Time to 1st closest provider	7.9 mins
Time to 2nd closest provider	16.0 mins
Time to 3rd closest provider	22.8 mins
Time to 4th closest provider	26.1 mins
Time to 5th closest provider	28.2 mins

Access Standard Comparison

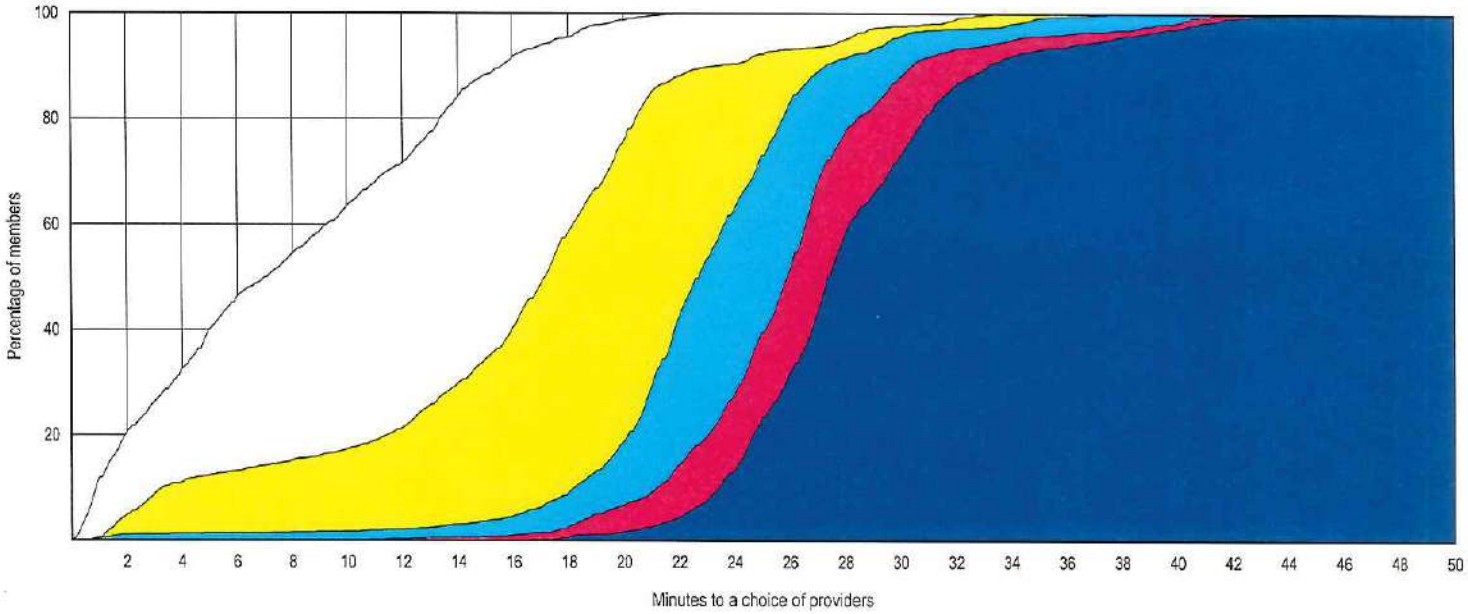

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Provider Locations

January 23, 2020

Region 2 Transportation Providers

Total Providers: 12

k All providers

Interstates

US Highways

State Highways

15.14 miles

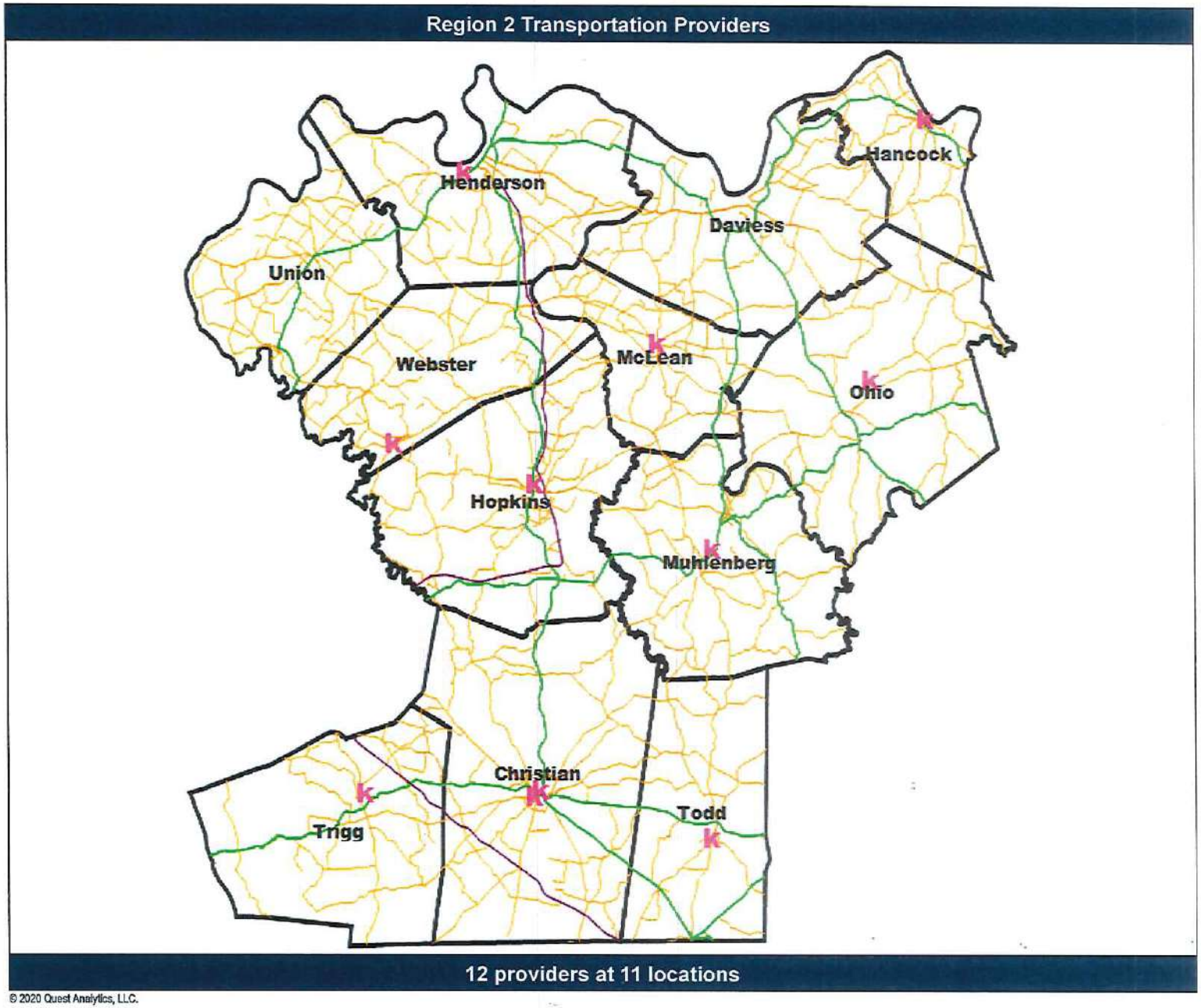

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Transportation Providers) provider in 30 miles

Overall Access[1]

16,143 Members
163 providers at 158 locations (Transportation Providers)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

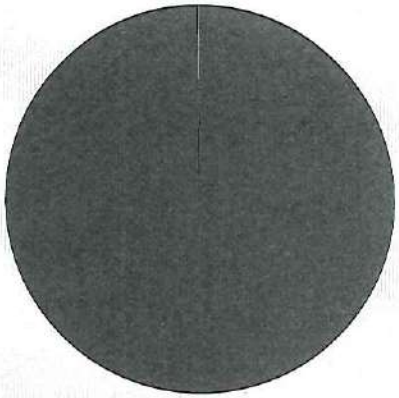

Distances

	Average
Distance to 1st closest provider	8.3 miles
Distance to 2nd closest provider	13.4 miles
Distance to 3rd closest provider	23.9 miles
Distance to 4th closest provider	26.6 miles
Distance to 5th closest provider	30.5 miles

Access Standard Comparison

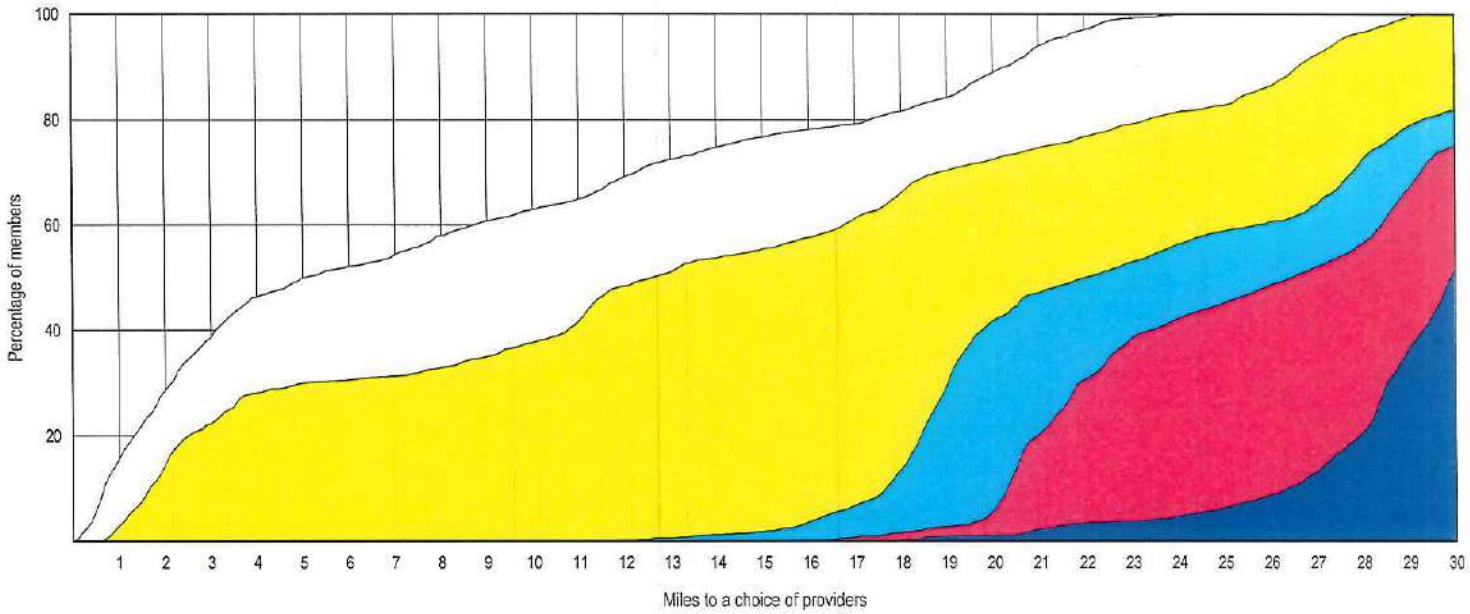

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Access Overview

January 24, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Transportation Providers) provider in 30 minutes

Overall Access[1]

16,143 Members
163 providers at 158 locations (Transportation Providers)

- 16,142 (99.9%) Members with access
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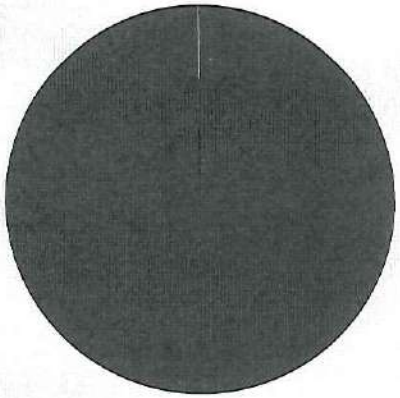

Times

	Average
Time to 1st closest provider	9.0 mins
Time to 2nd closest provider	14.9 mins
Time to 3rd closest provider	26.0 mins
Time to 4th closest provider	29.0 mins
Time to 5th closest provider	33.3 mins

Access Standard Comparison

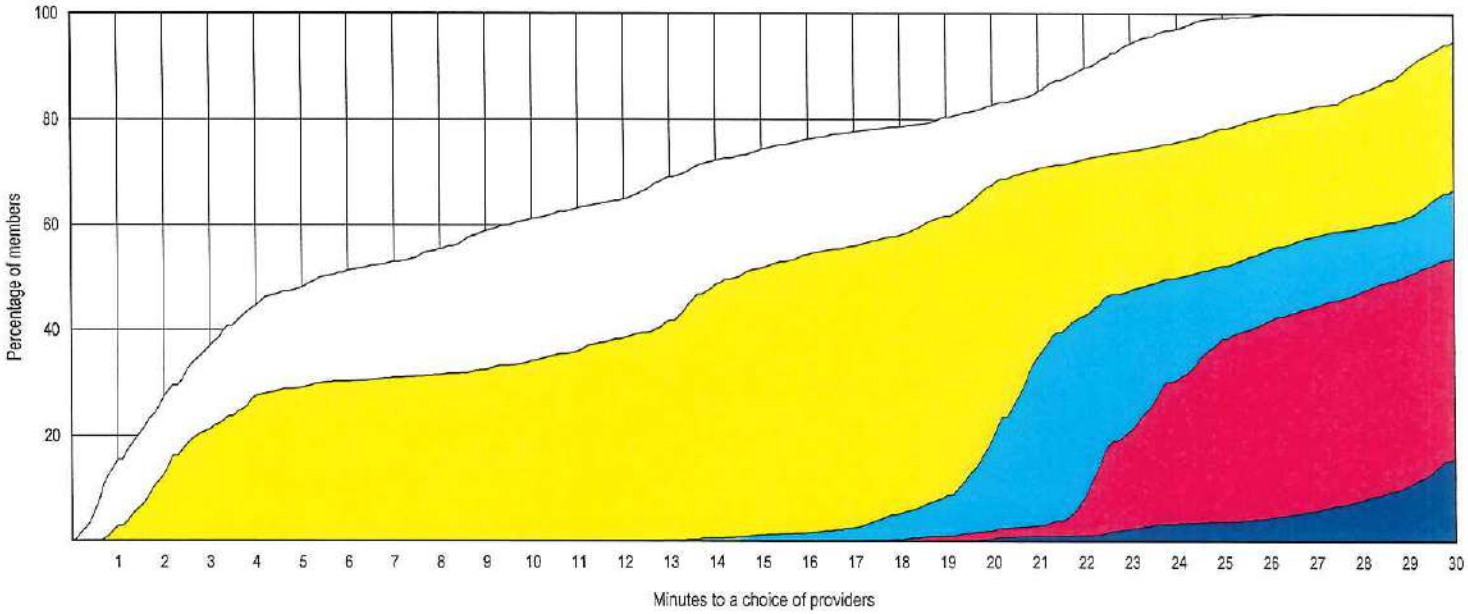

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 miles

Overall Access[1]

9,636 Members
163 providers at 158 locations (Transportation Providers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

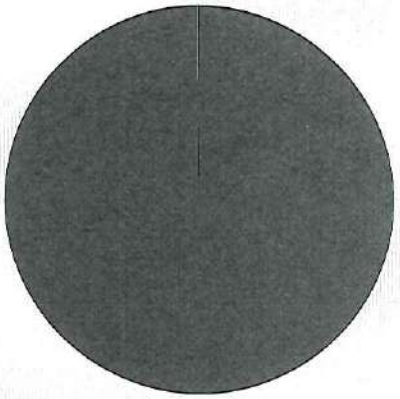

Distances

	Average
Distance to 1st closest provider	8.9 miles
Distance to 2nd closest provider	14.4 miles
Distance to 3rd closest provider	21.8 miles
Distance to 4th closest provider	24.4 miles
Distance to 5th closest provider	27.0 miles

Access Standard Comparison

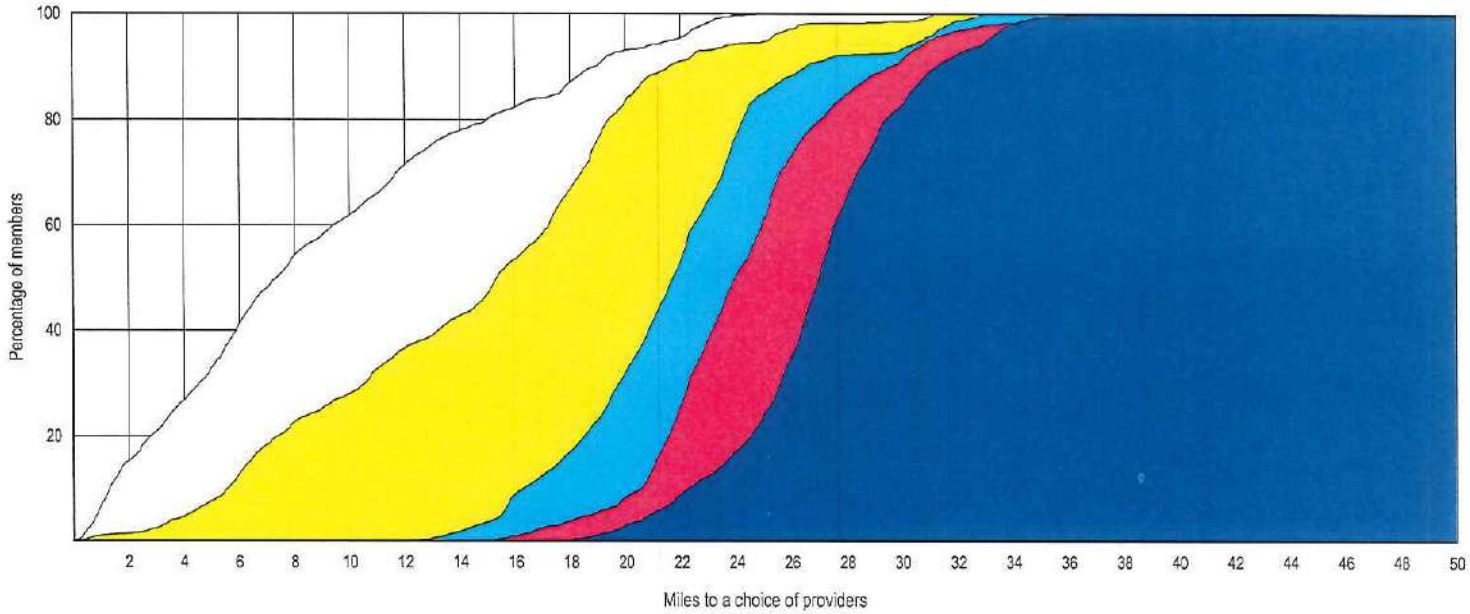

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 minutes

Overall Access[1]

9,636 Members
163 providers at 158 locations (Transportation Providers)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

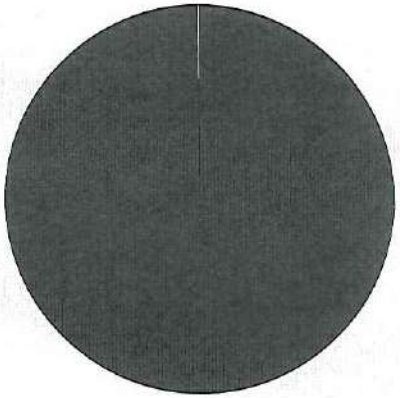

Times

	Average
Time to 1st closest provider	9.7 mins
Time to 2nd closest provider	15.7 mins
Time to 3rd closest provider	23.8 mins
Time to 4th closest provider	26.6 mins
Time to 5th closest provider	29.4 mins

Access Standard Comparison

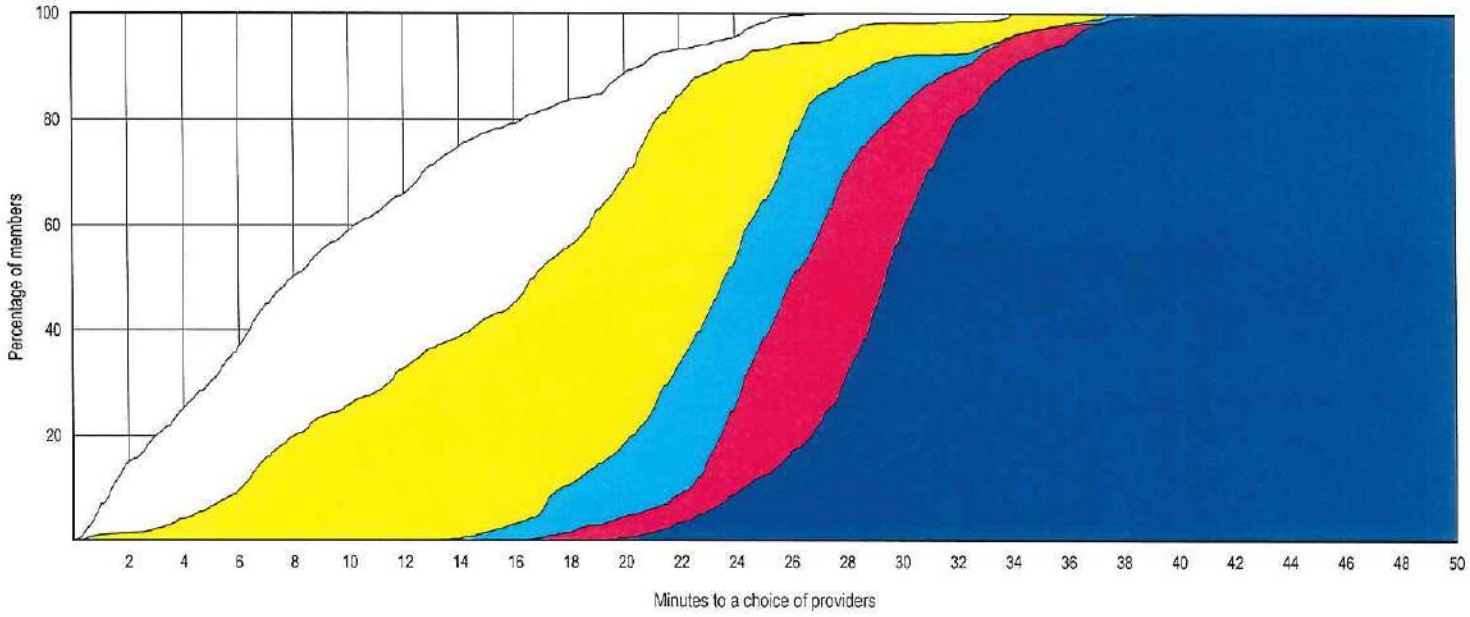

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Provider Locations

January 23, 2020

Region 3 Transportation Providers

Total Providers: 13

k All providers

Interstates

US Highways

State Highways

15.97 miles

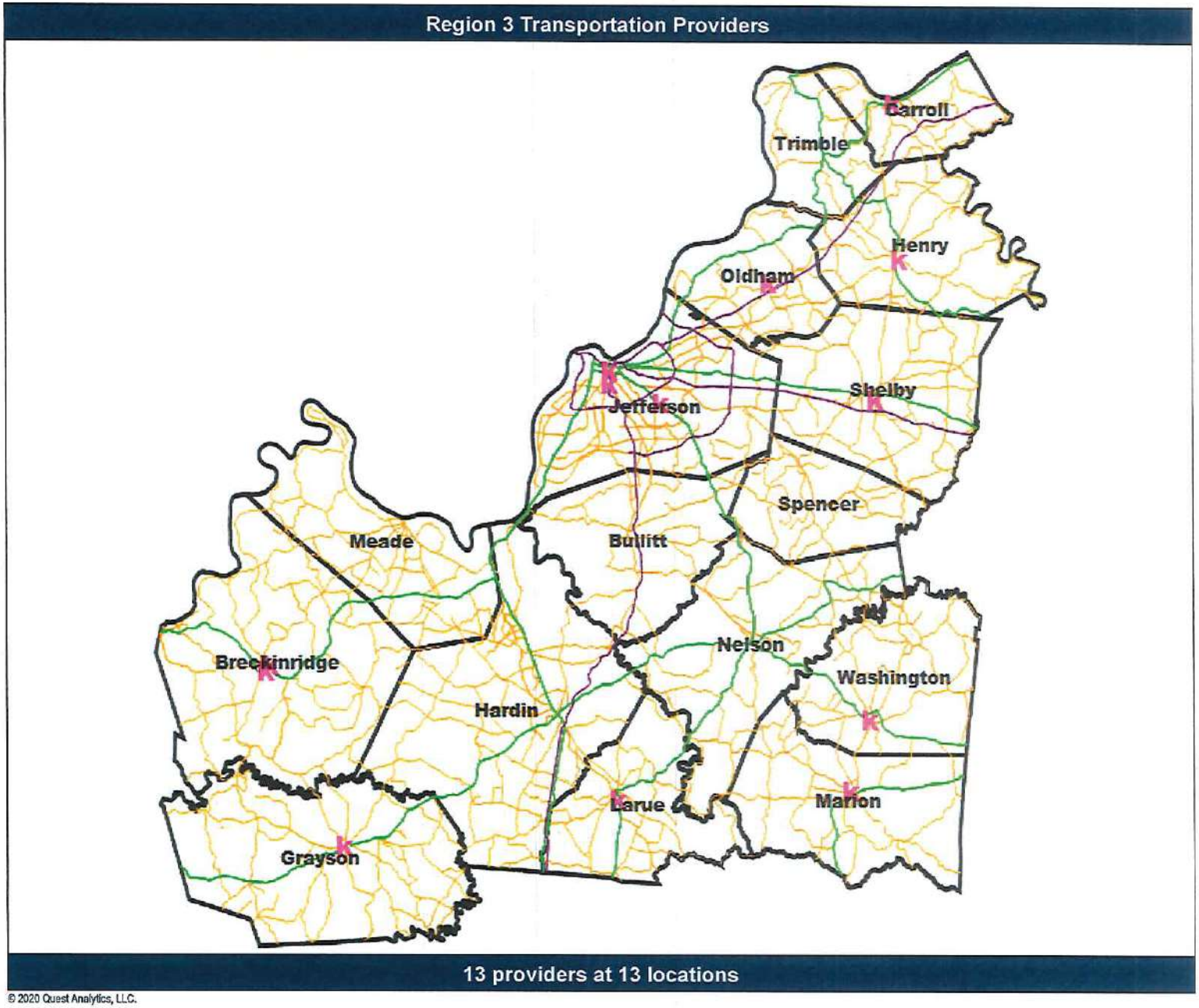

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Transportation Providers) provider in 30 miles

Overall Access[1]

18,130 Members
183 providers at 158 locations (Transportation Providers)

- 18,066 (99.6%) Members with access
- 61 (0.3%) Members without access
- 3 (0.0%) Members excluded

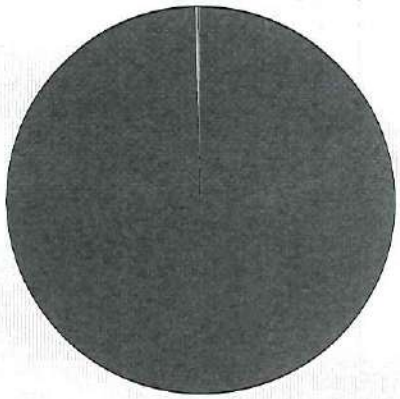

Distances

	Average
Distance to 1st closest provider	7.9 miles
Distance to 2nd closest provider	11.6 miles
Distance to 3rd closest provider	14.6 miles
Distance to 4th closest provider	27.5 miles
Distance to 5th closest provider	30.3 miles

Access Standard Comparison

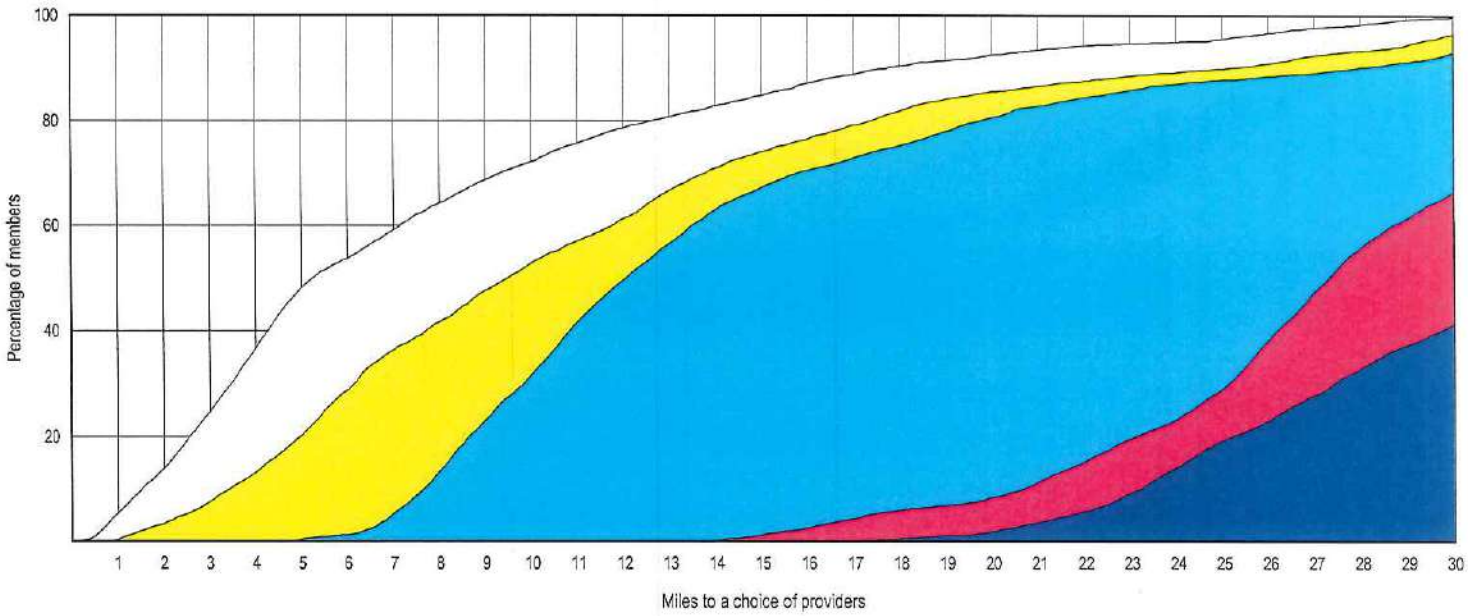

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Transportation Providers) provider in 30 minutes

Overall Access[1]

18,130 Members
163 providers at 158 locations (Transportation Providers)

- 17,502 (96.5%) Members with access
- 625 (3.4%) Members without access
- 3 (0.0%) Members excluded

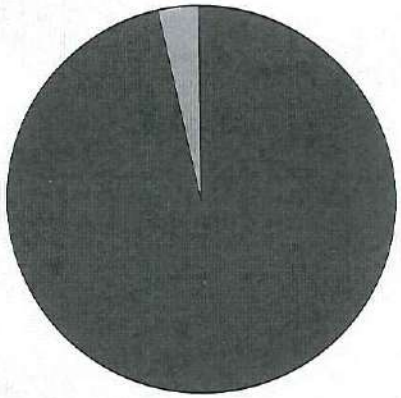

Times

	Average
Time to 1st closest provider	10.6 mins
Time to 2nd closest provider	15.3 mins
Time to 3rd closest provider	20.3 mins
Time to 4th closest provider	33.8 mins
Time to 5th closest provider	37.3 mins

Access Standard Comparison

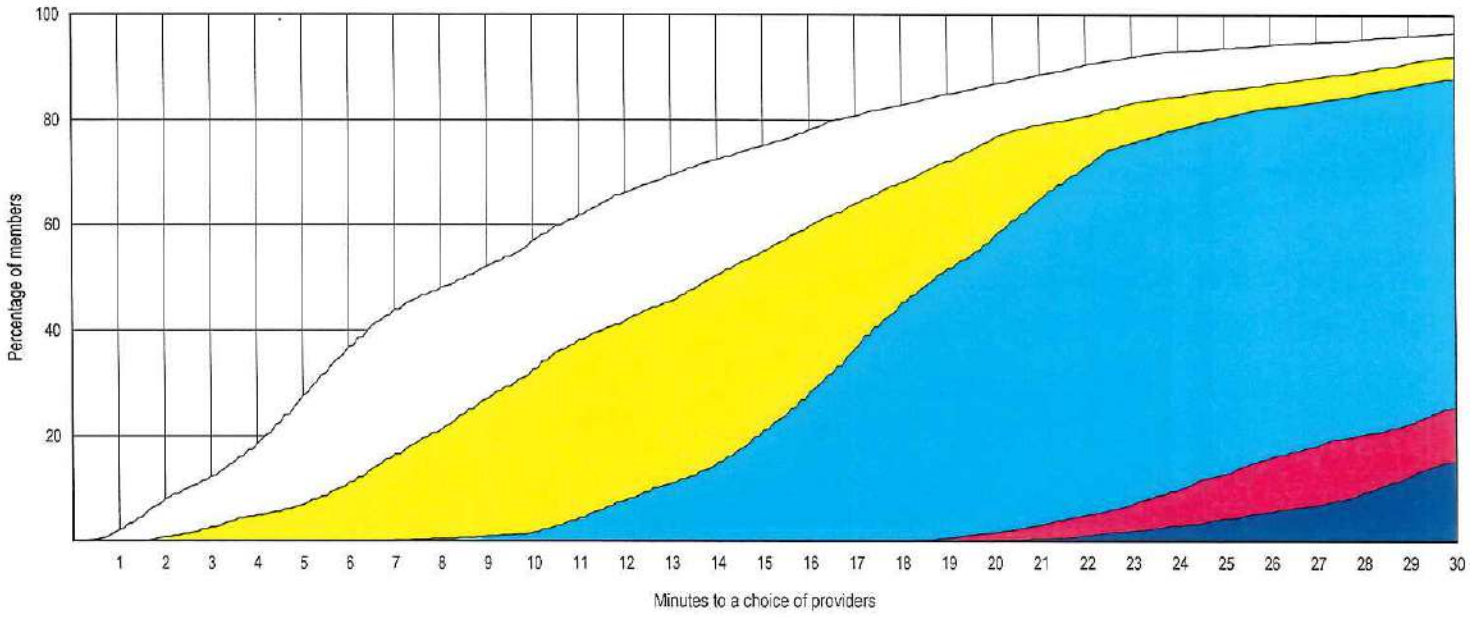

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 miles

Overall Access[1]

1,901 Members
163 providers at 158 locations (Transportation Providers)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

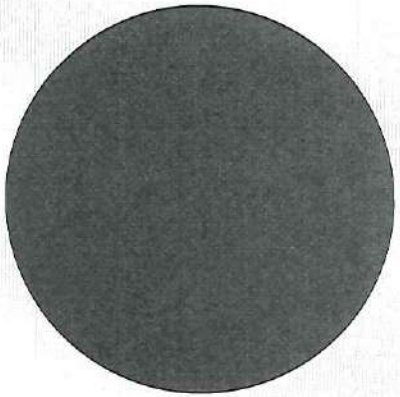

Distances

	Average
Distance to 1st closest provider	7.2 miles
Distance to 2nd closest provider	14.8 miles
Distance to 3rd closest provider	20.3 miles
Distance to 4th closest provider	23.8 miles
Distance to 5th closest provider	27.5 miles

Access Standard Comparison

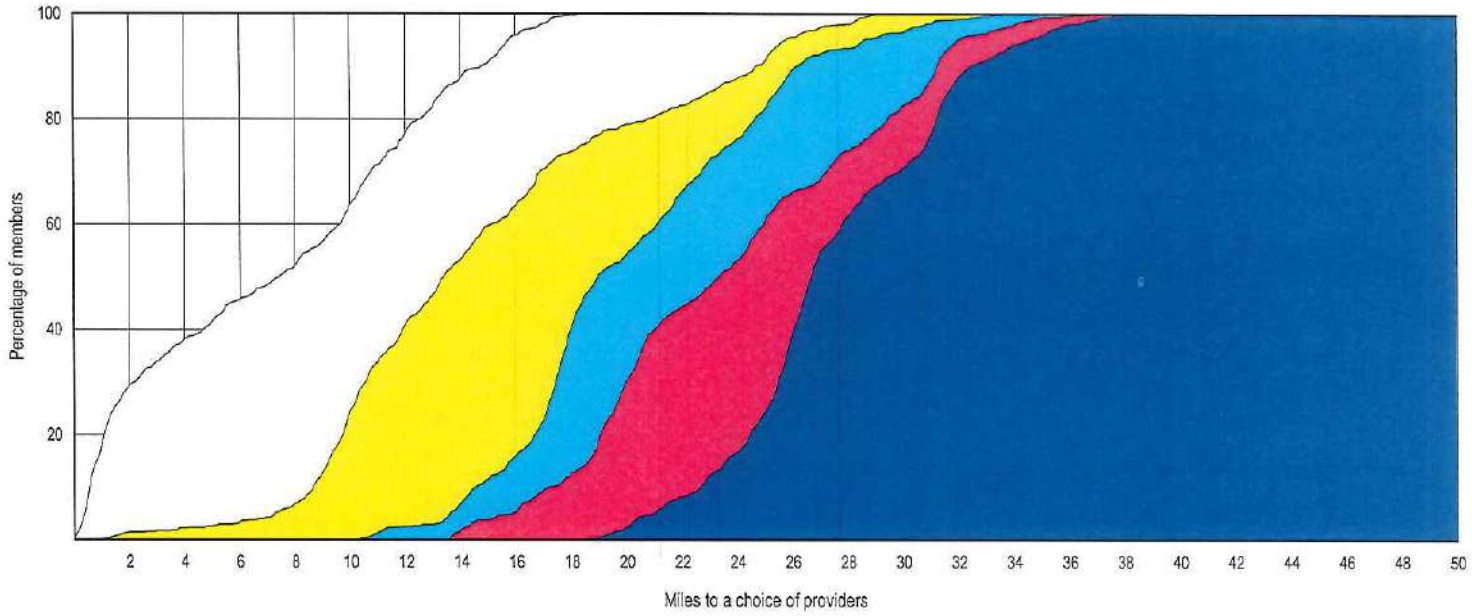

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 minutes

Overall Access[1]

1,901 Members
163 providers at 158 locations (Transportation Providers)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

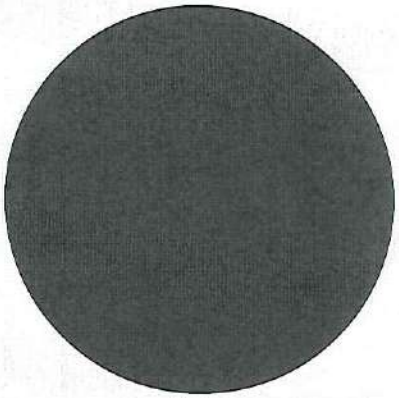

Times

	Average
Time to 1st closest provider	7.8 mins
Time to 2nd closest provider	16.1 mins
Time to 3rd closest provider	22.1 mins
Time to 4th closest provider	25.9 mins
Time to 5th closest provider	30.0 mins

Access Standard Comparison

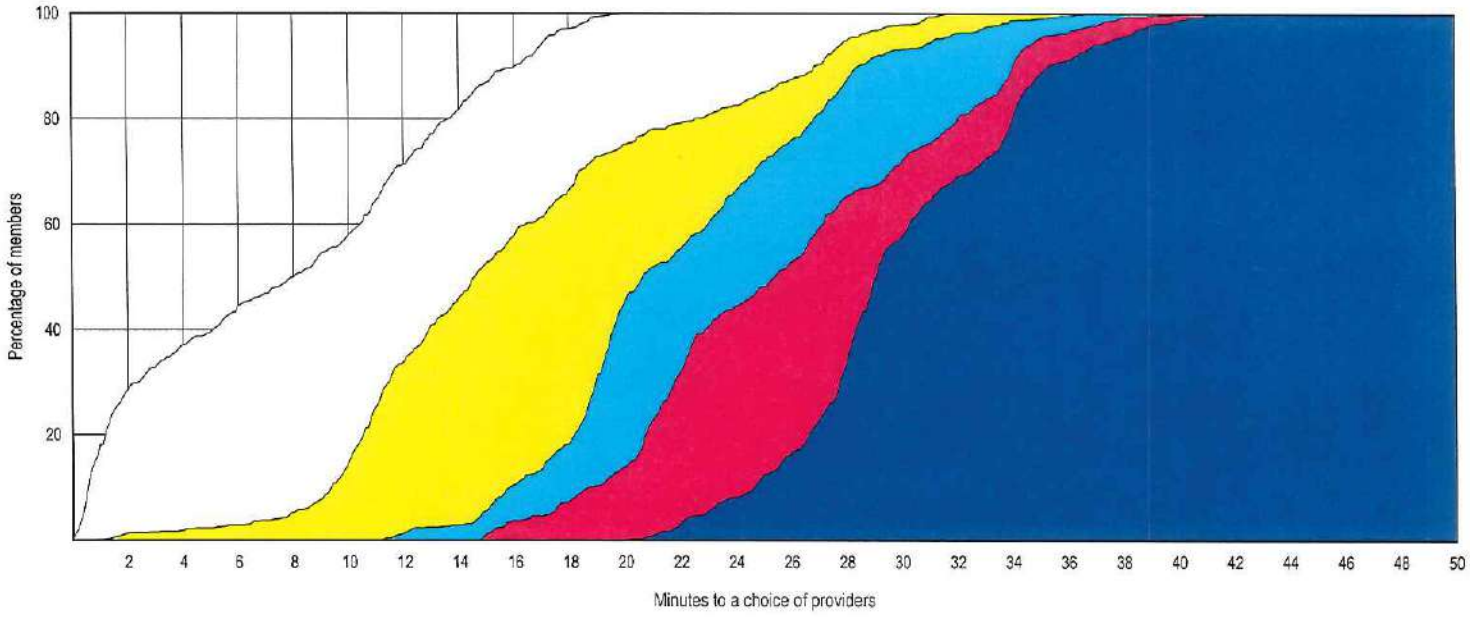

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Provider Locations

January 23, 2020

Region 4 Transportation Providers

Total Providers: 20

k All providers

Interstates

US Highways

State Highways

19.37 miles

Region 4 Transportation Providers

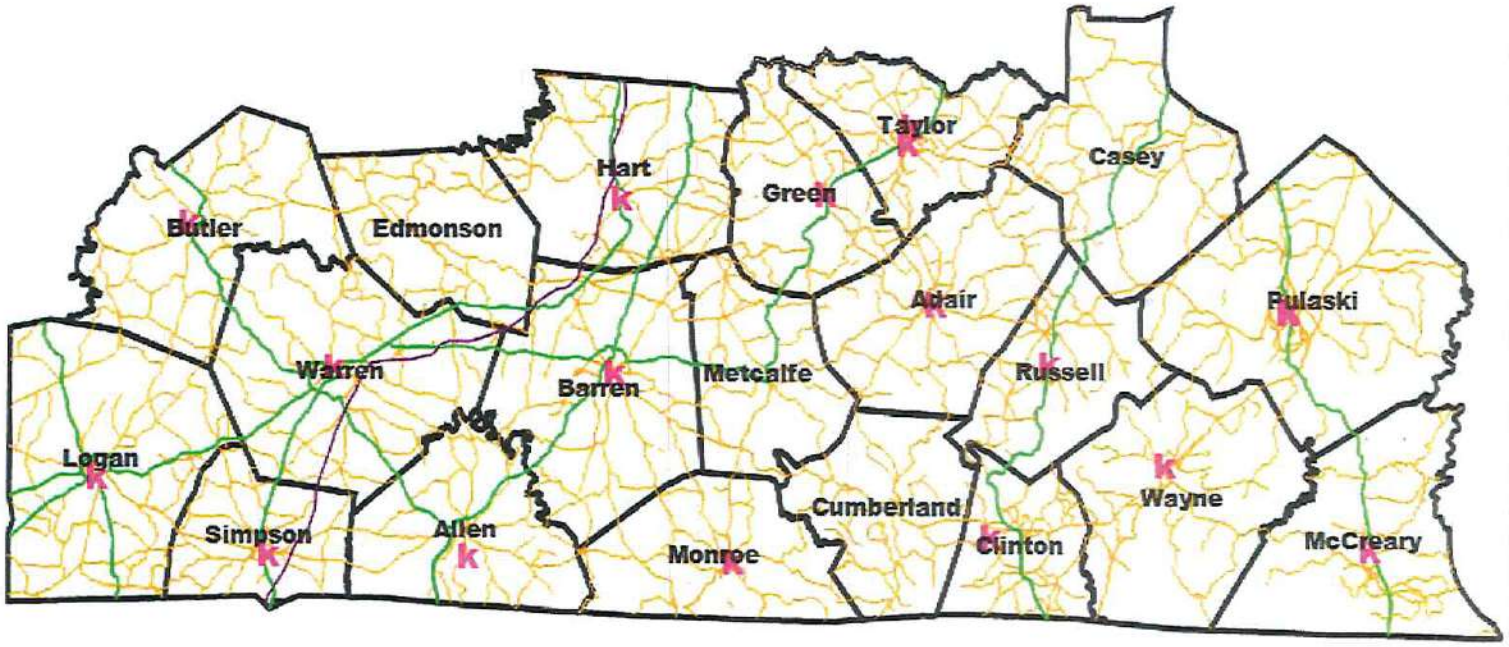

20 providers at 18 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Transportation Providers) provider in 30 miles

Overall Access[1]

7,413 Members
163 providers at 158 locations (Transportation Providers)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

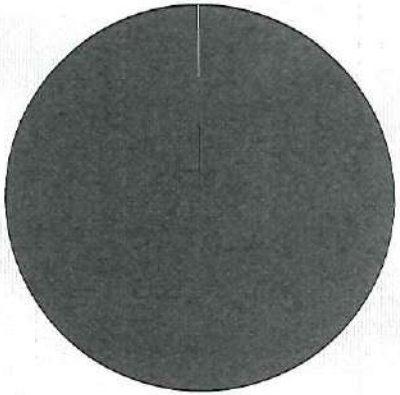

Distances

	Average
Distance to 1st closest provider	6.1 miles
Distance to 2nd closest provider	8.7 miles
Distance to 3rd closest provider	22.0 miles
Distance to 4th closest provider	26.3 miles
Distance to 5th closest provider	28.7 miles

Access Standard Comparison

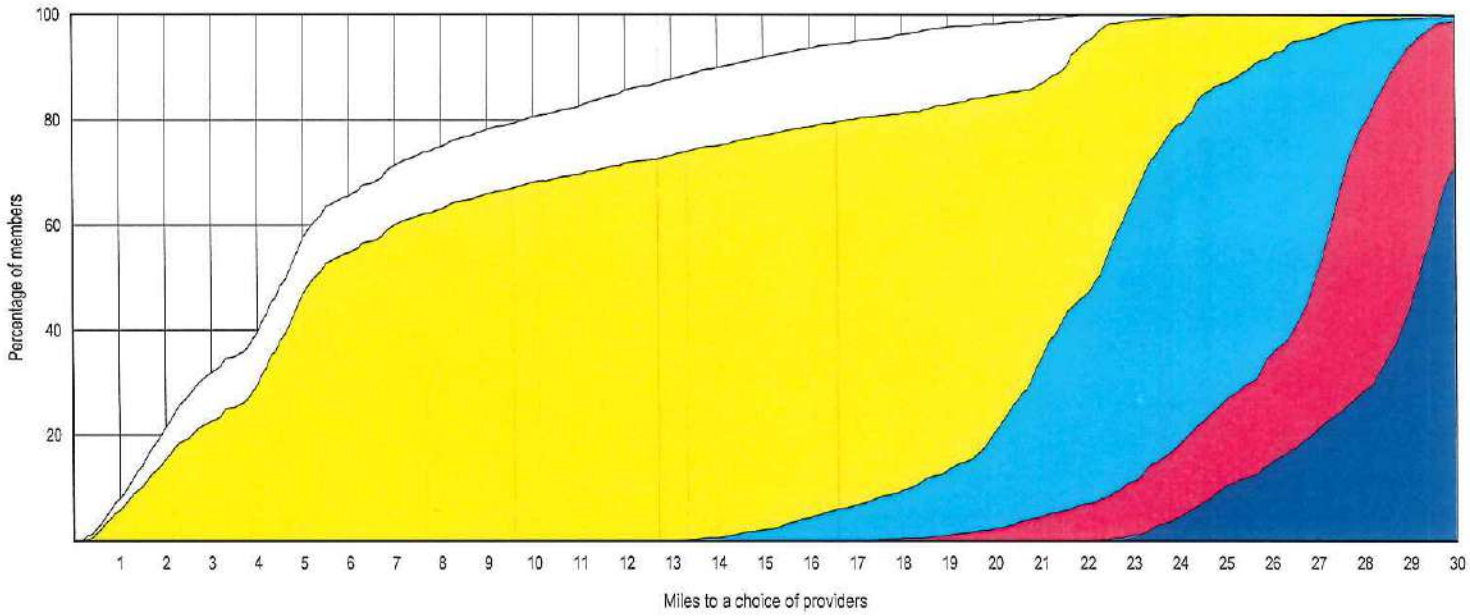

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Access Overview

January 24, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
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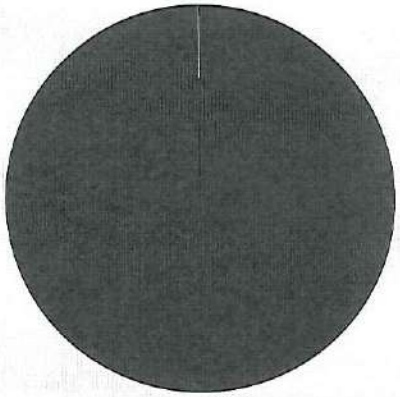

Times

	Average
Time to 1st closest provider	6.6 mins
Time to 2nd closest provider	9.4 mins
Time to 3rd closest provider	23.9 mins
Time to 4th closest provider	28.6 mins
Time to 5th closest provider	31.3 mins

Access Standard Comparison

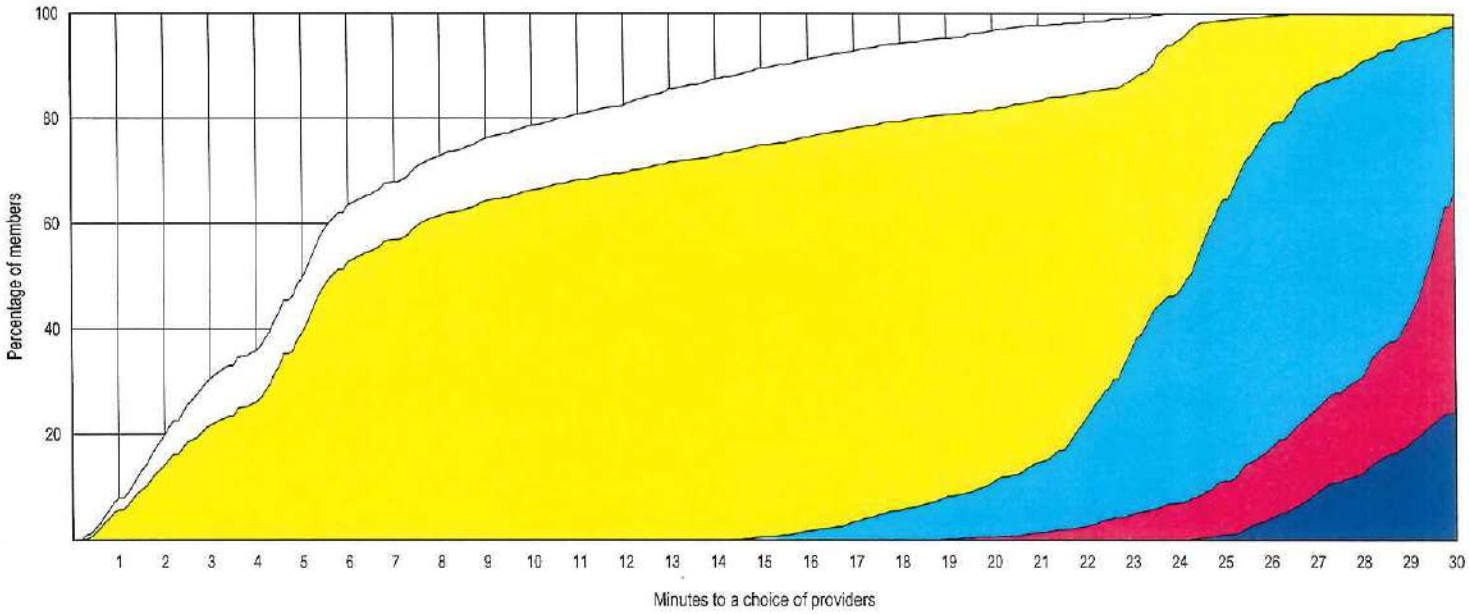

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 miles

Overall Access[1]

28,324 Members
163 providers at 158 locations (Transportation Providers)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

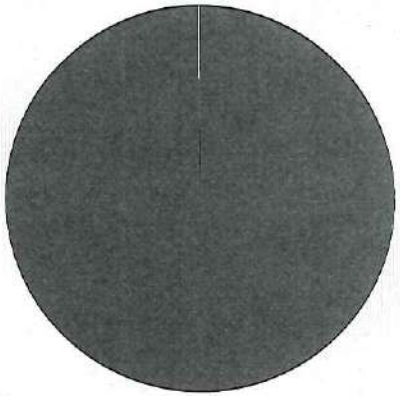

Distances

	Average
Distance to 1st closest provider	7.5 miles
Distance to 2nd closest provider	15.3 miles
Distance to 3rd closest provider	22.5 miles
Distance to 4th closest provider	25.1 miles
Distance to 5th closest provider	27.9 miles

Access Standard Comparison

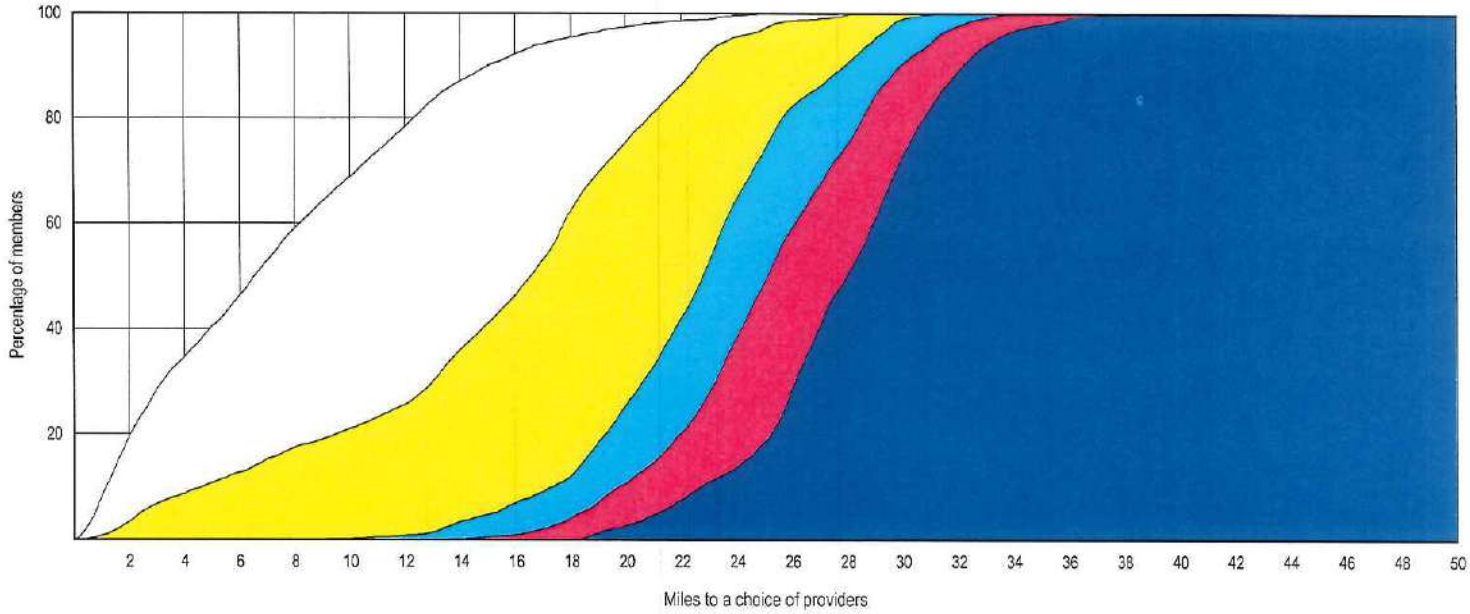

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
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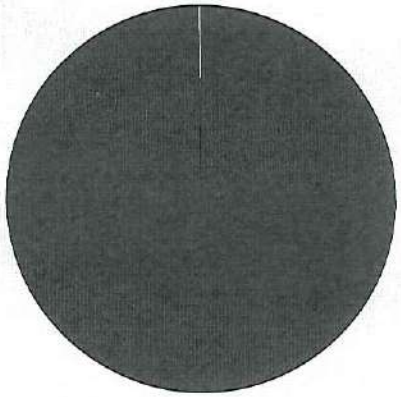

Times

	Average
Time to 1st closest provider	8.1 mins
Time to 2nd closest provider	16.6 mins
Time to 3rd closest provider	24.5 mins
Time to 4th closest provider	27.4 mins
Time to 5th closest provider	30.3 mins

Access Standard Comparison

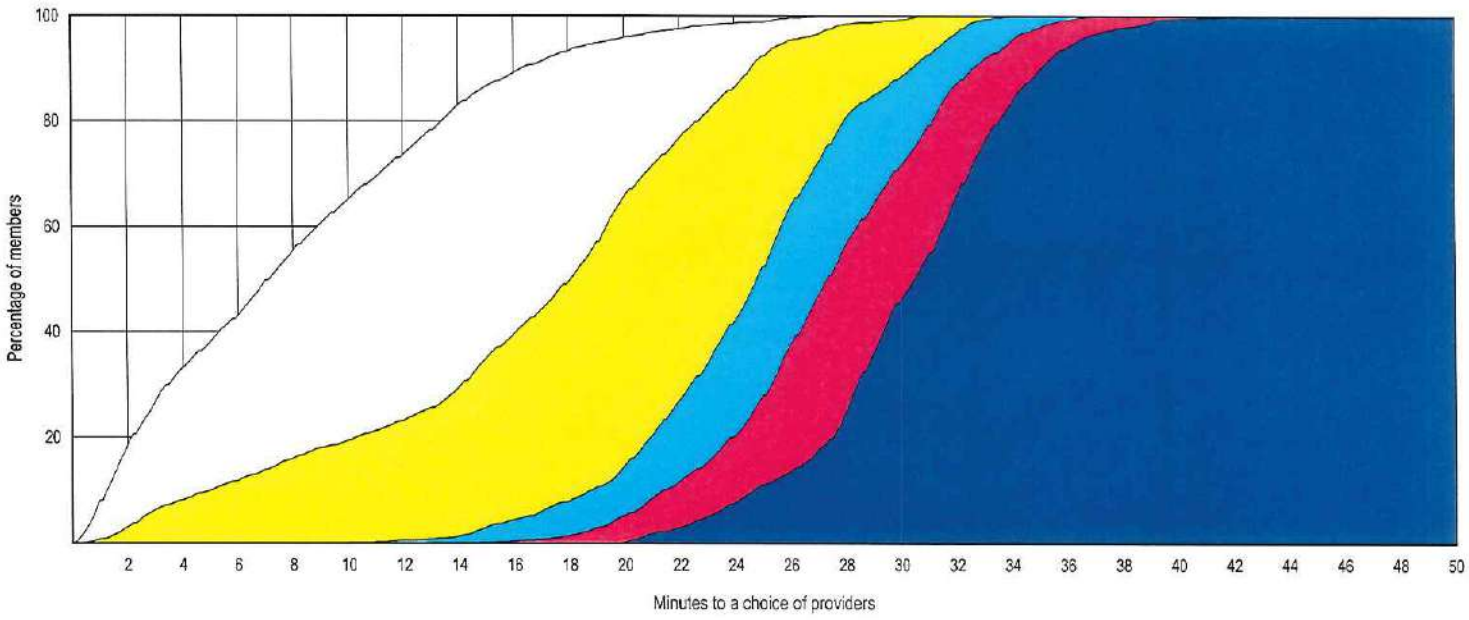

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Provider Locations

January 23, 2020

Region 5 Transportation Providers

Total Providers: 21

k All providers

Interstates

US Highways

State Highways

17.44 miles

Region 5 Transportation Providers

21 providers at 21 locations

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Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Transportation Providers) provider in 30 miles

Overall Access[1]

22,712 Members
163 providers at 158 locations (Transportation Providers)

- 22,696 (99.9%) Members with access
- 0 (0.0%) Members without access
- 16 (0.1%) Members excluded

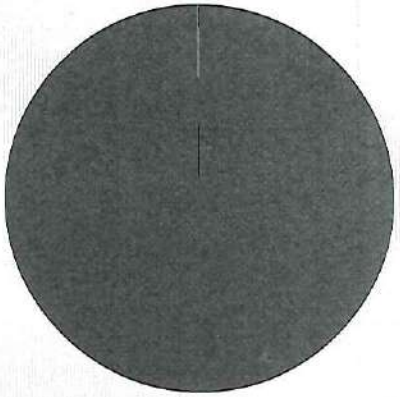

Distances

	Average
Distance to 1st closest provider	5.8 miles
Distance to 2nd closest provider	8.6 miles
Distance to 3rd closest provider	9.7 miles
Distance to 4th closest provider	10.3 miles
Distance to 5th closest provider	11.1 miles

Access Standard Comparison

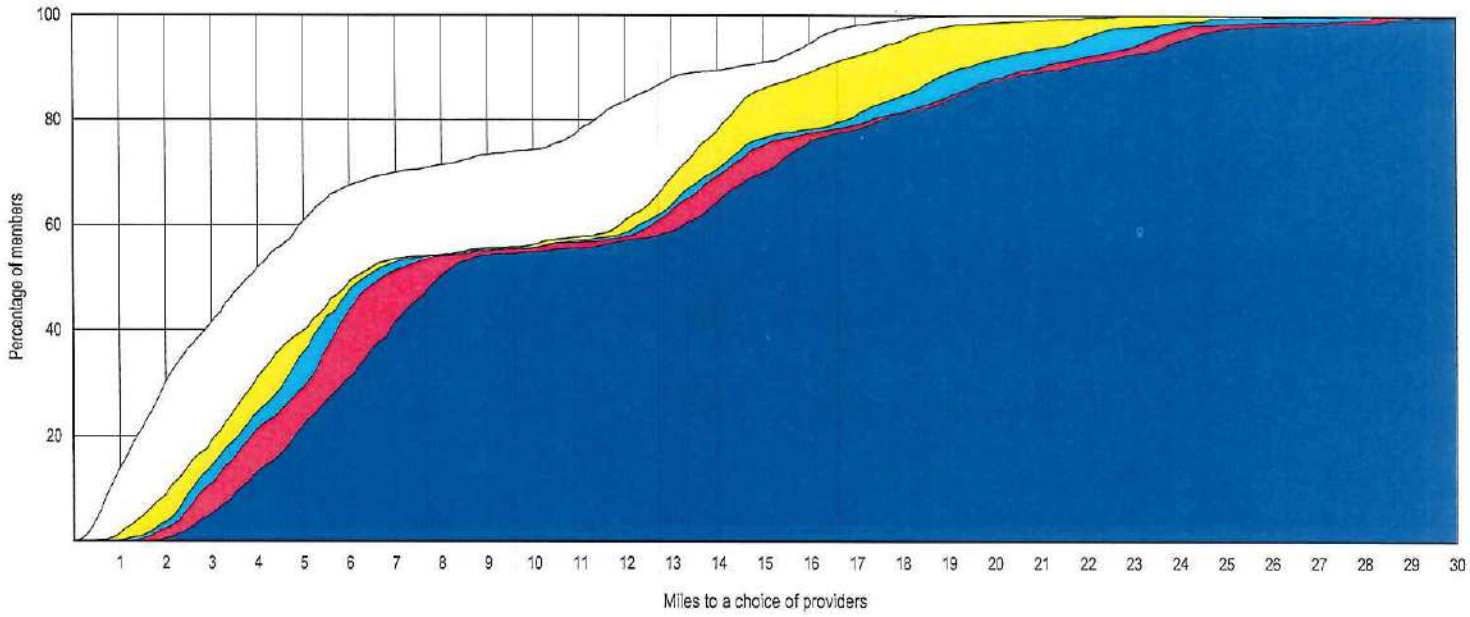

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Transportation Providers) provider in 30 minutes

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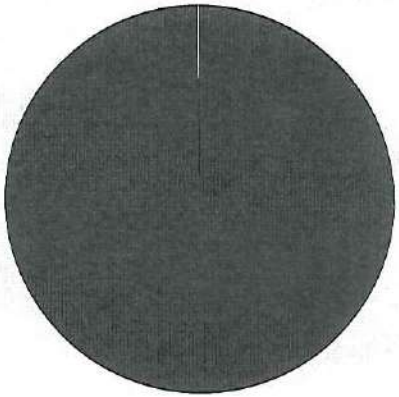

Times

	Average
Time to 1st closest provider	7.8 mins
Time to 2nd closest provider	11.7 mins
Time to 3rd closest provider	13.7 mins
Time to 4th closest provider	14.7 mins
Time to 5th closest provider	16.1 mins

Access Standard Comparison

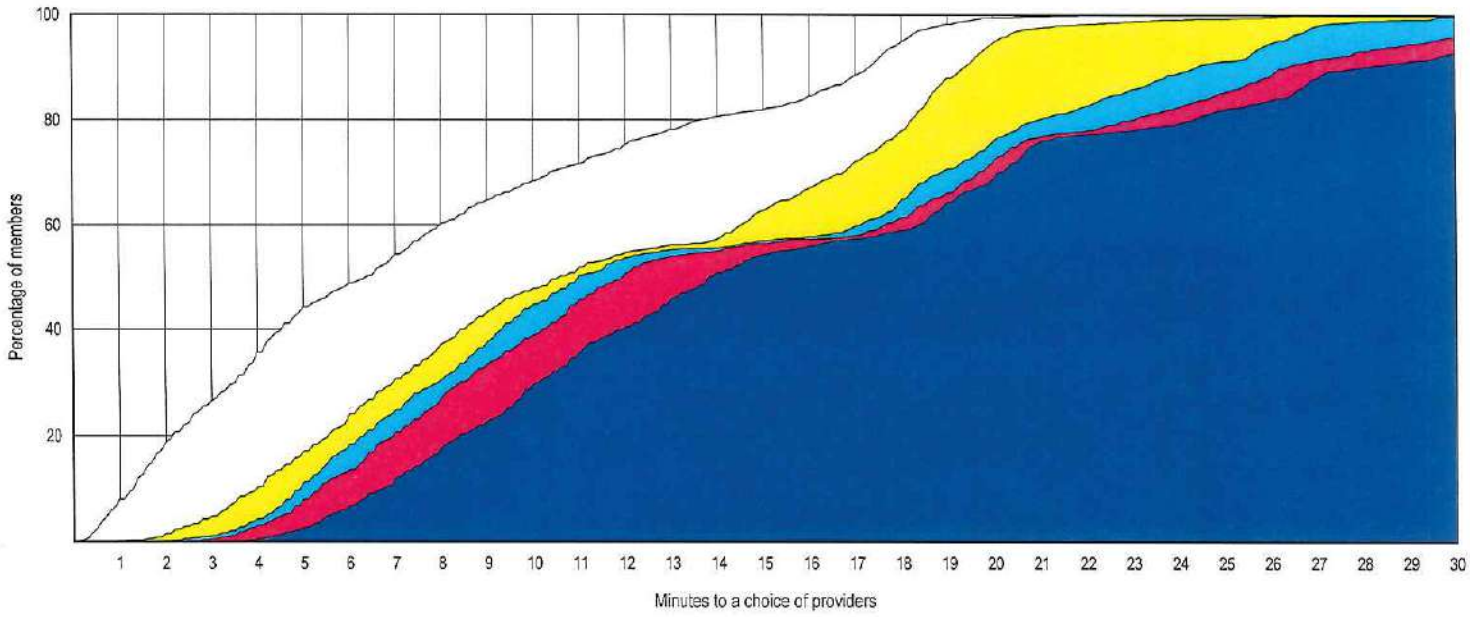

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Rural - 1 in 50 miles

Member / Provider Groups
Region 5 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 miles

Overall Access[1]

23,127 Members
163 providers at 158 locations (Transportation Providers)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

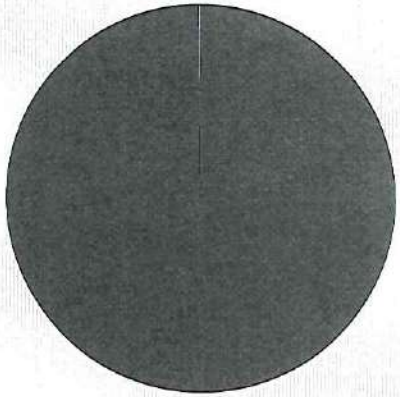

Distances

	Average
Distance to 1st closest provider	6.1 miles
Distance to 2nd closest provider	14.8 miles
Distance to 3rd closest provider	19.0 miles
Distance to 4th closest provider	22.1 miles
Distance to 5th closest provider	24.4 miles

Access Standard Comparison

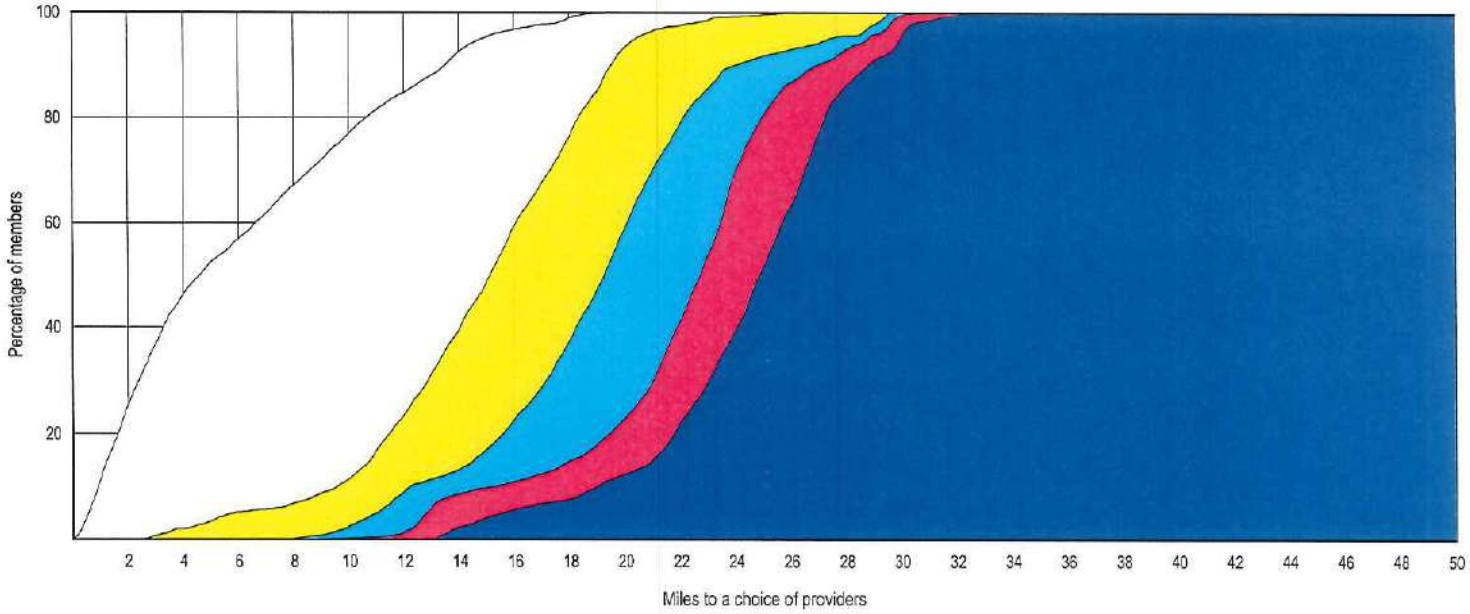

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

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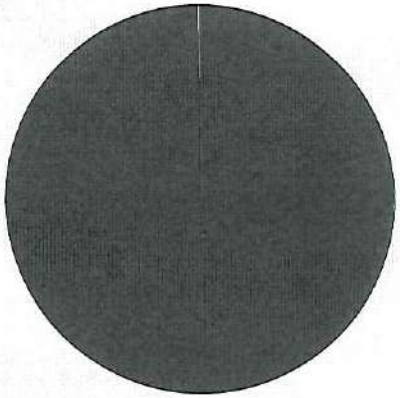

Times

	Average
Time to 1st closest provider	6.6 mins
Time to 2nd closest provider	16.1 mins
Time to 3rd closest provider	20.8 mins
Time to 4th closest provider	24.4 mins
Time to 5th closest provider	27.3 mins

Access Standard Comparison

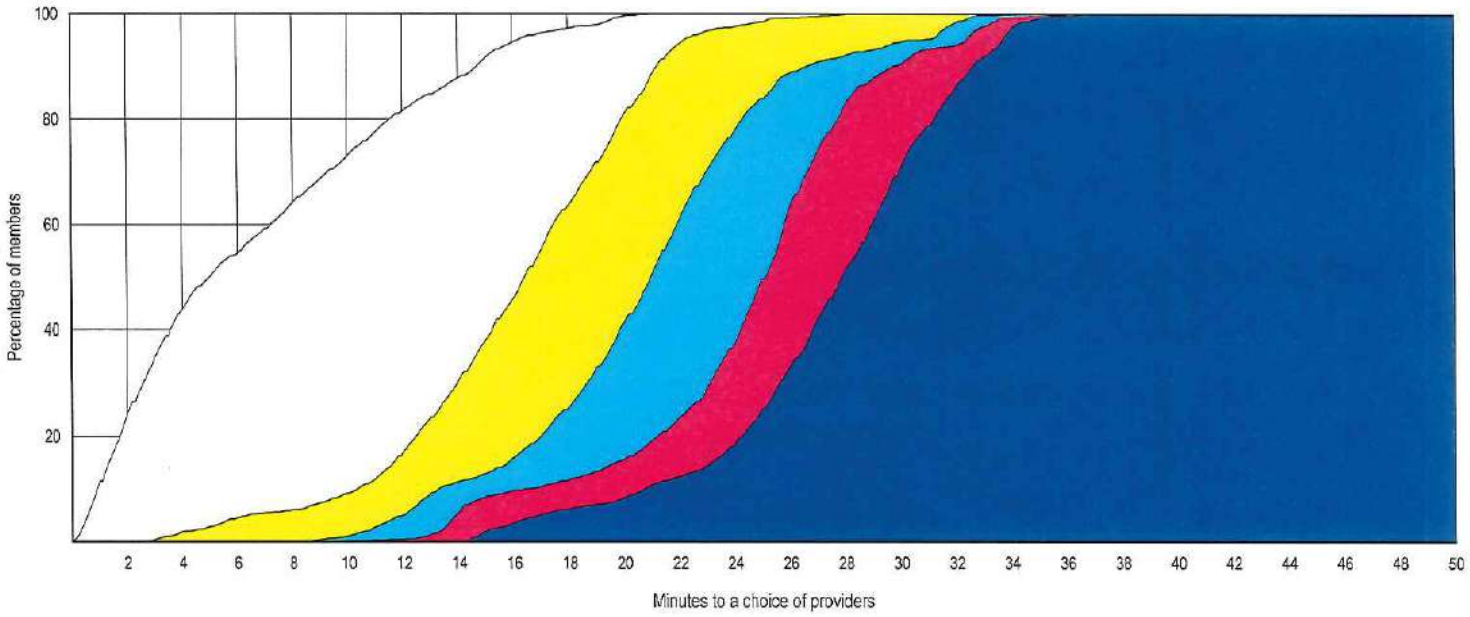

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Provider Locations

January 23, 2020

Region 6 Transportation Providers

Total Providers: 22

k All providers

Interstates

US Highways

State Highways

7.48 miles

Region 6 Transportation Providers

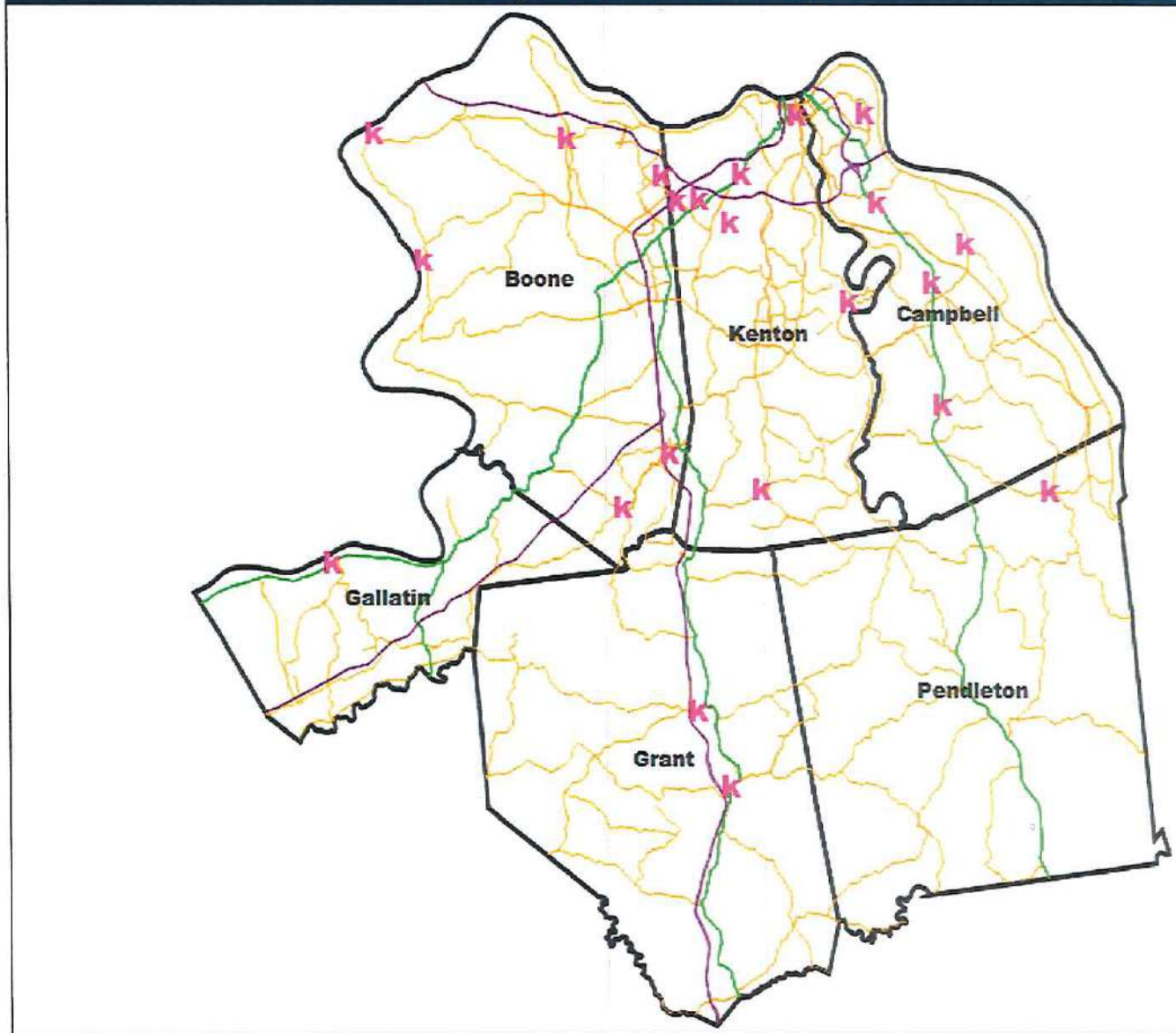

22 providers at 22 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Transportation Providers) provider in 30 miles

Overall Access[1]

22,413 Members
163 providers at 158 locations (Transportation Providers)

- 22,406 (99.9%) Members with access
- 0 (0.0%) Members without access
- 7 (0.0%) Members excluded

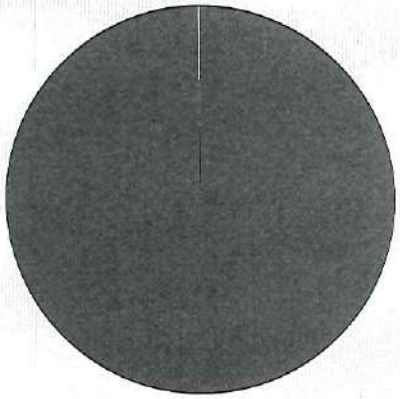

Distances

	Average
Distance to 1st closest provider	3.3 miles
Distance to 2nd closest provider	5.0 miles
Distance to 3rd closest provider	6.4 miles
Distance to 4th closest provider	7.6 miles
Distance to 5th closest provider	8.8 miles

Access Standard Comparison

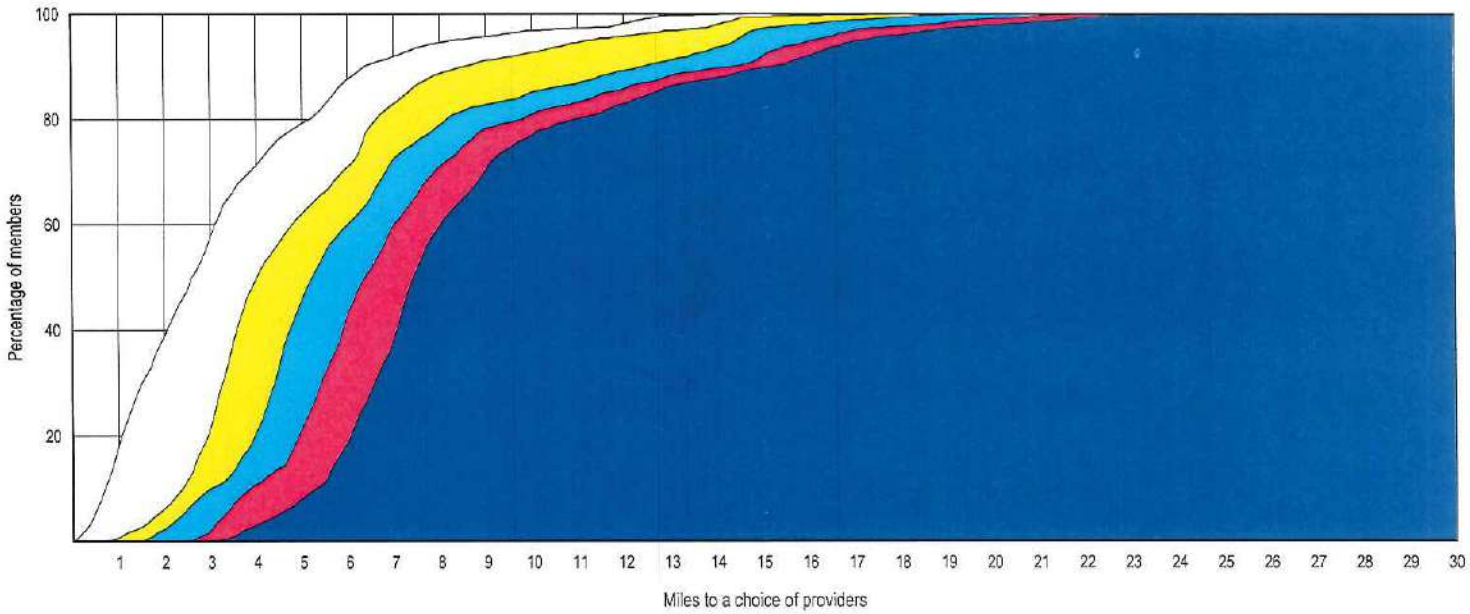

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 6 Urban - 1 in 30 minutes

Member / Provider Groups
Region 6 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
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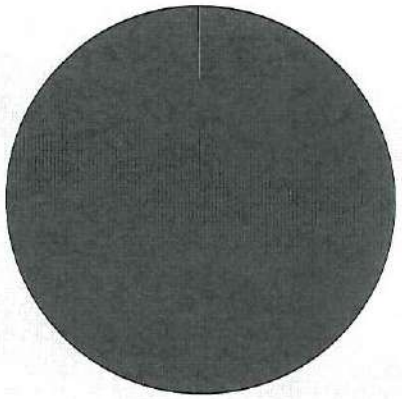

Times

	Average
Time to 1st closest provider	4.1 mins
Time to 2nd closest provider	6.2 mins
Time to 3rd closest provider	8.0 mins
Time to 4th closest provider	9.5 mins
Time to 5th closest provider	10.8 mins

Access Standard Comparison

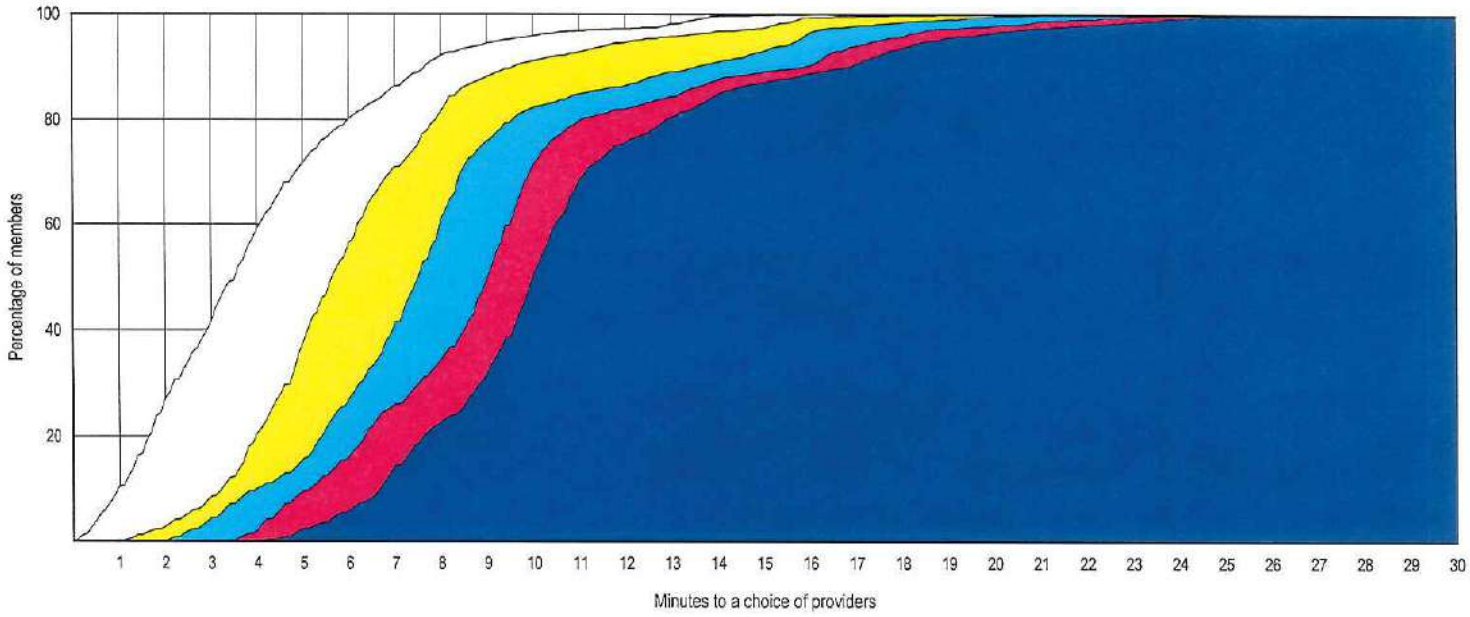

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Provider Locations

January 23, 2020

Region 7 Transportation Providers

Total Providers: 12

k All providers

Interstates

US Highways

State Highways

12.36 miles

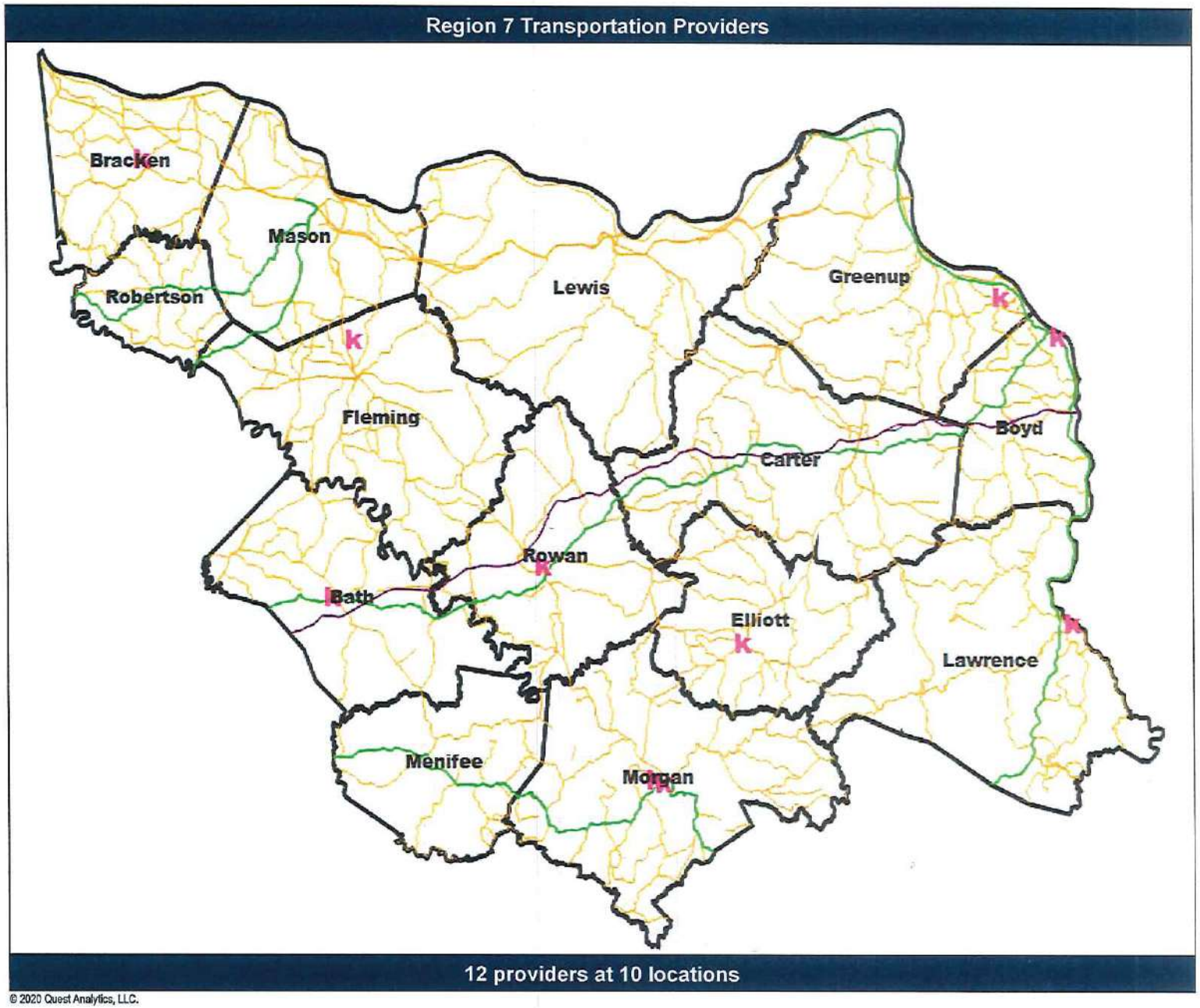

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Transportation Providers) provider in 30 miles

Overall Access[1]

2,907 Members
163 providers at 158 locations (Transportation Providers)

- 2,905 (99.9%) Members with access
- 0 (0.0%) Members without access
- 2 (0.1%) Members excluded

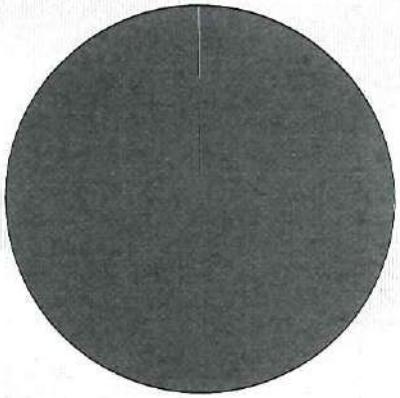

Distances

	Average
Distance to 1st closest provider	5.0 miles
Distance to 2nd closest provider	9.0 miles
Distance to 3rd closest provider	12.6 miles
Distance to 4th closest provider	14.6 miles
Distance to 5th closest provider	15.7 miles

Access Standard Comparison

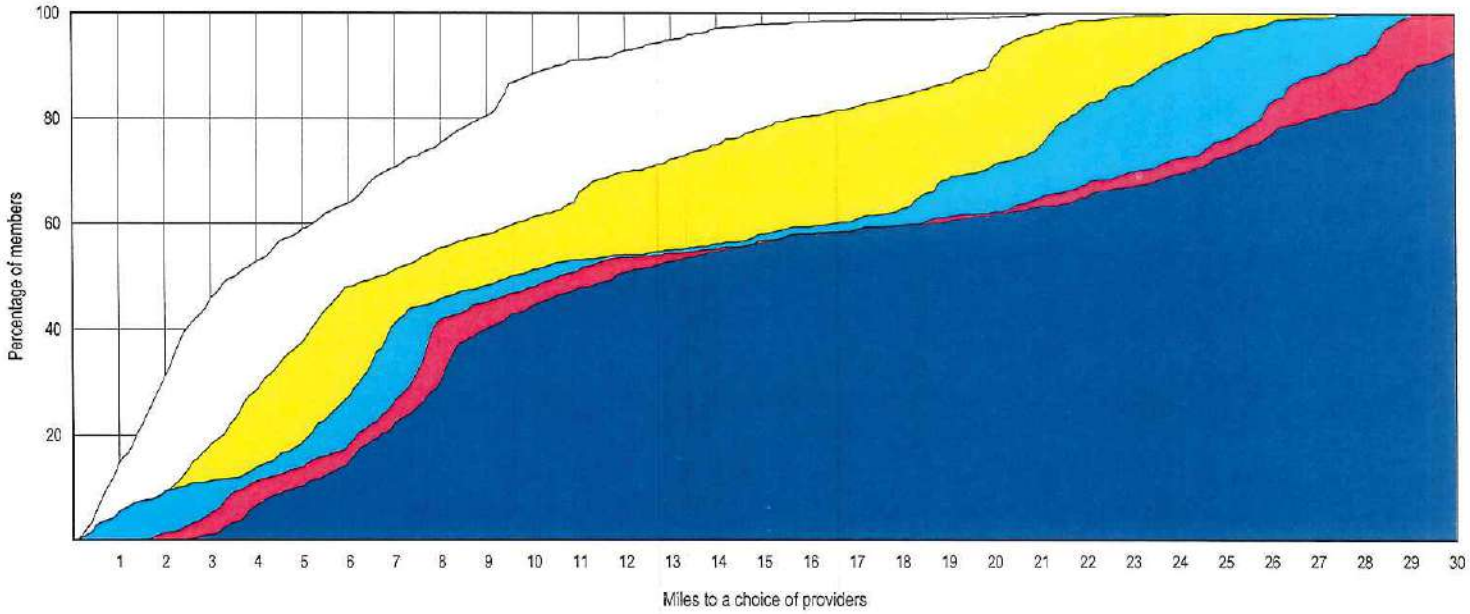

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Access Overview

January 24, 2020

Access Analysis
Region 7 Urban - 1 in 30 minutes

Member / Provider Groups
Region 7 Urban Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

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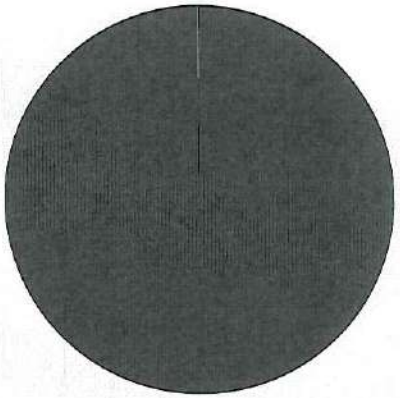

Times

	Average
Time to 1st closest provider	5.5 mins
Time to 2nd closest provider	9.9 mins
Time to 3rd closest provider	13.8 mins
Time to 4th closest provider	16.0 mins
Time to 5th closest provider	17.2 mins

Access Standard Comparison

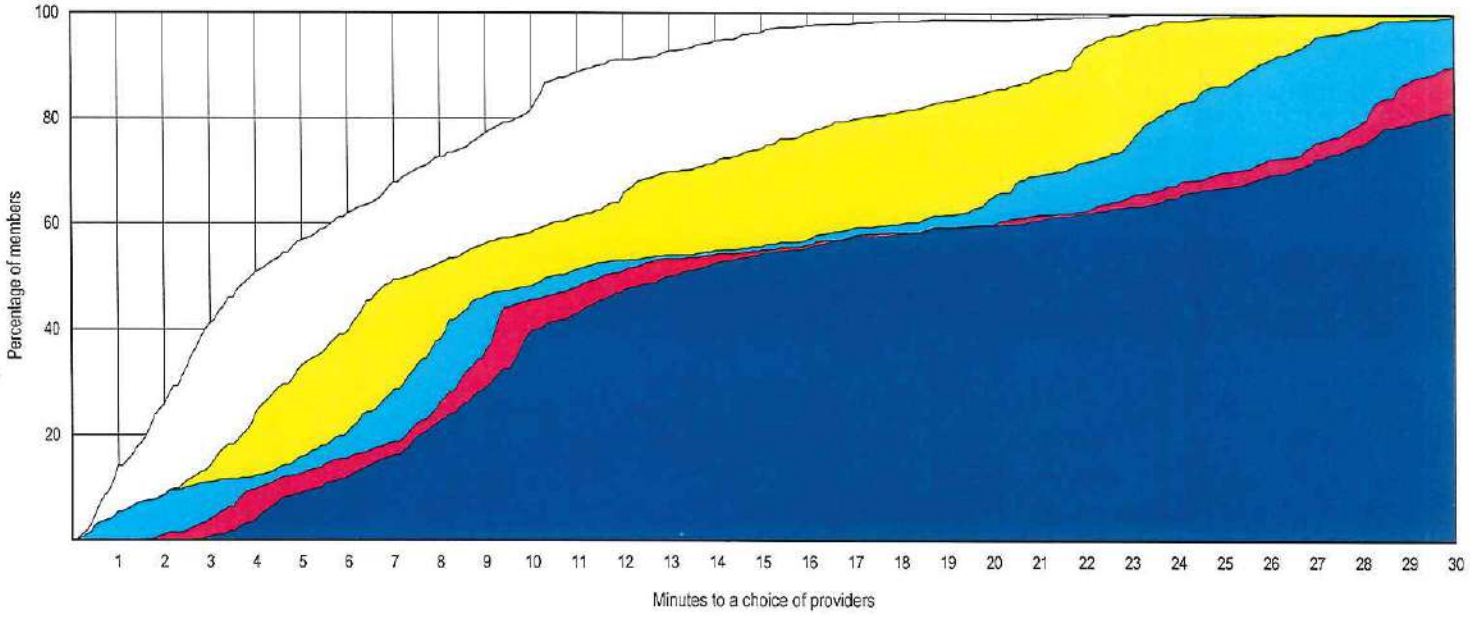

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 miles

Overall Access[1]

10,408 Members
163 providers at 158 locations (Transportation Providers)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

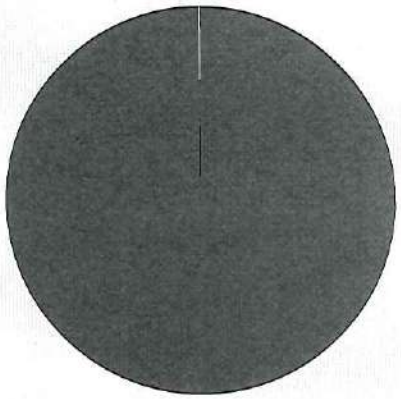

Distances

	Average
Distance to 1st closest provider	10.9 miles
Distance to 2nd closest provider	18.3 miles
Distance to 3rd closest provider	22.8 miles
Distance to 4th closest provider	27.2 miles
Distance to 5th closest provider	29.6 miles

Access Standard Comparison

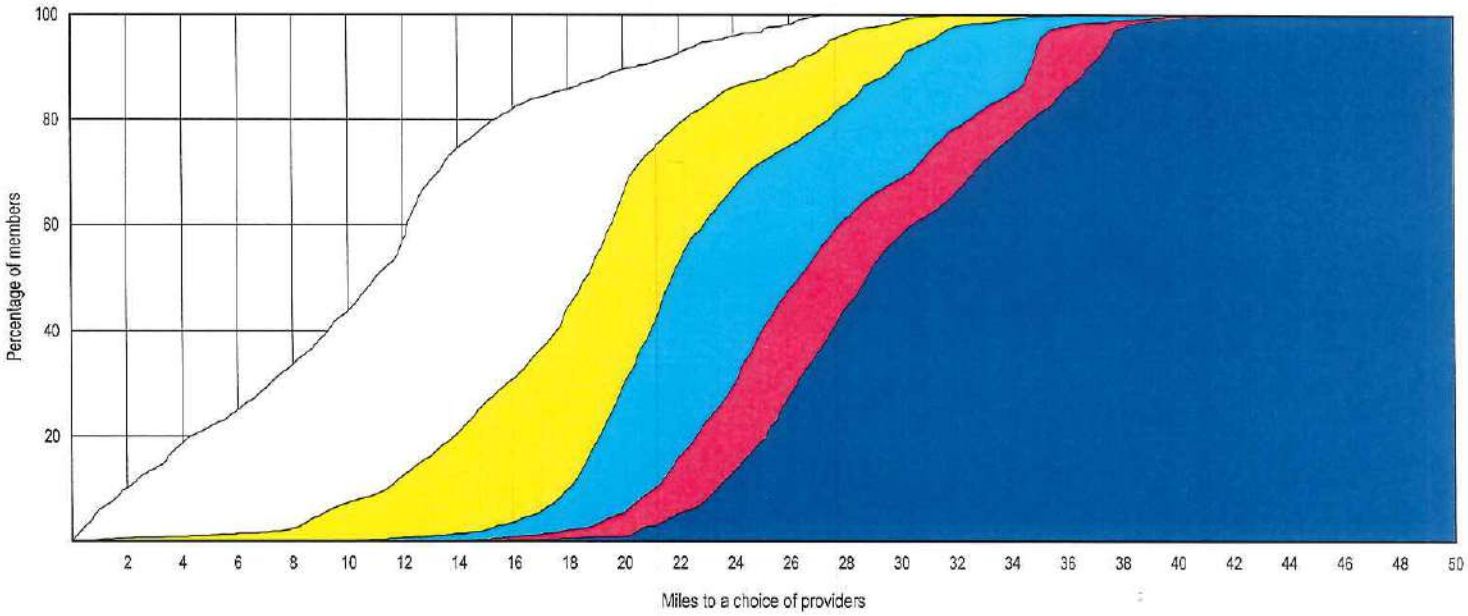

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Access Overview

January 24, 2020

Access Analysis
Region 7 Rural - 1 in 50 minutes

Member / Provider Groups
Region 7 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 minutes

Overall Access[1]

10,408 Members
163 providers at 158 locations (Transportation Providers)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

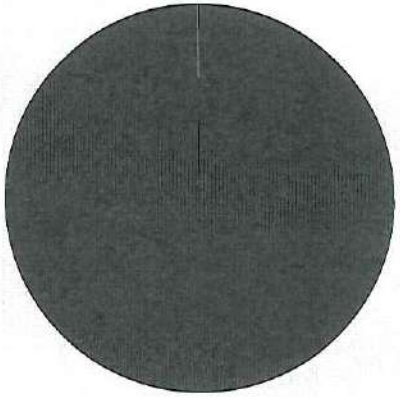

Times

	Average
Time to 1st closest provider	11.8 mins
Time to 2nd closest provider	19.9 mins
Time to 3rd closest provider	24.9 mins
Time to 4th closest provider	29.6 mins
Time to 5th closest provider	32.2 mins

Access Standard Comparison

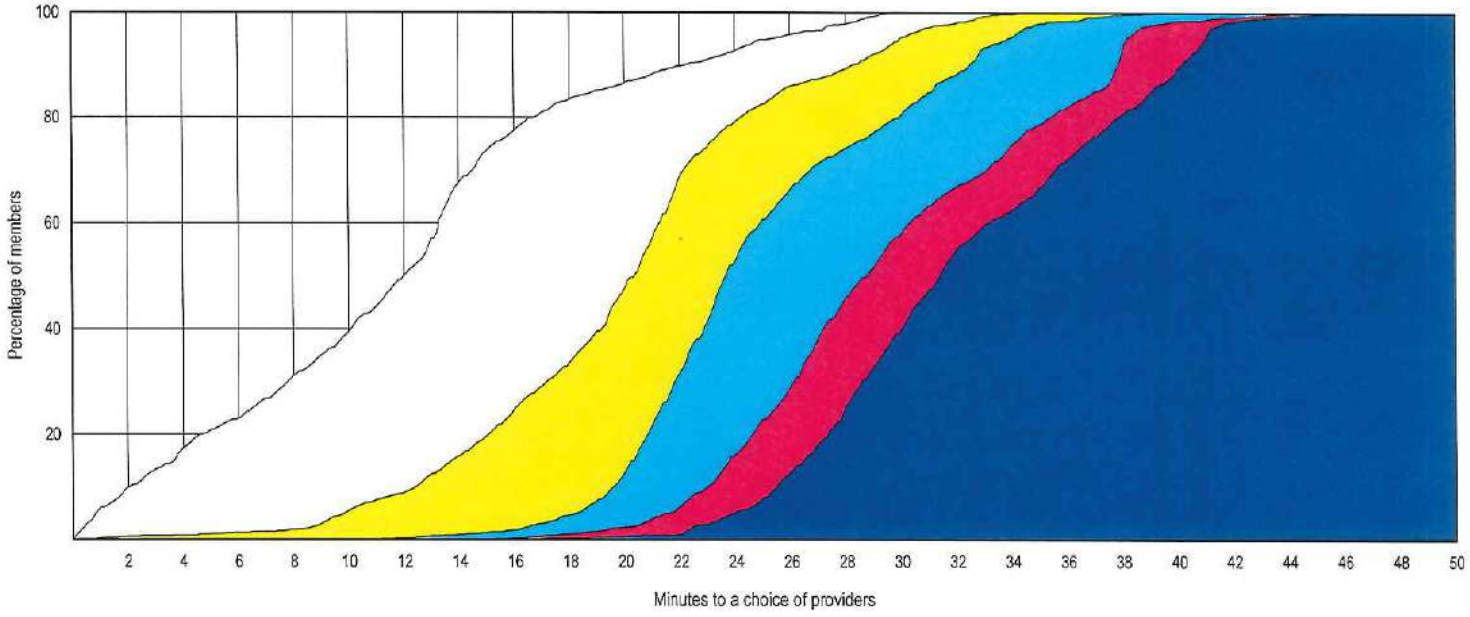

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Provider Locations

January 23, 2020

Region 8 Transportation Providers

Total Providers: 21

k All providers

Interstates

US Highways

State Highways

16.38 miles

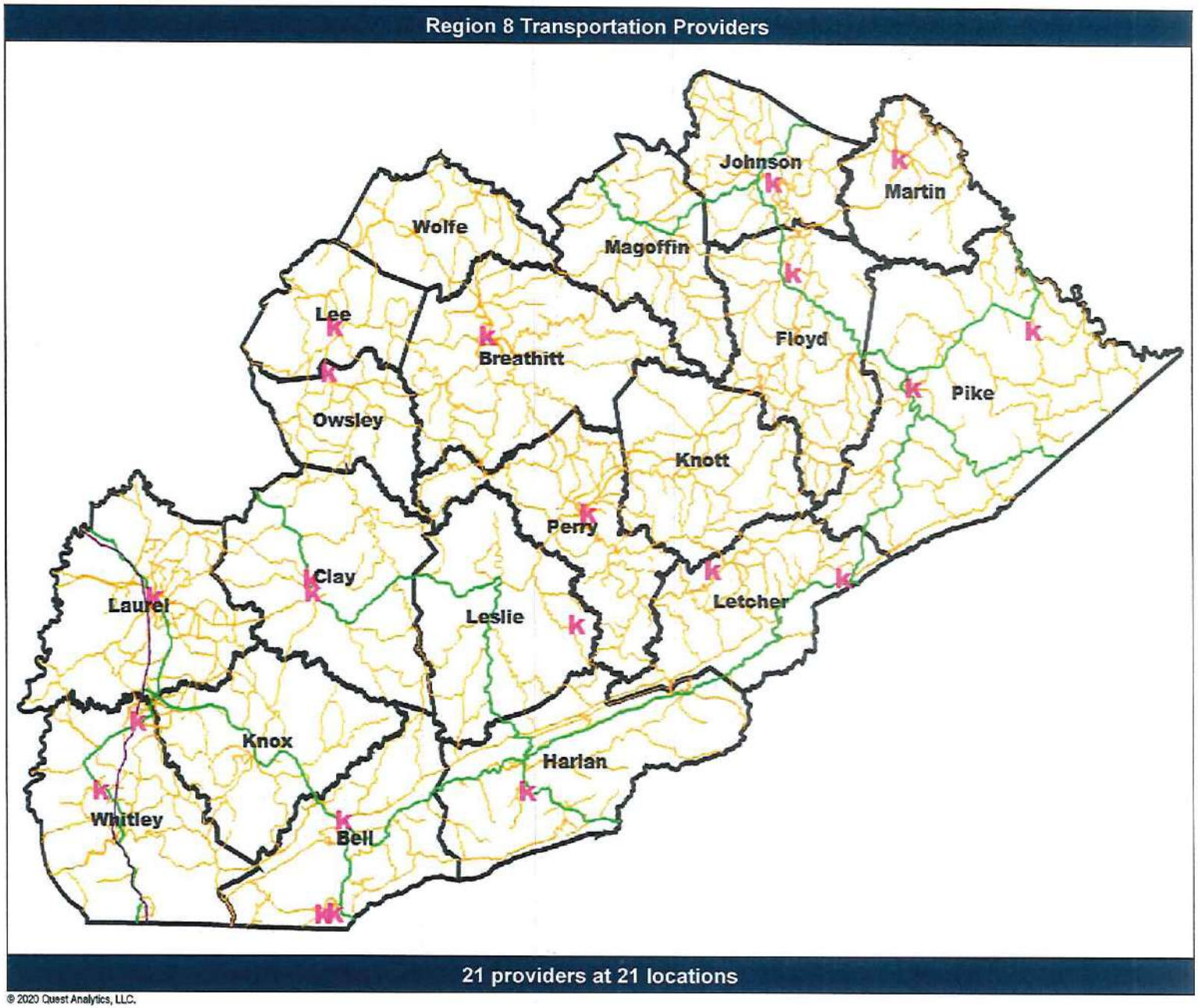

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Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 miles

Overall Access[1]

31,600 Members
163 providers at 158 locations (Transportation Providers)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

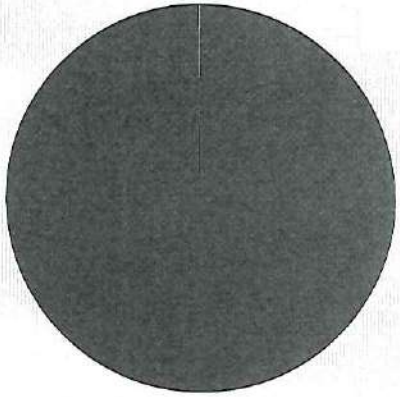

Times

	Average
Distance to 1st closest provider	8.3 miles
Distance to 2nd closest provider	15.1 miles
Distance to 3rd closest provider	20.6 miles
Distance to 4th closest provider	25.4 miles
Distance to 5th closest provider	28.0 miles

Access Standard Comparison

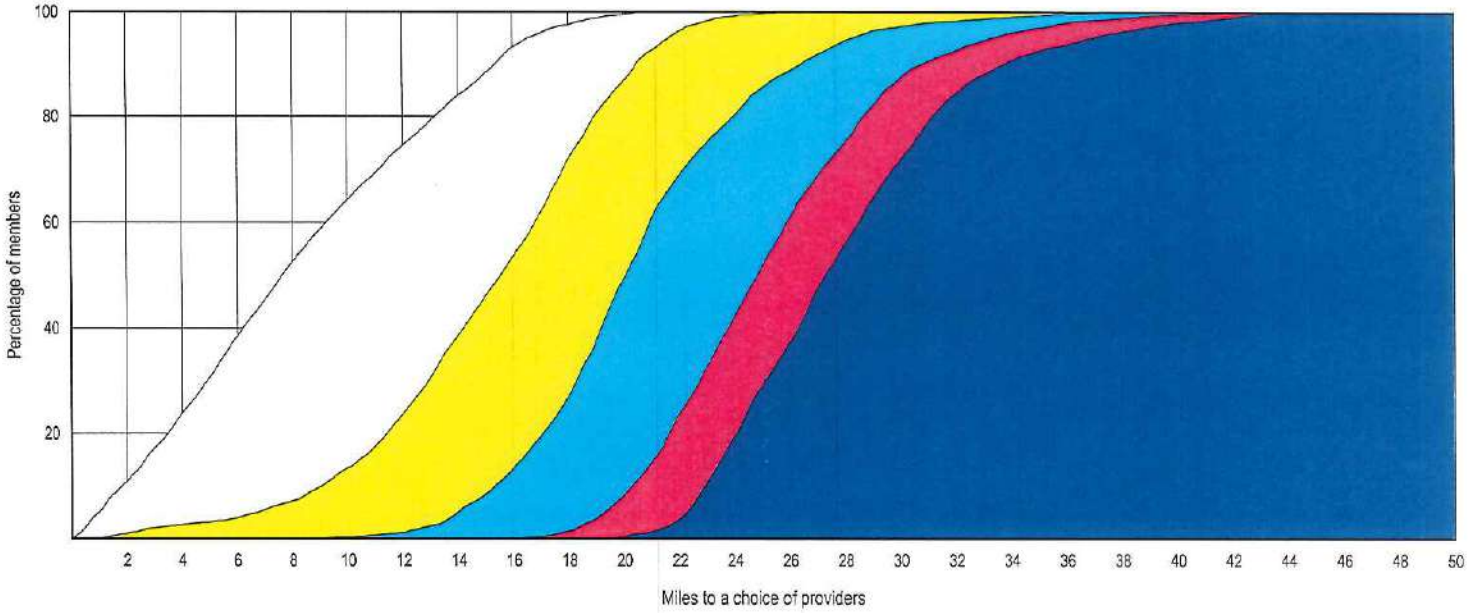

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Transportation Providers

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Transportation Providers) provider in 50 minutes

Overall Access[1]

31,600 Members
163 providers at 158 locations (Transportation Providers)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

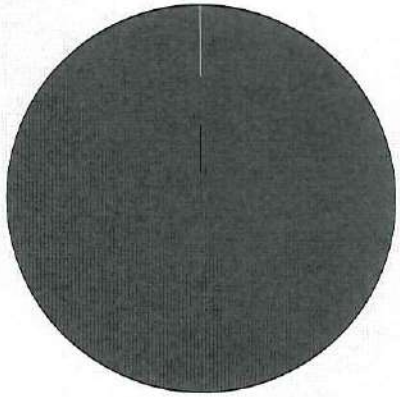

Times

	Average
Time to 1st closest provider	9.0 mins
Time to 2nd closest provider	16.4 mins
Time to 3rd closest provider	22.4 mins
Time to 4th closest provider	27.6 mins
Time to 5th closest provider	30.5 mins

Access Standard Comparison

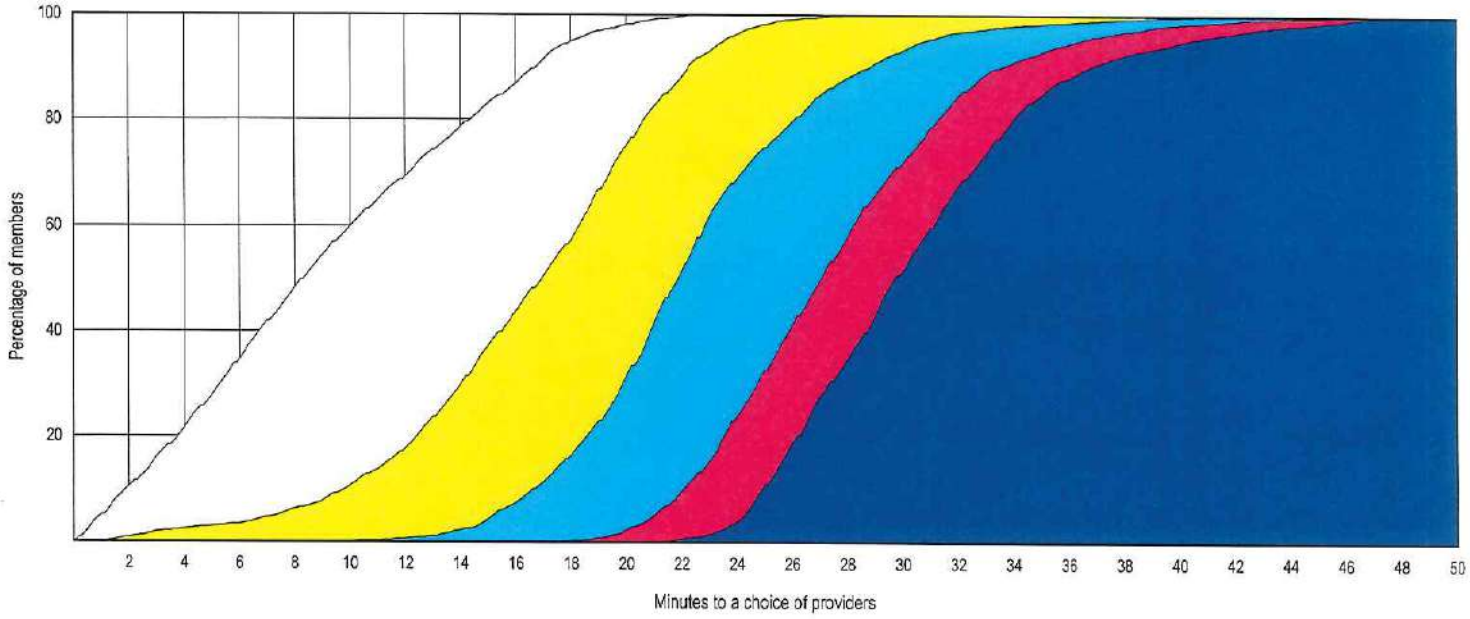

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Provider Locations

January 23, 2020

Region 1 Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special

Total Providers: 4

m All providers

Interstates

US Highways

State Highways

12.93 miles

ndividual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Specia

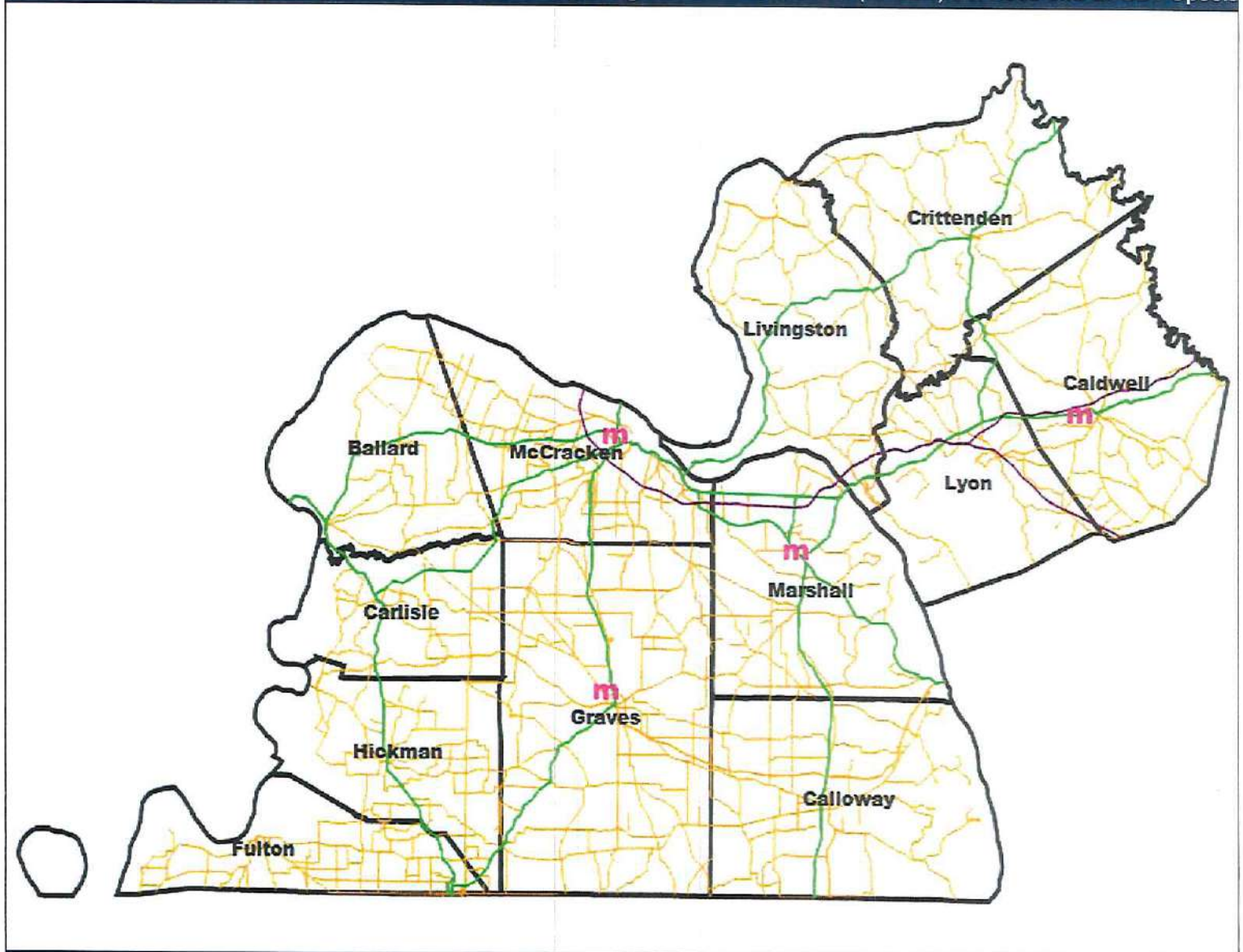

4 providers at 4 locations

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Access Overview

January 23, 2020

Access Analysis
Region 1 Rural - 1 in 50 miles

Member / Provider Groups
Region 1 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 miles

Overall Access[1]

11,338 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

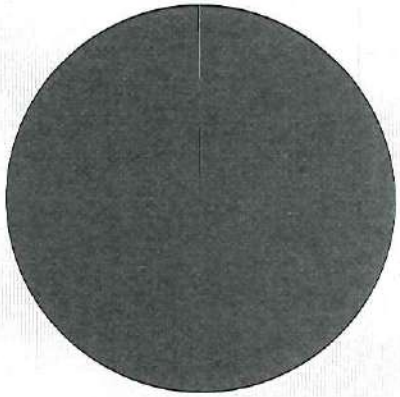

Times

	Average
Distance to 1st closest provider	12.7 miles
Distance to 2nd closest provider	27.0 miles
Distance to 3rd closest provider	33.2 miles
Distance to 4th closest provider	49.1 miles
Distance to 5th closest provider	60.6 miles

Access Standard Comparison

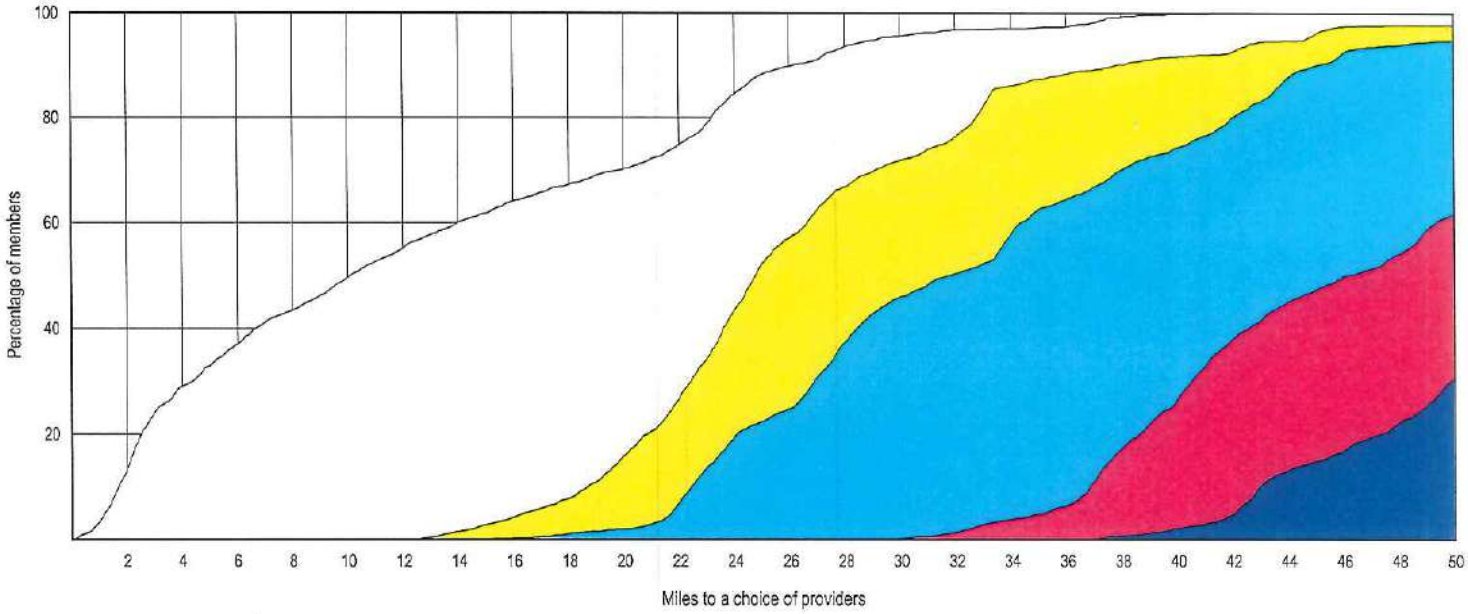

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Access Overview

January 24, 2020

Access Analysis
Region 1 Rural - 1 in 50 minutes

Member / Provider Groups
Region 1 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 1 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 minutes

Overall Access[1]

11,338 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 11,334 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.0%) Members excluded

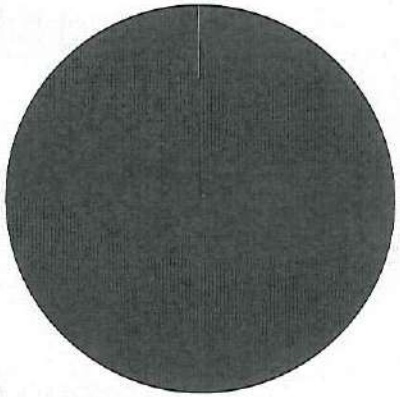

Times

	Average
Time to 1st closest provider	13.8 mins
Time to 2nd closest provider	29.4 mins
Time to 3rd closest provider	36.2 mins
Time to 4th closest provider	53.5 mins
Time to 5th closest provider	66.0 mins

Access Standard Comparison

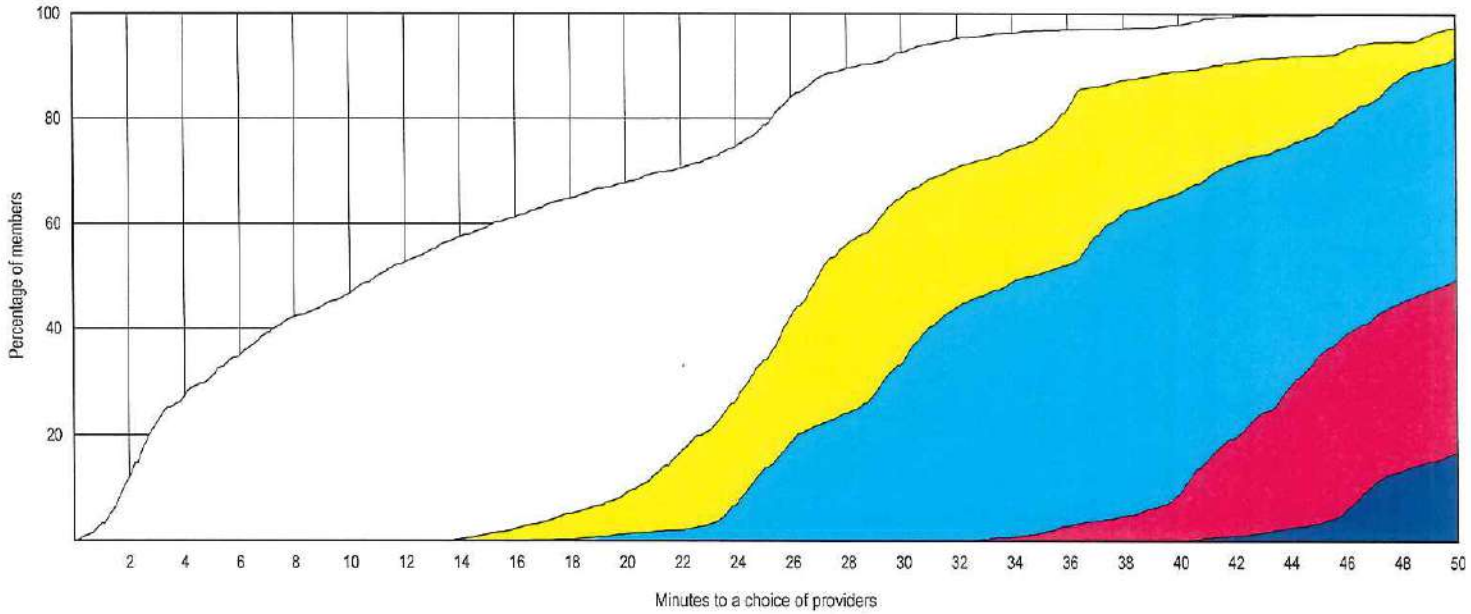

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Provider Locations

January 23, 2020

Region 2 Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special

Total Providers: 9

m All providers

Interstates

US Highways

State Highways

15.14 miles

ndividual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Specia

9 providers at 11 locations

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Access Overview

January 23, 2020

Access Analysis
Region 2 Urban - 1 in 30 miles

Member / Provider Groups
Region 2 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 miles

Overall Access[1]

16,143 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 16,142 (99.9%) Members with access
- 0 (0.0%) Members without access
- 1 (0.0%) Members excluded

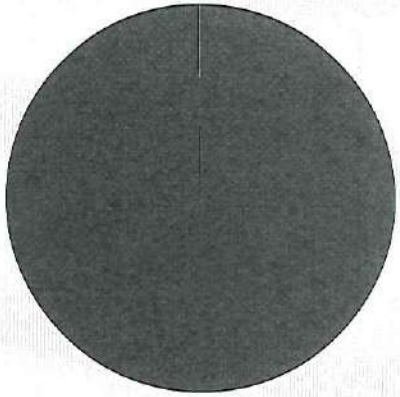

Distances

	Average
Distance to 1st closest provider	6.9 miles
Distance to 2nd closest provider	10.1 miles
Distance to 3rd closest provider	19.6 miles
Distance to 4th closest provider	30.1 miles
Distance to 5th closest provider	33.0 miles

Access Standard Comparison

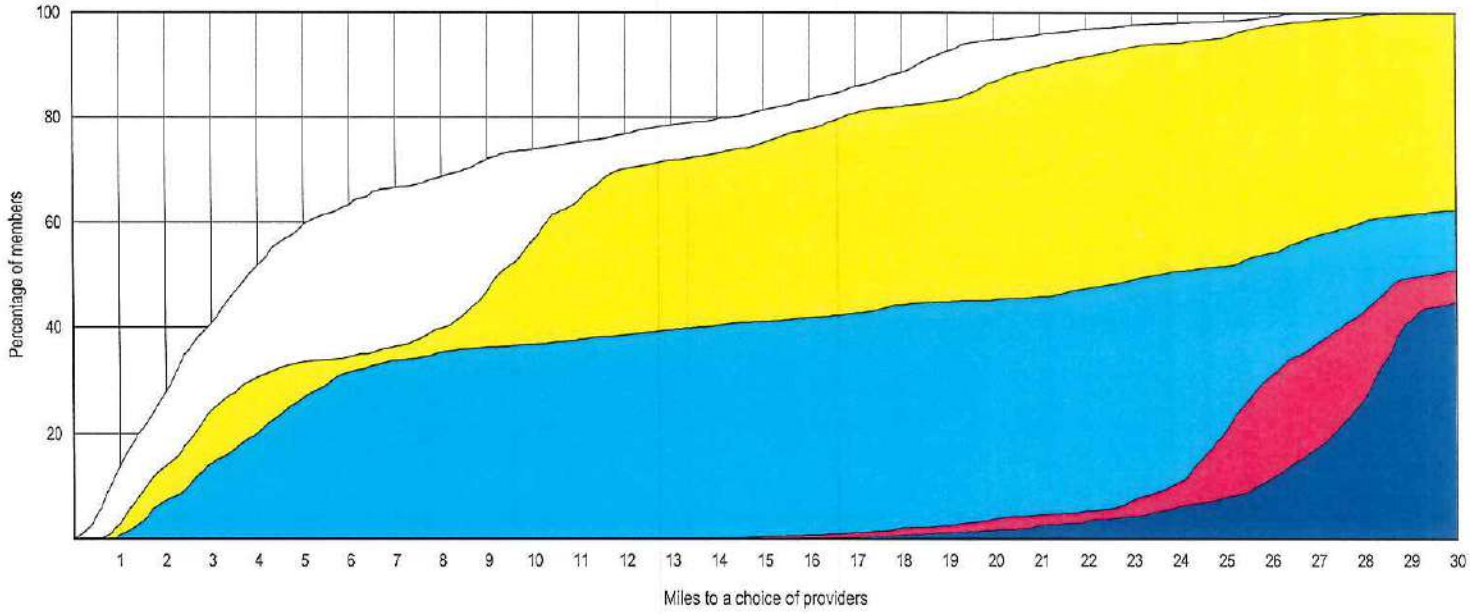

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Access Overview

January 24, 2020

Access Analysis
Region 2 Urban - 1 in 30 minutes

Member / Provider Groups
Region 2 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 minutes

Overall Access[1]

16,143 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 16,136 (99.9%) Members with access
- 6 (0.1%) Members without access
- 1 (0.0%) Members excluded

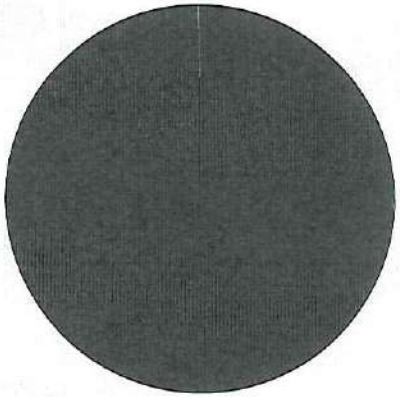

Times

	Average
Time to 1st closest provider	7.5 mins
Time to 2nd closest provider	11.0 mins
Time to 3rd closest provider	21.3 mins
Time to 4th closest provider	32.8 mins
Time to 5th closest provider	36.0 mins

Access Standard Comparison

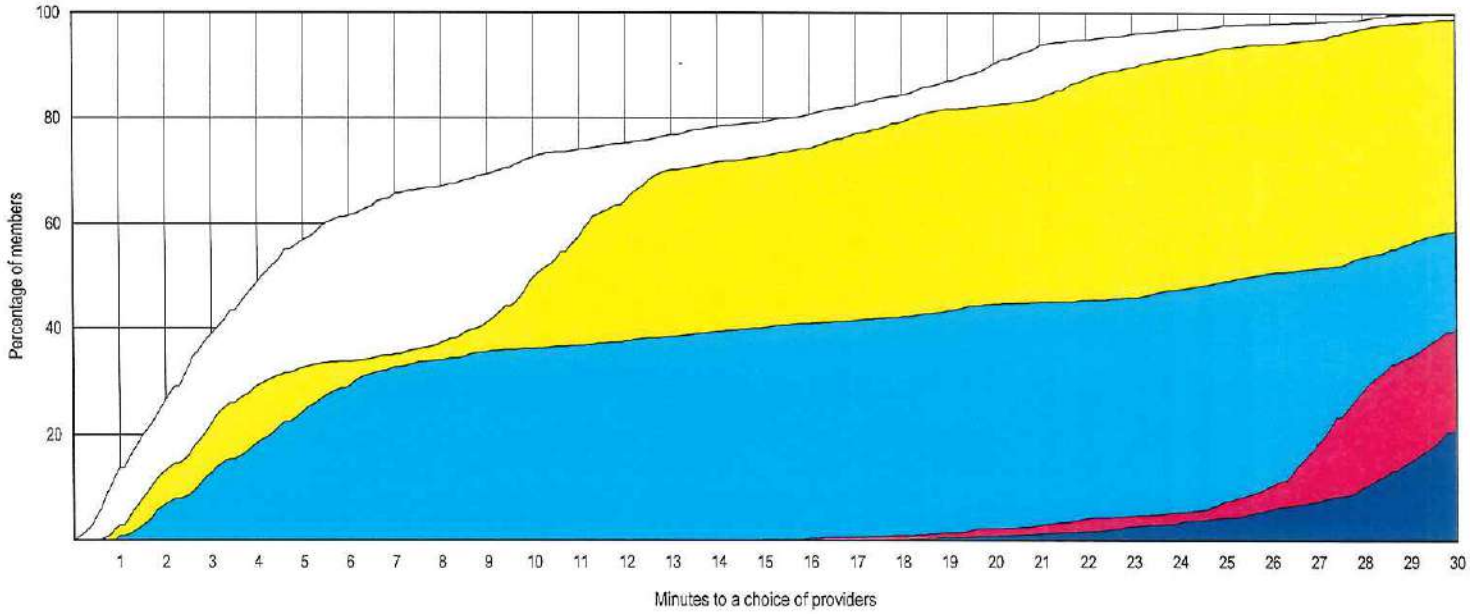

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Access Overview

January 23, 2020

Access Analysis
Region 2 Rural - 1 in 50 miles

Member / Provider Groups
Region 2 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 miles

Overall Access[1]

9,636 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

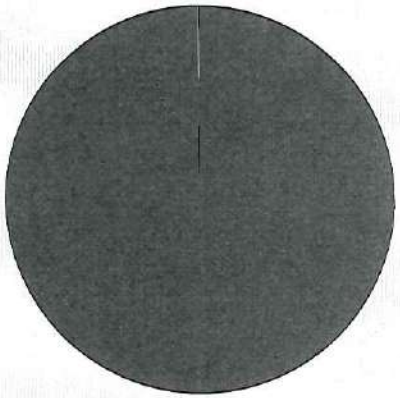

Distances

	Average
Distance to 1st closest provider	13.5 miles
Distance to 2nd closest provider	23.6 miles
Distance to 3rd closest provider	28.1 miles
Distance to 4th closest provider	33.7 miles
Distance to 5th closest provider	37.0 miles

Access Standard Comparison

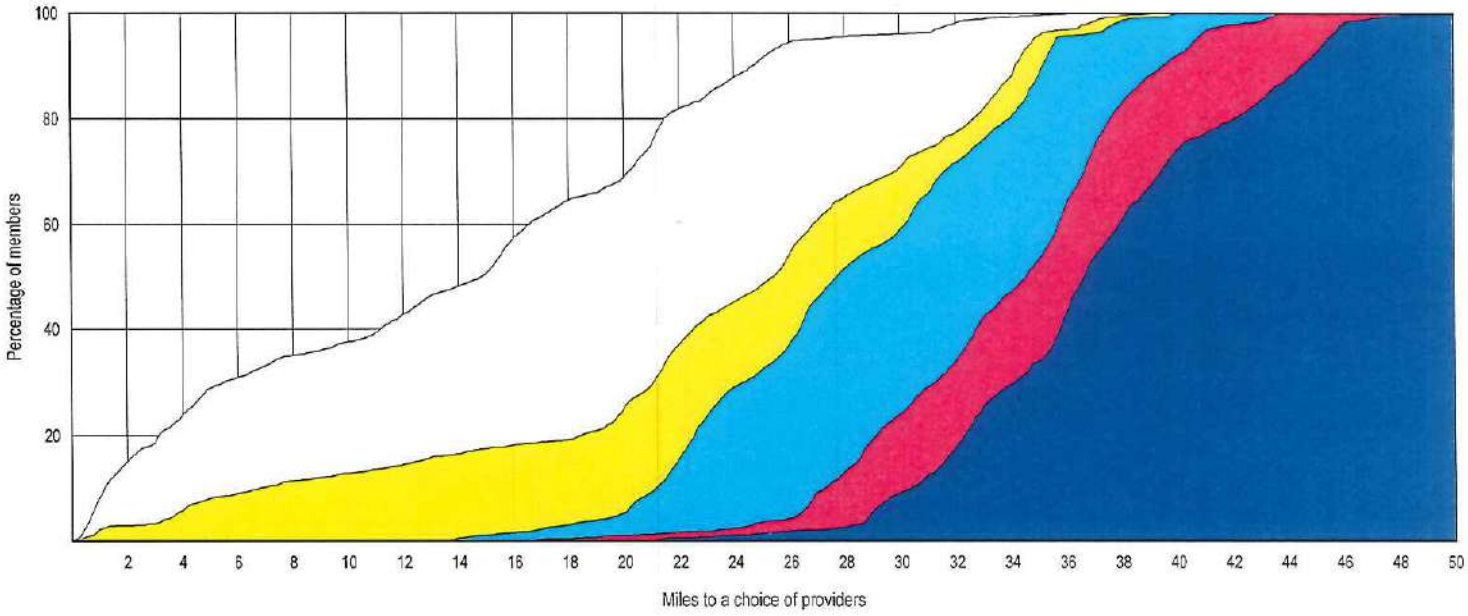

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Access Overview

January 24, 2020

Access Analysis
Region 2 Rural - 1 in 50 minutes

Member / Provider Groups
Region 2 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 2 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 minutes

Overall Access[1]

9,636 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 9,628 (99.9%) Members with access
- 0 (0.0%) Members without access
- 8 (0.1%) Members excluded

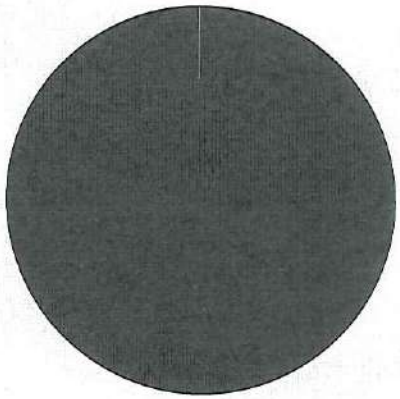

Times

	Average
Time to 1st closest provider	14.7 mins
Time to 2nd closest provider	25.8 mins
Time to 3rd closest provider	30.6 mins
Time to 4th closest provider	36.8 mins
Time to 5th closest provider	40.4 mins

Access Standard Comparison

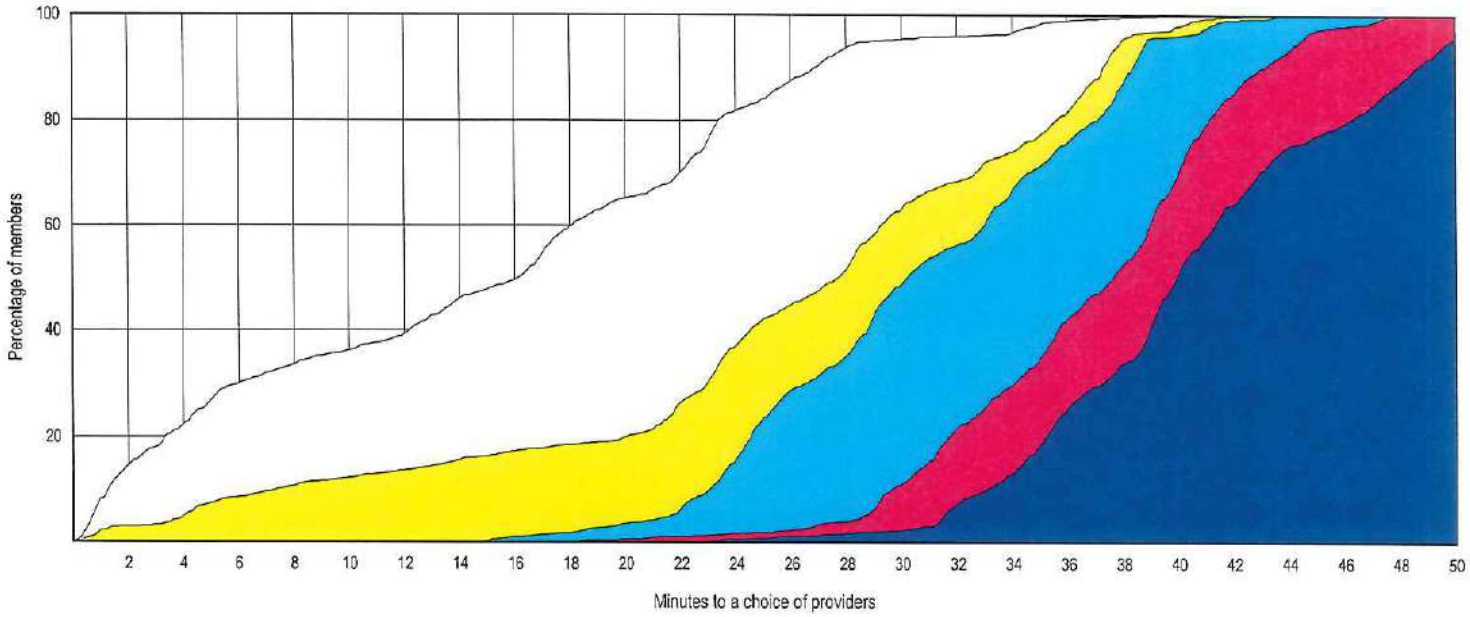

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Provider Locations

January 23, 2020

Region 3 Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special

Total Providers: 12

m All providers

Interstates

US Highways

State Highways

15.97 miles

ndividual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Specia

12 providers at 12 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 3 Urban - 1 in 30 miles

Member / Provider Groups
Region 3 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 miles

Overall Access[1]

18,130 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 17,812 (98.2%) Members with access
- 315 (1.7%) Members without access
- 3 (0.0%) Members excluded

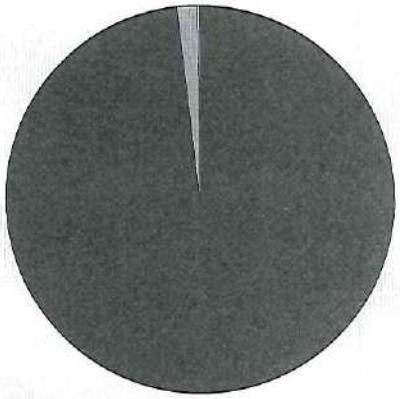

Distances

	Average
Distance to 1st closest provider	7.9 miles
Distance to 2nd closest provider	10.3 miles
Distance to 3rd closest provider	12.3 miles
Distance to 4th closest provider	14.0 miles
Distance to 5th closest provider	14.9 miles

Access Standard Comparison

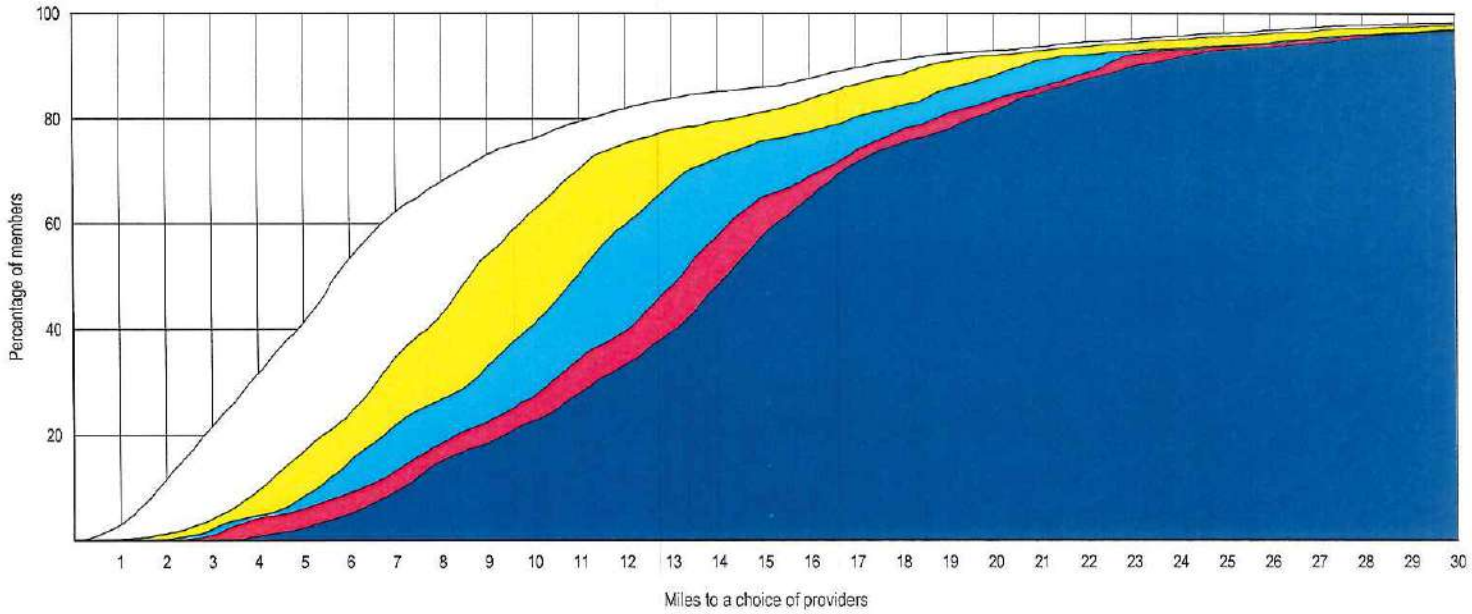

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 3 Urban - 1 in 30 minutes

Member / Provider Groups
Region 3 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 minutes

Overall Access[1]

18,130 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 17,652 (97.4%) Members with access
- 475 (2.6%) Members without access
- 3 (0.0%) Members excluded

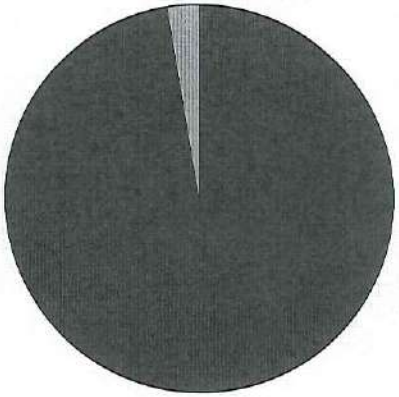

Times

	Average
Time to 1st closest provider	10.4 mins
Time to 2nd closest provider	13.6 mins
Time to 3rd closest provider	15.9 mins
Time to 4th closest provider	17.3 mins
Time to 5th closest provider	18.2 mins

Access Standard Comparison

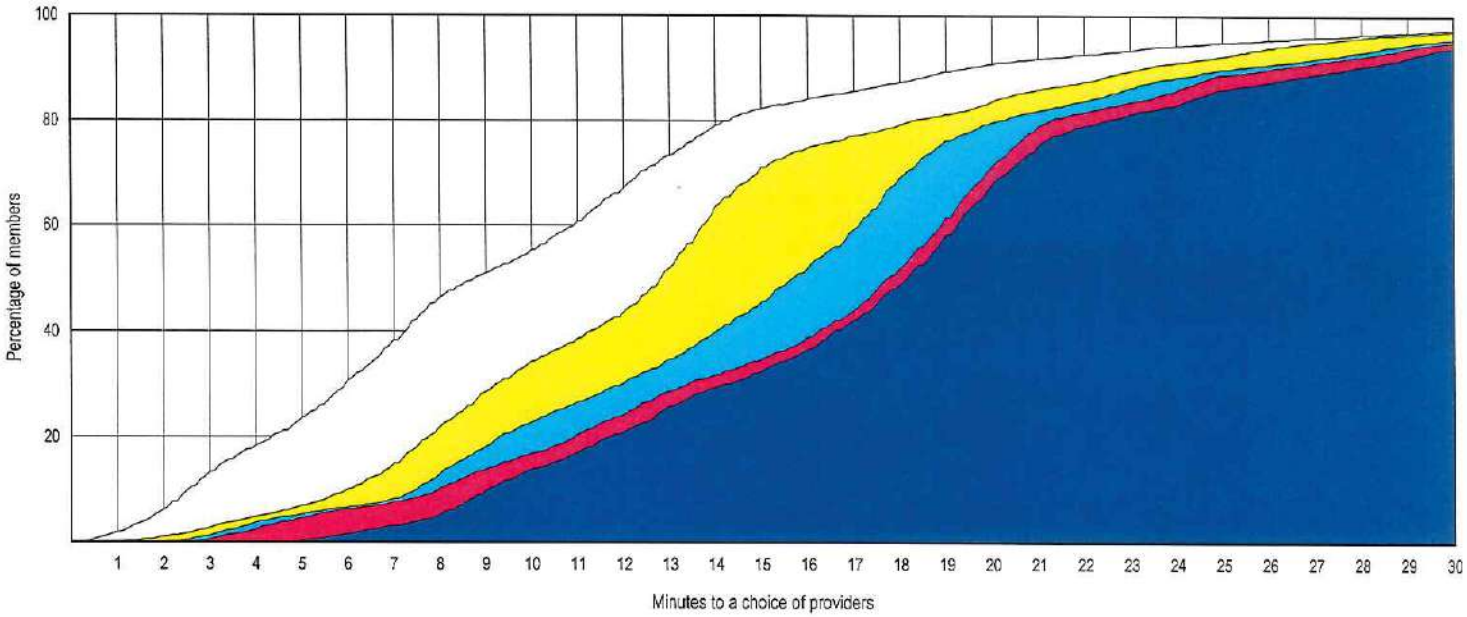

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Access Overview

January 23, 2020

Access Analysis
Region 3 Rural - 1 in 50 miles

Member / Provider Groups
Region 3 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 miles

Overall Access[1]

1,901 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

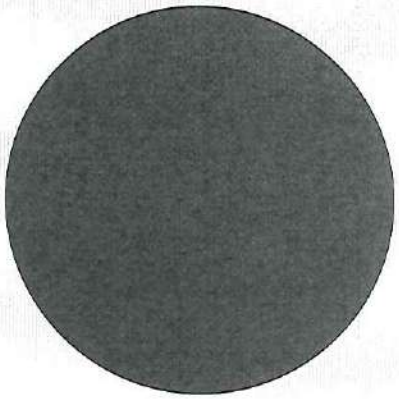

Distances

	Average
Distance to 1st closest provider	28.3 miles
Distance to 2nd closest provider	31.8 miles
Distance to 3rd closest provider	33.6 miles
Distance to 4th closest provider	35.3 miles
Distance to 5th closest provider	36.4 miles

Access Standard Comparison

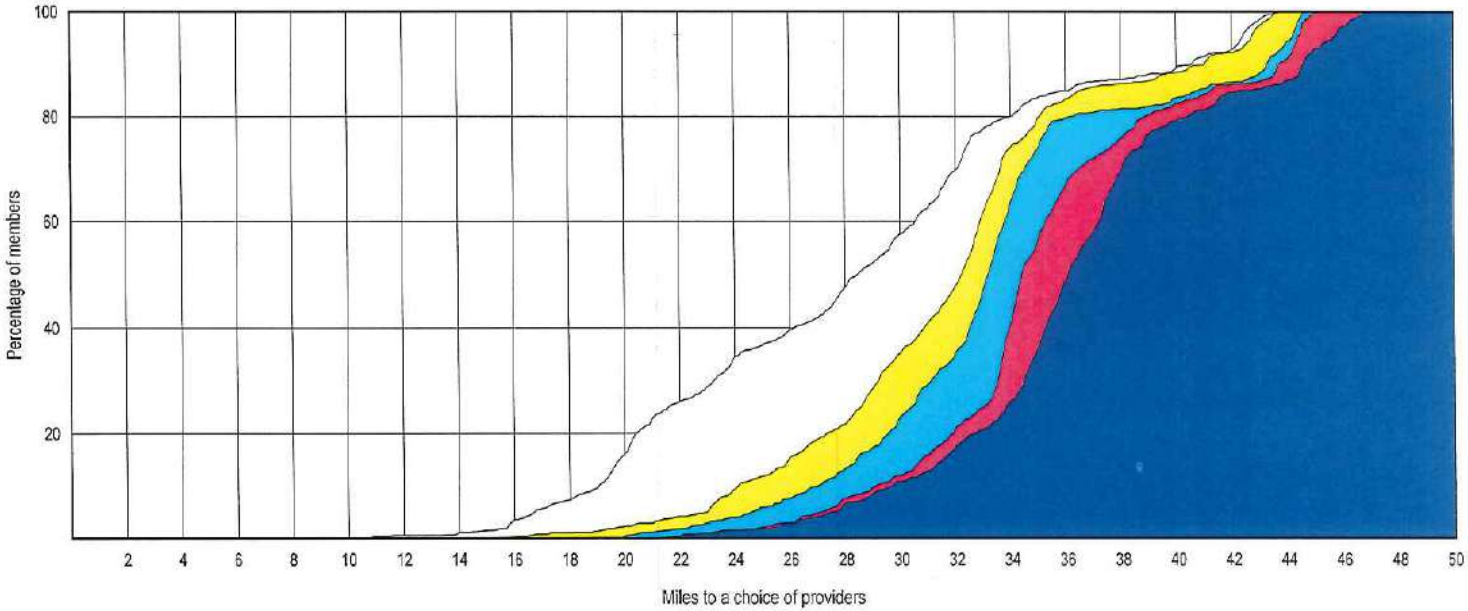

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Access Overview

January 24, 2020

Access Analysis
Region 3 Rural - 1 in 50 minutes

Member / Provider Groups
Region 3 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 3 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 minutes

Overall Access[1]

1,901 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 1,901 (100.0%) Members with access
- 0 (0.0%) Members without access
- 0 (0.0%) Members excluded

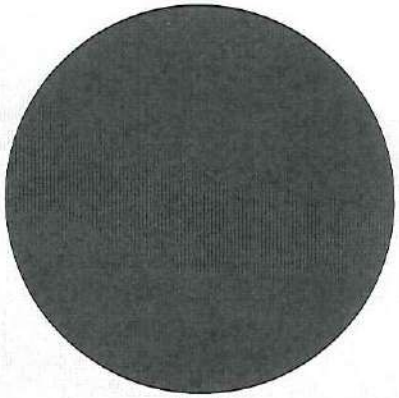

Times

	Average
Time to 1st closest provider	31.1 mins
Time to 2nd closest provider	34.8 mins
Time to 3rd closest provider	36.6 mins
Time to 4th closest provider	38.8 mins
Time to 5th closest provider	40.2 mins

Access Standard Comparison

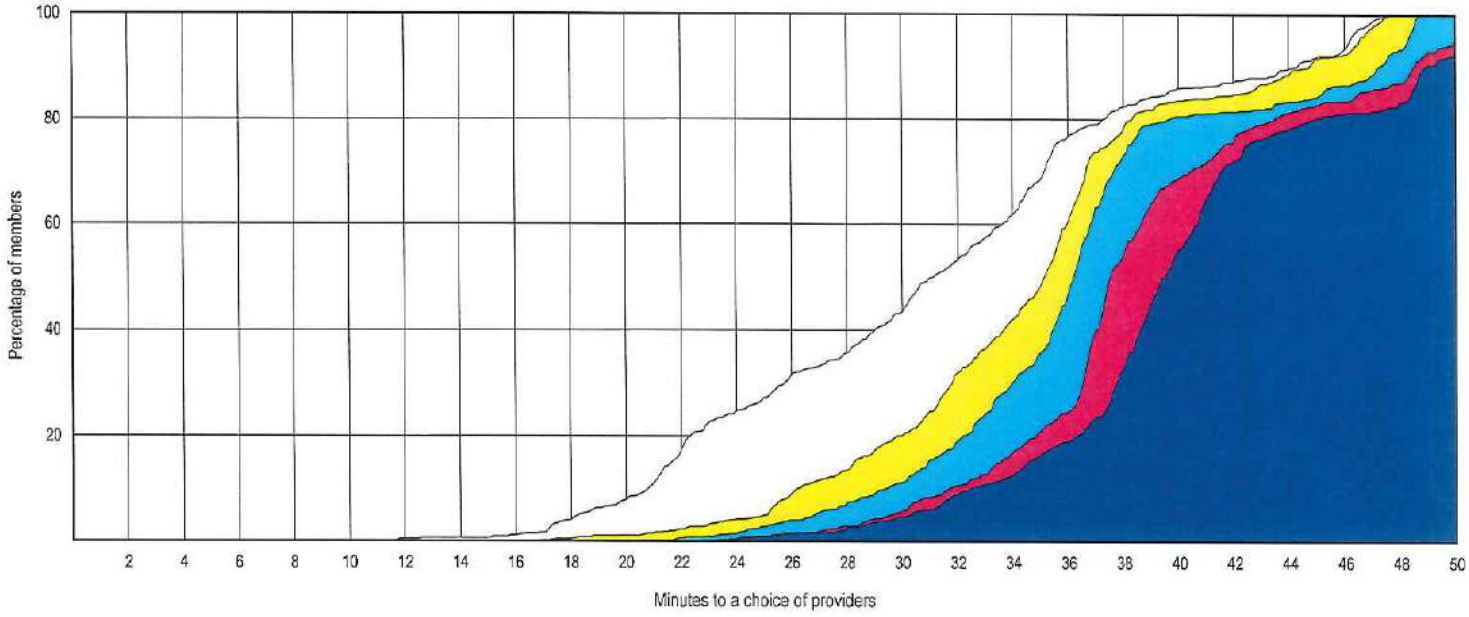

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Provider Locations

January 23, 2020

Region 4 Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special

Total Providers: 8

m All providers

Interstates

US Highways

State Highways

19.37 miles

ndividual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Specia

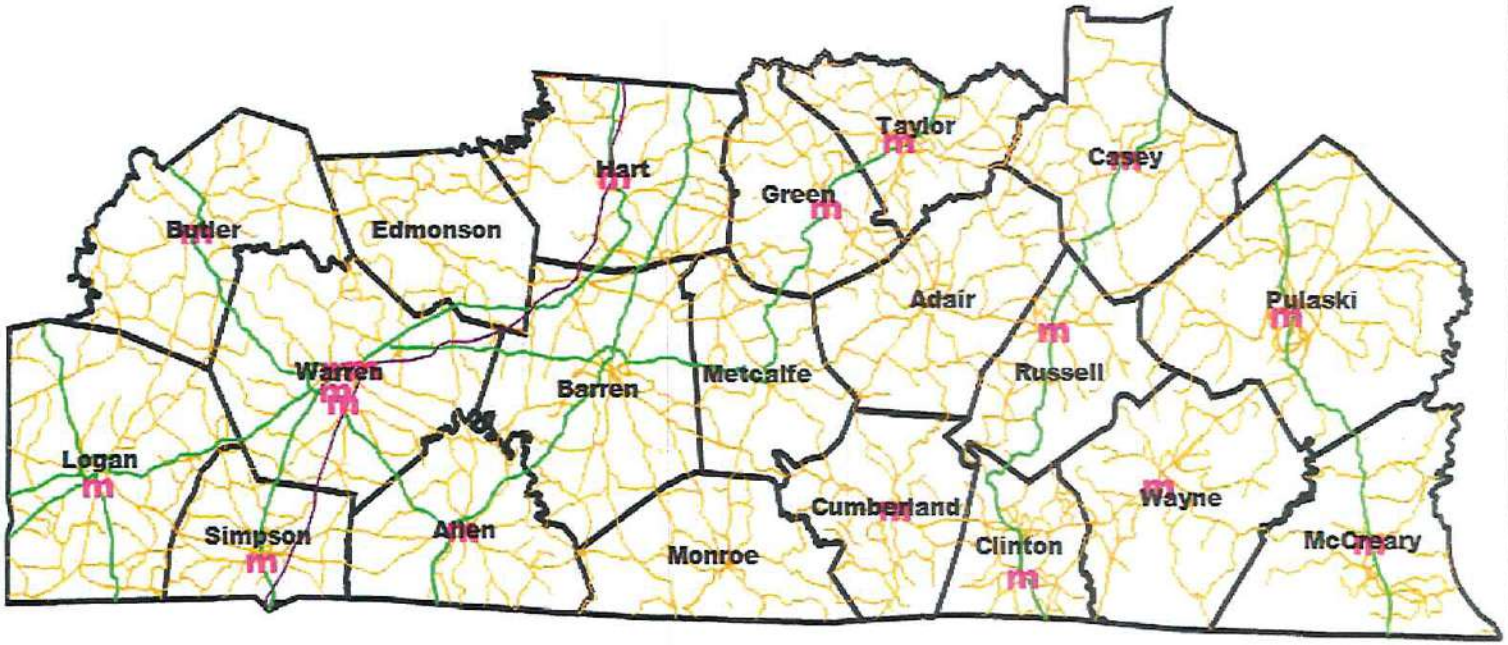

8 providers at 18 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 4 Urban - 1 in 30 miles

Member / Provider Groups
Region 4 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 miles

Overall Access[1]

7,413 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

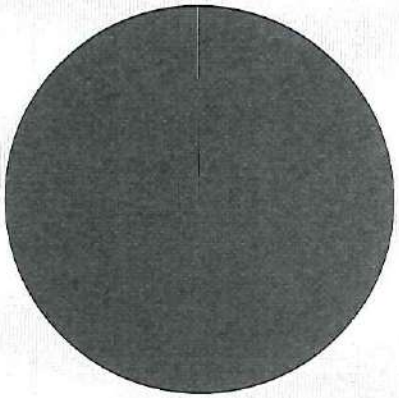

Distances

	Average
Distance to 1st closest provider	5.0 miles
Distance to 2nd closest provider	8.6 miles
Distance to 3rd closest provider	10.1 miles
Distance to 4th closest provider	11.3 miles
Distance to 5th closest provider	22.8 miles

Access Standard Comparison

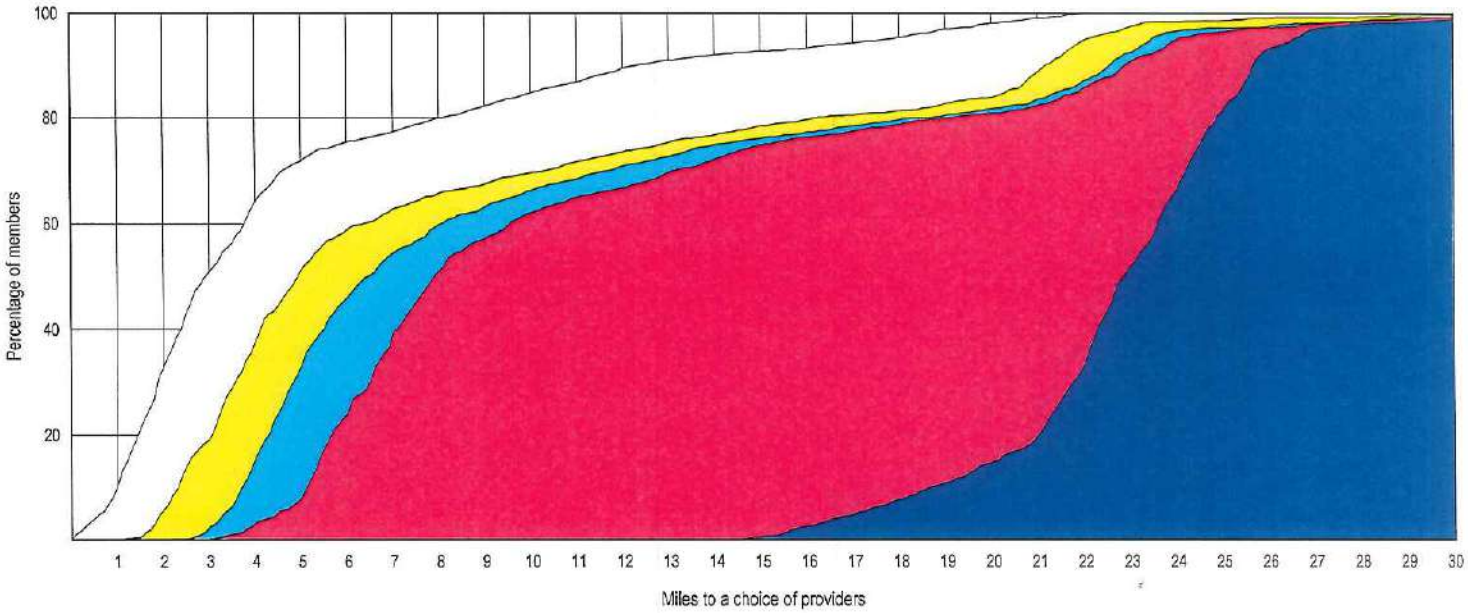

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 4 Urban - 1 in 30 minutes

Member / Provider Groups
Region 4 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 minutes

Overall Access[1]

7,413 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 7,409 (99.9%) Members with access
- 0 (0.0%) Members without access
- 4 (0.1%) Members excluded

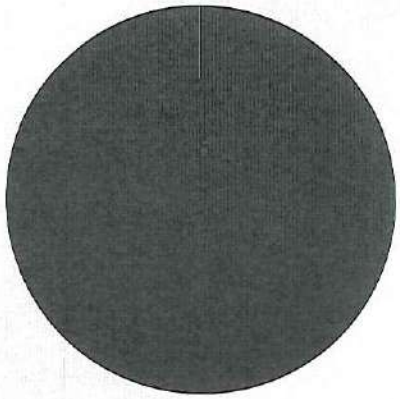

Times

	Average
Time to 1st closest provider	5.4 mins
Time to 2nd closest provider	9.3 mins
Time to 3rd closest provider	11.0 mins
Time to 4th closest provider	12.3 mins
Time to 5th closest provider	24.8 mins

Access Standard Comparison

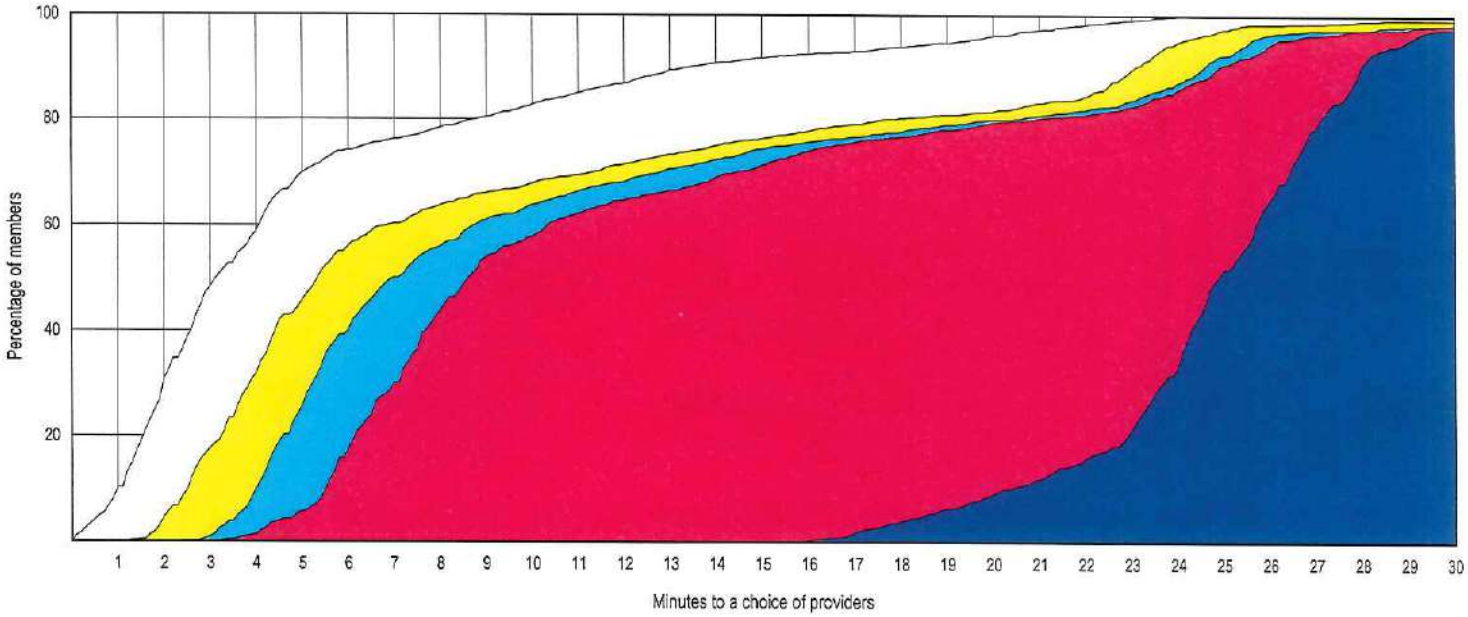

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Access Overview

January 23, 2020

Access Analysis
Region 4 Rural - 1 in 50 miles

Member / Provider Groups
Region 4 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 miles

Overall Access[1]

28,324 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

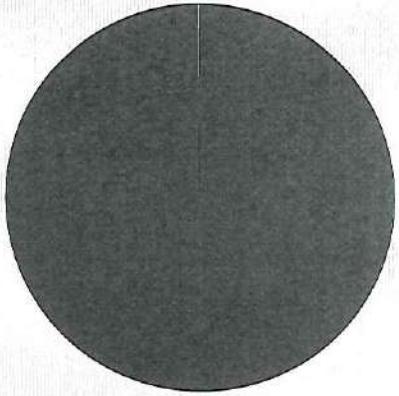

Distances

	Average
Distance to 1st closest provider	9.0 miles
Distance to 2nd closest provider	21.6 miles
Distance to 3rd closest provider	25.8 miles
Distance to 4th closest provider	28.6 miles
Distance to 5th closest provider	31.6 miles

Access Standard Comparison

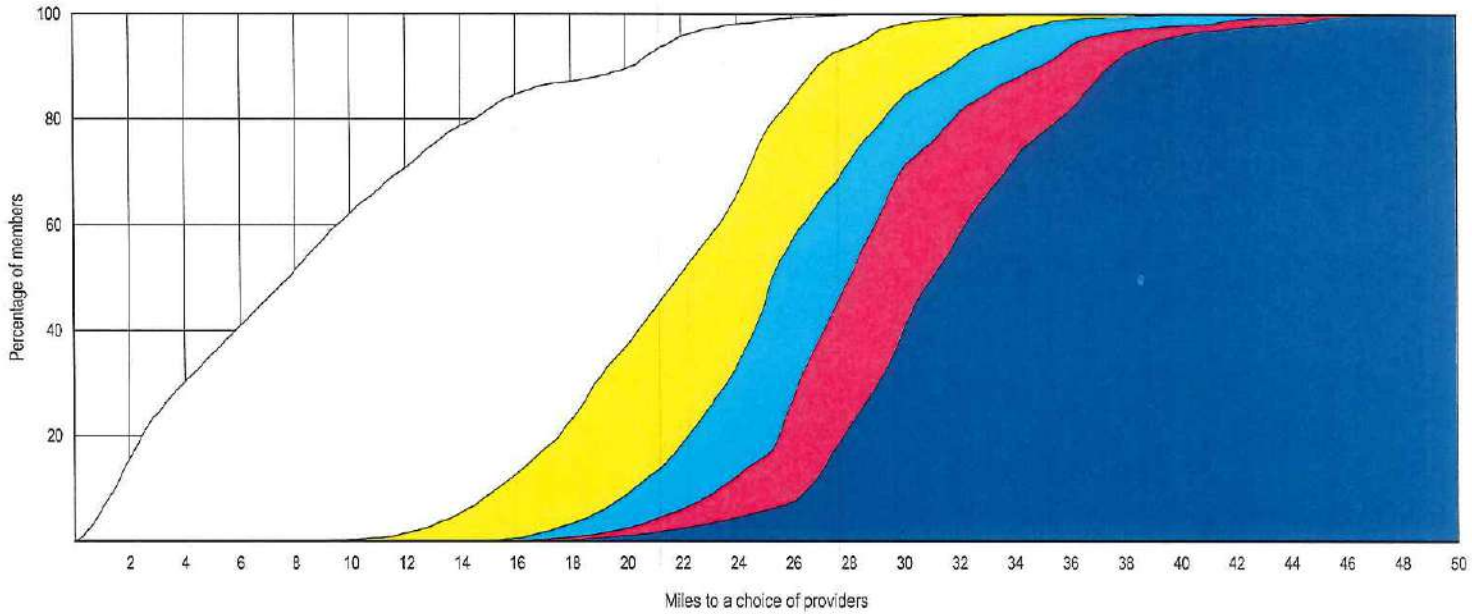

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 24, 2020

Access Analysis
Region 4 Rural - 1 in 50 minutes

Member / Provider Groups
Region 4 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 4 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 minutes

Overall Access[1]

28,324 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 28,315 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

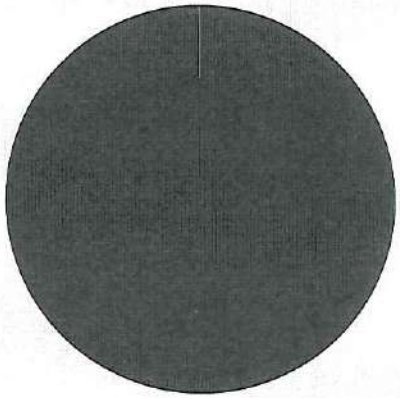

Times

	Average
Time to 1st closest provider	9.7 mins
Time to 2nd closest provider	23.5 mins
Time to 3rd closest provider	28.1 mins
Time to 4th closest provider	31.2 mins
Time to 5th closest provider	34.5 mins

Access Standard Comparison

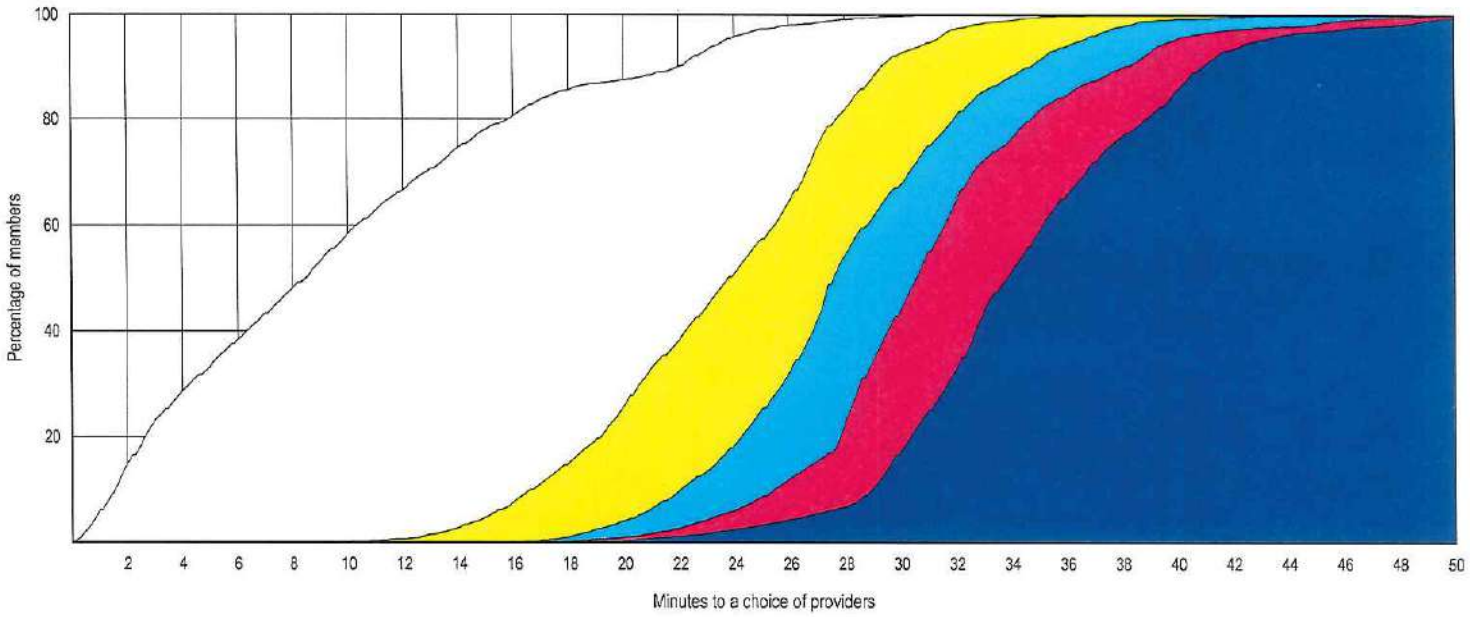

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Provider Locations

January 23, 2020

Region 5 Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special

Total Providers: 11

m All providers

Interstates

US Highways

State Highways

17.44 miles

ndividual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Specia

11 providers at 13 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 5 Urban - 1 in 30 miles

Member / Provider Groups
Region 5 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 miles

Overall Access[1]

22,712 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 22,682 (99.9%) Members with access
- 14 (0.1%) Members without access
- 16 (0.1%) Members excluded

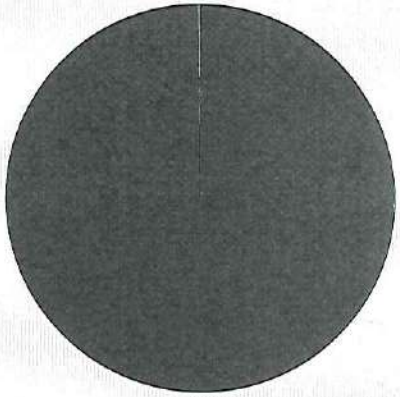

Distances

	Average
Distance to 1st closest provider	6.8 miles
Distance to 2nd closest provider	10.0 miles
Distance to 3rd closest provider	12.1 miles
Distance to 4th closest provider	15.8 miles
Distance to 5th closest provider	19.9 miles

Access Standard Comparison

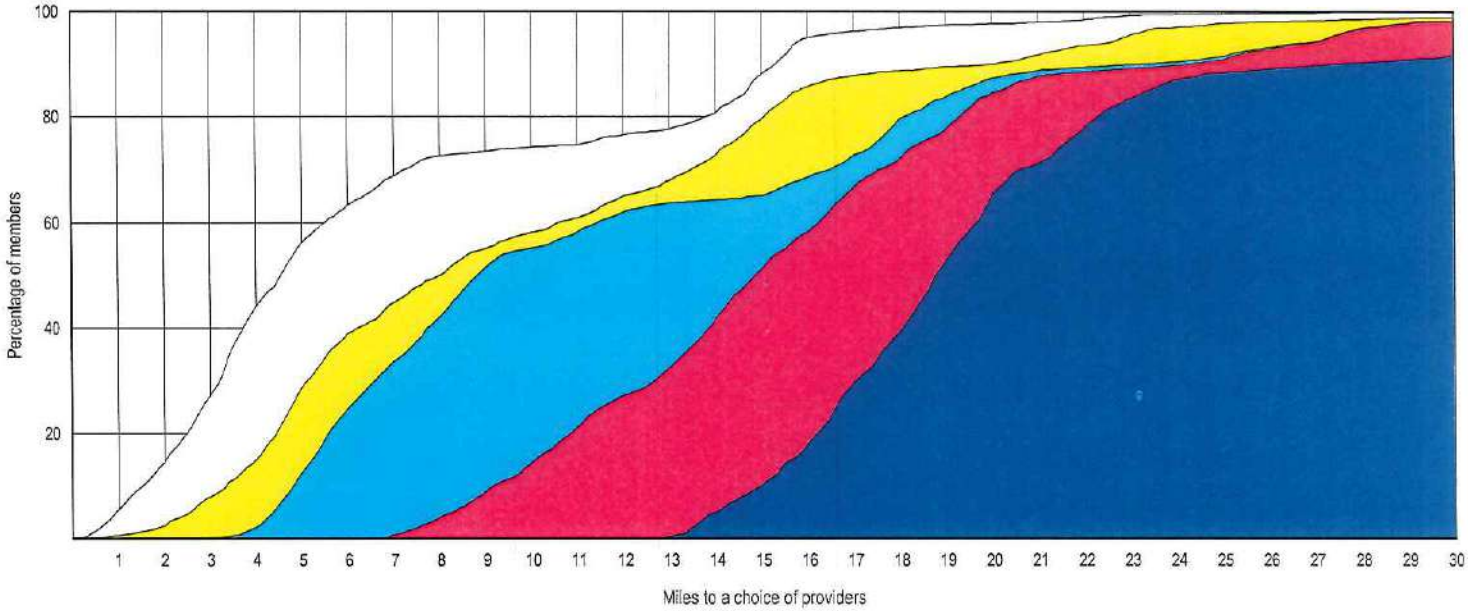

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Access Overview

January 24, 2020

Access Analysis
Region 5 Urban - 1 in 30 minutes

Member / Provider Groups
Region 5 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 minutes

Overall Access[1]

22,712 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 22,636 (99.7%) Members with access
- 60 (0.3%) Members without access
- 16 (0.1%) Members excluded

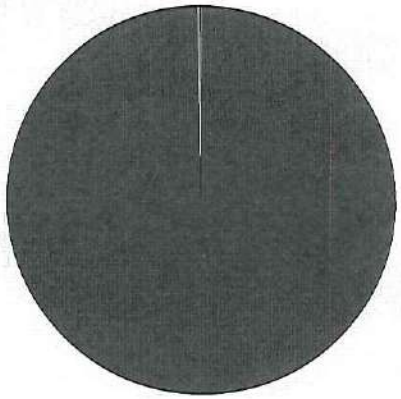

Times

	Average
Time to 1st closest provider	8.7 mins
Time to 2nd closest provider	13.7 mins
Time to 3rd closest provider	16.0 mins
Time to 4th closest provider	19.6 mins
Time to 5th closest provider	24.5 mins

Access Standard Comparison

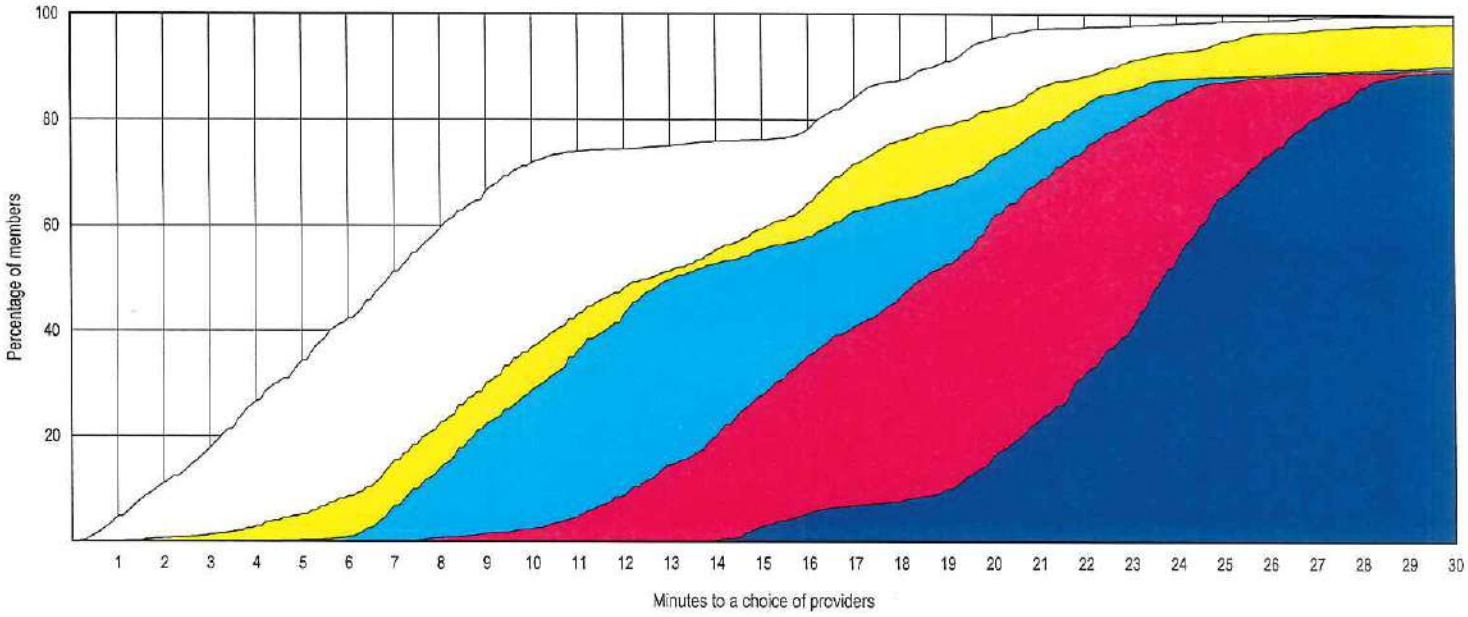

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis

Region 5 Rural - 1 in 50 miles

Member / Provider Groups

Region 5 Rural Members

Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph

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

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

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:

1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 miles

Overall Access[1]

23,127 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

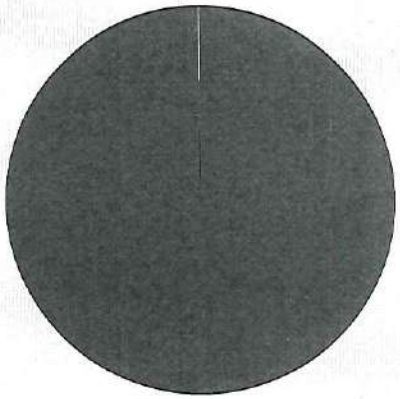

Distances

	Average
Distance to 1st closest provider	12.7 miles
Distance to 2nd closest provider	17.7 miles
Distance to 3rd closest provider	25.8 miles
Distance to 4th closest provider	27.6 miles
Distance to 5th closest provider	30.2 miles

Access Standard Comparison

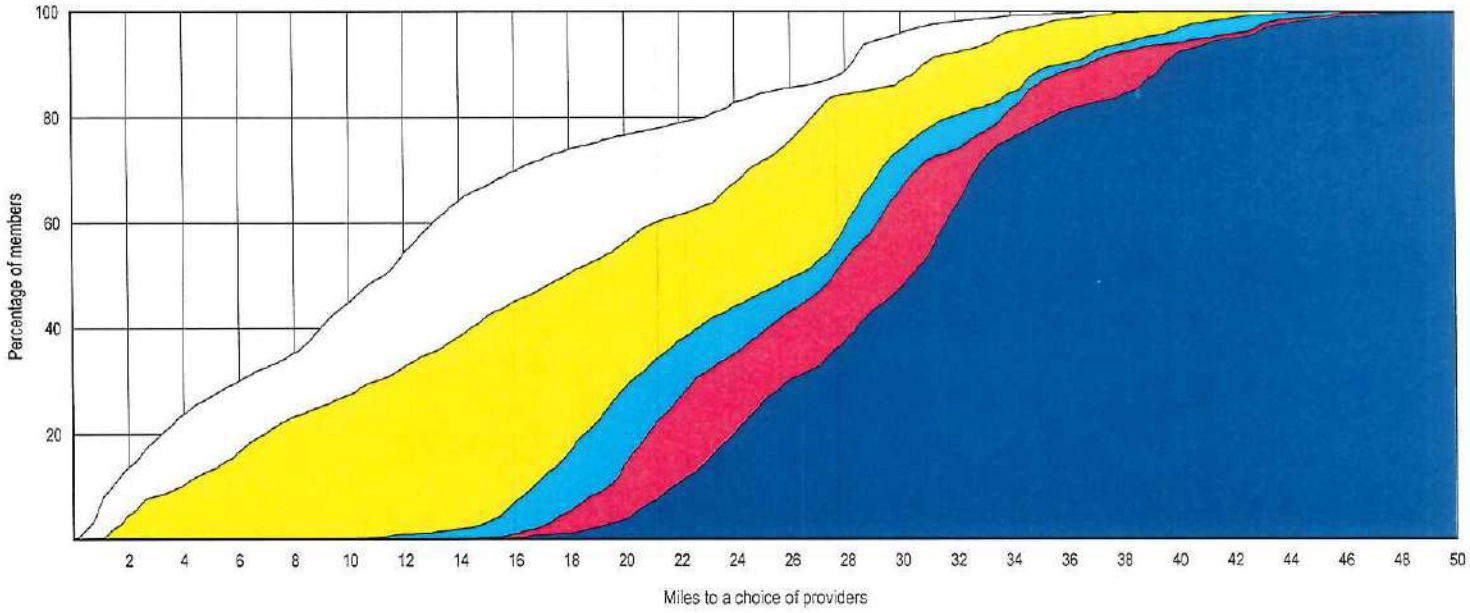

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Access Overview

January 24, 2020

Access Analysis
Region 5 Rural - 1 in 50 minutes

Member / Provider Groups
Region 5 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 5 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 minutes

Overall Access[1]

23,127 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 23,118 (99.9%) Members with access
- 0 (0.0%) Members without access
- 9 (0.0%) Members excluded

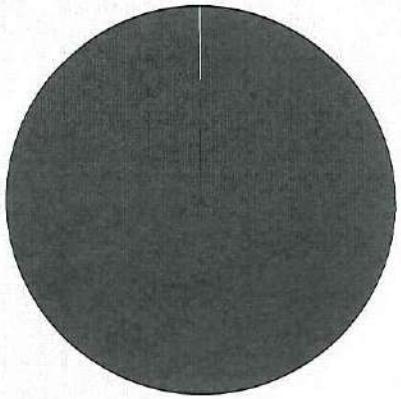

Times

	Average
Time to 1st closest provider	13.8 mins
Time to 2nd closest provider	19.3 mins
Time to 3rd closest provider	29.0 mins
Time to 4th closest provider	31.7 mins
Time to 5th closest provider	34.4 mins

Access Standard Comparison

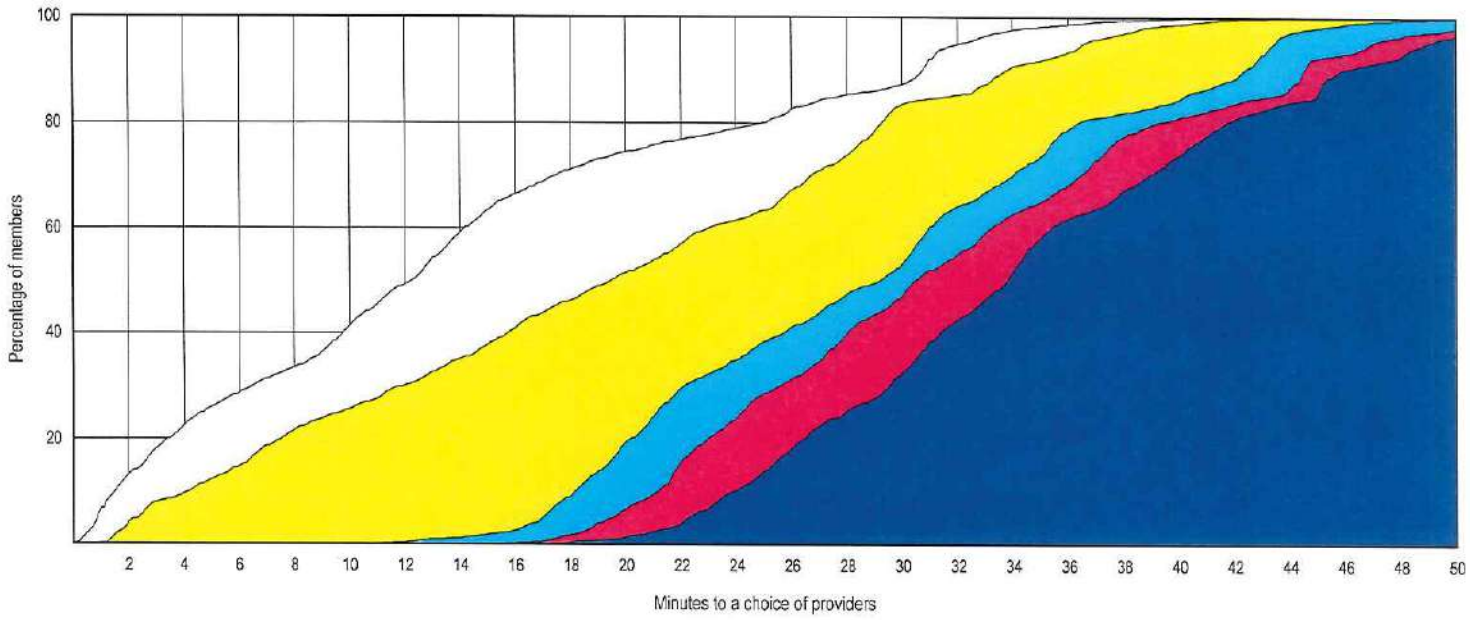

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Provider Locations

January 23, 2020

Region 6 Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Se

Total Providers: 5

m All providers

Interstates

US Highways

State Highways

7.48 miles

ndividual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Specia

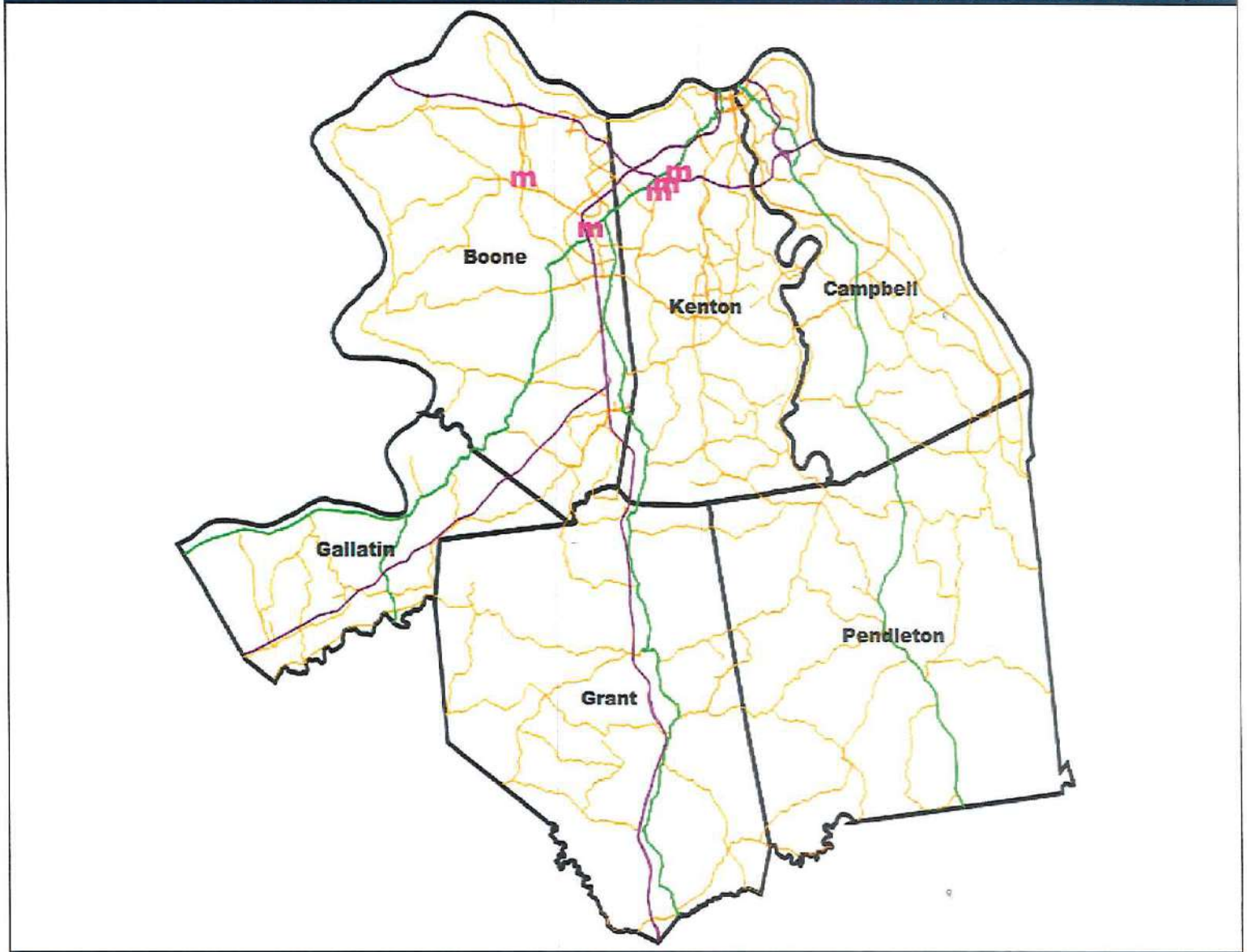

5 providers at 5 locations

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Aetna Better Health of Kentucky - Kentucky Medicaid Network

Access Overview

January 23, 2020

Access Analysis
Region 6 Urban - 1 in 30 miles

Member / Provider Groups
Region 6 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 6 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 miles

Overall Access[1]

22,413 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 21,505 (95.9%) Members with access
- 901 (4.0%) Members without access
- 7 (0.0%) Members excluded

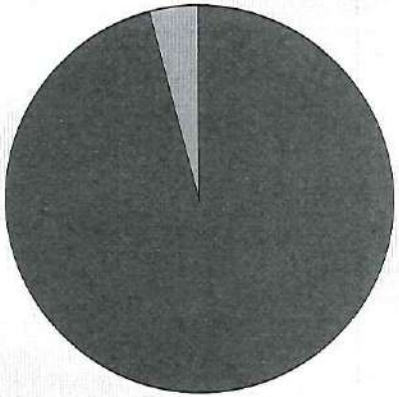

Distances

	Average
Distance to 1st closest provider	8.6 miles
Distance to 2nd closest provider	10.1 miles
Distance to 3rd closest provider	11.0 miles
Distance to 4th closest provider	12.9 miles
Distance to 5th closest provider	15.0 miles

Access Standard Comparison

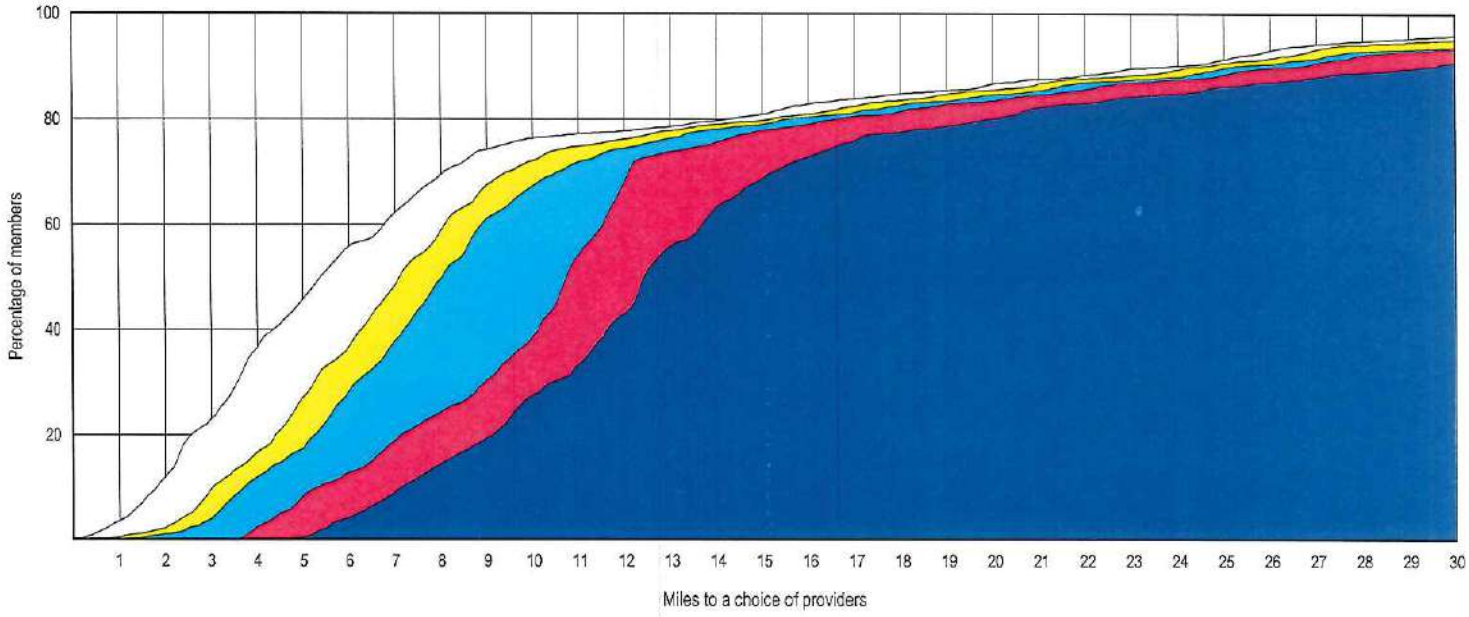

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Provider Locations

January 23, 2020

Region 7 Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Se

Total Providers: 3

m All providers

Interstates

US Highways

State Highways

12.36 miles

ndividual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Specia

3 providers at 3 locations

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Access Overview

January 23, 2020

Access Analysis
Region 7 Urban - 1 in 30 miles

Member / Provider Groups
Region 7 Urban Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Urban Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 30 miles

Overall Access[1]

2,907 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 2,883 (99.2%) Members with access
- 22 (0.8%) Members without access
- 2 (0.1%) Members excluded

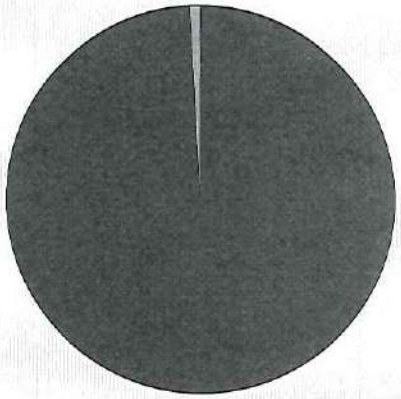

Distances

	Average
Distance to 1st closest provider	12.8 miles
Distance to 2nd closest provider	19.4 miles
Distance to 3rd closest provider	45.9 miles
Distance to 4th closest provider	50.3 miles
Distance to 5th closest provider	52.5 miles

Access Standard Comparison

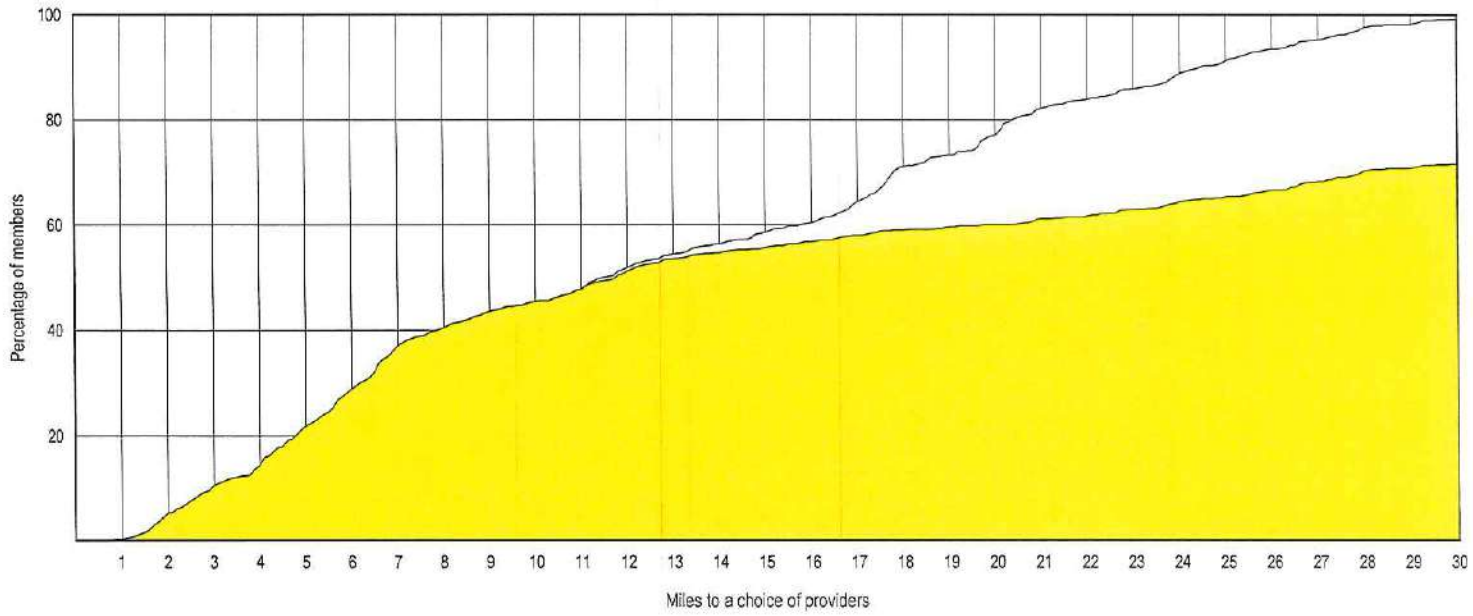

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Access Overview

January 23, 2020

Access Analysis
Region 7 Rural - 1 in 50 miles

Member / Provider Groups
Region 7 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 miles

Overall Access[1]

10,408 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

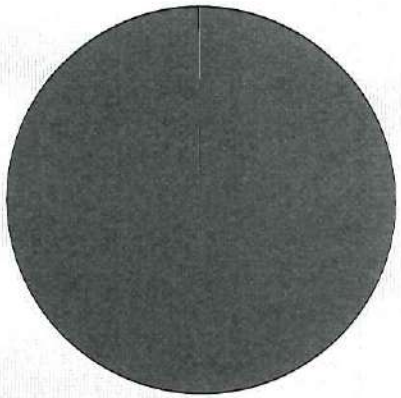

Distances

	Average
Distance to 1st closest provider	20.3 miles
Distance to 2nd closest provider	38.6 miles
Distance to 3rd closest provider	42.2 miles
Distance to 4th closest provider	45.6 miles
Distance to 5th closest provider	49.8 miles

Access Standard Comparison

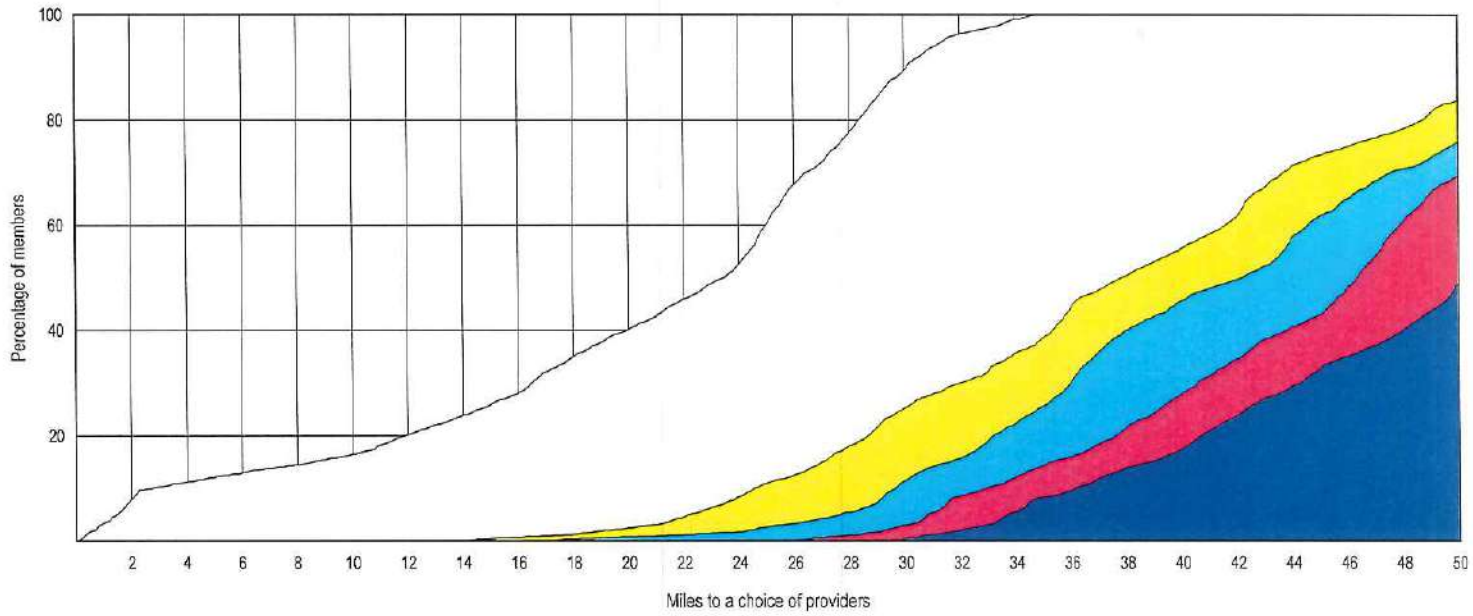

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Access Overview

January 24, 2020

Access Analysis
Region 7 Rural - 1 in 50 minutes

Member / Provider Groups
Region 7 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 7 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 minutes

Overall Access[1]

10,408 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 10,396 (99.9%) Members with access
- 0 (0.0%) Members without access
- 12 (0.1%) Members excluded

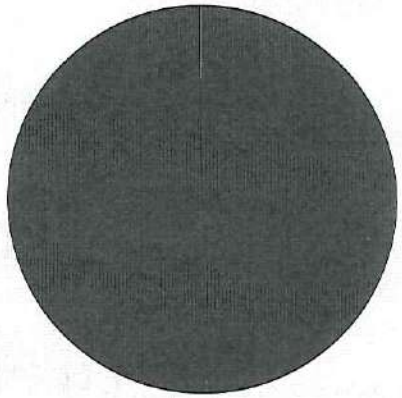

Times

	Average
Time to 1st closest provider	22.4 mins
Time to 2nd closest provider	42.9 mins
Time to 3rd closest provider	47.5 mins
Time to 4th closest provider	51.1 mins
Time to 5th closest provider	55.6 mins

Access Standard Comparison

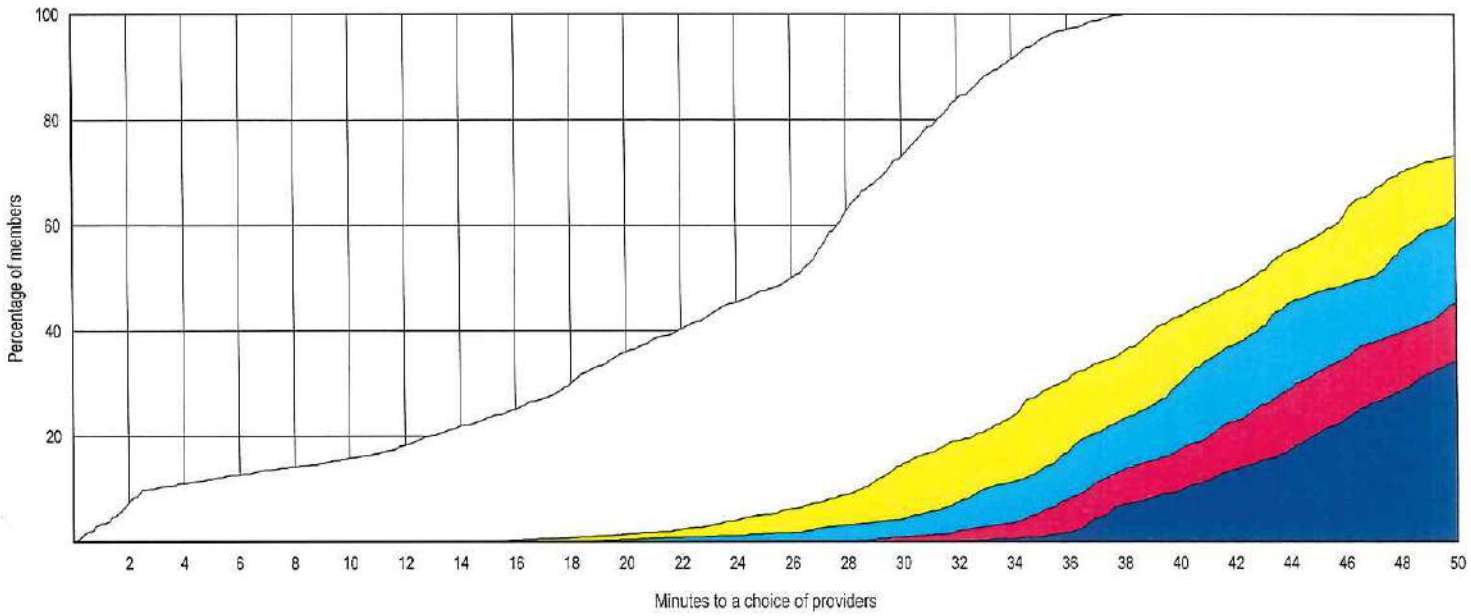

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Provider Locations

January 23, 2020

Region 8 Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Se

Total Providers: 19

m All providers

Interstates

US Highways

State Highways

16.38 miles

ndividual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Specia

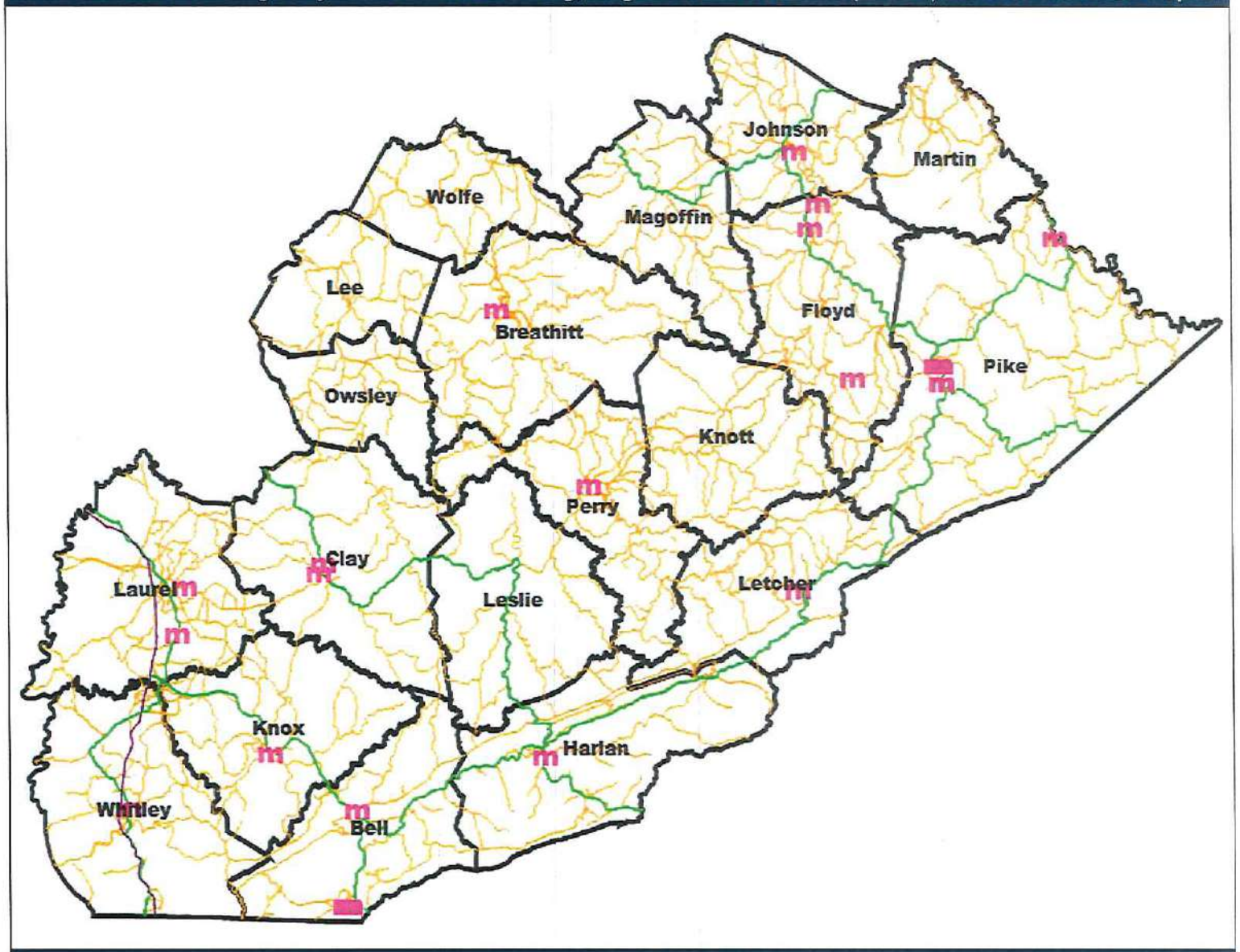

19 providers at 22 locations

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Access Overview

January 23, 2020

Access Analysis
Region 8 Rural - 1 in 50 miles

Member / Provider Groups
Region 8 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 miles

Overall Access[1]

31,600 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

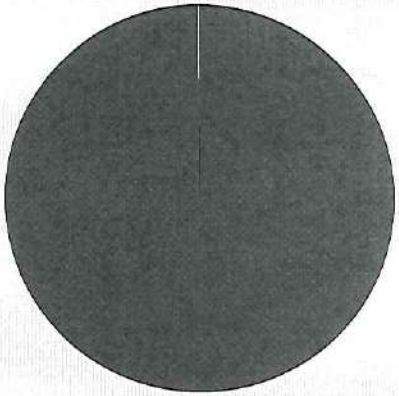

Times

	Average
Distance to 1st closest provider	8.7 miles
Distance to 2nd closest provider	13.7 miles
Distance to 3rd closest provider	17.7 miles
Distance to 4th closest provider	21.0 miles
Distance to 5th closest provider	24.7 miles

Access Standard Comparison

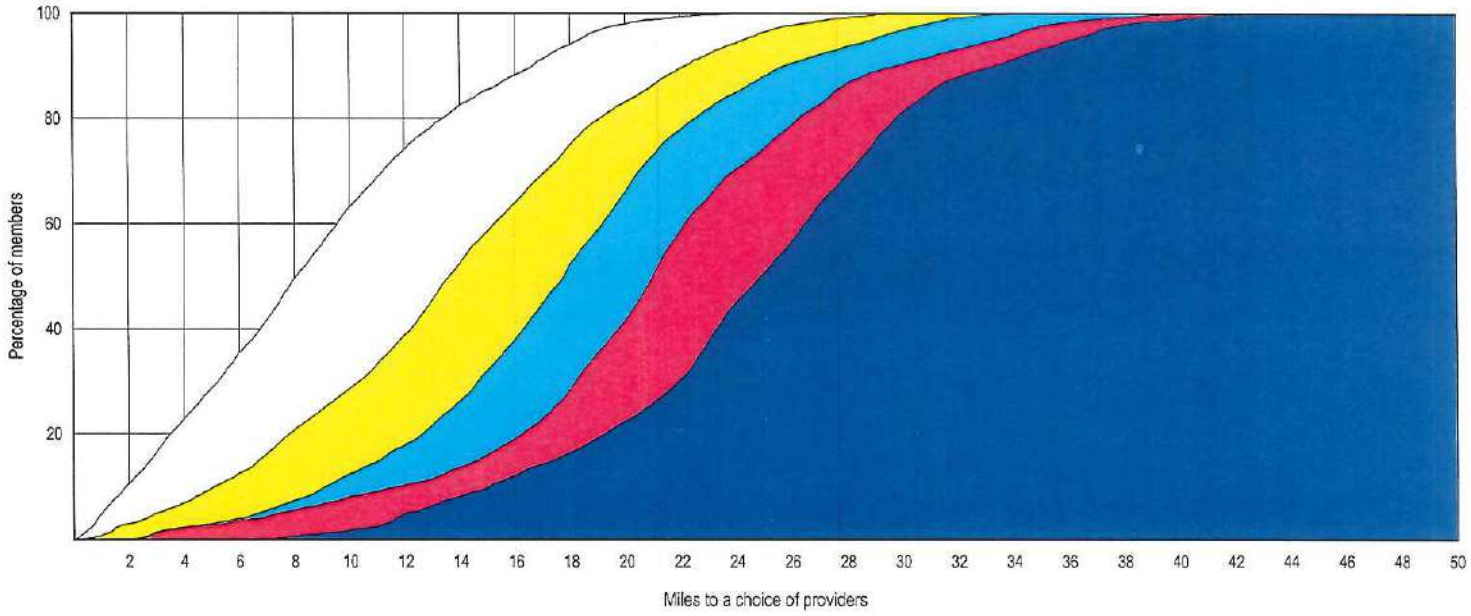

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Access Overview

January 24, 2020

Access Analysis
Region 8 Rural - 1 in 50 minutes

Member / Provider Groups
Region 8 Rural Members
Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services

Comparison Graph
Percent of members with access to a choice of providers over miles
- 1st closest
- 2nd closest
- 3rd closest
- 4th closest
- 5th closest

[1] The Access Standard is defined as (Region 8 Rural Members) members accessing:
1 (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services) provider in 50 minutes

Overall Access[1]

31,600 Members
67 providers at 94 locations (Individual/Clinic Providing Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and EPSDT Special Services)

- 31,585 (99.9%) Members with access
- 0 (0.0%) Members without access
- 15 (0.0%) Members excluded

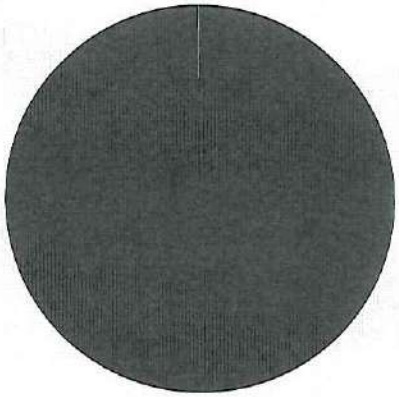

Times

	Average
Time to 1st closest provider	9.5 mins
Time to 2nd closest provider	14.9 mins
Time to 3rd closest provider	19.2 mins
Time to 4th closest provider	22.8 mins
Time to 5th closest provider	26.9 mins

Access Standard Comparison

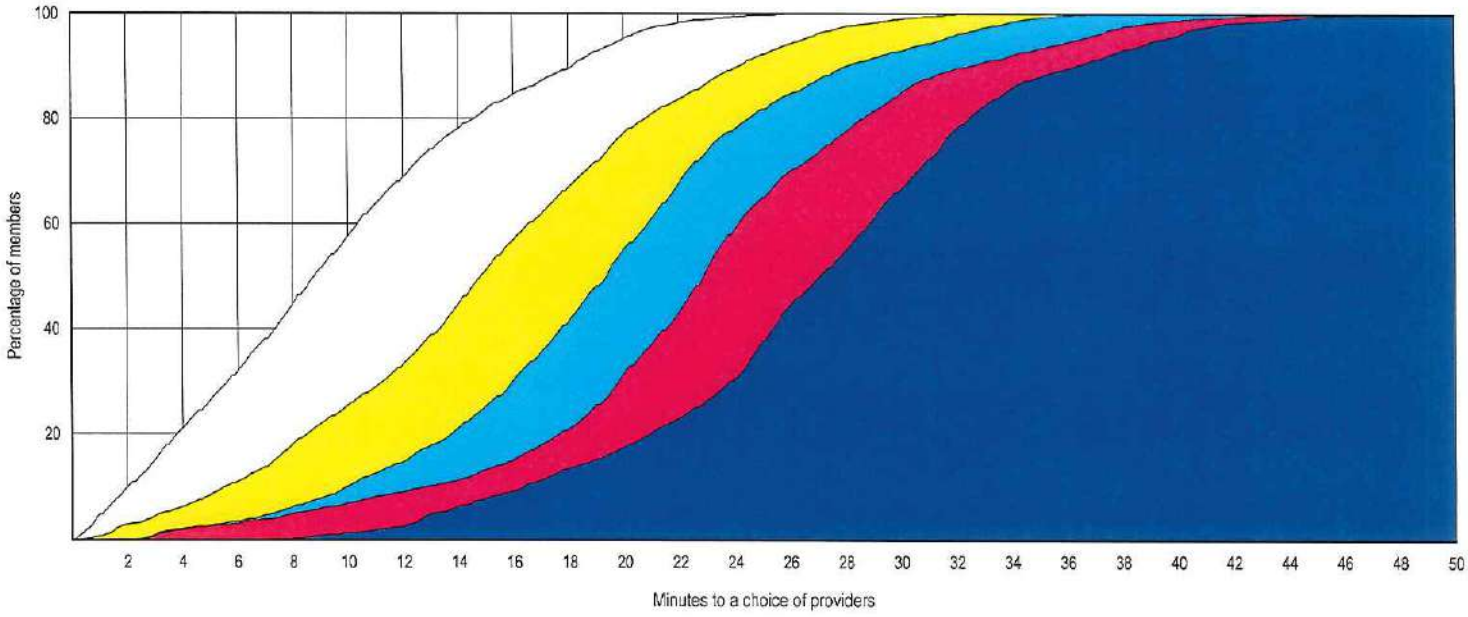

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Sample Network Monitoring Tool – 2018 Raw Data PATS Survey Workbook

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Provider Accessibility Telephonic Survey (PATS) (Secret Shopper)

Below is an example of the Aetna PATS Survey Access tool. The tool is customized by provider type and specific provider requirements. The results of the survey are provided to the Aetna Kentucky Quality Management/Utilization Management Committee for review and also included in NCQA reports. All data is collected via a phone call to the provider's office. Each response is stored in the Access tool and exported to an Excel document for reporting.

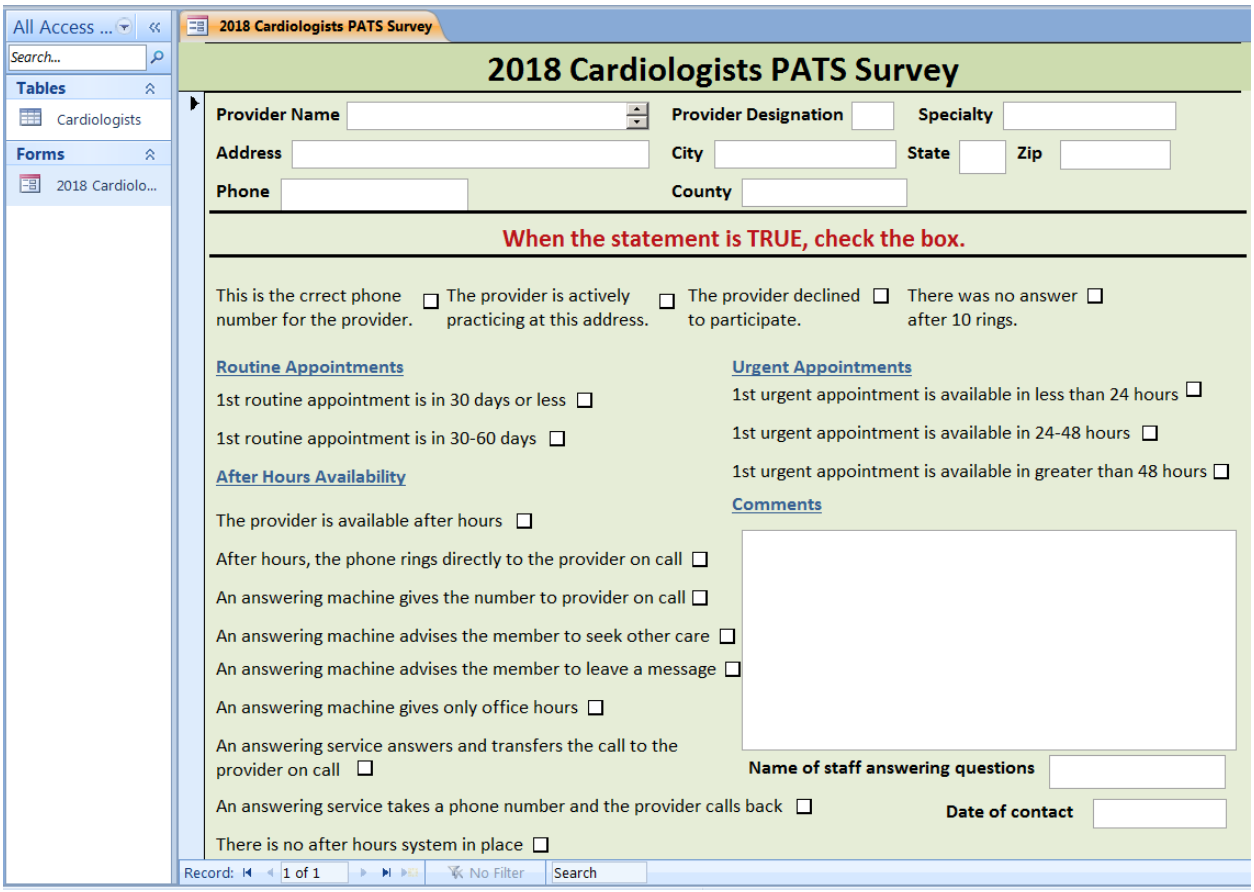

All Access Objects

Search...

Tables

PCP

Forms

PCP Survey Form

PCP Survey Form v2

PCP Survey Form

Provider Name **Provider Designation** **Specialty**

Address **City** **State** **Zip**

Phone **County** **Provider Region**

Is this the correct phone number for the provider? ☐ The provider is actively practicing at this location. ☐ The provider declined to participate. ☐ There was no answer after 10 rings. ☐

When the statement is TRUE, check the box.

Preventive Appointments

The 1st preventive appointment is available in 30 days or less. ☐

The 1st preventive appointment is available in 30-60 days. ☐

Routine Appointments

The 1st routine appointment is available in 30 days or less. ☐

The 1st routine appointment is available in 30-60 days. ☐

After hours availability

The provider available after hours. ☐

After hours, the phone ring directly to the provider on call. ☐

An answering machine gives the number to the provider on call. ☐

An answering machine advises the member to seek other care. ☐

An answering machine advises the member to leave message. ☐

Urgent Appointments

The 1st urgent appt. is available in less than 24 hours ☐

The 1st urgent appt. is available in 24 to 48 hours. ☐

The 1st urgent appt. is available in more then 48 hours. ☐

Comments

An answering machine gives only office hours. ☐

An answering service answers and transfers to the call to the provider on call. ☐

An answering service takes a phone number and the provider calls back. ☐

There is no after hours system in place. ☐

Date of contact **Name of office staff answering questions**

Record: 1 of 1 No Filter Search

All Access Obje...
Search...
Tables
Counselors & Therapi...
Forms
Counselors & Therapi...

Counselors & Therapists

Behavioral Health Provider 2018 PATS Survey

Provider Name **Provider Designation** **Speciality**

Address **City** **State** **Zip**

Phone **County** **Provider Region**

When the statement is TRUE, check the box.

This is the correct phone number for the provider.

The provider actively practicing at this office.

There was no answer after 10 rings.

The provider declined to participate.

There is a new patient appointment for a non-life threatening EMERGENCY within 6 hours.

There is a current patient non life threatening EMERGENCY appointment in 6 hours.

There is a new patient URGENT appointment available in 48 hours.

There is a current patient URGENT appointment available in 48 hours

There is a new patient THERAPY appointment in 10 days.

There is a current patient THERAPY appointment available within 10 days

Date of contact

Name of staff answering questions

The provider has after hours availability.

After hours, the phone rings directly to the provider on call.

After hours, an answering machine gives the phone number to the provider on call.

After hours an answering machine advises the member seek other care.

After hours, an answering machine gives only office hours.

After hours, an answering machine instructs the caller to leave message

After hours, an answering service transfers the caller to the provider on call.

After hours an answering service takes a phone number and the provider calls the member back.

There is no after hours system.

Comments

Record: 1 of 1 No Filter Search

All Access Objects

Search...

Tables

OBGYN

Forms

OBGYN1

OBGYN1

OBGYN

Provider Name **Provider Designation** **Provider Specialty**

Address **City** **State** **Zip**

Phone **County**

When the statement is TRUE, check the box.

This is the correct number for provider ☐ | This provider is actively practicing ☐ | There was no answer after 10 rings ☐ | The provider declined to participate ☐

First Trimester

An appointment is available for a 1st visit in the 1st trimester in 14 days or less. ☐

An appointment is available for a 1st visit in the 1st trimester in 21 days or less. ☐

An appointment is available for a 1st visit in the 1st trimester in more than 21 days. ☐

Second Trimester

An appointment is available for a 1st visit in the 2nd trimester in 7 days or less. ☐

An appointment is available for a 1st visit in the 2nd trimester in 14 days or less. ☐

An appointment is available for a 1st visit in the 2nd trimester in more than 14 days. ☐

Third Trimester

An appointment is available for a 1st visit in 3rd trimester in 3 days or less. ☐

An appointment is available for a 1st visit in 3rd trimester in 7 days or less. ☐

An appointment is available for a 1st visit in 3rd trimester in more than 7 days. ☐

Comments

Name of staff answering questions

Date of contact

After Hours Availability

The provider is available after hours. ☐

After hours, the phone rings directly to the provider on call. ☐

After hours, an answering machine gives the number to the provider on call. ☐

After hours, an answering machine advises the caller to seek other care. ☐

After hours, an answering machine says to leave a message. ☐

After hours, an answering machine gives only the office hours. ☐

After hours, an answering service transfers the call to the on call provider. ☐

After hours, an answering service takes the number and the provider calls back. ☐

There is no after hours system. ☐

Record: 1 of 1 No Filter Search

Sample Network Monitoring Tool – PATS Survey Access Tool

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Cardiologists

NPI	Provider Name	Provider Professional Designation	Provider Specialty	Address1	City	State	Zip	Phone	County	Thyis is the correct phone number

Cardiologists

This provider is actively practicing at this address	Provider declined to participate	There was no answer after 10 rings	1st routine appt is 30 days or less	1st routine appt is 30-60 days	1st urgent appt is less than 24 hours	1st urgent appt is in 24-48 hours	1st urgent appt is greater than 48 hours	The provider is available after hours	After hours, the phone rings directly to the provider on call	An answering machine gives the number to the provider on call

Cardiologists

An answering machine advises the member to seek other care	An answering machine advises the member to leave a message	An answering machine gives only office hours	An answering service transfers the call to the provider on call	An answering service takes a phone number and the provider calls back	There is no after hours system	Date of contact	Name of office staff answering questions	Comments

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PCPs

NPI	Provider Name	Provider professional designation	Provider Specialty	Address1	City	State	Zip	Phone	County	Provider Region	Is this the correct phone number

PCPs

This provider is actively practicing at this address	Provider declined to participate	There was no answer after 10 rings	1st preventive appt is in 30 days or less	1st preventive appt is in 30-60 days	1st routine appt is in 30 days or less	1st routine appt is in 30-60 days	1st urgent appt is less than 24 hours	1st urgent appt is in 24-48 hours	1st urgent appt is in more than 48 hours	The provider is available after hours

PCPs

After hours, the phone rings directly to the provider on call	An answering machine gives the number to the provider on call	An answering machine advises the member to seek other care	An answering machine advises the member to leave a message	An answering machine gives only office hours	An answering service transfers the call to the provider on call	An answering service takes a phone number and the provider calls back	There is no after hours system	Date of contact	Name of officer staff answering questions	Comments

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BH Provider (Therapist)

NPI	Provider Name	Provider professional designation	Provider Specialty	Address1	City	State	Zip	Phone	County	Provider Region

BH Provider (Therapist)

Is this the correct phone number	This provider is actively practicing at this address	There was no answer after 10 rings	Provider declined to participate	There is a new patient appt non-life threat EMERGENCY within 6 hours	There is a current patient non life threatening EMERGENCY appt in 6 hours	There is a new patient URGENT appointment in 48 hours	There is a current patient URGENT appointment in 48 hours	There is a new patient THERAPY appointment in 10 days	There is a current patient THERAPY appointment within 10 days	The provider has after hours availability

BH Provider (Therapist)

After hours, the phone rings directly to the provider on call	After hours, an answering machine gives the number to the provider on call	After hours an answering machine advises the member to seek other care	After hours, an answering machine gives only office hours	After hours, an answering machine instructs the member to leave a message	After hours, an answering service transfers the call to the provider on call	After hours, an answering service takes a phone number and the provider calls back	There is no after hours system	Date of contact	Name of officer staff answering questions	Comments

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OB_GYN

NPI	Provider Name	Provider prof desig	Provider Specialty	Address1	City	State	Zip	Phone	County	Is this the correct phone number	This provider is actively practicing at this address	There was no answer after 10 rings

OB_GYN

Provider declined to participate	An appt is available for a 1st visit in 1st trimester in 14 days or less	An appt is available for a 1st visit in 1st trimester in 21 days or less	An appt is available for a 1st visit in 1st trimester in more than 21 days	An appt is available for a 1st visit in 2nd trimester in 7 or less	An appt is available for a 1st visit in 2nd trimester in 14 or less	An appt is available for a 1st visit in 2nd trimester in more than 14 days	An appt is available for a 1st visit in 3rd trimester in 3 days or less	An appt is available for a 1st visit in 3rd trimester in 7 days or less	An appt is available for a 1st visit in 3rd trimester in more than 7 days	The provider is available after hours

OB_GYN

After hours, the phone rings directly to the provider on call	After hours, an answering machine gives the number to the provider on call	After hours, an answering machine advises the member to seek other care	After hours, an answering machine advises the member to leave a message	After hours, an answering machine gives only office hours	After hours, an answering service transfers the call to the provider on call	After hours, an answering service takes a phone number and the provider calls back	There is no after hours system	Date of contact	Name of officer staff answering questions	Comments

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Sample Network Monitoring Tool – SCA Report

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Aetna Better Health® of Kentucky

Single Case Agreement Inventory Overview

	06/10/2019	06/03/2019	05/27/2019	05/20/2019	05/13/2019	05/06/2019
Total # of Active SCAs						
% Change from previous week						
Average Age of Active SCAs						
% Change from previous week						
Top 5 CPT codes						
1						
2						
3						
4						
5						
Top 5 High Dollar Impact						
1						
2						
3						
4						
5						
Total SCA Count by Region						
1						
2						
3						
4						
5						
6						
7						
8						
OOS						

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Attachment Q

Kentucky | Transforming Health Care | **Aetna**

Attachment Q
C.20 – Covered Services

Provider Testimony ..... Att Q-3

Parity Grid ..... Att Q-7

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Provider Testimony

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Children's Alliance
Kentucky's voice for at-risk children & families

5/30/19

Kentucky Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6W-C
Frankfort, KY 40621

Re: Provider Testimony Regarding Aetna Better Health of Kentucky

To Whom it May Concern:

The Children's Alliance Board of Directors authorized the Children's Alliance to establish a separate Limited Liability Company to promote innovative, efficient, and effective behavioral health services in Kentucky. The Children's Alliance established the Children's Alliance Independent Provider Association, LLC (CA-IPA) with the mission to increase access and improve quality of behavioral health services for Kentucky's at-risk children and families.

The goal of the CA-IPA is to work in partnership with Kentucky Managed Care Organizations (MCO's) and eventually, commercial insurance carriers, to contract with our CA-IPA member agencies for value-based behavioral health services. The CA-IPA has talked with several MCO's regarding this approach; however, Aetna was the first MCO to initiate a partnership with the CA-IPA to create and execute a value-based services contract. The idea of the contract is to incentivize behavioral health care providers to achieve specific outcomes and improve the overall care and well-being of children and families in Kentucky.

Aetna's leadership and staff have been exceptional to work with and they have worked diligently to develop a contract that will move the health care of its members forward. It seems measuring outcomes and working to improve medical care has been implemented in Kentucky for many years, however, most of those value-based contracts have been centered around physical health. Because behavioral health is often more complex, regarding measuring outcomes, the MCO's have been hesitant to engage with the CA-IPA, apart from Aetna. Aetna leaders expressed their concern and commitment to specifically helping the most vulnerable children and families in Kentucky, which are those cared for by CA-IPA members.

Aetna has demonstrated their commitment to foster children and their willingness to work in partnership with providers who care for foster children in a collaborative and innovative way. Initially when Aetna agreed to work with us on this value-based services contract, back in 2017, I must admit I was bit concerned, because some of our member agencies were having trouble getting reimbursed for past services from Aetna. I expressed this concern to Aetna leadership and they immediately worked with our member agencies to ensure the reimbursement issues were resolved. Since that time, our members have worked well with Aetna and they have truly demonstrated a partnership to improve care for at-risk children and families.

If you would like to speak with me or have any questions, please feel free to contact me at michelle@childrensallianceky.org or 502-320-6484. Thank you for your time and consideration.

Sincerely,

Michelle M. Sanborn
President

420 Capitol Avenue • Frankfort, KY 40601 • 502-875-3399 • Fax: 502-223-4200

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Parity Grid

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Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
Medical Necessity Criteria	InterQual	InterQual and Aetna CPBs	No medical necessity guidelines for emergency care	Aetna Medicaid Pharmacy Guidelines	InterQual, ASAM, CASII	InterQual, ASAM, CASII, LOCUS, Aetna Clinical Policy Bulletin	No medical necessity guidelines for emergency care	Aetna Medicaid Pharmacy Guidelines
Prior Authorization	Prior authorization is required for all inpatient m/s treatment. Requests are reviewed by independently licensed nurses. Requests that do not appear to meet medical necessity criteria are reviewed by a Medical Director. Decisions are made within 2 business days of the receipt of the request by applying the appropriate InterQual criteria, or other state approved criteria where there is no applicable	Most standard outpatient services do not require prior authorization. Urgent outpatient prior authorization request decisions are made within 1 business day from the receipt of the request. All outpatient requests requiring prior authorization are reviewed by independently licensed nurses. Requests that do not appear to meet medical necessity criteria are reviewed by a Medical Director. Decisions on	No prior authorization required	Prior authorization is required for all non-formulary medications and some formulary medications, as determined by the Aetna Medicaid Pharmacy Guidelines. Prior authorizations will be reviewed within 24 hours for both urgent and non-urgent requests. Non-urgent requests can be pended for an additional 48 hours to allow for request/receipt of additional information to assist with the review of the request.	Prior authorization is required for all inpatient mh/SUD treatment. Requests are reviewed by independently licensed behavioral health clinicians. Requests that do not appear to meet medical necessity criteria are reviewed by a Medical Director. Decisions are made within 24 hours of the receipt of the request by applying the appropriate InterQual, ASAM or CASII criteria.	Most standard outpatient services do not require prior authorization. Decisions on non-urgent prior authorization requests are made within 2 business days from the receipt of the request. Urgent outpatient prior authorization request decisions are made within 24 hours from the receipt of the request. Requests are reviewed by independently licensed behavioral health clinicians. Requests that do	No prior authorization required	Prior authorization is required for all non-formulary medications and some formulary medications, as determined by the Aetna Medicaid Pharmacy Guidelines. Prior authorizations will be reviewed within 24 hours for both urgent and non-urgent requests. Non-urgent requests can be pended for an additional 48 hours to allow for request/receipt of additional information to assist with the review of the request.

aetna™

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
	InterQual criteria.	non-urgent requests are made within 2 business days of the receipt of the request. All decisions are made by applying the appropriate InterQual criteria, or other state approved criteria where there is no applicable InterQual criteria		Requests are initially reviewed by pharmacy technicians. Requests that may not meet clinical criteria developed through the contractually required pharmacy and therapeutics (P&T) committee are sent to a licensed pharmacist for additional review. If the pharmacist recommends denial, the request is forwarded to a medical director for final determination.		not appear to meet medical necessity criteria are reviewed by a Medical Director. Decisions are made by applying the appropriate InterQual, ASAM, LOCUS, and CASII or other state approved criteria where there is no applicable InterQual, ASAM, LOCUS, or CASII criteria.		Requests are initially reviewed by pharmacy technicians. Requests that may not meet clinical criteria developed through the contractually required pharmacy and therapeutics (P&T) committee are sent to a licensed pharmacist for additional review. If the pharmacist recommends denial, the request is forwarded to a medical director for final determination.
Concurrent Review	Concurrent review is required for all inpatient m/s treatment. Requests are reviewed by independently	Outpatient services do not require concurrent review. Requests for continued treatment	No concurrent review required	No concurrent review required	Concurrent review is required for all inpatient mh/SUD treatment Requests are reviewed by	Most standard outpatient services do not require concurrent review. Urgent outpatient services	No concurrent review required	No concurrent review required

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
	licensed nurses. Requests that do not appear to meet medical necessity criteria are reviewed by a Medical Director. Decisions are made within 24 hours of the receipt of the request by applying the appropriate InterQual criteria, or other state approved criteria where there is no applicable InterQual criteria.	and/or services are considered prior authorization requests and are handled via the process described above.			independently licensed behavioral health clinicians. Requests that do not appear to meet medical necessity criteria are reviewed by a Medical Director. Decisions are made within 24 hours of the receipt of the request by applying the appropriate InterQual, ASAM or CASII criteria.	requiring concurrent review are IOP, PHP ,ACT and TFC. Concurrent review is applied to these levels of care, rather than the prior authorization requirements on the m/s side, which ensures expeditious turnaround times for review and continuity of care for extension of previously approved services. Requests are reviewed by independently licensed behavioral health clinicians. Requests that do not appear to meet medical necessity criteria are reviewed by a Medical Director.		

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
						Decisions are made by applying the appropriate InterQual, ASAM, LOCUS, and CASII or other state approved criteria where there is no applicable InterQual, ASAM, LOCUS, or CASII criteria. Ongoing outpatient m/s services (i.e. outpatient therapy, home health) require authorization. These services are authorized as prior authorizations, rather than concurrent reviews. They have a turnaround time of 2 business days. Outpatient mh/sud are authorized as		

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
						concurrent reviews, with a turnaround time of 1 calendar day. The restrictiveness of the authorization requirements is equivalent between the two areas but offers mh/sud providers and members faster determinations.		
Retrospective Review	Retrospective review is required for all m/s inpatient treatment that did not receive prior authorization. Requests are reviewed by independently licensed nurses. Requests that do not appear to meet medical necessity criteria are reviewed by a Medical	Same as prior authorization requirements, when prior authorization was not obtained.	No retrospective review required since prior authorization isn't required	No retrospective review required	Retrospective review is required for all mh/SUD inpatient treatment that did not receive prior authorization. Requests are reviewed by independently licensed behavioral health clinicians. Requests that do not appear to meet medical	Same as prior authorization requirements, when prior authorization was not obtained	No retrospective review required since prior authorization isn't required	No retrospective review required

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
	Director. Decisions are made within 14 calendar days of the receipt of the request by applying the appropriate InterQual criteria, or other state approved criteria where there is no applicable InterQual criteria.				necessity criteria are reviewed by a Medical Director. Decisions are made within 14 calendar days of the receipt of the request by applying the appropriate InterQual, ASAM or CASII criteria.			
Prior Notifications	No prior notification required	No prior notification required	No prior notification required	No prior notification required	No prior notification required	No prior notification required	No prior notification required	No prior notification required
Other Utilization Review Strategies	No other utilization review strategies, at this time	No other utilization review strategies, at this time	No other utilization review strategies, at this time	No other utilization review strategies, at this time	No other utilization review strategies, at this time	No other utilization review strategies, at this time	No other utilization review strategies, at this time	No other utilization review strategies, at this time
Step or Fail First Therapies	Whether a step or fail first therapy is required is dependent upon the specific applicable InterQual criteria utilized, but Aetna does	Whether a step or fail first therapy is required is dependent upon the specific applicable InterQual criteria utilized, but Aetna does	No step or fail first therapies required	Step and fail first therapies are incorporated as part of the medical necessity review for all non-formulary medications. Medications that	No step or fail first therapies required.	No step or fail first therapies required.	No step or fail first therapies required	Step and fail first therapies are incorporated as part of the medical necessity review for all non-formulary medications. Medications that

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
	not have any step or fail first therapies outside of the InterQual criteria.	not have any step or fail first therapies outside of the InterQual criteria.		require step therapy are denoted on the Preferred Drug List and the Step Therapy guidelines. These drugs are either generic drugs or formulary brand drugs and require a trial and failure of first line agent(s) before approval of second line drugs. Step and fail first therapies are incorporated as part of the medical necessity review for all non-formulary medications. Medications that require step therapy are denoted on the Preferred Drug List and the Step Therapy guidelines.				require step therapy are denoted on the Preferred Drug List and the Step Therapy guidelines. These drugs are either generic drugs or formulary brand drugs and require a trial and failure of first line agent(s) before approval of second line drugs. Aetna has no step or fail first policies or processes for m/s or mh/sud inpatient or outpatient services, outside the contractually required medical necessity criteria of InterQual. InterQual is a nationally recognized, evidence-based set of criteria that uses best-

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Parity Grid

Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
			These drugs are either generic drugs or formulary brand drugs and require a trial and failure of first line agent(s) before approval of second line drugs. Aetna has no step or fail first policies or processes for m/s or mh/sud inpatient or outpatient services, outside the contractually required medical necessity criteria of InterQual. InterQual is a nationally recognized, evidence-based set of criteria that uses best-practices to determine what criteria are needed for each individual service. Step or				practices to determine what criteria are needed for each individual service. Step or fail first therapy may be required for some services, based on those best-practices. The number of criteria sets available is extensive and individualized to each service for both m/s and mh/sud.

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
				fail first therapy may be required for some services, based on those best-practices. The number of criteria sets available is extensive and individualized to each service for both m/s and mh/sud.				
Probability of improvement requirements	Probability of improvement may be required for some specific services within the InterQual criteria sets, but Aetna does not have any probability of improvement requirements outside of the InterQual criteria. Depending upon diagnosis, InterQual dictates current condition based	Probability of improvement may be required for some specific services within the InterQual criteria sets, but Aetna does not have any probability of improvement requirements outside of the InterQual criteria. To meet InterQual for most outpatient rehabilitation criteria sets, a goal to "improve	Probability of improvement requirements	No probability of improvement requirements	Probability of improvement may be required for some specific services within the InterQual criteria sets, but Aetna does not have any probability of improvement requirements outside of the InterQual criteria. To meet InterQual Inpatient, Residential Treatment Center or	Probability of improvement may be required for some specific services within the InterQual criteria sets, but Aetna does not have any probability of improvement requirements outside of the InterQual criteria. . To meet InterQual Partial Hospitalization, Intensive Outpatient	No probability of improvement requirements	No probability of improvement requirements

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Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
	on current length of stay. Aetna has no probability of improvement requirements for m/s or mh/sud inpatient or outpatient services, outside the contractually required medical necessity criteria of InterQual. InterQual is a nationally recognized, evidence-based set of criteria that uses best-practices to determine what criteria are needed for each individual service. Probability of improvement may be required for some services, based on those best-practices. The number of criteria sets	function and reduce limitation" is required.			Residential Crisis Program criteria for day 2+, symptom(s) must be expected to improve.	Program or Intensive Community Based Treatment for day 2+, symptom(s) must be expected to improve.		

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
	available is extensive and individualized to each service for both m/s and mh/sud.							
Exclusions based on failure to complete a course of treatment	No exclusion based on failure to complete a course of treatment	No exclusion based on failure to complete a course of treatment	No exclusion based on failure to complete a course of treatment	No exclusion based on failure to complete a course of treatment	No exclusion based on failure to complete a course of treatment	No exclusion based on failure to complete a course of treatment	No exclusion based on failure to complete a course of treatment	No exclusion based on failure to complete a course of treatment
Written treatment plan requirements	No written treatment plan requirements	Written treatment plans may be required for some specific services within the InterQual criteria sets, but Aetna does not have any written treatment plan requirements outside of the InterQual criteria. InterQual rehabilitation criteria have specific treatment plan requirements. As rehabilitation services are requested, an	No written treatment plan requirements	Written treatment plan requirements	No written treatment plan requirements	Written treatment plans may be required for some specific services within the InterQual criteria sets, but Aetna does not have any written treatment plan requirements outside of the InterQual criteria. InterQual ABA criteria has specific treatment plan requirements. As ABA services are requested, the written treatment plan	No written treatment plan requirements	No written treatment plan requirements

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Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
		evaluation listing the treatment components or the treatment plan should be included with the request.				should be included with the request.		
Experimental/ Investigational Determinations	Experimental and Investigational treatment requests are reviewed for coverage if not specifically excluded by KY Medicaid. Treatment requests must fall under FDA approval, which includes the purpose of the treatment. Any requested course of treatment that is not FDA approved or any deviance from FDA guidelines governing an already FDA approved treatment, will	Experimental and Investigational treatment requests are reviewed for coverage if not specifically excluded by KY Medicaid. Treatment requests must fall under FDA approval, which includes the purpose of the treatment. Any requested course of treatment that is not FDA approved or any deviance from FDA guidelines governing an already FDA approved treatment, will	Experimental and Investigational treatment requests are reviewed for coverage if not specifically excluded by KY Medicaid. Treatment requests must fall under FDA approval, which includes the purpose of the treatment. Any requested course of treatment that is not FDA approved or any deviance from FDA guidelines governing an already FDA approved treatment, will	Experimental and Investigational treatment requests are reviewed for coverage if not specifically excluded by KY Medicaid. Treatment requests must fall under FDA approval, which includes the purpose of the treatment. Any requested course of treatment that is not FDA approved or any deviance from FDA guidelines governing an already FDA approved treatment, will	Experimental and Investigational treatment requests are reviewed for coverage if not specifically excluded by KY Medicaid. Treatment requests must fall under FDA approval, which includes the purpose of the treatment. Any requested course of treatment that is not FDA approved or any deviance from FDA guidelines governing an already FDA approved treatment, will	Experimental and Investigational treatment requests are reviewed for coverage if not specifically excluded by KY Medicaid. Treatment requests must fall under FDA approval, which includes the purpose of the treatment. Any requested course of treatment that is not FDA approved or any deviance from FDA guidelines governing an already FDA approved treatment, will	Experimental and Investigational treatment requests are reviewed for coverage if not specifically excluded by KY Medicaid. Treatment requests must fall under FDA approval, which includes the purpose of the treatment. Any requested course of treatment that is not FDA approved or any deviance from FDA guidelines governing an already FDA approved treatment, will	Experimental and Investigational treatment requests are reviewed for coverage if not specifically excluded by KY Medicaid. Treatment requests must fall under FDA approval, which includes the purpose of the treatment. Any requested course of treatment that is not FDA approved or any deviance from FDA guidelines governing an already FDA approved treatment, will

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
	be consider experimental and as a standard, will not be covered. However, if the requested treatment is the only available treatment, the request with all supporting clinical literature may be submitted. Approval of the request can be made based on guidance from the State.	be consider experimental and as a standard, will not be covered. However, if the requested treatment is the only available treatment, the request with all supporting clinical literature may be submitted. Approval of the request can be made based on guidance from the State.	be consider experimental and as a standard, will not be covered. However, if the requested treatment is the only available treatment, the request with all supporting clinical literature may be submitted. Approval of the request can be made based on guidance from the State.	be consider experimental and as a standard, will not be covered. However, if the requested treatment is the only available treatment, the request with all supporting clinical literature may be submitted. Approval of the request can be made based on guidance from the State.	be consider experimental and as a standard, will not be covered. However, if the requested treatment is the only available treatment, the request with all supporting clinical literature may be submitted. Approval of the request can be made based on guidance from the State.	be consider experimental and as a standard, will not be covered. However, if the requested treatment is the only available treatment, the request with all supporting clinical literature may be submitted. Approval of the request can be made based on guidance from the State.	be consider experimental and as a standard, will not be covered. However, if the requested treatment is the only available treatment, the request with all supporting clinical literature may be submitted. Approval of the request can be made based on guidance from the State.	be consider experimental and as a standard, will not be covered. However, if the requested treatment is the only available treatment, the request with all supporting clinical literature may be submitted. Approval of the request can be made based on guidance from the State.
Provider Reimbursement	PAR providers are paid via their established contract; Non-par providers receive an established percentage of the Medicaid rate unless otherwise negotiated	PAR providers are paid via their established contract; Non-par providers receive an established percentage of the Medicaid rate unless otherwise negotiated	PAR providers are paid via their established contract; Non-par providers receive an established percentage of the Medicaid rate unless otherwise negotiated	N/A	PAR providers are paid via their established contract; Non-par providers receive an established percentage of the Medicaid rate unless otherwise negotiated	PAR providers are paid via their established contract; Non-par providers receive an established percentage of the Medicaid rate unless otherwise negotiated	PAR providers are paid via their established contract; Non-par providers receive an established percentage of the Medicaid rate unless otherwise negotiated	N/A
Usual, Customary and	All contracts are negotiated with	All contracts are negotiated with	All contracts are negotiated with	N/A	All contracts are negotiated with	All contracts are negotiated with	All contracts are negotiated with	N/A

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Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
Reasonable (UCR) Determination	the provider or are influenced by DMS Fee for Service rates	the provider or are influenced by DMS Fee for Service rates	the provider or are influenced by DMS Fee for Service rates		the provider or are influenced by DMS Fee for Service rates	the provider or are influenced by DMS Fee for Service rates	the provider or are influenced by DMS Fee for Service rates	
Network tier design	There is no tier design for medical/surgical providers	There is no tier design for medical/surgical providers	There is no tier design for medical/surgical providers	N/A	There is no tier design for BH providers	There is no tier design for BH providers	There is no tier design for BH providers	N/A
Network participation requirements in addition to Licensure/ Certification	Require providers to be Medicaid participating providers	Require providers to be Medicaid participating providers	Require providers to be Medicaid participating providers	N/A	Require providers to be Medicaid participating providers	Require providers to be Medicaid participating providers	Require providers to be Medicaid participating providers	N/A
Geographic Restrictions	No Geographic Restrictions	No Geographic Restrictions	No Geographic Restrictions	No Geographic Restrictions	No Geographic Restrictions	No Geographic Restrictions	No Geographic Restrictions	No Geographic Restrictions
Restrictions based on provider specialty	N/A	Restrictions based on provider type are specific to the code definitions and restrictions.	N/A	N/A	N/A	Restrictions based on provider type are specific to the code definitions and restrictions.	N/A	N/A
Restrictions based on facility type	Restrictions based on facility type are specific to the code definitions and restrictions and facility licensing.	Restrictions based on facility type are specific to the code definitions and restrictions and facility licensing.	N/A	N/A	Restrictions based on facility type are specific to the code definitions and restrictions and facility licensing.	Restrictions based on facility type are specific to the code definitions and restrictions and facility licensing.	N/A	N/A

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
Standards for Out-of-Network Coverage	Non-participating providers are considered for coverage when a participating provider is not available in a timely manner or if services are contractually excluded from network consideration. All non-participating providers receive an established percentage of the Medicaid rate unless otherwise negotiated	Non-participating providers are considered for coverage when a participating provider is not available in a timely manner or if services are contractually excluded from network consideration. All non-participating providers receive an established percentage of the Medicaid rate unless otherwise negotiated	All non-participating providers receive an established percentage of the Medicaid rate unless otherwise negotiated	N/A	Non-participating providers are considered for coverage when a participating provider is not available in a timely manner or if services are contractually excluded from network consideration. All non-participating providers receive an established percentage of the Medicaid rate unless otherwise negotiated	Non-participating providers are considered for coverage when a participating provider is not available in a timely manner or if services are contractually excluded from network consideration. All non-participating providers receive an established percentage of the Medicaid rate unless otherwise negotiated	All non-participating providers receive an established percentage of the Medicaid rate unless otherwise negotiated	N/A
Blanket exclusions for court-ordered or involuntary treatment that is medically necessary	Court ordered services are subject to medical necessity review but there are no blanket exclusions	Court ordered services are subject to medical necessity review but there are no blanket exclusions	N/A	Court ordered services are subject to medical necessity review but there are no blanket exclusions	Court ordered services are subject to medical necessity review but there are no blanket exclusions	No blanket exclusions for court ordered or involuntary treatment	N/A	No blanket exclusions for court ordered or involuntary treatment

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
Formulary Design	N/A	N/A	N/A	All medications are subject to the same consideration for formulary inclusion.	N/A	N/A	N/A	All medications are subject to the same consideration for formulary inclusion.
Pharmacy Benefit Tiers	N/A	N/A	N/A	ABHKY applies the exemptions as set forth in 907.KAR 1:604, which includes children, pregnant women, those receiving hospice care, preventative services, emergency services, family planning services and any other exemptions set forth in 907 KAR 1:604. This has been the case prior to 07/01/18 and from 07/01/18 and thru the present. Prior to 7/1/18, copays were as follows: $0 copay on	N/A	N/A	N/A	Prior to 7/1/18, copays were as follows: $0 copay on generics, $1 preferred brand drugs, and $4 non-preferred drugs. Exceptions, as set by DMS: non-preferred brand 2nd generation antipsychotics which carried a $1 copay and long acting injectable antipsychotics also carried a $1 copay. From 7/1/18 through the present, copays are as follows: Generic drug - $1; Preferred brand name drug $1

Parity Grid

Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
			generics, $1 preferred brand drugs, and $4 non-preferred drugs. Exceptions, as set by DMS: non-preferred brand 2nd generation antipsychotics which carried a $1 copay and long acting injectable antipsychotics also carried a $1 copay. From 7/1/18 through the present, copays are as follows: Generic drug - $1; Preferred brand name drug $1 when preferred over generic, otherwise $4; Non-preferred brand name drug $4. Exceptions, as set by DMS: non-preferred brand 2nd generation antipsychotics				when preferred over generic, otherwise $4; Non-preferred brand name drug $4. Exceptions, as set by DMS: non-preferred brand 2nd generation antipsychotics which carry a $1 copay and long acting injectable antipsychotics also carry a $1 copay.

Parity Grid

	Medical/Surgical NQTLs				Mental Health/SUD NQTLs			
	InPatient	Outpatient	Emergency Care	Prescription Drugs	InPatient	Outpatient	Emergency Care	Prescription Drugs
				which carry a $1 copay and long acting injectable antipsychotics also carry a $1 copay.				
Other NQTLs	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Attachment R

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Attachment R
C.21 – PBM Subcontract

Some pages of the attached Subcontract for pharmacy benefit manager services include confidential and proprietary information markings that were part of the original document and could not be removed. We do not consider these pages confidential for purposes of this proposal and therefore have not submitted them under separate sealed cover.

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EXECUTION VERSION

AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT

by and between

AETNA HEALTH MANAGEMENT, LLC
a Delaware limited liability company,

and

CAREMARKPCS HEALTH, L.L.C.
a Delaware limited liability company

Dated as of October 2, 2013

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AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT

This **AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT** (this "Agreement"), dated as of October 2, 2013 (the "Agreement Date"), is entered into by and between Aetna Health Management, LLC, a Delaware limited liability company ("Aetna"), on behalf of itself and its Affiliates Aetna Rx Home Delivery, LLC, a Delaware limited liability company ("Aetna Rx Home Delivery"), and Aetna Specialty Pharmacy, LLC, a Delaware limited liability company ("Aetna Specialty Pharmacy"), and CaremarkPCS Health, L.L.C., a Delaware limited liability company ("PBM"), on behalf of itself and its Affiliate Caremark Rx, L.L.C., a Delaware limited liability company ("Caremark Rx"), including the PBM Pharmacy Entities. Aetna and PBM are sometimes referred to herein collectively as "Parties" and individually as a "Party."

RECITALS

A. PBM offers, and has the expertise to provide, certain services related to the administration of prescription drug benefit programs, including claims processing, pharmacy network administration, member services and rebate administration, and also, through the PBM Pharmacy Entities provides, and has the expertise to provide, services to support mail order and specialty pharmacies.

B. Aetna manages, administers and performs various prescription drug and pharmacy benefit management functions and services for and on behalf of the Aetna Plan Affiliates and the Aetna Plans.

C. The Parties are party to that certain Pharmacy Benefit Management Subcontract Agreement, dated as of July 27, 2010, as amended (including through that certain Amendment to Pharmacy Benefit Management Subcontract Agreement dated as of the Agreement Date and entered into immediately prior to the execution of this Agreement) (the "Original Agreement") pursuant to which Aetna has subcontracted and delegated the performance of certain of such prescription drug and pharmacy benefit management-related functions and services to PBM, and PBM has agreed to perform such functions and services, all as specified therein.

D. Aetna Rx Home Delivery and Aetna Specialty Pharmacy respectively own and operate certain mail and specialty pharmacies.

E. Pursuant to the Original Agreement, Aetna, Aetna Rx Home Delivery and Aetna Specialty Pharmacy have outsourced to PBM the performance of certain back-end and supporting mail and specialty pharmacy functions and services currently performed by Aetna Rx Home Delivery and Aetna Specialty Pharmacy, and PBM has agreed to perform such functions and services, all as specified therein.

F. The Parties desire to amend and restate the Original Agreement, effective as of January 1, 2015 (the "Effective Date"), as set forth in this Agreement.

NOW, THEREFORE, in consideration of the promises, covenants, representations and warranties set forth herein, and other consideration, the sufficiency of which is hereby acknowledged, the Parties each hereby agree as follows:

ARTICLE I.
DEFINED TERMS

1.1 **Definitions.**

Unless otherwise expressly noted herein, capitalized terms used in this Agreement shall have the respective meanings specified in Annex A or as otherwise defined in the provisions of this Agreement.

ARTICLE II.
EFFECTIVENESS; TERM

2.1 **Effectiveness.**

The Parties agree that the Original Agreement will remain in full force and effect through December 31, 2014, and the Parties shall continue to perform their respective obligations thereunder through such date, and the terms and conditions of the Original Agreement (and not this Agreement) shall govern the rights and obligations of the Parties with respect to the performance of such obligations through such date. Effective as of 12:01 a.m. on the Effective Date, the terms and conditions set forth in this Agreement shall become effective, shall fully supersede the Original Agreement with respect to the performance obligations of the Parties from and after the Effective Date and shall govern the performance and obligations of the Parties hereunder with respect to all periods from and after the Effective Date. In the event of any termination, in whole or in part, of the Original Agreement prior to the Effective Date, this Agreement shall terminate to the same extent without further action of the Parties. Further, any dispute, right or obligation arising with respect to performance by the Parties under the Original Agreement prior to the Effective Date shall be governed by the Original Agreement (even if the matter arises after the Effective Date), and any dispute, right or obligation arising with respect to performance by the Parties under this Agreement from and after the Effective Date shall be governed by this Agreement. In no event does either Party, by such Party's execution and delivery of this Agreement or its performance or exercise of any rights under this Agreement, waive, release, discharge, or otherwise impair any rights or remedies of such Party that arise under the Original Agreement prior to the Effective Date, including on account of any Losses, breaches or acts or omissions arising or occurring thereunder prior to the Effective Date.

2.2 **Term.**

Unless earlier terminated pursuant to Article XII, this Agreement will be in effect for a term (the "Term") that commences on the Effective Date and ends on December 31, 2022 (the "Scheduled Expiration Date").

2.3 **Term Phases.**

The Term shall consist of the following phases (which will overlap in part):

(a) a transition-in phase (the "Transition-In Phase"), which is limited to a continuation of the Transition-In Phase under the Original Agreement and shall commence on the Effective Date and continue until the completion to Aetna's reasonable satisfaction of:

(i) all milestones and tasks set forth in Schedules A and A-1 to A-6 that have not been completed in accordance with the Original Agreement prior to the Effective Date (and during the Transition-In Phase, PBM shall perform the Transition-In Services under such portions of the Transition-In Plan to the extent not fully performed and completed in accordance with the Original Agreement prior to the Effective Date); and

(ii) all milestones and tasks set forth in Schedule A-7 that have not been completed in accordance with the Original Agreement prior to the Effective Date (and during the Transition-In Phase, PBM shall perform the Transition-In Services under Schedule A-7 to the extent not fully performed and completed in accordance with the Original Agreement prior to the Effective Date).

(b) a performance phase (the "Performance Phase"), which shall commence on the Effective Date and continue for the remainder of the Term, during which time PBM shall perform the PBM Services for and with respect to Covered Plans and Aetna Customers as and to the extent the applicable Cutover Dates have occurred.

2.4 Termination Transition Period.

If and to the extent Aetna so elects, and subject to Aetna's continued payment of all amounts due and owing to PBM under this Agreement, PBM shall provide the Transition-Out Services for a period that commences on the first to occur of (a) the date on which either Party, pursuant to Article XII, notifies the other Party of its intent to terminate this Agreement, or (b) January 1, 2022, and continues until the later of (i) the eighteen (18) month anniversary of the expiration or termination of the Term, regardless of the basis or circumstances for such expiration or termination, or (ii) if Aetna terminates the Agreement pursuant to Section 12.1(a) or PBM terminates this Agreement pursuant to Section 12.2(a), the thirty (30) month anniversary of the delivery by a terminating Party of a notice of termination in accordance with Article XII (the "Termination Transition Period"). Aetna shall have the right, in its sole discretion, to shorten the Termination Transition Period by delaying the commencement date and/or accelerating the end date of the Termination Transition Period, by giving written notice to PBM.

ARTICLE III.
SERVICES

3.1 Services During the Transition-In Phase.

During the Transition-In Phase, (i) PBM, at its sole cost, shall carry out the implementation, transition and migration plan described in Schedule A (the "Transition-In Plan") and shall perform the services described in Schedule A (the "Transition-In Services"), and (ii) PBM shall achieve the milestones, deadlines and customer performance standards and service levels set forth in Schedule A, in each case to the extent not fully performed or achieved in accordance with the Original Agreement prior to the Effective Date. In the event that PBM fails to achieve such milestones, deadlines, customer performance standards and service levels as set

forth in Schedule A, PBM shall pay Aetna the applicable Guarantee Amounts set forth in Schedule A.

3.2 **Services During the Performance Phase.**

(a) PBM Services. During the Performance Phase, with respect to all Covered Plans, Aetna Customers and PBM Services as to which and to the extent the applicable Cutover Dates have occurred, PBM shall provide Aetna and the Aetna Plan Affiliates with the following services (collectively, the "PBM Services"): (i) Benefit Plan Set-Up, as set forth in Schedule B; (ii) Eligibility Services, as set forth in Schedule C; (iii) Claims Processing and Adjudication Services, as set forth in Schedule D; (iv) Customer and Member Service, as set forth in Schedule E; (v) Prescription Drug Utilization Review Services, as set forth in Schedule F; (vi) Retail Pharmacy Network Services, as set forth in Schedule G; (vii) Member, Provider, Participating Pharmacy and Aetna Customer Communications, as set forth in Schedule H; (viii) Rebate Administration Services, as set forth in Schedule I; (ix) Clinical Services, as set forth in Schedule J; (x) Prior Authorization Services, as set forth in Schedule K; (xi) Sales Support and Account Management Services, as set forth in Schedule L; (xii) Supporting Mail Order Pharmacy Services, as set forth in Schedule M; (xiii) Supporting Specialty Pharmacy Services, as set forth in Schedule N; (xiv) Medicare Part D Services, as set forth in Schedule O; (xv) Medicaid and Other State Plan Services, as set forth in Schedule P, and (xvi) Retiree Drug Subsidy Services, as set forth in Schedule S. During the Performance Phase, the Parties also shall perform their respective responsibilities pursuant to Schedules DD, EE, FF and GG.

(b) Core Services & Optional Services. As noted in Schedule Y-7, certain specific PBM Services are designated as "Optional Services;" all other PBM Services are "Core Services." PBM shall provide Optional Services if, as and for so long as requested by Aetna.

(c) Third-Party State Plan Services. Except as provided in this Section 3.2(c), none of the Third-Party State Plans will be Covered Plans, and PBM shall not provide any PBM Services with respect thereto. At any time during the Term, Aetna shall have the right, by providing at least one-hundred eighty (180) days (or any shorter time period mutually agreed by the Parties on a case by case basis), prior written notice to PBM, to require PBM to provide the PBM Services for and with respect to any Third-Party State Plan for the period of time specified in such notice or until Aetna elects, by providing not less than one-hundred eighty (180) days (or any shorter time period mutually agreed by the Parties on a case by case basis) prior written notice to PBM, to terminate the provision of such PBM Services. In such event and for such period of time, such Third Party State Plan shall constitute a Covered Plan. In addition, if Aetna so requests in its written notice, PBM shall, within one-hundred eighty (180) days (or any shorter time period mutually agreed by the Parties on a case by case basis), enter into a Contract with the applicable Third-Party State Plan Sponsor confirming its agreement to provide the PBM Services for and with respect to the Third-Party State Plan in accordance with the terms and conditions of this Agreement together with such other terms and conditions as may be reasonably required by such Third-Party State Plan Sponsor and are reasonably acceptable to Aetna and PBM.

(d) Aetna Customer Elections; Adjudication of Claims Under Medical Benefit. It is understood that certain customers and prospective customers of Aetna may elect to purchase Aetna Plans that do not include pharmacy benefits or otherwise carve out pharmacy

benefits administration from their Aetna Plans. Such Aetna Plans shall not constitute Covered Plans except to the extent that Aetna, at its option, elects by providing reasonable written notice to PBM, to require PBM to provide PBM Services with respect to Specialty Products and/or other medical benefit-related pharmacy services under such Aetna Plans and as outlined in Schedules N and Y-6. It is also understood that other Aetna Plans that include pharmacy benefits will similarly have Claims that are adjudicated under Aetna's medical benefit and that Aetna may, at its option, elect, by providing reasonable written notice to PBM, to require PBM to provide PBM Services with respect to such Claims.

(e) Optional Plans. Except as otherwise provided in this Section 3.2(e), none of the Optional Plans shall be Covered Plans, and PBM shall not provide any PBM Services with respect thereto. At any time during the Term, Aetna shall have the right, by providing reasonable written notice to PBM, to require PBM to provide some or all of the PBM Services, as Aetna may specify, for and with respect to any Optional Plans for the period of time specified in such notice or until Aetna elects, by providing not less than one-hundred eighty (180) days (or any shorter time period mutually agreed by the Parties on a case by case basis), prior written notice to PBM, to terminate the provision of such PBM Services. In such event and for such period of time, such Optional Plan shall constitute a Covered Plan.

(f) Changes in Applicable Law. As further provided in Section 14.1, PBM shall perform the PBM Services for and with respect to each Covered Plan in accordance with all Laws applicable to the performance of such Services for such Covered Plan. In the event of any change in the Laws that are applicable to the PBM Services for or with respect to any Covered Plan, PBM shall comply with such changed Laws to the full extent applicable thereto. In addition, to the extent required under Section 9.11, the Parties shall pursuant to Section 9.11 negotiate in good faith appropriate amendments to this Agreement to address any change in the manner in which PBM must perform the Services in order to comply with such changed Law.

(g) Differing Interpretations of Laws; Inconsistencies. In the event the Parties disagree with respect to the interpretation of any Law applicable to this Agreement, the Parties will discuss their respective interpretations and will negotiate in good faith to reach agreement on the interpretation. If the Parties, acting in good faith, are unable to agree upon an interpretation of the applicable Law or a resolution of the inconsistency or conflict, (i) Aetna's interpretation of the Law or method for resolving the inconsistency or conflict shall govern and be controlling with respect to PBM's performance of the Services from and after the date on which Aetna notifies PBM of such interpretation (except to the extent PBM determines, based on the written opinion of its legal counsel, that Aetna's interpretation or the method of resolution would require PBM to perform any of the Services in a manner that would constitute a violation of applicable Law by PBM), and (ii) PBM shall (subject to the parenthetical in clause (i)) perform the Services in accordance therewith. In addition, to the extent required under Section 9.11, the Parties shall pursuant to Section 9.11 negotiate in good faith appropriate amendments to this Agreement to address any change in the manner in which PBM must perform the Services in order to comply with an interpretation of Law by Aetna as to which PBM disagrees. For clarity, Aetna's interpretation of any such Law or method for resolving any such inconsistency or conflict shall not be determinative with respect to whether any act or omission by PBM constituted a breach of this Agreement prior to Aetna notifying PBM of its interpretation of such Law.

(h) PBM Central Fill Pharmacies. With respect to matters relating to or involving Schedules M and N and/or the PBM Services set forth therein, any references in this Agreement to PBM shall be deemed to include each of the PBM Pharmacy Entities.

(i) Aetna Contracted Retail Pharmacies. Notwithstanding PBM's obligations to provide retail pharmacy network contracting services in accordance with Section 3.2(a)(vi) and Schedule G, Aetna, Aetna Plan Affiliates and Aetna Customers shall have the right at any time to negotiate and enter into Contracts with Jointly Contracted Pharmacies to the extent permitted by Schedule G.

3.3 **Transition-Out Services and Other Transition Arrangements.**

(a) Aetna Reliance. PBM acknowledges that, as a result of Aetna's retention of PBM to provide the PBM Services, Aetna will be transitioning responsibility for the performance of the PBM Services from Aetna (or Persons performing such services on Aetna's behalf) to PBM and that, in agreeing to undertake such a transition, Aetna is relying on PBM's assurances that, upon any expiration or termination of this Agreement, and also in the event of any Partial Termination, PBM will, if and as requested by Aetna, comply with PBM's obligations described in this Section 3.3. Without prejudice to the rights and remedies otherwise available upon any breach by PBM of this Section 3.3, PBM acknowledges that money damages would not be a sufficient remedy for any such breach and that, in connection with any such breach, Aetna shall be entitled to (i) seek specific performance, injunctive or other equitable relief including immediate issuance of a temporary restraining order or preliminary injunction enforcing this Agreement, (ii) seek a judgment for Losses caused by the breach, and (iii) any other remedies provided by applicable Law.

(b) Transition-Out Services. If, and as requested by Aetna, during the Termination Transition Period and in connection with any Partial Termination, (i) PBM shall provide the transition services described in Schedules T-1, T-2 and T-3, as applicable, as well as such other services that Aetna may reasonably request prior to or during any Termination Transition Period, or in connection with any Partial Termination, with respect to the transitioning of responsibility for the performance of all PBM Services (or the affected PBM Services in the case of a Partial Termination) to one or more successor pharmacy benefit providers, Aetna and/or any Affiliate of Aetna (collectively, the "Transition-Out Services"), and (ii) PBM shall achieve the transition milestones and deadlines set forth in Schedule T-1 (or, in the case of a Partial Termination, corresponding milestones and deadlines negotiated in good faith by the Parties for such Partial Termination, which shall be set forth in an amended Schedule T-2). In the event that PBM fails to achieve the applicable milestones (including, as applicable, with respect to any Partial Termination) set forth in Schedules T-1, T-2 or T-3, as applicable, by the applicable deadlines set forth therein, PBM shall pay Aetna the applicable Guarantee Amounts set forth in Schedules T-1, T-2 and T-3. In the event of any Partial Termination, PBM shall provide the Transition-Out Services to the extent applicable or necessary (as specified by Aetna) with respect to the Partial Termination for a period of eighteen (18) months following the date Aetna delivers notice to PBM of the Partial Termination, unless Aetna has elected by giving notice to PBM to shorten such period.

(c) No Impact From Successor Arrangement. Aetna's rights to receive the Transition-Out Services shall apply regardless of whether Aetna engages a successor pharmacy benefit provider or determines to perform the PBM Services itself or through an Affiliate of Aetna; *provided, however,* that in no event shall any Confidential Information of PBM be provided to any third party in connection with such transition without PBM's prior written consent (not to be unreasonably withheld if such third party agrees to abide by and implement reasonable measures to protect and preserve PBM's rights and interests in such Confidential Information).

(d) Aetna Customer Transitions. In connection with the termination of any Contract between Aetna and any Aetna Customer, to the extent applicable or necessary (as specified by Aetna), PBM shall provide the services described on Schedule T-2 at PBM's then-current customary prevailing rates with respect to such services, and shall also provide, at a reasonable cost to be agreed upon by PBM and Aetna based on the scope of such services and support, such other reasonable transition services and support as Aetna is required to provide pursuant to the applicable Contract and as agreed to by PBM and Aetna.

3.4 **Provisions Related to Service Levels and Guarantees.**

(a) In performing the Services, PBM shall meet or exceed the applicable performance standards and service levels set forth in Schedule R, Schedule EE and Schedule FF (collectively, the "Performance Standards") as applied and measured on an aggregate basis across all Covered Plans and Aetna Customers, in each case, as indicated on Schedule R. In the event that PBM fails to meet such Performance Standards, PBM shall, subject to Section 3.4(d) and in accordance with Section 3.4(i), pay or credit to Aetna the applicable Guarantee Amounts set forth in (or calculated in accordance with) this Section 3.4. PBM shall at all times use commercially reasonable efforts to maintain service levels that are consistent or better, on a per service/function basis, than those service levels customarily available in the pharmacy benefit management industry.

(b) In addition to the obligations under Section 3.4(a), PBM shall meet or exceed the Performance Standards (as set forth in Schedule R, but excluding those as to which Schedule R indicates that such Performance Standards are not applicable to Schedule R-1 Customers) as individually applied and measured against the PBM Services, collectively, provided with respect to each of the individual Aetna Customers as listed on Schedule R-1 (each a "Schedule R-1 Customer"). In the event that PBM fails to meet any of the Performance Standards as applied and measured against the PBM Services provided with respect to any Schedule R-1 Customer (including the Claims and Members associated with such Aetna Customer), then PBM shall pay or credit to Aetna the applicable Guarantee Amounts for such Schedule R-1 Customer as set forth in Schedule R-1 within thirty (30) days of PBM's receipt of written invoice therefor. Aetna, in its discretion, shall be entitled to update and amend Schedule R-1 from time to time to add or remove Aetna Customers as Schedule R-1 Customers and/or to amend the Guarantee Amounts applicable to Schedule R-1 Customers; *provided, however,* that the Aetna Customers included on Schedule R-1 shall not as of the Effective Date or on the date on which Aetna delivers an updated or amended Schedule R-1 comprise or represent more than twenty-five percent (25%) of the total number of Members then eligible for benefits under

Covered Plans. Any such amended and updated copy of Schedule R-1 shall become effective sixty (60) days after it has been delivered to PBM by Aetna.

(c) In addition to the obligations set forth under Section 3.4(a) and Section 3.4(b), PBM shall meet or exceed all performance standards and service levels and shall be subject to the corresponding guarantee, liquidated damage, penalty or similar payment obligations set forth in the Plan Contracts (and as set forth on Schedule R-2) with the individual Aetna Customers set forth on Schedule R-2 (each a "Schedule R-2 Customer"), to the extent applicable to the PBM Services ("Customer Performance Standards"), as applied and measured against PBM Services, collectively, provided pursuant to this Agreement with respect to each Schedule R-2 Customer (including the Claims and Members associated with such Schedule R-2 Customer). In the event that PBM fails to meet any Customer Performance Standards with respect to any Schedule R-2 Customer and such failure results in Aetna or an Aetna Plan Affiliate having to pay an applicable Schedule R-2 Customer a guarantee, liquidated damage, penalty or similar amount, then PBM shall pay or credit to Aetna the applicable Guarantee Amounts for such Schedule R-2 Customer as set forth in Schedule R-2 within thirty (30) days of PBM's receipt of written invoice therefor. With the prior approval of PBM (not to be unreasonably withheld), Aetna shall be entitled to update and amend Schedule R-2 from time to time to add or remove Aetna Customers as to whom Customer Performance Standards will be applicable and/or reflect new or changed Customer Performance Standards or Guarantee Amounts; *provided, however*, that (i) the Aetna Customers included on Schedule R-2 shall not as of the Effective Date or on the date on which Aetna delivers an updated or amended Schedule R-2 comprise or represent more than ten percent (10%) of the total number of Members then eligible for benefits under Covered Plans, and (ii) PBM shall be entitled to withhold its approval to any proposed update or amendment to Schedule R-2 that would result in the inclusion of Customer Performance Standards that are materially more burdensome than the Performance Standards or are otherwise not reasonably capable of being achieved by PBM. Any such amended and updated copy of Schedule R-2 shall become effective sixty (60) days after the Parties agreement thereto in accordance with the preceding sentence.

(d) Any Guarantee Payments not paid when due pursuant to this Section 3.4 shall, until paid, bear interest at the greater of the Prime Rate or four percent (4%) per annum.

(e) The Performance Standards and Guarantee Amounts set forth in Schedules R, R-1 and R-2, EE and FF and/or the Customer Performance Standards shall not relieve PBM of the obligation to provide all Services in accordance with all requirements and standards set forth in this Agreement and applicable Law; and payments or credits of Guarantee Amounts by PBM shall not be Aetna's exclusive remedy, nor shall they limit any right or remedy that may be available to Aetna under applicable Law or this Agreement on account of any individual failure or breach under this Agreement by PBM (even if such failure or breach contributed towards a failure by PBM to meet a Performance Standard or Customer Performance Standard), including the following rights and remedies of Aetna under this Agreement: termination rights under Article XII, rights to receive refunds or payments or credits on account of overcharges, underpayments, overpayments and other matters pursuant to Section 7.4, 9.8 or 9.10 and rights to indemnification pursuant to Section 15.1.

(f) [Reserved]

(g) The Performance Standards shall be measured as set forth in Schedule R, EE, or FF, as applicable, or, to the extent the measurement methodology in Schedule R, EE, or FF, as applicable, is incomplete or inadequate, a reasonable measurement methodology as agreed upon by the Parties acting in good faith. All surveys required under Schedule R, EE, or FF will be developed by PBM and approved by Aetna prior to initial distribution and shall include a statistically valid number of applicable respondents (*i.e.,* Members), as set forth or determined in accordance with Schedule R, EE, or FF, as applicable, or to the extent not addressed in Schedule R, EE, or FF, as applicable, as agreed upon by the Parties acting in good faith. PBM shall provide Aetna with the results of all such surveys for its review. The Customer Performance Standards shall be measured as set forth in Schedule R unless a different methodology is set forth in Schedule R-2.

(h) On the frequency required pursuant to Schedule R (including with respect to the Performance Standards set forth in Schedule EE or Schedule FF, unless otherwise provided in Schedule EE or FF, as applicable) R-1, or R-2, PBM shall deliver to Aetna a written report that sets forth (i) its actual performance on an aggregate basis across all Covered Plans and Aetna Customers during the applicable prior period with respect to, and as measured against, each of the Performance Standards categories set forth in Schedule R, EE, and FF, (ii) for each Schedule R-1 Customer, its actual performance on an individual Aetna Customer basis during the applicable prior period with respect to, and against, each of the Performance Standards, (iii) for each Schedule R-2 Customer, its actual performance on an individual Schedule R-2 Customer basis during the applicable prior period with respect to, and against, each of the Customer Performance Standards applicable to such Schedule R-2 Customer, and (iv) an itemization of all Guarantee Amounts due to Aetna under Schedules R, R-1, R-2, EE, or FF on account of PBM's failure to meet or exceed the Performance Standards and Customer Performance Standards with respect to the applicable month (or calendar quarter).

(i) Not later than sixty (60) days after the end of each calendar year, (i) PBM shall provide a written report to Aetna that sets forth an itemization of all Guarantee Amounts due to Aetna pursuant to this Section 3.4 with respect to such calendar year, certified as to its accuracy by an appropriate officer of PBM with actual knowledge of the content thereof, and (ii) PBM shall pay or credit to Aetna all such Guarantee Amounts (to the extent not previously paid or credited pursuant to Section 3.4(b) or Section 3.4(c)), in the case of payments, to Aetna by wire transfer of immediately available funds to an account designated by Aetna from time to time. If Aetna disputes all or a portion of the itemization of Guarantee Amounts provided by PBM pursuant to this Section 3.4(i), Aetna shall inform PBM of the disputed items, the amounts in dispute and the basis for such dispute; *provided, however*, that all undisputed Guarantee Amounts shall be paid or credited to Aetna in accordance with this Section 3.4(i) notwithstanding that resolution of disputed Guarantee Amounts remains pending. The Parties shall negotiate in good faith to resolve any dispute as soon as practicable, but in any event within sixty (60) days of Aetna's notice of dispute, and, upon resolution of such dispute, such resolved disputed amount shall be paid or credited to Aetna, in the case of payments, by wire transfer of immediately available funds. If the Parties are unable to resolve any such dispute within the sixty (60) day time period, the matter shall be resolved in accordance with Section 17.27. Aetna shall identify any disputed item with respect to the itemization of Guarantee Amounts provided by PBM pursuant to this Section 3.4(i) not later than ninety (90) days following the date on which Aetna first has actual knowledge of the facts or circumstances giving rise to such dispute.

(j) In the event a Performance Standard or Customer Performance Standard is not met, upon Aetna's request, PBM agrees to develop and deliver to Aetna a written corrective action plan in a format acceptable to Aetna, providing for the terms and conditions, including responsible parties and time frames for completion of the implementation of necessary actions to resolve any issues associated with the failure to perform any Services under this Agreement in accordance with the Performance Standards or Customer Performance Standards, as applicable. Such corrective action plan shall be provided by PBM to Aetna for review and approval, which shall not be unreasonably withheld, no later than fifteen (15) Business Days after receipt of Aetna's written request for a corrective action plan. Aetna may give written notice to PBM of any Aetna objections to the corrective action plan, and PBM shall, no later than five (5) Business Days after receipt of Aetna's objections, revise the corrective action plan to address such objections and resubmit it for Aetna's approval. Upon request, PBM shall provide Aetna periodic updates of progress made under the corrective action plan.

(k) The Performance Standards and Customer Performance Standards and PBM's obligations under this Section 3.4 shall apply throughout the Term and, if and for so long as PBM provides any of the PBM Services after the Term as part of the Transition-Out Services, during the Termination Transition Period; *provided, however,* that as set forth in Schedule R and Schedule R-2 certain of the Performance Standards and Customer Performance Standards are applicable only to the Transition-In Phase. The maximum Guarantee Amounts set forth in Schedule R shall be reduced on a pro rata basis as Members migrate to PBM's successor during the Termination Transition Period.

3.5 **Standard of Performance; PBM Resources; Technological Improvements.**

(a) Throughout the Term and any Termination Transition Period, PBM shall perform the Services in a competent and professional manner, in good faith, and with qualified, appropriately skilled and trained personnel who meet all applicable licensure requirements and, in the case of persons serving in functions described on Schedule BB, meet the requirements to serve the function set forth thereon. Without limiting the generality of the foregoing, PBM shall perform the Services in accordance with all accreditation standards (including NCQA and URAC) applicable to the performance of the Services by PBM (or that remain applicable to Aetna or any of its Affiliates notwithstanding that the Services are performed by PBM hereunder).

(b) PBM shall devote such personnel, project planning and management, systems, equipment, technology, tools, and other resources (including fully dedicated personnel and resources) as are required by Section 5.2 and as otherwise are necessary to perform the Services in accordance with the terms of this Agreement and to achieve all milestones, Performance Standards and Customer Performance Standards, including as set forth in the Transition-In Plan and Schedules R, R-2, T-1 and T-2.

(c) Throughout the Term, PBM shall ensure that all systems, equipment, technology, tools and other resources utilized by PBM to perform the Services are maintained, modified and upgraded and shall take all such other actions as are necessary to ensure that PBM is able to (i) perform the Services in a technologically advanced and high quality manner (as measured relative to the pharmacy benefit management industry); (ii) communicate and interface

with Aetna, Aetna Rx Home Delivery, Aetna Specialty Pharmacy, Aetna Plan Affiliates, Aetna Customers, Members, Providers and Participating Pharmacies using appropriate and advanced industry-competitive technologies and systems, including third-party e-prescribing, data exchange and other connectivity technologies and systems generally adopted in the marketplace; and (iii) employ industry best practices and processes (including use of technologically advanced methods or other reasonably appropriate methods) in the performance of the Services. In addition, if and as PBM or any of its Affiliates develops new, improved, modified or upgraded capabilities, processes, protocols, systems, programs and/or tools for its own use or that it makes available to or for any other PBM Customer, PBM shall, to the extent applicable to the Services and designed for use on the operating platform(s) used by PBM to provide the Services for Aetna, make the same available to or for Aetna and the Aetna Plan Affiliates, at Aetna's election, on terms no less favorable to Aetna than the terms on which PBM or any of its Affiliates makes such service available to any such PBM Customer where such service is made available to such PBM Customer subject to a separate charge. In addition, to the extent that PBM makes available any retrospective DUR or other clinical program or other similar offering that is neither a Core Service nor an Optional Service, PBM shall make the same available to Aetna and the Aetna Plan Affiliates, at Aetna's election, on terms that are no less favorable to or for Aetna than the most favorable terms on which PBM or any of its Affiliates makes such available to any other PBM Customer. PBM will not be required to provide Aetna any capabilities, processes, protocols, systems, programs and/or tools developed specifically for another PBM Customer unless PBM provides such capabilities, processes, protocols, systems, programs and/or tools to other PBM Customers, including any Affiliate of PBM.

(d) If any services, functions or responsibilities not specifically described in this Agreement are an inherent or customary part of the Services or required for the proper performance or provision of the Services, they shall be deemed to be implied by and included within the scope of the Services to the same extent as if specifically described in this Agreement, unless Aetna shall notify PBM in writing that Aetna does not wish for PBM to provide such services, functions or responsibilities.

3.6 **Use of Subcontractors.**

(a) PBM shall not subcontract or delegate any of the Services to any other Person (a "Subcontractor") without Aetna's prior written approval (such approval not to be unreasonably withheld); *provided, however,* that PBM may, without approval from Aetna, (i) subcontract or delegate any of the Services to any Affiliate of PBM (for so long as its remains an Affiliate of PBM), and (ii) contract with third parties to provide general services, support or maintenance for equipment, systems, software and tools utilized by PBM in the performance of the Services so long as such third parties do not directly perform any of the Services. For the avoidance of doubt, it is understood and agreed that wholly-owned Subsidiaries of Caremark Rx that own and/or operate one or more PBM Central Fill Pharmacies or PBM Central Fill Specialty Pharmacies are approved Subcontractors for the purpose of performing the PBM Services set forth in Schedules M and N. The non-Affiliate Subcontractors identified on Annex C are hereby approved by Aetna for the performance of the Services indicated for each such Subcontractor on Annex C. Prior to subcontracting or delegating any Services to any other Person that is not an Affiliate of PBM, and prior to subcontracting or delegating any new or additional Services to any previously approved non-Affiliate Subcontractor, PBM shall deliver a written notice to Aetna

setting forth a detailed description of such proposed subcontracting or delegation arrangement, including the name of the proposed non-Affiliate Subcontractor. Aetna shall, within ten (10) Business Days following its receipt of such a written notice, inform PBM as to whether Aetna approves the proposed subcontracting or delegation, which approval shall not be unreasonably withheld. If Aetna objects to the use of any such non-Affiliate Subcontractor within such period, the Parties shall negotiate to resolve any issues raised by Aetna, but in no event shall PBM commence or implement the proposed subcontracting or delegation arrangement unless and until Aetna provides its written approval.

(b) All Subcontractors of PBM must comply with all applicable compliance policies of PBM, including those policies pertaining to security safeguards, authorization requirements, compliance with Laws, record retention, and audit and all policies, procedures and requirements applicable to PBM under this Agreement to the extent applicable to the Services provided by such Subcontractor. PBM shall be fully responsible for all acts and omissions of its Subcontractors. PBM shall remain fully responsible for the timely and proper performance and discharge of all Services and other obligations of PBM that are subcontracted or delegated to any Subcontractor or that relate to any Service so subcontracted or delegated, in each case, to the same extent as if PBM had not subcontracted or delegated such Services or other obligations. Additionally, to the extent required in connection with any accreditation requirement, PBM and each other Subcontractor providing any portion of the Services shall enter into a written Contract conforming to the requirements of the applicable accreditation organization; *provided, however,* that if the requirement to enter into such written Contract requires PBM to undertake obligations not otherwise provided for in this Agreement, to the extent required under Section 9.11, the Parties shall pursuant to Section 9.11 negotiate in good faith appropriate amendments to this Agreement to take into account such additional obligations.

(c) After first notifying and discussing the issues in good faith with PBM in an effort to reach a mutual resolution, Aetna shall have the right to revoke its prior approval of a Subcontractor if PBM fails to perform in accordance with Section 3.6(b) or if any act or omission of such Subcontractor constitutes a breach of this Agreement or would constitute a breach of this Agreement if it had been an act or omission of PBM.

3.7 **Performance Outside the United States.**

PBM shall not perform or permit any Subcontractor or other Person acting for or on behalf of PBM to perform any of the Services outside the United States without Aetna's prior written approval; *provided, however,* that PBM may, without approval from Aetna, perform or permit Subcontractors and other Persons to perform outside the United States general services, support or maintenance for equipment, systems, software and tools utilized by PBM in the performance of the Services so long as such third parties do not directly perform any of the Services. In addition, PBM shall not, and shall not permit any Subcontractor or other Person to, make any use or disclosure of any protected health information (as defined in the most restrictive manner such concept is defined pursuant to HIPAA and any other applicable Law regarding confidentiality, security and electronic transactions and code sets) outside of the United States without Aetna's prior written consent. In any case where PBM, whether directly or through a Subcontractor or other Person, performs any of the Services outside the United States, PBM (i) shall comply with (and be responsible for any Subcontractor's or other Person's failure to

comply with) all applicable Laws, including Laws and instructions promulgated by CMS applicable to the performance of services for Medicare Plans outside of the United States, (ii) shall ensure that no Services are performed outside of the United States for or with respect to any Aetna Customers and Covered Plans that Aetna specifically excludes from its approval, and (iii) must retain the ability promptly to terminate the performance, usage or disclosure outside of the United States of any Services or protected health information, if so requested by Aetna, including on behalf of an Aetna Customer that so directs, or as required by a subsequent change in applicable Law.

3.8 **Aetna Plan Affiliates.**

The initial Aetna Plan Affiliates are listed on Annex D. Aetna may provide an updated Annex D to PBM from time to time in order to add any other Affiliate of Aetna as an Aetna Plan Affiliate or delete any Aetna Plan Affiliate that no longer issues, manages or administers any Aetna Plans or is no longer an Affiliate of Aetna, which updated Annex D shall supersede and replace the then-current Annex D. In conjunction with the delivery of such an updated Annex D, Aetna shall specify the timing for the commencement or cessation of the delivery of Services to and for the additional or deleted Aetna Plan Affiliate (and its Covered Plans), as the case may be, which timing shall be determined in good faith by Aetna after consultation with PBM.

ARTICLE IV.
FORMULARY; CARE MANAGEMENT & CLINICAL MATTERS; REBATES

4.1 **Formulary.**

As between Aetna and PBM, Aetna shall have the final and full authority to determine the composition of any and all Formularies applicable to Aetna Plans. PBM shall provide the formulary-related services as set forth in Schedule J. As further provided in Schedule J, Aetna shall have the right to change any Formulary at any time in Aetna's sole and absolute discretion, and PBM shall support and assist Aetna in the development, maintenance and administration of its Formularies.

4.2 **Care Management & Clinical Matters.**

As between Aetna and PBM, Aetna shall control and perform all care management and clinical functions and activities with respect to all Aetna Plans, Aetna Customers and Members, including development and oversight of clinical protocols and procedures. PBM shall provide the care management and clinical functions and activities as provided in Schedule J.

4.3 **Rebates.**

(a) Rebate Related Definitions. The following terms used in this Section 4.3 shall have the following meanings:

"Additional Rebates" means all rebates, discounts, service fees and other consideration paid, credited or owing to and/or collected by Aetna, PBM or any of their respective Affiliates from any Manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to (1) utilization (*e.g.*, market share,

growth, etc.) of certain prescription drugs within their respective therapeutic categories whether measured on the basis of Claims and/or Services arising under this Agreement and/or any other part of PBM's book of business in aggregate, or (2) services performed by Aetna, PBM or any of their Affiliates where Aetna, PBM or any of such Affiliates is paid fees or other compensation (excluding Service Fees) on the basis of the volume, value or acquisition cost of prescription drugs or other products that are prescribed or dispensed to Members. For avoidance of doubt, Additional Rebates include Manufacturer Administrative Fees but do not include Formulary Rebates or Service Fees.

"Aetna Rebates" means any and all Rebates, directly or indirectly, arising from or attributable to any of the Aetna Plans, the provision of Services and/or the prescribing, dispensing or provision of prescription drugs or other products or services to or for Members.

"Aetna Service Fees" means any and all Service Fees, directly or indirectly, arising from or attributable to any of the Aetna Plans, the provision of Services and/or the prescribing, dispensing or provision of prescription drugs or other products or services to or for Members.

"Formulary Rebates" means all payments, rebates and other consideration paid, credited or owing to and/or collected by Aetna, PBM and/or any of their respective Affiliates from any Manufacturer (1) arising from or as a result of (A) the inclusion or exclusion on any Formulary of Covered Drugs manufactured, sold or distributed by such Manufacturer and/or (B) a coverage decision made by Aetna, any Aetna Plan Affiliate or any Aetna Customer, or (2) otherwise involving or relating to drug formularies and/or member copayment, coinsurance or deductible strategies.

"Manufacturer" means a pharmaceutical, biotech, medical equipment or medical device manufacturer and any other Person that performs sales, distribution and/or marketing functions (including wholesalers and distributors) with respect to any such manufacturer's products.

"Manufacturer Administrative Fee" means any fee or other compensation paid to Aetna, PBM or any of their respective Affiliates by any Manufacturer for or by reason of any administrative or other services provided by Aetna, PBM or such Affiliate to or for such Manufacturer in connection with administering, computing, invoicing, allocating and/or collecting Rebates.

"Manufacturer Rebate Agreement" means a Contract entered into by PBM, any Affiliate of PBM, Aetna or any Affiliate of Aetna with a Manufacturer pursuant to which such Manufacturer has agreed to pay or provide Rebates.

"Other Manufacturer Payments" means any (1) pricing adjustments, payments and credits made in the ordinary course by any Manufacturer on account of product returns, delivery errors or shipping damage or losses arising from drugs and other products purchased from such Manufacturer by PBM or any of its Affiliates (including pharmacies owned by PBM or its Affiliates), or (2) pricing discounts paid or credited by any Manufacturer solely on account of pharmacies owned by PBM or any of its Affiliates having purchased a specified minimum

volume of prescription drugs and/or other products from such Manufacturer; *provided, however*, that clause (2) of this sentence shall not include any pricing discounts that, by their terms, are specifically tied to prescription drugs dispensed to Members, and the dollar value of any such discounts shall be deemed to constitute Service Fees. For the avoidance of any doubt, Other Manufacturer Payments exclude all payments, credits, fees, compensation and other consideration that constitute Rebates or Service Fees.

"Pharmacy Rebates" means all rebates, discounts, service fees, network administration or transmission fees, Administrative Costs, Direct or Indirect Remuneration and other consideration paid, credited or owing to and/or collected or earned by PBM or any of its Affiliates (including while acting for or on behalf of Aetna or any Aetna Plan Affiliate) from Participating Pharmacies; *provided, however*, that any such network administration or transmission fees shall not constitute Pharmacy Rebates to the extent such fees constitute fair and reasonable compensation for services actually performed by PBM or any of its Affiliates and the receipt and retention of such fees by PBM or any such Affiliate is in compliance with all applicable Laws.

"Rebates" means Formulary Rebates, Additional Rebates and Manufacturer Administrative Fees, but does not include Service Fees, Other Manufacturer Payments or Pharmacy Rebates.

"Service Fees" means any fees or other compensation paid, credited, or owing by a Manufacturer to Aetna or PBM or any of their respective Affiliates, as applicable, in exchange for the performance or provision of front-end pharmacy or clinical services or activities, including any of the following services and activities: (A) patient adherence or compliance services, (B) nursing or other patient support, (C) physician or Member communication services, (D) patient assistance and referrals, (E) product launch and similar support, (F) equipment replacement services, (G) clinical and other research or studies, (H) data and analytics, and (I) services to ensure the appropriate distribution of high risk biopharmaceuticals.

(b) Rebate and Service Fee Contracting.

(i) Except to the extent Aetna elects to have PBM perform and be responsible for such functions as Optional Services pursuant to Section 3.2(b), Schedule I and Schedule Y-7, (A) Aetna and Aetna's Affiliates will retain sole responsibility and authority for contracting with Manufacturers with respect to Rebates arising from or relating to Covered Drugs dispensed to Members, whether under the pharmacy or medical benefit segments of the Covered Plans, (B) except as otherwise provided in Schedule N, Aetna and Aetna's Affiliates will retain sole responsibility and authority for contracting with Manufacturers with respect to Service Fees arising from or relating to Covered Drugs dispensed to Members, whether under the pharmacy or medical benefit segments of the Covered Plans, and (C) Aetna and Aetna's Affiliates will retain sole responsibility and authority for implementing and administering such contractual arrangements with Manufacturers and for invoicing and collecting Rebates, Service Fees and other amounts owing thereunder, except as provided in Section 63 of Schedule N. As a part of its Core Service obligations, PBM shall assist, support and cooperate with the foregoing efforts to the extent undertaken by Aetna and Aetna's Affiliates.

(ii) Except to the extent Aetna elects to have PBM perform and be responsible for such functions as Optional Services pursuant to Section 3.2(b), Schedule I and Schedule Y-7, or except pursuant to and in accordance with the processes set forth in Schedule N, PBM shall not, and shall cause its Affiliates not to, negotiate, enter into or implement any Contract with any Manufacturer or other Person that would provide for the payment, directly or indirectly, of any Rebates or Service Fees arising from or attributable to any of the Aetna Plans or any Members, including the provision of Services and/or dispensing of Covered Drugs to Members, whether under the pharmacy or medical benefit segments of the Covered Plans. Notwithstanding the foregoing, nothing in this Section 4.3 shall limit the ability of the retail pharmacies owned and/or operated by PBM's Affiliates from contracting with Manufacturers to provide programs or services with respect to such retail pharmacies' patients so long as such arrangements, programs or services are not specifically directed towards or otherwise related to the Members, this Agreement or the Formulary. In addition, PBM shall not, and shall not permit any of its Affiliates, directly or indirectly, to negotiate or implement any Contract (including the retail pharmacy arrangements described in the preceding sentence) with any Manufacturer or other Person that would result or reasonably would be expected to result in Rebates or Service Fees payable by such Manufacturer to Aetna or any of its Affiliates being reduced or made less advantageous on account of or in exchange for the payment of greater or more advantageous Other Manufacturer Payments by such Manufacturer. Nothing set forth in this Section 4.3(b)(ii) is intended to limit or restrict PBM's role as a formulary manager for other PBM Customers, or its ability to operate independent pharmaceutical and therapeutic and formulary review processes in order to make clinical and formulary recommendations consistent therewith.

(c) Receipt and Collection of Rebates and Services Fees.

(i) Aetna, acting on behalf of and as agent for the Aetna Plan Affiliates, shall be entitled to receive or be credited with (1) any and all Aetna Rebates, (2) any and all Aetna Service Fees (except as otherwise provided in Section 4.3(c)(ii)), and (3) any and all Pharmacy Rebates arising from or attributable to retail Claims submitted by Members in those cases where Aetna or the applicable Aetna Plan Affiliate is charged Pass Through Pricing by PBM in respect of such Claims (collectively, the "Aetna Manufacturer Revenues"). Except as provided in Schedule I with respect to any period during which PBM is providing PBM Services thereunder, in the event that PBM or any of its Affiliates are paid or receive a credit for any Aetna Manufacturer Revenues, PBM shall, within ten (10) Business Days thereafter, pay or credit the full amount of such Aetna Manufacturer Revenues to Aetna.

(ii) Unless expressly authorized by Aetna in writing pursuant to Section 4.3(b)(ii) or as otherwise described in the Schedules, Aetna shall remain responsible for contracting with Manufacturers with respect to Service Fees arising from or relating to Covered Drugs dispensed to Members, whether under the pharmacy or medical benefit segments of the Covered Plans, and PBM shall not earn and retain or seek to earn and retain any Service Fees arising from or attributable to any of the Aetna Plans or any Members, including the provision of Services and/or dispensing of Covered Drugs to Members; and any Service Fees so authorized by Aetna shall not constitute Aetna Manufacturer Revenues.

(iii) PBM represents and warrants that Schedule W fully and accurately discloses all Contracts and sources and types of revenues and other economic benefits to which

PBM is, as of the Effective Date, contractually or legally entitled and that would generate Aetna Rebates or Service Fees as a result of the performance of the Services from and after the Effective Date. Without limiting any other provision in this Section 4.3, not later than ninety (90) days after the last day of each calendar year during the Term, PBM shall deliver a written report to Aetna that describes in reasonable detail all sources and types of Service Fees that PBM and its Affiliates earned during such calendar year as a result of the performance of the Services and includes an itemization, by type of Service Fee, of the total amount of such Service Fees that were earned by PBM and its Affiliates during such calendar year. PBM shall not in any such report indicate the amount or type of Service Fees that were paid by any particular Manufacturer.

ARTICLE V.
STRATEGIC COLLABORATION; COMMITTEES AND PERSONNEL

5.1 Strategic Partnership Commitment.

(a) The Parties intend to work together in a collaborative manner to identify and execute opportunities to collaboratively design, build, introduce to the market and implement differentiated and innovative solutions that will deliver enhanced services and value to Aetna Customers and Members, to make Aetna's pharmacy benefit offerings more competitive in the marketplace and to otherwise maximize the benefits of this Agreement, in each case, subject to any restrictions under applicable Law. In furtherance of the foregoing, at such times as the Parties shall mutually agree upon (but in no event less frequently than quarterly), the Senior Leaders (and other executive officers and consultants of PBM and Aetna, if so desired by the Parties) shall meet to discuss opportunities to achieve such purposes (such meeting, a "Senior Leader Summit"). The Parties shall jointly establish the agenda for each Senior Leader Summit, which shall include:

(i) a review of PBM's performance under this Agreement, including compliance with Performance Standards and Customer Performance Standards;

(ii) an update by PBM of any significant business actions, research and development efforts or initiatives at PBM or its Affiliates that are reasonably expected to impact the quality, performance and competitiveness of the Services;

(iii) an evaluation of methods for the Parties to work together to deliver enhanced services and value to Aetna Customers and Members;

(iv) a discussion of financial structures that will provide mutual benefit; and

(v) a discussion of integrated value propositions, supported by key strategic pillars such as (a) total cost and quality management (including pharmacy trend management, mail penetration rates, generic dispensing rate, cost management tools, and integrated HIT and data analytics), (b) clinical superiority (including a clinical pharmacy model focused on evidence-based therapeutic solutions, integration of policies and activities across a medical and pharmacy care management model, member engagement and behavior change and data and analytical integration across pharmacy and medical), (c) fostering a holistic, Member-centric experience (including integrated Member-facing infrastructure (applications, web,

customer service), a Member-centric integrated healthcare data warehouse, and a commitment to robust technology enhancements) and (d) market-leading growth opportunities (including clinical innovation capabilities, client facing analytical tools and pharmacy and medical technology).

(b) Senior Leader Summits shall be held at a mutually agreeable location as determined by the Senior Leaders. Each Party shall ensure that at least the minimum number of its respective Senior Leaders attend each Senior Leader Summit. Nothing in this Section 5.1 is intended to limit either Party's right to pursue any business opportunity not restricted pursuant to Section 16.1.

5.2 **Committees.**

PBM and Aetna shall constitute and maintain the committees set forth in Schedule Q (each such committee, a "Committee") in accordance with the requirements set forth therein, and subject to Aetna's rights to eliminate or disband any Committee as provided therein.

5.3 **PBM Customer Service and Technology Councils and Advisory Bodies**

PBM shall permit an Aetna representative to participate on any council or similar advisory body comprised of representatives of multiple PBM Customers in PBM's health plan segment, and shall give Aetna not less than ten (10) days prior written notice of any meeting of any such similar council or advisory body.

5.4 **PBM Committee Members and Employees.**

(a) Assignment and Removal. Aetna shall have the right to approve the personnel assigned by PBM to the Committees and the personnel assigned by PBM to fulfill the functions described on Schedule BB, such approval not to be unreasonably withheld. If Aetna becomes dissatisfied with the performance of any such person, PBM shall promptly take appropriate action and notify Aetna of the action taken to address the dissatisfaction. If despite such action, Aetna remains dissatisfied with such person, PBM shall assign another person who is suitably qualified to replace such person on the applicable Committee or for the applicable function described on Schedule BB, and such original person shall no longer serve on such Committee or provide such function. PBM shall not assign a person to serve as an additional or replacement member of any Committee or as an additional or replacement person to provide a function described on Schedule BB (whether on account of Aetna's dissatisfaction, resignation, termination, death, disability or otherwise) without Aetna's prior written approval, such approval not to be unreasonably withheld. PBM shall not reassign or otherwise modify the responsibilities of any person providing a function described on Schedule BB without notice to, or prior written approval of, Aetna, as applicable in accordance with Schedule BB. In addition, PBM shall comply with the requirements set forth on Schedule BB. Nothing in this Section 5.4(a) shall be deemed to create an employment relationship between Aetna and any PBM employee or to give Aetna any rights or powers as an employer over any PBM employee, including the right to control the work of or discipline any PBM employee or to require PBM to terminate any PBM employee's employment; rather, it is intended solely to give Aetna the right

to require that PBM provide appropriate staff to carry out the functions described on Schedule BB.

(b) Background Investigations. Before deploying any employee, consultant, contractor, agent or other individual ("Deployed Person") to provide or participate in the provision of Services, PBM shall conduct an investigation of such potential Deployed Person's background through a consumer reporting agency ("CRA"). PBM shall provide to Aetna an annual written certification that PBM has performed the background investigations required herein. Such investigations shall include the following:

(i) Verification of employment and salary as claimed by the Deployed Person for the previous five (5) years;

(ii) Verification of the Deployed Person's educational attainments (highest degree earned beginning with licenses and/or professional certifications and associates degrees as claimed by the Deployed Person);

(iii) To the extent permitted by applicable Law, a review of appropriate federal, state and local records to determine if the Deployed Person has a criminal record. This review shall include all addresses where the Deployed Person resided in the previous seven (7) years. A criminal conviction report shall include the type of offense and whether the listed offense is a felony or misdemeanor. Where a comprehensive statewide search initially indicates a criminal record the details of which are not available in five (5) Business Days, PBM shall conduct county searches. PBM shall conduct county searches in all other situations where comprehensive and timely statewide searches are not available;

(iv) A review as described in Schedule O with respect to each Deployed Person who will be engaged in providing Services for or relating to Medicare Plans;

(v) A review as described in Schedule P with respect to each Deployed Person who will be engaged in providing Services relating to Covered Plans for or under the Government Health Programs addressed in Schedule P; and

(vi) With respect to each Deployed Person who is a pharmacist and will be employed in pharmacies of PBM or any PBM Affiliate or would otherwise be involved in the provision of the Services, a review of the pharmacist's licensure status with regulatory agencies in each state where such pharmacist is licensed, a verification that such pharmacist has not been debarred, excluded or suspended from any state or federal health care program, and a review of any actions taken by the respective state or federal agency against such pharmacist.

In conducting background investigations, PBM shall comply with applicable Law, including the Fair Credit Reporting Act, as amended.

(c) CRA Report Discrepancies. PBM, without prior consultation with and written approval from Aetna, shall not deploy or utilize for purposes relating to the Services any Deployed Person for whom any CRA's report obtained by PBM indicates a material discrepancy between the criminal record, employment history, educational attainments, licenses and/or

professional certifications claimed by the Deployed Person and what has been verified by the CRA.

(d) Criminal Convictions. PBM, without prior consultation with and written approval from Aetna, shall not deploy or utilize for purposes relating to the Services any Deployed Person whose background investigation reveals that such person has been convicted of (i) any felony (including any criminal felony involving dishonesty or a breach of trust or any offense under 18 U.S.C. Section 1033 of the Violent Crime Control and Law Enforcement Act of 1994, which section is captioned "Crimes by or Affecting Persons Engaged in the Business of Insurance Whose Activities Affect Interstate Commerce, including activities by persons in the insurance industry who willfully and materially overvalue any land, property or securities; embezzlement or misappropriation of insurance premiums and other funds; the making of false entries or statements in reports with the intent to deceive another person engaged in the insurance industry; or the use of threat or force in an attempt to corrupt or obstruct administrative proceedings related to the insurance industry) or (ii) any misdemeanor (to the extent applicable state Law permits consideration of the applicable misdemeanor as a factor in employment decisions).

(e) Confidentiality, I/T Security Statement and Aetna Code of Conduct. PBM shall cause each Deployed Person, prior to performing or participating in the performance of any Services, to execute and deliver PBM's then standard employee confidentiality and security documents, including a certification and acknowledgment of the then-current Code of Conduct. PBM represents and warrants to Aetna that it has provided true and correct samples of its current employee confidentiality and security documents and agrees to provide modified versions thereof to Aetna promptly after any material modifications are made, to the extent such modified documents would be used in connection with any Deployed Person.

5.5 **Firewalls.**

(a) PBM shall ensure that Deployed Persons who perform or assist in the provision of Services to Aetna involving Aetna Customer- or potential Aetna Customer-facing sales or marketing activities (collectively, "Restricted Activities"), as well as employees of PBM who serve on a Committee related to Restricted Activities (such Deployed Persons and employees, "Restricted Workers") are not, directly or indirectly, utilized or assigned to perform services for or on behalf of any Aetna Competitor or any prescription drug plans of PBM or its Affiliates, except as may be expressly approved by Aetna. In addition, PBM at all times shall ensure that (i) Restricted Workers do not share, divulge or otherwise communicate any information concerning Restricted Activities or such related matters addressed by the applicable Committee (including any Confidential Information provided to any member of a Committee regardless of form) with other employees or contractors of PBM or its Affiliates or any other Persons who are not Restricted Workers except on a strict "need to know" basis and solely for the purpose of enabling PBM to satisfy its obligations under this Agreement, as required in connection with disclosures to PBM's senior management in accordance with PBM's standard operating procedures, or as required in connection with the administration of PBM's compliance program, and (ii) there are adequate protections with respect to its information technology systems to prevent Persons who are not Restricted Workers from having access to the data and

files created, utilized or maintained by Restricted Workers in connection with (A) the provision of the Services or (B) matters addressed by an applicable Committee.

(b) In addition to the Restricted Activities set forth in Section 5.5(a) above, the Restricted Workers and certain PBM personnel who have expertise in network contracting strategies and execution (collectively, the "Joint Contracting Team") may from time to time engage in the process of strategizing and negotiating arrangements with Jointly Contracted Pharmacies (collectively, "Joint Contracting Activities"). PBM shall ensure that members of the Joint Contracting Team do not, directly or indirectly, share, divulge or otherwise communicate any information concerning Joint Contracting Activities with anyone who is not a member of the Joint Contracting Team, except on a strict "need to know" basis and solely for the purpose of enabling PBM to satisfy its obligations under this Agreement, as required in connection with disclosures to PBM's senior management in accordance with PBM's standard operating procedures, or as required in connection with the administration of PBM's compliance program.

(c) PBM shall ensure that Deployed Persons who perform or assist in the provision of all other Services to Aetna (excluding Restricted Activities Services and Joint Contracting Activities Services referenced in Sections 5.5(a) and 5.5(b), respectively, above), as well as employees of PBM who serve on Committees unrelated to Restricted Activities (such Deployed Persons and employees, "Other Workers") do not, directly or indirectly, share, divulge or otherwise communicate any information concerning Services or matters addressed by the applicable Committee with anyone who is performing sales, marketing, underwriting, and/or related services for or on behalf of any Aetna Competitor or any prescription drug plans of PBM or its Affiliates ("PBM Sales Workers"), including any employee or contractor of PBM or its Affiliates or any other Persons, except on a strict "need to know" basis and solely for the purpose of enabling PBM to satisfy its obligations under this Agreement, as required in connection with disclosures to PBM's senior management in accordance with PBM's standard operating procedures, or as required in connection with the administration of PBM's compliance program. In addition, PBM at all times shall ensure that there are adequate protections with respect to its information technology systems to prevent PBM Sales Workers from having access to the data and files created, utilized or maintained by Other Workers in connection with this Agreement.

(d) PBM shall implement and maintain policies in order to ensure compliance with the foregoing firewall commitment and the confidentiality obligations hereunder, including annual employee training and the reporting of violations hereunder in accordance with PBM's compliance program.

(e) On an annual basis, and as otherwise reasonably requested by Aetna, PBM shall certify compliance with this Section 5.5.

(f) PBM acknowledges that money damages would not be a sufficient remedy for any failure by PBM to comply with the provisions of this Section 5.5, and that in connection with any such failure Aetna shall be entitled to (i) seek specific performance, injunctive or other equitable relief including immediate issuance of a temporary restraining order or preliminary injunction enforcing this Agreement, and (ii) seek a judgment for Losses caused by the breach, and (iii) any other remedies provided by applicable Law.

5.6 **Embedded Aetna Personnel at PBM Medicare Facilities.**

At Aetna's option, up to two Aetna operational integrity personnel may be assigned to be located within PBM Medicare facilities. Such Aetna personnel shall have reasonable access to PBM Medicare facilities and shall work collaboratively with their counterparts at PBM. These embedded resources will be allowed to monitor operational integrity and generally perform reviews of functional activities, from time to time, from a compliance standpoint, subject to PBM's right to protect privileged and proprietary business information and in collaboration of their PBM counterparts. Such Aetna personnel must always identify themselves as Aetna personnel when introduced to PBM employees. The embedded resources may make recommendations to, collaborate with, and assist their PBM compliance counterparts, with regard to PBM functional areas in anticipating regulatory areas of focus, implementing new regulatory requirements, developing and executing compliance with corrective action plans and generally enhancing the regulatory compliance posture of PBM's Medicare operations*; provided, however*, that such Aetna employees shall not disrupt the ordinary day-to-day business activities at the applicable Medicare-related facility. Aetna may exercise this option by providing 90 days advance notice to PBM, during which time PBM shall identify any programming and system costs that may be necessary to ensure appropriate role-based access and security, which costs shall be borne by Aetna. In addition, Aetna shall be solely responsible for any costs associated with build-out to provide such Aetna employees appropriate work space to ensure that such appropriate measures are in place to avoid unfettered access to PBM's confidential, privileged and proprietary business information. Upon receipt of this cost assessment, Aetna may elect to continue to pursue the option of embedding personnel at PBM facilities or pursue an alternative approach through remote access to the information such personnel would have reviewed at PBM's facilities. In either event, PBM shall make best efforts to meet Aetna's overall goals and offer a reasonable, low-cost alternative. The Parties agree that such access will be subject to PBM's generally applicable rules of conduct and generally applicable policies and procedures (including security procedures), as reasonably designated by PBM from time to time, and to appropriate background checks. Under no circumstances will such Aetna employees performing services at PBM's Medicare-related facilities be construed to be employees of PBM or entitled to participate in any PBM employee benefits or plans of any kind. In addition, in no event shall such Aetna employees have any authority to direct and control the activities of their PBM counterparts nor shall their PBM counterparts have any authority to direct and control the activities of such Aetna employees.

ARTICLE VI.
REPORTING AND INFORMATION TECHNOLOGY

6.1 **Periodic Reports.**

PBM shall, at no additional charge, provide Aetna with periodic "standard," "custom" and ad hoc reports as set forth in Schedule V.

6.2 **Data and Systems Access.**

Including as further set forth in Schedule U and without limiting PBM's obligations set forth elsewhere in this Agreement, including Section 3.5(b) and Section 3.5(c) and in various

Schedules, PBM shall, at no additional charge, except as provided in Section 6.3, provide or give Aetna and the Aetna Plan Affiliates access to such data, information technology support, systems and services as may be required by Aetna or any such Aetna Plan Affiliate to comply with reporting requirements, standards, audits, inquiries and investigations of Governmental Bodies, accreditation organizations and Aetna Customers and/or as may be necessary to manage and administer the Covered Plans in conjunction with PBM's performance of the PBM Services. Additionally, PBM shall, at PBM's expense, comply with all requirements regarding connectivity, data access and other matters, in each case, as addressed in Schedule V.

6.3 **Systems Development.**

(a) System Enhancements Made Available to Other PBM Customers. PBM shall bear the full cost of all System Enhancements used by PBM for the benefit of, or otherwise made available by PBM to, one or more PBM Customers (including PBM or its Affiliates) in addition to Aetna and its Affiliates. Except as provided in Section 6.3(b) or Section 6.3(c), PBM shall be fully responsible for the costs of any System Enhancements undertaken in order for the Services to comply with applicable Laws.

(b) Aetna Funded Customizations. Subject to Section 6.3(d) and Section 6.3(e), Aetna shall reimburse PBM for PBM's costs of any System Enhancements undertaken in order to develop an Aetna-required customization of a System Enhancement that PBM is in the process of developing for use with respect to multiple PBM Customers and Aetna does not desire to adopt PBM's standards for such System Enhancement (a "Customization").

(c) Aetna Funded Development Initiatives. Subject to Section 6.3(d) and Section 6.3(e), Aetna shall reimburse PBM for PBM's costs of Systems Development Work where Aetna requests that PBM develop a System Enhancement that requires system coding outside of the ordinary course of business operations of developing routine benefit variations (*e.g.*, the development of new PBM edits, programs, etc. to meet Aetna business requirements).

(d) Rates. The charges set forth on Schedule Y-7 shall be applicable to all Systems Development Work for which Aetna is required to reimburse PBM pursuant to Section 6.3(b) and Section 6.3(c) and such charges shall be the sole amount payable by Aetna to PBM on account of such Systems Development Work; *provided, however*, that PBM shall provide an allowance credit to Aetna with respect to the first $300,000 of such charges in each calendar year.

(e) Project Requirements, Budgets and Deadlines. The Parties shall cooperate and share information necessary in order to determine the Party responsible for payment for any Customization or other Systems Development Work to be funded by Aetna pursuant to Section Section 6.3(c) in advance of incurring any such costs. Where Aetna requires a Customization or is required to fund Systems Development Work pursuant to Section 6.3(c), the Parties shall negotiate in good faith and agree upon the requirements for such Customization or other Systems Enhancement, the budget for such Customization or other System Enhancement, and, except as otherwise provided in this Agreement, and without limiting any applicable Performance Standards, the required delivery timing of such Customization or other System Enhancement, in each case, prior to the commencement of work to be funded by Aetna. Thereafter the Parties

shall negotiate in good faith any change requests with respect to requirements, budget and/or delivery timing, with any such changes being subject to the Parties' mutual agreement. The amount charged by PBM to Aetna shall not exceed such budgeted amount absent Aetna's prior written consent, not to be unreasonably withheld, including as a result of any mutually agreed changes.

(f) Rights of Use. PBM shall not use any Customization or any other System Enhancement funded (or to be funded) by Aetna pursuant to Section 6.3(b) or Section 6.3(c) for the benefit of any PBM Customer (other than Aetna and its Affiliates), including any Affiliate of PBM, or otherwise make any Customization or any such System Enhancement available to any PBM Customer other than Aetna or its Affiliates, including any Affiliate of PBM, except (x) with Aetna's prior written consent, which may be withheld in Aetna's sole discretion, or (y) with respect to any Customization, if, prior to such use (or prior to making such customization available), PBM shall have reimbursed Aetna for the full amount paid by Aetna to PBM for the development of such Customization and agreed that Aetna is not required to fund any further Systems Development Work with respect to such Customization.

(g) Definitions. As used in this Section 6.3:

(i) "Systems Development Work" means work required in order for PBM to develop System Enhancements.

(ii) "System Enhancement" means any new, improved, modified or upgraded capabilities, hardware, processes, protocols, systems, programs and/or tools.

ARTICLE VII.
RECORDS/LEGAL PROCEEDING COOPERATION/AUDITS

7.1 **Record Keeping.**

PBM shall maintain, and shall cause its Affiliates to maintain, complete and accurate books and records (the "Required Books and Records") sufficient to support and document the performance of the Services by PBM, its Affiliates and Subcontractors, including performance in relation to the Performance Standards and Customer Performance Standards, and milestones provided for herein, the calculation of Guarantee Amounts, Aetna Manufacturer Revenues (to the extent relevant data and records are available or maintained by PBM or its Affiliates) and all other amounts payable to Aetna under this Agreement, amounts payable under this Agreement to or by Aetna or any of its Affiliates, amounts payable to Aetna Customers and Members under the Covered Plans and Plan Contracts, and all Administrative Costs, Direct or Indirect Remuneration, Service Fees and Other Manufacturer Payments to the extent earned or received by PBM, its Affiliates, or Subcontractors as a result of their performance of the Services, in each case, in accordance with generally accepted accounting principles, and records related to PBM's conduct of background investigations as required by Section 5.4(b). The Required Books and Records shall include operational, financial and administrative records, prescription and, as applicable, medical records, Contracts (including Contracts with Participating Pharmacies (including retail, mail and specialty pharmacies), Manufacturer Rebate Agreements, other Contracts with Manufacturers and Contracts related to data management), books, files and

documentation and all other data required to be maintained by PBM and its Affiliates pursuant to this Agreement, including as set forth in Schedule V and the other Schedules to this Agreement, and approved and denied utilization management reviews, clinical program outcomes, information regarding Member appeals and, with respect to pharmacy Claims, at least all fields from the most current version and release from the NCPDP. PBM shall maintain the Required Books and Records during the Term and for ten (10) years thereafter (or longer if required by applicable Law or any other provision of this Agreement). The Required Books and Records shall be maintained in a SSAE 16 compliant format, to the extent applicable, and in a manner sufficient to enable Aetna to determine PBM's compliance with its obligations under this Agreement and to permit Aetna to enforce its rights and entitlements under this Agreement, and to ensure PBM's compliance with applicable Law and the terms of each Covered Plan. PBM shall also require all Subcontractors to maintain equivalent books and records to those PBM is required to maintain pursuant to this Section 7.1.

7.2 **Cooperation with Respect to Legal Proceedings and Other Matters.**

(a) In the event that Aetna, any of its Affiliates or any Aetna Customer is prosecuting, contesting or defending against any threatened or pending charge, complaint, action, audit, suit, proceeding, hearing, investigation, claim or demand in connection with or relating to any Covered Plan (including any matter involving any Governmental Body and including any claim under the Freedom of Information Act), PBM shall, at its sole cost and expense, reasonably cooperate with Aetna, the Aetna Plan Affiliate and/or the applicable Aetna Customer in the prosecution, contest or defense, as the case may be, of such matter, including by making available its personnel to provide testimony, its facilities, and providing access to the Required Books and Records and other data maintained by PBM, in each case, to the extent reasonably requested by Aetna or any Aetna Plan Affiliate and without limiting Aetna's obligations with respect to PBM's Confidential Information.

(b) In any case where Aetna, an Aetna Plan Affiliate or an Aetna Customer suffers a Loss due to a Manufacturer's, pharmacy's or other Person's acts or omission and only PBM or an Affiliate of PBM has contractual privity or legal standing to assert the applicable claim or cause of action, if so requested by Aetna in writing, PBM shall, or shall cause its Affiliate(s) as applicable to, subrogate or assign such claim or cause of action to Aetna or any Affiliate of Aetna and shall take all such other actions as Aetna shall reasonably request to enable Aetna or any Affiliate of Aetna to prosecute such claim or cause of action, and recover such Losses; *provided, however,* that PBM and its Affiliates shall be permitted to retain their rights in any such claim or cause of action to the extent of any Losses suffered by them from the same acts or omissions.

7.3 **General Audit Rights.**

(a) General Aetna Audit Rights. PBM will maintain and provide a staff of audit-experienced and qualified employees sufficient to support, and shall support, Aetna's audit rights, including Aetna's monthly claims adjudication accuracy testing. Aetna, any of its Affiliates and Aetna Customers shall be entitled to conduct audits utilizing the resources of such audit staff. Aetna or any of its Affiliates (and/or their designated agents and representatives) may review and/or audit (i) during the Term and for a period expiring upon the second

anniversary of the end of the Termination Transition Period (or such later date to the extent required by applicable Law or as to any Required Books and Records that must be maintained for a longer period as provided in this Agreement or the Schedules hereto), on a quarterly basis (with respect to each type of audit) or more frequently as agreed upon by PBM (which agreement shall not be unreasonably withheld) any of the Required Books and Records, and (ii) during the Term and any Termination Transition Period, any facilities used by PBM to provide any of the Services. Such audits include those described on Schedule X and also shall include audits necessary to assess whether (A) PBM's information technology systems used in the performance of the Services are functioning in accordance with applicable specifications; (B) PBM is accurately adjudicating Claims, Cost Shares, and calculating pricing and discounts to AWP (or any successor standard adopted pursuant to Section 9.11), including accurate application of provider reimbursement rates passed through to Aetna, Aetna Plan Affiliates and Aetna Customers and accurate application of benefits under Covered Plans; (C) PBM is properly rejecting Claims where a Member's coverage has terminated; (D) PBM is correctly allocating Claims according to eligibility and requests from Aetna; (E) PBM is managing the PBM Central Fill Pharmacies and PBM Central Fill Specialty Pharmacies in accordance with its obligations under this Agreement and applicable Law; (F) PBM is fully complying with its obligations pertaining to Aetna Manufacturer Revenues, Other Manufacturer Payments, and Pharmacy Rebates under Section 4.3 and Schedule I; (G) PBM is maintaining all required firewalls and other security measures required under this Agreement and applicable Law; (H) as provided in Schedule Y, PBM's Guarantee Reports delivered pursuant to Schedule Y accurately reflect all information required to be set forth thereon; (I) as provided in Schedule Y, PBM's Retail Market Experience Reports delivered pursuant to Part 3 of Schedule Y accurately reflect all information required to be set forth thereon; (J) as provided in Schedule Y, PBM's Baseline Mail and Specialty Market Experience Report delivered pursuant to Part 4 of Schedule Y accurately reflect all information required to be set forth thereon; (K) as provided in Schedule Y, PBM's Annual Mail and Specialty Market Experience Reports delivered pursuant to Part 4 of Schedule Y accurately reflect all information required to be set forth thereon; (L) as provided in Schedule Y, PBM's Medicare Guarantee Adjustment Reports delivered pursuant to Part 5 of Schedule Y accurately reflect all information required to be set forth thereon; and (M) PBM is complying with all customer service requirements with respect to Members and Aetna Customers. Additionally, PBM must fully support audit requirements for Aetna's Medicare Part D audit plan, Aetna's Retiree Drug Subsidy audit plan, any Medicaid or other Government Health Program audit plans, as well as Aetna quality initiatives and accreditation requirements. Aetna, its Affiliates and Aetna Customers shall be entitled to select their designated agents or representatives for audit purposes in their sole discretion; *provided, however,* that (i) no such designated agent or representative shall be subject to an Auditor Conflict of Interest or shall have had a past business or other relationship with PBM which, in any such case, would prevent the auditor from performing an independent audit to conclusion and (ii) all Aetna audits undertaken to review Administrative Costs and Direct or Indirect Remuneration shall be performed by designated agents or representatives who comply with the foregoing clause (i). As used in this Agreement, "Auditor Conflict of Interest" means any situation in which the designated agent or representative (i) is employed by a Person, or an Affiliate of a Person, which is a competitor to PBM's pharmacy benefit management business (including its mail and specialty pharmacy operations conducted through Caremark Rx), (ii) has terminated employment with PBM or any of its Affiliates within twelve months prior to the commencement of the audit, (iii) is an Affiliate

of any Subcontractor engaged by PBM to provide any material portion of the PBM Services (including claims adjudication), (iv) is compensated by Aetna, its Affiliate or an Aetna Customer in a manner that would provide a financial incentive to the designated agent or representative to overstate or misconstrue data, including any contingency fee or fee based on a percentage of overpayments identified.

(b) Aetna Customer Audits. Subject to Section 7.3(a) and as further described in Schedule X, to the extent that any Aetna Customers also have contractual review or audit rights pursuant to the Plan Contract between Aetna and such Aetna Customer, PBM also shall permit such Aetna Customers (or their designated agents or representatives who comply with the requirements set forth in Section 7.3(a)) to review and/or audit the Aetna Customer specific Required Books and Records and PBM's facilities used to provide (or that will be used to provide) the Services or any portion thereof, on an annual basis or more frequently as agreed upon by PBM (which agreement shall not be unreasonably withheld). To the extent permitted by the Plan Contract between Aetna and such Aetna Customer, such audits may include Claims audits, pre-implementation audits, and operational audits. PBM shall not, absent Aetna's prior written consent, permit any Aetna Customer to conduct an audit in a manner that does not comply with the limitations on audit rights contained in the Plan Contract between Aetna and such Aetna Customer (including limitations on auditor conflicts of interest and limitations on the frequency and type of audits), to the extent Aetna discloses such requirements to PBM. In the event that PBM receives a request from an Aetna Customer to conduct an audit, PBM shall promptly, and in any event as soon as reasonably practicable, notify Aetna in writing of such request.

(c) PBM Audits and Other Audits. In addition to the review and audit rights set forth in this Section 7.3, (i) Aetna shall have the right to conduct, or PBM shall conduct, as applicable, those specific types of audits described on Schedule X hereto and (ii) PBM shall provide support in connection with third party audits, including market conduct examinations, other regulatory examinations and inquiries of Governmental Bodies (such as state financial audits and department of insurance audits).

(d) Sarbanes Oxley Compliance and SSAE 16.

(i) As required by this Section 7.3(d), PBM shall deliver to Aetna Auditing Standards Board of the American Institute of Certified Public Accountants (AICPA) Statement on Standards for Attestation Engagements (SSAE) No. 16 Service Organization Control Reporting, Type 2, SOC 1 and, at Aetna's request, SOC2 reports with respect to PBM and its Affiliates, in each case, prepared on a basis specific to the Services (together with any similar successor report or report prepared pursuant to any successor standard, the "SSAE 16"). PBM shall retain a nationally recognized accounting firm, registered with the Public Company Accounting Oversight Board, to conduct each SSAE 16 audit and prepare each SSAE 16 report. Each SSAE 16 audit and report shall contain a certification from PBM's auditor that specifically addresses all control objectives applicable to any of the Services, including controls related to information technology, specifying whether the control design meets the intended objective of the control. PBM shall deliver to Aetna (i) not later than May 31 of each calendar year during the Term and the Termination Transition Period a SSAE 16 that addresses a coverage period of at least the twelve (12) calendar months ending March 31 of such calendar year, and (ii) not later

than November 30 of each calendar year during the Term and the Termination Transition Period a SSAE 16 that addresses a coverage period of at least the twelve (12) calendar months ending September 30 of such calendar year. Further, each such SSAE 16 shall include a control test plan that demonstrates that the controls were achieved over the twelve (12) calendar month (or longer) coverage period addressed therein.

(ii) In addition, (i) not later than January 15, of each calendar year during the Term and the Termination Transition Period, PBM shall provide to Aetna PBM's management assertion, in the form of Annex K, with respect to the period from September 30 of the prior calendar year through December 31 of the prior calendar year and (ii) not later than July 15, of each calendar year during the Term and the Termination Transition Period, PBM shall provide to Aetna PBM's management assertion, in the form of Annex K, with respect to the period from March 31 of such calendar year through June 30 of such calendar year. Failure to deliver a SSAE 16 or a management assertion within the applicable time period specified above in this Section 7.3(d) shall constitute a material breach of this Agreement. To the extent not addressed in the SSAE 16 submission, at the time of its SSAE 16 submission to Aetna, PBM shall also supply Aetna with a report of the management responses to any weaknesses, deficiencies or other exceptions noted in the SSAE 16 and of actions taken and/or plans implemented to address any such weaknesses, deficiencies or other exceptions identified in the SSAE 16 audit, discuss with Aetna such actions and/or plans and permit Aetna (or its designated agents and representatives) to perform alternate control procedures and other tests Aetna (or such designated agent or representative) determines to be advisable as a result of such weakness, deficiency, or exception.

(iii) PBM shall provide such assistance as Aetna may reasonably request from time to time in connection with Aetna's and its Affiliates' SSAE 16 audits; and PBM shall reimburse Aetna and its Affiliates for any auditor's fees and expenses incurred by them in order to conduct additional procedures in the event that Aetna determines that it is unable to rely on any SSAE 16 delivered by PBM as a result of weaknesses, deficiencies or other exceptions identified therein. Aetna may provide PBM's SSAE 16 report to Aetna Customers or prospective Aetna Customers that are self-insured Employer Plan Sponsors (subject to such Aetna Customer's or such prospective Aetna Customer's agreement to abide by and implement reasonable measures to protect and preserve PBM's rights and interests in Confidential Information of PBM included therein).

(e) Audits of Aetna. PBM shall provide reasonable assistance to Aetna, the Aetna Plan Affiliates and, at Aetna's direction, the Aetna Customers, in connection with any audit conducted by any other Person (including any Aetna Customer, Governmental Body, Manufacturer, or accreditation organization (*i.e.*, NCQA and URAC PBM auditing activities)), including as provided in Schedule X. PBM shall make appropriate staff available to prepare for, assist with, and participate in all such audits, as reasonably requested by Aetna from time to time. PBM shall, and shall cause such staff to, assist Aetna in creating any necessary action plans to rectify any audit finding in a timely manner.

(f) Audit Expenses. Each Party shall bear its own costs in connection with audits performed under this Agreement, except to the extent constituting Losses indemnifiable pursuant to Article XV.

(g) Audit Access. To the extent permitted by this Section 7.3 and Schedule X, and as necessary to accomplish the reviews and audits permitted thereby, as part of such reviews and audits, PBM shall grant Aetna, any Affiliate of Aetna, any Aetna Customer, Governmental Body, or accreditation organization, as applicable, or their designated agents or representatives, access to PBM and its Affiliates' (i) personnel, (ii) claim adjudication systems, (iii) member service systems, (iv) patient management records, (v) in accordance with Schedule P, rebate systems and records related to Aetna Rebates (including Manufacturer Rebate Agreements), (vi) Service Fees, (vii) Contracts with Participating Pharmacies (including retail network agreements, but with redaction of specific pricing details except to the extent applicable to Pass-Through Pricing, and (viii) such other information as Aetna or any Affiliate of Aetna, Aetna Customer, Governmental Body, or accreditation organization may reasonably request, including all Required Books and Records and, upon reasonable notice, to PBM's and its Affiliates' facilities used to provide the Services.

(h) Subcontractor and Participating Pharmacy Obligations. As between Aetna, the Aetna Plan Affiliates and Aetna Customers and PBM, PBM shall have the sole and exclusive right to audit PBM's Subcontractors and retail Participating Pharmacies in connection with this Agreement. Such audits shall be conducted by PBM and PBM shall share the results and findings thereof with Aetna in accordance with the terms set forth in Schedule X. In addition, PBM shall conduct audits of such Subcontractors or Participating Pharmacies as Aetna may reasonably request from time to time and PBM shall share the results and findings thereof with Aetna in accordance with Schedule X. Additionally, PBM acknowledges that Aetna may require direct audit rights with respect to any Subcontractor as a condition to its approval of a Subcontractor pursuant to Section 3.6(a).

7.4 **Pricing and other Financial Adjustments.**

If in connection with any audit conducted under Section 7.3, Aetna determines that any adjustments or corrections are required and/or that it is entitled to any payments, credits or reimbursements from PBM, Aetna shall deliver a written notice (an "Adjustment Notice") to PBM that sets forth in reasonable detail the amounts at issue or to be paid or credited and Aetna's bases therefor. Subject to the resolution of any disputes pursuant to Section 7.5 and without limiting Aetna's rights under Section 9.8, if any Adjustment Notice indicates (i) an overpayment by Aetna, any Aetna Affiliate or Aetna Customer, or (ii) an underpayment by PBM to Aetna or any Aetna Affiliate with respect to Aetna Manufacturer Revenues, PBM shall, within thirty (30) days, pay or credit Aetna the overpayment or underpayment amount(s) or the amount of Aetna Rebates or other amounts that Aetna failed to receive, together with interest at the greater of (A) the Prime Rate, or (B) four percent (4%) per annum, for the period of time (x) with respect to overpayments by Aetna, from payment by Aetna to reimbursement by PBM, (y) with respect to underpayments by PBM, from the date that payment should have been made by PBM until such amount is paid by PBM and (z) with respect to Aetna Manufacturer Revenues or other amounts that would have been due from Manufacturers and Participating Pharmacies, from the date on which such payment would have been due to Aetna. Subject to the resolution of any disputes pursuant to Section 7.5 and without limiting PBM's rights under Section 9.8, if any audit indicates an underpayment by Aetna, any Aetna Affiliate or Aetna Customer, Aetna will, within thirty (30) days, pay or credit PBM the underpayment amount(s), together, if (and only if) such underpayment resulted from a breach, error, or mistake by Aetna or any Aetna Affiliate,

with interest at the greater of the Prime Rate or four (4%) per annum for the period of time from the date that payment should have been made by Aetna, the Aetna Affiliate, or Aetna Customer, until such amount is paid to PBM; *provided, however*, that if such underpayment did not result from a breach, error or mistake by Aetna or any Aetna Affiliate and if Aetna or an Aetna Plan Affiliate would in the ordinary course be entitled to pass on such underpayment for reimbursement or payment by an Aetna Customer but due to the passage of time Aetna or such Aetna Affiliate is no longer able to do so, Aetna shall not be obligated to pay or credit such underpayment amount(s) to PBM.

7.5 **Resolution of Financial Disagreement Arising from Audits.**

Disputes regarding the outcome of any audit and/or any Adjustment Notice requesting payments or credits delivered by Aetna pursuant to Section 7.4 shall be resolved in accordance with this Section 7.5. If PBM disagrees with any Adjustment Notice, it must, within thirty (30) Business Days after its receipt thereof, deliver a written notice to Aetna that sets forth in reasonable detail the nature and bases of its objections (a "Notice of Objection"). If PBM fails to issue a Notice of Objection to any Adjustment Notice within such time period, PBM shall be deemed to have accepted the Adjustment Notice and PBM shall be obligated to make the payments, credits or reimbursements set forth therein. If PBM issues a Notice of Objection, (i) all portions of the Adjustment Notice that are not specifically disputed in such Notice of Objection shall be final and binding on PBM and PBM shall be obligated to make the payments, credits or reimbursements for such portions of the Adjustment Notice, and (ii) any specifically disputed payment or credit amounts (all such disputed amounts, the "Disputed Amounts") shall be resolved as follows:

(a) PBM and Aetna shall promptly endeavor in good faith to resolve the Disputed Amounts set forth in the Notice of Objection. In the event that a written agreement determining the Disputed Amounts has not been reached within twenty (20) Business Days (or such longer period as may be agreed by Aetna and PBM) after the date of receipt by Aetna of the Notice of Objection, the resolution of such Disputed Amounts shall be submitted to a nationally recognized independent accounting firm reasonably acceptable to both Parties (the "Neutral Accounting Firm"), and if the Parties are unable to agree upon such an accounting firm, each party shall elect a recognized independent accounting firm, and the two firms so selected shall select the Neutral Accounting Firm.

(b) Aetna and PBM shall use their commercially reasonable efforts to cause the Neutral Accounting Firm to render a decision in accordance with this Section 7.5 along with a written statement of reasons therefor within twenty (20) Business Days of the submission of the Disputed Amounts, or a reasonable time thereafter, to the Neutral Accounting Firm. The decision of the Neutral Accounting Firm shall constitute an arbitral award that is final, binding and non-appealable upon the Parties and upon which a judgment may be entered by a court having jurisdiction thereover, absent manifest error therein.

(c) In the event PBM and Aetna submit any Disputed Amounts to the Neutral Accounting Firm for resolution, Aetna shall be responsible for that fraction of the fees and costs of the Neutral Accounting Firm as is equal to (i) the absolute value of the difference between Aetna's aggregate position with respect to the Disputed Amounts and the Neutral Accounting

Firm's final determination with respect to the Disputed Amounts over (ii) the absolute value of the difference between PBM's aggregate position with respect to the Disputed Amounts and Aetna's aggregate position with respect to the Disputed Amounts, and PBM shall be responsible for the remainder of such fees and costs.

(d) The Neutral Accounting Firm shall act as an arbitrator to determine, based upon the provisions of this Section 7.5, only the Disputed Amounts and the determination of each item included in the Disputed Amounts shall in any event be no less than the lesser of the amount claimed for such item by either Aetna, on the one hand, or PBM, on the other hand, and shall be no greater than the greater of the amount claimed for such item by either PBM, on the one hand, or Aetna, on the other hand.

7.6 Non-Financial Adjustments Arising from Audits.

If Aetna delivers an audit report to PBM describing failures by PBM to comply with one or more of PBM's obligations under this Agreement, PBM shall provide a researched response to the applicable audit findings within twenty (20) Business Days. An acknowledgement to receiving the report shall not be considered a response. PBM's response shall contain a reasonably detailed explanation of whether or not it agrees with the audit findings and, if it agrees with the audit findings, it shall contain a reasonably detailed corrective action plan designed to remedy the noncompliance with the applicable PBM obligations. PBM's corrective action plan shall be reasonably acceptable to Aetna. In the event that Aetna does not accept PBM's corrective action plan, Aetna shall give written notice to PBM specifying its objections in reasonable detail and PBM shall propose a revised corrective action plan that addresses Aetna's objections; and Aetna shall either accept such revised corrective action plan, if reasonably acceptable to Aetna, or provide written notice of any further objections to PBM. This process shall be repeated as necessary until PBM has delivered a corrective action plan that is reasonably acceptable to Aetna. PBM shall implement any such corrective action plan (or any portion thereof) immediately after such plan (or portion thereof) is approved by Aetna pursuant to this Section 7.6.

ARTICLE VIII.
PLAN DESIGN AND PRODUCT DEVELOPMENT

8.1 Plan Design.

As further provided in Schedule B, (i) PBM shall accommodate and implement all new or modified Benefit Plan Designs as established by Aetna or any Aetna Plan Affiliate and communicated to PBM from time to time, and (ii) PBM shall provide such analytical services as may be reasonably requested by or for Aetna and Aetna Plan Affiliates to assist them in creating or revising Benefit Plan Designs for Aetna Plans or prospective Aetna Plans, including in response to requests from Aetna Customers or potential Aetna Customers (including requirements set forth in requests for proposals). To the extent required by applicable Law, Aetna will provide Members with advance notice of Benefit Plan Design changes that Aetna plans to implement.

8.2 Product Development Requirements.

(a) Aetna and Aetna Plan Affiliates shall have full control and authority over the product development process pertaining to Aetna Plans, Benefit Plan Designs, Aetna Customers and/or their health plans business generally. At no additional cost to Aetna (except as otherwise expressly set forth in Schedule Y-7), PBM shall support those efforts by providing such assistance as Aetna may reasonably request from time to time, including that PBM shall regularly consult with Aetna and Aetna Plan Affiliates with respect to Aetna's product development activities.

(b) As further provided in Schedule B, with respect to Benefit Plan Design variations not in use as of the Effective Date, PBM shall accommodate all Aetna Benefit Plan Design variations, including Aetna Customer-requested Benefit Plan Designs for specific Aetna Customers, and PBM shall implement such Benefit Plan Design variations at no additional cost to Aetna, except to the extent provided in Section 6.3.

(c) PBM shall provide Aetna, the Aetna Plan Affiliates and any Aetna Customers with free access, subject to any limitations on the permitted number of users as expressly set forth in any Schedule to this Agreement, to all Benefit Plan Design analytical tools owned or hereafter developed by PBM or its Affiliates or which PBM or its Affiliates have the right to use pursuant to license or similar arrangements with a third party.

8.3 **Plan-Related Filing Requirements.**

Except as set forth in the Schedules, Aetna shall be responsible for all regulatory filings and submissions applicable to new and existing Aetna Plans. As requested by Aetna, PBM shall provide reasonable support for those efforts, at no additional cost, including that:

(a) PBM shall consult with Aetna in the development of necessary regulatory filings and submissions and assist Aetna in drafting any explanations relating to the Services. PBM shall provide written explanations in connection with routine or standard requests for which information is readily available within five (5) Business Days of Aetna's request, and as soon as reasonably practicable in all other cases (not to exceed the period required to provide sufficient lead time to enable Aetna to meet the timeframe required for the applicable filing, as reasonably determined by Aetna);

(b) PBM shall assist Aetna in responding to any regulatory inquiries resulting from the filing process or regulatory submissions. PBM shall provide draft responses to all such written responses within five (5) days of PBM's receipt of such inquiry, or such longer period as may be reasonably necessary on a case by case basis (provided that PBM shall use its best efforts to minimize such period and such period shall not in any event exceed the timeframe required to provide a draft response to Aetna with sufficient lead time to enable Aetna to meet the timeframe required by the applicable Governmental Body, as reasonably determined by Aetna), whether received by PBM directly from the applicable Governmental Body or from Aetna; and

(c) PBM shall provide such support as Aetna may reasonably request from time to time in connection with any regulatory or actuarial filings and submissions relating to the Services, including rate filings. Such support shall be provided in accordance with an agreed

upon schedule designed to assist Aetna in meeting regulatory requirements. PBM and Aetna shall negotiate such schedule in good faith.

ARTICLE IX.
PRICING

9.1 Pricing for Services and Covered Drugs; Annual Retail Pricing Adjustment.

(a) General. Schedule Y (including all sub-schedules of Schedule Y) sets forth the Administrative Fees, Dispensing Fees and Ingredient Cost Charges that shall be payable to PBM or certain of its Affiliates under this Agreement for the performance of all Core Services. Except for applicable Taxes as provided in Section 17.5, no additional fees, charges or other amounts shall be payable to PBM for the performance of any Core Services. Schedule Y-7 sets forth the Administrative Fees that shall be payable for any Optional Services performed by PBM and certain other financial terms that are applicable to Optional Services. Unless otherwise mutually agreed by Aetna and PBM, and subject to Section 9.11, pricing for all such Optional Services shall be fixed for the duration of the Term.

(b) Drug and Services Pricing and Cost Guarantees. The pricing for Covered Drugs and all Services shall, throughout the Term, comply and be in accordance with the pricing terms and guarantees set forth in Schedule Y, and PBM shall make the payments to Aetna required under Parts 2, 3 and 4 of Schedule Y if the amounts charged to Aetna under this Agreement for Covered Drugs and the Services for any Pricing Category fail to be in accordance with such terms and guarantees.

(c) Annual Adjustment of Lock-In Discounts for Commercial Plans.

(i) Not later than February 10 of each year during the Term or Termination Transition Period commencing with 2015, Aetna shall prepare and deliver to PBM a written forecast (an "Annual Retail Lock-In Forecast") setting forth its good faith estimate of the following amounts for such calendar year for each Retail Lock-In Plan Category: (1) projected average number of Members that will be entitled to benefits under all Covered Plans within such Retail Lock-In Plan Category, (2) projected number of Qualifying Brand Prescriptions that will be dispensed by retail pharmacies for all Covered Plans within such Retail Lock-In Plan Category, and (3) projected number of Qualifying Generic Prescriptions that will be dispensed by retail pharmacies for all Covered Plans within such Retail Lock-In Plan Category.

(ii) Not later than February 28 of each year during the Term or Termination Transition Period commencing with 2015, PBM and Aetna shall cause the Senior Leaders and such other representatives as each shall designate to confer and meet to (1) review and discuss the Annual Retail Lock-In Forecast prepared by Aetna for such calendar year, (2) consider, negotiate in good faith and agree upon any modifications to such Annual Retail Lock-In Forecast as PBM reasonably believes are necessary to cause the projections contained therein to be more accurate for such year, and (3) negotiate in good faith, agree upon and implement such adjustments to the Commercial Retail Lock-In Pricing Guarantees for such year as shall be necessary to cause such Commercial Retail Lock-In Pricing Guarantees to produce, on a projected basis using the data included in the Annual Retail Forecast for such year, the same

aggregate cost (*i.e.*, aggregate Ingredient Cost Charges and Dispensing Fees) to Aetna and the Members for all Qualifying Prescriptions dispensed during such year that will be subject to any of the Commercial Retail Lock-In Pricing Guarantees as would be the case if all such Qualifying Prescriptions had been charged on the basis of the Master AWP Discounts for such year (after taking into account any adjustments to the Master AWP Discounts pursuant to Part 3 of Schedule Y). Unless Aetna and PBM otherwise agree, all adjustments to the Commercial Retail Lock-In Pricing Guarantees required under clause (3) of the preceding sentence shall be made effective as of January 1 of such year.

(iii) In June and September of each year during the Term or Termination Transition Period and at such other times as may be mutually agreed upon by the Parties, the Parties shall jointly assess the accuracy of the Annual Retail Lock-In Forecast for such year (as the same may have been previously modified by the Parties). If the Parties determine that the actual performance of the Covered Plans during such year has differed in any material respect from the projections contained in such Annual Retail Lock-In Forecast, the Parties shall (1) negotiate in good faith and agree upon such modifications to such Annual Retail Lock-In Forecast as shall be reasonably necessary to cause the projections contained therein to be more accurate for such year, and (2) negotiate in good faith, agree upon and implement adjustments to the Commercial Retail Lock-In Pricing Guarantees in the manner set forth in clause (3) of Section 9.1(c)(ii) and with prospective effect for the remainder of such year.

(iv) In addition, not later than February 10 of each year during the Term or Termination Transition Period commencing with 2016, the Parties shall compute the aggregate cost (*i.e.*, aggregate Ingredient Cost Charges, Dispensing Fees and Administrative Fees) to Aetna and the Members that would have resulted from all Qualifying Prescriptions that were dispensed during the prior calendar year and charged to Aetna on the basis of the Commercial Retail Lock-In Pricing Guarantees if such Qualifying Prescriptions instead had been charged on the basis of the Master AWP Discounts for such prior calendar year (such amount, the "Pro Forma Aggregate Lock-In Charge"). If the actual aggregate cost to Aetna and the Members that resulted under this Agreement from such Qualifying Prescriptions exceeds the Pro Forma Aggregate Lock-In Charge (such excess amount, the "Forecast Miss Overcharge Amount"), Aetna and PBM shall reduce (in proportions equal to the relative proportion of the excess) the applicable Commercial Retail Lock-In Pricing Guarantees for the following (the then-current) calendar year to the extent necessary to enable Aetna, on a projected basis using the data included in the Annual Retail Lock-In Forecast, to realize the entire amount of the Forecast Miss Overcharge Amount. The Pro Forma Aggregate Lock-In Charge, such actual aggregate cost to Aetna and the Members and the Forecast Miss Overcharge Amount shall be computed after taking into account (i) any adjustments to the Master AWP Discounts and the Commercial Retail Lock-In Pricing Guarantees for such prior calendar year pursuant to Part 3 of Schedule Y, and (ii) any reconciliation payments made pursuant to Part 2(D) of Schedule Y with respect to the Commercial Retail Lock-In Guarantees for such prior calendar year; it being intended by the Parties that the Forecast Miss Overcharge Amount should capture and reflect overpayments to PBM that result from inaccuracies in the Annual Retail Lock-In Forecast (and not overpayments that result from PBM having underperformed on its Commercial Retail Lock-In Pricing Guarantees, which overpayments are to be addressed and reconciled pursuant to Part 2(D) of Schedule Y).

(v) Any adjustment to Commercial Retail Lock-In Pricing Guarantees under Section 9.1(c)(iv) shall be effected after implementing any adjustments required under Section 9.1(c)(ii). If in any calendar year PBM over delivered on any of its pricing guarantees in Schedule Y with respect to any Pricing Category of Qualifying Prescriptions (as reported pursuant to Part 2 of Schedule Y), then the actual aggregate cost to Aetna and the Members utilized with respect to such year under Section 9.1(c)(iv) shall be recomputed to be equal to the amount that would have resulted if PBM had exactly achieved such pricing guarantees. This Section 9.1(c) shall be applicable only to any calendar year that is included in the Term or any Termination Transition Period, and the Parties shall not, following the last day of the Term or any Termination Transition Period (whichever last occurs), make any payment or other retroactive adjustment in favor of the other pursuant to Section 9.1(c)(iv).

(d) Future Pricing Terms and Operating Models. If, in order to be fully competitive in the marketplace or due to changes in Law or other factors, Aetna hereafter determines that it is necessary or advisable for it to have available to it under this Agreement Commercial Plan, Medicare Plan, or State Plan pricing terms or operating models beyond those then provided for or addressed in Schedule Y, such as pricing terms or operating models that are based a limited or restricted pharmacy network, are not based on a Lock-In nor Pass Through pricing structure, are not based on AWP, establish a pharmacy network comprised of 340B contract pharmacies or specifically address Claims processed pursuant to a 340B program, Aetna shall deliver a written notice to PBM that describes the alternative pricing terms and/or operating model it desires. Not later than thirty (30) Business Days after receiving such a written notice, PBM shall in good faith prepare and deliver a written proposal to Aetna setting forth alternative pricing terms for the remainder of the Term of the type requested by Aetna and that are in the aggregate at least as competitive economically as the pricing terms applicable to Commercial Plans or Medicare Plans, as the case may be, then-included in Schedule Y; *provided, however*, that if Aetna's notice relates to a request for proposal or is otherwise subject to a timing deadline imposed by an Aetna Customer or potential Aetna Customer, PBM shall use commercially reasonable efforts to deliver its proposal to Aetna within a time frame that will enable Aetna to meet such deadline. Promptly thereafter, the Parties as necessary shall negotiate in good faith to agree upon any modifications or refinements to PBM's proposed pricing terms that Aetna may reasonably request; and upon reaching agreement on such alternative pricing terms, Schedule Y shall be amended to include such pricing terms.

(e) Application of Pricing Schedules. From time to time, Aetna shall in written notices to PBM designate the Retail Pricing Plan Category that will be applicable to each Covered Plan and Aetna Customer during each calendar year during the Term and Termination Transition Period.

9.2 **Additional Covered Drug Pricing Terms.**

(a) Updates to AWP. PBM shall update the pricing it receives from Medi-Span (or another mutually agreed upon drug pricing service) on a daily (Business Day) basis for all Covered Drugs in order to accurately reflect the market price of each such Covered Drug.

(b) No Pooling of Guarantees. Each individual guarantee for a Pricing Category set forth in Schedule Y, including each of the Retail Pricing Guarantees, Dispensing

Fee Guarantees, Mail Discount Guarantees, and Specialty Product Guarantees, shall be administered, measured and reconciled as unique and distinct categories, components or segments; and a deficit (over charge) in any one Pricing Category shall not be offset against or aggregated with a surplus (over performance) in any other Pricing Category, *except, however,* that deficits (over charges) in Pricing Categories from Schedules Y-1, Y-2, Y-3, Y-4, Y-13 or Y-14 (retail only in the case of Y-14) in a given calendar year may be offset against Minor Surpluses (and only Minor Surpluses) in any Pricing Categories from the same (and only the same) sub-schedule of Schedule Y in the same calendar year. With regard to Schedules Y-13 and Y-14, the exception to the general prohibition against offsetting set forth in the preceding sentence is subject to, and will be applicable only if consistent with, the requirements of applicable Law and Aetna's contractual commitments to the applicable Aetna Customer (which must be communicated to PBM). "Minor Surplus" means (i) in the case of a Retail Discount Guaranty for a given Pricing Category, a surplus (over performance) in that Pricing Category that does not exceed such Retail Discount Guaranty by more than two tenths of one percent (0.20%), and (ii) in the case of a Dispensing Fee Guarantee for a given Pricing Category, a surplus (over performance) that does not exceed the applicable Dispensing Fee Guaranty by more than ten cents ($.10) per Paid Claim. The application of this Section 9.2(b) is illustrated in Annex O.

(c) MAC List Matters. MAC Lists shall be governed by Schedule G.

(d) Pricing for New Specialty Products (including Biosimilar Drugs). Upon the introduction of any Specialty Product(s) (including new Specialty Product Generic Drugs) into the marketplace, the Parties shall negotiate in good faith the pricing and pricing guarantees that will be applicable thereto and shall set forth such pricing and pricing guarantees in an amendment to Schedule Y-6. The pricing and pricing guarantees applicable to such Specialty Product shall in no event exceed the applicable default pricing set forth in Schedule Y-6. In addition, the price for all new Specialty Product(s) introduced into the marketplace after the Effective Date shall in no event, through the term of this Agreement, exceed the price at which such Specialty Product would, with the exception of such Specialty Product adjudicating as a U&C Claim, adjudicate to Aetna (including any Cost Share) if dispensed by a retail Participating Pharmacy under pricing that would comport to the Master AWP Discounts in Schedule Y-8. For the purpose of the preceding sentence, the Schedule Y-8 comparison rate shall be established by determining the relationship of Schedule Y-2 Brand and Generic Discounts (including applicable MAC rates) pricing to Schedule Y-8 Master Brand and Generic AWP Discounts and applying that factor to the price at which such Specialty Product would have adjudicated under Schedule Y-2. For example, if at the measurement date, Schedule Y-2 Generic discounts are 280 basis points higher than the Schedule Y-8 Master AWP Discounts and if the drug in question would have adjudicated at a 78.78% discount under Schedule Y-2, then the discount to be used for purposes of this calculation would be 75.98%. In addition, during the Measurement Year, in no event shall PBM or any of its Affiliates provide pricing or pricing guarantees for any such Specialty Product to any Comparable PBM Customer (other than with respect to plans of such Comparable PBM Customer under or specifically serving the Federal Employees Health Benefits Program) that are lower or more favorable to such Comparable PBM Customer (taking into account ingredient cost charges, dispensing fees, rebates retained, and after reducing the amount charged to such Comparable PBM Customer by the Specialty Variable Cost Amount) than those made available to Aetna and the Aetna Plan Affiliates under this Agreement during the

Measurement Year. The pricing and pricing guarantees for any such Specialty Product as set forth in Schedule Y-6 shall be reduced from time to time as necessary to ensure that PBM complies with the requirements of this Section 9.2(d). Within sixty (60) days after the end of the Measurement Year applicable to each Specialty Product, PBM shall certify that the pricing provided with respect to such Specialty Product during the Measurement Year complied with this Section 9.2(d). The following terms used in this Section 9.2(d) shall have the following meanings for purposes of this Section 9.2(d):

(i) "Comparable PBM Customer" means, for a given Measurement Year, any PBM Customer (other than Aetna) for which PBM and/or any of its Affiliates, at any point during such Measurement Year, provided Comparable Services for or with respect to any Plans, *excluding, however,* any PBM Customer that had in such Measurement Year an Adjusted Prescription Volume that is greater than the Adjusted Prescription Volume of Aetna and the Aetna Plan Affiliates for such Measurement Year.

(ii) "Comparable Services" means all of the following when contracted for by a PBM Customer on an integrated basis with PBM: (i) specialty pharmacy services, and (ii) (x) PBM's contracting and management of a retail pharmacy network, and/or (y) claims processing services.

(iii) "Adjusted Prescription Volume" means, for a given PBM Customer and time period, the sum of (i) (1) three (3) multiplied by (2) the aggregate number of prescription drug claims (including claims for devices, OTC drugs and supplies) filled at mail (including Maintenance Choice claims) or specialty that are paid, administered and/or processed by PBM or any of its Affiliates for such PBM Customer in such time period (but excluding claims that are reversed, duplicate or rejected) plus (ii) the aggregate number of prescription drug claims (including claims for devices, OTC drugs and supplies) filled at retail (excluding Maintenance Choice claims) that are paid, administered and/or processed by PBM or any of its Affiliates for such PBM Customer in such time period (but excluding claims that are reversed, duplicate or rejected).

(iv) "Measurement Year" means, with respect to any Specialty Product not available in the marketplace as of the Effective Date, the calendar year during which such new Specialty Drug is launched by a Manufacturer and is available in the marketplace.

(v) "PBM Customer" means, for purposes of this section, any PBM Customer (i) other than Aetna; or (ii) other than those under or specifically serving the Federal Employees Health Benefits Program.

(vi) "Specialty Variable Cost Amount" means, with respect to any Measurement Year, the average, fully-loaded variable cost per claim/prescription incurred by PBM and its Affiliates to perform specialty pharmacy services that are equivalent to the specialty pharmacy services that Aetna Specialty Pharmacy is contemplated to perform for Covered Plans (*i.e.,* excluding the central fill and other support services to be provided by PBM pursuant to Schedule N), as determined in accordance with GAAP and taking into account all labor (including wages, salaries, bonuses and benefits), other direct costs and expenses and variable overhead incurred in connection incurred with the provision of such services by PBM and its

Affiliates. For purposes of this definition, "specialty pharmacy services" refer to services and functions customary performed by a specialty pharmacy in connection with the dispensing of a Specialty Product.

(e) House Generics. From time to time the PBM may dispense a Brand Drug as a "house generic" drug (DAW5). In each such case, the applicable pricing terms and guarantees for Generic Drugs set forth in Schedule Y shall determine the amount due from Aetna, an Affiliate of Aetna, the Aetna Customer and/or the Member, as the case may be, with the AWP of the "house generic" drug being (i) the average AWP across all Manufacturers of the corresponding (non-repackaged) Generic Drug where there are multiple generic Manufacturers (as reported by Medi-Span in its GEAP field) or (ii) the AWP of the corresponding Generic Drug where there is a single generic Manufacturer. In the event that Medi-Span ceases to publish or populate its GEAP field or Medi-Span GEAP field ceases to fairly reflect the average AWP per unit of equivalent Generic Drug products, Aetna and PBM agree to negotiate in good faith an alternative, economically neutral method for computing the pricing terms and guarantees that shall be applicable to "house generic" drugs.

(f) Treatment of Dual Eligibles. All Claims arising under any State Plan submitted by any Member who also is eligible for coverage under a Medicare Plan shall be adjudicated at the rates applicable to Medicare Plans and shall be treated as Claims under a Medicare Plan for all purposes under this Agreement and Schedule Y.

9.3 **[Reserved].**

9.4 **Transition-Out Services Pricing.**

The pricing terms and guarantees set forth in Schedule Y shall be applicable to all Covered Drugs dispensed and Services performed by PBM during the Termination Transition Period. If the Termination Transition Period extends beyond 2022, the pricing terms and guarantees set forth in Schedule Y for 2022 shall be applicable to all Covered Drugs dispensed and Services performed by PBM after 2022 during the Termination Transition Period. Except for the Administrative Fees, Dispensing Fees and Ingredient Cost Charges provided for in Schedule Y, and except as provided in Section 6.3, PBM shall not be entitled to any additional fees, charges or other amounts for the performance of Transition-Out Services.

9.5 **Invoices for Paid Claims; Payment Terms.**

PBM shall provide Aetna with weekly electronic files in an Aetna-specified format that set forth in reasonable detail all Claims that were processed respectively by PBM and the PBM Pharmacy Entities (including all Claims processed by the PBM Central Fill Pharmacies and PBM Central Fill Specialty Pharmacies) on the prior day, and the amounts owing to PBM and the PBM Pharmacy Entities, in accordance with the pricing terms and guarantees set forth in Schedule Y, with respect thereto (but excluding all Administrative Fees owing with respect to such Claims which shall be invoiced pursuant to Section 9.6). Each such file shall be presented so as to allocate Claims and the respective payment or reimbursement obligations of and to Aetna, Aetna Rx Home Delivery, Aetna Specialty Pharmacy and the Aetna Plan Affiliates, as applicable, and shall include such additional information as Aetna may reasonably request.

Within ten (10) Business Days after receipt of each such file, Aetna shall pay, and/or shall cause the applicable Aetna Affiliates to pay their respective portions of, such amounts in full, less any applicable credits pursuant to Section 3.4(i), or such amounts that Aetna or any Aetna Affiliate disputes pursuant to Section 9.7(a). PBM acknowledges and agrees that each Aetna Plan Affiliate shall be responsible only for amounts owing under this Agreement with respect to Claims arising under those Covered Plans that are issued, managed or administered by such Aetna Plan Affiliate, and only for Claims paid on behalf of eligible Members under such Covered Plans in accordance with the eligibility and coverage terms of the applicable Plan Contract, and shall not have any responsibility or liability for payment obligations arising from any other Claims. Similarly, Aetna Rx Home Delivery shall be responsible only for the amounts payable by it under Schedule Y-5, and Aetna Specialty Pharmacy shall be responsible only for the amounts payable by it under Schedule Y-6. Although such Aetna Affiliates, respectively, are expected to pay PBM for the amounts they are responsible for under this Agreement, Aetna will be responsible for payment of all amounts owing under this Section 9.5 to the extent not paid by such Aetna Affiliates when due hereunder.

9.6 **Invoices for Administrative Fees and Optional Services; Payment Terms.**

PBM shall provide Aetna an invoice setting forth all Administrative Fees owing with respect to (a) all Claims that were processed or dispensed by PBM and the PBM Pharmacy Entities (including all Claims dispensed by the PBM Central Fill Pharmacies and PBM Central Fill Specialty Pharmacies) during the prior month and (b) all Optional Services performed by PBM during the prior month, in each case, accompanied by supporting documentation setting forth in reasonable detail the Claims and the Optional Services included in such invoice and the amounts owing to PBM under this Agreement with respect thereto. Each such invoice shall be presented so as to allocate the Administrative Fees, Optional Services and the corresponding payment or reimbursement obligations to the applicable Aetna Plan Affiliate, and shall include such additional information as Aetna may reasonably request. Within fifteen (15) Business Days after receipt of each such invoice, Aetna shall pay, and/or shall cause the applicable Aetna Plan Affiliates to pay their respective portions of, such invoice in full, less any applicable credits pursuant to Section 3.4(i), or such amounts that Aetna or any Aetna Affiliate disputes pursuant to Section 9.7(a). PBM acknowledges and agrees that each Aetna Plan Affiliate shall be responsible only for amounts owing under this Agreement with respect to Claims arising under, and for Optional Services performed specifically for or with respect to, those Covered Plans that are issued, managed or administered by such Aetna Plan Affiliate, and only for Claims paid on behalf of eligible Members under such Covered Plans in accordance with the eligibility and coverage terms of the applicable Plan Contract, and shall not have any responsibility or liability for payment obligations owing with respect to any other Covered Plans or Claims. Although such Aetna Plan Affiliates, respectively, are expected to pay PBM for the amounts they are responsible for under this Agreement, Aetna will be responsible for payment of all amounts owing under this Section 9.6 to the extent not paid by such Aetna Affiliates when due hereunder.

9.7 **Disputed Invoices.**

If Aetna or an Aetna Affiliate disputes all or a portion of any invoice delivered by PBM or the PBM Pharmacy Entities, Aetna shall inform PBM of the disputed amount and the basis for such dispute. The Parties shall negotiate in good faith to resolve any dispute as soon as

reasonably practicable and, upon resolution of such dispute, assuming that payment is due from Aetna to PBM or the PBM Pharmacy Entities, Aetna shall promptly make such payment to PBM the PBM Pharmacy Entities, as applicable, or, with respect to amounts previously paid by Aetna or any Aetna Affiliate to PBM or the PBM Pharmacy Entities, assuming that payment is due from PBM or the PBM Pharmacy Entities to Aetna or the applicable Aetna Affiliate, PBM shall promptly make such payment to Aetna or the Aetna Affiliate, as applicable. Payments due hereunder shall in any event be made not later than fifteen (15) Business Days following the date on which the amount of such payment is determined.

9.8 **Payment Adjustments.**

(a) If at any time it is determined (other than in connection with an audit pursuant to Section 7.4, in which case Section 7.4 shall govern) that (i) due to any breach, error or mistake by PBM or any of its Subcontractors (including Claim processing, adjudication or payment errors, errors in Cost Share assessments, Member eligibility errors and errors in the set up or administration of Covered Plans or Formularies), PBM or the PBM Pharmacy Entities have, in any invoice or otherwise, overcharged Aetna, any Aetna Affiliate, or Aetna Customer; (ii) for any other reason any Paid Claim for which PBM or the PBM Pharmacy Entities have previously invoiced Aetna, any Aetna Plan Affiliate, or Aetna Customer becomes a Duplicate Claim or Reversed Claim; or (iii) PBM or the PBM Pharmacy Entities have failed to pay all or any portion of any amount owing to Aetna or any Aetna Affiliate under this Agreement, then PBM must immediately pay or credit Aetna the overcharged or unpaid amount(s), together with an amount equal to the greater of (x) interest at the greater of the Prime Rate or four percent (4%) per annum for the period of time (A) with respect to overpayments by Aetna or any Aetna Plan Affiliate, from the date of the overpayment to the date of reimbursement by PBM, and (B) with respect to underpayments by PBM, from the date that payment should have been made by PBM until such amount is paid by PBM or (y) any interest, penalty or other amount due from Aetna or any Aetna Affiliate to any other Person on account of such overpayment or underpayment.

(b) If at any time it is determined that PBM or the PBM Pharmacy Entities have, in any invoice or otherwise, charged Aetna, any Aetna Plan Affiliate, or any Aetna Customer any amounts in respect of any Claims that arose from any fraudulent, unlawful or other improper act or omission by any Person, then PBM shall immediately repay or credit Aetna and/or the applicable Aetna Plan Affiliate such charged amounts together with an amount equal to interest at the Prime Rate plus four percent (4%) for the period of time from the date of such payment to the date of reimbursement by PBM or, if none of Aetna or any Aetna Plan Affiliate has yet paid such invoiced or other charge, PBM shall notify Aetna thereof and shall send a corrected invoice or other notice of payment that excludes the amount at issue.

(c) If at any time it is determined (including in connection with an audit conducted under Article VII) that (i) due to any breach, error or mistake by PBM or any of its Subcontractors, a Member has paid a higher Cost Share with respect to a Claim than permitted under the terms of the applicable Covered Plan or Plan Contract, or (ii) PBM has failed to reimburse or pay a Member any amount owing to such Member in connection with a Claim, then PBM shall immediately pay such Member the overcharged or unpaid amount, together with such interest as may be required under applicable Law.

9.9 **Prohibition on Collection of Payments from Members.**

PBM shall not, and shall cause its Affiliates not to, bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member or any other Person acting on a Member's behalf, other than Aetna or an Aetna Plan Affiliate (as applicable), with respect to any amount (other than Cost Shares or fees for drugs other than Covered Drugs delivered on a fee-for-service basis to Members, which have not otherwise been paid by a primary or secondary carrier in accordance with the coordination of benefits responsibilities of PBM as part of the PBM Services), regardless of any nonpayment by Aetna or any Aetna Plan Affiliate of such amount, breach of this Agreement by Aetna, insolvency of Aetna, or any other basis. PBM further agrees that this Section 9.9 supersedes any oral or written Contract to the contrary now existing or hereafter entered into between PBM and a Member or Persons acting on a Member's behalf. As relates to any Member under a Medicare Plan or a State Plan, no modification of this provision shall be effective without the prior written approval of the appropriate state and/or federal Governmental Body. This provision shall survive the termination or expiration of this Agreement, regardless of the cause of the termination or expiration.

9.10 **Aetna Customer Undercharges Caused by PBM.**

(a) As further provided in the Schedules, including Schedule Y-10, PBM (i) shall be responsible for processing and adjudicating Claims in accordance with, and for accurately administering and implementing, the pricing terms agreed between each Aetna Customer and the applicable Aetna Plan Affiliate and, with respect to insured products, the pricing terms agreed between an Aetna Plan Affiliate and either Aetna or a second Aetna Plan Affiliate and (ii) shall provide Aetna and the Aetna Plan Affiliates with such data as shall be necessary to enable Aetna to accurately and fully invoice each Aetna Customer or, with respect to insured plans, the applicable Aetna Plan Affiliate, in each case, in accordance with such pricing terms. PBM shall inform Aetna promptly of any breaches, errors or mistakes by PBM or its Subcontractors with respect to the foregoing of which PBM becomes aware and shall pay Aetna for any Losses suffered by Aetna, any Aetna Plan Affiliate or Aetna Customer resulting from any such breaches, errors or mistakes, together with interest at the greater of the Prime Rate or four percent (4%) per annum from the date that each such Loss occurs until such amount is paid by PBM.

(b) Not later than March 31 of each year, PBM shall (i) provide a statement to Aetna that sets forth for each Aetna Customer and, with respect to each insured plan, the applicable Aetna Plan Affiliate, the total amount invoiced to such Aetna Customer or Aetna Plan Affiliate on account of Claims processed during the prior year and the total amount that should have been invoiced to such Aetna Customer or Aetna Plan Affiliate under the pricing terms of the applicable Plan Contract or, with respect to insured products, the applicable Contract with such Aetna Plan Affiliate, and (ii) pay to Aetna the aggregate amount of any invoicing shortfalls shown on such statement (excluding any shortfalls resulting from errors, mistakes or other actions on the part of Aetna or any Aetna Plan Affiliate) and as accurately calculated by PBM based on information provided by Aetna with respect to invoices it has issued to Aetna Customers and such Aetna Plan Affiliates.

9.11 **Effect of Certain Changes in Law or Pricing Mechanisms Adjustments to Pricing and Other Agreement Terms to Address Changes in Law or Other Circumstances.**

(a) "Material Change" means the occurrence of any of the following events or circumstances:

(i) a change in any Law applicable to the performance of the Services by PBM and/or the operations and business of Aetna and the Aetna Plan Affiliates relating to the pharmacy benefits provided under the Aetna Plans, if such change has or upon becoming effective will have a material adverse impact on the benefits, costs or economics for Aetna and the Aetna Plan Affiliates and/or PBM that arise from or relate to this Agreement, but in all cases excluding changes in the Laws governing any Taxes imposed on any Party or any of its Affiliates;

(ii) a change in any Law that will necessitate an expansion or modification of the Services or other amendment to the terms of this Agreement in order for Aetna, any Aetna Plan Affiliate or PBM to be and operate in compliance with all applicable Laws, if such expansion, modification or amendment will result in a material increase in PBM's cost of performance under this Agreement;

(iii) a change in any Law that causes any aspect of the Services to become unnecessary or necessary at a lower level of effort on the part of PBM and Aetna determines to eliminate or reduce PBM's obligations under this Agreement with respect to such Services to address such change in Law, if the elimination or a reduction in scope of such aspect of the Services would result in a material reduction in PBM's cost of performance under this Agreement;

(iv) Aetna pursuant to, and to the extent permitted by, Section 3.2(h) requires PBM to comply with an interpretation of Law as to which PBM disagrees and such interpretation will require PBM to change the manner in which it must perform the Service, if such change will result in a material increase or reduction in PBM's cost of performance under this Agreement;

(v) a change in the method for calculating AWP, including if AWP ceases to be published or otherwise becomes unavailable or PBM becomes required to change its AWP pricing source from Medi-Span to another Person if such change has or upon becoming effective will have a material adverse impact on the benefits, costs or economics for Aetna and the Aetna Plan Affiliates and/or PBM that arise from or relate to this Agreement; or

(vi) a change in the health care or pharmacy benefits industry with respect to the usage or acceptability of AWP-based pricing that causes substantial numbers of Aetna Customers and potential Aetna Customers to reject AWP-based pricing, and Aetna in a written notice to PBM, advises PBM that it wishes, in whole or in part, to discontinue the usage of AWP-based pricing in Schedule Y.

Notwithstanding the foregoing and for the avoidance of doubt, any change in Law, including any issuance, awarding or entering into of any order, decision, decree, judgment or settlement to the

extent affecting or relating to the ownership or operations of any retail pharmacy owned by PBM or any of its Affiliates shall not constitute a Material Change.

(b) If a Material Change occurs, or if a Material Change has been announced (with a future effective date), Aetna and/or PBM, promptly after becoming aware or notified of the same, shall provide written notice to the other Party, and following the receipt of any such notice the Parties shall negotiate in good faith to identify, draft and implement mutually acceptable amendments to this Agreement that to the greatest extent reasonably possible will preserve the respective benefits and economics of Aetna and the Aetna Plan Affiliates, on the one hand, and PBM, on the other, that arise from or relate to this Agreement as of immediately preceding the occurrence of the Material Change, and in addition:

(i) with respect to a Material Change under Section 9.11(a)(i), expand, eliminate, reduce or otherwise modify the Services as necessary to address requirements arising from the Material Change and equitably increase or decrease the pricing and fees set forth in Schedule Y to address the material adverse impact on the benefits, costs or economics for Aetna and the Aetna Plan Affiliates and/or PBM that arise from or relate to this Agreement;

(ii) with respect to a Material Change under Section 9.11(a)(ii), 9.11(a)(iii) or 9.11(a)(iv), expand, eliminate, reduce or otherwise modify the Services as necessary to address requirements arising from the Material Change and equitably increase or decrease, as applicable, the pricing and fees set forth in Schedule Y to address any material increase or decrease in PBM's cost of performance under this Agreement resulting therefrom;

(iii) with respect to a Material Change under Section 9.11(a)(v), equitably modify, increase or decrease the pricing and fees set forth in Schedule Y as necessary to address the impact of the Material Change on the benefits, costs or economics for Aetna and the Aetna Plan Affiliates and/or PBM that arise from or relate to this Agreement; and

(iv) with respect to a Material Change under Section 9.11(a)(vi), to the extent specified in Aetna's written notice to PBM, amend Schedule Y to replace AWP with an alternative, market-accepted and competitive pricing methodology and equitably modify the pricing terms and fees set forth in Schedule Y as necessary to address the impact of such replacements on the benefits, costs or economics for Aetna and the Aetna Plan Affiliates and/or PBM that arise from or relate to this Agreement.

(c) Any amendments made pursuant to this Section 9.11 shall, to the extent applicable, take into account any industry-wide practices and approaches utilized to address the Material Change. To the extent the Material Change impacts or is applicable to other existing and prospective PBM Customers, PBM shall disclose the practices and approaches utilized or proposed by PBM to address the Material Change for such other existing and prospective PBM Customers, and PBM shall not in any event seek amendments to this Agreement that would be inconsistent with or less favorable to Aetna than such practices and approaches. PBM shall not be required to breach any contractual obligations of confidentiality to any existing or prospective PBM Customer in order to perform its obligations pursuant to the preceding sentence; *provided, however,* that it shall disclose such information to the full extent permitted to do so without resulting in such a breach. If the Parties have not agreed upon such amendments prior to the

occurrence or effectiveness of the Material Change, such amendments shall be retroactively applied back to the date that the Material Change occurs or becomes effective.

(d) If, after a period of twenty (20) Business Days following the announcement or occurrence (whichever first occurs) of any Material Change, the Parties have not agreed upon amendments to this Agreement as provided in Sections 9.11(b) and 9.11(c), then the Parties shall promptly submit the matter to a non-binding mediation utilizing the procedures set forth in Section 17.27 and shall in good faith endeavor to utilize the mediation to develop mutually acceptable amendments to this Agreement as provided in Sections 9.11(b) and 9.11(c). If the matter is not resolved pursuant to such non-binding mediation, the Parties shall then submit the matter to the presidents (or equivalent officers) of the Parties for resolution, and the presidents (or equivalent officers) of the Parties shall meet and confer, which meeting may be by telephone, in an attempt to resolve the matter. If the presidents (or equivalent officers) are unable to resolve the matter within twenty (20) Business Days, the presidents (or equivalent officers) shall negotiate in good faith to determine a mutually agreed process for resolving such dispute, which may include submitting the matter to a neutral accounting firm or other independent party. If the presidents (or equivalent officers) are unable to agree upon a process for resolving such dispute, either party may exercise its rights and remedies pursuant to Section 17.27(b).

9.12 **Interest on Late Payments.**

Either Party shall pay the other Party interest on any past-due amounts owing by such Party to the other Party under this Agreement at a rate equal to the greater of the Prime Rate or four percent (4%) per annum. A Party shall reimburse the other Party for all collection costs reasonably incurred by such other Party as a result of any payment default by the defaulting Party under this Agreement.

ARTICLE X.
REPRESENTATIONS AND WARRANTIES

10.1 **By PBM.**

PBM represents and warrants to Aetna, as of the date hereof, and agrees, as follows:

(a) Organization and Standing. PBM is a Delaware limited liability company, duly formed, validly existing and in good standing, and has the corporate power and authority to own, lease and operate its assets and to carry on its business as it is now being conducted.

(b) Authorization. PBM has all corporate or other legal capacity, authority and power, as applicable, to execute, deliver and perform its obligations under this Agreement. PBM has taken all necessary action to authorize, execute, deliver and perform this Agreement and to authorize the consummation of the transactions contemplated hereby. Assuming due execution, delivery and performance of this Agreement by Aetna, this Agreement constitutes the valid and binding obligation of PBM, enforceable against PBM in accordance with its terms. Additionally, PBM has the authority to enter into this Agreement on behalf of Caremark Rx, and this Agreement constitutes the valid and binding obligations of Caremark Rx.

(c) Consents and Approvals. No consent, approval, authorization, ruling, order of, notice to or registration with, any Governmental Body or any other Person, is required for PBM's execution and delivery of this Agreement, or for the performance of PBM's obligations hereunder, and PBM is not aware of any Person that is required to be a party to this Agreement in order to implement the terms and provisions hereof. PBM shall, during the Term and the Termination Transition Period, maintain in good standing each consent, approval, authorization, ruling, order of, notice to or registration with, any Governmental Body or regulatory authority or any Person that is required for PBM's performance of its obligations under this Agreement.

(d) No Conflict or Violation. Neither the execution, delivery or performance of this Agreement nor the consummation of the transactions contemplated hereby in accordance with its terms and conditions will (i) be a violation of any term or provision of PBM's governance documents (e.g., its certificate of formation, limited liability company agreement or operating agreement), (ii) be a violation of, conflict with or result in the breach of any of the terms of, result in any modification of, accelerate or permit the acceleration of the performance required by, otherwise give any other contracting party the right to terminate, or constitute (with notice or lapse of time, or both) a default under any material Contract to which PBM or any of its Affiliates is a party or by which PBM or any of its Affiliates is bound, (iii) be in violation of any order judgment, injunction, award or decree of any court, arbitrator or Governmental Body binding upon PBM, or any agreement with, or condition imposed by, any Governmental Body binding upon PBM, or (iv) be in violation of any Law by which PBM is bound or to which PBM is subject. At no time during the Term of this Agreement shall PBM take any action that could reasonably be expected to result in the occurrence of any of the events described in (i) through (iv) above.

(e) No Actions Pending. There is no action, suit, investigation or proceeding pending or, to the best of PBM's knowledge, threatened against PBM or any properties or rights of PBM, by or before any Governmental Body, which action, suit, investigation or proceeding could reasonably be expected to impair the ability of PBM to perform its obligations under this Agreement. Except as disclosed in PBM Parent's public filings with the Securities Exchange Commission, neither PBM nor any of the PBM Related Parties has been party to any past or pending unsealed material action, suit, investigation or proceeding initiated by any Governmental Body (or any person acting on behalf of a Governmental Body, such as a *qui tam* plaintiff) relating to payment from a Governmental Body for healthcare and/or prescription drug services provided by PBM or PBM Related Parties during the three year period prior to the Effective Date.

(f) Compliance with Laws; No Contracts with Excluded Persons. PBM is in compliance with all applicable Laws in all jurisdictions in which it is presently doing business, except where the failure to be in compliance with such applicable Laws would not reasonably be expected to impair PBM's ability to perform its obligations under this Agreement. None of PBM, its Affiliates or any of the PBM Related Parties who is and/or will be fully or partially responsible for PBM's performance of Services has ever (i) been excluded from participation in any federal- or state-funded health program; or (ii) been listed in the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the exclusion lists maintained by the OIG or the GSA.

(g) Licenses, Permits and Accreditations. PBM is duly qualified to hold and holds all (i) necessary governmental licenses, certifications, registrations, permits and similar authorizations and is in good standing in every jurisdiction where the nature of the administration and servicing of this Agreement requires it to be qualified or licensed; and (ii) necessary, industry standard and advisable accreditations as may be applicable with respect to the Services, and in any event including accreditation by NCQA or URAC. There are no pending, or to the best of PBM's knowledge, threatened, suits or proceedings with respect to the suspension, revocation, or non-renewal of any such governmental license, certification, registration, permit, accreditation or similar authorization, and no event which (whether with notice or lapse of time or both) will or could result in a suspension, revocation, or non-renewal of any such governmental license, certification, registration, permit, accreditation or similar authorization has occurred. PBM is not operating under any agreement with any Governmental Body of any state which materially restricts its authority to do business or requires it to take, or refrain from taking, any material action that could reasonably be expected to adversely impact the administration and servicing of its obligations under this Agreement. Except to the extent prohibited by applicable Law, PBM shall promptly give notice to Aetna within five (5) Business Days of the occurrence of any event which would cause the representations and warranties made in this Section 10.1(g) to no longer be true and correct if made on such date.

(h) Financial Condition. PBM is not Insolvent, nor has PBM filed or had filed against it a petition in bankruptcy, made an assignment for the benefit of creditors or otherwise had a receiver or trustee appointed with respect to its properties or affairs or incurred any obligations, contingent or otherwise, which would cause it to become Insolvent.

(i) Sufficient Resources. PBM has such personnel, systems, equipment, technology, tools and other resources as are necessary to perform the Services in accordance with the terms of this Agreement, as are necessary to provide industry best practices and processes and as are necessary to achieve all milestones, Performance Standards and Customer Performance Standards applicable to the Services, including as set forth in the Transition-In Plan and Schedule R.

(j) Intellectual Property. The Services, systems and applications provided or made available by PBM hereunder and/or the use of the Services and such systems and applications by Aetna, Aetna Plan Affiliates, Aetna Customers and Members pursuant to this Agreement, do not and shall not infringe upon or misappropriate any Proprietary Right of any third party. PBM has and shall maintain at all times during the Term, the full authority to license or sublicense any and all information, systems, applications and/or software provided to Aetna, Aetna Plan Affiliates, Aetna Customers and/or Members hereunder and to perform all Services hereunder. The Services shall be free and clear of all liens, claims, encumbrances and demands of third parties. This warranty shall survive the expiration or termination of this Agreement.

(k) Participating Pharmacy Provider Contracts. PBM's Contracts with Participating Pharmacies are, and shall be, in compliance with all applicable Laws, including any willing provider Laws, prompt pay Laws, audit Laws, utilization review requirements, quality assurance and dispute resolution requirements, Laws prohibiting balance billing and Laws requiring certain time periods for notice of amendment and notice of termination. Each of PBM's Contracts with a Participating Pharmacy has been submitted for approval (and not

rejected) and/or received approval from each applicable Governmental Body whose approval of such Contract is required by applicable Law.

10.2 **By Aetna.**

Aetna represents and warrants to PBM as of the date hereof as follows:

(a) Organization and Standing. Aetna is a Delaware limited liability company, duly formed, validly existing and in good standing, and has the limited liability company power and authority to own, lease and operate its assets and to carry on its business as it is now being conducted.

(b) Authorization. Aetna has all limited liability company or other legal capacity, authority and power, as applicable, to execute, deliver and perform Aetna's obligations under this Agreement. Aetna has taken all necessary action to authorize, execute, deliver and perform this Agreement and to authorize the consummation of the transactions contemplated hereby. Assuming due execution, delivery and performance of this Agreement by PBM, this Agreement constitutes the legal, valid, and binding obligation of Aetna, enforceable against Aetna in accordance with its terms. Additionally, Aetna has the authority to enter into this Agreement on behalf of Aetna Rx Home Delivery and Aetna Specialty Pharmacy, and this Agreement constitutes the valid and binding obligations of such Affiliates of PBM.

(c) Consents and Approvals. No consent, approval, authorization, ruling, order of, notice to or registration with, any Governmental Body or any other Person is required for Aetna's execution and delivery of this Agreement, or for the performance of Aetna's obligations hereunder, and Aetna is not aware of any Person that is required to be a party to this Agreement in order to implement the terms and provisions hereof. Aetna shall, during the Term, maintain in good standing each consent, approval, authorization, ruling, order of, notice to or registration with, any Governmental Body or regulatory authority or any Person that is required for Aetna's performance of its obligations under this Agreement.

(d) No Conflict or Violation. Neither the execution, delivery or performance of this Agreement nor the consummation of the transactions contemplated hereby in accordance with its terms and conditions will (i) be a violation of any term or provision of Aetna's governance documents (e.g., its certificate of incorporation or bylaws), (ii) be a violation of, conflict with or result in the breach of any of the terms of, result in any modification of, accelerate or permit the acceleration of the performance required by, otherwise give any other contracting party the right to terminate, or constitute (with notice or lapse of time, or both) a default under any material contract, commitment, indenture, or other agreement or restriction to which Aetna is a party or by which Aetna is bound or (iii) be in violation of any order judgment, injunction, award or decree of any court, arbitrator or Governmental Body against, binding upon Aetna, or any agreement with, or condition imposed by, any Governmental Body binding upon Aetna, or (iv) be in violation of any Law by which Aetna is bound or to which Aetna is subject. At no time during the Term of this Agreement shall Aetna take any action that could reasonably be expected to result in the occurrence of any of the events described in (i) through (iv) above.

(e) No Actions Pending. There is no action, suit, investigation or proceeding pending or, to the best of Aetna's knowledge, threatened against Aetna or any properties or rights of Aetna, by or before any Governmental Body, which action, suit, investigation or proceeding could reasonably be expected to impair the ability of Aetna to perform its obligations under this Agreement. Aetna shall promptly provide notice to PBM during the Term of any such action, suit or investigation of which it becomes aware.

(f) Compliance with Laws. Aetna is in, and shall remain in, compliance with all applicable Laws in all jurisdictions in which it is presently doing business, except where the failure to be in compliance with such applicable Laws would not reasonably be expected to impair Aetna's ability to perform its obligations under this Agreement.

(g) Financial Condition. Aetna is not Insolvent, nor has Aetna filed or had filed against it a petition in bankruptcy, made an assignment for the benefit of creditors or otherwise had a receiver or trustee appointed with respect to its properties or affairs or incurred any obligations, contingent or otherwise, which would cause it to become Insolvent.

(h) Intellectual Property. The systems and applications provided or made available by Aetna or its Affiliates hereunder and/or the use of such systems and applications by PBM and its Affiliates pursuant to this Agreement, do not and shall not infringe upon or misappropriate any Proprietary Right of any third party. Aetna has and shall maintain at all times during the Term, the full authority to license or sublicense any and all information, systems, applications and/or software provided to PBM and its Affiliates pursuant to this Agreement. This warranty shall survive the expiration or termination of this Agreement.

ARTICLE XI.
DATA; DISASTER RECOVERY AND INTELLECTUAL PROPERTY

11.1 Use of Data and Information.

Except as specifically authorized as set forth in Schedule Z, PBM and its Affiliates shall not use, sell, distribute, transfer or disclose any Data and Information for any purpose, other than as required for the performance of Services, unless PBM is specifically and expressly authorized in writing in advance by an authorized Aetna representative and where such sale, distribution, transfer or disclosure (as authorized by Schedule Z or an authorized Aetna representative) complies with applicable Law. For avoidance of doubt, at a minimum, PBM and its Affiliates may not (a) sell or trade any Data and Information; (b) disclose, transfer, or distribute any Data and Information to any Person (including an Affiliate, employee, agent, or representative of PBM) unless necessary to perform the Services for Aetna; (c) publicize any Data and Information; or (d) produce, use, or distribute written reports containing Data and Information other than as reasonably required to provide the Services, as otherwise expressly required under this Agreement or as specifically and expressly permitted in writing in advance by an authorized Aetna representative. Any breach of this Section 11.1 shall constitute a material breach of this Agreement. To the extent required by all applicable Laws, PBM shall ensure that adequate authorization, consent, and release is obtained for the disclosure and distribution to Aetna of all Member-identifiable information obtained by PBM from Providers.

11.2 **Disaster Recovery Plan.**

(a) Recovery Plan. PBM shall maintain a current disaster recovery and business continuity plan (the "Disaster Recovery Plan") throughout the Term and any Termination Transition Period. The Disaster Recovery Plan shall at all times contain, at a minimum, PBM's plan for recovering each site (including all mail order and specialty pharmacies and all call centers) used by PBM to provide Services under this Agreement from a disaster, its plan to recover any data that may be lost in connection with such disaster and its plans to recover any other assets used by PBM to provide the Services at the time of such disaster. The Disaster Recovery Plan also shall (i) at all times include PBM's applications, software, hardware, network, internet connectivity and facility recovery plans, including those utilized by or for the PBM Central Fill Pharmacies and PBM Central Fill Specialty Pharmacies, (ii) comply with the requirements set forth in Schedules M and N, and (iii) reflect actions necessary to comply with the disaster recovery requirements set forth in Schedules E and U. PBM has made available to Aetna for review a complete copy of its current Disaster Recovery Plan, and represents and warrants that such current Disaster Recovery Plan meets all of the requirements set forth in this Section 11.2. PBM will make available to Aetna a complete copy of an updated version of the Disaster Recovery Plan on an annual basis and at such other points in time when PBM makes any material update to any of the plans or other information described therein. Additionally, the Disaster Recovery Plan shall at all times provide that PBM's systems and IT processes must be restorable and operational within defined disaster recovery timeframes set forth in the Schedules to this Agreement.

(b) Testing. PBM shall provide a testing plan on an annual basis, shall perform testing of the Disaster Recovery Plan on an annual basis and shall provide a copy of the results of such testing, including actionable observations, certified by an appropriate officer of PBM as to the accuracy and completeness thereof, to Aetna within ten (10) Business Days after completion of all testing activities. If any such testing results include actionable observations as mutually agreed by the Parties, or that will or would be reasonably likely to result in PBM's noncompliance with this Agreement, PBM shall take all such corrective actions as are required and shall keep Aetna reasonably apprised as to such efforts. No less than thirty (30) days prior to the commencement of annual Disaster Recovery Plan testing, PBM shall provide a written notice to Aetna that specifies in reasonable detail the testing protocols PBM proposes to use in conducting such testing. If so requested by Aetna within ten (10) Business Days of Aetna's receipt of such notice, PBM shall promptly meet with Aetna to discuss, and PBM shall in good faith consider, (i) any objections raised by Aetna to the testing protocols and (ii) any requests by Aetna for PBM to conduct additional tests; *provided, however,* that PBM shall not have any obligation to conduct additional tests pursuant to clause (ii) unless Aetna shall have agreed to reimburse PBM for its reasonable out of pocket costs to conduct such tests. At Aetna's request, PBM shall promptly provide written notice to Aetna of the reasonable out of pocket costs to be paid by Aetna pursuant to clause (ii) of the precedent sentence, and PBM shall not conduct any such testing (or shall conduct any such testing solely at its own expense), unless Aetna approves such costs in writing prior to the initiation of such testing. Upon the occurrence of any disaster, PBM shall notify Aetna of such occurrence and implement its Disaster Recovery Plan in accordance with its terms, and in any event in a manner designed to restore any lost capability to provide the Services in accordance with all Service Levels and other requirements of this Agreement as promptly as possible and in any event within the

timeframes set forth in the Schedules to this Agreement. PBM shall participate in Aetna's internal disaster recovery and business continuity exercises and plans as requested by Aetna.

11.3 **Intellectual Property.**

(a) Separate Intellectual Property. Absent a separate agreement between Aetna and PBM providing otherwise, neither PBM nor any of its Affiliates will have any ownership interests in any clinical programs or other Intellectual Property currently owned by or hereafter developed independently of PBM by Aetna or any of its Affiliates or currently or hereafter licensed by Aetna or any of its Affiliates from any Person other than PBM or its Affiliates (collectively, the "Aetna IP"), even if Aetna makes such Intellectual Property available for use by PBM or any of its Affiliates under a license, whether pursuant to this Agreement or otherwise. Likewise, absent a separate agreement between Aetna and PBM providing otherwise, neither Aetna nor any of its Affiliates will have any ownership interests in any clinical programs or other Intellectual Property currently owned by or hereafter developed independently of Aetna by PBM or any of its Affiliates or currently or hereafter licensed by PBM or any of its Affiliates from any Person other than Aetna or any of its Affiliates (collectively, "PBM IP"), even if PBM makes such Intellectual Property available for use by Aetna or any of its Affiliates under a license, whether pursuant to this Agreement or otherwise. Additionally, except as expressly set forth in any Schedule or elsewhere in this Agreement, nothing herein shall be deemed to grant to PBM or any of its Affiliates, by implication, estoppel, or otherwise, and neither PBM nor any of its Affiliates shall acquire, any right to use or license under any Aetna IP. Likewise, except as expressly set forth in any Schedule or elsewhere in this Agreement, nothing herein shall be deemed to grant to Aetna or any of its Affiliates, by implication, estoppel, or otherwise, and neither Aetna nor any of its Affiliates shall acquire, any right to use or license in or to any PBM IP.

(b) Jointly Developed Intellectual Property. The Parties, on a case by case basis, shall mutually agree in writing and in advance upon the allocation of rights and interests in any Intellectual Property jointly developed by Aetna or any of its Affiliates, on the one hand, and PBM or any of its Affiliates, on the other; *provided, however,* that:

(i) Aetna exclusively shall own all rights, title and interests in and to (A) any clinical programs and other Intellectual Property to which PBM or any of its Affiliates or Subcontractors contributes to the development thereof at Aetna's specific direction and request and pursuant to the terms of this Agreement or specifically in order to fulfill an express requirement under this Agreement, (B) any software or information technology systems PBM develops specifically and uniquely for the delivery of the Services (collectively, "Custom Software"), including all patents and copyrights therein, (C) all website content created by or on behalf of PBM for use in connection with Aetna-specific websites PBM is required to provide hereunder and all content included in Member, Aetna Customer, Provider or other communications created by or on behalf of PBM specifically in connection with the Services, and (D) any jointly developed Intellectual Property that is primarily derivative of Aetna IP (including all Aetna clinical programs) (the Intellectual Property described in this clauses (A) – (D), the "New Intellectual Property"); *provided, however,* that if with Aetna's prior written approval, any such Intellectual Property (i) is developed as an integrated part of any PBM IP or (ii) is specifically designed to operate solely upon or in connection with any PBM IP, such

Intellectual Property shall not constitute New Intellectual Property and shall be jointly owned by Aetna and PBM (or their respective Affiliates); and

(ii) except as provided in clause (i) of this Section 11.3(b) and absent a mutual agreement by the Parties with respect to any jointly developed Intellectual Property, the Parties shall jointly own jointly developed Intellectual Property without a duty of accounting to the other Party.

Except as the Parties may otherwise agree in writing, the Parties will consult with one another regarding prosecuting, in the name of both Parties, patents and other protections for jointly owned Intellectual Property, with the costs and expenses of pursuing and maintaining such jointly owned Intellectual Property being shared equally by the Parties.

(c) Use of New Intellectual Property. Aetna reserves the right to use any New Intellectual Property and to license and permit any other Person to use any New Intellectual Property (including Custom Software utilized in furtherance of Aetna's pharmacy benefit management and pharmacy operations) as Aetna may determine in its sole discretion from time to time.

(d) Works Made for Hire; Assignment of Additional Rights in New Intellectual Property. Without limiting the generality of the foregoing, all New Intellectual Property created by PBM, its Subcontractors, agents or Affiliate shall be deemed "work made for hire" for Aetna under the copyright laws of the United States. PBM shall secure the agreement of any Subcontractor, agent or Affiliate participating in the development of any New Intellectual Property that such New Intellectual Property shall be deemed "work made for hire" for PBM and shall be deemed to have hereby assigned such Intellectual Property rights to Aetna. If for any reason any such New Intellectual Property developed, in whole or in part, by any Subcontractor, agent or Affiliate of PBM is not considered "work made for hire," PBM shall enter into written Contracts with the applicable Subcontractor, agent or Affiliate of PBM vesting in PBM (i) all rights, title and interest worldwide to the New Intellectual Property, and (ii) to the extent permitted under applicable Law, all claims with respect to any copyright, patent and other rights in the New Intellectual Property, whether known or unknown; and PBM hereby irrevocably assigns and conveys all such copyright rights, title and interest in and to all such claims with respect to such New Intellectual Property to Aetna. PBM hereby assigns to Aetna all other Intellectual Property rights it may hold from time to time in the New Intellectual Property and agrees to take such further actions as Aetna may reasonably request in order to effectuate such assignment, including that PBM shall execute, without further consideration or compensation, all documents that Aetna reasonably determines may be necessary for perfection of Aetna's ownership of the New Intellectual Property. Consistent with the foregoing, Aetna shall have all patent rights in New Intellectual Property, including the right to file patent applications seeking patents with respect to New Intellectual Property.

11.4 **Licensed Intellectual Property.**

(a) PBM Licensed IP. PBM hereby licenses to Aetna, and agrees to make available to Aetna, the Intellectual Property set forth in Part 1 of Schedule AA ("PBM Licensed IP"), for use in connection with the Services during the Term and any Termination Transition

Period, which license and availability is provided on a fully-paid, non-exclusive, non-transferable (except in connection with any permitted assignment, in whole or in part, of this Agreement) basis. The PBM Licensed IP shall at all times include the most current versions of the Intellectual Property included in the PBM Licensed IP that operate or are capable of operating on the platform(s) used by PBM and its Affiliates to provide the Services. Aetna may permit the Aetna Customers and Aetna Plan Affiliates to access and use PBM Licensed IP in the manner contemplated by this Agreement, including the Schedules, and may permit vendors providing services to Aetna and the Aetna Plan Affiliates to access and use PBM Licensed IP for such purposes.

(b) Aetna Licensed IP. Aetna hereby licenses to PBM, and agrees to make available to PBM, the Intellectual Property set forth in Schedule 1 to the form of Transition Services Agreement, for use in connection with its performance of the Services from and after the Effective Date through the last day of the term of the Transition Services Agreement, which license and availability is provided on a non-exclusive, non-transferable (except in connection with any permitted assignment, in whole or in part, of this Agreement) basis and shall be subject to payment of the fees payable under the Transition Service Agreement (after it is entered into by the Parties) with respect to such Intellectual Property. PBM may permit its Affiliates that provide Service under this Agreement to access and use the Aetna Licensed IP in the manner contemplated by the Transition Services Agreement and this Agreement, including the Schedules.

11.5 **Confidentiality.**

Aetna and PBM shall treat all of the Intellectual Property covered by Section 11.3 and Section 11.4 as Confidential Information and to the extent any New Intellectual Property is deemed to be a trade secret each Party shall take customary steps to keep such New Intellectual Property confidential and subject to protections applicable to trade secrets under applicable Law.

11.6 **Branding.**

(a) Aetna will control the branding of all services, products, programs, websites and communications offered by or through Aetna or any Aetna Plan Affiliate and/or that relate to any Covered Plan, including the Services PBM performs or provides under this Agreement. Including as further provided in Schedule H, all such services, products, programs, websites and communications, including the Services, shall include only the Aetna brand as well as Aetna's various marks, as designated by Aetna from time to time, and shall not include PBM's or its Affiliate's brand or marks unless otherwise approved by Aetna prior to the inclusion of PBM's or its Affiliate's brand or marks or unless required under applicable Law, in which case such brand or marks shall be included only in accordance with Section 11.6(c).

(b) Aetna must review and approve in writing in advance all uses by PBM of the Aetna brand name and marks. PBM shall comply with all requirements related to the appearance of the Aetna brand name and marks as set forth on Annex F.

(c) The limited circumstances under which PBM's or its Affiliate's name must be used for licensing or regulatory purposes are set forth in Annex F. If, as a result of any

change of applicable Law or a change in the Services pursuant to any amendment to this Agreement, PBM's or its Affiliate's name must be used for other circumstances for licensing or regulatory purposes, PBM shall provide an updated Annex F to Aetna, which updated Annex F shall be accompanied by a notice specifying in reasonable detail the reasons why the use of PBM's or its Affiliate's name is required. To the extent that PBM's or its Affiliate's brand or mark must be included under applicable Law, such brand or mark shall be included in a manner reasonably acceptable to Aetna provided that Aetna must permit the inclusion of such brand or mark in a manner which satisfies the requirements of the applicable Law.

11.7 **Communications.**

(a) PBM shall prepare and disseminate Member, Provider, Participating Pharmacy, and Aetna Customer communications and materials relating to PBM Services in accordance with Schedule H and this Section 11.8 (and any other express requirements set forth in this Agreement). Subject to the following sentence, PBM acknowledges and agrees that all communications and materials to be provided by PBM to Members, Providers, Aetna Customers and Participating Pharmacies related to PBM Services, including identification cards, website content, advertisements and communications with Members and Providers regarding care management and clinical functions and activities, in each case, shall be subject to the prior written approval of Aetna, and PBM shall obtain Aetna's written approval prior to issuing any such communication or materials. Subject to any approvals required under other provisions of this Agreement, the Parties agree that all standard communications and materials to be provided by PBM to Members and Participating Pharmacies in the ordinary course provision of the Services, including recall letters, refill reminders, or drug or side effect information, will not require the prior approval of Aetna so long as Aetna has previously approved the form of such communication in writing and has not subsequently notified PBM that changes to such form are required; *provided, however,* that PBM acknowledges and agrees that certain Aetna Customers may require written approval of some or all of such standard communications and materials when utilized in connection with Services related to such Aetna Customers or their Members, and PBM agrees that it shall obtain Aetna's written approval prior to issuing any such communication or materials in connection with such Services. PBM shall implement all changes to its standard communications and materials for Members and Participating Pharmacies that Aetna reasonably requests from time to time or as required by any Aetna Customer.

(b) CMS Approvals of Communications. In the event that any communication or materials to be provided pursuant to this Agreement by PBM to a Member, Provider, Participating Pharmacy or Aetna Customer requires CMS approval, Aetna will be responsible for seeking CMS approval and communicating the CMS approval to PBM.

11.8 **Inclusion of Disclaimers.**

PBM shall comply with Aetna's requirements, as are communicated to PBM in writing from time to time and are not inconsistent with CMS requirements or applicable Law, with regard to legal/regulatory disclaimers and other required language in all applicable marketing and communications to or for Members or Aetna Customers and as shall be included in all Internet or other displays.

ARTICLE XII.
TERMINATION

12.1 **Termination by Aetna.**

(a) Grounds for For-Cause Termination by Aetna. Aetna may terminate this Agreement or the delivery of any or all Services with respect to any or all of the Covered Plans and/or any or all of the Aetna Customers, in each case as specified by Aetna, for cause if (i) a Major PBM Default occurs, (ii) PBM becomes Insolvent or becomes subject to bankruptcy proceedings, whether voluntary or involuntary, (iii) PBM's financial condition deteriorates below specified minimum levels, as reasonably determined by Aetna pursuant to Section 12.1(b), (iv) PBM becomes subject to a Change of Control in which any Aetna Competitor acquires control (as defined in the definition of Affiliate) of PBM, (v) PBM acquires or becomes an Affiliate of any Aetna Competitor or acquires all or substantially all of the assets of any Aetna Competitor, or (vi) PBM or any Affiliate of PBM commences offering health insurance / health plan products that are competitive with any of the Aetna Plans that provide medical and pharmacy benefits or medical only benefits in the United States. In addition, in the event that CMS notifies either Aetna or PBM that PBM is not, in the opinion of CMS, satisfactorily performing the Services with respect to any Covered Plans that are Medicare Plan(s), Aetna may terminate this Agreement for cause with respect to such Medicare Plan(s) and, in the event that any Third-Party State Plan Sponsor or Governmental Body with jurisdiction over a State Plan notifies either Aetna or PBM that PBM is not, in the opinion of such Person, satisfactorily performing the Services with respect to any Covered Plans that are State Plans, Aetna may terminate this Agreement for cause with respect to such State Plan(s). Further, Aetna may terminate this Agreement or the delivery of any or all Services with respect to any or all Medicare Plans, in each case as specified by Aetna, for cause if a Medicare Default occurs. Aetna shall exercise its right to terminate this Agreement under this Section 12.1(a) by giving written notice to PBM, which notice shall specify an effective date of such termination, which date shall be not less than ten (10) Business Days (or forty-five (45) Business Days if Section 12.1(b) is applicable) after the date of such notice.

(b) Determination of Deterioration in PBM Financial Condition. Aetna may terminate this Agreement for cause under clause (iii) of Section 12.1(a) if PBM Parent's Corporate Ratings fall below the applicable Minimum Corporate Rating and Aetna reasonably determines that PBM is, or reasonably could be expected to become, unable to fully perform and satisfy all of its obligations under this Agreement. If PBM Parent's Corporate Ratings fall below the Minimum Corporate Ratings, PBM shall provide Aetna with such financial information and reports as Aetna may reasonably request in order to allow Aetna to assess PBM's then-current financial condition and ascertain the extent and implications of any deterioration in PBM's financial condition as it may bear upon PBM's ability to satisfy its obligations under this Agreement over the remainder of the Term. If such information is not furnished to Aetna within five (5) Business Days or is not satisfactory in Aetna's reasonable judgment, Aetna may issue a written notice to PBM of its intent to terminate this Agreement, which notice shall specify an effective date of termination, which date shall not be less than forty-five (45) Business Days after the date of such notice. Upon delivery of such notice, Section 3.3 shall immediately become applicable and PBM shall perform the Transition-Out Services unless and until Aetna withdraws its termination notice pursuant to the following sentence. If during such notice period, PBM

Parent restores its Corporate Ratings to at least the Minimum Corporate Ratings or otherwise establishes to Aetna's reasonable satisfaction PBM's ongoing ability to fully perform all of its obligations under this Agreement, Aetna shall withdraw such termination notice and this Agreement shall not terminate by reason thereof. During the Term, upon Aetna's request and solely to the extent not generally publicly available, PBM shall provide Aetna with copies of PBM Parent's consolidated and consolidating audited financial statements within one hundred twenty (120) days after the end of each fiscal year of PBM Parent and, upon request from Aetna, unaudited quarterly statements within sixty (60) days after the end of each fiscal quarter of PBM Parent, all prepared in accordance with generally accepted accounting principles consistently applied.

(c) Termination Without Cause. Aetna may terminate this Agreement without cause upon not less than twelve (12) months' prior written notice to PBM; *provided, however,* that in no event shall any such termination be effective prior to January 1, 2020.

(d) Remedies. If Aetna terminates this Agreement pursuant to this Section 12.1, without limiting any other rights of Aetna hereunder, (i) Aetna will be entitled to payment of any Guarantee Amounts accrued prior to the date of termination and (ii) Aetna will be entitled to recover damages arising from any breach by PBM in accordance with normal contract law principles.

12.2 **Termination by PBM.**

(a) Grounds for For-Cause Termination by PBM. PBM may terminate this Agreement for cause if (i) Aetna fails to make any payment (or concurrently outstanding payments, individually or collectively) in excess of $200,000,000 in accordance with the terms of this Agreement, including under Sections 9.5 and 9.6, when due hereunder and fails to cure such payment default within ten (10) Business Days of Aetna's receipt of notice of such failure from PBM, (ii) Aetna materially breaches any of its other obligations under this Agreement and fails to cure the same within sixty (60) days of Aetna's receipt of notice of such breach from PBM, or (iii) Aetna becomes Insolvent or subject to bankruptcy proceedings. PBM shall exercise its right to terminate this Agreement under this Section 12.2 by giving written notice to Aetna, which notice shall specify an effective date of such termination, which date shall be not less than ten (10) Business Days after the date of such notice.

(b) Termination Without Cause. PBM may terminate this Agreement without cause upon not less than eighteen (18) months' prior written notice to Aetna*; provided, however,* that in no event shall any such termination be effective prior to January 1, 2020.

(c) Remedies. If PBM terminates this Agreement pursuant to Section 12.2(a), the sole and exclusive remedy available to PBM with respect to any and all claims arising out of, in connection with, or relating to such termination or the underlying facts giving rise thereto, shall be the right to require Aetna to pay to PBM, as liquidated damages, the applicable amount specified in Schedule CC (the "Liquidated Damages Amount"), plus any and all unpaid amounts owing to PBM under Schedule Y with respect to PBM Services and Transition-Out Services performed by PBM hereunder.

(d) Suspension of Performance. In the event Aetna fails to make any payment (or concurrently outstanding payments, individually or collectively) in excess of $200,000,000 in accordance with the terms of this Agreement, including under Sections 9.5 and 9.6, when due hereunder and fails to cure such payment default within five (5) Business Days of Aetna's receipt of notice of such failure from PBM, PBM may immediately, and without penalty or any liability for any Aetna Losses arising therefrom, suspend performance of the Services until such time as Aetna cures such payment default. Any such suspension of performance by PBM shall not constitute termination of this Agreement.

12.3 **Other Partial Terminations and Exclusions.**

Aetna may terminate or exclude from this Agreement any Aetna Plan Affiliate that becomes subject to a Change of Control, the result of which is that such Aetna Plan Affiliate ceases to be an Affiliate of Aetna.

12.4 **Effect of Termination.**

In addition to the survival of certain provisions under this Agreement, as addressed in Section 17.25, subject to Section 12.2(b), each Party shall remain liable for any breach by such Party of the terms and provisions of this Agreement that survive the termination of this Agreement or for any breach by such Party of the terms and provisions of this Agreement to the extent such breach occurred prior to the expiration or termination of this Agreement. Additionally, the expiration or termination of this Agreement shall not impair the right of any Party to compel specific performance by any other Party of its surviving obligations under this Agreement, as described in Section 17.25. In the event that any termination of some but less than all of the Services pursuant to this Article XII, the Parties shall, utilizing the procedures set forth in Section 9.11, amend Schedule Y to equitably reduce the prices and other charges set forth therein to account for the reduced level of Services to be provided by PBM.

ARTICLE XIII.
CONFIDENTIALITY

13.1 **Confidential Information.**

Each Party shall maintain the other Party's Confidential Information in the strictest confidence at all times and shall protect such Confidential Information with at least the same degree of care as it uses to protect its own Confidential Information, but always at least a reasonable degree of care. Except as provided in this Agreement, a Party shall not use or disclose Confidential Information of the other Party without the express prior written consent of the other Party, except (a) as required by Law, (b) in the case of PBM, as necessary for PBM to perform Services, (c) as reasonably contemplated by this Agreement, or (d) in the case of Aetna, as necessary for Aetna to perform its obligations under this Agreement or as reasonably necessary or advisable in the management and operation of Aetna Plans. A Party shall only permit access and use of any Confidential Information to its Representatives (i) who need to use the information to perform such Party's obligations under this Agreement, or to enforce such Party's rights, under this Agreement or, in the case of Aetna and its Affiliates, need to use the information to manage and operate the Aetna Plans, (ii) who have been informed of the

confidential and proprietary nature of the Confidential Information, and (iii) who have been directed to treat the Confidential Information in accordance with the terms of this Agreement. The disclosing Party shall be responsible for any failure of its Representatives to comply with the terms of this Agreement. Notwithstanding anything to the contrary in this Agreement, the Parties acknowledge and agree that prior to a Party's disclosure to a third party (other than such Party's accountants, attorneys or other professional advisors) of the terms and conditions of Article IX or Section 4.3 of the Agreement, or Schedule G, O, W, or Y, such Party shall have ensured that such third party: (A) will be independent and free from any conflicts of interest with PBM; (B) will maintain appropriate security requirements to ensure any Confidential Information that is disclosed is not used by such third party to compete against the other Party or its Affiliates; (C) will use the Confidential Information disclosed solely for the purpose identified above; and (D) executes a confidentiality agreement substantially in the form attached hereto as Annex Q. The terms of this Agreement shall be considered Confidential Information except to the extent that either Party determines on the advice of counsel that such terms must be disclosed to (including as part of any filing with) any Governmental Body under applicable Law or pursuant to the rules of any applicable securities exchange and except as either Party or any of its Affiliates may be required to disclose this Agreement to any accrediting agency in order to obtain an accreditation therefrom. In the event of any disclosure pursuant to the preceding sentence, the disclosing Party shall, to the extent reasonably practicable under the circumstances, notify the other Party of such disclosure in advance so that such other Party has an opportunity to seek confidential treatment or, to the extent such disclosure is governed by any freedom of information act or other similar Law, object to such disclosure.

13.2 **Ownership.**

The disclosing Party retains all right, title and interest in and to its Confidential Information, and all copies thereof will be and remain the property of the disclosing Party. All such Confidential Information and any and all copies and reproductions thereof shall, upon the expiration or termination of this Agreement, be promptly returned to the disclosing Party or destroyed at the disclosing Party's direction; *provided, however*, that the receiving Party shall not be required to return or destroy electronic copies of Confidential Information created pursuant to automatic archival backup procedures which cannot reasonably be deleted or to return or destroy Confidential Information to the extent that the return or destruction of such Confidential Information is not otherwise feasible or to the extent the receiving Party is required to retain such Confidential Information in accordance with applicable Laws or standards of professional pharmacy practice. If Confidential Information does not need to be returned or destroyed pursuant to the proviso to the preceding sentence, the receiving Party will continue to maintain the Confidential Information according to this Agreement.

13.3 **Remedy.**

Any unauthorized disclosure or use of Confidential Information, including the sharing of this Agreement, any of the financial terms related to this Agreement, tapes or Claims data with any consulting agents, advisors, brokers, or any other third party, would cause the disclosing Party immediate and irreparable injury or Losses that may not be adequately compensated with money damages. Accordingly, if the receiving Party fails to comply with this Article XIII, the disclosing Party will be entitled to seek (a) specific performance, injunctive or other equitable

relief including immediate issuance of a temporary restraining order or preliminary injunction enforcing this Agreement; (b) a judgment for Losses caused by the breach; and (c) any other remedies provided by applicable Law.

ARTICLE XIV.
COMPLIANCE WITH LAWS AND RELATED MATTERS

14.1 **Compliance with Laws.**

(a) General. PBM, at its own cost, shall, and shall cause its Affiliates to: (i) maintain all federal, state, and local accreditations, certifications, registrations, licenses, permits and similar authorizations that are necessary to provide the Services and to permit all delegations of Services by Aetna to PBM or any Subcontractor to the full extent contemplated by this Agreement; (ii) comply with all Laws and accreditation standards (including NCQA and URAC) applicable to the performance of the Services by PBM (including all Laws and accreditation standards that remain applicable to Aetna or any of its Affiliates notwithstanding that the Services are performed by PBM hereunder); (iii) require all Subcontractors and Participating Pharmacies to comply with clauses (i) and (ii) of this sentence, in each case, as applicable to such Subcontractor or Participating Pharmacy with respect to this Agreement and reasonably monitor such compliance; and (iv) at Aetna's request, certify PBM's compliance with (i), (ii) and (iii) of this sentence and the ongoing accuracy of PBM's representations and warranties as set forth in Section 10.1.

(b) Member Confidentiality; Security. PBM shall comply, and shall maintain systems and infrastructure sufficient to permit PBM to comply, with all applicable Laws regarding confidentiality, security and electronic transactions and code sets, including the regulations adopted pursuant to HIPAA, customary business associate obligations (as set forth in the HIPAA Confidentiality Agreement attached as Annex G-1, which the Parties are entering into concurrently herewith), obligations under the Gramm-Leach-Bliley Act (as set forth in the Gramm-Leach-Bliley Act Agreement attached as Annex G-2, which the Parties are entering into concurrently herewith), red flags rules and the Sarbanes-Oxley Act, each to the extent applicable to PBM and to the Services provided by PBM under this Agreement. With respect to PBM's status as a business associate under HIPAA, the Parties acknowledge and agree that PBM is a business associate of Aetna and each Aetna Plan Affiliate in connection with the provision of the Services to be performed by PBM hereunder, except to the extent PBM acts in the capacity of a dispensing pharmacy, in which case it is a Covered Entity.

(c) Certifications. At Aetna's reasonable request and in a time and manner agreed upon by the Parties, but in any event no later than the thirtieth (30th) day after Aetna's request, PBM shall certify (i) to the accuracy, truthfulness and completeness of any data provided to Aetna pursuant to this Agreement; and (ii) that such data was complied and transmitted in a manner that complies with applicable Laws.

(d) Equal Opportunity Employment; Compliance with Employment Laws.

(i) Equal Opportunity. PBM shall comply with all applicable Laws related to equal employment opportunity, non-discrimination within the workplace, including

that PBM shall comply with the equal employment opportunity clause set out at 41 C.F.R. 60-1.4, and PBM agrees that no facility maintained, provided or controlled by PBM shall be segregated. Additionally, PBM shall comply with the requirements for affirmative action for veterans and disabled persons set out at 41 C.F.R. 60-250.4 and 60-741.4, respectively, to the extent that they are applicable to PBM.

(ii) PBM Responsibility for Deployed Persons. Deployed Persons shall not be employees of Aetna or any Affiliate of Aetna for any purpose whatsoever, including federal, state and local Taxes (including the Federal Insurance Contribution Act and the Federal Unemployment Tax) and all insurance coverage, employee benefit plans, compensation programs, unemployment compensation and workers' compensation benefits. PBM shall, or shall cause an Affiliate of PBM or Subcontractor, as applicable, to withhold and pay all applicable federal, state and local employment Taxes (including the Federal Insurance Contribution Act and the Federal Unemployment Tax) applicable to Deployed Persons, and to provide any or all applicable insurance coverage, unemployment compensation and workers' compensation benefits.

(iii) Compliance with Wage Payment and Work Authorization Laws. PBM shall, and shall require its Affiliates and Subcontractors, to comply with all applicable Laws regarding payment of employee wages. PBM shall ensure that all Deployed Persons at all times during the Term are authorized to work in the United States at the job and location to which they are assigned, and that PBM and its Affiliates are and will remain in compliance with applicable provisions of the Immigration Reform and Control Act of 1986, as amended, with respect to Deployed Persons employed by PBM or its Affiliates. PBM shall use its commercially reasonable efforts to include this requirement in each Contract with a Subcontractor entered into after the date hereof; *provided, however,* that in no event shall PBM's failure to include such requirement in any manner limit PBM's responsibility for its Subcontractors' compliance with this Section 14.1(d)(iii)).

(iv) Drug-Free Workplace. PBM shall, and shall cause its Affiliates to, at all times comply with all applicable state and federal Laws with respect to maintaining a drug-free workforce and shall disclose its drug testing procedures to Aetna upon request. PBM shall use its commercially reasonable efforts to include this requirement in each Contract with a Subcontractor entered into after the date hereof; *provided, however,* that in no event shall PBM's failure to include such requirement in any manner limit PBM's responsibility for its Subcontractors' compliance with this Section 14.1(d)(iv)).

(e) Compliance Coordination. PBM shall designate a senior manager in its compliance department to serve as the point of contact for the Aetna Pharmacy Compliance Officer and shall also designate a senior manager in its compliance department to serve as the point of contact with Aetna with respect to Medicare compliance issues and another senior manager in its compliance department to serve as the point of contact with Aetna with respect to Medicaid compliance issues (each such PBM-designated point of contact, a "PBM Compliance Point of Contact"). Aetna shall have the right to review and approve, with such approval not to be unreasonably withheld, and provide input on each PBM Compliance Point of Contact based on the individual's qualifications, experience and role in the PBM. PBM shall provide the Aetna Pharmacy Compliance Officer with current information on PBM's compliance department (the

"PBM Compliance Department"), including: (i) a functional organization chart for PBM's Compliance Department and (ii) upon Aetna's request, all compliance policies and procedures (including legislative and regulatory tracking and implementation, privacy and security, reporting and correcting instances of non-compliance, record retention, and managing relationships with regulators) maintained by PBM and its Affiliates and applicable to PBM's provision of Services under this Agreement. PBM shall cause representatives of the PBM Compliance Department to meet on a monthly basis (or more frequently if reasonably requested by Aetna) with representatives of Aetna to review compliance issues and performance of the Services under this Agreement. Upon Aetna's request, PBM shall cause each PBM Compliance Point of Contact to provide Aetna with written documentation and supporting data reasonably necessary to verify compliance with Laws and as necessary to support Aetna's reporting and filing obligations with Governmental Bodies and governmental inquiries. Additionally, PBM shall notify Aetna, which notice shall include a reasonable description of, and reasonable supporting documents related to, any non-routine or out of the ordinary course interaction (oral or written) between PBM and any Governmental Body with jurisdiction over one or more of the Covered Plans to the extent that such interaction relates to the Services.

(f) MLR Reporting. If and as requested by Aetna, in order to support compliance by Aetna, Aetna Affiliates, and Aetna Customers with applicable Law, PBM shall promptly provide Aetna with information required to determine what portion of PBM's compensation pursuant to this Agreement is attributable to activities that improve health care quality under 45 C.F.R. § 158.150 and what portion is attributable to expenditures related to health information technology under 45 C.F.R. § 158.151.

(g) Delegation Requirements. Aetna and PBM also shall comply with the requirements of certain state Laws set forth on Annex H, the contents of which shall be negotiated in good faith by the Parties hereto between the Agreement Date and the Effective Date.

14.2 **Policies, Code of Conduct and Training.**

(a) Review of PBM Policies. PBM shall ensure that PBM's applicable policies and procedures at all times comply with applicable Law. Upon Aetna's request, PBM shall make copies of its policies and procedures applicable to the Services (the "PBM Policies") available to Aetna. Further, the Parties shall conduct a joint annual review of the PBM Policies and PBM shall make such commercially reasonable changes to the PBM Policies, which changes shall be applicable only with respect to the Services, as Aetna may request from time to time, in connection with such joint annual review or otherwise.

(b) Code of Conduct. PBM represents and warrants to Aetna that it has adopted and that it maintains, with respect to itself and its Affiliates, the written Code of Conduct, as previously provided to Aetna and as attached as Annex I hereto, and agrees that it shall, at all times during the Term, maintain a written code of conduct and ethics reasonably acceptable to Aetna that sets forth PBM's framework and commitment to legal and ethical behavior and that is consistent with the requirements under applicable Law (the existing PBM Code of Conduct as maintained, modified or amended in accordance with this provision, the "Code of Conduct"). In the event that PBM intends to make any material modifications or

material amendments to its Code of Conduct, PBM shall provide prior written notice, accompanied by a copy of such amendment, to Aetna at least sixty (60) days prior to the proposed effective date of such amendment and, upon Aetna's request, PBM shall adopt a mutually agreed supplement to the Code of Conduct, applicable only in connection with the Services, that contains such additional provisions related to the matters addressed by such amendment as Aetna and PBM have agreed. PBM shall ensure that the Code of Conduct reflects that internal reporting is important and is supported by PBM. PBM shall require PBM's employees providing Services under this Agreement to certify that they have read, understand and shall comply with the Code of Conduct, and PBM shall provide such certifications to Aetna within a reasonable time period following Aetna's request. PBM shall require agents and Subcontractors that assist with the administration or delivery of Services under this Agreement to indicate that they have adopted, and require their employees to comply with, a code of conduct that is similar in nature to the Code of Conduct. PBM shall periodically review and update the Code of Conduct and shall make such reasonable revisions thereto as Aetna may suggest from time to time, it being understood that Aetna shall have no obligation to review the Code of Conduct and shall not, regardless of whether it conducts any such review, have any liability related to the contents thereof.

(c) PBM Diversity. PBM shall comply with the requirements of Aetna's Supplier Diversity Program, a copy of which is attached as Annex J, or any similar successor policy proposed by Aetna; *provided, however,* that any such successor policy shall be subject to PBM's prior written consent, not to be unreasonably withheld. PBM shall submit to Aetna a quarterly report as described in the M/WBE Quarterly Results Report included on Annex J or any successor policy adopted pursuant to the preceding sentence.

(d) Education and Training. PBM shall require that all PBM's and PBM Affiliate's employees providing Services undergo general compliance education and training, and such other training regarding Aetna's business practices as the Parties may mutually determine is appropriate from time to time, in each case, when hired and periodically thereafter. Additionally, PBM shall require each of these employees, when hired and annually thereafter, to undergo compliance education and training tailored specifically to their particular job functions and the potential risks associated with those areas. For PBM employees dedicated to providing services to Aetna under this Agreement, this tailored education and training shall address at least the topics and areas required to be addressed in Schedules O, P, and S as well as other key risk area(s) identified by and agreed to by the Parties and also shall address matters related to the compliance with applicable antitrust laws. PBM shall maintain records of attendance, topics of training and training materials, which shall be provided to Aetna within a reasonable time following Aetna's request, but in any event within a time required to respond to a request from a Government Body. PBM shall require that employees, agents and subcontractors of its Participating Pharmacies receive general and specialized compliance education training that substantially meets the requirements described above. Aetna shall have the right to audit PBM's compliance with these requirements in accordance with the audit provisions set forth in this Agreement, and PBM shall require Participating Pharmacies to comply with substantially similar requirements and shall audit its Participating Pharmacies' compliance therewith.

(e) Noncompliance Reports.

(i) PBM shall provide a process by which all of PBM's and its Affiliates' employees, officer, directors, agents, Subcontractors and Participating Pharmacies may (i) report actual or potential violation of Laws, the Code of Conduct, applicable policies and procedures or this Agreement (a "Noncompliance Report") and (ii) ask questions about compliance issues or concerns. PBM shall structure the process in a manner that maintains confidentiality and allows any reports of actual or potential violations of Laws, the Code of Conduct, applicable policies and procedures or this Agreement to be made directly to a supervisor, the compliance officer or his/her designees or anonymously, such as through a toll-free telephone number. PBM shall ensure that all of PBM's and its Affiliates' employees, officer, directors, agents, Subcontractors, including Participating Pharmacies, are aware of the existence of the reporting process and shall emphasize the duty of such individuals and Participating Pharmacies to report any compliance violations, issues or concerns.

(ii) PBM shall develop and implement a process for evaluating, screening and investigating any Noncompliance Report. This process shall, at a minimum, require PBM to evaluate and conduct at least a preliminary investigation of Noncompliance Reports involving any Person providing Services under this Agreement. If PBM determines that the events described in any Noncompliance Report are reasonably likely to constitute a breach of this Agreement or a material violation of the Code of Conduct, any PBM Policy, or applicable Law or if PBM otherwise determines that it is reasonably likely that any breach of this Agreement, violation of the Code of Conduct, any PBM Policy, or violation of Law has occurred in connection with the Services, PBM shall, as promptly as practicable, provide notice of such determination, including a summary of the underlying facts and the applicable resulting breach of this Agreement or a material violation of any PBM Policy, the Code of Conduct, or applicable Law, to Aetna (a "Noncompliance Notice").

(iii) If PBM issues a Noncompliance Notice to Aetna, without limiting Aetna's remedies under this Agreement, PBM shall prepare and provide to Aetna, as soon as practicable after issuance of a Noncompliance Notice to Aetna, but in no event later than thirty (30) days thereafter, a proposed corrective action plan to address the violation. At a minimum, the corrective action plan shall include the monitoring and auditing of the circumstances that gave rise to such instance. PBM shall incorporate recommendations from Aetna into any such corrective action plan and shall implement such corrective action plan in accordance with its terms.

(iv) For Noncompliance Reports involving a Participating Pharmacy or PBM's agent or Subcontractor, if appropriate, PBM may notify the applicable Governmental Body with jurisdiction over the underlying matter; *provided, however*, that PBM shall consult with Aetna prior to doing so, unless otherwise required by Law. Additionally, PBM shall require such Participating Pharmacy, agent or Subcontractor to take corrective action to remedy the issue giving rise to the Noncompliance Report. For any such Participating Pharmacy, agent or Subcontractor of PBM, PBM shall take the following action:

(1) PBM shall consider whether it is appropriate to terminate the services of such Participating Pharmacy, agent or Subcontractor;

(2) PBM shall perform, or arrange for the performance of, appropriate future monitoring and auditing of the activities of such Participating Pharmacy, agent or Subcontractor; and

(3) PBM shall notify Aetna of any such corrective action plan and plans for monitoring and auditing within a reasonable time period following discovery or submission of a Noncompliance Notice, but no later than fifteen (15) Business Days following such discovery or Noncompliance Report.

(v) Aetna reserves the right to investigate any Noncompliance Report or other violation of applicable Law by PBM, its Affiliate or Subcontractor of which Aetna becomes aware, whether through PBM's reports or through other mechanisms. PBM shall cooperate, and shall require its agents, Affiliates, Subcontractors, and Participating Pharmacies to cooperate, in any such investigations and in developing and implementing any corrective action plan and additional monitoring and auditing that Aetna reasonably requests, including any decision by Aetna to report any potential issue of noncompliance to CMS or any other applicable Governmental Body.

(f) Notice of Claims. PBM shall promptly notify the Aetna Pharmacy Compliance Officer and Aetna (in accordance with Section 17.23) of any and all non-routine inquiries by any Governmental Body, Manufacturer, attorney, Member, Aetna Customer, or other Person with respect to Services provided by PBM, or any Affiliate or Subcontractor of PBM. Without limiting the generality of the foregoing, PBM shall notify Aetna promptly of: (i) the initiation at any time during the Term or the Termination Transition Period of any action, suit, investigation or proceeding of the types set forth in Section 10.1(e); (ii) the initiation at any time during the Term or the Termination Transition Period of any action, suit, investigation or proceeding brought against PBM or any of Representatives or Subcontractors related to Services provided to or on behalf of any Covered Plan that is a Government Health Program, any Medicare Plan, or any State Plan; (iii) any actions taken or investigations initiated by any Governmental Body, or PBM's receipt of notice thereof, involving the provision of Services by PBM or any of its Representatives or Subcontractors, including any that include allegations of fraud, abuse, false claims, or kickbacks; or (iv) the listing of PBM or any of its Affiliates in the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and/or the OIG or GSA exclusion lists. Upon Aetna's request, PBM shall provide to Aetna a true and complete description of all known details of any action, suit, investigation or proceeding required to be disclosed by PBM pursuant to this Section 14.2(g).

14.3 **Antitrust Guidelines.**

In the course of the conduct of their respective obligations under this Agreement, including with respect to meetings and activities of Committees, each of Aetna and PBM shall, and shall cause each of their employees, contractors, agents and representatives to, comply with the antitrust guidelines agreed upon by the Parties from time to time.

14.4 **Fraud and Abuse.**

(a) PBM shall maintain a program to prevent fraud, waste and abuse with respect to the Services. The program shall include, at a minimum, measures to detect, prevent and correct instances of fraud, waste and abuse by Members, Participating Pharmacies, pharmacists, prescribers and Subcontractors and any Affiliate of PBM providing any portion of the Services. PBM shall cooperate with Aetna's Anti-Fraud Program, including providing information requested by Aetna's Special Investigation Unit and other representatives of Aetna who are investigating potential instances of fraud, waste and abuse. PBM shall provide periodic reports to Aetna on the PBM's activities to prevent fraud, waste and abuse. PBM shall deliver such reports on a schedule and in a format mutually agreed upon by Aetna and PBM.

(b) Each Party, to the best of its knowledge after reasonable inquiry, represents and warrants that such Party and its respective officers and directors (i) have not engaged and will not engage in any activities which are prohibited under the federal Medicare and Medicaid statutes, including 42 U.S.C. § 1320a-7 or §1320a-7a, the regulations promulgated pursuant to such statutes, or under corresponding provisions of any applicable state Law, (ii) have not knowingly and willfully engaged and shall not knowingly and willfully engage in any activities which are prohibited under the federal Medicare and Medicaid statutes, including 42 U.S.C. § 1320a-7b, the regulations promulgated pursuant to such statutes, or under corresponding provisions of any applicable state Law and (iii) have not engaged and shall not engage in any activities that are prohibited under any state Law corresponding to clauses (i) or (ii) above with respect to any State Health Care Program other than Medicaid. PBM shall comply with the requirements with respect to the CMS Health Plan Management System, waste and abuse requirements as set forth in Schedules O and S.

(c) To the extent required by applicable Law, Aetna agrees to fully and accurately disclose and report to Medicare, Medicaid or other Government Health Care Programs any Aetna Manufacturer Revenues, discount or other credit received by or credited to Aetna under this Agreement, whether reflected in the fees for the products and services or otherwise provided hereunder, as discounts against the price of the drugs under all applicable state or federal programs that provide reimbursement to Aetna for products or services provided by PBM. It is the intention of the Parties, that for purposes of the Federal Healthcare Anti-Kickback Act, any Aetna Manufacturer Revenues, discount or other Aetna credit, shall, without derogation of the applicability of any other applicable safe harbor, constitute and be treated as a discount against the price of drugs within the meaning of 42 U.S.C. §1320a-7b(b)(3)(A). To facilitate Aetna's compliance with applicable reporting requirements, PBM shall provide to Aetna (and Aetna's obligations to PBM under this Section 14.4(c) shall be subject to PBM providing) full and accurate disclosure of and reports to Aetna regarding all Aetna Manufacturer Revenues, Pharmacy Rebates, discounts or other credits to the extent such amounts are required to be reported by applicable Law or are required for the applicability of any safe harbor under applicable Law. In addition, and if reporting by Aetna or any Aetna Customer is required by applicable Law, to the extent that PBM receives payment from Manufacturers or pharmacies for the funding and/or provision of any of the Services, PBM shall provide information sufficient for Aetna or such Aetna Customer to report such applicable payments in accordance with applicable Law. PBM agrees to provide to Aetna (and Aetna's obligations under this paragraph shall be subject to PBM providing) all information reasonably necessary for Aetna to prepare and provide all required disclosures and reports, including all information and reports required under the Schedules to this Agreement. Each Party agrees that, in establishing the terms of this

Agreement, neither Party has given or received remuneration in return for or to induce the provision or acceptance of business (other than business covered by this Agreement to which such remuneration directly relates) and that neither Party shall shift the financial burden of this Agreement to the extent that increased payments are claimed from a "Federal health care program" (within the definition set forth at 42 U.S.C. § 1320a-7b(f)). The Parties acknowledge not all Aetna credits extended by PBM are subject to such treatment as a discount against the price of drugs within the meaning of 42 U.S.C. §1320a-7b(b)(3)(A). By way of example, the following Aetna credits are not subject to such treatment: Guarantee Amounts, overpayments by Aetna, or interest due to Aetna on account of late payments.

(d) PBM agrees to (i) comply with any binding disclosure obligations imposed on PBM by regulations promulgated by the U.S. Department of Labor under Section 408(b)(2) of ERISA; and (ii) provide to Aetna and the Aetna Plan Affiliates such information (solely as related to compensation received by PBM in connection with this Agreement) as reasonably needed in order for Aetna, the Aetna Plan Affiliates and the Aetna Customers to comply with disclosure obligations imposed by any such Section 408(b)(2) regulations. PBM further agrees to provide to Aetna such information as reasonably needed in order for Covered Plans that are required to file Schedule C to Form 5500 to comply with their reporting and disclosure obligations, including in respect of all indirect compensation received by PBM, its Affiliates or Subcontractors.

(e) Each Party certifies that it shall not violate or cause to be violated the federal anti-kickback statutes, set forth at 42 U.S.C. § 1320a-7b(b) (the "Federal Healthcare Anti-Kickback Act") and 41 U.S.C. § 51 *et seq.*, the federal "Stark Law," set forth at 42 U.S.C. § 1395nn, or the False Claims Act, set forth at 31 U.S.C. § § 3729-3733; 18 U.S.C. § 287, in each case, with respect to the performance of its obligations under this Agreement.

ARTICLE XV.
INDEMNIFICATION

15.1 **Indemnification of Aetna.**

(a) PBM shall indemnify, defend and hold harmless Aetna, its Affiliates (including all Aetna Plan Affiliates), and their respective officers, directors, agents, employees, successors and permitted assigns (each an "Aetna Indemnified Party") from and against all Losses to the extent arising from or relating to (i) any breach of any representation, warranty or covenant in, or obligation under, this Agreement on the part of PBM or any Affiliate of PBM that provides Services under this Agreement or any Subcontractor; (ii) any negligence or willful misconduct on the part of PBM, any of its Affiliates or any Subcontractor in connection with the performance of any Services, dispensing of pharmaceutical drugs to a Member or any other matter relating to this Agreement; or (iii) any failure by PBM, any Affiliate of PBM, including any pharmacy owned and/or operated by PBM or an Affiliate of PBM that provides Services under this Agreement, or any Subcontractor to comply with applicable Law, including any failure of PBM to update its pricing information as required by Law or to comply with any prompt pay Law (but excluding any such failure to the extent arising from a breach or failure on the part of Aetna or any Affiliate of Aetna under this Agreement). For the avoidance of doubt, in the case of clauses (i) and (iii) of the preceding sentence, "Losses" shall include any interest,

penalties or other amounts owing to an Aetna Customer, Member or other Person as a result of PBM's failure to timely process a Claim (including with respect to any Claim arising under a Government Health Program, in accordance with the timing requirements of the applicable Government Health Program) or, with respect to any Government Health Program, as a result of PBM's failure to submit encounter data on a timely basis as required by applicable Law.

(b) PBM shall indemnify, defend and hold harmless the Aetna Indemnified Parties from and against all Losses to the extent arising from or relating to any infringement or misappropriation of any patent, trademark, copyright, trade secret or other proprietary right of any third party (collectively, "Proprietary Rights") by PBM or any Affiliate of PBM in the course of its performance under or otherwise in connection with this Agreement. If the performance of some or all of the Services by PBM and/or its Affiliates is found to infringe or misappropriate any Proprietary Rights, or any Aetna Indemnified Party's use or prospective use, in whole or in part, of the Services is enjoined, PBM shall, at its sole expense, either: (i) procure the necessary rights to enable PBM, its Affiliates and Subcontractors to perform such Services and enable the Aetna Indemnified Parties to use and receive the benefits of such Services, in each case without infringing or misappropriating such Proprietary Rights, or (ii) replace or modify such Services, or applicable portion thereof, so that PBM continues to perform the same function in an equally or more effective manner, as determined by Aetna and PBM in good faith, but without infringing or misappropriating such Proprietary Rights.

15.2 **Indemnification of PBM.**

(a) Aetna shall indemnify, defend and hold harmless PBM, its subsidiaries, Affiliates, and their respective officers, directors, agents, employees, successors and permitted assigns (each a "PBM Indemnified Party") from and against all Losses to the extent arising from or relating to (i) any breach of any representation, warranty or covenant in this Agreement on the part of Aetna or any Affiliate of Aetna; or (ii) any failure by Aetna or any Affiliate of Aetna to comply with applicable Law in connection with its performance under this Agreement or any other matter relating to this Agreement (but excluding any such failure to the extent arising from a breach or failure on the part of PBM or any Affiliate of PBM under this Agreement).

(b) Aetna shall indemnify, defend, and hold the PBM Indemnified Parties harmless from and against all Losses to the extent arising from or relating to any infringement or misappropriation of any Proprietary Rights by Aetna or any Affiliate of Aetna in connection with this Agreement. If any Aetna system or means of operation is found to infringe or misappropriate any Proprietary Rights and such infringement or misappropriation prevents PBM from providing some or all of the Services, Aetna shall, at its own expense, either (i) procure the necessary rights to enable PBM to perform such Services without infringing or misappropriating systems or operations, or applicable portion thereof, to provide the Services to Aetna; or (ii) replace or modify such systems or operations so that PBM will be able to continue to perform the Services in a manner that does not infringe or misappropriate such Proprietary Rights.

15.3 **Notice; Defense of Claim.**

If any claim or liability is asserted in writing against an Aetna Indemnified Party or a PBM Indemnified Party (each an "Indemnified Party") by a Person other than an Aetna

Indemnified Party or a PBM Indemnified Party that would give rise to a claim under this Article XV (a "Third-Party Claim"), the Indemnified Party shall promptly notify the Party providing the indemnity ("Indemnifying Party") in writing of the same. In any case in which the claim or liability has been asserted by a current or former Member, a current or former Aetna Customer or a Governmental Body, Aetna or an Aetna Plan Affiliate shall have the right to elect, by giving written notice to PBM, to defend the claim and control the defense, settlement and prosecution of any litigation (including any arbitration) in connection therewith. In all other cases, the Indemnifying Party shall have the right to defend the claim and control the defense, settlement and prosecution of any litigation (including any arbitration) in connection therewith; *provided, however,* that if the Indemnifying Party, within fifteen (15) days after written notice thereof, fails to defend such claim, the Indemnified Party will (upon further notice to the Indemnifying Party) have the right to undertake the defense, compromise or settlement of such claim on behalf of the Indemnifying Party, subject to the right of the Indemnifying Party to assume the defense of such claim at any time prior to settlement, compromise or final determination thereof. Anything in this Section 15.3 notwithstanding, (i) if there is a reasonable probability that a claim may materially and adversely affect the Indemnified Party other than as a result of money damages or other money payments, the Indemnified Party shall have the right, at its own cost and expense, to defend, compromise and settle such claim and (ii) whichever Party has assumed defense of the claim shall not, without the written consent of the Indemnified Party, settle or compromise any claim or consent to the entry of any judgment which does not include as an unconditional term thereof the giving by the claimant to the Indemnified Party a release from all liability in respect to such claim. All Parties agree to cooperate fully as necessary in the defense of such matters. If the Indemnified Party fails to notify the Indemnifying Party of the claim promptly as required above, this indemnity shall terminate and be of no further force and effect with respect to the subject matter of the required notice in the event, and to the extent, that the Indemnified Party's failure to notify in the time required above materially adversely affects the Indemnifying Party's ability to defend such matter.

15.4 **Limitations of Liability.**

No Party will be liable to any other Party for any Losses that constitute consequential, punitive, special, or exemplary damages arising under or in connection with this Agreement; *provided, however,* that nothing contained in this Section 15.4 will limit a Party's liability to the other Party for or on account of any Losses arising from (a) bodily injury, death, or damage to tangible real or tangible personal property proximately caused by such Party's misconduct or negligent act or omission or that of its agents, subcontractors or employees, (b) the other Party's violation of any applicable Law, (c) any Losses to the extent any such Losses are in the nature of damages paid by (or due from) an Indemnified Party to a third party in connection with a Third-Party Claim for which such Indemnified Party is entitled to indemnification under this Agreement.

ARTICLE XVI.
NON-SOLICITATION; COOPERATION; EXCLUSIVITY; NON-COMPETITION

16.1 **Non-Solicitation.**

(a) Solicitation of Employees. Except as provided in Schedules T-1, T-2 or T-3, during the Term and for a period of two (2) years after the expiration or termination of this Agreement, neither Party shall directly or indirectly solicit, recruit, induce, or encourage any director, officer, employee or associate of the other Party to discontinue, terminate or not renew his or her relationship with that Party. Except as provided in Schedules T-1, T-2 or T-3, during the Term and for a period of two (2) years after the expiration or termination of this Agreement, neither Party shall, directly or indirectly, solicit for employment, recruit or hire any employee of the other Party or its Affiliates serving in a position identified on Schedule BB (which Schedule shall not include more than twenty (20) such positions with respect to either Party and which list of positions may be updated by either Party, as to such Party, by written notice to the other Party from time to time) (each a "Designated Person"); *provided, however,* that the following activities shall not constitute solicitation for employment or recruitment (i) a Party's receipt of an Unsolicited Resume (as defined below) of a Designated Person and any interviews or negotiations which occur thereafter between such Party and such Designated Person, or (ii) a Party's placement of a general media advertisement or non-directed search inquiry and any interviews or negotiations which occurs thereafter between such Party and a Designated Person responding thereto; *provided, further,* that nothing contained herein shall prevent such Party from employing any Designated Person who (i) responds to a general media advertisement or non-directed search inquiry; (ii) makes an unsolicited contact for employment; and/or (iii) has been terminated by the other Party or its Affiliates prior to the commencement of employment discussions between such Party and such Designated Person. As used herein, the term "Unsolicited Resume" means a resume of any Designated Person, whether received directly from such Designated Person or from an employment agency or recruiter, other than a resume received following the soliciting Party's identification of a particular Designated Person by name in its request for resumes or the soliciting Party's identification that a particular Designated Person should apply for a position, whether such identification is made to such Designated Person or to an employment agency or a recruiter or any other Person.

(b) Solicitation of Aetna Customers for PBM Services. During the Term, without the prior written consent of Aetna, PBM shall not, and shall cause its Affiliates not to, directly or indirectly solicit any Aetna Customer with respect to which PBM is providing any PBM Services or Transition-Out Services hereunder for the purpose of performing any pharmacy benefit management services to such Aetna Customer or provide pharmacy benefit management services to any such Aetna Customer, unless (i) the Aetna Customer or other Person issues a request for proposal for such services (in which case PBM shall not be precluded from submitting a response thereto and otherwise pursuing the opportunity), (ii) the Aetna Customer or other Person is an existing customer of PBM for pharmacy benefit management services on a carve-out basis, (iii) the solicitation of the Aetna Customer or other Person is by a third party administrator, insurer, or other purchasing entity that is not an Affiliate of PBM, or (iv) PBM is a subcontractor to an Aetna Competitor that is not an Affiliate of PBM and that has a Contract with such Aetna Customer or other Person (in which case PBM shall not be precluded from providing pharmacy benefit management services to such Aetna Customer or other Person in its capacity as a subcontractor to such Aetna Competitor). As used in this Section, pharmacy benefit management services means services equivalent or similar to any of the PBM Services.

(c) Solicitation of Aetna Customers for ActiveHealth Services. During the Term, without the prior written consent of Aetna, PBM shall not, and shall cause its Affiliates

not to, directly solicit any Aetna Customer with respect to which PBM is providing any PBM Services or Transition-Out Services hereunder for the purpose of providing any services or products that are similar to or competitive with the services and products currently offered by ActiveHealth as such services and products are hereafter modified, upgraded or improved by ActiveHealth (or any corporate successor of ActiveHealth) or any natural extensions of such services and products that ActiveHealth (or any corporate successor of ActiveHealth) offers to customers during the Term (collectively, "ActiveHealth Services") unless the Aetna Customer issues a request for proposal for such ActiveHealth Services (in which case PBM shall not be precluded from submitting a response thereto and otherwise pursuing the opportunity).

(d) Indirect Solicitation. PBM shall not, and shall cause its Affiliates not to, encourage or provide specific incentives to any broker, consultant or other Person to solicit, on behalf or for the benefit of PBM or any of its Affiliates, any business from any Aetna Customer that PBM would not be permitted to solicit directly pursuant to Section 16.1(b) or Section 16.1(c).

(e) Solicitation of PBM Customers for PBM Services. During the Term, without the prior written consent of PBM, Aetna shall not, and shall cause its Affiliates not to, directly solicit any PBM Customer for the purpose of providing any pharmacy benefit management services to such PBM Customer, unless (i) the PBM Customer is an Aetna Customer (on a carve in or carve out basis), a customer or client of ActiveHealth or a customer or client of any Affiliate of Aetna with respect to behavioral health, disability or disease management plans, products or services, or (ii) the solicitation is for a medical and pharmacy offering (rather than a carve out pharmacy offering). As used in this Section 16.1(e), pharmacy benefit management services means services equivalent or similar to any of the PBM Services, and excludes any services not included in the PBM Services.

(f) Solicitation of Other Persons. Except as expressly set forth in Section 16.1(e), nothing in this Agreement restricts Aetna's rights to offer pharmacy and pharmacy benefit products and services (including Specialty Products and related services), whether integrated with one or more other products or on a standalone basis, or any products or service, to any existing or potential customer. Nothing in this Agreement restricts PBM's rights to offer pharmacy and pharmacy benefit products and services (including Specialty Products and related services), whether integrated with one or more other products or on a standalone basis to any existing or potential customer, or any other products or services, in each case, except as expressly prohibited in Sections 16.1(b) and 16.1(c) with respect to Aetna Customers.

16.2 **Notice of Certain Opportunities.**

PBM shall make reasonable efforts to provide Aetna with notice of all non-carve-out, pharmacy business opportunities and Aetna shall make reasonable efforts to provide PBM with notice of all carve-out pharmacy business opportunities. Any notice required pursuant to the preceding sentence shall contain a reasonably complete description of the opportunity and any terms related thereto which have been disclosed to the Party required to provide such notice. For purposes of this Section 16.2, "reasonable efforts" means that a Party will periodically (but not less than quarterly) request of its sales and/or marketing force information regarding opportunities that may be provided to the other Party under this Section 16.2. Nothing in this

Section 16.2 shall require either Party to breach any obligation of confidentiality it has with any Person in order to comply with the terms hereof.

16.3 **Exclusivity.**

During the Term, Aetna shall not, and shall cause its Affiliates not to, obtain from any Person (including, for the avoidance of doubt, Aetna and any Affiliate of Aetna, but without limiting the rights of Aetna Plan Affiliates to obtain services from Aetna to the extent subcontracted to PBM hereunder) other than PBM (or its Subcontractors) any services of the type included within the PBM Services for any of the Covered Plans; *provided, however,* that:

(a) nothing in this Agreement shall be deemed to prohibit or restrict Aetna or any of its Affiliates from obtaining any home or ambulatory drug infusion, clinical, care consideration, drug interaction monitoring or prevention services, disease management, EAP, wellness, or other ancillary services from any of their Affiliates or any other Person, but only to the extent that such services do not constitute Core Services;

(b) nothing in this Agreement shall be deemed to prohibit or restrict Aetna or any of its Affiliates from obtaining any Optional Services (or any other PBM Services which are described as a "Core Service" available at Aetna's "option" (or are similarly described) in any Schedule) or any prescription drug or pharmacy benefit management-related services that are not included within the PBM Services from any Person at any time during the Term;

(c) nothing in this Agreement shall be deemed to prohibit or restrict Aetna or any of its Affiliates from obtaining any type of pharmacy or pharmacy benefit management-related services with respect to prescriptions dispensed outside of the United States;

(d) nothing in this Agreement shall be deemed to prohibit or restrict Aetna or any of its Affiliates from entering into any Jointly Contracted Pharmacy Contract to the extent permitted by Schedule G;

(e) any Acquired Business shall be entitled to obtain (or Aetna shall be entitled to obtain with respect to any such Acquired Business) any services of the type included in the PBM Services utilizing internal pharmacy benefit management capabilities of the Acquired Business and/or from a Person other than PBM (any such internal capabilities or Person, an "Alternative PBM"); and in such event, such Acquired Business and any of its pre-acquisition Affiliates shall not constitute Aetna Plan Affiliates under this Agreement*; provided, however,* that (i) Aetna shall not, and shall cause each of the Aetna Plan Affiliates not to, (x) transition or otherwise transfer any of their Aetna Customers and Covered Plans (or any successor Covered Plans) to any such Alternative PBM for purposes of receiving any services equivalent or similar to the PBM Services, or (y) encourage or solicit any prospective Aetna Customer to utilize or receive any such services from the Alternative PBM, and (ii) the Acquired Business shall be free to encourage and solicit its customers and potential customers to utilize the Alternative PBM*; provided, further,* that this clause (e) shall not apply to:

(i) Coventry and the Coventry Plans, it being agreed that Aetna shall be required to substantially transition for service under this Agreement (I) all Coventry Plans that are Medicare Plans not later than January 1, 2016, and (II) all other Coventry Plans (other than

Coventry Plans that are Optional Plans) as soon as reasonably practicable after December 31, 2016*; provided, however,* that in no event shall Aetna or any Aetna Affiliate be required to breach or otherwise violate the terms of any Contract in effect as of the Effective Date (including, for the avoidance of doubt, any Contract with Medco Health Solutions, Inc. and its Affiliates) in order to transition any Coventry Plan to PBM. In the event that fewer than 3,690,000 members under Coventry Plans (at any time between the Agreement Date and June 30, 2017) become Members under any Covered Plan prior to June 30, 2017 (each such Person, a "Transitioned Coventry Life"), Aetna shall pay to PBM, as a liquidated damage and not as a penalty, an amount equal to (x) $6.00, multiplied by (y) the number by which the Transition Coventry Lives are less than 3,690,000. By way of example only, if there are only 3,590,000 Transitioned Coventry Lives, Aetna shall pay PBM $600,000. Any Member as of the Agreement Date who is transferred by Aetna to a Coventry Plan as part of Aetna's Coventry integration activities and who then again becomes a Member under a Covered Plan will be excluded from the count of Transitioned Coventry Lives. Aetna shall accurately calculate the amount of any payment due pursuant to the preceding sentence, shall provide PBM with reasonable documentation supporting Aetna's calculation, and shall pay any amount due to PBM, in each case, on or prior to August 15, 2017; and

(ii) Any Acquired Business that has fewer than 750,000 members enrolled in health plans that include a pharmacy benefit (measured as of the date on which Aetna or its Affiliate consummates such acquisition) if Aetna determines, in its sole discretion, that the pricing, guarantees and other economic terms that would be available to such Acquired Business under this Agreement, net of costs that Aetna, its Affiliates and/or such Acquired Business would incur in order to transition the health plans of such Acquired Business that include a pharmacy benefit to PBM, would be equivalent to or more favorable in the aggregate to Aetna than those available to such Acquired Business from its current Alternative PBM*; provided, however,* in no event shall Aetna, its Affiliate or such Acquired Business be required to breach or otherwise violate the terms of any Contract between the Acquired Business and the Alternative PBM in order to transition any health plan of any Acquired Business to this Agreement. Unless otherwise agreed in writing by the Parties or as otherwise specifically required in this Agreement, each Party shall be responsible for its costs incurred in order to transition an Acquired Business to this Agreement.

(f) with respect to any Covered Plans that are Coventry Plans, prior to the migration of services to PBM pursuant to the Transition-In Plan, Aetna and the Aetna Plan Affiliates shall be entitled to obtain any services of the type included within the PBM Services from any Person that provides such services to Aetna or any Aetna Affiliate under any Contract in effect as of the Effective Date (including, for the avoidance of doubt, Medco Health Solutions, Inc. and its Affiliates);

(g) the restrictions set forth in this Section 16.3 shall not apply to (i) any Aetna Plan Affiliate that ceases to be an Affiliate of Aetna as a result of a Change of Control transaction or to the Person that acquires control (as defined in the definition of Affiliate) of any Affiliate of Aetna in a Change of Control transaction or to any Affiliates of such Person, or (ii) in the event of a transaction constituting a Change of Control of Aetna, the Person that acquires Control of Aetna or any of the Affiliates of such Person (other than Aetna and the Affiliates of Aetna as of immediately prior to the consummation of such transaction);

(h) nothing in this Agreement shall be deemed to prohibit Aetna or any Aetna Plan Affiliate from (i) obtaining any services of the type included within the PBM Services from a Person other than PBM at the express direction of any Aetna Customer (including, for the avoidance of doubt, any administrative services only customer or any accountable care organization), (ii) working with any pharmacy benefit manager that an Aetna Customer has expressly directed Aetna or an Aetna Plan Affiliate to work with as a pharmacy benefit manager in servicing any such Aetna Customer, or (iii) providing services, including benefit management or coordination of benefit administration, condition management, or reporting, on behalf of or to an Aetna Customer that has directed Aetna to use a pharmacy benefit manager other than PBM in the performance of Aetna's Contract with such Aetna Customer; and

(i) Aetna and the Aetna Plan Affiliates shall be entitled to obtain any services of the type included within the PBM Services from any Person (A) as a replacement for any Service terminated by Aetna pursuant to Section 12.1(a), (B) for any Covered Plans as to which this Agreement has been terminated pursuant to Section 12.3, and (C) for any Third-Party State Plan that is not at the time such services are obtained a Covered Plan (either because such Third-Party State Plan has not at any time become a Covered Plan pursuant to Section 3.2(d) or because such Third-Party State Plan is no longer a Covered Plan pursuant to Section 3.2(d)) and (D) for any Optional Plan that is not at the time such services are obtained a Covered Plan (either because such Optional Plan has not at any time become a Covered Plan pursuant to Section 3.2(f) or because such Optional Plan is no longer a Covered Plan pursuant to Section 3.2(f)).

16.4 **Exclusive Use of Aetna Mail and Specialty Pharmacies.**

(a) Aetna Rx Home Delivery. As further provided in Schedules M and M-1, during the Term, the mail pharmacies owned or operated by Aetna Rx Home Delivery shall be the exclusive mail pharmacies utilized to dispense Covered Drugs to Members under Covered Plans in coordination with PBM Central Fill Pharmacies, except as otherwise set forth in the following sentence. PBM shall not authorize, contract for, or pay any other pharmacies for Covered Drugs fulfilled by mail pharmacies except (i) to the extent required by applicable Law, (ii) to the extent required under the terms of a Covered Plan or Plan Contract, and (iii) as otherwise authorized by Aetna. Nothing in this Section 16.4(a) shall be deemed to limit or modify the obligation of PBM to perform the central fill and supporting mail pharmacy services specified in Schedules M and M-1.

(b) Aetna Specialty Pharmacy. As further provided in Schedule N, during the Term, Aetna Specialty Pharmacy shall be the exclusive pharmacy utilized to dispense Specialty Products to Members under Covered Plans in coordination with PBM Central Fill Specialty Pharmacies, except as otherwise set forth in the following sentence. PBM shall not authorize, contract for, or pay any other pharmacies for Specialty Products for Members except (i) to the extent required by applicable Law, (ii) to the extent required under the terms of a Covered Plan or Plan Contract, and (iii) as otherwise authorized by Aetna. In addition, and notwithstanding anything in this Agreement to the contrary, Aetna Specialty Pharmacy shall be permitted to dispense drugs, medical devices and related services/supplies other than Specialty Products to any Member for which it dispenses Specialty Products. Nothing in this Section 16.4(b) shall be deemed to limit or modify the obligation of PBM to perform the central fill and supporting specialty pharmacy services specified in Schedule N.

ARTICLE XVII.
MISCELLANEOUS PROVISIONS

17.1 Impairment of Performance

(a) Impairment of PBM's Performance. If a failure by Aetna to perform any of its obligations under this Agreement or the Transition Services Agreement in accordance with the terms hereof and thereof (including its obligations under the Schedules) (1) impairs or eliminates PBM's ability to perform any of the Services in accordance with the terms of this Agreement, or (2) impairs or eliminates PBM's ability to achieve or meet any applicable milestones or performance standards set forth in this Agreement (including the Performance Standards, the Customer Performance Standards, and all milestones and performance standards applicable to the Transition-In Plan or any Transition-Out Services), then:

(i) to the extent Aetna's failure delayed or impaired PBM's performance of such Services or achievement of such milestones, PBM shall receive an extension of time as reasonably necessary to enable PBM to perform such Services or achieve such milestones;

(ii) to the extent Aetna's failure eliminated PBM's ability ever to perform such Services, PBM shall be relieved of its obligation to perform such Services; and

(iii) PBM shall not be obligated to pay Guarantee Amounts on account of its failure to meet such milestones or performance standards to the extent such failure by PBM was caused by Aetna's failure.

This Section 17.1(a) shall not be applicable to any failure by PBM to perform its obligations under this Agreement if (i) PBM does not notify Aetna of such failure by Aetna in writing as soon as practicable following PBM's determination that such failure (A) exists and (B) would have an effect specified in this Section 17.1(a), or (ii) Aetna's failure to perform was the result of a prior PBM failure to perform an obligation under this Agreement.

(b) Impairment of Aetna's Performance. If a failure by PBM to perform any of its obligations under this Agreement or the Transition Services Agreement in accordance with the terms hereof and thereof (including its obligations to provide the Services) (i) impairs or eliminates Aetna's ability to perform any of its obligations under this Agreement or the Transition Services Agreement in accordance with the terms hereof and thereof, then:

(i) to the extent PBM's failure delayed or impaired Aetna's performance of such obligations, Aetna shall receive an extension of time as reasonably necessary to enable Aetna to complete such performance; and

(ii) to the extent PBM's failure eliminated Aetna's ability ever to perform such obligations, Aetna shall be relieved of such obligation.

This Section 17.1(b) shall not be applicable to any failure by Aetna to perform its obligations under this Agreement if (i) Aetna does not notify PBM of such failure by PBM in writing as soon as practicable following Aetna's determination that such failure (A) exists and (B) would have an

effect specified in this Section 17.1(b), or (ii) PBM's failure to perform was the result of a prior Aetna failure to perform an obligation under this Agreement.

17.2 **No Guarantees.**

PBM acknowledges and agrees that Aetna has not and cannot warrant or guarantee the level, volume or amount of PBM Services that will be required by Aetna under this Agreement or the number or volume of Claims, Aetna Customers or Members that will become subject to this Agreement; and the terms of this Agreement are not subject to any minimum volume of Claims or PBM Services required.

17.3 **Insurance.**

At all times during the Term and while providing the Transition-Out Services (collectively, the "Insurance Term"), and for such additional periods of time as are specified in this Section 17.3, PBM shall maintain the insurance coverages and amounts set forth in this Section 17.3 and all other insurance coverages required to be maintained pursuant to applicable Law, in each case, with insurance companies that have A.M. Best's rating of at least A- (Financial Strength X). The insurance coverages and limits set forth in this Section 17.3 do not constitute limitations of the liability PBM has assumed, or will assume, under this Agreement.

(a) Commercial General Liability. PBM shall purchase and maintain Simplified ISO Commercial General Liability Insurance with coverage on a primary, non-contributing, occurrence basis including premises operations, personal injury and contractual liability coverage. The minimum combined single limit for bodily injury and property damage shall be $2,000,000 each occurrence, $5,000,000 aggregate.

(b) Professional Liability (Errors and Omissions). PBM shall purchase and maintain professional liability insurance on a claims-made basis which responds to claims for financial loss sustained by PBM, any Affiliate of PBM, Aetna, any Affiliate of Aetna, any Aetna Customer, any Member or a third party due to the rendering or failure to render professional services. Professional Service as defined by the professional liability insurance policy shall include all Services performed by PBM and its Affiliates pursuant to this Agreement. Coverage shall apply to claims-made by a single-plaintiff as well as by multiple plaintiffs (*e.g.*, class-action claims). The minimum limit to be maintained for the duration of the Insurance Term shall be $20,000,000 aggregate and $5,000,000 per claim. The claims-made policy shall have a retro-date of no later than the Effective Date and shall remain in effect for a period of at least three (3) years after the expiration or termination of the Insurance Term. If, at some point after termination or expiration of the Insurance Term, coverage is cancelled, non-renewed or otherwise terminated, PBM shall purchase extended reporting coverage for the policy for a period of at least three (3) years after the termination or expiration of the Insurance Term.

(c) Druggist Legal Liability. PBM shall purchase and maintain professional liability insurance on an occurrence basis which responds to claims for financial loss sustained by PBM, any Affiliate of PBM, Aetna, any Affiliate of Aetna, any Aetna Customer, or any Member due to, arising out of or in connection with any pharmacy owned or operated by PBM or its Affiliates, including PBM's and its Affiliates' mail order and Specialty Product delivery

pharmacy operations. Druggist Legal Liability insurance shall also include Contingent Products Liability coverage to cover claims of injury made by Aetna, any Affiliate of Aetna, any Aetna Customer, or Member caused by or arising out of use of pharmacy products distributed by PBM's mail order and Specialty Product delivery operations. The minimum limit to be maintained for the duration of this Agreement shall be $50,000,000 per claim and aggregate. Such occurrence basis policy shall have a retro-date of no later than the Effective Date and shall remain in effect for a period of at least three (3) years after the expiration or termination of the Insurance Term. If, at some point after termination or expiration of the Insurance Term, coverage is cancelled, non-renewed or otherwise terminated, PBM shall purchase extended reporting coverage for the policy for a period of at least three (3) years after the termination or expiration of the Insurance Term.

(d) Umbrella/Excess Liability. PBM shall purchase and maintain Umbrella/Excess liability insurance with limits of at least $50,000,000 providing excess coverage on a following form basis over PBM's General Liability, Pharmacy Liability and Workers' Compensation liability insurance program.

(e) Network (Cyber-Risk) Liability. PBM shall purchase and maintain Network (Cyber-Risk) Liability insurance on a claims-made basis which responds to claims for financial loss sustained by PBM, Aetna, any Affiliate of Aetna, any Aetna Customer or a third party arising out of any information technology incidents, including technology or internet errors or omissions, and network operations security. The minimum limit to be maintained for the duration of the Insurance Term shall be $50,000,000 per claim and aggregate. The claims-made policy shall have a retro-date of no later than the Effective Date and shall remain in effect for a period of at least three (3) years after the expiration or termination of the Insurance Term. If, at some point after termination or expiration of the Insurance Term, coverage is cancelled, non-renewed or otherwise terminated, PBM shall purchase extended reporting coverage for the policy for a period of at least three (3) years after the termination or expiration of the Insurance Term. Cyber Extortion Coverage will be included as part of the Network (Cyber-Risk) Liability policy, with coverage for financial loss sustained by PBM, any Affiliate of PBM, Aetna, any Affiliate of Aetna, any Member, or any Aetna Customer arising from cyber extortion threats. The minimum limit to be maintained for the duration of the Insurance Term shall be $15,000,000 per claim and aggregate. The claims-made policy shall have a retro-date of no later than the Effective Date and shall remain in effect for a period of at least three (3) years after the expiration or termination of the Insurance Term. If, at some point after termination or expiration of the Insurance Term, coverage is cancelled, non-renewed or otherwise terminated, PBM shall purchase extended reporting coverage for the policy for a period of at least three (3) years after the termination or expiration of the Insurance Term.

(f) Fidelity (Employee Dishonesty) Coverage. Employees of PBM and its Affiliates who handle or are responsible for funds of Aetna, any Affiliate of Aetna, any Member or any Aetna Customer shall be covered by fidelity insurance purchased and maintained by PBM. The minimum limit will be $10,000,000 per claim for money/funds of Aetna, any Aetna Plan Affiliate, any Member or Aetna Customer handled by PBM. Aetna and its Affiliates will be named as loss payee under such policy.

(g) Workers' Compensation. Workers' Compensation insurance sufficient to meet statutory liability limits in the state(s) wherein the work is to be performed and employer's liability insurance with minimum limits of $1,000,000 each accident for bodily injury by accident, $1,000,000 each employee for bodily injury by disease, and a policy limit meeting statutory limits.

(h) Evidence of Coverage. Prior to the Effective Date, PBM shall furnish to Aetna certificates of insurance evidencing issuance to PBM of the required insurance. Thereafter, PBM shall send a copy of certificates of insurance evidencing issuance to PBM of the required insurance to Aetna on an annual basis. All such certificates of insurance shall provide that cancellation, non-renewal, or coverage reduction shall not be effective sooner than thirty (30) days after written notice thereof to the certificate holder. Such certificates of insurance also must state that Aetna, Inc., Aetna, Affiliates of Aetna and, at Aetna's direction, Aetna Customers are named as an additional insureds per the terms and conditions of PBM's Commercial General Liability, Excess Umbrella and Professional Liability insurance policies as their interests may appear for the terms of this Agreement for the duration of the Insurance Term.

17.4 **Internet & Data Security.**

(a) PBM shall maintain and make available an Internet Protocol. PBM shall modify the Internet Protocol from time to time if such modifications will not diminish the security of PBM's systems.

(b) Not later than twenty (20) Business Days after the Effective Date and thereafter by such annual deadline as Aetna may establish from time to time, PBM shall accurately complete Aetna's Privacy & Security Attestation form (the "Aetna Vendor Attestation") as in effect from time to time (the current version of which is set forth in Annex L) and comply with any successor process or additional similar process Aetna conducts in order to verify that the information technology systems and data privacy and security practices of its vendors are in accordance with Aetna's most stringent requirements for its vendors. PBM shall commence preparation of the initial Aetna Vendor Attestation as soon as practicable following the Effective Date, and Aetna shall cooperate in good faith with PBM with respect to PBM's preparation of the Aetna Vendor Attestation. At all times during the Term, PBM shall maintain the systems and infrastructure necessary to enable PBM to accurately mark "yes" in the "Comply" column for each item included in the Aetna Vendor Attestation except (i) where PBM has previously notified Aetna in writing that it will not be doing so and Aetna has consented thereto, which consent Aetna may withhold in its sole discretion, and/or (ii) to the extent Aetna and PBM have agreed that one or more of the items included in the Aetna Vendor Attestation is not applicable to PBM. Any notice from PBM to Aetna indicating that PBM will not be complying with one or more of the items included in the Aetna Vendor Attestation shall be accompanied by a reasonably detailed description of compensating controls that PBM has in place to mitigate the risk exposure resulting from such noncompliance, implementation plans that PBM has in order to address the noncompliance, or, absent such compensating controls or implementation plans, an explanation for the noncompliance.

17.5 **Taxes.**

Any applicable sales, use, or other similarly assessed and administered tax imposed on items dispensed, or Services provided hereunder that PBM is required to collect and remit to the applicable Tax Authority will be the responsibility of Aetna or the applicable Aetna Plan Affiliate or their respective Members, as applicable. Any other amounts PBM may incur or be required to pay arising from or relating to PBM's performance of Services under this Agreement, in any capacity, will be the responsibility of PBM, including any Taxes however styled that reflects a revenue or business tax of any type or nature. If PBM is legally obligated to collect and remit sales, use, or other similarly assessed and administered Taxes in a particular jurisdiction, the Taxes will be reflected on the applicable invoice or subsequently invoiced at such time as PBM becomes aware of such obligation or as such obligation becomes due. PBM shall not invoice Aetna or any Aetna Plan Affiliate for any Taxes collected from a Member.

17.6 **Public Announcements.**

Except as required by Law, neither Party shall make any public announcement nor issue any press release relating to this Agreement without the prior written consent of the other Party. This provision does not restrict either Party from submitting necessary or appropriate filings to the SEC or to any other Governmental Body to the extent required by applicable Law and after good faith consultation with the other Party.

17.7 **Order of Preference.**

In the event of any conflict between the terms of this Agreement and the terms of any Schedule or Annex, the terms of this Agreement shall prevail.

17.8 **No Discrimination.**

PBM shall perform the Services in a manner that does not involve any discrimination or differentiation as among Aetna's Members whether on the basis of color, creed, age, gender, marital status, religion, health factors, claims experience, receipt of healthcare, medical history, genetic information, evidence of disability or otherwise, including that PBM shall comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act. Additionally, and without limiting the generality of the foregoing, PBM shall not take any retaliatory action against any Member on the ground that such Member files a complaint against PBM or Aetna or any of their Affiliates.

17.9 **Independent Contractors.**

The Parties to this Agreement are independent contractors. No Party is an agent, representative or partner of any other Party. No Party shall have any right, power or authority to enter into any agreement for or on behalf of, or incur any obligation or liability of, or to otherwise bind, any other Party. This Agreement shall not be interpreted or construed to create an association, agency, joint venture or partnership between the Parties or to impose any liability attributable to such a relationship upon any Party.

17.10 **No Third Party Beneficiaries.**

Aetna Plan Affiliates, Aetna Rx Home Delivery, Aetna Specialty Pharmacy, Aetna Indemnified Parties (solely for purposes of Article XV), PBM Indemnified Parties (solely for purposes of Article XV) and Members (solely for purposes of Section 9.9) are intended third party beneficiaries under this Agreement. Except as provided in the preceding sentence, (a) this Agreement has been entered into solely for the benefit of Aetna and PBM and no other Persons are intended to be, are or shall be third party beneficiaries of or under this Agreement, and (b) nothing in this Agreement shall be construed to create any legal, equitable or beneficial interest in any third party or to vest in any third party any interest as to enforcement or performance.

17.11 **Assignment, Transfer, Delegation.**

Neither this Agreement nor any interest, benefit, obligation or duty hereunder shall be assignable (by operation of Law or otherwise), transferable or delegable, in whole or in part, by PBM, except for delegations in accordance with Section 3.6, or by Aetna, except that Aetna may assign this Agreement or any rights hereunder, to one or more of its Affiliates. Without limiting anything in Section 3.6 of this Agreement, the Parties acknowledge that certain obligations of a Party under this Agreement may be performed by Affiliates of such Party or subcontractors, and that such performance shall not be considered an assignment of this Agreement. The provisions of this Agreement shall bind and inure to the benefit of the Parties hereto and their heirs, successors and assigns or merged or consolidated entities of the Parties except to the extent otherwise provided herein. In the event of a transaction constituting a Change of Control of Aetna, this Agreement shall remain binding upon Aetna and the Aetna Plan Affiliates as of immediately prior to the consummation of such transaction, but shall not be binding upon the Person that acquires Control of Aetna or any of the Affiliates of such Person (other than Aetna and such Aetna Plan Affiliates), and such Affiliates of such Person shall not constitute Aetna Plan Affiliates under this Agreement.

17.12 **Good Faith Performance.**

Each Party shall continue to perform its respective obligations under this Agreement during the pendency of any dispute between the Parties, subject to the terms and conditions of this Agreement.

17.13 **Amendments.**

This Agreement may be amended only in writing when signed by a duly authorized representative of each Party. Notwithstanding the foregoing, Aetna may amend this Agreement or any Schedule or Annex (i) to the extent expressly permitted in this Agreement and (ii) to the extent necessary to comply with any new or amended Law or accreditation standards that may become applicable during the Term; *provided, however*, that if the amendment necessary to address such new or amended Law or accreditation standard would have a material adverse impact on the benefits, costs or economics for Aetna or PBM arising from or relating to this Agreement, then Section 9.11 shall be applicable; *provided, further*, that in no event shall any delay in Aetna's amendment of this Agreement, or failure of Aetna to so amend this Agreement, limit PBM's obligations to comply with all applicable Laws pursuant to Section 14.1(a). Aetna shall give notice of any such amendment to PBM and any such amendment shall be effective when specified in such notice. In the event any Governmental Body with jurisdiction over

Aetna, any Aetna Plan Affiliate or any Covered Plan denies approval of this Agreement and such approval is required under applicable Law or informs Aetna or PBM that PBM shall not be permitted to provide all or part of the PBM Services with respect to one or more of the Aetna Plan Affiliates or Covered Plans, this Agreement shall not be effective with respect to the PBM Services to the extent specified by such Governmental Body, unless, and to the extent, PBM is able to satisfy the concerns of and obtain approval of such Governmental Body, to Aetna's satisfaction, within thirty (30) days. Termination of all or part of the PBM Services with respect to an Aetna Plan Affiliate pursuant to this Section 17.13 shall not affect the respective rights or obligations of the Parties with respect to acts and omissions prior to the effective date of such termination (including payment obligations) and any such termination shall constitute a Partial Termination for all purposes under this Agreement.

17.14 **Control of Aetna Plans.**

The applicable Aetna Plan Affiliate for each Covered Plan or, to the extent applicable, the Plan Administrator (as defined in Section 316 of the Employee Retirement Income Security Act of 1974, as amended) for each self-insured Covered Plan shall (i) retain the sole and absolute authority to design, amend, terminate or modify, in whole or in part, all or any portion of the Aetna Plans, including the sole authority to control and administer the Aetna Plans and any assets of the Aetna Plans and (ii) will have complete discretionary, binding and final authority to construe the terms of the Aetna Plans, to interpret ambiguous Aetna Plan language, to make factual determinations regarding the payment of claims or provisions of benefits, to review denied claims and to resolve complaints by its Members, Providers and, as applicable, Aetna Customers.

17.15 **No Modification of Aetna Plan Terms.**

Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Aetna Plan applicable to any Member.

17.16 **Force Majeure.**

(a) Neither Party will be deemed to have breached this Agreement or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Agreement if prevented from doing so by a cause or causes beyond its control (a "Force Majeure"). Without limiting the generality of the foregoing, such causes include acts of God or the public enemy, fires, floods, storms, earthquakes, riots, acts of terrorism, acts of war or war-operations, restraints of government, power or communications line failure or other circumstances beyond such Party's control. In no event shall any judgment, ruling or order of any court or agency of competent jurisdiction, or change of Law (or change in the interpretation thereof) subsequent to the execution of this Agreement constitute a "Force Majeure" and in no event shall any strike, work stoppage or work slowdown caused by or relating to a labor dispute constitute a "Force Majeure." For the avoidance of doubt, any change in Law, including any issuance, awarding or entering into of any order, decision, decree, judgment or settlement affecting or relating to the ownership or operations of any retail pharmacy owned by PBM or any of its Affiliates shall not constitute a "Force Majeure." In the case of a Force Majeure, the Party

affected shall give prompt notice to the other Party of such event (which notice shall describe in reasonable detail the Force Majeure event, its expected duration and the obligations under this Agreement being adversely affected thereby) and shall use its commercially reasonable efforts, as soon as practicable, to avoid or remove the cause of nonperformance and the unaffected Party will be excused from performance of its obligations to the extent such Party's obligations are related to the performance so interfered with. Both Parties shall proceed to perform their respective obligations once the Force Majeure has been removed or ceases. If a Force Majeure prevents a Party from performing its obligations under this Agreement for more than ninety (90) days, and the Parties are unable to agree upon other remedies, then the other Party may terminate this Agreement, in whole or in part, by giving seven (7) days' prior written notice to the non-performing Party. Upon termination, PBM shall perform the Transition-Out Services as provided in Section 3.3.

(b) Notwithstanding Section 17.16(a), no delay or other failure to perform will be excused pursuant to this Section 17.16 to the extent resulting from the acts or omissions of PBM's Subcontractors, suppliers, or other third persons providing products or services to PBM, unless such acts or omissions are themselves the product of a Force Majeure.

17.17 **Entire Agreement.**

This Agreement, including the Schedules and Annexes and all documents incorporated herein by reference, and, to the extent provided in Section 2.1, the Original Agreement constitute the entire agreement of the Parties with respect to the subject matter hereof and the transactions and performance contemplated hereby and supersede all prior agreements, renegotiations, discussions or representations, whether written or oral, with respect thereto.

17.18 **Rights and Remedies/Separate Obligations.**

No right or remedy contained herein is intended to be exclusive of any other right or remedy contained herein or provided by Law, and every such right or remedy shall be cumulative and not alternative. No Aetna Plan Affiliate shall be responsible for the obligations of any other Aetna Plan Affiliate under this Agreement.

17.19 **Representation by Counsel.**

Each Party represents and warrants that it has had the opportunity to be represented by counsel of its choice with respect to this Agreement. In view of the foregoing and notwithstanding any otherwise applicable principles of construction or interpretation, this Agreement shall be deemed to have been drafted jointly by the Parties and in the event of any ambiguity, shall not be construed or interpreted against the drafting Party.

17.20 **Construction.**

The Parties agree that any rule of construction to the effect that ambiguities are to be resolved against the drafting Party shall not be applied in the construction or interpretation of this Agreement.

17.21 **Rules of Interpretation.**

Except as otherwise expressly provided in this Agreement, the following rules of interpretation apply to this Agreement: (a) the singular includes the plural and the plural includes the singular; (b) "or" and "any" are not exclusive and "include" and "including" are not limiting; (c) reference to any Contract includes permitted supplements, amendments and modifications thereof; (d) a reference to a Law includes any amendment, modification or interpretation to such Law and any rules or regulations issued thereunder; (e) a reference to a Person includes its permitted successor and assigns; and (f) a reference in this Agreement to an Article, Section, Annex or Schedule is to the Article, Section, Annex or Schedule of this Agreement. References in this Agreement to a Schedule also include references to any sub-schedules referenced in such Schedule (*e.g.* a reference to Schedule G also shall be deemed to constitute a reference to Schedule G-1 attached to Schedule G).

17.22 **Counterparts.**

This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same instrument. A facsimile or other reproduction of this Agreement shall be deemed an original.

17.23 **Notices.**

Any notices, requests and other communications required or permitted to any Party under this Agreement shall be in writing and shall be sent by personal delivery, certified mail, return receipt requested, or by overnight courier service by a nationally recognized courier service, or by facsimile transmission confirmed by telephone conversation (recorded message is not sufficient), at the addresses and facsimile numbers below:

If to PBM at:

CaremarkPCS Health, L.L.C.
9501 East Shea Blvd. MC024
Scottsdale, Arizona 85260
Attn: Senior Vice President, Healthcare Services
Fax: 480-314-8231

and with a copy to:

CaremarkPCS Health, L.L.C.
2211 Sanders Road, NBT-10
Northbrook, Illinois 60062
Attn: Vice President and Senior Legal Counsel, Health Care Services
Fax: 847-559-4879

If to Aetna at:

Aetna Health Management, LLC

c/o Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156
Attention: Chief Executive Officer
Fax: 860-273-9020

and with a copy to:

Aetna Health Management, LLC
c/o Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156
Attention: General Counsel
Fax: 860-273-8340

All such notices and other communications will (a) if delivered personally or by courier to the address provided in this Section, be deemed given upon delivery, (b) if delivered by facsimile transmission to the facsimile number provided in this Section 17.23, be deemed given when receipt of transmission has been orally confirmed by the sending Party and (c) if delivered by certified mail in the manner described above to the address as provided in this Section 17.23, be deemed given (3) Business Days after deposit in the United States mail (in each case regardless of whether such notice, request or other communication is received by any other Person to whom a copy of such notice is to be delivered pursuant to this Section). Any notice of breach shall be prominently labeled as "Notice of Breach." Any Party from time to time may change its address, facsimile number or other information for the purpose of notices to that Party by giving written notice specifying such change to the other Party.

17.24 **No Waiver, etc.**

No failure on the part of any Party to exercise, and no delay in exercising, any right under this Agreement shall operate as waiver of any right, nor shall any single or partial exercise of any right under this Agreement by any Party preclude any other or further exercise of any other right, and no waiver whatsoever shall be valid unless in a signed writing executed by the Party granting such waiver, and then only to the extent specifically set forth in that writing. No waiver of any right under this Agreement shall operate as a waiver of any other or of the same or similar right on another occasion. No notice to or demand on one Party will be deemed to be a waiver of any obligation of that Party or of the right of the Party giving such notice or demand to take further action without notice or demand as provided in this Agreement. The rights and remedies of the Parties are cumulative and not alternative.

17.25 **Survival.**

Neither the expiration nor any termination of this Agreement shall terminate those obligations and rights of the Parties pursuant to provisions of this Agreement (including those set forth in the Schedules and Annexes) which by their express terms are intended to, or in order for a Party to comply with applicable Law must, survive, and such provisions shall survive the expiration or any termination of this Agreement. Without limiting the generality of the

foregoing, the respective rights and obligations of the Parties under Sections 2.1, 2.4, 3.3, 3.4(i), 4.3(c), 11.1, 11.3, 11.4, 11.5, 12.1(d), 12.2(c), 12.4, 16.1(a) and Articles VII, IX, XIII, XV and this Article XVII, in each case, shall survive the expiration or termination of this Agreement regardless of when such expiration or any termination becomes effective. In addition, all provisions of this Agreement shall survive and remain in effect during the Termination Transition Period to the extent applicable to the Transition-Out Services.

17.26 **Governing Law.**

Except to the extent preempted by federal Law, this Agreement will be governed by and construed in accordance with the internal laws of the State of New York applicable to agreements made and to be performed entirely within such State, without regard to the conflicts of law principles that would require the application of any other law.

17.27 **Mediation; Dispute Resolution.**

(a) Mediation.

(i) Except as provided herein, neither Party may commence any arbitration pursuant to Section 17.27(b) (other than any Abbreviated Arbitration Proceeding, cross-claim, or counterclaim) unless and until the initiating Party has submitted the dispute, claim or controversy to AAA for non-binding mediation in accordance with this Section 17.27(a)(i). Either Party may commence mediation by providing to AAA and the other Party a written request for mediation, setting forth the subject of the dispute and the relief requested. The Parties will cooperate with AAA and with one another in selecting a mediator from AAA's panel of neutrals, and in scheduling the mediation proceedings, including an initial medication session (the "Initial Mediation Session"). The Parties covenant that they will participate in the mediation in good faith, and that they will share equally in its costs (not including attorneys' fees and expenses, which will be borne by each side). All offers, promises, conduct and statements, whether oral or written, made in the course of the mediation by any of the Parties, their agents, employees, experts, attorneys and other advisors, and by the mediator and any AAA employees, are confidential, privileged and inadmissible for any purpose, including impeachment, in any civil action or other proceeding involving the Parties, *provided, however*, that evidence that is admissible or discoverable in any civil action as between a Party and any other Person shall not be rendered inadmissible or non-discoverable with respect to such civil action as a result of its use in the mediation.

(ii) Either Party may seek equitable relief prior to commencement or completion of an Initial Mediation Session required under Section 17.27(a)(i), to preserve the status quo pending the completion of an Initial Mediation Session relating to the subject matter of such equitable relief. Except for such an action to obtain equitable relief, neither Party may commence a civil action with respect to any dispute, claim or controversy arising out of or relating to this Agreement (other than any cross-claim or counterclaim) until the earlier of (i) the completion of the Initial Mediation Session with respect to such dispute, claim or controversy, or (ii) forty-five (45) days after the date of filing the written request for such a mediation with AAA. Mediation may continue after the commencement of a civil action, if the Parties so desire. The provisions of this Section 17.27(a) may be enforced by any court of competent jurisdiction,

and the Party seeking enforcement shall be entitled to an award of all costs, fees and expenses, including attorneys' fees, to be paid by the Party against whom enforcement is ordered.

(b) Arbitration.

(i) Submission of Claim or Controversy to Arbitration. Except for any dispute arising under Section 34 or Section 35 of Schedule G, any dispute, claim, or controversy arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration to be held in Hartford, Connecticut. Upon mutual consent of the parties, the arbitration will be administered by the American Arbitration Association ("AAA") in accordance with the AAA Commercial Arbitration Rules and Mediation Procedures, except to the extent modified by this Section 17.27(b). The arbitrator shall be, to the extent available, either a retired judge or selected from a panel of persons trained and expert in the area of health care law (any such person, an "Arbitrator"). Section 17.26 shall apply to the arbitration proceeding, except to the extent Federal substantive law would apply to any claim. The Party that initiated the arbitration demand or counterclaims must prove all material facts upon a preponderance of the evidence. Either Party may file a summary disposition motion of any kind with the Arbitrator. The Arbitrator shall prepare in writing and provide to the Parties an award including factual findings and the reasons on which its decision is based. If a Party believes that the Arbitrator has committed an error of law or legal reasoning, the Party can appeal to a court of competent jurisdiction to correct any such error of law or legal reasoning. There is no right to *de novo* review of the arbitration decision. The decision of the Arbitrator may be entered and enforced as a final judgment in any court of competent jurisdiction. A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds $250,000.00.

(ii) Confidentiality. Except as may be required by applicable Law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an Arbitrator may disclose the existence, content, record, status or results of a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation (collectively, the "Negotiation Record") or arbitration ("Arbitration Record"), is confidential. The arbitration hearing shall be closed to any Person other than the Arbitrator, the Parties, witnesses during their testimony, and attorneys of record. Upon the request of a Party, an Arbitrator may take such actions as are necessary to enforce this Section 17.27(b)(ii), including the imposition of sanctions.

(iii) Pre-hearing Procedure for Arbitration. The Parties will cooperate in good faith in the voluntary, prompt and informal exchange of (a) all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, (b) all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing, and (c) the identities of all individuals with knowledge about the dispute or claim. As they become aware of new documents or information (including experts who may be called upon to testify), each Party remains under a continuing obligation to provide relevant, non-privileged documents, to supplement their identification of

witnesses and experts, and to honor any understandings between the Parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing, the Parties will exchange and provide to the Arbitrator (1) a list of witnesses each Party intends to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (2) premarked copies of all exhibits they intend to use at the hearing.

(iv) Arbitration Award. The award shall be in satisfaction of all claims by all Parties as to the matter(s) presented for arbitration. Arbitrator fees and expenses shall be borne equally by the Parties. Postponement and cancellation fees and expenses shall be borne by the Party causing the postponement or cancellation. Fees and expenses incurred by a Party in successfully enforcing an award shall be borne by the other Party. Except as otherwise provided in this Agreement, each Party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorney's fees.

(v) Expedited Arbitration Procedure. Notwithstanding anything to the contrary in the foregoing provisions of this Section 17.27(b), at either Party's election exercisable by written notice to the other Party, Section 17.27(b)(iii) shall not apply with respect to any dispute, claim, or controversy where the amount in controversy with respect to any disclosed claim or counterclaim does not exceed $5,000,000 (any such dispute, claim, or controversy, an "Abbreviated Procedure Claim"). Where either Party has made such an election, arbitration of such Abbreviated Procedure Claim shall be administered in accordance with the Expedited Procedures of the AAA Commercial Arbitration Rules and Medication Procedures (an "Abbreviated Procedure Claim Arbitration"). In addition, notwithstanding anything in Section 17.27(b)(iv) to the contrary, the prevailing Party in an Abbreviated Procedure Claim Arbitration shall be entitled to an award of all reasonable costs, fees and expenses, including attorneys' fees, incurred by such prevailing Party, and the non-prevailing Party shall be responsible for all costs of the Abbreviated Procedure Claim Arbitration. In the event that the result of an Abbreviated Procedure Claim Arbitration is between the amounts proposed by the respective Party, the Party whose position is closest to that determined by the Arbitrator shall be deemed to be the prevailing party.

17.28 **Severability.**

If any provision of this Agreement or the application of any such provision to any Person or circumstance shall be held invalid, illegal or unenforceable in any respect by a court of competent jurisdiction, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement and all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect; *provided, however,* that in the event the severing of a provision has or will have a material adverse impact on the benefits, costs or economics for Aetna and the Aetna Plan Affiliates and/or PBM that arise from or relate to this Agreement, then such severing shall be treated in a manner equivalent to the treatment of a change in applicable Law under Section 9.11.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement as of the date first set forth above.

AETNA HEALTH MANAGEMENT, LLC

By: _____
Name: Joseph M. Zubretsky
Title: President

CAREMARKPCS HEALTH, L.L.C.

By: _____
Name:
Title:

[*Signature page to Amended and Restated Pharmacy Benefit Management Subcontract Agreement*]

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement as of the date first set forth above.

AETNA HEALTH MANAGEMENT, LLC

By: _____
Name:
Title:

CAREMARKPCS HEALTH, L.L.C.

By: Allison Brown
Name: Allison Brown
Title: Senior Vice President

ANNEX A

DEFINED TERMS

"AAA" has the meaning set forth in Section 17.27(b)(i).

"Abbreviated Procedure Claim" has the meaning set forth in Section 17.27(b)(v).

"Abbreviated Procedure Claim Arbitration" has the meaning set forth in Section 17.27(b)(v).

"Acquired Business" means (i) any Aetna Competitor that hereafter becomes an Affiliate of Aetna pursuant to a stock or equity acquisition, merger, consolidation or other transaction and (ii) any business unit, segment or division of any Aetna Competitor that issues, manages or administers any health insurance or health benefit plan or product and that hereafter is acquired by Aetna or any Affiliate of Aetna pursuant to an asset purchase or other transaction.

"ActiveHealth" means ActiveHealth Management Inc., a Delaware corporation.

"ActiveHealth Services" has the meaning set forth in Section 16.1(c).

"Additional Rebates" has the meaning set forth in Section 4.3(a).

"Adjustment Notice" has the meaning set forth in Section 7.4.

"Administrative Costs" means any profit retained by PBM or its Affiliates (including through Other Manufacturer Consideration or Pharmacy Rebates) with respect to the dispensing of Covered Drugs by Participating Pharmacies for Medicare Plans, excluding Administrative Fees.

"Administrative Fee" means any fee, charge, or other amount payable to PBM for the performance of PBM Services including any Optional Services pursuant to this Agreement, but excluding all Ingredient Cost Charges, Dispensing Fees and Taxes payable for Covered Drugs.

"Aetna" has the meaning set forth in the Preamble.

"Aetna Competitor" means any Person that issues, manages or administers any health insurance or health benefit plan or product that provides medical and pharmacy benefits or medical-only benefits in the United States (but excluding any such Person that engages in such activities solely as an Employer Plan Sponsor); *provided, however,* that Aetna and its Affiliates shall in no event constitute Aetna Competitors.

"Aetna Customer" means any Person or group of Persons, including any state Governmental Body that administers a State Health Care Program or Third-Party State Plan Sponsor, that is, as of any relevant date, a party to a Plan Contract. For the avoidance of doubt, Aetna Customer shall not include any Member who is not a party to a Plan Contract pursuant to which he or she receives health benefits under an Aetna Plan.

"Aetna Indemnified Party" has the meaning set forth in Section 15.1(a).

"Aetna IP" has the meaning set forth in Section 11.3(a).

"Aetna Manufacturer Revenues" has the meaning set forth in Section 4.3(c)(i).

"Aetna Pharmacy Compliance Officer" means the individual within Aetna's compliance organization primarily responsible for pharmacy compliance oversight and management.

"Aetna Plan" means any benefit product, plan or program now or hereafter issued, managed or administered by Aetna or any Aetna Plan Affiliate, including fully-insured and self-insured HMO, PPO, exclusive provider organization ("EPO"), point-of-service ("POS"), workers' compensation and indemnity health insurance plans and products, Discount Card products, high deductible health plans ("HDHP"), Medicare Plans, State Plans and any other forms of benefit plans, that includes or may include pharmacy-related benefits.

"Aetna Plan Affiliates" means those Affiliates of Aetna that are included on Annex D, as Annex D is hereafter updated and modified from time to time pursuant to Section 3.8.

"Aetna Rebate Agreement" has the meaning set forth in Section 4.3(b)(i).

"Aetna Rebates" has the meaning set forth in Section 4.3(a).

"Aetna Rx Home Delivery" has the meaning set forth in the Preamble and includes any additional or successor Affiliate of Aetna that owns and operates a mail pharmacy.

"Aetna Service Fees" has the meaning set forth in Section 4.3(a).

"Aetna Specialty Pharmacy" has the meaning set forth in the Preamble and includes any additional or successor Affiliate of Aetna that owns and operates a specialty pharmacy.

"Aetna Vendor Attestation" has the meaning set forth in Section 17.4(b).

"Affiliate" means, with respect to any Person, any other Person directly or indirectly controlling, controlled by or under common control with such first Person. The term "control" (including, with correlative meaning, the terms "controlled by" and "under common control with"), as used with respect to any Person, means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, whether through the ownership of voting securities, by Contract or otherwise.

"Agreement" has the meaning set forth in the Preamble and includes all Annexes and Schedules attached hereto.

"Agreement Date" has the meaning set forth in the Preamble.

"Alternative PBM" has the meaning set forth in Section 16.3(e).

"Annual Retail Lock-In Forecast" has the meaning set forth in Section 9.1(c)(i).

"Arbitration Record" has the meaning set forth in Section 17.27(b)(ii).

"Arbitrator" has the meaning set forth in Section 17.27(b)(i).

"ASRx Compass" means the primary information processing system owned by an Affiliate of Aetna and used by Aetna Specialty Pharmacy to manage all critical specialty pharmacy operations, including, without limitation, prescription drug input, clinical management, billing and accounting interface.

"Auditor Conflict of Interest" has the meaning set forth in Section 7.3(a).

"Authorized Generic Drug" means a drug listed in FDA's Orange Book that was approved under the Food Drug and Cosmetic Act § 505(c) (*i.e.* a "full" 505(b)(1) NDA or 505(b)(2) application, or a Biologic Licensing Application) and that is "marketed, sold, or distributed directly or indirectly to retail class of trade under a different labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trade mark than the listed drug. In no case will a Biosimilar Drug be an Authorized Generic Drug.

"AWP" means, the average wholesale price of a Covered Drug as identified by Medi-Span (or other drug pricing source mutually agreed upon by Aetna and PBM). The applicable AWP for prescriptions (a) filled in any retail Participating Pharmacy will be the AWP on the date the drug was dispensed for the 11-digit NDC for the package size from which the drug was actually dispensed as such 11-digit NDC is reported by the Participating Pharmacy, and (b) filled in any mail service or specialty Participating Pharmacy will be the AWP on the date the drug was dispensed for the 11-digit NDC for the package size from which the drug was actually dispensed. In the event that Medi-Span does not provide an AWP for a particular 11-digit NDC (and Aetna and PBM have not agreed upon another drug pricing source with respect thereto), the applicable AWP for such prescriptions shall be the lowest cost AWP per unit for such Covered Drug as reported by Medi-Span.

"AWP Discounted Rate" means the ingredient cost rate to be charged by PBM under this Agreement for all Paid Claims that are not adjudicated at the Participating Pharmacy's U&C Charge or MAC.

"Benefit Plan Design" means the terms, scope and conditions for prescription drug or device benefits under a Covered Plan, including Formularies, tier levels and drug coverage policies, exclusions, days of supply limitations, prior authorization or similar requirements, step therapy and dose consolidation protocols, site of drug dispensing and administration requirements, applicable Cost Share, benefit maximums, pharmacy network limitations and such other features or specifications as may be included in the plan documents or a Plan Contract applicable to such Covered Plan, as communicated by Aetna to PBM in accordance with the implementation procedures described in the Schedules.

"Biosimilar Drug" means an FDA ABLA (abbreviated biologic license application) approved biologic product that is considered interchangeable and freely substitutable by the FDA and other governing bodies to the referenced FDA approved branded BLA (biologic license application) product and which is classified in the compendia as such.

"Brand Drug" means a Covered Drug that is not a Generic Drug.

"Business Day" means any day (other than a Saturday or Sunday) on which banks are not required or authorized to close in the State of New York.

"Caremark Rx" has the meaning set forth in the Preamble.

"CDHP" means consumer directed health plans.

"Change of Control" means, with respect to a given Person, (a) the acquisition of ownership, directly or indirectly, beneficially or of record, in a transaction or series of transactions of equity securities in such Person representing more than fifty percent (50%) of either the aggregate voting power or the aggregate equity value represented by the issued and outstanding equity securities in such Person, whether pursuant to a merger, consolidation, reorganization (including the Bankruptcy Code of the United States of America), issuances of equity securities or otherwise, by any other Person or group of other Persons (within the meaning of Section 13(d)(3) or 14(d)(2) of the Securities Exchange Act of 1934, as amended), (b) a sale, assignment, transfer, contribution or other disposition, directly or indirectly, of all or substantially all of the property, business, or assets of such Person to any other Person or group of other Persons; or (iii) the dissolution or liquidation of such Person.

"Claim" means any electronic or paper request for payment or reimbursement arising from a pharmacy or other Provider dispensing a Covered Drug to or for a Member.

"CMS" means the Centers for Medicare & Medicaid Services.

"Code of Conduct" has the meaning set forth in Section 14.2(b).

"Commercial Retail Lock-In Pricing Guarantees" means, collectively, (i) the Large Account Retail Lock-in Guarantees and (ii) the Small Account Retail Lock-in Guarantees.

"Commercial Retail Pass Through Guarantees" means the Generic Drug and Brand Drug Retail Discount Guarantees and Dispensing Fee Guarantees for retail delivery for Covered Plans receiving Pass Through Pricing as set forth on Schedule Y-1.

"Commercial Plans" means any and all health benefit plans and products (including fully-insured and self-insured HMO, PPO, EPO, POS, indemnity health insurance and HDHP plans and products and including plans and products that provide medical and pharmacy benefits or pharmacy-only benefits), including Discount Card plan, Workers Compensation plans, State Plans, the DOD Contract, and any Plan Contract arising under CHAMPUS, TRICARE or other similar program of the United States government, but excluding all Medicare Plans.

"Commercial Retail Discount Guarantees" means, collectively, (i) the Large Account Retail Lock-in Guarantees, (ii) the Small Account Retail Lock-in Guarantees, and (iii) the Commercial Retail Pass Through Guarantees.

"Committee" has the meaning set forth in Section 5.2.

"Compound Drug" means a Covered Drug that (a) is comprised of two or more gaseous, solid, semi-solid, or liquid ingredients (other than water or flavoring added to any preparation) that are weighed or measured at a pharmacy and then prepared according to the prescriber's order and the pharmacist's art; (b) contains at least one FDA-approved federal legend drug as an active ingredient; (c) is not otherwise generally available in its compound form.

"Confidential Information" means any software, material, data or business, financial, operational, customer (including customer lists), vendor and other information disclosed or made available by one Party to the other Party and not generally known by or disclosed to the public, and shall include all data regarding the business operations of Aetna, any Affiliate of Aetna or PBM or any Affiliate of PBM, all product and plan design information, all marketing plans, all clinical programs, all pharmacy utilization data, all prescription data, all utilization review information, pricing data, trade secrets, all Member information, drug pricing information and the terms of this Agreement. Notwithstanding anything herein to the contrary, Confidential Information shall not include information that is: (a) publicly available or otherwise in the public domain prior to disclosure by a Party; (b) rightfully obtained by a Party from any third party having a right to disclose such information without restriction and without breach of any confidentiality obligation by such third party; (c) developed by a Party independent of any disclosure hereunder, as evidenced by written records; or (d) disclosed pursuant to the order of a court or administrative body of competent jurisdiction or a government agency; *provided, however*, that the Party receiving such an order shall notify the other Party prior to such disclosure and shall cooperate with the other Party in the event such Party elects to legally contest, request confidential treatment, or otherwise avoid or limit such disclosure.

"Consortium" means a group of Persons that have joined or allied, or been joined or allied, together through a consultant, coalition, collaboration or pooling mechanism for the purpose of purchasing health or drug benefits and plans.

"Contract" means any contract, agreement, subcontract, indenture, note, bond, loan, instrument, lease, mortgage, franchise, license, purchase order, sale order, understanding, arrangement or commitment, whether written or oral, that is legally binding.

"Core Services" has the meaning set forth in Section 3.2(c).

"Corporate Ratings" means, as of any date of determination, the "Long Term Issuer Credit Rating" from Standard & Poor's Rating Services ("S&P") and the "Long Term Obligations Rating" from Moody's Investors Service, Inc. ("Moody's").

"Cost Share" means the amount that a Member is required to pay under the terms of the applicable Covered Plan for a Covered Drug dispensed to such Member. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other similar amount and may be a fixed amount or a percentage of an amount.

"Coventry" means Coventry Health Care, Inc.

"Coventry Plans" means any Aetna Plan issued, managed or administered by Coventry or its Subsidiaries.

"Covered Drugs" means prescription and over-the-counter drugs, medicines, agents, substances, devices, supplies, and other therapeutic products that are prescribed for a Member and are covered under the Aetna Plan applicable to such Member, or for which coverage is otherwise available to a Member under the Aetna Plan applicable to such Member, and shall include all associated standard services usually and customarily rendered by a pharmacy or Provider in the normal course of business, including dispensing, counseling and product consultation. Covered Drugs shall also include prescription and over-the-counter drugs, medicines, agents, substances, devices, supplies, and other therapeutic products that are dispensed by a PBM Central Fill Pharmacy or PBM Central Fill Specialty Pharmacy to or for a Member in cases where there is no coverage under an Aetna Plan (*i.e.*, where the Member pays the full cost).

"Covered Plans" means all Aetna Plans other than Third Party State Plans, Optional Plans and any other Aetna Plan with respect to which, under the terms of this Agreement, no PBM Services are to be provided; *provided, however*, that (i) an Aetna Plan shall cease to be a Covered Plan from and after such time as Aetna has, pursuant to Section 12.3, terminated this Agreement with respect to such Aetna Plan, (ii) a Third-Party State Plan shall be a Covered Plan during such period(s), if any, as Aetna pursuant to Section 3.2(d) elects for it to be a Covered Plan, (iii) an Optional Plan shall be a Covered Plan during, but only during such period(s), if any, as Aetna pursuant to Section 3.2(f) elects for it to be a Covered Plan and (iv) Covered Plans do not include any Aetna Plan that does not include or provide prescription drug benefits.

"CRA" has the meaning set forth in Section 5.4(b).

"Custom Software" has the meaning set forth in Section 11.3(b).

"Customer Performance Standards" has the meaning set forth in Section 3.4(c).

"Customization" has the meaning set forth in Section 6.3(c)(ii).

"Cutover Date" means, with respect to a given PBM Service, Covered Plan or Aetna Customer, the first date as of which all transition, implementation, testing, milestone and timing requirements under the Transition-In Plan applicable to such PBM Service, Aetna Plan or Aetna Customer have been satisfied.

"Data and Information" means any and all data or information received or maintained electronically or in paper form relating to eligibility, Formularies, prescription or medical claims (including retail, mail order, specialty and otherwise), health status, Members, Rebates or benefits that are obtained in connection with the performance of Services, as well as any and all PBM-generated data, information, reports, analyses, statistics, or summaries derived from or related to the Services, whether or not such information or data is individually identifiable or aggregated.

"Delayed Employee Transfer Date" has the meaning set forth in Schedule A.

"Deployed Person" has the meaning set forth in Section 5.4(b).

"Designated Employee" has the meaning set forth in Schedule BB.

"Designated Person" has the meaning set forth in Section 16.1(a).

"Direct or Indirect Remuneration" means any discounts, charge backs or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits offered to some or all purchasers from any source (including Manufacturers, Participating Pharmacies, enrollees, or any other Person) that decrease, or have the effect of decreasing, the costs incurred by PBM and its Affiliates with respect to the procurement or dispensing of Covered Drugs for Medicare Plans.

"Disaster Recovery Plan" has the meaning set forth in Section 11.2.

"Discount Card" has the meaning set forth in Schedule G.

"Dispensing Fee" means, with respect to any Claim, the dispensing fee portion (*e.g.*, the dispensing fee charged by the dispensing pharmacy) of the amount paid or payable by Aetna, an Affiliate of Aetna, an Aetna Customer and/or a Member (as part of such Member's Cost Share), with respect to the applicable Covered Drug. For purposes of computing the Actual Discount Rate, the Actual Average Dispensing Fee, Percentage Shortfalls and Dispensing Fee Overcharge Amounts under Part 2 of Schedule Y, the Dispensing Fee amount applicable to a Claim shall be deemed to equal the amount paid to the pharmacy as a Dispensing Fee at the time of adjudication as indicated in the PBM Claims Processing Platform (or such other platform or system utilized by PBM to process the Claim). For clarity, in the case of any Paid Claim described in Section B of Part 2 of Schedule Y, the Dispensing Fee thereof shall be determined as set forth therein. For the avoidance of doubt, in the case of Lock-in Pricing, the "Dispensing Fee" is the only amount, other than Ingredient Cost Charges and applicable Tax, permitted to be charged with respect to a Claim.

"Dispensing Fee Commercial Guarantees" means, for a given time period and Retail Pricing Plan Category, the applicable Generic Drug dispensing fees and Brand Drug dispensing fees per prescription specified on Schedule Y for Covered Plans that are Commercial Plans.

"Dispensing Fee Medicare Guarantees" means, for a given time period, the applicable Generic Drug dispensing fees and the Brand Drug dispensing fees per prescription specified on Schedule Y for Medicare Plans.

"Dispensing Fee Guarantees" means, collectively, the Dispensing Fee Commercial Guarantees and the Dispensing Fee Medicare Guarantees.

"Disputed Amounts" has the meaning set forth in Section 7.5.

"DOD Contract" means the Contract between the U.S. Department of Defense and Aetna Life Insurance Company, Contract No. NAFBA1-08-c-0011 under the Uniform Health Benefits Program for Department of Defense Employees Assigned to Non-Appropriated Fund Instrumentalities, and any Contract entered into by Aetna or any Affiliate of Aetna for the provision of services under such program (or other similarly structured pass-through priced federal government program) from time to time.

"Duplicate Claim" means a Claim that has the same pharmacy, Member, date of service, prescription number and NDC as another Claim.

"DUR" means drug utilization review.

"Effective Date" has the meaning set forth in Recital F.

"Eligibility Data" means an electronically coded file in a format mutually agreed upon by the Parties that includes pertinent eligibility information, including effective dates of eligibility.

"Employee Benefits Data File" has the meaning set forth in Schedule A.

"Employer Plan Sponsor" means any Person that sponsors and administers one or more self-insured or insured health benefit plans for the benefit of its own employees and/or employees of one or more of its Affiliates.

"FDA" means the U.S. Food and Drug Administration.

"Federal Healthcare Anti-Kickback Act" has the meaning set forth in Section 14.4(e).

"FEHBP" or "Federal Employees Health Benefits Program" means the health benefits program established for federal government employees and annuitants and their dependents under 5 U.S.C. §§ 8901 et seq., as amended.

"Force Majeure" has the meaning set forth in Section 17.16(a).

"Forecast Miss Overcharge Amount" has the meaning set forth in Section 9.1(c)(iv).

"Formulary" means the list or lists of Covered Drugs with associated drug coverage decisions established for each Covered Plan by Aetna, an Aetna Plan Affiliate or Aetna Customer, in accordance with applicable Law and Aetna's policies related to formularies, as revised by Aetna, the Aetna Plan Affiliate or Aetna Customer from time to time in its sole discretion.

"Formulary Rebates" has the meaning set forth in Section 4.3(a).

"GAAP" means United States generally accepted accounting principles consistently applied during the applicable period(s).

"Generic Drug" means a Covered Drug, whether identified by its chemical, proprietary, or non-proprietary name, that (a) is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and (b) is classified as a generic drug by Medi-Span (or other drug pricing source mutually agreed upon by Aetna and PBM) file (except that PBM may override such classification in the event the Medi-Span (or other drug pricing source mutually agreed upon by Aetna and PBM) classification was in error, as reasonably verified by PBM). Generic Drugs shall in all events include multi-source Brand Drugs that adjudicate at MAC, Brand Drugs that are treated as "house" generic drugs (DAW5) by the Participating Pharmacy, Single Source Generic Drugs, Authorized Generic

Drugs, any drug that has been classified as a Generic Drug by Medi-Span (except to the extent an override has occurred pursuant to the preceding sentence), and other Covered Drugs as and to the extent mutually agreed in writing by the Parties.

"Government Health Program" means each of the following programs sponsored or administered by a Governmental Body (or any successor program thereto): (i) Medicare, (ii) Medicaid and all other State Health Care Programs, (iii) the Federal Employees Health Benefits Program, (iv) CHAMPUS, (v) TRICARE, (vi) the DOD Contract or (vii) any other program within the definition of "Federal health care program" set forth at 42 U.S.C. § 1320a-7b(f) (or any successor statute).

"Government Plan" means any health benefit product, plan or program that is a Medicare Plan or a State Plan.

"Governmental Body" means any government or quasi-governmental entity or municipality or political or other subdivision thereof, whether federal, state, city, county, regional, local, provincial, foreign or multinational, or any agency, department, board, self-regulating authority, bureau, branch, commission, authority, official or instrumentality of any of the foregoing, or any court, tribunal or arbitrator.

"GSA" has the meaning set forth in Schedule O.

"Guarantee Amount" means an amount specified in a Schedule to this Agreement to be paid by PBM to Aetna on account of a failure by PBM to achieve or satisfy a milestone, deadline, performance standard or service level set forth in such Schedule (including the Performance Standards), together with any amount PBM is required to pay and reimburse Aetna under Section 3.4(b), Section 3.4(c) or Section 3.4(d).

"HIPAA" means the Health Insurance Portability and Accountability Act.

"HMO" means a licensed health maintenance organization or similar organization.

"Indemnified Party" has the meaning set forth in Section 15.3.

"Indemnifying Party" has the meaning set forth in Section 15.3.

"Ingredient Cost Charge" means, with respect to any Claim, the ingredient cost portion (*e.g.*, the amount after application of the AWP Discounted Rate or MAC, as applicable) of the amount paid or payable by Aetna, an Affiliate of Aetna, an Aetna Customer and/or a Member (as part of such Member's Cost Share), with respect to the applicable Covered Drug. For the avoidance of doubt, Ingredient Cost Charge shall not include any Dispensing Fee or Taxes applicable to such Claim. For purposes of computing the Actual Discount Rate, the Actual Average Dispensing Fee, Percentage Shortfalls and Dispensing Fee Overcharge Amounts under Part 2 of Schedule Y, (i) the Ingredient Cost Charge of a Claim shall be deemed to equal the total amount paid by Aetna, an Affiliate of Aetna, the Aetna Customer and/or the Member, as the case may be, for such Claim minus the Dispensing Fee and Taxes applicable to the Claim as indicated in the PBM Claims Processing Platform (or such other platform or system utilized by PBM to process the Claim); and (ii) the MAC unit price applied as the Ingredient Cost Charge for each

MAC Claim shall be the MAC unit price from the applicable MAC Lists in effect at the date and time the Claim is processed. For clarity, in the case of any Paid Claim described in Section B of Part 2 of Schedule Y, the Ingredient Cost Charge thereof shall be determined as set forth therein.

"Initial Mediation Session" has the meaning set forth in Section 17.27(a)(i).

"Insolvent" means, with respect to any Person, that (a) the property of such Person, at a present fair saleable valuation, is less than the sum of such Person's debts and liabilities (including contingent and unliquidated debts and liabilities); (b) the present fair saleable value of the property of such Person is less than the amount that will be required to pay such Person's probable liability on its existing debts and liabilities as they mature; (c) such Person does not have adequate capital to carry on its business; or (d) such Person has incurred, or intends to incur, or believes that it has incurred, debts and liabilities beyond its ability to pay as such debts and liabilities mature. In computing the amount of contingent or unliquidated liabilities at any time, such liabilities will be computed at the amount which, in light of all the facts and circumstances existing at such time, represents the amount that can reasonably be expected to become actual or matured liabilities.

"Insurance Term" has the meaning set forth in Section 17.3.

"Intellectual Property" shall mean any of the following (a) United States and foreign patents, patent applications, and patent disclosures, together with all reissuances, divisions, continuations, continuations-in-part, substitutes, extensions, registrations and reexaminations thereof, and all improvements thereto; (b) registered and unregistered United States and foreign trademarks, service marks, pending trademarks, service mark registration applications, including intent-to-use registration applications, trade dress, logos, trade names, fictional business names, product names, Aetna Plan names, corporate names, and the goodwill associated therewith, and the registrations and applications for registration thereof, and extensions and renewals thereof, together with all translations, adaptations, derivations and combinations and like intellectual property rights; (c) copyrightable works and all United States and foreign copyrights, whether registered or unregistered, and all registrations, applications for registration and renewals thereof; (d) internet domain names; (e) formulations, know-how, show-how, confidential business information, trade secrets, research and development results, technical data, designs, drawings, diagrams, specifications, compositions, techniques, processes, catalogs, customer and supplier lists and contact information, pricing and cost information, business and marketing plans and proposals, and manufacturing, engineering, quality control, testing, operations, logistical, maintenance and other technical information and technology; (f) computer software (including data and related documentation), whether purchased, licensed or internally developed; (g) mask works and all applications, registrations and renewals in connection therewith; and (h) copies and tangible embodiments of the foregoing in whatever form or medium.

"Internet Protocol" means written and commercially reasonable encryption and other protocols to protect against unauthorized interception, corruption, use of or access to Confidential Information that it receives and/or disseminates over the internet.

"Joint Contracting Activities" has the meaning set forth in Section 5.5(b).

"Joint Contracting Team" has the meaning set forth in Section 5.5(b).

"Jointly Contracted Pharmacies" has the meaning set forth in Schedule G.

"Jointly Contracted Pharmacy Contracts" has the meaning set forth in Schedule G.

"Large Account" means any Aetna Customer other than a Small Account, a Governmental Body that administers a Medicare Plan or a State Plan, or a Third Party State Plan Sponsor (acting in such capacity).

"Large Account Retail Lock-in Guarantees" means the Generic Drug and Brand Drug Retail Discount Guarantees and the Dispensing Fee Guarantees for retail delivery for Covered Plans of Large Accounts as set forth on Schedule Y-3, as such guarantees may be hereafter modified pursuant to Sections 9.1(c).

"Law" means any foreign, federal, state and local laws, statutes, regulations, rules, codes, ordinances, orders or decisions adopted, issued or promulgated by any Governmental Body or common law, any consent decree or settlement agreement entered into with any Governmental Body, or any other pronouncement, instruction or guidance having the effect of law of any Governmental Body.

"Liquidated Damages Amount" has the meaning set forth in Section 12.2(b).

"Lock-In Pricing" or "Lock-In" means pricing applicable to Aetna under this Agreement for Paid Claims where the PBM applies and charges Aetna the applicable AWP Discounted Rate or, if applicable, MAC, and Dispensing Fees as specified in Schedule Y-2, Schedule Y-3 or Schedule Y-14 (and in accordance with the applicable Retail Discount Guarantee or Mail Discount Guarantee), recognizing that the actual AWP or other rate, MAC, dispensing fees and other charges PBM has contracted to pay Participating Pharmacies may vary from the amounts applied and charged to Aetna.

"Loss" or "Losses" means any direct or indirect liability, indebtedness, claim, loss, damage, lien, deficiency, obligation, cause of action, lawsuit, administrative proceeding, investigation, audit, judgment, penalty, responsibility, fine, cost, charge or expense (including reasonable attorneys' fees and disbursements and the costs of investigation and litigation) of any nature.

"MAC" or "Maximum Allowable Cost" means the maximum allowable Ingredient Cost Charge for a Covered Drug included on the applicable MAC List as set forth on such MAC List.

"MAC Lists" means the lists developed and maintained in accordance with the requirements set forth in this Agreement of prescription drugs, devices, supplies, and over-the-counter drugs identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case the Brand Drug may also be on the MAC List) and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of Manufacturers, utilization and/or pricing volatility.

"Mail Discount Guarantees" means the Generic Drug pricing discount guarantees (MAC & Non-MAC combined) and the Brand Drug pricing discount guarantees specified in Schedule Y-6 for Covered Drugs dispensed at mail. Mail Discount Guarantees shall be computed for a given time period utilizing the following formula: 1 minus (total Ingredient Cost Charge for all Qualifying Prescriptions dispensed at mail during such time period divided by the total AWP for the same Qualifying Prescriptions (both amounts to be calculated as of the dispensing date)). Mail Discount Guarantees shall be determined separately for Qualifying Brand Prescriptions and Qualifying Generic Prescriptions. Mail Discount Guarantees must apply to all Covered Plans (including CDHP plans); no exclusions of these Qualifying Prescriptions will be permitted.

"Major PBM Default" means any of the following: (a) PBM commits a material breach of its obligations under this Agreement or the Original Agreement and, in the case of a breach that is capable of cure within such time period, fails to cure such breach within sixty (60) days of PBM's receipt of notice of such breach from Aetna; (b) PBM is suspended, debarred, or excluded from participating in any Government Health Program or otherwise fails to maintain any accreditation, certification, registration, license, permit or similar authorization required for PBM to provide any services under this Agreement and, with respect to any such failure, fails to cure such failure to Aetna's satisfaction within thirty (30) days; (c) PBM fails to maintain in full force and effect the insurance required pursuant this Agreement; (d) PBM fails to comply with Performance Standards in a manner that constitutes a Major PBM Default under Schedule R; (e) PBM fails in any material respect to comply with the requirements set forth in Section 14.1 or any other provision in this Agreement obligating PBM to comply with Laws and, if capable of cure, PBM fails to cure such failure within sixty (60) days; or (f) PBM commits any fraud in the performance of the Services.

"Manufacturer" has the meaning set forth in Section 4.3(a).

"Manufacturer Administrative Fee" has the meaning set forth in Section 4.3(a).

"Manufacturer Rebate Agreement" has the meaning set forth in Section 4.3(a).

"Master AWP Discounts" means, for a given calendar year, the Generic Drug pricing discount, the Brand Drug pricing discount, the Generic Drug Dispensing Fee and the Brand Drug Dispensing Fee specified for Lock-In Pricing at retail delivery set forth on Schedule Y-8.

"Material Change" has the meaning set forth in Section 9.11(a).

"Medicaid" means the federal program of grants to states for medical assistance programs under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 - 1396v, as amended.

"Medical Only Plans" has the meaning set forth in Section 3.2(e).

"Medicare" means the program of Health Insurance for Aged and Disabled under Title XVIII of the Social Security Act, 42 U.S.C. §§1395-1395kkk-1.

"Medicare Customer Services" has the meaning set forth in Schedule A.

"Medicare Default" means PBM's indictment, conviction, or guilty or no contest plea for a felony or for any criminal charge.

"Medicare Plan" means a health benefit product, plan or program that is a Medicare Advantage Prescription Drug ("MA-PD") plan, a standalone Medicare Prescription Drug Plan ("PDP"), an employer group waiver plan, an 800 series employer group product, any Wrap Plan, or any future health benefit plan offered pursuant to a Contract with CMS under 42 U.S.C. § 1395w-101 et seq.

"Member" means each individual who is eligible for benefits under a Covered Plan.

"Minimum Corporate Rating" means, the following Corporate Ratings: BBB from S&P and/or Baa3 from Moody's.

"Minor Surplus" has the meaning set forth in Section 9.2(b).

"NCPDP" means the National Council for Prescription Drug Programs.

"NCPDP Standards" means the most current version of on-line pharmacy claims adjudication promulgated by NCPDP.

"NCQA" means the National Committee for Quality Assurance.

"NDC" means for each pharmaceutical product or device, a unique eleven (11) digit number assigned in part by the FDA and in part by the labeler or Manufacturer of the pharmaceutical product, that identifies the labeler, specific strength, dosage form, formulation and package size of such product.

"Negotiation Record" has the meaning set forth in Section 17.27(b)(ii).

"Neutral Accounting Firm" has the meaning set forth in Section 7.5(a).

"New Intellectual Property" has the meaning set forth in Section 11.3(b).

"Noncompliance Notice" has the meaning set forth in Section 14.2(f)(ii).

"Noncompliance Report" has the meaning set forth in Section 14.2 (f)(i).

"Notice of Objection" has the meaning set forth in Section 7.5.

"OIG" means the office of inspector general or any equivalent office of any Governmental Body with jurisdiction over PBM or the Services, including the Office of Inspector General of the U.S. Department of Health and Human Services, the U.S. Department of Defense, the U.S. Office of Personnel Management and the GSA.

"Optional Plan" means any Aetna Plan (i) issued, managed or administered as part of Aetna's Scrip World business line, (ii) issued, managed or administered as part of Aetna's Assurant business line, (iii) issued, managed or administered as part of Aetna's Behavioral Health line of business, (iv) that is a workers' compensation plan, (v) that is a Third Party State

Plan or a State Plan not fully insured by Aetna, or (vi) any other type of Aetna Plan that the Parties hereafter may agree in writing constitutes an "Optional Plan."

"Optional Services" has the meaning set forth in Section 3.2(b).

"Original Agreement" has the meaning set forth in Recital C.

"Other Manufacturer Payments" has the meaning set forth in Section 4.3(a).

"Other Workers" has the meaning set forth in Section 5.5(c).

"Outsourcing Readiness" has the meaning set forth in Schedule A.

"Paid Claim" means a Claim that meets coverage requirements under the applicable Aetna Plan and is payable or has been paid by PBM, Aetna, an Aetna Plan Affiliate and/or the applicable Member, not including any Reversed Claim, Duplicate Claim, or Rejected Claim.

"Partial Termination" means a termination by Aetna, pursuant to Section 3.2(d), Section 3.2(f), Section 12.1, or Section 12.3, of PBM's continued performance of (i) the PBM Services with respect to certain specified (but less than all) Covered Plans, Aetna Plan Affiliates and/or Aetna Customers, and/or (ii) with respect to a termination pursuant to Section 12.1(a) or 3.2(f), certain specified (but less than all) PBM Services.

"Participating Pharmacy" means a retail, mail-order, ITU, Specialty Product, home infusion, long-term care or other pharmacy that is owned by PBM or any Affiliate of PBM or has entered into a Contract with PBM setting forth the terms and conditions of such pharmacy's participation in PBM's pharmacy network and the dispensing of pharmaceuticals and related services by such pharmacy to Members, including the rates that PBM will pay such pharmacy. In addition, Participating Pharmacies shall include all mail and specialty pharmacies owned or operated by PBM or any of its Affiliates that provide any of the PBM Services (including the PBM Services specified in Schedules M, and N), but shall not include Aetna Rx Home Delivery or Aetna Specialty Pharmacy.

"Party" and "Parties" have the meaning set forth in the Preamble.

"Pass Through Pricing" or "Pass Through" means pricing applicable to Aetna under this Agreement for Paid Claims where the PBM applies and charges Aetna, an Affiliate of Aetna, an Aetna Customer and/or a Member (as part of such Member's Cost Share) the actual ingredient costs, dispensing fees and Taxes that PBM pays to the pharmacies for dispensing the Covered Drugs giving rise to such Paid Claims, net of all Pharmacy Rebates.

"PBM" has the meaning set forth in the Preamble.

"PBM Central Fill Pharmacy" has the meaning set forth in Schedule M.

"PBM Central Fill Specialty Pharmacy" has the meaning set forth in Schedule N.

"PBM Claims Processing Platform" or "RxClaim Platform" means the RxClaim pharmacy claim system and platform, which is owned and operated by PBM.

"PBM Compliance Department" has the meaning set forth in Section 14.1(e).

"PBM Compliance Point of Contact" has the meaning set forth in Section 14.1(e).

"PBM Customer" means any Person (including all Affiliates of such Person) (i) that issues, sponsors, manages or administers any health insurance or health benefit plan or product that provides medical and pharmacy benefits and/or pharmacy-only benefits, including Employer Plan Sponsors and Consortiums and including PBM and any Affiliate of PBM in either case if it issues any such plans, and (ii) for which PBM and/or any of its Affiliates provides any pharmacy benefit management services (including any services that are the same as or similar to any of the PBM Services). For the avoidance of any doubt, Aetna (together with the Aetna Plan Affiliates) is a PBM Customer.

"PBM Employee Transition Plan" has the meaning set forth in Section 5.4(a).

"PBM Indemnified Party" has the meaning set forth in Section 15.2(a).

"PBM IP" has the meaning set forth in Section 11.3(a).

"PBM Licensed IP" has the meaning set forth in Section 11.4.

"PBM Parent" means CVS Caremark Corporation, a Delaware corporation.

"PBM Pharmacy Entity" means each Affiliate of PBM that owns or operates a PBM Central Fill Pharmacy or a PBM Central Fill Specialty Pharmacy.

"PBM Policy" has the meaning set forth in Section 14.2(a).

"PBM Related Parties" has the meaning set forth in Schedule O.

"PBM Sales Workers" has the meaning set forth in Section 5.5(c).

"PBM Services" has the meaning set forth in Section 3.2(a).

"Performance Phase" has the meaning set forth in Section 2.3(b).

"Performance Standard" has the meaning set forth in Section 3.4(a).

"Person" means any general partnership, limited partnership, corporation, limited liability company, joint venture, trust, business trust, Governmental Body, cooperative, association, individual or other entity, and the heirs, executors, administrators, legal representatives, successors and assigns of such Person as the context may require.

"Pharmacy Rebates" has the meaning set forth in Section 4.3(a).

"Plan Contract" means a Contract between an Aetna Plan Affiliate and a Person or group of Persons, pursuant to which benefits under one or more Covered Plans are made available to such Person or Groups of Persons or employees, customers, beneficiaries or other individuals associated with such Person or group of Persons and such benefits are issued, managed or administered, in whole or in part, by such Aetna Plan Affiliate. A Plan Contract shall be deemed to include, as applicable, the evidence or certificate of coverage or similar document establishing the coverage to which such employees or other individuals are entitled.

"PPO" means a preferred provider organization.

"Pricing Category" has the meaning set forth in Part 2 of Schedule Y.

"Prime Rate" means, at any time, the annual interest rate set forth as the "Prime Rate" in the "Interest Rate" table of the most recent edition of *The Wall Street Journal*.

"Pro Forma Aggregate Lock-In Charge" has the meaning set forth in Section 9.1(c)(iv).

"Proprietary Rights" has the meaning set forth in Section 15.1(b).

"Provider" means a physician, clinic, hospital, laboratory, pharmacy or other provider of health services to Members.

"Qualifying Brand Prescriptions" means (a) in the case of Covered Drugs dispensed at retail, all Paid Claims for Covered Drugs that are Brand Drugs excluding (i) Claims for Compound Drugs, (ii) Claims pursuant to a 340B program, (iii) Long Term Care, Home Infusion, Indian Health (I/T/U) and Territory Claims under Medicare Plans, and (iv) Claims where Aetna is a secondary payer, and (b) in the case of Covered Drugs dispensed at mail or from a specialty pharmacy (including by Aetna Rx Home Delivery or Aetna Specialty Pharmacy), all Paid Claims for Covered Drugs that are Brand Drugs excluding Claims for Compound Drugs.

"Qualifying Generic Prescriptions" means (a) in the case of Covered Drugs dispensed at retail, all Paid Claims for Covered Drugs that are Generic Drugs excluding (i) Claims for Compound Drugs, (ii) Claims pursuant to a 340B program, (iii) Long Term Care, Home Infusion, Indian Health (I/T/U) and Territory Claims under Medicare Plans Claims under Medicare Plans, and (iv) Claims where Aetna is a secondary payer, and (b) in the case of Covered Drugs dispensed at mail or from a specialty pharmacy (including by Aetna Rx Home Delivery or Aetna Specialty Pharmacy), all Paid Claims for Covered Drugs that are Generic Drugs excluding Claims for Compound Drugs.

"Qualifying Prescriptions" means, collectively, (i) Qualifying Brand Prescriptions and (ii) Qualifying Generic Prescriptions.

"Rebates" has the meaning set forth in Section 4.3(a).

"Rejected Claim" means a Claim PBM rejects in the course of performing its claims adjudication functions as part of the PBM services.

"Representatives" means, in relation to any Party, that Party's Affiliates, and its and their directors, officers, employees, agents and advisers, including attorneys, accountants, consultants, bankers, financial advisers and any officers, directors and employees of any such advisers, and, in the case of PBM, any permitted Subcontractors.

"Required Books and Records" has the meaning set forth in Section 7.1.

"Restricted Activities" has the meaning set forth in Section 5.5(a).

"Restricted Workers" has the meaning set forth in Section 5.5(a).

"Retail Discount Guarantees" means the Generic Drug pricing discount guarantees (MAC & Non-MAC combined) and the Brand Drug pricing discount guarantees specified in Schedule Y for each Retail Pricing Plan Category. Retail Discount Guarantees shall be computed for a given time period, a given Retail Pricing Plan Category and a given days' supply category, utilizing the following formula: 1 *minus* (total Ingredient Cost Charge for all Qualifying Prescriptions dispensed by retail pharmacies during such time period and for such Retail Pricing Plan Category and days' supply category *divided by* the total AWP for the same Qualifying Prescriptions (both amounts to be calculated as of the dispensing date). Retail Discount Guarantees shall be determined separately for Qualifying Brand Prescriptions and Qualifying Generic Prescriptions, and in each case separately for the Retail Discount Guarantee for each days' supply category as set forth in Schedule Y. Retail Discount Guarantees must apply to all Covered Plans (including CDHP plans) that are within the applicable Retail Pricing Plan Category; no exclusions of these claims will be permitted.

"Retail Lock-In Plan Category" means each of the following categories of Covered Plans (i) Covered Plans of Large Accounts that are subject to Large Account Retail Lock-in Guarantees, and (ii) Covered Plans of Small Accounts that are subject to Small Account Retail Lock-in Guarantees.

"Retail Pricing Plan Category" means each of the following categories of Covered Plans (i) Covered Plans of Large Accounts that are subject to Large Account Retail Lock-in Guarantees, (ii) Covered Plans of Small Accounts that are subject to Small Account Retail Lock-in Guarantees, (iii) Commercial Plans that are subject to Commercial Retail Pass Through Guarantees, (iv) Medicaid Plans that are subject to Medicaid Plan Retail Lock-in Guarantees, (v) Medicaid Plans that are subject to Medicaid Plan Retail Pass Through Guarantees, (vii) Medicare Plans, (viii) Discount Card plans and (ix) Workers Compensation plans.

"Reversed Claim" means a Claim that initially is paid by PBM but as to which a Duplicate Claim is submitted for reversal of payment.

"Scheduled Expiration Date" has the meaning set forth in Section 2.2.

"Schedule R-1 Customer" has the meaning set forth in Section 3.4(b).

"Schedule R-2 Customer" has the meaning set forth in Section 3.4(c).

"Senior Leader Summit" has the meaning set forth in Section 5.1(a).

"Senior Leaders" means at least three (3) but not more than five (5) senior executive officers of Aetna and at least three (3) but not more than five (5) senior executive officers of PBM.

"Service Fees" has the meaning set forth in Section 4.3(a).

"Services" means all services, functions and work to be performed by PBM under this Agreement, including the Transition-In Services, PBM Services and Transition-Out Services.

"Single Source Generic Drug" means a Generic Drug manufactured by only one FDA-approved generic manufacturer of such Generic Drug. A Generic Drug shall cease to constitute a Single Source Generic Drug at such time as multiple Manufacturers of the Generic Drug exist, or upon the date which is 180 days after the date that the first FDA-approval of such Generic Drug is reported by Medi-Span (or other drug pricing source mutually agreed upon by Aetna and PBM), whichever is first to occur.

"Small Account" means any Aetna Customer that is (i) an Employer Plan Sponsor with less than 300 employees (as determined by Aetna) or (ii) an individual or single family as defined by Aetna (including any Member under an affinity plan).

"Small Account Retail Lock-in Guarantees" means the Generic Drug and Brand Drug Lock-in Retail Discount Guarantees and Dispensing Fee Guarantees for retail delivery for Covered Plans of Small Accounts as set forth on Schedule Y-4, as such guarantees may be hereafter modified pursuant to Sections 9.1(c).

"Specialty Product Discount Guarantees" means the Specialty Product pricing discount guarantees specified in Schedule Y-7 for each 11-digit NDC for Specialty Products dispensed by specialty pharmacies. Specialty Product Discount Guarantees shall be computed for a given time period utilizing the following formula: 1 minus (total Ingredient Cost Charge for all Qualifying Prescriptions of a given Specialty Product dispensed by a specialty pharmacy during such time period divided by the total AWP for the same Qualifying Prescriptions (both amounts to be calculated as of the dispensing date)). Specialty Product Discount Guarantees shall be determined separately for each Specialty Product. Specialty Product Discount Guarantees must apply to all Covered Plans (including CDHP plans); no exclusions of these Qualifying Prescriptions will be permitted.

"Specialty Products" means those injectable and non-injectable Covered Drugs, medicines, agents, substances and other therapeutic products that are designated in this Agreement as Specialty Products or that are hereafter designated as Specialty Products by Aetna on account of their having particular characteristics, including one or more of the following: (a) they address complex, chronic diseases with many associated co-morbidities (*e.g.*, cancer, rheumatoid arthritis, hemophilia, multiple sclerosis), (b) they require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste, (c) they have limited pharmaceutical supply chain distribution as determined by the drug's Manufacturer and/or (d) their relative expense. For clarity, all Biosimilar Drugs shall constitute Specialty Products.

"SSAE 16" has the meaning set forth in Section 7.3(d).

"State Health Care Program" means a program defined at 42 U.S.C. § 1320a-7(h), as amended, including Medicaid.

"State Plan" means a health benefit product, plan or program offered pursuant to a Contract with a state Governmental Body that administers a State Health Care Program, including, when used with respect to Aetna and any Aetna Plan Affiliate, any Third-Party State Plan, or when used with respect to any other PBM Customer, plans of such other PBM Customer that are analogous to Third-Party State Plans.

"Subcontractor" has the meaning set forth in Section 3.6(a).

"Subsidiary" of any Person, means any corporation, partnership, joint venture, limited liability company, trust or estate of which (or in which) at least fifty percent (50%) of (a) the issued and outstanding capital stock or other securities having voting power to elect a majority of the board of directors or managers (or other similar governing body) of such Person (irrespective of whether at the time capital stock of any other class or classes of such corporation will or might have voting power upon the occurrence of any contingency); (b) the economic or ownership interest in the capital or profits of such partnership, joint venture or limited liability company; or (c) the beneficial interest in such trust or estate, is at the time directly or indirectly owned or controlled by such Person, by such Person and one or more of its other Subsidiaries, or by one or more other Subsidiaries of such Person.

"System Enhancement" has the meaning set forth in Section 6.3(g)(ii).

"Systems Development Work" has the meaning set forth in Section 6.3(g)(i).

"Tax Authority" means any Governmental Body responsible for the collection of Taxes.

"Taxes" means (a) all taxes, assessments, charges, customs, duties, fees, levies, tariffs, imposts or other governmental charges of any kind whatsoever, including all United States of America federal, state, local, foreign and other net or gross income, franchise, profits, capital gains, capital stock, transfer, real property transfer, recordation, sales, use, occupation, property, excise, severance, ad valorem, valued added, windfall profits, stamp, license, payroll, withholding and other taxes (whether payable directly or by withholding and whether or not requiring the filing of a Tax Return) and all estimated taxes and deficiency assessments and (b) any interest, penalty or addition to any of the foregoing.

"Tax Return" means all returns, statements, forms and reports (including elections, waivers or extensions, declarations, disclosures, schedules, estimates and information returns) for Taxes required to be filed with the IRS or any other federal, foreign, state, local or provincial Tax Authority.

"Term" has the meaning set forth in Section 2.2(a).

"Termination Transition Period" has the meaning set forth in Section 2.4.

"Territory Claims" means Claims under Medicare Plans dispensed by retail Participating Pharmacies in Puerto Rico, U.S. Virgin Islands, America Samoa, Guam and any other current or new U.S. territory.

"Third-Party Claim" has the meaning set forth in Section 15.3.

"Third-Party State Plan" means a State Plan of a Third-Party State Plan Sponsor as to which Aetna and/or an Aetna Plan Affiliate provides administrative or management services pursuant to a Contract with such Third-Party State Plan Sponsor.

"Third-Party State Plan Sponsor" means a Person, other than Aetna or an Affiliate of Aetna, that issues, manages, or administers a State Plan pursuant to a Contract with the state Governmental Body that administers such State Plan.

"Transfer Date" has the meaning set forth in Schedule A.

"Transferred Employees" has the meaning set forth in Schedule A.

"Transition Employees" has the meaning set forth in Schedule A.

"Transition-In Phase" has the meaning set forth in Section 2.3(a).

"Transition-In Plan" has the meaning set forth in Section 3.1(a).

"Transition-In Services" has the meaning set forth in Section 3.1(a).

"Transition-Out Services" has the meaning set forth in Section 3.3(b).

"Transition Services Agreement" has the meaning set forth in Section 17.1.

"U&C Charge" means the amount an applicable Participating Pharmacy charges a regular cash paying customer for a Covered Drug, as submitted by a Participating Pharmacy to PBM as part of the Participating Pharmacy's Claim submission.

"U&C Claim" has the meaning set forth in Part 2.B.2 of Schedule Y.

"Unsolicited Resume" has the meaning set forth in Section 16.1(a).

"URAC" means URAC, Inc.

"Workers Compensation" means, with respect to any Covered Plan or Claim, that such Covered Plan provides coverage for, or such Claim relates to compensation of a Member for, work-related injuries funded by employer compensation insurance contributions.

"Wrap Plan" means any health benefit plan, product, or program now or hereafter issued, managed, administered, distributed or otherwise serviced by Aetna or an Aetna Affiliate that is provided in connection with and supplements a Medicare Plan and provides medical and/or pharmacy benefits that Medicare and such Medicare Plan does not cover.

AMENDMENT NUMBER 2 TO AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT

This **AMENDMENT TO AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT** (this "Amendment"), dated as of January 1, 2015 (the "Amendment Date"), is entered into by and between Aetna Health Management, LLC, a Delaware limited liability company ("Aetna"), on behalf of itself and its Affiliates Aetna RX Home Delivery, LLC, a Delaware limited liability company, and Aetna Specialty Pharmacy, LLC, a Delaware limited liability company, and CaremarkPCS Health, L.L.C., a Delaware limited liability company ("PBM"), on behalf of itself and its Affiliate Caremark Rx, L.L.C., a Delaware limited liability company. Aetna and PBM are sometimes referred to herein collectively as "Parties" and individually as a "Party." Unless otherwise noted, the effective date for the provisions of this Amendment is the date first above written.

RECITALS

A. Aetna and PBM are parties to a certain Amended and Restated Pharmacy Benefit Management Subcontract Agreement dated as of October 2, 2013 (the "PBM Agreement"). Capitalized terms used but not otherwise defined in this Amendment shall have the respective meanings specified in the PBM Agreement.

B. The Parties have agreed to amend the PBM Agreement in accordance with Section 17.13 thereof to set forth certain agreements between the Parties as set forth below.

NOW, THEREFORE, in consideration of the promises, covenants, representations and warranties set forth herein, and other consideration, the sufficiency of which is hereby acknowledged, the Parties each hereby agree as follows:

1. Pricing for Services and Covered Drugs: Section 9.1(c)(iv) of the PBM Agreement is hereby amended to read in its entirety as follows:

> In addition, not later than February 10 of each year during the Term or Termination Transition Period commencing with 2016, the Parties shall compute the aggregate cost (*i.e.*, aggregate Ingredient Cost Charges, Dispensing Fees and Administrative Fees) to Aetna and the Members that would have resulted from all Qualifying Prescriptions that were dispensed during the prior calendar year and charged to Aetna on the basis of the Commercial Retail Lock-In Pricing Guarantees if such Qualifying Prescriptions instead had been charged on the basis of the Master AWP Discounts for such prior calendar year (such amount, the "Pro Forma Aggregate Lock-In Charge"). If the actual aggregate cost to Aetna and the Members that resulted under this Agreement from such Qualifying Prescriptions exceeds the Pro Forma Aggregate Lock-In Charge (such excess amount, the "Forecast Miss Overcharge Amount"), Aetna and PBM shall increase (in proportions equal to the relative proportion of the excess) the applicable Commercial Retail Lock-In Pricing Guarantees for the following (the then-current) calendar year to the extent necessary to enable Aetna, on a projected basis using the data included in the Annual Retail Lock-In Forecast, to realize the entire amount of the Forecast Miss Overcharge

Amount. If the actual aggregate cost to Aetna and the Members that resulted under this Agreement from such Qualifying Prescriptions is less than the Pro Forma Aggregate Lock-In Charge (such shortfall, the "Forecast Miss Shortfall Amount"), Aetna and PBM shall reduce (in proportions equal to the relative proportion of the shortfall) the applicable Commercial Retail Lock-In Pricing Guarantees for the following (the then-current) calendar year to the extent necessary to enable PBM, on a projected basis using the data included in the Annual Retail Lock-In Forecast, to realize the entire amount of the Forecast Miss Shortfall Amount. The Pro Forma Aggregate Lock-In Charge, such actual aggregate cost to Aetna and the Members, the Forecast Miss Overcharge Amount and the Forecast Miss Shortfall Amount shall be computed after taking into account (i) any adjustments to the Master AWP Discounts and the Commercial Retail Lock-In Pricing Guarantees for such prior calendar year pursuant to Part 3 of Schedule Y, and (ii) any reconciliation payments made pursuant to Part 2(D) of Schedule Y with respect to the Commercial Retail Lock-In Guarantees for such prior calendar year; it being intended by the Parties that the Forecast Miss Overcharge Amount or the Forecast Miss Shortfall Amount, as the case may be, should capture and reflect overpayments or underpayments to PBM that result from inaccuracies in the Annual Retail Lock-In Forecast (and not overpayments or underpayments that result from PBM having underperformed or overperformed on its Commercial Retail Lock-In Pricing Guarantees, which overpayments/underpayments are to be addressed and reconciled pursuant to Part 2(D) of Schedule Y).

2. No Pooling of Guarantees: Section 9.2(b) of the PBM Agreement is hereby amended in its entirety to read as follows: (b) No Pooling of Guarantees. Each individual guarantee for a Pricing Category set forth in Schedule Y, including each of the Retail Pricing Guarantees, Dispensing Fee Guarantees, Mail Discount Guarantees, and Specialty Product Guarantees, shall be administered, measured and reconciled as unique and distinct categories, components or segments; and a deficit (over charge) in any one Pricing Category shall not be offset against or aggregated with a surplus (over performance) in any other Pricing Category, *except*, as follows: (i) Deficits (over charges) in Pricing Categories from Schedules Y-2, Y-3, Y-4, Y-5, Y-15P and Y-15L (retail only in the case of Y-15L) in a given calendar year may be offset against Minor Surpluses (and only Minor Surpluses) in any Pricing Categories from the same (and only the same) sub-schedule of Schedule Y in the same calendar year. "Minor Surplus" means (i) in the case of a Retail Discount Guaranty for a given Pricing Category, a surplus (over performance) in that Pricing Category that does not exceed such Retail Discount Guaranty by more than two tenths of one percent (0.20%), and (ii) in the case of a Dispensing Fee Guarantee for a given Pricing Category, a surplus (over performance) that does not exceed the applicable Dispensing Fee Guaranty by more than ten cents ($.10) per Paid Claim. The application of this Section 9.2(b)(i) is illustrated in Annex O.

(ii) The improved Retail Brand Discount Rates and Brand and Generic Dispensing Fees reflected in Schedules Y-2, Y-3, Y-4, Y-9 and Y-20 for any Claims dispensed for a days supply of 35-83 days and 84+ days must satisfy the following conditions to receive the improved Retail Brand Discount Rates and Brand and Generic Dispensing Fees stated in such Schedule: (i) Aetna Customers must have implemented

PBM's extended day supply retail network as its Benefit Plan Design; and (ii) any Claim for a days supply of 35-83 days and 84+ days will reject unless such Claim is dispensed by a retail pharmacy participating in PBM's extended day supply network. If any of the conditions described in this Section 9.2(b)(ii) are not satisfied, the Claim shall be deemed a 0-34 days supply Claim and shall receive the applicable pricing for a Claim for 0-34 days supply, and shall be reconciled in the 0-34 days supply Pricing Category.

3. The second and third sentences of Section 16.3(e)(i) of the PBM Agreement is hereby deleted and replaced with the following:

In the event that fewer than 3,400,000 members under Coventry Plans (at any time between the Agreement Date and June 30, 2017) become Members under any Covered Plan prior to June 30, 2017 (each such Person, a "Transitioned Coventry Life"), Aetna shall pay to PBM, as a liquidated damage and not as a penalty, an amount equal to (x) $6.00, multiplied by (y) the number by which the Transition Coventry Lives are less than 3,400,000. By way of example only, if there are only 3,390,000 Transitioned Coventry Lives, Aetna shall pay PBM $60,000. In the event that fewer than 3,690,000 members under Coventry Plans (at any time between the Agreement Date and January 31, 2018) become Members under any Covered Plan prior to January 31, 2018 (each such Person, a "Transitioned Coventry Life"), Aetna shall pay to PBM, as a liquidated damage and not as a penalty, an amount equal to (x) $6.00, multiplied by (y) the number by which the Transition Coventry Lives are less than 3,690,000, provided that such amount shall be reduced by any amounts paid under the preceding two sentences. By way of example only, if there are only 3,590,000 Transitioned Coventry Lives and if Aetna had paid a penalty of $60,000 under the preceding two sentences, Aetna would be obligated to pay PBM an additional $540,000 ((3,690,000 – 3,590,000) x $6.00) - $60,000 = $540,000.

4. Schedule B. Schedule B to the PBM Agreement is hereby amended and restated in its entirety in the form attached hereto as Appendix A.

5. Schedule D. Schedule D to the PBM Agreement is hereby amended by deleting section 11 in its entirety.

6. Schedule E. Schedule E to the PBM Agreement is hereby amended by modifying section 18 and adding section 45 in the form attached hereto as Appendix B.

7. Schedule F. Schedules F-1, F-2 and F-3 to the PBM Agreement are hereby amended and restated in their entirety in the form attached hereto as Appendix C.

8. Schedule I. Schedule I to the PBM Agreement is hereby amended and restated in its entirety in the form attached hereto as Appendix D.

9. Schedule O. Sections 12, 50, 78, 79 and 80 of Schedule O are hereby amended in their entirety in the form attached hereto as Appendix F.

10. Schedule O-2. A new Schedule O-2 is hereby added to the PBM Agreement in the form attached hereto as Appendix G.

11. Schedule P. Schedule P to the PBM Agreement is hereby amended by deleting Sections 15, 34, 35 and 36 in their entirety and inserting the words "Intentionally Omitted" in replace of the existing language thereof.

12. Schedule P(I-1). A new Schedule P(I-1) is hereby added to the PBM Agreement in the form attached hereto as Appendix H.

13. Schedule P(K-1). A new Schedule P(K-1) is hereby added to the PBM Agreement in the form attached hereto as Appendix I

14. Schedule R. Effective with respect to the measurement periods from and after January 1, 2015, Schedule R to the PBM Agreement is hereby amended in its entirety in the form attached hereto as Appendix J.

15. Schedule T-2. A new Schedule T-2 is hereby added to the PBM Agreement in the form attached hereto as Appendix K.

16. Schedule Y. Schedule Y to the PBM Agreement is hereby amended in its entirety in the form attached hereto as Appendix L.

17. Schedule AA. Effective August 1, 2015, Schedule AA to the PBM Agreement is hereby amended in its entirety in the form attached hereto as Appendix M.

18. Annex C. Annex C to the PBM Agreement is hereby amended in its entirety in the form attached hereto as Appendix N.

19. Effect of Amendment. Except as amended by this Amendment, the PBM Agreement remains in full force and effect. All references to the PBM Agreement in any other agreement or document shall hereinafter be deemed to refer to the PBM Agreement as amended by this Amendment.

20. Miscellaneous. The provisions set forth in Article XXIII, and Sections 17.19, 17.20, 17.21, 17.22 and 17.26 of the PBM Agreement shall be applicable to this Amendment No. 1 *mutatis mutandis* and to the full extent necessary shall be deemed to be incorporated herein.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the Parties hereto have executed this Amendment as of the date first set forth above.

AETNA HEALTH MANAGEMENT, LLC

Name: Sheryl A. Burke
Title: Senior Vice President

CAREMARKPCS HEALTH, L.L.C.

Name:
Title:

Appendix A

Amendment to Schedule B

Benefit Plan Set Up

Core Services.

Service	Description
Benefit Plan Set Up	1. PBM shall use its best efforts to coordinate Benefit Plan Design set up with Aetna to ensure plan benefits are accurately entered into the PBM claim adjudication system prior to the effective date of the plan benefits and in accordance with this Schedule B (Benefit Plan Set Up). As it specifically applies to Medicare, PBM shall also use its best efforts to coordinate Benefit Plan Design set up with Aetna to ensure plan benefits are accurately entered into the PBM claim adjudication system prior to Medicare Open Enrollment (as defined by CMS) and in accordance with this Schedule B (Benefit Plan Set Up)**.**
Benefit Plan Design Administration	2. PBM shall use its best efforts to code Benefit Plan Design data into its system(s) in a manner that reflects Aetna's usual and customary business practices. PBM shall accept from Aetna in a reasonable Aetna-specified format, apply, comply with, and otherwise use for adjudication purposes the Benefit Plan Design information furnished by Aetna or, at Aetna's direction, Aetna Plan Affiliates, including any and all Formularies and drug lists established by Aetna, its designees, or Aetna Customers. PBM shall load such Formularies, drug lists, and other Benefit Plan Design information into the electronic claims adjudication system to ensure that proper editing and messaging is provided at the point-of-sale ("POS") in accordance with this Schedule B (Benefit Plan Set Up). 3. Commercial Benefit Plan Set Up Timing Parameters. PBM shall load, update, and implement Benefit Plan Design information (new Benefit Plan Designs and revisions to existing Benefit Plan Designs) for all Commercial Plans with effective dates of November 1, 2015 or later as follows: a. Processing Categories for All Commercial Plans. Upon submission of Benefit Plan Design information for Commercial Plans to PBM, Aetna shall designate each such submission as falling within one of the following three processing categories: i. "Rework": A Benefit Plan Design submission that has been unsuccessfully processed on at least one prior occasion and has been designated by Aetna as "Rework". Aetna shall not identify more than fifteen percent (15%) of Commercial Plan submissions as "Rework" in any given calendar month. ii. "Escalation": A Benefit Plan Design submission that has been

Service	Description
	designated by Aetna as "Escalation" because Aetna has determined, in its sole judgment, that processing delays may cause harm to Aetna or its interests. Aetna shall not identify more than ten percent (10%) of Commercial Plan submissions as "Escalation" in any given calendar month. iii. "General": All Benefit Plan Design submissions not classified as either Rework or Escalation will fall within the "General" category. If Aetna fails to categorize a submission it will be deemed "General." b. Turnaround Times for Commercial Plans. PBM shall load and implement Benefit Plan Design information for Commercial Plans for all cases, including MOB and new cases, within the following timeframes. a. "Rework": Rework submissions shall be loaded and implemented within ten (10) calendar days of receipt of the necessary Benefit Plan Design information by PBM. b. "Escalation": Escalation submissions shall be loaded and implemented within five (5) calendar days of receipt of the necessary Benefit Plan Design information by PBM. c. "General": General submissions shall be loaded and implemented within fourteen (14) calendar days of receipt of the necessary Benefit Plan Design information by PBM. -Beginning January 1,-2017 General submissions shall be loaded within thirteen (13) calendar days of receipt of the necessary Benefit Plan Design information. -Beginning January 1, 2018 General submissions shall be loaded within twelve (12) calendar days of receipt of the necessary Benefit Plan Design information. -Beginning January 1, 2019 General submissions shall be loaded within eleven (11) calendar days of receipt of the necessary Benefit Plan Design information. -Beginning January 1, 2020 General submissions shall be loaded within ten (10) calendar days of receipt of the necessary Benefit Plan Design information. Regardless of processing category, PBM shall make best efforts to load and implement all Commercial Plans by the Plan effective date. For 2016, PBM and Aetna will mutually agree to a start date for performance guarantees aligned with these service levels, either 4/1/2016, 5/1/2016 or 6/1/2016, at which time the three measurements related to schedule R will go into effect. Prior to the Parties mutually agreeing to an effective date for this performance guarantees as described in the previous sentence, PBM interim performance standard shall be to load all cases and implement within fourteen (14) calendar days of the necessary Benefit Plan

Service	Description
	Design information by PBM. c. Open Enrollment Commercial Benefit Plan Design Forecasting. No later than August 1 of each year, Aetna shall provide PBM with an initial forecast of volumes for Commercial Plan set up activity in the fourth calendar quarter(hereinafter Open Enrollment Period). No later than September 1 of each year, Aetna shall provide PBM with an updated forecast of volumes for Open Enrollment Period Commercial Plan set up activity. PBM shall staff appropriately to meet the Commercial Plan turnaround times set forth in Section 3.b above for the Open Enrollment Period based upon Aetna's forecasts plus an additional margin of five percent (5%) over the forecasts. d. Monthly Commercial Benefit Plan Design Forecasting. No later than sixty (60) days prior to the 1st day of each month, Aetna shall provide PBM with a monthly forecast of volumes for Commercial Plan set up activity to be processed during the month. No later than thirty (30) days prior to the 1st day of each month, Aetna shall provide PBM with an updated forecast of volumes for Commercial Plan set up activity to be processed during the month. PBM shall staff appropriately to meet the Commercial Plan turnaround times set forth in Section 3.b above each month based upon Aetna's forecasts plus an additional margin of twelve percent (12%) over the forecasts. e. In the event the actual benefit plan forecast volumes for each month, for open enrollment and non-open enrollment, are over or under forecast for two months in a calendar year, by 20% or greater, the applicable Performance Guarantee penalty assessed, relating to Benefit Plan change turn-around times, will be reduced by 30% for each month this event occurs. Monthly staffing cushion applied by PBM is not considered part of the Aetna forecast for determination of forecasting accuracy. 4. Medicare Benefit Plan Set Up Timing Parameters. PBM shall load, update, and implement Medicare Benefit Plan Design information as follows: a. Processing Categories for Medicare Plans. Aetna shall designate Benefit Plan Design submissions as one of the following two processing categories: i. "Annual Benefit Installation". Medicare Benefit Plan Design submissions that are loaded as part of the jointly developed installation plan for each given year. ii. "All Other Submissions". All Medicare Benefit Plan Design submissions that are not part of the Annual Benefit Installation. b. Turnaround Times for Medicare Plans. PBM shall load and implement Benefit Plan Design information for Medicare Plans within the following timeframes: i. "Annual Benefit Installation". Benefit Plan Design submissions shall be loaded and implemented in accordance with the jointly

Service	Description
	developed installation plan for that year, modified as necessary to comply with CMS requirements. ii. "All Other Submissions". All Other Submissions shall be loaded and implemented within fourteen (14) calendar days of receipt of the necessary Benefit Plan Design information by PBM. -Beginning January 1, 2017, All Other Submissions shall be loaded within thirteen (13) calendar days of receipt of the necessary Benefit Plan Design information. -Beginning January 1, 2018, All Other Submissions shall be loaded within twelve (12) calendar days of receipt of the necessary Benefit Plan Design information. -Beginning January 1, 2019, All Other Submissions shall be loaded within eleven (11) calendar days of receipt of the necessary Benefit Plan Design information. -Beginning January 1, 2020, All Other Submissions shall be loaded within ten (10) calendar days of receipt of the necessary Benefit Plan Design information. Regardless of processing category, PBM shall make best efforts to load and implement all Medicare Plans by the Plan effective date. 5. Medicaid Benefit Plan Set Up Timing Parameters. PBM shall load, update, and implement Medicaid Benefit Plan Design information as follows: a. Standard benefit plan designs shall be loaded and implemented within three (3) business days of receipt of the necessary Benefit Plan Design information by PBM. b. Complex benefit plan designs shall be loaded and implemented within fifteen (15) business days of receipt of the necessary Benefit Plan Design information by PBM. c. Corrections to benefit plan designs shall be loaded and implemented within three (3) business days of receipt of the necessary Benefit Plan Design information by PBM. 6. Scrip World Benefit Plan Set Up Timing Parameters. PBM shall load, update, and implement all Scrip World Benefit Plan Design information within ten (10) business days. 7. General Requirements for All Benefit Plan Loads. The following general requirements apply to Benefit Plan set up activity for all Plans:

Service	Description
	a. Benefit Plan Design Loads: PBM shall make best efforts to accept Benefit Plan Design information via automated benefit loads from Aetna through an electronic feed in a mutually agreed upon format. PBM shall apply mutually agreed upon edits and parameters to all automated benefit loads prior to implementation of that automated load. PBM shall implement such Benefit Plan Design information changes and updates upon a mutually agreed upon daily schedule. In the event there is a critical error with the automated load, the Benefit Plan Design will not be implemented and PBM shall immediately notify Aetna in writing and make best efforts to resolve the error within twenty-four (24) hours or such longer time period reasonably agreed upon by Aetna so that the Benefit Plan Design can be implemented without error at the following 7:00 a.m. release. Upon PBM's receipt of Aetna's approval of Benefit Plan Design testing, PBM shall promote Benefit Plan Design coding to production within one (1) Business Day. If Aetna requests corrections upon review of plan design testing caused by PBM, PBM will make appropriate corrections to the coding and provide Aetna with a revised Benefit Plan Design coding for Aetna to approve within one (1) Business Day, or as otherwise mutually agreed upon by Aetna and PBM. b. Benefit Plan Design Loads – New System Coding Required. When PBM receives Benefit Plan Design information that reasonably requires new coding to implement (e.g., new complex clinical rules, new cost share or pricing logic not available in configurable templates), PBM shall promptly notify Aetna in writing that new system coding is required. Within thirty (30) calendar days from PBM's receipt of the Benefit Plan Design information, PBM shall prepare and deliver to Aetna a written requirements document setting forth the requirements and associated timeline for such coding, which shall be subject to Aetna's written approval. Upon PBM's receipt of Aetna's written approval of the requirements document, PBM shall complete the new system coding, comprehensive testing and load and implement the Benefit Plan Design information within one hundred twenty (120) calendar days (unless an alternative timeframe is mutually agreed upon by the Parties) of receipt of Aetna's written approval of the requirements document. In cases where implementation of the Benefit Plan Design information is contingent upon Client Acceptance Testing (CAT), PBM shall complete CAT immediately after loading the Benefit Plan Design information (in accordance with the timeline hereunder) and shall immediately provide the CAT results to Aetna. After Aetna's review of the CAT results, upon receipt of written direction from Aetna, PBM shall implement the Benefit Plan Design information

Service	Description
	within five (5) Business Days, but not later than one (1) day prior to the group and/or member effective date. 8. Testing - Benefit Plan Set Up/Changes For All Plans. The following testing requirements apply to Benefit Plan set up activity for all Plans: a. Testing Parameters. i. Benefit Plan Design Loads Not Requiring New System Coding. PBM and Aetna shall mutually agree on the testing parameters that PBM shall apply to manual loads not requiring new system coding, but in all cases, at a minimum, the testing shall include testing with respect to the addition(s) or change(s) manually input. a. Exclusively for Commercial Benefit Plan Set Up, the testing by PBM shall include a minimum of five hundred (500) Claims per day at the Aetna or Aetna Customer level as requested, and per Benefit Plan installed. ii. Benefit Plan Design Loads Requiring New System Coding. PBM and Aetna shall mutually agree on the testing parameters that PBM shall apply to manual loads requiring new system coding, but in all cases, at a minimum, the testing shall confirm accurate Claim rejections, Claim payments, application of accumulators, compliance with Formulary, messaging, and all other mutually agreed upon functions of benefit administration. iii. Test Results and Corrections. For all testing, PBM shall produce to Aetna (in a format mutually agreed to by the Parties), all testing results at the overall Aetna level, at the Aetna Customer level, and at the Benefit Plan level within a reasonable time after test completion but no later than forty-eight (48) hours after the completion of the testing by PBM. Test plans for all testing must receive Aetna's prior approval. Aetna and PBM shall mutually develop and agree upon a test bed to test plan changes so as to minimize the amount of time it will take to develop and approve test plans and to facilitate the testing. Benefit Plan Design test results will be provided by the PBM to Aetna in a format that is user-friendly to Aetna personnel who are not experts in the field of benefit plan services. The PBM will also provide training to Aetna on the analysis and review of the test results. For purposes of this Schedule B (Benefit Plan Set Up), "Error" shall mean any and all inaccuracies, mistakes, or omissions, regardless of materiality. iv. Timing of Testing. Unless otherwise mutually agreed in writing, all testing shall be done prior to implementation and in sufficient time to test and correct testing errors prior to the implementation time lines set forth in sections 3 and 4, above,

Service	Description
	of this Schedule B (Benefit Plan Set Up). In addition, PBM shall execute Claims testing on an alternative reasonable schedule when required by specific Aetna Customers as identified by Aetna from time to time. 9. PBM shall obtain Aetna's prior approval (and the approval of any applicable Aetna Customers, upon Aetna's request) of, and implement, all Plan level adjudication edits and hierarchy of Benefit Plan Design administration. PBM shall make such modifications as shall be necessary to address and resolve any concerns and issues reasonably raised by Aetna (or the applicable Aetna Customer) regarding Benefit Plan Design set-up and administration. 10. PBM shall provide to Aetna on a weekly basis a Benefit Plan Design information progress log, which tracks the status of loading, implementing, testing, and correcting Benefit Plan Design information (including Formularies) that is in progress and the status of such work completed or pending in accordance with Schedule V (Reporting). 11. PBM shall establish and use such policies and procedures and take such other actions as shall be necessary to ensure that Benefit Plan Design set-up and administration are provided in accordance with this Schedule B (Benefit Plan Set Up). PBM shall modify such policies and procedures as necessary to address and resolve any concerns and issues reasonably raised by Aetna. 12. Aetna may audit the testing, policies and procedures, and other requirements under and in connection with this Schedule B (Benefit Plan Set Up) in accordance with Schedule X (Audits) and Article VII of the Agreement. 13. As provided in Sections 7.4, 9.8, and 9.12 of the Agreement and the Claims Errors/Corrections section of Schedule D (Claims Processing and Adjudication)**,** PBM shall be responsible and liable for Losses to the extent imposed on Aetna by an Aetna Customer and/or Law, related to errors in Benefit Plan Design (including Formularies) set up and administration, to the extent the error is not a result of incorrect Benefit Plan Design information provided by Aetna or otherwise caused by Aetna (in which cases the Losses and interest payments and/or penalties will be allocated according to each party's respective responsibility for such error).
Quality Assurance	14. PBM shall have a quality assurance program to ensure that the Benefit Plan Design (including Formularies) set-up and administration are provided in accordance with this Schedule B (Benefit Plan Set Up), and PBM shall provide to Aetna on a monthly basis the results of such quality assurance program.
Training	15. In a manner, location, and frequency reasonably acceptable to Aetna, subject to Section 11.5 and Article XIII of the Agreement, PBM shall provide initial and ongoing training for Aetna personnel with respect to

Service	Description
	developing an understanding of Benefit Plan Design (including Formularies) set up in the PBM claim adjudication system.

Appendix B

Amendment to Schedule E

Contact Services - Call Centers and Correspondence

Core Services

Section 18 of Schedule E shall be amended to read in its entirety as follows:

18. PBM shall maintain adequate capacity and functionality to support outbound calls as reasonably requested by Aetna. These may include scheduled campaigns, ad hoc initiatives, and remedial and discretionary constituent improvement activities, as discussed and agreed to by the Parties. Outreach may be to Members, pharmacies and/or pharmacists. Aetna will partner with PBM to develop and/or enhance call scripts and talking points as needed. PBM agrees to commence such outbound call activities within one (1) Business Day of Aetna's request. Adequate capacity is defined as the ability to resource a daily volume of outbound calls equal to .01% of Aetna's active Rx membership, but only for calls occurring on Tuesdays through Fridays on non-holidays unless calls are related to an urgent or emergency need. All Members shall be included in this measurement. Adequate capacity, as defined above, relates to PBM's ability to perform Core Services and does not preclude Aetna from seeking additional calls as an Optional Service. For purposes of this Section, urgent/emergency need shall be defined as any regulatory request (e.g., CMS, OIG, HHS and state agencies) or any situation involving individual Member access to care or cost-sharing impacts. In the event the demand for outbound calls exceeds 0.01% of Aetna's active Rx membership per day, PBM is not responsible for additional outbound calls. In the event PBM agrees to provide outbound calls in excess of the above 0.01% threshold, such incremental services shall incur an additional fee as outlined further in Schedule Y-7. Outbound calls that are the result of PBM's failure to meet its PBM Service obligations under Article III of the Agreement shall not count towards the 0.01% threshold. Additional fees for services beyond the 0.01% threshold shall not be payable to the extent the outbound calls are necessitated by defects in PBM Services.

The following shall be added to Schedule E as a new Section 45 and 46:

Outbound Calls	45. Upon Aetna's reasonable request, PBM shall provide outbound calls in excess of the thresholds identified in Item 18 of this Schedule E. These calls may include scheduled campaigns, ad hoc initiatives, and remedial and discretionary constituent improvement activities, as discussed and agreed to by the Parties. Outreach may be to Members, pharmacies, and/or pharmacists. If the outreach is relating to other pharmacy-related matters and includes other Providers, the parties will mutually agree to such outreach projects. Aetna will partner with PBM to develop and/or enhance call scripts and talking

	points as needed. PBM agrees to commence such outbound calls within one (1) Business Day of Aetna's request. PBM understands and agrees that due to regulatory or high impact issues, calls may be required to commence with same day notice, upon mutual agreement by the Parties, condition upon Aetna providing PBM with materials and training. PBM will make up to three (3) attempts to contact the other party. PBM agrees to provide appropriate administrative support for the outbound calls but will not provide call recording or non-standard reporting relating to such outbound calls. PBM will provide a status report at the end of each campaign, indicating who was successfully contacted, who was not reached after three (3) attempts, and any other relevant information. Daily reporting will be required to provide status to Aetna. Reporting will be in a format agreed to by Aetna, and will be timely and accurate. For pharmacy call campaigns, activity involving each individual pharmacy shall be consolidated so that only one set of call attempts is made to each individual pharmacy. For transition fill prescriber letter campaigns, Members who receive a transition fill letter, PBM agrees to send a corresponding letter to the Member's prescriber. Reimbursement for the cost of this mailing, including setup and daily mailing fees, will be billed to Aetna for PBM's actual cost (other than postage) plus postage in accordance with Schedule Y-7, Optional Services, effective January 1, 2015. Such charges are only applicable for transition fill letters sent under Aetna's consumer business platform. Aetna shall provide appropriate training, member target lists and scripting for the outbound calls. Pre-call research is performed by the appropriate Aetna and/or PBM business unit based on the nature of the request and/or issue.

Commercial Client Support Team	46. PBM shall establish and maintain a Commercial Client Support Team ("CCST") for the purpose of researching and resolving escalated Member issues. The Parties agree to meet in the near future, with the intention of establishing the service levels and staffing for the CCST to perform, which service levels and staffing shall be consistent with 2015. The Parties will establish

	these service levels and staffing levels by March 31, 2016. The CCST shall meet the following requirements: a. The CCST shall be accessible to Aetna from Monday through Friday and 7 AM CT to 10 PM CT. Voicemail shall be offered as an option to callers when hold time is expected to exceed 180 seconds. b. The CCST is established for the purpose of escalated Member issues requiring immediate attention and does not circumvent the normal Member escalation process set forth in Section 6 of this Schedule E. Aetna shall provide to PBM an "authorized caller list" to manage utilization of the CCST. Aetna personnel who are not on the authorized caller list will be instructed to contact PBM's PHL for assistance. c. Within the first calendar quarter of 2016, the Parties shall cooperate to establish a set of criteria for determining when CCST personnel may provide point of service overrides. Once finalized, PBM shall not provide overrides inconsistent with the criteria. d. At a minimum, the CCST shall respond to escalated Member inquiries in writing within two hours within business hours, except where special circumstances require additional work. e. PBM shall maintain a database, accessible to Aetna, recording all issues brought to the CCST and the resolution of those issues. The database will include a "flag" for any requests that appear to circumvent policy or plan design. Information stored in the database shall be archived for a period of two years (or such longer time required by Law). Commencing January of 2016, PBM shall also provide Aetna a monthly report showing the issues brought to the CCST and their resolution, identifying the reasoning for all overrides and those issues that are flagged for appearing to circumvent policy or plan design.

Appendix C

Schedule F-1

[Provided to PBM on even date herewith]

Schedule F-2

Description of Current Aetna Retrospective DUR Services

Program Name	Description	Assessment	Contact(s)	Outreach Content	Reporting *
Acute Frequency – Proton Pump Inhibitor Program	This program tests claims data to identify members on multiple daily dosing of a proton pump inhibitor regimen. This program promotes once-daily dosing of proton pump inhibitors.	Daily/ RPh reviewed	- Prescriber letter	- Prescriber letter - Patient Profiler - Prescriber Response form	- Outreach - Activity - Cost Savings
Brand to Generic (DAW1)	This program tests claims data to determine if a prescriber has written a "dispense as written" prescription for a brand drug that has an "A" rated generic equivalent available. There must be savings for both carrier and member. The member savings must be at least $1.00. The default savings threshold is defined by APM, but can be modified by the carrier.	Daily	- Prescriber letter	- Prescriber letter - Prescriber Response form	- Outreach - Activity - Cost Savings
Drug/Drug Interaction	This program tests claims data to identify members receiving two drugs** at the same time that are known to cause a clinically significant interaction.	Daily/ RPh reviewed	- Prescriber call - Pharmacy call - Patient call - Prescriber letter	- Prescriber letter - Patient Profile - Prescriber Response Form	- Outreach - Activity
High Utilization	This programs tests claims data to identify who have received more that "X" claims for specific controlled drugs** or drugs** of misuse in a calendar month. The default threshold is defined by APM at three (3) claims, but can be modified by the carrier.	Monthly RPh reviewed	- Prescriber letter	- Prescriber letter - Patient Profile - Prescriber Response form	- Outreach - Activity - Cost Savings

Retail to Mail	This program tests claims to data to identify who have had a maintenance prescription filled through a retail pharmacy while they have a mail plan available. There must be savings for both carrier and member if the prescription is filled through mail-service. The savings must be at least $1.00. The default savings threshold is defined by APM, but can be modified by the carrier.	Daily	- Patient letter	- Patient letter - Mail-service enrollment form - Patient Response Form - Business Reply Envelope specific to client's mail service facility	- Outreach - Activity - Cost Savings
Thera-peutic Duplication	This program tests claims data to identify members receiving two drugs** from the same therapeutic class at the same time.	Daily/ RPh reviewed	- Prescriber call - Pharmacy call - Prescriber letter	- Prescriber letter - Patient Profile - Prescriber response form	- Outreach - Activity - Cost Savings
Patient Safety-Suboxone or Subutex/ Opioid only at this time	This program tests claim data to identify members with a prescription filled for a targeted drug (Suboxone or Subutex) and member subsequently fills a prescription for a drug (opioid) that is contraindicated in combination after the target drug therapy has been started.	Daily	- Prescriber letter - Prescriber call--follow-up by Rx Misuse, Waste and Abuse pharmacist	- Prescriber letter - Patient Profile - Prescriber response form	- Outreach - Activity - Cost Savings
Controlled Substance	Identifies fully-insured members who meet the following criteria during a rolling three month period: eight or more prescriptions for controlled substances, obtain controlled substance prescriptions from three or more prescribers, and obtain controlled substances from	Monthly	- Prescriber letter - Member letter	- Prescriber letter - Patient Profile - Prescriber response form - Patient letter	- Outreach - Activity - Cost Savings

	three or more pharmacies.				
Thera-peutic Optim-ization	This program identifies opportunities for once daily drugs that are frequently prescribed at lower doses for multiple daily dosing. The program suggests decreasing the frequency and increasing the dose accordingly.	Daily	- Prescriber letter	- Prescriber letter - Prescriber response form	- Outreach - Activity - Cost Savings
Stream-lining Therapy	This program identifies members newly placed on combination corticosteroid/long-acting beta agonist (LABA) inhalers, including Advair, Symbicort, and Dulera who have not tried a corticosteroid inhaler alone. Current guidelines from NHLBI for asthma treatment recommend the use of an inhaled corticosteroid prior to the addition of a long-acting beta-agonist.	Daily	- Prescriber letter	- Prescriber letter - Prescriber response form	- Outreach - Activity - Cost Savings
Length of Therapy	This program identifies members who have been taking medications longer than approved by the FDA or supported by clinical evidence. Drugs that are included in the Length of Therapy program have well-defined treatment courses and may present a potential safety concern when used beyond recommended time limits.	Daily/ RPh reviewed	- Prescriber letter	- Prescriber letter - Patient Profile containing only identified drug - Prescriber response form	- Outreach - Activity - Cost Savings
Maximum Dose	This program will identify members on daily doses of medication that are higher than what is supported in product literature.	Daily/ RPh reviewed	- Prescriber letter	- Prescriber letter - Prescriber response form	- Outreach - Activity - Cost Savings
Prescribing Cascade	Identify situations for members in which a	Daily/ RPh	- Prescriber letter	- Prescriber letter	- Outreach - Activity

	medication is prescribed to treat a side effect of another medication. In certain instances a physician may not realize that a member complaint is the result of a medication and inadvertently prescribe an additional medication to treat the side effect, rather than taking more appropriate action such as changing the offending medication or reducing the dose.	reviewed		- Prescriber response form	- Cost Savings

*Outreach reports are generated within the month following the outreach period. Activity reports are generated five (5) months and Cost Savings Reports are generated five (5) months or twelve (12) months following their respective Outreach period.

**The drug(s) analyzed per program are specified by Aetna's clinical staff as part of the program's criteria.

Aetna Rx Check program - Acute Frequency Program	1. PBM shall comply with Aetna Policies for acute frequency programs. 2. PBM shall identify and report, on a daily basis, each Acute Frequency Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 3. PBM shall require a DUR pharmacist to review each Acute Frequency Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 4. PBM shall send follow-up intervention letters to prescribers in accordance with Aetna Policies. 5. PBM shall enter responses received by prescribers into the appropriate PBM database.
Aetna Rx Check program - Drug/Drug Interaction Program	6. PBM shall comply with Aetna Policies for drug interaction programs. 7. PBM shall identify and report, on a daily basis, each Drug/Drug Interaction Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 8. PBM shall require a DUR pharmacist to review each Drug/Drug Interaction Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim.

	9. Phone interventions for this program are done by the DUR pharmacist and are primarily pharmacy-directed interventions, but at the discretion of the DUR pharmacist, prescribers or Members may be contacted by telephone. 10. Upon Aetna's approval, PBM shall send intervention packets to prescribers, consisting of a letter identifying the Member and the interacting drugs, and a response form to be filled out by said prescribers to provide feedback regarding the drug-drug interaction program. 11. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the duplicate therapy, and a response form to be filled out by prescriber to provide feedback regarding the therapeutic duplication program. PBM shall enter responses received by prescribers into the appropriate PBM database.
Aetna Rx Check program - High Utilization Program (Core Safety and Monitoring)	12. PBM shall comply with Aetna Policies for high utilization programs. 13. PBM shall identify, on a monthly basis, High Utilization Claims as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 14. PBM shall require a DUR pharmacist to review each High Utilization Claim to determine whether intervention is necessary. 15. Upon Aetna's approval, PBM shall send intervention packets to prescribers, consisting of a letter identifying the Member and the high utilization drugs used, Member drug history profile listing Claims for the previous four (4) months, and a response form to be filled out by said prescribers to provide feedback regarding high utilization. 16. PBM shall require the DUR pharmacist or administrative staff to enter an ICD-9 code if provided by a prescriber. 17. PBM shall send follow-up intervention letters to prescribers in accordance with Aetna Policies. 18. PBM shall enter responses received by prescribers into the appropriate PBM database.
Aetna Rx Check program - Therapeutic Duplication Program	19. PBM shall comply with Aetna Policies for therapeutic duplication programs. 20. PBM shall identify and report, on a daily basis, each Therapeutic Duplication Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 21. PBM shall require a DUR pharmacist to review each Therapeutic

	Duplication Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 22. PBM shall, as necessary, require phone interventions, with pharmacies, prescribers or Members, at the DUR pharmacist's discretion. 23. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the duplicate therapy, and a response form to be filled out by said prescribers to provide feedback regarding the therapeutic duplication program. 24. PBM shall send subsequent intervention packets to prescribers if the prescriber has responded and indicated that they would eliminate the duplicate therapy and the subsequent Claims history does not correlate with the response. 25. PBM shall enter responses received by prescribers into the appropriate PBM database.
Aetna Rx Check program - Brand Drug to Generic Drug Program	26. PBM shall comply with Aetna Policies for Brand Drug to Generic Drug programs. 27. PBM shall complete review of each identified Brand Drug to Generic Drug opportunity within forty-eight (48) hours after an eight (8) calendar day waiting period in accordance with Aetna specifications. 28. Upon Aetna's approval, PBM shall send intervention packets to prescribers, consisting of a letter identifying the Member, the Brand Drug medication identified, Member Brand Drug Cost Share, Member Generic Drug Cost Share, savings for the Member, savings for the Covered Plan, and a response form to be filled out by said prescribers to provide feedback regarding the Brand Drug to Generic Drug program. 29. PBM shall send follow-up intervention letters to prescribers in accordance with Aetna Policies. 30. PBM shall enter responses received by prescribers into the appropriate PBM database.
Aetna Rx Check program - Retail to Mail Program	31. PBM shall comply with Aetna Policies for return to mail programs. 32. PBM shall complete review of each identified Claim of a maintenance medication being filled at a retail pharmacy within forty-eight (48) hours after an eight (8) calendar day waiting period in accordance with Aetna specifications. 33. Upon Aetna's approval, PBM shall send intervention packets to Members, consisting of a letter identifying the specific maintenance medication the Member had filled at a retail pharmacy, cost savings

	for a 90-day supply of the identified medication at mail order, instruction on obtaining a new prescription for a 90-day supply of medication; standard mail order enrollment form; Member response form to provide any feedback regarding the return to mail program. 34. PBM shall send follow-up intervention letters to Member in accordance with Aetna Policies. 35. PBM shall enter responses received by Members into the appropriate PBM database.
Patient Safety– Identifies members receiving an opioid after receiving Suboxone/Subutex (for opioid dependence) which is known to cause a clinically significant interaction	36. PBM shall comply with Aetna Policies for Patient Safety programs. 37. PBM shall identify and report, on a daily basis, each Patient Safety Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 38. PBM shall require a DUR pharmacist to review each Patient Safety Claim to determine whether intervention is necessary within forty-eight (48) hours of receipt of the Claim. 39. PBM shall, as necessary, require phone interventions, with pharmacies, prescribers or Members, at the DUR pharmacist's discretion
Controlled Substance	40. PBM shall comply with Aetna Policies for Controlled Substance program. 41. PBM shall identify, on a monthly basis, Controlled Substance Claims as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 42. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the duplicate therapy, and a response form to be filled out by said prescribers to provide feedback regarding the Controlled Substance program. 43. PBM shall send follow-up intervention letters to Member in accordance with Aetna Policies. 44. PBM shall enter responses received by Members into the appropriate PBM database.
Therapeutic Optimization	45. PBM shall comply with Aetna Policies for Therapeutic Optimization program. 46. PBM shall identify and report, on a daily basis, each Therapeutic Optimization Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 47. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the therapeutic optimization, and a response form to be filled

	out by said prescribers to provide feedback regarding the therapeutic optimization program. 48. PBM shall enter responses received by Members into the appropriate PBM database.
Streamlining Therapy	49. PBM shall comply with Aetna Policies for Streamlining Therapy program. 50. PBM shall identify and report, on a daily basis, each Streamlining Therapy Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 51. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the streamlining therapy opportunity, and a response form to be filled out by said prescribers to provide feedback regarding the therapeutic optimization program. 52. PBM shall enter responses received by Members into the appropriate PBM database.
Length of Therapy	53. PBM shall comply with Aetna Policies for Length of Therapy program. 54. PBM shall identify and report, on a daily basis, each Length of Therapy Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 55. PBM shall require a DUR pharmacist to review each Length of Therapy Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 56. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the length of therapy opportunity, and a response form to be filled out by said prescribers to provide feedback regarding the length of therapy program. 57. PBM shall send subsequent intervention packets to prescribers if the prescriber has responded and indicated that they would eliminate the length of therapy and the subsequent Claims history does not correlate with the response. 58. PBM shall enter responses received by Members into the appropriate PBM database.
Maximum Dose	59. PBM shall comply with Aetna Policies for Maximum Dose program. 60. PBM shall identify and report, on a daily basis, Maximum Dose Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time.

	61. PBM shall require a DUR pharmacist to review each Maximum Dose Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 62. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the maximum dose opportunity, and a response form to be filled out by said prescribers to provide feedback regarding the therapeutic optimization program. 63. PBM shall send subsequent intervention packets to prescribers if the prescriber has responded and indicated that they would eliminate or modify the maximum dose and the subsequent Claims history does not correlate with the response. 64. PBM shall enter responses received by Members into the appropriate PBM database.
Prescribing Cascade	65. PBM shall comply with Aetna Policies for Prescribing Cascade programs. 66. PBM shall identify and report, on a daily basis, each Prescribing Cascade Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 67. PBM shall require a DUR pharmacist to review each Prescribing Cascade Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 68. PBM shall, as necessary, require phone interventions, with pharmacies, prescribers or Members, at the DUR pharmacist's discretion. 69. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the Prescribing Cascade opportunity, and a response form to be filled out by said prescribers to provide feedback regarding the Prescribing Cascade program. 70. PBM shall send subsequent intervention packets to prescribers if the prescriber has responded and indicated that they would eliminate or modify the prescribing cascade and the subsequent Claims history does not correlate with the response. 71. PBM shall enter responses received by prescribers into the appropriate PBM database.

Schedule F-3

Additional PBM Core Services

Clinical Programs	**PBM to Perform as part of their Core service**
	Base SVC
Pharmacy Programs	
Prior Authorization	X
Step Therapy	X
Quantity Limits	X
Age Appropriate Management (Age & Gender Edits)	X
Drugs to avoid in the elderly Edits	X
Refill too soon	X
Duration of Therapy Management (Cumulative Refill Edits)	X
Drug Interaction Management (Drug to Drug / Drug to Disease Edits)	X
Dose Optimization Management	X
Therapeutic Duplication Management	X
Retail to Mail	X
Patient Safety	X
100 dose limit edit	X
Max Pay edit	X
Transition Fill	X
Transition of Coverage	X
Electronic Prior Authorization	X

Appendix D

Schedule I

Rebate Administration

Core Services

Service	Description
Overview	1. This Schedule I reflects the terms of the Parties as agreed upon for the Rebate Administration services to be provided by PBM and the functionality of the computer systems used by PBM to administer its manufacturer rebates (the "PBM Rebate Administration Computer System"). The Parties agree that the use of the PBM Rebate Administration Computer System as contemplated by this Schedule I are included within the core pricing under the Agreement without any additional charge. Pursuant to Section 11.4(a) of the Agreement, PBM hereby grants Aetna a license to use the PBM Rebate Administration Computer System as set forth in this Schedule I. 2. The Effective Date of this Schedule I is January 1, 2013. As of such Effective Date, , Aetna opted to use the PBM Rebate Administration Computer System to administer Aetna Rebate Agreements. At any time, Aetna may elect upon written notice to PBM to no longer utilize the PBM Rebate Administration Computer System. The terms and conditions contained in this Schedule I (Rebate Administration), and the accepted PBM Rebate Proposal, contain the necessary processes and procedures and other Aetna requirements for administering Aetna Rebate Agreements via the PBM Rebate Administration Computer System. 3. The Parties agree that in the event the Agreement is terminated pursuant to Article XII, and notwithstanding anything to the contrary therein, Aetna shall have the right to exercise an option to continue utilizing the PBM Rebate Administration Computer System subsequent to any termination of the Agreement. This option shall continue for a period not to exceed three (3) years post termination of the Agreement. All of the terms and conditions of this Schedule I, as may be further amended, shall continue to be in full force and effect post the effective date of termination of the Agreement through the end of the option period as determined by Aetna. The Parties agree to negotiate in good faith to execute any necessary agreement in support of Aetna's exercise of this option period. The Parties

	agree that the terms and conditions of any such agreement shall not conflict with the terms and conditions already agreed to in this Schedule I, unless the Parties mutually agree to such terms. 4. Subject to the terms and conditions of the Agreement, PBM will fully support Aetna as needed and permit Aetna to access the PBM Rebate Administration Computer System to enable Aetna to fully administer Aetna Rebate Agreements as further described in the Agreement and this Schedule I. 5. In accordance with the terms and conditions of the Agreement, including this Schedule I, the PBM Rebate Administration Computer System shall be fully capable of, among other things, generating all invoices, tracking the receipt of all Aetna Rebates and allocating such Aetna Rebate amounts to enable Aetna to retain or to distribute the Rebates appropriately to Aetna's Affiliates and Aetna Customers in the manner required by Aetna. 6. PBM represents and warrants that the Rebate Administration Computer System can satisfactorily perform all of the services and functions described in this Schedule I. The Parties acknowledge that certain functionality set forth in Section 8.T of this Schedule I shall be delivered by the dates set forth herein unless otherwise agreed to by the Parties. PBM represents and warrants that the Rebate Administration Computer System will be able to satisfactorily perform such functionality upon the date such functionality is delivered to Aetna. 7. PBM further warrants that, during the term of Aetna's use of the PBM Rebate Administration Computer System as set forth herein (which shall include the option period exercised by Aetna as set forth above), the PBM Rebate Administration Computer System will conform to the written technical specifications and perform the functions described in this Schedule I and any related documentation, including functional specifications. During such period, PBM will maintain and support the PBM Rebate Administration Computer System at no charge to Aetna. Such maintenance and support services include PBM using its reasonable commercial efforts to correct promptly any errors or bugs in the PBM Rebate Administration Computer System (including compliance with Section 8.S of this Schedule I), supplying the correction to Aetna in a timely fashion and answering questions that Aetna may have regarding the PBM Rebate Administration Computer System. Other than scheduled maintenance and code pushes, PBM additionally warrants that the PBM Rebate Administration Computer System will be free from material interruptions, delays, errors, omissions or defects; will not adversely affect the performance of any software, firmware, hardware or system utilized by Aetna and/or any of its Aetna Plan Affiliates, Aetna Customers or other users; and with respect to the PBM Rebate Administration Computer System and related services, will be rendered in compliance with all

applicable laws, rules and regulations and in accordance with the performance standards set forth in the Agreement, including but not limited to Section 3.5 of the Agreement.

8. PBM shall ensure, and the PBM Rebate Administration Computer System shall provide all of the following capabilities and functionality on an "on-demand" basis, twenty-four (24) hours a day, seven (7) days a week, unless otherwise stated, as of the Effective Date of this Schedule I :

A. ADJUDICATED CLAIMS FLOW

1) PBM shall ensure that all Claims from all applicable platforms are available for Aetna to review through a re-validation process within the PBM Rebate Administration Computer System. This includes but is not limited to (a) pharmacy Claims adjudicated on both Aetna and PBM claim adjudication platforms, including those claims paid out of a member's medical benefit and (b) medically paid Claims (including but not limited to injectable and specialty drugs). Pharmacy Claims shall be viewable within the PBM Rebate Administration Computer System within seventy two (72) hours of Claim processing. Medical Claims shall be viewable within the PBM Rebate Administration Computer System within five (5) days of Aetna's transfer of the medical Claim file to PBM. PBM agrees it will consult with and get Aetna's approval before performing the monthly Claims period lock for Claims on the Aetna partition of the PBM Rebate Administration Computer System and will not do so before three (3) Business Days subsequent to the last calendar day of the previous month, unless specifically directed to do so by Aetna.

2) PBM shall ensure that any Claims that fall out due to missing information can be reviewed by Aetna in the PBM Rebate Administration Computer System.

3) PBM shall ensure that all Claims eligible for Rebates in accordance with the terms of Aetna Rebate Agreements are made available and viewable in PBM Rebate Administration Computer System within twenty-four (24) hours after Aetna approves PBM to perform Claim Lock. Claim Lock is the process whereby PBM finalizes the Claims for any Invoicing Period determined by Aetna such that neither PBM nor Aetna can add or delete Claims to be invoiced for the Invoicing Period. Invoicing Period shall be that period(s) of time (e.g., monthly or quarterly) as determined by Aetna and communicated to PBM, which includes all Claims to be invoiced by Aetna to drug manufacturers in accordance with the Aetna Rebate Agreements. For purposes of this Schedule I, "Invoicing Period" shall be defined as the period whereby manufacturers are invoiced by Aetna, which shall

occur no more frequently than monthly.

4) PBM Rebate Administration Computer System shall allow Aetna to invoice Claims for Rebates for any Invoicing Period to include all Claims with dates of service in any calendar quarter but processed in a subsequent calendar quarter which includes the Invoicing Period.

5) PBM Rebate Administration Computer System shall allow Aetna to invoice Claims for Rebates for any Invoicing Period to include all Claims paid within one hundred eighty (180) days prior to the end of the Invoicing Period.

B. REGISTRATION OF CUSTOMERS

1) PBM Rebate Administration Computer System shall enable Aetna to enter Customer information necessary (as determined by Aetna) for Rebate processing and/or payment of Rebates to Aetna Customers. This Customer information shall be at the level of detail specified by Aetna, and include, but not be limited to, Customer name, effective dates, group identifiers including carrier, account and group, joint venture identifiers including Organization ID, Organization Type and Organization Arrangement, Claim source, Plan design including but not limited to 100% copay, and Customer Rebate share terms. Subject to Section 8.U of this Schedule I, Aetna may request additional fields for Customer information and PBM shall implement such fields on the PBM Rebate Administration in a reasonable timeframe

2) PBM shall ensure that all applications of the PBM Rebate Administration Computer System, which need to read and process Customer information as referenced in Section 8.B. 1) above of this Schedule I, can accurately and timely update, read, process, and communicate all Customer information to any other necessary Aetna or PBM system.

3) PBM shall generate Claim fall out reports in order to identify Customers that are not correctly loaded into the Customer registration application of the system.

4) PBM Rebate Administration Computer System shall enable Aetna to edit Customer pricing information.

5) PBM Rebate Administration Computer System shall enable Aetna to add or terminate Customers. This includes but is not limited to Customers assigned to 100% copay plan

	designs. 6) Subject to Section 8.T of this Schedule I, the Rebate Administration Computer System shall identify Customers by risk indicators. 7) PBM shall ensure that the Rebate Administration Computer System accurately reflects all terminated Customers as terminated Customers with correct termination dates based on termination dates loaded into PBM Rebate Administration Computer System. C. PBM SET UP ACTIVITIES: 1) PBM shall load all drug manufacturers contracted with Aetna and all drug classes into the PBM Rebate Administration Computer System initially. After this initial set-up, PBM shall load all manufacturers subsequently contracted with Aetna and new drug classes or modifications to existing drug classes by such dates as reasonably requested by Aetna into PBM Rebate Administration Computer System. PBM shall make adjustments to drug classes and/or manufacturer set up as requested by Aetna. 2) PBM shall convert aberrant Claim unit quantities to correct unit quantities in the PBM Rebate Administration Computer System and as requested by Aetna. D. AETNA CONTRACT LOAD: 1) The PBM Rebate Administration Computer System shall enable Aetna to add/load Rebate Contracts into the system or modify Rebate Contracts within the system. This includes but is not limited to (a) contract effective dates (b) custom exclusions (c) market share terms (d) price protection terms (e) drug name (f) rebate rate (g) payment due date, and (h) pricing terms (e.g. WAC). E. MOCK INVOICING: 1) The PBM Rebate Administration Computer System shall enable Aetna to run all reporting related to test or “mock” invoicing at any point in time based on date parameters such as accrual (monthly), test (quarterly), or point in time basis.

F. DATA/FILE TRANSFER:

1) PBM shall ensure that a data repository is set up within the PBM Rebate Administration Computer System to enable Aetna and PBM to exchange data files and information through an Aetna approved file transfer process.

2) PBM shall send data files and information requested by Aetna within a reasonable timeframe as requested by Aetna utilizing the PBM Rebate Administration Computer System's data repository and Aetna endorsed file transfer process.

G. CLAIM RECONCILIATION:

1) PBM shall reconcile all Claims data within the source data warehouse application against all Claims data loaded in the PBM Rebate Administration Computer System within seven (7) days subsequent to the end of each Invoicing Period. PBM shall provide a report in the format requested by Aetna of such reconciliation and all discrepancies within seven (7) days subsequent to the end of each Invoicing Period. This reporting shall include but not be limited to: (a) pharmacy and medical claim aberrant claim quantity files; (b) Invoiced eligible claims by carrier; (c) all necessary claim fallout reports including but not limited to Carrier/Account/Groups not registered, self-insured groups mapped to risk rebate ID and self-insured groups mapped to Med D IDs.

2) PBM shall reasonably assist Aetna as requested by researching material discrepancies (greater than one half percent (0.5 %) of Claims being reconciled are discrepant.

3) Aetna shall provide written approval to PBM prior to PBM performing Claim Lock for any Invoicing Period. PBM shall perform Claim Lock within twenty-four (24) hours of written Aetna approval.

H. REBATE INVOICING:

1) The PBM Rebate Administration Computer System shall enable Aetna to modify drug classes by adding and/or deleting drugs from a drug class on a unique contract basis.

2) No later than four (4) business days subsequent to the end of any Invoicing Period, the

	PBM Rebate Administration Computer System shall enable Aetna to run reports at an NDC level including but not limited to, preliminary invoice summary reports, market share reports and exclusion reports. 3) No later than two (2) hours after the Claim Lock, the PBM Rebate Administration Computer System shall enable Aetna to generate Rebate invoices for all contracted manufacturers and consolidate all reports, as selected by Aetna, into one summary report for each Aetna Rebate Contract showing aggregated Claim information, without PHI, separated by book of business (e.g., commercial, Medicare, or such other business as determined by Aetna). 4) No later than two (2) hours after the Claim Lock, the PBM Rebate Administration Computer System shall enable Aetna to generate NCPDP 4.01 formatted detail claim level reports. 5) Within two (2) hours following Aetna's generation of Rebate invoices for each Invoicing Period, the PBM Rebate Administration Computer System shall enable Aetna to burn all applicable files generated from the system to disk. 6) No later than thirty (30) business days subsequent to the end of each Invoicing Period, PBM shall complete the "All Processed Claim" process which enables all rebate invoiced Claims to flow into downstream rebate applications within the PBM Rebate Administration Computer System. I. <u>BUSINESS REPORTING NEEDS:</u> 1) No later than thirty (30) business days subsequent to the end of each Invoicing Period, the PBM Rebate Administration Computer System shall enable Aetna to generate all actual rebated Claims at a detail Claim level for each particular Invoice Period. This includes reporting that supports invoicing, planning/forecasting, and audit requests by manufacturers, regulatory and/or government agencies and Customers. 2) No later than five (5) business days subsequent to the end of each Invoicing Period, the PBM Rebate Administration Computer System shall provide Aetna with forecast model and trend reporting for future Invoice Periods. 3) No later than thirty (30) business days subsequent to the end of each Invoicing Period, the

	PBM Rebate Administration Computer System shall enable Aetna to compare Claims invoiced for Rebates vs. received Claims at a Claim level detail for each particular Invoice Period. 4) No later than thirty (30) business days subsequent to the end of each Invoicing Period, the PBM Rebate Administration Computer System shall enable Aetna to access all Aetna Rebate information at a detailed Claim level for each such Invoicing Period. 5) Subject to Section 8.T of this Schedule I, the PBM Rebate Administration Computer System shall be able to map blank funding indicators to "risk" indicators. 6) Subject to Section 8.T of this Schedule I, the PBM Rebate Administration Computer System shall be able to identify all Claims paid out of Members' medical benefits and all Claims paid out of Members' pharmacy benefits. Aetna shall have access to PBM's claim adjudication application to look up Claims as needed. J. <u>PAYMENT RECONCILIATION:</u> 1) The PBM Rebate Administration Computer System shall enable Aetna to post payment received from pharmaceutical drug manufacturers in the system. 2) The PBM Rebate Administration Computer System shall enable Aetna to reconcile received Rebates to invoiced Rebates at a Claim level in the system. 3) The PBM Rebate Administration Computer System shall enable Aetna shall to approve variances of payment received vs. payment invoiced at multiple dollar limits as determined by Aetna, within the system. 4) The PBM Rebate Administration Computer System shall enable Aetna to post adjustments to all Rebate invoices in the system. 5) The PBM Rebate Administration Computer System shall perform data comparisons between the Invoicing Cash Reconciliation application and the downstream Rebate applications. 6) The PBM Rebate Administration Computer System, including all its rebate applications, shall accurately report all Rebate amounts invoiced, collected and due from all

manufacturers, and all invoice adjustments.

7) No later than twenty-four (24) hours after the daily reconciliation of the records by PBM, the system shall enable Aetna to pull all reporting needed by Aetna and related to the system's "Cash Reconciliation" function.

K. AUDITS:

1) Plan sponsor audits: The PBM Rebate Administration Computer System shall produce all reports requested by Aetna for Customer Audits, which shall include but not be limited to the following fields in such reports, and any other fields reasonably requested by Aetna: Claim reference number, mail/retail indicator, dispense date, NDC, Drug Name, Manufacturer name, Ingredient cost, dispense fee, Tax, Plan Pay Amount, Member Co-pay Amount, Quantity, Days Supply, CAG (Carrier Account Group)Accounting Period, WAC Price, Contracted rebate rate, Rebate dollars invoiced, Rebate dollars received, and Invoicing Period.

2) Manufacturer audits: The PBM Rebate Administration Computer System shall produce all reports requested by Aetna for manufacturer audits and shall include all Claim level detail fields and Rebate information as requested by Aetna, including but not limited to Claim reference number, WAC price, units, manufacturer name, dispense date, Invoicing Period, Customer name, Customer ID, invoice quarter/year, and any other fields reasonably requested by Aetna and required for the audit.

3) Government audits: The PBM Rebate Administration Computer System shall produce all reports requested by Aetna for government audits and shall include all Claim level detail fields and Rebate information as requested by Aetna, and any other fields reasonably requested by Aetna and required for the audit.

4) In accordance with Schedule X Audits and when requested by Aetna, PBM agrees to provide reasonable assistance to Aetna in response to requests for audits of Aetna's Rebate Contracts.

L. CUSTOMER REBATE PAYMENT ALLOCATION AND DISBURSEMENTS:

1) The PBM Rebate Administration Computer System shall enable Aetna to obtain a current

	list of all Customers not receiving Rebate payments for any Invoice Period. 2) The PBM Rebate Administration Computer System shall enable Aetna to place all Customers not receiving Rebate payments for any Invoice Period in a Hold Status. Hold Status shall mean that dollars have been calculated as payable to Customer by system but all or part of that payment is currently withheld from the payment process for varying reasons. 3) The PBM Rebate Administration Computer System shall enable Aetna to adjust Rebate amounts showing as owed to Customers and perform "overrides" on such amounts. 4) No later than forty-five (45) days subsequent to the end of any Invoicing Period, the PBM Rebate Administration Computer System shall enable Aetna to accurately process and complete payments to all Customers for each Invoice Period. 5) No later than forty-five (45) days after the end of each Invoicing Period, the PBM Rebate Administration Computer System shall generate a Customer Rebate payment reports that shows, for each Invoicing Period, all Rebate payments collected from each manufacturer and correctly allocated for disbursement to each Customer. Within three (3) Business Days of Aetna's request, the PBM Rebate Administration Computer System shall generate a Customer Rebate report for any Customer that correctly shows all Rebate payments collected from each manufacturer and correctly allocated for disbursement to each Customer, for any prior period of time requested by Aetna. 6) No later than fifteen (15) days subsequent to the end of each Invoicing Period, the PBM Rebate Administration Computer System shall enable Aetna to complete Rebate payments to Customers in advance of Rebate payments being received from manufacturers (e.g., minimum payment guarantees). 7) The PBM Rebate Administration Computer System shall at all times calculate Customer rebate payments accurately based on contractual terms entered by Aetna into the system. 8) The PBM Rebate Administration Computer System shall accurately store information related to Customer Hold Status and Customer Rebate allocation, adjustments and payments, and enable Aetna to compare Customer groups in Hold Status to Client Sub-ledger reporting in the system. 9) The PBM Rebate Administration Computer System shall enable Aetna to run final Client

Sub-ledger reports on the system.

10) Subject to the system existing capabilities, the PBM Rebate Administration Computer System shall enable Aetna to make changes to all Customer and/or Rebate related information in the system and accurately save and process such changes and information.

11) The PBM Rebate Administration Computer System shall generate upon request by Aetna, Customer specific Rebate distribution statements that accurately state the Rebate amounts due to Customer, if and as adjusted by Aetna, identifiable by Invoicing Period.

M. ACCOUNTS RECEIVABLE REPORTING:

1) The PBM Rebate Administration Computer System shall enable Aetna to view the current status of invoiced, collected and outstanding Rebates by manufacturer by book of business (e.g., commercial, Medicare or such other business as defined by Aetna).

2) The PBM Rebate Administration Computer System shall enable Aetna to view and run reports of accounts receivable "aging" (e.g., 30, 60, or 90 days past due) by manufacturer by book of business (e.g., commercial, Medicare or such other business as defined by Aetna).

N. DATA RETENTION:

1) PBM shall store and make available to Aetna on the PBM Rebate Administration Computer System all Rebate invoiced Claim information as listed on electronic invoice to manufacturer for at least ten (10) years from the date of service of the Claim. PBM shall store and make available to Aetna on the PBM Rebate Administration Computer System all other Rebate and/or Customer related information to include Customer contractual payment terms, and earned and paid Rebates entered into and/or generated by the system for at least ten (10) years from the date of entry/generation of the Rebate and/or Customer related information. For avoidance of doubt, Aetna Customer Rebate payment information or adjustments thereto will be stored at a Customer level after four (4) years.

O. GENERAL LEDGER REPORTING:

1) In accordance with the time frames identified below, PBM shall produce for Aetna three

	(3) Claim based files:(1) Original Invoice File; (2) Estimate File and (3) Adjustments File. The files will contain all Aetna required data (including but not limited to Member CUMB ID). PBM shall enhance these files to include or exclude new Aetna carrier identifiers on these files at no cost to Aetna as new Aetna carriers are created. 2) Upon request by Aetna, PBM shall make any corrections to these files no later than five (5) days after such request. ***a)*** ***Original Invoice File***: No later than thirty-three (33) days subsequent to the end of each Invoicing Period, PBM shall produce and provide to Aetna the Original Invoice File which shall contain all the originally invoiced Claims for Rebates and the Rebates by Invoicing Period. Each Original Invoice File shall identify the Invoicing Period and contain every Claim that was invoiced for Rebates and the Rebates in that Invoicing Period. ***b)*** ***Estimate File***: No later than seven (7) business days prior to each calendar month's end, PBM shall produce and provide to Aetna the Estimate File which shall contain Aetna claims with invoice eligible dates from the beginning of the quarter to the pre-determined end point. ***c)*** ***Adjustments File:*** The PBM Rebate Administration Computer System shall enable Aetna to submit a Heat Ticket to request production of Adjustment Files for the requested Invoicing Period, which shall contain all Claims originally invoiced for Rebates and all Claims for Rebates which were adjusted or modified by Aetna after originally being submitted for Rebates for the Invoiced Period requested. Aetna shall make separate requests for each calendar quarter, and may request and shall receive such Adjustment Files at any time for any Invoicing Period that is past, up to and including four (4) years prior to the request date. 3) All files identified in this Section O of this Schedule I, shall use the same file layout and details as are present in PBM's ITPR004713 file format.

	P. <u>STANDARD AND AD HOC REPORTING DATA ACCESS:</u> 1) PBM Rebate Administration Computer System shall provide Aetna access to all of the following applications and tools, any successor applications and tools, and to any other applications and tools as agreed to by the Parties: (i) MS Access and Toad capability (query tools), MS Excel (download) (ii) GDX BI Tool (Invoiced Claim Actual and Trend reporting) (iii) RPS Datamart (Invoiced Claim including client detail) (iv) Rx Metrics (manufacturer reporting – invoice support) (v) SAP (Accounts Receivable) (vi) EDW and Claim Adjudication query access (audit support) (vii) TelNet (password/set-up maintenance) Q. <u>ONGOING SUPPORT:</u> 1) PBM shall provide, at no cost to Aetna, during business hours, mutually agreed upon appropriate support which shall be no less than one (1) full time analyst to assist Aetna with the pharmaceutical Rebate invoicing and reconciliation applications and no less than one full time analyst to assist Aetna with the "Client Registration System," "Rebate Payment System," and "Rebate Payment System Datamart." R. <u>SYSTEM ACCESS</u> 1) PBM shall provide to Aetna access to the following applications, any successor applications, and to any other application agreed to by the Parties: - Application to register Aetna customers for rebate payment and eligibility *(current application: Client Registration).* - Application to perform drug manufacturer invoicing *(current application: GDX).* - Application to produce rebate and market share reporting to be distributed to drug manufacturers *(current application: RX Metrics).* - Application to perform cash posting/reconciliation activities as well as standard/ad hoc invoiced claims related reporting *(current application: GDX Business Intelligence Tool and*

GDX Cash Reconciliation).

- Application to perform reconciliation of claims received from manufacturer vs. invoiced *(current application: Backup File Formatter).*
- Application to analyze invoice and collected rebates and to perform accounts receivable functions *(current application: SAP).*
- Application to perform rebate share allocation and payment to plan sponsor including production of plan sponsor statements *(current application: Rebate Payment System).*
- Application to report on invoiced and collected claims at a detailed claim level including but not limited to Medicare DIR reporting, plan sponsor reporting and rebate trend reporting *(current application: RPS Datamart).*

S. SYSTEM PERFORMANCE:

1) PBM shall be reasonably available to Aetna to address any questions related to all activities described in this Schedule I.
2) PBM shall notify Aetna in writing in advance of all planned system backups impacting the PBM Rebate Administration Computer System and provide a complete future backup schedule to Aetna every three (3) months and as updated. PBM shall ensure that the PBM Rebate Administration Computer System remains available for Aetna's use during backup times.
3) PBM shall notify Aetna of all planned system outages impacting the PBM Rebate Administration Computer System and provide reasonable notice of any complete future maintenance and provide reasonable notice for any planned system code updates to Aetna every three (3) months and as updated.
4) PBM will notify Aetna immediately of any unplanned system outages and system issues affecting Aetna's use of the system and shall escalate any unplanned system outages and system issues to the level of authority required to fix the issue most expeditiously.
5) Disaster Recovery: In the event of a disaster, PBM shall ensure that the PBM Rebate Administration Computer System is made available to Aetna within 72 hours.
6) PBM shall provide initial response to all Aetna inquiries on system defects or issues with

the system within (six) 6 business hours of request.

7) PBM shall assist Aetna in initiating any problem tickets to PBM's IT department. Status updates shall be provided by PBM to Aetna on a daily basis or sooner as requested by Aetna.

8) PBM Rebate Administration Computer System issue support shall be designed to address Aetna rebate problem tickets with designated personnel.

9) PBM IT support shall be available to Aetna upon request through PBM consistent with the terms of Schedule U.

10) PBM's business team personnel will be available to respond to after business hour questions and to triage the issue prior to the start of the next business day.

T. SYSTEM FUNCTIONS IN PROGRESS

1) In response to Aetna's request submitted to the Joint Work Intake Committee (JWIC) and as directed by Aetna, PBM shall implement a solution within the Rebate Administration Computer System so that there is an automated process which assigns all Customers to the proper Customer default rebate ID on a date mutually agreed to by the parties which shall be no later than March 31, 2015.

2) In response to Aetna's request submitted to the Joint Work Intake Committee (JWIC) and as directed by Aetna, PBM shall implement a solution within the Rebate Administration Computer System to correctly identify and distinguish all Claims paid out of members' medical benefits and all Claims paid out of Members' pharmacy benefits on a date mutually agreed to by the parties which shall be no later than December 31, 2015.

3) In response to Aetna's request submitted to the Joint Work Intake Committee (JWIC) and as directed by Aetna, PBM shall implement a solution in the Rebate Administration Computer System that a) assigns all Assurant carrier account group combinations to a "non-risk" indictor; and b) defaults all remaining non-Assurant Claims with blank risk indicators to "risk" on a date mutually agreed to by the parties which shall be no later than March 31, 2015.

4) As reasonably requested by Aetna, and mutually agreed to by the parties, PBM shall

	implement a solution in the Rebate Administration Computer System to include "Option Codes" as defined in the Aetna systems that enables Aetna and manufacturers to identify the Formulary and plan design (e.g., Open, Closed, 3 tier, 5 tier, etc.) that applies to the plans no later than September 30, 2014. The "Option Code" shall be included in all components of invoicing and reporting (including but not limited to all reporting out of GDX BI and RPS Datamart). 5) As reasonably requested by Aetna, and mutually agreed to by the parties, PBM shall implement an ICD-9 or other diagnosis field and a physician billed amount field as defined by Aetna in Aetna's medical claim invoice detail reporting that is sent to pharmacy manufacturers, on a date mutually agreed to by the parties. 6) In response to Aetna's request submitted to the Joint Work Intake Committee (JWIC) and as directed by Aetna, PBM shall implement a solution in the PBM Rebate Administration Computer System to include various plan benefit design elements such as precertification, step therapy, quantity limits and RX Plan ID and to provide Aetna the capability to create rules and groupings to either include or exclude such plan benefit design elements for Rebate invoicing on a date mutually agreed to by the parties. PBM shall also include such plan benefit design elements in all PBM Rebate Administration Computer System reporting applications on a date mutually agreed to by the parties. 7) As reasonably requested by Aetna, and mutually agreed to by the parties, PBM shall implement a solution in the PBM Rebate Administration Computer System that includes providing NDC level Medicare Part D files to Aetna on a date mutually agreed to by the parties. PBM shall create a new set of files every year after the April "statementing" period is closed in the PBM Rebate Administration Computer System. Fields contained in the NDC level Medicare Part D files shall include but not be limited to: calendar quarter, Rebate ID, External Level 1, External Level 3, NDC, billed Rebates, collected Rebates, contract PBP and Medical indicator. PBM shall also run a file against All Processed Claims (APC) detail files to provide invoiced Rebate amounts for dates for drugs dispensed in the subsequent year. Fields contained in the APC files shall include but not be limited to: calendar quarter, Rebate ID, External Level 1, External Level 3, NDC, billed Rebates, contract PBP and Medical indicator. 8) The parties shall negotiate in good faith and mutually agree on payment for the

functionality described in this Section T. The parties agree to negotiate in good faith and amend this Schedule I (Rebate Administration) as reasonably required to incorporate any applicable PBM obligations related to the new PBM Rebate Administration Computer System functionality.

U. SYSTEM ENHANCEMENTS:

The systems enhancements addressed in this Section U shall not include the system functions specifically described in Section T above. The Parties agree that future system enhancements to the PBM Rebate Administration Computer System shall be addressed as follows:

1) Enhancements to the PBM Rebate Administration Computer System based fully on PBM requirements and timelines, including but not limited to those that arise due to industry-related changes (e.g., Health Care Reform), applicable law, or any acquisition or product expansion (e.g., Medicaid) will be the sole financial responsibility of PBM.

2) Enhancements to the PBM Rebate Administration Computer System driven specifically through Aetna request that will not be utilized in any way by PBM, and create a new functionality that the Rebate Administration Computer System does not currently have, or an extension of an existing functionality in the system, will be the sole financial responsibility of Aetna. PBM agrees that in the event it desires to use any functionality requested by Aetna for the benefit of PBM or any of its clients or customers, other than Aetna, PBM shall notify and reimburse Aetna all costs which Aetna previously paid PBM for such functionality.

3) Enhancements to the PBM Rebate Administration Computer System that benefit both Aetna and PBM will result in shared financial responsibility between Aetna and PBM at a mutually agreeable amount. Such enhancement costs will be estimated by PBM and Aetna will have opportunity to approve or reject the enhancement before any costs are incurred.

4) For those enhancements with all or some Aetna requirements and costs, Aetna will be responsible for providing any information or data requested by PBM per the timeline, and will have opportunity to participate in PBM key milestone and deliverable reviews.

5) PBM agrees to discuss with Aetna rebate administration managers at least monthly, or as otherwise agreed to by the parties, PBM rebate administration IT projects.

6) PBM agrees to support Aetna as reasonably necessary to review all change requests as requested by Aetna in a timely manner and to implement those changes to the PBM Rebate Administration Computer System as mutually agreed upon, whether requested by Aetna or determined by PBM to be necessary or required, in order for Aetna to conduct its existing business and support new business in accordance with Aetna standards and in compliance with applicable law.

7) The parties agree to negotiate in good faith and amend this Schedule I (Rebate Administration) as reasonably required to incorporate any new enhancements to and PBM obligations related to PBM Rebate Administration Computer System functionality.

V. DATA SECURITY:

1) PBM shall ensure that all components of the PBM Rebate Administration Computer System designed for Aetna use are separated from applications used by PBM via system firewall.

2) PBM shall limit access to all Aetna applications and information to a specific list of PBM employees agreed to by Aetna. Prior to accessing any Aetna applications or information, these PBM employees shall sign individual confidentiality agreements provided by Aetna that strictly forbid the disclosure of Aetna information to anyone.

W. TRAINING:

1) PBM shall provide training to Aetna rebate personnel on all Aetna applications in the PBM Rebate Administration Computer System and any other PBM related system for which Aetna is granted access under this Schedule I, at a frequency determined by Aetna. Such training shall be required before first time business use of applications and systems, and as requested by Aetna. This training shall include in-person, on-site training, written materials, and telephone and email support.

X. LICENSING:

1) In accordance with Schedule V-2 (Data Analysis and Connectivity Tools), Aetna shall not be financially liable for any licensing costs that may be required to access the PBM Rebate

	Administration Computer System (including, but not limited to rebate reporting). PBM agrees to bear all such licensing costs.

Appendix E

Intentionally Omitted

Appendix F

Amendment to Schedule O

Medicare Services

Sections 12, 50, 78, 79 and 80 of Schedule O shall be revised to read in their entirety as follows:

12. FIR. PBM shall receive and process Financial Information Reporting ("FIR") (as defined and supplied by CMS or any CMS designee, including the Daily Cumulative FIR Aging Report) transaction activity (including adjustments thereto) in accordance with CMS requirements and the Eligibility Data received from Aetna. Aetna shall research any individual FIR records that fall-out from the aforementioned PBM transaction activity as a result of eligibility related issues (e.g. eligibility, timing of eligibility, or 4Rx mismatch) and correct Eligibility Data within the Aetna source systems as necessary. Other fallout issues shall be researched and addressed by either Aetna or PBM based on the circumstances of the fallout issue in question, as mutually agreed to by the Parties.

50. Coverage Determinations. To the extent required by Aetna, PBM shall administer standard and expedited coverage determinations and redeterminations (including Formulary exceptions, tiering exception requests, non-Formulary exceptions, and Member requests for payment) in accordance with CMS requirements, including 42 C.F.R. Sections 423.128(b)(7), 423.562, 423.566(d), 423.568, 423.570, 423.572, and Chapter 18 of the CMS Prescription Drug Benefit Manual. PBM shall allow coverage determinations without a direct call to a physician to the extent all needed information to process the request is received and such contact is otherwise permitted by CMS. The process shall meet all CMS mandated time frames, include all CMS required notices, and satisfy all CMS staffing requirements (i.e., pharmacist availability), and shall include the following:

    a. PBM shall accept prior authorization requests via multiple inputs (e.g., telephone, fax, and paper/mail);

    b. PBM shall ensure that the content of prior authorization forms shall be in accordance with CMS requirements and shall not be used for a purpose that interferes with the Member's ability to use the pharmacy of their choice;

    c. PBM shall administer Aetna specific pharmacy clinical protocols (PA, QL, ST) agreed to by the parties;

    d. PBM shall review requests for Formulary and tiering exceptions in accordance with agreed upon criteria with prior

review and approval by Aetna;

e. PBM shall accept prior authorization requests twenty-four (24) hours per day, seven (7) days per week, and all after-hours emergency/urgent requests shall be handled by PBM in accordance with CMS requirements;

f. PBM shall respond to Member/Provider requests for prior authorization in accordance with CMS requirements

g. PBM shall track the time and date of all information required by CMS including receipt of a coverage determination request, a redetermination request, a physician's or other prescriber's supporting statement, the decision, and the decision notice to the Member and /or prescriber; and

h. PBM shall use CMS templates or CMS-approved language, as required by CMS, for all denial letters. PBM shall develop and maintain a written policy and procedure for this process in accordance with CMS requirements and guidance and Aetna requirements and shall make such policy and procedure available for inspection by CMS and/or Aetna upon request. Without limiting the generality of the foregoing, PBM shall:

    i. Ensure that expedited coverage determinations are processed as expeditiously as the Member's health condition requires, but no later than twenty-four (24) hours after receipt of the request.

    ii. Ensure that standard coverage determinations are processed as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receipt of the request.

    iii. Ensure that exception requests are processed in accordance with the regulatory timelines for processing coverage determinations. For exception requests, the processing timeframe begins upon receipt of the physician's supporting statement.

    iv. Ensure that expedited redeterminations are processed as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receipt of the request.

    v. Ensure that standard redeterminations are processed as expeditiously as the Member's health condition requires, but no later than seven (7) calendar days after receipt of the request.

    vi. Make Medicare Part B vs. Part D coverage determinations in accordance with Aetna requirements, allow appropriate processing of Claims for Members with medical-pharmacy benefits through the pharmacy adjudication system and deny PDP-only Part B Claims as required by Medicare regulations.

    vii. Have a medical director who is responsible for ensuring the clinical accuracy of all coverage determinations and redeterminations involving medical necessity and who is a physician with a current and unrestricted license to practice medicine in a State, Territory, Commonwealth of the United States or the District of Columbia.

viii. Retain the services of physicians or other appropriate health care professionals in accordance with 42 CFR Section 423.566(d) in cases where there is an expectation that there will be, in full or in part, an adverse coverage determination.

ix. Submit all CMS required documents to the Independent Review Entity ("IRE") if PBM fails to meet the time requirements for coverage determinations in accordance with CMS requirements. Provide to Aetna all documents submitted to the IRE, including root cause, upon occurrence or within 24 hours.

x. Provide to Aetna all relevant data in accordance with CMS requirements that is necessary for Aetna to administer grievances and appeals, in the timeframes determined by Aetna.

xi. All requests for precertification review for MA only members will be forwarded to Aetna's precertification department at the then current fax or phone number no later than six hours prior to CMS expiration time.

78. Upon Aetna's request, PBM shall support and/or administer Aetna's and/or Medicare Plans' MTM programs based upon program attributes filed with CMS and consistent with CMS guidance with respect to MTM services. PBM accountabilities for administering the MTM program include the following:

a. PBM shall identify to Aetna any Members meeting Aetna's eligibility criteria filed with CMS for MTM programs and shall administer Member "opt-out" enrollments.

b. PBM shall provide Aetna with the reports related to MTM program.

c. PBM shall perform all required Member and Provider outreach (mail, telephonic, face-to-face) consistent with Aetna's MTM program filed with CMS.

d. PBM shall establish appropriate policies and procedures to meet all CMS expectations for administration of the MTM program.

e. PBM shall track and report MTM program outcomes to Aetna and to CMS in accordance with CMS requirements, including the following: (i) annual comprehensive medication review with written summaries (as required by 42 C.F.R. 423.153(d)(1)(VII)(B); (ii) date of annual comprehensive review; (iii) number of targeted medication reviews; (iv) number of Provider interventions; (v) number of additions to drug therapy made as a direct result of MTM interventions; (vi) number of discontinuations in drug therapy made as a direct result of MTM interventions; (vii) number of dosage changes to existing drug therapy made as a direct result of MTM interventions; (viii) number of therapeutic substitutions made as a direct result of MTM interventions; (ix) number of Generic Drug substitutions made

as a direct result of MTM interventions; and (x) MTM program outcomes following each quarter's activity.

MTM is considered a Core Service offered by PBM. For 2016, PBM will administer Aetna's criteria as part of its Core Services designed to achieve a comprehensive medication review ("CMR") result of 20% for MAPD and 17% for PDP. In order to achieve such CMR rates, PBM shall target up to ten percent (10%) of the Aetna Medicare Members for MAPD Plans, and up to 15% for PDP Plans as part of its Core Services.

For 2016, Aetna may request PBM to support MTM program attributes in a manner sufficient to achieve a CMR rate in excess of those included in PBM's Core Services, as described above. Aetna may elect to such improved CMR rates at the individual H-Plan (MAPD) or S-Plan (PDP) level. In the event that Aetna requests such higher CMR rates, Aetna shall pay PBM in accordance with Schedule Y-8.

For 2017 and subsequent calendar years, the Parties will meet to finalize MTM program criteria, Aetna's CMR completion rate goals and the associated pricing by March 31st of the preceding year. Core Services shall reflect the greater of a 10% targeting rate and a 20% CMR completion rate for PDP and MAPD, or PBM's standard targeting rate and completion rate for its Medicare book of business.

For 2016 and later, Aetna shall have the right to adjust the CMR completion rate levels through the course of the year, provided (i) Aetna gives PBM reasonable notice of the changes and (ii) Aetna pays any corresponding adjustments to the fees determined in accordance with Schedule Y-8 (which may be upward or downward).

79. Upon Aetna's request, PBM shall make PBM's MTM program(s) available to Aetna for utilization upon Aetna election. In the alternative, in the event Aetna elects to establish a direct relationship with an MTM vendor, including potentially the vendor PBM uses for MTM services, PBM shall cooperate with Aetna and Aetna's vendor in the transition of some or all of MTM services and shall provide the vendor with such information as may be reasonably necessary for the vendor to perform the MTM services. PBM and Aetna agree to work together in good faith to agree upon the fees and/or charges necessary to support a direct Aetna relationship with a MTM vendor.

80. PBM shall collaboratively work with Aetna to develop an effective MTM program with a demonstrable positive ROI in terms of quality and cost effectiveness. PBM shall make best efforts to re-evaluate the scope of its provider fax validation efforts to limit validations to providers in the Medicare program. If PBM reduces the scope of its fax validations, the Parties shall negotiate in good faith to make equitable adjustments to the costs Aetna pays allocable to such services. If Aetna reduces the volume of required fax validations sent to PBM, the Parties shall negotiate in good faith to make equitable adjustments to the

costs Aetna pays allocable to such service. It is understood that Aetna will reimburse PBM for its cost for such program with no mark up.

Appendix G

Amendment to Schedule O-2
To Schedule O (Medicare Services)

Optional Service

Service	Description
Enhanced Safety and Monitoring Solution	PBM shall provide an enhanced fraud, waste and abuse program that provides continuous monitoring, intervention and special investigation, when warranted. PBM shall provide case management services and recommendations for courses of action and additional services. The courses of action included in the base fee include advanced lettering options, coordination with pharmacy audit activities, prescriber toolkit, continuous case management, and member specific utilization management edits. The optional courses of action which are available for an additional fee include prescriber consultations with an independent physician specialist, medication therapy counseling and special investigations.

Appendix H

Amendment to Schedule P(I-1)

Medicaid & Other State Plan Services

Optional Rebate Services

Service	Description
Rebate Administration Overview (See also Schedule I)	The requirements of Schedule I (Rebate Administration) govern the use of Aetna Manufacturer Rebate Agreements for the procurement of Rebates, and the Parties agree that for those State Plans designated by Aetna in writing as described in Section 1 below, PBM Manufacturer Rebate Agreements will be used for the procurement of applicable Rebates. Accordingly, the requirements of Schedule I (Rebate Administration), as it may be amended, will be modified to the extent necessary to meet this requirement in accordance with the terms and conditions described in this Schedule P(I-1) (State Plans - Full Rebate Contracting and Administration Services): 1. Applicable State Plans. The Parties agree that the Rebate administration service described in this Schedule P(I-1) (State Plans - Full Rebate Contracting and Administration Services) is an Optional Service which shall only apply to State Plans specifically designated by Aetna through amendment to the Agreement or upon advance written notice to PBM. Unless otherwise specified in a State Plan Specific Addenda, the services described in this Schedule P(I-1) (State Plan – Full Rebate Contracting and Administration Services) shall be provided for and included within the Administrative Fee. Unless otherwise specified in a State Plan Specific Addenda, the services under this Schedule P(I-1) (State Plan – Full Rebate Contracting and Administration Services) shall also apply with respect to medical Claims processed on PBM's claims adjudication systems (i.e., RxClaim) 2. Rebates. Subject to the terms and conditions of the Agreement, including any applicable State Plan-Specific Requirements, PBM will provide Rebate administration services to Aetna as set forth in this Schedule P(I-1) (State Plan – Full Rebate Contracting and Administration Services) for State Plans designated by Aetna. PBM shall use its best efforts to enter into Contracts with Manufacturers that secure the most advantageous Rebates for State Plans hereunder, and other terms and conditions for Aetna consistent with the State Plan Formularies. For purpose of this Schedule P(I-1) (State Plan – Full Rebate Contracting and Administration Services), "Aetna's designee" may include State Plans.

	3. PBM Manufacturer Rebate Agreements. PBM shall submit utilization under its Manufacturer Rebate Agreements ("PBM Manufacturer Rebate Agreements") in order to earn Rebates from Manufacturers. PBM shall be responsible for billing, generating all invoices, receiving all Rebates and allocating and paying such Rebates to Aetna (or Aetna's designee) in accordance with this Schedule P(I-1) (State Plan - Full Rebate Contracting and Administration Services), the Agreement and State Plan-Specific Requirements.
Rebate Eligibility and Remittance (See also Schedule I)	4. Eligibility. State Plans under this Schedule P(I-1) (State Plans - Full Rebate Contracting and Administration Services) shall receive Rebates earned from Manufacturers for Drugs dispensed to applicable State Plan Members in accordance with the subschedule to Schedule Y-15 (Medicaid Pricing) applicable to such State Plan. 5. Invoicing. PBM shall invoice Manufacturers for all Rebates that are eligible for payment in accordance with all PBM Manufacturer Rebate Agreements and applicable Laws and regulations. PBM will prepare and submit all invoices and supporting documentation required by the PBM Manufacturer Rebate Agreements and shall use its best efforts to collect all eligible Rebates. All invoices and supporting documentation shall be submitted in accordance with applicable Laws including HIPAA. 6. Confidentiality of Invoicing Information. PBM will ensure that each PBM Manufacturer Rebate Agreement that it enters into will include a provision that requires the Manufacturer to treat as confidential and prevent disclosure and use of the invoices and supporting documentation submitted to Manufacturer by PBM for any purpose other than the administration and payment of Manufacturer Rebates. PBM shall not provide any Confidential Information of Aetna (or State Plans) or any Protected Health Information (as defined under HIPAA) related to any State Plan Member to a Manufacturer or any other third party except as necessary to earn rebates or as specifically approved by Aetna in writing. To the extent any Protected Health Information is provided to a Manufacturer for purposes of obtaining Rebates, the information provided shall be the minimal amount of Protected Health Information necessary for purposes of obtaining such Rebates and in any event, consistent with the Agreement, shall not be disclosed or used by any Manufacturer outside of the United States without Aetna's prior written consent. 7. Rebate Remittance. PBM will remit electronically funds to Aetna (or to Aetna's designee) in accordance with the terms, rates and guarantees for all Rebates for State Plans in accordance with the subschedule to Schedule Y-15 (Medicaid Pricing) applicable to each such State Plan. Payment will be accompanied with a report setting forth detailed information relating to the source of payment including the invoiced amount from Manufacturer.

	8. Rebate Allocation. PBM shall allocate and disburse Rebates to each applicable State Plan at the level designated by Aetna and State Plan consistent with the hierarchy (e.g., State Plan, group level, carrier level). In the event Aetna elects to allocate and disburse Rebates to State Plans, PBM shall provide Aetna with a report that enables Aetna to accurately disperse Rebates to individual State Plans, groups or carriers. 9. No Self Dealing. PBM will diligently and in good faith work with Aetna with respect to the administration of pharmacy benefits to help ensure that each State Plan has the opportunity to qualify for the most favorable Rebates possible for that State Plan in accordance with Law. PBM agrees that it will not leverage the negotiation of rebates, including administrative fees, for State Plans receiving services under this Schedule P(I-1) (State Plan – Full Rebate Contracting and Administration Services) when negotiating rebates for other plans or blocks of business in a manner that could negatively impact the State Plan's Rebates. 10. Errors and Mistakes. PBM shall be responsible for any Rebate losses caused by its negligence or willful misconduct in accordance with Section 15.1 of the Agreement.
No Payment for Rebate Data/Encounter File	11. No Payment For Data. Except as otherwise permitted by the Agreement or Schedule Z (Authorized Uses of Data and Information), PBM agrees that it shall not receive any compensation or value for submission to any third party of the encounter file or any other data related to this Schedule P(I-1) (State Plans - Full Rebate Contracting and Administration Services).
Documents, Records and Reporting (See also Schedule I)	12. Complete and Accurate Records. PBM shall maintain records necessary to timely and accurately comply with its obligations and responsibilities under this Agreement including, but not limited to, (a) the payment and calculation of Rebates hereunder, (b) the preparation of invoices and invoice revisions, and (c) other records related to determining system performance as required under the Agreement. 13. Maintenance of Records. The PBM shall maintain all records effective as of the date upon which Rebate administration services commence for the State Plan, for as long as required by applicable Law but in any event PBM will ensure that the most recent three (3) calendar years of data are immediately available on its systems, and for the period beyond the three (3) years of immediate availability, PBM will otherwise retain data for the period for which Required Books and Records are required to be retained pursuant to Section 7.1 of the Agreement. 14. Aging Report. On a quarterly basis, PBM shall provide promptly to Aetna (or its designees) updated, current information regarding the amount of Rebates expected to be received from any Manufacturer on behalf of applicable State Plan Members. The applicable time period, form and content shall be

	mutually determined by the Parties. PBM will also provide to Aetna (or its designees) a quarterly aging report of Rebates in a mutually agreed upon format, time and manner. This Rebate aging report shall include, at a minimum, unless otherwise agreed to by the Parties, the number of days such amount is outstanding, and the invoice date, separated by Manufacturer. 15. Rebate Earned Amount Report. On a quarterly basis, PBM shall provide promptly to Aetna (or its designees) updated, current information regarding the amount of Rebates earned from all Manufacturers on behalf of applicable State Plan Members hereunder for the preceding calendar quarter. Such information shall be delivered in a format to be mutually determined by the Parties. 16. Rebate Allocation Report. The PBM shall provide reporting that includes the allocation of all Rebates to each applicable State Plan at the hierarchy level designated by Aetna and State Plan (e.g., group level, carrier level) in a file format mutually agreed to by the Parties. This reporting shall be provided in conjunction with the remittance of Rebates to Aetna (or its designees).
Audit (See also Schedule I)	17. Audit. Aetna and Aetna Customer-related audits shall be conducted in accordance with Section 7.3 of the Agreement, Schedule X (Audits) and the following audit rights: a. PBM Manufacturer Rebate Agreement Audits. Aetna or State Plan, through a mutually agreeable independent third party retained by such party, may conduct an annual Rebate audit for any prior year within the last three (3) years of the audit request. Such audit shall be limited to a review of up to ten (10) PBM Manufacturer Rebate Agreements directly related to the State Plan's Rebates as selected by the auditing party. Such review of PBM Manufacturer Rebate Agreements may include formulary and Rebate provisions to the extent permitted by such contracts and shall be limited to information necessary for validating the accuracy of the Rebate amounts remitted by PBM. Any mutually agreed upon third party auditor engaged by Aetna or a State Plan shall execute PBM's form confidentiality agreement prior to conducting a Rebate audit ensuring that all information reviewed during such audit and all details and terms of any PBM Manufacturer Rebate Agreements reviewed will be treated as confidential and will not be revealed in any manner or form by or to any third party, including Aetna or the State Plan. b. Rebate Administration Services Audits. Except as otherwise limited by Section 17. a. of this Schedule P(I-1) (State Plan – Full Rebate Contracting and Administration Services), the Parties acknowledge and agree that the scope of Aetna and State Plan audit rights under Section 6.a. of Schedule X (Audits) include Aetna and State Plans' right to audit all PBM's collection, payment and allocation of Rebates pursuant to this Schedule P(I-1) (State Plan – Full Rebate Contracting and Administration Services).

	c. Audit Assistance. PBM shall work in good faith to assist Aetna (or applicable State Plans hereunder) in connection with third-party requests related to Rebates, including but not limited to State Plan-related audits, Governmental Body requests or audits, and audits by accreditation organizations. The Parties agree that any Governmental Body requests or audits or accreditation organization audits shall not be limited by the terms set forth in Section 17 a. of this Schedule P(I-1) (State Plan – Full Rebate Contracting and Administration Services).

Appendix I

Schedule P(K-1)

Medicaid and Other State Plan Services

Optional Prior Authorization Services

Prior Authorization	1. Effective January 1, 2016, Prior Authorization for State Plans shall be an Optional Service, subject to the pricing in Schedule Y-7. If elected, PBM communications with Providers in connection with PBM's receipt, review, approval, and denial of pharmacy Prior Authorization Requests, if any, shall be made in accordance with the terms and conditions set forth in Schedule K or as otherwise required by the State Plan-Specific Requirements. a. In addition to the terms and conditions set forth in Schedule K (Prior Authorization Services) for PBM's receipt, review, approval and denial of Prior Authorization Requests, PBM shall have the ability to receive, review, deny and approve pharmacy Prior Authorization Requests submitted from the prescriber (including authorized prescriber staff/representative) and other providers (e.g., long term care pharmacies) by facsimile and in accordance with State Plan-Specific Requirements and applicable Law. b. With respect to denials of pharmacy Prior Authorization Requests, PBM shall only be authorized to recommend a denial, and is required to forward such recommendation to a State Plan medical director and/or pharmacist (as allowed by applicable Law), upon direction from Aetna, to process the final determination of such denial. Upon election and direction from State Plan, PBM may requested to perform the denials as allowed by Law. c. PBM shall adhere to State Plan approved Prior Authorization guidelines for State Plans. PBM shall not adhere to Aetna Clinical Policy Bulletins ("CPBs") or Aetna Pharmacy Clinical Policy Bulletins ("PCPBs") for State Plans unless directed by Aetna to do so.

	d. Notwithstanding Paragraph 13 of Schedule K (Prior Authorization Services), PBM shall perform its review in the timeline, as mutually agreed to by PBM and Aetna, in order to meet the coverage determination timeframe established by applicable Law or State Plan Specific Requirements. e. Notwithstanding Paragraph 29 of Schedule K (Prior Authorization Services), PBM shall communicate all denials to the applicable physician and to the Member within required timeframes established by applicable Law or State Plan-Specific Requirements. If such adverse determination time frames are not established by applicable Law or State Plan-Specific Requirements, then PBM shall communicate all denials to the applicable physician and to the Member within the timeline as agreed to by State Plan and PBM at time of implementation. 2. To the extent required or requested by a State Plan, PBM shall provide prior authorization services to State Plan(s) in compliance with State Plan-Specific Requirements (including prior authorization guidelines) and Schedule K (Prior Authorization Services). 3. Notwithstanding anything to the contrary in Schedule K (Prior Authorization Services), including references to Aetna Clinical Policy Bulletins (“CPBs”) and Aetna Pharmacy Clinical Policy Bulletins (“PCPBs”), for purposes of this Schedule P (Medicaid & Other State Plan Services), PBM shall comply with State Plan prior authorization guidelines and Medicaid prior authorization guidelines. 34. Notwithstanding anything to the contrary in Schedule K (Prior Authorization Services), for purposes of this Schedule P (Medicaid & Other State Plan Services), PBM shall have staff available (on call or otherwise) 24 hours a day, 7 days a week to accept and review urgent Prior Authorization Requests in accordance with State Plan-Specific Requirements.

Appendix J

Schedule R

Performance Standards and Service Levels

Core Services

Overview:
The Performance Standards in Schedule R are organized by business function into ten (10) suites found in Section 1 through Section 10. Schedule R specifies the financial guarantee amounts that must be paid if defined Performance Standards and Service Levels are not met for a given measurement period. Performance Standards and Service Levels as detailed in this Schedule R shall only apply to services performed on PBM systems. As used throughout this Schedule R, any reference to the "Aetna Book of Business," for the purposes of all Performance Standards, shall include any legacy Coventry Medicare Plans that are migrated to the PBM on January 1, 2016; unless otherwise specifically noted.

PBM's total financial liability in a given suite will be capped at the maximum amounts established on the Suite Payout Maximums Table in Section 12. A quarterly penalty will be applied no more than once per individual Performance Standard, per quarter, regardless of whether there is more than one performance target within the Performance Standard. Additionally, PBM's annual financial responsibility will be capped at an annual aggregate limit as defined in Section 13 Annual Aggregate Limits and Reconciliation.

PBM shall provide, sixty (60) days following the end of each quarter, a written report of the performance results for these Performance Standards for the preceding quarter. The report shall be accompanied by documentation supporting the result for each Performance Standard. For any Performance Standard not met, a written corrective action plan (CAP) shall be submitted. The CAP should include but not be limited to information pertaining to root cause, corrective action taken, and resolution. If a specific Performance Standard is under dispute, a CAP will be provided in a reasonable timeline upon mutual resolution of dispute.

The column labeled "Measurement and Assessment Frequency" indicates when each Performance Standard is measured and penalties assessed. No later than sixty (60) days following the end of each reporting period, PBM shall provide a written report to Aetna that sets forth an itemization of all Guarantee Amounts due to Aetna pursuant to this Schedule with respect to each reporting period. Additionally, PBM shall provide an annual reconciliation report, certified as to its accuracy by an appropriate officer of PBM with actual knowledge of the content thereof, no later than sixty (60) days after the end of the reporting period and PBM shall pay all such Guarantee Amounts to Aetna by wire transfer of immediately available funds to an account designated by Aetna.

PBM shall have the opportunity to earn a percentage of the total annual aggregate limit by achieving the performance standards allocated in Section 14. These amounts will apply if

PBM vendor exceeds the specific Performance Standards in that section.

Section 15 to Schedule R contains a set of Medicare Part D Implementation Performance Guarantees. The Medicare Part D Implementation Performance Guarantees shall be measured at year-end together with other calendar year and fourth quarter 2015 Performance Standards. The report provided by PBM within sixty (60) days of the end of the 2015 year shall include an assessment of the results for the Medicare Part D Implementation Performance Guarantees and CAPs for any Performance Standards not met. The Medicare Part D Implementation Performance Guarantees are not subject to any of the penalty maximums described above, including the Section 13 Annual Aggregate Limits.

Performance Standards found in this schedule will serve as the primary standards for Schedules R, R-1 and R-2 except where noted otherwise. For those Performance Standards found in both Sections 1 through 8 and Section 9 and/or Section 10, only the Performance Standards in Section 9 and/or Section 10 will apply. In these instances, Medicare and/or Medicaid lines of business will be excluded from Section 1 through 8 metrics. In addition, Scrip World, Assurant, and any other mutually agreed upon unique service model, will be excluded from the Performance Standards in this Schedule R. Performance Standards as detailed in Schedule FF and Schedule EE, respectively, will apply to those lines of business.

All Performance Standards and accompanying guarantees set forth in this Schedule R shall be considered final and binding. If upstream Aetna systems or business processes used to perform the services incur an issue that causes an effect on the ability to meet the guarantees in this Schedule R, the Parties will excuse the adverse impact from the measurement period for performance standard determination as long as adverse acts were not caused or derived from the acts or omissions of PBM personnel. If exclusion is not viable, the Parties will reach a mutually agreeable resolution for performance standard measurement or penalty determination. Notwithstanding the foregoing, the Parties shall cooperatively work to take appropriate measures to mitigate the time and/or adverse impact of a systems or business process issue; provided that such measures shall not include additional costs to PBM for Aetna systems and business process issues that are not caused by the acts or omissions of PBM personnel. PBM's inability to meet these standards for reasons outside of their control must be identified and submitted to Aetna in writing. Determination as to waiving or amending individual performance standards and associated guarantees pursuant to official written request by PBM will be mutually agreed upon. If mutual agreement does not occur, the Parties agree to follow the process outlined in Section 17.27 of this Agreement with respect to dispute resolution.

Unless specifically identified as a tiered penalty under Annual Guarantee Amount, all metrics are reported based upon the level of precision defined in the Agreement. For purposes of Schedule R, standard rounding methodology will apply based on the next decimal point right of the target precision level (e.g., value 5 through 9 will round up and 0 through 4 will round down). For example if target is 99.00%: a 98.999% result will report as 99.00% or a 98.994% result will report as 98.99%. For clarification purposes, the following sections contain a tiered penalty and will be excluded from this methodology: 5.1, 5.5, 5.6, 6.1, 7.1, 7.2, 7.3, 7.5, 7.6, 7.7, 7.9, 8.1, 8.2, 10.1.6, 10.2.1, 10.2.2, 10.2.3, 10.2.4, 10.3.1, 10.3.2, 10.4.1, 10.5.1,

10.5.2, 10.5.3, 10.5.4, 10.6.1, 10.6.2, 10.6.3 and 10.6.4.

The performance standards included in this schedule will become effective on January 1, 2016 unless otherwise agreed to by the Parties.

2. Data to be reconciled and impact the match rate calculation shall include, as a minimum:
   i) Member Eligibility:
      (1) Member ID
      (2) Member HICN
      (3) Member Cross-Walk ID
      (4) Name (First, Last)
      (5) DOB
      (6) Effective Date
      (7) Term Date
   ii) Group Eligibility:
      (1) Full CAG

3. All Aetna submitted group and member eligibility records will be included.

4. If Aetna fails to submit a group or make corrections to eligibility data based on the reject report, these members and groups will be excluded from the metric.

5. Rejected group and member records on load reports and suspended group and member records do not count against the match rate as these errors should be worked and resubmitted.

6. Manually added group and member records will not count against the match rate.

7. Group and member records applied to RxClaim after a reconciliation or compare file is generated also will not count against the match rate. The Aetna process dictates that PBM will not stop loading eligibility when performing an eligibility reconciliation and records added or modified after the reconciliation file is created are deemed as "explainable differences".

<u>Formulary/UM</u>

8. These metrics (i.e. match rate) pertain to the mutually defined, reviewed and approved "red" and "yellow" discrepancies.

9. All "red" and "yellow" discrepancies should be resolved with 100% accuracy by the December MOB 48k full regression testing. Should there be any unexpected fallout discovered through this regression testing, another full regression testing is required to demonstrate 100% accuracy. This final regression test and review may be completed post 1/1/16. If the execution

2. All Severity 1 issues from 1/1/2016 to 2/29/2016 resulting solely from Aetna's other vendor to PBM migration have been resolved, either by remediating the issue, mitigating it, and, with Aetna consent, moving the item to a lower Severity level by the due date established by the jointly managed Command Center;

PBM will apply $500,000 to each unresolved Severity 1 level issue up to $3,000,000.

Severity 1 is defined as an error that creates a major disruption to Aetna's business and must be resolved immediately. Severity 1 issues include significant access to care issues. This PG only includes those open Severity 1 issues that are a result of Aetna's other vendor to PBM migration and are reported by Aetna to CMS.

For the purposes of this PG "resolved" is defined as a fix has been implemented and the issue no longer occurs in production or has a validated workaround that resolves the access to care issue and provided that the change does not create another severity 1 issue. In any case, member remediation may still be necessary.

The resolution turnaround time measurement for PBM will begin when all required documentation and approvals are received from Aetna.

6. Post Migration: Completion of Post-Production Monitoring

Required Completion Date: No later than 1/14/2016.

Penalty: $1,000,000

Supporting Deliverables: Salesforce Issue reports and Compliance reports.

Objective Measures and Caveats: The intent of this guarantee is to ensure that PBM actively seeks to identify defects related to the Coventry Medicare business migration post go-live, As such it is critical that PBM achieves the following milestones based on the mutually agreed upon Post-Production Monitoring project plan, which includes the tracking and resolution of defects found:

1. PBM's Quality Management (QM) Team will execute a review of targeted rejects based on existing algorithms for a period of two weeks 1/1/2016 – 1/14/2016 (Includes reviews during the first weekend in January). The QM team will provide the results of this analysis to PBM Account Management team by 2 pm CT each day. The daily analysis will include claims for the prior day.

2. Account Management will review the analysis provided by PBM's QM team for the same two period of 1/1/2016 – 1/14/2016. This work will be completed for two thirds of the issues by 7:00 pm CT of each day (for claims processed the prior day). The work for the remaining one third will be completed by 11:00 am CT the next day. The Account Management team will document the results of the analysis in an email which will be sent to Aetna by 7:00 pm each day. This email will include: (a) trends found by the QM team, (b) number of potential issues found, and (c) description of the confirmed issues (along with the Salesforce.com shared case number). This work also includes opening up any Salesforce.com research or production correction cases (but not completing the research or the production changes). Aetna is also completing the same analysis and the results of both analyses will be discussed in the joint daily calls.

3. Execution of agreed upon individual test claims in production by Account Management. Aetna and PBM will jointly develop a test plan prior to 1/1/2016. The scope of this test plan will include up to 250 claims. PBM will execute these test claims on 1/1/2016 and 1/2/2016 and the results will be shared with Aetna as executed. The testing results will also be discussed during the daily command center calls and the appropriate research or production correction Salesforce.com cases will be opened as needed.

Any PBM system issue occurring during the period 1/1/16 to 1/14/16 that causes a delay of the QM report (in #1 above) will result in a different delivery schedule than what is listed above. In these cases, the timing listed above will be extended by the length of the system delay.

PBM will apply $250,000 to each of the first two milestones and $500,000 to the third milestone. For each of the first two milestones, PBM will apply $62,500 for each occurrence of a missed deadline up to $250,000.

CONDITIONS:

PBM shall provide the performance guarantee report card no later than sixty (60) days after the effective date of the migration. Any applicable amounts owed to Client will be processed according to the terms of the contract.

Appendix K

Schedule T-2

Termination Transition Services

Core Services

"Partial Termination" means the termination of any part of the Agreement or any of the Services being provided by PBM under the Agreement without terminating the entire Agreement. In the event of a Partial Termination the provisions of Schedule T-1 (Termination Transition Services) shall apply to such Partial Termination to the extent applicable.

Appendix M

Schedule AA

PBM Licensed IP

***Additional licenses and applications needed in connection with the services provided under the Agreement to be made available as identified and/or developed as mutually agreed by the Parties.*

PBM completes the template for all applications / data bases required to support Aetna contracted business processes including but not limited to claims processing, customer support, reporting, mail order and specialty processes.

Application / Data Base- Availability Tier	**Disaster Recovery Tier**	**Application / Data Base Functional Description**	**Business' Processes Supported**
LINKS – Tier 1	1	Mail order processing application	Mail Order System
PeopleSafe – Tier 1	1	Customer Care application used to service member calls. CRM tool.	Customer Service
RxClaim – Tier 1	1	Claim Adjudication platform	Adjudication Engine
HBS (previouslyRxSpecialty) – Tier 1	3	Order Management System specialty mail	Specialty System
SPARCs-Specialty A/R – Tier 1	3	Specialty Accounts Receivable	Specialty System
Fairfax/Captiva – Tier 2	2	Imaging	Mail Order
TriStar – Tier 1+	4	Pharmacy Dispensing Automation	Mail Order
CAS – Tier 1	2	Prior Authorization System	Clinical
Nuance IVR – Tier 1	2	Interactive voice response unit for participant self service	Customer Service
Caremark Messaging Platform (CMP) – Tier 1	2	Outbound messaging via phone, web and text	Customer Service
CareSource – Tier 1	2	Online work instructions and support documentation for Customer Care representatives	Customer Service
RxSource – Tier 1	1	Pharmacy Help Desk information.	Mail Order

		Online work instruction and support documentation for Mail Order colleagues	
Client Care Access (CCA) – Tier 1	2	Single sign-on portal for clients to access designated applications.	Customer Service
CVSCaremark.com– Member Portal – Tier 1	1	Member Portal; self service internet web site, inclusive of all associated applications: Google Health, Microsoft Health Vault, Dossier, Web services, Single Sign-on	Customer Service
ECS (Enterprise Common Services) - Tier 2	1	Common messaging architecture and services for accessing information from source applications.	Adjudication
Consumer Driven Health (CDH) – Tier 1	2	Integrated application with Health Care Providers to coordinate deductibles among other accumulators across Medical and Prescriptions.	Customer Service
Sentry – Tier 1	2	Eligibility File Integrator 4 files sent to Sentry from WH for translation.	Eligibility
Electronic commerce Workhorse- Tier 1	2	Eligibility file storage Workhorse 7 files (6 for eligibility; 1 FCl-flexible copay incentive	Eligibility
iTools – Tier 2	2	Complex query building tool for scheduled reporting against EDW	Reporting
RxInsights – Tier 2	2	Cost and utilization report tool	Reporting
RxPipeline – Tier 2	2	Online access to new products and upcoming generics	Customer Service
RxHub – Tier 2	2	Process electronic transactions to/from prescribers - including eligibility, claim history and formulary/drug coverage inquiries, new prescriptions, renewal requests/response, fill notification, rx change	Adjudication

		request/response, rx cancel request/response.	
Clinical Services System – Tier 2	2	Application which targets participants for gaps in care opportunities.	Clinical
IBenefits – Tier 2	2	Member focused comprehensive report based on their utilization trend which advises them on the best use of their prescription benefit.	Customer Service
Enterprise Data Warehouse (EDW) – Tier 3	3	Reporting data mart.	Reporting
RxNavigator – Tier 3	3	Ad Hoc reporting tool	Reporting

Effective 2015:

Application / Data Base-Availability Tier	**DR Tier**	**Application / Data Base Functional Description**	**Business' Processes Supported**
MedHOK – Tier 1	1	Prior Authorization	Other/Med D
Benefit Builder – Tier 2	2	Benefits Development	Supports automation of benefits development
SalesForce.com – Tier 2	2	Workforce management tool	Supports work requests and issue case

Inactive Application List

Application / Data Base	**Application / Data Base Functional Description**	**Business' Processes Supported**
RxSpecialty (previously ESPS) – Tier 1	Specialty drug processing application	Specialty System
BART – Tier 3	4	Benefits and Request Tracking

Appendix N

Insert Amended Annex C

To be provided by CVSH

AMENDMENT TO AMENDED AND RESTATED
PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT
(Kentucky Medicaid)

This amendment (the "Amendment") is made and entered into as of the 1st day of July 2020, unless stated otherwise, by and between Aetna Health Management, LLC, a Delaware limited liability company ("Aetna"), and CaremarkPCS Health, L.L.C., a Delaware limited liability company ("PBM"). This Amendment is made effective as of the date first above written.

RECITALS

A. Aetna and PBM have entered into the Amended and Restated Pharmacy Benefit Management Subcontract Agreement, dated as of October 2, 2013 (the "Agreement"). Capitalized terms used but not otherwise defined herein shall have the meaning assigned to them in the Agreement.

B. Aetna and PBM desire to modify the Agreement as set forth in this Amendment to reflect the understanding of the Parties with respect to the unique aspects of Aetna's Medicaid business in Kentucky, which is operated by Aetna's affiliate Aetna Better Health of Kentucky Insurance Company ("Aetna Better Health").

NOW, THEREFORE, in consideration of the premises and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto hereby agree as follows:

1. Schedule P (Medicaid & Other State Plan Services) to the Agreement is hereby amended to add the following Addendums thereto:

    a. Kentucky Regulatory Addendum to Schedule P (Regulatory Compliance Addendum Governing Kentucky Medicaid Serices).

2. Schedule Y (Pricing) is hereby amended to include the attached new Schedule Y-15-KY (Pricing for Kentucky Medicaid Plan).

3. Aetna represents and warrants that Aetna Better Health has duly authorized PBM to provide services to Aetna Better Health under the Agreement. Notwithstanding the foregoing, Aetna and PBM hereby agree that Aetna Better Health's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services that PBM provides with respect to the Covered Plans of Aetna Better Health under the Agreement.

3. Except to the extent specifically amended by this Amendment, all of the terms and conditions contained in the Agreement shall be and remain in full force and effect.

IN WITNESS WHEREOF, the Parties have executed this Amendment to the Agreement by duly authorized representatives as of the date first written above.

CAREMARKPCS HEALTH, L.L.C.	**AETNA HEALTH MANAGEMENT, LLC**
By: _____	By: _____
Its: _____	Its: _____
Date Signed: _____	Date Signed: _____

Kentucky Regulatory Addendum
To Schedule P (Medicaid & Other State Plan Services)

Regulatory Compliance Addendum
Governing Kentucky Medicaid Services

This Regulatory Compliance Addendum Governing Kentucky Medicaid Services (the "Kentucky Medicaid Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under the *Medicaid Managed Care Contract Between the Commonwealth of Kentucky on Behalf of Department for Medicaid Services and Contractor* (as amended or restated, the "State Contract"), under which contract Aetna Better Health of Kentucky Insurance Company (the "Company") serves as a managed-care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract.

The Commonwealth of Kentucky, its Finance and Administration Cabinet, its Cabinet for Health and Family Services, and/or its Department for Medicaid Services (collectively, the "State"), require that specific terms and conditions be incorporated into the Agreement. As such, this Kentucky Medicaid Addendum is incorporated by reference into the Agreement between Company (or its Affiliate, as the case may be) and the provider, vendor, contractor, or other entity executing this Agreement (as identified on the first page thereof), and such provider, vendor, contractor, or other entity must comply with the requirements set forth herein. Note that this Kentucky Medicaid Addendum contains some, but not all, of the terms and requirements with which you must comply. Other terms and requirements with which you must comply are set forth in the Agreement and in the policies, procedures, and provider manual of Company (or its Affiliate, as the case may be). This Kentucky Medicaid Addendum and the Agreement may be revised as directed by the State.

For purposes of this Kentucky Medicaid Addendum, the individuals who are enrolled with Company under the State Contract will be referred to as the "Members" or "Enrollees." All capitalized terms not defined in this Kentucky Medicaid Addendum shall have the respective meanings that are ascribed to them in the Agreement.

If there is any conflict between the terms of this Kentucky Medicaid Addendum and any of the other terms of this Agreement, including any attachments, schedules, exhibits, and/or addenda made part of this Agreement, the terms of this Kentucky Medicaid Addendum will govern and control with respect to the provision of Covered Services to Members who are eligible and covered under the State Contract and with respect to the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or to the State Contract. Except as provided herein, all other provisions of the Agreement not inconsistent with this Kentucky Medicaid Addendum shall remain in full force and effect, and to the extent possible under applicable law, the terms of this Kentucky Medicaid Addendum shall be construed to be supplementary to, and not in conflict with, the terms and conditions of the Agreement.

The provider, vendor, contractor, or other entity identified on the first page of the Agreement acknowledges and agrees that all provisions of this Kentucky Medicaid Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members who are eligible and covered under the State Contract, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the State Contract, and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Kentucky Medicaid Addendum and all applicable laws and regulations.

CONTRACTUAL AND STATUTORY/REGULATORY REQUIREMENTS

A. Definitions

The following additional definitions shall apply with respect to the requirements set forth in this Kentucky Medicaid Addendum:

a. "Medically Necessary" or "Medical Necessity" – Nothwithstanding any definition thereof set forth in the Agreement, the foregoing terms shall mean Covered Services that are medically necessary as defined

under Section 2 of 907 KAR 3:130, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. § 1396d(r). [State Contract § 1.0]

b. "Provider" – Any person or entity under contract with Company or Company's contractual agent that provides Covered Services to Members. [State Contract § 1.0]

c. "Subcontract" – Any agreement entered into, directly or indirectly, by Company to provide or arrange for the provision of Covered Services. The term "Subcontract" does not include a policy of insurance or reinsurance purchased by Company or its Subcontractor to limit its specific or aggregate loss with respect to Covered Services provided to Members under the State Contract, so long as Company or its risk-assuming Subcontractor assumes some portion of the underwriting risk for providing health care services to Members. [State Contract § 1.0]

d. "Subcontractor" – Any entity other than a Provider, a physician health organization, or a provider network with which Company has entered into a written agreement for the purpose of fulfilling an obligation of Company under the State Contract. [State Contract § 1.0]

B. Requirements Applicable to Contracts and Services

1. Provision of Covered Services. Provider agrees to provide Covered Services to Members as set forth in the Agreement, including without limitation the following when such Covered Services are specified in the Agreement:

a. If a Member requires emergency medical services, Provider will provide such services on a twenty-four (24) hour per day, seven (7) day per week basis. Provider will provide urgent care services within 48 hours of request. [907 KAR 17:015, § 2; State Contract §§ 29.7, 33.3]

b. If a Member requires the services of a specialist, Provider will provide such specialty services within thirty (30) days from the referral for routine care or within forty-eight (48) hours from the referral for urgent care. [907 KAR 17:015, § 2; State Contract § 29.7]

c. Provider shall provide Covered Services to Members in accordance with the State Medicaid plan, applicable State regulations, and the relevant policies and procedures applicable to each category of Covered Services. [State Contract § 31.1]

d. Provider shall provide basic, targeted, or intensive case management services as Medically Necessary to foster children who are discharged from a hospital or other residential facility, and shall thereafter participate in appropriate discharge planning that is focused on ensuring that the needed supports and services to meet the Member's behavioral-health and physical-health needs will be provided outside of the hospital or other residential facility. [State Contract § 36.4]

e. If Provider is a PCP, Provider shall perform the PCP functions set forth in Section 28.3 of the State Contract. [State Contract § 28.3]

f. Company shall not require Provider to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. § 438.102. Instead, Company shall have a referral process for situations in which a Provider declines to perform a service for ethical reasons. [State Contract § 28.12]

2. Claims; Payment; Coordination of Benefits.

a. Company shall only accept from Provider the uniform claim forms that have been approved by the State and that have been completed according to State guidelines. Provider acknowledges and agrees that the date of Company's receipt of any Provider claim shall be the date as indicated on its date stamp on the claim or other notation as appropriate to the medium used to file a claim, and that the date of payment shall be the date of the check or other form of payment. [State Contract §§ 30.1. 30.2]

b. Provider acknowledges and agrees that with respect to any Covered Services provided to Dual Eligible Members (as that term is defined in the State Contract), Company shall pay to Provider the lesser amount of: (1) Company's allowed amount minus the Medicare payment, or (2) the Medicare co-insurance and deductible up to Company's allowed amount. [State Contract § 30.4]

c. Provider/Subcontractor acknowledges and agrees that with respect to any Covered Services, Company shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) that is: (1) furnished by any individual or entity during any period when that individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act; (2) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); (3) furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments; (4) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; (5) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the State Medicaid plan; or (6) for home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in section 1861(o)(7) of the Social Security Act. [State Contract § 3.7(A)]

d. Upon request of Provider, Company shall provide or make available to Provider, when contracting or renewing this Agreement with such Provider, the payment or fee schedule or other information sufficient to enable Provider to determine the manner and amount of payments under the Agreement for Provider's services prior to the final execution or renewal of the Agreement, and shall provide any change in such schedules at least ninety (90) days prior to the effective date of any such amendment; provided, however, that Company may make periodic, non-material changes to its payment or fee schedules, such as updates to standard codes and guidelines developed by the American Medical Association or a similar organization, or such as changes required by the State or CMS, without prior written notice. [KRS 304.17A-527(1)(d); KRS 304.17A-577(1)(a); KRS 304.17A-577(2)]

e. In no event shall the State or any Member be liable for the payment of any debt or fulfillment of any obligation of Company, Provider/Subcontractor, or any subcontractor to any Provider/Subcontractor, supplier, out-of-network provider, or any other party, for any reason whatsoever, including the insolvency of Company or any Provider/Subcontractor. Provider/Subcontractor agrees that any contracts that Provider/Subcontractor has with its subcontractors will contain a hold harmless provision and will comply with all provisions of the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract § 13.2]

f. Provider/Subcontractor shall not directly receive payment or any type of compensation from Members for providing Covered Services. Provider/Subcontractor may not bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or any persons acting on their behalf, for services rendered in accordance with the Agreement. This prohibition applies even if Company becomes insolvent, fails to pay Provider/Subcontractor for services rendered, or otherwise breaches the Agreement. This provision does not prohibit the collection from Members of State-authorized co-pays, co-insurance, or deductibles for providing Covered Services. Member co-pay, co-insurance, or deductible amounts cannot exceed the amounts specified in 907 KAR 1:604. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527; State Contract §§ 11.8, 14.2, and 31.4]

g. Provider/Subcontractor shall not bill a Member for Medically Necessary Covered Services, with the exception of applicable co-pays or other cost sharing requirements provided under the State Contract. If Provider/Subcontractor knowingly and willfully bills a Member for a Medicaid Covered Service, Provider/Subcontractor shall be guilty of a felony and upon conviction may be fined as defined in Section

1128B(d)(1), 42 U.S.C. § 1320a-7b of the Social Security Act. This provision shall remain in effect even if Company becomes insolvent. If a Member agrees, in advance, to pay for a service that is not a Covered Service under the State Contract, Company or Provider/Subcontractor may bill the Member for that service. The standard release form signed by a Member at the time of services does not relieve Company or Provider/Subcontractor from the prohibition against billing a Member in the absence of a knowing assumption of liability for a non-Covered Service. The form or other type of acknowledgement relevant to the Member's liability for non-Covered Services shall specifically state the services or procedures that are not covered by Medicaid. [State Contract § 31.4]

h. If Provider/Subcontractor is involved in coordination-of-benefits collections, Provider/Subcontractor shall report coordination-of-benefits information to Company. Provider/Subcontractor shall not pursue collection from the Member, but rather must pursue collection directly from the third party payer or the provider. Access to Covered Services shall not be restricted due to coordination-of-benefits collection. The State has the right to review all billing histories and other data related to coordination-of-benefits activities for Members. [State Contract § 14.1]

i. Company shall process all health care claims submitted for the provision of Covered Services to Members in accordance with KRS 304.17A-726. [KRS 304.17A-726]

j. Provider/Subcontractor acknowledges and agrees that Company shall not pay a Provider/Subcontractor for any provider-preventable condition that meets the following criteria: (1) is identified in the State Medicaid plan; (2) has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; (3) has a negative consequence for the Member; (4) is auditable; and (5) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient. Provider/Subcontractor shall report all provider-preventable conditions associated with claims for payment or Member treatments for which payment would otherwise be made. [State Contract § 31.7]

k. Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state plan or waiver.

l. Company shall not be liable to make any payments for Covered Services for which Provider/Subcontractor fails to follow the preadmission authorization and eligibility verification (for inpatient or outpatient services) procedures set forth in the Agreement, the State Contract, or the Medicaid program. Furthermore, all or a portion of payment due to the Provider/Subcontractor may be denied by Company if such payment is specifically attributable to Provider/Subcontractor's rendering or ordering: (i) services that are not Medically Necessary; (ii) elective hospitalization not authorized by Company; (iii) services provided other than at an authorized level of care; (iv) services that are not Covered Services; or (v) services related to complications from a non-Covered Service. In the event Provider/Subcontractor does not agree with a denial of payment determination made, Provider/Subcontractor may file an appeal in accordance with applicable procedures. [State Contract § 28.9]

3. Any Willing Provider; Provider Application; No Discrimination. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall comply with the "any willing provider" statute as described in 907 KAR 1:672 and KRS 304.17A-270, as amended. Neither Company nor such Subcontractor shall require a Provider to enroll exclusively with its network to provide Covered Services under the State Contract. Nothing in the Agreement shall require or be construed to require a Provider, as a condition of participation in the Medicaid product that is the subject of the State Contract, to participate in any other products offered by Company. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall comply with the terms and obligations set forth in KRS 304.17A-525, and shall allow all providers who desire to apply for network participation an opportunity to apply at any time during the year or, where Company or such Subcontractor does not conduct open continuous provider enrollment, shall conduct a provider-enrollment period at least annually with the date publicized

to providers located in the geographic service area of the plan at least thirty (30) days in advance of such enrollment period. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall not discriminate against providers that serve high-risk populations or that specialize in conditions that require costly treatment, and shall not discriminate against a provider based upon that provider's licensure or certification. If Company or such Subcontractor declines to include a provider within its network, it shall give that affected provider written notice of the reason for its decision. Any option to terminate this Agreement without cause, or to non-renew this Agreement, that Company possesses under the terms thereof shall be subject to the "any willing provider" statute and to Provider's right to reapply for network participation, and Company will consider any such Provider reapplication consistent with the internal standards, policies, and procedures for provider participation that Company has developed in accordance with KRS 304.17A-270 and KRS 304.17A-525. [KRS 304.17A-150; KRS 304.17A-270; KRS 304.17A-525; State Contract § 29.1]

4. Anti-Gag Clause; No Retaliation. Company and Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall not limit a Provider's disclosure to a Member, or to another person on the Member's behalf, of any information relating to the Member's medical condition, health status, medical care, or treatment options (regardless of whether benefits for such care are provided under the State Contract), and shall not prohibit Provider from discussing all treatment options with the Member. Provider shall not be penalized, and no agreement with a Provider may be terminated, because Provider discusses Medically Necessary or clinically appropriate care with a Member or another person on the Member's behalf. Other information determined by Provider to be in the Member's best interest may be disclosed by Provider to Member or to another person on Member's behalf. Provider shall not be penalized for discussing with a Member any financial incentives and arrangements between the Provider and Company/Subcontractor, nor shall Company take any punitive action against a Provider that either supports, or requests an expedited resolution of, a Member's appeal. [KRS 304.17A-530; State Contract §§ 28.1, 28.12, 31.1]

5. Provider Grievances. Provider shall submit any grievance against Company on the State-approved provider grievance form. [State Contract § 28.9]

6. Connectivity to KHIE. If Provider is a PCP, Provider shall establish connectivity to the Kentucky Health Information Exchange ("KHIE") within one year of the effective date of this Agreement, or as otherwise determined by the State. If Provider is not a PCP, Company still encourages Provider to establish connectivity to KHIE. [State Contract § 17]

7. HEDIS and Encounter Data. Provider/Subcontractor shall submit all reports and clinical information required by Company, including but not limited to, HEDIS, EPSDT, etc., in such manner and pursuant to such timeframes requested by Company. Notwithstanding anything herein to the contrary, Provider/Subcontractor shall provide all necessary data, including but not limited to encounter and claims data, to Company in a format specified by the State in accordance with 42 C.F.R. § 438, unless otherwise agreed by the parties. Provider/Subcontractor shall report and/or submit all encounter records in an accurate and timely fashion. [State Contract §§ 16.1, 20.2, 33.1]

8. Amendments; Notice of Material Change. Company may unilaterally amend the Agreement to the extent necessary to comply with applicable federal or State law, regulatory requirements, accreditation standards, or licensing guidelines or rules ("Regulatory Amendment"). Company shall give advance written notice to Provider of such Regulatory Amendment and the effective date thereof. With respect to amendments other than Regulatory Amendments, Company shall give advance written notice to any "participating provider" of any "material change" to this Agreement, as those terms are used and defined in KRS 304.17A-578, at least ninety (90) days prior to the effective date of the amendment. If Provider is a "participating provider" as that term is used and defined in KRS 304.17A-578: (i) the material-change notice shall include a description of the material change and a statement that Provider has the option to withdraw from the Agreement prior to the material change becoming effective; and (ii) Provider shall send written notice no later than forty-five (45) days prior to the effective date of the material change if Provider opts to withdraw following notice of a material change; provided, however, if Company has not received notice of such withdrawal within that forty-five (45) day period, Provider's silence shall constitute acceptance of such amendment. If any change to the Agreement is with respect to an existing prior authorization, precertification, notification, or referral program, or changes to an edit program or specific edits, Company shall provide notice of the change to Provider at least fifteen (15) days prior to the change. [KRS 304.17A-578]

9. Assignment. The Agreement, being intended to secure the services of and be personal to Provider/Subcontractor, shall not be assigned or transferred by Provider/Subcontractor without the prior written consent of Company. Company may assign this Agreement without the consent of Provider/Subcontractor to any Affiliate or any other entity upon thirty (30) days' prior written notice. [State Contract § 6.2(H)]

10. Provider Subcontracts. If otherwise permissible under the Agreement, if Provider enters into a subcontract agreement with another provider to provide its licensed health care services to Members where the subcontracted provider will bill Company or Members directly for the subcontracted services, the subcontract agreement must meet all requirements of Ky. Rev. Stat. Chapter 304.17A and shall be filed with the Commissioner of the Kentucky Department of Insurance in accordance with Ky. Rev. Stat. § 304.17A-527(1)(e). [KRS 304.17A-527(1)(e)]

11. State Contract Creates No Third-Party Rights. Provider/Subcontractor acknowledges that the State Contract does not, and is not intended to, create any rights, benefits, or interests to Provider/Subcontractor. [State Contract § 4.5]

12. Subcontracts. With respect to any and all Subcontracts:

a. Subcontractor shall indemnify, defend, and hold harmless the State, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with the State Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor. [State Contract § 6.1]

b. Subcontractor, in the performance of its obligations, shall use only Medicaid-enrolled providers in accordance with the Agreement and the State Contract. [State Contract § 6.2(D)]

c. Subcontractor is prohibited from receiving any incentive, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services. In addition, a Subcontractor that performs utilization management activities is prohibited from receiving, and from providing to any individual or entity that performs such utilization management activities, any incentives for the denial, limit, or discontinuance of Medically Necessary Covered Services to a Member, all consistent with 42 C.F.R. §§ 422.208 and 438.6(h). [State Contract §§ 6.2(G), 21.2, 29.7]

d. Subcontractor is prohibited from assigning the Agreement or from further subcontracting without the prior written consent of the State. [State Contract § 6.2(H)]

e. The State is the intended third-party beneficiary of this Agreement and, as such, the State is entitled to all remedies that are afforded to third-party beneficiaries under the law. [State Contract § 6.2(I)]

f. Subcontractor, as required, shall timely submit encounter records in the format specified by the State so the Company can meet the specifications required by the State Contract. Subcontractor shall be responsible for transmitting all data to Company as required by 42 C.F.R. § 438. [State Contract §§ 6.2(J), 15.1]

g. Subcontractor shall comply with all provisions of the State Contract that relate to the services or activities that Company has delegated to Subcontractor under the Agreement, and Subcontractor shall furthermore comply with all applicable federal and State law and regulations, including but not limited to KRS 205.8451 through KRS 205.8483, all rules, policies, and procedures of the State, and all standards governing the provision of Covered Services and information to Members, all Quality Assessment/Performance Improvement (QAPI) requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of the State, the Office of Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and State agents to inspect, investigate, monitor, and audit operations, all indemnification and insurance requirements, and all obligations upon termination. [State Contract § 6.2(K)]

h. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, on an ongoing basis, Subcontractor's performance and accreditation. Subcontractor shall be subjected to formal review by Company. [State Contract §§ 4.3(C), 6.2(L)]

i. Any Subcontractor with NCQA/URAC or other national accreditation shall provide Company with a copy of its current certificate of accreditation, along with a copy of the survey report. [State Contract § 6.2(M)]

j. Subcontractor shall report suspected fraud and abuse to Company. [State Contract § 6.2(P)]

k. If Company delegates to Subcontractor any activities or obligations of Company under the State Contract, Company may revoke such delegation or impose other sanctions if the Subcontractor's performance is inadequate, all in accordance with the terms set forth in the Agreement. [State Contract § 4.3(A)]

l. If Company identifies deficiencies or areas for improvement in the Subcontractor's performance under the Agreement, Subcontractor shall cooperate with Company in taking all necessary corrective action. [State Contract §§ 4.3(D), 6.2(N)]

m. If Company delegates to Subcontractor the selection of Providers under the Agreement, Company shall retain the right to approve, suspend, or terminate any Provider selected by that Subcontractor. [State Contract § 4.3(E)]

n. Subcontractor shall at all times remain in compliance with the requirements of 42 C.F.R. § 438. [State Contract § 4.3(F)]

o. A Subcontractor that provides Covered Services shall inform Company if that Subcontractor itself engages a subcontractor in any transaction or series of transactions, in performance of any term of the State Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense. [State Contract § 6.3]

p. Subcontractor acknowledges that the State shall have the right to invoke against Subcontractor any remedy that is set forth in the State Contract, including the right to require the termination of any Subcontract, for each and every reason for which the State may invoke such a remedy against Company or for which the State may require the termination of the State Contract. [State Contract § 6.4]

q. If Company delegates to Subcontractor any utilization-management activities or obligations, Subcontractor shall ensure that all utilization-management programs, processes, and timeframes are in accordance with 42 C.F.R. §§ 431, 438, and 456, with the private-review agent requirements of Ky. Rev. Stat. Chapter 304.17A, and with the State Contract. Such Subcontractor shall adopt Interqual or Milliman for Medical Necessity, except in the event that Interqual or Milliman is not applicable to the specific service being provided, in which case Subcontractor may use other appropriate criteria so long as (1) that criteria or standard is a nationally recognized standard of which the State Department for Medicaid Services has received prior notice, and (2) Subcontractor has confirmed that Interqual or Milliman do not, in fact, contain standards applicable to the specific service being provided. With respect to behavioral-health Medical Necessity determinations, Subcontractor shall adopt the following standardized tools: for adults, Level of Care Utilization System (LOCUS); for children, Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children, Early Childhood Service Intensity Instrument (ECSII); and for substance use, American Society of Addiction Medicine (ASAM). [State Contract § 21.2]

r. If Company delegates to Subcontractor any credentialing or recredentialing activities/obligations, Subcontractor shall conduct all such activities/obligations in compliance with National Committee for Quality Assurance (NCQA) standards, with 907 KAR 1:672, with applicable federal law, and with the State Contract. [State Contract § 28.2]

s. Subcontractor acknowledges (1) that neither it nor its agents, officers, or employees shall be construed to be officers or employees of the State by virtue of the Agreement or the State Contract, and (2) that neither the Agreement nor the State Contract shall be construed as a partnership or joint venture between Subcontractor and the State. [State Contract § 41.7]

t. Subcontractor acknowledges that it is aware of the requirements and penalties outlined in KRS 45A.485, has properly disclosed all information required by this statute, and will continue to comply with such requirements for the duration of the State Contract. [KRS 45A.485]

u. Subcontractor acknowledges that it is aware of the requirements of Executive Order 2015-370 (Minimum Wage for State Employees and the Commonwealth's Service Providers) and that it will pay all workers working on or in connection with the State Contract a minimum of $10.10 per hour for all regular, hourly employees and a minimum of $4.90 per hour for all tipped employees for the duration of the State Contract. [Executive Order 2015-370]

13. Pharmacy Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to pharmacy-related Covered Services:

a. Provider/Subcontractor shall administer all pharmacy benefits in accordance with the provisions and requirements of Section 32.1 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 32.1]

b. If Company delegates to Provider/Subcontractor any pharmacy-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 32.0 of the State Contract. [State Contract §§ 32.0–32.11]

c. Provider/Subcontractor shall cooperate with Company with respect to Company's obligation to process, adjudicate, and pay pharmacy claims in accordance with Section 32.4 of the State Contract, and to submit National Drug Code (NDC) level information on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. [State Contract §§ 32.4, 32.5]

d. Provider/Subcontractor shall comply with the pharmacy prior-authorization provisions and requirements set forth in Section 32.6 of the State Contract. [State Contract § 32.6]

e. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract to (1) establish and maintain a generic-drug Maximum Allowance Cost (MAC) program, and (2) manage specialty pharmacy drugs. [State Contract §§ 32.7, 32.8]

14. Behavioral-Health Benefits. In addition to the other requirements set forth herein that are applicable to Covered Services, with respect to behavioral-health Covered Services:

a. Provider/Subcontractor shall administer all behavioral-health benefits in accordance with the provisions and requirements of Section 34.3 of the State Contract and in accordance with all applicable State and federal laws and regulations. [State Contract § 34.3]

b. If Company delegates to Provider/Subcontractor any behavioral-health-related activities or obligations under the State Contract, Provider/Subcontractor shall comply with the provisions and requirements set forth in Section 34.0 of the State Contract. [State Contract §§ 34.0–34.12]

c. Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record. [State Contract § 34.3]

d. If Provider is a PCP, Provider shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavior-health problems and disorders. PCPs may provide any clinically appropriate behavior-health services within the scope of their practice. [State Contract § 34.7]

e. Provider shall provide behavioral-health services (1) within twenty-four (24) hours of the referral if that service requires crisis stabilization, and (2) within forty-eight (48) hours of the referral if that service is for behavioral-health urgent care. A behavioral-health service appointment following a discharge from an acute psychiatric hospital shall occur within seven (7) days of discharge, and any behavioral-health service appointment not otherwise specified in this subparagraph shall occur within sixty (60) days of the referral. [907 KAR 17:015, § 2; State Contract § 34.8]

f. Provider that is providing behavioral-health services (1) shall refer a Member with known or suspected and untreated physical-health problems to the Member's PCP for examination and treatment with the consent of the Member or the Member's legal guardian; (2) may only provide physical-health services if it is licensed to do so; (3) shall send initial and quarterly (or more frequently if clinically indicated) summary reports of the Member's behavioral-health status to the PCP with the consent of the Member or the Member's legal guardian; and (4) shall ensure that all Members receiving inpatient behavioral-health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge, with Provider ensuring that such outpatient treatment occurs within seven (7) days from the date of discharge and with Provider contacting Members who have missed an appointment within twenty-four (24) hours to reschedule that appointment. [State Contract §§ 34.7, 34.8]

g. A Provider that is providing behavioral-health services: (1) shall ensure continuity of care for successful transition of Members back into community-based supports; (2) shall participate in quarterly continuity-of-care meetings hosted by State-operated or State-contracted psychiatric hospitals; (3) shall assign a case manager prior to or on the date of discharge and provide basic, targeted, or intensive case management services as Medically Necessary to Members with severe mental illness ("SMI") and co-occuring developmental disabilities who are discharged from a State-operated or State-contracted psychiatric facility for Members with SMI; (4) shall participate in discharge planning meetings to ensure compliance with federal *Olmstead* and other applicable laws, with discharge planning focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion; (5) shall thereafter ensure the community supports are meeting the needs of the Member discharged from a State-operated or State-contracted psychiatric hospital; and (6) shall assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs. [State Contract § 34.10]

15. Access to Premises. Subcontractor shall allow duly authorized agents or representatives of the State or federal government or the independent external quality-review organization required by Section 1902(a)(30)(c) of the Social Security Act, 42 U.S.C. § 1396a(a)(30), access to Subcontractor's premises during normal business hours to inspect, audit, investigate, monitor, or otherwise evaluate Subcontractor's performance. If such access to Subcontractor is requested, Subcontractor shall provide and make staff available to assist in the audit or inspection effort, and shall provide adequate space on its premises to reasonably accommodate the State, federal, or external quality-review personnel conducting the audit, investigation, or inspection effort. In addition, Subcontractor shall produce all records, documents, or other data requested as part of such review, investigation, or audit. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Subcontractor's activities. [State Contract § 5.6]

16. Physician Incentive Plan Requirements. In the event compensation to Provider under the Agreement includes Physician Incentive Plans as defined by federal law, those Physician Incentive Plans shall comply with 42 C.F.R. §§ 417.479, 422.208, 422.210, and 438.6(h). Company shall make no specific payment directly or indirectly under a Physician Incentive Plan to Provider as an inducement to reduce or limit Medically Necessary Covered Services furnished to a Member. The Physician Incentive Plans shall not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. Company shall disclose to CMS information on Physician Incentive Plans in accordance with 42 C.F.R. §§ 417.479(h)(1) and 417.479(l) and at the times indicated in 42 C.F.R. § 417.479(d)–(g). Provider further acknowledges and agrees that in the event Provider is deemed to be at substantial financial risk under applicable Physician Incentive Plan regulations, Provider shall (i) cooperate and assist Company in conducting satisfaction surveys of Members using the Provider's services, and (ii) obtain, at Provider's sole expense, any additional stop loss insurance required pursuant to the Physician Incentive Plan regulations. In the event Provider must obtain stop loss insurance pursuant to the Physician Incentive Plan regulations,

Provider shall obtain a stop loss policy with the following terms: (i) the policy is guaranteed renewable; (ii) termination of the policy shall not affect or reduce the policy insurer's obligation to cover, or responsibility for coverage of, the Provider's claims for Covered Services provided to Members during the term of such policy and which are covered under the applicable Plan; and (iii) the policy insurer will provide notice of termination or cancellation of the policy to Company. Bonus amounts paid pursuant to the Agreement, if any, shall not exceed 33% of the maximum payments possible to Provider for services that Provider furnishes directly to Members. [State Contract §§ 11.6, 11.7]

17. Stop-Loss Coverage. If Provider assumes substantial financial risk for contracted services, Provider shall maintain adequate stop-loss protection, sufficient proof of which, including the amount and type of stop-loss coverage maintained, shall be provided to Company by Provider upon request. [State Contract § 13.5]

18. Quality Assessment/Performance Improvement (QAPI) Program. Provider/Subcontractor shall participate in Company's Quality Assessment/Performance Improvement program activities (including but not limited to submission of complete encounter records), shall cooperate with Company with respect to Company's QAPI obligations under the State Contract, and shall cooperate with Company's Quality Improvement Committee. [907 KAR 17:025, § 6; State Contract §§ 19.1–19.4, 38.5]

19. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Provider/Subcontractor shall provide (and if Company delegates to Subcontractor the selection of Providers under the Agreement, Subcontractor shall ensure that its contracted Providers provide) EPSDT services to Members in compliance with the State Contract (and in particular Section 33.1 thereof), with 907 KAR 1:034, and with any policy statements issued by the State or CMS during the term thereof. Provider/Subcontractor shall also cooperate with Company with respect to Company's obligations under the State Contract to submit EPSDT reports to the State. [State Contract §§ 33.1, 38.9]

20. Third Party Liability. Provider/Subcontractor acknowledges and agrees that Medicaid payment, under the State Contract or otherwise, is secondary to other sources of payment for Covered Services provided to Members, and that Medicaid (and consequently Company, as a Medicaid MCO of the State) is the payer of last resort. Provider/Subcontractor furthermore acknowledges and agrees that when Company is aware of third-party sources of payment for Covered Services, Company is required by the State Contract to "cost avoid" (*i.e.*, deny) the associated claim and to redirect Provider/Subcontractor to bill that third-party source of payment as the primary payor. [State Contract § 14.2]

21. Cooperation with Company. Provider/Subcontractor shall cooperate with Company with respect to Company's obligations under the State Contract, including without limitation:

a. Company's obligation to assist the State with its planning process for the State's CMS/CMMI State Innovative Model Design Award initiative, which involves the State partnering with health-system stakeholders to develop a State Healthcare Innovation Plan (SHIP). [State Contract § 5.7]

b. Company's obligation to notify the State of the existence and nature of any capitation agreement that Company has with Provider/Subcontractor pursuant to which Provider/Subcontractor assumes risk, including without limitation information relating to how Provider/Subcontractor pays its downstream providers/subcontractors for providing Covered Services to Members. [State Contract § 6.5]

c. Company's obligation to cooperate with the State as part of any readiness review under the State Contract. [State Contract § 8.1]

d. Company's obligation to submit financial and expense-related reports/data to the State relating to the Risk Corridor Payment Adjustment and the Medical Loss Ratio Adjustment set forth in the State Contract. [State Contract §§ 11.4, 11.5]

e. Company's obligation to investigate, pursue, and report on coordination-of-benefit and third-party-liability resources and recoveries. [State Contract §§ 14.1, 14.2, 38.4]

f. Company's obligation to assist the State with verification that Providers are meeting the requirements of the Electronic Health Records Incentive Payment Program. [State Contract § 18.0]

g. Company's obligation to submit HEDIS reports/data to the State as set forth in the State Contract. [State Contract §§ 20.1–20.3]

h. Company's obligation to develop and implement Performance Improvement Projects as set forth in the State Contract. [State Contract § 20.5]

i. Company's obligation to provide orientation, education, and training for Providers as set forth in the State Contract. [State Contract § 28.5]

j. Company's obligation to reduce unnecessary emergency room visits so that the determination of non-emergent visits is reduced to no more than two (2%) percent in a rolling three (3) month period for that particular Medicaid region in the State. [State Contract § 29.7(J)]

k. Company's obligation to submit to the State claims-level cost data for payment-verification purposes relating to the State's supplemental payments, if any, under Section 30.11 of the State Contract. [State Contract § 30.11]

l. Company's obligation to conduct health risk assessments (HRAs) of Members as set forth in the State Contract. [State Contract § 35.1]

m. Company's obligation to perform care coordination and develop care plans for Members as set forth in the State Contract. [State Contract § 35.3]

n. Company's obligation to assist the State with its development of health homes for Company's medically complex Members. Once approved by CMS, Provider/Subcontractor shall comply with any health home program developed by the State. [State Contract § 35.4]

o. Company's obligation to coordinate with the Women, Infants and Children (WIC) program, including provision of medical information to the WIC program by Providers if requested by WIC agencies and if permitted by applicable law. [State Contract § 35.5]

p. Company's obligation to participate in transition planning and continued care coordination for Members with SMI who are transitioning from licensed personal-care homes, psychiatric hospitals, or other institutional settings to integrated, community-based housing, including the performance of a comprehensive physical and behavioral-health assessment designed to support the successful transition to community-based housing within fourteen (14) days of the transition. [State Contract § 36.6]

q. Company's obligation to respond to any letter of concern, written deficiency notice, or request for a corrective action plan that Company receives from the State relating to Subcontractor or the services that are within the scope of the Agreement. [State Contract § 40.4]

r. Company's obligation to comply with reimbursement rate changes to a pharmacy Provider required by the Department pursuant to KRS 205.647, and any regulations promulgated thereunder. [State Contract § 31.6]

s. Company's obligation to notify the Department of proposed reimbursement rate changes to a pharmacy Provider greater than five percent (5%) in no less than thirty (30) days in advance of the rate change. [State Contract § 31.6]

t. Company's obligation to reprocess any affected claims at the prior reimbursement rate without undue delay by a disallowance of a rate change referenced in paragraph (s) above. [State Contract § 31.6]

u. Company's obligation to comply with all dispensing fee requirements in the state contact, as well as two dollars ($2.00) added to any dispensing fee remitted to pharmacies for POS/retail claims pursuant to 18 RS HB 200. [State Contract § 31.6]

v. Company's obligation to submit all drug utilization and other data required for the Department to collect CMS level rebates on Medicaid MCO utilization, or for the Department to support rebate disputes and resolutions for rebates from drug manufacturers. This includes, but not limited to, information on diabetic testing supplies, insulin, and other drugs administered by Providers in an office or other non-instututional setting. [State Contract § 31.10]

w. Company's responsibility to maintain a claims system capable of identifying 340B drugs dispensed real time, prospectively and retrospectively, to support all Department based efforts and initiatives for 340B drug claim level identification, to reimburse 340B covered entities at the same rates for the same or similar drugs dispensed at non-340B covered entities, and to refrain from discrimination against a 340B covered entity in a way that prevents an enrollee's choice to receive such drugs from the entity. [State Contract § 31.11]

x. Company's obligation to establish a Maximum Allowable Cost (MAC) program, and to comply with all statutes and regulations promulgated thereunder by the Department of Insurance (DOI), the Department, or any other state or federal authority. [State Contract § 31.13]

y. Company's obligation to maintain a pass through pricing contract. [State Contract § 31.14]

22. Hospitalists. Nothing in the Agreement shall require, or be construed to require, the mandatory use of a hospitalist (defined as a physician of record at a hospital for a patient of a participating physician and who may return the care of the patient to that physician at the end of the hospitalization). [KRS 304.17A-532]

23. Licensing/Certification. Provider/Subcontractor shall meet all appropriate licensing and contract requirements specified in applicable State and federal laws and regulations. This includes certification, where required, to provide those health care services in the State as set forth in the Agreement, including certification under CLIA, if applicable. Where applicable, Provider/Subcontractor shall have a valid Drug Enforcement Agency registration number and valid NPI and taxonomy. [State Contract § 3.5]

24. Notice of Legal Action. Subcontractor shall provide written notice to Company of any legal action or notice listed below, within ten (10) days following the date Subcontractor receives written notice of:

a. Any action, proposed action, lawsuit, or counterclaim filed against Subcontractor related in any way to the Agreement or the State Contract;

b. Any administrative or regulatory action, or proposed action, respecting the business or operations of Subcontractor related in any way to the Agreement or the State Contract;

c. Any notice received by Subcontractor from the Kentucky Department of Insurance or the Kentucky Cabinet for Health and Family Services;

d. Any claim made against Subcontractor by a Member having the potential to result in litigation related in any way to the Agreement or the State Contract;

e. The filing of a petition in bankruptcy by or against Subcontractor, or the insolvency of Subcontractor; and

f. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in Subcontractor, or who is an agent or managing employee of Subcontractor, of a criminal offense related to that person's involvement in a program under Medicare, Medicaid, or Title XX of the Social

Security Act, or of fraud, or unlawful manufacture, distribution, prescription, or dispensing of a controlled substance, as specified in 42 U.S.C. § 1320a-7.

[State Contract 41.4]

25. Termination of Agreement and Effect Thereof. In the event the Agreement is terminated, such termination shall not constitute termination of any other agreement that Provider/Subcontractor has entered into with Company or an Affiliate of Company unless otherwise agreed to in writing by the Parties. Furthermore, in the event this Kentucky Medicaid Addendum is terminated, such termination shall not constitute termination of any other Product Addendum or Product Participation that Provider/Subcontractor has entered into with Company pursuant to the Agreement unless otherwise agreed to in writing by the Parties. In addition:

a. In the event of a breach of the Agreement by Company, the termination of the Agreement, or the insolvency of Company, Provider/Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Agreement for the remainder of any month for which the State has made payments to Company, and shall fulfill all of its obligations respecting the transfer of Members to other Providers/Subcontractors, including record maintenance, access, and reporting requirements, all such covenants, agreements, and obligations of which shall survive the termination of the State Contract and the Agreement. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(c); State Contract §§ 6.1, 40.8]

b. In the event of termination for any reason other than a quality of care issue or fraud, Company shall continue to reimburse Provider/Subcontractor in accordance with the Agreement until the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater; and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement is terminated. The terms and obligations set forth in this subsection shall survive the termination of the Agreement. [KRS 304.17A-527(1)(b)–(c); State Contract § 40.8]

c. Company and/or Subcontractor (if Subcontractor manages a network of providers as part of the services it provides to Company under the Agreement) shall terminate from participation any Provider that (i) engaged in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked, or suspended; (iii) has medical staff privileges at any hospital terminated, revoked, or suspended; or (iv) engaged in behavior that is a danger to the health, safety, or welfare of Members. Company and such Subcontractor may also terminate the participation of any Provider that has materially breached the Agreement and has failed to timely and adequately cure such breach. [State Contract § 29.6]

26. Protected Health Information. Provider/Subcontractor shall abide by the same statutes and regulations regarding the confidentiality of protected health information that Company is itself subject to under the State Contract and state and federal law, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d) and 45 CFR Parts 160 and 164. Company shall conduct HIPAA privacy and security audits of Provider/Subcontractor as prescribed by the State. This confidentiality provision shall survive termination of the Agreement. [State Contract § 39.1, 39.2, 41.15]

27. Access to Records. Provider/Subcontractor shall make all of its books, documents, papers, records, medical records, data, surveys, computer databases, or other evidence (collectively, the "Records") available for examination, audit, and/or program review by the State, the Finance and Administration Cabinet, the Auditor of Public Accounts, the Legislative Research Commission, the Attorney General of the State, the Kentucky Department of Insurance, the U.S. Department of Health and Human Services, CMS, the Office of Inspector General Comptroller, authorized federal or State personnel, and the authorized representatives of the governments of the United States and the State including, without limitation, any employee, agent, or subcontractor of the State, CMS, or the State's fiscal agent, for a period of five (5) years after termination of the State Contract, except when an audit has been conducted or audit findings are unresolved. In such case, Records shall be kept for a period of five (5) years in accordance with 907 KAR 1:672, or as amended or until all audit issues are finally resolved, whichever is later. Access shall be at the discretion of the requesting authority and shall be either through onsite review of Records or by submission of Records

to the office of the requesting authority. Any Records requested shall be produced immediately for onsite reviews or sent to the requesting authority by mail within fourteen (14) days following a request. All Records shall be provided at the sole cost and expense of Provider/Subcontractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping, and/or mailing of records. The State shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by Provider/Subcontractor. [State Contract §§ 38.2, 39.1, 41.17, 41.21]

28. Medical Records. With respect to medical records:

a. In addition to the requirements set forth in the Agreement, Provider/Subcontractor shall maintain Member medical records on paper or in an electronic format. Provider/Subcontractor shall maintain Member medical records in a timely, legible, current, detailed, and organized manner to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the State Contract. Medical records shall be signed by the Provider/Subcontractor, as the case may be. [907 KAR 17:015, § 12; State Contract § 28.7]

b. Although the medical records are the property of the Provider/Subcontractor that generates the record, each Member or the Member's representative is entitled to one (1) free copy of his/her medical record. Additional copies shall be made available at cost. Provider/Subcontractor shall preserve and maintain Member medical records for no less than five (5) years unless federal requirements mandate a longer retention period (*i.e.*, immunization and tuberculosis records shall be maintained for a Member's lifetime). [907 KAR 17:015, § 12; State Contract § 28.7]

c. Provider/Subcontractor's medical records shall meet the medical record standards that Company and the State Contract require for medical-chart organization and documentation, for the contents of the medical record, and for individual clinical-encounter documentation. Medical records will reflect all aspects of patient care, including ancillary services. Additionally, a PCP's primary medical record for each Member must contain sufficient medical information from all providers involved in that Member's care to ensure continuity of care. [State Contract § 28.7]

d. If any Covered Service provided by Provider/Subcontractor requires completion of a specific form (*e.g.*, hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation (KAR). Provider/Subcontractor shall retain that form in the event of an audit and a copy shall be submitted to the State upon request. [State Contract § 31.1]

e. If a Member changes PCPs, Provider/Subcontractor shall forward the medical records or copies thereof to the new PCP or provider within ten (10) days of the request. The PCP shall have the Member sign a release of medical records before a medical record transfer occurs. [State Contract § 39.1]

29. Licensing Requirements; Malpractice Insurance.

a. Provider/Subcontractor shall be properly licensed in accordance with all applicable State laws and regulations and shall have in effect a current policy of malpractice insurance as Company may require. [State Contract, Appendix J]

b. Provider/Subcontractor shall comply with Company's verification of Provider/Subcontractor's credentials and insurance coverage, including without limitation completing a credentialing application in accordance with the State's policies and procedures. [907 KAR 17:015, § 4; State Contract, Appendix J]

c. Provider cannot enroll or continue participation in Company's network if Provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if the Provider's required licenses and

certifications are not current, if the Provider owes money to the Medicaid Program, if the office of the Attorney General has an active fraud investigation involving the Provider, or if the Provider otherwise fails to satisfactorily complete the credentialing process. [State Contract § 29.3]

30. Disclosure of Ownership and Control.

a. Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that Company does not make a payment to an individual or entity that has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in federal health care programs, or is excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, Provider/Subcontractor shall disclose to Company: any required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest information; and information on any criminal convictions regarding Provider/Subcontractor and any owner(s) and managing employee(s) at the time this Agreement is executed and annually thereafter, and any time there are changes to such information. [State Contract § 38.15]

b. No Provider, no individual who has a direct or indirect ownership or controlling interest of 5% or more of that Provider, and no officer, director, agent, or managing employee (*i.e.*, general manager, business manager, administrator, director, or like individual who exercises operational or managerial control over that Provider or who directly or indirectly conducts the day-to-day operation of that Provider) shall be an entity or individual: (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. § 1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)–(3) of the Social Security Act (42 U.S.C. § 1320a-7(b)(1)–(3)); (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a State health care program. [State Contract § 3.6]

31. Orientation and Training. Provider shall require its officers and medical staff to attend initial orientation conducted by Company within thirty (30) days after Provider is placed on active status, and shall require same to attend any ongoing orientation and education required by Company as necessary to ensure full compliance with the State Contract and all applicable federal and State requirements. [907 KAR 17:015, § 7; State Contract § 28.5]

32. Advances and Loans. Company shall not, without thirty (30) days' prior written notice to and approval of State, make any advances to Subcontractor (not including capitation payments or payments made by Company to Company's network for the provision of Covered Services). [State Contract § 13.4]

33. Marketing Activities. Provider/Subcontractor shall comply with all allowable and unallowable marketing activities and practices pursuant to 42 C.F.R. § 438.104, and shall submit to Company for its review any marketing or information materials of Provider/Subcontractor that relate to the State Contract, prior to disseminating same. The State shall have the same approval authority for Subcontractor marketing materials as over Company's materials. [State Contract §§ 26.1, 26.2]

34. Advance Medical Directives. If Provider is a PCP, Provider shall have the responsibility to discuss advance medical directives with all adult Members at the first medical appointment of a Member and chart that discussion in the medical record of such Member. [State Contract §§ 28.3 & 28.8]

35. Accounting System. Provider/Subcontractor shall maintain its accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between Company and Provider/Subcontractor. These transactions shall include, but not be limited to, claims payment, refunds, and adjustment of payments. [State Contract § 38.14]

36. Compliance with Laws. Provider/Subcontractor shall adhere to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; the Americans with Disabilities Act of 1990, as amended; the Rehabilitation Act of 1973, as amended; Sec. 202 of Executive Order 11246, as amended; and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. Provider/Subcontractor shall not discriminate in the rendering of services to and/or employment of individuals because of race, gender, color, religion, sex, age, national origin, sexual orientation, gender identity, handicap, political beliefs, disabled veteran status, veteran status, or any other non-merit factor. Subcontractor shall cooperate with Company with respect to Company's obligation under the State Contract to monitor, through quality-assurance audits and otherwise, Subcontractor's compliance with the nondiscrimination provisions set forth in this Kentucky Medicaid Addendum. Subcontractor must also comply with the rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741, and regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112). In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq*.) and its implementing regulation at 45 C.F.R. Part 80, Provider/Subcontractor must take adequate steps to ensure that persons with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement. Provider/Subcontractor's locations shall meet all requirements of the Americans with Disabilities Act and all State and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures that are applicable to health care facilities. [State Contract §§ 5.3, 5.4]

37. State Hold Harmless. Provider/Subcontractor shall indemnify, defend, save, and hold harmless the State and its officers, agents, and employees (collectively, the "State Indemnified Parties") from all claims, demands, liabilities, suits, judgments, or damages, including court costs and attorney fees made or asserted against or assessed to the State Indemnified Parties, arising out of or connected in any way with the State Contract or the performance or nonperformance by Company, by Provider/Subcontractor, or by any officers, agents, employees, suppliers, subcontractors, or providers of any of the foregoing, including without limitation any claim attributable to:

a. The improper performance of any service, or improper provision of any materials or supplies, irrespective of whether the State knew or should have known such service, supplies, or materials were improper or defective;

b. The erroneous or negligent acts or omissions, including without limitation the disregard of federal or State law or regulations, irrespective of whether the State knew or should have known of such erroneous or negligent acts;

c. The publication, translation, reproduction, delivery, collection, data processing, use, or disposition of any information to which access is obtained pursuant to the State Contract in a manner not authorized by the State Contract or by federal or State law or regulations, irrespective of whether the State knew or should have known of such publication, translation, reproduction, delivery, collection, data processing, use, or disposition; or

d. Any failure to observe federal or State law or regulations, including but not limited to insurance and labor laws, irrespective of whether the State knew or should have known of such failure.

[State Contract § 13.2]

Schedule Y-15-KY

Pricing for Kentucky Medicaid Plan

Notwithstanding anything to the contrary in Schedule Y, this Schedule Y-15-KY sets forth the Pricing Retail Discount Guarantees, Mail Discount Guarantees, Dispensing Fee Guarantees and Rebate Guarantees (as defined below) applicable to all Covered Drugs dispensed by retail, mail and specialty Participating Pharmacies to Members under Aetna Better Health, Inc. (together with any successor Covered Plans, the "Kentucky Medicaid Plan"). Notwithstanding anything in the Agreement to the contrary, Section 1 shall constitute a Retail Pricing Plan Category for purposes of the definition of "Retail Discount Guarantees," and the mail pharmacy guarantees in Section 3 of this Schedule Y-15-KY shall constitute Mail Discount Guarantees. Claims under the Kentucky Medicaid Plan adjudicated under this Schedule Y-15-KY shall be excluded from the Retail Discount Guarantees, Dispensing Fee Guarantees, Mail Discount Guarantees, Specialty Product guarantees, and other terms set forth in Schedules Y-6, Y-7 and Y-15, including that such Claims shall not be taken into account for purposes of Guarantee Reports provided pursuant to Part 3 of Schedule Y.

1. Qualifying Prescriptions at Retail Under the Kentucky Medicaid Plan. All retail Participating Pharmacy Paid Claims shall be paid in accordance with Pass Through Pricing, in which PBM applies and charges the Kentucky Medicaid Plan and/or a Member (as part of such Member's Cost Share), if applicable, the actual ingredient costs, dispensing fees and Taxes that PBM pays to the retail Participating Pharmacies for dispensing the Covered Drugs giving rise to such Paid Claims.

A. Brand Drug Rates

In each calendar year set forth in the table below, PBM shall achieve, and shall use commercially reasonable efforts to achieve discounts that exceed, the following Retail Discount Guarantees for Qualifying Brand Prescriptions at retail under the Kentucky Medicaid Plan:

AWP Discounted Rates / Retail Discount Guarantees for Qualifying Brand Prescriptions at Retail			
Days Supply	**2020**	**2021**	**2022**
1-34	____%	____%	____%
35-83	____%	____%	____%
84+	____%	____%	____%

B. Brand Drug Dispensing Fees

In each calendar year set forth in the table below, PBM shall achieve the following Dispensing Fee Guarantees for Qualifying Brand Prescriptionsat retail under the Kentucky Medicaid Plan shall process and be charged to the Kentucky Medicaid Plan:

Dispensing Fee / Dispensing Fee Guarantee for Qualifying Brand Prescriptions at Retail			
Days Supply	**2020**	**2021**	**2022**
1-34	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee

35-83	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee
84+	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee

C. Generic Drug (MAC and non-MAC) Rates

In each calendar year, PBM shall achieve the following Retail Discount Guarantees for Qualifying Generic Prescriptions dispensed at retail under the Kentucky Medicaid Plan:

MAC and Non-MAC Combined Retail Discount Guarantees for Qualifying Generic Prescriptions at Retail			
Days Supply	**2020**	**2021**	**2022**
1-34	____%	____%	____%
35-83	____%	____%	____%
84+	____%	____%	____%

The above guarantees assume that PBM is providing its standard prior authorization services as contemplated by Schedule P in respect of the Kentucky Medicaid Plan. If Aetna elects to terminate PBM's provision of such standard prior authorization services with respect to the Kentucky Medicaid Plan, the above Retail Discount Guarantees for the Kentucky Medicaid Plan shall be increased by two-tenths of one percent (.20%)(*e.g.*, the 76.00% for 2014 would become 76.20%). If Aetna elects for PBM to provide non-standard Prior Authorization services as set forth in the State Plan Specific Addendum to Schedule P (Medicaid & Other State Plan Services) Aetna Better Health Inc., such pricing set forth in this Schedule Y-15-KY shall apply to the Kentucky Medicaid Plan.

Still subject to the Retail Discount Guarantees above, each individual Qualifying Generic Prescription under the Kentucky Medicaid Plan shall process and be initially charged to Aetna at the lesser of the applicable rate in the applicable MAC List or, if the Generic Drug is not on the applicable MAC List, at an Ingredient Cost Charge on a Pass Through Pricing basis that does not exceed the following non-MAC Generic Drug AWP Discounted Rates, or the pharmacy's U&C:

Non-MAC AWP Discounted Rate for Qualifying Generic Prescriptions at Retail			
Days Supply	**2020**	**2021**	**2022**
1-34	____%	____%	____%
35-83	____%	____%	____%
84+	____%	____%	____%

D. Generic Drug (MAC and non-MAC) Dispensing Fees (Effective July 1, 2018)

In each calendar year set forth in the table below, PBM shall achieve the following Dispensing Fee Guarantees for Qualifying Generic Prescriptions at retail under the Kentucky Medicaid Plan:

Dispensing Fee / Dispensing Fee Guarantee for Qualifying Generic Prescriptions at Retail			
Days Supply	**2020**	**2021**	**2022**
1-34	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee
35-83	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee
84+	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee

E. **Administrative Fees Applicable to all Retail Paid Claims under the Kentucky Medicaid Plan**.

Aetna shall pay the following Administrative Fees to PBM with respect to each Paid Claim arising from a Covered Drug dispensed by retail pharmacies to Members under the Kentucky Medicaid Plan:

Administrative Fee for Electronic Submitted Paid Claims at Retail			
Days Supply	**2020**	**2021**	**2022**
All	$____	$____	$____

2. U&C Claims

Each U&C Claim under the Kentucky Medicaid Plan shall process and be charged to Aetna on a Pass Through Pricing basis at the applicable U&C Charge.

3. Mail Order Prescriptions

A. Brand Drug Rates

Each individual Brand Drug prescription dispensed by PBM's mail order pharmacies under the Kentucky Medicaid Plan shall process and be charged to Aetna at the following guaranteed Brand Drug AWP Discounted Rates:

AWP Discounted Rates / Mail Discount Guarantees for Brand Drug Prescriptions by Mail Order			
Days Supply	**2020**	**2021**	**2022**
All	____%	____%	____%

B. Generic Drug Rates

Each individual Generic Drug prescription dispensed by PBM's mail order pharmacies under the Kentucky Medicaid Plan shall process and be charged to Aetna at the following guaranteed Generic Drug AWP Discounted Rates:

AWP Discounted Rates / Mail Discount Guarantees for Generic Drug Prescriptions by Mail Order			
Days Supply	**2020**	**2021**	**2022**
All	____%	____%	____%

C. Brand Drug and Generic Drug (MAC and non-MAC) Dispensing Fees (Effective July 1, 2018)

Each individual Brand Drug and Generic Drug prescription dispensed by PBM's mail order pharmacies under the Kentucky Medicaid Plan shall process and be charged to Aetna at the following Dispensing Fees:

Dispensing Fee Guarantee for Prescriptions by Mail Order			
Days Supply	**2020**	**2021**	**2022**
All	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee	$____ + $2.00 state mandated additional Dispensing Fee

D. Covered Drugs Dispensed by Non-PBM Mail Order Pharmacies

Each Paid Claim for a Covered Drug, other than a Specialty Product, dispensed by a mail Participating Pharmacy (other than PBM's mail pharmacies) under the Kentucky Medicaid Plan shall process and be subject to the Retail Discount Guarantees, Dispensing Fee Guarantees, Rebate Guarantees and other provisions of this Schedule Y-15-KY.

4. Specialty Products

A. Specialty Products Dispensed by Retail Pharmacies

Each Paid Claim for a Specialty Product dispensed by a retail or specialty Participating Pharmacy (other than PBM's specialty pharmacies) under the Kentucky Medicaid Plan shall process and be subject to the Retail Discount Guarantees, Dispensing Fee Guarantees, Rebate Guarantees and other provisions of this Schedule Y-15-KY.

B. Specialty Products Dispensed by PBM Specialty Pharmacies

Each individual Specialty Product prescription dispensed by PBM's Specialty Pharmacies under the Kentucky Medicaid Plan shall process and be charged to Aetna at the guaranteed AWP Discounted Rates set forth in the Y7. $100 Dispensing Fee, plus $2.00 state mandated additional Dispensing Fee ($102.00 in aggregate), charges shall be assessed for Specialty Products dispensed by PBM's specialty pharmacies.

NOTE:

1. New Specialty Products will be charged to Aetna at the default AWP Discounted Rates (unless otherwise determined by Aetna and PBM).

[Specialty Fee Schedule to be inserted]

5. Rebate Guarantees

PBM shall pass through to the Aetna Better Health of Kentucky Plan all Rebates for Brand Drugs at retail and PBM's mail order and specialty pharmacies, but no minimum guaranteed level of Reabtes are guaranteed.

6. Prior Authorization Services

Aetna has elected for PBM to provide non-standard Prior Authorization services as set forth above in Section 4 of this Amendment. The following pricing shall apply to Aetna Better Health of Kentucky and shall be invoiced by PBM and paid by Aetna in accordance with Section 9.6 of the Agreement, with the exception that such invoicing shall be done and payment shall be made on a quarterly basis:

	Optional Service	Description	Fees and Charges
Aetna Better Health of Kentucky	Prior Authorization without data entry	Prior Authorization Services as described in State Plan-Specific Addendum to Schedule P (Medicaid & Other State Plan Services) Aetna Better Health of Kentucky.	The pricing, terms and guarantees set forth in Section 3 of Schedule Y-8 (Optional Services Financial Terms)

aetna℠

William Wolfe
Vice President of Pharmacy
Aetna Pharmacy Management
151 Farmington Avenue, ANA3
Hartford, CT 06156

April 19, 2017

James Margiotta
Corporate Headquarters
CVS Caremark Corporation
One CVS Drive
Woonsocket, RI 02895

Re: Medicare Mail Order Pricing Amendment

Dear Mr. Margiotta:

This Letter of Intent (the "Letter") is intended to confirm the intention of Aetna Health Management, LLC, a Delaware limited liability company ("Aetna"), and CaremarkPCS Health, L.L.C., a Delaware limited liability company ("CVS") to amend the terms of Schedule Y to the Amended and Restated Pharmacy Benefit Management Subcontract Agreement (the "PBM Agreement") between Aetna and CVS dated as of October 2, 2013, as subsequently amended, to update the Mail Discount Guarantees applicable to all Covered Drugs dispensed by PBM Central Fill Pharmacies (or, to the extent provided in Schedule Y-6 to the PBM Agreement, Central Fill Specialty Pharmacies) to Members under Covered Plans that are Medicare Plans. Capitalized terms used but not otherwise defined in this Letter shall have the meaning set forth in the PBM Agreement.

The principal terms of this understanding, to the extent known at this point, are set forth below and will be reflected in a mutually agreeable definitive agreement executed and delivered between the parties. For clarity, the provisions of Sections 3 through 7 are intended to be binding agreements among the parties, enforceable in accordance with their terms.

1. **Schedule Y-6 (Mail Order Pricing).**

Schedule Y-6 to the PBM Agreement will be divided into two separate sections: one providing Mail Discount Guarantees for Medicare Plans and another providing Mail Discount Guarantees for Commercial Plans and, to the extent applicable, State Plans.

Except as set forth in Section 2 below, the pricing terms for Commercial Plans will not be impacted.

Except as set forth in Section 2 below, the Brand Drug and Generic Drug Dispensing Fees for Medicare Plans, or Compound Drug Claims will not be impacted.

3. **Timing.**

The parties will endeavor to execute and deliver the definitive agreement(s) relative to this Letter on or as soon as practicable after April 19, 2017, with an effective date of January 1, 2018. The parties will take necessary steps in advance of January 1, 2018 to enable timely implementation of the arrangements relative to this Letter.

4. **Required Conditions.** The definitive agreement(s) relating to this Letter would be subject to the following conditions, among others:

a. the negotiation, execution and delivery of mutually satisfactory agreements and related documentation (sometimes referred to in this Letter as the "definitive agreement" or "definitive agreement(s)") and the satisfaction or waiver of all conditions precedent contained or provided for therein;

b. the completion by the parties of their respective legal, regulatory and business reviews, and such other inquiries as any of them deem appropriate or necessary, with results satisfactory thereto in their respective sole discretion;

c. other conditions customary in arrangements and agreements of a similar nature.

5. **Confidentiality.** The parties agree to keep this Letter, its contents and the discussions between the parties related thereto confidential and not to disclose the same to any third party (except to attorneys or other professionals hired by them to advise on the negotiation and documentation of the definitive agreement(s) and related matters) without the prior written consent of the other party.

6. **Compliance with Law.** Any definitive agreement(s) related to this Letter would be developed in accordance with CMS regulations, policies, and other requirements and otherwise in accordance with applicable law.

7. **Expenses and Governing Law.** Unless otherwise agreed in writing by the parties, each party shall bear all fees, costs and expenses relative to in-house or retained professionals and other resources it incurs in connection with the planning, development, and negotiation of the definitive agreement(s) and related matters concerning this Letter. This Letter shall be governed by, and construed and enforced, in accordance with the laws of the State of New York, without regard to its conflicts of law's provisions.

This Letter is an expression of intent, and does not set forth all of the matters upon which one or more definitive agreements must be reached in order for the proposed arrangement to be consummated. The omission of certain terms from this Letter is not to be construed so as to diminish the importance or materiality of such other terms, and the parties acknowledge that, in addition to the proposed terms contained in this Letter, any definitive

agreement(s) may contain such additional terms as the parties mutually agree. The respective rights and obligations of the parties remain to be defined in the definitive agreement(s) (the terms and provisions of which will be subject to internal approval by the parties in each of their sole discretion), and the parties acknowledge that they are not legally bound by or otherwise will not incur any obligations under this Letter with respect to the proposed arrangement (other than, in each case the provisions of Sections 3 through 7 which are intended to be binding on the parties upon execution of this Letter). Notwithstanding the foregoing, each of the parties has entered into this Letter in good faith and with the intention of negotiating and executing definitive agreement(s) reflecting the terms and conditions set forth in this Letter. This Letter shall automatically expire upon delivery of the definitive agreement(s) relative to the Arrangement on or as soon as practicable after April 19, 2017.

Sincerely,

AETNA HEALTH MANAGEMENT, LLC

By: William F Wolfe

Its: William Wolfe
Vice President of Pharmacy

ACKNOWLEDGED AND AGREED TO THIS
19TH DAY OF APRIL, 2017.

CAREMARKPCS HEALTH, L.L.C.

By: _____

Its:

AMENDMENT NUMBER 4 TO
AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT
SUBCONTRACT AGREEMENT

This **AMENDMENT NUMBER 4 TO AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT** (this "Amendment"), dated as of April 19, 2017 (the "Amendment Date"), is entered into by and between Aetna Health Management, LLC, a Delaware limited liability company ("Aetna"), on behalf of itself and its Affiliates Aetna RX Home Delivery, LLC, a Delaware limited liability company, and Aetna Specialty Pharmacy, LLC, a Delaware limited liability company, and CaremarkPCS Health, L.L.C., a Delaware limited liability company ("PBM"), on behalf of itself and its Affiliate Caremark Rx, L.L.C., a Delaware limited liability company.

RECITALS

A. Aetna and PBM are parties to a certain Amended and Restated Pharmacy Benefit Management Subcontract Agreement dated as of October 2, 2013, as amended by a First Amendment dated as of February 18, 2015, Amendment Number 2 dated as of January 1, 2015 and Amendment No. 3 dated as of March 24, 2017 (the "PBM Agreement"). Capitalized terms used but not otherwise defined in this Amendment shall have the respective meanings specified in the PBM Agreement.

B. The Parties have agreed to further amend the PBM Agreement in accordance with Section 17.13 thereof to set forth certain agreements between the Parties as set forth below.

NOW, THEREFORE, in consideration of the promises, covenants, representations and warranties set forth herein, and other consideration, the sufficiency of which is hereby acknowledged, the Parties each hereby agree as follows:

1. Section 3.2(b). Section 3.2(b) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

> (b) Core Services & Optional Services. As noted in Schedule Y-8, certain specific PBM Services are designated as "Optional Services;" all other PBM Services are "Core Services." PBM shall provide Optional Services if, as and for so long as requested by Aetna.

2. Section 4.3.

(a) The following definitions in Section 4.3(a) of the PBM Agreement are hereby amended and restated in their entirety to read as follows:

> "Additional Rebates" means all rebates, discounts, service fees, financial adjustments and other consideration paid, credited or owing to and/or collected by Aetna, PBM or any of their respective Affiliates from any Manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to (1) utilization (*e.g.*, market share, growth, etc.) of certain prescription drugs within their respective therapeutic categories whether measured

on the basis of Claims and/or Services arising under this Agreement and/or any other part of PBM's book of business in aggregate, (2) services performed by Aetna, PBM or any of their Affiliates where Aetna, PBM or any of such Affiliates is paid fees or other compensation (excluding Service Fees) on the basis of the volume, value or acquisition cost of prescription drugs or other products that are prescribed or dispensed to Members, (3) the provision of financial protections or adjustments to address future price increases, (4) the efficacy of Covered Drugs or actual Covered Drug utilization outcomes, or (5) any other circumstance, matter, outcome or activity that does not give rise to Other Manufacture Payments or Service Fees. For avoidance of doubt, Additional Rebates include Manufacturer Administrative Fees but do not include Formulary Rebates or Service Fees.

"Formulary Rebates" means all payments, rebates, price protection adjustments and other consideration paid, credited or owing to and/or collected by Aetna, PBM and/or any of their respective Affiliates from any Manufacturer (1) arising from or as a result of (A) the inclusion or exclusion on any Formulary of Covered Drugs manufactured, sold or distributed by such Manufacturer and/or (B) a coverage decision made by Aetna, any Aetna Plan Affiliate or any Aetna Customer, or (2) otherwise involving or relating to drug formularies and/or member copayment, coinsurance or deductible strategies.

(b) The first sentence of Section 4.3(b)(i) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

(i) Except to the extent Aetna elects to have PBM perform and be responsible for such functions as Optional Services pursuant to Section 3.2(b) and Schedules I and I-1 (A) Aetna and Aetna's Affiliates will retain sole responsibility and authority for contracting with Manufacturers with respect to Rebates arising from or relating to Covered Drugs dispensed to Members, whether under the pharmacy or medical benefit segments of the Covered Plans, (B) except as otherwise provided in Schedule N, Aetna and Aetna's Affiliates will retain sole responsibility and authority for contracting with Manufacturers with respect to Service Fees arising from or relating to Covered Drugs dispensed to Members, whether under the pharmacy or medical benefit segments of the Covered Plans, and (C) Aetna and Aetna's Affiliates will retain sole responsibility and authority for implementing and administering such contractual arrangements with Manufacturers and for invoicing and collecting Rebates, Service Fees and other amounts owing thereunder, except as provided in Section 63 of Schedule N.

(c) The first two sentences of Section 4.3(b)(ii) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

(ii) Except to the extent Aetna elects to have PBM perform and be responsible for such functions as Optional Services pursuant to Section 3.2(b) and Schedules I and I-1 or except pursuant to and in accordance with the processes set forth in Schedule N, PBM shall not, and shall cause its Affiliates not to, negotiate, enter into or implement any Contract with any Manufacturer or other Person that would

provide for the payment, directly or indirectly, of any Rebates or Service Fees arising from or attributable to any of the Aetna Plans or any Members, including the provision of Services and/or dispensing of Covered Drugs to Members, whether under the pharmacy or medical benefit segments of the Covered Plans. Notwithstanding the foregoing, nothing in this Section 4.3 shall limit the ability of the retail pharmacies owned and/or operated by PBM's Affiliates from contracting with Manufacturers to provide programs or services with respect to such retail pharmacies' patients so long as such arrangements, programs or services are not specifically directed towards or otherwise related to the Members, this Agreement or the Formulary. In addition, PBM shall not, and shall not permit any of its Affiliates, directly or indirectly, to negotiate or implement any Contract (including the retail pharmacy arrangements described in the preceding sentence) with any Manufacturer or other Person that would result or reasonably would be expected to result in Rebates or Service Fees payable by such Manufacturer to Aetna or any of its Affiliates, or any other Aetna Rebates being reduced or made less advantageous on account of or in exchange for the payment of greater or more advantageous Other Manufacturer Payments or other financial consideration or benefits to PBM or its Affiliates.

(d) Section 4.3(b) of the PBM Agreement is hereby amended by adding a new Section 4.3(b)(iii) at the end thereof to read as follows:

(iii) With respect to each calendar year during which PBM performs Rebate Services for Rebate Covered Medicare Plans, PBM covenants and guarantees that the Aetna Rebates received by or credited to Aetna (or, at Aetna's direction, an Aetna Customer) with respect to each Rebate Category shall equal or exceed the applicable Rebate Guarantees set forth in Schedule Y-10. PBM shall pay or credit to Aetna the Aetna Rebates and Rebate Guarantees in accordance with the requirements set forth in Sections 3.1 and 3.3 of Schedule I-1 and Part 2 of Schedule Y. Each individual Rebate Guarantee shall be administered, measured and reconciled on an aggregate basis with respect all Rebate Covered Medicare Plans to which the corresponding Rebate Category applies. Each individual Rebate Guarantee shall be administered, measured and reconciled as a unique and distinct category, and a deficit (underpayment) in any one Rebate Guarantee in a given calendar year may not be offset against or aggregated with a surplus (or over-performance) in any other Rebate Guarantee or any Mail Discount Guarantee, Retail Discount Guarantee, Specialty Product Discount Guarantee, or Dispensing Fee Guarantee (nor shall any deficit (underpayment) in any such non-Rebate guarantee be offset against or aggregated with a surplus (or over-performance) in any Rebate Category); provided, however, that to the extent provided in Sections 3.1 and 3.3 of Schedule I-1, surpluses and deficits in Rebate Guarantees from the same Pooed Rebate Category and for the same calendar year may be aggregated and offset against each other. To the extent that PBM provides Rebate Services during the Termination Transition Period, the Rebate Guarantees for the Termination Transition Period will be determined in accordance with Section 6 of Schedule I-1.

3. Section 7.3(a). Section 7.3(a) of the PBM Agreement is hereby amended by adding the following to the end of the paragraph:

> Aetna shall provide advance notice to PBM in the event a third party auditor is engaged to perform Manufacturer Rebate audits under Section 11(a) of Schedule X, and if such auditor is not a major accounting firm, the auditor shall be subject to the prior approval of PBM, which shall not be unreasonably withheld. Any third party auditor performing Manufacturer Rebate audits shall maintain the confidentiality of all Confidential Information obtained from PBM in connection with the audit and shall firewall such information within its internal organization from all individuals performing other (non-audit) consulting services. Upon request, the third party auditor shall provide evidence, to PBM's reasonable satisfaction, of its policies and procedures regarding the firewall or assurances the Confidential Information is protected from unauthorized access.

4. Section 7.3(b). Section 7.3(b) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

> (b) Aetna Customer Audits. Subject to Section 7.3(a) and as further described in Schedule X, to the extent that any Aetna Customers also have contractual review or audit rights pursuant to the Plan Contract between Aetna and such Aetna Customer, PBM also shall permit such Aetna Customers (or their designated agents or representatives who comply with the requirements set forth in Section 7.3(a)) to review and/or audit the Aetna Customer specific Required Books and Records and PBM's facilities used to provide (or that will be used to provide) the Services or any portion thereof, on an annual basis or more frequently as agreed upon by PBM (which agreement shall not be unreasonably withheld). To the extent permitted by the Plan Contract between Aetna and such Aetna Customer, such audits may include Claims audits, pre-implementation audits, and operational audits. Aetna shall promptly notify PBM of any such Aetna Customer audit request and shall make best efforts to provide PBM no less than four weeks' notice of any on-site audits. With respect to Rebate Covered Medicare Plans, Aetna Customer audits also may include audits of PBM Rebate Agreements and Aetna Medicare Rebate Agreements under which such Aetna Customer receives Aetna Rebates. PBM shall not, absent Aetna's prior written consent, permit any Aetna Customer to conduct an audit in a manner that does not comply with the limitations on audit rights contained in the Plan Contract between Aetna and such Aetna Customer (including limitations on auditor conflicts of interest and limitations on the frequency and type of audits), to the extent Aetna discloses such requirements to PBM. In the event that PBM receives a request from an Aetna Customer to conduct an audit, PBM shall promptly, and in any event as soon as reasonably practicable, notify Aetna in writing of such request.

5. Section 9.2(f). Section 9.2(f) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

(f) Treatment of Dual Eligibles. All Claims arising under any State Plan submitted by any Dual Eligible (Medicare-Medicaid) Beneficiary shall be adjudicated at the rates applicable to Medicare Plans and shall be treated as Claims under a Medicare Plan for all purposes, including with regard to Rebates, under this Agreement, Schedule Y and Schedule I-1.

6. Annex A.

(a) The following definition in Annex A to the PBM Agreement is hereby amended and restated in their entirety to read as follows:

"Aetna Rebate Agreement" means a Manufacturer Rebate Agreement entered into by Aetna or its Affiliate with a Manufacturer.

(b) Annex A to the PBM Agreement is hereby amended by inserting the following new definitions therein (in their appropriate alphabetical location):

"Aetna Medicare Rebate Agreements" has the meaning given in Section 2.2.3 of Schedule I-1.

"Dual Eligible (Medicare-Medicaid) Beneficiary" means an individual who is entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, and enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a state plan under title XIX of such Act or under a waiver of such plan.

"PBM Rebate Agreements" has the meaning given in Section 2.2.1 of Schedule I-1.

"Pooled Rebate Category" means, collectively, the three Rebate Categories applicable to a specified Medicare Plan type and Formulary configuration (as set forth under each red heading in the tables in Schedule Y-10). For example, the Retail/Mail, HEP C Specialty and Non-HEP C Specialty Rebate Categories applicable to PDP Medicare Plans that utilize the CVS Standard 5T Closed Formulary are together a Pooled Rebate Category.

"Rebate Category" means each line item in the tables in Schedule Y-10 that sets forth Rebate Guarantees for a specified prescription category (e.g., Retail/Mail, HEP C Specialty or Non-Hep C Specialty), Medicare Plan type and Formulary configuration.

"Rebate Covered Medicare Plans" means, with respect to the relevant or applicable time period, any and all Covered Plans that are Medicare Plans for which PBM is performing or performed Rebate Services during such time period pursuant to Schedule I-1.

"Rebate Guarantees" means the Rebate guarantees set forth in Schedule Y-10.

"Rebate Services" has the meaning given in Section 1 of Schedule I-1.

7. Schedule G. Schedule G is hereby amended by adding at the end thereof a new Schedule G-3 in the form of Appendix 1 to this Amendment.

8. Schedule I.

(a) Schedule I is hereby amended by adding the following as a new Section 9 at the end thereof (immediately after Section 8(X)):

> 9. If and as elected by Aetna in accordance with Schedule I-1, PBM shall provide and perform Rebate Services, as defined in, and in accordance with, Schedule I-1 with respect to Covered Plans that are Medicare Plans. For clarity, except as provided in the preceding sentence, Aetna and Aetna's Affiliates shall continue to maintain sole responsibility and authority with respect to the Rebate contracting and other matters set forth in Section 4.3(b)(i) of the Agreement.

(b) Schedule I is hereby amended by adding at the end thereof a new Schedule I-1 in the form of Appendix 2 to this Amendment.

9. Schedule J.

(a) Sections 29 and 30 of Schedule J to the PBM Agreement are hereby amended and restated in their entirety to read as follows:

> 29. With respect to all Aetna Plans (including Medicare Plans), Aetna will retain responsibility for developing and determining all Aetna Formularies and Benefit Plan Designs, which shall be the sole property of Aetna; *provided, however*, that the CVS Medicare Part D Formularies (as defined below) shall be PBM's sole property. Aetna will maintain an Aetna Pharmacy and Therapeutics ("P&T") Committee. As used herein, "CVS Medicare Part D Formularies" means the lists of Brand Drugs with associated coverage decisions established by PBM as the Brand Drug component of its standard formularies for Medicare Plans as provided by PBM to Aetna via an 4/15/17 8:04 PM email from Joseph Vogel to Christopher Risher, Dominic Cioffi, Stephen Fisher, Terri Swanson and others (via four attached .zip files), together with such Brand Drug-related changes to such formularies as PBM may make from time to time and communicate to Aetna in accordance with Section 30 below.
>
> 30. PBM may propose changes to Aetna Formularies, but final discretion shall reside with Aetna and its Affiliates, and with Aetna Customers, as applicable. Without limiting the generality of the foregoing, PBM shall at all times make the applicable CVS Medicare Part D Formularies available to Aetna for use as an Aetna Formulary for Covered Plans that are Medicare Plans, if and to the extent determined by Aetna and Aetna Customers, as modified by Aetna's P&T Committee from time to time. With respect to the CVS Medicare Part D Formularies, PBM shall provide written notice to Aetna of each change to any of the applicable CVS Medicare Part D Formularies, including utilization management tier placement of Brand Drugs and utilization management criteria that impact rebate eligibility, in a timely manner to meet CMS formulary

deadlines and necessary approvals. In the case of new drug entities, PBM will make best efforts to provide direction at least sixty (60) days' prior to the effective date of the change in order to meet Aetna P&T Committee review. Aetna shall notify PBM on the same day it receives from CMS stage review, line item failure, or ad hoc communications related to formulary and/or utilization management criteria. PBM shall provide Aetna within twenty four (24) hours of receiving Aetna's communication PBM's initial response to such CMS' communication(s), and within two (2) business days of receiving Aetna's communication PBM's final guidance to such communication(s). Based on a mutually agreed upon timeline, PBM agrees to provide Aetna a dedicated trade resource to review and provide documentation and quantification relating to proposed changes to CVS Medicare Part D Formularies prior to Aetna submitting such changes to CMS. In the event Aetna's proposed change(s) may result in a negative formulary change that requires a negative change request, or a prior authorization/step file criteria update that requires a request to CMS to open the submission window, PBM will provide timely notification to allow Aetna to meet CMS required timelines.

(b) Section 32 of Schedule J is hereby amended and restated in its entirety to read as follows:

32. In accordance with a schedule to be determined by Aetna, PBM shall provide clinical information including standard drug monographs to Aetna to be used in developing and determining the Aetna Formularies and for use by the Aetna P&T Committee to support its determinations for specific lines of business (i.e. commercial, Medicare, State Health Care Program), including determinations made by PBM's P&T committee, together with support analysis. PBM shall not be part of Aetna's P&T Committee. For so long Aetna's pharmacy benefit membership is greater than one (1) million Members, PBM shall cause two person designated by Aetna (the "Aetna P&T Representatives") to serve as a member of PBM's P&T committee. The Aetna P&T Representatives shall be full participants/members of PBM's P&T committee but shall not have voting rights. The Aetna P&T Representatives may attend all PBM P&T committee meetings in person or by telephone at Aetna's discretion.

10. Schedule O.

(a) Schedule O to the PBM Agreement is hereby amended by inserting the following as a new Section 53 and renumbering the succeeding sections sequentially:

53. In the event Aetna retains responsibility for Coverage Determinations and Aetna also elects to obtain optional Rebate Services from PBM pursuant to Schedule I-1, PBM shall provide to Aetna such information regarding its utilization management criteria and clinical guidelines, to the extent applicable to Rebate Covered Medicare Plans as Aetna may reasonably request. Such information shall be provided in a mutually agreeable format according to the timelines specified in Schedule J and sufficiently far in advance of the

implementation of the criteria (or any changes to the criteria) to enable Aetna to incorporate the information in Aetna's Coverage Determination system and to provide any necessary training to Aetna's Coverage Determination personnel. In no event shall such information be provided to Aetna later than the date it is filed with CMS. PBM understands and agrees that Aetna is fully transparent about its Coverage Determination criteria and clinical guidelines and that Aetna makes such information available on its public Aetna.com internet site.

(b) Schedule O-2 to the PBM Agreement is hereby amended and restated in its entirety to read as set forth on Appendix 3 to this Amendment.

11. Schedule V. Schedule V to the PBM Agreement is hereby amended by adding the following row to the table of Standard Reports set forth therein:

Rebate Reports	1. The reports required under Section 3 of Schedule I-1.

12. Schedule X. Section 11.a of Schedule X to the PBM Agreement is hereby amended and restated in its entirety to read as follows:

a. Manufacturer Rebate Audits. PBM shall assist Aetna in the manner required by Aetna and in a manner consistent with the scope of PBM's obligations regarding rebate administration, including as set forth in Section 8.K of Schedule I, in connection with the administration and management of any audit relating to Aetna Rebates, including Aetna Customer audits, Manufacturer audits, Governmental Body requests or audits, and audits by accreditation organizations. PBM shall accommodate Governmental Body requests or audits as necessary in Aetna's discretion. Without limiting the generality of the foregoing, with respect to Covered Plans that are Medicare Plans, Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit or cause to be audited PBM's performance of its obligations under Schedule I-1 and the accuracy of the Rebate Guarantee Reports (as defined in Schedule Y) with respect to the Rebate Guarantees. As part of each such audit, PBM shall provide Aetna with access to all PBM Rebate Agreements that gave rise to Aetna Rebates that were paid or payable to Aetna during the applicable time period, except that, with respect to any PBM Rebate Agreement that does not solely apply to Aetna, PBM shall be entitled to redact any provision that is specifically applicable to a PBM Customer other than Aetna. Such review of PBM Rebate Agreements shall include all information necessary for Aetna or its third party independent auditor to review and verify, on an aggregate and Claim-by-Claim basis, the accuracy of the Aetna Rebates remitted to Aetna by PBM and PBM's performance of the Rebate Services under Schedule I-1. If any audit of the Rebate Services conducted for or by Aetna uncovers an error that relates to one or more prior years, PBM shall (i) investigate and determine the root cause of such error with respect to all affected or potentially affected years, (ii) work in good faith with Aetna and/or Aetna's third party independent auditor to quantify and resolve such error with respect to all such years (including providing Aetna

and/or the auditor with all information necessary to determine and confirm the cause, extent and resolution of such error) prior to the completion of such audit, and (iii) pay or credit such additional Aetna Rebates or other amounts to Aetna as are necessary to fully remedy and correct the error.

13. Schedules Y, Y-5, Y-8 and Y-10 to the PBM Agreement are hereby amended and restated in their entirety to read as set forth on Appendix 4 to this Amendment.

14. Schedule AA to the PBM Agreement is hereby amended by adding the following row to the bottom of the chart:

Performance Network Rebate Program	Retail Network	Retail

15. Effect of Amendment. All amendments to the PBM Agreement set forth herein shall be effective as of the Amendment Date. Except as amended by this Amendment, the PBM Agreement remains in full force and effect. All references to the PBM Agreement in any other agreement or document shall hereinafter be deemed to refer to the PBM Agreement as amended by this Amendment.

16. Miscellaneous. The provisions set forth in Article XXIII, and Sections 17.19, 17.20, 17.21, 17.22 and 17.26 of the PBM Agreement shall be applicable to this Amendment No. 4 *mutatis mutandis* and to the full extent necessary shall be deemed to be incorporated herein.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the Parties hereto have executed this Amendment as of the date first set forth above.

AETNA HEALTH MANAGEMENT, LLC

William F Wolf

Name: William F Wolf
Title: Vice President

CAREMARKPCS HEALTH, L.L.C.

Name:
Title:

- Claims processing through Long Terms Care ("LTC"), Assisted Living Facilities ("ALF"), Territories ("TER"), Home infusion services ("HIS") or Indian Health Services / Indian Tribal Urban network
- Rural claims
- Mail order claims
- Certain limited distribution specialty drugs (as noted in section 4)
- Claims from PNR Pharmacies that are going out of business
- For any Aetna Medicare Plans designated by Aetna to not have PNR in their retail networks

v. Aetna shall consult with PBM before making exceptions to the amount of Performance Rebates to be collected for chains, PSAOs or other Jointly Contracted Pharmacies for joint ventures or other purposes.

vi. PBM will apply Performance Rebates based on the program parameters and other measures which cannot change within any given Medicare Plan year. PBM shall evaluate PNR Pharmacy performance pursuant to PNR program parameters and payment schedules.

3. Miscellaneous

Aetna will be entitled to Performance Rebates so long as Aetna utilizes PBM's PNR parameters. If CMS requirements change, PBM may revise the PNR program to be in compliance with the CMS regulations. If Aetna requires PBM to revise the PNR program in a manner different than the revisions made by PBM, Aetna will be responsible for PBM's reasonable expenses to implement such revisions.

4. PBM's Specialty Drug List

Aetna shall utilize PBM's Specialty Drug list for Aetna's Medicare Part D Retail Network for PNR administration. While the Specialty Drug list is used in the determination of a pharmacy's status as a specialty pharmacy once a trimester, PBM agrees to update the Specialty Drug list on a weekly basis. PBM may amend the Specialty Drug list to include Specialty Drugs not included on PBM's standard "Universe" Specialty Drug list when the PBM makes the determination that those drugs are commonly considered specialty drugs within the specialty pharmacy community. For purposes of this section, a specialty pharmacy is defined as a PNR Pharmacy for which greater than 25% of its paid claims are for specialty drugs during a four month trimester. If a PNR Pharmacy does not meet the qualifying percentage for a specific trimester, the specialty adherence component will not be part of the Overall Adherence Score, as defined by the PBM for that Plan Year.

PBM will be solely responsible for distributing Specialty Drug list to all pharmacies in the program.

PBM exempts claims for selected limited distribution specialty drugs (LDD) and exclusive distribution drugs (EDD) from the Performance Network Rebate. However, the LDD and EDD

claims are included in the Performance Score calculation.

Aetna will use the PBM's Specialty drug-level list to establish an AWP rate for each drug, separate from the rates established by PBM. Aetna may use the PBM Specialty drug-level list to create one price list for preferred network pharmacies and a separate price list for standard network pharmacies. PBM and Aetna will endeavor to work collaboratively in establishing the drug level pricing for the standard network and Wrap Network pharmacies.

APPENDIX 2

Schedule I-1

[See attached.]

APPENDIX 2

Schedule I-1

Rebate Services

Optional Services

1. **Commencement and Termination of Rebate Services.**

1.1 **Overview.** If and as so elected by Aetna pursuant to Sections 1.2 and 1.3, PBM shall perform the Rebate-related contracting, billing, collection and other services described in this Schedule I-1 ("Rebate Services") in accordance with this Schedule I-1 with respect to certain or all Covered Plans that are Medicare Plans (such Covered Plans, "Rebate Covered Medicare Plans" for and with respect to the time period during which Rebate Services are provided with respect thereto). Rebate Services constitute Optional Services.

1.2 **Commencement of Rebate Services.** Commencing effective as of the first day of any calendar-year during the Term, Aetna shall have the right to have PBM perform Rebate Services with respect to, as designated by Aetna, certain of or all Covered Plans that are Medicare Plans. In order to exercise this right, Aetna must deliver to PBM, no later than May 1 of the year preceding the calendar-year in which Aetna wishes Rebate Services to commence, a written notice that specifies the Covered Plans for which Rebate Services are to be performed and the commencement date therefor. For purposes of this Section 1.2, it is agreed that Aetna has elected to have PBM perform Rebate Services for the Covered Plans listed on Exhibit 1 attached hereto, commencing effective as of January 1, 2018. In addition, after Aetna has elected to have PBM perform Rebate Services for a given time period, Aetna may, by giving written notice to PBM, elect to have Rebate Services also performed during such time period for any newly established Covered Plans that are Medicare Plans or any Medicare Plans of any new Affiliate of Aetna; and PBM shall perform Rebate Services for such additional Plans as soon as reasonably practicable after receipt of such notice.

1.3 **Termination of Rebate Services.** Without limiting Aetna's rights under Article XII of the Agreement, Aetna shall have the right to terminate PBM's provision of Rebate Services with respect to, as designated by Aetna, all or any Rebate Covered Medicare Plans effective as of January 1 of any year, subject to Aetna delivering to PBM written notice of any such termination not later than May 1 of the preceding year (a "Rebate Termination Notice"). In the event of and notwithstanding any termination of Rebate Services, PBM shall continue to invoice, collect and pay to Aetna the Aetna Rebates that are applicable to Paid Claims dispensed under Rebate Covered Medicare Plans for time periods for which PBM provided Rebate Services, and PBM's obligations with respect to the reconciliation of Rebate Guarantees applicable to such time periods pursuant to Schedules Y and Y-10 shall remain in effect.

1.4 **Aetna Right to Engage in Rebate Contracting.** Except to the extent Aetna elects to have PBM provide Rebate Services pursuant to Section 1.2, Aetna shall have the right, directly or through an Affiliate or other Person, to (i) negotiate and execute all contracts with Manufacturers and other Persons for the provision of Rebates for or with respect to all Covered Plans, including Covered Plans that are Medicare Plans, and (ii) perform all Rebate-related

billing, collection and other services. Notwithstanding anything to the contrary in the Agreement or this Schedule I-1, (a) Aetna shall have the right at any time to conduct request for proposal processes for the provision by any other Person of services similar to the Rebate Services and/or for Rebate proposals from Manufacturers for any Aetna Plans (including any Rebate Covered Medicare Plans) for any upcoming calendar year; and (b) from and after the date a Rebate Termination Notice is delivered to PBM with respect to any Rebate Covered Medicare Plans, Aetna may exercise its rights under the first sentence of this Section 1.4 to the extent relating to the following calendar year for and with respect to such Rebate Covered Medicare Plans.

2. **Rebate Services.**

2.1 **Aetna's Authorization.** For any time periods during which PBM performs Rebate Services with respect to Rebate Covered Medicare Plans, (a) Aetna authorizes PBM to contract with Manufacturers for Aetna Rebates as a group purchasing organization for all Rebate Covered Medicare Plans; and (b) PBM and Aetna shall collaborate and negotiate in good faith to jointly develop and agree upon the Rebate contracting strategy that will be implemented by PBM for Aetna for Rebate Covered Medicare Plans, with the objective of both achieving Aetna's clinical and care management objectives and optimizing Aetna Rebates for Aetna with respect to Rebate Covered Medicare Plans.

2.2 **Rebate Services**. Rebate Services shall include the following services, functions and tasks:

2.2.1 PBM shall negotiate and enter into Manufacturer Rebate Agreements (or amend or maintain existing Manufacturer Rebate Agreements to which PBM is a party) for the provision of Aetna Rebates for Aetna with respect to all Rebate Covered Medicare Plans in accordance with this Schedule I-1 ("PBM Rebate Agreements").

2.2.2 To the extent permitted by applicable Law, PBM shall keep Aetna apprised of the status of its efforts to negotiate and enter into PBM Rebate Agreements and shall provide to Aetna such information with respect thereto as Aetna may from time to time reasonably request. In addition, Aetna may, at its sole discretion, participate along with PBM in the negotiations or other discussions with Manufacturers regarding PBM Rebate Agreements with respect to (and only with respect to) terms that will be exclusively applicable to Aetna or one or more Rebate Covered Medicare Plans.

2.2.3 If a Manufacturer is willing to provide Aetna Rebates for Aetna with respect to Rebate Covered Medicare Plans on terms Aetna reasonably determines would provide good value and would be consistent with the Rebate contracting strategy under Section 2.1, but PBM is unable or unwilling to enter into a PBM Rebate Agreement with such Manufacturer on such terms within a reasonable period of time, then Aetna may enter into a Contract for the provision of Aetna Rebates for Rebate Covered Medicare Plans (an "Aetna Medicare Rebate Agreement") with such Manufacturer that includes such terms for Rebate Covered Medicare Plans (but for no other Aetna Plans). Upon the execution of any such Aetna Medicare Rebate Agreement, to the extent necessary, PBM and

Aetna shall equitably adjust the Rebate Guarantees pursuant to Section 5. In addition, with respect to such Aetna Medicare Rebate Agreement, PBM shall perform Rebate Administration Services (as defined in Section 4.1) on Aetna's behalf pursuant to Section 4.

2.2.4 At Aetna's request, PBM shall provide appropriate access to PBM's personnel, advice and other resources in order to assist Aetna, and, if applicable, Aetna P&T Committees, in considering whether Aetna should modify any Aetna Formularies and Benefit Plan Designs in order to increase or otherwise optimize the amount of Aetna Rebates received by Aetna under PBM Rebate Agreements.

2.2.5 PBM shall keep Aetna informed of, and provide reasonable guidance and assistance to Aetna regarding, any potential adverse or positive impacts on Aetna Rebates that may arise from decisions made by Aetna, and communicated to PBM, with respect to Aetna Formularies, Benefit Plan Designs, coverage determination information or other matters pertaining to care management or clinical functions.

2.2.6 PBM shall provide invoicing, collection and payment services with respect to all PBM Rebate Agreements, any Aetna Medicare Rebate Agreements entered into by Aetna pursuant to Section 2.2.3, and any Legacy Aetna Rebate Agreements for so long as they remain in effect.

2.2.7 PBM shall use commercially reasonable efforts (a) to contract with Manufacturers for Aetna Rebates for Rebate Covered Medicare Plans in a manner that will maximize Aetna Rebates and (b) to collect for Aetna all Aetna Rebates due from Manufacturers under PBM Rebate Agreements. In addition, PBM shall utilize and make fully available to Aetna the most advantageous financial terms available to PBM under PBM Rebate Agreements that are or reasonably could be made applicable to Claims under Rebate Covered Medicare Plans.

2.2.8 The services described in Sections 3, 4, 5, 6, 7, 8, 9 and 10 below.

2.3 **Legacy Aetna Rebate Agreements**. Notwithstanding anything to the contrary in the Agreement or this Schedule I-1, Aetna shall be permitted to keep in full force and effect and utilize with respect to Rebate Covered Medicare Plans any Aetna Rebate Agreement that was in effect prior to April 17, 2017 and that does not expire and is not terminable without penalty and without cause prior to January 1, 2018 (any such Aetna Rebate Agreement, a "Legacy Aetna Rebate Agreement"); and if and as requested by Aetna in writing, PBM shall perform Rebate Administration Services on Aetna's behalf pursuant to Section 4 with respect to each such Legacy Aetna Rebate Agreement and to the extent applicable to Rebate Covered Medicare Plans. Aetna and PBM shall cooperate with each other and use commercially reasonable efforts to cause each Legacy Aetna Rebate Agreement not to apply to Rebate Covered Medicare Plans after December 31, 2017 (or as soon as practicable thereafter) and thereafter be replaced by a PBM Rebate Agreement with the same Manufacturer with regard to Rebate Covered Medicare Plans; provided, however, that neither Party shall have any obligations to make any payment to a

Manufacturer or incur any charge or penalty in order to achieve this result. The Parties acknowledge in order for PBM to administer a Legacy Aetna Rebate Agreement (in the event it it not possible to replace it with a PBM Rebate Agreement pursuant to the preceding sentence with regard to Rebate Covered Medicare Plans), it must be administered by PBM on its system and the Legacy Aetna Rebate Agreement cannot be administered on PBM Rebate Administration Computer System at the same time. If a Legacy Aetna Rebate Agreement may not be administered by PBM on its system, as described in the previous sentence, the Parties will work in good faith to determine how to administer such Legacy Aetna Rebate Agreement.

2.4 **Control of Benefit Plan Design and Formulary**. PBM's performance of Rebate Services and the utilization of PBM Rebate Agreements shall not in any way limit Aetna's control over Benefit Plan Design or Formulary, it being understood that such decisions may impact the Rebates received by Aetna under PBM Rebate Agreements and may result in adjustments to the Rebate Guarantees to the extent provided in Section 5.

2.5 **Medicare Part B Claims**. PBM shall perform Rebate Services with respect to, and the Rebate Guarantees shall be applicable to, those Brand Drugs adjudicated under the Part B benefit of Rebate Covered Medicare Plans listed on Exhibit 2 attached hereto, but shall not apply to any other Brand Drugs when adjudicated under the Part B benefit of Rebate Covered Medicare Plans.

3. **Rebate Reporting and Payment For Periods When Rebate Services are in Effect.**

3.1 **Quarterly Rebate Reports**. Not later than forty-five (45) days after the last day of each calendar quarter during which PBM performs Rebate Services or collects any Aetna Rebates, PBM shall affirmatively and accurately determine (a) the Aetna Rebates that were invoiced by PBM on account of Paid Claims dispensed under Rebate Covered Medicare Plans during such quarter, and (b) the Aetna Rebates that were collected by or credited to PBM during such quarter on account of Paid Claims dispensed under Rebate Covered Medicare Plans. Upon completing such determination, and in all events within such forty-five (45) day period, PBM shall provide to Aetna a detailed, accurate and complete report of Aetna Rebates that have been invoiced by PBM, collected by PBM and/or paid to Aetna for or during such calendar quarter and each preceding calendar quarter in the same calendar year (each such report, a "Quarterly Rebate Report"). If PBM has performed Rebate Services for more than one calendar year, PBM shall provide to Aetna a separate Quarterly Rebate Report for each such calendar year (a "Report Year"), with each report addressing Aetna Rebates that arose from Paid Claims dispensed under Rebate Covered Medicare Plans during such Rebate Year; *provided, however,* that PBM may combine the Quarterly Rebate Reports for multiple Rebate Years into a single consolidated report so long as the information required for each Rebate Year is clearly and separately set forth. Each Quarterly Rebate Report for a Report Year shall include the following information, in each case calculated and itemized separately for each Rebate Covered Medicare Plan:

3.1.1 For each Rebate Category and each calendar quarter in the Report Year that has ended, the aggregate sum of Aetna Rebates that have been invoiced by PBM on account of Paid Claims dispensed within such Rebate Category during such calendar quarter ("Rebate Category Invoiced Rebates");

3.1.2 For each Rebate Category and each calendar quarter in the Report Year that has ended, the aggregate sum of Aetna Rebates that are guaranteed by PBM ("Rebate Category Guaranteed Rebates") based upon the applicable Rebate Guarantee and the Paid Claims dispensed within such Rebate Category during such calendar quarter;

3.1.3 For each Pooled Rebate Category and each calendar quarter in the Report Year that has ended, the aggregate sum of Aetna Rebates that have been collected by or otherwise credited to PBM on account of Paid Claims dispensed within such Pooled Rebate Category during such calendar quarter (the "Cumulative Collected Rebate Amount");

3.1.4 For each Pooled Rebate Category and each calendar quarter in the Report Year that has ended, the aggregate sum of all Aetna Rebates that have been paid or credited to Aetna by PBM (including payments of guaranteed Rebate amounts pursuant to Section 3.3.1 and less any amounts repaid by Aetna to PBM pursuant to Section 3.4) on account of Paid Claims dispensed within such Pooled Rebate Category during such calendar quarter (the "Cumulative Paid Rebate Amount"); and

3.1.5 To the extent such information is then reasonably accessible from the computer and IT systems used by PBM to administer Aetna Rebates, for each Rebate Category and each calendar quarter in the Report Year that has ended, the Rebate Category Invoiced Aetna Rebates itemized separately for base Rebates, price protection Rebates and other contingent Rebates.

3.2 **Monthly Rebate Reports**. Not later than the twenty-third (23rd) day of each month, PBM shall report to Aetna, in a mutually agreed upon format, the data described in Section 3.1 estimated in good faith for the prior month, for Aetna's use in preparing financial reports and financial statements.

3.3 **Payment of Rebate Guarantees and Collected Rebates to Aetna.** For any period during which PBM performs Rebate Services or collects any Aetna Rebates, within eighty-five (85) days after the end of each calendar quarter:

3.3.1 PBM shall pay to Aetna the full amount of all Rebate Category Guaranteed Rebates for the immediately preceding calendar quarter (based upon Paid Claims dispensed during such calendar quarter); and

3.3.2 for each Pooled Rebate Category and calendar quarter that has ended where the Cumulative Collected Rebate Amount exceeds the Cumulative Paid Rebate Amount, in each case calculated as of the last day of the most recently ended calendar quarter (or any later date specified by PBM) on an aggregate basis for all Rebate Covered Medicare Plans to which such Pooled Rebate Category is applicable, PBM shall pay the amount of such excess to Aetna.

3.4 **Reconciliation of Rebate Overpayments.** If, as of June 30 of any year, the total amount paid to Aetna pursuant to Section 3.3 on account of Paid Claims dispensed within any Pooled Rebate Category during the immediately preceding calendar year exceeds the greater of

(a) the aggregate sum of Aetna Rebates that were guaranteed by PBM with respect to such Paid Claims (based upon the applicable Rebate Guarantees for such calendar year and Pooled Rebate Category) or (b) the aggregate sum of Aetna Rebates that have been collected by or otherwise credited to PBM on account of such Paid Claims, then PBM shall deliver to Aetna a written report that sets forth the amount of such excess and itemizes in reasonable detail the computation thereof, and Aetna shall pay the amount of such excess to PBM within fifteen (15) Business Days thereafter.

3.5 **DIR Rebate Reporting.** For each calendar year during which PBM performs Rebate Services, PBM shall provide Aetna with required direct or indirect remuneration ("DIR") reports and all necessary data in support of CMS DIR-required data elements with respect to all Aetna Rebates earned or received with respect to such year ("DIR Rebate Reports"), as follows: (a) if CMS publishes the final DIR reporting requirements for the DIR report year at least thirty (30) days prior to the CMS submission due date, PBM shall provide to Aetna the DIR Rebate Reports for such year not less than twelve (12) days prior to the CMS submission due date; and (b) if Aetna notifies PBM that Aetna has identified any errors during its review of the DIR Rebate Reports that require a revision (and Aetna shall use commercially reasonable efforts to issue any such notice within three (3) days after receiving the DIR Rebate Reports from PBM), PBM shall correct and deliver to Aetna revised, corrected DIR Rebate Reports within three (3) days thereafter. In addition, if CMS publishes the final reporting requirements for the DIR report year less than thirty (30) days prior to the CMS submission due date or if CMS publishes material changes to its DIR reporting requirements for a year, Aetna and PBM will mutually agree upon alternative timing that will be applicable under this Section 3.4 to the DIR Rebate Reports for such year.

3.6 **Additional Rebate-Related Reports.** PBM shall provide Aetna with the following additional reports related to Aetna Rebates set forth on Exhibit 3 attached hereto.

4. **Rebate Administration.**

4.1 For and with respect to any period during which PBM is required to perform Rebate Services under this Schedule I-1, PBM shall provide the following as Rebate Services (collectively, the "Rebate Administration Services"):

4.1.1 PBM shall provide invoicing, collection and payment services for and with respect to all PBM Rebate Agreements, any Aetna Medicare Rebate Agreements entered into pursuant to Section 2.2.3 and any Legacy Aetna Rebate Agreements then in full force and effect. PBM shall invoice the applicable Manufacturers for Aetna Rebates arising from Paid Claims dispensed during a calendar quarter under Rebate Covered Medicare Plans not later than 45 days after the last day of such quarter, and shall use commercially reasonable efforts to collect such Aetna Rebates as soon as practicable thereafter.

4.1.2 PBM shall track the receipt of all Aetna Rebates arising from Rebate Covered Medicare Plans, accurately allocate such Aetna Rebates to the correct Aetna Plan, and report such information to Aetna, in each case, in order to enable Aetna to retain or to distribute such Aetna Rebates appropriately to Aetna's Affiliates and Aetna Customers in the manner required by Aetna.

4.1.3 PBM shall respond to, address and administer all audit requests from Manufacturers with respect to Aetna Rebates, PBM Rebate Agreements, Aetna Medicare Rebate Agreements and Legacy Aetna Rebate Agreements, in each case with regard to Rebate Covered Medicare Plans and Claims arising thereunder.

5. Equitable and Annual Adjustments to Rebate Guarantees.

5.1 Rebate Adjustment Events. PBM and Aetna shall in good faith equitably adjust the Rebate Guarantees as set forth in Schedule Y-10 (each such adjustment, a "Rebate Guarantee Adjustment") in accordance with this Section 5.1, upon the occurrence of any of the following events (each, a "Rebate Adjustment Event"):

5.1.1 The execution of an Aetna Medicare Rebate Agreement by Aetna pursuant to Section 2.2.3 to the extent that such Aetna Medicare Rebate Agreement reasonably would be expected to increase or decrease the total Aetna Rebates payable with respect to Rebate Covered Medicare Plans;

5.1.2 Rebates invoiced under a PBM Rebate Agreement being disputed by a Manufacturer based on the Manufacturer's claim that an Aetna Rebate Agreement (other than an Aetna Medicare Rebate Agreement executed pursuant to Section 2.2.3) precludes Claims under Rebate Covered Medicare Plans from being submitted for Aetna Rebates under the PBM Rebate Agreement (provided that the Parties shall use commercially reasonable efforts to cause the Manufacturer to pay such Rebates under the applicable PBM Rebate Agreement);

5.1.3 Any modification by Aetna of any of its Formularies with respect to Brand Drugs or any Generic Drug identified as being subject to this Section 5.1.3 in Schedule Y-10 for Rebate Covered Medicare Plans or any change by Aetna in its utilization management criteria for Rebate Covered Medicare Plans, in each case that would reasonably be likely to result in an increase or reduction in Aetna Rebates;

5.1.4 Aetna allows under any Rebate Covered Medicare Plan more transition fills than are required by CMS;

5.1.5 A change in any Law (including changes in CMS regulations, rules or guidelines) that has a materially adverse or materially positive impact on PBM's ability to contract for or receive Rebates from Manufacturers; or

5.1.6 Any material changes in the volume of 340B Claims, Lipid Disorders-PCSK9 Claims or new-to-market Biosimilar Claims.

5.2 PBM shall promptly notify Aetna in writing upon the occurrence of the events set forth in Section 5.1.2, 5.1.5 or 5.1.6. Aetna shall promptly notify PBM in writing upon the occurrence of the events set forth in Section 5.1.1, 5.1.3 or 5.1.4.

5.3 Notwithstanding anything in Section 5.1 to the contrary, in the event that a Rebate Adjustment Event impacts only certain Rebate Covered Medicare Plans or only a subset of Claims within one or more Rebate Categories, the Parties shall equitably adjust the Rebate Guarantees only with respect to those Rebate Covered Medicare Plans and Rebate Categories that are reasonably expected to be impacted by such Rebate Adjustment Event.

5.4 If so requested by Aetna, prior to the implementation or occurrence of a potential Rebate Adjustment Event that would result from a decision or action by Aetna, the Parties shall work together in good faith to determine as promptly as practicable what, if any, Rebate Guarantee Adjustment would be required if Aetna decided to proceed with the potential Rebate Adjustment Event.

5.5 Whenever feasible the Parties shall endeavor to agree upon a Rebate Guarantee Adjustment prior the occurrence of a Rebate Adjustment Event. If a Rebate Guarantee Adjustment is not effected prior to the occurrence of a Rebate Adjustment Event, the Parties shall work together in good faith to determine the amount of the Rebate Guarantee Adjustment, if any, as promptly as practicable following such occurrence. In either case, any Rebate Guarantee Adjustment shall take effect prospectively, unless either Party has failed to provide timely notice of the Rebate Adjustment Event as required under Section 5.2.

5.6 In determining the amount of any Rebate Guarantee Adjustment, the Parties shall, in good faith, as accurately as possible, estimate the difference in the total amount of Aetna Rebates that will be earned on account of Paid Claims under affected Rebate Covered Medicare Plans after such Rebate Adjustment Event as compared to the amount of Aetna Rebates that would have been earned on account of such Claims in the absence of such Rebate Adjustment Event. If the Aetna Rebate total after the Rebate Adjustment Event is expected to decrease, the Parties shall equitably reduce the affected Rebate Guarantees as necessary, on an aggregate basis, to equal the amount of the anticipated reduction. If the Aetna Rebate total after the Rebate Adjustment Event is expected to increase, the Parties shall equitably increase the affected Rebate Guarantees as necessary, on an aggregate basis, to equal the amount of the anticipated increase. When estimating the impact a Rebate Adjustment Event will have on future Aetna Rebates, the Parties shall:

5.6.1 Apply underwriting practices and guidelines that are consistent with the Baseline Underwriting Assumptions (as reasonably modified and updated to account for the Rebate Adjustment Event) and those utilized by PBM for its own internal purposes and for other PBM Customers (as disclosed by PBM to Aetna in reasonable detail, in writing);

5.6.2 Take into account assumptions determined by PBM, subject to Aetna's prior written approval (not to be unreasonably withheld), with respect to factors such as generic dispensing rate, market share shifts in therapeutic categories, the impact of any loss of patent exclusivity with respect to any Brand Drug, AWP inflation and mail order penetration rates; and

5.6.3 Take into account the most advantageous terms available to PBM under PBM Rebate Agreements that are or reasonably could be made applicable to Claims under Rebate Covered Medicare Plans.

6. Projection-Based Rebate Guarantees and Adjustments.

6.1 During the last ten (10) days of January of each calendar year of the Term (commencing with January of 2018), the Parties shall have an in-person strategic planning meeting to discuss and seek to jointly develop a strategy for Aetna Rebates that the Parties will pursue and implement for the following calendar year (assuming Aetna will elect to have PBM perform Rebate Services during such year), with the objective of both achieving Aetna's clinical and care management objectives and optimizing Aetna Rebates for Aetna with respect to potential Rebate Covered Medicare Plans for the following year. During or prior to such meeting, (a) Aetna shall advise PBM of Aetna's plans and objectives for the upcoming year, to the extent then known or formulated, for Aetna Rebates and the Formularies and Benefit Designs that Aetna expects to utilize for potential Rebate Covered Medicare Plans; and (b) PBM shall advise Aetna of PBM's plans and objectives for the CVS Medicare Part D Formularies for the upcoming year, its assessments and recommendations with regard to opportunities and approaches for maximizing Aetna Rebates in the upcoming year, and its good faith estimate of any improvements to the Rebate Guarantees for such year that will occur under Section 6.2.

6.2 Not later than March 15th and not later than April 8th of each calendar year of the Term (commencing with March of 2018), PBM shall determine, and shall deliver a written report (a "Rebate Projection Report") to Aetna that sets forth in reasonable detail, the projected Aetna Rebates per Brand Drug Claim for each Rebate Category that PBM reasonably and in good faith expects to be earned during the following calendar year (the "Future Year") (*e.g.*, Rebate Projection Reports provided in 2018 shall address Aetna Rebates expected to be earned in 2019). In preparing each Rebate Projection Report and computing the projected Rebate amounts therein, PBM shall:

6.2.1 Apply underwriting practices and guidelines that are consistent with the Baseline Underwriting Assumptions and those utilized by PBM for its own internal purposes and for other PBM Customers (as disclosed by PBM to Aetna in reasonable detail, in writing);

6.2.2 Take into account assumptions determined by PBM, subject to Aetna's prior written approval (not to be unreasonably withheld), with respect to factors such as generic dispensing rate, market share shifts in therapeutic categories, the impact of any loss of patent exclusivity with respect to any Brand Drug, AWP inflation and mail order penetration rates;

6.2.3 Take into account historical Claims experience and all other relevant information then reasonably available with regard to the Rebate Covered Medicare Plans; and

6.2.4 Take into account the most advantageous (Aetna Rebate maximizing) terms available or reasonably expected to be available to PBM under PBM Rebate Agreements that are or reasonably could be made applicable to Claims under Rebate Covered Medicare Plans in the Future Year.

PBM shall make available to Aetna or its representative such information as Aetna shall reasonably request in order to confirm and verify PBM's compliance with the foregoing

provisions of this Section 6.1 and the reasonableness and accuracy of the Rebate projections set forth in each Rebate Projection Report. In connection with the preparation of each Rebate Projection Report, Aetna shall make available to PBM information, to the extent then known, regarding the Formularies and Benefit Designs that Aetna then expects to utilize in the upcoming year for potential Rebate Covered Medicare Plans for such upcoming year, and the Parties shall otherwise cooperate in good faith.

6.3 In each case where the projected per Brand Drug Claim Rebate amount for a Rebate Category set forth in a Rebate Projection Report delivered in April exceeds the corresponding Rebate Guarantee then set forth in Schedule Y-10 for the Future Year, the Parties shall amend Schedule Y-10 to increase such Rebate Guarantee to equal such projected Rebate amount for the Future Year. Alternatively, if Schedule Y-10 does not then include Rebate Guarantees for the Future Year, the Parties shall amend Schedule Y-10 to include Rebate Guarantees for each Rebate Category for the Future Year, with the Rebate Guarantee for each such Rebate Category to be equal to the corresponding projected per Brand Drug Claim Rebate amount set forth in the Rebate Projection Report.

6.4 If Aetna identifies any errors in a Rebate Projection Report, Aetna shall provide PBM with written notice of the errors in reasonable detail, and PBM shall promptly provide a corrected Rebate Projection Report, and Section 6.2 shall be applied (or reapplied) on the basis of such corrected Rebate Projection Report.

6.5. The Parties by mutual written agreement may modify the timing or deadlines for the matters set forth in Sections 6.1 and 6.2.

7. Transition Adjustment to 2018 Rebate Guarantees.

7.1 During the period commencing on April 17, 2017 and ending on May 19, 2017 (the "Guarantee Adjustment Period"), the Parties shall regularly confer and collaborate in good faith to (i) in support of Aetna's Medicare Part D bid for 2018, estimate as accurately as possible the Aetna Rebates that Aetna will earn within each Pooled Rebate Category in 2018, and (ii) refine, update and adjust the Rebate Guarantees for 2018 as reasonably necessary to take into account the following factors and circumstances:

7.1.1 Any reallocations by Aetna during the Guarantee Adjustment Period of anticipated employer group waiver plan ("EGWP") covered lives from one Pooled Rebate Category to another Pooled Rebate Category (as compared to the allocations of such lives assumed by the Parties as of April 14, 2017);

7.1.2 Any modifications by Aetna during the Guarantee Adjustment Period of any of its Formularies or in its utilization management criteria for 2018 with respect to Brand Drugs for Rebate Covered Medicare Plans (including any such modifications made to take advantage of or address changes made during the Guarantee Adjustment Period to any CVS Medicare Part D Formularies for 2018); and

7.1.3 Any changes or reasonably expected changes in the level or rate of Rebates any Manufacturers will pay in 2018 under PBM Rebate Agreements (as compared to PBM's expectations as of April 14, 2017).

During the Guarantee Adjustment Period, (a) PBM shall advise Aetna of (i) any changes it has determined to make to CVS Medicare Part D Formularies for 2018, (ii) any changes or reasonably expected changes in the level or rate of Rebates any Manufacturers will pay in 2018, and (iii) its assessments and recommendations with regard to opportunities and approaches for maximizing Aetna Rebates in 2018 under PBM Rebate Agreements in view of such changes; and (b) Aetna shall keep PBM advised of the matters described in Sections 7.1.1 and 7.1.2.

7.2 Not later than the later of (a) two weeks after the date Aetna definitively advises PBM of the EGWP covered live reallocations Aetna has determined to make during the Guarantee Adjustment Period (per Section 7.1.1), or (b) one week after the date Aetna definitively advises PBM of the Formulary and utilization management criteria modifications Aetna has determined to make during the Guarantee Adjustment Period for Rebate Covered Medicare Plans (per Section 7.1.2), PBM shall determine, and shall deliver a written report (the "2018 Rebate Projection Report") to Aetna that sets forth in reasonable detail, the projected Aetna Rebates per Brand Drug Claim for each Rebate Category that PBM reasonably and in good faith expects to be earned during the 2018 calendar year. In preparing the 2018 Rebate Projection Report, computing the projected Rebate amounts therein and modifying Rebate Guarantees pursuant to Section 7.3:

7.2.1 PBM shall take into account the factors and circumstances described in Sections 7.1.1 – 7.1.3;

7.2.2 PBM shall not be permitted to reduce or effect any downward adjustment to the Aetna Rebate projection or Rebate Guarantee for any Rebate Category on account of the factors and circumstances described in Sections 7.1.1 and 7.1.3, it being understood that such factors and circumstances shall be taken into account only to the extent that they have a positive (increasing) impact on Aetna Rebates and Rebate Guarantees; and

7.2.3 To the extent not inconsistent with Sections 7.2.1 and 7.2.2, utilize the procedures described in Sections 6.2.1 – 6.2.4.

7.3 In each case where the projected per Brand Drug Claim Rebate amount for a Rebate Category set forth in the 2018 Rebate Projection Report exceeds the corresponding Rebate Guarantee then set forth in Schedule Y-10 for 2018, the Parties shall amend Schedule Y-10 to increase such Rebate Guarantee to equal such projected Rebate amount for 2018. In each case where the projected per Brand Drug Claim Rebate amount for a Rebate Category set forth in the 2018 Rebate Projection Report is less than the corresponding Rebate Guarantee then set forth in Schedule Y-10 for the Future Year, the Parties shall amend Schedule Y-10 to reduce such Rebate Guarantee to equal such projected Rebate amount for 2018.

8. Aetna Rebate Personnel; Firewalls.

8.1 Aetna shall limit access to all Claim-level and Drug-level Rebate data and information that PBM provides to Aetna under this Schedule I-1 ("Claim Level Rebate Data") to (a) Aetna's chief financial officer for Medicare and Aetna's chief financial officer for Medicaid and their respective staff who have a need to know such information for purposes of preparing and submitting DIR and other reports to CMS for Rebate Covered Medicare Plans or (b) persons

auditing Aetna Rebates or Rebate Covered Medicare Plans, (such employees, the "Aetna Permitted Employees"). Aetna Permitted Employees may not include any employees of Aetna or its Affiliates who perform duties related to the contracting for Rebates with Manufacturers (such employees, "Aetna Rebate Employees").

8.2 Aetna shall require all Aetna Permitted Employees who receive or have access to Claim Level Rebate Data to agree in writing, for PBM's benefit, not to disclose Claim Level Data to any Aetna Rebate Employees.

8.3 Aetna shall implement and maintain such firewalls as shall be necessary to ensure that Aetna Rebate Employees have no ability to access any Clam Level Data. Such firewalls shall be achieved by logical security protocols that separate Aetna Rebate Employees from Claim Level Rebate Data and from systems and hardware used to receive or store Claim Level Rebate Data.

EXHIBIT 1 to Schedule I-1

Rebate Covered Medicare Plans for 2018

All Medicare Plans that are Covered Plans.

EXHIBIT 2 to Schedule I-1

Medical Benefit / Part B Drugs Included in Rebate Services

LifeScan One Touch Test Strips

EXHIBIT 3 to Schedule I-1

Report Type	Report Description	Frequency	Due Date
Monthly Rebate Guarantee Estimate Report	PBM shall provide Aetna an estimate of the Aetna Rebates that will be an estimate of the Aetna Rebates that are guaranteed for the previous month based on Rebate category and subcategory. Aetna and the PBM will work to develop a solution for inclusion of a B vs. D split for the estimate report. [Report required by Section 3.2 of Schedule I-1.]	Monthly	23rd of each month
Quarterly Rebate Guarantee Estimate Report	PBM shall provide Aetna an estimate of the Aetna Rebate guaranteed amount PBM expects to pay eighty-five (85) days after the end of the quarter based on claims data through the 3rd week of the third month in the quarter being closed. The final 9-10 days of the quarter will be an extrapolation. Format will be the same as the monthly estimate above. Report format will match the Rebate Distribution Summary Sample from the email on Sample Rebate Reports.	Quarterly	Three days after the end of each calendar quarter
Quarterly Rebate Invoice Summary Report	PBM shall provide Aetna with invoice quarter, rebate category, rebate sub-category, Carrier, Account, Group, rebate guarantee, and invoiced rebates. Report format will match the Rebate Distribution Summary Sample from the email on Sample Rebate Reports.	Quarterly	Forty-five (45) days after the end of the quarter
Quarterly Rebate Invoice Breakdown Data File	PBM shall provide Aetna a data file for invoiced dollars grouped by Carrier, Account, Group, CMS Contract*, PBP*, date of service quarter, and invoiced quarter, manufacturer and Med D vs B. This report will not include the rebate guarantee.	Quarterly	Forty-five (45) days after the end of the quarter
Quarterly Paid Amount Breakdown Data File	PBM shall provide Aetna a data file that matches the payment amount to Aetna grouped by Carrier, Account, Group, CMS Contract*, PBP*, and invoiced quarter. If the payment amount is the guaranteed amount, then it will total to the guarantee. If PBM has collected more money than the guarantee, the payment amount must match the collected total. In addition, Aetna may elect to receive a second data file that includes Med D vs B by Carrier, Account, Group, invoice quarter (for all open quarters/still collecting), rebate category, rebate subcategory, invoiced dollars, and collected dollars. This report must cover each year of	Quarterly	Eighty-five (85) days after the end of the quarter

Report Type	Report Description	Frequency	Due Date
	service that is still active for collections.		
Quarterly Rebate Distribution Summary Payment Report	PBM shall provide Aetna the information contained in the Rebate Distribution Summary Report grouped at the Pooled Rebate Category levels. This report must tie to the quarterly Rebate Distribution Summary report. This report must cover each year of service that is still active for collections. This report must cover each year of service that is still active for collections. Report format will match the Rebate Distribution Summary Sample from the email on Sample Rebate Reports.	At the time of payment	Eighty-five (85) days after the end of the quarter

*A crosswalk will be created to map Carrier, Account, Group to CMS Contract and PBP ID.

The parties shall mutually agree upon the format for all of the above reports.

APPENDIX 3

Schedule O-2 (Medicare Services)

Optional Services

Service	Description
Enhanced Safety and Monitoring Solution	PBM shall provide an enhanced fraud, waste and abuse program that provides continuous monitoring, intervention and special investigation, when warranted. PBM shall provide case management services and recommendations for courses of action and additional services. The courses of action included in the base fee include advanced lettering options, coordination with pharmacy audit activities, prescriber toolkit, continuous case management, and member specific utilization management edits. The optional courses of action which are available for an additional fee include prescriber consultations with an independent physician specialist, medication therapy counseling and special investigations.
OTC Health Solutions	PBM will administer an over-the-counter product ("OTC") program that provides a specified allowance to eligible members to Aetna spend on select OTC products as chosen by Aetna. A. Program Description On an annual basis, PBM will provide a pre-defined list of OTC products, with associated formulary prices, and Aetna will select which OTC products to include in the member benefit (the "Plan Formulary"). On an annual basis, Aetna will set the dollar amount and frequency of the member benefit. Aetna may choose different dollar amounts and frequency by plan. During each quarterly or monthly benefit period ("Benefit Period"), as specified by Aetna, eligible members will have one opportunity to utilize the benefit. Eligible members may use the full amount of the benefit or a portion of the benefit, however, once an order is submitted, eligible members will not be able to submit another order until the next Benefit Period. However, PBM may process certain additional orders, including, but not limited to, orders containing damaged or missing items or to remedy an eligibility or benefit error. Aetna and PBM will jointly determine which channels eligible members may utilize to effectuate their benefit.

B. PBM Responsibilities

PBM will verify member's eligibility prior dispensing the OTC product.

Eligible members may use their benefit only once per Benefit Period up to the specified benefit amount. For each OTC product selected or ordered by an eligible member, PBM will charge the PBM retail price indicated on the order form.

PBM will primarily ship OTC products to eligible members via United States Postal Service, but may utilize other delivery services from time to time.

PBM will provide eligible members with toll free phone and fax numbers.

PBM will provide a bilingual (Spanish/English) customer service representative to assist eligible members with placing orders and questions related to the OTC program.

PBM and Aetna will work together to establish a website for eligible members to use to take advantage of their benefit. PBM will operate and support the website, which will feature the Aetna logo. PBM requires ninety (90) days to implement the website.

PBM may elect to deliver pharmacy label messages regarding PBM services to eligible members who elect to fill prescriptions at CVS/pharmacy.

PBM will ensure that eligible members 1) only receive items included on the OTC Plan Formulary, and 2) do not exceed the specified benefit amount and order frequency.

PBM will include a replacement order form inside each package shipped to be used for the eligible member's next order.

PBM may adjust retail prices on the Aetna selected OTC Plan Formulary once per year to reflect actual increases in product costs. PBM will provide thirty (30) days prior written notice in advance of such rate change. PBM may adjust shipping rates once per year.

PBM, through its affiliate, will invoice Aetna once per month. Invoices will specify product costs, sales tax, and shipping costs due to PBM.

PBM shall provide Aetna with monthly reports, including an itemized

	report of orders filled and shipped to each eligible member, and quarterly reports showing call center metrics. PBM will provide custom and ad hoc reporting in accordance with Schedule V. C. Aetna Responsibilities Aetna will provide PBM with an updated eligibility file at least once per month, indicating which members are eligible for the OTC program.
Vaccination Program	PBM will provide vaccination services to eligible members. The parties will review the Vaccine Program Enrollment Form to ensure that it accurately describes the services PBM will provide to Aetna. PBM will administer a Vaccine Program that includes the Aetna NAS Contracted Vaccine network as well as the PBM Vaccine Network. The Vaccine Program will be set up and administered by PBM as part of its existing Vaccine platform. PBM's standard Broader Vaccine Network (the "PBM Vaccine Network") will "wrap around" Aetna's NAS Contracted Vaccine Network and will utilize Aetna's contracted rates for the NAS Contracted Vaccine Network. NAS Contracted Vaccine Network is an enterprise-wide medical network that contracts with pharmacies for the purposes of providing vaccines, inclusive of, but not limited to, influenza and pneumonia. The NAS Contracted Vaccine Network is comprised of chains and independent pharmacies. If a pharmacy participates in both the PBM Vaccine Network and the Aetna NAS Contracted Vaccine network PBM shall apply Aetna NAS Contracted Vaccine Rates. Periodically, PBM will make available Vaccine Program Enrollment Forms which set forth specific Vaccine Program offerings Aetna will elect those specific Vaccine Program options that it wishes to utilize on such Vaccine Program Enrollment Form(s). Aetna's election to participate in a specific Vaccine Program is not exclusive and Aetna may choose to offer its members other options for vaccinations outside of the PBM Vaccine platform and PBM adjudication. The Aetna NAS contracted vaccine network to be set up and administered by PBM on their existing vaccination program platform as the primary network, and the PBM contracted vaccine network will wrap around that network. . In order for the vaccine claim to process through the Vaccine Program, the pharmacy in either the Aetna NAS Contracted Vaccine Network or the PBM Vaccine Network must be in the Aetna Broad Pharmacy Network. For purposes of the Vaccination Program, the "Aetna Broad Pharmacy Network" consists of the Aetna Med D Retail Pharmacy

Network and the home infusion, long-term care, assisted living, U.S. territory, Indian Health Services/Tribal/Urban Indian Health networks owned by PBM or any Affiliate of PBM.

Aetna is responsible for the contents of NAS Contracted Vaccine Network as provided to PBM.

The vaccine Claim must be submitted by the provider in NCPDP D.0 standard utilizing the proper triggers for vaccine processing.

Annual Flu Season Vaccination Elections

Unless otherwise specified in a Vaccine Program Enrollment Form, influenza vaccination Vaccine Program offerings will change each Flu Season. A "Flu Season" will generally begin in August or September of a calendar year and continue for several months thereafter into the succeeding calendar year, as set forth in a specific annual enrollment form. Specific Vaccine Program offerings may vary from one Flu Season to the next based on relevant considerations, including, but not limited to, vaccine availability, client requests, and availability of qualified personnel to administer vaccinations, and may include additional vaccination options in addition to influenza vaccinations.

Non-Seasonal Vaccination Elections

Under the Vaccine Program, certain non-seasonal vaccine offerings may be available from time to time, which will be set forth in a Vaccine Program Enrollment Form. Non-seasonal vaccine services under the Vaccine Program may be provided on an open-ended basis and span multiple Flu Seasons, as indicated on the respective Program Enrollment Form.

Periodic Vaccine Program Elections

While this Vaccine Program remains in effect, PBM shall, upon request, provide Aetna with one or more Vaccine Program Enrollment Forms which shall detail the specific features and fees of the Vaccine Program then available for the current Flu Season or other time period. Aetna shall indicate its election to participate in the Vaccine Program on the appropriate Vaccine Program Enrollment Form and return such signed Vaccine Enrollment Form to PBM. PBM shall provide Vaccine Program services to Aetna in accordance with the terms of this section and the applicable Vaccine Program Enrollment Form. The terms of any current, executed, Vaccine Program Enrollment Form shall, as

applicable, control over this section for the respective Flu Season services or non-seasonal vaccine services corresponding to such Vaccine Program Enrollment Form.

Termination of Participation

Aetna may terminate participation in the Vaccine Program as of the end of any Flu Season, or, with respect to any non-seasonal vaccination offerings, if available and elected, upon thirty (30) days' prior written notice to PBM.

Participating Vaccine Pharmacies.

Subject to pharmacy schedule and vaccine availability, certain NAS Contracted Vaccine Network pharmacies and in the PBM Vaccine Network shall administer the vaccinations elected in the respective Vaccine Program Enrollment Form. Participation in the Vaccine Program does not obligate Aetna to an exclusive vaccine administration arrangement with PBM provided that it is offered outside of the PBM Vaccine platform and PBM adjudication.

Those pharmacies that participate in the Vaccine Program are referred to as the "Participating Vaccine Pharmacies".

MinuteClinic locations are not Participating Vaccine Pharmacies and do not administer vaccinations under the Vaccine Program.

Availability of vaccines may vary by Participating Vaccine Pharmacy location.

At Aetna's request, PBM shall provide Aetna with a current list of Participating Vaccine Pharmacies. Aetna understands and acknowledges that PBM has the sole responsibility for administering the PBM National Network.

Vaccine Program Pricing

The NAS Contracted Vaccine Network vaccine claims will process at rates negotiated by Aetna for the NAS Contracted Vaccine Network. The pricing for NAS Contracted Vaccine Network vaccine claims will include a flat rate which incorporates the ingredient cost for the vaccine, vaccine administration fee, and dispensing fee.

The pricing terms for the PBM vaccine network are set forth in the Vaccine Program Enrollment Form and (a) for influenza vaccines, include a flat rate which incorporates the ingredient cost for the vaccine,

vaccine administration fee, and dispensing fee and (b) for non-seasonal vaccines include the vaccine, vaccine administration fee, and dispensing fee.

PBM shall collect member co-payments as agreed to by Aetna and PBM in a Vaccine Program Enrollment Form. PBM will invoice Aetna for the services described in this section and will not bill any payor other than Aetna for such services.. PBM disclaims any obligation to engage in coordination of benefits with respect to the vaccine services described in this section.

The provision of Vaccine Program services is subject, at all times, to vaccine availability. In the event of an epidemic, pandemic or similar public health incident(s), PBM may be unable to purchase and/or supply vaccine and product held by PBM may be subject to superseding requirements imposed by a governmental authority, including, without limitation, seizure.

PBM shall have no liability due to any resulting inability to provide Vaccine Program services. PBM will not implement the Vaccine Program without receipt of one or more executed Vaccine Program Enrollment Forms within the timeframe specified on the Vaccine Program Enrollment Form.

APPENDIX 4

Schedules Y, Y-5, Y-8 and Y-10

[See attached.]

AMENDMENT NUMBER 5 TO AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT

This **AMENDMENT NUMBER 5 TO AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT** (this "Amendment"), dated as of August 29, 2018 (the "Amendment Effective Date"), is entered into by and between Aetna Health Management, LLC, a Delaware limited liability company ("Aetna"), on behalf of itself and its Affiliates Aetna RX Home Delivery, LLC, a Delaware limited liability company, and Aetna Specialty Pharmacy, LLC, a Delaware limited liability company, and CaremarkPCS Health, L.L.C., a Delaware limited liability company ("PBM"), on behalf of itself and its Affiliate Caremark Rx, L.L.C., a Delaware limited liability company. Aetna and PBM are sometimes referred to herein collectively as "Parties" and individually as a "Party."

RECITALS

A. Aetna and PBM are parties to a certain Amended and Restated Pharmacy Benefit Management Subcontract Agreement dated as of October 2, 2013, as amended by a First Amendment dated as of February 18, 2015, Amendment Number 2 dated as of January 1, 2015, Amendment No. 3 dated as of March 24, 2017 and Amendment Number 4 dated as of April 19, 2017 (the "PBM Agreement"). Capitalized terms used but not otherwise defined in this Amendment shall have the respective meanings specified in the PBM Agreement.

B. Effective January 1, 2018, CMS transitioned coverage for the Covered Drug Sensipar from Medicare Part D to Medicare Part B ESRD bundles. The Parties agree that such transition of Sensipar constitutes a Rebate Adjustment Event, as set forth in Section 5.1.5 of Schedule I-1 of the Agreement.

C. The Parties have agreed to make a Rebate Guarantee Adjustment for Sensipar pursuant to Section 5.6 of Schedule I-1 of the Agreement.

D. At the request of PBM, Aetna has agreed to makes certain clinically appropriate Formulary additions and adjustments to increase the Rebates earned by the Aetna Rebate Covered Medicare Plans for prescription drugs being covered under such Plans without corresponding increases to Paid Claim Rebate Guarantees except as noted for HEP-C, provided that PBM makes Aetna whole for any adverse Net Plan Liability, as defined below, impact experienced by Aetna associated with such Formulary additions and adjustments adjusted for Net Retained Direct or Indirect Remuneration (DIR) under the Agreement, as defined in Section 2 below; and PBM desires to make Aetna whole for such impact in accordance with the methodologies outlined in the True-up Types in Appendix 1.

E. The Parties have agreed to further amend the PBM Agreement in accordance with Section 17.13 thereof to set forth certain agreements between the Parties as set forth below.

NOW, THEREFORE, in consideration of the promises, covenants, representations and warranties set forth herein, and other consideration, the sufficiency of which is hereby acknowledged, the Parties each hereby agree as follows:

b. With respect to Naïve Patients, the Parties shall make equitable adjustments for such Members' Claims for Trelegy or Nucynta ER that are processed during the period that such Members Claim experience falls within the Medicare Part D coverage gap phase or catastrophic coverage phase (the "Impacted Claims"). For each Impacted Claim, the Parties shall calculate the difference in Aetna Rebate Covered Medicare Plan liability between the prior same-drug-class therapy or therapies and Trelegy or Nucynta ER, as applicable. If such Naïve Patients were not utilizing a prior therapy in the same drug class, the calculation shall use $0 as the Aetna Rebate Covered Medicare Plan liability before the impact of the Impacted Claims. This difference shall then be divided by the Net Retained Direct or Indirect Remuneration (DIR) under the Agreement. The Parties acknowledge that Trelegy or Nucynta ER may replace multiple prior drug therapies and, in such event, the difference in Aetna Rebate Covered Medicare Plan liability in switching to Trelegy or Nucynta ER may be a negative value. The Parties shall net the liability calculations across all Impacted Claims across each Aetna Rebate Covered Medicare Plan to determine a final value for each such Plan and then divide by the Net Retained Direct or Indirect Remuneration (DIR) under the Agreement ("Impacted Claim Plan Total"). Adjustments pursuant to this Section 3 shall be referred to as "Gap and Cat" adjustments on Appendix 1, attached hereto.

4. Adjustments for Excess New Utilizers. As part of the annual pricing reconciliation as set forth in Section 3 of Schedule I-1 of the Agreement, the Parties shall meet and confer to make equitable adjustments for negative financial impacts experienced by Aetna, if any, as a result of adding Austedo to the Formulary for each Aetna Rebate Covered Medicare Plan pursuant to Section 1, above, as set forth below.

a. Adjustments pursuant to this Section 4 shall be limited to Members ("Naïve Patients") first filling prescriptions for Austedo in excess of the current run rate of 30 "Naïve Patients" per month after the date upon which these drugs are added to the Formulary for each Aetna Rebate Covered Medicare Plan. The first 30 "Naïve Patients" will be determined as the first 30 Naïve Patients per month first filling prescriptions for Austedo in chronological order by fill date. Members that have filled prescriptions for such drugs prior to such date shall be excluded from any adjustment calculations.

b. With respect to Naïve Patients, the Parties shall make equitable adjustments for such Members' Claims for Austedo that are processed during the period that such Members claims experience falls within the Medicare Part D ICL phase, coverage gap phase, or catastrophic phase after the formulary addition (the "Impacted Claims"). For each Impacted Claim, the Parties shall calculate the difference in

Aetna Rebate Covered Medicare Plan liability between the prior same-drug-class therapy or therapies and Austedo, as applicable. If such Naïve Patients were not utilizing a prior therapy in the same drug class, the calculation shall use $0 as the Aetna Rebate Covered Medicare Plan liability before the impact of the Impacted Claims. This difference shall then be divided by the Net Retained Direct or Indirect Remuneration (DIR) under the Agreement. The Parties acknowledge that Austedo may replace multiple prior drug therapies and, in such event, the difference in Aetna Rebate Covered Medicare Plan liability in switching to Austedo may be a negative value. The Parties shall net the liability calculations across all Impacted Claims across each Aetna Rebate Covered Medicare Plan to determine a final value for each such Plan and then divide by the Net Retained Direct or Indirect Remuneration (DIR) under the Agreement ("Impacted Claim Plan Total"). Adjustments pursuant to this Section 4 shall be referred to as "Adjustments for Excess New Utilizers" adjustments on Appendix 1, attached hereto.

5. After calculation for each Pooled Rebate category of the final value of the Impacted Claim Plan Total which by definition includes dividing by the Net Retained Direct or Indirect Remuneration (DIR) under the Agreement, pursuant to Subsection 2, 3(b), and 4 above, the Parties shall compare the final value of the Impacted Claim Plan Total against any minimum Paid Claim Rebate Guarantee overperformance for each Pooled Rebate Category. Such overperformance for each Pooled Rebate category is defined as the positive amount, if any, by which actual Paid Claim Rebates to Aetna exceed the minimum Paid Claim Rebate Guarantee for each Pooled Rebate Category

a. If there is no overperformance for the Pooled Rebate Category, then the PBM is liable to pay Aetna the minimum Paid Claim Rebate Guarantee plus the final value of the Impacted Claim Plan Total for the Pooled Rebate Category.
b. If the final value of the Impacted Claim Plan Total exceeds the overperformance for the Pooled Rebate Category, PBM is liable to pay Aetna the minimum Paid Claim Rebate Guarantee plus the final value of the Impacted Claim Plan Total less the overperformance for the Pooled Rebate Category.
c. If the final value of the Impacted Claim Plan Total is less than or equal to the overperformance for the Pooled Rebate category, then the PBM is liable to pay Aetna the minimum Paid Claim Rebate Guarantee plus any overperformance less the Impacted Claim Plan Total.
d. Further, for the purpose of the PBM being entitled to certain incentive payments if Aetna Rebates paid to Aetna exceed the minimum Paid Claim Rebate Guarantees for the Pooled Rebate category, the amount of the overperformance for determining and paying such incentive payments shall be determined after deducting the final value of the Impacted Claim Plan total for each Pooled Rebate category from the overperformance.

6. Parties mutually agree that the drugs shown in Appendix 1 classified as Hep C drugs (Mavyret, Vosevi, Zepetier), which are not designated as eligible for Hep C Specialty Rebate Guarantees prior to this Amendment, will become classified as eligible for Hep C Specialty Rebate Guarantees as of the Formulary Change Date. Per Appendix 1, minimum rebate guarantees have been reset for Hep-C and are found in Appendix 2. For EGWP, the revised minimum rebate guarantees have been specified and agreed to by product type, i.e., EGWP MAPD and EGWP PDP; the guarantees by product type will be further refined by formulary in order to align with the contractual categories EGWP A1, EGWP B2 and EGWP Open. The EGWP minimum guarantees by formulary will be equivalent to the EGWP minimum guarantees by product type when weighted by the same projected script count. See example in Appendix 3 for illustrative calculation.

7. In order for PBM to track its obligations, if any, related to Impacted Claims, Aetna shall provide PBM with the information on PDE records required to track such obligations for drugs listed in Appendix 1 marked with PDE information required, beginning within 30 days of the date such drugs are added to the Formulary for each Aetna Rebate Covered Medicare Plan.

8. Schedule Y-10. Section 1 of Schedule Y-10 (Medicare Plan Rebate Guarantees) to the PBM Agreement is hereby amended and restated as of January 1, 2018 as set forth in Appendix 2 to this Amendment.

9. Schedule I-1. Section 2.5 of Schedule I-1 to the PBM Agreement is hereby amended and restating in its entirety to read as follows:

   2.5 **Medicare Part B Claims**. PBM shall perform Rebate Services with respect to, and the Rebate Guarantees shall be applicable to, those Brand Drugs adjudicated under the Part B benefit of Rebate Covered Medicare Plans. Rebate Guarantees for Medicare Advantage with Prescription Drug plans (MAPD) and Medicare Advantage Medical Only plans (MA-only) include a Lifescan One Touch solo strategy in the diabetic strips category, except the open diabetic test strip strategy offers for MA-only, Medicaid MMP, EGWP A1, EGWP B2 and EGWP Open formularies. Rebate guarantees are based solely on PBM adjudicated claims and are not guarantees for Part B claims processed in medical or outside of the PBM adjudication. The rebate guarantees apply to all Part B PBM adjudicated claims for Brand Drugs.

10. Effect of Amendment. All amendments to the PBM Agreement set forth herein shall be effective as of the Amendment Effective Date. Except as amended by this Amendment, the PBM Agreement remains in full force and effect. All references to the PBM Agreement in any other agreement or document shall hereinafter be deemed to refer to the PBM Agreement as amended by this Amendment.

IN WITNESS WHEREOF, the Parties hereto have executed this Amendment by their respective duly authorized representatives as of the Amendment Effective Date.

AETNA HEALTH MANAGEMENT, LLC

Terri A Swanson Digitally signed by Terri A Swanson Date: 2018.08.30 16:29:25 -04'00'

Name:
Title:

CAREMARKPCS HEALTH, L.L.C.

LEGAL UCO REVIEW

Edward DeVaney

Name: Edward DeVaney
Title: Division Head

APPENDIX 1

Class	Drug Name	Formulary Tier Placement: 5-Tier Formulary	2-Tier Formulary	Rebate Category	True-Up Type	PDE Information Required
Hep C	Mavyret	Add to Tier 5	Add to Tier 2	HEP C SPECIALTY	Minimum rebate guarantee reset	No
Hep C	Vosevi	Add to Tier 5	Add to Tier 2	HEP C SPECIALTY	Minimum rebate guarantee reset	No
Hep C	Zepatier	Add to Tier 5	Add to Tier 2	HEP C SPECIALTY	Minimum rebate guarantee reset	No
Opioids	Nucynta ER	Add to Tier 3	Add to Tier 2	RETAIL 30 / RETAIL 90 / MAIL	Cost Share and Gap and Cat	Yes
Incretin Mimetics	Xultophy	Add to Tier 3	Add to Tier 2	RETAIL 30 / RETAIL 90 / MAIL	Cost Share	Yes
Incretin Mimetics	Soliqua	Add to Tier 3	Add to Tier 2	RETAIL 30 / RETAIL 90 / MAIL	Cost Share	Yes
Incretin Mimetics	Ozempic	Add to Tier 3	Add to Tier 2	RETAIL 30 / RETAIL 90 / MAIL	N/A	No
Incretin Mimetics	Trulicity	Move down to Tier 3	Add to Tier 2	RETAIL 30 / RETAIL 90 / MAIL	Cost Share	Yes
Movement Disorders	Austedo	Add to Tier 5	Add to Tier 2	RETAIL 30 / RETAIL 90 / MAIL	Adjustments for Excess New Utilizers	Yes
Actinic Keratosis	Picato Gel	Add to Tier 3	Add to Tier 2	RETAIL 30 / RETAIL 90 / MAIL	N/A	No

Ace Inhibitors	Tekturna	Add to Tier 4	Not Applicable	**RETAIL 30 / RETAIL 90 / MAIL**	**N/A**	**No**
Ace Inhibitors	Tekturna HCT	Add to Tier 4	Not Applicable	**RETAIL 30 / RETAIL 90 / MAIL**	**N/A**	**No**
COPD	Trelegy	Add to Tier 3	Add to Tier 2	**RETAIL 30 / RETAIL 90 / MAIL**	**Cost Share and Gap and Cat**	**Yes**

AMENDMENT NUMBER 6 TO
AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT

This **AMENDMENT NUMBER 6 TO AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT** (this "Amendment"), effective January 1, 2018 (the "Effective Date"), and entered into by and between Aetna Health Management, LLC, a Delaware limited liability company ("Aetna"), on behalf of itself and its Affiliates Aetna RX Home Delivery, LLC, a Delaware limited liability company, and Aetna Specialty Pharmacy, LLC, a Delaware limited liability company, and CaremarkPCS Health, L.L.C., a Delaware limited liability company ("PBM"), on behalf of itself and its Affiliate Caremark Rx, L.L.C., a Delaware limited liability company.

RECITALS

A. Aetna and PBM are parties to a certain Amended and Restated Pharmacy Benefit Management Subcontract Agreement dated as of October 2, 2013, as previously amended (the "PBM Agreement"). Capitalized terms used but not otherwise defined in this Amendment shall have the respective meanings specified in the PBM Agreement.

B. The Parties have agreed to further amend the PBM Agreement in accordance with Section 17.13 thereof to set forth certain agreements between the Parties as set forth below.

NOW, THEREFORE, in consideration of the promises, covenants, representations and warranties set forth herein, and other consideration, the sufficiency of which is hereby acknowledged, the Parties each hereby agree as follows:

1. Section 4.3.

(a) The definition of "Aetna Rebates" in Section 4.3(a) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

> "Aetna Rebates" means any and all Rebates, directly or indirectly, arising from or attributable to any of the Aetna Plans, the provision of services and/or the prescribing, dispensing or provision of prescription drugs or other products or services to or for Members; *provided, however*, that High-Value Plan Manufacturer Administrative Fees shall not constitute Aetna Rebates.
>
> "Additional Rebates" means all rebates, discounts, service fees, financial adjustments and other consideration paid, credited or owing to and/or collected by Aetna, PBM or any of their respective Affiliates from any Manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to (1) utilization (*e.g.*, market share, growth, etc.) of certain prescription drugs within their respective therapeutic categories whether measured on the basis of Claims and/or Services arising under this Agreement and/or any other part of PBM's book of business in aggregate, (2) services performed by Aetna, PBM or any of their Affiliates where Aetna, PBM or any of such Affiliates is paid fees or other compensation (excluding Service Fees) on the basis of the

volume, value or acquisition cost of prescription drugs or other products that are prescribed or dispensed to Members, (3) the provision of financial protections or adjustments to address future price increases, (4) the efficacy of Covered Drugs or actual Covered Drug utilization outcomes, or (5) any other circumstance, matter, outcome or activity that does not give rise to Other Manufacture Payments or Service Fees. For avoidance of doubt, Additional Rebates include Manufacturer Administrative Fees but do not include Formulary Rebates or Service Fees, or High-Value Plan Manufacturer Administrative Fees.

"Formulary Rebates" means all payments, rebates, price protection adjustments and other consideration paid, credited or owing to and/or collected by Aetna, PBM and/or any of their respective Affiliates from any Manufacturer (1) arising from or as a result of (A) the inclusion or exclusion on any Formulary of Covered Drugs manufactured, sold or distributed by such Manufacturer and/or (B) a coverage decision made by Aetna, any Aetna Plan Affiliate or any Aetna Customer, or (2) otherwise involving or relating to drug formularies and/or member copayment, coinsurance or deductible strategies.

(b) The following new definition is hereby added to Section 4.3(a) of the PBM Agreement immediately after the definition of Formulary Rebates:

"High-Value Plan Manufacturer Administrative Fees" means Manufacturer Administrative Fees that (i) are earned by PBM for the performance of administrative or other services in connection with Rebates arising from Claims under High-Value Plans and (ii) do not exceed 1-4% of WAC of the rebatable brand products dispensed across PBM's book of business for the administration of such rebate agreements (any Manufacturer Administrative Fees in excess of this limitation shall constitute Aetna Rebates).

(c) The first sentence of Section 4.3(b)(i) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

(i) Except to the extent Aetna elects to have PBM perform and be responsible for such functions as Optional Services pursuant to Section 3.2(b) and Schedules I I-1, and I-2 (A) Aetna and Aetna's Affiliates will retain sole responsibility and authority for contracting with Manufacturers with respect to Rebates arising from or relating to Covered Drugs dispensed to Members, whether under the pharmacy or medical benefit segments of the Covered Plans, (B) except as otherwise provided in Schedule N, Aetna and Aetna's Affiliates will retain sole responsibility and authority for contracting with Manufacturers with respect to Service Fees arising from or relating to Covered Drugs dispensed to Members, whether under the pharmacy or medical benefit segments of the Covered Plans, and (C) Aetna and Aetna's Affiliates will retain sole responsibility and authority for implementing and administering such contractual arrangements with Manufacturers and for invoicing and collecting Rebates, Service Fees and other amounts owing thereunder, except as provided in Section 63 of Schedule N.

(d) The first sentence of Section 4.3(b)(ii) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

> (ii) Except to the extent Aetna elects to have PBM perform and be responsible for such functions as Optional Services pursuant to Section 3.2(b) and Schedules I I-1, and I-2 or except pursuant to and in accordance with the processes set forth in Schedule N, PBM shall not, and shall cause its Affiliates not to, negotiate, enter into or implement any Contract with any Manufacturer or other Person that would provide for the payment, directly or indirectly, of any Rebates or Service Fees arising from or attributable to any of the Aetna Plans or any Members, including the provision of Services and/or dispensing of Covered Drugs to Members, whether under the pharmacy or medical benefit segments of the Covered Plans. In addition, PBM shall not, and shall not permit any of its Affiliates, directly or indirectly, to negotiate or implement any Contract (including the retail pharmacy arrangements described in the preceding sentence) with any Manufacturer or other Person that would result or reasonably would be expected to result in Rebates or Service Fees payable by such Manufacturer to Aetna or any of its Affiliates, or any other Aetna Rebates, being reduced or made less advantageous on account of or in exchange for the payment of greater or more advantageous Other Manufacturer Payments or other financial consideration or benefits to PBM or its Affiliates.

(e) Section 4.3(b) of the PBM Agreement is hereby amended by adding a new Section 4.3(b)(iv) at the end thereof to read as follows:

> (iv) With respect to each High-Value Plan with at least 10,000 members or more, PBM covenants and guarantees that the Aetna Rebates received by or credited to Aetna (or, at Aetna's direction, an Aetna Customer) with respect to each Rebate Guarantee (as defined in Schedule Y-17) applicable to such High-Value Plan shall, equal or exceed the applicable Rebate guarantees for such High-Value Plan set forth in Schedule Y-17 or, if applicable, the customized Rebate guarantees determined and agreed upon in writing by the Parties for such High-Value Plan pursuant to Section 5 of Schedule I-2 (the "Rebate Guarantees"). With respect to all High-Value Plans of 9,999 members or less, PBM covenants and guarantees that the Aetna Rebates received by or credited to Aetna (or, at Aetna's direction, an Aetna Customer) with respect to each Rebate Guarantee (as defined in Schedule Y-17) applicable to all of the High-Value Plan of 9,999 members, or less, shall, equal or exceed the applicable Rebate guarantees for these High-Value Plan in the aggregate as set forth in Schedule Y-17; for the avoidance of doubt, it is agreed that the volume shall be aggregated, and a deficit (underpayment) in any one Rebate Category in a given calendar year may be offset against or aggregated with a surplus (or over-performance) in any other Rebate Category. In the event of any failure to achieve a Rebate Guarantee, PBM shall pay or credit to Aetna the amount of the shortfall in accordance with the requirements set forth in Schedule Y. Each individual Rebate Guarantee shall be administered, measured and reconciled as unique and distinct categories for each High-Value Plan of 10,000 members or more, and a deficit (underpayment) in any

one Rebate Category for a given High-Value Plan of 10,000 members or more in a given calendar year may be offset against or aggregated with a surplus (or over-performance) in any other Rebate Category (for that or any other High-Value Plan of 10,000 members or more), but shall not be offset against or aggregated with a surplus (or over-performance) in any Mail Discount Guarantee, Retail Discount Guarantee, Specialty Product Discount Guarantee, or Dispensing Fee Guarantee (nor shall any deficit (underpayment) in any such non-Rebate guarantee be offset against or aggregated with a surplus (or over-performance) in any Rebate Category). To the extent that PBM provides Rebate Services (as defined in Schedule I-2) for any High-Value Plans during the Termination Transition Period, the Base Rebate Guarantees (as defined in Schedule Y) for the last year of the Term and any continuing customized Rebate Guarantees agreed upon pursuant to Section 5 of Schedule I-2 shall remain in effect throughout the Termination Transition Period.

2. Section 7.3(b). Section 7.3(b) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

(b) Aetna Customer Audits. Subject to Section 7.3(a) and as further described in Schedule X, to the extent that any Aetna Customers also have contractual review or audit rights pursuant to the Plan Contract between Aetna and such Aetna Customer, PBM also shall permit such Aetna Customers (or their designated agents or representatives who comply with the requirements set forth in Section 7.3(a)) to review and/or audit the Aetna Customer specific Required Books and Records and PBM's facilities used to provide (or that will be used to provide) the Services or any portion thereof, on an annual basis or more frequently as agreed upon by PBM (which agreement shall not be unreasonably withheld). To the extent permitted by the Plan Contract between Aetna and such Aetna Customer, such audits may include Claims audits, pre-implementation audits, and operational audits. Aetna shall promptly notify PBM of any such Aetna Customer audit request and shall make best efforts to provide PBM no less than four weeks' notice of any on-site audits. With respect to High-Value Plans, or Rebate Covered Medicare Plans, Aetna Customer audits also may include audits of PBM Commercial Rebate Agreements, or PBM Rebate Agreements, as applicable, and Aetna Commercial Rebate Agreements, or Aetna Medicare Rebate Agreements, as applicable, under which such Aetna Customer receives Aetna Rebates. PBM shall not, absent Aetna's prior written consent, permit any Aetna Customer to conduct an audit in a manner that does not comply with the limitations on audit rights contained in the Plan Contract between Aetna and such Aetna Customer (including limitations on auditor conflicts of interest and limitations on the frequency and type of audits), to the extent Aetna discloses such requirements to PBM. In the event that PBM receives a request from an Aetna Customer to conduct an audit, PBM shall promptly, and in any event as soon as reasonably practicable, notify Aetna in writing of such request.

3. Section 9.1.

(a) Section 9.1(c)(ii) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

> (ii) Not later than February 28 of each year during the Term or Termination Transition Period commencing with 2015, PBM and Aetna shall cause the Senior Leaders and such other representatives as each shall designate to confer and meet to (1) review and discuss the Annual Retail Lock-In Forecast prepared by Aetna for such calendar year, (2) consider, negotiate in good faith and agree upon any modifications to such Annual Retail Lock-In Forecast as PBM reasonably believes are necessary to cause the projections contained therein to be more accurate for such year, and (3) negotiate in good faith, agree upon and implement such adjustments to the Commercial Retail Lock-In Guarantees for such year as Aetna shall request and such additional adjustments as shall be necessary to cause the Commercial Retail Lock-In Guarantees to result in, on a projected basis using the data included in the Annual Retail Lock-In Forecast for such year, in the following outcome:
>
> A = B, where
>
> A = the sum of an aggregate Ingredient Cost Charges and Dispensing Fees that would result if all Qualifying Prescriptions dispensed during such year are subject to the applicable Commercial Retail Lock-In Pricing Guarantees in Schedule Y-3 (Broad), Schedule Y-4 (Broad), Schedule Y-3 (Managed) or Schedule Y-4 (Managed) (in each case as adjusted pursuant to this Section 9.1(c)(ii)).
>
> B = the sum of the aggregate Ingredient Cost Charges and Dispensing Fees that would result if all Qualifying Prescriptions dispensed during such year had been charged on the basis of the Master AWP Discounts set forth in Parts I and II of Schedule Y-9 for such year, as applicable (with Part I applied to Broad Network Claims and Part II applied to Managed Network Claims).
>
> And where B is computed after taking into account any adjustments to such Master AWP Discounts pursuant to Part 3 of Schedule Y.

(b) The first sentence of Section 9.1(c)(iv) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

> In addition, not later than February 10 of each year during the Term or Termination Transition Period commencing with 2016, the Parties shall compute the aggregate cost (*i.e.,* aggregate Ingredient Cost Charges, Dispensing Fees and Administrative Fees) to Aetna and the Members that would have resulted from all Qualifying Prescriptions that were dispensed during the prior calendar year and charged to Aetna on the basis of the Commercial Retail Lock-In Pricing Guarantees if such Qualifying Prescriptions instead had been charged on the basis of the Master AWP Discounts for Broad Networks or Managed Networks, as

applicable, for such prior calendar year (such amount, the "Pro Forma Aggregate Lock-In Charge").

(c) Section 9.1 of the PBM Agreement is hereby amended by adding a new Section 9.1(f) at the end thereof to read as follows:

(f) Designation of High-Value Plans.

(i) Subject to the limitations in Sections 9.1(f)(ii), and 9.1(f)(iii) , upon 30days prior written notice to PBM, unless otherwise mutually agreed upon by the parties for a shorter notice period, Aetna may designate any self-insured Aetna Plan that is sponsored by a new or current Aetna Customer in its capacity as an Employer Plan Sponsor, as a High-Value Plan, effective as of the date designated by Aetna.

(ii) Each High-Value Plan must use either (A) the CVS Advanced Control Specialty Formulary, and the CVS Opt-In Formulary (each as defined in Schedule J), or (B) the CVS Opt-Out Formulary.

(iii) No Renewal Customer may be designated as a High-Value Plan effective prior to January 1, 2018. In addition, for each of the 2018, 2019 and 2020 calendar years, the aggregate Ingredient Cost Charges arising from retail, Maintenance Choice and mail order Claims for High-Value Plans of Renewal Customers in such year shall be limited to an amount equal to the applicable percentage listed below of the aggregate Ingredient Cost Charges arising from retail, Maintenance Choice and mail order Claims for all High-Value Plans in such year (such amount, the "Maximum Renewal Customer Amount"). For the avoidance of doubt, (i) Claims arising from Specialty Products dispensed by Aetna Specialty Pharmacy or PBM Central Fill Pharmacies or the Specialty Connect program shall be included in the calculation of Maximum Renewal Customer Amount; (ii) Claims from High-Value Plans less than 10,000 members shall be included in the calculation of the aggregate Ingredient Cost Charges, and (iii) Claims from High Value Plans less than 10,000 members shall not count toward the Maximum Renewal Customer Amount.

Calendar Year	**Maximum Renewal Customer Amount Percentage for Covered Plans with 10,000 Members or More**
2018	10%
2019	20%
2020	30%

As an example:

Assume that in 2018 Aetna has $3 Million in aggregate Ingredient Cost Charges. $1 Million of Ingredient Cost Charges are attributable to Covered Plans with

10,000 members or more and $2 Million of Ingredient Cost Charges are attributable to Covered Plans with less than 10,000 members.

The Maximum Renewal Customer Amount for 2019 is 20%. Twenty percent of $3 Million is $600,000. So for 2019, Aetna may only move $600,000 in Ingredient Cost Charges attributable to Covered Plans with 10,000 members or more. With respect to Covered Plans with fewer than 10,000 members, there is no cap.

If for any such calendar year, which the parties will agree the measurement period will be between January 1 and September 30 of such calendar year, the aggregate Ingredient Cost Charges arising from High Value Plans of Renewal Customers exceeds the Maximum Renewal Customer Amount for such year, as measured January 1st through September 30th, the Claims giving rise to such excess amount shall be subject to, and reconciled against, the Large-Account Retail Lock-in Guarantees and Mail Discount Guarantees (and not the guarantees set forth in Schedule Y-16); provided, however, that such "excess amount" Claims shall continue to be treated as Claims of High-Value Plans for purposes of Aetna Rebates, Schedule I-2 and Schedule Y-17.

4. Section 9.2(b). The first paragraph of Section 9.2(b) of the PBM Agreement is hereby amended and restated in its entirety to read as follows (for clarity, the second paragraph of Section 9.2(b) (clause (ii) thereof) shall remain in full force and effect):

(b) No Pooling of Guarantees.

(i) Each individual guarantee for a Pricing Category set forth in Schedule Y, including each of the Retail Pricing Guarantees, Dispensing Fee Guarantees, Mail Discount Guarantees, and Specialty Product Guarantees, shall be administered, measured and reconciled as unique and distinct categories, components or segments; and a deficit (over charge) in any one Pricing Category shall not be offset against or aggregated with a surplus (over performance) in any other Pricing Category, except that Deficits (over charges) in Pricing Categories from Schedules Y-2 (Broad), Y-3 (Broad), Y-3 (Managed), Y-4 (Broad), Y-4 (Managed), Y-5, Y-15P, Y-15L (retail only in the case of Y-15L), and Y-16 (High Value Plan Retail Lock-In Pricing) in a given calendar year may be offset against Minor Surpluses (and only Minor Surpluses) in any Pricing Categories from the same (and only the same) sub-schedule of Schedule Y in the same calendar year; and, notwithstanding the foregoing to the contrary, individual guarantees for High Value Plans under 10,000 members may be aggregated across all High Value Plans under 10,000 members. "Minor Surplus" means (A) in the case of a Retail Discount Guaranty for a given Pricing Category, a surplus (over performance) in that Pricing Category that does not exceed such Retail Discount Guaranty by more than two tenths of one percent (0.20%), and (B) in the case of a Dispensing Fee Guarantee for a given Pricing Category, a surplus (over performance) that does not exceed the applicable Dispensing Fee Guaranty by

more than ten cents ($.10) per Paid Claim. The application of this Section 9.2(b)(i) is illustrated in Annex O.

5. Annex A.

(a) The following definitions in Annex A to the PBM Agreement are hereby amended and restated in their entirety to read as follows:

"Large Account" means any Aetna Customer other than a Small Account, Governmental Body that administers a Medicare Plan or a State Plan, a Third Party State Plan Sponsor (acting in such capacity), or an Aetna Customer that is the sponsor of a High-Value Plan (acting in such capacity).

"Large Account Retail Lock-in Guarantees" means the Generic Drug and Brand Drug Retail Discount Guarantees and the Dispensing Fee Guarantees for retail delivery for Covered Plans of Large Accounts as set forth on Schedule Y-3 (Broad) or Schedule Y-3 (Managed), as such guarantees may be hereafter modified pursuant to Section 9.1(c). For avoidance of doubt, the term "Large Account Retail Lock-in Guarantees" excludes any guarantees subject to Schedules Y-14, Y-15L, Y-16 or Y-19.

"Lock-In Pricing" or "Lock-In" means pricing applicable to Aetna under this Agreement for Paid Claims where the PBM applies and charges Aetna the applicable AWP Discounted Rate or, if applicable, MAC, and Dispensing Fees as specified in Schedule Y-3 (Broad), Schedule Y-3 (Managed), Schedule Y-4 (Broad), Schedule Y-4 (Managed), Schedule Y-15L, or Schedule Y-16 (and in accordance with the applicable Retail Discount Guarantee or Mail Discount Guarantee), recognizing that the actual AWP or other rate, MAC, dispensing fees and other charges PBM has contracted to pay Participating Pharmacies may vary from the amounts applied and charged to Aetna.

"Master AWP Discounts" means, for a given calendar year, the Generic Drug pricing discount, the Brand Drug pricing discount, the Generic Drug Dispensing Fee and the Brand Drug Dispensing Fee specified for Lock-In Pricing at retail delivery for Broad Networks and Managed Networks set forth on Schedule Y-9.

"Retail Pricing Plan Category" means each of the following categories of Covered Plans (i) Covered Plans that are subject to Commercial Retail Pass Through Pricing as set forth on Schedule Y-2 (Broad), (ii) Covered Plans that are subject to Commercial Retail Pass Through Pricing as set forth on Schedule Y-2 (Managed), (iii) Covered Plans of Large Accounts that are subject to Large Account Retail Lock-in Guarantees as set forth on Schedule Y-3 (Broad), (iv) Covered Plans of Large Accounts that are subject to Large Account Retail Lock-in Guarantees as set forth on Schedule Y-3 (Managed), (v) Covered Plans of Small Accounts that are subject to Small Account Retail Lock-in Guarantees as set forth on Schedule Y-4 (Broad), (vi) Covered Plans of Small Accounts that are subject to Small Account Retail Lock-in Guarantees as set forth on Schedule Y-4 (Managed), (vii)

High-Value Plans that are subject to High-Value Plan Retail Lock-In Pricing that utilize a Broad Network, (viii) High-Value Plans that are subject to High-Value Plan Retail Lock-In Pricing that utilize the Managed Network, (ix) Medicaid Plans that are subject to Medicaid Plan Retail Lock-in Guarantees, (x) Medicaid Plans that are subject to Medicaid Plan Retail Pass Through Guarantees, (xi) Medicare Plans, (xii) Discount Card plans, (xiii) Workers Compensation plans, (xiv) Commercial Plans that are subject to Script World Pricing (to the extent such pricing is applicable to Covered Drugs dispensed by retail pharmacies), and (xv) Commercial Plans that are subject to Commercial Restricted Network Standard Offering Pricing (to the extent such pricing is applicable to Covered Drugs dispensed by retail pharmacies).

"Small Account Retail Lock-in Guarantees" means the Generic Drug and Brand Drug Lock-in Retail Discount Guarantees and Dispensing Fee Guarantees for retail delivery for Covered Plans of Small Accounts as set forth on Schedule Y-4 (Broad) or Schedule Y-4 (Managed), as such guarantees may be hereafter modified pursuant to Section 9.1(c). For avoidance of doubt, the term "Small Account Retail Lock-in Guarantees" excludes any guarantees subject to Schedules Y-14, Y-15L, Y-16, or Y-19.

(b) Annex A to the PBM Agreement is hereby amended by inserting the following new definitions therein (in their appropriate alphabetical locations):

"Aetna Commercial Rebate Agreements" has the meaning given in Section 2.3 of Schedule I-2.

Broad Network" means any network of Participating Pharmacies established and maintained by PBM or its Affiliates that is not a Managed Network or a Limited or Preferred Pharmacy Network (as defined in Schedule Y).

"Consumer Business Plans and Sam's Club Plans" means any Aetna Plan issued, that is a membership retail program that provides Members discounts at certain retail pharmacy locations and Sam's Club.

"High-Value Plan" means an Aetna Plan designated by Aetna, by written notice to PBM in accordance with Section 9.1(f), to be a "High-Value Plan".

"High Value Plan Rebate Guarantees" means the Rebate guarantees set forth in Schedule Y-17.

"High Value Plan Rebate Services" has the meaning given in Section 1 of Schedule I-2.

"Mail Penetration Rate" means, for a given Aetna Plan and calendar year, the fraction, expressed as a percentage, obtained by dividing (i) an amount equal to three multiplied by the number of prescription drug claims filled at mail, by (ii) an amount equal to the sum of (x) the aggregate number of prescription drug claims

filled retail and (y) an amount equal to three multiplied by the number of prescription drug claims filled at mail.

"Managed Network" means a network of Participating Pharmacies that consists of approximately 51,000 retail pharmacies that have agreed to participate in the Managed, as such list of Participating Pharmacies is modified by PBM from time to time in accordance with Sections 20 and 21 of Exhibit G or customized at Aetna's request for particular Aetna Plans from time to time in accordance with Sections 5 and 20 of Exhibit G.

"PBM Commercial Rebate Agreements" has the meaning given in Section 2.2.1 of Schedule I-2.

"Rebate Guarantee" has the meaning set forth in Section 4.3(b)(iii).

"Renewal Customer" means an Employer Plan Sponsor that is a current Aetna Customer with respect to one or more Aetna Plans as of the time Aetna designates an Aetna Plan of such Employer Plan Sponsor as a High-Value Plan pursuant to Section 9.1(f)(i); provided, however, that any Aetna Customer that was not a Renewal Customer at the time any of its Aetna Plans was previously designated a High-Value Plan shall never be a Renewal Customer.

ScriptWorld Plans" means any Aetna Plan issued, managed or administered by ScriptWorld or its Subsidiaries.

6. Schedule G.

(a) The first sentence of Section 5 of Schedule G to the PBM Agreement is hereby amended and restated in its entirety to read as follows:

Subject to Sections 26 through 31 below, PBM shall negotiate, contract, create, and maintain a networks of Participating Pharmacies that are available to provide prescription drug benefits to Members of Aetna, Aetna Affiliates, and Aetna Customers, including the PBM Vendor National networks (*i.e.,* a non-Aetna specific network that may be used for other PBM clients), Broad Networks and, commencing as of April 1, 2017 for Commercial Plans only, Managed Networks, and that are otherwise in accordance with configuration and other requirements requested by Aetna.

(b) Sections 19 and 20 of Schedule G to the PBM Agreement are hereby amended and restated in their entirety to read as follows:

19. Notwithstanding anything to the contrary contained herein, PBM shall ensure that the Broad Networks utilized by Aetna, Aetna Affiliates, and Aetna Customers and the Managed Networks shall, at all times, meet or exceed network access standards set forth on Schedule G-2 (Network Adequacy Requirements) or such more stringent standards required by Law. In the event Aetna desires to implement a restricted or limited Aetna Network, other than Managed Networks,

the Parties agree to work in a cooperative manner to establish appropriate network access standards for such networks.

20. With respect to each Aetna Network that is or is intended to be a Broad Network, PBM shall ensure that the composition of Participating Pharmacies in each such Aetna Network, at a minimum and subject to Participating Pharmacies' compliance with PBM's standard terms and credentialing policies, mirror Aetna's pharmacy network(s) as of September 1, 2013. With respect to each Aetna Network that is or is intended to be a Managed Network, unless otherwise requested by Aetna to address the requirements of a particular Aetna Customer, PBM shall ensure that the composition of Participating Pharmacies in each such Aetna Network, at a minimum and subject to Participating Pharmacies' compliance with PBM's standard terms and credentialing policies, include at least ninety-five percent (95%) of the Participating Pharmacies included in the Original Managed Network List or, with Aetna's prior written consent (not to be unreasonably withheld), a lesser percentage of Participating Pharmacies from such list; and (b) PBM shall not make any material change to any Managed Network that would take effect on any date other than January 1 of any year without Aetna's prior written approval (not to be unreasonably withheld). In addition, further to Section 5 above, PBM shall make available to Aetna, for use with Aetna Customers, customized Managed Networks as requested by Aetna from time to time so long as the total number of Participating Pharmacies in any customized Managed Network does not exceed the number of Participating Pharmacies included in the Original Managed Network List by more than [five percent (5%)].

7. Schedule I.

(a) Section 4 of Schedule I is hereby amended and restated in its entirety to read as follows:

4. Subject to the terms and conditions of the Agreement, PBM will fully support Aetna as needed and permit Aetna to access the PBM Rebate Administration Computer System (a) to enable Aetna to fully administer Aetna Rebate Agreements as further described in the Agreement and this Schedule I, and (b) as further described in Schedule I-1 and Schedule I-2, to enable Aetna to monitor, administer, allocate and distribute, and create reports and support audits regarding, Aetna Rebates arising from High-Value Plans under PBM Rebate Agreements or Aetna H-V Plan Rebate Agreements (as such terms are defined in Schedule I-1 and Schedule I-2).

(b) Schedule I is hereby amended by adding the following as a new Section 9 at the end thereof (immediately after Section 8(X)):

9. With respect to High-Value Plans, PBM shall provide the Rebate Services, as defined in, and in accordance with, Schedule I-2 attached to this Schedule I.

(c) Schedule I is hereby amended by adding at the end thereof a new Schedule I-2 in the form of Appendix 1 to this Amendment.

8. Schedule I-1. Section 2.5 of Schedule I-1 to the PBM Agreement is hereby amended and restating in its entirety to read as follows:

> 2.5 **Medicare Part B Claims**. PBM shall perform Rebate Services with respect to, and the Rebate Guarantees shall be applicable to, those Brand Drugs adjudicated under the Part B benefit of Rebate Covered Medicare Plans. Rebate Guarantees for Medicare Advantage with Prescription Drug plans (MAPD) and Medicare Advantage Medical Only plans (MA-only) include a Lifescan One Touch solo strategy in the diabetic strips category, except the open diabetic test strip strategy offers for MA-only Medicaid MMP, EGWP A1, EGWP B2 and EGWP Open formularies. Rebate guarantees are based solely on PBM adjudicated claims and are not guarantees for Part B claims processed in medical or outside of the PBM adjudication. The rebate guarantees apply to all Part B PBM adjudicated claims for Brand Drugs.

9. Schedule J. Sections 29 and 30 of Schedule J to the PBM Agreement are hereby amended and restated in their entirety to read as follows:

> 29. Aetna will retain responsibility for developing and determining all Aetna Formularies and Benefit Plan Design, which shall be the sole property of Aetna; *provided, however*, that the CVS Advanced Control Specialty Formulary and the CVS Opt-In Formulary (each as defined below) shall be PBM's sole property. Aetna will maintain an Aetna Pharmacy and Therapeutics ("P&T") Committee. As used herein:
>
> a. "CVS Advanced Control Specialty Formulary" means the list of Covered Drugs with associated coverage decisions established by PBM as provided by PBM to Aetna via email from Mindy.Qiu@cvscaremark.com to rjrowley@aetna.com on January 4, 2018 (via the Microsoft Excel file titled "1555 CAREMARK PRESCRIB GUIDE PDL PS COMPREHENSIVE all drugs_010418.xlsx")[1], together with such changes to such formulary as PBM may make from time to time and communicate to Aetna in accordance with Section 30 below.
>
> b. "CVS Opt-In Formulary" means the list of Covered Drugs with associated coverage decisions established by PBM as provided by PBM to Aetna via email from Mindy.Qiu@cvscaremark.com to rjrowley@aetna.com on January 4, 2018 (via the Microsoft Excel file titled "1555 CAREMARK PRESCRIB GUIDE PDL PS COMPREHENSIVE all drugs_010418.xlsx")[1], together with such

1 This was a combined file, containing the full CVS Advanced Control Specialty Formulary and CVS Opt-In Formulary.

changes to such formulary as PBM may make from time to time and communicate to Aetna in accordance with Section 30 below.

30. PBM may propose changes to Aetna Formularies, but final discretion shall reside with Aetna and its Affiliates, and with Aetna Customers, as applicable. In the event Aetna and its Affiliates, or Aetna Customers, as applicable, do not accept all changes to the Aetna Formularies as proposed by PBM, the Rebate Guarantees attributed to the High Value Formulary do not apply; provided, however, Aetna and its Affiliates, or Aetna Customers, as applicable, may elect to adopt prior authorization options for the fees identified in Schedule Y-17. If Aetna and its Affiliates, or Aetna Customers, as applicable, request additional prior authorizations options than available in Schedule Y-17 the parties will agree to the fees Aetna will pay PBM for such additional services. Without limiting the generality of the foregoing, PBM shall at all times make the CVS Advanced Control Specialty Formulary and the CVS Opt-In Formulary available to Aetna for use as an Aetna Formulary, if and to the extent determined by Aetna and Aetna Customers, including in connection with High-Value Plans. With respect to the CVS Advanced Control Specialty Formulary and the CVS Opt-In Formulary:

a. PBM shall provide written notice to Aetna of each change to the CVS Advanced Control Specialty Formulary or the CVS Opt-In Formulary 60- days prior to the effective date of such change. Changes to the CVS Advanced Control Specialty Formulary or the CVS Opt-In Formulary shall be made no more frequently than once per quarter. For the avoidance of doubt, for purposes of communicating such changes to Members, Participating Pharmacies and Providers, the term "Formulary" as used in Schedule H shall also include the CVS Advanced Control Specialty Formulary and the CVS Opt-In Formulary.

b. PBM shall, within seven (7) days of a request from Aetna, provide appropriate access to its personnel, advice and other resources in order to assist Aetna, and, if applicable, the Aetna P&T Committees, in considering whether Aetna should modify any Benefit Plan Designs (other than with respect to Formulary) and care management initiatives in order to increase or otherwise optimize the amount of Aetna Rebates received by Aetna with respect to High-Value Plans under PBM Commercial Rebate Agreements.

c. PBM shall keep Aetna informed of any potential adverse impacts on Aetna Rebates that may arise from decisions made by Aetna, and communicated to PBM, with respect to Benefit Plan Designs or other matters pertaining to care management or clinical functions with respect to High-Value Plans. PBM shall advise Aetna with regard to such potential adverse impacts within seven (7) days of any such communication from Aetna, or if it is not reasonably practicable to

determine such adverse impacts within such seven (7) day time period, PBM shall as soon as practicable (but in any event within such seven (7) day time period) inform Aetna of the status and estimated time frame for advising Aetna as to such adverse impacts, and shall as soon as reasonably practicable thereafter advise Aetna with respect thereto.

10. Schedule V. Schedule V to the PBM Agreement is hereby amended by adding the following row to the table of Standard Reports set forth therein:

High-Value Plan Rebate Reports	1. The reports required under Section 3.1 of Schedule I-2.

11. Schedule X. Section 11of Schedule X to the PBM Agreement is hereby amended by adding a new subsection (b) as follows:

a. High Value Plans Manufacturer Rebate Audits. PBM shall assist Aetna in the manner required by Aetna and in a manner consistent with the scope of PBM's obligations regarding rebate administration, including as set forth in Section 8.K of Schedule I, in connection with the administration and management of any audit relating to Aetna Manufacturer Revenues, including Aetna Customer audits, Manufacturer audits, Governmental Body requests or audits, and audits by accreditation organizations. PBM shall accommodate Governmental Body requests or audits as necessary in Aetna's discretion. Without limiting the generality of the foregoing, with respect to the High-Value Plans, Aetna's third party designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit or cause to be audited PBM's performance of its obligations under Schedule I-2, as applicable, and the accuracy of the Rebate Guarantee Reports (as defined in Schedule Y) with respect to the Rebate Guarantees. As part of each such audit, PBM shall provide Aetna's third party designee with access to all PBM Rebate Agreements that gave rise to Aetna Rebates that were paid or payable to Aetna during the applicable time period, except that, with respect to any PBM Rebate Agreement that does not solely apply to Aetna, PBM shall be entitled to redact any provision that is specifically applicable to a PBM Customer other than Aetna. Such review of PBM Rebate Agreements shall include all information necessary for Aetna's third party independent auditor to review and verify, on an aggregate and Claim-by-Claim basis, the accuracy of the Aetna Rebates remitted to Aetna by PBM and PBM's performance of the Rebate Services under Schedule I-2. If any audit of the Rebate Services conducted for or by Aetna uncovers an error that relates to one or more prior years, PBM shall (i) investigate and determine the root cause of such error with respect to all affected or potentially affected years, (ii) work in good faith with Aetna's third party independent auditor to quantify and resolve such error with respect to all such years (including providing the auditor with all information necessary to determine and confirm the cause, extent and resolution

of such error) prior to the completion of such audit, and (iii) pay or credit such additional Aetna Rebates or other amounts to Aetna as are necessary to fully remedy and correct the error. , including that, as part of each such audit, PBM shall initially make available for review up to ten (as specified by Aetna) PBM Rebate Agreements. If any such audit by Aetna identifies any errors or inaccuracies, upon Aetna's request, PBM shall make available for review (a) some or all (as specified by Aetna) of the remaining PBM Rebate Agreements for the immediately preceding calendar year and (b) such PBM Rebate Agreements as Aetna may specify for any prior calendar year during which PBM performed Rebate Services for High-Value Plans. For clarity, such audit rights include the right to audit the High-Value Plan Manufacturer Administrative Fees.

12. Schedule Y to the PBM Agreement is hereby amended and restated in its entirety to read as set forth on Appendix 3 to this Amendment.

13. Effect of Amendment. [Unless otherwise expressively provided above, all] [All] amendments to the PBM Agreement set forth herein shall be effective as of the Amendment Date. Except as amended by this Amendment, the PBM Agreement remains in full force and effect. All references to the PBM Agreement in any other agreement or document shall hereinafter be deemed to refer to the PBM Agreement as amended by this Amendment.

14. Miscellaneous. The provisions set forth in Article XXIII, and Sections 17.19, 17.20, 17.21, 17.22 and 17.26 of the PBM Agreement shall be applicable to this Amendment No. 6 *mutatis mutandis* and to the full extent necessary shall be deemed to be incorporated herein.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the Parties hereto have executed this Amendment as of the date first set forth above.

AETNA HEALTH MANAGEMENT, LLC

Name: Randy Hyun
Title: Vice President, Pharmacy

LEGAL LUCOM REVIEW

CAREMARKPCS HEALTH, L.L.C.

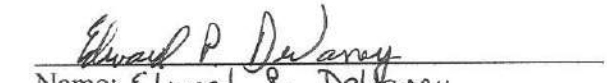

Name: Edward P. DeVaney
Title: Division Head, CVS Health

APPENDIX 1

Schedule I-2

Rebate Services

Optional Services

1. **Commencement and Termination of Rebate Services.**

1.1 **Overview.** If and as so elected by Aetna pursuant to Sections 1.2 and 1.3, PBM shall perform the Rebate-related contracting, billing, collection and other services described in this Schedule I-2 ("Rebate Services") in accordance with this Schedule I-2 with respect to certain or all Covered Plans that are High Value Plans (such Covered Plans, "Rebate Covered High Value Plans" for and with respect to the time period during which Rebate Services are provided with respect thereto). Rebate Services constitute Optional Services. Even if Aetna chooses to elect optional Rebates Services, those Rebate Services shall not apply to drugs covered under the medical benefit.

1.2 **Commencement of Rebate Services.** Commencing effective as of the first day of any calendar-year during the Term, Aetna shall have the right to have PBM perform Rebate Services with respect to, as designated by Aetna, certain of or all Covered Plans that are High Value Plans. In order to exercise this right, Aetna must deliver to PBM, no later than October 1 of the year preceding the calendar-year in which Aetna wishes Rebate Services to commence, a written notice that specifies the Covered Plans for which Rebate Services are to be performed and the commencement date therefor.

1.3 **Termination of Rebate Services**. Without limiting Aetna's rights under Article XII of the Agreement, Aetna shall have the right to terminate PBM's provision of Rebate Services with respect to, as designated by Aetna, all or any Rebate Covered High Value Plans effective as of January 1 of any year, subject to Aetna delivering to PBM written notice of any such termination not later than October 1 of the preceding year (a "Rebate Termination Notice"). In the event of and notwithstanding any termination of Rebate Services, PBM shall continue to invoice, collect and pay to Aetna the Aetna Rebates that are applicable to Paid Claims dispensed under Rebate Covered High Value Plans for time periods for which PBM provided Rebate Services, and PBM's obligations with respect to the reconciliation of Rebate Guarantees applicable to such time periods pursuant to Schedules Y and Y-16 shall remain in effect.

1.4 **Aetna Right to Engage in Rebate Contracting**. Except to the extent Aetna elects to have PBM provide Rebate Services pursuant to Section 1.2, Aetna shall have the right, directly or through an Affiliate or other Person, to (i) negotiate and execute all contracts with Manufacturers and other Persons for the provision of Rebates for or with respect to all Covered Plans, except for Rebate Covered High Value Plans, and (ii) perform all Rebate-related billing, collection and other services, except for Rebate Covered High Value Plans

Proprietary

2. **Rebate Services.**

2.1 **Aetna's Authorization.** For any time periods during which PBM performs Rebate Services with respect to Rebate Covered High Value Plans, Aetna authorizes PBM to contract with Manufacturers for Aetna Rebates as a group purchasing organization for all Rebate Covered High Value Plans.

2.2 **Rebate Services**. Rebate Services shall include the following services, functions and tasks:

2.2.1 PBM shall negotiate and enter into Manufacturer Rebate Agreements (or amend or maintain existing Manufacturer Rebate Agreements to which PBM is a party) for the provision of Aetna Rebates for Aetna with respect to all Rebate Covered High Value Plans in accordance with this Schedule I-2 ("PBM Commercial Rebate Agreements").

2.2.2 PBM shall keep Aetna informed of, and provide reasonable guidance and assistance to Aetna regarding, any potential adverse or positive impacts on Aetna Rebates that may arise from decisions made by Aetna, and communicated to PBM, with respect to Aetna Formularies, Benefit Plan Designs, coverage determination information or other matters pertaining to care management or clinical functions.

2.2.3 PBM shall use commercially reasonable efforts to collect for Aetna all Aetna Rebates due from Manufacturers under PBM Rebate Agreements. In addition, PBM shall utilize and make fully available to Aetna the most advantageous financial terms available to PBM under PBM Rebate Agreements that are or reasonably could be made applicable to Claims under Rebate Covered High Value Plans.

2.2.4 The services described in Sections 3, 4, 5, and 6 below.

2.3 **Control of Benefit Plan Design and Formulary**. PBM's performance of Rebate Services and the utilization of PBM Rebate Agreements shall not in any way limit Aetna's control over Benefit Plan Design or Formulary, it being understood that such decisions may impact the Rebates received by Aetna under PBM Rebate Agreements and may result in adjustments to the Rebate Guarantees to the extent provided in Section 5.

3. **Rebate Reporting and Payment For Periods When Rebate Services are in Effect.**

3.1 **Quarterly Rebate Reports**. Not later than sixty (60) days after the last day of each calendar quarter during which PBM collects any Aetna Rebates pursuant to this Schedule I-2, PBM shall affirmatively and accurately determine (a) the Aetna Rebates that were invoiced by PBM on account of Paid Claims dispensed under High Value Plans during such quarter, and (b) the Rebates that were collected by or credited to PBM during such quarter on account of Paid Claims dispensed under Rebate Covered High Value Plans. PBM agrees to provide Aetna reporting consistent with PBM's standard rebate reporting. In the event Aetna requests customized reporting, PBM and

Proprietary

Aetna will mutually agree to the report format and Aetna agrees to reimburse PBM for programing expenses related to such customized reports.

3.2 **Payment of Rebate Guarantees and Collected Rebates to Aetna**.

3.2.1 Within **sixty (60)** days' after the end of each calendar quarter PBM collects Rebates PBM shall pay to Aetna the full amount of all Rebates collected for the calendar quarter; and

3.2.2 At the close of collections, or 180-days after the end of the calendar year, PBM will pay Aetna the greater of (i) the Rebate Guarantees for the High Value Plans; or (ii) the collected Rebates.

4. Rebate Administration.

4.1 For and with respect to any period during which PBM is required to perform Rebate Services under this Schedule I-2, PBM shall provide the following as Rebate Services (collectively, the "Rebate Administration Services"):

4.1.1 PBM shall provide invoicing, collection and payment services for and with respect to all PBM Rebate Agreements. PBM shall invoice the applicable Manufacturers for Aetna Rebates arising from Paid Claims dispensed during a calendar quarter under Rebate Covered High Value Plans not later than 60 days after the last day of such quarter, and shall use commercially reasonable efforts to collect such Aetna Rebates as soon as practicable thereafter.

4.1.2 PBM shall track the receipt of all Aetna Rebates arising from Rebate Covered High Value Plans, accurately allocate such Aetna Rebates to the correct Aetna Plan, and report such information to Aetna, in each case, in order to enable Aetna to retain or to distribute such Aetna Rebates appropriately to Aetna's Affiliates and Aetna Customers in the manner required by Aetna.

4.1.3 PBM shall respond to, address and administer all audit requests from Manufacturers with respect to Aetna Rebates, PBM Rebate Agreements, Aetna High Value Rebate Agreements and, in each case with regard to Rebate Covered High Value Plans and Claims arising thereunder.

5. Equitable and Annual Adjustments to Rebate Guarantees.

5.1 Rebate Adjustment Events. PBM and Aetna shall in good faith equitably adjust the Rebate Guarantees as set forth in Schedule Y-17 (each such adjustment, a "Rebate Guarantee Adjustment") in accordance with this Section 5.1, upon the occurrence of any of the following events (each, a "Rebate Adjustment Event"):

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5.1.1 If any of the terms and conditions as described in Schedule Y-17 of the Agreement and/or the Pricing Commitment Documents[1] are not met;

5.1.2 Modification of Aetna's benefit design, including changes to the Plan's 90 days' supply incentives, exclusion of certain Specialty Drugs to be payable under the prescription benefit plan, formulary alignment, utilization management or step therapy edits, clinical programs that would reasonably be likely to result in an increase or reduction in Aetna Rebates; or

5.1.3 A change in any Law, or industry wide change that has a materially adverse or materially positive impact on PBM's ability to contract for or receive Rebates from Manufacturers.

5.2 PBM shall promptly notify Aetna in writing upon the occurrence of any event set forth in Section 5.1.

5.3 Notwithstanding anything in Section 5.1 to the contrary, in the event that a Rebate Adjustment Event impacts only certain Rebate Covered High Value Plans or only a subset of Claims within one or more Rebate Categories, the Parties shall equitably adjust the Rebate Guarantees only with respect to those Rebate Covered High Value Plans and Rebate Categories that are reasonably expected to be impacted by such Rebate Adjustment Event.

5.4 If so requested by Aetna, prior to the implementation or occurrence of a potential Rebate Adjustment Event that would result from a decision or action by Aetna, the Parties shall work together in good faith to determine as promptly as practicable what, if any, Rebate Guarantee Adjustment would be required if Aetna decided to proceed with the potential Rebate Adjustment Event.

5.5 Whenever feasible the Parties shall endeavor to agree upon a Rebate Guarantee Adjustment prior the occurrence of a Rebate Adjustment Event. If a Rebate Guarantee Adjustment is not effected prior to the occurrence of a Rebate Adjustment Event, the Parties shall work together in good faith to determine the amount of the Rebate Guarantee Adjustment, if any, as promptly as practicable following such occurrence.

6. Aetna Rebate Personnel; Firewalls.

6.1 Aetna shall limit access to all Rebate data and information that PBM provides to Aetna under this Schedule I-2 ("Rebate Data") to those of its and its Affiliates' employees that have a need to know such information for purposes of (a) developing or modifying Formularies and Benefit Plan Designs for Rebate Covered High Value Plans, (b) establishing pricing for Rebate

[1] The Pricing Commitment Documents are, with respect to 2018, that certain document prepared by PBM and accepted by Aetna, which lists proposed Rebate Guarantees, begins with the sentence, "The following summarizes CVS Health's rebate proposal for Aetna's ASO Commercial customers," and ended with the sentence, "Pricing and terms within this proposal are valid for 30 days from 2/27/2018;" and, with respect to 2019 and later years, that certain document prepared by PBM and accepted by Aetna, which lists proposed Rebate Guarantees, begins with the sentence, "The following summarizes CVS Health's rebate proposal for Aetna's ASO Commercial customers," and ended with the sentence, "Pricing and terms within this proposal are valid for 30 days from 8/16/2018;"

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Covered High Value Plans, (c) auditing High Value Plans, or (d) other business purposes not related to contracting for Rebates with Manufacturers (such employees, the "Aetna Permitted Employees"). Aetna Permitted Employees may not include any employees of Aetna or its Affiliates who perform duties related to the contracting for Rebates with Manufacturers (such employees, "Aetna Rebate Employees").

6.2 Aetna shall require all Aetna Permitted Employees who receive or have access to Rebate Data to agree in writing, for PBM's benefit, not to disclose Rebate Data to any Aetna Rebate Employees.

6.3 Aetna shall implement and maintain such firewalls as shall be necessary to ensure that Aetna Rebate Employees have no ability to access any Rebate Data. Such firewalls shall be achieved by logical security protocols that separate Aetna Rebate Employees from Rebate Data and from systems and hardware used to receive or store Rebate Data.

Proprietary

[TSA must be updated and included]

SCHEDULE A

TRANSITION-IN PLAN

Note: The text and provisions of this Schedule A (including its sub-schedules) that are included within starred square brackets (i.e., **[ ]**) are provisional, constitute Provisional Text and are subject to Section 17.29 of the Agreement.

I. Overview

This outsourcing readiness, implementation and transition plan (the "Transition-In Plan") defines and describes the scope and requirements for (i) the transition of certain prescription drug and pharmacy benefit management services and functions currently performed by Aetna on behalf of Aetna Plan Affiliates and other Aetna Customers to PBM, (ii) the transition of certain back-end and supporting mail and specialty pharmacy services and functions from Aetna RX Home and Aetna Specialty Pharmacy to PBM, (iii) the migration to, and replacement of certain systems, platforms and applications currently utilized by Aetna, Aetna RX Home and Aetna Specialty Pharmacy with, systems, platforms, applications and processes of PBM and its Affiliates, and (iv) associated business and systems integration, training, testing and other preparatory actions, tasks and work that must be completed to enable PBM to perform the PBM Services and Phase I PBM Services, as applicable, in accordance with the terms of the Agreement.

More specifically, this Transition-In Plan sets forth the Parties' plan and roadmap during the Transition-In Phase to accomplish the following:

A. Commencement of Services and Outsourcing Readiness. Full operational readiness for the transition to PBM of the outsourcing and performance of various prescription drug, pharmacy benefit management and back-end and supporting mail and specialty pharmacy functions and services that are currently performed by Aetna and certain of its Affiliates for the Aetna Plan Affiliates, Aetna Plans and Aetna Customers as more particularly described in Schedules A-1, A-3 and A-5, including (i) satisfaction of all governmental and regulatory filing and approval requirements applicable to such transition and outsourcing to PBM (including Required Transition Approvals(as defined below)), (ii) the transfer of certain employees of Aetna and certain of its Affiliates to PBM, and (iii) the completion of such other actions as are necessary to enable PBM, during the initial months of the Performance Phase, to perform the Phase I PBM Services in accordance with the terms of this Agreement, including with usage of certain Aetna systems, platforms and applications. The completion of all of the circumstances described in the preceding sentence is referred to as "Outsourcing Readiness." As outlined in Schedule A-1, Outsourcing Readiness will be achieved: (i) for all Phase I PBM Services, including the mail pharmacy services

set forth in Schedule M-1 (the "Phase I Mail Services") but excluding the Medicare Customer Services (as defined below) and Phase I Specialty Services (as defined below), by December 31, 2010, (ii) for the Medicare Plan customer services (the "Medicare Customer Services") currently performed by the Delayed Transition Employees (as defined below) by July 1, 2011, and (iii) for the specialty pharmacy services set forth in Schedule N-1 (the "Phase I Specialty Services") on a date to be mutually determined, but in no event later than July 1, 2011, based on completion of outsourcing tasks as outlined in Schedule A-3 for the Phase I Specialty Services.

B. Retail Pricing Transition. On or before December 31, 2010, (i) full readiness to implement and apply the retail Pass Through pricing terms provided in Schedules Y-1 and Y-2 for the 2011 calendar year, and (ii) the full conversion of Aetna's pharmacy network to the PBM's pharmacy network, including the loading of PBM's network providers and custom network configurations as necessary to support all Covered Plans and Aetna Customers and provide for no disruption to Aetna Customers as a result of this transition. The completion of all of the circumstances described in the preceding sentence is referred to as "Retail Pricing Transition."

C. Full Migration. On or before January 20, 2013 (or in the case of clause (iii) March 31, 2013), the migration of PBM's performance under this Agreement to PBM's own systems, platforms and applications and the Parties' desired end-state operating model, including (i) the implementation and application of the end-state (post-2011) retail pricing terms provided for in Schedule Y, (ii) the installation, integration and implementation of PBM's mail pharmacy systems, applications and processes at both of Aetna's mail pharmacies, (iii) the installation, integration and implementation of PBM's specialty pharmacy systems, applications and processes (including Rx Specialty) at Aetna's specialty pharmacy, (iv) the transition and migration to PBM's own systems, applications and processes in and for PBM's performance of all pharmacy benefit management operations and functions under this Agreement and (v) the completion of such other actions as are necessary to enable PBM to perform all of the PBM Services (and discontinue the performance of all Phase I PBM Services) in accordance with the terms of this Agreement. The completion of all of the circumstances described in the preceding sentence is referred to as "Full Migration."

D. Rx Specialty System. The development and implementation, in order to prepare for Full Migration for Specialty Services, by PBM of a new specialty pharmacy technology platform ("Rx Specialty") that will meet or exceed Aetna's and Aetna Specialty Pharmacy's specific requirements with respect to the provision of specialty back-end and support services contemplated by Schedule N and the other requirements of the Agreement applicable thereto. The completion of all of the circumstances described in the preceding sentence is referred to as "Rx Specialty Migration." Aetna and Aetna Specialty Pharmacy, PBM and Caremark Rx will cooperate in good faith with respect to all phases of the Rx Specialty development project, including that Aetna will, without limiting PBM's

obligation under the Agreement and Aetna's rights with respect thereto, (i) identify Aetna's and Aetna Specialty Pharmacy's business functional and non-functional requirements, (ii) participate in key review sessions and check-points during the requirements, design and testing phases of the work, (iii) have a right of review for purposes of the use of Rx Specialty pursuant to the Agreement, at key milestones and minimally at the conclusion of the requirements, design, testing and go/no-go check-points, (iv) conduct an independent use acceptance test prior to go-live, and (v) have appropriate representation on PBM's key governing bodies for the Rx Specialty development project. The Parties agree that the development of the Rx Specialty system shall be at PBM's discretion. The Parties further agree that Aetna may elect not to migrate to Rx Specialty if such system is not satisfactory to Aetna, in its discretion, and that if Aetna elects not to migrate to Rx Specialty (or to another specialty pharmacy technology platform offered by PBM), then PBM shall continue to use Aetna's specialty pharmacy technology platform (COMPAS or any successor provided by Aetna) pursuant to the terms of the Transition Services Agreement in order to provide the PBM Services contemplated by Schedules N and N-1.

E. Transition-In Timetable. The implementation and completion of the targeted events outlined on Schedule A-1 (the "Transition-In Timetable") in accordance with the dates and timetable set forth therein.

F. Transition-in Milestones. Completion of each of the milestones (the "Transition-In Milestones") set forth on Schedule A-5, in the manner described therein, on or before the applicable deadlines set forth therein.

The PBM Services Commencement Date is planned to occur on December 31, 2010. On the PBM Services Commencement Date, PBM shall commence the performance of all Phase I PBM Services, except for the Medicare Customer Services (which shall commence on July 1, 2011) and the Phase I Specialty Services (which shall commence not later than July 1, 2011).

The Phase I PBM Services shall consist of all PBM Services except that PBM will, as applicable and necessary, perform such services in a manner that utilizes certain of Aetna's existing systems, platforms and applications and the processes, protocols and methodologies currently utilized by Aetna and the Transferred Employees (collectively, "Legacy Systems and Processes"), except that in the case of the PBM Services set forth in Schedules M and N, the Phase I PBM Services shall consist of the services set forth in Schedules M-1 and N-1. As outlined in the Transition-In Timetable and in Schedule A-2, following the PBM Services Commencement Date, Full Migration will be achieved over time with respect to each of the PBM Services that initially will be dependent upon the Legacy Systems and Processes. From and after the date Full Migration is achieved with respect to a particular PBM Service (*i.e.*, its Cutover Date), PBM thereafter shall perform such PBM Service (and discontinue the corresponding Phase I PBM Service). In some cases Full Migration will be achieved with respect to a particular PBM Service on a single date; in other cases Full Migration of a PBM Service will be achieved in stages with respect to a group of Covered Plans or Aetna Customer.

This Transition-In Plan is comprised of this Schedule A and the following sub-schedules:

Schedule A-1 – Transition-In Timetable
Schedule A-2 – Process Flow Diagrams
Schedule A-3 – Outsourcing Readiness Tasks and Work
Schedule A-4 – Full Migration and Retail Pricing Transition Tasks and Work
Schedule A-5 – Transition Milestones
Schedule A-6 – Form of Transition Services Agreement

II. General Objectives

The principal objectives and goals of this Transition-In Plan are as follows:

1. Minimizing Member and Aetna Customer disruption – All Member and Aetna Customer administrative and other migration activities and tasks and conversion phases shall be structured to minimize disruption to Members' experience and Member and Aetna Customer perception of service quality.

2. Achieving a smooth transition from and after the Effective Date of the Phase I PBM Services and PBM Services from Aetna and its Affiliates to PBM and all related administration with no significant disruptions to Aetna Customers, Members or the business operations of Aetna, Aetna RX Home, Aetna Specialty Pharmacy and their Affiliates.

3. Achieving Full Migration as soon as practicable following the Effective Date so that the Parties are each able to realize the full benefits of the new business model reflected in this Agreement as quickly as possible following the Effective Date.

4. Maintaining and enhancing Aetna's "Integrated Value Proposition" – Member and Aetna Customer migration phases should synchronize with the implementation of new business operations and technology that will facilitate the integrated experience.

5. Minimizing business impact – Implementation, integration and migration activities for Aetna Plan and product segments and Aetna Customers and customer groups shall be structured and carried out to reduce potential adverse impacts to the business of Aetna and the Aetna Plan Affiliates, before, during and after Full Migration is completed, including potential bottlenecks during year-end renewals and other business events.

III. Transition-In Plan Phases

This Transition-In Plan is divided into two partially overlapping phases – an "Outsourcing Readiness Phase," and an "Implementation Phase." The Outsourcing Readiness Phase commences on the Effective Date and ends when Outsourcing Readiness has been completed (*i.e.*, the date as of which all of the Transition-In Milestones identified as necessary for Outsourcing Readiness in Schedule A-5 have been completed) for each category of PBM Services as outlined in paragraph I.A. above.

The Outsourcing Readiness Phase addresses the transition-in and implementation-related actions, tasks and work that the Parties have agreed must be accomplished in order to complete Outsourcing Readiness. Schedule A-3 (Outsourcing Readiness Tasks and Work) sets forth in

greater detail the actions, tasks and work to be completed as part of the Outsourcing Readiness Phase.

The Implementation Phase addresses transition-in and implementation related actions, tasks and work that the Parties have agreed must be accomplished in order to complete Retail Pricing Transition and Full Migration and allow the Cutover of applicable PBM Services. Schedule A-4 (Full Migration and Retail Pricing Transition Tasks and Work) sets forth in greater detail the actions, tasks and work to be completed as part of the Implementation Phase.

IV. Timeline

As of the date of this Agreement, the Parties have established the Transition-In Timetable (Schedule A-1) as a working timetable for this Transition-In Plan. Aetna and PBM will use their respective commercially reasonable efforts to carry out this Transition-In Plan in a manner that achieves the steps and outcomes included on the Transition-In Timetable within the applicable time periods shown thereon. The Parties (by mutual agreement) and/or the Transition Committee will update and modify the Transition-In Timetable from time to time as necessary to reflect changing circumstances.

V. Current, Closing and Full Migration Business and Systems Process Flows

Attached in Schedule A-2 are a series of Future State Business Process Flow Diagrams. Aetna and PBM plan and intend to complete, through the implementation and performance of this Transition-In Plan, the outcomes reflected in these Future State Business Process Flow Diagrams, in each case on or before the applicable target completion dates specified in Schedule A-2. Schedule A-2 also includes a table that sets forth various interim-state outcomes, which Aetna and PBM plan and intend to complete through the implementation and performance of this Transition-In Plan, in each case on or before the applicable target completion dates specified in such table. The Parties (by mutual agreement) and/or the Transition Committee will update and modify Schedule A-2 from time to time as necessary to reflect changing circumstances.

VI. Transition-in Plan Performance Obligations.

6.1 **Tasks and Work.**

(a) PBM Obligations. From and after the Effective Date, PBM, at its sole cost, shall (i) jointly with Aetna, implement this Transition-In Plan according to the timetable set forth on Schedule A-1, (ii) perform and complete the tasks and work assigned to PBM in Schedule A-3 (the "PBM Outsourcing Readiness Tasks"), and (iii) perform and complete the tasks and work assigned to PBM in Schedule A-4 (the "PBM Implementation Tasks" and together with the PBM Outsourcing Readiness Tasks, the "PBM Transition Tasks").

(b) Aetna Obligations. Aetna, at its sole cost (but subject to reimbursement pursuant to Section 3.1(c) of this Agreement), shall (i) jointly with PBM implement this Transition-In Plan, (ii) perform and complete the tasks and work assigned to Aetna in Schedule A-3 (the "Aetna Outsourcing Readiness Tasks"), and (iii) perform and complete the tasks and work assigned to Aetna in Schedule A-4 (the "Aetna Implementation Tasks" and together with

the Aetna Outsourcing Readiness, the "Aetna Tasks," and the PBM Tasks and Aetna Tasks, collectively, the "Transition Tasks").

(c) Transition Services Agreement. On or before the PBM Services Commencement Date, Aetna and PBM shall execute and deliver a Transition Services Agreement substantially in the form set forth in Schedule A-6. The text included in Schedule 1 (Description of Services) to such form of Transition Services Agreement, except for the fees, charges and cost methodologies set forth therein, constitutes Provisional Text and is subject to Section 17.29 of the Agreement.

6.2 **Failure to Complete Transition-In Milestones by Required Dates.**

(a) Subject to Section 6.3(d) below, (i) PBM shall implement this Transition-In Plan and perform the PBM Tasks in such a manner as will complete the milestones, objectives and targets set forth on Schedule A-5 (the "Transition-In Milestones") on or before the applicable due dates therefor (as set forth in Schedule A-5); and (ii) in the event that PBM fails to complete one or more of the Transition-In Milestones, including satisfaction of the testing requirements described in Section 6.4, by the applicable due dates therefor, PBM shall pay Aetna the applicable Guarantee Amount(s) set forth in Schedule A-5. In no event shall the total amount of Guarantee Amount payments that PBM is obligated to pay to Aetna pursuant to this Section 6.2 and Schedule A-5 during the Term exceed an amount equal to Fifty Million Dollars ($50,000,000) minus the total amount paid to Aetna by PBM pursuant to Section 3 of that certain Transition-In Plan Modification and Waiver Agreement dated August 16, 2012, between PBM and Aetna.

(b) To the extent indicated in Schedule A-5, the Guarantee Amounts payable under this Schedule A and Schedule A-5, and in accordance with Section 3.1(a) of the Agreement, shall be the sole and exclusive remedy for PBM's failure to meet the Transition-In Milestones. Notwithstanding the foregoing, none of the Transition-In Milestones or Guarantee Amounts shall relieve PBM of the obligation to perform its obligations under this Transition-In Plan in accordance with all requirements and standards set forth in this Agreement; and payment of Guarantee Amounts by PBM shall not be Aetna's exclusive remedy, nor shall they limit any right or remedy that may be available to Aetna under applicable Law or the Agreement on account of any individual failure or breach under the Agreement by PBM (even if such failure or breach contributed towards a failure by PBM to meet a Transition-In Milestone), including the following rights and remedies of Aetna under the Agreement: indemnification rights under Section 15.1 and termination rights under Article XII.

6.3 **Cooperation.**

(a) Cooperation. Each Party shall, and shall cause its Affiliates to, assist and cooperate in good faith with the other Party in connection with the performance of its obligations under this Transition-In Plan. Such cooperation includes, to extent commercially reasonable and subject to any limitations under applicable Law, (i) providing data and information to the other Party, (ii) responding as promptly as practicable to the other Party's requests for approvals, consents or other communications, and (iii) not acting or failing to act in any way that reasonably

could be expected to materially adversely affect the ability of the other Party to perform its obligations under this Transition-In Plan.

(b) Access to Aetna Facilities, Systems and Personnel. Subject to Aetna's reasonable requirements related to security and business continuity and any limitations under applicable Law, the Transition Services Agreement and the Subleases, Aetna will grant to PBM and its Subcontractors, at all reasonable times during the Transition-In Phase, (i) the right of ingress and egress to and from the facilities of Aetna, Aetna RX Home and Aetna Specialty, and (ii) access to the systems, applications, equipment, documentation, information and other materials and personnel of Aetna, Aetna RX Home and Aetna Specialty, in each case to the extent reasonably necessary and proper for the implementation of this Transition-In Plan and the performance of the PBM Tasks and PBM Consulting Services.

(c) Access to PBM Facilities, Systems and Personnel. Subject to PBM's reasonable requirements related to security and business continuity and any limitations under applicable Law, PBM will grant to Aetna and its Affiliates, at all reasonable times during the Transition-In Phase, (i) the right of ingress and egress to and from the facilities of PBM and its Affiliates, and (ii) access to the systems, applications, equipment, documentation, information and other materials and personnel of PBM and its Affiliates, in each case to the extent reasonably necessary and proper for the implementation of this Transition-In Plan and the performance of the Aetna Tasks, subject to Article XIII of the Agreement. In addition, from time to time and upon request from Aetna, PBM shall permit Aetna and its designees to monitor and observe the performance of the PBM Tasks at PBM's facilities, or at any other location at which such performance is occurring.

(d) Cooperation with Respect to Consents and Approvals. If during the Transition-In Period any consent, waiver, license, order, registration, approval, permit, tax ruling or authorization is necessary or advisable to be obtained from any Governmental Body in order to complete Outsourcing Readiness and/or Full Migration (collectively, "Required Transition Approvals"), each of the Parties will cooperate with each other with respect to the acquisition of the Required Transition Approvals, including that the Parties shall keep each other reasonably apprised of developments with respect to such Required Transition Approvals. In addition, with respect to Required Transition Approvals which Aetna is required by applicable Law to obtain, PBM shall, as promptly as practicable, respond to Aetna's requests, if any, for information and assistance with respect to the preparation and prosecution of applications seeking such Required Transition Approvals and related communications with Governmental Bodies.

6.4 Testing and Acceptance of PBM Tasks and Confirmation of Milestones.

PBM shall promptly notify Aetna and the Transition Committee in writing when it believes it has completed or fully completed (i) a PBM Task or series of related PBM Tasks for which acceptance or completion criteria is provided in Schedule A-3, A-4 or A-5 or (ii) a Transition-In Milestone. Promptly after the delivery of each such notice, Aetna shall, as soon as practicable and in accordance with any applicable acceptance or testing procedures set forth Schedules A-2, A-3, A-4, and/or A-5, evaluate and determine whether such PBM Task(s) or Transition-In Milestone has been completed in satisfaction of all applicable specifications and requirements set forth in the Transition-In Plan. If Aetna determines that such PBM Task(s) or

Transition-In Milestone has not been completed, Aetna shall advise PBM of the deficiencies, and PBM shall take such actions (including re-performance of any PBM Tasks) as shall be necessary, as soon as practicable, to complete such PBM Task(s) or Transition-In Milestone to Aetna's satisfaction. In the event of a dispute between the Parties as to whether or PBM Task or series of related PBM Tasks or a Transition Milestone has been completed, such dispute shall be referred to the Transition Committee (as defined below) for resolution within a 10 calendar day period and, if necessary, such dispute shall be escalated and resolved in the manner provided in Sections 6.5(e).

6.5 **Transition Committee.**

(a) Organization of the Transition Committee. The Parties will establish a Transition Services Steering Committee (the "Transition Committee") to oversee and coordinate the implementation of this Transition-In Plan and the performance of the PBM Tasks and Aetna Tasks, to attempt in good faith to resolve any disputes between the Parties relating to this Transition-In Plan and to review Change Requests (as contemplated by Section 6.7). The Transition Committee initially will consist of eight individuals (each, a "Committee Member") as indicated below. Aetna and PBM each will have the right to designate one-half of the individuals to serve on the Transition Committee. The initial Committee Members are as follows (and PBM will designate an additional three Committee Members by notice to Aetna within ten (10) Business Days of the Effective Date):

Initial Transition Committee	
Aetna Committee Members	Laurie Brubaker – Executive Business Owner Robert Galle – Pharmacy Business Owner Diane Bartunek – Migrations Leader Mary Beth Cardin – Program Manager
PBM Committee Members	Steve Cohan TBD TBD TBD

Each Party will take all necessary action in order to ensure that the composition of the Transition Committee is as set forth in this Section 6.5(a).

(b) Removal of Members. Each Party will have the exclusive right to remove any Committee Member appointed by it from the Transition Committee, for any or no reason. Any Party exercising the right to remove its designee from the Transition Committee shall promptly appoint a replacement Committee Member; *provided, however,* that any replacement of a PBM-appointed Committee Member must be acceptable to Aetna in its reasonable discretion.

(c) Meetings. The Transition Committee will meet, in person or via teleconference, at least once every week during the Transition-In Phase; *provided, however*, that the Transition Committee may, by majority vote of the Committee Members, elect to meet more or less frequently as it deems necessary. In addition, the Transition Committee will meet (i) as frequently as necessary to promptly resolve any disputes submitted to it, and (ii) at such times on

Business Days as either Party may request upon at least two days prior written notice to the other.

(d) Decision Making. The Parties intend that the Transition Committee shall act by consensus. Any matter brought to a vote before the Transition Committee shall be approved if a majority of the Committee Members designated by each Party approve such matter.

(e) Disputes. If the Transition Committee fails to make a decision, resolve a dispute or agree upon any necessary action relating to this Transition-In Plan within 2 Business Days of a written request made by any member of the Transition Committee that the Transition Services Committee make such a decision, resolve such dispute or agree upon any such necessary action, either Aetna or PBM may make a written request to escalate the matter to the officer level (an "Officer Escalation Notice"). Within one Business Day after a Party's receipt of an Officer Escalation Notice, each of Aetna and PBM will appoint a senior officer responsible for addressing any such unresolved matter. Within three Business Days after such appointment, the Parties shall cause the senior officers to confer and attempt in good faith to conclusively resolve any such unresolved matter. If the Transition Committee and such senior officers are unable to resolve any such unresolved matter within three Business Days after the senior officers have conferred, Aetna or PBM may make a written request to escalate the matter to the senior management level ("Senior Management Escalation Notice"). Within three Business Days after a Party's receipt of a Senior Management Escalation Notice, each Party will appoint a senior management representative who is the Chief Operating Officer or the equivalent of each Party, and the Parties shall cause such Chief Operating Officers or their equivalents to confer and attempt in good faith to conclusively resolve the matter within five Business Days after their appointment. The representatives will furnish to each other all non-privileged information with respect to the unresolved matter that the Parties believe to be appropriate and germane, all of which shall be deemed to be settlement materials within the meaning of Federal Rule of Evidence 408 and inadmissible in any subsequent legal proceeding. If the Parties do not resolve the matter within five Business Days following the issuance of a Senior Management Escalation Notice, either Party may take action as permitted by Section 17.27 of the Agreement.

6.6 **Program Management Leader.**

(a) Each Party will appoint a specifically named "Program Management Leader" who will have authority on behalf of such Party, among other things, to:

(i) make day to day decisions and commitments concerning the implementation of this Transition-In Plan and the performance of the PBM Tasks and Aetna Tasks;

(ii) participate in regular project review meetings;

(iii) agree to variations in the PBM Tasks and Aetna Tasks that do not need to be adopted in a Change Request, provided that variations that would delay or reasonably would be likely to delay the completion of any Transition-In Milestone may only be agreed in a Change

Order, as described in Section 6.7 below, by the Transition Committee or by the Parties in a written amendment of this Agreement;

(iv) make the appropriate resources available;

(v) act as a first level of issue resolution for issues escalated by any Operational Team and escalate such issues as needed to the Transition Committee; and

(vi) Manage risk and mitigation strategies.

(b) Neither Program Management Leader will have authority to amend or waive the terms of this Agreement. All such amendments or waivers (including any determined pursuant to Sections 6.5 or Section 6.7 of this Transition-In Plan) may be made only pursuant to Section 17.13 of this Agreement. Aetna's initial Program Management Leader shall be Mary Beth Cardin, and PBM's initial Program Management Leader shall be Kuldeep Sidhu. If an issue or controversy is under consideration by the Program Management Leaders and such issue or controversy is not resolved by the Project Management Leaders within fifteen (15) business days, the issue shall be automatically escalated to the Transition Committee; *provided, however*, that if either Party's Program Management Leader reasonably believes that the issue or controversy will not be resolved within such fifteen (15) business day period, or that escalation to the Transition Committee prior to the expiration of such fifteen (15) day period is necessary to avoid an adverse impact on such Party, then such Party shall be permitted to escalate such issue or controversy immediately to the Transition Committee.

6.7 **Change Requests.** If either Party, in order to better achieve the objectives set forth in the Transition-In Plan, believes (i) one or more of the Transition Tasks needs to be changed, modified or supplemented, (ii) additional Transition Tasks are necessary, or (iii) any Transition Milestone needs to be changed or modified, the requesting Party shall, in reasonable detail, request such changes, modifications, supplemental actions and additions in a written notice to the other Party and each Committee Member (any such request, a "Change Request"). Each Party, within three Business Days of receiving a Change Request, shall respond to the other Party in writing with one of the following: (a) an approval of the Change Request, (b) a proposed modification, in reasonable detail, to the Change Request, or (c) the reasons, in reasonable detail, why such Party will not agree to the Change Request. If a Party is not agreeable to a Change Request proposed by the other Party, either Party may refer the matter to the Transition Committee for resolution. If a Change Request is acceptable to both Parties (either as originally issued or as subsequently evaluated and/or modified by the Parties or the Transition Committee), the Parties promptly shall amend this Transition-In Plan as necessary to implement its terms. Notwithstanding anything to the contrary in this Agreement, each Party shall be entitled, in its sole discretion, to reject any Change Request that proposes a change or modification to any Closing Milestone; and any such Change Request shall be referred to the Transition Committee for resolution only with consent of both Parties.

6.8 **PBM Personnel.**

(a) Qualified Personnel. PBM shall provide qualified personnel to perform PBM Tasks and PBM's other obligations under this Transition-In Plan who are reasonably

acceptable to Aetna, and which shall include the positions (with PBM to provide notice to Aetna within ten (10) Business Days of the Effective Date setting forth the name of the individual who will fulfill each such position below):

Title/Position	Area of Responsibility Associated with Transition In Plan
PBM Services Leader	Transition of PBM Services, including services relating to the transition of Aetna Medicaid and affiliate business
Customer Care and Services Leader	Transition of Customer Call and Claims Services and Management of Member Experience Implications
Mail Order Services Leader	Transition of Mail Order Services
Specialty Services Leader	Transition of Specialty Services
Medicare Services Leader	Transition of Medicare Services
Information Technology Program Leader	Management of technology enablement required to successfully execute the Transition-In Plan; coordination with Aetna Technology Program
Human Resources Services Leader	Outsourcing of Functions, including smooth onboarding of Transferred Employees
Network and Retail Pricing Transition Leader	Responsible for transition to PBM's network and implementation of pricing schedules

Upon request from Aetna, PBM shall provide to Aetna the names of the members of the project teams utilized by PBM to perform any of the PBM Tasks and PBM Consulting Services, the role of each such project team member, the percentage of time each project team member is expected to devote to the PBM Tasks and PBM Consulting Services, and the resumes of such personnel.

PBM will make commercially reasonable efforts consistent with sound business practices and availability to honor all Aetna requests with regard to the assignment of specific PBM personnel.

(b) PBM Personnel Replacement. Aetna may, for reasons related to the quality of performance by an individual or security concerns regarding such individual's behavior while on the premises of Aetna or any Aetna Affiliate, request that such individual be removed (including, if Aetna determines is necessary, on an expedited basis) and replaced with other PBM personnel. PBM shall comply with such request as soon as reasonably practicable by removing and substituting different qualified PBM personnel.

6.9 **Transition Employees.**

(a) Not later than forty-five (45) days after the Effective Date (or, as noted in the Employee Benefits Data File with respect to certain employee positions supporting Medicare customer service function, not later than April 1, 2011 (the "Delayed Transition Employees")) PBM will make a written offer of employment to each of the employees of Aetna and its Affiliates identified in the Employee Benefits Data File (the "Transition Employees" and, for the avoidance of doubt, the Transition Employees include the Delayed Transition Employees), in each case for the same or similar job function and location as in effect immediately prior to the PBM Services Commencement Date, or in the case of the Delayed Transition Employees, the date on which the Medicare-related functions supported by the Delayed Transition Employees transfer to PBM (the "Delayed Employee Transfer Date" and the PBM Services Commencement Date and the Delayed Employee Transfer Date, as applicable to a Transition Employee, such Transition Employee's "Transfer Date"), in each case, on the terms and conditions set forth in this Section 6.9. Such offers of employment shall provide for the commencement of employment (i) by each Transition Employee who is actively at work as of the Transfer Date, commencing as of the Transfer Date , and (ii) by each Transition Employee who is on PTO (as defined below), certified FMLA, short-term disability leave or any other authorized leave of absence other than long-term disability as of the Transfer Date, whether paid or unpaid (any such absent employee, an "Inactive Transition Employee"), as of the first day such Inactive Transition Employee is available to return to active service, so long as such date of return occurs within 180 days of the Transfer Date; provided that in no case shall PBM be required to hire a Transition Employee prior to the PBM Services Commencement Date. As used herein, the term "PTO" means sick leave and other personal leave time with respect to which a Transition Employee is entitled to be paid while absent from work. Aetna may from time to time update the Employee Benefits Data File prior to the PBM Services Commencement Date or Delayed Employee Transfer Date to reflect replacements for Transition Employees identified thereon. To the extent that the Employee Benefits Data File includes positions identified as "open positions" or that the employment of any of the persons listed in the Employee Benefits Data File has terminated as of the PBM Services Commencement Date or Delayed Employee Transfer Date and no replacement is named pursuant to the preceding sentence, PBM shall seek to fill such position, with an employee meeting all criteria set forth in the Agreement, including in Article V thereof, as soon as practicable following the Transfer Date for such position and including to the extent accomplished by hiring the Prospective Hires (as defined below). Notwithstanding the foregoing, PBM's offer of employment to each Transition Employee shall be subject to and conditioned upon the person's satisfactory completion/passage of PBM's standard pre-hire requirements for employees in similar positions and completion of PBM's standard new-hire

paperwork for employees in similar positions. PBM shall have no obligation to extend an unconditional offer of employment to or actually hire any person who does not satisfactorily pass such pre-hire requirements and complete such new-hire paperwork. Moreover, prior to the Transfer Date and with respect to any acts or omissions by a Transition Employee that would have resulted in counseling, discipline or termination notwithstanding the Agreement, Aetna will in good faith handle the matter as it would have done notwithstanding the Agreement.

(b) Notwithstanding the foregoing, Transition Employees will exclude any employee who, (i) is on long-term disability leave as of the Transfer Date or (ii) has been terminated or has terminated his or her employment for any reason before the Transfer Date, but will include any person who has accepted an offer of employment to fill a position included in the Employee Benefits Data File (in lieu of one of the persons filling such position as of Effective Date) before the Transfer Date but whose employment start date will be on or after the Transfer Date (with the offer of employment to be effective as of such start date) (a "Prospective Hire"). Aetna shall consult in good faith with PBM prior to it making any offers of employment to any Prospective Hires. Aetna (or its employing Affiliate) shall retain responsibility for any Inactive Transition Employee who does not return to work within 180 days after the Transfer Date and shall be responsible for any and all severance and other related costs and expenses for such Inactive Transition Employee, if applicable.

(c) In order to effect the foregoing, immediately prior to the Transfer Date (or as applicable to the Delayed Transition Employees, the Delayed Employee Transfer Date), Aetna shall terminate the employment of all Transition Employees. Except as set forth in Section 6.9(h) with respect to PTO, Aetna shall be fully responsible for and shall pay to the Transition Employees at the time of termination all payments due to such employees, including all wages, severance, commissions and other remuneration due and payable to employees consistent with the policies and procedures of Aetna and its Affiliates (including pursuant to any Contract and applicable Law) with respect to their services as employees of Aetna. Aetna shall also pay (i) annual bonuses payable to the Transition Employees in accordance with Aetna's standard bonus practice and (ii) and special transition/retention bonus established by Aetna for which such Transition Employees are eligible, which payments may be made following the termination date of their employment with Aetna. Aetna shall provide any and all notice to the Transition Employees and Governmental Bodies that Aetna is required to provide pursuant to the Worker Adjustment and Retraining Notification Act, 29 U.S.C. §§ 2101, et seq. and/or any similar Law.

(d) PBM acknowledges that Aetna has provided to it an electronic file containing the following information about each Transition Employee: current annual compensation (including, where applicable, bonus or incentive compensation opportunity), legal employer, full or part time or leave status, work-at-home status, exempt/nonexempt status, hourly or salaried status, date of hire, adjusted date of hire, work location and job title (such information, collectively, the "Employee Benefits Data File"). Aetna also shall promptly provide updates to such information in order to address increases or other changes in compensation, benefits or other Employee Benefits Data. Aetna also shall provide similar information to PBM with respect to the job requirements applicable to each open position identified in the Employee Benefits Data File and, upon the extension of an offer to such person, each Prospective Hire. Aetna will not provide any information the disclosure of which (i) would reasonably be expected to violate applicable Law, (ii) would impair any privilege, including the

attorney/client privilege, or (iii) would result in the disclosure of personnel records of Aetna or any of its Affiliates relating to individual performance or evaluation records, medical histories or other information that in Aetna's good faith opinion is sensitive or the disclosure of which could subject Aetna or any of its Affiliates to risk of liability. PBM shall, and shall cause its Affiliates to, treat the information contained in the Employee Benefits Data File as confidential, and shall not use such information except for the purposes expressly contemplated by this Agreement. PBM shall implement reasonable and adequate safeguards to protect against the unauthorized or inadvertent disclosure, use, access, or acquisition of any information included in the Employee Benefit Data File, including as required by applicable Law. In the event of an unauthorized or inadvertent disclosure, use, access, or acquisition of any of the information included in the Employee Benefit Data File, PBM shall (i) notify Aetna within 48 hours and provide the Aetna with sufficient information for Aetna to perform any legally necessary notification; and (2) use commercially reasonable efforts to investigate the breach and prevent further or ongoing unauthorized or inadvertent disclosure, use, access, or acquisition of the information included in the Employee Benefit Data File.

(e) Between the Effective Date and the Transfer Date, Aetna shall not: (i) grant or increase any rights to severance or termination pay for (or amend any existing arrangement with) any Transferred Employee; or increase benefits payable under any existing severance or termination pay policies; or (ii) increase compensation, bonus or other benefits payable to any Transferred Employee except for regularly scheduled merit increases (which regularly scheduled increases shall for the avoidance of doubt not include market or promotion adjustments, but which shall include those increases scheduled for the first quarter of 2010 but delayed until August 2010) in the ordinary course consistent with past practices and as necessary to comply with applicable law. Nothing in this Section 6.9(e) shall prevent Aetna from making promotion related adjustments in the ordinary course of business. Additionally, nothing in this Section 6.9(e) shall prevent Aetna from making changes to its benefit programs applicable to Aetna employees generally, including the Transferred Employees, nor shall it prohibit Aetna from offering special transition/retention bonuses to any Transition Employee as contemplated by Section 6.9(c) above.

(f) The Transition Employees shall be solely employed by Aetna, and shall not constitute joint employees of PBM and Aetna, on and before the Transfer Date (or, as applicable to the Delayed Transition Employees, the Delayed Employee Transfer Date). The Transferred Employees (as defined below) shall be solely employed by PBM, and shall not constitute joint employees of PBM and Aetna, from and after the Transfer Date (or, as applicable to the Delayed Transition Employees, the Delayed Employee Transfer Date).

(g) For the twelve (12) months immediately following the month in which the Transfer Date occurs, the continued employment of each Transition Employee who accepts PBM's offer of employment hereunder and commences active employment with PBM or any of its Affiliates (each, a "Transferred Employee") will include (1) annual base salary or base wage rate at least equivalent to the annual base salary or base wage rate being paid to such Transition Employees, in each case as of the Transfer Date, (2) retirement, health and welfare benefits (other than severance) that are available to other similarly situated employees of PBM (taking into account job location) under employee benefit plans of the PBM (the "PBM Benefit Plans"), provided that PBM will not be required to provide retiree life insurance, and (3) eligibility to

participate in the applicable PBM cash incentive plan, the terms of conditions of such shall be governed exclusively by the applicable plan. For performance year 2011, and notwithstanding anything in clause (3) of the preceding sentence to the contrary, the Transferred Employee's target cash incentive opportunity under the applicable cash incentive plan shall be at least equivalent to the target cash incentive opportunity provided to the Transferred Employee under the comparable Aetna plan applicable to the Transferred Employee immediately prior to the Transfer Date. Notwithstanding anything in this Agreement to the contrary, and subject to Section 6.9(l) below, Transferred Employees will be deemed employees at will of PBM or an Affiliate of PBM, and nothing express or implied herein will obligate PBM or any of its Affiliates to provide continuing employment to any Transferred Employee after the Transfer Date for a specified period of time following the Transfer Date.

(h) Following the Transfer Date, PBM will, or will cause its Affiliates to assume, honor, accept transfer of, and be solely responsible for paying, providing or satisfying when due: (i) up to five (5) days of unused PTO that the Transferred Employee actually accrued while employed by Aetna prior to January 1, 2011, and (ii) the amount of PTO that the Transferred Employee actually accrued but had not yet used between January 1, 2011 and the Transfer Date. As to both (i) and (ii), the PTO shall be subject to the terms and conditions then in effect for PBM's PTO policies for similarly situated employees. For calendar year 2011, Transferred Employees shall accrue vacation under PBM's PTO policy at the same rate at which they accrued PTO at Aetna immediately prior to the Transfer Date. Following calendar year 2011, PBM's PTO policy shall apply in full, but PBM shall review and may adjust the accrual rates of Transferred Employees to a higher accrual rate than set forth in the PBM policy as it deems appropriate in its sole discretion. Notwithstanding the foregoing, for any Transition Employee who is subject to Laws that require the payment of all accrued but unused PTO/vacation at the time of termination, Aetna shall pay to the employee on the date of termination the entire amount of the employee's accrued but unused PTO, and the employee shall not have any accrued but unused PTO at the beginning of his or her employment with PBM. Such employees will be eligible to accrue PTO subject to terms and conditions then in effect under PBM's PTO policies for similarly situated employees.

(i) Following the Effective Date and to the extent permitted by applicable Law, Aetna will provide PBM reasonable access to, and facilitate meetings, which Aetna shall have the right to attend, with, the Transition Employees for the purposes of making announcements concerning, and preparing for the PBM Services Commencement Date and Delayed Employee Transfer Date. Prior to making any written or oral communications to any of the Transition Employees pertaining to compensation or benefit matters under this Section 6.9, Aetna and PBM shall each provide the other with a copy of such intended communication, whether online, print or other format, and the other Party shall have a reasonable period of time to review and comment on the communication, and PBM and Aetna shall cooperate in providing any such mutually agreeable communication.

(j) Effective as of the PBM Services Commencement Date, (i) PBM will have one or more group health plans in effect providing continuous uninterrupted welfare benefits for the Transferred Employees (effective upon their applicable Transfer Date) and their dependents, (ii) PBM will, or will cause its Affiliates to waive, or cause its health plan, dental plan and disability plan insurance carriers to waive, all limitations or exclusions as to pre-existing

conditions, evidence of insurability or good health, waiting periods or actively-at-work exclusions or other limitations or restrictions on coverage, if any, applicable to any Transferred Employees or their eligible spouses or dependents or beneficiaries under any welfare benefit plans in which such employees may be eligible to participate after the Transfer Date, and (iii) PBM will, or will cause its Affiliates to credit all costs or expenses incurred by Transferred Employees (and such Transferred Employees' eligible spouses or dependents) under any employee benefit plans of Aetna or its Affiliates prior to the Transfer Date, if any, for the year in which the Transfer Date occurs for purposes of satisfying applicable deductible, co-payment, coinsurance, maximum out-of-pocket provisions and like adjustments or limitations on coverage under any PBM Benefit Plans.

(k) Periods of employment with Aetna or any of its Affiliates (including any current or former Affiliate of Aetna or any predecessor of Aetna or any of its Affiliates) will be taken into account for purposes of determining, as applicable, the eligibility for participation, level of benefits and vesting under all employee benefit plans, policies, arrangements or practices to which PBM or its Affiliates contributes (or has an obligation to contribute) or is a party for the benefit of such Transferred Employees, including vacation plans and arrangements, 401(k) and other retirement plans, disability plans, paid time off plans, and any severance and welfare plans.

(l) Until the first anniversary of the Transfer Date, and subject to the requirements of the PBM severance plan, PBM will pay with respect to any Transferred Employee whose employment is terminated by PBM or any of its Affiliates at any time prior to the first anniversary of the Transfer Date, severance benefits under the applicable PBM severance plan. In determining the number of weeks of severance pay during this period, and notwithstanding any requirements in PBM's severance plan to the contrary, PBM shall pay the greater of the number of weeks of severance (including salary continuation and severance pay) such Transferred Employee would have been eligible to receive under Aetna's Job Elimination Benefits plans in effect as of the Effective Date (inclusive of any service accrued following the Effective Date) or the number of weeks of severance pay which such Transferred Employee would be entitled to receive under the applicable PBM severance plan. For the avoidance of doubt, a Transferred Employee will not be eligible for severance benefits pursuant to this Section 6.9(l) if their employment is terminated by PBM for cause or if the Transferred Employee voluntarily resigns.

(m) The portions of this Transition-In Plan pertaining to the Transition Employees and Transferred Employees have been entered into solely for the benefit of Aetna and the Aetna Affiliates and PBM. No other Persons (including Transition Employees and/or Transferred Employees) are intended to be or are third party beneficiaries of or under this Transition-In Plan, and nothing in this Transition-In Plan shall be construed to create any legal, equitable or beneficial interest in any third party or to vest in any third party any interest as to enforcement or performance.

SCHEDULE A-1

TRANSITION-IN TIME TABLE AND ASSOCIATED MILESTONES

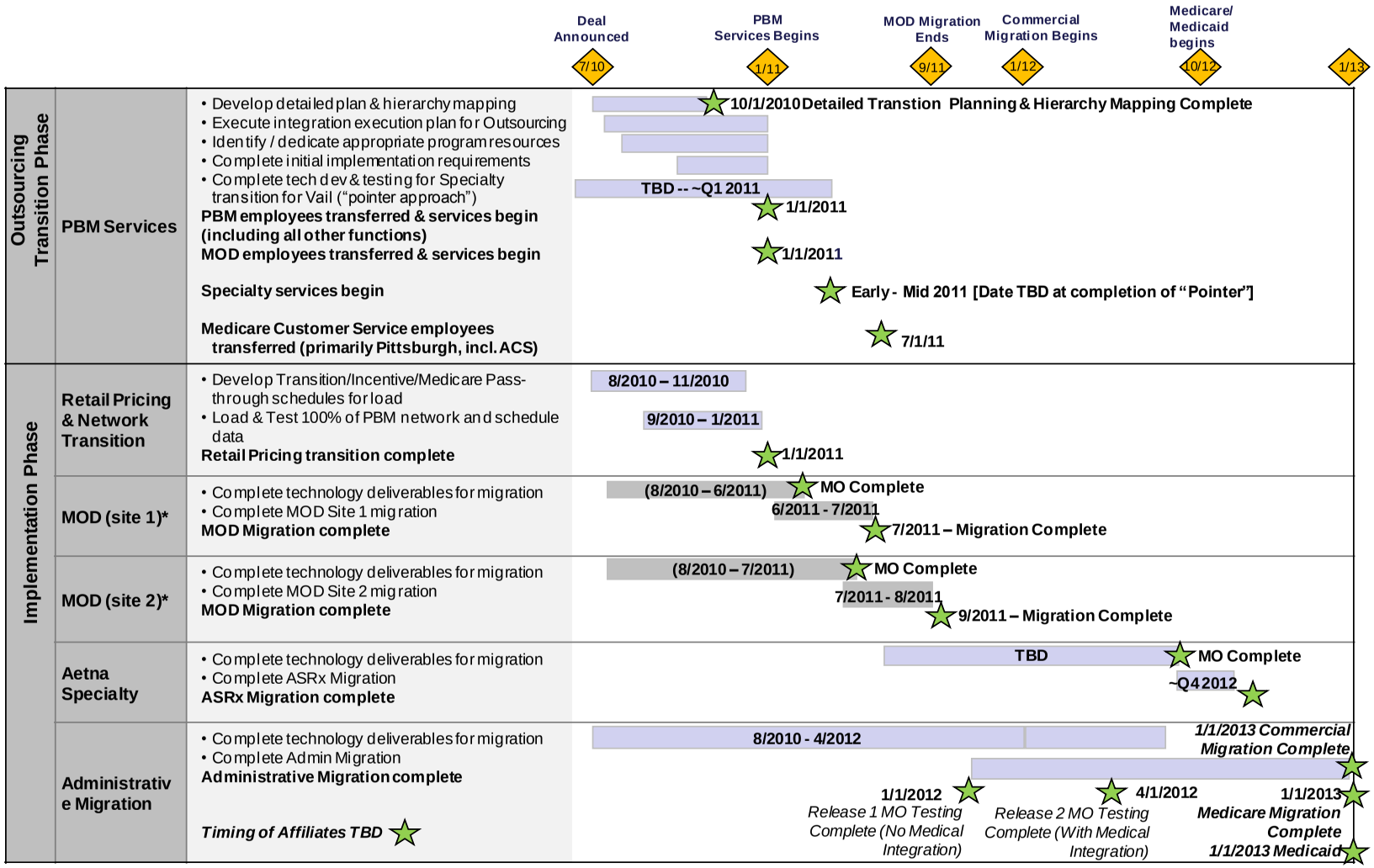

*The two MOD sites are Kansas City and Pompano. Timing on which location will migrate first will be determined in detailed planning phase

SCHEDULE A-2
PROCESS FLOW DIAGRAMS

This section indicates the timing of transition from current state to the end state for each PBM, ARxHD, and ASRx business function impacted. There are five distinct events throughout the overall transition period that can result in operational and systematic changes. These five events are listed in the order in which they occur below:

1. **Outsourcing Transition** - Upon commencement date of the outsourcing agreement, there will be no process changes.

2. **Retail Pricing Transition** – This event will result in the loading of PBM retail rates, network contractual terms and relationships, and associated network demographic data onto Aetna platforms. This event will not result in any new processes or changes to existing processes as Aetna and PBM will operate under current state model.

3. **Mail Order Migration -** Upon completion of this event, the following new processes will be implemented:

   Mail Order Prescription Processing

   - Mail Order Front End Processes (move to Counterparty platform)
   - Mail Order Back End Dispensing

   Product/ Strategy

   - Plan Set Setup (interim)
   - Eligibility (interim)

   Customer Service

   - Service Members (Navigator)

4. **Specialty Migration** - Upon completion of this event, the following future state processes will be achieved:
   - Specialty Pharmacy
   - Specialty Disease Management

5. **Administrative Migration –** Upon completion of this event, the following future end state processes will be achieved:

   Product/ Strategy

   - Plan Setup
   - Eligibility
   - ID Cards
   - COB and Member Term Recovery

   Network

   - Retail Network Visit

   Manufacturing Relations / Rebate Administration

   - High Level End to End Flow

   Claims Administration

   - Claims Disbursement
   - Prior-Authorization

   Customer Service – Commercial

   - Service Plan Sponsors and Members (Member Advocacy)
   - Service Members (Telephone & IVR)
   - Service Members (ASD)
   - Service Members (Written)
   - Intake of Complaints, Grievances, and Appeals
   - Pharmacy Help Desk (Eligibility Verification)

   Customer Service – Medicare

   - PDED Reconciliation (Medicare)

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VII. Aetna PBM Functions[1]

Business Function	Responsibility		Future State Business Process	Event				
	Aetna	PBM		Outsourcing Transition	Retail Pricing Transition	Mail Order Migration	Specialty Migration	Admin Migration
Product/ Strategy	X		• Plan Setup	Current State		Interim State		End State
			• Eligibility	Current State		Interim State		End State
			• ID Cards	Current State				End State
			• COB and Member Term Recovery	Current State				End State
Network		X	• Retail Network Visit	Current State				End State
Manufacturing Relations / Rebate Administration		X	• Pre-Invoice	Current State				End State
			• Invoice/Payment/Reconciliation	Current State				End State
			• Allocation/Distribution	Current State				End State
Claims Administration		X	• Prior-Authorization	Current State				End State
			• Claims Disbursement	Current State				End State
Customer Service – Commercial		X	• Intake of Complaints, Grievances, and Appeals	Current State				End State
			• Pharmacy Help Desk (Eligibility Verification)	Current State				End State
			• Service Members (Telephone & IVR)	Current State				End State
			• Service Members (ASD)	Current State				End State
			• Service Members (Written)	Current State				End State
			• Service Plan Sponsors and Members (Member Advocacy)	Current State				End State
Customer Service – Medicare	X	X	• PDED Reconciliation (Medicare)	Current State				End State

[1] Does not include Medicaid, Medicare or AWCRx lines of business, which may have a different workflow. Some calls will be taken by health plans or third party vendors.

For the processes outlined below, no additional future state process flows have been included but the future state is consistent with provisions outlined in Schedule I

Clinical / Formulary

Rebate Contracting

Sales / Marketing/ Pricing

Reporting / Analytics

[2] The future state process flows for Clinical/Formulary, Rebate Contracting, Sales/ Marketing/ Pricing, and Reporting/Analytics will be jointly developed post Effective Date with Aetna and PBM and are subject to final approval by Aetna.

Att R-984

7.1 ***Product/ Strategy***

(a) Plan Setup

Interim State: Upon Mail Order Migration, the plan and benefit setup and maintenance will continue to be performed by Aetna. A new interface containing plan and benefit data from APM to PBM will be implemented to support mail order fulfillment processing. New processes to support this interface will need to be implemented along with the systematic change.

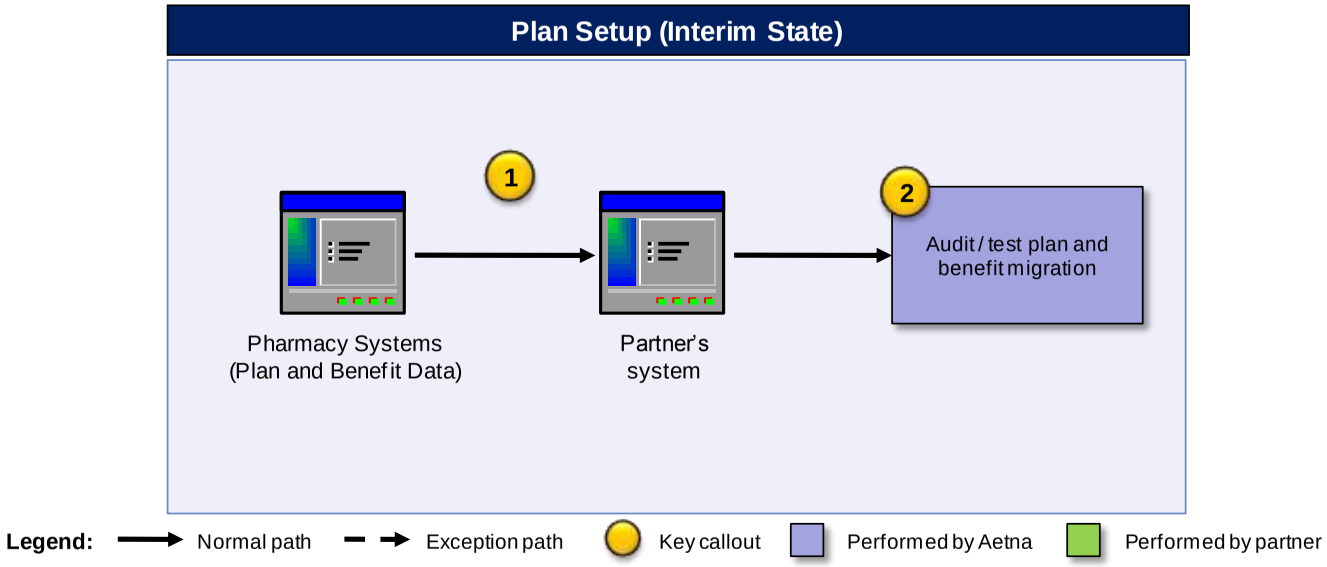

Key Highlights:

1. Initial migration of existing plan and benefit data and on-going feed of plan data to the partner will be system-driven

2. An audit of the migrated data will be performed to ensure that the information was loaded correctly and performs as expected

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End State: Upon Administrative Migration, the plan and benefit setup and maintenance will be setup manually in both the Aetna and PBM systems to allow for claims to process correctly on PBM systems while keeping Aetna's downstream systems whole. The interface containing plan and benefit data from APM to PBM that was implemented during the Mail Order Migration along with the supporting processes will continue to be intact. New processes for communicating plan and benefit changes to PBM will need to be established.

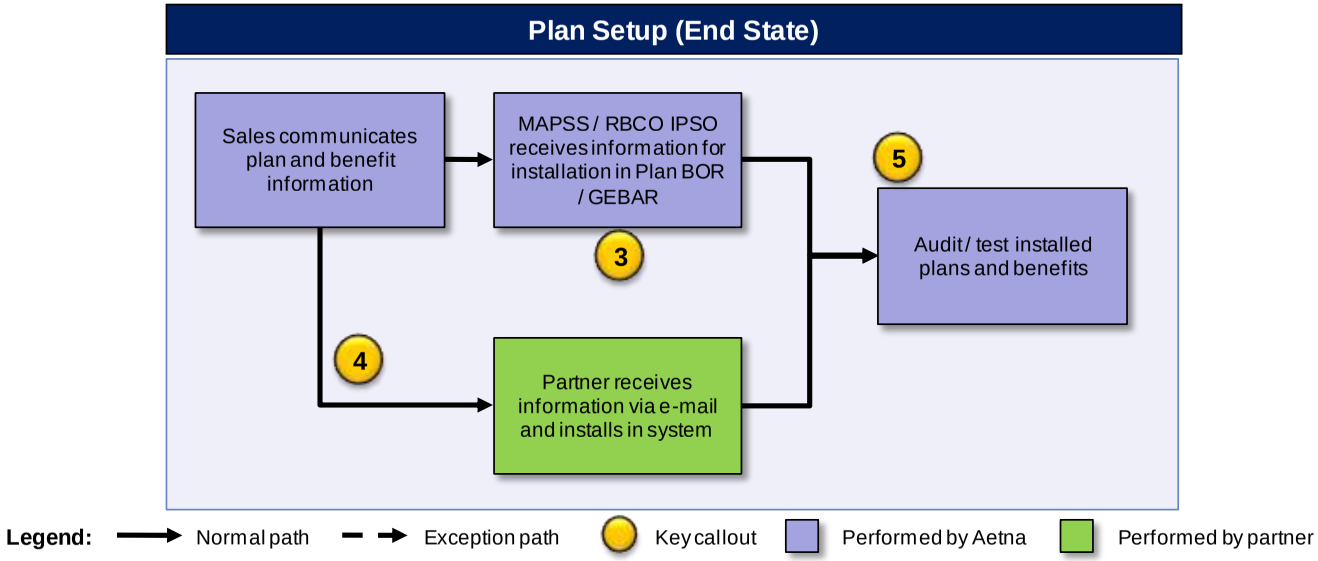

Key Highlights:

1. Initial migration of existing plan and benefit data and on-going feed of plan data to the partner will be system-driven
2. An audit of the migrated data will be performed to ensure that the information was loaded correctly and performs as expected

3. A number of critical data elements and other information will need to be fed to the partner to accomplish several key downstream activities (e.g., proper linkage of eligibility, claims adjudication, fulfillment of ID cards
4. The future state process for communicating cases to the partner will be "paper-based" (i.e., through e-mail)
5. A recurring audit and testing process will need to be established to ensure that the plans / benefits are installed correctly and perform as expected

(b) Eligibility

Interim State: Upon Mail Order Migration, the Eligibility setup and maintenance will continue to be performed by Aetna. A new interface containing minimum eligibility data from APM to PBM will be implemented to support fulfillment processing. New processes to support this interface will need to be implemented along with the systematic change.

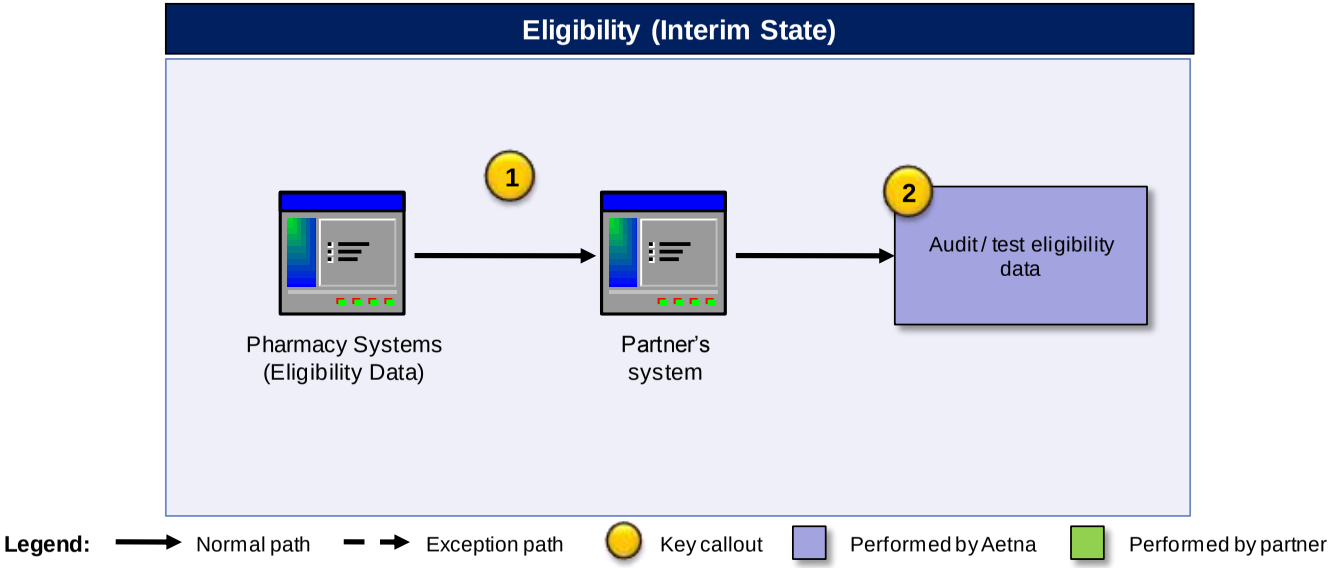

Key Highlights:

1. Initial migration of existing eligibility data and on-going feed of eligibility data to the partner will be system-driven

2. An audit of the migrated data will be performed to ensure that the information was loaded correctly and performs as expected

End State: Upon Administrative Migration, the Eligibility setup and maintenance will continue to be performed by Aetna. The interface containing eligibility data from APM to PBM that was implemented during the Mail Order Migration will be enhanced to include a full set of eligibility data required to support claims processing. New processes to support the end state will need to be established.

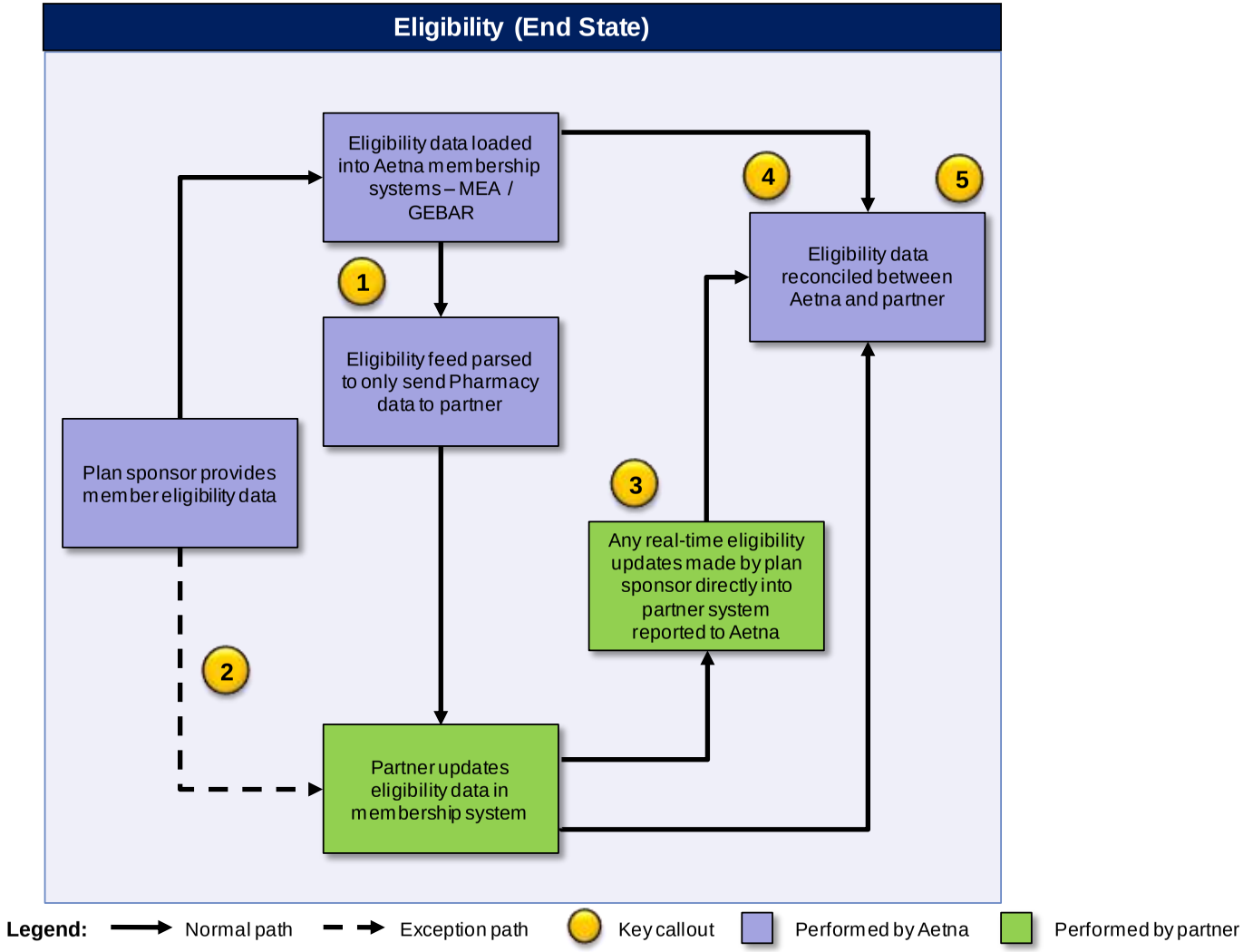

Key Highlights

1. Eligibility data that is fed from Aetna's systems, MEA (Traditional) and GEBAR (HMO), will need to be parsed in order to ensure that only Pharmacy data is fed to the partner (performed by RXSY today)
2. Plan sponsors will have the ability to directly access the partner's membership system to perform real-time eligibility transactions
3. Due to the ability by plan sponsors to directly access the partner's membership system, communication back to Aetna will be required to ensure eligibility data stays in sync
4. A routine eligibility data reconciliation process will need to occur between Aetna and PBM to identify discrepancies and identify possible problems early
5. This step also includes PDED (Medicare) eligibility reconciliation

(c) ID Cards

End State: Until Administrative Migration, this process will continue as business as usual via current state processes. Once a member is migrated to PBM platform, a new ID card will be issued and new processes for requesting replacement cards will need to be implemented.

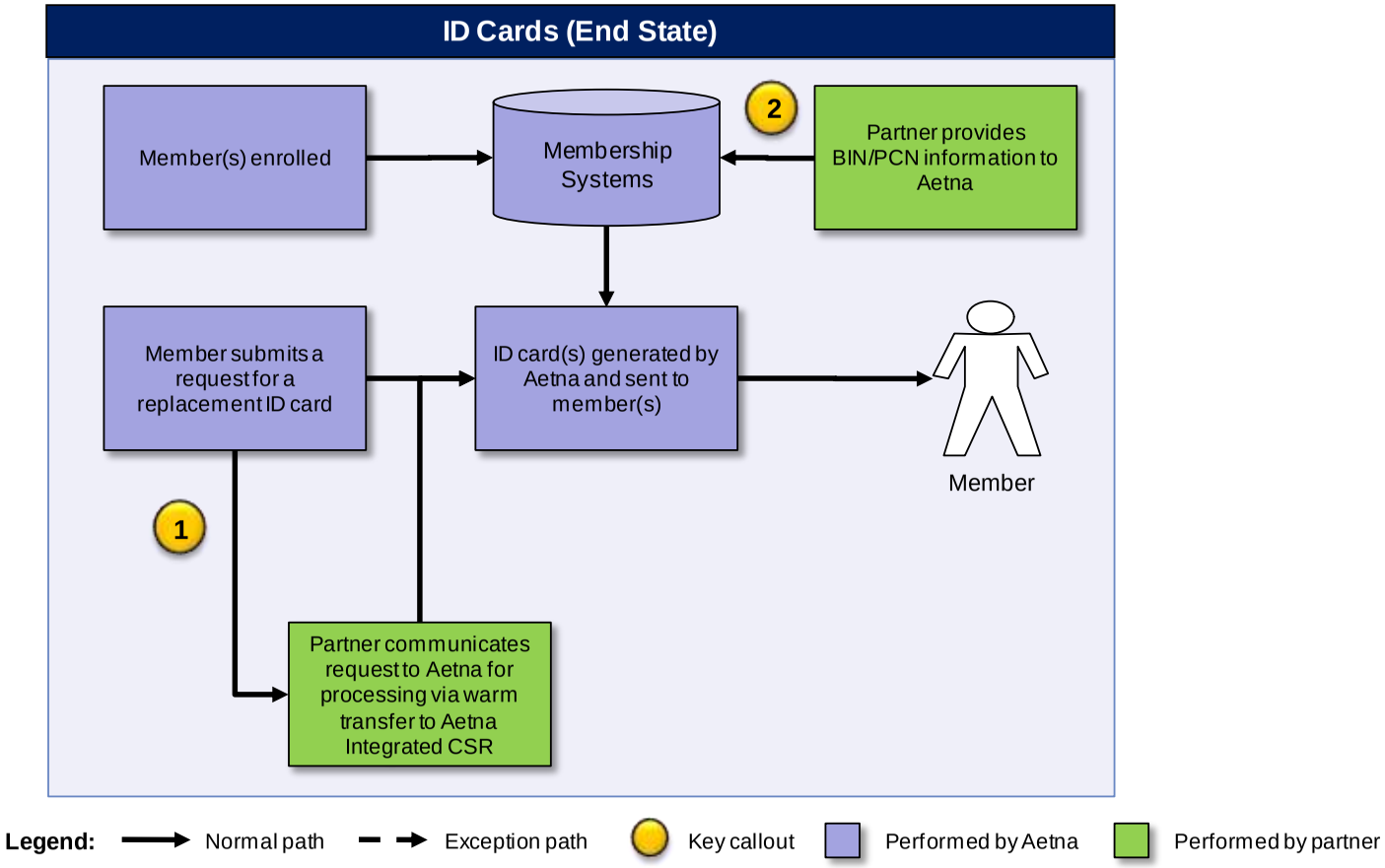

Key Highlights:

1. Requests for replacement ID cards that are received by the partner will have to be communicated to Aetna for processing
2. The information that will be required to be printed on ID cards will need to be coordinated between Aetna and partner (e.g. 800 #, BIN, PCN); this coordination will be critical to ensure that the appropriate information is present for efficient servicing of members as well as administration of benefits and claims

(d) COB and Member Term Recovery

End State: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. Once a member is migrated to PBM platform, the PBM will perform the member term recovery process.

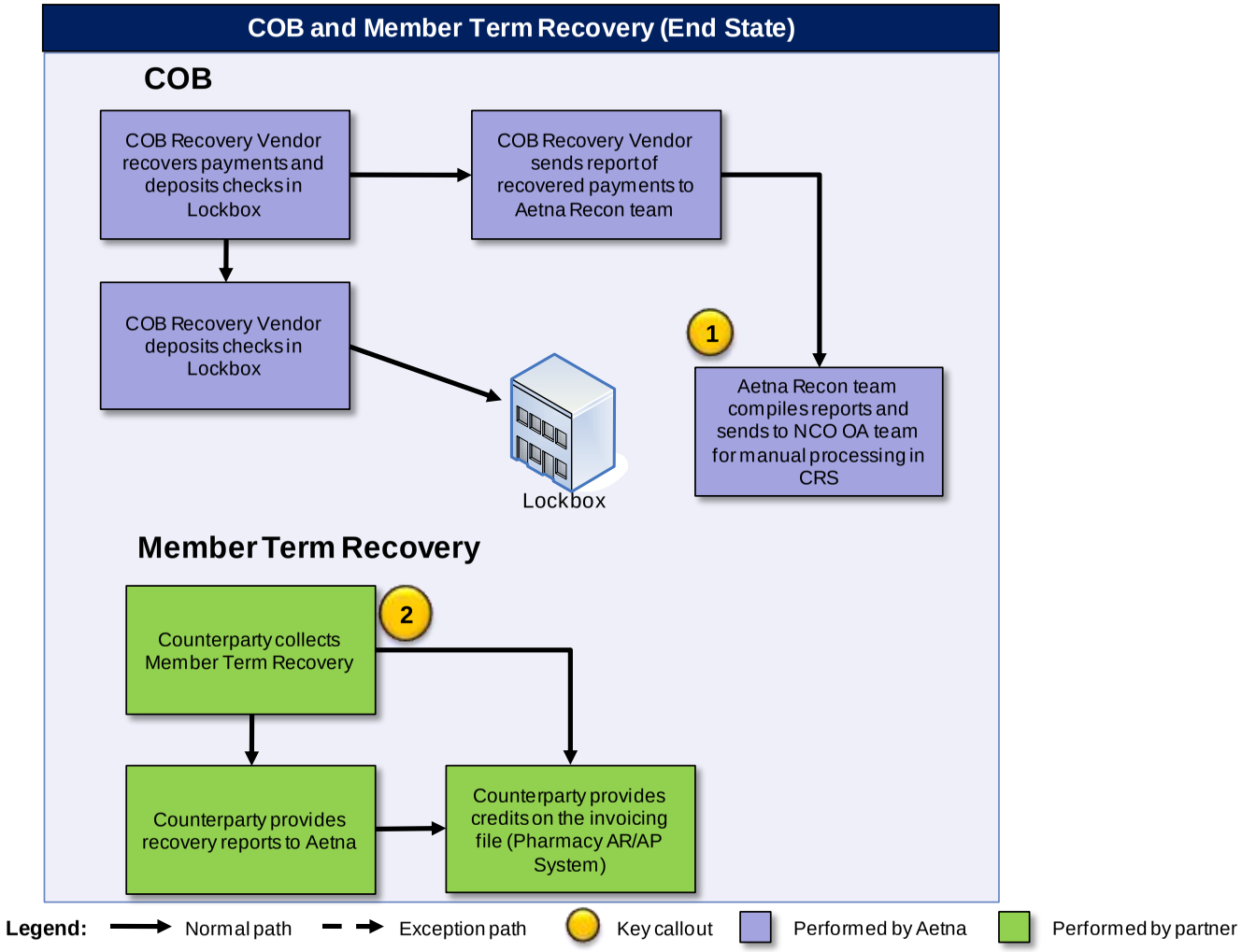

Key Highlights:

1. COB recovery will be retained by Aetna and will follow current state process.

2. Member Term process outsourced to Counterparty and managed as a part of the disbursement and reconciliation process

7.2 *Network*

(a) Retail Network Visit

End State: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. Once Administrative Migration begins, the PBM will systematically determine if the member has been migrated to the PBM platform. If the member has not been migrated the current process will continue. This determination will be seamless to both to the member and pharmacist.

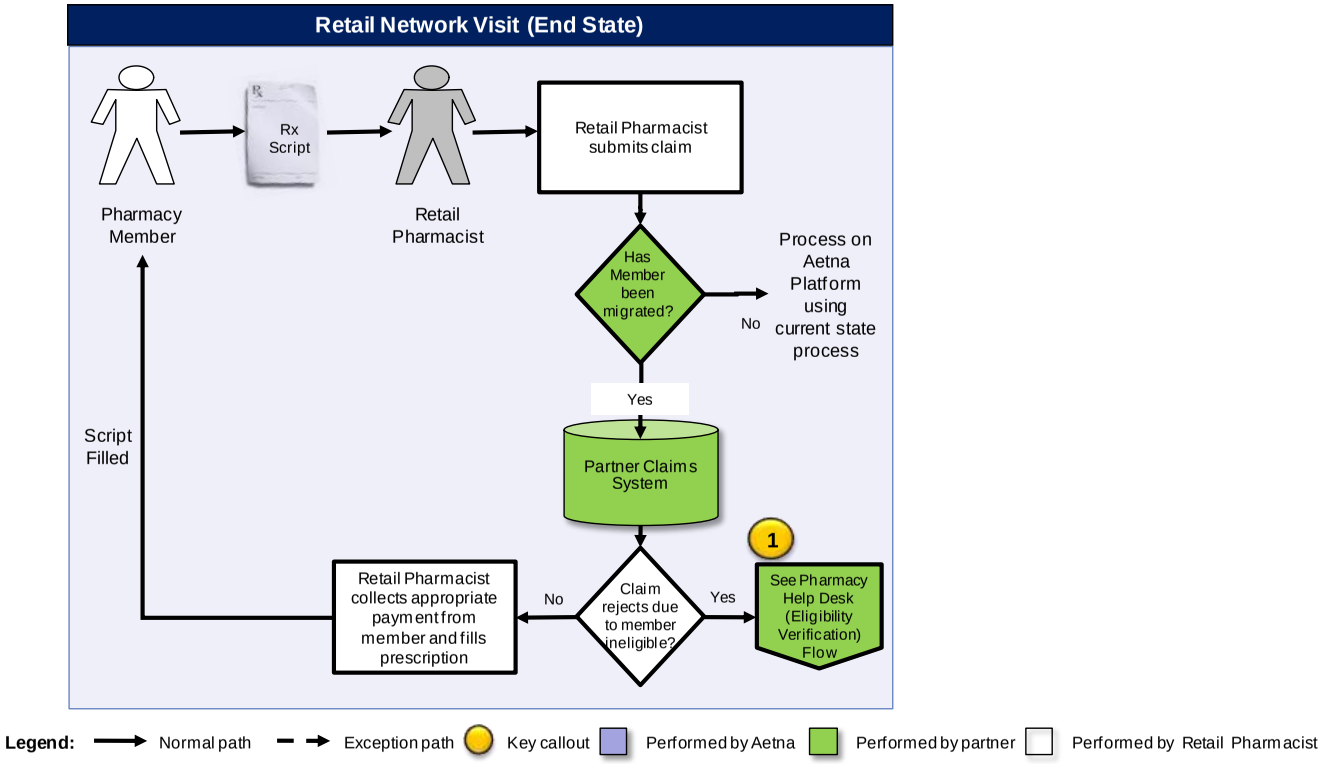

Key Highlights:

1. Partner responsible for resolving eligibility inquires from retail pharmacies

7.3 *Manufacturing Relations / Rebate Administration*

(a) High-Level End to End Flow

End State: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. In the end state Aetna will have access to the Partner's rebate administration system which will be used to conduct rebate administration activities.

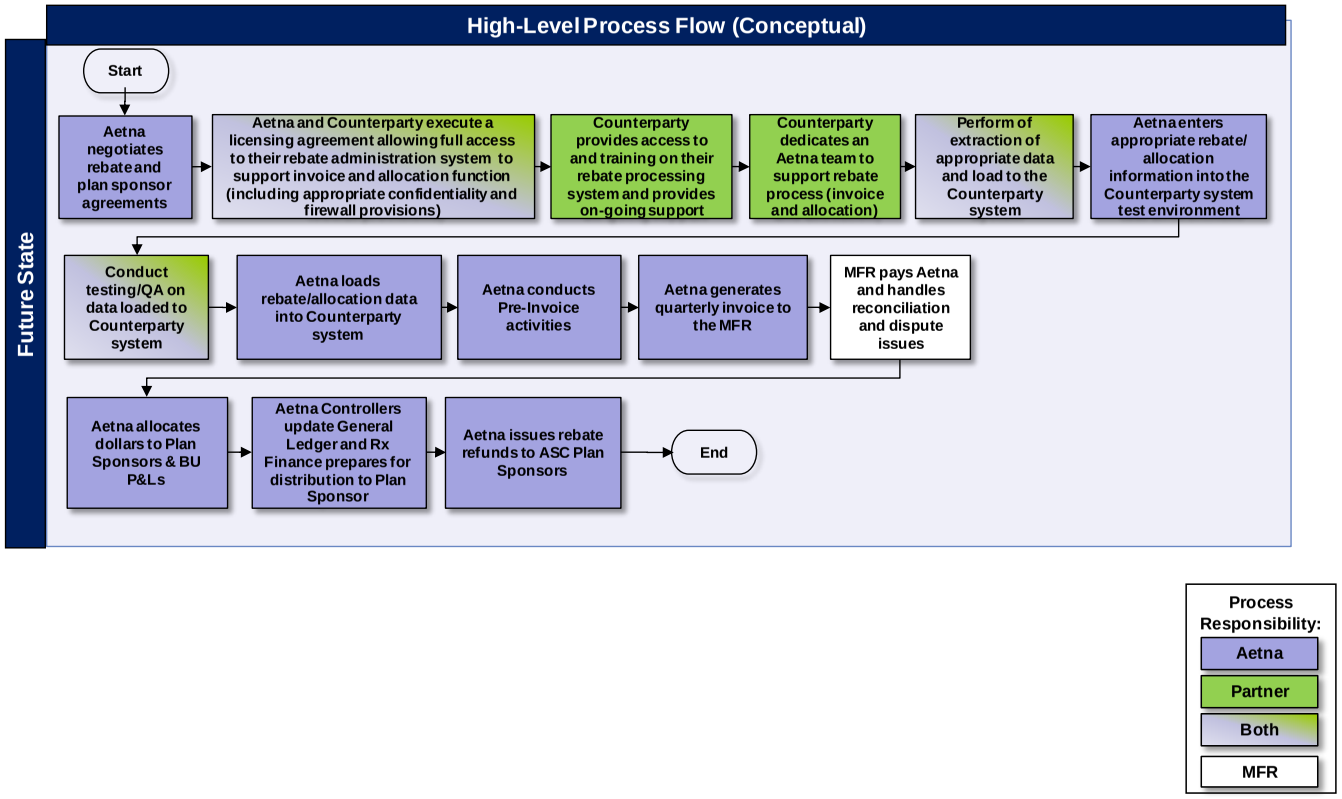

Key Highlights:

1. Details regarding confidentiality and access to Partner systems will be outlined in the Rebate schedule

2. Quarterly rebate payments will be sent to Aetna via EFT or deposited in Aetna's secure lockbox

3. Medical rebates are processed 8 weeks after the end of the quarter (as opposed to 2 weeks after the end of the quarter for Rx rebates)

4. Aetna utilization data processed on either Aetna platform or Partners platform will be combined to generate one quarterly invoice to the Pharmaceutical Manufacturer

5. Rebate refunds typically occur every 6 months but can also be quarterly or yearly depending on Plan Sponsor contracts

6. Plan sponsor rebate arrangements may vary (e.g. flat per script, flat percentage of dollars, percentage based on employee count)

7. Plan sponsor arrangement may be different for pharmacy based on and medical based rebates

8. Allocation will occur down to the product level (e.g. HMO vs. PPO, Medicare vs. Commercial, Fully Insured vs. Self Insured, Medical vs. Rx)

9. Aetna will be responsible for performing any requested plans sponsor audits with support from the Partner

10. Aetna will be responsible for Medicare rebate data reporting with support from the Partner

7.4 ***Claims Administration***

(a) Prior-Authorization

End State: Until Administrative Migration, this process will continue as business as usual on Aetna systems and both Aetna and PBM will operate via current state processes. Once Administrative Migration begins, the PBM will perform the prior authorization process for migrated members – including communication of decisions to Providers and Members.

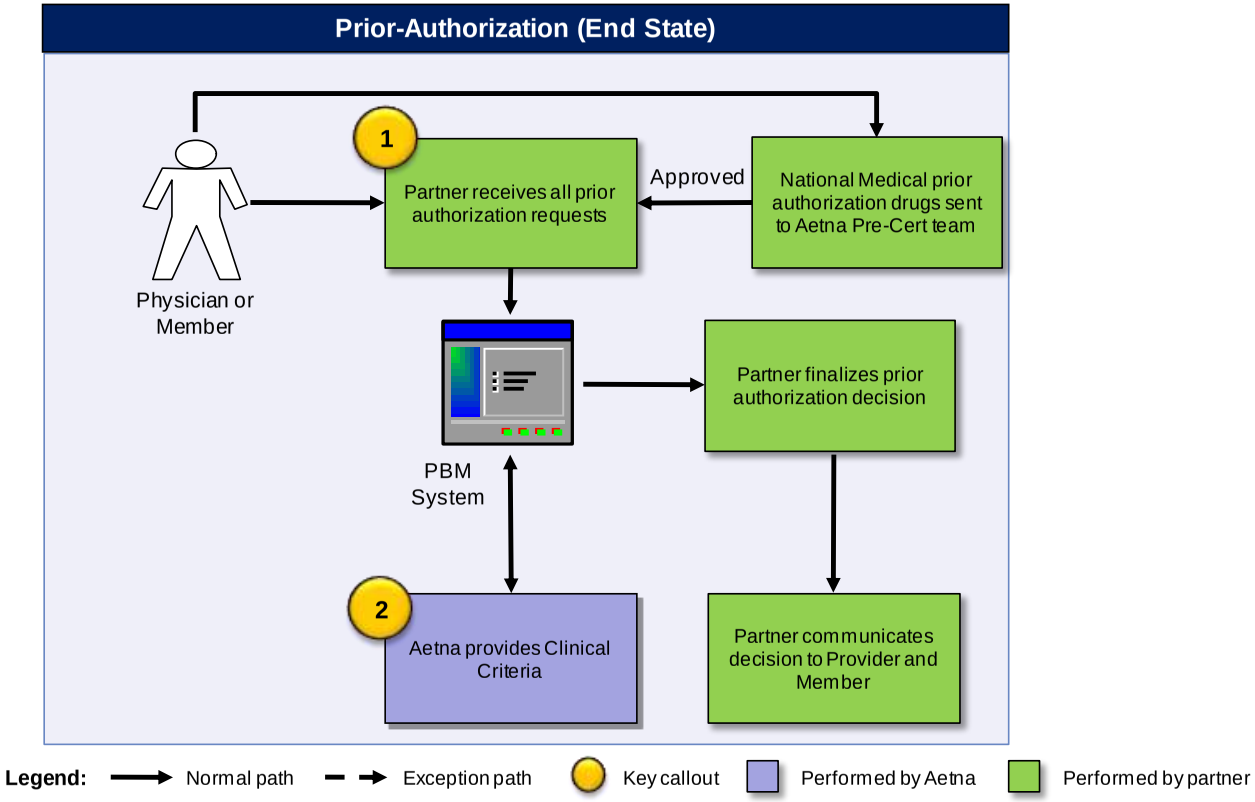

Key Highlights:

1. The Counterparty will receive all pre-authorization requests via call, fax, or web

2. The Counterparty will utilize Aetna's clinical criteria to process pre-authorization request

(b) Claims Disbursement

End State: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. Once Administrative Migration begins, Aetna will perform the claims disbursement process using claims data provided by the Counterparty.

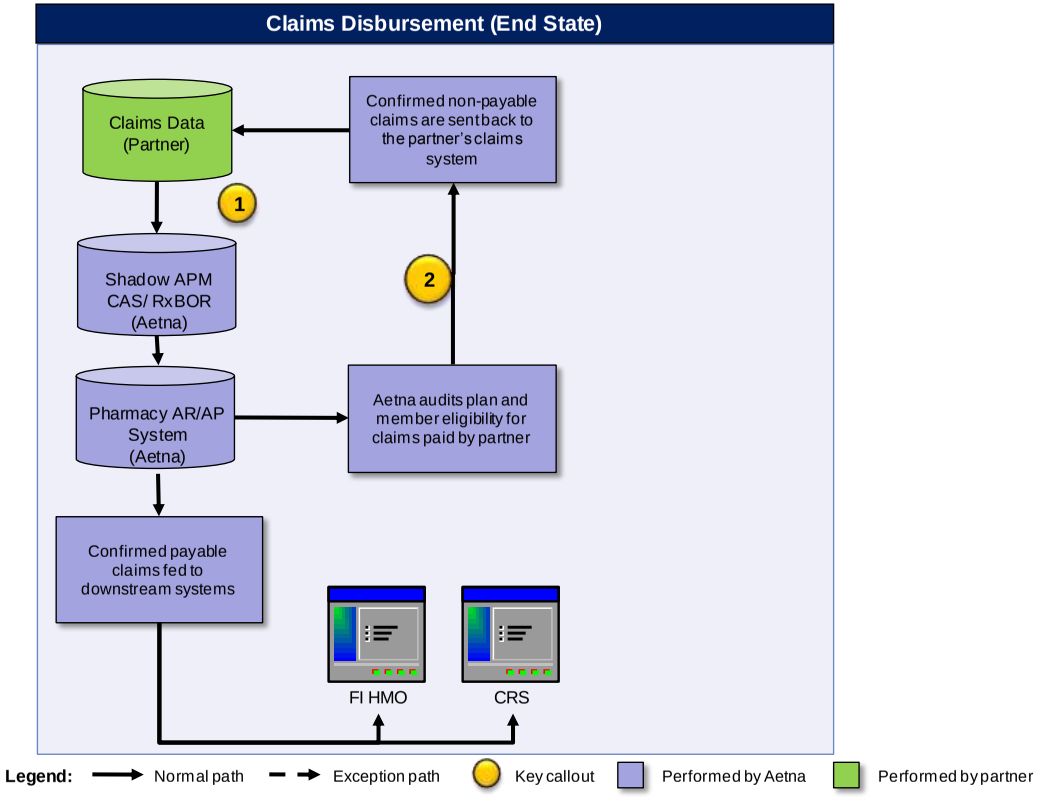

Key Highlights:

1. Claims data will be fed from the Counterparty's claim system to Shadow APMCAS / RxBOR on a daily basis

2. Aetna will audit a sample of paid claims; the investigation of non-valid claims will require collaboration between both Aetna and the Counterparty.

7.5 ***Customer Service – Commercial***

(a) Intake of Complaints, Grievances, and Appeals

End State: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. Once Administrative Migration begins, Aetna will remain the primary owner of logging grievances and appeals while the Counterparty will be responsible for logging all formal complaints received by Counterparty CSRs in a tracking tool that is accessible by Aetna.

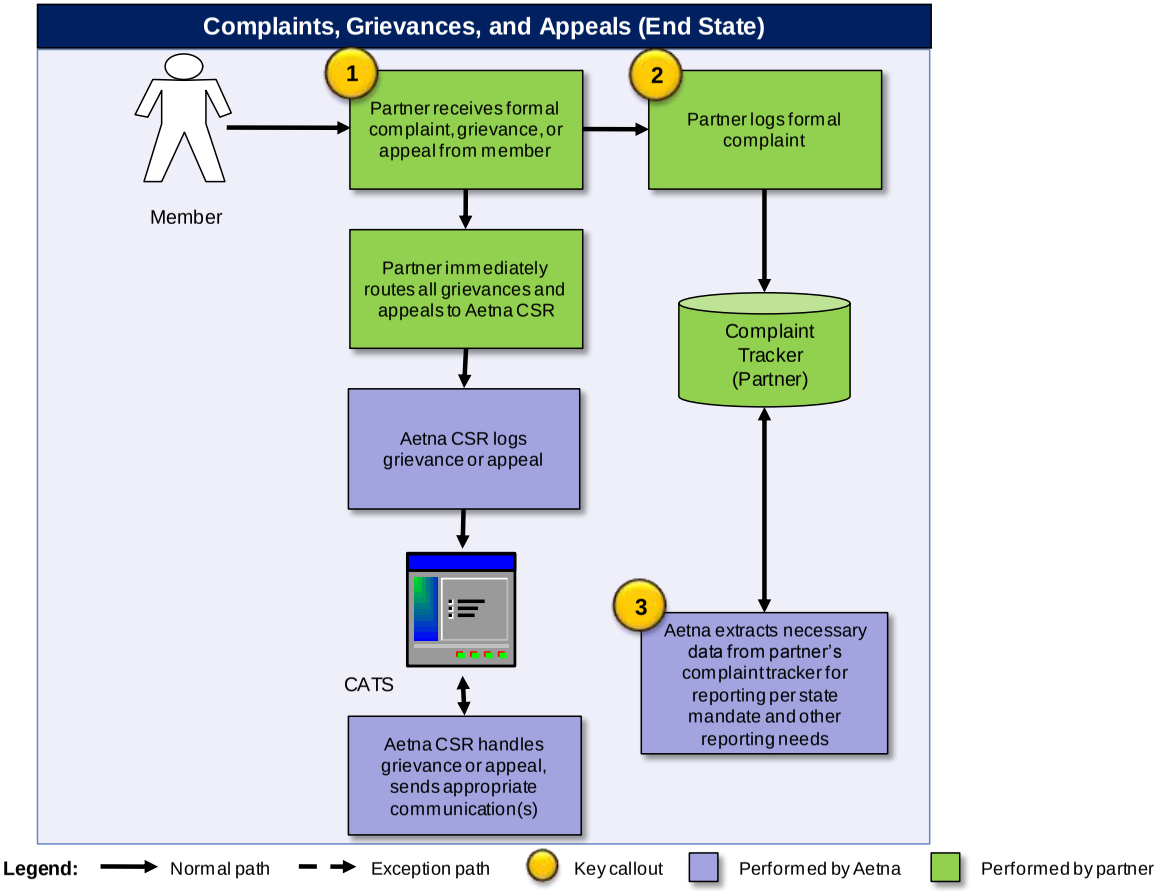

Key Highlights:

1. The Counterparty will be required to immediately route all formal grievances (regardless of level) to Aetna for resolution; a process will need to be established given the "time sensitive" nature for such matters

2. Since some states require that statistics pertaining to complaints be reported, the Counterparty will be required to log all complaints for reporting purposes

3. The Counterparty will provide a file to the Grievance and Appeal department for reporting needs

(b) Pharmacy Help Desk (Eligibility Verification)

End State: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. Once Administrative Migration begins, the PBM will perform the eligibility verification process for the Pharmacy Help Desk for all migrated members.

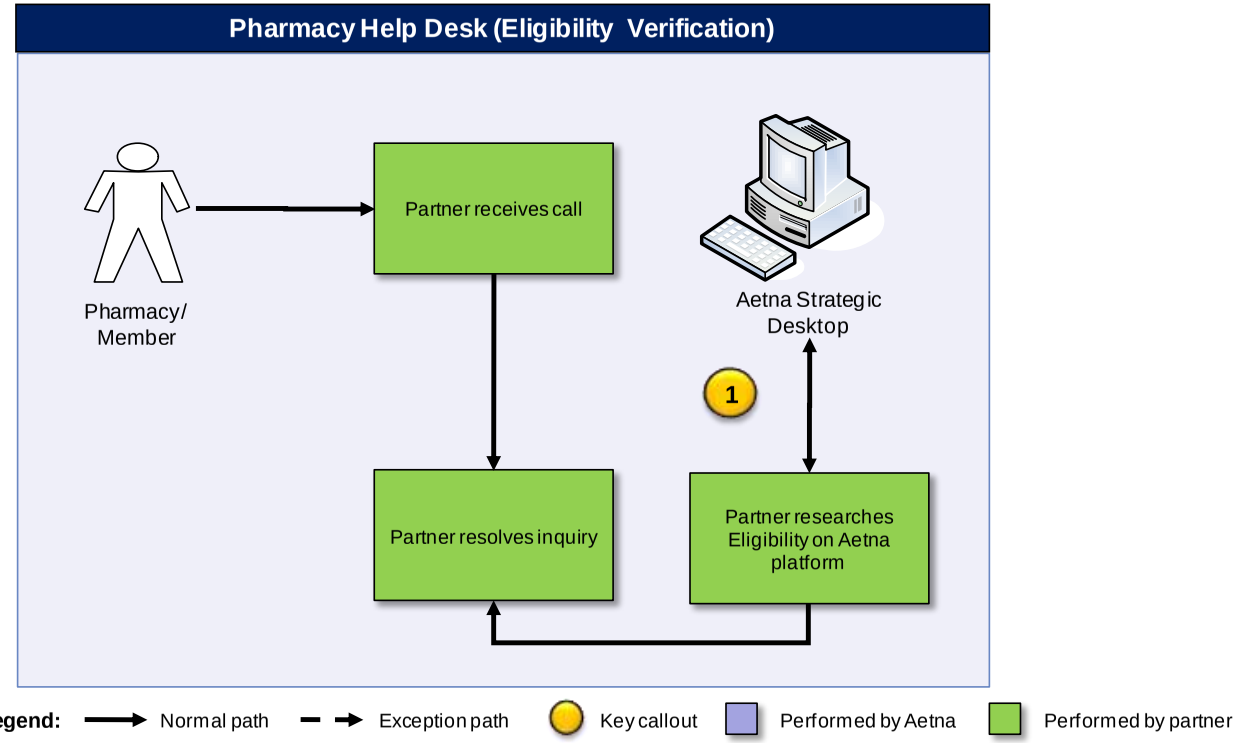

Key Highlights:

1. The Counterparty will access Aetna's membership information when member does not reflect active coverage in PBM system.

Att R-1002

(c) Service Members (Telephone & IVR) – Commercial & Medicare

End State: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. Once Administrative Migration begins, the PBM will be primarily responsible for handling Pharmacy related calls and IVR requests from migrated Commercial members. All non-Pharmacy related matters received by the Counterparty will be routed to Aetna for resolution. (Note: Medicare Part D related inquiries would continue to be handled by Aetna Medicare CSRs until Q3 2011. At this point the PBM would service all Pharmacy related telephone inquiries for Commercial and Medicare members.)

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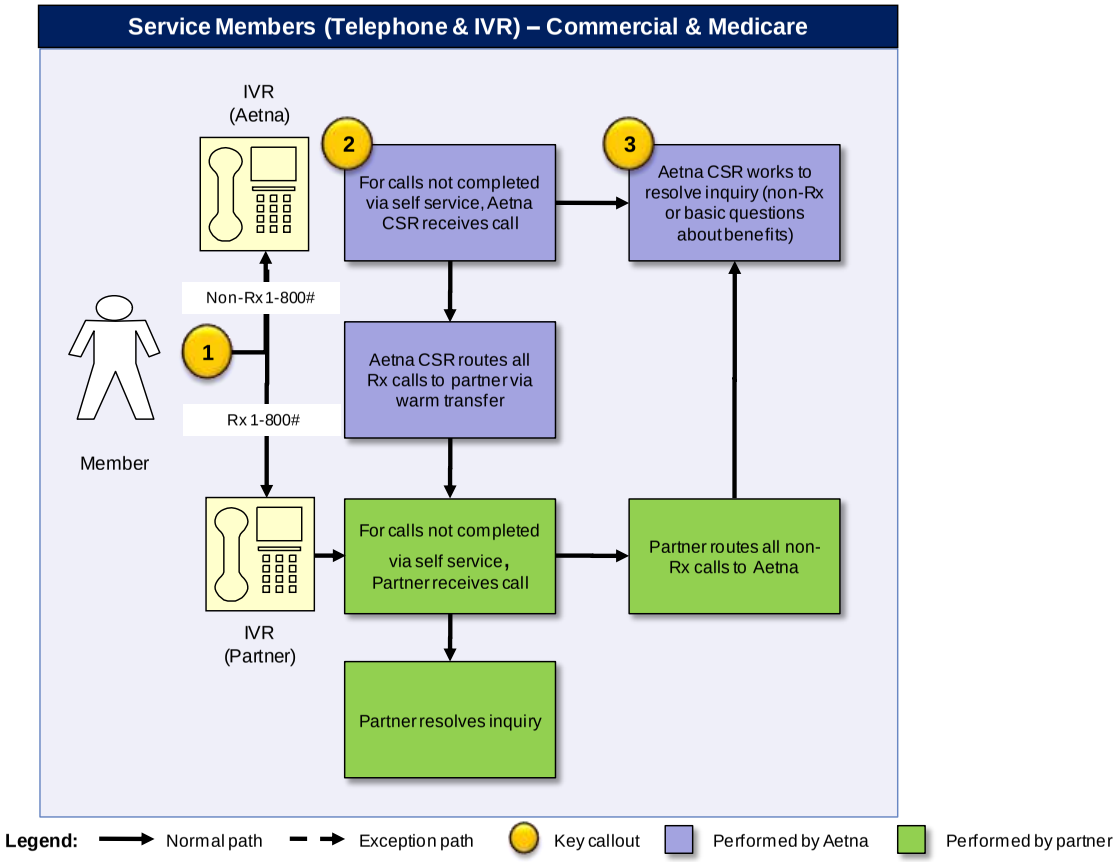

Key Highlights:

1. Members with Pharmacy benefits will be provided two separate 1-800 #s on ID cards for Member Service

   a. All non-Rx related matters will be handled by Aetna CSRs

   b. All Rx related calls will address by the partner

c. Medicare ID cards will have one 1-800 number and will utilize prompts for correct routing of calls

2. Any calls pertaining to Rx received by Aetna CSRs will be routed to the partner for resolution via warm transfer

3. Aetna CSRs will receive calls transferred by the partner that pertain to areas outside of Rx; the partner will also pass authentication information to eliminate need to re-authenticate member

(d) Service Members (ASD)

<u>End State</u>: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. Once Administrative Migration begins, the PBM will be granted access to the Aetna Strategic Desktop (ASD) in order to resolve some Pharmacy related inquiries as required. The PBM will also have access to transfer codes for routing calls back to Aetna when necessary.

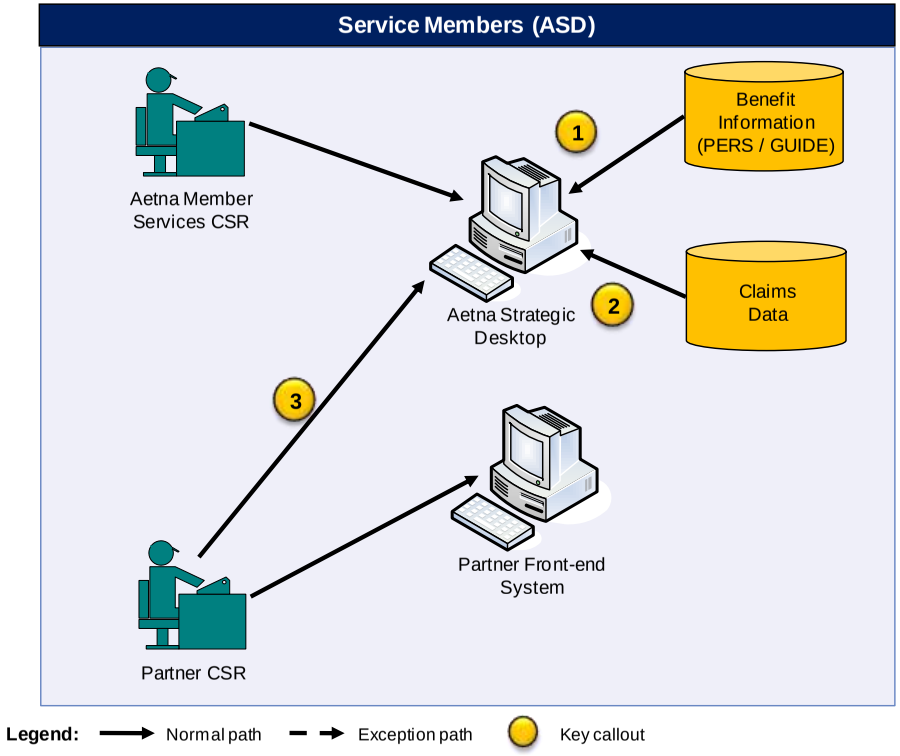

Key Highlights:

1. Aetna Strategic Desktop (ASD) will require feeds from PE/RS (Traditional) and GUIDE (HMO) to provide internal constituents with the required plan and benefit information; to maintain current functionality

Att R-1006

2. In order to retain existing functionality, Aetna Strategic Desktop (ASD) will require a feed for claims data (provided real-time today by APMCAS but frequency will need to be determined for future state)

3. The partner will need view-only access into Aetna ASD in order to address some Rx related inquiries pertaining to eligibility and transfer codes

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(e) Service Members (Written)

<u>End State</u>: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. Once Administrative Migration begins, the PBM will be responsible for resolving all Pharmacy related inquiries from migrated members. Any non-Pharmacy related written inquiries received by the PBM will be routed back to Aetna for resolution

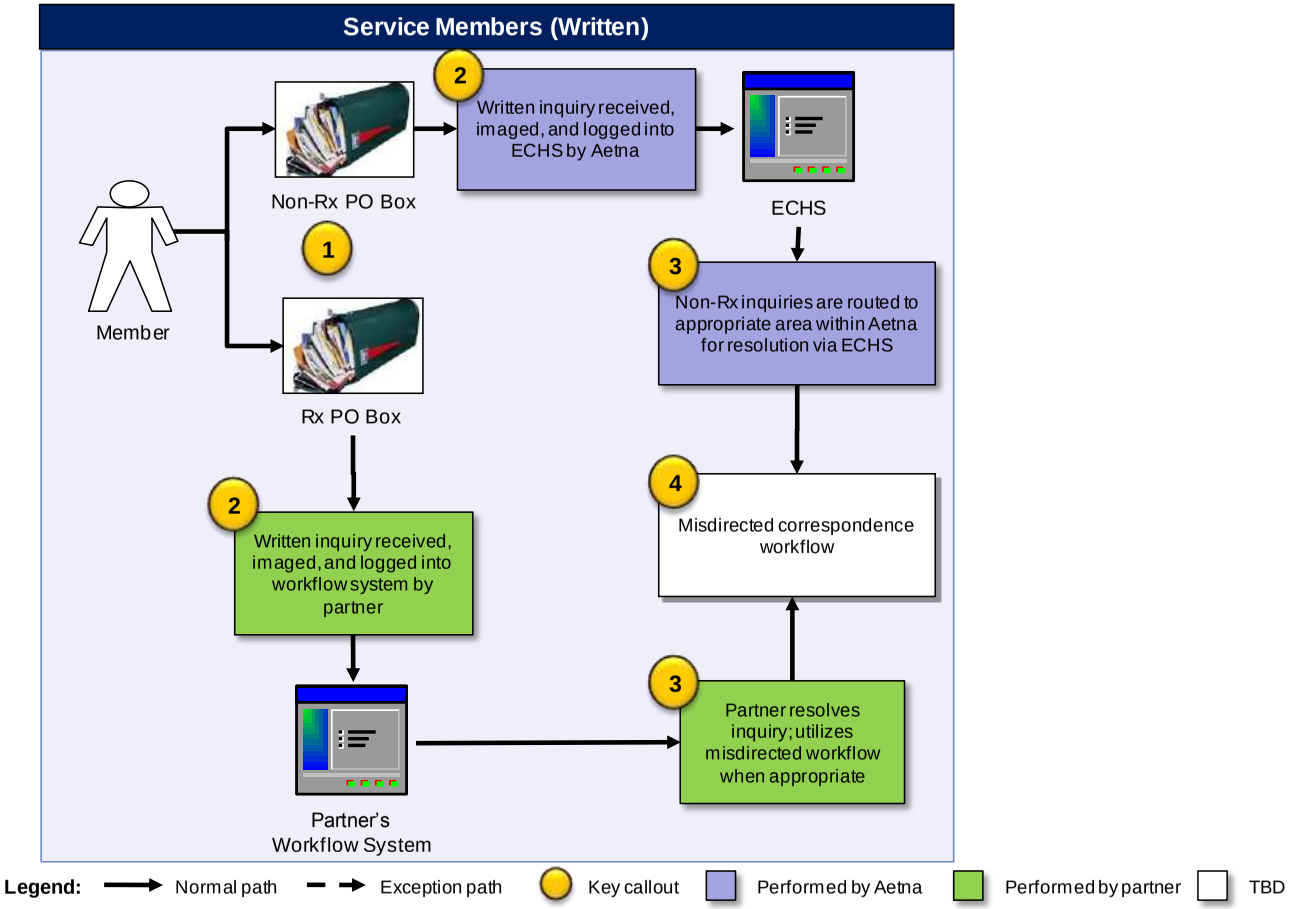

Att R-1008

Key Highlights:

1. There will continue to be separate PO boxes for Rx and non-Rx written correspondences
    a. The Rx PO Box will be managed by the Counterparty once transition is complete
    b. The non-RX PO Box will continue to be managed by Aetna
2. The written inquiry is then electronically scanned so an image can be stored.
    a. The Rx inquires will be imaged and recorded in Counterparty's system
    b. The non-RX inquires will be imaged and recorded in Aetna's ECHS system
3. Automated Work flow routes inquiry to appropriate area for resolution
4. Correspondences that are misdirected will need to be re-routed to the appropriate party for resolution; there will also need to be a process for handling "time sensitive" correspondences by the respective recipient

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(f) Service Plan Sponsors and Members (Member Advocacy)

End State: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes. Once Administrative Migration begins, the PBM will be responsible for resolving all Pharmacy related matters from Plan Sponsor, Account Executives, and members. Aetna will continue to resolve any non-Pharmacy related inquiries from Plan Sponsors, Account Executives, or members requiring escalation.

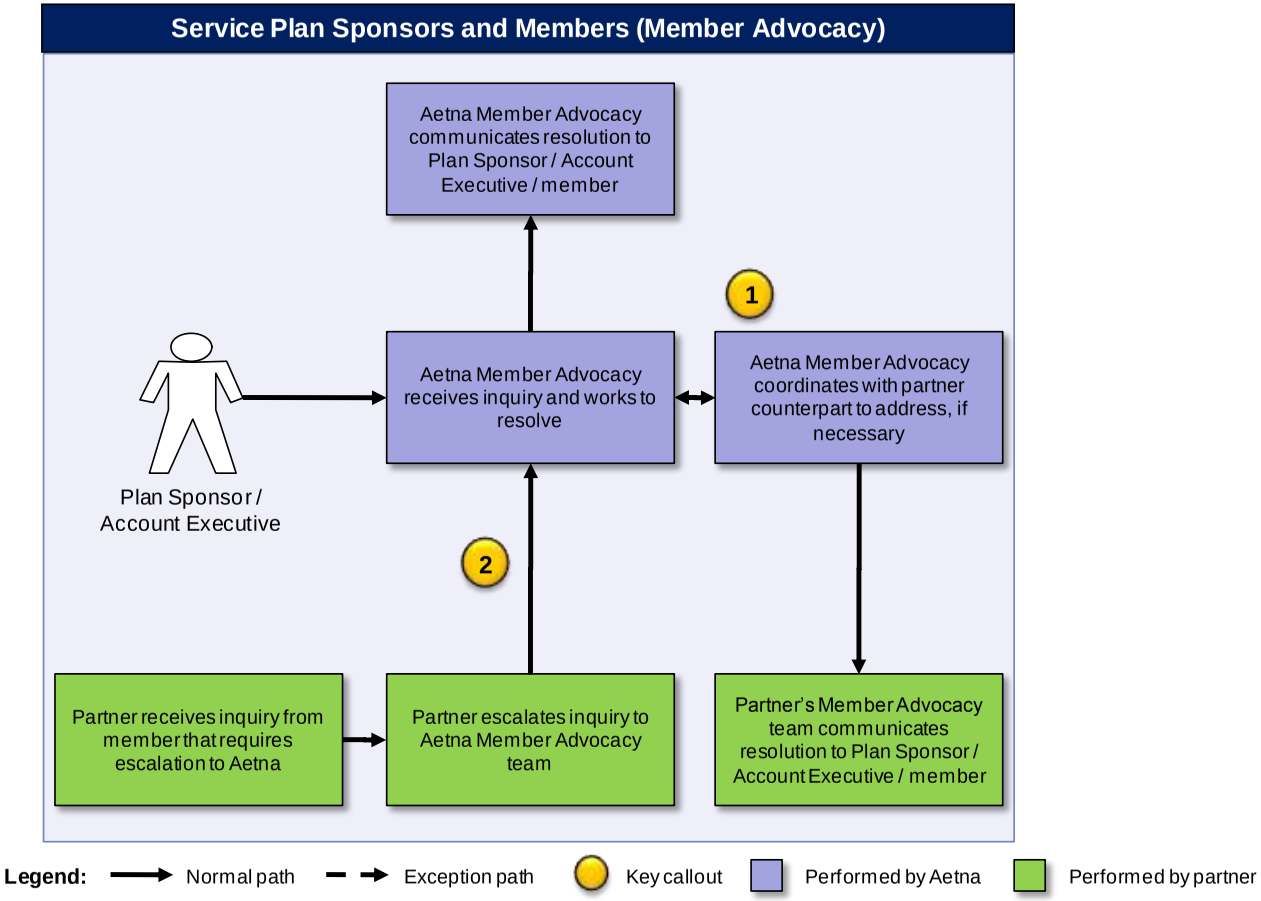

Att R-1010

Key Highlights:

1. There will be a team on the Counterparty's side similar to Aetna's Member Advocacy team that will field requests from Plan Sponsor / Account Executive inquiries transferred by Aetna

2. An escalation process and mechanism for routing inquiries received by the Counterparty to Aetna for resolution (and vice versa) – this will also include Grievances and Appeals

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7.6 *Customer Service – Medicare*

(a) Customer Service – Medicare PDED

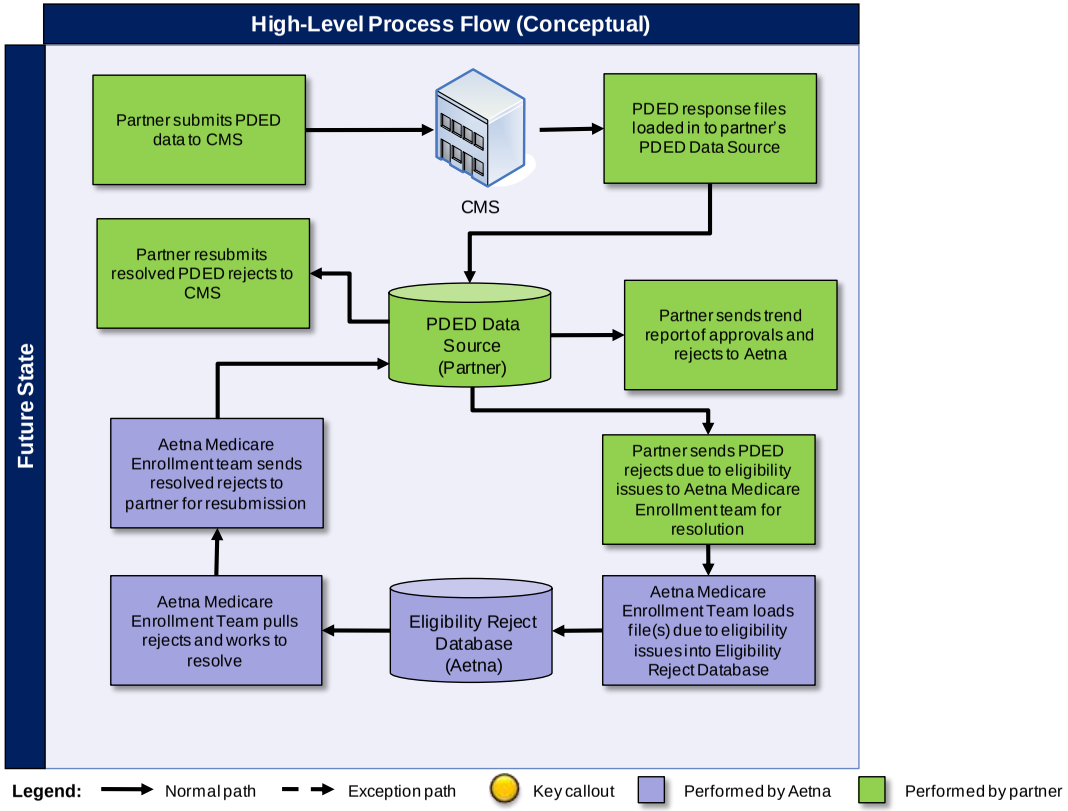

Att R-1012

VIII. ARxHD Functions

Business Function	Responsibility		Future State Business Process	Event				
	Aetna	PBM		Outsourcing Transition	Retail Pricing Transition	Mail Order Migration	Specialty Migration	Admin Migration
Rx Order Entry	X		• Mail Order Front End Processes	Current State		End State		
Pharmacist Verification	X			Current State		End State		
Customer/Order Issue Resolution	X							
Physician Communication	X							
Rx Imaging	X							
Purchasing/ Inventory Management		X	• Mail Order Distribution					
Order Fulfillment		X						
Customer Service		X		Current State		End State		

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8.1 *Mail Order*

(a) Mail Order Front End and Back End Dispensing

End State: Upon MOD Migration, the PBM will be responsible for the dispensing of mail orders from members. Aetna will continue to be responsible for the mail order intake and entry processes but will do so on the Counterparty's platform.

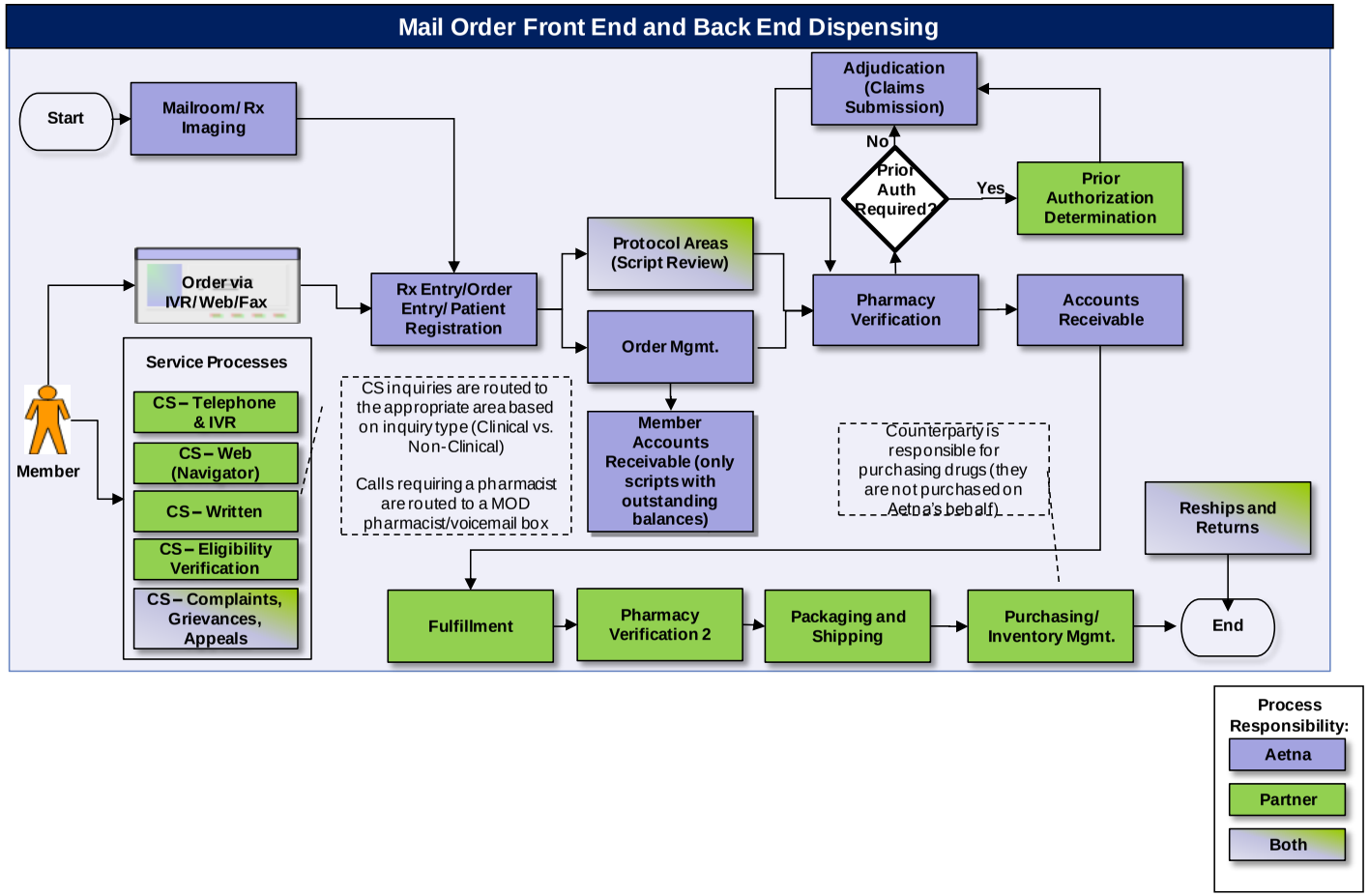

Att R-1014

Key Highlights:

1. Aetna Rx Home Delivery (ARxHD) will continue to maintain all front-end processes with the exception of Prior Authorization

2. ARxHD will convey Back End (dispensing and shipment) and Customer Service processes

3. MOD CSRs will be required to route any non-MOD related calls back to Aetna for resolution

4. Overrides will be conducted by Aetna employees in the following instances: Refill to Soon, DUR;

5. Any overrides that are a part of Customer Service today will be performed by the counterparty based on Aetna defined requirements

6. All tasks are on the Counterparty system unless otherwise noted

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(b) Service Members (Navigator)

End State: Until Administrative Migration, this process will continue as business as usual and both Aetna and PBM will operate via current state processes from a web front-end perspective. Backend operations related to Pharmacy such as the fulfillment of mail orders will largely performed by the PBM. Once Administrative Migration has begun, all Pharmacy related web inquiries and services will be performed on the PBM's web portal. All non-Pharmacy related matters will continue to be serviced by the Aetna web portal (Navigator). Single sign-on will also be implemented across the two portals.

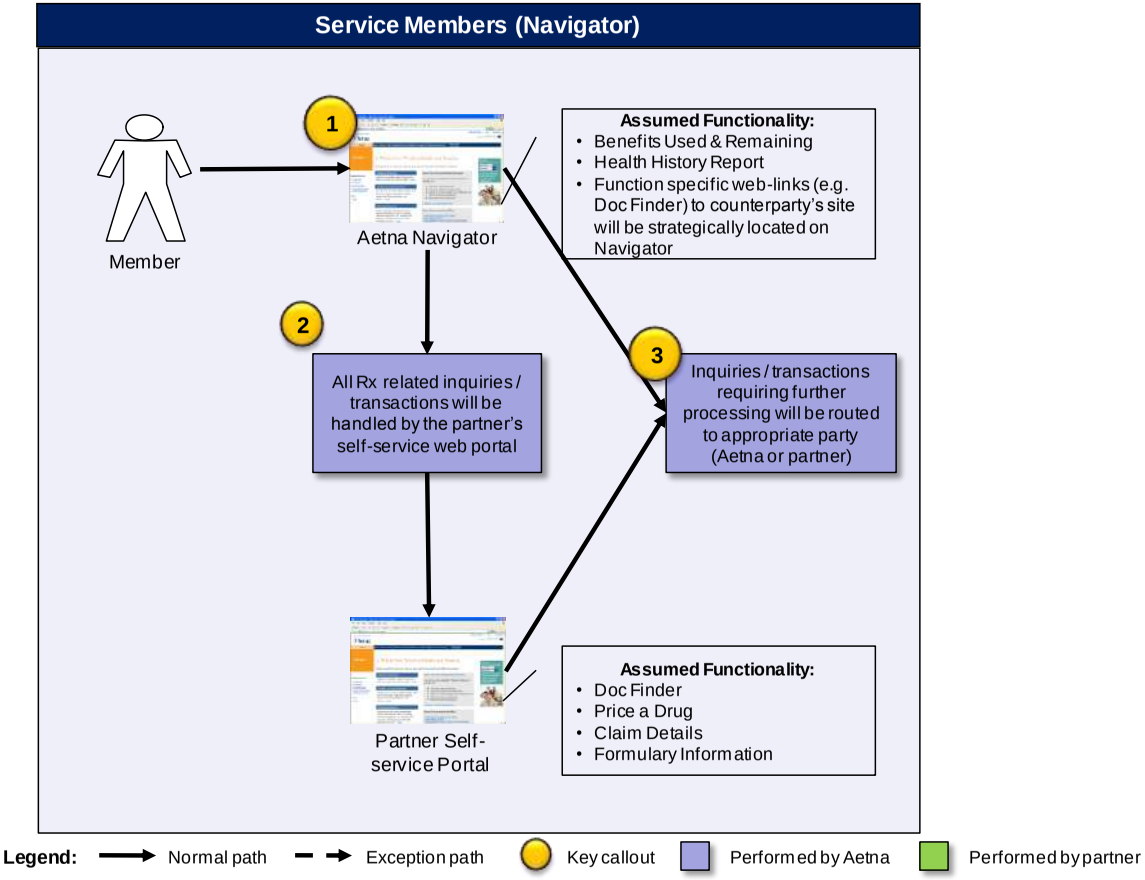

Key Highlights:

1. Members will sign into Aetna Navigator to utilize online Rx self-service capabilities

2. Navigator will redirect members wishing to perform Rx related transactions to the Counterparty's self-service portal

    a. The transition from Aetna's Navigator Website to Counterparty's website will appear seamless to the member as they will not be required to re-authenticate (i.e., single sign-on)

b. The Counterparty's web portal will have a consistent "look and feel" to Aetna Navigator

3. A process and workflow for communicating electronic inquiries / correspondence between Aetna and the Counterparty will need to be established

IX. *ASRx Functions*

Business Function	Responsibility		End State Business Process	Event				
	Aetna	PBM		Outsourcing Transition	Retail Pricing Transition	Mail Order Migration	Specialty Migration	Admin Migration
Rx Order Receipt/ Entry	X		• Specialty Pharmacy • Specialty Disease Management	Current State			End State	
Customer Service	X			Current State			End State	
Utilization Mgmt.	X			Current State			End State	
Patient Assessment Counseling/ Clinical Mgmt	X			Current State			End State	
Order Coordination/Billing/ Collections	X			Current State			End State	
Physician Communication	X			Current State			End State	
Contract/ Administration of Manufacturing Service Agreements	X			Current State			End State	
Purchasing/ Inventory Management		X		Current State			End State	
Order Fulfillment		X		Current State			End State	

9.1 ***Specialty Pharmacy***

(a) Specialty Pharmacy

End-State: Timing of Specialty Pharmacy migration is TBD.

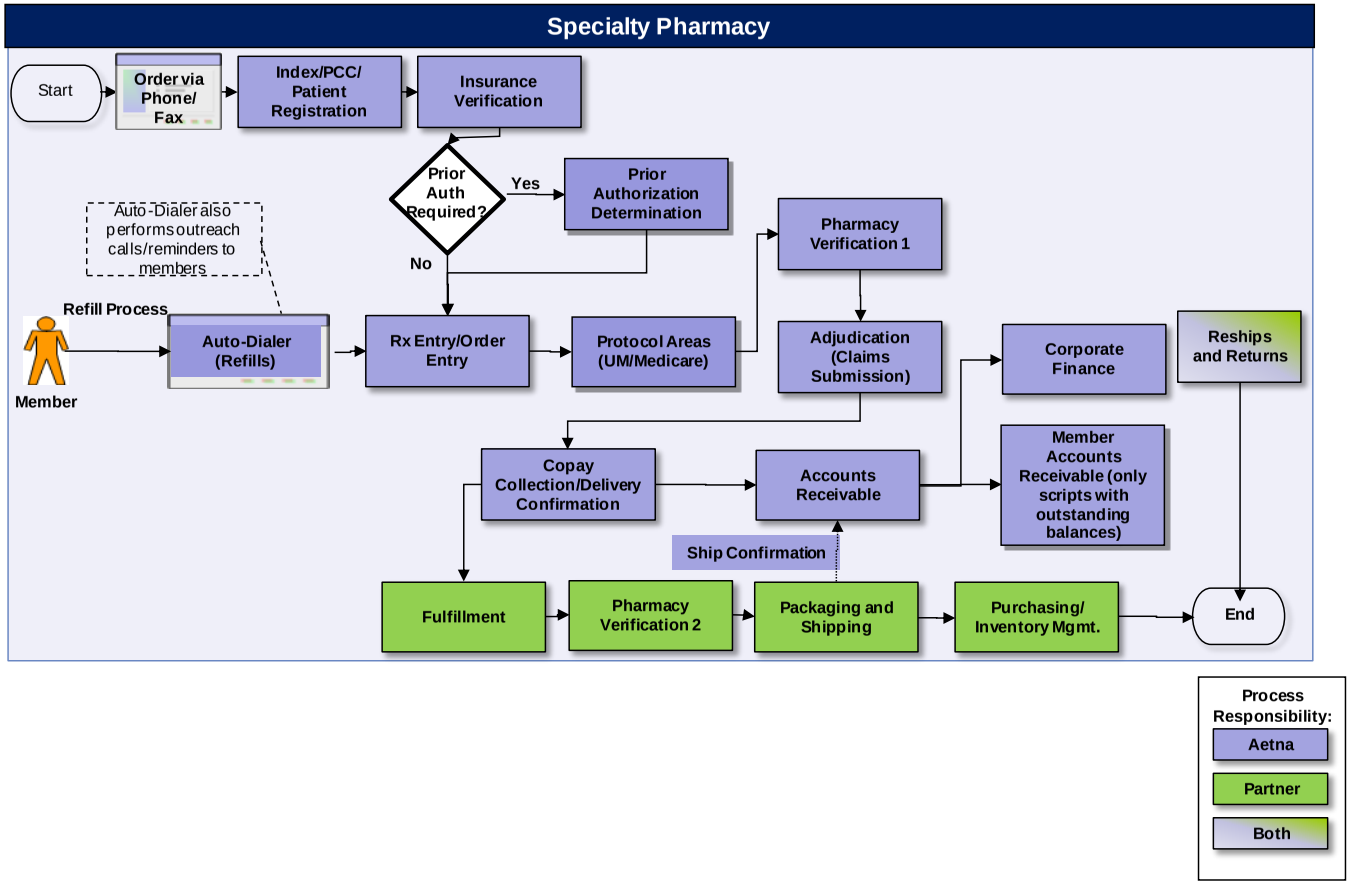

Key Highlights:

1. There is a separate process flow for Infusion Hub which is identical to what is displayed above. There are certain drugs which are part of this special handling group

2. Protocol Areas denotes a number of clinical and/or data gathering protocols that must be followed for various specialty drugs

3. Aetna Specialty Pharmacy (ASRx) utilizes the Avaya Auto-Dialer for managing outbound calls in the Refill, Collections and Delivery Confirmation Department

4. Medicare Part B verification and billing is handled in the Protocol Areas section, along with Nursing Utilization Management

5. Accounts Receivable and Member Pay Collections is handled after ship confirmation of the order

6. For PA Determination, if the drug is on the National Pre-cert List this step will still be covered by Aetna. If the drug is not on the National Pre-cert list and covered under Pharmacy the PA Determination step would be performed by the Counterparty

7. All tasks are on the Counterparty system unless otherwise noted

8. The Counterparty's purchasing strategies for MOD and ASRX will preclude strategies relating to any formulary obligations

(b) Specialty Disease Management

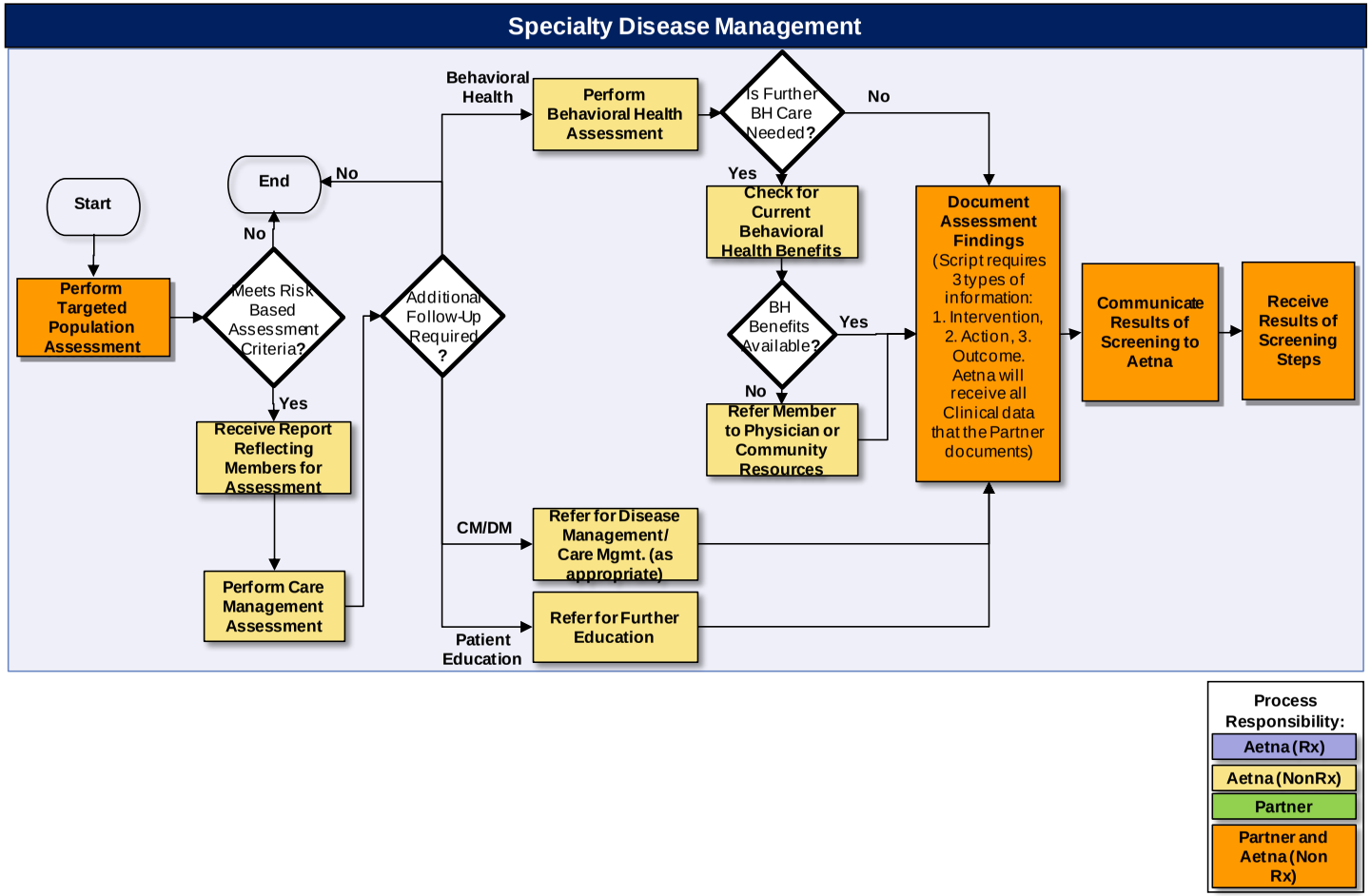

Key Highlights:

1. The report reflecting members for assessment will be based on data provided by the Counterparty based on criteria identified by Aetna

Att R-1022

SCHEDULE A-3

OUTSOURCING READINESS TASKS AND WORK

I. Outsourcing Tasks and Timing

Major work-streams include:

- Scoping and Planning
- TSA
- Human Resources (All Services Commencement Dates)
- Communication
- Legal / Regulatory / Filing Support
- Finance (applies to all Services Commencement Dates)
- Real Estate
- Customer Service (Inclusive of PBM Services, Mail Order Delivery, and Medicare)
- Home Delivery Pharmacy
- Specialty Pharmacy
- Specialty Pharmacy "Pointer" Implementation (Aetna Backend Transition to PBM and Alignment of Member Touchpoints and Reporting)

Aetna Better Health® of Kentucky

Dates and scope are subject to change and will be confirmed during Detailed Integration Planning.

Scoping and Planning					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Implementation Planning	(a) Establish the Transition team comprised of key personnel	Transition Team Established	PBM and Aetna	Effective Date	5 Business Days following Effective Date
	(b) Develop outsourcing readiness plan	Outsouring Readiness plan containing at a minimum key criteria for commencement readiness	PBM and Aetna	Effective Date	45 Days following Effective Date
	(c) Develop initial draft of implementation plan	Migration plan containing at a minimum the key milestones, tasks/deliverable, time frames, task owners	PBM and Aetna	Effective Date	30 Dates Following Effective Date
	(d) Develop joint comprehensive implementation plan	Migration plan containing at a minimum the key milestones, tasks/deliverable, time frames, task owners	PBM and Aetna	Effective Date	60 Days following Effective Date

TSA					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
2. TSA Services	(e) Finalize all required TSA services and Pricing	TSA Services and Pricing Documentation	PBM and Aetna	3 Months prior to Commencement Date	30 Days prior to PBM Services Commencement Date, but no later than December 31, 2010
	(f) Develop governance model and processes to manage TSAs	- Governance Model - Governance Processes	PBM and Aetna	3 Months prior to Commencement Date	30 Days following Effective Date

Human Resources (All Services Commencement Dates)					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/ Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
3. Finalize transferred employees listing	(a) Confirm final list of rebadged employees	Approved list of employees to be transferred	Aetna	Effective Date	1 week prior to applicable Services Commencement Date
4. Create and load HR Demographic Data File	(b) Provide PBM with a data extract of HR demographic data of the target employee population that will transfer.	- Define requirements for extract file - Develop and test file - Sign-off on testing - Create and provide production file at the appropriate time prior to PBM Services Commencement Date.	Aetna and PBM	Effective Date	30 days prior to Services Commencement Date
5. Set up Contingent Worker (CW) ID for transferred employees	(c) Employees that are transferring to the PBM will require access to Aetna systems for the period of time from the PBM Services Commencement Date to the applicable Migration date. (d) CW IDs will need to be created and assigned to the employees to provide the appropriate system access.	- Demonstrate Security Access for selected transferred employees	Aetna	Effective Date	Services Commencement Date

Human Resources (All Services Commencement Dates)					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/ Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
6. PBM Employee Access and Contingent Worker Status	(e) Identify PBM employees requiring Contingent Work (CW) status and approved access to Aetna systems and establish ongoing process for continued maintenance and update of approved CW list of PBM employees. (f) PBM will identify and communicate to Aetna those PBM employees that will require access to Aetna systems. Based on access needs, CW IDs will be created by Aetna.	PBM provides listing of Employees and related data required to establish CW status. - Define requirements for extract file - Develop and test file - Sign-off on testing - Submit production file for load to PeopleSoft	PBM	Effective Date	30 days prior to Services Commencement Date
7. Security Access / Roles Based Access Control (RBAC) Models	(g) RBAC models need to be established/modified for the employees transferring to the PBM and the PBM employees that will need access to Aetna systems.	- Determine if system access requirements (RBAC) can be copied over from the A ID to the N ID - Identify the RBAC model requirements - Create new RBAC models as appropriate - Link CW id's to RBAC model	Aetna	Effective Date	1 week prior to Services Commencement date
8. Provide new Employee ID Badges to transferred employees	(h) Transferred employees' Aetna ID badges will become inactive on the PBM Services Commencement Date. New badges will be provided reflective of the change to a CW and to establish appropriate building/site access.	Employees have new ID badges issued and are operational on the PBM Services Commencement Date	Aetna	30 days prior to Services Commencement Date	Services Commencement Date
9. Building access for vendor employees	(i) Determine building access and HR policies (j) For Co-habitated facilities	Plan agreed to by both parties	PBM and Aetna	Effective Date	Prior to Commencement Date

Human Resources (All Services Commencement Dates)					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/ Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
10. Offers of Employment	(k) PBM to provide offer letters to all transferring employees and provide appropriate onsite and other information and support tools to adequately address Employee questions.	- Aetna to provide any demographic information to PBM to support the initiation of the offer process if applicable. - Onsite support provided in all locations - Web Based tools available with PBM benefits, employment and other relevant data	PBM	Effective Date +45 Days	45 days after Effective Date
11. Employee Communications	(l) Coordinate and build with Aetna and PBM business and Corp Communications areas the employee communications that will be needed to effectively transfer employees.	- Ensure employee components are reflected on the T- plan - Employee communications are created and approved in advance of the Effective date and major milestones throughout the period of time between Effective and commencement.	PBM (in collaboration with Aetna Communications and Human Resource teams)	Effective Date	30 days prior to Services Commencement Date
12. Employee Onboarding and Benefits Enrollment	(m) Provide detailed communications and training and logistics plan for onboarding employees and supporting benefits enrollment and other required activities to achieve employee status as of the PBM Services Commencement Date	- Aetna to collaborate with PBM on employee meetings, information sharing and training that will be needed to effectively start to administer the population on day 1 post commencement. - Plan developed and approved that outlines the tasks that are needed to onboard the employee population.	PBM	Effective Date	30 days prior to Services Commencement Date
13. HR System access for Transferring Employees	(n) Establish limited system access to Human Resources and other related applications for conveyed employees to complete onboarding and employment transition activities	- Functional access for all transitioning employees	PBM	Effective Date	Within 60 Days of Effective Date
14. Coordination of Recruitment Process	(o) PBM will assume recruiting functions	Recruitment process in place	PBM	3 months prior to Services Commencement Date	On-going

Human Resources (All Services Commencement Dates)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/ Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
15. Establish a PBM management support structure for alignment with Aetna's management	(p) PBM provision of management structure	PBM Management employees in place prior to commencement	PBM	3 Months Prior to Services Commencement Date	30 Days Prior to Commencement Date

Communication					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
16. PBM Communications Materials / Inventory (Link to Schedule H)	(a) PBM shall provide to Aetna for its review, consideration, and use all of PBM's member, provider, pharmacy, and customer communication templates of PBM (including those applicable to PBM's mail order and specialty pharmacies).]		PBM	Within 15 days of Effective Date	30 days prior to Services Commencement Date
17. Joint Site Tour and ongoing interactions	(b) Prepare and Conduct joint site visits to impacted employee sites	Plan agreed to by both parties	Aetna and PBM	Effective Date	30 Days Post Effective Date

Legal / Regulatory / Filing Support					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
18. Provide / Respond to All Filing Data Requirements	(a) PBM will be responsible for timely response to all Aetna data requests necessary to complete state filings	Completed data requests	PBM	Effective Date	Effective Date + 3 weeks
19. Complete Necessary Filings and Support Approvals	(b) Coordinate with Aetna to complete and support necessary activities to assure timely approval	All necessary state filings approvals received by Aetna	PBM and Aetna	Effective Date	PBM Service Commencement Date

Finance (applies to all Services Commencement Dates)

Task/Activity	Description	Output/Deliverable Acceptance/Completion Criteria	Responsibility	Target Start Date	Target Completion Date
20. Accounts Payable/Billing Cutover Reconciliation	(a) Reconcile /coordinate run-out of outstanding accounts payable	Reconciliation plan agreed upon by both parties.	PBM and Aetna	TBD	60 Days Post-Services Commencement

Real Estate					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
21. Build a near-term and long term Real Estate strategy	(a) Establishment of a strategy to define a strategy on how to managementl impacted real estate .	1-Real Estate strategy agreed upon by both parties	PBM and AETNA	30 Days after Commencement Date	90 Days after Effective Date

Customer Service (Inclusive of PBM Services, Mail Order Delivery, and Medicare)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
22. Installation of Management tools for transitioned staff.	(b) Establish ability for management staff that are transitioned to PBM to access necessary management tools to support staff while working in Aetna space with Aetna desktops.	1-List of necessary tools/systems transitioned managers need to effectively manage transitioned resources for PBM 2-Confirmation that Aetna management staff to be transitioned can access actual subordinate information in PBM tools/systems.	PBM	30 days prior to Services Commencement Date	1 week prior to Services Commencement Date
23. Customer Service Reporting Protocols	(c) Develop and execute required reporting protocols and KPIs to assure appropriate and continuous management processes are in place for business activities that will be assumed by PBM on commencement date.	1-List of KPI reports due to Aetna with data and frequency requirements.	Aetna	3 weeks prior to Services Commencement Date	1 week prior to Services Commencement Date

24. Customer Service personnel training	(d) Development and execution of applicable training of PBM staff that will support Aetna transitioned business at PBM commencement date.	1-Roster Identification of PBM employees by function that will require training 2-Itinerary of applicable training by function 3-Completion/Certifcation of applicable training by PBM staff	Aetna and PBM	30 days prior to Services Commencement Date	Services Commencement Date
25. Customer Service Policies and Procedures	(e) Development of any necessary Policy/Procedure changes due to changes in responsibility of functions transitioned to PBM.	1-Identification of process implications due to change of accountabilities in function 2-Development of future state processes to mitigate impact 3-Implementation of processes	Aetna and PBM	30 days prior to Services Commencement Date	1 week prior to Services Commencement Date
26. Transition ACS Contracts and Other Related Services	(f) PBM will work with ACS/Vendors to establish plan and execute the transition of contracts to PBM to support operations	ACS/Vendor Contracts	PBM	Effective Date	30 days prior to Services Commencement Date

Home Delivery Pharmacy					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
27. Write transition plan for outsourced management of Orlando based fulfillment department.	(a) Define key tasks and milestones that will allow for a smooth transition of inventory, processes and staff on day of implementation of Vendor Services	Written document accepted by Steering Committee.	PBM and Aetna	Effective Date	Prior to Mail Order Commencement Date.
28. Determine inventory transfer strategy	(b) Determine how inventory "cut off" will be accomplished.	Written plan accepted by both parties.	PBM and Aetna	Effective Date	Prior to Mail Order Commencement Date
29. Manufacturer Contracting & Wholesaler Contracting	(c) ARxHD will need to review "en force" agreements and provide notice as a result of the new operating structure.	Cancelled and/or renewed agreements will all relevant pharma manufacturers	Aetna	Effective Date	Prior to Mail Order Commencement Date

Home Delivery Pharmacy					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
30. Accounting and financial systems support	(d) All systems in support of the fulfillment department will have to be reviewed for applicability to the vendor.	Plan agreed to by both parties	PBM and Aetna	Effective Date	Prior Mail Order to Commencement Date

Specialty Pharmacy					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
30. Write transition plan for outsourced management of Orlando based fulfillment department.	(a) Define key tasks and milestones that will allow for a smooth transition of inventory, processes and staff on day of implementation of Vendor Services	Written document accepted by Steering Committee.	PBM and Aetna	Effective date	60 Days Post Effective
31. Determine inventory transfer strategy	(b) Determine how inventory cut off will be accomplished.	Written plan accepted by both parties.	PBM and Aetna	Effective Date	Prior to Specialty Commencement Date
32. Manufacturer Contracting	(c) ASRx will need to review all 30 existing agreements and revise for the new operating structure.	Signed agreements will all relevant pharma manufacturers	PBM and Aetna	Effective Date	Prior to Specialty Commencement Date
33. Building access for vendor employees	(d) Determine building access and HR policies (e) For Co-habitated Orlando facility	Plan agreed to by both parties	PBM and Aetna	Effective Date	Prior to Specialty Commencement Date
34. Accounting and financial systems support	(f) All systems in support of the fulfillment department will have to be reviewed for applicability to the vendor.	Plan agreed to by both parties	PBM and Aetna	Effective Date	Prior to commencement
35. Private Labeling	(g) PBM will work with Aetna to identify and implement all private labeling requirements	Private Labeling Requirements Final Private Labeled Artifacts and Communications	PBM and Aetna	TBD	Prior to Services Commencement

Specialty Pharmacy "Pointer" Implementation (Aetna Backend Transition to PBM and Alignment of Member Touchpoints and Reporting)					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
36. Planning and Requirements	(a) Develop scope, technology requirements and implementation plan	S coping/Sizing Analysis Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy Implementation Plan	PBM and Aetna	Effective Date	60 Days Post-Effective
	(b) Define Transition/Cutover plan	Backend Transition/Cutover approach	PBM and Aetna	TBD	TBD
37. Design	(c) Complete technology design activities	Design Specification (Component, Application, Conversion) Test Plans	PBM and Aetna	TBD	TBD
38. Development	(d) Complete technology build	Unit Test Results Implementation/Deployment Plan System Test Plan	PBM and Aetna	TBD	TBD
39. Testing	(e) Complete testing	System Test Results Regression Test Results UAT Test Results Performance Test Results	PBM and Aetna	TBD	TBD
40. Deployment	(f) Deploy technology	Production Cut-over Checklist Migration Dry Runs Warranty Deployments Command Center	PBM and Aetna	TBD	TBD
	(g) Develop Schedule Drugs transfer protocol to PBM	Schedule Drugs Transfer Protocols	PBM and Aetna	TBD	TBD
41. Inventory depletion and fulfillment migration	(h) Execute and Monitor Inventory depletion and fulfillment migration	Plan agreed upon by both parties	PBM and Aetna	TBD	TBD

Notwithstanding the foregoing, it is understood and agreed that Aetna may, in its sole discretion, elect not to convert to the Specialty Pharmacy System. Aetna may also elect to delay implementation of the Specialty Pharmacy System for a reasonable period of time to further assess its utility.

SCHEDULE A-4

FULL MIGRATION TASKS AND WORK

I. Summary of Required Migration Capabilities (The following represents a high level migration work plan. Additional tasks will be required by both parties to complete the required migration capabilities and achieve Full Migration)

Event	Project	Responsibility	Project Description
Retail Pricing / Network Transition			
	Network Rate Tool	Joint	• Enhance automated network and rate loader capabilities
	Spread Pricing	Aetna-Only	• Enhance the current setup process for spread customers to include HMO • Expand current spread pricing to include HMO
	AR/AP Managing Payments/Fees & P/L	Aetna-Only	• Create capability to forecast and manage the cross Rx P/L • Install Oracle financials for new Rx P/L • Manage AP for Rx including new admin fee payments • Manage AR for Rx including new admin fee receipts
	Spread Audit/Forecasting Tool	Joint	• Purchase/build tool to forecast revenue/expenses under various spread scenarios and provide the following capabilities: – What-if capabilities to model various spread rate scenarios – Audit function to validate spread rate entry/claim adjudication accuracy – Reporting capability to provide information to management and plan sponsors the advantage of spread

Event	Project	Responsibility	Project Description
	Mail Order Fulfillment Migration	Joint	• Convert and interface ongoing minimum member eligibility data needed to support order fulfillment • Convert current and historical member fulfillment information (e.g. eligibility, scripts, orders, AR, allergy & health conditions, credit card, web registration, open renewals) from Pharmacare and Aetna MOD systems • Enable integrated online self-service capabilities via Navigator single sign-on • Enable new business on PBM platform & deactivate members on Aetna's systems • Develop web based "where am I" tool to determine what platform member data resides • Archive all historical data & sunset both PB & KC applications
Admin Migration 1			
	Clinical Mapping	Joint	• Analyze and map clinical rule sets for drug coverages, COB Rules, DUR (e.g. RTS rules/administrative edits)
	Account Structure Definition	Joint	• Define desired end state organization of plan sponsor data within the PBM's adjudication system necessary to support claim adjudication and required Sponsor and Member segmentation
	Plan and Benefit Mapping	Joint	• Analyze and map Plan Benefit Options, Plan Sponsors and Members from Aetna to PBM systems and assemble required linkages within PBM system to support adjudication
	Plan & Benefit Feed	Joint	• Convert and interface (bi-directional) current and historical Plan Sponsor & Plan Benefit data • Create capability to accept Plan Sponsor and Plan Benefit data from PBM and perform reconciliation/true-up to keep Aetna downstream systems whole and in sync with PBM system
	Eligibility Feed	Joint	• Convert and interface (bi-directional) current and historical Eligibility data • Create capability to accept Eligibility data from PBM and perform reconciliation/true-up to keep Aetna downstream systems whole and in sync with PBM system (18 months, monthly full file, 2x+/day change file)

Event	Project	Responsibility	Project Description
	Claim Feeds	Joint	• Convert and interface (bi-directional) current and historical Claim data • Create capability to accept Claim data from PBM into APMCAS Shadow and perform reconciliation/true-up (4x+/day) to keep Aetna downstream systems whole and in sync with PBM system • Covert and interface (bi-directional) required Claim data • Create and populate new data store, APMCAS Shadow, to temporarily store data coming back from PBM. Data Store will be used to keep Aetna downstream systems whole
	ID Cards	Aetna-Only	• Add second PBM phone number to ID card and produce cards upon administrative migration
	Prior Auth	Joint	• Convert and interface (bi-directional) current and historical Prior Authorization data • Create capability to accept Prior Authorization data from PBM and perform reconciliation/true-up (weekly) to keep Aetna downstream systems whole and in sync with PBM system
	Keep Down Streams Whole	Joint	• Re-direct all interfaces out of APMCAS to shadow for PBM feeds to downstream systems • Accept PBM data feeds into APMCAS Shadow and integrate with Aetna data to feed to Aetna downstream systems to feed to down streams
	Rx Member Service – ASD	Aetna-Only	• Enhance the Contact Database (CDAT) and Aetna Strategic Desktop (ASD) to store and display transfer codes that will route calls accurately and ensure a positive member experience • Associate a single transfer code to multiple Products, Segments, PS Unique and Controls per Contact/Subject entry in system admin • Add transfer code to eligibility file sent to PBM
	Rx Member Service – IVR	Joint	• Perform required telephony work to move control of the 1-800 number to PBM • Change the IVR application in order to allow a member to more quickly drop to a CSR • Enable bi-directional warm transfers between PBM and Aetna CSRs

Event	Project	Responsibility	Project Description
	Rx Member Service – Web	Joint	• Integrate Aetna web member portal with PBM web portal to provide members the ability to access: benefit summary, claim history, PAD, FSE, and Doctor Location functionality • Incorporate select PBM web functionality that Aetna would like to extend to its members
	Client Pricing Feed	Joint	• Interface (bi-directional) required Customer Pricing data for new business tool to manage/maintain client prices
	Off Renewal	Joint	• Convert and interface (bi-directional) Member Accumulator data required to support the migration of members prior to renewal
	Rebate Transition	Joint	• Convert Member Claim Data required for PBM to support rebate processing • Build capabilities for Aetna and PBM to jointly manage rebate processing and manufacturer relations
	Model Office	Joint	• Build out of required environments to support model office testing
Admin Migration 2			
	Service Integration	Joint	• Develop required integration points between Aetna and PBM to support medical claim integration and mail order integration for members who have been migrated to PBM
Specialty Transition			
	Specialty Transition	Joint	• Convert current & historical Specialty Pharmacy data (eligibility, scripts, orders, AR, allergy & health conditions, credit card, web registration, open renewals)

II. Migration Tasks and Timing

Major work-streams include:

- Scoping and Planning
- Financial Management (applies to all Implementation Phases)
- Retail Pricing/Network Transition
- Sales and Pricing Support
- ARxHD (MOD)
    - Site 1
    - Site 2
- Specialty Pharmacy (End-State Migration)
- Clinical Integration
- Rebate Administration Transition
- Administration Migration: Release 1
- Administrative Migration: Release 2 (Medical/Pharmacy Integration)
- Administrative Migration – Release 2 (Medicare)
- Administrative Migration: Release 3 (Medicaid & Affiliates)
- Workers Compensation

Att R-1038

Dates and scope are subject to change and will be confirmed during Detailed Integration Planning.

Scoping and Planning					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Implementation Planning	(a) Establish the Transition team comprised of key personnel	Transition Team Established	PBM and Aetna	Effective Date	5 Business Days following Effective Date
	(b) Discuss Available Implementation/Migration Accelerators	PBM will provide overview of available tools/accelerators to facilitate implementation/migration.	PBM and Aetna	TBD	TBD
	(c) Develop initial draft of implementation plan	Migration plan containing at a minimum the key milestones, tasks/deliverable, time frames, task owners	PBM	Effective Date	30 Days following Effective Date
	(d) Develop implementation staffing model	Implementation resource allocation model	PBM	Effective Date	60 Days following Effective Date
	(e) Develop joint comprehensive implementation plan	Migration plan containing at a minimum the key milestones, tasks/deliverable, time frames, task owners	PBM and Aetna	Effective Date	60 Days following Effective Date
	(f) Develop implementation plan for Medicaid and Affiliates	Migration plan containing at a minimum the key milestones, tasks/deliverable, and time frames	PBM and Aetna	Effective Date	60 Days following Effective Date
	(g) Develop implementation plan for Workers Compensation	Migration plan containing at a minimum the key milestones, tasks/deliverable, and time frames	PBM and Aetna	Effective Date	60 Days following Effective Date
	(h) Develop operating model and resource requirements, including dedicated and designated staffing models (as outlined in Schedule BB of this Agreement) for all key functions to be supported in end state model	End State PBM Staffing Models	PBM	Effective Date	TBD

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Financial Management (applies to all Implementation Phases)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Financial Record Alignment	(a) PBM will provide all necessary data feeds, reports and capabilities to maintain accurate financial records in accordance with Generally Acceptable Accounting Principles (GAAP)	PBM Provides all requested data, capabilities and reports and aligns all necessary financial processes & procedures.	PBM	TBD	TBD

Network Transition					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Planning & Strategy	(a) Finalize PBM Retail Network Build and Aetna Network termination Plan (Actions and Dates)	PBM Network Build Plan Network Termination Plan PBM Network Build Metrics Aetna Termination Metrics	PBM and Aetna	Effective Date	12/31/2010
	(b) Establish process/procedure flows for PBM Pharmacy network contracting end to end contracting and data load	E2E Contracting Process Flows Staff Roles and Responsibility Matrix Training Plan Policy & Procedure Inventory (to be revised / created)	PBM and Aetna	Effective Date	12//31/2010
	(c) Develop Technology requirements & artifacts	Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy	PBM and Aetna	Effective Date	12/31/2010
2. Plan sponsor pricing activity (installation activity/not network)	(d) Conduct mapping of PBM networks to Aetna customers at CSAP level	Network Mapping (Super RxNetwork)	PBM and Aetna	Effective Date	12/31/2010
	(e) Establish Transition/Incentive/Medicare Rate Schedules	Transition Pass-Through Schedule Incentive Spread Schedule Medicare Pass-Through Schedule	PBM and Aetna	Effective Date	12/31/2010
	(f) Develop retail pricing files for each pricing schedule	Transition Pass-Through Incentive Spread	PBM	Effective Date	12/31/2010

Network Transition					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
		Medicare Pass-Through			
	(g) Design retail Pharmacy pricing schedule load file format	Design Spec	PBM and Aetna	Effective Date	12/31/2010
3. Pharmacy Rate Loader Development and System Support	(h) Establish plan for developing PBM payable price schedules	Price Schedule Loading Plan	PBM and Aetna	Effective Date	12/31/2010
	(i) Complete technology support activities (Rate Loader Tool), including corresponding data load policies, staff training	Design Specification (Component, Application, Conversion) System Test Results Regression Test Results UAT Test Results Performance Test Results Model Office Test Results Training Materials Business Policies	PBM and Aetna	Effective Date	12/31/2010
	(j) Complete testing, conduct model office and finalize policies & procedures	System Test Results Regression Test Results UAT Test Results Performance Test Results Model Office Test Results Training Materials	PBM and Aetna	Effective Date	12/31/2010
	(k) Create new price schedules based on PBM contract rates and creation of network records	Network Record SuperRx Network with spread	PBM and Aetna	Effective Date	12/31/2010
4. Aetna Retail Network Termination	(l) Review Agreements for termination provisions and establish strategy and timeframes	Aetna Pharmacy Agreement termination plan	Aetna	Effective Date	12/31/2010
	(m) Establish Pharmacy Termination List and identify Exclusions	Pharmacy Termination List Pharmacy Exclusion List (will remain on Aetna paper)	PBM and Aetna	Effective Date	12/31/2010

Network Transition					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
	(n) Develop Pharmacy termination strategy and communication plan and materials	Pharmacy Communication Plan Agreement Termination Work Flow Communication Materials (including Web based) Staff Training Plan and Materials	PBM and Aetna	Effective Date	12/31/2010
	(o) Execute Pharmacy terminations (notices and system terminations)	Termination Letter templates Record Termination Audit Result	Aetna	Effective Date	12/31/2010
4. PBM Retail Network Build	(p) Complete Network Overlap Analysis and Pharmacy Lists (by provider type and network type, including Customer Specific)	Pharmacy Network Analysis (Overlap, PBM Only, Aetna Only) PBM Network Gap List Pharmacy Recruitment and Agreement completion tracking tool Key Pharmacy or Affinity partnership plan	PBM and Aetna	Effective Date	12/31/2010
	(q) Develop Amendment/Agreement Artifacts	Pharmacy Agreement Template	PBM	TBD	TBD
	(r) Establish Pharmacy recruitment/contracting strategy, communication plan and education materials	Pharmacy Communication/Education Plan Recruitment/Contracting Work flow Comm./Education Materials (including Web based) Staff Training Plan and Materials PBM Pharmacy Manual	PBM and Aetna	TBD	TBD
	(s) Establish Network configurations and Pharmacy demographic and rate data exchange requirements	Network configuratios and system hierarchy Pharmacy Data Exchange Work Flow Date Exchange Specifications	PBM and Aetna	TBD	TBD
	(t) Execute network credentialing and Pharmacy agreements	Agreement Distribution and Receipt strategy Signed Provider Agreements Delegated Credentialing Oversight Plan	PBM	TBD	TBD

Network Transition					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
	(u) Load Pharmacy demographics and Rates to enable adjudication of new pricing schedules	Record Loaded Audit Result	PBM and Aetna	TBD	TBD
	(v) Establish Network Access/Adequacy and Composition Reporting Requirements	Member Disruption Analysis requirements (geo access) CMS/Medicare /Customer Notice Plan Participating Pharmacy Directory/List Production Plan State/Federal Reg. Reporting Plan	PBM and Aetna	TBD	TBD
	(w) Establish ongoing Network Maintenance policies, processes and procedures	Network Maintenance Work Flow Network Maintenance Policies/ procedures (including terminations) Staff Training Plan Network Oversight and Audit Requirements	PBM	TBD	TBD

Sales and Pricing Support					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Process Review and Gap Assessment	(a) Determine how sales and pricing tools will be utilized to meet functional needs	Functional Needs Assessment Process Flows	PBM and Aetna	TBD	TBD
2. Design	(b) Design data/claims transfer load file format and process to enable PBM supported financial management	Design Spec	PBM	TBD	TBD
	(c) Design required training, develop sales/U/W/pricing service model and complete staffing model	Training Materials Service Model Staffing Model Policies and Procedures	PBM and Aetna	TBD	TBD

Sales and Pricing Support					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
3. Development	(d) Complete required technology build	Unit Test Results Integrated Test Results	PBM and Aetna	TBD	TBD
4. Deployment	(e) Deploy staff, technology and processes	Production Cut-over Checklist Warranty Deployments Command Center	PBM	TBD	TBD
5. Build & Execute Pricing, U/W and Financial Management	(f) PBM will work with Aetna to establish all agreed upon processes and capabilities to support Pricing, U/W and Financial Management	Agreed upon capabilities delivered and accepted by Aetna	PBM	TBD	9/20/2010

ARxHD (MOD Site 1)					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Planning and Requirements	(a) Develop Technology requirements & artifacts and process / workflow documentation to support the "event" business and technology needs.	Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy Process Flows Policy & Procedure Inventory (to be revised / created)	PBM and Aetna	TBD	TBD
	(b) Define order run-out strategy	Run-out approach	PBM and Aetna	TBD	TBD
	(c) Define MOD Customer Experience approach	Customer Experience Requirements	PBM and Aetna	TBD	TBD
	(d) Identify any client-specific requirements to consider	Identify any client specific requirements that exist	PBM and Aetna	TBD	TBD
	(e) Define Migration Plan	Migration / Conversion Approach Plan	PBM and Aetna	TBD	TBD

ARxHD (MOD Site 1)					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
	(f) Determine general requirements on reporting (Reference Schedule V, Item 1)	General requirements for reporting including identification of data fields that do not reside in PBM's systems that are required to complete required reporting	PBM and Aetna	TBD	TBD
2. Design	(i) Complete technology design activities	Design Specification (Component, Application, Conversion) Test Plans	PBM and Aetna	TBD	TBD
	(j) Develop policies, complete staffing & training plans and prepare contingency plans	Business Policies Staffing Model Training Plan Contingency Plans	PBM and Aetna	TBD	TBD
3. Development	(k) Complete technology build	Unit Test Results Integrated Test Results Implementation/Deployment Plan System Test Plan	PBM and Aetna	TBD	TBD
	(l) Develop procedures / job aides and build training curriculum	Procedures / Job Aides Training Curriculum & Plan Model Office Test Cases	PBM and Aetna	TBD	TBD
4. Testing	(m) Complete testing, conduct model office	System Test Results Regression Test Results UAT Test Results Performance Test Results	PBM and Aetna	TBD	TBD
	(n) Finalize policies & procedures	Model Office Test Results Training Materials	PBM and Aetna	TBD	TBD
5. Deployment	(g) Deploy staff, technology and processes	Production Cut-over Checklist Warranty Deployments Command Center	PBM and Aetna	TBD	TBD

ARxHD (MOD Site 2)					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Planning and Requirements	(a) Develop Technology requirements & artifacts and process / workflow documentation to support the "event" business and technology needs.	Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy Process Flows Policy & Procedure Inventory (to be revised / created)	PBM and Aetna	TBD	TBD
	(b) Define order run-out strategy	Run-out approach	PBM and Aetna	TBD	TBD
	(c) Define MOD Customer Experience approach	Customer Experience Requirements	PBM and Aetna	TBD	TBD
	(d) Identify any client specific requirements that exist	Identify any client-specific requirements to consider	PBM and Aetna	TBD	TBD
	(e) Define Migration Plan	Migration / Conversion Approach Plan	PBM and Aetna	TBD	TBD
1.	(f) Determine general requirements on reporting (Reference Schedule V, Item 1)	General requirements for reporting including identification of data fields that do not reside in PBM's systems that are required to complete required reporting	PBM and Aetna	TBD	TBD
2. Design	(g) Complete technology design activities	Design Specification (Component, Application, Conversion) Test Plans	PBM and Aetna	TBD	TBD
	(h) Develop policies, complete staffing & training plans and prepare contingency plans	Business Policies Staffing Model Training Plan Contingency Plans	PBM and Aetna	TBD	TBD
3. Development	(i) Complete technology build	Unit Test Results Integrated Test Results Implementation/Deployment Plan System Test Plan	PBM and Aetna	TBD	TBD

ARxHD (MOD Site 2)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
	(j) Develop procedures / job aides and build training curriculum	Procedures / Job Aides Training Curriculum & Plan Model Office Test Cases	PBM and Aetna	TBD	TBD
4. Testing	(k) Complete testing, conduct model office	System Test Results Regression Test Results UAT Test Results Performance Test Results	PBM and Aetna	TBD	TBD
	(l) Finalize policies & procedures	Model Office Test Results Training Materials	PBM and Aetna	TBD	TBD
5. Deployment	(m) Deploy staff, technology and processes	Production Cut-over Checklist Warranty Deployments Command Center	PBM and Aetna	TBD	TBD

Specialty Pharmacy (End-State Migration)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Planning and Requirements	(a) Develop Technology requirements & artifacts and process / workflow documentation to support the "event" business and technology needs.	Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy Process Flows Policy & Procedure Inventory (to be revised / created)	PBM and Aetna	TBD	TBD

Specialty Pharmacy (End-State Migration)					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
	(b) Determine general requirements on reporting (Reference Schedule V, Item 1)	General requirements for reporting including identification of data fields that do not reside in PBM's systems that are required to complete required reporting	PBM and Aetna	TBD	TBD
2. Design	(c) Complete technology design activities, develop policies, complete staffing & training plans and prepare contingency plans	Design Specification (Component, Application, Conversion) Service Contract Physical Data Model Test Plans Business Policies Staffing Model Training Plan Contingency Plans	PBM and Aetna	TBD	TBD
3. Development	(d) Complete technology build, develop procedures / job aides and build training curriculum	Unit Test Results Integrated Test Results Implementation/Deployment Plan System Test Plan Procedures / Job Aides Training Curriculum & Plan Model Office Test Cases	PBM and Aetna	TBD	TBD
4. Testing	(e) Complete testing, conduct model office and finalize policies & procedures	System Test Results Regression Test Results UAT Test Results Performance Test Results Model Office Test Results Training Materials	PBM and Aetna	TBD	TBD
	(f) Deploy staff, technology and processes	Production Cut-over Checklist Warranty Deployments Command Center	PBM and Aetna	TBD	TBD

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Clinical Integration (Aligns with Administrative Migration – Release 1)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Clinical Strategy	(a) Conduct joint clinical strategy session and gain alignment on strategic vision and value proposition	Clinical Strategic Vision Clinical Value Proposition	PBM and Aetna	TBD	TBD
2. Process Review and Gap Assessment	(b) Complete clinical program side-by-side comparison and determine future state scope of responsibilities	Final Clinical Program Grid	PBM and Aetna	TBD	TBD
	(c) Review clinical processes and determine future state operating model	Functional Needs Assessment Clinical Process Flows	PBM and Aetna	TBD	TBD
3. Design	(d) Design formularies and develop supporting business processes for formulary and P&T	Formulary Design Formulary/ P&T Business Processes	PBM and Aetna	TBD	TBD
	(e) Design clinical programs	Program Designs Clinical Program IT Development Requirements	PBM and Aetna	TBD	TBD
	(f) Develop clinical program and editing rules; determine current to future state mapping	Clinical Program Conversion Approach	PBM and Aetna	TBD	TBD
	(g) Test clinical systems and programs to ensure functionality to Aetna standards	Review and Approve PBM System Functionality	PBM and Aetna	TBD	TBD
	(h) Design required training and service model	Training Materials Service Model Policies and Procedures	PBM and Aetna	TBD	TBD

Rebate Administration (Aligns with Administrative Migration – Release 1)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Planning and Requirements	(a) TBD	TBD	TBD	TBD	TBD

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2. Design	(b) TBD	TBD	TBD	TBD	TBD
3. Development	(c) TBD	TBD	TBD	TBD	TBD
4. Testing	(d) TBD	TBD	TBD	TBD	TBD
5. Deployment	(e) TBD	TBD	TBD	TBD	TBD

Administrative Migration – Release 1					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Planning & Requirements	(a) Define account structure and plan benefit mapping approach.	Future State Account Structure Benefit Mapping Approach Custom Data Transfer / Storage Needs	PBM and Aetna	TBD	TBD
	(b) Develop technology requirements & artifacts and process / workflow documentation to support the "event" business and technology needs.	Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy Process Flows Policy & Procedure Inventory (to be revised / created)	PBM and Aetna	TBD	TBD
	(c) Define claim run-out strategy	Run-out Approach	PBM and Aetna	TBD	TBD
	(d) Define migration plan	Migration / Conversion approach	PBM and Aetna	TBD	TBD
	(e) Determine general requirements on reporting (Reference Schedule V, Item 1)	General requirements for reporting including identification of data fields that do not reside in PBM's systems that are required to complete required reporting	PBM and Aetna	TBD	TBD
2. Design	(f) Complete technology design activities	Design Specification (Component, Application, Conversion) Test Plans	PBM and Aetna	TBD	TBD

Administrative Migration – Release 1					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
	(g) Develop policies, complete staffing & training plans and prepare contingency plans	Business Policies Staffing Model Training Plan Contingency Plans	PBM and Aetna	TBD	TBD
3. Development	(h) Complete technology build	Unit Test Results Implementation/Deployment Plan System Test Plan	PBM and Aetna	TBD	TBD
	(i) Develop procedures / job aides and build training curriculum	Procedures / Job Aides Training Curriculum & Plan Model Office Test Cases	PBM and Aetna	TBD	TBD
4. Testing	(j) Complete testing, conduct model office	System Test Results Regression Test Results UAT Test Results Performance Test Results	PBM and Aetna	TBD	TBD
	(k) Finalize policies & procedures	Model Office Test Results Training Materials	PBM and Aetna	TBD	TBD
5. Deployment	(l) Deploy staff, technology and processes	Production Cut-over Checklist Migration Dry Runs Warranty Deployments Command Center	PBM and Aetna	TBD	TBD

Administrative Migration – Release 2 (Medical/Pharmacy Integration)

Task/Activity	Description	Output/Deliverable Acceptance/Completion Criteria	Responsibility	Target Start Date	Target Completion Date
1. Planning & Requirements	(a) Develop technology requirements & artifacts and process / workflow documentation to support the "event" business and technology needs.	Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy Process Flows Policy & Procedure Inventory (to be revised / created)	PBM and Aetna	TBD	TBD
	(b) Define migration plan	Migration / Conversion Approach Plan	PBM and Aetna	TBD	TBD
	(c) Determine general requirements on reporting (Reference Schedule V, Item 1)	General requirements for reporting including identification of data fields that do not reside in PBM's systems that are required to complete required reporting	PBM and Aetna	TBD	TBD
2. Design	(d) Complete technology design activities	Design Specification (Component, Application, Conversion) Test Plans	PBM and Aetna	TBD	TBD
	(e) Develop policies, complete staffing & training plans and prepare contingency plans	Business Policies Staffing Model Training Plan Contingency Plans	PBM and Aetna	TBD	TBD
3. Development	(f) Complete technology build	Unit Test Results Integrated Test Results Implementation/Deployment Plan System Test Plan	PBM and Aetna	TBD	TBD
	(g) Develop procedures / job aides and build training curriculum	Procedures / Job Aides Training Curriculum & Plan Model Office Test Cases	PBM and Aetna	TBD	TBD

Administrative Migration – Release 2 (Medical/Pharmacy Integration)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
4. Testing	(h) Complete testing	System Test Results Regression Test Results UAT Test Results Performance Test Results	PBM and Aetna	TBD	TBD
	(i) Conduct model office and finalize policies & procedures	Model Office Test Results Training Materials	PBM and Aetna	TBD	TBD
5. Deployment	(j) Deploy staff, technology and processes	Production Cut-over Checklist Warranty Deployments Migration Dry Runs Command Center	PBM and Aetna	TBD	TBD

Administrative Migration – Release 2 (Medicare)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Planning & Requirements	(k) Develop technology requirements & artifacts and process / workflow documentation to support the "event" business and technology needs.	Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy Process Flows Policy & Procedure Inventory (to be revised / created)	PBM and Aetna	TBD	TBD
	(l) Define migration plan to transition requirements to reach the end state model as described in Schedule O	Migration / Conversion Approach Plan	PBM and Aetna	TBD	TBD

Administrative Migration – Release 2 (Medicare)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
	(m) Determine general requirements on reporting (Reference Schedule V, Item 1)	General requirements for reporting including identification of data fields that do not reside in PBM's systems that are required to complete required reporting	PBM and Aetna	TBD	TBD
2. Design	(n) Complete technology design activities	Design Specification (Component, Application, Conversion) Test Plans	PBM and Aetna	TBD	TBD
	(o) Develop policies, complete staffing & training plans and prepare contingency plans	Business Policies Staffing Model Training Plan Contingency Plans	PBM and Aetna	TBD	TBD
3. Development	(p) Complete technology build	Unit Test Results Integrated Test Results Implementation/Deployment Plan System Test Plan	PBM and Aetna	TBD	TBD
	(q) Develop procedures / job aides and build training curriculum	Procedures / Job Aides Training Curriculum & Plan Model Office Test Cases	PBM and Aetna	TBD	TBD
4. Testing	(r) Complete testing	System Test Results Regression Test Results UAT Test Results Performance Test Results	PBM and Aetna	TBD	TBD
	(s) Conduct model office and finalize policies & procedures	Model Office Test Results Training Materials	PBM and Aetna	TBD	TBD

Administrative Migration – Release 2 (Medicare)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
5. Deployment	(t) Deploy staff, technology and processes	Production Cut-over Checklist Warranty Deployments Migration Dry Runs Command Center	PBM and Aetna	TBD	TBD

Administrative Migration – Release 3 (Medicaid & Affiliates)					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Planning & Requirements	(a) Develop Technology requirements & artifacts and process / workflow documentation to support the "event" business and technology needs.	Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy Process Flows Policy & Procedure Inventory (to be revised / created)	PBM and Aetna	TBD	TBD
	(b) Define claim run-out strategy	Run-out Approach	PBM and Aetna	TBD	TBD
	(c) Determine general requirements on reporting (Reference Schedule V, Item 1)	General requirements for reporting including identification of data fields that do not reside in PBM's systems that are required to complete required reporting	PBM and Aetna	TBD	TBD

Administrative Migration – Release 3 (Medicaid & Affiliates)					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
2. Design	(d) Complete technology design activities, develop policies, complete staffing & training plans and prepare contingency plans	Design Specification (Component, Application, Conversion) Test Plans Business Policies Staffing Model Training Plan Contingency Plans	PBM and Aetna	TBD	TBD
	(e) Define migration plan	Migration / Conversion Approach Plan	PBM and Aetna	TBD	TBD
3. Development	(f) Complete technology build, develop procedures / job aides and build training curriculum	Unit Test Results Integrated Test Results Implementation/Deployment Plan System Test Plan Procedures / Job Aides Training Curriculum & Plan Model Office Test Cases	PBM and Aetna	TBD	TBD
4. Testing	(g) Complete testing, conduct model office and finalize policies & procedures	System Test Results Regression Test Results UAT Test Results Performance Test Results Model Office Test Results Training Materials	PBM and Aetna	TBD	TBD
5. Deployment	(h) Deploy staff, technology and processes	Production Cut-over Checklist Warranty Deployments Command Center	PBM and Aetna	TBD	TBD

Workers Compensation					
Task/Activity	**Description**	**Output/Deliverable** **Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
1. Planning & Requirements	(i) Develop Workers Compensation implementation plan	Implementation Approach Plan	PBM and Aetna	TBD	TBD
	(j) Develop requirements & artifacts and process / workflow documentation to support the "event" business and technology needs.	Benefit Needs Analysis / Business Requirements Requirements Specifications Technical Architecture Testing Strategy Process Flows Policy & Procedure Inventory (to be revised / created)	PBM and Aetna	TBD	TBD
	(k) Determine general requirements on reporting (Reference Schedule V, Item 1)	General requirements for reporting including identification of data fields that do not reside in PBM's systems that are required to complete required reporting	PBM and Aetna	TBD	TBD
2. Design	(l) Complete design activities, develop policies, complete staffing & training plans and prepare contingency plans	Design Specification (Component, Application, Conversion) Test Plans Business Policies Staffing Model Training Plan Contingency Plans	PBM and Aetna	TBD	TBD
3. Development	(m) Complete build, develop procedures / job aides and build training curriculum	Unit Test Results Integrated Test Results Implementation/Deployment Plan System Test Plan Procedures / Job Aides Training Curriculum & Plan Model Office Test Cases	PBM and Aetna	TBD	TBD

Workers Compensation					
Task/Activity	**Description**	**Output/Deliverable Acceptance/Completion Criteria**	**Responsibility**	**Target Start Date**	**Target Completion Date**
4. Testing	(n) Complete testing, conduct model office and finalize policies & procedures	System Test Results Regression Test Results UAT Test Results Performance Test Results Model Office Test Results Training Materials	PBM and Aetna	TBD	TBD
5. Deployment	(o) Deploy staff, technology and processes	Production Cut-over Checklist Warranty Deployments Command Center	PBM and Aetna	TBD	TBD

Notwithstanding the foregoing, it is understood and agreed that Aetna may, in its sole discretion, elect not to convert to the Specialty Pharmacy System. Aetna may also elect to delay implementation of the Specialty Pharmacy System for a reasonable period of time to further assess its utility.

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SCHEDULE A-5

TRANSITION MILESTONES

Aetna and PBM will work to establish a process and scorecard to track a set of key metrics and defined targets/outcomes that measure the successful completion of each of the milestones outlined below.

Implementation Milestone	Acceptance/Completion Criteria	Required Completion Date	Prior to Services Commencement Date (Y/N)	Guarantee Amount
1. Detailed Transition & Integration Plan for each implementation event • **Outsourcing Phase** a. PBM Services b. MOD employees transference & services begin c. Specialty services begin d. Medicare Customer Service employees transference • **Implementation Phase** a. Retail Pricing and Network Transition b. MOD Migration c. Specialty Pharmacy Migration d. Administrative Migration i. Commercial ii. Medicare iii. Aetna Affiliates	• Individual Plans approved by Transition Committee and Aetna Executive Leadership	Within 60 Days of Effective Date	Y	$ 1,000,000

Implementation Milestone	Acceptance/Completion Criteria	Required Completion Date	Prior to Services Commencement Date (Y/N)	Guarantee Amount
2. Account Structure Hierarchy Mapping Complete	• PBM delivers a hierarchy specifications document for approval	Within 90 days of Effective Date	Y	$ 1,000,000
3. Readiness for Services Commencement Date Demonstrated (Applicable to all Services Commencements)	• All Outsourcing Readiness Services Tasks, excluding the tasks associated with the development, delivery and testing of the Specialty "Pointer" solution and ASRx Inventory cutover (Tasks 38-41 on Schedule A-3) on Schedule A-3 have been completed and approved by Aetna. • PBM delivers a written notice to Aetna advising the PBM is prepared to commence performance of all Services in accordance with the terms of this Agreement	One week prior to PBM and MOD Services Commencement Date	Y	$ 10,000,000
4. Retail Pricing Schedules and PBM proprietary Network Transition	• Network Rates loaded and Operational for all Aetna Customers • All Implementation Phase Tasks for Network and Retail Pricing on Schedule A-4 have been completed and approved by Aetna. • PBM delivers a written notice to Aetna advising the PBM is prepared to commence performance of all Medicare Services • No critical or high-level transition or production issues from transition start to 6 months following last transition date	Post Final Transition Date	Y	$10,000,000

Implementation Milestone	Acceptance/Completion Criteria	Required Completion Date	Prior to Services Commencement Date (Y/N)	Guarantee Amount
5. Mail Order Migration (Site 1 and 2) Successfully Completed	• Business sign-off on all integrated testing including Model Office • All Implementation Phase Tasks for MOD Site 1 and 2 on Schedule A-4 have been completed and approved by Aetna. • Migration plan is executed • PBM has demonstrated all private labeling and branding requirements have been implemented • All Aetna Customers migrated from Aetna Mail Order delivery platform to PBM Mail Order Platform • PBM delivers a written notice to Aetna advising the PBM is prepared to commence performance of all MOD Site 1 and 2 Services • No critical or high-level migration/service production issues from migration start to 3 months following final migration date	3 Months Post Final Migration (By Site)	N	$10,000,000

Implementation Milestone	Acceptance/Completion Criteria	Required Completion Date	Prior to Services Commencement Date (Y/N)	Guarantee Amount
6. Specialty Model Office Testing Complete	• Delivery of all critical capability required by AETNA on the PBM RxSpecialty platform • Demonstration of resolution of all high and critical defects and six months of stable production environment of PBM RxSpecialty • Completed Specialty migration of greater than 50% of PBM's health plan business to new RxSpecialty platform • Business sign-off on all integrated testing including Model Office of migration capabilities • All Implementation Phase Tasks for Specialty on Schedule A-4 have been completed and approved by Aetna. • PBM delivers a written notice to Aetna advising the PBM is prepared to commence performance of all Specialty Services • PBM has demonstrated all private labeling and branding requirements have been implemented	One Week Prior to Specialty MO Testing Completion Date	N	$ 5,000,000
7. Specialty Migration Successfully Completed	• Migration plan is executed • All Aetna Customers migrated from Aetna Specialty delivery platform to Vail Specialty Platform • PBM delivers a written notice to Aetna advising the PBM is prepared to commence performance of all Specialty Services • No critical or high-level migration production/service issues from migration start to 3 months following final migration date	3 Months Post Final Migration (By Site)	N	$10,000,000

Implementation Milestone	Acceptance/Completion Criteria	Required Completion Date	Prior to Services Commencement Date (Y/N)	Guarantee Amount
8. Administrative Migration – Release 1 Model Office Testing Complete	• Business sign-off on all integrated testing including Model Office • All Implementation Phase Tasks for Administrative Release 1 on Schedule A-4 have been completed and approved by Aetna. • PBM delivers a written notice to Aetna advising the PBM is prepared to commence migration • PBM has demonstrated all private labeling and branding requirements have been implemented	One Week Prior to Testing Completion Date	N	$20,000,000 *(Need to discuss loss to Financial Opportunity to Aetna)*
9. Administrative Migration – Release 2 Model Office Testing Complete	• Business sign-off on all integrated testing including Model Office • All Implementation Phase Tasks for Administrative Release 2 on Schedule A-4 have been completed and approved by Aetna. • PBM has demonstrated all private labeling and branding requirements have been implemented • PBM delivers a written notice to Aetna advising the PBM is prepared to commence migration	One Week Prior to Testing Completion Date	N	$50,000,000
10. Commercial Administrative Migration Successfully Complete	• Migration plan is executed • All Aetna Customers migrated from Aetna Commercial delivery platform to Vail Commercial Platform • PBM delivers a written notice to Aetna advising the PBM has completed migration • No critical or high-level migration production/service issues from migration start to 6 months following the completion of migration	6 Months Post Final Migration	N	$50,000,000

Implementation Milestone	Acceptance/Completion Criteria	Required Completion Date	Prior to Services Commencement Date (Y/N)	Guarantee Amount
11. Medicare Model Office Testing Complete	• CMS approval of Medicare migration plans and testing • Business sign-off on all integrated testing including Model Office • All Implementation Phase Tasks for Medicare on Schedule A-4 have been completed and approved by Aetna • PBM delivers a written notice to Aetna advising the PBM is prepared to commence performance of all Medicare Services • PBM has demonstrated all private labeling and branding requirements have been implemented	One Week Prior to Medicare MO Testing Completion Date	N	$ 50,000,000
12. Medicare Migration Successfully Complete	• Migration plan is executed • All Aetna Customers migrated from Aetna Medicare delivery platform to Vail Medicare Platform • PBM delivers a written notice to Aetna advising the PBM has completed Medicare migration • No critical or high- migration production/service issues from migration start to 6 months following migration date	6 Months Post Final Migration	N	$50,000,000

Implementation Milestone	Acceptance/Completion Criteria	Required Completion Date	Prior to Services Commencement Date (Y/N)	Guarantee Amount
13. Affiliate and Medicaid MigrationsSuccessfully Complete\	• All Aetna Customers migrated from Affiliate delivery platform to Vail delivery platform • All Implementation Phase Tasks for Affiliate Migration on Schedule A-4 have been completed and approved by Aetna. • PBM delivers a written notice to Aetna advising the PBM is prepared to commence performance of all AffiliatesMigration Services • No critical or high- migration production/service issues from migration start to 6 months following migration date • PBM has demonstrated all private labeling and branding requirements have been implemented	3 Months Post Final Migration Dates	N	$5,000,000

Att R-1066

SCHEDULE A-6

FORM OF TRANSITION SERVICES AGREEMENT

[See attached.]

Aetna Better Health® of Kentucky

TRANSITION SERVICES AGREEMENT

by and between

AETNA HEALTH MANAGEMENT, LLC
a Delaware limited liability company,

and

CAREMARKPCS HEALTH, L.L.C.
a Delaware limited liability company

Dated as of [_____, 20__]

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TRANSITION SERVICES AGREEMENT

This **TRANSITION SERVICES AGREEMENT** (this "Agreement"), dated as of [_____ __, 201_] (the "Agreement Date"), is entered into by and between Aetna Health Management, LLC, a Delaware limited liability company ("Aetna"), and CaremarkPCS Health, L.L.C., a Delaware limited liability company ("PBM"). PBM and Aetna are sometimes referred to herein collectively as "Parties" and individually as a "Party."

RECITALS

A. PBM and Aetna are parties to that certain Pharmacy Benefit Management Subcontract Agreement dated as of July 27, 2010 (the "PBM Agreement"), pursuant to which PBM and certain of its Affiliates, from and after the Agreement Date, will perform for Aetna, certain Aetna Affiliates and Aetna Customers certain prescription drug, pharmacy benefit management and back-end mail and specialty pharmacy functions and services performed by Aetna and certain of its Affiliates prior to the Agreement Date.

C. To assist PBM to perform the PBM Services and its other obligations under the PBM Agreement, Aetna has agreed to provide certain services to PBM, and PBM has agreed to engage the services of Aetna, during a transition period beginning on the Agreement Date, in accordance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the promises, covenants, representations and warranties set forth herein, and other consideration, the sufficiency of which is hereby acknowledged, the Parties each hereby agree as follows:

ARTICLE I.
DEFINED TERMS

Unless otherwise expressly noted herein, capitalized terms used in this Agreement shall have the respective meanings specified in Annex A or as otherwise defined in the provisions of this Agreement, and in the case of capitalized terms not defined in Annex A or elsewhere in this Agreement shall have the respective meanings specified in the PBM Agreement.

ARTICLE II.
PERFORMANCE OBLIGATIONS

2.1 **Aetna Transition TSA Service Obligations.**

(a) TSA Services. Aetna shall perform the services described on Schedule 1 (the "TSA Services") during the Term or for such shorter period as may be specified for a particular TSA Service on Schedule 1. Aetna or its Affiliates shall commence delivery of the TSA Services immediately following the Agreement Date unless a later commencement date is specified for a particular TSA Service on Schedule 1.

(b) Discontinuation or Reduction of TSA Services. During the Term, PBM may instruct Aetna to discontinue providing any of the TSA Services or otherwise reduce its

level of effort with respect to any of the TSA Services by giving Aetna at least thirty (30) days prior written notice; *provided, however,* that if PBM reduces or discontinues any TSA Service, PBM may not subsequently request or cause such TSA Service to be increased or resumed; *provided, further,* that PBM may not elect to discontinue any TSA Service that supports or is necessary for the performance of another TSA Service unless it elects to discontinue the performance of all such related TSA Services; *provided, further,* that PBM may not elect to reduce or discontinue any TSA Service to the extent that such reduction or discontinuation would impair PBM's and its Affiliates' ability to provide the Services in accordance with the PBM Agreement (including the processing of runoff Claims); *provided, further,* that PBM may not elect to reduce or discontinue the receipt of Aetna's specialty pharmacy technology platform (COMPAS or any successor) to the extent that Aetna does not approve the migration to Rx Specialty (as defined in Schedule A to the PBM Agreement) (or an alternative specialty pharmacy technology platform provided by PBM) pursuant to Section 1.D of Schedule A to the PBM Agreement. It is understood and agreed that Aetna has agreed to provide the TSA Services to PBM as an interim measure only for the duration of the Term.

(c) Priority. Due to the transitional nature of the TSA Services, Aetna shall have the right, if Aetna determines that such priorities are necessary, to establish reasonable priorities, as between Aetna and its Affiliates, on the one hand, and PBM, on the other, as to the provision of any of the TSA Services; *provided, however,* that Aetna will use reasonable commercial efforts to avoid the need to establish such priorities. If Aetna determines that such priorities are necessary, Aetna will consult with PBM as to the appropriate ordering, timing and prioritization of the affected TSA Services and will use reasonable commercial efforts to minimize the duration and impact of any delays resulting therefrom.

2.2 **Standard of Performance; Resources.**

(a) Standard of Performance. Aetna shall provide the TSA Services using the same degree of skill and care and in substantially the same manner as Aetna and its applicable Affiliates have used in performing the TSA Services for and in support of the pharmacy and pharmacy benefit management-related operations of Aetna and its Affiliates prior to the Agreement Date.

(b) Personnel and Resources. Aetna shall devote such personnel, project management, systems, equipment, technology, tools, software and other resources as are reasonably necessary to perform the TSA Services in accordance with the terms of this Agreement; *provided, however,* that Aetna shall not be obligated to: (i) hire any additional employees; (ii) maintain the employment of any specific employee; (iii) purchase, lease or license any additional systems, equipment, technology, tools or software, or (iv) seek, obtain or pay any consideration for any consents, approvals or waivers from third parties (except to the extent required by applicable Law).

2.3 **Cooperation.**

(a) General. PBM shall, and shall cause its Affiliates to, assist and cooperate in good faith with Aetna in connection with the performance of its obligations under this Agreement. Such cooperation shall include, to the extent commercially reasonable, (i) providing

data and information to Aetna, (ii) responding as promptly as practicable to Aetna's requests for approvals, consents or other communications and (iii) not acting or failing to act in a way that could adversely affect the ability of Aetna to perform its obligations under this Agreement.

(b) Access. Subject to reasonable security requirements, PBM will grant to Aetna and its Subcontractors, at all reasonable times during the Term, (i) the right of ingress and egress to and from the facilities of PBM and its Affiliates, and (ii) access to the systems, equipment, documentation, information and other materials and personnel of PBM and its Affiliates, in each case to the extent reasonably necessary and proper for the performance of the TSA Services.

(c) Failure to Cooperate. Aetna will not be responsible for any delays in, or nonperformance of, any of its obligations under this Agreement to the extent such delays or nonperformance result from a failure by PBM to cooperate as required in this Section 2.3 or to perform any of its other obligations under this Agreement.

2.4 **Use of Subcontractors.**

Aetna may not subcontract or delegate any of the TSA Services or any of its other obligations under this Agreement to any other Person (a "Subcontractor") other than to an Affiliate of Aetna, without the prior written consent of PBM. In connection with any permitted or approved subcontract or delegation, Aetna shall be fully responsible for all acts and omissions of its Subcontractors, and Aetna shall remain fully responsible for the timely and proper performance and discharge of all TSA Services that are subcontracted or delegated to any Subcontractor.

ARTICLE III.
COMPENSATION AND PAYMENT TERMS

3.1 **Compensation**. As compensation for the TSA Services, PBM will pay Aetna fees equal to (i) with respect to each TSA Service for which pricing is set forth on Schedule 1, the amounts calculated as set forth therein, and (ii) with respect to each other TSA Service, the sum of Aetna's Reimbursable Costs incurred in performing such TSA Services under this Agreement.

3.2 **Invoices; Payment Schedule and Invoice Disputes**.

(a) Invoices. Within twenty (20) Business Days after the end of each calendar month during the Term, Aetna will deliver to PBM an invoice for the fees covering the TSA Services provided during such month and the amounts owing hereunder with respect thereto (each, an "Invoice"). Each Invoice will contain a reasonable level of detail to show how the Reimbursable Costs were allocated among an itemized listing of the TSA Services provided for such month and the out-of-pocket costs incurred by Aetna during such month. Within fifteen (15) Business Days after receipt of each Invoice, PBM shall pay such Invoice to Aetna in full. In addition, PBM shall pay interest to Aetna on any past-due amounts owing hereunder at a rate equal to the greater of the Prime Rate or six percent (6%) per annum.

(b) Disputes. If PBM disputes all or a portion of any Invoice delivered by Aetna, PBM shall, within ten (10) Business Days after its receipt of the Invoice, deliver a written notice to Aetna that sets forth in reasonable detail the disputed amount, the specific TSA Services being disputed and the reasons for such dispute (a "Dispute Notice"). If PBM fails to issue a Dispute Notice within such time period, it shall be deemed to have accepted the Invoice and the Invoice shall be final and binding on PBM. If PBM issues a Dispute Notice, (i) all portions of the Invoice that are not specifically disputed in such Dispute Notice shall be final and binding on PBM, and (ii) any specifically disputed portions (all such disputed amounts, the "Disputed Amounts") shall be resolved according to this Section 3.2.

(c) Dispute Resolution. The Parties shall negotiate in good faith to resolve any Disputed Amounts set forth in a Dispute Notice as soon as reasonably practicable and, upon resolution of such dispute, assuming that a refund is due from Aetna to PBM, Aetna shall promptly make such refund to PBM. In the event that the Parties are not able to resolve all Disputed Amounts within ten (10) Business Days (or such longer period as may be agreed in writing by PBM and Aetna) after the date of receipt by Aetna of the Dispute Notice, PBM and Aetna will promptly thereafter cause a Neutral Accounting Firm to review this Agreement, the Invoice in dispute and the applicable Dispute Notice for the purpose of resolving such dispute. PBM and Aetna will use their commercially reasonable efforts to cause the Neutral Accounting Firm to render a decision in accordance with this Section 3.2 along with a report explaining and setting forth in reasonable detail the reasons for such decision within thirty (30) days of the date the dispute was submitted to the Neutral Accounting Firm. The decision of the Neutral Accounting Firm will constitute an arbitral award that is final, binding and non-appealable upon the Parties and upon which a judgment may be entered by a court having jurisdiction thereover, absent manifest error therein. Not later than five (5) Business Days after (i) PBM and Aetna have resolved the Disputed Amounts or (ii) the Neutral Accounting Firm has rendered its decision, if the outcome of such resolution or decision requires that Aetna refund a portion of a previously paid Invoice, Aetna shall promptly make such payment to PBM.

(d) Neutral Accounting Firm Fees. In the event PBM and Aetna submit any Disputed Amounts to a Neutral Accounting Firm for resolution, PBM will be responsible for that fraction of the fees and costs of the Neutral Accounting Firm as is equal to (i) the absolute value of the difference between the PBM's aggregate position with respect to the Disputed Amounts and the Neutral Accounting Firm's final determination with respect to the Disputed Amounts over (ii) the absolute value of the difference between Aetna's aggregate position with respect to the Disputed Amounts and PBM's aggregate position with respect to the Disputed Amounts, and Aetna will be responsible for the remainder of such fees and costs.

(e) Limitations. In resolving any dispute, the Neutral Accounting Firm will act as an arbitrator to determine, based upon the provisions of this Section 3.2, only the Disputed Amounts and the determination of each item included in the Disputed Amounts will in any event be no less than the lesser of the amount claimed by either PBM, on the one hand, or Aetna, on the other hand, and shall be no greater than the greater of the amount claimed by either PBM, on the one hand, or Aetna, on the other hand.

3.3 **Taxes**. Each Party will assume the cost of any sales, use, privilege and other transfer or similar taxes ("Taxes") imposed upon that Party under applicable Law as a result of the performance of the TSA Services and the transactions contemplated hereby. To the extent any exemptions from such Taxes are available, Aetna and PBM will cooperate to prepare any certificates or other documents necessary to claim such exemptions.

ARTICLE IV.
TERM AND TERMINATION

4.1 **Term**.

The term (the "Term") of this Agreement shall be for a period commencing on the Agreement Date and ending on the earlier of (i) [_____, 201_] and (ii) the first date as of which PBM, pursuant to Section 2.1(b), has instructed Aetna to discontinue all TSA Services, unless sooner terminated as provided herein.

4.2 **Termination**. This Agreement may be terminated:

(a) by the mutual written consent of Aetna and PBM; or

(b) by Aetna if PBM commits a material breach of this Agreement (including PBM's failure to pay amounts when due pursuant to Section 3.2), and fails to cure such breach within thirty (30) days of receiving written notice of such breach from Aetna.

4.3 **Survival**. Articles III, V, VI, VII and VIII shall survive the expiration or any termination of this Agreement.

ARTICLE V.
INTELLECTUAL PROPERTY

The provisions of Sections 11.3 and 11.5 of the PBM Agreement shall apply to this Agreement, *mutatis mutandis*, and are hereby incorporated herein by reference.

ARTICLE VI.
CONFIDENTIALITY

The provisions of Article XIII of the PBM Agreement shall apply to this Agreement, *mutatis mutandis*, and are hereby incorporated herein by reference.

ARTICLE VII.
INDEMNIFICATION

7.1 **Indemnification of Aetna**.

PBM shall indemnify, defend and hold harmless Aetna, its Affiliates (including all Aetna Plan Affiliates), and their respective officers, directors, agents, employees, successors and permitted assigns (each an "Aetna Indemnified Party") from and against all Losses arising from

or relating to (i) negligence or willful misconduct on the part of PBM or any Affiliate of PBM in connection with its performance under this Agreement, (ii) any breach of any covenant in this Agreement on the part of PBM, or (iii) any failure by PBM to comply with applicable Law in connection with its performance under this Agreement.

7.2 **Indemnification of PBM.**

Aetna shall indemnify, defend and hold harmless PBM, its subsidiaries, Affiliates, and their respective officers, directors, agents, employees, successors and permitted assigns (each a "PBM Indemnified Party") from and against all Losses arising from or relating to (i) negligence or willful misconduct on the part of Aetna or any Affiliate of Aetna in connection with its performance under this Agreement, (ii) any breach of any covenant in this Agreement on the part of Aetna, or (iii) any failure by Aetna to comply with applicable Law in connection with its performance under this Agreement.

7.3 **Notice; Defense of Claim**. If any claim or liability is asserted in writing against an Aetna Indemnified Party or a PBM Indemnified Party (each an "Indemnified Party") by a Person other than an Aetna Indemnified Party or a PBM Indemnified Party that would give rise to a claim under this Article VII (a "Third-Party Claim"), the Indemnified Party shall promptly notify the Party providing the indemnity ("Indemnifying Party") in writing of the same. In any case in which the claim or liability has been asserted by a current or former Member, a current or former Aetna Customer or a Governmental Body, Aetna or an Aetna Plan Affiliate shall have the right to elect, by giving written notice to PBM, to defend the claim and control the defense, settlement and prosecution of any litigation (including any arbitration) in connection therewith. In all other cases, the Indemnifying Party shall have the right to defend the claim and control the defense, settlement and prosecution of any litigation (including any arbitration) in connection therewith; *provided, however*, that if the Indemnifying Party, within fifteen (15) days after written notice thereof, fails to defend such claim, the Indemnified Party will (upon further notice to the Indemnifying Party) have the right to undertake the defense, compromise or settlement of such claim on behalf of the Indemnifying Party, subject to the right of the Indemnifying Party to assume the defense of such claim at any time prior to settlement, compromise or final determination thereof. Anything in this Section 7.3 notwithstanding, (i) if there is a reasonable probability that a claim may materially and adversely affect the Indemnified Party other than as a result of money damages or other money payments, the Indemnified Party shall have the right, at its own cost and expense, to defend, compromise and settle such claim and (ii) whichever Party has assumed defense of the claim shall not, without the written consent of the Indemnified Party, settle or compromise any claim or consent to the entry of any judgment which does not include as an unconditional term thereof the giving by the claimant to the Indemnified Party a release from all liability in respect to such claim. All Parties agree to cooperate fully as necessary in the defense of such matters. If the Indemnified Party fails to notify the Indemnifying Party of the claim promptly as required above, this indemnity shall terminate and be of no further force and effect with respect to the subject matter of the required notice in the event, and to the extent, that the Indemnified Party's failure to notify in the time required above materially adversely affects the Indemnifying Party's ability to defend such matter.

7.4 **Limitations of Liability.** No Party will be liable to any other Party for any Losses in the nature of consequential, punitive, special, or exemplary damages arising under or

in connection with this Agreement; *provided, however*, that nothing contained in this Section 7.4 will limit one Party's liability to the other Party for or on account of (a) the other Party's willful violation of any applicable Law or (b) any Losses to the extent any such Losses are in the nature of damages paid by (or due from) an Indemnified Party to a third party in connection with a Third-Party Claim for which such Indemnified Party is entitled to indemnification under this Agreement.

ARTICLE VIII.
MISCELLANEOUS PROVISIONS

8.1 **Compliance with Laws**. Aetna shall comply with all Laws applicable to its performance of the TSA Services.

8.2 **Independent Contractors**. The Parties to this Agreement are independent contractors. No Party is an agent, representative or partner of any other Party. No Party shall have any right, power or authority to enter into any agreement for or on behalf of, or incur any obligation or liability of, or to otherwise bind, any other Party. This Agreement shall not be interpreted or construed to create an association, agency, joint venture or partnership between the Parties or to impose any liability attributable to such a relationship upon any Party.

8.3 **No Third Party Beneficiaries**. This Agreement has been entered into solely for the benefit of the Parties and their Affiliates, and no other Persons are intended to be or are third party beneficiaries of or under this Agreement, and nothing in this Agreement shall be construed to create any legal, equitable or beneficial interest in any third party or to vest in any third party any interest as to enforcement or performance.

8.4 **Assignment, Transfer, Delegation**. Neither this Agreement nor any interest, benefit, obligation or duty hereunder shall be assignable (by operation of Law or otherwise), transferable or delegable, in whole or in part, by PBM, or by Aetna, except (i) for delegations in accordance with Section 2.4 and (ii) Aetna may assign this Agreement or any rights hereunder, to one or more of its Affiliates.

8.5 **Good Faith Performance**. Each Party shall continue to perform its respective obligations under this Agreement during the pendency of any dispute subject to the terms and conditions of this Agreement.

8.6 **Amendments**. This Agreement may be amended only in writing when signed by a duly authorized representative of each Party.

8.7 **Force Majeure.** Neither Party will be deemed to have breached this Agreement or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Agreement if prevented from doing so by a cause or causes beyond its control (a "Force Majeure"). Without limiting the generality of the foregoing, such causes include acts of God or the public enemy, fires, floods, storms, earthquakes, riots, acts of terrorism, acts of war or war-operations, restraints of government, power or communications line failure or other circumstances beyond such Party's control. In no event shall any judgment, ruling or order of any court or agency of competent jurisdiction, or change of Law and in no event shall any strike,

work stoppage or work slowdown caused by or relating to a labor dispute constitute a "Force Majeure." In the case of a Force Majeure, the Party affected shall, upon giving prompt notice to the other Party, use its commercially reasonable efforts to avoid or remove the cause of nonperformance and the unaffected Party will be excused from performance of its obligations to the extent such Party's obligations are related to the performance so interfered with. Both Parties shall proceed to perform their respective obligations once the Force Majeure has been removed or ceases.

8.8 **Entire Agreement**. This Agreement and the PBM Agreement (including the Annexes and Schedules hereto and thereto) and all documents incorporated herein by reference, constitute the entire agreement of the Parties with respect to the subject matter hereof and the transactions and performance contemplated hereby and supersedes all prior agreements, renegotiations, discussions or representations, whether written or oral, with respect thereto. In the event of any conflict between the terms of this Agreement and the PBM Agreement, the terms of the PBM Agreement shall prevail.

8.9 **Rights and Remedies/Separate Obligations**. No right or remedy contained herein is intended to be exclusive of any other right or remedy contained herein or provided by Law, and every such right or remedy shall be cumulative and not alternative.

8.10 **Representation by Counsel**. Each Party represents and warrants that it has had the opportunity to be represented by counsel of his/her/its choice with respect to this Agreement. In view of the foregoing and notwithstanding any otherwise applicable principles of construction or interpretation, this Agreement shall be deemed to have been drafted jointly by the Parties and in the event of any ambiguity, shall not be construed or interpreted against the drafting Party.

8.11 **Construction**. The Parties agree that any rule of construction to the effect that ambiguities are to be resolved against the drafting Party shall not be applied in the construction or interpretation of this Agreement.

8.12 **Rules of Interpretation**. Except as otherwise expressly provided in this Agreement, the following rules of interpretation apply to this Agreement: (i) the singular includes the plural and the plural includes the singular; (ii) "or" and "any" are not exclusive and "include" and "including" are not limiting; (iii) reference to any Contract includes permitted supplements, amendments and modifications thereof; (iv) a reference to a Law includes any amendment, modification or interpretation to such Law and any rules or regulations issued thereunder; (v) a reference to a Person includes its permitted successor and assigns; and (iv) a reference in this Agreement to an Article, Section, Exhibit or Schedule is to the Article, Section, Exhibit or Schedule of this Agreement. References in this Agreement to a Schedule also include references to any sub-schedules referenced in such Schedule.

8.13 **Counterparts**. This Agreement may be executed in one or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same instrument. A facsimile or other reproduction of this Agreement shall be deemed an original.

8.14 **Notices**. Any notices, requests and other communications required or permitted to any Party under this Agreement shall be in writing and shall be sent in accordance with Section 17.23 of the PBM Agreement, at the addresses and facsimile numbers below:

If to PBM at:

CaremarkPCS Health, L.L.C.
9501 East Shea Blvd. MC024
Scottsdale, Arizona 85260
Attn: Vice President and Senior Legal Counsel, Healthcare TSA Services
Fax: 480-314-8231

and with a copy to:
CVS Caremark Corporation
445 Great Circle Road
Nashville, TN 37228
Attn: General Counsel
Fax: 615-743-6611

If to Aetna at:

Aetna Health Management, LLC
c/o Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156
Attention: Chief Executive Officer
Fax: 860-273-9020

and with a copy to:

Aetna Health Management, LLC
c/o Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156
Attention: General Counsel
Fax: 860-273-8340

8.15 **No Waiver, etc.** No failure on the part of any Party to exercise, and no delay in exercising, any right under this Agreement shall operate as waiver of any right, nor shall any single or partial exercise of any right under this Agreement by any Party preclude any other or further exercise of any other right, and no waiver whatsoever shall be valid unless in a signed writing executed by the Party granting such waiver, and then only to the extent specifically set forth in that writing. No waiver of any right under this Agreement shall operate as a waiver of any other or of the same or similar right on another occasion. No notice to or demand on one Party will be deemed to be a waiver of any obligation of that Party or of the right of the Party

giving such notice or demand to take further action without notice or demand as provided in this Agreement. The rights and remedies of the Parties are cumulative and not alternative.

8.16 **Governing Law**. Except to the extent preempted by federal Law, this Agreement will be construed and governed in accordance with the Laws of the State of New York, without giving effect to conflicts of law principles.

8.17 **Mediation and Disputes**.

(a) Except as provided herein, neither Party may commence any civil action with respect to any dispute, claim or controversy arising out of or relating to this Agreement (other than any cross-claim or counterclaim) unless and until the initiating Party has submitted the dispute, claim or controversy to JAMS for non-binding mediation in accordance with this Section 8.17. Either Party may commence mediation by providing to JAMS and the other Party a written request for mediation, setting forth the subject of the dispute and the relief requested. The Parties will cooperate with JAMS and with one another in selecting a mediator from JAMS' panel of neutrals, and in scheduling the mediation proceedings, including an initial medication session (the "Initial Mediation Session"). The Parties covenant that they will participate in the mediation in good faith, and that they will share equally in its costs (not including attorneys' fees and expenses, which will be borne by each side). All offers, promises, conduct and statements, whether oral or written, made in the course of the mediation by any of the Parties, their agents, employees, experts, attorneys and other advisors, and by the mediator and any JAMS employees, are confidential, privileged and inadmissible for any purpose, including impeachment, in any civil action or other proceeding involving the Parties, *provided, however,* that evidence that is admissible or discoverable in any civil action as between a Party and any other Person shall not be rendered inadmissible or non-discoverable with respect to such civil action as a result of its use in the mediation.

(b) Either Party may seek equitable relief prior to commencement or completion of an Initial Mediation Session required under Section 8.17(a), to preserve the status quo pending the completion of an Initial Mediation Session relating to the subject matter of such equitable relief. Except for such an action to obtain equitable relief, neither Party may commence a civil action with respect to any dispute, claim or controversy arising out of or relating to this Agreement (other than any cross-claim or counterclaim) until the earlier of (i) the completion of the Initial Mediation Session with respect to such dispute, claim or controversy, or (ii) forty-five (45) days after the date of filing the written request for such a mediation with JAMS. Mediation may continue after the commencement of a civil action, if the Parties so desire. The provisions of this Section 8.17 may be enforced by any court of competent jurisdiction, and the Party seeking enforcement shall be entitled to an award of all costs, fees and expenses, including attorneys' fees, to be paid by the Party against whom enforcement is ordered.

(c) The provisions of this Section 8.17 shall not be applicable to any Dispute Notices or Disputed Amounts, and all Dispute Notices and Disputed Amounts shall be resolved in accordance with the procedures set forth in Section 3.2.

8.18 **Severability**. If any provision of this Agreement or the application of any such provision to any Person or circumstance shall be held invalid, illegal or unenforceable in any respect by a court of competent jurisdiction, such invalidity, illegality or unenforceability shall not affect any other provision hereof and all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the Parties hereto have executed this Transition Services Agreement as of the date first set forth above.

AETNA HEALTH MANAGEMENT, LLC

By: _____
Name:
Title:

CAREMARKPCS HEALTH, L.L.C.

By: _____
Name:
Title:

ANNEX A

DEFINED TERMS

"Aetna" has the meaning set forth in the Preamble.

"Aetna Indemnified Party" has the meaning set forth in Section 7.1.

"Agreement" has the meaning set forth in the Preamble and includes all Annexes and Schedules attached hereto.

"Agreement Date" has the meaning set forth in the Preamble.

"Dispute Notice" has the meaning set forth in Section 3.2(b).

"Disputed Amounts" has the meaning set forth in Section 3.2(b).

"Force Majeure" has the meaning set forth in Section 8.7.

"Indemnified Party" has the meaning set forth in Section 7.3.

"Indemnifying Party" has the meaning set forth in Section 7.3.

"Initial Mediation Session" has the meaning set forth in Section 8.17(a)."Invoice" has the meaning set forth in Section 3.2(a).

"Party" and "Parties" have the meaning set forth in the Preamble.

"PBM" has the meaning set forth in the Preamble.

"PBM Agreement" has the meaning set forth in Recital A.

"PBM Indemnified Party" has the meaning set forth in Section 7.2.

"Reimbursable Costs" means Aetna's direct and indirect costs incurred during the Term in connection with the TSA Services or the performance of any of its other obligations under this Agreement as determined and allocated by Aetna in accordance with its standard commercial accounting practices and will include labor costs (including wages and salaries, bonuses, deferred compensation, pension costs, health insurance benefits, life insurance benefits and savings plan benefits), travel costs, data processing and other systems costs, transportation costs, license and sublicense fees paid to third parties, payments to subcontractors, facilities (including lease obligations), taxes and other charges for which PBM is responsible under Section 3.3 but does not pay, and general and administrative expenses.

"Subcontractor" has the meaning set forth in Section 2.4.

"Taxes" has the meaning set forth in Section 3.3.

"Term" has the meaning set forth in Section 4.1.

"Third-Party Claim" has the meaning set forth in Section 7.3.

"TSA Services" has the meaning set forth in Section 2.1(a).

Schedule 1

Description of TSA Services

	Category	Services/Requirements	Fees/Costs
A	Technology Services/ Systems	1. General. Aetna currently operates the database systems and applications identified on Exhibit A hereto ("Systems"). To the extent permitted under applicable license agreements, Aetna will provide PBM with the Systems in accordance with past practices, including: (i) computer processing platform that supports the business applications, including operational support, application maintenance, and production processing; (ii) existing hardware (i.e., computers, servers, printers, routers, switches); and (iii) support for core infrastructure components (i.e., anti-virus, patch management, network monitoring and security, data backup, email and internet access). The Systems shall be available Monday through Sunday, except scheduled downtime. Only PBM personnel who have administrative tasks to perform at the application level and who have signed a non-disclosure form will be given access to the systems. Aetna will provide maintenance of Roles Based Security and Access controls (by employee) to applicable Systems. Aetna shall provide PBM with disaster recovery support related hereto. 2. Systems Upgrades. Technology improvements associated with Systems that are approved by both Aetna and PBM following the relevant PBM Services Commencement Date for such System.	Mail Order Pharmacy Information Systems Pompano Beach, Florida (Oracle Operating System): $583,000 per month while utilized by PBM mail order pharmacies* Kansas City, Missouri (Pharmacare Operating System): Aetna mail order pharmacy currently leases its mail order operating system from Pharmacare, an affiliate of PBM, pursuant to a lease agreement, which shall be assigned to and assumed by PBM as of the date the operating system is utilized by PBM mail order pharmacies. Specialty Pharmacy Information Systems (Orlando Florida, Florida Oracle Operating System): $250,000 per month while utilized by PBM specialty pharmacies* PBM Claims Processing Platform (APMCAS and related systems that are attached to such system): $833,000 per month while utilized by PBM through December 31, 2013. Commencing as of January 1, 2014, this fee will be revised according to the following schedule: - $625,000* per month for the first three full calendar months of 2014; - $415,000* per month for the next three full calendar months of 2014; - $210,000* per month for the next three full

	Category	Services/Requirements	Fees/Costs
			calendar months of 2014; - $105,000* per month for the next three full calendar months of 2014; - $0 per month for the first six full calendar months of 2015. - the lesser of (x) $100,000* or (y) fifty percent (50%) of Aetna's actual monthly costs to maintain APMCAS, as reasonably determined by Aetna, per month for the next twenty-four (24) full calendar months thereafter (the "Extended Fee Period"); *provided*, *however* that in no event shall the aggregate amount paid by PBM during the Extended Fee Period exceed $1,800,000. Following the Extended Fee Period, PBM shall have no further financial obligation to Aetna related to APMCAS and related systems that are attached to APMCAS. Aetna shall take such measures as are reasonably necessary to continue to maintain APMCAS through the Extended Fee Period. Following the expiration of the Extended Fee Period, and at no cost to PBM, Aetna will provide PBM with access to data housed in APMCAS in order for PBM to comply with its contractual obligations * Systems Upgrades: Monthly as costs are incurred on a cash basis *Such amounts shall be increased by three percent (3%) to adjust for inflation once every twelve (12) months. In the event PBM makes a Specialty Pharmacy System (as defined in Schedule N to the PBM

	Category	Services/Requirements	Fees/Costs
			Agreement) available to Aetna as contemplated by Section 3 of Schedule N-1 to the PBM Agreement, which system meets all of the existing requirements of Schedule N to the PBM Agreement (in particular the requirements of Sections 10, 11, 13, and 16 of Schedule N to the PBM Agreement) or any mutually agreed upon additional functionality, and Aetna elects, in its sole discretion, not to convert to such system (or delay conversion to such system), then PBM's obligation to pay the fee set forth above (initially $250,000 per month) shall end as of the date Aetna notifies PBM that it does not wish to convert to the Specialty Pharmacy System; *provided, however,* that such obligation shall automatically end in the event that Aetna does not provide notice of its intent to either convert or not convert to the Specialty Pharmacy system within ninety (90) days of the date PBM delivers the proposal for the Specialty Pharmacy System to Aetna. In addition, if Aetna elects, in its sole discretion, not to convert to such system (or delay conversion to such system), then each Party shall be responsible for its own costs associated with Aetna's connectivity to PBM's back-end fulfillment and order processing systems. In the event Aetna elects to convert to the Specialty Pharmacy System, the fee set forth above (initially $250,000 per month) shall continue for three (3) full months after Aetna completes the conversion.
B	Communications	1. Aetna will provide PBM with existing voice communication support,	Laptop Computer - $177 per month per

	Category	Services/Requirements	Fees/Costs
	Infrastructure	including voice line, PBX access, and voicemail, including existing hardware and software, based on past practices. 2. Aetna will provide support for existing network connectivity, including data lines, remote access, internet access, and existing hardware and software related thereto, based on past practices.	laptop computer assigned for use by PBM** Desktop Computer - $118 per month per desktop computer assigned for use by PBM** Network Access - $142 per month per connection for access** Telephone - $42 per month per telephone assigned for use by PBM, plus actual long distance cost** Plus telecommunication costs incurred in connection with establishing separate computer or telecom connectivity including hardware, software, build out and other related cost, to be paid monthly as such costs are incurred **Such amounts shall be adjusted by Aetna on an annual basis in accordance with Aetna's internal chargeback rate adjustment process to reflect internal chargeback rates in effect internally at Aetna for similar services.
C	Facilities Services	1. PBM will require the ability to occupy space, and obtain real estate and facilities services from Aetna in the following locations (collectively, the "Applicable Locations", or in the singular, each an "Applicable Location"): a. 730 Holiday Drive, Pittsburgh, PA; b. 300 Highway 160 South, St Louis Park, MN; c. 4400 NW, San Antonio, TX; d. 10991 NW Airworld, Kansas City, MO; g. 11500 NW Ambassador Drive, Kansas City, MO; and h. 2528 NW 19th Street, Pompano, FL.	The following terms shall be reflected in the formal agreements related to each Applicable Location: <u>Pompano Beach, Florida Mail Order Pharmacy Applicable Location</u> - $258,000 per month <u>Kansas City, Missouri Mail Order Pharmacy Applicable Location</u> - $75,000 per month <u>Applicable Locations In Which PBM Has</u>

	Category	Services/Requirements	Fees/Costs
		2. The parties acknowledge and agree that the formalization of such real estate transition services for the Applicable Locations will be completed between the time this Agreement is executed, through approximately October, 2010 (the "Real Estate Plan Period"). During the Real Estate Plan Period the parties shall work together, in good faith, to address the following issues in a separate written document for each Applicable Location, which issues may, or may not, be applicable based on the length of term: a. Length of term; b. Real estate services to be provided by Aetna to PBM, such as repair/maintenance, utilities, etc; c. Facilities services to be provided by Aetna to PBM, such as mail and security services; d. Payment of rent; and e. Demising of space, if necessary. 3. In addition, the parties acknowledge that landlord consent for some of the Applicable Locations will be required in order to allow PBM's employees to occupy Aetna space. The parties shall work together to obtain such consents prior to January 1, 2011. 4. During the formalization of the length of time PBM will occupy each Applicable Location, the parties will need to consider the opportunities that Aetna has at each location to terminate the entire lease, and/or surrender a portion of space, by providing notice to the applicable landlords by certain dates. These opportunities are critical to Aetna's real estate strategy and shall be taken into consideration during the Real Estate Plan Period.	Segregated Space (Excluding Mail Order Pharmacy Applicable Locations): Aetna will be reimbursed on a monthly basis its internal rent chargeback rates per square footage assigned for use by PBM in said facility. The internal rent chargeback rates shall be established by Aetna in accordance with its standard internal chargeback process to reflect internal chargeback rates in effect internally at Aetna for such facility). Applicable Locations In Which PBM and Aetna Employees Are Co-Located: Aetna will be reimbursed on a monthly basis its internal chargeback rate per PBM employee utilizing space in said facility. The internal chargeback rate shall be established by Aetna in accordance with its standard internal chargeback process to reflect internal chargeback rates per Aetna employee in effect internally at Aetna for such facility. In addition, physical build out costs (to be mutually agreed upon) associated with modifying facilities to have appropriate security and/or firewalls between Aetna and PBM co-located employees, to be reimbursed monthly as costs are incurred.
D	Mail Order Fulfillment Equipment	1. Aetna mail order pharmacies shall provide the pharmacy back-end fulfillment equipment currently in place ("Fulfillment Equipment") in accordance with Schedule M-1 of the PBM Agreement and shall maintain such Fulfillment Equipment in accordance with past practices.	PBM will reimburse Aetna for the depreciation of the equipment, maintenance and other costs associated with the equipment, including utilities, and all third party leasing and service costs, all to be

	Category	Services/Requirements	Fees/Costs
			reimbursed monthly.
E	Vendor Management	1. In order to facilitate an orderly transition during the Transition-In Phase of the PBM Agreement, Aetna will allow PBM to procure services through Aetna's existing supplier agreements in effect as of the PBM Service Commencement Date for a reasonable period following such PBM Services Commencement Date commensurate with PBM's responsibilities pursuant to the Agreement.	PBM will reimburse Aetna its costs related to payment to such vendors at least monthly or as otherwise required in accordance with Aetna's existing contract terms with such vendors.
H	Other Services	1. Aetna will provide such other services as mutually agreed upon.	To be mutually agreed upon.

Exhibit A

Name	Activities / Description
APMCAS	Real-time, POS **Aetna Pharmacy Claim Adjudication System** - adjudicates pharmacy claims in a 7x24 real time environment.
MOD Captiva	Produces electronic files based on scanned image documents. ***EMC* owned product**.
ASRx (Compass)	Application used for fulfillment of Specialty Pharmacy prescriptions.
DMR.DL	**Direct Member Reimbursement (DMR) Claim Denial Letters.** Creates letters direct to members based on state compliance regulations.
FSE	**Formulary Search Engine**. Enables Aetna members to search for drugs covered in their formulary plan.
MOD	Provides order entry, call center, inventory management, and related capabilities to support Aetna Pharmacy's **Mail Order Delivery** business.
MODPortal	MOD Portal (built off the MOD system – Oracle-based delivery) for operational reports.
PDED	CMS interface to report **Pharmacy Drug Event Data** (Rx Claims). Also provides capability to correct rejected Rx claims.
PreCert.Let	Prior Authorization approval and denial letters direct to members (and in some cases providers).
Rx.HMO	**HMO interface** for member, group and benefit data to the Rx systems (RXSY and APMCAS).
Rx.RDS	**Rx Reporting Data Store** (data mart) for CMS Reporting and other ancillary processing.
RxCompounder	Specialty Pharmacy application that assembles pharmaceutical components to form a compound and provides compound pricing. Vendor product (*PK Software*).
RxNavigator	Pharmacy Aetna Navigator (RxNavigator) is a component of the Aetna Navigator member website.
RxSy	Transforms plan benefits and member eligibility from Traditional and HMO platforms to the required format for APMCAS Rx adjudication. Acts as the intermediary for invoice claims from APMCAS to the payment systems for payment to providers & members. Processes & calculates rebate invoice and allocate dollars received from manufacturers. (**Rx System**)
SI Baker	High volume prescription fulfillment system. Works in concert with the MOD Aetna application. Aetna owned but vendor supported application (*McKesson*).
RxImtStmt	**Itemized Statements** is used to generate detailed monthly Explanation of Benefits for Aetna Medicare members.
EOB	**Formulary Comments for Pharmacy EOBs** is a Web application for entering comments to be entered on Pharmacy EOBs for Medicare patients. The comments are for Formulary notices about current or future drug changes (e.g., a drug going off patent or a drug being withdrawn).
SUB28	**28% Subsidy Web GUI** is a RxSy subsystem that enables business to upload information for MMA grievance and appeals related data.
FMM	**Formulary Mass Maintenance** automates the installation and maintenance process for plan sponsors with custom formularies in support of five static drug lists to be marketed to self-insured National Accounts and large Key Account plan sponsors.

Name	Activities / Description
TOC	**Termination of Coverage Letters** creates letters for Medicare Transition of Coverage.
RxClinicMaint	**Rx Clinical Maintenance** edits data for Formulary Search Engine (FSE).
NIS	The **Network Imaging System** images, stores, and retrieves Pharmacy network contracts and associated documentation for contract management.
AESecure	Secure storage of credit card information allowing MOD and ASRx to process credit card information through tokenization (PCI compliant)
PRICE A DRUG	Used to run a "test" claim for a drug to determine member responsibility.
RXONLINE	Aetna Pharmacy Management System
SalesForce.com	A web based sales support application used by ASRx inside sales team
First Data Bank	Used by ASRx for dispensing information and pricing
Other Enterprise Systems	Access will be provided to individual transferred employees to Aetna Enterprise Systems based on Roles Based Access Controls for each position, to be determined by Parties

Schedule A-7

Acquisition Transition Services

This Schedule A-7 applies to activities related to the transition of business of Coventry Healthcare from its existing pharmacy benefit manager to PBM, consistent with Aetna's contractual commitments to the existing pharmacy benefit manager, and to any future corporate acquisitions Aetna may conduct during the term of this Agreement. Schedules A and A-1 through A-6 shall remain in effect for the term of this Agreement and shall govern any remaining transition-related activities within the original scope of those Schedules relating to the transition of business to PBM's systems from Aetna's systems, including, without limitation, the transition of Aetna's Medicare business to PBM's claim system. Nothing in this Schedule A-7 shall be construed to alter or limit Aetna's rights and obligations under Section 16.3 of the Agreement.

Service	Description
Objectives and Goals	1. The principal objectives and goals of the Program are as follows: a. Minimizing Member and Customer disruption – All Member and Customer administrative and other migration activities and tasks and conversion phases shall be structured to minimize disruption to Members' experience and Member and Customer perception of service quality b. Achieving a smooth transition from the existing pharmacy benefit manager to PBM with no significant disruptions to Customers, Members or the business operations of Aetna. c. Maintaining and enhancing Aetna's "Integrated Value Proposition" – Member and Aetna Customer migration phases should synchronize with the implementation of new business operations and technology that will facilitate the integrated experience. d. Minimizing business impact – Implementation, integration and migration activities shall be structured and carried out to reduce potential adverse impacts to the business of Aetna, including potential bottlenecks during year-end renewals and other business events.
Transition Governance & Personnel	2. Aetna, any relevant parties of the acquired entity(ies) referenced above, and PBM will establish a Joint Transition Committee ("JTC") to oversee and coordinate the transition activities of all lines of business of the acquired entity (ies) (the transition activities noted herein shall be referred to as the "Program"). This team will be composed of Senior Leaders who will act as decision makers across

Service	Description
	all organizations and meet on a regular, agreed upon frequency. The joint governance for transition activities may be integrated and / or consolidated with existing forums for management of the PBM agreement. 3. Aetna and PBM and entity(ies) referenced above shall, no later than November 15, 2013 appoint appropriate representatives and other personnel to a transition team (the "Transition Team") to coordinate and oversee the Program and to otherwise execute the transfer of the PBM Services, including at least one representative with expertise in each of the domains identified in Sections 9.a and 9.b below. The composition of the Transition Team will evolve as the project moves forward. The PBM's resources assigned to this task must be dedicated to the implementation effort. Aetna, PBM and entity(ies) resources assigned to this task, including subject matter experts on specific domains, must have enough domain expertise to help provide intelligent input into the business requirements. 4. PBM and Aetna will proactively identify, recommend and define execution plans for technology, resource, quality and process modifications to adequately support the transition of business as well as the post transition operating model. PBM will proactively share best practices relating to similar transitions of this scale. 5. Each organization will be accountable for ensuring the appropriate communication within its own organization to ensure joint success. PBM will assist in developing communications materials that can be used by Aetna for this purpose. PBM resources may not be available to act as the primary communication liaison among Aetna business units. Each organization will be responsible for assigning an individual (or group of individuals) responsible for cross-functional intra-communications within their respective organizations that deliver consistent joint messages. Additionally, this individual (or group) will be responsible for activities that promote organizational change management adoption within their respective organizations to ensure that each organization is ready to accept and adapt to the new future operating model post-transition. 6. The Transition Team will be engaged in every major implementation activity under this Schedule A-7 involving PBM Services. 7. PBM shall establish resources to proactively manage data exchanges, fallout, controls, and reporting relating to responsibilities delegated to the PBM.

Service	Description
Transition Timeline	8. The Transition Team, at a date, time, and location acceptable to Aetna, shall convene to discuss and develop, in good faith, a detailed plan to transition the PBM Services of the Coventry Healthcare line of businesses to the PBM, consistent with pre-existing contractual obligations. The plan will provide a roadmap for the successful transition of the Coventry Healthcare line of businesses, Covered Plans, and Members to PBM's systems and services described in the Agreement including retail, mail and specialty claims under Covered Plans. The Transition Team will review project scope and define business requirements prior to the finalization of timelines and milestones. Project scope and critical business requirements will be defined within the timeline outlined in Section 9 of this Schedule A-7. The timelines and milestones shall be finalized by the Parties within thirty (30) days of completion of the business requirements. As part of this Transition Plan, Aetna and PBM will mutually agree to Customer specific transition dates occurring during the Transition Period. 9. Aetna, in consultation with PBM, will establish a kick off date and will immediately provide PBM with information regarding existing project plans requiring the pharmacy program alignment, along with all other key information needed to adequately prepare PBM. The Transition Team will have one hundred twenty (120) business days to complete the critical business requirements from the Program kickoff date established by Aetna, in consultation with PBM. . All Parties must have Key Personnel (defined below) identified, and staffing commitments finalized, prior to the commencement of the one hundred twenty (120) day period. All business requirements must be reviewed and approved by the Transition Team. The Parties shall make best efforts to seek to resolve any disputes relating to business requirements through the JTC. The start date for this activity will not be the Agreement Effective Date. The cycle described herein must be applied individually to all implementation activities including Commercial, Medicare, and Medicaid and other lines of business, and the Parties acknowledge each line of business may have different timelines and requirements, and that Aetna intends to conduct the entire process consistent with its contractual commitments to the existing pharmacy benefit manager. The Key Personnel for purposes of the Program shall, at a minimum, include the following:

Service	Description
	a. PBM Key Personnel will include, but not be limited to, resources from: Client Implementation, IT, Account Management, Client Benefits, and Operational business areas. PBM Key Personnel shall also include team members with detailed knowledge of the Aetna models, tools, systems and processes currently employed to manage Aetna business on the PBM's platform. b. Aetna Key Personnel will include, but not be limited to, resources from: IT, key decision makers in Aetna Pharmacy Management, Account Management, Operations, and individuals with detailed subject matter expertise with respect to benefit set-up/intent, and internal and external communications. 10. The final Program timelines will be agreed to within forty-five (45) business days after the business requirements have been approved by the Transition Team and JTC. This will allow the IT teams of all Parties time to evaluate any major changes to IT systems, applications, and infrastructure and provide input into the Program timelines. 11. Any changes to business requirements, scope, or timelines requested after the JTC has approved the initial business requirements will need to follow the Change Request process outlined in Section 11. The JTC must approve any changes to delivery dates, scope, and funding. Timelines and delivery dates will need to be re-evaluated based on the content of the change request. 12. A resource from each organization must be assigned to track and monitor all change requests. This team will be responsible for jointly ensuring that all approved changes are cascaded down to representatives across each organization in a timely manner.
Change Control	13. The JTC will be responsible for applying Change control processes and standards to the Program. Change control applies to all major milestones after the Program has completed the requirements phase. In some cases, the approval of a change request may require delivery dates to be modified. The JTC must approve any changes to delivery dates, scope, and funding. 14. A resource from each organization must be assigned to track and

Service	Description
	monitor all change requests. This team will be responsible for jointly ensuring that all approved changes are cascaded down to representatives across each organization in a timely manner.
Program Approvals	15. Aetna must clearly identify resources that will be responsible for approving project-level artifacts and benefit testing results created by PBM. These resources must adhere to providing written approvals to necessary project artifacts within five (5) business days, unless otherwise agreed to by the Parties, provided that the resources are given all necessary information to make an informed judgment on such artifacts. PBM will be unable to guarantee timely delivery of any project deliverables associated to any project where approvals are not received within five (5) business days of the date the reviewer is given all necessary information to make an informed judgment. 16. In the event the Aetna reviewer requests additional information relating to the project deliverables, benefit testing results and corresponding artifacts, PBM shall provide such information within five (5) business days. It is the responsibility of PBM to afford sufficient time in its project planning for this review process. 17. PBM shall create and review with Aetna business requirements documentation and will provide to Aetna detailed schedules for testing acceptable to Aetna. 18. Prior to the Program kickoff date and again prior to execution of Program business requirements, PBM shall provide the staffing reasonably necessary to meet Program requirements in a timely fashion, consistent with the requirements of the Agreement, and that the staff assigned to the various Program elements have appropriate skills, training and experience for their assigned roles; provided, however, such staff shall be subject to Aetna's approval, which shall not be unreasonably withheld. 19. A delegate must be identified in those instances where a named resource will be out of the office or unable to provide written approval within five (5) business days. Delivery timelines will be re-evaluated, and reasonable adjustments made, after all written business approvals are received.
Policies and Procedures	20. PBM shall be responsible for the development of policies and procedures for execution of Program requirements, including quality assurance. Such policies and procedures shall be developed in

Service	Description
	consultation with Aetna and shall be consistent with the provisions of Section 14.2 of the Agreement.
Professional conduct	21. All project team members from each organization must display the highest levels of professional courtesy and respect at all times. Any instance of poor behavior can be reported into each individual HR department and/or raised to the JTC. At such time, the situation will be reviewed by HR and/or the JTC. Either organization may require the removal of an individual from the Program if the organization has filed a written compliant with the other Party and resolution is not attainable within ninety (90) days.
Deliverables	22. To ensure a successful transition, all Parties must deliver on project tasks and major milestones (i.e., system enhancements, process modifications, eligibility files, CRDs, etc) within jointly agreed upon timelines.
Cooperation	23. The Parties shall cooperate with one another in accordance with the provisions of Section 6.3 of Schedule A.
Cost	24. Except as otherwise explicitly set forth in the Agreement, each Party shall bear its own costs in connection with all transition-related activities under this Schedule A-7.

Schedule AA

PBM Licensed IP

***Additional licenses and applications needed in connection with the services provided under the Agreement to be made available as identified and/or developed as mutually agreed by the Parties.*

PBM completes the template for all applications / data bases required to support Aetna contracted business processes including but not limited to claims processing, customer support, reporting, mail order and specialty processes.

Application / Data Base	Application / Data Base Functional Description	Business' Processes Supported
LINKS – Tier 1	Mail order processing application	Mail Order System
PeopleSafe – Tier 1	Customer Care application used to service member calls. CRM tool.	Customer Service
RxClaim – Tier 1	Claim Adjudication platform	Adjudication Engine
RxSpecialty (previously ESPS) – Tier 1	Specialty drug processing application	Specialty System
Fairfax – Tier 1	Imaging	Mail Order
TriStar – Tier 1	Pharmacy Dispensing Automation	Mail Order
CAS – Tier 1	Prior Authorization System	Clinical
Nuance IVR – Tier 1	Interactive voice response unit for participant self service	Customer Service
Caremark Messaging Platform (CMP) – Tier 1	Outbound messaging via phone, web and text	Customer Service
CareSource – Tier 1	Online work instructions and support documentation for Customer Care representatives	Customer Service
RxSource – Tier 1	Online work instruction and support documentation for Mail Order colleagues	Mail Order
Client Care Access (CCA) – Tier 1	Single sign-on portal for clients to access designated applications.	Customer Service
Enhanced Client Display/Client Access – Tier 1	Web based client inquiry tool for RxClaim (Available post-migration)	Customer Service
Caremark.com (to be re-launched as CVSCaremark.com) – Tier 1	Member Portal; self service internet web site, inclusive of all associated applications: Google Health, Microsoft Health Vault, Dossier, Web services, Single Sign-on	Customer Service

ECS (Enterprise Common Services) - Tier 1	Common messaging architecture and services for accessing information from source applications.	Adjudication
Consumer Driven Health (CDH) – Tier 1	Integrated application with Health Care Providers to coordinate deductibles among other accumulators across Medical and Prescriptions.	Customer Service
Enterprise Adjustment Systems – Tier 1	The system handles the introduction of adjustment requests. The financial impacts are calculated for each entity involved with a claim.	Government Services
RetroDUR – Tier 1	Clinical rules engine which identifies opportunities (savings & clinical) to intervene with physicians Compliance & Persistency: Adherence intervention application Enterprise Opportunity Management System: Rules Engine with creates or manages message opportunities to be delivered through CVS Caremark communication channels such as call center, portal, pharmacy, IVR or print.	Adjudication
EC (Eligibility Central) – Tier 1	Eligibility Central data store containing all eligibility information	Eligibility
Sterling Integrator – Tier 1	Eligibility File Integrator	Eligibility
Sentry – Tier 1	Eligibility configuration tool	Eligibility
iTools – Tier 2	Complex query building tool for scheduled reporting against EDW	Reporting
RxInsights – Tier 2	Cost and utilization report tool	Reporting
RxPipeline – Tier 2	Online access to new products and upcoming generics	Customer Service
RxHub – Tier 2	Process electronic transactions to/from prescribers - including eligibility, claim history and formulary/drug coverage inquiries, new prescriptions, renewal requests/response, fill notification, rx change request/response, rx cancel request/response.	Adjudication
Clinical Services System –	Application which targets	Clinical

Tier 2	participants for gaps in care opportunities.	
Prescription Savings Guide IBenefits – Tier 2	Member focused comprehensive report based on their utilization trend which advises them on the best use of their prescription benefit.	Customer Service
Enterprise Data Warehouse (EDW) – Tier 3	Reporting data mart.	Reporting
BART – Tier 4	Benefits and Request Tracking	Account Management
RxNavigator – Tier 4	Ad Hoc reporting tool	Reporting

Schedule BB

Description of PBM Designated and Dedicated Personnel

To conform with Section 16.1(a) of the Agreement, this Schedule BB will be updated and revised to (i) describe Aetna Designated and Dedicated Key Personnel and (ii) clarify that neither Party shall, directly or indirectly, solicit for employment, recruit or hire any employee of the other Party or its Affiliates serving in a position identified as Key Personnel herein.

Additional defined terms for this Schedule BB (Description of PBM Designated and Dedicated Personnel):

"Dedicated" means a position that is occupied by a full-time PBM employee and spends 100% of his/her work time performing PBM Services and shall not provide services to other customers or customer accounts of PBM.

"Designated" means a position that is occupied by a full-time PBM employee who regularly spends a portion of his/her work time performing PBM Services.

"Key Personnel" means those Dedicated and Designated personnel who are critical to the performance of PBM Services and whose absence therefrom would have a significant negative impact thereon. The Key Personnel as of the Effective Date are identified in the table at the end of this Schedule BB. Aetna may identify additional roles as Key Personnel in response to changing circumstances to appropriately support Aetna's ongoing business needs, subject to PBM's approval, which shall not be unreasonably withheld.

All Dedicated and Designated personnel will possess employment tenure, skills and capabilities acceptable to Aetna; capabilities and expertise must include but will not be limited to a significant understanding of the PBM industry, PBM operations and end to end business processes, pharmacy related regulatory and compliance requirements, business line or segment specific requirements (e.g., Medicare or Medicaid) and the PBM organization, key personnel, systems, processes and procedures. Dedicated and Designated personnel will be required to fully understand Aetna's requirements for performing PBM Services. Aetna reserves the right to assign such personnel to specific segments of Aetna's business (e.g., Medicare, Medicaid, or commercial, etc.) as it deems necessary.

PBM shall designate and/or dedicate the Key Personnel positions described below to perform PBM Services in accordance with the various Schedules and Article V of the Agreement. Unless otherwise indicated, the positions described below shall service all lines of Aetna's business.

On a quarterly basis, PBM shall provide a list of Deployed Persons identified as either Dedicated or Designated personnel. Changes to this list will be subject to the provisions of Section 5.4 of the Agreement, including with limitation a PBM Employee Transition Plan. PBM shall complete the actions required under the applicable PBM Employee Transition Plan within six (6) months of PBM's submission of such PBM Employee Transition Plan to Aetna and, during such period, PBM shall not reassign or otherwise modify the responsibilities of any Deployed Person that is the subject of the PBM Employee Transition Plan.

Aetna may approve or disapprove candidates for Key Personnel, provided that Aetna's approval shall not be unreasonably withheld.

All functions performed by PBM will be sufficiently staffed and trained to achieve related performance guarantees. Consistent with the provisions of Section 3.6 of the Agreement, and subject to the exceptions therein, PBM must seek Aetna's written approval for all Subcontractor

relationships. In connection with that approval, PBM must identify to Aetna the extent to which Subcontractor personnel will be performing Services historically performed by PBM personnel. If Subcontractor personnel are engaged to perform Services in more than a supplemental or contingent capacity, PBM's written request for approval must so indicate, and upon written approval by Aetna, the use of that Subcontractor's personnel must continue to conform to the description in the request for approval.

The assignment to and removal from the Key Personnel positions listed below in this Schedule BB (Description of PBM Designated and Dedicated Personnel) shall be in accordance with Article V of the Agreement and this Schedule BB (Description of PBM Designated and Dedicated Personnel).

The following chart outlines positions identified as Key Personnel required to be staffed by the PBM. These are all Dedicated PBM employees who are responsible for supporting Aetna's book of business. These Key Personnel are accountable for all results and management of employee performance of teams described in this section. Responsibilities of the PBM are not limited to these functional areas.

Key Personnel	Description of Dedicated Management Function
Senior Level Executive for Aetna Book of Business	The Senior Level Executive for the Aetna Book of Business has executive responsibility for all aspects of running PBM operations and program. This individual is fully accountable for all results of PBM Services performed under the terms of the Agreement. Has a proven track record of leading and managing large business operations and has direct reporting relationship to PBM executive leadership.
Senior Level Aetna Operations Lead	The Senior Level Operations Lead is accountable for all PBM operations, including but not limited to member services, member experience, network establishment and management, prior authorization, claims and fulfillment.
Aetna Contract Lead	Accountable for all Aetna relationship functions including contractual and performance issues. Responsible for the successful execution and implementation of program level activities and initiatives to support Aetna's book of business. Responsible for management and delivery of the terms and conditions of the Agreement and supporting Schedules, including monitoring and reporting on PBM operational results and performance guarantees
Aetna Clinical Program and Product Lead	Accountable for all aspects of clinical operations; provides dedicated consultation to Aetna clinical leaders to support successful execution of Aetna designed clinical programs, formulary and other clinical initiatives within the PBM business and systems environment. Additionally, the Clinical Program and Product Lead provides program management expertise to assure successful execution of new products, programs, business initiatives, and business models.
Aetna Client Service Lead	Responsible for the successful execution and performance of all account functions (e.g., eligibility, benefits administration, benefit control operations including clinical program changes, Plan changes, and any changes that impact the coding of the claims adjudication system, Medicaid, Medicare Part D Operations, paper claims). Expected skills include Plan management experience

Key Personnel	Description of Dedicated Management Function
Aetna Client Service Lead (Continued)	and industry knowledge. Accountable for all areas of client service including case installations. Staffing will consist of Dedicated employees that will work on behalf of Aetna's business lines, customer segments and customers. These areas will be adequately staffed and trained to work with the Aetna pharmacy account management teams to support Aetna and achieve related performance guarantees. This individual is accountable for all aspects of issue resolution.
Senior Level Aetna Commercial Business Owner	Accountable for delivery of all Commercial business PBM results for Aetna. Responsible for teams performing PBM services as specified throughout all schedules.
Senior Level Aetna Medicare Business Owner	Accountable for delivery of all Medicare PBM results for Aetna. Responsible for teams performing Medicare PBM Services as specified in Schedule O (Medicare Services).
Senior Level Aetna Medicaid Business Owner	Accountable for delivery of all Medicaid PBM results for Aetna. Responsible for each state Medicaid plan as specified in Schedule P (Medicaid) and its state specific sub schedules.

Schedule B

Benefit Plan Set Up

Core Services

Service	Description
Benefit Plan Set Up and Member and Group Eligibility Coordination	1. PBM shall use its best efforts to coordinate Benefit Plan Design set up and Eligibility Data management with Aetna to ensure plan benefits and membership are accurately entered into the PBM claim adjudication system prior to the effective date of the plan benefits, group effective date and Member's effective date of coverage and in accordance with this Schedule B (Benefit Plan Set Up)**.**
Benefit Plan Design Administration	2. PBM shall use its best efforts to code Benefit Plan Design data and Eligibility Data into its system(s) in a manner that reflects Aetna's usual and customary business practices. PBM shall accept from Aetna in a reasonable Aetna-specified format, apply, comply with, and otherwise utilize for adjudication purposes the Benefit Plan Design information furnished by Aetna or, at Aetna's direction, Aetna Plan Affiliates, including any and all Formularies established by Aetna, its designees, or Aetna Customers. PBM shall load such Formularies and other Benefit Plan Design information into the electronic claims adjudication system to ensure that proper editing and messaging is provided at the point-of-sale ("POS") in accordance with this Schedule B (Benefit Plan Set Up). 3. PBM shall load, update, and implement Benefit Plan Design information (new Benefit Plan Designs and revisions to existing Benefit Plan Designs) as follows: a. General Timing Parameters: PBM shall in all cases make best efforts to load and implement Benefit Plan Design information at least five (5) calendar days prior to the effective date. In addition, PBM shall load and implement Benefit Plan Design information in accordance with the specific timeframes set forth in Paragraph 3(b) below**.** Aetna will provide PBM with a monthly forecast of Benefit Plan volume sixty (60) days prior to the 1st day of the month, with agreed upon Benefit Plan volume revisions thirty (30) days prior to the first day of the month, except for January 1 plan volumes (hereinafter referred to as "Welcome Season Volumes"). With respect to all Benefit Plan volume Information updates, PBM agrees to apply appropriate resources (i.e. staffing, technology or process) to meet those forecasted plan volumes, including a staffing cushion of 12% applied by PBM to account for unknown instances. Welcome Season Volumes planning will include a forecast of plan volumes August 1st, agreed upon revision of forecast by September 1st, and Welcome Season Volume submission starting on October 1st of each year. PBM will apply a 5% staffing cushion to the Welcome Season Volumes for unknown instances.

Service	Description
	Aetna agrees to submit Benefit Plan Design documentation to PBM each month on the following schedule: 25% of the total monthly plan volume before the 15th of the month 75% of the total monthly plan volume before the 25th of the month Both Aetna and PBM acknowledge that Aetna may not be able to provide 100% of the Plan Design Information before the end of the month or before the plan effective date. Plans provided at the end of the month or after the plan effective date will be handled based on an agreed upon plan turn-around time and will be included in Performance Guarantee calculations based on the date provided. In the event the actual benefit plan forecast volumes for each month are over or under forecast for two months in a calendar year, by 20% or greater, the applicable Performance Guarantee penalty assessed, relating to Benefit Plan change turn-around times, will be reduced by 30% for each month this event occurs. Monthly staffing cushion applied by PBM is not considered part of the Aetna forecast for determination of forecasting accuracy. Regardless of accuracy of the monthly or Welcome Season forecast, PBM will make best efforts to code all plans in a timely manner working to ensure a good member experience. Upon PBM's receipt of Aetna's approval of Benefit Plan Design testing, PBM shall promote Benefit Plan Design coding to production within one (1) business day. If Aetna requests corrections upon review of plan design testing, PBM will make appropriate corrections to the coding and provide Aetna with a revised Benefit Plan Design coding for Aetna to approve within three (3) business days, or as otherwise mutually agreed upon by Aetna and PBM. b. <u>Benefit Plan Loads (excluding Formularies)</u>: i. <u>Automated Loads</u>: The automated loading of Benefit Plan Designs shall begin ninety (90) days prior to PBM Services Commencement Date. Following the PBM Services Commencement Date, for new groups using existing benefit structure and for changes to existing groups using the existing benefit structure (e.g., group changes, copay changes), PBM shall make best efforts to accept Benefit Plan Design information via automated benefit loads from Aetna through an electronic feed in a mutually agreed upon format. PBM shall apply mutually agreed upon edits and parameters to all automated benefit loads prior to implementation of that automated load. Unless both parties agree on alternative batch deadline times per day, PBM shall load and implement such Benefit Plan Design information as follows:

Service	Description
	a. If received by PBM on or before 2:00 a.m. (Monday through Saturday), PBM shall load and implement into the pre-production system at least 85% of the Benefit Plan Design information (measured on a plan basis) same day and 100% within twenty four (24) hours. b. If received by PBM after 2:00 a.m. (Monday through Saturday), PBM shall load and implement into the pre-production system at least 85% the Benefit Plan Design Information (measured on a plan basis) within 24 hours (excluding Sundays) and 100% within 36 hours. c. In the event there is a critical error (critical errors to be defined and mutually agreed upon by the Parties) with the automated load, the Benefit Plan Design will not be implemented and PBM shall immediately notify Aetna in writing and make best efforts to resolve the error within twenty-four (24) hours or such longer time period reasonably agreed upon by Aetna so that the Benefit Plan Design can be implemented without error at the following 7:00 a.m. release. ii. Manual Benefit Plan Design Loads Not Requiring New System Coding. For means other than an automated benefit load, PBM shall accept Benefit Plan Design information from Aetna in a mutually agreed upon format via a mutually agreed upon electronic channel and shall load and implement such Benefit Plan Design information as follows: a. When PBM receives Benefit Plan Design information that requires a manual load but involves no or simple configuration (e.g., copay value changes, reasonable changes to existing groups and existing drug lists), PBM shall load and implement the Benefit Plan Design information within three (3) Business Days of receipt of the Benefit Plan Design information. b. When PBM receives Benefit Plan Design information that requires complex configurations (e.g., new drug lists, new open enrollment or umbrella groups), PBM shall load and implement the Benefit Plan Design information within twelve (12) calendar days of receipt of the Benefit Plan Design information. iii. Manual Benefit Plan Design Loads Requiring New System Coding. When PBM receives Benefit Plan Design information that reasonably requires new coding to implement (e.g., new complex clinical rules, new cost share or pricing logic not available in configurable templates), PBM shall promptly notify Aetna in writing that new system coding is required. Within thirty (30) calendar days from PBM's receipt of the Benefit Plan Design information, PBM shall prepare and deliver to Aetna a written

Service	Description
	requirements document setting forth the requirements and associated timeline for such coding, which shall be subject to Aetna's written approval. Upon PBM's receipt of Aetna's written approval of the requirements document, PBM shall complete the new system coding, comprehensive testing and load and implement the Benefit Plan Design information within one hundred twenty (120)calendar days (unless an alternative timeframe is mutually agreed upon by the Parties) of receipt of Aetna's written approval of the requirements document. In cases where implementation of the Benefit Plan Design information is contingent upon Client Acceptance Testing (CAT), PBM shall complete CAT immediately after loading the Benefit Plan Design information (in accordance with the timeline hereunder) and shall immediately provide the CAT results to Aetna. After Aetna's review of the CAT results, upon receipt of written direction from Aetna, PBM shall implement the Benefit Plan Design information within five (5) Business Days, but not later than one (1) day prior to the group and/or member effective date. 4. Testing - Benefit Plan Set Up/Changes. a. Testing Parameters. i. Manual Benefit Plan Design Loads Not Requiring New System Coding. PBM and Aetna shall mutually agree on the testing parameters that PBM shall apply to manual loads not requiring new system coding, but in all cases, at a minimum, the testing shall include testing with respect to the addition(s) or change(s) manually input. The testing by PBM shall include a minimum of five hundred (500) Claims per day. ii. Manual Benefit Plan Design Loads Requiring New System Coding. PBM and Aetna shall mutually agree on the testing parameters that PBM shall apply to manual loads requiring new system coding, but in all cases, at a minimum, the testing shall confirm accurate Claim rejections, Claim payments, application of accumulators, compliance with Formulary, messaging, and all other mutually agreed upon functions of benefit administration. b. Test Results and Corrections. For all testing, PBM shall produce to Aetna (in a format mutually agreed to by the Parties), all testing results at the overall Aetna level as well as at the Aetna Customer level within a reasonable time after test completion but no later than forty-eight (48) hours after the completion of the testing by PBM. PBM shall make best efforts to correct all testing errors by the later of (i) the effective date of the Benefit Plan Design implementation or revisions, as applicable; or (ii) within twenty-four (24) hours after completion of the testing by PBM. Test plans for all testing must receive Aetna's prior approval. Aetna and PBM shall mutually develop and agree upon a test bed to test plan changes so as to

Service	Description
	minimize the amount of time it will take to develop and approve test plans and to facilitate the testing. Benefit Plan Design test results will be provided by the PBM to Aetna in a format that is user-friendly to Aetna personnel who are not experts in the field of benefit plan services. The PBM will also provide training to Aetna on the analysis and review of the test results. For purposes of this Schedule B (Benefit Plan Set Up), "error" shall mean any and all inaccuracies, mistakes, or omissions, regardless of materiality. c. Timing of Testing. Unless otherwise mutually agreed in writing, all testing shall be done prior to implementation and in sufficient time to test and correct testing errors prior to the implementation time lines set forth in paragraph 3, above, of this Schedule B (Benefit Plan Set Up). In addition, PBM shall execute Claims testing on an alternative reasonable schedule when required by specific Aetna Customers as identified by Aetna from time to time. 5. PBM shall obtain Aetna's prior approval (and the approval of any applicable Aetna Customers, upon Aetna's request) of, and implement, all plan level adjudication edits and hierarchy of Benefit Plan Design administration. PBM shall make such modifications as shall be necessary to address and resolve any concerns and issues reasonably raised by Aetna (or the applicable Aetna Customer) regarding Benefit Plan Design set-up and administration. 6. PBM shall provide to Aetna on a weekly basis a Benefit Plan Design information progress log, which tracks the status of loading, implementing, testing, and correcting Benefit Plan Design information (including Formularies) that is in progress and the status of such work completed or pending in accordance with Schedule V (Reporting). 7. PBM shall establish and utilize such policies and procedures and take such other actions as shall be necessary to ensure that Benefit Plan Design set-up and administration are provided in accordance with this Schedule B (Benefit Plan Set Up). PBM shall modify such policies and procedures as necessary to address and resolve any concerns and issues reasonably raised by Aetna. 8. Aetna may audit the testing, policies and procedures, and other requirements under and in connection with this Schedule B (Benefit Plan Set Up) in accordance with Schedule X (Audits) and Article VII of the Agreement. 9. As provided in Sections 7.4, 9.8, and 9.12 of the Agreement and the Claims Errors/Corrections section of Schedule D (Claims Processing and Adjudication)**,** PBM shall be responsible and liable for Losses to extent imposed on Aetna by an Aetna Customer and/or Law, related to errors in Benefit Plan Design (including Formularies) set up and administration, to the extent the error is not a result of incorrect Benefit Plan Design information provided by Aetna or otherwise caused by Aetna (in which cases the Losses and interest payments and/or penalties will be allocated

Service	Description
	according to each party's respective responsibility for such error).
Quality Assurance	10. PBM shall have a quality assurance program to ensure that the Benefit Plan Design (including Formularies) set-up and administration are provided in accordance with this Schedule B (Benefit Plan Set Up), and PBM shall provide to Aetna on a monthly basis the results of such quality assurance program.
Training	11. In a manner, location, and frequency reasonably acceptable to Aetna, subject to Section 11.5 and Article XIII of the Agreement, PBM shall provide initial and ongoing training for Aetna personnel with respect to developing an understanding of Benefit Plan Design (including Formularies) set up in the PBM claim adjudication system.

Schedule C

Eligibility

Core Services

Service	Description
Member and Group Eligibility	1. PBM shall receive, in an Aetna-specified format, and implement Eligibility Data along with pertinent ancillary data (e.g., coordination of business, diagnosis, lab data, etc.) ("Ancillary Data") with an Aetna-specified hierarchy, in accordance with timelines set forth in Paragraph 3 of this Schedule C (Eligibility), provided that Aetna includes all of the data elements reasonably required to load the information into PBM's eligibility system. 2. PBM shall maintain all Eligibility Data provided by Aetna to PBM in accordance with the document retention requirements of the Agreement. 3. PBM shall load and update the Eligibility Data: (i) on at least a daily basis (every calendar day) or more frequently if mutually agreed upon; and (ii) in a manner such that the nature, quality, standard of care, and service levels at which such updates are done are no less than the nature, quality, standard of care, and service levels at which Aetna updated the Eligibility Data during the period immediately prior to the Effective Date as communicated by Aetna to PBM. For purposes of clarification, Eligibility and Ancillary Data must be made available in the Participating Pharmacy claim adjudication system and any other systems utilized by PBM contact services within 24 hours of receipt of clean eligibility by PBM. A "clean eligibility" file for purposes of the Agreement is one that does not require the recipient to investigate, develop or clarify any further information before loading. 4. PBM shall accept Eligibility Data and Ancillary Data from Aetna in at least the following three (3) ways: a. Electronic: Aetna provides to PBM daily electronic files via electronic channels. b. Manual: PBM representatives shall be available to enter a reasonable number of temporary eligibility override transactions received via telephone, email, and such other mutually agreed upon means, including eligibility effective and termination dates for worker compensation Members on a close to real-time basis. c. Online (real-time): If applicable, Aetna will process Eligibility Data additions and changes real time via a PBM provided web-based tool. PBM and Aetna will create and agree to a service escalation process. This process will accommodate referrals to handle emergency transactions and address issues that need immediate attention outside of

Service	Description
	the standard service level agreement(s). 5. PBM shall use reasonable efforts to use Aetna approved edits during the Eligibility Data load process. Upon request by Aetna, PBM shall use all Eligibility Data load edits currently used by Aetna as of the Effective Date, as communicated by Aetna to PBM. Any additional edits requested by Aetna shall be by mutual agreement of the Parties. PBM shall produce to Aetna (in a format mutually agreed upon by the Parties) a report for all Eligibility Data transactions, indicating the records that were accepted and any errors that occurred. PBM shall coordinate with Aetna enrollment consultants to resolve any errors arising from an Eligibility Load no later than twenty-four (24) hours from the time the Eligibility Load has been completed by PBM. 6. PBM shall produce to Aetna (in a format mutually agreed upon by the Parties) a daily report identifying all manual eligibility updates processed by PBM. 7. PBM's eligibility system shall have automated edits, as required by Paragraph 5 of this Schedule C, that can be set at mutually agreed upon file levels (which at a minimum shall include the group and plan level when requested by Aetna`) to identify potentially problematic Eligibility Data files (*e.g.*, significant changes in Aetna Customer membership), in which case, PBM shall stop the file load/update, communicate with Aetna, and work together to resolve the issues prior to completing the load. 8. PBM shall produce a quarterly analysis of eligibility error trends including manual eligibility errors and manual eligibility updates (when needed on an Aetna Customer and Covered Plan basis). PBM shall coordinate with Aetna to use its best efforts to reduce the number of eligibility errors. 9. If an eligibility error results in incorrect Claims payment, PBM shall reprocess Claims according to Schedule D (Claims Processing and Adjudication) and shall effect any necessary payment adjustment in accordance with, and to the extent required by, Sections 7.4, 9.8, 9.10, and 9.12, as applicable, of the Agreement. PBM shall communicate the instance of incorrect Claims payments to Aetna as soon as they are known. Detailed information relating to the incorrect Claims payments will be provided to Aetna in writing in accordance with the provisions of Section 24.d of Schedule D. 10. PBM's customer service representatives shall process "eligibility overrides" in the manner described in Schedule E (Contact Services). 11. PBM shall establish and utilize such policies and procedures and take such other actions as shall be necessary to ensure that Eligibility Data and Ancillary Data loads and updates are provided in accordance with this Schedule C (Eligibility). PBM shall modify such policies and procedures as necessary to address and resolve any concerns and issues reasonably raised by Aetna. PBM's policies and procedures shall be disclosed to

Service	Description
	Aetna upon reasonable request. 12. Aetna and Aetna Customers may conduct eligibility audits in accordance with Paragraph 11(n) of Schedule X (Audits) and Article VII (Records/Legal Proceeding Cooperation/Audits) of the Agreement. 13. Notwithstanding anything else contained in this Schedule C, PBM shall support special eligibility requirements imposed upon health insurance exchanges ("HIX") by the Patient Protection and Affordable Care Act, including with limitation: a. Claims received in the second and third months of the grace period will be rejected at the point of sale with grace period specific message. If payment is later received and member is no long in grace period, manual (paper claims) can be submitted by member to cover any Usual & Customary costs incurred at that time. b. Manually updating and/or overriding HIX Pended Claims on a real time basis as instructed by Aetna.
Member Retro-Termination Recovery Program	14. PBM will administer a retro-termination recovery program for Aetna Commercial Business, in which PBM will pursue financial reimbursement from Members deemed not eligible for coverage after Claim payment has been made, in accordance with the following: As requested by Aetna, PBM shall identify on a monthly basis (i) Members whose eligibility was retro-terminated or whose eligibility effective period was decreased ("Retro-Term Members"); and (ii) identify all Claims paid with respect to such Retro-Term Members during the ineligible period. Within thirty (30) calendar days thereafter, PBM will generate an initial communication (in accordance with Schedule H (Communications)) to each Retro-Term Member whose overpayment exceeds the threshold amount established by Aetna. If no response is received to the initial communication within forty-five (45) calendar days, a second communication will be sent to the Retro-Term Member in accordance with Schedule H (Communications). If no response is received to the second communication, a third communication will be sent to the Retro-Term Member in accordance with Schedule H (Communications), and so on. Each communication will contain a letter seeking recovery of the overpayment (at a minimum via check or money order) and a return envelope (return postage not included). Aetna shall have the right to designate: (a) how many communications are to be sent; (b) the dollar threshold for recovery amounts; (c) when recoveries should no longer be attempted with respect to individual Retro-Term Members, groups, or plans; and (d) to which groups or plans this service should be applied or not applied. PBM shall track the identified overpayments, dates of communications to Retro-Term Members, and recovered overpayments, and shall provide a report to Aetna on a monthly basis containing such information. Member inquires will be supported by a designated accounts receivable team, in accordance with Schedule E (Contact Services) via a

Service	Description
	toll-free number, which shall be included in the recovery communication. All amounts recovered will be credited to Aetna on its next Administrative Fee invoice issued pursuant to Section 9.6 of the Agreement, and in all cases will be credited at least monthly. For avoidance of doubt, for the Medicare, Medicaid, Scrip World and Assurant lines of business Aetna will administer its own Retro-Termination Recovery Program. The PBM shall provide reporting to Aetna to support its recovery program. This reporting will be consistent with reporting provided for the Commercial Business. The Parties shall work collaboratively to develop a mutually agreeable application of the Retro-Termination Recovery Program for Scrip World on mutually acceptable terms. 15. Upon Aetna's request, PBM shall timely produce to Aetna and/or its third party vendor, such documentation and other reasonably required information to assist Aetna and/or its third party vendor in its recovery efforts with respect to amounts not collected through the retro-termination recovery process described above. 16. In the event of a Medicare Part D Claim overpayment, PBM shall adhere to the resubmission and/or reprocessing of Claims protocol as outlined in Schedule O, Section 17 (Medicare Services).
ID Cards	17. Upon Aetna's request for specific sponsors or groups, PBM shall create, prepare, and deliver to Members in an agreed upon format, Member identification cards in compliance with all applicable Laws.
Training	18. In a manner, location, and frequency reasonably acceptable to Aetna, subject to Section 11.5 and Article XIII of the Agreement, PBM shall provide initial and ongoing training for Aetna personnel with respect to developing an understanding of PBM's eligibility system and processes. Training provided to Aetna shall be inclusive of any relevant PBM owned systems used, or to be used, in performing PBM Services under this Schedule C with the purpose of enabling Aetna personnel to successfully access and employ such systems.

Schedule D

Claims Processing and Adjudication

Core Services

Service	Description
General Claims Processing and Adjudication Requirements	1. Claims Processing Services. PBM shall adjudicate all Claims accurately and provide Aetna with Claims processing services as set forth herein for all Claims, including the following: a. Pharmacy point-of-sale online Claims processing. b. Pharmacy universal Claim form (or other Aetna claim forms as mutually agreed to by the Parties; notwithstanding the foregoing, PBM shall continue to accept and process all Aetna approved claim forms in use by Aetna or an Aetna Customer prior to the PBM Commencement Date until such time that the Parties can agree on revisions to such claim forms) processing when point-of-sale processing is not available (including for out of network benefits). c. Direct Member reimbursement Claims processing. d. Batch and/or manual Claims processing for applicable secondary payers such as Medicaid subrogation or as otherwise required by Law or as reasonably required by Aetna. 2. System Availability. PBM shall have the claims processing system available twenty-four (24) hours a day, 365 days a year, less any scheduled maintenance in accordance with Schedule U. 3. Standards. In connection with the Claims processing services hereunder, PBM shall support and comply with the most current HIPAA mandated standards, D.0 format, and any future NCPDP format requirements and any other standard(s) required by Law. PBM shall use its best efforts to integrate and implement new versions of such standards on a timely basis, and in all cases within twelve (12) months of the release or such sooner time as required by Law, including as necessary working with system vendors and Participating Pharmacies. PBM shall use best efforts to use optional NCPDP data fields as instructed by Aetna in accordance with the form of the payer sheet provided to PBM by Aetna as applicable. PBM shall provide Aetna with guidance on adjudication improvement opportunities based on a review of Aetna's existing payer sheets. 4. Aetna Parameters. PBM shall adjudicate and process Claims accurately in accordance with Aetna approved parameters, including the terms of the Benefit Plan Design (i.e., correct Member Cost Share), requirements communicated by Aetna to PBM, DUR and other Claim edits, other requirements set forth herein, applicable Laws, and to the extent not inconsistent with the foregoing, PBM policies. Accordingly, as provided in Schedule B (Benefit Plan Set Up) and Article VIII (Plan Design and

Service	Description
	Product Development) of the Agreement, PBM shall enter into its Claims adjudication system the Benefit Plan Design information for the Covered Plans as necessary for PBM to perform Claims processing services, including information regarding Formularies, Member Cost Share, and other features of the Benefit Plan Design. 5. System Edits. The Parties shall mutually agree on all substantive system level adjudication edits (i.e., maximum pay edits and system level safety edits, but which does not include data validation edits). PBM shall notify Aetna in writing of any changes to substantive system level adjudication edits as soon as practical prior to such changes. PBM shall modify such edits as necessary to address and resolve any concerns and issues raised by Aetna. 6. Prior Authorizations and Clinical Services. When processing and adjudicating Clams, PBM shall comply with Schedule J (Clinical Services and Formulary Administration), Schedule I (Rebates), and Schedule K (Prior Authorization Services). 7. Administrative Overrides. PBM shall implement and process administrative overrides (e.g., early refill for vacations) consistent with Aetna Benefit Plan Designs and requirements communicated by Aetna to PBM. Aetna is not responsible for payment with respect to any Claims resulting from overrides performed by PBM in violation of Aetna Benefit Plan Designs and requirements communicated by Aetna to PBM ("Overrides Claim Violations"). Rather in accordance with Article XV of the Agreement, PBM agrees to indemnify Aetna for Losses due to against Override Claim Violations. 8. Accumulators. At a frequency determined by Aetna, PBM shall apply and share accumulator information via electronic interface with Aetna systems on Claims with integrated benefits for purposes of off-renewal migrations, periodic accumulator reconciliation, and correct adjudication, including coordinating with other entities for accumulator information (*e.g.*, situations where Aetna provides prescription benefit, but not medical benefit for a plan). 9. COB. PBM shall apply Aetna's coordination of benefits ("COB") payment requirements, as communicated by Aetna to PBM, for all Claim adjudications based on applicable "order of benefits" data provided by Aetna. Aetna shall provide to PBM either electronically or by paper information regarding primary and secondary payor status. PBM shall provide Aetna with quarterly reports of all COB savings in accordance with Schedule V (Reporting). If PBM receives an indication of other potential coverage from a Member or pharmacy via correspondence or otherwise, PBM shall promptly notify Aetna and provide Aetna with any such information PBM has received in a format and channel reasonably specified by Aetna. The parties acknowledge and agree that COB at point of sale is dependent on (i) the accurate submission of data on Claims by the pharmacy and (ii) the accurate adjudication by PBM based on relevant information provided to PBM from Aetna; notwithstanding the foregoing,

Service	Description
	if a pharmacy submits data with a Claim that is inconsistent with the order of payor information Aetna provided to PBM, PBM should adjudicate (i.e., pay or reject) the Claim in accordance with the information provided by Aetna. a. As directed by Aetna, PBM shall process secondary payments for specific drugs covered primary under Medicare Part B or liability benefits (*e.g*., auto coverage, workers compensation, etc.); provided that PBM receives some evidence of primary payment. b. As directed by Aetna, PBM shall process secondary payments for all drugs covered primary under Government Health Programs (including Medicare Part D and State Health Care Programs) and commercial Covered Plans; provided that PBM receives a copy of the applicable primary EOB. 10. Adjudication Blocks. PBM shall administer, using a process mutually agreed upon by the Parties, adjudication blocks on specific drugs in cases of third party liability or Medicare Part B coverage based on information provided by Aetna. 11. Subrogation. PBM shall cooperate, on terms reasonably agreed to by the Parties, with Aetna's subrogation vendor to ensure that the vendor has access to information necessary to provide overpayment recovery services on behalf of Aetna. In the event a pharmacy fails to timely reverse any Claims identified by Aetna as incorrectly billed to a Covered Plan (i.e., a Part B primary benefit billed incorrectly to a Covered Plan), PBM shall, to the extent consistent with applicable law, reverse such Claims for purposes of recovering the overpayment from the pharmacy; provided that: (a) the vendor provided timely notice and legal rationale for the reversal to the pharmacy, (b) the reversal complies with applicable law, and (c) the reversal is permitted under applicable law. 12. Pre-Existing Conditions. PBM shall administer pre-existing condition exclusion programs in accordance with Aetna requirements and Member Benefit Plan Design (*e.g.*, identification of drugs aligned with specific diagnosis codes for pre-existing condition exclusions and applying Member level specific drug exclusions, along with an exceptions process).
Electronic Claims	13. PBM shall provide online, real-time Member eligibility and Benefit Plan Design information to each Participating Pharmacy upon PBM's receipt of each Claim from a Participating Pharmacy. PBM shall electronically communicate to Participating Pharmacies the following information online, real-time, at the point of sale: (a) the Claim status, (b) Member Cost Share, (c) the difference between the Member's Cost Share for the Covered Drug dispensed and the lowest priced Generic Drug version of that Covered Drug that is therapeutically equivalent and bioequivalent at the Participating Pharmacy, (d) preferred alternative substitution opportunities as defined and approved by Aetna in writing (including Generic Drug substitution), (e) applicable DUR and safety edits, (f) Formulary products, (g) and other messages reasonably agreed upon by

Service	Description
	PBM and Aetna as part of the Claim adjudication process consistent with NCPDP and HIPAA. The parties agree that items (c), (d) and (f) above apply solely with respect to Medicare Part D Claims. The parties shall cooperate in good faith and mutually agree to a process for applying items (c) and (d) to all Claims if and to the extent requested by Aetna or an Aetna Customer.
Paper/Direct Member Reimbursement Claims	14. PBM shall accept and process Claims submitted by Members directly to PBM or sent by Aetna to PBM when such Members submit Claims properly completed on Aetna approved Claim forms, together with proof of payment. PBM shall produce and mail (in accordance with Schedule H (Communications): (i) a paper Claim reconciliation statement together with a check for the adjudicated reimbursement amount; (ii) requests for information for Claims that are ineligible for payment due to incomplete information; or (iii) if Claim payment is denied, a written notice of determination inclusive of appeal rights consistent with all applicable Laws. PBM shall issue and mail Member reimbursement payments each Business Day.
Medicare Part D Claims	15. PBM shall process and adjudicate Medicare Part D Claims in accordance with this Schedule D (Claims Processing and Adjudication) and Schedule O (Medicare Services) and shall comply with all new and revised Medicare Part D Claim adjudication requirements. 16. In conjunction with CMS processing requirements, PBM shall submit and reconcile Medicare Part D Prescription Drug Events ("PDE") in accordance with Schedule O (Medicare).
State Health Care Program Claims	17. PBM shall process and adjudicate State Plan Claims for State Plans that are Covered Plans in accordance with this Schedule D (Claims Processing and Adjudication) and Schedule P (Medicaid & Other State Plan Services) and shall comply with all new and revised State Plan Claim adjudication requirements arising under applicable Laws and the terms of the Plan Contract.
Medical Benefit Claims	18. PBM and Aetna shall mutually develop the process, subject to Aetna's reasonable approval, by which PBM shall establish a bi-directional connection to Aetna systems to allow for the exchange of Claim information to support Aetna's integrated suite of products. The connection shall support both real-time point of service claim adjudication and batch claim adjudication based on Aetna product requirements. Without limiting the generality of the foregoing, PBM through this connection shall support the following functions as they exist as of the PBM Commencement date between Aetna and appropriate systems unless the Parties mutually agree to changes to the scope of existing functionality: a. PBM shall cooperate with Aetna on its initiatives to eliminate duplicate payments between the medical benefits and the prescription benefits.

Service	Description
	b. To the extent applicable to a Covered Plan pursuant to Section 3.2(d) of the Agreement, PBM shall accept in real time National Drug Code ("NDC") information from the Aetna medical claim system for specific drugs (based upon claims submitted to Aetna by Providers using an Aetna designated format such as medical claim 835 transaction or HCFA 1500 forms) and provide to Aetna such pricing information as required by Aetna for these claims on a real time basis. c. To the extent applicable to a Covered Plan pursuant to Section 3.2(d) of the Agreement, PBM shall transmit to Aetna any Claims for pharmaceuticals covered under a Covered Plan that must be processed on Aetna's system for medical benefits, in the appropriate Aetna specified format. d. To the extent applicable to a Covered Plan pursuant to Section 3.2(d) of the Agreement, PBM shall obtain from Aetna and provide to Aetna information regarding medical claim copayments for select medical benefit drugs dispensed at Participating Pharmacies in accordance with Aetna Policies and requirements. These include vaccines, some durable medical equipment supplies, chemotherapy, and the like, as designated by Aetna. As directed by Aetna, PBM shall adjudicate medical benefit Claims on the PBM claim system and communicate applicable benefit information to the Participating Pharmacy real-time in accordance with procedures approved by Aetna. e. PBM shall share benefits data with other heath plans, subject to Aetna's prior written approval, in order to support Consumer Directed Health Plans and other Aetna requirements, including the maintenance/sharing of accumulators (including HDHP accumulators with medical vendors), flexible spending account ("FSA"), health reimbursement account ("HRA") and health saving account ("HSA") balances in real-time and batch mode with Aetna and vendors designated by Aetna (which as of the Effective Date include the following: United Healthcare, Cigna, Humana, and WellPoint). Upon Aetna's direction, PBM shall provide accumulator data sharing capabilities to any and all medical vendor relationships with which PBM has established connectivity, including any new future relationships formed with vendors to support this function. f. PBM shall access Aetna's fund information for Member responsibility to determine if HRA or FSA funds are available to cover Member responsibility. If funds are available, PBM shall apply available FSA or HRA funds to the Member cost

Service	Description
	share responsibility at POS, and Aetna will reimburse PBM for Member responsibility from Member's FSA or HRA fund account to cover a portion or all of the Member responsibility, as applicable.
Payments to Participating Pharmacies	19. PBM shall be solely responsible for payment to the Participating Pharmacies for Claims (exclusive of the applicable Member Cost Share) in accordance with Law and its Contracts with the Participating Pharmacies, subject to the Agreement, including Article IX of the Agreement and the requirements of Schedule G (Pharmacy Network Services), and Schedule Y (Pricing). 20. PBM shall process and pay Claims in accordance with all applicable prompt pay laws. PBM is financially responsible for interest and other penalties due on late paid Claims.
Compliance with ERISA	21. PBM shall comply with the Benefit Claims Procedure Regulation (29 C.F.R. 2560.503-1), or any successor regulation, in connection with Claims processing and adjudication or the performance of any other PBM Services, including complying with applicable claims procedure rules for claims for benefits and adverse benefit determinations.
Compliance with Escheat Laws	22. Unless otherwise notified in writing by Aetna with respect to all or certain Aetna Customers, PBM shall comply with any and all escheat Laws and obligations that directly or indirectly arise as a result of or in connection with Claims processing and adjudication or the performance of any other PBM Services. In accordance with this Agreement, Aetna shall be entitled to review PBM's escheat-related records and compliance policies and procedures, including systems utilized in the maintenance of aged records, compliance with state-mandated due diligence communications, and state reporting and remittance processes. In addition, PBM shall provide all data requested by Aetna in order for Aetna to satisfy any and all escheat obligations that are or may become the responsibility of Aetna or that relate to PBM's handling of the escheat laws and obligations that directly or indirectly arise as a result of or in connection with this Schedule D (Claims Processing and Adjudication) and this Agreement. Such data shall include account numbers, check numbers, issue dates, dollar amounts, company names/individual names, street addresses, payment types, and social security numbers/taxpayer identification numbers and other data requested by a state. Such information shall be provided by PBM upon request in an Aetna-specified electronic format.
Claim Errors/Corrections	23. Without limiting the generality of the foregoing, with respect to MAC List pricing, if it is determined that an error was made in the MAC program or the application of a MAC or MAC List, including, in each case to the extent that relevant information and data is provided to PBM by Aetna: 1) the placement of MAC pricing on a contracted Brand Drug product, or 2) the MAC price was only applied to a portion of products under the Generic Price Indicator list ("GPI") or National Drug Code ("NDC") list;

Service	Description
	then, to the extent the error was not an error caused by Aetna or an Aetna contracted vendor (excluding PBM), PBM shall be at full financial risk, including for Aetna's (and Aetna Customers') additional expenses and Losses, as set forth in Sections 7.4, 9.8, 9.10, and 9.12 of the Agreement. This includes but is not limited to loss of Manufacturer Rebate eligibility and overall increased Claim cost. 24. PBM shall manage Claims corrections and adjustments as follows: a. Upon identification of a Claims processing error that could potentially impact more than one Claim or Member, PBM shall communicate the instance of such error to Aetna as soon as known. Within five (5) business days (or another mutually agreed upon timeframe), PBM shall also deliver an impact report in accordance with Schedule V (Reporting), that includes at a minimum: i. A narrative which describes the background and history of the issue; ii. The root cause of the error; iii. All Members impacted and how they are impacted; iv. All Claims impacted and how they are impacted; v. All Participating Pharmacies impacted and how they are impacted; vi. All drugs impacted, if applicable; vii. The mitigation steps that were/are being/will be taken to correct the situation (which shall be subject to Aetna's approval, which approval shall not be unreasonably withheld); and viii. Measures and procedures that were/are being/will be implemented to mitigate this type of error in the future (which shall be subject to Aetna's approval, which approval shall not be unreasonably withheld). b. PBM shall accurately reprocess and/or make applicable financial adjustments to the Claims in a timely manner. c. In cases of Claims processing errors, unless otherwise directed by Aetna, PBM shall perform the following in accordance with a schedule reasonably established by Aetna: i. PBM shall generate and mail Aetna provided/approved reimbursement letters and Aetna approved Member reimbursement checks to affected Members. ii. PBM shall generate and mail Aetna provided/approved recoupment letters to affected Members.

Service	Description
	All such communications shall be done in accordance with Schedule H (Communications). d. PBM shall provide to Aetna within ten (10) Business Days after reprocessing and/or making the applicable financial adjustments to the Claims, a report identifying the "before and after" status of the Claims and all Claims values. 25. PBM shall track and administer Claim payment and overpayment recovery as a result of Claim processing errors, which such tracking shall be made available to Aetna upon request.
Itemized Statements	26. PBM shall provide an on-demand itemized statement at the request of any Member, Aetna Customer, or Aetna. The itemized statement shall include date of service, drug information, pharmacy, prescriber, and any other information required by Law. The form and content of such statement will be approved by Aetna in accordance with Schedule H (Communications).
Point of Sale Rebates	27. PBM shall administer Aetna's point-of-sale rebate strategies and methodologies using a process mutually developed by the Parties and subject to Aetna's reasonable approval, by which PBM (including for designated Aetna Customers), which shall include reduction of Member Cost Share responsibility at the point of sale and such reporting related thereto as required by Aetna or Aetna Customers.
Claims Files and Reporting	28. PBM shall provide Aetna (or its designee) in Aetna defined formats with data and/or reports with respect to Claims files in accordance with Schedule V (Reporting) and Schedule V-2 (Connectivity and Data Analysis Tools).
Testing	29. PBM shall perform Claims testing prior to the implementation of any new, or modification of an existing, administrative, clinical, or system program that affects Claims adjudication to confirm and assure accuracy. In performing such testing, PBM shall (at a minimum) test to confirm accurate Claim rejections, Claim payments, application of accumulators, compliance with Formulary, compliance with applicable Benefit Plan Design requirements, point of sale messaging edits to Participating Pharmacies and all other functions of Claim adjudication. Test plans for all testing must receive Aetna's prior written approval. 30. PBM shall produce to Aetna (in a format mutually agreed upon by the Parties), all testing results at the overall Aetna level as well as at the impacted Aetna Customer and Covered Plan levels within a reasonable time after test completion but no later than twenty-four (24) hours after the completion of the testing by PBM. 31. PBM shall correct all testing errors by the later of (i) the effective date of the implementation of such new, or modification of an existing, administrative, clinical, or system program; or (ii) within twenty-four hours after completion of the testing by PBM.

Service	Description
Training	32. In a manner, location, and frequency reasonably acceptable to Aetna, PBM shall provide pertinent initial and ongoing training for Aetna personnel with respect to interfaces with PBM reporting tools and the like. At a minimum, PBM shall train twenty (20) Aetna representatives in an intensive multi-day offsite training seminar, with ongoing support and just-in-time training support for changes and enhancements. 33. Further, in a manner, location, and frequency reasonably acceptable to Aetna, PBM shall provide initial and ongoing training for Aetna personnel with respect to developing an understanding of the PBM system adjudication logic. PBM shall also provide training to Aetna personnel for the purpose of accessing PBM systems and retrieving data in real-time. Training will result in Aetna personnel gaining Aetna's desired level of expertise in interpreting how pharmacy Claims are adjudicated in the PBM's Claim adjudication system.

Schedule E

Contact Services - Call Centers and Correspondence

Core Services

Service	Description
General Contact Services Requirements	1. General. PBM shall provide "Contact Services" as set forth herein, which shall include Member call centers, provider help desk, and Member inquiry responses via e-mail in accordance with Aetna requirements (including recording of calls and maintenance of other related documentation). If and when live chat services become available by PBM and/or are generally available in the PBM industry, PBM shall provide live chat Contact Services to Members in a mutually agreed upon manner. Requirements in this Schedule E (Contact Services - Call Centers and Correspondence) apply to Members and Providers even if not directly specified. For purposes of this Schedule E, Provider generally applies only to prescribing physicians and Participating Pharmacies. 2. Branding. All Contact Services shall be Aetna branded (*e.g.*, "Thank you for calling Aetna Pharmacy Management") in the manner determined by Aetna from time to time, excluding Medicaid and Scrip World lines of business. Aetna may at any time request deletion, replacement or modification of verbal, recorded and/or print versions of branding/scripting in order to meet the needs of Aetna and/or Aetna Customers. PBM shall maintain capability and capacity to implement these requests in a timely manner. 3. PBM Customer Service Representatives ("PBM CSR"). PBM shall staff its Contact Services with qualified PBM CSRs who have received appropriate training, including updates thereto. With respect to those contact centers that will be handling Aetna calls ("Aetna-designated call centers") (as specified and required below), Aetna desires that PBM CSRs have, and PBM shall make best efforts to meet, the following minimum qualifications: (i) prior customer service experience (except that for PBM CSRs handling prior authorization requests, prior experience as a pharmacy technician is highly desirable; otherwise, they shall have experience as a pharmacy customer service representative who has knowledge of basic insurance concepts and medical terminology); (ii) demonstrated ability to successfully multi-task; (iii) excellent oral and written communication skills; (iv) strong customer engagement, customer service skills, including mastery of de-escalation techniques; (v) demonstrated ability to handle multiple assignments competently, accurately and efficiently; and (vi) computer literacy in order to navigate through internal/external computer systems. All PBM CSRs responding to Aetna calls ("Aetna-designated PBM CSRs") shall be fully trained on all Aetna and Aetna Customer requirements applicable to Contact Services related to the services being provided under this Agreement. PBM shall provide Aetna with dedicated PBM CSR units for responding to Members

	of Covered Plans of specific Aetna Customers when requested by Aetna (e.g., Aetna One Premier Concierge) 4. Scripting. All PBM CSR scripting must be approved in advance and in writing by Aetna in accordance with Schedule H (Communications). In accordance with Schedule H (Communications), PBM shall provide Aetna with copies of all such scripting and any modifications thereto prior to use for Aetna's review and reasonable approval. 5. Privacy. PBM shall have, maintain, and comply with policies and procedures that are consistent with Aetna's privacy procedures and protocols, which shall be provided to PBM by Aetna, including procedures for (i) authenticating the identity of callers/inquirers, (ii) determining Persons to whom protected health information may be provided, (iii) informing callers/inquirers that calls or inquiries may be monitored or recorded, and (iv) implementing passwords, blocks, or other restrictions on protected health information. PBM shall inform Aetna, in a mutually agreeable format and media, any time a Member requests (i) that his/her protected health information be restricted from use or disclosure or (ii) that a restriction on the use or disclosure of his/her protected health information be deleted or revised. PBM shall accept a HIPAA privacy restriction file from Aetna in accordance with mutually agreeable specifications and apply it to PBM's applications to recreate privacy restrictions in accordance with HIPAA regulations and applicable Aetna Policies. In addition, all Contact Services shall be performed in accordance with all regulations, including without limitation, those regulations set forth in the Patient Protection and Affordable Care Act ("ACA"). 6. Translation Services. PBM shall provide translation services to accommodate non-English speaking callers and inquirers. In the event that PBM utilizes non-English speaking PBM CSRs, relevant supervisory and quality assurance staff will be fluent in the same language(s) as such PBM CSRs. 7. Eligibility Overrides. PBM Customer Care Unit shall process eligibility overrides in PBM Customer Care systems and/or eligibility systems as reasonably required and/or allowed by Aetna, which shall include researching the Member's eligibility (*e.g.*, via accessing Aetna's source systems for eligibility (via read-only access provided by Aetna) for overrides in all occurrences where eligibility does not exist in PBM system, including in the event that PBM eligibility information is out-dated (e.g. between eligibility loads)). In the event eligibility exists in the Aetna eligibility system, but not the PBM system, PBM Customer Care Unit shall place an "eligibility override" in PBM's system for proper Claim adjudication. In such cases, PBM shall be provided with only a secure view into the relevant Member information with both medical and pharmacy benefits. 8. Future Related Inquiries. PBM's system and processes shall be capable of supporting inquiries with respect to Members with future start dates and/or for upcoming Benefit Plan Design changes. Aetna shall provide such

	Benefit Plan Design changes and eligibility information necessary for PBM to perform the Services. Such changes and information shall be complete and accurate and provided in a timely, mutually agreeable format in advance, when possible. 9. State of Emergency. PBM shall monitor and track local, state, and federal declarations and/or proclamations of emergencies and/or disasters, and shall immediately, or if notification is not feasible immediately, as soon as is practicable, notify Aetna in writing in the event a local, state, and/or federal emergency and/or disaster is declared or proclaimed that could disrupt continuity of care for Members. PBM shall designate an individual on the Account Team as Aetna's point of contact during any such state of emergencies. Through this point of contact, PBM shall provide updates to Aetna about how the state of emergency is being handled. PBM shall have and maintain processes consistent with Aetna Policies for responding to such emergencies and/or disasters in effect as of the Effective Date to ensure that Members can obtain Covered Drugs during the time period of the declared emergency and/or disaster. In the event of a declared or anticipated emergency and/or disaster and PBM has not received any explicit instructions from Aetna with respect to Member access to Covered Drugs, PBM may employ its own judgment in determining how to provide PBM Services to those Members impacted by such emergency and/or disaster without Aetna's prior written consent. PBM shall make sure that notice of such judgment is received by Aetna as soon as practicable If Aetna does submit explicit instructions to PBM, PBM shall comply with Aetna's instructions with respect to Member access to Covered Drugs during a state of emergency and/or disaster and shall obtain Aetna's prior written consent before implementing or lifting any restrictions (i.e., lifting refill too soon edit restrictions), which may occur at various levels (i.e., a Covered Plan specific basis). PBM is expected to comply with any guidance or requirements provided by CMS in states of emergency. 10. Aetna will notify PBM in writing of any changes to Aetna Policies implemented after the Effective Date, and the Parties shall cooperate to institute mutually agreeable changes to PBM's processes to accommodate the changes to Aetna's Policies.
Extenuating Circumstances	11. PBM shall have in place written policies and procedures wherein PBM may expedite the dispensing of Covered Drugs in the event of extenuating circumstances under which if a prescription is not immediately filled serious harm may result. These circumstances include situations in which a Member or authorized representative states that an individual or personal situation is life threatening, may cause serious harm to the Member, and/or may create serious financial hardship to the Plan. All aforementioned policies and procedures created shall not conflict with any state laws or Aetna policies. 12. PBM shall submit a report of all overrides performed to Aetna on a quarterly basis.
General Call Center Requirements	13. PBM shall maintain and use toll-free service help lines for use by Aetna, Aetna Customers (when permitted by Aetna), Participating Pharmacies,

	Providers, and Members in accordance with the Agreement and this Schedule E (Contact Services) When requested by Aetna or otherwise specified herein, such toll-free service help lines shall: (i) be dedicated toll-free phone numbers for Members and Providers; and (ii) be dedicated toll-free phone numbers for specific Aetna Customers. Such dedicated toll-free telephone numbers will be proprietary to Aetna and transferred to Aetna, at Aetna's discretion, as part of the Transition-Out Services or in connection with a Partial Termination, as required by Schedule T. The call center networks shall provide coverage via live coverage or IVR 7 days a week, 24 hours a day, 365 days a year. A live person shall always be available to address emergency situations and a pharmacist shall always be available on-call. 14. PBM must have the capability to implement priority call routing for designated groups and/or products as directed by Aetna (e.g., placing Medicare calls ahead of Commercial calls in queue if needed for service/performance delivery, etc.). PBM shall have such capability where a dedicated phone number or the ability to prioritize exists. 15. PBM shall provide TDD/TTY services for hearing impaired callers, including transfers in and inbound calling support of 711 calls. In the event a caller has an inquiry that is not related to the pharmacy benefit, PBM shall warm transfer the call to the Aetna call center, utilizing mutually agreed upon protocols (including a cold transfer process if wait times exceed sixty (60) seconds). In addition, PBM shall accept and handle warm transfer calls from Aetna to PBM's call center, utilizing mutually agreed upon protocols (including a cold transfer process if wait times exceed sixty (60) seconds). The following requirements shall apply to all calls that require a warm transfer, including PBM to Aetna member services, PBM to Aetna RX Home, PBM to Aetna Specialty Pharmacy, and PBM to PBM transfers: (i) PBM CSR shall explain to the caller that the call needs to be transferred to another area; (ii) PBM CSR shall confirm with the caller that it is acceptable to transfer the call; (iii) PBM CSR shall obtain the following information from the caller prior to transferring the call: (a) the caller's name, (b) the Member's identification number, and (c) a general overview of the reason for the call; (iv) if there is no individual available to take the call transfer, PBM CSR shall explain to the caller that the caller will be placed into a voicemail and then transfer the call; (v) if the individual is available to take the call transfer, PBM CSR shall inform the Aetna CSR that there is a caller on hold, provide the caller's name, Member identification number, and the reason for the call and then transfer the call; and (vi) callers asking to speak with a supervisor or manager must be handled by a person with that title or a Senior CSR. If a person of that title or Senior CSR is not available, a call back will be offered. If accepted by the caller, the call back must be completed within 24 hours. In all cases, the warm transfer process will not require Members to re-authenticate during the transfer. Warm transfers are subject to the same service metrics as incoming calls as provided therefor in Schedule R. If a call is escalated to a manager or supervisor, PBM shall not record such

	calls. Such calls will be documented in the Call Escalation Database. Aetna acknowledges that PBM does not have capabilities to support supervisor call record at the time of execution of this Agreement. PBM agrees to support supervisor call record provided, however, Aetna, upon request of PBM, provide any development funding. If so, PBM will use reasonable commercial efforts to make sure capabilities operational by the Effective Date. 16. All supervisor and manager calls must be documented in the PBM systems and made available to Aetna upon request. 17. PBM shall utilize its own processes for multi-level call support, including escalated calls, subject to Aetna review and reasonable approval. These processes shall include a system for staffing, forecasting and utilization of escalation or rapid-resolution teams where necessary. Additionally, these processes shall include tracking reporting of daily volumes (calls offered and calls answered), Average Handle Time ("AHT"), Average Speed of Answer ("ASA"), Telephone Service Factor ("TSF"), and Abandoned Calls ("ABD"), call types and root cause trending. Any tracking reporting of this multi-level call support category shall be undertaken and maintained by PBM in a circumspect manner. 18. PBM shall maintain adequate capacity and functionality to support outbound calls as reasonably requested by Aetna. These may include scheduled campaigns, ad hoc initiatives, and remedial and discretionary constituent improvement activities, as discussed and agreed to by the Parties. Outreach may be to Members and/or Providers. Aetna will partner with PBM to develop and/or enhance call scripts and talking points as needed. PBM agrees to commence such outbound call activities within one (1) Business Day of Aetna's request. Adequate capacity is defined as the ability to resource volume of outbound calls equal to or greater than .01% of Aetna's active Rx membership, but only for calls occurring on Tuesdays through Fridays on non-holidays unless calls are related to an urgent or emergency need. For purposes of this Section, urgent/emergency need shall be defined as any regulatory request (e.g., CMS, OIG, HHS and state agencies) or any situation involving individual Member access to care or cost-sharing impacts. In the event the demand for outbound calls exceeds 0.01% of Aetna's active Rx membership, PBM is not responsible for additional outbound calls. In the event PBM agrees to provide outbound calls in excess of the above 0.01% threshold, such incremental services shall incur an additional fee as outlined further in Schedule Y-7. Additional fees for services beyond the 0.01% threshold shall not be payable to the extent the outbound calls are necessitated by defects in PBM Services. 19. PBM shall maintain multiple call center sites which are geographically dispersed to manage workload balance and to provide for immediate disaster back-up recovery. PBM shall support virtual call routing between call center sites. 20. As part of its toll-free service help lines, PBM shall support and provide

	interactive voice response ("IVR") technology in accordance with Aetna requirements and as approved by Aetna, which shall include Participating Pharmacy locator (which shall be updated as changes occur in the Participating Pharmacy network) and all other static and transactional pharmacy data as agreed by the Parties. a. PBM shall be capable of receiving and processing Automatic Number Identification ("ANI") Match data (caller ID and authentication information) from Aetna IVR, should Aetna make the data available to PBM. b. PBM IVR should present a consistent appearance to the caller and have greetings, introductions, and prompting consistent with Aetna IVR.
Aetna-Designated Call Centers	21. PBM shall maintain Aetna-designated call centers for Member and Provider calls related in any manner to pharmacy benefits and prescription matters, including such issues as Benefit Plan Design and structure, eligibility, accumulators, Member Cost Share, status of submitted paper Claims, recoveries related to retroactive eligibility terminations, prescription refill requests, order status, special delivery requests, completing a Claim form, Participating Pharmacy locations, including locating Participating Pharmacies in the Member's zip code area (which shall be updated as changes occur in the Participating Pharmacy network), and workers' compensation-related inquiries and prior authorization-related requests, including from non-Members such as nurses, adjustors, and case managers. The Aetna-designated call center shall provide support to Members and Providers with issues related to PBM's website. The Aetna-designated call center shall provide for access to Aetna's clinical pharmacists via warm transfer, including calls from Members for pharmacists related to Aetna RX Home and Aetna Specialty Pharmacy including prescription refill requests, order status, special delivery requests. The warm transfer process will not require Members to re-authenticate during the transfer. Aetna-designated call centers must be geographically dispersed such that Members and Providers have access to PBM CSRs. 22. When a Member expresses confusion, depression, or distress as reasonably determined by the PBM CSR, PBM shall warm transfer the call (in accordance with this Schedule E (Contact Services) to an Aetna CSR (as directed by Aetna from time to time) to assist with behavioral health benefits/services. In situations where the caller is attempting to hurt self or others, PBM shall use best efforts to contact 911 emergency services for assistance for the Member. This provision is not intended to replace the judgment of the PBM CSR, but the action taken should be documented in all cases. 23. In the event a Member requests pharmacist-conducted patient education and counseling on account of a Covered Drug dispensed by Aetna RX Home or Aetna Specialty Pharmacy, the Aetna-designated call center shall provide for access to those Participating Pharmacies' clinical pharmacists via warm transfer which will not require the Member to re-authenticate

	during the transfer. If such request arises from a Covered Drug dispensed by a Participating Pharmacy other than Aetna RX Home or Aetna Specialty Pharmacy, the Member may be requested to consult with such Participating Pharmacy.
Pharmacy/Provider Help Desk	24. PBM shall maintain an Aetna-designated call center for Participating Pharmacies and Providers to answer questions related in any manner to pharmacy benefits and prescription matters, including such issues as Claims processing status and edits, Claims payment, Benefit Plan Design, eligibility, and Member cost share. PBM CSRs shall be required to request a preferred call back number before the PBM CSR puts a Member or Provider on hold for any reason. If the PBM CSR is disconnected from the caller for any reason, the PBM CSR is required to attempt a call back using the preferred number immediately.
Member Mail/Fax/Internet/E-Mail Inquiries	25. PBM CSRs shall respond to Member inquiries made via regular mail/fax or email through the Member website and such other means required hereunder (as set forth in Schedule H (Communications). 26. PBM shall acknowledge receipt of all Member (including authorized representatives of Members) internet/email inquiries within twenty-four (24) hours, measured from the date and time the internet/email inquiry is received by PBM until the date and time the PBM sends its acknowledgement by email to the Member (or its authorized representative). 27. PBM shall respond in writing to all Member (including authorized representatives of Members) mail and fax inquiries within ten (10) calendar days. Such response shall resolve Member's mail or fax inquiry.
Complaints, Grievances, and Appeals (Members, Providers, and Aetna Customers)	28. Members and Providers (Excluding Pharmacies). a. PBM shall handle all verbal complaints and grievances it receives from Members or Providers that do not require action or input by Aetna in a manner and process as agreed by the Parties, and in accordance with all timelines required by Law and as otherwise agreed by the Parties. PBM shall respond to, track, and report such complaints in accordance with Law and Aetna's reasonable requirements. PBM shall provide a clinician who has access to all claims systems and can assist with the resolution of complaints and grievances. Examples of complaints and grievances that require action or input by Aetna would include issues regarding medical benefits or such other issues that are unrelated to the PBM Services. b. In the event that PBM receives a verbal complaint or grievance from an Aetna Member that requires action or input by Aetna, PBM shall promptly and timely route all such complaints and grievances, including all information and/or

	documentation reasonably available to PBM related to such complaint or grievance, to Aetna in the manner and format reasonably required by Aetna. PBM shall provide such information and documentation promptly and, in all cases, within turn around times reasonably proscribed by Aetna. c. In the event that PBM receives any written complaint or grievance from an Aetna Member, PBM shall promptly and timely route all such written complaints and grievances, including all information and/or documentation reasonably available to PBM related to such complaint or grievance, to Aetna in the manner and format reasonably required by Aetna. PBM shall provide such information and documentation promptly and, in all cases, within turn around times reasonably proscribed by Aetna, which in all cases will be real-time for telephone calls and no more than three (3) Business Days for written complaints and grievances (or such shorter time required to comply with Law). d. In the event that PBM receives an appeal from an Aetna Member, PBM shall promptly and timely route all such appeals, including all information and/or documentation reasonably available to PBM related to such appeals, to Aetna in the manner and format reasonably required by Aetna. PBM shall provide such information and documentation promptly and, in all cases, within turn around times reasonably proscribed by Aetna, which in all cases will be real-time for telephone calls and no more than three (3) Business Days for written complaints and grievances (or such shorter time required to comply with Law). e. If a caller expresses an intent to inform the media or public legal entity (e.g. government agency, public figure, etc.) of any material issues, PBM agrees to notify Aetna as soon as practicable after receiving information regarding such intentions, and PBM and Aetna agree to work in good faith to devise the appropriate protocol to resolve the issue as may be necessary. f. PBM shall reasonably cooperate with Aetna in the implementation and execution of future enhancements to the process and/or procedures for complaints, grievances, and appeals. g. For purposes of this Paragraph 29 of this Schedule E (Contact Services): (i) A "complaint" shall mean as follows: (i) With respect to Medicare, a written or oral communication from a

		Member, or his/her appointed representative, expressing dissatisfaction with any aspect of the organization's or provider's operation, activities, or behavior, regardless of whether any remedial action is requested. This may include what will be identified as an appeal or grievance; (ii) For all other Covered Plans, any oral or written expression of dissatisfaction/concern, other than an appeal, by a Member or a Member's authorized representative regarding services provided by Aetna, a health care professional or a vendor, including with respect to: (a) Potential quality of care by a participating health care professional; (b) Quality of administrative service provided by a participating health care professional; (c) Quality of administrative service provided by PBM and/or Aetna; (d) Use of the Member's protected health information; (e) A plan benefit, billing, eligibility or contract provision that does not involve a request to review a denied claim; and (f) Issues regarding premiums.
		(ii) A "grievance" shall mean as follows: (i) With respect to Medicare Part D, any complaint or dispute, other than one that involves a coverage determination or a low income subsidy or late enrollment penalty determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of Aetna or PBM, regardless of whether remedial action is requested; (ii) For all other plans, any oral or written communication from a Member, or his/her appointed representative, to Aetna or PBM expressing dissatisfaction with any aspect of the organization's or provider's operation, activities, or behavior, regardless of whether any remedial action is requested and which is not related to an initial determination.
		(iii) An "appeal" shall mean as follows: (i) For Medicare, any of the procedures that deal with the review of adverse coverage determinations and/or exception requests made with respect to the benefits under a Part D plan the enrollee believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the enrollee must pay for or have financial responsibility for the drug coverage, as defined in §423.566(b); (ii) For all other plans, a verbal or written request by a Member or a Member's authorized representative, requesting a change in the initial determination decision. Requests that would be considered appeals would include requests related to the following: (a) certification of

	health care services; (e.g., pre-certification, concurrent review, retrospective services); (b) claim payment; (c) plan interpretation; (d) benefit determinations; (e) eligibility. Disputes regarding the Member liability related to discount programs are not eligible for appeal. (iv) PBM shall not refer Members or Providers to CMS for any complaint, grievance or appeal, except if required to do so by CMS. 29. Pharmacies. PBM shall handle all complaints, grievances, and appeals it receives from pharmacies in accordance with all requirements and timelines required by Law. To the extent required by Law, PBM shall respond to, track, and report such complaints, grievances, and appeals in accordance with Law and provide such reports to Aetna as reasonably requested by Aetna. 30. Aetna Customers. In the event that PBM receives a complaint from an Aetna Customer, PBM shall promptly and timely route all such complaints, including all information and/or documentation reasonably available to PBM related to such complaint, to Aetna in the manner and format reasonably required by Aetna. PBM shall provide such information and documentation promptly and, in all cases, within turn around times reasonably proscribed by Aetna.
Reporting	31. PBM shall provide Aetna with reports in accordance with Schedule V (Reporting) (e.g., metrics for telephone queues servicing Aetna and Aetna Customers, Aetna Customer service level specific reporting, Member complaint and grievance tracking reporting, Participating Pharmacy complaint and grievance tracking reporting, etc.).
Systems Requirements	32. PBM shall use its PBM proprietary call center desktop and systems. PBM shall maintain said systems in accordance with the standards of leading PBMs and leading call centers in the healthcare industry. PBM shall provide read and/or write access (as specified by Aetna) to all such systems to designated Aetna employees. PBM will grant systems access to Aetna for call recordings, screen capture, benefit and Claim history, and global policies that affect Aetna Customers. 33. PBM shall maintain and utilize (and make jointly available to Aetna), a Customer Relations Management (CRM) application that provides at least the following functions: a. Documents all calls; b. Provides pop-up alerts to enable the PBM CSR to proactively engage the Member in health advocacy (i.e., medication adherence). 34. PBM shall provide read and/or write online web access to its CRM application via its client website to designated Aetna staff as directed by Aetna.

	35. To the extent consistent with the terms of the Agreement, PBM shall provide read and/or write access to PBM's applicable system (or its successor system thereto) to designated Aetna staff as directed by Aetna, which system shall at a minimum provide read access to all Claims information and write access to eligibility, prior authorizations, overrides, and notes. The PBM's applicable system shall further provide adequate information and access to assist Aetna in handling pre-enrollment calls (i.e., Copayments, Benefit Plan information, etc.).
Call Quality Monitoring and Recording	36. PBM shall regularly monitor call quality in accordance with a call quality program that Aetna has approved in writing and in accordance with applicable Law, including disclosures required by HIPAA. a. PBM shall track call quality trends in accordance with Schedule V (Reporting). b. PBM shall develop a process for Aetna to request call recordings and for PBM to provide call recordings within 24 hours of such request. PBM shall designate a point of contact to enable Aetna to request these recordings (i.e., an email inbox). 37. For any month where the required level of call quality is not achieved (including as described in Schedule R (Performance Standards and Service Levels) or as otherwise agreed in writing by the Parties), PBM shall report and remedy the non-compliance in accordance with Section 3.4(k) of this Agreement. 38. In addition, unless otherwise agreed upon by both Parties, PBM shall participate in quarterly business reviews with Aetna (in person or via conference call at Aetna's direction) where the Parties will review and calibrate call scores based on a sample of audited calls. Such quarterly business reviews shall be conducted within thirty (30) calendar days of the end of the calendar quarter. Within fifteen (15) Business Days from the completion of the joint quarterly review, PBM shall establish a written work plan for remedying deficiencies, which such work plan shall provide a remediation plan to remedy the non-compliance, which may include Aetna or PBM owned remediation activities. PBM shall modify the remediation plan to include, and shall implement, any additional corrective actions Aetna may reasonably request. Upon request, PBM shall provide Aetna periodic updates of progress made under the remediation plan. 39. PBM shall utilize technology for call quality monitoring that records call and screen capture activity. a. 100% of all calls (including Member and Provider) will be recorded. b. 100% of all PBM CSRs will have recorded screen capture (excluding Pharmacy Help Line), and a sufficient sample size will be monitored so as to achieve at a minimum a 95% confidence level. c. PBM shall retain, store, and make available to Aetna recorded screen capture data and recorded voice data for a minimum of

	ninety (90) days, or for as long as otherwise required by Law. In addition, PBM will comply with more restrictive call retention requirements for up to ten (10) plan sponsors with dedicated customer service units, including requirements to retain up to 100% of calls for up to eighteen (18) months. d. PBM shall retain all call recordings that are associated with appeals, grievances, and executive escalations in accordance with Aetna's document retention policy
Training	40. In a time, manner, and frequency as agreed by the Parties, and subject to Article XIII of the Agreement, , PBM shall provide Aetna-designated CSRs (which includes PBM CSRs dedicated to handling calls hereunder and any other non-dedicated call center staff who may at one time or another assist with calls with or relating to Aetna, Members, Aetna Customers, or Covered Plans) specific training on all Aetna and Aetna Customer requirements applicable to customer services related to the services being provided under this Agreement. a. PBM shall maintain and update these training materials in collaboration with Aetna. b. All training materials will include Aetna culture, values, and branding material and will be approved by Aetna. c. All newly hired staff will be required to complete soft-skills and de-escalation training. The training will consist of a minimum full day class that includes role play. d. All staff will be required to complete eight (8) hours annually of refresher training on soft-skills and de-escalation techniques. e. All newly hired staff will be required to complete Aetna values and culture training. f. Training will be relative to the job functions of the Aetna-designated employees. g. PBM must demonstrate proficiency with all trained Aetna-designated employees. h. PBM shall provide ongoing and refresher training in a time, manner, and frequency as reasonably requested by Aetna, but no less than once a year. i. Notwithstanding the foregoing, if required by Law or on account of an urgent event as determined by Aetna in its sole discretion, training must be made available to Aetna-designated employees as soon as possible. 41. PBM shall provide PBM Call Center Staff dedicated to Aetna with ongoing and refresher training and/or coaching in a time, manner, and frequency as reasonably requested by Aetna, but no less frequently than

	once a month. 42. The foregoing is in addition to any training required pursuant to Article XIV of the Agreement.
Designated Call Center Teams	43. PBM shall provide designated PBM CSRs to sufficiently support special Aetna service strategies (e.g., Aetna One Premier Concierge).
Forecasting of Staffing & Call Center Activity	44. PBM shall submit staffing forecasts to Aetna thirty (30) days before the beginning of the second, third and fourth calendar quarters. PBM shall submit a staffing forecast to Aetna ninety (90) days before the beginning of the first calendar quarter. Aetna designated call center forecasts shall include monthly volume (calls offered), AHT, TSF, and ABD call assumptions. PBM shall calibrate these forecasts quarterly and provide monthly updates.

Schedule F

Prescription Drug Utilization Review

Core Services

Service	Description
Support/Cooperation with Aetna Utilization Review	1. PBM shall provide real time concurrent drug utilization review ("DUR") edits at the dispensing Participating Pharmacy (including the Aetna Mail Order Pharmacies and the Aetna Specialty Pharmacies) point of sale ("POS") with respect to Covered Drugs dispensed to Members according to pharmacy benefit management industry standards, applicable accreditation standards, Law, Aetna Policies, and Aetna's clinical and quality initiatives as communicated to PBM by Aetna from time to time. These shall include step therapy, prior authorization, quantity limits, age and gender edits, drug-drug, drug-disease, drugs to avoid in the elderly, therapeutic duplication, all edits available under NCPDP messaging, and all edits required for accreditation with National Committee for Quality Assurance ("NCQA"), Utilization Review Accreditation Commission ("URAC"), and CMS. Such edits shall include functionality to permit the Participating Pharmacy to submit intervention codes and information regarding actions taken by PBM via the real-time POS claims system. 2. PBM shall consult with and assist Aetna in the development of DUR edits, with the objective of establishing unique, leading edge capabilities in a collaborative fashion. PBM shall provide Aetna with detailed information regarding "best practices" and shall disclose to Aetna all DUR edits it has developed for PBM's other customer relationships and as set forth in such customer contracts to determine whether it would be appropriate to adopt such edits for Members and/or Covered Plans. 3. PBM shall, using its clinical database, check all incoming prescription claims for inappropriate drug prescribing or consumption, medical conflicts, or potentially dangerous interactions, and alert the dispensing pharmacy at the point-of-sale. 4. PBM shall process Member submitted paper Claims through PBM's claims system to apply the same DUR edits to the Member submitted paper Claims as are applied to electronic POS Claims and add such paper Claims to the Member's history for future DUR reviews. DUR services under this Schedule F (Prescription Drug Utilization Review) shall apply equally to Member submitted paper Claims as to electronic POS Claims. For Medicare Part D paper claims, PBM will facilitate initiation of the coverage review for prior authorization, step therapy, or other coverage determinations. 5. POS edits must be in a format specified and approved by Aetna and PBM in accordance with Schedule H (Communications). Aetna will approve or disapprove the activation of each edit and the messaging that will return to the dispensing pharmacy. PBM shall add new Aetna-approved edits within a commercially reasonable timeframe. In urgent situations, PBM shall add new Aetna approved edits as soon as reasonably practicable, and in all cases within 72 hours, excluding weekends and holidays.

	6. Aetna and Aetna Customers shall have the ability to customize DUR edits either by direct access to PBM's systems or by directing PBM to implement the aforementioned edits. PBM shall support Aetna Customer-specific and Covered Plan-specific edits and customization. 7. The attached Schedule F-1 lists DUR edits that the PBM shall support. PBM shall also support all additional edits reasonably requested by Aetna, including on behalf of any Aetna Customer. 8. PBM shall incorporate clinical parameters as required by Aetna, including ICD-9 and ICD-10, into the online POS edit process. 9. PBM shall require its personnel, pharmacists, nurses, medical directors, and independent contractors to (i) be licensed and/or certified as required by applicable Law and the terms of the Agreement, (iii) comply with applicable URAC and NCQA standards, and (iv) cooperate with Aetna's utilization review team. Upon request, Aetna shall have the ability to review and approve PBM's policies relating to licensure and certification of PBM personnel, provided that Aetna's approval shall not be unreasonably withheld. 10. PBM shall provide all Aetna clinical staff, as identified by Aetna, with such read and query access, as is reasonably necessary to achieve Aetna's capability requirements, to PBM's real time, web-based Claim/Aetna Customer service information. This web access must include all NCPDP data fields related to the Covered Drug Claim. 11. PBM shall document all information regarding its clinical interactions with Members or Providers (on a Member's behalf) in an electronic format and provide such documentation to Aetna for incorporation into the Aetna clinical systems on a real time basis. This interaction documentation must include the specific information that was communicated to the Member or Provider. 12. PBM shall provide all Aetna staff, as identified by Aetna, with unlimited read and query access to each Member-specific written or electronic communication that is sent by PBM to the Member, the Provider, or an Aetna Customer.
Utilization Data Reporting	13. PBM shall provide Aetna with the DUR reports and data set forth on Schedule V (Reporting) and Schedule V-2 (Connectivity and Data Analysis Tools).
E-Prescribing	14. PBM shall provide and maintain direct connection with Surescripts (or any Aetna-approved successor to Surescripts) to enable real-time electronic prescribing transactions in accordance with the standards/guidance by NCPDP, Certification Commission for Healthcare Information Technology ("CCHIT"), National Committee on Vital and Health Statistics ("NCVHS"), and CMS. PBM shall provide data to Surescripts-certified vendors (e.g., AllScripts) via such connection, including eligibility, plan Formularies, Member-level Cost Share and Member-level prescription histories. PBM shall develop real-time Member-level e-prescribing transactions as these standards are adopted by NCPDP or CMS

	and become available as an industry standard. PBM shall be responsible for and pay the costs related to the connectivity with Surescripts and the transaction cost for eligibility requests and electronic scripts. 15. PBM shall provide reporting for electronic prescribing in accordance with Schedule V (Reporting).
DUR Modeling Tool	16. As requested by Aetna, PBM shall provide Aetna access to a modeling tool to assess needs for additional DUR programs. This modeling tool must include the application of DUR edits; Formulary modifications; application of prior authorization, step therapy, and quantity limit modifications, Member Cost Share; Manufacturer Rebates; as well as personal health record data (combined medical/pharmacy data).
Pharmacoeconomic / Pharmacovigilance	17. As requested by Aetna, PBM shall collaborate with Aetna for discovery and development of additional pharmacoeconomic and pharmacovigilance programs incorporating evidence based medicine, emerging technology, comparative studies and development of a ranking system for the evidence of conclusions in the studies. This collaboration shall include a focus on improved Member outcomes and incorporate site of service for medication dispensing, medication administration, and integration with medical benefit into the overall pharmacoeconomic analysis.
Retrospective DUR	18. To the extent requested by Aetna, PBM shall provide rapid, retrospective DUR daily upon receipt of Claim and running through algorithms that identify outreach to Providers and Members. Reporting of these programs shall be done at a Member, group, Aetna Customer, Covered Plan, Aetna regional and aggregate level. 19. Aetna administers a retrospective DUR service, which Aetna may continue to do at its discretion. As requested by Aetna, PBM shall make available to Aetna all of PBM's retrospective DUR services. At a minimum, if requested by Aetna, PBM shall make available to Aetna substantially similar retrospective DUR as Aetna currently utilizes. A description of the current retrospective DUR services is set forth in Schedule F-2 (Description of Current Aetna Retrospective DUR Services). To the extent a retrospective DUR service requested by Aetna is a core service that PBM standardly provides to other customers, such service shall be provided to Aetna as a Core Service.
Additional PBM Core Services	20. The PBM programs set forth in Schedule F-3 shall be provided to Aetna as Core Services.

Schedule F-1

Master DUR Edits

[To be Added]

Schedule F-2

Description of Current Aetna Retrospective DUR Services

Program Name	Description	Assessment	Contact(s)	Outreach Content	Reporting*
Acute Frequency – Proton Pump Inhibitor Program	This program tests claims data to identify members on multiple daily dosing of a proton pump inhibitor regimen. This program promotes once-daily dosing of proton pump inhibitors	Daily/ RPh reviewed	- Prescriber letter	- Prescriber letter - Patient Profiler - Prescriber Response form	- Outreach - Activity - Cost Savings
Brand to Generic (DAW1)	This program tests claims data to determine if a prescriber has written a "dispense as written" prescription for a brand drug that has an "A" rated generic equivalent available. There must be savings for both carrier and. The member savings must be at least $1.00. The default savings threshold is defined by APM, but can be modified by the carrier	Daily	- Prescriber letter	- Prescriber letter - Prescriber Response form	- Outreach - Activity - Cost Savings
Drug/Drug Interaction	This program tests claims data to identify members receiving two drugs** at the same time that are known to cause a clinically significant interaction.	Daily/ RPh reviewed	- Prescriber call - Pharmacy call - Patient call - Prescriber letter	- Prescriber letter - Patient Profile - Prescriber Response Form	- Outreach - Activity
High Utilization	This programs tests claims data to identify who have received more that "X" claims for specific controlled drugs** or drugs** of misuse in a calendar month. The default threshold is defined by APM at three (3) claims, but can be modified by the carrier.	Monthly RPh reviewed	- Prescriber letter	- Prescriber letter - Patient Profile - Prescriber Response form	- Outreach - Activity - Cost Savings
Retail to Mail	This program tests claims to data to identify who have had a maintenance prescription filled through a retail pharmacy while they have a mail plan available. There must be savings for both carrier and if the prescription is filled through mail-service. The savings must be at least $1.00. The default savings threshold is defined by APM, but can be	Daily	- Patient letter	- Patient letter - Mail-service enrollment form - Patient Response Form - Business Reply Envelope specific to	- Outreach - Activity - Cost Savings

	modified by the carrier.			client's mail service facility	
Thera-peutic Duplication	This program tests claims data to identify members receiving two drugs** from the same therapeutic class at the same time.	Daily/ RPh reviewed	- Prescriber call - Pharmacy call - Prescriber letter	- Prescriber letter - Patient Profile - Prescriber response form	- Outreach - Activity - Cost Savings
Patient Safety-Suboxone or Subutex/ Opioid only at this time	This program tests claim data to identify members with a prescription filled for a targeted drug (Suboxone or Subutex) and member subsequently fills a prescription for a drug (opioid) that is contraindicated in combination after the target drug therapy has been started.	Daily	- Prescriber letter - Prescriber call--follow-up by Rx Misuse, Waste and Abuse pharmacist	- Prescriber letter - Patient Profile - Prescriber response form	- Outreach - Activity - Cost Savings
Controlled Substance	Identifies fully-insured members who meet the following criteria during a rolling three month period: eight or more prescriptions for controlled substances, obtain controlled substance prescriptions from three or more prescribers, and obtain controlled substances from three or more pharmacies.	Monthly	- Prescriber letter - Member letter	- Prescriber letter - Patient Profile - Prescriber response form - Patient letter	- Outreach - Activity - Cost Savings
Thera-peutic Optim-ization	This program identifies opportunities for once daily drugs that are frequently prescribed at lower doses for multiple daily dosing. The program suggests decreasing the frequency and increasing the dose accordingly.	Daily	- Prescriber letter	- Prescriber letter - Prescriber response form	- Outreach - Activity - Cost Savings
Stream-lining Therapy	This program identifies members newly placed on combination corticosteroid/long-acting beta agonist (LABA) inhalers, including Advair, Symbicort, and Dulera who have not tried a corticosteroid inhaler alone. Current guidelines from NHLBI for asthma treatment recommend the use of an inhaled corticosteroid prior to the addition of a long-acting beta-agonist.	Daily	- Prescriber letter	- Prescriber letter - Prescriber response form	- Outreach - Activity - Cost Savings

Length of Therapy	This program identifies members who have been taking medications longer than approved by the FDA or supported by clinical evidence. Drugs that are included in the Length of Therapy program have well-defined treatment courses and may present a potential safety concern when used beyond recommended time limits.	Daily/ RPh reviewed	- Prescriber letter	- Prescriber letter - Patient Profile containing only identified drug - Prescriber response form	- Outreach - Activity - Cost Savings
Maximum Dose	This program will identify members on daily doses of medication that are higher than what is supported in product literature.	Daily/ RPh reviewed	- Prescriber letter	- Prescriber letter - Prescriber response form	- Outreach - Activity - Cost Savings
Prescribing Cascade	Identify situations for members in which a medication is prescribed to treat a side effect of another medication. In certain instances a physician may not realize that a member complaint is the result of a medication and inadvertently prescribe an additional medication to treat the side effect, rather than taking more appropriate action such as changing the offending medication or reducing the dose.	Daily/ RPh reviewed	- Prescriber letter	- Prescriber letter - Prescriber response form	- Outreach - Activity - Cost Savings

*Outreach reports are generated within the month following the outreach period. Activity reports are generated five (5) months and Cost Savings Reports are generated five (5) months or twelve (12) months following their respective Outreach period.

**The drug(s) analyzed per program are specified by Aetna's clinical staff as part of the program's criteria.

Aetna Rx Check program - Acute Frequency Program	1. PBM shall comply with Aetna Policies for acute frequency programs. 2. PBM shall identify and report, on a daily basis, each Acute Frequency Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 3. PBM shall require a DUR pharmacist to review each Acute Frequency Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 4. PBM shall send follow-up intervention letters to prescribers in accordance with Aetna Policies. 5. PBM shall enter responses received by prescribers into the appropriate PBM database.
Aetna Rx Check program - Drug/Drug Interaction Program	6. PBM shall comply with Aetna Policies for drug interaction programs. 7. PBM shall identify and report, on a daily basis, each Drug/Drug Interaction Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 8. PBM shall require a DUR pharmacist to review each Drug/Drug Interaction Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 9. Phone interventions for this program are done by the DUR pharmacist and are primarily pharmacy-directed interventions, but at the discretion of the DUR pharmacist, prescribers or Members may be contacted by telephone. 10. Upon Aetna's approval, PBM shall send intervention packets to prescribers, consisting of a letter identifying the Member and the interacting drugs, and a response form to be filled out by said prescribers to provide feedback regarding the drug-drug interaction program. 11. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the duplicate therapy, and a response form to be filled out by prescriber to provide feedback regarding the therapeutic duplication program. PBM shall enter responses received by prescribers into the appropriate PBM database.
Aetna Rx Check program - High Utilization Program (Core Safety and Monitoring)	12. PBM shall comply with Aetna Policies for high utilization programs. 13. PBM shall identify, on a monthly basis, High Utilization Claims as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 14. PBM shall require a DUR pharmacist to review each High Utilization Claim to determine whether intervention is necessary. 15. Upon Aetna's approval, PBM shall send intervention packets to prescribers, consisting of a letter identifying the Member and the high utilization drugs used, Member drug history profile listing Claims for the previous four (4) months, and a response form to be filled out by said prescribers to provide feedback regarding high utilization.

	16. PBM shall require the DUR pharmacist or administrative staff to enter an ICD-9 code if provided by a prescriber. 17. PBM shall send follow-up intervention letters to prescribers in accordance with Aetna Policies. 18. PBM shall enter responses received by prescribers into the appropriate PBM database.
Aetna Rx Check program - Therapeutic Duplication Program	19. PBM shall comply with Aetna Policies for therapeutic duplication programs. 20. PBM shall identify and report, on a daily basis, each Therapeutic Duplication Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 21. PBM shall require a DUR pharmacist to review each Therapeutic Duplication Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 22. PBM shall, as necessary, require phone interventions, with pharmacies, prescribers or Members, at the DUR pharmacist's discretion. 23. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the duplicate therapy, and a response form to be filled out by said prescribers to provide feedback regarding the therapeutic duplication program. 24. PBM shall send subsequent intervention packets to prescribers if the prescriber has responded and indicated that they would eliminate the duplicate therapy and the subsequent Claims history does not correlate with the response. 25. PBM shall enter responses received by prescribers into the appropriate PBM database.
Aetna Rx Check program - Brand Drug to Generic Drug Program	26. PBM shall comply with Aetna Policies for Brand Drug to Generic Drug programs. 27. PBM shall complete review of each identified Brand Drug to Generic Drug opportunity within forty-eight (48) hours after an eight (8) calendar day waiting period in accordance with Aetna specifications. 28. Upon Aetna's approval, PBM shall send intervention packets to prescribers, consisting of a letter identifying the Member, the Brand Drug medication identified, Member Brand Drug Cost Share, Member Generic Drug Cost Share, savings for the Member, savings for the Covered Plan, and a response form to be filled out by said prescribers to provide feedback regarding the Brand Drug to Generic Drug program. 29. PBM shall send follow-up intervention letters to prescribers in accordance with Aetna Policies. 30. PBM shall enter responses received by prescribers into the appropriate PBM database.

Aetna Rx Check program - Retail to Mail Program	31. PBM shall comply with Aetna Policies for return to mail programs. 32. PBM shall complete review of each identified Claim of a maintenance medication being filled at a retail pharmacy within forty-eight (48) hours after an eight (8) calendar day waiting period in accordance with Aetna specifications. 33. Upon Aetna's approval, PBM shall send intervention packets to Members, consisting of a letter identifying the specific maintenance medication the Member had filled at a retail pharmacy, cost savings for a 90-day supply of the identified medication at mail order, instruction on obtaining a new prescription for a 90-day supply of medication; standard mail order enrollment form; Member response form to provide any feedback regarding the return to mail program. 34. PBM shall send follow-up intervention letters to Member in accordance with Aetna Policies. 35. PBM shall enter responses received by Members into the appropriate PBM database.
Patient Safety– Identifies members receiving an opioid after receiving Suboxone/Subutex (for opioid dependence) which is known to cause a clinically significant interaction	36. PBM shall comply with Aetna Policies for Patient Safety programs. 37. PBM shall identify and report, on a daily basis, each Patient Safety Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 38. PBM shall require a DUR pharmacist to review each Patient Safety Claim to determine whether intervention is necessary within forty-eight (48) hours of receipt of the Claim. 39. PBM shall, as necessary, require phone interventions, with pharmacies, prescribers or Members, at the DUR pharmacist's discretion
Controlled Substance	40. PBM shall comply with Aetna Policies for Controlled Substance program. 41. PBM shall identify, on a monthly basis, Controlled Substance Claims as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 42. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the duplicate therapy, and a response form to be filled out by said prescribers to provide feedback regarding the Controlled Substance program. 43. PBM shall send follow-up intervention letters to Member in accordance with Aetna Policies. 44. PBM shall enter responses received by Members into the appropriate PBM database.
Therapeutic Optimization	45. PBM shall comply with Aetna Policies for Therapeutic Optimization program. 46. PBM shall identify and report, on a daily basis, each Therapeutic Optimization Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time.

	47. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the therapeutic optimization, and a response form to be filled out by said prescribers to provide feedback regarding the therapeutic optimization program. 48. PBM shall enter responses received by Members into the appropriate PBM database.
Streamlining Therapy	49. PBM shall comply with Aetna Policies for Streamlining Therapy program. 50. PBM shall identify and report, on a daily basis, each Streamlining Therapy Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 51. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the streamlining therapy opportunity, and a response form to be filled out by said prescribers to provide feedback regarding the therapeutic optimization program. 52. PBM shall enter responses received by Members into the appropriate PBM database.
Length of Therapy	53. PBM shall comply with Aetna Policies for Length of Therapy program. 54. PBM shall identify and report, on a daily basis, each Length of Therapy Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 55. PBM shall require a DUR pharmacist to review each Length of Therapy Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 56. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the length of therapy opportunity, and a response form to be filled out by said prescribers to provide feedback regarding the length of therapy program. 57. PBM shall send subsequent intervention packets to prescribers if the prescriber has responded and indicated that they would eliminate the length of therapy and the subsequent Claims history does not correlate with the response. 58. PBM shall enter responses received by Members into the appropriate PBM database.
Maximum Dose	59. PBM shall comply with Aetna Policies for Maximum Dose program. 60. PBM shall identify and report, on a daily basis, Maximum Dose Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 61. PBM shall require a DUR pharmacist to review each Maximum Dose Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim.

	62. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the maximum dose opportunity, and a response form to be filled out by said prescribers to provide feedback regarding the therapeutic optimization program. 63. PBM shall send subsequent intervention packets to prescribers if the prescriber has responded and indicated that they would eliminate or modify the maximum dose and the subsequent Claims history does not correlate with the response. 64. PBM shall enter responses received by Members into the appropriate PBM database.
Prescribing Cascade	65. PBM shall comply with Aetna Policies for Prescribing Cascade programs. 66. PBM shall identify and report, on a daily basis, each Prescribing Cascade Claim as defined by Aetna and in accordance with criteria approved by Aetna from time to time. 67. PBM shall require a DUR pharmacist to review each Prescribing Cascade Claim to determine whether intervention is necessary within seventy-two (72) hours of receipt of the Claim. 68. PBM shall, as necessary, require phone interventions, with pharmacies, prescribers or Members, at the DUR pharmacist's discretion. 69. Upon Aetna's approval, PBM shall send, via facsimile, intervention packets to prescribers, consisting of a letter identifying the Member and the Prescribing Cascade opportunity, and a response form to be filled out by said prescribers to provide feedback regarding the Prescribing Cascade program. 70. PBM shall send subsequent intervention packets to prescribers if the prescriber has responded and indicated that they would eliminate or modify the prescribing cascade and the subsequent Claims history does not correlate with the response. 71. PBM shall enter responses received by prescribers into the appropriate PBM database.

Schedule F-3

Additional PBM Core Services

[To be Added]

Schedule G

Pharmacy Network Services

Core Services

Service	Description
General Network Requirements	1. PBM shall provide the following pharmacy network administration and management services to all Participating Pharmacies and Participating Pharmacy networks and other Aetna Networks (as that term is defined in Paragraph 5 below): pharmacy contract maintenance, MAC program administration (subject to paragraph 32 through 34 below), pharmacy credentialing, pharmacy auditing, pharmacy support center, pharmacy payment and remittance advice, pharmacy termination, and annual pharmacy network analysis. PBM shall make available a full spectrum of Participating Pharmacy network options to Aetna, Aetna Affiliates, and Aetna Customers. These Participating Pharmacy network options shall meet or exceed the Participating Pharmacy network size and access standard of adequacy described in Schedule G-2 (Network Adequacy Requirements). PBM shall not discriminate against Aetna, Aetna Affiliates, or Aetna Customers in the scope of the Participating Pharmacies and Participating Pharmacy networks made available to Aetna and shall make available to Aetna all non-client specific Participating Pharmacy networks that PBM has contracted. 2. PBM shall not implement or promote any incentive or other program (*e.g.*, reduced or waived Member Cost Share) that provides incentives or encourages Members to utilize Participating Pharmacies, including those Participating Pharmacies that are in whole or in part owned or affiliated with PBM without Aetna's prior written approval, which shall be in Aetna's sole discretion. 3. Upon Aetna's request, PBM shall provide Aetna with all data, reporting, and documentation necessary to facilitate and support all state and federal network-related filing, reporting, examination, and other requirements under applicable Law. PBM shall cooperate with Aetna with respect to the submissions of Participating Pharmacy Contract templates or, if actual copies of the contracts are required by Law, Participating Pharmacy Contracts with redacted confidential pricing and cost information, unless expressly prohibited by Law, for federal and/or state regulatory approval as required by Aetna, including direct submission to state and/or federal agencies upon Aetna's written request. 4. Upon Aetna's request, PBM shall, upon terms mutually agreeable to PBM and Aetna, seek alternative partnerships and/or contracting solutions to support international network development in support of Aetna's global benefits and other international programs. This may include access to international retail networks and/or arrangement for international delivery

Service	Description
	to expatriate Members living in another country.
Network Management	5. Subject to Sections 26 through 31 below, PBM shall negotiate, contract, create, and maintain a network(s) of Participating Pharmacies that are available to provide prescription drug benefits to Members of Aetna, Aetna Affiliates, and Aetna Customers that includes the PBM Vendor National networks (*i.e.,* a non-Aetna specific network that may be used for other PBM clients) and is otherwise in accordance with configuration and other requirements requested by Aetna. Such network(s) shall be referred to as "Aetna Networks". As requested by Aetna or otherwise required by Law, the Aetna Network(s) shall include chains and independents, home infusion ("HIT"), long term care ("LTC"), the Indian Health Services, Indian tribes, tribal organizations, and urban Indian organizations ("I/T/U"), specialty, mail order, and 340B pharmacies that meet the PBM's reasonable credentialing criteria. The Aetna Network(s) shall also include Participating Pharmacies whereby Members will have access to limited distribution Covered Drugs when such drugs are not available through the Aetna Mail Order Pharmacies and/or the Aetna Specialty Pharmacies. Aetna Networks that are specifically contracted for Aetna, Aetna Affiliates, and/or Aetna Customers may not be used by other PBM clients. 6. Unless otherwise specified herein, the terms and conditions contained in this Schedule G (Pharmacy Network Services) (and related Schedule G-1 (Requirements for Participating Pharmacy Contracts) and Schedule G-2 (Network Adequacy Requirements)) and all Participating Pharmacy reporting requirements contained in Schedule V (Reporting) shall apply to all Aetna Networks. 7. PBM shall administer the Participating Pharmacy networks in accordance with this Schedule G (Pharmacy Network Services), the PBM's Contracts with Participating Pharmacies, the Agreement, and applicable Laws. 8. PBM will make networks available to Aetna, Aetna Affiliates, and Aetna Customers that shall include pharmacy discount card networks, pursuant to which Members are responsible for the entire cost of the drug, but receive the benefit of the negotiated discount card network rate under this Agreement (or as otherwise specified by Aetna) (any such discount card, a "Discount Card"). 9. Notwithstanding anything to the contrary herein, PBM will contract with 340B pharmacies identified by Aetna for the provision of certain hemophilia Covered Drugs at rates at least as aggressive as the rates Aetna has contracted with such pharmacies and on other terms required by Aetna as of the Effective Date. 10. If Aetna determines that a pharmacy or pharmacy chain that is not a

Service	Description
	Participating Pharmacy must be added as a Participating Pharmacy (*i.e.*, to meet the needs of an Aetna Customer, to support Aetna target market growth needs, to meet access requirements), Aetna will notify PBM and make a written request to include such pharmacy in the applicable Aetna Network(s). PBM shall make best efforts to enter into a Participating Pharmacy Contract with such pharmacies that contains the required terms as set forth on Schedule G-1 (Requirements for Participating Pharmacy Contracts) and under the terms and conditions of similarly situated Participating Pharmacies within thirty (30) calendar days of the receipt of Aetna's request (or such shorter time required by Law). If PBM does not secure such a Participating Pharmacy Contract with such pharmacy, Aetna shall have the right to contract directly with such pharmacy and PBM agrees to administer such pharmacy contract and treat such pharmacy as a Participating Pharmacy in the Aetna Network(s) specified by Aetna. In such cases, the Claims from such pharmacy(ies) will be excluded from rate guarantees. 11. As outlined herein, Participating Pharmacy Contracts shall contain a provision that will bar Participating Pharmacies from accepting manufacturer provided co-pay assistance cards on behalf of Aetna members. PBM will send out a client specific agreement to all pharmacies other than specialty pharmacies prohibiting these claims for Aetna, with termination/suspension provisions. Participating pharmacies participating in Medicare networks will be required to comply with Medicare regulatory requirements relating to co-pay assistance cards. Aetna understands and agrees that CVS Caremark currently has no effective mechanism for monitoring or enforcing this requirement because of limitation in the claim in-take process, however the Parties agree to cooperate to explore in good faith possible methods for enforcement in the future. PBM shall make commercially reasonable efforts to enforce Medicare regulatory requirements relating to co-pay assistance cards. 12. If at any time there exists a valid cause (as reasonably mutually determined by Aetna and PBM) for termination of a Participating Pharmacy from an Aetna Network, upon Aetna's request, PBM shall terminate such Participating Pharmacy's provision of services to Members in accordance with Law.
Credentialing	13. PBM shall credential and re-credential Participating Pharmacies in accordance with all applicable Laws and credentialing standards applicable to Aetna (as to pharmacy services delegated to PBM) and/or PBM now or hereafter in force and effect, and the requirements of Schedule G-1 (Requirements for Participating Pharmacy Contracts), including the following: PBM shall require Participating Pharmacies to be in compliance with all federal, state, and local provider accreditation and credentialing review requirements, including confirmation of DEA license, state and local pharmacy board certifications and/or licenses, and proof of

Service	Description
	insurance. Without limiting the generality of the foregoing, at a minimum, PBM shall conduct such re-credentialing or verification of credentialing of each Participating Pharmacy at least every two years. 14. PBM shall require and enforce that at no time shall any Participating Pharmacy or any of its pharmacists, employees, contractors, who are involved in the administration or delivery of Services to Members be on the OIG and/or GSA exclusion lists identified by CMS. PBM shall review on a monthly basis (or more frequently as required by Laws applicable to PBM, Aetna, Aetna Affiliates, and Aetna Customers) the OIG and GSA exclusion lists to identify those Participating Pharmacies that have received sanctions or been excluded, and PBM shall immediately remove any such Participating Pharmacy that appears on the OIG or GSA exclusion list, and take appropriate corrective action. PBM shall contractually require that Participating Pharmacies review the OIG and GSA exclusion lists regularly to verify that Participating Pharmacy pharmacists, employees, and contractors are not excluded and notify PBM of, and immediately remove, any excluded employee, pharmacist, or contractor.
Network Contracts	15. PBM shall have and maintain written contracts with each Participating Pharmacy. With respect to those pharmacies owned or operated by PBM or an Affiliate of PBM, PBM shall either (i) have and maintain written contracts with each such pharmacies; or (ii) if PBM does not have a written contract with each such pharmacy, PBM agrees on behalf of itself and all pharmacies it or its Affiliates own and operate to the terms and conditions set forth in this Schedule G (Pharmacy Network Services), including Schedule G-1 (Requirements for Participating Pharmacy Contracts). 16. All of PBM's Participating Pharmacy Contracts shall be in compliance with applicable Laws and contain, at a minimum, all of the covenants and requirements set forth in Schedule G-1 (Requirements for Participating Pharmacy Contracts) or substantively equivalent provisions, and PBM shall require Participating Pharmacies to comply with such covenants and requirements. 17. PBM's Participating Pharmacy Contracts shall include all contractual provisions required by Law, including all federal and state mandates that apply with respect to Aetna, Aetna Affiliates, Aetna Customers, Covered Plans, PBM, and the services provided to Members, with respect to all lines of business hereunder, including commercial, State Plans (including the requirements contained in Schedule P (Medicaid & Other State Plan Services), and Medicare (including the requirements contained in Schedule O (Medicare Services)). 18. PBM shall update its Participating Pharmacy Contracts to ensure

Service	Description
	compliance with all applicable Laws. PBM shall provide to Aetna a copy of its Participating Pharmacy Contract template and related documents (*i.e.*, pharmacy manual) upon reasonable request and in the event of any material modifications to the Participating Pharmacy Contract template and/or related documents to the extent related to or affecting Aetna, Aetna Network(s), Aetna Affiliates, Aetna Customers or Covered Plans.
Network Access and Composition	19. Notwithstanding anything to the contrary contained herein, PBM shall ensure that the broad national retail Aetna Networks utilized by Aetna, Aetna Affiliates, and Aetna Customers shall, at all times, meet or exceed network access standards set forth on Schedule G-2 (Network Adequacy Requirements) or such more stringent standards required by Law. In the event Aetna desires to implement a restricted or limited Aetna Network, the parties agree to work in a cooperative manner to establish appropriate network access standards for such networks. 20. With respect to each Aetna Network, PBM shall ensure that the composition of utilized pharmacies in each Aetna, Aetna Affiliates, and Aetna Customers networks, at a minimum and subject to Participating Pharmacies' compliance with PBM's standard terms and credentialing policies, mirror Aetna's pharmacy network(s) as of September 1, 2013. 21. Regardless of whether access requirements continue to be met, material changes shall not be made to pharmacy network(s) utilized by Aetna, Aetna Affiliates, and Aetna Customers and pharmacy networks utilized by Aetna, Aetna Affiliates, and Aetna Customers shall not be materially reduced in size (including removing a Major Pharmacy Chain from a network where "Major Pharmacy Chain" means a pharmacy with greater than twenty (20) locations) without prior notice to, and reasonable written approval of, Aetna. In situations where the material change is outside of PBM's reasonable control, which includes when a pharmacy refuses to accept guaranteed rates, Aetna's approval shall not be required, but PBM shall provide prompt written notice of such. The exception in the preceding sentence shall apply only to actions taken with regard to PBM's broad national network employed for other customers and not actions directed at Aetna specifically. Such notice shall not relieve PBM of its access and composition requirements hereunder. 22. Within fourteen (14) calendar days after the notice to Aetna aforementioned in Section 21 above (or such shorter time period required by Law or Governmental Body), PBM shall provide Aetna with the following in a form and format acceptable to the Parties: a. A geo-access report with respect to each affected Covered Plan. b. A thorough Member disruption analysis with respect to each affected Covered Plan, including a list of the names and ID numbers of the Members and group ID numbers of the groups that will be affected by any such change.

Service	Description
	c. PBM's recommended methods to ensure uninterrupted Member service.
Secondary Payors	23. PBM shall require Participating Pharmacies to cooperate with Aetna and/or PBM with respect to coordination of benefit matters in accordance with Law and any Covered Plan. 24. PBM shall require Participating Pharmacies to bill the primary payor, and submit secondary claim(s) to secondary payor(s) (when such secondary payor information is provided by the Member or Aetna). Subject to the foregoing obligations, applicable Law, and the applicable Covered Plan, PBM shall direct Participating Pharmacies to collect the remaining balance directly from the Member.
Aetna Customer Owned and/or Operated Pharmacies	25. PBM acknowledges that certain Aetna Customers may own, operate, and/or be affiliated with pharmacy(ies) (*e.g.*, university affiliated pharmacies for students) ("Aetna Customer Pharmacies"), and in such cases, when directed by Aetna, and subject to PBM's standard terms and credentialing requirements, PBM shall contract with Aetna Customer Pharmacies and include them in the applicable Aetna Network(s) as Participating Pharmacies. Aetna shall designate the rates for Aetna Customer Pharmacies or inform PBM that no rates apply. No rates will apply in situations where the Aetna Customer Pharmacy is dispensing Covered Drugs to the Aetna Customer's own employees. In such cases, PBM shall ensure that the Aetna Customer is not charged for those Covered Drugs dispensed by the Aetna Customer Pharmacies and the Aetna Customer Pharmacies are not paid for those Covered Drugs. All other applicable Claim adjudication requirements would apply (*i.e.*, coverage rules, concurrent DUR, Member Cost Share, etc.). In cases where Aetna designates rates for Aetna Customer Pharmacies, the Claims for such rates from such Aetna Customer Pharmacy(ies) will be excluded from rate guarantees.
	26. PBM acknowledges and agrees that Aetna has the right to negotiate rates, fees, and/or other service obligations directly with pharmacies for Covered Plans that are Medicare Plans ("**Jointly Contracted Pharmacies**"). For the avoidance of doubt, such right includes the establishment of narrow or preferred Jointly Contracted Pharmacy networks and broad networks. 27. Aetna shall have the right to directly enter into contracts with Jointly Contracted Pharmacies. PBM shall also enter into and maintain pharmacy contracts or addendums, as applicable, with such Jointly Contracted Pharmacies, as directed by Aetna and at the rates and fees and/or service obligations required by Aetna. Such contracts or addendums shall apply solely with respect to and be specific to Aetna. Such contracts and/or addendums, whether entered directly by Aetna (and communicated by Aetna to PBM) or by PBM at Aetna's direction, shall be referred to herein as "**Jointly Contracted Pharmacy Contracts**".

Service	Description
	28. Except as otherwise set forth in Section 35 below, PBM shall administer the Jointly Contracted Pharmacy Contracts and shall amend the Jointly Contracted Pharmacy Contracts to modify rates and/or other terms and conditions from time to time as required by Aetna. 29. Upon the expiration or earlier termination of the Agreement, upon the election of Aetna (which Aetna may make such election in its sole discretion at any time during the Termination Transition Period), PBM shall immediately assign to Aetna any or all Jointly Contracted Pharmacy Contracts entered into by PBM at Aetna's direction for administration by Aetna or its subsequent vendor, without a requirement of notice to or further assent by the pharmacy. For avoidance of doubt, this does not require PBM to assign or disclose PBM confidential pharmacy pricing information to Aetna, but does require PBM to assign pharmacy pricing information negotiated and/or arranged by Aetna in the Jointly Contracted Pharmacy Contracts. In this regard, PBM shall include (and maintain at all times) the following provision in each Jointly Contracted Pharmacy Contract entered into by it at Aetna's direction, substantially in the following form: Notwithstanding any other terms of the Agreement, in the event the arrangement between PBM and Aetna terminates or expires for any or no reason, upon the election of Aetna (which Aetna may make such election in its sole discretion), PBM shall, and pharmacy hereby consents to, immediately assign to Aetna the terms of this contract/addendum (including rates, services, and other applicable contract terms), for administration by Aetna or its subsequent vendor, without a requirement of notice to or further assent by pharmacy. In the event this addendum is so assigned: (i) it shall attach to and become a part of the pharmacy agreement executed between pharmacy and Aetna or Aetna's then current pharmacy benefit management vendor, as designated by Aetna; (ii) all references to "Agreement" shall thereafter refer to and mean the pharmacy agreement executed between pharmacy and Aetna or Aetna's then current pharmacy benefit management vendor, as designated by Aetna; and (iii) all references to "Caremark" or "PBM" shall thereafter refer to and mean Aetna or its then current pharmacy benefits manager, as designated by Aetna. 30. PBM shall adjudicate all Claims from Jointly Contracted Pharmacies, in such capacity, in accordance with the Jointly Contracted Pharmacy Contracts. For avoidance of doubt, the rates and terms required by Aetna under the Jointly Contracted Pharmacy Contracts shall control, not other existing contrary rates or terms such pharmacies may otherwise have under contract with PBM or its Affiliates. If any of the terms contained in the

Service	Description
	Jointly Contracted Pharmacy Contracts contain rate guarantees provided by or to such pharmacies, PBM shall be responsible for ensuring adherence therewith from an administrative standpoint and Aetna shall be financially responsible for making the pharmacy whole for the shortfall, consistent with the terms in the Jointly Contracted Pharmacy Contract. Claims for Covered Drugs dispensed by Jointly Contracted Pharmacies, in such capacity, shall not constitute Qualified Prescriptions and shall not be subject to the Retail Discount Guarantees or other discounts set forth in Schedule Y, except as required by the provisions of Part 5 of Schedule Y relating to Jointly Contracted Non-GER Pharmacies. Aetna shall be financially responsible for any financial obligations, or any financial benefit, arising from the management of the Jointly Contracted Pharmacies Contracts, subject to the provisions of Part 5 of Schedule Y relating to Jointly Contracted Non-GER Pharmacies. 31. PBM shall include the Jointly Contracted Pharmacies in the applicable Aetna Network(s) as Participating Pharmacies and treat all such Jointly Contracted Pharmacies as Participating Pharmacies for all other purposes, including pharmacy credentialing, pharmacy help desk support, and pharmacy auditing. Applicable Claim adjudication requirements shall apply (*i.e.*, coverage rules, concurrent DUR, Member Cost Share, etc.).
MAC Lists Requirements	32. MAC Lists for all Participating Pharmacies Other Than Jointly Contracted Pharmacies. PBM shall be responsible for the development of all MAC Lists other than those developed for Jointly Contracted Pharmacies under Section 34 below; *provided, however,* that the Parties shall work cooperatively in good faith in the development of such MAC Lists. At least three (3) days prior to any proposed utilization of a MAC List by PBM or to a proposed modification to a MAC List previously delivered to Aetna (a "Proposed MAC List"), PBM shall deliver to Aetna a copy of the Proposed MAC List together with such supporting documentation and information as reasonably necessary to allow Aetna to make an informed decision regarding the content and configuration of such Proposed MAC List, including the Claims or subset of Claims to which the Proposed MAC List would apply. PBM shall make its personnel available to discuss any questions or concerns Aetna may have with respect to any Proposed MAC List and shall in good faith consider any modifications thereto reasonably requested by Aetna. PBM shall at all times make available to Aetna complete copies of all MAC Lists being utilized by PBM under this Agreement. 33. Changes to MAC Lists. In no event shall any Generic Drug adjudicate at a price that is greater than AWP minus the guaranteed discount percentage applicable to Brand Drugs for the PBM fiscal year during which the Claim arises as set forth on Schedule Y. PBM shall not add any Brand Drug to any MAC List utilized by PBM in connection with any Covered Plan or Claim without Aetna's prior written approval, such approval shall not be

Service	Description
	unreasonably withheld. 34. MAC Lists for Jointly Contracted Pharmacies Subject to Guaranteed Effective Rates. a. It is understood that Aetna may negotiate arrangements with certain Jointly Contracted Pharmacies that provide for negotiated rates for Generic Drugs through mechanisms such as guaranteed effective rates for Generic Drugs. Such Jointly Contracted Pharmacies are hereinafter referred to as the "Jointly Contracted GER Pharmacies." The provisions of this Section 34 shall apply to all Jointly Contracted GER Pharmacies. It is also understood that Aetna may negotiate arrangements with certain Jointly Contracted Pharmacies that do not provide for negotiated rates for Generic Drugs through mechanisms such as guaranteed effective rates. Such Jointly Contracted Pharmacies are hereinafter referred to as the "Jointly Contracted Non-GER Pharmacies." The provisions of Section 35 shall apply to all Jointly Contracted Non-GER Pharmacies. b. PBM shall cooperate with Aetna, under Aetna's direction and control, in developing and updating all MAC Lists for Jointly Contracted GER Pharmacies. Aetna understands that PBM retains responsibility for ensuring that such MAC Lists comply with applicable Laws, and if PBM indicates that any action proposed by Aetna would violate a Law, PBM may decline to take such action. In cooperating with Aetna, PBM shall identify for Aetna its MAC pricing sources and Aetna shall consider using such sources in good faith when making MAC pricing determinations for Jointly Contracted GER Pharmacies. In addition, PBM may make changes in MAC pricing in response to supply chain exigencies for individual drugs, provided it immediately notifies Aetna of such actions and promptly consults with Aetna to determine if Aetna would like to make any further corrections in response to such supply chain exigencies or resulting changes. c. Consistent with Aetna's direction and control rights pursuant to Section 34.a above, Aetna shall provide PBM with at least three (3) Business Days prior written notice of any modification to a MAC List for Jointly Contracted Pharmacies (or such other period of time as the Parties shall mutually agree). d. Not later than three (3) Business Day after receiving a MAC List modification instruction from Aetna under Section 34.c above (or such other period of time as the Parties shall mutually agree), PBM shall have the right, by delivering a written notice to Aetna, to object to and/or request adjustments to the modifications set forth in Aetna's instructions, provided that PBM has a commercially reasonable basis for its objection or proposed adjustments. e. For a period of three (3) Business Days (or such other period of time

Service	Description
	as the Parties shall mutually agree) following any objection or adjustment notice delivered by PBM pursuant to Section 34.d. above, the Parties shall negotiate in good faith possible revisions or adjustments to the MAC List modifications included in Aetna's instructions to PBM. If Aetna and PBM are unable to reach agreement with regard to any of the matters raised in PBM's notice within three (3) Business Days, either Aetna or PBM may make a written request to escalate the matters to the head of Aetna's pharmacy business and PBM's senior manager of its relationship with Aetna (an "Officer Escalation Notice"). Within two (2) Business Days after a Party's receipt of an Officer Escalation Notice, each Party shall cause its applicable officer (or, if such officer is unavailable, a direct report to such officer) to meet with the other Party's applicable officer to confer and attempt in good faith to conclusively agree upon a resolution of the matters. If the Parties do not agree upon a resolution of the matters within two (2) Business Days of the receipt by a Party of an Officer Escalation Notice, either Aetna or PBM may make a written request to escalate the matter to the direct report to each Party's corporate parent's Chief Financial Officer who has primary responsibility for such Party's pharmacy business (a "Senior Executive Escalation Notice"), and such direct reports (or other equivalent officers) shall meet within five (5) Business Days following a Party's receipt of a Senior Executive Escalation Notice to confer and attempt in good faith to conclusively agree upon a resolution of the matters. 35. MAC Lists for Jointly Contracted Pharmacies that are not Subject to Guaranteed Effective Rates. a. PBM shall have the same responsibilities for the development of MAC Lists for Jointly Contracted Non-GER Pharmacies as are set forth in Section 34.a, except that PBM shall have direction and control over the MAC Lists used for Jointly Contracted Non-GER Pharmacies that is consistent with Aetna's product strategy, provided that in no event shall PBM take any action with regard to a MAC List for a Jointly Contracted Non-GER Pharmacy that Aetna determines to be contrary to applicable Law. b. Aetna shall have the right to request modifications to any PBM developed MAC List for Jointly Contracted Non-GER Pharmacies (or updates thereto), but consistent with PBM's right of direction and control over such MAC Lists, PBM shall not be required to implement such modifications if it reasonably believes Aetna's request is inconsistent with commercially reasonable pricing levels. If PBM indicates that any action proposed by Aetna would violate a Law, PBM may decline to take such action. c. In the event PBM declines to make a modification to a PBM

Service	Description
	developed MAC List requested by Aetna, Aetna may appeal PBM's decision using the dispute resolution mechanism described in Sections 34.d and e, including the timelines set forth therein. d. PBM shall be responsible for ensuring that the aggregate discounts achieved on all Claims dispensed by Jointly Contracted Non-GER Pharmacies shall be consistent with Aetna's product strategy. In addition, all Claims dispensed by Jointly Contracted Non-GER Pharmacies shall be subject to the guarantee mechanisms set forth in Part 5 of Schedule Y. e. PBM will consider the target GER a minimum level of discount performance and shall make commercially reasonable efforts to achieve improved financial contribution over the target GER in accordance with Aetna's product strategy, within acceptable tolerance levels as allowed in Section 35 of this Schedule G. 36. PBM and Aetna shall at all times comply with all Laws applicable to the creation and implementation of MAC Lists, including notice and contract requirements with pharmacies.
Audit Requirements	37. PBM shall conduct audits of Participating Pharmacies as set forth in Schedule X (Audits). Upon Aetna's reasonable request (or as otherwise recommended or required by Law or Governmental Body), PBM shall audit Participating Pharmacy(ies) specified by Aetna. 38. Upon Aetna's request and upon material modifications thereto, PBM shall provide to Aetna PBM's Participating Pharmacy fraud, waste, and abuse policies and procedures.
Participating Pharmacy Listings	39. Upon Aetna's request and as otherwise set forth herein, PBM shall provide to Aetna electronic listings (in mutually agreed upon format) that shall include, at a minimum, the following content: Participating Pharmacy names, Aetna Network listings, addresses, hours of operation where available, languages supported, handicap accessibility (if and where provided), ability to receive and recognize e-prescriptions, NCPDP/national provide identifier (NPI) numbers, type of pharmacy (i.e., retail, mail order, specialty), and all such other data or information which Aetna will require to comply with Law. This data and information may be used by Aetna to produce printed Participating Pharmacy directories. PBM shall ensure Aetna has legal rights to use names and/or logos of Participating Pharmacies for directories and related Member materials.
Reporting, Modeling, and Data Analysis	40. PBM shall provide Aetna with the network related reporting, modeling, and data analysis set forth in Schedule V (Reporting) for all Aetna Networks.

Service	Description
Participating Pharmacy Inquiries, Complaints, Grievances, & Appeals	41. PBM shall be responsible for handling all Participating Pharmacy inquiries, complaints, grievances, and appeals.
Regulatory Compliance	42. PBM shall maintain, administer, and manage its pharmacy network(s) and Participating Pharmacy Contracts in compliance with all applicable Laws, including the following types of Laws: any willing provider; prompt pay; pricing updates; method of payments; recovering overpayments; audit; utilization review; quality assurance; dispute resolution; balance billing prohibitions; pharmacy inquiries, complaints, grievances, and appeals; pharmacy contract amendments; and pharmacy contract terminations. 43. PBM shall require that Participating Pharmacies submit proper amounts of any and all applicable sales and/or other taxes, assessments or similar Governmental Body fees payable with respect to any sales or dispensing of Covered Drugs. PBM shall require that Participating Pharmacies apply such tax appropriately to the applicable Member, in addition to any applicable copayment, coinsurance or deductible, unless specifically prohibited from doing so under applicable law or unless the applicable governmental authority compensates or makes the Participating Pharmacy whole for any such taxes.

Schedule G-1

Requirements for Participating Pharmacy Contracts

All of PBM's Contracts with Participating Pharmacies shall require all of the following (as substantively set forth herein):

Requirement	Description
General Representations	1. Participating Pharmacy shall represent, warrant, and covenant that (i) it has and shall maintain throughout the term of the contract all appropriate license(s) and certification(s) mandated by Governmental Bodies, including DEA certification to the extent required by Law, an unrestricted license to perform its duties in the state(s) in which the Participating Pharmacy provides pharmacy services to Members, and a license free from restrictions, sanctions, penalties or probation; and (ii) it is, and will remain throughout the term, in compliance with all applicable Law, including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims and prohibition of kickbacks.
Credentialing	2. Participating Pharmacy and its pharmacists shall be licensed to operate a pharmacy pursuant to all applicable Laws, and shall be in good standing with all federal, state, and local regulatory bodies. Any Participating Pharmacy or pharmacists who is/are sanctioned by the Office of Inspector General ("OIG") or the General Services Administration ("GSA") and/or is not eligible to participate in Medicare, State Health Care Program, or other federal or state health care programs shall not be eligible or permitted to provide services to Members.
Non-Discrimination	3. Participating Pharmacy shall not discriminate, differentiate, or refuse to provide service to any Member as a result of a Member's enrollment in an Aetna plan or because of the Member's race, color, creed, national origin, ancestry, religion, health status, sex, marital status, age, disability/handicap, sexual orientation, source of payment, or any other basis prohibited by Law.
Pharmacy Dispensing	4. Participating Pharmacy shall dispense Covered Drugs to Members in accordance with its contract with PBM, plan requirements, and applicable Law, including product consultation and counseling requirements.
Requirements for Online Claim Submission	5. Participating Pharmacy shall submit all Claims online using the allowed NCPDP standard, including all information required by Aetna. Participating Pharmacy shall submit its Usual and Customary Charge with each Claim submission.
Cooperation with Patient Management Programs and Quality Activities	6. Participating Pharmacy shall comply with Aetna, Aetna Affiliate, and/or Aetna Customer programs and activities, including quality improvement, Formulary management, drug utilization review, Generic Drug substitution, disease management, and utilization management.
Utilization Management/Online Edits	7. Participating Pharmacy shall receive all pharmacy edits applicable to Members' plan electronically that are allowed by the HIPAA mandated NCPDP standards, at the point of sale, and shall respond

Requirement	Description
	appropriately to all such edits.
Member Complaints / Grievances / Appeals	8. Participating Pharmacy shall cooperate with Aetna and PBM in the investigation and resolution of Member grievances and complaints, and shall participate in and comply with Aetna's and PBM's applicable appeal, grievance, and external review procedures (including Medicare appeals and expedited appeals procedures), and shall abide by the decisions of Aetna related thereto.
Member Cost Share	9. Unless otherwise authorized in writing by Aetna and the applicable Covered Plan, Participating Pharmacy shall collect and retain from the Member at the time of dispensing the lesser of: (i) the applicable Member Cost Share; (ii) the Participating Pharmacy's Usual and Customary Charge, or (iii) the applicable contracted rate for the Covered Plan. Participating Pharmacy shall not waive, discount, reduce or defer the amount for which a Member is responsible, in whole or in part, unless otherwise required by Law, Aetna, Aetna Affiliate, or Aetna Customer. Participating Pharmacy shall not charge amounts above the amount for which the Member is responsible for Covered Drugs.
No Balance Billing; Holding Members Harmless	10. Participating Pharmacy shall not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against any Member (directly or indirectly) for Covered Drugs except the Member's applicable cost share amount. This shall include situations where payment to the Participating Pharmacy is denied because the Participating Pharmacy failed to comply with the terms of its contract with PBM and/or nonpayment, insolvency, or bankruptcy of Aetna or PBM, or where such amount is disallowed or not permitted by a Governmental Body. This shall not prohibit Participating Pharmacy from billing a Member for the following: (a) applicable co-payments, co-insurance, and deductibles owed by Member under the Member's plan; and (b) pharmacy services that are not covered under the Member's plan, provided that, (i) the Member's plan provides and/or PBM confirms that the specific services are not covered; and (ii) the Member was advised in writing prior to the services being rendered that the specific services are not covered under the Member's plan.
Negotiated Rate for Members	11. Participating Pharmacy shall give Members the benefit of the lesser of the Participating Pharmacy's Usual and Customary Charge and (i) the negotiated rate under this Agreement (or as specified by Aetna, Aetna's Contracts with Aetna Customers) or (ii) the negotiated rate under Participating Pharmacy's Contract with PBM where required by Law.
Recovery of Overpayments	12. PBM shall have the right to recover any overpayments paid to Participating Pharmacies upon notice to Participating Pharmacies, including overpayments related to audit discrepancies and failure of pharmacy to bill correct payer (including those involving coordination of benefits).
Confidentiality / Maintenance of	13. Participating Pharmacy shall maintain its agreement with PBM and all pharmacy, financial, and administrative information, records, and data

Requirement	Description
Information and Records	("Information and Records") relating to the provision of Covered Drugs to Members for a period of six (6) years (for commercial business) and ten (10) years (for Medicare) from the date the Covered Drug was dispensed to Member or completion of a governmental investigation or audit, whichever is later, or such longer period required by Law. Such Information and Records shall be maintained in a manner and format in accordance with standard pharmacy practice (including online systems), but in all events shall be reasonably accessible to PBM, Aetna, Aetna Affiliates, Aetna Customers, and Governmental Bodies. Participating Pharmacy shall treat such Information and Records and Member personal information as confidential, and shall comply with all Laws applicable to the confidentiality, use, disclosure, and maintenance of such confidential information, including Member's personal information.
Audit / Access to Information and Records	14. Participating Pharmacy shall give PBM and applicable Governmental Bodies access to and the right to audit the Participating Pharmacy and its Information and Records in accordance with the Agreement and applicable Law. Participating Pharmacy shall provide copies of or access to Information and Records within thirty (30) calendar days of the receipt of a request, where practicable, and in no event later than the date required by any applicable Law or Governmental Body. In addition, Participating Pharmacy shall provide Members with access to their health information as required by 45 C.F.R. § 164.524 and applicable state Law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state Law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state Law.
Consent to Release Medical Information	15. Participating Pharmacy shall obtain from Members the authorization to release information to PBM, Aetna, Aetna Affiliates, and Aetna Customers, to the extent required by Law.
Indemnification	16. Except as to the extent otherwise prohibited by Law, Participating Pharmacy shall indemnify Aetna from and against all liabilities, claims, losses, obligations, actions, demands, costs, and expenses, including attorneys' fees, which may arise out of any breach by the Participating Pharmacy of its contract with PBM or any negligence, gross negligence, or willful misconduct, in act or omission, of the Participating Pharmacy, its employees, agents, contractors, and representatives in connection with any services performed with respect to Members.
Insurance	17. Participating Pharmacy shall maintain in full force and effect general liability and professional liability, in form and amounts as shall be reasonable for the industry and for a provider of pharmacy services of the size, type, and location of the Participating Pharmacy. In all events, Participating Pharmacies shall maintain insurance at minimum levels no event less than: (a) professional liability insurance at a minimum level of one million dollars ($1,000,000) per claim and three million dollars ($3,000,000) in the annual aggregate; and (b) such

Requirement	Description
	other insurance and amounts as required by Law. Participating Pharmacy's insurance shall cover the acts and omissions of Participating Pharmacy as well as its agents and employees.
Use of Name and Marks	18. Participating Pharmacy shall grant Aetna, Aetna Affiliates, and Aetna Customers such rights and licenses as shall be necessary to allow them to use Participating Pharmacies' names, addresses, telephone numbers, hours of operation, etc in provider directories and in other materials and publications produced for marketing, administration, and/or operations of Aetna, Aetna Affiliates, and Aetna Customers. Participating Pharmacy shall not use the name, trademark, or logo of Aetna, Aetna Affiliates, or Aetna Customers in any advertisements, promotions, marketing, or otherwise without Aetna's prior written consent.
Compliance with Policies	19. Participating Pharmacy shall comply with all applicable PBM policies and procedures with respect to services provided to Members, including policies with respect to the Deficit Reduction Act of 2005.
Compliance with Laws	20. Participating Pharmacy shall comply with all applicable Laws.
Termination	21. Participating Pharmacy shall provide written notice to PBM of any of the following events, for which PBM shall have the right to terminate immediately Participating Pharmacy's participation with respect to Aetna, Aetna Affiliates, and Aetna Customers: (a) the withdrawal, expiration, or non-renewal of any federal, state, or local license, certificate, approval, or required authorization of Participating Pharmacy; (b) a suspension or revocation of Participating Pharmacy's DEA number or other right to dispense controlled substances; (c) the loss or material limitation of Participating Pharmacy's required insurance; (d) the debarment or suspension of Participating Pharmacy from participation in any governmental sponsored program, including Medicare or State Health Care Program; (e) the indictment, arrest or conviction of Participating Pharmacy or Participating Pharmacy's owners, managers, or employees for any felony; and (f) Participating Pharmacy's submission of false or fraudulent claims or failure to withdraw claims made for prescriptions which have been filled but were never received by the Member for any reason. In addition, (i) PBM shall have the right to terminate Participating Pharmacy's participation with respect to Aetna, Aetna Affiliates and Aetna Customers upon a determination by PBM or Aetna that Participating Pharmacy's continued participation in provider networks could result in harm to Members and (ii) PBM shall have the right, in accordance with any restrictions or notice provisions imposed by Law, to terminate Participating Pharmacy's right to service certain or all Aetna Members if so directed by Aetna, Aetna Affiliates, and/or Aetna Customers.
Interference with Contractual Relations	22. Subject to applicable Laws, Participating Pharmacy shall not engage in activities that will cause Aetna or Aetna Affiliates to lose existing or potential Members, including: (a) advising, encouraging, or suggesting (directly or indirectly) Aetna Customers or Members to

Requirement	Description
	cancel, or not renew, with Aetna or Aetna Affiliates; (b) impeding or otherwise interfering with negotiations that Aetna or any Aetna Affiliate is conducting for the provision of health benefits with respect to Covered Plans; or (c) using or disclosing to any third party Member information or list of Members acquired during the term of Participating Pharmacy's contract for the purpose of soliciting individuals who were or are Members or otherwise to compete with Aetna or any Aetna Affiliate.
Rebates	23. Participating Pharmacy shall not submit Claims for Covered Drugs dispensed to Members to pharmaceutical companies or others for purposes of receiving rebates, discounts, or the like if any such submission would impact Aetna's rebates or rebate eligibility; provided, however, this restriction does not apply to LTC Participating Pharmacies to the extent permitted by Law. Notwithstanding the foregoing, Participating Pharmacies (including LTC Participating Pharmacies) shall be required to dispense Covered Drugs on the applicable Formulary unless non-Formulary Covered Drugs are requested and required by the prescriber or Member. The Parties do not intend the foregoing restriction to inhibit a direct financial benefit to the Member under a manufacturer voucher or coupon program where permitted by Law.
Referrals to Non-Retail Participating Pharmacies	24. As required by Aetna, Aetna Affiliates, and Aetna Customers, Participating Pharmacies shall refer Members to mail order, specialty, and/or other specified vendors for certain pharmacy services.
Taxes	25. Participating Pharmacies shall submit the correct amount of any applicable taxes related to the dispensing of the Covered Drug or other applicable pharmacy services at the POS via the claims adjudication system.
Drug Manufacturer Cost Share Assistance Programs	26. Participating Pharmacies shall not accept any Cost Share assistance from drug manufacturers on behalf of Aetna members. PBM reserves the right to terminate a Participating Pharmacy Contract from any Aetna Network in the event of a violation of this condition.

Schedule G-2

Network Adequacy Requirements

Network accessibility means the extent to which Members have a choice of a Participating Pharmacy and the distance they must travel to a Participating Pharmacy in the PBM's broadest retail network. Network availability means the ratio of Members to Participating Pharmacies.

A minimum number, as determined by Aetna, of Participating Pharmacies must be available 24 hours a day seven (7) days a week.

I. Commercial:

Retail contracted Participating Pharmacy access requirements shall be as follows, which shall be met or exceeded by PBM with respect to each Covered Plan:

COMMERCIAL STANDARD (Participating Pharmacies)		**NETWORK ACCESS REQUIREMENT**
Geographic Area	Number of pharmacies and travel distance	
Urban area	1 pharmacy within 1-2 miles	95%
Suburban area	1 pharmacy within 5-7 miles	95%
Rural area	1 pharmacy within 10-15 miles	95%

II. Medicare Part D:

PBM shall ensure that the Aetna Networks utilized by Aetna, Aetna Affiliates, and Aetna Customers for Medicare Part D business shall meet or exceed all CMS required pharmacy access requirements, which are described more fully in Schedule O (Medicare Services).

III. State Health Care Programs:

PBM shall ensure that the Aetna Networks utilized by Aetna, Aetna Affiliates, and Aetna Customers for State Health Care Program business shall meet or exceed all state required pharmacy access requirements.

Schedule H

Communications

Core Services

Service	Description
General Requirements for all Communications	1. As used in this Schedule, "communications" shall include all communications directly or indirectly relating to PBM Services (including brochures, letters, and call center scripts) in any form, including written, verbal, electronic, and web-based as described in this Schedule H. Unless otherwise specified in this Schedule H (Communications) and the Agreement (including Section 11.7) or determined by mutual agreement of PBM and Aetna, PBM shall be responsible for the design, development, production (including printing), distribution (including mailing), and dissemination of all Member, Provider, Participating Pharmacy, and Aetna Customer communications relating to PBM Services, as described in this Schedule H (Communications). Unless otherwise set forth in the Agreement or this Schedule H (Communications), Aetna will have the right to review and approve, within mutually agreed timelines, the creation, content, format, and method of distribution or dissemination (including customization to conform with Aetna brand management goals, applicable Laws, "plain language" criteria, Aetna Customer requirements, and other reasonable Aetna business interests/goals) of all: (a) communications directed to Members, Aetna Customers, and Providers; and (b) communications directed to Participating Pharmacies that are either requested by Aetna or are specifically regarding Aetna. Aetna shall have full discretion to establish customization requirements to conform to Aetna brand management goals, applicable Laws and "plain language" criteria. Aetna shall also have full discretion to establish customization requirements to conform to Customer requirements and other reasonable Aetna business interests/goals, to the extent such requirements/interests/goals are consistent with the practices and capabilities of Aetna or PBM as of the Effective Date. Any additional customization requirements over this baseline would be by mutual agreement of the Parties. Except as specifically provided otherwise in the Agreement or this Schedule H (Communications), PBM shall obtain Aetna's prior written approval of all such communications prior to production, use, and/or distribution/dissemination by PBM. Such approval shall be provided in accordance with mutually agreed upon time frames. 2. On or before the PBM Services Commencement Date, PBM shall provide to Aetna for its review, consideration, and use all applicable PBM member, provider, pharmacy, and customer communication templates of PBM (including those applicable to PBM's mail order and specialty

Service	Description
	pharmacies). PBM shall provide to Aetna on an on-going basis at agreed upon timeframes (but no less often than quarterly) all of its new and updated member, provider, pharmacy and customer communication templates used for its book of business (as opposed to client-specific communications), including those applicable to PBM's mail order and specialty pharmacies, so that Aetna may evaluate whether to update (i.e., modify, add, delete), as mutually agreed by the Parties with respect to timing, its communications (including those issued by PBM in the performance of the PBM Services) based on such new or updated communication templates of PBM. 3. All communications shall include all disclosures required by applicable Law and accreditation standards. 4. All communications shall be private labeled with Aetna-approved branding unless specifically provided otherwise in the Agreement or this Schedule H (Communications). Any private label customization in addition to the Aetna brand will be mutually agreed upon, and may be subject to fees as detailed in Schedule Y-7 unless capabilities exist to deliver Aetna's request without development. 5. Communications regarding drug, side effect or administration information from PBM's mail order and specialty pharmacies that accompany drugs dispensed by the mail order and specialty pharmacies to Members shall not require the prior approval of Aetna, provided that Aetna has approved the source of the information contained in such communications or the information comes directly from the manufacturer of the drug and relates to the proper administration of the drug and PBM has identified such information to Aetna. For the avoidance of doubt, such communications shall include patient advisory leaflets and product enhancement notices and shall not include marketing materials from the manufacturer of the drug. 6. In the event that a drug dispensed by a PBM mail order pharmacy is recalled, PBM will provide Aetna with a draft of the recall communication with respect to Class I and patient level recalls it plans to send to Members along with the deadline for Aetna to provide any comments to such communication if, in PBM's professional judgment and discretion, time permits such procedure. Aetna acknowledges and agrees that any period of time given to it by PBM to review recall communications may be very brief, and that recall communications must be sent out in a timely manner due to health and safety concerns. If Aetna does not respond to PBM by the designated deadline, then PBM may send the recall communication to any Members who received the recalled drug from the mail order pharmacy without waiting for Aetna's approval. Such recall communications shall be Aetna-branded. If either Party becomes aware that a drug dispensed by a PBM specialty pharmacy is recalled, such Party shall notify immediately the other Party of same in order to effectuate together a drug recall plan. Aetna, with the

Service	Description
	cooperation of PBM, shall draft and send the specialty pharmacy recall communications to Members and provide copies of same to PBM. PBM shall provide Aetna with all information necessary to comply with the recall in a timely manner. 7. PBM shall provide all communications for which it is responsible under the Agreement, including this Schedule H (Communications), in accordance with the requirements of this Schedule H (Communications) and the Agreement. 8. The timelines for the communications described in this Schedule H, including without limitation, Member, Provider and PBM Member/Provider directed program communications, shall be set forth in a policy manual developed by Aetna and revised from time to time at Aetna's sole discretion (the "Communications Policy and Procedure Manual"), a copy of which shall be delivered to PBM prior to the Effective Date. 9. PBM understands and agrees that any failure to meet the performance guarantees as set forth in Schedule R may, in turn, escalate the provision of communications required under this Schedule H. In the event of such escalation, the timelines set forth in the Communications Policy and Procedure Manual may be immediately superseded by orders from Aetna at its sole discretion.
Member Communications	10. Member communications hereunder shall refer to and include timely distribution (which may include via mail, fax, web-based, and/or email as appropriate), consistent with agreed upon timeframes (but which shall in any event comply with applicable Law), of communications that Aetna may from time to time require, including the following: a. Member communications described in this Schedule H-1 (Required Communications); b. Member communications relating to Claims and reimbursement of Covered Drugs; c. Member denial letters, Formulary communications, identification cards, website content, and marketing materials; d. PBM's mail order pharmacies' Member communications, including Member recall letters, refill reminders, benefit policies, clinical program correspondence (if applicable), and drug or side effect information (All PBM specialty pharmacy member communications shall be made by Aetna excepting those communications described in Paragraph 5 of this Schedule H (Communications)); e. Member communications described in Schedule F (Prescription Drug Utilization Review) and Schedule F-2 (Description of Current Aetna Retrospective DUR Services);

Service	Description
	and f. 24/7 toll-free telephone access to a voice response unit or customer service representative, including access to information locating Participating Pharmacies in the zip code area (which shall be updated as changes are made to the network). g. Aetna shall have full discretion to require PBM to make Member communications to the extent such communications are consistent with the practices and capabilities of Aetna or PBM as of the Effective Date, all in accordance with the Communications Policy and Procedure Manual and the terms and conditions of this Schedule H. Any additional communication requirements over this baseline would be by mutual agreement of the Parties. 11. PBM shall private-label the check stock to be used for payments to Members in reimbursement of Member submitted paper Claims. Aetna may elect to have this check stock drawn on a PBM bank account or an Aetna bank account. 12. PBM shall provide all communications in English. In addition, PBM shall provide certain communications in Spanish and/or Mandarin as and to the extent indicated on Schedule H-1 (Required Communications). PBM shall provide additional communications in Spanish and/or Mandarin and designated communications in other languages as required by Law or as agreed upon by the Parties.
Provider Communications	13. Provider communications hereunder shall refer to and include timely distribution (which may include via mail, fax and/or email as appropriate), consistent with agreed upon timeframes (but which shall in any event comply with applicable Law), of communications that Aetna may from time to time require, including the following: a. All clinical program communications relating to programs performed by PBM personnel as outlined in Schedules J and K. Any communications relating to Aetna-specific programs performed by Aetna personnel will be by mutual agreement of the Parties. All such communications made by PBM shall be Aetna-branded and shall incorporate mutually agreed upon customizations. PBM acknowledges and agrees that Aetna shall have the right in its sole discretion to decline participation in any such PBM program. Such declination shall have no effect on the pricing terms under the Agreement, except to the extent such declination eliminates any charge otherwise applicable for the conduct of any such program. b. Provider communications described in Schedule F (Prescription Drug Utilization Review) and Schedule F-2

Service	Description
	(Description of Current Aetna Retrospective DUR Services). c. Any announcements or outreach to Providers related to Members, Aetna Customers, Covered Plans, process changes (including new forms and/or numbers), and internal updates (i.e., service centers, regions) which relate to the services provided by PBM to Aetna under the Agreement. d. PBM shall maintain the ability to communicate with Providers via fax and electronic media (provided that Aetna provides PBM the Providers' electronic addresses). e. Aetna shall have full discretion to require PBM to make Provider communications to the extent such communications are consistent with the practices and capabilities of Aetna or PBM as of the Effective Date, all in accordance with the Communications Policy and Procedure Manual and the terms and conditions of this Schedule H. Any additional communication requirements over this baseline would be by mutual agreement of the Parties.
Participating Pharmacy Communications	14. Participating Pharmacy communications hereunder shall refer to and include timely distribution (which may include via mail, fax, website posting, and/or email as appropriate), consistent with agreed upon timeframes (but which shall in any event comply with applicable Law), of communications, including the following: a. Communications with Participating Pharmacies regarding requirements of applicable Laws, new pharmacy contracts, pharmacy contract amendments, Formulary changes, Benefit Plan Design information and changes, MAC, and other pricing changes, as appropriate. b. Emergency notifications in times of natural disasters. c. Educational materials relating to PBM Services, Covered Drugs, and other relevant health, and/or pharmacy topics. d. Participating Pharmacy communications hereunder shall also refer to and include electronic messaging with Participating Pharmacies at the point of sale to identify, among other items, Formulary products, Generic Drug substitution opportunities, appropriate DUR, safety, and other Aetna Customer-specific edits (in accordance with Schedule F (Prescription Drug Utilization Review)) Member communications described in Schedule F (Prescription Drug Utilization Review) and Schedule F-2 (Description of Current Aetna Retrospective DUR Services). 15. PBM shall have the ability to communicate with Participating

Service	Description
	Pharmacies via fax and electronic media.
Aetna Customer Communications	16. Aetna Customer communications hereunder shall refer to and include timely distribution (which may include via mail, fax and/or email as appropriate), consistent with agreed upon timeframes (but which shall in any event comply with applicable Law), of communications that Aetna may from time to time require including the following: a. Network changes (when appropriate). b. Clinical program availability (for new programs created or adopted)**.** 17. All Aetna Customer communications shall be communicated to Aetna, and PBM shall not communicate with Aetna Customers unless and except as expressly directed otherwise by Aetna in writing or as expressly permitted under the Agreement.
Customized Communications	18. At Aetna's request and as agreed to by the Parties, PBM shall be responsible for all customized Aetna Customer-specific Member communications and Aetna Customer-specific Member communication requirements. In addition to the General Requirements above, such communications shall be approved in writing by the applicable Aetna Customer prior to publication, use, and/or distribution/dissemination by PBM, which such approval shall be obtained through Aetna (not directly with the Aetna Customer) unless otherwise directed by Aetna.
Web Experience; Rx Websites	19. Without limiting the generality and applicability of the foregoing sections of this Schedule H (Communications), PBM shall design, test, host, and maintain private label websites, exclusively branded as "Aetna", as mutually agreed by the Parties, to ensure brand and experience continuity (i.e., no co-branding with PBM), with separate websites for Members, Aetna Customers, and upon Aetna's request, Providers. The Parties shall work collaboratively to establish the "look and feel" of these websites to be consistent with the "look and feel" of other Aetna websites. Aetna shall have full discretion to impose requirements relating to Member websites and branding requirements relating to Provider and Customer websites. Aetna shall also have full discretion to impose any additional requirements relating to Provider, Customer and Participating Pharmacy websites to the extent such additional requirements are consistent with the practices and capabilities of Aetna or PBM as of the Effective Date. Any additional Provider, Customer or Participating Pharmacy website requirements over this baseline would be by mutual agreement of the Parties. a. Member Website. PBM shall comply with the following with respect to the Member website:

Service	Description
	i. The entryway for the Member web experience shall be through Aetna's Navigator (or such successor website designated by Aetna) through a hyperlink. Aetna Members shall be able to log into Navigator (or its successor) and then click on the Pharmacy Benefits link, which when clicked will take the Member directly to PBM's Member pharmacy benefit website. The PBM website utilized by Members shall not open up another browser window and shall instead be a part of the initial window. Members shall be able to use "single sign-on" capabilities from Navigator (or its successor) to PBM's pharmacy benefit Member website. PBM website shall maintain Member credentials and provide a return back to Aetna Navigator without the Member being required to re-authenticate. ii. The PBM pharmacy benefit website shall provide Member access to tools including: (i) Participating Pharmacy locator (which shall be updated as changes occur in the Participating Pharmacy network); (ii) Benefit Plan Design summary information; (iii) drug information, including alternatives; (iv) drug coverage and pricing; (v) twenty-four (24) months of Claims history detail and summary (including pricing); (vi) all other static and transactional pharmacy data identified by Aetna from time to time, including mail order/specialty order status; (vii) email inquiry capabilities as set forth in Schedule E (Customer and Member Service), (viii) refill and prescription order request capabilities, (ix) forms for medical exception requests; and (x) such other tools that the Parties may mutually agree to from time to time. The PBM pharmacy benefit website shall be updated in real time. iii. PBM shall provide Aetna with online view access of real time data contained in PBM's system consistent with Schedule J (Clinical Services and Formulary Administration). iv. PBM shall make the website for Members available in English and Spanish as and to the extent specified in Schedule H-1, and such other languages specified on Schedule H-1, and as required by Law or agreed to by the Parties. b. Aetna Customer Website. PBM shall provide Aetna with a link from Aetna's or PBM's Member website that includes all

Service	Description
	the capabilities offered to Members under the Member website, as well as pharmacy reports and modeling tools established from time to time in accordance with this Paragraph 19. c. Aetna Vendors. PBM shall cooperate and work in good faith with Aetna's designated vendor(s) to link Aetna's website to PBM's website(s). Upon Aetna's request, and subject to agreed upon pricing, PBM shall interface with Aetna designated vendors that provide Aetna with additional functionality and capabilities, including: (i) email capabilities for Providers and Members; (ii) mobile and text messaging applications; (iii) Member data (online and claims) mining to identify care considerations; and (iv) support for Aetna's Member health and wellness programs and provider health education.
Formulary Communication Requirements	20. Without limiting the generality and applicability of the foregoing paragraphs of this Schedule H (Communications), with respect to Formulary related matters, PBM shall provide the following (subject to Aetna's review and approval as set forth in the "General Requirements" section above): a. Drug recall communications/mailings to Members and Providers on an urgent basis; and b. Updates of Formulary changes to PBM's medication search application on a daily basis.
Member and Provider Directed Program Communication Requirements	21. PBM shall offer to Aetna all PBM Member and Provider directed programs available by PBM in accordance with PBM's standard requirements for such programs, with such changes as Aetna may reasonably require or as may be appropriate in light of Aetna's control over the Formulary to be used with Aetna plans. Such member and provider directed programs shall include the following: a. Mandatory/incentive mail order transition programs; b. Mandatory/incentive specialty pharmacy transition programs; c. Multi-source Brand Drug to Generic Drug savings programs; d. Single source Brand Drug to therapeutic equivalent Generic Drug savings program; e. Single source non-preferred Brand Drug to preferred Brand Drug notification program; f. Medication adherence programs; and g. Member education/informational opportunities. 22. Aetna is not required to use or participate in any of the PBM programs

Service	Description
	described in Paragraph 21 above. Rather, Aetna shall have the right (at its sole discretion) to select those PBM programs in which Aetna or an Aetna Customer may participate, which PBM shall provide to Aetna and/or Aetna Customers in accordance with this Schedule H (Communications), upon Aetna's written request. Aetna may terminate its or an Aetna Customer's participation in any PBM or Aetna program at any time. 23. Without limiting the generality and applicability of the foregoing paragraphs of this Schedule H (Communications), the following shall apply with respect to all programs hereunder and related communications to the extent applicable: a. All programs and communications shall be in compliance with Law. b. All criteria for each program and any changes thereto must be reviewed by Aetna and Aetna must agree to participate prior to initiation by PBM with respect to Aetna or Aetna Customers. c. PBM shall analyze data to assess potential savings for Members and Aetna (or applicable Aetna Customers) in connection with the use of any such programs prior to initiation for Aetna or Aetna Customers. PBM shall ensure that each program implemented shall not cause any Member to pay more than the Member would have paid without such program, unless agreed to in writing in advance by Aetna. PBM shall further ensure that each program implemented shall provide overall savings for Aetna or the applicable Aetna Customer (based on overall medical costs, it being understood that medication adherence/compliance programs may result in an increase in drug cost due to achieving the Member's desired medication adherence/compliance). d. The programs shall include program announcements that satisfy the requirements of this Schedule H (Communications), including Member and Provider outreach communications in all mediums (phone calls, secure email, letters, web, etc.), with such customizations as Aetna may request. Aetna shall have full discretion to impose such communication requirements to the extent such requirements are consistent with the practices and capabilities of Aetna or PBM as of the Effective Date. Any additional communication requirements over this baseline would be by mutual agreement of the Parties. e. All communications (including scripting) for each program shall be reviewed by Aetna prior to initiation, including any Aetna requested custom requests or exclusions.

Service	Description
	f. Aetna shall have full discretion to require PBM to make PBM Member and Provider directed program communications to the extent such communications are consistent with the practices and capabilities of Aetna or PBM as of the Effective Date, all in accordance with the Communications Policy and Procedure Manual and the terms and conditions of this Schedule H. Any additional communication requirements over this baseline would be by mutual agreement of the Parties.

Schedule H-1

Required Communications

This Schedule H-1 (Required Communications) contains a listing of the minimum communications required under Schedule H (Communications). It is not an all inclusive listing and shall not be construed to limit the communications required under Law, including, without limitation, applicable pharmacy regulations, or the Agreement.

Member Communications:

1. Apology Mailings Resulting from PBM Error
2. Brand Drug Going off Patent Mailing
3. Brand Drug to Generic Drug /Generic Drug Available Mailings
4. Copay Revision/Adjustment Mailing Resulting from PBM Error
5. Denial Process Letter
6. Direct Member Reimbursement Letters
7. Claim Processing Error Reimbursement Letters Resulting from PBM Error
8. Claim Processing Error Recoupment Letters Resulting from PBM Error
9. Error Mailings - Copay, Formulary, VBID, etc. Resulting from PBM Error
10. Mail Order - Forced Mail Order Delivery Mailings
11. Mail Order Forms - Generic, Aetna Client Specific (Spanish)
12. Mail Order Envelopes (Not postage paid)
13. Member Education Buckslips (e.g., RxHD Transition)
14. Member Mailings - Rx Transition Letters
15. Pharmacy Drug Lists
16. Pharmacy Network Change Notice
17. Pharmacy Network Lists (network pharmacies may be identified on PBM Vendor.com via “Find a Pharmacy” function)
18. Prescription Drug Change Mailing

19. Prescription Drug Recall/Withdrawal Mailings
20. Specialty Bio-Identical Mailings (when available)
21. Specialty Patient Medication Refill Information
22. System Error Letters Resulting from PBM Error
23. Unable to Contact Weekly Mailing
24. Claim Forms (available on-line at PBM Vendor.com)
25. Member Missing Information Letter for Paper Claims
26. Member website (Spanish)
27. Epilepsy Drug Change (for Tennessee Members)

Provider Communications:
1. Prior Authorization Communications as described in Schedule F
2. Communications Related to Dispensing by Mail Order and Specialty Pharmacies

Aetna Customer Communications
1. Quarterly Executive Summaries (see Schedule L (Sales Support and Account Management Services))
2. Network Changes

Web Sites
1. Member Web Site
2. Linkage to Aetna Customer Web Site
3. Linkage to Aetna Provider Web Site
4. Linkages to Aetna Vendor Tools

Member and Provider Directed Program Communications
1. Mandatory/Incentive Mail Order Transition Programs
2. Mandatory/Incentive Specialty Pharmacy Transition Programs
3. Multi-Source Brand Drug to Generic Drug Savings Programs
4. Single Source Brand Drug to Therapeutic Equivalent Generic Drug Savings Program
5. Medication Adherence Programs

Schedule H-2

Optional Communications ***(Pricing subject to mutual agreement)***

Member Communications

1. Annual Notice of Change Mailings (Spanish)
2. Apology Mailings Resulting from Aetna Error
3. Copay Revision/Adjustment Mailing Resulting from Aetna Error
4. Claim Processing Error Reimbursement Letters Resulting from Aetna Error
5. Claim Processing Error Recoupment Letters Resulting from Aetna Error
6. Error Mailings - Copay, Formulary, VBID, etc. Resulting from Aetna Error
7. Formulary Mailings/List
8. Member Mailings – Refunds
9. Member Mailings – Tier Changes
10. Notice of Privacy Practices (Spanish)
11. Specialty Out-of-Area Emergency Preparedness Notice
12. Specialty Patient Information and Assignment Agreement
13. System Error Letters resulting from Aetna error
14. Commercial Welcome Kit Mailings (Brochures, Enrollment Forms, etc.) (Spanish)

Provider Communications

1. Communications described in Schedule F other than Prior Authorization
2. Communications described in Schedule J

Aetna Customer Communications

1. Formulary Changes
2. Clinical Program Availability
3. Customized Communications

Member and Provider Directed Program Communications

1. Single Source Non-Preferred Brand Drug to Preferred Brand Drug Notification Program

Schedule I

Rebate Administration

Core Services

Service	Description
Overview	1. The Parties agree that on or before the Effective Date, this Schedule I (Rebate Administration) shall be amended to include the terms and conditions applicable to the PBM Rebate Administration Computer System, which shall be based on PBM's analysis to Aetna (the "PBM Rebate Proposal") of the most cost-effective and secure means for making available to Aetna the suite of computer systems used by PBM to administer its manufacturer rebates (the "PBM Rebate Administration Computer System") in order to permit Aetna to administer its Aetna Rebate Agreements in the manner necessary to meet Aetna's business requirements. This suite of systems will have the functionality described in this Schedule I, including the ability to protect the confidentiality of Aetna's and PBM's rebate data through appropriate firewalls and role-based access. The PBM Rebate Proposal forms the basis for the Parties to engage in good faith negotiations to establish commercially reasonable terms for the Rebate Administration services described herein. Once agreement is reached, this Schedule I, Schedule Y and, to the extent necessary, the Agreement shall be amended to reflect these terms. PBM agrees that the only costs included within the PBM Rebate Proposal are those reasonable costs solely for the build-out and/or modification of PBM's system in order to accommodate the administration of Aetna Rebate Agreements by Aetna personnel. The Parties will negotiate in good faith over the payment of such costs and to the extent that Aetna agrees to pay any costs, then such build-out costs shall be considered additional pricing under the Optional Services. PBM agrees that the use of the PBM Rebate Administration Computer System as contemplated by this Schedule I is included within the core pricing under the Agreement without any additional charge. 2. The requirements of this Schedule I (Rebate Administration) are subject to Section 4.3 of the Agreement. In the event of a conflict between the terms described in this Schedule I and the terms of the Aetna accepted form of the PBM Rebate Proposal, the terms of the accepted PBM Rebate Proposal shall govern (and this Schedule I shall be amended to be consistent therewith) except to the extent inconsistent with the Agreement, in which event the Agreement shall control. 3. To the extent Aetna opts to use the PBM Rebate Administration Computer System to administer Aetna Rebate Agreements, the Parties will work together to implement the necessary systems protections and coordinate necessary training and testing based on a mutually agreed upon timeline to reach full conversion to the PBM Rebate Administration Computer System ("Rebate Administration Commencement Date"). Ultimately, the Parties will use

	the terms and conditions contained in this Schedule I (Rebate Administration), as amended, and the accepted PBM Rebate Proposal to provide the basis for necessary processes and procedures and other Aetna requirements for administering Aetna Rebate Agreements via the PBM Rebate Administration Computer System. 4. Subject to the terms and conditions of the Agreement, effective upon the Rebate Administration Commencement Date, PBM will fully support Aetna as needed and permit Aetna to access the PBM Rebate Administration Computer System to enable Aetna to fully administer Aetna Rebate Agreements as further described in the Agreement, this Schedule I (Rebate Administration), as amended, and the accepted PBM Rebate Proposal. 5. In accordance with the terms and conditions of the Agreement, including this Schedule I, as amended, and the accepted PBM Rebate Proposal, the PBM Rebate Administration Computer System shall be fully capable of, among other things, generating all invoices, tracking the receipt of all Aetna Rebates and allocating such Aetna Rebate amounts to enable Aetna to retain or to distribute the Rebates appropriately to Aetna's Affiliates and Aetna Customers in the manner required by Aetna. 6. Among other things, the amended version of this Schedule I shall reflect the following terms: a. Detailed description of the capabilities of the PBM Rebate Administration Computer System; b. PBM representations and warranties regarding the PBM Rebate Administration Computer System; c. Terms for licensing of the PBM Rebate Administration Computer System to Aetna; d. Designated areas of access for each of Aetna's and PBM's employees, and requirements regarding the firewalling of each; e. Responsibilities for errors and omissions; f. Requirements for Rebate allocation; g. Requirements regarding reporting, record access and retention; h. Requirements regarding Benefit Plan Design changes and other modifications; and i. Systems audits.

Schedule J

Clinical Services and Formulary Administration

Core Services

Service	Description
Care Management – Overview	1. Aetna shall control the overall care management experience of Members. Care management is the interface between the Covered Plan clinical staff and the Member or Provider that provides clinical decision support information to benefit the Member's care. Care management does not include the prescription fulfillment component (e.g., dispensing and concurrent DUR). The care management programs described in this Schedule J are subject to change at Aetna's sole discretion and may be updated prior to the Effective Date to reflect PBM's specific programs and capabilities. 2. PBM shall not introduce any new or existing care management/clinical program (including patient persistence programs) for use with Members or Covered Plans without Aetna's prior written approval. PBM shall submit both content and form of any such programs to Aetna through the Executive Oversight and Product Strategy Committee for approval in accordance with Schedule Q (Description of Committees), including scripting and written communications (in accordance with Schedule H (Communications)). Aetna shall retain full discretion to conduct all clinical programs or to delegate such programs to PBM. PBM will adhere to Section 3.5 (c) of the Agreement related to clinical programs. . 3. To the extent a clinical program is delegated to PBM and/or Aetna approves a clinical program developed/initiated by PBM, PBM shall operate such program under Aetna's control, subject to applicable Law, Aetna Policies, NCQA, URAC, and CMS standards, and shall provide Aetna with such data relating to that program as Aetna may request. PBM shall accept such medical data, as directed by Aetna (*i.e.*, in a format and in a mutually agreed upon frequency), for use in PBM's clinical programs to foster Aetna's objective of maximizing clinical integration. 4. Aetna shall maintain decision making authority with respect to the installation, maintenance, and application of all care management and clinical program edits impacting the benefit adjudication process. For example, Aetna shall have the sole authority to (i) create, edit and maintain Cost Share tiers and levels as well as Formulary loads installed into PBM's systems in accordance with Schedule B, (ii) override care management and clinical program edits under certain circumstances as determined by Aetna, and (iii) otherwise apply edits to any care management and clinical program as it deems appropriate and as PBM functionality exists. PBM shall develop policies and procedures outlining installation and maintenance guidelines necessary to conform to Aetna's decision making authority as set forth in this Paragraph 4. Upon request, these policies shall be submitted to Aetna for approval, which shall not be unreasonably denied.

Service	Description
	5. For Aetna-approved but PBM delegated and executed clinical programs: a. PBM shall provide Aetna with all care management data for (i) Case Management ("CM"), Utilization Management ("UM"), and Disease Management ("DM") and (ii) any other clinical programs performed by PBM on behalf of Aetna in a format specified by Aetna in real time with IT connections between Aetna and PBM or, at Aetna's discretion, in batch. b. PBM shall work with Aetna to enable the daily transfer of Aetna care management data to PBM's CM system and vice versa. c. PBM shall give Aetna access to and oversight of return on investment calculations and other effectiveness studies and reporting for programs used by Aetna. For purposes of clarification, "effectiveness studies and reporting" are the potential savings analysis of drug therapy interventions and/or programs. Upon request, PBM shall also provide Aetna with general book of business return on investment data and other general book of business effectiveness studies for programs Aetna is evaluating for possible implementation. d. Unless expressly requested by Aetna, PBM shall not accept funds from Manufacturers or other third parties in connection with clinical programs being provided by PBM under this Agreement and/or with respect to the prescribing or dispensing of drugs to Members. 6. PBM shall accept medical data through Aetna's outbound medical claim format, at a frequency to be determined by Aetna, for use in PBM's clinical programs, including but not limited to Smart Edits, to foster Aetna's objective of maximizing clinical integration. 7. To the extent a clinical program is conducted by Aetna, PBM shall provide all data reasonably available to PBM in a form specified and as often as determined by Aetna to be necessary to support such program and to feed Aetna's Health Connection ("AHC"). PBM shall provide corresponding data and reporting capabilities with respect to successor programs conducted by Aetna, it being understood and agreed that the nature of such reporting capabilities will be jointly determined at the time the successor program is initiated and that pricing for such services will be reflected in the agreed-upon pricing for the program. 8. Except to the extent Aetna elects to have PBM provide retrospective DUR as an Optional Service, Aetna shall perform retrospective DUR for its Members. PBM shall provide Aetna with real time, read-only web based access to the PBM Claim/customer service information and all PBM communications to Members, Providers, and Aetna Customers, all as necessary to enable such review function. PBM shall also provide a data feed to Aetna which provides this information.

Service	Description
	9. PBM shall obtain prior written approval from Aetna: a. In order to use any Aetna data in (i) clinical studies/pilots, (ii) any studies, papers or other publications, etc. (and PBM shall give Aetna first right of refusal to co-publish), or (iii) trend or analytics related conferences. b. For any Aetna-specific algorithm used to identify Members for care management/clinical programs. c. For any Aetna-Specific clinical edits in PBM's systems as they pertain to the servicing of Members. 10. PBM shall provide Aetna with: a. All data necessary to bill Aetna Customers for clinical programs in a format reasonably acceptable to Aetna. Access to formulary maintenance files every Business Day. Daily Claims Detail Layout. b. Weekly updates of significant drug classification and coding changes. c. Weekly updates regarding drug pipeline activities to supplement Aetna's activities regarding drug pipeline knowledge. d. Real-time access to online tools that include Aetna-defined data fields indicating whether an Aetna-specific clinical program was applied to a particular Claim. e. All Aetna-specific clinical data held by or available to PBM and necessary for Aetna's personal health record in a format acceptable to Aetna. f. All data resulting from PBM's internal clinical studies and analyses to the extent not prohibited by contractual or other non-disclosure requirements. g. PBM shall designate clinical and technical resources to reasonably support Aetna's clinical programs referenced generally in Paragraph 7 above and more specifically below in this Schedule J. 11. PBM shall have the following automatic precertification capabilities: a. Ability via web for Providers and Members through secured web sites only to request precertification and if approved, have system capability to create the approval at the POS and give an authorization number to user (i.e., the Provider or Member) as well as create authorization within the adjudication system. b. Ability via phone or email for the above to occur. c. Automatic precertification system capabilities to allow online criteria to run through/triage through flow type diagrams with

Service	Description
	systematic criteria to handle precertification requests. 12. Communications with pharmacies, Providers, or Members regarding any clinical program shall only be made in compliance with the applicable provisions of Schedule H (Communications) governing Aetna's approval of all such communications.
Development of Clinical Programs; Coordination	13. Clinical Development. PBM shall consult with and assist Aetna in the development of clinical programs, with the objective of establishing unique, leading edge clinical capabilities in a collaborative fashion. PBM shall provide Aetna with detailed information regarding clinical "best practices" and, to the extent not prohibited by contractual or other non-disclosure requirements, shall disclose to Aetna clinical programs it has developed for its other customer relationships to determine whether it would be appropriate to adopt such programs for Members and/or Covered Plans. PBM shall provide reasonable support to tailor any of its clinical programs to meet Aetna's unique needs. This support shall include providing drug monographs within thirty (30) calendar days of drug launch to assure meeting the ninety (90) calendar day CMS turn around time. 14. Monthly Clinical Coordination Meetings. PBM shall participate in, at a minimum, monthly clinical coordination meetings that include clinicians from PBM and Aetna to discuss status of new drugs, new indications, new safety/black box warnings, new clinical programs being utilized for Members and/or Aetna Health Plans, and any clinical programs that PBM has in development. Additional topics will include new care management/clinical programs, review of trend analysis, review of existing clinical activities, review of new edits, review of new monographs or other developments. Focus will be a Member-centric view and providing decision support based upon clinical parameters. Decision support tools will be discussed in the context of just-in-time information delivery to constituents that will use the support tool. 15. Ad Hoc Support with Emerging Issues. PBM shall make available dedicated analytic and clinical resources to assist Aetna, upon request, with emerging clinical issues and opportunities in real-time. PBM clinical and financial personnel dedicated to Aetna shall provide all necessary ad-hoc data analysis in a timely fashion and provide administrative and clinical suggestions to support Aetna's clinical goals and improve Member safety and health outcomes.
Disease Management	16. Where PBM is performing clinical programs on Aetna's behalf, PBM shall make referrals to Aetna's and its Affiliates' DM, CM, Behavioral Health ("BH"), Specialty Pharmacy ("Specialty Rx"), Wellness, and other direct-to-Member, or direct-to-Provider programs in accordance with Aetna's specifications. To the extent directed by Aetna, such referrals shall be automated with logic pre-approved by Aetna. 17. PBM will not do disease management programs for Aetna unless requested and agreed upon in a separate agreement or addendum to this

Service	Description
	Agreement
Interface with Aetna Medical Care Management	18. PBM shall make referrals to Aetna's and/or Aetna Affiliate's medical UM programs (DM, CM, BH, Specialty Rx, and Wellness) in accordance with Aetna's specifications. To the extent directed by Aetna, such referrals shall be automated with logic pre-approved by Aetna. 19. PBM's utilization review systems shall feed data to Aetna's or it's Affiliates' systems as defined by Aetna. 20. Aetna shall be provided an opportunity to review and approve all Aetna utilization review edits in PBM's systems consistent with Schedule F (Prescription Drug Utilization Review). 21. PBM will make PBM pharmacists available telephonically as a resource to Aetna's clinical staff for purposes of providing guidance on key prescription drug therapy management issues, including safety, compliance, cost, and coverage issues. PBM pharmacists will be accessible via a toll-free number during the hours of 9:00 am ET to 8:00 pm ET Monday-Friday. Aetna clinical staff will use an Aetna-designated toll-free number to expedite access to a PBM pharmacist.
Drug Trend Analysis	22. PBM shall cooperate with Aetna on an ongoing basis to perform in depth analysis of drug trends. To support this analysis, PBM shall meet the data requirements set forth in Schedule V (Reporting). Such data shall be provided to Aetna in an electronic tool with unlimited read and query Aetna access. 23. PBM shall provide Aetna with PBM's own book of business trend analysis for review by Aetna. 24. PBM shall consult with Aetna monthly to help assess the Aetna data and provide drug trend analysis and suggestions for interpreting such drug trends utilizing blinded and/or aggregate benchmarks.
Medi-Span	25. PBM shall review and process therapeutic classification files on a daily basis as provided by Medi-Span. Aetna and PBM shall determine how these daily formulary maintenance files will be reviewed for appropriate preferred placement tiers, and PBM shall implement these updates into the PBM claim system on a daily basis with the PBM. 26. Aetna shall have the right to audit Formulary and coverage installation set up as outlined in Schedule X (Audits). 27. For purposes of providing services under this Agreement, PBM shall utilize the Medi-Span therapeutic classification system and databases. PBM shall not switch to a different therapeutic classification system without the execution of a written amendment to this Agreement. 28. PBM shall provide Aetna with real time, read-only web based access to the drug databases for the purposes of drug lookup for detailed drug parameters including: drug pricing, (AWP, WAC, direct, average AWP), therapeutic drug classification names & codes, drug status codes, J code conversion, distribution & packaging codes, Medicare indicators.

Service	Description
Formulary Management	29. Aetna will retain the responsibility of developing and determining all Aetna Formularies and Benefit Plan Design, which shall be the sole property of Aetna. Aetna will maintain an Aetna Pharmacy and Therapeutics ("P&T") Committee. 30. PBM may propose changes to Aetna Formularies, but final discretion shall reside with Aetna and its Affiliates, and with Aetna Customers, as applicable. 31. PBM shall comply with accurate and timely Claim adjudication installation and set-up of all Aetna Formularies, including any specific Formularies developed at the request of Aetna. Aetna will inform PBM of any Aetna Customer-specific Formularies at the time of plan set-up for that Aetna Customer and promptly after any subsequent revisions thereto. Formulary changes will be made in accordance with Schedule R, Section 5.4. 32. In accordance with a schedule to be determined by Aetna, PBM shall provide clinical information including standard drug monographs to Aetna to be used in developing and determining the Aetna Formularies and for use by the Aetna P&T Committee to support its determinations for specific lines of business (i.e. commercial, Medicare, State Health Care Program), including determinations made by PBM's P&T committee, together with support analysis. PBM shall not be part of Aetna's P&T Committee. Aetna will have a representative as an observer (i.e., non-voting member) of PBM's P&T committee as long as Aetna's pharmacy benefit membership is greater than one (1) million Members. Such representative may attend all PBM P&T committee meetings in person or by telephone at Aetna's discretion. 33. PBM shall load, update, test, and implement all Formularies and Formulary changes in accordance with Schedule B (Benefit Plan Design Set Up). PBM shall provide to Aetna the test results for each Covered Drug being loaded and/or updated in a level of detail and format mutually agreed to by the Parties. PBM shall resolve any coding errors identified in the testing in a manner to enable it to achieve the overall timeframes set forth in Schedule B. PBM shall make its formulary management system available to Aetna for purposes of loading and updating Formulary changes. Notwithstanding the foregoing, in implementing Formulary adjudication set up changes, PBM shall have the ability to support and shall support retrospective effective dates of such change(s). In addition, PBM shall be able to load and/or update daily changes to any Formulary and ensure proper testing thereof within twenty-four (24) hours as needed for urgent adjudication set up changes. 34. PBM shall track the status of Formulary work in progress and communicate status of such work completed or pending on a daily basis and in accordance with Schedule B (Benefit Plan Design Set Up). Notwithstanding the foregoing, the completion of any pending work shall be communicated to Aetna as soon as possible, but in no case later than twenty fours (24) from the time of completion.

Service	Description
	35. PBM shall communicate all negative Formulary changes to Members, pharmacies, and Providers for all of Aetna's Formularies within time frames designated by Aetna and in accordance with any regulatory requirements and Schedule H (Communications). PBM's responsibilities for Formulary communication items shall include but not be limited to web based applications including a medication search application and prescription pricing application for both the public domain and secure site. PBM shall also be responsible for printed and mailed Formulary communication items to Members, Providers and Aetna Customers in accordance with Schedule H. For purposes of clarification, PBM shall have capabilities to customize Formulary communication items and materials for Aetna Customers that do not have the Aetna standard Formulary benefits.
Clinical Safety Programs	36. In accordance with the requirements of Schedule H (Communications), PBM shall activate Aetna's drug recall process within twenty-four (24) hours and mail all prescriber and Member letters within seven (7) Business Days of manufacturer's announcement of recall. The drug recall process shall at a minimum include the following: a. PBM shall notify Aetna when the drug recall process is initiated. This drug recall process shall follow NCQA, URAC, and CMS standards for the three (3) types of recalls/withdrawals: Class I recalls. PBM shall establish a procedure approved by Aetna, which shall include details regarding pulling Claims reports, matching prescriber ID's with prescriber mailing addresses, blocking Claims for the impacted drugs in the PBM claim system, and revising of web and online references to the impacted drug. b. PBM shall develop and submit the following communication materials to Aetna for approval in accordance with Schedule H (Communications), and once approved, provide the communications listed below: i. Member notification - For Class 1 or Patient Level Recalls PBM shall send Aetna-approved letters to Members who have filled prescriptions for the recalled drug within the past six (6) months (or a timeframe deemed appropriate by Medical Affairs/Legal) to advise them to contact their physician immediately for consultation. ii. Aetna Customer letter - PBM shall create a drug recall letter to be used by Aetna at Aetna's discretion iii. PBM shall send Aetna-approved letters to physicians with Members taking the recalled drug for Class I Recalls. The physician letters shall include a list of their Aetna patients who have been prescribed the drug for the past six (6) months.

Service	Description
	iv. Website updates – Aetna-approved content regarding the drug recall shall be posted on the applicable web sites for Aetna Members and Providers. v. Talking points and Q&A document developed to assist customer service to help answer any questions Members, Providers, or Participating Pharmacies might have regarding the drug recall.
Auditing of Clinical Services	37. Aetna (or at Aetna's sole discretion, a designee selected by Aetna) and Aetna Customers may audit the requirements under and in connection with this Schedule J (Clinical Services and Formulary Administration) in accordance with Schedule X (Audits) and Section 7.3 of the Agreement.
Drug Information Services	38. As mutually agreed upon by the Parties, PBM shall provide a drug information service to respond to Aetna drug information requests on an ad hoc basis. The answers provided by the PBM shall include clinical drug literature references. In preparing such answers, PBM shall utilize all standard drug compendia and all standard utilized journals (including the top forty (40) most used journals). PBM shall provide, for a reasonable subscription charge, access to drug information libraries (e.g. Iowa Drug Information services) for all Aetna clinical staff as needed with individual ID/passwords. PBM shall have access to the required CMS drug compendia, MicroMedix, DrugDex, AHFI, Clinical Pharmacology, and NCCN Compendia. For Medicare based questions, the response must comply with CMS guidance.
PBM Clinical Program Support	~~39.~~ ~~40.~~ ~~41.~~ 39. PBM shall support the development of clinical programs including but not limited to the programs referenced generally in Section 7 above, and specifically outlined below in this Section 39. PBM shall support the implementation of clinical programs in the current PBM portfolio, Aetna's current portfolio, and future programs. Future programs and changes to current programs may be subject to reimbursement of costs consistent with the provisions of Section 6.3 of the Agreement. The Parties will work in good faith to mutually agree on requirements and fees for future programs. The adoption of such programs are subject to change from time to time upon request by Aetna. PBM shall work in good faith with Aetna to develop guidelines for any agreed upon future programs. 40. "Save-A-Copay Program" a. PBM shall have the ability to identify Members who would benefit from switching from a list of Aetna-approved, targeted drugs to preferred drugs.

Service	Description
	b. PBM shall send written communication to Members, in a form previously approved by Aetna, advising them of the program and instructions on how to participate in accordance with Schedule H (Communications). Members can receive up to three (3) letters per drug per year. c. PBM shall adjudicate Claims to waive imposition of copayments for a period of six (6) months for those Members who switch to preferred drugs through the Save-A-Copay Program. d. PBM shall have a process approved by Aetna to allow individual Members to opt out of the Save-A-Copay Program. 41. "Prescription Savings Program" a. PBM shall have the ability to identify Members who would benefit from substituting a Covered Drug from a list of Aetna-approved, non-Formulary Covered Drugs to preferred Covered Drugs. b. PBM shall send written communication to Members in accordance with Schedule H advising them of this (or any other) clinical program and instructing them on how to participate therein. Members can receive up to three (3) such written communications per Covered Drug per year. c. PBM shall have a process approved by Aetna to allow individual Members to opt out of the Prescriptions Savings Program. 42. "Generic Utilization Program" ("GUP") a. PBM shall conduct a point-of-service edit by sending the dispensing Participating Pharmacy a message about the generic availability for a targeted brand-name drug on PBM's targeted list. The list of targeted drugs shall be mutually agreed upon by the Parties, PBM's approval not to be unreasonably withheld. b. The network Participating Pharmacy shall enter an override code to enable PBM's system to adjudicate generic drugs substituted under this clinical program.
Quality Management Programs	43. Controlled Substance Use Program ("CSUP") a. PBM shall have a CSUP, approved by Aetna, to identify Members with potential drug seeking behavior and to encourage prescribers to coordinate care for their Members who may be receiving controlled substance prescriptions from multiple prescribers. b. PBM shall provide prescribers with specific information regarding utilization patterns, frequency, and quantities of controlled substances for a specific Member. Integrated

Service	Description
	medical and pharmacy data shall be used to identify and exclude Members with certain medical conditions where high doses of controlled substances may be medically appropriate (e.g. cancer). c. PBM shall send a written CSUP communication, in a form previously approved by Aetna, to the Member and prescriber on a quarterly basis in accordance with Schedule H (Communications). d. PBM shall coordinate with the Participating Pharmacy, Aetna Behavioral Health, PBM pharmacy auditing, and Aetna's Special Investigations Unit to ensure necessary clinical program communication and coordination and identify prescriber or pharmacy misconduct. 44. "Heart Care for Life" a. PBM shall identify Members with ischemic heart disease ("IHD") and a history of acute myocardial infarction ("AMI"). Integrated Medical and pharmacy data shall be used to identify Members. b. PBM shall provide an educational program, approved by Aetna, that is broad in scope and holistic in nature, addressing lifestyle changes and all medications (prescription and over the counter) used to treat IHD and avoid future AMI based on nationally recognized clinical treatment guidelines. PBM shall conduct outreaches to Members and prescribers at least twice annually. 45. Migraine Management a. PBM shall have the ability to identity Members with migraines. Integrated medical and pharmacy data shall be used to identify Members. b. PBM shall provide an educational program, approved by Aetna, that will be broad in scope and holistic in nature, addressing lifestyle changes and all medications (prescription and over the counter). PBM shall ensure that outreaches to Members and prescribers incorporate overall management of migraine and focus on improvement in outcomes. PBM shall conduct outreaches to Members and prescribers at least twice annually. 46. Compliance/Persistence/Adherence a. PBM shall provide a comprehensive program approved by Aetna to improve medication adherence to targeted class drug utilization to improve medical outcomes. 47. Data a. PBM shall provide Aetna with all data reasonably available to

Service	Description
	PBM and needed for Aetna integrated care management programs.
Blood Glucose Monitor	48. PBM shall accept requests for blood glucose monitors ("BGM") and provide BGMs to eligible Members, at no cost to the Member or to Aetna. 49. Members will use the same PBM customer service toll-free number (under Schedule E (Customer and Member Service)) to order BGMs. PBM shall order and track the order of all requested BGMs. PBM shall request that the BGM will be supplied and mailed to the Member within two (2) Business Days of a request for same by a third party to be determined by Aetna. 50. Aetna may contract with one or more BGM manufacturers to supply BGMs to eligible Members, or may request that PBM negotiate and enter into such Contract(s). Note: Requests for a BGM can be triggered by Aetna's case management, disease management, or a Member call.
Reporting	51. PBM shall report program results at the health plan region and Aetna Customer level on a monthly basis for all services listed above. Additionally, PBM shall meet the data requirements set forth in Schedule V (Reporting).
Pharmacy Advisor	52. PBM shall make its Pharmacy Advisor program available (with respect to which diabetes and cardiovascular conditions shall be considered Core Services; all other conditions and incremental activities shall be considered "Optional Services) to all Aetna Customers (which, for purposes of clarification, include Aetna's Commercial, Medicare and Medicaid lines of business as available), provided that such Aetna Customers shall be allowed to opt out of the entire program, including the auto-refill functionality. Pharmacy Advisor applies rules engine technology to claims data to identify Members with certain conditions who may have gaps in care or issues with medication adherence. The goal is to enable pharmacists at the point of sale to engage with Members to address these opportunities. Readi-Fill is an automated mail order prescription re-fill functionality. The Pharmacy Advisor program and the Readi-Fill functionality shall be coded by PBM at the group level to enable Aetna Customers to opt out of the entire program.

Schedule K

Prior Authorization Services

Optional Services[1]

Service	Description
General Requirements	1. Except for Prior Authorization Requests for Specialty Products paid through a medical benefit and listed on Aetna's "Medical National Pre-certification List" which shall be the sole responsibility of Aetna, PBM shall be responsible for receiving pharmacy Prior Authorization Requests (as defined below) from Members, and receiving, reviewing, approving, and denying pharmacy Prior Authorization Requests (as defined below) from Providers along with administering prior authorization overrides within the point of service ("POS") claim system; provided, however, that Aetna shall have the right to override a denial of a Prior Authorization Request. "Prior Authorization Requests" include requests for pharmacy pre-certification, step therapy exceptions, quantity limit exceptions, and medical exceptions to the Formulary applicable to the Covered Plan in which the Member participates. Prior Authorization Requests will also include copayment tiering reduction requests, Medicare Part B vs. Part D coverage determinations, and benefit coverage determinations as applicable based on the Covered Plans. PBM shall utilize toll free numbers, fax numbers, and P.O. boxes that are owned by and dedicated to Aetna. All materials and forms used, and prior authorization services performed, under this Schedule K shall be fully branded as Aetna materials, forms and services. 2. For Workers Compensation pharmacy claims, the Aetna Customer or its representative shall handle approvals and denials. PBM shall open the Prior Authorization Request received by PBM's customer service and handle the processing of Workers Compensation Prior Authorization Requests but not the decision making. Aetna Customers shall log into a Workers Compensation Customer Portal to approve/deny requests initiated by a pharmacy call to PBM's customer service. 3. PBM shall accept and administer Prior Authorization Request overrides received from Aetna via PBM's system or via the Workers Compensation Customer Portal referenced above. a. Documentation of Prior Authorization Request overrides shall be made in PBM's customer service system and include the name of the clinical staff person that approved the Prior Authorization override and the date of approval. b. The Prior Authorization Request override will reside in Member's

[1] Optional Service No. 1 in Schedule Y-7 of the Agreement describes the pricing arrangement for prior authorization services.

	eligibility master file and will be active at the time of entry. The override record will retain Aetna User ID, date and time, drug identifier, duration, free text description and other relevant data. This record will be viewable in the Member's prior authorization file in PBM's system. c. Notwithstanding the foregoing, all Prior Authorization Request overrides for Specialty Products paid through a medical benefit and listed on the "Medical National Precertification List shall be solely administered by Aetna. 4. PBM shall accept Prior Authorization Requests via multiple channels, including but not limited to telephone, fax, electronic, web-site, provider portal, and paper/mail. 5. For Prior Authorization Requests, PBM shall administer a reasonable amount of clinical rules and criteria in compliance with CMS requirements and all other applicable Laws that are: (i) applicable to the Aetna Health Plan in which the requesting Member participates, and (ii) approved by Aetna (via Aetna Clinical Policy Bulletins ("CPBs") and Aetna Pharmacy Clinical Policy Bulletins ("PCPBs")). For avoidance of doubt, PBM shall apply CMS required standards consistently across Aetna's entire book of business. Aetna shall provide CPBs and PCPBs to PBM through a combination of web and text format. PBM shall accept and implement clinical rules and criteria changes (via updated and/or new CPBs and PCPBs) in accordance with the following: (a) emergency CPBs and PCPBs within twenty-four (24) hours of receipt (which shall include a quality control process only after implementation); (b) urgent CPBs and PCPBs within two (2) business days of receipt (which shall include a quality control process); and (c) normal CPBs and PCPBs within ten (10) business days of receipt (which shall include a quality control process and review of applicable PBM Manufacturer Rebate Contracts with corresponding report to be provided to Aetna prior to implementation). Whether an updated or new CPB or PCPB shall be treated as "emergency," "urgent," or "normal" shall be determined by Aetna and communicated to PBM with the request. PBM shall communicate such updated and new CPBs and PCPBs to PBM personnel as appropriate to ensure compliance. Examples of updates or new CPBs or PCPBs that Aetna would determine to be "emergency" include updates or changes resulting from a drug recall or a material error found in the content of the CPB or PCPB. Examples of updates or new CPBs or PCPBs that Aetna would determine to be "urgent" include updates or changes necessary for processing Prior Authorization Requests shorter than the standard processing time due to new drugs (Brand Drugs or Generic Drugs) coming into the market only days after being FDA approved and before the normal criteria/CPB process occurs. 6. PBM shall incorporate clinical parameters as required by Aetna including ICD-9, lab tests, lab results, and lab values into the prior authorization process. PBM shall use ICD-9s (and upon conversion ICD-10s) in order to administer the online POS edit process.

	7. PBM shall customize the Prior Authorization Request clinical rules and criteria at the Member, group and Aetna Customer-level in accordance with Aetna's specifications as provided to PBM from time to time. PBM shall comply with applicable Law and with any notification provisions required by Aetna Customers as communicated to PBM. 8. PBM shall administer Prior Authorization Request services and utilize such multi-level personnel as required by Law, with Aetna retaining clinical quality oversight as provided in Paragraphs 32 through 35 of this Schedule K (Prior Authorization Services). 9. PBM shall at all times have staff available to accept and administer urgent Prior Authorization Requests twenty-four (24) hours per day, three hundred and sixty five (365) days per year. 10. PBM shall monitor for and identify jurisdictions within the United States that have turnaround time and other requirements for Prior Authorization Requests, as well as any other federal, state, or CMS regulatory updates, or accreditation standards including updates to NCQA or URAC PBM accreditation standards, which may have an impact on Prior Authorization Request processes. PBM shall be responsible for complying with all such requirements and standards in accordance with Aetna's interpretation and compliance standards and Aetna policies. 11. PBM shall have the following Prior Authorization Request capabilities: a. Ability via secured web site, email, provider portal, electronic means, and telephone for Providers and Members to make a Prior Authorization Request and, if approved, create the approval at the POS within the adjudication system. b. Automated Prior Authorization Request system capabilities to allow Aetna-approved online criteria (*e.g.*, provider id, etc.) to qualify drug coverage without a full Prior Authorization Request review.
Responding to Member Requests	12. PBM shall respond to all Member/Provider Prior Authorization Requests in accordance with applicable Law, Aetna's clinical rules and criteria, and Aetna Customer requirements as communicated to PBM from time to time. 13. For Coverage Determinations designated as urgent, such determinations shall be made within twenty-four (24) hours of receiving all information required to make a determination. All other Coverage Determination decisions and subsequent notifications will be made as soon as reasonably possible and within the time period required by applicable Law. 14. In making Prior Authorization Request determinations, PBM shall comply with all applicable Laws, the requirements of the applicable Covered Plan (including its Benefit Plan Design) and Aetna's clinical rules and criteria, as described in Aetna's CPBs and PCPBs. In the event of a conflict, the order of priority shall be: (i) requirements of Law, (ii) Covered Plan requirements; and (iii) Aetna's CPBs and PCPBs.

	15. PBM shall coordinate pharmacy Claim Prior Authorization Requests for Specialty Products paid through a medical benefit and listed on the Aetna Medical National Pre-certification List with the Aetna Medical National Pre-certification Team. PBM will document the date and name of the Aetna employee sending the request for such approval in the PBM claims systems.
Initial Review; Approval of Coverage	16. Prior Authorization Request initial determinations shall be reviewed by appropriate PBM personnel as required by Law, but in any event, at a minimum, by PBM personnel that are licensed pharmacy technicians supervised by licensed pharmacists. 17. Approvals may be granted by a PBM managed care representative, except where otherwise required by Law (*e.g.*, Texas). PBM shall have appropriate staff as required by Law and NCQA and URAC accreditation standards. Approvals of coverage shall be based on the processes provided under the section above titled General Requirements.
Form of Responses	18. As further provided in Section 11.8 of the Agreement and Schedule H (Communications), all responses (approvals and denials) to Prior Authorization Requests must be in writing in a form approved by Aetna, including the following requirements: a. PBM shall submit all prior authorization template letters (approvals and denials) to Aetna for prior written approval, and PBM shall make such modifications to such template letters as directed by Aetna. All changes to the template letters must be approved by Aetna in advance in writing. Changes shall be submitted to Aetna and reviewed in the ordinary course in connection with the quarterly prior authorization regulatory compliance meeting (as required by section 19 below). PBM or Aetna may submit changes off cycle in exceptional circumstances to meet regulatory requirements or as otherwise required by Aetna. b. PBM may deviate from the approved templates only in exceptional circumstances to comply with applicable Law, and then only to the extent required by Law. When possible, such deviations should only be made after receipt of Aetna's prior written approval. c. Aetna may require PBM to use specific templates for particular Aetna Customers that require customization. These templates are subject to change based on Aetna review, Aetna Customer requirements, or implementation of new business. d. Denials must contain Aetna-prescribed appeal language, denial language and such other language as may be required by Aetna, applicable Law and accreditation CMS state audit findings. e. All prior authorization Member and Provider communications shall be made in Aetna's name and shall not contain any PBM identification. If PBM concludes that its name must be

	included on any prior authorization communications to meet applicable PBM utilization review licensure requirements, it shall notify Aetna of such requirements in writing, and cooperate with Aetna to seek to identify and implement an alternative approach for meeting such applicable Law.
Prior Authorization Regulatory Compliance Meetings	19. PBM staff (as deemed appropriate by Aetna) shall initiate and participate in prior authorization regulatory compliance meetings at least quarterly, or more as mutually agreed upon by both Parties.
System Requirements	20. PBM shall provide Prior Authorization Request data to Aetna electronically on a daily basis (and in real time by a mutually agreed upon date in the future) in such format as is specified by Aetna. Said data shall include information as necessary for all state, federal, and CMS regulations, and NCQA and URAC PBM accreditation standards, including data to demonstrate compliance with said regulations and standards, as well as Aetna Policies. PBM shall monitor its operations to ensure compliance with state, federal, and CMS regulations, and other quality accreditation standards as communicated to PBM by Aetna. PBM shall provide reports and documentation to Aetna on a mutually agreed upon schedule sufficient to satisfy Aetna's oversight obligations under applicable accreditation standards. 21. Upon processing, all Prior Authorization Request approvals and denials must be entered into PBM's prior authorization system. 22. PBM shall accept electronic Prior Authorization Request files from Aetna or Aetna Customers that contain previous Prior Authorization Request information from previous PBMs or health plans dating back to a year prior to the transition date. PBM shall generate electronic Prior Authorization files for Aetna Customers that are leaving Aetna and moving to another health plan or PBM. 23. PBM shall provide access to its Prior Authorization Request application via real time web access for Aetna defined staff to view and enter and override Prior Authorization Request approval and denials and Member and Provider communications. 24. For Specialty Products paid through a medical benefit and listed on Aetna's Medical National Pre-Certification List, PBM shall exchange electronic documentation between Aetna and PBM for purposes of administering and documenting pre-certification status in the Aetna clinical systems (*e.g.*, e-TUMS, ATV) and the PBM clinical system. 25. PBM shall transact appeal decisions within the PBM claims system within twenty-four (24) hours or more expediently as regulatory requirements or patient needs dictate.
Denials of Coverage and Adverse Determinations	26. All denials must be made by PBM in writing on a form letter approved by Aetna and must be approved by appropriate PBM personnel in compliance with applicable Law, but in any event, at a minimum, by a licensed pharmacist or a medical director as required by law, all of which shall be

	in accordance with Schedule H (Communications). 27. Denial of coverage determinations and adverse determinations made by appropriate staff at PBM shall follow NCQA and URAC PBM accreditation standards; state, federal, and CMS regulations; and Aetna clinical rules and criteria as set forth in the CPBs and PCPBs. 28. As Aetna deems appropriate, adverse determinations for specific clinical rules may be retained by Aetna to be performed by Aetna's clinical pharmacist or medical director staff. 29. PBM shall fax all denials to the applicable physician and mail the same to the Member within required timeframes established by applicable Law, or, if applicable Law does not establish required timeframes, then within forty-eight (48) hours of the adverse determination.
Specialty Products	30. PBM shall notify Participating Pharmacies (including Aetna Mail Order Pharmacies and Aetna Specialty Pharmacies) via the online claims adjudication system at the point of sale of those Specialty Products requiring medical pre-certification or other requirements that are applicable to the dispensing of certain Specialty Products, as determined by Aetna from time to time. As and when required by Aetna, PBM shall require Participating Pharmacies submitting Claims for such Specialty Products to contact Aetna at the telephone number designed by Aetna. PBM and Participating Pharmacies shall comply with Aetna's pre-certification requirements applicable to such Specialty Products. Such requirements may include forwarding physician-supplied documentation to Aetna for review and approval, follow up with physician, and explaining to Members reasons for denial of coverage.
Quality Oversight	31. PBM shall make available appropriate and timely training for PBM staff handling Prior Authorization Requests on updates to Prior Authorization Request policies and procedures. Training content will be coordinated with, and reviewed by, appropriate Aetna staff. Following Aetna's review of such content, PBM agrees to work in good faith to resolve any issues identified by Aetna with respect to the training content. 32. All approval determinations and denials of coverage and adverse determinations on initial reviews made by the PBM shall be subject to audit oversight in accordance with Schedule X (Audits). 33. When requested by Aetna, PBM shall have appropriate prior authorization unit staff available to participate in Aetna quality management activities, committees, and meetings as deemed appropriate by Aetna, including complete end-to-end case reviews, call monitoring, and review of Aetna-specific training. 34. PBM shall administer a quality assurance program that reviews and scores the results of the services underlying Prior Authorization Requests in terms of decision appropriateness, system entry quality, and documentation of decision rationale ("PA Quality Assurance Program"). PA Quality Assurance Program results shall include statistically valid samples of approvals and denials by line of business (e.g., Commercial Plans, Medicare Plans, Medicaid Plans, etc.) and other reasonable reporting splits

	as requested by Aetna.

Schedule L

Sales Support and Account Management Services

Core Services

Service	Description
Client Management (Aetna as Client)	1. PBM shall provide Aetna with a comprehensive account management team (the "PBM Client Service Team"). The PBM Client Service Team(s) shall be comprised of staff and management who are experienced and have developed an expertise level reasonably acceptable to Aetna in each of Aetna's and Aetna Customers' lines of business. The PBM Client Service Team(s) shall address Aetna issues and concerns, including Aetna Customer-specific inquiries from the Aetna account management team applicable to Aetna and each Aetna Customer (each, an "Aetna Account Management Team") or other areas in Aetna as designated by Aetna from time to time for supporting day-to-day issue resolution with respect to Aetna and/or specific Aetna Customers. The PBM Client Service Team shall include, at a minimum and as directed by Aetna, the following dedicated personnel: a. Account Executives for each line of business to support business needs, including Covered Plans, ASC, and Medicare/State Health Care Program/Other b. Account Managers or equivalent for each line of business to support business needs, including Covered Plans, ASC, and Medicare/State Health Care Program/Other c. Account Service Representatives or equivalent for each line of business to support business needs, including Covered Plans, ASC, and Medicare/State Health Care Program/Other It is recognized that there may be multiple PBM Client Service Teams and that each such team may be responsible for working with multiple Aetna Account Management Teams. 2. PBM personnel as specified by Aetna shall attend all Aetna Account Management Team meetings as requested by Aetna in person or via electronic or telephonic means as Aetna shall determine. 3. The PBM Client Service Team and the applicable Aetna Account Management Team as directed by Aetna shall conduct monthly operating reviews and quarterly business reviews. During such monthly operating reviews and quarterly business reviews, PBM shall communicate effectively and professionally, conduct and facilitate meetings with an organized and well thought-out agenda which includes all applicable items and relevant performance metrics of the applicable Covered Plan, including, to the extent applicable, financial performance, operational performance, performance guarantee reviews, escalated issues, IT project status, and clinical programs savings, and which is provided to all applicable parties at least two (2) Business Days, but not more than five (5) Business Days, prior to the meeting. These meetings will be held in person at Aetna's preferred location with key PBM Client Service Team

	staff members (as identified by Aetna) present. 4. Aetna may request the removal of any individual assigned to the PBM Client Service Team at any time, with or without cause. Upon receipt of such a request, PBM shall remove such individual within a timeframe reasonably specified by Aetna, and PBM shall promptly replace such individual with a new PBM Client Service Team member who has been interviewed and reasonably approved by Aetna. 5. On an ongoing basis (and in all cases, at least annually), the PBM Client Service Team shall provide to Aetna recommendations relating to the delivery of PBM Services that are based upon PBM industry developments and industry best practices. At a minimum, such recommendations shall compare the utilization, quality, and appropriateness of Aetna's PBM Services to PBM's other clients and national PBM industry statistics for evaluation and possible incorporation into the PBM Services. PBM will also offer Aetna competitive intelligence reports indicating observations of competitor activity and trends impacting Aetna's position of services in the marketplace for each of their market segments. Such content will be in a format suitable for use in updating Aetna field sales organization on PBM industry and competitor developments.
Account Management Assistance/Support (Aetna Customer)	6. Aetna shall lead all Aetna Customer-directed account management activities that include any and all interactions with Aetna Customers. PBM shall assist with Aetna's account management activities as reasonably requested by Aetna including in the following manner: a. In accordance with Schedule H (Communications) and Schedule V (Reporting), PBM shall prepare or provide a self-service application that delivers to Aetna a comprehensive client report for each Aetna Customer as Aetna may request by line of business or otherwise in a previously agreed to format which shall address, at Aetna's direction financial, utilization, clinical, operational, and customer service performance subject matters and shall include relevant analysis data points and/or speaker's notes. Such client reports shall be prepared by PBM in accordance with Aetna designated brand standards and formats as communicated by Aetna and at no additional cost to Aetna, for delivery to Aetna Customers by Aetna and shall be delivered to Aetna within ten (10) calendar days of Aetna's request. Upon Aetna's request, PBM shall make personnel available to Aetna on a prompt basis to respond to questions relating to such executive summaries. b. PBM Client Service Team personnel shall, upon Aetna's reasonable request, participate in face-to-face Aetna Customer meetings, including Benefit Plan Design analysis sessions, reviews of plan administration performance, and clinical consultations. PBM shall not initiate any such meetings with Aetna Customers directly. All such meetings shall only be arranged through the applicable Aetna Account Management Team.

	c. The PBM Client Service Team shall be accessible to Aetna at all times during normal business hours from 8AM ET to 5 PM PT. Contact information for the PBM Client Service Team must be provided to Aetna and updated as appropriate, and must include key contact information (office, fax and cell phone numbers, email, and physical mailing addresses) for each PBM Client Service Team member. d. A pre-defined escalation process approved by Aetna will be used to resolve Aetna Customer issues in a timely fashion. PBM shall work with Aetna to establish such escalation process that would involve creation of an escalation hierarchy within the PBM Client Service Team. In addition, a jointly developed urgency scale shall be created to prioritize and define the associated turnaround time that is established for each escalation. At a minimum, PBM Client Service Team shall respond to the applicable Aetna Account Management Team on all Aetna Customer inquiries in writing within twenty-four (24) hours of transmission of such inquiry from the Aetna Account Management Team to PBM, and will use commercially reasonable efforts to resolve such inquiry in coordination with the Aetna Account Management Team according to the requirements outlined in Schedule R, Section 5. e. PBM shall expeditiously and effectively record in a jointly accessible database all account management issues and resolutions that address account management issues or problems as they arise, work to resolve problems, and communicate solutions to Aetna. PBM shall track all such issues and archive for a period of two (2) years (or such longer time required by Law) the record of the issue and resolution in a shared form and jointly accessible database. f. PBM shall provide Aetna Account Management with role-based access to the systems identified on Schedule L-1 (Account Management Systems), in accordance with the requirements set forth thereon, as applicable. g. In accordance with Schedule H (Communications), PBM shall create initial boilerplate materials and presentation documents and work collaboratively with Aetna to refine such materials for annual Aetna Customer reviews that meet Aetna's brand standards and objectives. h. In accordance with Schedule V (Reporting) and Schedule V-2 (Connectivity and Data Analysis Tools), PBM shall provide Aetna with self-service tools, data access, and data reporting to support account management and sales support. 7. Unless otherwise directed by Aetna, all Aetna Customer communications shall be distributed to Aetna for distribution to Aetna Customers. PBM shall not have direct contact with Aetna Customers unless otherwise

	specifically directed by Aetna.
Sales & Marketing Process	8. Aetna will retain all Aetna Customer market-facing roles, and PBM shall not have any direct contact with existing or potential Aetna Customers (as determined by Aetna) with respect to Aetna's sales and marketing process except as Aetna may request from time to time. 9. Aetna will retain and PBM shall provide Aetna with necessary tools and information to underwrite/price all new business and renewal cases pursuant to procedures designed to comply with applicable Law. 10. PBM shall not send any sales or marketing materials to existing or potential Aetna Customers relating to Services provided pursuant to this Agreement without Aetna's prior written consent. 11. PBM shall not send any sales or marketing or pre-enrollment materials to Members or prospective Members relating to Services provided pursuant to this Agreement without Aetna's prior written consent. 12. PBM shall not interfere in any way with Aetna's sales and marketing activities or disparage Aetna or any Aetna Customer.
PBM Sales Support	13. PBM shall prepare, in sufficient time and in a manner to allow Aetna to meet RFP and other new business requirements and deadlines, Aetna Customer and prospective Aetna Customer communications including at a minimum the following: a. Value proposition – Storyboard b. Marketing materials c. Sales materials – including RFP response and quotes 14. PBM shall provide (and update) template responses acceptable to Aetna for use in Aetna's RFP database relating to PBM's scope of services and frequently asked questions relating thereto. 15. PBM shall support Aetna in marketing proposals, as requested by Aetna, including by providing timely written responses to RFP questions describing or relating to PBM's scope of services. Aetna will brand, finalize, and have final authority over all proposals. 16. PBM shall provide full and complete RFP responses to Aetna within the time frames set forth in Schedule R (Performance Standards and Service Levels) to permit Aetna to provide a timely response to such RFP; provided that Aetna sends requests for RFP responses to PBM on a timely basis. 17. PBM shall, at Aetna's request and to the extent determined by Aetna, participate in finalist meetings or other Aetna Customer sales interactions. 18. PBM shall complete and/or provide to Aetna tools to complete, at Aetna's request, financial analysis exercises such as Claim re-pricing analysis, network access reports, Formulary disruption analysis, and therapeutic interchange analysis based on files provided to PBM from Aetna. PBM shall complete and/or provide to Aetna tools to complete financial and member impact analyses for all "value added" programs which may

	generate additional savings for Aetna Customers (e.g., step therapy, precertification, etc.) as PBM capability exists and as data provided by Aetna to PBM allows. PBM shall provide a dedicated resource or be staffed appropriately to meet the time frames set forth in Schedule R (Performance Standards and Service Levels). 19. All sales support activities conducted by PBM under this Agreement shall be performed by a dedicated team, with secure surroundings and controlled access to all information, conversations, and data. The firewall requirements set forth in Section 5.5 of the Agreement shall apply to all such sales support activities, and more specifically PBM shall fully firewall such information, conversations and data from all personnel supporting PBM's other sales activities. 20. PBM shall provide twice annual sales training opportunities (which may be conducted virtually) in support of improving sales skills and PBM industry and competitor awareness for both Aetna Pharmacy sales and account management teams and collaboration in developing training for broader Aetna field sales and account management. PBM shall also provide reasonable follow-up training opportunities on this subject matter, subject to mutual agreement as to the form and frequency of such training. 21. In the event an Aetna Customer's need does not fall within core PBM Services (such as a custom built retail network), PBM shall provide consultative solutions to assist Aetna in satisfying such need as PBM capabilities allow.

Schedule L-1

Account Management Systems

1. Access to all systems relevant to plan set-up and adjudication of Claims with read capabilities on a secure limited/security based rules access controlled environment.
2. View access into PBM's systems, similar to customer service representative view, indicating Claim status, outstanding approvals required, PA status, etc. Functionality shall also include adjudication analysis on the Aetna Customer level.
3. Online eligibility and override capabilities to update access via a web-based online tool (see Schedule C (Eligibility)).
4. Access to mail order pharmacy status tracking system. PBM will provide access to its specialty pharmacy status tracking system when available.
5. Access Member portals on behalf of the appropriate constituents, with appropriate HIPAA protections.
6. Demo IDs available for all portals to demonstrate capabilities to existing or potential Aetna Customers.
7. Access to all data tools necessary to perform Aetna Customer related analysis and outcomes reporting. This includes, but, is not limited to tools used to provide Claims data, program modeling, activity and outcomes reporting as PBM capability exists and as data provided by Aetna to PBM allows.

Schedule M

Supporting Mail Order Pharmacy Services

Core Services

Service	Description
Overview	1. Aetna RX Home owns and operates mail order pharmacies and provides mail order pharmacy services to Members of Aetna, Aetna Affiliates, and Aetna Customers ("Aetna Mail Order Pharmacies"). 2. PBM owns and operates mail order pharmacies, which have the expertise to provide centralized prescription filling services to support the fulfillment and shipping of mail order pharmacy services ("PBM Central Fill Pharmacies"). 3. Pursuant to this Schedule M (Supporting Mail Order Pharmacy Services) and the Agreement, PBM shall cause the PBM Central Fill Pharmacies to provide certain centralized prescription fulfillment services to Aetna Mail Order Pharmacies to support Aetna Mail Order Pharmacies in their fulfillment and shipping of mail order pharmacy prescription orders to Members of Aetna, Aetna Affiliates, and Aetna Customers. This Schedule M is applicable with respect to and commencing with the first prescription that Aetna enters into the Pharmacy System (as defined in Paragraph 10 below) and for all prescriptions entered into the Pharmacy System thereafter. PBM will continue to provide Aetna Mail Order Pharmacies with full access and data retrieval of archived data within the legacy CVS Caremark system as required by Aetna Mail Order Pharmacies and applicable Law, post the PBM Services Commencement Date. 4. This Schedule M (Supporting Mail Order Pharmacy Services) sets forth the central fill supporting services to be provided by the PBM Central Fill Pharmacies to Aetna RX Home and for the benefit of the Aetna Mail Order Pharmacies. Consistent with the provisions of Section 3.2(c) of the Agreement, Aetna may, at its option, require PBM to provide Supporting Mail Order Pharmacy Services for Third-Party State Plans, as outlined in Schedule P and Section 3.2(c) of the Agreement, and subject to associated pricing and terms. Alternatively, for Medicaid Plans, Aetna may, at its option, require PBM to provide the Mail Order Services described in Schedule P to the PBM Agreement, which do not involve the Aetna Mail Order Pharmacies in accordance with the pricing and other provisions set forth in Schedule P.
Pharmacy Locations	5. Without restricting Aetna Mail Order Pharmacies' rights to consolidate operations or change locations, in which case Aetna Mail Order Pharmacies may add or remove a location at its discretion, Aetna Mail Order Pharmacies currently are located at the following premises: 1600 SW 80th Terrace, 2nd Floor

Service	Description
	Plantation, FL 33324 10991 Airworld Dr. Airworld Center Kansas City MO 64153 KC Annex at 11500 Ambassador Dr. Suite 200 Kansas City MO 64153 6. PBM Central Fill Pharmacy locations will be defined prior to the commencement of the Agreement. : PBM reserves the right to adjust fees and level of support services if the number of Aetna Mail Order Pharmacies increases.
Pharmacy Licenses & Other Applicable Authorizations	7. Aetna Mail Order Pharmacies shall be responsible for obtaining and maintaining: (i) the appropriate licensure by the applicable Boards of Pharmacy to operate as resident pharmacies in such states, as applicable; and (ii) all other Board of Pharmacy, state, federal, and local licenses, business registrations, permits, certifications, and similar legal requirements applicable to the Aetna Mail Order Pharmacies and their operations, including appropriate active non-resident licensure as needed in all applicable states and jurisdictions. 8. PBM Central Fill Pharmacies shall be responsible for obtaining and maintaining: (i) the appropriate licensure and authorizations by the applicable Boards of Pharmacy to operate as a resident, non-resident, and/or central fill mail order pharmacy, as applicable, and pharmacist required licensure; and (ii) all other Board of Pharmacy, state, federal (*e.g.*, DEA), and local licenses, business registrations, permits, certifications, authorizations, provider numbers (including Medicare and Medicaid) and similar legal requirements applicable to the PBM Central Fill Pharmacies and their operations, including appropriate active non-resident licensure and central fill licensure or authorization as needed in all applicable states and jurisdictions. PBM Central Fill Pharmacies shall provide copies of all such licenses, certifications, permits, authorizations, pharmacist licenses, and pharmacy inspections related thereto (*i.e.*, State Board of Pharmacy inspections) upon Aetna Mail Order Pharmacies' request. 9. Aetna Mail Order Pharmacies and PBM Central Fill Pharmacies shall work together in good faith as necessary to assist each other in obtaining and maintaining required licensure and/or approvals for each to provide the PBM Services set forth in this Schedule M (Supporting Mail Order Pharmacy Services). Further, the Parties agree to mutually resolve any

Service	Description
	legal or regulatory matters that arise in the operation of pharmacy services under this Schedule M (Supporting Mail Order Pharmacy Services).
Equipment and Systems	10. Aetna Mail Order Pharmacies and PBM Central Fill Pharmacies shall share and have real time concurrent on-line access to a common electronic database and system ("Pharmacy System") that provides for the transfer of prescription information between the two pharmacies and that allows each pharmacy access to sufficient information necessary or required for fulfillment of prescription orders for Members as required by Law and this Schedule M (Supporting Mail Order Pharmacy Services). PBM Central Fill Pharmacies shall ensure that the Pharmacy System tracks each step of the prescription order fulfillment process, including which pharmacy is responsible for the associated task and the time and date of each applicable step. Further, PBM Central Fill Pharmacies shall ensure that the Pharmacy System shall be capable of supporting the following Aetna Mail Order Pharmacies' requirements: (i) provide accounts receivable and accounts payable functions for Aetna Mail Order Pharmacies with the ability to interface with Aetna Mail Order Pharmacies bank accounts; (ii) support credit card, EFT and other forms of electronic payment processing; (iii) handle Aetna clinical edits and programs. 11. PBM represents and warrants that the Pharmacy System has, and shall ensure that the Pharmacy System at all times shall have the capabilities to meet all Aetna Mail Order Pharmacy requirements under the terms of the Agreement and the applicable Schedules. PBM represents and warrants that the Pharmacy System shall be the same system, including any and all updates and enhancements during the term of the Agreement and thereafter as necessary, used by PBM Central Fill Pharmacies in all of its non-Aetna related operations. Further, the Pharmacy System shall (i) meet and maintain the highest industry standards for such systems in the administration of pharmacy services for companies of the size and scope of PBM Central Fill Pharmacies and Aetna Mail Order Pharmacies, and (ii) be fully compliant with all applicable Laws. The Pharmacy System shall be capable of performing its own periodic internal testing to ensure the accuracy of processing. 12. In accordance with the Agreement, including Section 11.4, PBM and PBM Central Fill Pharmacies shall license to Aetna Mail Order Pharmacies, for use in the conduct of activities related to the mail order pharmacy fulfillment services as described in the Agreement and this Schedule M (Supporting Mail Order Pharmacy Services) and as otherwise necessary, the use of the Pharmacy System and the use of any other PBM or PBM Central Fill Pharmacy materials or information throughout the Term or during the mutually agreed upon Termination Transition Period). 13. PBM Central Fill Pharmacies shall work collaboratively with Aetna Mail Order Pharmacies to provide access to and maintain in good working order at each Aetna Mail Order Pharmacy location the computer and voice

Service	Description
	systems (including, as required by Aetna, all hardware, software, automated outbound dialing technology, and other network requirements) necessary for Aetna Mail Order Pharmacies to have access to the Pharmacy System and for Aetna Mail Order Pharmacies to perform the services and obligations as set forth in this Schedule M (Supporting Mail Order Pharmacy Services). In a manner, location, and frequency reasonably acceptable to Aetna Mail Order Pharmacies, PBM Central Fill Pharmacies shall provide initial and ongoing training for Aetna Mail Order Pharmacies' personnel with respect to the Pharmacy System and such other computer hardware, software, and other network requirements required by Aetna as outlined in Schedule U. 14. All automated dispensing and storage systems utilized by PBM Central Fill Pharmacies hereunder shall be maintained and operated by PBM Central Fill Pharmacies in accordance with applicable Law. 15. PBM Central Fill Pharmacies shall comply with the most current Inventory Information Approval Systems, as modified from time to time. PBM Central Fill Pharmacies shall provide a written certification of such compliance upon Aetna Mail Order Pharmacies' request. 16. PBM Central Fill Pharmacies shall ensure that all equipment and systems required hereunder, including the Pharmacy System, support all legal and regulatory requirements as determined by Aetna Mail Order Pharmacies. 17. Notwithstanding anything contained in this Schedule M, (Supporting Mail Order Pharmacy Services) PBM and Aetna will mutually agree upon the computer hardware, software, and other network services to be used at each Aetna Mail Order Pharmacy for front-end services which will be linked to and communicate with the Pharmacy System for the provision of back-end pharmacy services as further described in the Agreement and this Schedule M (Supporting Mail Order Pharmacy Services). The Parties shall negotiate in good faith and implement such amendments to this Schedule M (Supporting Mail Order Pharmacy Services) as will be necessary to use said equipment and services.
Policies and Procedures	18. Aetna Mail Order Pharmacies and PBM Central Fill Pharmacies shall have, maintain, and update policies and procedures as required by applicable Law, including policies and procedures that document the agreed upon processes related to PBM Central Fill Pharmacies providing centralized filling services for Aetna Mail Order Pharmacies hereunder. Such policies and procedures shall include at a minimum the following: (i) descriptions of how each pharmacy will comply with federal and state laws and regulations; (ii) maintenance of appropriate records to identify the responsible pharmacist(s) in the dispensing and counseling processes; (iii) identification on the prescription label of all pharmacies involved in the filling and dispensing of the prescription as required by applicable

Service	Description
	Law; (iv) maintenance of a mechanism for tracking the prescription drug order during each step in the process; (v) provision of adequate security to protect the confidentiality and integrity of patient information including protected health information; (vi) maintenance of a quality assurance program for pharmacy services designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems; and (vii) such other policies and procedures as the Parties shall mutually agree upon. 19. All policies and procedures shall be maintained at each Aetna Mail Order Pharmacy and PBM Central Fill Pharmacy location, and PBM Central Fill Pharmacies shall make their applicable policies and procedures available to Aetna Mail Order Pharmacies, except for non-standard delivery options requested by Member. 20. All policies and procedures shall be made available to the applicable Boards of Pharmacy and other Governmental Bodies upon request.
Responsibilities of Aetna Mail Order Pharmacies	21. Aetna Mail Order Pharmacies shall accept prescription orders from Members and Providers via the U.S. mail, commercial carrier, electronically (*i.e.*, e-prescription, fax), phone, and such other means allowed by applicable Law. Upon receipt of prescription orders, Aetna Mail Order Pharmacies shall scan and enter a complete and accurate image of each prescription order into the Pharmacy System. 22. Aetna Mail Order Pharmacies shall maintain in the Pharmacy System up-to-date Member information, such as Member demographic information, allergy information (drug and food), and medical history ("Member Patient Profiles"), in electronic format. 23. After Aetna Mail Order Pharmacies have entered the prescription order image into the Pharmacy System, Aetna Mail Order Pharmacies shall utilize Member Patient Profiles contained in the Pharmacy System and shall review the prescription order, verify prescription order information, contact prescribers as necessary in the professional judgment of the pharmacists, perform benefits investigation, confirm refill information, conduct drug utilization review, determine generic or other appropriate therapeutic interventions/interchanges, communicate with Members and prescribers when necessary regarding the prescription order, input the order into the Pharmacy System, and otherwise be responsible for managing the resolution of issues related to prescription orders. 24. Aetna Mail Order Pharmacies shall submit the pharmacy Claim for each applicable clean prescription order to PBM for adjudication by PBM. 25. Aetna Mail Order Pharmacies shall collect from Members all Member

Service	Description
	Cost Share for the applicable prescription order by accepting personal checks, cashier checks, credit cards, as well as other standard methods of payment, as approved by Aetna Mail Order Pharmacies. Aetna Mail Order Pharmacies shall bear financial risk of collection of Member Cost Share from Members. 26. Aetna Mail Order Pharmacies shall enter final prescription order information for approved Claims into the Pharmacy System for filling and shipping by PBM Central Fill Pharmacies in accordance with this Schedule M (Supporting Mail Order Pharmacy Services). Such final prescription order information shall contain all information required by applicable Law. 27. Aetna Mail Order Pharmacies shall not input prescription order information into the Pharmacy System for prescription orders that are: (i) more than twelve (12) months after issuance of the prescription order for non-controlled substances; (ii) more than six (6) months after issuance of the prescription order for controlled drug substances; (iii) prohibited by applicable Law or the professional judgment of the Aetna Mail Order Pharmacy's pharmacist; or (iv) for a prescription order that the Aetna Mail Order Pharmacy would not be authorized to fill. In the event Aetna Mail Order Pharmacy determines that a prescription order cannot be filled (*i.e.*, Claim denied, no authorized refills, drug not covered, etc.), Aetna Mail Order Pharmacy shall provide notice of such to the Member, including an explanation for the denial and/or, in some circumstances, return of the prescription order. A hard copy of the prescription order is available upon request. 28. Unless the Parties mutually agree to an alternative, Aetna Mail Order Pharmacies shall continue to procure and dispense controlled substances to the extent required by applicable Law, and the Pharmacy System shall fully support this dispensing of controlled substances via Aetna Mail Order Pharmacies in accordance with Aetna requirements.
Responsibilities of PBM Central Fill Pharmacies	29. PBM Central Fill Pharmacies shall ensure that the Pharmacy System is structured such that upon entry of final prescription order information into the Pharmacy System by Aetna Mail Order Pharmacies, such prescription orders are queued and immediately accessible for fulfillment by PBM Central Fill Pharmacies in the order of the earliest date entered into the Pharmacy System by Aetna Mail Order Pharmacies. 30. Upon receipt of the final prescription order information by PBM Central Fill Pharmacies via the Pharmacy System, PBM Central Fill Pharmacy shall timely and accurately dispense such prescription orders in accordance with the prescription order, the Agreement, this Schedule M (Supporting Mail Order Pharmacy Services), and applicable Laws.

Service	Description
	31. PBM Central Fill Pharmacies shall procure, and ensure that the PBM Central Fill Pharmacies are stocked, with the appropriate amounts of pharmaceutical products and supplies necessary to provide the services set forth in this Schedule M (Supporting Mail Order Pharmacy Services). PBM Central Fill Pharmacies shall be capable of performing compounding services as required by Aetna Mail Order Pharmacies. 32. PBM Central Fill Pharmacies shall record in the Pharmacy System (and as otherwise required) information necessary to supplement the Member Patient Profile and such information as required by applicable Law as the central fill pharmacy. In addition to the foregoing, PBM Central Fill Pharmacy shall input into the Pharmacy System a record of the following information: the date of receipt of the prescription order by PBM Central Fill Pharmacy in the Pharmacy System, the name of the licensed pharmacist filling the prescription order, the date of shipping the prescription order, the method of delivery of the prescription order, the name and address where the prescription order was shipped, and identification of the pharmaceutical product and supplies actually shipped. PBM Central Fill Pharmacies shall ensure all such recorded information is accessible for view by Aetna Mail Order Pharmacies via the Pharmacy System in real time. 33. PBM Central Fill Pharmacies shall provide timely delivery of Covered Drugs to Members at the addresses designated by Members as reflected in the Pharmacy System via U.S. Postal Service or other appropriate carriers (postage prepaid). PBM Central Fill Pharmacies shall include product information and accessory warning labels (as appropriate) as required by applicable Law, with such shipments. All Covered Drugs shall be packaged and shipped in accordance with all applicable Laws, consistent with Aetna requirements, and in a manner to assure the integrity of the pharmaceutical product, including the use of appropriate packing materials that are durable, weather-resistant, water-resistant, and tamper-evident. Upon Aetna Mail Order Pharmacy's request, and upon the Parties' reasonable mutual agreement on a method to comply with automated packaging equipment, PBM Central Fill Pharmacies shall insert Aetna Mail Order Pharmacies' specified Member materials and messaging into the prescription packages (*e.g.*, messages around disease management or other communication messages as determined by Aetna Mail Order Pharmacies). PBM agrees that if PBM Central Fill Pharmacies develop or implement a process to permit patients using mail order to request that a prescription be delivered to a local retail pharmacy for pick-up, then PBM shall simultaneously make this same process or functionality available to Aetna. PBM Central Fill Pharmacies will designate a particular resource at each applicable facility to be available during all operating hours to respond immediately or otherwise as needed to any reasonable requests of Aetna Mail Order Pharmacies related to the PBM Services under this Schedule M.

Service	Description
	34. With respect to temperature-sensitive drugs, in addition to the requirements above, PBM Central Fill Pharmacies shall use an appropriate delivery service to ensure that temperature-sensitive Covered Drugs are delivered to the Member in a safe and effective manner. PBM Central Fill Pharmacies shall coordinate the delivery schedule of temperature-sensitive Covered Drugs with Aetna Mail Order Pharmacies to ensure appropriate delivery of temperature-sensitive Covered Drugs to Members. 35. PBM Central Fill Pharmacies shall ensure that Covered Drugs shipped to Members shall have no less than 180 day shelf life remaining as of the date of shipment without the express written consent of Aetna Mail Order Pharmacies. Notwithstanding the foregoing, the PBM will make every attempt to ensure that the inventory shall not include any Pharmaceutical Product that does not have at least 12 months expiration dating. In the event market best dating is less than 12 months a reasonably mutually agreed upon process will be followed to minimize the Member disruption 36. PBM Central Fill Pharmacies shall not charge Members any cost for shipping Covered Drugs. The Pharmacy System shall capture correct Member billing charges for expedited shipping at Member's expense in accounts receivable and shipping manifest systems. 37. PBM Central Fill Pharmacies shall be responsible for all requirements under applicable Law relating to the prescription label, cap, and bottle/package, and shall comply with the following: a. PBM Central Fill Pharmacies shall provide to Aetna Mail Order Pharmacies exact samples of the prescription bottle/package labels that will be affixed to show how the Aetna Mail Order Pharmacies' information will appear to Members, and shall make such modifications to such labels as Aetna Mail Order Pharmacies may reasonably request to the extent permitted by applicable Law. b. The prescription bottle/package cap shall be blank or "Aetna Mail Order Pharmacy" branded, as authorized by Aetna Mail Order Pharmacies. c. The prescription bottle/package cap, label, and container shall contain no advertising except as expressly authorized by Aetna Mail Order Pharmacies in writing. d. The prescription bottle/package labels shall identify the applicable Aetna Mail Order Pharmacy by name and address as the originating pharmacy and, unless prohibited by applicable Law, shall identify the applicable PBM Central Fill Pharmacy by a code mutually agreed upon by Aetna Mail Order Pharmacies and PBM Central Fill Pharmacies, and shall in all respects be in compliance with

Service	Description
	all applicable Laws. e. PBM Central Fill Pharmacies shall provide appropriate labels for Covered Drugs shipped to any visually impaired Member at Member's request as indicated in the Pharmacy System, including requests for Braille labels. 38. In the event PBM Central Fill Pharmacies will not be dispensing a prescription to a Member once it has been entered into the Pharmacy System by Aetna Mail Order Pharmacies as a prescription order ready for shipping (*i.e.,* out of stock, etc.), PBM Central Fill Pharmacy shall provide a written notice to the Member, including an explanation for the return of the prescription order. 39. In the event that a manufacturer, Governmental Body or other applicable Person orders a recall of a drug, PBM Central Fill Pharmacies shall conduct such product recall in accordance with Aetna policies and requirements and shall notify Aetna Mail Order Pharmacies and Members in accordance with applicable Law (and industry standard practices) at PBM Central Fill Pharmacies' cost. If PBM or PBM Central Fill Pharmacies receive any compensation from a third party with respect to a recalled drug, PBM and PBM Central Fill Pharmacies shall pay Aetna Mail Order Pharmacies the portion of such amount that is attributable to Members and Covered Plans, and will reverse Claims for any unused portion of a recalled product.
Pharmacist Access	40. Aetna Mail Order Pharmacies and PBM Central Fill Pharmacies shall ensure that between such pharmacies a pharmacist is available in person during all operating hours or via two-way communication technology (*i.e.,* telephone) during non-operating hours to provide patient counseling, including via a dedicated toll free telephone number (which in all cases shall be available not less than forty (40) hours per week). Upon Aetna Mail Order Pharmacies' request, PBM Central Fill Pharmacies' pharmacists shall be available during such times to assist Members and Aetna Mail Order Pharmacies with consultations or inquiries regarding prescription orders shipped by PBM Central Fill Pharmacies.
Pharmacy Errors	41. Each Aetna Mail Order Pharmacy and PBM Central Fill Pharmacy shall be responsible for their respective errors and omissions committed by such pharmacy during the performance of the obligations and functions of the pharmacy as set forth in this Schedule M (Supporting Mail Order Pharmacy Services). 42. On a monthly basis, PBM Central Fill Pharmacies shall provide to Aetna Mail Order Pharmacies a report of errors and omissions committed by PBM Central Fill Pharmacies with respect to Members, including error category (*e.g.,* Class 1 error), remediation plans, and trending information.

Service	Description
	If a Member rejects a drug due to PBM Central Fill Pharmacy error or omission, PBM Central Fill Pharmacy shall, at its cost and expense, immediately refill and ship to the Member via overnight courier the correct Covered Drug, and include a postage paid return shipping label for the Member to use to return the original shipment. An "error" shall have the meaning as defined in Schedule R (Performance Standards and Service Levels/Major PBM Defaults).
Lost and Damaged Shipments	43. For each prescription order received by PBM Central Fill Pharmacies via the Pharmacy System, PBM Central Fill Pharmacies are responsible for all lost or missing Covered Drugs not received by Members and for any damaged Covered Drugs received by Members, as well as any pharmacy errors attributable to the pharmacy Services performed by PBM Central Fill Pharmacies hereunder. 44. If a Member reports to Aetna Mail Order Pharmacies that a Covered Drug was not received, then Aetna Mail Order Pharmacies shall communicate such to PBM Central Fill Pharmacy, and PBM Central Fill Pharmacy shall immediately ship to the Member via overnight courier another shipment of the Covered Drug in accordance with Aetna Mail Order Pharmacies' policies at no cost to Member, Aetna, Aetna Plan Affiliates, Aetna Customers, or Aetna Mail Order Pharmacies. 45. If a Member rejects a drug due to the Covered Drug being damaged during shipment, PBM Central Fill Pharmacy shall immediately ship to the Member via overnight courier another shipment of the Covered Drug in accordance with Aetna Mail Order Pharmacies' policies at no cost to Member, Aetna, Aetna Affiliates, Aetna Customers, or Aetna Mail Order Pharmacies. With the new shipment, PBM Central Fill Pharmacy shall include a postage paid return shipping label for the Member to use to return the original damaged shipment.
Urgent Situations	46. In the event PBM Central Fill Pharmacies do not or cannot reship Covered Drug via overnight courier within twenty-four (24) hours of becoming aware of a reshipment requirement as specified herein or in the event of an "urgent" situation where the Member needs the Covered Drug immediately prior to when reshipment would be received, PBM Central Fill Pharmacies shall make arrangements with PBM for such Members to receive the Covered Drugs at retail Participating Pharmacies at PBM and/or PBM Central Fill Pharmacy's sole cost and expense (*i.e.*, PBM and PBM Central Fill Pharmacies shall not bill Aetna or Aetna Mail Order Pharmacies for local retail pharmacy supply overrides resulting from circumstances where PBM Central Fill Pharmacies shipped the wrong item, damaged items are received, or items have been shipped but not received by the Member in accordance with Aetna Mail Order Pharmacies' policies).
Mail Order Programs and Activities	47. PBM and PBM Central Fill Pharmacies shall obtain Aetna's prior written approval in accordance with Section 11.7 of the Agreement and Schedule

Service	Description
	H (Communications) before any programs or activities are initiated by PBM or PBM Central Fill Pharmacies with respect to mail order pharmacy services, including those that are designed to, or which do, encourage greater mail order utilization. Aetna shall have the right to grant, withhold, or revoke approval of such programs and activities in its sole discretion. PBM and PBM Central Fill Pharmacies shall not conduct any type of calling, or other program for Formulary, Brand Drug to Generic Drug, non-preferred Covered Drug to preferred Covered Drug, Brand Drug dispensed as Generic Drug using DAW logic, therapeutic substitution, prescription adherence, persistence, or compliance programs, or the like, that may involve calling or otherwise contacting a Provider or Member without Aetna's prior express review and written approval (which may be revoked at any time).
Mail Order Pharmacy Reporting	48. PBM Central Fill Pharmacies shall provide Aetna Mail Order Pharmacies with the reports related to PBM Central Fill Pharmacies set forth on Schedule V (Reporting) and such other reporting required by applicable Law. 49. PBM Central Fill Pharmacies also shall provide reports to Aetna Mail Order Pharmacies as reasonably requested by Aetna Mail Order Pharmacies and at such frequency as Aetna Mail Order Pharmacies consider appropriate to keep Aetna Mail Order Pharmacies informed as to the status and condition of the PBM Central Fill Pharmacies' compliance with this Schedule M (Supporting Mail Order Pharmacy Services) and other reports as required by Aetna Mail Order Pharmacies to manage and control the services performed by Aetna Mail Order Pharmacies. PBM Central Fill Pharmacies shall provide Aetna Mail Order Pharmacies with access to its mail operations "Datamart" system as part of the Pharmacy System to allow Aetna Mail Order Pharmacies to query the system and run necessary reports, including reports measuring turnaround time metrics. 50. PBM Central Fill Pharmacies shall give Aetna Mail Order Pharmacies prompt written notice if turnaround times and requirements are not being met or are in jeopardy of not being met by PBM Central Fill Pharmacies.
Data Use/ Disclosures	51. PBM and PBM Central Fill Pharmacies acknowledge and agree that PBM and PBM Central Fill Pharmacies are subject to and shall comply with the restrictions and requirements set forth in Section 11.1 of the Agreement and Schedule Z (Authorized Uses of Data and Information).
Recordkeeping	52. Without limiting the generality of Section 7.1 of the Agreement, PBM Central Fill Pharmacies shall maintain records related to the services provided by PBM Central Fill Pharmacies under this Schedule M (Supporting Mail Order Pharmacy Services), including the original prescription order and records related to the fulfillment and shipping of Covered Drugs to Members. PBM Central Fill Pharmacies shall make available to, or provide copies to, Aetna Mail Order Pharmacies of such

Service	Description
	records upon request by Aetna Mail Order Pharmacies.
Disaster Recovery & Business Continuity Plans	53. PBM Central Fill Pharmacies shall have disaster recovery plans and business continuity plans for central fill pharmacy services hereunder that enables the PBM Central Fill Pharmacies to continue to operate and perform the duties, obligations, and services hereunder in accordance with the standards set forth in Schedule R (Performance Standards and Service Levels). Notwithstanding the foregoing, in the event that a particular PBM Central Fill Pharmacy is unable to perform its duties, obligations, and services hereunder within twenty-four (24) hours of a disaster, such PBM Central Fill Pharmacy shall promptly notify Aetna Mail Order Pharmacies in writing and use all commercially reasonable efforts to have central fill pharmacy services provided by a different PBM Central Fill Pharmacy hereunder. In the event no PBM Central Fill Pharmacy is able to perform its duties, obligations, and services hereunder within twenty-four (24) hours of a disaster, PBM Central Fill Pharmacies shall require any alternate/backup pharmacy to comply with the terms and conditions of this Schedule M (Supporting Mail Order Pharmacy Services), subject to Aetna's prior written approval. 54. In the event of a disaster or substantial disruption in Aetna Mail Order Pharmacy services (as determined by Aetna Mail Order Pharmacies), at Aetna's option PBM Central Fill Pharmacies shall provide backup pharmacy services to assist Aetna Mail Order Pharmacies in their obligations hereunder according to terms and pricing to be mutually agreed upon in good faith.
Pharmacy Compliance and Cooperation	55. PBM Central Fill Pharmacies and Aetna Mail Order Pharmacies shall ensure that their respective pharmacies and operations are at all times in compliance with applicable Laws as determined by Aetna Mail Order Pharmacies. 56. PBM Central Fill Pharmacies shall promptly forward to Aetna Mail Order Pharmacies in a manner and form acceptable to Aetna Mail Order Pharmacies all inquiries, complaints, and grievances received by PBM Central Fill Pharmacies from any Member, Provider, or Governmental Body related to Aetna, Aetna Affiliates, Aetna Customers, Aetna Mail Order Pharmacies, Members, or the Agreement, including this Schedule M (Supporting Mail Order Pharmacy Services). PBM Central Fill Pharmacies shall cooperate in good faith with Aetna Mail Order Pharmacies and shall promptly provide to Aetna Mail Order Pharmacies such information and other documentation reasonably required to respond to such inquiries, complaints, and grievances. 57. From time to time, each party shall reasonably accommodate the other to discuss any problems or other matters regarding the Aetna Mail Order Pharmacies' or the PBM Central Fill Pharmacies' performances hereunder. PBM Central Fill Pharmacies shall use best efforts to

Service	Description
	cooperate with and accommodate Aetna Mail Order Pharmacies by making changes reasonably requested by Aetna Mail Order Pharmacies in connection with the mail order pharmacy services provided pursuant to this Schedule M (Supporting Mail Order Pharmacy Services).
Mail Order Pharmacy Private Label Branding	58. The following shall be provided in accordance with Section 11.6 of the Agreement: The entire mail order pharmacy Member experience, including answering calls, materials, communications, and the labels on prescription bottles, shall include, refer to, and continue to reflect Aetna and Aetna RX Home where appropriate and shall be in accordance with Aetna's reasonable requirements to the extent permitted by applicable Law, all of which shall be subject to Aetna's review and approval in accordance with Schedule H (Communications).
Pricing and Payment Terms	59. Aetna Mail Order Pharmacies and PBM Central Fill Pharmacies agree to the pricing and payment terms applicable to the Covered Drugs and services provided under this Schedule M (Supporting Mail Order Pharmacy Services) as set forth in Schedule Y and Article IX of the Agreement.

Schedule M-1

Full Mail Order Pharmacy Services

Optional Services

In the event that Aetna elects to have the full mail order pharmacy services set forth in this Schedule M-1 provided for all Covered Plans, this Schedule M-1 shall be subject to further revision.

Service	Description
Overview	1. PBM owns and operates mail order pharmacies ("PBM Mail Order Pharmacies"). PBM Mail Order Pharmacies may be responsible for the full mail order pharmacy delivery process – including the front-end mail collection, prescription/order entry, the prescription claims submission, the back-end dispensing process, the shipping process, and the delivery to the Member – at the election of Aetna in accordance with Item 11 of Schedule Y-7. Aetna may make such election with respect to one or more Covered Plans, one or more Aetna Customers, or one or more lines of business (*e*.g., Commercial Plans, Medicare Plans or Medicaid Plans). Such an election by Aetna may be applicable to mail order pharmacy services with respect to a particular Aetna Plan or Aetna Customer, or line of business, as mutually agreed upon by the Parties and with adequate advanced notice. In no event shall any such election modify the terms otherwise applicable to any Covered Plan and/or Aetna Customer to which such election does not apply. In the event that Aetna elects to have Optional Services provided under this Schedule M-1 with respect to all Covered Plans, as mutually agreed upon by the Parties and with adequate advanced notice, such services and functions may thereafter constitute a Core Service. Particular Aetna Plans, Aetna Customers or lines of business covered by this Schedule M-1are identified in Schedule GG.
Mail Order Pharmacy Services	2. PBM Mail Order Pharmacies shall accept prescription orders from Members and prescribers via the U.S. mail, commercial carrier, electronically (*i.e.*, e-prescription, fax), phone, and such other means allowed by applicable Law. 3. PBM Mail Order Pharmacies shall review the prescription order, verify prescription order information, contact prescribers as necessary in the professional judgment of the pharmacists, perform benefits investigation, confirm refill information, conduct drug utilization review, determine generic or other appropriate therapeutic interventions/interchanges, communicate with Members and prescribers when necessary regarding the prescription order, input the order into the pharmacy system, and otherwise be responsible for managing the resolution of issues related to prescription orders.

Service	Description
	4. PBM Mail Order Pharmacies shall, in electronic format in the mail order pharmacy system, maintain up-to-date Member information, such as Member demographic information, allergy information (drug and food), and medical history. 5. PBM Mail Order Pharmacies shall fill prescriptions subject to the professional judgment of the dispensing pharmacist, good pharmacy practices in accordance with local community standards, and product labeling guidelines. 6. PBM Mail Order Pharmacies shall timely and accurately dispense new or refill prescriptions following receipt from a Member or prescriber of (i) a prescription and a completed order or refill order form, and (ii) any applicable Member Cost Share where permitted by applicable Law, in accordance with the prescription order, the Agreement, this Schedule M-1, and applicable Laws. 7. PBM Mail Order Pharmacies shall provide timely delivery of Covered Drugs to Members via United States postal service or other appropriate carriers to the address provided by the Member (postage prepaid); include product information and accessory warning labels (as appropriate) as required by applicable Law, with such shipments. All Covered Drugs shall be packaged and shipped in accordance with all applicable Laws, and in a manner to assure the integrity of the pharmaceutical product, including the use of appropriate packing materials that are durable, weather-resistant, water-resistant, and tamper-evident. 8. PBM Mail Order Pharmacies shall maintain the appropriate licensure by (i) the applicable Boards of Pharmacy to operate as resident pharmacies in such states, as applicable; and (ii) all other Board of Pharmacy, state, federal, and local licenses, business registrations, permits, certifications, and similar legal requirements applicable to the mail order pharmacies and their operations, including appropriate active non-resident licensure as needed in all applicable states and jurisdictions. 9. PBM Mail Order Pharmacies shall comply with all applicable Laws related to the provision of mail order pharmacy services to Members. 10. PBM Mail Order Pharmacies shall not charge Members fees to use mail order pharmacy services, including postage and handling fees. 11. PBM Mail Order Pharmacies shall provide to Members toll-free telephone access to a pharmacist during business hours and on-call pharmacist access after-hours twenty-four (24) hours a day, seven (7) days a week. 12. Member Cost Share. PBM Mail Order Pharmacies shall collect from

Service	Description
	Members all Member Cost Share for the applicable prescription order by accepting personal checks, cashier checks, credit cards, as well as other standard methods of payment, as mutually agreed by PBM and Aetna. PBM Mail Order Pharmacies shall bear financial risk of collection of Member Cost Share from Members, and the collection process shall be determined by PBM and at PBM's sole discretion. 13. PBM Mail Order Pharmacies are responsible for replacement of any damaged Covered Drugs received by Members or other pharmacy errors attributable to the pharmacy Services performed by PBM Mail Order Pharmacies at the cost of PBM Mail Order Pharmacies. 14. PBM Mail Order Pharmacies are responsible for reshipment of lost or undelivered Covered Drugs and PBM Mail Order Pharmacies shall bear the cost of the lost or undelivered shipment upon receipt of written confirmation from the Member that the Covered Drug remains undelivered which confirmation shall be in the format and time period requested by PBM Mail Order Pharmacies.
Applicable Provisions of Schedule M (Supporting Mail Order Pharmacy Services)	15. Unless otherwise agreed to by Aetna in writing and to the extent applicable, all sections of Schedule M (Supporting Mail Order Pharmacy Services) shall apply to all Aetna Customers and Aetna Plan Affiliates electing this Optional Service. In the event of a conflict between the terms of this Schedule M-1 and Schedule M, the terms of this Schedule M-1 shall control. For purposes of this Schedule M-1 (Full Mail Order Pharmacy Services), the following references contained within such provisions in Schedule M (Supporting Mail Order Pharmacy Services) shall refer to and mean the following: a. All references to "PBM Central Fill Pharmacies" shall refer to and mean "PBM Mail Order Pharmacies"; b. All references to prescription orders received by PBM Central Fill Pharmacies via the Pharmacy System shall refer to and mean all prescription orders received by the PBM Mail Order Pharmacies; and c. All references to Aetna Mail Order Pharmacies shall refer to and mean Aetna.
Pricing	16. As provided in Schedule Y-5, Y-13 and Y-13, Aetna will be required to pay an increased Dispensing Fee during any period that Front-End Pharmacy Services are provided by PBM or its Affiliates under this Schedule M-1with respect to Claims subject to such sub-schedule of Schedule Y.

Schedule N

Supporting Specialty Pharmacy Services

Core Services

Service	Description
Overview	1. Aetna Specialty RX owns and operates specialty pharmacies and provides specialty pharmacy services to Members of Aetna, Aetna Affiliates, and Aetna Customers ("Aetna Specialty Pharmacies"). 2. PBM owns and operate specialty pharmacies, which have the expertise to provide centralized prescription filling services to support the fulfillment and shipping of specialty pharmacy services ("PBM Central Fill Specialty Pharmacies"). 3. Pursuant to this Schedule N (Supporting Specialty Pharmacy Services) and the Agreement, PBM shall cause the PBM Central Fill Specialty Pharmacies to provide certain centralized prescription fulfillment services to Aetna Specialty Pharmacies to support Aetna Specialty Pharmacies in their fulfillment and shipping of Specialty pharmacy prescription orders to Members of Aetna, Aetna Affiliates, and Aetna Customers. . 4. This Schedule N (Supporting Specialty Pharmacy Services) sets forth the central fill supporting services to be provided by the PBM Central Fill Specialty Pharmacies to Aetna Specialty RX and for the benefit of the Aetna Specialty Pharmacies. Consistent with the provisions of Section 3.2(c) of the PBM Agreement, Aetna may, at its option, require PBM to provide Supporting Specialty Pharmacy Services for Third-Party State Plans. Alternatively, for Medicaid Plans, Aetna may, at its option, require PBM to provide the Specialty Services described in Schedule P (Medicare and Other State Plan Services) to the PBM Agreement, which do not involve the Aetna Specialty Pharmacies in accordance with the pricing and other provisions set forth in Schedule P (Medicare and Other State Plan Services).
Pharmacy Locations	5. Without restricting Aetna Specialty Pharmacies' rights to consolidate operations or change locations in which case Aetna Specialty Pharmacy may add or remove a location at its discretion, Aetna Specialty Pharmacies currently are located at the following premises: Aetna Specialty Pharmacy 503 Sunport Lane Orlando, FL 32809 6. PBM Central Fill Specialty Pharmacies are located at the following premises:

Service	Description
Pharmacy Licenses & Other Applicable Authorizations	7. Aetna Specialty Pharmacies shall be responsible for obtaining and maintaining: (i) the appropriate licensure by the applicable Boards of Pharmacy to operate as resident pharmacies in such states, as applicable; and (ii) all other Board of Pharmacy, state, federal, and local licenses, business registrations, permits, certifications, and similar legal requirements applicable to the Aetna Specialty Pharmacies and their operations, including appropriate active non-resident licensure as needed in all applicable states and jurisdictions. 8. PBM Central Fill Specialty Pharmacies shall be responsible for obtaining and maintaining: (i) the appropriate licensure and authorizations by the applicable Boards of Pharmacy to operate as a resident, non-resident, and/or central fill specialty pharmacy, as applicable and pharmacist required licensure; and (ii) all other Board of Pharmacy, state, federal (*e.g.*, DEA), and local licenses, business registrations, permits, certifications, authorizations, provider numbers (including Medicare and Medicaid) and similar legal requirements applicable to the PBM Central Fill Specialty Pharmacies and their operations, including appropriate active non-resident licensure and central fill licensure or authorization as needed in all applicable states and jurisdictions. Further, PBM Central Fill Specialty Pharmacies shall be USP 797 compliant facilities in order to provide compounding services as needed. PBM Central Fill Specialty Pharmacies shall provide copies of all such licenses, certifications, permits, authorizations, pharmacist licenses and pharmacy inspections related thereto (*i.e.*, State Board of Pharmacy inspections) upon Aetna Specialty Pharmacies' request. 9. Aetna Specialty Pharmacies and PBM Central Fill Specialty Pharmacies shall work together in good faith as necessary to assist each other in obtaining and maintaining required licensure and/or approvals for each to provide the PBM Services set forth in this Schedule N (Supporting Specialty Pharmacy Services).
Equipment and Systems	10. While reserving the right to move to a new specialty pharmacy technology platform provided by PBM that will meet or exceed Aetna's or Aetna Specialty Pharmacy's specific requirements, Aetna Specialty Pharmacies shall utilize Aetna Specialty Pharmacy's existing computer hardware, software, and other network services in place at each Aetna Specialty Pharmacy for front-end services (the "Aetna Specialty Pharmacy System") which will be linked to and communicate with the pharmacy system currently utilized by the PBM Central Fill Specialty Pharmacies ("PMB Specialty Pharmacy System") for the provision of back-end pharmacy services as further described in the Agreement and this Schedule N (Supporting Specialty Pharmacy Services) as of the PBM Services Commencement Date. 11. All automated dispensing and storage systems utilized by PBM Central Fill Specialty Pharmacies hereunder shall be maintained and operated by PBM

Service	Description
	Central Fill Specialty Pharmacies in accordance with applicable Law. 12. PBM Central Fill Specialty Pharmacies shall comply with the most current Inventory Information Approval Systems, as modified from time to time. PBM Central Fill Specialty Pharmacies shall provide a written certification of such compliance upon Aetna Specialty Pharmacies' request. 13. PBM Central Fill Specialty Pharmacies shall ensure that all equipment and systems required hereunder, support all legal and regulatory requirements as reasonably determined by Aetna Specialty Pharmacies.
Policies and Procedures	14. Aetna Specialty Pharmacies and PBM Central Fill Specialty Pharmacies shall have, maintain and update policies and procedures as required by applicable Law, including policies and procedures that document the agreed upon processes related to PBM Central Fill Specialty Pharmacies providing centralized filling services for Aetna Specialty Pharmacies hereunder. Such policies and procedures shall include at a minimum the following: (i) descriptions of how each pharmacy will comply with federal and state laws and regulations; (ii) maintenance of appropriate records to identify the responsible pharmacist(s) in the dispensing and counseling processes; (iii) identification on the prescription label of all pharmacies involved in the filling and dispensing of the prescription as required by applicable Law; (iv) maintenance of a mechanism for tracking the prescription drug order during each step in the process; (v) provision of adequate security to protect the confidentiality and integrity of patient information including protected health information; (vi) maintenance of a quality assurance program for pharmacy services designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems; and (vii) such other policies and procedures as the Parties shall mutually agree upon. 15. All policies and procedures shall be maintained at each Aetna Specialty Pharmacy and at each PBM Central Fill Specialty Pharmacy location, and PBM Central Fill Specialty Pharmacies shall make their applicable policies and procedures available to Aetna Specialty Pharmacies. 16. All policies and procedures shall be made available to the applicable Boards of Pharmacy and other regulatory agencies upon request.
Responsibilities of Aetna Specialty Pharmacies	17. Aetna Specialty Pharmacies will be the contracted providers of Specialty Products to Aetna Members based on Aetna's approved Specialty Product list, including ready-to-use pre-filled syringe products for certain injectable drugs. Aetna may revise its Specialty Product list from time to time and will provide PBM Central Fill Specialty Pharmacies with notice of such updated Specialty Product list in a manner mutually agreed. 18. Aetna Specialty Pharmacies shall accept prescription orders from Members and Providers via the U.S. mail, commercial carrier, electronically (*i.e.*, e-

Service	Description
	prescription, fax), phone, and such other means allowed by applicable Law. Upon receipt of prescription orders, Aetna Specialty Pharmacies shall as necessary scan and enter a complete and accurate image of each prescription order into the Specialty Pharmacy System. 19. Aetna Specialty Pharmacy shall maintain in the Aetna Specialty Pharmacy System up-to-date Member information, such as Member demographic information, allergy information (drug and food), and medical history ("Member Patient Profiles"), in an electronic format. 20. After Aetna Specialty Pharmacies have entered the prescription order image into the Aetna Specialty Pharmacy System, Aetna Specialty Pharmacies shall utilize Member Patient Profiles contained in the Aetna Specialty Pharmacy System and shall review the prescription order, verify prescription order information, contact prescribers as necessary in the professional judgment of the pharmacists, perform benefits investigation, confirm refill information, conduct drug utilization review, determine generic or other appropriate therapeutic interventions/interchanges, communicate with Members and prescribers when necessary regarding the prescription order, input the order into the Aetna Specialty Pharmacy System, and otherwise be responsible for managing the resolution of issues related to prescription orders. 21. Aetna Specialty Pharmacies shall submit pharmacy Claims for each applicable clean prescription order to PBM for adjudication by PBM and submit medical Claims to the appropriate Payors (including any applicable government programs). Aetna Specialty Pharmacies shall coordinate care with a Member's Aetna case manager and/or home health care agency where appropriate based on the Member's Benefit Plan Design. Aetna shall be responsible for nursing charges in accordance with Aetna's Claim processing guidelines or the Member's Benefit Plan Design. 22. Aetna Specialty Pharmacies shall collect from Members all Member Cost Share for the applicable prescription order by accepting personal checks, cashier checks, credit cards, as well as other standard methods of payment, as approved by Aetna Specialty Pharmacies. Aetna Specialty Pharmacies also shall facilitate access for Members to applicable copayment and coinsurance assistance programs. Aetna Specialty Pharmacies shall bear financial risk of collection of Member Cost Share from Members. 23. Aetna Specialty Pharmacies shall enter final prescription order information for approved Claims into the Aetna Specialty Pharmacy System for filling and shipping by PBM Central Fill Specialty Pharmacies in accordance with this Schedule N (Supporting Specialty Pharmacy Services). Such final prescription order information shall contain all information required by applicable Law. 24. Aetna Specialty Pharmacies shall not input prescription order information into the Aetna Specialty Pharmacy System for prescription orders that are: (i)

Service	Description
	more than twelve (12) months after issuance of the prescription order for non-controlled substances; (ii) more than six (6) months after issuance of the prescription order for controlled drug substances; (iii) prohibited by applicable Law or the professional judgment of the Aetna Specialty Pharmacy's pharmacist; or (iv) for a prescription order that the Aetna Specialty Pharmacy would not be authorized to fill. In the event Aetna Specialty Pharmacy determines that a prescription order cannot be filled (*e.g.*, Claim denied, no authorized refills, drug not covered, etc.), Aetna Specialty Pharmacy shall provide notice of such to the Member, including an explanation for the denial or return of the prescription order. 25. Aetna Specialty Pharmacies shall communicate with applicable parties as necessary in order to coordinate the delivery of Covered Drugs to the physician's office or the Member's home as applicable based on information provided by PBM Central Fill Specialty Pharmacies. Aetna Specialty Pharmacy will also be responsible for all package tracking and communication of any recovery procedures for any of the shipments back to the PBM Central Fill Specialty Pharmacy. Aetna Specialty Pharmacies shall call the Member to notify him/her when a temperature-sensitive drug is shipped to ensure that someone will be available to receive the package when it is delivered. 26. Aetna Specialty Pharmacies shall provide all information required under the Omnibus Reconciliation Act of 1990 (OBRA 90) and applicable Law regarding utilization review and prescription drug counseling to Members or Members' representatives. 27. Aetna Specialty Pharmacies shall utilize pharmacists and nurses with applicable clinical and medication education, counseling and training, including with respect to self administration when appropriate, and provide any necessary clinical communications to Members. 28. Unless otherwise specifically authorized in writing by Aetna (or the Aetna Specialty Pharmacies) or required by applicable Law, all communications to a Member will be handled by Aetna Specialty Pharmacies. 29. Aetna Specialty Pharmacies shall be primarily responsible for compliance or management of any Risk Evaluation and Mitigation Strategies programs ("REMS"), and PBM Central Fill Specialty Pharmacies shall provide REMS support as described below. 30. Unless the Parties mutually agree to an alternative, Aetna Specialty Pharmacies shall continue to procure and dispense (i) controlled substances to the extent required by applicable Law and (ii) a very limited number of Specialty Products underlying certain REMS programs (currently Tysabri, Tracleer, Letairis and Revlimid). Further, unless the Parties mutually agree to an alternative, Aetna Specialty Pharmacies shall continue to procure and dispense products to be billed under Medicaid and Medicare part B so long as such products must be billed by the dispensing pharmacy under applicable

Service	Description
	Law, and the Aetna Specialty Pharmacy System shall fully support this dispensing of Medicaid and Medicare part B products via Aetna Specialty Pharmacies in accordance with Aetna requirements.
Responsibilities of PBM Central Fill Specialty Pharmacies	31. PBM Central Fill Specialty Pharmacies shall ensure that the PBM Specialty Pharmacy System is structured such that upon entry of final prescription order information into the Aetna Specialty Pharmacy System by Aetna Specialty Pharmacies, such prescription orders are queued and accessible for fulfillment by PBM Central Fill Specialty Pharmacies as scheduled by Aetna Specialty Pharmacies based on ship to date, deliver by date and class of delivery service. 32. Upon receipt of the final prescription order information by PBM Central Fill Specialty Pharmacies via the Aetna Specialty Pharmacy System, PBM Central Fill Specialty Pharmacies shall timely and accurately dispense such prescription orders in accordance with the prescription order, the Agreement, this Schedule N (Supporting Specialty Pharmacy Services), and applicable Laws. PBM Central Fill Specialty Pharmacies also shall provide ancillary supplies necessary for the Member to administer typical self-injectable Specialty Products at no cost to the Member, Aetna, or Aetna Customer. For infused Specialty Products PBM Central Fill Specialty Pharmacies shall supply all ancillary medical supplies necessary for administration including, but not limited to, IV administration sets, venous catheters, infusion pumps and pump sets. Such supplies are not included in the prescription cost, but are available at an additional cost under a per diem per treatment service fee, as set forth in Schedule Y-7. 33. PBM Central Fill Specialty Pharmacies shall procure, and ensure that the PBM Central Fill Specialty Pharmacies are stocked, with the appropriate amounts of pharmaceutical products and ancillary supplies necessary to provide the services set forth in this Schedule N (Supporting Specialty Pharmacy Services). 34. PBM Central Fill Specialty Pharmacies via the link back to the Aetna Specialty Pharmacy System shall provide Aetna Specialty Pharmacies with a record of the following information: the date of receipt of the prescription order by PBM Central Fill Specialty Pharmacy, the name of the licensed pharmacist filling the prescription order, the date of shipping the prescription order, the method of delivery of the prescription order, the name and address where the prescription order was shipped, and identification of the pharmaceutical product and any ancillary supplies actually shipped. 35. PBM Central Fill Specialty Pharmacies shall provide timely delivery of Covered Drugs and any required ancillary supplies to Members at the addresses designated by Members via FedEx, UPS or other appropriate carriers (postage prepaid) and, if required by exigent circumstances, in the time and manner as designated by Aetna Specialty Pharmacies (*e.g.*, via next

Service	Description
	day air). PBM Central Fill Specialty Pharmacies shall immediately notify Aetna Specialty Pharmacies when a shipment is sent (along with necessary shipping information) and immediately notify Aetna Specialty Pharmacies if a scheduled shipment was not sent when scheduled. PBM Central Fill Specialty Pharmacies shall provide direct delivery of Specialty Products to the physician's office or the Member's home or as otherwise expressly directed by the Aetna Specialty Pharmacies. PBM Central Fill Specialty Pharmacies shall include product information and accessory warning labels (as appropriate) as required by Law, with such shipments. All Covered Drugs shall be packaged and shipped in accordance with all applicable Laws, consistent with Aetna requirements, and in a manner to assure the integrity of the pharmaceutical product, including the use of appropriate packing materials that are durable, weather-resistant, water-resistant, and tamper-evident. Upon Aetna Specialty Pharmacy's request, PBM Central Fill Specialty Pharmacies shall insert Aetna Specialty Pharmacies' specified Member materials and messaging into the prescription packages (*e.g.*, messages around disease management or other communication messages as determined by Aetna Specialty Pharmacies). 36. With respect to temperature-sensitive drugs, in addition to the requirements above, PBM Central Fill Specialty Pharmacies shall use an appropriate delivery service to ensure that temperature-sensitive Covered Drugs are delivered to the Member in a safe and effective manner. PBM Central Fill Specialty Pharmacies shall coordinate the delivery schedule of temperature-sensitive Covered Drugs with Aetna Specialty Pharmacies to ensure Aetna Specialty Pharmacies' ability to timely communicate with Member's or Member's representative for the appropriate delivery of temperature-sensitive Covered Drugs to Members. 37. PBM Central Fill Specialty Pharmacies shall ensure that Covered Drugs shipped to Members shall have no less than 90 day shelf life remaining as of the date of shipment unless otherwise agreed upon by the Parties. 38. PBM Central Fill Specialty Pharmacies shall be capable of performing compounding services as required by Aetna Specialty Pharmacies. Further, PBM Central Fill Specialty Pharmacies shall support Aetna Specialty Pharmacies with reasonable requests to assist in facilitating any REMS requirements. 39. PBM Central Fill Specialty Pharmacies shall be responsible for all requirements under applicable Law relating to the prescription label, cap, and bottle/package, and shall comply with the following: a. PBM Central Fill Specialty Pharmacies shall provide to Aetna Specialty Pharmacies exact samples of the prescription bottle/package labels that will be affixed to show how the Aetna Specialty Pharmacies' information will appear to Members, and shall make such modifications to such labels as Aetna Specialty Pharmacies may reasonably request to the extent permitted by applicable Law.

Service	Description
	b. The prescription bottle/package cap shall be blank or "Aetna Specialty Pharmacy" branded, as authorized by Aetna Specialty Pharmacies to the extent allowed by applicable Law. c. The prescription bottle/package cap, label, and container shall contain no advertising except as expressly authorized by Aetna Specialty Pharmacies in writing. d. The prescription bottle/package labels shall identify the applicable Aetna Specialty Pharmacy by name and address as the originating pharmacy and, unless prohibited by applicable Law, shall identify the applicable PBM Central Fill Specialty Pharmacy by a code mutually agreed upon by Aetna Specialty Pharmacies and PBM Central Fill Specialty Pharmacies, and shall in all respects be in compliance with all applicable Laws. e. PBM Central Fill Specialty Pharmacies shall provide appropriate labels for Covered Drugs shipped to any visually impaired Member at Member's request as indicated by Aetna Specialty Pharmacies, including requests for Braille labels. 40. In the event PBM Central Fill Specialty Pharmacies will not be dispensing a prescription to a Member once it has been entered into the Aetna Specialty Pharmacy System by Aetna Specialty Pharmacies as a prescription order ready for shipping (*i.e.*, out of stock, etc.), PBM Central Fill Specialty Pharmacy shall provide immediate notice to Aetna Specialty Pharmacies and Aetna Specialty Pharmacies will provide notice to the Member, including any necessary explanation. 41. In the event that a manufacturer, Governmental Body or other applicable Person orders a recall of a drug, PBM Central Fill Specialty Pharmacies shall conduct such product recall in accordance with Aetna policies and requirements and shall immediately notify Aetna Specialty Pharmacies. Aetna Specialty Pharmacies will notify Members in accordance with applicable Law (and industry standard practices). If PBM or PBM Central Fill Specialty Pharmacies receive any compensation from a third party with respect to a recalled drug, PBM and PBM Central Fill Specialty Pharmacies shall pay Aetna Specialty Pharmacies the portion of such amount that is attributable to Members and Covered Plans, and will reverse Claims for any unused portion of a recalled product.
Pharmacist Access	42. Aetna Specialty Pharmacies will provide patient counseling, unless PBM Central Fill Specialty Pharmacies are otherwise authorized by Aetna Specialty Pharmacies to do so on a case-by-case basis or required to do so by applicable Law. PBM Central Fill Specialty Pharmacies' pharmacists will be available to provide such counseling on a 24/7/365 basis via a dedicated toll free telephone number for Members. Upon Aetna Specialty Pharmacies' request, PBM Central Fill Specialty Pharmacies' pharmacists shall be available on a 24/7/365 basis to assist Aetna Specialty Pharmacies with consultations or inquiries regarding prescription orders shipped by PBM Central Fill Specialty Pharmacies.

Service	Description
Pharmacy Errors	43. Each Aetna Specialty Pharmacy and PBM Central Fill Specialty Pharmacy shall be responsible for their respective errors and omissions committed by such pharmacy during the performance of the obligations and functions of the pharmacy as set forth in this Schedule N (Supporting Specialty Pharmacy Services). For purposes of corrective action and performance improvement: (a) Aetna Specialty Pharmacy shall promptly notify PBM Central Fill Specialty Pharmacy of any errors or omissions (or suspected errors or omissions) by PBM Central Fill Specialty Pharmacy that Aetna Specialty Pharmacy becomes aware of; and (b) PBM Central Fill Specialty Pharmacy shall promptly notify Aetna Specialty Pharmacy of any errors or omissions (or suspected errors or omissions) by Aetna Specialty Pharmacy that PBM Central Fill Specialty Pharmacy becomes aware of. 44. On a monthly basis, PBM Central Fill Specialty Pharmacies shall provide to Aetna Specialty Pharmacies a report of errors and omissions committed by PBM Central Fill Specialty Pharmacies with respect to Members, including error category (*e.g.*, Class 1 error), remediation plans, and trending information. If a Member rejects a drug due to a PBM Central Fill Specialty Pharmacy error or omission, PBM Central Fill Specialty Pharmacy shall, at its cost and expense, immediately refill and ship to the Member via overnight courier the correct Covered Drug, and include a postage paid return shipping label for the Member to use to return the original shipment. An "error" shall have the meaning as defined in Schedule R (Performance Standards and Service Levels/Major PBM Defaults). Aetna Specialty Pharmacies will be responsible for communications with Members and any credits or rebilling necessary under the foregoing circumstances.
Lost and Damaged Shipments	45. Each Aetna Specialty Pharmacy and PBM Central Fill Specialty Pharmacy shall be responsible for their respective errors and omissions resulting in lost or missing Covered Drugs not received by Members and for any damaged Covered Drugs received by Members. 46. If a Member reports to Aetna Specialty Pharmacies that a Covered Drug was not received, then Aetna Specialty Pharmacies shall communicate such to PBM Central Fill Specialty Pharmacy, and PBM Central Fill Specialty Pharmacy shall immediately ship to the Member via overnight courier another shipment of the Covered Drug in accordance with Aetna Specialty Pharmacies' policies at no cost to Member, Aetna, Aetna Plan Affiliates, Aetna Customers, or Aetna Specialty Pharmacies. 47. If a Member rejects a drug due to the Covered Drug being damaged during shipment, then at Aetna Specialty Pharmacies' direction PBM Central Fill Specialty Pharmacy shall immediately ship to the Member via overnight courier another shipment of the Covered Drug in accordance with Aetna Specialty Pharmacies' policies at no cost to Member, Aetna, Aetna Affiliates, Aetna Customers, or Aetna Specialty Pharmacies. With the new shipment, PBM Central Fill Specialty Pharmacy shall include a postage paid return shipping label for the Member to use to return the original damaged

Service	Description
	shipment. 48. PBM Central Fill Specialty Pharmacies shall comply with Aetna Policies for handling lost or damaged prescription shipments, including urgent situations. Notwithstanding anything to the contrary in this Schedule, Aetna Specialty Pharmacies shall track and monitor all shipments based on timely information provided by PBM Central Fill Specialty Pharmacies and PBM Central Fill Specialty Pharmacies shall comply with Aetna Specialty Pharmacies' direction with respect to the re-shipment or recovery of any Covered Drug shipments.
Urgent Situations	49. In the event PBM Central Fill Specialty Pharmacies do not or cannot reship the Covered Drug via overnight courier within twenty-four (24) hours of becoming aware of a reshipment requirement as specified herein or in the event of an "urgent" situation where the Member needs the Covered Drug immediately prior to when reshipment would be received, Aetna Specialty Pharmacies shall make arrangements with PBM for such Members to receive the Covered Drugs at retail Participating Pharmacies at PBM and/or PBM Central Fill Specialty Pharmacy's sole cost and expense (*i.e.*, PBM and PBM Central Fill Specialty Pharmacies shall not bill Member, Aetna or Aetna Specialty Pharmacies for local retail pharmacy supply overrides resulting from circumstances where PBM Central Fill Specialty Pharmacies shipped the wrong item, damaged items are received, or items have been shipped but not received by the Member in accordance with Aetna Specialty Pharmacies' policies).
Specialty Programs and Activities	50. PBM and PBM Central Fill Specialty Pharmacies shall obtain Aetna's prior written approval in accordance with Section 11.7 and Schedule H (Communications) before any programs or activities are initiated by PBM or PBM Central Fill Specialty Pharmacies with respect to specialty pharmacy services, including those that are designed to, or which do, encourage greater Specialty Product utilization by Members. Aetna shall have the right to grant, withhold, or revoke approval of such programs and activities in its sole discretion. PBM and PBM Central Fill Specialty Pharmacies shall not conduct any type of calling or other program for Formulary, Brand Drug to Generic Drug, non-preferred Covered Drug to preferred Covered Drug, Brand Drug dispensed as Generic Drug using DAW logic, therapeutic substitution, prescription adherence, persistence, or compliance programs, or the like, that may involve calling or otherwise contacting a Provider or Member without Aetna's prior express review and written approval (which may be revoked at any time).
Specialty Pharmacy Reporting	51. PBM Central Fill Specialty Pharmacies shall provide Aetna Specialty Pharmacies with the reports related to PBM Central Fill Specialty Pharmacies set forth on Schedule V (Reporting) and such other reporting required by Law. 52. PBM Central Fill Specialty Pharmacies also shall provide reports to Aetna Specialty Pharmacies as reasonably requested by Aetna Specialty Pharmacies and at a frequency as Aetna Specialty Pharmacies consider appropriate to

Service	Description
	keep Aetna Specialty Pharmacies informed as to the status and condition of the PBM Central Fill Specialty Pharmacies' compliance with this Schedule N (Supporting Specialty Pharmacy Services) and other reports as required by Aetna Specialty Pharmacies to manage and control the services performed by Aetna Specialty Pharmacies. 53. PBM Central Fill Specialty Pharmacies shall give Aetna Specialty Pharmacies prompt written notice if turnaround times and requirements are not being met or are in jeopardy of not being met by PBM Central Fill Specialty Pharmacies.
Data Use/ Disclosures	54. PBM and PBM Central Fill Specialty Pharmacies acknowledge and agree that PBM and PBM Central Fill Specialty Pharmacies are subject to and shall comply with the restrictions and requirements set forth in Section 11.1 of the Agreement and Schedule Z (Authorized Uses of Data and Information).
Recordkeeping	55. Without limiting the generality of Section 7.1 of the Agreement, PBM Central Fill Specialty Pharmacies shall maintain records related to the services provided by PBM Central Fill Specialty Pharmacies under this Schedule N (Supporting Specialty Pharmacy Services), including the original prescription order and records related to the fulfillment and shipping of Covered Drugs to Members. PBM Central Fill Specialty Pharmacies shall make available to, or provide copies to, Aetna Specialty Pharmacies of such records upon request by Aetna Specialty Pharmacies.
Disaster Recovery & Business Continuity Plans	56. PBM Central Fill Specialty Pharmacies shall have disaster recovery plans and business continuity plans for central fill pharmacy services hereunder that enables the PBM Central Fill Specialty Pharmacies to continue to operate and perform the duties, obligations, and services hereunder in accordance with the standards set forth in Schedule R (Performance Standards and Service Levels). Notwithstanding the foregoing, in the event that a particular PBM Central Fill Specialty Pharmacy is unable to perform its duties, obligations, and services hereunder within twenty-four (24) hours of a disaster, such PBM Central Fill Specialty Pharmacy shall promptly notify Aetna Specialty Pharmacies in writing and use all commercially reasonable efforts to have central fill pharmacy services provided by a different PBM Central Fill Specialty Pharmacy hereunder. In the event no PBM Central Fill Specialty Pharmacy is able to perform its duties, obligations, and services hereunder within twenty-four (24) hours of a disaster, PBM Central Fill Specialty Pharmacies shall require any alternate/backup pharmacy to comply with the terms and conditions of this Schedule N (Supporting Specialty Pharmacy Services), subject to Aetna's prior written approval. 57. In the event of a disaster or substantial disruption in Aetna Specialty Pharmacy services (as determined by Aetna Specialty Pharmacies), at Aetna's option PBM Central Fill Specialty Pharmacies shall provide backup pharmacy services to assist Aetna Specialty Pharmacies in their obligations hereunder according to terms and pricing to be mutually agreed upon in good faith.

Service	Description
Pharmacy Compliance and Cooperation	58. PBM Central Fill Specialty Pharmacies and Aetna Specialty Pharmacies shall ensure that their respective pharmacies and operations are at all times in compliance with applicable Laws as determined by Aetna Specialty Pharmacies. 59. PBM Central Fill Specialty Pharmacies shall promptly forward to Aetna Specialty Pharmacies in a manner and form acceptable to Aetna Specialty Pharmacies all inquiries, complaints, and grievances received by PBM Central Fill Specialty Pharmacies from any Member, Provider, or Governmental Body related to Aetna, Aetna Affiliates, Aetna Customers, Aetna Specialty Pharmacies, Members, or the Agreement, including this Schedule N (Supporting Specialty Pharmacy Services). PBM Central Fill Specialty Pharmacies shall cooperate in good faith with Aetna Specialty Pharmacies and shall promptly provide to Aetna Specialty Pharmacies such information and other documentation reasonably required to respond to such inquiries, complaints, and grievances. 60. Aetna Specialty Pharmacies shall promptly forward to PBM Central Fill Specialty Pharmacies in a manner and form reasonably acceptable to PBM Central Fill Specialty Pharmacies all inquiries, complaints, and grievances received by Aetna Specialty Pharmacies from any Member, Provider, or Governmental Body related to PBM, PBM Affiliates, PBM Central Fill Pharmacies, Members, or the Agreement, including this Schedule N (Supporting Specialty Pharmacy Services). Aetna Specialty Pharmacies shall cooperate in good faith with PBM Central Fill Specialty Pharmacies and shall promptly provide to PBM Central Fill Specialty Pharmacies such information and other documentation reasonably required to respond to such inquiries, complaints, and grievances. 61. From time to time, each party shall reasonably accommodate the other to discuss any problems or other matters regarding the Aetna Specialty Pharmacies' or the PBM Central Fill Specialty Pharmacies' performances hereunder. PBM Central Fill Specialty Pharmacies shall use best efforts to cooperate with and accommodate Aetna Specialty Pharmacies by making changes reasonably requested by Aetna Specialty Pharmacies in connection with the specialty pharmacy services provided pursuant to this Schedule N (Supporting Specialty Pharmacy Services).
Manufacturer Relations	62. PBM and/or PBM Central Fill Specialty Pharmacies shall disclose all initiatives between PBM Central Fill Specialty Pharmacies and Manufacturers or other Persons resulting in Rebates, Service Fees or other compensation or economic benefit to PBM or to its Affiliates (including PBM Central Fill Specialty Pharmacies) that are directly related to Aetna Members or to Aetna Member utilization. To the extent that any such initiative impacts, or is reasonably likely to impact, Aetna's ability to collect Rebates, Service Fees or other compensation or economic benefit under existing contracts between Aetna or Aetna Specialty Pharmacies and

Service	Description
	Manufacturers or other Persons, PBM and/or PBM Central Fill Specialty Pharmacy shall obtain prior written approval by Aetna and Aetna Specialty Pharmacies prior to entering into such initiative. PBM may provide evidence to Aetna that the compensation or economic benefit of an existing initiative between PBM and/or PBM Central Fill Specialty Pharmacies was included in the underwriting of the applicable Specialty Drug pricing set forth in Schedule Y-6. In such case, (i) Aetna shall authorize PBM, its Affiliate or PBM Central Fill Specialty Pharmacies in accordance with this Agreement to continue to provide such services, (ii) the parties will negotiate the feasibility of Aetna providing the services, thus satisfying the conditions for PBM or its Affiliates (including PBM Central Fill Specialty Pharmacies) to receive the Service Fees or other compensation or economic benefit or (iii) in the event neither (i) or (ii) occurs, PBM shall be relieved of the Pricing Guarantee applicable to such Specialty Product(s) as set forth on Schedule Y-6. For the avoidance of doubt, nothing in this Paragraph 62 will restrict PBM or its Affiliates (including PBM Central Fill Specialty Pharmacies) from contracting for and receiving Other Manufacturer Payments in the ordinary course of business as a dispensing pharmacy and absent the condition of any services. 63. In the event that PBM or its Affiliates contract with manufacturers for Other Manufacturer Payments which require the performance of services by PBM, its Affiliates or PBM Central Fill Specialty Pharmacies as a condition of obtaining a purchase discount or to maintain access to the Specialty Product, which services PBM or its Affiliates (including PBM Central Fill Specialty Pharmacies) would otherwise be restricted from performing pursuant to the preceding paragraph, then (i) Aetna shall authorize PBM, its Affiliate or PBM Central Fill Specialty Pharmacies in accordance with this Agreement to continue to provide such services, (ii) the parties will negotiate the feasibility of Aetna providing the services, thus satisfying the conditions for PBM or its Affiliates (including PBM Central Fill Specialty Pharmacies) to receive the Other Manufacturer Payment or continued access to the Specialty Product or (iii) in the event neither (i) or (ii) occurs, PBM shall be relieved of the Pricing Guarantee applicable to such Specialty Product(s) as set forth on Schedule Y-6.
Pricing and Payment Terms	70. Aetna Specialty Pharmacies and PBM Central Fill Specialty Pharmacies agree to the pricing and payment terms applicable to the Covered Drugs and services provided under this Schedule N (Supporting Specialty Pharmacy Services) as set forth in Schedule Y and Article IX of the Agreement.

Schedule N-1

Full Specialty Pharmacy Services

Optional Services

In the event that Aetna elects to have the full specialty pharmacy services set forth in this Schedule N-1 provided for all Covered Plans, this Schedule N-1 shall be subject to further revision.

Service	Description
Overview	1. PBM owns and operates specialty pharmacies ("PBM Specialty Pharmacies"). PBM Specialty Pharmacies may be responsible for the full specialty pharmacy delivery process – including the front-end mail collection, prescription/order entry, the prescription claims submission, the back-end dispensing process, the shipping process, and the delivery to the Member – at the election of Aetna in accordance with Item 11 of Schedule Y-7. Aetna may make such election with respect to one or more Covered Plans, one or more Aetna Customers, or one or more lines of business (*e*.g., Commercial Plans, Medicare Plans or Medicaid Plans). Such an election by Aetna may be applicable to specialty pharmacy services with respect to a particular Aetna Plan or Aetna Customer, or line of business, as Aetna shall determine in its discretion. In no event shall any such election modify the terms otherwise applicable to any Covered Plan and/or Aetna Customer to which such election does not apply. In the event that Aetna elects to have Optional Services provided under this Schedule N-1 with respect to all Covered Plans, such services and functions shall thereafter constitute a Core Service. Particular Aetna Plans, Aetna Customers or lines of business covered by this Schedule N-1are identified in Schedule GG.
Specialty Pharmacy Services	2. PBM Specialty Pharmacies shall accept prescription orders from Members and prescribers via the U.S. mail, commercial carrier, electronically (*i.e.*, e-prescription, fax), phone, and such other means allowed by applicable Law. 3. PBM Specialty Pharmacies shall review the prescription order, verify prescription order information, contact prescribers as necessary in the professional judgment of the pharmacists, perform benefits investigation, confirm refill information, conduct drug utilization review, determine generic or other appropriate therapeutic interventions/interchanges, communicate with Members and prescribers when necessary regarding the prescription order, input the order into the pharmacy system, and otherwise be responsible for managing the resolution of issues related to prescription orders. 4. PBM Specialty Pharmacies shall, in electronic format in the pharmacy system, maintain up-to-date Member information, such as Member demographic information, allergy information (drug and food), and medical history.

Service	Description
	5. PBM Specialty Pharmacies shall fill prescriptions subject to the professional judgment of the dispensing pharmacist, good pharmacy practices in accordance with local community standards, and product labeling guidelines. 6. PBM Specialty Pharmacies shall timely and accurately dispense new or refill prescriptions following receipt from a Member or prescriber of (i) a prescription and a completed order or refill order form, and (ii) any applicable Member Cost Share where permitted by applicable Law, in accordance with the prescription order, the Agreement, this Schedule N-1, and applicable Laws. 7. PBM Specialty Pharmacies shall provide timely delivery of Covered Drugs to Members via United States postal service or other appropriate carriers to the address provided by the Member (postage prepaid); include product information and accessory warning labels (as appropriate) as required by applicable Law, with such shipments. All Covered Drugs shall be packaged and shipped in accordance with all applicable Laws, and in a manner to assure the integrity of the pharmaceutical product, including the use of appropriate packing materials that are durable, weather-resistant, water-resistant, and tamper-evident. 8. PBM Specialty Pharmacies shall maintain the appropriate licensure by (i) the applicable Boards of Pharmacy to operate as resident pharmacies in such states, as applicable; and (ii) all other Board of Pharmacy, state, federal, and local licenses, business registrations, permits, certifications, and similar legal requirements applicable to the specialty pharmacies and their operations, including appropriate active non-resident licensure as needed in all applicable states and jurisdictions. 9. PBM Specialty Pharmacies shall comply with all applicable Laws related to the provision of specialty pharmacy services to Members. 10. PBM Specialty Pharmacies shall not charge Members fees to use specialty pharmacy services, including postage and handling fees. 11. PBM Specialty Pharmacies shall provide to Members toll-free telephone access to a pharmacist during business hours and on-call pharmacist access after-hours twenty-four (24) hours a day, seven (7) days a week. 12. <u>Member Cost Share.</u> PBM Specialty Pharmacies shall collect from Members all Member Cost Share for the applicable prescription order by accepting personal checks, cashier checks, credit cards, as well as other standard methods of payment, as approved by Aetna. PBM Specialty Pharmacies shall bear financial risk of collection of Member Cost Share from Members. 13. PBM Specialty Pharmacies are responsible for replacement of any damaged Covered Drugs received by Members or other pharmacy errors attributable to the pharmacy Services performed by PBM Specialty Pharmacies at the cost

Service	Description
	of PBM Specialty Pharmacies. 14. PBM Specialty Pharmacies are responsible for reshipment of lost or undelivered Covered Drugs and PBM Specialty Pharmacies shall bear the cost of the lost or undelivered shipment upon receipt of written confirmation from the Member that the Covered Drug remains undelivered which confirmation shall be in the format and time period requested by PBM Specialty Pharmacies.
Applicable Provisions of Schedule N (Supporting Specialty Pharmacy Services)	15. Unless otherwise agreed to by Aetna in writing and to the extent applicable, all sections of Schedule N (Supporting Specialty Pharmacy Services) shall apply to all Aetna Customers and Aetna Plan Affiliates electing this Optional Service. In the event of a conflict between the terms of this Schedule N-1 and Schedule N, the terms of this Schedule N-1 shall control. For purposes of this Schedule N-1 (Full Specialty Pharmacy Services), the following references contained within such provisions in Schedule N (Supporting Specialty Pharmacy Services) shall refer to and mean the following: a. All references to "PBM Central Fill Specialty Pharmacies" shall refer to and mean "PBM Specialty Pharmacies"; b. All references to prescription orders received by PBM Central Fill Pharmacies via the Aetna Pharmacy System shall refer to and mean all prescription orders received by the PBM Specialty Pharmacies; and c. All references to Aetna Specialty Pharmacies shall refer to and mean Aetna.
Pricing	16. As provided in Schedule Y-6, Y-13 and Y-13, Aetna will be required to pay an increased Dispensing Fee during any period that Front-End Pharmacy Services are provided by PBM or its Affiliates under this Schedule N-1with respect to Claims subject to such sub-schedule of Schedule Y.

Schedule O

Medicare Services

Core Services

Additional defined terms for Schedule O (Medicare Services):

"MMA" means the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, enacted at Public Law 108-173 and codified at Social Security Act 1860D-1, as may be amended, supplemented, or interpreted from time to time, and the regulations promulgated thereunder at 42 C.F.R. Part 422 and Part 423, as may be amended, supplemented, or interpreted from time to time.

"Part D Book of Business" means the prescription drug benefits offered by Medicare Plans pursuant to the MMA.

"Service Area" means the geographic area approved by CMS for the offering of a Medicare Plan pursuant to a CMS Contract.

Medicare Part D Book of Business
Aetna, Aetna Customers, and/or Aetna Plan Affiliates have entered into Contracts with CMS as required by the MMA (the "CMS Contract(s)"), pursuant to which Aetna, Aetna Plan Affiliate, and/or Aetna Customers are approved as Medicare Part D plan sponsors to offer one or more Medicare Plans. PBM acknowledges and agrees that in connection with providing Services to the Part D Book of Business, PBM shall be deemed a "first tier entity" to Aetna as defined by CMS and 42 C.F.R. Section 423.501. PBM agrees to provide Services with respect to the Part D Book of Business in accordance with its obligations as a first tier entity. PBM acknowledges and agrees that these obligations are set forth in the Law, the Agreement, and the Schedules to the Agreement. PBM shall review and implement any new or revised Law(s), CMS requirement(s) or guidance applicable to the Services provided to all or part of the Part D Book of Business as soon as is practicable and, in no event later than the effective date required by CMS. PBM agrees to timely comply (or modify the PBM Services as necessary so that Aetna can timely comply) with any such requirements and/or guidance. Notwithstanding the foregoing, PBM acknowledges and agrees that it is at all times required to comply with applicable Law and all CMS requirements and guidance, regardless of notice from Aetna. In general, the services, obligations and other requirements set forth in the Schedules (except Schedule S (Retiree Drug Subsidy Services), Schedule P (Medicaid & Other State Plan Services), and any other requirements for which the Parties mutually agree upon an exception) shall be applicable to each Covered Plan that is a Medicare Plan. This Schedule O (Medicare Services) sets forth additional and in some cases modified obligations and requirements applicable to Medicare Plans. In the event of any inconsistency or conflict between this Schedule O (Medicare Services) and the Agreement or any other Schedule to the Agreement, this Schedule O (Medicare Services) shall be controlling with respect to the Part D Book of Business. In addition, PBM shall promptly notify Aetna of any such inconsistency or conflict, and shall comply with any instructions provided by Aetna to resolve or reconcile the same. In addition, in the event that PBM believes any Aetna instruction, policy, procedure or requirement is inconsistent with or in conflict with Law or CMS requirements, PBM shall immediately notify Aetna of the inconsistency or conflict. PBM shall comply with any instructions provided by Aetna to resolve or reconcile the inconsistency or conflict.

Service	Description
Part D Application Support	1. PBM shall provide to Aetna in a timely manner CMS application material support including completing relevant sections of the CMS application template, litigation disclosures, Participating Pharmacy network listing in CMS required format, and geo access reports for Participating Pharmacy networks.
Eligibility	2. In addition to loading and updating Eligibility Data in accordance with Schedule C, Section 3, PBM acknowledges that the Eligibility Data files will include Medicare specific data elements, which shall be processed for Medicare Members in accordance with CMS requirements. The Eligibility Data files will contain a variety of eligibility transactions including new enrollments, terminations, changes, etc. These transactions will have effective dates that are in the future, current or past. The Parties acknowledge and agree that Aetna controls the eligibility information as between Aetna and PBM, but that PBM is responsible for ensuring that the eligibility data is accurately maintained in its systems as communicated by Aetna to PBM.
Low Income Cost-Sharing Subsidy	3. BAE. To the extent applicable and required by Aetna, PBM shall provide support to Aetna for compliance with CMS Best Available Evidence ("BAE") Guidance, including the guidance set forth in Chapter 13 of the Medicare Prescription Drug Benefit Manual (or its successor thereto), as set forth herein. In instances where Members or Participating Pharmacies on behalf of Members are calling with discrepant Low Income Cost-Sharing Subsidy (as defined by CMS) ("LICS") information, PBM shall collect BAE, provide the BAE to Aetna as required by Aetna, and update eligibility in order to update a Member's LICS level due to BAE. PBM shall provide a daily BAE activity report to Aetna's BAE contact daily to update Aetna when a Member's eligibility was edited by PBM during the previous calendar day, which will enable Aetna to research and update its eligibility records as well. Upon receipt of the Transaction Reply Report ("TRR"), Aetna shall conduct a reconciliation of the Member's LICS level according to CMS against the records of Aetna and PBM for such Member. Once sixty (60) days have passed, if CMS records do not match those of Aetna or PBM, Aetna shall send PBM an updated eligibility file for PBM to update PBM's LICS level for such affected Member(s). 4. LICS Cost Share. PBM shall adjudicate and report LICS level Cost Share, including reduced Cost Share for preferred and non-preferred drugs, in accordance with CMS requirements.
Claims Processing and Adjudication / Reporting	5. Online Claims Processing. PBM shall use a point-of-sale system that maintains real-time, accurate true out-of-pocket ("TrOOP") and total drug cost balances. PBM's online claims system will operate in accordance with standards set by CMS and Law. The online claims processing system shall provide for and require the use of the National Provider Identifier ("NPI") (the standard unique health identifier for health care providers

	mandated by HIPAA), as and to the extent required by Law. Further, the online claims processing system will in all cases process claims in accordance with CMS requirements and guidance. 6. Paper Claims Processing. PBM shall process all in and out-of-network Claims and Member submitted Claims, including claims incurred under and during the Medicare Coverage Gap Discount Program to the extent applicable, in accordance with standards and timelines set by CMS and Law. PBM shall comply with applicable requirements set forth in Paragraph 50 of this Schedule O (Medicare Services) as it pertains to Members' submission of paper Claims for reimbursement. 7. Claim Adjudication. PBM shall adjudicate online and paper claims, including retail, mail order drug, and specialty Claims according to the applicable Formulary and Benefit Plan Design (Cost Share, including deductible, ICL copayments, gap copayments, catastrophic copayments) using applicable network discounts based on Pass Through Pricing. PBM shall ensure that any messaging it sends at the point-of-sale to identify alternative medications when a drug is not covered or when certain UM requirements apply are consistent with the messages Aetna sends directly to Members. Without limiting the generality of the foregoing, PBM shall: a. Process Medicare Coverage Gap Discount Program claims in accordance with CMS requirements and guidance; b. Based on information provided by Aetna which identifies Members qualifying for such benefit, process renal dialysis services claims in accordance with CMS requirements and guidance so that drugs and biologicals are appropriately identified, processed and paid under the Members' pharmacy benefit as Medicare Part B covered drugs; c. Adjudicate generic drug claims in accordance with CMS ANDA/NDA guidance as well as Aetna Brand Generic Policy for both retail and mail order claims so that authorized generics are adjudicated in accordance with the gap discount program requirements and applying appropriate cost share for beneficiaries receiving low income subsidy. PBM shall administer Aetna's formulary as provided by Aetna and at the contracted pharmacy reimbursement rate consistent with brand and generic discounts established in the pharmacy network agreement and Aetna Brand-Generic policy. In the event of material changes to the Aetna Brand-Generic policy that PBM's then current capabilities cannot accommodate, the Parties shall work together in good faith to agree upon a process, timeline, and applicable costs related to implementation of the Aetna Brand-Generic policy changes. d. PBM shall comply with CMS requirements for limited days supply and trial supply prescriptions related to the retail setting as published. e. Process point-of-sale rebates in accordance with CMS

	requirements and guidance and/or as required by Aetna, as applicable. f. Ensure that, when filling a prescription at a retail Participating Pharmacy, Members will never pay more for three (3) thirty (30) days supply claims than they would pay for one (1) ninety (90) day supply claim. g. Ensure that Members are charged the lesser of: (i) the applicable Member Cost Share; (ii) the Participating Pharmacy's Usual and Customary Charge, and (iii) Aetna's contracted rate with PBM (i.e., no zero balance logic). h. Accommodate non-calendar year plans. i. Accommodate custom group set ups, including risk-sharing and wrap arrangements. j. When Members are paying for the entire cost of the drug because it is not a Covered Drug, adjudicate such claims for discount only purposes and point-of-sale rebates. k. Adjudicate Part B Covered Drugs at Participating Pharmacy contracted discounted rates applicable to medical claims. l. PBM shall provide a unique RxBin or RxBin/RxPCN combination and unique Part D Rx identifiers for Part D Members in accordance with 42 C.F.R. Section 423.120 and CMS guidance related thereto. m. PBM shall promptly adopt new messaging text and codes required by regulation or law or, if agreed upon by the parties, when approved by the NCPDP Workgroup and shall promptly adopt new messaging text required by Aetna, to adjudicate a Claim and appropriately coordinate benefits in real time, or as otherwise agreed upon by the Parties in writing. n. Adjudicate Part D claims according to coverage and apply applicable discounts. o. PBM shall correctly adjudicate Claims in accordance with all applicable Laws. <u>8. Excluded Providers.</u> PBM shall ensure that Claims are rejected or denied (both at the point-of-sale and for paper Claims) for prescriptions written by a prescriber or dispensed by a pharmacy that has been excluded by the OIG or from participation in federal or state health care programs. PBM shall otherwise comply with CMS requirements with respect to Claims related to excluded providers, including CMS' 2010 Call Letter issued March 30, 2009, Article VIII, Section titled "Claims for Drugs Prescribed by Excluded Providers," or successor CMS guidance thereto. a. Without limiting the generality of the foregoing, PBM shall at least monthly update its systems with the most

	current information on sanctioned providers and have processes in place to identify and prevent payment of Claims when such claims have been prescribed by excluded providers. 9. Prompt Pay. PBM shall process and pay Claims in accordance with CMS prompt pay requirements. PBM shall issue, mail, or otherwise transmit payment to Participating Pharmacies (other than mail-order and LTC Participating Pharmacies) for Clean Claims (as defined at 42 C.F.R. Section 423.520(b)) submitted by Participating Pharmacies on behalf of Members within fourteen (14) days for electronic Claims and within thirty (30) days for Claims submitted otherwise, or such other time periods as CMS regulations may require from time to time. PBM shall abide by CMS regulations in determining whether a Claim is a Clean Claim. PBM is financially responsible for interest and other penalties due on late paid Claims except to the extent that such failure or delay in payment is due to wrongful actions by Aetna. 10. Pricing Source/Updates. PBM shall utilize the most current Medi-Span electronic pricing compendium as its pricing source, or such other mutually agreed upon source, which PBM shall update on a daily basis. 11. Concurrent DUR. PBM shall adjudicate Claims using concurrent DUR edits at the dispensing Participating Pharmacy point of sale as set forth Schedule F (Prescription Drug Utilization Review). All references in this Schedule O (Medicare Services) to DUR (including to Schedule F (Prescription Drug Utilization Review)) shall include DUR edits required by Law (regardless of notification by Aetna), and DUR edits required by Aetna and/or the applicable Medicare Plan upon agreement of the Parties. PBM shall work together in good faith with Aetna to improve DUR controls, including concurrent and retrospective DUR in accordance with CMS requirements (including the 2013 Final CMS Call Letter) and shall implement such DUR controls required to comply with CMS requirements. 12. FIR. PBM shall receive and process Financial Information Reporting ("FIR") (as defined and supplied by CMS or any CMS designee, including the Daily Cumulative FIR Aging Report) transaction activity (including adjustments thereto) in accordance with CMS requirements and the Eligibility Data received from Aetna. 13. COB. PBM shall perform the following COB transaction activity (including adjustments thereto) in accordance with CMS requirements, including Chapter 14 of the Prescription Drug Benefit Manual and CMS' 2010 Call Letter issued March 30, 2009, Article VIII, Section titled "New Medicare Secondary Payer (MSP) Edits," or successor CMS guidance thereto. PBM shall provide accumulator information to Members and other plans in accordance with CMS requirements. PBM shall not impose fees on entities offering other prescription drug coverage that are unrelated to the cost of the COB to the extent prohibited by CMS. PBM shall coordinate reconciliation of Claims and correction of payments, in a manner and timeframe in effect as of the Effective Date of this Agreement up until migration to PBM's platform,

	and thereafter as otherwise previously agreed upon by the Parties with respect to post-migration to PBM's platform (or as otherwise agreed upon by the Parties) and in compliance with CMS regulations, when other payers (*e.g.*, SPAPs, MPAPs) have paid primary or on behalf of the Medicare Plan. Upon Aetna's request and at Aetna's option, PBM shall develop a cost-effective and efficient solution agreed upon by the Parties to accomplish the following: PBM shall perform all Coordination of Benefits ("COB") (as defined by CMS) transaction activity (including adjustments thereto) in accordance with CMS requirements, including Chapter 14 of the Prescription Drug Benefit Manual and CMS' 2010 Call Letter issued March 30, 2009, Article VIII, Section titled "New Medicare Secondary Payer (MSP) Edits," or successor CMS guidance thereto. Without limiting the generality of the foregoing, in connection with the cost-effective and efficient solution agreed to by the parties PBM shall perform the following: a. PBM shall develop and operate a system for collecting information from Members about their other health insurance, including whether such insurance covers outpatient prescription drugs. Without limiting the generality of the foregoing, in accordance with CMS requirements (including CMS required time frames) and at such other times reasonably required by Aetna, PBM shall provide reporting to allow for comparison of the Coordination of Benefits Contractor File ("COBC File") information and Aetna and Aetna Customer eligibility files. Once received by Aetna, if comparison reveals other health insurance information for Members (including whether such insurance covers outpatient prescription drugs), Aetna shall promptly communicate that information to PBM in the standard COBC File layout, or as otherwise mutually agreed upon by the Parties. Additionally, if, through any other means, PBM becomes reasonably aware of any information that indicates a Member has other health insurance, PBM shall promptly communicate such information to Aetna in a mutually agreed upon format. PBM shall coordinate with Aetna's member enrollment services to capture accurate information. b. To the extent required by Aetna, PBM shall provide to Aetna relevant information received by PBM for such information to be shared with State Pharmaceutical Assistance Programs ("SPAPs") and other third party payers to coordinate benefits as required by and in accordance with CMS requirements. c. To the extent required by Aetna, PBM shall conduct COB Member notifications required by CMS. d. Upon receipt of information pertaining to a Member's enrollment in an MPAP through the CMS COB file or other means, PBM shall conduct telephonic outreach, where possible, to MPAPs in order to obtain the drug/member-

	specific information necessary to set the system for both drug utilization review and correct claim adjudication. e. PBM shall send new information captured via the COB notification process about Members' other sources of prescription drug coverage by sending electronic updates to the COBC. f. PBM shall receive and process plan to plan reconciliation reports on a monthly basis in accordance with CMS and Aetna requirements. g. PBM shall pursue for recovery incorrect primary payments from insurers, group health plans, employer sponsors, workers' compensation, automobile insurance, other liable entities, and other Persons (excluding Members). h. To the extent required by Aetna, PBM shall periodically issue a COB letter to the Member to identify the payer and send the payer information to the COBC via Electronic Correspondence Referral System ("ECRS") (as defined by CMS) in the event that PBM receives a mismatched "N" transaction, but has no supplemental payer information on the COBC file to identify the payer. <u>14. PDE.</u> PBM shall create weekly prescription drug event ("PDE") files and submit such files to CMS on Aetna's behalf, including re-submissions, in accordance with Schedule V (Reporting) and CMS requirements, including CMS "Instructions: Requirements for Submitting Prescription Drug Event Data" dated January 10, 2006 and CMS final rule published on January 12, 2009 regarding negotiated prices under Medicare Part D and 42 C.F.R. Section 423.120 (and such successor guidance). PBM shall provide a copy of such files and/or make such files available to Aetna and its designees, as directed by Aetna. The data will be based on the actual reimbursement amount paid to pharmacies for the applicable Part D Claim and shall indicate the prescription origin code. PBM shall receive PDE response files from CMS, and PBM shall identify each rejected PDE and determine as best as possible whether the root cause of the rejection requires correction by Aetna, PBM, CMS, or a combination of any of these entities. PBM shall work internally as well with Aetna and CMS to investigate and resolve rejected PDE records. PBM shall coordinate the management of PDE error correction with support from Aetna. PBM shall recalculate and resubmit to CMS, PDE files based on such corrected PDE records. PBM shall collaborate with Aetna to decrease Aetna PDE error rates. a. PBM shall follow CMS requirements, including CMS "best practices" set forth in the 2010 Call Letter, regarding NDCs not registered and listed with the FDA and comply with service levels and timelines per Schedule R, section 10.6. b. PBM will ensure that each PDE record contains an active and valid individual prescriber NPI. Notwithstanding the

	foregoing, PBM will initially reject a Claim if it does not contain an active and valid NPI to the extent permitted by CMS (unless the Claim involves a foreign prescriber who does not have an NPI, in which case the Claim can be rejected at the point of sale). PBM shall communicate to Participating Pharmacies at the point of sale whether or not a submitted NPI is active and valid. If PBM communicates at the point of sale that the NPI is not active and valid (via SCC override to the extent permitted by CMS), PBM shall permit the Participating Pharmacy to confirm that the NPI is not active and valid, or in the alternative, correct it. If the Participating Pharmacy cannot or does not correct or confirm the NPI is active and valid, PBM shall require the Participating Pharmacy to resubmit the Claim. The back and forth between PBM and a Participating Pharmacy in this regard will take no more than 24 hours, and PBM will have controls in place to ensure Participating Pharmacies resubmit claims where PBM has communicated an issue with the NPI and the Participating Pharmacy cannot or does not correct or confirm that the NPI is active an valid. c. PBM shall comply with the timely response requirements for PDE Data Quality Reviews posted on the Data Quality Validation website. d. PBM shall complete and submit to Aetna an annual attestation in support of Aetna's PDE and DIR submissions and attestations to CMS. The form and content of such attestation shall be determined by Aetna. <u>15. TrOOP and Other Member Accumulators.</u> PBM's online claims adjudication system shall accept and maintain data provided with respect to Members' TrOOP costs and other Member accumulators in accordance with Law. PBM shall provide to Aetna Members accumulator information (including TrOOP information) in a form, format, and frequency required by Aetna that allows Aetna to satisfy its obligations to CMS, and as otherwise reasonably required or requested by Aetna. Accumulator reporting (including TrOOP) and related calculations shall use the actual reimbursement amount paid to the applicable pharmacy (including AWP discount, MAC, and Dispensing Fee). Without limiting the generality of the foregoing, PBM shall perform the following services and functions relating to Member accumulators: a. PBM shall track each Member's accumulator information, including TrOOP, as and to the extent applicable. b. PBM shall accept data concerning third party payers in a format specified by CMS for use in PBM's accumulator (including TrOOP) calculation. c. PBM shall process Claims and track accumulators (including TrOOP) in real time using the current HIPAA-approved NCPDP standard.

	d. PBM shall provide Members with a report on their accumulator status (including TrOOP) in accordance with CMS requirements via the monthly EOB if the Member has claims activity, has a disenrollment EOB, or if there is Financial Information Reporting activity for the current plan year. Provision of such EOB related to previous plan years will be provided as required by CMS. e. PBM shall provide Aetna customer service representatives access to PBM's customer service system to facilitate Members' daily access to their current accumulator status (including TrOOP) through Aetna's toll-free customer service phone number. f. In the event of disenrollment, PBM shall provide to the Member his/her accumulator status (including TrOOP) as of the effective date of the disenrollment, as and to the extent required by Aetna. g. PBM shall retroactively adjust Claims and recalculate TrOOP balances and other accumulators based on "N" transactions received from the TrOOP facilitator contractor that were created based on other than real-time TrOOP-eligible Claims. h. PBM shall retroactively adjust Claims and recalculate TrOOP balances and other accumulators based on documentation received from Members that reflect amounts the Member paid on other than real-time TrOOP-eligible Claims. i. PBM shall retroactively adjust Claims, recalculate accumulator balances (including TrOOP), and reimburse other payers (when applicable) whenever it receives information indicating that errors were made in the order of payment and there are multiple other payers on a Member record. j. PBM shall count other payer paid amounts as satisfying the Part D deductible in accordance with the Member's Benefit Plan Design in accordance with CMS requirements. k. PBM shall establish an EOB/FIR transfer contact who can be contacted by Aetna, CMS, the States and other payers to resolve EOB/FIR transfer issues ("Transfer Contact"). l. PBM shall send the Member's TrOOP balance and gross Covered Drug spending amount to the EOB transfer contact of a disenrolling Member's other Part D plan sponsor, and update these amounts when applicable, when PBM receives notice that a Member has disenrolled from a Medicare Plan hereunder. m. PBM shall develop and maintain the systems capability to receive and respond to real-time (or batch) transactions requesting TrOOP-related data for disenrolling Members as well as to receive these data for newly enrolling Members

	transferring mid-year from another plan. n. PBM shall develop the capacity to integrate data received via all electronic transactions, including "N" and "F" transactions, into those systems that track and apply Member-level TrOOP and gross Covered Drug costs. o. As and to the extent applicable, PBM shall ensure that costs incurred by AIDS Drug Assistance Programs and IHS count toward TrOOP. p. As and to the extent applicable, PBM shall ensure that manufacturer and Member liability incurred on Claims during the Coverage Gap counts toward TrOOP in accordance with CMS requirements. 16. Medicare Secondary Payer ("MSP") Requirements. PBM shall comply with the MSP Laws and any other applicable federal and state Laws in establishing and processing with respect to payers of last resort, including compliance with Chapter 14 of the Prescription Drug Benefit Manual and CMS' 2010 Call Letter issued March 30, 2009, Article VIII, Section titled "New Medicare Secondary Payer (MSP) Edits," or successor CMS guidance thereto. a. PBM shall follow as applicable the Rules for Coordination of Benefits adopted in the most current National Association of Insurance Commissioner Coordination of Benefits Model Regulation. b. PBM shall process Claims in real time to support the TrOOP facilitation process when the Medicare Plan is a secondary payer in accordance with the application of MSP rules. c. PBM shall provide to Aetna all data reasonably necessary to enable Aetna to pursue recovery from Members. 17. Resubmission and/or Reprocessing of Claims. PBM shall resubmit or reprocess Claims consistent with Chapter 14 § 50.14.3 as required by CMS and/or Part D requirements, including for Medicare Part D COB, low income subsidy, plan-to-plan reconciliations, errors, PDE, "N" transactions, FIR, Member reconciliation, Member overpayments and related issues. As part of this service, PBM shall issue checks to Members to reimburse any amounts owed resulting from such resubmission or reprocessing, as applicable. PBM shall issue refunds within forty-five (45) days of PBM's receipt of complete information regarding the adjustment per 42 C.F.R. Section 423.466, as applicable. Unless otherwise directed by Aetna, this shall include COB and plan-to-plan reconciliations. 18. Transition of Coverage ("TOC"). PBM shall implement a TOC process to address (1) the transition of new Members into Medicare Plans following the annual coordinated period; (2) the transition of newly eligible Members from other coverage; (3) the transition of individuals who switch from one plan to another after the start of the contract year; (4)

	Members residing in LTC facilities; (5) in some cases, current Members affected by formulary changes from one contract year to the next; and (6) the transitions to formulary drugs for Members who change treatment settings due to changes in level of care consistent with Aetna Policies and CMS requirements and guidance, including compliance with the guidance and recommendations in Chapter 6 of the Prescription Drug Benefit Manual. Upon Aetna's request and as PBM capabilities exist, PBM shall develop and implement follow-up outreach programs satisfactory to Aetna aimed at assuring that targeted Members have effectuated an appropriate and meaningful transition. Such programs may include mechanisms for appropriately identifying Members who are in need of follow-up and mailing of written communications to Members and Providers as required by Aetna. PBM is also responsible for reporting pre- and post-outreach transition results to Aetna; provided further that such program shall in all events satisfy any applicable CMS requirements. To the extent such programs go beyond the programs in existence as of the Effective Date of this Agreement or are not otherwise reasonably contemplated under the Agreement, the Parties shall agree upon such programs, and if applicable, any associated fees or charges. 19. Data Processing and Management System Requirements. PBM shall ensure that its data management processes and data systems will be capable of accomplishing the following: (a) collection of data in either NCPDP or such other CMS required format (encompassing quantity, type, and costs of Covered Drugs filled for Members, linked to Member identification numbers); (b) submission of Covered Drug Claims information in the format required by CMS using batch submission processes; (c) submission of data to Aetna or CMS (as directed by Aetna) in compliance with CMS requirements; (d) performance of data edit and quality control procedures to help ensure accurate and complete prescription drug data; (e) correction of all data errors identified by CMS; (f) collection of data for dates of service within the coverage period with a three (3) month close-out window for the submission of remaining unreported Claims data; (g) provision of additional information for the purposes of reconciliation of risk factors, low income subsidy payments, reinsurance payments, and risk corridor as required by CMS; and (h) sending and receiving Claims data to Aetna for third party payers from the CMS contractor that will serve as the clearinghouse for all Member outpatient drug Claims. 20. System Description. PBM shall have available for inspection by CMS and/or Aetna, a complete description of the claims adjudication system, including (a) hardware and software; (b) operating system; (c) MediSpan (or other agreed upon pricing source) database, including number of iterations saved; (d) number of sites processing Claims (including disaster recovery back-up system); and (e) system volume in covered lives, including the number of transactions the system can support per day and per hour. 21. System Testing. PBM shall have a testing process in accordance with the Schedules hereto to identify and correct plan configuration errors prior

	to implementation and shall document the manner and extent to which it has performed such testing. 22. Daily Cost-Sharing Rates. Beginning January 1, 2014, PBM will provide Members access to a daily cost-sharing rate when prescriptions dispensed by a Participating Pharmacy are for less than a thirty (30) day supply, in accordance with CMS requirements, including 42 CFR Section 423.104 and 42 CFR Section 423.153(b)(4).
Policies and Procedures	23. Policies and Procedures. PBM shall have available for inspection by CMS and/or Aetna, the following policies and procedures: (a) a complete description and flow chart detailing the Claims adjudication process for (i) Participating Pharmacies, (ii) out-of-network pharmacies, (iii) paper Claims, (iv) non-electronic claims submitted by Participating Pharmacies and other payers seeking to coordinate benefits; (v) batched processed Claims, and (vi) manual Claim entry (i.e., process for direct Member reimbursement); (b) a complete description of Claim detail management, including (i) the length of time that detailed Claim information is maintained online (which shall not be less than twelve (12) months), (ii) the data storage process after it is no longer online, and (iii) the length of time that detailed Claim information is stored when it is no longer online (which will not be less than ten (10) years); (c) a complete description of the accessibility of the following information for data capture purposes and flow chart of the Claims data retrieval process for each of the following: (i) entire Claims history file, (ii) file claims adjustments including records of reimbursements and recoveries due to network pharmacies and beneficiaries; (d) deductible files/ TrOOP/ and gross covered proscription drug cost accumulator; (e) IRE submissions; and (f) quality.
Customer and Contact Services	24. Provider Call Center. PBM shall operate a toll-free call center to respond to operational area inquiries from pharmacies and providers regarding Medicare Plans benefits hereunder, including inquiries related to Claims processing, benefit coverage, Claims submission, and Claims payment. Such call center must be available twenty-four (24) hours a day, seven (7) days a week, 365 days per year, via live coverage or IVR (to the extent permitted by CMS), and service any Member facing program required by Aetna. PBM shall meet all CMS requirements with respect to the provider call center. Without limiting the generality of the foregoing, the Provider call center shall meet all standards required by CMS or Law for each Medicare Plan. PBM shall provide reports on these standards in accordance with CMS requirements and as otherwise requested by Aetna. The Parties acknowledge and agree that Aetna may perform monitoring activities including listening to recorded calls as requested by Aetna, conducting call center site visits, and such other monitoring activities as agreed to by the Parties. 25. Member Call Center. Upon Aetna's request, PBM shall provide Member call center services for Medicare Part D related to the pharmacy benefits and prescription matters in accordance with Schedule E (Contact

	Services) and as otherwise required by CMS (including hours of operation and providing information on the plan's MTM program. In addition to the requirements set forth in Schedule E (Contact Services), if requested to provide Member call center services, PBM customer service representatives answering Medicare Part D Member calls shall be dedicated to Medicare Part D and receive ongoing specialized training, including training regarding CMS requirements and senior sensitivity training. PBM shall warm transfer misdirected calls to Aetna in accordance with Aetna requirements. PBM shall provide call center support to any member facing program required by Aetna. If, after the Effective Date, Aetna implements a member facing program that requires a material change to PBM's call center operations, the Parties will negotiate in good an equitable adjustment to the pricing and fees to account for such material change in the call center operations. The Parties acknowledge and agree that Aetna may perform monitoring activities including listening to recorded calls as requested by Aetna, conducting call center site visits, and such other monitoring activities as agreed to by the Parties. 26. Coverage Determination Requests. PBM shall operate a toll-free call center to respond to Providers and Participating Pharmacies for information related to coverage determination requests in accordance with CMS requirements, but in any event at least from 8:00 a.m. to 8:00 p.m. on all Business Days in all time zones in which Medicare Plans operate. 27. Outbound Calling Capabilities: PBM shall maintain outbound calling capabilities per Schedule E, Section 18.
Complaint Tracking Module	28. In addition to the requirements set forth in Schedule E (Contact Services), PBM shall respond to Aetna's request, daily if required by Aetna, concerning complaints received by Aetna via CMS' Compliant Tracking Module that involve Services provided by PBM or its downstream entities. As requested by Aetna, PBM shall assist Aetna is responding to and resolving any such complaints, perform root cause analysis of the complaints, and implement processes to prevent future complaints.
Participating Pharmacy Network Services	29. Part D Networks. PBM shall make available to Aetna, Aetna Plan Affiliates and Members enrolled in Medicare Plans all CMS-compliant Participating Pharmacy network options (e.g., wrap networks, concentric networks, reimbursement for trial fills, extended day supply networks, etc.). The Participating Pharmacy network maintained and provided by PBM to support and service Medicare Plans is referred to as the "Part D Network". At a minimum, PBM shall ensure that the composition of the Part D Network(s) utilized by Medicare Plans mirrors Aetna's Part D pharmacy network(s) as existed just prior to the Closing Date, including Aetna's extended day supply network; provided, that any pharmacy required to be added pursuant to this requirement agrees to PBM's standard terms and satisfies PBM's credentialing requirements. 30. Any Willing Pharmacy. PBM shall permit any pharmacy that is

willing to accept and meets PBM's standard terms and conditions, including PBM's pharmacy credentialing criteria (which in all cases will be objective criteria consistent with CMS requirements) to participate in the Part D Network. To the extent permitted by CMS, PBM may require variation in terms and conditions under applicable Participating Pharmacy Contracts, particularly with respect to payment terms, to accommodate geographical areas (e.g., rural pharmacies) or different types of pharmacies (e.g., mail order and retail), provided that all similarly-situated pharmacies are offered the same standard terms and conditions.

31. Preferred Pharmacies. If and to the extent applicable and required by Aetna, PBM shall use its best efforts to enter into Participating Pharmacy Contracts with those pharmacies designated by Aetna as "preferred pharmacies", which Contracts shall contain the required terms and conditions as identified by Aetna (which may include, but are not limited to, preferred rate schedules), within ten (10) calendar days of the receipt of Aetna's request. If PBM is unable to enter into a Participating Pharmacy Contract with terms and conditions acceptable to Aetna within ten (10) calendar days after receiving Aetna's request, then Aetna in its sole discretion, (i) may require PBM to cooperate with Aetna in attempting to obtain the pharmacy's agreement to the terms and conditions of the Contract previously between Aetna and the pharmacy ; and/or (ii) may be permitted to contract directly with such pharmacy, and PBM shall administer such pharmacy Contract in accordance with the terms and conditions of such Contract at the applicable Plan level, and in accordance with the Agreement, including proper Claim adjudication, Claims payment, credentialing, reporting, CMS submissions, Member communications, and other administrative services. If and to the extent applicable, PBM shall clearly designate in the Participating Pharmacy Contracts whether it is a preferred or non-preferred Participating Pharmacy. Aetna's right under (ii) above shall be in addition to and not in lieu of Aetna's right under Schedule G.

32. No Insurance Risk. PBM shall not require a Participating Pharmacy to accept insurance risk as a condition of participation in the Part D Network.

33. Participating Pharmacy Access. PBM shall include adequate HIT, LTC, I/T/U, specialty, mail order and retail pharmacy providers in PBM's Part D Network to meet CMS access requirements, including CMS access requirements set forth at 42 C.F.R. Section 423.120. PBM shall demonstrate compliance with the pharmacy access requirements based on a computation using total Medicare beneficiary counts by zip code, or such other counts as CMS may designate. The current Medicare Part D Network access requirements include the following (and apply on an individual Medicare Plan basis)

34. Medicare Part D Retail Access: PBM shall provide adequate access, in accordance with CMS requirements, to Retail Participating Pharmacies, which as of the Effective Date, is as follows:

a. At least 90% of Medicare Members in urban areas (as defined by CMS) served by a Medicare Plan live within two (2) miles

	of a retail Participating Pharmacy. b. At least 90% of Medicare Members in suburban areas (as defined by CMS) served by a Medicare Plan live within five (5) miles of a retail Participating Pharmacy. c. At least 70% of Medicare Members in rural areas (as defined by CMS) served by a Medicare Plan live within fifteen (15) miles of a retail Participating Pharmacy. 35. Medicare Part D HIT Access: PBM shall provide adequate access, in accordance with CMS requirements, to HIT Participating Pharmacies, and PBM shall provide as required by CMS, upon CMS' request, and as otherwise requested by Aetna, with a list of all HIT Participating Pharmacies, which CMS can use to develop a Member - HIT Participating Pharmacy ratio. 36. Medicare Part D Long Term Care ("LTC") Access: PBM shall ensure convenient access to LTC Participating Pharmacies for all Members residing in an institute for mental disease ("IMD") as defined at 42 U.S.C. Section 1396d(i) or intermediate care facility for the mentally retarded ("ICF-MR") as defined at 42 U.S.C. Section 1396d(d) designated by any state as an institution and in which any institutionalized individuals reside. PBM shall maintain in the Part D Network (and keep in full force and effect Participating Pharmacy Contracts with) a sufficient number of LTC pharmacies to provide all of Aetna's institutionalized Members access to LTC pharmacies in accordance with CMS requirements. PBM shall take actions associated with the Long Term Institutionalized (LTI) Resident Report (e.g., contracting with certain LTC pharmacies) to ensure Aetna's compliance with the CMS memorandum dated November 9, 2012. 37. Medicare Part D I/T/U Access: PBM shall provide, in accordance with CMS requirements, convenient access to I/T/U pharmacies operating in each Medicare Plan Service Area. 38. Participating Pharmacy Contract Crosswalk Requirements. PBM shall include in all Contracts with Participating Pharmacies in the Part D Network the contract provisions referenced in the CMS application appendices entitled: a. Crosswalk for Retail Participating Pharmacy Access Contracts b. Crosswalk for M.O. Participating Pharmacy Access Contracts c. Crosswalk for HIT Participating Pharmacy Access Contracts d. Crosswalk for LTC Participating Pharmacy Access Contracts e. Crosswalk for I/T/U Participating Pharmacy Access Contracts 39. Participating Pharmacy Contracts. Without limiting the generality of the foregoing paragraph above (Participating Pharmacy Contract Crosswalk Requirements) and in addition to the requirements contained in

	Schedule G-1 (Requirements for Participating Pharmacy Contracts) for Participating Pharmacy Contracts, all PBM Contracts with Participating Pharmacies providing services to Members of Medicare Plans shall also contain the following terms and conditions: a. PBM shall ensure that Aetna and/or the applicable Medicare Plan retain the right to approve, suspend, or terminate any Participating Pharmacy contracted by PBM to provide services to Members of Medicare Plans. b. With respect to Part D Claims, PBM shall issue, mail, or otherwise transmit payment to Participating Pharmacies (other than mail order and LTC Participating Pharmacies) for Clean Claims submitted by Participating Pharmacies on behalf of Members within fourteen (14) days for electronic Claims and within thirty (30) days for Claims submitted otherwise. c. PBM agrees that it will identify MediSpan as its third party pricing source (or such other pricing source agreed upon by the parties in accordance with the Agreement), for reimbursement and pricing updates for AWP. PBM shall update the pricing in its system on a daily basis (beginning with an initial update on January 1 of each year) to accurately reflect the market price of acquiring the drug. d. PBM shall require that pharmacies do not submit to PBM Medicare Part A or Medicare Part B Claims under Medicare Part D. PBM understands and agrees that if PBM or Aetna becomes aware that a Participating Pharmacy billed Claims for reimbursement under Medicare Part D that should have been billed under Medicare Part A or Part B, Aetna may require PBM to reverse such Claims, withhold any amounts due from such reversed Claims, and require Participating Pharmacy to refund Members who inappropriately paid Part D cost-sharing amounts. e. PBM shall ensure that Participating Pharmacies are required to submit Claims in real time by means of point of service Claims adjudication systems in compliance with CMS standards (except when necessary to provide access in underserved areas, I/T/U pharmacies and LTC Participating Pharmacies). PBM shall require Participating Pharmacies to include the Participating Pharmacy's and the Provider's NPI in electronic prescription Claims. f. PBM shall ensure that Participating Pharmacies support and comply with electronic prescription standards adopted by CMS, as such standards may be revised from time to time, including: (i) NCPDP for communications concerning prescriptions or prescription-related information between Participating Pharmacy and Providers; (ii) NCPDP Script 8.1 for communications concerning medication history between

	PBM, Participating Pharmacy and Providers and refill status between Participating Pharmacy and Providers; (iii) NCPDP Telecommunication Standard D.0 for communications concerning eligibility between PBM and Participating Pharmacy; and (iv) the Provider's NPI. Also, PBM shall require pharmacies to use NCPDP 5.1 Field 419 DJ – Prescription Origin Code so that the source of origin for prescriptions filled can be identified and reported. As PBM implements, acquires, or upgrades health information technology systems, where available, the health information technology systems and products shall meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by Section 13101 of the American Recovery and Reinvestment Act of 2009. g. PBM shall ensure that Participating Pharmacies comply with Medicare COB online processes consistent with all Laws and industry standards. h. PBM shall ensure that Participating Pharmacies do not hold Members liable for payment of any fees that are the legal obligation of PBM, Aetna, or a Medicare Plan. i. PBM shall ensure that Participating Pharmacies provide the negotiated prices to the Member even if no benefits are payable to the Member for Part D Covered Drugs. j. PBM shall ensure that Participating Pharmacies inform Members of any differential between the price of the dispensed drug and the price of the lowest priced Generic Drug version of that drug that is therapeutically equivalent and bioequivalent and available at the Participating Pharmacy, unless the particular drug being purchased is the lowest-priced therapeutically equivalent and bioequivalent version of that drug available at the Participating Pharmacy. PBM shall ensure that Participating Pharmacies provide this notice at the point-of-sale or, in the case of dispensing by mail order, at the time of delivery of the drug. PBM shall ensure that LTC Participating Pharmacies provide this notice in accordance with CMS requirements. The notice requirement in this section does not apply to I/T/U pharmacies or pharmacies located in any of the U.S. territories absent a change in Law. k. PBM shall ensure that Participating Pharmacies charge/apply the correct cost-sharing amount to the Member as indicated via the online Claims adjudication system, including that which applies to Members qualifying for the low-income subsidy. l. PBM shall ensure that Participating Pharmacies comply with minimum standards for pharmacy practice as established by the states. m. PBM shall ensure that Participating Pharmacies review DUR

	messages as they are received via the online claims adjudication system and use professional judgment as to whether action is required. n. PBM shall ensure that Participating Pharmacies offer patient counseling to Members when appropriate and must provide information regarding treatment options in a culturally-competent manner, including the option of no treatment. PBM shall ensure that Participating Pharmacies take action to ensure that Members with disabilities have effective communications in making decisions regarding treatment options. o. PBM shall ensure that Participating Pharmacies implement a method for maintaining up-to-date Member information, such as Member demographic information and Member allergy information (drug) to the extent required by CMS. In no event may Medicare Plans or PBM prohibit or otherwise restrict a Participating Pharmacy, acting within the lawful scope of practice, from advising or advocating on behalf of a Member about the Member's health status, medical care, treatment options, risks, benefits, consequences of treatment or non-treatment, or the opportunity to refuse treatment. p. Participating Pharmacy may not indemnify PBM or Medicare Plans against any civil liability for damage caused to a Member as a result of a Medicare Plan's denial of medically necessary care. q. PBM shall ensure that Participating Pharmacies track medication errors, take corrective action with respect to such errors in a manner consistent with the Medicare Plan's obligations under applicable CMS rules. Further, if PBM receives any information concerning a medication error, it shall take corrective action with respect to such errors and provide a report of such to Aetna with respect to Members. r. To the extent prohibited by CMS, PBM shall ensure that Participating Pharmacies do not distribute printed information comparing the benefits of different Medicare Plans unless the Participating Pharmacy accepts and displays materials from all Medicare Plans. s. In accordance with 42 C.F.R. Section 423.562(a)(3), PBM shall ensure that Participating Pharmacies use CMS Form 10147 entitled "Notice: Your Prescription Cannot Be Filled" (the "Medicare Rights Notice") to instruct Members to contact their Medicare Plan to obtain a coverage determination or ask for a Formulary or tiering exception if the Member disagrees with the information provided by a Participating Pharmacy concerning a requested prescription. PBM shall ensure that Participating Pharmacies distribute this Medicare Rights Notice to Members. The posted Medicare Rights Notices

must be at least as large as the individual notices that are distributed to Members, but larger dimensions and font size are permissible. If Participating Pharmacy is a LTC Participating Pharmacy, PBM shall ensure that LTC Participating Pharmacies send, fax, or otherwise deliver the Medicare Rights Notice to the location in the LTC facility designated to accept such notices. The LTC facility staff is responsible for providing the Member (or the Member's appointed representative) and the Member's treating physician with the notice. LTC Participating Pharmacies shall maintain a copy of the notice in the Member's file at the LTC facility. This is a standard notice. Participating Pharmacy shall not deviate from the content of the Medicare Rights Notice. The Office of Management and Budget ("OMB") control number must be displayed in the upper right corner of the Medicare Rights Notice. Participating Pharmacies may elect to place their logo in the space above "Notice: Your Prescription Cannot be Filled".

t. PBM shall require Participating Pharmacies to submit claims to PBM whenever the membership ID card is presented or on file at the Participating Pharmacy unless the Member expressly requests that a particular claim not be submitted.

u. PBM shall require Participating Pharmacies to ensure that all Covered Drugs it dispenses are pursuant to a valid prescription order in accordance with applicable state laws.

v. PBM's contracts with Participating Pharmacies shall provide for payment adjustment as the result of legislation, regulation, executive order or other federal mandate that results in payment reductions to Part D plan sponsors.

<u>40. LTC Participating Pharmacies.</u>

a. In addition to the other Participating Pharmacy Contract requirements set forth herein, PBM shall require that all LTC Participating Pharmacies in the Part D Network sign, directly or through a power of attorney, a Contract that: (i) requires the LTC Participating Pharmacy to meet the LTC dispensing, performance and service criteria established by CMS, including all the performance and service criteria for LTC pharmacies that are cited in section 50.5.2 of Chapter 5 of the Medicare Prescription Drug Benefit Manual (or such successor guidance thereto); and (ii) unless otherwise directed by CMS, provide that the LTC Participating Pharmacy shall have not less than thirty (30) days and no more than 90 days after the date of dispensing to submit all Claims for Part D Covered Drugs provided to Members.

b. PBM shall ensure that, in contracting with LTC Participating Pharmacies, it does not agree to particular contracting terms

	and conditions that have the net result of creating a non-uniform benefit for Members served by those LTC Participating Pharmacies relative to those residing in LTC facilities serviced by other Part D Network LTC Participating Pharmacies whose Contracts with the PBM do not include the same provisions. c. PBM shall require LTC Participating Pharmacies to reduce wasteful dispensing of Covered Drugs and dispense Covered Drugs and report information in accordance with 42 CFR Section 423.154 and CMS guidance related thereto. <u>41. HIT Participating Pharmacies.</u> a. In addition to the other Participating Pharmacy Contract requirements set forth herein, PBM shall require that all HIT pharmacies in the Part D Network sign, directly or through a power of attorney, a Contract that meets the following requirements: (i) PBM shall require Participating Pharmacies in the Part D Network that deliver home infusion Covered Drugs to deliver home infusion drugs in a form that can be administered in a clinically appropriate fashion in the Member's place of residence; (ii) PBM shall require Participating Pharmacies in the Part D Network that deliver home infusion Covered Drugs to ensure that the professional services and ancillary supplies necessary for home infusion are in place before dispensing home infusion Covered Drugs to the Member in his/her place of residence; and (iii) PBM shall require Participating Pharmacies in the Part D Network that deliver home infusion Covered Drugs to provide home infusion Covered Drugs within twenty-four (24) hours of discharge from an acute setting, unless the next required dose, as prescribed, is required to be administered later than twenty-four (24) hours after discharge (in which case PBM shall require such Participating Pharmacy to provide the home infusion Covered Drug prior to the first required administration). b. PBM shall maintain within the Part D Network a HIT Participating Pharmacy network containing a sufficient number of Participating Pharmacies capable of providing infusible Medicare Part D drugs for both short term acute care (e.g. IV antibiotics) and long term chronic care (e.g. alpha protease inhibitor) therapies for applicable Members. <u>42. I/T/U Pharmacies.</u> PBM's Contracts with Indian Health Services ("IHS") pharmacies and all pharmacies and dispensaries operated by the IHS, Indian tribes, tribal organizations, and urban Indian organizations shall conform to the model addendum required by CMS. 43. Specialty Participating Pharmacies. a. PBM shall not restrict access to Medicare Part D drugs by

limiting distribution through a subset of Participating Pharmacies in the Part D Network, except when necessary to meet FDA limited distribution requirements or to ensure the appropriate dispensing of Medicare Part D drugs that require extraordinary special handling, Provider coordination, or patient education when such extraordinary requirements cannot be met by a Participating Pharmacy, in accordance with CMS requirements.

b. PBM shall not restrict access solely on the placement of a Medicare Part D drug in a "specialty/high cost" tier because this tier placement alone is not indicative of any special requirements associated with such drug. PBM further agrees that any drug-by-drug requirements for Participating Pharmacies only apply to special handling and dispensing that may be required for a particular Specialty Product and not to reimbursement or other standard terms and conditions.

c. PBM shall not require a Participating Pharmacy in the Part D Network to be a "specialty" Participating Pharmacy in order to dispense any drug that requires special attention if the Participating Pharmacy is capable of appropriately dispensing the particular Medicare Part D drug or drugs in question.

43. Large Batch Claims. The Parties shall mutually agree to a process whereby PBM shall submit to Aetna for review and approval (which shall be timely and not unreasonably withheld) prior to adjudication and payment batch Claims that are large in volume and/or large in amount (both as reasonably determined by Aetna from time to time) (i.e., batch claims received from SPAPs, Medicaid, LTCs, etc.).

44. Participating Pharmacy Fraud, Waste, and Abuse. PBM's audits of Participating Pharmacies shall meet CMS requirements and recommendations related to fraud, waste, and abuse prevention and detection, and shall include CMS' requirements and recommendations set forth in Chapter 9 of the Prescription Drug Benefit Manual. PBM shall implement contractual terms and auditing and other internal controls to detect and prevent fraud, waste, and abuse and to ensure that pharmacies are not inappropriately splitting prescriptions to increase dispensing fees, and thus costs to Members and the Part D program, and shall take appropriate action against Participating Pharmacies that engage in such inappropriate activities, up to and including termination from the Medicare Plan's network.

45. Quality Based Programs: PBM shall administer quality-based programs for Medicare Plans including, but not limited to, pharmacy programs that establish financial incentives for the clinically appropriate dispensing of lowest cost generic drugs, and Member outreach and counseling programs to improve drug adherence for Members with chronic conditions. If, after the Effective Date, Aetna implements a new quality-based program that is not an extension or minor change or update to a quality-based program provided by PBM prior to the Effective Date,

	the Parties will negotiate in good faith an equitable adjustment to the pricing and fees to account for such material change in the operations resulting from such new program.
Communications	46. Member Communications (Not Including Enrollment Communications). PBM shall create and provide to Aetna the required Medicare Part D Member communications with respect to Medicare Plans set forth in Schedule O-1, for review, approval, and submission by Aetna to CMS, in accordance with CMS requirements (including CMS marketing guidelines). PBM shall provide to Aetna on an on-going basis all of its new and updated Member communication templates with respect to Part D so that Aetna may review and submit to CMS in accordance with CMS requirements. All Member communications provided by PBM with respect to Medicare Plans shall comply with all Laws and receive CMS approval. Approved Member communications shall be mailed to Aetna or Members (as designated by Aetna). Member communications with respect to Medicare Plans shall include all PBM Member Medicare Part D communication templates, Member retention communications, and employer/union-only group waiver plans ("EGWPs") communications. To the extent required by CMS, Aetna and/or the Plan shall provide to PBM Member materials in any language that is the primary language of at least 5% of the general population of the applicable Medicare Plan's Service Area and PBM shall make such materials available to Members. 47. Member Website. PBM shall, at Aetna's option, either (i) provide a secure decision support Member website in accordance with the requirements described in Schedule H (Communications) (e.g., Destination Rx or other similar tools) providing access to the following information, or (ii) provide Aetna with such data in acceptable format for loading on an Aetna-and/or Medicare Plan-maintained site tool: a. Formulary, utilization management ("UM") criteria, Benefit Plan Design data, including Member deductibles (Generic Drug only, Brand Drug only, Generic Drug and Brand Drug, including or excluding product selection penalties), maximum out of pocket (Generic Drug only, Brand Drug only, Generic Drug and Brand Drug, including or excluding product selection penalties), initial coverage limits, coverage gap and catastrophic coverage. b. Member accumulator balances (including TrOOP). c. A "one-stop" area on the Member website that provides needed information on the procedures, the forms and the contact information for Aetna's and/or Medicare Plan's prior authorization and exceptions processes, including information on prior authorization protocols in accordance with CMS requirements. 48. PBM shall provide an inventory of communications to Aetna which outlines all Medicare communications and the individual or function

	responsible for creating these communications. Aetna will provide a communications inventory to PBM upon commencement of the Agreement. 49. Provider Communications. PBM shall create, provide to Aetna (in accordance with Schedule H (Communications), and send to Providers all required Medicare Part D Provider communications with respect to Medicare Plans in accordance with CMS requirements, including: a. Transition of coverage letters to physicians in accordance with Paragraph 17 above and/or if required by CMS; b. Sixty (60) day advance written notice of Part D Formulary change letters; and c. Targeted excluded Provider letters to Participating Pharmacies.
Coverage Determinations (including Prior Authorization Services)	50. Coverage Determinations. To the extent required by Aetna, PBM shall administer standard and expedited coverage determinations and redeterminations (including Formulary exceptions, tiering exception requests, non-Formulary exceptions, and Member requests for payment) in accordance with CMS requirements, including 42 C.F.R. Sections 423.128(b)(7), 423.562, 423.566(d), 423.568, 423.570, 423.572, and Chapter 18 of the CMS Prescription Drug Benefit Manual. PBM shall allow coverage determinations without a direct call to a physician to the extent all needed information to process the request is received and such contact is otherwise permitted by CMS. The process shall meet all CMS mandated time frames, include all CMS required notices, and satisfy all CMS staffing requirements (i.e., pharmacist availability), and shall include the following: a. PBM shall accept prior authorization requests via multiple inputs (e.g., telephone, fax, and paper/mail); b. PBM shall ensure that the content of prior authorization forms shall be in accordance with CMS requirements and shall not be used for a purpose that interferes with the Member's ability to use the pharmacy of their choice; c. PBM shall administer Aetna specific pharmacy clinical protocols (PA, QL, ST) agreed to by the parties; d. PBM shall review requests for Formulary and tiering exceptions in accordance with agreed upon criteria with prior review and approval by Aetna; e. PBM shall accept prior authorization requests twenty-four (24) hours per day, seven (7) days per week, and all after-hours emergency/urgent requests shall be handled by PBM in accordance with CMS requirements; f. PBM shall respond to Member/Provider requests for prior

	authorization in accordance with CMS requirements g. PBM shall track the time and date of all information required by CMS including receipt of a coverage determination request, a redetermination request, a physician's or other prescriber's supporting statement, the decision, and the decision notice to the Member and /or prescriber; and h. PBM shall use CMS templates or CMS-approved language, as required by CMS, for all denial letters. PBM shall develop and maintain a written policy and procedure for this process in accordance with CMS requirements and guidance and Aetna requirements and shall make such policy and procedure available for inspection by CMS and/or Aetna upon request. Without limiting the generality of the foregoing, PBM shall: i. Ensure that expedited coverage determinations are processed as expeditiously as the Member's health condition requires, but no later than twenty-four (24) hours after receipt of the request. ii. Ensure that standard coverage determinations are processed as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receipt of the request. iii. Ensure that exception requests are processed in accordance with the regulatory timelines for processing coverage determinations. For exception requests, the processing timeframe begins upon receipt of the physician's supporting statement. iv. Ensure that expedited redeterminations are processed as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receipt of the request. v. Ensure that standard redeterminations are processed as expeditiously as the Member's health condition requires, but no later than seven (7) calendar days after receipt of the request. vi. Make Medicare Part B vs. Part D coverage determinations in accordance with Aetna requirements, allow appropriate processing of Claims for Members with medical-pharmacy benefits through the pharmacy adjudication system and deny PDP-only Part B Claims as required by Medicare regulations. vii. Have a medical director who is responsible for

	ensuring the clinical accuracy of all coverage determinations and redeterminations involving medical necessity and who is a physician with a current and unrestricted license to practice medicine in a State, Territory, Commonwealth of the United States or the District of Columbia. viii. Retain the services of physicians or other appropriate health care professionals in accordance with 42 CFR Section 423.566(d) in cases where there is an expectation that there will be, in full or in part, an adverse coverage determination. ix. Submit all CMS required documents to the Independent Review Entity ("IRE") if PBM fails to meet the time requirements for coverage determinations in accordance with CMS requirements. Provide to Aetna all documents submitted to the IRE, including root cause, upon occurrence or within 24 hours. x. Provide to Aetna all relevant data in accordance with CMS requirements that is necessary for Aetna to administer grievances and appeals, in the timeframes determined by Aetna. 51. PBM shall track the following information regarding coverage determinations in an agreed upon manner (i.e., report format, timing, etc.): a. Date of receipt of a coverage determination request (including an exception request) or redetermination request; b. Mode of receipt (i.e. fax, telephone, letter, etc.); c. Person who filed the request; d. Type of request made (i.e., standard or expedited); e. Date of receipt of a physician's supporting statement (for an exception request); f. Disposition of request; g. Date of disposition; h. Form of notice of disposition; and i. Date and time of notice of disposition. j. Provider in or out of network status 52. PBM shall require its Participating Pharmacies to distribute to Members the standardized pharmacy notice ("Notice: Your Prescription Cannot Be Filled") in accordance with the requirements set out in 42 C.F.R. Section 423.562 (a)(3).

Connectivity	53. In addition to all other connectivity requirements set forth in Schedule V-2 (Connectivity and Data Analysis Tools), PBM shall provide the following in accordance with the requirements set forth in Schedule V-2 (Connectivity and Data Analysis Tools): a. Access to all Part D customer and member service data in accordance with Schedule E (Contact Services); b. Write access to all Part D data to perform overrides, prior authorizations, eligibility updates, and such other changes where appropriate. For this purpose, PBM shall provide Aetna with all applicable screens and tools to make the appropriate changes. These tools and screens need to ensure the changes are applied in real-time. PBM shall be responsible for ensuring that the appropriate role-based security is in place for Aetna's access to the Part D data.
Product Design	54. Without limiting the generality or applicability of the other Schedules, PBM shall provide Aetna with utilization databases to meet varied reporting needs (standard and ad hoc) of actuarial, product, clinical, pre-certification, Manufacturer Rebate Agreement, etc., with refreshes of system's data – at a frequency not less than monthly and in a format mutually agreed upon by the Parties, for each Medicare Plan at the Plan Benefit Package ("PBP") level. 55. PBM shall provide Aetna with access to a database which contains competitor formulary and benefit design through the CMS available public use files. Such data shall be refreshed on at least a quarterly basis, with new plan year data being made available no later than two weeks following release. 56. PBM shall participate in regular onsite reviews during benefit development stage(s) prior to applicable filings with the goal of maximizing all opportunities to design the best possible Medicare Plan products from a cost and quality perspective, and minimizing financial risk for Aetna and the Medicare Plans. 57. PBM shall assist Aetna in converting annual formulary submissions and any monthly formulary submission updates from National Drug Code-11 ("NDC-11") to RxNorm Concept Unique Identifiers ("RxCUIs") using RXCUI information which is generally available in the PBM industry.
Product Implementation and Data Requirements	58. PBM shall provide general advisory and clinical account management support to Aetna in connection with Aetna's Formulary filing to CMS and applicable maintenance files in accordance with CMS requirements and consistent with CMS' schedule. In accordance with Section 5.5 of the Agreement, PBM shall establish and maintain a firewall that ensures that all PBM personnel who assist or participate in such submissions do not disclose any information contained in or relating to such submissions to other personnel of PBM and do not participate in similar submissions for the account of PBM, any Affiliate of PBM or any Aetna Competitor. 59. PBM shall submit to CMS related bi-weekly cost filing submissions

	(pricing file, Dispensing Fee, network discount file, etc.) as required (initial and maintenance). 60. PBM shall perform CMS-required market basket audits following each maintenance submission consistent with CMS guidance, as applicable. 61. PBM shall provide appropriate pricing files, pharmacy cost files and Formulary files for PDP and MAPD Plans to Aetna's external vendor for change updates for the Medicare Plan public Medicare website on a bi-weekly basis for adds, deletes, tier changes for drugs, and UM. In accordance with Aetna Policies and CMS requirements, PBM shall maintain records of any files submitted to CMS or Aetna's vendor for audit purposes. 62. In accordance with Aetna Policies and CMS requirements, PBM shall maintain CMS file submission policies and procedures where CMS submission services have been delegated to PBM. Such policies and procedures and any applicable updates thereto shall be communicated to the Aetna Medicare Clinical area. 63. PBM shall test the plan comparison data files for the Medicare Plan Finder for accuracy prior to submission to CMS through the establishment of a quality assurance process. This quality assurance process will allow sufficient time for file recreation, re-testing, and accurate submission of the plan comparison data for the Medicare Plan finder tool. 64. Following each Formulary update, PBM shall ensure that the Formularies loaded in PBM's systems and otherwise utilized by PBM in performing services hereunder are consistent with the HPMS approved Formulary files. PBM shall provide evidence and reporting related to this requirement with each Formulary update.
Financial Reconciliation	65. PBM shall provide to Medicare Plans all Aetna pertinent information and all pertinent information of PBM related to applicable PBM functions, in time frames designated by Aetna to resolve all enrollment and financial reconciliation discrepancies in accordance with CMS guidelines.
Reporting	66. PBM shall provide such information and reports as required by CMS in accordance with applicable CMS requirements, as updated from time to time, and as otherwise requested by Aetna, in order to allow Medicare Plans to satisfy their reporting obligations to CMS. PBM shall provide such information to Aetna in the time, frequency, and format required by CMS in accordance with applicable CMS requirements, as updated from time to time, and Aetna to allow Medicare Plans to satisfy their obligations to CMS. PBM shall conduct a quality assurance review, including content and format validation, prior to the submission of all such information and/or reporting. PBM shall cooperate with Aetna in responding to any questions or comments Aetna has regarding any such report and in making any necessary revisions thereto as a result of such comments or questions. a. PBM, as the pharmacy benefits manager and downstream entity that adjudicates and processes claims at the point of sale and/or negotiates with prescription drug manufacturers and

	others for rebates, discounts, or other price concessions on Covered Drugs, shall provide information related to PBM transparency as specified by and in compliance with the reporting requirements established in Section 6005 of the Affordable Care Act and 42 CFR Section 423.514. b. PBM shall have policies and procedures documenting the process for how PBM captures and validates data prior to CMS submission and all other policies and procedures required for a CMS Part D data validation audit, which all such policies and procedures shall be made available to Aetna upon request. 67. PBM shall either, at Aetna's direction with reasonably sufficient notice to (and/or based on direction provided to Aetna by an Aetna Customer) (i) submit such reports directly to CMS in accordance with CMS transmission requirements; (ii) enter CMS-required data elements into HPMS in accordance with CMS requirements; or (iii) prepare and deliver in an Aetna approved layout/format, such reports to Aetna for delivery to an Aetna Plan Affiliate, Aetna Customer and/or CMS. PBM shall follow an Aetna approved process and mutually agreeable timing requirements, with respect to all file transmissions to Aetna and/or CMS, which in all cases shall be in accordance with CMS requirements. PBM shall ensure that it has the system and other capabilities to submit reports to and receive reports from CMS in accordance with CMS requirements. PBM will provide to Aetna reports required for the CMS Quality and Performance Plan Reporting Module at least fifteen (15) calendar days prior to the CMS submission deadline. Where applicable, if Aetna identifies a potential error within the CMS report data, they are encouraged to notify PBM of such error as soon as reasonably possible, but no later than five (5) calendar days following receipt of the report. PBM shall provide a revised report to Aetna no less than (5) calendar days prior to the CMS submission deadline. PBM shall conduct quality assurance reviews of such reports prior to delivery of the reports to ensure that the reports are accurate and complete. 68. In addition to CMS required reporting, PBM shall: a. Provide to Aetna daily, weekly, and monthly reporting that includes PBM's standard metrics and any additional metrics as reasonably required by Aetna, to assess PBM and Aetna's compliance with Part D requirements and provide an overview of how the Part D Book of Business is performing, including highlighting performance issues; and b. At Aetna's request, PBM shall provide agreed upon reporting necessary for Aetna oversight (e.g., utilization, trend analysis, clinical, UM, high cost, non-Formulary usage, Members reaching gap, Members reaching catastrophic phase, Brand Drug to Generic Drug conversion, Member and Provider Call Center results, tracking to CMS star ratings or such other equivalent performance measurement rating or system adopted

	by CMS, and the like). 69. All Part D related reporting shall be at the Medicare Plan Benefit Package (PBP) level unless otherwise specified by Aetna in writing.
Vaccine Administration	70. PBM shall contract with Participating Pharmacies that are willing to accept the terms and conditions of participation for the administration of vaccines covered under Medicare Part D. 71. For vaccines processed on PBM's adjudication platform, PBM may contract directly with physicians ("Participating Physicians") to facilitate the processing of Claims for vaccines covered by Medicare Part D that are dispensed and/or administered by physicians (collectively, "Physician Vaccine Network"). In the event PBM contracts directly with physicians, PBM shall require Participating Physicians to agree to the provisions contained in Schedule G-1 (Requirements for Participating Pharmacy Contracts) and this Schedule O (Medicare Services) (contracting requirements for Participating Pharmacies and downstream entities above) substantially in the form attached hereto. If PBM does not contract directly with physicians, PBM shall contract with one or more third parties ("Physician Claims Processors") that contract with a network of physicians ("PCP Contracted Physicians"), for the Physician Vaccine Network. In the event PBM contracts with Physician Claims Processors, PBM shall require Physician Claims Processors to agree, and to require their PCP Contracted Physicians to agree, to the provisions contained Schedule G-1 (Requirements for Participating Pharmacy Contracts) and this Schedule O (Medicare Services) (contracting requirements for Participating Pharmacies and downstream entities above) substantially in the form attached hereto. 72. In the event there are physicians who are not participating in the Physician Vaccine Network (collectively "Non-Participating Physicians"), PBM shall be responsible for the review and approval of non-electronic Claims submitted by Non-Participating Physicians to PBM for reimbursement for the dispensing and/or administration of vaccines (including a determination that such Non-Participating Physician is not excluded from participation in federal and/or state healthcare programs by the OIG or GSA). 73. PBM shall provide on-line access to date through the Rx Navigator Tool identifying Part D vaccine Claims where the Administration Fee has not been submitted (whether as a single Claim or separate Claims). 74. In the event Aetna contracts directly with Physician Claims Processors, PBM shall administer such contracts and process and handle Claims from the PCP Contracted Physicians just as it would Claims from Participating Pharmacies.
State Pharmaceutical Assistance Programs ("SPAP")	75. As and to the extent applicable, PBM shall comply with all Laws and other federal and state requirements related to PBM Services involving SPAPs (including wrap SPAPs), including TrOOP accumulators, applicable Formulary requirements, reporting, single claim adjudication

	for wrap SPAPs, etc.
Medicare Coverage Gap Discount Program	76. PBM shall develop and implement the Medicare Coverage Gap Discount Program in accordance with all Aetna and CMS requirements and guidance. Without limiting the generality of the foregoing, PBM shall ensure that the applicable discount on applicable drugs is provided to applicable Members at the point-of-sale.
OTC Benefit Offering	77. Upon Aetna's request, PBM shall collaborate and cooperate with Aetna in good faith with respect to an OTC benefit offering for Members in accordance with applicable CMS requirements.
Medication Therapy Management ("MTM") Program	78. Upon Aetna's request, PBM shall support and/or administer Aetna's and/or Medicare Plans' MTM programs based upon reasonable program attributes filed with CMS. In the event Aetna materially modifies its MTM program after the Effective Date of the Agreement in such a way that would require substantial changes in PBM's support and/or administration of the MTM programs, the Parties will work together in good faith to agree upon the fees and/or charges related to such change(s). MTM program attributes filed with CMS include the following: a. PBM shall identify to Aetna any Members meeting Aetna's eligibility criteria filed with CMS for MTM programs and shall administer Member "opt-out" enrollments. b. PBM shall provide Aetna with the reports related to MTM program. c. PBM shall perform all required Member and Provider outreach (mail, telephonic, face-to-face) consistent with Aetna's MTM program filed with CMS. d. PBM shall establish appropriate policies and procedures to meet all CMS expectations for administration of the MTM program. e. PBM shall track and report MTM program outcomes to Aetna and to CMS in accordance with CMS requirements, including the following: (i) annual comprehensive medication review with written summaries (as required by 42 C.F.R. 423.153(d)(1)(VII)(B); (ii) date of annual comprehensive review; (iii) number of targeted medication reviews; (iv) number of Provider interventions; (v) number of additions to drug therapy made as a direct result of MTM interventions; (vi) number of discontinuations in drug therapy made as a direct result of MTM interventions; (vii) number of dosage changes to existing drug therapy made as a direct result of MTM interventions; (viii) number of therapeutic substitutions made as a direct result of MTM interventions; (ix) number of Generic Drug substitutions made as a direct result of MTM interventions; and (x) MTM program outcomes following each quarter's activity.

	79. Upon Aetna's request, PBM shall make PBM's MTM program(s) available to Aetna for utilization upon Aetna election. 80. PBM shall collaboratively work with Aetna to develop an effective MTM program with a demonstrable positive ROI in terms of quality and cost effectiveness.
CMS Star Rating	81. The Parties shall work together to identify and develop, and PBM shall achieve the performance targets and related standards and the allocation of the total performance guarantee amount established in Schedule R (Performance Standards and Service Levels), where a service provided by PBM has direct influence on the underlying metrics of a particular CMS Part D Star Ratings Element as identified in the Medicare Part D Plan Ratings Technical Notes or otherwise by CMS. Such performance targets shall, to the extent applicable and measurable, be designed in a manner consistent with achieving CMS requirements for a 4 star rating. The Parties shall review such performance targets, standards and metrics from time to time and adjust them as necessary to be consistent with any CMS revised guidance. PBM's failure to meet the performance targets set forth in Schedule R (Performance Standards and Service Levels) shall constitute a material breach of the Agreement with respect to the Medicare Part D line of business, provided that when identifying the performance targets, the Parties shall also mutually agree upon the parameters within which PBM's failure to meet the performance targets constitutes a material breach of the Agreement. If the mutually agreed upon parameters for a material breach are not met, but if PBM nonetheless fails to meet the performance targets, PBM shall notify Aetna of such failure immediately upon becoming aware, and develop and implement a written corrective action plan, as agreed upon in writing by Aetna, to address the underlying failure. PBM shall provide updates to Aetna on the status of such corrective action plan upon Aetna's request. Additionally, the Parties shall mutually agree upon a process for PBM to assist Aetna in star rating data validation and appeals to CMS.
Compliance	Without limiting the generality of Section 3.6 or Article 14 of the Agreement and in addition thereto: 82. PBM agrees to the following provisions and shall require that these provisions in the substantially same form with all of the material requirements set forth in each such provision be incorporated into any of PBM's Contracts with permitted downstream entities, including Participating Pharmacies, and shall require such downstream entities to include these provisions in the substantially same form with all material requirements set forth in each such provision in any Contracts between such downstream entities and their downstream entities: a. PBM acknowledges that Claims data and information provided

	in connection with the Agreement and compensation under the Agreement are used for purposes of obtaining federal funds. PBM agrees that it is bound by 2 C.F.R. Part 376. PBM agrees to comply with, to the extent applicable to PBM, as amended from time to time, Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, federal Laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. Sections 3729 et seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act), the Health Insurance Portability and Accountability Act administrative simplification rules at 45 C.F.R. Parts 160, 162 and 164, and any other Laws applicable to recipients of federal funds. b. PBM and the PBM Related Parties have not been excluded by the OIG or GSA or from participation in federal or state health care programs, are not the subject of any pending exclusion proceeding, and have not been adjudicated or determined to have committed any action that could subject PBM and/or PBM Related Parties to exclusion from a government program. PBM shall notify Aetna promptly upon receipt of notice of (a) exclusion or proposed exclusion from a state or federal health care program, or (b) adjudication or other determination that PBM or a PBM Related Party has committed any action which could lead to exclusion from a government program. PBM shall review the OIG and GSA exclusion lists upon hire of any employee, contractor, or agent that will be providing services to Aetna directly or indirectly ("Covered Individual"), and monthly thereafter , to ensure that all Covered Individuals are not excluded from government health care programs. PBM shall notify Aetna immediately upon receipt of any information indicating that PBM or a Covered Individual has been charged with a crime relating to healthcare or is facing a proposed debarment, exclusion, or other adverse action, in which case, PBM shall immediately remove any such Covered Individual(s) from direct responsibility for, or involvement in, services provided to Aetna related to government health care programs, and will take appropriate corrective actions in accordance with all Laws. These requirements refer to and include members of PBM's board of directors and any key management, executive staff, and any major stockholder. PBM shall provide Aetna with a certification or attestation by an officer or director of PBM of compliance with this section upon Aetna's request. c. To the extent that PBM generates and/or compiles and provides any data to Aetna that Aetna, in turn, relies upon or submits to Medicare Plans and/or CMS, PBM certifies, to the

	best of its knowledge, information, and belief, that such data is accurate, complete and truthful. d. Medicare Plans maintain ultimate responsibility for fulfilling the terms and conditions of their respective CMS Contracts and for ensuring that PBM satisfies its obligations under each Medicare Plan. e. PBM shall maintain books, records, documents and other evidence of accounting procedures and practices consistent with 42 C.F.R. Section 423.505(d) for a minimum of ten (10) years. PBM agrees to provide Aetna, CMS, and federal, state, and local Governmental Bodies having jurisdiction, or their designees, upon request, access to all books, records, and other papers (including medical and financial records and Contracts), computer or other electronic systems, and information relating to the Agreement and any Medicare Services rendered by PBM, its employees, independent contractors or subcontractors ("Information and Records"), and that this right of inspection, evaluation and audit will continue for the longer of: (i) a period of ten (10) years from the end of the Contract period of the applicable government Contract of Aetna, (ii) the date U.S. Department of Health and Human Services ("HHS"), CMS, the Comptroller General or their designees complete an audit, or (iii) the period required under applicable Laws. PBM also agrees to maintain Information and Records for the longer of: (i) ten (10) years from the end of the Contract period of any government Contract of Aetna, (ii) the date HHS, the Comptroller General or their designees complete an audit, or (iii) the period required by applicable Laws. This section shall survive the termination of the Agreement, including any Schedules or Attachments thereto, regardless of the cause of the termination. All audits by CMS, federal, state, and local Governmental Bodies having jurisdiction, or their designees, shall be conducted through and in conjunction with Aetna unless Aetna specifies otherwise in writing. f. PBM agrees that in no event, including nonpayment by the Aetna or the insolvency or breach of the Agreement by Aetna, shall PBM or any Participating Pharmacy bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or other person acting on a Member's behalf (other than the Medicare Plan), for the provision of services for Part D Covered Drugs. PBM agrees that: (a) this provision shall survive termination of the Agreement, including any applicable Schedule to the Agreement, regardless of the cause giving rise to termination and shall be construed for the benefit of Members, and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter

	entered into between PBM or a Part D Participating Pharmacy and a Member or persons acting on a Member's behalf. g. PBM acknowledges that Aetna and/or the applicable Medicare Plan may only delegate activities or responsibilities to PBM in a manner consistent with Medicare Laws, and that if any activity or responsibility is delegated by Aetna and/or the applicable Medicare Plan to PBM, such activity or responsibility may be revoked if CMS or Aetna and/or the applicable Medicare Plan determines that PBM has not performed satisfactorily or if applicable reporting or disclosure requirements are not otherwise fully met in a timely manner. In the event that Aetna and/or the applicable Medicare Plan or CMS exercise this right to revoke such program activities, no additional financial obligations shall accrue to Aetna with respect to such revoked activities. h. PBM acknowledges and agrees to allow Aetna and/or the applicable Medicare Plan and CMS to monitor and audit PBM's performance of Medicare Services on an ongoing basis, in accordance with Medicare Laws. PBM agrees to cooperate with the monitoring and oversight activities of Aetna, the applicable Medicare Plan, and CMS. i. The Parties shall meet regularly, at a frequency to be determined by Aetna, to collaborate on their respective Medicare Part D audit work plans with respect to Part D Services hereunder. PBM shall develop a mutually agreeable process which PBM will (1) fully cooperate with Aetna's requests to assess and prioritize risk under the Part D program, (2) develop and implement an Aetna approved strategy for oversight, monitoring and ongoing assessment of such risk; and (3) fully cooperate with Aetna's audit work plans, risk assessment plans and compliance plans. j. PBM shall comply with all applicable federal and state Laws, including CMS instructions and all Aetna requirements designed to ensure compliance with applicable Laws, including CMS instructions. k. PBM agrees that all Medicare Services will be consistent and comply with Medicare Plans' obligations as an MA organization and/or PDP sponsor under their respective CMS Contracts. l. PBM agrees to comply with all state and federal Laws relating to privacy, confidentiality, security, and accuracy of Member health records, including, without limitation, the requirements of 42 C.F.R. 423.136, 42 C.F.R. 423.505(b)(14), 42 C.F.R. 422.504(a)(13), and 42 C.F.R. 422.118, and any Aetna or CMS requirements designed to ensure compliance with such Laws. PBM shall do the following in connection with any

	Aetna records or other health and enrollment information PBM maintains with respect to Members: (1) abide by all applicable federal and state Laws regarding confidentiality and disclosure of Aetna records or other health and enrollment information of Members. With respect to information that identifies a particular Member, PBM shall have procedures that specify: (1) for what purpose the information is used within the organization; and (2) to whom and for what purposes it discloses the information outside the organization; (2) ensure that Aetna information is released only in accordance with applicable federal or state Law or under court orders or subpoenas; (3) maintain the records and information in an accurate and timely manner; and (4) ensure timely access by Members to the records and information that pertain to them. m. PBM shall comply with all Laws, including CMS instructions relating to the prevention and detection of fraud, waste and abuse that apply to services performed by contractors, Subcontractors and/or first tier or downstream entities for Medicare Plans. With respect to any Medicare Services that PBM performs for any of the Medicare Plans, PBM agrees to implement all applicable requirements and recommendations set forth in Chapter 9 of the CMS Prescription Drug Benefit Manual titled "Compliance Program Guidelines" ("FWA Guidance") (or successor guidance thereto) that apply to "subcontractors", "first tier entities" and/or "downstream entities" as those terms are defined and/or used in the FWA Guidance, including the following requirements and recommendations: (1) PBM agrees to adopt a code of conduct that meets the recommendations set forth in the FWA Guidance, and clearly articulates PBM's commitment to comply with all applicable statutory, regulatory, and other Medicare Part D program requirements, reflects PBM's commitment to detecting, preventing, and correcting fraud, waste and abuse in the administration and delivery of Medicare Part D benefits, delineates PBM's expectation of its employees and Subcontractors who perform Medicare Services to act in an ethical and compliant manner and includes the ramifications of failure to comply with the PBM's code of conduct; (2) consistent with the process described in the FWA Guidance, PBM agrees to obtain a signed conflict of interest statement, attestation, or certification from all managers, officers and directors of PBM responsible for the administration or delivery of Medicare Services with respect to Aetna's Medicare Plans at the time of hire and annually thereafter certifying that such person has reviewed PBM's conflict of interest policy, has disclosed any potential conflict of interest, and has obtained management approval to work despite any conflicts or has eliminated the conflict; and (3)

	PBM shall require each PBM employee, Subcontractor, agent, and director who performs services with respect to the Medicare Plans to participate in Medicare Part D compliance education and training acceptable to Aetna (including fraud, waste, and abuse training) on at least an annual basis (and within 90 days of hire or contracting), PBM shall be responsible for conducting such training and collecting and maintaining documentation of such; (4) with respect to all other downstream entities, PBM shall require that all employees, subcontractors, agents, and directors who perform services with respect to Medicare Plans participate in Part D compliance education and training (including fraud, waste, and abuse training) on at least an annual basis (and upon hire or engagement of any such individual), which training shall be in accordance with all CMS requirements and recommendations, including but not limited to those set forth in the FWA Guidance(e.g., to the extent prohibited by CMS, Participating Pharmacies cannot develop their own training materials); PBM shall be responsible for collecting and maintaining documentation of such training. PBM shall provide Aetna with a certification or attestation by an officer or director of PBM of compliance with this section. PBM shall provide Aetna with an attestation reflecting that PBM and its downstream entities have completed all CMS required training, including but not limited to fraud, waste, and abuse training in accordance with CMS requirements. PBM acknowledges and agrees that downstream entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse hereunder. Upon Aetna's request, PBM shall provide to Aetna documentation sufficient to evidence compliance with this section, which may include records of attendance, training logs, training materials, attestations (or reports documenting receipt of electronic attestations), and such other documentation reasonably requested by Aetna or otherwise required by CMS. PBM shall promptly report to Aetna's compliance officer, compliance hot line, or other designated compliance reporting mechanism compliance concerns and suspected or actual violations of Law or policy related to the services provided to Aetna. PBM shall have effective lines of communication with Aetna related to detecting, correcting, and preventing fraud, waste, and abuse in accordance with 42 C.F.R. Sections 423.504(b)(vi) and 422.503(b)(4)(vi). n. Without limiting the generality and applicability of Section 3.7 of the Agreement, PBM is prohibited from performing any Medicare Services or using any individual or entity to perform

	Medicare Services if the services are performed or the individual or entity is physically located outside of one of the fifty United States or one of the United States territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands) ("Offshore Entity"), unless Aetna in its sole discretion and judgment, agrees in advance and in writing to such offshore activities or the use of such Offshore Entity. In addition, PBM shall not make any use or disclosure of any protected health information (as defined by HIPAA) to an Offshore Entity without Aetna's prior written consent. In the event that Aetna provides PBM with prior written approval to use an Offshore Entity or conduct offshore activities to perform any services for Medicare Plans hereunder, PBM shall comply with all Laws, including, CMS instructions, applicable to the performance of any services for Medicare Plans outside of one of the fifty United States or one of the United States territories, including completing an Offshore Subcontractor Information and Attestation Form. In any case in which Aetna has given PBM written approval, PBM must retain the ability promptly to terminate the performance, usage, or disclosure outside of the United States of any such services or protected health information if so reasonably requested by Aetna, including on behalf of an Aetna Customer that so directs. 83. PBM shall develop a compliance plan (a "Medicare Compliance Plan") that addresses and monitors the potential fraud, waste and abuse risks associated with the Medicare Advantage and Medicare Prescription Drug Benefit Programs and compliance with MA/PDP Program Requirements and responsibilities under the Agreement. The Medicare Compliance Plan must be reviewed and approved by Aetna. At least once each year, and upon any material modification, PBM shall submit the Medicare Compliance Plan to Aetna for review and approval. PBM shall incorporate into the Medicare Compliance Plan guidance provided in MA/PDP Program Requirements and any modifications or instructions from Aetna. In addition, the Medicare Compliance Plan shall include and PBM shall implement the fraud, waste and abuse program required pursuant to Section 14.4(a) of the Agreement which, includes, at a minimum, the following elements: a. A compliance officer responsible for overseeing all Medicare Services which PBM is obligated to provide, directly or indirectly, to Plans' Medicare Advantage and Medicare Prescription Drug Benefit Programs under the Agreement. b. A compliance committee that complies with Parts C and D of Title XVIII of the Social Security Act, as amended; the regulations governing the Medicare Advantage and Medicare Prescription Drug Benefit Programs, set forth at 42 C.F.R. Parts 422 and 423, as amended; CMS guidance and

	instructions related to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; and the CMS Contract (together the "MA/PDP Program Requirements"). Without limiting the generality of the foregoing, among its responsibilities, the compliance committee shall (a) oversee PBM's performance of a risk assessment of the Part D Book of Business, (b) prioritize risks identified through the risk assessment and otherwise by Aetna, (c) develop a monitoring and auditing strategy in accordance with Aetna requirements, (d) oversee internal reviews and monitoring activities by PBM, and (e) evaluate the effectiveness of the auditing/monitoring strategy and follow-up actions. c. Written policies and procedures regarding the operation of PBM's compliance program and applicable risk areas specific to the Medicare Prescription Drug Benefit Program. Such policies and procedures shall address, at a minimum, those issues identified in MA/PDP Program Requirements.
Certifications	84. Upon Aetna's request, PBM shall provide Aetna with written certifications and/or attestations to support CMS certification and attestation requirements for downstream entities and Medicare Plans in a form acceptable to Aetna and without qualifications not permitted by Government requirements.
Corrective Action	85. In addition to the requirements set forth in Section 14.2(f) of the Agreement, if PBM, Aetna, or CMS identifies any non-compliance with Part D requirements or determines that inaccurate data relating to a Medicare Plan may have been submitted to CMS and/or Aetna, PBM shall immediately notify Aetna and undertake corrective action to revise, update and correct such process and/or data and adjust any payments to or from CMS or Aetna, including corrections at the Claim and PDE level. If Aetna and/or Medicare Plan agrees to a corrective action plan with CMS which relates in whole or in part on any Services provided by PBM, PBM shall promptly undertake such corrective action Aetna and/or Medicare Plan deems necessary consistent with such corrective action plan. PBM shall provide updates to Aetna on the status of the corrective actions described in this paragraph upon Aetna's request. In the event that Aetna and/or Medicare Plan agrees to a corrective action plan, they shall, to the extent not otherwise prohibited by CMS or by Law, consult with PBM in advance with respect to any requirements thereunder that will be applicable to PBM.
Cooperation	86. As reasonably requested by Aetna or as required by CMS, PBM shall fully cooperate and provide Aetna with the information necessary for Aetna and/or Medicare Plans to respond to and resolve questions/issues raised by CMS, Medicare Plans, and/or Aetna senior management related to PBM's performance and the services provided under this Schedule O

	(Medicare Services).

Schedule O-1

Member Communications Provided by PBM

In accordance with Schedule H, PBM shall create and provide to Aetna for its review, approval and submission to CMS Medicare Part D Member communications as required by CMS. While not inclusive, the following documents minimally represent the underlying subject matters of such communications.

1. Aetna RX Home and Aetna Specialty Pharmacy service order forms;
2. Drug list content for Abridged Formularies;
3. Drug list content for Comprehensive Formularies;
4. Participating Pharmacy network directories, containing all required CMS information, including (to the extent required by CMS) an indication of which Participating Pharmacies support e-prescribing;
5. Member notices regarding other prescription drug coverage notices (otherwise known as COBC survey;
6. Thirty (30) day advance notice regarding a Participating Pharmacy's termination from the Network;
7. Direct Claim forms;
8. Vaccine Claim forms;
9. Transition of coverage letters;
10. Sixty (60) day advance written notice of Part D Formulary change letters;
11. CMS compliant Member EOBs (including disenrollment EOBs), which shall include the following: (i) all mandated data elements and formatting as required by CMS (including, but not limited to, those required by the Medicare Coverage Gap Discount Program) and such optional data elements reasonably required by Aetna; (ii) the item or service for which payment was made; (iii) notice of the Member's right to an itemized statement; (iv) applicable Formulary changes; and (v) such other notices as may be required by Law. PBM shall provide: (a) EOB printing and distribution with the frequency required by CMS; (b) EOB regeneration upon request; (c) EOB storage; (d) view and print access for Aetna and for Members online for eighteen (18) months (and thereafter available from PBM upon request). PBM shall produce EOBs on a schedule reasonably coordinated and agreed upon by the Parties. PBM shall retain all data used to create Member EOBs in accordance with the record retention requirements in the Agreement.
12. Excluded Provider letters; and
13. Prescription transfer letters.

Schedule P

Medicaid & Other State Plan Services

Core Services

PBM acknowledges and agrees that Aetna and/or Aetna Affiliates, each Third-Party State Plan Sponsor and each State Plan retain the option to contract for or otherwise arrange for pharmacy benefit management services without consultation with or the involvement of PBM. Notwithstanding any other provision in the Agreement, under no circumstances can Aetna guarantee or commit that Aetna and/or Aetna Affiliates, any Third-Party State Plan Sponsor or any State Plan will opt to receive services from PBM. Additionally, under no circumstances can Aetna guarantee or commit to a timeframe under which Aetna and/or Aetna Affiliates, Third-Party State Plan Sponsor, or any State Plan may opt to receive services from PBM, if at all. PBM acknowledges and agrees that there shall be no implications whatsoever for Aetna under the Agreement or otherwise if Aetna and/or Aetna Affiliates, any (or all) Third-Party State Plan(s), or any (or all) State Plan(s) decide not to receive services from PBM. For purposes of this Schedule P (Medicaid & Other State Plan Services), "Aetna" may include Aetna Affiliates, and all references to Aetna and/or Aetna Affiliates in this Schedule P (Medicaid & Other State Plan Services) shall mean Aetna and/or Aetna Affiliates to the extent Aetna and/or Aetna Affiliates contract directly with a Government Sponsor concerning a State Plan.

Additional defined terms for this Schedule P (Medicaid & Other State Plan Services):

"Government Sponsor" means the state agency that has entered into a Contract with Aetna or a Third-Party State Plan Sponsor concerning a State Plan.

"State Plan", as defined by the Agreement, may include Medicaid, State Children's Health Insurance Programs ("SCHIP") and other health care programs for uninsured, high-risk pool, low-income, elderly, and/or disabled individuals.

"State Plan-Specific Addendum" means an addendum to this Schedule P (Medicaid & Other State Plan Services), which contains requirements that are particular and/or unique to a State Plan or a Third-Party State Plan as identified by Aetna. Such State Plan-Specific Addendum shall be deemed part of the Core Services hereunder. Aetna may provide PBM with one or more State Plan-Specific Addenda to this Schedule P (Medicaid & Other State Plan Services), which PBM shall review and sign, to the extent no additional revisions are subject to review by the applicable State Plan, within thirty (30) calendar days of receipt unless a shorter timeframe is applicable to a Third-Party State Plan or State Plan and communicated by Aetna to PBM. PBM shall use reasonable efforts to execute the addenda for the new State Plan within such shorter notice timeframe. For the

avoidance of doubt, the State Plan-Specific Addenda attached hereto for any given state shall become applicable, and PBM shall provide Services with respect to such State Plan, only if Aetna provides the notice as required herein with regard to the State Plan for such state.

"State Plan-Specific Requirements" means those requirements (as may be amended from time to time) that are particular and/or unique to a State Plan or a Third-Party State Plan which are set forth in the State Plan-Specific Addendum, the State Regulatory Addendum, are otherwise required by Law, identified by Aetna through implementation documentation, set forth in the applicable contracts between the Third Party State Plan/State Plan and the Government Sponsor and Schaller Anderson, or as otherwise mutually agreed upon by the Parties. Aetna agrees to notify PBM, in writing, of any State Plan Specific Requirements of which PBM would not be aware (e.g., requirements applicable to PBM and/or Third Party State Plan/State Plan that are set forth in contracts between the Government Sponsor and Third Party State Plan/State Plan and not otherwise set forth in Law, requirements set forth in the applicable contracts between the Third Party State Plan/State Plan and Schaller Anderson and not otherwise set forth in Law, State Plan implementation documentation). PBM agrees to timely comply (or modify the PBM Services as necessary so that Aetna can timely comply) with any such requirements. State Plan-Specific Requirements shall be deemed part of the Core Services hereunder. In the event there is a more stringent requirement set forth in the State Plan-Specific Addendum than elsewhere in the Agreement (including the Schedules and the State Regulatory Addenda) or elsewhere in the State Plan-Specific Requirements, the more stringent requirement shall apply. : If, after the "go-live" date for a State Plan, new State Plan-Specific requirements are required to be implemented by PBM other than those required by Law, such new requirements shall be subject to the provisions of Section 6.3 of the Agreement, and certain costs may be borne by Aetna in accordance with the provisions thereof. The cost of all State Plan-Specific requirements imposed as of the "go-live" date shall be included in the Core Services.

"State Regulatory Addendum" means an addendum to this Schedule P (Medicaid & Other State Plan Services), which contains requirements that are particular and/or unique to a State Plan or a Third-Party State Plan that are required by Law to be included in the Agreement. Aetna may provide PBM with one or more State Regulatory Addenda to this Schedule P (Medicaid & Other State Plan Services), or updates thereto, which PBM shall review and sign, to the extent no additional revisions are subject to review by the applicable State Plan, within thirty (30) calendar days of receipt, unless a shorter timeframe is applicable to a Third-Party State Plan or State Plan and communicated by Aetna to PBM. For the avoidance of doubt, the State Regulatory Addenda attached hereto for any given state shall become applicable, and PBM shall provide Services with respect to such, only if Aetna provides the notice as required herein with regard to a State Plan operating in such state.

General Requirements:

PBM acknowledges and agrees that in connection with providing Services to a State Plan, PBM shall be a "subcontractor",

downstream entity, or equivalent (depending on the terminology used by a state) to Aetna, Third-Party State Plan, and/or a State Plan. PBM agrees to provide Services with respect to a State Plan in accordance with its obligations as a subcontractor and in accordance with Law, this Agreement, the Schedules to the Agreement (including this Schedule P (Medicaid & Other State Plan Services)), any applicable State Plan-Specific Addenda, and the State Plan-Specific Requirements. In general, the services, obligations, and other requirements set forth in the Agreement and Schedules shall be applicable to each Covered Plan that is a State Plan except as otherwise set forth herein. Schedule O and Schedule O-1 (Medicare Services) and Schedule S (Retiree Drug Subsidy Services) shall only apply to the extent applicable (i.e., dual eligibles). This Schedule P (Medicaid & Other State Plan Services) and the State Plan-Specific Requirements provide for additional and in some cases modified obligations and requirements applicable to those State Plans. In the event of any inconsistency or conflict between this Schedule P (Medicaid & Other State Plan Services) and the Agreement, any other Schedule to the Agreement, any State Plan-Specific Addenda, and any State Plan-Specific Requirements, the following order of precedence shall govern as follows: (1) State Plan-Specific Addendum; (2) State Plan-Specific Requirements; (3) Schedule P (Medicaid & Other State Plan Services); (4) other Schedules to the Agreement; and (5) the Agreement. In addition, either Aetna or PBM shall promptly notify the other Party if either becomes aware of any such inconsistency or conflict, and PBM shall comply with any instructions provided by Aetna to resolve or reconcile the same.

Aetna may choose to add new State Plan(s) under the Agreement by providing ninety (90) calendar days notice prior to implementation to PBM, unless a shorter notice timeframe is applicable to a Third-Party State Plan or State Plan or the circumstances, in which case Aetna will notify PBM as soon as is practicable and PBM shall use reasonable efforts to implement the new State Plan within such shorter notice timeframe.

State Plan(s) may choose to add State Health Care Program(s) and/or a new group(s) of Members and/or other similar changes, which Aetna shall provide thirty (30) calendar days notice prior to implementation to PBM, unless a shorter notice timeframe is required by a Government Sponsor or Third-Party State Plan Sponsor, or the circumstances, in which case Aetna will notify PBM as soon as is practicable and PBM shall use reasonable efforts to implement the new State Health Care Program(s) and/or new group(s) of Members and/or other similar changes within such shorter notice timeframe. Aetna will provide PBM with any required implementation documentation for each State Plan, subject to PBM's obligations with respect to the State Plan-Specific Requirements.

Agreement to Modify:

Aetna and PBM acknowledge and agree that they have executed and/or agreed upon numerous amendments to Schedule P (Medicaid and other State Plan Services) to the Original Agreement which have yet to be incorporated into this Agreement. Certain such amendments must also be incorporated into the Original Agreement. The Parties agree to work together in good

faith to review and incorporate all the amendments to Schedule P (Medicaid and other State Plan Services) which have been executed or otherwise agreed upon between the Parties as soon as possible after execution of the Agreement into the Original Agreement and/or this Agreement, as applicable.

Service	Description
Medicaid Program Installation/Implementation	1. PBM acknowledges and agrees that Schedule BB (Dedicated and Designated Personnel) and Schedule A (Transition-In) are applicable in connection with the Medicaid Line of Business and this Schedule P (Medicaid & Other State Plan Services). PBM personnel thereunder shall be experienced and knowledgeable in connection with Medicaid and have strong project management and implementation skills (e.g., certified project manager (where possible) or implementation manager or project manager). 2. Functions of such implementation managers will include but not be limited to (i) development and management of detailed business and IT project plans; (ii) responsibility for implementation workgroups across all functional areas; (iii) preparation and management of implementation status documents, including identification of risks and mitigation actions; and (iv) execution of testing actions.
Benefit Plan Administration	3. PBM shall set up, load, update, and administer all Benefit Plan information for State Plans in accordance with Schedule B (Benefit Plan Set Up), Schedule R (Performance Standards and Service Levels) and subject to and in accordance with any additional State Plan-Specific Requirements. (i) Notwithstanding Paragraph 3(b)(iii) of Schedule B (Benefit Plan Set Up), in the event that a State Plan requires a shorter implementation timeline, Parties shall work in good faith to find a mutually acceptable solution that meets the State Plan requirement. (ii) Upon Aetna request, PBM shall obtain and administer a unique Issuer Identification Number (IIN) or (BIN) for Aetna Medicaid Pharmacy business. 4. Without limiting the generality and applicability of Paragraph 3, above, of this Schedule P (Medicaid & Other State Plan Services), PBM shall administer and adjudicate Claims under this Schedule P (Medicaid & Other State Plan Services) based on the following, as directed by Aetna and subject to applicable Law and State Plan-Specific Requirements: (i) State Plan pharmacy, prescriber and drug restrictions at the Member level; (ii) upper dollar limits at the plan level by prescription type (e.g., compounded), and/or pharmacy type (e.g., home infusion), and/or drug, and/or benefit (e.g., acute, LTSS, SMI, ABD, Dual Eligibles) as supported by client-selected hierarchy, (iii) drug coverage limits by rate codes as defined by mutual agreement of the Parties and as supported by client-selected hierarchy; (iv) drug coverage/formularies to each benefit (e.g., acute, LTSS, ABD, SMI, Dual Eligibles) according to

	Aetna requirements and State Plan-Specific Requirements; (v) certain drug carve outs; (vi) unique State Plan programs, including but not limited to monthly debit cards for over-the-counter products at designated pharmacies and for certain drugs as mutually agreed by the Parties; and (vii) all Aetna and State Plan-Specific Requirement data fields on all Member and provider files as mutually agreed by the parties.
Member and Group Eligibility	5. The electronic Eligibility Data that PBM accepts from Aetna in accordance with Schedule C (Eligibility) shall include electronic files and formats via all current technology (e.g., File Transfer Protocol (FTP) data transfers, including SFTP, FTPS, FTP/PGP, and Direct Connect (NDM)) and such other future technology and formats mutually agreed upon. 6. PBM shall reasonably accommodate and comply with State Plan-Specific Requirements related to the initial upload and ongoing maintenance of Eligibility Data. 7. PBM's eligibility system shall accommodate all mutually agreed upon data fields contained in Eligibility Data provided by Aetna to PBM for the State Plans, which may vary by State Plan. 8. PBM shall not place any eligibility overrides in the system unless expressly given direction and approval to do so in writing by Aetna or a State Plan. 9. PBM shall ensure that Aetna designated employees shall have write access to applicable PBM system to be able to update Member eligibility information.
Claim Processing and Adjudication	10. PBM shall comply with all regulatory requirements with respect to encounter file submissions, which includes, but may not be limited to, timely submission, required file format, satisfying regulatory acceptance/accuracy rate, timely error correction, and regulatory reporting. 11. PBM shall test, maintain issue logs, and resolve errors as needed to comply with the terms and timeframes set forth in applicable State Plan-Specific Requirements. PBM shall participate in bi-weekly meetings (or more frequently if required by Aetna and/or a State Plan) with Aetna and shall create and maintain a detailed action log of each encounter file error, and shall provide a copy of the log to Aetna in advance of each such bi-weekly meeting. This action log shall be reviewed by PBM and Aetna together at the start and before the end of each such bi-weekly meeting. 12. PBM shall not process State Plan Member submitted paper Claims unless expressly given direction and approval to do so in writing by Aetna or a State Plan, in accordance with policies or procedures mutually agreed to by PBM and Aetna and subject to applicable Law and State Plan-Specific Requirements.

Customer Service	13. Notwithstanding the requirements in Schedule E (Customer and Member Service) PBM shall not have any contact or otherwise communicate with any State Plan Members unless expressly given direction and approval to do so in writing by Aetna or a State Plan. 14. Notwithstanding the requirements in Schedule E (Customer and Member Service), unless otherwise requested by Aetna in writing, PBM shall not provide Member call center services to any State Plans. If any State Plan Member calls a Member call center staffed by PBM, PBM shall warm transfer the call to the State Plan's call center if required by applicable Law, utilizing mutually agreed upon protocols that are consistent with applicable Law and State Plan-Specific Requirements. If any Provider calls a call center staffed by PBM concerning a State Plan or State Plan Member, PBM shall warm transfer the call to the State Plan's call center, if required by applicable Law, utilizing mutually agreed upon protocols that are consistent with applicable Law and State Plan-Specific Requirements; however, if any Provider calls a call center staffed by PBM concerning a claims adjudication systems issue, PBM shall resolve that issue with the Provider.
Prior Authorization	15. Notwithstanding the foregoing, PBM communications with Providers in connection with PBM's receipt, review, approval, and denial of pharmacy Prior Authorization Requests, if any, shall be made in accordance with the terms and conditions set forth in Schedule K or as otherwise required by the State Plan-Specific Requirements. a. In addition to the terms and conditions set forth in Schedule K (Prior Authorization Services) for PBM's receipt, review, approval and denial of Prior Authorization Requests, PBM shall have the ability to receive, review, deny and approve pharmacy Prior Authorization Requests submitted from the prescriber (including authorized prescriber staff/representative) and other providers (e.g., long term care pharmacies) by facsimile and in accordance with State Plan-Specific Requirements and applicable Law. b. With respect to denials of pharmacy Prior Authorization Requests, PBM shall only be authorized to recommend a denial, and is required to forward such recommendation to a State Plan medical director and/or pharmacist (as allowed by applicable Law), upon direction from Aetna, to process the final determination of such denial. Upon election and direction from State Plan, PBM may request to perform the denials as allowed by Law.

	c. PBM shall adhere to State Plan approved Prior Authorization guidelines for State Plans. PBM shall not adhere to Aetna Clinical Policy Bulletins ("CPBs") or Aetna Pharmacy Clinical Policy Bulletins ("PCPBs") for State Plans unless directed by Aetna to do so. d. Notwithstanding Paragraph 13 of Schedule K (Prior Authorization Services), PBM shall perform its review in the timeline, as reasonably defined by Aetna, in order to meet the coverage determination timeframe established by applicable Law or State Plan Specific Requirements. e. Notwithstanding Paragraph 29 of Schedule K (Prior Authorization Services), PBM shall communicate all denials to the applicable physician and to the Member within required timeframes established by applicable Law or State Plan-Specific Requirements. If such adverse determination time frames are not established by applicable Law or State Plan-Specific Requirements, then PBM shall communicate all denials to the applicable physician and to the Member within the timeline as reasonably defined by State Plan to PBM at time of implementation.
Product Design	16. Without limiting the generality or applicability of the other Schedules, PBM shall provide Aetna with reports and with access to a database containing data, including Formulary and Benefit Plan Design data, from which Aetna may run queries and produce standard and ad hoc reports. Ad hoc reports shall be subject to mutual agreement of the parties, and shall be presented in a manner consistent with applicable Law and State Plan-Specific Requirements. Regardless of the reporting mechanism, such data shall be refreshed on a daily basis and with new plan year data no later than one week following release of such data.
Prescription Drug Utilization Review	17. Notwithstanding the requirements in Schedule F (Prescription Drug Utilization Review), PBM shall not directly communicate or otherwise have any interactions with any State Plan Members related to prescription drug utilization review services. 18. PBM shall implement and use all POS edits that are required by Law, State Plan-Specific Requirements, and Aetna-designed DUR edits that are specific to State Plans. Without limiting the generality of the foregoing or the applicability of Schedule F (Prescription Drug Utilization Review), PBM shall accommodate the following DUR edits: (i) refill too soon variable at the drug level (using various percentages of supply remaining on current fill and/or custom cumulative); (ii) maximum daily dose of acetaminophen; (iii) quantity limits by drug, by class, by number of prescriptions and by quantity per prescription within an Aetna-designated timeframe; (iv) step therapies with variable look back periods and

	with variable number of prescriptions before applicable step therapy; and (v) age and gender limits, including limiting the application of a utilization management rule to certain ages.
Network Development / Maintenance	19. PBM shall incorporate the terms and conditions applicable to each State Plan and required by Aetna and/or State Plan-Specific Requirements, as applicable, into all Contracts with Participating Pharmacies. 20. PBM shall meet or exceed the network accessibility requirements of Aetna and/or each State Plan in accordance with Schedule G-2 (Network Adequacy Requirements) and as required by Law and/or State Plan-Specific Requirements, as applicable. Notwithstanding anything to the contrary in Schedule G, if Aetna, a, Government Sponsor, or legal requirements applicable to a Third-Party State Plan or a State Plan dictate that a pharmacy or pharmacy chain that is not a Participating Pharmacy must be added as a Participating Pharmacy, Aetna will notify PBM and make a written request to include such pharmacy in the network. PBM shall make commercially reasonable efforts to enter into a Participating Pharmacy Contract with such pharmacy that contains the required terms as set forth on Schedule G-1 (Requirements for Participating Pharmacy Contracts) and under the terms and conditions of similarly situated Participating Pharmacies within thirty (30) calendar days of the receipt of Aetna's request. If PBM is unable to secure such a Participating Pharmacy Contract with such pharmacy, Aetna shall have the right to contract directly with such pharmacy and PBM agrees to administer such pharmacy contract and treat such pharmacy as a Participating Pharmacy in the Aetna Network(s). The pharmacy shall be included in any audit requirements to the extent that the agreement reached between Aetna and the pharmacy is inclusive of all audit criteria and audit rights. 21. PBM shall ensure that all Participating Pharmacies in networks used by State Plans have, and continue to have, active state identification and enrollment numbers, in accordance with State Plan-Specific Requirements. PBM shall include the Participating Pharmacies' active state identification and enrollment numbers in any reporting as required by Aetna or the State Plan-Specific Requirements. Aetna understands and validates that Participating Pharmacies that are unable to provide active state identification and enrollment numbers will not be allowed to process claims as required under applicable Law. 22. In addition to the required terms for Participating Pharmacy Contracts as set forth on Schedule G-1, all PBM's Contracts with Participating Pharmacies that provide services to State Plan Members must prohibit Participating Pharmacies from using a State Plan name without Aetna's, Third-Party State Plan Sponsor's, or a State Plan's prior written permission. 23. To the extent a 340B pharmacy exists and/or Aetna and/or a State Plan is required or desires to use a

	340B pharmacy provider, PBM shall contract with that 340B pharmacy for certain Covered Drugs under the terms and conditions of similarly situated pharmacies, or as otherwise required by applicable Law or State Plan-Specific Requirements. 24. PBM shall provide Aetna, Government Sponsor, Third-Party State Plan, or State Plan required information about Participating Pharmacies in a mutually agreed upon format monthly, quarterly and annually and as otherwise required by a State Plan.
Member and State Plan Communications	25. Notwithstanding the requirements in Schedule H (Communications), PBM shall not directly communicate or otherwise have any interactions with any State Plan Members, State Plans, Third-Party State Plans, Government Sponsors, or Third-Party State Plan Sponsors unless expressly given direction and approval to do so in writing by Aetna. 26. Notwithstanding the requirements in Schedule H (Communications), PBM shall not directly communicate with prescribers or pharmacies concerning State Plan(s), unless expressly given direction and approval to do so in writing by Aetna. 27. To the extent Aetna authorizes any communications or interactions in accordance with Paragraphs 25 and 26 of this Schedule P (Medicaid & Other State Plan Services), Schedule H (Communications) shall apply except as otherwise set forth below: a. The Parties agree that notwithstanding anything to the contrary in Schedule H (Communications), for purposes of this Schedule P (Medicaid & Other State Plan Services), PBM's obligations with respect to communications also include the Participating Pharmacy Locator b. The Parties agree that notwithstanding anything to the contrary in Schedule H (Communications), for purposes of this Schedule P (Medicaid & Other State Plan Services) , Aetna will have the right to review and approve, within mutually agreed timelines, the creation, content, format, and method of distribution or dissemination (including customization to conform with applicable Laws, State Plan-Specific Requirements, Aetna Customer requirements, and other reasonable Aetna business interests and goals) of all: (a) communications directed to Members, Aetna Customers, and Providers; and (b) communications directed to Participating Pharmacies that are either requested by Aetna or are specifically regarding Aetna. Additional

	fees may apply for communications not described in Schedule H and for Pharmacy communications done outside of fax or email. For avoidance of doubt, no additional fees shall apply for provider materials sent by fax or email (e.g., provider education faxes) or for communications to/with pharmacies, providers or Members related to an error or issue caused by PBM (e.g., outbound call campaign related to a PBM error). c. The Parties agree that if State Plan-Specific Requirements require branding of a State Plan on communications and such branding requirements require a material change to PBM's existing branding communications processes, the Parties agree to work in good faith to find a mutually acceptable solution. d. Notwithstanding anything to the contrary in Schedule H (Communications), for purposes of this Schedule P (Medicaid & Other State Plan Services), the following communications shall be branded Aetna or in the State Plan name if necessary to satisfy State Plan-Specific Requirements: i. All communications related to Prior Authorization ii. Pharmacy Drug Lists e. Notwithstanding anything to the contrary in Schedule H (Communications), for purposes of this Schedule P (Medicaid & Other State Plan Services), all references to DUR, including Schedule F (Prescription Drug Utilization Review) and Schedule F-2 (Description of Current Aetna Retrospective DUR Services), shall include DUR edits which may be required by Law and/or State Plan-Specific Requirements. f. Notwithstanding anything to the contrary in Schedule H (Communications), for purposes of this Schedule P (Medicaid & Other State Plan Services), unless otherwise required by Law and/or State Plan-Specific Requirements, PBM shall not be required to private-label the check stock to be used for payment to Members in reimbursement of Member submitted paper Claims. g. Notwithstanding anything to the contrary in Schedule H (Communications), for purposes of this Schedule P (Medicaid & Other State Plan Services), PBM shall provide communications in English and such other languages required by Law and/or State Plan-Specific Requirements.

	h. Notwithstanding anything to the contrary in Schedule H (Communications), for purposes of this Schedule P (Medicaid & Other State Plan Services), unless otherwise required by Law and/or State Plan-Specific Requirements, PBM shall not be required to design, test, host, and/or maintain private label websites for State Plan Members. 28. As directed by Aetna, PBM shall create and mail to Medicare Members who are "dual eligibles" (meaning Members who are entitled to Medicare and eligible for Medicaid benefits) EOBs as follows: i. PBM shall provide Members EOBs, which shall be bilingual as required by State Plan-Specific Requirements and/or Aetna, and include: (i) all mandated data elements and formatting as required by applicable Law; (ii) the item or service for which payment was made; (iii) notice of Member's right to an itemized statement; (iv) applicable Formulary changes; and (v) such other notices as may be required by applicable Law. PBM shall provide: (a) EOB printing and distribution with the frequency required by Aetna, subject to mutually agreed upon fees; (b) EOB regeneration upon request; and (c) EOB storage in compliance with applicable Law. 29. The Parties agree that PBM shall have no Workers Compensation requirement obligations with respect to State Plans.
Web Experience	30. As between Aetna and PBM, unless otherwise requested by Aetna in writing, PBM shall not design or maintain the websites for the State Plans. PBM shall permit access as required by State Plan and provide for links from each Aetna-maintained State Plan's website to tools for Members, which shall be specific for each State Plan and which shall be created and maintained by PBM including (i) Participating Pharmacy Locator, (ii) Formulary drug information, and (iii) such other tools that State Plan may require, subject to applicable customization fees.
Formulary Administration	31. Without limiting the generality or applicability of Schedule J (Clinical Services and Formulary Administration), PBM acknowledges that Aetna will maintain Aetna State Plan Pharmacy and Therapeutics ("State Plan P&T") Committees. PBM shall comply with any applicable clinical programs and/or protocols that are required by the State Plan P&Ts. For avoidance of doubt, the foregoing provision does not obviate the requirements in Section 3 of this Schedule P (Medicaid & Other State Plan Services), which continue to apply to any Formulary updates that

	fall within Schedule B (Benefit Plan Set Up). 32. For purposes of this Schedule P (Medicaid & Other State Plan Services), PBM will make PBM pharmacists available as a resource to Aetna in connection with operational formulary implementations and as an advisory resource for formulary clinical questions. 33. PBM shall make all changes to Formularies in connection with this Schedule P (Medicaid & Other State Plan Services) as requested by Aetna. Updates may be a result of changes made by State Plan P&T as well as changes in the market place (i.e., drug recalls, drug availability, state required benefit changes, etc.). PBM shall make such changes and provide Aetna with such updated Formularies in an Aetna acceptable format (i.e., Microsoft Word) within: (i) thirty (30) Business Days of written receipt of the required change from Aetna if such updates are the result of changes made by State Plan P&T, or such shorter time required by the government to the extent possible; or (ii) ten (10) Business Days of written receipt of the required change from Aetna for standard formulary updates, or such shorter time required by Law to the extent possible.
Prior Authorization Services	34. To the extent required or requested by a State Plan, PBM shall provide prior authorization services to State Plan(s) in compliance with State Plan-Specific Requirements (including prior authorization guidelines) and Schedule K (Prior Authorization Services). 35. Notwithstanding anything to the contrary in Schedule K (Prior Authorization Services), including references to Aetna Clinical Policy Bulletins ("CPBs") and Aetna Pharmacy Clinical Policy Bulletins ("PCPBs"), for purposes of this Schedule P (Medicaid & Other State Plan Services), PBM shall comply with State Plan prior authorization guidelines and Medicaid prior authorization guidelines. 36. Notwithstanding anything to the contrary in Schedule K (Prior Authorization Services), for purposes of this Schedule P (Medicaid & Other State Plan Services), PBM shall have staff available (on call or otherwise) 24 hours a day, 7 days a week to accept and review urgent Prior Authorization Requests in accordance with State Plan-Specific Requirements.
Review of Personnel	37. PBM and the PBM Related Parties have not been excluded by the Department of Health and Human Services Office of the Inspector General (OIG) or by the General Services Administration (GSA) or from participation in federal or state health care programs, are not the subject of any pending exclusion

	proceeding, and have not been adjudicated or determined to have committed any action that could subject PBM and/or PBM Related Parties to exclusion from a government program. PBM shall notify Aetna promptly upon receipt of notice of (a) exclusion or proposed exclusion from a state or federal health care program, or (b) adjudication or other determination that PBM or a PBM Related Party has committed any action which could lead to exclusion from a government program. PBM shall review the OIG and GSA exclusion lists upon hire of any employee, contractor, or agent that will be providing services to Aetna directly or indirectly ("Covered Individual"), and periodically thereafter (in all events no less than annually), to ensure that all Covered Individuals are not excluded from government funded health care programs. PBM shall notify Aetna immediately upon receipt of any information indicating that PBM or a Covered Individual has been charged with a crime relating to healthcare or is facing a proposed debarment, exclusion, or other adverse action, in which case, PBM shall immediately remove any such Covered Individual(s) from direct responsibility for, or involvement in, services provided to Aetna related to government health care programs, and will take appropriate corrective actions in accordance with all Laws. These requirements refer to and include members of PBM's board of directors and any key management, executive staff, and any major stockholder. PBM shall provide Aetna with a certification or attestation by an officer or director of PBM of compliance with this section upon Aetna's request.
Compliance Education and Training	38. PBM shall require each PBM employee, subcontractor, agent, and director who performs services with respect to Medicaid Plans participate in Aetna's Medicaid compliance education and training (including fraud, waste, and abuse training) on at least an annual basis (and upon hire or engagement of any such individual), which such training shall be developed by Aetna and provided to PBM. PBM shall be responsible for conducting such training and collecting and maintaining documentation of such training. With respect to all other downstream entities, PBM shall require that all employees, subcontractors, agents, and directors who perform services with respect to Medicaid Plans participate in Aetna's Medicaid compliance education and training (including fraud, waste, and abuse training) on at least an annual basis (and upon hire or engagement if any such individual). PBM shall be responsible for collecting and maintaining documentation of such training. PBM shall provide Aetna with a certification or attestation by an officer or director of PBM of compliance with this section.
Rebate Administration	39. Notwithstanding anything to the contrary in the Agreement, including Schedule I (Rebate Administration), Aetna shall have the right to designate whether a State Plan will receive rebate administration services under this Agreement. In the event Aetna elects for rebate administration services to apply to a State Plan, Aetna shall designate whether Schedule I (Rebate Administration) or Schedule

	P(I-1) (State Plan - Full Rebate Contracting and Administration Services) (attached hereto and incorporated herein) will apply to the applicable State Plan.
Mail Order Pharmacy Services	40. Notwithstanding anything to the contrary in the Agreement, including Schedule M (Supporting Mail Order Pharmacy Services), Aetna shall have the right to designate whether a State Plan will receive mail order pharmacy services under this Agreement. In the event Aetna elects for mail order pharmacy services to apply to a State Plan, Aetna shall designate whether Schedule M (Supporting Mail Order Pharmacy Services) or Schedule P(M-2) (State Plan - Full Mail Order Pharmacy Services) (attached hereto and incorporated herein) will apply to the applicable State Plan.
Specialty Pharmacy Services	41. Notwithstanding anything to the contrary in the Agreement, including Schedule N (Supporting Specialty Pharmacy Services), Aetna shall have the right to designate whether a State Plan will receive specialty pharmacy services under this Agreement. In the event Aetna elects for specialty pharmacy services to apply to a State Plan, Aetna shall designate whether Schedule N (Supporting Specialty Pharmacy Services) or Schedule P(N-2) (State Plan - Full Specialty Pharmacy Services) (attached hereto and incorporated herein) will apply to the applicable State Plan.
Service Performance Standards	42. PBM agrees to meet or exceed the service levels set forth in Schedule R Section 9 and the below service performance standards in the aggregate for Aetna Medicaid book of business, which PBM will track and report in writing to Aetna on an annual basis. PBM agrees to meet or exceed State required performance standards. 43. Client Satisfaction Survey: PBM shall conduct an annual survey of State Plan management to measure satisfaction of State Plan with PBM services. PBM guarantees a satisfaction rating of at least three (3) on a five (5) point scale. PBM shall be responsible for data collection, analysis, and any costs associated with the conducting of the survey. Survey design will be the responsibility of PBM with approval by Aetna. 44. Onsite Meetings: PBM account team members shall schedule and participate in quarterly meetings at Aetna offices to discuss utilization, financial, and clinical results. The PBM account team shall prepare and distribute agenda and meeting materials at least five (5) Business Days prior to the meeting date. PBM account team members shall prepare and distribute meeting notes and a list of follow-up items within five (5) Business Days following the meeting. 45. Modeling/Forecasting: PBM shall provide any modeling/forecasting for plan design changes for State

	Plans to Aetna within five (5) Business Days of written request, or other mutually agreed upon timeframe. PBM shall provide modeling/forecasting for formulary/rebate changes for State Plans to Aetna within four (4) weeks of written request. 46. Report Distribution: PBM agrees quarterly standard management reports for State Plans shall be available within thirty (30) days after the end of each calendar quarter. 47. On-Line Reporting: PBM agrees that data for on-line reporting will be available within fifteen (15) Calendar Days following the end of each month. 48. Benefit Design Error Resolution: PBM shall correct any identified benefit design set-up errors in RxClaim within five (5) Business Days unless otherwise mutually agreed upon. Upon learning of a set-up error, PBM will notify Aetna of an expected date such set-up error will be corrected. 49. Mail Order Pharmacy Turnaround Time: PBM guarantees that 95% of "clean" claims (those not requiring intervention/correction) will be processed and shipped within an average of two (2) days and 100% of ALL claims will be processed and shipped within an average of five (5) days. 50. Mail Order Pharmacy Accuracy: PBM guarantees that it will achieve a 99.9% accuracy rate in dispensing the correct drug, with the correct strength, and correct dosage, unless the error is due to the prescriber. 51. Prior Authorization Administration Accuracy: In State Plans where Prior Authorization has been subcontracted to PBM, percentage of prior authorization, step therapy, quantity limit and medical exception requests (together "prior authorization requests") where approval or denial decision is accurately determined shall be 99%, based on review of determinations provided by PBM, under the supervision of a pharmacist or PBM medical director.
Performance Guarantees	52. Schedule R, Section 9 (Performance Standards and Service Levels), as amended, shall apply to State Plans, as applicable. PBM shall adhere to Performance Standards as set forth in Schedule R, Section 9. State Plan-specific Performance Standards and Service Levels, as set forth in any amendment to, or addition to, Schedule R (Performance Standards and Service Levels), shall also apply to State Plans.

Schedule Q

Description of Committees

Core Services

PBM and Aetna shall constitute and maintain Committees in accordance with this Schedule Q (Description of Committees) and Article V of the Agreement. In its sole discretion, Aetna may eliminate and disband any Committee and/or create a new Committee in accordance with Article V of the Agreement. The composition of each Committee shall be of an adequate number, expertise, and seniority as reasonably acceptable to and approved by Aetna. The Committees listed in this Schedule Q (Description of Committees) shall be in accordance with Article V of the Agreement and this Schedule Q (Description of Committees). Aetna and PBM will co-chair each committee meeting, and co-facilitate for all meetings. Aetna reserves the right to assign agenda items with reasonable notice in advance of the sessions. PBM is required to prepare meeting materials and relevant documentation prior to committee meetings. PBM shall distribute the aforementioned materials as noted hereunder. After each committee meeting, PBM will be required to prepare and distribute meeting minutes within five (5) business days following the conclusion of the meeting.

PBM shall ensure that Committee meetings are attended by PBM Committee members. If agreed upon by Aetna and PBM, additional PBM personnel may attend Committee meetings, and the frequency and cadence of the meetings may be increased, decreased, or otherwise modified.

Members of the PBM-Aetna Committees will be categorized into one of three categories.

A.) **Strategic:** Accountable for the overall vendor relationship, ensuring delivery of the PBM strategy and achievement of business results. Focus on new business growth and opportunities, determine opportunities for future partnership and evaluate product strategy and technology enablement. Strategic committees will consist of the most senior individuals within the organization

B.) **Management:** Focus on specifics surrounding all aspects of delegated services.

C.) **Operational:** Focus on operational performance; includes day to day monitoring, creation and tracking of metrics, and issue resolution.

A.) Strategic Level Committees

Categorization	Name	Mission
Strategic Level	Executive / Oversight and Product Strategy Committee - Semi-annually	This Committee shall focus on gathering relevant data, managing the operations of the business, and evaluating and strategizing about the overall PBM/Aetna relationship across all facets of the relationship. Additionally, this Committee shall analyze and provide recommendations on Aetna's product strategy This Committee shall: (i) monitor the performance of existing products (ii) strategize on new and differentiated offerings in the marketplace (iii) consider and evaluate technology's role in Aetna's strategic planning and project management,

Categorization	Name	Mission
		including Aetna-specific investment needs and opportunities for broader PBM/Aetna technical collaboration and (iv) continuously consider ways to maximize the member-experience and member satisfaction components of all product offerings.

B.) Management Level Committees

Categorization	Name	Mission
Management Level	Sales, Account Mgmt & Marketing Committee – At least monthly	This committee shall review all activities pertaining to new business, retention, prospecting, future growth opportunities, and shall focus on (i) gathering and analyzing data relevant to Aetna's strengthening and expanding relationships with Aetna Customers and (ii) gathering and analyzing relevant data to evaluate, strategize and oversee the execution of strategic marketing aimed at Aetna's current and potential sales opportunities. This Committee shall be the first line of resolution for any disagreements between the Parties related to marketing rules-of-the-road policies and procedures set forth in Article XVI of the Agreement, and shall assign resources according to the best opportunities as determined by this Committee. All such sales and marketing process activities between the Parties shall be conducted in accordance with applicable Law, including antitrust laws and shall be subject to the firewall requirements set forth in Section 5.5 of the Agreement.
Management Level	Cost of Care Committee – Quarterly	In addition to any requirements set forth in Schedule J (Clinical Services and Formulary Administration), this Committee shall focus on gathering relevant data and analyzing Aetna's clinical strategy in terms of: (i) new programs; (ii) efficacy of existing programs & opportunities for improvement; (iii) clinical trends & best practices; (iv) synchronization and clarification of clinical policies; (v) Health Information Technology ("HIT") opportunities and how best to leverage assets across PBM and Aetna; and (vi) current or planned studies and opportunities for PBM and Aetna to co-publish findings.
Management Level	Pharmacy Management Committee - Monthly	This committee shall manage overall vendor performance, monitor escalations and evaluate/ approve individual project initiatives as well as make changes to the portfolio of project initiatives. This committee oversees commercial and Medicare operational performance.
Management	Compliance	This committee shall provide compliance oversight for

Categorization	Name	Mission
Level	Oversight Committee - Monthly	transition, migration and steady state periods. This committee oversees Compliance items for commercial, Medicare, Medicaid and SW.
Management Level	Contract and Financial Governance Committee – At least Quarterly	This committee shall govern changes to contract, perform issue management/dispute management and review financial reporting, pricing guarantees and performance.
Management Level	Medicare Services Committee – Quarterly	This Committee shall focus on gathering and analyzing relevant data to evaluate: all Aetna Medicare related opportunities, strategies and improvement opportunities within Aetna's existing Medicare Part D Book of Business including operational results.
Management Level	Medicaid and Other Government Programs (excluding Medicare Part D) Services Committee - Quarterly	This Committee shall focus on gathering and analyzing relevant data to evaluate all Aetna Medicaid and other government funded program (excluding Medicare Part D) related opportunities and strategies and the improvement of Aetna's existing Medicaid Book of Business.
Management Level	IT Oversight Committee - Quarterly	This is a joint committee that provides oversight for integrated IT environment and projects supporting the ongoing needs of Aetna's business and the Agreement.

C.) Operational Level Committees

Categorization	Name	Mission
Operational	Pharmacy Operations Committee – Daily (Weekdays)	This committee shall manage day to day vendor performance, monitor escalations and review any performance trends. Discussion topics for this committee shall cover all performance areas for delegated functions. This committee will discuss both commercial and Medicaid.
Operational	Information Technology Project Management Office - Monthly	This committee shall oversee and coordinate the successful transfer of data; integration of outgoing PBM, successor PBM and Aetna systems; and managing the overall technology effort to ensure continuity of PBM Services and PBM Services until all the Covered Plans and/or Aetna Customers have been successfully Cutover to successor PBM's systems and products. Focus will include integration planning, establishment of product and testing connections, data mapping, data transfers, test planning, test execution, and model office set up and utilization.
Operational	Mail Order and Specialty Pharmacies	These Committees shall focus on overseeing day-to-day operations and coordination between the Aetna Mail Order

Categorization	Name	Mission
	Committees - Weekly	Pharmacies and the PBM Central Fill Pharmacies, including work flow and issue resolution.
Operational Level	Data Quality and Monitoring Committee – Monthly	PBM and Aetna shall form a data quality and monitoring committee that will monitor quality and implement changes when issues are identified.

Schedule S

Retiree Drug Subsidy Services

Core Services

In general, the services, obligations and other requirements set forth in the Schedules (except Schedule O (Medicare Services) and Schedule P (Medicaid & Other State Plan Services)) shall be applicable to each Covered Plan that is a Qualified Retiree Prescription Drug Plan as defined at 42 C.F.R. Section 423.882 (each an "RDS Plan"). This Schedule S (Retiree Drug Subsidy Services) sets forth additional and in some cases modified obligations and requirements applicable to RDS Plans. In the event of any inconsistency or conflict between this Schedule S (Retiree Drug Subsidy Services) and the Agreement or any other Schedule to the Agreement with respect to an RDS Plan, this Schedule S (Retiree Drug Subsidy Services) shall be controlling with respect to an RDS Plan. In addition, PBM shall promptly notify Aetna of any such inconsistency or conflict, and shall comply with any instructions provided by Aetna to resolve or reconcile the same. Aetna agrees to notify PBM of any new or revised requirements or guidance applicable to the Services provided to RDS Plans as soon as is practicable. PBM agrees to timely comply (or modify the PBM Services as necessary so that Aetna can timely comply) with any such requirements and/or guidance. Notwithstanding the foregoing, PBM acknowledges and agrees that it is at all times required to comply with applicable Law and requirements and guidance, regardless of notice from Aetna.

Service	Description
General Description of Services	1. PBM shall provide the services described in this Schedule S (Retiree Drug Subsidy Services) with respect to RDS Plans. As provided below, Aetna Customers will make certain elections with respect to the implementation of the terms of RDS Plans and PBM shall provide the services required as a result of such elections. All references to Aetna Customers in this Schedule S (Retiree Drug Subsidy Services) are references to Aetna Customers that are sponsors of RDS Plans. 2. PBM shall also accommodate custom processes with respect to RDS-related reporting for certain Aetna Customers that are at least consistent with the custom processes and reporting that Aetna or PBM provides today, including ad hoc research and reporting requests. If Aetna or an Aetna Customer requires a custom process with respect to RDS-related reporting that is not currently provided by Aetna or PBM, the Parties shall mutually agree on how PBM will accommodate such process or request.
Initial Eligibility Reporting	3. PBM shall produce initial eligibility reports for each plan year in the layout required by CMS listing proposed Qualifying Covered Retirees (as such term is defined in 42 C.F.R. Section 423.882). This enrollment file shall incorporate eligibility information that Aetna will supply to PBM. PBM shall either, at Aetna's direction (based on direction provided to Aetna by the Aetna Customer), (i) submit such reports directly to CMS in accordance with CMS transmission

	requirements or (ii) prepare and deliver in an Aetna approved layout/format, such reports to Aetna for delivery to the Aetna Customer. PBM shall follow an Aetna approved process, including timing requirements, with respect to all file transmissions to Aetna and/or CMS, in a time reasonably required by Aetna.
Monthly Eligibility Reporting	4. PBM shall prepare monthly eligibility update reports in the layout required by CMS, listing proposed Qualifying Covered Retirees. PBM shall either, at Aetna's direction (based on direction provided to Aetna by the Aetna Customer), (i) submit such reports directly to CMS in accordance with CMS transmission requirements (including timing requirements) or (ii) prepare and deliver in an Aetna approved layout/format, such reports to Aetna for delivery to the Aetna Customer. PBM shall follow an Aetna approved process, including timing requirements, with respect to all file transmissions to Aetna and/or CMS, in a time reasonably required by Aetna.
Eligibility Information Reconciliation	5. For Aetna Customers that elect to have PBM manage RDS eligibility with CMS: a. PBM shall develop and maintain accurate listings (weekly) of approved Qualifying Covered Retirees for cost report production for Aetna Customers who have given Aetna "designee access" to their eligibility information on the CMS RDS website; b. PBM shall receive and compare response/weekly/CMS Covered Retiree List ("CRL") information to perform quality checks of such listings to confirm the correct Qualifying Covered Retiree information and subsidy periods; c. PBM shall produce a monthly enrollment report that outlines Qualifying Covered Retirees Member status to Aetna and/or Aetna Customers who have not given designee access, on Customer by Customer basis; d. PBM shall include resubmission records for CMS-approved "Reason Code 21" retirees in eligibility update reports; e. PBM shall provide RDS discrepancy rationalization reports to Aetna, which shall contain sufficient information to assist Aetna and Aetna Customers in better understanding the reasons for discrepancies in either eligible membership or subsidy (RDS plan vs. CMS); and f. As part of final annual reconciliation, PBM shall accept the CRL Aetna provides to compare, and use the CRL to produce the RDS subsidy reconciliation report. 6. For Aetna Customers that do not elect to have PBM manage RDS eligibility with CMS: a. PBM shall receive from Aetna and/or Aetna Customers the list

	of Qualifying Covered Retirees, including coverage periods; b. PBM shall maintain these listings of approved Qualifying Covered Retirees for cost report production; c. PBM shall provide RDS discrepancy rationalization reports to Aetna, which shall contain sufficient information to assist Aetna and Aetna Customers in better understanding the reasons for discrepancies in either eligible membership or subsidy (RDS plan vs. CMS); and d. As part of final annual reconciliation, to produce the RDS subsidy reconciliation report, PBM shall receive and compare the CMS CRL received from Aetna and/or Aetna Customers.
Interim Payment Requests	7. PBM shall prepare cost data and other information as necessary to satisfy CMS requirements applicable to optional interim payment requests. PBM's responsibilities shall include the following: a. Produce and provide interim cost reports based on the Aetna Customer's schedule (monthly, quarterly, annually) as notified by Aetna to PBM from time to time. PBM shall either, at Aetna's direction (based on direction provided to Aetna by the Aetna Customer), (i) submit such reports directly to CMS in accordance with CMS transmission requirements (including timing requirements) or (ii) prepare and deliver in an Aetna approved layout/format, such reports to Aetna for delivery to the Aetna Customer. PBM shall follow an Aetna approved process, including timing requirements, with respect to all file transmissions to Aetna and/or CMS, in a time reasonably required by Aetna. Frequency of reporting period to be no more frequent than monthly. b. Calculate Gross Covered Retiree Plan-related Prescription Drug Costs, Threshold Reduction Amount, Limit Amount and apply the Aetna-calculated cost adjustment percentages incurred for each Aetna Customer's Qualifying Covered Retirees during the applicable payment period for which the Aetna Customer has elected to receive the RDS. c. Aetna shall calculate Cost Adjustment Amounts inclusive of Rebates and including post adjudication mail order discounts and any other price concessions using historical data and generally accepted actuarial principles and otherwise in the manner required by CMS. Aetna will provide cost adjustment percentages to PBM on a monthly basis or when a change in the rate occurs, whichever is sooner. d. PBM shall coordinate individual retiree cost data as necessary under CMS rules.

Invoicing	8. PBM shall provide all data needed for Aetna to bill Aetna Customers for the specific services rendered to them by PBM.
Year-End Reconciliation	9. PBM will provide cost data and other information necessary to satisfy CMS requirements for year-end reconciliations, including the actual applicable Gross Retiree Costs, Threshold Reduction Amount, Limit Reduction Amount and Actual Cost Adjustment Amount (as defined in Law) and any other data CMS may require. The Cost adjustment amounts will be calculated based upon a percentage amount provide by Aetna. PBM will apply the percentage amount eligible cost. 10. PBM shall either, at Aetna's direction (based on direction provided to Aetna by the Aetna Customer), (i) submit such reports directly to CMS in accordance with CMS transmission requirements (including timing requirements) or (ii) prepare and deliver in an Aetna standard layout/format, such reports to Aetna for delivery to the Aetna Customer. PBM shall follow an Aetna approved process, including timing requirements, with respect to all file transmission to Aetna and/or CMS, in a time reasonably required by Aetna. 11. Aetna shall calculate Actual Cost Adjustment Amounts inclusive of Rebates and including post adjudication mail order discounts and other price concessions in the manner required by CMS. PBM will apply these cost adjustment assumptions to the RDS Cost reports by applying the Aetna-supplied percentage amounts to all eligible costs. 12. In preparing year-end reconciliations, PBM shall accommodate custom requirements of specific Aetna Customers and/or their external consultants who wish to review and provide input on the report prior to finalization as communicated to PBM by Aetna from time to time, including: a. PBM shall accommodate requests from Aetna Customers and/or their designees (including consultants) for multiple test reports. b. PBM shall participate in all NDC and excluded drug reviews requested by Aetna Customers and/or their designees (including consultants). c. PBM shall accommodate submission of final year-end reports with changes (i.e., addition of non-Aetna cost report data) made by Aetna Customers and/or their designees (including consultants). 13. PBM shall coordinate individual retiree cost data as required under CMS rules. 14. PBM shall accommodate requests for post reconciliation reporting reruns.
Records Retention and Access	15. PBM shall maintain all documentation of costs incurred and other relevant information utilized for calculating the amount of the subsidy

	payment, including the underlying Claims data and drug-specific Rebate data, for at least six (6) years after the expiration of the plan year in which such costs were incurred. In the event of an ongoing investigation, litigation, or negotiation involving civil administrative or criminal liability, CMS, HHS, the Comptroller General, the OIG may extend the six (6) year retention period, in which case PBM shall maintain all relevant information for such longer period. PBM shall make the records available to CMS, HHS, the Comptroller General, the OIG, Aetna, and/or the Aetna Customer or their designees upon request. Claim data shall be maintained by PBM at an individual claimant level. All audits by federal, state, and local Governmental Bodies having jurisdiction, or their designees, shall be conducted through and in conjunction with Aetna unless Aetna specifies otherwise in writing.
False Claims Act Acknowledgement	16. PBM hereby acknowledges that the data provided by PBM in support of an Aetna Customer's RDS request is used for the purpose of obtaining federal funds, which may be subject to the False Claims Act.

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Schedule T

Termination Transition Services

Core Services

Service	Description
Transition Timing	1. "Termination Date" means the final day of the Term, regardless of the basis or circumstances for the expiration or termination of the Term, which marks the beginning of the "period of eighteen (18) months following the expiration or termination of the Term" described in Section 2.3 of the PBM Services Agreement. 2. Subject to Section 2.3 of the PBM Services Agreement, not later than 18 months prior to the scheduled end of the Term, or as soon as reasonably practicable following any notice of termination of the Agreement prior to the expiration of the Term, the Termination Transition Team (as defined in Paragraphs 4 -6 of this Schedule T (Termination Transition Services)), at a date, time, and location acceptable to Aetna, shall convene to discuss and develop, in good faith, a detailed plan to transition the PBM Services to a successor pharmacy benefit manager (which may be a third-party, Aetna or an Affiliate of Aetna) (the "Successor PBM"), which plan will provide a roadmap for the successful transition of all Aetna Customers, Covered Plans, Members, and Aetna Affiliates to the Successor PBM's systems and services (the "Transition-Out Plan"). As part of this Transition-Out Plan, Aetna and PBM will mutually agree to Customer specific transition dates occurring during the Termination Transition Period. At a frequency specified by Aetna, but no less frequent than bi-monthly, PBM will provide reporting on progress towards key milestones set forth in the Transition-Out Plan. 3. PBM will reasonably cooperate with Aetna and Successor PBM to implement the Transition-Out Plan. The Termination Transition Team shall meet throughout the Termination Transition Period at such dates, times, and locations as reasonably requested by Aetna. Throughout the Termination Transition Period, in accordance with the requirements of this Schedule T (Termination Transition Services) and the Transition-Out Plan, and as otherwise reasonably requested by Aetna, PBM shall provide data and information to Aetna and the Successor PBM as set forth in this Agreement, and otherwise work and cooperate with Aetna and the Successor PBM, to facilitate a successful and seamless transition of all Covered Plans, Aetna Customers, Members and other contracted capabilities to the Successor PBM or other Aetna designated service providers.
Transition Team and Personnel	4. Aetna and PBM shall appoint appropriate representatives and other personnel to a transition team (the "Termination Transition Team") pursuant to Schedule Q-1 (Description of Committees) to coordinate and oversee the performance of the termination transition services and to otherwise assist with the transfer of PBM Services to the Successor PBM.

Service	Description
	PBM shall appoint personnel to the Termination Transition Team that have been actively involved with the Aetna account within the 18 months prior to the establishment of the Termination Transition Team and whom are reasonably acceptable to Aetna. 5. Aetna shall be entitled to include representatives of the Successor PBM in certain transition activities as specified by Aetna , subject, if applicable, to such representatives executing confidentiality agreements in a form reasonably acceptable to PBM; provided, however, PBM may request the Successor PBM representatives, employees, agents, or consultants be excluded from certain activities, discussions or meetings that may include certain functional, program, or business process discussions deemed by PBM to be proprietary and confidential. 6. In addition to the Termination Transition Team representatives, PBM shall, throughout the Termination Transition Period, designate appropriate and sufficient management and other personnel to facilitate the termination transition, which may include certain personnel listed in Schedule Q (Description of Committees) and/or BB (Description of PBM Designated and Dedicated Personnel) as agreed upon by Aetna and PBM. PBM shall provide Aetna with a current list of designated employees within 5 Business Days, or in a mutually agreed on time period, of the Transition-Out planning meeting and thereafter at a frequency specified by Aetna.
Cooperation with Successor PBM	7. PBM shall confer with the Successor PBM regarding, and provide the Successor PBM with reasonable access, as mutually agreed by the Parties to, relevant Services, related service levels, and other obligations of PBM under this Agreement, and otherwise cooperate with the Successor PBM and Other Persons designated by Aetna, so as to enable the Successor PBM to take over such Services and other obligations and successfully transition all Covered Plans, Aetna Customers, Members and other contracted capabilities to the Successor PBM or other Aetna designated service providers provided, however, that nothing in this paragraph shall obligate PBM to disclose proprietary information to the Successor PBM.
Communications	8. PBM shall assist and work jointly with Aetna and the Successor PBM to develop and implement a communications plan for Aetna Customers and Members and to develop and execute a strategy to provide adequate notice and information to Aetna Customers, Members, and Aetna Plan Affiliates as necessary based on the Transition-Out Plan requirements. All communications during the Termination Transition Period shall continue to be Aetna-branded and in compliance with the requirements of Schedule H (Communications). As Aetna Customers and Covered Plans are transitioned to the Successor PBM, and in accordance with a schedule mutually agreed upon by Aetna and PBM, PBM shall respond to all calls, faxes, emails, website inquiries, letters, pharmacy orders, or other communications received by PBM from Aetna Members, Aetna Providers and Participating Pharmacies that relate to Aetna Customers and Covered

Service	Description
	Plans that have transitioned away from PBM and to Successor PBM, in a manner directed by Aetna and agreed upon by PBM, which may include redirecting or forwarding to a new phone number, fax number, email address, website, or mailing address provided to PBM by Aetna. PBM will provide these services for as long as calls, faxes, emails, website inquiries, letters, pharmacy orders, or other communications are received by PBM after the end of the Termination Transition Period; PBM agrees to provide to Aetna, in an agreed upon format and at an agreed upon frequency, reports detailing material volumes, types and recipients of misdirected communications throughout the Termination Transition Period. 9. [Reserved]
Data Transfer	10. The Transition-Out Plan shall include the timely and adequate transfer of ~~all~~ data reasonably requested by Aetna or Successor PBM which is necessary to enable the Successor PBM to perform the Services for Aetna Customers, Covered Plans, Aetna Plan Affiliates, Aetna Health Plans, and Members (the "Data Transfer Plan"). Notwithstanding the establishment of the Termination Transition Team, PBM shall establish a dedicated "Data Transfer Team" comprised of individuals knowledgeable of Aetna's plan data structures residing within the PBM systems. The Data Transfer Team shall: a. Deliver data and information to the Successor PBM in an accurate and timely manner in accordance with the Data Transfer Plan and Schedule T-1. b. Provide day to day data analysis, reporting and research (for fall out or other issues requiring action) throughout the Transition Out phase. c. Interact directly with the Successor PBM's Transition In resources to assure successful data transition. 11. PBM shall generally transfer to the successor pharmacy benefit manager the following data in an industry standard format or as mutually agreed by the Parties, to the extent that PBM's system was the original source for such data or was otherwise provided by Aetna to PBM, for all Aetna Customers and Covered Plans and Aetna Members. Data to be transferred includes but is not limited to: a. Claims Data which contains Customer level pharmacy benefits information; b. Open script information including refills; c. Claims history for a period of no less than 36 months prior to the initiation of the beginning of the Transition-Out period, d. Aetna custom prior authorization criteria; e. Prior authorization history for a period of no less than two (2) years prior to the start of the transition of business;

Service	Description
	f. Custom network documentation g. TrOOP balances; h. Other information and data, as mutually agreed by the Parties, that relates to Aetna, Aetna Customers, Covered Plans, Members, or Aetna programs as captured in PBM's systems and necessary to ensure minimal disruption to Aetna Customers, Covered Plans, and Members (excluding data that is proprietary to PBM). 12. PBM is responsible for the accuracy and completeness of data transferred to the Successor PBM and will provide appropriate mechanisms to securely transfer this information to the Successor PBM. PBM will be responsible to remedy any data inaccuracies caused by PBM, at its sole cost, and in a timely manner. 13. To the extent that such data was provided by Aetna to PBM and is transferred without alteration by PBM, Aetna shall review and verify the accuracy of such data. 14. PBM shall provide data to be transferred to the Successor PBM in an industry standard or electronic format as mutually agreed upon by the Parties, and designed to enable seamless data transfer and integration to the Successor PBM's information systems platforms.
Information Technology	15. For a period of twelve months following the completion of the Claims run-off services described in Paragraph 20 of this Schedule T (Termination Transition Services), PBM shall provide Aetna continued access to data and provide Aetna with information technology support, systems and services, in the same manner as required by Section 6.2 of the Agreement and Schedule U (Information Technology Systems and Services) and to the extent necessary to protect Aetna from disruption and loss of service, including immediate access to necessary records in relation to Aetna Plans, Aetna Customers, and/or Members in electronic formats reasonably acceptable to Aetna. Such access to data and provision of information technology support, systems and services shall apply equally to any partial termination of PBM Services in accordance with Section 12.4 of the Agreement.
Transfer of Assets	16. At Aetna's option, PBM shall transfer to Aetna the following assets, to the extent proprietary to Aetna, used to provide PBM Services to Aetna and will provide attestation that this information has been secured and properly removed from the PBM environment: a. Aetna clinical program information b. Medical / Rx Integration Layer specifications c. Customer specific network requirements d. Aetna training materials, standard operating procedures / controls documentation relating specifically to Aetna

Service	Description
	Customers, Covered Plans, Members, and Affiliates. e. Aetna-specific telephone numbers. 17. Such assets shall be transferred at no charge to Aetna, to the extent that such transfer does not result in cost to PBM, and pursuant to bills of sale or other customary agreements in form and substance reasonably acceptable to the parties and free and clear of all liens, claims and encumbrances, other than certain customary permitted encumbrances.
Continuation of Services During Termination Transition Period	18. For so long as Aetna may direct during the Termination Transition Period on a plan-by-plan and customer-by-customer basis, PBM shall continue to provide and perform any or all of the Services for and with respect to any and all of the Covered Plans, Aetna Customers, and Aetna Plan Affiliates, in accordance with the terms and conditions of the Agreement.
Additional Claims Run-Off Services and General Coordination	19. During the Termination Transition Period, and following such period as reasonably requested by Aetna, PBM shall provide additional Claims run-off services, answer questions, and provide information, data, and records,. During the Transition Period, PBM services described herein are included as Core Services. In the event Aetna requires these services post Termination Transition period, PBM will provide these services for a monthly rate of $30K per month for the next sixteen (16) months post Termination Transition Period. Beyond the additional sixteen (16) months, PBM will provide these services at the PBM's prevailing rate. For avoidance of doubt, such Services shall include such activities as may be required to comply with applicable Law.
Post-Transition Prescriptions	20. PBM shall assist and work with Aetna and the Successor PBM to design and implement a process to provide for the transfer to the Successor PBM of any prescriptions received by PBM following initiation of services by the Successor PBM as per the Aetna Member transition timetable specified in the Transition-Out Plan.
Mail Order and Specialty	21. During the Termination Transition Period, PBM shall provide steps and materials, reasonably requested by Aetna, as needed to effectuate a smooth transition to the new mail order and specialty pharmacy vendor which shall include, without limitation, the provision of prescription records releases and histories, open refill transfer tapes, and Aetna process and training manuals; provided, however, that nothing in this paragraph shall obligate PBM to disclose proprietary information to Aetna, the Successor PBM, or the new mail order pharmacy or specialty pharmacy. 22. The PBM will provide Aetna with access to certain of its systems and will continue to support its systems throughout the Termination Transition Period. With respect to active Members that have not yet transitioned to the Successor pharmacy benefit manager, at no time will PBM limit access to systems in use to support access which has been previously approved by PBM.

Service	Description
Open A/R	23. Prior to the transition of each Member to the Successor PBM's platform, PBM shall return all open account receivable credits, if any, to such Member. PBM shall provide Aetna with a report showing all such open account receivable credits by Member and sorted by Covered Plan.
Billing Statements	24. PBM shall provide a final billing statement to each Member having an outstanding balance prior to the transition of such Member to the Successor PBM's platform. PBM shall provide Aetna with a report showing all such outstanding balances by Member and sorted by Covered Plan.
Reporting	25. During the Termination Transition Period and following such period if necessary, PBM shall provide agreed upon reporting for any Aetna Customer or Covered Plan with respect to any period of time that PBM was providing Services (and Phase I PBM Services) to such Aetna Customer or Covered Plan. PBM shall provide all such reports in accordance with the reporting schedule established in Schedules V and V-1. For the avoidance of doubt, such reporting shall only apply to Members who have not yet transitioned to the Successor PBM.

Termination Transition Milestones

The following tasks have been identified as minimum milestones for the Termination Transition Phase with the corresponding guarantee amounts to be paid if not met up to a maximum of $10,000,000. CVS Caremark's liability will be limited to items within its own control. During the Termination Transition Period, modifications to these tasks and their corresponding timing, measurements, and performance standards may be recommended by the Termination Transition Team and approved by the Parties. In the event of a partial termination of the Agreement, the performance standards in this Schedule R shall be equitably adjusted in proportion to the number of members impacted by the termination as compared to Aetna's overall book of business.

Termination Transition Milestones	Milestone Timing	Measurement	Subject to Performance Standard
Establishment of Termination Transition Team with PBM representation in accordance with this Schedule T and cooperative development of Transition-Out Plan Document in order to effect the successful transition of Aetna Customers, Members, Health Plans and Affiliates in accordance to the full faith and cooperation of each party. Failure of non-PBM parties to comply will result in revised milestone delivery date and delay of penalty assessment.	As mutually agreed by the Parties	Completed Plan Document with Approval of Transition Team Members	$1M for each week not completed by agreed upon milestone date
Completion of a Communications Plan to Aetna Customers, Members, Participating Pharmacies, and other Providers	As mutually agreed by the Parties	Approved Communications Plan Document and Artifacts	$.2M for each day not completed by agreed upon milestone date
Completion of detailed Data Mapping for all data elements supporting Aetna plans and creation of Data Transfer Plan for all data, including but not limited to the requirements of Schedule T-1. Data Transfer Plan must provide for data transfer prior to the Termination Date	As mutually agreed by the Parties	Approved Data Transfer Plan	$ 1M for each day not completed by agreed upon milestone date
Network Information for Network Disruption Analysis for customer migration planning and	As mutually agreed by the Parties	Data provided to complete network disruption analysis	$.2M per week not completed by agreed upon

Termination Transition Milestones	Milestone Timing	Measurement	Subject to Performance Standard
periodically updated to support customer migration			milestone date (applies to both initial disruption analysis and monthly updates)
Reporting by PBM of progress on meeting Transition Milestones as outlined in Transition-Out Plan Document and mitigating transition risks	As mutually agreed by the Parties	Timely receipt of reports for joint review by Transition Team	$.2M per week not completed by agreed upon milestone date
Support of and Joint Development / implementation of Aetna Customer level termination transition plans, outlining customer specific transition dates.	As mutually agreed by the Parties	Completed Plan Document	$.2M per week not completed by agreed upon milestone date
Successfully Manage Open Order Refill transfers to Successor PBM fulfillment changes	As mutually agreed by the Parties	Successful transfer of open order refills utilizing industry-standard formats and protocols	Subject to Performance Standard: $.25M per each Open Order Refill outbound file with greater than 0.1% inaccurate data which directly results in a mismanaged script. PBM is held harmless for any errors or actions by any other Party which results in a mismanaged script. All such scripts are precluded from inclusion in the performance standard.
Development of transition processes to assure minimal Aetna Member and Customer disruption, including processes	As mutually agreed by the Parties	Customer Touch point / Experience Transition Document	$ .2M per week not completed by agreed upon milestone date

Termination Transition Milestones	Milestone Timing	Measurement	Subject to Performance Standard
to support calls, emails, letters, web inquires and other communications received by PBM during the Termination Transition Period, and completion of a transition process audit with the Successor PBM resulting in Successor PBM's approval.			
Successful transition of the data specified in this Schedule T (Termination Transition Services) and per the Data Transfer Plan in appropriate electronic formats to allow for successful loading and processing to Successor PBM administrative platforms	As mutually agreed by the Parties	Timely receipt of data feeds by Successor PBM Agreed upon data load quality metrics provided in the Data Transfer Plan	$.5M for each day an individual data file (as provided for in the Data Transfer Plan is overdue past the agreed upon milestone date

Schedule T-1

Data Transfer Transition Requirements

As outlined in Schedule T, the Transition Team will convene to develop a detailed Transition Out plan to transition the PBM Services to a successor pharmacy benefit manager. This Transition Out plan will provide a roadmap for the successful transition of all Aetna Customers, Covered Plans, Members, and Aetna Affiliates to the Successor PBM's systems and services and all Aetna data transfer specifications required to support the following:

a) Establish Production Data History. PBM will support the establishment of a production data history at the time of the Transition.
   i) Throughout the Transition Out Period, the PBM will provide access to expert data resources to support mapping, data dictionary and other data management planning and execution to support the successful establishment of the production environment.

b) Maintain Claims Data Post Transition Start at the Successor PBM. The PBM will support the ongoing maintenance of production data processed by the PBM after the start of Transition for any Aetna Customers, Covered Plans, Members and Aetna Affiliates relating to run out and other transactions processed by the PBM during the Transition Out Period.
   i) The PBM will provide regular reports and will coordinate with the Successor PBM data reconciliation process (no less frequently than monthly) throughout the Transition Out Period on key data elements as defined in the Data Transfer Transition Plan

A Detailed Data Transfer Transition Plan will be created jointly by the PBM, Aetna and the Successor PBM to assure a smooth, accurate, timely and compliant transfer of all pertinent data elements and information required to provide PBM services. This plan will include but not be limited to the following items:

a) Data Transfer Protocols
   i) Data Transfer Naming Conventions and protocols (including file size requirements)
   ii) File security and encryption requirements
   iii) File receipt and load controls (e.g., record counts, control totals and error / fall out reports and action plans)
   iv) Industry standard file formats will be used where possible. Exceptions will be granted for Aetna proprietary data.
b) Data History Load Requirements, including data and file formats and definitions.
c) Data Load Timelines for all Data Transfer files and information
d) Establishment of data quality and data transfer accuracy metrics. Files which do not meet mutually agreed upon quality standards will be rejected. Data readiness criteria to jointly confirm readiness for transition in association with the Transition Out Guarantees provided for in Schedule T.

- .Aetna must provide an attestation back to PBM affirming the confidentiality provisions of this Agreement will be adhered to in passing the information to the Successor PBM in the event that Aetna is directly providing information to the Successor PBM. If custom reporting or programming is required by Aetna at transition, PBM will charge Aetna a fee, negotiated in good faith, for such reporting and/or programming.

File Type	Comments
Claims History	Format = NCPDP Post Adjudicated Layout or one of several other standard billing file layouts
Open Refills	Format = 1667-byte industry standard layout. File excludes compounds and controlled and specialty medications.
Open Prior Authorizations	Format = 600-byte industry standard layout. Currently includes active prior authorizations only
Account Balances	PBM proprietary layout. Includes deductibles, maximum benefits, and/or maximum out of pockets
Stand Alone Pharmacy Accumulators	Format = NCPDP Post Adjudicated Layout or one of several other standard billing file layouts

ID#	Inbound	Frequency	Description of File
Inbound - 7	AI.RETROFINALBILLING	Monthly	Retro-term recoveries are monies recovered from members who have received prescription payment benefits after they have terminated from their plan. PBM will recover the monies and pay Aetna the recovered funds. Aetna Integrator will receive a retro-term billing file from PBM for recovery process. PBM recovery files contain the recovery data at the member level.
Inbound - 9	AI.RETROINITBILLING.	Monthly	Retro-term recoveries are monies recovered from members who have received prescription payment benefits after they have terminated from their plan. PBM will recover the monies and pay Aetna the recovered funds. Aetna Integrator will receive a retro-term billing file from PBM for recovery process. PBM recovery files contain the recovery data at the member level.

ID#	Inbound	Frequency	Description of File
Inbound - 11	AI.RETROPAYMENTS	Monthly	Retro-term recoveries are monies recovered from members who have received prescription payment benefits after they have terminated from their plan. PBM will recover the monies and pay Aetna the recovered funds. Aetna Integrator will receive a retro-term payment claims detail file from PBM for recovery process. PBM recovery files contain the recovery data at the member level.

Schedule U

Information Technology Systems and Services

Core Services

Service	Description
Information Technology Systems	1. System Availability. PBM's systems (external and internal facing) shall be available twenty-four (24) hours a day, 365 days a year, less any scheduled maintenance which shall be performed during non-peak hours in accordance with the Agreement, including this Paragraph 1 of this Schedule U. Scheduled maintenance shall be performed during non-peak hours and shall not exceed seven (7) hours every other month. PBM shall notify Aetna in writing in advance of any major scheduled system downtime that impacts Aetna. Scheduled downtime shall not result in a diminishment in services related to Customer Service inquires or website usage. 2. System/Software Capabilities. PBM systems shall be capable of accomplishing and supporting the ongoing needs of Aetna and Aetna Customers, including supporting all Aetna prescription benefit related business functions, including those services outsourced to current vendors (*e.g.*, other or Optional Services performed by other vendors), as well as to additional vendors Aetna utilizes following the execution of the Agreement as mutually agreed upon (which PBM shall not unreasonably withhold its agreement thereto). PBM acknowledges that Aetna and certain Aetna Customers require private labeling for their branded websites and agrees that PBM shall private label such websites as reasonably required by Aetna and Aetna Customers. Any private label customization in addition to the Aetna brand shall be subject to the provisions of Section 4 of Schedule H. 3. System/Software Compliance. PBM systems shall comply with all applicable Laws, industry standards, and legally required code sets and file formats (i.e., HIPAA, ansi, X12, NDC, etc.). PBM shall be responsible for analyzing systems and providing the necessary upgrades to maintain compliance with such Laws, industry standards, and legally required code sets and file formats. PBM shall also be responsible for analyzing systems and providing the necessary upgrades to support changes Aetna makes in its business processes and operations to ensure Aetna's compliance with applicable Laws, provided the Parties shall cooperate to allow such upgrades to be made in the most cost-effective manner practicable. 4. Attestations. PBM shall attest initially and each year thereafter, in a manner satisfactory to Aetna, during the annual process of completing the Aetna Vendor Attestation that the PBM meets Aetna requirements for information privacy and security. Changes to the requirements for information privacy and security contained in the Aetna Vendor Attestation form or such other or successor forms or documentation for

Service	Description
	such attestations after the initial year shall be consistent with industry standards. 5. Documentation Support. PBM shall supply Aetna with documentation (*e.g.*, system flows, process charts, architecture diagrams, etc.) demonstrating technology solutions and capability used or proposed for use in the delivery of PBM Services and other services PBM provides under the Agreement. On an ongoing basis, PBM will use commercially reasonable efforts to proactively provide updated or new documentation to Aetna based on PBM's good faith understanding of Aetna's needs or upon Aetna's reasonable request. Further, to the extent that PBM undergoes material systems, process or infrastructure changes/modifications that impact Aetna, then PBM will provide Aetna with reasonable advance written notice. PBM shall ensure and provide documentation to Aetna that all commercially purchased hardware and software products are currently supported by the applicable hardware and/or software vendor. Aetna agrees to maintain the confidentiality of the materials described in this Section in accordance with the Agreement. 6. Hardware/System/Software Upgrades. PBM shall upgrade all hardware, software, service packs, and systems to current release levels within twelve (12) months of general availability unless (i) the new release requires major retooling of an application or (ii) it is generally accepted within the information technology industry that the current release is likely to impact system stability or reliability and Aetna reasonably agrees with such decision. If an upgrade cannot be completed within 18 months (because of major retooling or otherwise), PBM shall undertake reasonable efforts for the timely completion of the upgrade and provide to Aetna a timeline for implementation of such. PBM shall ensure that all hardware is updated at such frequency to remain on supported levels of vendor software versions and hardware. PBM shall be solely responsible for all costs related to upgrades. 7. Data Transfers. With respect to all data transfers to PBM, PBM shall provide file transfer, file processing validation, error reporting, and correction processes. PBM shall manage and report any errors and/or issues with respect to such data transfers to Aetna. 8. Data Back Up/Recovery. In addition to the requirements set forth in Section 11.2 of the Agreement, PBM shall maintain systems and management processes for backup and recovery, which at a minimum shall consist of retention and restoration methods consistent with industry standards (including images, prescription data, call recording, screen/keystroke capture, etc.) and shall restore systems within the timeframes (RTO - application availability) and data loss (RPO – data loss) parameters set forth in PBM's Disaster Recovery Tiers, as set forth in column 1 of Schedule AA.. PBM shall provide Aetna with a copy of its data back up/recovery processes initially and on an annual basis. PBM

Service	Description
	shall comply with the data back up/recovery processes Performance Standards set forth in Schedule R (Performance Standards and Service Levels). 9. Joint Development and Testing. PBM and Aetna will reasonably agree on a process for coordination of development, testing, model office usage, release schedules, and production implementations. PBM will align to Aetna's release calendar for major releases. 10. System Integration. The Parties shall work together in good faith to integrate appropriate systems so that both Parties have access to agreed upon Member pharmacy and medical information for purposes of coordination of benefits of Members. Additional system integration will be mutually agreed upon, and may be subject to fees as detailed in Schedule Y-7. 11. System Access. PBM agrees that Aetna shall have access through Citrix and/or web access to all PBM systems licensed to Aetna and any PBM system to which Aetna needs access in order to meet the ongoing needs of Aetna and Aetna Customers, including with respect to all Aetna prescription benefit related functions. PBM will be responsible for establishing and maintaining all system access requirements as defined by Aetna. All system access requests by domestic Aetna employees, including contingent workers, must be processed completely and accurately within a ten (10) business day turnaround time. Requests for Aetna offshore requests may require an additional ten (10) business days to complete. Recognizing that twenty (20) business days is a very long period of time for system access approvals, the Parties agree to work together cooperatively to seek to develop a process that reduces this turnaround time. Furthermore, all such employees requesting access shall receive notice from PBM that they have such access at the end of the turnaround time. 12. Capacity and Scalability. PBM shall have an annual capacity and software scalability program in place. PBM shall demonstrate the ability to monitor performance and scale systems and processes as needed to support initial and ongoing business volume. During the business migration period, PBM shall implement ongoing capacity/scalability meetings with Aetna to demonstrate readiness to absorb and service Aetna business volume. PBM shall reinstitute such meetings at Aetna's request if required post migration 13. PBM agrees to maintain existing data interchange process and formats as of the effective date. To the extent that new data interchanges or formats are required, PBM and Aetna will work in good faith to mutually agree to industry standard or better. If the change is initiated by PBM and solely for the purpose of internal PBM needs, PBM will work with Aetna to reimburse Aetna for costs associated with such change. If Aetna requires changes to the existing data interchange process, Aetna will be responsible for reimbursing CVS Caremark for reasonable costs associated

Service	Description
	with such change. 14. [Reserved]
Information Technology Support Services	15. <u>IT Management</u>. a. PBM shall manage systems development through industry standard project management and application development lifecycle methodologies. Project work products regarding or impacting Aetna and/or Aetna Customers will be jointly developed with Aetna where Aetna determines it to be necessary and all project plans, test plans, test results, business requirements, etc. regarding Aetna or impacting Aetna or an Aetna Customer will be shared with Aetna. b. PBM shall accept requests from Aetna for IT work not included in the Agreement and provide an estimate of the work, cost, and timeline to complete the request. Such estimates shall be provided within five (5) Business Days from completion of the requirements. c. PBM shall have and maintain a status reporting mechanism acceptable to Aetna that provides: (i) weekly and monthly project summary reporting; (ii) problem identification, escalation, and resolution reporting; (iii) testing results reporting; and (iv) project oversight and change order reporting. Upon Aetna's request and in a time and manner reasonably required by Aetna, PBM will provide any additional reports reasonably requested by Aetna. d. PBM shall monitor industry and technology issues and events and ensure systems and processes are upgraded and enhanced to provide Aetna with improved efficiencies, real-time integration and industry standard security and privacy protection in compliance with reasonable industry standards. 16. <u>Issue Tracking, Escalation, and Resolution</u>. a. PBM shall maintain systems and management processes acceptable to Aetna to identify and track IT related issues in accordance with the following priority classifications based on Priority: i. Priority 1: Critical problem, system failure, significant data corruption, etc. with no workaround, causing total loss of function or creating critical impact to PBM's business process. ii. Priority 2: Selected capability not functioning with no workaround possible, causing services to go down or to deliver inconsistent availability or degraded services to broad class of users, but is not halting PBM's business process. iii. Priority 3: Selected capability not functioning, workaround possible, causing minimal impact on PBM's business process. iv. Priority 4: Limited problem with minimal impact, cosmetic or

Service	Description
	non-critical bug, but functions of the application and system are operating, causing little or no impact on business process. b. PBM shall maintain systems and management processes acceptable to Aetna to notify and escalate IT related issues to Aetna, including the following in the event of a Priority 1 and Priority 2 IT related issue: i. PBM shall notify Aetna in writing of Priority 1 and Priority 2 IT related issues within the time period specified in Schedule R (Performance Standards and Service Levels), which such notice shall identify the priority classification, a description of the issue, root causes (if known), and proposed resolution (as available). ii. PBM shall have a team of individuals dedicated to and responsible for coordinating efforts and communications from the initial report of the Priority 1 or Priority 2 IT related issue throughout the cycle of investigation, determination, and resolution. Aetna IT staff may opt to participate in recovery assessment and planning meetings. iii. PBM shall provide Aetna with reports concerning the progress of the team ("Progress Reports") in resolving Priority 1 and Priority 2 IT related issues in accordance with the Performance Standards set forth on Schedule R (Performance Standards and Service Levels/Major PBM Defaults). c. With respect to Priority 3 and Priority 4 IT related issues, PBM shall provide reports in accordance with Schedule V (Reporting). d. PBM shall maintain systems and management processes reasonably acceptable to Aetna to resolve all IT related issues in accordance with the Performance Standards set forth on Schedule R (Performance Standards and Service Levels/Major PBM Defaults). 17. Continuity. PBM shall provide for operational processes to automatically rollover from the primary to a secondary system ("Failover") in the event of a system failure or disaster in accordance with the Performance Standards set forth in Schedule R (Performance Standards and Service Levels).
IT Related Vendors	18. PBM shall be responsible for and shall manage the relationships with all IT related vendors and shall be responsible for all costs and expenses with respect to such, including costs and expenses related to Emdeon/Per Se, switches, telecommunications, E-prescribing vendors, voice circuits, and data circuits, etc. 19. PBM acknowledges and agrees that in providing the IT services hereunder, from time to time Aetna may designate others (*i.e.*, consultants, fulfillment/print vendors, Affiliates of Aetna, etc.) for PBM to work with

Service	Description
	in connection with the IT services, including working with Aetna and/or Aetna designee(s) to identify and document IT work necessary to support Aetna's pharmacy benefit management business, including operational workflows and detailed business requirements, design, development, testing and implement systems and enhancements; provided, however, PBM shall not be required to provide proprietary information to a competitor.
Role Based Access	20. All internal PBM systems utilized to accomplish the ongoing needs of Aetna and Aetna Customers, including supporting all Aetna prescription benefit related business functions, will provide robust access controls for system security based on (i) specific role codes (or equivalent) architected to govern the functionality within the system, (ii) role codes to determine specific authorized levels of access and specific capabilities within the system (least privilege), and (iii) specific resources within the system permitted for access by an authorized agent. Such access controls, coupled with credential based authentication, group based authorization, additional internal system restriction flags as well as custom database view design allow for a comprehensive approach to protecting sensitive client data. All core PBM systems can log internal and external user activity and associated transactions. PBM will administer access to ensure Data and Information relating to Aetna, Aetna Affiliates or Aetna Customers remains inaccessible by any individuals other than Aetna or PBM employees, advisors, consultants and subcontractors with job functions requiring access to such Data and Information ("Authorized Employees"). PBM will also manage all business processes and ensure that all such Data and Information will be appropriately controlled and access to such Data and Information is restricted solely to Authorized Employees. All external PBM systems will provide for appropriate user authentication and authorization to ensure that all such Data and Information is protected from unauthorized access.
Systems Training	21. In a time, manner and frequency as agreed by the Parties, and further to Article VI of the Agreement, PBM shall provide specific training to Aetna trainers on all requirements applicable to understanding, and gaining access to, PBM's systems prior to go-live activities. . Training shall meet the following requirements: a. All training materials will be reviewed by Aetna before training sessions commence. b. PBM shall maintain and update training materials in collaboration with Aetna. c. All newly hired Aetna-designated employees shall receive the same comprehensive training by Aetna trainers. d. PBM shall provide ongoing and refresher training for Aetna

Service	Description
	trainers in a time, manner, and frequency as reasonably requested by Aetna, but no less than once a year. e. Notwithstanding the foregoing, if required by Law or on account of an urgent event as determined by Aetna in its sole discretion, training must be made available to Aetna-designated employees as soon as possible. f. Aetna shall maintain responsibility for tracking and monitoring of all Aetna employees requiring training. Aetna shall also maintain responsibility for ensuring that any Aetna users coordinate training activities for any missed training sessions.

Schedule V

Reporting

Core Services

Service	Description
General Requirements	1. PBM shall provide Aetna in a timely manner all data and reports that Aetna reasonably needs to meet its business and legal requirements consistent with the data and reports that Aetna receives as of the Effective date and such other data and reports as are mutually agreed by the Parties. Aetna shall provide to PBM all data fields which do not reside in PBM's system as of the Effective Date. Without limiting the generality of the foregoing, this Schedule V (Reporting) sets forth some of the specific reporting requirements of Aetna. 2. All reports and data shall be provided in accordance with this Schedule V and in a mutually agreed upon format and content. Content must be consistent with the specifications Aetna uses as of the Effective Date, excepting CMS-mandated reports and State Plan-mandated reports, which shall comply with Aetna requirements and CMS requirements and State Health Care Program and/or State Plan respectively. PBM shall provide Aetna with samples of all reports and data formats, which shall be subject to Aetna's review and approval. 3. Unless otherwise specifically identified, all reports and data described herein shall be available: (i) across all Aetna business (collectively); (ii) on an Aetna Customer specific basis; (iii) on a per Covered Plan basis (including at the group level); (iv) on a regional basis; (v) on a type of business (*e.g.*, Medicare Part D, State Health Care Program, workers' compensation, and commercial) basis; and (vi) for Medicare Part D, at a Plan Benefit Package level. Required data fields include: group data, benefit data, clinical data, drug data, authorization data, pharmacy provider data, pharmacy network data, reject data, and physician data. 4. Unless otherwise specifically identified, all reports and data described herein shall be provided to Aetna via an Aetna branded secure website (i.e., Aetna Customer portal). PBM shall provide daily, monthly and quarterly data loads to the PBM Vendor Data Warehouse based on Aetna's approval of load schedule. PBM reports and data shall be available for use via self-service reporting via query tools within three Business Days following each data load. PBM shall not run reports or data extracts prior to the third (3rd) Business Day following the end of the applicable period. Automated reports will run on a schedule mutually agreed upon by PBM and Aetna based on customer requirements and/or contracts. 5. PBM shall provide self-service tools to access PBM data including all standard, custom and ad hoc reports to Aetna.

Service	Description
	6. PBM shall implement logic to track and report Member Claims experience within a Plan year and across multiple Plan years for the purposes of claim adjudication at the point of sale.
Standard Reports	7. PBM shall provide to Aetna all standard reports that it provides to any and all other PBM customers in the manner it provides such reports to other customers and in the time frames required by Aetna as set forth in paragraph 4 above of this Schedule V (Reporting), unless otherwise directed by Aetna in writing. Such standard reports shall include at a minimum those reports identified in each of the Schedules to the Agreement and those reports set forth in Schedule V-1 (Standard Reports) hereto.
Custom Reports	8. PBM shall develop and provide to Aetna custom reports requested by Aetna in format reasonably agreeable to the Parties. A custom report is a report created and provided to Aetna that is continuously maintained by PBM and provided periodically to Aetna as described herein. Based on currently available data, Custom reports may include Aetna specified reports supporting, for example, clinical programs provided in accordance with Schedule J, accountable care organizations ("ACO"), health insurance exchanges, etc.
Ad-Hoc Reports	9. PBM shall develop and provide to Aetna reports requested by Aetna on an ad-hoc basis. Unless otherwise mutually agreed to by the Parties, PBM shall deliver each ad hoc report requested by Aetna to Aetna within Performance Standard requirements set forth in Schedule R (Performance Standards and Service Levels/Major PBM Defaults). An ad hoc report is a report created and provided to Aetna only one time and is not maintained on an ongoing basis. An example of ad hoc report is the Multiple Active Member report. 10. Without limiting the generality of the foregoing, PBM shall provide all ad-hoc data analysis reasonably agreeable to the parties within the timeframes reasonably requested by Aetna.
Governmental Body Required Reports	11. PBM shall develop and provide to Aetna upon request reports required by Governmental Bodies as applicable to Aetna, Aetna Affiliates, and Aetna Customers with respect to PBM Services within reasonable time to allow Aetna, Aetna Affiliates, and Aetna Customers to review and submit such report to the applicable Governmental Body in accordance with the timeframe and format mandated by applicable Law.
Connectivity and Data Analysis Tools	12. PBM shall provide to Aetna the connectivity and data analysis tools set forth on Schedule V-2 (Connectivity and Data Analysis Tools) hereto, in addition to any other connectivity and/or data analysis tool requirements referenced in the Agreement or the Schedules not otherwise set forth in Schedule V-2 (Connectivity and Data Analysis Tools), as well as any other connectivity and/or data analysis tool requirements requested by Aetna. 13. PBM shall assist Aetna in identifying additional data needs to support Aetna

Service	Description
	integrated reporting for its lines of business and shall provide reasonable support of such additional data needs.
Quality Assurance	14. PBM shall have a quality assurance program and commercially reasonable testing to ensure that data and reporting submitted to Aetna and to any Governmental Body on behalf of Aetna or an Aetna Customer by PBM is accurate and complete as compared to mutually agreed upon written requirements. Inaccurate reports shall be subject to penalties as described in Schedule R (Performance Standards and Service Levels) and subject to operational audits as outlined in Schedule X (Audits). 15. PBM shall provide Data Warehouse load statistics and monitoring reports to Aetna on a weekly basis. 16. Data accuracy shall be subject to penalties as described in schedule R (Performance Standards and Service Levels). 17. The Data Quality and Monitoring Committee as referenced in Schedule Q (Description of Committees) shall perform quarterly quality assurance evaluations of the reports described above.
Certification	18. PBM shall provide Aetna with complete and accurate encounter data by type of service rendered to Members in the form and manner as specified by Aetna. PBM shall certify that such encounter data is truthful and complete.
Turn around times	19. All report requests to PBM shall be completed in a reasonable timeline with the goal of ten (10) business days. The timeline will be dependent on the number and complexity of requests. PBM shall notify Aetna if a report will require more than ten (10) business days to complete and consult with Aetna to establish a reasonable alternative timeframe.
Documentation	20. PBM shall provide comprehensive documentation of all tables and fields for all data reporting and data sources. Upon Aetna's reasonable request in response to specific Aetna business needs, PBM shall provide (i) mapping of data fields used by Aetna to PBM source data, together with the definitions of those fields; and (ii) documentation of load and transformation processes for data.
Report request process	21. PBM and Aetna shall establish a process for requesting reports not available through self-service tools. PBM shall process requests within agreed upon timelines per Paragraph 19 above.
Data liaison	22. In accordance with Schedule BB (PBM Dedicated and Designated Personnel), PBM shall identify a Data and Analytics Manager responsible for identifying appropriate resources within PBM to address and resolve any reporting or data issues. 23. Liaison shall track data issues and provide estimate for correcting the issue.

Service	Description
Clinical Program Reporting	24. PBM shall provide self-service tools and/or reports (consistent with the provisions of Paragraphs 19 and 21 above) to support clinical programs referenced in Schedule J.

Schedule V-1

Standard Reports

Report Type	Report Description	Frequency	Section/ Schedule
PBM Standard Suite of Reports	All PBM reports included in PBM's standard suite of customer reports customizable, as mutually agreed upon, by a variety of potential parameters, including book of business, segment, product, funding, etc. and shall include, the following: operational, clinical, network, Medicare, and account management reports; key performance indicator reports; utilization summary reports; utilization trend reports (including identification of trend drivers); PMPM trend reports; Cost Share reports; Member profiles; top X Members; top X drugs; top N diseases; drug market share; top X prescribers; physician profiles; pharmacy profiles by therapeutic class; top X pharmacies; top N chains; executive summary; financial performance reports; preferred drug utilization reports; drug utilization review reports; pharmacy utilization reports; clinical program results; Specialty Product reports; coverage authorization reports; coordination of benefits activity reports; and all CMS required Part D reporting. PBM shall provide Aetna sample of existing reports and formats for Aetna's review and approval.	In accordance with PBM standard reporting frequency	N/A
Transition-In Phase Reporting (initial and on-going)	Transition Status Reports	In accordance with Schedule Q (Committees) and Schedule A	Schedule Q Schedule A
Data Quality	Data Warehouse tracking report which outlines data quality issues and resolution	Weekly	Various
Operational	Progress log for tracking the status of Benefit Plan Design (including Formularies) loads/updates, implementations, tests, and corrections, including the status of work completed and pending	Weekly	Schedule B
	Quality assurance program results for set-up and administration of Benefit Plan Designs (including Formularies)	Monthly	Schedule B

Report Type	Report Description	Frequency	Section/ Schedule
	All Eligibility Data transactions	Within an average of four (4) hours of completion of each Eligibility Data transaction	Schedule C
	Eligibility error trends reports	Quarterly	Schedule C
	Manual eligibility override reports, identifying all manual eligibility updates processed by PBM	Weekly	Schedule C Schedule E
	Retro-termination eligibility recovery program reports, identifying overpayments, recovered overpayments, and dates of communications to Retro-Term Members	Monthly	Schedule C
	Claims files (with daily electronic data feeds) that contain Covered Plan and Member-specific identifiers that are consistent with Aetna's mechanism for identifying Covered Plan and Member, including processed Claim information (including Claims paid and Claims deemed non-payable), Member Cost Share, ingredient costs, Claims inventory (including an aging analysis), and other details as required by Aetna. Claims files shall be in Medi-Span format/value and provide the Medi-Span GPI code number and the Medi-Span Generic Indicator code and other Aetna specified fields.	Daily Claims data extracts of the prior day shall be made available by PBM to Aetna via FTP in Aetna specified format within twenty-four (24) hours of the end of the prior Business Day. Cycle Claims data extracts shall be made available by PBM to Aetna via FTP in Aetna specified format within twelve (12) hours of the end of the PBM pharmacy payment cycle.	Schedule D
	Claims adjudication accuracy and trend reports (including consultative recommendations for improving the adjudication rates)	Monthly	Schedule D

Report Type	Report Description	Frequency	Section/ Schedule
	Claims processing error adjustment reports, identifying the "before and after" status of the Claims	Within ten (10) Business Days after reprocessing and/or making the applicable financial adjustments to the Claims	Schedule D
	Coordination of benefits savings reports	Quarterly	Schedule D
	Report of total pharmacy transactions denied due to the need for prior authorization, total number of prior authorizations requested, and total number of prior authorizations approved	Monthly	Schedule D Schedule K
	Manual Claims turn-around time	Monthly (or as otherwise requested by Aetna)	Schedule D
	Claim payment and overpayment recovery as a result of Claim processing errors.	Upon Aetna's Request	Schedule D
	All testing results at the overall Aetna level as well as at the impacted Aetna Customer and Covered Plan levels.	Within twenty-four (24) hours after testing complete	Schedule D
	Comparison report of MAC drugs to rebatable multi-source Brand Drugs that are generically available	Monthly Quarterly Annually	Schedule D
	Point-of-sale rebate reports	Monthly (or as otherwise requested by Aetna)	Schedule D
	Customer service reports including: a. Daily Total Service Factor ("TSF"), Average Speed of Answer ("ASA"), call volume handle time, and abandonment rate for all telephone queues servicing Aetna and Aetna Customers; b. PBM will provide prompt (within thirty (30) minutes) notification to designated Aetna	As designated	Schedule E, Schedule R

Report Type	Report Description	Frequency	Section/ Schedule
	personnel if) (i) Cumulative TSF for any business line falls below 70% OR (ii) if wait times exceed ninety (90) seconds OR (iii) the possibility of call blockage may occur or exists. Notifications will include root cause and remediation steps taken. PBM will follow with periodic communications to the resolution of root cause as well as hourly progress reports until service returns to acceptable levels. c. PBM will provide daily reporting which will include "snap shot" views at 11am and 5pm, 7 days per as well as nightly (same day) feeds in Aetna's call toolkit report for all sites taking Aetna calls. Aetna can reasonably request additional reporting during critical periods e.g. Open Enrollment, beginning of every year – first 2 weeks of January or to support unique business needs. Reporting will be provided at no additional costs to Aetna. d. Monthly IVR closure rates and IVR self service trends by category for all telephone queues servicing Aetna and Aetna Customers; e. Monthly call trending reports, identifying call type patterns, processing and volume; f. Daily internet inquiry turn around time and inventory authentication rate; g. Weekly, monthly, quarterly, and annual cumulative results for TSF, ASA, and abandonment rate for all queues and internet inquiries.		
	Aetna Customer service level specific reporting, containing Aetna Customer-specific performance metrics, on a schedule required by Aetna, based upon Aetna's Contract with the applicable Aetna Customer. Consistent with SLA requirements, but reported at the Plan Sponsor level.	As designated by Aetna	Schedule E
	Member complaint and grievance tracking reports	Monthly	Schedule E
	Reporting for electronic prescribing transactions,	Monthly	Schedule F

Report Type	Report Description	Frequency	Section/ Schedule
	including detail regarding, at a minimum: number of transactions by certified e-prescribing vendor, number of transactions by prescriber, e-prescribing vendor name, e-prescribing vendor type of transaction, e-prescribing vendor transactions rejected by vendor, prescriber national provider identifier, prescriber zip code, prescriber name and type of transaction.		
	Report on the Generic Drug dispensing rate	Monthly	Schedule Y
	Rapid retrospective DUR reports	Upon Aetna's request	Schedule F
	DUR Reports	Upon Aetna's request	Schedule F Schedule F-3
	Report on utilization and self-service metrics for each website (i.e., Member, Participating Pharmacy, Provider, and Aetna Customer websites)	Quarterly	Schedule H
	Report of prior authorization turn around times and accuracy	Daily	Schedule K
	Report of prior authorization statistics (including percent approved and denied)	Monthly	Schedule K
Accountable Care Organizations	Reports necessary to manage ACO business (requiring PBM to be able to accurately identify ACO claims, Members, groups)	Upon request	
Account Management	Account management and sales support reporting, as provided in Schedule L (Sales Support and Account Management Services)	Upon Aetna's request and as required by Schedule L (Sales Support and Account Management Services)	Schedule L Schedule L-1
	Reports with details and analyses of quality-related measures, including Member and Aetna Customer satisfaction and resolution of complaints and inquiries	Quarterly	Schedule E

Report Type	Report Description	Frequency	Section/ Schedule
	Required tools, data access, and reporting sufficient to enable Aetna to effectively provide account management and sales support, including implementation information; monitor/track the implementation process and accuracy, as provided in Schedule L (Sales Support and Account Management Services); complete and/or provide to Aetna tools to complete financial analysis at Aetna's request	Daily Monthly	Schedule L Schedule L-1
Customer Reporting	Aetna Customer specific utilization reports with recommendations for Aetna Customers addressing various items including financial, utilization, clinical, operational and customer service performance, and other relevant analysis data points and/or speaker notes	Quarterly (and upon Aetna's request)	Schedule L Schedule L-1
Clinical Reporting and Analytics	Reports on clinical program statistics, trends, and efficacy	Monthly Quarterly Annually	Schedule J
	Report on the medication adherence rate as defined by Aetna (differentiating adherence of new starts vs. continuers)	Monthly Quarterly Annually	Schedule J
	Reports identifying potential treatment gaps, under/over utilization, inappropriate use, co-morbidity, poly-pharmacy and poly-prescriber utilization	Monthly Quarterly Annually	Schedule J
	Report of drugs in the pharmaceutical pipeline including Specialty Products with expected impact to current trends	Monthly Quarterly Annually	Schedule J
	Reports/data feeds containing all data reasonably available to PBM to support Aetna clinical program and to feed Aetna's Health Connection ("AHC") system and personal health record ("PHR")	Daily	Schedule J
	All data and outcomes resulting from PBM's internal clinical studies and analyses to the extent not contractually prohibited.	Ad Hoc	Schedule J
	All data necessary to bill Aetna Customers for clinical programs in a format acceptable to Aetna	Monthly Quarterly Annually	Schedule J
	Report of outcomes and return on investments of all	Monthly	Schedule J

Report Type	Report Description	Frequency	Section/ Schedule
	clinical programs	Quarterly Annually	
	Reports on specific clinical interventions, Benefit Plan Design changes and other actions to allow for the timely assessment of these interventions from both clinical and financial vantage points	Monthly (and upon request)	Schedule J
	All PBM P&T committee standard clinical monographs developed by PBM, together with all available Aetna-specific supporting data and analyses	Quarterly Annually	Schedule J
	Standard PBM Reports for quality measures related to Participating Pharmacies to support NCQA and URAC accreditation	Monthly Quarterly Annually	Schedule J
	Prior Authorization Request data electronically in Aetna specified format to include all information as necessary for all state, federal, and CMS requirements, and NCQA and URAC PBM accreditation standards, including data to demonstrate compliance with such requirements and standards.	Daily (and in real time by a mutually agreed upon date in the future	Schedule K
	Drug recall reporting	Upon occurrence	Schedule J
	Necessary ad hoc data analysis and administrative and clinical suggestions to support Aetna's clinical goals and improve member safety and health outcomes	Upon Aetna's request	Schedule J
	All data reasonably available to PBM and needed for Aetna integrated care management programs	Monthly Quarterly Annually	Schedule J
	All URAC clinical quality reporting measures	Quarterly	Schedule J
Network Reporting	Pharmacy prompt pay reports, including late Claim/interest payment reports	Monthly Quarterly Annually	Schedule G
	Pharmacy complaints, grievance, and appeals reports	Upon Aetna's request	Schedule E Schedule G
	Credentialing/re-credentialing reports	Monthly Quarterly Annually	Schedule G

Report Type	Report Description	Frequency	Section/ Schedule
	340B pharmacy reports	Monthly Quarterly Annually	Schedule G
	All data reporting and documentation necessary to facilitate and support all state and federal network-related filings, reporting, examination and other requirements under Law	Upon Aetna's request	Schedule G
	Participating Pharmacy geo-access reports	Monthly	Schedule G Schedule G-2 Schedule O
PBM Central Fill Pharmacies (Mail Order and Specialty Must be Reported Separately)	PBM Central Fill Pharmacies Performance Reports, to include orders/prescriptions completed, time frames for completion, orders not completed, orders received/in selection, starting and ending queues, total orders/prescription completed by day/week/month, number of cold pack orders in process/completed, percentage of orders/prescriptions filled by department and type (e.g., XLO, controlled substances by schedule, tote, cold pack, etc.). Reporting shall include prompt written notice if PBM Central Fill Pharmacies' turnaround times and requirements are not being met or are in jeopardy of not being met.	Daily Weekly Monthly Quarterly Annually	Schedule M Schedule N
	PBM Central Fill Pharmacies work-in-progress ("WIP") report applicable to Member prescriptions	Daily	Schedule M Schedule N
	Turnaround reports showing percent of PBM Central Fill Pharmacies orders shipped by day, by month, by quarter and annually	Daily Monthly Quarterly Annually	Schedule M Schedule N
	PBM Central Fill Pharmacies dispensing error reports applicable to Member prescriptions (i.e., incorrect drug or strength dispensed, incorrect packaging or shipping error) at Member level	Daily report with a rolling thirty (30) day continuous summary of dispensing errors and status Monthly summary report	Schedule M Schedule N

Report Type	Report Description	Frequency	Section/ Schedule
	All reports required by Law related to PBM Central Fill Pharmacies	As required by Law	Schedule M
	Reports to Aetna Mail Order Pharmacies as reasonably requested and at a frequency requested by Aetna Mail Order Pharmacies to keep Aetna Mail Order Pharmacies informed as to the status and condition of the PBM Central Fill Pharmacies' compliance with Schedule M (Supporting Mail Order Pharmacy Services) and other reports required by Aetna Mail Order Pharmacies to manage and control the services performed by Aetna Mail Order Pharmacies.	Upon Aetna's request	Schedule M
	Reports to Aetna Specialty Pharmacies as reasonably requested and at a frequency requested by Aetna Specialty Pharmacies to keep Aetna Mail Order Pharmacies informed as to the status and condition of the PBM Central Fill Pharmacies' compliance with Schedule N (Supporting Specialty Pharmacy Services) and other reports required by Aetna Specialty Pharmacies to manage and control the services performed by Aetna Specialty Pharmacies.	Upon Aetna's request	Schedule M
State Health Insurance Exchanges	Ability to support tools and/or reporting required by state health insurance exchanges	As Required by Aetna	Various
State Plan Reporting	All files and other reporting as and when required by State Plans.	Submitted to Aetna for review and approval at least seven (7) days prior to the required submission date to the applicable state agency. Submission to applicable state agency within timeframe mandated by applicable Law, or, at Aetna's direction, submission to Aetna or Aetna	Schedule P

Report Type	Report Description	Frequency	Section/ Schedule
		Customer within reasonable time to allow Aetna or Aetna Customer to submit to state agency within timeframe mandated by applicable Law.	
	Reporting of Participating Pharmacies' active state identification and enrollment numbers	Upon Aetna's request	Schedule P
Medicare Reporting	All files (pricing, etc.) and reporting required by CMS	Timely submission to CMS; Submitted to Aetna for review and approval at least seven (7) days prior to the CMS required submission date, except for plan comparison price files which shall be submitted to Aetna for review and approval at least two (2) days prior to the CMS required submission date. Submission to CMS within CMS required timeframes, or, at Aetna's direction, submission to Aetna or Aetna	Schedule O

Report Type	Report Description	Frequency	Section/ Schedule
		Customer within reasonable time to allow Aetna or Aetna Customer to submit to CMS within required timeframes.	
	Pricing files, pharmacy cost files and formulary files for PDP and MAPD Plans to Aetna's external vendor that provides the application used for Aetna Medicare member web access	Every two weeks	Schedule O
	BAE activity reports that comply with CMS Best Available Evidence Guidance	Daily and Monthly	Schedule O
	PDE rejected Claims needing correction by Aetna	Upon receipt from CMS, but no less than monthly	Schedule O
	Provider, pharmacy, and Member call center reporting (including calls related to coverage determination requests)	As required by CMS and as otherwise requested by Aetna	Schedule O
	Reports or access to a query/reporting tool that contain competitor formulary and benefit design through the CMS available public use files.	Refreshed on at least a quarterly basis, with new plan year data being made available no later than one week following release	Schedule O
	MTM data needed for MTM reporting to CMS	As required by CMS	Schedule O
	Financial data/reports based on Medicare specific attributes (product; CMS Contract; Covered Plan Benefit Package identification; low income cost-sharing (LICS) indicators; reinsurance, benefit tier, etc.) based on both paid date as well as date of service	Monthly Quarterly Annually	Schedule O

Report Type	Report Description	Frequency	Section/ Schedule
	All reporting under Schedule O (Medicare Services)	As required by Schedule O (Medicare Services)	Schedule O
	Part D dashboard reports	Monthly, or more frequently as requested by Aetna.	Schedule O
	All relevant data requested by Aetna to oversee PBM Services with respect to Medicare Part D.	Upon request	Schedule O
Retiree Drug Subsidy	Initial eligibility reports for each plan year	As required by CMS and Schedule S (Retiree Drug Subsidy Services)	Schedule S
	Monthly eligibility update reports	As required by CMS and Schedule S (Retiree Drug Subsidy Services)	Schedule S
	RDS discrepancy rationalization and reconciliation reports as described in Schedule S (Retiree Drug Subsidy Services)	Quarterly Annually	Schedule S
	Rebate and cost data required by CMS under the retiree drug subsidy ("RDS") program	As necessary to satisfy CMS requirements and as otherwise requested by Aetna and Aetna Customers	Schedule S
	All reporting under Schedule S (Retiree Drug Subsidy Services)	As required by Schedule S (Retiree Drug Subsidy Services)	Schedule S

Report Type	Report Description	Frequency	Section/ Schedule
Performance Standards	Reports to support Performance Standards and guarantees as set forth in Schedule R (Performance Standards and Service Levels)	As indicated in Schedule R (Performance Standards and Service Levels)	Schedule R
Audit Reporting	PBM Central Fill Pharmacies audit result reports (to Aetna Mail Order Pharmacies)	Monthly	Schedule M Schedule X
	Participating Pharmacy audit result reports	Upon Aetna's request, as required by Law, Monthly	Schedule G Schedule X
	Claim audit result reports	Quarterly	Schedule X
	Compliance audit result reports	As mutually agreed upon	Schedule X
	Data integrity review result reports	Monthly	Schedule X
	Medicare related audit result reports	As indicated in Schedule X (Audits)	Schedule X
Financial Reporting	Control reports matching Claims to PBM request for payment (showing Claim ties to invoice)	Daily	Schedule Y
	Network discount reports to support financial guarantees for Aetna and Aetna Customers	Monthly	Schedule Y
IT	IT status report for (i) project summaries, (ii) problem identification, escalation and resolution (monthly only) (iii) testing results reporting, (iv) system downtime and (v) project oversight and change order reporting (available on a project by project basis)	Weekly Monthly	Schedule U
	Aging status reports with respect to Priority 3 and Priority 4 IT related issues	Monthly	Schedule U
	Report of completion of disaster recovery testing	Annually	Schedule U
Compliance Reporting	Reports to support all legal proceedings, state and federal filings, reportings, examinations, and other requirements, including regulatory or compliance reporting, state financial audits, and department of insurance pharmacy Claim audits	Upon request	All
	Reports reflecting PBM's licensure and registration required to perform services under the Agreement in the required states (such as third-party	Upon request	All

Report Type	Report Description	Frequency	Section/ Schedule
	administrator licenses or registrations), including detail on all licensure and registration applications and renewals of applications		
	Fraud, waste and abuse reports	Monthly	All

Schedule V-2

Connectivity and Data Analysis Tools

Service	Description
General Connectivity	1. PBM shall provide to Aetna connectivity to PBM systems used for PBM Services and shall ensure interface and compatibility of such PBM Systems with Aetna's systems. This connectivity shall be available to Aetna twenty-four (24) hours a day, seven (7) days a week, 365 days a year, less any scheduled maintenance which shall be performed during non-peak hours in accordance with Schedule U. PBM shall provide all required mapping/conversion. 2. Without limiting the generality of the foregoing, PBM shall ensure with cooperation from Aetna, appropriate and continuous connectivity as the business needs of Aetna dictate, including matters relating to: (i) establishing appropriate communication links and systems support between the Parties, including any third party identified by Aetna, for technology services support; (ii) workers' compensation support, (iii) interfacing, development, and appropriate testing for Member enrollment or termination, paid Claims, any medical data used for evidence based practice decisions if available, lab data if available, Providers, and Covered Plans; and (iv) providing on-going education and support to Aetna personnel with respect to the usage of PBM's software and hardware 3. PBM shall provide Aetna with real-time, online remote self-service data access, reporting, and tools as set forth herein. The databases related to such self-service data access, reporting, and tools shall be continually updated (and in all cases, unless otherwise specified, on at least a daily basis) and shall be in a form and format reasonably acceptable to Aetna. The databases shall contain not less than three (3) years of past data plus current data. 4. The connectivity hereunder shall allow Aetna to review, extract, run and publish reports, use the tools hereunder, etc, based on the following: (i) across all Aetna business (collectively); (ii) on an Aetna Customer specific basis; (iii) on a per Covered Plan basis (including at

Service	Description
	the group level); (iv) on a regional basis (as defined in the Plan hierarchy); and (v) on a type of business (*e.g.*, Medicare Part D, State Health Care Program, and commercial) basis. 5. PBM shall ensure the integrity, accuracy, and validity of the data from which the data extracts, reports, and tools contemplated hereunder will be provided and run and that all data used or included in each report and data accessed by Aetna will reconcile with data in all other reports and with all other data accessed by Aetna. 6. Any and all software (including software that PBM owns or licenses from an unrelated third parties) to which Aetna has connectivity necessary for or related to the PBM Services provided by PBM to Aetna will include a fully-paid, nonexclusive license for Aetna Users access and use during the Term and during any transition period. PBM shall ensure that its software systems and related intellectual property and their use by Aetna hereunder does not infringe upon or use without permission any third party's intellectual property.
Data Access - Aetna	7. PBM shall provide to Aetna real-time, online remote access to the PBM database, of Aetna data as required by Aetna, which shall include Claims data, Claims payment, drug usage, Benefit Plan Design, clinical data, banking and reconciliation, operational reporting, pharmacy demographics, Formulary tables, etc.), including the following: PBM shall provide the Aetna pharmacy data team with access to all tables the team will need to do queries and reporting. a. Read access to drug files and coverage and exclusion tables for restrictions and Formularies; b. Read access to the drug databases for the purposes of drug lookup for detailed drug parameters including: drug pricing (AWP, WAC, direct, average AWP), therapeutic drug classification names and codes, drug status codes, J code conversion, distribution and packaging codes, Medicare indicators; c. Read access to AWP and MAC pricing; d. Read access to online messages; e. Read access to processed Claims, including medical prescription Claims data; f. Read access to Claims payment information, including Participating Pharmacy payment information; g. Read, and edit access to case notes, including all care management data (including Case Management ("CM"), Utilization Management ("UM"), and Disease Management ("DM")); h. Read access to PBM's Customer Relations Management ("CRM") application as described in Schedule E (Customer and Member Service);

Service	Description
	i. Read, and edit access to PBM's claim adjudication system as provided in Schedule E (Customer and Member Service); j. Read access to PBM's real time, web-based Claim/Aetna Customer service information (which shall include all NCPDP data fields related to the drug Claim), as provided in Schedule F (Prescription Drug Utilization Review); k. Read access to all Member specific written or electronic communication that is sent to the Member, the Provider, or an Aetna Customer in connection with Schedule F (Prescription Drug Utilization Review); l. PBM shall make available to Aetna approved auditor, per Article 7 of the Agreement, Aetna specific data to support their rebate audit. m. Read access to the PBM claim/customer service information and all PBM communications to Members, prescribers and Aetna Customers (all as necessary to enable such review function, as provided in Schedule J (Clinical Services and Formulary Administration)); Read and query access to PBM's prior authorization application, as provided in Schedule K (Prior Authorization Services); n. Read, and edit access to claims system to override clinical criteria as required, or an acceptable alternative; o. Read, and edit access to PBM claim, clinical, and other systems necessary for investigating issues, overriding clinical decisions, etc.; p. Read access to accumulators, flexible spending account ("FSA"), health reimbursement account ("HRA") and health saving account ("HSA") balances in real-time with Aetna and vendors designated by Aetna vendors (i.e. CDHP, lifetime max, dollar limits, annual limits, lifetime visits max, annual visits limits, etc.), including HDHP accumulators with medical in accordance with Schedule D (Claims Processing and Adjudication); q. Access to Account Management Systems as identified in Schedule L-1 (Account Management Systems); r. Read access to customizable, dashboards, as they become available, that visually display key performance indicators in a consolidated, high-level format and are arranged on a single screen so the information can be monitored at a glance. In the manner specified by Aetna, all dashboards shall provide intuitive indicators, such as gauges and stoplights, which are instantly understandable - for example, red bar means problem, and green bar means everything is on plan. s. Read access to PBM Central Fill Pharmacies (mail order and specialty) Pharmacy Systems.

Service	Description
	t. Ability to load temporary tables to vendor reporting data stores. u. Ability to use SAS for querying against vendor reporting data stores. 8. PBM shall provide query access to data contained within the data warehouse. 9. PBM shall initially load thirty-six (36) months of Aetna historical data identified by Aetna (*e.g.*, Claims, Member and group Eligibility Data, benefits, etc.) to PBM reporting data store for access by Aetna. 10. PBM shall provide all data (i.e., Claims data) using Medi-Span values in accordance with Aetna requirements, including the Medi-Span GPI code number and the Medi-Span Generic Indicator code and other Aetna specified fields.
Data Reporting Programs	11. PBM shall provide Aetna with access to all of its real-time, online remote reporting programs/packages (including any subsequent updates and/or replacements) with respect to Aetna data, which shall include the following reporting functions: a. Provide reports by drug, Generic Drug code, therapeutic class, Member, and Provider. b. Provide trend reports of utilization by Aetna Customer, Formulary compliance, market share by drug, Provider, and Member Cost Share. c. Provide for the review and printing of Member, Participating Pharmacy, and Provider profiles. d. Provide for ad hoc query and review of eligibility by individual Member or Member demographic groups, Provider information, and Benefit Design and drug utilization by Aetna Customer. e. Provide outcomes analysis reporting which enables Aetna to evaluate and manage the cost effectiveness, quality, and efficiency of its Benefit Plan Designs. f. Provide outcomes analysis reporting which enables Aetna to identify utilization, prescribing, and benefit trends to enable Provider, Participating Pharmacy, Aetna Customer, or Member interventions by Aetna. g. Provide the capability for Aetna to do ad hoc reporting and creation of complex queries against PBM reporting data store; capability shall allow Aetna to create queries with complex code such as case statements to extract data and create reports that are not available using standard templates. h. Provide the capability for Aetna to report and support billing at the Aetna Customer level. i. Provide Aetna with an ad hoc query tool to access a claims

Service	Description
	utilization database to meet varied reporting needs of actuarial, product, clinical, . j. prior authorization, manufacturer contracting, etc., with daily refreshes of data within 72 hours of claim processing –individual, group, plan level, including Prescription Drug Plan ("PDP") and Medicare Advantage Prescription Drug Plan ("MA-PD") at Plan Benefit Package ("PBP") level and as otherwise provided in Schedule O (Medicare Services). PBM will provide ad hoc query tool that will allow Aetna users to do comprehensive reporting creating complex queries with all types of joins to multiple tables. Provide the capability for Aetna to run ad hoc reports of PBM's compliance with the Performance Standards set forth on Schedule R (Performance Standards and Service Levels/Major PBM Defaults) across all lines of Aetna's business or on a Covered Plan basis.
Data Analysis Tools	12. PBM shall provide Aetna with real-time, online remote access to data analysis tools, which shall provide the following functionality: a. Data to support clinical programs and integrated analytics as set forth in Schedule J (Clinical Services and Formulary Administration), including data needed for all clinical programs managed by PBM, retro-DUR, Aetna's Health Connection systems, Aetna's integrated care management programs, personal health record, clinical study data, and drug trends. b. Methodology for calculating return on investment of all clinical programs, including all data needed for oversight and calculation of return on investment calculations. c. Automated analysis of network access (including national and custom networks), using CMS approved software, including a mapped presentation of said analyses to facilitate sales support, which shall reflect Participating Pharmacies in network and be refreshed on at least a weekly basis. d. Analyze budgeting variances, the possible financial impact of proposed Benefit Plan Design changes, and the appropriateness and sufficiency of Participating Pharmacy access and services. e. Financial analyses and benefit modeling in support of strategic Aetna Customer discussions in connection with the services under Schedule L (Sales Support and Account Management Services). f. Enable Aetna to effectively provide new client installation or Benefit Plan Design change information to Aetna Customers, while providing the ability to monitor/track the installation/Benefit Plan Design changes in connection with the services under Schedule L (Sales Support and Account Management Services). g. Prescriber profiling tools.

Service	Description
	h. Interactive tool for specific pharmacy reports pertaining to clinical program statistics, trends, & efficacy, which allows Aetna users to customize reports based upon any predefined data fields determined by Aetna and PBM. Examples include NCPDP (National Council of Prescription Drug Programs) defined data fields, prescriber's national provider identifier matched with prescriber name, specialty, address (e.g., zip code) and data fields that identify Aetna groups, Aetna Customers, Aetna service areas, Aetna regions, funding type of plan (self-insured, fully insured, partial funding) and Aetna defined product type of plan (HMO, PPO, Medicare, State Health Care Program, etc.). 13. PBM's financial analysts dedicated to Aetna shall provide Aetna with real time, online remote access to a reporting data store that incorporates industry benchmark data as well as PBM book of business data for comparison to Aetna's book of business and for Aetna Customer reporting. In addition, PBM's financial analysts dedicated to Aetna shall provide comparison benchmark data based on Aetna Customer business type using mutually agreeable classification codes. 14. Upon Aetna's request, PBM shall provide Aetna with a report, analyzing budgeting variances (i.e., financial impact analysis related to changes in plan benefit design and pharmacy network), the possible financial impact of proposed Benefit Plan Design changes, and the appropriateness and sufficiency of Participating Pharmacy access and services, including recommendations by PBM related thereto. 15. All data provided will be in accordance with the Medi-Span therapeutic and drug classification system and as otherwise required by Aetna in accordance with Schedule F (Prescription Drug Utilization Review).
Aetna Users	16. PBM shall provide Aetna (and Aetna Customers) with web-based access through PBM supplied Aetna branded portals to standard reports, ad hoc query application and modeling application. 17. PBM shall provide Aetna and designated Aetna Customers online remote access to Aetna Customer reporting, modeling and analytic tools. Aetna Customer access to these tools will be delivered via Aetna's Aetna Customer portal. 18. PBM shall provide the database access, reporting programs, and data analysis tools under Schedule U (Information Technology Systems and Services) to a reasonable number of Aetna and Aetna Customer personnel as designated by Aetna ("Aetna Users"), who shall have real-time, concurrent access.
Training	19. In a manner, location, and frequency reasonably acceptable to Aetna, PBM shall provide initial and ongoing training of the appropriate user personnel, as reasonably determined by Aetna, on all applicable PBM network software and hardware, as applicable, as reasonably requested

Service	Description
	by Aetna.
Connectivity with Other Vendors	20. PBM shall provide and maintain real time, direct connection to Surescripts, and any additional or different vendors that Aetna utilizes for electronic prescribing or otherwise, in accordance with applicable standards, including the NCPDP, Certification Commission for Healthcare Information Technology (CCHIT), National Committee on Vital and Health Statistics (NCVHS), and CMS standards as described in Schedule F (Prescription Drug Utilization Review).

Schedule W

Manufacturer Revenues

As provided in Section 4.3 of the Agreement, this Schedule W (Manufacturer Revenues) fully and accurately discloses all Contracts and sources and types of revenues and other economic benefits to which PBM is, as of the Effective Date, contractually or legally entitled and that would or generate Aetna Rebates or Service Fees as a result of the performance of the Services from and after the Effective Date.

Contract or Source	**Type of Revenues and Other Economic Benefits**	**Estimated Annual Value Attributable to Aetna, Aetna Customers, Covered Plans, Members, and Services**
None	None	None

Schedule X

Audits

Core Services

Service	Description
PBM Audit Obligations	1. Participating Pharmacy Audits. PBM shall audit Participating Pharmacies (retail, mail order, specialty, etc.) in accordance with Law and all such audits will include a representative sample of Claims from each of Aetna's lines of business. In addition, PBM agrees to the following: a. PBM shall audit according to the terms of PBM's provider manual as of the Effective Date, with a goal of determining the Participating Pharmacy's adherence to pharmacy industry performance standards, requirements under applicable Law, and Contract requirements. PBM will notify Aetna of any changes to the provider manual that may materially impact audits of Participating Pharmacies and must receive Aetna's approval for such changes, which will not be unreasonably withheld. Certain Aetna Customer Contracts with Aetna may contain other and/or additional audits or audit parameter requirements with respect to audits of Participating Pharmacies. PBM shall conduct, annually, such other and/or additional reasonable audits or audit parameter requirements as contained in Aetna Customer Contracts as identified by Aetna from time to time. b. As part of the auditing process, PBM shall (i) provide a thorough and comprehensive Claim audit review that covers real-time point of sale edits, manual reviews, desktop audits, and onsite audits designed to detect and prevent pharmacy error, fraud, waste, and abuse; (ii) utilize real-time point of sale edits to detect high dollar Claim exceptions, quantity edits, or other similar activity that may result from Participating Pharmacy error, fraud, waste, or abuse; (iii) comply with all requirements of CMS for monitoring and auditing of providers with respect to federal programs, including Chapter 9 of Medicare Part D Prescription Drug Manual (or its successor thereto); and (iv) audit compliance with fraud, waste, and abuse training requirements, including verification of training and attestations. c. PBM shall provide copies of audit result reports to Aetna and Aetna Customers upon request and as required by Law, and at a minimum, on a quarterly basis. Aetna agrees to provide such information to Aetna Customers solely in accordance with Aetna's standard confidentiality provisions with its Aetna Customers. PBM shall reasonably assist Aetna, Aetna Plan Affiliates and Aetna Customers in their review of audit result reports upon request.

Service	Description
	d. PBM shall promptly notify Aetna in writing of Member-specific findings that have the potential for fraud, waste, and abuse or other violations of Law and work with Aetna's Special Investigation Unit (SIU) for Aetna, Aetna Plan Affiliate, and Aetna Customer specific audit events and in accordance with Section 14.2 of the Agreement. e. Upon Aetna's request, PBM shall provide Aetna with corrective action plans in a manner and time frame reasonably required by Aetna and in accordance with Sections 7.6 and 14.2 of the Agreement. f. On an annual basis, PBM shall conduct: (i) onsite audits of at least five percent (5%) of Participating Pharmacies processing at least 250 Aetna Claims per month; and (ii) daily review of Claims over one hundred dollars ($100) PBM shall make good faith efforts to collect and shall promptly return eighty percent (80%) of all non-PBM affiliated Participating Pharmacy onsite and investigational audit recoveries to Aetna and retain the remainder unless otherwise prohibited by law. PBM shall return one hundred percent (100%) of all other audit recoveries from non-PBM affiliated Participating Pharmacy (daily review) and all audit recoveries from PBM affiliated Participating Pharmacies. PBM shall promptly notify Aetna in writing of any audit recoveries which it reasonably determines are uncollectible. g. PBM shall have an independent third party auditor conduct all on-site audits of retail Participating Pharmacies that are an Affiliate of PBM. 2. Back End Fulfillment Pharmacy Audits (Mail Order and Specialty Pharmacies). Without limiting the generality of the foregoing, PBM shall conduct the following audits of PBM Mail Order Pharmacies and PBM Specialty Pharmacies providing the PBM Services described on Schedule M-1 (Supporting Mail Order Pharmacy Services) to Aetna RX Home and the PBM Services described on Schedule N-1 (Supporting Specialty Pharmacy Services) to Aetna Specialty Pharmacy contracted: (i) monthly audits to verify the PBM Mail Order Pharmacies' and the PBM Specialty Pharmacies' compliance with professional practice standards and the terms of the Agreement and Schedule M (Supporting Mail Order Pharmacy Services) and Schedule N (Supporting Specialty Pharmacy Services); and (ii) annual audits of at least one-half of one percent (0.5%) of prescriptions dispensed and shipped to Member by PBM Mail Order Pharmacies and annual audits of at least one-half of one percent (0.5%) of prescriptions dispensed and shipped to Member by PBM Specialty Pharmacies under this Agreement. In conducting such audits, PBM shall comply with the requirements set forth in sub-sections (a) – (g) of Paragraph 1 above, and the following:

Service	Description
	a. To the extent PBM determines, as a result of such audits that amounts have been overpaid by Aetna, PBM shall reconcile such audit discrepancies and shall immediately make Aetna whole, and financially adjust such Claims accordingly, in each case in accordance with Article IX of the Agreement. b. PBM shall provide an annual report to Aetna, due thirty (30) calendar days after the end of the year, relating to the audits it conducts pursuant to this provision and providing reasonable detail concerning (a) any deviations from professional practice standards and the terms of the Agreement, (b) any overpayments by Aetna, and (c) any corrective action that PBM has undertaken or will undertake to address the issues related to such audits (to the extent not previously provided to Aetna pursuant to Section 7.6 of the Agreement). 3. Front-End Pharmacy Services Audits (Mail Order and Specialty Pharmacies). Without limiting the generality of Paragraph 1 above, PBM shall conduct annual audits of front-end pharmacy services performed by PBM Mail Order Pharmacies and/or PBM Specialty Pharmacies in lieu of Aetna Mail Order Pharmacies and/or Aetna Specialty Pharmacies in accordance with Schedules P, EE, FF and GG or as otherwise requested by Aetna which measure: (i) prescription order errors, (ii) adequacy and quality of patient counseling, (iii) maintenance of Member Patient Profiles, (iv) resolution of issues related to prescription orders, (iv) personnel training protocol, (v) personnel performance and retention and (vi) adequacy of disaster recovery and business continuity plans. In conducting such audits, PBM shall comply with the requirements set forth in sub-sections (a) – (e) of Paragraph 1 above, and the following: a. PBM shall not exceed a one hundred (100) parts per million (1,000,000) annual prescription order error rate. In other words, PBM shall not commit more than one hundred (100) errors per million (1,000,000) prescription orders per year. b. PBM shall provide a report to Aetna, due thirty (30) calendar days after the end of this annual audit, relating to the audit it conducts pursuant to this provision and providing reasonable detail concerning (i) any deviations from professional practice standards and the terms of the Agreement and (ii) any corrective action that PBM has undertaken or will undertake to address the issues related to such audit (to the extent not previously provided to Aetna pursuant to Section 7.6 of the Agreement). 4. Claims Audits. PBM shall conduct a monthly audit of the adjudication accuracy of Claims processed for Aetna by PBM. Such audits shall be conducted by selecting a representative random sample of Claims processed for Aetna in order to determine whether the Claims were

Service	Description
	processed accurately. Sample size and methodology for such audits shall be reasonably determined by Aetna, with the understanding that the sample size shall be sufficient to achieve a ninety-eight percent (98%) confidence interval, with a five percent (5%) error rate and a standard deviation not greater than three percent (3%). The sample shall be selected by random sampling techniques and shall be drawn from a sample that includes all product lines and funding mechanisms. The sampled items shall be selected through the use of a random number generator applied to the total population of Claims. The population shall include all Claims adjudicated by PBM, including retail, mail-order, specialty, and direct. Such audits will review Claim adjudication and Claim financial accuracy. At a minimum, the components that are tested shall include Ingredient Cost, Dispensing Fee, Member Cost Share, patient eligibility, drug coverage, and deductible application. Audit results shall be provided to Aetna via the Performance Standard reports, provided to Aetna pursuant to Section 3.4(h) of the Agreement. In conjunction with Section 7.4 of the Agreement, adjustments or corrections which are necessary as a result of such Claims audits shall be addressed as follows: a. Medicare Part D Claims: PBM shall seek recovery from the Member/Provider for any issue that results in a plan overpayment in order to restate the Claim on PDE and update accumulators. b. All other Claims (excluding Medicare Part D Claims): In the event a Claim (other than a Medicare Part D Claim) was adjudicated incorrectly, PBM shall re-price the Claim through the PBM Point of Sale application by reversing the original Claim and generating a replacement Claim to reflect the way the Claim should have adjudicated. To the extent the adjudication inaccuracy is not the result of an Aetna error, PBM shall be responsible for the cost to correct the error and prevent reoccurrence. If a set up error results in an Aetna overpayment, PBM shall correct the Claims as they should have adjudicated and reimburse Aetna accordingly. If a set up error results in a Member overcharge, PBM shall correct the Claims as they should have adjudicated and reimburse the Member accordingly (in accordance with Schedule H (Communications). 5. Compliance Audits. PBM shall perform audits to ensure and verify that both PBM's general operations and the Services are in compliance with applicable Law (including the Medicare Modernization Act) and accreditation standards (including NCQA, URAC, and PBM accreditation standards). The scope and frequency of these audits shall be as mutually agreed upon by Aetna and PBM. 6. Medicare Related Audits. PBM shall perform all CMS required and recommended audits related to Medicare Part D in accordance with CMS guidance.

Service	Description
PBM Operational Audits	7. PBM shall perform audits at Aetna's request which measure the production and quality of operational functions falling within PBM Services. These audits shall be limited to existing Operations Reports as detailed in Schedule V-1. However, in the event and to the extent such Operations Reports are insufficient to effectively conclude such audits, PBM shall also audit any other documents and/or information reasonably necessary to reach such conclusion. Such functions may (i) be audited at a frequency reasonably determined by Aetna and reasonably agreed to by PBM, and (ii) also measure the performance of PBM Designated and Dedicated Personnel responsible therefor. 8. Regarding the operational functions set forth in Paragraph 7 above, Aetna will have the right to review PBM's protocol for (i) undertaking audits, (ii) measuring quality programs and (iii) determining the level of activity necessary to maintain the performance guarantees of PBM Services as set forth in the Agreement and Schedule R and suggest modifications thereof, and PBM shall reasonably consider such modifications. 9. Without limiting the generality of Paragraph 7 above, each month PBM shall submit production and quality metrics as detailed in Schedule V to Aetna or its designee to enable both Aetna and PBM to identify areas of concern, poor performance trends or control issues. 10. Audits undertaken under Paragraphs 7 and 9 above shall be compliant with all state, CMS, and accrediting entity requirements, as applicable. Such accrediting entities shall include the , National Committee for Quality Assurance (NCQA), National Association of Boards of Pharmacy (NABP), URAC (formerly known as the Utilization Review Accreditation Commission), and any other accrediting entities as agreed upon by the Parties.
Aetna Audit Rights	11. Audit Rights. Without limiting the generality of Aetna's audit rights pursuant to the Agreement (including pursuant to Article VII and any other Schedule), Aetna shall have the following audit rights: a. Manufacturer Rebate Audits. PBM shall assist Aetna in the manner required by Aetna and in a manner consistent with the scope of PBM's obligations regarding rebate administration, in connection with the administration and management of any audit relating to Manufacturer Rebate recoveries, including Aetna Customer-related audits, Manufacturer audits, Governmental Body requests or audits, and audits by accreditation organizations. PBM shall accommodate Governmental Body requests or audits as necessary in Aetna's discretion. b. Benefit Plan Design Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit or cause to be audited, Benefit Plan Design set-ups with respect to Aetna, Aetna

Service	Description
	Affiliates, and Aetna Customers for the purpose of validating compliance with the terms of the Agreement and requirements of the Benefit Plan Designs, including audits of the testing, policies and procedures, and other requirements under and in connection with Schedule B (Benefit Plan Set Up). c. Aetna Customer Pre-Implementation Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers shall have the right to conduct, or cause to be conducted, pre-implementation audits with respect to each Covered Plan within forty-five (45) calendar days prior to the effective date of the applicable Covered Plan. d. Aetna Customer Integration Audits. When adding a new Aetna Customer to the PBM Services, Aetna (or its designee), on its own behalf or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to conduct such Aetna Customer-specific integration/implementation audits as shall be necessary to satisfy the Aetna Customer's requirements, including auditing each new group or Aetna Customer addition that requires integration with real-time medical connections. These audits may be performed within fifteen (15) Business Days after the effective date of such Customer or such other period as may be provided by the applicable Plan Contract. e. Claims Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit or cause to be audited, PBM's Claims processing for the purpose of validating compliance with the terms of the Agreement, including network pricing and/or Aetna related MAC Lists for purposes of validating the accuracy of the MAC pricing and its application to Claims. Aetna or Aetna Customer will be allowed to audit one hundred percent (100%) of Claims in an electronic format. This includes Aetna's right to audit to ensure Claims are adjudicated at the guaranteed network rates and Dispensing Fees, including Pass Through Pricing rates and Dispensing Fees (including access to Participating Pharmacy Contracts, via Aetna' independent third party auditor, to verify Pass Through Pricing for pass through arrangements in accordance with the Agreement). Aetna shall have access to information from PBM reasonably necessary to verify correct payment of Claims under the Agreement, including, information regarding the applicable BIN number, group number, network, and applicable rates (including discount, Dispensing Fee, and MAC pricing) for Claim transmissions. f. Claims Test Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers shall have the right to audit the Claims tests performed by PBM,

Service	Description
	including the Claims tests provided in Schedule B (Benefit Plan Set Up) and Schedule D (Claims Processing and Adjudication), which may include auditing the policies and procedures related thereto (except to the extent covered by the applicable SAS 70). g. Compound Drug Claim Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit all Claims regarding Compound Drugs billed to Aetna that are greater than $1,000 for reasonableness. h. Accreditation Standards Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit all PBM activity and responsibilities necessary to meet accreditation standards applicable to Aetna, Aetna Plan Affiliates, or Aetna Customers to ensure compliance with accreditation requirements. For avoidance of doubt, this will not provide Aetna with access to information related specifically to other PBM clients. i. Regulatory Compliance Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit all PBM activity and responsibilities necessary to meet standards of Applicable Law applicable to Aetna, Aetna Plan Affiliates, or Aetna Customers to ensure compliance with Applicable law. For avoidance of doubt, this will not provide Aetna with access to information related specifically to other PBM clients. j. Delegation Oversight Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM for compliance with all delegation and clinical elements of Aetna's delegated services and applicable Aetna Policies. k. Clinical Program Audits. If applicable, Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit on a monthly basis, the testing, policies and procedures, set up, and performance of all clinical programs and services provided by PBM or its Affiliates under Schedule J (Clinical Services and Formulary Administration) applicable to Aetna, Aetna Plan Affiliates, or Aetna Customers, including quality and correctness of online criteria, Formulary search engine, mailing communications, pre-certification, delegation activities, correctness, quality, and timeliness (including timelines of Formulary communications). l. Adjudication Set-Up Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna

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	Customers, shall have the right to audit PBM to verify the correctness, quality, and timeliness of adjudication set up on a weekly basis for set-ups related to Aetna, Aetna Plan Affiliates, and Aetna Customers. m. Prior Authorization Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM's prior authorization request process related to Aetna, Aetna Plan Affiliates, Aetna Customers, and Members for accuracy, quality, and timeliness and for clinical appropriateness. n. Eligibility Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM to verify the correctness, quality, and timeliness of eligibility information and processes related to Aetna, Aetna Plan Affiliates, Aetna Customers, and Members (including manual eligibility overrides conducted by PBM), including the testing, policies and procedures, and other requirements (except to the extent covered by the applicable SAS 70). o. Formulary Communications Audits. If applicable, Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM to verify the correctness, quality, and timeliness of all Formulary communication items provided by PBM related to Aetna, Aetna Plan Affiliates, Aetna Customers, and Members on a monthly basis, as provided in Schedule J (Clinical Services and Formulary Administration). p. Formulary and Coverage Installation Set-Up Audits. If applicable, Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit Formulary and coverage installation set up related to Aetna, Aetna Plan Affiliates, and Aetna Customers at least monthly and as frequently as weekly, as provided in Schedule J (Clinical Services and Formulary Administration). q. Pharmacy Network Services Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM's compliance with the Participating Pharmacy network requirements set forth in Schedule G (Pharmacy Network Services), Schedule G-1 (Requirements for Participating Pharmacy Contracts), and Schedule G-2 (Network Adequacy Requirements). r. PBM Mail Order and PBM Specialty Pharmacy Audits. Aetna RX Home and/or Aetna Specialty RX (or its or their designee), on

Service	Description
	its or their own behalf and/or on behalf of Aetna, Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM's and its applicable pharmacies' compliance with the Agreement, including Schedule M (Supporting Mail Order Pharmacy Services), Schedule M-1 (Transition Supporting Mail Order Pharmacy Services), Schedule N (Supporting Specialty Pharmacy Services) and Schedule N-1 (Transition Supporting Specialty Pharmacy Services). s. Data Removal Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM compliance with the data removal requirement, as provided in Schedule T (Termination Transition Services), for all PBM data center(s) and all other PBM locations where separated data is located. t. PBM Disclosure Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit, through an independent third party auditor, that PBM has accurately disclosed and/or reported and otherwise followed the terms and conditions required in connection with Sections 4.3 and 11.1 of the Agreement, Schedule W (Manufacturer Revenues) and Schedule Z (Authorized Uses of Data and Information). Nothing in this section is intended to limit Aetna's audit rights described in the Agreement with respect to Aetna Rebates or Service Fees. u. Firewall Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM policies, procedures, documents, relevant PBM communications, and other related records in order to verify compliance with firewall and confidentiality obligations in the Agreement, including those related to Aetna Manufacturer Rebate Agreements and sales / account management services. v. Performance Standards Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM's compliance with the Performance Standards and Customer Performance Standards set forth in the Agreement and the reporting and the calculation and payment of Guarantee Amounts and other amounts related thereto. w. Operational Audits. As described in Paragraphs 7 through 10, Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to conduct operational audits, subject to the Parties' reasonable mutual agreement regarding times and processes, on PBM's premises related to the Agreement.

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	x. Medicare Related Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit PBM's compliance with Medicare Part D requirements and commitments to Medicare regulators related to Aetna, Aetna Plan Affiliates, Aetna Customers, and Members, including conducting periodic audits of the quality of any CMS required reports and files executed by PBM on Aetna's or an Aetna Plan Affiliate's behalf or prepared by PBM and submitted to Aetna. y. Customer Service Calls Audits. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to conduct customer service and call center audits as contemplated in Paragraph 40(c) of Schedule E, subject to the Parties' reasonable mutual agreement regarding times and processes, on PBM's premises related to the Agreement. z. Guarantee Reports. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates and Aetna Customers, shall have the right to audit or cause to be audited PBM's Guarantee Reports delivered pursuant to Schedule Y in order to confirm that such Guarantee Reports accurately reflect all information required to be set forth thereon. aa. Retail Market Experience Reports; Baseline Margin Percentage Report; and Annual Margin Experience Report. Aetna (or its designee), on its own behalf and/or on behalf of Aetna Plan Affiliates, shall have the right to audit or cause to be audited PBM's Retail Market Experience Reports, Baseline Mail and Specialty Market Experience Reports, Annual Mail and Specialty Market Experience Reports and Medicare Guarantee Adjustment Reports subject to and in accordance to and with Parts 3, 4 and 5 of Schedule Y, as applicable, in order to confirm that such reports accurately reflect all information required to be set forth thereon.

Schedule Y

Pricing

This Schedule Y and Article IX of the Agreement set forth all fees, compensation and other amounts that shall be payable to PBM and its Affiliates under the Agreement on account of its performance of the Services, and PBM and its Affiliates shall not be entitled to any fees, compensation or other amounts not expressly set forth in this Schedule Y or Article IX of the Agreement. The pricing terms set forth in this Schedule Y shall become effective on the Effective Date.

The pricing terms provided for in this Schedule Y include the following sub-schedules which are hereby incorporated herein by reference:

Schedule Y-1	Commercial Retail Pass Through Pricing
Schedule Y-2	Commercial Retail Large Account Lock-In Pricing
Schedule Y-3	Commercial Retail Small Account Lock-In Pricing
Schedule Y-4	Medicare Retail Pass Through Pricing
Schedule Y-5	Mail Order Pricing
Schedule Y-6	Specialty Pharmacy Pricing
Schedule Y-7	Optional Services Financial Terms
Schedule Y-8	Master AWP Discounts
Schedule Y-9	Reserved
Schedule Y-10	Pricing Administrative Services
Schedule Y-11	Retail Discount Card
Schedule Y-12	Retail Workers Compensation
Schedule Y-13	Medicaid Pass Through Pricing
Schedule Y-14	Medicaid Lock-In Pricing

For avoidance of doubt, all compensation owing to PBM for Core Services and all other Services except for Optional Services are included in the fees, compensation and other amounts set forth or provided for in Schedules Y-1 through Y-7 and in Schedules Y-11 through Y-14. With respect to Optional Services, PBM shall be paid the fees set forth or provided for in Schedule Y-7, subject to the following: Optional Services may only be provided upon prior, express written request of Aetna for such Services. Unless a prior, express written request for an Optional Service is provided to PBM by Aetna, PBM will not be entitled to charge fees for such Optional Service. Unless otherwise mutually agreed by Aetna and PBM (including pursuant to Section 9.11), pricing for all Optional Services shall be fixed for the duration of the Term and the Termination Transition Period. Schedule Y-7 also sets forth certain financial credits and other financial terms that would be applicable in the event that Aetna elects to have (or, in the case of prior authorization, not to have) PBM provide an Optional Service.

Part 1. APPLICABILITY OF SCHEDULE Y SUB-SCHEDULES

A. Commercial Plans (Other than Medicaid Plans)

The pricing provisions listed below in this Part 1(A) shall be applicable to all Covered Plans that are Commercial Plans, including Covered Plans that are Workers Compensation plans, Discount Card plans or State Plans or arise under the DOD Contract, FEHBP, CHAMPUS, TRICARE and any similar program of the U.S. government, but excluding all Medicaid Plans.

Schedule Y-1	Commercial Retail Pass Through Pricing
Schedule Y-2	Commercial Retail Large Account Lock-In Pricing
Schedule Y-3	Commercial Retail Small Account Lock-In Pricing
Schedule Y-5	Mail Order Pricing
Schedule Y-6	Specialty Pharmacy Pricing
Schedule Y-7	Optional Services Financial Terms
Schedule Y-11	Retail Discount Card
Schedule Y-12	Retail Workers Compensation

With respect to prescriptions dispensed at retail Participating Pharmacies for a given time period for each Commercial Plan that is not a Workers Compensation plan, Discount Card plan or Medicaid Plan, Aetna shall be subject to and pay the applicable fees and charges, and shall be entitled to the Retail Discount Guarantees and Dispensing Fee Guarantees, set forth in one of Schedule Y-1, Y-2, or Y-3, as specified by Aetna for such Commercial Plan for such time period pursuant to Section 9.1(e) of the Agreement. Schedule Y-11 shall be applicable to, and sets forth the Retail Discount Guarantees and Dispensing Fee Guarantees for, prescriptions dispensed at retail Participating Pharmacies for Covered Plans that are Discount Card plans. Schedule Y-12 shall be applicable to, and sets forth the Retail Discount Guarantees and Dispensing Fee Guarantees for, prescriptions dispensed at retail Participating Pharmacies for Covered Plans that are Workers Compensation plans.

Schedules Y-5 and Y-6 shall be applicable to, and set forth the Mail Discount Guarantees, Specialty Product Discount Guarantees, as well as the applicable Dispensing Fees and Administrative Fees applicable for, all Commercial Plans. Schedule Y-7 shall be applicable to all Commercial Plans.

B. Medicaid Plans

The pricing provisions listed below in this Part 1(B) shall be applicable to all Covered Plans that are Medicaid Plans.

Schedule Y-5	Mail Order Pricing
Schedule Y-6	Specialty Pharmacy Pricing
Schedule Y-7	Optional Services Financial Terms
Schedule Y-13	Medicaid Pass Through Pricing
Schedule Y-14	Medicaid Lock-In Pricing

With respect to prescriptions dispensed by retail Participating Pharmacies for a given time period for each Medicaid Plan, Aetna shall be subject to and pay the applicable fees and charges, and shall be entitled to the Retail Discount Guarantees and Dispensing Fee Guarantees set forth in Schedules Y-13, Y-14, or one of the sub-schedules of Schedule Y-13 or Y-14, as specified by Aetna for such Medicaid Plan for such time period pursuant to Section 9.1(e) of the Agreement.

Schedules Y-5 and Y-6 shall be applicable to, and set forth the Mail Discount Guarantees, Specialty Product Discount Guarantees, as well as the applicable Dispensing Fees and Administrative Fees applicable for, all Medicaid Plans. Schedule Y-7 shall be applicable to all Commercial Plans.

C. Medicare Plans

The pricing provisions listed below in this Part 2 shall be applicable to all Covered Plans that are Medicare Plans.

Schedule Y-4	Medicare Retail Pass Through Pricing
Schedule Y-5	Mail Order Pricing
Schedule Y-6	Specialty Pharmacy Pricing
Schedule Y-7	Optional Services Financial Terms

With respect to prescriptions dispensed by retail, mail or specialty Participating Pharmacies for a given time period for each Medicare Plan, Aetna shall be subject to and pay the applicable fees and charges, and shall be entitled to the applicable Retail Discount Guarantees, Mail Discount Guarantees, and Dispensing Fee Guarantees, set forth in Schedules Y-4, Y-5 and Y-6. Schedule Y-7 shall be applicable to all Medicare Plans.

Part 2. GUARANTEE REPORTING AND RECONCILIATION

A. Definitions

1. "Actual Discount Rate" means, for a given time period and Pricing Category (as defined below), the actual, effective/average AWP discount rate achieved (in terms of the amounts paid by Aetna and its Affiliates (including Member Cost Shares) to PBM and its Affiliates for the Services and, except as provided in Section B of this Part 2, disregarding sell-side pricing terms administered pursuant to Schedule Y-10) with respect to all Paid Claims processed by PBM or its Affiliates during such period for such Pricing Category. The Actual Discount Rate for each Pricing Category for a given time period shall be calculated using the actual applicable Ingredient Cost Charge (*i.e.*, utilizing the applicable 11 digit NDC code, drug name, strength, AWP and prescription volume) for each Paid Claim within such Pricing Category during such time period. If the amount charged to Aetna with respect to any Paid Claims was found to be in error and such error was corrected through a corresponding payment or credit between Aetna and PBM, the Actual Discount Rate that includes such Paid Claims shall take such corrections into account. The Actual Discount Rate shall be computed without regard to any reconciliation payments paid by PBM under Section D of this Part 2.

2. "Actual Average Dispensing Fee" means the average actual Dispensing Fee achieved (in terms of the amounts paid by Aetna and its Affiliates (including Member Cost Shares) to PBM and its Affiliates for the Services and, except as provided in Section B of this Part 2, disregarding sell-side pricing terms administered pursuant to Schedule Y-10) for each Paid Claim within a given Pricing Category and during a given time period. The Actual Average Dispensing Fee shall be computed without regard to any reconciliation payments paid by PBM under Section D of this Part 2.

B. Zero Balance Logic Claims & U&C Claims

1. In the case of any Paid Claim involving a Covered Drug dispensed by a retail Participating Pharmacy where the Cost Share paid by the Member exceeds the sum of the Ingredient Cost Charge, Dispensing Fee and Tax that would have been payable by Aetna under this Schedule Y with respect to such Paid Claim in the absence of any Cost Share payment by such Member, (a) for purposes of calculating Actual Discount Rates, the actual applicable Ingredient Cost Charge for such Paid Claim shall be deemed to equal the total Cost Share amount paid by such Member less the sum of the Dispensing Fee and Tax applicable to such Paid Claim, and (b) for purposes of calculating Actual Average Dispensing Fees, the dispensing fee for such Paid Claim shall be deemed to equal the actual dispensing fee amount charged for such Paid Claim by the Participating Pharmacy and included in such Cost Share. The foregoing sentence shall not apply to any Covered Plan that is fully insured by Aetna or an Aetna Plan Affiliate if the Cost Share to be paid by a Member thereunder is computed on the basis of any sell-side pricing terms administered pursuant to Schedule Y-10 (instead of the Ingredient Cost Charge, Dispensing Fee and Tax that would have been payable by Aetna under this Schedule Y in the absence of the Cost Share). As of the Agreement Date, there are no fully insured Covered Plans that compute Cost Shares in that manner; but if Aetna hereafter decides to offer and maintain such a fully insured Covered Plan, it will provide PBM no less than sixty (60) days advance notice thereof, and the provisions of Section 5 of Amendment 3 to

Pharmacy Benefit Management Subcontract Agreement dated August 16, 2012, between PBM and Aetna shall be applicable to Zero Balance Logic Claims (as defined in the Original Agreement) under any such fully insured Covered Plan.

2. For purposes of the calculation of Actual Discount Rates and Actual Average Dispensing Fees for retail Pricing Categories, the Dispensing Fee for each U&C Claim (as defined below) shall be deemed to equal the dollar amount of the Dispensing Fee Guarantee for the applicable days supply Pricing Category and the applicable calendar year, and the remainder of the U&C Charge for such U&C Claim shall be treated as the Ingredient Cost Charge of such U&C Claim. "U&C Claim" means Claim where the Ingredient Cost Charge applicable to such Claim plus the applicable Dispensing Fee is greater than or equal to the applicable U&C Charge.

C. Guarantee Reports – Retail Discount Guarantees, Mail Discount Guarantees & Dispensing Fee Guarantees

Within thirty (30) calendar days after the end of each calendar quarter and within sixty (60) calendar days after the end of the calendar year, PBM will provide to Aetna a detailed, accurate and complete Claim-level report (each such report, a "Guarantee Report") for all Paid Claims processed during the applicable reporting period (*i.e.*, for a calendar quarter or calendar year), within each Pricing Category below. Each Guarantee Report shall be certified as being true, accurate and complete by an appropriate officer of PBM with actual knowledge of the contents thereof. For purposes of this Part 2 and all Guarantee Reports, Paid Claims exclude Compound Drug Claims.

Each Guarantee Report shall include the following information with respect to such reporting period and, in the case of each Guarantee Report for a calendar quarter reporting period, with respect to the year-to-date period that ends with such quarter:

1. The actual amounts achieved for each of the following pricing categories (referred to herein as a "Pricing Category"):

a. Commercial Retail Pass Through Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (0 to 34 days supply)
b. Commercial Retail Pass Through Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (35 to 83 days supply)
c. Commercial Retail Pass Through Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (84+ days supply)
d. Commercial Retail Pass Through Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (0 to 34 days supply)
e. Commercial Retail Pass Through Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (35 to 83 days supply)
f. Commercial Retail Pass Through Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (84+ days supply)
g. Commercial Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (0 to 34 days supply)
h. Commercial Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (35 to 83 days supply)
i. Commercial Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (84+ days supply)
j. Commercial Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (0 to 34 days supply)
k. Commercial Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (35 to 83 days supply)
l. Commercial Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (84+ days supply)
m. Commercial Retail Large Account Lock-In Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (0 to 34 days supply)

n. Commercial Retail Large Account Lock-In Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (35 to 83 days supply)

o. Commercial Retail Large Account Lock-In Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (84+ days supply)

p. Commercial Retail Large Account Lock-In Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (0 to 34 days supply)

q. Commercial Retail Large Account Lock-In Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (35 to 83 days supply)

r. Commercial Retail Large Account Lock-In Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (84+ days supply)

s. Commercial Retail Large Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (0 to 34 days supply)

t. Commercial Retail Large Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (35 to 83 days supply)

u. Commercial Retail Large Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (84+ days supply)

v. Commercial Retail Large Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (0 to 34 days supply)

w. Commercial Retail Large Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (35 to 83 days supply)

x. Commercial Retail Large Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (84+ days supply)

y. Commercial Retail Small Account Lock-In Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (0 to 34 days supply)

z. Commercial Retail Small Account Lock-In Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (35 to 83 days supply)

aa. Commercial Retail Small Account Lock-In Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (84+ days supply)

bb. Commercial Retail Small Account Lock-In Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (0 to 34 days supply)

cc. Commercial Retail Small Account Lock-In Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (35 to 83 days supply)

dd. Commercial Retail Small Account Lock-In Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (84+ days supply)

ee. Commercial Retail Small Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (0 to 34 days supply)

ff. Commercial Retail Small Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (35 to 83 days supply)

gg. Commercial Retail Small Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (84+ days supply)

hh. Commercial Retail Small Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (0 to 34 days supply)

ii. Commercial Retail Small Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (35 to 83 days supply)

jj. Commercial Retail Small Account Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (84+ days supply)

kk. Medicare Retail Pass Through Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (0 to 34 days supply)

ll. Medicare Retail Pass Through Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (35 to 83 days supply)

mm. Medicare Retail Pass Through Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (84+ days supply)

nn. Medicare Retail Pass Through Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (0 to 34 days supply)

oo. Medicare Retail Pass Through Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (35 to 83 days supply)

pp. Medicare Retail Pass Through Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (84+ days supply)

qq. Medicare Retail Pass Through Pricing: Actual Discount Rate for Long Term Care Generic Drug Paid Claims

rr. Medicare Retail Pass Through Pricing: Actual Discount Rate for Long Term Care Brand Drug Paid Claims

ss. Medicare Retail Pass Through Pricing: Actual Discount Rate for Home Infusion Generic Drug Paid Claims

tt. Medicare Retail Pass Through Pricing: Actual Discount Rate for Home Infusion Brand Drug Paid Claims

uu. Medicare Retail Pass Through Pricing: Actual Discount Rate for I/T/U Generic Drug Paid Claims

vv. Medicare Retail Pass Through Pricing: Actual Discount Rate for I/T/U Brand Drug Paid Claims

ww. Medicare Retail Pass Through Pricing: Actual Discount Rate for Territory Generic Drug Paid Claims

xx. Medicare Retail Pass Through Pricing: Actual Discount Rate for Territory Brand Drug Paid Claims

yy. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions

zz. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions

aaa. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for Long Term Care Generic Drug Paid Claims

bbb. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for Long Term Care Brand Drug Paid Claims

ccc. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for Home Infusion Generic Drug Paid Claims

ddd. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for Home Infusion Brand Drug Paid Claims

eee. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for I/T/U Generic Drug Paid Claims

fff. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for I/T/U Brand Drug Paid Claims

ggg. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for Territory Generic Drug Paid Claims

hhh. Medicare Retail Pass Through Pricing: Actual Average Dispensing Fee for Territory Brand Drug Paid Claims

iii. Mail Order Pricing: Actual Discount Rate for Brand Drug Claims (Commercial Plans, Medicare Plans and Medicaid Plans Combined)

jjj. Mail Order Pricing: Actual Discount Rate for Generic Drug Claims (Commercial Plans, Medicare Plans and Medicaid Plans Combined)

kkk. Mail Order Pricing: Actual Average Dispensing Fee (Commercial Plans, Medicare Plans and Medicaid Plans Combined, with separate break-out for plans as to which optional front-end mail order services have been elected)

lll. Specialty Pharmacy Pricing: Actual Discount Rate for Brand Drug Specialty Product Claims (Commercial Plans, Medicare Plans and Medicaid Plans Combined), with the pricing guarantee for each individual Specialty Product being treated as a separate Pricing Category

mmm. Specialty Pharmacy Pricing: Actual Discount Rate for Generic Drug Specialty Product Claims (Commercial Plans, Medicare Plans and Medicaid Plans Combined), with the pricing guarantee for each individual Specialty Product being treated as a separate Pricing Category

nnn. Specialty Pharmacy Pricing: Actual Average Dispensing Fee (Commercial Plans, Medicare Plans and Medicaid Plans Combined, with separate break-out for plans as to which optional front-end mail order services have been elected)

ooo. Discount Card: Actual Discount Rate for Generic Prescriptions

ppp. Discount Card : Actual Discount Rate for Brand Prescriptions

qqq. Discount Card: Actual Average Dispensing Fee for Generic Drug Paid Claims

rrr. Discount Card: Actual Average Dispensing Fee for Brand Drug Paid Claims

sss. Workers Compensation: Actual Discount Rate for Generic Prescriptions

ttt. Workers Compensation: Actual Discount Rate for Brand Prescriptions

uuu. Workers Compensation: Actual Average Dispensing Fee for Generic Drug Paid Claims

vvv. Workers Compensation: Actual Average Dispensing Fee for Brand Drug Paid Claims

www. Medicaid Retail Pass Through Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (0 to 34 days supply)

xxx. Medicaid Retail Pass Through Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (35 to 83 days supply)

yyy. Medicaid Retail Pass Through Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (84+ days supply)

zzz. Medicaid Retail Pass Through Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (0 to 34 days supply)

aaaa. Medicaid Retail Pass Through Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (35 to 83 days supply)

bbbb. Medicaid Retail Pass Through Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (84+ days supply)

cccc. Medicaid Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (0 to 34 days supply)
dddd. Medicaid Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (35 to 83 days supply)
eeee. Medicaid Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (84+ days supply)
ffff. Medicaid Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (0 to 34 days supply)
gggg. Medicaid Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (35 to 83 days supply)
hhhh. Medicaid Retail Pass Through Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (84+ days supply)
iiii. For each Medicaid Plan sub-schedule to Schedule Y-13, the same Pricing Categories described in www – hhhh above
jjjj. Medicaid Retail Lock-In Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (0 to 34 days supply)
kkkk. Medicaid Retail Lock-In Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (35 to 83 days supply)
llll. Medicaid Retail Lock-In Pricing: Actual Discount Rate for Qualifying Brand Prescriptions (84+ days supply)
mmmm. Medicaid Retail Lock-In Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (0 to 34 days supply)
nnnn. Medicaid Retail Lock-In Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (35 to 83 days supply)
oooo. Medicaid Retail Lock-In Pricing: Actual Discount Rate for Qualifying Generic Prescriptions (84+ days supply)
pppp. Medicaid Retail Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (0 to 34 days supply)
qqqq. Medicaid Retail Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (35 to 83 days supply)
rrrr. Medicaid Retail Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Brand Prescriptions (84+ days supply)
ssss. Medicaid Retail Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (0 to 34 days supply)
tttt. Medicaid Retail Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (35 to 83 days supply)
uuuu. Medicaid Retail Lock-In Pricing: Actual Average Dispensing Fee for Qualifying Generic Prescriptions (84+ days supply)
vvvv. For each Medicaid Plan sub-schedule to Schedule Y-14, the same Pricing Categories described in jjjj – uuuu above

2. The difference between (i) the Actual Discount Rate or Actual Average Dispensing Fee, as applicable, reported for each Pricing Category above and (ii) the applicable corresponding Retail Discount Guarantee, Mail Discount Guarantee, Specialty Product Discount Guarantee or Dispensing Fee Guarantee, as the case may be, for such Pricing Category as set forth in the applicable sub-schedule of this Schedule Y and after taking into account any adjustments to such guarantees under Part 3, Part 4 or Part 5 of this Schedule Y. With respect to each Pricing Category that addresses an Actual Discount Rate, if such Actual Discount Rate is less than the applicable Retail Discount Guarantee, Mail Discount Guarantee or Specialty Product Discount Guarantee for such Pricing Category, each such difference shall be referred to as a "Percentage Shortfall."

3. For each Pricing Category that has a Percentage Shortfall for the applicable reporting period, the dollar amount equal to such Percentage Shortfall multiplied by the aggregate AWP of the Paid Claims included in such Pricing Category for such reporting period (such amount, the "AWP Overcharge Amount").

4. With respect to each Pricing Category that addresses an Actual Average Dispensing Fee, if the Actual Average Dispensing Fee is greater than the applicable Dispensing Fee Guarantee for such Pricing Category, the total dollar amount by which Aetna was charged Dispensing Fees in excess of the applicable Dispensing Fee Guarantee (the "Dispensing Fee Overcharge Amount").

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D. Reconciliation Payments.

1. Within sixty (60) days after the end of each calendar year, PBM shall pay to Aetna an amount equal to the sum of all AWP Overcharge Amounts and all Dispensing Fee Overcharge Amounts for such calendar year, as reported in the Guarantee Report for such calendar year; *provided, however*, that to the extent expressly so permitted in Section 9.2(b) of the Agreement, such amount may reduced by offsetting Pricing Category surpluses against Minor Deficits occurring within the same Schedule Y sub-schedule. In no case will Aetna be obligated to make any payment to PBM or any of its Affiliates, and PBM and its Affiliates shall not be entitled to receive a credit, on account of PBM or its Affiliates having exceeded any Retail Discount Guarantee, Mail Discount Guarantee, Specialty Product Discount Guarantee or Dispensing Fee Guarantee in any one or more Pricing Categories. No offsetting or commingling shall be permitted between Pricing Categories, and a surplus in one or more Pricing Categories may not be utilized to reduce or offset a deficit in any other Pricing Category, except to the extent expressly permitted pursuant to Section 9.2(b) of the Agreement.

2. Any and all adjustments to Retail Discount Guarantees and Dispensing Fee Guarantees made pursuant to Part 3 of this Schedule Y with respect to any calendar year shall be taken into account in the full year Guarantee Report for such calendar year, and AWP Overcharge Amounts and Dispensing Fee Overcharge Amounts payable under this Section D shall be computed as if such adjustments had been in effect as of January 1 of such year.

Part 3. ANNUAL COST-BASED ADJUSTMENTS TO COMMERCIAL PLAN RETAIL PRICING GUARANTEES

On an annual basis the pricing guarantees and terms in Schedules Y-1, Y-2, Y-3, Y-8, Y-13 and Y-14 shall be subject to adjustments as provided in this Part 3. Attached as Exhibit A to this Schedule Y is a pro forma spreadsheet that sets forth the Parties' intended application of this Part 3 (such spreadsheet, the "Part 3 Spreadsheet":)

A. Definitions

1. "Commercial Overall AWP Discount Percentage" means, for a given Measurement Year and Index Pricing Category, the aggregate average (based on dollar spend) percentage discount from AWP paid by PBM, PBM's Affiliates and members (*e.g.*, Cost Share equivalents) to retail pharmacies under Commercial Plans of PBM Customers (including Aetna) for all prescription drugs, devices and supplies dispensed within such Index Pricing Category during such Measurement Year under all such Commercial Plans (*e.g.*, AWP-80%); *provided, however*, that:

   (i) all prescriptions dispensed under PBM's Maintenance Choice Program by pharmacies that are owned or operated by PBM or any of its Affiliates shall be disregarded;

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(ii) Commercial Overall AWP Discount Percentage shall be calculated in each case net of all discounts, pricing adjustments, and Pharmacy Rebates received by PBM and its Affiliates by or from retail pharmacies with respect to or in connection with the prescriptions included in the calculation;

(iii) all prescriptions where the amount charged by the dispensing pharmacy for such prescription is determined pursuant to a Contract between a PBM Customer (other than an Affiliate of PBM) and the dispensing pharmacy shall be disregarded

(iv) all prescriptions provided free of charge by the dispensing pharmacy shall be disregarded;

(v) all prescriptions dispensed to members of a given PBM Customer (other than an Affiliate of PBM) where the dispensing pharmacy is owned or operated by such PBM Customer shall be disregarded;

(vi) all prescriptions dispensed to members pursuant to a Discount Card plan, Workers Compensation plan or an equivalent to any such plan shall be disregarded; and

(vii) all prescriptions for Compound Drugs shall be disregarded.

2. "Commercial Overall Average Dispensing Fee" means, for a given Measurement Year and Index Pricing Category, the aggregate average (per prescription) dispensing fee paid by PBM, PBM's Affiliates and members (*e.g.*, Cost Share equivalents) to retail pharmacies under all Commercial Plans of PBM Customers (including Aetna) for prescription drugs, devices and supplies dispensed within such Pricing Category during such Measurement Year under all such Commercial Plans; *provided, however*, that in each case the following prescriptions shall be disregarded:

(i) all prescriptions dispensed under PBM's Maintenance Choice Program by pharmacies that are owned or operated by PBM or any of its Affiliates;

(ii) all prescriptions where the amount charged by the dispensing pharmacy is determined pursuant to a Contract between a PBM Customer (other than an Affiliate of PBM) and the dispensing pharmacy;

(iii) all prescription provided free of charge by the dispensing pharmacy;

(iv) all prescriptions dispensed to members of a given PBM Customer (other than an Affiliate of PBM) where the dispensing pharmacy is owned or operated by such PBM Customer;

(v) all prescriptions dispensed to members pursuant to a Discount Card plan, Workers Compensation plan or an equivalent to any such plan; and

(vi) all prescriptions for Compound Drugs.

3. "Index Pricing Categories" means (i) Generic Drug prescriptions (all days of supply), (ii) Brand Drug prescriptions (all days of supply, but excluding claims dispensed for 35+ days supply that are processed by a subset of the CVS Caremark National Network to PBM Customers with a benefit plan design that rejects a claims with 35+ days supply at any retail pharmacy that does not participate in such subset), and (iii) Brand Drug prescriptions (35+ supply that are excluded from clause (ii)), in each of the foregoing cases excluding any prescriptions that are dispensed by a retail pharmacy while acting as a participating pharmacy in a Limited or Preferred Pharmacy Network.

4. "Limited or Preferred Pharmacy Network" means a network of retail pharmacies (i) that is comprised of at least five percent (5%) fewer pharmacies than any of the standard national pharmacy networks then maintained by PBM or its Affiliates, where plan members would be subject to less advantageous economic terms or benefits if they obtain prescriptions from retail pharmacies that are not included in such network, or (ii) where plan members are entitled to more advantageous economic terms or benefits if they obtain prescriptions from certain preferred retail pharmacies in such network, rather than from other non-preferred retail pharmacies in such network.

5. "Measurement Year" means a calendar year.

6. "2014 PBM AWP Discount Percentage" means, for a given Index Pricing Category, an amount equal to the Commercial Overall Average Discount Percentage for 2014 and such Index Pricing Category. This definition corresponds to column B, row 5 of the Part 3 Spreadsheet.

7. "2014 PBM Average Dispensing Fee" means, for a given Index Pricing Category, an amount equal to the Commercial Overall Average Dispensing Fee for 2014 and such Index Pricing Category. This definition corresponds to column B, row 28 of the Part 3 Spreadsheet.

8. "PBM Cumulative AWP Change Rate" means, for a given Index Pricing Category and Measurement Year, the amount by which the Commercial Overall AWP Discount Percentage for such year increased above or decreased below the 2014 PBM AWP Discount Percentage, computed as follows: (Commercial Overall AWP Discount Percentage for the Measurement Year, *minus* the 2014 PBM AWP Discount Percentage). For example, if the Commercial Overall AWP Discount Percentage for 2016 is AWP-84% and the 2014 PBM AWP Discount Percentage is AWP-81%, the PBM Cumulative AWP Change Rate would be 3%. This definition corresponds to column D, rows 6 – 12 of the Part 3 Spreadsheet.

9. "PBM Cumulative Dispensing Fee Change Amount" means, for a given Index Pricing Category and Measurement Year, the amount by which the Commercial Overall Average Dispensing Fee for such year increased above or decreased below the 2014 PBM Average Dispensing Fee, computed as follows: (Commercial Overall Average Dispensing Fee for the Measurement Year, *minus* the 2014 PBM Average Dispensing Fee). For example, if the Commercial Overall Average Dispensing Fee for 2017 is $1.00 and the 2014 PBM Average Dispensing Fee is $1.10, the PBM Cumulative Dispensing Fee Change Amount would be negative $0.10. This definition corresponds to column D, rows 29 – 35 of the Part 3 Spreadsheet.

10. "Effective Date Retail Discount Guarantees" means the Indexed Retail Discount Guarantees as of the Effective Date (and before any subsequent adjustment under this Part 3).

11. "Effective Date Dispensing Fee Guarantees" means the Indexed Retail Dispensing Fee Guarantees as of the Effective Date (and before any subsequent adjustment under this Part 3).

12. "2014 Aetna Pro Forma Discount Guarantee" means, for a given Indexed Retail Discount Guarantee, an amount equal to (i) the Effective Date Retail Discount Guarantee for 2015 for such Indexed Retail Discount Guarantee *minus* (ii) 0.75 multiplied by the PBM Cumulative AWP Change Rate for 2015 for the Index Pricing Category that corresponds to such Indexed Retail Pricing Guarantee. This definition corresponds to column C, row 21 of the Part 3 Spreadsheet.

13. "2014 Aetna Pro Forma Dispensing Fee Guarantee" means, for a given Indexed Retail Dispensing Fee Guarantee, an amount equal to (i) the Effective Date Retail Dispensing Fee Guarantee for 2015 for such Indexed Retail Dispensing Fee Guarantee *minus* (ii) 0.75 multiplied by the PBM Cumulative Dispensing Fee Change Amount for 2015 for the Index Pricing Category that corresponds to such Indexed Retail Dispensing Fee Guarantee. This definition corresponds to column C, rows 44 of the Part 3 Spreadsheet.

14. "Aetna Cumulative Contract AWP Change Rate" means, for a given Indexed Retail Discount Guarantee and Measurement Year, the amount by which the Effective Date Retail Discount Guarantee for such year and Indexed Retail Discount Guarantee increased above or decreased below the 2014 Aetna Pro Forma Discount Guarantee. For example, if the Effective Date Retail Discount Guarantee for 2016 is AWP-80% and the 2014 Aetna Pro Forma Discount Guarantee is AWP-76.5%, the Aetna Cumulative Contract AWP Change Rate would be 3.5%. This definition corresponds to column F, rows 6 – 12 of the Part 3 Spreadsheet.

15. "Aetna Cumulative Contract Dispensing Fee Change Amount" means, for a given Indexed Dispensing Fee Guarantee and Measurement Year, the amount by which the Effective Date Dispensing Fee Guarantee for such year and Indexed Dispensing Fee Guarantee increased above or decreased below the 2014 Aetna Pro Forma Dispensing Fee Guarantee. For example, if the Effective Date Dispensing Fee Guarantee for 2016 is $1.00 and the 2014 Aetna Pro Forma Dispensing Fee Guarantee is $1.10, the Aetna Cumulative Contract Dispensing Fee Change Amount would be negative $0.10. This definition corresponds to column F, rows 29 - 35 of the Part 3 Spreadsheet.

16. "Indexed Retail Discount Guarantees" means the Retail Discount Guarantees applicable to Commercial Plans (including Medicaid and all other State Plans) as set forth in Schedules Y-1, Y-2, Y-3, Y-8, Y-13 and Y-14.

17. "Indexed Retail Dispensing Fee Guarantees" means the Dispensing Fee Guarantees applicable to Commercial Plans (including Medicaid and all other State Plans) as set forth in Schedules Y-1, Y-2, Y-3, Y-8, Y-13 and Y-14.

B. Annual Market Experience Computations

Within forty-five (45) days after the last day of each Measurement Year (commencing with the 2015 Measurement Year), PBM shall accurately determine and compute, for each Index Pricing Category:

(i) the Commercial Overall AWP Discount Percentage for such Measurement Year;

(ii) the Commercial Overall Average Dispensing Fee for such Measurement Year;

(iii) if not previously determined pursuant to this Section B, the 2014 PBM AWP Discount Percentage;

(iv) if not previously determined pursuant to this Section B, the 2014 PBM Average Dispensing Fee;

(v) the PBM Cumulative AWP Change Rate for such Measurement Year; and

(vi) the PBM Cumulative Dispensing Fee Change Amount for such Measurement Year.

Prior to the expiration of such forty-five (45) day period, PBM shall (a) deliver to the Market Experience Report Accounting Firm (as defined below) an itemized written report setting forth all such determinations and computations (each such report, a "Retail Market Experience Report"), and (b) deliver to Aetna a redacted copy of the same Retail Market Experience Report with all competitively sensitive numerical values and amounts applicable to the computations and determinations under clauses (i) – (iv) above deleted.

C. Adjustment to Indexed Retail Discount Guarantees.

Promptly after the delivery of the Retail Market Experience Report for a given Measurement Year, the Parties shall effect the following amendments to the Indexed Retail Discount Guarantees and Indexed Dispensing Fee Guarantees with effect as of January 1 of such Measurement Year (and all Guarantee Reports and reconciliation payments required under Part 2 of this Schedule Y with respect to such Measurement Year shall be prepared and computed after taking into account all adjustments required under this Part 3 with respect to such year):

1. Adjustments to Indexed Retail Discount Guarantees.

For each Indexed Retail Discount Guarantee, the Parties shall amend the applicable Schedule Y sub-schedule if and as necessary to cause such Indexed Retail Discount Guarantee for the Measurement Year to be increased (improved), effective as of January 1 of the Measurement Year, utilizing the following formulation:

Amended Indexed Retail Discount Guarantee = greater of (i) [A + (greater of B or C)] or (ii) D.

Where:

A: is the 2014 Aetna Pro Forma Discount Guarantee for such Indexed Retail Discount Guarantee.

B: is the PBM Cumulative AWP Change Rate for the Measurement Year for the Index Pricing Category that corresponds to such Indexed Retail Discount Guarantee *multiplied by* 0.75.

C: is the Aetna Cumulative Contract AWP Change Rate for the Measurement Year for such Indexed Retail Discount Guarantee.

D: is the AWP Discount Rate for such Indexed Retail Discount Guarantee for the year that immediately precedes the Measurement Year or, in the case of 2015 Measurement Year, the corresponding Effective Date AWP Discount Guarantee for 2015.

The formulation set forth in this Section C(1) corresponds to columns D – J, rows 5 – 12, in the Part 3 Spreadsheet .

2. Adjustments to Indexed Dispensing Fee Guarantees.

For each Indexed Retail Dispensing Fee Guarantee, the Parties shall amend the applicable Schedule Y sub-schedule if and as necessary to cause such Indexed Retail Dispensing Fee Guarantee for the Measurement Year to be reduced (improved), effective as of January 1 of the Measurement Year utilizing the following formulation:

Amended Indexed Retail Dispensing Fee Guarantee = lesser of (i) [A + (smaller of B or C)] or (ii) D.

Where:

A: is the 2014 Aetna Pro Forma Dispensing Fee Guarantee for such Indexed Retail Dispensing Fee Guarantee.

B: is the PBM Cumulative Dispensing Fee Change Amount for the Measurement Year for the Index Pricing Category that corresponds to such Indexed Retail Dispensing Fee Guarantee *multiplied by* 0.75.

C: is the Aetna Cumulative Contract Dispensing Fee Change Amount for the Measurement Year for such Indexed Retail Discount Guarantee.

D: is the Dispensing Fee Guarantee for such Indexed Retail Dispensing Fee Guarantee for the year that immediately precedes the Measurement Year or, in the case of 2015 Measurement Year, the corresponding Effective Date Dispensing Fee Guarantee for 2015.

For the avoidance of doubt, if B and C are both negative numbers (*i.e.*, if both reflect reducing dispensing fee amounts), (i) the "smaller of B or C" shall mean whichever is the largest on an absolute value basis, and (ii) such absolute value amount shall be subtracted from A.

3. Coordination with Annual Lock-In Discount Adjustments Under Section 9.1(c). In the case of Indexed Retail Discount Guarantees that are Commercial Lock-In Guarantees, the computations and adjustments under this Part C shall be made as if any past or impending adjustments to address Forecast Miss Overcharge Amounts under Section 9.1(c)(iv) of the Agreement have not and will not occur; and as provided in Section 9.1(c)(iv), all such adjustments thereunder shall be computed and implemented after all adjustments under this Part C have been made.

4. Coordination with Annual Lock-In Discount Adjustments Under Section 9.1(c). In the case of Indexed Retail Dispensing Fee Guarantees that are Commercial Lock-In Guarantees, the computations and adjustments under this Part C shall be made as if any past or impending adjustments to address Forecast Miss Overcharge Amounts under Section 9.1(c)(iv) of the Agreement have not and will not occur; and as provided in Section 9.1(c)(iv), all such adjustments thereunder shall be computed and implemented after all adjustments under this Part C have been made.

D. Auditor Confirmation; Audit Rights.

For each Measurement Year (commencing with 2015), PBM shall engage [KPMG LLP] or another nationally recognized independent accounting firm reasonably acceptable to Aetna (the "Market Experience Report Accounting Firm") to (i) review the procedures and methodologies utilized by PBM in such year to make the determinations and computations required under this Part 3 and prepare the Retail Market Experience Report for such year; (ii) review, on a sampling basis, the accuracy of such procedures and methodologies; (iii) review the accuracy of the Retail Market Experience Report for such year; and (iv) provide a written report of its findings under clauses (i)–(iii) of this sentence to PBM and Aetna. The form of such report and the terms of PBM's engagement of the Market Experience Report Accounting Firm, for purposes of this Part 3, shall be in accordance with the requirements and specifications set forth on Annex P of the Agreement. In addition, in the event Aetna has a reasonable basis to believe that any Retail Market Experience Report delivered to it by PBM is inaccurate or incomplete in any material respect, it shall have the right to have a Neutral Accounting Firm audit PBM's compliance with this Part 3, including the accuracy of such Retail Market Experience Report, which audit shall be subject to the provisions of Section 7.3 of the Agreement. If the Market Experience Report Accounting Firm identifies any errors or discrepancies, (i) the Retail Market Experience Report for such year shall be revised as necessary to correct the same, (ii) the calculations and amendments made pursuant to this Part 3 shall be repeated and implemented retroactively as necessary to correct the same, and (iii) the amounts owing to Aetna under Section D of Part 2 above shall be recomputed as necessary to correct such errors and discrepancies, and PBM shall immediately pay Aetna the amount of any underpayment, together with interest thereon in

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accordance with Section 9.12 of the Agreement for the period of time elapsed from the date such payment should have been made under Section D of Part 2 above.

E. In Year Projections.

Within thirty (30) days after the last day of each calendar quarter of each Measurement Year (commencing with 2015), PBM shall, on the basis of data and forecasts then reasonably available to it, make and deliver to Aetna a good faith estimate, for each Index Pricing Category, of the PBM Cumulative AWP Change Rate and PBM Cumulative Dispensing Fee Change Amount that will result from the then-current Measurement Year. If such estimates indicate that substantial payments likely will become due to Aetna under Part 2 of this Schedule Y with respect to the current year as a consequence of adjustments under Section C of this Part 3, the Parties shall in good faith agree upon and make intra-year adjustments to the AWP Discount Rates and/or Dispensing Fees that will be used in the adjudication and pricing of retail Claims during the remainder of such year in order to yield a result expected to approximate the final Indexed Retail Discount Guarantees and Indexed Dispensing Fee Guarantees for the Measurement Year (after all adjustments under this Part 3).

G. Amendments to Include Future Limited or Preferred Networks.

If the Parties hereafter amend the Agreement and Schedule Y to include separate pricing guarantees and terms for Covered Plans that utilize a Limited or Preferred Pharmacy Network, the Parties shall in good faith negotiate and agree upon amendments to this Part 3 to cause the cost-based adjustment methodology set forth in this Part 3 to include the retail pricing guarantees applicable to such Covered Plans, including by amending (i) the definition of "Index Pricing Categories" to include as additional Index Pricing Categories prescriptions dispensed from such Limited or Preferred Network and all reasonably comparable Limited or Preferred Networks (in terms of the percentage of pharmacies that are excluded/preferred as measured against PBM's standard national pharmacy networks) utilized by other PBM Customers, and (ii) the definitions of "Indexed Retail Discount Guarantees" and "Indexed Retail Dispensing Fees" to include the retail Pricing Categories applicable to such Covered Plans.

Part 4. ANNUAL COST-BASED ADJUSTMENTS TO MAIL AND SPECIALTY PRICING GUARANTEES

On an annual basis the Mail Discount Guarantees and Specialty Product Discount Guarantees set forth in Schedules Y-5 and Y-6 shall be subject to adjustments as provided in this Part 4. Attached as Exhibit B to this Schedule Y is a pro forma spreadsheet that sets forth the Parties' intended application of this Part 4 (such spreadsheet, the "Part 4 Spreadsheet":)

A. Definitions

1. "Inventory Cost Pricing Categories" means (i) Generic Drug prescriptions dispensed by PBM Central Fill Pharmacies and Generic Drug (non-Specialty Product) prescriptions dispensed by PBM Central Fill Specialty Pharmacies priced in accordance with

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Schedule Y-5, (ii) Brand Drug prescriptions dispensed by PBM Central Fill Pharmacies and Brand Drug (non-Specialty Product) prescriptions dispensed by PBM Central Fill Specialty Pharmacies priced in accordance with Schedule Y-5, (iii) Generic Drug (Specialty Product) prescriptions dispensed by PBM Central Fill Specialty Pharmacies, and (iv) Brand Drug (Specialty Product) prescriptions dispensed by PBM Central Fill Specialty Pharmacies. Clauses (iii) and (iv) of this definition are sometimes collectively referred to as the Schedule Y-6 Inventory Cost Pricing Categories.

2. "Annual Drug AWP Amount" means, with respect to a given Covered Drug (measured at the NDC level) dispensed by PBM Central Fill Pharmacies or PBM Central Fill Specialty Pharmacies during a given calendar year and with respect to a specified Inventory Cost Pricing Category, the aggregate AWP amount applicable to all quantities of such Covered Drug that were dispensed to Members during such year *except*, with respect to a Covered Drug dispensed by PBM Central Fill Specialty Pharmacies, the Annual Drug AWP Amount shall exclude AWP amounts applicable to newly launched drugs during the same calendar year. This definition corresponds to the amounts set forth in columns F, K and P, rows 12 – 25, on page 1 of the Part 4 Spreadsheet for Mail and to the amounts set forth in column F, rows 12 - 21, column K, rows 12 – 21, and column P, rows 12 – 23, on page 3 of the Part 4 Spreadsheet for Specialty.

3. "PBM Per Drug Annual Acquisition Cost" means, with respect to a given Covered Drug dispensed by PBM Central Fill Pharmacies or PBM Central Fill Specialty Pharmacies during a given calendar year and with respect to a specified Inventory Cost Pricing Category, the total actual amount paid by PBM or its Affiliates to Manufacturers (excluding any Affiliates of PBM) with respect to quantities of such Covered Drug that were dispensed to Members during such year, calculated net of all procurement-related pricing discounts, any other procurement-related pricing adjustments and credits and all Other Manufacturer Payments, paid or credited to, or otherwise received by, PBM and its Affiliates from or by Manufacturers with respect to such Covered Drugs. PBM Per Drug Annual Acquisition Cost shall be computed in accordance with GAAP (x) utilizing a weighted average cost inventory methodology, or (y) for any Covered Drug where a weighted average cost inventory methodology would be impracticable, utilizing an assumption that the net acquisition cost of such Covered Drug at the NDC level is equal to the average net amount paid by PBM and its Affiliates to acquire such Covered Drug in the year in which the Covered Drug was dispensed. In the event that, during any period, PBM and its Affiliates have more than one Contract or pricing arrangement applicable to the facility/pharmacy that dispensed such Covered Drug, for purposes of computing PBM Per Drug Annual Acquisition Cost, it shall be assumed that such Covered Drug was purchased under the Contract or pricing arrangement that provided the lowest and most favorable net acquisition cost to PBM and its Affiliates. This definition corresponds to the amounts set forth in columns H, M and R, rows 12 – 25, on page 1 of the Part 4 Spreadsheet.

4. "PBM Aggregate Drug Acquisition Cost" means, with respect to a given calendar year and Inventory Cost Pricing Category, the sum of the PBM Per Drug Annual Acquisition Cost amounts for all Covered Drugs dispensed by PBM Central Fill Pharmacies or PBM Central Fill Specialty Pharmacies during such calendar year and with respect to such Inventory Cost Pricing Category; *provided*, *however*, that any Specialty Product dispensed by PBM Central Fill Specialty Pharmacies that was newly launched during such calendar year shall be excluded from such computation. This definition corresponds to the amounts set forth in

column H, row 27, column M, row 27, and column R, row 27, on page 1 of the Part 4 Spreadsheet for mail and to the amounts set forth in column H, row 27, and column M, row 27 and column R, row 27, on page 3 of the Part 4 Spreadsheet for specialty.

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5. "PBM Fully Loaded Aggregated Drug Acquisition Cost" means, with respect to a given calendar year and Inventory Cost Pricing Category, the *sum of* (i) the PBM Aggregate Drug Acquisition Cost for such year and Inventory Cost Pricing Category *plus* (ii) an amount equal to the number of prescriptions of Covered Drugs that were dispensed in such year with respect to such Inventory Cost Pricing Category by PBM Central Fill Pharmacies or PBM Central Fill Specialty Pharmacies (*provided, however,* that any prescriptions by PBM Central Fill Specialty Pharmacies for a Specialty Product that was newly launched during such calendar year shall be excluded from such number) *multiplied by* the Per Script Overhead Amount for such year and Inventory Cost Pricing Category. This definition corresponds to the amounts set forth in column H, row 39, column M, row 39 and column R, row 39, on page 1 of the Part 4 Spreadsheet for mail and to the amounts set forth in column H, row 41, column M, row 41 and column R, row 41, on page 3 of the Part 4 Spreadsheet for specialty.

6. "PBM Fully Loaded Aggregate AWP Discount Rate" means, with respect to a given calendar year and Inventory Cost Pricing Category, a percentage computed as follows: (A/B) – 1, where (i) A is the PBM Fully Loaded Aggregate Drug Acquisition Cost for such year and Inventory Cost Pricing Category, and (ii) B is the sum of the Annual Drug AWP Amounts for all Covered Drugs dispensed by PBM Central Fill Pharmacies or PBM Central Fill Specialty Pharmacies during such year and with respect to such Inventory Cost Pricing Category. This definition corresponds to the amounts set forth in column H, row 41, column M, row 41, and column R, row 41, on page 1 of the Part 4 Spreadsheet for mail and to the amounts set forth in column H, row 43, column M, row 43, and column R, row 43 on page 3 of the Part 4 Spreadsheet for specialty

7. "2014 PBM Fully Loaded AWP Discount Rate" means, for a given Inventory Cost Pricing Category, an amount equal to the PBM Fully Loaded Aggregate AWP Discount Rate for 2014 and such Inventory Cost Pricing Category. This definition corresponds to column H, row 41, on page 1 of the Part 4 Spreadsheet for mail and to column H, row 43, on page 3 of the Part 4 Spreadsheet for specialty.

8. "PBM Cumulative AWP Change Rate" means, for a given calendar year and Inventory Cost Pricing Category, the amount by which the PBM Fully Loaded Aggregate AWP Discount Rate for such year increased above or decreased below the 2014 PBM Fully Loaded AWP Discount Rate, computed as follows: (PBM Fully Loaded Aggregate AWP Discount Rate for such year *minus* the 2014 PBM Fully Loaded AWP Discount Rate). For example, if the PBM Fully Loaded Aggregate AWP Discount Rate for 2017 is AWP-90.25% and the 2014 PBM Fully Loaded AWP Discount Rate is AWP-89.11%, the PBM Cumulative AWP Change Rate would be 1.14%. This definition corresponds to the amounts set forth in column D, rows 6 – 12, on page 2 of the Part 4 Spreadsheet.

9. "2014 Per Script Back End Variable Cost" means the average, per prescription fully-loaded variable cost incurred by PBM and its Affiliates in the 2014 calendar year in connection with the performance by the PBM Central Fill Pharmacies or the PBM Central Fill Specialty Pharmacies, as the case may be, of back-end central fill and support services for Covered Plans pursuant to Schedule

M or N, as the case may be, as determined in accordance with GAAP and taking into account all labor (including wages, salaries, bonuses and benefits), other direct costs and expenses and variable overhead incurred in connection with the provision of such services by PBM and its Affiliates, but *excluding* all inventory costs, other costs of goods sold and all shipping, freight, packaging and label printing costs. This definition corresponds to the amount set forth in column G, row 33, on page 1 of the Part 4 Spreadsheet.

10. "Per Script Shipping Cost" means the average, per prescription cost incurred by PBM and its Affiliates in a given calendar year for shipping, freight, packaging and label printing costs in connection with Covered Drugs dispensed to Members by the PBM Central Fill Pharmacies or the PBM Central Fill Specialty Pharmacies, as the case may be, in such year pursuant to Schedule M or N, as the case may be, as determined in accordance with GAAP. This definition corresponds to the amount set forth in column G, row 34, column L, row 34, and column Q, row 34 on page 1 of the Part 4 Spreadsheet.

11. "CPI" means the Consumer Price Index for All Urban Consumers (CPI-U) as published by the U.S. Bureau of Labor Statistics.

12. "Per Script Overhead Amount" means (a) with respect to the 2014 calendar year and Inventory Cost Pricing Categories applicable to the PBM Central Fill Pharmacies, the *sum of* (x) the 2014 Per Script Back End Variable Cost for such Inventory Cost Price Categories *plus* (y) the Per Script Shipping Cost for such Inventory Cost Price Categories in 2014; (b) with respect to each subsequent year and Inventory Cost Price Categories applicable to the PBM Central Fill Pharmacies, the *sum of* (i) the 2014 Back End Variable Cost for such Inventory Cost Price Categories increased on January 1 of each year (commencing January 1, 2015) by the percentage rate of increase in the CPI over the prior calendar year *plus* (ii) the Per Script Shipping Cost for such Inventory Cost Price Categories in such year; (c) with respect to the 2014 calendar year and Inventory Cost Price Categories applicable to the PBM Central Fill Specialty Pharmacies, the *sum of* (x) the 2014 Per Script Back End Variable Cost for such Inventory Cost Price Categories *plus* (y) the Per Script Shipping Cost for such Inventory Cost Price Categories in 2014; and (d) with respect to each subsequent year and Inventory Cost Price Categories applicable to the PBM Central Fill Specialty Pharmacies, the *sum of* (i) the 2014 Back End Variable Cost for such Inventory Cost Price Categories increased on January 1 of each year (commencing January 1, 2015) by the percentage rate of increase in the consumer price index (CPI) over the prior calendar year *plus* (ii) the Per Script Shipping Cost for such Inventory Cost Price Categories in such year. This definition corresponds to the amount set forth in column G, row 35, column L, row 35, and column Q, row 35 on page 1 of the Part 4 Spreadsheet.

13. "2014 Aetna Pro Forma Mail Discount Guarantee" means, for a given Mail Discount Guarantee, an amount equal to (i) the Effective Date Mail/Specialty Discount Guarantee for 2015 for such discount guarantee *minus* (ii) 0.50 multiplied by the PBM Cumulative AWP Change Rate for 2015 for the Inventory Cost Pricing Category that corresponds to such discount guarantee. This definition corresponds to column C, rows 18 – 21, on page 2 of the Part 4 Spreadsheet.

14. "2014 Aetna Pro Forma Specialty Discount Guarantee" means, for a given Schedule Y-6 Inventory Cost Pricing Category, an amount equal to (i) the Aetna Cumulative Specialty Contract Overall AWP Effective Rate for 2015 for such Schedule Y-6

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Inventory Pricing Category *minus* (ii) 0.50 multiplied by the PBM Cumulative AWP Change Rate for 2015 for such Inventory Cost Pricing Category. This definition corresponds to column C, rows 18 – 21, on page 2 of the Part 4 Spreadsheet.

15. "Aetna Cumulative Mail Contract AWP Change Rate" means, for a given Mail Discount Guarantee and calendar year, the amount by which the Effective Date Mail/Specialty Discount Guarantee for such year and discount guarantee increased above or decreased below the 2014 Aetna Pro Forma Non-Retail Discount Guarantee. For example, if the Effective Date Mail/Specialty Discount Guarantee for 2016 is AWP-80% and the 2014 Aetna Pro Forma Discount Guarantee is AWP-76.5%, the Aetna Cumulative Contract AWP Change Rate would be 3.5%. This definition corresponds to column F, rows 6 – 12, on page 2 of the Part 4 Spreadsheet.

16. "Aetna Cumulative Specialty Contract Overall AWP Effective Rate" means, for a given calendar year and with respect to *all* Specialty Product Pricing Categories within a given Schedule Y-6 Inventory Cost Pricing Category, a percentage computed as follows: (A/B) – 1, where (i) A is the total amount paid pursuant to Schedule Y-6 by Aetna and its Affiliates to PBM and its Affiliates for Specialty Product Covered Drugs dispensed by PBM Central Fill Specialty Pharmacies during such calendar year within such Schedule Y-6 Inventory Pricing Category, and (ii) B is the sum of the Annual Drug AWP Amounts for all such Covered Drugs so dispensed by PBM Central Fill Specialty Pharmacies during such year. For the avoidance of doubt, the Aetna Cumulative Specialty Contract Overall AWP Effective Rate is an average discount rate for the same inventory of all drugs that are included in the PBM Aggregate Drug Acquisition Costs for the same measurement year priced individually at the drug prices specified on Schedule Y-6.

17. "Aetna Cumulative Specialty Contract Overall AWP Change Rate" means, for a given calendar year and given Schedule Y-6 Inventory Cost Pricing Category, the amount by which the Aetna Cumulative Specialty Contract Overall AWP Effective Rate for such year and Schedule Y-6 Inventory Cost Pricing Category increased above or decreased below the 2014 Aetna Pro Forma Specialty Discount Guarantee. For example, if the Aetna Cumulative Specialty Overall AWP Effective Rate for 2016 is AWP-21.0% and the 2014 Aetna Pro Forma Specialty Discount Guarantee is AWP-20.0%, the Aetna Cumulative Specialty Contract Overall AWP Change Rate would be 1.0%. This definition corresponds to column F, rows 6 – 12, on page 2 of the Part 4 Spreadsheet.

18. "Effective Date Mail/Specialty Discount Guarantees" means the Mail Discount Guarantees and Specialty Product Discount Guarantees set forth in Schedules Y-5 and Y-6 as of the Effective Date (after taking into account any adjustment to Generic Drug Mail Discount Guarantees made pursuant to Section 1(C) of Schedule Y-5 but before any adjustment under this Part 4).

B. Annual Mail and Specialty Market Experience Reports

Within forty-five (45) days after the last day of each calendar year commencing with 2015, PBM shall accurately determine and compute for each Inventory Cost Pricing Category:

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(i) the Annual Drug AWP for each Covered Drug dispensed by PBM Central Fill Pharmacies or PBM Central Fill Specialty Pharmacies during such calendar year;

(ii) the PBM Per Drug Annual Acquisition Cost for each Covered Drug dispensed by PBM Central Fill Pharmacies or PBM Central Fill Specialty Pharmacies during such calendar year;

(iii) the PBM Aggregate Drug Acquisition Cost for such calendar year;

(iv) the Per Script Overhead Amount for such calendar year together with the Per Script Shipping Cost used therein;

(v) the PBM Fully Loaded Aggregate Drug Acquisition Cost for such calendar year;

(vi) the PBM Fully Loaded Aggregate AWP Discount Rate for such calendar year;

(vii) the PBM Cumulative AWP Change Rate for such calendar year;

(viii) if not previously determined pursuant to this Section B, the 2014 Per Script Back End Variable Cost;

(ix) if not previously determined pursuant to this Section B, the Per Script Overhead Amount for 2014 together with the Per Script Shipping Cost used therein;

(x) if not previously determined pursuant to this Section B, the PBM Fully Loaded Aggregate Drug Acquisition Cost for 2014;

(xi) if not previously determined pursuant to this Section B, the 2014 PBM Fully Loaded Discount Rate;

(xii) the Aetna Cumulative Mail Contract Overall AWP Change Rate;

(xiii) Aetna Cumulative Specialty Contract Overall AWP Effective Rate

(xiv) the Aetna Cumulative Specialty Contract Overall AWP Change Rate; and

(xv) total prescriptions processed for such calendar year.

Prior to the expiration of such forty-five (45) day period, PBM shall (a) deliver to the Market Experience Report Accounting Firm an itemized written report setting forth all such determinations and computations (each such report, a "Annual Mail and Specialty Market Experience Report"), and (b) deliver to Aetna a redacted copy of the same Annual Mail and Specialty Market Experience Report with all competitively sensitive numerical values and amounts applicable to the computations and determinations under clauses (ii) – (vi)

and (viii) – (xi) above deleted. Computations (i), (vii), and (xv) will be provided separately by PBM Central Fill Pharmacies and PBM Central Fill Specialty Pharmacies.

C. Adjustments to Mail Discount Guarantees; Specialty Product Reconciliation Payments.

1. Adjustment to Mail Discount Guarantees. Within ten (10) days after the delivery of the Annual Mail and Specialty Market Experience Report for a given calendar year, the Parties shall effect the following amendments to the Mail Discount Guarantees set forth in Schedules Y-5 with effect as of January 1 of such calendar year (and all Guarantee Reports and reconciliation payments required under Part 2 of this Schedule Y with respect to such calendar year shall be prepared and computed after taking into account all adjustments required under this Part 4 with respect to such year):

   For each Mail Discount Guarantee set forth in Schedules Y-5, the Parties shall amend the Schedule Y-5 as necessary to cause such discount guarantee for such calendar year to be increased (improved), effective as of January 1 of such year, utilizing the following formulation:

   Amended Discount Guarantee = greater of (i) [A + (greater of B or C)] or (ii) D.

   Where:

   A: is the 2014 Aetna Pro Forma Mail Discount Guarantee for the Inventory Cost Pricing Category that corresponds to such discount guarantee.

   B: is the PBM Cumulative AWP Change Rate for such calendar year for the Inventory Cost Pricing Category that corresponds to such discount guarantee *multiplied by* 0.50.

   C: is the Aetna Cumulative Mail Contract AWP Change Rate for such calendar year for such discount guarantee.

   D: is the AWP Discount Rate for such discount guarantee for the year that immediately precedes such calendar year or, in the case of the 2015 calendar year, the corresponding Effective Date Mail/Specialty Discount Guarantee for 2015.

   The formulation set forth in this Section C(1) corresponds to columns D – J, rows 5 – 12, on page 2 of the Part 4 Spreadsheet.

2. Payment of Specialty Guarantee Surpluses. If, for a given calendar year (commencing with 2015), (i) an amount equal to 0.50 *multiplied by* the PBM Cumulative AWP Change Rate for a given Schedule 6 Inventory Cost Pricing Category is greater than (ii) the Aetna Cumulative Specialty Contract Overall AWP Change Rate for such year and Schedule 6 Inventory Cost Pricing

Category (such excess amount, a "Specialty Product Surplus Percentage"), then immediately after the delivery of the Annual Mail and Specialty Market Experience Report for such year, PBM shall pay Aetna an amount equal to (x) the sum of the Annual Drug AWP Amounts for all Specialty Product Covered Drugs dispensed by PBM Central Fill Specialty Pharmacies during such year for such Inventory Cost Pricing Category (*provided* that any Specialty Product dispensed by PBM Central Fill Specialty Pharmacies that was newly launched during such calendar year shall be excluded from such computation) *multiplied by* (y) such Specialty Margin Surplus Percentage. The formulation set forth in this Section C(2) corresponds to columns D – J, rows 5 – 12, on page 2 of the Part 4 Spreadsheet.

D. Auditor Confirmation; Audit Rights.

For each calendar year (commencing with 2015), PBM shall engage the Market Experience Report Accounting Firm to (i) review the procedures and methodologies utilized by PBM in such year to make the determinations and computations required under this Part 4 and prepare the Baseline Mail and Specialty Market Experience Report or Annual Mail and Specialty Market Experience Report, as applicable, for such year; (ii) review, on a sampling basis, the accuracy of such procedures and methodologies; (iii) review the accuracy of the Baseline Mail and Specialty Market Experience Report or Annual Mail and Specialty Market Experience Report, as applicable, for such year; and (iv) provide a written report of its findings under clauses (i)–(iii) of this sentence to PBM and Aetna. The form of such report and the terms of PBM's engagement of the Market Experience Report Accounting Firm, for purposes of this Part 4, shall be in accordance with the requirements and specifications set forth on Annex P of the Agreement. In addition, in the event Aetna has a reasonable basis to believe that the Baseline Mail and Specialty Market Experience Report or Annual Mail and Specialty Market Experience Report delivered to it by PBM is inaccurate or incomplete in any material respect, it shall have the right to have a Neutral Accounting Firm audit PBM's compliance with this Part 4, including the accuracy of such Annual Mail and Specialty Market Experience Report, which audit shall be subject to the provisions of Section 7.3 of the Agreement. If the Market Experience Report Accounting Firm identifies any errors or discrepancies, (i) the Baseline Mail and Specialty Market Experience Report or Annual Mail and Specialty Market Experience Report, as applicable, for such year; shall be revised as necessary to correct the same, (ii) the calculations and amendments made pursuant to this Part 4 shall be repeated and implemented retroactively as necessary to correct the same, and (iii) amounts owing to Aetna under Section D of this Part 4 above shall be recomputed as necessary to correct such errors and discrepancies, and PBM shall immediately pay Aetna the amount of any underpayment, together with interest thereon in accordance with Section 9.12 of the Agreement for the period of time elapsed from the date such payment should have been made under Section D of this Part 4 above.

E. In Year Projections.

Within thirty (30) days after the last day of each calendar quarter of each calendar year (commencing with 2015), PBM shall, on the basis of data and forecasts then reasonably available to it, make and deliver to Aetna a good faith estimate, for each Inventory Cost Pricing Category, of the adjustments to the Mail Discount Guarantees and Specialty Product Surplus Percentage payments that will be required under Section C of this Part 4 with respect to such year. If such estimates indicate that substantial payments likely will become due to Aetna under Part 2 of this Schedule Y or under Section C(2) of this Part 4, the Parties shall in good faith agree upon

and make intra-year adjustments to the AWP Discount Rates that will be used in the adjudication and pricing of prescriptions that will be dispensed by PBM Central Fill Pharmacies or PBM Central Fill Specialty Pharmacies, as applicable, during the remainder of such year in order to yield a result expected to approximate the final Mail Discount Guarantees and to minimize any Specialty Product Surplus Payments for such year (after all adjustments under this Part 4).

Part 5. JOINTLY CONTRACTED PHARMACY ADJUSTMENTS TO MEDICARE PRICING GUARANTEES.

As provided in this Part 5, the pricing guarantees and terms in Schedule Y-4 applicable to a given calendar year shall be subject to potential adjustments (positive or negative) if any Participating Pharmacies will be Jointly Contracted Pharmacies in such year pursuant to Section 3.2(i) of the Agreement and Schedule G. Attached as Exhibit C to this Schedule Y is a pro forma spreadsheet that sets forth the Parties' intended application of this Part 5 (such spreadsheet, the "Part 5 Spreadsheet").

A. Definitions.

1. "Medicare Discount Guarantee Categories" means the Pricing Categories in Schedule Y-4 that set forth Retail Discount Guarantees.

2. "Medicare Dispensing Fee Categories" means the Pricing Categories in Schedule Y-4 that set forth Dispensing Fee Guarantees.

3. "Effective Date Medicare Discount Guarantees" means the Retail Discount Guarantees set forth in Schedule Y-4 as of the Effective Date (and before any subsequent adjustment under this Part 5) or, in the case of 2014, as set forth in Schedule Y-5 of the Original Agreement (as amended).

4. "Effective Date Medicare Dispensing Fee Guarantees" means the Dispensing Fee Guarantees set forth in Schedule Y-4 as of the Effective Date (and before any subsequent adjustment under this Part 5) or, in the case of 2014, as set forth in Schedule Y-5 of the Original Agreement (as amended).

5. "2014 Baseline Pharmacy Average AWP Discount Rate" means, for a given Participating Pharmacy and Medicare Discount Guarantee Category, the aggregate average (based on dollar spend) percentage discount from AWP paid by PBM, PBM's Affiliates and Members (through Cost Share assessments) to such pharmacy for all prescriptions dispensed to Members within such Medicare Discount Guarantee Category during 2014 calendar year under Covered Plans that are Medicare Plans (*e.g.*, AWP-80%). Each 2014 Baseline Pharmacy Average AWP Discount Rate shall be computed on the basis of the data provided in the Guarantee Reports delivered by PBM to Aetna under Part 3 of Schedule Y of the Original Agreement. This definition corresponds to the amounts set forth in column D, rows 6 – 15, in the Part 5 Spreadsheet. In the case of any pharmacy that was not a Participating Pharmacy in 2014, its 2014 Baseline Pharmacy Average AWP Discount Rate for each Medicare Discount

Guarantee Category shall be deemed to equal the Aggregate Average Pro Forma Pharmacy Average AWP Discount Rate for 2014 for such Medicare Discount Guarantee Category.

6. "2014 Baseline Pharmacy Average Dispensing Fee" means, for a given Participating Pharmacy and Medicare Dispensing Fee Category, the aggregate average (per prescription) dispensing fee paid by PBM, PBM's Affiliates and Members (through Cost Share assessments) to such pharmacy for all prescriptions dispensed to Members within such Medicare Dispensing Fee Category during the 2014 calendar year under Covered Plans that are Medicare Plans. In the case of any pharmacy that was not a Participating Pharmacy in 2014, its 2014 Baseline Pharmacy Average Dispensing Fee for each Medicare Dispensing Fee Guarantee Category shall be deemed to equal the Aggregate Average Pro Forma Pharmacy Average Dispensing Fee for 2014 for such Medicare Dispensing Fee Category.

7. "Aetna Cumulative Contract Medicare AWP Change Rate" means, for a given Medicare Discount Guarantee Category and calendar year, the amount by which the Effective Date Medicare Discount Guarantee for such year and Medicare Discount Guarantee Category increased above the corresponding Effective Date Medicare Discount Guarantee for 2014. For example, if the Effective Date Medicare Discount Guarantee for 2016 is AWP-80% and the Effective Date Medicare Discount Guarantee for 2014 is AWP-76.5%, the Aetna Cumulative Contract Medicare AWP Change Rate would be 3.5%.

8. "Medicare Pro Forma Pharmacy AWP Discount Rate" means, for a given calendar year, Participating Pharmacy and Medicare Discount Guarantee Category, an AWP discount percentage equal to (i) the 2014 Baseline Pharmacy Average AWP Discount Rate for such pharmacy and Medicare Discount Guarantee Category *plus* (ii) the Aetna Cumulative Contract Medicare AWP Change Rate for such year and Medicare Discount Guarantee Category. This definition corresponds to column K, rows 6 – 15 of the Part 5 Spreadsheet.

9. "Medicare Pro Forma Pharmacy Dispensing Fee" means, for a given calendar year, Participating Pharmacy and Medicare Dispensing Fee Guarantee Category, an amount equal to (i) the 2014 Baseline Pharmacy Average Dispensing Fee for such pharmacy and Medicare Dispensing Fee Guarantee Category *plus* (ii) the Aetna Cumulative Contract Medicare Dispensing Fee Change Amount for such year and Medicare Dispensing Fee Guarantee Category.

10. "Aggregate Average Pro Forma Pharmacy Average AWP Discount Rate" means, for a given calendar year and Medicare Discount Guarantee Category, the aggregate, weighted average (based on dollar spend) of the Medicare Pro Forma Pharmacy Average AWP Discount Rate for a specified group of Participating Pharmacies. This definition corresponds to the amounts set forth in columns D and K, rows 18 – 21, in the Part 5 Spreadsheet.

11. "Aggregate Average Pro Forma Pharmacy Dispensing Fee" means, for a given calendar year and Medicare Dispensing Fee Category, the aggregate, weighted average (based on prescription count) of the Medicare Pro Forma Pharmacy Average Dispensing Fee amounts for a specified group of Participating Pharmacies.

B. Notice of Jointly Contracted Pharmacies.

The Parties agree that on or before December 31 of each year (commencing with 2014), Aetna shall provide PBM with the names of all Participating Pharmacies that, pursuant to Schedule G, will be Jointly Contracted Pharmacies (as defined in Schedule G) in the following calendar year. With respect to each such Jointly Contracted Pharmacy, Aetna shall further advise PBM whether it will be a Jointly Contracted GER Pharmacy or a Jointly Contracted Non-GER Pharmacy (as such terms are defined in Schedule G) in such calendar year.

C. Medicare Guarantee Adjustment Report

Within forty-five (45) days after the last day of each calendar year (the "Prior Year") (commencing with 2014), PBM shall accurately determine and compute:

(i) if not previously determined pursuant to this Section C, for each Medicare Discount Guarantee Category and for each Participating Pharmacy, the 2014 Baseline Pharmacy Average AWP Discount Rate;

(ii) if not previously determined pursuant to this Section C, for each Medicare Dispensing Fee Category and for each Participating Pharmacy, the 2014 Baseline Pharmacy Average Dispensing Fee;

(iii) for each Medicare Discount Guarantee Category and with respect to *all* Participating Pharmacies, the Aggregate Average Pro Forma Pharmacy Average AWP Discount Rate for the Prior Year for such group of pharmacies (each, a "Prior Year All In Pro Forma AWP Discount Rate"); (This corresponds to columns D and K, rows 16 and 21, of the Part 5 Spreadsheet.)

(iv) for each Medicare Dispensing Fee Guarantee Category and with respect to *all* Participating Pharmacies, the Aggregate Average Pro Forma Pharmacy Dispensing Fee for the Prior Year for such group of pharmacies (each, a "Prior Year All In Pro Forma Dispensing Fee");

(v) for each Medicare Discount Guarantee Category and with respect to all Participating Pharmacies that will *not* be Jointly Contracted Pharmacies in the Adjustment Year, the Aggregate Average Pro Forma Pharmacy Average AWP Discount Rate for the Prior Year for such group of pharmacies (each, a "Prior Year Non-Jointly Contracted Pro Forma AWP Discount Rate"); (This corresponds to columns D and K, row 18, of the Part 5 Spreadsheet.)

(vi) for each Medicare Discount Guarantee Category that specifies a Retail Discount Guarantee for Generic Drugs and with respect to all Participating Pharmacies that will be Non-GER Jointly Contracted Pharmacies in the Adjustment Year, the Aggregate Average Pro Forma Pharmacy Average AWP Discount Rate for the Prior Year for such group of pharmacies (each, a "Prior Year Non-GER Jointly Contracted Pro Forma AWP Discount Rate"); (This corresponds to column K, row 20, of the Part 5 Spreadsheet.)

(vii) for each Medicare Dispensing Fee Category and with respect to all Participating Pharmacies that will *not* be Jointly Contracted Pharmacies in the Adjustment Year, the Aggregate Average Pro Forma Pharmacy Dispensing Fee for the Prior Year for such group of pharmacies (each, a "Prior Year Non-Jointly Contracted Pro Forma Dispensing Fee Guarantee"); and

(viii) for each Medicare Dispensing Fee Category that specifies a Dispensing Fee Guarantee for Generic Drugs and with respect to all Participating Pharmacies that will be Non-GER Jointly Contracted Pharmacies in the Adjustment Year, the Aggregate Average Pro Forma Pharmacy Dispensing Fee for the Prior Year for such group of pharmacies (each, a "Prior Year Non-GER Jointly Contracted Pro Forma Dispensing Fee Guarantee").

Prior to the expiration of such forty-five (45) day period, PBM shall deliver to Aetna an itemized written report setting forth all such determinations and computations (each such report, a "Medicare Guarantee Adjustment Report").

D. Adjustments to Medicare Retail Discount Guarantees.

If there will be any Participating Pharmacies that will be Jointly Contracted Pharmacies in the year that immediately follows the Prior Year (such year, the "Adjustment Year"), then the Parties shall make the following amendments to the Retail Discount Guarantees and Dispensing Fee Guarantees for the Adjustment Year set forth in Schedule Y-4 promptly after the delivery of the Medicare Guarantee Adjustment Report effective as of January 1 of the Adjustment Year:

1. Adjustments to Medicare Retail Discount Guarantees.

For each Medicare Discount Guarantee Category, the Parties shall amend Schedule Y-4 as necessary to cause the Retail Discount Guarantee for the Adjustment Year for such Medicare Discount Guarantee Category to be increased or decreased, effective as of January 1 of the Adjustment Year, utilizing the following formulation:

Amended Adjustment Year Retail Discount Guarantee = A + B – C + D

Where:

A: is the Effective Date Medicare Discount Guarantee for 2014 for such Medicare Discount Guarantee Category.

B: is the Aetna Cumulative Contract Medicare AWP Change Rate for such Medicare Discount Guarantee Category for the Adjustment Year.

C: is the Prior Year All In Pro Forma AWP Discount Rate for such Medicare Discount Guarantee Category.

D: is the Prior Year Non-Jointly Contracted Pro Forma AWP Discount Rate for such Medicare Discount Guarantee Category.

The formulation set forth in this Section D(1) corresponds to column K, rows 32 – 36, in the Part 5 Spreadsheet.

2. Establishment of New Generic Drug Retail Discount Guarantees for Non-GER Jointly Contracted Pharmacies.

For each Medicare Discount Guarantee Category that sets forth a Retail Discount Guarantee for Generic Drugs, the Parties shall amend Schedule Y-4 as necessary to include a new Generic Drug Retail Discount Guarantee Pricing Category for the Adjustment Year, that will be applicable, effective as of January 1 of Adjustment Year, to prescriptions dispensed by Non-GER Jointly Contracted Pharmacies, utilizing the following formulation:

New Adjustment Year Generic Drug Retail Discount Guarantee = A + B – C + D

Where:

A: is the Effective Date Medicare Discount Guarantee for 2014 for such Medicare Discount Guarantee Category.

B: is the Aetna Cumulative Contract Medicare AWP Change Rate for such Medicare Discount Guarantee Category for the Adjustment Year.

C: is the Prior Year All In Pro Forma AWP Discount Rate for such Medicare Discount Guarantee Category.

D: is the Prior Year Non-GER Jointly Contracted Pro Forma AWP Discount Rate for such Medicare Discount Guarantee Category.

The formulation set forth in this Section D(1) corresponds to column L, rows 32 – 36, in the Part 5 Spreadsheet.

3. Adjustments to Medicare Dispensing Fee Guarantees.

For each Medicare Dispensing Fee Guarantee Category, the Parties shall amend Schedule Y-4 as necessary to cause the Dispensing Fee Guarantee for the Adjustment Year for such Medicare Dispensing Fee Guarantee Category to be increased or decreased, effective as of January 1 of Adjustment Year, utilizing the following formulation:

Amended Adjustment Year Dispensing Fee Guarantee = A – (B – C)

Where:

A: is the Effective Date Dispensing Fee Guarantee for 2014 for such Medicare Discount Guarantee Category.

B: is the Prior Year All In Pro Forma Dispensing Fee for such Medicare Dispensing Fee Guarantee Category.

C: is the Prior Year Non-Jointly Contracted Pro Forma Dispensing Fee Guarantee for such Medicare Dispensing Fee Guarantee Category.

For the avoidance of doubt, if B is greater than C, then under the above formula, the amount of the excess shall be added to A.

4. Establishment of New Generic Drug Dispensing Fee Guarantees for Non-GER Jointly Contracted Pharmacies.

For each Medicare Dispensing Fee Guarantee Category that sets forth a Dispensing Fee Guarantee for Generic Drugs, the Parties shall amend Schedule Y-4 as necessary to include a new Generic Drug Dispensing Fee Guarantee Pricing Category for the Adjustment Year, that will be applicable, effective as of January 1 of the Adjustment Year, to prescriptions dispensed by Non-GER Jointly Contracted Pharmacies, utilizing the following formulation:

New Adjustment Year Dispensing Fee Guarantee = A – (B – C)

Where:

A: is the Effective Date Dispensing Fee Guarantee for 2014 for such Medicare Discount Guarantee Category.

B: is the Prior Year All In Pro Forma Dispensing Fee for such Medicare Dispensing Fee Guarantee Category.

C: is the Prior Year Non-GER Jointly Contracted Pro Forma Dispensing Fee Guarantee for such Medicare Dispensing Fee Guarantee Category.

For the avoidance of doubt, if B is greater than C, then under the above formula, the amount of the excess shall be added to A.

Part 6. OTHER CONDITIONS AND CLAIM PRICING REQUIREMENTS.

A. PBM acknowledges and agrees that the rates and dispensing fees Aetna charges to Aetna Customers may be different than the rates set forth in this Schedule Y. As provided in Section 9.10 of the Agreement and Schedule Y-12, PBM shall, on behalf of Aetna and the Aetna Plan Affiliates, process and administer Claims for Aetna Customers at such rates and dispensing fees as are communicated to PBM by Aetna from time to time.

B. Subject to reconciliation under Part 2 and Part 3 above, all Claims for Covered Drugs dispensed by retail Participating Pharmacies shall process and be charged to Aetna at the lowest of (i) the Participating Pharmacy's U&C Charge, (ii) if applicable MAC plus Dispensing Fee, or (iii) the applicable AWP Discounted Rate plus Dispensing Fee.

C. In the event PBM fails to update its pricing information as required by Law or pay pharmacies or Members in sufficient time to satisfy prompt pay and other Laws, PBM shall be responsible for any and all penalties, interest, charges, and/or fines that may be associated with such Claims.

D. The pricing and pricing guarantees provided for herein for each Pricing Category shall be administered and reconciled as a unique and distinct obligation and commitment of PBM, and no commingling or offsetting of such pricing terms and guarantees shall be allowed.

E. PBM will assume all risks associated with negotiating and contracting with Participating Pharmacies in connection with the Lock In Pricing provided for in this Schedule Y (*i.e.*, Large Account Lock-In, Small Account Lock-In, Medicaid Lock-In, Discount Card and Workers Compensation). PBM will be responsible for any amounts owed to Participating Pharmacies that exceed the payment it receives from Aetna for Claims that are subject to Lock-In Pricing and will retain any amount that it receives from Aetna that is more than the amount it is obligated to pay the Participating Pharmacies, subject to reconciliation pursuant to Part 2 and Part 3 of this Schedule Y.

Schedule Z

Authorized Uses of Data and Information

Pharmacy claims data, as well as eligibility information, which is de-identified in accordance with HIPAA and other applicable Laws, and which is not identifiable on an Aetna, Aetna Customer, and/or Member basis, may be used, disclosed, reproduced, adapted or sold by PBM. Such de-identified data may be provided to nationally recognized data integration firms to support appropriate administration of PBM's drug management programs or such other purpose consistent with improvement of programs and services provided by PBM to clients. This benchmarking data enables PBM to compare against other drug population sets and improve programs and services for clients. Notwithstanding the foregoing, in no case can PBM use, disclose, reproduce, adapt, or sell: (i) any data of Aetna Customer that restricts such uses, disclosures, adaptations, or sales, as identified by Aetna to PBM from time to time; (ii) any data obtained from Aetna Specialty Pharmacies; and/or (iii) any medical, dental, bio-metric, genetic, health status, wellness or other non-pharmacy data or information of Aetna, Aetna Affiliates, Aetna Customers or Members.

Schedule DD

Workers' Compensation Schedule

Core Services

Aetna's Workers' Compensation line of business is currently minimal. However, if Workers' Compensation Plans gain traction, they may be subject to certain general requirements of the other operating schedules under the Agreement. This Schedule DD will contain any modifications to the requirements of the other schedules and additional requirements not addressed in the other schedules. Accordingly, the Parties will collaborate following the Effective Date to develop this Schedule DD to meet the Parties' reasonable business requirements, all Aetna Customer obligations and all legal obligations in a cost effective manner and in a manner that ensures a smooth transition from any existing Aetna vendor with minimal disruption. The parties acknowledge that PBM, at its discretion, may engage a third party subcontractor to execute services described in this Schedule, and that the subcontractor may establish direct connectivity with Aetna and PBM in order to fulfill the requirements described herein.

SCHEDULE EE

ASSURANT HEALTH PBM AGREEMENT

I. Overview

PBM and Aetna have entered into a Letter of Agreement dated February 8, 2013, whereby the parties have agreed that Aetna will subcontract and delegate to PBM certain prescription drug and pharmacy benefit management functions and services ("PBM and Rx Services") required under the Managed Prescription Drug Program Agreement entered into by and between Aetna and Assurant Health as of April 5, 2012 (the "Carrier PBM Agreement"). In view of this new contractor/subcontractor relationship, certain modifications are hereby made to the Agreement through this Schedule EE which, in turn, incorporates by reference relevant sections of the Carrier PBM Agreement, a copy of which will be provided to PBM by Aetna. The obligations of the parties under this Schedule EE shall continue until the termination of the Carrier PBM Agreement, even if any term of the Carrier PBM Agreement extends beyond the term of the Agreement.

II. Article XV - Agreement – Indemnification

A. *General Statement of Intent:* In general terms, the intent is for the parties to indemnify, defend and hold harmless each other from and against all Losses arising out of the Agreement.

B. *Unique Requirements and Deviations from Article XV of the Agreement:*

1. The indemnification language provided in Article XV must extend to Losses arising out the Carrier PBM Agreement.

III. Schedule B -- Plan Benefit Set Up

A. *General Statement of Intent:* In general terms, the intent is for PBM to accept and load plan benefit information directly from Assurant Health ("Carrier") in accordance with the overall requirements of Schedule B.

B. *Unique Requirements and Deviations from Schedule B:*

1. The word "Carrier" should generally be substituted for "Aetna" throughout Schedule B.

2. PBM will make best efforts to accept Carrier's Benefit Plan Design information via (i) Aetna or (ii) Carrier in accordance with a process mutually agreed upon by PBM and Aetna.

3. PBM must comply with the provisions of Section 2.4 of the Carrier PBM Agreement.

4. PBM must provide a CVS Caremark branded web site customized for Carrier with single sign-on capabilities in accordance with the terms of the Carrier request for proposal, dated July 1, 2011 and the provisions of Section 2.5 of the Carrier PBM Agreement.

IV. Schedule C -- Eligibility

A. *General Statement of Intent:* In general terms, the intent is for PBM to accept and load eligibility information directly from Carrier in accordance with the overall requirements of Schedule C.

B. *Unique Requirements and Deviations from Schedule C:*

1. The word "Carrier" should generally be substituted for "Aetna" throughout Schedule C.

2. Without limiting the generality of the foregoing, PBM must give Carrier the ability to enter Eligibility Files directly on-line to PBM's claims processing system.

3. PBM must comply with the provisions of Sections 2.2, 2.3 (including the requirement in Section 2.3.4 to deliver at least one annual benefits statement at no cost), 2.5, 3.1.13, 3.2, and 3.4.2.2 .

V. Schedule D -- Claims Processing and Adjudication

A. *General Statement of Intent:* In general terms, the intent is for PBM to perform claims processing and adjudication for the Program in accordance with the requirements of Schedule D, subject to a relatively small number of unique requirements for Carrier, as a distinct health insurer.

B. *Unique Requirements and Deviations from Schedule D:*

1. PBM must comply with the requirements of Section 3.2 of the Carrier PBM Agreement, including the requirements in Section 3.2.1 to comply with prompt pay deadlines of Carrier. As further provided in Section 3.2.1, Carrier shall have final responsibility for all decisions relating to coverage and allowable benefits, including determining whether any rejected or disputed claim shall be allowed. PBM shall cooperate with Carrier to establish the same kind of appeal coordination protocols between PBM and Carrier that PBM has established with Aetna.

2. PBM must provide a claim file to Carrier in accordance with Section 3.2.2 of the Carrier PBM Agreement.

3. PBM shall comply with the claim processing turnaround time requirements in Section 3.2.3 of the Carrier PBM Agreement.

VI. Schedule E -- Customer and Member Services

A. *General Statement of Intent:* In general terms, the intent is for Carrier to retain responsibility for Customer and Member Services, and for PBM to support those capabilities, through on-line tools, reporting capabilities and general account management support.

B. *Unique Requirements and Deviations from Schedule E:*

1. The following provisions of Schedule E shall not apply to the Program:

   a. Section 1 -- Carrier will provide Customer and Member Services

   b. Section 2 -- Customer and Member Services will not be Aetna branded.

   c. Section 3 -- Carrier will manage CSRs.

   d. Section 4 -- Scripting is inapplicable.

   e. Section 7 -- Carrier will manage CSRs. PBM shall provide the systems capabilities for Carrier's CSRs to process eligibility overrides.

   f. Section 13 -- Carrier will utilize its own processes for multi-level call support.

   g. Section 16 -- Carrier will operate its own Member Call Center (except PBM shall provide IVR capabilities in accordance with the requirements of Section 3.2.4 of the Carrier PBM Agreement.

   h. Section 34 -- The workers' compensation provisions are inapplicable to this relationship.

2. The following provisions of Schedule E shall continue to apply, but with the following deviations:

   a. Section 5 -- The word "Carrier" should be substituted for “Aetna" in this Section.

   b. Section 12 -- Inasmuch as Carrier is retaining the CSR function, the need for call transfers will arise less frequently, but where the need does arise, the word "Carrier" should be inserted for "Aetna" in this Section.

   c. Sections 19 through 21 -- Carrier will respond to Member inquiries received through the Member Call Center, but PBM shall comply with the requirements for member issue resolution set forth in Section 3.2.5.

   d. Section 22 -- Carrier shall handle all verbal and written complaints and grievances, provided that PBM shall assist with member issue resolution in accordance with the requirements of Section 3.2.5 of the Carrier PBM Agreement. With regard to the requirements for appeals, the word "Carrier" should be inserted for "Aetna".

   e. Section 24 -- In the event PBM receives a complaint from a customer of Carrier, PBM shall promptly and timely route such complaints to Carrier in accordance with the requirements of Section 24.

f. Sections 26 through 29 – PBM must provide system access, interface and other web-based tools to Carrier, Participating Pharmacies, and Carrier's members in accordance with Section 2.5 of the Carrier PBM Agreement; provided, however, that any links mutually developed by Aetna and Carrier under Section 2.5.4 of the Carrier PBM Agreement must be approved by PBM.

g. Sections 30 through 33 and 35 shall continue to apply, but in a much more limited respect since Carrier will be managing the Member Call Center.

3. PBM will be only responsible for "after hours" customer and member services.

VII. Schedule F – Prescription Drug Utilization Review

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide Aetna with DUR edits.

B. *Unique Requirements and Deviations from Schedule F:*

1. PBM will be providing DUR edits to Carrier in accordance with the instructions provided to PBM by Aetna regarding same and as generally described in Sections 3.5.3.1 and 3.5.3.2 of the Carrier BM Agreement. Accordingly, all references to Aetna shall mean references to Carrier.

VIII. Schedule G – Pharmacy Network Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide and maintain its Participating Pharmacies for Aetna.

B. *Unique Requirements and Deviations from Schedule E:*

1. PBM must comply with Section 3.1 of the Carrier PBM Agreement. All references to Aetna shall apply to Carrier.

2. Without limiting the generality of the foregoing, PBM must triage materially negative effects on member access in Section 3.1.9 of the Carrier PBM Agreement which differ somewhat from the Agreement.

IX. Schedule H – Communications

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide Aetna branded communications.

B. *Unique Requirements and Deviations from Schedule H:*

1. Communications may be private labeled for Carrier or they may be PBM labeled subject to Carrier's requirements. It is not the intent to have Aetna branded communications under the Carrier PBM Agreement.

X. Schedule I – Rebate Administration

A. *General Statement of Intent:* In general terms, the intent is for Aetna to administer its own rebate program, but to have access to PBM's suite of computer systems to conduct more cost effective rebate administration once such systems become available to Aetna.

B. *Unique Requirements and Deviations from Schedule I:* There are no unique requirements or deviations. Aetna will continue to administer its rebate program under this Schedule I as written.

XI. Schedule J – Clinical Services and Formulary Administration

A. *General Statement of Intent:* In general terms, the intent is for Aetna to retain control over Clinical Services to the same degree as specified in Schedule J. Similarly, Aetna will control the formulary. Communications with members will not be Aetna branded.

B. *Unique Requirements and Deviations from Schedule J:*

1. The exchanges of medical and care management data in accordance with Carrier requirements shall be conducted directly with Carrier rather than Aetna.

2. The approvals contemplated by Section J.8 shall be obtained from Carrier rather than Aetna.

3. The disease management coordination contemplated by Section J.15 and the care management coordination contemplated by Sections J.17, 18 and 20 shall be conducted with Carrier rather than Aetna.

4. Aetna shall provide directly to Carrier the General Support and Consultative Services set forth in Section 3.4.1 of the Carrier PBM Agreement and shall provide to Carrier the standard financial management, utilization, clinical and decision support data reporting and on-line access services set forth in Sections 2.7, 3.4.3 and 3.14 of the Carrier PBM Agreement.

5. For purposes of clarification, Aetna will provide directly to Carrier the clinically-based programs and services described in Section 3.5 of the Carrier PBM Agreement except for the prior authorization services described in Section 3.5.5 of the Carrier PBM Agreement which will be undertaken by Carrier.

XII. Schedule K – Prior Authorization Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to administer prior authorization requests from Members and providers in accordance with Aetna's Clinical Policy Bulletins.

B. *Unique Requirements and Deviations from Schedule K:*

1. Carrier will administer the prior authorization services for its members in accordance with Section 3.5.5 of the Carrier PBM Agreement. References to Aetna and Members shall mean Carrier and Carrier's members.

XIII. Schedule L – Sales Support and Account Management Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide account management services for Aetna's customers and lines of business.

B. *Unique Requirements and Deviations from Schedule L:*

1. For purposes of this Schedule L, "Aetna Customer" shall mean Carrier and its downstream lines of business. Aetna will provide the account management services for Carrier's customers and lines of business in accordance with Section 3.4 of the Carrier PBM Agreement.

XIV. Schedule M – Supporting Mail Order Pharmacy Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide only back-end services for Aetna's mail order pharmacies.

B. *Unique Requirements and Deviations from Schedule M:*

1. PBM will provide both front-end and back-end pharmacy mail service to Carrier's members. All mail service prescription orders for mail service will be sent directly to PBM by providers and Carrier's members. PBM will be servicing Carrier's members under PBM's brand and label. All reference to Aetna and Members shall mean Carrier and Carrier's members.

2. PBM will meet the liability insurance requirements set forth in Section 6.1 of the Carrier PBM Agreement.

3. PBM will meet the audit requirements set forth in Section 3.1.11 of the Carrier PBM Agreement.

4. PBM will meet the eligibility, generic substitution and cost share collection requirements of Section 3.1.12 of the Carrier PBM Agreement.

XV. Schedule M-1 – Transition Mail Order Pharmacy Services

NOT APPLICABLE

XVI. Schedule N – Supporting Specialty Pharmacy Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide only back-end services for Aetna's specialty pharmacy if and to the extent that Carrier elects to obtain specialty pharmacy services under the Carrier PBM Agreement.

C. Unique Requirements and Deviations from Schedule N:

1. PBM will provide both front-end and back-end services for Aetna's specialty pharmacy at the request of Carrier. Currently, Carrier intends to use its own specialty pharmacy network. However, in the event Carrier requests specialty pharmacy services from PBM, PBM will operate under its own brand name, including all prescription drug labeling. All reference to Aetna and Members shall mean Carrier and Carrier's members.

2. If requested to provide specialty pharmacy services, PBM will meet the liability insurance requirements set forth in Section 6.1 of the Carrier PBM Agreement.

3. If requested to provide specialty pharmacy services, PBM will meet the audit requirements set forth in Section 3.1.11 of the Carrier PBM Agreement.

4. If requested to provide specialty pharmacy services, PBM will meet the eligibility, shipping and cost share collection requirements of Section 3.1.15 of the Carrier PBM Agreement.

XVII. Schedule N-1 – Transition Specialty Pharmacy Services

NOT APPLICABLE

XVIII. Schedule O – Medicare Services

NOT APPLICABLE

XIX. Schedule P – Medicaid and Other State Plan Services

NOT APPLICABLE

XX. Schedule Q – Description of Committees

NOT APPLICABLE

XXI. Schedule R – Performance Standards and Service Levels

A. *General Statement of Intent:* In general terms, the intent is to establish the performance standards and service levels acceptable to Aetna.

B. *Unique Requirements and Deviations from Schedule R:* Insofar as Aetna has defined Carrier as an R1 customer, PBM will provide Carrier-specific performance guarantee reporting.

C. PBM acknowledges and agrees that the performance guarantees undertaken by PBM pursuant to the Agreement may not be comparable to, or may be measured and reported differently from, those performance guarantees to be undertaken by PBM pursuant

to the Carrier PBM Agreement. More specifically, in accordance with Section 3.7 and Exhibit D of the Carrier PBM Agreement, PBM agrees to undertake responsibility for the following performance guarantees.

1. Performance Guarantee #1 (System Outage) measured and reported on a Contract Quarter and PBM's book of business basis.

2. Performance Guarantee #2 (System Availability) measured and reported on a Contract Quarter and PBM's book of business basis.

3. Performance Guarantee #3 (Mail Turnaround Time Not Requiring Intervention) measured and reported on a Contract Quarter and PBM's book of business basis.

4. Performance Guarantee #4 (Mail Turnaround Time Requiring Intervention) measured and reported on a Contract Quarter and PBM's book of business basis.

5. Performance Guarantee #5 (Mail Service Prescription Dispensing Accuracy) measured and reported on a Contract Quarter and PBM's book of business basis.

6. Performance Guarantee #6 (Network Stability) measured and reported on a Contract Quarter and PBM's book of business basis.

7. Performance Guarantee #7 (Disaster Recovery Plan) measured and reported on a Contract Year and PBM's book of business basis.

8. Performance Guarantee #8 (Member Submitted Claim Financial Accuracy) measured and reported on a Contract Quarter and PBM book of business basis.

9. Performance Guarantee #9 (Phone Average Speed of Answer) measured and reported on a Contract Quarter and PBM's book of business basis.

10. Performance Guarantee #10 (Call Blockage) measured and reported on a Contract Quarter and PBM's book of business basis.

11. Performance Guarantee #11 (Phone Abandonment Rate) measured and reported on a Contract Quarter and PBM's book of business basis.

12. Performance Guarantee #12 (Written Inquiries) measured and reported on a Contract Quarter and PBM's book of business basis.

13. Performance Guarantee #13 (Management Report Accuracy) measured and reported on a Contract Quarter and Carrier specific basis.

14. Performance Guarantee #14 (Account Management Availability of Online Tool Prescription Drug Package Management Reports) shared with Aetna, measured on a monthly and Contract Quarter basis and reported on a Contract Quarter and Carrier specific basis.

15. Performance Guarantee #20 (Member Satisfaction Surveys) measured on a Contract Year basis and reported on a Contract Year and Carrier specific basis.

16. Performance Guarantee #21 (Member Submitted Claim Turnaround Time) measured and reported on a Contract Quarter and Carrier specific basis.

17. Performance Guarantee #22 (Eligibility Updates) measured and reported on a Contract Quarter and Carrier specific basis.

18. Performance Guarantee #23 (Plan Designs Changes/Updates/New Installations Accuracy) measured and reported on a Contract Quarter and Carrier specific basis.

19. Performance Guarantee #24 (Reporting) measured and reported on a Contract Quarter and Carrier specific basis.

20. Performance Guarantee #25 (Electronic Prescription Drug Claims Processing Accuracy) measured and reported on a Contract Quarter and Carrier specific basis.

21. Performance Guarantee #26 (Retail Pharmacy Network Access) measured and reported on a Contract Quarter and Carrier specific basis.

D. In accordance with Section 3.7 and Exhibit D of the Carrier PBM Agreement, Aetna agrees to undertake responsibility for the following performance guarantees.

1. Performance Guarantee #14 (Account Management Availability of Online Tool Prescription Drug Package Management Reports) shared with PBM, measured on a monthly and Contract Quarter basis and reported on a Contract Quarter and Carrier specific basis.

2. Performance Guarantee #15 (Account Management Peer-Reviewed Management Report) measured and reported on a Contract Quarter basis and Carrier specific basis.

3. Performance Guarantee #16 (Account Management Team Satisfaction) measured and reported on Contract Quarter and Carrier specific basis.

4. Performance Guarantee #17 (Account Management Delivery of Peer-Reviewed Audit Guarantee Results) measured on a Contract Year basis and reported on a Contract Quarter and Carrier specific basis.

5. Performance Guarantee #18 (Account Management Responsiveness) measured and reported on a Contract Quarter and Carrier specific basis.

6. Performance Guarantee #19 (Account Management Issue Resolution) measured and reported on a Contract Quarter and Carrier Specific basis.

7. Performance Guarantee #27 (Annual Report) provided to Carrier at least six (6) weeks prior to Aetna's presentation of the annual report to Carrier's senior management team.

E. The Performance Guarantee report card shall be provided to Carrier no later than thirty (30) days after the end of the applicable Contract Quarter for those guarantees that monitored on a Contract Quarter basis.

F. The Performance Guarantee report card shall be provided to Carrier no later than sixty (60) days after the end of the applicable Contract Year for those guarantees that are monitored on a Contract Year basis.

G. Performance guarantees measured across PBM's book of business shall be based on PBM's standard calculation methodology except as may be otherwise set forth in Exhibit D. "Book of business" shall mean measured in the aggregate across all PBM clients.

XXII. Schedule S – Retiree Drug Subsidy Services

NOT APPLICABLE

XXIII. Schedule T-1 – Termination Transition Services

A. *General Statement of Intent:* In general terms, the intent is for the parties to establish a good faith transition in the event of a termination of the Agreement.

B. *Unique Requirements and Deviations from Schedule T-1:* The terms and conditions of Schedule T-1, other than the performance guarantees set forth therein which are specific to Aetna, shall also apply to the termination of the Carrier PBM Agreement.

XXIV. Schedule U – Information Technology Systems and Services

A. *General Statement of Intent:* In general terms, the intent is to provide information technology support and private label web site interaction for Aetna and its customers.

B. *Unique Requirements and Deviations from Schedule U:*

1. PBM will supply the IT systems and services described in Schedule U to Carrier, Carrier's customers and affiliates to the extent required by and negotiated with Carrier. Aetna Customer shall mean Carrier and Carrier's customers.

2. Aetna will provide the program management services described in Sections 2.7 and 3.4.3 of the Carrier PBM Agreement.

XXV. Schedule V – Reporting

A. *General Statement of Intent:* In general terms, the intent is to provide standard, custom, ad-hoc, quality assurance and other reports to Aetna as negotiated by the parties.

B. *Unique Requirements and Deviations from Schedule V:*

1. Aetna will provide standard management information reporting to Carrier in accordance with Section 2.7 and Exhibit B of the Carrier PBM Agreement.

2. Aetna, with the assistance of PBM, will provide drug utilization review reporting in accordance with Section 3.5.3 of the Carrier PBM Agreement.

3. Aetna, with the assistance of PBM, will provide Carrier data and negotiated on-line reports in accordance with Section 3.4.2 of the Carrier PBM Agreement.

4. PBM will negotiate with Carrier for any other reporting desired by Carrier.

XXVI. Schedule W -- Manufacturer Revenues

NOT APPLICABLE

XXVII. Schedule X – Audits

A. *General Statement of Intent:* In general terms, the intent is to describe PBM's audit obligations and Aetna's rights to audit certain negotiated services, e.g., pharmacy operations, claims, benefit plans, compliance with prior authorization and eligibility, etc.

C. *Unique Requirements and Deviations from Schedule X:*

1. PBM and Aetna will meet Carrier's audit requests in accordance with Sections 3.1.10, 3.1.11, 3.7, 4.4.1, 4.4.2 and Exhibit C of the Carrier PBM Agreement.

XXVIII. Schedule Y – Pricing

A. *General Statement of Intent:* In general terms, the intent is to define the pricing terms that are charged to Aetna for services and goods rendered to Members.

B. *Unique Requirements and Deviations from Schedule Y:*

Carrier's pricing will be reconciled with all of the Aetna Schedule Y-2 Customers in the aggregate and custom adjusted to deliver on the pricing set forth in Exhibit A to the Carrier PBM Agreement. Assurant Members will be subject to the pricing set forth in the Supplemental Pricing Schedule set forth below effective January 1, 2013.

XXIX. Schedule Z – Authorized Uses of Data and Information

NOT APPLICABLE

XXX. Schedule AA – PBM Licensed IP

NOT APPLICABLE

XXXI. Schedule BB – Description of PBM Designated and Dedicated Personnel

A. *General Statement of Intent:* In general terms, the intent is to describe the staffing of adequately trained and background investigated employees for Aetna's line(s) of business.

B. Unique Requirements and Deviations from Schedule BB:

1. PBM agrees to meet the very high security controls for its employees and subcontractors, including off-shore subcontractors, as set forth in Section 3.15 of the Carrier PBM Agreement.

XXXII. Schedule CC – Liquidated Damages

NOT APPLICABLE

XXXIII Schedule DD – Workers' Compensation Schedule

NOT APPLICABLE

XXXIV Schedule FF – ScripWorld PBM Agreement

NOT APPLICABLE

XXXV Schedule GG – Aetna Plan Affiliates and/or Aetna Customers Receiving Front End Pharmacy Services from PBM

Assurant Health will be identified on this Schedule GG.

SUPPLEMENTAL PRICING SCHEDULE

Schedule FF

Scrip World PBM Agreement

I. Overview

PBM and Aetna have entered into an amendment effective the 1st day of January, 2013, whereby the parties have agreed that Scrip World, LLC ("Scrip World"), an Acquired Business, and PBM will incorporate those prescription drug and pharmacy benefit management services described in the Prescription Benefit Services Agreement by and between Scrip World and PBM effective as of September 1, 2011 into the Agreement. Such prescription drug and pharmacy benefit management services shall fall within PBM Services. To facilitate such incorporation, it is necessary to restate the Schedules to the Agreement under this Schedule FF to reflect that PBM Services will also be provided on behalf of Scrip World and its customers as necessary to fulfill certain obligations of Scrip World under the Pharmacy Benefits Agreement by and between Scrip World and Meritain Health, Inc. effective as of September 1, 2011 (the "Global Meritain Agreement") and accompanying Joinder Agreements. Notwithstanding anything contained in either the Aetna PBM Agreement or this Amendment, the Parties understand and agree that due to the Scrip World third-party administrator business model, (i) Scrip World, or Prodigy its parent company, shall have the option at its sole discretion to subcontract PBM Services to pharmacy benefit managers other than PBM and (ii) the election of such option shall not constitute a breach of either the Aetna PBM Agreement or this Amendment.

For purposes of this Schedule FF and the Schedules described below:

"Aetna Plan Affiliates" and "Aetna Customers" shall also mean those entities that (i) provide prescription drug benefits to plan participants, (ii) contract with Meritain Health, Inc. to manage and administer such benefits, and (iii) contract with Scrip World to receive PBM Services for their plan participants; and

"Member" shall also mean those individuals eligible to receive PBM Services through Scrip World.

II. Article XV - Agreement – Indemnification

A. *General Statement of Intent:* In general terms, the intent is for the parties to indemnify, defend and hold harmless each other from and against all Losses arising out of the Agreement.

B. *Unique Requirements and Deviations from Article XV of the Agreement:* The indemnification language provided in Article XV must extend to Losses arising out of the Agreement for services performed for and under the Global Meritain Agreement.

III. Schedule B -- Plan Benefit Set Up

A. *General Statement of Intent:* In general terms, the intent is for PBM to accept and load plan benefit information directly from Aetna in accordance with the overall requirements of Schedule B.

B. *Unique Requirements and Deviations from Schedule B:* PBM shall now also accept and load plan benefit information directly from Scrip World or Scrip World's customers.

1. Scrip World or Scrip World's customers shall provide PBM with ten (10) days prior written notice of any proposed changes to the Benefit Plan Design, which changes shall be consistent with the scope and nature of the Services to be performed by PBM under the Agreement.

2. For non-standard benefit additions or complex changes the parties shall mutually agree on an appropriate extension.

3. Scrip World shall provide PBM with five (5) business days prior written notice of any new Nation Care Benefit Plan Design or Nation Care option, which shall be consistent with the scope and nature of the Services to be performed by PBM under the Agreement for Nation Care. The Benefit Plan Design request provided by Scrip World shall be accurate and complete. If PBM receives additions or modifications to the Nation Care Benefit Plan Design request or Nation Care option, the five (5) business day period shall start at the time PBM receives any addition or modification to the Benefit Plan Design request. This service level criteria applies to Nation Care Benefit Plan Design or option submitted by Scrip World that does not require a custom formulary.

4. PBM will notify Scrip World in writing within one business day of the receipt of the Nation Care Benefit Plan Design or option, that the Nation Care Benefit Plan Design or option received requires a custom formulary. In such cases, PBM will provide the custom formulary within ten (10) business days. Scrip World acknowledges custom formularies are subject to a modification or amendment of the financial provisions in the Agreement.

5. Scrip World agrees that it is responsible for Losses resulting from (i) any failure to implement Benefit Plan Design changes which are not communicated in a written format acceptable to PBM, or (ii) PBM's implementation of Scrip World's verbal or written direction regarding exception or overrides to the Benefit Plan Design.

6. Scrip World shall cause notification to be given by its customers to notify Plan Participants of any Benefit Plan Design changes prior to the effective date of any such changes.

IV. Schedule C -- Eligibility

A. *General Statement of Intent:* In general terms, the intent is for PBM to accept and load eligibility information directly from Aetna in accordance with the overall requirements of Schedule C.

B. *Unique Requirements and Deviations from Schedule C:* The only material deviation is that PBM shall now also accept and load all eligibility information directly from Scrip World, including Scrip World's customers under contract with Meritain Health.

V. Schedule D -- Claims Processing and Adjudication

A. *General Statement of Intent:* In general terms, the intent is for PBM to perform claims processing and adjudication for Aetna's Customers and Members in accordance with the Benefit Plan Designs and the requirements of Schedule D.

B. *Unique Requirements and Deviations from Schedule D:* The only material deviation is that PBM shall now also perform claims processing and adjudication for Scrip World's customers and plan participants in accordance with their Benefit Plan Designs

VI. Schedule E -- Customer and Member Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide customer services, including member call centers, branded as Aetna in accordance with the overall requirements of Schedule E.

B. *Unique Requirements and Deviations from Schedule E:* The only material deviation is that PBM is not required to brand such services in the name of Scrip World. Rather, these services will be identified as PBM branded services, unless otherwise mutually agreed to by Scrip World and PBM.

1. With respect to Scrip World's customers' prescription drug benefit plans (the "Plan"), Scrip World's customers retain the sole and absolute authority to design, amend, terminate or modify, in whole or in part, all or any portion of the Plan, including the sole authority to control and administer the Plan and any assets of the Plan and to construe the terms of the Plan, to interpret ambiguous Plan language, to make factual determinations regarding the payment of Claims or provision of benefits, to review denied Claims and to resolve member complaints. PBM shall not be (i) the administrator of the Plan for any purpose; (ii) a named fiduciary with respect to the Plan for purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") or any applicable state law; (iii) delegated discretionary authority or responsibility, or exercise discretionary authority or control, with respect to the Plan or its administration; or (iv) deemed a fiduciary with respect to the Plan for purposes of ERISA or any applicable state law, except as may be expressly set forth in Appendix A.

VII. Schedule F – Prescription Drug Utilization Review

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide Aetna with DUR edits.

B. *Unique Requirements and Deviations from Schedule F:* PBM will be offering and providing PBM's standard point of sale (concurrent) DUR edits to Scrip World subject to Scrip World's selection and approval thereof. Such edit programs may include, but not necessarily be limited to, (i) Acute Frequency – Proton Pump Inhibitor Program, (ii) Brand Drug to Generic Drug, (iii) Drug/Drug Interaction, (iv) High Utilization (Core Safety and Monitoring), (v) Retail to Mail, (vi) Therapeutic Duplication and (vii) Patient Safety. PBM shall not be required to implement custom Aetna DUR edits or processes as defined in Schedule F.

VIII. Schedule G – Pharmacy Network Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide and maintain its Participating Pharmacies for Aetna.

B. *Unique Requirements and Deviations from Schedule E:* The only material deviation is that PBM will be providing and maintaining its Participating Pharmacies for Scrip World as well.

IX. Schedule H – Communications

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide Aetna branded communications.

B. *Unique Requirements and Deviations from Schedule H:* The only material deviation is that written marketing materials may be Scrip World branded or co-branded with Scrip World and PBM as mutually agreed and as standard PBM operations allow. Member services call center communications will be PBM labeled.

X. Schedule I – Rebate Administration

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide Rebate Administration services to Scrip World.

B. *Unique Requirements:* Scrip World authorizes PBM to contract with pharmaceutical companies for Rebates as a group purchasing organization for the Plan. PBM or its affiliates may hold contracts with pharmaceutical companies relating to products covered under this Schedule FF. In connection with such contracts, PBM or its affiliates may have a financial relationship with such pharmaceutical companies and may receive and retain fees or other compensation from pharmaceutical companies for services rendered and property provided to pharmaceutical companies, including, without limitation, administrative fees that range between one percent (1%) and four percent (4%) of the wholesale acquisition cost of the products dispensed across PBM's book

of business. In addition, PBM or its affiliates may receive and retain rebates and discounts from such pharmaceutical companies which are attributable to or based on products purchased by PBM's affiliated dispensing pharmacies. Such rebates and discounts are negotiated on behalf of, and belong exclusively to, PBM or its affiliates and are not negotiated on behalf of any client or plan. Neither Scrip World nor any of its customers shall have any right to or interest in such rebates or discounts.

XI. Schedule J – Clinical Services and Formulary Administration

A. *General Statement of Intent:* In general terms, the intent is for Aetna to retain control over Clinical Services to the same degree as specified in Schedule J. Similarly, Aetna will control the formulary. Communications with members will be Aetna branded.

B. *Unique Requirements and Deviations from Schedule J:* The major deviations are that (i) PBM will control all clinical services and the formulary and (ii) communications may be PBM branded, Scrip World branded or co-branded with Scrip World and PBM as mutually agreed and as standard PBM operations allow.

XII. Schedule K – Prior Authorization Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to administer prior authorization requests from Members and providers in accordance with Aetna's Clinical Policy Bulletins.

B. *Unique Requirements and Deviations from Schedule K:* The major deviation is that PBM will administer prior authorization services entirely within its own clinical policies.

XIII. Schedule L – Sales Support and Account Management Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide account management services for Aetna's customers and lines of business.

B. *Unique Requirements and Deviations from Schedule L:* The major deviation is that PBM is only obligated to provide base support for sales and account management services. Incremental support may be subject to fees as described further in Section 3 of Appendix B hereto. Scrip World will be primarily responsible for sales and account management services.

XIV. Schedule M – Supporting Mail Order Pharmacy Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide only back-end services for Aetna's mail order pharmacies.

B. *Unique Requirements and Deviations from Schedule M:* Scrip World's customers may elect to use PBM's mail order pharmacies. In such event, the major deviation is that PBM will provide full service (both front-end and back-end) pharmacy mail order services to Scrip World's eligible members. All mail

order pharmacy prescription orders will be sent directly to PBM by providers and Scrip World's members. PBM will be servicing Scrip World's eligible members under PBM's branding and prescription drug labeling.

XV. Schedule M-1 – Transition Mail Order Pharmacy Services

NOT APPLICABLE

XVI. Schedule N – Supporting Specialty Pharmacy Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide only back-end services for Aetna's specialty pharmacy.

B. *Unique Requirements and Deviations from Schedule N:* Scrip World's customers may elect to use PBM's specialty pharmacies. In such event, the major deviation is that PBM will provide full service (both front-end and back-end) specialty pharmacy services to Scrip World's eligible members. All specialty pharmacy prescription orders will be sent directly to PBM by providers and Scrip World's eligible members. PBM will be servicing Scrip World's eligible members under PBM's brand name and prescription drug labeling.

XVII. Schedule N-1 – Transition Specialty Pharmacy Services

NOT APPLICABLE

XVIII. Schedule O – Medicare Services

NOT APPLICABLE

XIX. Schedule P – Medicaid and Other State Plan Services

NOT APPLICABLE

XX. Schedule Q – Description of Committees

NOT APPLICABLE

XXI. Schedule R – Performance Standards and Service Levels

A. *General Statement of Intent:* In general terms, the intent is to establish the performance standards and service levels acceptable to Aetna.

B. *Unique Requirements and Deviations from Schedule R:* PBM will be required to perform the performance guarantees, and measure and report same, as described in Appendix C hereto.

XXII. Schedule S – Retiree Drug Subsidy Services

NOT APPLICABLE

XXIII. Schedule T-1 – Termination Transition Services

A. *General Statement of Intent:* In general terms, the intent is for the parties to establish a good faith transition in the event of a termination of the Agreement.

B. *Unique Requirements and Deviations from Schedule T-1:* The terms and conditions of Schedule T-1, other than the performance guarantees set forth therein which are specific to Aetna, shall also apply to Scrip World.

XXIV. Schedule U – Information Technology Systems and Services

A. *General Statement of Intent:* In general terms, the intent is to provide information technology support and private label web site interaction for Aetna and its customers.

B. *Unique Requirements and Deviations from Schedule U:* The major deviation is that PBM is not required to provide private label web site interaction but, rather, a PBM labeled internet website where Scrip World's eligible members can access information with respect to plan specific drug information, the formulary, cost shares, Participating Pharmacy listings and prescriptions. PBM will also provide support for single sign-on requirements through the Scrip World website. Scrip World's customers and members will be able to access PBM's formulary search engine via link from Scrip World's web site. And, PBM will customize, where possible, Scrip World logos and PDF placement. Insofar as PBM will be providing the PBM Services entirely on its own systems, the remaining information technology systems and services remain geared for Aetna. Scrip World may have access to any functionality and/or enhancements created for Aetna by PBM under the Agreement to the extent that such functionality and/or enhancements are compatible with the operating systems utilized by Scrip World and PBM in connection with the services provided under this Schedule FF.

XXV. Schedule V – Reporting

A. *General Statement of Intent:* In general terms, the intent is to provide standard, custom, ad-hoc, quality assurance and other reports to Aetna as negotiated by the parties.

B. *Unique Requirements and Deviations from Schedule V:* The reporting requirements for Scrip World are generally less stringent than those requirements for Aetna.

1. PBM shall prepare and provide Scrip World with PBM's standard management and utilization reports.

2. At Scrip World's expense, PBM may prepare and provide non-standard management and utilization reports and ad hoc reports within an agreed-upon time and format, at rates mutually agreed to by the parties.

3. If requested, PBM shall provide Scrip World with a copy of its most recent Type II SAS 70 report in accordance with the terms and conditions of such report.

4. PBM will report to Scrip World the pricing differential between Scrip World's customer account pricing rates and fees and the pricing rates and fees charged by PBM to Scrip World as set forth in Appendix B hereto. Scrip World will determine the pricing rates and fees for each of its customer accounts. PBM will provide accounting and reconciliation services to Scrip World through a monthly report that tracks the pricing differential between individual customer account pricing rates and the pricing rates and fees listed in Appendix B. The report, consisting of a data file submitted in NCPDP 2.0 format, will include Claims level detail for the pricing provided to Scrip World by PBM as set forth in Appendix B and the pricing provided to Scrip World's customers as determined by Scrip World. Claims level detail will include but not necessarily be limited to, fill date, NABP #, 11 digit NDC number, AWP, discounted AWP, dispensing fee, account cost, member cost (co-pay or co-insurance), quantity, U&C, and mail/retail indicator.

XXVI. Schedule W -- Manufacturer Revenues

NOT APPLICABLE

XXVII. Schedule X – Audits

A. *General Statement of Intent:* In general terms, the intent is to describe PBM's audit obligations and Aetna's rights to audit certain negotiated services, e.g., pharmacy operations, claims, benefit plans, compliance with prior authorization and eligibility, etc.

B. *Unique Requirements and Deviations from Schedule X:* The only deviation is that the audit procedures described in this Schedule X apply equally to Scrip World with the addition that PBM shall also audit the front-end fulfillment pharmacy services undertaken by its mail order and specialty pharmacies.

XXVIII. Schedule Y – Pricing

A. *General Statement of Intent:* In general terms, the intent is to define the pricing terms that are charged to Aetna for services and goods rendered to Members.

B. *Unique Requirements and Deviations from Schedule Y:* Scrip World's current invoicing and payment terms and conditions are set forth in Appendix B. Going forward, Scrip World's pricing under the Agreement shall be directionally the same as Aetna going forward as an Acquired Business and result in a revision to Schedule Y reflecting same.

XXIX. Schedule Z – Authorized Uses of Data and Information

A. *General Statement of Intent:* In general terms, the intent is to describe the conditions under which de-identified pharmacy claims data and eligibility

information of Aetna Customers and Members may be used, disclosed, reproduced, adapted or sold by PBM to nationally recognized data integration firms.

B. *Unique Requirements and Deviations from Schedule Z:* The authorized uses of data and information as set forth in Schedule Z shall apply equally to Scrip World Customers and Members.

XXX. Schedule AA – PBM Licensed IP

NOT APPLICABLE

XXXI. Schedule BB – Description of PBM Designated and Dedicated Personnel

A. *General Statement of Intent:* In general terms, the intent is to describe the staffing of adequately trained and background investigated employees for Aetna's line(s) of business.

B. *Unique Requirements and Deviations from Schedule BB:* The only major deviation is that PBM will designate personnel to service Scrip World's customer accounts as well.

XXXII. Schedule CC – Liquidated Damages

NOT APPLICABLE

XXXIII. Schedule DD – Workers' Compensation

NOT APPLICABLE

XXXIV. Schedule EE – Assurant Health

NOT APPLICABLE

XXXV. Schedule GG – Aetna Plan Affiliates and/or Aetna Customers Receiving Front-End Pharmacy Services from PBM

Scrip World will be identified on this Schedule GG.

APPENDIX A

ERISA Appeals

1. Scrip World represents that certain customers' Plans[1] are governed by ERISA. Rules related to the review of denied claims under ERISA Plans are provided below.

2. Scrip World will review denied level 1 Benefit Coverage Claims (i.e., claims related to eligibility and coverage of prescription drug benefits) and PBM (or Meritain Health at Scrip World's option) will review denied level 2 Benefit Coverage Claims. PBM will also conduct Medical Necessity Reviews (i.e., reviews resulting from a denial of authorization of prescription drug benefits where the Plan beneficiary is entitled to obtain a review of the denial by an independent physician specialist). Scrip World represents that it will provide PBM with a current and accurate copy of the applicable Plan Document, as defined herein. The "Plan Document" shall be the written document, as required by ERISA, which sets forth the Plan design and all other information concerning the prescription drug benefit plan including, but not limited to, eligibility for such benefits, the benefits to be provided, limitations on such benefits and the Plan's claims and review procedures. Scrip World, at its expense, will provide PBM with sufficient advance notice of any proposed amendments to the Plan Document.

3. Scrip World and PBM will conduct their respective appeals programs as described in Sections 3.a. and 3.b. below ("Appeals Programs").

   a. *Benefit Coverage Claims*. Level 1 and Level 2 appeals for Benefit Coverage Claims reviews will be based on the Plan Document provisions and criteria approved by the Plan, with respect to coverage of prescription drug benefits only, and shall not include a review of medical necessity as may be defined under the terms of the Plan Document. With respect to such review of Benefit Coverage Claims, PBM shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. PBM's decision shall be final, subject to judicial review only for abuse of discretion. PBM, in its sole discretion, consider the opinions of additional medical and/or legal experts with respect to interpretation of the Plan Document. PBM will review appeals in accordance with the rules and procedures established by it to govern appeals from the denials of Benefit Coverage Claims, as may be amended from time to time. PBM agrees to be a fiduciary solely for the purpose of reviewing appeals related to coverage of prescription drug benefits.

   b. *Medical Necessity Reviews*. PBM has contracted with an independent vendor or vendors for the processing of appeals resulting from Medical Necessity Reviews. PBM has entered or will enter into an agreement with the independent vendor(s), which provides for an appeals process consistent with the Appeals Programs. With respect to such reviews, the independent vendor shall act as a fiduciary and shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of the independent vendor shall be final, subject to judicial

[1] "Plan" means the health benefit plan(s) sponsored by Scrip World's Participating Groups' that includes the prescription drug benefit. "Participating Group" means a Plan sponsor that receives PBM Services through a pharmacy benefit management agreement with Scrip World.

review only for abuse of discretion. Scrip World shall pay PBM five hundred dollars ($500) per medical necessity appeal.

c. Under the Appeals Programs, Scrip World and PBM agree to be fiduciaries solely for the purposes described herein.

Non-ERISA Appeals

1. Scrip World represents that certain Plans are NOT governed by ERISA. Scrip World and PBM agree that the rules related to ERISA appeals as described immediately above shall apply equally to non-ERISA appeals.

Schedule GG

Aetna Plan Affiliates and/or Aetna Customers Receiving Front-End Pharmacy Services

Aetna Plans, Aetna Customers and/or lines of business covered by Schedule M-1 and/or Schedule N-1 will be identified in this Schedule GG.

1. Assurant Health, as described further in Schedule EE.

2. Scrip World, as described further in Schedule FF.

3. Dow, as described further in Schedule G-1.

Schedule GG-1

Dow Front-End Mail Order Pharmacy Services

I. Overview

Aetna and PBM have entered into the Dow Amendment effective the first day of January, 2013, whereby the Front-End Mail Order Pharmacy Services and other terms and conditions related thereto as more fully described in the Agreement shall be the responsibility of PBM's mail order pharmacies for Dow Members ("Dow FE Services") and no longer the responsibility of Aetna's mail order pharmacies as of January 1, 2013. To facilitate such new responsibilities, it is necessary to restate the Schedules to the Agreement under this Schedule GG.

II. Article XV – Agreement - Indemnification

A. *General Statement of Intent:* In general terms, the intent is for the parties to indemnify, defend and hold harmless each other from and against all Losses arising out of the Agreement.

B. *Unique Requirements and Deviations from Article XV of the Agreement:* The indemnification language provided in Article XV must extend to Losses arising out of the Agreement on account of Dow FE Services.

III. Schedule B -- Plan Benefit Set Up

NOT APPLICABLE - NO CHANGES

IV. Schedule C -- Eligibility

NOT APPLICABLE - NO CHANGES

V. Schedule D -- Claims Processing and Adjudication

NOT APPLICABLE - NO CHANGES

VI. Schedule E -- Customer and Member Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide customer services, including member call centers, branded as Aetna in accordance with the overall requirements of Schedule E.

B. *Unique Requirements and Deviations from Schedule E:* The only material deviation is that all customer services arising from Dow FE Mail Order Services will be branded in the name of PBM rather than Aetna. Customer care telephone numbers will remain the same.

VII. Schedule F – Prescription Drug Utilization Review

NOT APPLICABLE - NO CHANGES

VIII. Schedule G – Pharmacy Network Services

NOT APPLICABLE - NO CHANGES

IX. Schedule H – Communications

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide Aetna branded communications.

B. *Unique Requirements and Deviations from Schedule H:* The only material deviation is that certain written communication materials arising from Dow FE Services may be PBM branded or co-branded with Aetna.

X. Schedule I – Rebate Administration

NOT APPLICABLE - NO CHANGES

XI. Schedule J – Clinical Services and Formulary Administration

NOT APPLICABLE - NO CHANGES

XII. Schedule K – Prior Authorization Services

NOT APPLICABLE - NO CHANGES

XIII. Schedule L – Sales Support and Account Management Services

NOT APPLICABLE - NO CHANGES

XIV. Schedule M – Supporting Mail Order Pharmacy Services

A. *General Statement of Intent:* In general terms, the intent is for PBM to provide only Back-End Mail Order Pharmacy Services.

B. *Unique Requirements and Deviations from Schedule M:* The major general deviation is that PBM will provide Dow FE Services in accordance with Exhibit A and as otherwise set forth in the Dow Amendment. Specifically:

1. All Dow FE Services will be performed by PBM under PBM's brand and proprietary programs and systems, including without limitation, "CVS Caremark FastStart Process".

2 All mail order pharmacy prescription orders for Dow Members will be sent directly to PBM.

3. Prescription drug labeling, will be performed under PBM's brand.

4. PBM's mail order pharmacies performing Dow FE Services will be the pharmacies of record for purposes of fulfilling prescription drug orders on behalf of Dow Members.

5. PBM and Aetna may mutually agree to co-brand Dow Member materials such as custom mail forms with Dow specific phone numbers.

6. Dow Member access to web portal and point of entry will remain unchanged. Content may vary to support PBM mail order services.

7. PBM will be responsible for collecting Dow Member Cost Share from Dow Members only using PBM's policies and procedures.

8. The Dow FE Services are applicable only to those commercial Dow Members receiving services from Aetna

9. PBM is obligated to undertake the below client specific performance guarantees previously undertaken by Aetna's mail order pharmacies on account of Dow FE Services.

Mail Order Claim Administration	
▪ Turnaround Time – Clean Claims	98.0% within 2 business days of receipt
▪ Turnaround Time – Claims Requiring Intervention	95.0% within 5 business days of receipt
▪ Mail Order Dispensing Accuracy	99.98%

PBM may agree to undertake further, mutually agreed upon, performance guarantees as requested by Dow but, in no case, will such performance guarantees exceed those performance guarantees afforded to Aetna under the Agreement.

10. Controlled substances will be dispensed and shipped by PBM's mail order pharmacies rather than Aetna's mail order pharmacies.

11. Dow's commercial plans will be excluded from Aetna's mail order pharmacies' operations books of business reports.

12. Dow's commercial plans will be included in Aetna's book of business reports.

XV. Schedule M-1 – Transition Mail Order Pharmacy Services

NOT APPLICABLE - NO CHANGES

XVI. Schedule N – Supporting Specialty Pharmacy Services

NOT APPLICABLE - NO CHANGES

XVII. Schedule N-1 – Transition Specialty Pharmacy Services

NOT APPLICABLE - NO CHANGES

XVIII. Schedule O – Medicare Services

NOT APPLICABLE - NO CHANGES

XIX. Schedule P – Medicaid and Other State Plan Services

NOT APPLICABLE - NO CHANGES

XX. Schedule Q – Description of Committees

NOT APPLICABLE - NO CHANGES

XXI. Schedule R – Performance Standards and Service Levels

NOT APPLICABLE - NO CHANGES

XXII. Schedule S – Retiree Drug Subsidy Services

NOT APPLICABLE - NO CHANGES

XXIII. Schedule T-1 – Termination Transition Services

NOT APPLICABLE - NO CHANGES

XXIV. Schedule U – Information Technology Systems and Services

NOT APPLICABLE - NO CHANGES

XXV. Schedule V – Reporting

NOT APPLICABLE - NO CHANGES

XXVI. Schedule W -- Manufacturer Revenues

NOT APPLICABLE - NO CHANGES

XXVII. Schedule X – Audits

NOT APPLICABLE - NO CHANGES

XXVIII. Schedule Y – Pricing

A. *General Statement of Intent:* In general terms, the intent is to define the pricing terms that are charged to Aetna for services and goods rendered to Members.

B. *Unique Requirements and Deviations from Schedule Y:* The major deviation is the more favorable commercial retail incentive pass-through and mail

order/Maintenance pricing for Dow as a High Value Customer in accordance with Section 9.1(e) of the Agreement, as of January 1, 2013.. This pricing is set forth in Exhibit B (Schedule Y-17).

XXIX. Schedule Z – Authorized Uses of Data and Information

NOT APPLICABLE - NO CHANGES

XXX. Schedule AA – PBM Licensed IP

NOT APPLICABLE - NO CHANGES

XXXI. Schedule BB – Description of PBM Designated and Dedicated Personnel

NOT APPLICABLE - NO CHANGES

XXXII. Schedule CC – Liquidated Damages

NOT APPLICABLE - NO CHANGES

XXXIII. Schedule DD – Workers' Compensation

NOT APPLICABLE - NO CHANGES

XXXIV. Schedule EE – Assurant Health

NOT APPLICABLE - NO CHANGES

XXXV. Schedule FF – Scrip World

NOT APPLICABLE - NO CHANGES

XXXVI. Schedule GG – Aetna Plan Affiliates and/or Aetna Customers Receiving Front-End Pharmacy Services from PBM

Dow is identified on this Schedule GG.

REBATE ADMINISTRATION AND PHARMACY NETWORK AMENDMENT TO AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT

This **REBATE ADMINISTRATION AND PHARMACY NETWORK AMENDMENT TO THE AMENDED AND RESTATED PHARMACY BENEFIT MANAGEMENT SUBCONTRACT AGREEMENT** (this "Amendment"), effective January 1, 2019 (the "Amendment Effective Date"), and entered into by and between Aetna Health Management, LLC, a Delaware limited liability company ("Aetna"), on behalf of itself and its Affiliates Aetna RX Home Delivery, LLC, a Delaware limited liability company, and Aetna Specialty Pharmacy, LLC, a Delaware limited liability company, and CaremarkPCS Health, L.L.C., a Delaware limited liability company ("PBM"), on behalf of itself and its Affiliate Caremark Rx, L.L.C., a Delaware limited liability company.

RECITALS

A. Aetna and PBM are parties to a certain Amended and Restated Pharmacy Benefit Management Subcontract Agreement dated as of October 2, 2013, as previously amended (the "PBM Agreement"). Capitalized terms used but not otherwise defined in this Amendment shall have the respective meanings specified in the PBM Agreement.

B. The Parties have agreed to further amend the PBM Agreement in accordance with Section 17.13 thereof to set forth certain agreements between the Parties relating to the administration of rebates for Aetna's plans, mail order and specialty pharmacy services, and other matters as set forth below.

NOW, THEREFORE, in consideration of the promises, covenants, representations and warranties set forth herein, and other consideration, the sufficiency of which is hereby acknowledged, the Parties each hereby agree as follows:

1. Section 4.3.

(a) The definition of "Additional Rebates" in Section 4.3(a) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

> "Additional Rebates" means, except as set forth below, all rebates, discounts, service fees, financial adjustments and other consideration paid, credited or owing to and/or collected by Aetna, PBM or any of their respective Affiliates from any Manufacturer arising from or as a result of any arrangements, commitments, programs or activities involving or relating to (1) utilization (*e.g.*, market share, growth, etc.) of certain prescription drugs within their respective therapeutic categories whether measured on the basis of Claims and/or Services arising under this Agreement and/or any other part of PBM's book of business in aggregate, (2) services performed by Aetna, PBM or any of their Affiliates where Aetna, PBM or any of such Affiliates is paid fees or other compensation (excluding Service Fees) on the basis of the volume, value or acquisition cost of prescription drugs or other products that are prescribed or dispensed to Members, (3) the provision of financial

protections or adjustments to address future price increases, (4) the efficacy of Covered Drugs or actual Covered Drug utilization outcomes, or (5) any other circumstance, matter, outcome or activity that does not give rise to Other Manufacture Payments or Service Fees. For avoidance of doubt, Additional Rebates do not include Formulary Rebates or Service Fees. In addition, Additional Rebates include Manufacturer Administrative Fees, if any, with respect to (i) Rebate Covered Medicare Plans and (ii) State Plans, but *do not* include Manufacturer Administrative Fees with respect to any other Commercial Plans.

(b) The definition of "Aetna Rebates" in Section 4.3(a) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

"Aetna Rebates" means any and all Rebates, directly or indirectly, arising from or attributable to any of the Aetna Plans, the provision of services and/or the prescribing, dispensing or provision of prescription drugs or other products or services to or for Members; *provided, however,* that Manufacturer Administrative Fees shall not constitute Aetna Rebates, except with respect to (i) Rebate Covered Medicare Plans, and (ii) State Plans.

(c) The definition of "Manufacturer Administrative Fee" in Section 4.3(a) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

"Manufacturer Administrative Fee" means any fee or other compensation paid to PBM or any of its Affiliates by any Manufacturer for or by reason of any administrative or other services provided by PBM or such Affiliate to or for such Manufacturer in connection with administering, computing, invoicing, allocating and/or collecting Rebates, which range between [redacted] of the WAC of the brand products dispensed across PBM's book of business.

(d) The definition of "Rebates" in Section 4.3(a) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

"Rebates" means Formulary Rebates, Additional Rebates and Manufacturer Administrative Fees, if any, attributable to (1) Rebate Covered Medicare Plans and (2) State Plans. "Rebates" does not include Service Fees, Other Manufacturer Payments, Pharmacy Rebates or Manufacturer Administrative Fees attributable to Commercial Plans other than State Plans.

(e) The definition of "High-Value Plan Manufacturer Administrative Fes" in Section 4.3(a) is hereby deleted in its entirety.

(f) Subsection (i) of Section 4.3(b), "Rebate and Service Fee Contracting" of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

"(i) Aetna elects to have PBM perform and be responsible for contracting with Manufacturers with respect to Rebates arising from or relating to Covered Drugs dispensed to Members under the pharmacy benefit segment of the Covered Plans, as Optional Services pursuant to Section 3.2(b) and Schedules I I-1,

and I-2. PBM's Affiliates that participate in Aetna's Participating Pharmacy network will retain authority for contracting with Manufacturers with respect to Service Fees arising from or relating to Covered Drugs dispensed to Members by such Affiliates, whether under the pharmacy or medical benefit segments of the Covered Plans. PBM and PBM's Affiliates will possess responsibility and authority for implementing and administering contractual arrangements with Manufacturers regarding, and for invoicing and collecting, Rebates, Service Fees and other amounts owing thereunder.

(g) Subsections (ii) and (iv) of Section 4.3(b), "Rebate and Service Fee Contracting" of the PBM Agreement are hereby deleted in their entirety.

(h) Subsection (iii) of Section 4.3(b), "Rebate and Service Fee Contracting" of the PBM Agreement is hereby renumbered as Subsection (ii) and amended and restated in its entirety to read as follows:

(ii) With respect to each calendar year during which PBM performs Rebate Services for Rebate Covered Medicare Plans, PBM covenants and guarantees that the Aetna Rebates received by or credited to Aetna (or, at Aetna's direction, an Aetna Customer) shall equal [redacted] of the Aetna Rebates collected by PBM. PBM shall pay or credit to Aetna the Aetna Rebates in accordance with the requirements set forth in Section 3.3 of Schedule I-1.

(i) Section 4.3(c) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

(c) Receipt and Collection of Rebates and Services Fees.

(i) Aetna, acting on behalf of and as agent for the Aetna Plan Affiliates, shall be entitled to receive or be credited with (1) any and all Aetna Rebates, and (2) any and all Pharmacy Rebates arising from or attributable to retail Claims submitted by Members in those cases where Aetna or the applicable Aetna Plan Affiliate is charged Pass Through Pricing by PBM in respect of such Claims (collectively, the "Aetna Manufacturer Revenues"). Except as provided in Schedule I with respect to any period during which PBM is providing PBM Services thereunder, in the event that PBM or any of its Affiliates are paid or receive a credit for any Aetna Manufacturer Revenues, PBM shall, within ten (10) Business Days thereafter, pay or credit the full amount of such Aetna Manufacturer Revenues to Aetna.

(ii) Any Service Fees collected by PBM's Affiliates that participate in Aetna's Participating Pharmacy network, as contemplated by Section 4.3(b)(i), shall not constitute Aetna Manufacturer Revenues.

2. Section 9.1.

(a) Subsection 9.1(f)(iii) of the PBM Agreement is hereby amended and restated in its entirety to read as follows:

(iii) No Renewal Customer may be designated as a High-Value Plan effective prior to January 1, 2018.

3. Annex A.

(a) Annex A to the PBM Agreement is hereby amended by inserting the following new definitions:

"Rebate Covered Commercial Plans" has the meaning given in Section 1.1 of Schedule I-2.

"Scrip World Plan" shall mean any Aetna Plan subject to the pricing terms set forth in Schedule Y-20 of this Agreement.

(b) Annex A to the PBM Agreement is hereby amended by deleting the following definitions in their entirety:

"Aetna Commercial Rebate Agreements".

"High Value Plan Rebate Guarantees"

"High Value Plan Rebate Services"

4. Schedule I.

(a) Schedule I and Schedule I-2 of the Agreement are hereby amended and restated in their entirety in the form attached hereto as Appendix A and Appendix B, respectively.

(b) Schedule I-1 of the Agreement is hereby amended as follows:

i. As of January 1, 2019, all references to Guaranteed Rebates are stricken from Schedule I-1 of the Agreement and all sections thereof previously containing a reference to Guaranteed Rebates shall be construed, to the greatest extent possible, to interpret references to Guaranteed Rebates to mean [redacted] of Aetna Rebates collected by PBM with respect to Rebate Covered Medicare Plans.

ii. Section 3.3 of Schedule I-1 of the Agreement is hereby amended and restated in its entirety to read as follows:

> 3.3 **Payment of Rebates to Aetna.** For any period during which PBM performs Rebate Services or collects any Aetna Rebates, within ninety (90) days after the end of each calendar quarter, or such other time period mutually agreed upon by the Parties, PBM shall pay to Aetna [redacted] of the Rebate Category Invoiced Rebates, for the immediately preceding calendar quarter (based upon Paid Claims dispensed during such calendar quarter). Upon the close of collections with Manufacturers, or at such other time mutually agreed upon by the Parties, and in no event less frequently than one hundred eighty (180) days

following the close of each calendar year, PBM shall reconcile Rebates paid to Aetna against [redacted] of Rebates collected, and (a) if Rebates collected exceed Rebates previously paid, PBM shall promptly pay any excess to Aetna, or (b) if Rebates previously paid to Aetna exceed Rebates collected, Aetna shall promptly repay such overage to PBM.

5. Schedule J. Sections 29 and 30 of Schedule J to the PBM Agreement are hereby amended and restated in their entirety to read as follows:

29. Aetna will retain responsibility for developing and determining all Aetna Formularies and Benefit Plan Designs for all Aetna Plans. Aetna may, at its option, maintain its own Pharmacy and Therapeutics ("P&T") committee to oversee formulary decisions.

30. Aetna may elect, as an Optional Service, to use one or more PBM proprietary formularies for some or all Aetna Plans. In such event, Aetna will delegate to PBM the responsibility for maintaining a P&T Committee to oversee formulary determinations in accordance with industry practice and applicable Law. PBM shall provide Aetna with reasonable advance written notice of each change to any such formularies, including utilization management and tier placement of Brand Drugs. Aetna may require PBM to make changes to PBM's proprietary formularies, as applied to Aetna Plans.

6. Schedule M.

(a) Notwithstanding anything to the contrary in the Agreement, including but not limited to, Section 3.2 or Schedule Y-7, Supporting Mail Order Pharmacy Services, pursuant to Schedule M, and Supporting Specialty Pharmacy Services, pursuant to Schedule N, shall constitute Optional Services.

(b) Schedule M-1 and Schedule N-1 are hereby amended and restated in their entirety in the form attached hereto as Appendix C and Appendix D, respectively.

7. Schedule P. Section 7 of Schedule P(I-1) to the PBM Agreement is hereby amended and restated in its entirety as follows:

7. Rebate Remittance. PBM will remit funds to Aetna (or to Aetna's designee) in accordance with the following terms, unless otherwise set forth in the subschedule to Schedule Y-15 (Medicaid Pricing) applicable to a State Plan. PBM shall pay to Aetna [redacted] of the Aetna Rebates collected for State Plans, during the immediately preceding calendar quarter (based upon Paid Claims dispensed) within sixty (60) days of the close of the quarter. PBM shall reconcile total Aetna Rebates distributed against applicable minimum Rebate guarantees annually, within one hundred-eighty (180) days after year end and pay any minimum guaranteed Rebates owed within thirty (30) days of such reconciliation. Payment will be accompanied with a report setting forth detailed information relating to the source of payment including

the invoiced amount from Manufacturer.

8. Schedule R. Schedule R is hereby amended by deleting Section 6.1 (Aetna PBM Customer Satisfaction Survey) in its entirety.

9. Schedule X. Subsection 11(bb) of Schedule X to the PBM Agreement is hereby amended and restated in its entirety as follows:

> bb. Rebate Covered Plans Manufacturer Rebate Audits. PBM shall assist Aetna in the manner required by Aetna and in a manner consistent with the scope of PBM's obligations regarding rebate administration, including as set forth in Schedule I, in connection with the administration and management of any audit relating to Aetna Manufacturer Revenues, including Aetna Customer audits, Manufacturer audits, Governmental Body requests or audits, and audits by accreditation organizations. PBM shall accommodate Governmental Body requests or audits as necessary in Aetna's discretion. As part of each such audit, PBM shall provide Aetna or its third party designee with access to all PBM Rebate Agreements that gave rise to Aetna Rebates that were paid or payable to Aetna during the applicable time period, except that, with respect to any PBM Rebate Agreement that does not solely apply to Aetna, PBM shall be entitled to redact any provision that is specifically applicable to a PBM Customer other than Aetna. Such review of PBM Rebate Agreements shall include all information necessary for Aetna or its third party independent auditor to review and verify, on an aggregate and Claim-by-Claim basis, the accuracy of the Aetna Rebates remitted to Aetna by PBM and PBM's performance of the Rebate Services under Schedule I-2. If any audit of the Rebate Services conducted for or by Aetna uncovers an error that relates to one or more prior years, PBM shall (i) investigate and determine the root cause of such error with respect to all affected or potentially affected years, (ii) work in good faith with Aetna or its third party independent auditor to quantify and resolve such error with respect to all such years (including providing the auditor with all information necessary to determine and confirm the cause, extent and resolution of such error) prior to the completion of such audit, and (iii) pay or credit such additional Aetna Rebates or other amounts to Aetna as are necessary to fully remedy and correct the error, including that, as part of each such audit, PBM shall initially make available for review up to ten (as specified by Aetna) PBM Rebate Agreements. If any such audit by Aetna identifies any errors or inaccuracies, upon Aetna's request, PBM shall make available for review some or all (as specified by Aetna) of the remaining PBM Rebate Agreements for the preceding calendar years.

10. Schedule Y

(a) Schedule Y-6 (Mail Order Pricing) to the PBM Agreement is hereby amended to insert the following at the end of the first paragraph:

> "The pricing terms set forth herein shall not apply to prescriptions dispensed

through Network Mail Order Pharmacies, as contemplated in Schedule M-1."

(b) Schedule Y-7 (Specialty Pharmacy Pricing) to the PBM Agreement is hereby amended to insert the following at the end of the first paragraph:

"The pricing terms set forth herein shall not apply to prescriptions dispensed through Network Specialty Pharmacies, as contemplated in Schedule N-1."

(c) Schedule Y-8 (Optional Services Financial Terms) to the PBM Agreement is hereby amended to amend and restate Section 20 as follows:

7. Commercial Rebates Services	The performance by PBM of Rebate Services pursuant to Schedule I-2	As provided in Schedule I-2

(d) Schedule Y-10 (Medicare Plan Rebate Guarantees) to the PBM Agreement is hereby amended by amending and restating Section 2.A as follows:

A. Base Administrative Fees.

As base compensation for the performance of Rebate Services, Aetna shall pay PBM Administrative Fees equal to [redacted] of the applicable Cumulative Paid Rebate Amount for Brand Drug Paid Claims under Rebate Covered Medicare Plans. For example, if the Cumulative Paid Rebate Amount is [redacted], the Administrative Fee under this Section 2(A) would be equal to [redacted]. Administrative Fees owing under this Section 2(A) shall be invoiced and paid monthly in accordance with Section 9.6 of the Agreement.

(e) Schedule Y to the PBM Agreement is hereby amended to remove all references to Schedule Y-17 (High-Value Plan Rebate Guarantees), as follows:

i. All references to Schedule Y-17 in any table are hereby revised to be labelled "*reserved*".

ii. Part 1, Section E (High-Value Plan Rebate Guarantees) is hereby deleted in its entirety.

iii. Part 2, Section D (Guarantee Reports - Rebate Guarantees) is hereby deleted in its entirety.

(f) Schedule Y to the PBM Agreement is hereby amended to delete Schedule Y-17 (High-Value Plan Rebate Guarantees) in its entirety and replace it with the label "*reserved*".

(g) PART TWO: TRANSPARENT OPTION; PART THREE: TRANSPARENT OPTIONS WITH REBATE GUARANTEES; and PART FOUR: HIGH VALUE PLANS of Schedule Y-20 (Scrip World Pricing) to the PBM Agreement are each hereby amended to remove all references to Rebates and/or minimum Rebate guarantees and to replace such references with the following: "See Schedule I-2 for Rebate Terms."

11. Effect of Amendment. Unless otherwise expressly provided above, all amendments to the PBM Agreement set forth herein shall be effective as of the Amendment Date. Except as amended by this Amendment, the PBM Agreement remains in full force and effect. All references to the PBM Agreement in any other agreement or document shall hereinafter be deemed to refer to the PBM Agreement as amended by this Amendment.

12. Miscellaneous. The provisions set forth in Article XXIII, and Sections 17.19, 17.20, 17.21, 17.22 and 17.26 of the PBM Agreement shall be applicable to this Amendment No. 7 *mutatis mutandis* and to the full extent necessary shall be deemed to be incorporated herein.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the Parties hereto have executed this Amendment as of the date first set forth above.

AETNA HEALTH MANAGEMENT, LLC

Name:
Title:

LEGAL WCM REVIEW

CAREMARKPCS HEALTH, L.L.C.

Name: James C. Margiotta
Title: Senior Vice President

Signature page to Rebate Administration and Pharmacy Network Amendment to Amended and Restated Pharmacy Benefit Management Subcontract Agreement

APPENDIX A to
Rebate Administration and Pharmacy Network Amendment
Schedule I

Rebate Administration

Core Services

1. This Schedule I reflects the terms of the Parties as agreed upon for the Rebate Administration services to be provided by PBM and the functionality of the computer systems used by PBM to administer its manufacturer rebates (the "PBM Rebate Administration Computer System"). The Parties agree that the use of the PBM Rebate Administration Computer System as contemplated by this Schedule I are included within the core pricing under the Agreement without any additional charge. Pursuant to Section 11.4(a) of the Agreement, PBM hereby grants Aetna a license to use the PBM Rebate Administration Computer System as set forth in this Schedule I.

2. PBM shall perform all Rebate Administration services for Aetna for all Aetna Rebates, whether arising pursuant to Manufacturer Rebate Agreements entered into with a Manufacturer by Aetna or by PBM, including all Rebate invoicing functions. Furthermore, upon election of Aetna, PBM shall perform all Manufacturer Rebate Agreement negotiation and contracting for all Aetna Rebates.

3. Subject to the terms and conditions of the Agreement, PBM will fully support Aetna as needed and permit Aetna to access the PBM Rebate Administration Computer System to enable Aetna to fully administer Aetna Rebate Agreements to the extent necessary and appropriate to administer such agreements.

4. PBM shall ensure, and the PBM Rebate Administration Computer System shall provide all of the following capabilities and functionality on a commercially reasonable basis, consistent with prevailing industry standard, on an "on-demand" basis:

    a. PBM shall ensure that all Claims from all applicable platforms are available for Aetna to review through a tracking and re-validation process within the PBM Rebate Administration Computer System.
    b. PBM Rebate Administration Computer System shall enable Aetna to enter Customer information necessary (as determined by Aetna) for Rebate processing and/or payment of Rebates to Aetna Customers.
    c. PBM shall ensure that a data repository is set up within the PBM Rebate Administration Computer System to enable Aetna and PBM to exchange data files and information through an Aetna approved file transfer process, and send data files and information requested by Aetna within a reasonable timeframe as requested by Aetna.
    d. PBM shall reconcile all Claims data within the source data warehouse application against all Claims data loaded in the PBM Rebate Administration Computer System.
    e. The PBM Rebate Administration Computer System shall enable Aetna to generate all actual rebated Claims at a detail Claim level reporting as agreed to by the parties.

f. The PBM Rebate Administration Computer System shall support Rebate payment reconciliation as agreed to by the parties.
g. The PBM Rebate Administration Computer System shall produce reports reasonably requested by Aetna for Customer Audits, manufacturer audits, and government audits, in accordance with Schedule X Audits.
h. The PBM Rebate Administration Computer System shall provide appropriate capabilities and reporting to enable Aetna to properly allocate and distribute Customer Rebates.
i. The PBM Rebate Administration Computer System shall provide Aetna with reasonable accounts receivable and general ledger reporting information, as well as ad hoc reporting capabilities, as agreed upon by the parties.
j. PBM shall store and make available to Aetna on the PBM Rebate Administration Computer System all Rebate invoiced Claim information as listed on electronic invoice to manufacturer for at least ten (10) years from the date of service of the Claim.
k. PBM shall provide to Aetna access to PBM Rebate Administration Computer System applications, as agreed to by the Parties.

5. With respect to Covered Plans that are Medicare Plans, PBM shall provide and perform Rebate Services, as defined in, and in accordance with, Schedule I-1, attached to this Schedule I.

6. With respect to Covered Plans that are State Plans, PBM shall provide and perform Rebate Services, as defined in, and in accordance with, Schedule P(I-1) of the Agreement.

7. With respect to any Covered Plans that *are not* Medicare Plans or State Plans, and any other Aetna Plans designated by Aetna, PBM shall provide and perform Rebate Services, as defined in, and in accordance with, Schedule I-2, attached to this Schedule I.

APPENDIX B to
Rebate Administration and Pharmacy Network Amendment

Schedule I-2

Rebate Services

Optional Services

1. **Commencement and Termination of Rebate Services.**

1.1 **Overview.** PBM shall perform the Rebate-related contracting, billing, collection and other services described in this Schedule I-2 ("Rebate Services") in accordance with this Schedule I-2 with respect to all Covered Plans that are not Medicare Plans or State Plans, and any other Aetna Plans designated by Aetna (such Covered Plans, "Rebate Covered Commercial Plans"). Rebate Services constitute Optional Services.

1.2 **Commencement of Rebate Services.** Commencing effective as of the first day of any calendar-quarter during the Term, Aetna shall have the right to have PBM perform Rebate Services with respect to, as designated by Aetna, any Aetna Plans not already included in these Rebate Services pursuant to Section 1.1, above. In order to exercise this right, Aetna must deliver to PBM, no later than ninety (90) days preceding the calendar-quarter in which Aetna wishes Rebate Services to commence, a written notice that specifies the Aetna Plans for which Rebate Services are to be performed and the commencement date therefor.

2. **Rebate Services.**

2.1 **Aetna's Authorization.** For any time periods during which PBM performs Rebate Services with respect to Rebate Covered Commercial Plans, Aetna authorizes PBM to contract with Manufacturers for Aetna Rebates as a group purchasing organization for all Rebate Covered Commercial Plans.

2.2 **Rebate Services**. Rebate Services shall include the following services, functions and tasks:

2.2.1 PBM shall negotiate and enter into Manufacturer Rebate Agreements (or amend or maintain existing Manufacturer Rebate Agreements to which PBM is a party) for the provision of Aetna Rebates for Aetna with respect to all Rebate Covered Commercial Plans in accordance with this Schedule I-2 ("PBM Commercial Rebate Agreements").

2.2.2 PBM shall keep Aetna informed of, and provide reasonable guidance and assistance to Aetna regarding, any potential adverse or positive impacts on Aetna

Rebates that may arise from decisions made by Aetna, and communicated to PBM, with respect to Aetna Formularies, Benefit Plan Designs, coverage determination information or other matters pertaining to care management or clinical functions.

2.2.3 PBM shall use commercially reasonable efforts to collect for Aetna all Aetna Rebates due from Manufacturers under PBM Rebate Agreements.

2.2.4 The services described in Sections 3, 4, 5, and 6 below.

2.3 **Control of Benefit Plan Design and Formulary**. PBM's performance of Rebate Services and the utilization of PBM Rebate Agreements shall not in any way limit Aetna's control over Benefit Plan Design or Formulary, it being understood that such decisions may impact the Rebates received by Aetna under PBM Rebate Agreements.

3. **Rebate Reporting and Payment.**

3.1 **Quarterly Rebate Reports**. Not later than sixty (60) days after the last day of each calendar quarter during which PBM collects any Aetna Rebates pursuant to this Schedule I-2, PBM shall affirmatively and accurately determine (a) the Aetna Rebates that were invoiced by PBM on account of Paid Claims dispensed under Rebate Covered Commercial Plans during such quarter, and (b) the Rebates that were collected by or credited to PBM during such quarter on account of Paid Claims dispensed under Rebate Covered Commercial Plans. PBM agrees to provide Aetna reporting consistent with PBM's standard rebate reporting. In the event Aetna requests customized reporting, PBM and Aetna will mutually agree to the report format and Aetna agrees to reimburse PBM for programing expenses related to such customized reports.

3.2 **Payment of Rebates to Aetna, Excluding Scrip World Plans**. Within ninety (90) days after the end of each calendar quarter, or such other time period mutually agreed upon by the Parties, PBM shall pay to Aetna [redacted] of the Aetna Rebates invoiced for Rebate Covered Commercial Plans, for the immediately preceding calendar quarter (based upon Paid Claims dispensed during such calendar quarter). Upon the close of collections with Manufacturers, or at such other time mutually agreed upon by the Parties, PBM shall reconcile Rebates paid to Aetna against [redacted] of Rebates collected, and (a) if Rebates collected exceed Rebates previously paid, PBM shall promptly pay any excess to Aetna, or (b) if Rebates previously paid to Aetna exceed Rebates collected, Aetna shall promptly repay such overage to PBM.

3.3 **Payment of Rebates to Aetna Scrip World Plans**. PBM shall pay [redacted] of all Rebates collected with respect to Scrip World Transparent Option Plans to Aetna as follows. Within ninety (90) days after the end of each calendar quarter, or such other time period mutually agreed upon by the Parties, PBM shall pay to Aetna [redacted] of the Aetna Rebates invoiced for Scrip World Plans, for the immediately preceding calendar quarter (based upon Paid Claims dispensed during such calendar quarter). Upon the close of collections with Manufacturers, or at such other time mutually agreed upon by the Parties, PBM shall reconcile Rebates paid to Aetna against [redacted] of Rebates collected, and (a) if Rebates

collected exceed Rebates previously paid, PBM shall promptly pay any excess to Aetna, or (b) if Rebates previously paid to Aetna exceed Rebates collected, Aetna shall promptly repay such overage to PBM. In lieu of invoicing Aetna a fee for the management and collection of Rebates for Scrip World Plans, PBM shall be entitled to retain, as a fee for service, all Rebates collected with respect to Scrip World in excess of [redacted] of Rebates actually collected.

4. **Rebate Administration.**

4.1 For and with respect to any period during which PBM is required to perform Rebate Services under this Schedule I-2, PBM shall also provide the following as Rebate Services (collectively, the "Rebate Administration Services"):

4.1.1 PBM shall provide invoicing, collection and payment services for and with respect to all PBM Rebate Agreements. PBM shall invoice the applicable Manufacturers for Aetna Rebates arising from Paid Claims dispensed during a calendar quarter under Rebate Covered Commercial Plans not later than 60 days after the last day of such quarter, and shall use commercially reasonable efforts to collect such Aetna Rebates as soon as practicable thereafter.

4.1.2 PBM shall track the receipt of all Aetna Rebates arising from Rebate Covered Commercial Plans, accurately allocate such Aetna Rebates to the correct Aetna Plan, and report such information to Aetna, in each case, in order to enable Aetna to retain or to distribute such Aetna Rebates appropriately to Aetna's Affiliates and Aetna Customers in the manner required by Aetna.

4.1.3 PBM shall respond to, address and administer all audit requests from Manufacturers with respect to Aetna Rebates, PBM Rebate Agreements, Aetna Rebate Agreements and, in each case with regard to Rebate Covered Commercial Plans and Claims arising thereunder.

4.1.4 PBM shall provide mutually agreed upon Aetna employees NDC-level projections of Rebates earned for purposes of Aetna's planning and administration of the Aetna Plans. These projections shall be used exclusively for this purpose and shall not be disclosed to third parties without PBM's prior written approval. Aetna employees receiving these projections may be required to execute an appropriate non-disclosure agreement.

5. Retention of Manufacturer Administrative Fees. Aetna and PBM agree that PBM may contract for and retain any and all Manufacturer Administrative Fees that it may collect with respect to the Rebate Covered Commercial Plans as a service fee for its Rebate Services provided under this Agreement. Notwithstanding the foregoing, the Parties may mutually agree in writing to share with Aetna some or all of the Manufacturer Administrative Fees, either on a book of business basis or in relation to the Claims attributable to one or more specific Aetna Customers.

6. Point of Sale Rebate Program. Effective as of April 1, 2019, for Aetna Plans designated by Aetna in its discretion, PBM shall provide its Point of Sale Rebate Program ("POS Rebate Program") as set forth in this Section 6.

6.1 **Point of Sale Rebate Application.** For Aetna Plans implementing the POS Rebate Program, PBM shall apply an estimate of the anticipated Aetna Rebate ("POS Estimated Rebate") at the point of sale as a real time manufacturer discount. The POS Estimated Rebate shall be applied to the ingredient cost of the adjudicated Claim after applying the appropriate network discount and before applying the applicable Cost Share amount. PBM shall review the POS Estimated Rebate at least quarterly and make adjustments, if necessary, based on likelihood of collection, previous experience and potential Manufacturer issues. PBM shall use good faith efforts to project the anticipated POS Estimated Rebate, however, PBM shall have no responsibility or liability to Members for Aetna Rebate overpayments or underpayments at point of adjudication. PBM may adjust the POS Estimated Rebate on Claims in an equitable manner in the event: (i) a generic version of a branded product is unexpectedly introduced in the market; (ii) a branded product is recalled or withdrawn from the market; (iii) actual collection experience varies significantly from that expected; or (iv) prior POS Estimated Rebate payout experience varies significantly from Aetna Rebates actually earned.

6.2 **POS Rebate Group Eligibility.** For Aetna Plans implementing the POS Rebate Program, Aetna shall provide a "POS Rebate Indicator" on the group file feeds it provides to PBM, including an effective date, which will trigger the application of POS Estimated Rebate for the indicated groups.

6.3 **POS Rebate Type Indicator and Rebate Reconciliation.** PBM shall report total POS Estimated Rebates applied on the Aetna Claims Experience Tape (CET) files provided to Aetna, including a POS Rebate Type Indicator. Aetna Plans that Aetna has designated for implementation of the POS Rebate Program will be designated by PBM as "Type 2," and Rebates shall not be advanced to Aetna or any Aetna Customer by PBM with respect to such Aetna Plans.

6.3.1 The POS Estimated Rebate amount shall be added by Aetna to the Aetna Customer amount payable in Aetna's weekly pharmacy cost invoice to the Aetna Customer and Claims for such Aetna Plans shall be identified with a POS Rebate Type Indicator of "2". For such Claims identified with a POS Rebate Type Indicator of "2", PBM shall not "prepay" or advance Aetna Rebates to Aetna or any Aetna Customer at point of sale, and PBM Rebate payments, processes and timing shall not be impacted.

6.3.2 PBM shall provide the portion of the reduction in Member Cost Share attributed to the POS Estimated Rebate applied to the Claim ("POS Rebate Member Share") on the CET files. PBM shall provide Aetna with a quarterly aggregate report of all POS Rebate Type Indicator of "2" POS Estimated Rebates and Aetna Rebate invoiced amounts. PBM shall work collaboratively with Aetna to modify existing Rebate reporting to support Aetna Customer requirements, as applicable.

APPENDIX C to
Rebate Administration and Pharmacy Network Amendment

Schedule M-1

Mail Order Pharmacy Adjudication-Only Services

Optional Services

Aetna may elect to fulfill all mail order pharmacy services for Covered Plans through utilization of PBM Affiliates that have contracted directly with Aetna to participate in its pharmacy network ("Network Mail Order Pharmacies"). In the event that Aetna makes such election, PBM shall adjudicate mail order pharmacy Claims only and provide the adjudication results to Aetna and/or the Network Mail Order Pharmacies, as mutually agreed upon by the parties. Aetna may elect to transition mail order pharmacy dispensing services to Network Mail Order Pharmacies in whole or in part, including though a phased transition approach.

APPENDIX D to
Rebate Administration and Pharmacy Network Amendment

Schedule N-1

Specialty Pharmacy Adjudication-Only Services

Optional Services

Aetna may elect to fulfill all specialty pharmacy services for Covered Plans through utilization of PBM Affiliates that have contracted directly with Aetna to participate in its pharmacy network ("Network Specialty Pharmacies"). In the event that Aetna makes such election, PBM shall adjudicate specialty pharmacy Claims only and provide the adjudication results to Aetna and/or the Network Specialty Pharmacies, as mutually agreed upon by the parties. Aetna may elect to transition specialty pharmacy dispensing services to Network Specialty Pharmacies in whole or in part, including though a phased transition approach.

Attachment S

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Attachment S
C.24 – Population Health Management Program

ICM Program Description ..... Att S-3

Population Health Management Strategy 2019 ..... Att S-35

Health Risk Assessment ..... Att S-77

Enrollee Needs Assessment Questionnaire ..... Att S-85

Care Plan Development and Updating ..... Att S-99

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ICM Program Description

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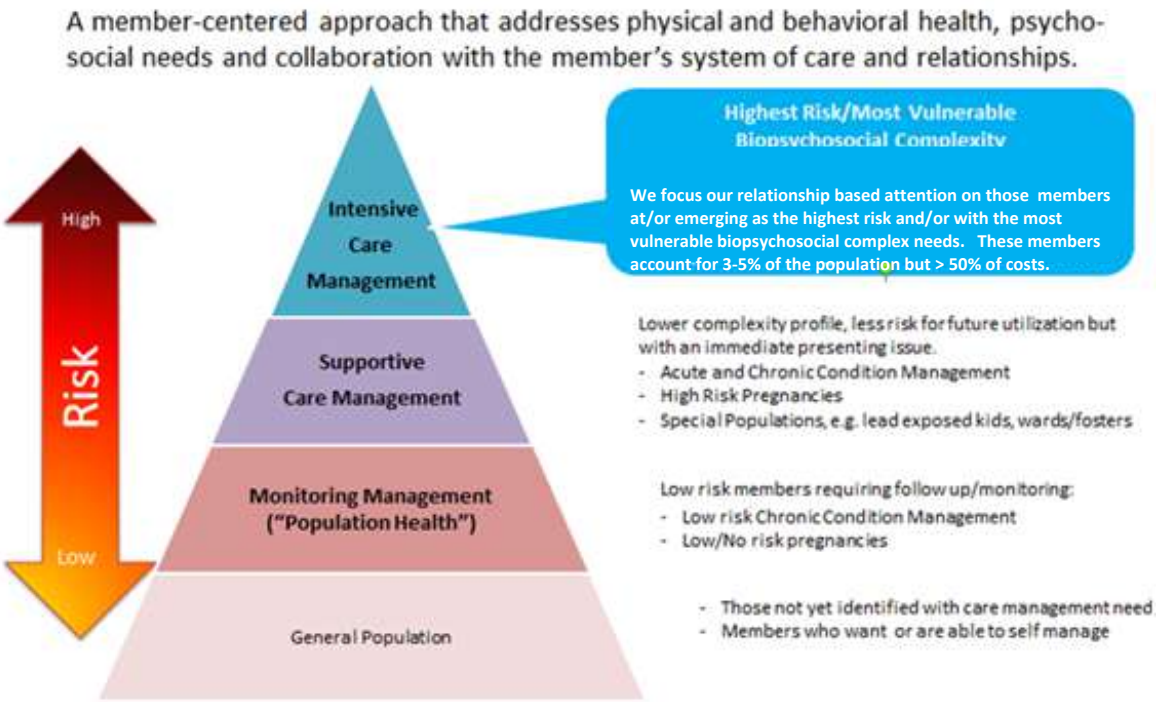

Philosophy and Guiding Principles[1]

The primary **goal** of Aetna Medicaid's Integrated Care Management (ICM) Program is to coordinate and facilitate the seamless delivery of high quality, person centered, trauma informed care and services for our members. Our program ensures that the care and services members receive aligns with their preferences, needs and goals, utilizing motivational interviewing to optimize their self-empowerment and self-sufficiency.

The **focus** of ICM is to address the biopsychosocial needs of our members, while integrating cultural humility into our practices to enhance members' quality of life. Our case managers partner with members, providers, caregivers and support systems. Each member's characteristics and potential barriers associated with social determinants of health (SDoH) are considered when addressing acute illnesses, chronic conditions, functional and social (biopsychosocial) needs to support improved outcomes.

The ICM program is **designed** to identify members who may benefit from care management services. Members choosing to participate receive an evaluation of their risk and at a minimum, receive education to support their adoption of healthy behaviors and self-management. Those at higher risk are engaged to recognize their personal strengths and barriers, determine health goals and develop interventions to help them meet those goals. Based on their needs, members receive ongoing support and services through integrated case rounds, interdisciplinary care team meetings, scheduled contacts and ad hoc communications.

Foundation

Program Development and Design

The ICM program was developed by Aetna Medicaid Services in 2010, and initiated by Aetna Better Health (ABH-KY) of KY in 2016. The program is based on literature indicating that people who have complex illnesses or comorbid conditions and require care across multiple clinical and social domains are likely to be less responsive to standard care and more likely to benefit from an individualized approach to meeting their unique healthcare needs (biopsychosocial).[2]

The program design is based on professional care management standards, guidelines, and research published by agencies such as:

- Case Management Society of America (CMSA)
- Centers for Medicare and Medicaid services (CMS)
- National Committee for Quality Assurance (NCQA)
- National Coalition of Care Coordination
- Agency for Healthcare Research and Quality (AHRQ)
- Kaiser Family Foundation.[3]

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[1] Draft ICM Philosophy Statement, 2/20/2019

[2] Stiefel, Stiegel, et al. Operationalizing Integrated Care on a Clinical Level the INTERMED Project. Med Clin N Am 90 (2006) 713-758.

[3] NCQA HP 2018/2019 PHM1

In addition, Healthy People 2020 serves as the resource for identification of SDoH that impact health outcomes. Management of chronic physical and behavioral health conditions is integrated into the ICM program and offered to members as part of their care management services. This integration creates a true biopsychosocial approach to member care.

Care Management Steering Committee

The Care Management (CM) Steering Committee provides oversight and approves the development, implementation and continuous improvement of Aetna Medicaid's primary ICM and chronic condition management programs and services. The CM Steering Committee is composed of care management program leaders from Aetna Medicaid Clinical Operations and each health plan to enable a local approach to care management that is supported by nationally recognized standard regulatory and operational practices. The Committee addresses all foundational ICM programs and services to:

- Organize services around the member and their family/circle of supports
- Adhere to the core set of biopsychosocial principles and evidence-based practices endorsed by Aetna Medicaid
- Measure and improve clinical and utilization outcomes for members
- Align with Aetna Medicaid standards
- Meet or exceed regulator and other applicable external requirements such as NCQA
- Create competitive advantages both for Aetna Medicaid Plans in current markets and for growth into new markets
- Anticipate and position Aetna Medicaid well for future market demands
- Make the best use of Aetna resources through disciplined accountability to show the initial feasibility, business case and return-on-investment of all ICM programs and services

Integration with Population Health Management (PHM)

The ICM Program is congruent with Aetna Medicaid's Population Health Management (PHM) Strategy, recognizing that health is more than the optimal delivery of clinical care but is also about the "health of the population, including the distribution of health outcomes and disparities in the population" as the National Quality Forum defines it. As in PHM, the ICM program aims for equitable health care and services that are person-centered, accessible, holistic, and evidence-based. ICM programs are designed to engage members with the right level of clinical and social support depending on many factors that affect an individual's health status, overall well-being and ability to self-manage and function optimally in their preferred setting. We define care management as a collaborative process of biopsychosocial assessment, planning, care coordination, and advocacy for service and support options to meet a member's comprehensive care needs to promote quality and cost-effective outcomes.

Systems of Care

Aetna Medicaid incorporates a system of care (SoC) approach with a full spectrum of effective, community-based biopsychosocial care and support. Our SoC also includes psychosocial services and supports for individuals, their families/circle of support, that:[4]

[4] NCQA HP 2018/2019 PHM1 A4

- Are organized into a coordinated network-within-a-network functioning as a "virtual team"
- Drive collaboration across agencies and community-based organizations
- Build meaningful partnerships with members and their families/circle of support
- Address peoples' cultural and linguistic needs

ICM staff coordinate medical and/or behavioral health services covered by the plan's benefit structure as well as services from local community-based or federally funded organizations, faith based organizations, social clubs, condition specific organizations, and/or those not covered in the member's benefits. This coordination in achieved in collaboration with special program coordinators, and SoC team members. [5]

ABH-KY informs and educates practitioners about how to use care management services, including chronic condition management, and how the plan works with the members' practitioners in the program. This information is provided to practitioners, in writing, through direct mail and provider handbook. Detailed program information is also available on the ABH-KY website

Care Management Team Structure

The Care Management Department is under the direction of the Chief Medical Officer (CMO) and the Director of Medical Management. Care management staff in each plan report to a supervisor or manager, who in turn reports to a director of care management. The number of supervisors and managers depends on the size and complexity of the health plan population as well as any state-mandated requirements (e.g., ratios).

Care management staff include:

- Case Managers who serve as primary points of contact to their assigned members. These licensed and non-licensed staff lead the collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's comprehensive health needs.
- Case Management Associates (CMAs) who assist members and the care management team with non-clinical activities.

Case Manager caseloads align with their education, licensure, experience and expertise. In addition, caseloads vary by service level for complexity of member needs and frequency of the interactions with the member and their care team. If case managers carry a mixed caseload, a case weight is applied to ensure they have the appropriate capacity to meet the needs of their members.

Caseload		
ICM Service Level	**Non-LTSS ICM Caseload Ratio**	
Intensive	1:41	
Supportive	1:125	
Population Health	1:400	

[5] NCQA HP 2018/2019 PHM5 C12

Care management supervisors routinely review case manager caseloads to ensure they do not exceed the caseload or total case weight limit. The review determines caseload distribution between teams to maximize available staff and adjust caseloads and case manager assignments as necessary.

Care Management Business Application System

The ICM business application software provides an integrated system for collecting and tracking comprehensive information and outcomes on each member in ICM. The system incorporates evidence-based guidelines, automatically documents user information, date/time stamps activities, and provides algorithms that guide case managers. Documentation entered in the system includes health and risk assessments, questionnaire results, stratification decisions, care management information, SDoH, interdisciplinary case rounds and ICT activities. System capabilities include data tracking and trending functions for the purposes of managing the program as well as reporting to state and federal regulators, customers, health plan management and staff. Web based portals are used to facilitate communication between the case manager, member, care team, and providers across the continuum of care.

Care Management and Coordination of Care

Populations

ICM is available to the entire eligible population across all lines of business and to any member who needs, requests or requires care management services. The assessed needs of the member determine the level and type of care management. Typical recipients of ICM are those members:

- At high risk of poor health outcomes and high utilization
- From ethnic/racial minorities and other traditionally underserved populations
- With significant or multiple chronic conditions for which care management and/or chronic condition management interventions are indicated or are required by contract
- Who have had difficulty managing their health care, and require complex or frequent healthcare and services
- Included in special populations with complex medical, behavioral and/or social needs such as:[6]
  - Children and adolescents with special healthcare needs
  - Children in foster care or adoption assistance programs
  - Members who are pregnant with a higher intensity of services offered to members with a high risk pregnancy
  - Members who are frail or elderly
  - Members with mental health conditions such as substance use disorders (SUD) and/or serious and persistent mental illness (SPMI)
  - Members with brain injuries and/or with cognitive or memory problems (e.g., dementia)
  - Member nearing the end of life and receiving palliative services or hospice benefits
  - Any additional members identified through State, CMS, or contractual requirements:[7]

[6] NCQA HP 2018/2019 PHM2 B1-4, NCQA HP 2018/2019 LTSS1 A1
[7] NCQA HP 2018/2019 PHM2 A7

ABH-KY provides all members with the following ICM program information either in writing, in-person or by telephone:

- How to use care management services
- How members become eligible to participate in ICM
- How to opt in or opt out of ICM
- Member choice and rights and responsibilities related to healthcare decisions

MEMBER IDENTIFICATION AND PRIORITIZATION

When care management is not mandatory, ICM identifies and prioritizes members who may benefit, from multiple sources. Sources used to identify and prioritize members for ICM include:

- Enrollment and additional files received from state Medicaid agencies and other program purchasers
- Predictive modeling using claim/encounter information, including pharmacy data if available
- Internally available data and reports such as the HCE Dashboard, operational dashboards, and through UM and other ABH-KY department processes
- Member self-reported information from health risk appraisals, screening tools, questionnaires, requests for support, and ad hoc contacts
- Organizational partners providing data utilization of emergency, inpatient admissions and discharge, pharmacy and laboratory testing and results
- Referrals from plan departmental staff and providers of care and services such as health management, chronic condition self-management, wellness or health coaching programs, and
- Electronic health records and health information exchanges[8]

Predictive modeling uses analytic methods to rank all plan members from highest to lowest risk in our General Risk Model (GRM). The model identifies people at risk of high cost and/or high utilization in the future by using medical, behavioral, laboratory and pharmacy diagnoses and claims data, and the likelihood of ICM making an impact. Additional predictive modeling techniques are used to identify members at risk for emergency department or inpatient utilization in the next 12 months. The predictive modeling shows that our highest risk members have multiple physical health conditions, and 70% to 90% had co-morbid behavioral health conditions.

The top 1% of members in the GRM is combined with members at high or moderate risk for inpatient utilization and high risk for emergency department utilization in a Consolidated Outreach and Risk Evaluation (CORE) report that is produced monthly.[9] The risk rankings feed directly into our care management software to allow health plans to identify and prioritize members for outreach into intensive or supportive care management as well as those who would benefit from chronic condition management.

The HCE Dashboard consists of enterprise, state, regional, local, and member level data related to SDoH, condition prevalence, and potential disparities within a market. Measures included are: gender,

[8] NCQA HP 2018/2019 LTSS1 A1

age, race/ethnicity, language and health conditions. The Dashboard provides health plans with a tool to support the analysis of their population, identify geographical areas of risk, help inform further ICM program planning activities and target interventions to address health disparities. Descriptive statistics of membership enable the comparison of individual plans to overall Aetna Medicaid members within the same lines of business and demographic distribution.

Aetna Medicaid contracts with ActiveHealth, an NCQA accredited organization, to obtain information from members on their perceptions of their health and wellness. These **health appraisal**[10] results are evaluated separately and tracked through the referral process. Upon health plan enrollment, members are informed of the opportunity to provide self-reported health information via through the ActiveHealth website. Case managers receive a weekly report on health appraisal results. They review the member self-reported responses and reach out to the member to evaluate them for inclusion in care management if clinically indicated.

Members are also identified for care management through their contact with a 24 hour **health information line**[11]. After the health information line nurse completes a call or email exchange, information via an intake form is entered into the care management system to trigger screening for possible enrollment into ICM.

The **Health Risk Questionnaire (HRQ)** [12] is administered by ICM program staff and gathers member self-reported information on health conditions and healthcare utilization history. The responses drive a risk score that assists in determining the need for care management or high or low-risk chronic condition management.

ENROLLMENT AND ENGAGEMENT in CARE MANAGEMENT

Outreach

Once identified, the members are outreached by care management staff to discuss the ICM program, the reason they have been identified, explore their interest in participating and complete additional screening. Members have the right to decline participation or dis-enroll from care management programs. Members may also choose to opt out of the chronic condition management portion of the program at any time.

Non-LTSS members who receive custodial institutional care are referred for care management. For members with LTSS needs who are not yet enrolled with the state LTSS program, ABH-KY assists the member to apply for eligibility for LTSS.

Unsuccessful Outreach Attempts

Aetna Medicaid documents all attempts to contact the member utilizing various methods (e.g. telephone, letter, e-mail, authorized care giver channels) on different dates and at different times of the

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[11] NCQA HP 2018/2019 PHM5 A1
[12] NCQA HP 2018/2019 PHM2 A4

day. We may also utilize Community Health Workers (CHWs) or other care management staff to visit the member's home or contact the member's PCP or pharmacy. We also reach out to local homeless shelters, hospitals, food pantries, libraries, and clinics in an attempt to locate members in need of our ICM program.

Non-dual or non-LTSS members who are pregnant or who have chronic conditions and are not reached during outreach attempts are automatically assigned to population health level of ICM where their utilization can be monitored, and they can be outreached again as indicated.

Member Evaluation

Aetna Medicaid utilizes a combination of enterprise developed and standardized assessments and tools. Assessments and screening tools used by case managers were developed using evidenced based clinical practice guidelines promulgated by nationally recognized entities including, but not limited to:

- Centers for Disease Control and Prevention (CDC)
- National Heart, Lung and Blood Institute (NHLBI)
- American Psychiatric Association (APA)
- American Congress of Obstetricians and Gynecologists (ACOG)
- American Diabetes Association (ADA)
- Healthy People 2020
- Substance Abuse and Mental Health Services Administration (SAMHSA).[13]

The specific issues addressed in the member's assessment are delineated in Aetna Medicaid Policy 7500.05 Integrated Care Management.[14] Clinical guidelines are reviewed by a standing Aetna Medicaid clinical committee. The guidelines are from nationally recognized sources and updated at least every two years and whenever significant changes are made to the guidelines.

When assessments for a specific condition (e.g., heart failure, depression) are developed or revised, the national guidelines are incorporated into the assessment and associated care plan intervention options. The name of the guideline(s) used and link(s) to the entire document are provided within the assessment. All guidelines are available as links from the plan's web site and in the provider handbook. Providers are educated about where to find these guidelines when they join the plan and when guidelines are revised.

Unless otherwise required by contract, member assessments are started within thirty (30) days of being identified for care management and completed within 60 days.[15] Members with chronic conditions are assessed in relation to their specific condition(s) to determine appropriate interventions to be addressed in the care plan.

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[13] NCQA HP 2018/2019 PHM5 B1

[14] Aetna Medicaid Administrators LLC Policy #7500.05, Integrated Care Management, Member Evaluation pages, 11 and 12.

[15] NCQA HP 2018/2019 PHM5 G (File review- timeliness of assessment)

Members receiving complex care management receive a comprehensive assessment upon enrollment into the ICM program and at least annually thereafter. The following elements are evaluated as part of the initial comprehensive assessment and annual re-assessments: [16]

- Health status, indications for ICM program enrollment, and condition specific issues including screening for presence or absence of comorbidities and their current status, medications, and self-reported health
- Clinical history (condition onset, emergency department, inpatient stays, medications)
- Activities of daily living (ADLs), instrumental activities of daily living (iADLs) and functional status of the member related to self-care and the use of any supports
- Behavioral health status (issues and service needs, depression screening, substance use disorder history and treatment)
- Level of cognitive functioning
- Social determinants of health (SDoH) such as safety and availability and adequacy of food, housing, personal relationships, community, etc.
- Social functioning in the member's ability to engage in social interactions, interpersonal relationships, and ADLs.
- Health Literacy
- Health beliefs and behaviors (including readiness for change)[17]
- Plans for handling health, personal affairs and life-planning[18]
- Linguistic, cultural and spiritual needs, preferences and limitations
- Visual and hearing status, needs, preferences and limitations
- Physical environment for risk[19]
- Scope of benefits for which the member is eligible, including health plan and other resources, such as community and faith based organizations[20]
- Paid and unpaid (informal) caregiver resources, needs of unpaid caregivers, and opportunities to meet those needs.
- Unpaid caregivers' desired level of involvement in the member's care management plan.
- Community services and ongoing health treatments
- Current living situation and preferences

Further, as behavioral health and substance use issues are commonly co-occurring, each member identified as having concerns in one of these areas (either by self-report, referral, claims data or at the time of initial assessment) is screened for <u>both</u> issues using the following evidence-based tools: [21]

[16] NCQA HP 2018/2019 PHM5 C1-11
[17] NCQA HP 2018/2019 LTSS B1-9
[18] NCQA HP 2018/2019 LTSS1 E3
[19] NCQA HP 2018/2019 LTSS1 B10-12
[20] NCQA HP 2018/2019 LTSS1 C2-3
[21] NCQA HP 2018/2019 PHM5 C4

Screening Tools		
Kessler Screening Scale for Psychological Distress (K-6)[22]	Screens for mental health problems	Adults
UNCOPE[23]	Identifies risk of abuse and dependence for drugs and alcohol	Adults
Pediatric Symptom Checklist (PSC-17)[24]	Facilitates the recognition of cognitive, emotional, and behavioral problems	Under 19
CRAFFT[25]	Screens adolescent members for abuse/dependency for alcohol/other drugs	Under 21
Patient Health Questionnaire 9 (PHQ9)[26]	Tool to screen, diagnosis, monitor, and measure severity of depression	Vulnerable Subpopulations
Generalized Anxiety Disorder 7 item scale (GAD 7)[27]	Screens for 7 common anxiety symptoms. Scores mild, moderate, and severe anxiety. Further evaluation is indicated when the score is 10 or greater.	Vulnerable Subpopulations
Edinburgh Postnatal Depression Scale (EPDS)	Screens / identifies members at risk for "perinatal" depression.	Recently pregnant females

Evaluation of the SDOH is an ongoing relational process to ensure all members have equal access to benefits and services in a way that acknowledges their values/ preferences and overcomes social, cultural and geographical barriers. SDOH data are used to guide care plan development and resource allocation.[28]

Care management staff have the ability to capture, within the documentation system, SDOH data elements from the following (6) categories as defined by Healthy People 2020:

- Demographics
- Economic Stability
- Education
- Health and Health Care
- Neighborhood and Built Environment
- Social and Community Context

Documentation of the initial assessment includes an evaluation of the information collected; a summary and conclusion of the meaning or implications of the information to the member's situation is noted. Information from the assessment is used to inform the member's individualized care plan.

Needs Based Stratification and Services

Upon completion of their health screenings and assessments, members enrolled in care management are stratified based on the complexity of their individual needs and are assigned a program level

[22] http://www.hcp.med.harvard.edu/ncs/k6_scales.php
[23] Hoffmann, N. G. Retrieved from: http://www.evinceassessment.com/ UNCOPE
[24] Gardner W, Murphy M, Childs G, et al. The PSC-17: a brief pediatric symptom checklist including psychosocial problem subscales: a report from PROS and ASPN. *Ambulatory Child Health.* 1999; 5:225–236.
[25] http://www.ceasar-boston.org/clinicians/crafft.php
[26] http://www.phqscreeners.com/select-screener Accessed 3/2017
[27] http://www.phqscreeners.com/select-screener Accessed 3/2017
[28] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

commensurate with those needs. Each level of the ICM program provides members with education, encouragement to learn self-management skills and coordination of access to the appropriate services and supports. A summary of program indications, services and associated interventions is found in *Appendix A*. When health care disparities are identified as contributing factors to poor health outcomes Health Care Equity (HCE) innovative strategies are deployed in conjunction with traditional care management.[29]

Regardless of program level, all members involved with the ICM program receive initial contact, a culturally aligned Welcome Letter to any programs in which the member enrolls, and needs evaluations. Members are encouraged to communicate with their care and service providers and Primary care providers are notified of each member's enrollment. Providers are educated about the program and services and informed on how they can best support their patients in their use of care management services. If identified as being diagnosed with a chronic condition of focus, members receive culturally aligned bi-annual newsletters for the chronic condition(s). KRAMES and/or other evidence-based educational materials are available and provided as indicated and upon request.

The ICM team also provides community based referrals for services related to identified SDOH, support in addressing Health Literacy, and coordination of care to minimize barriers to access to care and increase access to culturally aligned services

Exceptions to the stratification may be driven by individual member preferences, assessment findings, person-centered goals, state Medicaid agency requirements, interdisciplinary care team collaboration, and/or the case manager's judgement.

Person Centered Care Planning

The care plan includes the assessment of the member's needs, prioritized goals, individual preferences, barriers to optimal health, personal affairs, life planning, and caregiver status. Motivational interviewing (MI) techniques are used throughout the assessment, care planning and ongoing care management process. MI facilitates the assessment of the member's preferences, helps to identify and prioritize goals, and evaluate progress toward achieving those goals through actions, interventions, and measurable outcomes.[30] The case manager identifies the member's preferred communication methods and desired level of involvement in care and service planning activities. The case manager works with the member to determine frequency and time frame for contact and reevaluation[31]. The member and case manager identify resources to be utilized including appropriate level of care, plan for continuity including transitions of care, and determine the member's desired level of involvement in care and service planning activities.

Case managers facilitate a multidisciplinary approach to care planning by partnering with:

- Members
- Primary care providers
- Specialty care providers

[29] NCQA HP 2018/2019 PHM5 C5
[30] NCQA HP 2018/2019 LTSS E1-3
[31] NCQA HP 2018/2019 LTSS E4

- Behavioral health providers
- Community social workers
- Ancillary providers
- Caregivers
- Pharmacy providers
- Hospital discharge planners
- Family /circle of support
- Interdisciplinary care teams (ICT) when requested by the member.

Case managers also collaborate with utilization reviewers, pharmacy, member services and other internal resources to ensure that all appropriate information is considered for incorporation in the member's care plan. This collaboration and coordination of care and service needs encourages efficient utilization to avoid gaps in care or duplications in services and supports. The plan reflects the collaborative approach that is appropriate for the member and the level of family/circle of support participation. For all members, the case manager facilitates and encourages communication across various disciplines and care settings within and outside the health plan, including the PCP and any other practitioners/providers.[32]

The member's assigned case manager initiates and facilitates the ICT meetings to support the member's care and service needs. The ICT participates in the development and implementation of a written, person-centered care plan to assist each member with establishing access to covered and non-covered services and supports. The composition and frequency of ICT meetings are based on the unique needs and risks of the individual member. The ICT serves as a forum to address the member's specific needs and may include the discussion of any physical health, behavioral health and socio-cultural factors that may be having an impact on the member's overall health or place the member at risk for an adverse outcome. Input is provided by the ICT based on their expertise in physical and behavioral health, or social and community services. The ICT includes the member and is responsible for coordination of care, services and supports that are transparent, individualized, accessible, and delivered with dignity in a linguistic and culturally competent manner.

Any biopsychosocial issues, cognitive limitations, and SDOH impacting members are incorporated into their individualized care plans, as are the cultural practices and beliefs that are most important to the member. Barriers to improving health and root causes of poor health outcomes are specifically addressed to help both the case manager and the member better understand what has prevented full engagement with a suggested plan of care.[33]

[32] NCQA HP 2019 LTSS1 A5
[33] NCQA HP 2018/2019 PHM5 C12-13; PHM5 E1-5

The individualized care plan includes specific interventions or tasks that will facilitate the member achieving their care plan goals such as referrals to a provider or community resource, assistance with access to a resource or service and follow-up to ensure care or service was received.

The care plan is reviewed and revised on a specific follow-up schedule based on the member's ICM program level.[34] It is also updated whenever there is a change in condition, status or placement or other changes that warrant an update such as loss of employment, housing, etc. All initial and subsequent care planning activities are tracked on the written care plan and in the care management business application system. [35]

ONGOING CARE MANAGEMENT

As case managers work with members to meet their goals, they will identify and use all available resources. Case managers incorporate respite and caregiver support into the care plan for coordination of care provided to the member. Case managers encourage members and ICT participants to contact them with any needs or changes in condition. The member is provided with the care management staff name(s), phone number, or e-mail address through a culturally aligned welcome letter, and in each care plan.

Our goal is to address specific cultural and language needs that might challenge a member's ability to access care or understand practices that lead to optimum health outcomes. We understand that cultural competency goes well beyond ensuring availability of a language interpreter or translating printed materials into languages other than English. There are questions in our assessments that are intended to elicit cultural beliefs so that the case manager can begin to understand how these are impacting the member's health and how care and services can be coordinated to align with the member's cultural needs. Cultural competency is a part of all ICM training and is expected to be an integral part of the mentoring of ICM staff by their managers and clinical leaders.

Members with HEDIS gaps in care are identified in our business application system to alert case managers to follow up with the members and their providers to obtain appropriate clinical screenings and comply with clinical practice guidelines.

Case managers also use care plan interventions as options to help address a member's chronic condition goals. Management of chronic conditions may include to assist with the following interventions:

- Provide the member with appropriate resources, training and support to help him/her complete tasks as necessary to achieve care plan goals
- Conduct face-to-face coaching sessions, reinforcing following the care plan and adjusting tasks to align with the member's culture, language and religion
- Reinforce education related to self-management of chronic condition(s) while respecting the member's culture, ethnicity and religion

[34] NCQA HP 2018/2019 QI5 F15
[35] NCQA HP 2018/2019 PHM5 C17; NCQA HP 2018/2019 LTSS1 A5, F8

All case managers utilize referrals to community based organizations (CBOs) during their work with members. CBOs include external entities such as:

Adult Protective Services	Dept. of Health Facilities, Evaluation and Licensing	
Accredited training agencies	Providers, including those in health homes and Systems of Care	
AAA/Aging & Disability Resource Centers	Public Guardians	Ombudsman
Consumer advocacy groups	Local law enforcement	Department of Health Services
County and / or state based emergency preparedness groups	Dept. of Child Protection Services	Department of Guardianship Services

The health information line provides all members' 24-hour, toll-free access to a team of registered nurses experienced in providing information on a variety of physical and behavioral health topics. The health information line also features an audio/video health library covering more than 2,000 health topics available in both English and Spanish. The health information line can also be accessed for non-symptom related, general health information questions by email through the member web portal. Reports on members accessing the health information line are integrated into the ICM program.

Integrated case rounds are held at least twice monthly and provide a forum for the care management team, utilization management staff, internal SoC staff, pharmacy staff, and clinical leaders to discuss complex members and collaborate on ways to better assist them. The clinical leaders also interface with the provider community when needed to assist our ICM team and to enhance care for our members. Providers may be invited to attend integrated case rounds in person or by phone.

ABH-KY uses pharmacy and utilization data to identify members who may be misusing, abusing and/or diverting controlled substances and limits their access to these medications through our Member Restriction program. The program provides support to identify alternative treatments, to provide referrals for pain management or substance use disorder when indicated, assist with managing pharmacy and benefit utilization to meet member healthcare needs, and coordinate care with primary care practitioners and other practitioners/providers.

The case manager, member, and the member's care team adjust the care plan and may change service providers if repeated service gaps occur. Conflict free case management elements are fully incorporated into ABH-KY's care management program, including its integration of:

- Physical health, behavioral health, and LTSS
- Individuals into the community where they have access to activities that are meaningful to them, including social, spiritual and productive employment
- Medicare and Medicaid services in that members may be eligible for both government programs
- Care management activities provided by ABH-KY are separated from the provision of direct care or services.

ABH-KY responds to and supports members who present in person or over the telephone as being in a physical or behavioral health crisis by assisting members to access the appropriate services to manage the situation.

ABH-KY employees are obligated to report events and incidents regarding member safety to applicable authorities as required by state law and state Medicaid agency requirements. Any report to state authorities must be provided in a manner consistent with state requirements for such reporting. Health plan staff members are required to cooperate with any investigation conducted by the health plan, its designee or outside agencies, including law enforcement.

Member Re-Assessment and Care Plan Updates

Members enrolled in ICM are re-assessed at least annually, upon significant change in condition, upon member / representative request and as contractually required. Annual comprehensive re-assessments include all components of the member's initial assessment. During each reassessment, member stratification is reviewed and potentially adjusted.

Regularly scheduled contact and use of the Interval Assessment provides feedback, allowing case managers to evaluate members' progress toward their person-centered goals, and determine if the current care plan is meeting the member's needs or if needs have changed. The Interval Assessment may indicate a need for a care plan update or comprehensive reassessment, and/or identify a significant change in condition.

Additionally, members may experience a change in condition that may require a different care setting or level of care. Case managers are notified when a member is admitted to an acute or sub-acute care facility to begin collaborating with the member, concurrent review nurse, facility discharge planner, and ICT to identify the root cause of admission and develop a discharge plan.

Practices used by case managers to facilitate the safe transition of members between care settings include:

- Identifying members transitioning between settings to provide care coordination, communication, support and assistance to arrange services for the members, caregivers, and providers as soon as the transition is identified and continuing through the transition period as indicated by member's needs.
- Reassessing the member's needs and the appropriateness of an existing care plan post transition, modification of that plan as indicated, and discussion of changes with the member as indicated by the members' needs but no later than 30 days post transition.
- Conducting medication reconciliation after transition between care settings, documenting each medication with the member and their designated representatives and communicating any identified discrepancies with the appropriate provider(s).[36]

As members move toward their goals, the case manager works with them to establish a plan for effective self-management, where appropriate. Activities include the identification of any services or resources the member can independently access. Members enrolled in Medicaid-only plans who achieve their goals are discharged from ICM.

[36] NCQA HP 2018/2019 LTSS3 A

Program Effectiveness

Goals, Interventions, and Measures

The overarching goal of the ICM program is to engage members to address their physical, behavioral, long term services and supports, environmental and social needs in the right setting and in a cost effective manner. We strive to help them retain, if not improve, their health, self-management and functional levels. To that end, ABH-KY's ICM program includes specific goals, actions and measures of effectiveness. See *Appendix B* for a full summary.

Program Evaluation

Aetna Medicaid conducts a comprehensive evaluation of processes, resources and the effectiveness of its care and chronic condition management programs on an annual basis to ensure interventions and strategies remain consistent with the most current Standards for Medical Care and other community standards.[37] In all of our programs, including care management, we consider a member's protected health information (PHI) private and confidential. Aetna Medicaid maintains policies and procedures to protect PHI against unlawful use and disclosure.

The plan staff annually review and update the ICM processes and resources to address member needs to identify opportunities to develop plans for improvement. The review also includes measurements of member enrollment, engagement, and satisfaction outcomes. The effectiveness of any actions taken will be assessed with re-measurement.

Quality Audits

ICM program supervisors audit their staff to ensure that the appropriate follow though is conducted on member raised issues/concerns and that documentation is accurate and complete. This may include review of member files in our care management system as well as monitoring phone conversations with members.

All staff quality reviews are performed to validate that staff are conducting their activities in accordance with program principles and processes, including compliance with applicable regulatory requirements and accreditation standards. Reviews are structured to evaluate the consistency by which staff in comparable roles perform their required functions. Each staff member is expected to meet or exceed the goals established by the department. Staff not meeting or exceeding department goals receive additional training with specific performance improvement activities. They are audited more frequently and mentored to support improvement until goals are met.

Member Experience Survey [38]

Annual member satisfaction surveys are used to obtain feedback from members about their experience with ICM programs. All responses are analyzed by clinical leadership along with member complaints related to care management. Survey outcomes are used to enhance the care management processes

[37] NCQA HP 2018/2019PHM6 A
[38] NCQA HP 2018/2019 PHM5 F1-2, NCQA HP 2018/2019 LTSS2 1A

and staff performance to improve the program and each member's satisfaction with services. Opportunities for improvement are identified, evaluated and actions to address them are implemented as indicated.

Communication of Findings

The findings of the annual program evaluation are presented to the ABH-KY Quality Management / Utilization Management (QM/UM) Committee for review and discussion. Process and performance activities are based on identified opportunities for improvement. Corrective action plans are developed as indicated and progress reports provided to the committee on a regular basis as determined by the health plan.

ICM Program Description Appendix A

ICM Program Stratification, Services [39] and Associated Interventions Program Indications	Program Services	Care Management Interventions
Intensive Care Management (includes Chronic Condition Management)		

Non-LTSS
• Behavioral & physical health co-morbidities
• Higher risk for Inpatient/ED utilization and unplanned transitions
• New or unstable chronic condition management incorporated
	• Complex clinical and psycho-social care coordination and planning including covered and wrap around services.
	• Chronic condition management education as appropriate as well as assistance with accessing care across the continuum.
	• Member education and coaching to self-manage their conditions and issues.
	• Monthly contact, face to face visits, frequent visits during acute or transitional episodes, and an annual comprehensive assessment by a licensed care manager.
	• Community based referrals for services related to health plan identified SDOH
	  o Health Literacy
	  o Barriers to access
	  o Culturally aligned services
		• Face to face visit - offered within 30 days of enrollment in care management when feasible and and quarterly thereafter based on member needs and preferences
		• Comprehensive bio-psychosocial assessment including behavioral health, substance abuse, and functional screening
		• Condition specific assessments for physical and behavioral health
		• Case Formulation/Synthesis (summary of the member's story)
		• Integrated care and service planning, including covered and wrap around services
		• Chronic condition management provided by a clinician
		• Monthly member contact and care plan reviews and updates based on progress toward prioritized goals and communication of the care plan with the member, PCP, and others of the members' choosing
		• Member contacts, including face to face visits, based on member needs and / or change in condition
		• Annual re-assessments based on member needs and as indicated by a change in condition.
		• Complex care coordination informed and supported by health plan based multi-disciplinary case rounds and the member's interdisciplinary care team (ICT) which includes the member and his/her identified support system

Supportive Care Management (includes Chronic Condition Management)		

[39] NCQA HP 2018/2019 LTSS1 A4

ICM Program Stratification, Services [39]and Associated InterventionsProgram Indications	Program Services	Care Management Interventions
• Members with the following chronic conditions: o Asthma o CAD o COPE o Depression o Diabetes o Heart Failure o Chronic Kidney • High risk pregnancies • Members who have lesser clinical and biopsychosocial complexity. • State required populations, e.g. Lead exposed children or other health plan identified SDOH •	• Standard care coordination and planning. • Condition specific assessments for conditions of focus • Coaching on the management of conditions and issues and self-care • Encouraging members to communicate with their care and service providers • Education on disease process, self-management skills, and adherence to recommended testing and treatment • Quarterly (minimum) care plan review, goal discussion, and updates • Member contacts as clinically indicated by the member's needs, change in condition, or CM's judgment (every 90 days at minimum) • May be brief and condition focused • Community based referrals for services related to health plan identified SDOH o Health Literacy o Barriers to access o Culturally aligned services	• Face to face visits, as indicated or required by contract • Condition specific assessments for conditions of focus. • Biopsychosocial, person-centered care plan which includes activities for chronic conditions, and service plans • Chronic condition management support and referral to a clinician for clinically based needs associated with the condition(s) • Coaching on the management of conditions and issues and self-care • Encouraging members to communicate with their care and service providers • Education on disease process, self-management skills, and adherence to recommended testing and treatment • Quarterly (minimum) care plan review with discussion of goals and progress toward achieving them, revisions, and communication of updated care plan with the member, PCP and others at the request of the member • Member contacts as clinically indicated by the member's needs, change in condition, or CM's judgment (every 90 days at minimum) • Annual re-assessments based on member needs and as indicated by a change in condition • Care team coordination informed and supported by health plan based multi-disciplinary case rounds and the member's interdisciplinary care team (ICT) which includes the member and his/her identified support system as indicated
Population Health Non-LTSS only, (includes low risk Chronic Condition Management)		
• Low risk pregnant mothers for	• Monitoring and education for low risk special populations.	• Low/No Risk pregnant members: Quarterly screening to identify risk factors

ICM Program Stratification, Services [39] and Associated Interventions Program Indications	Program Services	Care Management Interventions

quarterly risk screening
• Low risk chronic condition specific mailings
	• Basic educational outreach
	• Individualized services to members who require routine screening, monitoring, and follow-up.
	• Deployment of additional staff such as CHW or Peer Support
	• Health plan identified SDOH for disparity focused population
	  o Advocacy
	  o Community based education
	  o Community resource referrals
		• Dually enrolled Medicare-Medicaid: Annual HRQ, low risk care plans, Krames materials
		• Special populations: monitoring/tracking per state requirements

ICM Program Description Appendix B

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
ABH-KY evaluates its populations to define health service needs and ensure health care is available, accessible, and appropriate.	• In support of the PHM annual evaluation, actively participate in assessment by providing care management information related to member populations and demographic characteristics. • Adjust care management programs and processes to address identified needs and improve existing programs.	**Populations are evaluated[41]** • Membership profile (population assessment) conducted per process described in PHM Strategy Framework. • Evaluation of processes and resources as evidenced by Care Management Program Evaluation report and related discussion found in QA/PI Committee Minutes
Members are identified for ICM and aligned with the appropriate level of care determined by their individual needs.	Identify and engage members appropriate for care management through enrollment, self-reported health status information, planned and unplanned utilization, and individual referral processes.	Using established criteria, evaluate monthly and quarterly reports:[42] • Percent members reached for enrollment in CM • Percent of members enrolled in care management programs • Percent of Members enrolled in CM who are also engaged. (Target: >85%) • Percent of members enrolled in complex care management identified with a chronic condition who receive condition specific assessments (goal 75%) • Percent of members receiving timely initial assessments • Percent of members receiving timely annual reassessments (Target: 100%)
Members access a continuum of services and supports based on the intensity and complexity of their	Monitor utilization to care and services, interacting with members as indicated to promote utilization of PCP and specialty services and take action to mitigate risk	Decrease avoidable emergency department utilization by *2%* annually : • ER utilization per thousand (monthly review)

[40] NCQA HP 2018/2019PHM5, PHM 6A1-3 , NCQA HP 2018/2019, LTSS1 A4, A2
[41] NCQA HP 2018/2019 PHM2 B1-4, PHM2 C1-2

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
needs and utilize those services in an efficient and effective manner.	and decrease unplanned transitions and / or inappropriate utilization of resources.	• Increase use of specialty care and services targeted to specific member needs • Specialist visits per thousand (monthly review) Evaluate monthly: • Hospital Admissions per 1000 **Transition of care** between inpatient and home settings are coordinated and free of avoidable adverse outcomes • Percent members discharged from acute inpatient facility to home or community based setting who receive post discharge questionnaire (PDQ) screening • Hospital Readmissions within 30 days per 1000 for members enrolled in Care • Hospital Readmissions within 30 days with PCP visit within 7 days of initial discharge • Hospital Readmission within 30 days with PCP visit within 8-14 days of initial discharge
Care plan interventions are timely with performance goals that support members receiving care in the most integrated, least restrictive, and cost effective setting while encouraging optimal functioning and acknowledging personal preferences.	Assess case management activities for adherence to program standards, including through regularly scheduled file audits to evaluate: • Assessment, re-assessments, and contact with members at predetermined intervals to evaluate status • Person centered care planning and follow up to monitor achievement of goals in the individual member's treatment plan • Education of member and circle of supports, • Inclusion of providers, and the member's representative(s) in the development of the care plan and	File audits conducted on an statistically valid volume of member files, including at least three files per case manager quarterly per Staff Quality Review policy (Target: CM supervisors complete prescribed number of file audits per staff person). Conduct quarterly file audits using an approved audit tool that evaluates the documentation of all essential CM activities. (Target: >85Percent of staff scoring 90% or more on file audits.).

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
	provision of updates to support the member achieving their goals • Assisting members with achievement of individualized goals, such as meaningful employment or palliative care needs[43]	
ICM promotes and facilitates behavioral changes that supports self-management and improved health outcomes.	Engage members in activities aimed at improving their life goals, health outcomes and quality of life, including: • Addressing social determinants of health • Supporting existing treatment plans • Providing reminders on disease prevention, health and wellness • Providing information related to their chronic conditions and self-management of those conditions	• Members receive education and information about their conditions, medications, available services and resources, and/or options that will help them to achieve their identified plan of care goals (Target: 100% members enrolled in ICM receive education and/or materials) • Evaluate members' perception of their quality of life measured through the use of the pre/post SF10 and/or SF12 questionnaire within 90 days of members' enrollment in ICM and at least annually thereafter • (Target: 90% of members receive evaluation)
Social, educational, environmental, racial and ethnic disparities in health care are identified and reduced through care coordination, collaboration, and network management.	• Evaluate adherence to evidence based guidelines and interventions using established metrics. • Collaborate with Quality Management to meet performance targets, optimize quality incentives and avoid sanctions or penalties. • Collaborate with SDOH to develop and implement integrative clinical programs that address cultural and linguistic needs of Aetna Medicaid members, and address racial and ethnic disparities in health care	• Complete evaluation of monthly gaps in Care and interim HEDIS data at least quarterly • Meet or exceed targeted HEDIS benchmarks for members engaged in ICM. • Facilitate and support integrative clinical programs and HEDIS® based initiatives that address cultural and linguistic needs of ABH-KY members (Target: 1 program per year) • Participate in initiatives to address racial and ethnic disparities in health care.

[43] NCQA HP 2018/2019 PHM5 E1-5

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
Members receive interventions that promote health literacy.	• Provide interventions that reflect awareness of health literacy's impact on health care to improve member health literacy and outcomes. • Utilize articles in culturally aligned semi-annual chronic condition newsletters to support understanding of conditions. • Internal staff training on the use of plain language in communication • Promotion of external communication resources • Technological improvements (e.g., track phone, cellular phone applications)	• Creation and distribution of pre-printed member facing information meet "easily readable" criteria (Target: 100% member-facing pre-printed materials at or below 6th grade reading level) •
Collaboration and coordination is promoted to integrate member health information across all departments.[44]	Analyze data gathered from inter-departmental resources collectively and routinely to identify opportunities for process improvement across all departments.	Determine effectiveness in the following areas: • HEDIS Gaps in Care • Health appraisals • Health care equity findings • SDOH data • Health information line • Interdisciplinary case rounds Evidenced by the annual evaluation of Care Management program and the Quality Management/Utilization Management (QM/UM) annual evaluation.
Members experience improvement with health care delivery.	• Regularly obtain and evaluate input from members, caregivers, and other stakeholder regarding their experience with health care and care management services and health, using information gained to improve quality of care and service • Monitor monthly grievance and appeals reports • Conduct ongoing member satisfaction surveys	• Percent of grievances related to non-LTSS care management activities (Goal 2% improvement per year) • Percent positive responses (response ratings of 4 or 5) to the Satisfaction with CM Services to the following questions: ○ I am happy with the care management services I've received.

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
		○ My case manager helped me get all of the services that I needed (Target: 90% for each question)[45]
Promote health and wellness through the use of preventive and routine care and services.	• Effectively communicate the value of prevention and wellness activities using multiple modalities (telephone calls and mailers) and resulting in increased use of these services. • Member education through culturally aligned member newsletter articles • Promotion of wellness visits (as part of treatment goals) • Offer incentives	• Written Member information /education on the value of preventive and care aimed at promoting health and wellness are provided to members through culturally aligned quarterly member newsletter articles at least quarterly (Target: 100%) • Care plans include documented promotion of health and wellness related activities as evidenced in File Reviews and visits (as part of treatment goals) (Target: 75%) • Improved use of preventive measures such as well woman, well man, EPSDT and immunizations.
Chronic Condition Management within Integrated Care Management Goals: Aims to reduce longer-term premature morbidity (complications) and mortality of the condition. Appendixes I through VI describe condition specific goals, metrics, and interventions. The following apply to all Health Plan members and reflect common goals and metrics of the six Chronic Condition Management programs		
Staff will promote member participation in chronic condition management programs.	Identify and enroll members with diagnoses of diabetes, heart failure, depression, asthma, COPD, chronic kidney disease and / or coronary artery disease into chronic condition self-management programs.	Percent of members with identified chronic conditions who participate in at least one (1) chronic condition management program specific to the members condition
Members will demonstrate improvement in their ability to self-manage their identified chronic condition.	Provide culturally aligned education and / or information specific to members to encourage accurate perceptions of their condition(s) and improve their ability to self-management.	• Evidence of distribution of culturally aligned chronic condition management related information to all identified members (Target: Materials sent to 100% of identified members) • Percent of members engaged in care management with identified

[45] NCQA HP 2018/2019 PHM6 A1-2

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
		chronic conditions that receive active care management for their specific condition within a given year.

ICM Program Description Appendix C

Glossary of Terms

- **Behavioral health:** Behavioral healthcare is an umbrella term and refers to a continuum of services for individuals at risk of, or suffering from, mental, behavioral, or addictive disorders. Behavioral health, as a discipline, refers to mental health, psychiatric, marriage and family counseling, and addictions treatment, and includes services provided by social workers, counselors, psychiatrist, psychologists, neurologists, and physicians.

- **Care Management:** A collaborative process of biopsychosocial assessment, planning, facilitation, care coordination, evaluation, and advocacy for service and support options to meet a member's comprehensive care needs to promote quality cost-effective outcomes. Care management includes assistance to members with the management of chronic conditions, providing them education and encouragement to learn self-management skills and coordinating access to the appropriate services and supports.

- **Care Setting:** A provider or place that delivers health care and health-related services.

- **Care Transition:** Movement of members between care settings (e.g., from home to hospital) as their condition and care needs change during the course of a chronic or acute illness.

- **Chronic Condition Management:** Consists of a stratified group of interventions within the ICM program designed to manage chronic conditions using a systematic and structured member-centric approach based on condition severity and member needs. The aim of the program is to help members understand and control the effect of their condition by encouraging self-management, family involvement, support systems, and community awareness. Management of chronic conditions involves ongoing monitoring and encouraging members to adhere to necessary interventions that will help improve outcomes and enable individuals to more effectively manage and live with their chronic condition.

- **Enrolled in Care Management:** For LTSS and Duals (DSNP/MMP): Care management is required for these members so they are automatically considered enrolled in care management upon their health plan eligibility date. Mandatory population that is eligible, whether or not they have been outreached or have an initial outreach attempt, are considered "enrolled". For Non-LTSS/Non-Dual members, any member with an open episode in the ICM business application software is considered enrolled in care management.

- **Engaged in Care Management:** Members are considered engaged in ICM when they are enrolled in the program and have an active care plan they have agreed or partially agreed to.

- **General Risk Model (GRM)**: Proprietary predictive modeling program that shows all members in the health plan and their general risk score to identify high risk members. The top 1% of members are ranked by highest score. This is based on claims, authorizations and eligibility. The GRM serves as the basis for the CORE.

- **Health Care Equity:** Health equity exists when individuals have equal opportunities to be healthy. The ability to be healthy is often associated with factors such as social position, race, ethnicity,

gender, religion, sexual identity, or disability. When these factors limit a person's ability to be healthy it can lead to health inequity.[46]

- **Integrated Care Management (ICM):** Aetna Medicaid's model of care management and care coordination in which members are stratified by the complexity of their needs and assigned program levels, including: Intensive Case Management (Complex Case Management); Supportive Case Management; and Population Health/Monitoring and Consultation. All levels of care management include assistance to members with the management of chronic conditions (disease management), providing them education and encouragement to learn self-management skills and coordinating access to the appropriate services and supports.

- **ICM Business Application Software**: The primary web-based system used to document and coordinate all care management activities.

- **Krames Patient Education:** Provides booklets, brochures, workbooks and tear sheets online and via mail to engage patients throughout the continuum of care; motivate behavior change and build self-care skills; and support shared decision making and informed consent.

- **MyActiveHealth:** An Aetna owned company, ActiveHealth Management is Wellness and Health Promotion (WHP) accredited by NCQA. MyActiveHealth is a confidential and secure internet-based service that allows health plan members to obtain access to and organize their own health information. The website provides useful information about opportunities for improving the quality of medical care that you can be shared with the treating provider.

- **Population Health Level of Care Management:** A level of care management that offers basic educational outreach and includes individualized services to members who require routine screening, monitoring, and follow-up.

- **Population Health Management (PHM) Model Graphic:**

[46] *(The Guide to Community Preventions Services, 2016)*
Available at: http://www.thecommunityguide.org/healthequity/index.html

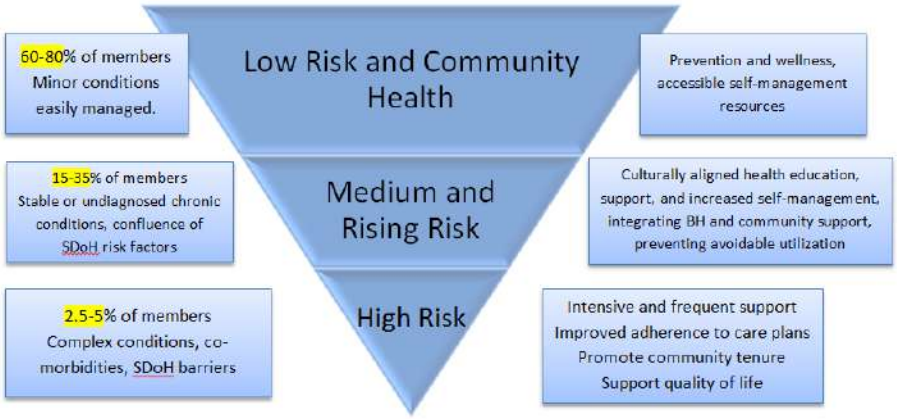

- **Social Determinants of Health (SDOH):** The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems." [47]

- **System of Care (SoC):** A collection of integrated services and supports that help people achieve goals that are important to them. The integrated services and supports may include all forms of health services, as well as housing, employment, healthy food, transportation and other living supports to optimize resiliency and independence. The SoC is grounded in the demonstration of trauma informed care, culturally and linguistically appropriate services, and recovery principles.

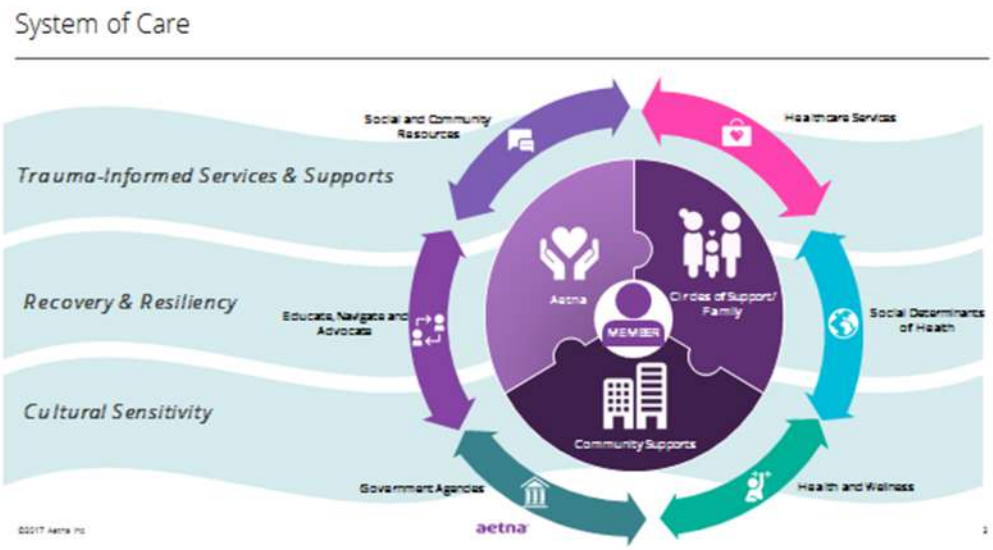

[47] World Health Organization. Available at: http://www.who.int/social_determinants/en/

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Population Health Management Strategy 2019

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Population Health Management Strategy 2019

Aetna Better Health® of Kentucky

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Population Health Management Strategy Framework

Aetna Medicaid's Population Health Management Strategy (PHM) explains the guiding principles which will inform our implementation of an innovative Population Health Management Program to improve the overall health of our members through an innovative, person centered approach that addresses medical and non-medical drivers of health while reducing inappropriate utilization and costs. The goal of Aetna's PHM Program is to drastically improve outcomes for a variety of healthcare conditions and to empower individuals to improve their health and engage in their healthcare. The PHM program should support members across the care continuum, promoting healthy behaviors and self-management as well as providing care coordination and the management of complex health conditions as supported by evidence-based medicine and national best practices.

Key Strategy Principles

Aetna's PHM program will strive to maintain or improve the physical and psychosocial wellbeing of individuals and address health disparities through cost effective and tailored health solutions. Aligning with National Committee for Quality Assurance (NCQA) standards, the framework of our total population health management strategy supports the state's goals of advancing the population's self-sufficiency, recovery, and resiliency. Best practice principles guide our program to influence the health of the population at the socio-cultural, economic and individual level. Our approach to PHM includes person centered approaches, prevention and early intervention, accessible programming, integrative partnerships, accounting for holistic factors affecting member's health, commitment to health equity, and data and evidence-driven strategies. Our processes are grounded in trauma-informed care (TIC) and trauma- informed approaches, culturally and linguistically appropriate services, and recovery principles that guide our care management service delivery model.

Person-centered

The Aetna Medicaid PHM strategy is a personalized approach that emphasizes empowering members to achieve health goals by recognizing and elevating the individual's expertise and central role in their own health. Our PHM programs meet members with the right level of services for each person and enable members to use those services to achieve their individual health goals. Person-centered supports will focus on the whole person, addressing physical health, behavioral health, functional, and social needs.

Accessible

Our programs ensure convenience and easy-to-access resources that are targeted to meet the needs of our populations. Our programs are coordinated so all benefits and resources can be accessed regardless of point of access, cultural orientation, health literacy, preferred language or social determinants of health factors that impact accessibility.

Integrated

We aim to increase integration of members' care across internal and external partners and providers, including care managers, patient centered medical homes, specialist care and community resources. An effective strategy is one that coordinates to minimize silos in our system.

Holistic

Our PHM strategy is holistic. We seek to recognize the unique biological, cognitive, social and cultural factors

that culminate in member and community health outcomes. We deploy personalized care planning and programs that incorporate a member's assets and attend to their needs stemming from each of these intersecting factors.

Health Care Equity

Health Care Equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.[1]

Members groups experience major obstacles to health due to socio-economic disadvantages and injustices. These members may face social inequities based on race, gender, class, sexual orientation, or immigration status. They may face economic inequities when government or community institutions use their authority to limit educational or job opportunities. The environment or area in which the member lives may also contribute to inequity particularly for rural areas where access to health care may be limited. To assist members to achieve health equity, it is important to identify the root causes of health. Our PHM strategy strives to reduce the disparities and lack resources and opportunities for our low-income members, and their inability to access needed services.

Data and Evidence Driven

Programs follow from a locally rooted understanding of population health priorities, needs and assets while having the underpinnings of a national structure driven by population data analytics and evidence- based practices that focus our PHM activities for distinct member populations throughout the continuum of care.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863701/

PHM Conditions and Populations

Aetna Medicaid's PHM key strategy principles recognize the need to align the right resources with the right member at the right time. Member's needs and assets are diverse, and not everyone requires the same level of support. Some members require fewer health services and prefer to interface with self- management tools at their own convenience but may also need reminders for or notifications of missed preventive services like flu vaccines, well child visits and cancer screenings. Others require some support to manage chronic disease such as culturally appropriate health education materials or low-frequency one-to-one support or direct coordination with healthcare practitioners. There are others who frequently utilize high cost services; they may require a higher level of integrative support to help manage serious, debilitating or co-occurring health conditions, transitions between health care settings and the community and to receive the appropriate clinical care and community resources to have fewer days outside of their communities.

ABHK's PHM strategy is based on the identified needs of the community, state, members and the overall population of Kentucky. We seek to understand each member in the context of their lives, their environment, and their genetics, while co- facilitating a holistic model of supports and services that enhances their quality of life and assists them to reach their individual person-centered goals. Our innovative integrated system of care approach is based on a whole-person view of our members' physical health, behavioral health, oral health, health literacy, functional needs and social determinants of health. With the intent to use our integrated system of care that demonstrates our comprehensive focus on meeting members' needs and goals, we will use ABHK covered services, their circle of support, and community-based organizations while focusing on cultural sensitivity, recovery and resiliency, and adopting trauma-informed practices.

Aetna Medicaid's PHM strategy incorporates a continuous improvement cycle that begins with an annual population characteristic and health needs assessment of ABHK's membership. This is accompanied by a risk stratification process and the resulting alignment of members categorized in each segment of the population within our population health pyramid model. As members are stratified, their conditions, diagnoses, risk for future ED visits or inpatient admissions, and gaps in care areidentified.

Resources are distributed to members based on characteristics identified through population assessment, factors that influence stratification level and subsequent individual level assessments.

ABH-KY uses a variety of tools to support identification of and care for members as part of our PHM Program. ABHK uses clinical claims data, financial data, social determinant of health (SDOH) data, and operational data together to create actionable analytics that identify and address health disparities in at-risk populations. For example, ABHK has a proprietary dashboard that identifies disparities around our enrollees that frequent emergency rooms.

Assessments and analyses are completed at the population and individual level. Assessments and analyses include:

- Membership profile analysis
- General Risk Model (GRM) and Consolidated Outreach and Risk Evaluation (CORE) analysis, Aetna's proprietary risk assessment and predictive modeling processes
- Healthcare equity (HCE) dashboard reporting
- Community Health Needs Assessment using CommunityCommons.org and/or Market Regional Health Profiles

- Federal/state/ county/ municipal/ community population health surveys and assessments
- Member Health Risk Appraisal (HRA)
- Care Management comprehensive and focused assessments and questionnaires

Certain health conditions and populations are identified as a priority for our PHM interventions through this continuous improvement cycle. These conditions include asthma, heart disease, diabetes, obesity, tobacco use, cancer, infant mortality, low birth weight, behavioral health and substance disorders. At risk populations that are also prioritized include adults and children with special health care needs and high-risk pregnant women.

Innovations and Program Elements to Support Overall PHM Goals

ABH-KY recognizes that incorporating innovations into its PHM Program will produce the highest potential for success within the Kentucky healthcare landscape. Aetna's innovative PHM model combines integrated services, collaborations with key stakeholders, and advanced technologic and mobile supports to promote positive outcomes and reduce population health disparities. Key innovations and program components of Aetna's PHM model range from high-touch, personal interactions to technology-based solutions and are highlighted below.

Innovations
Aetna's PHM strategy uses a wide range of innovations determined by the needs of our members and our review of internal and external data. Some of our innovations include: our collaborative effort to address social determinants of health; transformation into a trauma-informed organization; innovative programs to engage at-risk enrollees through collaboration with state agencies and providers; and technology to increase service efficiency and effectiveness.

Unite Us / Community Health Workers: ABHK is partnering with Unite Us in a unique collaboration to address the full spectrum of social determinants of health (SDOH). The partnership; currently in one location in the state; establishes new and innovative models that improve the engagement between members, traditional health care providers (e.g., PCPs) and social services providers. ABHK's intent is to expand this partnership statewide. This SDOH services integrated model connects enrollees to community-based organizations who participate in the closed-loop referral network, including all types of social service agencies

- CHWs serve as a liaison or bridge between the member (community) and health/social services. Their role is meant to facilitate access to services and improve the quality and cultural competence of service delivery. The CHW serves as an important member of the fully integrated system of care team (SOC). CHWs facilitate as a bi-directional conduit of information between members and the health system (i.e., practitioners, hospital, Aetna Medicaid) by:
- Engaging Aetna Medicaid members, experiencing or at risk of health disparities, to improve their health care engagement, access to care, and reduce unnecessary hospitalizations and
- Emergency Department (ED) visits.
- Educating health care professionals about opportunities for improving and understanding the social determinants of health that may be impacting the member's engagement, health and treatment plan.
- Serving as a member of the multidisciplinary team treating Aetna Medicaid members. This level of involvement will allow the CHW to bridge information back to the treatment team regarding any identified cultural and other psychosocial elements.

Trauma Informed Practice: Aetna is undertaking a system-wide transformation initiative to enhance our system of care into a system that includes trauma-informed practices and providers. This transformation is occurring at all levels of the organization from the CEO to care managers as well as member services staff, human relations,

and all aspects of the healthcare company. Aetna subscribes to the following tenets as established by the National Institute for Trauma-Informed Care: "We realize that trauma is common; we recognize how trauma affects individuals seeking care; we are committed to implementing TIC best practices; and at all costs avoiding re-traumatization." As a trauma-informed organization, our care management, enrollee services, and community outreach staff receive comprehensive and ongoing training established in partnership with the National Council for Behavioral Health. Some of the comprehensive training includes: Motivational Interviewing (MI) and Mental Health First Aid (MHFA) for our member-facing staff.

At-Risk Member Focused: Aetna is also implementing innovative programs to engage at-risk enrollees through collaboration with State agencies and providers. Based on State goals, population-based data, and community and population needs, Aetna has facilitated several programs to engage at risk enrollees and populations, to address population gaps, disparities, and inequities. For example, some of these innovative population health programs include initiatives to address smoking among pregnant women, early identification and education among members with pre-diabetes, and a re-entry program focused on improving the lives of individuals that have become involved in the criminal justice system.

Technologic supports to advance service delivery:

- Self-service options, such as public kiosks, to improve access to preventive care.
- Integrated information management tools, including predictive modeling and our proprietary electronic population health management platform, to identify and stratify our enrollees by risk, capture information relevant to care gaps and transitions, share information and data with providers. We co-locate Population Health Specialists with a select group of our providers to help expand their quality outcomes, improve their incentive recognition, and develop more opportunities for value-based contracting to improve quality and reduce cost.
- Remote patient monitoring program for enrollees with specific chronic or high-risk diseases, such as, diabetes, high risk pregnancy, asthma/respiratory disorders and certain behavioral health conditions. We use remote monitoring to elicit enrollee empowerment; improve disease management; improve access, adherence and compliance, decrease ED utilization; and lower total cost of care.
- Telehealth and telemedicine strategies are utilized to improve access to services in traditionally underserved areas. Telehealth services, available 24 hours a day/7 day a week, support our populations by increasing the opportunity to both provide access and integrate care with an enrollee's selected PCP. All telehealth visits are documented and become part of the enrollees' health record with a copy sent to the PCP of record with enrollee consent.

Population Health Management Risk Model

ABHK uses an inverted pyramid for our population health model. Members are stratified to high risk, medium/ rising risk and low risk level as indicated by their known risk factors.

- Low risk: The majority of members (60-80%) are identified as low risk. These members have little or no risk factors, minimal gaps in care, limited ED or inpatient utilization, few prescription medications or have reported that they do not require a higher level of support. These members receive health promotion interventions focused on maintaining health and keeping risk low, such as annual visits to their primary care physician, virtual access to care, recommended screenings and self- management tools. Wellness and prevention services and supports are provided to encourage members to become proactive participants in their health and wellbeing and that promote healthy lifestyles. The area of focus for low risk members and programs directed toward them is **keeping members healthy**.
- Medium risk and rising risk: A smaller proportion of members (15-35%) are identified as medium and

rising risk. These subpopulations include members with chronic conditions like asthma or diabetes, mental illness, high risk pregnancy and other special populations. These members haven't yet exhibited high risk utilization trends but likely may in the future if left unmanaged. These members receive disease management education materials and programs, supports to access health services effectively, and low-frequency care management. These services, through integrative care and care coordination, aim to reduce healthcare costs and improve quality of life and help members address potential co-morbidities or other complications and help to avoid complications. The area of focus for medium risk members and programs directed toward them is primarily **managing emerging risk,** but also includes all other focuses in the appropriate situations including **keeping members healthy, managing multiple chronic conditions** and **outcomes across settings** where members require support to coordinate care**.**

- High risk: The smallest proportion of members (2.5-5%) are identified as high risk. These members may frequently utilize the ED or have had multiple inpatient admissions and/or may require high risk, high cost medications. They may have multiple chronic and/or disabling conditions like substance use disorder and serious mental illness. High risk members indicate potentially requiring the highest level of resources from complex case management in addition to disease or condition management support and preventive care programs. Complex case management services include the development of a person-centered Care Plan, coordination of care to address all required needs and to support the member in obtaining the required care, and telephonic and face-to-face engagement with members as deemed necessary. Members who receive complex case management are assigned care managers to support implementation of the Care Plan and to facilitate receipt of necessary care and services. The area of focus for high risk members and programs directed toward them is **managing multiple conditions** and **outcomes across settings.**

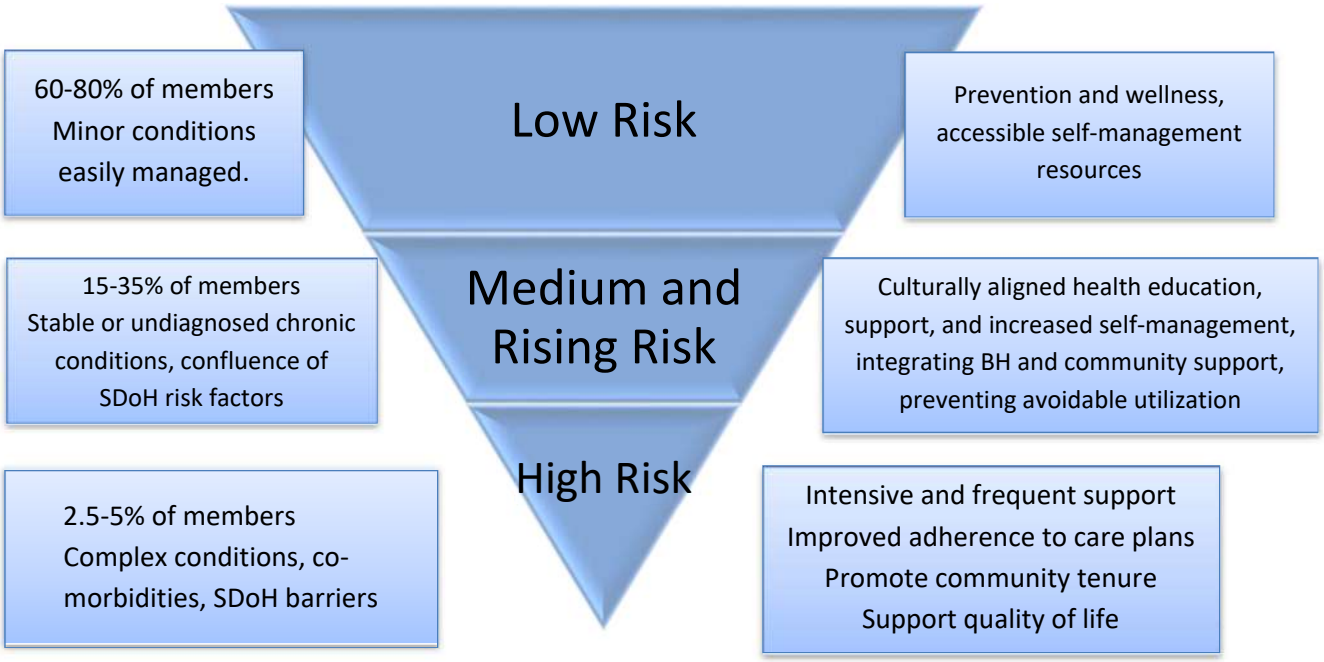

Integrated Care Management - Subpopulation of PHM

Care management programs are designed to engage members with the right level of clinical and social support depending on many factors that affect an individual's health status, overall well-being and ability to manage it.

Care management service level corresponds with the stratified risk level; further member assessment and the member's expressed desire for or decline of support may modify the assigned care management level.

- Low risk -> Population health: Members who require education, monitoring, or occasional outreach to review risk levels and may be stratified for low risk chronic condition management interventions.
- Medium risk -> Supportive Care Management: Members with limited bio- psycho- social complexity or with adequate strengths and supports to manage that complexity. Interventions focus on problem-solving, supporting therapy adherence and promoting behaviors that can prevent continued risk escalation. These members may require assistance with acute or chronic conditions or who may need service coordination.
- High risk -> Intensive (Complex) Care Management: Members characterized by their bio-psycho- social complexity and their caregivers or family members will be offered highlyindividualized care coordination. Interventions help members, their caregivers and family members manage serious and complex conditions and co-occurring social determinants of health that are persistent and substantially disabling or life threatening.

Population Health Management Programs

ABHK's population assessment activities inform the programs and activities targeting members, practitioners, providers and others in the system of care to support cost reduction, better health outcomes of the population and individual members in achieving their personal health goals. The programs operated are intended to serve the specific needs of each group within the population. Members have the option to participate in Aetna's PHM Program based on the identification of each individual member's needs for support. While members are not mandated to participate, the Aetna implements innovative strategies to attain high levels of member participation.

Member programs are targeted according to members' individual risks as identified through stratification and/or member responses to individual assessments. Programs and activities directed towards practitioners or providers and across systems of care are designed to support delivery of care and resources in accordance with population and individual needs. Each PHM program includes defined and measurable goals that are used as indicators of program effectiveness; these goals are defined within each program description. Program impact is regularly monitored and evaluated annually to determine whether the activities completed produce the stated goals within the targeted populations groups. Program evaluation results drive further analysis to identify areas for improvements or changes as needed where goals or population needs are not met.

Areas of Focus

Four focus areas in our PHM Program align programs to each group in the population and the identified risk level of each member. Programs may flow between different areas of focus as members within population groups are monitored on an ongoing basis. As the individual needs of members within population segments change, or as members move between population segments, programs and aligned resources serving those members can shift to support them. Aspects used to delineate focus areas with population groups include:

Focus Area 1: Keeping Members Healthy

- Programs are targeted to aligns with low risk population
- Emphasis on preventive health, screenings, using health benefits effectively and engaging with PCP/ medical home
- Practitioner and provider-facing activities focused on closing gaps in care, engaging new patients,

accessibility
- Members at higher risk levels also receive these interventions, in addition to other more targeted initiatives. Every population segment needs preventative health care.

Focus Area 2: Managing Members with Emerging Risk

- Activities and programs are targeted to align with medium risk/ rising risk population
- Emphasis on health maintenance, self-management, preventing conditions from worsening
- Factors that are predictors of rising risk, including social determinants of health, are identified and addressed. Accessing community resources is emphasized.
- Health Care Equity (HCE) dashboard helps identify areas of potentially greater risk to certain communities and populations; Relias HCE assessments support ability to address these at the individual level
- Engagement with practitioners and providers focuses on supporting PCMH models to centralize care, encouraging monitoring, cost-effective care choices and patient-driven decision making

Focus Area 3: Patient Safety and Outcomes across Settings

- Activities and programs are targeted to align with any segment of the population that experiences health services across settings and/or benefit program eligibility changes, such as use of inpatient/ ED, nursing facilities, specialty care, community-based medical homes and home-based care
- Rising risk and high-risk members receive a higher percentage of resources due to higher utilization of services, greater risk of an adverse event arising from medical care, and/or transitional situations requiring need for coordination and continuity of care.
- Engagement with practitioners and providers focuses on communication and collaboration with their patients, other practitioners through transitions of care, PCMH models with centralized coordination, and sharing information as permitted to prevent duplication and potential for harm

Focus Area 4: Managing Multiple Chronic Conditions

- Activities and programs are targeted to align with high risk population
- Emphasis on seeing the member as a whole person rather than a set of conditions where patient goals for health are priority and recognizing that each condition is influenced by the greater whole. This is true across the continuum of care and population segments but is especially critical for increasing self-efficacy with the highest risk population.
- Engagement with practitioners and providers focuses on maintaining engagement outside of clinic, frequent and regular office visits, integrated health models

Members receive information about all population health management programs through various communication sources such as member handbook, member newsletter and postings on the website. Specific levels of contact are described in each program description. See addendum for population health management program member resources and activities.

Non-member Facing Activities

ABH-Ky activities that support its population health management strategy which are not direct member interventions include:

- Information sharing with individual practitioners. Examples of activities include the following: Gaps in care reports (focus 1 - keeping members healthy; focus 2 – emerging risk); Care Plan sharing with practitioners (focus areas 2, 3 and 4); notification to prescribers of medication interaction risk (focus 3 – patient safely); peer-to-peer interactions with discharge planners at acute hospitals and LTC facilities in transfer of care and home based service agencies (focus 3 – outcomes across settings). Evidence-based practice guidelines in provider portal (all focus areas)
- Technology support and integration with PCMHs, value-based payment arrangements.
- Population Health integrated care model which facilitates processes and workflows at the organization level through supported use of web-based technology platform CareUnify to support medical homes and community-based clinics manage membership and improve health outcomes while reducing cost to meet VBS contract targets.

Integrating stakeholders, organizations and resources

Our Community Based Organizations (CBOs) engage members to understand their individual and unique needs through collaborations with community agencies. Case managers and practitioners support meeting the needs of members and streamlining delivery of services to targeted populations through CBO partnerships, some of these include and are not limited to:

- Kentucky Department of Health
- Smiles Kentucky - an oral health collaborative
- Metro United Way
- March of Dimes –maternal health program
- Foundation for Healthy Kentucky
- Kentucky Cancer Consortium
- Healthy Babies Louisville Coalition – maternal health collaborative
- American Heart Association
- Kentucky Oral Health Coalition
- Family Resource Youth Centers- school based resource
- Federal Qualified Health Centers
- Homeless Shelters
- Drug Rehab Centers: Healing Place, Beacon House and Morton Center
- Neighborhood Place – one stop shop for community services
- Kentucky Diabetes Network
- Big Sandy Diabetes Coalition
- American Diabetes Association
- Juvenile Diabetes Research Foundation
- Hope Central – community resource in region 7
- Neighbors Helping Neighbors – community resource in region 7
- Hillcrest Bruce Mission – community resource in region 7
- Kentucky Homeplace – community resource in regions 7 & 8 providing classes on chronic diseases
- Kentucky Reentry Councils
- Community Collaboration for Children – a social service collaborative to meet the needs of families in the community
- Lee County Diabetes Coalition
- Morgan County Diabetes Coalition
- Greenup County Diabetes Coalition

- Healthy Choices Healthy Communities Coalition
- Appalachian Diabetes Control and Translation Project
- University of Louisville Dental School
- University of Kentucky Nursing School
- University of Kentucky School of Public Health
- Healthy Choices Healthy Community Coalition
- Transitioning Community Partners Coalition – community partnership for the homeless, veteran and those transitioning from incarceration

Coordination of member programs

ABHK collaborates with regulatory agencies, national and regional quality associations, healthcare practitioners and providers, community resources, and members to facilitate safe, effective, integrated health care. ABHK develops, implements and utilizes organizational processes within and between the programs it operates to link delivery of services to members with seamless transitions, efficiency, maintained continuity of care and enhanced member experience. Effort is guided to minimize confusion for members being contacted from multiple sources. For further details, PHM program descriptions describe coordination efforts specific to program activities.

Informing members

ABHK informs members of all available population health programs through a listing on the ABHK website. Notification to members that this information is available on the website is included in mailed quarterly newsletters. Each program delivers communication describing member eligibility and reasons they are receiving program information, how to use program services, and the method for contact between member and health plan by which the member may opt in or out of the program. If two-way interactive contact is incorporated into the program, the program description describes the specific method of interactive contact, which may include the following:

- Interactive web portals (member, practitioner and provider)
- Shared written communications (e.g., care plans, mailings, facsimiles, newsletters, and member and provider handbooks)
- Health fairs and community events
- Interdisciplinary Care Team (IDT) participation
- Case manager facilitation of PCP and specialty care (e.g. joint face to face visits in practitioner offices)
- Engagement with and referral of members to community resources
- Interactive Voice Response (IVR) calls
- Text messaging with response options
- Telephonic and in person interaction with members

Population Identification

Data Integration

ABHK integrates a range of data sources, systems, care sites and domains to identify member populations and sub-populations, understand their care needs and operate programs designed to help meet those needs.

Enrollment data is received from the contracting State agency, the Kentucky Department of Medicaid Services, and is integrated into ABHK's member databases and aggregated to quantify the basic demographic and benefit program eligibility category across all plan membership. This data set is used to complete the annual membership profile in order to monitor population characteristics and changes in terms of geographic distribution, age, sex and race/ethnicity distribution, language preferences, cultural diversity trends and changes in rate-group and within the health plan membership.

After the membership profile is generated, enrollment data set is integrated with medical, behavioral and pharmacy claims data and lab results. Together, these data sources make up the key data elements necessary to run the General Risk Model which is a component of identification of targeted populations for certain PHM programs. Risk stratification, medical, behavioral and pharmacy claims data – and in the case of immunization records, member pregnancy identification, certain chronic conditions such as HIV/AIDS and opioid use disorder, state registries or file feeds - are integrated with HEDIS gap in care identification for members missing recommended services. The presence of conditions, medical utilization trends, certain pharmacy utilization or trends, and/or open gaps in care together with membership profile characteristics based on these data sources indicate eligibility for population health management programs that target specific populations.

Other data sources are obtained and integrated with health plan applications and processes to inform, enhance and enable program activities; these are described below.

Health Appraisal Results

Health appraisal responses, completed by members through the ActiveHealth website which members access via the Aetna member portal, are synthesized to generate monthly member-level result reports. The Care Management team identifies members that report having diabetes and/or hypertension and incorporates them into regular diabetes and hypertension educational mailings, which are components of the Diabetes Management and Chronic Condition Management program activities. Health appraisal results are also made available to Care Management team members and can be used to support determination of CM program enrollment. Appraisal results are imported into plan folders in Excel format for access by CM team members.

Health Care Equity Contact Assessment

Dynamo Health Care Equity Contact Assessment Section allows for capturing, documenting, tracking and reporting of Social Determinants of Health (SDoH). The intent is for the SDoH data captured to be

incorporated into the development of the personalized member centric care plan. Member responses are used to inform Care Management approaches or the lens through which PHM program activities are performed, and areas of supports offered.

Prior Authorizations and Inpatient Census

The concurrent review process is the mechanism used to confirm eligibility and to evaluate the medical necessity of continued services. The concurrent review process may apply to both inpatient and outpatient/ambulatory settings. ABHK's concurrent review process includes multiple steps in order to complete

a determination. An authorization request can be placed by inbound telephone call, ABHK web portal, facsimile, or a Concurrent Review nurse may review hospital electronic records or perform on-site reviews.

Authorizations created in ABHK's claims system generate Inpatient Alerts in the care management system, Dynamo. This alert is managed by the Care Management team process followed in the Appropriate Use of Acute Care Settings program.

Data sources for ABHK's population health management programs are identified in the table below:

Integrated Data Sources for PHM Programs		
Focus Area	**Program**	**Data Sources**
1 – Keeping members healthy	Flu Vaccine Program	Enrollment file, medical claims and pharmacy claims
2 - Managing Members with Emerging Risks	Be Healthy	Medical claims and pharmacy claims lab results, health appraisal results, HRQ and Care Management assessment results
3 - Patient Safety and Outcomes across Settings	Lock-in Program	Medical claims, pharmacy claims, that are aligned by the state approved criteria
4 - Managing Multiple Chronic Conditions	Aetna Cares	Medical claims, pharmacy claims, Care Management assessments and surveillance

Population Assessment

The annual population assessment is performed by ABHK's quality management department. The purpose of this analysis is to provide a comprehensive assessment of the ABHK Medicaid population. The analysis includes an assessment of the SDoH of the member population and relevant member subpopulation and is based on economic, social, cultural and environmental conditions that affect a wide range of health functioning and quality-of-lie outcomes and risks. In addition, the needs of children and adolescent members, members with disabilities and members with serious and persistent mental illness (SPMI) are assessed. Assessment results are used to understand membership population characteristics and care needs to determine the necessary structure and resources for the PHM program and support meeting the population's care needs at the highest levels. These needs include provider accessibility and availability, translation services, wellness and preventive health services, services for members with multiple or specific chronic conditions or severe injuries, community-based service resources, and continuity and coordination of care. Population assessment results inform PHM programs including prevention initiatives, self-management programs, performance improvement activities, integrated care management and other quality initiatives that are implemented to meet member needs.

Population Assessment Process

The membership profile analysis, which integrates data from the state enrollment file and medical, behavioral and pharmacy claims and lab results as described above, initiates the population assessment process. In addition to and following the membership profile analysis, the population assessment undertakes or incorporates the following data sources, reports and processes.

Risk Stratification/ GRM General Risk Model™ – ABHK uses a proprietary risk assessment application called General Risk Model (GRM), which is our technology for identifying members who currently have or are at risk of developing complex and/or chronic health care needs. The GRM accomplishes this task through an internal diagnostic grouping process that evaluates over 15,000 ICD-10 codes including behavioral health codes and DSM-IV behavioral health diagnoses to identify specific chronic and acute conditions having long recovery timeframes (such as spinal cord injuries or chronic mental illness or substance use disorders. The goal is to accurately identify chronic conditions that will inform the care needed by each member.

Consolidated Outreach and Risk Evaluation (CORE) analysis – We also use a proprietary, evidence- based process called Consolidated Outreach and Risk Evaluation (CORE) to provide further refinement to our predictive modeling. CORE builds General Risk Model (GRM) data adding algorithms to prospectively identify members who are at risk for inpatient and/or emergency department utilization within the next 12 months.

Our CORE approach is based on the following:

- Predictive modeling risk score in which the top one percent of members ranked by this score are considered high risk
- Emergency department risk score in which a logistic regression model assesses the likelihood of a member utilizing the emergency department in the next 12 months
- Members with a probability of 80 percent are considered high risk for an emergency department visit. Performance of this model is very good, with a positive predictive value of 72.1 percent. This means that 72.1 percent of the time, the predicted emergency department utilization occurs in the next 12 months.

Inpatient admission risk score in which a logistic regression model addresses the likelihood of a member utilizing the inpatient admission in the next 12 months. Members who have a probability between 50 to 69 percent are considered medium risk and 70 percent or more are high risk for an inpatient admit. (This excludes maternity admits.)

Members are placed within one or more of these three risk groups. In order to understand the significance of the overlap between these risk groups, the following diagram illustrates the overlapping relationships between the three different risk groups. Each of the three overlapping circles in the CORE diagram represents a different predicted risk category; creating seven distinct risk groups:

Aetna Medicaid's Consolidated Outreach and Risk Evaluation (CORE) tool identifies members who will benefit most from our Integrated Care Management program. This tool uses acute care, and pharmacy claims data to identify members at high risk for adverse future health outcomes.

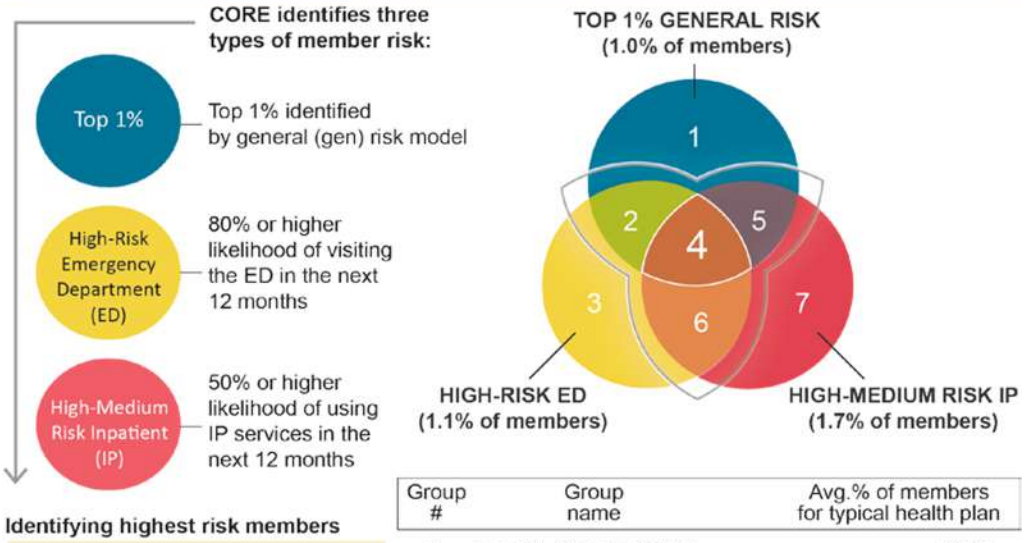

Identifying highest risk members

This diagram shows three risk categories. The areas of overlap represent members at high risk (groups 2, 4, 5 and 6) for adverse health outcomes. Group 4 represents members at the highest risk, falling into all three risk categories.

Group #	Group name	Avg.% of members for typical health plan
1	Top 1% Gen risk ONLY	0.6%
2	Top 1% Gen risk / High-risk ED	<0.1%
3	High-risk ED ONLY	0.3%
4	High-med risk IP/Top 1% Gen risk/High-risk ED	0.2%
5	Top 1% Gen risk / High-med risk IP	0.2%
6	High-risk ED / High-med risk IP	0.6%
7	High-med risk IP ONLY	0.7%
Percentage of members not in CORE:		97.4%

Note: Percentages may not add up to 100% due to rounding

Group 1: Top one percent Predictive Modeling Only
Group 2: Top one percent Predictive Modeling and High-Risk Emergency Department
Group 3: High-Risk Emergency Department Only
Group 4: Top one percent Predictive Modeling, High-Risk Emergency Department and High- Medium Risk Inpatient
Group 5: Top one percent Predictive Modeling and High-Medium Risk Inpatient
Group 6: High Risk Emergency Department and High-Medium Risk Inpatient
Group 7: High-Medium Risk Inpatient only

Health Care Equity Dashboard

The Health Care Equity (HCE) Dashboard is a tool to support health plans with analyzing their population health data to understand population characteristics such as race/ ethnicity and how these correspond to geographic area, CORE risk level, and prevalence of certain health conditions or of gaps in recommended health services. This tool is used to help inform planning activities to improve population health and interventions to address health disparities. The dashboard is a visually rich and dynamic tool which synthesizes ABHK's population demographics, based on monthly member enrollment data; HEDIS data; and utilization data from medical, behavioral and pharmacy claims. Health plan staff use the tool to understand dominant population characteristics across these factors. The tool features several filters that users can apply to several reports meant to dissect prevalence and distribution of characteristics and factors across population groups.

Available reports include the Demographics Dashboard, which segments benefit groups, age, gender,

race/ethnicity, language, certain health conditions and General Risk Model category. The next report is a Demographic Map Dashboard. This displays a heat map of member distribution at the county level.
Users can filter by the demographic factors previously listed and explore the geographic population distributions of filter selections. Users may also drill down to the zip code level within a county to explore population distribution and concentration.

The HCE Dashboard allows analysis of HEDIS data through a HEDIS dashboard and HEDIS Map Dashboard. These reports allow analysis of groups to identify disparities in gaps in care based on geography and the demographic factors previously listed and presence of certain health conditions, including serious mental illness. The HEDIS Map dashboard features a heat map visual representation of all HEDIS measure rates down to the zip code level using NCQA Quality Compass national percentile benchmarks.

A Utilization Dashboard features a geographic representation of utilization metrics, including PMPM and utilization rate/1000 member months for ED, inpatient, PCP visits and 30-day readmissions at the county and zip code levels. The report enables analysis of utilization distribution across demographicfactors, conditions and assigned PCP. The Quarterly Utilization Trend report depicts a selected utilization metric over the previous four quarters for selected demographic and condition factors.

Community Health Needs Assessment with Community Commons

Community Commons aggregates a range of publicly available data sources that monitor and collect surveillance data for communities across the nation. The free tool allows anyone to run SDoH indicator reports for any geographic area down to the zip code level. ABHK uses this tool to supplement internal population assessments that are limited to our member health and demographic data. The use of internal data elements alone risk limiting ABHK's comprehensive assessment of population characteristics and needs only to those for which ABHK collects and reports at the population level.
Supplementing with community-level data allows greater understanding of the wider community population characteristics and factors that impact our membership's health.

ABHK synthesizes Community Health Needs Assessment reports for the following SDoH categories and indicators for the counties in which ABHK's membership resides. The factors and indicators selected support the broadest level of understanding about how the SDoH's of public aid reliance, poverty, transportation, housing and food access affect the communities in which our members live.

Social & Economic Indicators:

- Households with no motor vehicles
- Income – public assistance income
- Insurance – population receiving Medicaid
- Poverty – population below 100% FPL Physical Environment Indicators:
- Food Access – Low Income & Low Food Access
- Housing – Assisted Housing
- Housing – Substandard Housing

Regional Health Profiles
The objective of the Regional Health Profiles reports is to develop a "snapshot" of health in each managed care region in the state of Kentucky. Data sources include 2017 County Health Rankings and Roadmaps and Kids Count Data Center. Factors included in the analysis include social determinants of health that affect ABHK's population, but the analysis is based on data sources that survey the populations in regions included in the analysis, not ABHK's members alone.

This report is an analysis that was completed by grouping health ranking results by counties based on the managed care regions as defined by Kentucky Department of Medicaid Services. When corresponding data was available, weighted scores of the regional average were developed to reflect the total regional population. When corresponding data was not available, unweighted scores of the regional average were provided as an average of the counties' measure for that region.

Factors assessed in the Regional Health Profiles include indicators of social well-being such as prevalence of public insurance and overall other public support, healthcare provider to population ratios, social determinants of health such as educational attainment, unemployment, physical inactivity and access to amenities, food insecurity, poverty, violence and crime.

Activities and Resources
Assessment of population size and demographic characteristics of members is critical to defining health service needs, ensuring accessible health care and developing appropriate quality improvement interventions. Annually health plan staff review the population assessment and evaluate whether health plan infrastructure, processes, services and links to community-based resources meet the needs of the various membership populations served. Evaluation of assessment results is completed in the annual Adequacy of Population Health Management Program report. The evaluation is conducted to review and update PHM activities and resources, their alignment with population characteristics and trends and review community resources for integration into PHM programs to address member needs.

The information from the sources above will be used to evaluate and improve existing programs or develop new ones as needed. The evaluation of programs and the extent to which they reach the intended targeted populations and serve their needs may lead to changes in the goal targets or metrics used for evaluation, adjustment in how targeted populations are identified, changes in how program activities are practiced or development or removal of programs executed within the PHM strategy.

Segmentation
The population assessment identifies sub-populations who may be targeted for inclusion in PHM programs. For example, members who are identified as having chronic conditions and being at higher risk for acute events as a result of their conditions through the population assessment methodologies are likely to be targeted for inclusion in the Chronic Condition Management program. Members are segmented based on the characteristics defining them as belonging to a PHM program's targeted population. Members may belong to more than one subpopulation segment and may be targeted for inclusion in multiple PHM programs.

Delivery System Supports
ABHK shares information with practitioners and providers to increase engagement and collaboration with the intent of improving health outcomes for our members. The sharing of targeted member- specific data allows ABHK to establish solid relationships with practitioners and providers built upon trust and transparency. It also provides a means for ABHK to assist practitioners and providers in delivering comprehensive and personalized health care services across all member populations served by the health plan.

Data sharing is also a major component of ABHK's value-based purchasing (VBP) arrangements with practitioners and providers. VBP programs, called Aetna Better Value, utilized by our Medicaid product line, offer an array of alternative payment methodologies designed to help ensure participation of large or small, traditional or non-traditional practitioners and providers. From full-risk capitation to VBP arrangements with patient-centered medical homes (PCMHs) as well as shared risk and other incentive payment options, it is ABHK's goal to have the majority of our membership attributed to network practitioners and providers in value-based contracts that concentrate on improving quality, reducing costs, and increasing member satisfaction. ABHK's data sharing is dynamic and occurs at regular intervals varying by program or application from daily to monthly.

Gaps in Care

ABHK is committed to working with our network practitioners and providers in achieving the triple aim as defined by the Institute of Healthcare Improvement:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations, and
- Reducing the per capita cost of healthcare

Our goal is to work collaboratively with primary care practitioners (PCPs) to identify and eliminate gaps and barriers to care for our members. To support our achievement of these goals, ABHK distributes toolkits to our PCPs via web portal to help them in the management of our members in their care. This toolkit includes: a Member Gaps in Care (GIC) Report, tips for successfully leveraging the report, a billing guide, billing codes, HEDIS measure definitions, and patient chart tips which include how to maximize HEDIS gap in care closure opportunities. ABHK provider services and quality improvement staff are available to discuss the toolkit and GIC report with practitioners and their office staff for measures such as cervical cancer screenings, mammograms, immunizations, routine child or adult well visits, and diabetic screenings among others. The GIC report allows PCPs a mechanism to easily identify members in their panels who have not received needed services/care.

The GIC report is distributed monthly to PCPs in user-friendly reports. PCPs can easily identify improvement opportunities and engage in quality improvement strategies based on the data in the reports. The GIC report compares an individual practitioner's performance to practitioner group performance and overall health plan network performance, as well as NCQA benchmarks on the included set of HEDIS measures.
The GIC report contains a list of members who need care or services for individual HEDIS measures, so practitioners can preferably address all known gaps in care when members are in their offices. The report can also be used by practitioners to perform targeted outreach to their assigned members who have a gap in care. Practitioner feedback on the utilization of GIC reports has been positive since the tool was launched in the fourth quarter of calendar year 2015. ABHK continues to refine the tool to be more user-friendly with interactive formats accessible on both computers and mobile devices.

Continuum of VBP Contractual Arrangements

Practitioners and providers who participate in Aetna Better Value's VBP arrangements have individually designed agreements that align financial incentives with improved quality, cost, utilization, and outcomes through shared financial accountability between the health plan practitioners and providers. Our VBP incentive model not only includes primary care, specialty care, and hospital-based care, but expands into other treatment venues, such as:

- Community mental health centers (CMHCs)

- Federally qualified health centers (FQHCs)
- Rural health centers (RHCs)
- Non-traditional providers (i.e., home and community-based services)

ABHK's VBP program was developed using evidence-based health care guidelines where available. The program also factors in the cost of episodes of care and the cost of practitioner and provider services. While VBP models may vary based on the degree of financial risk assumed, each model includes quality and outcome metrics that are directly tied to practitioner and provider payment. These metrics are customized to primary care, specialty care, and hospital-based services. ABHK approaches VBP relationships collaboratively to maximize program participation by utilizing the following continuum of payment arrangements:

Pay for Quality: An annual bonus program related to quality metrics for practitioners and providers who do not immediately qualify for our other VBP agreements. This program rewards practitioners and providers for achieving better performance on a broad spectrum of HEDIS and utilization metrics for their [PLAN] member panel. This program is used for PCPs (including FQHCs/RHCs), specialists, and hospital-based providers. PCPs with smaller numbers of assigned members may also participate in this program.

Patient-Centered Medical Home (PCMH): This program is a medical home model for members with complex needs or requiring an integrated behavioral health/physical health home. PCMHs help address the complex health needs of the entire community through a highly coordinated system of care that includes comprehensive primary care, specialty care, acute care, behavioral health integration, and community services. [PLAN] PCMHs are supported through capitation payments to deliver integrated care. Our agreements are collaborative and outline the expectations of both stakeholders so there is shared accountability for outcomes. This model is primarily used with PCPs, but it can also be used with specialists.

Shared Savings: A program for practitioners serving large panels of Medicaid enrollees. These practitioners are deemed by [PLAN] to possess the skills and infrastructure necessary to manage their populations. This model accommodates practitioners who desire to assume increased risk and is suitable in an Accountable Care Organization (ACO) or clinically integrated network (CIN) environment. It may be used with PCPs, specialists, and hospital-based practitioners.

Bundled or Global Payments: This program provides an opportunity for specialists who would not ordinarily participate in primary care incentives to receive a bundled rate for services rendered by condition and/or procedure. The payment and associated incentives are directly dependent on quality of care and patient outcomes. This is an option for specialists or hospital-based practitioners.

Full Risk Capitation: This program rewards practitioners for access, affordability, and quality of care in a gain-share, risk-share, or full-risk manner.

ABHK recognizes that not every practitioner or provider is appropriate for value-based arrangements, and we assess practitioners and providers closely and provide technical assistance to ensure a successful transition to value-based arrangements. We meet these practitioners and providers where they are along the VBP continuum, and we support their unique capabilities and readiness, which in turn has the effect of helping them become more adept at effectively and efficiently managing the care of our members.

ABHK's VBP arrangements incentivize practitioners and providers for quality improvements resulting in the following:

- Improved performance for specific HEDIS measures
- Improved member access to care

- Reduction of gaps in care through greater coordination between PCPs, specialists, and hospital- based physicians
- Improved transition of care across the continuum of care – primary care, specialty care, hospital-based care, PCMHs, etc.
- Less polypharmacy and redundancy in prescriptions
- Fewer duplicative inpatient and outpatient services such as radiology and labs
- Improved member engagement and education with PCP, PCMH, and behavioral health care
- Improved member, practitioner and provider satisfaction
- Reduction in potentially preventable events (primary care, specialty care and hospital-based care) such as:
    - Hospital readmissions
    - Unnecessary emergency department visits
    - Unnecessary inpatient visits
    - Preventable complications

To further support our data sharing and VBP initiatives, ABHK encourages the use of evidence-based clinical practice and preventive services guidelines by our practitioners and providers. Guidelines are posted on ABHK website and are adopted from nationally recognized sources and peer reviewed medical literature. The guidelines cover various conditions such as Asthma, Diabetes, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease. They also address other topics such as medication management, prenatal care, and dental services.

CareUnify

CareUnify is used as part of ABH-KY's population health initiatives to assist practitioners and providers in transformational efforts through better use of available data and technology, integration of multiple data sources, usage of best practice protocols, and identification of gaps in care to engage in care management and care coordination activities and achievement of value-based contracting objectives. CareUnify aids the care management process by connecting practitioners and providers with ABH-KY's to promote a team-based approach to care. It involves all parties involved with members and supports better care coordination by reducing fragmentation of services. CareUnify gives practitioners and providers meaningful, well-organized, easy to navigate, comprehensive clinical and utilization information, cost data and analytical information. This enables all stake holders to have expanded information and fuller knowledge about the members they serve which advances the provision of more appropriate and effective health care.

ABH-KY's providers have access to CareUnify, a state-of-the-art, mobile web-based population health management solution tool that enables linkages among health care practitioners and providers, the health plan, and community agencies to share member-specific actionable information to support the effective and efficient collaboration, coordination, and management of members' healthcare needs. The web-based application provides a 360- degree view of patient data, risk stratification levels, gaps in care and care plans used to drive collaboration between ABH-KY's providers and health systems and other community service providers, and implement action-oriented, strategic interventions to improve members' health outcomes. CareUnify aggregates data from multiple internal and external systems, including medical, behavioral and pharmacy claims, data analytics, cost trends and HEDIS data, lab results, Admit-Discharge-Transfers (ADTs) events from state or regional Health Information Exchanges (HIEs) and individual hospital systems, and electronic health records (EHR). Practitioners log onto CareUnify through a secure web portal provided to them by ABH-KY There is no cost for practitioners and providers to utilize CareUnify. Implementation, training and ongoing support is

provided by the ABH-KY Population Health Specialist (PHS) team and Innovations technical team.

CareUnify is also beneficial to ABH-KY's internal care coordination activities that support integration with network practitioners and providers. ADT events, viewed by health plan CareUnify users in the ADT feed, provide real-time notifications of hospitalizations and emergency department events. Care management activities process these events and initiate or facilitate transition of care needs in collaboration with admitting hospitals, PCPs, or other providers.

CareUnify consumption of EHR records is made possible through integration with individual provider practices wherever possible, as well as through enterprise-wide integrations with large EHR vendors such as Athena. These integrations allow ABH-KY to ingest electronic clinical data sources (ECDS) through the CCD/EHR integration engine that is built into CareUnify and managed by the third-party vendor, Health BI. The documentation in these records is translated to digital codes of health services (CVX, LOINC, and ICD-10) and integrated into administrative claims data as supplemental data to satisfy HEDIS measure requirements.

These integrations are completed by the Innovations technical team, Population Health Specialist team, national Quality Management and Informatics teams and provider or EHR vendor counterparts. The results of these efforts support providers in achieving performance targets in VBP contracts.

The data and information compiled in CareUnify support value-added benefits for members including:
Better Health Proactive, individualized, best practice plans of care and workflows combined with insight into care opportunities that empower care delivery and care management teams with tools and knowledge to improve overall health status, quality of life, and management of chronic health conditions.
Better Care Enhanced historical and current information, including social determinants of health; timely notification of admit-discharge-transfer events; and shared care plans yield improved care transitions, coordination, follow-up, communication, and education and result in better safety and clinical outcomes.
Lower Cost of Care Facilitates smooth transitions of care between providers, such as between hospitals and post-acute sites of care, to reduce avoidable hospital readmissions and overall care costs. Shared information enables avoidance of unnecessary duplicate testing.

Population Health Initiative

The transition of health care payment from volume oriented to value-based is a foundation for changing behavior, engagement, and outcomes at the practitioner, provider, member, and health plan levels. ABHK's VBP arrangements, Aetna Better Value, support practice transformation through our Population Health[1] Initiative, which builds true partnerships with our practitioner and provider network. We understand that to obtain the collective vision of achieving the triple aim, we must be locally engaged and closer to our practitioner and provider network. This enables, close collaboration and a clinically integrated approach that supports and enhances the practitioner/provider-member relationship.

As part of our effort to drive population health support for our practitioners and providers, ABHK created a new and innovative role—the population health specialist (PHS). Our population health specialists are a multitalented team of experienced clinicians and non-clinical health industry specialists who understand the challenges members face in navigating the health care system, whether in a small community clinic setting or a large integrated delivery system, as well as the challenges practitioners and providers are faced with in shifting to practice care under reimbursement reform policies. The population health specialists know the business of health care and understand that data-driven decisions tied to increased integration between care team members lead to more effective care and successful value-based arrangements and incentive programs. They act

as consultants to key practices in our network, focusing on practitioners and providers with value-based arrangements. Specifically, our population health team provides the following practice support:

- Serves as the dedicated manager for practitioner and provider relationships and single point of contact for the health plan.
- Provides training support and adoption of CareUnify, Aetna's proprietary web-based population health management platform.
- Performs data and workflow analysis; guides practitioner/provider-driven development of new or optimized workflows and practices using actionable data and supports sustainable implementation into their current systems and processes.
- Performs regular data and metric reviews (daily or weekly as indicated by practice size) of performance on total cost of care, utilization trends, and quality outcomes
- Reviews and identifies high-risk members needing care and services, aligns care and services in the right setting for their PCMH
- Coordinates regular care team rounds, especially for complex members, around clinical events such as a hospital discharge and confirm follow-up appointments are completed
- Coordinates with the health plan care management and quality teams to streamline resources and processes that support providers' VBP goals
- Supports the provider, enrollee, and their circle of support with community service agencies where appropriate
- Supports providers' practice transformation with integration of our data and systems with their workflows, processes, and goals
- Aligns and drives additional resources and care coordination with hospital systems or behavioral health providers to increase integration of the care delivery system

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[1] The term *population health* in this discussion refers to Aetna's internal program with this name, which derives from the VBP strategy, and does not refer to the term as it is used in the PHM standards.

Physicians play a pivotal role in improving quality, reducing costs and potentially preventable events (PPEs), and ensuring efficient and effective use of health care resources. Aetna will help practitioners and providers achieve these goals by developing financial models that awards physicians for quality and appropriate service utilization.

Wellness and Prevention

Wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk are provided to members by providing access to ActiveHealth Management's (AHM) health appraisal and self-management tools. AHM is a contracted vendor who is NCQA Wellness and Health Promotion (WHP) accredited.

Health Appraisal

Adult members have access to AHM's online, telephonic, and print health assessment. The results of the health assessment summarize the member's risk factors and wellness profile and identifies opportunities for participation in targeted population health programs and services. Information is provided to the member on specific health behaviors changes that will reduce the member's risk factors. ABHK staff contact members based on their identified risks and conditions to offer targeted population health programs and services.

Self-Management Tools

ABHK provides member access to AHM's online materials and interactive videos on multiple wellness and health promotion topics including smoking and tobacco use cessation, nutrition, and managing stress. The materials

are also available in print. Members can set wellness goals and track their progress through online tools.

Measuring Effectiveness

ABHK conducts an annual quantitative analysis of our population health strategy using relevant clinical, cost and utilization and member experience measures. The analysis evaluates the impact of the programs implemented by ABHK for each of the four focus areas; specifically whether they resulted in improved outcomes for members who were stratified and segmented for receipt of targeted interventions. ABHK's Population Health Strategy is multifaceted and aligned with the plan's holistic model of care. The programs driving the strategy are integrated and reflect membership's health priorities. Following the strategy's hierarchy of need, population strata and ongoing safety initiatives the evaluation of the program(s) requires a multidimensional approach to continuous quality and process improvement.

ABHK takes a comprehensive approach to the evaluation process of all its population health programs. Unique identification(s) of the intent [objectives] of the program(s) drives the selection of the analysis components. Measuring effectiveness of the population health strategy requires an intricate approach inclusive of identification of evidence-based clinical process ad outcome measurements, utilization trends and/or associated costs and overall member satisfaction with the programs being offered. Each selected evaluation component addresses the target population's ongoing needs as identified in ABHK's population assessment and program objectives.

As ABHK's goal is to improve and/or maintain health outcomes for the served membership through the development and deployment of its population health strategy, it is imperative to perform a multifaceted analysis looking at different aspects of the population and plan impact. ABHK selects the most appropriate, meaningful and impactful measures for each program to ensure that ongoing program development can be implemented in an efficient and effective manner while keeping members at the center.

ABHK will utilize evidence-based process and outcome measures to evaluate the clinical components of the programs offered. Measures are selected to align with the objectives of the programs for the target population, such measures that include, but are not limited to, NCQA's HEDIS® performance datasets and SF12® outcome surveys. ABHK will also evaluate program-specific utilization trends and/or associated costs that are relevant to the objectives of each program.

An additional component of measuring effectiveness that will be used is to assess our performance by obtaining feedback from the membership using focus groups or satisfaction surveys for at least two types of programs. ABHK uses member experience results from its intensive case management program and assesses the Diabetes Management program via the monthly Condition Management Survey. At a minimum, feedback covers:

- Information about the overall program
- The program staff
- Usefulness of the information disseminated
- Member's ability to adhere to recommendations
- Percentage of members indicating that the program helped them achieve health goals

This feedback facilitates the implementation of an effective population health management strategy that meets the characteristics and needs of the member population.
Based on the results of the annual multifaceted quantitative analysis which evaluates the ongoing programs

targeting various population subsets, ABHK will complete a qualitative analysis in order to identify opportunities for improvement and develop and implement programmatic changes designed to improve performance.

PHM Program Descriptions

Flu Vaccine Program – Keeping Members Healthy

Program	Focus	Goals	Targeted populations	Informing members	Evidence
Flu vaccine program	Keeping Members healthy (1)	Increase the rate of annual flu vaccination from 10th NCQA benchmark percentile to the 25th percentile	All members over 6 months of age	Mailed vaccine reminders and EPSDT mailers; reminder voice message, text message and email; newsletters; website; social media	

Activities and services

Flu vaccination educational activities are undertaken to increase flu vaccination rates among all members six (6) months of age and older with a special focus on those members at high risk of flu complications including pregnant women, young children, and people with chronic disease. Activities and services implemented include the following:

- Active Flu Committee: including Flu champions who plan and coordinate flu activities and education to members, providers and plan staff regarding flu vaccines and flu safety tips.
- Leave Behind Flyer: A leave behind reminder to be distributed to members and providers reminding the importance of the flu shot.
- Flu Email Campaign: partnership with segment analytics team. Email campaign to increase flu shot compliance with emotional vs. rational messaging.
- Flu Social Media Campaign: partnership with segment analytics team. Social Media campaign to increase flu shot compliance via Facebook.
- Member services inbound call message: recorded message that will play to anyone that calls in to the member services line (member or provider) while they are on hold.
- Care Management live flu reminder when on member's calls: Members will be asked if they have had a flu shot, if they have- they CM staff will create a flu event in Dynamo recording the date the flu shot was given. If the member has not had the shot, the event will be created, and the date will be left blank to follow up with the member regarding their flu shot.
- CVS Health Tag Flu Reminder: Collaboration with CVS to offer flu messages to members during the flu season (late fall through March). A flu shot message is included on the pharmacy tag receipt for any member that fills a prescription in a CVS retail store (message delivered one time only). The messaging included the rationale for flu shots and the process for getting the shots at the pharmacy.
- Flu Text Message: Text messages about flu shots delivered once per month from October through March to all households to increase flu shot utilization and educate on benefits of flu shot. The messages are more frequent at the beginning of flu season to encourage early vaccination.
- EPSDT Mailer: Mailers include flu shot in recommended vaccine schedule for children beginning at age 6 months through 2 ½. Mailers are sent at regular intervals aligning with well-child visit schedule to children's parents/guardians according to date of birth. Mailer frequency with flu vaccine reminder is annual for children/adolescents age 3 through 20.

Coordination Mailings are coordinated and implemented by the Corporate Quality Management team in collaboration with the local health plan and CVS retail. The goal is to reduce duplication of efforts to ensure members are not receiving redundant information regarding flu education.
Eligibility, using services and opting in/out Members are informed how they became eligible to participate in the program, how to use program services and how to opt in or opt out of the program through: • Distribution of materials via member newsletter, member website under the heading "Health & Wellness"; including a pharmacy locator to assist members in finding a pharmacy near them, and a leave behind flyer that is distributed at community/member events. All members 6 months of age and older are eligible; special attention is paid to those members at high risk of flu complications including pregnant women, young children, and people with chronic disease. Members may opt out of mailings and voicemail message calls by calling Member Services and requesting no contact from the health plan. Participation in text messaging services is voluntary and requires members to possess a cellular phone or obtain a free LifeLine cellular phone. Aetna Better Health of Kentucky informs members about the texting programs and how to obtain a free Lifeline phone, if they don't have a cellular phone, through newsletters, the member handbook and during phone or in-person interactions with members. Text messages contain an option to opt out of the service.
Community Resources • Local Health Departments provide flu shots or special flu clinics • Local pharmacies provide flu shots • Health Fairs provide information on the important of flu shots

Be Healthy – Managing Members with Emerging Risk

Program	Focus area	Goals	Targeted population	Informing members	Evidence
Be Healthy	Managing Members with Emerging Risk (2)	Aetna Better Health of Kentucky aims to reduce the percentage of members age 18+ with potentially preventable ED visits for diabetes by 2 percentage points compared to the baseline measurement year.	ABH-KY members who are adults ≥ 18 yrs. with diabetes with an ED visit for diabetes short-term complications	Member communication of program and services may be through the following: phone calls, mailings, website.	**Policy**: • AMA 7000.38 Self-Management Tools • AMA 7000.43 Coordination of Member Care • AMA 7500.05 Integrated Care Management • AMA 7500.07 Health Risk Screening Process • AMA 8200.12 Member Incentives • AMA 8200.06 HEDIS Interventions • AMA 8300.05 Prevention and Wellness Program • AMA 8300.52A Text Messaging Program • AMA 8000.70 Quality Management Oversight **Desktop:** • CM ER Outreach (need link to file) • Chronic Condition Management.docx • **Job Aid:** • Enhanced Action and Interventions List.docx

BE HEALTHY Program

According to the American Diabetes Association Standards of Medical Care in Diabetes, members and care providers should focus together on how to optimize lifestyle as a fundamental aspect of diabetes care throughout the continuum of care. Specifically, there are four critical times to evaluate the need for diabetes self-management education and support: at diagnosis, annually, when complicating factors arise, and when transitions in care occur (2019). Aetna Better Health of Kentucky seeks to provide diabetes education, outreach, and coordination of care at each of those critical times.

ABH-KY's BE HEALTHY program encompasses multiple services and activities that are offered to plan members across the Commonwealth of Kentucky. While continuing to develop services and activities that target members with emerging risk at the pre-diabetes stage, upon diagnosis and on an annual basis, ABH-KY's BE HEALTHY will initially target members who are experiencing short term complications and who have reached a transition of care event. BE HEALTHY activities will aim to support members through a short-term complication episode and reduce ED/ER usage by working closely with the members, providers, facilities, and social supports to ensure both medical and non-medical issues which lead to ED/ER usage are addressed for members.

Activities and services

Diabetes ER Outreach Service:

The goal of the ER Outreach Service is to assist members with identifying and removing barriers that prevent them from having a medical home in which they can seek care for diabetes complications.

- The ER Outreach team accesses informatics reports that identify members who have utilized ER services and have diabetes.
- The ER Outreach team then interacts with members by phone to provide education on ER use and to identify and reduce barriers that prevent the member from receiving care in their medical home or outpatient specialist office. Interventions include education, community resource and social determinant of health referrals, and problem solving with member about barriers and deterrents to the member's health maintenance plan.
- The ER Outreach Team is staffed by nurses from both the Care Management and Quality Management teams. If a member agrees, a referral is also made to the appropriate case management team for ongoing support and assistance with their chronic condition.
- Members who opt in to the ER Outreach program who are not engaged in case management receive ongoing telephonic support on a monthly basis from the ER Outreach team to reinforce members' utilization of their medical home rather than the ER and to continue to identify and overcome barriers that prevent them from having a medical home to manage their diabetes.

Additional BE HEALTHY Activities and Services

- Community Health Worker employed by ABH-KY who work to link members with community-based organizations, using the UniteUs platform to address social determinants of health.
- Low Risk Chronic Condition Management for members with diabetes
- Intensive Care Management for members with diabetes
- Kiosk Retinal Screening
- Comprehensive DRE Program
- Medicaid Holistic Health Campaign
- Aetna A1C and Eye Exam Health Tag Message
- Take Charge – Member Education Program
- Avēsis Oral and Ocular Care Coordination Program (O2C2)
- KATS Program

- Diabetes Prevention and Education Initiatives
    - Slow Cooking Nutrition Course
    - HealthRunsDeep
    - Diabetes Nutrition Course
    - Chronic Disease Self-Management Education Program
    - Diabetes Prevention Program
    - Microclinics
    - Garden to Pantry

Coordination

The ER Outreach Team is staffed by nurses from both the Care Management and Quality Management teams who coordinate with members, providers and formal supports. If the ER Outreach Team unsuccessfully attempts contact with the member, the staff will then attempt to outreach Member's medical home to notify provider of excessive ER use, and if they receive narcotics related to the ER visits to ensure the provider is aware of member's health issues and treatments.

Coordination between members, providers, and ABH-KY is facilitated through access to web portals with member and provider information; shared written communications (e.g., care plans); Interdisciplinary Care Team (IDT) participation; case manager facilitation of PCP and specialty providers; referral of members to and resource of providers of community resources; and joint face to face visits in provider offices.

Eligibility, using services and opting in/out

Members are informed how they became eligible to participate in the program, how to use program services and how to opt in or opt out of the program through:

- ABH-KY identifies eligible members by reviewing claims data and automatically enrolls eligible members into program upon discharge. A mailing is sent to all eligible members informing member about the Be Healthy Program, including ER Outreach Service, of his or her eligibility for the program, and contact information for the Be Healthy team. Interactive contact is initiated by telephone between the member and a nurse on the ER Outreach team. If the staff identifies a member who requests no further contact, the staff member will not initiate any member contact. This information is added in the member's record.
- Distribution of materials- brochure, member handbook, member newsletter, website

Community Resources

- Big Sandy Health Care Chronic Disease Self-Management Classes/Outreach:
    - Region 8 serves Floyd, Pike, Martin, Magoffin and Johnson Counties. Evidence based program led by community health workers that educates people on how to manage a chronic disease. Participation is at no cost and is offered on a regular basis.
- Big Sandy Diabetes Coalition:
    - Structured group of all county diabetes coalitions in Floyd, Pike, Martin, Magoffin and Johnson Counties. Meets monthly. Decision makers and those who can connect members to local support are present.
- KY Diabetes Network:
    - Statewide coalition of Certified Diabetes Educators, Providers, and others who serve the population of people with diabetes in Kentucky.
- American Diabetes Association:
    - National Organization with an office in Lexington. Provides education, risk tests, awareness and advocacy support to people living with diabetes.
- Juvenile Diabetes Research Foundation:

- National organization. Provides education and awareness support to people living with diabetes.
- Kentucky Homeplace:
  - Located in Regions 7 & 8 provides Chronic Disease Self-Management Classes, and community health workers to support individuals and families.
- Lee County Diabetes Coalition
- Morgan County Diabetes Coalition
- Greenup County Diabetes Coalition
- Healthy Choices Healthy Communities Coalition
- Appalachian Diabetes Control and Translation Project
- Family Health Center:
  - Organization in Region 3 that provides Aetna sponsored nutrition and chronic disease self-management courses to the community.

Reference:

American Diabetes Association, Diabetes Care 2019 Jan; 42(Supplement 1): S46-S60. https://doi.org/10.2337/dc19-S005

Lock-in Program - Member Safety

Program	Focus area	Goals	Targeted population	Informing members	Evidence
Lock-in	#3: Member Safety	Increase the number of lock-in members receiving medication assisted treatment (Suboxone) by 2%	Members who misuse pharmacy, physician and/or emergency department benefits may be restricted to the use of one pharmacy, physician and/or hospital Excluded from the Lock-In Program are: 1. members in personal care homes; 2. members under eighteen years of age; 3. members receiving hospice services; 4. Members receiving services through a home and community based waiver program (these members are typically excluded from managed care); or 5. Utilized Medicaid services in a medically necessary manner to treat a complex, life-threatening medical condition, as determined by ABH-KY.	The MCO notifies the member of his/her Lock-in status by written notice within sixty (60) days of the member's Lock-in effective date. 30 days after letter is sent, Lock In staff follows the UTR process of reaching out to members.	Policy 7500.03 Lock In Program

Activities and Services
The focus of the Lock-in program is to support members with biopsychosocial needs, assist members to establish a medical home (PCP), adjust their pharmacy and benefit utilization as appropriate to their healthcare needs and coordinate care with members' primary care practitioners (PCP) and other practitioners/providers as needed.

Evidence of member abuse or misuse of benefits or fraud is subject to review for the Lock-in Program. Referrals to the Lock-in Program may come from Aetna Better Health of Kentucky staff, practitioners, providers, caregivers/family members, or any state entity. The member can be locked into a Primary Care Provider / Pharmacy and/or Hospital Provider.

Lock-in Committee
The Lock-in Committee reviews the clinical review summary and associated claims to determine the following: overutilization of emergency room services as a provider for pain management, the prescribers of opioids and other controlled substances, members who seek early refills of controlled substances and members who seek controlled prescription and refills from multiple providers in multiple cities, overutilization of providers, pharmacies and prescribed medications. The Lock-in Committee reviews the appropriateness of providers who prescribe controlled substances, and whether these members are in pain management. The Lock-in Committee is also responsible for referring members and providers to the Aetna Better Health of Kentucky Surveillance and Investigation Unit for those cases that warrant further investigation.

The Lock-In Committee shall consist of at least the following voting members:

1. One RN case manager
2. One social worker case manager
3. The pharmacy director
4. A Medical Director

A Quorum is met when more than half of the voting members are present. A Medical Director must be present for quorum to be met.
Members will be locked in to designated provider/pharmacy and/or hospital for a period of two years. Thereafter, the Lock-In Committee will monitor the medical claims and pharmacy use of Lock-In members at least annually. A member may request to change Aetna Better Health of Kentucky's designated practitioner/ provider/ pharmacy or hospital. The request may be verbal or in writing. If one (1) of the following happens, the change can be made for cause:

- The member is approved for a practitioner/provider/pharmacy or hospital change
- The member leaves the area
- The practitioner/provider/pharmacy or hospital leaves Aetna Better Health of Kentucky's provider panel
- The practitioner/provider/pharmacy or hospital tells Aetna Better Health of Kentucky they will no longer be the member's Lock In assignment
- Aetna Better Health of Kentucky will decide if the requested change meets the criteria.

Annual Lock In Program Re-evaluation
Aetna Better Health of Kentucky re-evaluates a member's enrollment in the Lock In Program after a member's initial twenty-four (24) month lock in period and then annually (based on date of enrollment into the program). The following elements are evaluated in addition to the standard criteria listed above:

- Number of narcotic prescribers for filled and rejected prescriptions (controlled substances, benzodiazepines, and muscle relaxants)
- ER usage, including overdose and poisoning

- Any clinical changes (i.e., new cancer diagnosis, change in pain pattern)
- Any reported positive drug screenings for non-prescribed medications (i.e., marijuana, etc.)
- Any reported violation of pain contract
- Provider change due to member behavior
- Any reported prescriptions paid via cash

Following the annual evaluation of the above criteria, a decision is rendered to continue the restriction or to terminate the member from the program.

Terminating Lock In

Criteria for terminating a member's enrollment in Lock In Program include the following:

- Member is no longer enrolled in Aetna Better Health
- Member has expired
- Member has a significant change in health sh6tatus
- Member filed an appeal resulting in overturn or early termination of the original decision to restrict the member
- Annual re-evaluation of the restriction is completed and member is no longer exhibiting behaviors of potential abuse, misuse, or fraud of pharmacy or medical services

In the event of an emergency, if a member is locked into a pharmacy that does not have twenty-four (24) hour access or if pharmacy does not have the medication prescribed; the Lock In will be temporarily "lifted" to allow access to that pharmacy.

Coordination

Cases are referred to Clinical Care Managers (Registered Nurses and/or Licensed Clinical Social Workers) and Care Management Coordinators who make attempts to engage members in the Aetna Integrated Care Management Program to address the biopsychosocial needs of the member. Case Management assists and educates the member on the importance of establishing a relationship with a Primary Care Provider, utilizing one pharmacy and the appropriate use of the emergency room. This may also include assisting a member with locating a pain management provider.

Eligibility, using services and opting in/out

Members are informed how they became eligible to participate in the program and how to use program services through:

- Distribution of materials such as t*he* Initial Lock-in Notification Letter (that includes Lock In FAQ's), member outreach, member handbook, member newsletter and Aetna Better Health of Kentucky website under heading "For Members."
- A member is identified as eligible for review for the Lock In Program when any of the following criteria are met:
- If within two consecutive 180-day periods the member:
    - Received services from at least five (5) different providers; (2) Received at least ten (10) different prescription drugs; and (3) Received prescriptions from at least three (3) or more different pharmacies;
    - *Or*
    - Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition; or (2) Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.

Informing members:

A member receives a written notice telling him/her that he/she is being enrolled in the Lock-in Program. Aetna Better Health of Kentucky chooses a practitioner/provider/pharmacy and/or hospital. The practitioner/provider/pharmacy will be reasonably close to the member's home address on record. The selection will be for the entire period of enrollment in the Lock-in Program unless the member is approved for a practitioner/provider/pharmacy and/or hospital change during a re-evaluation.
The member notice includes the following information:

- Explanation of why he/she is being restricted
- The practitioner/provider/pharmacy and/or hospital selected
- How to contact Aetna Better Health of Kentucky with any questions
- Offer of care management if the member is not already enrolled
- The right to file an appeal for a re-review in response to the decision

Appeals
Members may file an appeal by calling Aetna Better Health of Kentucky if they disagree with the restriction. In the appeal, the members need to state why they feel the restriction is not appropriate or no longer applicable and submit any documentation they have in support of their request. This can be done verbally or in writing. The member will have ten (10) calendar days from the date of the oral appeal to provide the request in writing.

All members are advised in writing of the outcome of the investigation of the appeal or grievance, inclusive of fair hearing rights when necessary.

Community Resources

- The Lock-in Care Manager makes outreach attempts to the member 30 days after the date of the Initial Lock-in Notification Letter to assist members with medication issues, finding a provider, addressing health care concerns, and community resources.
- ABHKY will work with select members using controlled substances for pain management and their providers to explore evidence-based alternatives. In addition, members who are experiencing problems with misuse or abuse of these medications will be assisted to obtain substance use treatment and treatment for the root cause that led to the initial use of the medication.
- Members with needs related to controlled substances use will also be assisted to manage their utilization of the healthcare system to include education, referrals, communication with providers and pharmacy restriction to select providers, pharmacies, and/or medication limits when indicated.
- ABHKY has partnered with University of Kentucky providers who specialize in the treatment of substance use disorders. Members discharged from inpatient treatment can receive 14-day prescriptions for Suboxone with the no disruption in care to allow them to transition to outpatient providers for continued medication assisted treatment.
- The Lock-in program collaborates with participating Behavioral Health providers who serve the ABHKY members. This includes Community Mental Health Centers.

Aetna Cares - Managing Multiple Chronic Illnesses

Program	Focus area	Goals	Targeted population	Informing members	Evidence
Aetna Cares	Managing multiple chronic illnesses (4)	• Reduce inpatient re-admission within 30 days by 2% annually. • Increase follow up with BH provider within 7 days and again at 30 days after discharge from a BH admission (HEDIS measure) by 2% over baseline.	ABH-KY Members with a diagnosis of Asthma, COPD, CHF, and depression who have had a recent in-patient hospitalization.	Member communication of program and services may be through the following: phone calls, mailings, website	Policy: AMA 7500-05 Integrated Care Management Policy Desktop: Job Aid: Managing Inpatient Alerts and Post Discharge Follow Up Social Determinants of Health (SDoH) for Health Care Equity in CM

Activities and services

ABH-KY's Aetna Cares program seeks to improve overall health outcomes, reduce hospital readmissions, and increase primary care and behavioral health follow up for members who have Asthma, CHF, COPD, and depression. The staff who implement Aetna Cares work closely with the members, providers, facilities, community and social supports to ensure both medical and non-medical issues which lead to frequent hospitalizations are addressed for members who have chronic conditions. Aetna Cares is comprised of activities and services that provide members with education and support for issues linked to their chronic illnesses, including inadequate control of their condition, lack of caregivers and resources related to social determinants of health, multiple co-morbidities requiring multiple providers, higher risk for complications, need for behavioral health care, and multiple prescriptions that need pharmacy consultation.

Re-Admission Reduction Service

The ABH-KY Re-Admission Reduction service targets members with a diagnosis of Asthma, COPD, CHF, and depression who have had a recent in-patient hospital stay. The Re-Admission Reduction Team sends members a program brochure and completes a Post Discharge Questionnaire (PDQ) with targeted members by phone. The team reviews the member's Personal Discharge summary record or discharge instructions, educates the member on post discharge recommendations and provides support and assistance to encourage member's access to follow up services. The nurse also completes a medication and service reconciliation by comparing pre-admission

and post discharge medication needs and can refer member to another service within Aetna Cares, the Aetna Medicaid Hospital Readmission Reduction Program (HRRP) which is a clinical program focused on coordinating care between providers, Case Managers and Clinical Pharmacists as members are discharged from the hospital. The nurse encourages follow up with PCP / specialists following discharge and follow up with BH provider within 7 days and again at 30 days after discharge from a BH admission. If there are social determinants of health factors assessed that limit members' ability to self-manage their condition, the Re-Admission Team addresses those during the initial phone call and during ongoing support. The team also assesses the members' knowledge and understanding of how their medical/behavioral health condition led to the hospitalization and provides education about warning signs of when to call the doctor. During the re-admission reduction service, the member may receive interventions such as assistance with appointment set up, medication reminder system set up, transportation set up, and referrals to community resources provided by the Re-Admission Reduction Team.

If a review of the PDQ indicates a potential need for CM services, the member will be offered case management services. If a review of the PDQ indicates no need for CM services, the member will be supported by the Re-Admission Reduction team with ongoing follow up. The Re-Admission reduction team is comprised of Case Management and Population Health staff.

Additional Aetna Cares Activities and Services

- Intensive Care Management for members with asthma, CHF, COPD, and depression
- Low Risk Chronic Disease Management for members with asthma, CHF, COPD, and depression
- KATS Transitional Care
- Aetna Medicaid Hospital Readmission Reduction Program (HRRP)
- Asthma Text Campaign
- Spirometry Incentive for COPD (SPR)
- Behavioral Health Crisis Line
- Community Outreach Activities
    - Chronic Disease Self-Management Program (CDSMP)
    - Slow Cooking Nutrition
    - MicroClinics
    - Metamorphosis
    - Hand-Washing Classes
    - Garden to Pantry

Coordination

Members' providers and formal supports (e.g. pharmacies) are engaged in the Aetna Cares program through communications with ABH-KY staff. Coordination between members, providers, and ABH-KY is facilitated through access to web portals with member and provider information; shared written communications (e.g., care plans); Interdisciplinary Care Team (IDT) participation; case manager facilitation of PCP and specialty providers; referral of members to and resource of providers of community resources; and joint face to face visits in provider offices.

Eligibility, using services and opting in/out

Members are informed how they became eligible to participate in the program, how to use program services and how to opt in or opt out of the program through:

ABH-KY identifies eligible members by reviewing Inpatient Census Reports and automatically enrolls eligible members into program upon discharge. A mailing is sent to all eligible members informing member about the Aetna Cares Program, including Re-Admission Reduction Service, of his or her eligibility for the program, and contact information for the Aetna Cares team. Interactive contact is initiated by telephone between the member and a nurse on the Re-Admission Reduction team. If the Re-Admission Reduction staff identifies a member who requests no further contact, the staff member will not initiate any member contact. This information is added in the member's record. Distribution of materials- brochure, member handbook, member newsletter, website
Community Resources • Aetna Better Health of Kentucky maintains a resource library used by multiple divisions with up to date information on services and referrals to community-based resources in all regions. • UniteUs

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Health Risk Assessment

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MEMBER INFORMATION

Member name*: _____
Member address: _____
Member phone: _____
Member date of birth*: _____ Age: _____
Member ID#: _____
Emergency contact name: _____ Phone: _____
Date completed: _____
Who is completing this form for you? _____

HEALTH ASSESSMENT *All Required

#	Question	Responses
1.	What is your gender?	1. Male 2. Female
2.	What is your race or ethnicity	1. African American 2. American Indian or Alaskan Native 3. Asian 4. Native Hawaiian or Pacific Islander 5. White Non-Hispanic

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		6. Hispanic or Latino 7. Multiracial 8. Other
3.	What is your highest level of education?	1. Elementary School (K-5) 2. Middle School (6-8) 3. High School (9-12) 4. High School graduate 5. Some College 6. College Graduate 7. Graduate School 8. N/A
4.	What is your preferred language to speak at home?	1. English 2. Spanish 3. Other
5.	What is your living situation?	1. Own 2. Rent 3. Live with family 4. Live with friends **5. Homeless** 6. Other
6.	Are you currently pregnant?	**1. Yes** 2. No
7.	Has a doctor ever told you that you have the following?	1. Diabetes 2. High blood pressure

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		3. Heart disease 4. Kidney disease **5. Cancer** 6. Asthma 7. COPD 8. Allergies **9. HIV/AIDS** **10.Hepatitis** 11.Depression 12.Anxiety 13.Bipolar disorder **14.Schizophrenia** **15.** N/A
8	Do you currently take prescription medicine?	1. Yes 2. No
9.	Do you currently use any of the following?	1. Hearing aids 2. Glasses or contacts **3. Wheelchair or walker** **4. Other assistive devices** 5. N/A
10.	How often do you exercise?	1. 2-3 times per week 2. Once per week 3. Rarely 4. Never

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11.	How often do you use alcohol?	**1. Everyday** 2. Two or more days per week 3. Rarely 4. Never
12.	Do you use tobacco or tobacco products?	1. Yes 2. No **3. I would like help quitting**
13.	In general, how would you rate your overall health?	1. Excellent 2. Very Good 3. Good 4. Fair **5. Poor**
14.	Do you need help with any of the following? (Mark all that apply)	**1. Food** 2. Clothing **3. Housing** 4. Employment 5. Mobility **6. Getting to medical appointments** 7. Safety 8. N/A
15.	Do you need help performing any of the following daily activities?	**1. Accessing medication** 2. Bathing 3. Eating

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		4. Dressing 5. Shopping 6. Managing finances 7. N/A
16.	Compared to one year ago, my health is worse.	1. Yes 2. No
17.	Have you received dental care in the past year?	1. Yes 2. No
18.	Have you been to the emergency room in the last three months?	1. Yes 2. No
19.	Would you like your health plan to contact you about any other health concerns?	**1. Yes** 2. No

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Enrollee Needs Assessment Questionnaire

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Questionnaire: ICM Outreach

[Plan]
Care Management
Case Manager (CM), Care Management Associate (CMA)

Q#	Question/Selections
1	**Was this tool completed by telephone or face to face?** ☐Face to face ☐Telephone
2	**If Q1 = Face to Face** **Face to Face Location** ☐Member's own home (house, apartment, mobile home, etc.) ☐Assisted Living Facility or Alternative Residential Setting ☐BH Assisted Living Home or Facility ☐I/DD Group Home ☐Foster Home-Adult ☐Foster Home-Child ☐Nursing Facility (state name, and what type in narrative) ☐IMD ☐ICF/MR ☐Work site ☐Day program out of own home (I/DD, Adult) ☐Provider Office (including physician, vendor, specialist, etc.) ☐Hospital ☐Member is homeless-in community (state where in narrative) ☐Other (list in narrative) **<Narrative>**
3	Care Team Participation HIPAA **Outreach call conducted with:** ☐Member ☐Parent/Guardian ☐Foster Parent ☐Spouse ☐Son/Daughter ☐Significant other ☐Other: **<Narrative>** Additional Instructions *If questionnaire being completed by anyone other than the member, modify the script and questions accordingly. For instance, instead of saying "You / Your" say "Your Child" or "Your Parent", etc.* *CM to review care team participant overlay and HIPAA. Obtain consent from the member prior to completing assessment with anyone other than the member.*

4	**What language do you speak most often?**

☐Amharic	☐Gujarat	☐Persian
☐Arabic	☐Hebrew	☐Polish
☐Armenian	☐Hindi	☐Portuguese
☐Bengali	☐Hungarian	☐Romanian
☐Burmese	☐Ilocano	☐Russian
☐Cajun	☐Italian	☐Samoan
☐Cambodian	☐Japanese	☐Serbocroatian
☐Chin	☐Karen	☐Slovak
☐Chines	☐Korean	☐Spanish
☐Croatian	☐Kru	☐Swahili
☐Czech	☐Lithuanian	☐Swedish
☐Danish	☐Mandarin	☐Syriac
☐Dutch	☐Malayalam	☐Tagalog
☐English	☐Miao	☐Thai
☐Finnish	☐Mon-Khmer	☐Turkish
☐Formosan	☐Navajo	☐Ukrainian
☐French	☐Norwegian	☐Vietnamese
☐French Creole	☐Panjabi	☐Yiddish
☐German	☐Pennsylvania Dutch	☐Other: **<Narrative>**
☐Greek		

5

If Q4 = English hide this question

An interpreter is someone who repeats what one person says in a language used by another person. Under your plan, there is no cost to you for an interpreter.
Would you like me to get an interpreter on the line now?
Would you like to have an interpreter each time you talk to one of our staff members?

Interpreter requested? (Required, if member language listed as other than English)

☐Yes, this call only
☐Yes, all calls
☐No

Additional Instructions
MANUAL WORK PROCESS: If interpreter is requested for current call, CMA should contact Language Line. Update the member's entity record with the type of communication assistance needed.

6

Do you need any service for hearing in order for us to communicate easily?

☐Yes, this call only
☐Yes, all calls
☐No

	Additional Instructions *(Such as TTY)* *MANUAL WORK PROCESS: if TTY is requested for current call, arrange TTY services.*
7	*You already told us* (list of HRQ questions): Questions regarding health: **HRQ response** HRQ on (No HRQ) NOTE TO CMA: If no HRQ exists, ask question as written. IF HRQ DOES EXIST, ASK THIS: *I can see from questions you have previously answered, it looks like you have* _____. CMA should just confirm list as shown in HRQ, check appropriate boxes in Outreach questionnaire, and determine if any others are not already listed. **Has a doctor or clinic ever told you that you have one of the following?** ☐Pregnant (Currently) ☐Autoimmune disorder like: RA, Lupus, Myasthenia Gravis, ITP ☐Blood clots (+pre=high risk) ☐Blood disorders like anemia or sickle cell (+preg=high risk) ☐Bone or joint problems like arthritis, amputation, chronic low back pain ☐Bowel or stomach problems like ulcers, chronic diarrhea ☐Breathing problems like asthma, difficulty breathing, COPD ☐Cancer ☐Diabetes (+preg=high risk) (*ACSC*) ☐Hearing problems like deafness, hearing aids ☐Heart problems like chest pain, heart attacks, congestive heart failure (+preg=high risk) ☐High blood pressure (+preg=high risk) (*ACSC*) ☐Infection problems like Hepatitis, STD, HIV/AIDS, or TB ☐Kidney problems like dialysis (+preg=high risk) ☐Mental Health: Anxiety (*ACSC*) ☐Mental Health: Depression (*ACSC*) ☐Nerve or brain problems like: stoke, multiple sclerosis, spinal cord injury, epilepsy/seizures ☐Organ transplant ☐Problems with alcohol or drug use (+preg=high risk) (*ACSC*) ☐Vision problems like blindness ☐Other: **<Narrative>** ☐None Additional Instructions *MANUAL PROCESS (For training): Any state mandated condition will be referred to CM for completion for the*

	condition specific assessment. *If other is chosen, CMA should staff condition with clinical person before referring for CM referral.*
8	**Show if Q7 = Heart problems like chest pain…** **What type of heart problems?** ☐CHF (*ACSC*) ☐CAD ☐Previous heart attack ☐Other: **<Narrative>**
9	**Show if Q7 = Breathing problems like asthma…** **What type of breathing problems?** ☐Asthma (*ACSC*) ☐COPD (*ACSC*) ☐Chronic ☐Emphysema ☐Other: **<Narrative>**
10	**Show if Q7 = Vision Problems like blindness** **Do you have any preference for how we can best communicate with you given your visual impairment?** ☐Yes – Sent me summaries of discussions in writing (larger font) ☐Yes – Please verbally summarize our discussion at the end of our calls ☐No ☐Other **<Narrative>**
11	**Show if Q7 = Infection problems like Hepatitis…** **What type of infection do you have?** ☐Hepatitis ☐STD ☐HIV/AIDS ☐TB ☐Other – w/ narrative **<Narrative>**
12	**What other services do you receive?** ☐Case management services ☐Chemotherapy/Radiation Therapy ☐Day program (i.e., adult day care) ☐Dialysis ☐Home Health Services ☐Homemaker services ☐Hospice ☐Meals on Wheels ☐Nutrition classes/education ☐Occupational Therapy (OT) ☐Pain Management ☐Private duty nurse ☐Physical Therapy (PT) ☐Programs for Children with Disabilities (community or school based) ☐Skilled nursing ☐Speech and Hearing Services or Therapy (ST) ☐Substance Abuse Services ☐Transportation ☐WIC - Women, Infants, and Children program ☐Wound care

☐Case management services ☐Chemotherapy/Radiation Therapy ☐Dialysis ☐Mental health services e.g. counseling, intensive outpatient treatment, partial hospitalization, residential treatment	☐Vocational / Rehabilitative Services ☐Respite services ☐Services for the Blind	☐Food stamps ☐Other : **<Narrative>** ☐No – not receiving other services

Additional Instructions
Read the list of services to member to get the answer. If you need to explain the services, use the CMA job aid for scripting.

13

Some people use special things to help them in their day-to-day life. These include things like a cane, wheelchair, or a special bed.

What special equipment do you use or need to take care of yourself?

☐AB monitor ☐Bedside commode ☐Blood glucose monitor ☐Blood pressure monitor ☐Breathing machine (CPAP, BiPAP, tracheotomy, ventilator) ☐CAD pump ☐Catheter supplies ☐Crutch ☐Communication devices ☐Cough assistance vest	☐Diabetic pump ☐Feeding pump and tube feeding supplies ☐Glucometer ☐Grab bars (shower) ☐Incontinence supplies ☐Insulin pump ☒IV pump ☐Mechanical Left (Hoyer Lift) ☐Nebulizer/humidifier	☐None ☐Ostomy Supplies ☐Other: **<Narrative>** ☐Oxygen ☐Pain pump ☐Peak flow meter ☐Picc Line ☐Power scooter ☐Prosthesis/braces ☐Raised toilet seat ☐Scale	☐Shower chair/bench ☐Specialty Bed/Mattress ☐Suction machine ☐SVN machine ☐Trach supplies ☐Ventilator ☐Walker cane ☐Wheelchair ☐Wound supplies ☐Wound VAC

Additional Instructions
If you need to explain the equipment, use the CMA job aid for scripting.

14

I would like to ask you about other people who may be part of your life.

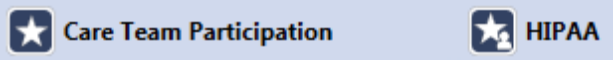

When you need help in day to day life, is there someone you can count on?

☐Spouse
☐Parent
☐Sibling
☐Friend/neighbor
☐Caregiver
☐Son/Daughter
☐Other: **<Narrative>**
☐No one

	Additional Instructions • *If member identifies someone, ask whether he/she would like for us to be able to talk to any of them regarding his/her condition. Of so, create HIPAA event and Care Team Participation event as appropriate.* • *If member answers no one, ask if you can help them with a referral to a support group. Take appropriate referral action.*
15	**Show if Q14 = any answer except No one** **In what way(s) does this person or persons help you?** ☐Getting to appointments ☐Picking up my medication ☐Taking my medication ☐Remembering appointments ☐Cleaning ☐Cooking/Making Meals ☐Dressing ☐Bathing ☐Grooming ☐Eating ☐Laundry ☐Going to the bathroom ☐Walking ☐Getting out of bed ☐Getting out of chairs ☐Using the telephone ☐Other (free text) **<Narrative>**
16	*I would like to go over all the medications you are taking now.* **What drugs are you currently taking that your doctor prescribed? (Our case manager may have more questions for you about medications at a later time.)** **<Narrative>** Additional Instruction *Intent is to get an initial list of medications from member. CMA should simply note in text box, with the amount of detail they can gather with member. (Ideally, medication, dosage, what the med is for.)*
17	**Do you take any herbal or home remedies or over the counter drugs? If so, what are those?** ☐Yes ☐No **<Narrative>**

18	**How many times in the last month did you use drugs not prescribed for you by your doctor (including over-the-counter, prescription, herbal and street drugs)?** ☐0 ☐1 ☐2 ☐3 ☐More than 3
19	**Do you have problems with any of the following:** ☐Bathing ☐Dressing ☐Eating ☐Getting out of bed or chair ☐Solving problems ☐Talking ☐Toileting ☐Reading or writing ☐Walking ☐Being able to do more than one thing at a time ☐Concentrating ☐Remembering things (short and long-term memory) ☐Doing laundry ☐Preparing meals ☐Housekeeping ☐Shopping ☐Taking/getting medications ☐Transportation ☐Finances ☐Using the telephone ☐Confusion ☐Being tied/sleepy (Lethargy) ☐None of the above
20	**Has a doctor or provider ever asked you to follow a certain type of diet?** ☐Yes – Renal diet ☐Yes – ADA – Diabetic diet ☐Yes – Kosher diet ☐Yes – Low salt/sodium diet ☐Yes – weight management diet ☐Yes – other: **<Narrative** ☐No
21	*You already told us:* How many different addresses have you had in the last 12 months? (Answer from HRQ) **What is your current living environment?** ☐Lives alone ☐Spouse/Significant other ☐Lives with friends ☐Lives with family ☐Foster Care Home ☐Assisted Living Home ☐Behavioral Health Placement ☐TBI Placement ☐Assisted Living Center ☐Alzheimer's Assisted Living ☐SNF ☐SNF – Wandering Dementia ☐Homeless (Please comment in narrative) ☐Single parent home ☐Two parent home ☐Single foster parent/guardian home ☐Other: **<Narrative>**
22	**Do you feel safe at home?** ☐Yes ☐No **If answer = No show**

	Are you in immediate danger? Is it OK to continue talking? (Do you have the privacy to complete our interview today?) Additional Instructions *If NO – Ask: Are you in immediate danger? Is it OK to continue talking? (Do you have the privacy to complete our interview today?)*
23	**Show if Q22 = No** **Can you tell me why?** ☐Can't say/Don't want to say ☐Condition of home ☐Fall hazards ☐Neighborhood ☐People that I live with ☐Other: **<Narrative>**
24	**Show if Q7 = Pregnant** *Now, I'd like to ask you some questions about your pregnancy as well as any others you may have had in the past. Would this be ok?* **When is your baby due?** EDC: **<Click here to enter a date.>**
25	**Show if Q7 = Pregnant** **What was the delivery date of your last baby?** ☐< 15 months ☐=> 15 months ☐N/A
26	**Show if Q7 = Pregnant** **Are you seeing someone for prenatal care?** ☐Yes ☐No Additional Instructions *If member indicates YES, check the Care Team Participant event to see if this provider is already listed for this member. If not, complete a Care Team Participant event to record prenatal provider.* *If no provider identified, make referral to OB/GYN as needed.*
27	**Show if Q7 = Pregnant** **Have you picked a doctor to care for your baby?** ☐Yes ☐No provider indicated

	Additional Instructions *If YES, check the Care Team Participant event to see if this provider is already listed for this member. If not, complete a Care Team Participant event to record prenatal provider.* *If no provider identified, make referral to pediatrician as needed.*
28	**Show if Q7 = Pregnant & if Q27 = Yes** **When is your next prenatal check-up?** • Exact • Estimate • No appt. scheduled Appointment Date: Click here to enter a date. Additional Instructions *If member indicates no appointment is scheduled, assist in coordinating an appointment for prenatal care.*
29	**Show if Q7 = Pregnant** *"Sometimes women have health issues or conditions that can cause problems during your pregnancy or for your baby. I would like to ask you some questions about whether you have, or have had, some of these issues".* **In this pregnancy or in past pregnancies are you or have you…?** ☐Any abdominal or cervical surgery ☐Any leaking of your water or membranes ☐Any vaginal bleeding or spotting ☐Baby has/had a birth defect or other similar conditions ☐Baby is having trouble growing ☐Currently pregnant with more than 1 baby ☐Had a baby more than 3 weeks early (don't ask if first pregnancy) ☐In this pregnancy had more than 1 urinary tract infection (on antibiotics more than 2 x this preg) ☐Low birth-weight baby ☐None of the above ☐Uterine malformations ☐Preterm labor requiring medication and/or bed rest ☐None of the above
30	**About how tall are you without shoes?** ☐Height: **<Narrative>** ☐Member refused
31	**How much do you weigh without shoes?** ☐Weight **<Narrative>** ☐Member refused ☐Member doesn't remember

32	**Show if Q7 = Pregnant** **Before you were pregnant how much did you weigh?** ☐Weight **<Narrative>** ☐Member refused ☐Member doesn't remember
33	Material Request - Contact Member Community Resources/ Referral **Do you smoke or use other tobacco products?** ☐No ☐Yes, smoke more than ½ pack of cigarettes per day (+ preg = high risk) ☐Yes, other tobacco, other: **<Narrative>** Additional Instructions *CMA Instructions:* • *Mail smoking cessation information if member says "yes" to either.* • *If yes and wants to quit – provide referrals to smoking cessation programs.*
34	*Your insurance covers many types of services. Also, other resources are sometimes available in the community that may be able to help you.* **Would you like any additional information about your insurance benefits?** ☐Yes – insurance benefits ☐Yes – community resources ☐No **<Narrative>**
35	**Do you have a written plan for health care you want if you cannot speak for yourself?** ☐Yes, advance directive ☐Yes, medical POA ☐Yes, mental health POA ☐Yes, living will ☐Don't know ☐No Additional Instructions *If member indicates no, ask if he/she would like more information? Provide member information or refer to appropriate sources.*
36	*Many people have important beliefs about the way they care for their health. For example, some people do not eat certain kinds of food. Other people do not believe in shots. Some people go to different kinds of healers to get well.* **Are there any beliefs you have, cultural or spiritual that I should know about that will help us work better**

	together? ☐Food practices ☐Illness beliefs ☐Medication avoidance ☐Organ donation ☐Pain management ☐Religious Healers or rituals ☐Other: **<Narrative>** ☐None cited **<Narrative>**
37	**Are there other telephone numbers at which you may be reached?** ☐Yes ☐No Create New Event - Address/Phone/E-Mail Change Additional Instructions *If member indicates other that is not in system, add manual phone numbers as needed.*
38	**Our records show your primary care doctor as (_____). Is this correct?** ☐Yes ☐No Create New Event - Care Team Participation Additional Instructions *If PCP in system in not correct, ask for correct PCP and complete manual PCP event. If no PCP identified, make referral as needed.*
39	**Do you have an immediate concern regarding your health care?** ☐Yes **<Narrative>** ☐No
40	**Are there other services I can help you with today?** ☐Referral to provider ☐Referral to social services ☐Transportation to any appointments ☐Remembering appointments ☐Getting equipment (DME) ☐Other: **<Narrative>** ☐None Additional Instructions *Assist member as needed with any referrals, non-clinical needs.*

41	*Based on our conversation today….There are some items I can help you with today (like setting up an appointment with your doctor, referral for community services, etc.)* *AND/OR* *I would like to set up an appointment with one of our case managers who can further assist you with_____ (cite condition / your health care needs)* *If yes –* *This is a voluntary program. You have the right to change your mind later at any time late. Simply call us at XXX and let us know you have changed your mind and no longer wish to participate* **Based on our conversation today….Would you like to participate in case management?** ☐Yes ☐No (or has no CM needs) Additional Instructions *This is the ENROLLMENT point for care management.* **Vary scripting as appropriate. If member has ambulatory care sensitive condition, has triggered any other high risk indicator and has expressed any-clinical needs, then set an appointment with CM. If member has no ambulatory care sensitive conditions, no other high risk indicators and no expressed clinical needs, then assist with any service coordination needs.* **When in doubt – CONSULT WITH CARE MANAGER.*
42	**(If answer to "would you like to participate" is NO)** *"OK. So that we know how to better manage our program…"* **Is there a particular reason why you would not like to participate?** Member doesn't feel they need help ☐Member doesn't have time to participate in interview / program ☐Other: _____ ☐Member requests NO OUTREACH AT ANY POINT IN FUTURE (HARD NO)
43	*You have the right to change your mind later if you wish to participate. Simply call us at XXX and let us know you have changed your mind.* **Member has identified service coordination needs?** ☐Yes ☐No

Created/Revised	Revised by:	Date Revised	Changes: Yes/No
Created			
Reviewed	Virginia McCarthy	1/30/17	
Updated to match Golden	Virginia McCarthy	5/31/17	

Care Plan Development and Updating

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Care Plan Development and Updating

Introduction

- **Creating the Care Plan**
- **Updating the Care Plan**
- **Care Plan Sharing and Output Document (ICM only)**

The care plan is created for all members enrolled in Care Management (CM). When the care plan is created, the barriers, protective factors, and high priority member issues identified during Case Formulation will automatically be populated into the care plan window.

Business Rules:

- The initial care plan has to be completed as soon as possible, but no later than 30 calendar days from completion of the initial assessment unless a plan's contractual requirements indicate a shorter timeframe than 30 days.
- Prior to moving a member from one level of care to another (e.g. Intensive to Supportive), the Case Manager will complete and document the following;
  - Interval Assessment (IA) and SF Tool
  - New Case Formulation to update the member's barriers, protective factors and issues.
  - In collaboration with the member, a full review of the active care plan with revisions as indicted OR the creation of a new Care Plan.

Creating the Care Plan

When the Case Formulation is completed & saved, the Care Plan will launch to the screen. Refer to Case Formulation desktop for instructions to complete the event.

Step	Action
1.	Click the **HCE Data** tab at the bottom of the Care Plan screen to review any information previously entered to ensure any social determinants of healthcare equity (SDoH) relevant to the member are addressed during care planning. • Click the hyperlink under Assessment Date heading to view the information.

	 Refer to Social Determinants of Health (SDoH) for Health Care Equity in CM desktop for more information on SDoH.
2.	Click the Care Plan tab at the bottom of the HCE Data screen to return to the Care Plan screen. 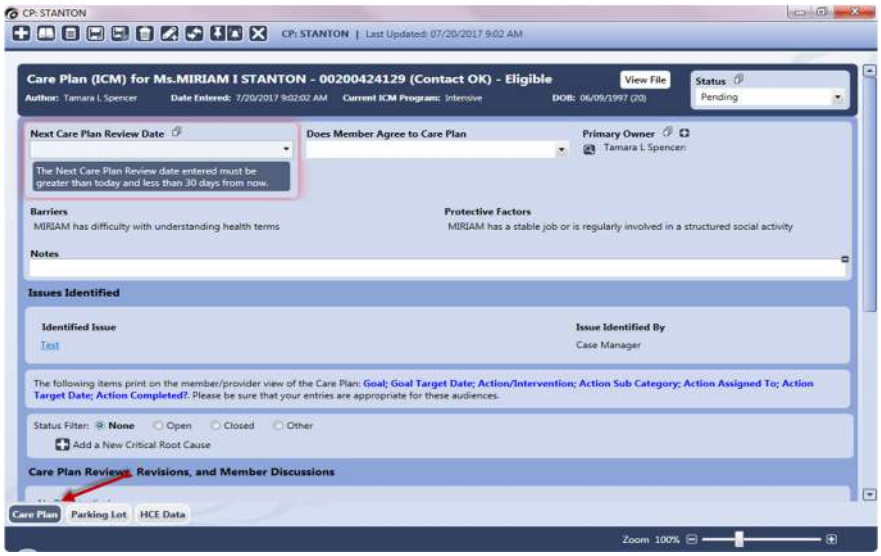
3.	Scroll down the Care Plan screen and click **Add a new Critical Root Cause**.

	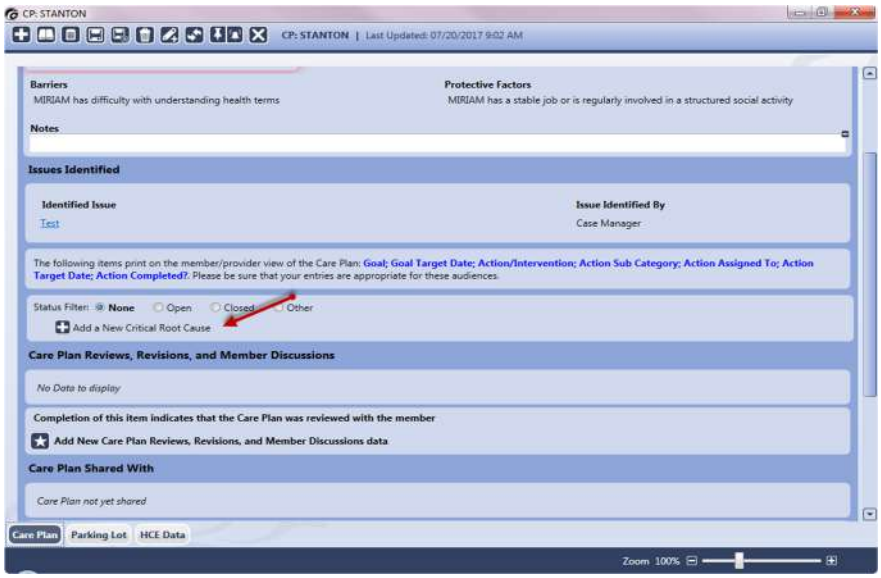

4.	Consider the issues identified as priority during Case Formulation and select the Root Cause from the dropdown menu that applies to the issue with first priority.
	
	Result: The root cause will default to **Active** status and the date will default to today's date.
	
	Note:
	
	• Case Manager can add as many root causes as appropriate for the care plan, but generally a care plan should not have more than three (3) root causes at a time to prevent overwhelming the member.
	• Selected items become read-only.
	• If an entry is selected in error, hover the cursor to the far right of the Root Cause field & right-click to display **Remove this Critical Root Cause**.
	  – Click **Remove this Critical Root Cause**.
	  – Click **Delete** in the Warning dialog box that displays.

5. Click **Add a New Goal(s)** link that displays to the right of the Root Cause field.

Result: Fields for completing the goal information appear.

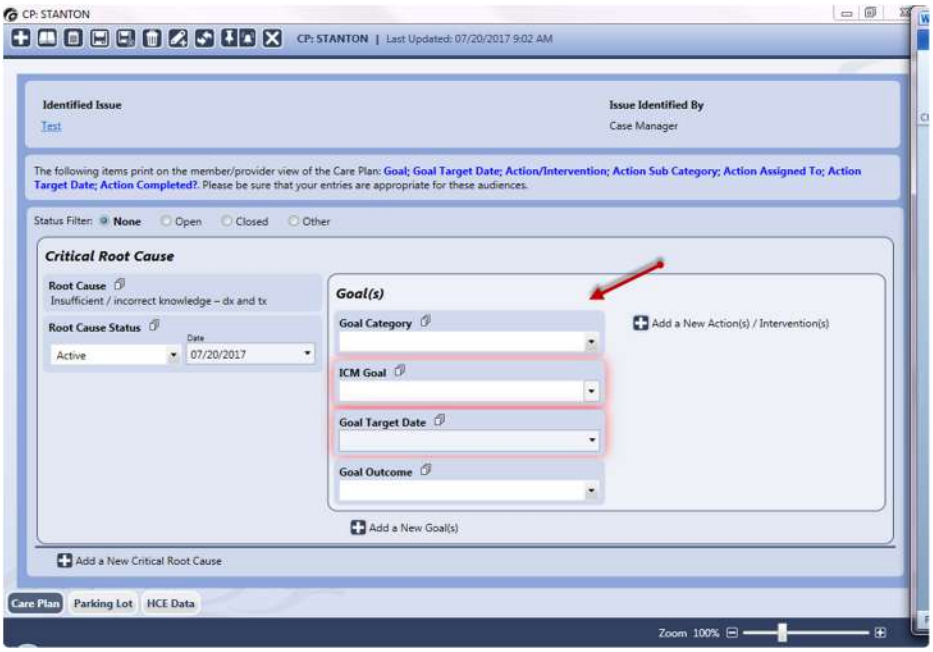

Note:

- A care plan should not have more than three (3) goals at a time to avoid overwhelming the member.

	• If the goal was created in error, right-click to the right of the goal, and click **Remove this Goal(s)**.
6.	Select the appropriate **Goal Category** from the dropdown menu in that field.
7.	Select the appropriate goal from the dropdown menu under **ICM Goal** beginning with the goal of first priority. **Note:** • If the goal of choice is not available in the dropdown list, change the Goal Category as needed until the desired goal is located. • Selected items become read-only (with the exception of the **Other** selection). If **Other** is selected, a description field will appear to specify. 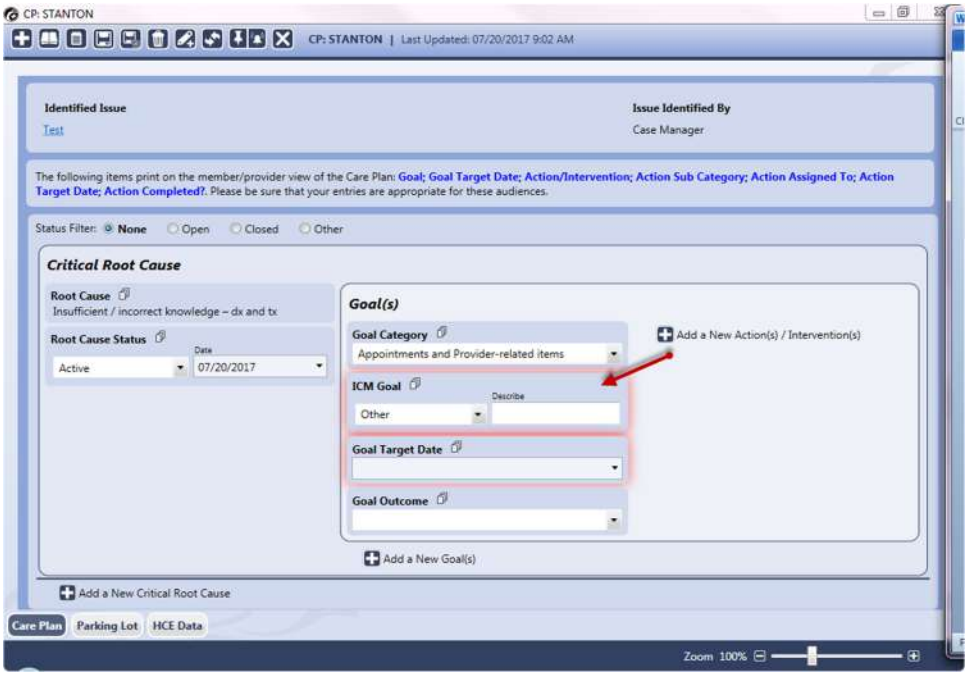
8.	Select the target date for achievement of the goal under **Goal Target Date**. **Note:** • **Goal Target Date** should be within the next care plan review timeframe for the member's **ICM Program Type** (i.e. 30 days for Intensive and 90 days for Supportive). • Do not enter anything into the **Goal Outcome** field at this time.
9.	Click **Add a New Action(s)/Intervention(s)** to the right of the **Goal(s)** field. .

Result: Fields for entering the intervention information relevant to that specific goal will appear.

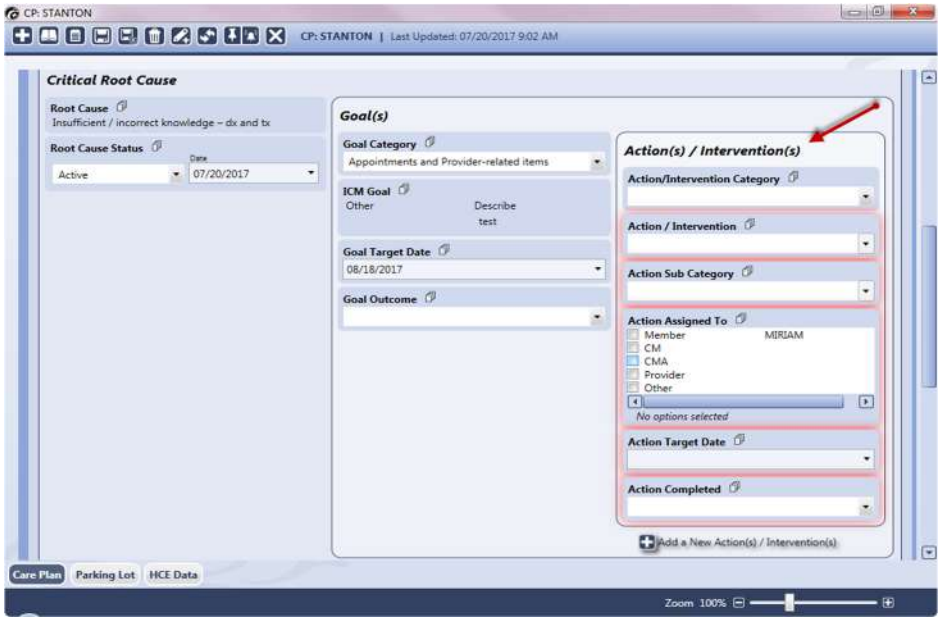

Note: To remove **Action(s)/Intervention(s)** created in error, right-click at the right of the action/intervention, and click **Remove this Action(s)/Intervention(s)**.

10. Complete the following fields for the **Action/Intervention** section:

Field Name	Action
Action/Intervention Category	Select the category that contains the desired action/intervention from the dropdown menu.
Action/Intervention	Select the action/intervention that applies to that goal. **Note:** If the desired action/intervention is not on the list, change the Action/Intervention Category to locate it.
Action Sub Category	Select the appropriate option for the action/intervention selected. **Note:** If Action Sub Category field does not display, there are no sub categories related to the selected action/intervention.
Action Assigned To	Select all the parties to which the action is assigned.

		Note: The information entered here is used to demonstrate movement of member toward self management. Initial care plans may have more actions/interventions assigned to CM or CM & Member. As CM progresses, Member should be responsible for more and more actions/interventions which demonstrates increase in the ability to self-manage.
	Action Target Date	Select a target date for the action/intervention to be completed. **Note:** • **Action Target Date** should be within the next care plan review timeframe for the member's **ICM Program Type** (i.e. 30 days for Intensive and 90 days for Supportive). • If an action/intervention can't be completed within the next care plan review timeframe, consider breaking it down into smaller steps to encourage success.
	Action Completed	Select the appropriate option in the drop-down box: • **Not Yet Started** • **In Progress** • **Yes** • **No** • **No Longer Applicable**
	Note: Add as many actions/interventions as appropriate for the goal without overwhelming the member.	
11.	Repeat Steps 3-10 for each new root cause that is appropriate for this care plan.	
12.	Scroll down to the lower portion of the window, and click the star next to **Add New Care Plan Reviews, Revisions, and Member Discussions Data.**	

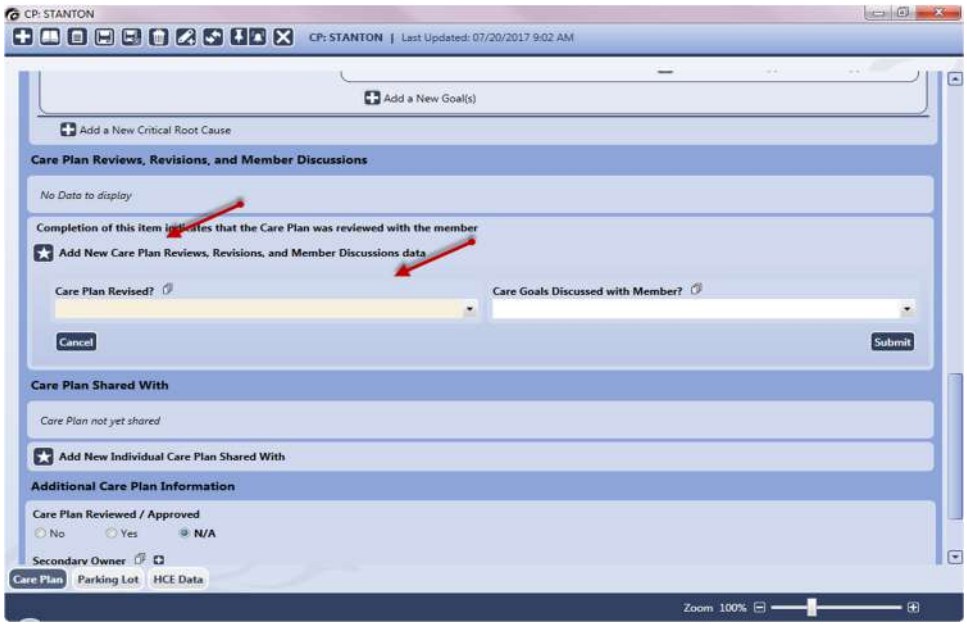

13. Complete the following fields:

Field Name	Action
Care Plan Revised	No & enter date.
Care Plans Goals Discussed with Member/rep	Select Yes or No and date if the care plan goals were discussed with the member or with any member of the interdisciplinary team.

Click **Submit** in the bottom, right of the **Add New Care Plan Reviews, Revisions, and Member Discussions Data** section.

14. Scroll down to the lower portion of the window, and click the star next to **Add New Individual Care Plan Shared With**.

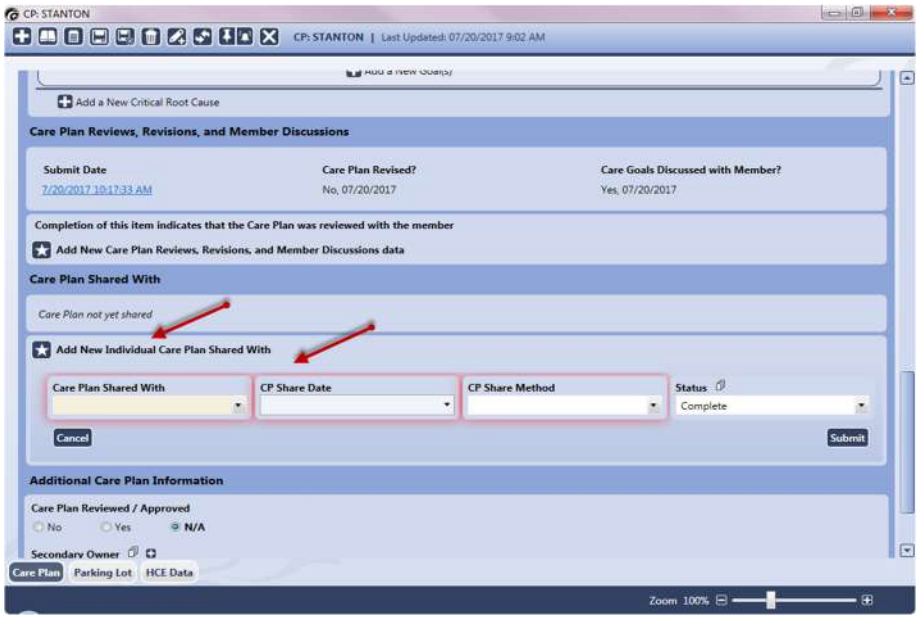

15. Complete the following fields:

Field Name	Action
Care Plan Shared With	Select the person or entity with whom the member's care plan is being shared.
Resulting text field	Type the entity or person's name with which you are sharing the care plan.
CP Share Date	Select the date on which the care plan is/will be shared.
CP Share Method	Select the method used to share the care plan.
Status	Select **Complete** (this is the default selection).

Note:

- At minimum, the care plan must be shared with the member & the PCP.
- Obtain appropriate member consents to share with care team participants and document in the HIPAA event.

16. Click **Submit** in the bottom, right of the Add New Individual Care Plan Shared With field.

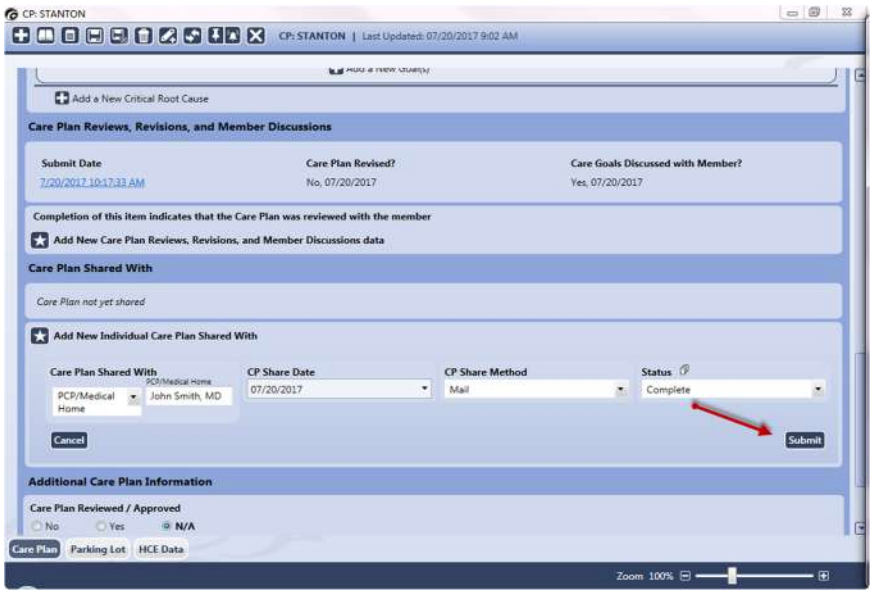

17.	Repeat Steps 14-16 for each additional entity or person with whom the care plan will be shared.
18.	Complete the following fields at the top of the care plan window:

Field Name	Action

Next Care Plan Review Date

Select the date the care plan will be formally reviewed based on the following business rules:

Standard Business Rules for Completion of Member Care Plan Review (after initial care plan is completed)	
	ICM Program
Complex Care Management	30 days
Chronic Condition Management	90 days
Health Promotion and Wellness	365 days

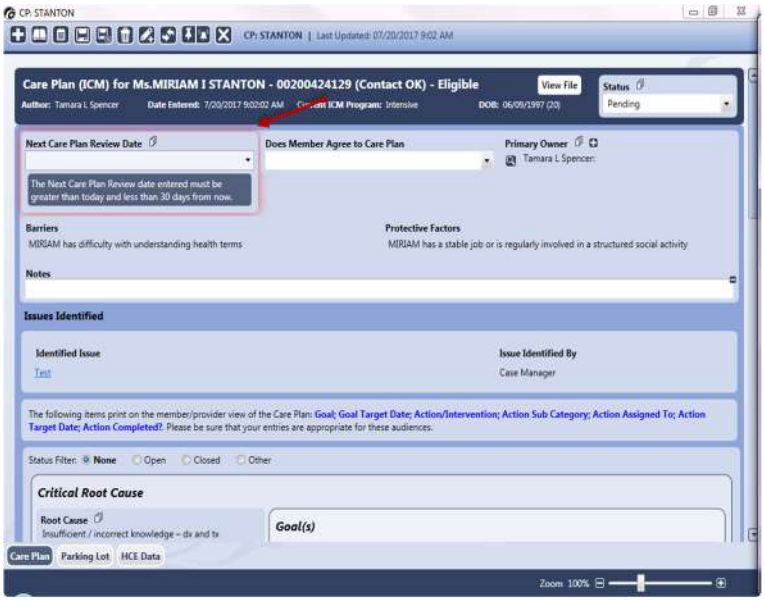

Note: Care plans must also be updated if there is a significant change in the member's needs and/or placement.

	Does Member Agree to the Care Plan	• Select whether or not the member agrees with the care plan. • Select the date that the member agreed or disagreed with the care plan. **Note:** The answer selected here should always be **Yes** unless the health plan requires that member's be managed for a particular reason even if the member does not agree with the care plan (e.g. Persistent Outreach). Answering Yes or No will not drive any system workflow. **Once the member agrees to the care plan, this field should not be changed during care plan reviews or revisions as this is the initial Engagement date for the member.**
	Status	Select **Active**.
	For ICM – Continue to Step 21.
19.	Print copies of the Care Plan Output Letter/Plan of Care to hand deliver to the member & identified care team participants OR save the documents in Print Documents Status to route for vendor to mail. **Note: ICM/ILTCM Welcome Member** and **Welcome Provider** letters should be delivered/mailed along with the initial care plan.
20.	Click **Save Record and Close** in the **Care Plan** window. **Process is complete.**

Updating the Care Plan

Care plans are updated for a variety of reasons, including but not limited to:

- Completion of a new Comprehensive Assessment (i.e. Care Plan Interview, interRAI, etc)
- Completion of goals or actions/interventions
- Care Plan Approval by the member and/or care team
- Significant changes in the member's needs and/or placement
- Moving a member between Intensive and Supportive levels

Step	Action
1.	Click the **ICM History/ILTCM History** tab at the bottom of the member's Dynamo **Care Management Episode/ILTCM Episode (Episode)**. • Click the hyperlink for the date of the Care Plan that is showing in Active Status under the Care/Service Plans section of the screen to open the Care Plan. 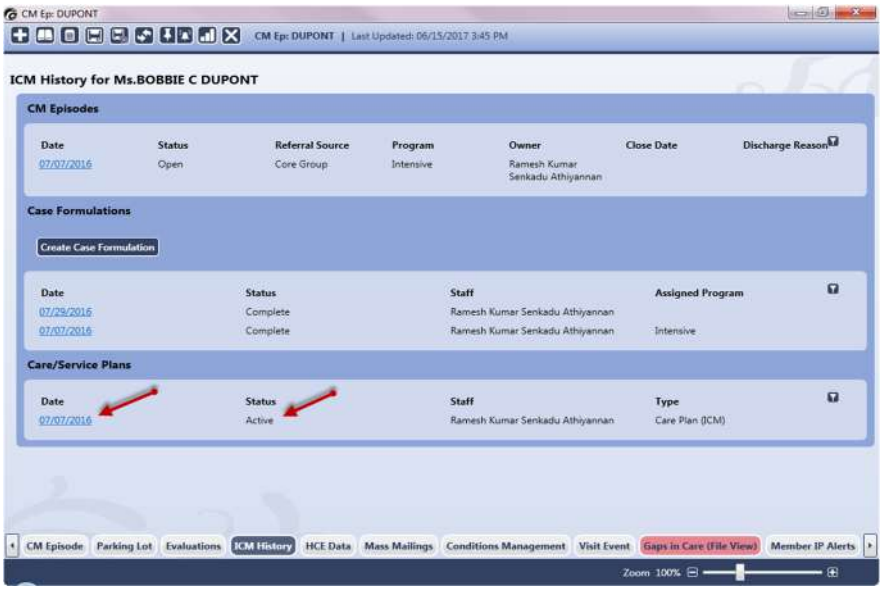 **Note:** A hyperlink to the existing Care Plan can also be found at the bottom of the Case Formulation screen.
2.	Make any appropriate updates to the **Action(s)/Intervention(s)**: • Set the **Action Completed** field to **Yes**, **No**, or **No Longer Applicable**. • Select a date of completion.

	 Note: To demonstrate progress toward goals, the **Action Completed** field should have an entry on or before the **Action Target Date**. Actions not completed can be entered again for the next care plan cycle if the member would like to continue to work on it.
3.	Make any appropriate updates to the Goal(s): • Set the **Goal Outcome** field to **Met**, **Partially Met**, or **Unmet**. • Select a date of completion. • Choose the appropriate **Goal Not Met Reason** from the dropdown list in the new field that generates when **Partially Met** or **Unmet** is entered for **Goal Outcome**. **Note:** Goal(s) must have a **Goal Outcome** entry during each care plan review cycle to demonstrate progress toward goals. If member would like to continue to work on **Partially Met** or **Unmet** goals, **Goal was refinded** can be used as **Goal Not Met** Reason and goal can be entered for the next care plan cycle with new **Goal Target Date**.

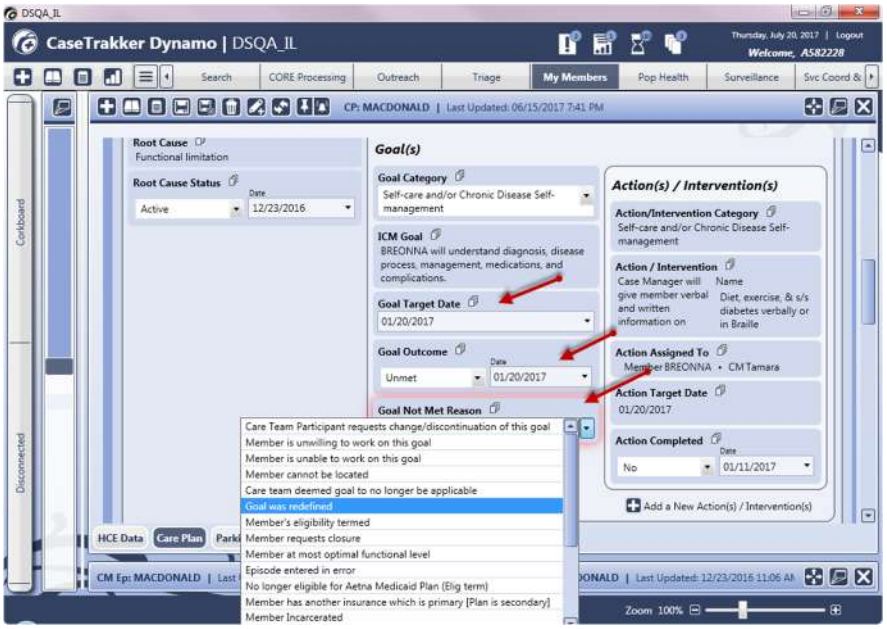

4.	Make any appropriate updates to the **Root Cause.** • Set the **Root Cause Status** field to **Archived** if root cause is resolved. • Select the date the root cause was considered to be resolved. **Note: Root Cause** does not need to be updated with each care plan cycle. The Root Cause is only **Archived** if there is no longer a need related to that root cause.
5.	Create any necessary new **Root Causes**, **Goals**, and **Actions/Interventions** based on discussion with the member and any relevant care team participants. **Note:** Member must have at least one (1) Root Cause, one (1) Goal, and one (1) Action/Intervention for the care plan to be considered valid & active.
6.	Scroll down to the lower portion of the window, and click the star next to **Add New Care Plan Reviews, Revisions, and Member Discussions Data**
7.	Complete the following fields:

Field Name	Action
Care Plan Revised	Select **Yes** and enter the date the member's care plan was reviewed and revised.

	Care Plan Goals Discussed with Member/rep — Select **Yes** or **No** and date based on whether or not the care plan goals were discussed with the member or with any member of the interdisciplinary team. Click **Submit** in the bottom, right of the **Add New Care Plan Reviews, Revisions, and Member Discussions Data** section.
8.	Click to **Add New Individual Care Plan Shared With** & complete for each member of the care team who will receive a copy of the updated care plan. **Note:** Each time the care plan is updated, a copy must by shared with member & PCP at minimum.
9.	Click **Save** to keep the Care Plan window open. **Note:** Use the **Status Filter** buttons (None, Open, Closed, Other), just under the Issues Identified section to view previously completed goals, activities and root causes. • Selecting **none** will show open and closed care plan items. • Selecting **Open** will show open items. • Selecting **Closed** will show closed items. • Do NOT use **other**; it does not apply.
10.	Use the **Create New Item** (+sign) to generate a new Care Plan Output Letter/Plan of Care Letter & edit as needed. • Save in Print Documents Status to route for vendor to mail to the member & any care team participants. **Note:** In order for the vendor to mail, a separate copy must be created & edited for name/address of each person who is to receive a copy. **Process is complete.**

Care Plan Sharing and Output Document (ICM only)

Use the steps in the following table to share the hard copy of the care plan document. Each **Care Plan Output Letter** is automatically saved to the journal for future reference.

Step	Action
1.	Click the **Create New Item** button (+sign) to create the care plan letter.

	Note: The care plan must be open on the screen to create the letter. Care Plan must be Saved before information will populate to the letter.
2.	Select **ICM/ILTCM Shared**, and then select **ICM Care Plan Output Letter.** 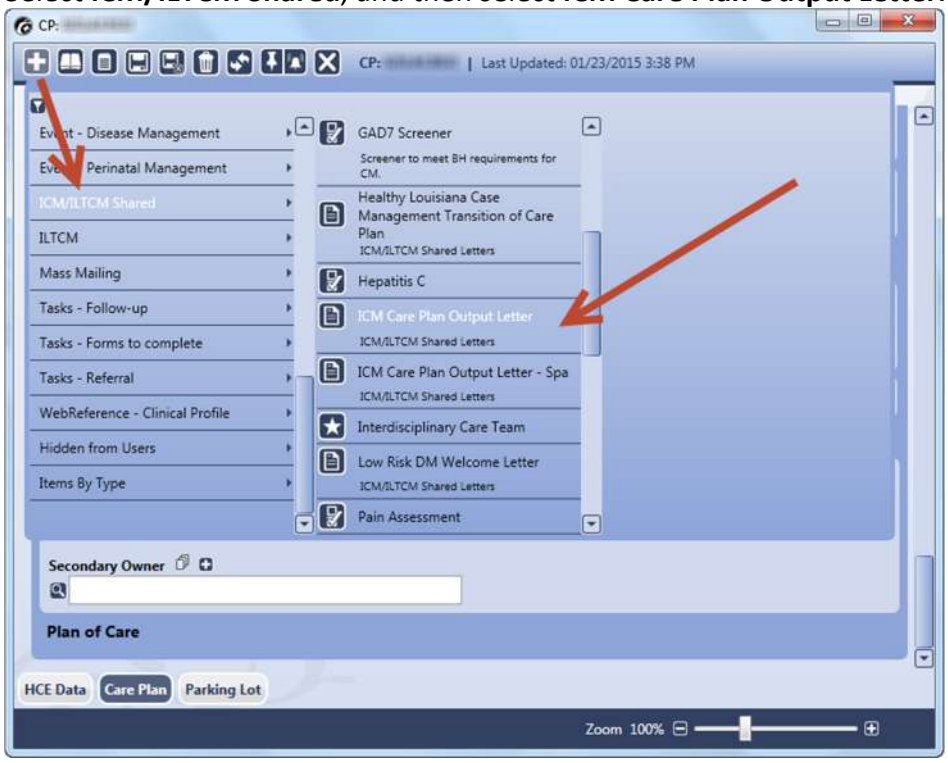 **Result:** System will launch letter.
3.	Determine if the letter will be printed now or queued for vendor mailing. **Note:** Letters printed now must be hand delivered to the receiver & must not be mailed by health plan staff. **If …** / **Then…** The letter will be printed now, / Change the letter status to **Documents Printed**. **Note:** Saved letters will be stored in the journal for future access. **Proceed to next step.** The letter will be mailed by the vendor, / Leave the default status of **Print Documents**.

	Note: Letter will be stored in the journal & display in the queue to be picked up & mailed by the vendor. **Proceed to next step.**
4.	Use the **Create New Items** button (+sign) to create **ICM Welcome Member-Letter** & **ICM Welcome Provider-Letter** to mail with the initial care plan. **Note:** These letters are only mailed with the first care plan being shared & not when an updated care plan is being shared.
5.	Use the filter & begin typing in the title of the letter. • Click the letter when it appears on the list. **Result:** System will automatically launch letter.
6.	Determine if the letter will be printed now or queued for vendor mailing. **Note:** Letters printed now must be hand delivered to the receiver & must not be mailed by health plan staff.

If …	Then…
The letters will be printed now,	Change the letter status to **Documents Printed**. **Note:** Letters will be saved in the journal for future reference. **Process is complete.**
The letters will be mailed by the vendor,	Leave the default status of **Print Documents**. **Note:** Letter will be stored in the journal & display in the queue to be picked up & mailed by the vendor. **Process is complete.**

Attachment T

Kentucky | Transforming Health Care | **Aetna**

Attachment T
C.26 – Program Integrity

Sample Provider Letter ..... Att T-3

Prepayment Policy ..... Att T-7

Prepayment Letter Template ..... Att T-11

SIU Overview ..... Att T-17

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Sample Provider Letter

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151 Farmington Avenue, RWA4
Hartford, CT 06156-7626

INV NAME
Sr. Investigator
Special Investigations Unit
Phone: (XXX) YYY-YYYY

DATE

PROVIDER NAME
ATTN:
STREET ADDRESS
CITY STATE AND ZIP

Case #:

Dear,

Aetna Better Health of @@@@@@ has completed a review of claims submitted by your office under Tax Identification XX-XXXXXXXX The sample was chosen from claims processed between DATE and DATE.

An audit was conducted based on services billed to Aetna Better Health of @@@@ using [Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT)] code number H0000 and 99999. Medical records were requested from your office.

The [HCPCS/CPT] defines [these/this] code(s) as:
ENTER CODE and DESCRIPTION HERE

Medical records where received from your office. Our clinical staff reviewed the records submitted by your office for the XX [patients/claims – 745 claims] selected in the sample.

Detail the findings and Quote any policies, education material, state regulations, etc. to support the determination

The attached spreadsheet details the claims reviewed and the Medical Director determinations on each service included in the audit. Enclosed is a password protected CD containing a detailed patient report for the overpayment. Please call me at XXX-XXX-XXXX to obtain the password.
OR
If you wish to receive a spreadsheet that details the claims reviewed and the determinations on each service included in the audit, please contact me with a secure email address. You may call or email me as indicated below.

If you would like to have a discussion about these findings or dispute these findings, please notify us of your desire to have a discussion or provide us with the basis for your disagreement or dispute; including any additional documentation you would like us to review by (DATE 15 days from date of letter).

You may resolve this overpayment by sending us payment of the full amount by (DATE 30 days from date of letter). Please send a bank check or money order for **$$$** made payable to Aetna Better Health of STATE to the following address:

Aetna – SIU Overpayments
P.O. Box 981105
El Paso, TX 79998-1105

Please include case #**CASE NUMBER** on your check.

If we have not heard from you by (DATE 30 days from date of letter) we will proceed according to the statute and the parties' contract.

Returning the money paid for these claims resolves only the overpayment. It does not impact any other investigation relating to the particular claims identified on the spreadsheet previous provided, nor will it impact any resulting civil, criminal or administrative action undertaken.

If you have any questions about our findings, or about the aforementioned process, please contact me directly at (XXX) XXX-XXXX or email me at EMAIL ADDRESS.

Thank you for your cooperation.

Sincerely,

NAME
Senior Investigator

Prepayment Policy

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SIU Operational Policies & Procedures

SUBJECT: Provider Watch Policy

POLICY INFORMATION:

Policy #:	021 MCD	**Business Owner:**	Tabitha Kielb
Effective Date:	09/05/2012	**Contact:**	Tabitha Kielb
Revision:	4	**Approval Date:**	09/05/2012

REVISION HISTORY:

Date	Revision	Reason
09/05/2012	1.0	New Policy
09/14/2016	2.0	Updated FACTS to Case Tracker. Removed outdated steps.
02/08/2017	3.0	Policy updated for Legal/Contract Reference
09/29/2018	4.0	Updated Business Owner and Contact

IMPACT:

Affected Lines of Business	Medicaid

DRAFT

PURPOSE: To provide an instruction for the Medicaid Special Investigations Unit staff when placing a provider on prepayment review.

LEGAL/CONTRACT REFERENCE:

- State Contract
- State and Federal regulations and requirements (including, but not limited to: Title 42 Code of Federal Regulations (C.F.R.)

POLICY STATEMENT: Aetna maintains a Special Investigations Unit (SIU) that is responsible for the detection, prevention, and investigation of allegations of healthcare fraud, waste, and abuse; recovery of benefit dollars obtained by deceit and/or misrepresentation; and compliance with state and federal regulations concerning anti-fraud plans and fraud reporting.

This instruction will assist the SIU investigator when they have determined that a provider(s) claims should be reviewed prior to payment being issued by the health plan.

- Prepare the Prepayment Review Letter that will be sent to the provider and forward the draft to the Supervisor using the workflow tracking in SharePoint. Once the letter is approved, forward to the required plan staff including the Compliance Manager for review.
- Once the letter is approved by the plan, send to the provider via UPS tracking. Save the letter in the case file on the Medicaid SIU SharePoint site along with the UPS tracking information.
- Update Case Tracker with the activity regarding the letter being mailed and include the tracking number. Update the plan details within Case Tracker with the date the flag was submitted.
- The investigator will notify the plan's Provider Relations Department with a statement to be added into the claims processing system. This memo will assist in directing the caller back to the letter and investigator with any questions..
- The Investigator will then submit the request to the SIU Data Analytics mailbox with instructions specific to the flag (provider name, TIN, NPI, code(s), etc)
- The claims matching the flag specifics will then be denied and medical records will be reviewed prior to the claim being adjusted for payment.

- At the End of the Designated Review Time Period

a. The SIU analyst will notify the investigator of the claim activity and medical review decisions.
b. The Investigator will update the case in Case Tracker.
c. The Investigator will review and determine with the Team Lead if the provider should continue to be on watch. If they feel the provider should remain on watch, they will discuss next steps with the health plan.

Prepayment Letter Template

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151 Farmington Avenue, RWA4
Hartford, CT 06156-7626

Inv Name
Senior Investigator
Special Investigations Unit
Phone: XXX-XXXX

DATE

Category code: SIUA

Doctors Name MD
Attn: Office Manager
Address
City, State Zip

Case #: 201YXXXX
Control: MED003
TIN: XXXXXXXXX

DRAFT

Dear Office Manager:

We have conducted a review of data based on claims submitted by your office to Aetna Better Health of XXXXX under Tax Identification Number XX-XXXXXXX.

Specifically, we conducted data analysis of Current Procedural Terminology (CPT) code number [Specific CPT Code]. This analysis has identified you as a potential outlier of this CPT code for the time period of [Date] – [Date].

According to the [20XX] CPT manual, this code number is used to describe the following service: [Quote description of the service as found in CPT manual]

Include here the specific details for the prepayment review

Effective immediately, Aetna Better Health of XXXXX will require that any claims for CPT/HCPCS codes [Codes Here] that you submit for reimbursement be reviewed prior to payment. When claims are submitted in the future, you will be required to provide documentation to support the billed services. The documentation will be reviewed by our clinical staff. You can help speed the review process and reduce the disruption of payments by promptly providing treatment records.

Claims must be submitted through your normal process, either mailing or submitting electronically to the Claims Department. **DO NOT SUBMIT MEDICAL RECORDS WITH THE CLAIM.** Directions on what records are needed and where to send the documentation is provided below.

To expedite the clinical review, documentation should be submitted with a copy of this letter or the attached cover sheet. We request that you mail the documentation needed at the same

time the claim is submitted. You will receive a provider remittance notice with a denial message stating that we have insufficient information and records will be needed. This will also remind you that documentation needs to be submitted. If you have not already done so, when you see this denial message, please submit the requested information with a copy of this letter or the attached cover sheet. If documentation is not received, the claim will remain denied.

Please provide the following records for review. State timely filing requirements apply.

[Investigator will enter requested documentation such as:]

- Daily treatment or progress notes
- Medical and social histories
- Records of the patient's chief complaint
- Record of the treating provider's findings
- Record of the treating provider's preliminary and final diagnoses
- Copy of all diagnostic and laboratory test results, and x-ray reports
- Operative reports
- Anesthesiology records
- Pathology reports
- Referring physician orders/requisitions/prescriptions
- Plan of care
- Initial nursing assessment and re-assessments
- Supervisory visit documentation
- Timesheets (RN and/or Home Health Aide)
- Clinical records containing pertinent past and current information
- Discharge summary
- Sign in sheets
- Daily log of activities
- All reports/forms prepared by aid
- Medication log/prescription copies
- Delivery records
- Invoices

The medical records must be forwarded to the following address:

Aetna - SIUA
PO Box 981105
El Paso, TX 79998-1105
Attn: Prepayment Team – MED003

- Please include a complete copy of the attached coversheet or this letter when mailing the medical records.

Should you disagree with the individual claim determination after the records have been reviewed, as always, you may pursue the claim further through the Aetna Better Health of XXXXX provider appeals process. Normal appeals timeframes and requirements apply.

If you disagree with our position regarding these billings, please submit a written explanation of the basis for your disagreement, along with any and all documents that support your position.

Please be advised no additional requests for documentation will be issued regarding this particular matter. If you have any questions about our findings, or about the aforementioned process, please contact me directly at [phone number] or email me at [email address].

Thank you for your cooperation.

Sincerely,

Inv Name
Senior Investigator

Medical Record Cover Sheet

The medical records should be forwarded to the following address:

Aetna - SIUA
PO Box 981105
El Paso, TX 79998-1105
Attn: Prepayment Team – MED003

Please include a copy of this sheet with every medical record you send in related to this audit.

This will assist in expediting your claim review.

SIU Overview

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Aetna Better Health of Kentucky
SIU and FWA
An Introduction

Kim Gentry, SIU Supervisor
Phyllis Wells, Sr. SIU Investigator

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Today

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We'll talk about:

- SIU Focus: Fraud, Waste, and Abuse
- Definitions
- Kentucky In The News
- Member/Pharmacy Schemes
- Provider Schemes
- How to Refer Potential Fraud to SIU

SIU Focus Fraud, Waste, and Abuse

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Mission:
To protect the health and financial wellness of the people we serve by leading the fight against health care FWA as we help to build a healthier world.

Major Activities

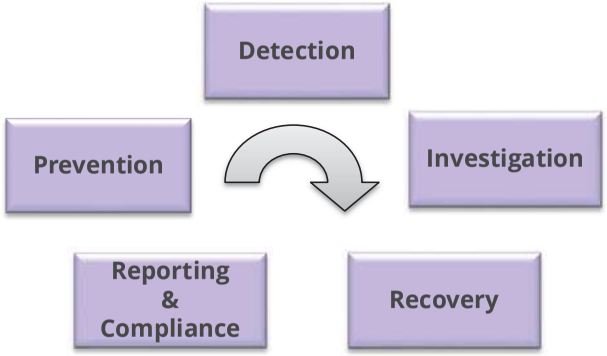

- **Detection –** Proactive data analysis identifies providers of interest based on behavior within peer group.
- **Investigation –** Thoroughly explore all of a provider's billing/practice behavior, not just a single issue.
- **Recovery –** Work with providers to understand/educate and/or pursue recovery
- **Reporting & Compliance –** Operational and financial results reporting, mandated state and federal fraud reporting
- **Prevention –** Pre-payment claim review and routing avoids fraudulent payments

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Definitions

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Fraud generally is defined as an intentional deception or intentional misrepresentation that a person makes to gain a benefit for which that person is not entitled.

Examples of fraud in health care may include:

* Knowingly billing for services that were not furnished
* Knowingly altering claim forms to receive a higher payment amount
* Falsifying documentation
* Using unlicensed individuals to provide services

Waste is overutilization of services or other practices that, directly or indirectly result in unnecessary costs to the health care system. It is not generally considered to be caused by criminally-negligent actions but by payment errors, referred to as "improper payments," and the misuse of resources. Deficient management, practices, or controls can result in waste. Given the complexity of payment systems, waste is much more common than fraud and abuse.

Examples of waste may include:

* Spending on services that lack evidence of producing better outcomes compared with less-expensive alternatives
* Failures of care coordination that result in unnecessary hospital readmissions, avoidable complications, and declines in functional status
* Ordering unnecessary tests to guard against liability in malpractice lawsuits

Abuse involves payment for items or services when there is no legal entitlement to that payment, and the health care provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples of abuse may include:

* Misusing codes on a claim
* Charging excessively for services or supplies
* Billing for services that were not medically necessary
* Unbundling and billing individual components of a service instead of the all-inclusive procedure

Kentucky In The News

- Williamsburg Pharmacist Convicted
- KY Attorney General's Office Settlement with Dialysis Provider
- Louisville Chiropractor to Pay 114K to Resolve Allegations of Medicaid Fraud
- KY Ambulance Service Owner Sentenced for Health Care Fraud

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Member/ Pharmacy Schemes

- Doctor Shopping
- Forged Scripts
- Misuse of Member Credentials

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Provider Schemes

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- Services Not Rendered
- Unlicensed Provider
- Upcoding
- Unbundling Codes
- Altered or Fabricated Billings
- Medically Unnecessary Services
- Phantom Providers

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How to Refer Suspected Cases of Fraud to SIU

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VM Attended Hotline: This is a toll-free line that instructs the caller to leave as much information as possible regarding the Fraud, Waste, or Abuse allegation. A contact name and number or email is helpful but not necessary.

Internal Referral: This form is accessible to all employees via AetNet Essential Links. Information regarding the person making the referral is pre-populated. Once in Essential Links, click on Fraud Referral Form to report Fraud, waste and abuse. Additionally, the form can always be accessed from SIU's Intranet Site or the AetNet Directory.

Plan Specific Website: These are accessible via the web, and therefore available to the general public as well as members, practitioners and pharmacies.

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Questions

Thank you

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Attachment U

Kentucky | Transforming Health Care | **Aetna**

Attachment U
D - Implementation Plan

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ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
1			**KY Implementation Work Plan**	**0%**	**298 days**	**Mon 1/20/20**	**Wed 3/10/21**		
2			**Business Opportunity Response**	**0%**	**15 days**	**Mon 1/20/20**	**Fri 2/7/20**		
3			Required Implementation Section Provided to RFP Staff	0%	1 day	Mon 1/20/20	Mon 1/20/20		MSI- Implementation
4			Proposal/Application Submitted	0%	1 day	Fri 2/7/20	Fri 2/7/20		Business Development
5		**MILESTONE**	**MILESTONE: Contract Awarded**	**0%**	**0 days**	**Thu 4/30/20**	**Thu 4/30/20**		
6			**Initiate Implementation**	**0%**	**133 days**	**Mon 1/20/20**	**Wed 7/22/20**		MIS- Implementation
7			**RFP to Implementaiton**	**0%**	**83 days**	**Mon 1/20/20**	**Wed 5/13/20**		MIS- Implementation
8			Approval to initiate/assemble implementation	0%	5 days	Thu 4/30/20	Wed 5/6/20	5	MIS- Implementation
9			Name Implementation Team	0%	2 days	Mon 1/20/20	Tue 1/21/20		MIS- Implementation
10			Implementaiton ITWR submitted to IT, CRQ Number Assigned (P1)	0%	5 days	Mon 1/20/20	Fri 1/24/20		MIS- Implementation
11			Implementation PPM submitted	0%	2 days	Mon 1/20/20	Tue 1/21/20		MIS- Implementation
12			Network Build Meetings Scheduled	0%	5 days	Mon 3/2/20	Fri 3/6/20		
13			RFP to Implementation Hand Off Meeting	0%	1 day	Mon 3/2/20	Mon 3/2/20		MIS- Implementation
14			**Requirements Document Development**	**0%**	**25 days**	**Mon 2/3/20**	**Fri 3/6/20**		MIS- Implementation
15			Requirements Document Initial Development	0%	10 days	Mon 2/3/20	Fri 2/14/20		MSI- Implementation
16			Requirements Document Assignment and Confirmation	0%	10 days	Mon 2/17/20	Fri 2/28/20	15	MSI- Implementation
17			Obtain Commitments List	0%	5 days	Mon 3/2/20	Fri 3/6/20	16	RFP Team
18			Develop Required Training List	0%	5 days	Mon 3/2/20	Fri 3/6/20	16	MSI- Implementation
19			Obtain Value Added Benefit List	0%	5 days	Mon 3/2/20	Fri 3/6/20	16	MSI- Implementation
20			In Lieu of Services Identified	0%	5 days	Mon 3/2/20	Fri 3/6/20	16	MSI- Implementation
21			**Unique Contractual (and Proposal) Requirements/Deliverables**	**0%**	**10 days**	**Thu 4/30/20**	**Wed 5/13/20**		
22			Social Determinants of Health Integration Model	0%	10 days	Thu 4/30/20	Wed 5/13/20		Quality Management,Population
23			Aetna's Transformation into a Trauma-informed Program	0%	10 days	Thu 4/30/20	Wed 5/13/20		Care Management
24			Expand CPESN Program	0%	10 days	Thu 4/30/20	Wed 5/13/20		Care Management,Popula
25			**Deep Dive with all Departments**	**0%**	**68 days**	**Mon 2/10/20**	**Wed 5/13/20**		**MSI- Implementation**
26			Deep Dive Introduction Meeting Virtually	0%	1 day	Mon 2/10/20	Mon 2/10/20		MSI- Implementation
27			Schedule and Coordinate Deep Dive Logistics	0%	1 day	Tue 2/11/20	Tue 2/11/20	26	MSI- Implementation
28			Conduct Onsite Deep Dives	0%	2 days	Tue 3/3/20	Wed 3/4/20	27FS+14 day	MSI- Implementation
29			Identify inter-departmental dependencies	0%	5 days	Thu 3/5/20	Wed 3/11/20	28	MSI- Implementation

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
30			Risk Identification	0%	5 days	Thu 3/5/20	Wed 3/11/20	28	MSI- Implementation
31			Virtual Functional Area Deep Dives	0%	7 days	Thu 3/5/20	Fri 3/13/20	28	MSI- Implementation
32			**Functional Area Work Plan Initiation**	**0%**	**43 days**	**Mon 3/16/20**	**Wed 5/13/20**		**MSI- Implementation**
33			Functional Area Work Plans Requested	0%	5 days	Mon 3/16/20	Fri 3/20/20	31	MSI- Implementation
34			Functional Area Work Plans Received	0%	5 days	Mon 3/23/20	Fri 3/27/20	33	MSI- Implementation
35			Functional Area Work Plan Meetings with Implementation Team Occurred	0%	10 days	Thu 4/30/20	Wed 5/13/20		MSI- Implementation
36			**Pre-Award Set Up**	**0%**	**102 days**	**Tue 3/3/20**	**Wed 7/22/20**		MIS- Implementation
37			Implementation HUB site deployed, key documents stored, OneNote structure	0%	10 days	Tue 3/3/20	Mon 3/16/20	13	MSI- Implementation
38			Lead Team Roster and Outlook Distribution List Developed	0%	10 days	Tue 3/3/20	Mon 3/16/20	13	MSI- Implementation
39			Lead Team Access Requested (HUB)	0%	5 days	Tue 3/17/20	Mon 3/23/20	38	MSI- Implementation
40			Cost center request from finance	0%	30 days	Tue 3/3/20	Mon 4/13/20	13	Finance
41			Implementation Governance (L2) Meetings Schedul	0%	30 days	Thu 3/5/20	Wed 4/15/20	28	MSI- Implementation
42			Request Dates for L1	0%	3 days	Thu 3/5/20	Mon 3/9/20	28	MSI- Implementation
43			Status reporting, dashboard templates prepared	0%	30 days	Tue 3/17/20	Mon 4/27/20	37	MSI- Implementation
44			Develop Project Charter	0%	60 days	Thu 3/5/20	Wed 5/27/20	28	MSI- Implementation
45			**Administrative**	**0%**	**60 days**	**Thu 4/30/20**	**Wed 7/22/20**		**CEO Health Plan**
46			Budget Approved by Sr. Leaders	0%	60 days	Thu 4/30/20	Wed 7/22/20	5	CEO Health Plan
47			Staffing Plan Approval by Sr. Leaders	0%	60 days	Thu 4/30/20	Wed 7/22/20	5	CEO Health Plan
48			**Implementation Kickoff Actions**	**0%**	**78 days**	**Mon 3/16/20**	**Wed 7/1/20**		MIS- Implementation
49			Unique requirements, commitments stored/communicated	0%	10 days	Mon 3/16/20	Fri 3/27/20		MSI- Implementation
50			Required policies, program documents, requirements are listed & communicated	0%	20 days	Mon 3/16/20	Fri 4/10/20		Compliance
51			Key state Interchange file layouts requirements & technical manual obtained/distributed	0%	45 days	Thu 4/30/20	Wed 7/1/20	5	MSI-Tech
52			Kick off Deck Created	0%	5 days	Thu 4/30/20	Wed 5/6/20	5	MSI- Implementation
53			Kick off Scheduled	0%	5 days	Thu 4/30/20	Wed 5/6/20	5	MSI- Implementation
54			Kick off Conducted	0%	10 days	Thu 4/30/20	Wed 5/13/20	5	MSI- Implementation
55			Master workplan published	0%	14 days	Thu 5/14/20	Tue 6/2/20	35	MSI- Implementation
56			**Execute Implementation (After Award)**	**0%**	**139 days**	**Thu 4/30/20**	**Tue 11/10/20**		
57			**Post Award Execution**	**0%**	**20 days**	**Thu 5/14/20**	**Wed 6/10/20**		**MSI- Implementation**

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
58			Project Charter Sign Off by Executive Leadership	0%	10 days	Thu 5/28/20	Wed 6/10/20	44	MSI- Implementation
59			Schedule and Conduct L1 weekly	0%	5 days	Thu 5/14/20	Wed 5/20/20	54	MSI- Implementation
60			**Submit Pre-Go Live Deliverables**	**0%**	**75 days**	**Fri 5/29/20**	**Thu 9/10/20**		**MSI- Implementation**
61			0-30 Day	0%	20 days	Fri 5/29/20	Thu 6/25/20		MSI- Implementation
62			31-60 Day	0%	20 days	Tue 6/30/20	Mon 7/27/20		MSI- Implementation
63			61-90 Day	0%	30 days	Fri 7/31/20	Thu 9/10/20		MSI- Implementation
64			91-Go-Live	0%	30 days	Mon 7/6/20	Fri 8/14/20		MSI- Implementation
65			**Readiness Review**	**0%**	**139 days**	**Thu 4/30/20**	**Tue 11/10/20**		**MSI- Implementation**
66			KY Communicates Readiness Timeline and Tool	0%	1 day	Wed 7/15/20	Wed 7/15/20		MSI- Implementation
67			Meet with DHS to review tool	0%	1 day	Thu 7/16/20	Thu 7/16/20	66	Health Plan Operations
68			**Desk Review Documentation Review**	**0%**	**32 days**	**Thu 7/16/20**	**Fri 8/28/20**		**MSI- Implementation**
69			Style Guide Developed	0%	5 days	Thu 7/16/20	Wed 7/22/20	66	MSI- Implementation
70			Tool (Element Requirements) Received, Updated for Internal Use	0%	5 days	Thu 7/16/20	Wed 7/22/20	66	MSI- Implementation
71			Expectations and Timeline Communicated	0%	2 days	Thu 7/23/20	Fri 7/24/20	70	MSI- Implementation
72			Assignments distributed & SMEs actively in work	0%	10 days	Mon 7/27/20	Fri 8/7/20	71	MSI- Implementation
73			**Review tool established**	**0%**	**10 days**	**Mon 8/10/20**	**Fri 8/21/20**	**72SS**	**MSI- Implementation**
74			Internal Approval (Implementation Director, Compliance)	0%	10 days	Mon 8/10/20	Fri 8/21/20	72	MSI- Implementation
75			Style Guide and PDF Requirements Check	0%	3 days	Mon 8/24/20	Wed 8/26/20	74	MSI- Implementation
76			DHS submission for approval	0%	2 days	Thu 8/27/20	Fri 8/28/20	75	MSI- Implementation
77			**Desk Review Documentation Feedback**	**0%**	**43 days**	**Fri 9/11/20**	**Tue 11/10/20**		**MSI- Implementation**
78			Feedback received and communicated	0%	1 day	Fri 9/11/20	Fri 9/11/20		MSI- Implementation
79			Expectations and Timeline Communicated	0%	2 days	Mon 9/14/20	Tue 9/15/20	78	MSI- Implementation
80			Assignments distributed	0%	10 days	Wed 9/16/20	Tue 9/29/20	79	MSI- Implementation
81			**Review tool established**	**0%**	**10 days**	**Wed 9/30/20**	**Tue 10/13/20**		**MSI- Implementation**
82			Internal Approval (Implementation Director, Compliance)	0%	10 days	Wed 9/30/20	Tue 10/13/20	80	MSI- Implementation
83			Style Guide and PDF Requirements Check	0%	3 days	Wed 10/14/20	Fri 10/16/20	82	MSI- Implementation
84			DHS submission for approval	0%	2 days	Mon 10/19/20	Tue 10/20/20	83	MSI- Implementation
85		MILESTON	MILESTONE: Desk Review Documentation Approved by DHS, Passing Report Received	0%	0 days	Tue 11/10/20	Tue 11/10/20	84FF+15 days	MSI- Implementation
86			**Operational Onsite Readiness Review (if required)**	**0%**	**139 days**	**Thu 4/30/20**	**Tue 11/10/20**		**MSI- Implementation**

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
87			**Mock Readiness Reviews (if required)**	**0%**	**15 days**	**Thu 4/30/20**	**Wed 5/20/20**		**MSI- Implementation**
88			Initial Mock Readiness Review Conducted with All Functional Areas	0%	5 days	Thu 4/30/20	Wed 5/6/20		MSI- Implementation
89			Develop and Distribute DHS Data Sheets	0%	5 days	Thu 5/7/20	Wed 5/13/20	88	MSI- Implementation
90			Second Round (if necessary after DHS agenda received) Mock Readiness Review Conducted with All Functional Areas	0%	5 days	Thu 5/14/20	Wed 5/20/20	89	MSI- Implementation
91			Agenda Received from state of KY	0%	1 day	Mon 10/12/20	Mon 10/12/20		MSI- Implementation
92			Assignments, Schedule distributed	0%	3 days	Tue 10/13/20	Thu 10/15/20	91	MSI- Implementation
93			Onsite Presentation Deck Constructed and Apprc	0%	7 days	Tue 10/13/20	Wed 10/21/20	91	MSI- Implementation
94			Onsite Binder Prepared and Printed	0%	7 days	Tue 10/13/20	Wed 10/21/20	91	MSI- Implementation
95			On-site Readiness Review logistics confirmed (room, travel, food/beverage, equipment, etc.)	0%	7 days	Tue 10/13/20	Wed 10/21/20	91	MSI- Implementation
96			On-site Readiness Review conducted/completed	0%	2 days	Thu 10/22/20	Fri 10/23/20	95	MSI- Implementation
97			**Operational Onsite Review Feedback**	**0%**	**12 days**	**Mon 10/26/20**	**Tue 11/10/20**		**MSI- Implementation**
98			KY Deliverables list distributed for response	0%	10 days	Mon 10/26/20	Fri 11/6/20	96	MSI- Implementation
99			KY Deliverables submitted	0%	2 days	Mon 11/9/20	Tue 11/10/20	98	MSI- Implementation
100			State Readiness Review signed off/approved	0%	0 days	Tue 11/10/20	Tue 11/10/20	99	MSI- Implementation
101			**Functional Areas**	**0%**	**255 days**	**Thu 3/19/20**	**Wed 3/10/21**		**MSI- Implementation**
102			**Configuration (CSRA)**	**0%**	**231 days**	**Mon 4/20/20**	**Mon 3/8/21**		**CSRA**
103			Initial State rate schedule defined/documented	0%	100 days	Thu 4/30/20	Wed 9/16/20		CSRA
104			**Setup Contracts**	**0%**	**105 days**	**Mon 4/20/20**	**Fri 9/11/20**		**CSRA**
105			Identify contracts needed for load	0%	40 days	Mon 4/20/20	Fri 6/12/20		CSRA
106			Build contracts in QNXT	0%	15 days	Mon 6/15/20	Fri 7/3/20	105	CSRA
107			Validate contract load	0%	40 days	Mon 6/15/20	Fri 8/7/20	106SS	CSRA
108			Contract testing	0%	65 days	Mon 6/15/20	Fri 9/11/20	107SS	CSRA
109			**Setup Benefits**	**0%**	**125 days**	**Thu 4/30/20**	**Wed 10/21/20**		**CSRA**
110			Review and verify understanding of plan requirements	0%	5 days	Thu 4/30/20	Wed 5/6/20		CSRA
111			Review and receive finalized Benefit Grid	0%	30 days	Thu 5/7/20	Wed 6/17/20	110	CSRA
112			Review PA Requirements	0%	5 days	Thu 6/18/20	Wed 6/24/20	111	CSRA
113			Receive approval/signoff from Health Plan/Implementation Team	0%	5 days	Thu 6/25/20	Wed 7/1/20	112	CSRA
114			Build benefit properties	0%	60 days	Thu 7/2/20	Wed 9/23/20	113	CSRA

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
115			QC benefit setup	0%	20 days	Thu 9/24/20	Wed 10/21/20	114	CSRA
116			**Setup Providers**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**CSRA**
117			Review reporting/data and directory requirements - determine overall provider setup	0%	60 days	Thu 4/30/20	Wed 7/22/20		CSRA
118			Re-assess the network against compliance requirements	0%	30 days	Thu 4/30/20	Wed 6/10/20		CSRA
119			Review Non Par Market Rules	0%	5 days	Thu 7/23/20	Wed 7/29/20	117	CSRA
120			Review of Provider Maintenance Activities	0%	90 days	Thu 7/23/20	Wed 11/25/20	117	CSRA
121			QC and Testing provider loads	0%	25 days	Thu 11/26/20	Wed 12/30/20	120	CSRA
122			**Pre-Go-Live Activities**	**0%**	**10 days**	**Thu 10/22/20**	**Wed 11/4/20**		**CSRA**
123			Promote/validate all configuration moved to Production	0%	10 days	Thu 10/22/20	Wed 11/4/20	115	CSRA
124			**Go-Live**	**0%**	**46 days**	**Mon 1/4/21**	**Mon 3/8/21**		**CSRA**
125			Post production Claims Review	0%	45 days	Mon 1/4/21	Fri 3/5/21		CSRA
126			Coordinate transition to Maintenance Mode	0%	1 day	Mon 3/8/21	Mon 3/8/21	125	CSRA
127			**Claims**	**0%**	**202 days**	**Thu 4/30/20**	**Fri 2/5/21**		**Claims**
128			**Readiness Review**	**0%**	**75 days**	**Thu 4/30/20**	**Wed 8/12/20**		**Claims**
129			Review/Update Policies & Procedures	0%	35 days	Thu 4/30/20	Wed 6/17/20		Claims
130			Submit for internal review	0%	10 days	Thu 6/18/20	Wed 7/1/20	129	Claims
131			Submit for State approval	0%	30 days	Thu 7/2/20	Wed 8/12/20	130	Claims
132			**Department Report Readiness**	**0%**	**10 days**	**Thu 8/13/20**	**Wed 8/26/20**		**Claims**
133			Production Reports	0%	5 days	Thu 8/13/20	Wed 8/19/20	131	Claims
134			Inventory Reports	0%	5 days	Thu 8/20/20	Wed 8/26/20	133	Claims
135			**Claims Testing (if needed - validate new benefits)**	**0%**	**52 days**	**Thu 10/22/20**	**Fri 1/1/21**		**Claims**
136			Review/approve testing documentation	0%	15 days	Thu 10/22/20	Wed 11/11/20	115	Claims
137			Claims Testing (if needed)	0%	37 days	Thu 11/12/20	Fri 1/1/21	136	Claims
138			Post Go-Live Claims Tracking (continue in post go live workplan)	0%	25 days	Mon 1/4/21	Fri 2/5/21	137	Claims
139			**Compliance / HP Operations**	**0%**	**40 days**	**Thu 4/30/20**	**Wed 6/24/20**		**Compliance**
140			Policies/Procedures/Program Requirements - Submitted to DHS for Approval	0%	40 days	Thu 4/30/20	Wed 6/24/20		Compliance
141			Complete State Compliance Deliverables	0%	20 days	Thu 4/30/20	Wed 5/27/20		Compliance
142			Complete Emergency Preparedness Policy, Procedure and Ownership	0%	20 days	Thu 4/30/20	Wed 5/27/20		HP Operations

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
143			Complete Disaster Recovery Policy, Procedure and Ownership	0%	20 days	Thu 4/30/20	Wed 5/27/20		HP Operations
144			**Contracts & Licenses**	**0%**	**90 days**	**Thu 4/30/20**	**Wed 9/2/20**		**Legal**
145			State Contract executed	0%	14 days	Thu 4/30/20	Tue 5/19/20		Legal
146			License / Bond Requirement resubmitted to the Sta	0%	30 days	Thu 4/30/20	Wed 6/10/20		Legal
147			Lobbying disclosure resubmitted to the State	0%	30 days	Thu 4/30/20	Wed 6/10/20		Legal
148			Required Insurance for Plan documented	0%	90 days	Thu 4/30/20	Wed 9/2/20		Finance
149			**Credentialing**	**0%**	**150.4 days**	**Thu 4/30/20**	**Thu 11/26/20**		**Credentialing**
150			Schedule Credentialing Requirement Review Meetir	0%	1 day	Thu 4/30/20	Thu 4/30/20		Credentialing
151			Credentialing Requirement Review	2%	30 days	Thu 4/30/20	Thu 6/11/20	150	Credentialing
152			Plan (Work Plan, HUB site, etc.)	2%	30 days	Thu 4/30/20	Thu 6/11/20	150	Credentialing
153			**Execute Work Plan for new requirements & progra**	**0%**	**120 days**	**Thu 6/11/20**	**Thu 11/26/20**		**Credentialing**
154			Quick Base Update	0%	10 days	Thu 6/11/20	Thu 6/25/20	152	Credentialing
155			Provider Data Alignment	0%	10 days	Thu 6/25/20	Thu 7/9/20	154	Credentialing
156			Tailor Applications and Forms	0%	10 days	Thu 7/9/20	Thu 7/23/20	155	Credentialing
157			Submit Access Requests for Credentialing Analys	0%	5 days	Thu 7/23/20	Thu 7/30/20	156	Credentialing
158			Tailor Policies	0%	20 days	Thu 7/23/20	Thu 8/20/20	156	Credentialing
159			Complete Must/Shalls	0%	20 days	Thu 7/23/20	Thu 8/20/20	156	Credentialing
160			Tailor Desktops	0%	20 days	Thu 8/20/20	Thu 9/17/20	159	Credentialing
161			Tailor Letters	0%	20 days	Thu 8/20/20	Thu 9/17/20	159	Credentialing
162			Create reports	0%	5 days	Thu 8/20/20	Thu 8/27/20	159	Credentialing
163			Complete new provider credentialing	0%	90 days	Thu 7/23/20	Thu 11/26/20	156	Credentialing
164			**Encounters**	**0%**	**157 days**	**Thu 4/30/20**	**Fri 12/4/20**		**Encounters**
165			**Requirements Development Review**	**0%**	**40 days**	**Thu 4/30/20**	**Wed 6/24/20**		**Encounters**
166			**Define mapping requirements (if changes)**	**0%**	**40 days**	**Thu 4/30/20**	**Wed 6/24/20**		**Encounters**
167			837P - Professional Claim	0%	20 days	Thu 4/30/20	Wed 5/27/20		Encounters
168			837I - Institution Claim	0%	20 days	Thu 5/28/20	Wed 6/24/20	167	Encounters
169			837 - Vision Claim	0%	15 days	Thu 4/30/20	Wed 5/20/20		Encounters
170			Pharmacy (NCDPD D.0 or pAH 4.2)	0%	30 days	Thu 4/30/20	Wed 6/10/20	169SS	Encounters
171			Define State response requirements	0%	30 days	Thu 4/30/20	Wed 6/10/20	170SS	Encounters
172			Define Vendor response requirements	0%	30 days	Thu 4/30/20	Wed 6/10/20	171SS	Encounters
173			**Create Business Requirements Document (BRD)**	**0%**	**30 days**	**Thu 4/30/20**	**Wed 6/10/20**		**Encounters**
174			Develop BRD & obtain internal approvals	0%	30 days	Thu 4/30/20	Wed 6/10/20	172SS	Encounters

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
175			**Testing - as necessary**	**0%**	**127 days**	**Thu 6/11/20**	**Fri 12/4/20**		**Encounters**
176			Create test plans - QA, UAT and IT	0%	30 days	Thu 6/11/20	Wed 7/22/20	174	Encounters
177			Code delivery from Enrollment Manager vendor	0%	30 days	Thu 6/11/20	Wed 7/22/20	176SS	Encounters
178			Completion of QA testing	0%	30 days	Thu 6/18/20	Wed 7/29/20	177SS+5 day	Encounters
179			Execute test scripts (internal)	0%	30 days	Thu 7/30/20	Wed 9/9/20	178	Encounters
180			**Complete State testing (external) - as needed**	**0%**	**55 days**	**Thu 9/10/20**	**Wed 11/25/20**		**Encounters**
181			837P - Professional Claim	0%	45 days	Thu 9/10/20	Wed 11/11/20	179	Encounters
182			837I - Institution Claim	0%	45 days	Thu 9/10/20	Wed 11/11/20	179	Encounters
183			837 - Vision Claim	0%	45 days	Thu 9/10/20	Wed 11/11/20	179	Encounters
184			Pharmacy (NCDPD D.0 or pAH 4.2)	0%	45 days	Thu 9/10/20	Wed 11/11/20	179	Encounters
185			State certification of results	0%	10 days	Thu 11/12/20	Wed 11/25/20	184	Encounters
186			Approval to move new requirement into Product	0%	7 days	Thu 11/26/20	Fri 12/4/20	185	Encounters
187			**Enrollment**	**0%**	**176 days**	**Thu 4/30/20**	**Thu 12/31/20**		**Enrollment**
188			**QNXT Eligibility Configuration - as needed**	**0%**	**105 days**	**Thu 4/30/20**	**Wed 9/23/20**		**Enrollment**
189			QNXT Enrollment (Org Policy) Structure defined/signed off	0%	40 days	Thu 4/30/20	Wed 6/24/20		Enrollment
190			QNXT Eligibility Configuration Completed	0%	20 days	Thu 6/25/20	Wed 7/22/20	189	Enrollment
191			Contract/RFP Review	0%	25 days	Thu 7/23/20	Wed 8/26/20	190	Enrollment
192			Policies/Procedures/Desktops	0%	45 days	Thu 7/23/20	Wed 9/23/20	191SS	Enrollment
193			**ID Card Requirements**	**0%**	**105 days**	**Thu 4/30/20**	**Wed 9/23/20**		**Enrollment**
194			File requirements	0%	10 days	Thu 4/30/20	Wed 5/13/20		Enrollment
195			Vendor discussions	0%	45 days	Thu 7/23/20	Wed 9/23/20	190	Enrollment
196			**Build attributes/restrictions**	**0%**	**100 days**	**Thu 7/23/20**	**Wed 12/9/20**		**Enrollment**
197			Vendor files	0%	100 days	Thu 7/23/20	Wed 12/9/20	195SS	Enrollment
198			**Reports & Queries**	**0%**	**85 days**	**Thu 7/23/20**	**Wed 11/18/20**		**Enrollment**
199			Reports build	0%	85 days	Thu 7/23/20	Wed 11/18/20	190	Enrollment
200			Queries build	0%	85 days	Thu 7/23/20	Wed 11/18/20	190	Enrollment
201			**Testing**	**0%**	**30 days**	**Thu 11/19/20**	**Wed 12/30/20**		**Enrollment**
202			File testing	0%	30 days	Thu 11/19/20	Wed 12/30/20	200	Enrollment
203			QNXT testing	0%	30 days	Thu 11/19/20	Wed 12/30/20	202SS	Enrollment
204			**Deploy Implementation of new contract**	**0%**	**9 days**	**Mon 12/21/20**	**Thu 12/31/20**		**Enrollment**
205			Receive Production 834 Enrollment File	0%	1 day	Mon 12/21/20	Mon 12/21/20		Enrollment
206			PCP Assignment new members	0%	7 days	Tue 12/22/20	Wed 12/30/20	205	Enrollment

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
207			Confirm ID cards and welcome kit to new membe	0%	8 days	Tue 12/22/20	Thu 12/31/20	205	Enrollment
208			**Finance, Actuarial, Check Run**	**0%**	**70 days**	**Thu 4/30/20**	**Wed 8/5/20**		**Finance**
209			**Budget and Planning**	**0%**	**70 days**	**Thu 4/30/20**	**Wed 8/5/20**		**Finance**
210			**Health Plan Operations**	**0%**	**70 days**	**Thu 4/30/20**	**Wed 8/5/20**		**Finance**
211			Required insurance secured (reinsurance)	0%	40 days	Thu 4/30/20	Wed 6/24/20		Finance
212			Value add benefits approved through Senior Leadership	0%	60 days	Thu 4/30/20	Wed 7/22/20		Finance
213			Executive Management approval - Implementation Budget	0%	65 days	Thu 4/30/20	Wed 7/29/20		Finance
214			Executive Management approval - Ongoing bu	0%	65 days	Thu 4/30/20	Wed 7/29/20		Finance
215			Policies and Procedures Reviewed/Updated	0%	5 days	Thu 7/30/20	Wed 8/5/20	214	Finance
216			**Grievance & Appeals - update as needed for new con**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**Grievance & Appeals**
217			**Create documentation**	**0%**	**120 days**	**Thu 4/30/20**	**Wed 10/14/20**		**Grievance & Appeals**
218			Member policies & procedures	0%	60 days	Thu 4/30/20	Wed 7/22/20		Grievance & Appeals
219			Provider policies & procedures	0%	60 days	Thu 4/30/20	Wed 7/22/20	218SS	Grievance & Appeals
220			Operational policies & procedures	0%	50 days	Thu 4/30/20	Wed 7/8/20	219SS	Grievance & Appeals
221			Remaining documentation - NOA, Workflows, handbooks, etc.	0%	70 days	Thu 4/30/20	Wed 8/5/20	220SS	Grievance & Appeals
222			Submit documentation for internal review	0%	10 days	Thu 8/6/20	Wed 8/19/20	221	Grievance & Appeals
223			Submit documentation for State approval	0%	40 days	Thu 8/20/20	Wed 10/14/20	222	Grievance & Appeals
224			**Dynamo Appeal & Grievance Application (DAG)- update as needed**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**Grievance & Appeals**
225			Complete DAG requirements	0%	90 days	Thu 4/30/20	Wed 9/2/20		Grievance & Appeals
226			Configure and Test DAG	0%	75 days	Thu 9/3/20	Wed 12/16/20	225	Grievance & Appeals
227			Deploy DAG for Go-Live	0%	10 days	Thu 12/17/20	Wed 12/30/20	226	Grievance & Appeals
228			**Training**	**0%**	**45 days**	**Thu 10/15/20**	**Wed 12/16/20**		**Grievance & Appeals**
229			Review/Update training materials	0%	45 days	Thu 10/15/20	Wed 12/16/20	223	Grievance & Appeals
230			**Infrastructure**	**0%**	**176 days**	**Thu 4/30/20**	**Thu 12/31/20**		**Infrastructure**
231			**Administrative Tasks**	**0%**	**75 days**	**Thu 4/30/20**	**Wed 8/12/20**		**Infrastructure**
232			Create State required files spreadsheet	0%	15 days	Thu 4/30/20	Wed 5/20/20		Infrastructure
233			Update required files spreadsheet after all source documents delivered	0%	60 days	Thu 5/21/20	Wed 8/12/20	232	Infrastructure
234			**State Vendors**	**0%**	**30 days**	**Thu 4/30/20**	**Wed 6/10/20**		**Infrastructure**
235			Enrollment Broker	0%	30 days	Thu 4/30/20	Wed 6/10/20		Infrastructure

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
236			Identify delegated vendors	0%	30 days	Thu 4/30/20	Wed 6/10/20		Infrastructure
237			**Required Files**	**0%**	**90 days**	**Thu 5/21/20**	**Wed 9/23/20**		**Infrastructure**
238			Establish any new required file exchange with State and vendors	0%	90 days	Thu 5/21/20	Wed 9/23/20	232	Infrastructure
239			**Review Files from Regulator for new requirements**	**0%**	**30 days**	**Thu 9/24/20**	**Wed 11/4/20**		**Infrastructure**
240			Enrollment - 834	0%	30 days	Thu 9/24/20	Wed 11/4/20	238	Infrastructure
241			Capitation - 820	0%	30 days	Thu 9/24/20	Wed 11/4/20	240SS	Infrastructure
242			Other	0%	30 days	Thu 9/24/20	Wed 11/4/20	241SS	Infrastructure
243			**Validate test files as applicable**	**0%**	**30 days**	**Thu 9/24/20**	**Wed 11/4/20**		**Infrastructure**
244			Vendor files	0%	30 days	Thu 9/24/20	Wed 11/4/20	238	Infrastructure
245			Inbound test files	0%	30 days	Thu 9/24/20	Wed 11/4/20	244SS	Infrastructure
246			Outbound test files	0%	30 days	Thu 9/24/20	Wed 11/4/20	245SS	Infrastructure
247			State files	0%	30 days	Thu 9/24/20	Wed 11/4/20	246SS	Infrastructure
248			**Validate Online Provider Directory**	**0%**	**41 days**	**Thu 11/5/20**	**Thu 12/31/20**		**Infrastructure**
249			1st Test Cycle	0%	1 day	Thu 11/5/20	Thu 11/5/20	247	Infrastructure
250			2nd Test Cycle	0%	1 day	Fri 11/6/20	Fri 11/6/20	249	Infrastructure
251			Vendor directory files received	0%	1 day	Mon 11/9/20	Mon 11/9/20	250	Infrastructure
252			Format vendor data for directory	0%	1 day	Tue 11/10/20	Tue 11/10/20	251	Infrastructure
253			Final file received	0%	1 day	Wed 11/11/20	Wed 11/11/20	252	Infrastructure
254			Finalize Aetna & vendors data for Marketing	0%	1 day	Thu 11/12/20	Thu 11/12/20	253	Infrastructure
255			Submit Production files	0%	2 days	Fri 11/13/20	Mon 11/16/20	254	Infrastructure
256			Create paper version for on-demand printing	0%	7 days	Wed 12/23/20	Thu 12/31/20		Infrastructure
257			**Informatics / Reporting**	**0%**	**201 days**	**Thu 4/30/20**	**Thu 2/4/21**		**Informatics**
258			Capture reporting requirements	0%	30 days	Thu 4/30/20	Wed 6/10/20		Informatics
259			Finalize reporting requirements	0%	30 days	Thu 6/11/20	Wed 7/22/20	258	Informatics
260			Submit Informatics work requests	0%	51 days	Thu 7/23/20	Thu 10/1/20	259	Informatics
261			Test and validate reports	0%	50 days	Fri 10/2/20	Thu 12/10/20	260	Informatics
262			DEPLOYMENT	0%	40 days	Fri 12/11/20	Thu 2/4/21	261	Informatics
263			**IT**	**0%**	**225 days**	**Thu 4/30/20**	**Wed 3/10/21**		**IT**
264			IT Kickoff Conducted	0%	10 days	Thu 4/30/20	Wed 5/13/20		IT
265			**Release 1 - Marketing Readiness - review of existing applications for contract compliance**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
266			Review Requirements	0%	60 days	Thu 5/14/20	Wed 8/5/20	264	IT

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
267			Review Design & Development	0%	80 days	Thu 8/6/20	Wed 11/25/20	266	IT
268			Testing if appropriate	0%	20 days	Thu 11/26/20	Wed 12/23/20	267	IT
269			Deployment & Warranty as needed	0%	55 days	Thu 12/24/20	Wed 3/10/21	268	IT
270			**Release 2 - Eligibility Readiness (Enrollment)-review of existing applications and processes for contract compliance**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
271			Review Requirements	0%	60 days	Thu 5/14/20	Wed 8/5/20	264	IT
272			Review Design & Development	0%	80 days	Thu 8/6/20	Wed 11/25/20	271	IT
273			Testing if appropriate	0%	20 days	Thu 11/26/20	Wed 12/23/20	272	IT
274			Deployment & Warranty as needed	0%	55 days	Thu 12/24/20	Wed 3/10/21	273	IT
275			**Release 3 - Health Plan Go-Live**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
276			Review Requirements	0%	60 days	Thu 5/14/20	Wed 8/5/20	264	IT
277			Review Design & Development	0%	80 days	Thu 8/6/20	Wed 11/25/20	276	IT
278			Testing if appropriate	0%	20 days	Thu 11/26/20	Wed 12/23/20	277	IT
279			Deployment & Warranty as needed	0%	55 days	Thu 12/24/20	Wed 3/10/21	278	IT
280			**Release 4 - Encounters Medicaid**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
281			Review Requirements	0%	60 days	Thu 5/14/20	Wed 8/5/20	264	IT
282			Review Design & Development	0%	80 days	Thu 8/6/20	Wed 11/25/20	281	IT
283			Testing if appropriate	0%	20 days	Thu 11/26/20	Wed 12/23/20	282	IT
284			Deployment & Warranty as needed	0%	55 days	Thu 12/24/20	Wed 3/10/21	283	IT
285			**Member and Provider Portals / Public Websites**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
286			Review Requirements	0%	60 days	Thu 5/14/20	Wed 8/5/20	264	IT
287			Review Design & Development	0%	80 days	Thu 8/6/20	Wed 11/25/20	286	IT
288			Testing if appropriate	0%	20 days	Thu 11/26/20	Wed 12/23/20	287	IT
289			Deployment & Warranty as needed	0%	55 days	Thu 12/24/20	Wed 3/10/21	288	IT
290			**Human Capital - Staffing**	**0%**	**200 days**	**Thu 3/19/20**	**Wed 12/23/20**		**MSI - Human Capital**
291			Hiring team identified; requisitions assigned	0%	40 days	Thu 4/30/20	Wed 6/24/20		MSI - Human Capital
292			Hiring governance established	0%	10 days	Thu 6/25/20	Wed 7/8/20	291	MSI - Human Capital
293			Hiring toolkit and protocols developed/published	0%	5 days	Thu 6/25/20	Wed 7/1/20	292SS	MSI - Human Capital
294			HR Dashboard constructed	0%	5 days	Thu 7/2/20	Wed 7/8/20	293	MSI - Human Capital
295			**New positions posted**	**0%**	**90 days**	**Thu 3/19/20**	**Wed 7/22/20**		**MSI - Human Capital**
296			JVS review/mapping completed	0%	40 days	Thu 4/30/20	Wed 6/24/20	291SS	MSI - Human Capital
297			Job requisitions created/submitted to Gatekeepe	0%	60 days	Thu 4/30/20	Wed 7/22/20	296SS	MSI - Human Capital

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
298			Requisitions approved by Gatekeeper	0%	60 days	Thu 4/30/20	Wed 7/22/20	297SS	MSI - Human Capital
299			Requisitions received in Talent Acquisition; Recruiter Assigned, Intake conducted	0%	60 days	Thu 4/30/20	Wed 7/22/20	298SS	MSI - Human Capital
300			Org Hierarchy constructed	0%	60 days	Thu 3/19/20	Wed 6/10/20	299SS-30 da	MSI - Human Capital
301			**Key Positions/Non-Key Positions Filled**	**0%**	**130 days**	**Thu 6/25/20**	**Wed 12/23/20**		**MSI - Human Capital**
302			Interviewer resources assigned	0%	40 days	Thu 6/25/20	Wed 8/19/20	291	MSI - Human Capital
303			Advertising commenced	0%	40 days	Thu 6/25/20	Wed 8/19/20	302SS	MSI - Human Capital
304			Sourcing commenced	0%	90 days	Thu 6/25/20	Wed 10/28/20	303SS	MSI - Human Capital
305			Hiring events executed	0%	90 days	Thu 6/25/20	Wed 10/28/20	304SS	MSI - Human Capital
306			ERP Campaign executed	0%	90 days	Thu 6/25/20	Wed 10/28/20	305SS	MSI - Human Capital
307			Interviewing completed	0%	120 days	Thu 6/25/20	Wed 12/9/20	306SS	MSI - Human Capital
308			New employee orientation and onboarding completed	0%	10 days	Thu 12/10/20	Wed 12/23/20	307	MSI - Human Capital
309			**Learning and Performance**	**0%**	**189.8 days**	**Thu 4/30/20**	**Wed 1/20/21**		**Learning & Performance**
310			**Initiate**	**0%**	**109.8 days**	**Thu 4/30/20**	**Wed 9/30/20**		**Learning & Performance**
311			SMEs identified (all functional areas)	0%	30 days	Thu 4/30/20	Wed 6/10/20		Learning & Performance
312			Review unique training requirements	0%	55 days	Wed 6/10/20	Wed 8/26/20	311	Learning & Performance
313			L&P Review training strategy kick off	0%	25 days	Wed 8/26/20	Wed 9/30/20	312	Learning & Performance
314			L&P Resources Identified (writers; trainers)	0%	25 days	Wed 8/26/20	Wed 9/30/20	312	Learning & Performance
315			**Plan**	**0%**	**17 days**	**Wed 9/30/20**	**Fri 10/23/20**		**Learning & Performance**
316			System Access Logistics for L&P team and HP Staff - QA & Production	0%	17 days	Wed 9/30/20	Fri 10/23/20	314	Learning & Performance
317			Rosters for HP Staff Tracked/Posted (by functional area)	0%	17 days	Wed 9/30/20	Fri 10/23/20	314	Learning & Performance
318			Training Scheduled (all functional areas) including training room logistics (unless training	0%	17 days	Wed 9/30/20	Fri 10/23/20	314	Learning & Performance
319			**Execute Work Plan**	**0%**	**60 days**	**Wed 9/30/20**	**Wed 12/23/20**		**Learning & Performance**
320			Curriculum Development Complete (all functional areas) including HP Overview and Training Attestations (see notes % completed)	0%	45 days	Wed 9/30/20	Wed 12/2/20	314	Learning & Performance
321			Internal SME Review and QC of Curriculum (all functional areas) complete	0%	10 days	Wed 12/2/20	Wed 12/16/20	320	Learning & Performance
322			Train-the-Trainer Sessions scheduled and compl	0%	5 days	Wed 12/16/20	Wed 12/23/20	321	Learning & Performance
323			Training of all staff completed	0%	25 days	Wed 12/16/20	Wed 1/20/21	321	Learning & Performance

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
324			**Marketing ADVERTISING**	**0%**	**173.77 days**	**Thu 4/30/20**	**Tue 12/29/20**		**Marketing Advertising**
325			**PLAN**	**0%**	**102.77 days**	**Thu 4/30/20**	**Mon 9/21/20**		**Marketing Advertising**
326			**Project Planning Tasks**	**0%**	**102.77 days**	**Thu 4/30/20**	**Mon 9/21/20**		**Marketing Advertising**
327			Identify and Document Project Stakeholders	0%	10 days	Thu 4/30/20	Wed 5/13/20		Marketing Advertising
328			Update Marketing plan	0%	74 days	Wed 5/13/20	Tue 8/25/20	327	Marketing Advertising
329			Update Effectiveness Tracking Mechanisms	0%	19 days	Tue 8/25/20	Mon 9/21/20	328	Marketing Advertising
330			**EXECUTION**	**0%**	**90 days**	**Tue 8/25/20**	**Tue 12/29/20**		**Marketing Advertising**
331			**Launch Tactical Initiatives**	**0%**	**90 days**	**Tue 8/25/20**	**Tue 12/29/20**		**Marketing Advertising**
332			Update Health Plan logo	0%	3 wks	Tue 8/25/20	Tue 9/15/20	328	Marketing Advertising
333			Launch campaign	0%	75 days	Tue 9/15/20	Tue 12/29/20	332	Marketing Advertising
334			**Marketing OPERATIONS**	**0%**	**167 days**	**Thu 4/30/20**	**Fri 12/18/20**		**Marketing Operations**
335			**INITIATE**	**0%**	**0 days**	**Thu 4/30/20**	**Thu 4/30/20**		**Marketing Operations**
336			Determine Requirements	0%	0 days	Thu 4/30/20	Thu 4/30/20		Marketing Operations
337			Determine Resources	0%	0 days	Thu 4/30/20	Thu 4/30/20		Marketing Operations
338			Determine Timelines	0%	0 days	Thu 4/30/20	Thu 4/30/20		Marketing Operations
339			**Plan**	**0%**	**10 days**	**Thu 4/30/20**	**Wed 5/13/20**		**Marketing Operations**
340			Identify and Document Project Stakeholders	0%	10 days	Thu 4/30/20	Wed 5/13/20	337	Marketing Operations
341			Develop Work Plan / Schedule	0%	8 days	Thu 4/30/20	Mon 5/11/20	337	Marketing Operations
342			Develop and complete Project Documents	0%	7 days	Thu 4/30/20	Fri 5/8/20	337	Marketing Operations
343			Submit for State Approval	0%	1 day	Mon 5/11/20	Mon 5/11/20		
344			**EXECUTION**	**0%**	**167 days**	**Thu 4/30/20**	**Fri 12/18/20**		**Marketing Operations**
345			Obtain Plan Information	0%	27 days	Thu 4/30/20	Fri 6/5/20		Marketing Operations
346			**Welcome Enrollment Packet Materials-review for compliance**	**0%**	**105 days**	**Mon 5/11/20**	**Fri 10/2/20**		**Marketing Operations**
347			Welcome Letter -State Compliance Review	0%	30 days	Mon 5/11/20	Fri 6/19/20	342	Marketing Operations
348			Welcome Notice --State Compliance Review	0%	30 days	Mon 5/11/20	Fri 6/19/20	342	Marketing Operations
349			Nondiscrimitative Notice - -State Compliance Review	0%	30 days	Mon 5/11/20	Fri 6/19/20	342	Marketing Operations
350			Transition of Care Form and Return Envelope (if needed)	0%	30 days	Mon 5/11/20	Fri 6/19/20	342	Marketing Operations
351			Determine Envelope needed for Welcome Pa	0%	30 days	Mon 5/11/20	Fri 6/19/20	342	Marketing Operations
352			Send to State for Approval	0%	45 days	Mon 6/22/20	Fri 8/21/20		Marketing Operations
353			MILESTONE: State APPROVAL OF WELCOME ENROLLMENT PACKET	0%	0 days	Fri 8/21/20	Fri 8/21/20	352	Marketing Operations

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
354			Updated Welcome Packet to Translation	0%	15 days	Mon 8/24/20	Fri 9/11/20	352	Marketing Operations
355			Updated Welcome Packet to Print Procureme	0%	15 days	Mon 9/14/20	Fri 10/2/20	354	Marketing Operations
356			**ID Cards - if necessary**	**0%**	**70 days**	**Mon 6/8/20**	**Fri 9/11/20**		**Marketing Operations**
357			Update ID Cards	0%	66 days	Mon 6/8/20	Mon 9/7/20	345	Marketing Operations
358			Update ID Card Carrier Letters	0%	70 days	Mon 6/8/20	Fri 9/11/20	345	Marketing Operations
359			ID Card Mailing Envelope	0%	50 days	Mon 6/8/20	Fri 8/14/20	345	Marketing Operations
360			**Provider Directory**	**0%**	**75 days**	**Mon 9/7/20**	**Fri 12/18/20**		**Marketing Operations**
361			Complete Provider Directory	0%	45 days	Mon 9/7/20	Fri 11/6/20		Marketing Operations
362			Sent to State for Approval	0%	30 days	Mon 11/9/20	Fri 12/18/20	361	Marketing Operations
363			MILESTONE: State APPROVAL OF PROVIDER DIRECTORY	0%	0 days	Fri 12/18/20	Fri 12/18/20	362	Marketing Operations
364			**Provider Manual**	**0%**	**20 days**	**Tue 9/1/20**	**Mon 9/28/20**		**Marketing Operations**
365			Complete Branding	0%	5 days	Tue 9/1/20	Mon 9/7/20		Marketing Operations
366			Send to Translation	0%	15 days	Tue 9/8/20	Mon 9/28/20	365	Marketing Operations
367			**Member Handbook**	**0%**	**50 days**	**Mon 9/21/20**	**Fri 11/27/20**		**Marketing Operations**
368			Complete Branding and design	0%	5 days	Mon 9/21/20	Fri 9/25/20		Marketing Operations
369			MILESTONE: Obtain State Approval	0%	30 days	Mon 9/28/20	Fri 11/6/20	368	Marketing Operations
370			Send to Translation	0%	15 days	Mon 11/9/20	Fri 11/27/20	369	Marketing Operations
371			**Website**	**0%**	**125 days**	**Mon 6/8/20**	**Fri 11/27/20**		**Marketing Operations**
372			Update Website Content	0%	45 days	Mon 6/8/20	Fri 8/7/20	345	Marketing Operations
373			Update Basic Site Map	0%	45 days	Mon 6/8/20	Fri 8/7/20	345	Marketing Operations
374			MILESTONE: WEBSITE CONTENT CREATED	0%	0 days	Fri 8/7/20	Fri 8/7/20	372	Marketing Operations
375			Send to Compliance for Approval	0%	5 days	Mon 8/10/20	Fri 8/14/20	374	Marketing Operations
376			Send to State for Approval	0%	30 days	Mon 8/17/20	Fri 9/25/20	375	Marketing Operations
377			Send to Website Development	0%	45 days	Mon 9/28/20	Fri 11/27/20	376	Marketing Operations
378			**Medical Management (CM, UM)**	**0%**	**177 days**	**Thu 4/30/20**	**Fri 1/1/21**		**Medical Management**
379			**Identify requirements, documents & reports**	**0%**	**30 days**	**Thu 4/30/20**	**Wed 6/10/20**		**Medical Management**
380			Licensure requirements	0%	10 days	Thu 4/30/20	Wed 5/13/20		Medical Management
381			Credentialing requirements	0%	10 days	Thu 5/14/20	Wed 5/27/20	380	Medical Management
382			Carved Out Vendor Services	0%	10 days	Thu 5/28/20	Wed 6/10/20	381	Medical Management
383			Medical Mgmt. Kickoff Conducted	0%	10 days	Thu 6/11/20	Wed 6/24/20	382	Medical Management
384			**Phone service requirements**	**0%**	**10 days**	**Thu 5/28/20**	**Wed 6/10/20**		**Medical Management**
385			Interactive Voice Response	0%	10 days	Thu 5/28/20	Wed 6/10/20	382SS	Medical Management

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
386			After hours	0%	10 days	Thu 5/28/20	Wed 6/10/20	385SS	Medical Management
387			Crisis/Emergency support	0%	10 days	Thu 5/28/20	Wed 6/10/20	386SS	Medical Management
388			Informed Health Line/Nurse Line	0%	10 days	Thu 5/28/20	Wed 6/10/20	387SS	Medical Management
389			Documents - Letters, Policies, Procedures, Desktops	0%	60 days	Thu 5/28/20	Wed 8/19/20	388SS	Medical Management
390			Reports and Queries	0%	60 days	Thu 5/28/20	Wed 8/19/20	389SS	Medical Management
391			**Application Assessments**	**0%**	**90 days**	**Thu 6/25/20**	**Wed 10/28/20**		**Medical Management**
392			Complete System Requirements Assessment	0%	90 days	Thu 6/25/20	Wed 10/28/20	383	Medical Management
393			**Review & update required documents**	**0%**	**35 days**	**Thu 8/20/20**	**Wed 10/7/20**		**Medical Management**
394			**Letters**	**0%**	**35 days**	**Thu 8/20/20**	**Wed 10/7/20**		**Medical Management**
395			Submit for internal approval	0%	5 days	Thu 8/20/20	Wed 8/26/20	389	Medical Management
396			State submission for approval	0%	30 days	Thu 8/27/20	Wed 10/7/20	395	Medical Management
397			Submit to IT for upload	0%	10 days	Thu 8/27/20	Wed 9/9/20	396SS	Medical Management
398			**Desktops/Job Aids**	**0%**	**5 days**	**Thu 8/20/20**	**Wed 8/26/20**		**Medical Management**
399			Submit for internal approval	0%	5 days	Thu 8/20/20	Wed 8/26/20	389	Medical Management
400			**Policies/Procedures**	**0%**	**35 days**	**Thu 8/20/20**	**Wed 10/7/20**		**Medical Management**
401			Submit for internal approval	0%	5 days	Thu 8/20/20	Wed 8/26/20	389	Medical Management
402			State submission for approval	0%	30 days	Thu 8/27/20	Wed 10/7/20	401	Medical Management
403			**Program Descriptions**	**0%**	**35 days**	**Thu 8/20/20**	**Wed 10/7/20**		**Medical Management**
404			Submit for internal approval	0%	5 days	Thu 8/20/20	Wed 8/26/20	389	Medical Management
405			State submission for approval	0%	30 days	Thu 8/27/20	Wed 10/7/20	404	Medical Management
406			**Review MM Sections**	**0%**	**10 days**	**Thu 8/20/20**	**Wed 9/2/20**		**Medical Management**
407			Provider Manual updates	0%	10 days	Thu 8/20/20	Wed 9/2/20	389	Medical Management
408			Member Handbook updates	0%	10 days	Thu 8/20/20	Wed 9/2/20	389	Medical Management
409			**Validate Application Functionality**	**0%**	**10 days**	**Thu 10/29/20**	**Wed 11/11/20**		**Medical Management**
410			**Phone Services**	**0%**	**5 days**	**Thu 10/29/20**	**Wed 11/4/20**		**Medical Management**
411			Interactive Voice Response	0%	5 days	Thu 10/29/20	Wed 11/4/20	392	Medical Management
412			After hours	0%	5 days	Thu 10/29/20	Wed 11/4/20	392	Medical Management
413			Crisis/Emergency support	0%	5 days	Thu 10/29/20	Wed 11/4/20	392	Medical Management
414			Informed Health Line/Nurse Line	0%	5 days	Thu 10/29/20	Wed 11/4/20	392	Medical Management
415			**Health Plan Web Site**	**0%**	**10 days**	**Thu 10/29/20**	**Wed 11/11/20**		**Medical Management**
416			Med Mgmt. guidelines, forms, key documents for website submitted	0%	10 days	Thu 10/29/20	Wed 11/11/20	392	Medical Management

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
417			Med Mgmt. documentation on Health Plan web site validated	0%	10 days	Thu 10/29/20	Wed 11/11/20	392	Medical Management
418			**Utilization Management**	**0%**	**46 days**	**Wed 10/28/20**	**Wed 12/30/20**		**Medical Management**
419			Review and approval health plan benefits	0%	30 days	Thu 10/29/20	Wed 12/9/20	392	Medical Management
420			Obtain State approval of Clinical Policy Bulletins (CPB)	0%	30 days	Wed 10/28/20	Tue 12/8/20		
421			Review standard prior auth requirements - obtain Health Plan/Implementation Team	0%	30 days	Thu 10/29/20	Wed 12/9/20	392	Medical Management
422			Review non-covered codes (no rates) and determine codes that will require default	0%	15 days	Thu 12/10/20	Wed 12/30/20	421	Medical Management
423			**Case/Care Management**	**0%**	**30 days**	**Thu 10/29/20**	**Wed 12/9/20**		**Medical Management**
424			Disease and case management programs documented (policies/Dynamo)	0%	30 days	Thu 10/29/20	Wed 12/9/20	392	Medical Management
425			ICM Requirements documented (policies/Dynam	0%	30 days	Thu 10/29/20	Wed 12/9/20	392	Medical Management
426			SODH Requirements documented (policies/Dyna	0%	30 days	Thu 10/29/20	Wed 12/9/20	392	Medical Management
427			Health Equity Requirements documented (policies/Dynamo)	0%	30 days	Thu 10/29/20	Wed 12/9/20	426SS	Medical Management
428			**Mental Health Parity**	**0%**	**31 days**	**Thu 10/29/20**	**Thu 12/10/20**		**Medical Management**
429			Training/overview for Implementation team	0%	1 day	Thu 10/29/20	Thu 10/29/20	392	Medical Management
430			Training of health plan management	0%	15 days	Fri 10/30/20	Thu 11/19/20	429	Medical Management
431			Training/information for health plan staff	0%	15 days	Fri 11/20/20	Thu 12/10/20	430	Medical Management
432			**Testing**	**0%**	**100 days**	**Thu 8/6/20**	**Wed 12/23/20**		**Medical Management**
433			Identify applications and testers	0%	10 days	Thu 8/6/20	Wed 8/19/20	392SS+30 da	Medical Management
434			Update UAT scripts/kickoff meeting	0%	30 days	Thu 8/20/20	Wed 9/30/20	433	Medical Management
435			Complete systems UAT	0%	60 days	Thu 10/1/20	Wed 12/23/20	434	Medical Management
436			**Transition of / Coordination of Care**	**0%**	**137 days**	**Thu 6/25/20**	**Fri 1/1/21**		**Medical Management**
437			Determine requirements, file layouts and timelin	0%	90 days	Thu 6/25/20	Wed 10/28/20	383	Medical Management
438			Update COC policies and procedures	0%	20 days	Thu 8/27/20	Wed 9/23/20	437FS-45 da	Medical Management
439			Implement COC (continue into post-go-live work plan)	0%	1 day	Fri 1/1/21	Fri 1/1/21		Medical Management
440			**Member Services**	**0%**	**176 days**	**Thu 4/30/20**	**Thu 12/31/20**		**Member Services**
441			Identify Non-Standard requirements	0%	90 days	Thu 4/30/20	Wed 9/2/20		Member Services
442			**Review/update policies&procedures & job aides**	**0%**	**35 days**	**Thu 6/11/20**	**Wed 7/29/20**		**Member Services**
443			Submit for internal review/approval	0%	5 days	Thu 6/11/20	Wed 6/17/20	441SS+30 da	Member Services

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
444			State submission for approval	0%	30 days	Thu 6/18/20	Wed 7/29/20	443	Member Services
445			**Member Letters**	**0%**	**45 days**	**Thu 6/11/20**	**Wed 8/12/20**		**Member Services**
446			Provider Termination Letters	0%	5 days	Thu 6/11/20	Wed 6/17/20	441SS+30 da	Member Services
447			Member Letters	0%	5 days	Thu 6/18/20	Wed 6/24/20	446SS+5 day	Member Services
448			Submit for internal review/approval	0%	5 days	Thu 6/25/20	Wed 7/1/20	447SS+5 day	Member Services
449			State submission for approval	0%	30 days	Thu 7/2/20	Wed 8/12/20	446,447,448	Member Services
450			Submit for translation	0%	10 days	Thu 7/9/20	Wed 7/22/20	449SS+5 day	Member Services
451			**Member Handbook**	**0%**	**161 days**	**Thu 5/21/20**	**Thu 12/31/20**		**Member Services**
452			Review/update handbook	0%	15 days	Thu 5/21/20	Wed 6/10/20	441SS+15 da	Member Services
453			Submit for internal review/approval	0%	5 days	Thu 6/11/20	Wed 6/17/20	452	Member Services
454			State submission for approval	0%	30 days	Fri 10/16/20	Thu 11/26/20	453	Member Services
455			Submit for translation	0%	10 days	Fri 10/23/20	Thu 11/5/20	454SS+5 day	Member Services
456			Submit to Fulfillment Vendors - Print Procurement/Marketing	0%	5 days	Fri 11/27/20	Thu 12/3/20	454,455	Member Services
457			Begin Mailings	0%	0 days	Thu 12/31/20	Thu 12/31/20	456FS+20 da	Member Services
458			**Welcome Packet Materials**	**0%**	**160 days**	**Thu 5/21/20**	**Thu 12/31/20**		**Member Services**
459			Identify HealthChoice requirements	0%	10 days	Thu 5/21/20	Wed 6/3/20	441SS+15 da	Member Services
460			Work with Marketing to update content	0%	10 days	Thu 6/4/20	Wed 6/17/20	459	Member Services
461			Submit for internal review/approval	0%	5 days	Thu 6/18/20	Wed 6/24/20	460	Member Services
462			State submission for approval	0%	30 days	Thu 6/25/20	Wed 8/5/20	461	Member Services
463			Submit for translation	0%	15 days	Fri 8/21/20	Thu 9/10/20	462	Member Services
464			Submit for printing, assembly, mailing	0%	10 days	Fri 9/11/20	Thu 9/24/20	463	Member Services
465			Mailings begin	0%	0 days	Thu 12/31/20	Thu 12/31/20	464FS+30 da	Member Services
466			**Mailbox and FAX (as needed)**	**0%**	**77 days**	**Mon 9/14/20**	**Tue 12/29/20**		**Member Services**
467			Order New Mailbox and FAX	0%	5 days	Mon 9/14/20	Fri 9/18/20		Member Services
468			Verify mailbox and FAX	0%	30 days	Mon 9/21/20	Fri 10/30/20	467	Member Services
469			Test website "contact us"	0%	5 days	Wed 12/23/20	Tue 12/29/20		Member Services
470			**Call Center Metrics**	**0%**	**110 days**	**Thu 4/30/20**	**Wed 9/30/20**		**Member Services**
471			Determine/Verify Call Center Metrics	0%	10 days	Thu 4/30/20	Wed 5/13/20	441SS	Member Services
472			Obtain approvals	0%	10 days	Thu 5/14/20	Wed 5/27/20	471	Member Services
473			Update required documents	0%	90 days	Thu 5/28/20	Wed 9/30/20	472	Member Services
474			**Enrollment**	**0%**	**25 days**	**Mon 11/2/20**	**Fri 12/4/20**		**Member Services**
475			Determining call center needs during Enrollment	0%	10 days	Mon 11/2/20	Fri 11/13/20	441SS	Member Services

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
476			Determine who will support (new hires/other HP	0%	5 days	Mon 11/16/20	Fri 11/20/20	475	Member Services
477			Update training materials to support Enrollment	0%	10 days	Mon 11/23/20	Fri 12/4/20	476	Member Services
478			**Call Center Staffing**	**0%**	**45 days**	**Thu 6/11/20**	**Wed 8/12/20**		**Member Services**
479			Update staffing plan as required	0%	45 days	Thu 6/11/20	Wed 8/12/20	300	Member Services
480			**Training**	**0%**	**55 days**	**Thu 9/3/20**	**Wed 11/18/20**		**Member Services**
481			Send policies and procedures for training	0%	5 days	Thu 9/3/20	Wed 9/9/20	444SS	Member Services
482			Review materials	0%	10 days	Thu 9/10/20	Wed 9/23/20	481	Member Services
483			Verify training is scheduled	0%	10 days	Thu 9/24/20	Wed 10/7/20	482	Member Services
484			Confirm staff trained and ready for calls	0%	30 days	Thu 10/8/20	Wed 11/18/20	483	Member Services
485			**Network Contracting**	**0%**	**215 days**	**Thu 4/30/20**	**Wed 2/24/21**		**Network Ops**
486			**Pre-Campaign Research & Analysis**	**0%**	**20 days**	**Thu 4/30/20**	**Wed 5/27/20**		**Network Ops**
487			GEO Report Analysis	0%	20 days	Thu 4/30/20	Wed 5/27/20		Network Ops
488			**Business Requirements**	**0%**	**30 days**	**Thu 5/28/20**	**Wed 7/8/20**		**Network Ops**
489			Par & Non-Par Provider Rules	0%	30 days	Thu 5/28/20	Wed 7/8/20	487	Network Ops
490			State Reimbursement Requirements	0%	30 days	Thu 5/28/20	Wed 7/8/20	489SS	Network Ops
491			**Communications**	**0%**	**60 days**	**Thu 5/28/20**	**Wed 8/19/20**		**Network Ops**
492			Obtain Credentialing Requirements (Standard & Non-Standard)	0%	10 days	Thu 5/28/20	Wed 6/10/20	490SS	Network Ops
493			**Communicate Data Element Requirements to N**	**0%**	**10 days**	**Thu 6/11/20**	**Wed 6/24/20**		**Network Ops**
494			Individual Provider Data Requirements Communicated	0%	10 days	Thu 6/11/20	Wed 6/24/20	492	Network Ops
495			Facility/Ancillary Data Requirements Communicated	0%	10 days	Thu 6/11/20	Wed 6/24/20	494SS	Network Ops
496			Non-Standard Provider Data Requirements Communicated	0%	10 days	Thu 6/11/20	Wed 6/24/20	495SS	Network Ops
497			**HPRA Notifications**	**0%**	**30 days**	**Thu 7/9/20**	**Wed 8/19/20**		**Network Ops**
498			HPRA Single Point of Contact Determined	0%	10 days	Thu 7/9/20	Wed 7/22/20	488	Network Ops
499			Communicate HPRA Outbound/Inbound Report Schedule	0%	20 days	Thu 7/23/20	Wed 8/19/20	498	Network Ops
500			**State Provider Files**	**0%**	**26 days**	**Thu 4/30/20**	**Thu 6/4/20**		**Network Ops**
501			Build Provider File Reporting in QuickBase	0%	10 days	Thu 4/30/20	Wed 5/13/20		Network Ops
502			Test Provider Reporting from QuickBase	0%	10 days	Thu 5/14/20	Wed 5/27/20	501	Network Ops
503			QNXT (Attributes & Specialties)	0%	6 days	Thu 5/28/20	Thu 6/4/20	502	Network Ops
504			**Network Contracting Recruitment**	**0%**	**195 days**	**Thu 5/28/20**	**Wed 2/24/21**		**Network Ops**

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
505			Develop target list based on geo access by zone	0%	45 days	Thu 5/28/20	Wed 7/29/20	487	Network Ops
506			Initiate network recruitment	0%	100 days	Thu 7/30/20	Wed 12/16/20	505	Network Ops
507			Contract review and provider load process (network in place 45 days before go-live)	0%	50 days	Thu 12/17/20	Wed 2/24/21	506	Network Ops
508			**Implementation and Processing**	**0%**	**80 days**	**Thu 5/28/20**	**Wed 9/16/20**		**Network Ops**
509			Policies & Procedures/Desktop Updates	0%	45 days	Thu 5/28/20	Wed 7/29/20	503SS	Network Ops
510			Submit for Internal Approval	0%	10 days	Thu 7/30/20	Wed 8/12/20	509	Network Ops
511			Submit for State Approval	0%	25 days	Thu 8/13/20	Wed 9/16/20	510	Network Ops
512			**Delegated National Vendor Contracts**	**0%**	**100 days**	**Thu 7/9/20**	**Wed 11/25/20**		**Network Ops**
513			Obtain copy of executed agreement and/or amendments	0%	90 days	Thu 7/9/20	Wed 11/11/20	488	Network Ops
514			Save copy of executed agreement and/or amendments	0%	10 days	Thu 11/12/20	Wed 11/25/20	513	Network Ops
515			**Load to QNXT/PCRs - as needed for new requireme**	**0%**	**170 days**	**Thu 4/30/20**	**Wed 12/23/20**		**Network Ops**
516			Non Par load upfront	0%	30 days	Thu 4/30/20	Wed 6/10/20		Network Ops
517			Providers confirmed loaded to QNXT	0%	120 days	Thu 6/11/20	Wed 11/25/20	516	Network Ops
518			Provider Data Auditing	0%	120 days	Thu 6/18/20	Wed 12/2/20	516FS+5 day	Network Ops
519			**State Provider files - as needed for new requirements**	**0%**	**50 days**	**Thu 10/15/20**	**Wed 12/23/20**		**Network Ops**
520			Submit Provider file reporting from Quickbase	0%	40 days	Thu 10/15/20	Wed 12/9/20	517FS-30 da	Network Ops
521			Transition Provider File reporting to IT for QNX	0%	10 days	Thu 12/10/20	Wed 12/23/20	520	Network Ops
522			**Provider Directory**	**0%**	**30 days**	**Mon 11/9/20**	**Fri 12/18/20**		**Network Ops**
523			Marketing obtains approval from Implementat	0%	1 day	Mon 11/9/20	Mon 11/9/20	361	Marketing
524			State approval received	0%	30 days	Mon 11/9/20	Fri 12/18/20	361	Marketing
525			Marketing for layout and translation	0%	12 days	Mon 11/9/20	Tue 11/24/20	524SS	Marketing
526			**Pharmacy - verify all components meet new contract requirement**	**0%**	**146 days**	**Thu 6/25/20**	**Thu 1/14/21**		**Pharmacy**
527			Pharmacy Kickoff Conducted	0%	1 day	Thu 6/25/20	Thu 6/25/20	383	Pharmacy
528			Contract pricing determination	0%	20 days	Fri 6/26/20	Thu 7/23/20	527	Pharmacy
529			Benefits requirement definition	0%	30 days	Fri 7/24/20	Thu 9/3/20	528	Pharmacy
530			Formulary/PDL Requirements	0%	35 days	Fri 8/14/20	Thu 10/1/20	529SS+15 da	Pharmacy
531			Utilization Management requirements	0%	45 days	Fri 8/14/20	Thu 10/15/20	530SS	Pharmacy
532			DUR- Drug Utilization Review requirements	0%	60 days	Fri 8/14/20	Thu 11/5/20	531SS	Pharmacy
533			Clinical Programs	0%	60 days	Fri 8/14/20	Thu 11/5/20	532SS	Pharmacy

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
534			Benefits - Design & Development (Code Benefit Plans)	0%	40 days	Fri 8/14/20	Thu 10/8/20	533SS	Pharmacy
535			Benefit pricing profile (BPP) setup	0%	30 days	Fri 10/9/20	Thu 11/19/20	534	Pharmacy
536			Formulary/PDL development	0%	30 days	Fri 10/9/20	Thu 11/19/20	535SS	Pharmacy
537			Utilization Management - clinical edits tracker design & development	0%	30 days	Fri 10/9/20	Thu 11/19/20	536SS	Pharmacy
538			DUR design and development	0%	30 days	Fri 10/9/20	Thu 11/19/20	537SS	Pharmacy
539			Clinical program design and development	0%	30 days	Fri 10/9/20	Thu 11/19/20	538SS	Pharmacy
540			CVS benefits testing	0%	30 days	Fri 10/9/20	Thu 11/19/20	539SS	Pharmacy
541			Formulary validation testing	0%	5 days	Fri 11/20/20	Thu 11/26/20	540	Pharmacy
542			Joint review/testing results sign off	0%	15 days	Fri 11/27/20	Thu 12/17/20	541	Pharmacy
543			Benefits deployment	0%	5 days	Fri 12/18/20	Thu 12/24/20	542	Pharmacy
544			Eligibility Received	0%	1 day	Tue 12/22/20	Tue 12/22/20		Pharmacy
545			Pharmacy Prior Auths	0%	25 days	Fri 11/20/20	Thu 12/24/20	537	Pharmacy
546			**Pharmacy Encounters**	**0%**	**20 days**	**Fri 12/18/20**	**Thu 1/14/21**		**Pharmacy**
547			Encounters testing	0%	10 days	Fri 12/18/20	Thu 12/31/20	542	Pharmacy
548			Paid Claims File	0%	10 days	Fri 1/1/21	Thu 1/14/21	547	Pharmacy
549			**Pharmacy Network**	**0%**	**60 days**	**Thu 9/3/20**	**Wed 11/25/20**		**Pharmacy**
550			Manage network access/GEO & Overlay	0%	60 days	Thu 9/3/20	Wed 11/25/20		Pharmacy
551			**Population Health**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**Pop Health**
552			Determine contract requirements	0%	60 days	Thu 4/30/20	Wed 7/22/20		Pop Health
553			Development and documentation	0%	80 days	Thu 7/23/20	Wed 11/11/20	552	Pop Health
554			Implement Telehealth	0%	110 days	Thu 7/23/20	Wed 12/23/20	552	Pop Health
555			Cultural Competency Policy and Procedures and Training Established	0%	30 days	Thu 9/17/20	Wed 10/28/20	553FS-40 days	Pop Health
556			Deployment and Training	0%	35 days	Thu 11/12/20	Wed 12/30/20	553	Pop Health
557			**Program Integrity**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**SIU**
558			Identify contract requirements and deliverables	0%	60 days	Thu 4/30/20	Wed 7/22/20		SIU
559			Develop and approve policies and procedures	0%	60 days	Thu 7/23/20	Wed 10/14/20	558	SIU
560			State approval of policies and deliverables	0%	25 days	Thu 10/15/20	Wed 11/18/20	559	SIU
561			Staff training (if applicable)	0%	30 days	Thu 11/19/20	Wed 12/30/20	560	SIU
562			**Quality - validate new contract requirements**	**0%**	**130 days**	**Thu 6/25/20**	**Wed 12/23/20**		**Quality**
563			**Quality Management**	**0%**	**130 days**	**Thu 6/25/20**	**Wed 12/23/20**		**Quality**
564			Establish committee structure	0%	30 days	Thu 6/25/20	Wed 8/5/20	383	Quality

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
565			Establish vendor oversite	0%	40 days	Thu 8/6/20	Wed 9/30/20	564	Quality
566			Setup EPSDT communications	0%	60 days	Thu 8/6/20	Wed 10/28/20	565SS	Quality
567			Setup HEDIS processes	0%	60 days	Thu 8/6/20	Wed 10/28/20	566SS	Quality
568			Delegation audits completed, deficiencies logged/tracked - reported to Credentialing	0%	45 days	Thu 8/6/20	Wed 10/7/20	567SS	Quality
569			PPE (Provider Preventable Events) 3M	0%	60 days	Thu 10/1/20	Wed 12/23/20	565	Quality
570			**Real Estate & Telcom - for new contract elements**	**0%**	**165 days**	**Thu 4/30/20**	**Wed 12/16/20**		**Real Estate**
571			**Main & Regional Offices- Equipment/furniture che**	**0%**	**30 days**	**Thu 4/30/20**	**Wed 6/10/20**		**Real Estate**
572			Leadership approval/METAL & Lease renewed	0%	30 days	Thu 4/30/20	Wed 6/10/20		Real Estate
573			Punchlist/final clean	0%	30 days	Thu 4/30/20	Wed 6/10/20		Real Estate
574			**800 Number Active (ACD) for CareConnector Progr**	**0%**	**115 days**	**Thu 4/30/20**	**Wed 10/7/20**		**Real Estate**
575			Obtain secure toll free number	0%	10 days	Thu 4/30/20	Wed 5/13/20		Real Estate
576			Design, program, record active call distribution	0%	30 days	Thu 5/14/20	Wed 6/24/20	575	Real Estate
577			Call tree programmed, reviewed/approved	0%	30 days	Thu 6/25/20	Wed 8/5/20	576	Real Estate
578			Test active call distribution	0%	30 days	Thu 8/6/20	Wed 9/16/20	577	Real Estate
579			Go live with calls	0%	0 days	Wed 10/7/20	Wed 10/7/20	578FS+15 da	Real Estate
580			**Call Recording**	**0%**	**35 days**	**Thu 6/25/20**	**Wed 8/12/20**		**Real Estate**
581			Infrastructure analysis & obtain approvals	0%	10 days	Thu 6/25/20	Wed 7/8/20	576	Real Estate
582			Build call recording infrastructure	0%	20 days	Thu 7/9/20	Wed 8/5/20	581	Real Estate
583			Build accounts	0%	5 days	Thu 8/6/20	Wed 8/12/20	582	Real Estate
584			**Hardware**	**0%**	**110 days**	**Thu 4/30/20**	**Wed 9/30/20**		**Real Estate**
585			Define hardware and configuration requirements	0%	20 days	Thu 4/30/20	Wed 5/27/20		Real Estate
586			Order laptops and equipment	0%	60 days	Thu 5/28/20	Wed 8/19/20	585	Real Estate
587			System access requests	0%	30 days	Thu 8/20/20	Wed 9/30/20	586	Real Estate
588			**Health Plan Training**	**0%**	**90 days**	**Thu 8/13/20**	**Wed 12/16/20**		**Real Estate**
589			Update training/job aids	0%	10 days	Thu 8/13/20	Wed 8/26/20	583	Real Estate
590			Schedule phone/ACD Training	0%	40 days	Thu 8/27/20	Wed 10/21/20	589	Real Estate
591			Train New Health Plan Staff & Admin	0%	40 days	Thu 10/22/20	Wed 12/16/20	590	Real Estate
592			**User Acceptance New State Requirements Testing- if needed**	**0%**	**50 days**	**Thu 10/15/20**	**Wed 12/23/20**		**Testing**
593			Finalize Testing Requirements	0%	5 days	Thu 10/15/20	Wed 10/21/20		Testing
594			Claims	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	Claims
595			Encounters	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	MPST

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
596			Finance	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	MPST
597			Ancillary Files	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	Claims
598			Dynamo	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	Claims
599			Appeals & Grievances	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	IT
600			Clinical	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	MM
601			Enrollment/ID Cards	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	Enrollment
602			Vendor Eligibility Files	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	Infrastructure
603			Digital	0%	45 days	Thu 10/22/20	Wed 12/23/20	593	Marketing - Digital
604			**Value Added Benefits**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**Health Plan Owners**
605			Value Added Benefits Kickoff Conducted	0%	30 days	Thu 4/30/20	Wed 6/10/20		Health Plan Owners
606			Finalize Value Adds	0%	60 days	Thu 6/11/20	Wed 9/2/20	605	Health Plan Owners
607			Determine Delegated Entities (if applicable)	0%	30 days	Thu 9/3/20	Wed 10/14/20	606	Health Plan Owners
608			Procedures and Job Aids	0%	45 days	Thu 10/15/20	Wed 12/16/20	607	Health Plan Owners
609			Staff Training	0%	10 days	Thu 12/17/20	Wed 12/30/20	608	Health Plan Owners
610			**Vendor / Subcontractor Management**	**0%**	**205 days**	**Thu 5/14/20**	**Wed 2/24/21**		**HP Vendor Manager**
611			Vendor Kickoffs Conducted	0%	15 days	Thu 5/14/20	Wed 6/3/20	264	HP Vendor Manager
612			Develop business requirement and delegation chart	0%	45 days	Thu 6/4/20	Wed 8/5/20	611	HP Vendor Manager
613			Identify vendors and subcontractors (Standard)	0%	55 days	Thu 6/4/20	Wed 8/19/20	611	HP Vendor Manager
614			**Subcontractor Plan**	**0%**	**45 days**	**Thu 8/20/20**	**Wed 10/21/20**		**HP Vendor Manager**
615			Contracts/Amendments executed for vendors	0%	15 days	Thu 8/20/20	Wed 9/9/20	613	HP Vendor Manager
616			Approval of subcontractor / vendors by State	0%	30 days	Thu 9/10/20	Wed 10/21/20	615	HP Vendor Manager
617			Operation and Process Development (Functional Ar	0%	60 days	Thu 9/10/20	Wed 12/2/20	615	HP Vendor Manager
618			Systems Initiation, Validation and Testing	0%	75 days	Thu 9/10/20	Wed 12/23/20	615	HP Vendor Manager
619			Post Implementation (Validation)	0%	45 days	Thu 12/24/20	Wed 2/24/21	618	HP Vendor Manager
620			**Unique Contractual (and Proposal) Requirements/Deliverables Execution**	**0%**	**120 days**	**Wed 7/1/20**	**Tue 12/15/20**		**Health Plan Owners**
621			Finalize CVS initiatives and programs	0%	120 days	Wed 7/1/20	Tue 12/15/20		Health Plan Owners
622			Develop requirements list for all unique deliverable	0%	120 days	Wed 7/1/20	Tue 12/15/20		Health Plan Owners
623			**Deploy Implementation**	**0%**	**20 days**	**Mon 12/7/20**	**Fri 1/1/21**		**MSI - Implementation**
624			**Printed Materials**	**0%**	**1 day**	**Mon 12/21/20**	**Mon 12/21/20**		**Enrollment**
625			Confirm all member materials ready for distribution	0%	1 day	Mon 12/21/20	Mon 12/21/20		Enrollment
626			**Go Live Preparations**	**0%**	**20 days**	**Mon 12/7/20**	**Fri 1/1/21**		**MSI - Implementation**

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
627			Document Transition (Including Policies) to Health Plan HUB Site Completed	0%	20 days	Mon 12/7/20	Fri 1/1/21		MSI- Implementation
628			Go-Live Checklist Support identified/posted	0%	5 days	Tue 12/15/20	Mon 12/21/20		MSI- Implementation
629			Pre-Go-Live Punch List finalized/approved	0%	4 days	Tue 12/22/20	Fri 12/25/20	628	MSI- Implementation
630			Command Center Scheduled/Initiated	0%	1 day	Mon 12/28/20	Mon 12/28/20	629	MSI- Implementation
631			Post Go-Live Issue log opened	0%	1 day	Tue 12/29/20	Tue 12/29/20	630	MSI- Implementation
632			Pharmacy Command Center Scheduled/Initiated	0%	1 day	Wed 12/30/20	Wed 12/30/20	631	Pharmacy
633			Go Live	0%	1 day	Fri 1/1/21	Fri 1/1/21	632	MSI- Implementation
634			--Go to Post Implementation Work Plan for transition to operations	0%	1 day	Fri 1/1/21	Fri 1/1/21		MSI- Implementation

Attachment V

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Attachment V
G.2 – Corporate Experience

Resumes.....Att V-3

Proposed Training Program and Curriculum.....Att V-53

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Resumes

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Dawn E. Price, MBA, PMP

Project Manager

Dawn Price, a native Kentuckian who grew up in the Bowling Green area, attended Western Kentucky University where she received her Master of Business Administration and Bachelor of Science in Human Resource Management. She will serve as the interim project manager for the Kentucky SKY program. Dawn has over 14 years of health care industry experience in program and project management and 8 years of managed Medicaid experience. She is currently serving as a business development manager in Aetna's Medicaid organization. Dawn has extensive experience leading large-scale, fast-paced projects for Medicaid and Medicare as well as pharmacy/pharmacy benefit management implementations. Prior to joining Aetna, she worked as a senior project manager for CareSource, Ohio's largest managed Medicaid provider. Dawn furthered her professional skillset by obtaining her Project Management Professional (PMP) certification in 2011.

Experience

Aetna Medicaid Organization 2016 – Present

Manager, Business Development/Interim Project Manager

- Successfully manages extensive, large-scale projects for the Aetna Medicaid organization's Business Development division
- Aligns business development initiatives with the appropriate cross-functional teams
- Applies various project management tools and methodologies to effectively deliver on multiple projects with compressed implementation timelines
- Provides strategic support of business development senior directors and Business Development team
- Ensures full collaboration with subject matter experts throughout the enterprise by including key resources from community and local market, Aetna Foundation, State Government Affairs, Corporate Communications, Public and Labor, local market heads, field marketing, and enterprise intel
- Builds strong relationships with stakeholders, business owners, and executives by providing quality deliverables

CareSource Ohio 2012 – 2016

Senior Project Manager

- Managed Medicaid, Medicare, and ACA projects for CareSource's Business Development and Implementations division
- Applied various project management tools and methodologies and managed implementation timelines
- Captured project risks, issues, and decisions and communicates the information as appropriate
- Worked closely with C-suite and Executive Leadership team on project initiatives

RightSourceRx/Humana 2012 – 2012

Project Manager, Pharmacy Operations

- Oversaw a new pharmacy claims adjudication system in conjunction with the vendor
- Worked cross-functionally to ensure all impacted areas were kept informed of the system changes, tests, outcomes, and issues
- Assisted in the development and coordination of new processes and quality improvement initiatives
- Developed and assisted with implementation of optimized schedules for all areas of pharmacy operations

Dawn E. Price, MBA, PMP

WellPoint Anthem 2005 – 2012

- As a business change manager, worked extensively within the Medicare segment to develop ACO relationships to support organizational goals
- Held a variety of professional positions supporting the WellPoint PBM (NextRx) until the division was purchased by Express Scripts in 2010
    - Upon position elimination in April 2010, was hired back as a project consultant for WellPoint to oversee the technical migration from Anthem's pharmacy claims adjudication system to Express Script's system
    - As a program manager, was responsible for the full spectrum of retail pharmacy client relationships, including chains, PSAOs, and independent pharmacies
    - Was the senior human resources manager for WellPoint's pharmacy, which consisted of over 1,000 individuals in both exempt and non-exempt roles

Business Change Manager – Medicare 2011 – 2012
Contract Project Manager (Assigned to WellPoint NextRx) 2010 – 2011

Program Manager – WellPoint NextRx (PBM) 2007 – 2010
Sr. Human Resources Manager 2005 – 2007

Education

- PMP Certification, 2011 (current status)
- Master of Business Administration, Western Kentucky University, 2004
- Bachelor of Science in Human Resource Management, Western Kentucky University, 1991

Licensures and Certifications

Project Management Professional Certification, 2019

Kelly Gannon, MSW, MBA

Executive Director, SKY Program

Kelly Gannon is an experienced executive leader in behavioral health with more than 30 years of community mental health and nonprofit experience. Her expertise includes strategic planning and implementation, process improvement and creating strategic partnerships to achieve results. In her role as executive director of the SKY Program for Aetna Better Health of Kentucky, Kelly will be responsible for directing and overseeing implementation of SKY and successfully managing all aspects of ongoing program operations. Her vast experience and proven record with outcome based clinical programming places her in a great position for setting the bar for healthier kids and families in Kentucky. Kelly has experience with operational oversight of key programs that intersect with DCBS, such as Children's Review Program, while serving as Director of Clinical Health Services at Bluegrass MH-MR Board. More importantly, Kelly has firsthand understanding navigating the foster care system as her five year old daughter was adopted out of Kentucky's foster care system. This personal experience provided her with a keen sense of appreciation for the challenges families and children face while navigating the system.

Prior to joining Aetna, Kelly served as chief operating officer for Centerstone, the largest community mental health center in Kentucky, where she oversaw a $100 million operations budget for a seven-county region. She effectively identified client trends and areas for service growth, while working with community stakeholders to address social determinants of health.

Her educational background includes Bachelor and Master degrees in Social Work as well as a Master in Business Administration. Currently, she is a Doctoral Candidate in the College of Social Work at the University of Southern California focusing on social innovation for complex problems.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2019 – Present
Director of Clinical Health Services

- Effectively manages care management services for over 200,000 members across Kentucky
- Creates and negotiates value-based contracts with providers
- Identifies innovative solutions for business growth and better health outcomes
- Develop strategic goals and plans for a future vision
- Works effectively with government agencies to deliver great health plan care to members

Centerstone 2011 – 2019
Chief Operating Officer (COO)

- Effectively managed a $100 Million operations budget for a 7-county region
- Proactively identified issues and develops risk management plans
- Directed and managed a multitude of projects with sense of urgency for change
- Created and negotiated value-based contracting with managed care organizations
- Identified market trends and areas for business growth and improvement
- Drove business growth with the development of new and expanding service lines
- Partnered with executive team and community stakeholders to execute key initiatives including city-wide suicide prevention program for non-profit and for-profit business sectors

Kelly Gannon, MSW, MBA

New Vista, formerly Bluegrass MH-MR Board 2001 – 2011

Director of Clinical Services (2007 – 2011)

- Responsible for financial performance of all diverse service lines across a 17 county region
- Provided Strategic Clinical direction and future vision
- Developed and Implemented key strategic goals including opening of a utilization management unit for the start of Managed Care
- Provided leadership in implementation of evidence-based practices, and oversight of Joint Commission accreditation and regulatory compliance

Service Area Manager/Program Director (2001 – 2007)

- Responsible for the quality of clinical care for two county service area with clinical interventions for substance use and mental illness.
- Directed and provided consultation to program directors on issues of clinical care, program management, personnel supervision, and strategic planning
- Responsible for financial performance

Fellow, North Staffordshire Combined Healthcare Trust, Stoke-on-Trent, England (2005)

- Selected from over 1,000 employees to participate in a work exchange in England
- Worked collaboratively with CEO of National Health Service to exchange best practices for individuals with chronic mental illness, substance use disorder and developmental disabilities
- Served as a research assistant in a qualitative study on opiate addiction
- Served as team lead on several committees designed to market and expand programming

Education

- Doctorate in Social Work, Key Focus: Social innovation, University of Southern California, Expected December 2020
- Master of Business Administration, University of Louisville, Louisville, Kentucky, 2016
- Master of Social Work, University of Kentucky, Lexington, Kentucky, December 1994
- Bachelor of Social Work, University of Kentucky, Lexington, Kentucky, December 1991

Susan Vickers, MSW, CSW

Chief of Staff and Director of Stakeholder Engagement and Education

Susan Vickers is an experienced quality improvement specialist with 18 years of health care industry experience and 5 years of managed Medicaid experience. Susan is a leader of successful training programs and program implementation for health care entities and focuses on ensuring program excellence through evaluation and assessment of program operations. Her expertise includes extensive work in the quality, leadership, and hospice arenas. Her educational background includes a Master of Social Work and Graduate Certificate in Gerontology from the University of Kentucky School of Social Work and a Bachelor of Science in Psychology from Centre College. Prior to joining Aetna, Susan served as a Hospice and Palliative Care Social Worker for St. Anthony's Hospice in Hendersonville, Kentucky.

Experience

Aetna Better Health of Kentucky 2019 – Present
Behavioral Health Education Director

- Implements QAPI programs and policies
- Builds and maintains relationships with providers, facilities, plan sponsors, and regulatory agencies
- Acts as a business partner in network development
- Works closely with community partners such as the foster care system and juvenile justice system
- Applies evidence-based practices such as trauma-informed care
- Represents quality and continuous improvement on various committees

St. Anthony's Hospice 2018 – 2019
Hospice and Palliative Care Social Worker

- Provided social work and case management services to caseload of community-based palliative care patients, in-home hospice patients, and inpatient hospice patients as part of an interdisciplinary team
- Served as quality and clinical services consultant on organization's leadership team
- Developed and administered the organization's new palliative care program
- Created policies and procedures for the organization
- Provided compliance oversight and quality outcomes tracking and reporting
- Developed relationships with local long-term care facilities to initiate palliative consult partnerships

Hugh Edward Sandefur Training Center 2015 – 2018
Basic Assurance Director

- Developed, implemented, and enhanced day program with focus on individualized planning to meet each person's needs
- Ensured compliance with Medicaid regulations
- Drove organizational quality improvement and training initiatives

Henderson Leadership Initiative 2013 – 2017
Executive Director

- Responsible for overall strategic and operational responsibility of programs, expansion, and execution of the program's mission
- Ensured ongoing programmatic excellence and program evaluation targeted at potential, existing, and former HLI class members
- Conducted day-to-day finance and administration functions
- Assisted founders and directors with fundraising and grant writing

Susan Vickers, MSW, CSW

- Refined all aspects of communication both within and outside of HLI's network
- Leveraged existing relationships to garner new opportunities for programming, recruitment of new classes, and fellows' engagement
- Mentored and developed HLI class members

University of Southern Indiana 2013 – 2015
Adjunct Instructor in College of Nursing and Health Professions

- Developed Death, Dying, and Grief course for the Gerontology department
- Instructed students in the Gerontology department

St. Anthony's Hospice 2007 – 2013
Director of Quality

- Developed programs that raised the standards and operations of care
- Established and maintain the organization's first quality assessment and performance improvement program
- Expanded the bereavement program
- Created the clinical processes related to the implementation of an electronic medical records system
- Created policies and procedures for the organization
- Managed the clinical leadership team
- Provided compliance oversight and quality outcomes tracking and reporting

University of Kentucky 2003 – 2004
Resource Counselor for the Sanders Brown Center on Aging, Elder Care Program

- Provided assessment, counseling, referrals and information to UK employees, retirees, and their spouses
- Responsible for recording and maintenance of program's extensive database and resource library
- Promoted and facilitated educational seminars and caregiver support groups on campus

Hospice of the Bluegrass 2002 – 2003
Team Social Worker

- Served as a participant on the interdisciplinary team
- Provided social work services to hospice patients

Education

- Master of Social Work, University of Kentucky School of Social Work, 2002
- Bachelor of Science in Psychology, Centre College, 2000

Licensures and Certifications

- Licensed Clinical Social Worker
- Graduate Certificate in Gerontology from the University of Kentucky School of Social Work, 2002

Andrea D. Bennett, PhD, MSW

Local Senior Advisor to the Executive Director

Andrea Bennett is a seasoned policy specialist with over 10 years of experience working on public policy issues with a focus on health and child well-being. Her expertise includes policy development and implmentation, advocacy, coalition building, and Medicaid program design. Andrea spent several years working at Kentucky Youth Advocates as the chief external affairs officer. During this time, she oversaw coalition building, strategic communications, and policy development related to issues impacting children and families in Kentucky, including economic security, health, child safety, and youth justice. She collaborated with private, nonprofit, and state agencies on policy solutions that created better outcomes for children across the state. She led two statewide coalition efforts to improve outcomes for children, including the Blueprint for Kentucky's Children and the Kosair Charities Face It® Movement to end child abuse. Prior to joining Aetna, Andrea served as the Director of the Medicaid Evidence-based Decisions Project at the Center for Evidence-based Policy. In that role, she led a network of 20 Medicaid agencies across the country on issues related to Medicaid program structure and benefit design, waiver planning, pharmacy, and value-based payments. Andrea holds a PhD in Education and Social Change from Bellarmine University and a Master of Social Work from Saint Louis University.

Experience

Aetna Better Health of Kentucky 2019 – Present

Senior Advisor to the Executive Director/Senior Director, Public Policy

- Serves in a public policy leadership role focusing on state and federal Medicaid issues
- Collaborates with multiple Medicaid departments across the business on policy development to support plans and growth
- Assists in policy product development and research to advance Aetna's goals and priorities of advancing better health

Center for Evidence-based Policy 2017 – 2018

Director, Medicaid Evidence-based Decisions Project

- Led network of 20 Medicaid agencies in the Medicaid Evidence-based Decisions project, including responding to state public policy needs and project management
- Provided technical assistance to Medicaid agencies implementing health care policy changes such as payment and practice reforms, including strategic consulting, community and stakeholder engagement, and organizational change planning
- Provided health policy trainings to state legislative and executive branch policymakers
- Engaged in partnerships with national organizations such as the National Governors Association, Medicaid and CHIP Payment and Access Commission, National Conference of State Legislatures, and Milbank Memorial Fund on important public policy issues and trends impacting state Medicaid agencies and other health care payers
- Facilitated discussions with the Centers for Medicare & Medicaid Services and state Medicaid agencies on issues related to high cost drugs, waivers, state plan amendments, and coverage criteria policies

Andrea D. Bennett, PhD, MSW

Kentucky Youth Advocates 2009 – 2017
Chief External Affairs Officer

- Led a coalition of over 100 diverse partners on a multi-year campaign to improve child well-being in Kentucky, including child welfare system reform with the executive, legislative, and judicial branches of government
- Provided policy research and analysis on issues related to child welfare, including child abuse substantiation protocols, kinship care, foster care, and family preservation via the creation of fact sheets, issue briefs, bill summaries, and infographics
- Led the Kosair Charities Face It® Movement to end child abuse with more than 30 nonprofit, government, and business partners to stop child maltreatment across Kentucky

Education

- Doctor of Philosophy in Education and Social Change, 2017
- Master of Social Work, Saint Louis University, 2009
- Bachelor of Science, John Brown University, 2007

Josh Boynton, MS

National Senior Advisor to the Executive Director

Josh Boynton is a highly accomplished and goal-driven executive with more than 20 years of behavioral health care industry leadership experience and 7 years of managed Medicaid experience. His expertise includes managing business change processes and strategic planning. Josh serves as the current segment lead for strategy and implementation of WV Mountain Health Promise (sole source Child Welfare/Foster Care contract awarded to Aetna Better Health of West Virginia in 2019). He is a successful entrepreneur who founded LifeShare, a nationally recognized, multi-million-dollar company that supports people with intellectual disabilities. In his role as executive director/vice president for Aetna Better Living, Josh is responsible for segment strategy, business growth, and development of the complex care intellectual and developmental disabilities (IDD), child welfare/foster care, and managed long-term services and supports (MLTSS) segments. Prior to joining Aetna, Josh served as the managing director for VERTESS, where he consulted with large managed care organizations to develop complex care strategic framework and build national products. His educational background includes a Master of Science in Management and Leadership from New England College and a Bachelor of Science in Psychology with a concentration in Clinical Psychology from Keene State College. In 2009, Josh was named by *Business NH Magazine* as one of 25 leaders to watch in the next 25 years and was appointed by Governor Lynch as a Commissioner for the NH Commission for Human Rights. Josh was appointed by Governor Craig Benson to serve on the NH Developmental Disability Council and appointed by Governor Jeanne Shaheen to serve on the Statewide Independent Living Council and served as the chairperson for 4 years. Josh was named to the 40 under 40 Class of 2007 and was also awarded the Keene State College Alumni Inspiration Award. He has served in various advisory/leadership positions in the disability and child welfare community.

Experience

Aetna Better Health of Kentucky 2018 – Present
Vice President, Aetna Better Living

- Serves as the current segment lead for strategy and implementation of WV Mountain Health Promise (sole source Child Welfare/Foster Care contract awarded to Aetna Better Health of WV in 2019).
- Serves in a strategic leadership role that facilitates business growth and development for the Aetna Medicaid segment, specifically complex care IDD, child welfare/foster care, and MLTSS
- Collaborates with various Medicaid officials and other leaders to support existing and new health plans including the development, implementation, support, and promotion of health care strategies, policies, and programs to establish a sustainable competitive business advantage for the Aetna Medicaid organization
- Participates in product development and national stakeholder engagement through thought leadership

VERTESS 2016 – 2018
Managing Director

- Represented multi-million-dollar health care companies in M&A transactions
- Conducted market research and analysis
- Consulted with large managed care organizations to develop complex care strategic framework and build national products using scalable operating platforms

Josh Boynton, MS

- Consulted nationally with health care providers (including child welfare organizations) to build value-based solutions and develop growth strategies and overall managed care business acumen support
- Development of a proprietary enterprise platform to support M&A related to IDD, MLTSS, and child welfare/foster care verticals

Centene Corporation 2014 – 2016
Chief Executive Officer (CEO), LifeShare

Served as president and CEO during the integration of the firm and was later awarded with the role of Chairman Emeritus.

LifeShare Management Group, LLC 2018 – Present
Founder/CEO

- Established, developed, and led a high-performing, multi-payer, multi-million-dollar, multi-product organization; expanded the enterprise into ten states with a large and diverse workforce
- Transformative development of bold 'go-to-market,' person-centered, whole-person, community-based solutions in the human services and health care sector
- Introduced, implemented, and managed fully integrated and scalable value-based managed care solutions and opportunities based on IDD, child welfare/foster care/DJJ, serious mental illness, and MLTSS
- Served as highly visible and a resourceful community leader. Operated within the larger Medicaid and human service industry to create collaborations that benefit the greater good while advancing the organization's mission and goals. Highly effective at forming advantageous partnerships for all stakeholders. Participated in multiple non-profit boards and advisory groups throughout the country.
- Identified, analyzed, and interpreted emerging trends, competitive market position, and available opportunities so that specific strategic investments could be planned with an emphasis on prioritization and resource allocation
- Led the LifeShare Senior Leadership team and other key stakeholders to shape and guide the evolution, development, and execution of the organization's strategic plan for 20 highly successful years

Education

- Master of Science in Health Care Management and Leadership, New England College , 2005
- Bachelor of Science in Psychology with a concentration in Clinical Psychology, Keene State College, 1996

Stephanie A. Whyte, MD, MBA, CHQCM, CHIE

SKY Medical Director

Dr. Stephanie Whyte joined Aetna Better Health of Kentucky as a Medical Director in November 2018 and holds a Kentucky medical license. She has been with Aetna Better Health since March 2015. While at Aetna, she has participated in the Health Care Equity Committee and National Pharmacy and Therapeutics Committee as well as serving as the Interim Chief Medical Officer for the Illinois plan. Additionally, Dr. Whyte has served as a brand ambassador by representing Aetna Medicaid on the National Quality Forum's Medicaid CHIP (MAC) Scorecard Committee in 2019.

Prior to joining Aetna, Dr. Whyte was the first ever Chief Health Officer for the Chicago Public Schools (CPS)—the third-largest school district in the nation. She established a new office to focus on student health and wellness policy and programming, with an emphasis on removing barriers to learning. During her tenure, CPS became the first large urban school district to put undesignated epinephrine auto-injectors in each school for emergency use, and as a result, saved 70 lives! Before CPS, Dr. Whyte served as the Medical Director of Mobile C.A.R.E. Foundation, where she spent over a decade caring for children with asthma in Chicago's most underserved neighborhoods.

Dr. Whyte is a board-certified pediatrician. She received her bachelors' degree in biology from Illinois Wesleyan University, her MD from the Chicago Medical School, and completed her Pediatric residency at Louisiana State University Medical Center in New Orleans. She also holds a MBA in Public and Nonprofit Management from Saint Xavier University; is a certified health care insurance executive; and board certified in Health Care and Quality Management. Dr. Whyte has been honored with the "Distinguished Alumnus Award" from both the Chicago Medical School (2013) and Illinois Wesleyan University (2015). Dr. Whyte is a published author, lecturer, media spokesperson, and has served on various local, regional and national advisory boards.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2019 – Present

Deputy Chief Medical Officer with Aetna Better Health of Kentucky (2019 – Present)
Medical Director with Aetna Better Health of Kentucky (2018 – 2019)

- Development of strategic approaches to optimize company performance
  - Identification and analysis of medical cost drivers and trends
  - Evaluation of provider network for enhancement and expansion
  - Direct clinical aspects of value-based solutions opportunities
- Management of Health Services Team
  - Oversight of medical directors, nurse case and utilization review managers, and non-clinical staff – 7 direct reports and approximately 160 FTE supervised
  - Lead quality improvement projects and collaborate with quality team
- Clinical liaison to Department of Medicaid Services
  - Represent health plan in State meetings and special projects

Aetna Better Health of Illinois, Chicago, Illinois 2015 – 2018

Interim Chief Medical Officer (2017 – 2018)
Medical Director (2015 – 2017)

- Lead strategic activities to drive performance of markets and quality of patient care.
- Participate in program planning, total quality management, and external relations.

Stephanie A. Whyte, MD, MBA, CHQCM, CHIE

- Focus on Medicaid managed care lines of business (TANF/ACA, MMAI, ICP, LTSS, MLTSS).
- Develop, implement, support, and promote strategies for utilization management,
- quality management, network management, and clinical coverage & policies to drive
- delivery of quality of care.
- Oversee utilization review/quality assurance, directing case management.
- Provide clinical expertise and business direction in support of medical management programs
- through participation in clinical team activities.
- Liaise with network providers and facilities to support effective execution of medical
- service programs by clinical teams.
- Member, Aetna Medicare-Medicaid National Pharmacy & Therapeutics Committee.
- Served as Chairperson for HEDIS child health quality team, lead for neonatal abstinence
- syndrome program, and member of the national health care equity group.

Chicago Public Schools, Chicago. IL 2012 – 2015
Chief Health Officer

- Selected as inaugural Chief Health Officer, overseeing critical student health and wellness programming within CPS, while collaborating with Chicago Department of Public Health (CDPH) on the city's first public health agenda - Healthy Chicago.
- Implemented life-saving epinephrine auto-injectors in all schools to prevent fatal allergic reactions (first large urban school district in the nation), and wellness policies to set standards for nutrition education and physical activity.
- Introduced new sexual health education policy that promotes age-appropriate health and safety decision-making, as well as a new physical education (PE) policy to ensure that all students receive high-quality PE on a daily basis.
- Secured $10MM in multi-year Federal & Local funds to support student health and wellness.

Education

- AHIP – Certified Healthcare Insurance Executive, Kellogg Executive Education, Northwestern University, 2017
- Master of Business Administration, Saint Xavier University, 2009
- General Pediatrics Residency Training, Louisiana State University Medical Center, 1999
- Doctor of Medicine, The Chicago Medical School, Finch University of Health Services, 1996
- Bachelor of Arts, Illinois Wesleyan University, 1991

Licensures and Certifications

- American Board of Pediatrics, Diplomat 1999 to Present
- State of Illinois Licensed Physician 1999 to Present

Sandra D. Wendt, MA, CPHQ

SKY Quality Improvement Director

Sandra Wendt is an innovative and versatile leader with over 20 years of health care industry experience and more than 5 years of managed Medicaid experience. Her expertise includes managing large-scale teams and projects, building and executing strategies collaborating with all operational areas, and reengineering business processes. In her role as quality improvement director for Aetna, Sandra is responsible for developing and implementing the Quality Assessment and Performance Improvement (QAPI) programs and policies in addition to running the department's operations. Prior to joining Aetna, Sandra served as the director of quality management for Magellan Health Services where she coordinated and supervised activities that promoted continuous quality improvement and monitored the agency's compliance. Her educational background includes a Master of Education in Elementary Education from the University of Phoenix and a Bachelor of Social Work from Arizona State University.

Experience

Aetna Better Health 2018 – Present

Quality Improvement Director/Vice President of Quality Management

- Develops and implements QAPI programs and policies
- Enhances relationships with providers, facilities, plan sponsors, and regulatory agencies
- Acts as a key business partner in network development, product design, and strategic planning
- Continuously assesses the effectiveness of functional processes to lead progressive improvement initiatives applying principles of process excellence
- Teaches, coaches, and mentors employees at all levels in quality and continuous improvement
- Works closely with community partners such as the foster care system and juvenile justice system
- Applies evidence-based practices such as trauma-informed care
- Represents quality and continuous improvement with the executive team

Aetna Better Health 2014 – 2018

Quality Management Administrator

- Developed and managed clinical operations focused on improving clinical and financial outcomes, member engagement, and satisfaction
- Served as liaison with regulatory and accrediting agencies and other health business units
- Formulated and implemented strategies for achieving applicable department/unit metrics and provide operational direction
- Served as technical, professional, and business resource (may cross multiple business functions)
- Developed and participated in presentations and consultations to existing and prospective customers
- Directed/provided enhancements to business processes, policies, and infrastructure to improve operational efficiency (may cross multiple business functions)
- Participated in internal and external health industry development efforts
- Developed, implemented, and evaluated policies and procedures, which met business needs
- Implemented and monitored business plan and oversaw implementations/business transitions that impacted service operations
- Collaborated and partnered with areas across/within regions or segments and to ensure all workflow processes and interdependencies were identified and addressed

Sandra Wendt, MA, CPHQ

Magellan Health Services 2009 – 2014
Director of Quality Management

- Coordinated and supervised activities that ensured the agency's provision of quality services, promoted continuous quality improvement, and monitored the agency's compliance with all applicable quality management requirements
- Promoted improvement in the quality of care provided to members through established quality management and performance improvement processes, including the analysis and synthesis of medical record review data, outcomes data, provider dashboards, and quality of care investigations
- Developed, implemented, communicated, and maintained a quality management program description consistent with all ADHS/DBHS and AHCCCS requirements
- Actively collaborated with system stakeholders and contracted providers to identify and address sub-standard performance by utilizing proven quality improvement techniques
- Ensured 100% compliance with ADHS/DBHS annual administrative review quality management standards over the past two years
- Applied a root-cause analysis in collaboration with contracted providers to identify and implement targeted improvement actions to improve coordination of physical and behavioral health care performance measures required under the AHCCCS and ADHS/DBHS contract
- Developed and implemented a comprehensive provider-monitoring program to ensure timely access to covered services and appropriateness of care for vulnerable populations, including children with serious emotional disturbance and adults with serious mental illness (SMI)

Magellan Health Services 2008 – 2009
Regional Director

- Provided clinical, administrative, and financial oversight to six outpatient psychiatric direct care clinics serving persons with SMI in the eastern region of Maricopa County
- Acted as the responsible party for the clinical outcomes of approximately 3,500 adults diagnosed with SMI
- Ensured that services were provided in accordance with evidence-based and promising practices
- Oversaw approximately 450 staff comprised of multiple disciplines
- Ensured compliance with all regulatory agencies: ADHS, AHCCCS, ADHS/Office of Behavioral Health Licensure, and the Superior Court of Arizona, Office of the Court Monitor

Education

- Master of Education in Elementary Education, University of Phoenix, 2004
- Bachelor of Social Work, Arizona State University, 1994

Licensures and Certifications

Certified Professional in Healthcare Quality (CPHQ), 2016

Cathy Jones, MSW, LCSW

SKY Behavioral Health Director

Cathy Jones is a longtime Kentucky resident and experienced behavioral health management professional with 17 years of health care industry experience and 12 years of managed Medicaid experience. Her expertise includes leadership roles in the utilization management, behavioral health, and social work arenas. She has forged several relationships in the Kentucky community as it relates to appropriate therapeutic care for clients and available programs for those in need. In her role as a behavioral health director for Aetna, Cathy leads and supports the Behavioral Health staff and works with upper management to develop the strategic direction of the department. She also oversees the utilization management of behavioral health services, assisting in the resolution of presenting issues and reducing risk factors. Prior to joining Aetna, Cathy served as a behavioral health case manager for Coventry Health Care. Her educational background includes a Master of Social Work and a Bachelor of Science in Psychology, both from University of Louisville. Cathy is also a licensed clinical social worker.

Experience

Aetna Better Health of Kentucky 2018 – Present
Behavioral Health Director

- Accountable for meeting the financial, operational, and quality objectives of the unit
- Works closely with functional area managers to ensure consistency in clinical interventions
- Communicates strategic plan and specific tactics to meet plan
- Identifies opportunities to implement best practice approaches and introduce innovations to better improve outcomes
- Participates in the recruitment and hiring process for staff
- Assesses developmental needs and collaborates with others to identify and implement action plans that support the development of high-performing teams
- Evaluates and interprets data and identifies areas of improvement

Aetna Better Health of Kentucky 2012 – 2018
Behavioral Health Utilization Management Supervisor

- Provided daily oversight and direction to Behavioral Health staff
- Provided direction, leadership, and support to staff
- Monitored and evaluated utilization management clinicians' performance, efficiency, and productivity according to quality management standards
- Assisted senior management with operations planning and monitoring by recommending and implementing changes that would improve or enhance the delivery of service
- Recruited, developed, and motivated staff
- Assisted with quality improvement and utilization improvement activities as required

Coventry Health Care 2011 – 2012
Behavioral Health Case Manager

- Provided case management services including pre-certification and concurrent review to assigned cases
- Evaluated acuity for medical necessity and made appropriate utilization determination
- Provided triage and assessment of members or others acting on members' behalf who requested non-routine behavioral health care

Cathy Jones, MSW, LCSW

- Utilized medical necessity criteria when performing reviews and referred to peer reviewer when criteria was not met
- Provided clinical review of requests for services through the Impact Plus Program

SHPS 2008 – 2011
Clinical Reviewer

- Responsible for delivering the utilization management process which included assessing, planning, implementing, and coordinating clinical recommendations regarding medical necessity
- Responsible for overseeing clinical services provided by home care vendors or sub-acute facilities
- Conducted ongoing assessment of cases and made plan modifications to achieve patient goals and improve outcomes
- Utilized clinical experience and judgment when determining medical necessity and quality
- Monitored daily workflow queues and performed necessary calls to ensure completion of reviews
- Assisted with development and implementation of medical review criteria and products

Seven Counties Services, Inc. 2006 – 2008
Unit Manager

- Supervised and directed both clinical and administrative personnel, including scheduling and coordinating activities, conducting performance reviews, providing training, etc.
- Participated and/or led a variety of meetings, including treatment planning, case review, committee meetings, and departmental meetings
- Planned and implemented unit programming, including identifying and addressing trends, addressing problematic issues with existing programs, developing new programs and services, and assisting with division planning
- Monitored fiscal performance and effectiveness of unit and maintained related documentation
- Interviewed and hired new staff and handled personnel issues and grievances
- Provided community education and public relations support for unit's clinical programs to EAPs, other agencies, referral sources, and local communities
- Provided clinical services as a principal therapist

Education

- Master of Science in Social Work, University of Louisville, Kent School of Social Work, 2002
- Bachelor of Science in Psychology, University of Louisville, 1997

Licensures and Certifications

Licensed Clinical Social Worker (LCSW) – (License #2042)

Amy Schuten, MA, LISAC

SKY Utilization Management Director

Amy Schuten is an experienced behavioral health professional with 20 years of behavioral health care industry experience and 10 years of managed Medicaid experience. She is a leader of successful teams, initiatives, and operations that have served Medicaid populations in several states. Amy has focused most of her work on leading and implementing behavioral health programs focused on quality and cost-effective care. In her role as a utilization management director for behavioral health for Aetna, Amy oversees utilization management programs focused on the behavioral health needs of members with serious mental illness, children in foster care and juvenile justice, and members with developmental disabilities. Prior to joining Aetna, Amy served as the director of clinical services for Magellan Health Services. Her educational background includes a Master of Arts in Clinical Psychology from the Illinois School of Professional Psychology, Argosy, and a Bachelor of Science in Psychology from the University of Illinois.

Experience

Aetna Medicaid Organization 2016 – Present
Director of Behavioral Health Utilization Management

- Responsible for oversight and implementation monitoring and evaluation of the behavioral health management program on an annual basis. The program manages multiple lines of business including adults with serious mental illness, children and adults with general mental health challenges, long-term care services, and children in state custody; strategically develops process to meet all plan goals, and implements strategies based on actual performance and assessment of risk of non-compliance to requirements.
- Institutes process improvements in managing retrospective and claim review processing based on participation in risk assessment of program
- Works with Data Analytics to develop reporting that improves the team's ability to manage workflow and identifies high-risk processes to drive member- and program-level intervention
- Organizes and manages operational review where the Medical Management team was awarded a 95% compliance rating from contractor improvement from previous reviews
- Responsible for departmental policies and procedures, including development of new policies and annual review of existing policies; behavioral health subject matter expert in the developed merged polices for the Arizona Complete Care implementation

Magellan Health Services, Presbyterian Centennial Care 2013 – 2015
Director of Clinical Services

- Developed and implemented the Presbyterian Health Plan's Centennial Care program as senior leader of Behavioral Health Clinical department, which served over 200,000 members statewide. Centennial Care is the New Mexico Medicaid plan to integrate behavioral and physical health and long-term care services from each awarded health plan.
- Implemented best practices in the Utilization Management department and the Care Coordination department, including care plan development, discharge planning, standardized review, and assessment and identification of members with behavioral health risks
- Obtained renewal of National Committee for Quality Assurance accreditation for both new utilization management and complex case management programs

Amy Schuten, MA, LISAC

- Participated with Behavioral Health Service Division of the State of New Mexico on initiatives, including the implementation of the ABA model of care and the revision of the level of care guidelines for behavioral health services

Magellan Health Services, State of Louisiana Medicaid Program 2012 –2013
Adult System Administrator

- Worked with community providers to understand and implement the Medicaid managed care system for behavioral health services
- Collaborated with the State of Louisiana's permanent supportive housing program and state behavioral health department to develop a program intended to align service funding from a grant to sustainable Medicaid reimbursement to 3,300 households that participated in the housing program
- Participated with community leaders to improve services provided to adults and to have peers support services recognized, allowing them to qualify as providers for Medicaid reimbursement
- Coordinated with the state's birth outcomes initiative to improve the birth rate by establishing a system that streamlined and improved coordination of care

Magellan Health Services, Maricopa County RBHA 2008 – 2012
Supervisor Adult Concurrent Care Management

- Management and supervision of the Utilization Management team in the Arizona Medicaid program
- Implemented activities that increased the coordination of care with outpatient clinics to improve discharge planning that decreased readmission rates and met annual cost of care targets and achieved URAC accreditation
- Designed utilization management process for residential levels of care and implemented a supportive care management program for members with high risk for readmission

Magellan Health Services, ValueOptions, Inc. 2006 – 2008
Outpatient Clinical Director, Alma School Clinic

- Oversight provided to the staff of a clinical that provided case management to 1,300+ clients
- Ensured the clinic's performance met or exceeded target expectations and benchmarks
- Provided strategic and clinical leadership to improve quality and implement best practices in clinical models of community mental health, including 2 assertive community treatment (ACT) teams, 5 supportive treatment teams, and 2 connective treatment teams

Education

- Master of Arts in Clinical Psychology, Illinois School of Professional Psychology, Argosy, 1997
- Bachelor of Science in Psychology, University of Illinois, 1993

Licensures and Certifications

Licensed Independent Substance Abuse Counselor (#10975) – Arizona

Kim Schuetze, RN, ACSW, CCM

SKY Care Management Director

Kim Schuetze is a Registered Nurse and Certified Social Worker (CSW) with more than 30 years of experience developing and implementing best practice approaches and introducing innovations to better improve outcomes. In her role as Director of Care Management for the SKY program with Aetna Better Health of Kentucky, Kim is responsible for supervising care management services for the Kentuckians in the Foster Care program. She ensures the best practice approaches are utilized to promote better health outcomes. Prior to joining Aetna, Kim provided direct patient care in a clinical inpatient facility and, as a Social worker, provided support and care coordination in an outpatient setting. She ensured evidenced based practices were used and implemented process improvements related to safety and discharge planning. Her educational background includes a Bachelor and master's degree in Social Work and her associate degree for Registered Nurse. Additionally, Kim is a member of the Academy of Certified Social Workers through NASW and is a Certified Case Manager through the Commission for Case Management Certification.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2011 – Present

Director of Clinical Case Management (2020 – Present)

- Accountable for meeting the financial, operational, and quality objectives of the unit
- Works closely with functional area managers to ensure consistency in clinical interventions
- Communicates strategic plan and specific tactics to meet plan
- Identifies opportunities to implement best practice approaches and introduce innovations to better improve outcomes
- Participates in the recruitment and hiring process for staff
- Assesses developmental needs and collaborates with others to identify and implement action plans that support the development of high performing teams
- Evaluates and interprets data and identifies areas of improvement
- Works effectively with government agencies to deliver great health plan care to members

Manager, Clinical Health Services (2018 – 2019)

- Supervise the following Care Management Teams: Integrated Care Management, CPESN Collaborative Initiative, Collaborative CM program with Community provider partners (KY One, KPCA, Kidz Club).
- Complete monthly audits of staff and member files
- Manage state inquiries to ensure timely and comprehensive issue resolution,
- Improved the CM process with increased outcomes in productivity.
- Prepare and present CM files for NCQA and state IPRO audits and state studies
- Lead interdisciplinary treatment team rounds to discuss and problem solve complex cases
- Conduct educational staff trainings on various behavioral health topics
- Participate in Social Determinants of Health and Adverse Childhood Experiences Workgroups
- Participate in interdepartmental teams to develop Population Health strategies and programs

Supervisor, Clinical Health Services (2016 – 2018)

- Supervise the following Care Management Teams: Management Associates, ER CM, Integrated CM, and Hepatitis CM.
- Complete monthly audits of staff and member files

Kim Schuetze, RN, ACSW, CCM

- Increased the efficiencies for CMA outreach.
- Prepare and present CM files for NCQA and state IPRO audits and state studies
- Completed ABX Yellow Belt Training
- Lead interdisciplinary treatment team rounds to discuss and problem solve complex cases
- Conduct educational staff trainings on various health topics

Nurse Educator Care Management (2013 – 2016)

- New Employee Training and Mentoring program
- Prepare and present CM files for NCQA and state IPRO audits and state studies
- Coordination and training for migration to new operating platforms
- Complete monthly audits of staff and member files
- Motivational Interviewing Champion: training on MI Skills for CM staff
- Implemented Relias Behavioral Health Training for health plan.

Complex Case Manager, (2011 – 2013)

- Successfully case managed and maintained a full case load
- Advocated for member needs by initiating Single Case Agreements
- Provided ongoing Care Management support and Crisis Management
- Collaboration with Medical Directors member advocacy.
- Presented and participated in Interdisciplinary case rounds.

Jewish Hospital and St Mary's Healthcare 2009 – 2011

Registered Nurse (2009 – 2011)

- Responsible for direct patient care on a 42-bed unit.
- Primary RN with usual daily caseload of 6-7 patients: diagnoses include CHF, COPD, DM, ESRD, tracheostomy care, abdominal pain +/or surgery, pneumonia, UTI, SBO, sepsis, pancreatitis, colon resection (open and laparoscopic), feeding tube placement, kidney stone, MRSA, VRE.

Floyd Memorial Home Health 2006 – 2011

Medial Social Worker (2006 – 2011)

- Responsible for providing assessment and service delivery to patients with identified bio-psychosocial home care needs in six counties in southern Indiana.
- Additional responsibilities included staff education and Quality Review Committee member.

Education

- Associate Degree, Registered Nursing, Jefferson Community and Technical College, 2009
- Master of Science Social Work, University of Louisville, 1983
- Bachelor of Social Work, University of Wisconsin, 1981

Licensures and Certifications

- Registered Nurse, Commonwealth of Kentucky; License Number: 1121902
- Licensed Social Worker, Commonwealth of Kentucky; CSW License Number: KY 1237
- Academy of Certified Social Workers, 1986 to present
- The Commission for Case Manager Certification, 2003 to present
  - Chair, 2006 - 2007; Chair Elect, 2005; Treasurer, 2004
  - Outside Committee Member (Programs and Services; Governance and Nominations, Case Manager Body of Knowledge), 2008 to present
  - Participant in development of CCM test preparation, 2008 to present
  - Certification 360 Workshop Facilitator, 2017 through present

Kelsey Isaacs, LCSW

SKY Behavioral Health Clinician

Kelsey Isaacs is a solid behavioral health specialist with more than five years of health care industry experience and five years of Medicaid experience. Her expertise includes instructional leadership, clinical case management, and strategic insights in the behavioral health and social work arena. She has forged several relationships in the Kentucky community as it relates to juveniles and their behavioral care. In her role as a behavioral health clinical case manager for the foster care population, Kelsey acts as a liaison between Aetna and the foster care recipients and their caregivers. Her responsibilities include but are not limited to managing behavioral health admissions and discharges, assisting in the resolution of presenting issues, reducing risk factors, and collaborating with DCBS caseworkers and community partners. Prior to joining Aetna, Kelsey served as a behavioral therapist for Somerset Mental Health, PSC, and is currently an adjunct instructor of social work for Campbellsville University. Her educational background includes a Master of Social Work and a Bachelor of Science in Social Work, both from Campbellsville University. Kelsey is also a licensed clinical social worker.

Experience

Aetna Better Health of Kentucky 2019 – Present
Behavioral Health Clinician

- Manages behavioral health admissions and discharges for children currently in or have been adopted from foster care and assists in resolution of presenting issues within the framework of medication adherence, treatment planning, medical necessities, and access to appropriate levels of care
- Applies clinical judgement and strategies that reduce risk factors and address complex clinical indicators that impact care planning and member issue resolution while collaborating with DCBS caseworkers
- Attends and engages in trainings and meetings in an effort to remain informed about evidence-based practices, changes in policies, and availability of effective resources
- Collaborates with DCBS caseworkers, community partners, regional DCBS staff, and others to provide comprehensive and services and resources and meet the needs of the foster care recipients both physically and mentally

Campbellsville University 2017 – Present
Adjunct Instructor

- Provides educational instruction to students to increase academic performance and understanding of social work ethics and principles
- Maintains CSWE standards to provide optimal education to students
- Manages assignments, discussion board posts, and completion of field hours for students
- Facilitates meetings with students and administration to build positive relationships and foster positive personal learning experiences
- Meets with administration to remain aware of policy and teaching updates

Kelsey Isaacs, LCSW

Somerset Mental Health, PSC 2015 – 2019
Behavioral Therapist

- Counseled children, adolescents, and adults in individual and family therapy and administered the most proper therapeutic approaches based on the individual's and family's needs
- Customized resources for families based on collaborated identified needs
- Conceptualized treatment plans in collaboration with individuals and their families
- Identified symptoms and established long-term and short-term goals to resolve negative symptoms and increase positive behavior
- Managed individual's progression toward creation and review of treatment goals through treatment planning
- Consulted in group settings to ensure proper service delivery for specified needs
- Utilized various interventions and therapies based on diagnoses and needs of the clients
- Collaborated with external agencies and resources to meet the needs of clients and families
- Completed continuing education and trainings to remain informed on most effective treatment procedures, evidence-based practice interventions, and strategies

Somerset Mental Health, PSC 2014 – 2015
Administrative Assistant

- Answered telephones and communicated with clients and agencies regarding appointments, referral information, addressed needs, supplied information, and communicated messages
- Assisted with the contracting of providers with insurance companies and managed their participation with insurance companies and CAQH
- Maintained client appointments and arranged agency meetings
- Communicated with employees in the office to clarify information and inform them of new updates regarding client care

Administrative Office of the Courts 2013 – 2014
Teen Court Coordinator

- Supervised training sessions and led youths to conduct mock court trials
- Prepared a swearing-in ceremony for the youths and their families to recognize their accomplishments
- Organized meetings with youths and their families who were receiving services
- Appointed youths to fill positions within the court system

Education

- Master of Social Work, Campbellsville University, 2014
- Bachelor of Science in Social Work, Campbellsville University, 2013

Licensures and Certifications

Licensed Clinical Social Worker (License #253127)

Shantoria Gonya, MS

SKY Behavioral Health Specialist

Shantoria Gonya is an experienced behavioral health specialist with eight years of health care industry experience and five years of managed Medicaid experience. Her expertise includes extensive work in both the behavioral health and social work arenas. In her role as a behavioral health specialist for Aetna, Shantoria creates and implements outreach strategies and serves as an advocate for members by creating a bridge between Aetna, community programs, and social services. Prior to joining Aetna, Shantoria served as a lead teacher for KinderCare Learning Center. Her educational background includes a Master of Science in Human Services specializing in Leadership and Organizational Management from Capella University (that she anticipates receiving in December 2019) and a Bachelor of Science in Human Development and Family Studies Specializing in Adolescent and Youth Development from the University of Alabama at Tuscaloosa.

Experience

Aetna Better Health of Kentucky 2015 –Present

Care Management Coordinator – Homeless Initiative

- Aids in obtaining essential support services for members such as food stamps, housing, and health services
- Serves as an advocate for members by creating a bridge between them, community programs, and social services
- Provides basic health education to members
- Conducts health risks assessments and meets with family members to understand the needs of members
- Creates and implements outreach strategies to ensure the success of the program
- Oversees and coordinates donations for basic need items for the homeless population
- Determines type and availability of resources needed to meet the individual needs of members
- Provides materials for members to inform them of the time, place, and type of services being made available to them

Care Management Associate – Foster Care

- Functioned as a foster care point of contact for state liaisons
- Operated multiple systems/programs at once
- Assisted nurses and social workers with coordination of care for members
- Communicated effectively with members, providers, and stakeholders
- Responsible for meeting minutes, referrals, mailings, and outreach

KinderCare Learning Center 2013 –2015

Lead Teacher

- Created age-appropriate lesson plans and implemented them in a classroom setting
- Provided a nurturing and safe environment
- Attended professional development trainings to enhance performance
- Conducted parent-teacher conferences and student evaluations
- Planned and executed family-friendly events

Shantoria Gonya, MS

Uspiritus 2014 – 2014
Youth Worker 1

- Performed crisis management and prevention
- Planned and conducted therapeutic activities
- Provided a safe environment for adolescent with behavioral health issues

NeuroRestorative 2013 – 2013
Life Skills Trainer

Assisted participants of all ages suffering from brain and spinal cord injuries with activities of daily living, social skills, and community outreach.

University of Alabama, W.O.W. Program 2013 – 2013
Care Worker/Safety

- Mentored and educated female juvenile delinquents in preparations for their return into society
- Developed and taught life skill activities
- Employed de-escalation and crisis intervention and safety planning

Youth Villages 2012
Behavioral Youth Counselor

- Taught necessary life skills and provided for physical daily care
- Participated in recreation therapy with children
- Assisted with treatment planning for each child
- Improved children's behaviors through teaching coping skills and therapeutic interventions

Education

- Master of Science in Human Services Specializing in Leadership and Organizational Management, Capella University, anticipated graduation date: December 2019
- Bachelor of Science in Human Development and Family Studies Specializing in Adolescent and Youth Development, University of Alabama at Tuscaloosa, 2012

Erneshia Pinder, MS

Family/Youth Peer Support Specialist

Erneshia Pinder is an energetic and inspirational professional with 14 years of health care industry experience and 4 years of managed Medicaid experience. Her expertise includes building partnerships to promote recovery and wellness and advocating for service environments that are supportive and welcoming for members. In her role as the administrator of the Office of Individual and Family Affairs for Aetna, Erneshia is responsible for managing the departmental staff and promoting the development and use of member and family support programs. Prior to joining the Aetna Medicaid organization, Erneshia served as the program manager for health for Aetna International, where she organized and directed day-to-day activities leading to the launch of virtual primary care hubs in the Middle East and Southeast Asia. Her educational background includes a Master of Science in Healthcare Administration and a Bachelor of Science in Legal Studies, both from the University of Maryland, University College.

Experience

Aetna Medicaid Organization 2019 – Present

Family/Youth Peer Support Specialist/Administrator, Office of Individual and Family Affairs

- Builds partnerships with individuals, families, youth, and key stakeholders to promote recovery, resiliency, and wellness, and communicates to identify concerns and remove barriers to service
- Establishes structure and mechanisms to increase the member, family, and community voice in areas of leadership, service delivery, and system administration
- Advocates for service environments that are supportive, welcoming, and recovery-oriented by working with providers to implement trauma-informed care service delivery approaches and other initiatives
- Promotes the development and use of member and family support programs
- Collaborates with AHCCCS and Office of Individual and Family Affairs as well as other vested state, local, and community stakeholders
- Facilitates and participates in internal and external trainings to educate Mercy Care staff, behavioral health providers, physical health providers, and community members on recovery-oriented systems of care
- Chairs Member Advocacy Committee, ensuring coverage and action on key issues
- Manages all staff in the Individual and Family Affairs department, ensuring adherence to company policies and procedures

Aetna International 2017 – 2019

Program Manager, vHealth

- Planned, organized, and directed day-to-day activities leading to the launch of virtual primary care hubs in the Middle East and Southeast Asia. Activities included managing cross-functional, global teams and deliverables related to real estate, international regulatory compliance, data and privacy, human resources and staffing, and marketing and branding.
- Served as a business product owner leading development, testing, and roll-out of patient management system using agile methodologies
- Engaged local market leadership, sales, and account management to develop go-to market strategic roll-out plans
- Developed policies and procedures
- Managed relationships

Erneshia Pinder, MS

Aetna Behavioral Health 2015 – 2017
Senior Strategic Planner

- Responsible for the development and execution of strategies and specified outcome measures in support of business priorities
- Ensured alignment of business strategies with overall enterprise strategies
- Worked collaboratively with senior leadership and teams to ensure successful achievement of strategic goals and led quarterly strategic meetings with senior leadership
- Monitored and reported on performance relative to plan
- Led external thought leadership initiatives in support of ABH's collaborative partnership with Give-an-Hour/Campaign to Change Direction and Harvard's T.H. Chan School of Public Health
- Mentored high performing/high potential staff in support of talent development strategy
- Facilitated ABH leadership roundtable discussions with BH managers and supervisors

Aetna, Inc. 2013 – 2014
Enterprise Leadership and Development Program, Associate

- First Rotation – Aetna Pharmacy Management (Hartford, CT): Led process improvement project related to vendor contract management, member experience improvement, and pharmacy culture change advocacy
- Second Rotation – Aetna Behavioral Health (Phoenix, AZ): Led project to develop an implementation blueprint for behavioral health components of Medicaid plans and partnered with community leaders to promote behavioral health awareness
- Third Rotation – Aetna Service Operations (Harrisburg, PA): Led operations project for business conversion activities, process improvement related to Customer Service Operations team member engagement, service operations site culture advocacy, and promoting volunteerism within the site
- Fourth Rotation – Aetna Foundation (Hartford, CT): Supported the development of digital health and agri-based national philanthropic activities to improve health outcomes of targeted populations/communities

Maritain Health, Inc. 2006 – 2012
Regional Director

- Led team responsible for production of client contract agreements and procurement and maintenance of TPA, business entity, and PBM licensing
- Single point of contact/subject matter expert for state regulatory affairs issues, licensing, and client contract negotiations
- Worked directly with clients, brokers, and attorneys to successfully resolve contract issues
- Established contracting process across company and subsidiaries/affiliates to promote consistency and uniformity; developed best practices for contract intake, tracking, drafting, and revision
- Developed regulatory tracking system to monitor changes impactful to company's licenses

Education

- Master of Science in Healthcare Administration, University of Maryland, University College, 2012
- Bachelor of Science in Legal Studies, University of Maryland, University College, 2004

Anna Mauzey, MA, LPCC

Prior Authorization/Pre-certification Coordinator

Anna Mauzey is an experienced behavioral health and clinical specialist with nine years of health care industry experience and seven years of Medicaid managed care experience. Her expertise includes utilization management and strategic insights in the behavioral health and social work arena. She is a mental health professional who strives to improve the mental, physical, and emotional well-being and overall quality of life for members. In her role as a prior authorization/pre-certification coordinator, Anna leads the Behavioral Health Clinical staff at Aetna as they facilitate their duties, which include but are not limited to managing behavioral health admissions and discharges, coordinating prior authorizations and pre-certifications, and assisting in the resolution of presenting issues. Prior to joining Aetna, Anna served as a senior therapist for Seven Counties Services, Incorporated. Her educational background includes a master's degree in education with a mental health concentration from the University of Louisville, where she was recognized as "Outstanding Mental Health Counseling Graduate Student." She also has a bachelor's degree in psychology from Indiana University Southeast, where she was a member of the Psi Chi Honor Society and on the Dean's List. Anna is also a licensed professional clinical counselor.

Experience

Aetna Better Health of Kentucky May 2019 – Present
Prior Authorization/Pre-Certification Coordinator

- Works closely with management and the medical director to ensure that the department is running smoothly and that standards of service are achieved
- Supports the Behavioral Health Clinical staff by addressing their needs
- Manages minor provider issues and refers these issues to Provider Relations when necessary
- Onboards and trains new hires and preside over staff meetings
- Coaches and supports Behavioral Health Clinical staff to deliver continuous improvement on an individual basis—as part of a team delivering the highest standards of service
- Completes case assignments, staffs cases, audits cases and denial letters, monitors phone queue, runs behavioral health rounds, reviews denied cases, completes daily census tracker, enters appeals decisions in the behavioral health system, and reviews after-hour cases and production reports

Aetna Better Health of Kentucky 2013 – 2019
Behavioral Health Utilization Management Clinical Consultant

- Developed, implemented, supported, and promoted behavioral health services strategies, tactics, policies, and programs that drive the delivery of quality health care to establish competitive business advantage for Aetna
- Utilized clinical skills to coordinate, document, and communicate all aspects of the behavioral health utilization/benefit management program
- Applied critical thinking and knowledge to clinically appropriate treatment, evidence-based care, and medical necessity criteria for appropriate utilization of services
- Consulted and lent expertise to internal and external constituents in the coordination and administration of the behavioral health utilization/benefit management function
- Gathered clinical information and applied the appropriate medical necessity criteria/guideline, policy, procedure, and clinical judgment to render coverage determination/recommendation/discharge planning along the continuum of care

Anna Mauzey, MA, LPCC

- Utilized clinical experience and skills in a collaborative process to evaluate and facilitate appropriate behavioral health care services/benefits for members including urgent or emergent interventions (such as triage/crisis support)
- Coordinated/communicated with providers and other parties to facilitate optimal care/treatment
- Identified members who may benefit from behavioral health care management programs and facilitates referral

Seven Counties Services, Inc. (school-based) 2011 – 2013
Senior Therapist

- Performed clinical services and therapeutic interventions such as group, individual, and family therapy, and crisis intervention as a licensed professional counselor associate
- Completed and maintained service documentation such as psychosocial assessments, case notes, case reviews, letters, etc., according to prescribed standards
- Conducted case reviews and determined current and future treatment
- Collaborated with external agents including school officials, family members, and other health agencies regarding organizational programs and client needs and conditions
- Attended and participated in staff meetings, treatment planning meetings, case conferences, and clinical seminars, providing information relating to program administration and development
- Wrote correspondence on behalf of clients and their families such as court reports, letters of recommendation, etc., according to prescribed standards

Bridgehaven Mental Health Services 2010
Intern Counselor

- Provided therapeutic services, including individual therapy, group therapy, therapeutic rehabilitation activities, and treatment planning for individuals with severe and persistent mental illness and completed case notes as required by the site
- Participated in meetings and training seminars, including Safe Crisis Management training
- Participated in and presented cases in treatment team meetings with onsite mental health professionals

Archdioceses of Louisville, St. Paul School 2010
Intern Counselor

- Provided therapeutic services, including individual therapy, family therapy, and behavior modification plans for adolescents
- Completed case notes as required by the site
- Collaborated with teachers and administrators as needed

Education

- Master of Education, Mental Health Concentration – University of Louisville, 2010
- Bachelor of Arts, Psychology, Indiana University Southeast, 2008

Licensures and Certifications

Licensed Professional Clinical Counselor (LPCC) – (License #102183)

Dustin Johnson, MS

SKY Provider Relations Liaison

Dustin Johnson is a team-oriented Kentuckian and experienced behavioral health professional with more than 15 years of health care industry experience and a year of managed Medicaid experience. His expertise includes many leadership roles in both the behavioral health and social work arenas. Dustin has focused most of his work on organizational leadership and knows how to develop relationships to improve the outcomes of the members. His years of experience working with children and families in the State of Kentucky make him an asset. In his role as a behavioral health provider relations liaison for Aetna, Dustin creates a bridge between Aetna, the behavioral health providers, and the enrollees. He serves as the point of contact for educating and contracting for the providers as well. Prior to joining Aetna, Dustin served as the Director of Residential Based Services for CHNK Behavioral Health. His educational background includes a Master of Science in Business Communication from Spalding University and a Bachelor of Sociology with a Major in Criminology and a Minor in Social Work from Morehead State University.

Experience

Aetna Better Health of Kentucky 2019 – Present
Behavioral Health Network Manager (Provider Relations Liaison)

- Serves as the primary resource and liaison for assigned community mental health centers and assigned behavioral health providers throughout Kentucky
- Defines contracting options that meet the needs of the local behavioral health provider community and Aetna
- Manages the behavioral health provider recruitment process in Kentucky for Aetna
- Maintains ongoing relationship with behavioral health providers through regular meetings and communications with local behavioral health leadership

CHNK Behavioral Health 2015 – 2018
Director of Residential Based Services

- Provided direct supervision for clinical manager, operations manager, and certified recreation therapist
- Supervised the operations of 60+ employees
- Ensured compliance with budget, regulatory requirements, and maintained COA accreditation standards
- Responded to agency needs with 24/7 on-call crisis support
- Developed a process to enhance therapeutic communication between direct service providers and patients
- Created and implemented procedures to mitigate risks after identifying serious patient safety concerns
- Increased numbers of patients receiving services by more than 20% within first 6 months of employment
- Enhanced treatment alignment to support patients with higher acuity
- Developed leadership structure to become more cost-effective while improving service quality

Dustin Johnson, MS

Sunrise Children's Services 2013 – 2015
Program Director

- Supervised the operations of 32+ employees including registered nurses, clinicians, and case manager
- Ensured compliance with budget, regulatory requirements, and maintained JCAHO accreditation standards
- Responded to agency needs by providing 24/7 on-call crisis support
- Developed a more therapeutic environment by creating a patient-centered approach
- Increased number of patients receiving services by more than 50% within first 6 months of employment

Uspiritus 2009 – 2013
Director of PRTF Programs

- Provided direct supervision for program managers, treatment coordinators, and education manager
- Supervised the operations of 75-140 employees
- Ensured compliance with budget and regulatory requirements and maintained COA accreditation standards
- Responded to agency needs and provided 24/7 on-call crisis support
- Improved recruitment process that enabled the agency to increase service capacity
- Implemented new staffing schedules to support the needs of patients and team members
- Opened an additional 9-bed psychiatric residential treatment facility (PRTF) with total of 54 PRTF beds
- Assisted with merger of two non-profit agencies and supported new partnerships with other non-profit agencies

Education

- Master of Science in Business Communication, Spalding University, 2012
- Bachelor of Sociology with a Major in Criminology and Minor in Social Work, Morehead State University, 2006

Jessica Hillyard, RN, BSN

SKY Complex Care Management Manager

Jessica Hillyard is an experienced case management nurse with a demonstrated history of working in the health and wellness industry. Jessica is a strong health care services professional skilled in critical care nursing, health care, health education, and patient advocacy. Jessica has a Bachelor of Science in Nursing from the University of Louisville.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2015 – Present

Clinical Case Manager, Community Pharmacy Enhanced Services Network (CPESN) Pilot (2019 – Present)

- Primary point of contact for CPESN pharmacy's
- Review all CPESN referrals and care plans for appropriateness
- Coordinate and lead monthly rounds with multi-disciplinary teams
- Educate ICM staff on CPESN pilot
- Key participant in the concept and development of CPESN emergency kits and SDOH tool to address social determinants of health needs
- Showcase pilot through multiple successes:
  - 60% enrollee engagement in CPESN Pilot program
  - ED utilization decreased cost by $28,070
  - Outpatient Utilization decreased cost by $141,299
  - Inpatient Utilization decreased cost by $45,147

Clinical Case Manager, Physical Health (2015 – Present)

- Manage the most vulnerable populations with complex biopsychosocial needs
- Identify and address root causes of health inequities and health disparities
- Assess complex medical conditions
- Formulate highly individualized care plans and interventions
- Remove barriers to care
- Coordinate care with multi-disciplinary teams
- Provided extensive education on disease states
- Serve as ICM point person
- Conduct bimonthly team meetings
- Prepare charts and documentation for IPRO audits

Norton Brownsboro Hospital, Louisville, KY 2014 – 2015

Inpatient Neuro Intensive Care Unit; Staff nurse

- Maintained a caseload of high acuity adult patients
- Demonstrated critical thinking skills and responded to life saving situations
- Maintained patient's hemodynamic stability
- Participated in multi-disciplinary teams

Jessica Hillyard, RN, BSN

Kentucky One Health Jewish Hospital, Louisville, KY 2008 – 2014

Post Anesthesia Care Unit; Charge and Staff nurse (2010 – 2014)

- Created patient assignments
- Participated in the recruitment and hiring process for staff
- Served as a preceptor and mentor for new employees and nursing students
- Coordinated care with Anesthesiology and Surgical teams
- Assessed and monitored patient's condition immediately following surgical procedures
- Maintained patient's hemodynamic stability
- Demonstrated critical thinking skills and responded to life saving situations
- Initiated patient education programs and discharge planning

Inpatient Cardiac/Surgical Intensive Care Unit; Staff nurse (2008 – 2010)

- Maintained a caseload of high acuity adult patients
- Demonstrated critical thinking skills and responded to life saving situations
- Maintained patient's hemodynamic stability
- Participated in multi-disciplinary teams
- Served as a preceptor and mentor for new employees and nursing students.

Education

- Bachelor of Science in Nursing, University of Louisville, 2008

Licensures and Certifications

- Basic Life Support Certification, BLS

Janna Cheek, RN, BSN

SKY Intense Care Management Manager

Janna Cheek is a Registered Nurse with more than 22 years of experience providing clinical care, case management and care coordination and education to patients in a variety of pediatric settings. Prior to joining Aetna, Janna served as a staff nurse within a hospital and clinic setting. Her educational background includes a Bachelor of Science in Nursing from Indiana Wesleyan University.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2013 – Present

Foster Care Case Manager (2014 – Present)

- Complete Health Risk Assessment on children within my regions with new eligibility to Foster Care, Foster Children who have been deemed medically complex, and Foster Children who utilize Commission Services
- Make referrals to community resources for food, clothing, and First Steps as appropriate
- Provide education to DCBS Workers and /or foster parents that is relevant to the foster child
- Collaborate with multi-disciplinary teams and attend interagency meetings such as RIAC and Out of Home Care meetings to provide comprehensive support to foster children and families

Pediatric Case Manager (2013 – 2014)

- Complete Health Risk Assessments and other assessments as appropriate on high risk members with chronic disease processes to formulate care plans to improve health outcomes
- Educate a culturally diverse population in self- management skills for diabetes, asthma, and other pediatric disease processes / illnesses
- Participate in multi-disciplinary rounds
- Refer member to community agencies as appropriate.

Kentucky Clinic – UK Healthcare 2011 – 2013

Pediatric Pulmonology Clinic Nurse Clinician

- Provide direct outpatient nursing care for patients with complex respiratory health issues
- Daily initiation of prior authorizations for procedures, medication, and DME
- Assist with managing clinic flow
- Coordinate inpatient and outpatient services for patients
- Make referrals to home health agencies and DME's

University of Kentucky – Kentucky Children's Hospital 1999 – 2011

Pediatric Nurse, PerDiem and On-Call (2001 – 2011)

- Provide primary nursing care to critically ill children in PICU and NICU
- Provide primary nursing care to children on Medical-Surgical and Oncology floor

NICU Staff Nurse (1999 – 2001)

- Provide primary nursing care to critically ill neonatal patient population
- Coordinate care from admission to discharge
- Collaborate with members of healthcare team

Saint Joseph Hospital 1998 – 1999

Registered Staff Nurse, Orthopedic / Neurology Floor

- Provide care to patients who had orthopedic or neurological related surgeries
- Involved with pre-surgical preparation to post-operative care

Janna Cheek, RN, BSN

- Educate patients and families regarding post-operative care
- Provide education on available services to community groups resulting in increased referrals and utilization of services.

Education

- Bachelor of Science in Nursing, Indiana Wesleyan, 2015
- Associate of Nursing, Midway College, 1998

Licensures and Certifications

Kentucky Nursing License #1089645

Monica Thompson, BSN, RN, CCM

SKY Intensive Care Management Manager

Monica Thompson is a Certified Case Manager, with more than 8 years of experience providing coordination of care, education, and resources utilizing evidence-based practice to provide the best care for members. In her role as a pediatric nurse case manager for Aetna Better Health of Kentucky, Monica exhibits caring and problem solving when parents are in their most vulnerable state. Monica works to help parents navigate the health care system and educate with the goal of eventual self-management. In previous positions, Monica has worked in acute settings, providing direct patient care. She used nursing judgement and best practice to ensure that her patients had tools needed to return to optimal health prior to discharge. At The Kidz Club, Monica provided direct patient care, in addition to case management duties. Her educational background includes a Bachelor of Science in Nursing, a Bachelor of Arts in Biology and is a Certified Case Manager.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2014 – Present
Pediatric Case Manager

- Utilize critical thinking and judgment to collaborate and inform during the case management process
- Assist in facilitating appropriate healthcare outcomes for members by providing care coordination
- Support and education for members through the use of care management tools and resources
- Evaluate and interpret claims data in an effort to identify trends and develop care plans to address areas of concern
- Provide member education to encourage better self-management skills

The Kidz Club 2012 – 2014
Pediatric Case Manager

- Coordinated care of the child and family assessing needs and coordination of appropriate clinical options
- Facilitated referrals to primary providers, specialists, healthcare facilities and community resources
- Responsible for direct client care and supervising team providing a holistic approach to the care of children and their families
- Performed daily nursing assessments, medication administration, and preventative care

Norton Audubon Hospital 2012
Registered Nurse

- Performed assessments and reassessments as warranted by patient condition
- Collaborated with patient/family and interdisciplinary services utilizing resources appropriately
- Evaluated, monitored and documented responses to clinical interventions provided
- Provided education specific to patient/family needs
- Maintained a secure, trusting environment while providing patient privacy

Education

- Bachelor of Science, Spalding University, 2011
- Bachelor of Arts, Biology, University of Louisville, 2001

Licensures and Certifications

- Registered Nurse, Commonwealth of Kentucky; License #1129274
- Commission for Case Manager Certification, Certified Case Manager #421901

Robin Holloway, RN

SKY Care Management Manager

Robin Holloway is an RN with more than 10 years of experience in nursing. Her nursing experience prior to working at Aetna was in med-surg and neurology. She is currently responsible for outreaching plan members who have had recent emergency department visit(s) to identify gaps in care and assisting them to resolve barriers to getting needed care. She also educates our members on why continuity of care is important and helps our members establish a medical home. Prior to becoming an RN, she was a social worker. As a social worker she worked for the Cabinet for Health and Family Services in Child Protection. She brings knowledge of chronic health conditions as well as understanding of human motivation and how social determinants affect individuals' health. Robin believes her position at Aetna Better Health of Kentucky allows her to fold in the knowledge and skills she has gained from her background as a social worker and a nurse, as well as her experience in the business sector. Robin received a Bachelor of Arts in Social Work from the University of Kentucky (1990) and an Associate Degree in Nursing from Jefferson Community and Technical College (2009). She is also certified by Commission for Case Management Certification (CCMC).

Experience

Aetna Better Health of Kentucky, Louisville, KY 2012 – Present
RN, Care Manager

- Outreach members with recent emergency department claims for chronic conditions, substance use disorder or depression.
- Educate members on the importance of primary care/medical home and continuity of care.
- Communicate with providers (physician's offices and pharmacies) to ensure that members get needed care, services, medications, medical equipment/devices.
- Communicate with leadership regarding issues at the plan level that may decrease emergency department visits and improve overall health and outcomes for members.
- Collaborate with co-workers regarding resources in the state that may be helpful to our members

Frazier Rehabilitation Institute 2009 – 2012
Registered Nurse

- Delivered direct patient care on fast-paced neuro rehabilitation unit. Majority of patients had suffered a stroke or traumatic or anoxic brain injury.
- Communicated with hospitalists, specialists, PT, OT, Speech Therapists to gage member's progress and assisted and educated family to prepare for discharge.
- Unit also received patients for pulmonary rehab, post organ transplant and post ventricular assist device (VAD) placement for rehab and education, so I acquired a wide array of knowledge and skills.

Gap in Employment 2000 – 2009
Stay at Home Mom

- Cared for my children and attended nursing school
- Completed Nursing School May 2009.

Quality Communications, Inc. 1998 – 2000
Project Management Consultant

- Met with clients and assisted to identify needs and opportunities for "savings." Clients included Kaiser Permanente, Adventist Healthcare and Vencor.

Robin Holloway, RN

- Served as liaison between Business Operations, Sales Department and IT to ensure understanding of scope of project and agreed upon deliverables.

Vencor, Inc. (now Kindred Healthcare) 1995 – 1998
Purchasing Assistant

- Reported to VP of Purchasing.
- Assisted department managers and executives with purchasing medical supplies, textiles, equipment for chain of long-term care hospitals and skilled nursing facilities.
- Reviewed contracts/agreements prior to submitting to counsel to assure they were consistent with what was agreed upon in the negotiations.

Cabinet for Health and Family Services, Department of Social Services (Fayette County) 1990 – 1994
Child Protective Services

- Case managed families in crisis, specifically families where there was proven or suspected child abuse and/or neglect.
- Educated families and directed them toward services to ensure safety and promote wellness of child(ren) and family members.
- Participated in multidisciplinary task force to investigate and address reports of child sexual abuse in Fayette County.
- Communicated with physicians, school personnel, law enforcement, mental health providers.
- Prepared documents for and made recommendations to the courts.
- Referred and directed clients to appropriate community resources.

Education

- Associate Degree Nursing, Jefferson Community and Technical College, 2009
- Bachelor of Arts in Social Work, University of Kentucky, Lexington, Kentucky, 1990

Licensures and Certifications

Certification, Commission for Case Management Certification (CCMC)

McKenzie Clarke, LCSW

SKY Care Coordination Manager

McKenzie Clarke is a Licensed Clinical Social Worker (LCSW) with six years of experience providing case management, individual and group therapy, and crisis intervention services to individuals and their families dealing with comorbid health conditions. In her role as Clinical Care Manager Behavioral Health for Aetna Better Health of Kentucky, McKenzie manages a caseload of individuals with diverse physical and mental health conditions. McKenzie utilizes evidence-based practices to ensure all members are receiving adequate and appropriate care in the community. McKenzie advocates for her members to receive all available health care services at the least restrictive level of care. Prior to her current role with Aetna, McKenzie served as a Psychiatric Social Worker at Eastern State Hospital. In this role, McKenzie counseled individuals and their families and provided therapeutic techniques for crisis management. She led group therapies and completed ongoing biopsychosocial assessments with patients. During her time at Eastern State Hospital, McKenzie was promoted to Float Social Worker, which allowed her to utilize best practices with transitioning some of the hospital's most vulnerable and institutionalized individuals from the inpatient setting to the community. McKenzie provided individual therapy to these individuals during these difficult transitions. McKenzie has maintained independent licensure as a licensed clinical social worker (LCSW). McKenzie's educational background includes a Bachelor of Arts in Psychology and a Master of Clinical Social Work.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2017 – Present
Clinical Case Manager, Behavioral Health (LCSW)

- Manages a caseload of roughly 30-40 members, assisting with services including, but not limited to provider referrals, medication coverage concerns, teaching coping strategies and encouraging autonomy in caring for one's health.
- Provides evidence-based techniques including motivational interviewing and a strengths-based approach.
- Leads weekly ICM team huddle meetings as an ICM point person. Assists with determining solutions for ICM team members when they have member or policy related concerns or questions.
- Presented a Behavioral Health Training to the Kentucky Primary Care Association and several Primary Care clinics affiliated with KPCA.
- Provides option for face to face meeting with all member's enrolled in ICM.
- Works with members to reduce ED utilization through maintaining medication adherence and practicing healthy coping skills.
- Collaborates with staff in various departments at ABHKY to ensure members receive all necessary resources and services.
- Presents difficult cases in ICM and BH rounds and participates in ICM and BH rounds by offering clinical guidance and feedback on presented cases.
- Created a portion of the CM enrollment note to assess for trauma.
- Initiates Single Case Agreements for members to receive necessary services for improving their health outcome.
- Volunteers monthly reading to students in Fayette County Public Schools on behalf of ABHKY.
- Nominated for ABHKY Health Plan CM Opioid Program Champion.
- Yellow Belt Certified.

McKenzie Clarke, LCSW

Eastern State Hospital 2014 – 2017
Psychiatric Social Worker (LCSW)

- Counseled individuals through times of crises and provided therapeutic techniques for crisis management.
- Led group therapies with a focus in Dialectical Behavioral Therapy and Cognitive Behavioral Therapy practices.
- Debriefed individuals after suicide attempts and taught individuals self-harm prevention strategies through evidence-based therapeutic techniques.
- Worked parallel with a team of interdisciplinary psychiatric providers.
- Completed biopsychosocial assessment through interview with the patient and their family
- Provided therapy for individuals with mental illness, including, but not limited to, Major Depressive Disorder, Schizophrenia, Schizoaffective Disorder and Bipolar Disorder.
- Organized difficult placement transitions to the community.
- Nominated for Corales Award for Excellence in Teamwork for successfully transitioning patient to the community after years of institutionalization.
- Promoted to float Social Worker leading to a caseload of patients on numerous units.
- Selected to serve on committee for hospital-wide introduction of electronic medical records.

Education

- Master of Clinical Social Work, University of Kentucky, 2014
- Bachelor of Arts, Psychology, University of Kentucky, 2012

Licensures and Certifications

Licensed Clinical Social Worker (LCSW)

Rachel Fox, LPCC

SKY Care Coordination Manager

Rachel Fox is a Licensed Professional Clinical Counselor (LPCC) with more than 7 years of experience providing both case management and therapeutic counseling treatment to children and adults residing in Kentucky who participated in Medicaid insurance coverage. Rachel has diverse experience in clinical settings, ranging from Community Mental Health, private practice and currently with Aetna Better Health. In her current role as a Clinical Case Manager, Rachel is responsible for assisting the members with whom she is working on coordinating appropriate physical and behavioral health care, identifying barriers to care and social determinates of health and assisting members with resolving those barriers so they can receive the care that is needed. Her educational background includes a Bachelor of Arts in Psychology and a Master's in Counseling & Personnel Services with a concentration in Counseling Psychology. Rachel maintains her independent behavioral health license as an LPCC.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2017 – Present
Clinical Case Manager, Behavioral Health

- Facilitates appropriate member physical health and behavioral healthcare through assessment and care planning, direct provider coordination/collaboration, and coordination of psychosocial wraparound services
- Applies clinical judgment to the incorporation of strategies designed to reduce risk factors and address complex clinical indicators which impact care planning and resolution of member issues.
- Identifies and escalates quality of care issues through established channels
- Utilizes influencing/motivational interviewing skills to ensure maximum member engagement and promotes lifestyle/behavior changes to achieve optimum level of health
- Provides coaching, information and support to empower the member to make ongoing independent medical and/or healthy lifestyle choices.
- Helps member actively and knowledgably participate with their provider in healthcare decision-making

J. P. Interventions, Inc. 2014 – 2017
Licensed Professional Counselor Associate/Licensed Professional Clinical Counselor

- Complete court-ordered mental health assessments and trauma assessments as requested
- Complete three session assessment process and make appropriate recommendations for services
- Conduct weekly individual, family, parenting, and group therapy sessions utilizing evidence-based therapeutic interventions with clients both in office and in New Haven Elementary and Middle Schools
- Collaborate with various community agencies and partners, i.e., DCBS, court systems, schools, medical providers, case managers to ensure utilization of appropriate need-based services
- Assist with making referrals to appropriate internal and outside service providers as needed
- Bi-monthly treatment status updates provided to DCBS for clients in state custody
- Monitor and assess for client safety and utilize crisis services as needed
- Secure appropriate Prior Authorizations from MCOs for services such as individual, family, parenting and group therapy sessions
- Maintain compliance with required documentation

Rachel Fox, LPCC

Communicare 2010 – 2014

Mental Health/Behavior Supports Therapist (2013-2014)

- Conduct individual, family and group therapy sessions
- Complete Functional Behavioral Assessments, Behavior Support Plans and monthly monitoring
- Conduct in-home individual and family therapy sessions with an emphasis on behavior modification as well as effective parenting strategies for individuals and their families on Michelle P. and SCL waivers
- Monitor and assess for client safety and utilize crisis services as needed.
- Collaborate with service providers from both internal and outside agencies to provide appropriate services and level of care for clients
- Secure appropriate Prior Authorizations from MCOs for services such as individual and family therapy sessions
- Maintain compliance with required documentation

Student Intern (2012)

- Conduct individual and group therapy sessions
- Administer psychological tests, complete reports and provide feedback to clients
- Attend treatment team meetings
- Attend supervision sessions
- Develop rapport with clients and work on client goals
- Complete all documentation and paperwork in a timely manner

Support Broker (2010 – 2011)

- Work with Intellectually and Developmentally Disabled individuals to help them become more independent
- Collaborate with families on the Michelle P Waiver, Consumer Directed Option (CDO), to receive services
- Collaborate with Medicaid and other state agencies to broker services for the individuals
- Advocate for the individual's rights as well as monitor health, safety and welfare
- Complete all documentation and paperwork in timely manner
- Develop rapport with families and individuals receiving services
- Check family timesheets and documentation and resolve payment issues in a timely manner

Education

- Master of Education in Counseling & Personnel Services with concentration in Counseling Psychology, University of Louisville, 2012
- Bachelor of Arts: Psychology, Hanover College, 2008

Licensures and Certifications

Licensed Professional Clinical Counselor (LPCC)

Lynne Kain, BSN, RN

SKY Care Coordination Manager

Lynne Kain is a Registered Nurse (BSN, RN) with 15 years of pediatric experience focusing neonatal nursing care. In her role as Neonatal Abstinence Syndrome (NAS) Nurse Case Manager Lynne is responsible for implementing, supporting, and promoting the NAS program that provides member centric case management for pregnant women with Substance Use Disorder (SUD) and their infants with NAS. Lynne was highlighted for the Aetna Health Hero as a nurse and Aetna case manager, she is dedicated to helping women overcome opioid addiction during their pregnancies and stay sober after delivery. Prior to joining Aetna Lynne was a bedside nurse in multiple hospital NICU's one being level 4 NICU and a Neonatal/ Pediatric Flight nurse at Kentucky Children's Hospital. These positions put Lynne at the forefront of the opioid crisis, working directly with families dealing with substance use disorder and infants exposed to opioids and the resulting treatments utilized. Her educational background includes a Bachelor of Science in Nursing.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2005 – Present

Foster Care/NAS Case Manager (2005 – Present)

- Provider Outreach-Setting up meetings between our Medical Directors, program manager and myself with residential treatment programs, intensive outpatient programs, and high-risk obstetricians (The Chrysalis House, The Nile, Sobertoo, Polk Dalton)
- Department for Community Based Services (DCBS) For infants placed into foster care maintain a connection with infant member's DCBS case worker to assist with any foster care needs from case worker and or foster parents, complete state mandated assessments and provide nurse case management services as needed
- Member Connections-Through the use of clinical tools and information/data review, conduct comprehensive assessments of referred member's needs/eligibility and determines approach to case resolution and/or meeting needs by evaluating member's benefit plan and available internal and external programs/services.
- Face to Face- in person meetings with members where available to address member focused concerns and incorporate strategies to reduce their specific risk factors through referral to appropriate providers, resources, and programs.
- Education/training- attended additional training in-Motivational Interviewing, Trauma Informed Care and ACEs through work seminars and conferences focusing on the Opioid Crisis, Pregnant women with opioid use, NAS, 2019 CHFS Child Welfare Summit
- Created brochures to be used to educate providers on Aetna's NAS case management program, and to assist in educating our pregnant mothers about NAS before and after delivery
- Meetings with local stakeholder groups including NICU at Kentucky Children's Hospital, Plan of Safe Care (POSC), Recovery Oriented System of Care (ROSC), Regional Interagency Council (RIAC)

Kentucky Children's Hospital (KCH) 2005 – 2015

NICU Staff Nurse (2005 – 2015)

- Provide direct patient care in 64 bed level 4 NICU
- Orientation/Preceptor of new staff nurses in NICU
- Provide direct patient care if needed to PICU, general peds floor

Lynne Kain, RN, BSN

- Provide support and healthcare teaching for families coping with illness throughout KCH

Neonatal/Pediatric Transport Nurse KCH (2008-2015)

- Assist in the management and implementation of direct patient care with Advanced Neonatal/Pediatric Transport Nurse
- Participate in quarterly competency for advanced skills i.e.: intubation and airway management, placement of umbilical arterial and venous lines, radial arterial punctures, chest tube placement, cricothyrotomy, external jugular IV insertion and nitric oxide therapy
- Emergency Nursing Pediatric Course (ENPC) Instructor
- Protocol committee for transport team-evaluation and updating of current policies procedures to meet evidence-based practice
- Attend public relation events as needed (Touch a Truck, school visits)

On Call for Pediatric Sedation Unit at KCH (2013-2015)

- Prepared pediatric patients for procedures requiring sedation (labs, IV placement, fluids, medications, monitoring equipment placed, education of parents (patients if age appropriate)
- Monitoring of patients while under sedation and in recovery

Frankfort Regional Medical Center

NICU Staff Nurse 2010 – 2015

- On call Staff nurse for Level 2 NICU and Newborn Nursery
- Attend vaginal/cesarean section births providing direct patient care immediately after birth, assessment, obtaining APGAR scores, initiating any resuscitative efforts if needed until neonatologist or OB at bedside
- Provide healthcare teaching and promotion and support to families

Education

- Bachelor of Science, Nursing, Eastern Kentucky University, 2004
- Bachelor of Science, Veterinary Technology, Morehead State University, 1991
- Associate in Applied Science, Veterinary Technology, Blueridge Community College, 1989

Sally Wylie, BSN, RN

SKY Department of Juvenile Justice Care Management Manager

Sally Wylie is a Registered Nurse with more than 35 years of experience providing clinical care, case management and care coordination and education to patients in a variety of settings. Prior to joining Aetna, Sally provided case management services to members at a managed care organization and hospital. Her educational background includes a Bachelor of Science in Nursing from Illinois Wesleyan University and a Master of Science in Health and Physical Education from Illinois State University. Additionally, Sally also is a certified case manager.

Experience

Aetna Better Health of Kentucky, Louisville, KY 2013 – Present

Foster Care Case Manager (2017 – Present)

- Complete Health Risk Assessment on children within my regions with new eligibility to Foster Care
- Make referrals to community resources for food, clothing, and First Steps as appropriate
- Complete Health Risk Assessment on young adults with Foster Care who are turning 18
- Provide education to young adults on available services based upon whether or not they extend care
- Collaborate with multi-disciplinary teams and attend interagency meetings such as RIAC, Independent Living Coalition, and Out of Home Care meeting to provide comprehensive support to foster children and families

Intensive Case Manager (2013 – 2017)

- Complete Health Risk Assessments and other assessments as appropriate on high risk members with chronic disease to formulate care plans to improve help members improve their health
- Educate a culturally diverse population in self- management skills for diabetes, COPD and CHF
- Participate in multi-disciplinary rounds
- Refer member to community agencies as appropriate.

Kentucky Spirit Health Plan 2011 – 2013

Case Manager

- Complete appropriate assessments on high risk members with chronic disease to formulate care plans to improve help members improve their health
- Educate a culturally diverse population in self- management skills for diabetes, COPD and CHF leading to behavior change
- Participate in multi-disciplinary rounds
- Coach members in appropriate utilization of the health care system and how to advocate for themselves resulting in members feeling empowered.
- Refer member to community agencies as appropriate.

St. Joseph Hospital 2010 – 2011

Case Manager

- Facilitate discharge of patients to the safest, most appropriate level of care resulting in length of stay of less than five days.
- Collaborate with a multi-disciplinary team to meet patient's needs resulting in a decreased length of stay.
- Participate in utilization review activities using Interqual criteria to provide updates to insurance companies
- Make referrals to home health agencies, DMEs and SNFs

Sally Wylie, BSN, RN

University of Kentucky 2006 – 2010
Research Assistant
- Identify appropriate participants for cardiovascular research resulting in an adequate sample size for several studies.
- Conduct home visits to educate participants to improve compliance with study protocol.
- Collect research data at the Clinical Research Center (CRC) resulting in completion of several cardiovascular research studies.

Madison County Health Department 2003 – 2006
Bioterrorism Training Coordinator
- Coordinate education programs for a five county region resulting in key personnel being more familiar with bioterrorism issues.
- Market educational programs to ensure attendance by a diverse population.
- Establish a Community Emergency Response Team resulting in lay person being able to assist with community emergencies.

Division of Specialized Care for Children 2001 – 2003
Nurse Consultant
- Provide care coordination for children with special health care needs to ensure health care needs were being met in most expedient and cost-effective manner.
- Ensure appropriateness of services for children and then authorize benefit payments accordingly.
- Provide education on available services to community groups resulting in increased referrals and utilization of services.

Community Nursing Organization 1997 – 2001
Case Manager
- Maintain a high-risk caseload of 100 members for this federally funded Medicare demonstration project resulting in successful completion in project.
- Refer member to appropriate community resources allowing members to remain in their homes for a longer time.
- Educate members on chronic diseases, such as diabetes, CHF, and COPD resulting in improved self-management skills.

Carle Foundation Hospital 1990 – 1997
Diabetes Program Coordinator
- Engage hospitalized patients in diabetes education enabling them to perform necessary diabetes self-care skills upon discharge from the hospital.
- Train hospital staff regarding diabetes improving adherence with diabetes standards of care.
- Implement a diabetes resource team which incorporated a “diabetes expert” on each nursing unit to better disseminate necessary education and information.

McLean County Health Department 1987 – 1988
Public Health Nurse
- Provided care coordination for both chronic disease and maternal child caseload.
- Conducted classes on health issues for schools
- Participated in various clinics at the health department and in the community
- Served as a nurse consultant for four elementary schools

Champaign-Urbana Public Health District 1985 – 1987
Public Health Nurse

- Provided care coordination for both chronic disease and maternal child caseload.
- Conducted classes on health issues for community groups and school classes
- Participated in various clinics at the health department and in the community

Education

- Master of Health and Physical Education, Illinois State University, 1990
- Bachelor of Science in Nursing, Illinois Wesleyan University, 1982

Licensures and Certifications

Certified Case Manager, Commission for Case Management Certification.

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Proposed Training Program and Curriculum

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Changing Course Overview Training Agenda

Aetna Better Health for West Virginia Foster Care Model

"Changing Course"

Course Description: This Overview provides an introduction to the new West Virginia Foster Care Model and Aetna Better Health for WV as the Managed Care Organization. Attendees will require definitions, historical context, and current foster care data in order to grasp the significance of the innovation, and the urgent need for lasting change.

I. **Introduction** – *A Call to Action*

A. Youth and Family Foster Care System Experience – (Live/recorded Personal Experiences)

II. **Foster Care System Current and Historical Context** – *Nationally and West Virginia*

A. From Orphanages to Residential – (PowerPoint slides)
B. Foster Care System Philosophy and Outcomes – "The Apple doesn't fall far from the Tree" and the effects of poverty, trauma, stigma and institutionalized racism
C. West Virginia Foster Care System Outcomes – (data and handout)

III. **Foster Care Reform** – *Family First Prevention Services Act, 2018*

A. FFPSA Overview and Highlighted Mandates and Funding – (Federal FAQ p. handout)
B. West Virginia FFPSA Plan and Timeline – (PowerPoint slide)

IV. **Vision Statement and Philosophy** - *Home and Healthy*

A. A Good Life – Description of what is meant by "a good life"(PowerPoint slide)
B. Is it Good Enough for My Own Child? – The ethical question for any provider
C. Principles of Care – (PowerPoint, definitions, handout)

V. **The Youth and Parent Perspective** – *Not About Me Without Me*

A. HERO, CFE and Wraparound Success Stories – (Live/recorded 2-3 brief youth/parent success stories and 1p handouts of model briefs)
B. Voice, Choice and Preference – (PowerPoint slide with definition and competencies in action)
C. Engagement and Re-engagement – (definition and outcomes data – PowerPoint)

VI. **Innovation and Change Methodology** – *Not Business as Usual*

A. Inverted Organizational Structure – voice, choice and preference by design,
B. Employee engagement – (PowerPoint slides)
C. Collaboration from Care Teams up to Governance – rationale for collaboration and parallel process – (PowerPoint slide and handout)
D. Change Management Model – how do systems and organization create sustainable change over time – (PowerPoint slide)
E. Whole Person Care – integrated care model and simultaneous, interdependent needs and positive outcomes – (PowerPoint slide and handout)

VII. **The West Virginia Foster Care Model** – *No Time to Waste*

A. DHHR RFP Requirements – highlights (PowerPoint)
B. Top Five Outcomes – explain the rationale for the top five (handout with current WV data)
C. Innovation – describe/define; TIC, CFE, Wraparound, LifeCourse, HERO, circles of care - (PowerPoint slides & 1p. briefs as handouts)
D. Current example Success Stories - (e.g. Lily's Place graduate live/recorded)

VIII. **Roles and Responsibilities Highlights** – *Whose Who in Aetna WV*

A. Aetna Leadership and Governance Committee - (PowerPoint slide, description and handout)
B. Interdisciplinary Work Teams - (PowerPoint graphic design, purposes and handout)
C. MAC and Focus Groups - (PowerPoint with descriptions, purposes and handout)
D. Access and Aetna FC Website - (PowerPoint screen shot of website, describe all aspects to guarantee access, handout website link and other key contacts/resources)

IX. **Collaboration** – *Philosophy in Action*

A. Collaboration definition – team decision making, divergent perspectives, accountability and creativity - (PowerPoint slides)
B. Collaboration requirements in FFPSA and WV RFP - (references in slides)
C. Examples of current, successful WV-Aetna collaborations – point out that innovation is already happening because mission driven individuals seem to always know the right thing to do and nothing stops them - (PowerPoint slides)

X. **Circles of Care** – *Everyone Belongs v. Loneliness That Kills*

A. Description and examples - (PowerPoint slides describe the ITC with examples and share research on the long-term effects of loneliness)
B. Natural members - (PowerPoint slide define and explain the importance)
C. Balance of formal services and creative strategies - (PowerPoint slide describe rationale, differences and transition of formal to informal over time)
D. Crisis stabilization and proactive safety plans – (PowerPoint slide decreasing crises through proactive responses to underlying unmet needs)

XI. **Creating Community Capacity** –*"It Truly Does Take a Village"*

A. These are our neighbors – We don't turn away from suffering - (WV values statement)
B. We can help so much more than we thought possible – We just need to know how and when and with what to help
C. Examples of Community Resourcing – (PowerPoint slides with 2-3 current, and accurate resources)

XII. **Outcome Driven** – *Keep Doing What You're Doing and You'll Keep Getting What You're Getting*

A. Outcomes-based care models – Beginning with the family's vision of a Good Life -(PowerPoint slide illustrating the LifeCourse map examples)
B. Measurement at all levels – all convenings have a purpose and an end goal -(PowerPoint listing of each committee/work team's purpose, rules of engagement and outcome measurement methods)
C. Continuous Quality Improvement (CQI) – data driven and rapid course corrections - (PowerPoint slide illustrating CQI Rapid Change Model)
D. Reporting and Course Correction from ICT to State – ICT meeting evaluations, MAC, Focus Groups and Interdisciplinary Work Team

improvement plans and reports - (PowerPoint listing various reports, timelines and accountability structure)

XIII. **Celebrating Success** – *Strengths v. Problems*

A. Minor wins and major victories – the importance of celebrating - (PowerPoint illustrating the positive effects of gratitude on physical health and brain functioning)
B. "What Have You Done for Me Lately?"- the lure of the tyranny of the urgent - (Combatting vicarious trauma, burnout and modeling wellness for those we serve)

XIV. **How You Can Help Now** – *Changing One's Mind in a Flash*

A. Download the Aetna App and checkout the website - (example PowerPoint slide)
B. Join a Foster Care Initiative (see sign-up sheets) – handout with brief description of volunteer activities
C. Consider being a Kinship stabilization home for a relative in need – foster care recruitment process - (PowerPoint and handout)
D. Jot down three positive things you heard today – shifting the mindset (quick experiential)

XV. **Q&A** – *Here to Listen*

A. Panelists to respond to questions from audience members
B. "Parking Lot" Notes and follow up - (recording on Post-It Note flip charts)

Changing Course

Overview handout

Aetna Better Health for West Virginia Foster Care Model

"Changing Course"

West Virginia is committed to transforming the foster care system and improving the outcomes for children and families. Across the United States a wave of transformation promises to interrupt the abysmal outcomes that foster care system involved youth have experienced for decades; homelessness, incarceration, addiction, poverty, school dropout and unwanted pregnancies.

We have no time to waste as we are talking about children who are languishing in a system ill-equipped to offer healing and the chance for a better future. There are numerous examples in various states where children have remained safe with their biological parents and kin while families have received timely and effective help in order to avoid neglect or resort to abuse. These pockets of success have demonstrated the positive use of innovative interventions and models of care.

West Virginia has faced the harsh realities of its Foster Care outcomes and has put a stake in the ground by getting onboard with the Federal Family First Prevention Services Act of 2018 and issuing its own Foster Care Managed Care Organization Request for Proposal (RFP) in spring 2019. This RFP emphasizes;

- Collaboration – Innovation – Prevention and Family Centered Care
- Reduction in removals as well as reduction in the use of residential care facilities

Aetna Better Health of West Virginia (ABHWV) welcomes the opportunity to partner with the Department of Health and Human Resources (DHHR) to design and collaborate in transforming the foster care system while partnering with key stakeholders, the provider network, community members and most importantly with youth and parents. Aetna asserts the following components in its model will contribute to lasting positive change for West Virginia children and families.

- Family-Centered, Preventative and Supportive Services
- Whole Person and Comprehensive, Multiple Life Domain Care
- Collaboration and Blended Perspectives
- Community Capacity and Creative Resourcing
- Trauma Transformation and Workforce Wellness

Aetna believes that in order to turn the foster care system around, to keep children safe at home and to return children to their families, there needs to be numerous convenings, the establishment of collaboratives and an ability to finally listen deeply to children and parents in order to be successful and to not repeat the mistakes that have led to;

1. 4,000 children in foster care

2. 1,500 children in long-term residential care with 450 out-of-state
3. Xxxx aging out without permanency

Aetna will approach its role as the MCO by forging key relationship and partnerships while introducing innovative interventions and models of care focused on the family, on creating comprehensive whole person care plans, and on building community capacity across West Virginia. Aetna welcomes divergent perspectives and knows that blended perspectives will lead to dynamic and effective plans that are sustained over time.

For more information on the Aetna WV Foster Care Program please visit the website at – XXXXXX and for new plan members please call our 24/7 information line at XXXXXXX

Aetna Better Health® of Kentucky

Course title: Changing Course Overview				
Length of time: Scalable from 2-3.5 hours dependent on audience				
Frequency of offering: Multiple times per month from January – July 2020 after which the frequency will reduce to twice monthly for the remainder of the first launch year and then monthly in subsequent years contingent on workforce attrition and significant changes in the foster care model.				
Audience: This class is intended for onboarding, direct care, mangers and leaders serving the foster care youth and families across the system internal to Aetna as well as external stakeholders, provider network personnel and key community partners and leaders.				
Course description: This Overview provides an introduction to the new West Virginia Foster Care Model and Aetna Better Health for WV as the Managed Care Organization. Attendees will require definitions, historical context, and current foster care data in order to grasp the significance of the innovation, and the urgent need for lasting change.				
Goal of the course: To introduce the federal act that supports foster care reform, the WV foster care plan,				
Module	**Lessons and topics**	**Objectives**	**Additional resources**	**Level 2**
Introduction **Background** **Context**	Youth and Family Perspective Foster Care History and Current State Foster Care Reform	• Introduce the youth and family perspective. • Provide background on the foster care system. • Introduce the Family First Prevention Services Act. • Explain the need for foster care reform.	• Personal youth and parent stories of foster care system involvement • FFPSA Federal FAQ sheet	• Provide Train the Trainer (T4T) curriculum prior to start of Overview • T4T post training debrief

Att V-61

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Att V-62

West Virginia Foster Care Reform Plan	Vision Statement Philosophy Goals Access – 24/7 1-800 xxxxxxxx Aetna Foster Care website	• Orient attendees on the WV approach to the FFPSA. • Attendees understand the vision and goals for the WV FFPSA Plan • To convey the philosophy of care and the proven practices that have contributed to the FFPSA Clearinghouse as well as those included in the WV Plan • Highlight components of the WV Foster Care model • Describe the Aetna system of care, its benefits and components. • Introduce the Aetna WV FC leadership team	• Provide Aetna access information • Provide Aetna roles and responsibilities	• T4T attendees assist with handout distributions
Collaboration **Infrastructure** **Workforce Wellness**	Roles and Responsibilities Circles of Care Interdisciplinary Care Team Care Coordination Team Focus Groups	• Describe the philosophy behind teamwork as the basis for circles of care to the Governance Committee • Explain blended perspectives, shared outcomes and proactive teaming • Describe various interdisciplinary teams, purpose and products/reports, • Describe workforce engagement and the parallel process with direct work,	• Offer concrete opportunities for attendee involvement in the change effort • Attendees receive one-page handout on FC Model with 24/7 access line and website information	• T4T attendees reach out during breaks to audience members who express

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	Member Advisory Committee Training Collaborative Governance Committee	the workforce, leadership and governance,		interest in further involvement in change efforts
Outcomes-driven **Next steps** **Q&A**	Evaluation Evidence-based and promising practices Process assessments Improvement and Continuous Quality Improvement Plans	• Attendees understand the importance of process and product measurement • Describe ITC process evaluation up to FC Program Outcome evaluation methodology and reports • Attendees learn of the FC timelines and are encouraged to ask pertinent questions and or make suggestions	• Attendees experience the Parking Lot approach to ideas, concerns and questions for follow-up • Panelists from DHHR, Aetna and other stakeholders, address Q&A	• T4T record Parking Lot comments, collate for trainers post training for follow up,

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West Virginia Foster Care *Changing Course* Overview

Aetna for Better Health West Virginia and The Department of Health and Human Resources

Presenters Names (Aetna & DHHR)

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Month 00, 2020

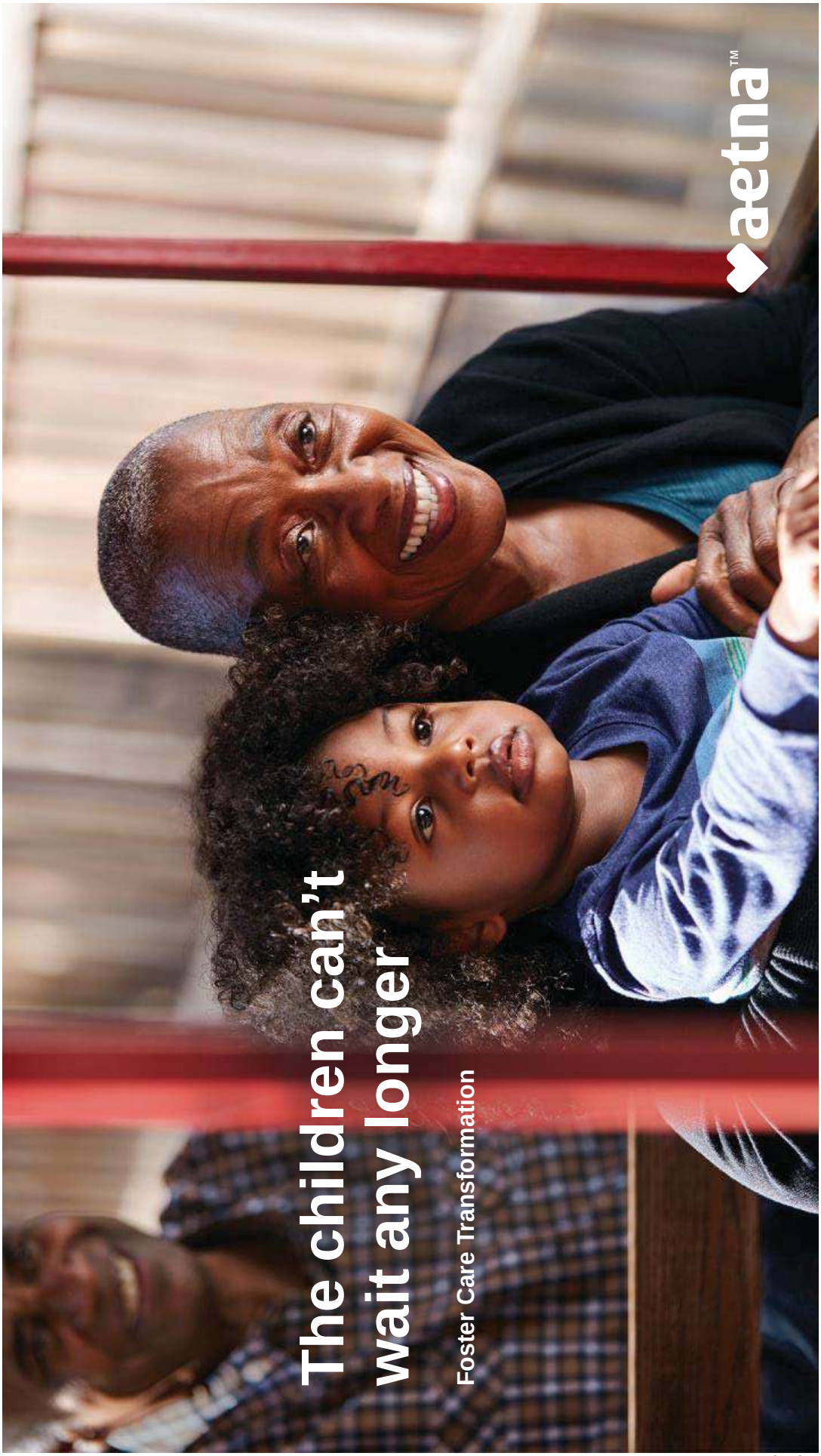
The children can't wait any longer
Foster Care Transformation
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Foster Care System History

- From Orphanages to Residential Facilities
- "The Apple Doesn't Fall Far From The Tree"
- Social Services and The Judicial System
- Long-term Out of Home Care
- Fost-Adopt

* Myers, J.E.B. (2006). *Child protection in America: past, present, and future*. New York: Oxford University Press.

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Foster Care Outcomes

- 400,000 children in our nation's foster care system
- 100,000 waiting to be adopted
- 23,000 age out of the system without permanency
- Without permanency; challenges with completing their education, unemployment, financial security and the criminal justice system.
- Disproportionate representation of African-American and Native-American children and youth in foster care.

** Child Welfare Information Gateway. (2019). Foster care statistics 2017. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.*

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Removal due to Neglect

Neglect is the failure of a parent or other caregiver to provide for a child's basic needs.

Over 74% of the children removed from their biological parents are removed due to neglect.

The sources of parental neglect can be due to;

- Poverty
- Isolation
- Unmet mental health and behavioral health needs
- Lack of parental skills and understanding of developmental needs

**U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). Child Maltreatment 2017. Available from https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/child-maltreatment.*

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Families First Prevention Services Act

- Signed into law as part of the Bipartisan Budget Act on February 9, 2018,

- Reforms federal child welfare financing in order to provide services to families who are at risk of entering the child welfare system,

- Aims to prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skill training,

- Seeks to improve the well-being of children already in foster care and to reduce placements in congregate care,

* Family First Prevention Services Act, Bill Summary, March, 2018, First Focus Campaign for Children – FFC-Short-Summary-FFPSA, 1400 Eye Street NW, Suite 650, Washington, D.C. 20005, www.firstfocus.org

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West Virginia Foster Care

Changing Course Overview

Presenter name

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Month 00, 2019

“It’s Time to Stop Confusing Poverty With Neglect”

- *Dr. Jerry Milner, Acting Commissioner of The Administration for Children and Families of the US Government*

** Knowing the Difference Between Poverty and Neglect, It’s Time to Stop Confusing Poverty With Neglect, Jerry Milner and David Kelly, December 2019/January 2020, Vol. 20, No. 10, https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewPrinterFriendlyArticle&articleID=5474*

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Principles of Care

Not business as usual

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Month 00, 2019

Whole Person Care Principles

- Strengths-based
- Family Centered
- Outcomes Driven and Accountable
- Team-based and Collaborative
- Culturally Accurate
- Individualized and Needs Driven
- Voice and Choice
- Community-based
- Creative
- Flexible and Accessible
- Comprehensive
- Unconditional

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DHHR Social Workers & Care Coordinators

Collaboration in Support of Youth & Families

Presenter name

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Divider slide

Youth and Family Perspective

Circles of Care

Presenter name

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West Virginia Foster Care Model Goals

Aetna WV Foster Care Program

Roles and Responsibilities

- Leadership
- Management
- Member Services
- Care Coordinators
- Provider Network
- SNS

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Innovation

Collaborative Family Engagement (CFE)

A method to engage with the child's family and community in an authentic manner, to develop networks of support that become the center of our casework practice, and to allow these networks to participate and share in decision making responsibilities for safety while also providing critically needed love, affection and acceptance, along with encouragement and guidance.

Trauma Informed Care (TIC)

An organizational structure and treatment framework built on understanding, recognizing and responding to all kinds of trauma. Implementing trauma-informed approaches marks a fundamental shift in care delivery that can catch health issues upstream, reduce dependence on emergency departments (EDs) and decrease missed appointments, resulting in reduced costs and an enhanced health care experience.

Wraparound

A comprehensive, holistic, youth and family-driven way of responding when children experience serious mental health or behavioral challenges. Family's ideas about what they need drive the work. A team, which includes friends and community members, as well as providers of services and supports creates its vision and goals and guides individualized services and supports. Team members work together to put the plan into action, monitor progress, and change it as needed.

HERO Workshop

A three-day intensive, youth led workshop for current foster care involved youth which assists them in designing their own team of support, transition to adulthood plan of action and the identification of supportive and accessible resources. Each youth walks out with a viable plan ready for implementation.

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Wellness

- Physical Vibrancy
- Intellectual Clarity and Creativity
- Connectedness and Resourcefulness
- Being of Service and Fulfillment
- Learning and Growth
- Joy and Celebration

* Descartes, Rene, *The Philosophical Writings of Descartes*, 3 vols., trans. John Cottingham, Robert Stoothoff, Dugald Murdoch and Anthony Kenny, Cambridge: Cambridge University Press, 1984-1991

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Youth and Family Centered Wellness Planning

- Youth and Family Voice, Choice and Preference
- Circles of Care and Interdisciplinary Care Team
- Comprehensive Life Domain Planning Process
- Formal Services and Community-based Resources
- Community Capacity Building

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Collaboration
Circles of Care to Governance

Interdisciplinary Care Team

The youth and family team comprised of natural members and providers

Care Coordination Team

Regional interdisciplinary teams of professionals in support of ITC

Training Collaborative

Leaders and trainers across all stakeholder groups and community services

Governance
Member Advocacy Committee
&
Focus Groups

Leaders, advocates, parents, community members and other stakeholders

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Tradition v. Innovation

Illness Model

- Body/mind dualism
- Disease and Pathology
- Costly and extensive treatment
- Expert Professional Care

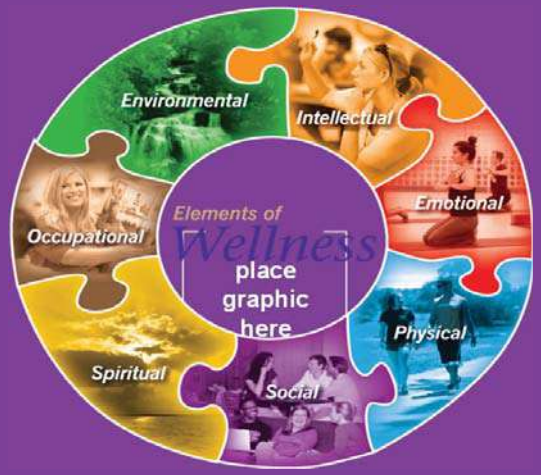

Wholeness Model

- Balance
- Wellness
- Connections & interdependency
- Inherent strengths & health

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Outcomes & Evaluation

- Interdisciplinary Care Team process and outcome evaluations
- Mental Health services measurements and evaluations
- Surveys, focus groups and the Member Advisory Committee
- Foster Care Program Evaluations
- Quality Improvement Plans and Continuous Quality Improvement methodologies

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Employee Engagement and Wellness

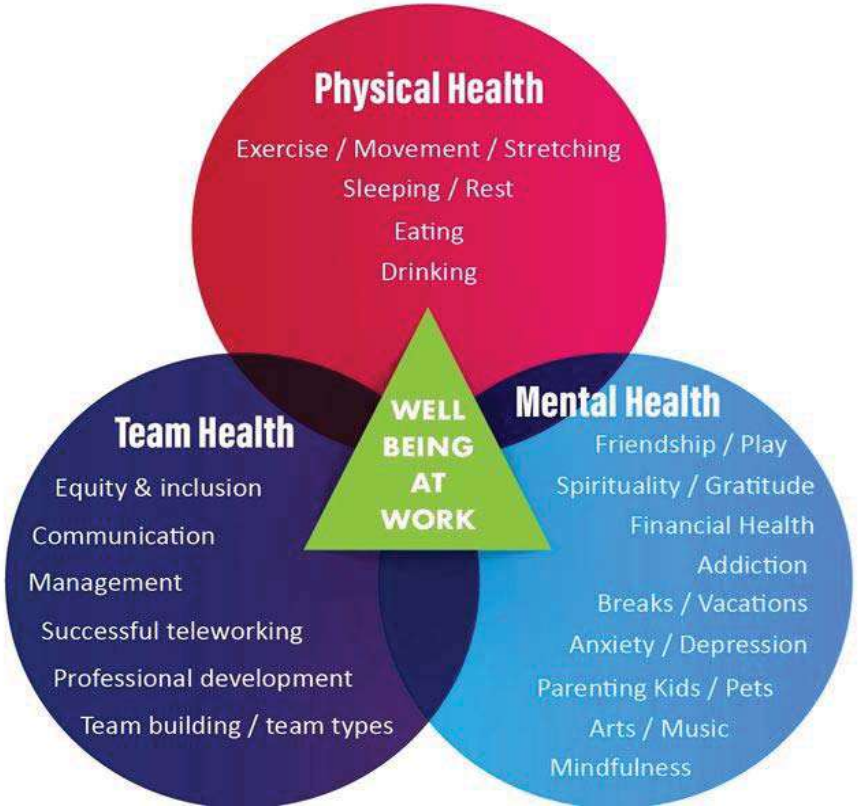

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You might be temporary in their lives. They might be temporary in yours. But there is nothing temporary about the love or the lesson.

— TONIA CHRISTLE

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Next steps

2019

Interdepartmental Collaborations

Enrollment of Foster Care Members

Training Collaboration

2020

Review of all outcome measures

PIP and CQI Plans

Community Capacity Building

2021

Sustainability of Gains Made

Increased Prevention Efforts

Measurement of Positive Wellness Longitudinal Outcomes

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In closing

Foster Care is changing for the better

- Children can be safe at home
- Transformation requires strong relationships and full collaboration
- Communities have capacity

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Q & A

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How You Can Help Now

- ***Visit the WV Foster Care website and familiarize yourself with the model, services and supports***
- ***Join a Foster Care Initiative***
- ***Consider being kinship support for a family member in need***
- ***Jot down three positive things you learned from this presentation***

Be the Change You Want to See In the World

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December 2019/January 2020, Vol. 20, No. 10

Spotlight on Knowing the Difference Between Poverty and Neglect

It's Time to Stop Confusing Poverty With Neglect

Written by Jerry Milner and David Kelly

As a field, we are fond of saying that child abuse and neglect cross all economic strata, but we know that it is not reported or handled equally or proportionally across all strata, as reflected by the children and families involved in the child welfare system. There is also a common refrain among many in the field that we should create a system that is "good enough for our own children." While the sentiment is earnest, we know that for most of us, the system will never be truly good enough for the children in our own lives. The truth is, for most people of certain socioeconomic standing and race, removal of a child to foster care is not a reality they will ever face—whether warranted or not. Moreover, to make that statement and mean it requires a fierce urgency in making the changes necessary to bring such a system to life. Should the improbable happen and a child in one of our lives require placement in the child welfare system, incremental improvement would never be satisfactory. It would be unacceptable.

Yet, as a field, we seem quite comfortable with very small, incremental improvements and minor tweaks to the way we operate—tweaks that often benefit the operators more than those living the experience; tweaks that may not result in noticeable improvements in the way children, youth, and parents experience the system at all; and tweaks that are not likely to mitigate the need to enter the system. We have to be honest in examining why we allow this to be so.

We have to be honest that a large part of the problem is the way we see and judge families that make contact with the system. We see poor and vulnerable families as the "other."

The role that poverty plays in child welfare decision-making is a topic that has yet to be meaningfully confronted and addressed. Poverty is a risk factor for neglect, but poverty does not equate to neglect. The presence of poverty alone does not mean a child is unsafe, unloved, or that a parent lacks the capacity to care for his or her child. Poverty can make it more challenging for parents to meet certain of their children's needs. We must be resoundingly clear that a child should never be removed from his or her family due to poverty alone.

We must also be very clear that poverty is disproportionately present in communities of color and that this fact carries direct implications for child welfare.

Overwhelmingly, the faces of the children, youth, and parents involved in child welfare are black and brown or very poor and white—people who data tell us are more often economically vulnerable or disadvantaged. Most of the reasons for child welfare involvement fall into what we call "neglect" rather than physical abuse or exploitation. Our most recent child maltreatment data tell us that 60 percent of victims have a finding of neglect only. There are different types and definitions of neglect around the country. Neglect can take the form of failing to attend school and not keeping up with necessary medical care. It can also take the form of not meeting the emotional needs of a child. More times than not, poverty and struggles to meet the basic, concrete needs of a family are a part of the equation in all types of neglect. Substance use and or mental health challenges can exacerbate or perpetuate these challenges, but these conditions are not always present.

Rather than seeing these root causes with clear eyes, calling them out, and taking them on with intention, we remain stuck as a system and society that focuses on the harmful aftereffects, often casting blame on

vulnerable families for their very vulnerability. Rather than trying to prevent poverty and the many challenges associated with poverty, such as social isolation and lack of meaningful opportunities and support, we search for increasingly sophisticated evidence-based interventions to treat the trauma or "fix" the symptoms arising from a family's inability to meet their children's fundamental needs.

We believe this must change.

For the past 2 and a half years, we have listened carefully to the stories of parents struggling to provide for their children while trying to keep the threat of child removal at arm's length. Sometimes they are successful, and sometimes they are not. We have also visited programs and learned of efforts across the country that are committed to making sure families have the help and support they need, before, during, and after the crisis arises—the most impactful of which focus on preventing the crisis from arising in the first place.

Many of the stories and programs speak directly to or reside at the intersection of poverty and neglect. The consistency with which poverty has been a leading part of the story parents tell is eye opening but sadly not surprising. The following are some of those stories:

A young mother had to make a difficult decision on whether to use money for a flat tire she got on her way to work soon before her rent was due, knowing that she would not be able to pay for both. She needed the tire to drive to work to earn money for rent and to meet her child's needs.

Young parents who are foster care alumni incurred a burdensome debt while trying to earn an education critical to landing good jobs, while holding down very low-paying jobs and meeting the basic needs of their children.

Children were removed from their parents due to chronic homelessness or housing instability.

The children of a young, single mother were removed solely due to an eviction. She had hoped that the system would rally to help her find decent, safe housing only to be told "you must comply with this or that in your case plan in order to regain custody."

Countless parents knew they needed help but did not have the means to obtain it on their own and were afraid to ask for it for fear of removal.

Parents were required to pay for certain services or drug testing they could not afford and had that inability to pay used against them as failure to comply with a case plan, preventing them from regaining custody of their children.

Each of these examples brings the challenges of poverty and lack of resources or support into acute focus. Absent such challenges and scarcities, odds are less that the families in the examples would make contact with the child welfare system. On the other hand, we have also seen exceptional efforts to address basic, poverty-related issues before and after child welfare intervention becomes necessary. We have seen common-sense, kind, and effective efforts to assist families to overcome poverty related challenges and stay together. The following are a few examples:

A community adoption agency took on the prevention mantle by rallying around a family at risk of losing its children by lining up safe child care, bringing meals to the family, and securing rent to head off an impending eviction.

Several community-led organizations provided basic, concrete supports to families in need before those needs escalate to hotline reports (e.g., food, rent assistance, legal aid, and safe places with people that listen).

A prosperity project designed to support economic mobility of parents provided job training and support, educational opportunities, and child care.

A tribal Early Head Start and child care program provided children with a safe, educational environment while their parents learned about child development, received job training, and sometimes even became employed as teachers and aids within the program.

A judge ordered a child welfare agency to pay for a necessary repair to a septic tank that would otherwise leave a home uninhabitable and a family separated.

A parent attorney successfully argued that supplemental security income death and disability payments be made to a mother positioning herself for reunification instead of the child welfare agency so that she would not lose her apartment.

Several subsidized housing programs operated within the child welfare system by both public and private agencies provided stable housing and support for youth emancipating from foster care to help prevent them from becoming homeless, allowing them to save money and to get an education. Some programs also provided housing to parents that have been or are working to reunify with their children or who are at risk of losing their children.

These are two very different sets of examples and two very different types of stories that should be instructive to all of us on what is necessary to reimagine a child welfare system focused on strengthening the capacities of parents to keep their children safely at home. By investing heavily in the second set of examples, we can profoundly reduce the incidence, number, and severity of the first set of examples.

We also must be clear about the likelihood that parents who are dealing with housing emergencies or food scarcity will be able to benefit from evidence-based services that require regular attendance or completion of a predetermined dose or number of sessions. Will the parenting classes or therapy, even if well-supported by the evidence, take or be sustainable when a parent does not have a place to live, a steady income, or a way to feed their children?

Committing to a system that takes on poverty-related neglect in humane and effective ways requires active partnering with public and private entities that can, collectively, create the conditions where families can thrive and children are free from harm. It requires partnership with communities that know and understand the needs of their families and children. And, it requires a willingness to rally around families that are vulnerable and struggling with poverty, rather than judging them, labeling that vulnerability as neglect, and pathologizing them.

If we truly care about children and families, it's time to stop confusing poverty with neglect and devote ourselves to doing something about it.

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Contact us at cb_express@childwelfare.gov.

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Attachment W

Kentucky | Transforming Health Care | **Aetna**

Attachment W
G.6 - SKY Implementation Plan

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ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
1			**KY SKY Implementation Work Plan**	**0%**	**298 days**	**Mon 1/20/20**	**Wed 3/10/21**		
2			**Business Opportunity Response**	**0%**	**15 days**	**Mon 1/20/20**	**Fri 2/7/20**		
3			Required Implementation Section Provided to RFP Staf	0%	1 day	Mon 1/20/20	Mon 1/20/20		MSI- Implementation
4			Proposal/Application Submitted	0%	1 day	Fri 2/7/20	Fri 2/7/20		Business Development
5		**MILESTONE**	**MILESTONE: Contract Awarded**	**0%**	**0 days**	**Thu 4/30/20**	**Thu 4/30/20**		
6			**Initiate Implementation**	**0%**	**133 days**	**Mon 1/20/20**	**Wed 7/22/20**		MIS- Implementation
7			**RFP to Implementaiton**	**0%**	**83 days**	**Mon 1/20/20**	**Wed 5/13/20**		MIS- Implementation
36			**Pre-Award Set Up**	**0%**	**102 days**	**Tue 3/3/20**	**Wed 7/22/20**		MIS- Implementation
48			**Implementation Kickoff Actions**	**0%**	**78 days**	**Mon 3/16/20**	**Wed 7/1/20**		MIS- Implementation
56			**Execute Implementation (After Award)**	**0%**	**139 days**	**Thu 4/30/20**	**Tue 11/10/20**		
57			**Post Award Execution**	**0%**	**20 days**	**Thu 5/14/20**	**Wed 6/10/20**		**MSI- Implementation**
60			**Submit Pre-Go Live Deliverables**	**0%**	**75 days**	**Fri 5/29/20**	**Thu 9/10/20**		**MSI- Implementation**
65			**Readiness Review**	**0%**	**139 days**	**Thu 4/30/20**	**Tue 11/10/20**		**MSI- Implementation**
66			KY Communicates Readiness Timeline and Tool	0%	1 day	Wed 7/15/20	Wed 7/15/20		MSI- Implementation
67			Meet with DHS to review tool	0%	1 day	Thu 7/16/20	Thu 7/16/20	66	Health Plan Operations
68			**Desk Review Documentation Review**	**0%**	**32 days**	**Thu 7/16/20**	**Fri 8/28/20**		**MSI- Implementation**
77			**Desk Review Documentation Feedback**	**0%**	**43 days**	**Fri 9/11/20**	**Tue 11/10/20**		**MSI- Implementation**
86			**Operational Onsite Readiness Review (if required)**	**0%**	**139 days**	**Thu 4/30/20**	**Tue 11/10/20**		**MSI- Implementation**
101			**SKY Implementaion**	**0%**	**190 days**	**Thu 4/30/20**	**Wed 1/20/21**		
102			Identify the SKY Dedicated Team	0%	5 days	Thu 4/30/20	Wed 5/6/20		MIS- Implementation
103			**Identify Program Enhancements**	**0%**	**10 days**	**Thu 4/30/20**	**Wed 5/13/20**		**Business Development**
104			**Unique SKY Contractual (and Proposal) Requirements/Deliverables**	**0%**	**10 days**	**Thu 4/30/20**	**Wed 5/13/20**		
105			Aetna Care Duffle Bag and Birthday Box Program	0%	10 days	Thu 4/30/20	Wed 5/13/20		SKY Care Management
106			Mobile Crisis Stabalization Team	0%	10 days	Thu 4/30/20	Wed 5/13/20		Behavioral Health,SKY Car
107			Regional Shared Children, Youth and Family Teams and stakeholder meetings	0%	10 days	Thu 4/30/20	Wed 5/13/20		SKY Executive Management
108			Behavioral Health and Psychiatric Treatment contracting	0%	10 days	Thu 4/30/20	Wed 5/13/20		Behavioral Health,Network,SKY Care
109			Medically Complex Needs program	0%	10 days	Thu 4/30/20	Wed 5/13/20		Utilization Management,S
110			Trauma-Informed Care (TIC) Training	0%	10 days	Thu 4/30/20	Wed 5/13/20		Provider Relations,SKY Car
111			**Identify, Enhance, Review and Submit Required Docu**	**0%**	**10 days**	**Thu 5/14/20**	**Wed 5/27/20**	**103**	
112			Submission of a network development plan to meet requirements	0%	10 days	Thu 5/14/20	Wed 5/27/20		Network

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
113			Submission of a staffing plan that details the staffing levels dedicated to SKY program	0%	10 days	Thu 5/14/20	Wed 5/27/20		Human Capital
114			Communication plan outlining steps Aetna will take to build relationships, educate, train and collaborate with DCBS staff and the DCBS units dedicated to ICAMA and ICPC services	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Executive Management
115			Plan outlining how Aetna will build relationships, educate, train and collaborate with DJJ staff at the Community District level.	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Executive Management
116			Development of transition policies and procedures during implementation, including the guidelines Aetna will use to collaborate with DCBS and DJJ to identify Medically Complex Children and Children with Special Health Care Needs	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Executive Management
117			Submission of policies and procedures related to the provision of all required health screenings and assessments within the prescribed timeframes	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Care Management
118			Submission of policies and procedures for conducting the initial assessments and provision of required services	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Care Management
119			Submission of policies and procedures for tracking and reporting individual health outcomes for SKY Enrollees including reporting whether an Enrollee's health outcomes improved as a result of Care Coordination activities	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Care Management
120			Submission of a Kentucky SKY Enrollee education and outreach plan.	0%	10 days	Thu 5/14/20	Wed 5/27/20		Member Services
121			Submission of an education and outreach plan for Providers, court personnel, law enforcement, and others on Trauma-informed Care, evidenced based practices applicable to the Kentucky SKY populations, etc.	0%	10 days	Thu 5/14/20	Wed 5/27/20		Provider Relations
122			Submission of policies and procedures related to Care Coordination Teams, health records, privacy requirements and other activities or requirements specific for Kentucky SKY Enrollees.	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Care Management

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
123			Submission of privacy policies and procedures for Kentucky SKY Enrollees, including staff and Provider training and re-training protocols.	0%	10 days	Thu 5/14/20	Wed 5/27/20		Learning & Performance,Provider Relations
124			Submission of policies and procedures related to the ability to share Care Coordination and Case Management Information electronically with DCBS and DJJ staff.	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Care Management
125			Submission of Enrollee Services policies and procedures including the 24/7 Call Center.	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Executive Management
126			Detailed plans for coordinating with other sister agencies, such as DBHDID, Department of Public Health and Department of Education, as needed.	0%	10 days	Thu 5/14/20	Wed 5/27/20		SKY Executive Management
127			**Transiton of Care Enhancement**	**0%**	**60 days**	**Thu 4/30/20**	**Wed 7/22/20**		
128			Identify required Information	0%	20 days	Thu 4/30/20	Wed 5/27/20		MIS- Implementation
129			Work with Appropriate Departments to identify Infomration Exchange	0%	40 days	Thu 5/28/20	Wed 7/22/20	128	MIS- Implementation
130			**Identify Enhancement of Web Site**	**0%**	**20 days**	**Thu 4/30/20**	**Wed 5/27/20**		
131			Memebr Web Site	0%	20 days	Thu 4/30/20	Wed 5/27/20		Marketing Operations
132			Member Portal	0%	20 days	Thu 4/30/20	Wed 5/27/20		Portal Development
133			Provider Web Site	0%	20 days	Thu 4/30/20	Wed 5/27/20		Marketing Operations
134			Provider Portal	0%	20 days	Thu 4/30/20	Wed 5/27/20		Portal Development
135			**System and Process Enhancements**	**0%**	**100 days**	**Thu 4/30/20**	**Wed 9/16/20**		
136			Enrollment	0%	100 days	Thu 4/30/20	Wed 9/16/20		Enrollment
137			Case Mnagement (Dynamo)	0%	100 days	Thu 4/30/20	Wed 9/16/20		Medical Management
138			Information Interface Development	0%	100 days	Thu 4/30/20	Wed 9/16/20		IT
139			Reports & Queries	0%	100 days	Thu 4/30/20	Wed 9/16/20		Informatics
140			**Provider Recruitment**	**0%**	**20 days**	**Thu 4/30/20**	**Wed 5/27/20**		**Network Ops**
141			Provider Recuitment Starategy Development	0%	20 days	Thu 4/30/20	Wed 5/27/20		Network Ops
142			**Human Capital - Hiring**	**0%**	**140 days**	**Thu 4/30/20**	**Wed 11/11/20**		
143			SKY Staffing Plan Submission	0%	40 days	Thu 4/30/20	Wed 6/24/20		Health Plan Operations
144			SKY Organizational Chart Developed	0%	10 days	Thu 6/25/20	Wed 7/8/20	143	Health Plan Operations
145			SKY Job Descriptions Completed	0%	10 days	Thu 4/30/20	Wed 5/13/20		Health Plan Operations
146			SKY - Plan for Background Check Process Developed	0%	30 days	Thu 4/30/20	Wed 6/10/20		Health Plan Operations

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
147			Identify need to colocate and request approval as necessary	0%	30 days	Thu 4/30/20	Wed 6/10/20		Health Plan Operations
148			Positions Posted	0%	10 days	Thu 6/25/20	Wed 7/8/20	143	Human Capital
149			Follow Human Capital Hiring Section 438	0%	140 days	Thu 4/30/20	Wed 11/11/20		Human Capital
150			**Network Development**	**0%**	**120 days**	**Thu 4/30/20**	**Wed 10/14/20**		
151			**Develop and Submit Netowrk Development Plar**	**0%**	**10 days**	**Thu 4/30/20**	**Wed 5/13/20**		**Network Ops**
152			Pedaticians	0%	10 days	Thu 4/30/20	Wed 5/13/20		
153			Behavioral Health Providers	0%	10 days	Thu 4/30/20	Wed 5/13/20		
154			Providers with Trauma-Informed Care	0%	10 days	Thu 4/30/20	Wed 5/13/20		
155			Identify gaps	0%	20 days	Thu 4/30/20	Wed 5/27/20		Network Ops
156			Recruite Providers to fill gaps	0%	100 days	Thu 5/28/20	Wed 10/14/20	155	Network Ops
157			**Training Staff**	**0%**	**60 days**	**Thu 4/30/20**	**Wed 7/22/20**		
158			Develop Training Plan	0%	60 days	Thu 4/30/20	Wed 7/22/20		Learning & Performance
159			**Training Providers**	**0%**	**20 days**	**Thu 4/30/20**	**Wed 5/27/20**		
160			Development of provider training plan	0%	20 days	Thu 4/30/20	Wed 5/27/20		Provider Experience
161			**Community Partnership Develpment**	**0%**	**60 days**	**Thu 4/30/20**	**Wed 7/22/20**		
162			Committee Development	0%	40 days	Thu 4/30/20	Wed 6/24/20		Business Development
163			Committee Reporting	0%	20 days	Thu 6/25/20	Wed 7/22/20	162	Business Development
164			**Testing**	**0%**	**60 days**	**Thu 9/17/20**	**Wed 12/9/20**	**139**	
165			Enrollment	0%	60 days	Thu 9/17/20	Wed 12/9/20		Enrollment
166			Case Mnagement (Dynamo)	0%	60 days	Thu 9/17/20	Wed 12/9/20		Medical Management
167			Web Site (Member and Provider)	0%	60 days	Thu 9/17/20	Wed 12/9/20		Marketing Operations
168			Portal (Member and Provider)	0%	60 days	Thu 9/17/20	Wed 12/9/20		Portal Development
169			Deploy Systems	0%	30 days	Thu 12/10/20	Wed 1/20/21	168	Medical Management,Ma
170			**Functional Areas**	**0%**	**255 days**	**Thu 3/19/20**	**Wed 3/10/21**		**MSI- Implementation**
171			**Configuration (CSRA)**	**0%**	**231 days**	**Mon 4/20/20**	**Mon 3/8/21**		**CSRA**
196			**Claims**	**0%**	**202 days**	**Thu 4/30/20**	**Fri 2/5/21**		**Claims**
208			**Compliance / HP Operations**	**0%**	**40 days**	**Thu 4/30/20**	**Wed 6/24/20**		**Compliance**
213			**Contracts & Licenses**	**0%**	**90 days**	**Thu 4/30/20**	**Wed 9/2/20**		**Legal**
218			**Credentialing**	**0%**	**150.4 days**	**Thu 4/30/20**	**Thu 11/26/20**		**Credentialing**
233			**Encounters**	**0%**	**157 days**	**Thu 4/30/20**	**Fri 12/4/20**		**Encounters**
256			**Enrollment**	**0%**	**176 days**	**Thu 4/30/20**	**Thu 12/31/20**		**Enrollment**
277			**Finance, Actuarial, Check Run**	**0%**	**70 days**	**Thu 4/30/20**	**Wed 8/5/20**		**Finance**

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
285			**Grievance & Appeals - update as needed for new contract**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**Grievance & Appeals**
299			**Infrastructure**	**0%**	**176 days**	**Thu 4/30/20**	**Thu 12/31/20**		**Infrastructure**
326			**Informatics / Reporting**	**0%**	**201 days**	**Thu 4/30/20**	**Thu 2/4/21**		**Informatics**
332			**IT**	**0%**	**225 days**	**Thu 4/30/20**	**Wed 3/10/21**		**IT**
333			IT Kickoff Conducted	0%	10 days	Thu 4/30/20	Wed 5/13/20		IT
334			**Release 1 - Marketing Readiness - review of existing applications for contract compliance**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
339			**Release 2 - Eligibility Readiness (Enrollment)-review of existing applications and processes for contract compliance**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
344			**Release 3 - Health Plan Go-Live**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
349			**Release 4 - Encounters Medicaid**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
354			**Member and Provider Portals / Public Websites**	**0%**	**215 days**	**Thu 5/14/20**	**Wed 3/10/21**		**IT**
359			**Human Capital - Staffing**	**0%**	**200 days**	**Thu 3/19/20**	**Wed 12/23/20**		**MSI - Human Capital**
378			**Learning and Performance**	**0%**	**189.8 days**	**Thu 4/30/20**	**Wed 1/20/21**		**Learning & Performance**
393			**Marketing ADVERTISING**	**0%**	**173.77 days**	**Thu 4/30/20**	**Tue 12/29/20**		**Marketing Advertising**
403			**Marketing OPERATIONS**	**0%**	**167 days**	**Thu 4/30/20**	**Fri 12/18/20**		**Marketing Operations**
447			**Medical Management (CM, UM)**	**0%**	**177 days**	**Thu 4/30/20**	**Fri 1/1/21**		**Medical Management**
509			**Member Services**	**0%**	**176 days**	**Thu 4/30/20**	**Thu 12/31/20**		**Member Services**
554			**Network Contracting**	**0%**	**215 days**	**Thu 4/30/20**	**Wed 2/24/21**		**Network Ops**
595			**Pharmacy - verify all components meet new contract requirement**	**0%**	**146 days**	**Thu 6/25/20**	**Thu 1/14/21**		**Pharmacy**
620			**Population Health**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**Pop Health**
626			**Program Integrity**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**SIU**
631			**Quality - validate new contract requirements**	**0%**	**130 days**	**Thu 6/25/20**	**Wed 12/23/20**		**Quality**
639			**Real Estate & Telcom - for new contract elements**	**0%**	**165 days**	**Thu 4/30/20**	**Wed 12/16/20**		**Real Estate**
661			**User Acceptance New State Requirements Testing- if needed**	**0%**	**50 days**	**Thu 10/15/20**	**Wed 12/23/20**		**Testing**
673			**Value Added Benefits**	**0%**	**175 days**	**Thu 4/30/20**	**Wed 12/30/20**		**Health Plan Owners**
679			**Vendor / Subcontractor Management**	**0%**	**205 days**	**Thu 5/14/20**	**Wed 2/24/21**		**HP Vendor Manager**
689			**Unique Contractual (and Proposal) Requirements/Deliverables Execution**	**0%**	**120 days**	**Wed 7/1/20**	**Tue 12/15/20**		**Health Plan Owners**

ID	Task Mo	M/D Identifier	Task Name	% Complet	Duration	Start	Finish	Predecessor	Resource Names
692			**Deploy Implementation**	**0%**	**20 days**	**Mon 12/7/20**	**Fri 1/1/21**		**MSI - Implementation**
693			**Printed Materials**	**0%**	**1 day**	**Mon 12/21/20**	**Mon 12/21/20**		**Enrollment**
695			**Go Live Preparations**	**0%**	**20 days**	**Mon 12/7/20**	**Fri 1/1/21**		**MSI - Implementation**
702			Go Live	0%	1 day	Fri 1/1/21	Fri 1/1/21	701	MSI- Implementation
703			--Go to Post Implementation Work Plan for transition to operations	0%	1 day	Fri 1/1/21	Fri 1/1/21		MSI- Implementation

Attachment X

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Attachment X
G.6 - Provider Network Plan

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Netwtork Development Activities - KDMS - SKY	Timeline from Award	Actionable Party	Executive Accountability
Network Recruitment Activities for SKY			
Develop Recruitment Letter if applicable	within 1 week of award	Network Management	COO
Submit Letter for Approval	within 1 week of award	Network Management	COO
Determine what new provider types to recruit	within 2 weeks of award	Network Management	COO
Identify specific providers to recruit	within 4 weeks of award	Network Management	COO
Determine recruitment strategy to deepen Network accessibility	within 4 weeks of award	Network Management	COO
Define recruitment template format	within 4 weeks of award	Network Management	COO
Assign providers to network recruiters	within 4 weeks of award	Network Management	COO
Track and monitor recruitment activity	Ongoing	Network Management	COO
Credentialing Criteria			
Coordinate with CVO on new provider type requirements, if applicable	within 2 weeks of award	Network Management	COO
Access & Density			
Confirm State of KY access and density standards	within 4 weeks of award	Network Mangement	COO
Obtain data for forecasted membership	within 4 weeks of award	Network Mangement	COO
Develop Access plan to address any network gaps	within 6 weeks of award	Network Mangement	COO
Contracting Documents			
Determine if KY Medicaid Addendum can be used or modification needed	within 8 weeks of award	Legal	COO
Recruitment Bundles for New Practitioners/Groups/Facilities			
Identify documents required for packet	within 8 weeks of award	Network Management	COO
Create mailing bundle matrix	within 8 weeks of award	Network Management	COO
Initial Recruitment Mailing Practitioners/Groups/Facilities			
Mail or email packets to Providers	within 12 weeks of award	Network Management	COO
Review return mail process and modify as needed	Ongoing	Network Management	COO
Specialty Provider Type			
Providers with specialization in Child and Adolescent Needs and Strengths (CANS)	within 12 weeks of award	Network/Care Management	COO/CMO
Ready Responders	within 12 weeks of award	Network/Care Management	COO/CMO
Emergency EMS - Treat-and-Refer	within 12 weeks of award	Network/Care Management	COO/CMO
Event Based Community clinics in rural, underserved areas	within 12 weeks of award	Network/Care Management	COO/CMO
After-school behavioral health counseling services - in school setting > add NEMT wraparound services for transportation	within 12 weeks of award	Network/Care Management	COO/CMO
Peer Support Specialty Network and referral for at-risk youth	within 12 weeks of award	Network/Care Management	COO/CMO
Foster care access direct support and training	within 12 weeks of award	Network/Care Management	COO/CMO

Netwtork Development Activities - KDMS - SKY	Timeline from Award	Actionable Party	Executive Accountability
Foster care respite Network services	within 12 weeks of award	Network/Care Management	COO/CMO
Foster care counseling	within 12 weeks of award	Network/Care Management	COO/CMO
Adoption Assistance Agencies	within 12 weeks of award	Network/Care Management	COO/CMO
Post adoption support counseling	within 12 weeks of award	Network/Care Management	COO/CMO
Juvenile Court - Jail Diversion	within 12 weeks of award	Network/Care Management	COO/CMO
Specialty Program			
Trauma Informed Care	within 12 weeks of award	Network/Care Management	COO/CMO
Crisis Services	within 12 weeks of award	Network/Care Management	COO/CMO
Jail Diversion	within 12 weeks of award	Network/Care Management	COO/CMO
SMI training/emphasis/monitoring in Drug Court	within 12 weeks of award	Network/Care Management	COO/CMO
Adoption Training, post-adoption support counseling	within 12 weeks of award	Network/Care Management	COO/CMO
Integrated Behavioral Health Services	within 12 weeks of award	Network/Care Management	COO/CMO
Behavioral Health Centers of Excellence	within 12 weeks of award	Network/Care Management	COO/CMO
Centers of Excellence - Autism Spectrum Disorder	within 12 weeks of award	Network/Care Management	COO/CMO
SIX Seconds Emotional Intelligence	within 12 weeks of award	Network/Care Management	COO/CMO
Telemedicine Expansion - Teladoc, MDLive, One TeleMed	within 12 weeks of award	Network/Care Management	COO/CMO
Member Identification	within 12 weeks of award	Network/Care Management	COO/CMO
Workforce Development - supported employment	within 12 weeks of award	Network/Care Management	COO/CMO
Multi Specialty Integrated Clinics - children	within 12 weeks of award	Network/Care Management	COO/CMO
E-consult - Primary Care Providers	within 12 weeks of award	Network/Care Management	COO/CMO
Fee Schedules			
Determine if additional Medicaid fee schedules need to be developed	within 16 weeks of award	Network Management	CFO
Obtain approval of fee schedules	within 16 weeks of award	Network Management	CFO
System/Reporting Enhancements			
Determine what reporting will be required for internal and external stakeholders	within 16 weeks of award	Network Management	COO
Determine if enhancements are needed to support reporting needs	within 16 weeks of award	Network Operations	COO
Determine if new levels of care are required	within 16 weeks of award	Network Operations	COO
Configure enhancements needed	within 16 weeks of award	Network Operations	COO
Develop Network dashboard report to include recruitment activity	within 16 weeks of award	Network Operations	COO

Attachment Y

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Attachment Y
G.7 – Sample Trauma-Informed Care Training Materials

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Advancing Trauma-Informed Care in the Primary Care Setting

Identify and Respond to Trauma Among Patients

2019

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Overview

- The Importance of Trauma History in Primary Care
- Preparation, Process and Procedures
- Develop a Treatment Referral Network
- Choose an Inquiry Tool
- Educate and Train Staff
- Create an Inquiry Model
- Develop a Response Algorithm and Plan

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First – a brief focus on Why?

- Universal trauma screening and specific trauma assessment methods are necessary to developing collaborative relationships with trauma survivors and offering appropriate services (Harris & Fallot, 2001)
- Necessary in order to avoid re-traumatization, honoring the dictum: “Above all, Do No Harm”
- Sets the stage for building resilience, recognition of a survivors strengths and builds a healing alliance

Conduct Inquiry for Presence of Trauma

Inquiry + conversation + screening tool (as needed) = Better understanding of patient's history, needs and resilience factors

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Getting Ready

- Create safe, secure and trusting environments
- Establish policies, procedures and pathways related to inquiry
- Develop responses to inquiries about trauma
- Train all practice staff

Patient education

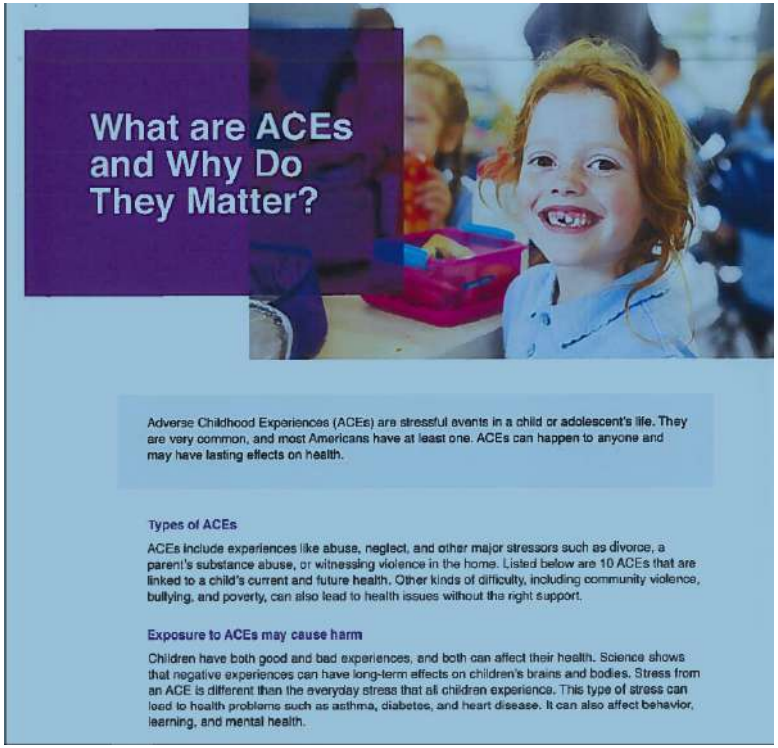

What are ACEs and Why Do They Matter?

Adverse Childhood Experiences (ACEs) are stressful events in a child or adolescent's life. They are very common, and most Americans have at least one. ACEs can happen to anyone and may have lasting effects on health.

Types of ACEs

ACEs include experiences like abuse, neglect, and other major stressors such as divorce, a parent's substance abuse, or witnessing violence in the home. Listed below are 10 ACEs that are linked to a child's current and future health. Other kinds of difficulty, including community violence, bullying, and poverty, can also lead to health issues without the right support.

Exposure to ACEs may cause harm

Children have both good and bad experiences, and both can affect their health. Science shows that negative experiences can have long-term effects on children's brains and bodies. Stress from an ACE is different than the everyday stress that all children experience. This type of stress can lead to health problems such as asthma, diabetes, and heart disease. It can also affect behavior, learning, and mental health.

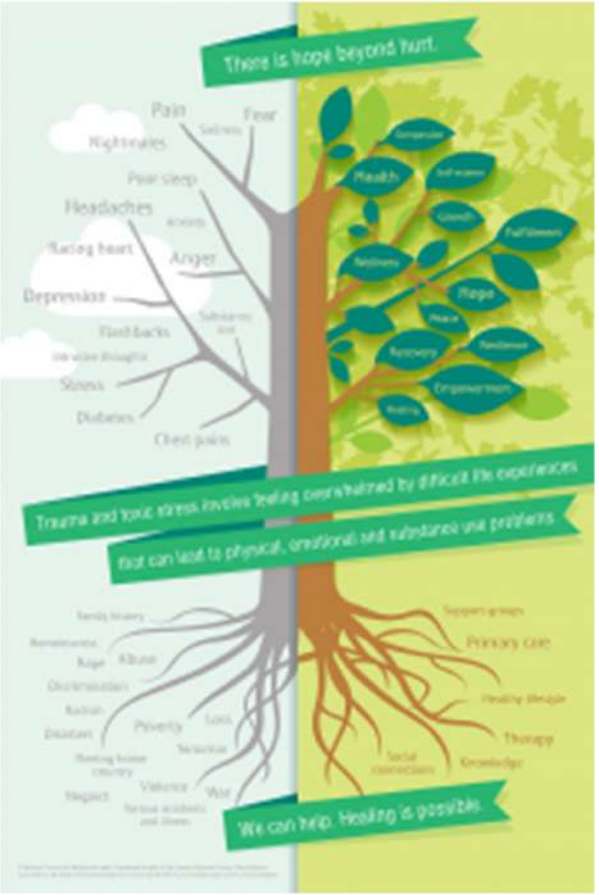

Conversations about Trauma with Patients

Tools & Resources

- Motivational Interviewing Skills
- Active Listening Process
- Using Shared Decision Making

Sample Trauma Screening Tools

- Adverse Life Experiences (ACEs) Questionnaire
- Trauma Assessment for Adults - Self-report (TAA)
- Trauma History Screen (THS)
- Trauma History Questionnaire (THQ)
- Life Events Checklist for DSM-5 (LEC-5)
- Traumatic Events Questionnaire (TEQ)
- Primary Care PTSD Screen (PC-PTSD)
- PTSD Checklist for DSM-5 (PCL-5)

Sample Trauma Inquiry Workflow Model

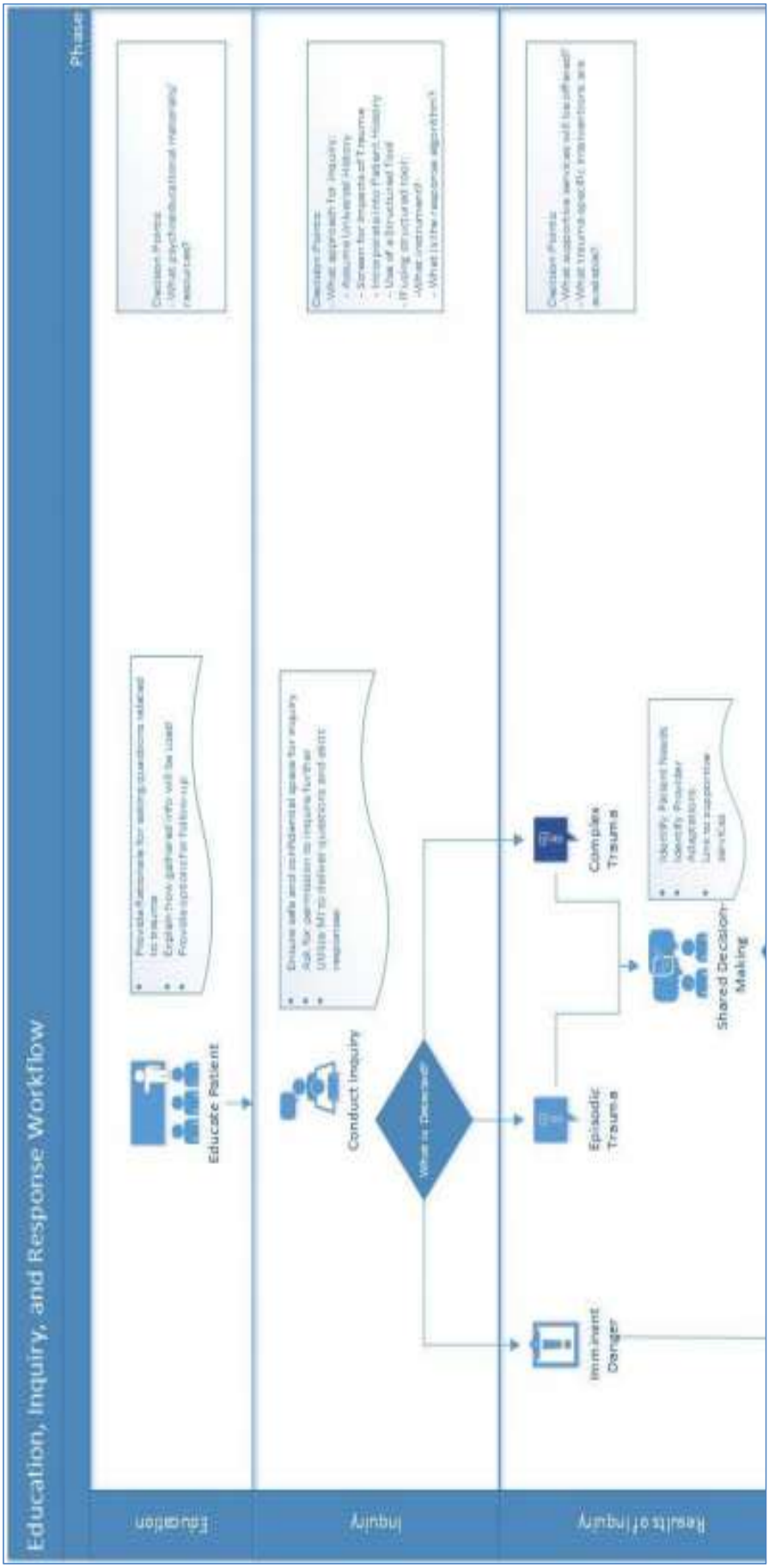

Develop a Response Algorithm and Care Pathway

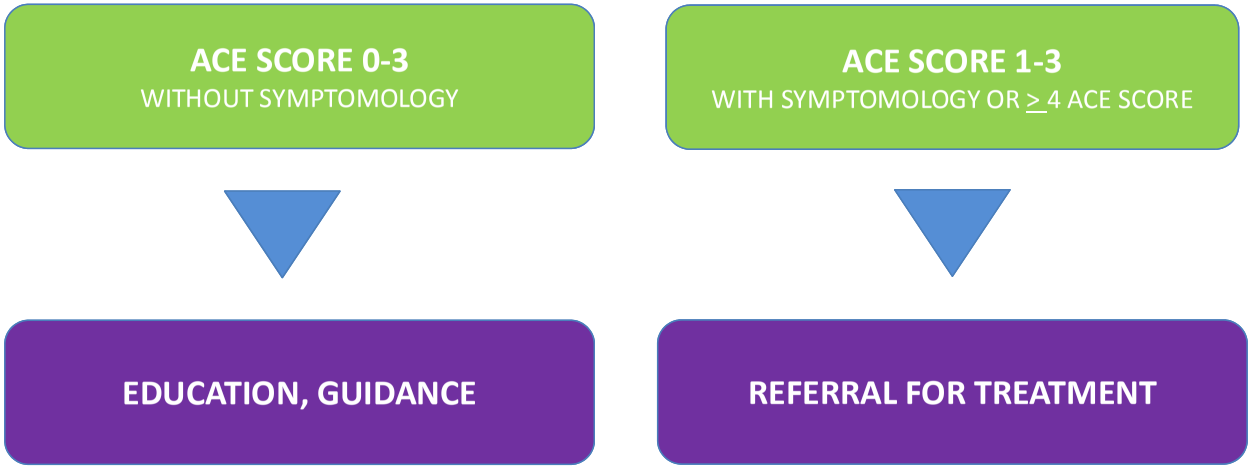

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health begins with hope

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Plan to Respond

Type of Trauma	Response
Interpersonal Violence **Intimate Partner Violence** **Domestic Violence** **Danger to Children** **Suicidal or homicidal ideation**	Immediate assistance and connection with support services Comply with mandated reporting laws Patient education Referral to trauma-informed behavioral health provider
Episodic Trauma: Exposure to an episodic or singular event	Patient education, connect to trauma-informed supportive service
Complex Trauma: Repetitive, prolonged or cumulative	Patient education, connect to trauma-informed supportive services, referral to trauma-informed behavioral health provider or other supports
Systemic Trauma: Results from the contextual features of environments and institutions	Patient education, connect to trauma-informed supportive services, referral to trauma-informed behavioral health provider or other supports

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The Urgency to Address Trauma in our Organizations and Communities What it Means to Be Trauma-Informed

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Overview

- Prevalence and impact of trauma
- Trauma and the human stress response
- Becoming a trauma-informed organization
- Compassion in our work – Self-care and building a resilient work force
- Trauma and addictions
- Trauma in the context of culture
- Infusing trauma-informed approaches in our daily work

What is Trauma?

Definition includes three elements: "The 3 E's"

*Individual trauma results from an **event**, series of events, or set of circumstances that is **experienced** by an individual as overwhelming or life-changing and that has profound **effects** on the individual's psychological development or well-being, often involving a physiological, social, and/or spiritual impact.*

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

What is Resilience?

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress. It means "bouncing back" from difficult experiences.

American Psychological Association. *The Road to Resilience.* Retrieved from http://www.apa.org/helpcenter/road-resilience.aspx

Types of Trauma

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Adverse Childhood Experiences (ACEs) Affect on Health and Well-being

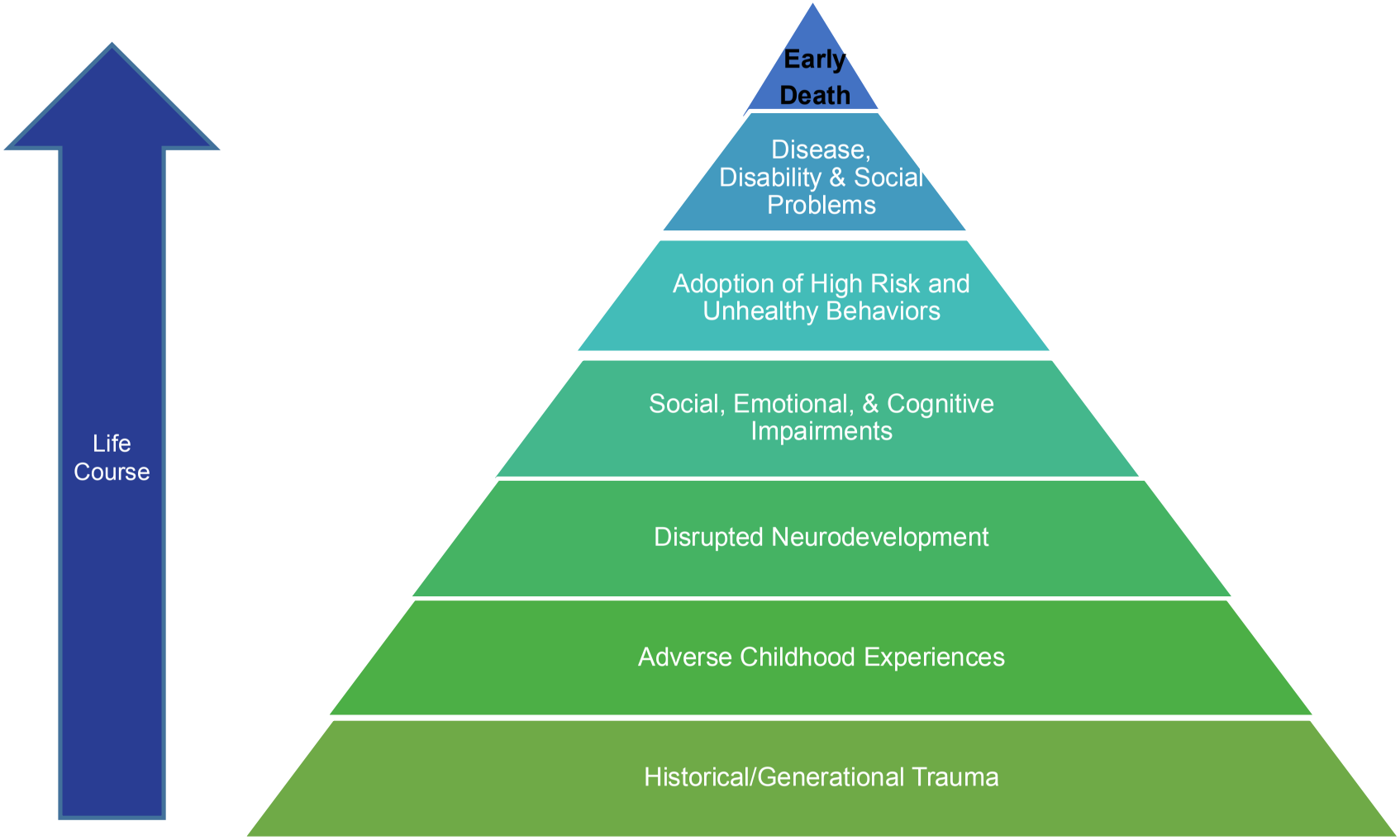

Adverse Childhood Experiences (ACE) and adolescent health. Retrieved from https://www.cdc.gov/violenceprevention/acestudy/

Trauma-Informed Provider Network

Robert M. Atkins, M.D., MPH
Senior Medical Director
Aetna Medicaid

Model Design Features

- Integrate all Personalized Health domains in one model:
  - Intersectionality of TIC and SDoH
  - Cultural Competency
  - Health Equity
  - Systems of Care
- Prioritize the member's experience
- Mirror broadly accepted SAMHSA model for BH/PH integration
- Agnostic regarding the model/approach
- Low barriers to entry: start simple
- Behaviorally anchored descriptions of each level
- Recognize and reward individual practitioners as well as provider organizations
  - Provider Database: QNXT attributes
  - Incentives: Value-Based Solutions
  - Performance metrics/Outcomes
- Recognize & reward progression
  - Incentives begin at Level 1
  - "Certification" as "trauma-informed" begins at Level 3

Model Design

- Six Levels
  - Trauma Aware
    - Level 1 —Foundational Awareness
    - Level 2 — Enhancing Routine Clinical Practice
  - Trauma-Informed
    - Level 3 — Basic Trauma-Informed Care
    - Level 4 — Advanced Trauma-Informed Care
  - Trauma-Transformed
    - Level 5 —Close/Full Collaboration in a Merged Practice
    - Level 6 —Trauma-Informed System of Care
- Two tracks
  - Individual Practitioners
  - Provider Organizations
- Integration into single track at Level 5
- Detailed Features of a Trauma-Informed Provider Organization: Site visit audit tool

Trauma Aware

Level 1 —Foundational Awareness

- **Individual Practitioners** are well-informed about ubiquity of trauma and its likely impact on their patients/clients. They understand the critical role of social determinants of health [SDoH] as drivers of clinical, functional and quality of life outcomes.
- **Provider Organizations** are committed to becoming trauma-informed. Both clinical and non-clinical staff describe this as “a good place to work.” Patients/clients describe this is “a good place to come for care” expressed as:
  - I feel safe here.
  - I trust the clinicians and the non-clinical staff.
  - People listen to me and care about what I say.
  - I feel welcome and respected.

Trauma Aware

Level 2 — Enhancing Routine Clinical Practice

- **Individual Practitioners** integrate Level 1 knowledge into routine clinical practice using evidence-based tools. “I’m doing the clinical work I’ve always done, and have added clinical tools that address trauma and SDoH to my routine toolbox.”
- **Provider Organizations** promote trauma-informed primary prevention as a routine practice for all patients/clients, analogous to childhood vaccinations, flu shots, *etc*.
- Routine clinical care:
  - Includes patient/client education about how to thrive and flourish, build resiliency, enhance protective factors and minimize the risks of trauma.
  - Assesses and addresses SDoH as standard elements of a person’s treatment/recovery plan

Trauma-Informed

Level 3 — Basic Trauma-Informed Care

- **Individual Practitioners** expand routine clinical practice by integrating treatments, services and supports that explicitly address trauma. "*The scope of my practice has expanded*" by either:
  - Adding qualifications in evidence-based and/or promising Trauma-Specific Treatments, Services and Supports
  - Integrating Level 2 practice into serving populations at high risk of trauma: people with complex needs and/or marginalized populations
- **Provider Organizations** perform trauma-informed secondary prevention for all people they serve, using universal screening for early adversity, historical, and on-going trauma, and for SDoH risk factors. They have identified resources to respond to a person's immediate and on-going needs, including but not limited to Trauma-Specific Services. They collaborate [SAMHSA Levels 2-3] with Trauma-Informed Level 3 Individual Practitioners. Current *Joint Commission* standards for accreditation for behavioral health require use of a trauma screening tool during the admission process.

Trauma-Informed

Level 4 — Advanced Trauma-Informed Care

- **Individual Practitioners** include considerations of complex trauma and social determinants of health within routine clinical practice, using a biopsychosocial model of care that integrates physical and behavioral health.
- **Provider Organizations** are a Trauma-Informed Center of Excellence [CoE] for at least one high risk/rising risk population:
  - marginalized population; or
  - people with complex needs.

  CoEs are provider organizations that offer state-of-the-art and innovative treatments, services and supports for people with complex needs. They may focus on improving health outcomes for a well-defined population. They develop and implement practices and clinical pathways that the larger healthcare community may adopt as clinical standards of care. They are often referral and consultation centers, embedded within a larger system of care. There is close collaboration with trauma-informed [Level 3/4] **Individual Practitioners.** See lists of potential populations

Trauma-Transformed

Level 5 —Close/Full Collaboration in a Merged Practice

- **Provider Organizations** include trauma-informed [Level 3/4] **Individual Practitioners** on inter-disciplinary care teams, in addition to the usual treatment team members for that Provider Organization. There are high levels of collaboration and integration between behavioral and physical health providers [SAMHSA Levels 5-6].

  SAMHSA Level 6: *The highest level of integration involves the greatest amount of practice change. Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients/clients, not just targeted groups.*

Trauma-Transformed

Level 6 —Trauma-Informed System of Care

- **Provider Organizations** collaborate across sectors to meet the complex needs of people they serve within a larger community context.
- The **Provider Organization** implements a broad, community-wide focus on the underlying social and economic conditions in which people live, in addition to supporting people to meet their immediate individual needs.
- The **Provider Organization** bridges the dichotomy between individual-level "social needs" and community-level "social determinants."
- While targeted, small-scale social interventions provide invaluable assistance for individuals, the **Provider Organization** remains focused on the social determinants that perpetuate poor health at the community level.

https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/

Features of a Trauma-Informed Provider Organization

Feature	Level of Practice					
	Trauma Aware		Trauma Informed		Trauma Transformed	
	Level 1 — Foundational Awareness	Level 2 — Enhancing Routine Clinical Practice	Level 3 — Basic Trauma-Informed Care	Level 4 — Advanced Trauma-Informed Care	Level 5 — Collaboration in a Merged Practice	Level 6 —Trauma-Informed System of Care
Individual Voice & Choice						
Staff Beliefs, Attitudes & Behaviors						
Leadership Commitment						
Disclosure Readiness						
Staff Well-Being						
Staff Knowledge & Skills						
Individual Practitioners						
Diversity Hospitable						
Complexity Capable						

Assigning Provider Level

- Identify the performance domains that apply to the provider; *e.g.,* a solo practitioner will have fewer performance domains than a Federally Qualified Health Center or a health system
- To achieve a Level assignment, performance must be
  - ≥75% of applicable domains are at or above that level
  - ≤25% of applicable domains are one level below that level
  - No applicable domain is > one level below the assigned level

Next Steps

- Internal consensus
  - Coordinate within Provider Network Workgroup
    - Incentives w VBS
    - QNXT attributes
    - Outcomes
  - Coordinate with other workgroups
    - Training
    - Communication
    - Outcomes
- Feedback from field with on-going “rapid-cycle” improvement
  - Stakeholder organization in each pilot state
  - Presentations to critical audiences
  - Phase 1 providers in each pilot state: market leaders
- Revise to produce version 1.0

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Attachment Z

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Attachment Z
G.8 – Provider Network

Foster Care Assessment ..... Att Z-3

Protective Factors for Children ..... Att Z-7

Crisis Situations: Phone Calls and Face to Face Visits ..... Att Z-13

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Foster Care Assessment

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Foster Care Assessment

Name of Child (Last name, first name) Click here to enter text.	Date Of Birth: Click here to enter a date.	SSN: Click here to enter text.

Date of Placement: Click here to enter a date.	Date child came into care: Click here to enter a date.
Foster parent name/phone: Click here to enter text.	Does Aetna have permission to contact the foster parent: YES ☐ NO☐

What is child's permanency plan? Click here to enter text.

Does the child have a primary care provider? YES ☐ NO☐ Name: Click here to enter text.

Does the child have specialty providers (therapist, psychiatrist, etc.)? YES ☐ NO☐

If yes, please provide names of the specialty providers:
Click here to enter text.

List All Medications:

Name: Click here to enter text.	Name: Click here to enter text.	Name: Click here to enter text.
Dosage: Click here to enter text.	Dosage: Click here to enter text.	Dosage: Click here to enter text.
Frequency: Click here to enter text.	Frequency: Click here to enter text.	Frequency: Click here to enter text.
Name: Click here to enter text.	Name: Click here to enter text.	Name: Click here to enter text.
Dosage: Click here to enter text.	Dosage: Click here to enter text.	Dosage: Click here to enter text.
Frequency: Click here to enter text.	Frequency: Click here to enter text.	Frequency: Click here to enter text.

Does the child take medication for Attention Deficit Disorder, depression or any other mental health condition? YES ☐ NO☐

In general, would you say the child's health is: Choose an item.

Does the child have any physical health or mental health diagnoses? YES ☐ NO☐

If yes, please list: Click here to enter text.

Are immunizations up to date? YES ☐ NO☐	Does the child have a current flu shot? YES ☐ NO☐

Has the child been diagnosed with high lead levels? YES ☐ NO☐

Date of last well-child check: Click here to enter a date.	Date of last dental visit: Click here to enter a date.	Date of last vision visit: Click here to enter a date.

Does the child have a hard time with emotions, learning, focusing, or getting along with others?
Choose an item.

Does the child see a doctor for his/her emotions, growth, or behavior? YES ☐ NO☐

If yes, please provide name and specialty: Click here to enter text.

Can the child do the following as well as children his/her age? (mark all that apply):

☐ Eating ☐ Dressing ☐ Walking ☐ Bathing ☐ Toileting ☐ Talking

In the last year, did the child get any special treatments? (PT, ST, OT, home health, etc.) YES ☐ NO☐		
Does the child require specialized medical equipment, orthotics, or other special assistance: YES ☐ NO☐		
In the last 6 months, has the child gone to the ER or stayed overnight in the hospital more than 2 times? YES ☐ NO☐		
How many addresses has the child had in the last month: Choose an item.		
In the last year, how many school days did the child miss because he/she was sick or hurt? Choose an item.		
Does the child utilize school based services? YES ☐ NO☐		
Is the child part of an Individualized Education Plan (IEP)? YES ☐ NO☐		
Is the child seen by the Commission for Children with Special Health Care Needs? YES ☐ NO☐		
Is the child receiving special EPSDT services? YES ☐ NO☐		
Does the child have any of the following? (mark all the apply) ☐ WIC ☐ HANDS ☐ First Steps ☐ Community Resources ☐ Other: Click here to enter text.		
Is the child pregnant? YES ☐ NO☐ If yes, how many weeks? Click here to enter text.		
Does the child have vision impairments? YES ☐ NO☐	Does the child have hearing impairments? YES ☐ NO☐	
Does the child have any dental or oral health issues, including decay or cavities? YES ☐ NO☐		
Does the child smoke cigarettes? YES ☐ NO☐		
Child's Race: Click here to enter text.	Child's Height: Click here to enter text.	Child's Weight: Click here to enter text.

Additional comments/concerns: Click here to enter text.

Completed by (include your relationship to child): Click here to enter text.

Date: Click here to enter a date.

The **Informed Health Line** is open for Aetna Better Health members 24 hours a day, seven days a week. Friendly registered nurses give expert advice and quick answers. Our nurses speak English and Spanish. Interpreters are available for other languages. (855) 620-3924

Protective Factors for Children

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Protective Factors for Children

Introduction:	This job aid describes the types of protective factors to consider when evaluating children for the support and skills to develop self-management and autonomy.

The more protective factors a child has in place, the more likely that child is to have healthy outcomes. Protective factors are highly tied to the development of self-management skills and autonomy.

Consider each of the sub-bulleted items when identifying protective factors for children

- **My child has an active and supportive family/parental involvement**
  - Child's family has clear rules, supervision, and discipline practices
  - There is a mutual attachment between child and parent(s)
  - There is parent involvement in the child's life, education, and activities
  - Child has a safe and stable place to live
  - Child has caring relationship(s) and support from one or more family members
- **My family has clear rules, supervision, and discipline practices**
- **There is a mutual attachment between my child and me.**
- **I am involved in my child's life, education, and activities.**
- **My child has a safe and stable place to live.**
- **My child has caring relationship(s) and support from one or more family members.**
- **My child has a positive and encouraging educational environment.**
- **My child is engaged at school/having a positive educational experience**
  - Child has healthy relationships with adults and peers in school
  - Success in school and education are important to the child
  - Child has a safe and supportive school environment
  - Child's parent(s) support, encourage, and are involved in the child's education
- **My child has healthy relationships with adults and peers in school.**
- **Success in school and education are important to my child.**
- **My child has a safe and supportive school environment.**
- **I am a parent who supports, encourages, and is involved in my child's education.**
- **My child has friends/peers who are a positive influence**
  - Child has good relationships with other youth
  - Child's parent(s) know and approve of child's friends/ peers
  - Child has friends/peers who do not use drugs or alcohol
  - Child has friends who exhibit respect for authority

  - Child spends time with friends being physically active or being involved with other positive activities
- **My child has good relationships with other youth.**
- **I know and approve of my child's friends/peers.**
- **My child has friends/peers who do not use drugs or alcohol.**
- **My child has friends who exhibit respect for authority.**
- **My child spends time with friends being physically active or being involved with other positive activities.**
- **My child has a safe and stable home and community.**
- **My child has access to physical and behavioral healthcare, social services, and community resources.**
  - Child lives in a safe and stable neighborhood
  - Child has access to resources (housing, health care, child care, jobs, recreation, etc.)
  - Child participates with religious and/or community groups
  - Child's community supports anti-drug and anti-violent behaviors
- **My child lives in a safe and stable neighborhood.**
- **My child has access to resources such as housing, health care, child care, jobs, recreation, etc.**
- **My child participates with religious and/or community groups.**
- **Our community supports anti-drug and anti-violent behaviors.**
- **My child exhibits good self-esteem/self-worth.**
- **My child has supports to develop good decision making skills**
  - Child has a sense of belonging
  - Child has responsibility for other people or pets
  - Child has the ability to be a friend
  - Child has a sense of self-worth and self-confidence
  - Child has self-motivation
  - Child gives of self in service to others or a cause
- **My child has a sense of belonging.**
- **My child helps me and/or my family care for other people or pets.**
- **My child has the ability to be a friend.**
- **My child has a sense of self-worth and self-confidence.**

- **My child has self-motivation.**
- **My child gives of self in service to others or a cause.**
- **Other**
- **Unknown/Persistent Outreach**

Crisis Situations: Phone Calls and Face to Face Visits

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Crisis Situations: Phone Calls and Face to Face Visits

Medical Management Cross-Functional

- **Handling and Transferring Potential Crisis Calls**
- **Emergent Life Threatening and Emergent Non-Life Threatening Calls – Clinician Role**
- **Urgent and Routine Calls – Clinician Role**
- **Call Documentation and Follow-Up – Clinician Role**
- **Contact Options for Emergency Services**
- **Face to Face Crisis Situations**

Aetna Better Health uses the following process for appropriately handling crisis, urgent or emergency situations. This process is not intended to be exhaustive nor is it intended to be prescriptive or to replace clinical judgment. Staff directly involved in managing the crisis situation should engage with the member as necessary until the member is safe. **Though the majority of this desktop speaks to behavioral health crises there are also physical health crises that may occur and that may need to be handled by the plan's physical health clinicians for triage.**

Note: Not all angry members are considered to be in crisis even though they may be hostile or difficult to understand or engage. Members that are not making a direct threat are dealt with at the non-clinical staff level unless the situation requires escalation to a supervisor. Refer to **7000.50T Guide to Identifying When a Member is Suicidal** toolkit for possible signs that the member may be suicidal.

The following process summary is meant as a high-level process overview; please review specific steps in the titled sections if you are in need of detailed instructions for handling crisis situations.

1. Situation is being handled by either a clinical or non-clinical staff member.
2. Determine if the member is in a medical or behavioral health crisis by using the following checklist:
   - Member stating intent to harm self or others
   - Member sounding as if in distress or irrational
   - Member having slurred speech and/or not thinking clearly (potentially intoxicated or overmedicated)
   - Member describing an urgent/emergent need for medical treatment

   Note: When in doubt about whether a member is in a crisis situation, treat it as a crisis situation.
3. If you are on the phone, inform the caller that you need to transfer him or her to a clinician who has been trained to handle crisis situations. If possible (i.e. caller is cooperative), obtain the caller's name and phone number in case the call is disconnected; provide this information to the care manager when the call is warm transferred.

   Note: Always warm transfer crisis calls to ensure that the caller is connected to a live person and not disconnected by mistake.

4. Clinical staff members will assess the situation and respond based on the level of urgency and crisis type.

Handling and Transferring Potential Crisis Calls

Use the steps in the following table to connect the caller with the appropriate clinician to handle the crisis situation and to properly document the call if received by a non-clinician.

Note: A crisis call could potentially come in to any Medicaid employee. These calls should always be given to a clinician to handle as soon as possible. **Important:** If at any time during a potential crisis call you suspect the member may be suicidal, refer to the **7000.50T Guide to Identifying When a Member is Suicidal** toolkit.

Players:	Utilization Management (UM), Care Management (CM) or Member Services staff members
Player performing this piece of the process:	UM, CM or Member Services staff members (both clinical and non-clinical)
Process Initiation:	Potential crisis call is received by staff member

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Determine if the caller is in a crisis situation by using the following criteria:
• Caller stating intent to harm self or others
• Caller sounding as if in distress or irrational
• Caller having slurred speech and/or not thinking clearly (potentially intoxicated or overmedicated)
• Caller describing an urgent/emergent need for medical treatment as a result of either a medical or a behavioral health issue
<table>
<tr><th>If the caller…</th><th>then…</th></tr>
<tr><td>appears to be in a crisis situation,</td><td>attempt to obtain the caller's name and phone number (i.e. caller is cooperative) in case the call is accidentally disconnected.
Proceed to Step 2.</td></tr>
<tr><td>does NOT appear to be in a crisis situation,</td><td>handle the call according to appropriate departmental procedures.</td></tr>
</table></td></tr>
<tr><td>2</td><td>Determine the next step according to your level of training.
<table>
<tr><th>If you…</th><th>then…</th></tr>
<tr><td>are a clinician or are receiving a crisis call transfer from a non-clinician,</td><td>proceed to the appropriate section according to the level of crisis:
• Proceed to the Emergent Life Threatening and Emergent Non-Life Threatening Calls section if the member has a life threatening condition or emergency, is in immediate danger, appears to be a threat to himself or herself or others, if there is a vague threat to the</td></tr>
</table></td></tr>
</table>

	member's safety, member has intent to harm himself/herself or others but has no means to do so, and member has an inadequate support system. • Proceed to the **Urgent and Routine Calls** section if the member is in distress and requires intervention but is not at immediate risk, risk of harming himself/herself or others, the member does not have a life threatening condition, or there are not emergent or urgent needs, but the member requires clinical assessment to determine the needs.
are NOT a clinician,	proceed to Step 3.

3	Initiate the Instant Message alert (i.e. Emergency Button), which requests team/plan specific assistance with a crisis call from a trained clinician.
4	When the clinician responds to the emergency alert, inform the caller that you need to transfer him or her to a clinician who has been trained to handle crisis situations. **Note:** Refer to the **7000.50T Crisis Calls – Plan-specific Handling Notes** toolkit.
5	Warm transfer the call to the clinician/care manager and provide the caller's name and phone number, if obtained. **Note:** Always warm transfer crisis calls to ensure that the caller is connected to a live person and not disconnected by mistake.
6	After transferring the call, instant message the crisis distribution list for assistance. **Note:** Refer to the **7000.50T Crisis Calls – Plan-specific Handling Notes** toolkit.
7	Document the call according to the system in which you work:

If you work in…	then…
QNXT,	Document the call in Call Tracking using **Care Management** as the call type and **Referral to Care Management** as the call code. Notate if a referral was also made to care management in the Notes section (if the Member Alert does not reflect that member is already in CM). Check the Member Alert in QNXT to see if case is open to care management.
Dynamo	Document the call in a CM Activity Tracking event on the entity side if case is not already open and in the same event type on the case side if case is open.

8	Enter the notes according to the situation and the samples below: **Sample A** (if case is NOT already open) Call received from member X. Member made statements that indicate they were in a BH (or PH) crisis situation. Warm transferred the member to a case manager with applicable clinical experience Y. Referred member to care management program. **Sample B** (if case is already open) Call received from member T. Member was crying and was very emotional. Warm transferred the member to their assigned Case Manager as member is receiving CM services. BH CM to talk to member and assist with clinical needs.

Emergent Life Threatening and Emergent Non-Life Threatening Calls – Clinician Role

Use the steps in the following table to handle crisis calls from members when the member has a life threatening condition or emergency, is in immediate danger, appears to be a threat to himself/herself or others, there is a vague threat to the member's safety, the member has intent to harm himself/herself or others but denies having the means to do so, and/or member has an inadequate support system.

Note: If the member is in distress and requires intervention but there is no evidence the member is at risk of harming himself/herself or others, the member does not have a life threatening condition, and there are no emergent or urgent needs, and the member requires clinical assessment to determine the needs, proceed to the **Urgent and Routine Calls** section.

Important: If at any time during a potential crisis call you suspect the member may be suicidal, refer to the **7000.50T Guide to Identifying When a Member is Suicidal** toolkit.

Players:	Care manager
Player performing this piece of the process:	Care manager
Process Initiation:	Clinician receives call or warm transfer of a potential emergent life threatening or non-life threatening crisis call

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Ask the caller if there is someone with him/her who can call 911 for the member.
<table>
<tr><th>If the member…</th><th>then…</th></tr>
<tr><td>has someone,</td><td>ask to speak to that person and have the person call 911.
• If that person feels comfortable with calling 911 on the member's behalf, document that the individual agreed to call 911 and, if indicated, remain on the line until help is received.
• If that person does not feel comfortable calling 911 on the member's behalf, proceed to Step 2.

Note: If possible, it is a good idea to keep the caller on the line with you until help arrives unless the emergency responder needs you to keep the line open.</td></tr>
<tr><td>does NOT have someone,</td><td>proceed to Step 2.</td></tr>
</table></td></tr>
<tr><td>2</td><td>Find the emergency services number in the member's area using the appropriate option described in the Contact Options for Emergency Services section.</td></tr>
<tr><td>3</td><td>Confirm the phone number and address of the member's current location.</td></tr>
<tr><td>4</td><td>Use any means at your disposal to contact another Aetna employee (e.g. Mute your phone</td></tr>
</table>

and state aloud "I have a crisis call" or use Instant Message to send a Crisis Alert to the plan's crisis response team [some plans may call this their "Emergency Button"]).

If another colleague…	then…
is available,	1. Stay on the line with the member and have a colleague call emergency services. 2. Provide the phone number and address of the member's current location to the colleague contacting emergency services.
is NOT available,	1. Tell the member you are going to call for help and ask the member to wait for the emergency personnel. **Note:** If possible, it is a good idea to keep the caller on the line with you until help arrives unless the emergency responder needs you to keep the line open. 2. If a second line is not available, and there is no other person/staff available to assist, use the Microsoft Communicator (also known as "Instant Messenger" or "IM") to contact **Emergency Corporate Security.** 3. Indicate in the IM that you need assistance dispatching Emergency Services to a member. 4. Provide the phone number and address of the member's current location to the staff member from Corporate Security responding to your IM. 5. Provide answers to any other questions from Corporate Security so they can relay this information to Emergency Services in the appropriate area. **Note:** Please see the **7000.50T Crisis Calls – Plan-specific Handling Notes** toolkit for details on how plans want this handled if no one is available to assist

Note: If appropriate you can conference call the member to crisis services in their area. If you MUST disconnect the line with the member, then inform the member that someone will call back immediately, either you or the emergency personnel.

5 Provide the emergency personnel with the member's phone number and address and explain the emergency.

6 Ask if you should stay on the line with the member or leave the line free.

If emergency personnel…	then…
are intending to call the member,	disconnect the call or proceed as directed by the emergency personnel.
are NOT intending to call the member,	stay on the line with the member until emergency personnel arrive.

7 After the member is put into contact with emergency services and the call is disconnected, document the call and begin the follow-up process; proceed to the **Call Documentation and Follow-Up** section.

Urgent and Routine Calls – Clinician Role

Use the steps in the following table to handle crisis calls from members when the member is in distress and requires intervention, but there is no evidence the member is at risk of harming himself/herself or others, the member does not have a life threatening condition, and there are notemergent or urgent needs, and the member requires clinical assessment to determine the needs.

Note: If the member appears to be a threat to himself/herself or others, there is a vague threat to the member's safety, the member has intent to harm himself/herself or others but denies having the means to do so, and/or the member has an inadequate support system, proceed to the **Emergent Life Threatening and Emergent Non-Life Threatening Calls** section.

Important: If at any time during a potential crisis call you suspect the member may be suicidal, refer to the **7000.50T Guide to Identifying When a Member is Suicidal** toolkit.

Players:	Care manager
Player performing this piece of the process:	Care manager
Process Initiation:	Clinician receives call or warm transfer of a potential urgent crisis call where the member is not requiring immediate assistance but has an urgent health issue

Step	Action
1	After receiving the call, assess the situation.
2	Assist the member in getting an urgent appointment to meet their needs; this may involve: • Calling providers to request urgent appointments • Referring the member to an urgent care center • Assisting with transportation arrangements • Calming the member down by talking through the urgent needs and concerns (telephonic crisis intervention) **Note*:** Urgent appointments should be secured within 48 hours. If it is not possible for an appointment to be scheduled in 48 hours, respond to the call according to the emergent life threatening or emergent non-life threatening procedures and direct the caller to the nearest ER or crisis center. For non-urgent (routine) situations where an appointment is needed, this must be scheduled within 10 days- *NCQA standard.
3	Set a reminder to follow up with the member and provider within 48 hours to find out the

	outcome of their urgent appointment and to assist with arranging any other needed services that resulted from the urgent treatment.
4	Refer the member to care management to receive ongoing assistance with his or her healthcare concerns.
5	After the member is stabilized and the call is disconnected, document the call and begin the follow-up process; proceed to the **Call Documentation and Follow-Up** section.

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Call Documentation and Follow-Up – Clinician Role

Use the steps in the following table to document and follow up on the crisis call. Clinicians must ensure the following guidelines are adhered to throughout the handling and follow-up process:

- Life threatening/Emergent calls are followed up on until you are satisfied that the member has been evaluated and is safe.
- Clinicians must always do the follow up when a clinical update is necessary.
- All requests for follow up are completed within one (1) business day.
- If the member is refusing a referral or there are other complications, the non-clinical staff contacts the clinician to outreach to the member to resolve.
- Clinicians follow up on urgent, emergent, and non-life threatening calls when they feel it is clinically appropriate.

Players:	Care manager
Player performing this piece of the process:	Care manager
Process Initiation:	Clinician completes an emergent or urgent crisis call and begins the documentation and follow-up process

Step	Action
1	Complete the open call tracking note in QNXT that was started by the staff member who first spoke to the caller. **Note:** This is done only if the call came in to a staff member working in an area other than care management; otherwise, the note should be entered only in Dynamo by a CM staff member.
2	The note in QNXT's Call Tracking should be limited to basic resolution description of the call. **Example 1:** Member was stabilized telephonically and referred to the ER for assessment.

	Example 2: Member was deemed to be at risk. Emergency responders notified." Specific clinical details of the crisis are not noted in Call Tracking. **Note:** If the initial call is taken by a non-CM clinician, the clinical details of the call are emailed to the plan's Crisis Email Distribution List; this must be entered into a CM Activity Tracking event in Dynamo. For ICM: The notes are entered on the Entity side if a case is not already open and on the Case side if already in care management. Call resolution is also noted here.
3	For ICM members: Referrals to care management (if not already enrolled) are made either through Call Tracking or email; referrals must be made to care management for every crisis call. **Note:** Please see the **7000.50T Crisis Calls – Plan-specific Handling Notes** toolkit for details on how plans want this handled if no one is available to assist.
4	Once the member is enrolled in Care Management, the CM staff will enter the care manager's name and phone number in the Member Alert in QNXT. **Note:** Leave the alert open for other plan staff to be aware of.
5	After the call, debrief any staff who either took the call or were impacted by the call.
6	Document the call, disposition, and follow-up/next steps needed in the appropriate patient management system (i.e. QNXT for UM staff; Dynamo for CM staff).
7	Set a task or reminder (or to a non-clinical staff as clinically appropriate) to make a follow-up call and label the task/reminder **Crisis Call Follow Up**.
8	Review the call with the supervisor to ensure the appropriate steps were taken to resolve the member's issues.
9	The member's assigned care manager within the plan should be notified of the crisis as soon as possible; if the member is not in Care Management, make the referral. **Note:** The case manager may opt to handle the follow-up calls with the member.
10	Notify the Aetna Better Health Compliance officer if any disclosure of a member's personal health information is made to a third or outside party. **Example:** If you have to call the police to respond to a crisis situation and have to provide the member's personal information in order for them to respond only provide information pertinent to the situation per HIPPA guidelines
11	In consultation with Compliance, management should consider if notifying key stakeholders is needed or required, including the following entities: • Department of Health and Hospitals (DHH) • Medicaid vendor with which the plan is a sub-contractor • Member's treatment team including Community Mental Health Center CMHC if applicable

	• Member's PCP • Other applicable entities **Note:** HIPAA guidelines should be considered if this type of disclosure is made.
12	According to Aetna Better Health's internal process, notify the director of Quality Management of the call for any trending or reporting needs.

Face to Face Crisis Situations

Use the steps in the following table to respond to crisis situations encountered during a face to face visit.

Players: Case Manager (CM), Case Management Coordinator (CMC), Case Management Associate (CMA)

Player performing this piece of the process: CM, CMC, CMA

Process Initiation: The staff recognizes a Crisis Situation during a visit with the member.

Step	Action
1	Determine if you are in danger If… / Then… You are not in danger / Proceed to Step 3 You are in danger / Proceed to Step 2
2	You must first ensure you are in a safe place before moving forward. Safely remove yourself from the situation so that you can call for help. This may require leaving the home and driving to a different location. Once you are safe, proceed to step 3 **Note: If you do not ensure you are safe you may be harmed and then unable to help the member.**
3	Determine the type of assistance needed If… / Then… The member is in immediate risk of physical or medical harm / a. Call 911 first. Provide the address immediately, then relevant information as needed (such as if an ambulance is needed, are there weapons involved, etc). Let the

		911 dispatcher know your location b. Contact your supervisor to report the crisis situation as soon as it is safe to do so
	The member is experiencing a behavioral health crisis and is a threat to self or others	a. Call 911 first. Provide the address immediately, then relevant information as needed (such as if an ambulance is needed, are there weapons involved, etc). Let the 911 dispatcher know your location b. Contact your supervisor to report the crisis.
	The member is experiencing a behavioral health crisis and there are **no** immediate safety concerns to self or others	a. If there are any concerns that the situation may escalate to a safety concern call 911 first. Provide the address immediately, then relevant information as needed (such as if an ambulance is needed, are there weapons involved, etc). Let the 911 dispatcher know your location Contact your supervisor to report the crisis.
4	Depending on the situation the police and PIHP may need additional information, which should be provided only as relevant (follow HIPAA laws).	
5	Consider what other arrangements may be necessary. Work with the member and/or supports to ensure arrangements can be made (for example: if the member has a child and is going to the ER find out who can take care of the child).	
6	Coordinate with providers as needed (i.e. informing the caregiver if the member is not going to be home for a scheduled visit).	
8	Document the crisis situation details and steps taken in CM Activity Tracking.	
9	Speak with your supervisor for further direction and follow related business processes as they apply, which may include: • Reporting Abuse and Neglect	
10	Complete any follow up and coordination related to the situation until there is a plan in place to help the member stay stable, documenting in CM Activity Tracking as needed. End of Process	

Contact Options for Emergency Services

Use the steps in the following table to document and follow up on the crisis call. Clinicians must ensure the following guidelines are adhered to throughout the handling and follow-up process:

Step	Action
1	**Option A** (Local area only) Call 911. **Note:** This option can only be used if the member is calling from the local area.
2	**Option B** (USA only) 1. Go to **www.usacops.com**. 2. In the upper left-hand corner of the site, select the appropriate state from the **Sort Depts by State** drop-down box, and click **GO!** 3. Below the state map that appears, click the Sheriffs, Police, Constable, Marshals, Fire & Rescue link, or whatever applies. 4. Click the appropriate city or county name. 5. Click the appropriate option. • **SO** – Sheriffs Office • **PD** – Police Dept. 6. All phone numbers will appear for the selected department (Chief, emergency, & non- emergent)
3	**OPTION C (**AetNet**)** 1. Go to the AetNet homepage, and click **AetNet Directory**. 2. Under **Quick Links**, Click **External Phone Book**. 3. Click **Business/Gov't**. 4. Type the city and the word **Police** in the **Business Name** field. **Example:** San Antonio Police 5. Type the city in the **City** field. 6. Select the state from the **State** drop-down box. 7. Click **search**.
4	**OPTION D (Emergency Services outside of the local area)** 1. Using the Microsoft Communicator (also known as “Instant Messenger” or “IM”) double click the contact named **Emergency Corporate Security** Emergency C… Presence unknown **Note:** Status indicator button **MAY NOT** show as Green, and status message may indicate ‘Presence Unknown’, but IM’s are received by Corporate Security in real time and answered immediately. 2. Indicate in the IM that you need assistance dispatching Emergency Services to a

	member who is outside of your local calling area. 3. Using the IM, provide answers to questions from Corporate Security so they can contact Emergency Services in the appropriate area **Note:** Obtain information with the caller on the phone as you WILL NOT be able to transfer the call to Corporate Security.

Created/Revised	Revised by:	Date Revised
Created	Kelly DeFrancisco	Fall 2009
Revised	Kelly DeFrancisco	09/09/2011
Revised	Kelly DeFrancisco	01/19/2012
Resived -2Q/12 Update	Michael Hedden	05/25/2012
Revised -3Q/12 Update	Michael Hedden	09/06/2012
Revised -4Q/12 No Changes	Michael Hedden	11/08/2012
Annual Review	Marcia LeBlanc	12/21/2014
Annual Review	Renee' Tumolo/Tammy Smith	12/5/14
Review to add face to face	Renee' Tumolo/Neal Holden	2/3/15

Attachment AA

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Attachment AA
G.10 – Population Health Management and Care Coordination

Foster Care Assessment ..... Att AA-3

Health Risk Assessment ..... Att AA-7

Enrollee Needs Assessment ..... Att AA-15

Provider Testimony ..... Att AA-29

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Foster Care Assessment

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Foster Care Assessment

Name of Child (Last name, first name) Click here to enter text.	Date Of Birth: Click here to enter a date.	SSN: Click here to enter text.
Date of Placement: Click here to enter a date.	Date child came into care: Click here to enter a date.	
Foster parent name/phone: Click here to enter text.	Does Aetna have permission to contact the foster parent: YES ☐ NO☐	
What is child's permanency plan? Click here to enter text.		
Does the child have a primary care provider? YES ☐ NO☐ Name: Click here to enter text. Does the child have specialty providers (therapist, psychiatrist, etc.)? YES ☐ NO☐ If yes, please provide names of the specialty providers: Click here to enter text.		
List All Medications:		

Name: Click here to enter text.	Name: Click here to enter text.	Name: Click here to enter text.
Dosage: Click here to enter text.	Dosage: Click here to enter text.	Dosage: Click here to enter text.
Frequency: Click here to enter text.	Frequency: Click here to enter text.	Frequency: Click here to enter text.
Name: Click here to enter text.	Name: Click here to enter text.	Name: Click here to enter text.
Dosage: Click here to enter text.	Dosage: Click here to enter text.	Dosage: Click here to enter text.
Frequency: Click here to enter text.	Frequency: Click here to enter text.	Frequency: Click here to enter text.

Does the child take medication for Attention Deficit Disorder, depression or any other mental health condition? YES ☐ NO☐		
In general, would you say the child's health is: Choose an item.		
Does the child have any physical health or mental health diagnoses? YES ☐ NO☐ If yes, please list: Click here to enter text.		
Are immunizations up to date? YES ☐ NO☐	Does the child have a current flu shot? YES ☐ NO☐	
Has the child been diagnosed with high lead levels? YES ☐ NO☐		
Date of last well-child check: Click here to enter a date.	Date of last dental visit: Click here to enter a date.	Date of last vision visit: Click here to enter a date.
Does the child have a hard time with emotions, learning, focusing, or getting along with others? Choose an item.		
Does the child see a doctor for his/her emotions, growth, or behavior? YES ☐ NO☐ If yes, please provide name and specialty: Click here to enter text.		
Can the child do the following as well as children his/her age? (mark all that apply): ☐ Eating ☐ Dressing ☐ Walking ☐ Bathing ☐ Toileting ☐ Talking		

In the last year, did the child get any special treatments? (PT, ST, OT, home health, etc.) YES ☐ NO☐		
Does the child require specialized medical equipment, orthotics, or other special assistance: YES ☐ NO☐		
In the last 6 months, has the child gone to the ER or stayed overnight in the hospital more than 2 times? YES ☐ NO☐		
How many addresses has the child had in the last month: Choose an item.		
In the last year, how many school days did the child miss because he/she was sick or hurt? Choose an item.		
Does the child utilize school based services? YES ☐ NO☐		
Is the child part of an Individualized Education Plan (IEP)? YES ☐ NO☐		
Is the child seen by the Commission for Children with Special Health Care Needs? YES ☐ NO☐		
Is the child receiving special EPSDT services? YES ☐ NO☐		
Does the child have any of the following? (mark all the apply) ☐ WIC ☐ HANDS ☐ First Steps ☐ Community Resources ☐ Other: Click here to enter text.		
Is the child pregnant? YES ☐ NO☐ If yes, how many weeks? Click here to enter text.		
Does the child have vision impairments? YES ☐ NO☐	Does the child have hearing impairments? YES ☐ NO☐	
Does the child have any dental or oral health issues, including decay or cavities? YES ☐ NO☐		
Does the child smoke cigarettes? YES ☐ NO☐		
Child's Race: Click here to enter text.	Child's Height: Click here to enter text.	Child's Weight: Click here to enter text.

Additional comments/concerns: Click here to enter text.

Completed by (include your relationship to child): Click here to enter text.

Date: Click here to enter a date.

The **Informed Health Line** is open for Aetna Better Health members 24 hours a day, seven days a week. Friendly registered nurses give expert advice and quick answers. Our nurses speak English and Spanish. Interpreters are available for other languages. (855) 620-3924

Health Risk Assessment

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MEMBER INFORMATION

Member name*: _____
Member address: _____
Member phone: _____
Member date of birth*: _____ Age: _____
Member ID#: _____
Emergency contact name: _____ Phone: _____
Date completed: _____
Who is completing this form for you? _____

HEALTH ASSESSMENT *All Required

#	Question	Responses
1.	What is your gender?	1. Male 2. Female
2.	What is your race or ethnicity	1. African American 2. American Indian or Alaskan Native 3. Asian 4. Native Hawaiian or Pacific Islander 5. White Non-Hispanic

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		6. Hispanic or Latino 7. Multiracial 8. Other
3.	What is your highest level of education?	1. Elementary School (K-5) 2. Middle School (6-8) 3. High School (9-12) 4. High School graduate 5. Some College 6. College Graduate 7. Graduate School 8. N/A
4.	What is your preferred language to speak at home?	1. English 2. Spanish 3. Other
5.	What is your living situation?	1. Own 2. Rent 3. Live with family 4. Live with friends **5. Homeless** 6. Other
6.	Are you currently pregnant?	**1. Yes** 2. No
7.	Has a doctor ever told you that you have the following?	1. Diabetes 2. High blood pressure

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		3. Heart disease 4. Kidney disease **5. Cancer** 6. Asthma 7. COPD 8. Allergies **9. HIV/AIDS** **10.Hepatitis** 11.Depression 12.Anxiety 13.Bipolar disorder **14.Schizophrenia** **15.** N/A
8	Do you currently take prescription medicine?	1. Yes 2. No
9.	Do you currently use any of the following?	1. Hearing aids 2. Glasses or contacts **3. Wheelchair or walker** **4. Other assistive devices** 5. N/A
10.	How often do you exercise?	1. 2-3 times per week 2. Once per week 3. Rarely 4. Never

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11.	How often do you use alcohol?	**1. Everyday** 2. Two or more days per week 3. Rarely 4. Never
12.	Do you use tobacco or tobacco products?	1. Yes 2. No **3. I would like help quitting**
13.	In general, how would you rate your overall health?	1. Excellent 2. Very Good 3. Good 4. Fair **5. Poor**
14.	Do you need help with any of the following? (Mark all that apply)	**1. Food** 2. Clothing **3. Housing** 4. Employment 5. Mobility **6. Getting to medical appointments** 7. Safety 8. N/A
15.	Do you need help performing any of the following daily activities?	**1. Accessing medication** 2. Bathing 3. Eating

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		4. Dressing 5. Shopping 6. Managing finances 7. N/A
16.	Compared to one year ago, my health is worse.	1. Yes 2. No
17.	Have you received dental care in the past year?	1. Yes 2. No
18.	Have you been to the emergency room in the last three months?	1. Yes 2. No
19.	Would you like your health plan to contact you about any other health concerns?	**1. Yes** 2. No

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Enrollee Needs Assessment

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Questionnaire: ICM Outreach

[Plan]
Care Management
Case Manager (CM), Care Management Associate (CMA)

Q#	Question/Selections
1	**Was this tool completed by telephone or face to face?** ☐Face to face ☐Telephone
2	**If Q1 = Face to Face** **Face to Face Location** ☐Member's own home (house, apartment, mobile home, etc.) ☐Assisted Living Facility or Alternative Residential Setting ☐BH Assisted Living Home or Facility ☐I/DD Group Home ☐Foster Home-Adult ☐Foster Home-Child ☐Nursing Facility (state name, and what type in narrative) ☐IMD ☐ICF/MR ☐Work site ☐Day program out of own home (I/DD, Adult) ☐Provider Office (including physician, vendor, specialist, etc.) ☐Hospital ☐Member is homeless-in community (state where in narrative) ☐Other (list in narrative) **<Narrative>**
3	Care Team Participation HIPAA **Outreach call conducted with:** ☐Member ☐Parent/Guardian ☐Foster Parent ☐Spouse ☐Son/Daughter ☐Significant other ☐Other: **<Narrative>** Additional Instructions *If questionnaire being completed by anyone other than the member, modify the script and questions accordingly. For instance, instead of saying "You / Your" say "Your Child" or "Your Parent", etc.* *CM to review care team participant overlay and HIPAA. Obtain consent from the member prior to completing assessment with anyone other than the member.*

4	**What language do you speak most often?**

☐Amharic	☐Gujarat	☐Persian
☐Arabic	☐Hebrew	☐Polish
☐Armenian	☐Hindi	☐Portuguese
☐Bengali	☐Hungarian	☐Romanian
☐Burmese	☐Ilocano	☐Russian
☐Cajun	☐Italian	☐Samoan
☐Cambodian	☐Japanese	☐Serbocroatian
☐Chin	☐Karen	☐Slovak
☐Chines	☐Korean	☐Spanish
☐Croatian	☐Kru	☐Swahili
☐Czech	☐Lithuanian	☐Swedish
☐Danish	☐Mandarin	☐Syriac
☐Dutch	☐Malayalam	☐Tagalog
☐English	☐Miao	☐Thai
☐Finnish	☐Mon-Khmer	☐Turkish
☐Formosan	☐Navajo	☐Ukrainian
☐French	☐Norwegian	☐Vietnamese
☐French Creole	☐Panjabi	☐Yiddish
☐German	☐Pennsylvania Dutch	☐Other: **<Narrative>**
☐Greek		

5

If Q4 = English hide this question

An interpreter is someone who repeats what one person says in a language used by another person. Under your plan, there is no cost to you for an interpreter.
Would you like me to get an interpreter on the line now?
Would you like to have an interpreter each time you talk to one of our staff members?

Interpreter requested? (Required, if member language listed as other than English)

☐Yes, this call only
☐Yes, all calls
☐No

Additional Instructions
MANUAL WORK PROCESS: If interpreter is requested for current call, CMA should contact Language Line. Update the member's entity record with the type of communication assistance needed.

6

Do you need any service for hearing in order for us to communicate easily?

☐Yes, this call only
☐Yes, all calls
☐No

	Additional Instructions *(Such as TTY)* *MANUAL WORK PROCESS: if TTY is requested for current call, arrange TTY services.*
7	*You already told us* (list of HRQ questions): Questions regarding health: **HRQ response** HRQ on (No HRQ) NOTE TO CMA: If no HRQ exists, ask question as written. IF HRQ DOES EXIST, ASK THIS: *I can see from questions you have previously answered, it looks like you have* _____. CMA should just confirm list as shown in HRQ, check appropriate boxes in Outreach questionnaire, and determine if any others are not already listed. **Has a doctor or clinic ever told you that you have one of the following?** ☐Pregnant (Currently) ☐Autoimmune disorder like: RA, Lupus, Myasthenia Gravis, ITP ☐Blood clots (+pre=high risk) ☐Blood disorders like anemia or sickle cell (+preg=high risk) ☐Bone or joint problems like arthritis, amputation, chronic low back pain ☐Bowel or stomach problems like ulcers, chronic diarrhea ☐Breathing problems like asthma, difficulty breathing, COPD ☐Cancer ☐Diabetes (+preg=high risk) (*ACSC*) ☐Hearing problems like deafness, hearing aids ☐Heart problems like chest pain, heart attacks, congestive heart failure (+preg=high risk) ☐High blood pressure (+preg=high risk) (*ACSC*) ☐Infection problems like Hepatitis, STD, HIV/AIDS, or TB ☐Kidney problems like dialysis (+preg=high risk) ☐Mental Health: Anxiety (*ACSC*) ☐Mental Health: Depression (*ACSC*) ☐Nerve or brain problems like: stoke, multiple sclerosis, spinal cord injury, epilepsy/seizures ☐Organ transplant ☐Problems with alcohol or drug use (+preg=high risk) (*ACSC*) ☐Vision problems like blindness ☐Other: **<Narrative>** ☐None Additional Instructions *MANUAL PROCESS (For training): Any state mandated condition will be referred to CM for completion for the*

	condition specific assessment. *If other is chosen, CMA should staff condition with clinical person before referring for CM referral.*
8	**Show if Q7 = Heart problems like chest pain…** **What type of heart problems?** ☐CHF (*ACSC*) ☐CAD ☐Previous heart attack ☐Other: **<Narrative>**
9	**Show if Q7 = Breathing problems like asthma…** **What type of breathing problems?** ☐Asthma (*ACSC*) ☐COPD (*ACSC*) ☐Chronic ☐Emphysema ☐Other: **<Narrative>**
10	**Show if Q7 = Vision Problems like blindness** **Do you have any preference for how we can best communicate with you given your visual impairment?** ☐Yes – Sent me summaries of discussions in writing (larger font) ☐Yes – Please verbally summarize our discussion at the end of our calls ☐No ☐Other **<Narrative>**
11	**Show if Q7 = Infection problems like Hepatitis…** **What type of infection do you have?** ☐Hepatitis ☐STD ☐HIV/AIDS ☐TB ☐Other – w/ narrative **<Narrative>**
12	**What other services do you receive?** ☐Case management services ☐Chemotherapy/Radiation Therapy ☐Day program (i.e., adult day care) ☐Dialysis ☐Home Health Services ☐Homemaker services ☐Hospice ☐Meals on Wheels ☐Nutrition classes/education ☐Occupational Therapy (OT) ☐Pain Management ☐Private duty nurse ☐Physical Therapy (PT) ☐Programs for Children with Disabilities (community or school based) ☐Skilled nursing ☐Speech and Hearing Services or Therapy (ST) ☐Substance Abuse Services ☐Transportation ☐WIC - Women, Infants, and Children program ☐Wound care

☐Case management services ☐Chemotherapy/Radiation Therapy ☐Dialysis ☐Mental health services e.g. counseling, intensive outpatient treatment, partial hospitalization, residential treatment	☐Vocational / Rehabilitative Services ☐Respite services ☐Services for the Blind	☐Food stamps ☐Other : **<Narrative>** ☐No – not receiving other services

Additional Instructions
Read the list of services to member to get the answer. If you need to explain the services, use the CMA job aid for scripting.

13

Some people use special things to help them in their day-to-day life. These include things like a cane, wheelchair, or a special bed.

What special equipment do you use or need to take care of yourself?

☐AB monitor ☐Bedside commode ☐Blood glucose monitor ☐Blood pressure monitor ☐Breathing machine (CPAP, BiPAP, tracheotomy, ventilator) ☐CAD pump ☐Catheter supplies ☐Crutch ☐Communication devices ☐Cough assistance vest	☐Diabetic pump ☐Feeding pump and tube feeding supplies ☐Glucometer ☐Grab bars (shower) ☐Incontinence supplies ☐Insulin pump ☒IV pump ☐Mechanical Left (Hoyer Lift) ☐Nebulizer/humidifier	☐None ☐Ostomy Supplies ☐Other: **<Narrative>** ☐Oxygen ☐Pain pump ☐Peak flow meter ☐Picc Line ☐Power scooter ☐Prosthesis/braces ☐Raised toilet seat ☐Scale	☐Shower chair/bench ☐Specialty Bed/Mattress ☐Suction machine ☐SVN machine ☐Trach supplies ☐Ventilator ☐Walker cane ☐Wheelchair ☐Wound supplies ☐Wound VAC

Additional Instructions
If you need to explain the equipment, use the CMA job aid for scripting.

14

I would like to ask you about other people who may be part of your life.

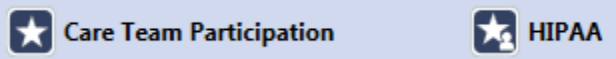

When you need help in day to day life, is there someone you can count on?

☐Spouse
☐Parent
☐Sibling
☐Friend/neighbor
☐Caregiver
☐Son/Daughter
☐Other: **<Narrative>**
☐No one

	Additional Instructions • *If member identifies someone, ask whether he/she would like for us to be able to talk to any of them regarding his/her condition. Of so, create HIPAA event and Care Team Participation event as appropriate.* • *If member answers no one, ask if you can help them with a referral to a support group. Take appropriate referral action.*
15	**Show if Q14 = any answer except No one** **In what way(s) does this person or persons help you?** ☐Getting to appointments ☐Picking up my medication ☐Taking my medication ☐Remembering appointments ☐Cleaning ☐Cooking/Making Meals ☐Dressing ☐Bathing ☐Grooming ☐Eating ☐Laundry ☐Going to the bathroom ☐Walking ☐Getting out of bed ☐Getting out of chairs ☐Using the telephone ☐Other (free text) **<Narrative>**
16	*I would like to go over all the medications you are taking now.* **What drugs are you currently taking that your doctor prescribed? (Our case manager may have more questions for you about medications at a later time.)** **<Narrative>** Additional Instruction *Intent is to get an initial list of medications from member. CMA should simply note in text box, with the amount of detail they can gather with member. (Ideally, medication, dosage, what the med is for.)*
17	**Do you take any herbal or home remedies or over the counter drugs? If so, what are those?** ☐Yes ☐No **<Narrative>**

18	**How many times in the last month did you use drugs not prescribed for you by your doctor (including over-the-counter, prescription, herbal and street drugs)?** ☐0 ☐1 ☐2 ☐3 ☐More than 3
19	**Do you have problems with any of the following:** ☐Bathing ☐Dressing ☐Eating ☐Getting out of bed or chair ☐Solving problems ☐Talking ☐Toileting ☐Reading or writing ☐Walking ☐Being able to do more than one thing at a time ☐Concentrating ☐Remembering things (short and long-term memory) ☐Doing laundry ☐Preparing meals ☐Housekeeping ☐Shopping ☐Taking/getting medications ☐Transportation ☐Finances ☐Using the telephone ☐Confusion ☐Being tied/sleepy (Lethargy) ☐None of the above
20	**Has a doctor or provider ever asked you to follow a certain type of diet?** ☐Yes – Renal diet ☐Yes – ADA – Diabetic diet ☐Yes – Kosher diet ☐Yes – Low salt/sodium diet ☐Yes – weight management diet ☐Yes – other: **<Narrative** ☐No
21	*You already told us:* How many different addresses have you had in the last 12 months? (Answer from HRQ) **What is your current living environment?** ☐Lives alone ☐Spouse/Significant other ☐Lives with friends ☐Lives with family ☐Foster Care Home ☐Assisted Living Home ☐Behavioral Health Placement ☐TBI Placement ☐Assisted Living Center ☐Alzheimer's Assisted Living ☐SNF ☐SNF – Wandering Dementia ☐Homeless (Please comment in narrative) ☐Single parent home ☐Two parent home ☐Single foster parent/guardian home ☐Other: **<Narrative>**
22	**Do you feel safe at home?** ☐Yes ☐No **If answer = No show**

	Are you in immediate danger? Is it OK to continue talking? (Do you have the privacy to complete our interview today?) Additional Instructions *If NO – Ask: Are you in immediate danger? Is it OK to continue talking? (Do you have the privacy to complete our interview today?)*
23	**Show if Q22 = No** **Can you tell me why?** ☐Can't say/Don't want to say ☐Condition of home ☐Fall hazards ☐Neighborhood ☐People that I live with ☐Other: **<Narrative>**
24	**Show if Q7 = Pregnant** *Now, I'd like to ask you some questions about your pregnancy as well as any others you may have had in the past. Would this be ok?* **When is your baby due?** EDC: **<Click here to enter a date.>**
25	**Show if Q7 = Pregnant** **What was the delivery date of your last baby?** ☐< 15 months ☐=> 15 months ☐N/A
26	**Show if Q7 = Pregnant** **Are you seeing someone for prenatal care?** ☐Yes ☐No Additional Instructions *If member indicates YES, check the Care Team Participant event to see if this provider is already listed for this member. If not, complete a Care Team Participant event to record prenatal provider.* *If no provider identified, make referral to OB/GYN as needed.*
27	**Show if Q7 = Pregnant** **Have you picked a doctor to care for your baby?** ☐Yes ☐No provider indicated

	Additional Instructions *If YES, check the Care Team Participant event to see if this provider is already listed for this member. If not, complete a Care Team Participant event to record prenatal provider.* *If no provider identified, make referral to pediatrician as needed.*
28	**Show if Q7 = Pregnant & if Q27 = Yes** **When is your next prenatal check-up?** • Exact • Estimate • No appt. scheduled Appointment Date: Click here to enter a date. Additional Instructions *If member indicates no appointment is scheduled, assist in coordinating an appointment for prenatal care.*
29	**Show if Q7 = Pregnant** *"Sometimes women have health issues or conditions that can cause problems during your pregnancy or for your baby. I would like to ask you some questions about whether you have, or have had, some of these issues".* **In this pregnancy or in past pregnancies are you or have you…?** ☐Any abdominal or cervical surgery ☐Any leaking of your water or membranes ☐Any vaginal bleeding or spotting ☐Baby has/had a birth defect or other similar conditions ☐Baby is having trouble growing ☐Currently pregnant with more than 1 baby ☐Had a baby more than 3 weeks early (don't ask if first pregnancy) ☐In this pregnancy had more than 1 urinary tract infection (on antibiotics more than 2 x this preg) ☐Low birth-weight baby ☐None of the above ☐Uterine malformations ☐Preterm labor requiring medication and/or bed rest ☐None of the above
30	**About how tall are you without shoes?** ☐Height: **<Narrative>** ☐Member refused
31	**How much do you weigh without shoes?** ☐Weight **<Narrative>** ☐Member refused ☐Member doesn't remember

32	**Show if Q7 = Pregnant** **Before you were pregnant how much did you weigh?** ☐Weight **<Narrative>** ☐Member refused ☐Member doesn't remember
33	Material Request - Contact Member Community Resources/ Referral **Do you smoke or use other tobacco products?** ☐No ☐Yes, smoke more than ½ pack of cigarettes per day (+ preg = high risk) ☐Yes, other tobacco, other: **<Narrative>** Additional Instructions *CMA Instructions:* • *Mail smoking cessation information if member says "yes" to either.* • *If yes and wants to quit – provide referrals to smoking cessation programs.*
34	*Your insurance covers many types of services. Also, other resources are sometimes available in the community that may be able to help you.* **Would you like any additional information about your insurance benefits?** ☐Yes – insurance benefits ☐Yes – community resources ☐No **<Narrative>**
35	**Do you have a written plan for health care you want if you cannot speak for yourself?** ☐Yes, advance directive ☐Yes, medical POA ☐Yes, mental health POA ☐Yes, living will ☐Don't know ☐No Additional Instructions *If member indicates no, ask if he/she would like more information? Provide member information or refer to appropriate sources.*
36	*Many people have important beliefs about the way they care for their health. For example, some people do not eat certain kinds of food. Other people do not believe in shots. Some people go to different kinds of healers to get well.* **Are there any beliefs you have, cultural or spiritual that I should know about that will help us work better**

	together? ☐Food practices ☐Illness beliefs ☐Medication avoidance ☐Organ donation ☐Pain management ☐Religious Healers or rituals ☐Other: **<Narrative>** ☐None cited **<Narrative>**
37	**Are there other telephone numbers at which you may be reached?** ☐Yes ☐No Create New Event - Address/Phone/E-Mail Change Additional Instructions *If member indicates other that is not in system, add manual phone numbers as needed.*
38	**Our records show your primary care doctor as (_____). Is this correct?** ☐Yes ☐No Create New Event - Care Team Participation Additional Instructions *If PCP in system in not correct, ask for correct PCP and complete manual PCP event. If no PCP identified, make referral as needed.*
39	**Do you have an immediate concern regarding your health care?** ☐Yes **<Narrative>** ☐No
40	**Are there other services I can help you with today?** ☐Referral to provider ☐Referral to social services ☐Transportation to any appointments ☐Remembering appointments ☐Getting equipment (DME) ☐Other: **<Narrative>** ☐None Additional Instructions *Assist member as needed with any referrals, non-clinical needs.*

41	*Based on our conversation today….There are some items I can help you with today (like setting up an appointment with your doctor, referral for community services, etc.)* *AND/OR* *I would like to set up an appointment with one of our case managers who can further assist you with_____ (cite condition / your health care needs)* *If yes –* *This is a voluntary program. You have the right to change your mind later at any time late. Simply call us at XXX and let us know you have changed your mind and no longer wish to participate* **Based on our conversation today….Would you like to participate in case management?** ☐Yes ☐No (or has no CM needs) Additional Instructions *This is the ENROLLMENT point for care management.* **Vary scripting as appropriate. If member has ambulatory care sensitive condition, has triggered any other high risk indicator and has expressed any-clinical needs, then set an appointment with CM. If member has no ambulatory care sensitive conditions, no other high risk indicators and no expressed clinical needs, then assist with any service coordination needs.* **When in doubt – CONSULT WITH CARE MANAGER.*
42	**(If answer to "would you like to participate" is NO)** *"OK. So that we know how to better manage our program…"* **Is there a particular reason why you would not like to participate?** Member doesn't feel they need help ☐Member doesn't have time to participate in interview / program ☐Other: _____ ☐Member requests NO OUTREACH AT ANY POINT IN FUTURE (HARD NO)
43	*You have the right to change your mind later if you wish to participate. Simply call us at XXX and let us know you have changed your mind.* **Member has identified service coordination needs?** ☐Yes ☐No

Created/Revised	Revised by:	Date Revised	Changes: Yes/No
Created			
Reviewed	Virginia McCarthy	1/30/17	
Updated to match Golden	Virginia McCarthy	5/31/17	

Provider Testimony

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Children's Alliance
Kentucky's voice for at-risk children & families

5/30/19

Kentucky Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6W-C
Frankfort, KY 40621

Re: Provider Testimony Regarding Aetna Better Health of Kentucky

To Whom it May Concern:

The Children's Alliance Board of Directors authorized the Children's Alliance to establish a separate Limited Liability Company to promote innovative, efficient, and effective behavioral health services in Kentucky. The Children's Alliance established the Children's Alliance Independent Provider Association, LLC (CA-IPA) with the mission to increase access and improve quality of behavioral health services for Kentucky's at-risk children and families.

The goal of the CA-IPA is to work in partnership with Kentucky Managed Care Organizations (MCO's) and eventually, commercial insurance carriers, to contract with our CA-IPA member agencies for value-based behavioral health services. The CA-IPA has talked with several MCO's regarding this approach; however, Aetna was the first MCO to initiate a partnership with the CA-IPA to create and execute a value-based services contract. The idea of the contract is to incentivize behavioral health care providers to achieve specific outcomes and improve the overall care and well-being of children and families in Kentucky.

Aetna's leadership and staff have been exceptional to work with and they have worked diligently to develop a contract that will move the health care of its members forward. It seems measuring outcomes and working to improve medical care has been implemented in Kentucky for many years, however, most of those value-based contracts have been centered around physical health. Because behavioral health is often more complex, regarding measuring outcomes, the MCO's have been hesitant to engage with the CA-IPA, apart from Aetna. Aetna leaders expressed their concern and commitment to specifically helping the most vulnerable children and families in Kentucky, which are those cared for by CA-IPA members.

Aetna has demonstrated their commitment to foster children and their willingness to work in partnership with providers who care for foster children in a collaborative and innovative way. Initially when Aetna agreed to work with us on this value-based services contract, back in 2017, I must admit I was bit concerned, because some of our member agencies were having trouble getting reimbursed for past services from Aetna. I expressed this concern to Aetna leadership and they immediately worked with our member agencies to ensure the reimbursement issues were resolved. Since that time, our members have worked well with Aetna and they have truly demonstrated a partnership to improve care for at-risk children and families.

If you would like to speak with me or have any questions, please feel free to contact me at michelle@childrensallianceky.org or 502-320-6484. Thank you for your time and consideration.

Sincerely,

Michelle M. Sanborn
President

420 Capitol Avenue • Frankfort, KY 40601 • 502-875-3399 • Fax: 502-223-4200

Attachment BB

Kentucky | Transforming Health Care | **Aetna**

Attachment BB
G.12 - ICM Program Description

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ICM Program Description

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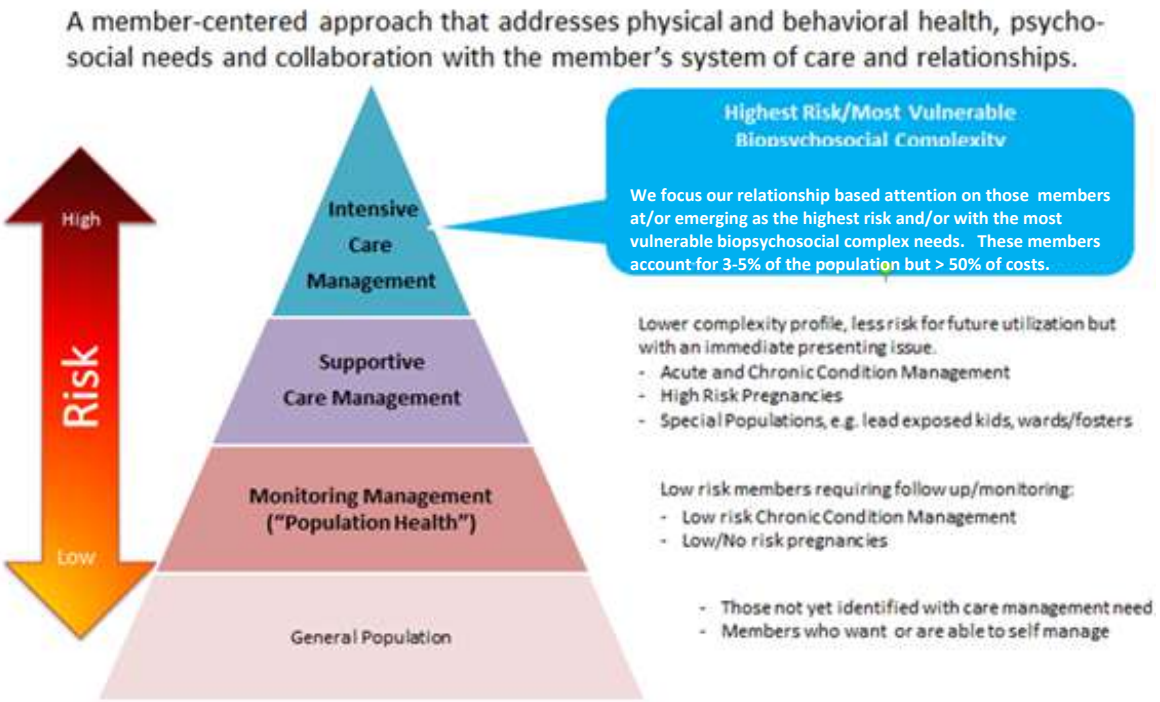

Philosophy and Guiding Principles[1]

The primary **goal** of Aetna Medicaid's Integrated Care Management (ICM) Program is to coordinate and facilitate the seamless delivery of high quality, person centered, trauma informed care and services for our members. Our program ensures that the care and services members receive aligns with their preferences, needs and goals, utilizing motivational interviewing to optimize their self-empowerment and self-sufficiency.

The **focus** of ICM is to address the biopsychosocial needs of our members, while integrating cultural humility into our practices to enhance members' quality of life. Our case managers partner with members, providers, caregivers and support systems. Each member's characteristics and potential barriers associated with social determinants of health (SDoH) are considered when addressing acute illnesses, chronic conditions, functional and social (biopsychosocial) needs to support improved outcomes.

The ICM program is **designed** to identify members who may benefit from care management services. Members choosing to participate receive an evaluation of their risk and at a minimum, receive education to support their adoption of healthy behaviors and self-management. Those at higher risk are engaged to recognize their personal strengths and barriers, determine health goals and develop interventions to help them meet those goals. Based on their needs, members receive ongoing support and services through integrated case rounds, interdisciplinary care team meetings, scheduled contacts and ad hoc communications.

Foundation

Program Development and Design

The ICM program was developed by Aetna Medicaid Services in 2010, and initiated by Aetna Better Health (ABH-KY) of KY in 2016. The program is based on literature indicating that people who have complex illnesses or comorbid conditions and require care across multiple clinical and social domains are likely to be less responsive to standard care and more likely to benefit from an individualized approach to meeting their unique healthcare needs (biopsychosocial).[2]

The program design is based on professional care management standards, guidelines, and research published by agencies such as:

- Case Management Society of America (CMSA)
- Centers for Medicare and Medicaid services (CMS)
- National Committee for Quality Assurance (NCQA)
- National Coalition of Care Coordination
- Agency for Healthcare Research and Quality (AHRQ)
- Kaiser Family Foundation.[3]

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[1] Draft ICM Philosophy Statement, 2/20/2019

[2] Stiefel, Stiegel, et al. Operationalizing Integrated Care on a Clinical Level the INTERMED Project. Med Clin N Am 90 (2006) 713-758.

[3] NCQA HP 2018/2019 PHM1

In addition, Healthy People 2020 serves as the resource for identification of SDoH that impact health outcomes. Management of chronic physical and behavioral health conditions is integrated into the ICM program and offered to members as part of their care management services. This integration creates a true biopsychosocial approach to member care.

Care Management Steering Committee

The Care Management (CM) Steering Committee provides oversight and approves the development, implementation and continuous improvement of Aetna Medicaid's primary ICM and chronic condition management programs and services. The CM Steering Committee is composed of care management program leaders from Aetna Medicaid Clinical Operations and each health plan to enable a local approach to care management that is supported by nationally recognized standard regulatory and operational practices. The Committee addresses all foundational ICM programs and services to:

- Organize services around the member and their family/circle of supports
- Adhere to the core set of biopsychosocial principles and evidence-based practices endorsed by Aetna Medicaid
- Measure and improve clinical and utilization outcomes for members
- Align with Aetna Medicaid standards
- Meet or exceed regulator and other applicable external requirements such as NCQA
- Create competitive advantages both for Aetna Medicaid Plans in current markets and for growth into new markets
- Anticipate and position Aetna Medicaid well for future market demands
- Make the best use of Aetna resources through disciplined accountability to show the initial feasibility, business case and return-on-investment of all ICM programs and services

Integration with Population Health Management (PHM)

The ICM Program is congruent with Aetna Medicaid's Population Health Management (PHM) Strategy, recognizing that health is more than the optimal delivery of clinical care but is also about the "health of the population, including the distribution of health outcomes and disparities in the population" as the National Quality Forum defines it. As in PHM, the ICM program aims for equitable health care and services that are person-centered, accessible, holistic, and evidence-based. ICM programs are designed to engage members with the right level of clinical and social support depending on many factors that affect an individual's health status, overall well-being and ability to self-manage and function optimally in their preferred setting. We define care management as a collaborative process of biopsychosocial assessment, planning, care coordination, and advocacy for service and support options to meet a member's comprehensive care needs to promote quality and cost-effective outcomes.

Systems of Care

Aetna Medicaid incorporates a system of care (SoC) approach with a full spectrum of effective, community-based biopsychosocial care and support. Our SoC also includes psychosocial services and supports for individuals, their families/circle of support, that:[4]

[4] NCQA HP 2018/2019 PHM1 A4

- Are organized into a coordinated network-within-a-network functioning as a "virtual team"
- Drive collaboration across agencies and community-based organizations
- Build meaningful partnerships with members and their families/circle of support
- Address peoples' cultural and linguistic needs

ICM staff coordinate medical and/or behavioral health services covered by the plan's benefit structure as well as services from local community-based or federally funded organizations, faith based organizations, social clubs, condition specific organizations, and/or those not covered in the member's benefits. This coordination in achieved in collaboration with special program coordinators, and SoC team members. [5]

ABH-KY informs and educates practitioners about how to use care management services, including chronic condition management, and how the plan works with the members' practitioners in the program. This information is provided to practitioners, in writing, through direct mail and provider handbook. Detailed program information is also available on the ABH-KY website

Care Management Team Structure

The Care Management Department is under the direction of the Chief Medical Officer (CMO) and the Director of Medical Management. Care management staff in each plan report to a supervisor or manager, who in turn reports to a director of care management. The number of supervisors and managers depends on the size and complexity of the health plan population as well as any state-mandated requirements (e.g., ratios).

Care management staff include:

- Case Managers who serve as primary points of contact to their assigned members. These licensed and non-licensed staff lead the collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's comprehensive health needs.
- Case Management Associates (CMAs) who assist members and the care management team with non-clinical activities.

Case Manager caseloads align with their education, licensure, experience and expertise. In addition, caseloads vary by service level for complexity of member needs and frequency of the interactions with the member and their care team. If case managers carry a mixed caseload, a case weight is applied to ensure they have the appropriate capacity to meet the needs of their members.

Caseload		
ICM Service Level	**Non-LTSS ICM Caseload Ratio**	
Intensive	1:41	
Supportive	1:125	
Population Health	1:400	

[5] NCQA HP 2018/2019 PHM5 C12

Care management supervisors routinely review case manager caseloads to ensure they do not exceed the caseload or total case weight limit. The review determines caseload distribution between teams to maximize available staff and adjust caseloads and case manager assignments as necessary.

Care Management Business Application System

The ICM business application software provides an integrated system for collecting and tracking comprehensive information and outcomes on each member in ICM. The system incorporates evidence-based guidelines, automatically documents user information, date/time stamps activities, and provides algorithms that guide case managers. Documentation entered in the system includes health and risk assessments, questionnaire results, stratification decisions, care management information, SDoH, interdisciplinary case rounds and ICT activities. System capabilities include data tracking and trending functions for the purposes of managing the program as well as reporting to state and federal regulators, customers, health plan management and staff. Web based portals are used to facilitate communication between the case manager, member, care team, and providers across the continuum of care.

Care Management and Coordination of Care

Populations

ICM is available to the entire eligible population across all lines of business and to any member who needs, requests or requires care management services. The assessed needs of the member determine the level and type of care management. Typical recipients of ICM are those members:

- At high risk of poor health outcomes and high utilization
- From ethnic/racial minorities and other traditionally underserved populations
- With significant or multiple chronic conditions for which care management and/or chronic condition management interventions are indicated or are required by contract
- Who have had difficulty managing their health care, and require complex or frequent healthcare and services
- Included in special populations with complex medical, behavioral and/or social needs such as:[6]
  - Children and adolescents with special healthcare needs
  - Children in foster care or adoption assistance programs
  - Members who are pregnant with a higher intensity of services offered to members with a high risk pregnancy
  - Members who are frail or elderly
  - Members with mental health conditions such as substance use disorders (SUD) and/or serious and persistent mental illness (SPMI)
  - Members with brain injuries and/or with cognitive or memory problems (e.g., dementia)
  - Member nearing the end of life and receiving palliative services or hospice benefits
  - Any additional members identified through State, CMS, or contractual requirements:[7]

[6] NCQA HP 2018/2019 PHM2 B1-4, NCQA HP 2018/2019 LTSS1 A1
[7] NCQA HP 2018/2019 PHM2 A7

ABH-KY provides all members with the following ICM program information either in writing, in-person or by telephone:

- How to use care management services
- How members become eligible to participate in ICM
- How to opt in or opt out of ICM
- Member choice and rights and responsibilities related to healthcare decisions

MEMBER IDENTIFICATION AND PRIORITIZATION

When care management is not mandatory, ICM identifies and prioritizes members who may benefit, from multiple sources. Sources used to identify and prioritize members for ICM include:

- Enrollment and additional files received from state Medicaid agencies and other program purchasers
- Predictive modeling using claim/encounter information, including pharmacy data if available
- Internally available data and reports such as the HCE Dashboard, operational dashboards, and through UM and other ABH-KY department processes
- Member self-reported information from health risk appraisals, screening tools, questionnaires, requests for support, and ad hoc contacts
- Organizational partners providing data utilization of emergency, inpatient admissions and discharge, pharmacy and laboratory testing and results
- Referrals from plan departmental staff and providers of care and services such as health management, chronic condition self-management, wellness or health coaching programs, and
- Electronic health records and health information exchanges[8]

Predictive modeling uses analytic methods to rank all plan members from highest to lowest risk in our General Risk Model (GRM). The model identifies people at risk of high cost and/or high utilization in the future by using medical, behavioral, laboratory and pharmacy diagnoses and claims data, and the likelihood of ICM making an impact. Additional predictive modeling techniques are used to identify members at risk for emergency department or inpatient utilization in the next 12 months. The predictive modeling shows that our highest risk members have multiple physical health conditions, and 70% to 90% had co-morbid behavioral health conditions.

The top 1% of members in the GRM is combined with members at high or moderate risk for inpatient utilization and high risk for emergency department utilization in a Consolidated Outreach and Risk Evaluation (CORE) report that is produced monthly.[9] The risk rankings feed directly into our care management software to allow health plans to identify and prioritize members for outreach into intensive or supportive care management as well as those who would benefit from chronic condition management.

The HCE Dashboard consists of enterprise, state, regional, local, and member level data related to SDoH, condition prevalence, and potential disparities within a market. Measures included are: gender,

[8] NCQA HP 2018/2019 LTSS1 A1

age, race/ethnicity, language and health conditions. The Dashboard provides health plans with a tool to support the analysis of their population, identify geographical areas of risk, help inform further ICM program planning activities and target interventions to address health disparities. Descriptive statistics of membership enable the comparison of individual plans to overall Aetna Medicaid members within the same lines of business and demographic distribution.

Aetna Medicaid contracts with ActiveHealth, an NCQA accredited organization, to obtain information from members on their perceptions of their health and wellness. These **health appraisal**[10] results are evaluated separately and tracked through the referral process. Upon health plan enrollment, members are informed of the opportunity to provide self-reported health information via through the ActiveHealth website. Case managers receive a weekly report on health appraisal results. They review the member self-reported responses and reach out to the member to evaluate them for inclusion in care management if clinically indicated.

Members are also identified for care management through their contact with a 24 hour **health information line**[11]. After the health information line nurse completes a call or email exchange, information via an intake form is entered into the care management system to trigger screening for possible enrollment into ICM.

The **Health Risk Questionnaire (HRQ)** [12] is administered by ICM program staff and gathers member self-reported information on health conditions and healthcare utilization history. The responses drive a risk score that assists in determining the need for care management or high or low-risk chronic condition management.

ENROLLMENT AND ENGAGEMENT in CARE MANAGEMENT

Outreach

Once identified, the members are outreached by care management staff to discuss the ICM program, the reason they have been identified, explore their interest in participating and complete additional screening. Members have the right to decline participation or dis-enroll from care management programs. Members may also choose to opt out of the chronic condition management portion of the program at any time.

Non-LTSS members who receive custodial institutional care are referred for care management. For members with LTSS needs who are not yet enrolled with the state LTSS program, ABH-KY assists the member to apply for eligibility for LTSS.

Unsuccessful Outreach Attempts

Aetna Medicaid documents all attempts to contact the member utilizing various methods (e.g. telephone, letter, e-mail, authorized care giver channels) on different dates and at different times of the

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[11] NCQA HP 2018/2019 PHM5 A1
[12] NCQA HP 2018/2019 PHM2 A4

day. We may also utilize Community Health Workers (CHWs) or other care management staff to visit the member's home or contact the member's PCP or pharmacy. We also reach out to local homeless shelters, hospitals, food pantries, libraries, and clinics in an attempt to locate members in need of our ICM program.

Non-dual or non-LTSS members who are pregnant or who have chronic conditions and are not reached during outreach attempts are automatically assigned to population health level of ICM where their utilization can be monitored, and they can be outreached again as indicated.

Member Evaluation

Aetna Medicaid utilizes a combination of enterprise developed and standardized assessments and tools. Assessments and screening tools used by case managers were developed using evidenced based clinical practice guidelines promulgated by nationally recognized entities including, but not limited to:

- Centers for Disease Control and Prevention (CDC)
- National Heart, Lung and Blood Institute (NHLBI)
- American Psychiatric Association (APA)
- American Congress of Obstetricians and Gynecologists (ACOG)
- American Diabetes Association (ADA)
- Healthy People 2020
- Substance Abuse and Mental Health Services Administration (SAMHSA).[13]

The specific issues addressed in the member's assessment are delineated in Aetna Medicaid Policy 7500.05 Integrated Care Management.[14] Clinical guidelines are reviewed by a standing Aetna Medicaid clinical committee. The guidelines are from nationally recognized sources and updated at least every two years and whenever significant changes are made to the guidelines.

When assessments for a specific condition (e.g., heart failure, depression) are developed or revised, the national guidelines are incorporated into the assessment and associated care plan intervention options. The name of the guideline(s) used and link(s) to the entire document are provided within the assessment. All guidelines are available as links from the plan's web site and in the provider handbook. Providers are educated about where to find these guidelines when they join the plan and when guidelines are revised.

Unless otherwise required by contract, member assessments are started within thirty (30) days of being identified for care management and completed within 60 days.[15] Members with chronic conditions are assessed in relation to their specific condition(s) to determine appropriate interventions to be addressed in the care plan.

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[13] NCQA HP 2018/2019 PHM5 B1

[14] Aetna Medicaid Administrators LLC Policy #7500.05, Integrated Care Management, Member Evaluation pages, 11 and 12.

[15] NCQA HP 2018/2019 PHM5 G (File review- timeliness of assessment)

Members receiving complex care management receive a comprehensive assessment upon enrollment into the ICM program and at least annually thereafter. The following elements are evaluated as part of the initial comprehensive assessment and annual re-assessments: [16]

- Health status, indications for ICM program enrollment, and condition specific issues including screening for presence or absence of comorbidities and their current status, medications, and self-reported health
- Clinical history (condition onset, emergency department, inpatient stays, medications)
- Activities of daily living (ADLs), instrumental activities of daily living (iADLs) and functional status of the member related to self-care and the use of any supports
- Behavioral health status (issues and service needs, depression screening, substance use disorder history and treatment)
- Level of cognitive functioning
- Social determinants of health (SDoH) such as safety and availability and adequacy of food, housing, personal relationships, community, etc.
- Social functioning in the member's ability to engage in social interactions, interpersonal relationships, and ADLs.
- Health Literacy
- Health beliefs and behaviors (including readiness for change)[17]
- Plans for handling health, personal affairs and life-planning[18]
- Linguistic, cultural and spiritual needs, preferences and limitations
- Visual and hearing status, needs, preferences and limitations
- Physical environment for risk[19]
- Scope of benefits for which the member is eligible, including health plan and other resources, such as community and faith based organizations[20]
- Paid and unpaid (informal) caregiver resources, needs of unpaid caregivers, and opportunities to meet those needs.
- Unpaid caregivers' desired level of involvement in the member's care management plan.
- Community services and ongoing health treatments
- Current living situation and preferences

Further, as behavioral health and substance use issues are commonly co-occurring, each member identified as having concerns in one of these areas (either by self-report, referral, claims data or at the time of initial assessment) is screened for <u>both</u> issues using the following evidence-based tools: [21]

[16] NCQA HP 2018/2019 PHM5 C1-11
[17] NCQA HP 2018/2019 LTSS B1-9
[18] NCQA HP 2018/2019 LTSS1 E3
[19] NCQA HP 2018/2019 LTSS1 B10-12
[20] NCQA HP 2018/2019 LTSS1 C2-3
[21] NCQA HP 2018/2019 PHM5 C4

Screening Tools		
Kessler Screening Scale for Psychological Distress (K-6)[22]	Screens for mental health problems	Adults
UNCOPE[23]	Identifies risk of abuse and dependence for drugs and alcohol	Adults
Pediatric Symptom Checklist (PSC-17)[24]	Facilitates the recognition of cognitive, emotional, and behavioral problems	Under 19
CRAFFT[25]	Screens adolescent members for abuse/dependency for alcohol/other drugs	Under 21
Patient Health Questionnaire 9 (PHQ9)[26]	Tool to screen, diagnosis, monitor, and measure severity of depression	Vulnerable Subpopulations
Generalized Anxiety Disorder 7 item scale (GAD 7)[27]	Screens for 7 common anxiety symptoms. Scores mild, moderate, and severe anxiety. Further evaluation is indicated when the score is 10 or greater.	Vulnerable Subpopulations
Edinburgh Postnatal Depression Scale (EPDS)	Screens / identifies members at risk for "perinatal" depression.	Recently pregnant females

Evaluation of the SDOH is an ongoing relational process to ensure all members have equal access to benefits and services in a way that acknowledges their values/ preferences and overcomes social, cultural and geographical barriers. SDOH data are used to guide care plan development and resource allocation.[28]

Care management staff have the ability to capture, within the documentation system, SDOH data elements from the following (6) categories as defined by Healthy People 2020:

- Demographics
- Economic Stability
- Education
- Health and Health Care
- Neighborhood and Built Environment
- Social and Community Context

Documentation of the initial assessment includes an evaluation of the information collected; a summary and conclusion of the meaning or implications of the information to the member's situation is noted. Information from the assessment is used to inform the member's individualized care plan.

Needs Based Stratification and Services

Upon completion of their health screenings and assessments, members enrolled in care management are stratified based on the complexity of their individual needs and are assigned a program level

[22] http://www.hcp.med.harvard.edu/ncs/k6_scales.php
[23] Hoffmann, N. G. Retrieved from: http://www.evinceassessment.com/ UNCOPE
[24] Gardner W, Murphy M, Childs G, et al. The PSC-17: a brief pediatric symptom checklist including psychosocial problem subscales: a report from PROS and ASPN. *Ambulatory Child Health.* 1999; 5:225–236.
[25] http://www.ceasar-boston.org/clinicians/crafft.php
[26] http://www.phqscreeners.com/select-screener Accessed 3/2017
[27] http://www.phqscreeners.com/select-screener Accessed 3/2017
[28] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

commensurate with those needs. Each level of the ICM program provides members with education, encouragement to learn self-management skills and coordination of access to the appropriate services and supports. A summary of program indications, services and associated interventions is found in *Appendix A*. When health care disparities are identified as contributing factors to poor health outcomes Health Care Equity (HCE) innovative strategies are deployed in conjunction with traditional care management.[29]

Regardless of program level, all members involved with the ICM program receive initial contact, a culturally aligned Welcome Letter to any programs in which the member enrolls, and needs evaluations. Members are encouraged to communicate with their care and service providers and Primary care providers are notified of each member's enrollment. Providers are educated about the program and services and informed on how they can best support their patients in their use of care management services. If identified as being diagnosed with a chronic condition of focus, members receive culturally aligned bi-annual newsletters for the chronic condition(s). KRAMES and/or other evidence-based educational materials are available and provided as indicated and upon request.

The ICM team also provides community based referrals for services related to identified SDOH, support in addressing Health Literacy, and coordination of care to minimize barriers to access to care and increase access to culturally aligned services

Exceptions to the stratification may be driven by individual member preferences, assessment findings, person-centered goals, state Medicaid agency requirements, interdisciplinary care team collaboration, and/or the case manager's judgement.

Person Centered Care Planning

The care plan includes the assessment of the member's needs, prioritized goals, individual preferences, barriers to optimal health, personal affairs, life planning, and caregiver status. Motivational interviewing (MI) techniques are used throughout the assessment, care planning and ongoing care management process. MI facilitates the assessment of the member's preferences, helps to identify and prioritize goals, and evaluate progress toward achieving those goals through actions, interventions, and measurable outcomes.[30] The case manager identifies the member's preferred communication methods and desired level of involvement in care and service planning activities. The case manager works with the member to determine frequency and time frame for contact and reevaluation[31]. The member and case manager identify resources to be utilized including appropriate level of care, plan for continuity including transitions of care, and determine the member's desired level of involvement in care and service planning activities.

Case managers facilitate a multidisciplinary approach to care planning by partnering with:

- Members
- Primary care providers
- Specialty care providers

[29] NCQA HP 2018/2019 PHM5 C5
[30] NCQA HP 2018/2019 LTSS E1-3
[31] NCQA HP 2018/2019 LTSS E4

- Behavioral health providers
- Community social workers
- Ancillary providers
- Caregivers
- Pharmacy providers
- Hospital discharge planners
- Family /circle of support
- Interdisciplinary care teams (ICT) when requested by the member.

Case managers also collaborate with utilization reviewers, pharmacy, member services and other internal resources to ensure that all appropriate information is considered for incorporation in the member's care plan. This collaboration and coordination of care and service needs encourages efficient utilization to avoid gaps in care or duplications in services and supports. The plan reflects the collaborative approach that is appropriate for the member and the level of family/circle of support participation. For all members, the case manager facilitates and encourages communication across various disciplines and care settings within and outside the health plan, including the PCP and any other practitioners/providers.[32]

The member's assigned case manager initiates and facilitates the ICT meetings to support the member's care and service needs. The ICT participates in the development and implementation of a written, person-centered care plan to assist each member with establishing access to covered and non-covered services and supports. The composition and frequency of ICT meetings are based on the unique needs and risks of the individual member. The ICT serves as a forum to address the member's specific needs and may include the discussion of any physical health, behavioral health and socio-cultural factors that may be having an impact on the member's overall health or place the member at risk for an adverse outcome. Input is provided by the ICT based on their expertise in physical and behavioral health, or social and community services. The ICT includes the member and is responsible for coordination of care, services and supports that are transparent, individualized, accessible, and delivered with dignity in a linguistic and culturally competent manner.

Any biopsychosocial issues, cognitive limitations, and SDOH impacting members are incorporated into their individualized care plans, as are the cultural practices and beliefs that are most important to the member. Barriers to improving health and root causes of poor health outcomes are specifically addressed to help both the case manager and the member better understand what has prevented full engagement with a suggested plan of care.[33]

[32] NCQA HP 2019 LTSS1 A5
[33] NCQA HP 2018/2019 PHM5 C12-13; PHM5 E1-5

The individualized care plan includes specific interventions or tasks that will facilitate the member achieving their care plan goals such as referrals to a provider or community resource, assistance with access to a resource or service and follow-up to ensure care or service was received.

The care plan is reviewed and revised on a specific follow-up schedule based on the member's ICM program level.[34] It is also updated whenever there is a change in condition, status or placement or other changes that warrant an update such as loss of employment, housing, etc. All initial and subsequent care planning activities are tracked on the written care plan and in the care management business application system. [35]

ONGOING CARE MANAGEMENT

As case managers work with members to meet their goals, they will identify and use all available resources. Case managers incorporate respite and caregiver support into the care plan for coordination of care provided to the member. Case managers encourage members and ICT participants to contact them with any needs or changes in condition. The member is provided with the care management staff name(s), phone number, or e-mail address through a culturally aligned welcome letter, and in each care plan.

Our goal is to address specific cultural and language needs that might challenge a member's ability to access care or understand practices that lead to optimum health outcomes. We understand that cultural competency goes well beyond ensuring availability of a language interpreter or translating printed materials into languages other than English. There are questions in our assessments that are intended to elicit cultural beliefs so that the case manager can begin to understand how these are impacting the member's health and how care and services can be coordinated to align with the member's cultural needs. Cultural competency is a part of all ICM training and is expected to be an integral part of the mentoring of ICM staff by their managers and clinical leaders.

Members with HEDIS gaps in care are identified in our business application system to alert case managers to follow up with the members and their providers to obtain appropriate clinical screenings and comply with clinical practice guidelines.

Case managers also use care plan interventions as options to help address a member's chronic condition goals. Management of chronic conditions may include to assist with the following interventions:

- Provide the member with appropriate resources, training and support to help him/her complete tasks as necessary to achieve care plan goals
- Conduct face-to-face coaching sessions, reinforcing following the care plan and adjusting tasks to align with the member's culture, language and religion
- Reinforce education related to self-management of chronic condition(s) while respecting the member's culture, ethnicity and religion

[34] NCQA HP 2018/2019 QI5 F15
[35] NCQA HP 2018/2019 PHM5 C17; NCQA HP 2018/2019 LTSS1 A5, F8

All case managers utilize referrals to community based organizations (CBOs) during their work with members. CBOs include external entities such as:

Adult Protective Services	Dept. of Health Facilities, Evaluation and Licensing	
Accredited training agencies	Providers, including those in health homes and Systems of Care	
AAA/Aging & Disability Resource Centers	Public Guardians	Ombudsman
Consumer advocacy groups	Local law enforcement	Department of Health Services
County and / or state based emergency preparedness groups	Dept. of Child Protection Services	Department of Guardianship Services

The health information line provides all members' 24-hour, toll-free access to a team of registered nurses experienced in providing information on a variety of physical and behavioral health topics. The health information line also features an audio/video health library covering more than 2,000 health topics available in both English and Spanish. The health information line can also be accessed for non-symptom related, general health information questions by email through the member web portal. Reports on members accessing the health information line are integrated into the ICM program.

Integrated case rounds are held at least twice monthly and provide a forum for the care management team, utilization management staff, internal SoC staff, pharmacy staff, and clinical leaders to discuss complex members and collaborate on ways to better assist them. The clinical leaders also interface with the provider community when needed to assist our ICM team and to enhance care for our members. Providers may be invited to attend integrated case rounds in person or by phone.

ABH-KY uses pharmacy and utilization data to identify members who may be misusing, abusing and/or diverting controlled substances and limits their access to these medications through our Member Restriction program. The program provides support to identify alternative treatments, to provide referrals for pain management or substance use disorder when indicated, assist with managing pharmacy and benefit utilization to meet member healthcare needs, and coordinate care with primary care practitioners and other practitioners/providers.

The case manager, member, and the member's care team adjust the care plan and may change service providers if repeated service gaps occur. Conflict free case management elements are fully incorporated into ABH-KY's care management program, including its integration of:

- Physical health, behavioral health, and LTSS
- Individuals into the community where they have access to activities that are meaningful to them, including social, spiritual and productive employment
- Medicare and Medicaid services in that members may be eligible for both government programs
- Care management activities provided by ABH-KY are separated from the provision of direct care or services.

ABH-KY responds to and supports members who present in person or over the telephone as being in a physical or behavioral health crisis by assisting members to access the appropriate services to manage the situation.

ABH-KY employees are obligated to report events and incidents regarding member safety to applicable authorities as required by state law and state Medicaid agency requirements. Any report to state authorities must be provided in a manner consistent with state requirements for such reporting. Health plan staff members are required to cooperate with any investigation conducted by the health plan, its designee or outside agencies, including law enforcement.

Member Re-Assessment and Care Plan Updates

Members enrolled in ICM are re-assessed at least annually, upon significant change in condition, upon member / representative request and as contractually required. Annual comprehensive re-assessments include all components of the member's initial assessment. During each reassessment, member stratification is reviewed and potentially adjusted.

Regularly scheduled contact and use of the Interval Assessment provides feedback, allowing case managers to evaluate members' progress toward their person-centered goals, and determine if the current care plan is meeting the member's needs or if needs have changed. The Interval Assessment may indicate a need for a care plan update or comprehensive reassessment, and/or identify a significant change in condition.

Additionally, members may experience a change in condition that may require a different care setting or level of care. Case managers are notified when a member is admitted to an acute or sub-acute care facility to begin collaborating with the member, concurrent review nurse, facility discharge planner, and ICT to identify the root cause of admission and develop a discharge plan.

Practices used by case managers to facilitate the safe transition of members between care settings include:

- Identifying members transitioning between settings to provide care coordination, communication, support and assistance to arrange services for the members, caregivers, and providers as soon as the transition is identified and continuing through the transition period as indicated by member's needs.
- Reassessing the member's needs and the appropriateness of an existing care plan post transition, modification of that plan as indicated, and discussion of changes with the member as indicated by the members' needs but no later than 30 days post transition.
- Conducting medication reconciliation after transition between care settings, documenting each medication with the member and their designated representatives and communicating any identified discrepancies with the appropriate provider(s).[36]

As members move toward their goals, the case manager works with them to establish a plan for effective self-management, where appropriate. Activities include the identification of any services or resources the member can independently access. Members enrolled in Medicaid-only plans who achieve their goals are discharged from ICM.

[36] NCQA HP 2018/2019 LTSS3 A

Program Effectiveness

Goals, Interventions, and Measures

The overarching goal of the ICM program is to engage members to address their physical, behavioral, long term services and supports, environmental and social needs in the right setting and in a cost effective manner. We strive to help them retain, if not improve, their health, self-management and functional levels. To that end, ABH-KY's ICM program includes specific goals, actions and measures of effectiveness. See *Appendix B* for a full summary.

Program Evaluation

Aetna Medicaid conducts a comprehensive evaluation of processes, resources and the effectiveness of its care and chronic condition management programs on an annual basis to ensure interventions and strategies remain consistent with the most current Standards for Medical Care and other community standards.[37] In all of our programs, including care management, we consider a member's protected health information (PHI) private and confidential. Aetna Medicaid maintains policies and procedures to protect PHI against unlawful use and disclosure.

The plan staff annually review and update the ICM processes and resources to address member needs to identify opportunities to develop plans for improvement. The review also includes measurements of member enrollment, engagement, and satisfaction outcomes. The effectiveness of any actions taken will be assessed with re-measurement.

Quality Audits

ICM program supervisors audit their staff to ensure that the appropriate follow though is conducted on member raised issues/concerns and that documentation is accurate and complete. This may include review of member files in our care management system as well as monitoring phone conversations with members.

All staff quality reviews are performed to validate that staff are conducting their activities in accordance with program principles and processes, including compliance with applicable regulatory requirements and accreditation standards. Reviews are structured to evaluate the consistency by which staff in comparable roles perform their required functions. Each staff member is expected to meet or exceed the goals established by the department. Staff not meeting or exceeding department goals receive additional training with specific performance improvement activities. They are audited more frequently and mentored to support improvement until goals are met.

Member Experience Survey [38]

Annual member satisfaction surveys are used to obtain feedback from members about their experience with ICM programs. All responses are analyzed by clinical leadership along with member complaints related to care management. Survey outcomes are used to enhance the care management processes

[37] NCQA HP 2018/2019PHM6 A
[38] NCQA HP 2018/2019 PHM5 F1-2, NCQA HP 2018/2019 LTSS2 1A

and staff performance to improve the program and each member's satisfaction with services. Opportunities for improvement are identified, evaluated and actions to address them are implemented as indicated.

Communication of Findings

The findings of the annual program evaluation are presented to the ABH-KY Quality Management / Utilization Management (QM/UM) Committee for review and discussion. Process and performance activities are based on identified opportunities for improvement. Corrective action plans are developed as indicated and progress reports provided to the committee on a regular basis as determined by the health plan.

ICM Program Description Appendix A

ICM Program Stratification, Services [39] and Associated Interventions Program Indications	Program Services	Care Management Interventions
Intensive Care Management (includes Chronic Condition Management)		

Non-LTSS
• Behavioral & physical health co-morbidities
• Higher risk for Inpatient/ED utilization and unplanned transitions
• New or unstable chronic condition management incorporated
	• Complex clinical and psycho-social care coordination and planning including covered and wrap around services.
	• Chronic condition management education as appropriate as well as assistance with accessing care across the continuum.
	• Member education and coaching to self-manage their conditions and issues.
	• Monthly contact, face to face visits, frequent visits during acute or transitional episodes, and an annual comprehensive assessment by a licensed care manager.
	• Community based referrals for services related to health plan identified SDOH
	  o Health Literacy
	  o Barriers to access
	  o Culturally aligned services
		• Face to face visit - offered within 30 days of enrollment in care management when feasible and and quarterly thereafter based on member needs and preferences
		• Comprehensive bio-psychosocial assessment including behavioral health, substance abuse, and functional screening
		• Condition specific assessments for physical and behavioral health
		• Case Formulation/Synthesis (summary of the member's story)
		• Integrated care and service planning, including covered and wrap around services
		• Chronic condition management provided by a clinician
		• Monthly member contact and care plan reviews and updates based on progress toward prioritized goals and communication of the care plan with the member, PCP, and others of the members' choosing
		• Member contacts, including face to face visits, based on member needs and / or change in condition
		• Annual re-assessments based on member needs and as indicated by a change in condition.
		• Complex care coordination informed and supported by health plan based multi-disciplinary case rounds and the member's interdisciplinary care team (ICT) which includes the member and his/her identified support system

Supportive Care Management (includes Chronic Condition Management)		

[39] NCQA HP 2018/2019 LTSS1 A4

ICM Program Stratification, Services [39] and Associated Interventions Program Indications	Program Services	Care Management Interventions
• Members with the following chronic conditions: o Asthma o CAD o COPE o Depression o Diabetes o Heart Failure o Chronic Kidney • High risk pregnancies • Members who have lesser clinical and biopsychosocial complexity. • State required populations, e.g. Lead exposed children or other health plan identified SDOH •	• Standard care coordination and planning. • Condition specific assessments for conditions of focus • Coaching on the management of conditions and issues and self-care • Encouraging members to communicate with their care and service providers • Education on disease process, self-management skills, and adherence to recommended testing and treatment • Quarterly (minimum) care plan review, goal discussion, and updates • Member contacts as clinically indicated by the member's needs, change in condition, or CM's judgment (every 90 days at minimum) • May be brief and condition focused • Community based referrals for services related to health plan identified SDOH o Health Literacy o Barriers to access o Culturally aligned services	• Face to face visits, as indicated or required by contract • Condition specific assessments for conditions of focus. • Biopsychosocial, person-centered care plan which includes activities for chronic conditions, and service plans • Chronic condition management support and referral to a clinician for clinically based needs associated with the condition(s) • Coaching on the management of conditions and issues and self-care • Encouraging members to communicate with their care and service providers • Education on disease process, self-management skills, and adherence to recommended testing and treatment • Quarterly (minimum) care plan review with discussion of goals and progress toward achieving them, revisions, and communication of updated care plan with the member, PCP and others at the request of the member • Member contacts as clinically indicated by the member's needs, change in condition, or CM's judgment (every 90 days at minimum) • Annual re-assessments based on member needs and as indicated by a change in condition • Care team coordination informed and supported by health plan based multi-disciplinary case rounds and the member's interdisciplinary care team (ICT) which includes the member and his/her identified support system as indicated
Population Health Non-LTSS only, (includes low risk Chronic Condition Management)		
• Low risk pregnant mothers for	• Monitoring and education for low risk special populations.	• Low/No Risk pregnant members: Quarterly screening to identify risk factors

ICM Program Stratification, Services [39]and Associated InterventionsProgram Indications	Program Services	Care Management Interventions
quarterly risk screening • Low risk chronic condition specific mailings	• Basic educational outreach • Individualized services to members who require routine screening, monitoring, and follow-up. • Deployment of additional staff such as CHW or Peer Support • Health plan identified SDOH for disparity focused population o Advocacy o Community based education o Community resource referrals	• Dually enrolled Medicare-Medicaid: Annual HRQ, low risk care plans, Krames materials • Special populations: monitoring/tracking per state requirements

ICM Program Description Appendix B

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
ABH-KY evaluates its populations to define health service needs and ensure health care is available, accessible, and appropriate.	• In support of the PHM annual evaluation, actively participate in assessment by providing care management information related to member populations and demographic characteristics. • Adjust care management programs and processes to address identified needs and improve existing programs.	**Populations are evaluated[41]** • Membership profile (population assessment) conducted per process described in PHM Strategy Framework. • Evaluation of processes and resources as evidenced by Care Management Program Evaluation report and related discussion found in QA/PI Committee Minutes
Members are identified for ICM and aligned with the appropriate level of care determined by their individual needs.	Identify and engage members appropriate for care management through enrollment, self-reported health status information, planned and unplanned utilization, and individual referral processes.	Using established criteria, evaluate monthly and quarterly reports:[42] • Percent members reached for enrollment in CM • Percent of members enrolled in care management programs • Percent of Members enrolled in CM who are also engaged. (Target: >85%) • Percent of members enrolled in complex care management identified with a chronic condition who receive condition specific assessments (goal 75%) • Percent of members receiving timely initial assessments • Percent of members receiving timely annual reassessments (Target: 100%)
Members access a continuum of services and supports based on the intensity and complexity of their	Monitor utilization to care and services, interacting with members as indicated to promote utilization of PCP and specialty services and take action to mitigate risk	Decrease avoidable emergency department utilization by *2%* annually : • ER utilization per thousand (monthly review)

[40] NCQA HP 2018/2019PHM5, PHM 6A1-3 , NCQA HP 2018/2019, LTSS1 A4, A2
[41] NCQA HP 2018/2019 PHM2 B1-4, PHM2 C1-2

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
needs and utilize those services in an efficient and effective manner.	and decrease unplanned transitions and / or inappropriate utilization of resources.	• Increase use of specialty care and services targeted to specific member needs • Specialist visits per thousand (monthly review) Evaluate monthly: • Hospital Admissions per 1000 **Transition of care** between inpatient and home settings are coordinated and free of avoidable adverse outcomes • Percent members discharged from acute inpatient facility to home or community based setting who receive post discharge questionnaire (PDQ) screening • Hospital Readmissions within 30 days per 1000 for members enrolled in Care • Hospital Readmissions within 30 days with PCP visit within 7 days of initial discharge • Hospital Readmission within 30 days with PCP visit within 8-14 days of initial discharge
Care plan interventions are timely with performance goals that support members receiving care in the most integrated, least restrictive, and cost effective setting while encouraging optimal functioning and acknowledging personal preferences.	Assess case management activities for adherence to program standards, including through regularly scheduled file audits to evaluate: • Assessment, re-assessments, and contact with members at predetermined intervals to evaluate status • Person centered care planning and follow up to monitor achievement of goals in the individual member's treatment plan • Education of member and circle of supports, • Inclusion of providers, and the member's representative(s) in the development of the care plan and	File audits conducted on an statistically valid volume of member files, including at least three files per case manager quarterly per Staff Quality Review policy (Target: CM supervisors complete prescribed number of file audits per staff person). Conduct quarterly file audits using an approved audit tool that evaluates the documentation of all essential CM activities. (Target: >85Percent of staff scoring 90% or more on file audits.).

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
	provision of updates to support the member achieving their goals • Assisting members with achievement of individualized goals, such as meaningful employment or palliative care needs[43]	
ICM promotes and facilitates behavioral changes that supports self-management and improved health outcomes.	Engage members in activities aimed at improving their life goals, health outcomes and quality of life, including: • Addressing social determinants of health • Supporting existing treatment plans • Providing reminders on disease prevention, health and wellness • Providing information related to their chronic conditions and self-management of those conditions	• Members receive education and information about their conditions, medications, available services and resources, and/or options that will help them to achieve their identified plan of care goals (Target: 100% members enrolled in ICM receive education and/or materials) • Evaluate members' perception of their quality of life measured through the use of the pre/post SF10 and/or SF12 questionnaire within 90 days of members' enrollment in ICM and at least annually thereafter • (Target: 90% of members receive evaluation)
Social, educational, environmental, racial and ethnic disparities in health care are identified and reduced through care coordination, collaboration, and network management.	• Evaluate adherence to evidence based guidelines and interventions using established metrics. • Collaborate with Quality Management to meet performance targets, optimize quality incentives and avoid sanctions or penalties. • Collaborate with SDOH to develop and implement integrative clinical programs that address cultural and linguistic needs of Aetna Medicaid members, and address racial and ethnic disparities in health care	• Complete evaluation of monthly gaps in Care and interim HEDIS data at least quarterly • Meet or exceed targeted HEDIS benchmarks for members engaged in ICM. • Facilitate and support integrative clinical programs and HEDIS® based initiatives that address cultural and linguistic needs of ABH-KY members (Target: 1 program per year) • Participate in initiatives to address racial and ethnic disparities in health care.

[43] NCQA HP 2018/2019 PHM5 E1-5

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
Members receive interventions that promote health literacy.	• Provide interventions that reflect awareness of health literacy's impact on health care to improve member health literacy and outcomes. • Utilize articles in culturally aligned semi-annual chronic condition newsletters to support understanding of conditions. • Internal staff training on the use of plain language in communication • Promotion of external communication resources • Technological improvements (e.g., track phone, cellular phone applications)	• Creation and distribution of pre-printed member facing information meet "easily readable" criteria (Target: 100% member-facing pre-printed materials at or below 6th grade reading level) •
Collaboration and coordination is promoted to integrate member health information across all departments.[44]	Analyze data gathered from inter-departmental resources collectively and routinely to identify opportunities for process improvement across all departments.	Determine effectiveness in the following areas: • HEDIS Gaps in Care • Health appraisals • Health care equity findings • SDOH data • Health information line • Interdisciplinary case rounds Evidenced by the annual evaluation of Care Management program and the Quality Management/Utilization Management (QM/UM) annual evaluation.
Members experience improvement with health care delivery.	• Regularly obtain and evaluate input from members, caregivers, and other stakeholder regarding their experience with health care and care management services and health, using information gained to improve quality of care and service • Monitor monthly grievance and appeals reports • Conduct ongoing member satisfaction surveys	• Percent of grievances related to non-LTSS care management activities (Goal 2% improvement per year) • Percent positive responses (response ratings of 4 or 5) to the Satisfaction with CM Services to the following questions: ○ I am happy with the care management services I've received.

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
		○ My case manager helped me get all of the services that I needed (Target: 90% for each question)[45]
Promote health and wellness through the use of preventive and routine care and services.	• Effectively communicate the value of prevention and wellness activities using multiple modalities (telephone calls and mailers) and resulting in increased use of these services. • Member education through culturally aligned member newsletter articles • Promotion of wellness visits (as part of treatment goals) • Offer incentives	• Written Member information /education on the value of preventive and care aimed at promoting health and wellness are provided to members through culturally aligned quarterly member newsletter articles at least quarterly (Target: 100%) • Care plans include documented promotion of health and wellness related activities as evidenced in File Reviews and visits (as part of treatment goals) (Target: 75%) • Improved use of preventive measures such as well woman, well man, EPSDT and immunizations.
Chronic Condition Management within Integrated Care Management Goals: Aims to reduce longer-term premature morbidity (complications) and mortality of the condition. Appendixes I through VI describe condition specific goals, metrics, and interventions. The following apply to all Health Plan members and reflect common goals and metrics of the six Chronic Condition Management programs		
Staff will promote member participation in chronic condition management programs.	Identify and enroll members with diagnoses of diabetes, heart failure, depression, asthma, COPD, chronic kidney disease and / or coronary artery disease into chronic condition self-management programs.	Percent of members with identified chronic conditions who participate in at least one (1) chronic condition management program specific to the members condition
Members will demonstrate improvement in their ability to self-manage their identified chronic condition.	Provide culturally aligned education and / or information specific to members to encourage accurate perceptions of their condition(s) and improve their ability to self-management.	• Evidence of distribution of culturally aligned chronic condition management related information to all identified members (Target: Materials sent to 100% of identified members) • Percent of members engaged in care management with identified

[45] NCQA HP 2018/2019 PHM6 A1-2

Summary of ICM Goals, Interventions, and Measures of Effectiveness[40]		
Goals	**Action**	**Measurements**
		chronic conditions that receive active care management for their specific condition within a given year.

ICM Program Description Appendix C

Glossary of Terms

- **Behavioral health:** Behavioral healthcare is an umbrella term and refers to a continuum of services for individuals at risk of, or suffering from, mental, behavioral, or addictive disorders. Behavioral health, as a discipline, refers to mental health, psychiatric, marriage and family counseling, and addictions treatment, and includes services provided by social workers, counselors, psychiatrist, psychologists, neurologists, and physicians.

- **Care Management:** A collaborative process of biopsychosocial assessment, planning, facilitation, care coordination, evaluation, and advocacy for service and support options to meet a member's comprehensive care needs to promote quality cost-effective outcomes. Care management includes assistance to members with the management of chronic conditions, providing them education and encouragement to learn self-management skills and coordinating access to the appropriate services and supports.

- **Care Setting:** A provider or place that delivers health care and health-related services.

- **Care Transition:** Movement of members between care settings (e.g., from home to hospital) as their condition and care needs change during the course of a chronic or acute illness.

- **Chronic Condition Management:** Consists of a stratified group of interventions within the ICM program designed to manage chronic conditions using a systematic and structured member-centric approach based on condition severity and member needs. The aim of the program is to help members understand and control the effect of their condition by encouraging self-management, family involvement, support systems, and community awareness. Management of chronic conditions involves ongoing monitoring and encouraging members to adhere to necessary interventions that will help improve outcomes and enable individuals to more effectively manage and live with their chronic condition.

- **Enrolled in Care Management:** For LTSS and Duals (DSNP/MMP): Care management is required for these members so they are automatically considered enrolled in care management upon their health plan eligibility date. Mandatory population that is eligible, whether or not they have been outreached or have an initial outreach attempt, are considered "enrolled". For Non-LTSS/Non-Dual members, any member with an open episode in the ICM business application software is considered enrolled in care management.

- **Engaged in Care Management:** Members are considered engaged in ICM when they are enrolled in the program and have an active care plan they have agreed or partially agreed to.

- **General Risk Model (GRM)**: Proprietary predictive modeling program that shows all members in the health plan and their general risk score to identify high risk members. The top 1% of members are ranked by highest score. This is based on claims, authorizations and eligibility. The GRM serves as the basis for the CORE.

- **Health Care Equity:** Health equity exists when individuals have equal opportunities to be healthy. The ability to be healthy is often associated with factors such as social position, race, ethnicity,

gender, religion, sexual identity, or disability. When these factors limit a person's ability to be healthy it can lead to health inequity.[46]

- **Integrated Care Management (ICM):** Aetna Medicaid's model of care management and care coordination in which members are stratified by the complexity of their needs and assigned program levels, including: Intensive Case Management (Complex Case Management); Supportive Case Management; and Population Health/Monitoring and Consultation. All levels of care management include assistance to members with the management of chronic conditions (disease management), providing them education and encouragement to learn self-management skills and coordinating access to the appropriate services and supports.

- **ICM Business Application Software**: The primary web-based system used to document and coordinate all care management activities.

- **Krames Patient Education:** Provides booklets, brochures, workbooks and tear sheets online and via mail to engage patients throughout the continuum of care; motivate behavior change and build self-care skills; and support shared decision making and informed consent.

- **MyActiveHealth:** An Aetna owned company, ActiveHealth Management is Wellness and Health Promotion (WHP) accredited by NCQA. MyActiveHealth is a confidential and secure internet-based service that allows health plan members to obtain access to and organize their own health information. The website provides useful information about opportunities for improving the quality of medical care that you can be shared with the treating provider.

- **Population Health Level of Care Management:** A level of care management that offers basic educational outreach and includes individualized services to members who require routine screening, monitoring, and follow-up.

- **Population Health Management (PHM) Model Graphic:**

[46] *(The Guide to Community Preventions Services, 2016)*
Available at: http://www.thecommunityguide.org/healthequity/index.html

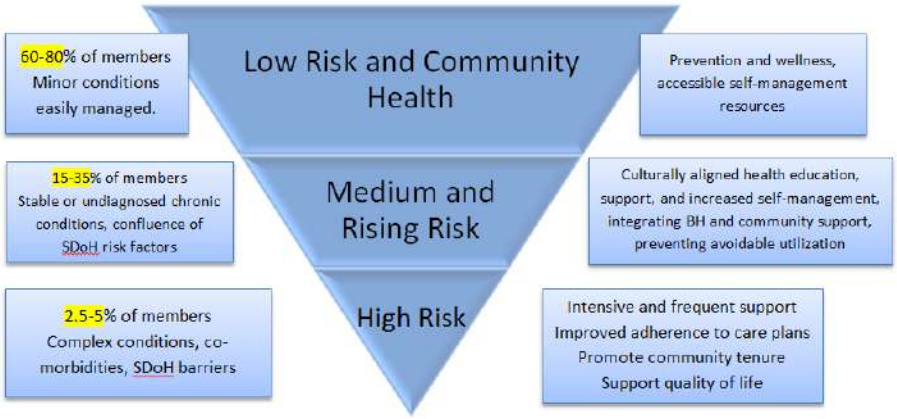

- **Social Determinants of Health (SDOH):** The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems." [47]

- **System of Care (SoC):** A collection of integrated services and supports that help people achieve goals that are important to them. The integrated services and supports may include all forms of health services, as well as housing, employment, healthy food, transportation and other living supports to optimize resiliency and independence. The SoC is grounded in the demonstration of trauma informed care, culturally and linguistically appropriate services, and recovery principles.

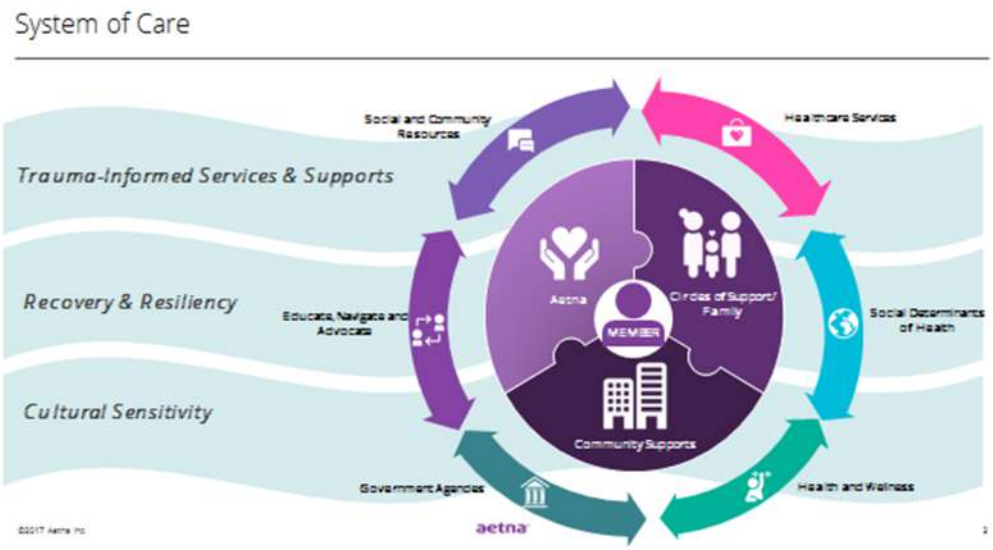

[47] World Health Organization. Available at: http://www.who.int/social_determinants/en/

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Attachment CC

Kentucky | Transforming Health Care | **Aetna**

Attachment CC

60.7.B.2 Corporate Information ..... Att C-3

2010 Centene 10-K ..... Att CC-17

2011 Centene 10-K ..... Att CC-23

2012 Centene 10-K ..... Att CC-29

2013 Centene 10-K ..... Att CC-35

2014 Centene 10-K ..... Att CC-43

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2017 Centene 10-K ..... Att CC-63

2018 Centene 10-K ..... Att CC-71

2019 Centene 10-Q Ending March 31 ..... Att CC-81

2019 Centene 10-Q Ending June 30 ..... Att CC-89

2019 Centene 10-Q Ending September 30 ..... Att CC-97

On January 23, 2020, CVS Health Corporation (CVS Health) acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare), which is now Aetna Better Health of Kentucky's affiliate and a subsidiary of our ultimate parent, CVS Health. ***Attachment CC*** *contains IlliniCare's responses to applicable RFP questions requiring Vendors to include information for parent companies, affiliates, and/or subsidiaries (collectively referred to hereinafter as "Affiliates"). Responses for other applicable Affiliates of Aetna Better Health of Kentucky can be found in the main body of our proposal.*

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60.7.B.2 Corporate Information

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60.7.B.2 Corporate Information

d. Provide a statement of whether there is any past (within the past ten (10) years or pending) litigation against the Vendor or sanctions, including but not limited to the following:

   i. Litigation involving the Vendor's failure to provide timely, adequate, or quality Covered Services. If any litigation listed, include damages sought or awarded or the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether the pending or recent litigation will impair your organization's performance in a Kentucky Medicaid Managed Care Contract.

   Include information for Parent Company, affiliates, and subsidiaries. The Vendor may exclude workers' compensation cases.

Table CC-1 describes litigation against IlliniCare Health Plan, Inc. within the past 10 years, involving its alleged failure to provide timely adequate or quality coverage for Covered Services.

Table CC-1: Litigation against IlliniCare Health Plan, Inc. within Past 10 years

Court/Venue	Parties' Names	File Date	Subject Matter	Damages Sought (damages alleged in complaint)	Damages Awarded	Status or Final Disposition	Close Date
District Court	Aperion, Bria Health Services LLC. Everest Care Group LLC, Grand Lifestyles, LLC, ICARE Financial Services, ITEX Company, Legacy Healthcare Financial Services, Maestro Consulting Services, LLC, Villa Financial Services, LLC v. Illinicare Health Plan, Inc., et al	9/19/19	A class action in which Plaintiffs' long-term care and skilled nursing facilities, purportedly as "authorized representatives" of the respective residents, accuse the State of Illinois Department of Healthcare and Family Services and Defendant Medicaid Managed Care Organizations of failing to timely provide Medicaid benefits to the Plaintiffs' residents. Plaintiffs contend that the Defendants' failure to timely provide benefits is a violation of the Federal Medicaid Act and the Americans with Disabilities Act. District Court granted the Defendants' Motion to Dismiss after concluding that the Plaintiffs lack standing. Plaintiffs appealed the dismissal to the Seventh Circuit Court of Appeals, and oral argument was held on September 19, 2019. We can anticipate a decision on appeal in approximately 2-3 months.	N/A	N/A	In Progress (Decision in the next 2-3 months)	N/A

CVS Health Corporation (CVS Health) acquired the stock of IlliniCare Health Plan, Inc. (IlliniCare) on January 23, 2020. IlliniCare is now a subsidiary of CVS Health, Aetna Better Health of Kentucky's ultimate parent, and an affiliate of Aetna Better Health of Kentucky. IlliniCare records reserves for outstanding legal matters when it believes it is probable that a loss will be incurred, and the amount can be reasonably estimated. It evaluates, on a regular basis, developments in legal matters that could affect the amount of any reserve and developments that would make a loss contingency both probable and reasonably estimable. IlliniCare is covered by insurance policies that are customary and adequate for its size and industry. In the opinion of Aetna Better Health of Kentucky and its counsel, the litigation pending against IlliniCare does not present a risk that Aetna Better Health of Kentucky's performance in a Kentucky Medicaid Managed Care Contract will be impaired.

60.7.B.2 Corporate Information

d. Provide a statement of whether there is any past (within the past ten (10) years or pending) litigation against the Vendor or sanctions, including but not limited to the following:

ii. Sanctions for deficiencies in performance of contractual requirements related to an agreement with any federal or state regulatory entity. Include monetary sanctions the Vendor has incurred pursuant to contract enforcement from any state, federal, or private entity, including the date, amount of sanction, and a brief description of such enforcement, corrective action, and resolution.

Include information for Parent Company, affiliates, and subsidiaries. The Vendor may exclude workers' compensation cases.

Table CC-2 describes sanctions against IlliniCare Health Plan, Inc. within the past 10 years for deficiencies in performance of contractual requirements related to an agreement with any federal or state regulatory entity.

Table CC-2: Sanctions against IlliniCare Health Plan, Inc. within Past 10 Years

Category	Additional Category Specification	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Corrective Action Plan (CAP)	Illinois Department of Healthcare and Family Services	11/9/15—IlliniCare received a Notice of Non-Compliance from HFS for failure to submit accurate and complete encounter data for FHP/ICP. A response letters was send on 12/4/15 asking the department to withdraw the Notice of Non-Compliance. IlliniCare had ensured HFS new processes would be implemented. Remediation: IlliniCare Health worked with HFS to implement an internal process to bring encounter data reporting into compliance.	—	Please refer to Description of Regulatory Action Column
CAP	Illinois Department of Healthcare and Family Services	11/16/15—IlliniCare Health received a Notice of Non-Compliance from HFS for violation of the ICP contract in related to HCBS waiver rates. A formal request to withdraw the Notice of Non-Compliance was submitted to HFS. This issue was remediated by signing the rate amendment and was officially closed on 6/8/2016. Remediation: IlliniCare Health worked with Centene National Contracting team to incorporate into the Medicaid Fee for Service.	—	Please refer to Description of Regulatory Action Column
CAP	Illinois Department of Healthcare and Family Services	4/27/16—IlliniCare Health received a Notice of Non-Compliance from HFS for not completing the required percentage of new member care plans for both its ICP and FHP contracts. Remediation: IlliniCare Health submitted a closure request to HFS in March 2017 due to achieving 85% completion for ICP and 73% completion for FHP.	—	Please refer to Description of Regulatory Action

Category	Additional Category Specification	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
CAP	Illinois Department of Healthcare and Family Services	3/14/18—IlliniCare Health received a Notice of Non-Compliance from the Bureau of Behavioral Health at HFS for failure to be in compliance with Illinois MCO Mental Health Parity requirements. Remediation: IlliniCare Health identified and submitted a corrective action plan to HFS for all six of the parity compliance deficiencies on 3/23/2018. IlliniCare Health implemented the remediation items by 7/1/2018 as provided to HFS in the initial response and analysis.	—	Please refer to Description of Regulatory Action
CAP	Illinois Department of Healthcare and Family Services	5/4/15—CAP to remediate volume of preventable errors in encounter data. Remediation: CAP Closed April 2016. Remediation efforts included implementing system updates and programming and increased oversight.	—	Please refer to Description of Regulatory Action
CAP	Illinois Department of Healthcare and Family Services	4/17/18—Three untimely responses to Illinois' MCO Provider Complaint portal tickets. Remediation: Robust action plan developed including root cause analysis of all complaints. Weekly monitoring in place to ensure compliance. The Provider Portal response team has also been trained on HFS's new policy, which came out on 4/17/18.	—	Please refer to Description of Regulatory Action
CAP	Illinois Department of Healthcare and Family Services	5/14/18—MCO Provider Complaint portal; Health Plan received a ticket on November 6, 2017 and did not respond timely. Remediation: IlliniCare Health has deployed additional enhancements to avoid missed Provider Complaint Portal deadlines.	—	Please refer to Description of Regulatory Action

Category	Additional Category Specification	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
CAP	Illinois Department of Healthcare and Family Services	12/21/18—Deficiencies in quality and performance metrics required by a consent decree. Remediation: Four Corrective Action Plans were submitted to IDoA on December 27, 2018. There was a follow-up meeting with IDoA on Friday January 4, 2019. IDoA presented IlliniCare staff with a formal letter and a Transition Achievement Plan with 10 areas of correction that IDoA set the deadline for January 18, 2019. Debra Brophy set the internal Deadline for a draft Transition Achievement Plan to be completed by COB on 1/9/2019. Long Term Care and Support Services Department has already worked with IDoA to set up future trainings, increased monitoring of staff accuracy and time frame completion, and adjusting targets to improve quality of assessments over quantity. Extra focus has been given to areas that were identified in the Transition Achievement Plan.	—	Please refer to Description of Regulatory Action
CAP	Illinois Department of Healthcare and Family Services	1/23/19—Failure for 2 service plans to meet 85% goal for Colbert Decree members. Remediation: To improve overall assessment and service plan reviews quality scores peer-to-peer support via clinical rotation was implemented on 7/1/2019. Employees with scores below 70% were placed on corrective action including supervision and weekly monitoring.	—	Please refer to Description of Regulatory Action
Sanction	Illinois Department of Healthcare and Family Services - Encounters	6/27/19—Failure to meet Encounter Utilization Monitoring (EUM) 96% threshold. Remediation: In order to reach the required acceptance percentage, IlliniCare Health made data corrections/enhancements to rejected encounters as well as installed claims edits to prevent paying claims for which it cannot create clean encounters. Since encounters are scored by the State in months in arrears, this edits will prevent sanctions in future Encounter scoring periods.	$50,000	Paid

Category	Additional Category Specification	Description of Regulatory Actions	Monetary Sanction (if applicable)	Final Disposition
Sanction	Illinois Department of Healthcare and Family Services - Encounters	10/21/19—Failure to meet Encounter Utilization Monitoring (EUM) 96% threshold Remediation: Remediation activities aimed at creating clean encounters records/data were completed at the end of 2019; all remediation activities have been completed.	$50,000	Paid

60.7.B.2 Corporate Information

d. Provide a statement of whether there is any past (within the past ten (10) years or pending) litigation against the Vendor or sanctions, including but not limited to the following:

iii. Any Securities Exchange Commission (SEC) filings discussing any pending or recent litigation. Include information for Parent Company, affiliates, and subsidiaries. The Vendor may exclude workers' compensation cases.

Please refer to files included as part of **Attachment CC** for copies of Securities Exchange Commission filings discussing any pending or recent litigation for Aetna's Parent Company, affiliates, and subsidiaries.

60.7.B.2 Corporate Information

e. For the Vendor, Parent Company, subsidiaries and all Subcontractors list and describe any Protected Health Information (PHI) breaches (within the past five years) that have occurred and the response. Do not include items excluded per 45 CFR 164.402.

Table CC-3describes protected health information (PHI) breaches that have occurred for IlliniCare Health Plan, Inc. within the past 5 years.

Table CC-3: PHI Breaches for IlliniCare Health Plan, Inc. within Past 5 Years

Discovery Date	Description	Response	Plan(s) of Impacted Enrollee(s)
Date of Occurrence	Description of Incident	Response	Plan(s) of Impacted Enrollee(s)
02/21/2017	An updated in the member portal functionality inadvertently allowed 2 members to access each other's accounts.	This incident was reported to OCR in February 2018 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
04/10/2018	A member's identification (ID) card and welcome packet was inadvertently mailed to the incorrect address and was accessed by the resident.	This incident was reported to OCR in February 2019 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
04/10/2018	A member's ID card and welcome packet was inadvertently placed into another member's envelope and was accessed by the resident.	This incident was reported to OCR in February 2019 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
07/11/2018	A member condition education packet was mailed to the incorrect member.	This incident was reported to OCR in February 2019 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc
07/12/2018	A member's records were incorrectly faxed to an unauthorized recipient.	This incident was reported to OCR in February 2019 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
03/12/2019	A member's ID card and welcome packet was inadvertently mailed to the incorrect address and was accessed by the resident.	This incident will be reported to OCR in February 2020 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.

Discovery Date	Description	Response	Plan(s) of Impacted Enrollee(s)
03/29/2019	A member's ID card and welcome packet was inadvertently mailed to the incorrect address and was accessed by the resident.	This incident will be reported to OCR in February 2020 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
04/24/2019	A member's records were incorrectly faxed to an unauthorized recipient.	This incident will be reported to OCR in February 2020 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
07/02/2019	An email was incorrectly sent to a member that contained the information of other IlliniCare members.	This incident will be reported to OCR in February 2020 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
07/24/2019	A member's ID card and welcome packet was inadvertently mailed to the incorrect address and was accessed by the resident.	This incident will be reported to OCR in February 2020 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
07/26/2019	IlliniCare accidently uploaded documents containing PHI to a website that was not designated to store it.	This was reported to OCR in August 2019 as required by the HIPAA breach notification rules related to incidents that affect more than 500 individuals.	IlliniCare Health Plan, Inc.
07/30/2019	A member's ID card was inadvertently mailed to the incorrect address and was accessed by the resident.	This incident will be reported to OCR in February 2020 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
09/04/2019	A member's Notice of Denial letter was inadvertently mailed to the incorrect address and was accessed by the resident.	This incident will be reported to OCR in February 2020 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.
09/20/2019	A member's ID card and welcome packet was inadvertently mailed to the incorrect address and was accessed by the resident.	This incident will be reported to OCR in February 2020 as required by the HIPAA breach notification rules related to incidents that affect less than 500 individuals.	IlliniCare Health Plan, Inc.

60.7.B.2 Corporate Information

f. Has the Vendor ever had its accreditation status (e.g., National Committee on Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), or Accreditation Association for Ambulatory Health Care (AAAHC)) in any state for any product line adjusted down, suspended, or revoked (within the past five years)? If so, identify the state and product line and provide an explanation. Include information for the Vendor's Parent Company and subsidiaries.

Table CC-4 describes if IlliniCare Health Plan, Inc. ever had its National Committee for Quality Assurance (NCQA) accreditation status adjusted, suspended, or revoked within the past 5 years.

Table CC-4: IlliniCare Health Plan, Inc.'s NCQA Accreditation Adjustments within Past 5 Years

State	Health Plan	Current NCQA Status	Accreditation Expiration Date	NCQA Accreditation Adjustment	Explanation
Medicaid					
Illinois	IlliniCare Health Plan, Inc.	Accredited	7/06/20	None	N/A

60.7.B.2 Corporate Information

g. Provide a listing of Medicaid managed care contracts held in the past ten (10) years for which the Vendor has:
   i. Voluntarily terminated all or part of the contract under which it provided health care services as the licensed entity.
   ii. Had such a contract partially or fully terminated before the contract end date (with or without cause).
   iii. Had a contract not renewed.
   iv. Withdrawn from a contracted service area.
   v. Had a reduction of enrollment levels imposed?

Table CC-5 describes if IlliniCare Health Plan, Inc., within the past 10 years, voluntarily terminated a contract, had a contract terminated prior to the contract end date, had a contract not renewed, withdrew from a service area, or had a reduction of enrollment levels imposed.

Table CC-5: IlliniCare Health Plan, Inc.'s Contract Terminations, Non-renewals, Withdrawals, and Enrollment Level Reductions Imposed In the Past 10 Years

Health Plan Name	Date of Action	Reason
IlliniCare Health Plan, Inc.	N/A	N/A

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

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2010

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware **(State or other jurisdiction of incorporation or organization)**	**42-1406317** **(I.R.S. Employer Identification Number)**
7700 Forsyth Boulevard **St. Louis, Missouri** **(Address of principal executive offices)**	**63105** **(Zip Code)**

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value **Title of Each Class**	**New York Stock Exchange** **Name of Each Exchange on Which Registered**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require to submit and post such files). Yes T No £

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "small reporting company" in Rule 12b-2 of the Exchange Act. Large accelerated filer T Accelerated filer £ Non-accelerated filer £ (do not check if a smaller reporting company) Smaller reporting company £

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2010, was $1.0 billion.

As of February 4, 2011, the registrant had 52,197,869 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2011 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

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Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own both of our corporate office headquarters buildings located in St. Louis, Missouri. During 2008, 2009 and 2010, our capital expenditures included costs for the construction of a new real estate development on the property adjoining our corporate office, which we believe is necessary to accommodate our growing business.

We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings***

In May 2008, the Internal Revenue Services began an audit of the Company's 2006 and 2007 tax returns. In connection with the IRS examination, the field agent initially denied the $34.9 million tax benefit related to the abandonment of the FirstGuard stock in 2007 based on certain assumptions of fact by the IRS. The most significant change was to re-characterize the loss as a capital loss versus an ordinary loss.

In connection with an appeals conference in August 2010, the Company responded to the field agent's original write-up and provided additional documentation to the Appeals Officer to support the Company's view that sufficient technical tax authority existed at the time of the FirstGuard abandonment to support the Company's tax position. The Company is proceeding with the appeals process and believes that once the factual issues surrounding the abandonment are understood by the IRS, the position, more likely than not, will be upheld.

We routinely are subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, we do not expect the results of any of these matters individually, or in the aggregate, to have a material effect on our financial position or results of operations.

Item 4. ***[Removed and Reserved]***

PART II

Item 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Market for Common Stock; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2010 Stock Price		2009 Stock Price	
	High	Low	High	Low
First Quarter	$ 25.03	$ 17.60	$ 22.50	$ 15.00
Second Quarter	25.95	20.51	21.00	17.29
Third Quarter	23.65	20.00	20.48	16.89
Fourth Quarter	26.43	21.19	22.02	17.25

As of February 4, 2011, there were 59 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

On October 26, 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program, however, the terms of the Senior Notes require that all such redemptions are consummated on or before April 1, 2011. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2010, we did not repurchase any shares through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2010

Period	Total Number of Shares Purchased	Average Price Per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
October 1 – October 31, 2010	949	$ 23.19	—	1,667,724
November 1 – November 30, 2010	3,946	22.66	—	1,667,724
December 1 – December 31, 2010	99,470	24.11	—	1,667,724
TOTAL	104,365[1]	$ 24.04	—	1,667,724

[1] Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes upon vesting of restricted stock units.

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2011 Centene 10-K

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

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2011

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware **(State or other jurisdiction of incorporation or organization)**	**42-1406317** **(I.R.S. Employer Identification Number)**
7700 Forsyth Boulevard **St. Louis, Missouri** **(Address of principal executive offices)**	**63105** **(Zip Code)**

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value **Title of Each Class**	**New York Stock Exchange** **Name of Each Exchange on Which Registered**

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require to submit and post such files). Yes T No £

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "small reporting company" in Rule 12b-2 of the Exchange Act. Large accelerated filer T Accelerated filer £ Non-accelerated filer £ (do not check if a smaller reporting company) Smaller reporting company £

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2011, was $1.7 billion.

As of February 3, 2012, the registrant had 50,916,959 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2012 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

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Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings located in St. Louis, Missouri. During 2009 through 2011, our capital expenditures included costs for the construction of a new real estate development on our property, which has accommodated our growing business. During 2011, our capital expenditures also included costs for the construction of a new datacenter.

We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings***

The Internal Revenue Service (IRS) performed an examination of the Company's 2006 and 2007 tax returns and initially denied a tax benefit related to the abandonment of the FirstGuard stock in 2007. In 2011, the Company agreed to a settlement for the open tax years of 2006 and 2007. The settlement did not have a material impact on the consolidated financial statements.

The Company is routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position or results of operations.

PART II

Item 5. ***Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

Market for Common Stock; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2012 Stock Price (through February 15, 2012)		2011 Stock Price		2010 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$ 50.00	$ 38.97	$ 32.99	$ 25.08	$ 25.03	$ 17.60
Second Quarter			39.25	31.34	25.95	20.51
Third Quarter			39.35	25.64	23.65	20.00
Fourth Quarter			40.81	25.28	26.43	21.19

As of February 3, 2012, there were 54 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

On October 26, 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2011, we did not repurchase any shares through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2011

Period	Total Number of Shares	Average Price Per Share	Total Number of Shares	Maximum

2012 Centene 10-K

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2012

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**

7700 Forsyth Boulevard

St. Louis, Missouri	**63105**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	**Name of Each Exchange on Which Registered**

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

None

(Title of Each Class)

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require to submit and post such files). Yes ☒ No ☐

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

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

☒ Large accelerated filer ☐ Non-accelerated filer (do not check if a smaller reporting company)
☐ Accelerated filer ☐ Smaller reporting company

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 29, 2012, was $1.6 billion.

As of February 1, 2013, the registrant had 52,333,516 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2013 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
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An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

Goodwill and other intangible assets were $276.6 million as of December 31, 2012. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment.

If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The American Recovery and Reinvestment Act of 2009 further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, requiring new disclosures if a data breach occurs, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri. During 2010, our capital expenditures included costs for the construction of a new real estate development on our property, which has accommodated our growing business. During 2011, our capital expenditures also included costs for the construction of a new datacenter.

We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings.***

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. The Company has also filed a formal dispute with the Cabinet for damages incurred under the contract. That dispute is currently on appeal to the Finance and Administration Cabinet. In addition, the Company has filed a lawsuit in Franklin Circuit Court against the Commonwealth of Kentucky seeking declaratory relief as a result of the Commonwealth's failure to completely and accurately disclose material information. On January 23, 2013, the Franklin Circuit Court denied the Commonwealth's Motion to Dismiss and retained jurisdiction of the lawsuit, but stayed the proceedings pending a formal, written determination by the Finance and Administration Cabinet.

The Company is routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position or results of operations.

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2013

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification Number)**

7700 Forsyth Boulevard

St. Louis, Missouri	**63105**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	**Name of Each Exchange on Which Registered**

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

None

(Title of Each Class)

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require to submit and post such files). Yes ☒ No ☐

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

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

☒ Large accelerated filer ☐ Accelerated filer

☐ Non-accelerated filer (do not check if a smaller reporting company) ☐ Smaller reporting company

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 28, 2013, was $2.9 billion.

As of February 14, 2014, the registrant had 57,615,380 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2014 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
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reliable or available in a timely manner. As a result, implementation of ICD 10 may have a material adverse effect on our results of operations, financial position and cash flows.

A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber attacks, could have an adverse effect on our business.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. We experience attempted external hacking attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri. We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings.***

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. The Company also filed a lawsuit in Franklin Circuit Court against the Commonwealth seeking a declaration of the Company's right to terminate the contract on July 5, 2013. In April 2013, the Commonwealth answered that lawsuit and filed counterclaims against the Company seeking declaratory relief and damages. In May 2013, the Franklin Circuit Court ruled that Kentucky Spirit does not have a contractual right to terminate the contract early. Kentucky Spirit has appealed that ruling to the Kentucky Court of Appeals.

The Company also filed a formal dispute with the Cabinet for damages incurred under the contract, which was later appealed to and denied by the Finance and Administration Cabinet. In response, the Company filed a lawsuit in April 2013, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. This lawsuit was subsequently consolidated with the original lawsuit for declaratory relief and continues to proceed.

Kentucky Spirit's efforts to resolve issues with the Commonwealth were unsuccessful and on July 5, 2013, Kentucky Spirit proceeded with its previously announced exit. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25.0 million performance bond. Any claim for damages by the Commonwealth may include the costs of transition and the additional costs to the Commonwealth to cover Kentucky Spirit's former members through July 5, 2014. Kentucky Spirit is pursuing its litigation claims for damages against the Commonwealth and will vigorously defend against any allegations that it has breached the contract.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If the Company prevails on its claims, Kentucky Spirit would be entitled to damages under its lawsuit. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky

litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of December 31, 2013. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, cash flow or results of operations.

Item 4. ***Mine Safety Disclosures***

Not applicable.

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2014 Centene 10-K

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2014

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
7700 Forsyth Boulevard **St. Louis, Missouri**	**63105**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	Name of Each Exchange on Which Registered

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

None

(Title of Each Class)

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require to submit and post such files). Yes ☒ No ☐

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

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

☒ Large accelerated filer ☐ Accelerated filer

☐ Non-accelerated filer (do not check if a smaller reporting company) ☐ Smaller reporting company

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2014, was $4.4 billion.

As of February 20, 2015, the registrant had 118,820,237 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2015 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

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Item 3. ***Legal Proceedings.***

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. On July 3, 2014, the Commonwealth's attorneys asserted in a letter to the Cabinet for Health and Family Services that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." Kentucky Spirit intends to seek Kentucky Supreme Court review of the finding that its departure constituted a breach of contract. The Commonwealth may seek review of the ruling that the liquidated damages provision is applicable in the event of a premature termination.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. Discovery is proceeding on those claims.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of December 31, 2014. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

Item 4. ***Mine Safety Disclosures***

Not applicable.

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2015 Centene 10-K

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2015

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)

7700 Forsyth Boulevard

St. Louis, Missouri — **63105**

(Address of principal executive offices) — (Zip Code)

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	Name of Each Exchange on Which Registered

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

None

(Title of Each Class)

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require to submit and post such files). Yes ☒ No ☐

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

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

☒ Large accelerated filer ☐ Accelerated filer

☐ Non-accelerated filer (do not check if a smaller reporting company) ☐ Smaller reporting company

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2015, was $9.6 billion.

As of February 17, 2016, the registrant had 121,654,923 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2016 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

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Item 3. ***Legal Proceedings***

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract's liquidated damages provision "is applicable in the event of a premature termination of the Contract term." On September 8, 2015, Kentucky Spirit filed a motion for discretionary review seeking Kentucky Supreme Court review of the finding that Kentucky Spirit's departure constituted a breach of contract. On October 9, 2015, the Commonwealth filed a response opposing discretionary review.

On May 26, 2015, the Commonwealth issued a demand for indemnification to its actuarial firm for "all defense costs, and any resultant monetary awards in favor of Kentucky Spirit, arising from or related to Kentucky Spirit's claims which are predicated upon the alleged omissions and errors in the Data Book and the certified actuarially sound rates." On August 19, 2015, the actuarial firm moved to intervene in the litigation. The Franklin Circuit Court granted the actuarial firm's motion on September 8, 2015 and ordered a forty-five day stay of all pretrial proceedings in order for the firm to review the record. Also, on August 19, 2015, the actuarial firm filed a petition seeking a declaratory judgment that it is not liable to the Commonwealth for indemnification related to the claims asserted by Kentucky Spirit against the Commonwealth. On October 5, 2015, the Commonwealth filed an answer to the actuarial firm's petition and asserted counterclaims/cross-claims against the firm.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet (FAC), Kentucky Spirit contested CHFS' jurisdiction to make such a determination. The FAC did not issue a decision within the required 120 days. On August 13, 2015, Kentucky Spirit filed a declaratory judgment action against the Commonwealth in Franklin Circuit Court seeking a declaration that the Commonwealth may not purport to issue a decision against Kentucky Spirit awarding damages to itself when the matter is already before the Kentucky courts, and that the Commonwealth has waived its claims against Kentucky Spirit for damages arising out of the contract. The Commonwealth filed counterclaims seeking a Declaration of Rights and Entry of Judgment on its determination letter. On December 1, 2015, the Franklin Circuit Court consolidated this declaratory judgment action with Kentucky Spirit's other litigation claims against the Commonwealth. On December 15, 2015, the Franklin Circuit Court denied Kentucky Spirit's motion to dismiss the Commonwealth's counterclaim for Declaration of Rights and Entry of Judgment. Discovery is proceeding in the consolidated litigation matters.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of December 31, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

Item 4. ***Mine Safety Disclosures***

Not applicable.

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2016 Centene 10-K

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2016

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
7700 Forsyth Boulevard **St. Louis, Missouri**	**63105**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	Name of Each Exchange on Which Registered

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

None

(Title of Each Class)

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require to submit and post such files). Yes ☒ No ☐

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

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

☒ Large accelerated filer ☐ Accelerated filer

☐ Non-accelerated filer (do not check if a smaller reporting company) ☐ Smaller reporting company

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2016, was $12.2 billion.

As of February 17, 2017, the registrant had 172,028,161 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2017 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
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Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri, which is used by each of our reportable segments. We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities and expansion plans are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings***

A description of the legal proceedings to which the Company and its subsidiaries are a party is contained in Note 18 to the consolidated financial statements included in Part II of this Annual Report on Form 10-K, and is incorporated herein by reference.

Item 4. ***Mine Safety Disclosures***

Not applicable.

17. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Tenant improvement allowances are recorded as a liability and amortized against rent expense over the term of the lease. Rent expense was $137 million, $64 million and $46 million for the years ended December 31, 2016, 2015 and 2014, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows ($ in millions):

2017	$	128
2018		117
2019		105
2020		92
2021		75
Thereafter		114
	$	631

In connection with obtaining regulatory approval of the Health Net acquisition from the California Department of Insurance and the California Department of Managed Health Care, the Company committed to certain undertakings. See Note 3, *Health Net* for further details.

18. Contingencies

Overview

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period the Company’s financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including as described below. Except for the proceedings discussed below, the Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations, cash flow or liquidity.

Kentucky

On July 5, 2013, the Company's subsidiary, Kentucky Spirit, terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believed it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. In response, the Commonwealth alleged that Kentucky Spirit's exit constituted a material breach of contract. The Commonwealth sought to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputed the Commonwealth's alleged damages on several grounds. Prior to terminating the contract, Kentucky Spirit filed a legal complaint in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches.

On May 26, 2015, the Commonwealth issued a demand for indemnification to its actuarial firm, for "all defense costs, and any resultant monetary awards in favor of Kentucky Spirit, arising from or related to Kentucky Spirit's claims which are predicated upon the alleged omissions and errors in the Data Book and the certified actuarially sound rates." The actuarial firm moved to intervene in the litigation and the Franklin Circuit Court granted that motion on September 8, 2015. Also, on August 19, 2015, the actuarial firm filed a petition seeking a declaratory judgment that it is not liable to the Commonwealth for indemnification related to the claims asserted by Kentucky Spirit against the Commonwealth. On October 5, 2015, the Commonwealth filed an answer to the actuarial firm's petition and asserted counterclaims/cross-claims against the firm.

On November 3, 2016, all parties entered into a settlement agreement with respect to all lawsuits and complaints associated with the aforementioned contract termination. Under the terms of the settlement agreement, Kentucky Spirit received an immaterial cash payment from the Commonwealth's actuarial firm and each party dismissed all claims related to the litigation with prejudice. In addition, the Commonwealth and Kentucky Spirit have agreed that neither party acted in bad faith; that the parties took reasonable positions in light of the applicable contractual language; and that the parties acted in good faith in attempting to address a difficult situation.

California

The Company's California subsidiary, Health Net of California, Inc. (Health Net California), has been named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned as Michael D. Myers v. State Board of Equalization, et al., Los Angeles Superior Court Case No. BS158655. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that Health Net California, a California licensed Health Care Service Plan (HCSP), is an “insurer” for purposes of taxation despite acknowledging it is not an “insurer” under regulatory law. Under California law, “insurers” must pay a gross premiums tax (GPT), calculated as 2.35% on gross premiums. As a licensed HCSP, Health Net California has paid the California Corporate Franchise Tax (CFT), the tax generally paid by California businesses. Plaintiff contends that Health Net California must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the California taxing agencies to collect the GPT, and seeks an order requiring Health Net California to pay GPT, interest and penalties for a period dating to eight years prior to the October 20, 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities. The Company expects an initial status conference shortly. The Company intends to vigorously defend itself against these claims; however, this matter is subject to many uncertainties, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Federal Securities Class Action

On November 14, 2016, a putative federal securities class action was filed against the Company and certain of its executives in the U.S. District Court for the Central District of California. The plaintiffs in the lawsuit allege that the Company's accounting and related disclosures for certain liabilities acquired in the acquisition of Health Net violated federal securities laws. The Company denies any wrongdoing and is vigorously defending itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Civil Investigative Demand

On December 15, 2016, a Civil Investigative Demand (CID) was issued to Health Net by the United States Department of Justice regarding Health Net’s submission of risk adjustment claims to the CMS under Parts C and D of Medicare. The CID may be related to a federal qui tam lawsuit filed under seal in 2011 naming more than a dozen health insurers including Health Net. The lawsuit was recently unsealed when the Department of Justice intervened in the case with respect to one of the insurers (not Health Net). The Company is complying with the CID and will vigorously defend any lawsuits. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Miscellaneous Proceedings

Excluding the matters discussed above, the Company is also routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of out-of-network claims, submissions to CMS for risk adjustment payments or the False Claims Act, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

- litigation arising out of general business activities, such as tax matters, disputes related to health care benefits coverage or reimbursement, putative securities class actions and medical malpractice, privacy, real estate, intellectual property and employment-related claims;

- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims, and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in awards of damages, fines or penalties, which could be substantial, and/or could require changes to the Company's business. The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being sought.

19. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the years ended December 31 ($ in millions, except per share data):

	2016	2015	2014
Earnings (loss) attributable to Centene Corporation:			
Earnings from continuing operations, net of tax	$ 559	$ 356	$ 268
Discontinued operations, net of tax	3	(1)	3
Net earnings	$ 562	$ 355	$ 271
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	159,567,607	119,100,744	116,345,764
Common stock equivalents (as determined by applying the treasury stock method)	4,407,800	3,965,626	4,014,448
Weighted average number of common shares and potential dilutive common shares outstanding	163,975,407	123,066,370	120,360,212
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 3.50	$ 2.99	$ 2.30
Discontinued operations	0.02	(0.01)	0.03
Basic earnings per common share	$ 3.52	$ 2.98	$ 2.33
Diluted:			
Continuing operations	$ 3.41	$ 2.89	$ 2.23
Discontinued operations	0.02	(0.01)	0.02
Diluted earnings per common share	$ 3.43	$ 2.88	$ 2.25

2017 Centene 10-K

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2017

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)

7700 Forsyth Boulevard

St. Louis, Missouri	**63105**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	Name of Each Exchange on Which Registered

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

None

(Title of Each Class)

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was require to submit and post such files). Yes ☒ No ☐

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

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

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐ (do not check if a smaller reporting company)	Smaller reporting company ☐
	Emerging growth company ☐

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

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2017, was $13.8 billion.

As of February 16, 2018, the registrant had 173,495,595 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2018 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
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- creating liens on assets;
- entering into sale and leaseback transactions;
- making investments, loans or advances;
- entering into hedging transactions;
- engaging in mergers, consolidations or sales of all or substantially all of their respective assets; and
- engaging in certain transactions with affiliates.

In addition, the combined company will be required to maintain a minimum amount of excess availability as set forth in these agreements.

The combined company's ability to maintain minimum excess availability in future periods will depend on its ongoing financial and operating performance, which in turn will be subject to economic conditions and to financial, market and competitive factors, many of which are beyond the combined company's control. The ability to comply with this covenant in future periods will also depend on the combined company's ability to successfully implement its overall business strategy and realize contemplated synergies.

Various risks, uncertainties and events beyond the combined company's control could affect its ability to comply with the covenants contained in its debt agreements. Failure to comply with any of the covenants in its existing or future financing agreements could result in a default under those agreements and under other agreements containing cross-default provisions. A default would permit lenders to accelerate the maturity of indebtedness under these agreements and to foreclose upon any collateral securing such indebtedness. Under these circumstances, the combined company might not have sufficient funds or other resources to satisfy all of its obligations. In addition, the limitations imposed by financing agreements on the combined company's ability to incur additional indebtedness and to take other actions might significantly impair its ability to obtain other financing.

We have obtained commitment letters for the senior unsecured budge loan facility. However, neither the definitive loan documents, nor the terms of any debt financing in lieu of such bridge financing, have been finalized.

Future issuances and sales of additional shares of preferred or common stock, including shares issued in connection with the Proposed Fidelis Acquisition, could reduce the market price of our shares of common stock.

Subject to market conditions, we intend to fund the purchase price for the Proposed Fidelis Acquisition with $2.3 billion of new equity, including shares paid as consideration. Any such issuances and sales of our preferred or common stock could have the effect of depressing the market price for our common stock. Further, any sale of shares to finance a portion of the purchase price for the Proposed Fidelis Acquisition will be subject to market conditions and could be negatively impacted by a decline in the market price for our common stock. In addition, in the future we may issue additional securities to raise capital or in connection with acquisitions. We often acquire interests in other companies by using a combination of cash and our common stock or just our common stock. Further, shares of preferred stock may be issued from time to time in one or more series as our Board may from time to time determine each such series to be distinctively designated. The issuance of any such preferred stock could materially adversely affect the rights of holders of our common stock. Any of these events may dilute your ownership interest in our company and have an adverse impact on the price of our common stock.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri, which is used by each of our reportable segments. We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities and expansion plans are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings***

A description of the legal proceedings to which we and our subsidiaries are a party is contained in Note 18 to the consolidated financial statements included in Part II of this Annual Report on Form 10-K, and is incorporated herein by reference.

18. Contingencies

Overview

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period the Company's financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including as described below. Except for the proceedings discussed below, the Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations, cash flow or liquidity.

California

The Company's California subsidiary, Health Net of California, Inc. (Health Net California), has been named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned as Michael D. Myers v. State Board of Equalization, et al., Los Angeles Superior Court Case No. BS158655. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that Health Net California, a California licensed Health Care Service Plan (HCSP), is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. Under California law, "insurers" must pay a gross premiums tax (GPT), calculated as 2.35% on gross premiums. As a licensed HCSP, Health Net California has paid the California Corporate Franchise Tax (CFT), the tax generally paid by California businesses. Plaintiff contends that Health Net California must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the California taxing agencies to collect the GPT, and seeks an order requiring Health Net California to pay GPT, interest and penalties for a period dating to eight years prior to the October 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities. In September 2017, the Company filed a demurrer seeking to dismiss the complaint, and a motion to strike the allegations seeking retroactive relief. In January 2018, the Court held a hearing on the Company's demurrer. No decision has been issued yet. The Company intends to vigorously defend itself against these claims; however, this matter is subject to many uncertainties, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position, results of operations and cash flows.

Federal Securities Class Action

In November 2016, a putative federal securities class action was filed against the Company and certain of its executives in the U.S. District Court for the Central District of California. In March 2017, the court entered an order transferring the matter to the U.S. District Court for the Eastern District of Missouri. The plaintiffs in the lawsuit allege that the Company's accounting and related disclosures for certain liabilities acquired in the acquisition of Health Net violated federal securities laws. In July 2017, the lead plaintiff filed a Consolidated Class Action Complaint. The Company filed a motion to dismiss this complaint in September 2017. The Company denies any wrongdoing and is vigorously defending itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Additionally, in January 2018, a separate derivative action was filed on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. Plaintiff purports to bring suit derivatively on behalf of the Company against certain officers and directors for violation of securities laws, breach of fiduciary duty, waste of corporate assets and unjust enrichment. The derivative complaint repeats many of the allegations in the federal securities class action described above and asserts that defendants made inaccurate or misleading statements, and/or failed to correct the alleged misstatements.

Medicare Parts C and D Matter

In December 2016, a Civil Investigative Demand (CID) was issued to Health Net by the United States Department of Justice regarding Health Net's submission of risk adjustment claims to CMS under Parts C and D of Medicare. The CID may be related to a federal qui tam lawsuit filed under seal in 2011 naming more than a dozen health insurers including Health Net. The lawsuit was unsealed in February 2017 when the Department of Justice intervened in the case with respect to one of the insurers (not Health Net). In subsequent pleadings, both the Department of Justice and the Relator excluded Health Net from the lawsuit. The Company is complying with the CID and will vigorously defend any lawsuits. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Veterans Administration Matter

In October 2017, a CID was issued to Health Net Federal Services, LLC (HNFS) by the United States Department of Justice. The CID seeks documents and interrogatory responses concerning whether HNFS submitted, or caused to be submitted, excessive, duplicative or otherwise improper claims to the U.S. Department of Veterans Affairs under a contract to arrange healthcare services for veterans. The contract began in late 2014. In 2016, modifications to the contract were made to allow for possible duplicate billings with a reconciliation period at the end of the contract term. The Company is complying with the CID and believes it has been meeting its contractual obligations. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Guaranty Fund Assessment

Under state guaranty association laws, certain insurance companies can be assessed for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), neither of which is affiliated with the Company, in rehabilitation and petitioned a state court for approval to liquidate Penn Treaty. In March 2017, the court issued the final liquidation order, and as a result, during the twelve months ended December 31, 2017, the Company recognized $56 million representing its undiscounted estimated share of the guaranty association assessment as selling, general and administrative expenses.

Ambetter Class Action

In January 2018, a putative class action lawsuit was filed against the Company and certain subsidiaries in the U.S. District Court for the Eastern District of Washington. The complaint alleges that the Company failed to meet federal and state requirements for provider networks and directories with regard to its Ambetter policies, denied coverage and/or refused to pay for covered benefits, and failed to address grievances adequately, causing some members to incur unexpected costs. The Company intends to vigorously defend itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Miscellaneous Proceedings

Excluding the matters discussed above, the Company is also routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of out-of-network claims, submissions to CMS for risk adjustment payments or the False Claims Act, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

- litigation arising out of general business activities, such as tax matters, disputes related to healthcare benefits coverage or reimbursement, putative securities class actions and medical malpractice, privacy, real estate, intellectual property and employment-related claims;

- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims, and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in awards of damages, fines or penalties, which could be substantial, and/or could require changes to the Company's business. The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being sought.

19. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings (loss) per common share for the years ended December 31 ($ in millions, except shares in thousands and per share data in dollars):

	2017	2016	2015
Earnings (loss) attributable to Centene Corporation:			
Earnings from continuing operations, net of tax	$ 828	$ 559	$ 356
Discontinued operations, net of tax	—	3	(1)
Net earnings	$ 828	$ 562	$ 355
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	172,427	159,568	119,101
Common stock equivalents (as determined by applying the treasury stock method)	4,275	4,407	3,965
Weighted average number of common shares and potential dilutive common shares outstanding	176,702	163,975	123,066
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 4.80	$ 3.50	$ 2.99
Discontinued operations	—	0.02	(0.01)
Basic earnings per common share	$ 4.80	$ 3.52	$ 2.98
Diluted:			
Continuing operations	$ 4.69	$ 3.41	$ 2.89
Discontinued operations	—	0.02	(0.01)
Diluted earnings per common share	$ 4.69	$ 3.43	$ 2.88

The calculation of diluted earnings (loss) per common share for 2017, 2016 and 2015 excludes the impact of 53 thousand shares, 126 thousand shares and 7 thousand shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

20. Segment Information

Centene operates in two segments: Managed Care and Specialty Services.

The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products. Factors used in determining the reportable business segments include the nature of operating activities, the existence of separate senior management teams, and the type of information presented to the Company's chief operating decision-maker to evaluate all results of operations.

2018 Centene 10-K

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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2018

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)

7700 Forsyth Boulevard

St. Louis, Missouri	**63105**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	Name of Each Exchange on Which Registered

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

None

(Title of Each Class)

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

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

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).

Yes ☒ No ☐

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

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

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

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

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2018, was $25.3 billion.

As of February 15, 2019, the registrant had 413,170,382 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2019 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
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Item 3. ***Legal Proceedings***

A description of the legal proceedings to which we and our subsidiaries are a party is contained in Note 17. *Contingencies* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K, and is incorporated herein by reference.

Item 4. ***Mine Safety Disclosures***

Not applicable.

16. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Tenant improvement allowances are recorded as a liability and amortized against rent expense over the term of the lease. Rent expense was $207 million, $171 million and $137 million for the years ended December 31, 2018, 2017 and 2016, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows ($ in millions):

2019	$	174
2020		176
2021		145
2022		101
2023		71
Thereafter		200
	$	867

In connection with obtaining regulatory approval of the Fidelis Care acquisition, the Company entered into certain undertakings with the New York State Department of Health in 2018. See Note 3. *Fidelis Care Acquisition* for further details. The Company also committed to certain undertakings with the California Department of Insurance and the California Department of Managed Health Care in connection with obtaining regulatory approval of the Health Net acquisition in 2016 The Health Net commitments related to the undertakings are as follows:

- invest an additional $30 million through the California Organized Investment Network over the five years following completion of the acquisition;
- build a service center in an economically distressed community in California, investing $200 million over 10 years and employing at least 300 people, of which the Company has incurred $8 million through 2018;
- contribute $65 million to improve enrollee health outcomes ($10 million over five years), support locally-based consumer assistance programs ($5 million over five years) and strengthen the healthcare delivery system ($50 million over five years), of which the Company has contributed $13 million through 2018, and;
- invest $75 million of its investment portfolio in vehicles supporting California's healthcare infrastructure, of which the Company has invested $12 million through 2018.

17. Contingencies

Overview

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period the Company's financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including as described below. Except for the proceedings discussed below, the Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations, cash flow or liquidity.

California

On October 20, 2015, the Company's California subsidiary, Health Net of California, Inc. (Health Net California), was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned as Michael D. Myers v. State Board of Equalization, Dave Jones, Insurance Commissioner of the State of California, Betty T. Yee, Controller of the State of California, et al., Los Angeles Superior Court Case No. BS158655. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that Health Net California, a California licensed Health Care Service Plan (HCSP), is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. Under California law, "insurers" must pay a gross premiums tax (GPT), calculated as 2.35% on gross premiums. As a licensed HCSP, Health Net California has paid the California Corporate Franchise Tax (CFT), the tax generally paid by California businesses. Plaintiff contends that Health Net California must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the California taxing agencies to collect the GPT, and seeks an order requiring Health Net California to pay GPT, interest and penalties for a period dating to eight years prior to the October 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities (collectively, "Related Actions"). In September 2017, the Company filed a demurrer seeking to dismiss the complaint, and a motion to strike the allegations seeking retroactive relief. In March 2018, the Court overruled the Company's demurrer and denied the motion to strike. In August 2018, the trial court stayed all the Related Actions pending determination of a writ of mandate by the California Court of Appeals in two of the Related Actions. The Company intends to vigorously defend itself against these claims; however, this matter is subject to many uncertainties, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position, results of operations and cash flows.

Federal Securities Class Action

On November 14, 2016, a putative federal securities class action, Israel Sanchez v. Centene Corp., et al., was filed against the Company and certain of its executives in the U.S. District Court for the Central District of California. In March 2017, the court entered an order transferring the matter to the U.S. District Court for the Eastern District of Missouri. The plaintiffs in the lawsuit allege that the Company's accounting and related disclosures for certain liabilities acquired in the acquisition of Health Net violated federal securities laws. In July 2017, the lead plaintiff filed a Consolidated Class Action Complaint. The Company filed a motion to dismiss this complaint in September 2017. In February 2018, the Court held a hearing on the motion to dismiss but has not yet issued a ruling.

The Company denies any wrongdoing and is vigorously defending itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Additionally, on January 24, 2018, a separate derivative action was filed by plaintiff Harkesh Parekh on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. Plaintiff purports to bring suit derivatively on behalf of the Company against certain officers and directors for violation of securities laws, breach of fiduciary duty, waste of corporate assets and unjust enrichment. The derivative complaint repeats many of the allegations in the federal securities class action described above and asserts that defendants made inaccurate or misleading statements, and/or failed to correct the alleged misstatements.

A second shareholder derivative action was filed on March 9, 2018, by plaintiffs Laura Wood and Peoria Police Pension Fund on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. This second derivative complaint repeats many of the allegations in the securities class action and the first derivative suit.

A third shareholder derivative action was filed on December 14, 2018, by plaintiffs Carpenter Pension Fund of Illinois and Iron Workers Local 11 Pension Fund on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. This third derivative action repeats many of the allegations in the securities class action and the other derivative suits and adds additional allegations asserting violations of securities laws, breach of fiduciary duty, insider trading and unjust enrichment. On January 9, 2019, the Court consolidated the three derivative suits and established a schedule for determining lead plaintiff and lead counsel.

Medicare Parts C and D Matter

In December 2016, a Civil Investigative Demand (CID) was issued to Health Net by the United States Department of Justice regarding Health Net's submission of risk adjustment claims to CMS under Parts C and D of Medicare. The CID may be related to a federal qui tam lawsuit filed under seal in 2011 naming more than a dozen health insurers including Health Net. The lawsuit was unsealed in February 2017 when the Department of Justice intervened in the case with respect to one of the insurers (not Health Net). In subsequent pleadings, both the Department of Justice and the Relator excluded Health Net from the lawsuit. The Company is complying with the CID and will vigorously defend any lawsuits. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Veterans Administration Matter

In October 2017, a CID was issued to Health Net Federal Services, LLC (HNFS) by the United States Department of Justice. The CID seeks documents and interrogatory responses concerning whether HNFS submitted, or caused to be submitted, excessive, duplicative or otherwise improper claims to the U.S. Department of Veterans Affairs (VA) under a contract to provide health care coordination services for veterans. The contract began in late 2014 and ended September 30, 2018. In 2016, modifications to the contract were made to allow for possible duplicate billings with a reconciliation period at the end of the contract term. The Company is complying with the CID and believes it has been meeting its contractual obligations. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter. This matter is separate from the negotiated settlements with the VA in connection with the contract expiration on September 30, 2018.

Ambetter Class Action

On January 11, 2018, a putative class action lawsuit was filed by Cynthia Harvey and Steven A. Milman against the Company and certain subsidiaries in the U.S. District Court for the Eastern District of Washington. The complaint alleges that the Company failed to meet federal and state requirements for provider networks and directories with regard to its Ambetter policies, denied coverage and/or refused to pay for covered benefits, and failed to address grievances adequately, causing some members to incur unexpected costs. In March 2018, the Company filed separate motions to dismiss each defendant. In July 2018, the plaintiff voluntarily filed a First Amended Complaint that removed Steven Milman as a plaintiff, dropped Centene Corporation and Superior Health Plan as defendants, abandoned certain claims, narrowed the putative class to Washington State only, and added Centene Management Company as a defendant. In August 2018, the Company moved to dismiss the First Amended Complaint. In response, the plaintiff voluntarily filed a Second Amended Complaint. In September 2018, the Company filed a motion to dismiss the Second Amended Complaint. On November 21, 2018, the Court granted in part and denied in part the Company's motion to dismiss. Plaintiff Cynthia Harvey filed a Third Amended Complaint, on November 28, 2018, against Centene Management Company and Coordinated Care Corporation ("Defendants"), both subsidiaries of the Company. Defendants filed an answer on December 12, 2018 and the matter is expected to proceed. The Company intends to vigorously defend itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Miscellaneous Proceedings

Excluding the matters discussed above, the Company is also routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of out-of-network claims, submissions to CMS for risk adjustment payments or the False Claims Act, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

- litigation arising out of general business activities, such as tax matters, disputes related to healthcare benefits coverage or reimbursement, putative securities class actions and medical malpractice, privacy, real estate, intellectual property and employment-related claims;

- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in awards of damages, fines or penalties, which could be substantial, and/or could require changes to the Company's business. The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being sought.

18. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the years ended December 31 ($ in millions, except shares in thousands and per share data in dollars):

	2018	2017	2016
Earnings attributable to Centene Corporation	$ 900	$ 828	$ 562
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	390,248	344,853	319,135
Common stock equivalents (as determined by applying the treasury stock method)	8,258	8,551	8,816
Weighted average number of common shares and potential dilutive common shares outstanding	398,506	353,404	327,951
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	$ 2.31	$ 2.40	$ 1.76
Diluted earnings per common share	$ 2.26	$ 2.34	$ 1.71

The calculation of diluted earnings per common share for 2018, 2017 and 2016 excludes the impact of 58 thousand shares, 106 thousand shares and 252 thousand shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

19. Segment Information

Centene operates in two segments: Managed Care and Specialty Services.

The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products. Factors used in determining the reportable business segments include the nature of operating activities, the existence of separate senior management teams, and the type of information presented to the Company's chief operating decision-maker to evaluate all results of operations.

In January 2017, the Company reclassified Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan from the Specialty Services segment to the Managed Care segment due to a reorganization of the Arizona management structure following the Health Net integration. As a result, the financial results of Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented.

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2019 Centene 10-Q Ending March 31

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended March 31, 2019

OR

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

For the transition period from to

Commission file number: 001-31826

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
7700 Forsyth Boulevard **St. Louis, Missouri**	**63105**
(Address of principal executive offices)	*(Zip Code)*

Registrant's telephone number, including area code: **(314) 725-4477**

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

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

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

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

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

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

As of April 12, 2019, the registrant had 413,320,160 shares of common stock outstanding.

CENTENE CORPORATION
QUARTERLY REPORT ON FORM 10-Q
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Segment information for the three months ended March 31, 2018, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 12,449	$ 745	$ —	$ 13,194
Total revenues from internal customers	25	2,231	(2,256)	—
Total revenues	$ 12,474	$ 2,976	$ (2,256)	$ 13,194
Earnings from operations	$ 470	$ 70	$ —	$ 540

11. Contingencies

Overview

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

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California

On October 20, 2015, the Company's California subsidiary, Health Net of California, Inc. (Health Net California), was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned as Michael D. Myers v. State Board of Equalization, Dave Jones, Insurance Commissioner of the State of California, Betty T. Yee, Controller of the State of California, et al., Los Angeles Superior Court Case No. BS158655. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that Health Net California, a California licensed Health Care Service Plan (HCSP), is an “insurer” for purposes of taxation despite acknowledging it is not an “insurer” under regulatory law. Under California law, “insurers” must pay a gross premiums tax (GPT), calculated as 2.35% on gross premiums. As a licensed HCSP, Health Net California has paid the California Corporate Franchise Tax (CFT), the tax generally paid by California businesses. Plaintiff contends that Health Net California must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the California taxing agencies to collect the GPT, and seeks an order requiring Health Net California to pay GPT, interest and penalties for a period dating to eight years prior to the October 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities (collectively, "Related Actions"). In March 2018, the Court overruled the Company's demurrer seeking to dismiss the complaint and denied the Company's motion to strike allegations seeking retroactive relief. In August 2018, the trial court stayed all the Related Actions pending determination of a writ of mandate by the California Court of Appeals in two of the Related Actions. In March 2019, the California Court of Appeals denied the writ of mandate and the defendants in those Related Actions have sought review by the California Supreme Court. It is not yet known whether the trial court will stay the Related Actions pending a decision from the California Supreme Court. The Company intends to vigorously defend itself against these claims; however, this matter is subject to many uncertainties, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position, results of operations and cash flows.

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Federal Securities Class Action

On November 14, 2016, a putative federal securities class action, Israel Sanchez v. Centene Corp., et al., was filed against the Company and certain of its executives in the U.S. District Court for the Central District of California. In March 2017, the court entered an order transferring the matter to the U.S. District Court for the Eastern District of Missouri. The plaintiffs in the lawsuit allege that the Company's accounting and related disclosures for certain liabilities acquired in the acquisition of Health Net violated federal securities laws. In July 2017, the lead plaintiff filed a Consolidated Class Action Complaint. The Company filed a motion to dismiss this complaint in September 2017. In February 2018, the Court held a hearing on the motion to dismiss but has not yet issued a ruling.

The Company denies any wrongdoing and is vigorously defending itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

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Medicare Parts C and D Matter

In December 2016, a Civil Investigative Demand (CID) was issued to Health Net by the United States Department of Justice regarding Health Net's submission of risk adjustment claims to CMS under Parts C and D of Medicare. The CID may be related to a federal qui tam lawsuit filed under seal in 2011 naming more than a dozen health insurers including Health Net. The lawsuit was unsealed in February 2017 when the Department of Justice intervened in the case with respect to one of the insurers (not Health Net). In subsequent pleadings, both the Department of Justice and the Relator excluded Health Net from the lawsuit. The Company is complying with the CID and will vigorously defend any lawsuits. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

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Ambetter Class Action

On January 11, 2018, a putative class action lawsuit was filed by Cynthia Harvey and Steven A. Milman against the Company and certain subsidiaries in the U.S. District Court for the Eastern District of Washington. The complaint alleges that the Company failed to meet federal and state requirements for provider networks and directories with regard to its Ambetter policies, denied coverage and/or refused to pay for covered benefits, and failed to address grievances adequately, causing some members to incur unexpected costs. In March 2018, the Company filed separate motions to dismiss each defendant. In July 2018, the plaintiff voluntarily filed a First Amended Complaint that removed Steven Milman as a plaintiff, dropped Centene Corporation and Superior Health Plan as defendants, abandoned certain claims, narrowed the putative class to Washington State only, and added Centene Management Company as a defendant. In August 2018, the Company moved to dismiss the First Amended Complaint. In response, the plaintiff voluntarily filed a Second Amended Complaint. In September 2018, the Company filed a motion to dismiss the Second Amended Complaint. On November 21, 2018, the Court granted in part and denied in part the Company's motion to dismiss. Plaintiff Cynthia Harvey filed a Third Amended Complaint, on November 28, 2018, against Centene Management Company and Coordinated Care Corporation ("Defendants"), both subsidiaries of the Company. Defendants filed an answer on December 12, 2018. Class certification discovery is occurring. The Company intends to vigorously defend itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Miscellaneous Proceedings

Excluding the matters discussed above, the Company is also routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of out-of-network claims, submissions to CMS for risk adjustment payments or the False Claims Act, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

- litigation arising out of general business activities, such as tax matters, disputes related to healthcare benefits coverage or reimbursement, putative securities class actions and medical malpractice, privacy, real estate, intellectual property and employment-related claims;

- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in awards of damages, fines or penalties, which could be substantial, and/or could require changes to the Company’s business. The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being sought.

PART II
OTHER INFORMATION

ITEM 1. ***Legal Proceedings.***

A description of the legal proceedings to which the Company and its subsidiaries are a party is contained in Note 11 to the consolidated financial statements included in Part I of this Quarterly Report on Form 10-Q, and is incorporated herein by reference.

ITEM 1A. ***Risk Factors.***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company. Unless the context otherwise requires, the terms the "Company," "we," "us," "our" or similar terms and "Centene" (i) prior to the closing of the WellCare Transaction, refer to Centene Corporation, together with its consolidated subsidiaries, without giving effect to the WellCare Transaction, and (ii) upon and after the closing of the WellCare Transaction, refer to us, after giving effect to the WellCare Transaction.

Reductions in funding, changes to eligibility requirements for government sponsored healthcare programs in which we participate and any inability on our part to effectively adapt to changes to these programs could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, CHIP, LTSS, ABD, Foster Care and Health Insurance Marketplace premiums. Under most programs, the base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs for this program, with the federal share currently averaging around 59%. We are therefore exposed to risks associated with federal and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state governments to terminate contracts with them, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; and our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity. For example, future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD and Foster Care. Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 ("sequestration"), subject to a 2% cap, which was extended by the Bipartisan Budget Act of 2018 for an additional two years through 2027. In addition, reductions in defense spending could have an adverse impact on certain government programs in which we currently participate by, among other things, terminating or materially changing such programs, or by decreasing or delaying payments made under such programs. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs remains steady or increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of one or more contracts for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows. In addition, if another federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD, Foster Care and the Health Insurance Marketplaces, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

2019 Centene 10-Q Ending June 30

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the quarterly period ended June 30, 2019

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission file number: 001-31826

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
7700 Forsyth Boulevard **St. Louis, Missouri**	**63105**
(Address of principal executive offices)	*(Zip Code)*

Registrant's telephone number, including area code: (314) 725-4477

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

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on Which Registered
Common Stock $0.001 Par Value	**CNC**	**New York Stock Exchange**

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

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

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

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

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

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

As of July 12, 2019, the registrant had 413,605,377 shares of common stock outstanding.

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11. Contingencies

Overview

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period the Company's financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including as described below. Except for the proceedings discussed below, the Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations, cash flow or liquidity.

California

On October 20, 2015, the Company's California subsidiary, Health Net of California, Inc. (Health Net California), was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned as Michael D. Myers v. State Board of Equalization, Dave Jones, Insurance Commissioner of the State of California, Betty T. Yee, Controller of the State of California, et al., Los Angeles Superior Court Case No. BS158655. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that Health Net California, a California licensed Health Care Service Plan (HCSP), is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. Under California law, "insurers" must pay a gross premiums tax (GPT), calculated as 2.35% on gross premiums. As a licensed HCSP, Health Net California has paid the California Corporate Franchise Tax (CFT), the tax generally paid by California businesses. Plaintiff contends that Health Net California must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the California taxing agencies to collect the GPT, and seeks an order requiring Health Net California to pay GPT, interest and penalties for a period dating to eight years prior to the October 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities (collectively, "Related Actions"). In March 2018, the Court overruled the Company's demurrer seeking to dismiss the complaint and denied the Company's motion to strike allegations seeking retroactive relief. In August 2018, the trial court stayed all the Related Actions pending determination of a writ of mandate by the California Court of Appeals in two of the Related Actions. In March 2019, the California Court of Appeals denied the writ of mandate. The defendants in those Related Actions sought review by the California Supreme Court, which declined to review the matter. The case is back before the trial court which has scheduled a hearing in January 2020 to consider a motion for summary judgment by Health Net California. In the meantime, discovery will proceed. No trial date has been set. The Company intends to vigorously defend itself against these claims; however, this matter is subject to many uncertainties, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position, results of operations and cash flows.

Federal Securities Class Action

On November 14, 2016, a putative federal securities class action, Israel Sanchez v. Centene Corp., et al., was filed against the Company and certain of its executives in the U.S. District Court for the Central District of California. In March 2017, the court entered an order transferring the matter to the U.S. District Court for the Eastern District of Missouri. The plaintiffs in the lawsuit allege that the Company's accounting and related disclosures for certain liabilities acquired in the acquisition of Health Net violated federal securities laws. In July 2017, the lead plaintiff filed a Consolidated Class Action Complaint. The Company filed a motion to dismiss this complaint in September 2017. In February 2018, the Court held a hearing on the motion to dismiss but has not yet issued a ruling.

The Company denies any wrongdoing and is vigorously defending itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Additionally, on January 24, 2018, a separate derivative action was filed by plaintiff Harkesh Parekh on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. Plaintiff purports to bring suit derivatively on behalf of the Company against certain officers and directors for violation of securities laws, breach of fiduciary duty, waste of corporate assets and unjust enrichment. The derivative complaint repeats many of the allegations in the federal securities class action described above and asserts that defendants made inaccurate or misleading statements, and/or failed to correct the alleged misstatements.

A second shareholder derivative action was filed on March 9, 2018, by plaintiffs Laura Wood and Peoria Police Pension Fund on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. This second derivative complaint repeats many of the allegations in the securities class action and the first derivative suit.

A third shareholder derivative action was filed on December 14, 2018, by plaintiffs Carpenters Pension Fund of Illinois and Iron Workers Local 11 Pension Fund on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. This third derivative action repeats many of the allegations in the securities class action and the other derivative suits and adds additional allegations asserting violations of securities laws, breach of fiduciary duty, insider trading and unjust enrichment. The three derivative suits have been consolidated. Lead plaintiffs and counsel have been appointed. On July 11, 2019, the Court entered an order staying the consolidated derivative action, pending resolution of the motion to dismiss that is under submission in the Sanchez matter.

Medicare Parts C and D Matter

In December 2016, a Civil Investigative Demand (CID) was issued to Health Net by the United States Department of Justice regarding Health Net's submission of risk adjustment claims to CMS under Parts C and D of Medicare. The CID may be related to a federal qui tam lawsuit filed under seal in 2011 naming more than a dozen health insurers including Health Net. The lawsuit was unsealed in February 2017 when the Department of Justice intervened in the case with respect to one of the insurers (not Health Net). In subsequent pleadings, both the Department of Justice and the Relator excluded Health Net from the lawsuit. The Company is complying with the CID and will vigorously defend any lawsuits. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Veterans Administration Matter

In October 2017, a CID was issued to Health Net Federal Services, LLC (HNFS) by the United States Department of Justice. The CID seeks documents and interrogatory responses concerning whether HNFS submitted, or caused to be submitted, excessive, duplicative or otherwise improper claims to the U.S. Department of Veterans Affairs (VA) under a contract to provide healthcare coordination services for veterans. The contract began in late 2014 and ended September 30, 2018. In 2016, modifications to the contract were made to allow for possible duplicate billings with a reconciliation period at the end of the contract term. The Company is complying with the CID and believes it has met its contractual obligations. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter. This matter is separate from the negotiated settlements with the VA in connection with the contract expiration on September 30, 2018.

Ambetter Class Action

On January 11, 2018, a putative class action lawsuit was filed by Cynthia Harvey and Steven A. Milman against the Company and certain subsidiaries in the U.S. District Court for the Eastern District of Washington. The complaint alleges that the Company failed to meet federal and state requirements for provider networks and directories with regard to its Ambetter policies, denied coverage and/or refused to pay for covered benefits, and failed to address grievances adequately, causing some members to incur unexpected costs. In March 2018, the Company filed separate motions to dismiss each defendant. In July 2018, the plaintiff voluntarily filed a First Amended Complaint that removed Steven Milman as a plaintiff, dropped Centene Corporation and Superior Health Plan as defendants, abandoned certain claims, narrowed the putative class to Washington State only, and added Centene Management Company as a defendant. In August 2018, the Company moved to dismiss the First Amended Complaint. In response, the plaintiff voluntarily filed a Second Amended Complaint. In September 2018, the Company filed a motion to dismiss the Second Amended Complaint. On November 21, 2018, the Court granted in part and denied in part the Company's motion to dismiss. Plaintiff Cynthia Harvey filed a Third Amended Complaint, on November 28, 2018, against Centene Management Company and Coordinated Care Corporation ("Defendants"), both subsidiaries of the Company. Defendants filed an answer on December 12, 2018. Class certification discovery is occurring. The Company intends to vigorously defend itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Miscellaneous Proceedings

Excluding the matters discussed above, the Company is also routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of out-of-network claims, submissions to CMS for risk adjustment payments or the False Claims Act, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

- litigation arising out of general business activities, such as tax matters, disputes related to healthcare benefits coverage or reimbursement, putative securities class actions and medical malpractice, privacy, real estate, intellectual property and employment-related claims;

- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in awards of damages, fines or penalties, which could be substantial, and/or could require changes to the Company’s business. The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being sought.

PART II
OTHER INFORMATION

ITEM 1. ***Legal Proceedings.***

A description of the legal proceedings to which the Company and its subsidiaries are a party is contained in Note 11 to the consolidated financial statements included in Part I of this Quarterly Report on Form 10-Q, and is incorporated herein by reference.

ITEM 1A. ***Risk Factors.***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company. Unless the context otherwise requires, the terms the "Company," "we," "us," "our" or similar terms and "Centene" (i) prior to the closing of the WellCare Transaction, refer to Centene Corporation, together with its consolidated subsidiaries, without giving effect to the WellCare Transaction, and (ii) upon and after the closing of the WellCare Transaction, refer to us, after giving effect to the WellCare Transaction.

Reductions in funding, changes to eligibility requirements for government sponsored healthcare programs in which we participate and any inability on our part to effectively adapt to changes to these programs could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, CHIP, LTSS, ABD, Foster Care and Health Insurance Marketplace premiums. Under most programs, the base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs for this program, with the federal share currently averaging around 59%. We are therefore exposed to risks associated with federal and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state governments to terminate contracts with them, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; and our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity. For example, future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD and Foster Care. Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 ("sequestration"), subject to a 2% cap, which was extended by the Bipartisan Budget Act of 2018 for an additional two years through 2027. In addition, reductions in defense spending could have an adverse impact on certain government programs in which we currently participate by, among other things, terminating or materially changing such programs, or by decreasing or delaying payments made under such programs. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs remains steady or increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of one or more contracts for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows. In addition, if another federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD, Foster Care and the Health Insurance Marketplaces, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

2019 Centene 10-Q Ending September 30

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

☒ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the quarterly period ended September 30, 2019

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission file number: 001-31826

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
7700 Forsyth Boulevard **St. Louis, Missouri**	**63105**
(Address of principal executive offices)	*(Zip Code)*

Registrant's telephone number, including area code: (314) 725-4477

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

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on Which Registered
Common Stock $0.001 Par Value	**CNC**	**New York Stock Exchange**

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

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

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

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

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

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

As of October 11, 2019, the registrant had 413,796,072 shares of common stock outstanding.

CENTENE CORPORATION
QUARTERLY REPORT ON FORM 10-Q
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Segment information for the nine months ended September 30, 2019, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 53,283	$ 2,493	$ —	$ 55,776
Total revenues from internal customers	116	7,681	(7,797)	—
Total revenues	$ 53,399	$ 10,174	$ (7,797)	$ 55,776
Earnings from operations	$ 1,587	$ (83)	$ —	$ 1,504

Segment information for the nine months ended September 30, 2018, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 41,153	$ 2,404	$ —	$ 43,557
Total revenues from internal customers	76	6,919	(6,995)	—
Total revenues	$ 41,229	$ 9,323	$ (6,995)	$ 43,557
Earnings from operations	$ 983	$ 87	$ —	$ 1,070

11. Contingencies

Overview

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period the Company’s financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including as described below. Except for the proceedings discussed below, the Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations, cash flow or liquidity.

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California

On October 20, 2015, the Company's California subsidiary, Health Net of California, Inc. (Health Net California), was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned as Michael D. Myers v. State Board of Equalization, Dave Jones, Insurance Commissioner of the State of California, Betty T. Yee, Controller of the State of California, et al., Los Angeles Superior Court Case No. BS158655. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that Health Net California, a California licensed Health Care Service Plan (HCSP), is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. Under California law, "insurers" must pay a gross premiums tax (GPT), calculated as 2.35% on gross premiums. As a licensed HCSP, Health Net California has paid the California Corporate Franchise Tax (CFT), the tax generally paid by California businesses. Plaintiff contends that Health Net California must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the California taxing agencies to collect the GPT, and seeks an order requiring Health Net California to pay GPT, interest and penalties for a period dating to eight years prior to the October 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities (collectively, "Related Actions"). In March 2018, the Court overruled the Company's demurrer seeking to dismiss the complaint and denied the Company's motion to strike allegations seeking retroactive relief. In August 2018, the trial court stayed all the Related Actions pending determination of a writ of mandate by the California Court of Appeals in two of the Related Actions. In March 2019, the California Court of Appeals denied the writ of mandate. The defendants in those Related Actions sought review by the California Supreme Court, which declined to review the matter. The case is back before the trial court which has scheduled a hearing in February 2020 to consider a motion for summary judgment by Health Net California. In the meantime, discovery will proceed. No trial date has been set. The Company intends to vigorously defend itself against these claims; however, this matter is subject to many uncertainties, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position, results of operations and cash flows.

Federal Securities Class Action

On November 14, 2016, a putative federal securities class action, Israel Sanchez v. Centene Corp., et al., was filed against the Company and certain of its executives in the U.S. District Court for the Central District of California. In March 2017, the court entered an order transferring the matter to the U.S. District Court for the Eastern District of Missouri. The plaintiffs in the lawsuit allege that the Company's accounting and related disclosures for certain liabilities acquired in the acquisition of Health Net violated federal securities laws. In July 2017, the lead plaintiff filed a Consolidated Class Action Complaint. The Company filed a motion to dismiss complaint in September 2017. In August 2019, the Court granted the Company's motion to dismiss in part and denied it in part, dismissing allegations regarding certain statements and thereby narrowing the time period to which the allegations will be subject. The case will now move into the discovery phase.

The Company denies any wrongdoing and is vigorously defending itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Additionally, on January 24, 2018, a separate derivative action was filed by plaintiff Harkesh Parekh on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. Plaintiff purports to bring suit derivatively on behalf of the Company against certain officers and directors for violation of securities laws, breach of fiduciary duty, waste of corporate assets and unjust enrichment. The derivative complaint repeats many of the allegations in the federal securities class action described above and asserts that defendants made inaccurate or misleading statements, and/or failed to correct the alleged misstatements.

A second shareholder derivative action was filed on March 9, 2018, by plaintiffs Laura Wood and Peoria Police Pension Fund on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. This second derivative complaint repeats many of the allegations in the securities class action and the first derivative suit.

A third shareholder derivative action was filed on December 14, 2018, by plaintiffs Carpenters Pension Fund of Illinois and Iron Workers Local 11 Pension Fund on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. This third derivative action repeats many of the allegations in the securities class action and the other derivative suits and adds additional allegations asserting violations of securities laws, breach of fiduciary duty, insider trading and unjust enrichment. The three derivative suits have been consolidated. Lead plaintiffs and counsel have been appointed. On July 11, 2019, the Court entered an order staying the consolidated derivative action, pending resolution of the motion to dismiss that is under submission in the Sanchez matter. As a result of the August 2019 ruling in the Sanchez matter described above, the parties filed a joint status report and a motion to lift the stay in the consolidated derivative action. The court entered an order lifting the stay and set a briefing schedule on a motion to dismiss. Pursuant to that schedule, defendants are to file a motion to dismiss on October 31, 2019.

Medicare Parts C and D Matter

In December 2016, a Civil Investigative Demand (CID) was issued to Health Net by the United States Department of Justice regarding Health Net's submission of risk adjustment claims to CMS under Parts C and D of Medicare. The CID may be related to a federal qui tam lawsuit filed under seal in 2011 naming more than a dozen health insurers including Health Net. The lawsuit was unsealed in February 2017 when the Department of Justice intervened in the case with respect to one of the insurers (not Health Net). In subsequent pleadings, both the Department of Justice and the Relator excluded Health Net from the lawsuit. The Company is complying with the CID and will vigorously defend any lawsuits. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Veterans Administration Matter

In October 2017, a CID was issued to Health Net Federal Services, LLC (HNFS) by the United States Department of Justice. The CID seeks documents and interrogatory responses concerning whether HNFS submitted, or caused to be submitted, excessive, duplicative or otherwise improper claims to the U.S. Department of Veterans Affairs (VA) under a contract to provide healthcare coordination services for veterans. The contract began in late 2014 and ended September 30, 2018. In 2016, modifications to the contract were made to allow for possible duplicate billings with a reconciliation period at the end of the contract term. The Company is complying with the CID and believes it has met its contractual obligations. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter. This matter is separate from the negotiated settlements with the VA in connection with the contract expiration on September 30, 2018.

Ambetter Class Action

On January 11, 2018, a putative class action lawsuit was filed by Cynthia Harvey and Steven A. Milman against the Company and certain subsidiaries in the U.S. District Court for the Eastern District of Washington. The complaint alleges that the Company failed to meet federal and state requirements for provider networks and directories with regard to its Ambetter policies, denied coverage and/or refused to pay for covered benefits, and failed to address grievances adequately, causing some members to incur unexpected costs. In March 2018, the Company filed separate motions to dismiss each defendant. In July 2018, the plaintiff voluntarily filed a First Amended Complaint that removed Steven Milman as a plaintiff, dropped Centene Corporation and Superior Health Plan as defendants, abandoned certain claims, narrowed the putative class to Washington State only, and added Centene Management Company as a defendant. In August 2018, the Company moved to dismiss the First Amended Complaint. In response, the plaintiff voluntarily filed a Second Amended Complaint. In September 2018, the Company filed a motion to dismiss the Second Amended Complaint. On November 21, 2018, the Court granted in part and denied in part the Company's motion to dismiss. Plaintiff Cynthia Harvey filed a Third Amended Complaint, on November 28, 2018, against Centene Management Company and Coordinated Care Corporation ("Defendants"), both subsidiaries of the Company. Defendants filed an answer on December 12, 2018. Class certification discovery is occurring. The Company intends to vigorously defend itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Miscellaneous Proceedings

Excluding the matters discussed above, the Company is also routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of out-of-network claims, submissions to CMS for risk adjustment payments or the False Claims Act, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

- litigation arising out of general business activities, such as tax matters, disputes related to healthcare benefits coverage or reimbursement, putative securities class actions and medical malpractice, privacy, real estate, intellectual property and employment-related claims;

- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in awards of damages, fines or penalties, which could be substantial, and/or could require changes to the Company's business. The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being sought.

12. Goodwill and Intangible Impairment

During the third quarter of 2019, the Company recorded $271 million of non-cash goodwill ($259 million) and intangible asset ($12 million) impairment, substantially all associated with the Company's U.S. Medical Management (USMM) physician home health business in the Specialty Services segment. The impairment was identified as part of the Company's quarterly review procedures, which included an analysis of new information related to its shared savings demonstration programs, slower than expected penetration of the physician home health business model into its Medicaid population, and the related impact to revised forecasts. The Company conducted an impairment analysis of the identifiable intangible assets and goodwill of the reporting unit using the income approach, in which fair value is derived based on the present value of discounted expected cash flows.

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PART II
OTHER INFORMATION

ITEM 1. ***Legal Proceedings.***

A description of the legal proceedings to which the Company and its subsidiaries are a party is contained in Note 11 to the consolidated financial statements included in Part I of this Quarterly Report on Form 10-Q, and is incorporated herein by reference.

ITEM 1A. ***Risk Factors.***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company. Unless the context otherwise requires, the terms the "Company," "we," "us," "our" or similar terms and "Centene" (i) prior to the closing of the WellCare Transaction, refer to Centene Corporation, together with its consolidated subsidiaries, without giving effect to the WellCare Transaction, and (ii) upon and after the closing of the WellCare Transaction, refer to us, after giving effect to the WellCare Transaction.

Reductions in funding, changes to eligibility requirements for government sponsored healthcare programs in which we participate and any inability on our part to effectively adapt to changes to these programs could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, CHIP, LTSS, ABD, Foster Care and Health Insurance Marketplace premiums. Under most programs, the base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs for this program, with the federal share currently averaging around 59%. We are therefore exposed to risks associated with federal and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state governments to terminate contracts with them, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; and our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity. For example, future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD and Foster Care. Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 ("sequestration"), subject to a 2% cap, which was extended by the Bipartisan Budget Act of 2018 for an additional two years through 2027. In addition, reductions in defense spending could have an adverse impact on certain government programs in which we currently participate by, among other things, terminating or materially changing such programs, or by decreasing or delaying payments made under such programs. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs remains steady or increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of one or more contracts for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows. In addition, if another federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD, Foster Care and the Health Insurance Marketplaces, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

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